

GP Palliative care study day: symptom control case studies **ANSWERS**

PAIN (1)

You have been called out to see a 76-year old man who has a diagnosis of Ca prostate with bony metastases. He has had increasing pain day and night over his lumbar spine. MST has been increased from 40mg bd to 80mg bd over the last 4 days. He is now muddled and too nauseated to take his medications.

His medication is:- *MST 80 mg bd, Lansoprazole 15mg od, Temazepam 10 mg nocte, Gabapentin 300 mg tds*

How would you manage him?

Opioid toxicity causing side-effects (but check bloods for metabolic/infective causes).

Need to examine his spine and neurology to exclude spinal cord compression. Any suspicion (history very suggestive), arrange urgent admission for MRI scan and commence Dexamethasone 8mg stat.

Reduce MST back down, start NSAID and consider increasing gabapentin.

Consider bisphosphonates.

PAIN (2)

You are asked to visit Mrs Brown, a 38-year old married lady. She has carcinoma of the cervix with local spread in her pelvis. She has become increasingly drowsy and her husband thinks this may have coincided with Fentanyl patch increase from 50 to 100 mcg/hr 3 days ago. Her leg and back pain have worsened and she has been crying out for the last 12 hrs. Oral medication is becoming a problem because of the drowsiness.

Her medication is:-*Diclofenac 50mg tds, Lansoprazole 30mg od, Amitriptyline 50mg nocte, Fentanyl patch 100mcg/hr, Gabapentin 600mg tds*

How would you manage her?

History from husband – recent deterioration or gradual over last few weeks?

Drowsy due to - incr fentanyl/infection/disease progression eg renal failure

Consider causes of increased pain – enlarging tumour in pelvis +/- abscess, bony involvement, loss of control and total pain.

Consider s/d with diclofenac or use pr.

Consider s/d with anxiolytic eg Midazolam 5-10mg if psychological distress

Reduce fentanyl patch back to 50mcg/hr

Consider adding dexamethasone 4mg daily

Check bloods particularly looking for infection, renal function

Discuss options with husband. Plan to explore psychological/spiritual distress when/if less drowsy

May need to consider epidural injection or infusion.

VOMITING (1)

You are visiting a 56-year old lady who has breast cancer with bone and liver metastases. Nausea and vomiting have been a problem for 4 days. She also has bone pain, abdominal pain, constipation, headache and anorexia.

Current medication: *Anastrozole, paracetamol, lactulose, Zomorph and prn oramorph and domperidone suppositories. recent anti-emetics have included stemetil and cyclizine.*

What are the possible causes of her vomiting? hypercalcaemia, squashed stomach from liver enlargement, liver failure, excessive opioid use (how much oramorph? recent incr in Zomorph dose?), brain mets, constipation, anxiety.

You plan to set up a syringe driver, what anti-emetic(s) would you choose and why?

Metoclopramide 30mg as helpful for metabolic/drug causes of vomiting, prokinetic effect, constipation.

Levomopromazine 6.25-12.5mg as broad-spectrum receptors (chemoreceptor trigger zone and vomiting centre) and effects as antiemetic and anxiolytic.

Cyclizine is an alternative (not if using dexamethasone).

Consider dexamethasone 4-8mg for pain, nausea, brain metastases and anorexia.

VOMITING (2)

You are caring for a 75-year old married lady with ovarian carcinoma and intra-abdominal spread. She has been vomiting intermittently for the last 3 days but this evening the volume of vomit is much larger and she has developed colicky abdominal pain. She has not had her bowels open for 2 days. She has always been most insistent that she does not want to go to hospital and has never had any surgery.

Her present medication is:- *Metoclopramide 10 mg tds, MST 20mg bd, Movicol 1 sachet per day.*

What do you think is causing her vomiting? Intestinal obstruction

You want to manage her at home. How would you control her vomiting?

Stop metoclopramide.

Start a s/d with diamorphine/oxycodone 10-15mg (to replace oral morphine), buscopan 60mg for colic, and dexamethasone 4mg to reduce oedema around tumour.

Consider using levomopromazine 6.25mg as anti-emetic of choice if want some anxiolytic effect and also. Cyclizine is an alternative if not using dexamethasone.

May need stat dose of buscopan to deal with colic.

Consider addition of octreotide (second driver needed) in 24-48 hours if no improvement.

FATIGUE

You are asked to see a 52 yr old self-employed builder who has colon ca and liver mets. One month ago chemotherapy was abandoned because of increasing size of metastases. He is separated from his wife, has 3 children and now lives with his partner of 3 years. He complains of poor appetite, altered taste, extreme fatigue, weight loss and insomnia. His partner's main concern is that he is spending most of his time in bed.

What is your plan of management?

Exclude reversible causes of fatigue eg. anaemia, infection, uraemia, other metabolic disturbances, drugs (e.g. antihypertensives).

Include physical/psychological/social/spiritual perspectives in your questioning.

Explore his perspective and interpretation of his problems. How has he faced difficulties in life previously? Is he depressed?

Include partner in discussion to try and link each of their perspectives.

Consider referral to DHouse for fatigue management with physiotherapists, Day Patient Unit.

Consider referral for DH admission to In Patient Unit if the above seems too much to achieve from home.

Consider antidepressants

BREATHLESSNESS

A 63 yr old lady lives in a first floor flat with her family above their family shop. 5 yrs ago, she was found to have breast cancer and was treated with surgery, chemotherapy and radiotherapy. She now has increasing shortness of breath with some cough, panicking at night and is too frightened to go out.

O/E she has a few basal crackles in her lungs.

Previous CXR raised the possibility of lymphangitis carcinomatosa.

Current drugs: *Exemestane, Ibuprofen, Omeprazole and a laxative.*

How can you/we help her?

Panicking and frightened therefore need to explore her view of problem(s), her interpretation of symptoms and her worries about what is happening to her.

What is the family involvement? Are they around or out working?

Consider other causes for breathlessness – lymphangitis, PE's, infection.

Management options include non-pharmacological (breathlessness coping strategies with DHouse physios, including advice about positioning, hand-held fan) and pharmacological approaches.

O/E check O2 sats – if hypoxic, may need O2 concentrator.

Trial of dex 4mg for lymphangitis. Consider diazepam at night for panic, oramorph at night and ?during the day aiming to reduce sensation of breathlessness.

Contact oncologist about stopping exemestane as disease progression despite this.

Depending on her condition, is it feasible to try and get her out?

NON-MALIGNANT DISEASE

A 72 yr old man has end-stage heart failure. His main problems are extreme lethargy, SOB/OE, general weakness, dizziness, insomnia and constipation.

O/E he is cachectic and has peripheral oedema. No pleural effusions. His liver is palpable and he has faecal loading of the colon.

Current medications: *Furosemide, spironolactone, ACE inhibitor, beta-blocker, digoxin and nitrates.*

What issues need to be addressed? Physical, psychological, social, spiritual.

Are there any reversible elements to his weakness and lethargy? eg. rationalising some of his medications – might be hypotensive now.

Constipation.

Care and adaptations to house.

Explore his perspective and interpretation of where he is at in his disease. Sensitive exploration about the future addressing his concerns – is he open to discussing this and doing some advanced care planning including preferred place of care when terminal, and DNAR wishes.

TERMINAL RESTLESSNESS

A 52 year old man with known renal carcinoma with liver, bone and lymph node metastases has rapidly deteriorated. He is now jaundiced, oedematous and probably slipping into renal failure. Your medical and nursing colleagues agree that he is now dying. You are called to see him by his wife who is very concerned because he is very agitated and difficult to manage.

What are the likely causes?

Urinary retention, constipation??, liver failure, renal failure with acidosis, (high blood glucose should be considered if on big doses of dexamethasone). Opioid toxicity. Infection. Brain secondaries. Hypercalcaemia and hypoxia. Emotional distress. Pain.

What is the appropriate management?

Accurate assessment. Catheterisation. Stopping inappropriate medication or doses.

Analgesia (NSAIDs usually appropriate). Sedation – midazolam and/or levomepromazine via stat doses and syringe driver.

Supporting his wife.

What other issues need to be considered?

Accessing extra care and support. Anticipating other symptom control problems – rattling secretions, vomiting, breathlessness etc. Just In Case box medication. Ensure effective communication amongst all involved. Check religious and cultural needs.