

CASE REPORT

A case study: Concurrent palliative care based on SENS-structure for patients with advanced prostate cancer

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Abstract

On an acute urological ward, it is challenging to meet all needs of patients with life-limiting progressive cancer disease in complex situations. The focus shifts from curation to the holistic palliative approach aiming at patients' and their families' needs and planning care in advance with an interprofessional attitude. Based on a patient with castration refractory prostate carcinoma with multiple metastasis, the aim of this case study is to describe the palliative care approach, using the established so-called SENS-structure (Symptoms, End-of-life decisions, Network and Support of the carer) in which the bio-, psycho-, social and spiritual needs are addressed. We report on our practice experience using the SENS-structure, in which the team discusses palliative care interventions with patients and their family: management of (potential) symptoms and self-supporting strategies, expectations and end-of-life decisions including advance care planning, evaluation of patients' social and professional network and setting up additional support. The palliative care team provides advice to the treating team on future treatment strategies and care activities. The complex situation of a patient with metastatic prostate cancer and his personal sufferings illustrate the interprofessional use and person-centred focus of the SENS-structure. Important in this phase is—next to the family carers—the involvement of all professions and disciplines to break down the complexity of the situation into manageable proportions. Early involvement of palliative care for patients with advanced cancer is highly recommended. The SENS-structure helps to prioritize and include the personalized approach which is strongly supported by nurses.

KEYWORDS

advance care planning, advanced prostate cancer, discharge planning, early, interprofessional collaboration, palliative care, SENS-structure

1 | INTRODUCTION

If in the course of advanced, refractory or progressive cancer, the medical intention of cure shifts to a palliative treatment approach, the focus changes towards facing challenges of the final phase of patients' life by adding quality rather than quantity. Palliative care (PC) is a holistic approach aimed at improving quality of life of patients¹⁻³ until death and supporting their family in bereavement. It includes the early

identification, prevention and relief of (potential) suffering.⁴ Professionals support patients in their decision on future medical treatment and care including times when they lose their decision-making capacity. This is often referred to as anticipation including advance care planning (ACP).⁵

The PC team is called in by the treating team if the situation becomes multidimensional and unmanageable, complex and instable^{6,7} and the predictability of the future is challenging. The specialized

interprofessional PC team discusses the focus of care with patients, organizes care with a problem- rather than diagnosis-driven approach^{8,9} and provides support for families and the treating team. In our university hospital, the concurrent support of the PC team comprises a structured conversational intervention based on SENS, an acronym for Symptoms, Expectations and (End-of-life) decisions, Network and Support (see Figure 1).⁸

We illustrate the impact of the SENS-based PC intervention in which the team discusses with patients/families the management of (potential) symptoms, expectations and end-of-life decisions including ACP, evaluates patients' social network and sources to support them. The PC team provides advice on future treatment and care activities.

1.1 | Case

Mr. T, 64 years of age, married with no children, was diagnosed with castration refractory prostate carcinoma, osseous, lymphogenic and hepatic metastasis in July 2018.

He was admitted to the emergency department in December 2018 for pain exacerbation in the lumbar and right thoracic region and severe dyspnoea with a suspicion of disseminated liver metastasis and progress of diffuse osseous metastasis. In addition, a deep pelvic veins thrombosis was diagnosed. His cognition was adequate. Because of his fatigue, he intended to set only small goals day by day. He still owned a business which he will "have to shut down", but he mentioned that all is on track. He had an advance directive and his lawyer would take over his financial business. Currently, he had no unfinished projects or wishes and expressed no specific spiritual needs.

Up to now, the focus lay mainly on treating his tumour and less on personal challenges that he encountered during the course of the disease. For the PC team, the main concern was the suffering of the patient—looking specifically at his physical, psychological, social and spiritual distress. Based on SENS, we discovered the following areas of focus:

1.2 | Symptoms

He suffered from tremendous lower back pain and dyspnoea. He feared the symptoms, which decreased after chemotherapy but now regained strength. While resting, he tolerated pain and dyspnoea with

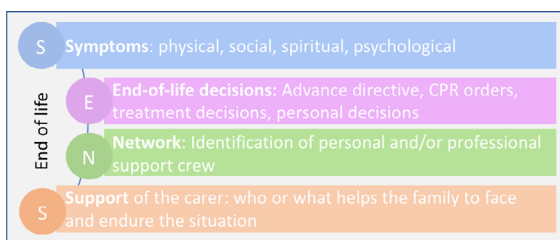


FIGURE 1 SENS-structure

WHAT IS KNOWN ABOUT THIS TOPIC

- Palliative care is a holistic approach and with which the interprofessional team adds quality rather than quantity to patients' life
- Health care professionals often apply the concept of palliative care in a late stage, because they understand it as a concept for end of life only.

WHAT THIS PAPER ADDS

- Palliative care should be incorporated alongside regular oncological care for patients with advanced cancer, being a person-centred approach next to a disease-related approach
- SENS is a structure that breaks down the many challenges of patients with a life-limiting disease into manageable proportions
- Nurses play an important role in recognizing patients suitable for specialized palliative care and help the palliative care team in identifying challenges of concern

Fentanyl transcutaneous 50 µg/h and Methadon hydrochlorid 5 mg bid. He was afraid to get up because pain and dyspnoea became extremely strong in the upright position. Despite compression, his legs were strongly oedematous which also hindered him to mobilize. However, he believed that without pain he could walk again. Because of a lack of appetite, he currently barely ate but drank cold liquids. He had no bowel movement for the last 5 days. He felt very weak, dozed during the day; he believed that this came from chemo- and radiation therapy. Due to all of these symptoms, he feared that discharge would not be possible.

1.3 | End of life decisions/expectations

He hoped that pain and dyspnoea would get under control, so that he would regain mobility. With the help of home care nurses, he wished to go home to be with his wife and arrange business things. A premise to go home was to be able to walk short distances. He firmly believed that this would be possible when his pain was under control. He considered these ups and downs as a normal process. He hoped that the current radiotherapy would relieve his pain. If this would not occur, then he would reconsider and decide whether to undergo any other anti-tumour therapies. He refused to talk about dying since his wish to go home was very strong. Nonetheless, he stated that he did not want any life-prolonging therapy such as resuscitation or invasive ventilation.

1.4 | Network-organization

The couple lived in their own disability adapted flat with a lift to the fifth floor. Being an entrepreneur, he had no financial worries. The couple made all important decisions together. Presently they had only little contact with their friends because he wanted to avoid the necessity of justifying the situation to everyone. The home care nurses came three times a week to support him with personal hygiene. The specialized PC team came once a month to co-ordinate and plan ahead, adjust medications and provide psychological support. The contact to the GP, who made home visits, was good. Although the couples' wish was that he would come home, both realized that this was currently impossible. They agreed to be transferred to the specialized PC unit and if necessary to be transferred later to a hospice.

1.5 | Support for the carers

He had concerns regarding his wife since she said that she lived only for him. She felt very distressed, was not able to sleep and felt very strained, feared that she would not have the strength to live through what was about to happen—meaning his death. She always wanted to be there for her husband. She was keeping her sorrows for herself and hardly talked to her family or friends about the situation. She asked for sleeping medication. On our advice, she agreed that we contact the psycho-oncologist to support her in this crisis. Although her husband supported this very much, she refused to make use of this offer.

1.6 | Aims of palliative care

The following goals were defined with the patient and his wife:

- to preserve patients' autonomy, decision-making and self-management by reducing pain to tolerability
- to enhance mobility to enable discharge
- in a later stage to evaluate options of chemo- and radiotherapy—what does the patient want to achieve with this strenuous treatment
- to well prepare transfer to PC Unit
- to offer psychological support to his wife whenever she is ready for it.

1.7 | Interprofessional care planning

With their clinical expertise in holistic care and skills in navigating patients and their families through difficult and sometimes complex situations, nurses play a central role within the interprofessional team.¹⁰ Their interconnectedness across all health care settings is vital for a proactive care planning and improving patients' condition and quality of life while taking the potential burden of the family into consideration.

The urological clinical nurse specialist carried out the SENS assessment with patient and his wife, suggesting to involve the PC team because the situation was very complex and instable, being indicators for specialized PC support.¹¹ She monitored the symptoms, and supported the patient and his wife emotionally and involved the psycho-oncologist. The urology nurses took care of his pain, nausea and bowel management, supported Mr. T. in personal hygiene and mobilization, assisted in sufficient food & fluid intake offering food supplements based on a nutrition protocol.

The urologist took over the lead for Mr. T. He co-ordinated the various specialist consultations, informed and supported the patient and his wife in making decisions about future therapies. He optimized medication treatment regarding pain, nausea and constipation. The medical- and radio-oncologists evaluated together with the orthopaedist the option of another chemotherapy, radiotherapy & indication for vertebroplasty while the physiotherapist trained and instructed techniques for mobilization. In the meantime, the dietician advised additional supplementary nutrition. The interprofessional PC team organized the admission to the PC unit for stabilization of the situation and complex discharge preparations and advised the general practitioner and community nurses in pain therapy and reserve medication.

2 | DISCUSSION

Concurrent with the regular oncological treatment,¹² it is necessary to look at the personal concerns of the patient specifically in times when the focus shifts towards adding quality rather than quantity of life. To address these issues the interdisciplinary and interprofessional team requires time to sit down, listen, and discover who the person behind the disease is and to distribute tasks and responsibilities effectively. The SENS-structure proved to be helpful to break down the many concerns of patients into manageable proportions early on in the disease trajectory and to develop a patient centred care plan. This timely person-centred approach supports enhancing the quality of life of the patient and lessens distress of the family.¹³ To reach out with home care professionals such as general practitioners or district nurses is essential for the continuity of care and the preparedness for emergency situations at home. Planning for times when the patient is no longer capable to make decisions and documenting these decisions in an advance care plan or advance directive accessible to all involved helps the family to take off the burden from their shoulders of making hard decisions in difficult times.

3 | CONCLUSION

The early involvement of palliative care for patients with advanced cancer is highly recommended by the American Society of Clinical Oncology¹⁴ in which the holistic approach to patients' life is included and goals of care (ACP) are clarified. SENS provides a useful and comprehensive thematic structure, which helps patients and their family

to lay focus on challenges in other areas than simply the diagnosis-driven approach. Planning for times when a patient needs support from family and professionals helps to free time for things that are more important at the end of life.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

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