Journal of Palliative Care & Medicine
ISSN: 2165-7386
Rosenbaum, J Palliat Care Med 2022, 12:3
Short Communication Open Access

Palliative Care in Treating Women with Ovarian Cancer

Linda Rosenbaum*

Division of Gynecologic Oncology, Department of Obstetrics and Gynecology, University of Virginia, Charlottesville, United States

Introduction

Despite significant breakthroughs in surgery, initial chemotherapy, and innovative recurrent disease treatments, advanced epithelial ovarian cancer remained lethal in the majority of cases in 2016. Furthermore, both the disease and the accompanying adjuvant treatment have a significant impact on overall quality of life. The malignancy causes symptoms, but the therapy might lead to even more serious issues, such as neuropathy, nausea, exhaustion, anorexia, and discomfort. As oncology practitioners, we have a natural propensity to focus on the disease and treatment response rather than the treatment related pain of our patients. Our patients, on the other hand, are hesitant to report their problems for fear of having their treatment interrupted or altered. As a result, while rigorous surgery and adjuvant therapy may temporarily beat the disease into submission, the patient may be suffering from treatment-related symptoms that are sometimes permanent.

Early incorporation of palliative care into the treatment of women with advanced epithelial ovarian cancer allows us to address this conundrum and, in some cases, prolong life. 151 patients with newly diagnosed metastatic non-small cell lung cancer were randomized to integration of outpatient palliative care from the time of cancer diagnosis vs. conventional oncologic therapy in the most well-known of the cancer patient randomized studies [1]. Despite less active intervention at the end of life, the early palliative care integration group not only had significant improvements in quality of life and mood, but also (unexpectedly) had a statistically significantly better overall survival (11.6 versus 8.9 months, $p = 0.02$). Other investigations in oncology patients [2] have corroborated the findings of this study. In their Choosing Wisely campaign, our own Society of Gynecologic Oncology has lobbied for the inclusion of palliative care in the care of women with gynecologic cancer.

What does palliative care entail, and how should it be delivered? Palliative care is defined by the World Health Organization (WHO) as "an approach to improving the quality of life of patients and their families facing problems associated with life-threatening illness, through the prevention and relief of suffering through early detection and impeccable assessment and treatment of pain and other physical, psychosocial, and spiritual problems." To put it another way, palliative care takes a comprehensive approach to the patient, addressing all aspects of the individual and her caregivers/family, including those that many oncologists are ill-equipped to treat. Primary palliative care and speciality primary care services are two types of palliative care services. Most oncologists have been educated to give primary palliative care to their patients and are comfortable doing so; in the case of gynecologic oncologists, this includes basic symptom management and aligning treatment options with patient goals. A team of clinicians, comprising a palliative care trained physician, nurse or advanced practice provider, social worker, chaplain, pharmacists, nutritionists, rehabilitation therapists, and direct care workers, among others, provides speciality palliative care. The goal of the speciality palliative care team is to address all aspects of palliative care, including the physical, emotional, spiritual, and social aspects of treatment. All of these domains are included in a comprehensive assessment of palliative care needs, which necessitates a multidisciplinary approach to the patient and her family. As a result, early incorporation of palliative care allows us to continue caring for our ovarian cancer patients while simultaneously addressing their suffering and increasing their overall quality of life.

Why haven't we accepted early palliative care integration into the care of women with advanced ovarian cancer? The most significant impediment to early integration is a misunderstanding of what "palliative care" entails [3]. Palliative care is wrongly equated with end-of-life care, making it incompatible with anticancer therapy for both patients and doctors. Patients worry that palliative care means the oncologist is "giving up," and evidence from providers shows that many people wrongly think of palliative care as synonymous with end-of-life care, making it incompatible with anticancer therapy [3]. "One of the greatest remaining challenges is the need for better understanding of the role of palliative care among both the public and professionals across the continuum of care so that hospice and palliative care can achieve their full potential for patients and their families," according to the Institute of Medicine report "Dying in America." 2 stated there are also misconceptions regarding the purpose of hospice and the hospice benefit, resulting in a low number of patients with ovarian cancer using the hospice benefit at the end of their lives and very late hospice referrals [4].

Other significant obstacles to integrating palliative care early in the course of a cancer, such as advanced ovarian cancer, exist. There is a perceived lack of training and exposure by oncologists in providing basic palliative care services, as well as a lack of availability of outpatient specialty palliative care services, poor reimbursement for palliative services, and a perceived lack of availability of outpatient specialty palliative care services. While outpatient specialty palliative care services are available at most NCI-designated cancer centres, they are significantly less widespread in the community. Palliative care reimbursement continues to be inadequate, contributing to a scarcity of services. Until recently, clinicians were not reimbursed for discussing advance care planning with their patients, a conversation that can take a long time in a busy cancer clinic if done well.

Finally, assessments of medical and gynecologic oncology fellows indicate that they are unprepared to give primary palliative care, have uncomfortable talks, or discuss end-of-life planning with their patients [5]. In gynecologic oncology fellowships, there is obviously room to improve the palliative care curriculum and exposure.

***Corresponding author:** Linda Rosenbaum, Division of Gynecologic Oncology, Department of Obstetrics and Gynecology, University of Virginia, Charlottesville, United States, E-mail: duska@virginia.edu

Received: 01-Mar-2022, Manuscript No. jpcm-22-57063; **Editor assigned:** 03-Mar-2022, PreQC No. jpcm-22-57063 (PQ); **Reviewed:** 17-Mar-2022, QC No. jpcm-22-57063; **Revised:** 22-Mar-2022, Manuscript No. jpcm-22-57063 (R); **Published:** 29-Mar-2022, DOI: 10.4172/2165-7386.1000446

Citation: Rosenbaum L (2022) Palliative Care in Treating Women with Ovarian Cancer. J Palliat Care Med 12: 446.

References

1. 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 Engl J Med 363(8):733-742.
2. Bakitas MA, Tosteson TD, Li Z, Lyons KD, Hull JG, et al. (2015) Early versus delayed initiation of concurrent palliative oncology care: patient outcomes in the ENABLE III randomized controlled trial. J Clin Oncol 33(13):1438-1445.
3. Bakitas M, Lyons KD, Hegel MT, Ahles T (2013) Oncologists perspectives on concurrent palliative care in a National Cancer Institute designated comprehensive cancer center. Palliat Support Care 11(5):415-423.
4. Brown AJ, Sun CC, Prescott LS, Taylor JS, Ramondetta LM, et al. (2014) Missed opportunities: patterns of medical care and hospice utilization among ovarian cancer patients. Gynecol Oncol 135(2):244-248.
5. Lefkowits C, Sukumvanich P, Claxton R, Courtney Brooks M, Kelley, et al. (2014) Needs assessment of palliative care education in gynecologic oncology fellowship: we are not teaching what we think is most important. Gynecol Oncol 135(2):255-260.