Annals of Clinical Case Reports

Case Report
Published: 08 Apr, 2021

Breaking Bad News of Cancer Diagnosis and Its Impact on Health Literacy among Patients Newly Diagnosed with Advanced Cancer, a Case-Based Discussion

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Abstract

Background: The diagnosis of cancer has a daunting impact on healthcare personnel and the patients and their relatives. Depending on the patient reaction and the approach of breaking bad news, the diagnosis of cancer, especially if it is an advanced stage, can lead to physical and psychiatric deterioration.

Case Report: We present a case of a fifty-five year old female diagnosed with advanced-stage adenocarcinoma of the sigmoid colon, the diagnosis results in a negative impact on the patient's behavioral and psychiatric status.

Conclusion: Early referral to palliative care is the most suitable approach for a patient diagnosed with advanced-stage cancer; also, delivering bad news using a patient and family-centered approach is more reliable to minimize the negative psychiatric impact of unpleasant news.

Keywords: Advanced cancer; Palliative care; Patient and family-centered approach

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Received Date: *22 Mar 2021*
Accepted Date: *05 Apr 2021*
Published Date: *08 Apr 2021*

Citation:
Talib SI, Alaziz M, Mustafa K, Vasudev D, Alijandra R, Bilal A, et al. Breaking Bad News of Cancer Diagnosis and Its Impact on Health Literacy among Patients Newly Diagnosed with Advanced Cancer, a Case-Based Discussion. Ann Clin Case Rep. 2021; 6: 1937.

ISSN: 2474-1655

Introduction

Delivering bad news is one of the dreadful challenges to the physicians and can be a source of distress for the patient. Bad news can be defined as a cognitive, behavioral, or emotional deficit in the person receiving the news that persists for some time after the news is delivered. The delivery of bad news is a subjective topic, and it is difficult to anticipate a particular impact on each patient and their families because patients respond differently to bad news; studies showed that patients diagnosed with cancer could react to the bad news with shock, fright, acceptance, sadness, or not worried. Also, the language barrier can result in a misunderstanding and contribute to distress after delivering bad news. Physician training represents a crucial element of breaking bad news, and the lack of proper delivery can negatively impact the patient and their families and the subsequent treatment plans. Despite the enormous amount of information available about breaking bad news, many peer-reviewed published studies showed a lack of adequate training in communicating bad news to the patients and their families. The functional decline at the end of life is significantly different between patients diagnosed with cancer and other advanced organ diseases. Patients diagnosed with terminal stage cancer may experience various physical and psychiatric symptoms that can negatively affect their awareness about the progression of the disease and their prognosis. We reported a case diagnosed with advanced-stage colon cancer at the time of admission to the hospital, which results in a negative impact on patient behavior and perception.

Case Presentation

Fifty-five years old female presented to the emergency room at our hospital with fatigue and weakness. Her vital signs were within the normal limit. Fecal occult blood was positive; hemoglobin level was 6 mg/dl; other complete blood count parameters were normal. Carcinoembryonic antigen was elevated. Further workup revealed metastatic lesions in the liver and lung from adenocarcinoma of the sigmoid colon. Hematology/Oncology specialists were consulted and decided the patient will not benefit from curative therapy as her Karnofsky scale was 30 and advised for palliative care. A long discussion was conducted with the patient about her diagnosis and prognosis, and the patient decided to go for home hospice. The next day, the patient returned to the hospital because she

had a mechanical fall not complicated by injury. The physical exam was normal, and her lab results were not changed compared to the previous results. The patient was admitted for observation. During her stay at the hospital, she inquired about the reason for her fall and asked if it could be related to the side effect of chemotherapy. The patient claimed that she received chemotherapy at our hospital. We had a lengthy discussion with her, and the treating physicians explained that she is not eligible for chemotherapy; however, the patient insisted that she got chemotherapy at our hospital, and she is due for the next cycle of chemotherapy. A psychiatric specialist was consulted and screened her for depression or hallucination, no need for psychiatric intervention as she is not experiencing any psychiatric issues, and her behavior probably due to the denial of her diagnosis. Unfortunately,

The patient died on the same day from cardiac arrest.

Discussion

Advanced cancer patients commonly have misunderstandings about the intentions of treatment and their overall prognosis. Several studies have shown that large numbers of patients receiving palliative care hold unrealistic hopes of their cancer being cured by such therapies. This review aimed to explore the factors associated with patients developing unrealistic expectations; the implications of having unrealistic hopes and the effects of raising patients' awareness about prognosis, and patients' and caregivers' perspectives on disclosure and their preferences for communication styles. This could be due to doctors' reluctance to disclose terminal prognosis or using facts and logic to distance themselves from the patient, and the patient's ability to process or accept such information [1-10]. The major factors have profound effects on patients' comprehension of the presented information including Patients' barriers and communication style [11-14]. Barriers were classified into four subgroups: structural and physical (inadequate access to care and public transportation), supportive (lack of support, resources and technology, and less access to healthcare), or culture barriers (language differences, illness beliefs, and low levels of cancer care knowledge). The proper approach to communicating the information can clarify the patient's confusion about the diagnosis, treatment plan, or prognosis. The patient and family-centered approach are more reliable to communicate information about patient condition, in this approach, the physician focus on and respect the values and needs of the patient and their support system including cultural, spiritual, and religious belief, besides, inpatient and family-based approach, the patient is involved in the discussion about the goals of care, this is in contrasts with the emotional centered approach in which the physician focus on the sadness of the information by demonstrating excessive sympathy. Early palliative care improves patients' quality of life, less end-of-life treatment, and decreased medical costs; also, early palliative care reduces depressive disorder and improves outcomes in a cancer patient. Early palliative care improves the quality of life of the patient's family and ameliorates end-of-life care aggressiveness. Palliative care, unlike hospice, can be used simultaneously with disease-modifying or curative therapies. This is in contrast to hospice, which is a model of palliative care offered to patients at the end of life when life-prolonging Therapy is no longer indicated.

Conclusion

Earlier referral to hospice for advanced cancer patients is highly recommended because this approach is associated with fewer hospitalizations and visits to emergency departments and lessens the need for invasive, aggressive treatment at the end of life. Although physicians often feel challenged by the need to deliver difficult prognostic information to patients, especially for those with a life-limiting illness, while at the same time support their hopes, the use of patient and their family-centered approach is more reliable to reduce the negative psychiatric impact of the unwanted news, as such approach is more aligned with patient's values and wishes.

References

1. Monden KR, Gentry L, Cox TR. Delivering bad news to patients. Proc (Bayl Univ Med Cent). 2016;29(1):101-2.
2. Back AL, Curtis JR. Communicating bad news. West J Med. 2002;176(3):177-80.
3. Bumb M, Keefe J, Miller L, Overcash J. Breaking Bad News: An evidence-based review of communication models for oncology nurses. Clin J Oncol Nurs. 2017;21(5):573-80.
4. Kyota A, Kanda K. How to come to terms with facing death: A qualitative study examining the experiences of patients with terminal Cancer. BMC Palliat Care. 2019;18(1):33.
5. Lunney JR, Lynn J, Foley DJ, Lipson S, Guralnik JM. Patterns of functional decline at the end of life. JAMA. 2003;289(18):2387-92.
6. Hong CS, Moliterno J. The patient-centered approach: A review of the literature and its application for acoustic neuromas. J Neurol Surg B Skull Base. 2020;81(3):280-6.
7. Bouleuc C, Burnod A, Angellier E, Massiani AM, Robin ML, Copel L, et al. [Early palliative care in oncology]. Bull Cancer. 2019;106(9):796-804.
8. Schlick CJR, Bentrem DJ. Timing of palliative care: When to call for a palliative care consult. J Surg Oncol. 2019;120(1):30-4.
9. Mohr C, Milgrom J, Griffiths M, Nomikoudis K. Breaking the bad news: Dilemmas in shared decision-making in medical practice. Aust Psychol. 1999;34(1):45-8.
10. Armstrong J, Holland J. Surviving the stresses of clinical oncology by improving communication. Oncology (Williston Park). 2004;18(3):363-8.
11. Lee SJ, Back AL, Block SD, Stewart SK. Enhancing physician-patient communication. Hematology Am Soc Hematol Educ Program. 2002;464-83.
12. Prout HC, Barham A, Bongard E, Tudor-Edwards R, Griffiths G, Hamilton W, et al. Patient understanding and acceptability of an early lung cancer diagnosis trial: A qualitative study. Trials. 2018;19(1):419.
13. Byers LA, Rudin CM. Small cell lung cancer: Where do we go from here? Cancer. 2015;121(5):664-72.
14. Martinez-Donate AP, Halverson J, Simon NJ, Strickland JS, Trentham-Dietz A, Smith PD, et al. Identifying health literacy and health system navigation needs among rural cancer patients: Findings from the Rural Oncology Literacy Enhancement Study (ROLES). J Cancer Educ. 2013;28(3):573-81.