CLiP

15 minute Worksheet

Helping patients with symptoms other than pain

10: Recognising emergencies

Intermediate level

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Aim of this worksheet

To learn to recognise emergencies in patients with advanced disease

How to use this worksheet

- You can work through this worksheet by yourself, or with a tutor.
- Read the case study below, and then turn to the Work page overleaf.
- Work any way you want. You can start with the exercises on the Work page using your own knowledge. The answers are on the Information page - this is not cheating since you learn as you find the information. Alternatively you may prefer to start by reading the Information page before moving to the exercises on the Work page.
- This CLiP worksheet should take about 15 minutes to complete, but will take longer if you are working with colleagues or in a group. If anything is unclear, discuss it with a colleague.
- If you think any information is wrong or out of date let us know.
- Take this learning into your workplace using the activity on the back page.

Case study

John is a 54 year old man who had surgery for a carcinoma of the colon. Two weeks ago his wife noticed he seemed vague on occasions. Over the past week he has become increasingly disorientated. Overnight he has become drowsy. At times he becomes agitated and seems in pain, but is unable to describe his symptoms.

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Identifying emergencies in advanced disease

In someone with a progressing, advanced disease it is easy to assume that any deterioration is due to the disease and to assume that this is inevitable and irreversible. However, there are many conditions that can be treated or reversed that will improve the quality of life for such patients. This is important for John, whose confusion will be distressing for him and his family. Although treatment will not always be possible because the patient is too ill or they refuse treatment, it is important to identify the possibilities.

Severe pain: any severe pain needs treatment. Pain worsened by even the slightest movement may be due to a fracture of a long bone or a vertebral collapse. This will need analgesics and may need surgery or radiotherapy. (See CLIP worksheet on *Managing Severe Pain*)

Agitation: this may be because of fear or be part of a confusional state (see CLiP worksheet on *Delirium*).

Blue fingers: this shows that the amount of oxygen in the blood is low (although it is possible to be low on oxygen- hypoxic- and still look pink). Causes of hypoxia are reduced ventilation (respiratory depression due to drugs), reduced lung capacity (infection, pleural effusion, cancer, COPD), reduced blood circulation (pulmonary embolus) or reduced gas transfer in the lungs (pulmonary oedema, lymphangitis, fibrosis).

Fatigue: this is common in advanced disease and, although it needs to managed and treated if possible, it is not an emergency. See CLiP worksheet on *Fatigue, Lethargy, Drowsiness and Weakness.*

Sudden drowsiness: this is unusual in advanced disease and suggests an urgent problem. It is unusual for someone to be up and about one day and then become bed bound and sleepy within a few days. Possible causes are hypoxia, hypercalcaemia, steroid withdrawal, glucose abnormality (high or low), seizure, drug adverse effect, CVA, raised intracranial pressure, and severe infection.

Swollen face: this can be due to blockage of the main vein draining the head, the Superior Vena Cava (SVC) by tumour in the chest. It needs urgent treatment with steroids and radiotherapy (chemotherapy is used for SVC obstruction in patients with sensitive malignancies such as small cell lung cancer).

Delirium: this is distressing for all. The commonest causes are drugs, infection, and blood chemistry abnormalities (see CLiP worksheet on *Delirium*).

Weak legs: in the presence of fatigue it is tempting to put this complaint down to the general effects of the disease. In cancer, however, vertebral collapse can compress the spinal cord. If this is not treated urgently then paralysis of the legs is the result.

Chest pain: this may be due to a myocardial infarction, pulmonary embolus or chest infection. All need treatment.

Sudden breathlessness: this is distressing for the patient and needs urgent assessment. See the causes of hypoxia above and the CLiP worksheet on *Breathlessness*.

Rasping breathing: this is unusual in advanced disease but can be due to narrowing of the airway (usually by tumour) when it is called 'stridor'. It needs emergency treatment to stop the airway closing off altogether.

'Coffee-ground' vomit: this indicates altered blood due to an ulcer or inflamed stomach lining. This may be due to the physical and psychological stress of the illness or to drugs such as nonsteroidal anti-inflammatory drugs. It needs urgent treatment to prevent severe bleeding.

Blood in sputum: this is common in lung cancer and is usually just streaks in the sputum. More troublesome bleeding needs drugs that reduce bleeding (eg tranexamic acid), radiotherapy or embolisation .

Swollen legs: this is common and not usually an emergency, but sudden swelling suggests a blood clot (DVT- deep venous thrombosis) or blockage of the Inferior Vena Cava (IVC) and these need urgent assessment.

Decisions in unexpected deterioration

1. *Are drugs the cause?* Reduce the drug dose and, if necessary, partially reverse their effects (eg. naloxone for opioid toxicity). NB in palliative care, reversal should be titrated so the benefit of the original drugs is not lost.
2. *Is comfort only possible?* eg. very short prognosis (hour by hour deterioration), patient refusing treatment, irreversible problem. Company and warmth are the most important- if sedation is needed ask advice.
3. *If treatment is clearly appropriate* arrange tests and treat cause.
4. *If the need for treatment is uncertain* consult with the patient if they are able to understand and discuss what is going on. Otherwise talk to partner or family as they may indicate what the patient has said previously. Consult with the care team taking into account the history, rate of deterioration and availability of treatment. Judgement of the patient's previous quality of life by others is not helpful- there is good evidence of its subjectivity and inaccuracy.
5. *If need for treatment is still unclear* use the rule of 3- if deteriorating hourly wait 3 hours, if deteriorating daily wait 3 days. If further deterioration has occurred then treat for comfort, otherwise consider treating.

NB. Assessment of quality of life by professionals should *not* be used in deciding treatment- there is good evidence to show that professionals are very inaccurate in such assessments. Only patients can estimate their own quality of life.

Where to get help

Decisions about emergencies can be clear cut, but in patients with advanced disease there are many occasions when uncertainty exists whether the deterioration is treatable, if it should be treated and how it should be treated. Advice can be sought from specialist teams for the disease concerned, pain teams and palliative care (PC) teams. See www.hospice.org.uk for information on local PC teams. Some provide 24 hour advice on difficult problems.

Choose **Ring** **those features which you think might indicate an emergency**

Severe pain	Agitation
Blue fingers	Fatigue
Rapid drowsiness	Swollen face
Acute confusion (delirium)	Weak legs
Chest pain	Sudden breathlessness
Rasping breathing	Blood in sputum
'Coffee-ground' vomit	Sudden swollen legs

Choose **Ring** **whichever of the following you think would be helpful in deciding if treatment should be considered**

Current drugs as a cause	Rate of deterioration
Patient's opinion	Whether cause is treatable
Partner's opinion	Patient's previous views
Availability of treatment	Professional's view of patient's quality of life
Wait and see what happens	

Write **Where can you get advice?**

FURTHER ACTIVITY: Recognising emergencies

Think back to the last emergency you were part of and consider which factors made decisions on treatment harder and which made them easier.

FURTHER READING: Recognising emergencies

Journal articles

Appleton R, Macleod S, Martland T. Drug management for acute tonic-clonic convulsions including convulsive status epilepticus in children. *Cochrane Database of Systematic Reviews*. 2008; **(3)**: CD001905.

Aurora R. Milite F. Vander Els NJ. Respiratory emergencies. *Seminars in Oncology.* 2000; **27**(3): 256-69.

Brigden ML. Hematologic and oncologic emergencies. Doing the most good in the least time. *Postgraduate Medicine.* 2001; **109**(3): 143-6.

Donato V, Bonfili P, Bulzonetti N, Santarelli M, *et al*. Radiation therapy for oncological emergencies. *Anticancer Research.* 2001; **21**(3C): 2219–24.

Drudge-Coates L, Rajbabu K. Diagnosis and management of malignant spinal cord compression: part 2. *International Journal of Palliative Nursing.* 2008; **14**(4): 175-80.

Flombaum CD. Metabolic emergencies in the cancer patient. *Seminars in Oncology.* 2000; **27**(3): 322-34.

Innes H, Lim SL, Hall A, Chan SY, Bhalla N, Marshall E. Management of febrile neutropenia in solid tumours and lymphomas using the Multinational Association for Supportive Care in Cancer (MASCC) risk index: feasibility and safety in routine clinical practice. *Supportive Care in Cancer*. 2008; **16**(5): 485–91.

Keefe DL. Cardiovascular emergencies in the cancer patient. *Seminars in Oncology.* 2000; **27**(3):244-55.

Manglani HH. Marco RA. Picciolo A. Healey JH. Orthopedic emergencies in cancer patients. *Seminars in Oncology.* 2000; **27**(3): 299-310.

Nauck F. Alt-Epping B. Crises in palliative care--a comprehensive approach. *Lancet Oncology.* 2008; **9**(11): 1086-91.

NICE (National Institute for Health and Clinical Excellence. *Metastatic spinal cord compression: diagnosis and management of patients at risk of, or with, metastatic cord compression (Clinical guideline. 75)*. London: NICE, 2008 (www.nice.org.uk/G75)

Penel N, Dewas S, Doutrelant P, Clisant S, *et al.* Cancer-associated hypercalcemia treated with intravenous diphosphonates: a survival and prognostic factor analysis. *Supportive Care in Cancer*. 2008; **16**(4): 387–92.

Prommer E. Management of bleeding in the terminally ill patient. *Hematology*. 2005; **10**(3): 167-75.

Quinn JA. DeAngelis LM. Neurologic emergencies in the cancer patient. *Seminars in Oncology.* 2000; **27**(3): 311-21.

Rowell NP, Gleeson FV. Steroids, radiotherapy, chemotherapy and stents for superior vena caval obstruction in carcinoma of the bronchus. *Cochrane Database of Systematic Reviews.* 2001; **4**: CD001316.

Russo P. Urologic emergencies in the cancer patient. *Seminars in Oncology.* 2000; **27**(3):284-98.

Schnoll-Sussman F. Kurtz RC. Gastrointestinal emergencies in the critically ill cancer patient. *Seminars in Oncology.* 2000; **27**(3): 270-83.

Schrijvers D, van Fraeyenhove F. Emergencies in palliative care. *Cancer Journal*. 2010; **16**(5): 514-20.

Tan SJ. Recognition and treatment of oncologic emergencies. *Journal of Infusion Nursing.* 2002; **25**(3): 182-8.

Further resources

A Guide to Symptom Relief in Palliative Care, 6th ed. Regnard C, Dean M. Oxford: Radcliffe Medical Press, 2010

e-lfh: e-Learning for Healthcare contains a range of online self-learning programmes, including several relating to end-of-life care (e-ecla). Registration is required but is free. http://www.e-lfh.org.uk/projects/e-elca/index.html

Oxford Textbook of Palliative Medicine 4th ed. Hanks G, Cherny NI, Christakis NA, Fallon M, Kaasa S, Portenoy RK. eds. Oxford : Oxford University Press, 2010.

PCF6- Palliative Care Formulary, 6th ed. Twycross RG, Wilcock A, Howard P. www.palliativedrugs.com

Symptom Management in Advanced Cancer, 4th edition.. Twycross RG, Wilcock A, Stark Toller C. Oxford: Radcliffe Press, 2009