Urgent Dialysis as a Bridge to Palliative Care in Advanced Cancer Patients

Dear Editor,

I am writing to highlight the imperative role of urgent dialysis as a bridge to palliative care in the management of advanced cancer patients with renal complications.

A 39-year-old woman, diagnosed with extensive anorectal cancer, underscores the complexities of managing renal dysfunction in the palliative care setting.[1] Despite exhaustive chemotherapy regimens the patient's disease progressed relentlessly, compelling the primary team to transition her to best supportive care. Earlier in her disease course, the palliative medicine team managed her symptoms, focusing on pain control and preserving quality of life. The recent onset of symptoms suggestive of uremic encephalopathy, including flapping tremors, asterixis, and intractable vomiting, raised concern for acute kidney injury (AKI) secondary to obstructive uropathy. Laboratory investigations confirmed severe uremia with creatinine at 9.7 mg/dL. Point-of-care ultrasound demonstrated bilateral hydronephrosis, consistent with disease progression leading to post-renal AKI.

Considering her deteriorating clinical status and the urgency of symptom management, urgent dialysis emerged as a pivotal intervention. By promptly addressing the metabolic derangements associated with severe uremia, dialysis provided immediate relief, aligning with the ethos of best supportive care. It served as a bridge, affording time for planning a percutaneous nephrostomy (PCN) to alleviate the obstructive etiology of the AKI. In palliative care, where curative measures are no longer feasible, interventions must be judiciously selected to optimize comfort and dignity.[2] Urgent dialysis, as demonstrated in this case, represents a critical adjunct to palliative care, facilitating symptom control and preserving quality of life in the face of complex medical challenges.[3]

Conflicts of interest

There are no conflicts of interest.

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References

1. Grubbs V, Moss AH, Cohen LM, Fischer MJ, Germain MJ, Jassal SV, *et al*. Dialysis advisory group of the American society of nephrology. A palliative approach to dialysis care: A patient-centered transition to the end of life. Clin J Am Soc Nephrol 2014;9:2203–9.
2. Moss AH. Integrating supportive care principles into dialysis decision making: A primer for palliative medicine providers. J Pain Symptom Manage 2017;53:656–62.e1.
3. Sturgill D, Bear A. Unique palliative care needs of patients with advanced chronic kidney disease - the scope of the problem and several solutions. Clin Med (Lond) 2019;19:26–9.

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Tetany in a Patient with Gastroesophageal Reflux Disease

Dear Editor,

Proton pump inhibitors (PPI) are widely prescribed drugs and generally well tolerated. However, prolonged intake of PPI increases risk of micronutrient deficiency (iron, magnesium, and vitamin B12), infections, and kidney disease.[1] We report the occurrence of tetany due to hypomagnesemia in a patient who had been on long-term PPI therapy for gastroesophageal reflux.

Our patient was a 32-year-old man, who had been receiving pantoprazole 40 mg/day and domperidone 20 mg/day for 5 years for refractory gastroesophageal reflux disease. Attempts to stop pantoprazole resulted in resurgence of reflux symptoms. He presented during peak summer with recurrent muscle cramps to different hospitals where heat cramp was diagnosed and treated symptomatically. There was no respite of symptoms and he presented to our emergency room with generalized muscle cramps. He had excess fatigue and cramping was aggravated by ambulation. There was no associated fever, vomiting, or diarrhea. He consumed alcohol occasionally and denied intake of illicit drugs. He did not have diabetes mellitus or hypertension, and he was not taking any other medications. Family history was unremarkable.

On arrival, he was conscious, oriented, afebrile lean-built, and his vital signs were normal. Inflation of blood pressure cuff provoked tetany [Figure 1a]. Plantar reflex was flexor, muscle power and sensory system examination werenormal and deep tendon reflexes were brisk. A diagnosis of tetany was made.