PALLIATIVE CARE AND PROSTATE CANCER SCC PATIENT

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Received: September 2020; Accepted: October 2020; Published: November1, 2020
Citation: . Middle East Journal of Nursing 2020;
14(2):35-37. DOI: 10.5742/MEJN2020.93789

Case Report

Abdolreza, 73 years old, was diagnosed with prostate cancer soon after marrying for the second time. He underwent a TURP and had localised radiotherapy to his prostate area. Abdolreza has a past history of hypertension.

Abdolreza and his wife Rezan live in a rural area. Four years after his original diagnosis of prostate cancer, Abdolreza presented with moderately severe abdominal pain. A CT scan revealed secondaries in several pelvic lymph nodes. A bilateral orchidectomy was performed and he was referred to a radiation oncologist for review. He and his wife Rezan seek the services of a Palliative Care nursing team. Abdolreza remains optimistic about his condition until he is reviewed by his oncologist several weeks after undergoing the bilateral orchidectomy.

A bone scan, PSA and ALP are ordered and the results are as follows:

Bone Scan: multiple sites of active disease in the spine, pelvis, ribs and proximal appendicular skeleton.

PSA: 75 (Normal < 4.0 ng/ml) ALP: 410 (Normal range 30-120 U/L)

The radiation oncologist informed Abdolreza that his recent orchidectomy was unsuccessful as the bone scan revealed the cancer had spread to many bones throughout his body. He is left with the impression that nothing can really be done for his condition. He is advised that he and his wife Rezan seek the services of a Palliative Care nursing team.

On the first home visit by the Palliative Care nurse Abdolreza is weak can hardly stand up. He tells of increasing back pain over the previous three days which is exacerbated by lying down, coughing or straining.

On examination Abdolreza is distressed when moving from a sitting position to lying down in bed. He is tender over his thoracic vertebrae at the level of T11 and T12. Flexion and extension of his back is reduced. Straight leg raising is limited to 70 bilaterally and is painful. Power of his hips and knees (flexion and extension) is assessed as being grade 4 out of 5 bilaterally, with decreased tone bilaterally. Knee jerks are present, but weak. Both plantar responses are downgoing.

Some subjective altered sensation is present but there are no objective sensory signs. Abdolreza's bladder is not distended and his anal tone is normal. His gait is ataxic.

Radiotherapy is usually the treatment of first choice for SCC, in conjunction with oral steroids. It is particularly appropriate when compression is present at multiple levels. Back pain tends to resolve in 60-80% of patients as a result of having radiotherapy. The steroids reduce oedema, which is due to compression. Neurological signs need to be monitored carefully. If continued deterioration occurs, neurosurgery may be indicated, particularly if the patient is not terminally ill and/or does not have compression at multiple levels.

In general however the results of treatment with dexamethasone and radiotherapy, compared to dexamethasone, laminectomy and radiotherapy are equivalent from a neurological point of view.

A posterior laminectomy is the emergency treatment of choice for SCC patients with rapid neurological deterioration.

The contraindications to having a posterior laminectomy are listed below:

- established paraplegia (> 72 hrs)
- complete and rapid paralysis secondary to spinal cord infarction
- restricted mobility
- severely debilitated patients.

You inform Abdolreza his back pain and weakness need to be urgently investigated in hospital.

After being in a hospital, several hours drive from home, for 11 days, Abdolreza becomes increasingly despondent. He requests the radiotherapy be ceased due to a lack of response. He expresses a strong desire to return home to die in peace. He refuses to swallow any medication and keeps saying he just wants to go home.

A long discussion between Abdolreza, Rezan and the radiation oncologist ensues. The radiation oncologist's registrar informs them that Abdolreza will be discharged the following day. He adds the hospital staff 'don't think Abdolreza will live through the weekend'.

Caring for a dying person at home is a twenty four hour task which requires a broad range of skills. A palliative care nurse and a general practitioner is in an ideal situation to manage a dying patient at home, and to coordinate their care. Members of a community based palliative care service can offer additional assistance.

THE PALLIATIVE CARE NURSE SHOULD BE ABLE TO:

- assess symptom control
- provide information and support to patient and family (including advice about preventing pressure sores and what to expect as death approaches)
- attend to patient hygiene e.g. mouth care
- use complementary therapies (e.g. foot massage, therapeutic touch)
- discuss food and fluids according to needs
- set up syringe driver if required
- perform enemas, if patient is constipated
- stay with the family following death and involve them in the laying out process if they wish.

Abdolreza arrives home by ambulance at 4pm on Friday. Rezan telephones you and you visit soon after the palliative care nurse has been. She telephones to discuss Abdolreza's condition and also writes extensive notes in a home based medical record. This is an excellent vehicle for communication, if available. It can record important aspects of the patient's medical, social and psychological assessments and should be used by the general practitioner in order to ensure continuity of care is maintained. In this way, all members of the palliative care team have access to each other's notes.

At review the following day, Rezan reports that Abdolreza continues to be pain free.

One of the palliative care nurses has been to visit and continues to give ongoing support to both Abdolreza and Rezan. Despite being on Lactulose 30 mg bd, Abdolreza is constipated. A rectal examination reveals hard faeces. An enema given by the palliative care nurse gives a satisfactory result.

Abdolreza's condition deteriorates over the next couple of days. He becomes profoundly weak, is bed bound and develops Cheyne-Stokes breathing

All treatment is ceased except for morphine, which is adminstered by continuous subcutaneous infusion. Abdolreza is visited twice daily by a palliative care nurse.

Abdolreza remains peaceful and conscious for the next five days, during which time he is bedridden and slowly deteriorates. He is still able to respond with a smile when greeted just a few hours before his death. His conscious state deteriorates a short time before he dies.