1.

今天，我通过视频会议与菲比·史密斯（Phoebe Smith）的 23 岁外孙女卡米拉（Camilla）进行了讨论，她是菲比的主要照护者。

史密斯女士最近从 ABC 医院出院。她是一名 85 岁的老人，患有进行性痴呆症，最近因尿路感染引起的意识混乱而入院，接受了抗生素治疗。

在过去的几个月中，她的病情有所恶化，身体日渐虚弱，食欲不振，进食量少，且吞咽药片困难。她目前食用软质饮食，但即使尝试了各种食物，她仍然觉得食物无味，药物也需要碾碎服用。我建议对她的药物进行重新评估和调整，同时探索其他的给药途径。

住院期间，我院的辅助医疗团队对她进行了评估，营养师提供了 Sustagen（营养补充剂），她现在正在尝试少量多餐；职业治疗师为她安排了淋浴椅，由家人协助她洗澡，并计划安装扶手支架。她目前大部分时间卧床休息，需要家人协助使用两轮助行器行走。在排泄方面，她使用成人纸尿裤。

今天，我讨论了引入社区姑息护理服务的好处，并提醒卡米拉（Camilla）也可以探索当地市政服务。我会安排社区姑息护理的转诊。同时，我向卡米拉保证，考虑到菲比的英语水平有限，将会提供翻译服务。

我将在两周后与卡米拉进行一次随访咨询。

2.

今天，我有幸在姑息治疗虚拟诊所通过视频会议审查了比尔·史密斯先生。史密斯先生由血液科转介，目的是进行姑息治疗评估、症状管理和药物合理化。

史密斯先生是一位 70 岁的男士，患有晚期急性髓性白血病（AML），该病未对干细胞移植治疗产生反应，目前没有进一步的治疗选择。他还患有移植物抗宿主病（肺部）。

他之前经历了几种治疗方案，包括：

1. 阿糖胞苷 + 达诺霉素
2. VEN-HMA（维奈克拉+阿扎胞苷）
3. HMA 单药治疗（地西他滨）
4. LDAC（低剂量阿糖胞苷）
5. FLT3 抑制剂

他目前的主要问题是：

1. 由先前化疗引起的神经性疼痛，主要分布在手和脚部位。该疼痛的背景严重度为 3/10，但晚上会升高至 7/10。疼痛描述为刺痛、灼热和尖锐感，BTD 吗啡效果不佳。此前未发现符合复杂区域痛症（CRPS）的迹象，神经传导测试结果也无异常。他对加巴喷丁、三环类抗抑郁药、SSRIs、NSAIDs 以及包括奥施康定和美沙酮在内的阿片类

药物轮换无效。目前，他使用的是 MS Contin 200mg 每天两次和 40mg 按需服用的奥迪宁 （吗啡口服液），且剂量已迅速增加。

2. 严重疲劳和失眠。这些问题已经困扰他 6 个月，并且部分归因于类固醇的使用。他报告说活动能力下降，能走的距离非常短（ECOG 3），并且逐渐卧床不起。

其他并发症包括胃食管反流。

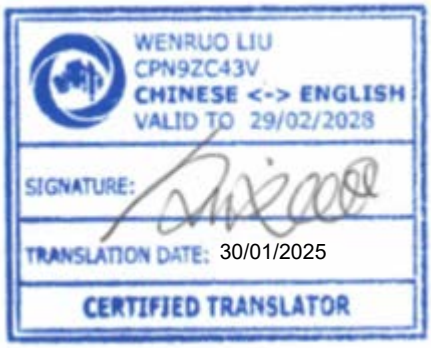
当前用药：

- MS Contin 200mg 每日两次
- 奥迪宁（吗啡口服液） 40mg 按需服用
- 孟鲁司特
- 丝必达
- Ventolin（沙丁胺醇）
- 镁
- 维生素 D
- Nexium（埃索美拉唑）
- 利普托（阿托伐他汀）
- 泼尼松龙 25mg 每日

今天，我向他介绍了姑息治疗的概述及其整体护理模式，以支持他的治疗。我还介绍了社区姑息治疗服务的可能性，并将为他安排转介。

我还审查了他的用药。我已停止使用利普托和维生素 D。针对他较差的睡眠模式，我认为这加重了他的疲劳感，我建议他早晨服用泼尼松龙，并计划逐步减量。

关于他的阿片类药物难治性神经性疼痛，我已安排他入院接受进一步评估，并考虑进行持续皮下注射（CSCI）氯胺酮和阿片类药物替代治疗（替代为氢吗啡酮）。另一个可能性是使用 CSCI 利多卡因。我将再次评估他的情况，并安排一次家庭会议，讨论他的治疗目标。



Translated pages: 1-2

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1.

Today I had a discussion with Phoebe Smith's 23-year-old granddaughter Camilla who is her primary carer via video conference.
Mrs Smith was recently discharged from ABC Hospital. She is a 85 year old who suffers from progressive dementia and was recently admitted with confusion due to a urinary tract infection and treated with antibiotics.

Over the last months, her condition has deteriorated, and she has been increasingly weak with poor appetite, eating little and having difficulty swallowing tablets. She is on a soft diet which is unappetising despite trying various foods and medications are needing to be crushed. I have suggested reviewing and rationalising her medications and also exploring alternative routes of administration.

During her admission our allied health team reviewed her and the dietitian has provided Sustagen and she is now taking smaller portioned meals; the occupational therapist has organised a shower seat with family assisting with showering; and support rails will be installed. She is currently mostly bed bound and uses a 2-wheel walking frame with assistance from the family. In regard to continence, she is using adult diapers.

Today I discussed the benefits of involving community palliative care services and reminded Camilla to also explore local council services. I will organize a referral for community palliative care. I also reassured Camilla that given Phoebe has limited English interpreters will be available.

I will have another follow-up consultation with Camilla in 2 weeks' time.

2.

I had the pleasure to review Bill Smith today in the Palliative Care Virtual Clinic via videoconferencing. Mr Smith was referred to us by the Haematology for palliative care review, symptom management and to rationalise medications.

Mr Smith is a 70 year old gentleman with advanced AML which has not responded to stem cell transplantation and is without further treatment options. He also has graft versus host disease (pulmonary).

Previously has progressed through several lines of treatment including :

1. cytarabine + daunorubicin
2. VEN-HMA (venetoclax + azacitidine)
3. HMA monotherapy (decitabine)
4. LDAC (low-dose cytarabine)
5. FLT3

His main issues currently are:
1/Neuropathic pain related to prior chemotherapy with hand and foot distribution. The pain has a background severity level of 3/10 but is 7/10 at night. It is described as being shooting, burning and sharp, with BTD morphine not effective. It has been noted that previously there are no signs consistent with CRPS and nerve conduction tests have been unremarkable. He

has not responded to gabapentanoids, TCA, SSRI, NSAID, and opioid rotation including oxycontin, and methadone. Currently, he is on MS Contin 200MG BD and 40mg prn ordine. The dose has been rapidly escalated.

2/Severe fatigue and insomnia
These have been problematic for 6 months and attributes them in part due to steroids. He reports decreased performance status and is only able to ambulate short distances (ECOG 3) and is becoming increasingly bed bound.

Other comorbidities include gastric reflux

Current Medications:
MS Contin 200mg BD
Ordine 40mg prn
Montelukast
Seretide
Ventolin
Magnesium
Vitamin D
Nexium
Lipitor
Prednisolone 25mg daily

Today I provided him with an overview of palliative care and its holistic paradigm of care to support him. I have introduced the possibility of community pall care services supporting him and will make a referral.
I also reviewed medications. I have ceased Lipitor and Vitamin D. In terms of his poor sleep pattern, which I believe is exacerbating his fatigue, I have asked him to take his prednisolone in the morning with a view to wean.

In regards to his opioid refractory neuropathic pain, I have organised for him to be admitted to our unit for further assessment and for consideration of a trial of CSCI ketamine and opioid substitution to hydromorphone. A further possibility is CSCI lignocaine. I will review him further at this time and also organise a family meeting to discuss his goals of care.