GYNAECOLOGY NURSING ONCOLOGY & PALLIATIVE CARE GUIDELINES

Document Control

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## CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Introduction</td>
<td>4</td>
</tr>
<tr>
<td>1.1</td>
<td>Gynae Oncology as a Specialty</td>
<td>4-5</td>
</tr>
<tr>
<td>1.2</td>
<td>Standards of Care</td>
<td>6</td>
</tr>
<tr>
<td>1.3</td>
<td>Nursing Considerations</td>
<td>6</td>
</tr>
<tr>
<td>2</td>
<td>Core Nursing Considerations</td>
<td>7</td>
</tr>
<tr>
<td>2.1</td>
<td>Information</td>
<td>7-8</td>
</tr>
<tr>
<td>2.2</td>
<td>Spiritual Issues</td>
<td>9-10</td>
</tr>
<tr>
<td>2.3</td>
<td>Social/Psychosocial</td>
<td>11-12</td>
</tr>
<tr>
<td>2.4</td>
<td>Psychological</td>
<td>12-14</td>
</tr>
<tr>
<td>2.5</td>
<td>Physical</td>
<td>14-15</td>
</tr>
<tr>
<td>2.6</td>
<td>Communication</td>
<td>15</td>
</tr>
<tr>
<td>2.7</td>
<td>Coping</td>
<td>15-16</td>
</tr>
<tr>
<td>2.8</td>
<td>Sexual/Psychosexual</td>
<td>17</td>
</tr>
<tr>
<td>2.9</td>
<td>Rehabilitation</td>
<td>18</td>
</tr>
<tr>
<td>3</td>
<td>Tumour Specific Considerations Cervix</td>
<td>19</td>
</tr>
<tr>
<td>3.1</td>
<td>Staging</td>
<td>19</td>
</tr>
<tr>
<td>3.2</td>
<td>Treatment</td>
<td>20-21</td>
</tr>
<tr>
<td>3.2.1</td>
<td>Surgery</td>
<td>21</td>
</tr>
<tr>
<td>3.2.2</td>
<td>Chemo-Radiation</td>
<td>21</td>
</tr>
<tr>
<td>3.2.3</td>
<td>Radiotherapy</td>
<td>21</td>
</tr>
<tr>
<td>3.2.4</td>
<td>Chemotherapy</td>
<td>21</td>
</tr>
<tr>
<td>3.2.5</td>
<td>Recurrent Disease</td>
<td>21</td>
</tr>
<tr>
<td>3.3</td>
<td>Nursing Considerations</td>
<td>22</td>
</tr>
<tr>
<td>3.3.1</td>
<td>Advanced disease/ Palliative Care</td>
<td>22</td>
</tr>
<tr>
<td>3.3.2</td>
<td>Symptom Control</td>
<td>22</td>
</tr>
<tr>
<td>3.4</td>
<td>Actions and Interventions</td>
<td>23-24</td>
</tr>
<tr>
<td>4</td>
<td>Tumour Specific Considerations – Vulva</td>
<td>25</td>
</tr>
<tr>
<td>4.1</td>
<td>Staging</td>
<td>25</td>
</tr>
<tr>
<td>4.2</td>
<td>Treatment</td>
<td>26</td>
</tr>
<tr>
<td>4.2.1</td>
<td>Surgery</td>
<td>27</td>
</tr>
<tr>
<td>4.2.2</td>
<td>Radiotherapy</td>
<td>27</td>
</tr>
<tr>
<td>4.2.3</td>
<td>Chemo-Radiotherapy</td>
<td>27</td>
</tr>
<tr>
<td>4.2.4</td>
<td>Chemotherapy</td>
<td>27</td>
</tr>
<tr>
<td>4.2.5</td>
<td>Recurrent Disease</td>
<td>28</td>
</tr>
<tr>
<td>4.3</td>
<td>Nursing Considerations</td>
<td>28</td>
</tr>
<tr>
<td>4.3.1</td>
<td>Advanced disease/Palliative Care</td>
<td>28</td>
</tr>
<tr>
<td>4.3.2</td>
<td>Symptom Control</td>
<td>28</td>
</tr>
<tr>
<td>4.4</td>
<td>Actions and Interventions</td>
<td>29-30</td>
</tr>
<tr>
<td>5</td>
<td>Tumour Specific Considerations- Endometrium</td>
<td>31</td>
</tr>
<tr>
<td>5.1</td>
<td>Staging</td>
<td>31</td>
</tr>
<tr>
<td>5.2</td>
<td>Treatment</td>
<td>32</td>
</tr>
<tr>
<td>5.2.1</td>
<td>Surgery</td>
<td>32</td>
</tr>
<tr>
<td>5.2.2</td>
<td>Radiotherapy</td>
<td>32</td>
</tr>
<tr>
<td>5.2.3</td>
<td>Chemotherapy</td>
<td>33</td>
</tr>
<tr>
<td>5.2.4</td>
<td>Recurrent Disease</td>
<td>33</td>
</tr>
<tr>
<td>5.3</td>
<td>Nursing Consideration</td>
<td>33</td>
</tr>
<tr>
<td>5.3.1</td>
<td>Advanced Disease/Palliative Care</td>
<td>34</td>
</tr>
<tr>
<td>5.3.2</td>
<td>Symptom Control</td>
<td>34</td>
</tr>
<tr>
<td>5.4</td>
<td>Actions and Interventions</td>
<td>35-36</td>
</tr>
<tr>
<td>6</td>
<td>Tumour Specific Considerations Ovary</td>
<td>37</td>
</tr>
<tr>
<td>6.1</td>
<td>Staging</td>
<td>37</td>
</tr>
<tr>
<td>6.2</td>
<td>Treatment</td>
<td>38-40</td>
</tr>
<tr>
<td>6.2.1</td>
<td>Surgery</td>
<td>40</td>
</tr>
<tr>
<td>6.2.2</td>
<td>Chemotherapy</td>
<td>41-44</td>
</tr>
<tr>
<td>6.2.3</td>
<td>Hormone Treatment</td>
<td>44</td>
</tr>
<tr>
<td>6.2.4</td>
<td>Radiotherapy</td>
<td>44</td>
</tr>
<tr>
<td>6.2.5</td>
<td>Clinical Trials</td>
<td>44</td>
</tr>
<tr>
<td>6.3</td>
<td>Nursing Considerations</td>
<td>44</td>
</tr>
<tr>
<td>6.3.1</td>
<td>Advanced Disease/Palliative Care</td>
<td>44</td>
</tr>
<tr>
<td>6.3.2</td>
<td>Disease Dissemination</td>
<td>45</td>
</tr>
<tr>
<td>6.3.3</td>
<td>Symptom Control</td>
<td>45</td>
</tr>
<tr>
<td>6.4</td>
<td>Actions and Interventions</td>
<td>46</td>
</tr>
<tr>
<td><strong>7</strong></td>
<td><strong>Appendices</strong></td>
<td>47</td>
</tr>
<tr>
<td>7.2</td>
<td>Treatment Induced Menopause</td>
<td>47-48</td>
</tr>
<tr>
<td>7.3</td>
<td>Infertility Issues/needs</td>
<td>48-49</td>
</tr>
<tr>
<td>7.4</td>
<td>Concerns Checklist</td>
<td>50</td>
</tr>
<tr>
<td>7.5</td>
<td>PLISSIT Model</td>
<td>51</td>
</tr>
<tr>
<td>7.6</td>
<td>BETTER model</td>
<td>52</td>
</tr>
<tr>
<td>7.7</td>
<td>Assessing Sexual Needs</td>
<td>52</td>
</tr>
<tr>
<td>7.8</td>
<td>Support for Altered Body Image</td>
<td>53</td>
</tr>
<tr>
<td>7.9</td>
<td>Lymphoedema</td>
<td>53-54</td>
</tr>
<tr>
<td>7.10</td>
<td>Nutrition</td>
<td>54-55</td>
</tr>
<tr>
<td>7.11</td>
<td>Clinical Trials</td>
<td>55-58</td>
</tr>
<tr>
<td>7.12</td>
<td>Nursing Management of Radiotherapy side effects</td>
<td>59-62</td>
</tr>
<tr>
<td>7.13</td>
<td>Nursing Management of Chemotherapy side effects</td>
<td>62-68</td>
</tr>
<tr>
<td>7.14</td>
<td>Nursing Management of Alopecia and hair thinning</td>
<td>69-70</td>
</tr>
<tr>
<td><strong>8</strong></td>
<td><strong>References</strong></td>
<td>71-73</td>
</tr>
<tr>
<td><strong>9</strong></td>
<td><strong>Reading and Book List</strong></td>
<td>74</td>
</tr>
</tbody>
</table>
1. Introduction

**Aim:** Provision of guidance for professionals in the care of women with a diagnosis of a gynaecological cancer.

**Scope:** Primarily aimed at healthcare professionals, particularly nurses working within this patient group in a hospital setting.

**Rationale:** To provide a framework of standards of care that are measurable and auditable, in order to enhance care provision and support implementation of the Clinical Outcomes Guidelines for Gynaecological Cancers (1999).

The aim of this document is to provide guidance for all healthcare professionals who may be involved in the care of women and their families who may be affected by a gynaecological cancer diagnosis. The guidelines will help promote the provision of high quality, consistent and seamless care throughout the patient journey, across secondary and tertiary settings, with particular emphasis on the provision of nursing care.

The authors recognize that the use of this document will commence once the patient is within the hospital setting whilst acknowledging that the journey is often initiated in primary care and may return to that setting. However many of the nursing considerations raised within this document are generic and will be applicable to all healthcare domains.

The epidemiology and aetiology of gynaecological cancers is not included in these guidelines, please refer to the Mersey and Cheshire Clinical Guidelines (2013) for each tumour type if this information is needed.

1.1. Gynaecology Oncology as a Specialty

It has been recognized for some time that the management of Gynaecological cancer involves more than the surgical and non-surgical treatment given to cure/control the disease. A gynaecological cancer may affect the woman and her family unit in many ways. Both the cancer treatment and possible subsequent side effects can affect a person’s ability to cope with living with a cancer whilst balancing this with a sense of well-being and everyday life. expectations. These physical, social, psychological, sexual and spiritual issues demand the professional expertise of the multi-professional Gynae-Oncology team to provide truly holistic care whilst incorporating the primary healthcare team members and palliative care team.

Nurses are in a unique position to develop an ongoing therapeutic relationship with a woman affected by a gynaecological cancer, utilizing her skills to assess in an holistic manner, the Woman’s information and supportive needs. The nurse should possess up-to-date knowledge regarding specific tumour sites and the impact of a cancer diagnosis, in order to support the woman in maintaining her quality of life although it is recognized that the level of knowledge possessed by the nurse will vary according to her role, work setting and level of clinical experience.

The cancer journey should be patient centered and therefore set by the patient’s agenda. Women diagnosed with a gynaecological cancer, and their families, should have access to the Gynaecological-Oncology Clinical Nurse Specialist (CNS) throughout their cancer journey.

The CNS has a specific remit in supporting the patient, family and carers, providing relevant, accessible and comprehensive information to the patient and carers. Information should be available to the patient and their carers in both verbal and written forms with access to interpreter’s and foreign language literature available as required. This will ensure that the woman is supported and enabled to make informed choices with regard to her...
treatment and planning. The CNS can act as the patient’s advocate, particularly representing the patient views within the forum of the Multidisciplinary team. The CNS may also by referred to as the Keyworker and in many instances they will be the primary contact for the woman. However the woman may have different Key workers as their cancer journey evolves i.e. CNS at the unit then at the centre or the primary care e.g. district nurse.

The CNS’s at the centre liaise closely with those in the units to ensure patients have the most appropriate Keyworker based on patient choice, treatment and follow up locality.

In response to and in keeping with the principles outlined by the Calman-Hine Report (DOH, 1995) and the standards agreed and produced by the British Gynaecological Cancer Society (1999), and the NHS Executive North West brought together a working group compromising of nurses and allied health professional (AHP’s). Members of the group were perceived experts within this area and their collaboration resulted in the development of the document ‘Gynaecological Cancer Pathway’, (2000). This document was then distributed to all hospitals across the North West region.

The Pathway interlinks with these guidelines produced by the Mersey and Cheshire Cancer network and outlines the care that a woman with a Gynaecological cancer can expect from nurses and AHP’s across this region.

The pathway exists as a framework to guide practice and enhance the quality of care provision for this patient group and their families/carers, as recommended in the Calman-Hine Report (DOH, 1995),

• Improving Outcomes in Gynaecological Cancer (DOH, 1999)
• NHS Cancer Plan (DOH, 2000).
• NICE Supportive and Palliative Care for Adults with Cancer (2004)
• Cancer Reform Strategy (2007)
• DOH National Cancer Survivorship Initiative (2010)

The Pathway provides standards from which it is possible to monitor and evaluate the service provided to this patient group, particularly with regard to milestones that a woman may encounter during her cancer journey. These are detailed below;

1. Abnormal screening results
   Confirmation of malignancy
2. Pre-surgery support
3. Surgery
4. Post-surgery support
5. Referral to oncologist clinical/medical
6. Acute side effects and complications of treatment
7. Discharge
8. Complications of disease/treatment
9. Recurrent disease.

(Working Group for Gynaecological Cancer 2000)
1.2. Standards of Care

Standards of care have also been developed by the British Gynaecological Cancer Society (1999), and there are six key questions that it is recommended every woman should ask about her cancer treatment,

"Will I have..."

1. The opportunity of a prompt referral to a consultant team specializing in the diagnosis and treatment of gynaecological cancer?
2. Full discussion about options such as surgery, radiotherapy and chemotherapy before the treatment starts?
3. Surgery performed by a gynaecologist who has a special interest in gynaecological cancer?
4. Radiotherapy and chemotherapy undertaken by staff with a special interest in gynaecological cancer?
5. Access to a specialist nurse or counsellor and a symptom control (palliative care) team?
6. Information on support services for myself and my partner?

Within the Merseyside and Cheshire Cancer Network it has been recognized that support for the carers is vital, which has been echoed by Macmillan and Liverpool Council.

Support for carers can be in many forms and is provided for in a lot of the cancer support groups throughout the region.

The term Carer encompasses both family providing hands on care and other family members or friends also.

1.3. Nursing Considerations

The key to all nursing and supportive care is a thorough assessment. All assessment should be holistic and the use of the Distress thermometer/ Concerns Checklist (see 2.4 and appendix 3) for a Holistic Needs assessment (HNA) is suggested the benefits for this are,

- It identifies people who need help/support with physical, psychological, spiritual, social and sexual effects.
- It provides the opportunity for the person to think through their needs and together with the Health care professional make a plan about how to best meet this need.
- It promotes and helps with self management.
- It helps health care teams target support and care effectively and efficiently by making appropriate informed decisions.

Individual Assessment tools also can act as a framework to guide any assessment undertaken. i.e body image, sexual health etc. These tools are found in the appendix.

The document has been written showing the key core nursing considerations for all patients. This is then enhanced with tumour specific issues.

All women should be considered and offered participation in relevant clinical trials available. See Appendix 7.9
2. **Core Nursing Considerations**

- Information
- Spiritual Issues
- Psychological
- Social
- Physical
- Communication
- Coping
- Psychosexual
- Rehabilitation

Treatment includes:
- Initial Surgery
- Interval Debulking Surgery
- Chemotherapy
- Hormonal Therapy
- Radiotherapy
- Second Look Surgery
- Surgery for palliative intent.

All therapeutic interventions may be radical or palliative.

Each of these will now be explored individually as they are common to each tumour site. This will be followed by nursing considerations specific to each tumour site.

2.1. **Information**

Most patients and carers want information about cancer and its treatment throughout the patient journey. They expect information to be up-to-date and of high quality. The nature, level and format of information sought may vary, depending on many factors, including the stage of disease, and cultural and ethnic influences.

**High Quality Information.**

Information needs to be of high quality to inform, support and reassure the patients and carers. This means it should meet the needs of the target group and be evidenced based, balanced, regularly updated, culturally sensitive, and available in a variety of formats and composed in plain language. Service users and experts should be involved in its design and development.

It is recommended that the information and its delivery to patients and carer follow the principles of the NHS Information Prescriptions Project ([www.informationprescription.info](http://www.informationprescription.info)). The information should be tailored to the principles of the patients pathway and adhere to the information policy of the individual trust hospital.

Information is a constant two way process requiring continuing evaluation.
<table>
<thead>
<tr>
<th>IDENTIFICATION</th>
<th>ACTION</th>
<th>REFERRAL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assessment</strong></td>
<td>• Ensure gynaecology information pack given (2013), add chemotherapy and radiotherapy as appropriate</td>
<td>• CNS</td>
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<tr>
<td>• Level of information</td>
<td>• Give at appropriate level – to competency of information provider.</td>
<td>• Consultant</td>
</tr>
<tr>
<td>• Level of understanding</td>
<td>• Refer on as necessary.</td>
<td>• Macmillan Information centre (CCC, RLUH, Aintree, APH, St.Helens.)</td>
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<tr>
<td>• Mode of information</td>
<td>• Document what has been given or declined.</td>
<td>• Local resources</td>
</tr>
<tr>
<td>• Based on patient agenda, disease, treatment, rehabilitation/survivorship,</td>
<td>• Assess understanding</td>
<td>• Trial Nurse Coordinator (CCO)</td>
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<tr>
<td>• Carers needs</td>
<td>• Inform MDT of patient's information needs.</td>
<td>• Interpreter Macmillan language lines available also. I.e. polish speaking.</td>
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<tr>
<td>Individual needs e.g.</td>
<td>• Offer the support of Special Needs Adviser</td>
<td>• Printed leaflets available also</td>
</tr>
<tr>
<td>• Visual disability</td>
<td>• Refer to Special Needs Adviser within the trust</td>
<td>• Young Persons Group</td>
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<tr>
<td>• Hearing Disability</td>
<td>• Access to translators' via NHS trusts</td>
<td><a href="http://www.cancerhelp.org.uk">www.cancerhelp.org.uk</a></td>
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<tr>
<td>• Special needs</td>
<td>• Assess and give as per desired mode.</td>
<td><a href="http://www.macmillan.org.uk">www.macmillan.org.uk</a></td>
</tr>
<tr>
<td>• Literacy</td>
<td>• Appropriate mode of information, i.e. audio tapes/books.</td>
<td><a href="http://www.nhschoices.gov">www.nhschoices.gov</a></td>
</tr>
<tr>
<td>• Cultural / Ethnicity</td>
<td>• Offer assistance to question and clarify understanding.</td>
<td></td>
</tr>
<tr>
<td>• Age</td>
<td>• Guide to accredited sites.</td>
<td>To Trials CNS (CCC or Local)</td>
</tr>
<tr>
<td>• Variety information, disease, treatments</td>
<td>• Ensure women have the appropriate information enabling them to make an informed decision.</td>
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</tr>
<tr>
<td>• Internet</td>
<td>• As per hospital policy</td>
<td></td>
</tr>
<tr>
<td>Understanding of consent procedure.</td>
<td>• Mental Capacity Act.</td>
<td></td>
</tr>
<tr>
<td>Clinical Trials</td>
<td>Explain basic information.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Give appropriate leaflets.</td>
<td></td>
</tr>
</tbody>
</table>
2.2. Spiritual Issues

Spiritual issues have been highlighted as a concern by many within cancer care and palliative care. They are part of the key areas within the Supportive and Palliative Strategy for adults with cancer (DOH 2004b).

Numerous authors have attempted to clarify a universal meaning of the term spirituality. This lack of a cohesive definition makes spiritual care ambiguous by its essence.

Authors have commented on its close link to religion, however the two are not always entwined, a person can be spiritual without being religious and vice versa.

When compiling these guidelines the authors have attempted to select a definition which illustrates the depths of spirituality whilst embracing its uniqueness to each individual.

The authors ask the reader to compare this definition to the ones they already possess, as this is a guide only.

Fowler (1997) in Taylor (2002) offers a definition which illustrates its uniqueness

“Spirituality is the way in which a person understands and lives life in the view of her or his ultimate meaning, beliefs, and values. It is the unifying and integrative aspects of the person’s life and, when lived intentionally, is experienced as a process of growth and maturity. It integrates, unifies and verifies the whole person’s narrative or story, embeds his or her core identity, establishes the fundamental basis for the individual’s relationship with others and with society, includes a sense of the transcendent, and is an interpretive lens through which the person sees the world.” (p47).

Govier (2000) offers a framework or tool by which, spiritual care may be broken down into parts to make it appear more manageable to put into daily clinical practice.

**Five R’s of Spirituality (Govier, 2000).**

**Reason and Reflection** – A desire to search for, or find meaning and purpose in one’s life; to reflect and meditate on one’s existence (may be enhanced through art, music or literature).

**Religion** – A means of expressing spirituality through a framework of values and beliefs often actively pursued in rituals, religious practices and reading of sacred text; religion might be institutionalized or informal.

**Relationships** – A longing to relate to one’s self, others and a deity/higher being (may be expressed via service, love, trust, hope and/or creativity); the appreciation of the environment.

**Restoration** – The ability of the spiritual dimension to positively influence the physical aspects of care (certain life events can be detrimental, resulting in spiritual distress)

Within the MCCN a spiritual sub group was established in 2005 primarily within Specialist Palliative Care however the key principles are good practice. The group has audited both practice and staff confidence with this area of care, The Spiritual care policy and Guidelines underpins the principles below

1. Spiritual needs are included as part of the initial holistic assessment and ongoing care for every patient who has contact with a gynae-oncology professional. Evidence of this should be documented.
2. Spiritual care offers the forum for someone to share their worries and concerns and formulate their own personal plans RESIST THE URGE TO FIX IT, AS OUR SOLUTION MAY NOT BE RIGHT FOR THEM (i.e. why me? finding a meaning to what
is happening, finding inner harmony out of chaos, existential issues, fostering of realistic hope and the promotion of wellbeing.)

3. To be aware of any faith traditions and the significance of this for the patient and family. Evidence of this should be documented.

4. To enable individuals and groups in a health care setting to respond to spiritual and emotional need & to the experiences of life and death, illness and injury, and in the context of a faith or belief system if they have one.

5. Professionals to be aware of the spiritual concerns for the patient and family and feel confident to respond in a flexible none imposing or judgemental manner, without necessarily having to refer on.

6. Education and training is available both face to face and e learning details on www.openingthespiritualgate.net

7. Awareness of religious needs website which offers a reference guideline to many faith traditions and the key concerns within them.

www.queencourt.org.uk/religiousneeds

Patients within this group remind us of why it is important that their wishes are respected and we can facilitate if needed.

1. "As patients, we want to be treated holistically by all personnel involved in our care. We expect to be treated with respect, dignity & kindness which must extend to our family & friends. Information should be provided which is appropriate to our condition and ability, without being patronizing or condescending.

2. We want to be treated with compassion (an old fashioned word which encompasses a great deal). Encourage us to be assertive where possible, but when appropriate, speak to us in a kindly soothing voice.

3. The use of touch should not be underestimated, a hand on the shoulder (or feet of those confined to bed), the gentle stroking of an arm, or simply holding a hand can make us feel cared for and important. We want to feel the presence of a caring individual (if necessary at the end of a call bell). a. To recognise the human need of every individual for security, significance, self worth and meaning

The Patients do not want deep theological answers, just for us to be there

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</table>
| Is there evidence of distress? | • Explore, the nature of the distress religious or spiritual  
• Acknowledge the distress can offer comfort.  
• Seek permission that the person wishes to talk today and to you.  
• Use the simple skill secret tool (Groves and Baldry 2009) .encourage patient to formulate own personal plan  
• Document assessment, and action using telegram technique.  
Useful skills  
• Active listening  
• Empathy  
• Open questions, exploring how they usual cope with things ,What uplifts them, where do they get there strength, how does their faith help them, what would help now  
Therapeutic touch /Relaxation/ imagery/visualization  
Reminiscence  
Art/ music/poetry | • CNS is pt talking to someone who feels beyond their scope of practice.  
• Follow personal plan i.e. nil action needed for HCP or referral to Chaplaincy team, or Personal Minister, Age Concern, charities, outreach support  
• Referral to complementary therapist i.e. art music, choir, reiki  
• Referral to local support groups. |
2.3. Social – Psychosocial

**Definition**

The diagnosis and treatment of cancer can be associated with high levels of psychological distress and morbidity (Walker et al 1999, Zabora et al 2001).

Evidence that psychological interventions can improve the quality of life is growing, (Fawzyer et al (1995 in Taylor et al 2004), Mayer and Manix 1995), which has encouraged palliative care teams to offer psychological support from diagnosis (National Council for Hospice and Specialist Palliative Care services 1997).

<table>
<thead>
<tr>
<th>IDENTIFICATION</th>
<th>ACTION</th>
<th>REFERRAL</th>
</tr>
</thead>
</table>
| Assessment of patient / family variables-  
  • Age  
  • Gender  
  • Family members  
  • Socio-economic status  
  • Family stressors  
  • Quality of relationship  
  • Marital communication  
  • Social support  
  • Social Work need | Psychosocial Support –  
  From the time of diagnosis  
  each patient should have access to a named nurse who can support them.  
  • Partners/carers should be encouraged (if patient wishes) to attend clinic appointments to support patient and have their own support needs met.  
  • Carers have own information needs addressed | Referral to teenage and Young adults team if indicated  
  • Referral to Benefits Advisor locally /CAB/  
  • Referral to Medical Social Worker and/or other agencies i.e. age uk/ red cross/care line.  
  • Local cancer support groups  
  • Local cancer information center.  
  • Referral to carers support group  
  • Referral to local team for Psychological assessment and ongoing support. |

• Genetic risk assessment.  
  • Access via a Genograms as per Palliative Care Guidelines.  
  • Ongoing support for relatives considered high risk with appropriate referral for Genetic Counseling.  
  • Provide appropriate written literature | Genetic Associates  
  • GP for further discussion | |

• People from different cultures should have their differing needs assessed and be offered appropriate personnel for support.  
  • Clarify and discuss with patients prior to any referral and document.  
  • Access to written information in own language | Ethnic minority link person  
  • Interpreter  
  • [www.macmillian.org.uk](http://www.macmillian.org.uk)  
  • Own trust literature. |
### Identification
- Assessment of
  - Financial needs/requirements
- Supportive Care needs
- Potential discharge needs for equipment
- Employment/retraining issues
- Childcare Needs.

### Action
- Provide access to written information i.e. Welfare benefits, employment rights
- Provide free prescription form FP92A
- Provide information on accessing information i.e. red cross, Macmillan.

### Referral
- Referral to welfare benefits locally
- Occupational Therapist
- Medical Social Worker
- Physiotherapist
- Health visitor
- Liaise with District Nurse and Community nurse teams
- Family Support Worker
- WHISC
- Blackburne House

### 2.4. Psychological

Psychological distress is an understandable response to a traumatic experience for people affected by cancer. Many people who feel distress seek help informally from friends, relatives or peers. Others may need professionals who provide psychological support (DOH 2004b).

**Psychological Implications**

The nurse should have the skills necessary to facilitate exploration of psychological sequel at every stage of the patient's journey, awareness of local professional support network and facilitate access for specialist intervention; assessment and ongoing support.

Each assessment should include exploring and facilitating to the appropriate level, the woman's needs regarding effects of subsequent treatment and possible side effects.

For over 2 decades it has been known that up to 50% of patients diagnosed with cancer exhibit emotional difficulties (Derogatis et al 1983). Generally the psychological complications take the form of adjustment problems, depressed mood, anxiety, impoverished life satisfaction or loss of self esteem.

Those most at risk of developing depression and other psychiatric illnesses are those with advanced disease, a prior psychiatric history, poorly controlled pain and other life stressors or losses (Kathol et al 1990) other studies have suggested that negative self beliefs, feelings of hopelessness and a lack of perceived social support are also significant (Pennix et al 1998, Badger et al 1999).

The Network Psychological Support Group (PSG) is a multi-professional group made up of various health professionals from across the Merseyside and Cheshire area including a user representative.

The group has the responsibility for supporting and implementing the aspects of psychological support services of the NICE guidance documents (DOH 2004b) across MCCN.
The role of the PSG includes

- Service planning
- Service Improvements
- Service Monitoring (Clinical Performance and outcomes)
- Workforce development
- Research and Development.

Amongst the various roles the groups have worked towards developing training programs to support Health care professionals in their ongoing screening, assessment and the provision of support for patients and carers. As part of the patients cancer journey/pathway ensuring a Holistic Needs Assessment i.e. concerns checklist is undertaken at key points during this pathway, using an assessment tool.

- Around the time of diagnosis.
- Commencement of treatment.
- Completion of primary treatment.
- Each episode of recurrent disease.
- At the point of recognition of in curability.
- At the recognition of end of life.
- The point at which dying is recognized.
- Any other time the patients may request it.
- Any time the health care professional feels it may be necessary,

To support the HCP in the screening and assessment of the patients and carers the PSG has developed and implemented across the Network Training program in assorted methods.

Holistic Needs Assessment and The use of the Concerns Checklist. (2 days)
Advanced communication skills. (3 days).
Solution Focused Approach.
Spiritual Awareness Training.
An annual study day held in Liverpool for HCP, patients and carers.
Psycho-sexual health Issues (2 days).
Following a review of services available for patients and HCP, uses and carers there are support teams available in each locality to provide support both for patients/carers/family.

The teams are also planning and supporting clinical supervision for the HCP.

Within the supportive and Palliative care Guidance for adults with cancer (DOH 2004b); it illustrates a model of differing levels of psychological support available throughout the patient’s journey.

**Recommended Model of Psychological Assessment and Support.**

<table>
<thead>
<tr>
<th>Level</th>
<th>Group</th>
<th>Assessments</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Health and Social Care professionals</td>
<td>Recognition of psychological Needs</td>
<td>Effective information giving. Compassionate communication and general psychological support</td>
</tr>
<tr>
<td>2</td>
<td>As above with added expertise</td>
<td>Screening for psychological distress</td>
<td>Psychological intervention (such as anxiety management and problem solving)</td>
</tr>
<tr>
<td>3</td>
<td>Trained and accredited professionals</td>
<td>Assessed for psychological distress and diagnosis of some psychopathology</td>
<td>Counseling and specific psychological therapies, CBT, SFA delivered according to an explicit theoretical framework.</td>
</tr>
<tr>
<td>4</td>
<td>Mental health specialists, clinical psychologists and psychiatrists</td>
<td>Diagnosis of psychopathology</td>
<td>Specialist psychological and psychiatric interventions.</td>
</tr>
</tbody>
</table>
## IDENTIFICATION

Ascertain previous/current psychological history/state
- Anxiety
- Depression
- Obsessive Compulsive Disorders /Phobia –
- Other psychological distress (agoraphobia, panic attacks)
- Post Traumatic Stress Disorder
- Post Natal Depression,
- Grief.
- Addictions – drugs, alcohol-others.

## ASSESS

- If previous episode what treatment was effective – is it appropriate to refer to Other HCP’s / CNS Psychologist.
- CPN.
- Psychiatrist.
- Drug therapist

The use of tools for assessment, Concerns checklist, Solution focused approach, others

- Level of impact of current emotional and psychological response with regard to
  - Quality of life
  - Activities of daily living/work
  - Relationships
  - finances

## ACTIONS

- Appropriate level of reassurances/empathy.
- Open honest communication
- Facilitate exploration of issues and feelings.
- The use of tools for ongoing assessment

### REFERRALS

- GP
- CPN
- CNS
- District Nurse
- Psychiatrist
- Psychology teams locally.
- New Psychology department in RLUH for people with cancer to access
- Counsellor/ therapist
- Drug therapist
- Associated organization for support
- Psycho-sexual counselor
- Hospice team – Outreach
- Outpatients.
- Psychological medicine team if attending CCC/ APH/Whiston/Southport/ MCCC.

### 2.5. Physical

It is suggested in support of the model of care you use within your area, the following are also considered:

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Action</th>
<th>Refer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre existing medical conditions</td>
<td>Investigate all new health problems</td>
<td>CNS</td>
</tr>
<tr>
<td>Current drugs</td>
<td>Aim to maximize pain control</td>
<td>Manage by assessor, refer to tumour specific actions further on</td>
</tr>
<tr>
<td>Allergies</td>
<td>Relieve symptoms</td>
<td>Acute Pain Nurse</td>
</tr>
<tr>
<td>Current and potential physical/structural/functional changes to disease associated to treatment, i.e.</td>
<td>Promote comfort</td>
<td>Physiotherapist</td>
</tr>
<tr>
<td>Pain – i.e. tissue damage, nerve pain or visceral pain</td>
<td>Maintain dignity</td>
<td>Social Worker</td>
</tr>
<tr>
<td>Mobility – i.e. Lymphoedema, nerve damage</td>
<td>Aim for optimum quality of life</td>
<td>Occupational therapist</td>
</tr>
<tr>
<td>Altered bowel/bladder functions</td>
<td>Recognize the problem and discuss with patient and carer</td>
<td>Lymphoedema – see Appendix</td>
</tr>
<tr>
<td>Discharge</td>
<td>Acknowledge the patient’s and carer’s concerns</td>
<td>Stoma Care/Continence Advisor</td>
</tr>
<tr>
<td>Fatigue</td>
<td>Explain the referral process or plan of care</td>
<td>Dietitian</td>
</tr>
<tr>
<td>Nutrition</td>
<td>Access to specific written information.</td>
<td>Use of regional palliative guidelines i.e. fatigue</td>
</tr>
<tr>
<td>MUST score.</td>
<td></td>
<td>Palliative Care Consultant</td>
</tr>
<tr>
<td>Waterlow score / risk assessment</td>
<td></td>
<td>Hospice/ other pain specialists – Inpatient/outpatient/outreach team.</td>
</tr>
<tr>
<td>Stoma/incontinence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>VTE Score</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Evaluation

Care must be evaluated and documented, reviewed, reassessed and refer to appropriate health care professional.

* See also appendices

7.10 Nursing Management of side effects of Radiotherapy

    7.11 Nursing Management of the side effects of Chemotherapy

2.6. Communication

Inter personal communication is the process of information exchange among patients, carers and health and social professionals.

Communicating effectively guidelines were produced by MCCN and locally adapted to each Trust; all staff should follow these guidelines.

Patients are encouraged to participate and direct the flow of the communication which is likely to result in improved patient outcomes. This yields a greater understanding, heightened ability to participate in the decision making process, enhanced health related quality of life and a better experience of care.

Objectives

- All patients and carers have the opportunity throughout the patient pathway to raise and discuss problems or concerns related to the disease, its treatment and its impact, with knowledgeable and skilled professionals as per HNA.
- The patient needs to be heard to allow decisions to be made in an atmosphere of genuine partnership.
- All patients who have a desire to participate in decision making about their treatment and care should be given the opportunity to do so.
- Resources should be made available to aid communications where there is deficit.
- The language used should be understood by the patient (avoid jargon).
- The rate and depth of the dialogue should be at the level determined by the patient.
- All Core member of the MDT should attend the Advanced Communication Course – Mandatory for Peer and good practice. Provided by the Cancer Network.
- Once all core members completed then other members of the MDT.
- Outcome of consultation between patient and Health Care Professional should be;
- recorded in the patients notes
- Communicated to other health care professionals involved in the patient’s care across all sectors.
- Offer patient’s copy of consultation as per Trust policy.

2.7. Coping

Coping with cancer means utilizing a strategy to enable an individual to adapt and face the challenge of a stressful situation posed by the 4 D’s of living with the disease:
Disruption to one’s life
Dependence, having to accept support whilst trying to maintain autonomy
Disability caused by the disease and treatment
Disfigurement affecting self-esteem and role function

(Ref Adapted from Kirsh & Passue 2002)

Cancer coping strategies have been categorized as seeking or using social support, focusing on the positive, distancing, using cognitive escape avoidance and behavioral escape – avoidance. (Dunkel – Schelter et al 1992).
Coping is entwined with every aspect of the holistic person and is therefore based on
• Goal setting – short/long term reaching attainable goals
• Realistic Positive thinking – truly believe, i.e. imagery/visualization/relaxation/positive reading
• Talking to others – accessing local/national support group – EVOC / Ovacome /Other
• Spiritual fulfillment – harmony
• Identification of pre existing usual methods of coping i.e. practical/distraction/one person to share.

The supportive care strategy (DOH 2004b) also highlights the importance of support groups, and the positive impact they may have on coping and life with a cancer diagnosis. Support groups are available on a national level such as:

• Ovacome for Ovarian cancer,
• Jo’s Trust for Cervical cancer,
• VACO for Vulval cancer,
• Macmillan Cancer Support for general.
• Eve Appeal
• Target Ovarian.

On a more local level support groups are also advantageous. Within this region there are many established groups such as:

• Sunflowers Cancer Support Centre,
• Sefton Cancer Support Group,
• Lyndale Support Group
• Cancer information Centre at the Linda McCartney Centre and Clatterbridge Cancer Centre. These are all groups for all types of cancer.
• Young person’s support group (commencing 2013).

In this region there are 2 site specific support groups for gynaecological cancer patients and their carers. Southport has established a support group specifically for women with ovarian and endometrial cancer the meeting are held on a bimonthly basis. It has the support of the CNS in post at Southport, but is steered by the group itself. (01695 656964)

EVOC (Endometrial, Vulval, Ovarian, and Cervical) is another local support group, this is for all patients and carer’s who have had or still have a gynaecological cancer, its focus is on rehabilitation and living life after treatment, whether curative or palliative. This group runs one evening 5 times per year; its semi structural approach has evaluated well by its users, and is led by these evaluations. The group now includes a younger persons support element also. The group itself is backed by the CNS at the Liverpool Women’s Hospital and throughout the region, as it is a regional group. EVOC is now registered as a charity and is looking towards more users becoming involved in its running. (Contact Number, 0151 702 4186)

If any more information is needed on any of these groups please contact Esther Lennon CNS at Southport and Ormskirk (01695 656964) or the Macmillan Office at the Liverpool Women’s Hospital.

Written material

• A booklet has been produced by the Patient Focus group at the surgical centre which focuses on coping entitled We’ve been there too. It is based on their own experience of what help them at different point in their cancer journey as well as insight from the nurse specialists. It is the woman’s gift to all those in a similar situation.
• A booklet to guide people into the adjustment after cancer and treatment Moving On Together, is now available.
2.8. Sexual / Psychosexual

This area of nursing can at times be the area that no one wishes to delve into with the fear of offending the other person; however literature suggests that if the nurse does not broach the subject, neither will the patient, thus negatively reinforcing that it is not important. As Woods definition infers, sexuality goes beyond the ability of the individual to engage in intercourse.

Woods (1979 in Jusenius 1987) asserts that sexuality is an integral part of our personalities woven into the physical, psychological, cultural and spiritual aspects of people’s lives. Thus suggesting that sexual health is a part of being human, and in the age of holistic care then sexual health needs should be addressed. This is a view supported by the RCN which led to the development of a sexual health strategy to facilitate nurses to work effectively in this challenging and sensitive field of sexuality and health (RCN 2001).

Webb (1985), all nurses should be concerned with sexual health issues as, “Sexuality involves the totality of being a person and therefore nurses and patients are only given the respect of people when nursing care has firm foundations in a truly holistic approach incorporating sexuality as a vital aspect of humanity” (pg 5).

This however may illustrate why it is important, but not answer the question on how and where to start, within the appendix there are 3 models which offer a framework as to where to begin and possible questions to ask. Please see appendix 7.3- 7.6 for the PLISSIT model (1976), and BETTER model (2003).

There are recognized local and national study days available on sexual health and body image issues.

The MCCN PSG have provided a 2 day course on psychosexual health issues to support the HCP in their assessment and support in this specialist area.

Across the network there are specialists available to provide level 4 support to the patients access via local psychological assessment team e.g. abacus/ relate.

<table>
<thead>
<tr>
<th>IDENTIFICATION</th>
<th>ACTION</th>
<th>REFERRAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment of Physical/Psychological/Social dimensions for contributing factors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Structural/Functional effects</td>
<td></td>
<td></td>
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<tr>
<td>• Disease related symptoms</td>
<td></td>
<td></td>
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<tr>
<td>• Medication currently used</td>
<td></td>
<td></td>
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<tr>
<td>• Pre existing issues</td>
<td></td>
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<tr>
<td>• Body Image issues</td>
<td></td>
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<tr>
<td>• Previous medical (physical/emotional) conditions</td>
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<tr>
<td>• Relationship issues/concerns</td>
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<tr>
<td>• Lifestyle stressors.</td>
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<tr>
<td>• Cultural and religious beliefs</td>
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<tr>
<td>Use of Merseyside &amp; Cheshire Palliative Care Audit Group Standards and Guidelines on sexual health assessment</td>
<td></td>
<td></td>
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<tr>
<td>• Referral to appropriate health care professionals</td>
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<td></td>
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<tr>
<td>• Administer appropriate drug</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Address symptoms particularly discharges and odours</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Address with Practical aspects</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Local Psychological teams if appropriate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Psychosexual Counselor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Abacus.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Therapist.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Medical staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Relate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gynae/Oncology CNS</td>
<td></td>
<td></td>
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<tr>
<td>Lymphoedema CNS</td>
<td></td>
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<tr>
<td>Stoma CNS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dietitian</td>
<td></td>
<td></td>
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<tr>
<td>Continence Advisor</td>
<td></td>
<td></td>
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<tr>
<td>Complementary Therapies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychologist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>National support groups</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2.9. Rehabilitation/ Recovery.

AIMS

- Maximize patient’s ability to function, to promote their independence and assist adaptation to their condition.
- Maximize dignity and to reduce the extent, to which cancer interferes with an individual’s physical, psychosocial and economic functioning, no matter where they are in their cancer journey, (DOH 2004b).

Quality of life is most affected from diagnosis through to completion of treatment. It improves 6 – 12 months afterwards and stabilizes at 2 years.

Increased levels of anxiety and depression may be influenced by risk factors. Risk factors for maladjustment include:
- Radiotherapy
- Multi-modal treatment
- Duration of treatment
- Younger women
- Poor education
- Lack of social support network
- Low level of religious beliefs.
- Financial

Survivorship is a key agenda item within health care, the fore runner in this has been Macmillan who has worked with health care professionals and patients to explore this issue. Resulting in the formation of survivorships programs developed locally and nationally for patients and their carers they have included a variety of topics to help people’s lives such as dietary advice, benefit advice, work related issues etc.

Teams need to be aware of and adhere to the National Rehabilitation Measures (Department of Health 2008).

<table>
<thead>
<tr>
<th>ASSESS</th>
<th>EXPLORE THE PROBLEM</th>
<th>REFERRAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical – structural/functional.</td>
<td>Mutually set goals and actions,</td>
<td>To appropriate Health Care Professional:</td>
</tr>
<tr>
<td>Emotional – adjustment psychological status i.e. anxiety, depression, coping, level of self esteem, Level of self confidence, relationship issues.</td>
<td>Returning to work, encourage to discuss issues with personnel</td>
<td>- Menopause Nurse.</td>
</tr>
<tr>
<td>Social – practical issues (stairs/equipment/mobility) role, family dynamics, work, financial issues.</td>
<td>Phased return to work.</td>
<td>- Dietician.</td>
</tr>
<tr>
<td>Spiritual – Any Distress - Why me?</td>
<td>Advice on women’s health and education groups and colleges.</td>
<td>- Stoma Nurse.</td>
</tr>
<tr>
<td></td>
<td>Identify with patient coping strategies.</td>
<td>- Continence Nurse.</td>
</tr>
<tr>
<td></td>
<td>Involve the family.</td>
<td>- Social Worker.</td>
</tr>
<tr>
<td></td>
<td>Provide ongoing support.</td>
<td>- Occupational therapist.</td>
</tr>
<tr>
<td></td>
<td>Invite to EVOC or designated support group.</td>
<td>- Chaplain/other.</td>
</tr>
<tr>
<td></td>
<td>Travel advice.</td>
<td>- Complementary therapist</td>
</tr>
<tr>
<td></td>
<td>Information Booklets by Macmillan on work and employment rights/living with cancer/ survivorship.</td>
<td>Other organizations re adoption/fertility</td>
</tr>
<tr>
<td></td>
<td>Assess spiritual concerns</td>
<td>Consider outside agencies e.g.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Outreach teams</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Local hospice</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- WHISC</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Blackburne House</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Wirral Holistic Centre.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Local Support Groups</td>
</tr>
</tbody>
</table>
3. **Tumour Specific Considerations - Cervix**

There are 2 main types of cancer of the cervix.
- Squamous 85%
- Adenocarcinoma 10-15%

Rarer types include small cell/sarcoma/lymphoma/adenosquamous (Shafi, et al 2001). All patients need adequate staging investigations. (see algorithm over).

### 3.1 Staging


| Stage 0 | Intraepithelial neoplasia |
| Stage 1 | The carcinoma is strictly confined to the cervix, extension to the uterine corpus should be disregarded. |
| Stage 1a | Invasive carcinomas which can be diagnosed only by microscopy, with deepest invasion <5mm largest extension >7mm. |
| Stage 1a1 | measured stromal invasion of <3mm in depth and not >7mm. |
| Stage 1a2 | measured stromal invasion of >3mm and not >5mm with an extension of not >7mm. |
| Stage 1b | Clinical visible lesion limited to the cervix uteri or pre cancers greater than 1A. |
| Stage 1b1 | Clinical visible lesion less than 4cm in greatest dimension. |
| Stage 1b2 | Clinical visible lesion greater than 4cm in size. |
| Stage 2 | Cervical carcinoma invades beyond the uterus, but not into the pelvic wall or the lower 1/3 of the vagina. |
| Stage 2a | Without parametrical invasion. |
| Stage 2a1 | Clinically visible lesion <4 cm in greatest dimension. |
| Stage 2a2 | Clinically Visible lesion >4cm in greatest dimension. |
| Stage 2b | With obvious parametrial invasion. |
| Stage 3 | The tumour extends to the pelvic wall and/or involves the lower 1/3 of the vagina and/or causing hydronephrosis or non functioning kidney. |
| Stage 3a | Tumour involves the lower 1/3 of the vagina, with no extension to the pelvic wall. |
| Stage 3b | Extension onto the pelvic wall and/or hydronephrosis or non-functioning kidney. |
| Stage 4 | Extension of the carcinoma beyond the true pelvis or has involved (biopsy proven) the mucosa of the bladder or rectum. A bullous oedema, as such does not permit a case to be allotted in stage 4. |
| Stage 4a | Spread of growth to adjacent organs. |
| Stage 4b | Spread to distant organs. |
3.1. Treatment Algorithm for Cervical Cancer.

Histopathologically confirmed Cervical Cancer

Staging investigations

- MRI Abdomen and Pelvis.
- Chest Xray
- FBC, U&E, LFTs.
- Staging, EUA Cystoscopy, PR and Cervical loop Biopsy

Referral to Gynaecological Oncologist
Referral to Clinical Nurse Specialist
Referral to Gynaecology Oncology MDT

Stage 1A

- Radical Trachelectomy, to preserve fertility, (stage 1a2/1b1) (LWH – individual assessment)
- Open or laparoscopic Radical hysterectomy with pelvic node dissection.(LWH)
- External beam and intracavity radiotherapy is advised if the patients general health/age is a co-morbidity to surgery.
- Conservation of ovaries in pts <45 years if squamous Ca / <40 years if adenocarcinoma.

Follow up at colposcopy clinic

Stage 1a1-2a (less than 4cms)

- Cone Biopsy,
- Referral to Gynaecological Oncologist
- Referral to Clinical Nurse Specialist
- Referral to Gynaecology Oncology MDT
- MRI Abdomen and Pelvis.
- Chest Xray
- FBC, U&E, LFTs.
- Staging, EUA Cystoscopy, PR and Cervical loop Biopsy

Stage 1b2, 2 -4

- Pelvic radiotherapy, external beam followed by intracavity. +/- Chemotherapy.
- Concurrent weekly Cisplatin 50mg if adequate renal function

Follow up at the Combined Oncology Clinic for 3 years

Post operative radiotherapy +/- chemotherapy is

- Considered if the patient has one or more positive lymph nodes on histology.
- Offered if the patient has positive resection margins after radical hysterectomy.
- Discussed in cases where patients are treated inadvertently with simple hysterectomy, reoperation with parametrectomy, pelvic lymphadenectomy and upper vaginectomy can have substantial complications
- Considered with view to an extended field radiotherapy for patients with microscopic nodal disease intraoperatively or small volume para aortic disease.

Palliative radiotherapy is

- considered with either Advanced, recurrent, metastatic disease or for unfit patients with any stage disease.
- Patients with advanced disease should be assessed re referral to specialist palliative care.

(see also 3.2.4)

RARE TUMOUR GROUPS

- Small Cell Carcinomas (neurendocrine tumours, malignant carcinoids) treated by combined modality with chemotherapy and radiotherapy.
Whilst surgery and radiotherapy have been proven to be equally effective in treating cancer of the cervix, the decision regarding treatment of an individual patient is decided after MDT discussion and consultation with the patient. More recently chemo radiation has been found to help with locally advanced disease.

Treatment options are dependent on the stage of the disease (see algorithm 1). Treatment modalities may include the following:

3.2. **Surgery**

- Cone Biopsy
- Pelvis Lymph-node Dissection (PND)
- Radical Trachelectomy
- Laparoscopic Radical Hysterectomy
- Radical Hysterectomy
- Modified Radical Hysterectomy
  (Simple hysterectomy in certain circumstance)

3.2.1. **Chemo – Radiotherapy**

Treatment for larger tumors is usually a combination on chemotherapy and radiotherapy. The patients will be given weekly Cistplatin with concurrent radiotherapy. Radiotherapy treatment is given from the outside from a machine called a linear accelerator. This external treatment is usually given on a daily basis for 25 treatments Monday-Friday, then internal treatment can also be given, by placing a tube containing a radiotherapy source in the Vagina (similar to a large tampon), under sedation or anaesthetic for a period of time If radiotherapy is primary treatment then Internal and external would be given. This Internal radiotherapy is given (bracytherapy) HDR usually 3 treatments over a 2 week period.

However the type of radiotherapy and length of time will be planned and decided individually between the doctor and the patient. (See Clatterbridge Centre for Oncology radiotherapy booklet for more information).

3.2.2. **Radiotherapy**

Radiotherapy treatment can be administered alone if patients are not fit enough to receive chemotherapy or their renal function will not allow.

3.2.3. **Chemotherapy**

Can be considered as Neo -adjuvant prior to radiotherapy if nodal disease outside the treatment field to down stage.

Is rarely used alone unless for palliative intent.

However other chemotherapy drugs may be used in the management of advanced disease or different cell type (ie small cell).

3.2.4. **Recurrent Disease**

Patients who relapse locally should be fully reassessed at the cancer centre and consideration for:

- Further surgery i.e. Exenteration (total, anterior, posterior).
- Radiotherapy if radiation naïve or outside original treatment field
- Chemo- radiation.
- Palliative chemo for advanced metastatic disease
- Palliative radiotherapy for symptom control (i.e. bleeding, pain, PV discharge).
3.3. Nursing Considerations

3.3.1. Advanced Disease / Palliative Care

Palliative care aims to improve the quality of life for the whole person throughout the patient's cancer journey and should involve the family. The symptoms of advanced disease need to be managed with consideration given to the woman as a whole within the framework of her family and friends (RCN 1999).

The most common problems include:

- Pain
- Neuropathic pain which can be difficult to control
- Vaginal bleeding or discharge
- Fistula / Stoma formation
- Difficulty in passing urine / faeces
- Renal failure
- Lymphoedema
- Hypercalcaemia
- Deep Venous Thrombosis

Due to the effects of the disease itself or the result of the treatment, the woman may be cured of her cancer, but experience difficult symptoms affecting the quality of her life. Palliative Care - has developed an important and vital role in the mainstream care of women with Gynaecological Cancer. There should be appropriate referral to a Consultant in Palliative Medicine / Clinical Nurse Specialist and Hospice support.

3.3.2. Symptom Control

Gynae tumours by their mass and infiltrative effects within the pelvis are prone to affecting:

- The lymphatic and venous drainage system causing obstruction of the vessels leading to lymphoedema and thrombosis.
- The nervous system - especially the lumbosacral plexus, causing neuropathic pain and loss of limb motor and sensory function and interface of bladder and bowel function.
- The musculoskeletal system producing pain in the pelvis or causing spasm of the pelvic muscles.
- The bowel and abdomen causing problems of (bleeding), obstruction and ascites.
- The urinary tract causing obstruction and occasionally obstructive neuropathy.

### Para-neoplastic Syndrome examples:

- Endocrine system - hypercalcaemia, inappropriate ADH secretion, Cushing’s syndrome
- Renal System - nephrotic syndrome, obstruction by tumour products
- Nervous system - cerebellar degeneration, peripheral neuropathy, encephalomyelitis
- Haematological system - anaemia, thrombo-embolism, DIC
- Muscle & Joints - polymyositis
- GI system - anorexia, cachexia, malabsorption syndromes
- Miscellaneous - fever of unknown origin

These rare syndromes result from the secretion of substances usually proteins, by the primary tumour or metastases. These substances include hormones, growth factors, cytokines, antibodies and other immune products (Haapoja 2000).
### 3.4 Actions and Interventions

<table>
<thead>
<tr>
<th>IDENTIFICATION</th>
<th>CONSIDERATIONS – Resulting in Dysfunction</th>
<th>ACTION / INTERVENTION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Removal of organs and tissues</strong></td>
<td><strong>Physical</strong>: Structural and functional impact. Psychological • Loss of fertility • Loss of self identity • Loss of femininity <strong>Impact on sexual health</strong> <strong>Body Image and Hip Abduction</strong> <strong>Hormonal Issues, (Physical, or Emotional)</strong> <strong>Wound Issues</strong> <strong>Stoma Issues</strong> <strong>Lymphoedema - Mobility, Pain</strong></td>
<td>Please see Core issues and appendices, i.e. sexual health, menopause. Suggestion issues below. • Infertility – Facilitate exploration of issues and support with info regarding treatment options. i.e. HRT and alternatives • Dilator support and advice • National Networks • Psychosexual Counsellor • Role of Complementary Therapies • Pain - Refer to Palliative Care Regional Guidelines • Psychosocial Support • Menopause Specialist</td>
</tr>
<tr>
<td><strong>Nerve damage</strong></td>
<td>Pain type? Nerve? General</td>
<td>Refer to Merseyside &amp; Cheshire Palliative Care Audit Group Standards and Guidelines.</td>
</tr>
<tr>
<td><strong>Fibrosis of Vagina</strong></td>
<td>Pain/Discomfort/Sexual Health</td>
<td>See above and appendices</td>
</tr>
<tr>
<td><strong>Urinary disturbances/alterations</strong></td>
<td><strong>Continence</strong> <strong>Body Image</strong> <strong>Skin care</strong> <strong>Pads</strong> <strong>Underwear</strong></td>
<td>• Ensure ref to Gynae Onc CNS • Referral on to dietician may help • Medication, re Bowel and bladder symptoms eg Codeine, Imodium &amp; Predsol. • Assess physical need – maintain comfort and skin care • Refer to stoma/continence advisor • Refer to district Nurse • Radar key for public toilets • Consider financial implications</td>
</tr>
<tr>
<td><strong>Bowel problems</strong></td>
<td><strong>Stoma formation</strong></td>
<td>• CNS-Gynae –Onc • Consultant – To assess and advise • Role of antibiotics if appropriate</td>
</tr>
<tr>
<td><strong>Vaginal discharge and bleeding</strong></td>
<td>• Body Image • Cause of bleeding • Exclude infection • ?Tumour • ?Recurrence</td>
<td>• Keep area cool • Rub rather then scratch • Dry skin emollients • Eurax • Menthol and Phenol • Calamine • Cotton bedding and clothing.</td>
</tr>
<tr>
<td><strong>Pruritis</strong></td>
<td>• Cause • Bio chemical Related • Drug related • Environment • Clothing • Bedding</td>
<td></td>
</tr>
<tr>
<td>IDENTIFICATION</td>
<td>CONSIDERATIONS – Resulting in Dysfunction</td>
<td>ACTION / INTERVENTION</td>
</tr>
<tr>
<td>----------------</td>
<td>------------------------------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td>Fistulae</td>
<td>Physical</td>
<td>• Ensure ref to Pts Consultant</td>
</tr>
<tr>
<td></td>
<td>Vesico Vaginal (bladder vagina)</td>
<td>• Ensure ref to Gynae Onc CNS</td>
</tr>
<tr>
<td></td>
<td>Recto Vaginal (rectum vagina)</td>
<td>• Skin Care i.e. Cavilon/Barrier</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>• Carboflex – Odour-absorption</td>
</tr>
<tr>
<td></td>
<td>Psychological</td>
<td>• Consider Octreotide in faecal fistulae</td>
</tr>
<tr>
<td></td>
<td>Body Image</td>
<td>• Consider Anti-biotic pain relief</td>
</tr>
<tr>
<td></td>
<td>Other.</td>
<td>• Dignity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Stoma Team</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Body Image and sexual health support</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Dietitian – low residue diet advice</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• ? Refer to Urologist/General Surgery re Stoma</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Environment i.e. Odour</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Aroma ball/ Plug in’s/ burners</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Citrus oils mask odours</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Clothing, Washing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Radar key for access to toilets</td>
</tr>
<tr>
<td>Lymphoedema</td>
<td>Due to Disease/treatment</td>
<td>• Referral to Lymphoedema Nurse</td>
</tr>
<tr>
<td></td>
<td>Altered body image</td>
<td>• Encourage Mobility</td>
</tr>
<tr>
<td></td>
<td>Sexual health</td>
<td>• Skin care/ Hosiery</td>
</tr>
<tr>
<td></td>
<td>Social implications e.g. equipment / clothing / shoes / financial</td>
<td>• If applicable Refer to Occupational therapist and District Nurse for needs assessment</td>
</tr>
<tr>
<td></td>
<td>Physical pain</td>
<td>• Self Help, exercise</td>
</tr>
<tr>
<td></td>
<td>Infection</td>
<td>Literature</td>
</tr>
<tr>
<td></td>
<td>Mobility issues</td>
<td>• Appropriate compression hoisery</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Referral to social worker for financial support for extra needs</td>
</tr>
</tbody>
</table>

See also appendices 7.9 and 7.10 for the nursing management of the side effects of radiotherapy and chemotherapy.
4. **Tumour Specific Considerations - Vulva**

There is one main type of vulval carcinoma – squamous cell. However rarer types include malignant melanoma, basal cell and Bartholin’s gland. (Shafi, Lusley, Jordan, 2001)

All patients need adequate staging EUA, Mapping, Biopsy, +/- MRI/CT/USS Chest X ray and full blood count and Urea and Electrolytes.

4.1. **Staging (FIGO 2009).**

<table>
<thead>
<tr>
<th>Stage 1</th>
<th>Tumour confined to the vulva.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1a</td>
<td>Lesion &lt;2cm, in size confined to the vulva or perineum and with stromal invasion &lt;1mm, no nodal metastasis.</td>
</tr>
<tr>
<td>Stage 1b</td>
<td>Lesions &gt; 2 cm in size or with stromal invasion &gt;1mm, confined to the vulva or perineum with negative nodes.</td>
</tr>
<tr>
<td>Stage 2</td>
<td>Tumour of any size with extension to adjacent perineal structures (1/3 lower urethra, 1/3 lower vagina, anus) with negative nodes.</td>
</tr>
<tr>
<td>Stage 3</td>
<td>Tumour of any size with or without extension to adjacent perineal structures (1/3 Lower vagina, 1/3lower urethra, vagina, anus), with <strong>positive</strong> inguino-femoral lymph nodes.</td>
</tr>
<tr>
<td>Stage 3a (i)</td>
<td>With 1 lymph node metastasis (&gt;5mm), or</td>
</tr>
<tr>
<td>(ii)</td>
<td>1-2 Lymph node metastasis (&lt;5mm).</td>
</tr>
<tr>
<td>Stage 3b (i)</td>
<td>With 2 or more lymph nodes (&gt;5mm), or</td>
</tr>
<tr>
<td>(ii)</td>
<td>3 or more lymph nodes (&lt;5mm)</td>
</tr>
<tr>
<td>Stage 3c</td>
<td>With positive lymph nodes with extra capsular spread.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stage 4</th>
<th>Tumour invades other regional (2/3 upper urethra, 2/3 upper vagina), or distant structures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 4a</td>
<td>Tumour invading any of the following upper urethra and/or vaginal mucosa, bladder mucosa, rectal mucosa, or fixed to the pelvic bone, or</td>
</tr>
<tr>
<td>(i)</td>
<td>Fixed or ulcerated inguino-femoral lymph nodes</td>
</tr>
</tbody>
</table>

All patients with a confirmed or high level of suspicion/suggestion of cancer should be referred to the cancer centre and the MDT.

If a melanoma is confirmed referral to Skin/Melanoma MDT is required.
4.2. Treatment algorithm for Vulvar Cancer

**Early Stage (No nodal metastasis)**
- Removal of primary tumour should be possible without damage to the midline structures such as anus and urethra.
- Surgery to access possible nodal metastasis in all cases except stage 1a1, basal cell, verrucous and malignant melanoma.
- The intention is too maximise cure whilst minimising morbidity.

**Advanced Stage (Nodal metastasis)**
- Surgery dependent on site / size of disease and if mid line structures are involved.
- Radical vulvectomy or even exenterative surgery (1cm disease free margins).
- Reconstructive surgery may need to be considered.
- Groin node dissection in all cases unless fixed or ulcerated groin nodes - in this case FNA to confirm involvement.

---

**Referral to Gynaecological Oncologist.**
- CT / MRI pelvic nodes if groin clinically suspicious.
- Chest Xray.
- FBC, U&E, LFTs.
- Referral to Clinical Nurse Specialist.
- Referral to Cancer Centre.

**Histopathologically confirmed Vulval Cancer**
- CT / MRI pelvic nodes if groin clinically suspicious.
- Chest Xray.
- FBC, U&E, LFTs.
- Referral to Gynaecological Oncologist.
- Referral to Clinical Nurse Specialist.
- Referral to Cancer Centre.

---

**Pre-operative radiotherapy** is considered in fit patients with large inoperable tumours in an attempt to down stage and facilitate Viscera-preserving surgery.

**Adjunct Radiotherapy** is considered when two/more nodes are involved or one node completely replaced by tumour and has extra capsular spread.

If excision margins +ve, but re-excision and surveillance with surgical salvage of reoccurrence is valid.

**Primary Radiotherapy** is suitable when there is a very small lesion in elderly frail patients.
- Young patients with clitoral lesions, when surgery is associated with major psychosexual sequelae.
- Patients with advanced diseases that are unfit for surgery. (palliative or radical).

**Irradiation of inguinal Nodes** is considered inferior to surgery and is reserved for unfit patients.

**Palliative radiotherapy** elderly patients with poor performance status and advanced disease. Symptom control such as bleeding or pain.

---

**Chemo-radiation. insufficient evidence** to advocate it as the sole treatment for vulvar cancer.

**Chemotherapy** can be considered in patients with metastatic disease.

---

**Hormone therapy** no significant role.

**Treatment of relapse** selected on individual basis.
The principle management for early stage disease is surgery – Radiotherapy given alone or in conjunction with chemotherapy may be used in advanced stage to downstage the tumour prior to surgery if needed. However the treatment is dependant on location and size of tumour and morbidity issues.

Treatment choices dependent on stage may be:

4.2.1. **Surgery - may include one of the following or combinations.**

- Local excision.
- Wide local excision.
- Anterior/Posterior vulvectomy.
- Hemi-vulvectomy.
- Radical vulvectomy +/- Plastics and reconstruction.
- Unilateral node dissection
- Bilateral node dissection.
- Fine needle aspiration of groin nodes

If the excision margin is positive, then both, re excision by surgical salvage or surveillance of recurrence are equally valid approaches.

If surgery not suitable then consider radiotherapy.

4.2.2. **Radiotherapy.**

**Primary radiotherapy** is considered for patients who have a small lesion and are unfit for surgery. Patients with clitoral lesions where surgery would be associated with major psycho-sexual sequelae. When advanced disease and surgery is not appropriate, then radical radiotherapy with con current chemo is preferred. Usually 20-25 treatments however some patients have more then one phase of treatment.

**Adjuvant treatment** is considered when surgical excision margins are close or positive. When 2 or more nodes are involved or when 1 node is completely replaced by tumour and has extra capsule spread.

If 1 groin is positive and the other has not been dissected.

Can be considered if an infiltrative growth pattern and lympho vascular space invasion are present as potential of local recurrence.

Sometimes radiotherapy is given as neo-adjuvant treatment to reduce size of tumour pre-surgical completion of removal.

4.2.3. **Chemo-Radiotherapy.**

Can be considered if the lesion is too large to surgically remove or surgery would be exenterative. It is an aggressive approach and patients must be appropriately considered as can be associated with morbidity.

Chemotherapy is usual 5FU and Cisplatin in week 1 and 5 and 25 daily treatments of radiotherapy.

4.2.4. **Chemotherapy.**

Not regarded as standard treatment, however needs to be considered for treatment of melanomas, and selected patients with metastatic disease. The drugs of choice are 5FU and cisplatin alone or in combination. Single agent Taxol can be considered in those who progress following first line treatment.
4.2.5. **Recurrent Disease.**

Local relapse should be fully assessed at the cancer centre, and considered for:
- Further surgery.
- Radiotherapy if radiation naïve or outside the treatment field.
- Palliative radiotherapy for symptom control.
- Consider chemotherapy.

4.3. **Nursing Considerations**

4.3.1. **Advanced Disease / Palliative Care**

Palliative care aims to improve the quality of life for the whole person throughout the patient’s cancer journey and should involve the family. The symptoms of advanced disease need to be managed with consideration given to the woman as whole within the framework of her family and friends (RCN 1999).

The most common problems include:

- Fungation of wound.
- Neuropathic pain which can be difficult to control
- Vaginal bleeding or discharge
- Fistula / Stoma formation
- Difficulty in passing urine / faeces
- Renal failure
- Lymphoedema
- Hypercalcaemia
- Deep Venous Thrombosis
- Pain/tumour pain.
- Faecal incontinence.
- Skin problems
- Positioning
- Mobility
- Sexual health

Refer to Gynaecology Pathway
Mersey Cheshire Network
Palliative Care Audit Group
Standards & Guidelines
(2010)

Due to the effects of the disease itself or the result of the treatment, the woman may be cured of her cancer, but experience difficult symptoms affecting the quality of her life. Palliative Care - has developed an important and vital role in the mainstream care of women with Gynaecological Cancer. There should be appropriate referral to a Consultant in Palliative Medicine / Clinical Nurse Specialist and Hospice support.

4.3.2. **Symptom Control**

Gynae tumours by their mass and infiltrating effects within the pelvis are prone to affecting:

- The lymphatic and venous drainage system causing obstruction of the vessels leading to lymphoedema and thrombosis.
- The musculoskeletal system producing pain in the pelvis or causing spasm of the pelvic muscles.
- The urinary tract causing obstruction and occasionally obstructive neuropathy.
- Problems of bleeding and infection.
Distant effects can cause: Para-neoplastic Syndrome examples:

<table>
<thead>
<tr>
<th>Para-neoplastic Syndrome examples:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Endocrine system - hypercalcaemia, inappropriate ADH secretion, Cushing’s syndrome</td>
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<td>- Renal System - nephrotic syndrome, obstruction by tumour products</td>
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<tr>
<td>- Miscellaneous - fever of unknown origin</td>
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These rare syndromes result from the secretion of substances usually proteins, by the primary tumour or metastases. These substances include hormones, growth factors, cytokines, antibodies and other immune products (Haapoja 2000).

4.4. Actions and Interventions

<table>
<thead>
<tr>
<th>IDENTIFICATION</th>
<th>CONSIDERATIONS</th>
<th>ACTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment of wound</td>
<td>• ?Infection • Poor healing • Nutrition • Lymphocyst • Disease - fungatation • Hygiene • Excoriation • ↓ Mobility • Age • Medical History • Contamination by urine or faeces</td>
<td>• Early referral to appropriate Nurse/healthcare professional e.g. Tissue viability Nurse Dietitian – Nutritional Support Measures to eliminate odour i.e. charcoal dressing etc Hygiene issues Lymphoedema Link Nurse</td>
</tr>
<tr>
<td>Removal of organs</td>
<td>Physical – Functional and structural changes: • Impact Sexual Health • Body Image • Fibrosis of Orifices • Interruption/damage to muscle control • Urine Dysfunction i.e. Spraying • Appropriate skin care/pads/underwear. • Faecal incontinence</td>
<td>Support whilst visualizing wound i.e. mirror environment. Use of dilator Continence Advisor Use of funnel / cup to avoid spraying. Physiotherapist Colorectal CNS Continence advisor Dietitian Complementary Therapies Enhance Positive Aspects Accentuate the person Psychosexual Counseling</td>
</tr>
<tr>
<td>Clitoris Labia Minora Labia Majora</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Altered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clitoris Anal Sphincter Urethra Introitus</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IDENTIFICATION</th>
<th>CONSIDERATIONS</th>
<th>ACTIONS</th>
</tr>
</thead>
</table>
| **Lymphoedema** | Due to disease/treatment –  
- Altered body image  
- Sexual health  
- Social implications e.g. equipment / clothing / shoes / financial  
- Physical pain  
- Infection  
- Mobility issues | • Referral to Lymphoedema Nurse  
• Encourage Mobility  
• Skin care/ Hosiery  
• If applicable Refer to Occupational therapist and District Nurse for needs assessment  
• Self Help, exercise Literature  
• Appropriate compression hosiery.  
• Referral to social worker for financial support for extra needs |
| **Pruritis** | • ? Cause  
• Bio chemical Related  
• Drug related  
• Environment  
• Clothing  
• Bedding | • Keep area cool  
• Rub rather then scratch  
• Dry skin emollients  
• Eurax  
• Menthol and Phenol  
• Calamine  
• Cotton bedding and clothing. |

See also appendices 7.10 and 7.11 nursing management of the side effects of radiotherapy and chemotherapy.
5. **Tumour Specific Considerations - Endometrium**

The commonest type of endometrial cancer is endometrioid adenocarcinoma which accounts for approximately 75%.
The remaining 25% consists of Papillary Serous, Carcinosarcoma, Mucinous, Serous, Clear cell.

5.1. **Staging**

FIGO Staging for endometrial carcinoma (2009).

<table>
<thead>
<tr>
<th>Stage 1 - Grade 1,2,3</th>
<th>Tumour confined to the corpus uteri</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1a - Grade 1,2,3</td>
<td>No or less than half myometrial invasion</td>
</tr>
<tr>
<td>Stage 1b – Grade 1,2,3</td>
<td>Invasion equal to or more then half of the myometrium</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stage 2 - Grade 1,2,3</th>
<th>Tumour invades cervical stroma, but does not extend beyond the uterus (endocervical glandular involvement only should be considered as stage 1 no longer stage2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 3 Grade 1,2,3.</td>
<td>Local and/or regional spread tumour.</td>
</tr>
<tr>
<td>Stage 3a – Grade 1,2,3</td>
<td>Tumour invades serosa of the corpus uteri and/or adenexae</td>
</tr>
<tr>
<td>Stage 3b – Grade 1,2,3</td>
<td>Vaginal and/or parametrial metastases.</td>
</tr>
<tr>
<td>Stage 3c – Grade 1,2,3</td>
<td>Metastases to pelvic and/or para-aortic lymph nodes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stage 4 Grade 1,2,3</th>
<th>Tumour invades bladder and or bowel mucosa, and/or distant metastases.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 4a – Grade 1,2,3</td>
<td>Tumour invasion of the bladder and/or the bowel mucosa</td>
</tr>
<tr>
<td>Stage 4b</td>
<td>Distant metastases including intra-abdominal and/or inguinal lymphnodes</td>
</tr>
</tbody>
</table>

**POSITIVE CYTOLOGY HAS TO BE REPORTED SEPERATLEY WITHOUT CHANGING THE STAGE.**

All patients with a confirmed diagnosis should be discussed at a MDT meeting, and the appropriate treatment and place for treatment should be negotiated.
5.2. Treatment algorithm for endometrial cancer

Histopathologically confirmed Endometrial Cancer

- Referral to Gynaecological Oncologist if high risk prognostic factors present
- Referral to Clinical Nurse Specialist
- If Grade 3 or Serous papillary or sarcoma need CT staging)
- MRI Abdomen and Pelvis/ CT scan grade and sub type of cancer (carcino sarcoma need a CT of chest)
- Chest Xray
- FBC,U&E,LFTs, +/- CA125

Stage 1

- Hysterectomy LAVH, LTH. TAH BSO via Midline incision
- Peritoneal washings for cytology.
- Palpation of Lymph nodes plus sampling if suspicious
- Pelvic radiotherapy
- Role of debulking surgery should be considered by the MDT
- Assessment re referral to specialist palliative care.

- LOW RISK PTS
  - G1/G2 tumours , stage 1A or 1B. DONOT REQUIRE POST OP RADIOTHERAPY
  - G3 stage 1A tumours consider radiotherapy.

- MODERATE TO HIGH RISK PTS
  - Consider post op radiotherapy-Opinion offered for Stage 1B Grade 3
  - Stage 2 or above should be considered for post op radiotherapy, this is dependent on performance status and assessment must be made by the MDT.

Stage 2/ Stage 3 / Stage 4

- Referral to centre for individual treatment plan
- Uterine papillary serous carcinoma- debulking surgery, pelvic radiotherapy, consider chemotherapy.
- Clear Cell Carcinomas- debulking surgery, pelvic radiotherapy, consider chemotherapy.
- Uterine sarcomas – consider chemotherapy

RARE TUMOUR GROUPS

- Referral to centre for individual treatment plan
- Uterine papillary serous carcinoma- debulking surgery, pelvic radiotherapy, consider chemotherapy.
- Clear Cell Carcinomas- debulking surgery, pelvic radiotherapy, consider chemotherapy.
- Uterine sarcomas – consider chemotherapy

5.2.1. Surgery

Surgery is the main focus of treatment. This being a hysterectomy which can be done by a variety of ways laparoscopic, abdominal or vaginal. The decision is dependant upon the patient's suitability to the approach. Surgery is usually with curative intent however can be used for palliative intent.

5.2.2. Radiotherapy

Radiotherapy treatment is given externally (from the outside) from a machine called a linear accelerator. Treatment can also be internally; this is given by placing a tube containing a radiotherapy source in the Vagina (similar to a large tampon), under sedation or anaesthetic for a period of time.
• Adjuvant Treatment.
  Is offered to those patient with stage 1b disease or greater and dependant on type, treatment is given externally to the pelvis.

  This is usually followed up by 1 treatment of internal radiotherapy (brachytherapy).

  Internal radiotherapy (brachytherapy) can sometime be used alone this is usually given as 3 treatments over a 2-3 week period.

• Primary Treatment
  Radiotherapy is considered for all patients with co morbid conditions or patients who are not suitable for surgery.

5.2.3. Chemotherapy and Hormone Treatments.

Chemotherapy is favoured for the rarer tumour types such as papillary serous adenocarcinoma as these tend to behave like an ovarian tumour. This group of women may receive chemotherapy followed in some cases by pelvic radiotherapy, to reduce the chances of distant and local relapse.

In the more common types of endometrial cancer, chemotherapy tends to be used in more advanced disease or recurrent disease.

However is a woman is too frail to receive primary or adjuvant treatment they mean be considered for hormonal treatment alone once agreed by the MDT. This is thought it may enhance survival in the palliative group; however there are no randomized controlled trials in this group.

5.2.4. Recurrent Disease.

Patients with a local relapse should be fully assessed at the unit MDT and at Central MDT (if surgery being considered) considerations for:
  • Further surgery i.e. extentionation.
  • Radiotherapy if radiation naïve

Patients with distant relapse should be fully assessed at the MDT centre and considered for:
  • Chemotherapy.
  • Hormonal treatment, Provera max dose 400mg a day.
5.3. Nursing Considerations

5.3.1. Advanced Disease / Palliative Care

Palliative care aims to improve the quality of life for the whole person throughout the patient's cancer journey and should involve the family. The symptoms of advanced disease need to be managed with consideration given to the woman as whole within the framework of her family and friends (RCN 1999).

The most common problems include:
- Pain
- Ascites
- Breathlessness
- Neuropathic pain which may be difficult to control
- Vaginal bleeding or discharge
- Pre existing instability of co morbid conditions.
- Difficulty in passing urine / faeces
- Renal failure
- Lymphoedema
- Hypercalcaemia
- Deep Venous Thrombosis

Due to disease progression or as a result of treatment, the woman may be cured of her cancer, but experience difficult symptoms affecting the quality of her life.

Palliative Care - implying both palliation and care has developed an important and vital role in the mainstream care of women with Gynaecological Cancer.

There should be appropriate referral to a Consultant in Palliative Medicine / Clinical Nurse Specialist and Hospice support.

5.3.2. Symptom Control

Gynae tumours by their mass and infiltrate effects within the pelvis are prone to affecting:
- the lymphatic and venous drainage system causing obstruction of the vessels leading to lymphoedema and thrombosis.
- the nervous system - especially the lumbosacral plexus, causing neuropathic pain and loss of limb motor and sensory function and interface of bladder and bowel function.
- the musculoskeletal system producing pain in the pelvis or causing spasm of the pelvic muscles.
- the bowel and abdomen causing problems of (bleeding), obstruction and ascites.
- the urinary tract causing obstruction and occasionally obstructive neuropathy.

Distant effects can cause:

Para-neoplastic Syndrome examples:
- Endocrine system - hypercalcaemia, inappropriate ADH secretion, Cushing’s syndrome
- Renal System - nephrotic syndrome, obstruction by tumour products
- Nervous system - cerebellar degeneration, peripheral neuropathy, encephalomyelitis
- Haematological system - anaemia, thrombo-embolism, DIC
- Muscle & Joints - polymyositis
- GI system - anorexia, cachexia, malabsorption syndromes
- Miscellaneous - fever of unknown origin

These rare syndromes result from the secretion of substances usually proteins, by the primary tumour or metastases. These substances include hormones, growth factors, cytokines, antibodies and other immune products (Haapoja 2000).
### 5.4. Actions and Interventions

<table>
<thead>
<tr>
<th>IDENTIFICATION</th>
<th>CONSIDERATIONS</th>
<th>ACTION / INTERVENTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Removal of organs and tissues</td>
<td><strong>Physical</strong> structural and functional changes.</td>
<td>Please see Core issues and appendices sexual health, menopause. Suggestion issues below.</td>
</tr>
<tr>
<td>Uterus</td>
<td></td>
<td>• Infertility – facilitate exploration of issues and support with info re treatment options. i.e. HRT and its alternatives</td>
</tr>
<tr>
<td>Ovaries</td>
<td></td>
<td>• Dilator support and advice</td>
</tr>
<tr>
<td>Cervix</td>
<td><strong>Loss of fertility</strong></td>
<td>• National Networks</td>
</tr>
<tr>
<td>Shortened Vagina</td>
<td><strong>Loss of self identity</strong></td>
<td>• Psychosexual Counselor</td>
</tr>
<tr>
<td>Bowel</td>
<td><strong>Loss of femininity</strong></td>
<td>• Role of Complementary Therapies</td>
</tr>
<tr>
<td>Bladder</td>
<td>Impact on sexual health</td>
<td>• Pain - refer to Palliative Care Regional Guidelines or Appendix</td>
</tr>
<tr>
<td>Lymph Nodes</td>
<td>↓ Body Image and ↓ Hip Abduction</td>
<td>• Psychosocial Support</td>
</tr>
<tr>
<td></td>
<td>Hormonal Issues, Physical, Emotional</td>
<td>• Menopause Specialist</td>
</tr>
<tr>
<td></td>
<td>Wound Issues</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Stoma Issues</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lymphoedema - Mobility, Pain</td>
<td></td>
</tr>
<tr>
<td><strong>Nerve damage</strong></td>
<td>Pain type? Nerve ?General</td>
<td>Refer to Merseyside &amp; Cheshire Palliative Care Audit Group Standards and Guidelines.</td>
</tr>
<tr>
<td><strong>Fibrosis of Vagina</strong></td>
<td>Pain/Discomfort/Sexual Health</td>
<td>As above and appendices.</td>
</tr>
<tr>
<td><strong>Urinary disturbances/ alterations</strong></td>
<td>Continence</td>
<td></td>
</tr>
<tr>
<td>Bowel problems</td>
<td>Body Image</td>
<td></td>
</tr>
<tr>
<td>Stoma formation.</td>
<td>Skincare</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Underwear</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pads</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Refer to Consultant</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Refer to Gynae Onc CNS</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Refer to stoma/continence advisor.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medication re Bowel and bladder symptoms e.g. Codeine Imodium Predsol.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Assess physical need – maintain comfort and skin care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Radar key for public toilets.</td>
<td></td>
</tr>
<tr>
<td><strong>Vaginal discharge and bleeding</strong></td>
<td>▪ Exclude recurrence</td>
<td>Ensure ref to Gynae Oncology CNS</td>
</tr>
<tr>
<td></td>
<td>▪ Cause of bleeding</td>
<td>Referral on to others may help</td>
</tr>
<tr>
<td></td>
<td>▪ Exclude infection</td>
<td>• CNS</td>
</tr>
<tr>
<td></td>
<td>Body Image</td>
<td>• Consultant</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Consider role of radiotherapy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Antibiotic/ Hormones/ Tranexamic acid</td>
</tr>
<tr>
<td>IDENTIFICATION</td>
<td>CONSIDERATIONS</td>
<td>ACTION / INTERVENTION</td>
</tr>
<tr>
<td>----------------</td>
<td>----------------</td>
<td>----------------------</td>
</tr>
<tr>
<td><strong>Pruritus</strong></td>
<td>? Cause</td>
<td>Keep area cool</td>
</tr>
<tr>
<td></td>
<td>Bio-chemical Related</td>
<td>Rub rather than scratch</td>
</tr>
<tr>
<td></td>
<td>Drug related</td>
<td>Dry skin emollients</td>
</tr>
<tr>
<td></td>
<td>Environment</td>
<td>Eurax</td>
</tr>
<tr>
<td></td>
<td>Clothing</td>
<td>Menthol and Phenol</td>
</tr>
<tr>
<td></td>
<td>Bedding</td>
<td>Calamine</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cotton bedding and clothing</td>
</tr>
<tr>
<td><strong>Fistulae</strong></td>
<td></td>
<td>• Skin Care i.e. Cavilon/Barrier</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Carboflex – Odour-absorption</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Consider Octreotide in faecal fistulae</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Consider Anti-biotic, pain relief</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Dignity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Stoma Team</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Body image and sexual health support</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Dietitian – low residue advice</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• ?refer to urologist/General Surgery re Stoma</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Environment i.e. Odour</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Aroma ball, Clothing, Washing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Consider financial implications</td>
</tr>
</tbody>
</table>

See also appendices 7.12 and 7.14 nursing management of the side effects of radiotherapy and chemotherapy.
6. Tumour Specific Considerations - Ovary

Ovarian cancer is the commonest gynaecological cancer and the fourth most frequently diagnosed cancer in women, attributable for 6% of cancer deaths in women each year in the UK (CRUK 2004a&b). Pathologically it occurs as either an **epithelial** or a **non-epithelial** tumour with epithelial tumours accounting for over 90% of all ovarian tumours. It is often referred to as “the silent killer” as advanced disease is found at initial presentation in over 60% of cases (SIGN 2003).

Incidence increases with age peaking in the sixth decade and rarely occurring in women under 30 years of age. Most cases of epithelial ovarian cancer are sporadic occurring in women with no previous family history of the disease. It appears to be more common in nulliparous women and risk is decreased for women who have used the contraceptive pill (Franceschi et al 1991).

Approximately 200 cases are diagnosed in women in Merseyside and Cheshire annually under the age of 70, and 15% of cancers arise in patients under 55 years.

For the majority of women with epithelial ovarian cancer standard therapy consists of surgery followed by chemotherapy. Survival is dependent on the stage of cancer at initial presentation and histological sub-type. Whilst stage I disease has a five year survival rate of 85%, stage IV disease has a five year survival rate of only approximately 10% (Kristensen & Trope 1997).

Treatment is not usually curative for the majority of women. A typical patient will develop relapsed disease requiring repeated courses of chemotherapy. Recurrence is inevitably palliative and its diagnosis has a huge impact on the patient and her family.

### 6.1. Staging FIGO (2009)

<table>
<thead>
<tr>
<th>Stage 1</th>
<th>Tumour is confined to the ovary/ovaries.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1a</td>
<td>Only one ovary is affected by the tumour, the ovary capsule is intact. No tumour detected on the surface of the ovary, malignant cells are not detected in ascites or peritoneal washings.</td>
</tr>
<tr>
<td>Stage 1b</td>
<td>Both ovaries are affected by the tumour. The ovary capsule is intact. No tumour detected on the surface of the ovary, malignant cells are not detected in ascites or peritoneal washings.</td>
</tr>
<tr>
<td>Stage 1c</td>
<td>The tumour is limited to one or both ovaries, with any of the following, the ovary capsule ruptured, the tumour detected on the ovary surface. Positive malignant cells are detected in the Ascites or peritoneal washings.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stage 2</th>
<th>Tumour involves one or both ovaries and has extended into the pelvis.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 2a</td>
<td>The tumour has extended and/or implanted into the uterus and/or fallopian tubes. Malignant cells are not detected in Ascites or peritoneal washings.</td>
</tr>
<tr>
<td>Stage 2b</td>
<td>The tumour has extended to another organ in the pelvis. Extension to other pelvic tissues. Malignant cells are not detected in Ascites or peritoneal washings.</td>
</tr>
<tr>
<td>Stage 2c</td>
<td>Tumours are as defined in 2A/B, and malignant cells are detected in the Ascites or peritoneal washings.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stage 3</th>
<th>Tumour involving one or both ovaries with microscopically confirmed peritoneal metastasis outside the pelvis and/or regional lymphnode metastasis. Including liver capsule metastasis.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 3a</td>
<td>Microscopic peritoneal metastasis beyond the pelvis.</td>
</tr>
<tr>
<td>Stage 3b</td>
<td>Microscopic peritoneal metastasis beyond the pelvis 2cm or less in greatest dimension.</td>
</tr>
<tr>
<td>Stage 3c</td>
<td>Microscopic peritoneal metastasis beyond the pelvis more than 2 cm in greatest dimension and/or regional lymph node metastasis.</td>
</tr>
<tr>
<td>Stage 4</td>
<td>Distant metastasis beyond the peritoneal cavity, and liver parenchyma metastasis.</td>
</tr>
</tbody>
</table>
6.2. Treatment algorithm for ovarian cancer

- **Histopathologically confirmed / High Index of Suspicion** *(RMI score > 250) or clinical suspicion*
- **62 days to treat if under 2WR**
- **31 Days from diagnosis to treatment**
- **Multidisciplinary assessment**: re - Radical Cytoreductive surgery / Primary or neo-adjunctive chemotherapy or Palliative Care and Support
- **Primary Laparotomy**:
  - Aim: “Optimal debulking” Minimal (less than 1cm) or No residual disease.
  - Vertical incision
  - Peritoneal washing / ascites for cytology
  - Assessment of abdominal contents and peritoneal surface for macroscopic disease
  - After assessment resection of disease, including TAHBSO and resection of infracolic omentum even if macroscopically normal
  - Retroperitoneal palpation of node chains.
  - Lymphadenectomy is only *indicated* where this would potentially affect the stage of the disease or result in the removal of bulky disease.
  - **Selective** lymphadenectomy of pelvic and para-aortic nodes is *recommended* by GOG in patients with no gross residual disease regardless of stage, gross residual disease limited to the pelvis, Gross residual disease outside the pelvis largest diameter 1cm.
  - **Systematic** removal of pelvic and para-aortic lymph nodes *must only take* place within the boundaries of a trial.

- **In stage 1a** disease where patients wish to **preserve fertility**, removal of the unilateral ovary with careful examination of the entire abdominal cavity *is acceptable*.

- **Follow up**: The combined Oncology Clinic for ALL ovarian cancer patients

- **Secondary look Laparotomy** has *no place* in the routine management of ovarian cancer
- **Interval debulking**: Surgery post three cycles of chemotherapy where there is evidence of response to treatment both biochemically and clinically, *may be considered* by the MDT
- **Salvage surgery**: attempts to perform secondary cytoreduction after a long disease free interval should *only be considered* within the boundaries of a clinical trial, or on an individual basis after MDT dialogue.

- **Referral to Gynaecological Oncologist**
- **Referral to Clinical Nurse Specialist**
- **Referral to gynaecology oncology MDT**
- **CT Abdomen and Pelvis**.
- **Chest Xray**
- **FBC, U&E, LFTs. CA125 +/- CEA**
- **Tissue diagnosis if appropriate / Cytology in selected patients with ascites where surgery may be deferred**


Page 38
First line chemotherapy:

- Women may be offered the opportunity to participate in relevant clinical trials

Standard Regime: Carboplatin and paclitaxel or single agent carboplatin is;

- Considered in patients with Stage 1a grade 2/3 disease, ≥ stage 1B disease
- Paclitaxel and carboplatin repeated at 21-day intervals, maximum 6 cycles.
- Poor Performance Status/elderly patients are considered for single agent carboplatin at 21 day intervals for up to 6 cycles
- If Creatinine Clearance < 50, may be treated at lower dose to prevent further nephrotoxicity

Second line chemotherapy:

- Women may be offered the opportunity to participate in relevant clinical trials

Standard second line regime:

- Patients who relapse > 6 months post completion of platinum treatment are considered for Single agent carboplatin 21 day intervals, up to 6 cycles
  To be assessed by medical oncologist after 3 cycles, re biochemical and clinical response.
- Patients who relapse < 6 months post platinum (platinum resistant) PS 0-1
  No prior Taxanes therapy considers paclitaxel, maximum 6 cycles, 21-day intervals

Risk of Malignancy Index (RMI)

The RMI predicts whether or not an ovarian mass is likely to be malignant. All women with an RMI score > 250 should be referred to a centre with experience in ovarian surgery (NICE guidelines 2011).

RMI score = USS score x menopausal score x CA125 U/ml

<table>
<thead>
<tr>
<th>USS feature</th>
<th>RMI score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multilocular cyst</td>
<td>0 = none</td>
</tr>
<tr>
<td>Solid areas</td>
<td>1 = one abnormality</td>
</tr>
<tr>
<td>Bilateral lesions</td>
<td>3 = ≥ 2 abnormalities</td>
</tr>
<tr>
<td>Ascites</td>
<td></td>
</tr>
<tr>
<td>Intra-abdominal metastases</td>
<td></td>
</tr>
<tr>
<td>Premenopausal</td>
<td>1</td>
</tr>
<tr>
<td>Postmenopausal</td>
<td>3</td>
</tr>
<tr>
<td>CA125</td>
<td>U/ml</td>
</tr>
</tbody>
</table>
The patient’s case is then discussed at the Multidisciplinary Team meeting with pathology and relevant radiological and surgical findings to determine the most appropriate treatment strategy. This is then discussed with the patient in the Combined Oncology Clinic informing the patient and her family enabling them to participate in any decision-making regarding subsequent treatment.

6.2.1. Surgery

The role of surgical debulking has been well established over the last 20 years, but with the introduction of more effective cytotoxic chemotherapy the relative timing of surgery and chemotherapy has been questioned.

Primary debulking where feasible remains the standard treatment. The ideal being a complete debulking with no visible disease at the end of surgery.

- Laparotomy - Staging should be made through a mid-line excision to allow palpation of all peritoneal surfaces.
- Total Abdominal Hysterectomy (TAH), bilateral salpingo-oophorectomy (BSO) and resection of the infracolic omentum is undertaken, with peritoneal washings or ascites sent for cytology.
- Close inspection and palpation of the liver, spleen, peritoneum, retroperitoneal nodes, appendix and diaphragm to exclude disease, biopsies taken if suspicious areas identified.
- In early stage disease in women who wish to conserve their fertility a unilateral salpingo-oopherectomy may be performed if the contra lateral ovary appears normal.
- In advanced disease (FIGO ≥ Ic) aggressive surgical cytoreduction aims to leave no residual disease or “optimal debulking” where residual tumour deposits are less than 1cm.
- Bowel surgery may be performed where obstruction is imminent or where it enables optimal cytoreduction to be achieved. This may lead to stoma formation.
- Lymphadenectomy is not routinely performed.
- Interval debulking may be performed in women whose tumour mass has decreased following 3 cycles of chemotherapy and who have previously been sub optimally cytoreduced.
- A needs assessment is undertaken and the patient referred to appropriate services as required to support her through the cancer journey.
- In the management of relapsed disease particularly if there has been a significant period of disease remission, the multidisciplinary team should decide whether there is a role for surgery.

Definitions.

<table>
<thead>
<tr>
<th>Complete Debulking</th>
<th>No visible disease remaining.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Optimal Debulking</td>
<td>Where disease remaining is less than 1 cm 3</td>
</tr>
<tr>
<td>Sub Optimal Debulking</td>
<td>Disease remaining is greater than 1cm 3</td>
</tr>
</tbody>
</table>
6.2.2. **Chemotherapy**

Ovarian cancer is a chemo sensitive disease and the use of first line platinum based chemotherapy improves the prognosis of patients with advanced disease. Most women will respond to chemotherapy however the risk of relapse is high particularly in advanced disease (≥ stage II).

- Currently optimal chemotherapy is considered to be paclitaxel & carboplatin or single agent carboplatin after a review of the evidence by NICE (2003).
- Women with ≥ stage IA (grade 2-3 differentiation) should be supported and given appropriate information to enable them to make a decision regarding chemotherapy options.

Investigations pre-chemotherapy include:
FBC, Baseline clinical chemistry profile (U&E’s, renal & liver function), CA125 (see box 4.1)
Height & Weight
Baseline CT scan

**Summary of first line chemotherapy options.**

<table>
<thead>
<tr>
<th>First Line Chemotherapy</th>
<th>Schedule</th>
<th>Concomitant medications</th>
<th>Possible side-effects</th>
</tr>
</thead>
</table>
| **Carboplatin**         | - IV over 1hr  
- 21 day interval  
- up to 6 cycles  
*(28 day if PS > 2 or repeated myelosuppression)* | Granisetron 1mg  
Dexamethasone 16mg  
*Take home meds:*  
Domperidone 20mg qid – 3-5 days longer if reqd.  
Dexamethasone 4mg tds – 3 days | Nausea & vomiting  
Renal impairment  
Myelosuppression  
Slight hair thinning  
Hypersensitivity  
Fatigue  
Bowel disturbance  
Rare S/A  
Peripheral neuropathy  
Hearing loss (12%) |
| **Paclitaxel** (TAXOL) | - IV over 3hrs  
- 21 day interval  
- up to 6 cycles  
*NON-PVC giving sets & bags MUST be used, with a filter.* | IV Chlorpheniramine 10mg  
Dexamethasone 20mg  
Ranitidine 50mg  
*(30-60mins pre taxol)* | Hypersensitivity *(cutaneous flushing, urticaria, ↓BP, ↓P, dyspnoea, bronchospasm, chest & abdo pain)*  
Rash  
Myelosuppression  
Peripheral neuropathy  
Arthralgia  
Myalgia  
Cardiac conduction defects with arrhythmias  
Alopecia  
Fatigue  
+  
Nausea & vomiting |
## Guidelines 2013-2016

### First Line Chemotherapy

<table>
<thead>
<tr>
<th>Schedule</th>
<th>Concomitant medications</th>
<th>Possible side-effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carboplatin</td>
<td>Take home meds; Domperidone 20mg qid – 3-5 days longer if reqd. Dexamethasone 4mg tds – 3 days</td>
<td>Renal impairment Bowel disturbance Rare S/A Ototoxicity (Need to be aware of risk of peripheral neuropathy in pts with diabetes, alcohol abuse)</td>
</tr>
</tbody>
</table>

- The side-effects of chemotherapy should be assessed after each cycle and appropriate interventions implemented and subsequently evaluated by the medical oncology team.
- Chemotherapy for recurrent disease is palliative, aims to reduce symptoms and prolong survival.
- Risks and benefits of the options available should be discussed with each individual woman before the choice of second line or subsequent chemotherapy is made. The impact of toxicities on the woman’s quality of life must be balanced against their anticipated response to treatment.

### Summary of chemotherapy treatment options for recurrent disease

<table>
<thead>
<tr>
<th>Disease recurrence</th>
<th>Schedule</th>
<th>Concomitant medications</th>
<th>Possible side-effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relapse &gt; 6 months post 1st line Tx</td>
<td>As above for 1st line Repeat CA125 &amp; CT after 3 cycles. Assess response</td>
<td>As above for 1st line</td>
<td>As above for 1st line</td>
</tr>
<tr>
<td>Single agent Carboplatin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relapse &lt; 6 months post 1st line Tx:</td>
<td>- IV over 3hrs - 21 day interval - up to 6 cycles</td>
<td>IV Chlorpheniramine 10mg Dexamethasone 20mg Ranitidine 50mg (30-60mins pre taxol) Granisetron 1mg (may be given as reqd)</td>
<td>Hypersensitivity (cutaneous flushing, urticaria, ↓BP, ↓P, dyspnoea, bronchospasm, chest &amp; abdo pain) Rash Myelosuppression Peripheral neuropathy Arthralgia Myalgia Cardiac conduction defects with arrhythmias Diarrhoea Alopecia Fatigue Infusion reaction (flushing, chills, dyspnoea, facial swelling, headache, back pain, chest or</td>
</tr>
<tr>
<td>No prior taxane → Paclitaxel (TAXOL)</td>
<td>NON-PVC giving sets &amp; bags MUST be used, with a filter.</td>
<td>Take home meds; As above in combined regimen IV Dexamethasone 8-16mg</td>
<td></td>
</tr>
</tbody>
</table>

Guidelines 2013-2016. Page 42
<table>
<thead>
<tr>
<th>Disease recurrence</th>
<th>Schedule</th>
<th>Concomitant medications</th>
<th>Possible side-effects</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prior taxane</strong></td>
<td>- IV over 1hr&lt;br&gt;- 28day cycle&lt;br&gt;- up to 6 cycles&lt;br&gt;Repeat CA125 &amp; CT after 3 cycles.&lt;br&gt;Assess response</td>
<td>Granisetron 1mg (may be given as reqd)&lt;br&gt;&lt;br&gt;<strong>Take home meds as above</strong></td>
<td><strong>throat tightness, ↓BP</strong>&lt;br&gt;Myelosuppression&lt;br&gt;Mucositis&lt;br&gt;Palmer-plantar syndrome&lt;br&gt;Nausea &amp; vomiting&lt;br&gt;Diarrhoea&lt;br&gt;Possible cardiac changes&lt;br&gt;Possible vesicant (&lt; risk than doxorubicin)&lt;br&gt;Red urine&lt;br&gt;Myelosuppression&lt;br&gt;Alopecia&lt;br&gt;Throat tightness, ↓BP&lt;br&gt;Mucositis&lt;br&gt;Nausea &amp; vomiting&lt;br&gt;Bowel disturbance</td>
</tr>
<tr>
<td><strong>→ Liposomal Doxorubicin (CAELYX)</strong></td>
<td>OR</td>
<td>IV dexamethasone 8mg as reqd&lt;br&gt;&lt;br&gt;<strong>Take home meds:</strong>&lt;br&gt;Domperidone 20mg qid</td>
<td></td>
</tr>
<tr>
<td><strong>OR</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>→ Topotecan (HYCAMPTIN)</strong></td>
<td>- IV over 30 mins&lt;br&gt;- days 1-5 every 21 days&lt;br&gt;- up to 6 cycles&lt;br&gt;Repeat CA125 &amp; CT after 3 cycles.&lt;br&gt;Assess response</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Women with ≥ stage III disease are advised to take laxatives for at least 48hrs post chemotherapy due to the high risk of constipation (s/a of granisetron, disease and surgery induce a sluggish bowel).
- Women with a high risk of imminent bowel obstruction or constipation should be referred to the dietician as a low residue diet may be appropriate.
- Further information regarding the potential side-effects of chemotherapy and contact numbers for Delamere (day chemotherapy suite) and Sulby (in-patient ward) at CCC are discussed and given to the patient.
- The patient also has access to the CNS for women’s cancer at CCC.
Other chemotherapy treatments, which may be considered in ovarian cancer. Avastin can be considered and applied for by the compassionate drugs fund programme in certain situations although currently not approved by NICE.

The Role of CA125

CA125 is a glycoprotein antigen found in the blood, the measurement of which is widely used to detect ovarian cancer. Approximately 80% of women with advanced ovarian cancer have an elevated CA125 however only 50% of patients with early stage 1 disease have significantly elevated levels (Jacobs & Bast 1989).

Elevated levels are also associated with malignant tumours of the pancreas, breast, lung and colon and benign conditions such as endometriosis, pelvic inflammatory disease, liver disease and even menstruation.

Despite its poor sensitivity and specificity CA125 is most useful for detecting and monitoring non-mucinous epithelial tumours of the ovary in conjunction with clinical assessment.

6.2.3. Hormonal Therapy

In some instances it may be considered particularly in women for whom chemotherapy may not be appropriate. Refer to Merseyside and Cheshire network medical protocol for further information.

6.2.4. Radiotherapy

Radiotherapy is of limited effectiveness and is toxic to other abdominal organs. It may be considered for the palliation of distant metastases i.e. brain or bone which occasionally occur.

6.2.5. Clinical Trials

At any point throughout her cancer journey a woman should be offered the opportunity to participate in relevant clinical trials if she fulfils the eligibility criteria. See appendix 7.9

6.3. Nursing Considerations

6.3.1. Advanced Disease / Palliative Care

Palliative care aims to improve the quality of life for the whole person throughout the women’s cancer journey. The symptoms of advanced disease need to be managed therefore with consideration to the woman as a whole within the framework of her family and friends (RCN 1999).

Women who develop ovarian cancer may need rehabilitative, functional, social and/or financial support services. These can be provided by agencies both within and outside the health service, most of which are available in specialist palliative care settings. The Gynae/oncology CNS also performs a role in the assessment and co-ordination of these services. The effectiveness of specialist palliative care services and CNS provision involves the assessment of the different dimensions of care provided, such as pain and other symptom control, psychological care, care of the family and carers, rehabilitation and terminal care.

Specialist palliative care is an integral component of the care of women with advanced ovarian cancer.
6.3.2. **Disease dissemination**

- Direct spread to the uterus and fallopian tubes
- Spread via the peritoneum to the rest of the peritoneal cavity, especially the omentum
- Spread via the lymphatic system to pelvic and para-aortic lymph nodes
- Spread via the blood system to the liver, lungs and other distant organs.

6.3.3. **Symptom Control**

**The most common symptoms include:**

- Intestinal obstruction
- Pleural effusion → dyspnoea, chest pain or discomfort
- Ascites→ abdominal distension, pressure effects on the bladder and rectum, indigestion, dyspnoea, mimicking irritable bowel syndrome
- Renal impairment
- Constipation
- Nausea and vomiting
- Abdominal pain & distension
- Lymphoedema
- Fatigue
- Deep vein thrombosis
- Malnutrition

Occasionally there are indirect tumour effects termed “para-neoplastic” syndrome (see box 6.2). Such systemic metabolic effects may be the presenting features of the cancer but are usually more marked with advanced disease. Treatment of the underlying disease is the most beneficial therapy.

**Para-neoplastic Syndrome examples:**

<table>
<thead>
<tr>
<th>System</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Endocrine system</td>
<td>hypercalcaemia, inappropriate ADH secretion, Cushing’s syndrome</td>
</tr>
<tr>
<td>Renal System</td>
<td>nephrotic syndrome, obstruction by tumour products</td>
</tr>
<tr>
<td>Nervous system</td>
<td>cerebellar degeneration, peripheral neuropathy, encephalomyelitis</td>
</tr>
<tr>
<td>Haematological system</td>
<td>anaemia, thrombo-embolism, DIC</td>
</tr>
<tr>
<td>Muscle &amp; Joints</td>
<td>polymyositis</td>
</tr>
<tr>
<td>GI system</td>
<td>anorexia,Cachexia, malabsorption syndromes</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>fever of unknown origin</td>
</tr>
</tbody>
</table>

These rare syndromes result from the secretion of substances usually proteins, by the primary tumour or metastases. These substances include hormones, growth factors, cytokines, antibodies and other immune products (Haapoja 2000).

- Women with advanced ovarian cancer require a co-ordinated, multi-professional approach with access to a specialist palliative care team.
- Women with persistent poorly controlled symptoms should be referred to the specialist palliative care team.
### 6.4. Actions and Interventions

<table>
<thead>
<tr>
<th>IDENTIFICATION</th>
<th>CONSIDERATIONS – Resulting in Dysfunction</th>
<th>ACTION / INTERVENTION</th>
</tr>
</thead>
</table>
| **Removal of organs and tissues**  
Uterus  
Ovaries  
Cervix  
Shortened Vagina  
Bowel  
Bladder  
Lymph Nodes | **Physical** structural and functional changes.  
**Psychological**  
• Loss of fertility  
• Loss of self identity  
• Loss of femininity | Please see Core issues and appendices sexual health, menopause. Suggestion issues below.  
• Infertility – facilitate exploration of issues and support with info re treatment options. i.e. HRT and its alternatives  
• Dilator support and advice  
• National Networks  
• Psychosexual Counselor  
• Role of Complementary Therapies  
• Pain - refer to Palliative Care Regional Guidelines or Appendix  
• Psychosocial Support |
| **Urinary disturbances/alterations**  
Bowel problems  
Stoma formation. | Continence  
Body Image  
Skincare  
Underwear  
Pads | Refer to stoma/continence advisor.  
Referral to Dietician.  
Medication re Bowel and bladder symptoms e.g. Codeine Imodium Predsol.  
Assess physical need – maintain comfort and skin care  
Radar key for public toilets.  
Consider financial implications |
| **Bowel Obstruction** | | See regional guidelines |

See also appendix 7. Treatment induced Menopause
See also appendix 7.11 nursing management of the side effects of chemotherapy
See also appendix 7.12 nursing management of the side effects of Alopecia and hair thinning
7 APPENDICES

7.1 Treatment Induced Menopause

This is one of the side effects of many of the treatments used when treating a gynaecological cancer, this is not only applicable to the surgical removal of the organ, but the effect chemotherapy and radiotherapy also have upon the reproductive system.

- Surgery results in a sudden impact and permanent amenorrhoea.
- Chemotherapy effects usually occur over time 6-12 weeks post chemotherapy with potential for permanent amenorrhoea.
- Radiotherapy the effect is overtime but more rapid than chemotherapy, permanent amenorrhoea with radical radiotherapy.

It is the most common long-term consequence of survivorship, and the symptoms add to the distress of a cancer diagnosis.

Potential Impacts on the woman

Structural:
- Anatomical alteration
- Removal of organs
- Vaginal stenosis
- Altered body image.

Functional:
- Intense vasomotor symptoms
- Loss of fertility
- Sexual dysfunction
- Urogenital dysfunction
- Cognitive changes.

Psychological:
- Loss of identity
- Loss of self esteem
- Loss of self confidence
- Loss of image and status
- Loss of fertility
- Emotional response
- Anxiety
- Depression.
- Altered body image

Social:
- Loss of role (family, sexual and work)
- Loss of status
- Loss of youth
- Loss of identity with peers
- Impact of societies attitude.

Reading Material:
- www.marilynglenville.com excellent website for literature and vitamins

Support with verbal and written information and offer appropriate support network contact telephone number.
For vaginal dryness
- suggest and assess for the use of prescribed topical lubricants
- Offer informed advice around oral potential therapies in the form of vitamin E found in vegetable oils, cereals, dried beans and grains, calcium supplements, vitamin D, Bio phosphates.
- assess and advise re: conventional hormone replacement therapies and refer to appropriate health care practitioners as needed

Other therapies, which may be helpful in the menopause, include:

Dietary changes, exercise, homeopathic medicine, acupuncture, massage, aromatherapy and relaxation. Awareness of the National Osteoporosis Society, Tel 0845 450 0230 or www.nos.org.uk

Nurses should provide information and have the knowledge of how and where women can obtain the above therapies.

7.2 Infertility Needs / Issues

Unfortunately due to the stress surrounding the diagnosis and need for treatment, the quality of life issues regarding infertility can be overlooked.

The role and aim of Gynae/Onc nurses is to utilize opportunities to have an impact not only for the woman, but also her partner and family in exploring their identified met and unmet needs and expectations and provide support and written information on this subject.

**Support for infertility issues.**

- Develop a good rapport, allow exploration and acknowledgment of emotional feelings.
- Support the partner also.
- Provide information of treatment options, locally and nationally.
- Encourage use of support network
- Honesty regarding finances, expectations.
- Provide support and hopefulness, as new treatment modalities evolve.
- Ongoing support to help improve quality of life.

**Including**

- how treatments alter fertility
- treatment options / specialist centres
- Collection oocytes and rapid cycles of fertility to treatment for the storage embryo’s
- knowledge of up to date research/techniques
- legal and ethical implications
- psychological, social, cultural, gender and sexual health effects

It is suggested that nurses refer to the Gynaecology Oncology Group ward file and Link Nurse file on fertility issues.
Infertility: Links-Support

Infertility Network UK.
Charter House
43 St Leonards Rd
Bexhill on Sea
East Sussex
TN40 1JA
Tel: 0800 0087464. www.infertilitynetwork.com

The Role of the HFEA
Human Fertilisation Embryology Authority
Finsbury Tower
103-105 Bunhill Row
London EC1Y 8HF
Tel: 020 729 18200 www.hfea.gov.uk

British Infertility Counselling Association
69 Division Street
Sheffield
S1 4GE
WWW.BICA.NET

C.O.T.S. Childlessness Overcome Through Surrogacy.
Moss Bank
Manse Road
Lairg
IV27 4EL
Tel: 0844 414 0181 or 01549 402 777
Email: info@surrogacy.org.uk, WWW.surrogacy.org.uk
7.3 Holistic Needs Assessment Concerns Checklist.

Name…………………………………….  Date
Address…………………………………  Key Stage
Postcode ………………………………..  Assessor
Tel …………………………………………..  Signature

Patient Concerns Checklist

1. Using the thermometer, please circle a number that best describes how much stress you have felt in the past week, including today.

2. Please tick any concerns that have been a cause of distress for you in the past week, including today.

Very distressed

- 10  - 9  - 8  - 7  - 6  - 5  - 4  - 3  - 2  - 1

No distress

Practical/social concerns
- Child care
- Housing
- Insurance/finances
- Getting to places
- Work/school/college issues
- Feeling isolated
- Housework/shopping
- Washing/dressing
- Walking/getting around
- Preparing meals/drinks
- Sexual functioning

Family/relationship concerns
- Dealing with children
- Dealing with partner
- Dealing with people close to you
- Looking after parents
- Intimacy

Emotional concerns
- Depression
- Fears/worries
- Sadness/grief
- Anger
- Panicky
- Restlessness/unable to relax
- Nervousness
- Confusion/understanding
- Unable to make plans
- Loss of interest in usual activities
- Too much/too little information
- Conflicting/confusing information

Physical concerns
- Nose dry/congested
- Breathing difficulties/coughing
- Mouth sores/oral health
- Eating/drinking/swallowing
- Nausea/vomiting
- Indigestion
- Changes in bowel/constipation or diarrhoea
- Changes in urination
- Fatigue/tiredness
- Fevers/temperature changes
- Swelling
- Tingling in hands/feet
- Changes to skin/nails/hair
- Pain/changes in sensation
- Poor sleep
- Memory/concentration
- Body image
- Genital/gynaecological
- Fertility
- Weaknesses
- Weight loss
- Wound care
- Balance
- Hearing
- Seeing
- Speech

Spiritual/religious concerns
- Loss of faith
- Loss of meaning/purpose in life
- Relating to God
- Why me?

Other problems:
7.4 OUTLINE OF P-LI-SS-IT MODEL*

LEVEL 1: Permission (P)

The challenge for all nurses at level one is to create a comfortable environment that gives patients permission to discuss concerns and problems related to their sexuality and sexual health by:

- Ensuring the physical environment is comfortable and private.
- Communicating to the patient using acceptable counselling skills such as openness, reflection and paraphrasing
- Using cue questions to give the patient the opportunity to raise any sexuality and sexual health concerns
- Giving reassurance, where required, that the patient’s current sexual practices are appropriate and healthy, or that experimentation is appropriate
- Having a range of information available that is educational and non-personal
- Knowing where to get further information from, and routes of referral for the patient
- Acknowledging the needs of sexual partners. For example, the spouses and partners of people with dementia, or partners of gays or lesbians, may welcome specific supportive measures
- Acknowledging the sexuality and sexual health needs of patients in relation to their cultural background

LEVEL 2: Limited Information (LI)

This is where nurses provide non-expert, or limited information relating to sexuality and sexual health. For example, a woman receiving pelvic radiotherapy will need to know about vaginal dryness and possible implications for her future fertility; and a man who has had a prostatectomy will need to be told about retrograde ejaculation resulting in cloudiness in his urine.

LEVEL 3: Specific Suggestions (SS)

To provide specific suggestions to help patients with sexuality and sexual health needs, nurses need to complete training at specialist practitioner level. Nurses may have to advise patient with respiratory problems on ways to minimize breathlessness during sexual intercourse. Or the nurse may give advice on safe and comfortable positions for sex to patients with chronic arthritis, disability, or who are rehabilitating from a stroke.

LEVEL 4: Intensive Therapy (IT)

The most advanced level of nursing in sexuality and sexual health care involves complex interpersonal and psychological issues, and is used with patients who have specific sexual problems such as erectile dysfunction. Relationship counselling falls into this category.

Nurses providing this level of care will be specialists with family planning qualifications, and further training, for example in psychosexual counselling and therapy.
7.5 **Outline of the BETTER Model.** (Mick et al 2003)

- **B** Bringing up the topic
- **E** Explaining that sexuality is part of quality of Life and you are open to discussing the issues
- **T** Tell patients that sexual dysfunction can happen and that you will find appropriate resources to address their concerns.
- **T** Timing the discussion to the patient’s preference
- **E** Educating the patient about side effects of treatment which may impact on sexuality.
- **R** Recording in the case notes.

7.6 **Assessing Sexual Health Needs**

Incorporate a model of assessment i.e. PLISSIT (Appendix 7.3) or ask the following four questions as suggested by (Lamb & Woods 1981).

1. Has being ill interfered with you being a mother / father? Wife / husband/ partner
2. Has your illness changed the way you see yourself as a man/woman?
3. Has your illness affected your relationship with your partner?
4. Has the cancer affected your ability to function sexually

Consider other factors which may affect sexual function:
- Medical conditions
- Drugs
- Alcohol
- Psychological state
- Predisposing mental health conditions

Nurses can facilitate open communication regarding issues of sexuality by:
- being at ease with one’s own sexuality
- being non judgmental
- creating the appropriate environment and space
- ensuring privacy and confidentiality at all times
- encouraging a partner to be present if desired

Be prepared and have knowledge of the appropriate therapist to support the woman if it’s beyond your professional boundary.

A list of therapist may be obtained from
British Association for Sexual & Relationship l Therapists (National Registry)
The Administrator
BASRT
PO Box 13686.
London SW20 9ZH
www.Barst.org.uk
info@barst.org.uk

Also refer to Merseyside & Cheshire Palliative Care Audit Group Standards and Guidelines.
7.7 Support for Altered Body Image

**Assessment**

Use PLISSIT model Appendix 7.4
Use Questions appendix 7.5 and 7.6
Clarify and explore the fear or pre conception of the issues, using empathy and acknowledge apprehension and fear.

**Action**

Encourage the setting of small achievable realistic goals i.e. wearing comfortable underwear as opposed to net knickers.

Encourage the patient to touch the affected area, some patients may use a “facecloth” so that they are not directly touching the area, and gradually becoming more confident.

Progress on to visualising the area, starting with a brief glance with or without clothing whichever is more appropriate and building up to looking for longer periods of time.

Consider the use of a mirror to aid visualization as a clearer and larger view.

Provide support for the patient going through this process using explanations and empathy.

Give encouragement and assurance when providing care and support.

If recurring issues are identified, clarify them with the patient and negotiate a referral on to an appropriate health care professional e.g.

- Lymphoedema issues i.e. swollen limb – lymphoedema link nurse or practitioner.
- Bladders i.e. stress incontinence – urodynamics advisor / community continence advisor.
- Bowel i.e. recto vaginal fistula – continence advisor, stoma nurse.
- Stoma i.e. ileosotomy – stoma advisor
- Weight problems i.e. Too thin or obese – dietician
- Mobility or equipment i.e. bath aides or wheel chair – occupational therapist
- Social/ financial i.e. no finances – benefits advisor or social worker
- Emotional anxiety i.e. not coping – complementary therapist
- Psychological – psychologist or therapist
- Sexual health – psycho sexual counselor

Use local resources available, such as support groups, the local hospices and primary care teams.
Offers national support organizations that provide excellent written information; practical help and advice

7.8 Lymphoedema

Best Practice for the Management of Lymphoedema (2006) is a document produced an International Consensus group and endorsed by the British Lymphology Society in the UK. This Framework provides the standards of practice for people at risk of or who develop Lymphoedema. It gives step by step guidance and advice on Lymphoedema assessment and treatment decisions.

The Consensus document defines Lymphoedema as a swelling of one or more limb and may include the corresponding quadrant of the trunk. It can also affect areas such as the neck and genitalia. It is the result of accumulation of fluid and other elements i.e. proteins in the tissue spaces due to an imbalance between interstitial fluid production and transport. It can be primary i.e. a congenital problem or secondary as a result of surgery or treatment which has
affected the lymphatic system. It is quoted 28-47% patients which gynaecological cancer will develop it (Ryan et al, 2002, Hong 2003 in Consensus Document).

Lymphoedema is not life-threatening but can be very distressing, causing major physical psychological and social problems. There is no cure for lymphoedema but with patient cooperation and appropriate treatment it can be kept under control. (BLS 2001)

If lymphoedema is suspected i.e. 1 or 2 swollen legs it is vital that a DVT excluded by Doppler scan. If possible also ascertain if the cause for this presentation isn’t recurrence of disease by way of a scan or clinical examination. Prior to giving advice.

Not all lymphoedema problems will be apparent immediately post-op, therefore monitoring should continue with patients in Outpatient follow ups.

**Nursing Interventions**

- Commence on-going assessment and education in lymphoedema management in pre-op and post-op period
- Provide written and verbal information on skin care, massage and exercise post op
- Provide contact numbers and information of local / national support networks
- Offer advice on hosiery and support garments if patient develops lymphoedema
- Refer to lymphoedema practitioner for ongoing assessment and management as appropriate

**4 Corner stone’s of Care.**

- **SKIN CARE**- to maintain good skin condition, or reverse skin changes caused by oedema.
- **EXERCISE** – to enhance muscle pumping action upon lymphatic drainage without over exertion, to help maintain/improve range of movement.
- **SIMPLE LYMPH DRAINAGE** – helps stimulate normal draining lymphatics, and siphons fluid away from congested areas.
- **COMPRESSION HOSIERY** – enhances lymph drainage by improving muscle pump efficiency.

**TREATMENT OBJECTIVES.**

- Reduction or maintenance of excess limb volume.
- Reduction of pain or discomfort.
- Maintain or improve function.
- Avoids episodes of infection.
- Improves quality of life.

**PATIENT COMPLIANCE.**

The patient needs to be aware that their role in the treatment plan is recognised as being a vital component of the plan, (Twycross 2000)

It is suggested nurses refer to the Gynaecology Pathway and Mersey Palliative Care Audit Group standards and guidelines.

**7.9 The Role of Nutrition and the Dietitian in Gynaecological Cancers.**

The role of nutrition is important in all stages of the cancer journey from diagnosis through to intensive treatments and including the palliative stage, by helping to control symptoms, maintain nutritional status and improve quality of life. Studies suggest that loss of appetite and weight are the most distressing aspects of the disease for many patients and their carers.
Identification of patients who are malnourished or at risk of becoming malnourished should be a high priority and it is recommended by BAPEN that all patients should be screened as part of the admissions process using a validated nutrition assessment tool such as MUST (Malnutrition Universal Screening Tool). Vulnerable patients should then be referred to a dietician. Early intervention enables problems to be identified and addressed at an early stage.

The role of the Registered Dietician is to assess, advice and monitor and needs to be carried out as part of the multi-disciplinary team. All members of the team can play a part in helping to improve the nutritional status of the patient and should be aware of their role. In general, between 30 and 50% of all food provided in hospitals is wasted and average food intakes are less than 75% of that recommended (Allison 1999). It is therefore particularly important that staff at ward level monitor the intakes of vulnerable patients and refer to the dietician when needed. Systems such as the ‘red tray’ given to vulnerable patients at mealtimes can help ensure extra support is given.

Nutrition support is particularly important for patients with gynaecological cancers because of the location of the large and small bowel in the pelvic area. The presence of the tumour and treatments to this area can lead to bowel problems which may severely compromise nutritional status. For this reason, nutrition support is particularly important during radiotherapy and chemotherapy, when the effects of the treatment, including diarrhoea, constipation, anorexia, taste changes, nausea and vomiting can rapidly lead to malnutrition and reduced ability to withstand the effects of treatment. All patients should undergo nutrition screening such as MUST prior to treatment to identify those at risk and weight and intake monitored during treatment.

Referral to a dietician is particularly important for patients experiencing radiation enteritis as this group can have bowel problems which may have a serious effect on their quality of life and may continue in the long term. Many such patients will benefit from a referral to a gastroenterologist.

Patients with bowel problems, which may require a low residue diet such as fistula or obstruction or other problems such as short bowel syndrome, ileostomy or colostomy should always be referred to a dietician as this group is at increased risk of malnutrition.

Dieticians also have a role to play in the survivorship programme. Appropriate dietary and lifestyle advice.e can help improved health, quality of life and outcome.

7.10 Clinical Trials and the Role of the Research Nurse Practitioner

Advances in medical treatments available today have occurred because of the application of new knowledge gained from experiments conducted over the last 250 years. New treatments for gynaecological cancers are being developed all the time. Although we have many new ways to treat cancer today, we do not have all the answers, and often do not have proof or clear evidence to show that one treatment option is better than another.

For example randomized clinical trials have provided the strongest evidence on the efficacy of surgical and chemotherapy treatments for ovarian cancer. Despite their value, recruitment to trials is often limited with only a small proportion of ovarian cancer patients receiving treatment as part of a clinical trial (SIGN 2003).

The ultimate objectives of clinical studies in oncology are too;

- Increase the cure rate,
- Prolong survival or
- Improve quality of life for patients.
Summary of the Development of New Therapeutic Modalities.

<table>
<thead>
<tr>
<th>Preclinical:</th>
<th>Idea</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Laboratory development</td>
</tr>
<tr>
<td></td>
<td>Animal testing and defining toxicities</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Clinical Trials:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase I</td>
<td>Preliminary testing in humans</td>
</tr>
<tr>
<td>Phase II</td>
<td>Preliminary testing in specific tumour sites</td>
</tr>
<tr>
<td>Phase III</td>
<td>Full scale clinical evaluation</td>
</tr>
<tr>
<td>Phase IV</td>
<td>Post marketing surveillance</td>
</tr>
</tbody>
</table>

**Preclinical research**

New drug development is a multi-step process where a sound scientific concept or idea is translated from theory into the development of a new drug or treatment. Alternatively large numbers of chemicals or natural products are screened in the hope of discovering a useful compound. The potential new treatment is tested on cancer cells grown in test tubes (in vitro) or tumours grown in rodents (in vivo). The main objective after determining a response is to define a starting dose safe to use in man. In addition information about the nature and the reversibility of side effects (toxicities) is gathered.

**Clinical Trials**

**Phase I**  After scientists have spent many years testing the drug on cancer cells in the laboratory setting observing an effect, the drug then enters this next phase. These studies have small numbers of patients and are only offered to patients whose cancer is not curable and for which there is no other standard treatment. It is not expected that the treatment will cure the cancer, rather that the trial aims to:
- Identify toxicities including the dose limiting toxicity (DLT),
- Establish the maximum tolerated dose (MTD) for use in phase II
- To determine the anti–cancer effect i.e. is it an active drug.
- Investigation of pharmacokinetic behaviour

Clinical experience has shown that some health care professionals may be skeptical about patients entering phase I trials, they feel it is unethical because of the poor chance of response (5%). However patients themselves challenge this viewpoint. Hutchison’s (1998) study suggests that although patients may hope for a therapeutic benefit they do not all expect it. Often they feel altruistic and wish to contribute to future ‘cures’ for others as they have no other options left.

**Phase II**  If the drug shows cancer activity in phase I then it can enter phase II. Researchers know a lot of information about this drug i.e. the dose to use and potential side effects. The aim of this stage is to:
- Identify which type of cancer responds to the drug
- Identify the optimal schedule (best way to give it)
- Further document the spectrum and frequency of toxic effects particularly cumulative toxicities.

Again only small numbers of patients will enter this phase (20-40).

**Phase III**  This final phase will determine whether or not this new drug is effective enough against cancer to obtain a license and be marketed as an established treatment. The aim is:
- To compare the effectiveness and safety of the trial drug with the best current standard treatment available (which may be no treatment).
- To determine the therapeutic benefit of the trial drug.
These are *Randomized Controlled Trials (RCT)* with half the patients in the trial receiving the trial drug/new treatment and the other half standard treatment. Once a patient has consented to take part in the trial a computer randomly decides which treatment the patient receives. This phase may involve hundreds sometimes thousands of patients and may take many years to complete.

**The Role of the Research Practitioner**

The role of the research practitioner is multifaceted and pivotal in the successful implementation and evaluation of clinical trials. Working closely with all members of the Merseyside and Cheshire Gynaecology team the aim is to offer the opportunity for women fulfilling the eligibility criteria to enter into a clinical trial, which has been approved by the local ethics committee.

All trials are well regulated and strictly monitored. To ensure that accurate data is obtained there are specific rules or criteria, which determine whether or not a woman is eligible to participate. The research practitioner provides both verbal and written information to ensure that the patient is able to make an informed decision, explaining and ensuring that she and her family understand the aims and commitments of the study.

Entry into the study is voluntary, if women are invited to enter but do not wish to do so this in no way affects their rights or treatment that they subsequently receive. Also a woman may withdraw from a trial at any time without a reason and this will not affect their care.

---

**Treatment options discussed at combined oncology/gynaecology clinic.**

**Trial vs Standard treatment**

1. If the patient agrees to consider trial participation -> screening investigations as part of the eligibility criteria. (If more investigations than normal are required a consent form may be required to be signed at this point)

2. **Eligible**
   - Treatment as per protocol once informed consent signed
   - Treatment evaluation as per protocol
   - Response
   - Progression
   - FU as per protocol

3. **Not Eligible**
   - Return to original treatment options if appropriate
     - No treatment
     - Standard treatment
     - Different Trial
   - FU as per protocol
At each step in the process the nurse plays a key role in assisting the patient to understand and commit to protocol requirements. 

**The success of a clinical trial is dependent on the efforts of a multidisciplinary team. Nurses are integral members of this team whether their focus is on primary care of the patient or on the conduct of clinical trials.**

Research fills a vital and important role in our society. Informed consent, defined as a process rather than merely a onetime contractual agreement, plays an essential role in clinically based research. The role of the nurse in assuring that a potential participant is fully informed and willing to enrol or remain in a clinical trial is pivotal to gaining the requisite knowledge to move science forward and to ultimately identify and influence health care outcomes.

**The Future?**

As previously mentioned there is an ongoing search for new treatments for gynaecological cancers mostly related to the biological processes involved in the development of cancer. Non-chemotherapy treatments may include “biological response modifiers” which are large molecules that exert an effect on the immune system of the patient and include interferons, interleukins, monoclonal antibodies and tumour vaccines. Ongoing clinical trials with a cervical cancer vaccine have recently reported positive results (CRUK 2004).

Another area being extensively explored is that of small molecules which may interfere with aberrant signal transduction or gene expression. There is also great interest in the genetic manipulation of tumours.

Research gives hope, hope for the future ..........
7.11 **Nursing management of the side-effects of Radiotherapy:**


<table>
<thead>
<tr>
<th>Irradiated body part / organ</th>
<th>Radiation effect</th>
<th>Nurse intervention</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General</strong></td>
<td>Fatigue</td>
<td>Forewarn patients of the likely occurrence during and post radiotherapy. Provide appropriate information about the experience and pattern of symptoms. Assess and promote self-care strategies. Referring to appropriate AHCP’s as necessary.</td>
<td>To foster independence, encouraging energy saving activities. Slowly increase activity. To prevent feelings of social isolation, low mood and decrease anxiety levels.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Assess baseline fatigue levels prior to treatment starting</td>
<td>To monitor changes over time and need for further intervention.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Check for physical, biochemical and psychological causes of fatigue.</td>
<td>Electrolyte imbalances/anaemia may be corrected. Appropriate psychological support can be given.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Encourage patients to maintain a daily record of fatigue levels and the relationship to activities.</td>
<td>Enhances the ability to control activities or plan ahead, goal setting and prioritizing.</td>
</tr>
<tr>
<td><strong>Skin</strong> – some areas more at risk of reactions i.e. groin, skin folds.</td>
<td>General Advice</td>
<td>When washing/bathing/showering on a daily basis: • Use warm/tepid water, with un-perfumed soap if desired. • Do NOT use perfumed products within the treatment area • Avoid rubbing the treatment area and use a soft towel to pat the area dry (avoiding friction) (Scottish guidelines 2010, Kumar et al 2001) • Avoid direct application of heat or cold to the area. • Friction will be reduced with the avoidance of scratching, rubbing and massaging the skin. • Loose natural fibre clothing will help avoid friction. • Use of a mild detergent (fragrance-free if possible), for washing clothing to be worn next to the skin. • Adhesive tape should always be avoided within the treatment area during treatment and until any reaction has settled. • Avoid sun exposure or cover the area during treatment and until any skin reaction has settled. There is a permanent risk of developing a skin cancer at the irradiated site, so appropriate protective measures should continue indefinitely, particularly when the irradiated area is a habitually sun-exposed site.</td>
<td>May reduce irritation to skin</td>
</tr>
<tr>
<td>Irradiated body part / organ</td>
<td>Radiation effect</td>
<td>Nurse intervention</td>
<td>Rationale</td>
</tr>
<tr>
<td>-----------------------------</td>
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</tr>
<tr>
<td><strong>Skin</strong></td>
<td>No Visible change to skin</td>
<td>To apply aqueous cream initially twice a day</td>
<td>Promote hydration to the skin and skin integrity.</td>
</tr>
<tr>
<td>RTOG 1</td>
<td>Faint or dull erythema. Mild tightness of skin including itching</td>
<td>Increase use of aqueous as needed. 1% hydrocortisone cream may be helpful. Also oral analgesia</td>
<td>Promote hydrated skin, patient comfort and maintain skin integrity, To treat itchy skin and reduce soreness, pain and discomfort.</td>
</tr>
<tr>
<td>RTOG 2</td>
<td>Bright erythema / dry desquamation. Sore/itchy and tight skin</td>
<td>Increase aqueous, and continue hydrocoriscone</td>
<td>Promote hydrated skin, patient comfort and maintain skin integrity, To treat itchy skin and reduce soreness, pain and discomfort.</td>
</tr>
<tr>
<td>RTOG 2.5</td>
<td>Patchy moist desquamation. Yellow/pale exudates. Soreness with oedema</td>
<td>Continue aqueous on unbroken skin. Stop hydrocortisone on unbroken skin. Apply appropriate dressing on exuding areas (e.g polyMen, Mepilex). Analgesia, Loose fitting clothing</td>
<td>To promote comfort, reduce risk of infection, complications or trauma.</td>
</tr>
<tr>
<td>RTOG 3</td>
<td>Confluent, moist desquamation. Yellow/pale exudates. Soreness with oedema</td>
<td>Stop using aqueous on broken/moist skin. Continue as per RTOG 2.5. Trimovate is only indicated if infection is likely to occur.</td>
<td>To promote comfort, reduce the risk of complications of further trauma and infection.</td>
</tr>
<tr>
<td>RTOG 4</td>
<td>Ulceration, bleeding, necrosis (rare)</td>
<td>Seek specialist advice i.e clinical oncologist, Clinical Nurse/radiographer Specialist in your area.</td>
<td>Some patients are unable to eat after treatment due to nausea.</td>
</tr>
</tbody>
</table>

**Abdomen and pelvis**

1. Nausea and vomiting. Due to inflammation of gastrointestinal epithelium; also a generalized radiation reaction

<table>
<thead>
<tr>
<th>Nurse intervention</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Encourage a small meal 3 hours before treatment and light snacks after. Regular antiemetics: systematically try various kinds and routes Distraction/relaxation techniques. Monitor fluid and food intake</td>
<td>Some patients are unable to eat after treatment due to nausea. Regular administration required to prevent and relieve nausea. There may be a contributing psychological factor in nausea (Holmes 1996) To avoid dehydration</td>
</tr>
<tr>
<td>Irradiated body part / organ</td>
<td>Radiation effect</td>
</tr>
<tr>
<td>-----------------------------</td>
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</tr>
<tr>
<td>2. Diarrhoea, possibly accompanied by rectal bleeding</td>
<td>Maximise privacy</td>
</tr>
<tr>
<td></td>
<td>Administer antidiarrhoeals as prescribed</td>
</tr>
<tr>
<td></td>
<td>Low-residue, bland diet, low fat</td>
</tr>
<tr>
<td></td>
<td>Observe for dehydration</td>
</tr>
<tr>
<td></td>
<td>Maintain high fluid intake</td>
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<tr>
<td></td>
<td>Observe peri anal skin: gently apply barrier cream after washing if necessary</td>
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<tr>
<td></td>
<td>Refer to dietician</td>
</tr>
<tr>
<td>Cystitis due to inflammation of urinary tract. Predisposition to urinary tract infection</td>
<td>Encourage high fluid intake (3 L daily)</td>
</tr>
<tr>
<td></td>
<td>Encourage and/or assist with personal hygiene</td>
</tr>
<tr>
<td></td>
<td>Regular collection of urine specimens for microbiology</td>
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<tr>
<td>Altered sexual function (degree depends on exact treatment site and dosage)</td>
<td>Psychological support and counselling</td>
</tr>
<tr>
<td></td>
<td>Include partner in discussion if patient wishes</td>
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<tr>
<td></td>
<td>Assess the need for psycho-sexual counselling</td>
</tr>
<tr>
<td>Women: Sterility (if ovaries are irradiated). May be temporary or permanent Dyspareunia due to vaginal fibrosis and dryness</td>
<td>Advise continued contraception during and for several months after treatment</td>
</tr>
<tr>
<td></td>
<td>Advise use of water based vaginal lubricant</td>
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<tr>
<td></td>
<td>Use of barrier contraceptives e.g. condom during intercourse</td>
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<tr>
<td></td>
<td>Education and use of vaginal dilators during (if tolerated). If not sexually active can stop at end of follow up. For younger ladies to continue despite being sexually active. If sexually active use 1-2 a twice in combination.</td>
</tr>
<tr>
<td></td>
<td>This should be reviewed regularly by the clinician</td>
</tr>
<tr>
<td>Irradiated body part / organ</td>
<td>Radiation effect</td>
</tr>
<tr>
<td>----------------------------</td>
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</tr>
<tr>
<td></td>
<td>Premature menopause (if ovaries irradiated)</td>
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</tbody>
</table>

### 7.12 Nursing Management of Chemotherapy Related Toxicity

The following information is to be used as a guide, please refer to up to date local chemotherapy administration, extravasation and anaphylaxis guidelines/policies and appropriate texts (see references). All suspected chemotherapy related adverse events should be reported to CCO.

Guide to illustrate main Cytotoxic drugs used presently in the treatment of Gynaecological Cancers and their common side effects.

<table>
<thead>
<tr>
<th>Drug Type (Brand Name)</th>
<th>Common Side Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cisplatinum (Cisplatin)</td>
<td>Bone Marrow Depresssion – anaemia, thrombocytopenia, neutropenia (leucopenia) nadir days 7-10, Nausea &amp; vomiting, Diarrhoea (high doses), Metallic taste, Renal toxicity, Ototoxicity – tinnitus, high frequency hearing loss, Peripheral neuropathy (tends to manifest 6 wks post treatment), Occasional allergic reaction/ anaphylaxis</td>
</tr>
<tr>
<td>Carboplatin</td>
<td>Bone Marrow Depresssion – anaemia, thrombocytopenia, neutropenia (leucopenia) nadir days 14-17, Nausea &amp; vomiting/anorexia/thinning/brittle hair, Diarrhoea (high doses)/constipation, Metallic taste, Renal toxicity, Occasional neurological toxicity particularly if pretreated with cisplatin, Occasional allergic reaction /anaphylaxis, rash</td>
</tr>
<tr>
<td>Paclitaxel (Taxol)</td>
<td>Allergic reaction / Anaphylaxis, Bone Marrow Depresssion – anaemia, thrombocytopenia, neutropenia (leucopenia) nadir day 4-7, Hypotension, Nausea &amp; vomiting – mild, Diarrhoea – mild -&gt; moderate, Mucositis, Alopecia, Arthralgia / Myalgia, Sensory peripheral neuropathy – numbness, Tingling, Burning, Extravasation.</td>
</tr>
<tr>
<td>Liposomal Doxorubicin (Caelyx)</td>
<td>Bone Marrow Depression – anaemia, thrombocytopenia, neutropenia (leucopenia) nadir days 7-14</td>
</tr>
</tbody>
</table>
- Allergic reaction – fever, chills, backache, hot flushes, occasional anaphylaxis
- Mucositis
- Skin changes – darker pigmentation, sun hypersensitivity, Palmar / Plantar Erythema (PPE) or Hand/Foot Syndrome
- Urine discoloration
- Mild Nausea & Vomiting
- Fatigue
- Cardiac changes
- Hair thinning

**Doxorubicin (Adriamycin)**
- Bone Marrow Depression – anaemia, thrombocytopenia, neutropenia (leucopenia) nadir days 10-14
- Mucositis
- Skin changes – darker pigmentation, sun hypersensitivity, nail ridging
- Urine discoloration / Red urine
- Nausea & Vomiting
- Cardiac myopathy
- Hepatotoxicity
- Extravasation
- Alopecia

**Topotecan**
- Bone Marrow Depression (anaemia, thrombocytopenia, neutropenia (leucopenia) nadir days 10-14
- Occasional mucositis
- Mild nausea
- Hair thinning
- Diarrhoea
- Fatigue

**Gemcitabine**
- Bone Marrow depression.
- Allergic reaction
- Nausea & Vomiting
- Loss of apetite
- Liver changes (lfts to be monitored during treatment likely to return to normal following)
- Sore Mouth
- Breathlesness
- Diarrhoea/Constipation
- Hair may thin or fall out
- Impact on fertility
- Skin Reaction
- Fluid retention
- Flu like symptoms
- Fatigue
- Renal toxicity (rare)

Other general side effects can include fatigue, anorexia, taste changes, effects on fertility i.e. premature menopause etc. It is not possible in this document to discuss all the possible toxicities and their management however below are guidelines for the management of *selected* toxicities. Side effects of chemotherapy may occur with varying degrees, often dependent on regime and/or dose, everyone having their own individual experience of treatment.

*However if the patient is not educated or the appropriate intervention carried out some of these potential effects may become life threatening very quickly.*

Effective communication skills and up to date knowledge are essential requirements for carrying out a comprehensive assessment of the degree of toxicity experienced by individuals, which may require a treatment dose reduction or further intervention. A toxicity grading system such as the NCI’s Common
Toxicity Criteria (CTC) is beneficial for assessment of toxicities and assists with decision-making regarding dose reduction or treatment delays.

<table>
<thead>
<tr>
<th>Toxicity</th>
<th>Intervention</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bone Marrow</td>
<td>♦ Observe for pallor, dizziness, dyspnoea, tachycardia, hypotension, headaches, palpitations, irritable</td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>♦ Full blood count pre treatment and if symptomatic</td>
<td>To prevent hypovolaemic shock and minimise associated fatigue and thus improve QOL.</td>
</tr>
<tr>
<td>Anaemia</td>
<td>♦ Establish other risk factors for low Hb such as acute/chronic haemorrhage, bone marrow failure</td>
<td>To promote comfort and prevent any complications.</td>
</tr>
<tr>
<td></td>
<td>♦ Blood transfusion or administration of s/c erythropoietin as per local policy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>♦ Energy conservation measures as for fatigue</td>
<td></td>
</tr>
<tr>
<td>Thrombocytopenia</td>
<td>♦ Baseline FBC</td>
<td>To prevent / minimise bleeding which may become life threatening. Spontaneous bleeding occurs when Pl&lt;20</td>
</tr>
<tr>
<td></td>
<td>♦ Inform medical staff or chemo triage team at CCO if platelets &lt; 100</td>
<td>Symptoms of haemorrhage</td>
</tr>
<tr>
<td></td>
<td>♦ Educate patient to observe for early signs - &gt; excessive bruising, nose bleeds, bleeding gums, petechiae, purpura in the skin &amp; mucous membranes, haematuria, bleeding etc and report to medical staff as per local policy. Recheck platelet count.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>♦ Be aware of other medications which affect platelet count e.g. Dipyridamole, aspirin etc. and those that irritate the gastric mucosa e.g. NSAID's</td>
<td></td>
</tr>
<tr>
<td></td>
<td>♦ Administration of platelet transfusion for active bleeding as per policy.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>♦ Avoid practices that increase risk of active bleeding or trauma e.g. Contact sports, use of razor</td>
<td></td>
</tr>
<tr>
<td></td>
<td>♦ If Pl&lt;50 avoid where possible invasive procedures e.g. PR medication, enemas, injections etc</td>
<td></td>
</tr>
<tr>
<td></td>
<td>♦ Observe for pallor, dyspnoea, tachycardia, hypotension, changes in mental and neurological status.</td>
<td></td>
</tr>
<tr>
<td>Neutropenia</td>
<td>♦ Baseline FBC</td>
<td>To minimise risk of infection and prevent sepsis which is life threatening.</td>
</tr>
<tr>
<td></td>
<td>♦ Inform medical staff at CCO if WBC &lt; 3.0, Neuts &lt; 1.5 pre chemotherapy</td>
<td>Active treatment required as soon as possible to prevent sepsis.</td>
</tr>
<tr>
<td></td>
<td>♦ Educate patients and carers to observe for signs of infection and report any signs/symptoms to medical staff immediately. Contact CCO Chemo Triage team for advice if any uncertain. Repeat FBC is required.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>♦ If Temp &gt; 38°C or feeling unwell instruct patient to contact CCO Chemo triage team – 24hr telephone numbers should be given to the patient and their carers. Repeat FBC &amp; blood cultures are required.</td>
<td></td>
</tr>
<tr>
<td>Toxicity</td>
<td>Intervention</td>
<td>Rationale</td>
</tr>
<tr>
<td>----------</td>
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</tr>
</tbody>
</table>
| ♦ If febrile, infection screening required, MSU, Faecal specimen, wound swab for sensitivity, blood cultures. Antibiotics administered as per protocol.  
♦ If neutrophils are < 0.5 reverse barrier nursing may be required. (See local guidelines). If asymptomatic patient needs to be protected from infection.  
♦ Administration of Granulocytic Colony Stimulating Factor (GCSF) may be required.  
♦ Avoid use of corticosteroids  
♦ Ensure good dietary intake (high protein & calories), if prolonged neutropenia refer to the dietician for a ‘clean’ diet.  
♦ Ensure adequate fluid intake 2-3L/day  
♦ Minimise invasive procedures and promote integrity of skin & mucous membranes.  
♦ Provision of emotional and psychological support for the patient and their family.  
♦ Ensure meticulous oral hygiene is carried out. Refer to local evidence based guidelines | To identify the source of infection so that appropriate treatment may be administered.  
To stimulate stem cells to mature into neutrophils.  
Steroids may mask infection  
To provide energy to combat infective processes and aid healing.  
Prevent dehydration  
To decrease the risk of trauma and thus infection  
The patient is often very unwell particularly if septic and this may be a frightening experience for all concerned. Most septic episodes originate from the oral cavity due to mucositis and the breakdown of mucosal integrity | |
| ♦ Assess risk factors for nausea & vomiting – prone to indigestion, motion sickness, anxiety, morning sickness in pregnancy, bowel obstruction etc  
♦ Explore remedies that have previously been helpful in alleviating nausea.  
♦ Use of complementary therapies acupuncture, relaxation, distraction, visualization  
♦ Use of a short acting benzodiazepine e.g. Lorazepam to reduce anxiety and alleviate anticipatory N&V.  
♦ Ensure all anti-emetics prescribed are taken regularly after the FIRST cycle of chemotherapy and not as required.  
♦ Suitability of prescribed anti-emetic should be assessed. Educate patient to take anti-emetics as prescribed and warn of potential side effects: Steroids – gastric irritation, must be taken with food  
- Increase in blood sugar  
- Mask infection  
- Hyperactivity and mood irritability, therefore instruct to take before 4pm and some | Risk assessment to ensure appropriate antiemetic regimen given and minimise risk of anticipatory N&V occurring.  
If the patient experiences no or minimal nausea, anxiety is decreased and subsequent treatments are better tolerated. Medication taken regularly maintains optimal blood levels and is more effective.  
To minimise complications and further side effects.  
May require H2- antagonist (e.g. ranitidine) or proton pump inhibitor (e.g.omeprazole) which inhibit gastric acid and thus reduce gastric irritation. | |

## Toxicity

<table>
<thead>
<tr>
<th>To optimise anti-emetic regimen.</th>
<th>To reduce anxiety and provide reassurance that they are in a safe environment. Early signs may prevent a more serious event.</th>
<th>A reaction to treatment will be prevented.</th>
</tr>
</thead>
<tbody>
<tr>
<td>♦ Assessment of potential risk either due to known side effect of the drug or patient history / risk factors e.g. asthma, hay fever, eczema etc.</td>
<td>♦ Baseline vital signs</td>
<td>♦ To anticipate and prevent reaction by administering pre-medications.</td>
</tr>
<tr>
<td>♦ Steroid and antihistamine pre-medication regimen as prescribed prior to treatment.</td>
<td>♦ Ensure patient and relatives warned, told what to expect and action to be taken if a reaction occurs. Advise of the signs and symptoms and instruct to report immediately.</td>
<td></td>
</tr>
<tr>
<td>♦ Ensure emotional and psychological support is given. Deal with the situation in a calm, relaxed environment.</td>
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</tr>
</tbody>
</table>

### Allergic Reactions / Anaphylaxis

**IN CASE OF ACUTE REACTION REFER TO LOCAL ANAPHYLAXIS POLICY**

<table>
<thead>
<tr>
<th>To anticipate and prevent reaction by administering pre-medications.</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>♦ To optimise anti-emetic regimen.</td>
<td></td>
</tr>
<tr>
<td>♦ To reduce anxiety and provide reassurance that they are in a safe environment. Early signs may prevent a more serious event.</td>
<td></td>
</tr>
<tr>
<td>♦ A reaction to treatment will be prevented.</td>
<td></td>
</tr>
</tbody>
</table>

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5HT3 antagonists e.g. Ondansetron, Granisetron
- headaches
- constipation which may be severe. Prophylactic laxatives are required for many women post surgery, with advanced disease where gut motility is reduced.

Metoclopramide - may cause dystonic reactions particularly in younger women (40yrs). Cogentin may be required as an antidote.

- If gastric absorption is poor alternative methods of anti-emetic administration should be explored e.g. PR intervention, use of continuous subcutaneous anti-emetics via a syringe driver
- Prior to each chemotherapy cycle assess and evaluate effectiveness of anti-emetic regimen. Also assess for other causative factors, which may require alternative treatment or investigation e.g. Constipation, bowel obstruction, UTI, liver or brain metastases etc
- Encourage small meals often, low in fat, bland minimal spices.
- Dietician referral may be required
- Minimising strong odours e.g. Perfumes, foods etc when chemotherapy is being administered
- Provision of calm, relaxing environment with decreased stimuli, fresh air.

Foods high in fat increase gastric acidity and therefore irritation in the gastric mucosa, causing nausea. To prevent malnutrition and excessive weight loss. May stimulate vomiting reflex and be associated with anticipatory N&V

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### Guidelines 2013-2016

Page 66
<table>
<thead>
<tr>
<th>Toxicity</th>
<th>Intervention</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>a calm, confident and reassuring manner at all times. ♦ Observe for signs and symptoms of anaphylaxis; <strong>Mild</strong> – flushing, headache, urticaria, N&amp;V, light headedness, dyspnoea, generally feeling unwell. <strong>Moderate</strong> – wheezing, facial oedema <strong>Severe</strong> – sudden hypotension, tachycardia, changes in levels of consciousness, bronchospasm, respiratory arrest, cardiac arrest.</td>
<td>In all cases the infusion should be STOPPED and reported to medical staff once patient safety &amp; comfort established. Never leave the patient alone due to potential collapse. Policies &amp; procedures for such an emergency situation should be followed. <strong>Mild</strong> – further IV hydrocortisone &amp; IV chlorpheniramine may be administered and once the patient is relaxed and symptoms have resolved the infusion may be restarted slowly and titrated up as tolerated or given at a lower rate over a prolonged time. <strong>Moderate – Severe</strong> – Oxygen, Adrenalin etc, emergency procedures for respiratory/cardiac arrest.</td>
<td>very frightening for the patient and carers, leading to anxiety and fear of further treatment, or treatment being discontinued.</td>
</tr>
</tbody>
</table>

**Renal toxicity**
- Baseline Urea, Creatinine, calculated creatinine clearance (CrCl)
- IV hydration pre and post chemotherapy if CrCl <50 or cytotoxic drug known to be nephrotoxic e.g. Cisplatin
- Ensure adequate urine output i.e. equivalent to 100mls urine passed /hr
- Renal function must be closely monitored throughout treatment and periodically post completion.
- If symptoms of renal toxicity develop or there is pre-existing renal impairment there should be a chemotherapy dose reduction.
- Hypomagnesaemia & hypocalcaemia may occur resulting in symptoms of muscular spasm, cardiac arrhythmia, tingling of the fingers, tetany, and tremors. Both occur together and require replacement.

To assess kidney function and hydration status. Further pre or post hydration may be required to optimise renal excretion and prevent nephrotoxicity.

Forced diuresis may be required with further hydration and use of diuretics.

**Hepatotoxicity**
- Baseline Bilirubin and transaminases (ALT, AST)
- If higher than normal level of bilirubin, chemotherapy should be withheld and discussed with medical staff
- Abnormally high transaminase levels should be discussed with medical staff.
  ♦ Observe for signs of jaundice – test urine for bilirubin

To assess liver function and ability to metabolise medication. For chemotherapy drugs excreted by the liver (doxorubicin), abnormal liver function leads to excessive toxicity and places the patient in a potentially life threatening situation. Give an indication of level of liver function.
<table>
<thead>
<tr>
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<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>♦</td>
<td>Obtain a baseline if person experienced any neuropathy previously, or any medical history which could contribute to this.</td>
<td>To highlight if potentially at great risk.</td>
</tr>
<tr>
<td>♦</td>
<td>Consider alternative causes of the neuropathy e.g. direct pressure on the nerves</td>
<td>To exclude other causes and ensuring is chemotherapy related.</td>
</tr>
<tr>
<td>♦</td>
<td>Observe for signs of neuropathic disturbance especially in the hands and feet e.g. altered sensation cold or heat, heaviness sensations of electric shocks or pins and needles. Assess if these are constant or triggered by things such as holding a cup.</td>
<td>To assess the extent of the problem and how much impact it is having on independent and activities of living.</td>
</tr>
<tr>
<td>♦</td>
<td>Grade neuropathy Grade 0-4 NCI Common toxicity Criteria version 2.</td>
<td>To allow for standardized assessment, and the appropriate intervention.</td>
</tr>
<tr>
<td>♦</td>
<td>Grade 0 no effect on life.</td>
<td></td>
</tr>
<tr>
<td>♦</td>
<td>Grade 1 Loss of deep tendon reflexes or paraesthesia but not interfering with function.</td>
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<tr>
<td>♦</td>
<td>Grade 2 objective sensory loss or paraesthesia interfering with but not affecting daily living</td>
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<tr>
<td>♦</td>
<td>Grade 3 sensory loss or paraesthesia interfering with daily living.</td>
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<td>♦</td>
<td>Grade 4 permanent sensory loss that interferes with function.</td>
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<td>♦</td>
<td>If neuropathy having a marked effect upon life then discuss with the medical staff as may benefit from a dose reduction chemotherapy</td>
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<td>♦</td>
<td>If severe chemotherapy may need to be altered or stopped.</td>
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<tr>
<td>♦</td>
<td>Provide emotional support for the person as neuropathy can result in lower self esteem and distress.</td>
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<tr>
<td>♦</td>
<td>Medications may benefit from simple analgesia on a regular basis, NSAIDS could also be considered.</td>
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<tr>
<td>♦</td>
<td>If nil effect then considered medications for neuropathy.</td>
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<td>♦</td>
<td>Considering referring on the specialist pain team for additional advice and support.</td>
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<td>♦</td>
<td>Consider referral on to other members of the MDT to assess and contribute to future management and to actively promote independence.</td>
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<tr>
<td>♦</td>
<td>The effectiveness of any medication should be assessed at regular intervals and treatments altered accordingly.</td>
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<td>♦</td>
<td>Consider the role of complementary Therapies to help patient.</td>
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### 7.13 Nursing management of the side-effects Alopecia and hair thinning

Adapted from Cancer backup Macmillan (2006)

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<tr>
<td>Hair Thinning</td>
<td>Carboplatin Cistplatin</td>
<td>Educate patients of the likely occurrence during chemotherapy and the time frame.</td>
<td>Information can aid effective coping with this side effect.</td>
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<td>Assess the potential impact this will have on body image and psychological status.</td>
<td>To evaluate if person will needs extra psychological support.</td>
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<td>Use gentle hair products i.e. mild shampoo.</td>
<td>To prevent dryness to the hair and scalp.</td>
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<td>Brush hair gently.</td>
<td>To avoid pulling the hair.</td>
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<td>Avoid excessive heat e.g. hairdryers and heated rollers sleeping in rollers.</td>
<td>To care for the scalp and to avoid unnecessary pulling at the hair root.</td>
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<td>Sleep in a hair net.</td>
<td>To collect the hair so patient does not experience unnecessary trauma of seeing the hair loss.</td>
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<td>If hair long avoid plating and wearing a tight band.</td>
<td>To avoid unnecessary trauma and pulling onto the root.</td>
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<td></td>
<td></td>
<td>Gentle massage of the scalp.</td>
<td>May improve the blood supply to the follicles.</td>
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<td></td>
<td>Avoid nylon pillowcases</td>
<td>Can cause excess head heat.</td>
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<td></td>
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<td>Avoid using chemicals e.g. colourants, perms on the hair.</td>
<td>May make hair unhealthy and contribute to hair loss.</td>
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<tr>
<td>Alopecia.</td>
<td>Taxol Doxorubicin Etoposide</td>
<td>Forewarn patients of the likely occurrence during with chemotherapy. Including loss of body hair as well e.g. eyebrows and eyelashes. Forewarn that hair can come out in clumps, and the time for hair loss is variable for each chemotherapy.</td>
<td>Information can aid effective coping with this side effect.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Assess the potential impact this will have.</td>
<td>To evaluate if person will needs extra psychological support.</td>
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<td></td>
<td>Assess information needs.</td>
<td>Booklets available by</td>
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Guidelines 2013-2016. Page 69
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<td></td>
<td>Provide information and discussion on the role of the beautician, for eyelash replacement, and eyebrow tattooing or penciling.</td>
<td>Good hair care.</td>
<td>cancer backup on hair loss, body image and self esteem.</td>
</tr>
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<td></td>
<td>If hair long suggest cutting short.</td>
<td></td>
<td>To promote body image and self esteem.</td>
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<td></td>
<td>Use of a cold cap. – Although bear in mind there are side effects to the cold cap. It needs to be worn for longer than the infusion so the time length is variable, can also have an “ice cream” type headache.</td>
<td></td>
<td>To ensure healthy hair.</td>
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<td></td>
<td>Provide information on wigs and alternatives. (Turbans, hats, scarves, and provide contact no for Wiggins)</td>
<td></td>
<td>To relieve the weight of the hair pulling a creating hair loss sooner, and to aid transition of hair loss.</td>
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<td></td>
<td>Ensure person is aware can obtain a prescription for subsidy towards the cost – Macmillan grant also available. Wiggins at CCO Wed, Chester Tues, Warrington Friday. Patients can attend “Headstart” for advice on headwear. (CCO Reception)</td>
<td></td>
<td>To reduce hair loss although the evidence this variable,</td>
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<td></td>
<td>Forewarn that hair will grow back slowly post treatment, and it may grow back differently both in colour and texture.</td>
<td></td>
<td>To ensure protection and a healthy scalp.</td>
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<tr>
<td></td>
<td>Avoid using chemicals e.g. perming or dyeing the hair for 6 months post treatment.</td>
<td></td>
<td>To prevent unnecessary distress.</td>
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<td></td>
<td>To ensure all toxins are excreted and that the new hair is healthy.</td>
<td></td>
<td>To ensure all toxins are excreted and that the new hair is healthy.</td>
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</tbody>
</table>
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9  **Suggested Booklist**


