



# Understanding the Difficulty

Elaine B. Llanos, MSN, RN, OCN®

Safely administering infusional therapies is my primary role as an oncology nurse working in the outpatient setting. Included in this function are many supportive measures to ensure that each patient has the optimal chance not only to benefit from this encounter, but to experience the least harm. Last September, a 69-year-old retired men's clothing designer named A.C., who had metastatic colon cancer diagnosed in 2006, was scheduled in my clinic to receive IV hydration. This was necessitated by intractable diarrhea presumed to be a result of previous chemotherapy drugs, which had since been discontinued. He reported emptying his colostomy of two to three liters of liquid stool per day and had recently been discharged from a four-week inpatient stay for the same reason. He was still receiving single-agent IV immunotherapy every two weeks, which, as indicated on computed tomography scan, had kept his disease stable; however, A.C. suffered daily with the effects of prolonged, unrelenting diarrhea. Of note, A.C. was a Medicare recipient and also maintained long-term disability that provided a home health attendant (HHA) for both he and his wife, who had multiple sclerosis.

Providing IV hydration to patients before, during, or after chemotherapy as a supportive measure is not unusual. However, to administer IV electrolytes plus hydration seven days a week for a minimum of five hours a day was unprecedented in our outpatient setting. Responsibility for coordinating these appointments fell to my clinic Monday through Friday, an ambulatory center on Saturday, and our urgent care center on Sunday. Nurses, physicians, pharmacists, and physician's office assistants (POAs) all took part in providing this patient with the unique

care his condition required. We followed the prescribed plan for weeks, encountering a variety of challenges on any given day. Laboratory results for A.C. often were reported in the life-threatening category, which required additional electrolyte infusions. These extended his appointments to eight hours, and angered him. When this occurred, he was too exhausted to walk out (he had been able to walk into the clinic when he arrived) and, instead, was taken by wheelchair to the lobby to get his taxi home.

At times A.C. seemed genuinely appreciative of our nursing care, thanking us for answering his multitude of questions or for arranging his session to be done in his favorite room. Although his calling us "sweetheart" was not taken by all the nurses as an affectionate gesture, it seemed better than the times he cursed at us for not increasing the infusion rate so he would be finished sooner. Despite explanations why the latter request could not be granted, A.C. would not hesitate to use his cell phone while in our clinic to contact the POAs or call the pharmacy directly to argue whether this truly was valid. Another dilemma we encountered at times was his refusal to empty his colostomy in the toilet, rather than the sink. When asked repeatedly not to do so for hygienic reasons, he would reply, "Don't tell me what to do, just turn on my TV."

The weeks we continuously hydrated A.C. on a daily basis soon became two months. Questions began to arise among staff as to just how long this would continue. We expected at first for it to be a temporary measure, but realized it now

Although his calling us "sweetheart" was not taken by all the nurses as an affectionate gesture, it seemed better than the times he cursed at us for not increasing the infusion rate.

seemed to be the very treatment that sustained his life. Without this massive hydration and replacement of electrolytes, A.C. would surely not survive. He was able to eat and drink and did so on a limited basis, but with the continued diarrhea, along now with intermittent vomiting, there was no way for him to maintain an adequate fluid status.

## Team Effort

Because I cared for A.C. on more days than any other nurse, declaring myself his primary nurse gave me the responsibility to sort out all of the concerns and comments about this patient to re-evaluate our plan of care for him. Foremost, I knew this must be a collaborative effort, and I began by discussing A.C.'s case with his attending physician. Dr. S revealed that, ideally, this patient should be receiving home total parenteral nutrition (TPN) to better meet his

Elaine B. Llanos, MSN, RN, OCN®, is a CNIV ambulatory infusion nurse at Memorial Sloan-Kettering Cancer Center in New York, NY. The author takes full responsibility for the content of the article. The author did not receive honoraria for this work. No financial relationships relevant to the content of this article have been disclosed by the author or editorial staff. Llanos can be reached at [llanose@mskcc.org](mailto:llanose@mskcc.org), with copy to editor at [CJONEditor@ons.org](mailto:CJONEditor@ons.org).

Digital Object Identifier: 10.1188/13.CJON.213-214