



Longitudinal assessment of quality of life in ovarian cancer patients

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A B S T R A C T

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Objective: The objective of this work was to evaluate longitudinally the quality of life (QOL) in women treated for ovarian cancer, pre-operatively, three and six months postoperatively.

Methods: A longitudinal cohort study. A total of 93 patients with newly diagnosed ovarian cancer in F. Chopin Voivodeship Specialist Hospital in Rzeszow, Poland were interviewed pre- and post-operatively with two questionnaires: EORTC QLQ-C30 and QLQ-OV28 between October 2006 and December 2008.

Results: Based on EORTC QLQ-30 it was found that global health and emotional functioning improved. An improvement regarding symptoms such as nausea and vomiting was recorded between T2 and T3. Patients complained less of pain in the whole studied period of time. Based on the modules of the QLQ-OV28 showed improvement of QOL on the scales concerning abdominal and attitude to disease/treatment. Decrease of symptoms on the scales concerning body image and sexual worries were observed. Increase of chemotherapy side effects and hormonal symptoms were observed between T1 and T2, but then improved.

Conclusions: QOL of patients had increased after the treatment in comparison to the baseline. There is a need to implement the assessment of quality of life in ovarian cancer patients in practice.

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Introduction

Ovarian cancer still remains one of the deadliest cancers in the world; nevertheless, latest improvements in diagnostics, more effective surgical techniques, and newer treatment models have increased the curability of this neoplasm and have allowed more patients to live longer with their disease (Stavraka et al., 2012). Advances in ovarian cancer care have also provided new opportunities for oncology nurses to improve the quality of life of their patients' lives.

Different approaches in quality-of-life (QOL) studies in ovarian cancer have been applied in recent years. Researchers have employed validated (Greimel et al., 2003) or unvalidated tools (Marcinkiewicz et al., 2006). Some QOL studies have used telephone surveys (Cox et al., 2008), others have used mail surveys (Fang et al., 2009), or surveys have been conducted in the presence of researchers (Fasching et al., 2007). A few studies were carried out

in different clinical stages – i.e. FIGO stages III or IV (Chie et al., 2010), FIGO stage III (Koensgen et al., 2010) – and different treatment modalities (i.e. first-line chemotherapy, combination or single-drug second-line therapy (Stavraka et al., 2012)). Some previous studies have included not only ovarian cancer but other gynaecological malignancies (Fasching et al., 2007; Golbasi and Erenel, 2012). It is therefore difficult to draw general conclusions concerning QOL in ovarian cancer patients.

Although it can be argued that QOL is a difficult concept to define and measure, over the last decade considerable progress has been made in developing robust and standardized QOL measures (McCabe et al., 2008). QOL in ovarian cancer patients may be measured using both generic and/or condition-specific scales to capture relevance to a patient's life and to assess a direct relationship between treatment and specific outcomes. Various measures are available, and especially widely used are the 30-item EORTC QLQ-C30 (European Organization for Research and Treatment of Cancer Questionnaire) and FACIT (the Functional Assessment of Chronic Illness Therapy) or FACT (Functional Assessment of Cancer Therapy) (Arriba et al., 2010).

Longitudinal assessments of QOL in the field of oncology are relevant, although challenges in conducting them are many. Researches on this concept require enormous amounts of time and

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are quite expensive. Missing data in such studies are an important issue too. However, the concept of QOL in ovarian cancer is increasingly important as a valid indicator of whether or not a given medical treatment is beneficial. Such studies provide meaningful information for those planning the mode of treatment (Halyard and Ferrans, 2008; Andersen et al., 2012) or care plans (Greimel and Nordin, 2010; Bahrami and Arbon, 2012), or developing a therapeutic nurse–patient relationship (King, 2006; King and Hinds, 2012).

Aim

The objective of this work was to evaluate longitudinally the quality of life in women treated for ovarian cancer preoperatively and 3 and 6 months postoperatively.

Methods

Design

This is a longitudinal cohort study targeting Polish ovarian cancer patients. The Commission for Bioethics at the Medical Department of University of Rzeszow approved the study protocol, which was conducted in accordance with the Helsinki Declaration.

Sample and setting

The study was carried out on a convenient sample of cancer patients. Study participants were identified from the patients' logs at F. Chopin Voivodeship Specialist Hospital in Rzeszow, Poland. Eligibility was confirmed by a gynaecological oncologist. Eligibility criteria were women with newly diagnosed FIGO (IC-III) ovarian cancer receiving the same treatment (chemotherapy) following the surgery. The inclusion criteria for patients were as follows:

- being hospitalized, diagnosed with ovarian cancer, and qualified for surgical treatment;
- not having any cognitive disorders;
- being aware of their cancer diagnosis;
- having signed a consent form.

The exclusion criteria were as follows

- patients with diagnosed malignant disease of the reproductive organs other than ovarian cancer, and previously treated for such disease (surgery, chemotherapy, radiotherapy, hormonal therapy, immune therapy);
- patients with other malignant disease concurrent or diagnosed within the previous 5 years.

A total of 118 women newly diagnosed with FIGO (IC-III) ovarian cancer were approached; 102 agreed to participate (86%). Eventually 93 (78%) completed all three assessments; four patients died (T3) and five resigned during the study (two women at T2, three women at T3) between October 2006 and December 2008.

Participation in the study survey was both voluntary and anonymous, and the research material was treated confidentially. Patients were asked to sign an informed consent form.

Procedures

Patients attending the oncology department of the F. Chopin Voivodeship Specialist Hospital in Rzeszow, Poland, were invited to participate. Patients were approached in the waiting room, informed about the study, and provided with questionnaires and

a patient information sheet. Patients were given the option of completing the questionnaire and returning it during their visit or completing and returning the questionnaire in the scheduled time (T1, T2, T3), (a freepost envelope was provided). Patients were provided with both oral and written instructions on how to complete the questionnaire. A baseline QOL questionnaire was handed out and discussed individually with each patient during the baseline enrolment interview during hospitalization (T1). Follow-up questionnaires were sent directly to the patients' home addresses at 3 and 6 months (T2 and T3). The questionnaires were self-completed by the patients themselves. Patients were considered evaluable for QOL assessment if they returned the baseline and two follow-up questionnaires.

Measures

Quality of life was assessed using the EORTC QLQ-C30 and QLQ-OV28 questionnaires. These are both validated and standardized measures for the assessment of overall health-related quality of life for cancer patients (QLQ-C30) and specifically for ovarian cancer patients (QLQ-OV28) (Cull et al., 2001; Greimel et al., 2003). In order to employ two questionnaires – the EORTC QLQ-C30 and QLQ-OV28 – a required consent from the EORTC was obtained.

EORTC QLQ-C30 is an important tool for assessing the generic aspects of QOL, and is most appropriate for long-term cancer survivors; this study focuses on identifying change over a period of time within a group of individuals. However, it has limitations, and therefore disease-specific treatment measurement (QLQ-OV28) was adopted to identify differences in QOL among patients who have active disease (King and Hinds, 2012).

The EORTC QLQ-C30 is a questionnaire assessing global quality of life of cancer patients. It consists of 30 questions that assess five functioning domains (physical functioning; role functioning; emotional functioning; cognitive functioning; social functioning), three symptom domains (fatigue, nausea and vomiting, pain), six single items (dyspnoea, insomnia, appetite loss, constipation, diarrhoea, financial difficulties), and global QOL scales (global health status and quality of life).

The EORTC QLQ-OV28 was designed as a supplement to the EORTC QLQ-C30 for use in ovarian cancer clinical trials (Greimel et al., 2003; Arraras et al., 2004). It contains seven subscales: (1) abdominal/gastrointestinal symptoms; (2) peripheral neuropathy; (3) other chemotherapy side effects; (4) hormonal/menopausal symptoms; (5) body image; (6) attitude to disease and treatment; (7) sexual function.

QOL assessments were done according to the following schedule: preoperative period (T1), 3 months (T2) and 6 months (T3) after surgery. The 3-month surveys (T2) occurred during chemotherapy, and the 6-month (T3) occurred after completion of chemotherapy treatment.

All items were rated on the four-point Likert scale: “not at all”, “a little”, “quite a bit”, “very much”, with the exception of the impact of patient's health on global QOL, which is scored on a scale ranging from “1, very poor” to “7, excellent”. Scores were linearly transformed into a 0–100 scale in accordance with the EORTC scoring manual (Cull et al., 2001). For symptom scales, a higher score means a poorer QOL. For function scales (BI and SEF), a higher score means a better QOL.

Reliability and validity

The quality of life was measured with the use of the Polish version of an internationally validated and widely used EORTC QLQ-C30 and QLQ-OV28, and data were analysed in accordance with methodological recommendations (Velikova et al., 2012).

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