“Pain is inevitable…..suffering is optional”

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VICS VICTORIAN INTEGRATED CANCER SERVICES Together for better cancer care

LA TROBE UNIVERSITY

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How far we have come.....

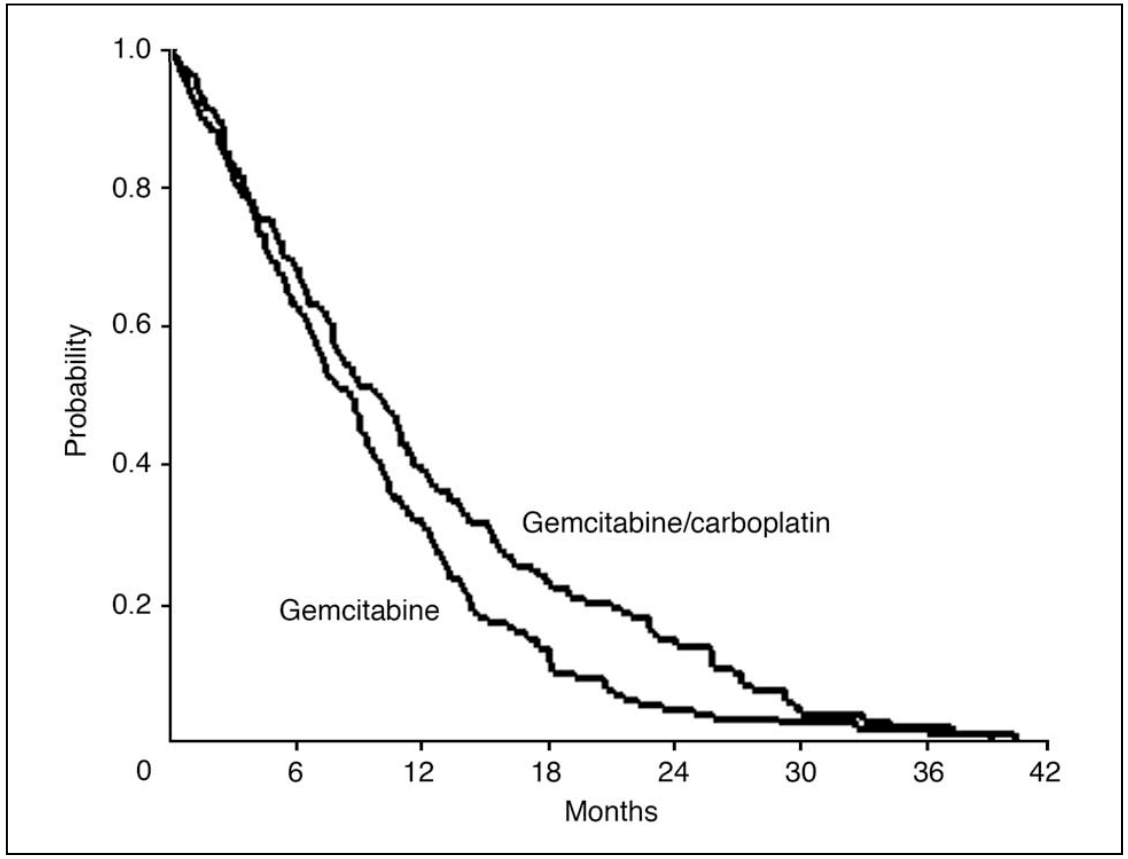
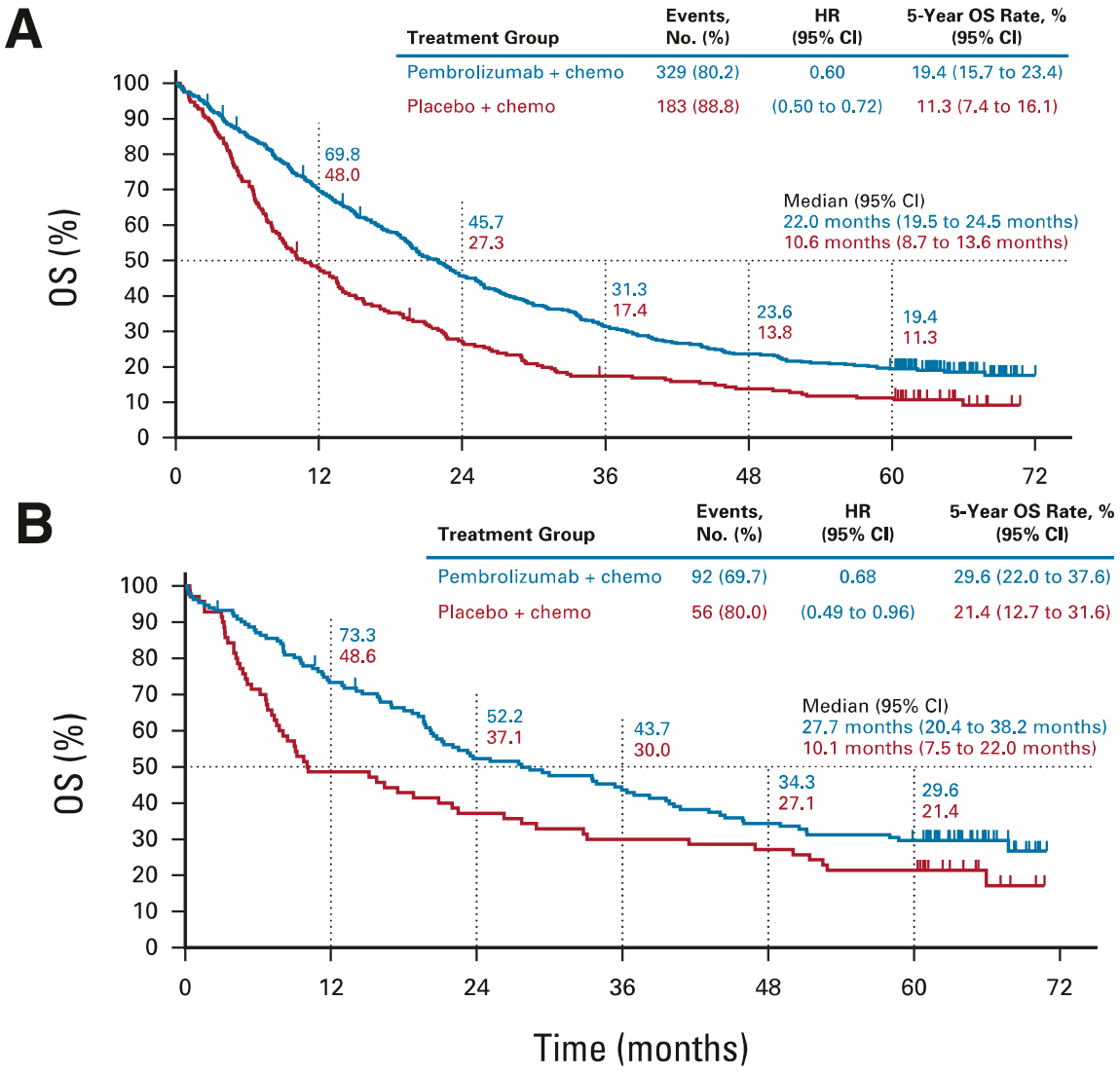


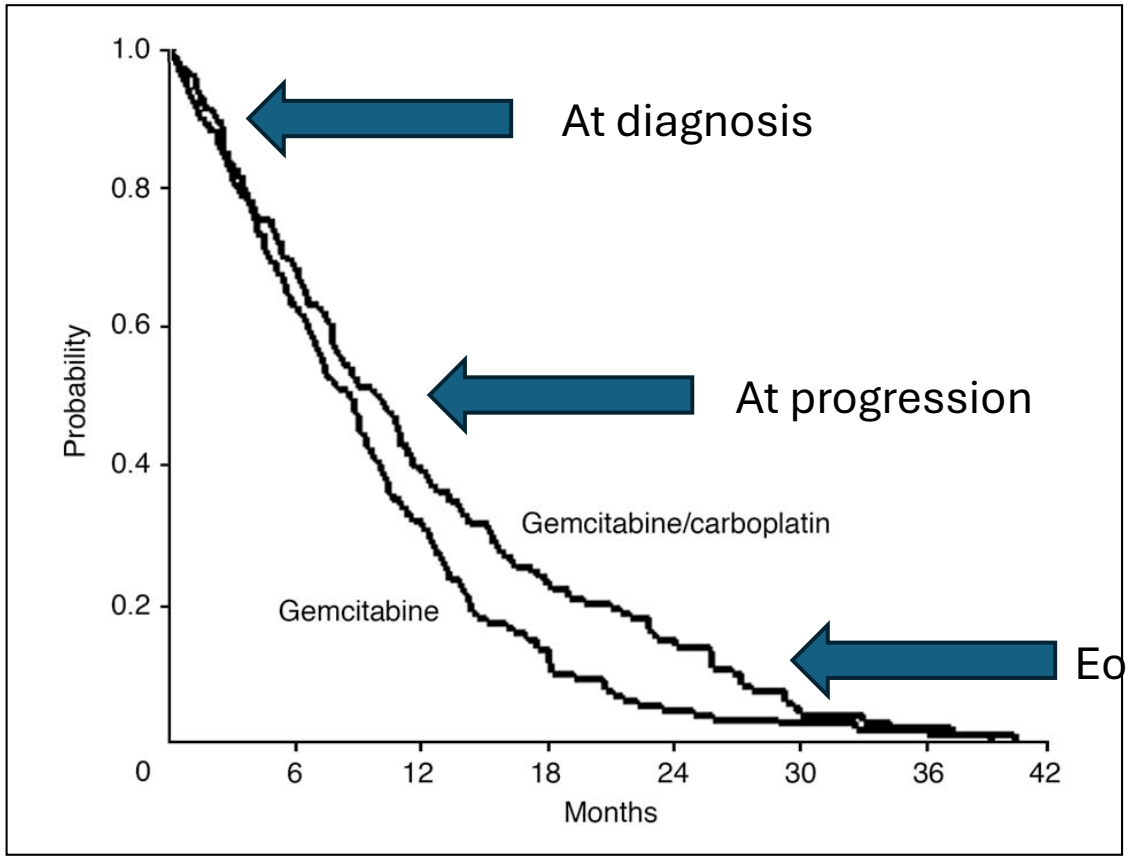
Fig 1. Overall survival in relation to treatment. Intent-to-treat analysis, n = 334. Log-rank *P* = .0205. Median survival was 8.6 months (95% CI, 7.3 to 9.9 months) for gemcitabine and 10.0 months (95% CI, 8.0 to 12.0 months) for gemcitabine plus carboplatin. Hazard ratio = 0.767 (95% CI, 0.612 to 0.960).

JCO (2005). 23(33): 8380-8388



JCO (2023). 41:1992-1998

Palliative care used to be easy (I think)….



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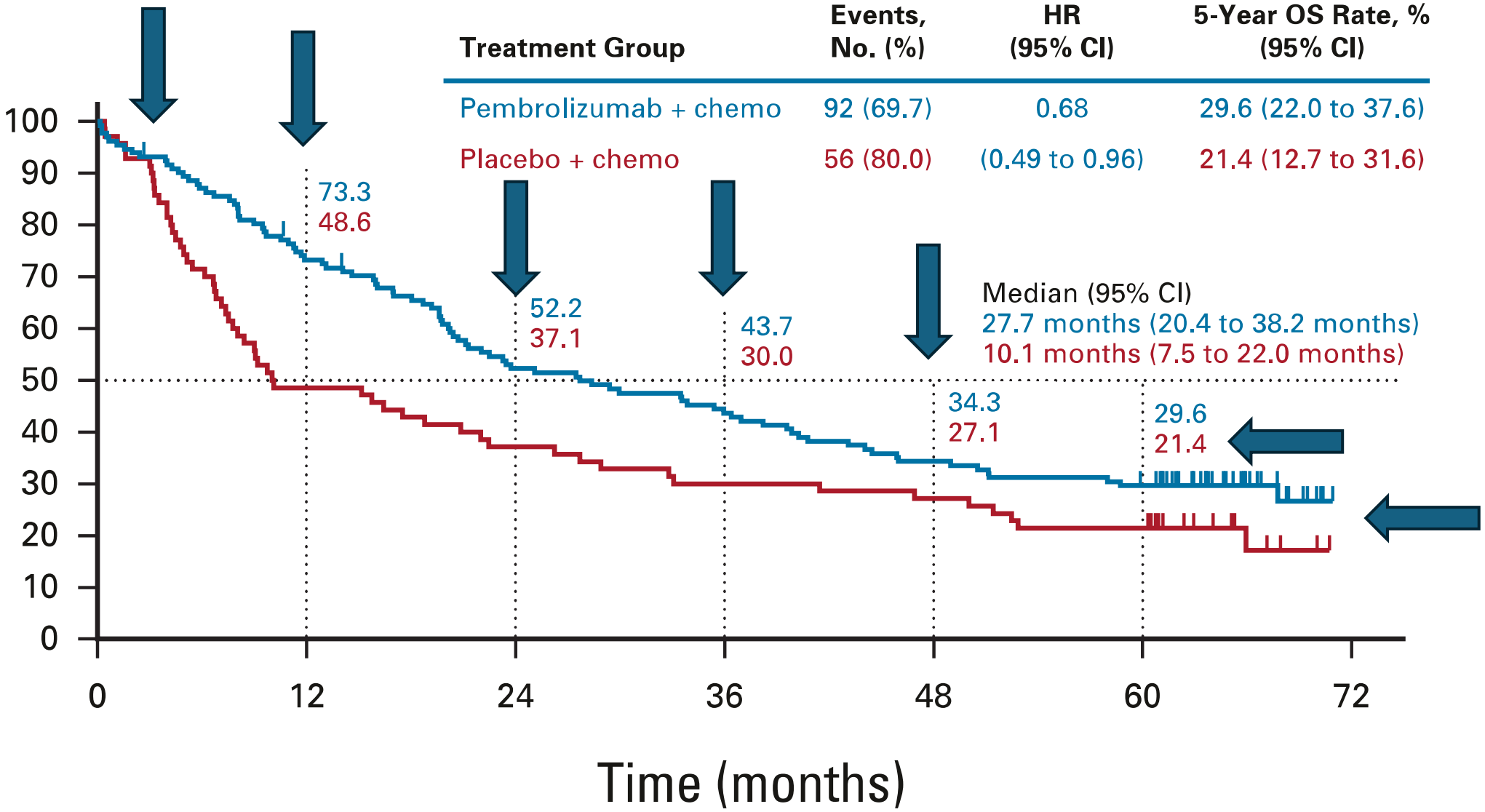
With great advances, comes greater challenges…..



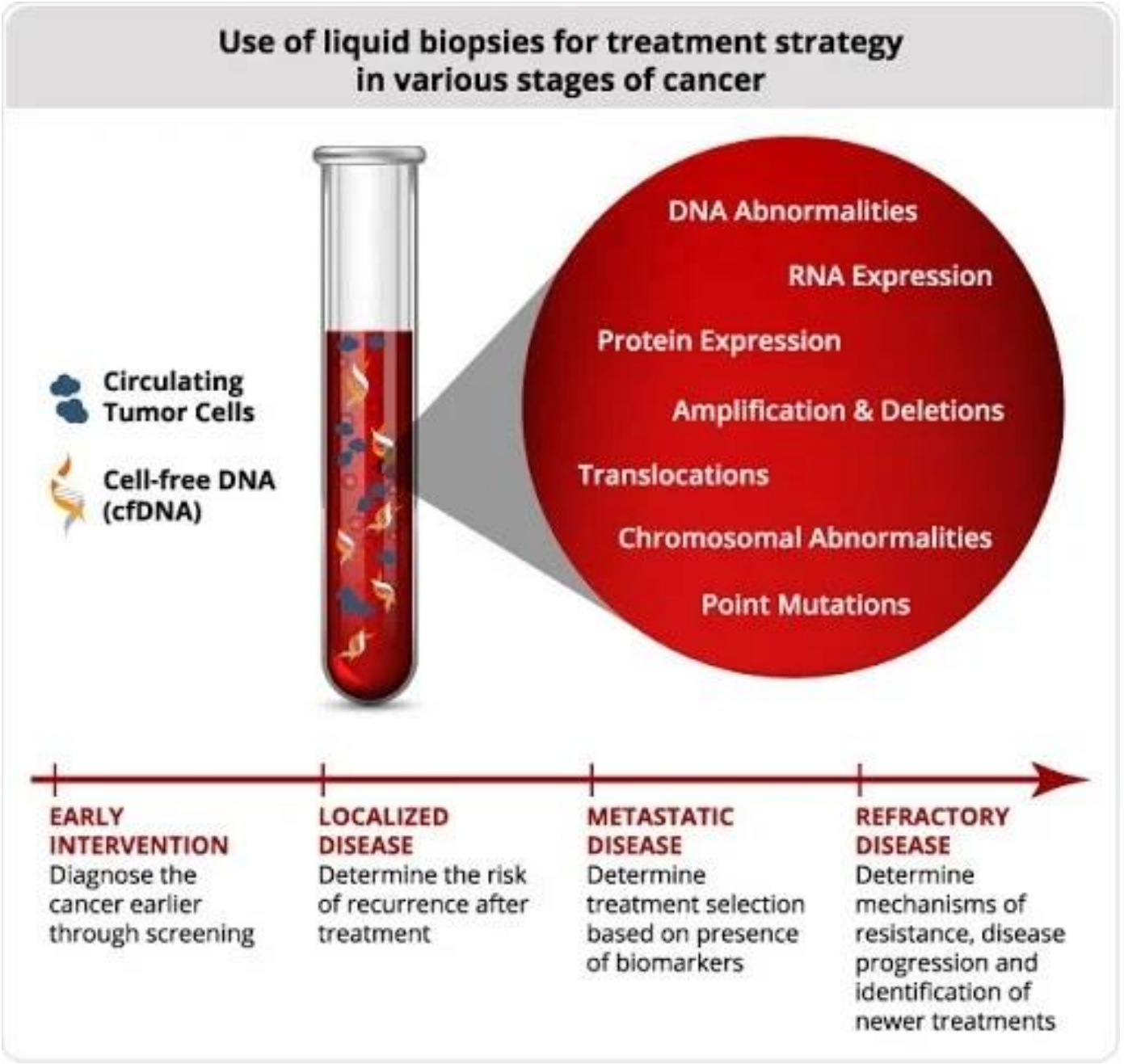
Challenges…..points to ponder

- **Early referral……..how early is too early?**
- **Pseudo-progression vs hyper-progression…….how do you know?**
- **Going well……..discharge from Pall Care?**
- **Going well……..stay with Pall Care…….how long for?**
- **Prognostication……..it is a science or an art?**
- **VAD request……what if?**

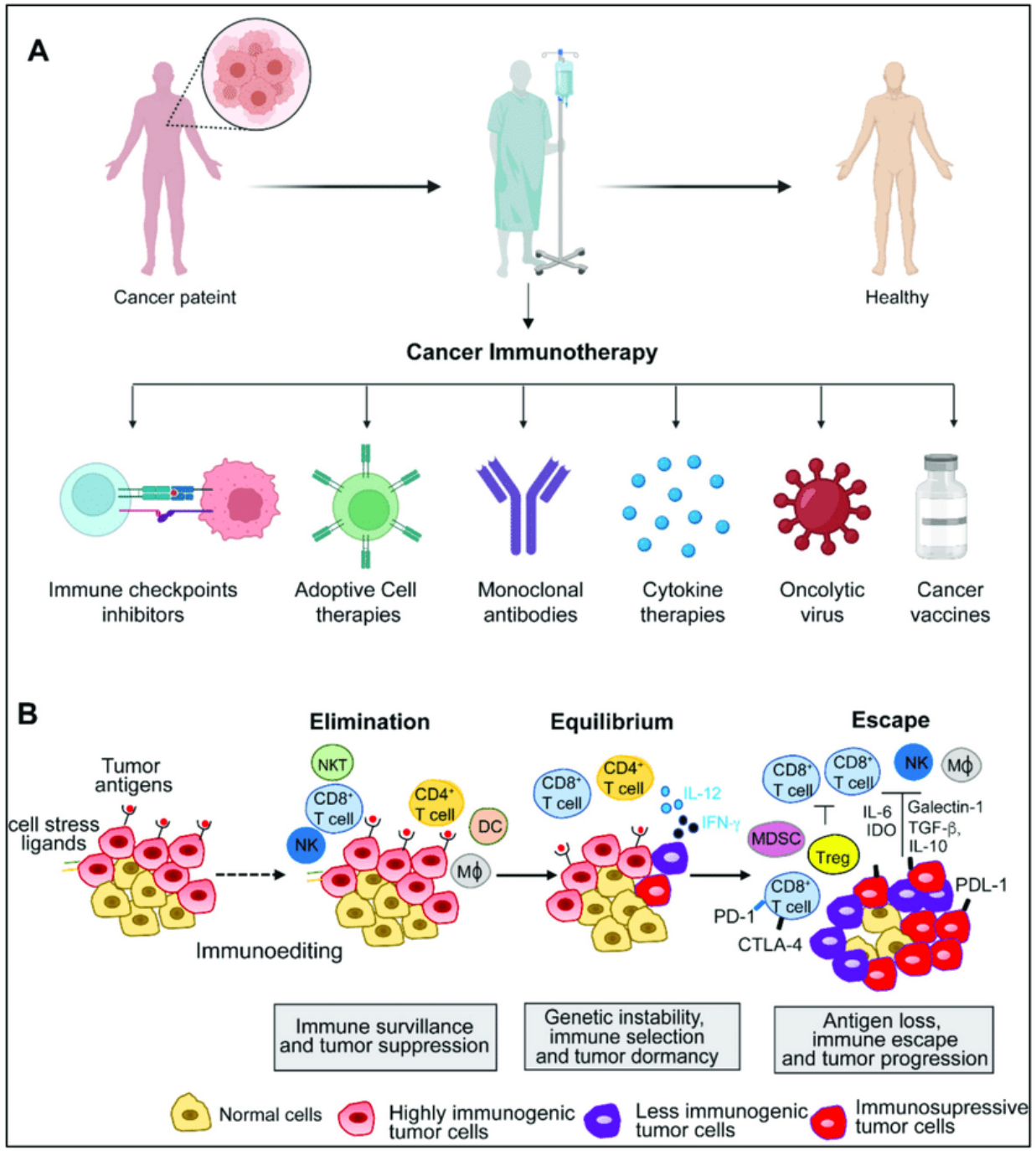
Advances in Oncology

- Diagnostic:
  - Liquid Biopsy
- Therapeutic
  - Chemotherapy
  - Immunotherapy
  - Newer generation of immunotherapy
  - Targeted therapy
  - ADC
  - Tumour vaccines
  - Theranostics
  - Any combination of above
- Supportive

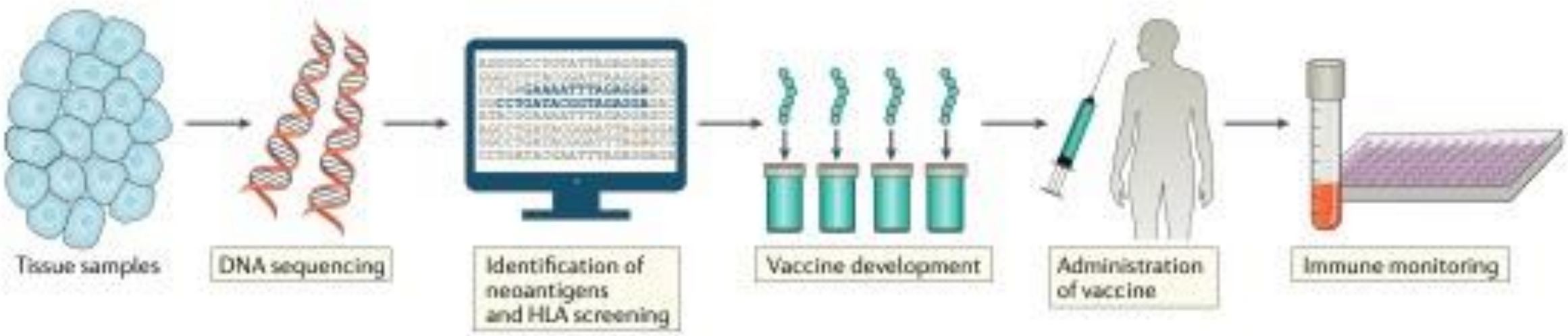
Liquid Biopsy



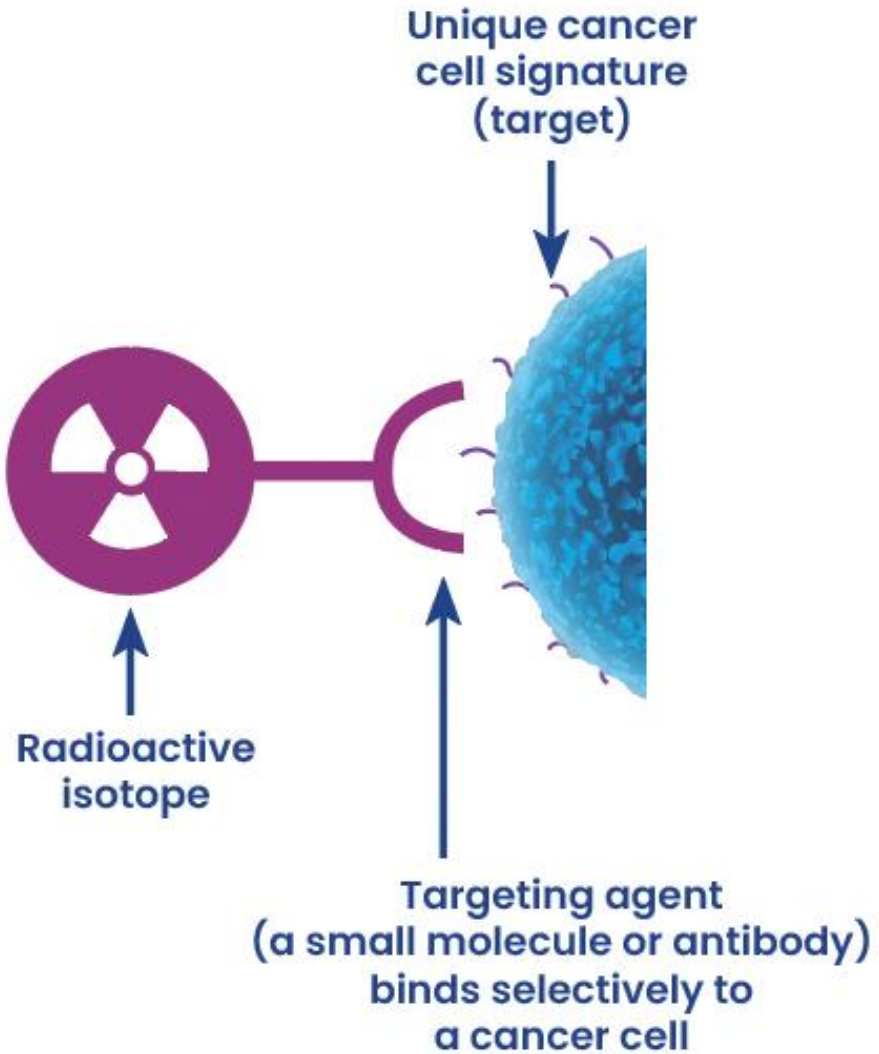
Immunotherapy in cancer



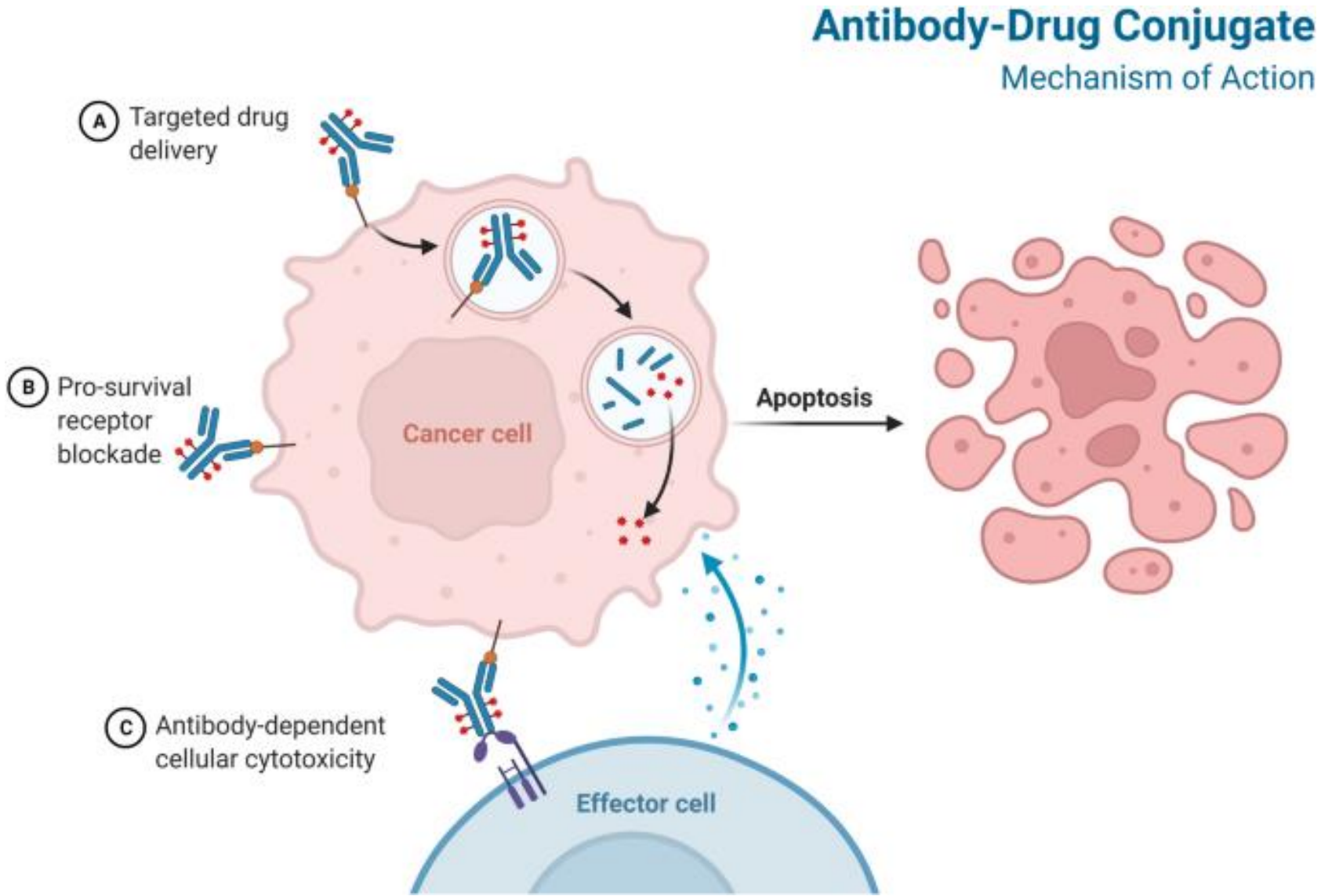
Tumour Vaccines



Theranostics in cancer



Antibody-Drug Conjugates (ADC)



Advances in Supportive Care in Oncology

- Analgesics, Anti-emetics, Aperients, etc.
- Innovative models of supportive care delivery
- Medicinal cannabis
- Survivorship care
- Greater patient autonomy
- Rise of the Social Media……help or hindrance?

Toxicities of interest…….old is new again.

- A case from 2013…..long before immunotherapy was routine
  - 65F with metastatic vulval SqCC with nodal mets, chronic leg lymphoedema
  - Surgery, Pall RT & chemo, on watch & wait, ECOG 1
  - Co-morbidities: GORD, IBS, Hypothyroid, OA
  - 3x hospital admissions with leg pain
    - 1st admission - Opiate rotation from Fentanyl to MS Contin, and commenced on Gabapentin
    - 2nd admission: Left leg extensive DVT, commenced on LMWH
    - Current admission: Ongoing L-leg pain with suboptimal pain control

Case....continued

- On admission:
  - MS Contin increased from 60mg BD to 90mg BD, Gabapentin increased from 100mg TDS to 300mg TDS.
  - Concomitant UTI: MSU >100 WBC, Enterococcus and enteric Gm neg Rods. Given stat dose Gentamycin 300mg & Flucloxacillin 2g IV. Commenced on PO Cephalexin 500mg QID
  - ARF: eGFR 45 (base line >75), pre-renal

Current Admission (cont.)

- Admission Day 4:
  - pain well controlled, but new onset delirium and visual hallucinations.
  - Gabapentin dose reduced to 100mg TDS
  - PRN Benzodiazepins for delirium

- Admission Day 5:
  - Worsening delirium, febrile
  - Blood cultures – Neg, CXR- NAD, CRP 421
  - Gabapentin stopped, MS Contin reduced to 60mg

Current Admission (cont.)

- Over Christmas/New Year holiday period:
  - Deteriorating, with increasing drowsiness, unable to take oral meds, increasing confusional state - ?terminal delirium
  - Oral meds ceased
  - Commenced on SCIP with Fentanyl 750mcg, Midazolam 7.5mg, Haloperidol 2mg
  - Agitation, myoclonus: changed to Sufentanyl 125mcg, Midazolam 15mg, Haloperidol 2.5mg
  - Increasing agitation: Sufentanyl increased to 150mcg, Midazolam 20mg and changed to Levomepromazine 25mg.

Current Admission (cont.)

- Admission Day-9:
  - GCS 4/15, Hypothermic (35.2), Clinically dehydrated
  - SCIP changed to Hydromorphone 9mg, with Levo reduced to 12.5mg and Midazolam to 15mg.
  - 1L SC fluid given overnight.
  - IM Ceftriaxone commenced

Current Admission (cont.)

- Admission Day-10:
  - Hx and progress reviewed.
  - Clinical deterioration not fully explained by cancer burden.
  - O/E: GCS 5/15, Deep tendon reflexes absent
  - Urgent TSH 11.67, free T4 17
  - FBC, U&Es, LFTs, CMP, random Cortisol all normal. CRP 121

Working Hypothesis

- Clinical deterioration
  - precipitated by Sepsis (UTI), leading to probable myxedema coma (due to omission of Thyroxine for 5-days, on a background of subclinical hypothyroidism)
  - Contributed by escalating doses of Benzos and antipsychotics.

Management

- Midazolam and Levomepromazine stopped.
- Stat dose Hydrocortisone 200mg IV and commenced on IV Hydrocortisone 100mg QID
- Stat dose IV Thyroxine 20mcg given

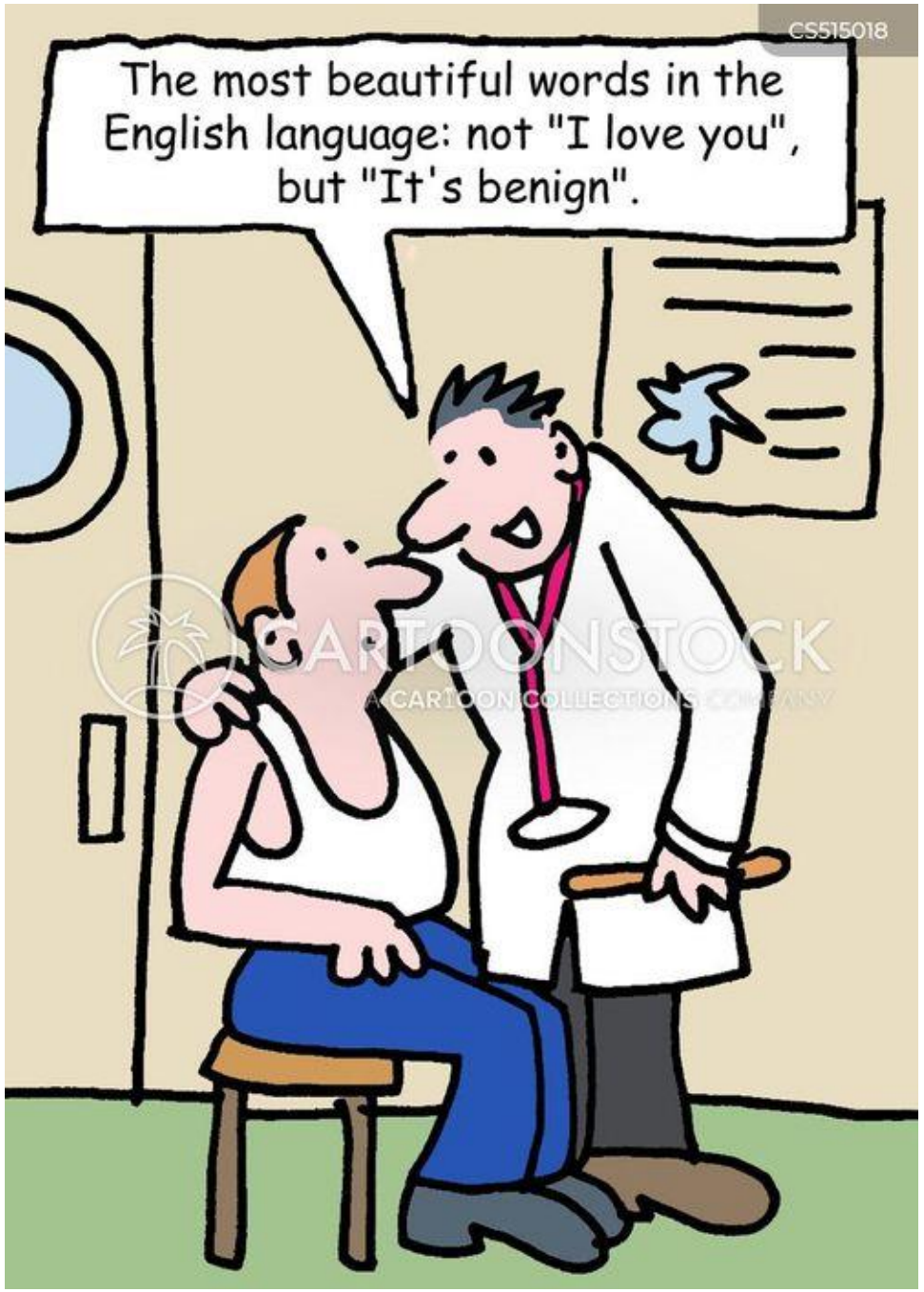
Next day..

- GCS 15/15
- Oriented to time, place, person.
- Recommenced on PO Thyroxine, PO ABx, IV cannula removed.

New drugs…….old toxicities…..different expectations

- Hypothyroidism
- Hyperthyroidism
- Pneumonitis
- Colitis
- Drug-induced liver injury/hepatitis
- Any other “..itis” you can think of

Thank you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The most beautiful words in the English language: not "I love you", but "It's benign".
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