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Patient with disseminated renal cell cancer with severe bone and neuropathic pain syndrome and social problems — a case report

Abstract

A 72-years-old woman diagnosed with renal cell carcinoma and metastases to pelvic bones that caused severe bone and neuropathic pain was depicted. Apart from difficulties in pain management social problems connected with the care for a patient's spouse who also needed palliative care due to disseminated prostate cancer and died during the care for the patient were discussed. This patient's case indicates the need for holistic approach to patients in palliative care with the provision of effective symptomatic treatment along with comprehensive psychosocial and spiritual support.

Key words: analgesics, pain, palliative care, treatment

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A 72-years-old lady was diagnosed in 2003 with renal cell carcinoma and subjected to left nephrectomy. After 3 years bone metastases were revealed by scintgraphy and by X-rays in left hip and in the left temporal bone. An osteolytic lesion around the left sacroiliac joint and an osteoporotic compression fracture of L1 were diagnosed. Pain in the left hip caused difficulties in walking (she used a crutch); two courses of palliative radiotherapy to the left hip (20 Gy in July 2006 and 16 Gy in November 2006) were given, apparently with no analgesic effect. There were paresthesias and abnormal sensitivity presented in the left leg.

She was admitted to our Palliative Care Department — Home Hospice on the 9th November 2006 with pain (NRS at rest 1–3, on a movement 8–10), weakness, fatigue and depressive mood. Physical examination did not show any significant abnormalities. Her medication was regular morphine controlled release 10 mg b.i.d., morphine immediate release 5–10 mg p.r.n., ketoprofen controlled release 1 × 200 mg, gabapentin 100 mg t.i.d., mianserin 10 mg b.i.d., omeprazole 1 × 20 mg, metoclopramide 3 × 10 mg, lactulose 3 × 15 ml and bisacodyl 5 mg tablet in case lack of bowel movement for 2 days. Additionally 90 mg pamidronate was prescribed, administered at home in 2 h *i.v.* infusion in 500 ml 0.9% NaCl. Because of drowsiness mianserin was discontinued and lorazepam 1 mg administered in case of anxiety exacerbation. Morphine (30 mg b.i.d.) and gabapentin (300 mg t.i.d.) doses were gradually increased because of pain in December 2006. In January 2007 a decrease in serum calcium level vitamin D_3 and calcium were

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administered. With the third pamidronate administration she felt painful and confused; the next infusions were performed at the out-patient clinic.

In February 2007 she reported pain in all bones and all the body, her psychological stage deteriorated. Regular morphine dose was increased to 40 mg b.i.d. The patient refused psychologist intervention and antidepressants; she continued lorazepam and received support from frequent nurse and physician visits. Because of increase in potassium level (5.6 mmol/l) furosemide 1 × 40 mg was prescribed, with normal serum creatinine level. In March on the lateral ankle of the right leg deep pressure sore appeared, treated with local antiseptic cream subsequently changed to hydrocolloid with hydrogel. She felt better and apart of regular analgesics administration received 10 mg immediate release morphine for breakthrough pain with satisfactory relief. She continued pamidronate infusions at the out-patient clinic. At the end of March she felt an "electric-like shock" sensations in the left leg and stabbing pain but she refused the X-ray to check the disease progression, spine and pelvic bones status. An increase of gabapentin dose to 600 mg t.i.d. resulted in an improvement in pain relief. In April due to increase in potassium level (5.9 mmol/l) furosemide was administered 40 mg b.i.d., again creatinine serum level was normal. The dose was subsequently reduced to 20 mg twice daily due to low blood pressure (80/50); cardiamid-coffein drops (1 ml contains a mixture of nicetamid 100 mg, caffeine 100 mg and strychnine 0.25 mg) were additionally prescribed 20 drops t.i.d. with significant improvement (110/75). A moderate edema of left leg was observed for the next months without signs of thrombophlebitis.

At the end of May due to increase in pain intensity the regular morphine dose was escalated to 2 × 50 mg and diclofenac in gel on the left leg edema was administered. In the mid of June pain was more severe and controlled release morphine dose was increased to 2 × 60 mg, 20 mg p.r.n. Again a gradual increase of gabapentin dose was ordered to 900 mg t.i.d., which resulted in an improvement in pain relief without adverse effects. At this month the stage of a patient's husband deteriorated, which caused her depression; she refused to admit her husband to hospice and the care was continued at home with the support from our team and a career from Polish Red Cross. In September again increase in morphine dose to 2 × 90 mg was necessary due to pain exacerbation. At this time dexamethasone 2 mg was added and a new pressure sore (4th step) appeared on the left right foot treated with hydrocolloid changed to local antiseptic cream. She had more difficulties in moving within the flat; a further deterioration of her husband was observed. At the end of October her husband died peacefully at home, which again deteriorated her mood. In November morphine dose was increased to 2 × 120 mg due to more intense pain, other drugs were not changed. After two weeks from husband death she felt better physically and mentally. In December the morning morphine dose was increased to 180 mg due to pain exacerbation on movement; an evening dose was not changed (120 mg). Legs edema and a pressure sore at the coccygeal region (2 step) appeared the latter treated with local antiseptic cream.

Since the beginning of the New Year she was unable to walk and a necrosis at the right foot pressure sore was observed, which was treated with antiseptic cream — the leg edema decreased. At the beginning of February on the left part of the chest herpetic infection was recognized; the patient recovered after acyclovir administration systematically and locally with zinc. A new deep pressure sore was found at the left shin (4th step), which was protected by hydrocolloid and hydrogel. At the beginning of March she was more depressed and needed care for 24 h a day. Pressure sores at the foot and at the shin started to bleed with exudate; on 20th March she was admitted to the in-patient unit at Palium Hospice after intense bleeding episode, which was stopped by local dressings and then surgical eradication. After three days she lost consciousness and left hemi paresis appeared. The patient recovered after dexamethasone (16 mg) and mannitol (250 ml of 20% solution) *i.v.* administration. Due to poor condition investigations were not performed. She was successfully treated with intravenous morphine infusion (120 mg per day) with clonazepam (2 mg per day), piracetam 1 g t.i.d. and a blood transfusion due to severe anemia.

The patient wished to go home but her sons did not agree as they claimed they were unable to provide continuous care for 24 h a day. Her relationship with sons aged 38 and 45 was difficult. The older son lived with his family and only occasionally visited the patient. The younger son lived with the patient; he was involved in the care but he was often on leave. This was the problem for the patient as she expected that he will spend more time with her. In addition she did not accept his partner. During the stay at the in-patient unit her condition deteriorated significantly with high probability of brain metastases appearance. She died peacefully at the end of June.

Discussion

The patient suffered from severe bone and neuropathic pain syndrome connected with the dissemination to pelvic bones and probably nerves involvement. Pain was exacerbated on movement and treatment (radiotherapy, opioids, NSAIDs, corticosteroids, anticonvulsants, bisphosphonates) was partially successful as the patient for most of the time used rescue morphine doses (on average 1–2 daily) [1, 2]. This problem resolved at the in-patient unit when the patient became non-ambulant. She refused to perform any investigations that could elucidate the exact cause of pain. In addition her mental state was fluctuating with episodes of depressive mood caused by the social situation and progression of the disease [3]. The patient also refused antidepressants and psychologist intervention but occasionally used lorazepam. With time pressure sores were one of main problems and the bleeding episode was the reason for admission to the in-patient unit [4].

A significant problem of this patient was her mental state and social situation. Her husband was diagnosed with a prostate cancer. Ten years ago he had an insult but he recovered fully and care for himself. Within long period of care for the lady he deteriorated after fell and broke left forearm. Then he demanded palliative care, which was provided also for him. He died quickly at home but this event was harmful for our patient — she was more depressed and her mental status deteriorated as was the case of her physical condition [5]. This patient case showed the need for close cooperation within the team especially between physician and nurse who played the most prominent role in the care for this patient as she refused the psychological assistance. It was also difficult to care for the patient especially after the spouse death.

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