Palliative Care Emergencies

27TH MAY 2025

DR EILIDH BURNS

CONSULTANT IN PALLIATIVE MEDICINE

BEATSON WEST OF SCOTLAND CANCER CENTRE

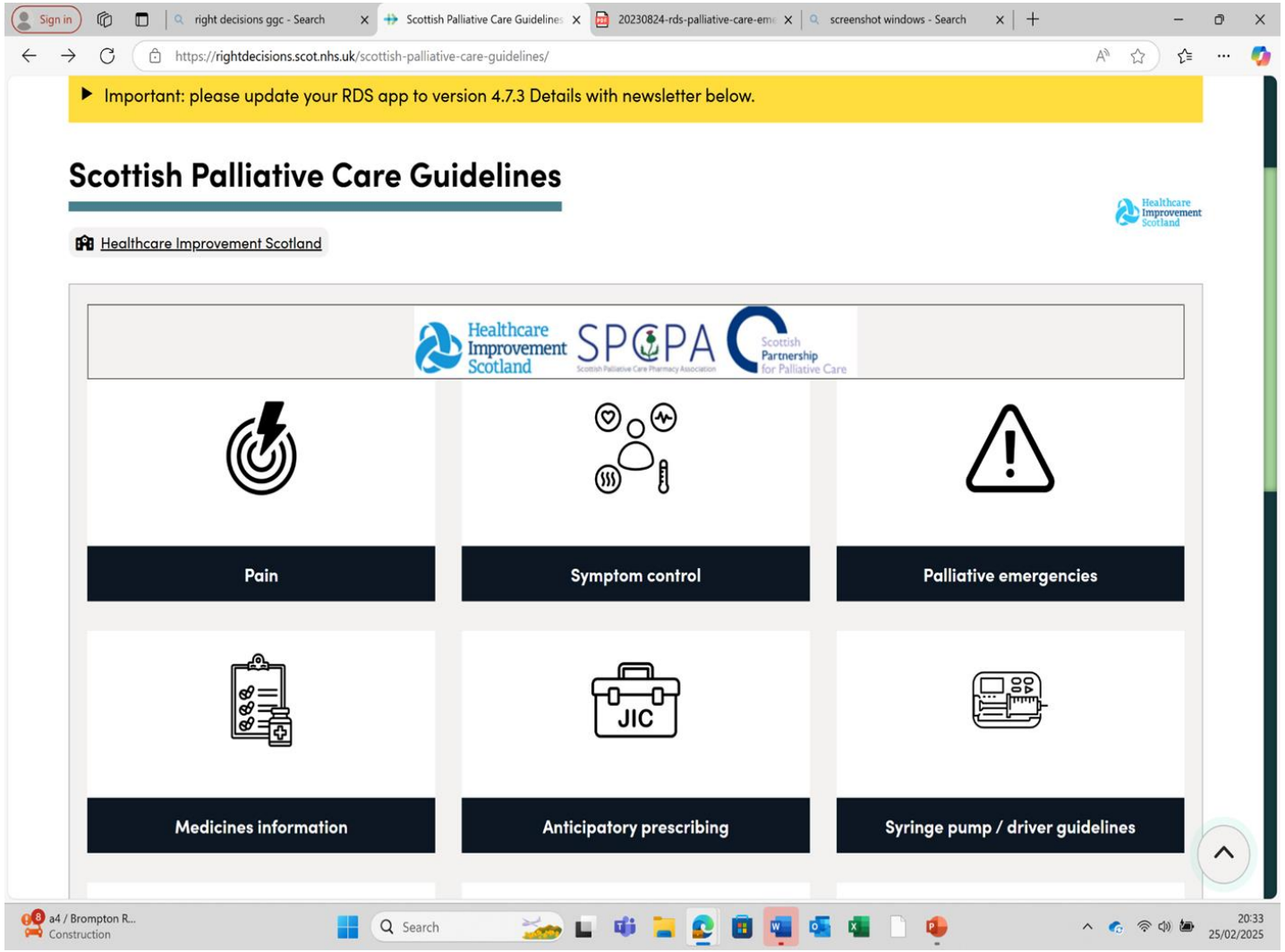
Learning Objectives

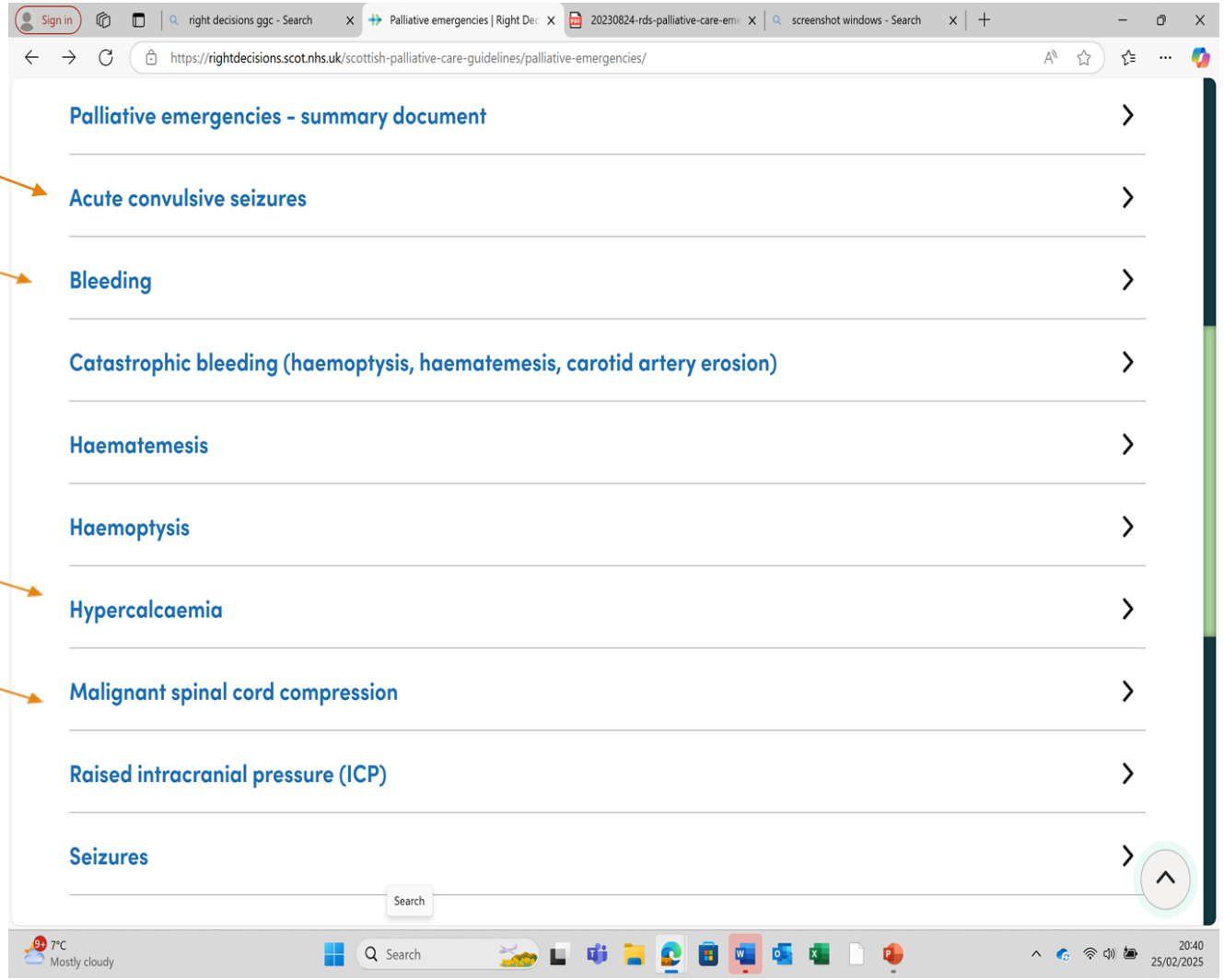
1. Demonstrate an understanding of common palliative care emergencies

2. Discuss the context of palliative care emergencies for an individual patient including the clinical presentation; assessment and management

What is a Palliative Care Emergency?

- A situation, if left untreated, that will seriously threaten the quality of life remaining
- Can still be life threatening
- Good palliative care is planned and not a crisis intervention BUT emergencies do occur and require prompt assessment and treatment decisions


Important: please update your RDS app to version 4.7.3 Details with newsletter below.
Scottish Palliative Care Guidelines
Healthcare Improvement Scotland
Healthcare Improvement Scotland
SPCPA
Scottish Partnership for Palliative Care
Pain
Symptom control
Palliative emergencies
JIC
Medicines information
Anticipatory prescribing
Syringe pump / driver guidelines


Sign in
right decisions ggc - Search
Palliative emergencies | Right Dec
20230824-rds-palliative-care-eme
screenshot windows - Search
https://rightdecisions.scot.nhs.uk/scottish-palliative-care-guidelines/palliative-emergencies/
Palliative emergencies - summary document
Acute convulsive seizures
Bleeding
Catastrophic bleeding (haemoptysis, haematemesis, carotid artery erosion)
Haematemesis
Haemoptysis
Hypercalcaemia
Malignant spinal cord compression
Raised intracranial pressure (ICP)
Seizures
Search
7°C
Mostly cloudy
Search
20:40
25/02/2025

Bleeding

- 10-20% patients with advanced cancer (frank/occult)
- Fear of a major bleed can prevent continuing care at home

- Assessment
  - Local or systemic
  - Life threatening or controllable with measures
  - Drugs – antiplatelets, anticoagulants, NSAIDs

- Management –
  - Anticipate
  - Discuss with patient and family
  - Emergency contact numbers – 999, ensure that ACP has been shared
  - Ensure medication in place for sedation if needed
  - Dark towels, gloves, aprons, disposal bags
  - Ensure GP/DNs know the plan

Bleeding

MANAGEMENT – SEVERE, ACUTE BLEEDING

NON-PHARMACOLOGICAL

- STAY CALM……and get help . . . but then come back
- Dark towels
- Pressure on the bleeding point if possible
- Position patient

PHARMACOLOGICAL

- Benzodiazepine – Midazolam 10mg
- IM / IV / buccal / sublingual (NOT SC)

Bleeding

MINOR BLEEDING

- May herald a fatal bleed
- Can be distressing
- Review medications
- Consider interventions eg laser, diathermy, radiotherapy, embolisation, scope

SKIN/FUNGATING TUMOUR

- Direct pressure
- Gauze soaked in tranexamic acid (500mg in 5ml) or adrenaline
- (epinephrine) 1 in 1000.
- Haemostatic alginate dressings such as Kaltostat®
- Nasal tampons or Rapid Rhino® nasal packs
- Systemic (PO/SC) tranexamic acid (antifibrinolytic)

Bleeding

Respiratory tract

- Mortality high
- Use O2 and suction
- Consider infection or PTE

Urinary tract

- Consider infection
- Risk of clot retention
- Bladder irrigation with 0.9& saline

Haematological

- Consider transfusions……but when to stop if marrow failure

Hypercalcaemia

SIGNS AND SYMPTOMS?

Hypercalcaemia

Signs and symptoms:

- Malaise
- Nausea
- Pain
- Weakness
- Constipation
- Confusion
- Hallucinations
- Polyuria and polydipsia

Hypercalcaemia

- Check bloods - Corrected or adjusted calcium, UEs, Albumin
- Commonest life-threatening metabolic disorder in cancer patients
- Don’t assume due to malignancy may be due to calcium supplements, hyperparathyroidism, vit D deficiency.
- Bone mets from renal / lung / breast / thyroid / myeloma
- 20% do NOT have bone metastases
- Severe: drowsiness and coma
- Pain may be exacerbated or precipitated

Hypercalcaemia

Treatment:

- IV fluids
- Bisphosphonate (Zoledronic Acid or Pamidronate)
- Takes up to 5 days to normalise
- Speed of recurrence indicates poor prognosis
- Untreated = fatal
- May need to be retreated
- High clinical suspicion and low threshold for checking
- In refractory hypercalcaemia can give denosumab 120mg sc (specialist advice)

Bisphosphonates and duration of action

Tables are best viewed in landscape mode on mobile devices

	Zoledronic acid	Disodium pamidronate
Intravenous (IV) dose	4mg	30mg to 90mg
Onset of effect	<4 days	<3 days
Maximum effect	4 to 7 days	5 to 7 days
Duration of effect	4 weeks	2.5 weeks

Malignant Spinal Cord Compression (MSCC)

Occurs when the dural sac and its contents is compressed at the level of the cord or cauda equina

5-10% cancer patients esp lung / breast / prostate

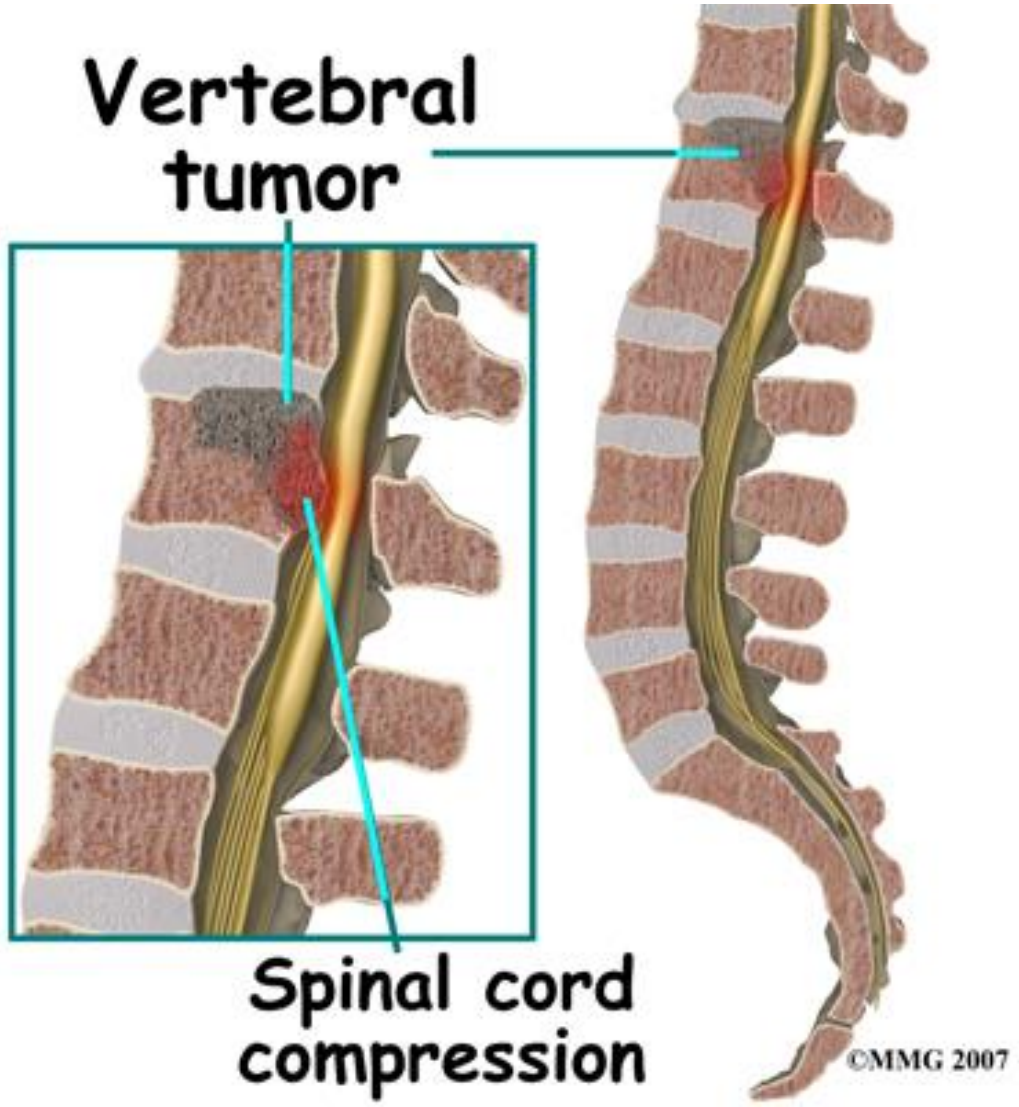
Thoracic = commonest (70%), 20% lumbosacral, 10% cervical

Causes:

Direct pressure/tumour growth

Vertebral collapse or instability

Compression results in oedema, venous congestion and demyelination



Symptoms

- PAIN – new/worsening
  - Localised or radicular
  - Coughing/straining increases pain
- Reduced power/mobility
- Sensory impairment
- Saddle numbness
- Bladder/bowel disturbance
- Loss of anal reflex

MSCC – Investigation & Treatment

Take a history

Perform a neurological examination
- Above L1 UMN, below L1 LMN

Dexamethasone 8mg BD – last dose before 2pm

PPI – omeprazole

LMWH

ANALGESIA

If possible – nurse flat

Urgent MRI spine – refer to oncology/neurosurgery

	UMN	LMN
Tone	↑	↓
Power	↓	↓
Sensation	Loss	Loss
Reflexes	↑	Absent/ reduced

Treatment

Need to consider:

- Steroids
- Radiotherapy
- Surgery

Should be aiming to treat before loss of function occurs

Affect on prognosis?

Seizures

Occurs in 10-15% patients with palliative care needs but 70% patients with brain tumours.

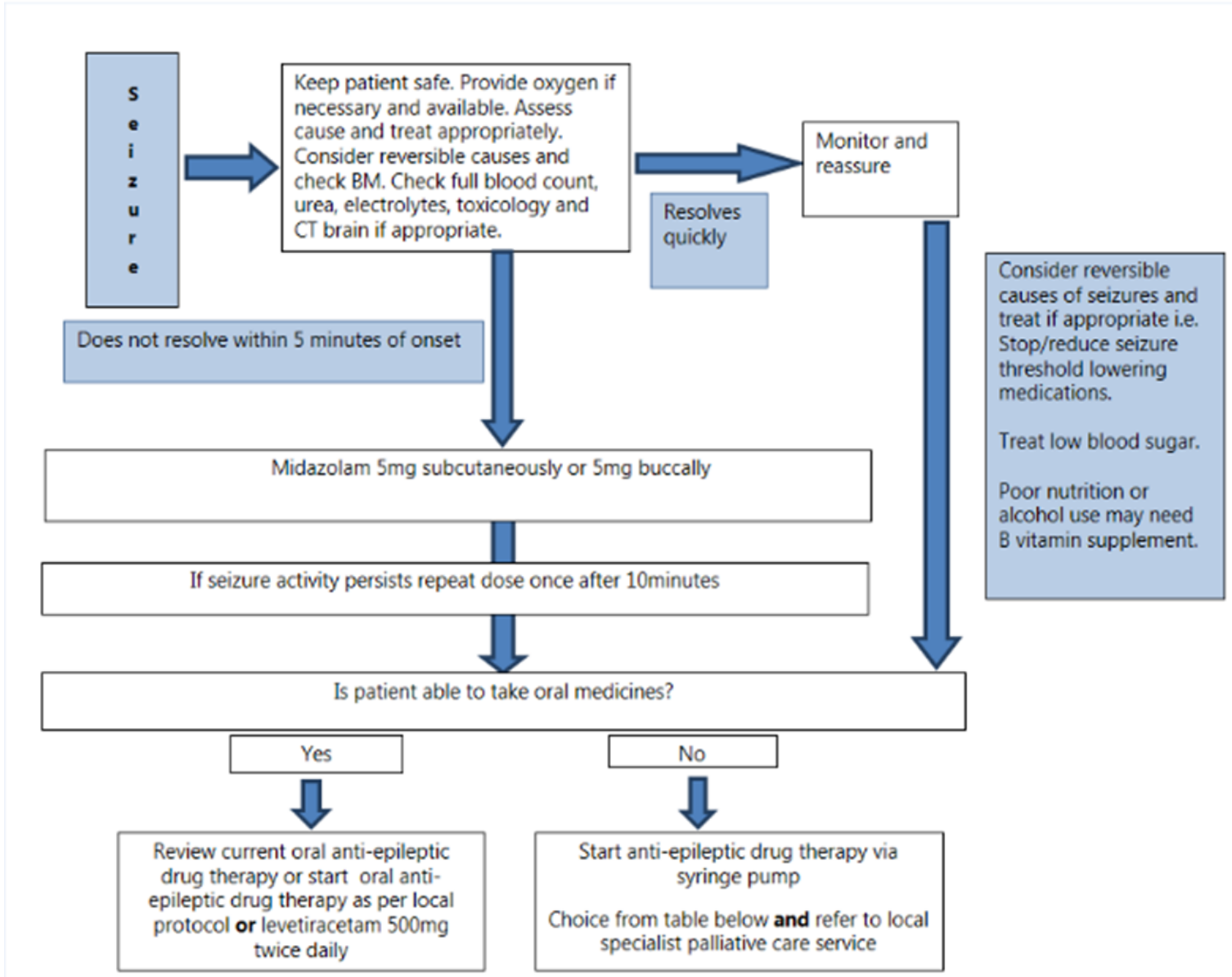
Assessment:

- Check for other causes – missed medication doses / vasovagal / postural ↓BP / hypoglycaemia
- Primary or secondary brain tumours / cerebrovascular disease / epilepsy/ biochemical abnormalities

Have an anticipatory care plan – can be distressing

BTRE – Brain tumour related epilepsy

- BTRE = one or more seizures in a patient with brain tumour
- Occurs in 90% of adults with low grade glioma and often presenting symptom
- Slow growing low-grade tumours have higher risk of seizure than aggressive high grade gliomas or brain mets
- Presenting feature in 15-40% patients with brain tumour
- Up to 50% of patients with BTRE have intractable seizures and require combination therapy
- Goal of treatment - reduce seizure frequency with acceptable safety profile and tolerability of ASMs


Seizure
Keep patient safe. Provide oxygen if necessary and available. Assess cause and treat appropriately. Consider reversible causes and check BM. Check full blood count, urea, electrolytes, toxicology and CT brain if appropriate.
Resolves quickly
Monitor and reassure
Consider reversible causes of seizures and treat if appropriate i.e. Stop/reduce seizure threshold lowering medications.
Treat low blood sugar.
Poor nutrition or alcohol use may need B vitamin supplement.
Does not resolve within 5 minutes of onset
Midazolam 5mg subcutaneously or 5mg buccally
If seizure activity persists repeat dose once after 10minutes
Is patient able to take oral medicines?
Yes
No
Review current oral anti-epileptic drug therapy or start oral anti-epileptic drug therapy as per local protocol or levetiracetam 500mg twice daily
Start anti-epileptic drug therapy via syringe pump
Choice from table below and refer to local specialist palliative care service

Treatment

Start ASM after a seizure

Risk of recurrence is high

1st line –levetiracetam

Consider dexamethasone

Avoid enzyme inducers as they can compromise efficacy/interact with other meds – like chemotherapy agents

Need to patient needs/route/prognosis

Treatment

If end of life consider CSCI midazolam –20-30mg dose for seizure control

Other measures –

- CSCI levetiracetam
- Under specialist guidance – phenobarbital and propofol

ASMs in CSCI

Drug	Experience of use in syringe pump	Oral to CSCI conversion	Starting dose for seizures (over 24 hours)	Sedating effect	Guide dose titration
Midazolam	Extensive	NA	20mg to 30mg	Often	Increase by 5mg to 10mg every 24 hours
Levetiracetam*	Some	1:1	1g (or equivalent to current oral dose)	No	Increase by 500mg every 2 weeks (max 3g may need 2 syringe pumps)
Sodium Valproate*	Very limited (specialist advice)	1:1	1g	No	Increase by 200mg every 3 days (max 2.5g)
Phenobarbital*	Extensive (under specialist advice only)	Not applicable	200mg to 400mg (stat bolus of 100mg to 200mg IM/IV may also be needed)	Yes	Increase by 200mg every 24 to 48 hours
* **Only for use in conjunction with advice from specialist palliative care.**					

Case Study

70 year old man with prostate cancer and bone mets

In hospital for UTI

Weekend – fall on the ward, moved to the nurses station

Urinary retention - Multiple attempts at catheter over night – 3 different doctors!

Dex and discussion with the oncology team - radiotherapy

Other emergencies?

Superior Vena Cava Obstruction (SVCO)

Opioid toxicity

- Use of naloxone

Questions?

CASE STUDY

- Janice is a 55y old lady with breast cancer
- Widespread bony metastases
- Receiving chemotherapy
- Becoming less well at home with increasing pain in her mid-back. Needing to take more Oramorph
- Mobility is less good (unsteady) and she has a fall
- She's gone off her food and becoming a bit muddled and is spending more of the day asleep
- Husband very worried and calls the GP

The Prince & Princess of Wales Hospice

NHS Greater Glasgow and Clyde

- Admitted to hospital
- Bloods show eGFR of 40 and Adj Ca 3.0

CASE STUDY

The Prince & Princess of Wales Hospice

NHS Greater Glasgow and Clyde

- Admitted to hospital
- Bloods show eGFR of 46 and Adj Ca 3.0
- Given IV fluids and Zoledronic acid as per protocol
- Nursed in bed

CASE STUDY

The Prince & Princess of Wales Hospice

NHS Greater Glasgow and Clyde

Cautions

Opioid toxicity

- Admitted to hospital
- Bloods show eGFR of 46 and Adj Ca 3.0
- Given IV fluids and Zoledronic acid as per protocol
- Nursed in bed
- Over the next few days she becomes brighter and begins to eat and drink
- Lower back is very sore and pain travels down posterior thigh. Episode of faecal incontinence

CASE STUDY

The Prince & Princess of Wales Hospice

NHS Greater Glasgow and Clyde

CASE STUDY

- Admitted to hospital
- Bloods show eGFR of 46 and Adj Ca 3.0
- Given IV fluids and Zoledronic acid as per protocol
- Nursed in bed
- Over the next few days she becomes brighter and begins to eat and drink
- Lower back is very sore and pain travels down posterior thigh. Episode of faecal incontinence
- ?MSCC → urgent MRI
- Start Dexamethasone 8mg BD with PPI cover

The Prince & Princess of Wales Hospice

NHS Greater Glasgow and Clyde

- Admitted to hospital
- Bloods show eGFR of 46 and Adj Ca 3.0
- Given IV fluids and Zoledronic acid as per protocol
- Nursed in bed
- Over the next few days she becomes brighter and begins to eat and drink
- Lower back is very sore and pain travels down left posterior thigh. Episode of faecal incontinence
- ?MSCC → urgent MRI
- Start Dexamethasone 8mg BD with PPI cover
- MRI shows bony mets at L1 and L3 with evidence of cord compression
- Speak to oncology – arrange to transfer for urgent radiotherapy

CASE STUDY

The Prince & Princess of Wales Hospice

NHS Greater Glasgow and Clyde

- Spends 1 week in the Beatson receiving radiotherapy then returns to base hospital for discharge planning
- Dexamethasone being reduced – now on 2mg od
- Still a little muddled from time to time, and now complaining of headaches (new)
- Overnight has 1st seizure

CASE STUDY

The Prince & Princess of Wales Hospice

NHS Greater Glasgow and Clyde

- CT brain in the morning confirms presence of widespread brain mets

- Dexamethasone ↑ 8mg bd again with slower reduction and commenced on Levetiracetam

CASE STUDY

The Prince & Princess of Wales Hospice

NHS Greater Glasgow and Clyde