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PALLIATIVE CARE FROM A MOBILE TEAM FOR A PATIENT WITH METASTATIC BREAST CANCER AT HOME: A CLINICAL CASE

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ABSTRACT

Relevance: *Palliative care aims to improve patient care by correctly diagnosing and effectively treating pain and other severe symptoms that worsen the patient's condition. It also includes educating relatives about care and providing psychological and social support to the patient and his/her family.*

The purpose was to *study the role of a mobile team in providing comprehensive palliative care at home to a patient diagnosed with tumor-infiltrative breast cancer with metastatic lesions.*

Methods: *The article presents a clinical case of a patient with tumor-infiltrative breast cancer of stage III B, complicated by metastases to the brain and pelvic bones and bedsores of stage III-IV. The disease progressed despite four cycles of neoadjuvant polychemotherapy and four cycles of targeted therapy. Special attention is paid to the work of the visiting team, which provides comprehensive medical, psychological, and social support to the patient and his/her family at home. The main aspects of palliative care include competent identification and effective management of pain symptoms, care and treatment of bedsores, nasogastric tube feeding, and interaction with family members to reduce emotional stress.*

Results: *Treatment of stage III-IV bedsores gave positive dynamics in the form of transition to the granulation phase after 1.5 months of conservative therapy. Modern wound treatment methods, including antiseptic solutions and antibiotic ointments, helped reduce infectious complications and improve the patient's condition. The work of the mobile team highlighted the importance of an individualized approach that includes both medical and social support within palliative care.*

Conclusions: *Mobile teams providing palliative care at home to severe terminal cancer patients improve their quality of life and satisfaction with the care provided.*

Keywords: *breast cancer, tumor-infiltrative form, palliative care, mobile team, bedsores treatment, metastases, quality of life.*

Introduction: Treatment of patients with metastatic forms of breast cancer at a late stage is a complex task in modern oncology and requires a comprehensive approach, including palliative care. This approach is based on early diagnosis and personalized treatment to improve the quality of life and reduce the symptom burden [1, 2].

The tumor-infiltrative form of breast cancer accompanied by metastatic bone and brain involvement is characterized by rapid progression and severe course, as in the presented case. In cases of significant deterioration of the patient's condition, neoadjuvant polychemotherapy (NAPCT), targeted therapy (TT), and palliative radiotherapy are becoming the standard of care for such forms despite limited resources and high complication rates [3, 4].

Stage III B breast cancer is complicated by brain and pelvic metastases and degree III-IV skin ulcers. This emphasizes the importance of a timely multidisciplinary approach, including the involvement of a mobile palliative care team that provides medical care and psychosocial support to the family [5, 6].

The study aimed to investigate the role of a mobile team providing comprehensive palliative care at home to a patient diagnosed with tumor-infiltrative breast cancer with metastatic lesions.

Materials and methods: This article presents a clinical case of a patient diagnosed with stage III B infiltrative breast cancer complicated by metastases to the brain and pelvis and the development of degree III-IV skin ulcers.

Clinical case:

Patient information: Patient K., 76 years old. Clinical diagnosis: Cancer of the left breast, stage IIIB (T4N1M0). Type I - infiltrative. Status after 4 cycles of NAFT treatment. Accelerated process with brain and pelvic bone involvement with multiple metastases. Status after 4 cycles of NACHT treatment. Right-sided hemiparesis. Skin ulcer of the occipital region, stage III-IV, dry necrosis phase. Additional diagnosis: Arterial hypertension stage 3, risk 4. Coronary heart disease, FC 3. Severe tension angina pectoris. Stage I of chronic heart failure (CHF).

Medical History: The patient has been ill since Spring 2023. Applied to the local polyclinic with complaints of

a thickening in the left breast. 08.06.2023 A targeted ultrasound examination of the left breast at the border of quadrants revealed an irregularly shaped, inhomogeneous structure with a hypoechogenic area of 16×10 mm in size. Conclusion: Dense mass in the left breast (B3-4).

Diagnostics

Histological examination result: No. 21941-42 Infiltrative breast cancer.

IHC study result: No. 1257/23 Morphological picture and immunophenotype are consistent with infiltrative breast cancer, G. II (2+2+3). Her2/neu-positive type. ICD-O code 8500/3.

From 25.08.2023 to 10.11.2023, the patient received 4 inpatient NAFT courses. Manifestations of asthenia and vomiting syndrome accompanied the treatment.

20.12.2023: CT of chest/abdominal/pelvic cavity organs with intravenous contrast agent: CT signs of mass (Cr) in the left breast. Unilateral and bilateral compressed nodules in both lungs and bilateral hydrothorax. Negative dynamics compared to the CT data of 17.07.2023 was manifested by an increase in the mass of the formation.

CT signs: hypodensitis of the liver (mts suspected). Liver cysts, gallbladder obstruction. Cysts of both kidneys and the spleen. Fatty degeneration of the pancreas. Hypodense formations appeared in the liver compared to the CT data of 17.07.2023. CT scan of pelvic organs revealed involutional changes in pelvic organs.

20.12.2023: The result of the echocardiographic study: Echocardiography on the background of arrhythmia. Aortic walls are thickened. The contractility was moderately reduced. No hypokinesia. Small calcificates in the interventricular atrium. Moderate hypertrophy of the left ventricle. Regurgitation in the aortic valve. 20.12.2023 Cardiologist consultation: Diagnosis: Coronary heart disease. Functional class II with increased angina. SNFC II. Arterial hypertension stage 2, risk group 3.

From 04.01.2024 to 17.05.2024: received 4 courses of NACHT treatment. Treatment regimen: Docetaxel 100 mg intravenously, Trastuzumab 324 mg intravenously, Pertuzumab 420 mg intravenously on day 1 of adjuvant therapy.

26.06.2024: CT brain findings: Signs of brain metastases were found in frontal, temporal, occipital, parietal, and cerebellar regions. Left maxillary sinus cysts, subatrophic changes of brain tissue, dyscirculatory encephalopathy.

26.06.2024: CT scan of the chest organs: signs of volumetric mass in the left breast (c-r). Skeletal bone lesions with metastases. Half of the lung nodes are compacted, lymphadenopathy of mediastinal lymph nodes. Acceleration of the process with the appearance of MTS foci.

26.06.2024: CT scan of abdominal cavity organs: signs of liver cysts, gallbladder obstruction. Cysts in the kidneys and spleen. Fatty degeneration of the pancreas. Metastases in the bones of the skeleton.

26.06.2024: CT scan of the pelvic organs: Bladder wall thickening. Metastases to pelvic bones.

From 15.07.2024 to 17.07.2024: Total conformal radiotherapy (3DCRT) with a total focal dose of 9 Gy to the brain areas affected by metastases under the control of an imaging system (IGRT), with comparison of soft tissue and bone structures was performed for palliative purpose. The planned total focal dose was 30 Gy. Due to the deterioration of the patient's condition, the possibility of continuing radiotherapy was discontinued.

29.07.2024: By the decision of the Multidisciplinary Team (MT) No. 9142, due to the acceleration of the process, deterioration of the general condition, pain syndrome, and exacerbation of the tumor toxicity syndrome the patient was assigned to the IV clinical group, and remained under the observation of the visiting team to receive palliative care at home.

31.07.2024: Deadline for applications for assistance to the mobile palliative care team.

Clinical data: 08.01.2024: A physician, nurse, and psychologist initially assessed the patient's condition. The medical examination was conducted in the presence of epy patient's daughter. According to her daughter, the patient complained of anxiety, which was particularly aggravated when the patient changed her body position. The patient's taciturnity did not allow them to localize the painful symptoms. The patient had a nocturnal sleep disturbance not caused by pain. The patient's daughter attributed her mother's deterioration to radiation therapy and reported that her condition had worsened over the past week.

On examination, the patient's condition was extremely severe. The pain score on the PAINAD scale – 3 points.

Neurological status: Level of consciousness – deep shock, unconscious. Meningeal symptoms were negative. Pupil OD=OS, photoreaction was lively. Nystagmus: none. Facial symmetry: Preserved. Right-sided hemiparesis. Numerical cognition could not be assessed. Breathing was even, spontaneous. Auscultation revealed equally diminished breath sounds on both sides. No wheezing was heard. Heart sounds were muffled, and tachycardia was present. Blood pressure: 90/60 mm Hg. Heart rate: 98 beats per minute. Oxygen saturation: 90%. Body temperature: 36.1°C. The patient was motionless and required full assistance. The skin was pale and dry. No shortness of breath or coughing. The tongue was dry and coated with a white film. The swallowing reflex was impaired. Feeding was via a nasogastric tube. The second option was soft and non-tender. No fracture was detected. Urination was through the bladder. The stool was spontaneous and regular. Quality of life on the Karnofsky Performance Scale was 30%.

Local Findings: An ulcer was noted in the inguinal-occipital area, measuring 11.0×8.0 cm. Shape: round. Stage: III-IV. Inflammatory phase with a black scab. The wound edges were red and irregular. A foul odor and abundant

purulent discharge were present. Swelling. Painfullness. The wound bed was not visible.

The patient's daughter was angry, aggressive, and anxious. She answered questions angrily, briefly, and resentfully. According to the daughter, the patient knew the diagnosis but did not want to know the prognosis. The daughter was not willing to accept the severity and course of her mother's illness. She believed that the patient would be able to stand on her feet and walk.The patient's husband was also present during the examination.

Explanations were provided to establish a reliable connection. The assistance and actions of the mobile medical team were fully explained. Medical assistance was provided with the daughter's consent after completing the assessment. The pain level of the non-verbal patient was assessed using a special PAINAD scale.

Treatment:

Medical attention included:

1. IM administration of Analgin 50% (2.0 mL) + Ketatop (2.0 mL) and Dexamethasone (8 mg).

2. Bladder probe care, nasogastric tube care, and feeding skills were taught.

3. Conservative treatment of skin ulcers: washing with 0.05% chlorhexidine solution, 0.9% sodium chloride solution, actinosep, application of Oflomelid ointment and healing dressing, wound closure, and dressing securing.

4. All general and special care measures were performed.

Treatment prescribed: 1. Dexamethasone 4 mg – 1.0 intramuscularly once daily No. 10.

2. For mild pain – Ketop 2.0 + Analgin 50%-2.0 intramuscularly No. 1.

3. For night anxiety - Dimedrol 1% – 1.0 + Analgin 50% – 2.0 intramuscularly No. 1.

4. Consult a specialist in case of no stools for more than 3-4 days.

5. Relatives have been trained in nursing skills.

6. A functional bed, a special mattress to prevent skin ulcers in other areas, an electric medical suction for quality oral hygiene, and an oxygen concentrator to provide oxygen to the body are provided to ensure quality care.

7. A doctor visits depending on the severity of the patient's condition. Daily visits of a nurse or a nurse attendant. Psychologists and social workers' visits depending on the need.

The severity of the patient's condition, combined with her daughter's unstable psycho-emotional state, requires daily observation and comprehensive support. After the assistance was provided, the patient calmed down and foll asleep. The daughter calmed down considerably, though her anxiety and worry persisted.

The nurse conducted follow-up visits. The patient's condition remained extremely serious and required constant medical supervision and full care. The patient's daughter had consistently high levels of anxiety and irritability. She constantly protested and required the nurse to come and provide care before or after lunch, refusing to be present in the morning. In some cases, she completely refused care. The situation remained complex, given the severity of the patient's condition, the presence of extensive, complicated grade III-IV skin ulcers, and her daughter's unstable psycho-emotional state. It required constant monitoring, comprehensive medical care, and ongoing psychosocial support from all caregivers.

The next visit was performed by the head of the visiting team, a nurse, and a social worker (a team of women to create a comfortable environment for the relatives). The daughter continued to receive extremely negative, critical attitudes. The daughter was alone with her mother during the examination.

Neurological status: The level of consciousness – stupor. Meningeal symptoms – negative. Pupil OD=OS, photoreaction was lively. Nystagmus: none. Facial symmetry: Preserved. Right-sided hemiparesis. Numerical cognition cannot be assessed. According to the patient's daughter, she complained of frequent tremors in both upper and lower extremities. No vibrations were detected during the examination. During patient care, increased pain was observed during body movement, loud moaning, and restlessness. The pain was scored 4 on the PAINAD scale.

The situation was very serious. Breathing was even, spontaneous. Auscultation revealed equally diminished breath sounds on both sides. No wheezing was heard. Heart sounds were muffled, and tachycardia was present. Blood pressure: 90/60 mm Hg. Heart rate: 112 beats per minute. Oxygen saturation: 96%. The oxygen concentrator was often added. Body temperature: 37.8°C. The patient was motionless and required full assistance. The skin was pale and dry. No shortness of breath or coughing. The tongue was dry and clean. The swallowing reflex was impaired. The patient was fed via a nasogastric tube. The second option was soft and non-tender. No fracture was detected. Urination occurs through the bladder. The stool was spontaneous and regular. Quality of life on the Karnofsky Performance Scale – 30%.

Local Findings: An ulcer was noted in the inguinal-occipital area, measuring 11.0×8.0 cm. Shape: round. Stage: III-IV. Inflammatory phase with black scales. Wound edges are red and irregular. An unpleasant pungent odor and copious purulent discharge persisted. Swelling. Painfullness. The wound bed was not visible.

Medical assistance was provided after obtaining the daughter's consent and conducting a full assessment. Medical attention provided:

1. Suppression of pain and symptoms of hyperthermia.

2. Patient care. (Oral treatment, skin cleansing, washing, changing clothes and bed linen, etc.). All general and special care measures were performed.

3. Bladder probe care, nasogastric tube care, and feeding skills were taught.

3. Conservative treatment of skin ulcers: washing with 0.05% chlorhexidine solution, 0.9% sodium chloride solution, actinosep, application of Oflomelid ointment and healing dressing, wound closure, and dressing securing.

After the rendered help, the patient calmed down, and her body temperature was 36.2°C. the pain was scored 0 on the PAINAD scale.

Treatment prescribed: 1. Dexamethasone 4 mg – 1.0 intramuscularly once daily No. 10.

2. Tramadol 5% – 1.0 intramuscularly every 12 hours, regular, long term, under observation.

3. Carbamazepine 100 mg twice daily via a gastric tube or sublingually for a long time under observation.

2. For mild pain – Ketop 2.0 + Analgin 50% – 2.0 intramuscularly No. 1.

3. For night anxiety - Dimedrol 1% – 1.0 + Analgin 50% – 2.0 intramuscularly No. 1.

4. Consult a specialist if stools are absent for more than 3-4 days.

5. Relatives have been trained in nursing skills.

6. Relatives were trained in the proper use and care of the devices provided to improve the quality of patient care: functional bed, mattress, electric medical suction, and oxygen concentrator.

7. The doctor's appointment schedule depends on the severity of the patient's condition. Daily visits of a nurse. Psychologists and social workers' visits depending on the need.

During a conversation with the patient's daughter, it became clear that the cause of her intense anxiety and distress was not dissatisfaction with the medical care but rather her psycho-emotional state. In the course of the conversation, she spoke about her life, including the difficulties she experienced due to two failed marriages, her mother's current critical condition, and how it had significantly affected her overall emotional state.

She spoke of her mother's three marriages and her negative memories of her father. She mentioned that her mother's relationship with her third husband was difficult. Her mother lived separately from her husband until her condition deteriorated. After her mother's condition worsened, the daughter took both her mother and her husband into her home. The daughter does not like her mother's husband because all men remind her of her failed family life. For this reason, she shared that she experiences heightened anxiety when a nurse (a man) comes.

During the psychological intervention, the daughter cried for a long time and then said she began to feel better. She recalled that at first encounter with the mobile team, she could not fully open up because they were strangers to her, and she initially met them with distrust. "I met you with disapproval, but after seeing how you treat my mother, I changed my opinion and began to trust you." "However, if possible, I would prefer female staff to assist my mother," she said.

Results: A nurse (woman) performed the visits for a long time. As a result of the continuous provision of necessary medical care, quality nursing, and psychological and social support, the daughter's psycho-emotional state significantly improved. Pain symptoms were controlled, and the patient's condition was stable but serious. During care, the skin ulcer in the occipital region began to heal slowly. Her daughter fully mastered caregiving skills.

The patient was under the care of the mobile team for 2 months and 4 days. The daughter expressed her gratitude for the assistance provided to her mother and for helping her find peace and confidence.

Healing and recovery dynamics of skin ulcers with conservative treatment:

A skin ulcer measuring 11.0×8.0 cm in the occipital region. The shape – round. Stage: III-IV. Inflammatory phase with a black scab. Wound edges are red and irregular. A foul, pungent odor and abundant purulent discharge were present. Swelling. Painfullness. The wound bed was not visible.

Considering the severity of the patient's condition, conservative treatment was performed: the ulcer was treated with 0.05% chlorhexidine solution, 0.9% sodium chloride solution, actinosep, Oflomelid ointment was applied, the wound was sutured, and a bandage was applied. The treatment aimed to soften the necrotic hard black crust (Figure 1a).

A localized skin ulcer with dimensions of 11.0 × 8.0 cm was detected in the occipital region. The shape was round. Stage: III-IV. In the inflammatory phase, the black crust slightly decreased in size, and the wound edges became more distinct. The first fracture was slightly depressed. Unpleasant odor and copious purulent discharge have decreased. Pain persisted. The wound bed was not visible.

The conservative treatment was performed: the ulcer was washed with 0.05% chlorhexidine, 0.9% sodium chloride, and actinosep. A dressing with Oflomelid ointment was applied, the wound was sutured, and the dressing was fixed. The treatment aimed to soften the necrotic hard black crust (Figure 1b).

A localized skin ulcer with dimensions of 11.0 × 8.0 cm was detected in the occipital region. The shape was round. Stage: III-IV. In the inflammatory phase, the number of black scales significantly decreased, and the wound edges became clearer and more defined. The first fracture had healed. No unpleasant odor or purulent discharge was detected. The pain subsided. The wound bed was not yet fully visible.

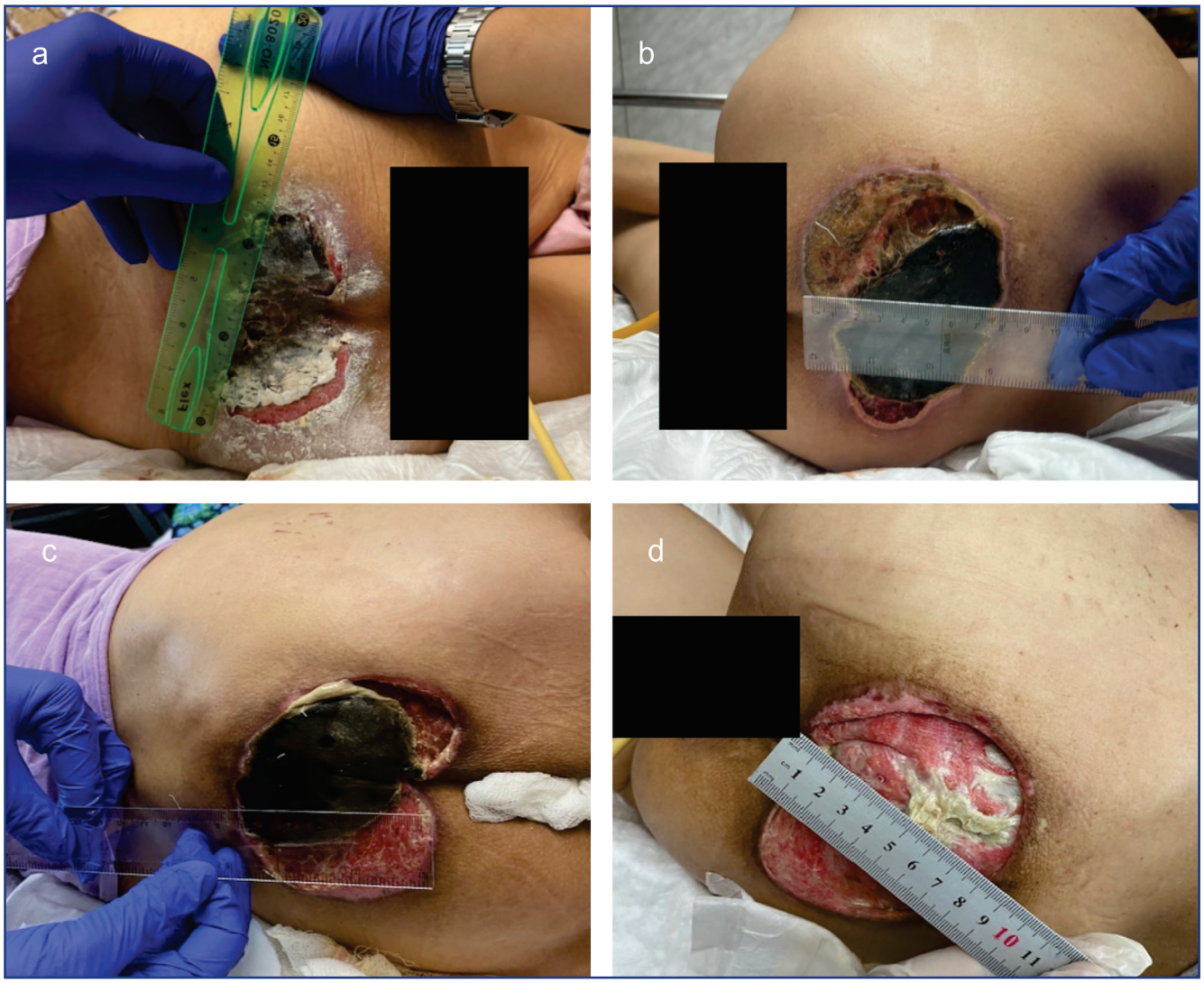

Figure 1 – Healing and recovery dynamics of skin ulcers with conservative treatment

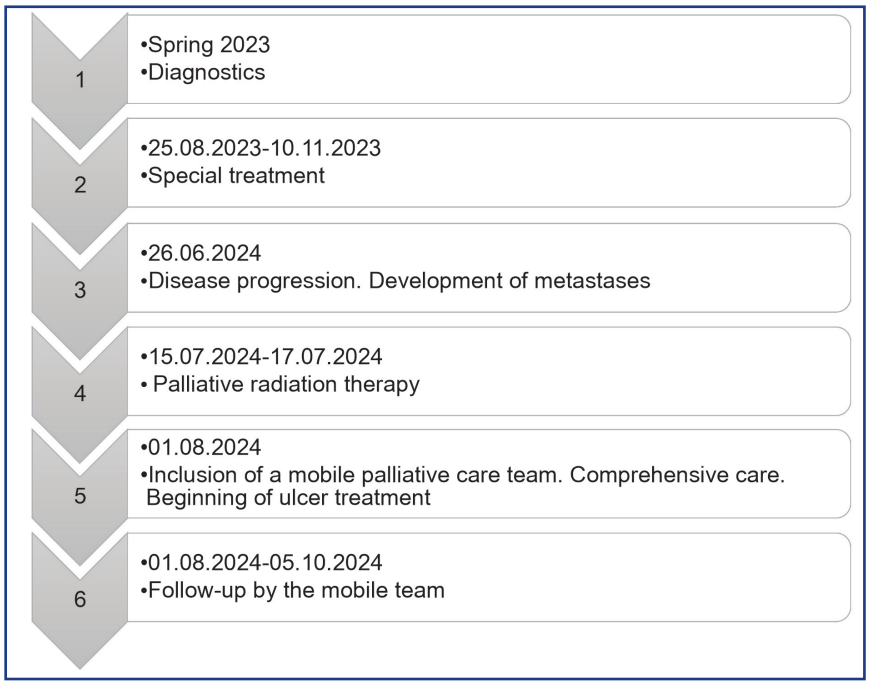

Figure 2 – Timeline of palliative care for a patient with metastatic breast cancer

Conservative treatment was performed: the ulcer was cleansed with a 10% betadine solution, necrotic black crusts were mechanically excised, and purulent cavities were opened. Baneocin ointment was applied, a healing dressing was placed over the wound, and the dressing was secured. The treatment aimed to soften and excise the necrotic hard black crust (Fig. 1c).

Locally, a skin ulcer measuring 10.0 × 7.0 cm in the occipital region was identified, which had progressed to the granulation phase. The shape was round. Stage: III-IV. The black crust has completely disappeared. No fractures are observed. The unpleasant odor and purulent discharge have completely resolved. No signs of pain are detected. No nook was present. The wound bed was fully visible. The wound edges are smooth, and granulation tissue formation is observed.

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Conservative treatment was provided: the ulcer was cleansed with a 0.9% sodium chloride solution and Octenisept. Foreign bodies and plaque were mechanically removed. A therapeutic dressing with methyluracil ointment was applied, the wound was sutured, and the dressing was secured. The treatment aimed to accelerate wound healing and recovery (Fig. 1d).

The timeline of the clinical case is presented in Figure 2.

Discussion: This clinical case of a patient with tumor-infiltrative breast cancer at stage III B illustrates the challenges associated with treating late-stage metastatic tumors. Disease progression, accompanied by metastases to the brain and pelvis and the development of degree III-IV skin ulcers, highlights the need for an interdisciplinary approach to optimize patient care and improve quality of life.

The tumor-infiltrative type of breast cancer is characterized by aggressive progression and a poor prognosis. Early diagnostics and targeted therapy based on HER2-positive status, as in this case, can slow disease progression and improve overall prognosis [7].

Treatment regimens containing docetaxel, trastuzumab, and pertuzumab are standard for HER2-positive breast cancer, although limited data suggest that their effectiveness diminishes in the very late stages of the disease [8, 9].

Particular attention was paid to treating degree III-IV skin ulcers that significantly deteriorate the patient's quality of life and increase the risk of infectious complications. Conservative treatment with ointments based on antibiotics and anti-inflammatory components, such as Oflomelid, has proven effective in reducing inflammation and softening necrotic hard crusts. The transition of the wound into the granulation phase after 1.5 months of treatment confirms the effectiveness of the chosen approach [10].

The work of the mobile palliative care team is a key component of care for terminal cancer patients at home. In this case, the cooperation of the physician, nurse, psychologist, and social worker not only provided the patient with the necessary care but also helped stabilize the emotional state of the patient's family members, which directly affects patient satisfaction with care outcomes and quality of life [11]. Effective communication between team members and patients' relatives helps reduce stress and aggression, which is especially important in families with a tense psychological environment [12, 13].

The mobile team's specialists also played an essential role in training the patient's relatives in caregiving skills. Step-by-step instruction, support, and regular monitoring ensured the correct implementation of all necessary procedures, including skin ulcer treatment care for the nasogastric tube and urinary catheter, contributing to a significant improvement in the condition of the skin ulcers and a reduction in complications. This emphasizes the importance of medical intervention and social support as part of palliative care [14, 15].

Conclusion: This case demonstrates that an interdisciplinary approach can achieve optimal outcomes even in complex clinical situations. The involvement of a team of specialists, modern care protocols, and attention to the emotional needs of the patient and their family are essential to successful palliative care. Skin ulcer healing is a long-term process. Unfortunately, terminally ill patients often do not live to see the complete resolution of the ulcerative condition. However, the outcomes of the care provided can significantly improve the patient's quality of life.

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АНДАТПА

МЕТАСТАЗДЫ ЗАҚЫМДАЛУМЕН СҮТ БЕЗІ ҚАТЕРЛІ ІСІГІ ДИАГНОЗЫМЕН НАУҚАСҚА МОБИЛЬДІ ТОПТЫҢ ҮЙ ЖАҒДАЙЫНДА ПАЛЛИАТИВТІ КӨМЕГІ: КЛИНИ-КЛЫҚ ЖАҒДАЙ

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Өзектілігі: *Паллиативті көмектің мақсаты ауырсыну және науқас жағдайын нашарлататын басқа да клиникалық белгілерді сауатты диагностикалап тиімді емдеу, науқас күтімі және туыстарына күтім дағдыларын үйрету, науқас және отбасына психологиялық, әлеуметтік қолдау.*

Зерттеу мақсаты *– метастатикалық зақымдануы бар-ісікті-инфильтративті сүт безі обыры диагнозы қойылған науқасқа үй жағдайында кешенді паллиативтік көмек көрсететін мобильді топтың рөлін зерттеу.*

Әдістері: *Мақалада бас миының, жамбас сүйектерінің метастаздармен зақымдалуы және III-IV дәрежелі терінің ойық жарасының дамуымен асқынған III В сатыдағы сүт безі қатерлі ісікті-инфильтративті түрі диагнозымен науқастың клиникалық жағдайы келтірілген. 4 цикл неоадъювантты полихимиотерапия және 4 цикл таргетті терапияның жүргізілгеніне қарамастан, үрдістің үдеуі. Науқас және оның отбасына үй жағдайында паллиативті кешенді медициналық және психологиялық, әлеуметтік қолдау көрсеткен мобильді топ жұмысына ерекше назар аударылады. Паллиативті көмектің негігі аспектілері ауырсыну белігілерін сауатты диагностикалап, нәтижелі емдеу.Төсек ойық жарасының күтімі, емі, назогастральды түтік арқылы тамақтануды, сондай-ақ эмоционалды шиеленісті азайту үшін туыстарымен өзара әрекеттесуді қамтыды.*

Нәтижелері: *III-IV дәрежелі терінің ойық жарасын емдеу нәтижелері оң динамиканы көрсетті, жараның 1,5 айға созылған консервативті емнен кейін грануляция фазасына ауысуы. Жараларды емдеудің заманауи әдістерін, соның ішінде антисептикалық ерітінділер мен антибиотикалық майларды қолдану инфекциялық асқынуларды азайтуға және науқастың жағдайын жақсартуға мүмкіндік берді. Мобильді топтың жұмысы паллиативтік көмек шеңберінде медициналық ғана емес, әлеуметтік қолдауды да қамтитын жеке көзқарастың маңыздылығын атап өтті.*

Қорытынды: *Мақала онкологиялық аурудың терминальды сатысындағы ауыр науқастарға үй жағдайында паллиативті көмек беру мобильді тобының қызметі науқастардың өмір сүру сапасын жақсарта отырып, көрсетілген көмекке қанағаттанушылығын арттыруға ықпал ететіндігін атап көрсетеді.*

Түйінді сөздер: *сүт безі қатерлі ісігі, ісікті-инфильтративті түрі, паллиативтік көмек, мобильді топ, терінің ойық жараларын емдеу, метастаздар, өмір сүру сапасы.*

АННОТАЦИЯ

ПАЛЛИАТИВНАЯ ПОМОЩЬ МОБИЛЬНОЙ БРИГАДЫ ПАЦИЕНТУ С МЕТАСТАТИЧЕСКИМ РАКОМ МОЛОЧНОЙ ЖЕЛЕЗЫ: КЛИНИЧЕСКИЙ СЛУЧАЙ

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Актуальность: *Цель паллиативной помощи – грамотная диагностика и эффективное лечение боли и других тяжелых симптомов, ухудшающих состояние пациента, уход за больным и обучение родственников навыкам ухода, оказание психологической и социальной поддержки пациенту и его семье.*

Цель исследования *– изучить роль мобильной бригады в оказании комплексной паллиативной помощи на дому пациенту с диагнозом отечно-инфильтративного рака молочной железы с метастатическим поражением.*

Методы: *В статье представлен клинический случай пациента с диагнозом отечно-инфильтративной формы рака молочной железы стадии III В, осложнённого метастазами в головной мозг, тазовые кости и развитием пролежней III-IV степени. Несмотря на проведение 4 циклов неоадъювантной полихимиотерапии и 4 циклов таргетной терапии, процесс прогрессировал. Особое внимание уделено работе мобильной бригады, оказывающей комплексную медицинскую, психологическую и социальную поддержку пациенту и его семье в домашних условиях. Основные аспекты паллиативной помощи включали грамотное выявление и эффективное лечение болевых симптомов, уход и лечение пролежней, питание через назогастральный зонд, а также взаимодействие с родственниками для уменьшения эмоционального напряжения.*

Результаты: *Результаты лечения пролежней III-IV степени продемонстрировали положительную динамику: переход раны в фазу грануляции спустя 1,5 месяца консервативного лечения. Применение современных методов лечения ран, включая антисептические растворы и антибиотиковые мази, позволило снизить риск инфекционных осложнений и улучшить состояние пациента. Работа мобильной бригады подчеркнула важность индивидуального подхода, включающего не только медицинскую, но и социальную поддержку в рамках паллиативной помощи.*

Заключение: *Деятельность мобильных бригад, оказывающих паллиативную помощь тяжёлым онкологическим пациентам на терминальной стадии в домашних условиях, способствует улучшению качества жизни пациентов и повышению удовлетворённости получаемой помощи.*

Ключевые слова: *рак молочной железы, опухолево-инфильтративная форма, паллиативная помощь, мобильная группа, лечение пролежней, метастазы, качество жизни.*

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