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PRIMARY CARE PALLIATIVE MANAGEMENT OF DYSPNEA IN GLOTTIC SQUAMOUS CELL CARCINOMA WITH LUNG METASTASES

聲門鱗狀細胞癌肺轉移的原發性姑息治療：緩解症狀與臨終關懷之間的平衡

Balancing Symptom Relief and End-of-Life Decisions

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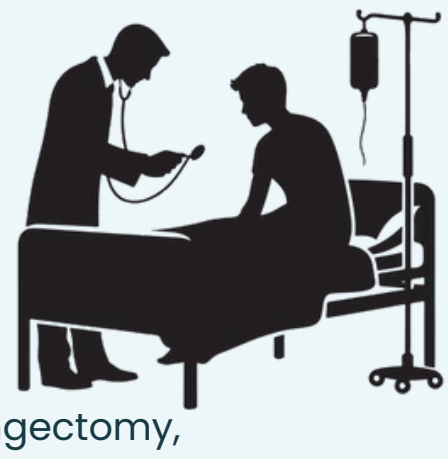
INTRODUCTION

Dyspnea in terminal cancer is not merely a physical burden; it is a profound emotional and existential distress.
Primary care physicians are in a unique position to lead the integration of palliative care, ensuring that treatment is consistent with both clinical evidence and patient values, particularly in the context of complex family dynamics.

CASE SUMMARY



- **Patient**: 73-year-old widowed male, Glottic SCCA Stage IVA with lung metastases
- **History**: s/p total laryngectomy, thyroidectomy, chemoradiation
- **Problem**: Persistent dyspnea and tracheostomal bleeding
- **Complication**: The Advance directive was signed but neglected due to caregiver fear and emotional unreadiness
- **Baseline ECOG 1 → ECOG 4 upon admission**

INSIGHTS

- Primary care physicians are central to delivering dignified end-of-life care. In emotionally complex cases, our strength lies not only in medical decisions—but in guiding families through fear, uncertainty, and grief with clarity and compassion.
- The most powerful interventions are not always pharmacologic. Helping a daughter say, "*Let Papa rest*", or a patient say, "*I forgive you*", may bring more peace than any drug.
- Advance care planning is not a one-time form— it's a long-term relationship. Family doctors are best positioned to revisit goals, support emotional readiness, and translate silent suffering into shared decisions.

INTERVENTION & OUTCOMES

PARAMETER	INITIAL STATUS	POST-INTERVENTION IMPROVEMENT
SATURATION	67–75%	80–90%
RDOS	6 (Severe) HR: 111 (+2) RR: 31 (+2) Look of fear / eyes wide open (+2)	2 (Improved) HR: 105 (+1) RR: 30 (+1)
BPS	6 (Distress) Facial: Brow lowering (+2) Arms: Partially bent (+2) Ventilator: Coughing (+2)	4 (Improved) Facial: Relaxed (+1) Arms: Partially bent (+2) Ventilator: Tolerating (+1)
INTERVENTION	—	MORPHINE 2 MG IV

END-OF-LIFE MOVEMENT

Despite relief from morphine, the patient's breathing remained labored, his oxygen still low. His daughter, torn between hope and helplessness, sat beside him, remembering his advance directives—but clinging to the man who had always been her strength.

"Thank you. I'm sorry. I forgive you. I love you. Goodbye."
謝謝你。對不起。我原諒你。我愛你。再見。
She whispered these five sacred words—full of years of unspoken love, pain, and peace.

Later that day, his body weakened. A code was called.
Seven cycles. Seven returns. But his soul had already begun to drift.

With trembling voice, his daughter made the hardest decision a child can make:

"Tama na, Doc... Pahinga na si Papa."
(That's enough, Doctor... Let Papa rest.)
夠了，醫生。讓爸爸好好休息吧。

🕯️ Time of death was called.

The next day, bereavement care was offered via telemedicine. Through tears, his daughter softly said:

"Doc... salamat." (Thank you.)

RECOMMENDATIONS

Strengthen palliative care training in family medicine by ensuring longer, structured rotations in hospice and end-of-life settings—where skills in communication, compassion, and continuity can be truly developed.

Keywords: Palliative Care · Dyspnea · Primary Care · Advance Directives · RDOS · Morphine · End-of-Life