

## CASE REPORT

# Psychosocial Palliative Care in ICU for a Metastatic Breast Cancer: A Case Report

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## ABSTRACT

**Introduction:** Palliative care does not always mean an active treatment but maybe in the form of counseling and psychosocial support. We present a case of metastatic breast cancer where the psychosocial principle of palliative care was applied.

**Case History:** A 20-year-old breast cancer patient was treated with surgery, radiotherapy, and chemotherapy before it metastasized to lung and liver. The disease was slowly progressing, and she was deteriorating symptomatically in terms of breathlessness. The father of the patient informed about the marriage of her younger daughter after one week and was not able to take care of the elder daughter (patient). We assured him to help during admission while he may continue his preparations for the marriage. The patient had developed pleural effusion for which she was treated by pulmonologist by tapping the pleural fluid. One day before the marriage of her younger sister, the condition of the patient started deteriorating. On phone consultation and the consent, we shifted the patient in ICU. It was a very difficult decision for a father to take care of both her daughters at the same time. We counseled the father and brother not to worry and assured them all logistic help during the duration of stay in the hospital while he may continue his preparations for the marriage of his younger daughter. The patient expired on the day of marriage, and the father was humbly informed about the bad news. The patient was kept in mortuary. The father approached the hospital authorities after two days to collect the body of his daughter. The father and son were very grateful about the help that they received from the institute, our team of doctors and paramedical staff.

**Conclusion:** In the terminal phase of cancer, we need to approach patients as a family physician rather than treating oncologist.

**Keywords:** Metastatic breast cancer, Palliative care, Psychosocial care.

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## INTRODUCTION

Cancer patients are admitted in the ICU for complications due to cancer or its treatment as well as due to other diseases unrelated to the neoplastic disease. Survival of cancer patients admitted to the ICU is influenced by the physiological disturbances caused by the complications leading to ICU admission.<sup>1</sup>

Psychosocial care is a major part of palliative care, where listening to the patient is the foremost concern. It may give us a lot of clues in the management of the patient. Moral boost to the patient, making him feel that the physician is available at any point in time is an important part of psychosocial care. Regular and positive counseling also has a key role in palliative treatment.

A terminally ill patient is not alone; there is a whole world revolving around him/her, and everyone in their family is affected. They may be affected either in the form of social outcasts in communities where they can't tell about the disease to others, or they may have to see their loved ones in pain. It is not always about treating the patient with medicines, but sometimes counseling, compassion, feeling their pain, and helping them to cope up with tough situations is also necessary. Palliative care doesn't always mean an active treatment but maybe in the form of psychosocial support. We present a case of metastatic breast cancer where the application of the psychosocial principle of palliative care was necessary in decision making.

## CASE HISTORY

A 21-year-old unmarried female came to our OPD with chief complaints of a lump in the left breast associated with pain for six months, which was diagnosed as malignant on fine-needle aspiration cytology. The patient underwent right modified radical mastectomy, and the histopathology revealed invasive ductal carcinoma. The case was presented in a tumor board where the management was decided in terms of adjuvant chemotherapy, followed by radiotherapy and hormone therapy.

She received four cycles of adjuvant chemotherapy with adriamycin, cyclophosphamide, followed by four cycles of docetaxel. Thereafter, she was then planned for adjuvant radiotherapy. The radiotherapy dose delivered was 50 Gy in 25 fractions @ 2Gy/fraction to the chest wall

and axilla. Finally, patient was prescribed Tamoxifen 20 mg PO OD for five years. The patient was advised to be on follow up every 2 months.

The patient came in OPD after three years with the PET-CT report of visceral metastasis (Lung and Liver) and multiple vertebral metastases (D8-D11 along with the collapse of D9). The father was explained the poor prognosis. The patient received palliative radiotherapy to the involved vertebra (30 Gy in 10 fractions @ 3 Gy/fraction). Thereafter, the patient was started on 2<sup>nd</sup> line of hormonal therapy (Anastrozole 1mg OD) and Zoledronic acid 4 mg monthly. The disease was progressing slowly during treatment.

After a few months, she developed complaints of breathlessness. Poor prognosis was explained to her father and brother. During the consultation in OPD, her father revealed his personal commitment regarding the marriage of his younger daughter after one week. The dilemma of the father was how to take care of the elder daughter in the hospital and at the same time, how to make preparations of marriage of his younger daughter. We, being professionals, had to step down to think as their family physicians. We counseled the father and brother not to worry and assured them all logistic help during the duration of stay in the hospital while he may continue his preparations for the marriage of his younger daughter.

The patient, during her admission, developed pleural effusion for which she was consulted with a pulmonologist, and the pleural fluid was tapped. The decision was made in consultation with her father. Three days before the marriage of the younger daughter, we took full responsibility for the patient and relieved her father for final preparations of the marriage. One day before marriage, the condition of the patient started deteriorating. On phone consultation and consent, we shifted the patient in the intensive care unit (ICU). At this point of time, it was very difficult for the father to decide whether to attend the elder daughter in the hospital struggling in her last breaths or perform marriage formalities of his younger daughter, who would be starting a new phase of her life.

Our team of doctors volunteered to take charge of this difficult situation. We assured the family of going ahead with the marriage preparations of their younger daughter while we would be taking care of their elder daughter (patient). The patient expired on the day of marriage, and the father was humbly informed about the bad news. The patient was kept in a mortuary. The father approached the hospital authorities after two days to collect the body of his daughter. The father and son were very grateful for the help that they received from the institute, our team of doctors and paramedical staff.

## DISCUSSION

Admitting cancer patients into an ICU needs a discussion between the intensivist and the oncologist regarding the therapeutic options available and the prognosis of the disease.<sup>2</sup> In a study by Destrebecq *et al.*<sup>2</sup> describes that independent predictors of death during hospitalization were related to the acute complications (SOFA score and cardiovascular-related admission) while cancer parameters retained their prognostic significance for survival after hospital discharge (metastatic disease, therapeutic limitations). In our case, the patient was though mainly admitted for acute pulmonary complications (pleural effusion) but was retained in the ICU for psychosocial care. Our patient did not have cardiovascular complications which were prevalent in this study due to the cardiotoxic effect of some drugs like anthracyclines derivatives and trastuzumab.

In a study by Headley *et al.*,<sup>3</sup> which was dealing only with breast cancer patients, found out that the main causes of admission in the ICU were a respiratory failure (29%), pericardial effusion (6%), and arrhythmias (6%). It stated that when aggressive therapies seem futile, then supportive and palliative care should be offered. Thus, unnecessary ICU admissions that prolong distress to the patient and increase distress for the family members can be avoided. In our case, ICU admission was due to contrary reasons. The patient was admitted in ICU to relieve her of distress from for acute complications of respiratory failure (pleural effusion). Further, the admission was prolonged to take care of their personal commitments, which may otherwise have caused them inconvenience or distress during preparations of marriage of their younger daughter.

Tarek *et al.*<sup>4</sup> tried to find out the importance and use of chemotherapy in the last month of life (CLML) of cancer patients. An aggressive approach stated that over-treatments remain frequent despite the current recommendations to limit CLML as it seems to cause more harm than benefits even in palliative settings. In our case, we opted for supportive and psychosocial palliative care during the last month of the patient. It is fundamental that recommendations for CLML can be tailored according to each patient in this era of personalized medicine.

Ostermann *et al.*,<sup>5</sup> study on breast cancer patients found 31.6% of ICU mortality. In this study, the decisions to withhold or withdraw life support were made collectively when all the participants were convinced that maintenance or increase of life-sustaining therapies was futile. It was seen that a high rate of mortality does not favor ICU admissions since the prognosis is poor with no benefit in survival. In the present case report,

the patient had a poor prognosis and the futility of ICU admission was also discussed with them. When the patient's condition deteriorated, she had to be shifted to the ICU in view of psychosocial support to the family, regarding the marriage of younger sister the next day, on the request of the father.

There may be several challenging issues during the decision making of the critically ill cancer patient in ICU, which may be unique to the patient. This may require not only professional expertise along with the other medical team members but also the application of the practice of psychosocial principles in palliative care.

## **CONCLUSION**

In the terminal phase of cancer, we need to approach patients as family physicians rather than treating oncologist.

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