Managing Familial Cancer in Palliative Care

Focussing on HNPCC (Hereditary Non-Polyposis Colorectal Cancer)
A Case Report
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Summary

A patient sparked an interesting discussion when it was noted that she had suffered with 4 different types of cancer. It was thought that there could be a genetic component to her illnesses and HNPCC was suggested as a possible cause. Research in oncology is identifying familial traits predisposing people to particular cancers in the aim of detecting them earlier. This poster describes a patient who had multiple cancers, which may or not represent a familial cancer syndrome. We use this case to highlight the importance of HNPCC, and the impact that it can have on palliative care.

Case Report

GD, age 81 years, was referred to Severn Hospice as she was not coping at home. She presented with vomiting, constipation, difficulty mobilising, and anxiety.

Her significant past medical included:
- Breast carcinoma (1979, mastectomy, radiotherapy & chemotherapy)
- Gynaecological cancer (1985, hysterectomy and bilateral salpingo-oophorectomy, unsure of exact cancer diagnosis, notes unavailable)
- Colorectal cancer (2010, right hemicolectomy)
- Pancreatic cancer (2013, no diagnostic biopsy or treatment wanted)
- Insertion of biliary sent (2014, for CBD obstruction)

She is taking Metoclopramide, Omeprazole, Paracetamol, Movicol, Fentanyl patch, and as required: Oral Morphine, Cyclizine, & Buscopan.

Her father passed away with bowel cancer, she has no children of her own, and is unsure if any other family members have had cancer.

She lives alone, and has no family nearby. Friends and district nurses support her in activities of daily living.

As the possibility of a familial cancer syndrome has not been previously raised, no genetic testing has been performed.

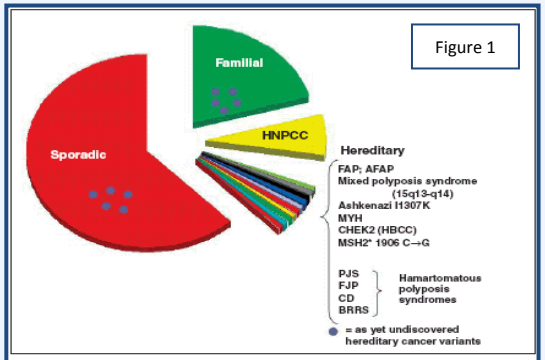

Figure 1: Colorectal Cancer and Heredity—Relative numbers of colorectal cancer cases that are considered sporadic, familial, or due to a recognized hereditary cancer syndrome. AFAP = attenuated familial adenomatous polyposis; BRRS = Bannayan-Ruvalcaba-Riley syndrome; CD = Cowden's disease; FAP = familial adenomatous polyposis; FJP = familial juvenile polyposis; HNPCC = hereditary nonpolyposis colorectal cancer; PJS = Peutz-Jeghers syndrome. Reprinted, with permission, from Lynch et al.[2]

Ethical Implications for Palliative Care

Palliative care aims to improve the quality of life of patients with terminal illnesses by providing a holistic approach to care which includes managing physical and psychological symptoms, for the patients and their families.[4]

One study [5] emphasises that palliative care may have a role in identifying patients who potentially have familial cancers and consenting them for genetic testing so, if appropriate, family members can be offered genetic counselling. This not only raises the ethical implications of genetic testing in patients at the end of life, but also, testing during a time of bereavement for their families.

The psychological support available in palliative care might be appropriate for family members facing decisions regarding genetic testing.

HNPCC [1][3]

- Autosomal dominant condition causing a mutation of DNA mismatch repair (also called Lynch Syndrome)
- Primarily causes colon cancer with early age of onset
- Others include: endometrium and the hepatobiliary system (also ovary, stomach, urinary tract, brain, skin)
- Up to a third of colorectal cancers are thought to be familial or hereditary (fig.1)
- New research suggests that breast may also play a part
- It is caused by a mutation in a DNA mismatch-repair gene, most commonly MSH2, MLHIV
- At risk individuals are identified using the Amsterdam Criteria (see below)
- Diagnosis confirmed with immunohistochemical testing for mismatch repair gene mutations in MLH1/MSH2/MSH6/PMS2 or microsatellite instability (MSI) testing

Amsterdam Criteria [3]

- Three or more family members with HNPCC-related cancers, one of whom is a 1st degree relative of the other two
- Two successive affected generations
- One or more of the HNPCC-related cancers diagnosed under age 50 years
- Familial adenomatous polyposis (FAP) excluded

Surveillance [2]

- Colonoscopy from age 25 and every 2 years after
- Endometrial aspiration biopsy and transvaginal ultrasound

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