

Case Report

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Beyond *striae cutis*: A case report on how physical skin complaints unveiled end-of-life total experience

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Abstract

Background. End-of-life is a unique and multidimensional experience, and physical complaints can reveal other areas of distress.

Method. A case report of a woman with terminal cancer with painful and deforming skin *striae* cared by a multidisciplinary team.

Results. After initially treating her physical pain, other end-of-life psychosocial, spiritual, and existential aspects could be addressed.

Significance of results. Physical distress can unveil other essential areas of end-of-life experience when multidisciplinary teams caring for the terminally ill patients use holistic approaches.

Introduction

Attentiveness to our daily practices brings us the certainty and realization that nothing has changed in the holistic aspect of palliative care's (PC) definition: reducing the physical, mental, social, and spiritual pain of the critically ill patients irrespective of the diagnosis and prognosis (Van Mechelen et al., 2013).

There is always something beyond physical complaints and a deeper meaning that needs to be embraced and understood by health professionals (HPs) caring for the terminally ill. We contact many end-of-life individuals and their families daily. By believing in the true PC *ethos*, we come to understand and realize that total pain experience occurs (Julião et al., 2020) and can be revealed and addressed adequately after solving urgent physical problems, behind which a unique, multifaceted illness experience hides and unfolds.

Conscious reflections on patients' cases help further human understanding. Therefore, we present a case report of a young woman with terminal cancer who is referred to our PC evaluation because of painful, deforming and undignifying skin *striae*, as a consequence of systemic treatments. Understating her entire-self far beyond her *striae* and her physical skin complaints unveiled a human end-of-life whole experience.

Case presentation

M. is a 32-year-old married female, mother of two sons, with high-grade astrocytoma. After her diagnosis, she was submitted to chemotherapy (temporarily suspended due to liver toxicity) and holo-cranial radiotherapy and began systemic dexamethasone (8 mg, id) to reduce perilesional brain edema. As a consequence of systemic steroids, she developed severe *striae rubra* located to her abdomen, groins, and armpits, bilaterally. Her *striae* were friable and telangiectatic provoking minor bleeding and pain with movement, mainly at night, especially in the abdomen and armpits. After her liver enzymes normalized, M. began second-line palliative chemotherapy and reduced dexamethasone to 1.5 mg, id; but soon she had to increase to 3 mg, id, due to drowsiness and speech impairment.

M.'s *striae* were the reason for palliative dermatological referral by her doctor, mainly the somatic pain and bleeding. In her referral, poor quality of life, depressive symptoms, social isolation, high burden, and hopelessness were also evident. It was then clear that M. had a lot more to deal with beyond her deforming skin condition.

In the first visit accompanied by her father, M. presented with acute pain located to her armpits and abdomen (intensity of 8/10) whenever she moved her arms at home, stretching her fragile skin. She referred that one of her most profound sadness was "not being able to play freely with her kids, without pain and bleeding."

In our person-centered initial assessment, it was evident that M. had more concerns than only physical pain. However, she strongly mentioned that the pain provoked by the *striae* was

her chief complaint, and if we could ameliorate it, she could continue her follow-up solving other end-of-life issues, namely the psychosocial and existential. In her assessment using a numerical scale (Hui and Bruera, 2017), M. had severe fatigue (9/10) and low general well-being (8/10), mainly because of her skin problems; she reported having insomnia and felt like being depressed (Julião et al., 2016) and a burden to her family. It was clear during her interview a profound sense of hopelessness, and her father affirmed that their lives were “falling apart and all was fear and anger.”

It became clear that we had to care for this case as a dermatology palliative consultation *ab initio*, respecting her first wish. Reaching alleviation in the dermatologic area was crucial to address other M.'s areas of suffering in future follow-ups. Therefore, a non-presential specialist dermatology consultation was made with two colleagues, using a telephone case description, signs and symptoms, and *striae* images sent via e-mail. After discussing the case and looking closely at images, the dermatologists both agreed to prescribe *Arnica montana* containing gel to apply bid to her skin lesions, potentially diminishing the hyper vascularization, reducing bleeding, and increasing epithelium growth. M. was also prescribed with transdermal buprenorphine 17.5 µg/h for her pain.

In the follow-up consultation one week after, her *striae* began to improve, with gradual resolution of the purpuric component and no further bleeding. M. could now make pain-free abdominal and arm movements when playing with her two small sons, saying that her skin seemed “more elastic and strong,” felling “less frightened.” She began to seek the PC team's advocacy for knowing her prognosis and treatment options. She wanted to tighten the relationship with her husband and sons. Her father felt that the *striae* aspect was “outstandingly better” which helped him ease the pain. Although he knew about her terminality, he could now enjoy her daughter's life to the fullest, not feeling sad or helpless.

In her assessment, she did not feel depressed; fatigue lowered to 5/10, and well-being improved (3/10). Her quality of life increased substantially. She could finally begin to focus on developing therapeutic conversations about other relevant themes like prognostic awareness, existential issues, familial and friendship end-of-life enclosure tasks.

The dermatologists continue to support M.'s clinical progression weekly. Because of the positive dermatological outcomes after their initial prescription, no therapeutic changes were deemed necessary.

M. continues her regular PC visits. Her dermatological problems always initiate her consultations, serving as the *motto* to go further, step-by-step, in her vital terminal journey.

Discussion

The case of M. raises several important issues for reflection.

Firstly, one thing was initially crucial for M.'s sense of being supported and understood: a shared plan existed between PC and dermatology to help her severe pain due to skin lesions; but mostly, that all HP involved acknowledged that her distress was a total experience in need for physical control first, and psychosocial and existential control after. Therefore, total pain is not a theoretical and hollow concept existing only in PC book chapters; it is an intricate experience between multiple interdependent human dimensions (Julião et al., 2020), which need to be

acknowledged by HP so that patients witness it during clinical contacts and in the eyes of their beholders.

Secondly, PC continues to affirm itself as a specialized area for people with serious illnesses, focusing on providing patients with relief from their whole suffering. M.'s case reaffirms the concept that suffering can be subdivided into acute physical issues (like M.'s dermatological problem), which needed urgent relief, and other issues related to the meaning of life that must be openly assessed and intervened after effective physical control (Hui and Bruera, 2016). Therefore, it is of the utmost importance to keep in mind that one should first address and alleviate physical distress. However, once relieved, other more profound areas of the human experience reveal, where “mental distress may be perhaps the most intractable pain of all” (Saunders, 1963), in need for relevant expertise, close collaboration and interdisciplinary teamwork (Hui and Bruera, 2016), supportive care interventions (Rhondali et al., 2014), and effective psychotherapeutic approaches (Saracino et al., 2019).

To address such a large group of issues anchored in patients' end-of-lives, building bridges between different specialties like dermatology is fundamental. Dermatology plays a crucial role in PC, although there is an absolute scarcity of the literature on its integration (Bishurul Hafi and Uvais, 2018). Skin diseases are common in the PC context (De Conno et al., 1991; Barnabé and Daeninck, 2005; Hansra et al., 2008; Neloska et al., 2017) and most often ignored by patients, HP, and caregivers, negatively affecting patient's mental and emotional status, and self-esteem (Bishurul Hafi and Uvais, 2018). Psychological distress at the end-of-life, such as depression and anxiety, may be linked with skin diseases causing significant mental suffering, shame, disfigurement, and social inhibitions. This is, undoubtedly, a multidirectional pathway, and irrespective of its origin, adequate assessment and interventions must be holistic.

Finally, one can conclude that understanding one's illness's dynamic and unique experience can “heal many other wounds of suffering” after the real skin scars form.

As for M., other terminally ill continue their PC follow-ups all over the world and initiate consultations with their physical concerns — pain, nausea, or skin problems.

As for M., other terminally ill continue to take physical distress as a *motto* to go further, step-by-step, in their complete vital terminal journey, offering HP an open window into their whole person.

As for M., other terminally ill continue to use their “*striae*” as a non-verbal and implicit request for help.

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