Peri-operative ovarian cancer guidelines: psycho-oncology

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Biography: Christina Fotopoulou is the Professor of Gynaecological Cancer Surgery in the Department of Surgery and Cancer, Faculty of Medicine of Imperial College London, UK. She is the Deputy director of the Ovarian Cancer Action Research Centre at Imperial College. She holds an honorary chair in the Gynaecology Department at the Charite' University of Berlin, where she was trained and then later took the role of the Vice Director of the Gynecological Department. Her surgical and scientific expertise focuses on the management of patients with advanced and relapsed ovarian cancer, profiling of tumor heterogeneity and integration of tumor biology factors with surgical effort under the umbrella of individualization of surgical care. She has served as the Chair of the guidelines committees of the British Gynaecological Cancer Society (BGCS) and of ESGO (European Society of Gynaecologic Oncology). She has been an elected member of the ESGO Council and is also a member of the German AGO-Ovarian Cancer Group. She is on the editorial board and reviewer of numerous international gynaecological and oncological journals and is a member of various international oncological committees, including BGCS, ASCO, ESGO, IGCS, ESMO, ENGOT, AGO, SGO and NOGGO.

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The diagnosis of a life-threatening disease such as cancer is associated with enormous distress, which can manifest at the somatic (eg, fatigue, pain) and psychological levels with significant social/financial implications as well as spiritual and existential concerns.[1]

Holistic support with evaluation of psychological distress symptoms, sexual function, psychiatric comorbidities, and psychosocial needs should therefore be offered at the time of diagnosis, during treatment, and at follow-up and survivorship to all affected patients (Figure 1).

Treatment approaches should be tailored to individual needs and availability of interventions.

The National Comprehensive Cancer Network (NCCN) distress thermometer serves as an easily manageable first-stage screening tool to evaluate a patient's distress in areas such as practical, family, emotional, spiritual, sexual, and physical problems.[2] A cut-off of >4 is recommended

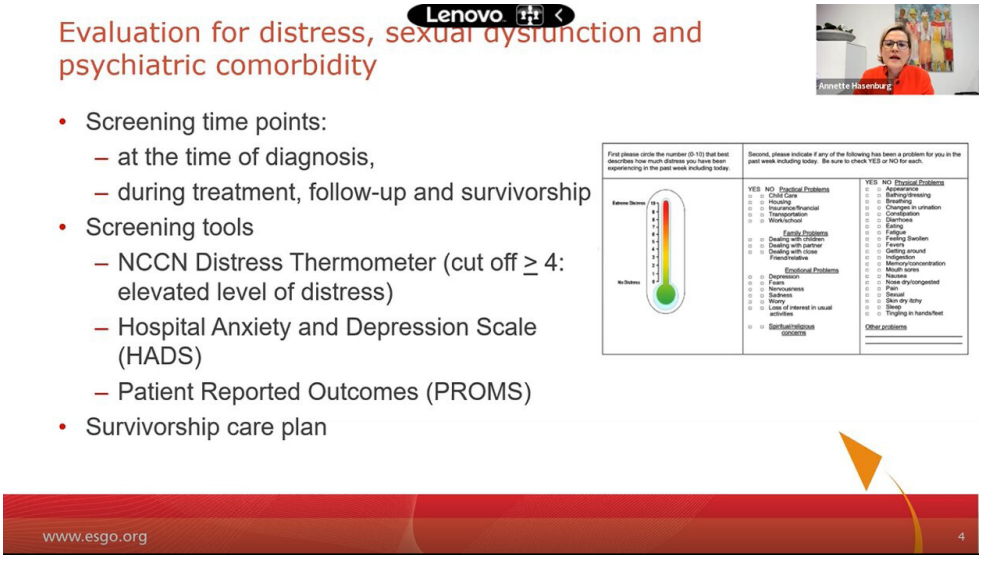

Figure 1 Standardized evaluation tools for the peri-operative psychosexual assessment of patients with advanced ovarian cancer are now an integral part of peri-operative algorithms in an effort to routinely establish more holistic care for these patients.

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Video 1 Standardized evaluation tools for the peri-operative psychosexual assessment of patients with advanced ovarian cancer are now an integral part of peri-operative algorithms in an effort to routinely establish more holistic care for these patients.

to identify patients with clinically elevated levels of distress.[3] Further scales such as the Hospital Anxiety and Depression Scale and the Female Sexual Function Index can supplement the diagnostic process and identify areas of need. Patient-reported outcomes may help to monitor treatment side effects.[4] A survivorship care plan may support the patient to organize his/her life with and after cancer.

Patients with a low level of distress should be offered patient-orientated information and psychosocial consultation.[5] Patients with a high level of distress should be seen by specialized caregivers to provide high standard psycho-oncological and psychosocial support. An armamentarium of interventions including counseling, psychoeducation, dignity-based therapy, relaxation, all creative therapies including art, music, creative writing and movement therapies, and guided imagery techniques can help to reduce patients' anxiety and improve their quality of life.[6 7]

Love, affection, and sexuality are essential elements of life. The type and radicality of surgical treatment influence sexual function and overall quality of life, which are—in any case—often impaired by the cancer diagnosis itself, with subsequent hormonal imbalance that may additionaly be potentiated by the side effects of systemic therapy.

Almost 50% of women with cancer lack adequate information about sexual function and associated challenges during their treatment journey, such as vaginal dryness, dyspareunia, and impairment of orgasm. Therefore, prior to surgery and during treatment the patient and, where applicable, her partner should be appropriately counseled regarding potential sexual dysfunction and options of support.

Communication is one of the backbones of such a holistic care approach and of a balanced doctor–patient relationship. In this context, all members of the medical staff as well as the relatives should be involved. Breaking bad news, especially in the context of surgical complications, is a major challenge in the clinical routine that needs adequate training.

Various tools and techniques, including the 'SPIKES' model (Setting up, Perception, Invitation, Knowledge, Emotions with Empathy, and Strategy or Summary), are available to teach and learn verbal and non-verbal communication.

All the above strategies will need to be under a holistic care umbrella to fit the patient's need in an individualized approach, and also to adapt to the infrastructure and support of each given environment.

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