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 for high distress.

Evaluation for distress, sexual dysfunction and psychiatric comorbidity

- Screening time points:
  - at the time of diagnosis,
  - during treatment, follow-up and survivorship
- Screening tools
  - NCCN Distress Thermometer (cut off ≥ 4: elevated level of distress)
  - Hospital Anxiety and Depression Scale (HADS)
  - Patient Reported Outcomes (PROMS)
- Survivorship care plan

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.
Educational video lecture

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 additionally 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.

Author affiliations
1Department of Gynecology and Obstetrics, University Medical Center of the Johannes Gutenberg University Mainz, Mainz, Germany
2Gynecology with Center of Oncological Surgery, Charité Universitätsmedizin Berlin, Berlin, Germany
3Gynaecologic Oncology, Imperial College London Faculty of Medicine, London, UK

Presented at
Published in partnership with the European Society for Gynecologic Oncology and BMJ

Contributors
All authors collected data, wrote the statements and did the videos.

Funding
The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests
None declared.

Patient consent for publication
Not applicable.

Ethics approval
Not applicable.

Provenance and peer review
Commissioned; internally peer reviewed.

Data availability statement
Data are available in a public, open access repository.

ORCID ID
Christina Fotopoulou http://orcid.org/0000-0001-6375-9645

REFERENCES
4 Snaith RP. The Hospital Anxiety and Depression Scale. Health Qual Life Outcomes 2003;1:29.