

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 BTM 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 gabapentinoids, TCA, SSRI, NSAID, and opioid rotation including oxycodone, and methadone. Currently, he is on MS Contin 200MG BD and 40mg prn as needed. 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

As needed 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.



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