A Case Study of Colorectal Cancer

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Client History

The patient is a 46 year old, hispanic male, 59.5kgs, DNR/DNI. He was admitted for having a psychotic episode with hallucinations. He stated, “bad people put rats on my pants and I can see them”. He has a history of colon cancer (2013), polysubstane abuse, acute kidney injury, vertebral osteomyelitis, chronic back pain (from jumping off of a 6th story building 10 years ago), Covid-19 and HTN. His surgical history includes a tumor resection in 2014, with a gastrojejuonstomy and jejunojejunostomy for a small bowel obstruction in 2019. He is methadone dependent and uses heroin, cocaine (2 bags daily), opioids, benzodiazepines, and IV drug use. After his resection in 2014, he did not follow up with hematology and oncology and lost contact with the hospital. He now has stage 4 colorectal cancer with metastasis to the lungs and liver.

Assessment

His vital signs were: Temperature 97.5 orally, pulse 90, respirations 17, blood pressure 117/61 left arm sitting upright, Oxygen 98% on room air, and 10/10 non radiating lower abdominal and back pain. Patient is alert and oriented to person, place, and time. Normocephalic with pupila equal round and reactive to light and accommodation. He has clear lung sounds across all lung fields. Upon auscultation of his heart S1, S2 is present with regular rate and rhythm and no murmurs. He has +2 radial and dorsal pedal pulses bilaterally with a capillary refill of 2 seconds. He has mild abdominal distention with 10/10 pain and is continent of bowel and bladder. HIS muscle strength is a 5/5 with full range of motion. He is also unable to ambulate due to pain. A CT scan of his abdomen revealed his cancer has metastasized to his liver and lungs. He has no family and is currently homeless with no support system. He is very aggressive and agitated, and

will not engage unless methadone is given. The nursing diagnoses for this patient include risk for infection secondary to immunocompromised state and chronic pain secondary to metastatic malignancy as evidenced by guarding, opioid dependency, and stating a 10/10 pain.

Interventions/Challenges

The treatment options for this patient are complex yet limited due to the severity of his cancer and polysubstance abuse. The most important factor is pain management due to his cancer and chronic back pain. The concern with pain management is his opioid addiction and the difficulty of knowing if the patient is truly in pain or not. Sturdivant et al. (2020) explains the importance of nurse advocacy in situations of having to treat acute pain with patients who have a history of opioid addiction. Nurses must advocate for their patient by suggesting lower doses and offering non opioid methods of pain relief first (Sturdivant et al., 2020). The better option for this patient would be to split his methadone dose into 3 divided doses to better manage pain, instead of one dose daily. Pain is better managed when doses can be consistently given every 6 to 8 hours compared to a single dose (Broglio, K., & Matzo, M. 2018). The nurse plays a vital role in identifying and managing treatments that are not effective and should suggest new recommendations to the provider (White et al. 2017).

Another intervention that is of great importance is the caution of treatment due to the presence of Covid-19 which has changed the dynamics of the clinical system. Oncological patients are at greater risk for acquiring infections because they are immunocompromised. Stage 3-4 cancer patients must be educated about the importance of social distancing, hand washing and speaking with their provider on other treatment options that do not increase their immunocompromised state (Zaniboni et al., 2020). This study highlighted the increase in mortality rate for those who suffered with cancer that had acquired the Covid-19 virus as well. Due to this patient's homelessness, and limited amount of resources, he must be careful to avoid crowds and unsanitary places upon discharge. If he decides to pursue treatment such as

chemotherapy and radiation, he may want to weigh the risks and benefits due to its immunocompromising effects. Zaniboni et al. (2020) suggests treatments such as radiotherapy or surgery should be omitted or shortened in the presence of Covid-19 because of immune related adverse effects. Since his cancer is advanced and unlikely to be cured, the best option would be to omit radiation and chemotherapy and focus on symptomatic care while following the rules and regulations to decrease the risks of acquiring Covid-19.

Lastly, the patient should receive quality palliative care due to the aggressive nature of his cancer, which is unlikely to be cured. Palliative care is intended to relieve symptoms that appear when cancer is progressing and allow patients to live comfortably rather than cure the disease (Abu-Odah et al., 2020). Palliative care does not only refer to symptomatic treatment but also involves psychological and religious concerns. To provide the best overall care, all caregivers should pay attention to the potential fear of death the client may be having or religious needs towards the end of life. All healthcare providers should recognize that preferences may differ for homeless people compared to non homeless people and should ask specific questions regarding their feelings and future preferences (Klop et al. 2018). The majority of homeless people have experienced a lot of loss in their life and have little to no family to go back to. This means that healthcare providers should be extra sensitive to their psychological needs during this phase of care.

Evaluation/Long Term Plan/Patient Teaching/Discharge

The evaluation for the effectiveness of the interventions will be based on the ability to manage their pain, decrease the risk of infection, and provide palliative care. Before the initiation of treatment, the patient stated that his pain was a level 10 from a scale of 0-10. Once the methadone doses were able to be divided into 3 even doses, the patient stated his pain went down to a 5 for the majority of the shift. This means that the goal has been met because prior to this treatment, his pain consistently stayed at a 10/10. The evaluation to determine if the interventions

to decrease his risk of acquiring Covid-19 were based on his temperature and negative Covid PCR swab. Unfortunately, this goal was unmet because he had tested positive for Covid-19 on October 14th, days after his admission. The last evaluation for implementing palliative care was based on the ability to educate the patient on his possible options for treatment as well as offering different locations to continue his palliative treatment. This goal was met because the patient was able to verbalize understanding of his options and the process of getting him to a facility that provides palliative care had already been initiated.

The long term plan for this patient is to provide all of the resources available that can provide him with continuous care. Most homeless patients rely on the emergency department physician as their primary care provider and usually have nowhere to go even after a palliative care/hospice referral has been made ("Providing hospice," 2020). Many of them do not know that there are organizations dedicated to providing care for the homeless. If they do not choose to follow up with care, it is important to educate them on the signs and symptoms of worsening conditions such as melena and nausea/vomiting, and to immediately be seen by the emergency department. Lastly, it is vital to educate them on what to expect due to their advanced diagnosis and provide them with psychosocial care. They may experience worsening weakness, fatigue, and muscle loss and thinning as the cancer progresses and they reach the end of life.

Summary Statement

To summarize the events that have occurred, the patient was admitted due to "bad people putting rats on his pants" and his concerning history of colon cancer which he did not follow up with care. The nursing diagnoses for this patient include risk for infection secondary to immunocompromised state and chronic pain secondary to metastatic malignancy as evidenced by guarding, opioid dependency, and stating a 10/10 pain. The interventions for the risk of infection included omitting or shortening immunocompromising treatments and educating the patient on proper hand hygiene/social distancing. The intervention for his chronic pain included dividing

his daily dose of methadone into 3 doses throughout the day to better manage pain. The patient achieved the goal of chronic pain management but did not meet the goal of avoiding the Covid-19 virus. Due to his homeless status and immunocompromised state, it is much easier for him to be exposed to this virus. The long term plan is to educate the patient on all available resources for him to receive continuous care once he leaves the hospital, and to be aware of signs and symptoms of his condition worsening if he decides not to receive care through palliative/hospice services.

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