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Palliative Care in Gynecologic Cancers

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Abstract

Gynecologic cancers constitute a significant part of cancer load, especially in developing countries, and may be an important reason for mortality and morbidity for women in these countries. Procedures in diagnosis and treatment for gynecologic cancers might remain insufficient, and disorders related to symptoms may negatively influence the quality of life of women and their families. In this respect, interest on palliative care in gynecologic cancer cases has increased. The literature demonstrates that palliative care allows women to remain active as much as possible in the period between diagnosis and death, aids in management of pain and discomfort during the terminal stage, and ensures a comfortable death process. Palliative care has been shown to improve quality of life, mood, symptom control, satisfaction, survival duration, and caregiver satisfaction, depression, and stress burden. Palliative care improves healthcare utilization outcomes such as decreased hospital costs. Therefore, healthcare provider training and palliative care for patients need to be integrated into standard oncology care.

Keywords: Palliative care; Gynecologic malignancies; Gynecologic cancer; Oncology care

Introduction

Palliative care is a philosophy of care that aims to enhance patient quality of life through effective management of pain and other symptoms and provide psychosocial and spiritual care by taking into consideration patient values, beliefs, and culture [1]. Applying this philosophy of care begins when a patient is diagnosed, continues until death with curative therapy, and finishes with care supporting the family and other caregivers during the grief process after death [2-6]. With an interdisciplinary team approach, it aims to prevent situations that have a negative influence on patients and their families and to assist them as they grieve [3,7,8].

Today both national and international institutions argue for the necessity of integrating palliative care into cancer care. Palliative care is accepted as one of five main headings (prevention, early detection, diagnosis, treatment, and palliation) in World Health Organization (WHO) cancer control programs [9]. The article "Cancer Care During the Last Phase of Life," published by the American Society of Clinical Oncology (ASCO) in 1998, emphasizes the importance of a palliative care service that is accessible, useable, and provided by experts in palliative care to provide optimal end-of-life care [10]. ASCO also states that palliative care needs to be a routine part of cancer care at least by 2020 [11]. The 58th World Health Assembly, organized in 2005, strongly recommended palliative care and defined it as one of the components of extensive cancer care, such as medical, surgical, and radiation oncology therapy and integration of palliative care into national cancer programs [12]. Turkey started a national cancer control program in 2009, and palliative care was integrated into the program. In addition, the national palliative care program was prepared in 2009 and the Pallia-Turk project, which is a nurse-based, population-based project, was started in 2011 [5,13]. Pilot studies were initiated [5,13] within the scope of the Pallia-Turk project, and Turkey has become one of the few countries rising to group III B in the WHO classification in 2011 [2].

Cancer is an important public health problem and is ranked as second among causes for death in Turkey and globally [14]. Gynecologic cancers are one of the main reasons for morbidity and mortality in women following breast cancer [15]. Because of this, patients with gynecologic cancers remain an ideal population for palliative care. In this review, the importance and effects of palliative care in gynecological cancer are summarized.

Importance of Palliative Care in Gynecologic Cancers

It is estimated that 1,085,948 women in the world and 7,873 in Turkey have been diagnosed with gynecologic cancer, and approximately half of these women died because of cancer [14]. Procedures of diagnosis and treatment applied for gynecologic cancers negatively influence patient and family quality of life in terms of body image, sexual identity, and ability of reproduction, in addition to the problems experienced in cancers in other organs [16,17]. Treatments administered during the disease process may remain ineffective [18-20], and the disease may progress or relapse [15,18,20]. Patients can experience numerous symptoms during the diagnosis and treatment process [19-22]. In a prospective study on 240 patients with cancer, patients experienced an average of 13 (range 2–30) symptoms during the diagnosis and treatment process [23]. In the retrospective study by Jung et al. to determine symptoms experienced by patients with gynecologic cancer, 82% of patients experienced pain (defined as Edmonton System Assessment Scale scores ≥ 4), 72% anorexia, 69% fatigue, and 54% insomnia problems [24]. Symptoms may impair the quality of life of women and their families [17,22,25] and make compliance with treatment recommendations difficult [17,22].

The literature states that some therapies, including chemotherapy, are administered until the day before death in patients with

gynecologic cancer [6,18,21,26-28]. Fauci et al. reported that 57.8% of patients with gynecologic cancer received curative chemotherapy within the final 6 months of life, 7.1% received radiotherapy, 58.6% underwent at least one procedure for curative therapy, and 84.7% applied for admission to a hospital at least 1 to 14 times [27]. This condition may prolong admission time and length of hospital stay of patients with gynecologic cancer and increase healthcare costs.

Being diagnosed with gynecologic cancer has considerable impact on not only the patient but also caregivers [29-31]. Caregivers of patients with terminal cancer may spend at least 8 h per day in activities such as symptom management, emotional and mental support, maintenance of personal care and daily life necessities, and ensuring communication and coordination with the healthcare team [32]. At the same time, caregivers may experience considerable stress [29]. The study by Rivera and Mcmillan stated that caregivers of patients with cancer encountered problems such as depression and depression-induced fatigue, insomnia, hypersomnia, and difficulty in concentration and decision making [31].

In this respect, interest has increased in palliative care, which provides a holistic approach to patients with gynecologic cancer and their families [1,6,15,20,21,27]. The Society of Gynecologic Oncology (SGO) encourages maintaining and supporting qualified clinical care during the course of disease and states that it is important to integrate principles of palliative care into patient care [8]. In addition, the SGO emphasized that initiating basic palliative care in women with terminal or relapsed gynecologic cancer should not be delayed and these patients must be referred for special palliative care when appropriate. The SGO published evidence-based recommendations in 2013 concerning tests and procedures to avoid in gynecologic oncology [33]. Referring patients to early palliative care may reduce the number of hospitalizations and procedures performed [7].

The Effect of Palliative Care on Gynecologic Cancers

The goal of gynecologic cancer treatment is to maximize survival results by minimizing negative effects of disease or effects of treatment on quality of life [34]. Few prospective studies have researched the effect of palliative care on quality of life in gynecologic cancers [28]. A prospective study by Rugno demonstrated the benefits of early integration between palliative care and standard anticancer treatment on the quality of life scores reported by patients with gynecologic cancer [28]. At the same time, studies in the liturature indicate that palliative care, which is assumed to be an inseparable part of cancer therapy, increases quality of life for patients with cancer [4,35-37]. The Educate, Nurture, Advise, Before Life Ends (ENABLE) II project indicated that life quality mean scores of patients who received palliative care from the time they were diagnosed with cancer were higher than in patients receiving standard oncology treatment [35]. A landmark study by Temel et al. determined that quality of life and state of mind of patients with cancer receiving early palliative care were higher than in patients receiving standard care. In addition, they stated that survival time of patients with cancer who received palliative care was longer and these patients were exposed to less aggressive end-of-life care practices (e.g., chemotherapy) [38].

Palliative care focuses particularly on symptom control in the progressive stage of gynecologic cancer [20,21]. Randomized controlled studies emphasize that palliative care integrated into standard oncology care ensures symptom control [35-38] and increases satisfaction of the patient and family [25,32,38,39]. In the retrospective study conducted by Keyser et al. to determine the effect of palliative care on patient outcomes and interventions in patients with terminal gynecologic cancers, symptom control of patients receiving palliative care therapy was better, they received less chemotherapy in the final 4 weeks of life, and survival was extended by 8 weeks [7]. In the study conducted by Dionne-Odom et al. to assess the effect of early (immediately after diagnosis) and late (3 months after diagnosis) palliative care, depression scores of caregivers who recieved early palliative care were lower and they experienced less depression and stress, especially when their patients were in the terminal stage [32].

The literature reports that qualified palliative care service also causes healthcare cost reduction [34,37,39-41]. In a retrospective study with 100 patients who died as a result of gynecologic cancer, timely palliative care consultation occurred in only 18% of cases and decreased late aggressive interventions and health costs [40]. In the study conducted by Albanase et al., cancer patients, regular use of palliative care units provided savings of approximately $850,000 per year to the hospital [41]. In addition, Gade et al. stated that use of palliative care in the last month of cancer provided savings of $5,000 per patient [39].

Conclusion and Clinical Implication

Palliative care and symptom management are integral components of practice for women with gynecologic cancer. Patients receiving treatment with curative intent with surgery, chemotherapy, and/or radiation often develop life-altering side effects such physical and psychological symptoms. Healthcare professionals who provide palliative care for patients with gynecologic cancer spend a significant amount of time palliating symptoms. Involvement of specialty palliative care providers can assist in managing the complex patient. Palliative care ensures patients with gynecologic cancer and their families have active lives as much as possible and reduced symptom severity during in the period between diagnosis and death. Applied palliative care practices are effective in the experience of enhanced quality of life and a comfortable death process and may have a positive influence healthcare costs. Therefore, palliative care should be integrated into standard oncology care at the time a person is diagnosed with gynecologic cancer and/or has a high symptom burden. Training of oncology healthcare professionals should include delivery of palliative care.

Limited data exist on the impact of palliative care on patients with gynecologic cancer and their caregivers. Future studies should investigate survival outcomes, quality of life, patient and caregiver satisfaction, symptom management, etc., in a prospective and/or randomized fashion to better characterize the optimal standard of palliative care for women with gynecologic malignancies.

References

1. Landrum LM, Blank S, Chen LM, Duska L, Bae-Jump V, et al. (2015) Comprehensive care in gynecologic oncology: the importance of palliative care. Gynecol Oncol 137: 193-202.
2. Worldwide Palliative Care Alliance (2014) Global Atlas of Palliative Care at the End of Life.
3. Institute for Clinical Systems Improvement (2013) Palliative Care for Adults.
4. World Health Organization (WHO) (2012) Definition of Palliative Care.
5. Terzioglu F, Uslu Sahan F, Boztepe H (2015) Palliative Care to the Cancer Patient: Turkish perspectives. J Palliat Care Med S5: S5-004.

6. Levy MH, Adolph MD, Back A, Block S, Codada SN, et al. (2012) Palliative care clinical practice guidelines in oncology. J Natl Compr Canc Netw 10: 1284-1309.
7. Keyser EA, Reed BG, Lowery WJ, Sundborg MJ, Winter WE, et al. (2010) Hospice enrollment for terminally ill patients with gynecologic malignancies: impact on outcomes and interventions. Gynecol Oncol, 118: 274-277.
8. Smith TJ, Temin S, Alesi ER, Abernethy AP, Balboni TA. (2012) American Society of Clinical Oncology provisional clinical opinion: the integration of palliative care into standard oncology care. J Clin Oncol 30: 880-887.
9. World Health Organization (2016) National cancer control programmes.
10. American Society of Clinical Oncology (1998) Cancer care during the last phase of life. J Clin Oncol 16:1986-1996.
11. American Society of Clinical Oncology (2015) Palliative Care in Oncology.
12. World Health Assembly (2005) WHA58.22 Cancer Prevention and Control.
13. Republıc of Turkey Ministry of Health (2015) Turkey Cancer Control Programme.
14. International Agency for Research on Cancer (IARC) (2012) Globocan
15. Eskander RN, Osann K, Dickson E, Holman LL, Rauh-Hain JA, et al. (2014) Assessment of palliative care training in gynecologic oncology: a gynecologic oncology fellow research network study. Gynecol Oncol 134: 379-384.
16. Nazik E, Ozdemir F, Soydan S (2014) Social support and quality of life in Turkish patients with gynecologic cancer. Asian Pac J Cancer Prev 15: 3081-3086.
17. Pinar G, Okdem S, Buyukgonenc L, Ayhan A (2012) The relationship between social support and the level of anxiety, depression, and quality of life of Turkish women with gynecologic cancer. Cancer nursing 35: 229-235.
18. Zakhour M, LaBrant L, Rimel BJ, Walsh CS, Li AJ, et al. (2015) Too much, too late: Aggressive measures and the timing of end of life care discussions in women with gynecologic malignancies. Gynecol Oncol 138: 383-387.
19. Pathy S, Raheja SG, Rakhi S (2008) Palliative care in advanced gynecological cancers: Institute of palliative medicine experience. Indian J Palliat Care 14: 86-89.
20. Mishra K (2011) Gynaecological malignancies from palliative care perspective. Indian J Palliat Care 17: 45-51.
21. Rezk Y, Timmins PF, Smith HS (2011) Review article: palliative care in gynecologic oncology. Am J Hosp Pallıat Care 28: 356-374.
22. Agarwal S, Bodurka DC (2010) Symptom research in gynecologic oncology: a review of available measurement tools. Gynecol Oncol 119: 384-389.
23. Homsi J, Walsh D, Nelson KA, LeGrand SB, Davis M, et al. (2002) The impact of a palliative medicine consultation service in medical oncology. Support Care Cancer 10: 337-342.
24. Kim YJ, Munsell MF, Park JC, Meyer LA, Sun CC, et al. (2015) Retrospective review of symptoms and palliative care interventions in women with advanced cervical cancer. Gynecol Oncol, 139: 553-558.
25. Tahmasebi M, Yarandi F, Eftekhar Z, Montazeri A, Namazi H (2007) Quality of life in gynecologic cancer patients. Asian Pac J Cancer Prev, 8: 591-592.
26. Dalrymple JL, Levenback C, Wolf JK, Bodurka DC, Garcia M, et al. (2002) Trends among gynecologic oncology inpatient deaths: is end-of-life care improving? Gynecol Oncol 85: 356-361.
27. Fauci J, Schneider K, Walters C, Boone J, Whitworth J, et al. (2012) The utilization of palliative care in gynecologic oncology patients near the end of life. Gynecol Oncol 127: 175-179.
28. Rugno FC, Paiva BSR, Paiva CE (2014) Early integration of palliative care facilitates the discontinuation of anticancer treatment in women with advanced breast or gynecologic cancers. Gynecol Oncol 135: 249-254.
29. Kim Y, Given BA (2008) Quality of life of family caregivers of cancer survivors. Cancer 112: 2556-2568.
30. Mystakidou K, Tsilika E, Parpa E, Galanos A, Vlahos L (2007) Caregivers of advanced cancer patients: feelings of hopelessness and depression. Cancer nursing 30: 412-418.
31. Rivera HR, McMillan SC (2010) Predictors of depression symptoms in hospice caregivers. J Hosp Palliat Nurs 12: 345-357.
32. Dionne-Odom JN, Azuero A, Lyons KD, Hull JG, Tosteson T, et al. (2015) Benefits of early versus delayed palliative care to informal family caregivers of patients with advanced cancer: outcomes from the ENABLE III randomized controlled trial. J cli oncol 23:1-9.
33. Society of Gynecologic Oncology (2013) SGO's 5 tests or procedures to avoid.
34. Lopez-Acevedo M, Lowery WJ, Lowery AW, Lee PS, Havrilesky LJ (2013) Palliative and hospice care in gynecologic cancer: a review. Gynecol Oncol 131: 215-221.
35. Bakitas M, Lyons KD, Hegel MT, Balan S, Brokaw FC, et al. (2009) Effects of a palliative care intervention on clinical outcomes in patients with advanced cancer: the Project ENABLE II randomized controlled trial. Jama 302: 741-749.
36. Gomes B, Calanzani N, Higginson IJ (2014) Benefits and costs of home palliative care compared with usual care for patients with advanced illness and their family caregivers. JAMA 311: 1060-1061.
37. Morrison RS, Dietrich J, Ladwig S, Quill T, Sacco J, et al. (2011) Palliative care consultation teams cut hospital costs for Medicaid beneficiaries. Health affairs 30: 454-463.
38. Temel JS, Greer JA, Muzikansky A, Gallagher ER, Admane S, et al. (2010) Early palliative care for patients with metastatic non–small-cell lung cancer. N Eng J Med 363: 733-742.
39. Gade G, Venohr I, Conner D, McGrady K, Beane J, et al. (2008) Impact of an inpatient palliative care team: a randomized controlled trial. J Palliat Med 11: 180-190.
40. Nevadunsky NS, Gordon S, Spoozak L, Van Arsdale A, Hou Y, et al. (2014) The role and timing of palliative medicine consultation for women with gynecologic malignancies: association with end of life interventions and direct hospital costs. Gynecol Oncol 132: 3-7.
41. Albanese TH, Radwany SM, Mason H, Gayomali C, Dieter K (2013) Assessing the financial impact of an inpatient acute palliative care unit in a tertiary care teaching hospital. J Palliat Med 16: 289-294.