Nursing Management of a Patient with Ovarian Cancer

Jane A. Student
Pasadena City College
Nursing Management of Patient with Ovarian Cancer

H.S., a 57 year old female with a medical history of hypertension and chronic kidney disease, was diagnosed with a Stage IIIB clear cell carcinoma of the ovary and had surgery in April of 2007. When the patient began to have physical discomfort, an exploratory laparotomy was performed. A pelvic mass had developed post peritoneal chemotherapy. The patient had surgery to remove the intraperitoneal port, pelvic mass fluid drainage and pelvic biopsy. Often patients with cancer develop cachexia and should be assessed for adequate nutritional intake. Martin (2006) states that one of the greatest challenges for a woman with ovarian cancer is malnutrition: she may have little appetite as a result of treatment of advancing disease, causing her to lose weight.

Pathophysiology

The symptoms of ovarian cancer are vague and the causes may be related to several factors. As Bohnenkamp (2007) has explained, one or more risk factors may increase the likelihood of developing ovarian cancer, but their presence does not guarantee the cancer will occur. Martin (2006) claimed that the most significant risk is a positive family history of the disease; it is present in about 10% of women with the disease. Although it is not known if H.S. had a history of ovarian cancer in her family, Ignatavicius (2006) noted that other risk factors include being over the age of 40, family history, diabetes mellitus, null parity, being under 30 years of age at first pregnancy, breast cancer, colorectal cancer, infertility, and BRCA1 or BRCA2 gene mutations. Martin (2006) found that 70% of women with ovarian cancer had symptoms for 3 months or longer before diagnosis; H.S. states her symptoms were present for two years, which is why her ovarian cancer had advanced.
History

H.S., a 57 year old female, has a medical history of hypertension and chronic kidney disease. She was diagnosed with Stage IIIIB clear cell carcinoma of the ovary and had surgery in April of 2007. The patient had 18 cycles of peritoneal and intravenous chemotherapy and had an excellent response with C-125 that reached a low of 10. After completion of chemotherapy, the patient was readmitted 11/15/2007 for removal of a pelvic mass status post peritoneal chemotherapy. The pelvic mass was simple cyst structure with displayed the bladder bilaterally. The patient elected for removal of the peritoneal port and a laparotomy with biopsies to ascertain the nature of the abdominal cyst, which was benign.

Nursing Physical Assessment

H.S. was alert and oriented to person, place and time. The patient’s temperature was 98.0 F, pulse rate was 74, respirations were 18, blood pressure was 126/66, oxygen saturation on room air was 98%, apical pulse was 74, lungs were clear, and the patient stated her pain level was 5. The patient has an IV heplock in her right jugular. The patient’s skin was warm and dry with a moderate bilateral hand grip. The patient’s surgical incision was from the umbilicus to suprapubic with staples and was intact with no erythema. The patient’s bowel sounds were hypoactive and stated no bowel movement today but had passed flatus. The urine output from 0600-0800 was 200ml. The patient was on a liquid diet starting 11/06/2007 and changed to a regular diet on 11/08/2007. The patient ate 70% of her breakfast and stated she did not have much of an appetite. H.S. appeared frail and thin with some general weakness. The patient’s height was 5’7” (1.70m) and her weight was 105 lbs (47.7 kg). The patient was ambulatory and was able to perform independent activities of daily living. The patient used the incentive spirometer ten times an hour as instructed by physician.
Related treatments

The patient has no allergies to latex, iodine, or adhesives and is using an abdominal binder for support. The patient has an IV heplock in her right jugular vein due to chemotherapy. As Ignatavicius (2006) has noted, insertion sites must be chosen carefully after consideration of skin integrity, vein condition, and activities of daily living. Ignatavicius (2006) also has stated that IV therapy involves the entire vascular system or multiple systems. Access to other sites for IV insertion was not available due to damage occurring from chemotherapy. The patient was ambulatory and used the incentive spirometer ten times every hour as ordered by physician. The patient stated her pain level is a 5. According to Ignatavicius (2006), the Numeric Pain Distress Scale of 0-10 has zero to 4 being no pain, 5 to 9 being distressing pain, and 10 being unbearable pain. The patient was taking pain medication of Motrin 600mg as needed. The physician’s discharge orders were to stay on a low cholesterol, low fat diet and no lifting over 15 pounds. Carpenito (2000) has explained that even though some people can ingest food, they may eat an inadequate or imbalanced quality or quantity. For instance, the diet may be insufficient protein or excessive fat content. Ignatavicius (2006) stated that recent testing and management guidelines from the National Cholesterol Education Program (NCEP) have a major preventive focus for individuals with multiple risk factors. The patient’s medications were Ducosate Sodium – 100mg tab to promote bowel movements; VICODIN – 5-500mg every 4 hours for pain as needed.; Metroclopramide – 10mg every 6 hours for nausea and vomiting; and Enoxaparin injection – 40mg – an anticoagulant as a prophylactic to prevent deep vein thrombosis after surgery. Since the patient stated that she was no longer nauseated and her pain level was a five, she chose to not take metoclopramide for nausea or vicodin for pain. Because the patient was up and out of bed
and walked up and down the halls at least three times per shift, there was a decreased chance of deep vein thrombosis.

Nursing Care Plan

H.S.’s nursing diagnosis is nutrition, altered: less than body requirements related to increased caloric requirements and difficulty in ingesting sufficient calories secondary to cancer (Carpenito, 2000). According to Martin (2007), malnutrition is one of the greatest concerns for a patient with ovarian cancer. Fitch (2006) also noted that fatigue and anorexia are not uncommon side effects of both chemotherapy and surgery. Patient’s appearance was frail, with dry skin, and she was underweight for her height. Her height and weight were obtained and compared to the BMI. Patient’s height was 5’7” (1.70m) and her weight was 105lbs (47.7kg). Her BMI was 16.50 and needs to be at least 19 (Christensen & Kockrow, 1999). The short term goal is to assess appetite, dietary patterns, activity levels, and knowledge of nutrition (Carpenito, 2000).

Nursing interventions for the patient include explaining the need for adequate consumption of carbohydrates, fats, protein, vitamins, minerals, and fluids. Determine the patient’s food preferences and arrange to have these foods provided, as appropriate. Give the patient printed materials outlining a nutritious diet that includes a high intake of complex carbohydrates and fiber with a decreased intake of sugar, salt, cholesterol, total fat, and saturated fats (Carpenito, 2000). The patient needs proper caloric intake to reach ideal weight, which is at least 121 lbs. The rationale behind this is that food nutrients provide an energy source, build tissue, and regulate metabolic processes (Carpenito, 2000). Even though the patient stated that she was no longer nauseous, she complained of decreased appetite and was unable to finish her meals. Carpenito (2000) has claimed that an even distribution of the total daily caloric intake throughout the day helps prevent gastric distention, possibly increasing appetite. If unable to
tolerate increased food intake, she should be offered frequent small meals throughout the day, as well as liquid nutritional supplements (Christensen & Kockrow, 1999). The patient was responsive to education regarding nutrition and requested a consultation with a nutritionist on discharge.

Recommendations

The patient should follow up with her physician regarding surgery and post-cancer treatment, as scheduled. The patient should also follow up with a nutritionist regarding her diet to gain weight. Christensen (1999) has claimed that dietary treatment should create both a positive energy and a nitrogen balance in the underweight patient, and advised that high-kilocalorie and high-protein diets can provide this in frequent small-volume meals. Martin (2007) suggested that medications such as oxandrolone or megestrol be given to improve appetite. She also advised supplying small, frequent meals served at room temperature, as well the use of nutritional supplements.

Fitch (2006) has pointed out that nurses can teach patients how to advocate for themselves with their healthcare providers by helping them formulate and write down questions about their treatment to bring to appointments and by encouraging them to bring a supportive person with them to their medical appointments.
References


Note: This paper received 18/20 points. 1 point was deducted for missing key intervention areas and patient data. 1 point was deducted for problems with APA formatting, although these problems have been corrected in this version (so there are no APA errors in this version).