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Mod 5 Discussion 2

Pain, as well as nausea/vomiting and anorexia/cachexia, is a component of palliative and end of life care. Choose either pharmacologic or non-pharmacologic management of the aforementioned symptoms.

Respond to a peer that chose a treatment regimen that differs from yours.

Posted By Jason Lohmeyer
09/06/10 5:36pm





Comments

There are many complications that come with the end of a person's life. Pain can manifest in many forms, such as physical and emotional pain. Nausea and vomiting is experienced by as many as 30-60% of patients at the end of their lives (Norlander, 2008). Anorexia and cachexia can also manifest at the end of life in patients. There are many pharmacologic interventions for these symptoms and complications, however, nurses can not only rely on those pharmacologic interventions. They can also use non-pharmacologic measures to help ease the pain, nausea and vomiting, and anorexia and cachexia. For pain, there are many options for non-pharmacologic care of the patient. By listening to the patient describe their pain and really understand where the patient is coming from, a nurse can develop trust and really get a good idea of what the patient is feeling. A patient will not be open to talking to a nurse that they don't trust. A nurse can also give the patient options as much as possible, which can encourage the patient to be an active part of their pain control. By giving the patient time to think about pain control and really talk it over with their family if necessary, they can feel empowered and really want to take an active role in their treatment. By providing therapeutic communication as well as building a professional relationship with the patient, a nurse can truly help with pain control in the end of life as well as the suffering the patient is going through. Pain can manifest in many different ways

Posted By Samantha Hammis
10/26/10 9:50pm



depending on the patient, therefore individualizing treatment is key in treating patients at the end of life. (Norlander, 2008)

If a patient is experiencing nausea and vomiting at the end of life, a nurse can easily give a medication to try and remedy the symptoms. It is tougher, however, to give non-pharmacologic support as a medical professional. The nurse can really take an active role in the treatment by recognizing a pattern in which the nausea and vomiting is occurring, such as after meals only, and therefore providing support at those times. If a patient does not have a family member present and is vomiting, a nurse can simply be present if the patient so desires and provide touch, use therapeutic silence, and keep the patient company so that the patient has a support system in the room with them. If the patient is experiencing cachexia and anorexia, which is common at the end of life, the nurse can provide support for those symptoms as well. For example, the nurse can offer the patient's favorite food as an incentive to eat, reduce portion sizes, take away dietary restrictions, involve the family in the understanding of the disease and alternatives that can be used to who support, and even use alcohol as an appetite stimulant (Norlander, 2008, p. 53). A patient at the end of life does not need another reason to be frustrated about the disease process they are experiencing, so they must have support and love from their family as well as the medical team working with them. Pharmacologic interventions can be very helpful with patients who are suffering, but caring and support means so much to them at the end of their life and patients will truly appreciate the work that is put into taking care of them.

Norlander, L (2008). *To comfort always: A nurse's guide to end of life care*. Indianapolis, IN: Sigma Theta Tau International.

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Samantha

I like the fact that you brought solid attention to the idea of non-pharmacological techniques, even though we tend to not always think of that as an option. I do believe that it should be one of our first methods and should always at least be tried.

Emanuel and Librach (2007), also bring light to the idea of bringing a nutritionist and regulating the patient's food

Posted By Katie Fochtman
10/31/10 4:35pm



intake to discover and avoid trigger foods or smells. I think that we often forget about the tools we have at our fingertips to utilize beyond our medications at hand.

Perhaps it would also minimize our constant care, in that if we help our patients recognize these things and help them treat them independently, we won't have to be so very cautious of the medications and their side-effects.

Reference:

Emanuel, L., & Librach, S. (2007). *Palliative care: Core skills and clinical competencies*. Philadelphia, PA: Saunders Elsevier.

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Good insights and ideas - what pharm interventions would have helped Vivian?

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Posted By Jason Lohmeyer
10/31/10 5:17pm



Samantha-

I also liked that you address non-pharmacological methods of alleviating nausea and vomiting. Emmanuel and Librach (2007) mention a few other non-pharmacological techniques as well. Some suggestions that they give include relaxation therapy, guided imagery, and hypnosis. I thought that hypnosis was a particularly intriguing option for relieving nausea and vomiting.

Reference

Emanuel, L. L., & Librach, S. L. (2007). *Palliative care: Core skills and clinical competencies*. Philadelphia, PA: Saunders Elsevier.

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Posted By Marcia Lindsay
10/31/10 8:23pm



Posted By Brianna Pieri

Sami-

I think it is very true what you say about how it is more difficult for nurses to implement a nonpharmacological intervention than it is for us to administer a pill. As horrible as it sounds, I choose to talk about medications because I figure a lot of time medications is the only thing you will be doing about a patient's N/V. I like that you and the book mentioned figuring out what is causing the vomiting or nausea though. Also, it was interesting that Norlander (2008) states that vomiting can come from cerebral pressure, mechanical obstruction, medications and infection (pg. 53). I think it is important for us to take time to look further into these things and not just administer medication.

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11/01/10 8:27pm



As if pain is not bad enough other symptoms that can arise such as nausea/vomiting or anorexia/cachexia are also things that a patient can be enduring. Like pain there are ways we can help treat these issues, both non-pharmacological and pharmacological measures.

When it comes to anorexia these changes can come on from changes in taste buds and the responses to certain tastes differ, it can often lead to alteration in nutrition, resulting from poor calorie intake (Bare, Cheever, Hinkle & Smeltzer, 2008, p.429) Cachexia with cancer patients is related to inadequate nutritional intake along with increasing metabolic demand, increased energy expenditure due to anaerobic metabolism, competition of the tumor cells for nutrients, altered lipid metabolism, and a suppressed appetite (p.428). As these two issues become more and more serious, if a patient is malnourished, certain considerations need to be taken.

The first and foremost effort should be to be the oral route of obtaining nutrients. If food is prepared the way the patient likes, also in an eye appealing manner it can only help the chances of it being appetizing to eat. Also, if one is desperate, the patient should be able to choose what may sound most appetizing, to try any way to obtain nutrients, at least in the beginning. Small more frequent meals also help

Posted By Katie Fochtman
10/31/10 3:30pm



with not feeling overwhelmed and decreasing chances to feel sick if eating too much at one time (CITE). If the oral route is not a possibility, nutritional support via the enteral route may be necessary to try. Short-term nasogastric tubes can be used, but if needed longer than several weeks, a gastrostomy or jejunostomy tube may need to be inserted (CITE). If malabsorption is an issue, enzyme and vitamin replacement might need to be instituted, as well as possible parental nutrition methods (CITE). These methods do not prolong survival or significantly improve nutritional status, they are purely a reduction in cachexia and anorexia.

Nausea/vomiting are also common issues and have common pharmacological options. Vomiting induced by chemotherapy can be treated with several different kinds of antiemetics, such as Zofran and Compazine. Compazine effects result from blockade of dopamine receptors in the CTZ (Lehne, 2007, p.911). They tend to have side effects, such as extrapyramidal symptoms, hypotension and sedation and the patient should be monitored closely for these issues. Another drug for nausea and vomiting is Reglan, its prokinetic agents block dopamine and serotonin receptors in the CTZ, and thereby suppress emesis (p.912). This drug also has its side effects, including extrapyramidal symptoms.

We learn from day one that pain is subjective, it is what the patient says it is. These issues, such as nausea can be what a patient perceives as their pain, their ultimate discomfort, therefore should be treated and paid attention just as highly as pain.

References:

- Smeltzer, S., Bare, B., Hinkle, J., & Cheever, K. (2008). *Brunner & Suddarth's: Textbook of medical-surgical nursing* (11th Edition). Philadelphia: Lippincott Williams & Wilkins.
- Lehne, R. (2007). *Pharmacology: For nursing care* (6th Edition). St. Louis, MO: Saunders Elsevier.

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Oops, forgot a few "(CITE)s"...

(Bare, Cheever, Hinkle & Smeltzer, 2008)
(2008, p.429)

Posted By Katie Fochtman
10/31/10 4:32pm

(p.430)

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Thanks.

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Posted By Jason Lohmeyer
10/31/10 5:18pm



Katie-

I thought it was interesting that you mention that when referring to the use of artificial nutrition as a treatment for cachexia, "These methods do not prolong survival or significantly improve nutrition status, they are purely a reduction in cachexia and anorexia". I found similar information supporting this in Emanuel and Librach. According to Emanuel and Librach, "Patients and their families should be educated that simply loading the patient with calories will often not lead to weight gain and may even cause additional distress to the patient who is physically unable to eat a lot of calories" (p. 1260). I feel as though a lot of the information on artificial nutrition seems a bit contradictory, touting as a good option for treating anorexia and cachexia, but also saying that it can do more harm than good. I suppose that it depends on the particular situation and patient.

Reference

Emanuel, L. L., & Librach, S. L. (2007). *Palliative care: Core skills and clinical competencies*. Philadelphia, PA: Saunders Elsevier.

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Posted By Marcia Lindsay
10/31/10 8:28pm



Katie-

Posted By Brianna Pieri
11/01/10 8:31pm

Its interesting that you bring up the change in taste buds as a possible reason for anorexia. Norlander (2008) suggests that "reducing portion sizes and eliminating dietary restrictions" and "offering the patient's favorite food" are non pharmacological ways to treat anorexia (p. 53). I think as nurses we have to be creative sometimes with how we help our patients. If there is a food we can get them, even if it is extremely wierd due to changes in taste buds, we need to help them get whatever they will eat.



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Anorexia and cachexia can be a manifestation of a terminal illness such as HIV or cancer. Anorexia includes loss of a normal appetite while cachexia includes nutritional deficiencies and weight loss. When seen together at the end of illness, anorexia and cachexia often consists of nutritional changes, weakness, and wasting. Risk factors can include dry mouth, early satiety, constipation, dysphagia and changes in taste or olfaction. This condition can potentially be fatal, and needs to be addressed. Anorexia and cachexia can be difficult to treat, and is typically handled by addressing other issues first, such as nausea and vomiting, constipation, and infection. If this fails to reverse cachexia and anorexia, drugs that stimulate the appetite are also extremely useful in combating these conditions. The main drug used to stimulate the appetite is megestrol acetate, which is a progestogen. Alternatively, cannabinoids, corticosteroids, and drugs such as thalidomide and metoclopramide can be helpful. Lastly, cyproheptadine, hydrazine sulfate, and pentoxifylline can sometimes be used to treat anorexia/cachexia, although their use is limited. There are also new drugs that are still being tested that include melatonin, omega-3 fatty acids, growth hormone, and insulin-like growth hormone. Often, the physician prescribes drugs based upon the disease that is causing cachexia/anorexia. For example, thalidomide is most often used in HIV patients.

Reference

Emanuel, L. L., & Librach, S. L. (2007). *Palliative care: Core skills and clinical competencies*. Philadelphia, PA: Saunders Elsevier.

Posted By Marcia Lindsay
10/31/10 7:55pm



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Marcia, as I did not talk about pharmacological interventions, I really enjoyed reading your posts about what drugs can be used in the patient that is experiencing anorexia and cachexia. Norlander (2008) states that the most commonly used drugs include megestrol, prednisone, or dexamethasone to help with stimulating the appetite and assist in reducing nausea and vomiting. However, you state many more drugs that can be used and the many reasons certain drugs would be used. I find it very interesting that the physician prescribes based on what disease is causing the cachexia and anorexia. I think you made many great points about patients all receiving drugs specific to their case and specific illness.

Norlander, L (2008). To comfort always: A nurse's guide to end of life care. Indianapolis, IN: Sigma Theta Tau International.

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Posted By Samantha Hammis
11/01/10 1:23pm



Marcia-

I think it is so interesting that both books suggest unhealthy things to do to stimulate appetite. As I mentioned in my post Norlander (2008) suggests using alcohol and an appetite stimulant and I see you have mentioned that the other book suggests using cannabis. It is hard for me to wrap my head around those things because we spend so much time on health prevention and maintenance that I have difficulty trying to imagine myself doing these things. I suppose at the end of life whatever helps and makes the patient happy and comfortable is what a nurse should do. I suppose I would hope someone would do that for my family.

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Posted By Brianna Pieri
11/01/10 8:35pm



Marcia, it makes sense to try to treat symptoms before determining a pharmacological treatment for anorexia/

Posted By Emily Walter
11/03/10 10:57am

cachexia. I know when I am vomitting or sick I neither feel like eating or am getting the right amount of nutrition. I thought it was interesting that they specialize the drugs for cachexia/anorexia depending on the disease, such as thalidomine for HIV patients. According to Reyes-Teran et al. (1996), thalidomide not only haults wasting syndrome in HIV patients, but does some reversal. This seems like one of the best pharmacological benefits a drug like that could give! Especially since HIV patients' major cause of morbidity and otality is anorexia-cachexia syndrome (Emanuel & Librach, 2007).

References

Emanuel, L. L., & Librach, S. L. (2007). *Palliative care: Core skills and clinical competencies*. Philadelphia, PA: Saunders Elsevier.

Reyes-Teran, G., Sierra-Madero, J., Martinex del Cerro, V., Arroyo-Figueroa, H., Pasquetti, A., Calva, J., & Ruiz-Palacios, G. (1996). Effects of thalidomind on HIV-associated wasting syndrome: a randomized, double-blind, placebo-controlled clinical trial. *AIDS*. 10(13), p.1501-7

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According to Muir et al. (2009), approximately 60 percent of terminally ill patients experience nausea and 30 percent experience vomiting (as cited in Norlander, 2008). With such high incident rates, intervention is necessary to maintain comfort. Yet, with this symptom, investigation must be done to find the source, as it can come from mechanical obstruction, medications, or infection (Norlander, 2008). Assessment can be done to find the source through determining a pattern that it may start or worsen such as after meals or before certain activities. (Norlander, 2008)

Once the cause is determined, more specialized treatment can be done to avoid or decrease the incidence of nausea/vomiting. Goals for patients with nausea and vomiting include increasing quality of life, preventing or eliminating symptoms, provide convenient care, reduce hospital time, and reduce treatment costs (Emanuel & Librach, 2007, p. 120). Nonpharmacological intervention that can be used to manage nausea/vomiting includes relaxation therapy, guided

Posted By Emily Walter
11/01/10 1:18pm



imagery, and hypnosis. These examples can help a patient with anxiety-induced emesis. Acupuncture has been shown to decrease nausea, according to Emanuel and Librach (2007). Working with intake with a nutritionist may help avoid smell or food related nausea/vomiting. Especially for chronic sufferers of nausea and vomiting, avoiding the trigger foods and smells can allow for more symptom control. (Emanuel & Librach, 2007)

References

Emanuel, L. & Librach, S. (2007). *Palliative care: Core skills and clinical competencies*. Philadelphia, PA: Saunders Elsevier.

Norlander, L. (2008). *To comfort always: A nurse's guide to end-of-life care*. Indianapolis, IN: Sigma Theta Tau International.

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Emily, I appreciate that you pointed out the importance of determining the cause of the nausea and treating that rather than just going straight for the nausea itself. According to Emanuel and Librach (2007) in order to have the best success at treating emesis and improving quality of life for the patient, the triggers and pathways of emesis for the individual patient need to be determined and treated (p. 117). I also find it interesting how relaxation, guided imagery, and hypnosis are treatment methods for nausea and vomiting as well as for pain as we have discussed in previous modules. It seems that anxiety can play a major role in pain and emesis and by helping to reduce a patient's anxiety, we can eliminate some of these symptoms (Emanuel & Librach, 2007, p. 124).

Emanuel, L. L., & Librach, S. L. (2007). *Palliative care: Core skills and clinical competencies*. Philadelphia, PA: Saunders.

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Posted By Lindsey Foley
11/03/10 9:25am



Emily, I liked that you wrote about some of the non-pharmacological interventions that nurses can perform for

Posted By Marcia Lindsay
11/01/10 2:27pm

patients with nausea and vomiting. I feel like its so easy sometimes to just prescribe a pill, and often, assesemtns are not done to find out why the patient is even having these symptoms. I thought it was particularly interesting the Emanuel and Librach (2007) suggest ginger as a non-pharmacological intervention for nausea and vomiting.



References

Emanuel, L. & Librach, S. (2007). Palliative care: Core skills and clinical competencies. Philadelphia, PA: Saunders Elsevier.

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Muir et al. (1999) states that "close to 60 percent of terminally ill patients experience some type of nausea, and 30 percent experience vomiting" (as cited in Norlander, 2008, p. 53). controlling nausea and vomiting is vital to the treatment of our patients. If the patient is nauseous it is very likely this will add to the presense of anorexia and cachexia. Storey (1996) states that controlling other symptoms such as nausea and vomiting can be as usefull as medications (as cited in Norlander, 2008, p. 53). Medications to help control loss of appetite include megestrol, prednisone, and dexamethasone to stimulate the appetitie (Norlander, 2008, p. 53). I thought it was interesting that Norlander (2008) included using alcohol such as a glass of wine to stimulate appetite. As far as decreasing nausea and vomiting medications such as antiemetics such as Zofran and Reglan (GlobalRPH, 2007). Admnister the medication before the patient is asked to eat this will decrease the chances of the patient turning down the meal as a whole. It seems that if the nurse can work to make nausea and vomiting go away there is a better chance that anorexia and cachexia will occur. Using medications can help increase appetite along with decreasing vomitting and nausea.

The Clinician;s Ultimate Reference. (2007). Retrieved from www.globalrph.com/antiemetics.htm

Norlander, L. (2008). To always comfort: A nurse's guide to end-of-life care. Indianapolis, IN: Sigma Theta Tau International.

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Posted By Brianna Pieri
11/01/10 8:10pm



Pain, nausea/vomiting, and anorexia/cachexia are common symptoms associated with end-of-life care, especially in patients with cancer. Treatment of these is necessary in order to prevent as much suffering as possible. Both pharmacologic and nonpharmacologic measures should be taken to help relieve these symptoms and provide the best possible care as a person's life comes to an end. Though both modalities are necessary, I will focus on pharmacologic measures for this discussion. Though medications can be extremely useful in treating a plethora of symptoms, they all come with a price to pay as well. The right mix needs to be determined in order to treat the symptoms without causing the patient to be miserable due to the various side effects.

Pain management is an art that takes much practice and skill. Opioid administration is the preferred method for moderate to severe pain. When using medication therapy for treatment of pain, there are several guidelines to follow so that the patient's pain is properly managed with the fewest possible side effects. It is important to assess the patient's pain on a regular basis and establish a baseline of acceptable pain level so that the medical team and the patient/family are on the same page. Education of the patient and family about the various aspects of pain and pain control as well as side effects to monitor for should be done early on so that they understand what is to come and can help monitor for adverse outcomes (Emanuel & Librach, 2007, p. 99). When using medications to control pain, it is important to prescribe and administer around the clock dosing at regular intervals to keep the pain suppressed and to provide doses for breakthrough pain if it does occur. A combination of opioid and nonopioid analgesics is the standard for controlling moderate to severe pain. Common nonopioid analgesics are acetaminophen, NSAIDs, and tramadol. Common opioids are morphine, oxycodone, hydrocodone, and fentanyl. The main side effects to be concerned about with opioids are constipation, sedation, n/v, pruritis, urinary retention, and respiratory depression. Another important point of medication administration for pain is to use adjuvant therapies such as antidepressants, anticonvulsants, and radiotherapy or surgery. (Emanuel & Librach, 2007, 100-108)

Posted By Lindsey Foley

11/03/10 9:19am



Nausea and vomiting are also common symptoms in end-of-life care due to medication side effects, gastrointestinal problems, tumors, and psychological problems (Emanuel & Librach, 2007, p. 117). The goal of treatment is to enhance the patient's quality of life and several medications are available to help with these symptoms. Common therapies are dopamine antagonists (metoclopramide, haloperidol, trifluoperazine, and domperidone), 5-HT₃ antagonists (ondansetron, granisetron, and dolasetron), cannabinoids, and corticosteroids (Emanuel & Librach, 2007, p. 120-124).

Anorexia-cachexia is another common problem as a person dies from long-term illnesses, especially from certain cancers and ADIS. These symptoms are due to major changes in the person's body which cause them to no longer have an appetite and not be able to keep anything down that they do eat. Pharmacologic treatment for anorexia-cachexia is geared at treating the underlying cause such as n/v, constipation, or infection and stimulating the person's appetite. The drug of choice for appetite stimulation is megestrol acetate. Other drugs are being tested but this is the most effective at this time. Enteral or parenteral nutrition and fluids may also be needed. (Emanuel & Librach, 2007, p. 124-126)

Reference

Emanuel, L. L., & Librach, S. L. (2007). *Palliative care: Core skills and clinical competencies*. Philadelphia, PA: Saunders.

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For nausea and vomiting, the best approach is a preventative strategy. Nausea and vomiting are much easier to prevent than to treat. Anti-emetics should be administered before any treatment that has the potential to cause emesis, such as chemotherapy. From a non-pharmacologic standpoint, relaxation therapy, guided imagery, and hypnosis can help relieve anxiety-induced emesis. Accupuncture and accupressure can relieve some of the symptoms of nausea and ginger can be given orally or mixed into a soda or tea to help calm the stomach. Additionally, the nurse should involve a nutritionist in planning the patient's diet and avoid trigger foods and smells. (Emanuel & Librach, 2007)

Treatment for anorexia/cachexia focuses on alleviating the causative factor(s) associated with the syndrome, if possible.

Posted By Lacy Lesko
11/03/10 6:21pm



Causative factors can include nausea and vomiting, constipation, and infection. Also, the nurse will also want to modify the types of food eaten and the timing of meals to stimulate the patient's desire to eat. The nurse should ask the patient about favorite foods and drinks and make sure they are available at all times. The nurse should provide the patient with frequent small meals instead of three large meals. Spicy and fatty foods should be avoided because they have the potential to upset the stomach, thereby contributing to further anorexia. Also, nutritional supplements and multivitamins might be indicated and enteral/parenteral nutrition might be suggested for some patients. (Emanuel & Librach, 2007)

Non-pharmacological management of pain can be achieved with radiation therapy if the patient experiences localized cancer-related bone pain, tumor growth, and infiltration.

Also, relaxation therapy and distraction can help patients better cope with high levels of pain. Physical and occupational therapy provides pain relief for patients with contractures and fractures. Transcutaneous electrical nerve stimulation and acupuncture are other adjuvant therapies that can be combined with pharmacological interventions to provide comfort. (Emanuel & Librach, 2007)

Reference:

Emanuel, L. L., & Librach, S. L. (2007). Palliative care: Core skills and clinical competencies. Philadelphia, PA: Saunders Elsevier.

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I chose to focus my discussion on anorexia/cachexia. In my med-surg clinical today, I cared for patient who was recently diagnosed with small cell carcinoma of the left lung that has metastasized to the lymph nodes in the neck and throat. This was my first time caring for a patient that is near death (not only because of the cancer but because of multiple other medical diagnosis that were found during his admission through the ER). This patient is unable to talk and swallow. The patient suffers from nutritional imbalance: less than body requirements. He refuses to eat and drink. Therefore, anorexia/cachexia is a major concern. For this patient, a PEG

Posted By Shannon Larson
11/03/10 7:20pm



tube was necessary to sustain life. Tube feeding ran continuously. He has no appetite which could be caused by recent chemotherapy treatments which cause nausea and vomiting. Nonpharmacological care I would provide for this client include keeping the head of his bed elevated to at least 30 degrees and basic care and comfort. Good oral care is extremely important for this patient to prevent thrush or other infections. Pharmacological methods for anorexic clients could include an anti-fungal medication to prevent infection and appetite stimulants. However, for this particular client, an appetite stimulant was not found necessary because he is receiving feeding through the PEG tube. Patients receiving PEG feeding with head and neck cancers tolerate treatments better (Ganzini, L. 2006). Understanding the underlying cause of the nausea/vomiting and or anorexia/cachexia is important in providing symptom management. Otherwise, symptoms may not be controlled because the cause is still present. Furthermore, this patient is in need of palliative care. Providing tube feedings can improve his level of comfort and quality of life (Godard, T.). The tube feedings are a pharmacological intervention. However, through a PEG tube the patient can take oral medications directly through the tube rather than having to swallow them (which in this case, swallowing was not safe). Moreover, the insertion of the PEG tube allowed the physician to not have to prescribe several medications that could further damage his weakened body (kidney's & liver being the major concern). Through the tube feedings, the client is receiving the nutrients required by the body without having to suffer and experience pain with swallowing and force feedings by the family.

Ganzini, L. (2006). *Artificial Nutrition and Hydration at the End of Life: Ethics and Evidence. Palliative and Supportive Care*. 4:135-143.

Godard, T. (nd). *Everything Stops for Tea: Nutrition, Eating, and Palliative Care*. (Powerpoint from module)

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Very insightful discussion, thanks.

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Posted By Jason Lohmeyer
11/08/10 10:56am

Comment:



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