#PCUKStudyDay

Pancreatic CANCER UK

Case Study

Patient: Jacky, 70-year-old female, retired, previously fit and well

- Jacky has a suspected pancreatic cancer and had undergone a biopsy at her local hospital the week prior to presentation. Currently awaiting tissue diagnosis but aware probability is that this is a pancreatic malignancy.
- Attended A&E at the beginning of January due to increased abdominal pain – transferred for care under gastro team
- Raised infection markers and suspected biliary obstruction on CT (however bloods not reflective of this – treatment started for biliary sepsis
- Referred to palliative care by A&E team due to increased pain not responding to oral PRN medications – patient reported to be writhing in pain and increasingly distressed

Introduction to Palliative Care

- Urgent review by hospital Specialist Palliative Care Team consultant and CNS – main symptoms: Increased abdominal pain, nausea & constipation
- Jacky and family reported pain has been increasing in last few weeks – GP started 5mcg Buprenorphine patch and PRN oral Morphine as needed
- Subcutaneous syringe pump started – **20mg Oxycodone & 30mg Metoclopramide** (Oxycodone started as patient reported Morphine had previously been ineffective for pain and loss in faith about effectiveness
- Buprenorphine patch stopped and replace with syringe pump – **Not normal practice, however due to only recently starting decision made to use only one form of opiate and titrate as needed** (Transdermal patches not most effective source of symptom control in uncontrolled pain due to prolonged onset)

Ongoing Palliative Care Input

- Further scans in early days of admission reported evidence of both liver and pulmonary disease/metastases

- Jacky seen regularly throughout admission and pain became increasingly complex/difficult to manage – **Mostly right sided abdominal pain –** Jacky reports bowels opening regularly however, ongoing twisting/sharp pain

- Jacky has over the course of a week escalated to high level of opiates with an average of 6 PRN doses used every day despite escalation – reports some effectiveness but not long lasting

Suggestions for management of pain?

Poll 1

Best advice for further pain management?

- Escalate opiates further in CSCI & continue PRNs
- Consider steroids & why?
- Alternative medications

What happened next?

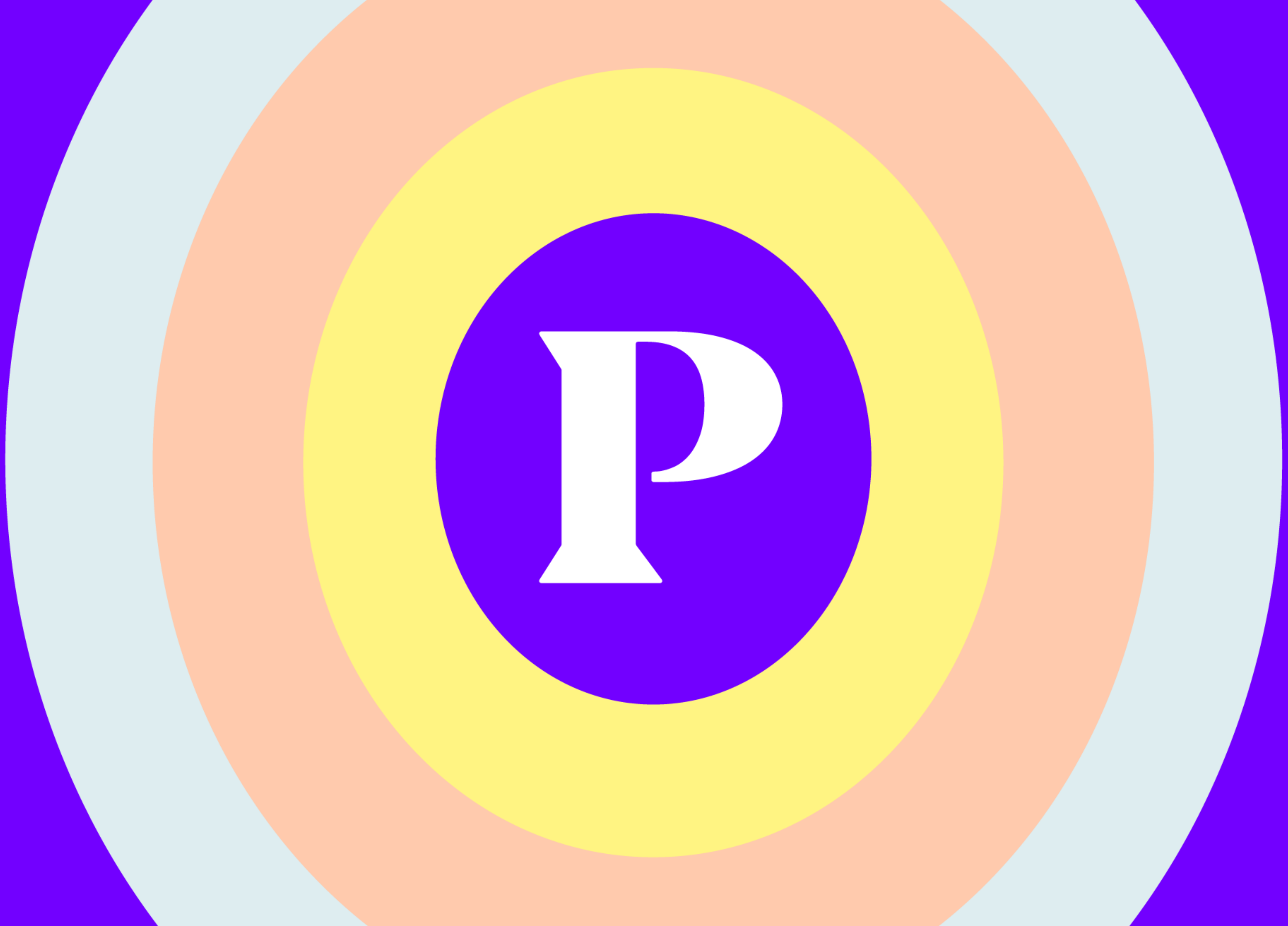
- Trial of steroids for suspected liver capsule pain – initially effective however due to nature wean needed
- Started on Pregabalin 25mg twice daily for suspected celiac axis pain
- Pain improving - however vulnerable – **Syringe pump currently at 80mg Oxycodone, 30mg Metoclopramide with added PRN and other supportive PO medications**
- Responded to antibiotics and feeling brighter/better - Eager for discharge and awaiting MDM plan - ?chemotherapy

Discharge…

- Jacky discharged from hospital after 2 weeks and antibiotic treatment for biliary sepsis
- Discharged home with syringe pump – managed by local community palliative care and district nursing team
- Plan to switch from syringe pump to Transdermal patch when pain control stable on regime
- Hopeful for treatment plan from Oncology within the coming weeks

Concluding Thoughts..

- Complex symptoms related to location of disease and common areas of metastatic spread
- Multiple different agents for various causes of pain – opiate/neuropathic etc – **The need to think of alternatives instead of continued titration of one medication**
- Syringe pumps – effectiveness in complex symptom control – not just for EOLC as normally perceived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Case Study

- 4 weeks following discharge, Jacky presented to local A&E much less well – jaundice with increased symptoms of SOB and pain, and likely infection
- Blood test reporting: **CRP 131, WCC 12.1, ALT 97, ALP 1008, Bili 190**
- Started Ivabx for ?biliary sepsis ?chest sepsis (Hx of COPD) and transferred to Brighton for treatment under gastro team

Assessment

- Recent Oncology OPA in which plan was made to start palliative treatment the following week – would need to be held due to infection
- Syringe driver from previous admission has remained insitu since last DC (Oxycodone 100mg & Metolcopramide 30mg)
- Reviewed by SPCT: Symptoms of band like/cramping abdominal pain making it hard to sit up, SOB (worse when laying down) and nausea – Also reported increased anxiety and fear
- Alterations to syringe pump – Oxycodone 100mg , Haloperidol 2mg and Midazolam 5mg

Treatment

- CT CAP reported rapid disease progression in short period of time with noticeable growth in pancreatic tumour as well as biliary obstruction & bilateral pleural effusions
- Temperature spikes and much less well in days following – treated for sepsis and plan made for ERCP when well enough to aim for biliary stent
- Reviewed further by SPCT – **‘currently’** not well enough for ERCP and stent
- Conversations started regarding Jacky being **‘sick enough to die’** during admission – DNACPR in place and TEP for WBCC
- Focus for Jacky and family became getting better for ERCP/intervention

On-going Symptom Management

- Despite active intervention for infection, symptoms escalated – increased pain and fatigue main concerns for Jacky – reports feeling increasingly anxious
- Jacky now needed o2 via nasal specs due to dropping o2 saturations
- On review noticeable jerking/myoclonus in arms but no other reported side effects
- CSCI altered (Oxycodone 120mg & Midazolam 10mg)
- Now noticeable peripheral oedema
- **Jacky remains for active intervention and medical emergency calls**

Ongoing plan

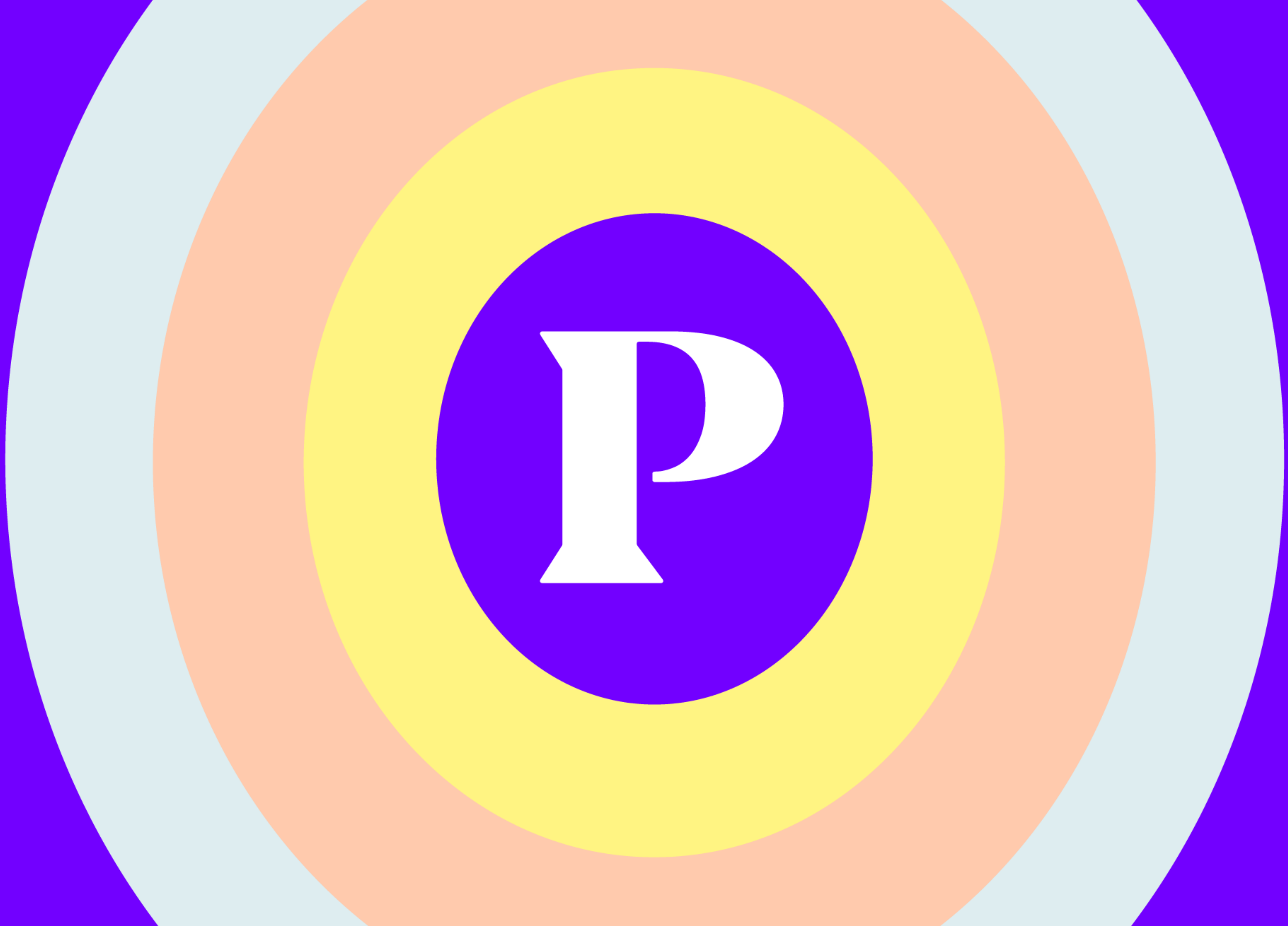
- Remains on antibiotics – NEWs high and no signs of improvement
- Symptoms well managed – however increasingly weak
- Discussions during palliative care review regarding current treatment plan and no improvement – conversations surrounding wishes at the end of life with Jacky and her family
- Husband at the time – shocked but understanding
- Review by treating team at the time and decision made to switch comfort care and observations

End Of Life

- Decision made to refer to hospice as per patient and family wish
- Syringe driver remained and PRN as needed
- Monitoring stopped – comfort observations started
- Jacky declined chaplaincy – stating no religious beliefs – supported by family
- Died on the ward 24 hours following focus of care switch

Conclusion

- Complex symptom management
- Identification of what is reversible and what is not
- Impact of rapid progression
- Communication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