Chapter 8

Health problems in the care of a patient with prostate cancer

Iwona Twardak[1]
https://orcid.org/0000-0001-6990-5738

Izabela Olejarz[1]
https://orcid.org/0000-0009-8605-6153

Aleksandra Lisowska[1]
https://orcid.org/0000-0002-1429-0673

Agnieszka Kraińska[1]
https://orcid.org/0000-0002-5740-2954

Jerzy Twardak[2]
https://orcid.org/0000-0002-6710-3739

[1] Wroclaw Medical University, Faculty of Health Sciences, Department of Nursing and Obstetrics, Division of Family and Pediatric Nursing
[2] Wroclaw Medical University, Faculty of Health Sciences, Department of Nursing and Obstetrics, Division of Internal Medicine Nursing

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Abstract
Prostate cancer is the second most frequently diagnosed cancer in men worldwide, after lung cancer. In the early stages in Poland it is usually detected accidentally. Despite effective treatment methods, a large group of men with symptoms of disseminated cancer process become patients of palliative care. This chapter reports the case of a man, aged 89, residing in an inpatient hospice with a diagnosis

of advanced prostate cancer (Gleason Score 5 + 3 = 8), with bone metastasis, who had previously been treated with hormone therapy. At the time of nursing care, the patient scored ten points on the Barthel Index, seven points on the NRS pain scale, and nineteen points on the MNA nutrition scale and had a BMI of 20.76. He showed incomplete acceptance of the disease (twenty points on the AIS scale) and features of mild depression (seventeen points on the Beck depression scale). The main health problems/nursing diagnosis are pain, swelling, difficult urination, constipation, weakness and malnutrition. End-stage prostate cancer has a strong impact on the ability to perform daily activities and limits independence. Caring for cancer patients requires nurses to be highly qualified and skilled, as well as capable of showing understanding and compassion.
Key words: prostate cancer, generalised neoplastic process, palliative care

Introduction

Prostate cancer (*carcinoma prostatae*) is one of the world's major health care problems due to the rapid increase in the number of cases. According to the World Health Organization (WHO), it is the second most common cancer in men worldwide, after lung cancer. An estimated 1.4 million new cases of prostate cancer were predicted to be diagnosed worldwide in 2020. According to 2020 Polish National Cancer Registry data, the condition accounted for 19.6% of all registered cancer cases in men and 10.6% of cancer deaths in Poland in 2020 [1]. The most important predisposing factor for the disease is age. The likelihood of developing the disease is higher the older a man is. Other factors that increase the risk of prostate cancer include inadequate diet (including too much fat consumption, meat consumption, low number of vegetables), sedentary lifestyle, alcohol abuse, stress and nervous tension, infections and also the influence of the external environment [2, p. 19].

Prostate cancer may be asymptomatic for a long time and detected incidentally during screening. Initial urinary abnormalities are not a symptom to differentiate prostate cancer from benign prostatic hyperplasia. In the advanced form of cancer, the following symptoms appear: obstructed urination, weakened urine stream, increased frequency and prolonged micturition time (especially at night), haematuria, pain in the lumbar region, bone pain, complete urinary retention or penile erectile dysfunction [3]. Early detection of prostate cancer is crucial for

successful treatment. Therefore, it is important to have regular preventive examinations, especially for men aged 50 and older. The basic test is a per rectum examination (digital rectal examination, DRE,) and laboratory determination of the concentration of specific steroidal antigen (Prostate-Specific Antigen, PSA) in the blood serum. The final diagnosis of prostate cancer is determined by prostate biopsy. Currently, the "gold standard" is a thick-needle biopsy under TRUS (Transrectal Ultrasonography) guidance [4]. The TNM (Tumor, Nodules, Metastases) system is used to classify the clinical stage of prostate cancer. The choice of treatment depends on the stage, the patient's age, comorbidities, the degree of histological malignancy as determined by the Gleason Score, and the patient's choice of treatment method. The Gleason Score is based on the histological differentiation of the tumour and correlates with the clinical course of the disease. The higher the grade, the greater the risk of disease progression and metastasis, and the greater the likelihood of a shorter survival time [5].

Regular preventive examinations are important for this type of cancer, especially for men aged 50 and older. Treatment can be varied and depends on a number of factors: the stage of the disease, the patient's age, general health and patient preference. The first method of treatment is surgical removal of the prostate gland, called a prostatectomy. The operation is performed in the traditional open form or using laparoscopic techniques. Another method of treating prostate cancer is radiation therapy. Chemotherapy is used for advanced prostate cancer that has not responded to other forms of treatment. Hormone therapy is used for advanced prostate cancer that is hormone-dependent. It is also often used for palliative treatment [6–8].

A diagnosis of cancer is often perceived by patients as a sentence of inevitable suffering and death. The disease disrupts the patient's previous functioning, which ultimately worsens the patient's quality of life, so the actions of medical personnel should be holistically focused. The nurse, therefore, plays a key role in patient care, being a member of the therapeutic team and having the most frequent contact with the patient. His/her activities do not focus only on biological aspects, but also on emotional,

motivational, counselling and educational support. Through frequent contact, the nurse earns the patient's trust, which allows for a personalised approach and comprehensive care. S/he monitors the patient's condition, ensures the patient's comfort, supports the patient in daily activities, provides contact with loved ones and educates the patient and the family [9].

Objective of the study

The purpose of this study was to identify the health problems/nursing diagnosis of a patient with stage IV prostate cancer, as well as to present current information on this disease entity.

Methods, techniques and research tools

The study used a research method, namely, an individual case study using the nursing process developed on the basis of the care model of D. Orem for a patient with prostate cancer. In order to collect information, research techniques such as direct observation, interview and medical records, medical and nursing, were used. In addition, the following research tools were used: the Gleason Score, BMI (Body Mass Index), the MNA (Mini Nutritional Assessment) questionnaire, the NRS (Numerical Rating Scale), the Barthel Index, Beck Depression Inventory (BDI), the AIS (Acceptance of Illness Scale) questionnaire and the Multidimensional Scale of Perceived Social Support (MSPSS).

A case report

The patient is aged 89. He presented to the emergency department two years ago because of urinary problems. He was admitted to the ward, where a bladder catheter was inserted to decompress the bladder, and laboratory tests and a biopsy of the prostate were performed. The biopsy revealed the presence of a malignant neoplasm within the prostate gland (Gleason Score 5 + 3 = 8). In his history, the patient also admitted to experiencing pain in his bones, for which reason additional tests were ordered, namely tumour markers, radiographs, bone scintigraphy and

a CT scan. The examinations confirmed the spread of the cancerous process with grade IV bone metastasis. On the basis of the patient's history, the test results obtained and the prediction of disease progression, a decision was made to administer hormonal treatment. After the treatment was established, advice was given on home management and the timing of subsequent follow-up visits, and the patient was discharged home. The man was hospitalised several more times due to difficulties in urination and complaints of pain. As a result of the patient's deteriorating general condition and lack of support in the home environment, he was admitted to an inpatient hospice.

The patient is currently staying in an inpatient hospice. He is conscious and fully coherent. His body build is average and his nutritional status is mediocre. His height is 170 cm, weight 60 kg (BMI = 20.76), which for people aged 65 and over is associated with a feeding problem. On the basis of the MNA scale for assessing nutritional status, in which the patient scored nineteen points, the patient was found to be at high risk of malnutrition. On the day of the examination, the skin was pale, with visible eruptions all over, but sores or scars were not present. Oedema was present around the ankles of the lower extremities. The lymph nodes were not enlarged. The patient wears glasses for reading and watching TV. The nose is straight and unobstructed. Oral mucous membranes were dry, indicating slight dehydration. The abdomen was symmetrical and soft, there was no pathological resistance, and audible peristalsis and peritoneal symptoms were absent. Goldflam's sign was negative. Meningeal signs were absent, muscle tone was normal, and paresis was absent. The spine was painful in the thoracolumbar region and ribs; the patient rated the pain as seven on the NRS scale. Paresis or contractures of the upper and lower extremities were absent. Comorbidities included hypertension.

The patient reported no allergies, but spoke of weakness and dizziness. The patient was recumbent, needing assistance with all activities of daily living: eating, getting in and out of bed, maintaining hygiene and toileting, climbing and descending stairs, and controlling urination and bowel movements; the patient scored ten on the Barthel Index.

The patient is a widower, and his children are also deceased. The only close person who cares for him is the daughter of friends. The patient suffers from mild depression (seventeen points on BDI), which is caused by his cancer diagnosis. He received a score of twenty on the AIS scale, which confirms a medium level of acceptance of the disease and a sense of being a burden to loved ones and those caring for him. However, on the MSPSS, the patient received no fewer than eighty points, proving that he receives a lot of support from his goddaughter, with whom he can experience the disease and share every sorrow. However, she lives some distance away, so frequent visits are a great problem, but they maintain constant telephone contact.

In the course of the nursing care of a patient under inpatient hospice care, the following nursing diagnoses were observed and established.

Nursing diagnosis

Nursing diagnosis 1:
spinal pain due to bone metastasis of the primary cancer site and continuous progression of the disease, manifested by limitation of activity and feeling of anxiety.
Purpose of care:
reduction of pain.
Nursing intervention plan:
assessment of the severity, nature and location of pain – the NRS scale:

- observing the patient for behaviours (e.g., facial expressions, gestures) that provide information about the presence of pain, symptoms to which the patient is unwilling to admit;
- alleviating anxiety and fear by patiently listening to the patient's feelings, concerns and complaints;
- using extra pillows and other comforts to position the patient in bed in a convenient position;
- consultation with a physiotherapist regarding the adjustment of physical activity and rehabilitation to the patient's condition;
- application of warming ointments to the site of pain;

– administration of pain medications according to the physician's order sheet;
– documentation of the measures taken in the medical record.

Justification for implementing nursing interventions:
in order to alleviate and counteract pain, it is not enough to limit oneself to identifying it once. Pain management includes assessment of pain on multiple levels and should be performed systematically, no less than twice a day. The assessment consists of determining the severity, location, nature, aggravating factors and its impact on daily functioning such as mobility, sleep, diet. Taking into account the patient's subjective feelings, we can determine a specific form of therapy. The use of percussive equipment will reduce the discomfort caused by pain. Physiotherapists and warming ointments can also help manage pain [10–12].

Evaluation of care outcomes and nursing interventions undertaken:
pain has decreased, activities must continue. Further verification of pain intensity needed: NRS 4.

Nursing diagnosis 2:
risk of infection and discomfort caused by the need to maintain a catheter to drain urine from the bladder.

Purpose of care:
preventing infection by inserting a Foley catheter and improving patient comfort.

Nursing interventions plan:
– observation of urine outflow and its appearance, colour;
– daily monitoring of the inserted catheter;
– placing a urine bag below the bladder;
– perineal and catheter hygiene twice a day;
– checking the patency of the catheter;
– use of a urine-acidifying diet to prevent the development of infection;
– preventive administration of preparations containing cranberry extract;
– providing adequate amounts of oral fluids;
– emptying the urine bag twice a day;

– systematic replacement of urine bags;
– fluid balance: completing documentation;
– report any abnormalities to the doctor.

Justification for implementing nursing interventions:
maintaining a Foley catheter involves the risk of infection. Daily monitoring of the catheter, urine and toileting will help detect infection and remove it. Placing a urine bag below the bladder will ensure that urine does not back up. Drinking cranberry juice will have an acidifying effect on the urine, which will reduce the risk of urogenital infections. Following the rules of aseptics and antiseptics will reduce the risk of infection. Observation for infection will allow immediate interventions [13–16].
Evaluation of care outcomes and nursing interventions undertaken:
there was no infection of the Foley catheter. Patient comfort was increased.

Nursing diagnosis 3:
risk of malnutrition due to lack of appetite and insufficient food intake.
Purpose of care:
improve appetite and maintain proper nutritional status.
Nursing interventions plan:
– determining the cause of lack of appetite: constipation, pain complaints;
– ensuring proper conditions for taking meals: a comfortable position, ventilation of the room;
– serving meals at fixed times of the day;
– serving meals of proper temperature and consistency;
– taking into account the patient's dietary preferences;
– taking care of oral hygiene, dentures;
– feeding frequently, but in small volumes;
– encouraging the patient to eat or feeding him;
– controlling body weight;
– controlling bowel movements;
– keeping nursing records.

Justification for implementing nursing interventions:
taking a thorough history will allow a detailed diagnosis of the problem. The correct conditions for taking meals, namely the position, a ventilated room, fixed meal times and their correct temperature and consistency, will allow the patient to gain pleasure from eating. In view of the patient's mental state and ailments, it is important that the diet take into account the patient's food preferences. It is also beneficial for the patient to be verbally encouraged to eat, as well as to be fed frequently but in small volumes. Monitoring body weight and bowel movements will help guide the patient's nutritional situation [10,17–19].
Evaluation of care outcomes and nursing interventions undertaken:
appetite has improved. The steps taken should be continued.

Nursing diagnosis 4:
constipation caused by long-term immobilisation in bed, manifested by difficult passage of stools.
Purpose of care:
normalisation of intestinal function.
Nursing interventions plan:
- interviewing the patient about past defaecation, duration of constipation, the patient's diet;
- pulse examination of the abdomen for the presence of faecal masses or bloating;
- application of a high-residue diet: grain products, fruits and vegetables;
- taking care of proper hydration of the patient;
- increasing physical activity in bed, as much as the patient's pain will allow: changing positions, abdominal massage;
- taking care of regular bowel movements, recommending attempting to pass stools five to ten minutes after meals up to about thirty minutes;
- use of rectal procedures: cleaning enema, rectal infusion of paraffin, glycerin or oil;

– ensuring intimacy and convenient conditions during defaecation;
– administration of laxatives according to the physician's order sheet;
– documentation of nursing actions.

Justification for implementing nursing interventions:
in order to plan measures to prevent constipation, a thorough patient history and abdominal palpation should be conducted. Increasing the intake of high-residue diet foods and proper hydration will soften the stool and have a positive effect on excretion. Physical activity in bed and abdominal massage accelerate intestinal peristalsis. Attempts at regular bowel movements can also be taken care of. Rectal procedures and laxatives irritate the intestinal mucosa and cause defecation [17,20,21].
Evaluation of care outcomes and nursing interventions undertaken:
constipation eliminated. The measures taken should be continued.

Nursing diagnosis 5:
excessive drying of oral mucous membranes as a result of dehydration, manifested by a burning sensation.
Purpose of care:
reduce feelings of dryness and moisturise mucous membranes.
Nursing interventions plan:
– systematic observation of the oral mucosa;
– frequent and thorough care of the oral cavity;
– prescribing mouthwash: using moisturising liquids, with an anti-inflammatory effect, herbal infusions;
– taking care of proper hydration of the patient;
– sucking on frozen pineapple and ice cubes;
– providing easy access to a glass of water at night;
– administering pain medication prescribed by the doctor.

Justification for implementing nursing interventions:
changes in the mucous membranes badly affect the functioning of many systems and contribute to various ailments, so they should be observed regularly. Oral care and rinsing help reduce the number of microorganisms in the mouth. Drinking beverages is responsible for hydration, and sucking on pineapple and ice cubes provides constant hydration. Care

should also be taken to ensure that the patient always has a glass of water at the bedside in case he or she wants a drink [22–24].
Evaluation of care outcomes and nursing interventions undertaken:
proper hydration of the mucous membranes has been restored.

Nursing diagnosis 6:
discomfort caused by reduced independence in activities of daily living resulting from dizziness and weakness, manifested by a deepening sense of disability.
Purpose of care:
reduce the discomfort associated with reduced independence and help with daily functioning.
Nursing interventions plan:
- assessing the patient's degree of independence;
- assisting the patient with activities with which s/he has difficulty;
- ensuring comfort and intimacy during bathing;
- establishing a rehabilitation plan with the physiotherapist and doctor;
- motivating the patient, providing support;
- providing assistive items: tapes, bed pull-up ladder.

Justification for implementing nursing interventions:
before doing anything, the patient's level of independence should be assessed. Assisting in activities in which he or she has a problem are intended to improve the patient's comfort. Hygienic activities, such as bathing, are very tiring, so we perform them only when the patient feels well. Rehabilitation is aimed at improving well-being and physical fitness. Motivation positively affects the patient's condition and the healing process. Facilities, such as bands and ladders, improve his/her comfort in bed [25,26].
Evaluation of care outcomes and nursing interventions undertaken:
the patient's self-perception has improved. The patient is trying to participate in daily activities.

Nursing diagnosis 7:
self-care deficit in the need for personal and environmental cleanliness due to low mood and weakness, manifested by the inability to wash, dry, and keep the surroundings clean.
Purpose of care:
assist in maintaining hygiene of the patient's body and environment.
Nursing interventions plan:
- toilet the body with soap and water and thoroughly dry the skin twice a day;
- performing toileting at fixed times of the day;
- observing the skin and mucous membranes during toileting;
- changing personal underwear and bedding;
- changing nappies when soiled;
- providing necessary utensils and assisting in performing oral toileting;
- encouraging people to take care of their own bodies and surroundings.

Justification for implementing nursing interventions:
by toileting the body and changing personal and bed linen at regular times, the patient's personal hygiene and order can be maintained. During toileting, it is also beneficial to wash the skin and mucous membranes to prevent them from drying out. Involving the patient in grooming activities is a good way to take care of his/her own condition [27,28].
Evaluation of care outcomes and nursing interventions undertaken:
hygiene of the patient's body and surroundings maintained.

Nursing diagnosis 8:
decreased mood due to advanced stage of illness, awareness of death and being in a hospice.
Purpose of care:
improving the patient's well-being and acceptance of the disease, since his current mood is manifested by poor well-being, and creating a friendly environment.
Nursing interventions plan:
- familiarising the patient with the topography of the hospice;
- familiarising the patient with the other patients in the room;

– enabling consultation with a psychologist and psychiatrist;
– enabling contact with the family;
– enabling conversation with the rest of the medical staff;
– explaining to the patient the nature of the disease, listening to his comments and answering his questions;
– using language that the patient understands during the conversation;
– ensuring silence and calmness;
– talking to a patient who is dying.

Justification for implementing nursing interventions:
familiarising the patient with the topography of the hospice and other patients will help him find his way in the situation placed before him. Consultation with specialists will allow the patient to understand his mental state, and contact with his family will reassure him. Conversation and control of the patient will allow quick intervention in a crisis situation. If necessary and if the patient is willing, there may be conversation and reflection on death [9,29–31].
Evaluation of care outcomes and nursing interventions undertaken:
there has been an improvement in the patient's well-being.

Summary

In the treatment of patients in the advanced stages of cancer, the cooperation of the interdisciplinary team plays a key role. The patient is an active participant in the nursing and therapeutic process. Priority is given to a holistic approach that takes into account the holistic condition of the patient and his/her family [32]. The terminal period is characterised by a gradual progression of the disease process despite treatment: periodic aggravation of complaints or the appearance of new ones. Exacerbation of physical symptoms usually causes unpleasant psychological reactions, worsening to a significant degree the quality of life of patients. The patient is often helpless in the face of the disease and is unable to cope on his/her own. During the hospice stay, the patient receives systematic, multifaceted support, such as talks, visits from clergy, family and a psychologist. A sense of security and belonging to society is provided. The disease significantly

affects the patient's functioning in society, making them reevaluate their life, subordinating it to the disease [33].

One of the most common symptoms with cancer is pain. It has a very significant impact on patients' lives, as it limits their functioning to a great extent. In their article, Blacharska-Krzanowska *et al.* define pain as a mixed pain syndrome, which can be somatic, visceral or neuropathic [34]. In most cases, it is the result of the interaction of multiple factors, such as inflammatory, neuropathic and ischemic processes, often localising to several sites. Identification of these factors is extremely important from a therapeutic perspective, enabling the use of appropriate treatments for effective pain relief. In the case of bone metastatic lesions, the pain usually develops gradually and is often described by patients as dull and well-localised in a specific area. It particularly intensifies during the night, which can be difficult for patients, making it difficult for them to sleep soundly.

The negative emotions of hospice patients appear particularly intense when the patient first faces the prospect of incurability and death. Patients often react with complete mental disorganisation expressed in some by inhibition, silence and confinement, in others conversely by agitation and complaints. In all, a mixture of intense feelings of anxiety, anger, depression and despair can be observed, occurring alternately and interspersed with flashes of hope. A patient's psychological adjustment to cancer can express itself on different levels, depending on the patient's personality, life experiences and, level of adjustment. Two extreme attitudes of adaptation are observed: active, manifested by a desire to overcome the disease, and passive, manifested by resignation [32]. Psychotherapy, individually tailored to improve the patient's condition, plays an important role in the treatment process. Often the patient may have difficulty accepting the diagnosis and adjusting to a new and difficult situation [35,36].

Among the difficult emotions that have a significant impact on the patient as well as staff is anxiety. This is a response to danger, to the possibility of losing an important value (health, life, etc.) or to instability – the prospect of being in an unknown situation. Inside a person, there is an existential fear of dying, of losing life, of being dead, of annihilation. The

fear of the unknown of one's own future is especially connected to anxiety about the future of the loved ones that one leaves behind. This feeling is intensified when the patient experiences incomprehension and isolation from those around him/her. It is a symptom that is rarely expressed in words. It has many causes: the personality of the patient, certain medications, hypoxic conditions, hypoglycaemia and pain or cessation of physiological activities. Along with anxiety, a feeling of anger is often born. Sometimes the feeling of anxiety turns into anger and this can develop into an attitude of rebellion. In a person at the end of their life, anger at the injustice of fate may arise, resentment and even rebellion against God may arise. The patient's right to be angry should be recognised. Many patients fall into a state of despondency, or prolonged sadness. Depression is a form of grief associated with passing away.

Currently, a large group of palliative care and hospice patients are patients with advanced prostate cancer. These are mostly men on hormone treatment [37]. Hormone therapy in the treatment of prostate cancer is mainly associated with its use in patients with advanced disease, where the cancer has spread beyond the prostate gland, with the goal of slowing tumour growth and relieving clinical symptoms of metastasis. Particularly in patients with bone metastases, the use of androgen deprivation therapy (ADT) often has beneficial effects, improving patients' quality of life, primarily by reducing or completely resolving pain associated with bone metastases [38].

The advanced stage of the disease is often accompanied by anorexia. Lack of appetite, severe restriction of meals or complete refusal to take them can be due to physical and psychological reasons. The former include pain, constipation, metabolic disorders, while the latter include anxiety, apathy, depression, sometimes mental breakdown and a desire to die sooner. ESPEN (European Society for Clinical Nutrition and Metabolism), defines malnutrition as "a condition resulting from a failure to absorb or consume nutrients, leading to a change in body composition […] and thus leading to impaired physical and mental activity of the body and adversely affecting the outcome of the underlying disease" [18, p. 303]. This problem can lead to nutrient deficiencies, such as vitamins, minerals

and proteins, which can affect the body's already severe health and function. A patient suffering from malnutrition experiences fatigue, weakness, concentration problems and lowered mood, which negatively affects the quality of life [18]. Daniluk [21], Walewska and Ścisło [24] define the same in their articles, referring to constipation and oral mucosal changes. The stress of the disease, pain and discomfort associated with constipation can affect the patient's overall emotional state, causing increased anxiety, lowered mood or a sense of reduced control over one's body and health. The same is true for lesions on the oral mucosa – a troublesome problem. This is why it is important for the medical team caring for a cancer patient to also take into account gastrointestinal problems and take appropriate measures to alleviate these symptoms.

The specificity of a nurse's work in caring for an oncology patient includes not only the physical aspects, but also emotional, psychological and social ones. The nurse is present with the patient, providing emotional and psychological support during the difficult period of cancer. S/he also places great importance on rehabilitative care, helping the patient maintain or improve his/her physical function and ability to perform daily activities. The nurse cares for the oncology patient in a holistic way, that is, taking into account all aspects of the patient's life and health. S/he takes care of the patient's comfort, alleviates symptoms of the disease and side effects of therapy, supports the patient in dealing with emotional challenges, provides necessary information, and plans and coordinates the care of the medical team [9]. All of this is aimed at ensuring that the patient has the highest possible quality of life during cancer treatment.

Conclusions

The analysis of nursing problems occurring in a patient with prostate cancer allowed the following conclusions to emerge:

– The main health problems/nursing diagnoses of a patient with prostate cancer relate to the effects of the disease; these include bone pain, swollen ankles, constipation, weakness and malnutrition.

- Prostate cancer affects the patient's quality of life depending on the stage of the disease and the treatment. Cancer in its final stage has a strong impact on the ability to perform daily activities and limits independence. To a large extent, it makes the patient feel depressed and unhappy.
- A patient's attitude toward cancer can be very complex and individual for each patient. It is influenced by factors such as age, gender, personality, life experiences, support from family and friends, as well as the stage of the disease and prognosis of treatment.
- The role of the nurse in the therapeutic team is to provide support and care in many aspects of the patient's life, including the emotional sphere.
- Caring for cancer patients requires nurses to be highly qualified and skilled, as well as capable of showing understanding and compassion.

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