Palliative Care Emergencies

DR JULIE CARON AND DR AMANDA MURDOCH

GEORGIAN BAY PALLIATIVE CARE TEAM

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AGENDA

- Review of common emergencies in palliative care

- Clinical assessment / how to recognize common emergencies

- Management for common emergencies

For any palliative care emergency...

- Review and consider Goals of Care
- Vitals and physical exam
- +/- transfer to hospital based on the above

ACUTE RESPIRATORY DISTRESS

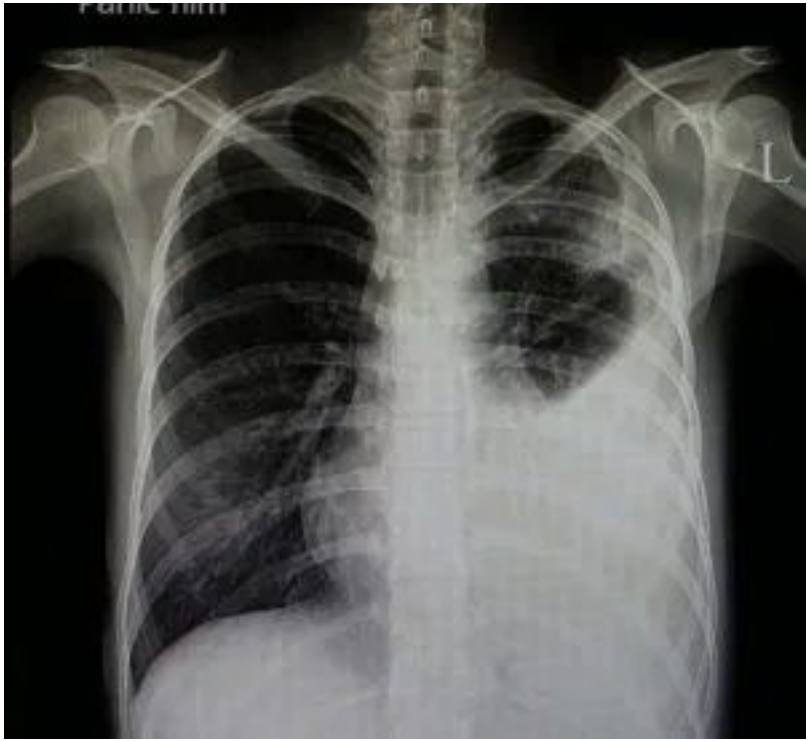
DDX: Pulmonary edema, malignant pleural effusion, PE, AECOPD, pneumonia

Assessment: increased work of breathing, crackles, wheezes, chest pain, decreased air entry, worsening pedal edema, sputum, hemoptysis, fever/diaphoresis

Management: diuretics, antibiotics, steroids, drain, opioids, benzodiapzapines

ex/ Malignant Pleural Effusion

- Shortness of breath
- Decreased air entry
- Treat with thoracentesis
- Pleurodesis for recurrent effusion
  - fairly robust patient
  - hard to get in this region
  - painful



ACUTE CHANGE IN MENTAL STATUS

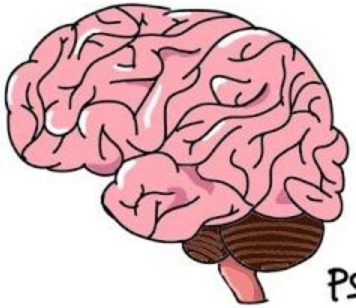
DDX: infection, brain mets, terminal delirium, electrolyte abnormalities, stroke, medication s/e

Assessment: decreased level of consciousness vs hyperactive, pupils, hallucinations, fever, one sided weakness

Management: antibiotics, antipsychotics, benzodiazapines, steroids, medication assessment

Ex/Hypercalcemia

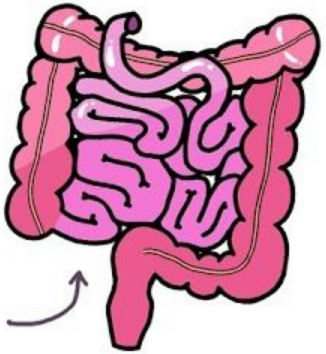
- Paraneoplastic syndrome (10-30% of cancers) - PTHrP
  - Lung, ovarian, breast, pancreatic, renal
- Bone mets
  - Prostate, breast, lung, renal



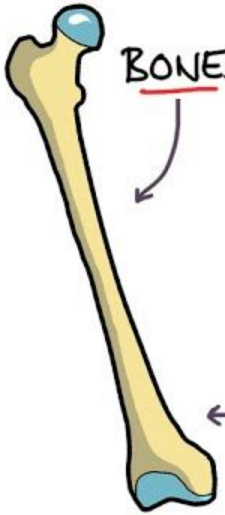
PSYCHIATRIC OVERTONES

PARATHYROID HORMONE

SMALL INTESTINE ABSORPTION



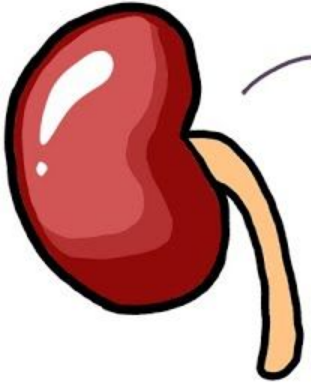
BONES



HYPERCALCEMIA

OSTEOLYTIC LESIONS

STONES



1α HYDROXYLASE

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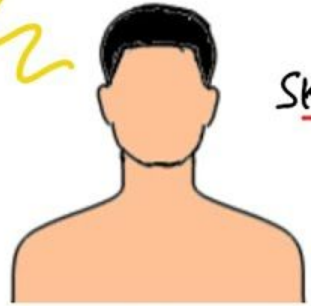
ACTIVATED VITAMIN D (CALCITRIOL)

UV LIGHT



SKIN

Hypercalcemia

Management:

- Hydration ++++
- Stop vit D, calcium, dairy, thiazide diuretics
- Calcitonin
- Bisphosphonates
- Denosumab (Prolia)
- steroids

*median survival 30-60 days after dx

*treatment does provide good symptom relief

ex/ SEIZURE

- Most likely cancers to metastasize to brain are breast, lung, kidney, colon and melanoma.
- May be gradual or sudden onset personality changes, headaches, confusion
- May present with seizure
- Treat with steroids SC or PO
- Consider seizure prophylaxis

BOWEL OBSTRUCTION

DDX: obstructing mass, carcinomatosis & omental cake, severe Oglive's/pseudo-obstruction, constipation

Assessment: abdo distended, emesis of feculent material, early satiety, pain, not passing gas, nausea

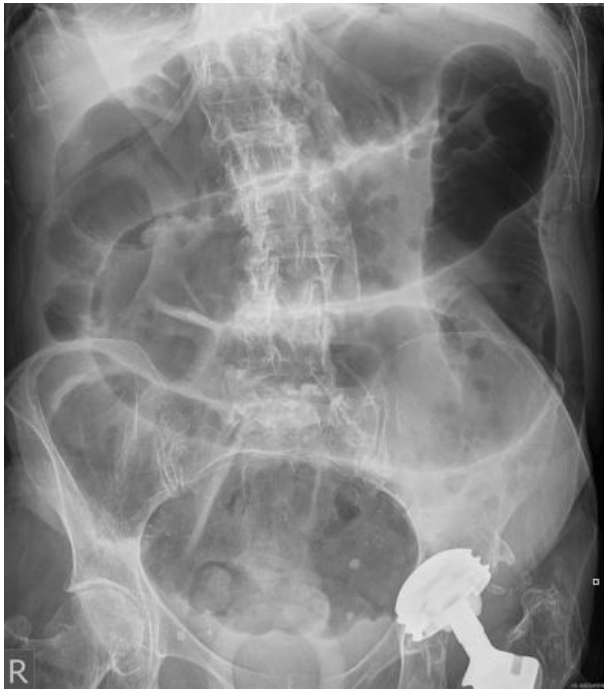
Management: palliative ostomy, NG decompression, bowel rest/NPO, anti-nauseants, palliative sedation

EX/OBSTRUCTING MASS IN CRC

- NPO
- Anti-nauseants (not metaclopramide)
- Haldol, steroids
- +/- NG for decompression
- CT scan and general surgery consult
- Diverting colostomy

OR

- NPO, anti-nauseants, midaz on hand for prompt palliative sedation if perforates



HEMORRHAGE / BLEEDING

- necrotic/fungating tumour
- Vascular invasion
- Coagulopathy

Mgmt: direct pressure, stop blood thinners, TXA

Specialist Mgmt: embolization, cryotherapy, radiation, laser

**Upsetting for patients and families (dark towels)

- Discuss in advance, anticipate

Ex/ Fungating Tumour

- Oozing from surface vs actively bleeding vessel vs venous sinus tract
- Risk for exsanguinating event if tumour invades artery
- Tranexamic acid can be given IV, PO or topically
- Stop antithrombotics
- Apply metronidazole topically if malodorous
- Apply direct pressure

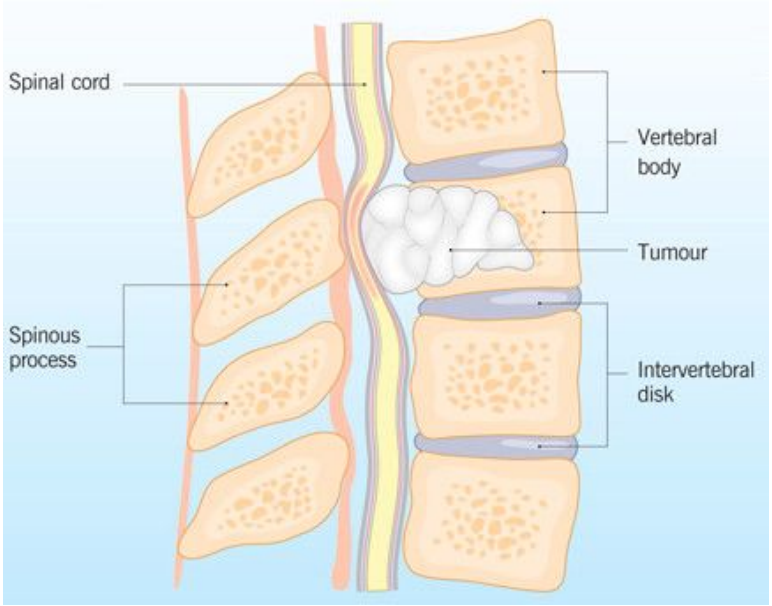
SPINAL CORD COMPRESSION

DDx: Tumour invading into spinal canal, metastatic disease in vertebrae, leptomeningeal disease

Assessment: pain, weakness, bowel/bladder dysfunction, ataxic gait, sensory changes

Management: radiation (anticipate), steroids

1 in 5 patients presenting with cord compression, this is first presentation of cancer



PAIN CRISIS

- Refractory to available analgesia at home
- Make sure using multi-modal approach including NSAID, steroids and gabapentinoids if appropriate
- Use SRK if available
- May require trip to ER for management if intolerable

EMERGENCIES UNRELATED TO PRIMARY PALL CARE DX

- Palliative patients can still have heart attacks, strokes, injuries etc like anyone else
- Go to ER if appropriate for their goals of care