Palliative Care Needs for Gynecologic Cancer Patients

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Objectives

- Understand common palliative care issues in patients with gynecologic cancers
- Describe strategies to treat and improve sexual dysfunction following treatment
- Describe issues in surgical palliative care

Case

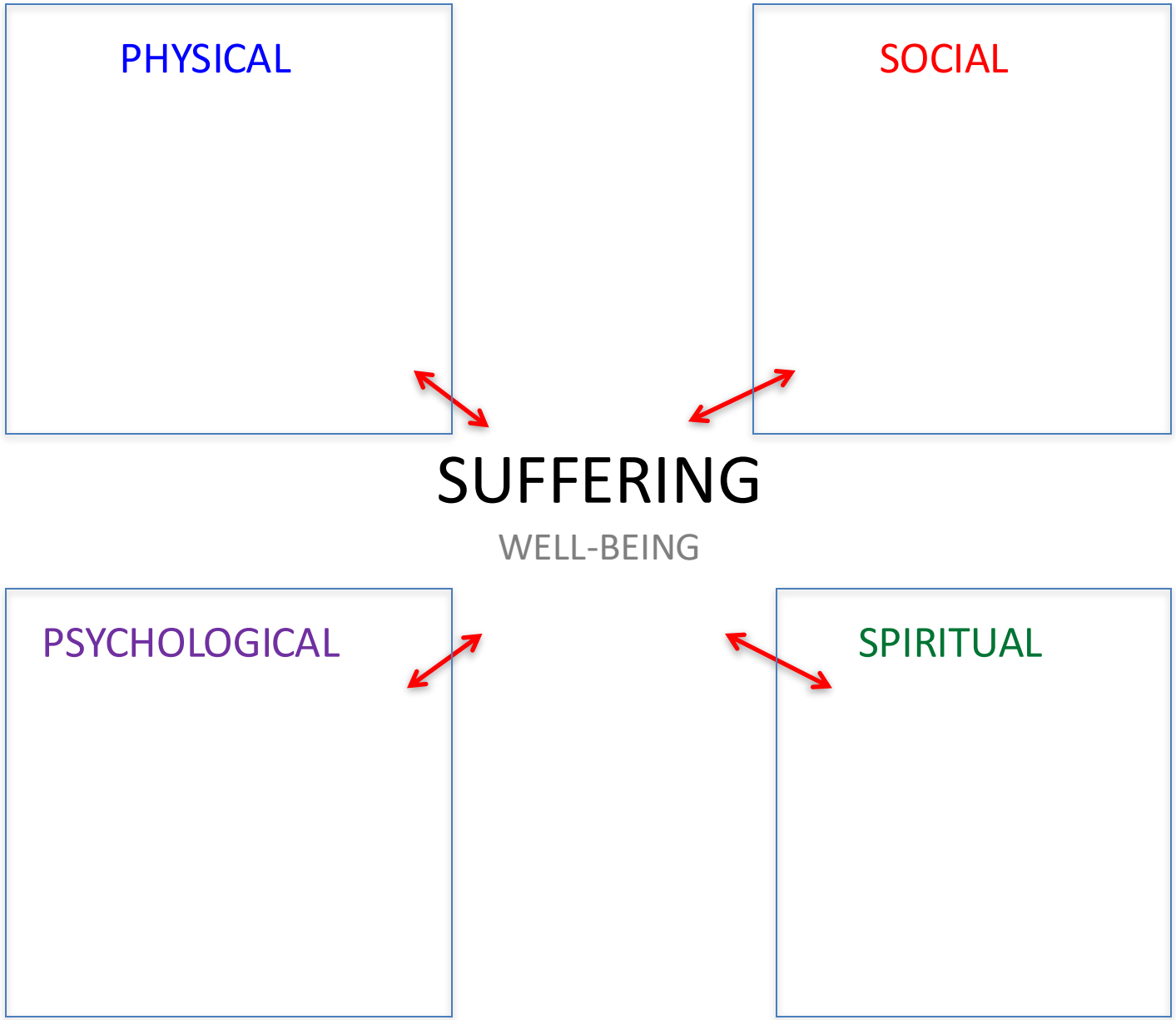
J is a 32yo G10P8119. She delivered her youngest child by c-section in May given bleeding and concern for a placental abruption. About 1 month postpartum she presented to the emergency department with heavy vaginal bleeding, back and flank pain, and nausea. During her workup she was found to have a large cervical mass causing right hydronephrosis. She was taken to the OR for an exam under anesthesia with cervical biopsies. She had a PCN placed during the same admission. Pathology confirmed squamous cell carcinoma of the cervix.

Following hospital discharge, she was seen in clinic to discuss her diagnosis and treatment plan. She came to her appointment with her partner and one of her children. Reviewed the diagnosis of stage III cervical cancer given hydronephrosis and ureteral obstruction and the necessary treatment. It was recommended she undergo definitive pelvic radiation with sensitizing chemotherapy and concurrent immunotherapy. We reviewed the schedule of treatment of radiation daily, Monday-Friday, for 5 weeks, followed by brachytherapy, chemotherapy once-weekly, and immunotherapy every 3 weeks which would continue following completion of radiation every 6 weeks.

At her visit, she endorsed continued bleeding and significant pain, both in the pelvis and at the PCN site. She was discharged from the hospital on short-acting oxycodone and reported sub-optimal pain relief.

She lives in an apartment with her partner, 9 children, and younger sister. Her oldest child is 15 years old. She expressed concerns about her apartment being sold and needing to move, difficulty with affording her rent, as well as recent property damage to her apartment. She does not have a car and took the bus to her first clinic appointment. She does not have access to consistent child-care.

What are this issues this patient is facing?



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PHYSICAL

- Pain
- Bleeding
- Fatigue
- Treatment schedule

SOCIAL

- Mother
- Partner
- Care giver
- Housing
- Transportation

SUFFERING

WELL-BEING

PSYCHOLOGICAL

- Advanced cancer diagnosis

SPIRITUAL

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Symptoms and issues in gynecologic cancers

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Issues specific to gynecologic cancers*

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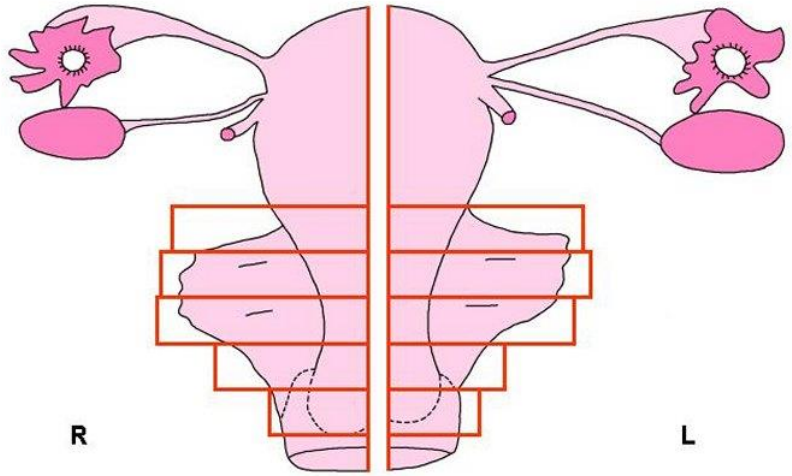
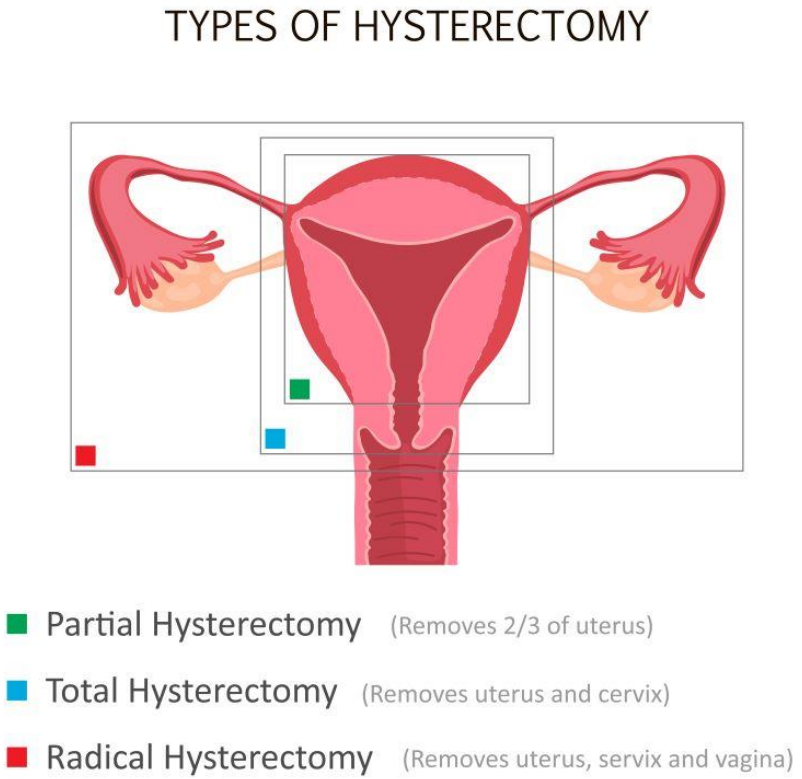
Cervical, vulvar, vaginal cancer

- Radical hysterectomy
- Chemo-RT





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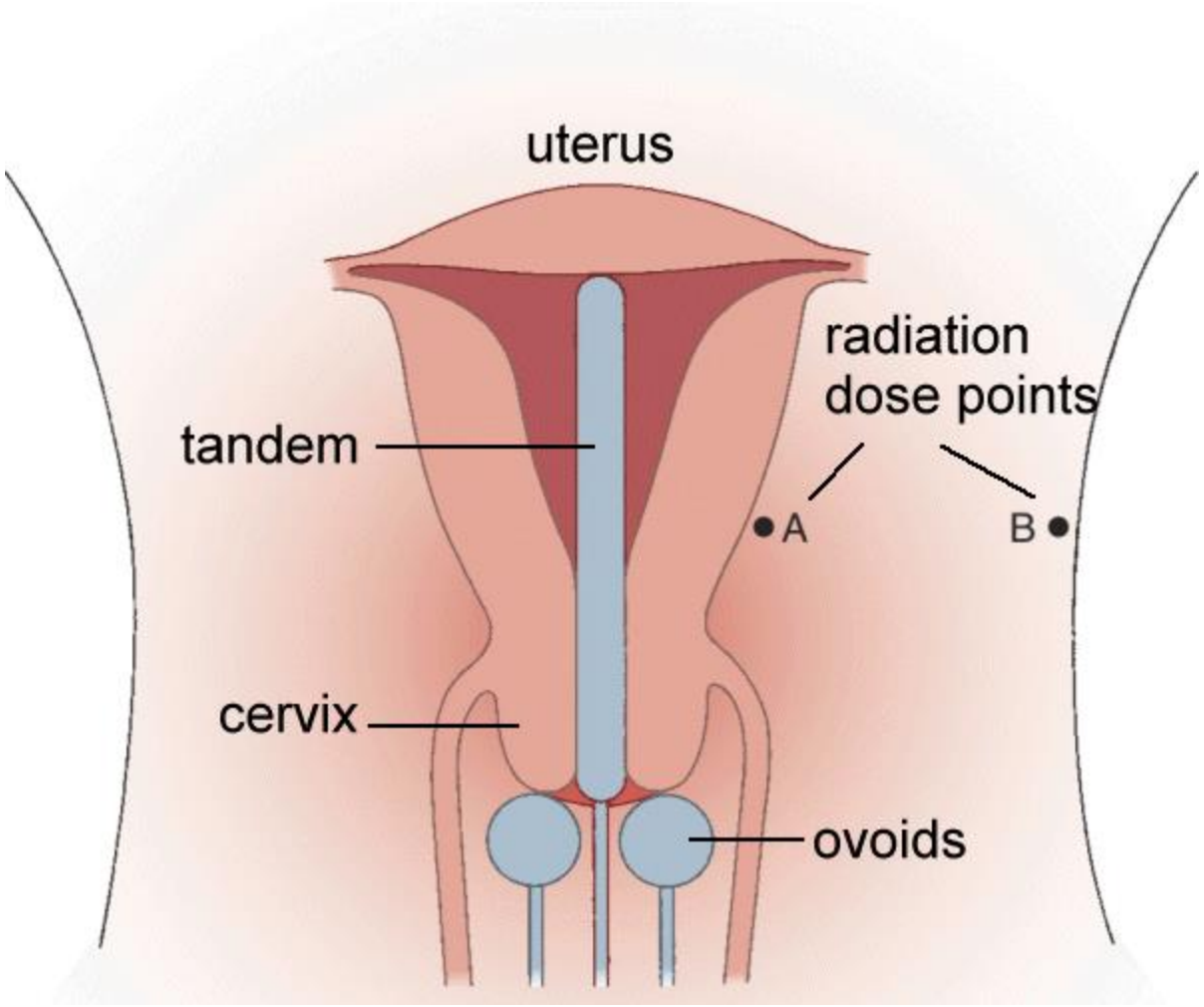

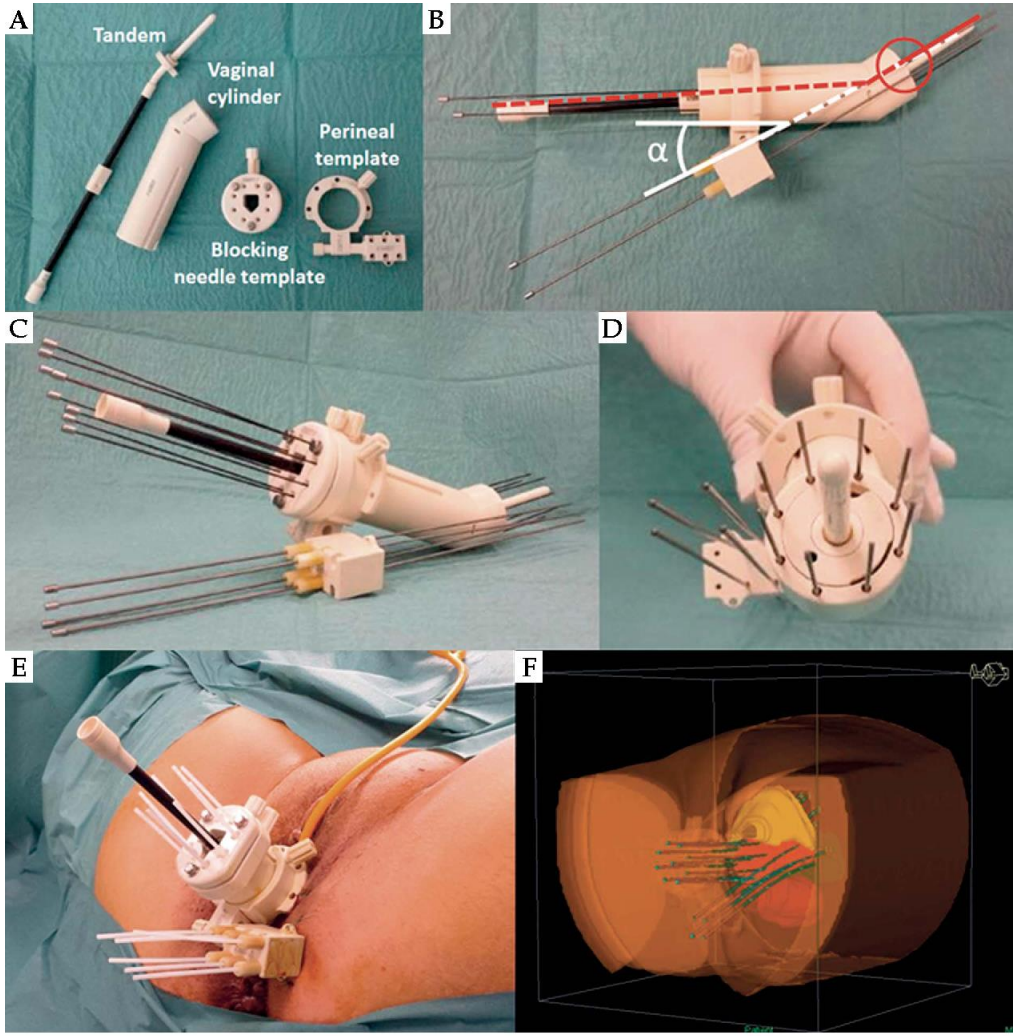

Fig. 1 Overview of the applicator allowing concomitant endocavitary and interstitial implant for cervical and parametrial dis-

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Effects of definitive radiation/radical surgery

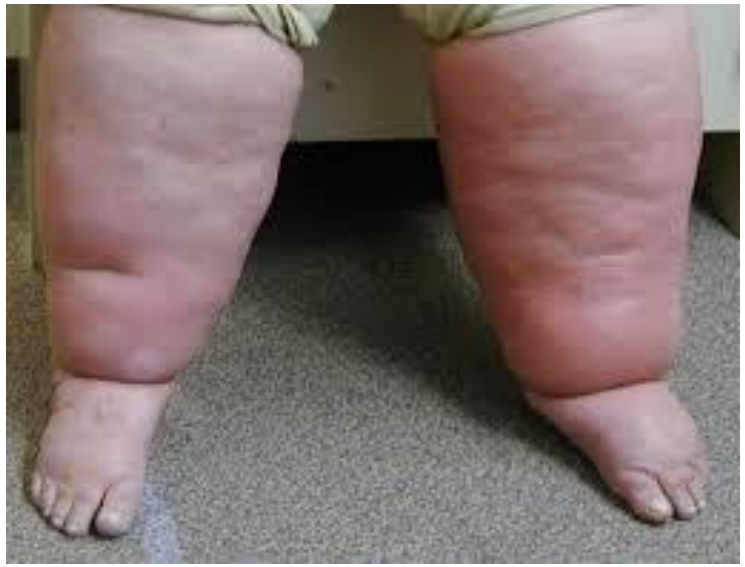
- Menopause
- Vaginal shortening, stenosis, atrophy
- Sexual dysfunction, dyspareunia
- Acute and late GI toxicity
- Skin changes
- Fistula
- Trauma

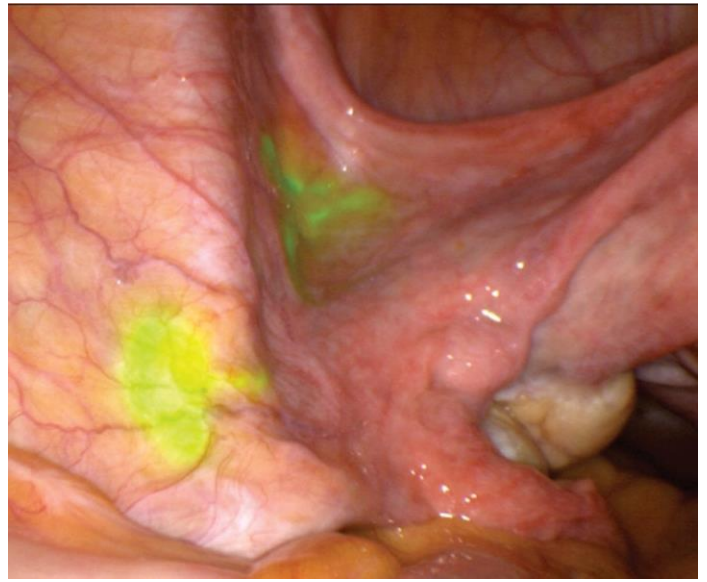
Symptom management for J

- Pain
  - Multimodal, complicated, ongoing
- Menopausal symptoms
  - HRT
- Anxiety/depression
  - SSRI offered, along with therapy
  - Engagement with LCSW

Uterine cancer

- Surgery
- Pelvic lymphadenectomy
- EBRT, brachytherapy





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Ovarian cancer

- Surgical cytoreduction
- Small and large bowel resections
- HIPEC
- Ascites, pleural effusions
  - PleurX
  - Aspira
- Maintenance therapy
  - PARPi
  - Bevacizumab

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Case

T is a 42yo with history of IIIC cervical cancer. She was diagnosed in 2021and was planned to have a radical hysterectomy. However, the procedure was aborted given concern for an enlarged lymph node which was positive on frozen section, changing her from stage I to stage III. She thus received chemo-RT which she tolerated well overall, completing in 2022.

She is married and has three young children. She has always been an avid runner, has completed marathons and triathlons. Returning to her active lifestyle was very important to her following treatment.

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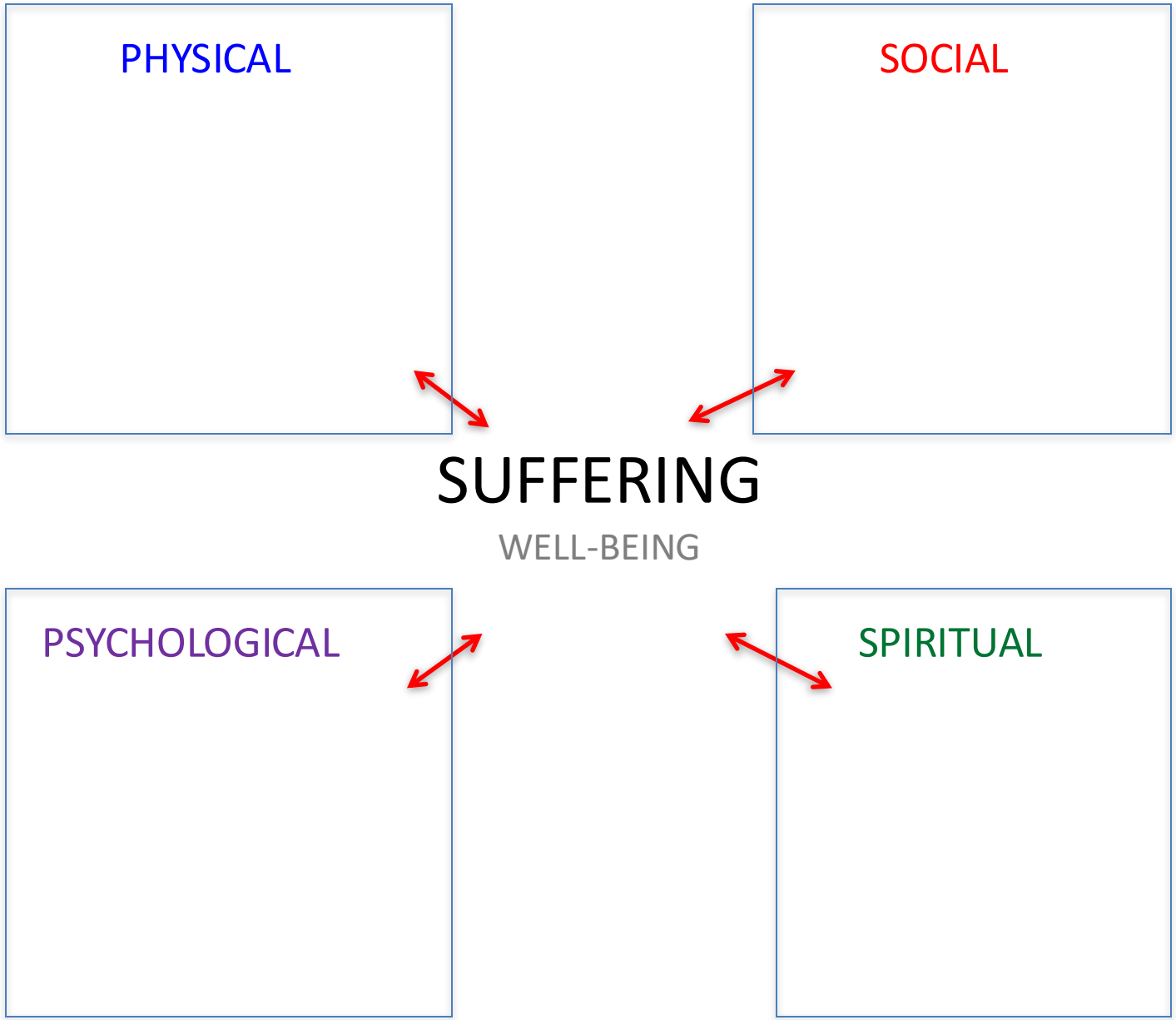
At a follow up visit she endorsed new onset symptoms first noticed during running, including severe pressure and burning pain with urination. No clear source was noted with several evaluations and workups. Over few weeks, this transitioned into severe obstipation. She was found to have a stricture of the sigmoid colon with a contained perforation. She ultimately underwent a diverting end colostomy.

She is currently undergoing surveillance and is not on active therapy. She also developed a ureteral stricture. It was first thought to be a recurrence of her cancer, but was confirmed not to be. She had cystoscopy and urology evaluation, but did not require stenting.

She overall manages her ostomy well. She had hoped it would be reversible. She continues to be active though not to the degree she once was and desires to be. She continues to be sexually active with her husband. She expresses feeling guilty for her current health state, that she blames herself for needing to undergo an ostomy, and worries about being available long-term for her young children. She has intermittent spotting which never stops being worrisome for her.



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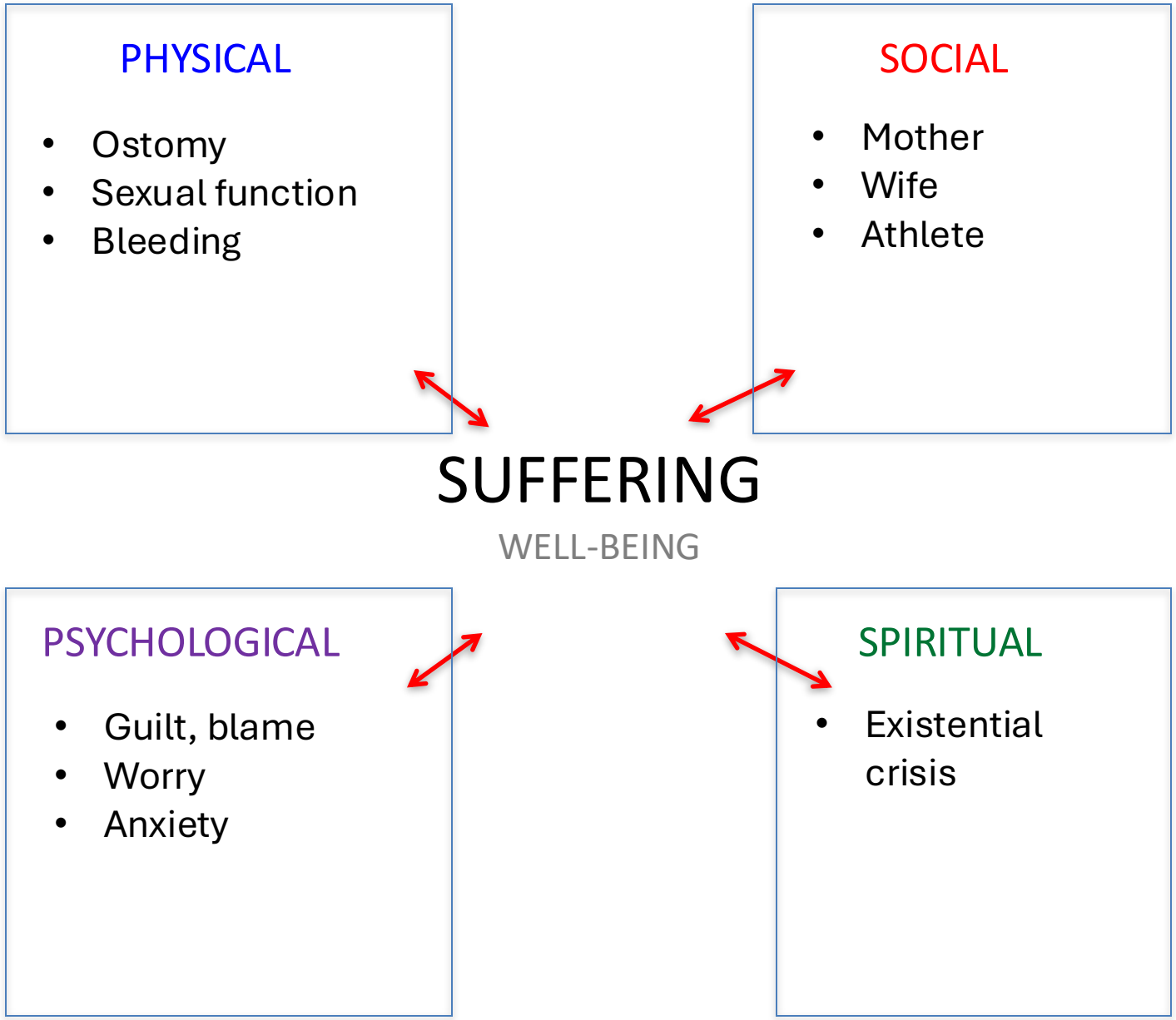

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Sexual dysfunction and menopausal symptoms

- Pain, poor lubrication, post-intercourse bleeding, anorgasmia
- Mainstays of treatment
  - Vaginal dilators (stenosis, shortening)
  - Vaginal estrogen (stenosis, shortening, atrophy)
  - Lubrication (stenosis, shortening, atrophy)
  - Hormone replacement therapy (surgical/RT induced)
  - CBT, hypnosis, sexual wellness/therapy, education

Hormone replacement therapy

- Vaginal estrogen does not equal HRT
- Can be safely used in many cancers, even some endometrial cancer patients
- HRT not contradicted for many gynecologic cancer patients
  - Cervical
  - BRCA*
  - Ovarian

For those who cannot receive HRT

- SSRI
- Veozah
- Gabapentin

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Symptom management for T

- HRT
- Vaginal estrogen
- Therapy and counseling

- Desired ostomy reversal

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Surgical Palliative Care

- Palliative care skillsets can and should be applied broadly to improve care for surgical patients
- Symptom management
- Palliative procedures

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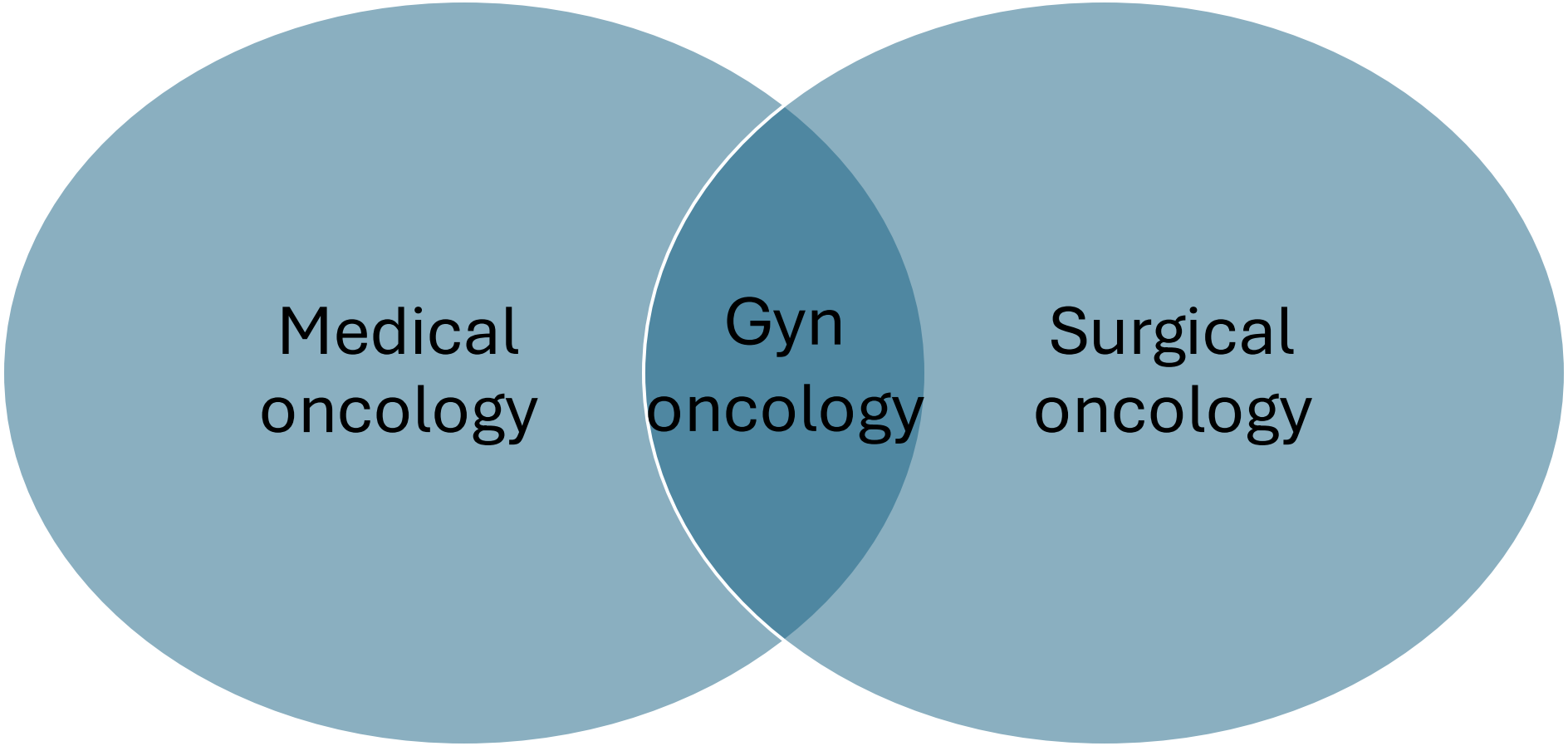
Surgical Palliative Care



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Surgical patients have significant palliative care needs

- Pre/postop symptom management
- Complex perioperative decision making
  - Patient: advanced age, frailty, co-morbidities
  - Surgery: Complications, functional disability, mortality
- Establishing goals of care for both acute and chronic illness
  - Timing important for both acute and chronic needs

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Slide adapted from Spoozak “Palliative care for surgeons” ACS presentation

Surgical patients less likely to receive palliative care

- 1671 outpatient specialty palliative care referrals were placed.
  - 57% medical oncologists
  - 21% inpatient palliative care consulting service at hospital discharge
  - **14% by surgical oncologists (including gynecologic oncology, ENT, urologic oncology, colorectal surgery and surgical oncology)**

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Ratnaparkhi et al. Oncologic outpatient specialty palliative care referral utilization: A single institution quality improvement project. J Clin Oncol 42, 2024 (suppl 16; abstr e23205)
Slide adapted from Spoozak "Palliative care for surgeons" ACS presentation

Complexities in palliative procedure decision-making

- Treatment decision-making is complicated by illness uncertainty and a sense of urgency.
- Patients and caregivers want clear, consistent, closed-loop communication from their clinicians, both specific to treatment and prognosis and relevant to the greater context of their disease.
- Patients and their caregivers want information about the potential impact of a palliative procedure on their daily routine and symptoms.
- Misalignment between the intent of a palliative procedure and the patient's and caregiver's goals may exacerbate suffering.

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Wall JA, Pozzar RA at al. Improving the palliative-procedure decision-making process for patients with peritoneal carcinomatosis: A secondary analysis. Gynecol Oncol. 2024 Sep;188:125-130. doi: 10.1016/j.ygyno.2024.06.014. Epub 2024 Jul 1. PMID: 38954989; PMCID: PMC11740732.

Summary

- Gynecologic cancers patients face unique palliative care challenges
- Early, comprehensive, multidisciplinary palliative care is warranted
- Strategies to improve access are highly needed

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Thank you!

Questions?

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