



## The Student Corner

We are very happy to launch 'The Student Corner'. Our hope is that both the medical students and our other members would benefit. The aim is a two-way communication and we look forward to the students' contributions in the future. You can write a short story about your first meeting with a patient with cancer or maybe your ideas of how to improve teaching in palliative medicine. We value comments and questions.

As you may know medical students can be members of our society (see 'Membership Application/Renewal Form'), we invite you to attend our meetings and to become members.

We are eagerly looking forward to your valuable contributions.

<b>Quiz for newsletter</b>
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Dr Michael Sham

A 74-year-old woman with carcinoma of cervix had pelvic pain controlled with morphine. She also had obstructive uropathy and was on percutaneous nephrostomy. She complained of nausea with repeated vomiting. She also had constipation.

What are the differential diagnoses of her vomiting?

### **Discussion:**

Constipation, nausea and vomiting are common adverse effects of morphine. Vomiting is also a feature of acute pyelonephritis well described in textbooks. The pelvic pain may be a result of bone invasion by the carcinoma, and hypercalcaemia is also possible cause of vomiting and constipation. Because of urinary tract infection and dehydration as a result of repeated vomiting, the patient may also develop renal failure resulting in vomiting. Dehydration also leads to constipation. Pyelonephritis may also give rise to urinary sediments which may block the nephrostomy tube, further aggravating the renal failure and the vomiting. The primary tumour in the pelvis may also cause intestinal obstruction causing constipation and vomiting. Para-aortic secondaries are not uncommon in advanced stage carcinoma of cervix and may compress on the stomach causing vomiting. Other differential diagnoses include huge liver secondaries which may also compress on the stomach, and brain secondaries causing increased intracranial pressure.

### **Progress of the patient:**

Morphine was substituted with methadone. The patient vomited less. As the pain became mild, dextropropoxyphene was prescribed instead of methadone. Urine culture was positive, treated with antibiotics. Vomiting, however, persisted, though improved. Abdominal radiograph revealed the stomach distended with gas. Oesophago-gastro-duodenoscopy revealed duodenal obstruction. A retro-peritoneal hard mass was found during operation with gastro-jejunostomy done. The patient's vomiting was relieved.