Conclusion

In conclusion, physicians' commitment to face the unknown with the patient and not to abandon their patients is of paramount importance. One should explore the patient’s hope and inquire about his fears after carefully listening to the patient. This is the necessary first step before any genuine reassurance can be given. If the physician cannot provide the option of physician assisted suicide because of moral, personal and legal constraints, this should be communicated to the patient unhesitatingly. The patient will be much reassured if it is communicated that should the situation become intolerable to the patient in the future, everything would be done to ease the patient, including heavy sedation. The knowledge that there could be an escape for the patient is important to many, though few will ever need it. The physicians and other care professionals alike should not forget one's own support. It is important for you to obtain support by having the opportunity to share your grief, uncertainties when facing your own mortality, abilities and limitations in caring of the dying patients with others you are comfortable with.

References:

Management of Hypoglycaemia in Palliative Care
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Introduction

Hypoglycaemia is a significant cause of morbidity in cancer patients. Among hospital in-patients, the presence of malignancy is indeed an important risk factor for hypoglycaemia. Hypoglycaemia can occur in association with a variety of tumours, and can be very difficult to manage. Furthermore, hypoglycaemia occurring in terminal cancer patients also carries with it some practical and ethical issues that warrant discussion. We presented 2 cases of refractory hypoglycaemia in cancer patients recently admitted to our palliative care unit in order to illustrate some of the clinical issues. The pathophysiology of tumour-associated hypoglycaemia and the choices of available treatments were also discussed.

Case histories

Our first case was a 79 year old man who was diagnosed to have carcinoma of the pancreas in July 2001 and had a total pancreatectomy. Histology confirmed adenocarcinoma of the pancreas. All resection margins were clear of tumour and there were no lymph node involvement. The patient developed diabetes after his pancreatectomy and was started on insulin and his diabetes was well controlled on protaphane insulin 16u OM, 8u PM with HbA1c 7.7%. He was found to have hepatic and portal lymph node metastases 2 years later and the patient opted for conservative management. Since January 2004, the patient began to be affected by repeated hypoglycaemic attacks requiring progressive reduction in his insulin treatment. Following an admission with acute confusional state in March 2004, the patient was transferred to the palliative care ward in SH, and was noted to have recurrent episodes of symptomatic hypoglycaemia despite progressive reduction of his insulin dose to protaphane 4 units daily. He was on no other medications except frusemide for mild ankle oedema. Liver function tests were normal except a mildly elevated alkaline phosphatase of 144 IU/l (normal 40-100). His CXR was normal. A short synacthen test excluded adrenal insufficiency. In view of the recurrent episodes of symptomatic hypoglycaemia, he was eventually taken off all...