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NURSING PALLIATIVE CARE IN PATIENT WITH TEREBRATING BASAL CELL CARCINOMA: A CASE STUDY

CUIDADOS PALIATIVOS DE ENFERMAGEM A PACIENTE COM CARCINOMA BASOCELULAR TEREBRANTE: ESTUDO DE CASO

CUIDADOS PALIATIVOS DE ENFERMARÍA A PACIENTE CON CARCINOMA BASOCELULAR TEREBRANTE: ESTUDIO DE CASO

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ABSTRACT

Objective: to describe palliative nursing care applied to a patient with Terebrating Basal Cell Carcinoma (TBCC). **Method:** case study held during the month of July 2014 in a Unit of Clinical Oncology of a specialized hospital in Campina Grande - PB. This study is part of a large project, whose Certificate of Presentation for Ethical Consideration is 13341413.0.0000.5182. **Results:** palliative nursing care provided to the patient with TBCC included individual assessment of the patient and the wound; and different types of coverages and medication were recommended and used to control the signs and symptoms of the wound, according to the stage, considering the specificities of the injury. **Conclusions:** palliative nursing care promoted comfort to the patient during hospital stay and home care, and were paramount to control the signs and symptoms, promoting thereby dignity during the terminal process. **Descriptors:** Palliative Care; Nursing Care; Basal Cell Carcinoma.

RESUMO

Objetivo: descrever os cuidados paliativos de enfermagem aplicados a um paciente com Carcinoma Basocelular Terebrante (CBCT). **Método:** estudo de caso realizado durante o mês de julho de 2014 em uma Unidade de Oncologia Clínica de um hospital especializado localizado em Campina Grande - PB. Este estudo faz parte de um projeto amplo, cujo o número do CAAE é 13341413.0.0000.5182. **Resultados:** os cuidados paliativos de enfermagem prestados ao paciente com CBCT abrangeram avaliação individual do paciente e da ferida; e foram recomendados e utilizados diferentes tipos de coberturas e medicamentos para o controle dos sinais e sintomas da ferida, de acordo com o estadiamento, considerando as especificidades da lesão. **Conclusões:** os cuidados paliativos de enfermagem promoveram conforto ao paciente durante a internação hospitalar e domiciliar, e foram primordiais para o controle dos sinais e sintomas, promovendo, dessa forma, dignidade durante o processo de terminalidade. **Descritores:** Cuidados Paliativos; Cuidados de Enfermagem; Carcinoma Basocelular.

RESUMEN

Objetivo: describir los cuidados paliativos de enfermería aplicados a un paciente con Carcinoma Basocelular Terebrante (CBCT). **Método:** estudio de caso realizado durante el mes de julio de 2014 en una Unidad de Oncología Clínica de un hospital especializado localizado en Campina Grande - PB. Este estudio hace parte de un proyecto amplio, cuyo el número del CAAE é 13341413.0.0000.5182. **Resultados:** los cuidados paliativos de enfermería prestados al paciente con CBCT abarcaron evaluación individual del paciente y de la herida; y fueron recomendados y utilizados diferentes tipos de coberturas y medicamentos para el control de las señales y síntomas de la herida, de acuerdo con el estadio, considerando las especificidades de la lesión. **Conclusiones:** los cuidados paliativos de enfermería promovieron confort al paciente durante la internación hospitalaria y domiciliar, y fueron primordiales para el control de los señales y síntomas, promoviendo, así, dignidad durante el proceso de terminalidad. **Descritores:** Cuidados Paliativos; Cuidados de Enfermería; Carcinoma Basocelular.

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INTRODUCTION

Skin neoplasias have become especially relevant in recent decades because of increasing incidence. Among them, the non-melanoma skin cancer accounts for one third of all malignant neoplasias of the human being. The most common tumors among non-melanoma skin cancers are basal cell (BCC) and squamous (SCC) carcinoma.¹

Basal cell carcinoma is a tumor composed of cells morphologically similar to the basal cells of the epidermis, with very slow growth, local invasiveness, however destructive, though not causing metastasis.²

The National Cancer Institute³ showed an estimate of 182,130 new cases of non-melanoma skin cancer for the year 2014, among them, 98,420 were men and 83,710 were women per 100,000 inhabitants. In Paraíba state, this estimate is of 2,070 cases and, of these, 1,160 are in women and 910 in men, with crude incidence rates of 57.89 and 48.28 per 100,000 inhabitants, respectively. In João Pessoa, the estimate corresponds to 280 cases, being 140 in women and 140 in men per 100,000 inhabitants. Unfortunately, this government agency does not provide specifically data on the incidence of basal cell and squamous cell carcinoma.

The BCC predominant etiopathogeny is related to exposure to ultraviolet radiation. Whatever the source causing the cancer, natural or artificial, over-exposure has a cumulative effect and manifests itself intensely after the age of 40 years. Thus, the most sun-exposed areas as nose, ears, eyelids, forehead and upper limbs are often affected. The incidence is higher in male Caucasian population, older than 40 years.⁴

From the onset of the initial injury, the BCC generally has a slow growth through months or years, causing tissue destruction at the site of primary region. When expressed on the terebrating form, considered the worst prognosis, presents ulcerated lesion with rapid invasion, causing great destruction of the central massif of the face, bringing together the mouth and nostrils in one single hole; in other instances, the terebrating form destroys the ocular globe and may even invade the cranial vault.⁵

This situation means installation of *gangosa* syndrome (superficial ulcerations followed by progressive destruction of the tissue and the bony walls of the oral and nasal cavities, which become a single large cavity, and causes loss of smell and taste).⁶

Patients who have this type of injury experience the occurrence of signs and symptoms resulting from ulcerative process of this cancer: intense pain, profuse exudation, foul odor, bleeding and fistulas. In addition to physical implications, terebrating BCC brings psychological, social and spiritual consequences such as low self-esteem, social-familial isolation, embarrassment and feeling of disgust of himself/herself.⁷

These wounds are treatable provided the cancer is at early stage and has curability. However, when the disease is at an advanced stage and the antitumor treatment is no longer indicated, the conduct is only palliative, for control of physical and psychosocial symptoms and prevention of complications, promoting improved quality of life.⁸

In this perspective, the treatment of terebrating BCC at advanced stage includes health multidisciplinary care with palliative care, since the patient has no therapeutic possibilities of cure. Meanwhile, it is noteworthy that palliative care is the approach that promotes quality of life of patients and their families when facing diseases that threaten the continuity of life through the prevention and relief of suffering. Palliative care requires early identification of complications of disease progression, assessment and relief from pain and other problems of physical, psychosocial and spiritual nature.⁹⁻¹⁰

As regards the treatment of wounds, the purpose is always healing. However, in palliative care, treatment aims at controlling the symptoms of lesions and aims at offering comfort to the patient in relation with wound. In this sense, planned palliative care can provide relief (partial, full or temporary) without expecting cure and cicatrization. In this sense, the guiding principle of palliation for wounds is related to the control of signs and symptoms of the injury.¹¹

Due to the complexity of the problem, the patient with BCC represents a challenge for nurses, as these professionals are part of the multidisciplinary palliative care team and are responsible for evaluation of the patient and the injury, choice of the bandage and performance of dressings. In this sense, the nurse needs to develop skills and abilities to identify, assess and treat these lesions, providing comprehensive care to patients and their families.

Therefore, developing studies on the subject contributes to skilled nursing care and provide dissemination of knowledge on the treatment of malignant lesions arising from

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BCC for scientific and healthcare community about the practice in the area of palliative care for neoplastic wounds, in order to strengthen the teaching and practice of nursing.

Thus, the aim of this study is to report palliative nursing care provided to a patient with terebrating basal cell carcinoma.

METHOD

Case study, conducted from July to August 2014, period elapsed between admission and discharge of the patient in the Unit of Clinical Oncology of a specialized hospital located in Campina Grande/PB and his return home.

This study is part of a larger project entitled "The pain in the perception of patients with neoplastic wounds" whose approval was issued by the Research Ethics Committee of the University Hospital Alcides Carneiro, Federal University of Campina Grande (UFCG) - PB, under the CAAE 13341413.0.0000.5182. The rules of Resolution

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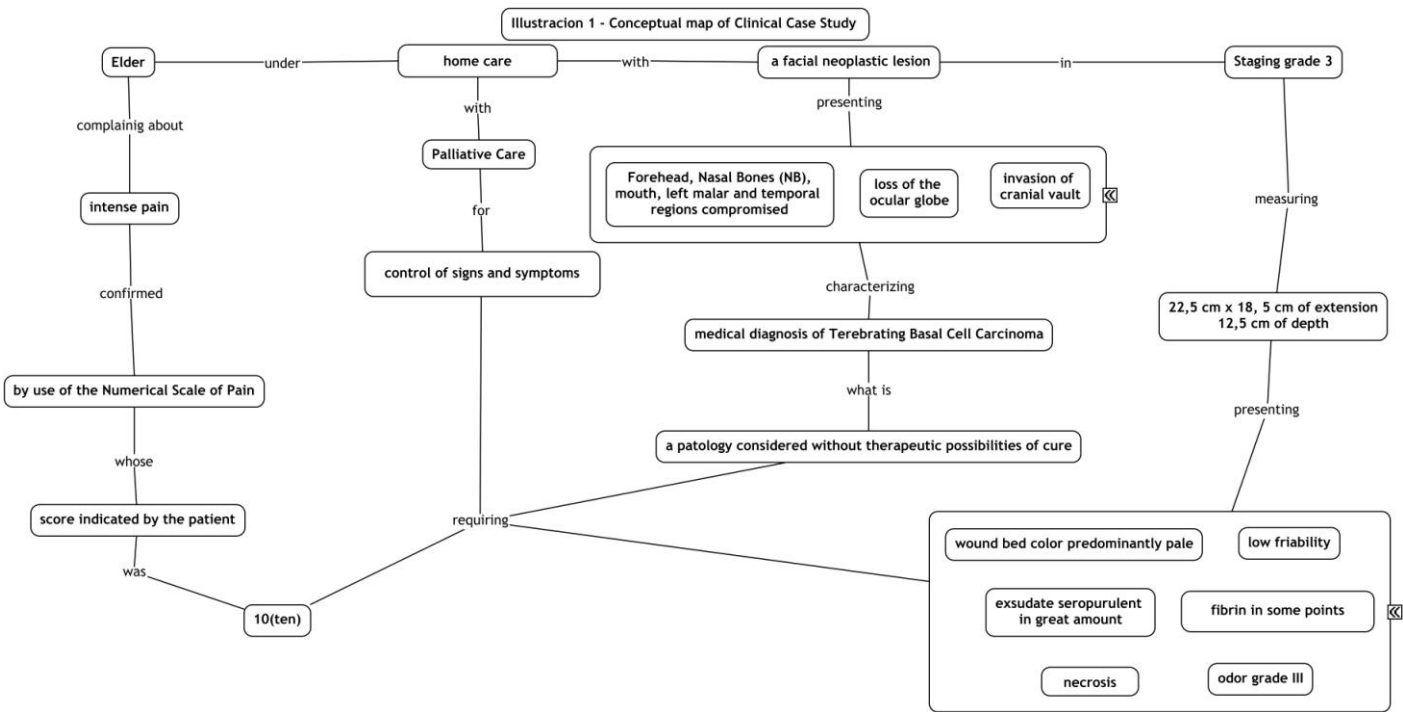
466/2012, which guides research involving human beings, were obeyed.

In order to collect data and to monitor the assistance, a script was used for anamnesis, physical examination and evaluation of the wound. The follow-up stages of the patient included: anamnesis, physical examination, evaluation of the lesion, therapeutic conduct and guidelines for discharge.

Data analysis was based on literature concerning the type of cancer and the evaluation and treatment of tumor wounds disclosed in Protocol of the National Cancer Institute.¹²

Presentation of the Clinical Case

Figure 1 shows a conceptual map representing the patient's case in order to illustrate the signs and symptoms presented by TBCC and the interrelationship between the identified data.



MSS, 78 years old, male, brown-skinned race, Brazilian, illiterate, Catholic, retired, married, father of six children, coming from Baraúnas/PB. The patient lived with a son and wife in their own home, masonry, earning the minimum wage. He denied underlying diseases, drug allergies, smoking, alcohol drinking and illicit drug use. He showed no signs of mental and psychological changes. The wife reported progression of a skin lesion for about two years, which began with a granuloma in the frontal region. He informed a surgical procedure for removal of the granuloma and after that the patient did not attend the hospital for the removal of points and the realization of curative and monitoring

of disease. Over the years, the lesion progressed, prompting the patient to retire on disability, but he refused to seek medical help. Only with increased pain, the patient accepted hospitalization in the institution, locus of this research.

The first contact with the referred patient occurred at the institution, two years after the onset of the disease which was already at an advanced stage, with invasion on facial structures and no possibility of cure. The patient was admitted on July 9, 2014, for biopsy and palliative care. The histopathological report presented itself conclusive for advanced Terebrating Basal Cell Carcinoma.

The return of the patient to his home took place on July 30, 2014 at request of his wife as it was the spouse's desire to spend the last days of his life at home. The patient and wife accepted the treatment protocol for cancer and palliative care offered by nursing staff. The patient authorized, and the wife signed an informed consent form, allowing photographic documentation and subsequent exposure of the case to scientific academia.

At that time, the patient and his wife were informed about the hygiene, feeding, dressing and pain control. Nursing care was based on INCA protocol¹² and scientific literature that recommend palliative actions toward malignant lesions.

In a second step, the nurse and nursing technician were contacted to conduct the daily dressing, for guidance on cleaning technique and adequate coverage. At that moment, dressing was carried out in the presence of caregiver and nursing technician, and material was delivered to perform the same procedure in the following days. As far as coverage and medicines in the Family Health Unit were available, the use of gel metronidazole and calcium alginate for application on the wound, and oral intake of weak opioids (codeine associated to paracetamol) for relief of the pain were recommended.¹²

♦ Physical exam

The patient evolved with weakened general condition, pronounced weight loss, conscious, oriented in time and space, bedridden, poor oral and body hygiene, impaired sleep and rest, cachectic, pale mucous membranes, acyanotic, anicteric, hard oral communication, responding through signals with extensive lesion on the face affecting the forehead, nasal bones (NB), mouth, left malar

and temporal regions, with loss of the left eye and with invasion to the right facial region and cranial vault. RS: eupneic, bilateral chest expansion preserved, vesicular murmurs preserved, adventitious noises absent. CVS: Heartbeat regular in 2 times, normal phonetic heart sounds and no murmurs. GIS: Abdomen flat, painless to superficial and deep palpation, decreased bowel sounds in all four quadrants, intestinal elimination present in alternated days (according to information collected). GUS: diuresis present in adult diapers (according to information collected). Vital signs: HR: 87 bpm; P: 87 bpm; RF: 18 breaths per minute; T: 37,5° C; BP: 110 x 80 mmHg.

After anamnesis and physical examination, initial cleaning with 0.9% saline solution in jet (with 20 mL syringe and needle 40X12) and evaluation of the injury were performed, showing up: extension from the forehead region to the lip (Figures 2 , 3), asymmetric, measuring 22.5 cm x 18.5 cm, with a depth of 12.5 cm, odor grade III (odor sensed in the environment without opening the dressing, strong and nauseating), irregular borders, color of the wound bed predominantly pale and slightly friable, with necrosis and fibrin in some points, seropurulent exudate and biofilm in moderate quantity. According to the characteristics presented, the lesion was classified as malignant with staging grade 3 because of the presence of fetid odor, bleeding, intense local pain, profuse exudate, tunneling.¹² Peripheral Skin: hyperemia (Figure 2) during the dressing change. The patient complained about intense pain, what was confirmed by using the Numerical Scale of Pain¹² whose score indicated by the patient was 10 (ten).



Ilustracion 2. Terebrating basal cell carcinoma
- 07.30.2014.



Ilustracion 3. Terebrating basal cell carcinoma - 07.30.2014.

DISCUSSION

Terebrating Basal Cell Carcinoma is revealed as a highly invasive and disfiguring tumor that quickly destroys healthy tissues. Chances of cure greatly increase when the lesion is treated at early stages and the successful healing essentially depends on the patient acceptance to participate in self-care, as it happens in any case of neoplastic wound.²

The hygiene of environment and body relieve the discomfort and reduce the chances of wound infection. The preparation of the wound bed creates an environment of improving cicatrisation by promoting a better vascularization, with less exudate, and controlling bacterial balance.¹³

Thus, cleaning is a vital component in the treatment of wounds. The neoplastic lesion,

besides disfiguring, exhales strong odor resulting from the release of putrescine and cadaverine gases from microorganism metabolism action, and it is exuding, friable and painful.¹⁴

In this sense, the cleaning performed with saline 0.9% in jets (with 20 mL syringe and needle 40 x 12) reduced the risk of damaging friable tissue and the pain at bandage change.

Irrigation is a technique that has gained more acceptability due to the benefits described above. The effectiveness of this technique in treating wounds encompasses not only the pressure (8 to 14 psi) as well as the irrigate solution. Studies have demonstrated that irrigation with saline solution reduces the rate of infection in wounds and its success is proportional to the amount of solution used.¹⁵

Based on recommendations of INCA¹² and due to limited resources, Metronidazole

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vaginal cream cover was indicated for odor control. Metronidazole is an antibiotic derived from imidazole, acting directly in the DNA of microorganisms, which has activity against anaerobic bacteria, preventing the multiplication of these microorganisms and the dryness of the wound bed. Thus, odor regression was noticed with the use of this product, which provided more comfort to the patient and his caregiver.¹⁶

Treatment with metronidazole is a successful therapy for patients with neoplastic wounds since it is easy to apply, of low cost and its administration is not associated with pain and discomfort. Studies show that there is significant decrease in odor within 24 hours after the first application and effectiveness in odor reduction in 100% of cases within two consecutive weeks of treatment.¹⁶⁻¹⁸

Calcium Alginate has been indicated for bleeding and exudative areas since this coverage works as a real hemostatic and keeps moisture controlled when in contact with the exudate of the lesion.¹⁹ The high level of exudation of the neoplastic wound may be due to increased permeability of blood vessels within the tumor, as well as the occurrence of infection.¹⁴ Ion exchange between sodium present in the exudate and calcium present in the Calcium Alginate dressing helps in both the autolytic debridement and in absorption. In this interaction, a gel is produced and keeps the bed of injury wet and induces hemostasis.²⁰

A study²¹ conducted with patients with malignant vegetative injury found that there was an increase of granulation and epithelization after application of gel coated bandage with calcium alginate since this substance has shown anti-microbial effect and anti-inflammatory properties when applied to malignant wounds.

Analgesia with codeine was applied for control of the pain. Pain control is important from the perspective of palliative care, when in case of the concept of total pain, the one that involves physical, mental, social and spiritual aspects.¹⁰

In this case, the use of opioid accessible to the patient helped to relieve pain and gave him back the possibility of sleep and rest that had been compromised for so long.

The nurse should monitor the level of pain using scales. Analgesia may be required thirty minutes before painful procedures such as dressings. We recommend the use of non-adhesive bandages, exchanging when the secondary bandage is saturated, use of cold saline solution in case of bleeding vessels, soft

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touch and communication that calms the patient. These are some measures that favor pain relief.²²

In 1986, the World Health Organization⁹ introduced the Analgesic Ladder for the treatment of cancer pain. Since then, pain related to cancer now has a rational treatment, with effectiveness around 95%. This scheme calls for the use of analgesic drugs staggered by power, always in combination, and each step represents both the drugs to be used and the pain intensity according to the Visual Analogue Scale. If the pain reaches high intensity (VAS 8-10), strong agonist opioids (morphine, methadone, fentanyl or oxycodone at high doses) must be used. However, the Tylex (codeine associated to paracetamol) was the only opioid analgesic that the Basic Health Unit disposed at the time in the present case.

Codeine is a weak opioid derived from morphine, and is indicated for the treatment of pain of moderate intensity. Its metabolism is hepatic, by demethylation, forming norcodeine and morphine. About 10% of the codeine is transformed into morphine, responsible for the analgesic effect of codeine.²³

Multicenter study of 70 patients with malignant wounds found that advanced age, frequency of dressing change, pain and symptoms of wound, such as odor and bleeding, are negative correlations that significantly interfere with the quality of life.²⁴

The care provided had a multidisciplinary approach, in which the doctor performed the prescription of medication, nurses accompanied at home with guidance and assessments, and the nursing technician performed the dressings in the absence of nurses, what is required for patients in palliative care. The presence of other professionals, like speech therapist and nutritionist, was necessary. However, as the patient refused hospitalization, the presence of these professionals became impossible for the municipality of his residence is distant from major centers with specialized treatment.

With regard to diet, the disease imposes intense catabolism, concomitant with anorexia, which generates a frame of cachexia, a recurrent complication observed in patients with malignant tumors.

It is noteworthy that changes in energy metabolism are manifested through hypermetabolism or persistent catabolism. The carbohydrate metabolism alteration

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causes glucose intolerance and peripheral resistance to insulin. The protein metabolism is altered and results in the depletion and atrophy of skeletal muscle and visceral organs, myopathy and hypoalbuminemia. Altered lipid metabolism is manifested as depleted fat reserves and hyperlipidemia. In addition to metabolic changes, hormonal changes and increased circulating cytokines also occur.²⁵

The lack of appetite and severe weight loss are already expected in cancer patients with advanced disease and may be indicative of proximity with terminal phase. In this sense, the diet should provide primarily comfort and not rehabilitation of the nutritional status of people with cancer. Thus, some appropriate nutritional recommendations are: the family should not press the patient to feed if he does not want to; fractionate feeding in about six meals a day and consume foods with high caloric and protein content.²⁶

However, the financial limitation hindered access to a diet rich in special nutrients, such as polyunsaturated fatty acids eicosapentaenoic acid (EPA) EPA and DHA docosahexaenoic acid (DHA), amino acids such as glutamine and arginine and nucleotides, since these elements improve body weight, lessen anorexia and increase protein synthesis.²⁷

However, guidance on how to prepare and deliver the food available was important to offer a minimum of essential nutrients and dignity in the face of death and dying process to that patient that was feeding at the base of mushes and porridges with great difficulty.

FINAL REMARKS

Psychomotor and speech difficulty of the patient to participate in the study interfered with the implementation of palliative care in its fullness. In addition, there was also difficulty of assistance because the patient comes from a very small town without specialized network in oncology and far from major centers. Concomitant to this problem, the patient refused to be admitted to a treatment center in another city, where he would receive more consistent care for his needs. In addition, a diet rich in protein intake was not possible due to financial limitation and loss of food in the oral cavity due to injury and profuse salivation.

We believe that the patient received comfort despite all the limitations, and its autonomy was respected, which is essential for a dignified death within the concept of palliative care. Pain was relieved and allowed

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improved quality of sleep and rest. Care of the injury was implemented, seeking to meet as much as possible the recommendations for the treatment of neoplastic wounds.

This study provided data about a particular case. However, further studies are needed for the care of people with tumor wounds without healing possibilities, including new practices, products and even theories that may support nursing care with regard to knowledge and actions in this palliative care.

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