

# Chapter 8

# Palliative Care Emergencies

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## Learning Objectives

By the end of this chapter you should be able to:

- Demonstrate an understanding of the common palliative care emergencies including:
  - Hypercalcaemia of malignancy
  - Malignant spinal cord compression
  - Bleeding
  - Seizures
  - Superior vena cava obstruction (SVCO)
  - Bowel obstruction.
- Demonstrate an understanding of the context of a palliative care emergency for an individual patient.
- Be able to discuss the common features of palliative care emergencies, including:
  - Clinical presentation
  - Assessment
  - Management.

## Scenario

### *Background*

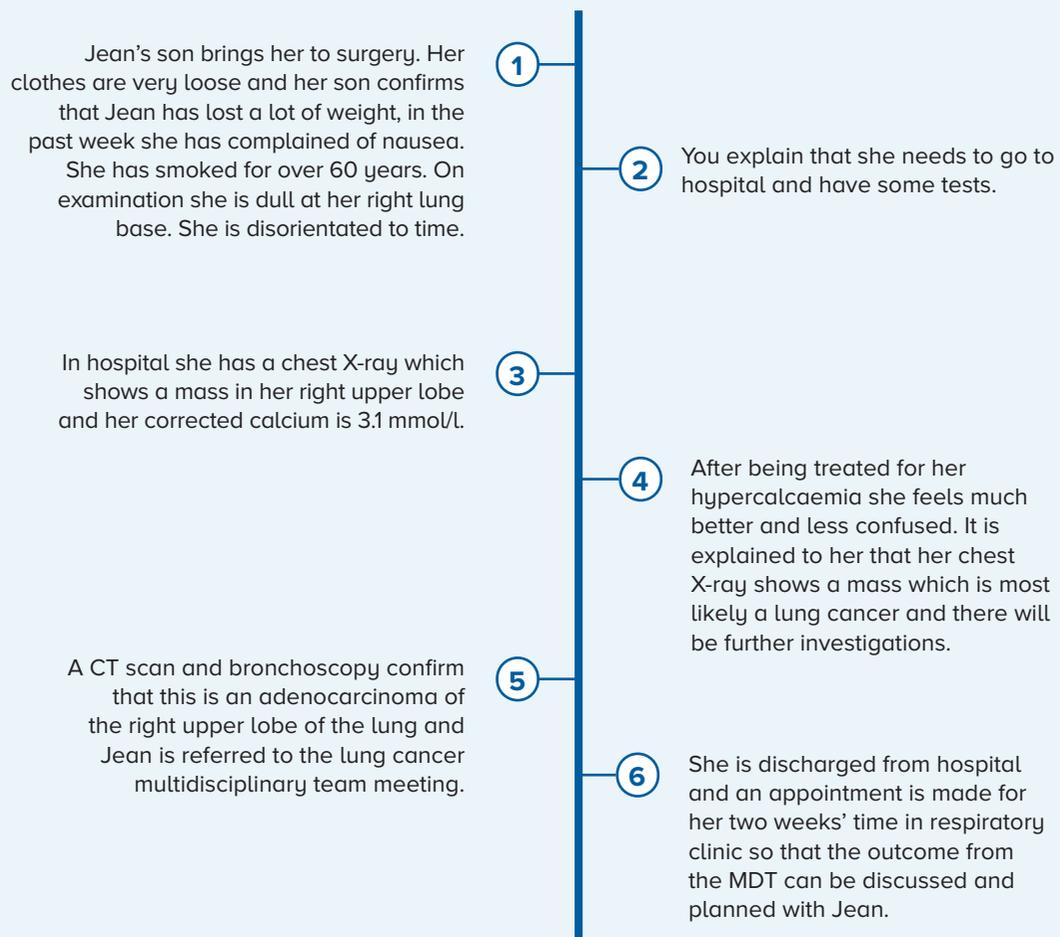
You are the duty doctor in your practice. The son of 67-year-old Jean Brown calls to say he is worried about his Mum. Jean usually takes care of his children one day a

week but recently she has struggled because she is so tired. He arrived at her home today and his Mum was still in her pyjamas. The house was untidy, she seemed dazed and her conversation was muddled.

### Key Points

- You should have a low threshold for testing for hypercalcaemia. It can often mimic other problems or it can be very insidious.
- Management, depending on the patient's priorities, usually requires hospitalisation especially if it is associated with other red flags for malignancy.
- Lung cancer is one of the commonest causes of hypercalcaemia in a hospital setting.

### Timeline



### **Key Considerations**

- What are the key signs and symptoms that should make you consider hypercalcaemia?
- What would your priorities be in managing a patient with hypercalcaemia depending on which area you work in?

## **Introduction: What Is an Emergency?**

An emergency is a serious, unexpected situation requiring an immediate response. In the setting of palliative care, emergencies may be sudden life-threatening changes in a patient's condition that, without an adequate response, will result in deterioration in that person's health or quality of life.

Some patients can be identified at higher risk because of the nature of their disease and emergency situations can be anticipated and planned for. In these circumstances the patient's wishes can be ascertained and discussions about the clinical response required to meet the patient's wishes can be established. It is important to discuss the benefits, burdens, harms and limits of acute treatments.

The palliative care emergencies which will be discussed in this chapter are:

1. Hypercalcaemia of malignancy
2. Malignant spinal cord compression
3. Bleeding
4. Seizures
5. Superior vena cava obstruction (SVCO)
6. Bowel obstruction.

### **Practice Point**

Often some of the most challenging decisions that we have to make is how to manage a person who has had an acute, unexpected, deterioration in the context of a life-limiting illness, for example a hip fracture in someone who has advanced dementia.

In these circumstances always:

- Give immediate focus on symptoms while decision making is occurring – relieve pain/nausea/breathlessness as quickly as possible.
- Consider the person's baseline function. It is likely to deteriorate and if the person's functional status has been in decline (changing month on month

or week on week) then it is likely to accelerate, even if the best outcome is achieved from the acute issue.

- Talk to the person and their relatives about the uncertainty.
- After the immediate situation has been resolved ensure that there is an advanced care planning discussion either for anticipated deterioration or, if the person stabilises, consider what should be done the next time if something similar happens.

## Hypercalcaemia of Malignancy

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### Introduction

Hypercalcaemia is the commonest life-threatening metabolic disorder in cancer patients. It occurs in about 20–30% of patients with cancer (Lindner et al., 2013).

There are several pathological mechanisms whereby hypercalcaemia of malignancy can occur:

- Parathyroid hormone (PTH) related peptide released by tumour,
- Osteolytic bone metastases,
- Rarely, patients with cancer will present with primary hyperparathyroidism.

Eighty percent of hypercalcaemia of malignancy is mediated by the production of recombinant parathyroid hormone, PTHrP (Stewart, 2005).

PTHrP (PTH related peptide) is produced physiologically but some cancers produce this in large amounts. PTHrP causes osteoblasts to signal to osteoclasts to increase bone reabsorption which subsequently causes increases in the concentration of calcium in the blood.

Osteolytic metastatic bone disease can lead to excessive calcium release from the bone and an increase in serum calcium.

It is important to understand these mechanisms. It is a common misconception that a patient needs to have lytic bone lesions to develop hypercalcaemia and this is not the case. Conversely, an episode of hypercalcaemia does not always herald the presence of bone metastases; 20% of patients with hypercalcaemia do not have bone metastases (Jick et al., 2015).

### Assessment

There are two main factors that determine how severe the symptoms of hypercalcaemia are:

1. The level of calcium,
2. The rapidity of the rise in the calcium.