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Case Report

Nursing Experience in Caring for A Patient with Right-Eye Proptosis Caused by Ocular Adnexal Lymphoma

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Abstract

Ocular adnexal lymphoma (OAL) can cause periorbital pain, cancer-related anxiety, and disfigurement. We present the case of a patient with lymphoma with right-eye proptosis secondary to tumor compression who received pharmacological and non-pharmalogical interventions to address these effects of OAL. During the patient's hospitalization for di-agnostic evaluation, partial tumor resection, and chemotherapy treatment, case data were collected and organized using Gordon's Eleven Functional Health Patterns framework; the patient was experiencing pain, disrupted body image due to proptosis, and anxiety. He received pharmacological treatment and the following non-pharmacological interventions. For pain management, the strategies included music therapy, comfortable positioning, and acupressure. Regarding his disrupted body image, he was encouraged to express his feelings with nurses engaging in active listening, being present, and empathetic communication to foster a trusting nurse-patient relationship engage in expressive writing, and employ methods for concealing the proptosis. For his anxiety, the strategies included music therapy, acupressure, and aromatherapy. After implementing the afore-mentioned strategies, the patient's pain score, rated on the Numerical Rating Scale, improved from 7 to 2. The patient's Body Image Visual Analogue Scale score improved from 25 mm to 75 mm. The patient's Beck Anxiety Inventory score improved from 28 to 14. The use of individualized non-pharmacological interventions improved the patient's pain, disrupted body image, and anxiety, with this facilitated by a positive nurse-patient relationship fostered through active listening, being present, and empathetic communication. These findings can serve as a reference for nurses managing patients with similar conditions in the future.

Keywords: Ocular adnexal lymphoma; proptosis; Gordon's Eleven Functional Health Patterns

Introduction

According to the most recent national statistics, malignant tumor/neoplasm is the leading cause of death in Taiwan. One such neoplasm, non-Hodgkin's lymphoma, is the ninth most common cause of cancer-related mortality in both men and women in Taiwan; it has a standardized mortality rate of 2.4%–4.0% (Health Promotion Administration, Ministry of Health and Welfare, 2023). Although Ocular Adnexal Lymphoma (OAL) ac-counts for only 1% of all non-Hodgkin's lymphoma cases, it is one of the most commonly occurring malignant tumors of the ocular adnexa, representing approximately 55% of all orbital malignancies. Patients with OAL who receive radiotherapy, chemotherapy, or immunotherapy often have a 5-year survival rate between 50% and 94%, with the majority retaining favorable physiological functioning [1]. Although these clinical outcomes are favorable, individuals with OAL often experience periorbital pain, cancer-related anxiety, and visible disfigurement caused by tumor induced

proptosis. These challenges may adversely affect patients' quality of life and satisfaction with medical care [1-3]. Therefore, in addition to managing physical pain and psychological distress, clinical nurses should focus on facilitating positive adaptation to changes in physical appearance.

The current study describes the case of a patient given a diagnosis of lymphoma presenting with right-eye proptosis. He was initially hospitalized for diagnostic evaluation, underwent partial tumor resection, and subsequently received chemotherapy. During the course of hospitalization, he experienced persistent orbital pain and facial disfigurement, both of which were difficult for the patient to accept. In addition, he was the primary financial provider in his family, and consequently, he expressed feeling profound anxiety regarding the potential for a poor prognosis or death. These clinical observations motivated the author to document the case and the individualized and continual physical and mental care strategies implemented to comprehensively address the patient's needs. This care experience may provide a reference for clinical nurses managing patients with similar conditions in future practice

OAL primarily involves the conjunctiva, lacrimal gland, orbital fat, lacrimal sac, and eyelids. Because it does not have prominent symptoms or lead to visible changes in the early stages of the disease, OAL is often difficult to differentiate from other orbital diseases. As it advances, patients may present with proptosis, palpable masses, periorbital swelling, ptosis, restricted ocular motility, globe displacement, and diplopia [1]. Achieving an ac-curate diagnosis of OAL requires the use of both imaging modalities and histopathological analyses, and treatment strategies for the disease commonly include radiotherapy, chemotherapy, or immunotherapy to achieve tumor reduction, with surgical resection considered on the basis of the patient's clinical condition and response to initial therapy [1,4].

OAL may cause pain due to tumor compression in the orbital region. For patients who undergo surgery as part of treatment, postoperative wound pain may compound this discomfort, leading to such patients experiencing greater pain. Therefore, effective pain control is critical to improving the quality of life of such patients [1-2]. To achieve effective pain control, nurses should administer analgesics as prescribed, encourage patients to describe their pain experiences, and conduct thorough assessment to determine pain location, characteristics, severity, duration, and precipitating factors as well as to quantify pain using the Numerical Rating Scale (NRS, 0-10). Patients should also be provided with nutrition education, with an emphasis on consuming a high- protein diet and adequate vitamin C, which can support wound healing. Non-pharmacological strategies are as crucial as pharmacological strategies are in pain management, and nurses should implement strategies such as guided deep breathing and adjustment of positioning to minimize traction-induced pain [5]. In addition, research indicates that complementary therapies, such as music therapy and acupressure, can be effective in alleviating cancer-related and postoperative pain [6].

OAL often leads to proptosis, resulting in visible changes to facial appearance. These changes can trigger psychological responses such as depression, diminished self-esteem, and social withdrawal, ultimately undermining a patient's sense of identity and self-worth. Facilitating positive coping in patients can help alleviate negative emotions and foster stronger emotional connections with others [1,7]. Nurses play a critical role in this process because they can help patients articulate their perceptions of and emotional responses to changes in their appearance through active listening, being present, engaging in empathetic communication, and initiating guided conversations. Developing an individualized care plan is also essential in addressing the psychosocial needs of patients with OAL. Such care plans may include sharing examples of successful adaptation, teaching strategies for concealing visible changes such as using clothing, accessories, or subtle makeup to cover up changes prior to tumor reduction, and encouraging family and friends to provide consistent emotional support throughout the care process. The Body Image Visual Analogue Scale (BIVAS) may be employed to evaluate a patient's satisfaction with their body image following appearance changes; on the scale, 0 mm indicates extreme dissatisfaction, and 100 mm indicates complete satisfaction [2]. Research also indicates that expressive writing interventions, such as those involving reflections on aspects of one's body that one is grateful for or statements emphasizing perceived control, are effective in promoting acceptance of physical changes [7].

Patients who have been diagnosed with cancer commonly experience anxiety stemming from uncertainty regarding prognosis and the potential for mortality [3]. In addition, studies indicate that approximately 60% of patients' experience varying degrees of anxiety prior to surgery. When effectively managed, anxiety can be reduced, which can lead to improved treatment adherence, accelerated wound healing, and reduced length of hospital stay [8]. In evaluating anxiety severity, nurses generally use assessment tools such as the Beck Anxiety Inventory (BAI), which categorizes anxiety levels as follows: 0 to 7, nor-mal; 8 to 15, mild; 16 to 25, moderate; and 26 to 63, severe. Furthermore, establishing a trusting nurse-patient relationship is essential; it can be achieved through being present, empathetic communication, and active listening. Providing patients with clear information about the progression of their disease, treatment plans, and follow- up care and inviting patients to participate in decision-making can enhance their sense of control. Moreover, receiving emotional support from family members, friends, and religious re-sources can enhance

psychological well-being. Furthermore, complementary therapies such as music therapy, acupressure, and aromatherapy have been demonstrated to effectively reduce anxiety [3], [8-9].

Nursing Assessment

The patient in this case study is named Mr. Chang. He is a 41-year-old man, a high school graduate, and believes in Taoism. He is a fruit farmer and is married. He lives in a multigenerational household with his wife (aged 38 years), son (aged 10 years), father (aged 78 years), and mother (aged 77 years). The family is close and supportive. During Mr. Chang's hospitalization, his wife was the primary caregiver.

Medical History and Current Hospitalization

Mr. Chang has no family history of cancer, no prior medical or surgical conditions, and no known allergies to food or medications. In early October 2023, he noticed mild proptosis of the right eye. By mid-October, the condition had progressed, with this accompanied by a sensation of orbital fullness and pain. On October 26, he sought medical attention at the reporting hospital.

Computed tomography identified a 1 × 1.2 cm^2 mass in the right orbit, a 1 × 0.8 cm^2 mass in the right cervical region, and several subcentimeter lesions in the right axilla. Following clinical evaluation, surgical removal of the right cervical and axillary tumors was recommended. Chemotherapy was planned as the initial treatment for the orbital tumor, with ophthalmologic surgery to be considered thereafter. The patient was admitted on October 28. On October 29, he underwent surgical excision of the right cervical and axillary tumors with concurrent pathological sampling. A subclavian Port-A catheter was placed for subsequent chemotherapy administration. A whole-body positron emission tomography scan performed on November 1 identified multiple lymphatic lesions less than 0.3 cm in the right orbit, bilateral cervical regions, clavicular areas, and bilateral axillae. Pathological analyses confirmed a diagnosis of stage III malignant lymphoma. The patient was discharged on November 4 and subsequently continued outpatient follow-up and chemotherapy as scheduled.

Nursing Process

The patient received nursing care from October 28 to November 4, 2023. Data regarding this case were collected through observations, patient interviews, medical record re-views, physical assessment, and direct care. The information was organized using Gordon's Eleven Functional Health Patterns framework, as detailed in the following:

Health perception and health management patterns

The patient reported no history of smoking, alcohol consumption, or betel nut chew-ing. He considered himself to be in good health, maintained a regular lifestyle, and routinely took multivitamins to support his well-being. When he experienced minor illnesses such as a cold, he typically self-medicated with over-the-counter drugs and sought hospital care only if his symptoms did not improve. Following his diagnosis of OAL, he initially struggled to accept that he had the condition, particularly because of his young age and role as the family's primary financial provider. Nevertheless, he exhibited a proactive attitude; he cooperated with surgical treatment and sought information regarding chemo-therapy and ongoing care. He demonstrated adequate health perception and self-management; no problems related to this specific domain were noted.

Nutritional-metabolic patterns

The patient is 174.5 cm tall and weighs 71 kg, with a body mass index of 23.3 kg/m^2, which is within the normal range. Over the 3 months following the initiation of treatment, his weight remained stable, changing by less than 1%. He reported having a good appetite, no food aversions, and no specific dietary preferences. His typical meals consisted of 1 bowl of rice with vegetables and meat, and his daily fluid intake was approximately 1800 to 2000 mL. Laboratory data collected on October 28 revealed a hemoglobin level of 12 g/dL, sodium level of 137 meq/L, potassium level of 4.5 meq/L, albumin level of 4.0 g/dL, and white blood cell count of 8450/μL all of which are within normal reference ranges. On October 29, the patient underwent surgical excision of tumors in the right cervical and axillary regions, with incisions approximately 3 cm in length made at each site. A subclavian Port-A catheter was also inserted for subsequent chemotherapy administration. Throughout the postoperative period, sterile dressing changes were routinely performed. The patient maintained a good appetite and consistently finished his meals. Other than the wounds from surgery, his skin remained intact and elastic. His hair was black and glossy. The oral mucosa was healthy and intact, and his chewing and swallowing functions were normal. No nutritional or metabolic problems were identified.

Excretion Patterns

During hospitalization, the patient exhibited regular excretion patterns. Bowel movements occurred every 1 to 2 days and consisted of soft, medium-volume, yellow-brown formed stools. His daily urinary frequency ranged from 6 to 8 times, with a total urine output of approximately 1500 to 1800 mL. The urine appeared pale yellow, clear, and free of sediment. No deviations from his usual bowel or urinary habits were noted. Abdominal assessment revealed slight distension. Auscultation detected 7 to 10 bowel sounds per minute. Percussion produced mild tympany, and palpation confirmed a soft, nontender abdomen without palpable masses. No edema was observed in the extremities.

Laboratory results obtained on October 28 revealed a blood urea nitrogen level of 6.1 mg/dL and a creatinine level of 0.62 mg/dL; both were within normal reference ranges. No excretion-related health problems were noted.

Activity and exercise patterns

Prior to hospitalization, the patient was fully independent in all activities of daily living. He regularly visited his orchard as part of his occupational routine and engaged in recreational physical activities such as family outings and hiking on weekends or during agricultural downtime. A chest X-ray conducted on October 28 revealed no notable abnormalities. During hospitalization, the patient scored 100 on the Activities of Daily Living scale, which indicated full functional independence. Muscle strength was graded 5/5 in all 4 limbs. The patient's vital signs remained stable throughout his hospitalization: his body temperature ranged from 36.4°C to 37.1°C, his pulse from 67 to 85 beats per minute, his respiratory rate from 16 to 20 breaths per minute, and his blood pressure from 121 to 133/62 to 76 mmHg. His respirations were smooth, with oxygen saturation maintained at 98% to 100%. The patient exhibited good peripheral circulation; his extremities and lips were pink. Respiratory auscultation revealed clear lung sounds without adventitious noises such as crackles or wheezes. Although the orbital tumor resulted in right-eye proptosis due to local compression, his visual acuity remained mostly unaffected. His gait was stable and coordinated, and no mobility problems were identified.

Sleep and rest patterns

The patient did not require regular use of sleep aids. His usual routine involved going to bed before 10:00 p.m. and waking at 6:00 a.m. to inspect the orchard; this provided him with approximately 8 hours of uninterrupted sleep per night. He did not take daytime naps and reported good overall sleep quality. However, on October 28, he experienced difficulty in falling asleep due to right orbital discomfort and preoperative anxiety. After consulting with the physician, he was given an analgesic and Xanax (0.5 mg), which enabled him to sleep through the night. Following surgery on October 29, the prescribed analgesics and anxiolytics were continued. Throughout his hospitalization, the patient remained energetic during the day, with no signs of fatigue, excessive yawning, or dark circles under his eyes. He consistently reported achieving 8 hours of restful sleep each night. No sleep or rest problems were identified.

Cognitive-perceptual patterns

The patient had normal eyesight and was alert and fully oriented to person, place, and time. His cognitive functions, including his judgment, orientation, memory, and thought processing, were intact. His sensory perception, including his responses to temperature and pain, remained within normal limits. He was also able to accurately verbalize discomfort. On October 28, he reported, "My right eye has become more swollen and painful over the past few days. Sometimes the pain radiates to the right side of my head. Pressing on the eye worsens the pain. It typically takes about 30 to 40 minutes after I take analgesics for the discomfort to subside." Physical assessment on the same day (October 28) revealed proptosis and swelling of the right eye caused by tumor compression. The patient exhibited signs of discomfort, including a furrowed brow, cold sweats, and frequent head rubbing. He rated his pain as 7 out of 10 on the NRS. On October 29, following surgery, the patient stated, "Now I feel pain on the right side of my neck, in my armpit, and in the area where the catheter was inserted. Moving causes discomfort in the areas where the wounds are. My right eye is also starting to hurt again. Can I have more pain medication?" Subsequent assessment revealed approximately 3-cm surgical wounds in both the right cervical and axillary regions, and a subclavian Port-A catheter was placed. The patient continued to furrow his brow, frequently pressed on his right eye with his left hand, and avoided movement because of wound discomfort. Assessment indicated the presence of acute pain.

Self-perception and self-concept pattern

The patient considered himself to be a mild-tempered, optimistic individual with a strong sense of responsibility toward his family. Prior to his cancer diagnosis, he maintained positive relationships with his family and friends and was generally perceived to be cheerful and outgoing. On October 28, he expressed, "I want to decline all visitors except my wife. With how I look now, I don't want others to see me." He further inquired, "Can I keep wearing a hat? When I leave the ward to get water or go to the convenience store, I feel like my eye is bulging. If it frightens even me myself—imagine how others must feel." During the same day, the patient was observed wearing a hat at all times in an attempt to conceal the protrusion of his right eye. He declined visits from anyone other than his wife and consistently drew the bedside curtain while in the room. Even when receiving nursing care, he kept his head lowered to avoid exposing his right eye. On October 29, he asked the nurse: "Do you think my right eye looks ugly? Will I scare people if I go out? I really think I look worse every time I see myself." He was seen repeatedly examining his right eye in the mirror and questioning the nurses about his appearance. He demonstrated signs of denial and dissatisfaction regarding his physical changes. Assessment conducted using the BIVAS yielded a score of 25 mm, indicating significant dissatisfaction with his body image. This assessment revealed a disturbance in body image.

Role and relationship pattern

The patient's primary role is that of an adult male; his secondary roles include being a husband, son, father, and fruit farmer. His tertiary role is a patient with cancer. Within his household, the patient is both the main decision-maker and the main financial provider. The family has a stable financial status, with no outstanding loans, and the patient's hospitalization expenses have been covered by insurance. On October 30, his wife shared, "Although we sometimes argue over minor daily matters, our family is close, and we genuinely care for one another. Earlier, my in-laws had a video call with us and our son to express their concern." Throughout his hospitalization, the patient had positive interactions with his wife, who remained with him and provided consistent emotional support. During episodes of anxiety or pain, she exhibited empathy and offered comfort and encouragement. The patient also consistently had cooperative and respectful interactions with the health-care team. No health concerns were identified in this domain.

Sexuality and reproductive patterns

The patient married at age 30 and currently has 1 child. He reported maintaining a regular sexual relationship with his wife, typically engaging in sexual activity 1 to 2 times per week, using condoms for contraception. Over the past 2 weeks, the frequency had de-creased to approximately once per week because of orbital pain; however, this change had not affected the couple's emotional intimacy. During the patient's hospitalization, physical assessment revealed no abnormalities in the genital area and no unusual discharge. No health concerns were identified in this domain.

Coping and stress tolerance patterns

The patient stated that under normal circumstances, he copes with stress by spending time in the orchard, discussing problems with his wife, or socializing with his friends over tea. However, his cancer diagnosis posed a considerable emotional and physical burden. On October 28, he reported, "Since I've learned that I have cancer, I've been feeling low. I often feel agitated and constantly fear that it might be untreatable that I might die." He also shared, "The surgery is scheduled for tomorrow. Although I know it's just a minor excision and biopsy, it's my first surgery, so I feel nervous." On the day of surgery, he appeared visibly anxious when discussing his diagnosis furrowing his brow, lowering his head, and frequently sighing. He exhibited signs of emotional distress related to both the cancer diagnosis and the upcoming procedure. Assessment conducted using the BAI revealed a score of 28, indicating moderate anxiety. After the physician explained the pathological findings and positron emission tomography scan results to the patient on November 1, the patient was shocked, stating, "What? A malignant tumor? And there are more tumors in other areas? What am I supposed to do? I still have to support my family!" He further inquired, "Will chemotherapy completely cure this? Is there a high chance of recurrence?" He appeared visibly tense clenching his fists, rubbing his hands, and repeatedly expressing concerns over the prognosis and effectiveness of chemotherapy. On the basis of these responses and behavior, the patient was determined to be experiencing clinically significant anxiety.

Values and belief patterns

The patient believes in Taoism and routinely engages in ancestral worship during the Chinese New Year and other major holidays. Prior to his admission, he and his wife visited a temple to pray for smooth surgery and treatment outcomes. On November 2, he expressed, "I used to think that earning more money to provide for my family was my top priority, but now I realize that health is the foundation of everything without it, I can't work or support my family. I'm truly relying on you. I will fully cooperate with the treatment." No health concerns were noted in this domain.

Problem Identification

According to the aforementioned assessment, the patient demonstrated the following health concerns: acute pain associated with tumor-induced compression of the right eye and postoperative surgical wounds; disrupted body image related to changes in physical appearance caused by proptosis of the right eye due to tumor compression; and anxiety resulting from the initial cancer diagnosis, upcoming surgical procedures, and uncertain-ty regarding prognosis and treatment outcomes.

Subjective and Objective Data	S1. On October 28, the patient reported, *"My right eye has become more swollen and painful over the past few days. Sometimes the pain radiates to the right side of my head. Pressing on the eye worsens the pain. It typically takes about 30 to 40 minutes* *after I take analgesics for the discomfort to subside."* S2. On October 29, the patient stated, *"Now I feel pain on the right side of my neck, in my armpit, and in the area where the catheter was inserted. Moving causes discomfort in the areas where the wounds are. My right eye is also starting to hurt again. Can I have more pain medication?"* O1. On October 28, the patient presented with right-eye proptosis and periorbital swelling due to tumor compression. He was observed to have a furrowed brow, cold sweats, and repeated rubbing of his head. He rated his pain as 7 out of 10 on the NRS. O2. On October 29, after his surgery, 2 wounds approximately 3 cm in length were noted in the right cervical and axillary regions, and a Port-A catheter had been placed in the right subclavian area. The patient appeared to be in discomfort, as evidenced by a furrowed brow, repeated application of light pressure to his right eye with his left hand, and apparent reluctance to move because of surgical pain on the right side.
Goals	1. By October 29, the patient will be able to accurately employ at least 2 nonpharmacological strategies for managing tumor-related pain. 2. By October 30, the patient will be able to discuss at least 2 nonpharmacological methods for relieving postoperative wound pain. By November 1, the patient will report overall pain relief, with an NRS pain score of below 3.

Nursing Interventions	1-1 1-1 On October 28, a handout for a personalized pain management plan was provided to the patient. Both the patient and his spouse were instructed on the following nonpharmacological pain relief methods: (1) Deep breathing: The patient was instructed to inhale through the nose for 5 seconds, hold his breath for 3 seconds, and exhale slowly through his mouth for 8 seconds and to repeat this process as necessary. (2) Comfortable positioning: The patient was instructed to elevate the head of his bed by 30° to 45° or to adopt a left lateral position to reduce blood accumulation in the right eye, which can worsen swelling. (3) Music therapy: The patient was instructed to listen to music that he enjoyed, either by using an earbud in the left ear or by placing a mobile device set to a low volume near his pillow. (4) Acupressure: The patient was instructed to apply circular pressure to the Xuehai (SP10), Sanyinjiao (SP6), and Hegu (LI4) points; press each point for 5 seconds; relax for 1 second; and repeat this process for 2 to 5 minutes per session. 1-2 1-2 On October 28, after a consultation between the physician and the patient, Traceton 1# PO q6h—which was previously prescribed in the outpatient setting—was continued. Pain levels were reassessed 30 to 60 minutes postadministration and documented. 1-1 2-1 On October 29, after the surgery, the pain management handout was revisited, with postoperative wound pain management emphasized. The patient and his spouse were instructed in how to implement the following strategies: (1) Deep breathing, music therapy, and acupressure, with these applied as described for the previous day. (2) Comfortable positioning: The patient was instructed to elevate the head of the bed by 30° to 45°. He was told that when he was in the supine position, he should place a pillow under the right side of the body to facilitate venous return toward the left and reduce swelling. (3) Nutrition: The patient was instructed to increase his intake of vitamin C-rich food (eg, broccoli, bell peppers, and the patient's homegrown guava) and high-protein items (eg, eggs, tofu, fish, and chicken) to promote wound healing. 1-2 2-2 On October 29, postoperative pain management was adjusted following a consultation with the physician. Morphine (5 mg IVD q12h) was initiated, with reassessment of analgesic efficacy conducted 30 minutes after administration and the results documented. 1-1 3-1 The patient's spouse actively participated in reinforcing the nonpharmacological pain relief strategies, including in the following manners: (1) Guided deep breathing: During episodes of rapid breathing associated with pain, the spouse prompted the patient to inhale through his nose for 5 seconds, hold his breath for 3 seconds, and exhale through his mouth for 8 seconds, encouraging him to repeat this process to alleviate discomfort. (2) Comfortable positioning: The patient's spouse assisted him in elevating the head of his bed and placing a pillow along the right side of his back. (3) Acupressure: The patient's spouse helped him to apply pressure to the Xuehai, Sanyinjiao, and Hegu points to relieve pain. (4) Nutritional support: The patient's spouse prepared meals high in vitamin C and protein to aid in his recovery. 3-2 3 - 2 Throughout the care period, pain was continually assessed using the NRS, with pain location, quality, intensity, duration, and triggers evaluated. The patient was encouraged to express his pain experience in detail.
Outcome Evaluation	1. On October 29, the patient stated, "*I tried deep breathing and listening to music yesterday. My wife also helped raise the head of the bed, and it really helped ease the pain in my right eye."* The patient was observed to maintain 45° elevation of the bed's headrest. During episodes of mild discomfort, he independently practiced deep breathing and listened to music to achieve pain relief. His spouse consistently provided acupressure massages 3 times daily— in the morning, afternoon, and evening. 2. On October 30, the patient reported, *"I can still use deep breathing, music, and acupressure. Since the wound is on the right side, I've been using a pillow to elevate that area. I also know I need to eat more food rich in vitamin C and protein to support wound healing."* Observations confirmed that the patient continued implementing the nonpharmacologic strategies, that is, the deep breathing, music therapy, and appropriate positioning. The patient's spouse remained actively engaged in the process, assisting with the acupressure therapy and preparing meals high in vitamin C and protein, such as fish soup, guava, and chicken with rice. 3. On November 1, the patient remarked, *"Over the past few days, the pain in my right eye and the size of the surgical wounds have decreased significantly."* Although the right eye remained visibly protruded, the frequency and intensity of pain episodes were reduced. The patient's overall pain score, as assessed using the NRS, had decreased to 2 to 3.

Table 1: Acute pain associated with tumor-induced compression of the right eye and postoperative surgical wounds (October 28 to November 4).

Subjective and Objective Data	S1. On October 28, the patient stated, *"I want to decline all visitors except my wife. With how I look now, I don't want others to see me."* S2. On October 28, the patient asked, *"Can I keep wearing a hat? When I leave the ward to get water or go to the convenience store, I feel like my eye is bulging. If it frightens even me myself—imagine how others must feel."* S3. On October 29, the patient asked, *"Do you think my right eye looks ugly? Will I scare people if I go out? I really think I look worse every time I see myself."* O1. On October 28, the patient was observed to be wearing a hat at all times in an attempt to conceal the protrusion of the right eye. He declined all visitors except his wife and drew the bedside curtain during his hospital stay, even when he was receiving nursing care. He kept his head lowered to avoid revealing his right eye to others. O2. On October 29, the patient was observed repeatedly examining his right eye in a mirror, persistently asking nursing staff about his appearance, and expressing denial regarding his physical changes. The patient's body image was assessed using a visual analogue scale, and the score was 25 mm, indicating severe dissatisfaction with his appearance.
Goals	1. By October 30, the patient will be able to verbalize his true feelings regarding changes in his facial appearance. 2. By October 31, the patient will engage in a discussion with health-care professionals about at least 2 coping strategies for managing his altered appearance. 3. By discharge, the patient will demonstrate at least 1 positive behavioral response to changes in his appearance (eg, participation in expressive writing and initiating open conversations with medical staff), and his body image visual scale score will increase to at least 60 mm.
Nursing Interventions	appearance due to his right-eye protrusion, including his perceptions regarding the influence of these changes on his daily life and work. The care plan was adjusted on the basis of the patient's expressed concerns. 2-1. The patient's verbal and nonverbal indications of his views regarding his body image during interactions and outings were continually monitored, with the observations used to assess his coping capacity and adaptation to his altered appearance. 2-2. On October 29, nurses and the patient collaborated to develop appearance-modifying strategies that aligned with his usual clothing habits: (1) Wearing sunglasses: The patient typically wore sunglasses while inspecting the orchard to protect his eyes from strong sunlight. Incorporating this habit into his daily routine was proposed as a strategy for concealing the protruding eye. (2) Wearing a hat: The patient typically wore a traditional bamboo hat while working. A strategy was proposed in which the patient wore a baseball cap with an extended brim to help conceal his eye in public. 3-1. The patient's wife was encouraged to remain present and actively involved in all aspects of care. Video calls with other family members were also recommended to provide additional emotional support. 3-2. On October 29, the patient and his wife were presented with information regarding similar case experiences, with this including information regarding (1) the typical duration required for tumor size reduction, (2) common functional and psychological challenges faced before visible improvement occurs, and (3) potential difficulties encountered during treatment and strategies for coping with these difficulties. 3-3. On October 29, the purpose and benefits of expressive writing interventions were explained to the patient, with emphasis placed on how articulating positive thoughts about an illness can reframe one's perception, enhance one's sense of control, and build one's confidence in accepting changes in one' s appearance. 3-4. On October 30, the patient was guided through an expressive writing activity, with the patient provided with illustrative examples from previous patients to support engagement. The examples included the following: "*During treatment, I am supported by my family and the medical team. I am not alone." "Although my facial appearance has changed because of the tumor, I have support from health-care professionals and my family to help me cope with it."* These statements served as prompts to encourage the patient to compose 1 positive reflection per day. 3-5. On October 31, the patient's wife was invited to join the expressive writing intervention, with this intended to foster emotional connection and increase the patient's motivation to continue his participation in the activity. 3-6. Throughout the care period, the patient was consistently encouraged to continue engaging in expressive writing. The BIVAS was used at appropriate intervals to monitor changes in body image perception, to evaluate the effectiveness of the intervention, and to evaluate the patient's physical and psychological status.

Outcome Evaluation	1. On October 30, the patient stated, *"I'm not worried about work since I'm my own boss, but I do worry that when I go out to meet friends or pick up my child from school, people will be startled by how I look."* This indicates that the patient was able to articulate his concerns regarding changes in his appearance. 2. On October 31, the patient shared, *"I can use sunglasses and a baseball cap to manage the change in my appearance. I'm also open to trying other methods if they're available."* 3. On October 31, the patient and his wife engaged in the expressive writing activity. The patient wrote: *"I'm not alone—my loving wife is by my side."* 4. On November 2, although the patient continued to avoid direct eye contact with other patients, he was able to engage in open and sustained dialogue with nursing staff without averting his gaze. He remarked, *"Over the past few days, I've come to realize that the most important thing is to take good care of myself."* The patient's Body Image Visual Scale score increased to 60 mm, indicating improved acceptance of his altered appearance.

Table 2: Acute pain associated with tumor-induced compression of the right eye and postoperative surgical wounds (October 28 to November 4).

Subjective and Objective Data	S1. On October 28, the patient stated, *"Since I've learned that I have cancer, I've been feeling low. I often feel agitated and constantly fear that it might be untreatable—that I might die."* S2. On October 28, the patient reported, *"The surgery is scheduled for tomorrow. Although I know it's just a minor excision and biopsy, it's my first surgery, so I feel nervous."* S3. On November 1, upon learning about his diagnosis, the patient exclaimed, *"What? A malignant tumor? And there are more tumors in other areas? What am I supposed to do? I still have to support my family!"* S4. On November 1, the patient asked, *"Will chemotherapy completely cure this? Is there a high chance of recurrence?"* O1. On October 28, when discussing his cancer diagnosis, the patient had a furrowed brow and a tense facial expression; he frequently sighed and lowered his head. The patient expressed anxiety related to the diagnosis and upcoming first surgery. His BAI score was 28. O2. On November 1, upon receiving the pathology report indicating malignant lymphoma and the presence of multiple tumors, the patient exhibited signs of emotional distress, including a tense expression, mild hand clenching and rubbing, and repeated verbalization of anxiety about the diagnosis and questions regarding the efficacy of chemotherapy.
Goals	1. By October 29, the patient will be able to correctly implement at least 3 nonpharmacological anxiety-reduction techniques. 2. Prior to discharge, the patient will report a noticeable reduction in anxiety, as evidenced by a BAI score lower than 14.
Nursing Interventions	1-1. On October 28, the patient and his spouse were provided with education on anxiety- reduction strategies, including the following: (1) Music therapy: The patient was encouraged to listen to calming music, such as that including nature sounds and no lyrics. (2) Acupressure: The patient was instructed to apply circular pressure to the Neiguan (PC6), Laogong (PC8), Taichong (LR3), and Yongquan (KI1) points, with each point being pressed for 5 seconds and released for 1 second and with sessions lasting 2 to 5 minutes. (3) Aromatherapy: Because the patient had no prior experience with using essential oils, lavender oil was recommended to him. He was instructed that it could be applied topically during acupressure or dripped onto a piece of gauze and placed near his pillow to promote relaxation through scent. (4) Religious practice: As a follower of Taoism, the patient was encouraged to pray to deities for surgical success and recovery and to use this as an outlet for expressing his internal fear and anxiety. 1-2. On October 29, nurses participated in a multidisciplinary consultation with the physician, patient, and spouse to explain the postoperative evaluations that would be required and treatment plans. The patient's wife was encouraged to participate actively in the patient's care to enhance the patient's sense of control. 1-3. On November 2, the nurses collaborated with the physician to explain the anticipated treatment course to the patient and his spouse, including the need for regular chemotherapy sessions (approximately half- to full-day visits) and scheduled follow-up appointments to monitor treatment outcomes. 2-1. Throughout the care period, a trusting nurse-patient relationship was established by the nurses consistently being present and engaging in empathetic communication and active listening. The BAI was administered periodically to assess changes in the patient's anxiety levels.

Outcome Evaluation	1. On October 29, the patient stated that the anxiety-reduction strategies were similar to those used for pain management, noting that they included listening to music and performing acupressure but that the acupressure points differed. He reported improved sleep quality and an overall sense of relaxation. 2. From October 30 to 31, the patient was observed consistently using a combination of music therapy, acupressure, and aromatherapy. His spouse remained present to provide emotional support and assistance. His BAI score decreased to 14, indicating a significant reduction in anxiety. 3. On November 4, prior to discharge, the patient expressed: *"Over the past few days, I've grown to feel much calmer. I'm really not as anxious anymore. Thank you all."*

Table 3: Anxiety resulting from the initial cancer diagnosis, upcoming surgical procedures, and uncertainty regarding prognosis and treatment outcomes (October 28 to November 4).

Discussion and Conclusions

This study presents a nursing care experience involving a patient with a new diagnosis of lymphoma, which had led to his right-eye proptosis. During hospitalization, the patient underwent a series of diagnostic evaluations, including a pathological biopsy, and was scheduled to receive outpatient chemotherapy following discharge. Throughout the course of care, 3 primary health concerns were identified: acute pain, body image disturbance, and anxiety. Pharmacological pain management was administered as pre-scribed by the attending physician. In parallel, non-pharmacological strategies including music therapy, comfortable positioning, and acupressure were introduced, and they effectively reduced the patient's perceived pain. To address the patient's psychological, dis-tress related to his altered appearance, the care team encouraged him to openly express his emotions and discussed practical methods for concealing the visible effects of proptosis during his social interactions. Expressive writing was implemented as a structured intervention, with it used to help the patient gradually accept changes in his appearance. A trusting nurse-patient relationship was fostered through active listening, being present, and empathetic communication. An interdisciplinary team provided the patient with disease-specific education and reinforced the use of non-pharmacological anxiety-reduction techniques, including music therapy, acupressure, and aromatherapy. These interventions aligned with findings from the reviewed literature. Before discharge, follow-up outpatient appointments were arranged, and the patient was referred to an oncology case manager for continued support. A detailed handover of the patient's medical and psychosocial needs was conducted. At that time, the patient's self-perceived body image as measured using the BIVAS was 60 mm. As part of the postdischarge care plan, the patient, his spouse, and the case manager agreed to continue the expressive writing intervention, with support in the form of regular telephone follow-ups by the case manager and outpatient visits. The patient reported in an outpatient follow-up on November 20 that he had consistently engaged in the daily expressive writing practice. His BIVAS score had risen to 75 mm, indicating a notable improvement in his self-image and a greater lev-el of acceptance toward the changes in his physical appearance.

Although the study hospital actively promotes evidence-based practice, it lacks a comprehensive framework for integrating various evidence-based interventions into clinical workflows. For example, in the current case, expressive writing was incorporated into care, and although the nursing staff were aware of its evidence-based rationale, their individual interpretations of and methods of implementing the intervention varied considerably. This inconsistency led to uneven patient education and implementation of the intervention. To address this problem in future cases, a dedicated evidence integration team can be established to develop standardized guidelines and protocols for each evidence-based intervention. Furthermore, offering online training courses would enhance nursing staff's knowledge of interventions and ensure consistent application across the care team. Such initiatives would facilitate individualized nursing care tailored to patient needs while ensuring consistency in the implementation of care practices.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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