Urgent Care End of Life / Cancer Dilemmas

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“… the choices don’t stop. Life is full of choices, and they are relentless. No sooner have you made one choice then another is upon you … but after a certain point the direction of travel becomes clear.”

Objectives for today

- To explore our approach to managing some common urgent care cancer problems
- To discuss cases where cancer may be diagnosed as an emergency
- To explore the factors that help us determine if a patient is “becoming” palliative (in or out of hours setting)
- To consider factors that influence our prescribing and management decisions in patients with multi-morbidity

Cancer Care In The UK …

- Nationally 45% of people die in their own homes
- 23% of all cancers diagnosed via the emergency route
- Most complaints regarding cancer care relate to poor communication & organisation

Symptom Control

- Palliative care handbook
- GSF Prognostic Indicator Guidance
  - Rainy day thinking – hope for the best but prepare for the worst

Cancer diagnosed as an emergency – what are the clues?

Cancers present differently in the emergency setting

- Lung cancer more likely to present with non respiratory symptoms
- Colorectal cancer more linked to pain / obstruction / weight loss than “classic” bleeding or change in bowel habit

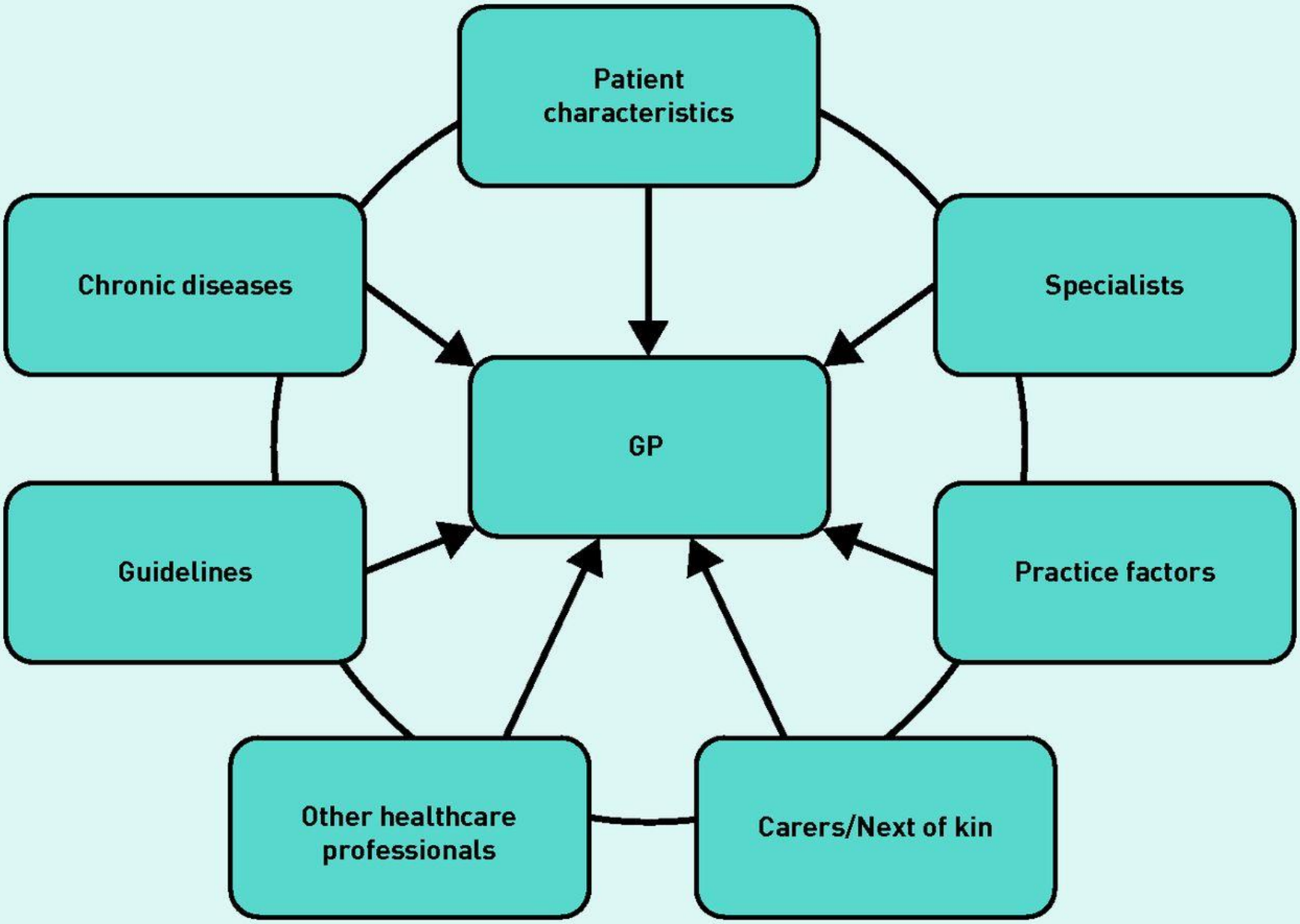
Prescribing in patients with multi-morbidity

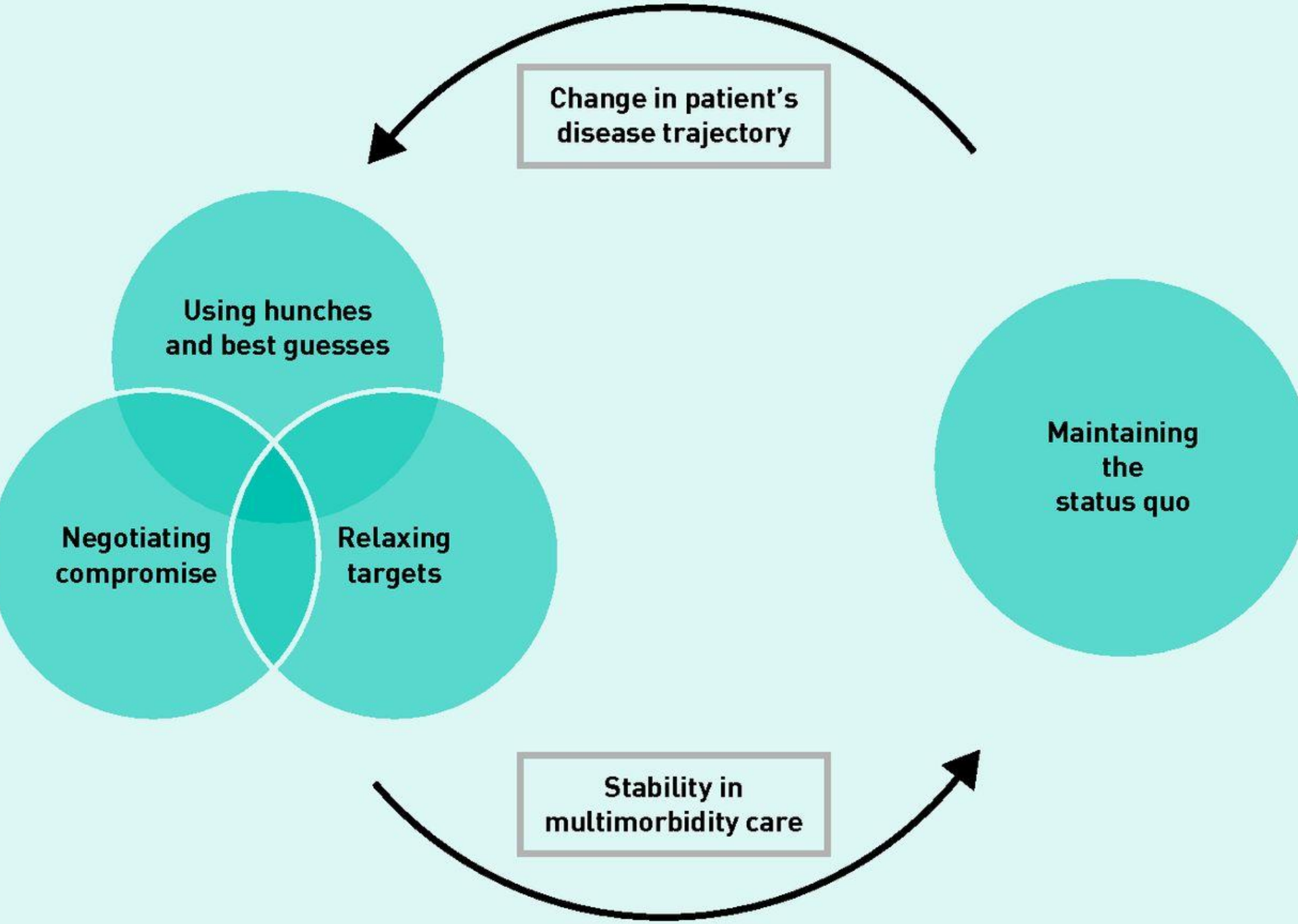
- Prescribing requires safe amalgamation of patient drug and condition factors
- Multiple conditions can involve multiple conflicting guidelines not possible to follow all guidelines concurrently

Prescribing in patients with multi-morbidity

- Practical know how is used by experienced clinicians and is difficult to share with colleagues or trainees
- Satisficing - where doctors accept care is satisfactory and sufficient for that particular patient
- Includes the trade off between drugs diseases and best practice recommendations

What to give the patient who has everything?




Change in patient's disease trajectory
Using hunches and best guesses
Negotiating compromise
Relaxing targets
Maintaining the status quo
Stability in multimorbidity care

NG31 – Care of adults in the last days of life

Recognising dying

- Multiple or progressive changes
- Signs of agitation, Cheyne-Stokes breathing, reduced level of consciousness, mottled skin
- Noisy respiratory secretions
- Progressive weight loss / social withdrawal

NG31 – Care of adults in the last days of life … or in practice …

Recognising Dying

"Would you or the family be surprised if they deteriorated further and passed away later today / tonight?"

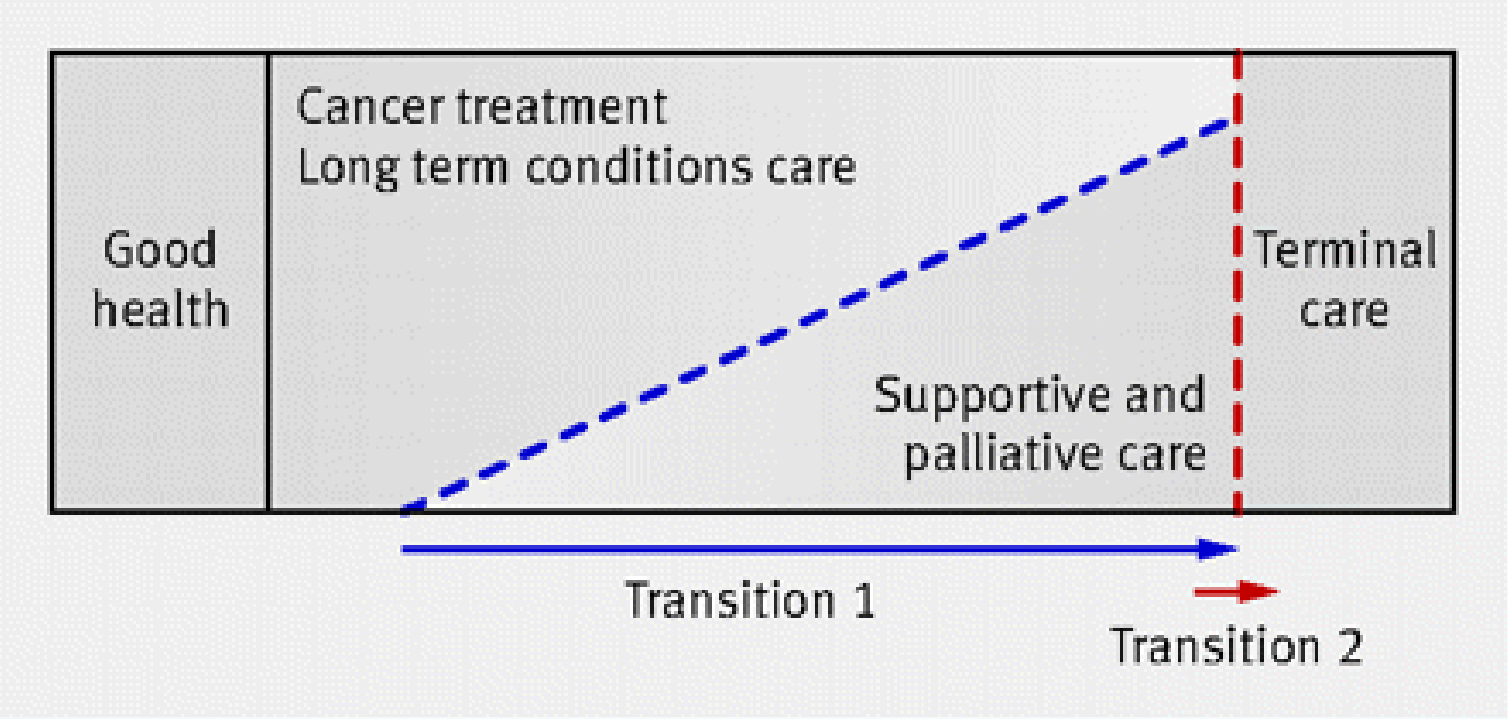
The GSF Prognostic Indicator Guidance for clinicians to support earlier recognition of patients nearing the end of life

Needs Based Coding and Needs Support Matrices

Identifying the stage of illness and anticipating needs and support– to deliver the right care at the right time for the right patient

- **A – All – stable from diagnosis - years**
- **B – Unstable, advanced disease - months**
- **C – Deteriorating, exacerbations - weeks**
- **D – Last days of life pathway - days**

Clinical indicators for terminal care



Boyd & Murray, BMJ 2010

Recognising & managing key transitions in end of life care

Have all reversible causes been excluded

- Infection (UTI / chest / cholangitis / peritonitis)
- Dehydration
- Biochemical disturbance (calcium, glucose, sodium)
- Drug toxicity

- If in doubt – give treatment and review in 24 hours
- If all conditions met then EOL care is appropriate

Any questions?

Can you just …?

Can you just ….

- 1. write up JIC medications for this patient
- 2. write up a syringe driver for this patient?
- 3. increase the dose of diamorphine in the driver for this patient as their usual GP is away and they are still in pain
- 4. write up some morphine amps for this patent, the chemist can't get diamorphine but they say they have morphine
- 5. write up some fortisip for this lady – she's not eating and her family would like her to have them?
- 6. organise oxygen for them as they are "ever so breathless"

NG31 – Care of adults in the last days of life

Maintaining hydration

- Assess swallow / risk of aspiration
- Offer frequent mouth and lip care, include the management of dry mouth in care plan, if needed
- help with cleaning teeth / dentures
- Encourage carers / family to offer frequent sips of fluid

NG31 – Care of adults in the last days of life

Discuss risks / benefits of clinically assisted hydration and advise that, for someone who is in the last days of life

- fluids may relieve distressing symptoms or signs related to dehydration, but may cause other problems (see recommendation 1.4.9)
- it is uncertain if giving clinically assisted hydration will prolong life or extend the dying process
- it is uncertain if not giving clinically assisted hydration will hasten death

NG31 – Care of adults in the last days of life

- Consider use of syringe driver if two or more doses of any “prn” drugs have been given within the last 24 hours
- Be aware that not everyone with cancer is in pain
- Do not routinely offer oxygen to manage breathlessness
- Consider retention / constipation as a cause of agitation / pain

In Summary

- *Individualise care – not box ticking / pathway*
- *Recognise EOL – be proactive if you spot the signs*
- *Address the concerns of any HCP present*
- *Think about implications of hydration*