Cancer, delirium or psychosis in a pharmacist?

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Emergencies can spring up at any time and in many incarnations. Are you adequately equipped to deal with them? Each month we present a case study in emergency medicine based on real cases and events. Would you have been able to help this patient?

Working as a GP in the area, as well as doing shifts in the Emergency Department, you have become accustomed to meeting people and patients you know.

You have just started your shift and, as is usual, it is time for the round. The pack is made up of doctors, key nurses, the social worker and the drug and alcohol counsellor. There is often a tail made up of local and overseas students. It has been a fairly awful day so there are a few patients still to be seen, lying in the cubicles with that apprehensive 'Am I going to see the doctor soon?' look.

First time round

The patient

Near the end of the round an older man spots you and calls you by your first name. Although you have not seen him for years, you know him well. He was the really nice local chemist who gave you jelly beans as a child. Then he became a good friend of your father, and there were many weekends spent playing tennis with him at the local public courts. You last saw him a few years ago when his wife, who was dying of bowel cancer, was admitted several times over the period of a year. It was a very sad situation as his partner of 50 years wasted away in pain, then died. There were no children.

He was among the patients yet to be seen. You are asked if you mind seeing him, and you do so happily.

The history

The presenting problem is severe abdominal, colicky pain across the middle of the abdomen. It has only settled a little some 10 hours after onset. It was still 5/10 in severity but improving. You do your standard work up.

The history reveals a fit 80-year-old man who really has had very few health problems. There is no pattern to the pain. You both agree on intravenous fluids, nil by mouth, and a work up for possible gallstones or an ulcer, because the relevant areas of his abdomen are the most tender. There is no blood on haemoccult testing of his faeces.

Management

You prescribe intravenous morphine 2.5 mg aliquots as needed and metoclopramide 10 mg as needed, up to three times per day. You send off blood for blood tests including liver function tests. You then order an erect abdominal film in case of subacute obstruction, which may show with some fluid levels. You phone through to the ultrasound people to sell the ultrasonagraphers on the benefits of a quick upper abdominal scan. They are very helpful and realise the ultrasound may help discharge the patient much earlier, even though the situation is not urgent, and the diagnosis of biliary colic is a long shot. They give you a slot in an hour, telling you jokingly that it will cost you a coffee. You go back and write it all down.

Outcome

After a few hours you review the patient, who is feeling much better and wants to go home. As with many cases of severe abdominal pain, you do not have any answers. All the tests are negative. Given the obvious concern about more serious underlying disease, he happily accepts a referral to a gastroenterologist. You think no more of it. You do not get a copy of the feedback letter to his GP from the specialist.

Four months later...

As fate would have it, the same patient spots you on a round some four months later. He is back again with severe abdominal pain. He does not look well. He has lost weight, looks haggard and depressed and you believe you see a tinge of jaundice. Although you are not looking after him, you sit at his bedside to have a quick chat. It turns out that after a couple of endoscopies and a CT, cancer of the pancreas was diagnosed.

You feel a bit strange as you reflect back to the little person looking up to the tall, clever, kind man in the white coat in his chemist shop – the same man who is now looking to you, as a doctor and long-time friend, for hope and advice. You find it tough as you basically confirm, without being too specific, the bad news and the prognosis which he had been given by his doctors. As he has

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Mini-mental state examination*

Add points for each correct response — Date:

	Score	Points
Orientation		
1. What is the:		
• Year	___	1
• Season	___	1
• Date	___	1
• Day	___	1
• Month	___	1
2. Where are we?		
• State	___	1
• Suburb	___	1
• City	___	1
• Hospital (if at home, house number and street)	___	1
• Floor	___	1
Registration		
3. Name three objects, taking one second to say each. Then ask the patient to name all three after you have said them. Give one point for each correct answer. Repeat the objects until the patient learns all three.	___	3
Attention		
4. Ask the patient to count in serial sevens. Give one point for each correct answer. Stop after five answers. Alternatively, ask the patient to spell 'world' backwards.	___	5
Recall		
5. Ask for the names of the three objects learned in Question 3. Give one point for each correct answer.	___	3
Language		
6. Point to a pencil and watch. Have the patient name them as you point.	___	2
7. Have the patient repeat after you the phrase 'No ifs, ands or buts'.	___	1
8. Have the patient follow a three-stage command: 'Take this paper in your right hand. Fold the paper in half. Put the paper on the floor'.	___	3
9. Have the patient read and obey the following: 'Close your eyes'.	___	1
10. Have the patient write a sentence of his or her choice. The sentence should contain a subject and an object and should make sense. Ignore spelling errors when scoring.	___	1
11. Have the patient copy the design [not provided here] on the back of the sheet below the design. Give one point if all sides and angles are preserved and if the intersecting sides form a quadrangle.	___	1
Total score:	___	**/30**

Level of consciousness

Estimate the patient's level of sensorium along a continuum, from alert on the left to coma on the right:

Alert Drowsy Stupor Coma

* Adapted from: Mini-Mental State Examination Form, St Vincent's Hospital, Sydney.

good support at home, he is discharged. Your day is spoilt.

The next month

Presentation

A month later, before the round starts, the nurses grab you and another doctor to help with a violent and disoriented patient who has just been brought in by ambulance. You are surprised to find it is your friend the chemist.

He does not recognise you as you – and the rest of the team – try to reason with him. You end up giving him some intravenous sedation (10 mg of diazepam), which settles him down. The emergency registrar takes on the patient.

The history

The patient had deteriorated over the last week. His full-time carer was able to give the ambulance team a concise account of increasing confusion, abnormal behaviour, and not eating or drinking for long periods.

The patient had been under good medical care. He had been seeing a psychiatrist who had been giving him major tranquilisers for severe depression and anxiety, including reliving traumatic wartime experiences.

There was also active involvement by a palliative care doctor who was supervising pain relief for the patient. The mainstay of pain therapy was oxycodone and mist morphine.

Apparently over the last 24 hours the patient had become more paranoid and violent. He accused his nurse of stealing and tried to throttle her. This is when the ambulance was called.

The patient was clinically quite dehydrated, the effects of which were accentuated by his unshaven and dishevelled appearance.

On the advice of the psychiatrists, haloperidol was charted; however, with intravenous hydration and massive reassurance, the patient settled down.

Possible causes

Chasing the diagnosis of an organically based delirium (that is, a toxic state due to pathology such as sepsis or drugs), a detailed blood work up was performed. The patient was afebrile and normotensive, and had a regular pulse of 90 beats per minute. His blood sugar level was 5 mmol/L, measured by finger prick.

The white cell count was slightly raised at 11.6 x 10^9 (normal: 4–11) with a neutrophilia of 9.3 x 10^9 (normal: 2–7.5). All his liver functions were mildly deranged. Although he was not anaemic, his albumin was decreased (28 g/L; normal: 36–47). Renal function and electrolytes were not a concern.

A mini-mental state examination was performed. The patient's score was 14/30 (see the box on page 123).

Although a bone scan had revealed likely widespread metastases, it was decided, after discussion with the palliative care physician, that a CT scan of the head would not help. It also was thought that since there were no localising neurological signs, as the patient had vastly improved with simple hydration, there was quite possibly no cerebral secondary.

Outcome

The psychiatrists came and confirmed that there were now no delusions or hallucinations. They set a regimen of continuing treatment with tranquilisers, especially flupenthixol.

As the input and co-ordination of medical carers had been optimal, the patient was transferred, with his acquiescence, to the hospice. He was well cared for, but continued to deteriorate from his metastatic pancreatic cancer and died.

You thought about going to the funeral but stayed with your policy that you do not 'do' funerals and you hope to miss your own. MT