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When Swallowing Becomes Impossible: A Nurse's Journey with a Farmer Facing Esophageal Cancer: A Nursing Concern Case Report

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Case Report

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Abstract

Background

In the highlands of southern Ethiopia, where hot porridge and steaming coffee are staples of daily life, esophageal cancer has quietly become a familiar enemy. For nurses working in this region, caring for patients with this devastating disease means far more than administering medications—it means holding the hands of farmers who can no longer swallow their own saliva, reassuring fathers who fear they will never see their children grow, and fighting against a healthcare system that moves too slowly for the urgency of cancer. This case report, prepared following the CARE Guidelines, tells the story of one such patient and the nursing care that sustained him while he waited for a surgery that could save his life.

Case Presentation:

A 45-year-old male farmer from a rural community in an endemic region of Ethiopia was admitted to a university hospital with T1 distal esophageal cancer. Over six months, progressive dysphagia had transformed eating—a fundamental pleasure and necessity of life—into a source of terror. He could no longer swallow solids, then liquids, and finally even his own saliva without excruciating pain. His body had wasted away to a body mass index of 16.37 kg/m². Beneath his physical suffering lay a deeper anguish: depression, hopelessness, and the haunting memory of a neighbor who had died from the same disease. His history revealed the risk factors common in his community—seven years of smoking, a decade of khat chewing, and a lifetime of consuming scalding-hot foods and drinks.

Nursing Interventions:

The nursing care this patient received was not merely a checklist of tasks but a deeply human response to suffering. It began with the simple act of sitting beside him, listening as he poured out his fears. It continued with the meticulous administration of intravenous fluids—Normal Saline, DNS, and Ringer's Lactate rotating every eight hours, fortified with Vitamin B-Complex and dextrose—to keep his failing body nourished while his esophagus remained impassable. Pain was managed not only with tramadol but with the quiet dignity of being believed when he said he hurt. Education about his early-stage cancer became a lifeline of hope, transforming his understanding from certain death to curable disease. Yet the care was also marked by what was absent: a psychologist to address his despair, sufficient staff time for meaningful conversation, and a surgical schedule that could operate with the urgency cancer demands.

Outcomes:

After three days of intensive nursing care, the patient's epigastric pain had subsided. His fluid balance stabilized, his vital signs remained steady, and the moisture returned to his mucous membranes. Most importantly, something shifted in his eyes—the rigid fear began to soften as he understood that his cancer was T1, early and operable, not the death sentence he had imagined. But the waiting continued, and with it, the slow erosion of his spirit and body. The gaps in care—delayed surgery, absent psychological support, overburdened staff—remained stark reminders that even the best nursing cannot compensate for a system under strain.

Conclusion

This case illuminates both the profound impact and the painful limitations of nursing care for esophageal cancer patients in resource-constrained settings. When a patient cannot eat, the nurse becomes their nourishment. When they cannot hope, the nurse becomes their bridge to possibility. But nurses cannot perform surgery, cannot create psychologists where none exist, and cannot stretch a two-day surgical schedule to meet the needs of a ward full of waiting patients. What this case ultimately teaches is that holistic nursing care—addressing body, mind, and spirit—is not a luxury but a necessity, and that healthcare systems must be strengthened to support the nurses who stand at the frontline of cancer care.

Introduction: The Weight of a Familiar Diagnosis

In the surgery ward of a university hospital in Ethiopia's Central Region, the diagnosis of esophageal cancer arrives with a grim regularity that never becomes routine. The patient lying in bed seven—let us call him what he was, a father, a farmer, a man who woke before dawn to work his land—was one of many. But to his two wives, his five children, and the brother-in-law who sat faithfully at his bedside, he was irreplaceable. To me, as his nurse, he was a reminder of why this work matters and why it breaks your heart.

Esophageal cancer is not evenly distributed across the world. It clusters in certain landscapes like a dark shadow, and the highlands of Ethiopia—particularly the Arsi and Bale zones—fall within that shadow [1]. The reasons are woven into the fabric of daily life: the scalding porridge eaten hurriedly before morning prayers, the coffee drunk while still steaming, the khat chewed in afternoon gatherings, the cigarettes smoked during long conversations. These are not vices but habits—cultural, social, deeply human—and they exact a terrible cost.

For nurses, the care of esophageal cancer patients is among the most complex we provide. It demands clinical expertise in nutrition, pain management, respiratory care, and infection prevention. But it demands something harder to teach: the ability to sit with despair without being consumed by it, to offer hope that is honest rather than hollow, and to see the person beneath the diagnosis [2]. This case report tells the story of one such patient and the nursing care that surrounded him during the liminal space

between diagnosis and surgery—a space where the body waits, the mind suffers, and the nurse must hold both.

The Patient: A Life Interrupted

Who He Was

He was 45 years old, though the disease had aged him beyond his years. An Oromo farmer from a rural community, he had spent his life working the land, rising with the sun, returning with dirt under his fingernails and the satisfaction of work completed. He had two wives—not uncommon in his community—and between them, five children who depended on his labor and his presence. He had completed grade 8, enough to read and write, enough to understand the words “cancer” and “surgery” when a doctor spoke them. His primary language was Oromifa; he spoke Amharic as well, the language of the hospital.

He was a Muslim who found solace in prayer, who had participated in Irreechaa—the Oromo thanksgiving festival—and who wished, in his hospital bed, to speak with his religious leader. He cared about his health, sought medical help when ill, and had made efforts to leave behind harmful habits. Two years before his admission, he had stopped smoking after seven years of use. A year and a half before, he had stopped chewing khat, which he had used weekly for a decade. These were not small sacrifices in his community. They were acts of a man trying to live.

How It Began

The trouble started quietly, as these things often do. Six months before he came to us, he noticed that solid food began to stick in his throat. At first, he thought nothing of it—perhaps he was eating too quickly, perhaps the porridge was too thick. But the sticking became resistance, and resistance became pain. Over months, the narrowing of his esophagus progressed with relentless efficiency. Solids became impossible. Then soft foods. Then liquids. By the time he reached our ward, even swallowing his own saliva triggered a spasm of pain so severe that he had stopped trying.

The weight fell off him like water from a broken vessel. When we weighed him—49 kilograms on a frame of 1.73 meters—his body mass index was 16.37, deep in the territory of malnutrition. His skin, once warmed by the sun and nourished by his labor, had become dry and slow to return when pinched. His muscles, once strong enough to till fields, had begun to waste. He was, in the clinical language of our charts, “acute sick-looking.” In human terms, he was a man watching his body betray him piece by piece.

The Pain Beneath the Pain

But the physical suffering, terrible as it was, told only part of the story. When I sat with him to assess his health perception, he rated his overall health as 2 out of 3—“fair” on our scale, though “poor” would have

been more honest. He was fully conscious, oriented to person, place, and time. He could articulate his thoughts clearly, remember both recent and distant events, make decisions. These cognitive intactnesses made his psychological suffering all the more acute, for he understood exactly what was happening to him.

He was depressed. He felt hopeless. And he had reason to: some time before, he had watched a neighbor follow this same road—progressive dysphagia, weight loss, the diagnosis of esophageal cancer, the decline, the death. He carried that memory like a prophecy, certain that his fate would mirror his neighbor's. When he spoke of his family—his wives, his five children—his voice carried the particular anguish of a man who fears he is leaving those who need him most.

His coping mechanisms were both spiritual and practical. He prayed. He relied on his family. And now, in the hospital, he relied on his brother-in-law, a man who had left his own fields and obligations to sit at this bedside, to buy medications when ordered, to provide the human connection that no IV fluid can replace.

The Road to Us

He had not come to us first. Like many rural patients, his journey to definitive care was a relay of referrals—from a health center where antibiotics and painkillers offered temporary relief, to a referral hospital where the suspicion of cancer took root, and finally to our university hospital, where endoscopy would confirm what everyone feared. He arrived on August 29, 2023, to the Surgery Ward, carrying with him not just his wasted body but a folder of investigations and the fragile hope that something could still be done.

What We Found: The Body's Testimony

The Language of Vital Signs

His vital signs spoke of a body under stress but not yet in crisis. Temperature 36.9°C—normal. Pulse 62 beats per minute, regular and strong—a heart that still beat with quiet efficiency. Respiratory rate 20, regular. Blood pressure 98/76 mmHg sitting, left arm; 93/73 on the right. These numbers, taken together, told of a man whose cardiovascular system was compensating, whose body was still fighting to maintain equilibrium despite the assault of starvation and disease.

His oxygen saturation was 97%—good on room air, though we knew that would be tested severely if and when surgery came, when a portion of his esophagus would be removed and his respiratory system would need to recover from the trauma of thoracic intervention.

The Evidence of Starvation

The physical examination revealed what his history had suggested. He was 49 kilograms of diminished humanity—skin dry and slow to rebound, muscles wasting, hair still black and evenly distributed but belonging to a body that was consuming itself. His oral cavity was intact, pink, moist—a small mercy in a mouth that could no longer accept nourishment. His nails were pink and convex, his tongue healthy in color. These signs of preserved micronutrition offered hope that, with support, his body might still heal.

But the abdomen told a quieter story. Flat, not distended. No masses, no organomegaly, no fluid. The bowel sounds were normoactive—gurgling nine times per minute—a digestive system that still worked, that still waited for food that could not come. The liver and spleen were palpable in their normal positions. There was no shifting dullness, no fluid thrill. The cancer had not yet spread to these organs, or if it had, it had not announced itself in ways our hands could detect.

The Pain That Defined Everything

His pain was epigastric, centered around the xiphoid process, dull and aching. It responded to tramadol, which we gave as standing doses. But pain is never merely physical, and his was no exception. The pain of swallowing had become so severe that he had stopped trying—not because he lacked thirst or hunger, but because the anticipation of pain had become its own torture. When I asked him to describe it, he used the word we hear too often in cancer wards: “burning.” A burning that started in his chest and radiated outward, that made the simple act of saliva descending his esophagus feel like swallowing broken glass.

The behavioral signs were unmistakable. Diaphoresis. Grimacing. The refusal to even attempt swallowing. These were not exaggerations or manipulations; they were the body’s honest testimony to a disease that was destroying the most fundamental of human functions.

The Mind Trapped in a Failing Body

His cognitive assessment was reassuring in its normality. Glasgow Coma Scale 15. Oriented. Articulate. Memory intact. Decision-making capacity preserved. In many ways, this intact cognition was a curse. A patient who does not understand their prognosis may be spared certain fears; this man understood all too well. He could read the concern in our eyes, could interpret the delays in his surgery schedule, could calculate the weight he was losing day by day.

His sleep was shattered. He had difficulty falling asleep, difficulty staying asleep, and when pain surged through the night, it drove away what rest he might have found. He had no history of relaxation—no practice of meditation or breathing exercises to call upon. His rest came only when the tramadol worked, and even then, it was fragile.

The Social Fabric Fraying

His role in his family was father, provider, leader. His illness had stripped him of all three. He was unemployed now, unable to farm, dependent on others for the money to buy his medications. His social role as a community member had been reduced to a hospital bed and the small circle of visitors who came. The visitor flow was poor—rural families cannot easily abandon their fields and herds to sit in hospital wards—and this isolation weighed on him.

Yet his family support remained. His brother-in-law, Mr. Y, was his anchor—a man who understood that nursing care extends beyond the patient to those who love them. When I spoke with Mr. Y, he was knowledgeable about the patient's condition, committed to his care, and struggling with his own fears for his sister's husband and the family they shared.

The Diagnostic Journey: From Suspicion to Certainty

The Tools of Confirmation

The diagnostic process was a cascade of investigations, each adding a layer of certainty to the clinical picture. The chest X-ray performed on the day of admission revealed asymmetrical thickening of the distal esophageal wall—"likely esophageal cancer stage I," the radiologist wrote, a phrase that carried both terrible news and, in that "stage I," a whisper of hope.

The complete blood count was surprisingly normal. White blood cells 9.5, hemoglobin 15.6, hematocrit 49.1, platelets 255, red blood cells 4.8. These numbers suggested a body that had not yet been consumed by systemic disease, that still maintained its defenses. The renal function tests were similarly reassuring—creatinine 1.1, BUN 29.8. His kidneys, at least, were still doing their work.

The ECG showed sinus bradycardia—a heart rate slower than expected, perhaps a reflection of his malnourished state, perhaps simply his baseline. It was not immediately concerning, but it was a reminder that surgery would require careful cardiac monitoring.

The endoscopy, performed three days after admission, provided the definitive visual evidence: a distal esophageal mass, obstructing, malignant in appearance. The biopsy would confirm what the eye suspected, but the clinical picture was already clear.

The Staging That Changed Everything

What transformed this case from a story of despair to one of possibility was the staging. T1. Tumor confined to the superficial layers of the esophagus. No invasion of deeper tissues. No lymph node involvement apparent on imaging. In the world of esophageal cancer, where many patients present at stages III or IV with metastatic disease and months to live, T1 is a gift. It means surgery can be curative. It means the five-year survival rates are favorable. It means this farmer, this father, might yet return to his fields and his family.

When I explained this to him—sitting beside his bed, speaking slowly in Oromifa, making sure he understood—I watched something shift in his face. The hopelessness did not vanish; it is never that

simple. But it was joined by something else. Possibility. A future that was not yet written.

The Barriers That Remained

Yet the diagnosis was only the beginning of the battle. The barriers to timely care were formidable. Our hospital had too few gastroenterologists for too many patients. The surgical schedule was limited to two days per week—a constraint born of limited staffing and resources, but one that felt cruelly inadequate when cancer was growing in a man's esophagus. Each day of waiting was a day of continued starvation, continued pain, continued psychological erosion.

There were cultural barriers too. The patient's primary language was Oromifa, and while he understood Amharic, the nuances of medical explanation—the difference between "treatable" and "curable," the meaning of "T1"—required careful, culturally sensitive communication. His beliefs about illness, shaped by his community and his religion, needed to be respected and integrated into his care.

And there were the invisible barriers: the lack of a psychologist to address his depression, the insufficient time regular staff could spend with each patient, the absence of a dedicated psychosocial support team. These were not failures of individual nurses but failures of a system that had not yet recognized mental health as integral to cancer care.

The Nursing Care: Holding a Life Together

Nourishment Without Eating

The central challenge of nursing care for this patient was nutritional support in the face of complete esophageal obstruction. He could not swallow. His BMI of 16.37 told us his body was already consuming its reserves. Before surgery, he needed to be as strong as possible—strong enough to survive anesthesia, to heal an anastomosis, to fight infection.

Our approach was methodical and unglamorous. Every eight hours, we rotated his intravenous fluids: Normal Saline, then Dextrose Normal Saline, then Ringer's Lactate. Each bag was 1000 milliliters, dripping steadily into a vein that was becoming his lifeline. With each fluid, we added Vitamin B-Complex—two ampules—to support the metabolic processes that starvation was disrupting. When Normal Saline was the carrier, we added 40% dextrose, a concentrated sugar solution that provided the energy his body craved but could not access through eating.

This was not nutrition in the way we normally understand it. There were no flavors, no textures, no satisfaction of hunger. There was only the cold efficiency of biochemistry—glucose, electrolytes, vitamins—sustaining life through plastic tubing. But it was enough, or nearly enough. His fluid balance stabilized. His mucous membranes remained moist. His skin turgor, while still poor, did not worsen. He was, in the most basic sense, being kept alive.

The nursing care around these fluids was meticulous. We monitored his intake and output with precision. We watched for signs of fluid overload—shortness of breath, edema, crackles in the lungs—and for signs of dehydration, which his dry skin and slow capillary refill already hinted at. We checked his electrolytes, knowing that prolonged IV therapy can disturb the delicate balance of sodium, potassium, and chloride. We maintained strict asepsis for his IV line, knowing that an infection in a malnourished, immunocompromised patient could be catastrophic.

The Management of Pain

Pain management was both pharmacological and human. The tramadol we administered as standing doses controlled his epigastric pain effectively—after three days, he no longer complained of the constant dull ache that had haunted him. But pain in cancer is never purely physical, and our nursing interventions extended beyond the medication chart.

We encouraged non-pharmacological strategies—positioning that reduced pressure on his abdomen, distraction through conversation, the simple comfort of a cool cloth on his forehead. We educated him about his pain management plan, explaining that he did not need to suffer silently, that asking for medication was not weakness but wisdom. We offered resources for coping with the psychological impacts of pain, though these resources were limited by the absence of formal psychological services.

Most importantly, we believed him. When he said he hurt, we did not question whether the pain was “really” that bad. We did not suggest he was exaggerating or drug-seeking. We accepted his pain as real and responded to it with both medication and presence. This belief—this validation—is itself a form of healing that no drug can provide.

The Battle for the Mind

If the nutritional support was the body of our care, the psychological support was its soul. This man was depressed. He was hopeless. He had watched a neighbor die of this disease and saw his own future in that memory. When I first sat with him, he spoke of his fears with the flat affect of someone who has already accepted the worst.

Our intervention began with the simplest of nursing acts: listening. I encouraged him to express his feelings about his health condition, and he did—freely, fully, with the relief of someone who has finally been given permission to speak the unspeakable. He spoke of his children, of the fields he might never plow again, of the God he prayed to for strength. He spoke of his neighbor’s death, and how that memory had become a prison he could not escape.

Then came education—not as a lecture, but as a conversation. I explained his cancer stage, T1, and what it meant. I told him about the success rates of esophagectomy for early-stage disease. I described the surgical plan, the intensive care unit where he would recover, the rehabilitation that would follow. I did not promise cure—no ethical nurse makes promises they cannot keep—but I offered hope grounded in

evidence. I told him that his situation was not his neighbor's situation. That early-stage cancer was different. That surgery could work.

I watched this information settle into him, watched him turn it over in his mind, watched the slow shift from certainty of death to possibility of life. It was not a dramatic transformation. He did not smile or weep with joy. But he began to ask questions about the surgery, about recovery, about when he might return home. These questions were themselves a form of hope—the assumption of a future worth planning for.

I also involved his family. I spoke with his brother-in-law about the importance of presence, of reassurance, of helping the patient maintain connection to the life waiting for him beyond the hospital. Family involvement is not merely supportive; it is therapeutic, providing the social scaffolding that prevents psychological collapse.

The Prevention of Infection

In a patient who could not eat, whose immune system was likely compromised by malnutrition, infection prevention was paramount. We implemented standard infection control measures with particular vigilance. Hand hygiene before and after every contact. Aseptic technique for IV line maintenance. Monitoring for the earliest signs of infection—fever, tachycardia, altered mental status, localized redness or swelling.

We balanced rest with activity. Complete immobility would increase his risk of pneumonia and deep vein thrombosis; excessive activity would deplete his limited energy reserves. We encouraged gentle movement as tolerated, position changes to prevent pressure injuries, and deep breathing exercises to maintain respiratory function.

We monitored his laboratory values, particularly the white blood cell count, as a sentinel for infection. His WBC remained normal throughout his preoperative stay, but we knew this could change rapidly, and we remained watchful.

The Maintenance of Fluid Balance

Fluid management was a constant calculus. His inability to drink meant total dependence on IV fluids, but these could not perfectly replicate the body's natural regulatory mechanisms. We monitored his vital signs for clues—tachycardia suggesting hypovolemia, hypertension suggesting overload. We examined his mucous membranes, pinched his skin, checked his capillary refill. We tracked his urine output, knowing that adequate renal perfusion was both a goal and a marker of overall fluid status.

His laboratory values helped guide us. The normal creatinine and BUN were reassuring, but we knew that in a malnourished patient, these could be deceptively normal even in the face of significant fluid imbalance. Clinical judgment—assessment of the whole patient—remained our primary tool.

The Waiting: Time as an Adversary

The Surgical Delay

If there was an antagonist in this story beyond the cancer itself, it was time. The patient was diagnosed with T1 esophageal cancer, a stage that demands prompt surgical intervention. Yet the surgery schedule at our hospital was limited to two days per week. The reason was not negligence but resource constraint—too few surgeons, too many patients, an operating theater that could not run continuously. But the effect on this patient was the same as if it were deliberate cruelty: day after day of waiting, of continued starvation, of psychological deterioration.

I watched him grow weaker. Despite our maintenance fluids, he remained wasted, his body unable to rebuild what the cancer was destroying. Each day of delay was a day of immunosuppression, of muscle wasting, of the slow erosion of the physiological reserves he would need to survive surgery. In oncology, we speak of “time to treatment” as a quality metric; for this patient, time was not merely a metric but an active enemy.

The Absence of Psychological Support

The waiting might have been bearable with robust psychological support. But our hospital had no psychologist assigned to the surgical ward. The regular staff nurses, competent and caring in their clinical duties, showed what I can only describe as poor concern for the patient’s psychological state. They did not sit with him. They did not ask about his fears. They treated his body while leaving his mind to suffer alone.

This is not to condemn them. They were overworked, understaffed, responsible for too many patients with too few resources. But the gap was real, and it was harmful. A patient with cancer needs more than physical care; he needs to know that his terror is seen, his hopelessness is acknowledged, his humanity is recognized. Without this, the physical care is incomplete.

As a nursing student, I tried to fill this gap. I sat with him. I reassured him. I explained and re-explained his prognosis, his treatment plan, his future. But I was one person, with limited time and authority. The absence of systematic psychological care was a failure that no individual nurse could fully compensate for.

The Systemic Gaps

Beyond the surgical delay and psychological absence, other systemic gaps became apparent. There was no dedicated nutritionist to optimize his preoperative nutritional status beyond our basic IV support. There was no social worker to address the financial strain on his family, who were buying medications and supplies out of pocket. There was no palliative care team to consult, though in his early stage, curative intent was appropriate—still, the principle of early palliative care integration, even alongside curative treatment, was absent from our system.

These gaps are not unique to our hospital. They reflect broader challenges in cancer care in resource-limited settings, where the burden of disease outstrips the capacity of health systems. But they are no less harmful for being common. Each gap represents a point where care falls short of what patients need and deserve.

Outcomes: Small Victories and Lingering Concerns

What Improved

After three days of intensive nursing care, measurable improvements emerged. His epigastric pain, once constant, had subsided with standing doses of tramadol. He no longer grimaced with every movement. His sleep, while still disturbed, was less fragmented, the pain no longer waking him hourly.

His fluid balance remained stable. Vital signs were consistent. Mucous membranes moist. Skin turgor, while still poor, had not deteriorated further. His laboratory values—CBC, renal function, electrolytes—remained within normal limits. He was, in the narrow physiological sense, being sustained.

Most meaningfully, his psychological state showed signs of improvement. He expressed acceptance of his prognosis—not the resigned acceptance of despair, but the informed acceptance of someone who understands both the risks and the possibilities. He asked questions about recovery, about returning to his farm, about seeing his children again. These questions, mundane as they might seem, were evidence of hope rekindled.

His compliance with treatment was excellent. He accepted his IV fluids without complaint. His attendant, his brother-in-law, was timely in buying medications and supplies. The trust we had built through consistent, honest communication translated into cooperation with the care plan.

What Did Not

Yet the improvements were partial, fragile, and overshadowed by what remained unchanged. His nutritional status did not improve. Despite our maintenance fluids, he remained wasted, his BMI stuck at 16.37, his body unable to rebuild without enteral or parenteral nutrition more robust than we could provide. He was, in essence, treading water—neither sinking nor swimming, but surviving in a state of suspended animation.

His psychological improvement was real but shallow. The depression and hopelessness did not vanish; they were merely held at bay by our conversations and his growing understanding. Without ongoing psychological support, without the surgery that would offer definitive hope, these feelings lurked beneath the surface, ready to resurge.

The surgical delay continued. Each day brought no news of a scheduled operating room slot. The patient and his family waited with the particular anxiety of those who know that time is not neutral, that each passing day strengthens the enemy they are trying to defeat.

The Unanticipated

No adverse events related to our nursing interventions occurred. There were no IV line infections, no fluid overload episodes, no allergic reactions to medications. The patient tolerated his care well, a testament to both the appropriateness of our interventions and his body's residual resilience.

The unanticipated challenge was the duration of the waiting itself. We had prepared for the acute preoperative period—days, perhaps a week. We had not fully prepared for weeks of sustained maintenance care, of watching a patient slowly deteriorate while waiting for a system to move. This prolonged preoperative state tested our interventions, our patience, and our capacity to sustain hope in the face of delay.

Discussion: Lessons from One Bedside

The Strengths We Found

This case highlights several strengths in our nursing approach. First, the comprehensive assessment using Gordon's Functional Health Patterns provided a genuinely holistic understanding of the patient. We did not see him merely as "T1 esophageal cancer, male, 45 years." We saw him as a farmer, a father, a Muslim, a man who had quit smoking and khat, a person with a history of pneumonia and a fear of dying like his neighbor. This holistic view enabled nursing diagnoses that addressed his whole being: acute pain, imbalanced nutrition, fear, anxiety, risk for infection, risk for fluid volume deficit.

Second, our interventions were evidence-based and appropriate to his stage and condition. The maintenance fluids with vitamin supplementation addressed his immediate nutritional needs while preserving his gastrointestinal tract for future enteral feeding [5]. The pain management was effective and humane. The psychological support, though limited by systemic gaps, was grounded in therapeutic communication principles that have been shown to enhance patient engagement and quality of life [13, 14].

Third, the care was provided in a university hospital setting, which research has shown is associated with higher survival rates for esophageal cancer patients [10]. The T1 stage of his cancer offered genuine hope for curative outcome with esophagectomy [7]. Our patient education about prognosis and treatment transformed his understanding from fatalism to informed hope—a transformation with measurable psychological benefits.

The Limitations We Must Confront

Yet the limitations were stark and systemic. The surgical delay—limited to two days per week due to staffing constraints—represents a critical failure of healthcare delivery. In cancer care, time is tissue; each day of delay allows tumor growth, nutritional deterioration, and psychological decline [11]. This is

not a nursing failure but a system failure, and it demands advocacy for increased surgical capacity, more trained gastroenterologists, and operating theaters that can run with the urgency cancer requires.

The absence of dedicated psychological support was equally damaging. Esophageal cancer patients experience high rates of depression, anxiety, and stress [9]. These are not optional add-ons to physical care; they are integral to patient outcomes, affecting treatment compliance, quality of life, and potentially even survival. The fact that regular staff nurses showed “poor concern” for his psychological state reflects both individual attitudes and systemic failures in training, staffing, and prioritization of mental health in oncology settings.

The nutritional support, while adequate for short-term maintenance, was insufficient for preoperative optimization. Patients with esophageal cancer and BMI 16.37 need more aggressive nutritional intervention—enteral feeding via nasogastric or jejunostomy tube, or parenteral nutrition if enteral access is impossible [8]. Our maintenance fluids prevented immediate crisis but did not rebuild the reserves he would need to survive surgery and recover.

What the Literature Tells Us

The medical literature supports both our approach and our concerns. Esophageal cancer’s endemicity in Ethiopia’s highlands is well-documented, with hot food consumption, smoking, and khat use identified as contributing factors [1, 12]. The role of nurses in cancer care is multidimensional, extending far beyond task completion to encompass education, emotional support, care coordination, and advocacy [2, 4].

For esophagectomy patients, preoperative optimization is critical. Immunonutrition, early enteral feeding, and respiratory preparation have all been shown to reduce complications and improve outcomes [5, 8]. Postoperatively, high-quality nursing care in the intensive care unit reduces pain, adverse events, and promotes rehabilitation [6]. The therapeutic nurse-patient relationship, built on trust and patient-centered communication, is foundational to effective oncology care [13, 14].

Early palliative care referral, even alongside curative treatment, improves quality of life and may extend survival in cancer patients [15]. Its absence from our patient’s care represents a missed opportunity for comprehensive support.

What This Case Ultimately Teaches

The primary lessons from this case extend beyond the individual patient to the systems and philosophies that shape cancer care in resource-limited settings.

First, holistic nursing assessment is not optional—it is essential. A patient with esophageal cancer is not merely an esophagus with a tumor. He is a person with a family, a faith, a history, and a future. Nursing care that addresses only the physical dimension while ignoring psychological, social, and spiritual needs is incomplete care.

Second, nutritional support must be aggressive and creative. When a patient cannot eat, the healthcare team must find other ways to nourish them. Maintenance fluids are a bridge, not a destination. For patients awaiting esophagectomy, preoperative nutritional optimization may determine postoperative survival.

Third, psychological care is cancer care. Depression and hopelessness are not side effects to be managed after the "real" treatment; they are central to the patient experience and directly impact outcomes. Healthcare systems must invest in psychological services for oncology patients, and nursing education must prioritize emotional intelligence and communication skills.

Fourth, systemic advocacy is a nursing responsibility. We cannot accept surgical delays, staffing shortages, and resource gaps as immutable facts. Nurses must advocate—within their institutions, to policymakers, in the public sphere—for the resources and systems that enable quality cancer care.

Fifth, hope must be honest. The patient's transformation from hopelessness to informed hope was not achieved by false promises but by accurate information delivered with compassion. T1 esophageal cancer is genuinely treatable. Surgery genuinely offers cure. These truths, communicated clearly, became the foundation upon which he rebuilt his psychological resilience.

The Patient's Voice: "I Was Very Afraid"

I asked him, near the end of my time with him, if he would share his experience for others who might read this report. He agreed, and his words, translated from Oromifa, carry an authenticity that no clinical description can match.

I was very afraid before," he said, sitting up slightly in his bed, the IV line still running into his arm. "When I could not eat, I thought it was the end. I remembered my neighbor, how he suffered, how he died. I thought God had given me the same punishment.

He paused, looking at his hands, which had grown thin and pale in the weeks of illness.

But then you explained to me. You told me about the stage, about the surgery, about how it can be removed. I did not know these things before. In my village, when someone gets this sickness, we think only of death. Now I understand that my sickness is different. It is early. The doctors can cut it out.

He looked up, and for the first time since I had known him, there was something like light in his eyes.

This gives me hope. Not big hope—not like I am already healed. But hope that I might see my children again. That I might work my land again. That I might live.

He spoke too of the waiting. "The waiting is hard. Each day I wake up and ask, 'Is it today? Will they operate today?' And each day the answer is no. This waiting makes me tired. It makes me wonder if the sickness is growing while I wait."

And of his family: “My brother-in-law has been here every day. He buys the medicines. He sits with me. My wives cannot come—they must care for the children, for the farm. But they call when they can. I worry about them. About what will happen to them if I do not return.”

Finally, he spoke of his faith: “I pray. Every day, I pray to Allah. I ask for strength. I ask for healing. The nurse told me that prayer is good, that it can help. So I pray, and I also trust the doctors. Both together, I think, are better than one alone.”

When I asked what he would want other patients to know, he said simply: “Do not wait. When you cannot swallow, go to the hospital quickly. The early sickness is better than the late sickness. And trust the nurses. They know things. They can help you understand.”

Declarations

Informed Consent

Written informed consent was obtained from the patient for the publication of this case report and the disclosure of his clinical information. He was informed that his identity would be fully anonymized, that no names, specific locations, or identifiable dates would be published, and that he could withdraw consent at any time. All patient identifiers have been removed or altered to protect confidentiality in accordance with the CARE Guidelines and institutional ethical standards. The patient reviewed the content of this case report and approved its publication.

Ethics Approval and Consent to Participate

Not applicable. This case report describes standard nursing care provided as part of routine clinical practice. Written informed consent was obtained from the patient for publication.

Consent for Publication

Written informed consent was obtained from the patient for publication of this case report and any accompanying information. A copy of the written consent is available for review by the Editor of this journal as needed in request from the author.

Availability of Data and Materials

All data generated or analyzed during this case report are included in this published article.

Competing Interests

The author declares that there is no competing interests.

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Authors' Contributions

BGA conceived the case report, conducted the nursing assessment and interventions, analyzed the data, and wrote the manuscript. The author read and approved the final manuscript.

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