



Oral Care for Hospice Patients With Severe Trismus

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Oral care is a hallmark of attentive, high-quality nursing care. Oral care improves a patient's sense of well-being, communication, and nutritional status, and lowers the risk for pneumonia. However, for patients with severe trismus, oral care may seem impossible. Trismus is the inability to open the mouth more than 35 mm and often results from medical therapies for head and neck cancers. This article details a simple approach to oral care that was implemented successfully with five hospice patients with severe trismus.

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A married, 41-year-old male of mixed Maori and New Zealand European ethnicity named M.C. had been employed as a painter. Nine months prior to his admission to an urban hospice service, he had been diagnosed with tonsillar carcinoma that grew at the right base of his tongue and tonsil. After diagnosis, M.C. had a percutaneous endoscopic gastrostomy tube inserted and began receiving radiation and chemotherapy with curative intent.

One month prior to his admission to the hospice program, the cancer recurred locally. M.C. refused the offer of a neck dissection, but continued to receive chemotherapy. Because most of his care was received in the home, he did require some support in the hospice inpatient unit (IPU). At that time (two months prior to his death), M.C. could not talk and had difficulty swallowing. He received medication via a dermal patch to dry oral secretions. Although the jaw and neck pain were managed by several analgesics, breakthrough pain did occur. M.C. also received antibiotics for pneumonia. While in the IPU, M.C. had not received any oral care for several weeks because

of the pain and difficulty with severe trismus, and family and healthcare providers could not identify a way to offer this most basic hygiene.

Trismus, the inability to open the mouth more than 35 mm, often results from therapies for head and neck cancers (Bensadoun et al., 2010). Findings note that 25%–50% of all patients undergoing primary treatment for a head and neck cancer suffer from trismus (Bensadoun et al., 2010; Louise Kent et al., 2008; Weber, Dommerich, Pau, & Kramp, 2010). Although several mechanical, medical, and surgical treatments have been developed to ameliorate the symptom of trismus (Chen, Wong, Ou, & Lee, 2010; Hartl, Cohen, Julieron, Marandas, Janot, & Bourhis, 2008; Mardini, Chang, Tsai, Coskunfirat, & Wei, 2006; Shulman, Shipman, & Willis, 2008; Stubblefield, Manfield, & Riedel, 2010), no description exists in the literature about how to provide oral care for patients who continue to experience trismus.

Oral care not only contributes to feelings of well-being (e.g., diminishes halitosis, improves taste), it also plays a significant role in eating, nutritional

status, and verbal and nonverbal communication (Stout, Goulding, & Powell, 2009; Sumi, Ozawa, Miura, Michiwaki, & Umemura, 2010). In addition, oral care significantly reduces the risk for pneumonia and other respiratory infections in institutionalized older adults and ventilated patients (Arpin, 2009; El-Solh, 2011; Goss, Coty, & Myers, 2011).

Administering the Procedure

This article describes an approach to oral care that was successfully implemented with M.C. and four subsequent patients with severe trismus (see Figure 1). The patients could not open their mouths more than 5–10 mm and were unable to use a foam swab or toothbrush for several weeks because of their severe trismus. The procedure for this oral care is as follows. First, ensure that the patient is as comfortable as possible (e.g., pain medication delivered 30 minutes prior to oral care). Describe the procedure to the patient and have supplies ready, including mouth rinse at lukewarm temperature (saline, boiled or sterile water, or nonalcoholic mouth rinse work best) (Stricker & Sullivan, 2003). Next, assist the patient with sitting up in a bed or chair, place a basin or bowl beneath his or her head, and drape a towel around the patient's neck and upper body. Give the patient the distal end of a size 12 or 14 suction catheter to insert into his or her mouth. Draw up the mouth rinse in 50 cc syringe, and slowly push it into the catheter. The patient is to let the mouth rinse and accompanying debris then drip into the basin.

The rinsing procedure is continued; allow the patient to move the end of the catheter around the inside of his or her mouth as needed, until the patient reports satisfaction with the oral care or