

# Addressing Uncontrolled Symptoms and Communication Gaps in a Patient with Metastatic Cholangiocarcinoma: Lessons from a Palliative Care Case

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## Abstract

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**Background** : Timely integration of palliative care is essential in managing advanced cancer patients, addressing both physical symptoms and psychosocial distress. Delayed communication of prognosis and inadequate symptom control can result in unnecessary suffering for patients and emotional distress for their families.

**Case Presentation** : We report a 49-year-old male with metastatic cholangiocarcinoma, admitted with severe abdominal pain, nausea, and vomiting. He had undergone a Longmire procedure and gastrojejunostomy three weeks prior. Despite surgical intervention, his symptoms remained poorly controlled. Upon assessment, he expressed fear of death, while his wife struggled with the emotional burden of his prognosis, indicating a lack of prior communication regarding his terminal condition. Symptom management included oral morphine for pain and a combination of ondansetron, omeprazole, and haloperidol for nausea and vomiting, leading to improved symptom control. However, his condition deteriorated with pneumonia and respiratory failure, marking the transition to end-of-life care. He passed away peacefully 15 days after admission.

**Discussion** : This case highlights the consequences of delayed prognosis disclosure and inadequate early symptom management. The absence of structured communication contributed to family distress, underscoring the importance of models like SPIKES in breaking bad news. The need for a multidisciplinary palliative care approach, including psychological support and optimized opioid management, was evident.

**Conclusions** : Early palliative care involvement, proactive symptom control, and clear communication of prognosis are crucial in advanced cancer care. Establishing a dedicated palliative care team can improve quality of life, facilitate shared decision-making, and enhance end-of-life experiences for patients and families.

## Introduction

The integration of palliative care at an early stage in the management of advanced cancer is critical for improving

patient outcomes, as it ensures a comprehensive approach to symptom control, psychosocial support, and end-of-life care planning. Palliative care not only focuses on alleviating distressing physical

symptoms such as pain, nausea, and dyspnea but also addresses the emotional, psychological, and spiritual concerns of both patients and their families. Evidence suggests that early involvement of palliative care leads to better symptom management, improved quality of life, and even prolonged survival in some cases.<sup>1,2</sup> However, in many healthcare settings, palliative care is often introduced late in the disease trajectory, limiting its potential benefits.

### **Case Report**

Mr R, 49 years old, presented to our emergency department with chronic unbearable abdominal pain and nausea-vomiting. His past history was significant for advanced metastatic cholangiocarcinoma diagnosed 3 months prior. Three weeks earlier, he had undergone an abdominal laparotomy with a Longmire procedure, along with a bypass gastrojejunostomy and stoma placement, in other hospital. He resided with his spouse and did not have any kids. He previously worked as an administrator in a private company but was no longer employed due to his illness. He is a devout Muslim and still regularly participates in religious activities.

During general physical examination, it was noted that Mr. R was fully alert, afebrile, with a blood pressure of 100/70 mmHg, a heart rate of 104 beats per minute, and a respiratory rate of 20 breaths per minute. He conveyed a pain intensity

rating of 7 out of 10 on the numerical rating scale. He was also notable for jaundice, a functional stoma bag on the abdomen, and mild bilateral peripheral edema. Upon assessment by the digestive surgeon, the patient was referred to internal medicine and palliative care.

After clinical assessment, it was noted that the patient's primary concerns were the fear of death, and the psychological burden of his prognosis. His wife, who was not fully prepared for the severity of his condition, expressed distress and surprise upon learning of the terminal prognosis. She reported inadequate prior communication from the previous treating team regarding the grave nature of her husband's illness. Afterwards, we finalized the clinical evaluation indicating that the patient's predominant physical problems were severe cancer pain and intractable nausea.

Easing the pain and nausea were the initial main objectives because of the preoccupation of the physical condition. Morphine 5 mg per oral (PO) QID and haloperidol 0.5 mg PO BID, as well as intravenous (IV) ondansetron 8 mg TID and IV omeprazole 40 mg BID, were prescribed for nausea-vomiting management. Pain scale was frequently monitored, and the dose of morphine was adjusted based on the evaluation.

During hospitalization, Mr. R developed acute respiratory distress, which was subsequently diagnosed as pneumonia. Despite antibiotic therapy, his

respiratory status continued to decline, leading to respiratory failure. Concomitantly, he exhibited fluctuating levels of consciousness and episodes of delirium, prompting the dying phase of his illness. Family members were counseled on the terminal nature of his condition. Mr. R's condition continued to decline, and he passed away 15 days after admission.

## Discussion

The first emotional response from Mr R and his wife reflects a common psychological trajectory after breaking bad news. The patient's wife exhibited considerable emotional distress upon learning the prognosis, expressing shock and confusion. This suggests a breakdown in communication between the previous medical team and the family, where the gravity of the illness was not sufficiently conveyed. Inadequate communication about prognosis and the goals of care may lead to misunderstandings and unrealistic expectations among family members. The possibility of not delivering a straightforward prognosis due to concerns about causing emotional distress or harming the patient-doctor relationship is commonly encountered but should be avoided because clear communication is essential for patient autonomy, informed decision-making, and trust in the medical process. After several sessions of structured family meetings and clear

discussions around end-of-life goals, both the patient and his wife eventually managed to accept this terminal condition.

Despite the initial outward acceptance of his wife, in the brink of her husband death, his wife did not stay beside him. This action may have been due to depression, stress reaction or other psychological reactions which should have been considered by conducting psychological/psychiatric consult for both the patient and his wife.

Cancer pain was the forefront of physical symptoms which have been addressed in the assessment of the patient. Mr. R's pain was assessed as severe based on reported numerical rating scale of 7/10; while considering his unresponsiveness to previous pain medication (NSAID), he must be managed with opioid therapy. Based on World Health Organization (WHO) analgesic ladder for management of pain, we prescribed morphine as the first-line agent for managing moderate to severe cancer pain.<sup>3</sup> Oral lactulose was given to prevent the constipation side effects of morphine. The patient pain was fully controlled in 30 mg total doses of oral morphine per 24 hours. In total pain assessment, we have also evaluated other aspects, including psychological, social, and spiritual factors. However, it appeared that physical pain predominates in Mr R cancer pain severity.

In addition to pain, his second predominant physical symptom was intractable nausea and vomiting. These symptoms are often multifactorial, with potential causes including bowel obstruction, opioid use, pain, and the progression of the underlying cancer. In this case, my assessment suggests that the nausea may be due to gastric irritation from NSAID use and uncontrolled cancer pain. Consequently, combination of ondansetron, omeprazole, and low-dose oral haloperidol were prescribed. These medications along with pain control successfully controlled his nausea and vomiting.

As Mr. R's condition deteriorated with the onset of pneumonia and respiratory failure, he entered the terminal phase of his illness. The transition to the dying phase necessitates us to shift our focus from active treatment to comfort care, ensuring the patient's remaining time is as peaceful and free from distress as possible. Delirium, which Mr. R developed, is also a sign of this terminal condition. After explaining this condition and the futility of further aggressive interventions to the family, additional dose of haloperidol was prescribed on top of antiemetic dose of haloperidol to ease his delirium, with continuation of the broad-spectrum antibiotics (meropenem 1 gr three times daily and levofloxacin 750 mg IV once daily) for its pneumonia. Mr. R passed peacefully after 15 days of admittance to hospital. The

family bereaved peacefully and accepted the passing of Mr. R.

I believe that there was a breakdown in communication with the family at the first place. While this is not pointing blame to others, communicating the diagnosis with grave prognosis should have been taken place earlier before the last surgery. The early communication with family members regarding prognosis is essential for the effective management of anticipatory grief and the promotion of collaborative decision-making, particularly within the framework of end-of-life care.<sup>4</sup> Early psychological support for terminally ill patients can effectively address distress, enhancing their quality of life by helping them cope with emotional challenges and find meaning in adversity.<sup>5</sup> Furthermore, early integration of mental health professionals as palliative team member may facilitate effective symptom management and psychosocial support, leading to reduced rates of depression and improved emotional well-being both for the patient and his family.<sup>6</sup>

The physical symptoms of the patient should be comprehensively managed following the establishment of a definitive diagnosis. From the history, it seemed that both the physical symptoms of pain and nausea were not fully controlled for a great amount of time. Early referral to palliative care, ideally at the time of cancer diagnosis, is crucial for the effective management of

complex physical symptoms. The delayed consultation with palliative care, which was evident in this case, resulted in prolonged suffering for the patient, as earlier intervention could have alleviated his symptoms and improved overall wellbeing. Research indicates that the interplay between pain and emotional well-being is profound, necessitating aggressive management for controlling physical symptoms for reducing psychological distress, thus increasing comfort and quality of life for cancer patients.<sup>7</sup>

Clear and compassionate communication about a grave prognosis should be provided early to both the patient and their family. Unfortunately, in this case, early communication was not addressed. The SPIKES model, commonly used for delivering bad news, offers a structured approach involving six key steps: Setting, Perception, Invitation, Knowledge, Emotions, and Strategy. While this model is widely applied in palliative care, it is not well known among non-palliative care doctors in Indonesia. This gap exists because communication models like SPIKES are not typically integrated into the standard training modules for general practitioners. Encountering this case underlines the importance of disseminating this model to medical students and other clinicians, which is one of my objectives soon as both a palliative care clinician and a medical faculty staff member. By doing so, I hope to ensure clear and compassionate

communication that integrates emotional support, helping clinicians manage the challenges of breaking bad news effectively.

Effective management of physical symptoms is crucial, as mitigating discomfort profoundly influences emotional health by diminishing anxiety and depression, thereby improving the overall quality of life for patients receiving palliative care.<sup>7</sup> Adequate cancer pain control is quintessential for enhancing the quality of life in individuals with advanced malignancies.<sup>8</sup> The intricate management of refractory nausea and vomiting in palliative care necessitates a comprehensive evaluation and customized treatment strategy to markedly enhance patient outcomes.

Early integration of palliative care into oncology has been shown to significantly improve outcomes for cancer patients.<sup>1,2</sup> This multidisciplinary approach enhances patient outcomes, with solid evidence of improved quality of life, reduced depressive symptoms alongside superior pain management and better nutritional outcomes.<sup>2</sup> Despite the absence of a dedicated palliative care team in our hospital's oncology unit, compelling evidence underscores the pressing necessity for its establishment. This team-based holistic approach not only addresses physical symptoms but also emphasizes emotional and spiritual well-being, offering

comprehensive support that can greatly enhance the experience of patients and their families.

Despite extensive evidence, the necessity for a dedicated palliative care team within our hospital is inadequately acknowledged, probably due to a lack of comprehensive understanding of its benefits; thus, effectively conveying this requirement to hospital management and fellow clinicians is imperative for initiating a collaborative palliative care framework. By promoting awareness and showcasing the importance of this service, we can manage to establish this care model that fulfills the physical, emotional, and psychosocial requirements of our patients.

## Conclusion

The case of Mr. R underscores the importance of early palliative care integration, effective symptom

management, and clear communication of prognosis. Delayed disclosure of a terminal diagnosis not only contributed to emotional distress but also hindered shared decision-making. Implementing structured communication models, such as SPIKES, in medical training can enhance patient autonomy and family preparedness. Additionally, the inadequate control of pain and nausea in this case highlights the need for early and aggressive symptom management from the time of diagnosis. Establishing a dedicated palliative care team is essential to provide comprehensive, multidisciplinary support addressing physical, psychological, and spiritual well-being. By advocating for these improvements, we can enhance the quality of end-of-life care, ensuring a more compassionate and patient-centered approach.

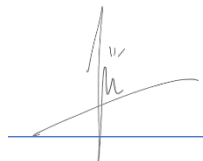
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