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CASE REPORT

A multidisciplinary approach to palliative care for a terminal gastric cancer patient

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ABSTRACT

BACKGROUND: *When the general situation of the patients becomes worse, the patient's families and the patient can not cope with this problem and apply to the hospital. Integrated palliative care (IPC) has been introduced more appropriate to patients and family carers needs. It aims to achieve quality of life for the patient and the family.*

CASE REPORT: *The patient was diagnosed with gastric cancer which stage was T4N3M1. Oral capecitabine treatment started. After recurrence of gastroesophageal area, palliative radiotherapy and concurrent oral capecitabine treatment were used. After 2 months, tumor implants were detected in the abdominal wall. The patient's pain had palliatied after 40Gy RT. After 6 months the tumor marker values began to rise and the patient was treated with cisplatin for 2 cure but grade 3 neurotoxicity occured. The patient was admitted to our palliative care department with oral malnutrition and delirium findings. The Patient nutrition screening tools were shown to be malnutrition. In the psychological evaluation, it was determined that he was in the process of accepting the disease by leaving the stages of shock, anger and denial behind in the process between diagnosis and palliative care unit.*

Significant improvement was seen in delirium findings after corticosteroids.

The patient was instructed to use his muscles twice a day, exercised, and mobilized.High calorie nutrition support was provided to the patient as enteral nutrition product in cooperation with the physician.

Cognitive Existentialist psychotherapy was applied to the patient twice a week. Acceptance of the socioeconomic and physical limitations

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brought about by the disease, future plan, treatment compliance studies.

RESULTS: *Patient was discharged by oral feeding, VAS value 2, ECOG Performance score 3, improved delirium table after two months. Palliative care units were also presented as a case study showing how important the multidisciplinary approach is for patients in this situation.*

DISCUSSIONS: *It may be possible to deal with some serious problems with a good evaluation and team work in terminal period illnesses.T here are many scales developed to evaluate the situation of patients and their families. These can be identified with the appropriate ones*

KEYWORDS*: Palliative gastric cancer, palliative radiotherapy, nrs2002, mna, msas*

INTRODUCTION

Patient with non-curable life-limiting disease want to remain at home as long as possible (1, 2, 3). However, when the general situation of the patients becomes worse, the patient's families and the patient can not cope with this problem and apply to the hospital (3). Integrated palliative care (IPC) has been introduced more appropriate to patients and family carers needs. It aims to achieve quality of life for the patient and the family (4).

Patients with advanced cancer must be copes significant psychological and physical distress, The lack of energy, pain, feeling bloated, and difficulty sleeping, were most distressing problems in terminal stage palliative care patients. Symptom related distress causes worsening of Quality of Life (QOL) (5).

CASE REPORT: A 65-year-old male patient was diagnosed with gastric cancer 21 months ago. Adjuvant radiotherapy was not needed for the reason that adenocancer cells were positive in the peritoneal fluid. The gastric cancer stage of patients was T4N3M1. Oral capecitabine treatment started. After 4 months of treatment, recurrence of gastroesophageal area occurred and palliative 45Gy radiotherapy and concurrent oral capecitabine treatment were used. After 2 months, tumor implants were detected in the abdominal wall. Radiotherapy for new recurrence field was started because severe pain. The patient's pain had palliatied after 40Gy RT. After 6 months the tumor marker values began to rise and the patient was treated with cisplatin for 2 cure but grade 3 neurotoxicity occured. The patient was admitted to our palliative care department with oral malnutrition and delirium findings. Tension arterial was determined as 140/70 mmHg, liver palpable and painful, appearance icteric, skin tightened, mild acid on internal examination. Hypoalbuminemia, hyponatremia were detected in laboratory tests. Algologic examination revealed severe pain in the abdomen and waist region, weakness in the legs and in the crows with pain. Visual Analog Scale (VAS) and Visual Pain Scale (VPS) values were measured as 8 (6, 7). Physical therapy and rehabilitation were evaluated as Eastern Cooperative Oncology Group (ECOG) Performance 4 (8) (Table 1). Upper and lower extremity muscles were atrophic but muscular strength was normal. After admission to the palliative care unit) Memorial Symptom Assessment Scale MSAS, Mini Nutritional Assesment (MNA), Nutritional Risk Scale (NRS2002), Malnutrition Screening Tool (MST) and Subjective Global Assessment (SGA) nutrition and brain screening tools and anthropometric measurements were used to determine nutritional status (9-.12).

Table 1: ECOG Performance status

GRADE	ECOG PERFORMANCE STATUS
0	Fully active, able to carry on all pre-disease performance without restriction
1	Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work
2	Ambulatory and capable of all selfcare but unable to carry out any work activities; up and about more than 50% of waking hours
3	Capable of only limited selfcare; confined to bed or chair more than 50% of waking hours
4	Completely disabled; cannot carry on any selfcare; totally confined to bed or chair

The patient nutrition screening tools were shown to be malnutrition. In the psychological

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evaluation, it was determined that he was in the process of accepting the disease by leaving the stages of shock, anger and denial behind in the process between diagnosis and palliative care unit.

After the general condition improved with supportive care during the first week, the patient was transferred to the intensive care unit again with the delirium table and the saturations were reduced to 40, then the general condition was relatively improved and transferred to our service again. Tramadol 37.5 mg + paracetamol 325 mg and pregablin 75 mg were started as medical treatment for the patient. When the patient was diagnosed with chemotherapy-induced neurotoxicity, 80 mg single-dose corticosteroids were administered to the patient after the other treatments did not benefit. Significant improvement was seen in delirium findings after corticosteroids.

Anemia and electrolytes were corrected, albumin was added to reduce acid and edema, and recovery in the general condition. The dietician consulted the patient twice a week and suggested feeding according to their symptoms.

The patient was instructed to use his muscles twice a day, exercised, and mobilized.
High calorie nutrition support was provided to the patient as enteral nutrition product in cooperation with the physician.

Cognitive Existentialist psychotherapy was applied to the patient twice a week. Acceptance of the socioeconomic and physical limitations brought about by the disease, future plan, treatment compliance studies. Psycho-social problems and solutions that may be encountered in the post-discharge home care process. Active participation have been discussed, such as re-observing their life and setting short-term goals and its importance in the course of illness in accordance with the conditions. The subjects who expressed feelings of retention, acceptance of the past, and focus on the present were studied with the patient who had deep retrospective feelings about their relationship with their spouse and children and business preferences. Before the diagnosis, the patient's spouse and son were interviewed about the marital problems that existed and continued to date, the additional stressor factor to the disease, and communication problems with other members of the family.

Ethical considerations: This study was designed with the aim of obtaining to tools data and anthropometric measurements that did not compromise patient's safety. A written informed consent was obtained from patient and family.

RESULTS

Patient was discharged by oral feeding, VAS value improved from 8 to 2, ECOG Performance score from 4 to 3. NRS2002 scoring improved from 4 to 2 and delirium table totally palliated after two months. Palliative care units were also presented as a case study showing how important the multidisciplinary approach is for patients in this situation.

DISCUSSION

Some serious problems can be solve with a good evaluation and team work in terminal period illnesses. There are many scales developed to evaluate the situation of palliative patients and their families. The patient symptoms can be identified with the appropriate ones. The MSAS is a scale which measuring to evaluate the intensity and distress from a list of 33 symptoms for palliative patients. The scale can evaluates physical symptoms as well as psychosocial symptoms (9).

The prevalence of hospital malnutrition varies between 27% to more than 50% depending to various patient characters (13-17).

NRS-2002, MUST, and the MNA are validated screening tools for identified malnutrition risk (10-12). A score ≥ 2 accepted to identify patients at nutritional risk.

Nutritional risk assessment with NRS-2002 has given a predictive value for complications, mortality and length of hospital stay (10, 18).

Elderly and inpatient of hospital especially with multiple comorbid disorders had a greater risk of

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malnutrition than outpatients and younger patients (19).

Our case study shown to importance of multimodal palliative therapy and patient care with a good team. Patient VAS value improved from 8 to 2, ECOG Performance score from 4 to 3. NRS2002 scoring improved from 4 to 2 and delirium table totally palliated and patient discharged with ability of oral feeding after two months. This study showed how important the multidisciplinary approach for patients in this situation.

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