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Palliative care unit treatment and care for a terminal breast cancer patient with untreated obsessive-compulsive disorder

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Case Report

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Abstract

Objectives. Although palliative care units treat patients with various comorbidities, there are no reports of patients with obsessive-compulsive disorder (OCD).
Methods. The treatment and care of a breast cancer patient with OCD are presented.
Results. A woman in her 40s was admitted to the palliative care unit for terminal breast cancer. She spent most of the day cleaning the bath and bed areas, ignoring efforts to restrain her actions by the staff. After being diagnosed with OCD, the above symptoms improved through the coordinated action of the staff and medication.
Significance of results. This is the first report of the diagnosis and treatment of a patient with OCD in a palliative care unit. Early psychiatric diagnosis and subsequent staff response contributed to improvement in the patient's quality of life.

Introduction

End-of-life care for patients with cancer consists of the relief of unpleasant physical symptoms, the provision of support in daily life, actively listening to the patient, and caring for their psychological state; however, an increasing number of patients are now approaching the end of life with comorbidities (Sleeman et al. 2021).

Obsessive-compulsive disorder (OCD), which is positioned in the mental disorder domain, is a type of mental disorder in which irrational actions and thoughts are repeated against one's will (Goodman et al. 2014). It consists of "compulsions" in which the same behavior is repeated and "obsessions" 'in which the same thoughts are repeated, and many people spend more than an hour per day engaging in such behavior (American Psychiatric Association 2013). The National Institute for Health and Clinical Excellence (2005) Guidelines for the treatment of OCD recommend the use of cognitive behavioral therapy (CBT), antidepressants (e.g., selective serotonin reuptake inhibitors), and deep brain stimulation therapy. Previous studies suggest that psychological treatments based on the cognitive-behavioral model are effective therapies for adults with OCD, especially in consultation-liaison and psychosomatics-based systems. However, large-scale, high-quality randomized controlled trials are needed to validate CBT and other psychological approaches to treating adults with OCD (Gava et al. 2007).

Although OCD at the end of life can be expected to interfere with or even prevent appropriate treatment, we are not aware of any reports of terminal cancer patients with OCD.

The case of a terminal cancer patient with untreated, severe OCD who was admitted to a palliative care unit and for whom care was continued in the palliative care unit after treatment based on her clinical diagnosis and medical condition is presented.

Case report

The patient was a woman in her 40s with nothing particular in her medical history, no history of alcohol or drug dependence, and no history of psychiatric consultation.

With regard to her personal history, she had been reluctant to clean her room and toilet every day from junior high school, and when sick continued to be reliant on her family. She was diagnosed with left breast cancer 7 years earlier and underwent neoadjuvant chemotherapy followed by mastectomy and chest wall irradiation. Three years earlier, bone metastases were observed, and she was diagnosed with cancer recurrence.

Two months earlier, she was admitted to a general hospital for blood transfusion due to anemia, and although the anemia improved, she was readmitted to the palliative care unit for the purpose of pain control. Her performance status (PS) at that time was 2.

From about 1 week after admission to the palliative care unit, the patient requested that she be allowed to take a bath every day. Although she spent as long as 1 to 1.5 hours in the bathroom, when the nurse checked the bathroom after bathing, there were no water droplets observable in the bathtub or on the floor. On checking with the patient, she said that she had wiped the area dry after bathing. In addition, the patient became concerned with hair loss around the bed, so she wore a towel wrapped around her head to prevent hair loss, and cleared dust and hair off the bed all day long using tape. She also spent time squatting down to wipe the area around her bed. This cleaning was done every day until as late as 2:00 am. When the staff, who were worried about her worsening pain and physical condition, warned her about such behavior, her mood deteriorated, and she refused to listen.

After 2 weeks of hospitalization, she began crouching down to wipe the edge of the bed and every corner near the casters of the bed with a wet tissue. When she was called by the medical staff, she only looked up for a moment, showed no interest in them, and continued cleaning without letting her hands rest.

After approximately 3 weeks of hospitalization, she reached a state in which she gave priority to cleaning over her own treatment, saying that she wanted to stop rehabilitation but wanted to continue cleaning.

As the above symptoms continued for 4 weeks after admission, the patient was referred to the department of psycho-oncology. A diagnosis of OCD was made on the basis of the above symptoms and her living conditions at home. Mirtazapine 15 mg was prescribed because she also was diagnosed with depression. On the night of the same day, the pain in her left thigh increased, and she became unable to move. On examination, there was a left femoral diaphyseal fracture, and open reduction and fixation were performed. After surgery, the patient was transferred to the orthopedic ward for 1 week and then re-admitted to the palliative care unit, but she was prescribed bed rest for 2 weeks after the surgery. During that time, she continued to want to move about and clean; however, since she was restricted to bed rest after surgery and was not allowed to move, she told the nurse to wipe and clean on her behalf. The staff therefore held a conference where it was decided that incorporating all of the patient's requests would not be appropriate treatment for OCD, and the nurses took over cleaning the areas of concern, as they would for other patients. The patient actively listened to the nurses when she was informed of this decision. Rehabilitation began at 3 weeks after surgery, and the cleaning continued as soon as the patient was able to get out of bed. However, as she began to follow medical instructions that she should not force herself to clean, priority was given to the patient's mental well-being, and she was allowed to do some cleaning when she wanted to.

Discussion

The case of a terminal cancer patient with severe OCD was described. This case showed important findings in relation to the management of patients with OCD in palliative care units. The patient mentioned that she has been feeling the need to clean the entire house every day since she was in middle school, and on days when she was unable to do it herself, she would ask her family for help. She believes that the onset of her OCD was during her middle school years. During her first hospitalization, her symptoms were not prominent, so she was admitted to a palliative care ward. However, it seems that her OCD symptoms became more prominent due to the increase in stress related to her terminal cancer.

The patient had a decreased PS due to cancer progression. However, she continued to engage in obsessive-compulsive behaviors. This patient developed a femoral neck fracture, which may have occurred while engaging in her compulsive behaviors. This case was also influenced by the fact that the OCD had gone undiagnosed. It is difficult for staff in palliative care units to recognize that certain symptoms are indicative of OCD; however, if a patient exhibits problematic behavior, early psychiatric diagnosis and therapeutic intervention may be necessary to improve the patient's quality of life. In the patient in the present case, antidepressants were administered but could not be continued due to her poor overall physical condition. Therefore, psychotherapy was primarily conducted. The staff members listened to the patient's daily complaints while discussing what could and could not be done on the palliative care ward, and conveyed this to the patient. As the patient's physical strength was low, the staff also specifically explained the drawbacks of compulsively cleaning, such as exacerbating her pain. It is considered useful to have clearly conveyed the limit of what the staff can do and to have uniformly implemented it among the staff to prevent worsening of the patient's symptoms. The staff carried out what they could do selflessly, taking time to be involved with her and speaking in a gentle tone. The patient made a statement that she wanted to stay here forever.

After the patient's femoral fracture, there was a period during which she was unable to engage in compulsive acts, leading to a situation in which she requested a nurse to perform these acts on her behalf. The nurse attempted to fulfill the wishes of the patient in order to realize her desires, since there is a desire to fulfill the wishes of terminally ill patients (Miyashita et al. 2007; Steinhauser et al. 2000). For this reason, the focus shifted to the degree to which the patient's desires could be supported in a case of OCD, and a policy of discussing care policies with unit staff was adopted. Fulfilling the patient's wishes is not a cure for OCD nor is it the proper work of a nurse, so the staff response to the situation was coordinated during a unit conference. As a result, the patient herself accepted the treatment, showing that coordinated staff action is important in such cases.

There is a possibility that the patient had a naturally high level of anxiety, which may have led to compulsive cleaning as a way to alleviate her anxiety. Her OCD symptoms may have worsened due to the stress of being hospitalized in the palliative care ward, but once she received a proper diagnosis and a care plan was established, the staff was able to effectively communicate what they could and could not do for her, while still addressing her needs as much as possible. This approach helped her feel more at ease with the staff and trust them enough to delegate her cleaning tasks, ultimately resulting in an improvement of her OCD symptoms. Further large-scale, high-quality randomized controlled trials are needed to evaluate the effectiveness of CBT and other psychological approaches for treating adult patients with OCD receiving palliative treatment.

Conclusion

This is the first report of the diagnosis and treatment of a patient with OCD in a palliative care unit. Early psychiatric diagnosis and subsequent staff response contributed to improvement in the patient's condition.

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Competing interests. The authors declare none.

Ethical approval. This work received approval from the Institutional Review Board of Fujisawa Shounandai Hospital (ID: 04-013). After the patient's death, consent was obtained from the patient's family regarding publication of this case report.

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