

Emergencies in oncology and palliative care

1st November 2007 MIMS Oncology & Palliative Care Journal

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Part one of this series outlines the importance of meticulous planning for emergency care.

Introduction:

This article introduces a series on emergencies in oncology and palliative care, focusing on recognition and management of emergency scenarios during the care of cancer and palliative care patients. A number of authors will provide a broad overview of what to consider when faced with such an event. Each article will offer a general view of a specific emergency that may occur in those with life limiting illness.

Palliative care emergencies can be divided into two categories: imminently life threatening and potentially resulting in a persistent and worsened morbidity.¹

A calm and efficient approach is achieved by anticipating and meticulously planning for potential events, for example, haemorrhage from a fungating tumour near a major vessel.² After an emergency, it is good practice to hold a debriefing session to provide a learning opportunity, particularly because some events can be difficult to witness.

Regular updates

Not all emergencies can be anticipated; however, regular updates on the most common scenarios are essential to provide a healthcare team with the confidence they need to manage potential situations. Use of the familiar approach of ABC (airway, breathing, circulation) may sometimes be appropriate in palliative care, but this depends on the situation.³

Conversely, if a patient is very unwell or nearing the end of life, or it has been specified that comfort care is applicable, priorities may focus on management of agitation, pain and dyspnoea, and provision of emotional support.⁴

Good clinical practice in oncology and palliative medicine involves meticulously assessing the patient's clinical course, recognising and establishing variants and aberrations in disease trajectories. Often, the natural progression of a life-limiting illness will involve emergencies that can be anticipated and planned for. At other times, new symptoms will occur, providing a fresh challenge: is this part of the overall illness, or a short-term, acute problem that is reversible?

Reversibility is an important concept in an emergency. A patient may have received a maximum amount of treatment and continue to develop new symptoms

that are irreversible. However, the problem may be due to something not anticipated, such as an intervention (drug therapy or radiotherapy).

The key questions to ask are: What is the new problem? How quickly has it come about? Have there been changes in the patient's management concurring with the new problem? Can we treat the cause of the problem and reverse it? Does the patient want treatment?

The last question is particularly important and should be promptly answered. Patients should be involved in decisions regarding their treatment and care; however, where this is not possible, it may be necessary to ask relatives.

In an emergency, this may not always be possible, so it is important to establish a clear plan at an early stage. Good communication should start from first contact and establish the patient's and relatives' wishes.

When emergencies occur

Those working in oncology and palliative care will be familiar with the common emergencies, such as spinal cord compression, hypercalcaemia, massive haemorrhage and superior vena cava obstruction (see box 1).^{5 67} Emergencies can occur at any time, but they will often happen at home and at times when professionals who are familiar with the patient are unavailable. A well-run out-of-hours service with palliative care protocols is of significant benefit.

BOX 1: EMERGENCIES IN PALLIATIVE CARE

<ul style="list-style-type: none">• Overwhelming pain and distress• Superior vena cava obstruction• Hypercalcaemia• Spinal cord compression• Cardiac tamponade• Pathological fractures• Terminal delirium/agitation• Cardiopulmonary arrest	<ul style="list-style-type: none">• Overdose• Alcohol and drug withdrawal• Hypoglycaemia• Acute dystonia, oculogyric and serotonergic crises• Neuroleptic malignant syndrome• Acute urinary retention• Pneumothorax• Pulmonary embolism• Stridor• Bronchospasm
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<ul style="list-style-type: none"> • Massive haemorrhage • Epileptic fits • Anaphylaxis • Acute confusional states • The violent patient • Acute suicidal ideation 	<ul style="list-style-type: none"> • Acute congestive cardiac failure • Acute renal failure • Predictable complications of therapeutic interventions or procedures, • including advanced life support if appropriate
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Source: Specialty Training Curriculum for Palliative Medicine. Joint Royal Colleges of Physicians

Training Board, London, May 2007

It is advisable to include palliative medication or emergency packs in an on-call bag. Parenteral opioids to control acute pain, parenteral haloperidol for nausea, vomiting and agitation, and parenteral midazolam for anxiety, agitation and convulsions can all be useful. If there is any doubt about dosage, advice can be sought from the on-call palliative medicine doctor.

Patients and carers often do not know whom to contact in an emergency and may be reluctant to call 999. Consequently, such situations can be very frightening for everybody involved and the thought that there is nobody around to ask for help can simply make matters worse.

Educating patients and carers about services is essential to ensure that they can confidently access professional help when required. Similarly, establishing service standards and frameworks for palliative care patients is valuable. Frameworks can help in establishing communication pathways, such as a fax update service providing those in an out-of-hours service with vital background information and those regularly managing a patient with details of out-of-hours developments.⁸

Conclusion

Emergencies in oncology and palliative care can be more effectively managed when a healthcare professional is prepared for the potential scenarios and is supported with information on local services and the patient's individual needs and wishes. The second article in this series will focus on the management of hypercalcaemia, a commonly encountered problem on the wards and in the community.

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