Case Study

Authors: Nandita Naik – Staff Nurse | Ramesh MN – Social Worker | Dr Anvitha – Guide

(Name of the patient is masked, for patient confidentiality reasons)

Mrs X is a 40-year-old woman with advanced gastric cancer whose story illustrates the physical, emotional, social, and spiritual dimensions of end-of-life care and the role of a multidisciplinary palliative care team.

Clinical background and presentation

Mrs X, a 40-year-old widow from Bengaluru, lives with her 21-year-old son and 19-year-old daughter; she was the sole earner until illness forced her to stop working and the family has been surviving on limited savings. She initially presented in August 2025 with vomiting and abdominal pain that was treated as gastritis, but subsequent endoscopy in a private hospital revealed a gastric tumour and she was referred to a Kidwai Memorial Institute of Oncology. After evaluation at Kidwai, she was diagnosed with carcinoma stomach and underwent surgery followed by radiotherapy. Following 25 cycles of radiotherapy, she developed severe abdominal pain; CT scan suggested radiation-related injury, and a high-risk open laparotomy was conducted during which multiple intestinal metastases were found, confirming stage IV disease and leading to cessation of curative treatment and referral to palliative medicine.

On admission to the palliative ward (21 January), she had severe abdominal pain radiating to her back and legs up to the ankles, was on fentanyl patches 75 micrograms per hour plus antispasmodics and gastroprotection, and had not passed stools for 20 days, consistent with complex total pain and refractory constipation.

Family situation and challenges

Mrs X’s husband died 14 years earlier and the family has lived independently in Bengaluru, with little contact with extended relatives in Tamil Nadu. Her son, a BSc student, is the primary caregiver and struggles to balance bedside care with imminent final examinations and the need to complete his degree to support the family. Her daughter, also a student, wants to stay home to provide care and plans to focus on supporting her mother until her brother finishes exams and secures employment. The family’s savings are depleting; they have no current income and express a clear need for financial assistance alongside medical and emotional support, which reflects common socioeconomic burdens among Indian families facing advanced cancer.

The children’s main wishes are that their mother’s pain be relieved, that she receive compassionate emotional care, and that they obtain guidance and support to cope with impending bereavement.

Patient’s emotional and spiritual state

Mrs X reports a profound loss of independence and role within her family and worries that she has become a burden, typical themes in advanced cancer. She feels anxious and fearful about her future, experiences a sense of social suffocation, and believes others keep their distance because of her cancer, indicating internalised stigma and isolation. She has chosen not to inform relatives in Tamil Nadu about her illness because she fears her children may also be stigmatised if people know their mother died of cancer.

Her priorities are to have her pain controlled, to return home, and to ensure that her children’s education and future are not derailed by her illness. She worries deeply about their emotional and financial survival after her death, reflecting anticipatory grief and maternal concern. Spiritually, she initially blamed God for her cancer but has gradually moved towards acceptance, acknowledging that “everyone has to die” and that her own death may be near, which is consistent with spiritual adjustment often seen in palliative care.

Palliative care team assessment and interventions

Palliative care in advanced cancer aims to improve quality of life of patients and families by early identification and impeccable assessment and treatment of pain and other problems—physical, psychosocial, and spiritual. Mrs X’s team conducted a comprehensive assessment of “total pain,” exploring physical symptoms (severe abdominal and neuropathic-type pain, constipation), emotional distress (anxiety, fear, perceived burden), social issues (financial strain, children’s education, lack of family support), and spiritual concerns (initial anger at God, movement to acceptance).

The ongoing and possible future interventions include:

- **Physical symptom management**
    - Optimising opioid therapy (titrating fentanyl or other stronger opioids, adding adjuvant analgesics for neuropathic pain, and using non-pharmacological measures).
    - Aggressive management of constipation with laxatives, enemas, and, if needed, manual or procedural interventions, as prolonged stool retention worsens pain and distress.
    - Treating other symptoms such as nausea, insomnia, and fatigue.
- **Psychological support**
    - Providing a safe space for Mrs X to express fear, anger, and guilt, and validating her worries about her children.
    - Using supportive counselling, basic cognitive-behavioural strategies, and, medications for significant anxiety or depression.

  - Encouraging her to identify achievable goals, such as having important conversations with her children.

- **Family, Friends and social support**
  - Coaching the son and daughter in basic nursing tasks (medication administration, comfort measures) and planning a sustainable caregiving routine that allows the son to attend college and exams while the daughter provides more hands-on care, with backup from home-based palliative care – once the home-based care program becomes operational.
  - Connection to NGOs for scholarship support or financial aids for completing education, and other social schemes.
- **Planning for end-of-life and place of care**
  - Discussing Mrs X's preference to be at home if her symptoms can be controlled, and organising transitions between hospital, and home-based palliative care.
  - Preparing the children for progressive decline, teaching them what to expect physically and emotionally.

The interdisciplinary team— including a palliative physician, nurse, social worker, and counsellor — continues to coordinate these interventions, review symptom control regularly, and adjust the care plan as the disease progresses.

Learning points from this case

- Advanced gastric cancer often presents to palliative care with complex pain, multiple prior treatments, and limited disease-directed options, making symptom relief and quality of life the primary goals.
- "Total pain" includes physical, emotional, social, and spiritual dimensions; failure to address any component can leave the patient suffering despite high-dose analgesia.
- Families like Mrs X's face intertwined challenges of caregiving burden, financial insecurity, educational disruption, and anticipatory grief, all of which require structured psychosocial and practical support.
- A multidisciplinary palliative care team can significantly improve comfort, coping, and decision-making for both patient and family, even when cure is no longer possible.