

THE EXPERIENCES OF OLDER ADULTS WITH CANCER IN MANAGING HYPERTENSION AS A COMORBIDITY DURING END OF LIFE CARE

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ABSTRACT

Managing comorbidities such as hypertension in geriatric cancer patients during end-of-life care presents a profound clinical and psychological dilemma, as treatment goals shift from strict physiological control to comfort. This study aimed to deeply explore the authentic lived experiences of older adults with advanced cancer in managing hypertension as a comorbidity during their end-of-life care phase. A qualitative descriptive phenomenological approach was conducted. Purposive sampling was used to recruit eight geriatric cancer patients (aged ≥ 60 years) with a documented history of comorbid hypertension who were currently receiving palliative or end-of-life care in East Java, Indonesia. Semi-structured, face-to-face in-depth interviews were carried out over a six-month period. The qualitative data were transcribed verbatim and analyzed systematically using Colaizzi's seven-step phenomenological method to maintain structural rigor. The study successfully identified three main themes: (1) The Burden of Dual Illness: navigating the physical overlap of cancer pain and hypertensive distress; (2) The Treatment Dilemma: patient and family perceptions regarding the necessity of anti-hypertensive polypharmacy versus palliative comfort; and (3) Seeking a Peaceful Death: balancing existential acceptance with the daily stress of physiological monitoring. The study contributes an experiential perspective on how older adults negotiate cardiovascular management, treatment burden, autonomy, and psychospiritual priorities when hypertension coexists with advanced cancer at the end of life. These findings support flexible, individualized, comfort-oriented palliative nursing care that integrates symptom relief, medication review, shared decision-making, and patients' cultural and spiritual values.

Keywords: *End-of-life care; Geriatric; Oncology; Hypertension; Palliative nursing*

INTRODUCTION

The intersection of oncology, geriatrics, and cardiovascular care is increasingly important because older adults with cancer frequently present with cardiovascular risk factors and may be particularly vulnerable to treatment-related cardiovascular toxicity (Ioffe et al., 2024). Hypertension is also a recognized complication of several contemporary anticancer therapies, including vascular endothelial growth factor pathway inhibitors and tyrosine kinase inhibitors, requiring individualized cardiovascular assessment and management (Cohen et al., 2023). At the end of life, however, the goals of care may change substantially: rather than pursuing long-term prevention alone, clinicians must balance disease management with symptom relief, treatment burden, patient preferences, and quality of life (Huo et al., 2022). In Indonesia, these considerations are further shaped by family involvement, collective decision-making, and religious beliefs, which are important components of advance care planning and serious-illness communication (Martina et al., 2022).

Hypertension in patients with advanced cancer may reflect pre-existing cardiovascular disease, cancer-related mechanisms, or adverse effects of anticancer treatment. Contemporary evidence emphasizes that cancer therapy-related hypertension requires attention to baseline cardiovascular risk, treatment-specific mechanisms, and individualized blood-pressure management (Cohen et al., 2023; Koskina et al., 2023). In older adults with frailty and multiple comorbidities, hypertension management is additionally complicated by the potential harms of intensive treatment, including hypotension and treatment burden (Hu et al., 2023). For patients approaching the end of life, these clinical issues can coexist with cancer-related pain, fatigue, weakness, and other symptoms, making symptom attribution and prioritization particularly challenging. Accordingly, palliative nursing assessment should integrate symptom intensity, functional status, medication burden, and the patient's goals of care rather than relying on physiological measurements alone (Ioffe et al., 2024).

Furthermore, the psychological and existential impact of maintaining rigid physiological monitoring during the end-of-life phase remains largely under-explored in qualitative research. Geriatric patients frequently express a deep sense of futility, frustration, and emotional exhaustion when subjected to strict polypharmacy regimens. They often view the mandatory ingestion of daily anti-hypertensive medications, which offer no immediate relief for their cancer-induced pain, as an unnecessary medicalization that disrupts their spiritual tranquility and inner preparation for a peaceful death (Van Merendonk & Crul, 2022). While extensive quantitative literature details the cardiovascular toxicities of oncological treatments, a distinct theoretical gap remains regarding how older adults subjectively construct meaning out of living with hypertension under the immediate shadow of terminal cancer (Kurtgöz & Keten Edis, 2023). Gaining a profound understanding of these emotional perspectives and localized cultural adaptations is essential for nurses to design truly patient-centered care. Therefore, this study aims to deeply explore the authentic lived experiences of older adults with advanced cancer in managing hypertension as a comorbidity during their end-of-life care.

METHODS

This study employed a qualitative descriptive phenomenological design to systematically capture, interpret, and reconstruct the authentic lived experiences and psychological configurations of geriatric cancer patients navigating comorbid hypertension during the end-of-life phase. Phenomenology was selected as the optimal methodological framework because it allows researchers to look past preconceived clinical assumptions and directly explore the subjective meanings that individuals attach to their dual-illness state (Charalambous et al. 2016). The study was conducted within the specialized palliative care units, oncology wards, and outpatient geriatric clinics of a prominent tertiary referral hospital in East Java, Indonesia. This clinical setting serves as a major regional hub for oncology care, providing a rich, socio-culturally diverse environment for exploring complex palliative nursing phenomena.

The target population encompassed all older adult patients diagnosed with advanced malignancies and pre-existing chronic hypertension who were currently receiving formal palliative care. A purposive sampling strategy was deliberately utilized to select participants

who could provide rich, deeply reflective, and articulate insights regarding the specific phenomenon under investigation (Moser and Korstjens, 2018). The sample size was determined based on the principle of data saturation, the point during data collection where no new conceptual properties, themes, or perspectives emerge from subsequent interviews (Saunders et al., 2018). Saturation was structurally achieved at the eighth participant (N = 8).

The stringent inclusion criteria for this study were strictly enforced: (1) individuals aged 60 years or older; (2) histologically confirmed diagnosis of advanced cancer (Stage III or IV); (3) a documented medical history of comorbid primary hypertension requiring active pharmacological management; (4) currently classified under a palliative care regimen or designated as receiving end-of-life care; and (5) possessing stable cognitive and communicative capacity. Cognitive integrity was objectively screened and verified prior to recruitment using the Mini-Mental State Examination (MMSE), with a mandatory cutoff score of >24 to eliminate the confounding effects of advanced delirium or cognitive decline (Nursalam et al., 2022). Patients experiencing acute, unmanaged physical distress (such as severe breakthrough oncological pain or hypertensive encephalopathy) or those undergoing active psychiatric crisis were excluded from the study.

The research process spanned six months, from October 2025 to March 2026. Consistent with qualitative phenomenology, the study did not define conventional quantitative variables; instead, it explored participants' perceptions of symptom experiences, the emotional and practical burden of antihypertensive polypharmacy, and psychospiritual adjustments while balancing treatment preferences with the pursuit of a dignified death. The sample size was guided by the adequacy and saturation of qualitative data; recent methodological evidence emphasizes that saturation should be explicitly justified according to the characteristics and objectives of the study rather than determined solely by a fixed numerical rule (Hennink & Kaiser, 2022).

The primary instrument in this qualitative inquiry was the researcher himself acting as the human instrument, which required the continuous application of reflexivity and bracketing (epoche), the systematic suspension of the researcher's personal biases, prior clinical experiences, and theoretical preconceptions regarding cardio-oncology care to ensure the purity of the data (Husserl 2012). Data collection was facilitated by a semi-structured interview guide developed based on extensive literature and reviewed by an expert panel in palliative nursing. The guide utilized open-ended questions designed to stimulate deep reflection, such as: *"Could you describe what it feels like to manage your blood pressure while simultaneously dealing with your cancer treatments?"* and *"How do you perceive the necessity of your daily heart medications at this stage of your life?"*.

In-depth, face-to-face, semi-structured interviews were conducted individually in quiet, private consultation rooms or at the patient's bedside during stable intervals to guarantee confidentiality and emotional comfort. Each interview lasted between 45 to 65 minutes. With the explicit, written permission of the participants and their family caregivers, all interviews

were digitally audio-recorded. Field notes were simultaneously maintained to capture non-verbal cues, sighs, long pauses, and emotional expressions that added contextual depth to the transcripts.

The qualitative data were transcribed verbatim within 24 hours of each interview to maintain immediate immersion in the data. The transcripts were analyzed using Colaizzi's (1978) rigorous seven-step phenomenological descriptive method to guarantee structural dependability (Morrow, Rodriguez, and King 2015). The analysis proceeded through the following structured phases: (1) Familiarization: Reading and re-reading all transcripts multiple times to obtain a holistic feeling for the participants' reality. (2) Extracting Significant Statements: Identifying and isolating phrases and sentences directly pertaining to the experience of managing hypertension in a terminal cancer state. (3) Formulating Meanings: Developing creative, empathetic meanings from the significant statements while constantly cross-checking against the original protocols. (4) Clustering Themes: Grouping the formulated meanings into unique clusters of themes and subsequent overarching themes. (5) Developing an Exhaustive Description: Integrating the clustered themes into a comprehensive, rich description of the core phenomenon. (6) Producing the Fundamental Structure: Condensing the exhaustive description into a dense, essential statement that defines the invariant structure of the experience. (7) Member Checking: Returning the final thematic structures to three available participants to validate whether the findings accurately reflected their lived experiences, ensuring qualitative credibility.

Given the immense vulnerability of geriatric patients facing terminal illnesses, ethical integrity was prioritized throughout the study. The research protocol underwent rigorous institutional scrutiny and successfully obtained formal ethical clearance and an official fit test from the Institutional Health Research Ethics Committee of the participating hospital.

Written informed consent was secured from all individual participants prior to the commencement of data collection. To minimize ethical distress, the consenting process was witnessed and co-signed by the primary family caregiver (family caregiver burden consideration). Participants were explicitly informed of their absolute right to pause or terminate the interview at any juncture without any negative repercussions to their standard medical treatment. Principles of anonymity and data confidentiality were strictly protected by stripping all personal identifying data from the transcripts and replacing them with alphanumeric codes (e.g., Participant 1 as P1). All digital recordings and transcripts were stored in encrypted, password-protected cloud storage accessible solely by the primary research team.

RESULTS

Characteristics of Participants

The demographic and clinical analysis indicated that all participants ($N = 8$) were older adults aged between 62 and 78 years, diagnosed with advanced-stage malignancies (Stage III and IV) and presenting with a long-standing history of comorbid essential hypertension. The detailed demographic profiles are systematically outlined in Table 1:

Table 1. Demographic and Clinical Characteristics of Geriatric Participants

Participant Code	Age (Years)	Gender	Cancer Type and Stage	Hypertension Duration	Palliative Care Setting
P1	67	Male	Stage IV Lung Cancer	5 years	Inpatient Palliative Unit
P2	72	Female	Stage IV Colorectal Cancer	8 years	Home-based Palliative Care
P3	64	Female	Stage III Breast Cancer	3 years	Inpatient Oncology Ward
P4	78	Male	Stage IV Prostate Cancer	12 years	Home-based Palliative Care
P5	62	Female	Stage IV Cervical Cancer	6 years	Inpatient Palliative Unit
P6	69	Male	Stage III Gastric Cancer	4 years	Inpatient Oncology Ward
P7	75	Female	Stage IV Ovarian Cancer	10 years	Home-based Palliative Care
P8	71	Male	Stage IV Liver Cancer	7 years	Inpatient Palliative Unit

Thematic Analysis Results

Through inductive analysis utilizing Colaizzi's seven-step descriptive phenomenological framework, the essential structure of the participants lived experiences was uncovered. This data abstraction process yielded three main themes, six sub-themes, and nine highly distinct categories, as comprehensively structured in Table 2 to 4:

Table 2. Themes, Sub-themes, and Categories of The Burden of Dual Illness

Main Themes	Sub-themes	Identified Categories
Theme 1: The Burden of Dual Illness	1.1. Symptom Overlap and Discomfort	1.1.1. Inability to differentiate cancer pain from hypertensive headache.
		1.1.2. Cumulative physical frailty and exhaustion.
	1.2. Heightened Existential Anxiety	1.2.1. Fear of sudden stroke accelerating oncology related death.

Theme 1: The Burden of Dual Illness

The first theme captures the deep physical and psychological distress experienced by older adults when the symptoms of advanced oncological disease directly collide with hypertensive episodes.

Sub-theme 1.1: Symptom Overlap and Discomfort

"When my head feels like it is going to explode from the back of my neck, I am genuinely confused... Is this because my cancer has spread everywhere, or is it because my blood pressure suddenly spiked? This old body is far too weak to endure two separate torments at the exact same time." (P1, 67 years old, Lung Cancer)

"It is incredibly exhausting. Sometimes I just want to lie completely still because this cancer makes my bones ache deeply, but then suddenly the room spins violently because my blood pressure is up. I feel like there is no room left in this body to just feel comfortable." (P5, 62 years old, Cervical Cancer)

Sub-theme 1.2: Heightened Existential Anxiety

"I already know this cancer cannot be cured, and I have accepted that. But what I fear most is if this high blood pressure suddenly causes a stroke. I do not want to die paralyzed and become an even heavier burden to my children." (P4, 78 years old, Prostate Cancer)

Table 3. Themes, Sub-themes, and Categories of The Treatment Dilemma

Main Themes	Sub-themes	Identified Categories
Theme 2: The Treatment Dilemma	2.1. Polypharmacy Fatigue	2.1.1. Perceived futility of daily blood pressure pills in terminal stage.
		2.1.2. Physical difficulty swallowing multiple medications.
	2.2. Autonomy vs. Medical Compliance	2.2.1. Intentional non-compliance to prioritize immediate comfort.

Theme 2: The Treatment Dilemma

The second theme underscores the internal conflict that older patients face regarding the necessity of maintaining strict adherence to anti-hypertensive regimens while their baseline physical condition deteriorates.

Sub-theme 2.1: Polypharmacy Fatigue

"Every single morning the nurse brings a small cup full of pills. There are pain medications, anti-nausea drugs, and then I still have to take this blood pressure pill. Why must I keep swallowing this heart medication? This cancer is going to kill me very soon, not my blood pressure. Swallowing just one pill makes my throat reject it." (P8, 71 years old, Liver Cancer)

"My mouth is entirely covered in painful ulcers due to past chemotherapy treatments. Forcing myself to swallow those large blood pressure tablets every single day feels like an additional punishment." (P3, 64 years old, Breast Cancer)

Sub-theme 2.2: Autonomy vs. Medical Compliance

"Sometimes I purposefully hide the blood pressure pill under my pillow. If I take that medicine alongside the strong cancer painkillers, my body immediately feels weak, like I am floating, and I cannot even sit up. I prefer my blood pressure to be slightly high, as long as I can still sit up and talk with my family." (P6, 69 years old, Gastric Cancer)

Table 4. Themes, Sub-themes, and Categories of Seeking a Peacefull Death

Main Themes	Sub-themes	Identified Categories
Theme 3: Seeking a Peaceful Death	3.1. Shifting Priorities to Spiritual Peace	3.1.1. Relinquishing physiological control through religious surrender.
		3.1.2. Valuing family presence over rigid clinical monitoring.
	3.2. De-medicalization of the Final Days	3.2.1. Requesting safety de-escalation of blood pressure checks.

Theme 3: Seeking a Peaceful Death

The final theme reflects a profound phase of psychospiritual adaptation, where the participants' focus shifted entirely away from objective physiological metrics toward achieving inner tranquility.

Sub-theme 3.1: Shifting Priorities to Spiritual Peace

"I told my son, stop wrapping that blood pressure cuff around my arm every hour. A reading of 160 or 120 makes absolutely no difference for someone who is preparing to go home to God like me. It is much better to guide me through my prayers rather than busily checking those digital numbers." (P4, 78 years old, Prostate Cancer)

"My peace of mind right now comes from prayers and having my grandchildren sit next to this bed. Knowing that my blood pressure is normal does not make my cancer disappear, so let me focus on preparing my soul to meet Him peacefully." (P2, 72 years old, Colorectal Cancer)

Sub-theme 3.2: De-medicalization of the Final Days

"Every time that machine pumps tightly against my arm, my heart actually beats faster out of fear. I asked the nurses not to check me with those devices so frequently. Just let my remaining time in this hospital pass quietly without the constant disruption of medical sensor alarms." (P7, 75 years old, Ovarian Cancer)

DISCUSSION

The findings of this descriptive phenomenological study offer deep, authentic insights into the intricate physical, clinical, and existential realities of geriatric cancer patients who must navigate comorbid chronic hypertension during their end-of-life care. The structural analysis of their lived experiences reveals a profound shift from a focus on physiological metrics to a prioritization of psychospiritual tranquility. This section critically discusses the three emergent themes, aligning them with contemporary nursing theories, cardio-oncological literature, and established palliative frameworks.

The Symptom Overlap and Cumulative Distress of Dual Illness

The theme *The Burden of Dual Illness* highlights a prominent clinical challenge in contemporary cardio-oncology nursing: the profound physical ambiguity caused by overlapping symptom thresholds. Geriatric patients in this study expressed significant distress over their inability to differentiate whether acute head discomfort arose from a sudden hypertensive crisis or from the progressive, metastatic trajectory of their cancer. Established medical facts indicate that advanced malignancies induce a state of chronic systemic inflammation and neurological stress, which can inherently lower a patient's subjective threshold for physical pain (Kurnia et al., 2018). When this fragile state is compounded by sudden spikes in systemic vascular resistance, manifesting as hypertensive headaches or occipital rigidity, the cumulative physical toll becomes overwhelming.

The findings suggest that symptom interpretation becomes particularly complex when cancer-related pain, weakness, fatigue, and cardiovascular symptoms coexist. Contemporary cardio-oncology evidence emphasizes that cardiovascular risk and cancer-treatment toxicity should be assessed within the broader clinical context of older adults, including functional status, comorbidities, cognition, and quality of life (Ioffe et al., 2024). In addition, hypertension and cardiovascular risk in patients receiving cancer therapy may require individualized monitoring rather than a uniform approach (Cohen et al., 2023). The present findings add an experiential dimension to this evidence: participants described uncertainty about the source of discomfort and fear of sudden loss of function. Therefore, palliative nurses should combine symptom assessment with individualized cardiovascular assessment and explicit discussion of patient priorities, rather than interpreting blood-pressure values in isolation.

The Clinical Dilemma of Polypharmacy and Patient Autonomy

The theme *The Treatment Dilemma* exposes a clear conflict between standard, rigid disease-management guidelines and the individual needs of terminal geriatric patients. Our findings show that older adults experience profound polypharmacy fatigue, viewing the daily enforcement of long-term preventative medications, such as anti-hypertensive pills, as an unnecessary and physically painful medical burden. In advanced oncology settings, physiological changes like chemotherapy-induced mucositis, malignant dysphagia, and cachexia make the mechanical act of swallowing multiple large tablets highly distressing (Papadopoulos et al., 2020). When patients force themselves to adhere to these regimens, it can diminish their immediate quality of life.

From a palliative-care perspective, the central issue is not simply whether antihypertensive treatment should continue, but whether its expected benefits remain aligned with the patient's prognosis, goals, and treatment burden. Recent evidence supports individualized medication optimization for older adults with advanced cancer and limited life expectancy (Brokaar et al., 2023). Reviews of deprescribing in palliative cancer care likewise emphasize that preventive medications should be reconsidered when their potential benefits are unlikely to be realized within the patient's remaining lifespan (van Merendonk & Crul, 2022). Recent evidence on

early palliative care further supports a model that prioritizes quality of life, symptom control, coping, and patient-centred goals alongside disease-directed treatment (Huo et al., 2022).

The intentional withholding of medication described by participants can be interpreted not merely as non-compliance but as an expression of perceived treatment burden and an attempt to preserve functional autonomy. This interpretation is consistent with contemporary deprescribing evidence, which recommends systematic medication review for older adults with advanced cancer and emphasizes the identification of potentially inappropriate medications (Fernández-Fradejas et al., 2024). Antihypertensive deprescribing in older adults should also be individualized, with attention to frailty, blood pressure, adverse effects, and monitoring after withdrawal (Sheppard et al., 2022). Importantly, decisions about treatment reduction should not be made unilaterally. Shared decision-making allows patients and families to negotiate treatment goals and preferences within the clinical context of palliative care (Symmons et al., 2023).

De-medicalization and the Transition toward Spiritual and Dignified Passing

The final theme, seeking a Peaceful Death, illustrates how participants shifted attention from physiological control toward meaning, spirituality, family connection, and preparation for death. Contemporary qualitative research indicates that spiritual care in oncology and palliative settings involves patients' needs for meaning, hope, religious practice, compassionate presence, and culturally responsive communication (Kurtgöz & Keten Edis, 2023; Mercier et al., 2023). In the Indonesian context, family involvement and religious beliefs are particularly relevant to discussions about future care and decision-making (Martina et al., 2022), while recent Indonesian research also highlights the importance of family preparedness and cultural practices surrounding death and dying (Rochmawati & Wiechula, 2023). These findings support the interpretation that palliative nursing should recognize spiritual and relational priorities as legitimate components of end-of-life care rather than treating them as secondary to physiological monitoring.

The persistent use of loud, intrusive clinical monitoring equipment, such as automated blood pressure cuffs that squeeze the arm at regular intervals, can disrupt this essential tranquility. Participants in our study noted that continuous physiological checks caused secondary anxiety and distracted them from their spiritual and emotional preparation for death. This finding strongly supports the concept of de-medicalization in terminal care, the deliberate reduction of non-essential diagnostic or monitoring interventions to create a calm, sacred environment for the dying individual (Suza et al., 2020).

Palliative nursing care must actively champion this approach. Rather than focusing heavily on maintaining blood pressure within narrow, arbitrary parameters, nurses should work closely with the medical team to transition care plans toward comfort-driven protocols. This includes reducing the frequency of routine vital sign checks for stable terminal patients and focusing instead on supporting psychological comfort, managing breakthrough symptoms, and

facilitating a peaceful environment that honors the patient's cultural and spiritual values (Hasanah, Nursalam, and Pradanie, 2023).

CONCLUSIONS

Older adults with advanced cancer and comorbid hypertension experience a multidimensional burden involving overlapping symptoms, treatment burden, concerns about loss of function, and psychospiritual needs. The present study contributes a qualitative account of how these patients negotiate the tension between maintaining physiological control and preserving comfort, autonomy, family connection, and spiritual peace at the end of life.

Suggestions: Palliative and oncological nursing protocols should incorporate individualized assessment of comorbidities, medication burden, symptom distress, prognosis, and patient goals at the end of life. Clinical practice should support shared decision-making and structured medication review, including consideration of deprescribing non-beneficial preventive therapies when consistent with the patient's goals and clinical status. Blood-pressure monitoring should likewise be individualized according to symptom burden, stability, prognosis, and patient preference. A comfort-oriented approach that integrates physical, psychological, social, and spiritual needs may reduce treatment burden while supporting a dignified and patient-centred end-of-life experience.

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