Developing a singular therapeutic project based on palliative care

Desenvolvimento de um projeto terapêutico singular baseado em cuidados paliativos

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1 INTRODUCTION

The Singular Therapeutic Project (PTS) is a care tool focused on a singular approach, which is capable of looking at the subject as a multiple being who presents several processes that intertwine throughout the course of life. It has an interdisciplinary idea, based on a multiprofessional team, so that, through it, it is possible to acquire new visions and possibilities of care, going far beyond mechanistic medical practice and contributing to the diversification of offers in health services (PINTO et al., 2011; OLIVEIRA, 2007; SLOMP et al,2022).

The PTS aims to formulate therapeutic conducts directed to an individual, family or collectivity, in order to build care strategies (OLIVEIRA, 2007). However, it is worth mentioning that the PTS is not fixed or definitive, so that it is always open to new ideas and changes, being characterized as dynamic as it is permanently under evaluation and construction (SLOMP et al,2022).

Thus, the Singular Therapeutic Project (PTS) to be developed in this work was built through the theoretical and practical classes of the Community Health III (SCIII) discipline attended in the third period of Medicine of Macaé of the Institute of Medical Sciences of the Multidisciplinary Center of the Federal University of Rio de Janeiro (ICM/CM/UFRJ), making it possible to collect data in interviews with a user of the Unified Health System (SUS), attended at the Dona Sid Carvalho Rehabilitation Center, located in the municipality of Macaé, Rio de Janeiro, as well as with health professionals from that unit.

A concept of paramount importance to be highlighted to assist in understanding the objective of this PTS is that of Palliative Care (PC). PC seeks the prevention and relief of suffering and the promotion of dignity, in order to enable a better quality of life and adaptation to progressive diseases for patients with chronic, complex or life-limiting health problems and their families. This form of care promotion presents some principles, which are extremely necessary for the construction of the PTS in question, such as relief of pain and other symptoms that cause suffering, integration of psychic, spiritual and physical aspects, a team that can meet the needs of patients and their families, offer a support system to help the patient live as actively as possible until death and consider death as a natural process of life (SOUZA FILHO; TRITANY, 2020). Thus, because patient R has a rare degenerative disease, which has not been identified so far and the cause is unknown, it is not possible to intervene directly in its evolution, so this PTS seeks to offer principles of PC to assist in the treatment of the patient and seek to improve her quality of life.

PC should be performed in conjunction with other therapies and treatments aimed at improving the patient's quality of life and prolonging it, investigating possible worsening. In addition, a multidimensional understanding of health is necessary, analyzing not only the patient's physical state, but also the emotional, social and spiritual aspects of pain and suffering. This understanding should not be restricted only to the patient, but should include all those involved in this process, such as family members and the multidisciplinary team (SOUZA FILHO; TRITANY, 2020).

Thus, it is possible to bring the objectives of this study, which are: the elaboration of a shared assessment of the conditions of the user under study and new perspectives of care; the analysis of the individual in its singularity and multiplicity; the understanding of the physical, emotional, social and spiritual components of pain and the search for a better quality of life for the patient.

Finally, the construction of the PTS for the case of patient R. brings with it the importance of analyzing her clinical picture in a multidisciplinary way, in order to enable approaches in different areas of the patient's life, which, together, can generate a physical and emotional improvement, allowing a better quality of life. In addition, the realization of a PTS helps us to understand that medicine is not only about solving the problem that led the patient that day, it goes far beyond that, being necessary to look at the individual as a whole and his networks to be able to help him effectively.

2 OBJECTIVE

To build a Singular Therapeutic Project of a user of the Unified Health System (SUS) of the municipality of Macaé based on Palliative Care.

3 METHODOLOGY

The present study was developed as part of the activities of the Community Health III discipline, taught to students of the third period of the Medicine course of the Institute of Medical Sciences of the Federal University of Rio de Janeiro (ICM/CM/UFRJ). For this purpose, a tutorial group was formed, composed of 11 (eleven) students and accompanied by two teachers, with the objective of getting to know a health care service in the municipality of Macaé, Rio de Janeiro, and a user of this service, with a view to the elaboration of a PTS.

Initially, medical records of patients who underwent physiotherapeutic treatment at the rehabilitation clinic of the Dona Alba Medical Specialties Center, located in the city of Macaé (RJ), were analyzed. The case studied was chosen through subjective criteria of the authors of the work, taking into account points such as the complexity of the case and the patient's willingness to participate in the research. Face-to-face meetings were scheduled at the rehabilitation center to conduct interviews with the patient and the health professional who follows the treatment, in order to understand the case in depth. Both interviews were transcribed and the main parts for the construction of the PTS were selected and shared among the group.

For theoretical basis, a search for existing bibliographic materials on subjects related to the case was made. About 29 scientific materials were analyzed, such as articles and books, which added knowledge to the group and contributed to the construction of the present study, with themes related to palliative care, singular therapeutic project, lines of care, biopsychosocial model, mental health, degenerative diseases, thyroiditis and multisystemic protein therapy.

In addition, a lecture on palliative care given by Breno Bormann, PhD in Epidemiology and Public Health and Master in Palliative Care, offered by the Community Health discipline of the ICM/CM UFRJ, was important for a better understanding of the subject and for the foundation of the study.

Thus, the construction of this PTS was possible through information acquired through interviews and theoretical research. In addition, some auxiliary elements, such as an echogram and a genogram, could be elaborated in order to better understand the patient's family and social situations, understanding her needs and enabling a complete and individualized approach.

This work is part of the research "Training doctors/researchers: case study of educational experiences in the teaching of collective health in the medical undergraduate program of UFRJ/Macaé", approved by the Research Ethics Committee (CAAE 53249921.9.0000.5699). The participants signed the Informed Consent Form, agreeing to participate in the study and academic activity.

4 RESULTS

4.1 IDENTIFICATION AND BRIEF DESCRIPTION OF THE CASE

The PTS analyzes the health situation of the user R., a 66-year-old retired woman. R. has two children and currently lives with her husband, who works as a taxi driver, in the municipality of Macaé. Since adolescence, the patient has had constipation and used laxatives to treat it. At the age of 40, she was diagnosed with depression and, according to the patient, was prescribed drugs that were not very effective. In addition, in 1996, also at the age of 40, she was diagnosed with Hashimoto's thyroiditis and, in 2008, she was diagnosed with fibromyalgia, being prescribed pregabalin at maximum dose to improve the condition. This last diagnosis brought many changes in R.'s life, since the symptoms of the disease make it difficult to perform routine activities, in addition to leading to a return of the depressive state and the approval of her retirement due to disability. It is worth mentioning that the patient denies hypertension, denies diabetes and also has osteoporosis and osteopenia.

Currently, the user's main complaint is difficulty walking and lack of strength in her hands, due to R.'s current illness, which is still undiagnosed. She reports suffering many falls during her adult life and, after the COVID-19 pandemic, reports many bruises caused by falls and pain unrelated to fibromyalgia. These signs and symptoms led her to seek an orthopedist who prescribed anti-inflammatory and painkillers, but there was no significant improvement in the condition. Months later, after the pain radiated to the right lower limb, the patient was referred to a neurologist who, after prescribing an electroneuromyography, identified that R. had a myopathy and prescribed pregabalin as treatment.

The symptoms also manifested in the right upper limb and, therefore, the user sought a geriatrician. At the consultation, she was instructed to perform a second electroneuromyography at a private clinic and the result of this procedure found myopathy. To investigate the case, R. was hospitalized at the Pedro Ernesto University Hospital in April 2022 for about 20 days, where it was revealed that the symptoms were consistent with neuropathy, the main diagnostic hypothesis so far. In the same hospital, another electroneuromyography and skull resonance imaging were performed, in addition to genetic and cerebrospinal fluid tests. During hospitalization, amyotrophic lateral sclerosis (ALS) was suspected, but after the tests, this hypothesis was ruled out.

Currently, the clinical manifestations of neuropathy indicate a chronic and progressive motor condition, initiated with paresis in the right lower limb of distal predominance and foot drop, with escarvante gait, right foot drop, dysarthria, interosseous atrophy on the right, atrophy of the short extensor of the toes, achilles arreflexia, in addition to tongue fasciculations and discrete fasciculation in the upper limbs. To improve the condition, the patient has been undergoing speech therapy and physiotherapy at the

Dona Sid Carvalho Rehabilitation Center, located in the municipality of Macaé, since June 2022 with a focus on muscle strengthening, joint mobilization, gait and balance training. In addition, he uses six medications: Duloxetine, Clomipramine, Rivotril, Puran T4, Rosuvastatin and Pregabalin, to help treat depression, thyroiditis and fibromyalgia.

It is important to note that R.'s residence has several physical adaptations that contribute to his locomotion within the house and that the case of fibromyalgia is monitored by a Basic Health Unit (UBS) in the municipality of Macaé, however, the main current diagnostic hypothesis, degenerative neuropathy, as well as myopathy, are not yet part of the treatment plan of the team of this unit.

4.2 LIST OF HEALTH PROBLEMS

1. Clinical Issues:
    a. Recurrent constipation since the pubertal stage
    b. Development of autoimmune diseases
        i. Hashimoto's thyroiditis
        ii. Fibromyalgia
    c. Depression
    d. Osteoporosis
    e. Osteopenia
    f. Progressive peripheral neuropathy
        i. Change in balance
        ii. Myopathy
        iii. Dysarthria
        iv. Paresis of the lower limbs
        v. Scarcity march
        vi. Dropped right foot
        vii. Interosseous atrophy
        viii. Short extensor atrophy of the toes
        ix. Achilles Reflexia
        x. Fasciculations of the tongue
        xi. Fasciculation in upper limbs
    g. Fecaloma
    h. Has a family member with similar symptoms
2. Non-clinical problems:

a. Progressive loss of autonomy in basic and instrumental activities of life
b. Loneliness
c. Decreased social support networks
d. Fragility
e. Vulnerability
f. Social dependency

In view of the identification and description of the clinical case, it is possible to detail and elucidate the health problems experienced by the patient from the study and interpretation of the set of signs and symptoms, as well as the description of the diseases affected, such as: autoimmune diseases, such as Hashimoto's thyroiditis and fibromyalgia, in addition to the development of depression, fecaloma, myopathy and neuropathy that may be associated with neurodegenerative disease.

Autoimmune diseases are caused by a persistent loss of the control mechanisms responsible for maintaining tolerance to self antigens (FARIAS, 2021).

Fibromyalgia (FM) is a chronic neurological syndrome and rheumatic condition without inflammation (PITA et al., 2022). It affects about 2.5% of the world's population and is considered the second most frequent cause of consultations in rheumatology outpatient clinics. The fibromyalgia (FM) population is mostly composed of women, mainly affecting patients between 30 and 55 years old (CAVALCANTE et al, 2006). The etiopathogenesis is unknown and is related to autoimmune diseases, generalized fatigue, morning stiffness, stress, sleep disorders, anxiety and depression, interfering with the patient's overall quality of life (PITA et al., 2022). The central mechanism of this disease is the alteration in the neurotransmitters of the central nervous system and is characterized by diffuse and chronic pain (minimum period of three months), usually associated with painful points on palpation (LORENA et al., 2016). Thus, this pathology negatively interferes with the patient's quality of life. They have difficulties in everyday tasks, this makes them insecure about performance, whether in family or professional life (MARTINEZ, 2006). Therefore, due to the lack of knowledge of the origin of the disease, the adoption of global strategies to approach the patient is often limited. The control of pain is described as the main objective of interdisciplinary treatment of FM, basically aimed at restructuring the functional capacity and improving the quality of life (QOL) of the patient (SMARR et al., 1997).

It is possible to hypothesize about an association between FM and the development of depression in the patient. This is because the central feature of FM is pain, which has a negative impact on health-related quality of life and also increases levels of stress and negative affect. However, the affective symptoms that characterize the FM syndrome (WOLFE et al., 2010) may also be relevant to the impairment of QoL. Negative emotional states may increase the perception and disability of symptoms by different mechanisms, such as increased interoceptive attention and somatosensory and symptom amplification, and interpretation of them in more negative terms (WATSON AND PENNEBAKER, 1989). As such, a vicious circle can be established, whereby pain increases the degree of depression-anxiety and the latter in turn increases pain perception and thus decreases the patient's health-related QoL (PERROT et al. 2011). In addition, activation of the autonomic nervous system (ANS), linked to anxiety and depression, can generate somatic correlates, leading to increased symptom perception.

Regarding the other autoimmune disease developed by the patient, autoimmune diseases affecting the thyroid constitute 30%, highlighting Hashimoto's thyroiditis (HT). HT is a disease characterized by the presence of autoantibodies that destroy thyroid tissues. The susceptibility of HT development is associated with genetic and environmental factors, but its pathogenesis is not fully understood (DA NÓBREGA et al, 2021). This pathology leads to a clinical condition called primary hypothyroidism, which results from insufficient thyroid hormones in the body. HT is found in any age group and gender, with a variable incidence, however, epidemiologically, it is more common in females and mainly affects the age group of 30 to 50 years. In addition, the clinical manifestations of hypothyroidism are very broad, with weight gain and fatigue being the most common, and the prognosis of the disease varies according to diagnostic and therapeutic efficacy. Regarding diagnosis, this is performed through anamnesis, physical examination and, indispensably, through laboratory tests with evaluation of free T4 and TSH. Therapeutic management is done pharmacologically through Levothyroxine, whose objective is the hormonal replacement of T4 (DE CARVALHO et al, 2022).

Regarding degenerative diseases, it is important to understand their concepts in order to elucidate their involvement in the patient. Degenerative diseases are those that lead to the debilitation of the health of the individual affected by it, in a progressive way (Ministry of Health, 2013). Of multifactorial etiology, they arise from an interaction between behavior, the environment and the genetic profile; their onset is gradual, and the prognosis is, in most cases, uncertain, and their duration is long or indefinite. Its clinical courses may change throughout the progression of the disease, which may generate periods of worsening of the condition and, to the affected, disabilities (Fiocruz, 2016).

According to the Global Burden of Disease (2016), some of the determinants of chronic degenerative diseases, in terms of Disability Adjusted Life Years (DALY), are attributable to behavioral risks such as poor nutrition, high body mass index, smoking habits, high alcohol consumption and low levels of physical activity, as well as genetic factors.

Neurodegenerative diseases affect the nervous system and, consequently, have repercussions on other structures dependent on this system, such as muscles and other organs; their symptoms can be isolated or systemic, such as specific pains - headaches, pain in isolated limbs -, changes in sensory functions - vision, taste, smell, hearing -, motor function, sensitivity, among others.

Frequently observed symptoms range from muscle weakness to lack of coordination; they can also interfere with sleep patterns and generate psychological changes, triggering depressive episodes, for example. More general symptoms, such as pain, muscle dysfunction, vertigo, altered state of consciousness, may indicate the altered health status of individuals affected by such pathologies, and more specific symptoms are essential in the final analysis in order to conclude the diagnosis.

Addressing on symptomatologies, neuropathic pain has been defined as a consequence of certain dysfunctions, affecting about 3-17% of the general population, and is characterized by positive (extra sensations perceived by the patient, such as pain, paresthesia, numbness and tingling) and negative aspects (loss of functions such as sensory, motor and cognitive deficits). Neuropathy can be part of mixed pain syndromes and can be a component of chronic pain. Usual analgesics effective in treating nociceptive pain may be ineffective in neuropathic pain. Neuropathic pain has also been associated with neurological disorders (such as multiple sclerosis (MS), stroke, centralized pain syndromes). Neuropathic control in patients with neurological conditions relies on symptomatic relief usually through multimodal pharmacological therapy. As a general rule, first-line approaches include gabapentinoids, tricyclic antidepressants and serotonin-norepinephrine reuptake inhibitors (SNRIs), however, opioids, topical lidocaine or capsaicin and even botulinum toxin may be considered second- or third-line therapies. New treatments are being considered as the mechanisms underlying neuropathic pain are better elucidated (MITSIKOSTAS et al, 2022).

As for muscle disorders, they can be subdivided into myopathy, when the pathology is confined to the muscle without any structural abnormality in the peripheral nerve, and neuropathy or neurogenic disorder in which muscle weakness is secondary to alteration of the peripheral nerve, i.e. from the anterior tip of the medulla to the neuromuscular junction. Most muscle disorders produce muscle weakness and atrophy especially of the proximal muscles with the distal muscles being less affected. Some of them, such as muscular dystrophies, develop early; others later. Some progressively worsen without good response to treatment; others are treatable and remain stable (CARVALHO et al, 2013). There is no approved disease-modifying therapy for myopathy and management is supportive. Patients should be followed by a multidisciplinary clinic at least every 6 months; components of this clinic should include a neurologist, physiotherapist, occupational therapist, psychologist, respiratory therapist and social worker. The team should manage symptoms of limb and bulbar weakness, respiratory dysfunction, and muscle cramps (KORB, 2022).

In addition, another symptomatology reported by the patient is the presence of fecaloma. Chronic constipation is a more common condition in the elderly. It has a multifactorial etiology and may be related to metabolic, endocrine, neurological diseases, morphofunctional disorders or drug side effects. Fecaloma is a severe stage of constipation, due to incomplete evacuation for a prolonged time. It presents as abdominal pain and distension, tenesmus, partial or total intestinal obstruction, as well as compressive symptoms due to mass effect (FERREIRA, 2021).

Regarding the discarded diagnostic hypotheses in which the patient was submitted, it is important to understand some of them, such as neuropathies involving the development of Charcot-Marie-Tooth Disease and Amyotrophic Lateral Sclerosis (ALS), and Multisystemic Protein Therapy (MSP), this being a rare genetic disease.

Among the known genetic neuropathies, there is Charcot-Marie-Tooth disease, a group of disorders characterized by slowly progressive muscle weakness affecting the distal muscles of the hands and feet. Charcot-Marie-Tooth disease type I (CMT1) forms a heterogeneous group, with autosomal dominant, autosomal recessive and X-linked inheritance pattern. CMT type IA, of autosomal dominant inheritance, is characterized by muscle atrophy and decreased nerve conduction velocity. Nerve biopsy shows a hypertrophic demyelinating neuropathy. Lower motor neuron diseases include Spinal muscular atrophies. Spinal muscular atrophies (SMA) are genetic diseases characterized by symmetrical proximal muscle weakness associated with degeneration of anterior horn cells. In the most severe cases, of the bulbar motor nuclei. Inheritance is autosomal recessive. Acute and chronic forms have been described: Werdnig-Hoffmann disease (SMA type I), intermediate SMA (SMA type II) and Kugelberg-Welander disease (chronic form or SMA type III). In addition, it is possible to point out Amyotrophic Lateral Sclerosis (ALS) which is a degenerative disease of the lower motor and cortical neurons, causing progressive muscle weakness and atrophy, with fatal evolution usually within 5 years. The etiology is unknown, but approximately 5-10% of cases are familial forms, suggesting a genetic cause. Familial ALS is inherited in an autosomal dominant manner (KIYOMOTO, 1996)

It is also important to highlight Multisystem Protein Therapy (MSP). MSP is a rare and heterogeneous genetic disease that can cause: inclusion body myopathy, affecting the muscular system and having axial and proximal weakness progressing distally as the most common symptomatology, although presentations similar to facioscapulohumeral muscular dystrophy, oculopharyngeal muscular dystrophy and distal myopathy have been described; Paget's bone disease, which affects the skeletal system and is symptomatic of bone pain, bone deformities, pathological fractures, hearing loss; sensorimotor neuropathies, such as Charcot Marie Tooth Axon Disease (CMT), which affects peripheral nerves, among other systemic manifestations that include Parkinsonism, Amyotrophic lateral sclerosis (ALS) and Frontotemporal Dementia (KORB, 2022).

In addition, it is worth noting that health problems go beyond the clinical field. This is because the patient reports progressive loss of her ability to adapt to the environment and impairment in performing her daily tasks, thus causing greater vulnerability and dependence.

Functional capacity can be defined as the potential that individuals have to decide and act in their lives independently, in their daily lives. And functional disability refers to the difficulty or need for help for the individual to perform tasks in their daily lives, covering two types of activities: Basic Activities of Daily Living (BADL) and Instrumental Activities of Daily Living (IADL). Mahoney and Barthe and Lawton and Brody presented two functional assessment scales that classified activities of daily living according to their level of complexity. They developed a scale to assess IADLs with eight activities: preparing meals, doing household chores, washing clothes, handling money, using the telephone, taking medication, shopping and using transportation. Regarding BADL, the Katz index is one of the instruments used to assess BADL and was created by Sidney Katz in 1963 to assess the functional capacity of the individual. Katz established a list of six items that are hierarchically related and reflect the patterns of child development, i.e., that the loss of function begins with the most complex activities, such as dressing, bathing, until reaching those of self-regulation such as feeding and elimination or excretion. Therefore, it is based on the premise that functional decline and loss of ability to perform activities of daily living in patients follow the same pattern of evolution, i.e. the ability to bathe is lost first, followed by dressing, transferring from chair to bed (and vice versa) and feeding. Recovery occurs in the reverse order (BARBOSA et al., 2014).

Still in this context, it is possible to find in the literature some studies that suggest depressive symptomatology as a predictor of decline in ADL, intellectual activities and performance in social activities. This decline may start by deteriorating performance in IADLs, later evolving into deterioration of simpler activities in BADLs. It is likely that a subject with a depressed mood may have less willingness to participate or integrate in the society in which he/she lives. For this reason, it is hypothesized that depressive symptomatology, in addition to the other factors involved, can begin to deteriorate more complex activities of daily living, in a short period of time, having a greater impact than traditional risk factors (KAZAMA et al., 2011).

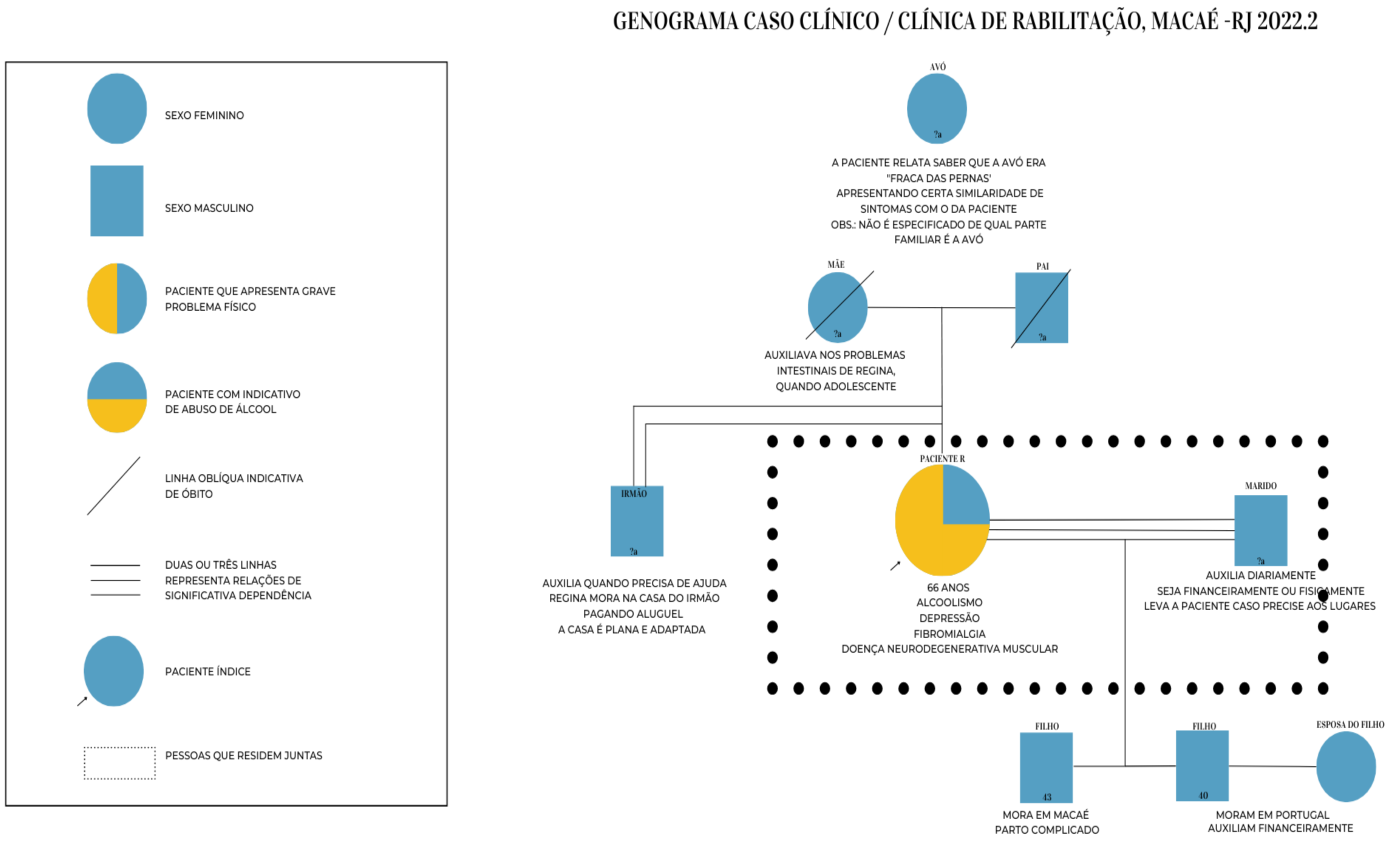
4.3 FAMILY AND HOUSEHOLD APPROACH TOOLS

Family and household approach tools are essential for organizing the information collected. There are several proposals for tools that serve as standardized models that facilitate the family approach (SLOMP et al, 2022). In the present study, the genogram and ecomap were used to trace the family history and understand the dimension of their relationships in health care. According to Gusso et.al (2019), the genogram is a graphic summary of the family relationships of the individuals studied. This consists of explaining the history of people and their families, allowing a mapping and expansion of knowledge about the singularities of each case.

The model for its formulation is constituted from the index person and establishes the direct links with close and distant individuals. In addition, it is also possible to trace existing health conditions in the family history. The construction of the genogram showed a strong interaction between spouses. During the meetings, it was possible to realize that the user's family relationships are well established.

In the elaboration of the PTS, it is essential to indicate these relationships, since they can contribute to the health care process (SLOMP et al, 2022). According to Figure 1, the patient has a strong relationship with her husband, who becomes the main member of her care network. In addition to the husband, the children actively participate by contributing material and financial resources and psychological support, in addition to the brother who made it possible to provide the flat-plan residence in which the patient lives and which is now adapted.

Figure 1 - Genogram of patient R.



Source: own elaboration.

Another highlight was the relationship of the history of diseases that the genogram allows to analyze. According to data collected, the interviewee has a family member, explained by her grandmother, with symptoms similar to the one reported by the patient as "weak in the legs". This fact corroborates the effectiveness of using tools to establish hypotheses and broaden the view regarding family interference in the health-disease process, and especially, to know the family relationship with existing diseases and health problems, which invariably affects the experience of illness experienced by the user.

The Ecomap, in turn, is a useful tool in the family approach since it is able to identify the systems that relate to the index person. It is possible to trace through the ecomap the links between the family and community services and social groups and significant relationships such as friends or neighborhood that encompass the patient's daily life. In this way, it allows the evaluation of support networks and social relationships, whether strong or subtle (CARNEIRO et al., 2022).

In the ecomap (figure 2) established for this PTS, the strong bonds are mentioned, described by arrows, the patient's rewarding relationships in relation to health services. It is worth mentioning that the Basic Health Unit frequented by the patient is to her liking, since it has green areas and appears to be a harmonious place, which the user reports presenting "a lot of green, a feeling of peace"; the Public Hospital of Macaé was reported as an important space during the SARS-COV-2 pandemic in the face of the diagnosis of fecaloma, where the patient was treated with dignity.

A similar report was established for Pedro Ernesto Hospital, where, although on the first day of care it was a relative wait, it is also a place where she feels respected and welcomed and treated in a humanized way. In addition, the work as a public servant was reported as very valuable for the patient; however, the need to retire due to the health condition of fibromyalgia was observed. Regarding religious relations, her work in a spiritist center in the Macaé region was mentioned, reported as a welcoming place for the patient in question. However, this relationship was recently interrupted, also due to her current health condition and, above all, due to the difficulty of locomotion.

Figure 2 - Ecomap of patient R.

Source: own elaboration.

4.4 RECONSTRUCTING LIFE STORIES

Using another PTS tool, it is possible to trace the user's life story, based on her personal accounts collected through the recorded interview, bringing her memory and incorporating it into her treatment process. In this way, we seek to bring to the focus of the therapeutic project the needs of the individual whom we seek not only to treat, but to listen, understand and, above all, offer a maximum quality of life, within the realities of their clinical condition. Some "existential turning points" - "(...) event(s) that, at a certain moment in our lives, and under certain conditions, made us think and act differently, (...) changing the way we conduct our relationships." (SLOMP JUNIOR; FEUERWERKER; MERHY, 2015) - are highlighted during the user's narrative, mainly because they are thresholds of physical, psychological or emotional changes, perceived both in the course of the story and in the patient's own expressions during her speech.

R. currently lives only with her husband, a cab driver, and her caregiver - all the help for locomotion, food and personal hygiene are provided by her partner. However, his absence due to work generates a certain loneliness to the user, since, due to the evolution of her condition, she no longer participates in her former social activities, such as her visits to the spiritist center and her beloved walks in the open air. Her children, despite maintaining a good relationship and helping her whenever possible, have their independence - one lives in another city, and the other in another country.

The patient tells, with some humor, about her youth: she tells how she lived the years of Tropicália, with the presence of a temporary smoking and with periods of alcohol dependence. Such dependence visits the story several times, in oscillating frames, always presenting some emotional background linked to its occurrence.

When asked about the births of her children, R. is emphatic in mentioning the "abnormal" birth - a word emphasized time after time during the report - of her first child. In addition to a conflicting relationship with the birth team, a specific noise was highlighted, involving a medical student, who decided for a vaginal delivery and, even after the occurrence of maximum dilation and the difficulty of passing the baby, used violence, causing laceration of the patient and subsequently performing an episiotomy, which was reported as an explicit picture of obstetric violence. Her second pregnancy - a scheduled cesarean section - was accompanied by an episode of alcoholism, and even the occurrence of anemia, due to bad habits cultivated during the period.

Next, the user mentioned suffering from chronic constipation since her adolescence, being dependent on the frequent use of laxative medications and, with certain recurrence, requiring intestinal washings performed in a hospital environment.

At the age of 40, after a depressive state and a whole investigation carried out by her doctor, the patient was diagnosed with Hashimoto's thyroiditis; until the conclusion of this diagnosis, R. reports the anguish generated by the process of trying to treat her with medication and its inefficiency, with constant returns to the doctor until the hormonal imbalance was detected. reports the anguish generated by the process of attempting drug treatment and its inefficiency, with constant returns to the professional who accompanied her until, in fact, the hormonal imbalance was detected and, after its adequate treatment, how her quality of life showed an exponential improvement, demonstrating the importance of an attentive analysis of the patient's whole, and not just the main complaint presented, since health is a holistic aspect of the individual.

The narrative takes on a more cheerful tone when the user's move between cities is mentioned, as well as her approval in a competitive examination, which guaranteed her a stable job and the possibility of completing her studies, which had been postponed after her marriage and her first pregnancy. Her entire trajectory in this unit is told with great satisfaction, both for the bond created with the team, as well as for the environment and the feeling of belonging, of usefulness to her function; however, when mentioning the death of her manager and close friend, a melancholic tone is assumed, and it is perceived how much the loss affected her emotionally.

Following her story, and after mentioning the performance of repetitive and manual work, the user reports the appearance of pain in her right arm that persists and soon radiates throughout the body, to the point of making her bedridden. After some difficulties in the search for care in the city where she was, the patient moved to her former municipality and, during a consultation with a rheumatologist, received the diagnosis of fibromyalgia. Apparently, the news did not shake her as much as the proposed treatment: the medication used to control her pain made her lethargic, and left her, for a period, only "eating and sleeping", a fact that seemed to bother her. In addition, the return of her depression and a disability retirement pressured by her social security system - leading to a decrease in her purchasing power - are reported with a certain weight in her voice.

Returning to her cheerful tone of narrative, the user mentions having developed the habit of walking during the pandemic, and talks for a while about the pleasure she had in simply walking around her neighborhood, alone, and enjoying the nature around her -

another denoted passion of hers. Then, in an amused tone, she says she has always suffered many falls during her adult life; one day, after moving to her brother's house, which was flatter and more adapted to her age, which was already approaching 60, she suffered a fall and needed help from her family to recover. Due to the Covid-19 pandemic period, R. reports having felt afraid to seek an emergency service, since everyone was overloaded by those affected by the disease; however, such fear would be overcome by the persistence of a pain that, as she reports, "was different from the one already known, caused by fibromyalgia". After seeking an orthopedist, she was referred to a neurologist, when she received the diagnosis of myogenic myopathy.

The pain, initially felt in her right foot, now appears in another limb: her right hand. Uncertain about the previous doctor with whom she had consulted, the user then goes to a geriatrician with whom she had a closer bond, where she hears a speech that brings, until the present day, very vivid in her memory: "if she continued her treatment with doctors from the public network of Macaé, she would be walking in stride to a wheelchair". Guided by this doctor to perform an electroneuromyography in Rio de Janeiro, even impacted by the information received, she did not have the financial resources to continue with the investigation - when she mentions, with a very evident affection, the organization of the nephews so that the collection was carried out by the family itself, guaranteeing the performance of the procedure.

After confirmation of the diagnosis of myopathy, the patient was advised to be admitted to the Pedro Ernesto University Hospital for specialized follow-up with a neurologist and her team, since her diagnosis was more complex than initially assumed, and so it was done. Even showing some dissatisfaction with the delay in mobilizing the team to actually accompany her - the patient mentions a period of holidays -, the great impact and perception of what was actually happening occurred during the visit of a team composed of doctors, guests, students and the neurologist herself; it is remarkable how, at that moment, the user internalized the complexity of her case and that, perhaps, she could not simply have a diagnosis and follow her treatment aiming at rehabilitation, as she expected. After several examinations - genetic tests, MRI scans, biopsies, cerebrospinal fluid tests, neuron analysis - it was noted that, even with all the emotional and psychological strain imposed on her, the greatest discomfort still existing is the inconclusiveness of all the tools that are within the reach of current medicine.

In spite of everything, R. always shows a serene presence and an extremely humorous attitude; after transmitting a message from her Spiritist doctrine to the team of students who interview her, she goes on to mention her wish that, with her participation in research like this, new patients will not go through the same saga she went through or, at least, not with so much suffering, and demonstrates peace, even knowing the degenerative character of her condition. Naturally, the whole team was moved, not only by his story and all his obstacles, but especially by his attitude towards such suffering and, even so, the maintenance of his welcoming and simple behavior.

4.5 CAUSES OF DISEASE AND AGGRAVATION, AND RISK FACTORS: CROSSINGS OF ILLNESS AND DEATH

In order to support the PTS care proposals, it is necessary to understand the macro-political and micro-political dimensions of this case, in order to adopt a perspective that contemplates both dimensions at the same time. In this sense, the macro-political dimension of the case covers scientific and official aspects, such as care guidelines, risk factors or health determinants, the structure of health services, among others. The micropolitical dimension, on the other hand, covers more subjective aspects that are essential for understanding the individual and their particularities, such as the traversals of illness and death and the life and health agencias (MERHY et al., 2022).

The crossings are understood as forces that act on a composition of singularities. Macropolitically, they are identified as health determinants or risk factors. In a micro-political way, they are identified as the processes related to the territory. In the area of collective health, the territory goes beyond the physical area, that is, it comprises existential, bodily, cognitive and affective aspects, which can be crossed by illness or even death. Thus, throughout life, the individual can undergo deterritorializing and reterritorializing processes (MERHY et al., 2022).

Regarding the case of the present PTS, the patient has multiple comorbidities, such as fibromyalgia, Hashimoto's thyroiditis, severe and recurrent constipation, panic, depression, in addition to moments in the life of alcohol dependence. During his adult life, he reported frequent falls associated with muscle weakness. These aforementioned issues are important for understanding the causes of disease and the risk factors associated with her current condition.

Often, situations like this, characterized by periods of intense pain and suffering, require a high demand on energy. Chronic diseases such as Hashimoto's thyroiditis can be considered risk factors for triggering depression, for example. Alcohol dependence and complications in childbirth related to obstetric violence are also evident.

The patient reported that in the past she enjoyed hiking, especially in contact with nature, and even performed it as a form of therapy. She also attended a Spiritist Center, which was an important ally for well-being. In addition, she demonstrated that she had satisfaction when she felt solicitous, for example, when she worked in a school and had great affection for the social cycle of that place. However, due to the current situation, such life habits have changed and directly impact the user's quality of life. Currently, she misses the walks, the contact with nature and the support networks of yesteryear and sometimes feels lonely. These determinants can actively influence the onset of diseases, their clinical evolution and outcomes.

Another important aspect to be highlighted is the fact that the diagnosis is not completely elucidated. Throughout her life, the patient underwent several tests and consulted several health professionals. However, during this journey, doctors did not always have good communication with the patient, who did not receive completely elucidative information about her case. In addition, the health center in her neighborhood follows her case of fibromyalgia, but has no contact with the recent history of myopathy and neuropathy. The patient also stated that she had never received a home visit from a health team. These crossings can generate wear and tear and a reduction in the power to act. Deleuze and Guattari (2005) understand that such crossings can be called capture, characterized by a strong appropriation of the existential territory, as if there were a "knot" in the possibilities of life and health.

In an interview with the physiotherapist responsible for the care of this user, it was reported that contact between the teams is practically non-existent. The possible diagnosis of Amyotrophic Lateral Sclerosis (ALS), for example, was discarded, however, this fact was not known to the physiotherapist, due to the precariousness of multiprofessional care. This is another crossing that generates failure to ensure quality care.

That said, the present PTS has the capacity to produce life power, "untie the knots" and increase the capacity to act, in order to reverse the crossings that bring illness (MERHY et al., 2022).

4.6 PROTECTIVE FACTORS AND POTENTIALITIES: LIFE AND HEALTH AGENCIES

Agencies are effects generated by something in us, which alter our perception of the world in which we live due to the fixation and registration of these experiences in the body. This altered perception is our existential territory, that is, human subjectivity

(SLOMP JUNIOR; FRANCO; MERHY, 2022). This phenomenon is responsible for deterritorializations and reterritorializations in human beings, taking them from subjective places to others, deconstructing images and reconstructing others, enabling the dynamism of human subjectivity. This process generates the living networks that we are, sometimes predictable and sometimes not so much (MERHY et al., 2016).

Thus, this part of the PTS aims to explore variables present or possible to become present in the patient's life that promote effects opposite to those that the risk factors would promote, making the experience more fluid and potentially improving the way the health condition and its impacts are seen and treated by the individual and his support network.

In this sense, R.'s support network stands out. Her close family, children and husband, even if they do not live with her mother or, in the case of her husband, have to work hard to cover all the extra expenses that have arisen and arise due to R.'s condition, are essential in caring for the patient. Her husband, with whom she lives, is responsible for day-to-day care, always ready to take her by car to places she needs to go, whether for leisure or medical appointments, due to the patient's difficulty in getting around. Her children also share this care, in addition to financial help for the mother, who is retired and cannot cover all her expenses.

Even though she receives follow-up, diagnostic tests and treatments mostly through the Unified Health System (SUS), as her case is still investigative and of greater complexity, there were times when she underwent tests in private clinics, and her extended family also proposed to raise money to help her pay for these services. In addition to the direct family support network, R. also has external help for cleaning the house and preparing her food, since she can no longer do such activities due to the progression of her condition. R.'s relationship with her children and husband is positive and very affectionate, which is also a factor that enhances this care. Thus, this support network is essential for the patient, who can have some of her needs met by these family members and employees, and is a protective factor, as it provides tools for her to carry out all the investigative and therapeutic procedures she needs, in addition to making her daily life and experience less exhausting and, in a way, lighter.

In her interview, the patient appeared to cope well with her limitations, sometimes even with some humor. Despite her extensive history of illnesses and conditions, such as depression, fibromyalgia, myopathy and neuropathy, some of which started very early in her life, R. manages to treat her experience and everything that stems from it in a relaxed manner. Such a note may lead to the question that, at least in part, her structured and interested support network could have an influence on how she sees the crossings of her life and how this reflects on her life and health arrangements.

4.7 CARE PLAN

The care plan is fundamental in the implementation of the care process, as it is the daily or scheduled script that coordinates the action of the nursing team in the appropriate care to meet the basic and specific needs of the human being (HORTA, 1979). It is extremely important to achieve a respectful and individualized treatment and, consequently, the best possible prognosis, given its ability to cover the needs and particularities of the patient. In addition, the care plan facilitates communication between the professionals involved in the case, enabling continuity of care.

In the case of R., the absence of tools such as the care plan does not prevent treatment, but it does harm it, since it hinders integrated care between the team and the patient ends up not having contact with all the therapeutic strategies that could be offered to her. Therefore, the development of a care plan for R. is fundamental for the improvement of this PTS.

Another important point concerns palliative care, since the patient, aware of her condition and the absence of a closed diagnosis by the health team, is surrounded by numerous uncertainties. Palliative care is defined as an expanded method of care, and aims to improve the quality of life of these individuals and their families, through the relief of pain and emotional, social and spiritual problems. It consists, in a simplified way, of a specialized care approach that assists individuals in experiencing complex and/or life-threatening chronic health problems in the best possible way (EVANGELISTA, et al. 2016). In this sense, it is worth reflecting on a care strategy not only aimed at discovering the disease and its possible cure, but also a care that goes beyond that, present in the hypothesis of offering the user a higher quality of life. The patient reports during the interview some things that make her happy, such as practicing physical activity and nature. Although today the practice of physical activity that R. used to do is no longer feasible, thinking of a way to adapt her exercises and her way of dealing with the difficulties faced now can provide the return of R.'s pleasure, which, during the evolution of her clinical condition, was suppressed. In addition, another strategy to ensure a more expanded care would be to bring the patient new passions, such as art, a new core of friends and support, relief of pain symptoms so that she can contemplate nature, among others.

Thus, although it is not possible to return to the activities as it was in the past, an efficient care plan is essential for the adaptation of the patient to her new condition, thinking of ways to adapt the old activities to the new reality or even replacing the activities that she was used to doing with other activities that are more accessible to her.

In this case, for example, something that was part of her life was the frequent visit to the spiritualist center, but due to the location of difficult access and the limitations resulting from her condition, it became a lack in her life. However, given a search for Macaé, it is noted that some spiritist centers offer home visits that would be possible solutions to such a serious lack in her life, reiterating that it will hardly be the same situation since her former spiritist center was in a place surrounded by nature, which in her words brought much comfort and happiness. However, adaptations are necessary to try to bring as much comfort as possible and satisfy the needs of the PTS patient, since one cannot ignore these spiritual, physical and psychological needs, to prioritize only the biological condition of the organism.

Thus, the aim of the care plan is to try to cover the patient's problems in the most humane and empathetic way possible. When it is not possible to adapt, it is necessary to look for new possibilities of activities that can offer completeness to the individual if he or she misses it. The Macaé City Hall, through the Benedicto Lacerda Coexistence Center, offers open face-to-face and remote workshops for young people, adults and the elderly with accessibility. In this way, a wide range of activities can be offered, such as crochet, meditation, reading, music therapy, among others. This would be extremely relevant for R. who, in his report, states that he considers social interaction very important for well-being and that he misses more active socialization, in addition to the evident impact of leisure on mental health.

Therefore, thinking about a care context focused on the patient's needs is what contemplates the elaboration of the care plan, as this must be thought of jointly, with concrete action plans in order to raise favorable clinical results, but not only that, in addition to the "health x disease" advance, the care plan guarantees a better relationship between the patient and the team, as well as their more assiduous frequency in the treatment proposals and even in the biopsychosocial sphere.

5 DISCUSSION

From the patient's clinical history, it is possible to infer that, in an initial analysis, since her pubertal phase the patient already presented signs and symptoms that were able to compromise her health and quality of life. In this sense, it is worth noting that, when it comes to adolescent health, it is necessary to take into account the singularities of this moment of growth and development, marked by the impact of physical, psychological, family and social changes, experienced differently in different contexts having their relevance throughout the individual's life.

It is also important to highlight that several diseases were developed by the patient during her life, such as depression, autoimmune diseases - such as Hashimoto's thyroiditis and fibromyalgia -, in addition to the presence of a chronic and progressive motor condition related to a neuropathy and a myopathy, which corroborate to a considerable impairment of the quality of life of this patient.

In addition, despite the various diagnoses and tests to which the patient was submitted at various times and stages of her life, she still does not have her main diagnosis determined. The diagnostic hypotheses involving the diseases Amyotrophic Lateral Sclerosis (ALS) and Multisystemic Proteinopathy were discarded. Currently, the main diagnostic hypothesis is degenerative neuropathy which, as well as myopathy, is not yet part of the treatment plan of the team accompanying the patient.

It is important to point out the Lines of Care, which are defined as actions and services that should be developed at the different points of care in a network (primary, secondary and tertiary levels), and in support systems, designing the therapeutic itinerary of users in the network. In relation to this care inherent to the individual, it is possible to highlight the importance of treating the individual as a whole, and not treating the physical body structure as something only pathological or biological. This becomes even clearer from the patient's report on her care in the health network, which, according to her, is guided by multiprofessional teams by which she is assisted, making it possible to reaffirm the importance of the Unified Health System (SUS) in people's lives.

Another factor of great relevance exposed by the patient is how her family network is being essential for the monitoring of her therapeutic project. In addition to family support, her residence has several adaptations that facilitate her locomotion, in addition to being able to do routine speech therapy and physical therapy at the Dona Sid Carvalho Rehabilitation Center with a focus on muscle strengthening, mobilization, in addition to gait and balance training. It is worth noting that family and friends support, the belief in what she believes in, are examples of support that the user needs, especially in the case of individuals who are going through a delicate health situation - the progressive nature of their muscular and nervous degenerative condition, their loss of motility and autonomy, the uncertainty of their diagnosis and, consequently, of the best therapeutic framework to be adopted -, and of extreme need for attention and care, such as her dependence on her partner to carry out daily activities, the need to adapt equipment for her safe locomotion, physiotherapeutic and speech therapy follow-up, her motor limitation - which greatly affected her by limiting access to pleasurable activities that connected her with her religiosity and with nature, among many subjective aspects resulting from living with her prognosis.

In view of this, it is worth highlighting actions that go beyond the health network itself, that is, social, religious, family factors - as pointed out by the patient herself. In this sense, reestablishing the religious bond can allow a spiritual strengthening, as well as the improvement in the patient's social life, given the importance of spiritism in her life, pointed out by her. With this, the human being is understood as a biopsychosocial being, a term that covers different approaches that form individual capacities and interests. This multidimensional model, established due to the insufficiency of the biomedical model focused only on the disease, allows the analysis of social, environmental and bodily factors that complete information about the individual (CASTANEDA, 2019). In this perspective, when facing a problem, the search for solutions, can take place not only by a biological look of resolution based on the dichotomy of body and mind, but by a holistic view aiming at integral care. (MURAKAMI et al, 2012). Thus, religiosity enters the field of care as a tool capable of increasing the quality of life. According to Murakami et al, the religious bond is associated with better coping with stressful situations and promoting strengthening from the mobilization of positive energies, such as faith. In addition, the link with the physical space generates a feeling of collectivity and unity, making the individual belong to that space. These factors are capable of promoting health protection (MURAKAMI et al, 2012).

In view of this, the application of practices that reestablish the religious bond in patient R. are extremely important for her therapeutic project, since the relationships explained in the ecomap and in the life crossings demonstrated a split of her bond with the religious institution, but not with her spirituality. Unlike religiosity, spirituality involves a relationship of self-knowledge and stimulates interest in others and in oneself, being able to give meaning to life and suffering (MURAKAMI et al, 2012). As reported in the reconstruction of her life story, during the interview, the patient transmits a religious message, indicating an involvement with her spirituality, in addition to demonstrating positivity of her state and responsibility towards others.

Integration into a religious space is capable of inserting the individual into a network of social relationships (MURAKAMI et al, 2012), which is essential to the PTS in question, since the patient is excluded from her relationships due to her illness; that is, she was deterritorialized, crossed, in her singularity, by the disease. One of the possibilities raised by the study to include in the therapeutic project was the search for religious centers, in the municipality of Macaé, that allow weekly or monthly meetings at home, since the patient is unable to attend them in person. For this, the search for a Spiritist Center took place through direct contact with a faithful woman from the municipality of Macaé, in which it was possible to report the case, without exposing names, just signaling the existence of the problem and the possibilities for the case. In response, the representative of the Spiritist Union offered to contact the patient to better understand her situation and, if possible, schedule a visit for future relations. The PTS proposal for this demand is to reestablish R.'s religious bond, so that she can express her religion according to the individuality of her faith.

In this sense, it was possible to realize how the patient's health problem also involves the reflection of her multiple experiences. However, above all, it was possible to reflect how much the lifestyle, family relationships, life history, faith and the relationship with the environment in which she is inserted, in her health, are essential for her care. Thus, in a scenario, in which health professionals are trained to take care of other lives with the utmost attention, care and professionalism, putting these actions into practice can, in addition to finding the diagnosis to deliver to the patient, provide him with a greater and better quality of life.

Given the above, the group members, from the understanding of the Singular Therapeutic Project, pointed out some actions aimed at the user's individuality, which could enhance the treatment and her way of living. Among the possibilities imagined, aiming at improving the quality of life offered to the user, within the limitations of her condition, are the proposition of playful activities of her choice since, as mentioned in her interview, she feels lonely and, in addition, demonstrates a desire to feel as lonely as at the time she practiced her previous profession.

In addition, after analyzing the complaint about her chronic constipation, it was discussed among the participants in the elaboration of this Singular Therapeutic Project the possibility of the patient's access to a nutritionist professional, since much of the health of the intestinal microbiota is dependent on the nutritional constitution of the individual's diet. Access to this professional would be made by contacting the team of the Basic Health Unit responsible for the territorial coverage of the patient's home, or even the Rehabilitation Center, which she already attends and for which she demonstrates availability of travel. Once the Basic Health Unit has been contacted, it would also be of great benefit to mobilize a team responsible for Home Care in the territory, since the case analyzed is a user with a degenerative disease, with a possible progression of the case, and who could benefit from routine monitoring of her evolution and the emergence of possible new needs.

As for the loneliness reported by the user, possibilities were imagined, such as, for example, her reconnection to her Spiritist Center, either by holding meetings in a better adapted space, which allows her participation, or even by moving a group attending the Center to her home, so that her social integration is preserved and, at the same time, her contact with her spirituality and her religiosity, elements so present in her personality and in her serene way of dealing with her health condition, are guaranteed.

The patient also emphatically mentions her passion for nature; in view of this, possibilities of occasional visits to some park better adapted for people with reduced mobility were theorized, in addition to the appropriate accompaniment by a family member or professional who provides the necessary support, ensuring her well-being and the full enjoyment of the activity carried out.

After mentioning his request for a wheelchair from SUS, questions were raised about the progress of the request, as well as about his right to other equipment that, if guaranteed and used correctly, would improve his quality of daily life, both in his routine activities and in the possibilities mentioned here.

All of the project's authors emphasized the importance of her continued follow-up by physiotherapy and speech therapy professionals, both to improve the prognosis of her case and to prevent a possible degenerative muscular and neurological evolution of the user.

In view of the results, many notes emerged, in the face of threatening situations suffered by patient R. One of the most pertinent, perhaps the one that most negatively impacts her quality of life, is the lack of diagnosis. During the interview with the professional at the Rehabilitation Center, it became evident that the lack of diagnosis makes it difficult to develop and use more specific techniques, using care that avoids overloading her preserved functions.

In addition, beyond the physical impact, there is the psychosocial impact of illness. Still in the meeting with the professional, she reports that, during some sessions, she perceives moments of discouragement of the patient in the face of the progressive condition. According to the Brazilian Society of Geriatrics booklet on palliative care, the needs of the patient and his family during the disease process involve several domains of equal importance, such as physical, spiritual, psychological and disease management issues. According to the family relationships shown in the ecomap and the life potentialities highlighted, R. has an established family network, with strong bonds, which allows an optimistic coping with his condition. However, the lack of diagnosis may have subjective interferences, explained by the patient in moments of anguish, involving the uncertainty regarding the elucidation of the case.

For the PTS in question, it was found that the patient is already well directed to the medical resources available, in search of the diagnosis. Thus, it becomes necessary to work together, with a closer look at the impacts of the uncertainty of their aggravations. For this, one of the ways would be to work with psychotherapy to face the waiting relationship in the face of the progressive condition. One of the possibilities raised, considering not to burden the patient financially, was the integrative community therapy, offered by the Center of Coexistence in Macaé. After contacting the unit, it was informed that the therapy consists of a conversation circle where life experiences and concerns are shared in the presence of a community therapist. The meetings take place online and in person, and it is not necessary to register, just contact the community center directly. In this way, it would be possible not only to promote greater socialization of the patient, but also to guarantee holistic care, aiming at maintaining her mental health, in addition to the biologicist view of treating the analyzed body dysfunction.

6 FINAL CONSIDERATIONS

During the construction of this PTS, it was possible to realize the importance of palliative care for improving the patient's quality of life, since it is a form of health promotion that can be worked together with other therapies and treatments. Palliative care involves the patient's main current complaints, which are related to the psychic, social, spiritual and physical spheres. In addition, one of the proposals of this method of care is to help the patient to obtain a better acceptance of her condition and its possible outcome, in order to have a more active life according to her peculiarities.

Given this description, regardless of the diagnosis, the PTS focused on improving the patient's quality of life as much as possible and, for this, a possible rapprochement with the spiritualist center was proposed, as well as a search for accessible green areas and coexistence centers. As well as the treatments that are already being done in relation to some of her diseases, these measures are important to expand care, alleviate other possible sufferings, such as depression, and improve the prognosis of her comorbidities. In this sense, it is necessary to emphasize the importance of multiprofessional work for the full understanding of their singularities. However, there is a lack of integration of health professionals involved in patient care, impairing the quality of care.

Another relevant point for the development of the PTS is the links established with the patient's support network, especially with family members and health professionals involved in the therapeutic follow-up. This network can also be analyzed as a care proposal, since it can act as a protective factor.

Finally, it is concluded that palliative care, quality of life and the support network were key points for the development of this patient's PTS. Thus, the construction of this PTS is important for the enhancement of care, since it aims to obtain a multidimensional and intersectoral understanding of the case and promote an improvement of a moment of life, without focusing on the cure and diagnosis of the disease.

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