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Case Report

Palliative Care for a Patient with Advanced Cervical Cancer - Case Report

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Abstract

Patients with advanced cancer are often affected by multiple symptoms, causing both physical and psychosocial suffering. Palliative care is a holistic approach of care that focuses on symptom management and increasing quality of life. Patients with gynecologic malignancies, particularly cervical cancers, are ideally suited for palliative care interventions. In the following case study, we present a patient with advanced cervical cancer receiving palliative care at the terminal phase of her illness. The complex symptoms, especially pain, were managed by the palliative care team and multidisciplinary care was given at the end of life. Early referral to palliative care services during comprehensive cancer care is essential in order to improve patient outcomes.

Keywords: Gynecologic malignancies; Cervical cancer; Palliative care; Symptom management; Quality of life; End-of-life care

Introduction

Palliative Care (PC) is the comprehensive and integrated care provided to patients and their families facing the challenges associated with a life-threatening illness. PC is an approach that focuses on the optimal management of distressing symptoms, while incorporating psychosocial and spiritual care according to needs, values, beliefs and cultures [1-3]. Cancer patients often experience a multitude of symptoms concurrently, complicating the management of the illness from the time of diagnosis, throughout the treatment and until the terminal phase. Therefore, a combined plan of standard oncology care and PC should be considered early in the course of treatment for any patient with metastatic cancer and/or high symptom burden [4,5]. Cervical cancer is the fourth most common cancer in women, globally, and disproportionately affects the poor, who often lack access to disease prevention, early diagnosis, treatment and PC utilization. Most cervical cancer patients have multiple physical symptoms along with psychological, social and spiritual suffering [6,7]. Patients with gynecologic malignancy, in particular cervical cancer, constitute a significant population which would require PC interventions. In this report, we introduce a patient with advanced metastatic cervical cancer who received multidisciplinary care in a hospital PC unit. The high symptom burden of the patient, primarily pain, as well as the other PC care required throughout the disease trajectory, are reviewed.

Case Presentation

A 52-year-old woman with recurrent metastatic cervical cancer presents to the emergency department with abdominal pain, nausea, vomiting, fatigue and low oral intake. After an initial assessment by the medical oncology department, it was decided to follow up the patient with basic supportive care. The PC team was subsequently consulted for management of pain and other symptoms, and the patient was transferred to the PC unit of the hospital. Two years prior, the patient had received a diagnosis of irresectable cervical squamous cell carcinoma. She had a family history (sister, grandmother, grandfather and aunt) with various types of cancer. She had received several rounds of chemotherapy and radiotherapy, but refused to have anymore, expressing her wish for only comfort measures of care instead. Upon admission to the PC unit, she was experiencing severe pain in her pelvis, which she rated as an 8 on a 10-point numeric rating scale, 10 being the worst pain imaginable. She was cachectic and had an infective erosive gluteal lesion invading the skin and swelling of the left limb. She had bilateral nephrostomies due to bladder outlet obstruction and hydronephrosis. One year after diagnosis, an intestinal fistula had developed and she still had an actively functioning colostomy. She also described symptoms other than pain, such as nausea, vomiting, dyspnea, fatigue and low oral intake. Her palliative performance score was 30%, indicating that she was totally bed-bound. She had recurrent urinary infections and antimicrobial therapies with mildly elevated serum creatinine levels. She was under pain management control at Pain Polyclinic and strong opioids were administered for pain. The opioid doses were gradually escalated from a tramadol-paracetamol combination to immediate release morphine, oxycodone and transdermal fentanyl. She received transdermal fentanyl 75 mcg/hr, immediate release oxycodone 20 mg twice a day for breakthrough pain and pregabalin 300 mg/day was started for the neuropathic pain, which she described as numbness and a burning and shooting pain radiating to her left limb. Although she was offered epidural catheterization and neuraxial infusion for pain control, she didn't want to receive the procedure as she already had two nephrostomy catheters and a colostomy. Doppler ultrasonography did not reveal deep venous thrombosis in the limb that was swollen. The recent computerized tomography scan showed enlarged lymph nodes, invasion to the pelvic wall, bladder and rectum, and metastasis to the lungs. The analgesic medications prescribed were: transdermal

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fentanyl 100 mcg/hr, pregabalin 300mg/day, immediate release morphine 30mg on an as-needed basis and dexamethasone 4-8 mg/day with a proton pump inhibitor. Drugs such as metoclopramide, ondansetron, lactulose, antispasmodics and paracetamol were given and routinely used when needed. Her wound care was very painful and required subcutaneous morphine, sublingual fentanyl or, occasionally, ketamine-midazolam boluses. The patient was divorced from her husband and living with her 14-year-old daughter. Her sister had been helping them from the onset of the illness. She was very anxious and experienced great psychosocial distress and loss of function. Spiritual suffering arose from worrying about her daughter, feeling guilty for being ill, feeling abandoned and losing meaning in life. The psychologist, social worker and spiritual care provider were brought into the care plan to reduce the patient's and the family's distress and increase quality of life. Lorazepam 0.5-1 mg was added to the regimen to reduce anxiety and aid sleep. The patient's status gradually deteriorated and she was unable to swallow the drugs or food. The symptom of dyspnea increased, due to the progression of multiple lung metastases. After an evaluation for treatable causes and conservative interventions, subcutaneous morphine was started both for dyspnea and breakthrough pain. She developed delirium presenting as an acute and fluctuating confused state, and intravenous haloperidol was given to control the symptoms. The patient died with multiple organ failure after a 12-day stay at the PC unit.

Discussion

Cervical cancer is one of the most common cancers and causes of cancer-related death in women [6]. It is a preventable and also curable disease if diagnosed early. Globally, the annual number of new cases of cervical cancer has been projected to increase from 570,000 to 700,000 between 2018 and 2030. More than 85% of those affected are young patients who live in low- and middle-income countries, where the death rate is three times higher than in high-income countries [6,7]. Our patient was a middle-aged woman whose tumor was unresectable at the time of diagnosis. After a treatment period of two years, the disease progressed, accompanied by multiple symptoms causing physical and emotional suffering and a deterioration in her quality of life. The World Health Organization (WHO) developed the Global Strategy to Accelerate the Elimination of Cervical Cancer as a Public Health Problem, which was adopted by the World Health Assembly in August 2020 [8]. The three main pillars of the strategy are primary prevention through vaccination, screening and treatment of precancerous lesions, and management of invasive cervical cancer, including PC. PC has become the main focus of care when disease-directed, life-prolonging therapies are no longer effective, appropriate or desired [2,9]. Despite the increasing availability of PC services and awareness of the importance of early referral, oncology providers often underutilize these resources [10]. In their study, Krauker et al. [7] demonstrated that women with cervical cancer experience physical, psychological, social and spiritual suffering that is more prevalent, complex and severe than the suffering associated with most other serious illnesses. Pain is one of the most devastating symptoms experienced by cancer patients during both curative and palliative therapy. Many surveys estimate that 30% to 50% of cancer patients in active therapy have pain, rising to 60% to 90% with advanced disease [11,12]. The pelvic region is highly innervated and the invasion or compression of neural structures may cause neuropathic pain, which is more difficult to control than nociceptive pain [13]. Peripheral neuropathic pain is also a common adverse effect of the chemotherapeutic agents used to treat cervical cancer. Radiotherapy to the pelvis may result in chronic pain from vaginitis, cystitis or proctitis [7]. The patient in the study initially presented with visceral nociceptive pain but, with the progression of the disease, she developed neuropathic pain experienced as burning and shooting pain with numbness radiating to her left limb. 'Total pain', which was defined by Dame Cicely Saunders, evaluates pain as a biopsychosocial model involving physical, psychological, social and spiritual components [14]. After comprehensively assessing the patient's pain and addressing the psychosocial and emotional features, analgesia is commenced according to the severity of pain. The WHO pain ladder provides a three-step approach that has been effective in more than 80% of cases [15]. Interventional pain techniques can be considered at any step when conventional analgesics do not provide adequate pain relief or result in intolerable side effects. Our patient was started on weak opioids and titrated to strong opioids, including morphine, oxycodone and transdermal fentanyl as the severity of pain increased. Pain control became more difficult after the initiation of neuropathic pain. The patient was offered to insert an epidural catheter for neuraxial analgesic infusion, but refused, as she did not want any further intervention. She said that the bilateral nephrostomies and colostomy were hard enough to bear and wanted to continue with the current analgesic therapy. Pregabaline was added to relieve neuropathic pain. Sedoanalgesia was also needed for painful change of wound dressings at the PC unit. Patients with cervical cancer experience many symptoms that contribute to the high prevalence of psychological suffering, including anxiety, depressed mood and sexual dysfunction. Pain, malodorous vaginal discharge, bleeding, obstructive nephropathy, bowel obstruction, nausea-vomiting, fistulas, edema, venous thrombosis, delirium and dyspnea are among the most common symptoms. Patients may also suffer financial distress, social isolation or stigmatization, loss of faith or meaning in life [7,16,17]. Our patient experienced most of these symptoms throughout her disease trajectory. She had received bilateral nephrostomies and a colostomy due to the urinary and intestinal obstruction, respectively. After the diagnosis of cancer, she and her husband divorced and she felt abandoned. She was anxious and worried about her daughter's future. It has been previously shown in various studies that high anxiety levels result in higher symptom expression [18]. The patient was not using a regular antidepressant drug or an anxiolytic. Lorazepam was started to relieve anxiety and help sleep at night. Scheduled visits by the psychologist and spiritual care provider were continued for the patient and the family until the end of life. Delirium is an acute neuropsychiatric syndrome characterized by alterations in the level of consciousness and changes in cognitive functions that tend to fluctuate during the day [19]. It is a complex but common disorder in PC patients, with a prevalence between 28-42% at admission, rising to 88% at the end of life [19,20]. Although delirium is an important prognostic factor of morbidity and mortality, it is still frequently under-diagnosed [21]. In addition to treatment with neuroleptics, its multifactorial nature and potential for reversibility should be recognized, and possible interventions such as altering medication, increasing hydration or correcting electrolyte imbalance must always be considered. Dyspnea, defined as an uncomfortable shortness of breath, is a frequent symptom in patients with advanced illness and has been well-documented enough to have prognostic value. The highest prevalence of dyspnea occurs in lung cancer, increasing in the terminal phase (80%) with a significant negative impact on the quality of life [22]. Symptomatic management of dyspnea includes oxygen therapy, drugs, and general measures of psychological support and counseling. Opioids are the

only pharmacological agents with sufficient evidence in the palliation of dyspnea [23]. The effect of opioids in combating dyspnea seems complex and several mechanisms of action have been postulated. The patient in the present study requiring medical treatment for symptoms of both delirium and dyspnea; haloperidol was used to control delirium and morphine for dyspnea, due to lung metastases. The primary aim of the PC team was to provide comfort to the patient and reduce anxiety and suffering while avoiding aggressive interventions. PC is a fundamental human right and an essential component of comprehensive and integrated cancer care. Although it should be considered an ethical duty for health professionals and should be provided in any health care setting, it is not yet equally available to all patients, even those in highly organized systems [3]. In oncology, studies have shown that, in the cancer care continuum, early referral to PC provides improved patient outcomes, including survival, quality of life, symptom management and end-of-life care [24,25].

Conclusion

Patients with gynecologic malignancies, particularly cervical cancer, have to bear a high burden of symptoms and suffering during the course of their disease. The integration of PC into standard gynecologic cancer care and an early collaboration between oncologists and PC providers through a multidisciplinary approach is essential to obtainoptimal quality of life outcomes for patients and their families.

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