Care, Coordination, and Multidisciplinary Management of Brain Tumor Patients
Elizabeth Walkowiak, GNP-BC
June 13, 2010

Objectives

1. Discuss the concept, theoretical underpinnings, and attributes of Nursing Presence, as it relates to the art of nursing.
2. Describe the individualized preoperative and postoperative care of surgical patients with brain tumors, in the context of Nursing Presence.
3. Discuss case studies, demonstrating the utility of Nursing Presence in provision of care to patients with brain tumors.

Agenda

- The Nurse
- The Patient
- The Process
- Case Studies
- Beyond the Hospital
“Nursing is an art; and if it is to be made an art, requires as exclusive a devotion, as hard a preparation, as any painter's or sculptor's work; for what is the having to do with dead canvas or cold marble, compared with having to do with the living body - the temple of God's spirit? It is one of the fine arts, I had almost said, the finest of the fine arts.”

-Florence Nightingale

Nursing: An Art and Science

- Theory: a set of interrelated concepts that give a systematic view of a phenomenon that is explanatory and predictive in nature.
- Not easily explained or defined.
- Art

Nursing: An Art and Science

- Praxis: the clinical practice activities that we perform each day.
- Skills, the technical accountabilities that are concrete, measurable, and easily defined.
- Science
Nursing: An Art and Science

- Theory guides practice.
- **Presence** is a theoretical concept that guides my practice in treating patients with brain tumors. It is the art that acts as the backdrop to my practice.
- Duality to our roles as midlevel providers/nurses in patient care:
  1. **“Being”/Presence Theory: Art**
  2. **“Doing”/Praxis: Science**

Presence

- Why did I become a nurse?
- Enjoy “being with” patients, “being there” to provide care and navigate through the journey of illness.

**Patient Gestalt:** the result of what we do (as providers), is much greater than the sum of our interventions.

Presence: Theoretical Underpinnings

- Vaillot (1962)
- Patterson and Zderad (1976)
- Gardner (1985)
- Benner and Wrubel (1989)
- Parse (1992)
Presence: Definition (Dooney, Haggerty, and Chase, 1999)

- An encounter between a nurse and a patient in which the nurse encounters the patient as a unique human being in a unique situation and chooses to spend her/himself on the patient's behalf.
- Decision: to immerse into the patient situation.
- Patient willingness to let the nurse into that experience.
- As a result: both nurse and patient are changed. Presence mutually benefits both the patient and nurse through self reflection, healing, and personal growth.

Prerequisites for Presence

- Expertise
- Time
- Inquiry
- Need
- Self-reflection
- Situation
- Preparation
- Presence

Attributes/Features

- Listening
- Silence
- Unique
- Sensing
- Time
- Unconditional positive regard
- Compassion
- Humor
- Vigilance
- Reassurance
- Authenticity
- Openness
- Touch
Barriers

• Time Constraints
• High patient acuity
• Perceived low value
• Discomfort with this intense communication.
• “Burn out”: Disengagement and absence of motivation to connect with patients.

Brain Tumor Patients: A Unique Population

• Brain: organ that is viewed as the seat of an individual’s identity, memory, and cognition.
• The tumor threatens the essence/existence of the individual.
• Different from other forms of cancer or illness.
• The terms “benign” or “malignant” do not always apply when physical, cognitive, and emotional functioning are threatened.

Some Tumors Encountered

• “Benign”—although not cancerous, this can be “malignant,” due to the location and biology of the tumor
  – Meningiomas: can range from benign to malignant (anaplastic); some can be watched, others that are large and cause symptoms need urgent intervention (example: skull based).
  – Cranopharyngiomas (near the pituitary: optic nerve deficits, hormone alterations, headaches)
Gliomas (Low Grade to High Grade): Development and Grading (WHO)

<Diagram>

Some Tumors Encountered

- Brain Metastasis from Systemic Carcinoma (Most Common Aggressors)
  - Breast
  - Lung
  - Melanoma
  - Renal
  - Colon

Tumor Tissue Diagnosis Aside...

- Regardless of what the tissue pathology is, patients and their families will look to you for expertise in treatment and will place their lives and fears in the hands of the surgeon but also in the hands of the nurse or midlevel provider.
- The Midlevel Provider/Nurse will be their linchpin, resource, and connection to this unknown world of tumor treatment—which requires Presence.
**Team Approach**

- **Patient and Family**
- Neurosurgeons:
  - Jason Heth MD
  - Stephen Sullivan MD
  - William Chandler MD
  - Oren Sagher MD
- **Nurse Practitioners**
  - Elizabeth Walkowiak NP
  - Charlotte Gunden NP
  - Donna Rossini NP
- Brain Tumor Board
  - Neuro-oncology:
    - Larry Junck MD
    - Jessica Eikmeier PA
  - Radiation Oncology:
    - Christina Tsien MD
    - Ted Lawrence MD
    - James Hayman MD
  - Medical Oncology, Neuropathology and Neuroradiology
  - Neuro-ophthalmology
  - Psycho-oncology
  - PMR (PT, OT, and Speech)
  - Social Work

**Neurosurgery Team: Physician, Midlevel Provider, and Patient Triad**

- **Initial Consult**
- Rapidity of sequence of events (symptoms/incidental finding, MRI, sitting in a neurosurgeon’s office).
- Patient and family members presenting with a diagnosis of “tumor.”
- Presence Model: Medical (surgeon) + Nurse (midlevel provider) = Comprehensive Care

**Initial Consult: Coordinated Effort**

- Patient Story
- Neurological Exam
- Review of Imaging
- Treatment Plan
  - Team Player Discussion (involves care team, patient, and family members)
  - Surgery (resection, biopsy)
  - Admission
  - Discussion of other options: radiation, observation
- Time
- Balance
Preoperative History and Physical

• Ideal opportunity for the Midlevel Provider to utilize both Praxis and Presence.
• Ideal for this visit to occur on a day separate from the initial consult.

The Nurse
The Patient
The Process
Case Studies
Beyond the Hospital

Preoperative History and Physical: Praxis

• Medical history
• Social history
• Exam: Both Comprehensive and Neurologically Focused
• Labs
• Diagnostic Testing
• Neuroimaging
• Anesthesia Referral
• Referrals to Adjunct Services
• Surgical Consent

The Nurse
The Patient
The Process
Case Studies
Beyond the Hospital

Preoperative History and Physical: Teaching/Presence at the Summit

• Preoperative instructions
  – The "Spiel": Walking the patient through the journey from prep admit, the operation, the hospital experience, and discharge.
• Postoperative discussion
• Questions
• Prerequisites and Attributes of Presence are key in this visit

The Nurse
The Patient
The Process
Case Studies
Beyond the Hospital
Postoperative Care: Coordinated Effort

- Presence Model:
  Medical (surgeon) + Nurse (midlevel provider) = Comprehensive Care
- Rounding as team to evaluate patient from both surgical and nursing perspectives

Postoperative Care: First Postoperative Visit

- Brain Tumor Board
- Joint visit by surgeon and the midlevel provider at 7 days from operative date
- Midlevel Provider
  - Wound assessment staple or suture removal
  - Comprehensive postoperative assessment
    - Assessment of patient symptoms (pain, sleep disturbances, irritability, fatigue, etc)
    - Reinforcement of postoperative activities and education
- Surgeon
  - Pathology review and explanation of diagnosis
  - Next steps
    - Referrals: radiation oncology, neuro-oncology, oncology, psych-oncology

Postoperative Care: Second Postoperative Visit

- Second Postoperative Visit
  - 4 weeks from operative date (3 weeks from first postoperative visit).
  - This time frame allows for our team to really “touch base” with the patient at several points during their operative journey at frequent intervals
  - Release from postoperative restrictions
  - Begin the transition to normal life, or what the patient will see as a “new normal”
  - Further referrals as necessary
Postoperative Care

- Interval follow-up based on individual patient and diagnosis.
- Patient/Provider relationship continues as the patient progresses forward with therapies.
- Coordination of appointments with other specialties, maintaining a multidisciplinary approach.
- Communication continues with the "Team" providers and the patient and family.

Clinical Issues

1. Steroids

   - Corticosteroids (Dexamethasone) are designed to temporarily relieve symptoms related to increased intracranial pressure and edema.
   - Traditionally: dosing 4-6 mg po Q 6 hours, which can cause problems
     - Agitation/anxiety
     - Weight gain
     - Glucose control (affects operation and recovery)
     - Adrenocortical atrophy from prolonged use which makes withdrawal difficult
     - Myopathy with prolonged use, contributing to disability.
Clinical Issues: Steroids

- Minimize steroids where possible
- Asymptomatic/incidental discovery without mass effect: consider no steroid use
- Minimal edema or symptoms: consider no steroid use to small dose of 2 mg po BID to 4 mg po BID
- Moderate to significant symptoms or edema on MRI: consider 4 mg po BID, TID, or QID (q 6 hour or q 8 hour dosing not necessary)
- Ryken, et al. (2010)

Clinical Issues: Anticonvulsants (AEDs)

- Anticonvulsants (AEDs): If the patient has a seizure there is no question
  - Levetiracetam (Keppra): Our first line treatment now
    - Easily dosed (500mg PO BID; dispensed as 500 and 750mg tablets)
    - No levels to check
    - No interactions with other medications
    - Doesn’t induce enzymes (improves chemotherapy)
    - Generally well tolerated
    - Problems: expensive for those without a good drug plan, possibly may induce irritability and anger

- Phenytoin (Dilantin): Commonly used, but has problems
  - Bothersome side effects
  - Need for levels to be checked
  - Many drug-drug interactions
  - Serious reactions: anticonvulsant hypersensitivity syndrome, serious rash, purple glove syndrome, necrosis when extravasated
  - Main benefit: inexpensive alternative when patient has limited financial means
**Case Study #1**


**Case Study #2**


**Brain Tumor Support Group**

- Why Travel Alone?
- Meetings held once per month for patients with brain tumors and their family members.
- Annual GlioBlastoff Run/Walk
- Special Events: Voices Against Brain Cancer Scholarship provided funds for:
  - Dinner Theater outing
  - Complementary Therapy "Spa" day
  - Christmas Banquet
References


doi:10.1177/0894318409353805


doi: 10.1177/0898010199017005

References, continued


References, continued