THE THERAPEUTIC PROCESS AND CARE PROBLEMS OF A PATIENT WITH ADVANCED VULVAR CANCER

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ABSTRACT

The study analysed the case of a 74-year-old woman with a diagnosis of FIGO IVA vulvar carcinoma. The patient was also suffering from other diseases such as type 2 diabetes, hypertension, obesity, and permanent atrial fibrillation. Among the patient's most significant nursing problems, self-care deficit, impaired mobility, impaired ability to perform hygiene and self-toileting, and lack of knowledge about disease were singled out.

The aim of the work is to present knowledge and explain the subject of the therapeutic process and nursing problems of a patient with advanced vulvar cancer based on an individual case study. ICNP® reference terminology was used to develop care plans.

The midwife's care of a patient with advanced vulvar cancer requires special consideration of education, health promotion, and self-management activities, assisting with hygiene activities, and providing psychological support. The overarching goal in the patient's care is to strive for the highest possible degree of self-care.

Key words: vulvar cancer, vulva, gynaecological oncology.

INTRODUCTION

Tumours of the vulva comprise a statistically small group among all female genital cancers, accounting for 4-5% of them [1, 2]. The incidence of this cancer is usually observed in the age group of postmenopausal women [1-3]. However, observations indicate an increasing incidence of this disease among younger patients [3-5]. The vulvar neoplasm usually develops as a single lesion, but it can also be multifocal and is usually located on the labia majora [2, 6]. A correlation between human papilloma virus (HPV) or herpes virus (HSV) type 2 infection and vulvar cancer has been demonstrated. A history of vulvar lichen sclerosus is also cited as a risk factor [6-8]. Patients with vulvar cancer most commonly report symptoms such as itching and burning of the vulva. Women with advanced vulvar cancer complain of additional complaints such as pain, unpleasant odour, blood-like discharge, or enlarged lymph nodes in the groin area. When the location of the tumour involves the urethral region, there may also be soreness and discomfort when urinating [1, 2, 9]. Whenever vulvar cancer is suspected, it is recommended that a biopsy be taken from the part of the lesion that is of concern [2, 6]. Surgical treatment is the preferred method of treatment, and its extent depends on the stage of the tumour or the presence of metastases [4, 9]. Radiotherapy and chemotherapy for this type of cancer are often complementary treatments [1, 2, 9, 10].

Late diagnosis of vulvar cancer correlated with advanced stage is still a serious problem. This results in an unfavourable prognosis for female patients [1, 11, 12]. The detection of the disease at an early stage and, consequently, the timely commencement of individualised treatment have a positive impact on the therapeutic outcome. Holistic, appropriately planned obstetric care also plays an important role in the course of hospitalisation of a patient with vulvar cancer [1, 13]. Currently, there is no specific secondary prevention for vulvar cancer. Due to the rare occurrence of this cancer and the complexity in its treatment, it should be treated in highly specialised centres [10].

The midwife provides gynaecological care and is part of the multidisciplinary team in the treatment of cancers of the female genital tract. An important element of obstetric care for a patient with advanced vulvar cancer is the provision of support, both to the patient herself and to her immediate environment. The cancer process is associated with pain and discomfort, and the patient's psychological health is affected. The psychological dimension of the illness is also very important [13-17]. Among the psychological disorders in this group of people, depressive disorders predominate, which show a varying form of severity correlating with the degree of the neoplasm. Studies indicate that this complication affects 26-45% of cancer patients [17]. A factor that could improve the quality of care for patients diagnosed with cancer is the routine introduction of a psycho-oncologist into the multidisciplinary team [16].

A report published in 2022 by the Sarcoma Association, which presents the results of a public opinion survey on cancer prevention among Polish women and men, indicates low public awareness of screening and possible cancer prevention. According to the report, 39% of surveyed Poles are not aware of the existence of preventive tests reimbursed by the NFZ, which make it possible to detect cancer at an early stage, and 64% of them declare that they do not participate in cancer detection tests. Early diagnosis of cancer significantly increases the chances of a positive treatment outcome. Many tests targeted at cancer diagnosis can be performed free of charge in Poland [18]. Knowledge is key, and it is important that it comes from a good source. Hence the invaluable role of the interdisciplinary team, including the role of the midwife as an educator and health promoter [1].

The average life expectancy of Polish women is 82 years. Demographic trends are not optimistic, and the ageing of the Polish population is accelerating. According to statistical projections of the Central Statistical Office, in 2050, people over 65 years of age will constitute 33% of the population [19]. Also importantly, this age group is significantly dominated by the female gender. Women over 60 years old are often patients with numerous chronic diseases, and as a result of ageing, their organisms undergo progressive and irreversible changes in their health. The age of older women also correlates with an increased risk of several cancers or gynaecological conditions [20]. These facts lead to the conclusion that it is essential for midwives to be familiar with the physiology and characteristics of old age, because women in this age group make up a large proportion of their patients. Indeed, the midwife cares for the woman in all periods of her life, from birth to old age [13]. The main aim of health education is to increase the awareness of the population and to create good health habits, as a result of which it is possible to reduce the level of anxiety felt by the patient and increase the chance of earlier detection of the disease [13, 14].

The aim of the presented work is to present knowledge and explain the subject of the therapeutic process and care problems of a patient with advanced vulvar cancer based on an individual case study.

MATERIAL AND METHODS

A case study was used in this study, which included a description of the obstetric and clinical condition. The patient gave informed consent to participate in the study, and the management of the institution where the patient was hospitalised agreed to share her medical records, which were used in this study. The study was conducted in accordance with the Declaration of Helsinki and approved by the Institutional Review Board Independent Bioethics Committee for Scientific Research at the Medical University of Gdańsk, Poland (KB/640/2023) for studies involving humans. The research techniques used were interview, observation, and analysis of medical records. A physical examination of the patient was also carried out. Viewing and palpation techniques were used in the aspect of assessing the vulvar lesion. Palpation of the abdomen and lymph nodes was performed. A gynaecological examination of the patient was hampered due to severe pain in the vulvar region. The patient's vital signs were also measured: blood pressure, heart rate, and body temperature. Patient assessment tools from the C-HOBIC system were also used; these are indicators of quality nursing care outcomes, i.e. scales for assessing the functioning, knowledge, and skills of patients. The basic tools of the C-HOBIC system are functional scales, safety scales, clinical symptom assessment scales, and treatment recommendation scales [21, 22]. Due to the need to assess the patient's ability to self-care and her level of performance, taking into account her age and cancer stage, the Activities of Daily Living (ADL) scale was also used. The ADL scale was used as an indicator of a person's functional status for home care (Table 1). This scale allows assessment of the patient's ability to move, eat, control physiological activities, and maintain body hygiene. The Activities of Daily Living (ADL) Basic Assessment Scale was developed by American gerontologist Sidney Katz. Inability to meet basic activities means total dependence and the need for constant care. The scale was assessed with a rating of 0 to 6, where 0 indicated independent and 6 indicated totally dependent. Assessment results using the ADL scale can be transferred to the ICNP system [22]. The Numerical Rating Scale (NRS) was used to monitor pain, with pain severity indi-

Table 1. Assessment of vital signs (ADL) for patients in the home care

C-HOBIC	HOBIC code	Diagnosis according to ICNP
Bed mobility	0	Able to move in bed – [10029240]
Transfer	0	Able to transfer – [10028322]
Walk in the room	2	Impaired walking – [10001046]
Walk in the corridor	4	Impaired mobility – [10001219]
Dressing	0	Able to dress – [10028211]
Eating	0	Able to feed self – [10028253]
Toilet use	3	Impaired self-toileting – [10000994]
Personal hygiene	3	Impaired ability to perform hygiene – [10000987]
Bathing	3	Impaired ability to bathe – [10000956]

cated by numbers 0-10, with 0 indicating no pain and 10 indicating unbearable pain. The patient received a score of 3 on admission due to pain in the vulvar region on the NRS scale. With analgesic treatment, the pain score on the NRS scale decreased to 2 and 1 on the following days of hospitalisation. The diagnosis of malnutrition was made on the basis of the laboratory test (Table 2) and the NRS 2002 scale carried out. A score between 0 and 3 was given for each criterion. Nutritional status was determined by 3 variables: body mass index (BMI), recent weight loss, and food intake in the past week. Disease severity was analysed by assessing increased nutritional requirements due to recent medical history (falls, fractures, surgery, oncology, and intensive care therapy) and coexisting chronic diseases. The patient scored a maximum of 3 points in the nutritional status category due to > 5% weight loss in the last month. In the disease severity category, the patient received 2 points out of a possible 3. The woman received an additional one point due to her age exceeding 70 years. The patient received a total of 6 points. Receiving 3 or more points on the NRS 2002 scale indicates the need for nutritional treatment. The diagnosis of risk of pressure ulcer was made on the basis of the Norton scale; the patient was assessed in 5 categories: physical state, mental state, activity, mobility, and urinary/faecal incontinence. The patient scored 14, which translates into a high risk of pressure ulcer.

The study was conducted in the Gynaecology Unit of a tertiary care hospital in one of the centres in northern Poland. The study was carried out from 31/12/2022 to 16/02/2023. On this basis, care plans were created using a web-based tool available on the International Council of Nurses website – ICNP 2019 Version [23] and the ICNP® dictionary in Polish [24].

Table 2. Laboratory investigations of the patient performed on 31/12/2022

Lab tests	Results	Optimum results
CRP	31.6 mg/l	0-5 mg/l
Albumin	33.5 g/l	35-52 g/l
Total protein	58.9 g/l	66-87 g/l
Iron	11.2 µg/dl	33-193 µg/dl
WBC	10.62 thousand/µl	3.98-10.04 thousand/µl
RBC	3.69 mln/µl	3.9-5.1 mln/µl
Haemoglobin	9.7 g/dl	11.2-15.7 g/dl
Total cholesterol	206 mg/dl	115-190 mg/dl

CASE STUDY

The patient is a 74-year-old woman with no history of pregnancy or childbirth, living with her husband in the city, who described her housing conditions as good. In December 2022 the patient was transferred by the Emergency Care Team to the Operative Gynaecology, Oncology, and Urogynaecology sub-unit due to purulent discharge oozing from a vulvar ulcer and significant weakness and intolerance to exercise, as well as abnormal bleeding from the genital tract. Due to significantly reduced mobility the patient's transport was in a reclining position.

She had a history of chronic diseases: hypertension, persistent atrial fibrillation, type 2 diabetes mellitus, obesity class 2 (BMI = 35.16). During the physical examination, the patient admitted that she had self-resigned from anticoagulant therapy with rivaroxaban without prior consultation with her doctor due to the onset of genital bleeding. The woman reported that perineal pains had been bothering her for several months. Palpation of the abdomen and lymph nodes was performed: abdomen soft, slight pain in the lower abdomen, no pathological resistance, and peritoneal symptoms negative. During the gynaecological examination, an extensive ulceration was found on the right labia minora, covering the entire greater and lesser labia minora and the posterior spiracle, and oozing of a malodorous discharge was observed from the ulceration site. Vital signs were also assessed: blood pressure (BP) 133/100 mmHg, heart rate (HR) 80 beats/min, body temperature 36.7°C. During the interview on admission, information about the patient's social status indicated that she required contact with a social worker. The patient was assessed as calm, demonstrating logical verbal contact, with retained orientation to time, place, and self. A tumour on the vulva causing difficulty in movement and severe pain had caused the patient to significantly reduce interpersonal contact in recent times. During the admission, the patient expressed her fears and anxieties about the disease and its complications and pain. Emotional reaction

to the illness: fear. The patient understood the need for hospitalisation and agreed to the planned treatment. The patient's water balance was assessed, and a balance of fluid intake and excretion was maintained. On the day of admission, the balance was negative: 1200 ml of fluids were admitted, and 2500 ml were excreted. On this basis, dehydration was demonstrated in the patient. Due to reduced protein and albumin levels, the occurrence of water-electrolyte disturbances (negative fluid water balance), and visible oedema, kwashiorkor malnutrition was diagnosed. Oral protein supplementation was ordered. The patient was also diagnosed with iron deficiency anaemia (Table 2) caused by bleeding from the genital tract, and the attending physician recommended that the patient be given 500 mg of iron in saline solution intravenously. Observations by the multidisciplinary team suggested hygienic neglect of the patient. During hospitalisation, an internal medicine consultation was ordered due to weakness and dyspnoea. A return to anticoagulant therapy and exclusion of pulmonary embolism by angio-CT examination was suggested. The examination did not reveal features of pulmonary embolism. A cardiac ECHO and a cardiology consultation were performed, finding no significant abnormalities. The cardiologist advised the patient to take 1 × 20 mg rivaroxaban on a regular basis once haemostasis was achieved. The patient was qualified to have biopsy material taken from the vulvar tumour for histopathological examination. A vulvar biopsy procedure was performed. After 5 days of hospitalisation, the patient was discharged home in good condition and was advised to re-visit the hospital after receiving the result of the vulvar biopsy. The patient was advised to continue at home the pharmacotherapy provided in the hospital: 1 × 40 mg pantoprazole, metoprolol 3 × 50 mg, 3 × 500 mg metformin, and 1 ´ 60 mg gliclazide.

On the basis of the histopathological examination result, the following diagnosis was made: FIGO IVA vulvar carcinoma within the right greater labia minora, right lesser labia minora, and left greater labia minora and enlargement of the right inguinal and right external iliac lymph nodes. In February 2023 the patient was readmitted to the ward for further diagnostic and therapeutic management. Vital parameters on admission: BP 153/117 mmHg, HR 91 beats/min, and body temperature 36.8°C. Result of blood glucose measurement on admission: 268 mg/dl. The patient reported that she was still not following the prescribed anticoagulant therapy. The woman reported complaints of vulvar pain and had limited ability to move independently. Blood glucose measurements indicated ineffective diabetes management, and the patient was unable to provide blood glucose measurements measured at home. Due to the resulting ulceration in the groin on the right side and a significantly increased C-reactive protein (CRP) level (43.8 mg/l), a swab was ordered from this area for microbiological examination, and empirical antibiotic therapy was initiated: 875 mg + 125 mg amoxicillin + clavulanic acid 2 × 1 tablet, with instruction to continue it for a week at home. The patient was informed about the need to receive the results of the microbiological test after discharge from the hospital and to see a doctor for possible modification of the empirical antibiotic therapy. The alginate dressing was applied to the groin wound. A transdermal system buprenorphine patch (Transtec 52.5 mcg/1 h) was applied to the skin to alleviate the pain, with the recommendation that it should also be used at home and replaced every 3 days. The patient was qualified for palliative treatment in the form of radio/chemotherapy and hospice care. Continued pain management was recommended in consultation with the hospice care physician. Results of vital signs measurements at the patient's discharge: blood pressure (BP) 120/80 mmHg, heart rate (HR) 78 beats/min. Glucose measurement result: 124 mg/dl. The following insulin therapy regimen was introduced: with meals 4-8 units of short-acting insulin (Gensulin R 300 u/3 ml) and 6-8 units of intermediate-acting insulin (Gensulin N 300 u/3 ml) once a day before bed to maintain normal glycaemic levels at night. The patient was educated on the need (and how) to self-monitor her blood glucose levels at home. The woman gained the skills to self-measure her blood glucose levels and apply insulin. To maintain normal blood pressure and adequate cardiac function, it was recommended that she continue the medication therapy used in hospital after discharge: 3 × 50 mg metoprolol, 1 × 5 mg perindopril. The patient's attention was drawn to the need to take 1 × 20 mg rivaroxaban on a regular basis due to her persistent atrial fibrillation and increased risk of venous thromboembolism. The patient was asked not to self-administer the recommended pharmacotherapy. After 3 days of hospitalisation, the patient was transported home in a stable condition after receiving instructions for further nutritional and nursing management. The patient was advised to limit physical exertion, use only showers, and wear loose clothing made of natural fabrics. It was recommended that she continue the diabetic diet and watch for worrying symptoms.

INTERPRETATION OF ADL SCALE RESULTS

The ADL scale contains scores (HOBIC code) from 0 to 6, where individual scores had the following rating: 0 – independent, 1 – initial help/direction of change, 2 – requires supervision, 3 – less assistance,

4 – more assistance, 5 – maximum assistance, 6 – totally dependent.

A score of zero on the ADL (independent) scale in the ICNP system indicates the ability to perform the activity. A residual score of 1-6 on the ADL scale in the ICNP system indicates an inability to perform the activity.

The assessment of ADL led to the creation of 5 diagnoses: impaired ability to transfer, impaired mobility, impaired ability to perform hygiene, impaired ability of self-toileting, and impaired ability to bath.

FIVE NURSING DIAGNOSES WERE CREATED BASED ON THE ADL SCALE

Diagnosis 1: Impaired ability to transfer [10001005].
Interventions (IC):
- Arranging transport of device [10030493],
- Assisting [10002850],
- Assessing mobility pattern [10030641],
- Demonstrating falls prevention [10040248],
- Assisting with walking using device [10036520] (+ term from axis M: wheelchair [10021052]).

Outcome: No transfer injury [10033659].

Diagnosis 2: Impaired mobility [10001219].
Interventions (IC):
- Advancing mobility [10036452],
- Assisting [10002850],
- Arranging transport of device [10030493],
- Assessing mobility [10030527].

Outcome: Impaired mobility [10001219].

Diagnosis 3: Impaired ability to perform hygiene [10000987].
Interventions (IC):
- Teaching about hygiene [10044549],
- Promoting hygiene [10032477],
- Assisting with toileting [10023531],
- Skin care [10032757],
- Teaching about vaginal hygiene [10043438],
- Perineal care [10045154].

Outcome: Able to perform hygiene [10028708].

Diagnosis 4: Impaired self-toileting [10000994].
Interventions (IC):
- Promoting hygiene [10032477],
- Assisting with toileting [10023531],
- Maintaining dignity and privacy [10011527].

Outcome: Impaired self-toileting [10000994].

Diagnosis 5: Impaired ability to bathe [10000956].
Interventions (IC):
- Bathing the patient [10045986],
- Promoting hygiene [10032477],
- Maintaining dignity and privacy [10011527].

Outcome: Impaired ability to bathe [10000956].

OTHER DIAGNOSES

Diagnosis 6: Pain [10013950] + L: Vulvar region [10020872] + F: Cancer pain [10003841].
Interventions (IC):
- Assessing control of pain [10002710],
- Monitoring pain [10038929],
- Administering medication [100252544],
- Assessing pain [10026119].

Outcome: Reduced pain [10027917].

Diagnosis 7: Self-care deficit [10023410].
Interventions (IC):
- Reinforcing self-efficacy [10022537],
- Motivating [10012242],
- Assisting with self-care [10035763],
- Assessing degree of independence [10002723].

Outcome: Self-care deficit [10023410].

Diagnosis 8: Lack of knowledge of disease [10021994]/Low self-control [10027469].
Interventions (IC):
- Teaching about disease [10024116],
- Assessing knowledge of disease [10030639],
- Providing instructional material [10024493],
- Assessing readiness to learn [10002781],
- Promoting medication adherence [10038051],
- Assessing attitude toward disease [10024192],
- Teaching about perineal care [10045165],
- Teaching about anticoagulation therapy [10036531].

Outcome: Adequate knowledge [10027112]/ Improved self-control [10035576].

Diagnosis 9: Impaired acceptance of health status [10029480].
Interventions (IC):
- Providing emotional support [10027051],
- Assessing coping [1002723],
- Assessing anxiety [10041745],
- Assessing attitude toward disease [10024192].

Outcome: Acceptance of health status [10023499].

Diagnosis 10: Impaired nutritional status [10025746] + F: Malnutrition [10042077]/ Dehydration [10041882].
Interventions (IC):
- Assessing fluid intake [10044176],
- Managing nutritional status [10036013],
- Managing hydration [10046317],
- Assessing nutritional status [10039660].

Outcome: Positive nutritional status [10025002].

Diagnosis 11: Risk for infection [10015133].
Interventions (IC):
- Monitoring body temperature [10012165],
- Assessing signs and symptoms of infection [10044182],

- Promoting self-management of symptom [10038469],
- Administering medication [10025444].

Outcome: No infection [10028945].

Diagnosis 12: Risk for pressure ulcer [10027337].
Interventions (IC):

- Use supportive positioning [10035467],
- Assessing skin integrity [10033922],
- Pressure ulcer prevention [10040224],
- Assessing risk for pressure ulcer [10030710],
- Teaching about pressure ulcer prevention [10036861].

Outcome: No pressure ulcer [10029065].

Diagnosis 13: Functional dyspnoea [10029414].
Interventions (IC):

- Monitoring psychological status [10012183] (+ Dyspnoea [10006461]/F),
- Monitoring respiratory status [10012196],
- Assessing respiratory status [10036786],
- Positioning patient [10014761].

Outcome: Effective breathing [10041334].

Diagnosis 14: Diabetes [10005876].
Interventions (IC):

- Monitoring blood glucose [10032034],
- Administering insulin [10030417],
- Measuring blood glucose [10041212],
- Managing blood glucose [10046262].

Outcome: Blood glucose within normal limits [10033685].

Diagnosis 15: Obese [10013457].
Interventions (IC):

- Monitoring weight [10032121],
- Teaching about exercise [10040125],
- Teaching about effective weight [10033001],
- Teaching about nutrition [10024618],
- Weighing patient [10033323],
- Providing instructional material [10024493].

Outcome: Obese [10013457].

Diagnosis 16: Impaired cardiovascular system [10022949].
Interventions (IC):

- Diagnostic testing [10031140],
- Monitoring blood pressure [10032052],
- Monitoring cardiac status [10034285],
- Monitoring response to treatment [10032109],
- Promoting self-management of symptom [10038469].

Outcome: Effective cardiovascular status [10033692].

SUMMARY

The presented case of a patient with advanced cancer is that of an elderly woman burdened with numerous comorbidities, including type 2 diabetes, grade 2 obesity, hypertension, and persistent atrial fibrillation. The patient had a significant self-care deficit and a deficit in knowledge of her condition. The patient required comprehensive care from multiple specialists, including holistic obstetric care. Obstetric care in the presented case was focused on measures to make the patient as independent as possible in terms of self-care and self-monitoring. Obstetric care for the patient should include education, increasing awareness of one's own health, assisting with hygiene and nursing activities, and learning to manage one's symptoms. Sixteen care plans were created. Among the nursing diagnoses are those derived from the ADL scale regarding daily functioning, such as impaired ability to perform hygiene and impaired mobility, as well as those resulting from cancer, such as pain, lack of knowledge about disease, and risk for infection. Also included in the nursing diagnoses are the patient's comorbidities – impaired cardiovascular system, diabetes, obesity. The ICNP terminology enabled all nursing interventions implemented to be fully documented.

CONCLUSIONS

When caring for an elderly patient, attention should be paid to any deficits in self-care, and it is worth using activities of daily living scales such as the ADL scale.

The cancer patient requires education about the disease, obstetric care should implement emotional support activities and motivation to continue with the planned treatment process.

The patient's multimorbidity requires collaboration with multiple specialists. Obstetric care taking into account multimorbidity should include educating the patient on self-care and self-monitoring and motivating regular specialist consultations.

Disclosures

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