So we have Mr. Sachin Kumar here, he is the senior nursing officer at TMS, a machine
nurse in oncology and 15 plus years of clinical experience at Tata Hospital and he is a active
member of CPCR TMS TMS.
Welcome Sachin.
Thank you, ma'am.
Thank you for a wonderful introduction.
Okay.
Today I am going to present my topic on navigating barriers in life with lung cancer through
a palliative nursing.
In lung cancer diagnosis can be a daunting and a overwhelming experience to the patients
and relative.
Feeling with the support of a compassionate palliative nursing team, the nurses and the
patients have a comfort quality and this presentation have a multi-phase needs palliative cancers.
Mainly, we understand the lung cancer experiences.
Mainly, we divide it as a three parts.
First one is a physical impact, second one is emotional and third one is a practical
one.
In a physical impact, lung cancer can cause debilitating symptoms such as shortness of
deep fatigue, pain and decreased a palliative which can significantly impact a patient's
day to day life.
Second one is emotional impact after diagnosis of a lung cancer patients and the relatives
suffer from anxiety, depression and the placement of heavy emotional on our patients and their
loved ones.
Practical challenges, navigating the healthcare system, managing financial concerns, balancing
work and caregiving responsibilities can add additional stress and complexity to the lung
cancer journey.
First mainly the role of a palliative nursing in the supportive care, we do the symptomatic
management, the lung cancer patients have a symptoms like breathlessness, pain, nutritional
support and the fatigue.
In the lung cancer patients, mainly we go to the oxygen therapy.
In that low flow system, we provide a relatively stable FiO2 in a low flow oxygen system as
long as a spirit plate and a patterns are stable, can deliver high FiO2 but the actual amount
we vary from breath to breath.
First example may be the nasal cannula, everyone knows this the nasal cannula, mainly 126 liters
per minute we will give.
In nasal cannula, the advantages are safe, simple and easily tolerated, not expensive,
patient can speak and have phone.
But the disadvantages is if we give more than 4 liters, then the patient feel the dryness
of a mouth and the respiratory tract and the chance of having epistaxes.

And simple mask, we have mainly in the time of whoever patient is having a respiration
through mouth, we will use the simple mask.
And the rebreather mask and the face thing to use in a rebreather mask, we have two types, one is the non-breederetharmask and rebreather mask.
In a non-breederetharmask, we have two volts and rebreather mask, we have only one mask.
For a rebreather mask, whenever the patient exhales CO2, it can be inhaled by itself
from the patient.
But in non-breederetharmask, the 100% of oxygen will be given to the patient.
High flow system indicates in patients with variable respiratory rate and pattern to provide
appropriate FIO2 to meet patient's respiratory demand.
The examples include the venturi mask.
Here we can see the different colors of a walls, which can be given different amount
of oxygen.
First one is a view which delivers 24% of oxygen that is FIO2, it mixes with the normal
room L, 76% and we will give to the patient.
Most of the cases at the time of COPD, we use the VUs eventually masking at the time
of a COVID, we have used more venturi mask.
At the vocal deliverable 24% of COPD with permanent emitters per minute, we have to do.
Next one is a LO, LO deliverable 28% of oxygen with a 4 liter of per minute oxygen delivery.
White one is 31% O2 with a 6 liters per minute and green 35% of a FIO2 with a 6 liters per
minute pink one 40% O2 with a 8 liters of oxygen delivery or inch 50% of oxygen and 50% of room L with a 10 liters per minute.
Develization mask, whenever we give the nevelization only for the nevelization with the dewoline or a buddokod, anything else, we have to give for the O2 oxygen therapy,
we have to use particular the oxygen mask.
High floor nasal canal already excellent by the subraya bedder.
Mechanical ventilation will be used in ICU.
Same of the delivery systems with their oxygen delivery, those are we mainly divided
in the non-in-majou, in-majou means which we penetrate to the respiratory system and
the non-in-majou means without penetration of the respiration system, we will give the
oxygen therapy.
The ETA tube have a 6 to 15 liters per minute, take us to me 4 to 10 liters per minute,
CBF 5 to 60 liters per minute, T-P is 10 to 16 liters per minute and non-in-majou, low
floor oxygen nasal catheter is a 6 liters per minute, face mask is 6 to 10 liters per
minute, rebreather mask.
The inner rebreather mask, I have already explained that a barshing rebreather mask and non-rebreather mask, the difference between these two are mainly the valve which will
be different from each other, but here there will be no contraindication and this will
be the moody preferred rebreather mask because in our hospital we will not give humidified

oxygen therapy to the patients because of the infection control policies, but here the
rebreather mask have a humidified air which can reduce the dinosaur respiratory system
or a oral dehydration.
So, in a high floor, venturing mask 4 to 12 liters per minute, CPAP and BIPAP is 5 to
60 liters per minute.
Next one is pain management, pain management in a palliative care for lung cancer patients
focus on improving quality of a life and providing relief from pain and other symptoms.
The pain is a holistic and involves pharmacological and non-pharmacological and international methods
tailored to the individual's needs.
The pharmacological management, we have mild to moderate pains for opioids and non-opioids
and adjuvant, non-opioids, pharmacological, sorry, parasitomol and non-steroidal inflammatory
drugs we have, ibuprofen and dichlyphinite can be used for a first line agents and adjuvant
for the neuropathic pain and a bone, drugs like anti-depressants, anti-convergence and causticosteroids.
Moderate to severe pain, we use weak opioids, strong opioids for inner weak opioids, according
terminal for a moderate pain.
For strong opioids, we use morphine, oxycodone, fintany and for the severe pain.
But the dosage will be differ from the patients of patients and the side effects.
Breakthrough pain, rapid acting opioids like a trans muscular fintany can be at this episodic
pain.
Management, we see most of the times after giving the morphine, patients have constipation.
So with that, we have to give the laxative for the patients.
Nausea for weak opioids like a tramadol, some of the patients after giving tramadol patients
are not safe.
So that time, we have to use anti-imetics before giving the tramadols.
Traditions, if the patients have more sedation by using opioids, so we have to convert it
into the mild opioids or a first line drugs.
So interventional approaches will be the radiation therapy, palliative radiation for
a localized bone pain metastasis, nerve block for a severe localized pain, and response
to systematic medications, an example intercostal or a celiac plexus block, spinal analgesia
or interthetical administration of an opioid solid local anesthetics for refractory pain.
So next is addressing the emotional and the spiritual needs of a patient already counseling
and support.
Before this one, the counseling and support in our hospitals, the counselors and the, which
are present, they coordinated go through the patients, normal feelings, which are not the
patient.
Anyway, the palliativeness provides a space for a patient's express their fears, concerns

and emotions of her empathetic listening, empathetic listening, connecting with the mental and
the professional as needed.
Spiritual guidance, the spiritual guidance, work complaint, chaplain surface spiritual
leaders to support patients, spiritual religious beliefs, helping them to find the meanings and purposes.
In our hospital, some of the cases happen.
One patient's always the, it's not the mechanical which we do for giving medicine, but we have
to go through the spiritual guidance also spiritual guidance where one example happened with me
in the day care.
One patient told me, just I have asked him whether you had the breakfast or not, he told
sir before coming to the chemotherapy, we will have a bath and we will come, we will
have a bath and we take a breakfast and we will come.
I told very good then, again he told that you people's are like a pujadi, which gives
other to us, which we received very happily.
So the work and the spirituality together, mixed together have a wonderful treatment
outcome.
So spirituality comes with the, we have to coordinate with the spirituality and the medications and family support.
Family support is very important here, here also I have gone through some of the examples
in the world, a very educated person asked that if already her mother is having cancer,
he asked me whether it will come to our children's also what, if we touch or not.
So the family support and family knowledge is very important to go through the particular
cancer diagnosis.
So family should know whether the cancer spreads or not, this one is a family support
which I have experienced in our work.
And grief and bereavement, paleo-to-nushes offer compassionate end of life support and
collaborate with the grief counselors to help patients and families, navigating grieving
process, ensuring peaceful and a dignified transition.
The practical challenges, care and coordination already, Shwetamam has explained the nursing
responsibility in her first slides, navigating the healthcare system and her resources, care
and coordination.
The paleo-to-nus patients and the family navigate the complex healthcare system, coordinating
appointments, managing medical records and ensuring seamless transactions between providers
and settings.
The second one is a financial assistance, we have financial assistance like Rajagandis
scheme, Bhagmat, sorry, Rajagandis scheme and we have the categories like NC categories.
So here the nurses and the government and the doctors will go help financially support
the patient through the different organizations like one of the anand pharmacies

there in
a palliative department.
They gives whoever is the very poor person, they gives a free of course the dressing materials,
medicines.
So some of the associations and organizations are there which will help for the financial
support.
And next one is a community support.
The palliative nurses length the patients and families with the local support groups,
either it may be a politically, non-politically.
Patients advocacy organizations and other resources that can provide emotional, social and
practical support throughout the cancer journey.
So the community will help the patients and patients relative to go through a proper diagnosis
or a proper help for the patients.
So we are here, I am concluding that the navigating the problems and different challenges are
very important for the palliative patients and we are navigating the patients and the
relative's problems also.
So thank you, thank you for everyone and thank you for Madam for giving me wonderful opportunity
to present my topic.
Here I am concluding, thank you.
Thank you.