

Palliative care in gynaecological oncology

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Abstract

Women with a gynaecological malignancy often suffer significant symptom burden, both physically and psychologically, throughout the course of their disease. Despite advances in treatment, up to 25% of women diagnosed with a gynaecological malignancy will die from recurrent disease. Early palliative care involvement can provide a holistic approach to care with the benefit of improving symptom control and quality of life for both the patient and carer as well as lowering resource utilisation at the end of life. Palliative care can be offered alongside curative or life prolonging treatment as well as at end of life. This article reviews the management of common physical symptoms and complications experienced by patients with advanced gynaecological malignancy.

Keywords cervical cancer; end of life care; endometrial cancer; gynaecological malignancy; ovarian cancer; palliative care; vaginal cancer; vulval cancer

Introduction

In 2014, more than 21,000 women were diagnosed with gynaecological malignancy in the UK, accounting for approximately 12% of all female cancer diagnoses (Table 1). Despite an improvement in both diagnosis and treatment unfortunately more than 7000 women died from gynaecological malignancy in the UK in 2014. In particular the prognosis for patients with ovarian cancer is much worse than those diagnosed with other gynaecological malignancy. Women with ovarian cancer often present late with advanced disease. If diagnosed at an early stage nine out of 10 women with ovarian cancer will survive at least 5 years however this falls to less than five in 100 women when diagnosed at a late stage.

Women with advanced gynaecological malignancy can suffer significant physical and psychological distress throughout the course of their disease. An early introduction of palliative care during both treatment and disease progression can improve symptom control and quality of life for both patients and carers. NICE 2004 define palliative care as 'the active holistic care of patients with advanced, progressive illness. Management of pain and other symptoms and provision of psychological, social and

spiritual support is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families. Many aspects of palliative care are also applicable earlier in the course of the illness in conjunction with other treatments.' The 2012 WHO statement on palliative care adds to this by 'encouraging palliative care to affirm life and regard dying as a natural process, neither hastening nor postponing death, enhancing quality of life and using a team approach to address patient and family's needs.'

This article reviews the presentation and management of common physical symptoms and complications experienced by patients with advanced gynaecological malignancy.

Common symptoms experienced by patients with advanced gynaecological malignancy

Pain

Pain is a common symptom experienced by patients with advanced malignancy, if left uncontrolled it can significantly impact a patient's quality of life. Pain can be directly related to disease, treatment, debility or be due to unrelated co-morbidities. More than 40% of patients with ovarian cancer and 70–75% of patients with cervical cancer report experiencing cancer related pain. Patients with cervical cancer may experience neuropathic pain secondary to sacral nerve infiltration, whereas patients with ovarian cancer may describe abdominal pain and distension from bowel obstruction. Treatment related pain can be peripheral neuropathy due to the administration of chemotherapy drugs such as cisplatin or paclitaxel.

Gynaecological malignancy often occurs in young women, which can make these patients at higher risk of experiencing distress. Pain can be highly complex with behavioural, cognitive, emotional, spiritual and interpersonal features, often defined as total pain.

Thorough clinical assessment including the use of a standardised pain assessment tool will help identify the aetiology of pain and guide management. It is crucial to assess whether there is any evidence of psychological, spiritual or emotional distress, which has the potential to alter the patient's perception of pain.

After assessment, analgesia should be commenced at a level appropriate for the patient's severity of pain. The World Health Organisation (WHO) pain ladder (Figure 1) provides a simple three step approach, which has been used since the mid 1980's and has been shown to be effective for pain management in up to 90% of cases. Analgesia should be regularly reviewed and titrated depending on the severity of pain.

Oral morphine is a strong opioid and is the medication of choice for treatment of severe pain in cancer. When starting a strong opioid any weak opioid should be discontinued and either a 4-hourly immediate release or a 12-hourly modified release strong opioid preparation commenced. In addition to a regular strong opioid, breakthrough medication should be available for the instances where pain intensity rises above the background pain level. Breakthrough pain is as an escalation in pain of moderate to severe intensity on a background of controlled pain. It can be spontaneous or incident, when it is related to a specific activity. For incident pain patients often benefit from a rapid acting opioid via the buccal, sublingual or intra-nasal route. Patients should be counselled on side effects of opioid medication.

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Incidence, mortality and 5-year survival rates for gynaecological malignancy in the UK in 2014

Cancer	Incidence	Deaths	5-year Survival
Endometrium	9324	2166 (3 %)	79%
Ovarian	7378	4128 (5 %)	46%
Cervical	3224	890 (1 %)	67%
Vulva	1313	453 (<1 %)	64%
Vagina	254	110 (<1%)	64%

Table 1

Persistent effects can include constipation, nausea and vomiting which can usually be managed with the use of anti-emetics and laxatives.

Oral administration is the route of choice for medication but it is not always possible. In gynaecological cancer, patients frequently have symptoms of vomiting which results in poor absorption from the gastrointestinal tract. In this scenario it is more appropriate to administer medication via the subcutaneous route, commonly in a syringe driver.

At any step in the WHO ladder a combination of opioid, non-opioid and adjuvant medication can be used to manage pain. When used in combination their effect can be synergistic and provide enhanced analgesia at lower doses of opioid, potentially reducing side effects. Non-opioids such as paracetamol and non-steroidal anti-inflammatory drugs (NSAIDs) are widely accepted as part of the management for cancer related pain and should be prescribed if there are no contraindications. Patients should be aware of the side effects of NSAIDs, which include gastrointestinal ulceration and fluid retention. Caution must be used when prescribing NSAIDs, as they can be associated with renal impairment. Anticonvulsant or antidepressant medications like gabapentin, carbamazepine and amitriptyline are useful adjuvant medications in the management of neuropathic pain. Neuropathic pain is often only partially opioid responsive hence the addition of an adjuvant can be beneficial. Ketamine can be used in patients with persistent neuropathic pain, ischaemic or refractory cancer pain unresponsive to other medications and is usually prescribed by a pain or palliative medicine specialist. Bisphosphonates can be valuable in the management of patients with pain related to hypercalcaemia and metastatic bone disease. Corticosteroids are useful in patients with symptoms of raised intracranial pressure, peripheral nerve involvement and visceral organ invasion. Muscle relaxants like diazepam or baclofen can be used for painful muscle spasm. Topical anaesthetics such as lidocaine patches can be used in the management of focal neuropathic pain.

Radiotherapy is the treatment of choice for bone pain caused by bone metastases. Surgery can provide relief from bone pain due to a pathological fracture.

Non-pharmacological options can be used together with medication to aid pain management and include reflexology, massage and aromatherapy, acupuncture, hypnotherapy and transcutaneous electrical nerve stimulation (TENS).

If pain control remains inadequate more invasive intervention such as a neurolytic block, cordotomy, intrathecal opioid and local anaesthetic administration may be considered. Intrathecal

administration of opioid with local anaesthetic can improve pain control whilst reducing side effects especially drowsiness and constipation.

Practice points

- Accurate clinical assessment of pain will help determine aetiology of pain and guide management.
- A combination of pharmacological, non-pharmacological and oncology techniques should be considered in the management of cancer related pain.
- If pain control remains inadequate despite optimisation interventional technique may need to be considered.

Nausea and vomiting

Nausea and vomiting affects 50–70% of patients with advanced malignancy, if left untreated it can be severely debilitating for patients and their families. Nausea is triggered by various receptors throughout the cerebral cortex, chemoreceptor trigger zone (CTZ), gastrointestinal tract, limbic system and vestibular apparatus. Vomiting occurs as a result of stimulation of these receptors. Patients who have nausea and vomiting are at risk of having other poorly controlled symptoms as well as pain and dehydration.

Establishing the cause is central to guiding management but this can be difficult and it is often multifactorial. Important features from the history to help establish the cause include the pattern, quantity, exacerbating and relieving factors, bowel habit and previously trialled medications and route of administration. Clinical examination may reveal evidence of dehydration, sepsis or drug toxicity. In advanced ovarian cancer, patients may present with vomiting secondary to bowel obstruction or ascites which may be evident on abdominal examination. Biochemical abnormalities such as hypercalcaemia, uraemia and deranged liver function should be excluded.

Management depends on the cause but general measures include eating small, frequent portions, keeping hydrated and avoiding smells from cooking. Relaxation techniques as well as acupuncture and other psychological techniques are known to be effective. Clinically assisted hydration via intravenous or subcutaneous fluids may be appropriate if a patient is dehydrated and symptomatic.

Pharmacological measures depend on the potential cause of nausea (Table 2). Anti-emetic drug therapy is primarily for the control of nausea. It is often not appropriate to treat every episode of vomiting and many patients can tolerate an occasional vomit if nausea is controlled. The first choice route of administration is oral, however if a patient is nauseous or vomiting the absorption of medication may not be adequate and should be prescribed parenterally. Anti-emetics should be prescribed regularly with an alternative available to be given as required. Multiple anti-emetics may be required or a broad spectrum anti-emetic, such as levomepromazine, if multiple causative factors are present. Prokinetic medication should not be used in combination with anticholinergic medication due to their antagonistic actions. In some refractory cases it may be necessary to trial a course of corticosteroids or benzodiazepines.

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