Palliative care in gynaecological oncology

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Abstract

More than 20,000 new gynaecological malignancies are diagnosed each year. Sadly in many cases the disease is too advanced to be cured and management focuses on prolonging life and palliation of symptoms. Palliative care is a holistic approach to caring for individuals with advanced disease. It is multidisciplinary and aims to improve the overall quality of life for patients and their families. Provision of palliative care is not universal and management of symptoms both physical and psychological has been found to be suboptimal in many settings in the UK and worldwide. The World Health Organisation has targeted palliative care as a clinical priority.

This article reviews management of physical symptoms; including pain, psychological and social support, and discusses issues around end of life care.

Keywords gynaecological cancer; palliative care; social care

Introduction

In 2011 over 20,000 women in the UK were diagnosed with a gynaecological malignancy. Endometrial cancer is the fourth most common malignancy in women in the UK and its incidence has increased significantly (23%) over the last decade. Although the incidence of ovarian cancer had decreased by 10% over the same time period, it remains the fifth most common cancer for women in the UK with more than 7000 cases diagnosed in 2011. Cervical, vulval and vaginal cancers are rare in comparison; 2.4, 0.7 and 0.2 per 100,000 women respectively in 2011; the rates of cervical and vulval cancer however are rising. There is a stark difference in the incidence and mortality of ovarian cancer compared to other gynaecological malignancies as shown in Table 1. This is due in part to the stage of disease at which women present as well as management options available; for ovarian cancer, the majority (greater than 55%) present with advanced disease (stage 3 or 4) with a ten year survival of around 35%, unlike endometrial cancer where overall the ten year survival rate is more than 75% as the majority of women present early in the disease process.

Palliative care is a holistic approach to the care of patients and their families with advanced incurable disease. It is multidisciplinary with involvement of physicians, surgeons, specialist nurses, therapists and others. Palliative medicine focuses on improving the quality of life for patients with advanced disease, including cancer, who experience physical and psychological symptoms. This may be in the patient's own home, hospital or hospice. The aim is to assist the person to live as full and as active a life as possible, free from the symptoms caused by their disease; this can sometimes be for many years (Box 1).

Recent reports conducted by the Royal College of Physicians and the World Health Organisation (WHO) have highlighted significant problems with the provision of palliative care and suboptimal management of patients in the advanced stages of their disease. Adverse media reports regarding the use of 'end of life care pathways' in secondary care for patients dying from their disease have led to a withdrawal of these pathways in many trusts in the UK, and created anxiety and uncertainty for staff caring for terminal ill patients and their relatives.

This article focuses on the management of common symptoms in advanced gynaecological malignancy as well as discussing the importance of psychological support, the multidisciplinary approach and issues around end of life care.

Symptom management

Pain

At least two-thirds of patients with advanced disease including cancer will suffer from pain severe enough to require opiate analgesia. A recent review by the European Society of Medical Oncology found nearly half of patients with cancer pain are under treated and WHO made provision of adequate analgesia for palliative care patients a priority in 2008. Greater than 40% of patients with advanced ovarian cancer and 70–75% with advanced cervical cancer experience pain that significantly impairs their quality of life.

Assessment of pain needs to encompass the physical and psychological effects the pain causes the person, as well as taking into account how it affects their ability to function and their beliefs about the nature and cause of the pain. The patient's overall situation, emotional state, support network, physical and mental health will have an impact on how they experience pain; for example difficulty sleeping is well known

Incidence, deaths & mortality rate/100,000 women for gynaecological malignancies in 2011 (data from the Cancer Research UK Incidence Report 2011)

Primary cancer site	Incidence (number of new cases in 2011)	Deaths (2011)	Mortality rate/ 100,000 women
Endometrium	8475	1930	3.8
Ovarian	7116	4272	9.0
Cervix	3064	972	2.4
Vulva	1203	404	0.7
Vagina	256	91	0.2

Table 1

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Principles and aims of palliative care.

National Institute of Health and Care Excellence (NICE) 2004

- Provide relief from pain and other distressing symptoms
- Integrate the psychological and spiritual aspects of patient care
- Offer a support system to help patients to live as actively as possible until death and to help the family to cope during the patient's illness and in their own bereavement
- Be applied early in the course of illness in conjunction with other therapies to prolong life (such as chemotherapy or radiation therapy), including investigations to better understand and manage distressing clinical complications

World Health Organisation 2012

- Provide relief from pain and other distressing symptoms
- Affirm life and regard dying as a normal process
- Neither hasten nor postpone death
- Integrates the psychological and spiritual aspects of patient care
- Offer a support system to help patients live as actively as possible until death
- Offer a support system to help the families of patients to cope during the patient's illness and in their own bereavement
- Uses a team approach to address the needs of patients and their families including bereavement counselling, if indicated
- Will enhance quality of life, and may also positively influence the course of the illness
- Is applicable early in the course of the illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications

Box 1

to have a negative impact on a person's ability to manage pain. Pain management needs to include all of these issues in order to treat the pain effectively. The WHO pain relief ladder (Figure 1) provides a framework for the pharmacological management of cancer pain and can effectively manage up to 90% of patients with cancer pain. It should be remembered that when 'stepping up' the analgesic ladder, the medication from the previous step such as paracetamol, should also be continued because of its continued benefits in the overall control of the patient's pain.

Opiates (the third level of the WHO ladder) most commonly morphine, have been the main stay for the management of pain in advanced cancer for many years. Increasingly newer opiates such as oxycodone, with improved pharmacokinetics and a lower side effect profile especially for constipation have replaced morphine as the drug of choice for long term pain management. Oral morphine however, remains the primary choice for initial management, given in 4 hourly doses and titrated up to the optimal dose that alleviates pain without causing unacceptable side effects such as day time drowsiness. Sustained release preparations should be used in conjunction with rescue doses (15–20% of the total daily dose), for breakthrough pain, defined as a transient increase in pain intensity over the background pain.

Opiates may be administered in a variety of methods from oral, transdermal (e.g. Fentanyl), transmucosal or subcutaneous depending on other symptoms the patient may be experiencing such as nausea or vomiting. NICE gives guidance on how to start opiate medication in palliative care (Practice point 1).

For patients with moderate pain, upwards titration of the dose should be by 25–50% and 50–100% for those with severe pain.

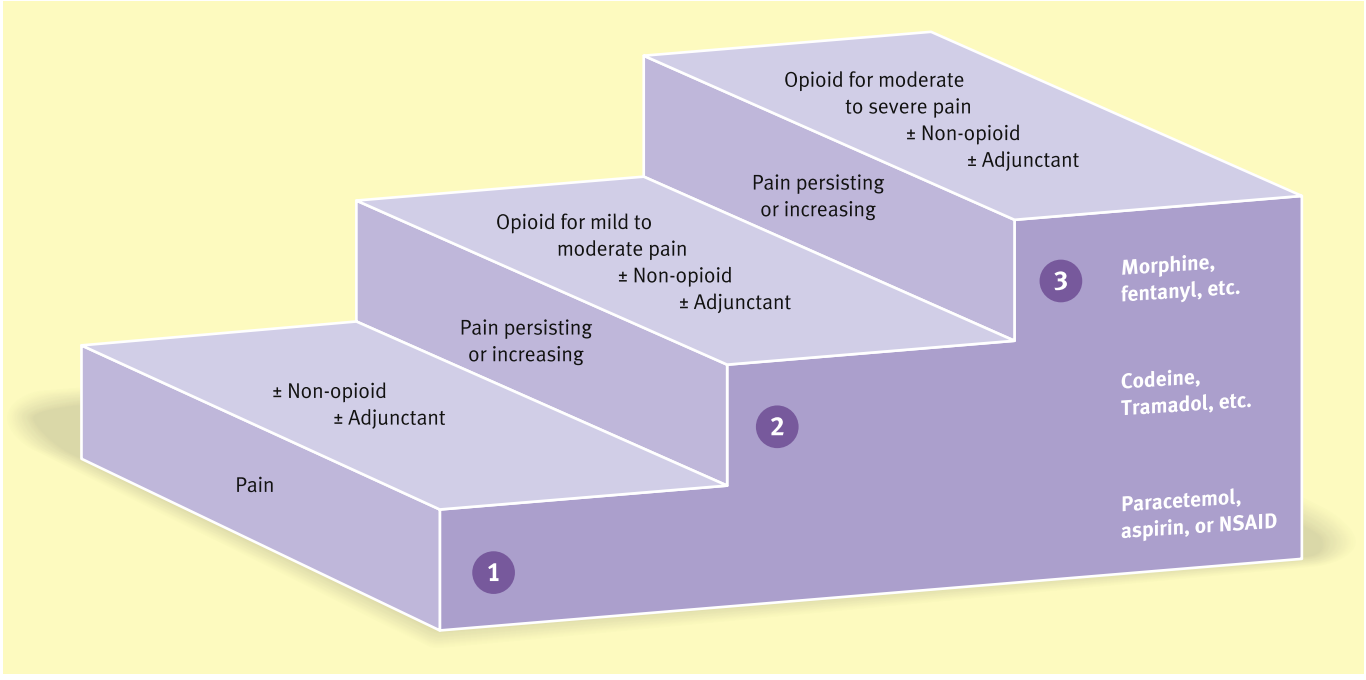

Figure 1 World Health Organization's (WHO) three-step analgesic ladder. NSAID, non-steroidal anti-inflammatory drug. This figure is reproduced with permission from the WHO's cancer pain relief and palliative care (technical report series 804). Geneva: WHO; 1990.