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CLINICAL CASE STUDY ARTICLE

PALLIATIVE NURSING CARE TO PATIENTS WITH MOUTH SQUAMOUS CARCINOMA: CLINICAL CASE STUDY

CUIDADOS PALIATIVOS DE ENFERMAGEM A PACIENTE COM CARCINOMA ESPINOCELULAR DE BOCA: ESTUDO DE CASO CLÍNICO

CUIDADOS PALIATIVOS DE ENFERMERÍA AL PACIENTE CON CARCINOMA ESPINOCELULAR DE BOCA: ESTUDIO DE CASO CLÍNICO

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ABSTRACT

Objective: to describe the palliative nursing care applied to a patient with mouth squamous cell carcinoma. **Method:** case study during the month of July 2014 in a Unit of Clinical Oncology in a specialized hospital in Campina Grande/PB. **Results:** palliative nursing care for patients with OSCC with individual assessment of the patient and the wound; and there were different types of coverage and medication recommended and used to control the signs and symptoms of wound, according to the stage, considering the specifics of the injury. **Conclusion:** palliative nursing care promoted comfort to the patient during hospital and home care, and were essential for the control of symptoms and signs, promoting thereby dignity during the terminally process. **Descriptors:** Palliative Care; Nursing Care; Carcinoma Squamous Cell.

RESUMO

Objetivo: descrever os cuidados paliativos de enfermagem aplicados a um paciente com carcinoma espinocelular (CEC) de boca. **Método:** estudo de caso clínico realizado durante julho de 2014 em uma Unidade de Oncologia Clínica de um hospital especializado em Campina Grande/PB. **Resultados:** os cuidados paliativos de enfermagem prestados ao paciente com CEC de boca 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. **Conclusão:** 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 de Células Escamosas.

RESUMEN

Objetivo: describir los cuidados paliativos de enfermería aplicados a un paciente con carcinoma espinocelular de boca. **Método:** estudio de caso clínico realizado durante el mes de julio de 2014 en una Unidad de Oncología Clínica de un hospital especializado en Campina Grande/PB. **Resultados:** los cuidados paliativos de enfermería prestados al paciente con CEC de boca cubren evaluación individual del paciente y de la herida; y fueron recomendados y utilizados diferentes tipos de coberturas y medicamentos para el control de los señales y síntomas de la herida, de acuerdo con su etapa, considerando las especificidades de la lesión. **Conclusión:** 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, de esa forma, dignidad durante el proceso terminal. **Descriptor:** Cuidados Paliativos; Cuidados de Enfermería; Carcinoma de Células Escamosas.

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INTRODUCTION

Oral squamous cell carcinoma (OSCC) is about 90% to 95% of cases of oral cancer. The natural history of cancer of the oral cavity begins with uncontrolled cell proliferation and faster than normal cells, where numerous genetic and environmental factors interact during a variable period of time.¹

The National Cancer Institute (2014) estimated for 2014, 11,280 new cases of oral cavity cancer in men and 4,010 in women. These values correspond to an estimated risk of 11.54 new cases per 100 thousand men and 3.92 per 100 thousand women. Excluding non-melanoma skin tumors, oral cancer in men is the fourth most common cancer in the Northeast. In Paraíba, the estimate for 2014 was 170 men and 120 women per 100,000 inhabitants. In João Pessoa, the estimate was 30 men and 20 women per 100,000 inhabitants.² It is important to emphasize that oral cancer constitutes a public health problem due to its high lethality even with early diagnosis possibilities, and should be seen as a priority problem.

With regard to risk factors for OSCC, studies mainly highlight tobacco and alcohol consumption associated with genetic predisposition. In addition, the human papilloma virus is also considered a carcinogen for the development of oral cavity cancer. The research adds that eating habits with low nutritional standards, sun exposure, chronic mechanical irritation (poorly fitting dentures, broken bones, absence of teeth) or chemical (use solutions for oral hygiene), poor oral hygiene are associated with etiology oral cancer, and occupational factors, probably due to exposure to toxic products.^{3,4,5}

Clinically, the OSCC can take on different aspects in its early stages and may be associated with or be preceded by exophytic or endophytic lesions, especially leukoplakic, eritroplakic and eritroleukoplakic injuries. The clinical presentation forms most frequently found are vegetating, ulcerated, and infiltrative ductile, and usually happening the combination of one or more of these characteristics.¹

There is clinical evidence to support the diagnosis of OSCC as not to spontaneous healing of the lesion within 15 days of injury or carton basic ulcerated lesions everted and hardened edges, with no erythematosis and painless halo earlier.⁶ Therefore, it is essential in oral clinical evaluation careful examination of mucous membranes of the oral cavity and upper aerodigestive tract, allowing determination of synchronous and

metachronous lesions. In the case of proposed signs, diagnostic confirmation is only possible by incisional biopsy, should be implemented as soon as possible to avoid time consuming and expensive diagnostic investigations that only delay the start of treatment.^{1,6}

The survival for an oral cancer depends on the tumor stage. The survival rate for five years disease-free for OSCC is 76%, being directly related to the extent of injury, also increasing the frequency of occurrence with increasing age.⁶

In this perspective, people who have this type of injury, experience the occurrence of signs and symptoms resulting from ulcerative process of this cancer: severe pain, profuse exudation, fetid odor, bleeding and fistulas and sometimes by poor hygiene and protection from injury and myiasis. In addition to the physical implications, the OSCC brings psychological, social and spiritual consequences such as low self-esteem, social-family isolation, embarrassment and feeling of disgusting of themselves.⁷

Treatment for OSCC at an advanced stage includes health multidisciplinary care with palliative care, since the patient is without therapeutic possibilities of cure. Meanwhile, it is noteworthy that palliative care is the approach that promotes quality of life of patients and their families on diseases that threaten the continuity of the good life, from prevention and relief of suffering; still requiring early identification of complications of disease progression, assessment and relief of pain and other problems of physical, psychosocial and spiritual nature.⁸

As regards the treatment of wounds, the purpose is always healing. However, treatment in palliative care is aimed at controlling the symptoms of lesions and patient comfort in relation to the wound. In this sense, the planned palliative care can provide relief (partial, full or temporary) without expected cure for healing. Thus, the guiding principle of palliation for wounds is related to the control of signs and symptoms that present injury.⁹

In this context, the patient with OSCC is a challenge for nurses, as these professionals are part of the multi-professional palliative care team and are responsible for the evaluation and treatment of malignant lesions, with the completion of healing. In this sense, the nurse needs to develop skills and abilities to identify, assess and treat these lesions, providing comprehensive patient care. Thus, the aim of this study is to report the palliative nursing care of patients with squamous cell carcinoma of the oral cavity.

The proposed study may contribute to a skilled nursing care and provide dissemination of knowledge for the scientific and healthcare community about the practice in the area of palliative care in neoplastic wounds, in order to strengthen the teaching and practice of nursing.

METHOD

This is a case study, conducted during the period from February to March 2014, from admission of the patient in a medical oncology unit of a specialized hospital, located in Campina Grande - PB, until his death.

This study is part of a larger project entitled "The pain perception in patients with neoplastic wounds", whose approval was issued by the Research Ethics Committee of the University Hospital Alcides Carneiro, of the Federal University of Campina Grande (UFCG) - PB, under CAAE 13341413.0.0000.5182. It is noteworthy that the rules of Resolution 466/2012, which guides research involving human beings was respected.

For data collection a script for the anamnesis and physical examination was used. Data analysis was based on the literature relevant to the type of cancer - OSCC - and the evaluation and treatment of tumor wounds provisions of the National Cancer Institute Protocol.

RESULT

◆ Case report

M.I.B.D, 40 years old, female, Caucasian, Brazilian, illiterate, single, Catholic, retired, with a daughter, coming from Picuí - PB. She lived with her daughter and partner in their own masonry home, showing income of a minimum wage. She had medical diagnosis of Systemic Lupus Erythematosus with 37 years old and reported smoking status since she was 14 years old. She reported the appearance of a small pleomorphic lesion in lower lip in December 2012 and did not seek medical help, believing to be 'thrush' or Ocra injury. Six months later, the lesion progressed, extending across the lower lip, causing severe pain, exudate in small quantities and fetid odor, reasons that led to hospitalization.

The first contact with that patient occurred in the institution in June 2013, when she was admitted for diagnostic investigation and treatment of the disease, with an installed ulcerated wound. On that date, the lesion was 5.8 cm long and 2.2 cm (Figure 1), bed of predominantly yellow wound, with vegetating aspect, slightly crumbly, exuding small

amount and odor¹. The patient reported moderate and persistent pain, confirmed by use of the Numerical Pain Scale, whose score verbalized by the patient was 7 (Septe). The biopsy was held by fine needle injury and histopathological report presented conclusive for Squamous Cell Carcinoma, indicating chemo and radiation. However, the patient refused to undergo treatment, as reported that the hospital was one of the impediments to smoking.

After eight months after the discovery of the squamous cell carcinoma, the patient was readmitted to the same institution, in February 2014, with extensive wound (Figures 2 and 3), reaching lip, floor of the mouth, jaw and jaw rights, with signs of infection and presence of myiasis, with invasion across cavity lesion. Drug prescription of the patient consisted of Ranitidine, B complex associated with Vitamin C, dipyrone, Tramal, Tilatil, Diazepam and Amitriptyline.

As the availability of drugs and antiseptic solutions in the institution, the research site, recommended to clean the oral cavity with a topical solution of benzydamine hydrochloride before manual extraction of the larvae, Tyrothricin solution associated with Quinosol (Malvatricin) every day for oral hygiene, oral Ivermectin for the control of parasitic infestation, fentanyl or morphine for pain relief and compresses and/or gauze soaked chamomile tea, and primary cover of the oral cavity.

◆ Physical exam

The patient evolved with impaired general condition, with marked weight loss, conscious, oriented in time and space, worried by the pain and the presence of larvae in the lesion, ambulating, poor oral hygiene and body, impaired sleep and rest, emaciated, pale mucous membranes, cyanosis, anicteric, hard oral communication, with extensive lesion on the face, affecting lips (upper and lower), jaw. SR: eupneic, bilateral chest expansion preserved, decreased vesicular murmurs, absent breath sounds. SCV: regular heart rate in 2 times normal heart sounds without murmurs. SGI: Abdomen flat, painless to superficial and deep palpation, decreased bowel sounds in four quadrants, absent bowel movements for six days (SIC). SGU: this diuresis (SIC). The vital signs: HR: 81 bpm; Q: 80 bpm; FR: 17 breaths per minute; T: 38.5 ° C; PA: 112 x 80 mmHg.

After the anamnesis and physical examination, an initial cleaning of the oral cavity was carried out with Tyrothricin associated Quinosol solution (Malvatricin), with the aid of spatulas and gauzes and

evaluation of the lesion, demonstrating: lesion extending from the left cleft lip region until articulation of the mandible and maxilla right (Figure 3) asymmetric measuring 14.5 cm long, 8.5 cm high and 2.3 cm deep with odor grade 3 (odor considered that sense the environment without opening the dressing , strong and nauseating), everted edges and indurated, the wound bed coloring predominantly pale and very friable, with necrosis and fibrin in some spots, bloody

exudate and presence of myiasis. According to the characteristics presented (presence of fetid odor, bleeding, intense local pain, exudate profuse, tunnel)¹², it was classified as malignant lesion staging grade 3 peripheral skin showing hyperemia, edema (Figure 2 and 3) and injuries pleomorphic. Complaining of excruciating pain, confirmed by use of Pain Number Scale¹², with scores indicated by the patient was more than 10 (ten).



Figure 1. OSCC stage III. Campina Grande, PB/June, 2013



Figure 2. OSCC stage IV. Campina Grande, PB/February, 2014



Figure 3. OSCC stage IV. Campina Grande, PB/February, 2014

DISCUSSION

The Squamous cell carcinoma is a malignant neoplasm of aggressive behavior, with early cervical metastasizing whose treatment is complex, multidisciplinary and multimodal character. The clinical aspect of the oral mucosa SCC may present as an exophytic or endophytic or even at an early stage is characterized as a leukoplasic injury, erythroplasic or eritroleukoplasic. Furthermore, there are studies based on evidence confirming that these lesions do not heal spontaneously, have carton base with everted and hardened edges.^{4,6}

The clinical staging system of TNM tumors has been the classification used to characterize tumors, propose the most appropriate therapy and estimate the survival of patients.⁴ However, clinically early tumors, even properly treated, can cause patients to death.⁶ Therefore, the additional tests must be requested and the histopathology of malignant skin lesion can contribute to clarifying the origin of the tumor.¹

Study in Germany¹⁰ emphasized that to proceed with the proper treatment of malignant lesions, it is necessary to conduct thorough and individual assessment of the patient and injury, including: patient data (demographic, diagnosis and comorbidities); size, type and location of the wound (length, depth/height); wound characteristics (humidity, bleeding, secretion, coloring, odor); pain (usually in the lesion during dressing removal); Octros symptoms associated with the wound (like itching); recognition of the autonomy of the patient; goals of wound care (relative to the lesion in relation to quality of life); wound care (cleaning, irrigation, measures to reduce odor, dressing); dressing realization of peculiarities; Patient consent of the photographic record and photo-documentation.

As regards the treatment of wounds tumor, INCA¹¹ protocol recommends the use of some coverage and substances for the purpose of controlling the signs and symptoms. In this context, the substances recommended for the patient are in accordance with the staging of the lesion.

Palliative care recommended for patients were: keep the oral mucosa and lips clean (where possible) and always moisturized; elimination of plates and food debris with the help of gauze and spatulas after every meal; analgesia as needed; where possible, avoid prolonged fasting, acidic foods, provide liquid diet, avoid excess sugar and offer ice cubes and cold drinks in order to stimulate salivation.¹²

The lack of oral hygiene enhances the appearance and maintenance of gram-negative bacteria in the oral cavity, since they proliferate when the microbiota is altered due to the biofilm accumulation and SCC tumor growth.¹³ The oral care then has to reduce that oral colonization, prevent and control infections, and provide comfort.

Thus, oral hygiene is a critical need in the treatment of lesions in the oral cavity. Neoplastic lesions in the oral cavity, in addition to being disfiguring, exudes strong odor resulting from the release of gases putrescine and cadaverine from microorganism metabolism action.^{14,15} In addition, in precarious hygiene conditions, injuries can be sites of attraction and myiasis proliferation.⁵

Myiasis is a parasitic infection caused by dipterous larvae, which feed on dead or living host tissues and fluids. The infection may be primary or secondary, which is caused by necrobiontophagous fly larvae. The most common are *Cochliomya macellaria* and *cuprina Phaenicia*, known as *Lucilia*. The secondary myiasis proliferate in skin tissues, subcutaneous, into cavities and intestines. The most common form propagates in necrotic

lesions cavity, middle ear, nasal ulcerogranulomatous tumors or diseases, tumors oral, anal, vaginal, ophthalmic, as well as skin lesions.^{13,16,17,18}

Oral parasitic larva is a common occurrence in malignant skin wounds such as basal cell and squamous cell carcinomas. This typically occurs in the terminal phase when the patient's general condition is debilitating. Octro factor associated with infestation in malignant wounds is related to the fact that these patients are often victims of social isolation due to the foul odor produced by wounds.^{13,16,17,18}

Historically, there are irritating topical substances as chloroform, ether, iodoform or Octros occlusive agents to block larval respiration, causing the larvae migrate to the surface of the lesion in search of oxygen, thus facilitating its extraction.^{17,18} However, this procedure was not used in patient monitoring, since it had restless, uncooperative, complaining of severe pain. Furthermore, the use of these substances are not suitable for use in nasal and oral cavity especially in view of the risk of inhalation.

For quality care, there was cleaning with spatulas involved in gauze soaked in mouthwash Benzidamine hydrochloride 1.5 mg/ml (Flogoral), lasting twenty minutes before manual extraction of the larvae to promote effect local anesthetic. This solution promoted analgesic and anesthetic effect, and refreshing scent, since the mechanical removal of larvae is a procedure painful, uncomfortable and embarrassing for the patient. After the oral hygiene, 75 larval were taken on the first day of treatment from the oral cavity of the patient and after 24 hours, 32 more were extracted totaling 107 larvae, without major problems.

The therapeutic indications of benzydamine (mouthwash) are for the treatment of inflammatory processes, edematous swellings surgical, traumatic or inflammatory, and exert antimicrobial activity.¹⁹ Benzydamine has been tested for the prevention and treatment of mucositis, but the results are not conclusive in clinical trials. These are weak evidence, which require performing more qualified studies.¹⁴

For daily oral hygiene, Mouthwash based on Tyrothricin 0.3 mg / mL associated with Quinosol 10 mg/mL (Malvatricin) was recommended and used by the nursing staff whose shares are antiseptic, antibacterial, antifungal and presents deodorant properties.²⁰

Study of the Malvatricin Mouthwash, found that the Quinosol, this substance in its

composition, presented antimicrobial activity similar to Chlorhexidine against Streptococcus mutans, Lactobacillus spp and on a pool of the oral cavity microorganisms.²⁰

With regard to oral hygiene, 0.12% Chlorhexidine gluconate is a widely used antimicrobial agent in patients who are under palliative care. Studies claim that chlorhexidine, although not prevent the occurrence of mucositis, causing a decrease in the severity of clinical symptoms, in patients using the medication and have lower grades of oral mucositis.¹⁴ As the hospital where the study was conducted did not have Chlorhexidine at the time of nursing consultation, Malvatricin, mouthrinse were recommended used as a second option for daily oral hygiene.

For the control of larvae, it was recommended the use of Ivermectin, antibiotic semisynthetic macrolide isolated from Streptomyces avermitilis, widely used to treat infestations as pediculosis, scabies and myiasis; also used to spontaneous output of the larvae, avoiding the need for extensive mechanical extraction of difficult access holes, which can result in damage and functional limitations to the patient.^{13,16,17,18}

Studies have reported successful treatment with the combination of manual extraction of larvae and Ivermectin. However, the authors recommend that prevention is the best way to combat parasitic infestation through proper oral hygiene/body and health education through specific training to the public and health professionals.^{13,16,17,18}

Prior to first hospitalization, the patient was taking Paracetamol, Tilatil, dipyrone, Tramadol and Amitriptyline for pain relief. However, for increasing the extent of neoplastic lesion, the patient verbalize the pain not yielded with this regimen, careful evaluation being carried out pain through Numerical Pain Scale, whose score obtained was 10 (ten). The patient also complained of insomnia, impaired rest, once considered the unbearable pain. Therefore, it was recommended the suspension of the treatment regimen in use, with the exception of benzodiazepines and antidepressants, and the inclusion of strong opioids such as morphine or Fentanyl, as are drugs recommended by the Brazilian Consensus on Pain Management related to Cancer (2014) to severe pain. Thus, it was prescribed by the treating physician Injectable Fentanyl and suspended the use of Paracetamol, dipyrone and Tramadol. The amitriptyline and diazepam continued on prescription.

In this particular case, the use of fentanyl, diazepam and Amitriptyline for patient assisted in relieving pain and promoted sleep and rest, which for months were committed.

In addition to assessing the intensity of pain, it is necessary to determine the underlying pathophysiological mechanism (nociceptive or neuropathic), so that the most appropriate treatment options are set. Severe pain uncontrolled becomes a medical emergency and requires prompt medical intervention with implementation of nursing. In addition to the intensity and the pathophysiology of pain, it should also be evaluated the location, frequency, distinguishing characteristics, factors associated with improvement or worsening, experiences as pain consequences, treatment currently used and response to previous treatment.²¹

In case of severe pain (7-10 on a numerical rating scale), strong opioids associated with adjuvants, NSAIDs, and Octras interventions distracting and minimize pain are commonly used. The patient should be evaluated every 30 minutes according to the opioid dose titration protocols.²¹

The US Agency for Medicines (FDA - Food and Drug Administration), through a statement on January 14, 2014, recommended to health professionals that interrupt the prescription and dispensing of medicines containing paracetamol in combination in dose above 325 mg. The National Health Surveillance Agency, recommends that physicians not prescribe drugs containing acetaminophen at doses above 325 mg concomitantly with medications that also present Octros paracetamol in his compositions.²¹

In cases of neuropathic pain, such as the patient monitoring, tricyclic antidepressants and anxiolytics have a fundamental role, and are commonly used. These drugs do not produce pain relief, however many neurotransmitters involved in nociception are affected by tricyclic antidepressants and anxiolytics, blocking the reuptake of serotonin and noradrenaline, which in turn enhance analgesia, increasing plasma levels of the opioid.^{21,22} Therefore, in the case in point, the attending physician has continued the use of amitriptyline and diazepam.

Study of 118 patients with advanced cancer found that concomitant use of opioids, antidepressants and benzodiazepines to control the pain in all patients and was shown to be a safe and low-cost method, may be used in hospital and home environment. In a hospital setting, it was used, and preferably

the intravenous route and at home, we established drugs whose administration is orally.²³

In this perspective, it is urgent to point out that the nursing team should reevaluate patients with cancer pain continuously, be available and accessible to answer calls and answer questions from patients and families. Also they need to develop treatment programs that are simple and easy to follow at home with periodic supervision by the palliative care team.

For lesions in oral cavities, recommended the use of masks by the patient and filling the floor of the mouth with gauze or surgical dressings soaked in chamomile tea, as there are no curative and/or specific coverage to the oral cavity when it presents tissue destruction at great length. It also states the use of mouth washes anesthetic action, analgesic and anti-inflammatory and antimicrobial for the purpose of relieving pain, reducing halitosis and to facilitate swallowing.^{12,18}

Despite the lack of scientific studies proving the effectiveness of chamomile tea use, the oncology treatment units have observed good results, helping to reduce damage and relief of symptoms of mucositis, which can be associated with anti-inflammatory action substance said.^{14,24,25}

With regard to the feeding pattern, the patient showed considerable degree of malnutrition due to the extensive damage and pain. For these reasons, the following measures were recommended: discuss diet alternatives patient in conjunction with a nutritionist, considering food preferences, in a multidisciplinary perspective; perform anthropometric measurements daily, to estimate weight loss; provide pleasant surroundings for food; fractionate the pasty and liquid diet; provide adequate relief of pain and odor before meals and stimulate fluid intake.

Caring for patients with squamous cell carcinoma of head and neck, and especially in oral region presenting extensive injury and without therapeutic possibilities of cure becomes a challenge for nurses, requiring scientific, technical and awareness before the clinical manifestations and needs of oral hygiene of the patient. In this sense, palliative care is a therapeutic modality best suited to these situations, as they promote comfort, improves self-esteem, promotes power minimizing the anorexia-cachexia syndrome, thereby providing better quality of life and appreciation of human dignity until the end of time.

In palliative care, the mouth (which is gradually losing its chewing and swallowing functions) should not be evaluated only as a cavity, but should be considered for its key role in the expression of feelings, such as laughing, crying and kissing. Without this care, the patient may lose the ability to express feeling unsafe to interact with people. Initially, by impaired verbal communication, which unfortunately will lead to social isolation and suffering.

FINAL REMARKS

Taking care of the wound in the mouth of a patient in palliative care, especially when in terminally process, is a task that involves the patient (when possible), multidisciplinary team and family, which should be counseled about the importance of procedures, not without considering the emotional coping capacity of these for this task.

It is important that nurses value the changes and lesions in the oral cavity of the patient, determining nursing diagnoses (real and potential), planning, executing, evaluating and recording all interventions in medical records. For the implementation of these actions, it is mister availability and dedication of the professional, since this set of actions aimed at relieving discomfort, minimize isolation, maintain the dignity and reinforce this attention as evidence of excellence in palliative care.

In this particular case, the applied palliative care has turned primarily to control pain, beware of injury, maintenance of oral hygiene and participation in food planning of the patient, strong impact of problems in the comfort of terminal patients. Her results may contribute to the improvement of nursing professionals in patient care with advanced malignant neoplastic disease, especially regarding the care of ulcerated wound and the institution's interest in awakening the implementation of protocols that support greater autonomy of nurses in decisions, ensuring professional legal support to meet the needs of patients and families.

Additionally, she can contribute to investments in studies related to the practice of palliative nursing care directed to neoplastic wounds, in order to strengthen the teaching and practice of nursing.

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