

Problems Experienced by Ovarian Cancer Survivors During Treatment

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ABSTRACT

Objective: To identify problems at different treatment points (early treatment, mid-treatment, early posttreatment, and late posttreatment) among women with ovarian cancer.

Design: Longitudinal and cross-sectional study design.

Setting: An academic and community clinical cancer center in the Southeastern United States.

Participants: Sixty-eight women with Stage I to IV ovarian cancer.

Methods: Variables assessed included reported problems (physical, psychosocial, pain, marital, medical interaction), social support, optimism, and responses to open-ended questions. Analysis involved mixed models for longitudinal repeated measures and unpaired *t* tests and content analysis to describe responses to open-ended questions.

Results: Physical and psychosocial problems were greatest during early treatment and decreased throughout the treatment trajectory. Women with greater levels of social support and optimism at baseline had fewer problems over time. Women who did not have trouble paying for basics had fewer problems related to pain and psychological problems.

Conclusion: Problems across all domains must be addressed throughout the treatment trajectory, even after chemotherapy has ended. Nurses are well positioned to refer women appropriately to social workers and clinical navigators across all domains of care and should consider systemic assessment of patient-reported problems as a routine form of practice.

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In the United States, it is estimated that more than 230,000 women are living as ovarian cancer survivors (Siegel, Miller, & Jemal, 2016). *Cancer survivorship*, as defined by the National Cancer Institute (2016), begins after the time of diagnosis and extends until the woman's death, regardless of cause of death. Ovarian cancer occurs without early signs or symptoms, and up to 77% of women with ovarian cancer have advanced disease at diagnosis with poor prognosis (Lockwood-Rayermann, 2006; Price et al., 2016). The clinical course for women with advanced disease often involves aggressive therapies, including surgery and multiple courses of chemotherapy that usually include six cycles of combination chemotherapy with cisplatin or carboplatin plus a taxane (Lockwood-Rayermann, 2006). Approximately 80% of women experience disease recurrence and subsequently require additional courses of chemotherapy and adjuvant modalities over a number of years (Beesley et al., 2013). Because of the usually late stage of

diagnosis, poor prognosis, debilitating treatment options, and great likelihood of recurrence, the trajectory of treatment among ovarian cancer has numerous physical, psychological, and social effects.

At time of diagnosis and throughout early treatment, physical symptoms such as fatigue, nausea/vomiting, diarrhea, and pain are often the primary focus of cancer-related concerns (Portenoy et al., 1994; von Gruenigen et al., 2009). Initial tumor debulking surgery can be an intensive procedure with a significant period of recovery (Minig et al., 2013; Tangjitgamol, Manusirivithaya, Laopaiboon, Lumbiganon, & Bryant, 2016). Additionally, because of the close proximity of the ovaries to the gastrointestinal tract, initial tumor debulking can be associated with significant changes in bowel habits such as constipation or diarrhea (Minig et al., 2013; Tangjitgamol et al., 2016). A colostomy may be required to manage acute problems such as

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intestinal obstruction (Lockwood-Rayermann, 2006). The chemotherapy that follows can lead to prolonged periods of nausea, vomiting, fatigue, pancytopenia, alopecia, weight loss, changes in food taste, and periods of constipation or diarrhea, with certain nonreversible adverse effects such as peripheral neuropathy and premature menopause (de Moor et al., 2006; Ersek, 1997; Lockwood-Rayermann, 2006; Pokrzywinski et al., 2011).

Physical symptoms and pain have been associated with poorer health-related quality of life (HRQOL) and less vigor (Lutgendorf et al., 2002) and often contribute to prolonged psychological distress, but this connection has not been well studied in women with ovarian cancer (Norton et al., 2005). Additionally, women undergoing treatment for ovarian cancer are at greater risk for depression and anxiety and have greater depression symptoms compared with other cancer populations (Norton et al., 2004). Between 30% and 50% of women with an ovarian cancer diagnosis report moderate to severe levels of anxiety (Kornblith et al., 2010).

Ovarian cancer differs from other cancers because of the greater possibility of recurrence even after an initial period of no evidence of disease. Thus, psychological needs throughout the cancer experience are varied and often related to baseline levels of depression and anxiety as well as the amount of social support and optimism present throughout the cancer trajectory (Beesley et al., 2013; de Moor et al., 2006; Fitch & Steele, 2010; Kornblith et al., 2010). Qualitative inquiry has shown how ovarian cancer can stress relationships and life at home (Ferrell, Smith, Ervin, Itano, & Melancon, 2003), but the overall effect on marriage or long-term partnered relationships is not well understood.

Previous researchers found that greater levels of optimism (de Moor et al., 2006), active coping (Canada et al., 2006; Lutgendorf et al., 2002), greater spirituality (Canada et al., 2006), better physical function (Kornblith et al., 1995), and greater social support (Lutgendorf et al., 2002) were associated with better HRQOL in women with ovarian cancer. However, we do not know the

relationship of these variables with reported problem areas over the disease trajectory.

Despite these well-known adverse effects of ovarian cancer and its treatment, there are scant empirical data to examine when problems are most likely to occur. A better understanding of the timing of specific problems may help to identify the optimal timing of interventions by clinicians (Lakusta et al., 2001). For example, at diagnosis, women may experience the psychological distress and physical adverse effects of surgery, whereas physical discomfort, functional disability, and pain may be important problems to address during treatment. Additionally, financial and relationship concerns, as well as posttraumatic stress and anxiety, may be concerns as women enter survivorship. Finally, there is a paucity of evidence to suggest the long-term survivorship needs of women with ovarian cancer.

The purpose of our study was to use a mixed-methods design to identify specific problem areas (physical, pain, medical interaction, marital, psychosocial) that ovarian cancer survivors experience at different points along the treatment continuum: early treatment, mid-treatment, early posttreatment, and late posttreatment. An additional objective was to identify individual characteristics related to specific problem areas over time. Within each of these objectives, we used quantitative and qualitative data to address the research questions. We hypothesized that specific problems will vary over the different time points from diagnosis.

Methods

We used a longitudinal and cross-sectional descriptive study design to identify problems at different points (early treatment, mid-treatment, early posttreatment, and late posttreatment) among women with ovarian cancer. The study was approved by the institutional review boards at Wake Forest University Health Sciences and Forsyth Medical Center and by the Department of Defense Human Subjects Protection Office.

Participants

Women diagnosed with ovarian cancer were recruited after surgery (but before first chemotherapy treatment), during treatment, or after treatment. Women were recruited from the Section on Gynecologic Oncology at the Comprehensive Cancer Center of Wake Forest University and the Forsyth Medical Center Gynecologic

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