

Crises in Palliative Care



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Overview



- Clinical focus, case based
- Challenges
- Discussion ++

What is a crisis?



What is a crisis?



1. A time of intense **difficulty** or **danger**
 2. A time when a difficult or important **decision** must be made
 3. (medical) the turning point of a disease when an important change takes place, indicating either recovery or death
- medical Latin, from Greek krisis 'decision', from krinein 'decide'

Oxford English Dictionary

What characterises a crisis?



- Sudden
- Needs immediate action
- Frightening?
- Urgent assessment, decision making and treatment as a (multidisciplinary) team

Implications of a crisis in palliative care?



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- Can determine quality of last phase of illness
- Can affect family/carer bereavement response
- Can achieve preferred place of death

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- May be difficult to make the right decision in a short space of time
- ...especially if you don't know that person
- ...or their wishes
- And they are too unwell to discuss this

A Crisis Requires:



- Awareness
- Recognition early
- When making decisions –
 - What's appropriate – where is someone in their illness?
 - What are the goals of care?
 - What does the patient want?
 - What are the implications for place of care?
 - Up front “cost” – overall benefit?
 - Keep symptom control of crucial importance

Cases in crisis



Case 1: Mr K



- Prostate cancer
- Widespread bony metastases
- Castrate resistant and not responding to 3rd line oncological treatment

- Thirsty
- Passing large volumes of urine
- Fatigued
- Confused
- Constipated

On review at home



- AMT 2/4
- Wife reports: not made it to bowling green that week
- Vomits during review
- Twitchy
- Seems uncomfortable but unable to describe his symptoms

- Plan: admit for investigations and further management

Mr K: initial lab investigations



- Adjusted calcium 3.4 (normal 2.1-2.55)
- Renal function normal

Malignant Hypercalcaemia



- 10 - 30% of all patients with malignancy
- Commonest life threatening metabolic disorder in cancer
- CAUSES
 - humoral (PTHrP) bone destruction
 - tumour Vit D analogues (lymphoma)
- Myeloma, breast, lung cancer
- Often the first presentation of a cancer
- Generally, advanced disease
- 80% die within 12 months
- Recurrent episodes = bad news

Symptoms and Signs

Mild

- Nausea/vomiting
- Anorexia
- Constipation
- Thirst
- Polyuria

Severe

- Gross dehydration
- Drowsiness
- Delirium
- Coma
- Abnormal neurology
- Cardiac arrhythmias

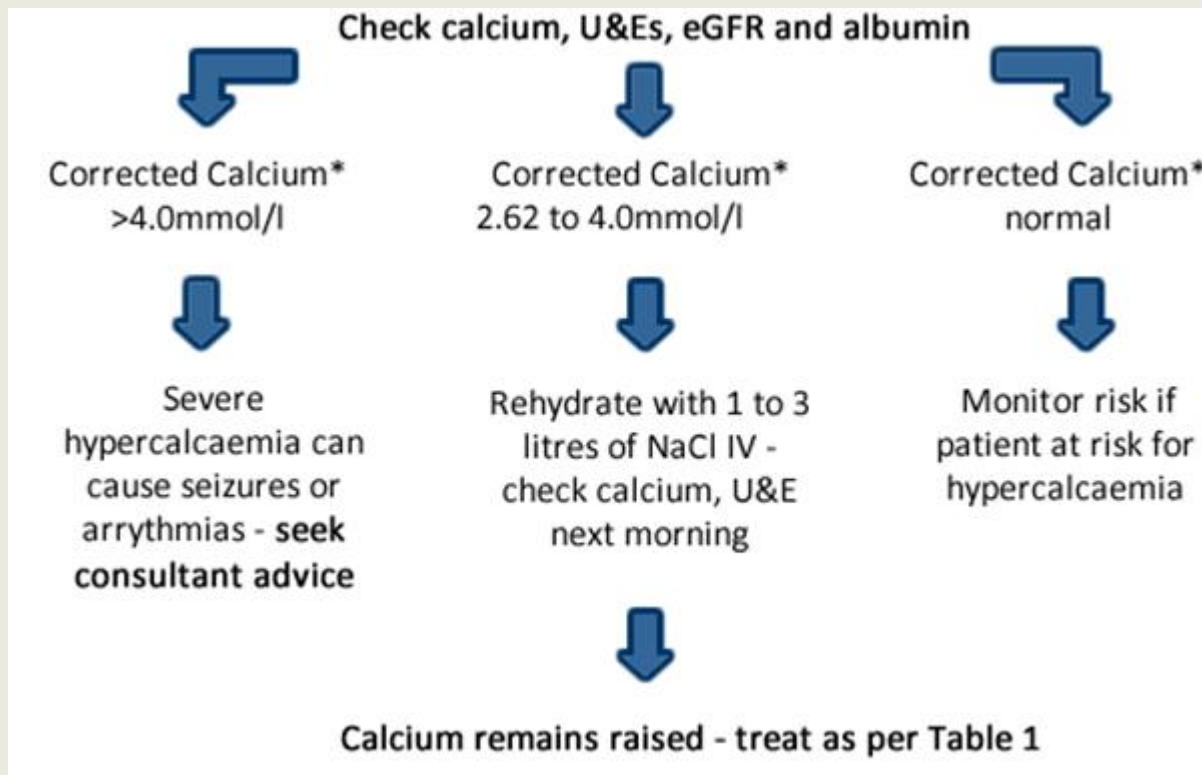
Management of Hypercalcaemia



- Scottish Palliative Care Guidelines

<http://www.palliativecareguidelines.scot.nhs.uk/guidelines/palliative-emergencies/Hypercalcaemia.aspx>

- IV rehydration with 0.9% NaCl
- IV bisphosphonate (pamidronate/zolendronate)
- Time to take effect (up to 7)
- Can repeat dose
- Rebound hypocalcaemia possible





Corrected calcium* (mmol/l)	Drug & Dose	Diluent and maximum infusion rate
	disodium pamidronate	
2.62 to 3.0	15mg to 30mg	500ml NaCl 0.9% over > 60 minutes
3.0 to 3.5	60mg	500ml NaCl 0.9% over > 60 minutes
3.5 to 4.0	90mg	500ml NaCl 0.9% over > 90 minutes
>4.0	90mg	500ml NaCl 0.9% over > 90 minutes
	zoledronic acid	
>3.00	4mg	100ml NaCl 0.9% over 15 minutes

Factors to Consider



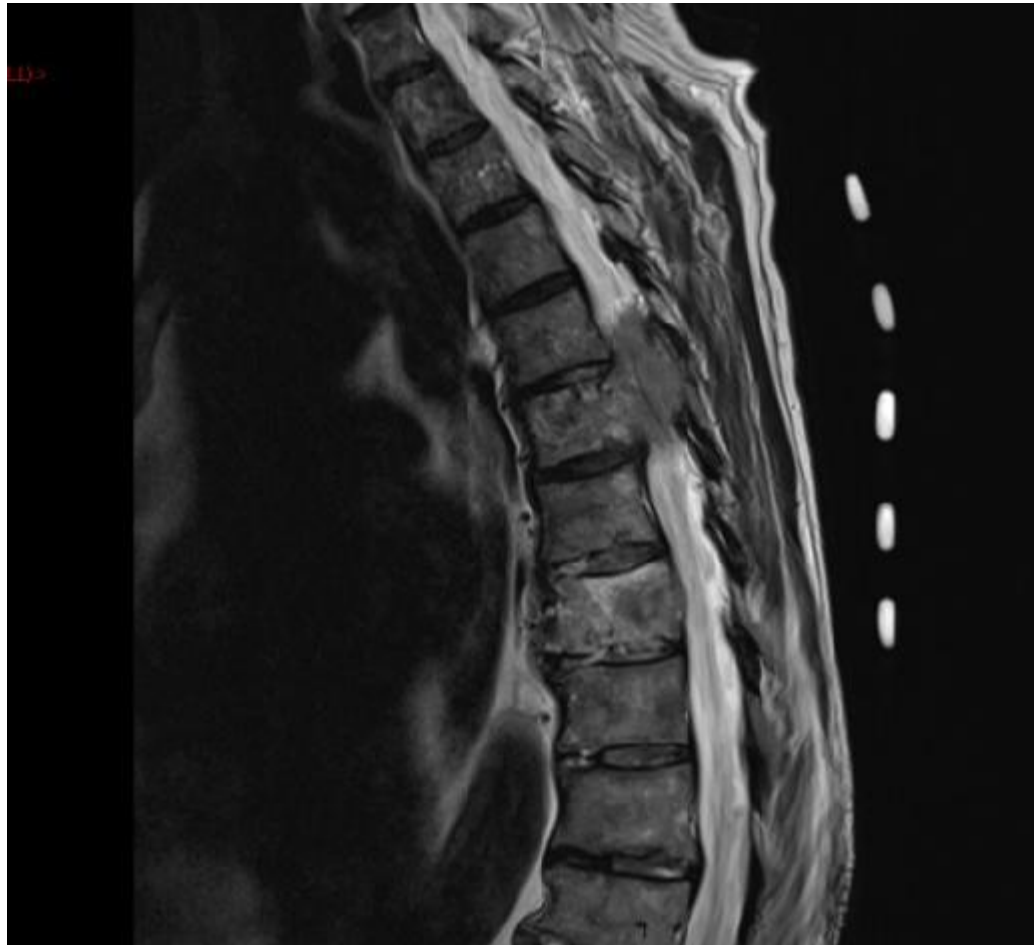
- Resistant/refractory hypercalcaemia?
- Time to treat?
- Where to treat?
- What are the goals of care?

Case 2: Mr E



- 58
- T2N2 NSCLC diagnosed 18 months ago
- Completed palliative chemoradiotherapy
- “Watchful waiting”
- Urgent appointment at the surgery
- 5 weeks of increasing back pain
- “Like a band” round middle, worse on coughing and sneezing
- Shooting down left leg

Diagnosis?



Malignant spinal cord compression



CANCER

SEVERE BACK/NEUROGENIC PAIN

NEW DIFFICULTY WALKING

Management



- Urgent MRI of WHOLE spine (NB: predicting compression level 21% plain x-ray; 19% bonescan)
- Empirical high dose steroids pending scan to reduce vasogenic oedema
- Early diagnosis makes a huge difference...

Malignant spinal cord compression (MSCC)



- 3 - 5% of patients with cancer
- 10% of those with spinal metastases
- In 60%: breast, lung or prostate cancer
- >90% have back pain
- Clue is the description of the pain
- DO NOT want to wait until immobile
- Sensory level not always there, and not always accurate

Original Article

What Happens to People after Malignant Cord Compression? Survival, Function, Quality of Life, Emotional Well-being and Place of Care 1 Month after Diagnosis

R. Conway^{*}, J. Graham[†], J. Kidd[‡], P. Levack[§]
and other members of the Scottish Cord Compression Group¹

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ABSTRACT:

Aims: To present further findings from the Scottish Cord Compression Study, in which the diagnosis, management and outcome of 319 patients with a definitive diagnosis of malignant cord compression (MCC) were examined.

Materials and methods: In total, 256 (80%) patients in the study consented to be interviewed shortly after diagnosis and at follow-up interviews. One hundred and twenty-eight patients were interviewed 1 month after diagnosis (40% of the total; 57% [128/224] of patients alive 1 month after diagnosis; 68% [128/188] of patients who also consented to follow-up). Survival data of the whole MCC population and data from interviewing 128 patients 1 month after diagnosis are presented.

Results: The median survival of all patients was 59 days (95% confidence interval [CI] 43–75 days). The median Karnofsky performance status was 50 (interquartile range 40–60), indicating a need for considerable nursing and medical care, and was poorest for patients with lung cancer (median 40; interquartile range 30–60). The place of care was dependent on mobility at diagnosis; patients walking at diagnosis were more likely to be at home, whereas patients requiring assistance or who were unable to walk were more likely to be in institutional care ($P = 0.019$). Mobility and bladder function were determined by mobility and bladder function at diagnosis ($P < 0.001$). Of those unable to walk at diagnosis, 7% regained full mobility. Of those catheterised at presentation, 28% regained full bladder function. Forty-

MSCC: early recognition



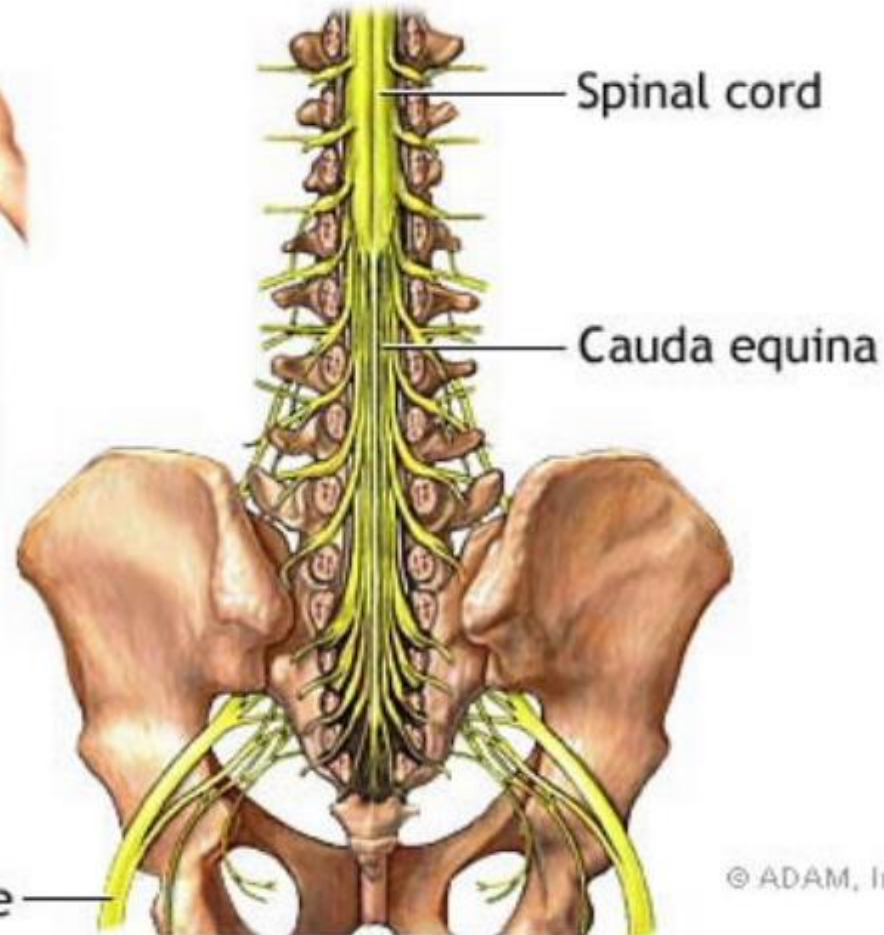
- Can prevent paralysis and incontinence
- 70% of patients mobile at diagnosis remain mobile
- <5% who are paralysed at diagnosis manage to walk again

MSCC: treatment



- Admit
- Dexamethasone 16mg (1mg dex=7.5mg pred)
- Discuss with oncology re: radiotherapy
- UK: 20Gy in 5#; single posterior field; supine; abnormal area +/- 1 to 2 vertebrae
- Neurosurgery (single area/previous XRT/no known primary)
- Chemotherapy (lymphoma/teratoma/??SCLC)
- MDT care - nursing/physio/OT

Cauda equina syndrome



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Considerations



- Performance status and prognosis?
- Time to take effect

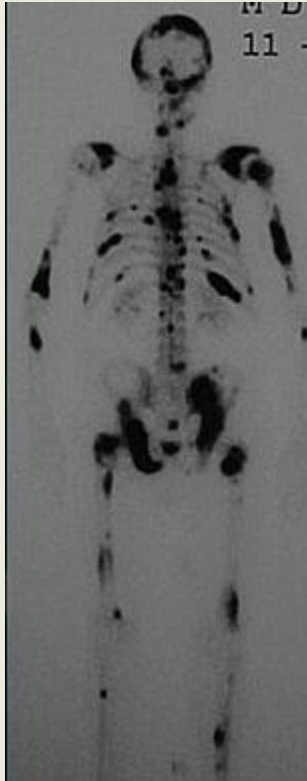
Case 3: Mr L



- Renal cell carcinoma
- Frail
- Widespread bony metastases

- Turned in bed and heard a “crack”
- Pain and deformity right upper arm

Radiological Investigations



Pathological Fracture



- Secondary bone disease or bony metastases
- Primary bone cancer
- Sites: long bones, vertebrae
- Radiology useful (previous as well)
- Treatment often involves other specialties to help with pain control:
 - Splints
 - Fixation
 - Follow up radiotherapy
 - Anaesthetic team

Pathological Fracture



- Patient condition important:
 - Are they fit for transfer or treatment?
 - Is prognosis long enough to gain benefit from fixation? (>2 weeks)
 - Treatment needs to outlive patient
 - What does the patient want?

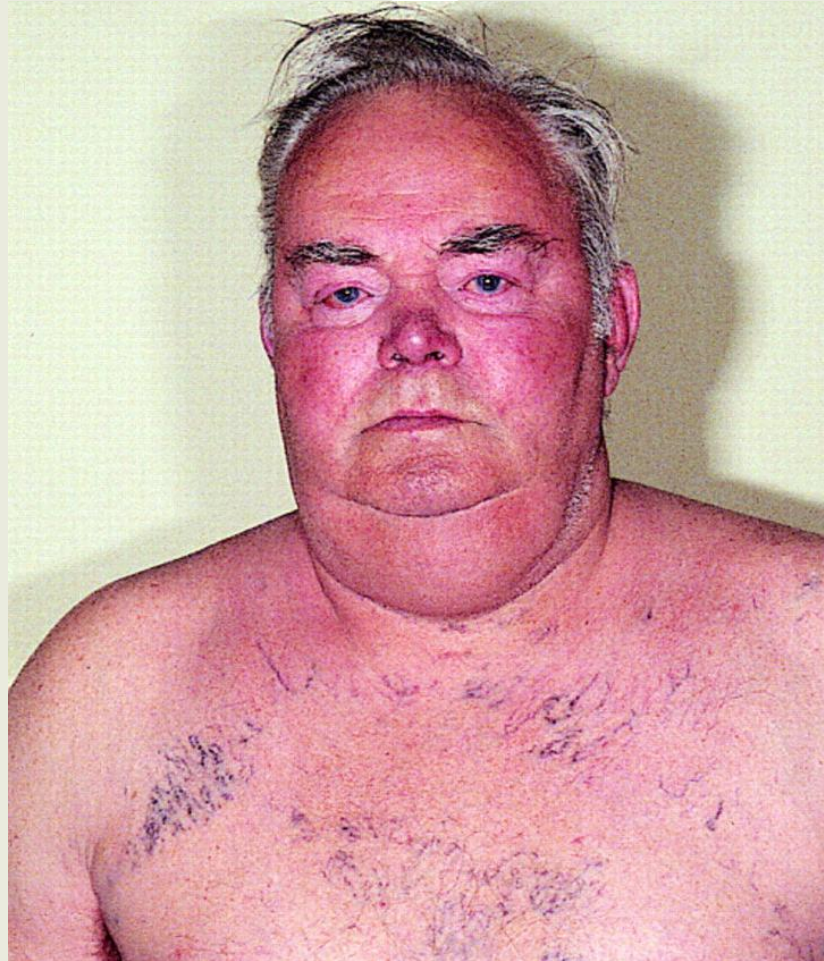
Case 4: Mr T



- 62 year old man
- Lifelong smoker

- Headache
- More short of breath recently
- Shirt collar won't button up
- Wife says he looks "sunburnt"

Mr T: diagnosis?



Superior Vena Caval Obstruction (SVCO)



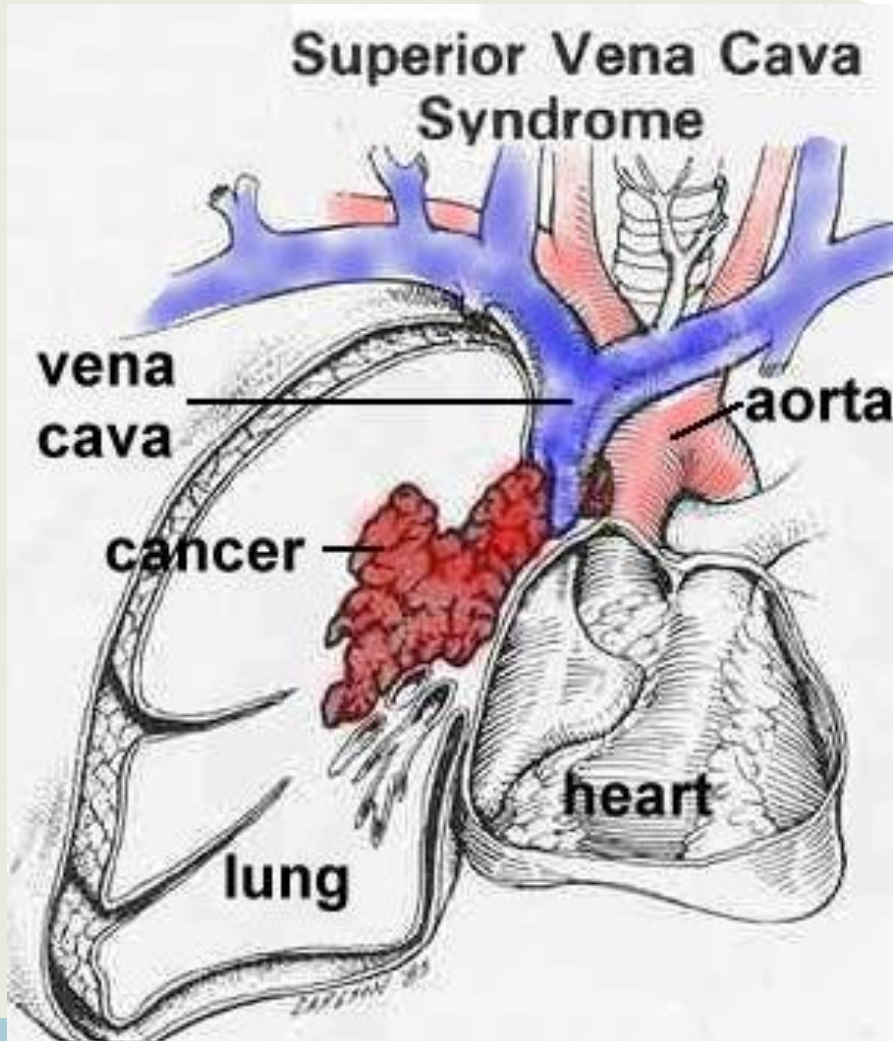
- Can be first presentation of cancer
- Signs and symptoms insidious in onset...

SVCO



Not always this obvious!

SVCO



- SVC: venous return from head, upper limbs
- Obstruction:
 - Extrinsic compression (tumour)
 - Direct invasion
 - Intrinsic compression (thrombus)

SVCO



- Commonest in lung cancer (75% of SVCO)
- Any tumour with mediastinal nodes

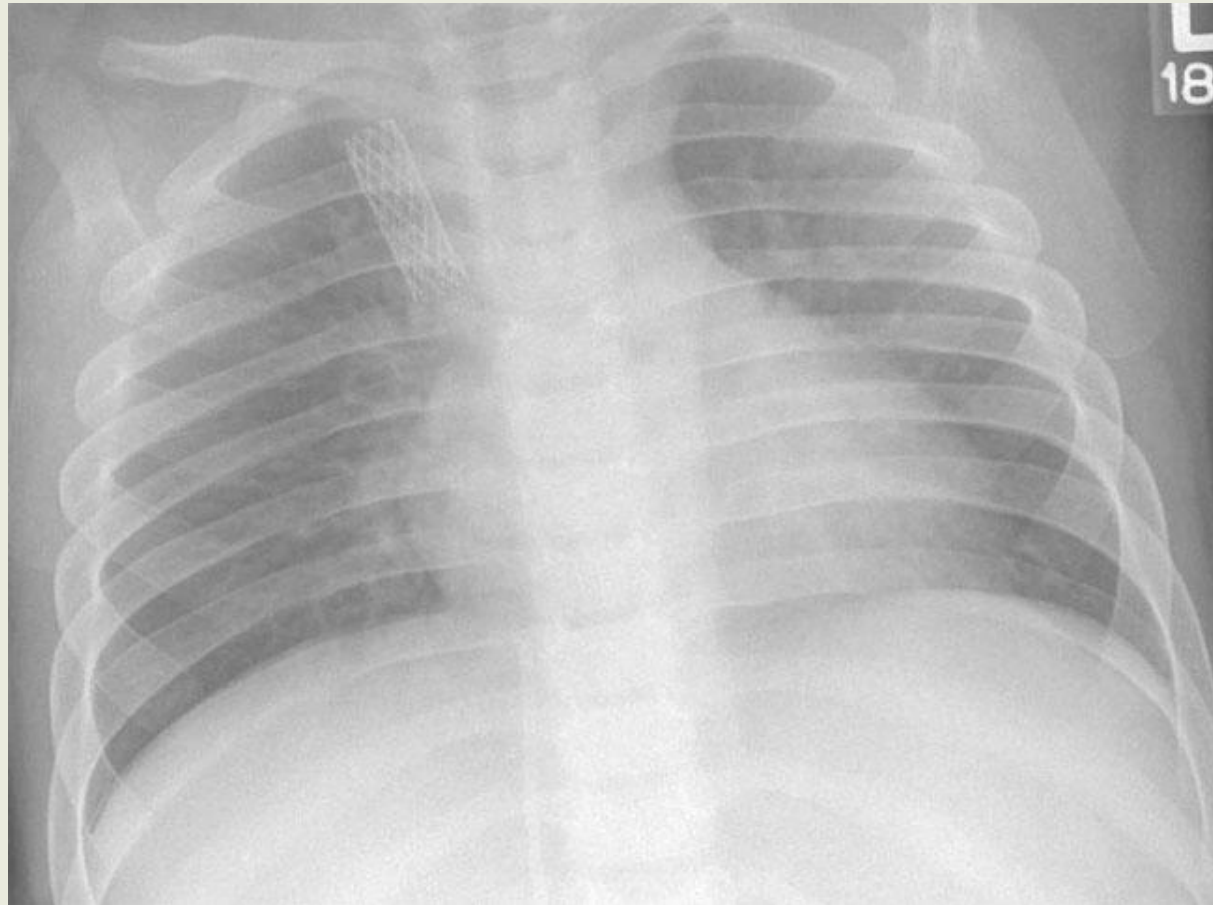
- 15% lymphoma
- 10% breast, colon, oesophagus, testicular
- Prognosis is that of the underlying disease

SVCO



- Treatment can vary according to cancer type
- Sit up and give oxygen to support
- High dose dexamethasone (no evidence for extrinsic compression)
- Appropriate investigations – clinical radiology/oncology liaison
- Stenting +/- thrombolysis +/- anticoagulation
- Radiotherapy or chemotherapy

Intervention?



Mrs HP



- Lung cancer
- Previous debulking and palliative chemotherapy
- Latest CT (6 weeks ago) “huge volume of metastatic disease within the brain”
- Started dexamethasone 16mg

Mrs HP



- Headache, worst on lying flat and in the morning
- Nausea, no vomiting
- Husband: “totally disabled by this”

Raised intracranial pressure



- Goals of care?
- Steroids...
- Opioids often needed too
- Centrally acting antiemetic – cyclizine (150mg sc)

- Seizure management
- Pre-emptive v reactive
- Setting important re: drugs available/route

Case 5: Mrs M



- Thyroid cancer
- Aggressive tumour
- Opted for non-surgical management

- In hospital for presumed chest infection (more short of breath than usual)
- 11pm and ward TV being switched off
- Nurse notices “breathing sounds funny”

Stridor



- NOT wheeze
- Large airways obstruction
- Inspiratory sound

- Head and neck tumours
- Lung cancers
- Mediastinal disease
- Often subtle, insidious onset

Stridor: Management



- Oxygen to support
- Level of intervention:
 - ENT input – consider tracheostomy
 - Steroids
 - Stenting
 - Radiotherapy
- Or...active sedation

Crisis Airway Management in Malignant Disease



➤ Complexity...

Mr C



- 80
- Previous T2N0 SCC larynx
- Total laryngectomy/radiotherapy 1997
- Recent formation of fistula in neck
- Attended clinic after CT scan for review

At Clinic



- “concerning necrotic looking mass clinically”
- CT: large tumour right neck encasing major vessels

- Biopsy in clinic...

What Happened Next



- Brisk bleed
- 999 ambulance to QEUH
- Bleeding stopped en route
- “settled, comfortable” on ward
- Wanted to go home

The Next 8 Days



Day 1

- Coughing – bleed
- Discussions re: place of care
- Symptoms – pain

Day 2/3

- No bleeding

Day 4 (25/12)

- “catastrophic bleed”
- Midazolam given iv (10mg)*

The Next 8 Days (contd)



Day 5

- Awake, lucid
- Ward round: “comfortable. No need for sedation”
- Review: “Frightened”
- Csci commenced after discussion

Day 6/7

- Asleep long periods but anguished when awake
- Intermittent ooze
- Able to wake to write on pad “No more”

Last Days



csci :

- Midazolam 50mg
- Levomepromazine 150mg
- Morphine 50mg

- Died peacefully with family present.

Afterwards



- Debrief on ward
- Met family
- Departmental meeting
- Policy development

Major Haemorrhage



➤ ACUTE

- Erosion of major artery
- *Massive* haematemesis

➤ NON-ACUTE

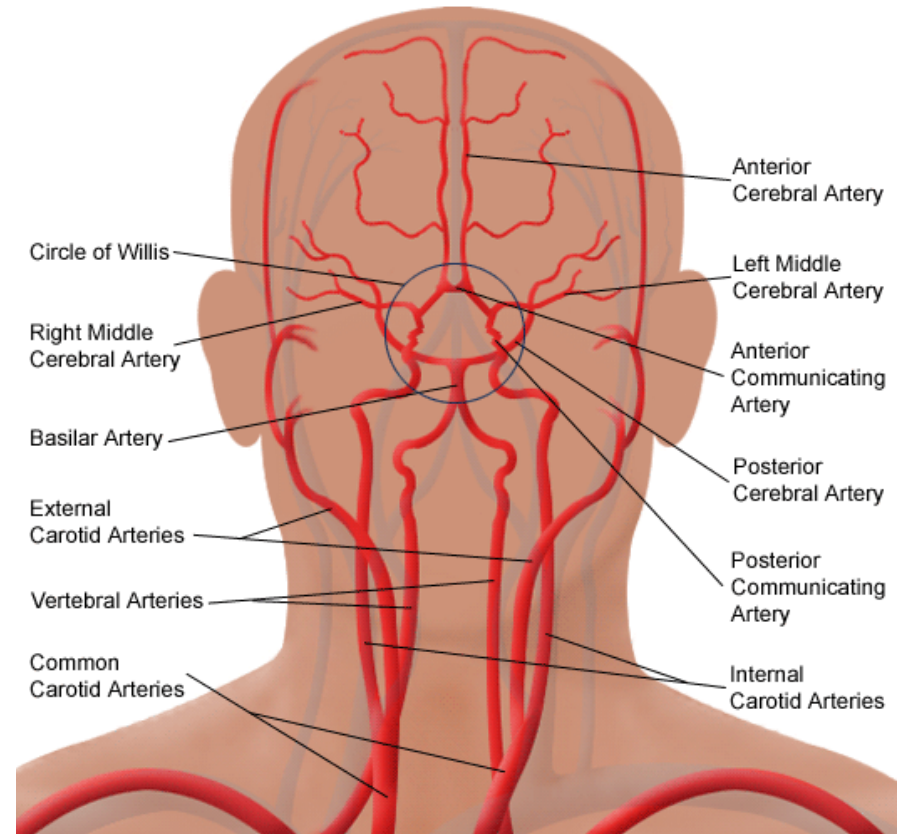
- “Minor “ GI bleeding
- PR, PV or surface bleed

Major haemorrhage: at risk patients



- Head and neck tumours – “carotid blow-out”
- Any tumour round major artery
- Lung tumours
- Clotting problems

Arterial Circulation of the Brain, Including Carotid Arteries



Major Haemorrhage: Management



- **Someone should stay with the patient at all times**
- Decision about level of intervention – is active resuscitation indicated?
- Pre-emptive “crisis management” often prescribed
- **DO NOT LEAVE A PATIENT ALONE TO GET THESE DRUGS**

Major Haemorrhage: Management



- Planning ahead
- Place of care
- Dark towels
- Crisis medication: large doses of midazolam, IM or IV
- Buccal preparations

- New West of Scotland Guideline*

Major Haemorrhage: Management



- Family support following event
- Support to team following event
- Rare event, but familiarity with potential situation is vital
- New WoSCAN guideline for management of bleeding in the palliative care setting (head and neck) – hopefully will be ratified for all cancer sites

Crises Covered



- Malignant hypercalcaemia
- Malignant spinal cord compression
- Pathological fracture
- SVCO
- Terminal agitation
- Raised intracranial pressure
- Stridor
- Haemorrhage
- Pain crisis

Preventing emergencies?



- Awareness leads to more recognition
- Decision making as a team involving patient/carers
- Consider stage/phase of illness, reversibility and goals of care
- Done well, can have profound impact on patient (survival or death)

Discussion

