CASE STUDY

James is a 69 year old man with metastatic carcinoma of the prostate. This case study highlights two of his admissions within the last year of his life and how physiotherapy and occupational therapy made a difference.

1st Admission (31 January 2011)

Medical issues
Suprapubic catheter, permanent R nephrostomy, moderate Lumbo-sacral Plexopathy, R foot drop, moderate pain in leg, small lung metastases, reduced anal sphincter tone (rectum filled with soft faeces, constant ooze). James’ leg pain responded well to medication, however, faecal incontinence was a major factor affecting discharge. A paraplegic spinal bowel regime was implemented but incontinence persisted.

Allied health identified issues
James was independent in all transfers and mobilising with SPS. He occasionally used a 4 wheel walker (4WW) when tired. Two major issues impacting function were a complete right foot drop and impaired sensation around the buttocks that made it difficult for James sit symmetrically and safely in a chair.

James’ goals
James’ overall goal was to return home again and to “do something useful”, which to him meant returning to the family business and to “get control of my bowels”.

PT and OT interventions
• The PT worked to optimise James’ strength, mobility and safety in mobilising. Interventions also addressed respiratory function (shortness of breath) and energy conservation.
• The OT worked with James’ sitting posture, pressure care management, self-care, his return to work.
• Interventions included:
  o Provision of an Ankle Foot Orthosis (AFO) and 4WW, training in an exercise routine
  o Completion of Occupational Self-Assessment [1] to identify James’ priorities at this time and review of functional status
  o Liaison with James and wife in plans regarding discharge home, to clarify concerns and also possibilities
  o Trial of a ROHO (pressure cushion) to optimise comfort, reduce pressure ulcer risk and obtain symmetrical sitting posture, identification of achievable work tasks.

Research into rehabilitation goals and priorities at the EOL highlights that people want education and practical training in how to manage transfers and mobility within everyday contexts. [2]

Outcomes
• Increased confidence to mobilise (AFO, 4WW & supervision).
• Able to sit symmetrically on ROHO cushion, more comfortable, able to read, work, use laptop for longer.

The main barrier to discharge was continuous faecal incontinence and James was transferred to a private hospital on 17 March 2011 for a relieving colostomy. He was discharged home post-operatively after a successful procedure. He returned to work in his family business post discharge.
Irrespective of functional decline, in fact because of functional decline, PT and OT involvement is vital to maintain the function that remains. It is also essential to plan with the patient and family for potential deterioration. James’ goal of returning home was achieved.

**Third Admission: 5 August 2011**

James had deteriorated, so focus of care was now on comfort and support of James and his family. With a large fungating pelvic tumour and spinal cord compression, James required a hoist for all transfers and wheelchair for all mobility. He was also experiencing significant fatigue, decreased concentration and short term memory loss, however, James still wanted to go home. His mobility was very poor and the PT trialed the overhead tracking machine which allowed him to attempt standing in the safest possible environment. James tried three times to move from sitting to standing and still could not achieve this. James realised then, that he could not go home again. This is consistent with research around the importance of people testing out their bodies to determine what they are able to/not able to do as a vital part of adjusting to functional decline. [3,4]

James still wanted to have an impact on people in his world, to be useful, and of value to society. His legacy was in his family and he continued working until two weeks before his death. His legacy is also, in this case, study. He wanted health clinicians to know how important it was that we help people at the end-of-life keep doing things, that they don’t want to sit and vegetate just because they are receiving palliative care. James died peacefully and comfortably on 28 August 2011.

REFERENCES

4. Morgan DD. The ordinary becomes extraordinary: the occupation of living whilst dying. [PhD thesis]. [Melbourne]: School of Health Sciences, Faculty of Medicine, Dentistry & Health Sciences, The University of Melbourne. 2012.

Authors: Dr Deidre Morgan (OT), Ms Pauline Cerdor (PT).

CareSearch Resources

There are resources within CareSearch that could help allied health professionals in the care and support of James. Some of them have been highlighted here:

- There are Systematic Reviews that include various symptoms, Cancer, Advance Care Planning and Quality of Life. There are PubMed Topic searches, again on various symptoms and on Advance Care Planning and End-of-Life Care.
- In the Allied Health Hub there is information on Helping Maintain Hope, on Adapting Goals, Working with Families and on When a Patient Dies.
- In the Clinical Evidence section there is information on Advance Care Planning, on Patient Management including symptoms (eg, Pain and Fatigue) and Symptom Management at the End of Life.
- In the Nurses Hub there is a page on Managing Fungating Wounds, in the RAC Hub a page on Bowel Management and in Life, Hope and Reality a page called: Experiencing Bowel Problems?
- In the For Patients and Families section there is information on Living with Illness that includes pages on Changes over Time, and Continuing to Work which has been important for James.