Palliative Care Emergencies

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Overview

- “Acute Palliative Care”

Symptom focussed presentations
- Pain
- Nausea and vomiting
- Bowel obstruction
- Seizures
- Bleeding
Hospital palliative care improves symptoms and other patient outcomes¹

It probably also reduces costs – reduced length of stay and altered resource utilisation²,³,⁴

Biggest effects seen with earlier intervention⁵

Acute Palliative Care

- When oncology patients come in acutely
  - Late first presentation – high symptom load
  - Disease progression
  - Deterioration
  - Metabolic disturbance
  - Effects of treatment
Presentations

- Neutropenic sepsis
- Hypercalcaemia
- MSCC
- N+V – Chemo induced?
- Effusion
- SVCO
- Ascites
Symptoms
Pain
TOTAL PAIN

**PHYSICAL**
- Disease
- Treatment (surgery, RTx)
- Immobility, debility
- Procedural
- Other symptoms (constipation...)
- All exacerbated by poor sleep

**EMOTIONAL**
- Low mood
- Anger
- Anxiety
- Fear
- Frustration
- Helplessness, loss of control
- Altered body image
- Adjustment to transition to PC

**SOCIAL**
- Social isolation
- Family and relationship issues
- Finances

**SPIRITUAL**
- Why me?
- Why our family?
- What will happen to me?
Pain – things to find out on assessment

- What is their opioid history
- Have there been any recent dose changes
- What route are they taking it?
  - Absorption
- If they have a patch
  - Is it on
  - Is it sticking fully
  - When was it last changed
- What other medicines are they taking for pain
- Are they getting any side effects
Pain – where to start

- Some cautions
  - Codeine
  - Tramadol
  - Fast acting fentanyl
  - Clonazepam

- Perfectly reasonable to start with low dose oral morphine – regular and PRN
Pain – some tips

- Increasing transdermal patches rarely helpful in pain crisis
- If patient well established on opioids consider an adjuvant
  - Gabapentin/pregabalin
  - Amitriptyline
- If newly starting on opioids beware sickness and constipation
  - Laxative and antiemetic
- Do not alter methadone or ketamine
- Beware the patient with rapidly increasingly opioids over the previous 2 weeks - hyperalgesia
Nausea and vomiting

**Vestibular system**
1. H1, ACh
2. Motion, opioids, base of skull tumours
3. Cyclizine

**Chemoreceptor trigger zone**
1. D2, 5HT3, NK1
2. Drugs, metabolic, toxins
3. Haloperidol, metoclopramide sertrons (aprepitant)

**Gastrointestinal tract**
1. 5HT4 receptors - prokinetic
2. D2 receptors - activation slows gastric emptying
3. Gastric stasis
4. Domperidone, metoclopramide (prokinetic)
5. 5HT3 receptors - activation on vagal nerve endings leads to emesis
6. ACh receptors - blockade slows GI tract
7. Visceral/serosal
8. Cyclizine to slow transit (e.g. subacute bowel obstruction with colic)

**Cerebral cortex**
1. GABA, H1
2. Pain, fear, anxiety
3. Raised ICP
4. Cyclizine

**Vomiting centre**
1. H1, ACh, 5HT, NK1 mu
2. Raised ICP
3. Meningeal infiltration
4. Cyclizine
5. Levomepromazine (aprepitant)

H1 = histamine type 1 receptor, ACh = acetylcholine receptor, 5HT4 = serotonin type 4 receptor, 5HT3 = serotonin type 3 receptor, D2 = dopamine type 2 receptor, mu = μ-opioid receptor, NK1 = neurokinin 1 receptor, ICP = intracranial pressure.

*Vomiting centre in humans is a collection of nuclei within brainstem. It receives inputs from cerebral areas, gastrointestinal tract via vagal afferents, area postrema or chemoreceptor trigger zone, and vestibular system. Antiemetics mediate their clinical effect by acting as antagonists at different receptors in this pathway. This schematic aetiological approach is likely a simplification; it is more probable that emetic triggers act at multiple points within pathway and receptors are more widely distributed than depicted.

Nausea and vomiting

- Establish underlying cause
- Correct what you can
- Give anti-emetics regularly
  - Oral
  - IV
  - SC infusion
- Pick something appropriate to underlying cause
- Broad spectrum e.g. cyclizine or levomepromazine often will have sedative side effects
Bowel Obstruction

- Functional
- Partial
- Complete
Bowel obstruction

- Anti-secretory, Anti-emetic, Analgesia
  - Hyoscine butyl bromide
  - Haloperidol/levomepromazine
  - Opioid

- Some limited evidence for steroids
- Good evidence for octreotide
- Consider fluids, nutrition and venting gastrostomy
Seizures

- Up to 15% of palliative care patients
- Due to primary/secondary brain involvement
- Frightening and upsetting for patients, families and potentially staff
Seizures – acute Mx

- Someone to stay with patient +/- relative
- Maintain airway, oxygen, likely to resolve quickly
- If persists (approx 5 mins)
  - Check a BM (check anyway) and correct
  - Stat benzodiazepine – IV lorazepam, buccal midazolam, SC midazolam, SC clonazepam
- If persists
  - More benzos
  - IV keppra/phenytoin – neuro advice
- If end of life – above may still be appropriate, phenobarbital 200mg IV or deep SC – palliative care only
Seizures – general Mx

- First seizure – start anti-epileptics
- Probably doesn’t matter which AED you choose
  - Sodium valporate
  - Phenytoin
  - Leveteracetam (keppra)

- Can bridge oral titration with oral clonazepam
- Keppra can be delivered via subcutaneous syringe driver
Bleeding

- Life threatening, Controllable or Terminal?
- Acute haemorrhage is distressing
- Head and neck disease, groin masses, upper GI bleeds
- If it can be anticipated then make a bleed plan – balance preparing patient and family vs unnecessary upset
Minor bleeding

- Can herald larger bleeds
- Common sites: skin, fungating tumours, mucous membranes, respiratory tract, Urinary tract, GI tract

Topical measures
- Adrenaline soaked gauze (vial of 1 in 1000 poured onto some gauze)
- Tranexamic acid soaks (500mg/5ml ampoule onto some gauze)
- Tranexamic mouth wash – crush a 500mg tablet into 10mls water

Bleeding from other sites
- Tranexamic acid 1-1.5g TDS
Severe Acute Bleeding

- Is the bleeding controllable with specific measures?
  - Is it due to local effects or systemic factors
  - Are they any medications implicated
  - Adrenaline soaked gauze

- If acute severe bleeding not controllable – is this likely to be a terminal event?
  - Most important thing you can do is stay calm, ask for some help, but DO NOT leave the patient
  - Patient and family likely to be distressed. Do not prioritise sedative medicines until help arrives.
  - Light pressure with dark – ideally green – towels/blanket
Questions?
Summary

- Pain
- Nausea and vomiting
- Bowel obstruction
- Seizures
- Bleeding

http://www.palliativecareguidelines.scot.nhs.uk