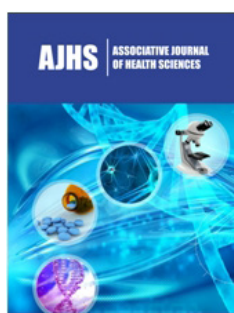


Role of the Family Care Unit at Home Care in Patients with Terminal Cancer

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Opinion

Palliative care patients and their families present pain and suffering in this situation, which is changing, and the number of complications increases as it develops. The approach to palliative care at home must be comprehensive, including the family care unit (medical and nursing team), the social worker and hospital care staff [1] in order to improve care, follow-up and care, to prevent both patients and families from feeling overwhelmed and helpless.

We share the case of a patient in a terminal situation, including her relatives and the resources needed to resolve the complications that arose during the course of the disease: progress of the disease and change of treatment, economic needs, burnout of the caregiver and the relief of suffering.

This is a 65-year-old woman diagnosed with advanced glioblastoma with metastases, pathological fractures, arterial hypertension, osteoporosis, and hiatal hernia; She is receiving daily treatment with 25mcg fentanyl patches, 8mg dexamethasone and 10mg enalapril.

We went to assess her at home after a recent hospital discharge. Her follow-up has been dismissed by the medical oncology service due to the impossibility of curative therapies. In this case, where the prognosis is limited, it is advantageous to organize a palliative care plan shared and focused on the comfort of the patient and the relief of suffering for both the caregiver and the family [2].

After an initial assessment, we found several diagnoses to address neoplastic complications such as vertebral fractures secondary to steroid treatment of the tumor with intense somatic pain, cognitive impairment secondary to the intracranial expansive process, constipation related to taking opioids, behavioral disorders such as restlessness nocturnal predominance, risk of seizures and physical and emotional overload in the family.

To assess their basal and functional situation, we used the Karnofsky Index (KI) with a total of 40 points and the Palliative Performance Scale (PPS) with a result of 40%. This last scale is a tool that makes an approximate prediction of survival time in palliative patients; Patients with a baseline PPS score of 40 or greater are estimated to have the highest survival rates with a 5-month survival of 40%, however patients with a PPS score of 30 and 20 have survival rates at 5 months less than 40% and 20% respectively [3].

The Pfeiffer test, which assesses cognitive ability, shows mild cognitive impairment. In the rest of the physical examination, the following stands out: severe cachexia and cushingoid appearance, probably related to taking corticosteroids; Left hemiparesis as a sequel to his glioblastoma with no other type of neurological focus.

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In summary, we have cognitive impairment and behavioral disorders, pain secondary to bone fractures, side effects of the treatment itself such as constipation due to the use of opioid derivatives, Cushing's syndrome due to corticosteroids, and also potential risks for the fragile patient and his environment.

It is essential to establish the care plan from Primary Care to provide support to both the family and the patient in advance². In this way we will pharmacologically treat the complications that occur and alleviate the signs or symptoms of suffering. We will show the family the possible difficulties that may arise in order to try to avoid worries and uncertainty, and we will begin to work on mourning, favoring the release of emotions such as anguish and fear.

The organization of this care plan can also facilitate communication between doctors of different levels and the rest of the health personnel, establishing certain guidelines and therapeutic adaptation in case assistance is required by other professionals who are less familiar with the patient [4].

Initially we will adjust chronic and incidental pharmacological treatment, as well as non-pharmacological treatments. In our case, we recommend prescribing dexamethasone at the minimum effective dose to control headaches secondary to the neoplasia and its expansive process, thus trying to avoid corticosteroid overdose [5].

Regarding the 25mcg fentanyl patches, we decided to keep them, since they provided good pain control, and we added 10mg lactulose to improve constipation. We added a new drug: levomepromazine 25mg drops, to control agitation or delirium [6]. We explain to the family what delirium consists of, when it appears and what would be the alarm signs for which they should call the emergency service, since this symptom is one of the most stressful events for caregivers. It has been shown that raising awareness about the existence and management of delirium is essential to address it and to reduce stress levels in family members [7].

Regarding the family members and main caregiver, apart from trying to solve their multiple doubts about evolution, expectations and management of symptoms, they were offered greater accessibility and even psychological help to avoid overload, and the advice and support of the social worker. An empathic attitude and trust with the referring physician of the family and the patient is essential both to alleviate suffering and to achieve a better adaptation to the dying process [8].

Social workers provide great support to the action plan, especially if they are trained in communication and psychosocial support [9]. They offer us a wide variety of economic and material resources, as well as rights and benefits that promote the relief of the burden of the caregiver and the patient. In our case, the patient and her family required specific resources for her care (crane and articulated bed) and a financial benefit.

In the event of complications that we cannot control on an

outpatient basis, coordination with hospital units such as palliative care or the emergency service is very important.

Our patient finally died after months of continued care at home by the family care unit. With this, she benefited from better symptomatic control in her last days, avoiding suffering and maintaining support and family support. After the death, the relatives were emotionally content, with better grief management and expressed their gratitude to the team.

The available evidence suggests that palliative care is optimized through a multidisciplinary team, preserving the patient's autonomy and quality of life, reducing hospitalization rates and favoring stay at home [10]. Our role in the home care of this type of patient is substantial and performing it adequately requires a multidimensional and holistic assessment of the somatic, psycho-affective, cognitive and family areas.

Ethical Considerations

The patient's consent was obtained, complying with the protocols of the work centers on the treatment of patient information.

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Conflict of Interests

The authors declare they have no conflict of interest.

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