Association for Palliative Medicine
Of Great Britain and Ireland

October 2023

APM Juniors Newsletter

EDITOR'S NOTE

Hello again everyone!

If you have not heard already, the registration for the APMJ Conference is now open! More details in the newsletter.

In this issue, we have a few golden nuggets from Dr Tony Duffy about malignant spinal cord compression. Finally, we also hear from Dr Polly Edmonds who is sharing with us her journey in her becoming and as a palliative care consultant.

We are very keen for anyone to submit to our monthly newsletter. If you have any ideas or thoughts, please do get in touch!

Follow us

https://twitter.com/APMJuniors

https://www.facebook.com/APMJuniors/

submissions.apmj@gmail.com

A WORD FROM ALICE ROGERS

APMJ research coordinator

Welcome to this month's juniors' newsletter! As the academic year gets fully underway, we look forward to future conferences and events for sharing of knowledge and dissemination of new ideas.

Throughout my time as the APMJ research rep, I have been so encouraged by seeing my friends and colleagues get stuck into palliative care research. For many, it was their first taste of academic medicine. The field has grown considerably in the last few decades and it is really exciting to be a part of!

For any junior doctor or medical student interested in pursuing research in palliative care, I would encourage you to check out the APM/PCRS research directory (link at the end of the newsletter) where you can find local groups in your area. If study budgets and time allows, the APM juniors conference in November 2023 and the Palliative Care Congress in March 2024 are both wonderful events – I always leave feeling enthused and motivated, with new ideas and new contacts. Furthermore, the Palliative Care Research Society (PCRS) hosts webinars and workshops for budding academics, as well as circulating a newsletter about recent studies.

Join us at our

APM JUNIOR CONFERENCE 2023

Registration now open here

Speakers
Henry Marsh
Caroline Shulman
Kathryn Almack
Siobhan Fox
Sabrina Bajwa
Rosie Weir
Fiona Wiseman
Yakubu Salifu
Poorni Jaganathan
Arjun Kingdon
Victoria Cox
Dying at Home
Stories 4 Life
No Barriers Here

Fees
Medical students £8
APM members £12
Non-member junior doctors £16

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MALIGNANT SPINAL CORD COMPRESSION (MSCC)

BY DR TONY DUFFY

Dr Tony Duffy is a palliative medicine consultant in Scotland. He shares his thoughts and tips on his blog here and Twitter page @Existential_Doc

The thread below has been extracted from his Twitter page with Dr Duffy's permission.

Can be the presenting symptom of previously unknown cancer.

Most commonly occurs in patients with a known malignancy (5-10% of all patients)

More common in the following cancers:

-breast
-lung
-melanoma
-prostate
-myeloma
-lymphoma

#0554E6

#0554E6

Can occur with ANY malignancy

Malignant destruction of vertebrae or soft tissue extension through the dural sacleads to ischaemia and compressive disruption of the fragile spinal cord and/or nerves that leave the spinal cord.

Site of compression:
Thoracic region 70%
Lumbosacral 25%
Cervical 5%

Symptoms

Pain 90%

-new back pain
-radicular pain (can be felt as a band around the chest or abdomen)
-pain worse on coughing, sneezing, straining
-pain radiating down the leg(s) or arm(s)
-worse on lying down and often wakes person from sleep

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Important!

New back or neck pain in any patient with known or previously treated malignancy = suspected MSCC until proven otherwise.

Time= Nerve Function

Don't over complicate your differential diagnosis, other causes of back pain can be looked at AFTER excluding MSCC

Loss of function usually occurs AFTER pain- things are progressing! This is a medical emergency

-motor weakness
UMN if spinal cord
LMN if cauda equina

-sensory disturbances such as paraesthesia, shooting "electric shocks" up the back, walking on "cotton wool"

Bladder and bowel disturbance
Often occurs earlier in cauda equina involvement

Bladder- urinary retention with slow overflow. Often painless retention

Bowel- check for perianal paraesthesia. May present as "constipation" and often leads to incontinence

What to do?

Know your local oncology pathway for MSCC

As a general rule
Cancer/suspected cancer+pain needs MRI same week

Cancer/suspected cancer +/- pain with any new neurology should have an MRI within 24 hours

Speak to Oncology without delay for guidance

Management

Lie flat or stabilise spine as best possible -reduce bending and rotational torsion.

Dexamethasone 16mg/day +PPI
Unless oncology advise otherwise e.g. in suspected lymphoma

Steroids reduce cord oedema, they mainly help with pain.

MRI or occasionally CT follows

May require urinary catheter if retention evident

Pressure relief is vital

Thromboprophylaxis

Opioid analgesia may be required

Reassurance and explanation of what is happening at all times.

Surgical fixation

Discuss with surgeons if

-single level of compression
-minimal motor function loss
-prognosis >3months
-good physiological reserve
-poorly radiosensitive cancer such as renal cell cancer
-usually not had radiotherapy to the area prior to surgery

Most patients with MSCC have advanced cancer, multilevel spinal disease and a limited prognosis. Surgical intervention often not appropriate or possible.

When it is an option it provides better outcomes for pain and function than radiotherapy alone.

Always ask the question

Radiotherapy

This is the mainstay of treatment
It provides pain relief and can help preserve or improve neurological function if delivered BEFORE significant deficits occur.

Ideally radiotherapy should be administered within 24 hours of a positive MRI diagnosis

Radiotherapy is usually given a a single 8Gy fraction.
Some patients may receive 5 fractions on an individual basis after oncology assessment.

Pain can increase initially with radiotherapy, steroid use should continue after radiotherapy to cover this period.

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Patients with neurological deficits lasting >48 hours are unlikely to regain neurological function when treated with radiotherapy. The focus may be on the pain relief properties of the treatment here.

Full pain relief may take 2-3 weeks to occur.

Not all patients will receive radiotherapy due to:

-being too frail to undergo scanning or radiotherapy
-short prognosis of days/weeks meaning radiotherapy benefits won't have time to manifest
-patient choice

Steroids can still be helpful for pain in such patients

Steroids should be weaned gradually over 2 weeks following radiotherapy. High doses over longer periods can lead to significant toxicities including worsening of residual muscle power in the form of myopathy. Oncology guidance is usually very clear

MSCC can be a devastating event for people. The median survival after MSCC is 2-3 months.

Impacts on independence, social roles and personal dignity cannot be underestimated and support requires a MDT approach.

Physiotherapist and occupational therapist support is vital

Neuropathic pain may become a feature as well as spasticity. Palliative care advice on management is just a phone call away.

Skin and pressure area care needs meticulous attention.

Pressure damage can occur in short hours just from sitting on a chair

Spinal compression at T6 or above can lead to a condition called autonomic dysreflexia.

A thread on autonomic dysreflexia

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REFLECTIONS OF A CAREER IN PALLIATIVE MEDICINE

BY DR POLLY EDMONDS

Dr Edmonds is a palliative medicine consultant at King's College Hospital. She is also the chair of the Palliative Medicine SAC and had led the work on behalf of the SAC to develop the updated curriculum. Her other interests include skiing, cycling, food and wine.

I graduated in 1987, the year that Palliative Medicine was recognised as a medical specialty by the Royal College of Physicians. In medical school, I remember one lecture from the local hospice consultant on pain management, but otherwise had never even heard of palliative care, let alone considered it as a career.

As a house officer (old money for Foundation training), I did a gastroenterology/ general medicine job and we had a number of patients with advanced cancer. These patients were often symptomatic and languished in bed; no one had a clear idea of how to care for them. We would refer to the local hospice and the consultant would come to the ward to assess; I remember being struck by her compassion and 'can do' approach; for me, this was inspiring and showed me a new way to practice as a doctor. In subsequent medical training, I was drawn to the more palliative patients and then took a SHO post at the Royal Marsden, working for one of the pioneers of palliative care in the UK, Professor Geoff Hanks. I loved the work and felt I had found my home in Medicine. On Prof Hanks' advice (and as there were no training posts at that time), I then did further training as a medical registrar and then oncology registrar to broaden my experience. When a training post in southwest London was created, I was on my way!

It was exciting being a Palliative Medicine trainee in the UK in the 1990s. There were relatively few of us and most of us met through the APM Doyle Club and at conferences. Registrar numbers increased rapidly into the 2000s and have now stabilised, but the connections formed as one of the early cohort of UK registrars remain to this day.

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I feel incredibly lucky to have loved my career as a doctor and particularly a doctor in Palliative Medicine. I am very aware that it is incredibly tough being a doctor now and this leads to some considering moving away from the UK or careers outside of Medicine. You cannot compare my experiences as a young doctor in the 1980s and 1990s to today (it is a different time), but I hope I can reflect on what drew me to and kept me in Palliative Medicine.

First of all, I love working as part of a team, where there is mutual respect between professionals and we can work together to utilise each other's knowledge and skills. I appreciate that due to shift work, many doctors now do not feel part of ward teams – but working in Palliative Care can give people the team and the support it brings, back. What else do I enjoy? I love the variety that Palliative Medicine brings, both in terms of patients' age, culture and diagnoses and also how even with similar conditions, no one patient or family are the same. It is never dull or boring, but consistently different and challenging. I also enjoy having that bit more time to spend with patients and families, even at a time of crisis, and to be able to work with them to work towards solutions, trying to provide realistic hope in difficult situations. I enjoy working in the grey area of uncertainty and helping both clinicians, patients and families navigate this. And I enjoy complex, challenging decision-making – and in Palliative Medicine there is plenty of this.

No career in perfect – all come with challenges and Palliative Medicine is emotionally demanding and absolutely not for everyone. As Medicine and the patients we see become ever more complex, I also hope that the new training curriculum, dual training with Internal Medicine, will keep the consultant workforce of tomorrow equipped with the knowledge and skills to manage patients' needs.

If you are interested in Palliative Medicine, please do seek out opportunities for a taster, clinical attachment or post, or see if you can get involved in a project with your local team. Talk to doctors in training and consultants to get more of a feel about what they do. Try it out and I hope you all find your path to as fulfilling career as I have been lucky enough to have.

Dr Polly Edmonds
Consultant – King's College Hospital
Chair – Palliative Medicine SAC
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UPCOMING EVENTS

18th October 2023

APM Undergraduate Medical Education Special Interest Forum

https://payments.liv.ac.uk/conferences-and-events/events-at-liverpool/faculty-of-health-and-life-sciences/institute-of-life-course-medical-sciences/apm-undergraduate-medical-education-special-interest-forum-2023

18th November 2023

APM Juniors Conference

https://apmeducationhub.org/events/apmj-conf-23/

January 2024

Virtual Ethics Course

https://apmeducationhub.org/events/virtual-ethics-january-2024/

21st & 22nd March 2024

Palliative Care Congress

https://pccongress.org.uk/

OTHER OPPORTUNITIES

Medical Student Rep

The APM juniors committee to recruit medical school representatives from each of the UKs medical schools. This is a role that would involve spreading awareness amongst medical students of the APM juniors and its opportunities. The role would include:

- Promotion of the APM including membership, events, and educational opportunities
- Stimulating interest and awareness of palliative medicine as a specialty
- The opportunity to take part in a national network of medical students interested in palliative medicine
- Gathering feedback from medical students regarding educational needs
- Helping recruit a new member for the role following your graduation

If you are a medical student and this is something you would be interested in, please contact Dr Angus Grant, APM Juniors Chair, at angus.grant1@nhs.net

APM Juniors Survey

We want to better understand what you want from an APM Juniors membership and would appreciate your feedback via this survey. It should take no longer than 10 minutes.
https://docs.google.com/forms/d/e/1FAIpQLSdne2yTuwoZsrMIjpn3u1C39qkRgEzLz5orrbiWi2UH1HfWmw/viewform?pli=1

USEFUL RESOURCES

APM/ PCRS Research directory

https://apmeducationhub.org/wp-content/uploads/2023/06/Palliative-Care-Network-April-2023.pdf

e-ELCA

https://portal.e-lfh.org.uk/myElearning/Index?HierarchyId=0_29&programmeId=29

Palliative Medicine Curriculum

https://www.jrcptb.org.uk/sites/default/files/Palliative%20Medicine%202022%20curriculum%20FINAL.pdf