Objectives: ‘forewarned is forearmed’

- Highlight range of palliative care emergencies
- Increase your awareness of people potentially at risk
- Increase your capacity to identify emergencies
- Increase your confidence in articulating your assessment to get appropriate review
- Increase your knowledge of how they could be managed

What is a Palliative Care Emergency?

- Palliative care emergencies involve situations that can cause imminent death or result in extreme changes to the quality of life for the patient and their family and whānau.

Therapeutic emergencies (Twycross et al 2002)

1. Haematological – haemorrhage
2. Respiratory - SVC obstruction
3. Neurological – Spinal cord compression
4. Neurological - Seizures

To treat or not to treat...?

The decision whether to take emergency action must be based on the answer to the following questions:

- Is the problem reversible?
- Will reversal of the problem improve/maintain the patient’s quality of life?
- What is patient’s general condition, the disease and its prognosis?
- What are the patient’s and family’s wishes?
- Will burden of any proposed treatment outweigh the distress caused by the symptoms?
Assessment of patient’s history and current findings

**RISK**
- Advancing metastatic disease
- Platelet dysfunction
- Hepatic dysfunction
- Drug risk – e.g. NSAIDs, anticoagulants
- Chemotherapy
- Known tumour invasion of major structures/vessels

**Facts**
- Bleeding in advanced cancer not uncommon - different to catastrophic haemorrhage
- Bleeding occurs in approximately 20% of patients with advanced cancer
- Contributes significantly to the patient’s death in about 5% of people with advanced cancer
- External catastrophic bleeding less common than internal occult bleeding in people with cancer
- Haemorrhage – non malignant (e.g. AAA and haemorrhagic stroke)

**Life Threatening Haemorrhage**
- Erosion of artery by a malignant ulcer e.g. Neck, Axilla or Groin
- Massive haemoptysis (haemoptysis life threatening only in 1%)
- Major haematemesis
  - Peptic ulcer – NSAID induced
  - Gastric Cancer
- Fresh melena
- Vaginal bleeding
- Aneurysm (e.g AAA)

**Your assessment to establish a plan**
- Know the extent and nature of a person's disease
- Be pre-emptive in discussions with colleagues (nursing and medical) re establishing a plan.
- Convey rationale for the need for an 'Action Plan' – participate in discussions.

**Management**
- Anticipate and discuss with patient and family if haemorrhage is a significant possibility regarding use of
  - sedation,
  - family presence in an emergency and
  - resuscitation measures
- Ensure dark towels are available at all times (external haemorrhage)
- Ensure appropriate drugs are charted and available e.g. Midazolam 5-10mg S/C stat
- Someone (doctor, nurse, caregiver) remain with patient
- Consider blood transfusion if patient survives 24hrs

**Some sources of non catastrophic haemorrhage may be responsive to:**
- Tranexamic acid
- Radiotherapy

**Remember:** Please contact the specialist palliative care service to discuss (earlier is best) if required.
Facts: What is SVCO?

- The superior vena cava drains blood from the head, neck and upper chest to the heart.
- Compression or invasion of the superior vena cava (SVC) itself can obstruct flow.
- The SVC can be extrinsically compressed by tumour or mediastinal nodes at the right main bronchus.

Assessment of patients history and current findings

**RISK** – advanced metastatic Ca
- Lung Ca responsible for 80%
  - SVCO occurs in about 15% of lung Ca – particularly Small Cell Lung Cancer (SCLC).
- Higher risk of SVCO with Lymphoma, Breast Ca, and Testicular Seminoma.
- Non cancer causes include central venous catheters, post radiotherapy fibrosis, thrombosis.

The common symptoms? (pt complains of)

Symptoms are due to raised pressure in the venous system:
- Breathlessness (50%)
- Neck and facial swelling (40%)
- Trunk and arm swelling (40%)
- Sensation of choking
- A feeling of fullness in the head
- Headache
Other potential symptoms

- Chest pain
- Cough
- Dysphasia
- Cognitive impairment
- Hallucinations
- Seizures

Physical signs? (you see/hear)

**Common:**
- Thoracic vein dissention - 65%
- Neck vein distension - 55%
- Facial oedema - 55%
- Tachypnoea - 40%
- Plethora of face 15%
- Cyanosis 15%
- Arm oedema 10%
- Vocal cord paresis
- Horner’s syndrome 3%

**If severe:**
- Stridor
- Coma
- Death

How is it diagnosed?

- Usually presents over days/weeks
- Be suspicious if patient's history and symptoms align
- Be suspicious in the absence of a cancer diagnosis if symptomatic – especially stridor
- Convey assessment
- Urgent CT scan or MRI
- May need a tissue diagnosis if the patient is not known to have cancer

Management

- If risk identified earlier, a discussion with patient and family is recommended regarding the possibilities that it may occur and possible management (e.g. stenting, palliative radiotherapy, palliative chemotherapy, sedation, and their preference for levels of intervention)
- Can progress over days or weeks to death
- Usually there is time to plan treatment

Emergency treatment for advanced SVCO

- Oxygen may be appropriate
- High dose cortico-steroids e.g. Dexamethasone 16mg OD
- Symptomatic treatment e.g. furosemide, morphine elixir 2.5mg – 5mg 4hrly for breathlessness
- Explanation and reassurance
- Radiotherapy referral

Management

- Radiotherapy to mediastinum is effective in most cases.
- Chemotherapy is helpful in cancers sensitive to chemotherapy (e.g. Small Cell Lung Cancer or Lymphoma)
- High dose steroids help to reduce swelling and are useful while waiting for definitive treatment or if no treatment is possible
- In patients who fail to improve (or if recurs <10%) with the above stenting may be an option
- Radiotherapy or chemotherapy may prolong survival by several months
BUT it may be a terminal event, characterised by breathlessness and fear. Sedation may be required using midazolam

Remember: Please contact the specialist palliative care service to discuss (earlier is best).

Assessment of patients history and current findings

RISK – Advanced metastatic Ca, (lung, breast, prostate, kidney, multiple myeloma and non-Hodgkins lymphoma)
- Occurs in 3-5% of patients with advanced cancer
- Cancers of breast, bronchus and prostrate account for 40%
- Most occur in the thorax
- There is compression at more than one level in 20%
- Below the level of L2, the compression is of the Cauda Equina (Peripheral nerves)

What are the signs and symptoms?
- Pain - back/neck – 90%
  - cervical region- 10%
  - thoracic region- 70%
  - lumbar region- 20%
- Pain -Banded in nature in line with dermatones
- Local tenderness
- Weakness of limbs – 75%
- Sensory disturbance – 50%
- Incontinence of urine/faeces – 40%

How is it diagnosed?
- High index of suspicion if history of malignancy
- Clinical findings
- Urgent MRI
How is it managed?

- **Corticosteroids:** 16mg dexamethasone usually IV or orally as soon as diagnosis is suspected to reduce swelling
- **Radiotherapy:** to try and restore neurological function and reduce pain.
- **Chemotherapy:** Some tumours respond
- **Surgery:** If biopsy needed, spinal collapse, radiotherapy ineffective or a cervical lesion

What is the prognosis?

- **30% alive after 1 year**
- With urgent radiotherapy:
  - if walking at the time of diagnosis, 70% are able to walk
  - if paralysed at the time of diagnosis, only 5% will walk again
- Most people present late or are diagnosed too late

Further Management

- If paraplegic:
  - wheelchair, catheter, bowel regulation, pressure area care, physio, OT, psychological support

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Neurological: Seizures

Assessment of patients history and current findings

**RISK**

- History of epilepsy
- Previous CVA
- Brain tumour (primary and secondary)
- Renal dysfunction/failure, severe hyponatraemia

- In relatively fit palliative care patients the cause of seizure(s) should be investigated and appropriate management established
- Discussion with patient and family recommended re their preference for care and level of intervention may be appropriate if the persons disease is very advanced
In the imminently terminal patient

- If risk identified, ensure PRN medications are available
  - E.g. For focal seizures midazolam (S/C or Intranasal spray) may be appropriate.
  - For tonic/clonic seizures midazolam (S/C or Intranasal spray), Diazepam (STESOLID PR or sublingual) or clonazapam drops may be appropriate.
- In the imminently terminal patient replacement anticonvulsant therapy may be required (in the syringe driver prescription, or alternative route)

**Remember:** Please contact the specialist palliative care service to discuss (earlier is best) if required.

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References

- Google images