International Journal of Innovation Scientific Research and Review
Vol. 05, Issue, 05, pp.4475-4478, May 2023
Available online at http://www.journalijisr.com
SJIF Impact Factor 2023: 6.599

ISSN: 2582-6131

Research Article

PALLIATIVE CARE MANAGEMENT OF OVARIAN CANCER

[1,] *I Gde Sastra Winata, [1]William Alexander Setiawan,[1]Gde Bagus Rizky Kornia, [1]Ni Luh Wita Astari Widhusadi, [2]Tjokorda Istri Apriliyanty Pemayun, [2]Komang Adya Data Agrasidi, [2]Dewa Gde Agung Aditya Mahadarmika

[1]Obstetrics and Gynecology Department, Prof. Dr. I.G.N.G. Ngoerah Hospital/Medical Faculty of Udayana University, Bali, Indonesia.
[2]Medical Faculty of Udayana University, Bali, Indonesia.

Received 08th March 2023; Accepted 09th April 2023; Published online 25th May 2023

ABSTRACT

Background & Aims: The majority of ovarian cancers are not discovered until the disease has spread outside of the ovary. As a result, a diagnosis is made at an advanced stage (stages III and IV), when treatment is less successful and resulting a poor prognosis. Therefore, patient with any form or stage of ovarian cancer is required a comprehensive approach, such as palliative care to improve their quality of life. This paper aims to summarize the management of ovarian cancer-specific palliative care. **Method:** Literature review were compiled based on article obtained using search engine “Google Scholar” and “PubMed” with keywords “Palliative Care”, “Ovarian Cancer”, and “Quality of Life”. There were 16 articles were appropriate for this purpose. **Discussion:** Palliative care is an approach that helps patients and their family quality of life when they are dealing with challenges driven by a life-threatening illness. The Association of Regional Cancer Centers (ACCC) launched an advocacy-led, multi-step initiative to improve care for patients diagnosed with ovarian cancer in the United States, with three key components. Quality-based recommendations were made for the program's seven core components that focuses on ensuring quality care for patients with ovarian cancer through improved patient education and participation by addressing unmet medical and supportive care needs, there are : patient education and care coordination, screening and prevention, initial management and diagnosis, treatment strategy, disease monitoring, equity in healthcare, and quality of life. One of the obstacles in implementing comprehensive palliative care program is the limited time for medical personel to identify patient problems other than medical problems. **Conclusion** Given the complexity of ovarian cancer, navigator-led, and person-centered programs are urgently needed with an emphasis on critical aspects such as multidisciplinary team-based care, access to clinical trials, and the provision of ancillary services.

Keywords: Palliative Care, Ovarian Cancer, Quality of Life.

INTRODUCTION

Background

Generally, the incidence and mortality rate of cancer, particularly ovarian cancer, is rising significantly. A malignant tumor in one or both ovaries is called ovarian cancer (OC). It is associated with the highest fatality rate among gynecological cancers. Ovarian cancer is ranks fifth most frequent cause of mortality in woman [1] It could happen to anyone at any age, with varying histologic subtypes. The incidence rate rises correspondingly with age. Ovarian cancer is most frequently diagnosed in women over 50, while it can also be seen in children. The age range of 55 to 64 is where ovarian cancer patients are most commonly diagnosed [2]According to U.S. cancer statistics, ovarian cancer was reported for 13.445 deaths among women in 2019, placing it fifth overall.[3] Based on WHO Globocan databased, In Indonesia, there were 14.896 new cases of ovarian cancer in 2020 which resulted in 9.581 death cases [4] The majority of ovarian cancers are not discovered until the disease has spread outside of the ovary. As a result, a diagnosis is made at an advanced stage (stages III and IV), when treatment is less successful. The overall 5-year survival rate is less than 50% [5] The lack of an efficient screening approach and the asymptomaticity or late onset of symptoms are the root causes resulting this poor prognosis.[6]

Therefore, a comprehensive approach, such as palliative care, is required to assist patients with cancer. Health professionals must be deeply involved in helping patients to understand and cope with their sickness and to achieve the outcomes of their therapy. Palliative care is a field of medicine and nursing that focuses on symptom management, pain relief, phychological, social, social and emotional support for people with life-threatening illnesses, particularly cancer. Patients with any form or stage of cancer can improve their quality of life through palliative treatment. In addition to improving quality of life, palliative care, which includes supportive care, can also help with symptom control and prolong patients’ life [7]Palliative care aims to improve patient's current medical treatment by emphasizing both the patient's and their family's quality of life. Consequently, in this article, we will discuss about ovarian cancer-specific palliative care. We hope that this article will help readers to understand and expand their perspective about palliative care.

METHOD

Literature review were compiled based on article obtained using search engine “Google Scholar” and “PubMed” with keyword “Palliative Care”, “Ovarian Cancer”, and “Quality of Life”. There were 16 articles were appropriate for this purpose.

DISCUSSION

Definitions of Palliative care

Palliative care is an approach that helps patients' (adults and children's) and their families' quality of life when they are dealing with challenges driven by a life-threatening illness. Through the early detection, accurate assessment, and treatment of pain and other issues, whether physical, mental, or spiritual, it both minimizes and alleviates pain and suffering [8] All patients who need symptom relief as

***Corresponding Author: I Gde Sastra Winata,**
1Obstetrics and Gynecology Department, Prof. Dr. I.G.N.G. Ngoerah Hospital /Medical Faculty of Udayana University, Bali, Indonesia.

well as those who need psychological and supportive care for themselves, and their family will be provided by palliative care. This is particularly relevant for individuals who are at an advanced stage of the disease and have a small chance of recovery or who are in the final stages of the illness. Palliative care services addressing the needs of patients and their families from the time of diagnosis can improve quality of life and the capacity to cope due to the emotional, spiritual, social, and economic repercussions of cancer and its management.[8]

Its clinical practice is based on the principle of enhancing the quality of life for patients and their families who are dealing with serious illnesses. This interdisciplinary specialty's goals are to help patients transition to the end of life while decreasing the burden of their symptoms, treating spiritual and psychological distress, improving understanding of the illness and prognosis to establish goals of care, and assisting them in coping with their condition and their final moments [9]. A key component of palliative care when a patient reaches the end of life is assisting patients and their families in understanding the nature of the illness and prognosis. Palliative care professionals also assist patients and their families in deciding the proper medical treatment and coordinating their objectives for care with other members of the medical care team. In addition to doctors, nurses, social workers, chaplains, and pharmacists, palliative care teams occasionally also include physician assistants, dietitians, and physical and occupational therapists. They are employed in a variety of places, such as health care facilities, outpatient clinics, and occasionally nursing homes or patient residences [10]

Palliative Program

Palliative care is specialized medical care focused on relieving symptoms and stress in critically ill patients. Community-based palliative care (CBPC) serves critically ill patients by integrating symptom and stress relief into the community health system. According to The National Comprehensive Cancer Network, palliative care should be applied in to cancer care since cancer diagnosis. However, palliative care usually prioritized for cancer patients at the end-of-life.[11]Clinical consensus recommends that high-quality end-of-life care includes enrollment in hospice when a patient has a prognosis that is less than 6 months and does not include the receipt of intensive or invasive care, andif it does not meet those standards indicates aggressive end-of-life care.[12]Programs of palliative care may include training a program for general practitioners or community volunteers, general practitioners providing palliative care within the community, or specialists working in multidisciplinary teams with nurses and general practitioners. Other professionals such as social he workers, chaplains and care coordinators may also be part of her CBPC team. To meet this growing need, the World Health Organization recommends integrating palliative care into primary health care, outpatient and home care, and volunteer networks. [13]
Ovarian cancer is a disease that requires complex treatment planning and high-quality care which is a challenge in the entire range of treatment for this disease. These challenges emphasize the importance of a multidisciplinary team approach to the delivery of care at this disease site. Ovarian cancer quality-care initiative was led by a multidisciplinary expert steering committee,

including pathologists, gynecologic oncologists, a nurse navigator, a genetic counsellor, cancer center administrators and social workers. [14]Based on study, the average age of gynecologic cancer patients receiving palliative care was 66 years. The 5% of all patients with metastatic gynecologic oncology received palliative care overall. Of those who received palliative care, 62% used surgery, radiation, or chemotherapy alone, and 12% used pain management as a form of palliative care.[11]

In 2019, the Association of Regional Cancer Centers (ACCC) launched an advocacy-led, multi-step initiative to improve care for patients diagnosed with ovarian cancer in the United States, with three key components: 1) developing and managing a workshop adapted survey to identify the needs of patients diagnosed with ovarian cancer in multiple cancer programs. 2) adoption and implementation of quality improvement initiatives by three selected ACCC member programs on issues specific to ovarian cancer development, from diagnosis to survival; 3) dissemination of results via a curated comprehensive resource library hosted by the ACCC for patient and provider-specific ovarian cancer educational resources.[14]
Quality-based recommendations were made for the program's seven core components. It focuses on ensuring quality care for patients with ovarian cancer through improved patient education and participation by addressing unmet medical and supportive care needs.[14]

Patient Education and Care Coordination
All patients are recommends to: 1) be educated about ovarian cancer, staging, prognosis, potential treatment side effects, and response expectations by a multidisciplinary cancer care team member prior to therapy initiation; 2) participate in shared decision-making regarding their comprehensive cancer care plan; and 3) have access to multidisciplinary cancer care team members who can answer questions and assess and address potential barriers to treatment success, such as housing, transportation, financial, and treatment costs as well as prediagnosis comorbidities; and 4) have ongoing access to a multidisciplinary cancer care team member who can address emotional, psychosocial, and/or spiritual care concerns and needs.[14]

Screening and Prevention
There are two fundamental components to risk reduction or prevention. First, in individuals with an average risk of ovarian cancer, opportunistic salpingectomy at the time of hysterectomy, other pelvic surgery, or in lieu of tubal ligation is recommended; and risk-reducing salpingo-oophorectomy is recommended for patients with an increased genetic risk of ovarian cancer (family history; BRCA1, BRCA2, and other inherited mutations) at the completion of childbearing or at an age determined by family history or specific mutations. [14]

Initial Management and Diagnosis
Prior to treatment commencement, recommendations for initial workup will ideally include: 1) examination by a gynecologic oncologist; 2) tumor marker assessment (cancer antigen 125, carcinoembryonic antigen, and/or cancer antigen 19-9), as clinically needed before therapy initiation; and 3) tumor marker assessment (cancer antigen 125, carcinoembryonic antigen, and/or cancer antigen 19-9). 3) comprehensive pathologic examination; 4) surgical decision and time established by a gynecologic oncologist; 5) Nutrition analysis and referral; 6) screening for emotional distress/support, referral for psychosocial needs, and/or spiritual care referral; and 7) referral to a concurrent, supportive oncologist/palliative care expert where indicated.[14]

Treatment Strategy
Treatment for ovarian cancer must be tailored to the patient's performance status, care goals, and germline and somatic genetic testing results. A general treatment plan includes the following components: 1) a multidisciplinary review of the treatment plan for consensus recommendations; 2) evaluation for clinical trials in the upfront and recurrent settings to be considered first; 3) a care plan compliant with the 13 components of the Institute of Medicine's Care Management Plan provided to patients before the first therapeutic modality; and 4) early integration of supportive and palliative care services. The scarcity of clinical trials for ovarian cancer patients, as well as the poor enrollment of older patients and those from

traditionally under-represented racial and ethnic groups, offer obstacles.[14]

Disease Monitoring

Post treatment surveillance includes detecting disease recurrence as well as late treatment side effects. It is recommended to standardize surveillance protocols that include a history and physical examination63, as well as an assessment of tumor markers, if warranted (visits every 2-4 months for the first two years, every 3-6 months for the next three years, and annually after five years). Routine imaging is not advised, but should be performed if disease-related symptoms or an increase in a tumor marker appear. For imaging, computed tomography is suggested, with positron emission tomography reserved for special cases. For patients with surgically resected ovarian cancer who are being treated with curative intent, survivorship care plans should be prepared.[14]

Equity in Healthcare

There are significant discrepancies in access to and receipt of high-quality ovarian cancer care among patients from historically under-represented racial and ethnic groups, as well as those with lower socioeconomic status.[14]

Quality of Life

Because of the side effects of therapeutic interventions, such as fatigue, bloating, pain, peripheral neuropathy after taxane-based chemotherapy, sexual dysfunction, and morbidity from disease-related symptoms, health-related QoL is an important consideration for patients diagnosed with ovarian cancer.[14]Aggressive end-of-life care is well defined in a set of validated claims-based metrics that reflect inappropriate end-of-life care among populations dying of cancer. Utilizing these measurements, results included end-of-life medications, indicators for hospice utilize, and end-of-life healing center utilization. Treatment measures included chemotherapy within the final 2 weeks of life, life-extending strategies (ventilation, revival, or bolstering tubes), and obtrusive methods (surgery requiring anesthesia, radiotherapy, interventional radiology procedure, endoscopy, pelvic examination with tissue inspecting, placement of blood vessel or central line). Hospice utilize included not selecting in hospice (no hospice) or hospice enrollment less than 3 days some time recently passing (late hospice). Healing center utilization measures included > 1 ED visit or healing center confirmation, ICU affirmation, and passing in an intense care hospital. [15]Women with ovarian cancer who have lower overall continuity of care (COC), likely reflecting the complexity of the care they receive. Patients with higher continuity of care were more likely not to be admitted to hospice. These patients were more likely to have received chemotherapy within the first two weeks of life.[15] End-of-life chemotherapy is considered low-quality care since it decreases quality of life without increasing survival, and it can increment hazard for receipt of other forceful care such as ventilation and dying in an ICU. COC at the end of life is complicated and may pose unique challenges in providing quality end of life care. Future work exploring the specific facets of continuity associated with quality end of life care is needed.[16]

Given the complexity of ovarian cancer, with its numerous and diverse tumor subtypes, as well as the dynamic therapy management landscape, a single model cannot be utilized to characterize ovarian cancer care delivery for patients across several settings. The task force's suggestions can be used by cancer programs as a quality-directed resource covering the ovarian cancer care continuum. Navigator-led and person-centered programs are urgently needed, with an emphasis on critical aspects such as multidisciplinary team-based care, access to clinical trials, and the provision of ancillary services such as genetic counseling, supportive care, fertility preservation, and nutritional counseling, all of which can significantly improve the lives of ovarian cancer patients.[14]

Barrier

There are several obstacles in the implementation of palliative care programs. The limited time for medical personel to identify patient problems other than medical problems is one of the obstacles in implementing comprehensive palliative care. This can be overcome by providing education to patients and caregivers about other resources that can be obtained locally, regionally, or online and making every health care facility have the same facilities and accommodations. Low rates of prophylaxis and risk reducing surgery which can be treated with continuing education of gynecologists, surgeons, pathologists, and oncologists on the role of risk-reducing surgery and thorough pathologic evaluation (SEE-FIM) of specimens after risk-reducing surgery to detect occult tubal carcinomas and precursor lesions. Problems with equality in service and with qualityof life problems due to patients who are reluctant to share their problems with their clinician or other members of the health care team. [14]

CONCLUSION

Given the complexity of ovarian cancer, navigator-led, and person-centered programs are urgently needed with an emphasis on critical aspects such as multidisciplinary team-based care, access to clinical trials, and the provision of ancillary services.

REFERENCES

1. Arora T, MS and LMR,. Ovarian cancer. 2021;
2. Doubeni CA, DAR, & MAE. Diagnosis and management of ovarian cancer. Am Fam Physician. 2016;93(11):937–44.
3. CDC. United States Cancer statistic: data visualizations. 2019.
4. WHO. Global Cancer Observatory. 2020;
5. Wu J, SH, YL, DY, YY, WS, YG and MH. Improved survival in ovarian cancer, with widening survival gaps of races and socioeconomic status: a period analysis. J Cancer. 2018;9(19):3548.
6. Chien J and P. Ovarian cancer prevention, screening, and early detection: report from the 11th biennial ovarian cancer research symposium. International Journal of Gynecologic Cancer. 2017;27(S5).
7. Wajid M, RE, RJ, GAJ, LR and SS,. Why is hospice care important? An exploration of its benefits for patients with terminal cancer. BMC Palliat Care. 2021;20(1):70.
8. WHO. Palliative Care. 2020;
9. Agarwal R and EAS. The role of palliative care in oncology. In Seminars in interventional radiology . 2017;34(04):307–12.
10. Brown TJ, STJ and GA. Palliative care. JAMA Oncol. 2019;5(1):126–126.
11. Islam JY, DA, PRA, & AT. Racial and ethnic disparities in palliative care utilization among gynecological cancer patients. Gynecol Oncol. 2021;160(2):469–76.
12. Mullins MA, RJJ, CP, US, WLP, & CML. Trends and racial disparities in aggressive end-of-life care for a national sample of women with ovarian cancer. Cancer. 2021;127(13):2229–37.
13. Vernon E, HMC, & KM. Measuring effectiveness in community-based palliative care programs: a systematic review. Soc Sci Med. 2022;296:114731.
14. Temkin SM, SMP, DMD, BLM, SL, BDR, . . . & TPH. Improving the quality of care for patients with advanced epithelial ovarian cancer: Program components, implementation barriers, and recommendations. Cancer. 2022;128(4):654–64.

15. Mullins MA, RJJ, CP, US, CML, & WLP. Continuity of care and receipt of aggressive end of life care among women dying of ovarian cancer. Gynecologic oncology. 2021;162(1):148–1.
16. Mullins MA, US, RJJ, CML, CP, & WLP. Physician influence on variation in receipt of aggressive end-of-life care among women dying of ovarian cancer. JCO Oncol Pract. 2022;18(3):e293–303.

****