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Case Report

Care of a Patient with Palliative Care Needs

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Abstract

Background: Palliative care is an integral component in cancer care. Palliative care is holistic care. Correctable problems should be corrected at the right time rather than waiting for the terminal stage of the disease. Objectives: To evaluate the care of a patient with palliative care needs followed in the tertiary cancer care Centre.

Methods: A concurrent method was adopted to care of a patient with palliative care.

Keywords: *Palliative; Advance Cancer*

Introduction

I am working as a nurse educator, after having completed M.sc in psychiatric nursing. For 3 years I was working in a nursing college and I have delivered lectures on nursing courses. I implemented learning strategies to promote independent learning, involved students in classroom discussion, participated in professional development activities, developed study plan based on student's academic needs, conducted examinations. I was working in a psychiatric clinical set up for the next 3 ½ years. There I have provided care to both in patients and out patients, interacted with the medical bodies in the hospital in providing comprehensive care to the patient and family. I was also involved in training the new recruiters.

For the last 4 years I have been working in a tertiary cancer care hospital and handling the responsibility to basic care to the advanced cancer patients, assessment and management of symptoms to promote patient wellbeing. I prescribe the medications within the scope of practice, develop treatment plans to reduce and other difficulties. Treating bedsores, wounds and rashes on the body, order lab tests, prescribe diets and exercises for the patients, providing emotional support to the patients and families, counsel patients and give adequate pain relief.

Case Summary

Patient was diagnosed to have squamous cell carcinoma of uterine cervix stage 111.

S. No	Investigations done	Reasons why the investigations was done
1	Complete blood count	To rule out anemia and immature cells
2	Renal function test	To rule out renal failure and renal involvement
3	Liver function test	To rule out liver involvement
4	Chest X- ray	To rule out secondary's and lung pathology
5	Echo	To determine coronary sufficiency and cardiac blood flow
6	Serum electrolytes	To rule out electrolyte imbalance
7	ECG	To rule out cardiac dysfunction
8	USG kidneys	To determine the renal lesion
9	Biopsy	To conform and determine the type of cancer cells and the nature of the cells
10	HPE	To determine the type of cancer cells and the nature of the cells
11	USGM	To study the various organs involved and the involvement of nodes
12	Cystoscopy	To rule out obstructive uropathy

Table: *Showing the investigations.*

Patient was apparently well till 6 months ago, when she developed irregular bleeding from her vagina. Patient consulted local physician and referred to our hospital for future management as malignancy was suspected. She had normal bladder and bowel habits. No history of cough with expectoration, hemoptysis, vomiting, hematemesis, headache, blurring of vision. No history of loss of appetite or loss of weight. Local examination showed, infiltrating growth 5 - 6 cm extending to the cervix and adjoining vaginal walls, rest of the vagina was clinically free, cervical cancer not defined; uterus was bulky with restricted mobility. Right parametrium infiltrated short of pelvic wall, left parametrium infiltrated up to pelvic wall. Bladder and rectal mucosa was clinically free, no inguinal or iliac adenopathy, liver was not palpable and breasts were supple. No supraclavicular adenopathy.

Patient was subjected to the following investigations.

The patient was treated with 15MV X-ray beam therapy to pelvis TD: 50GY (55GY) followed by 3-HDR-ICA to deliver 1950CGY at point. A partial regression of lesion in the cervix. On follow-up patient presented with right hip pain. On examination, she had progressive disease. Patient's progressive disease was explained to patient's attender (daughter and son). After 2 months patient again presented with pain. She was given symptomatic care with analgesics and packed red blood cells transfusion. Followed that Pain and palliative clinic reviewed her. The patient was symptomatically better. As, she is an advanced cancer patient, we cannot cure her disease. Instead by providing supportive treatment, her symptoms were relieved and she felt comfort.

Doctors, social worker and staff nurses were involved in her care. Their contributions were helpful in providing comfort, improving her quality of life and in controlling her symptoms. They helped to promote confidence and a sense of well-being. It avoided isolation and helped or improves her quality of life.

Doctors took care of pharmacological management. In order to relieve her pain, strong opioids are given and haemostatic drugs were administered in order to arrest or decrease her hemorrhages.

Nurses were involved with educating the patient and family about the nature of the illness, the day to day care, personal hygiene and nutritional needs.

Social worker contributed by addressing financial concerns, raising funds for treatment and counseling the family and improving the social support.

Candidates learning of palliative care principles and practice

- **How I have managed the patient with my new learning:** Before training, it was hard to speak with patients and care givers about their prognosis. This training improved communication among advanced cancer patient, family and health care team. Started listening to the patients with more empathy. I am also now giving priority and importance to their ideas and views. I tried to understand the family and community factors which have implications for the patient well-being. Now I focus more on the quality of life rather than increasing the quantity of life. I am able to handle patients at the advance stage of the disease. I could see that by empowering the caregivers to handle patient at the last phase so that the quality of care is significantly better. Tried to treat them as a "whole person".

- **What changes occurred in me at a personal level:** Having seen suffering of people with pain and death closely, it helped me become more appreciative of health and life. I have become more grateful for health and developed a deeper sense of spirituality.

- **What changes occurred in me at professional level:** I had opportunity to practically apply the communication skills learnt specially in difficult situations pertaining to breaking bad news, helping the patient cope with terminal illness and accept death. I have learnt skills of addressing pain, bleeding, and fatigue and learnt how to assess pain with the help of pain scale.

Palliative care is provided through comprehensive management of the physical, psychological, social and spiritual needs of patients, while remaining sensitive to their personal, cultural and religious values and beliefs.

Physical care

The patient's physical pain is relieved by strong opioids. Advised the patient to take the medicine at correct time (4^{th} hourly) with correct interval. Advised to maintain proper personal hygiene. Advised her to take balanced diet with the diet rich in iron and protein.

Psychosocial care

Our doctor found that the patient pain was related to psychological distress. So, she referred to social worker for counseling. Psychosocial assessments were taken by him. Report says that patient had high distress due to her family situation. She separated from her husband 5 years after her marriage. She had one son and daughter. She could not focus on their growth. So, her son involved in antisocial activities and he got separated. Her daughter married and now patient staying with her daughter. That made patient to feel guilty and induced distress. Financially she does not have support from anyone except her daughter. She reported that she face discrimination from her society. Spoke with her daughter regarding this, it eased her psychological suffering.

Spiritual care

She had a question that "Why me" and "Why it happened only to me". This made her to hate the supernatural power. Now she started to hate herself. No answer to deliver for her so just kept quiet.

Issues of communication with patient and family

Explaining the nature of disease prognosis was honest process of communication. At the beginning of my conversation she was not in the position to listen my words. Gaining trust was very difficult. Later, built good rapport and made it easy to communicate.

Holistic care

The palliative care is the holistic care of terminal illnesses to minimize and/or relieve the sufferings associated with them. It involves recognition that the needs (Physical, Psychological, Social, Economic and Spiritual) of a dying patient go beyond just the clinical and physical.

The relationship between sympathy, empathy and compassion

Components	Sympathy	Empathy	Compassion
Definition	A pity-based response to a distressing situation.	An affective response that acknowledges and attempts to understand an individual's suffering through emotional resonance. An affective response that acknowledges and attempts to understand an individual's suffering through emotional resonance	A virtuous response that seeks to address the suffering and needs of a person through relational understanding and action
Defining characteristics	Observing Reacting Lack of understanding Unhelpful	Acknowledgment of suffering Understanding the person Affective response Acknowledgment of suffering Understanding the person	Non-conditional Instrumental Action-oriented response
Type of response	A visceral reaction to a distressing situation	Objective and affective response to a distressing situation Objective and affective response to a distressing situation	A proactive and targeted response to a distressing situation

Response to suffering	Acknowledgment	Acknowledgment, understanding and emotional resonance	Acknowledgment, understanding, and emotional resonance linked with action.
Patient reported outcomes	Demoralized Overwhelmed Compounded suffering	Heard Understood	Relief of suffering Enhanced sense of well-being Enhanced quality of caregiving Relief of suffering Enhanced sense of well-being Enhanced quality of caregiving
Examples	"I'm so sorry" "I can't imagine what it must be like"	"Help me to understand your situation" "I get the sense that you are feeling …" "I feel your sadness"	"I know you are suffering, but there are things I can do to help it be better?" "What can I do to improve your situation?"

Discussion

Patients living with terminal illness are uniquely positioned to provide insights into the constructs of compassion, empathy, and sympathy. They have extensive experience with the healthcare system and its ability to respond to their suffering. The client was given the superficial acknowledgment of suffering, invoking a pity-based response that failed to sufficiently acknowledge the person. Patient felt that empathy and compassion share attributes of acknowledging, understanding, and resonating emotionally with a person.

Policy and innovations

The Pap test is a useful and cost effective cancer screening method. Since its introduction in the U.S in the 1950s, cervical cancer deaths in the U.S have decreased 74%. Most cases of invasive cancer are preventable with regular screening and follow up of abnormal results. About 50% to 64% of invasive cancer cases are not among women who have never been screened nor have suboptimal screening. (Screening intervals longer than 5 years) [1,2].

Decreased incidence of cervical cancer will be best achieved by improving screening practices among those women who have never been screened or who are screened infrequently and increasing HPV vaccination. Screening with the co-test is an option for women between the ages of 30 and 65 years [3,4].

Continued screening is still needed after HPV vaccination. Cervical cancer cytology screening recommendations remain unchanged for women who have been vaccinated for HPV because 10% to 30% of cervical cancer is caused by HPV types not included in the vaccine, and sexually active women could have been infected prior to vaccination [5].

A Cochrane review of palliative measures to control vaginal bleeding in advanced cervical cancer, found no evidence supporting or refusing use of vaginal packing, trenaxemic acid or interventional radiology approaches as compared to traditional radiotherapy [6].

A brief course of palliative radiation therapy yields substantial pain reduction in a high percentage of patients and also it controls bleeding [7].

Evidence shows that treatment with low molecular weight heparin is more effective and safe in cervical cancer patients when compared to warfarin [8].

Continued anticoagulation in palliative care patients with limited life expectancy is controversial. Some patients may find daily injections both painful and inconvenient. While therapy can initially provide improvement in symptoms, it may be of limited use at the end of life [9].

Palliation fistulas may be surgically accomplished by creation of an ureterointestional conduct or by placement of bilateral percutaneous nephrostomies to decompress the uterus. Placement of nephrostomy tubes is a simpler procedure than surgical diversion a urethral outflow. The tube can be a source of infection and do require changing every few months. Patients should also be educated regarding signs and symptoms of blockage as tubes can become kinked or dislodged [7].

Conclusion

Palliative care improves the quality of life of people with life-threatening or debilitating illness by providing relief from pain and other physical symptoms and care for psychosocial needs. To ensure the most effective care for patients, palliative care begins at the point of diagnosis, continues throughout treatment, and bereavement support is offered to the family after the patient's death.

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