Case Report

Abdolreza, 73 years old, was diagnosed with prostate cancer soon after marrying for the second time. He underwent a TURP and had localised radiotherapy to his prostate area. Abdolreza has a past history of hypertension.

Abdolreza and his wife Rezan live in a rural area. Four years after his original diagnosis of prostate cancer, Abdolreza presented with moderately severe abdominal pain. A CT scan revealed secondaries in several pelvic lymph nodes. A bilateral orchidectomy was performed and he was referred to a radiation oncologist for review. He and his wife Rezan seek the services of a Palliative Care nursing team. Abdolreza remains optimistic about his condition until he is reviewed by his oncologist several weeks after undergoing the bilateral orchidectomy.

A bone scan, PSA and ALP are ordered and the results are as follows:

**Bone Scan:** multiple sites of active disease in the spine, pelvis, ribs and proximal appendicular skeleton.

**PSA:** 75 (Normal < 4.0 ng/ml)  **ALP:** 410 (Normal range 30-120 U/L)

The radiation oncologist informed Abdolreza that his recent orchidectomy was unsuccessful as the bone scan revealed the cancer had spread to many bones throughout his body. He is left with the impression that nothing can really be done for his condition. He is advised that he and his wife Rezan seek the services of a Palliative Care nursing team.
On the first home visit by the Palliative Care nurse, Abdolreza is weak and can hardly stand up. He tells of increasing back pain over the previous three days which is exacerbated by lying down, coughing or straining.

On examination, Abdolreza is distressed when moving from a sitting position to lying down in bed. He is tender over his thoracic vertebrae at the level of T11 and T12. Flexion and extension of his back is reduced. Straight leg raising is limited to 70 bilaterally and is painful. Power of his hips and knees (flexion and extension) is assessed as being grade 4 out of 5 bilaterally, with decreased tone bilaterally. Knee jerks are present, but weak. Both plantar responses are downgoing.

Some subjective altered sensation is present but there are no objective sensory signs. Abdolreza's bladder is not distended and his anal tone is normal. His gait is ataxic.

Radiotherapy is usually the treatment of first choice for SCC, in conjunction with oral steroids. It is particularly appropriate when compression is present at multiple levels. Back pain tends to resolve in 60-80% of patients as a result of having radiotherapy. The steroids reduce oedema, which is due to compression. Neurological signs need to be monitored carefully. If continued deterioration occurs, neurosurgery may be indicated, particularly if the patient is not terminally ill and/or does not have compression at multiple levels.

In general however the results of treatment with dexamethasone and radiotherapy, compared to dexamethasone, laminectomy and radiotherapy are equivalent from a neurological point of view.

A posterior laminectomy is the emergency treatment of choice for SCC patients with rapid neurological deterioration.

The contraindications to having a posterior laminectomy are listed below:
- established paraplegia (> 72 hrs)
- complete and rapid paralysis secondary to spinal cord infarction
- restricted mobility
- severely debilitated patients.

You inform Abdolreza his back pain and weakness need to be urgently investigated in hospital.

One of the palliative care nurses has been to visit and continues to give ongoing support to both Abdolreza and Rezan. Despite being on Lactulose 30 mg bd, Abdolreza is constipated. A rectal examination reveals hard faeces. An enema given by the palliative care nurse gives a satisfactory result.

Abdolreza's condition deteriorates over the next couple of days. He becomes profoundly weak, is bed bound and develops Cheyne-Stokes breathing.
All treatment is ceased except for morphine, which is administered by continuous subcutaneous infusion. Abdolreza is visited twice daily by a palliative care nurse.

Abdolreza remains peaceful and conscious for the next five days, during which time he is bedridden and slowly deteriorates. He is still able to respond with a smile when greeted just a few hours before his death. His conscious state deteriorates a short time before he dies.