

# **ELNEC-For Veterans**

END-OF-LIFE NURSING EDUCATION  
CONSORTIUM

## **Palliative Care For Veterans**

### **Module 3**

# **Symptom Management**

## **CASE STUDIES**

## **Module 3: Symptom Management Case Studies**

### **Module 3 Case Study #1 Ms. Smith: Anorexia/Depression/Anxiety**

Ms. Smith is an 85-year-old, World War II Veteran with end-stage cardiac disease in a home hospice program. She has been very comfortable, not experiencing any other symptoms, and has been quite functional until the last two weeks. Her family contacts the home hospice nurse concerning her lack of appetite, “continual sadness,” and anxiety which they feel is affecting her ability to function.

During a routine home visit by the hospice nurse, Ms. Smith relates she has no appetite and is quite comfortable just having occasional "snacks" when she pleases. However, her family remains adamant that she require better nutrition and they request an IV be inserted. In addition, the family believes Ms. Smith is depressed and “too antsy,” and these symptoms contribute to her lack of appetite. Ms. Smith states that she has had trouble with depression for many years, but has always tried to find “the brighter side” to fight off the sadness. She also acknowledges that she becomes anxious when her children come to visit, as they “don’t want to admit I am dying,” she says. She reports that she does not always sleep well at night, because she is afraid to die and leave her family behind. She says, “I wish I had raised my children better. If I had, there might not be all of this fighting going on about my care. I wish they would leave me alone so I can die the way I want to.”

#### Discussion Questions:

1. How might the hospice nurse incorporate interdisciplinary care for this Veteran?
2. What additional assessments would be needed?
3. What interventions might be considered?

**Module 3**  
**Case Study #2**  
**Joe: PTSD and End-of-Life Issues**

Joe is 42-years old and served in the first Gulf War in 1991. Eighteen months ago, he was diagnosed with metastatic malignant melanoma. Despite aggressive treatment, he has wide-spread metastasis and he is now being seen by the palliative care team. Joe has lived in and out of a homeless shelter for the past eight years. His wife was killed in a car accident ten years ago and he has no children. He states he is estranged from his only sibling, a brother, and does not wish to contact him. Both of his parents are deceased.

Joe does not understand why he needs the palliative care team to see him. “I’m just going to let nature take its course and I refuse to get any more chemotherapy.” He states he made it clear to his oncologist that he does not want any “heroics” done. “I want to just die and get out of my misery.” Joe states that he has not had any peace since he went to Iraq back in 1991. He witnessed many atrocities, including the death of six of his comrades in Iraq. When his wife died, “that was it!” “I have tried to get help, but the process and filling out all of the papers takes too much energy.” He states he has not had a peaceful sleep in over 18 years. He says he has nightmares every night and relives much of what he witnessed in Iraq.

Joe has agreed to come to his oncologists' office to meet with the palliative care nurse and talk about "next steps." Because of his need for supplemental oxygen, the case manager has been working to get him into some type of stable environment (half-way house, hospice, etc). You are the palliative care nurse coming to see Joe for the first time. Upon greeting him and introducing yourself, he states that he is exhausted, anxious, nervous, and is concerned about where he will die (since he lives in a homeless shelter). He states he has a pain score of “8” due to pain “all over” and remarks that his breathing is becoming more difficult without his oxygen. Finally, he shares with you that he has always considered himself an atheist, but now is wondering if there are spiritual needs that he might have. He says that he has begun praying for himself over the past 1-2 weeks.

Discussion Questions:

1. Where would you begin with this Veteran?
2. What are Joe’s primary physical needs? How could the palliative care team address these?
3. How would you assess not only his physical needs, but also his psychological, social, and spiritual needs? How could the palliative care team address these?
4. What other members of the interdisciplinary team need to be consulted with?
5. Where would you send Joe after his hospitalization, since he has no permanent home?
6. What modifications might you need to make the plan of care because of Joe’s PTSD?

**Module 3**  
**Case Study #3**  
**Mr. J: Constipation/Depression/Confusion**

Mr. J. is an active 71-year old Hispanic Veteran whose home health nurse calls you to tell you about his symptoms, which includes increase in lethargy, constipation and questionable altered mental status. The Veteran is known to have widely metastatic prostate cancer, including bone metastasis. A recent MRI of his brain was positive for metastatic disease. He is very proud of his military service, but is a private man. His wife says that he doesn't always listen to what the doctor tells him.

As the nurse in the medical oncology clinic, you have cared for this Veteran and family for several months. He has been on long-acting morphine at 200-mg q 12 hours po with morphine sulfate immediate release tablets 30mg to be taken q 2-3 hours po prn for pain. His pain has been well managed on this regimen for the last month. He has been on an effective bowel regimen until the last week. You, the oncology nurse, instruct the home care nurse to have the patient come to the clinic.

Discussion Questions: Part 1:

1. Discuss the physical assessment that would be conducted on Mr. J.
2. What laboratory or radiographic studies might be ordered? Why?
3. Discuss the differential diagnosis for these complaints and how might these be managed?
4. What education would you provide to the patient/family?
5. Describe the strategies you would review with the home care nurse in promoting a comprehensive plan of care for this Veteran.

Case continued:

Mr. J's wife is concerned about his mental status. She states he has become very withdrawn and has refused to see any family or friends. He stays in bed most of the day with the curtains closed. His appetite is poor. He becomes confused and agitated at times. "My husband's brother committed suicide three years ago and I am afraid my husband may do the same thing."

Discussion Questions: Part 2:

6. How would you assess depression in a Veteran who is confused?
7. What other members of the interdisciplinary team should be involved with Mr. J?
8. What community services would you suggest for Mrs. J?

**Module 3**  
**Case Study #4**  
**Mrs. Paul: Fatigue/Weight Loss/Nausea/Vomiting/Family Needs**

Mrs. Paul is a 48-year old Veteran dying of end-stage liver disease and chronic renal failure. She is fatigued and has experienced significant weight loss, despite significant edema. She was diagnosed with colon cancer three years ago.

Mrs. Paul's family is very upset and wants aggressive interventions done to help improve her appetite, curb her weight loss (she has lost 18 pounds in the last four weeks) and prevent nausea/vomiting. Her physician believes that one of the contributing factors to her fatigue is that her hemoglobin and hematocrit are very low. So she has received four units of packed red blood cells over the past two weeks. The patient states that the fatigue continues, despite the blood transfusions. She has intractable nausea/vomiting and, as a result, she is frequently admitted to the hospital. As the advanced practice nurse (APN) on the medicine unit, you are consulted to address these frequent hospitalizations. As you assess these admissions, you learn that the staff is very upset when caring for this family. Neither the primary physician or oncologist have taken an active role in discussing palliative care with the patient or the family. One of the staff nurses confided in you that "this family and patient deserve better—someone needs to be truthful with them so they know that their loved one is dying."

Discussion Questions: Part 1:

1. Discuss your evaluation process in this case (fatigue, weight loss, nausea, vomiting).
2. Based on your assessments, identify what management strategies you would use. What issues would you want to discuss with the interdisciplinary team?
3. Considering Mrs. Paul's and her family's needs and concerns, what strategies and interventions might you consider in her plan of care?
4. How would you approach the physician about entertaining the possibility of palliative care for this patient and her family?

Case continued:

Mrs. Paul has four children (ages 15, 17, 21, 25). You happen to have a conversation with the two youngest children, as they have come to the hospital after school to visit their mother. Their mother has gone to radiology for a CT-scan and you decide that this would be a good time to talk with the children. The youngest confides in you that she knows her mother is dying. "I saw her vomit blood before we brought her into the hospital." "We used to put puzzles together, but she is too tired to do that anymore." "Is my mother going to die?"

Discussion Questions: Part 2:

5. How would you respond to the 15-year-old daughter?
6. What other members of the interdisciplinary team would you want to contact to assist with this family?

**Module 3**  
**Case Study #5**  
**Mr. Hayes: Diarrhea/Agitation/Anxiety**

Mr. Hayes is a 58-year-old Vietnam Veteran with widely metastatic colon cancer, which has spread throughout his abdomen. He arrives on your palliative care unit with a chief complaint of intractable nausea and vomiting for 24 hours and diarrhea (1000 cc emesis and 400 cc diarrhea in the past 24 hours). He describes that he is barely capable of managing any activities of daily living. Mr. Hayes has been found to have a non-resectable partial small bowel obstruction. The Veteran asks, "How much longer do I have?" and "Can we speed this up?" "I don't want my children (ages 11 & 13) to see me like this." The Veteran admits to feeling down but denies any suicidal ideation. He is clearly anxious about becoming a burden to his family and wonders how his children see him. His 13 year-old daughter confides in you that she is "afraid" her daddy is going to die. He is a devout Catholic and mentions to the night shift nurse that he is certain his symptoms and suffering are a punishment for his having a divorce ten years ago. He says to the nurse that he just wants to be left alone and does not want anyone to bother him tonight. He also confides in you that he was treated for post-traumatic stress disorder (PTSD) when he returned home from Vietnam.

Discussion Questions:

1. What additional assessment should be done?
2. Is additional suicide assessment indicated?
3. How might various disciplines contribute to his care?
4. How would you answer the daughter who says she is afraid her "Daddy is going to die?"
5. What community resources are available to assist Mr. Hayes and his children?
6. What role might his religion play in his illness?

Case continued:

Two days later he becomes confused, agitated and anxious. Upon doing a physical assessment of Mr. Hayes, his nurse sees that a decubitus ulcer had started on his COCCYX. So the nurse obtains an air mattress and tells Mr. Hayes she's blowing it up." This set Mr. Hayes off into an aggressive agitated state.

Discussion Question: Part 2:

7. What could have set this Veteran off?
8. What other words/phrases do you use that could cause similar reaction?

**Module 3**  
**Case Study #6**

**Ms. King: Dyspnea/Nausea/Vomiting/Anxiety/Agitation/Delirium/Staff Issues**

Ms. King is a 32-year old single Caucasian woman who is actively dying of AIDS (has Kaposi sarcoma, as well as central nervous system lymphoma) on the VA medicine unit. She has lived in a nursing home for the past 18 months and has no immediate family. When her symptoms became more pronounced and her pulse oximeter read 76% on room air, the nursing home sent her to the hospital to be admitted two days ago. She is dyspneic and has reduced breath sounds bilaterally. For the past three days she has had a productive cough and becomes extremely dyspneic when coughing (chest x-ray revealed pneumonia) and also begins to vomit. She is anxious and becomes agitated easily. Generally, she is confused and becomes delirious, mostly at night. “If I go to sleep, I know I will never wake-up,” she told the nurse last night. She is not oriented to time, place or person. She has not slept for three days/nights. She also has nausea and vomiting (3-4 times/day—total emesis over the past 24 hours = 650 cc). She denies the presence of pain.

The staff on this unit is young, for the most part, and has an average of one year of nursing experience. Most of the nurses have not cared for people with AIDS. Some are fearful, others are judgmental. Some staff members have significant anticipatory grief reactions and have difficulty caring for Ms. King. A do-not-resuscitate order (DNR) is in place and the orders revolve around “comfort care.”

As the nurse on this medical unit, you decide that some additional education is needed for the staff. You will provide general AIDS education and then help them to develop a palliative care plan around the dyspnea, nausea/vomiting, cough, anxiety, agitation, and delirium.

Discussion Questions:

As the nurse developing this education for your staff:

1. What drug treatments would you want to share with the staff in regards to the symptoms listed above?
2. What non-drug treatments would you want to review?
3. Discuss your plan to address the staff’s discomfort in providing care to Ms. King.
4. Detail educational opportunities for the staff to improve the care provided to Ms. King.

**Module 3**  
**Case Study #7**  
**Mr. C: Dyspnea/Fatigue**

Mr. C. is a 75-year-old African American man with end-stage cardiac disease and long standing congestive heart failure including pulmonary edema. He experienced his first myocardial infarction at 45 years of age, had a quadruple bypass procedure at 58, and repair of an abdominal aortic aneurysm at 62. He has been retired for 15 years after working as an engineer. He lives at home with his wife, who is a cancer survivor. He has led a very active life, even after retirement, but in the past few months has experienced severe fatigue that leaves him unable to participate in or enjoy previous activities. He often says, “I feel as if I have no ambition,” and “I can’t do anything anymore. I am worthless.” In the past few weeks, Mr. C. has been experiencing shortness of breath, initially relieved with oxygen. Unfortunately, the dyspnea has progressed during the past week and he has developed a dry cough. He has no advance directive.

Discussion Questions:

1. What interventions might you consider?
2. What patient/family teaching is essential?
3. What cultural considerations might be assessed and addressed?
4. What long-term planning should be considered? Discuss how to approach the patient’s physician who is opposed to hospice.

**Module 3**  
**Case Study #8**  
**Mrs. H: Anxiety/Depression/Delirium/Constipation/Pain**

Mrs. H., a 55-year-old divorced Hispanic woman with stage IV breast cancer, is admitted to the ED suffering from confusion, pain, anxiety, agitation and constipation (states she has not had a bowel movement in six days). In obvious distress, she is crying, moaning, and attempting to get out of bed. Her sister reports that she first noticed that Mrs. H. was more anxious than usual approximately 12 hours earlier. Assessment reveals Mrs. H. to be mildly dehydrated, as demonstrated by poor skin turgor and a heart rate of 110. An IV is started, and she receives hydromorphone 1 mg IV push to control her pain and lorazepam 0.5 mg IV to reduce her agitation. Her laboratory values are normal, as is her oxygenation level (O<sub>2</sub> sat is 93% on room air). She becomes less agitated and is transferred to the oncology unit. Mrs. H. has had several prior admissions for treatment of bone pain, primarily in several ribs on the lower left thorax and the right femur. During her last stay, Mrs. H. described right upper quadrant pain and was found to have liver metastases. She was placed on an analgesic regimen of long-acting morphine 60 mg every 12 hours, with immediate-release morphine 20 mg for breakthrough pain as needed. Until a few days ago, she required only two or three doses of breakthrough pain medication daily. But her pain recently intensified, and she has needed as many as six to eight doses of immediate-release morphine daily. She contacted her oncologist, and dexamethasone 4 mg PO BID was started two days ago. The nursing staff is surprised to see Mrs. H. so agitated. During past admissions, she appeared sad and somewhat withdrawn, although she consistently denied being depressed. Her sister and two teenage daughters have offered considerable support, visiting often during each of her previous hospitalizations. At the bedside now, they are tearful at witnessing their mother's confusion about where she is and why she's in bed.

Discussion Questions:

1. How would you assess each of these symptoms (anxiety, depression, delirium, constipation, pain)?
2. How would you develop a care plan to address each of these symptoms?
3. What patient/family teaching is essential?
4. What cultural considerations might be assessed and addressed?
5. What long-term planning should be considered?

**For Additional Supplemental Teaching Materials:**

See AJN article for more complete description of syndromes and interventions:  
Paice, J. (2002). Managing psychological conditions in palliative care. *American Journal of Nursing*, 102(11), 36-42.