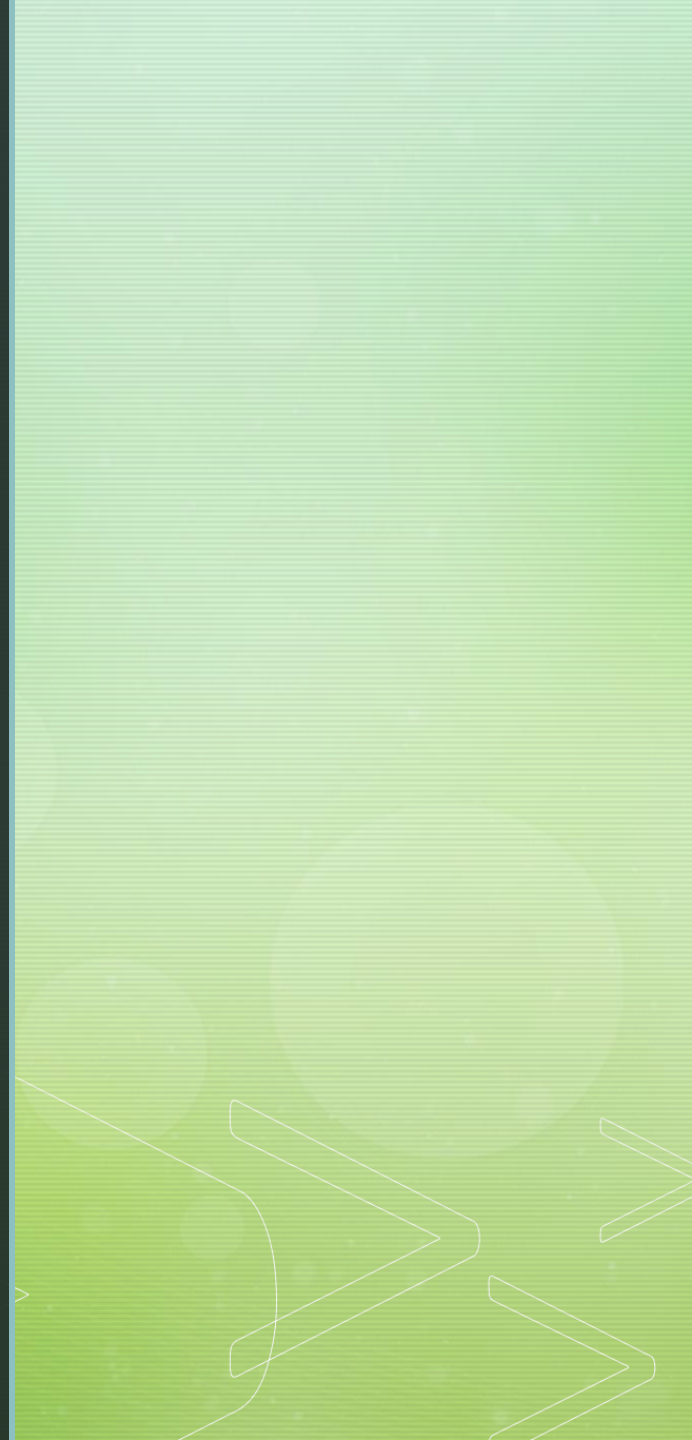


Gynecologic Malignancies and Palliative Care



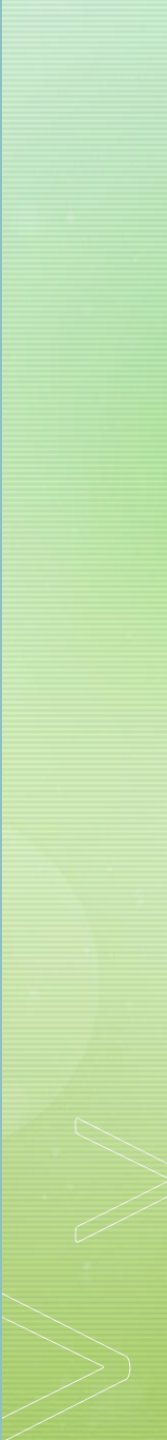
Timothy Weiss, MD

Updated January 2020



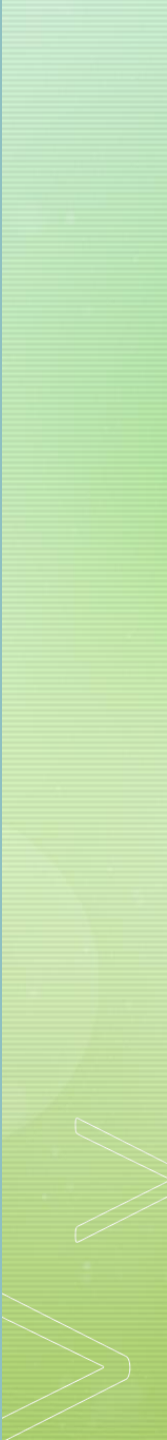


Gynecologic Malignancies and Palliative Care

- 1. An overview of gynecologic cancers
 - 2. An overview of symptom management and palliative care of patients with gynecologic cancer
 - 3. A case or two, and a reminder of why we do what we do
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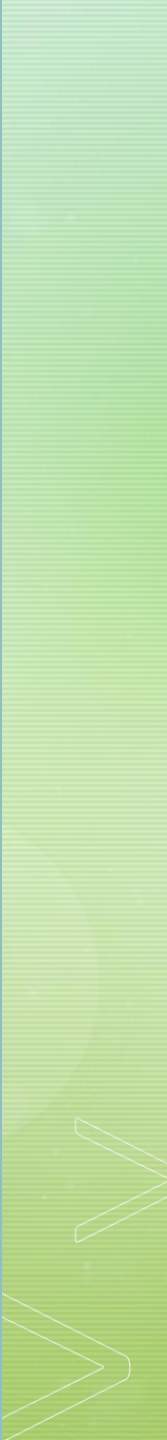


A Brief Case

- 72 y/o F with stage IB serous uterine CA diagnosed in late 2016 s/p extensive surgery for resection, with recurrence in early 2018. Admitted to hospital with severe pain. Also with vesicovaginal/rectovaginal fistulae. Urine and feces per vagina. Severe pain in vaginal area resulting from chemical irritation from feces/urine. Palliative care was consulted to assist with symptom management. Treated with IV opioids for pain and had long talks with patient as a show of support.
- 



A Brief Case

- Patient was scheduled for fistula repair / colostomy placement surgery about a week after admission. It was a joint surgery with attendings from Urology, Gyn-Onc, and Surgical Oncology. Surgery was performed one week after admission and was successful in remedying the fistula issue. Patient was followed by anesthesia pain team in the post-operative period. During the same hospitalization, consults were also obtained for IR and pet/animal therapy. Patient also seen by Heme/Onc and GI as an outpatient. Currently still in-patient, but pain is much improved from previous.
- 

Overview of Gynecologic Cancers

- Altogether account for 12% of new cancer diagnoses in U.S. women
- Made up of ovarian CA, uterine CA, cervical CA, vaginal CA, vulvar CA
- Different risk factors, prognoses, treatments, etc. for each one

Top 10 Cancers by Number of New Cancer Cases

United States, 2015, Female



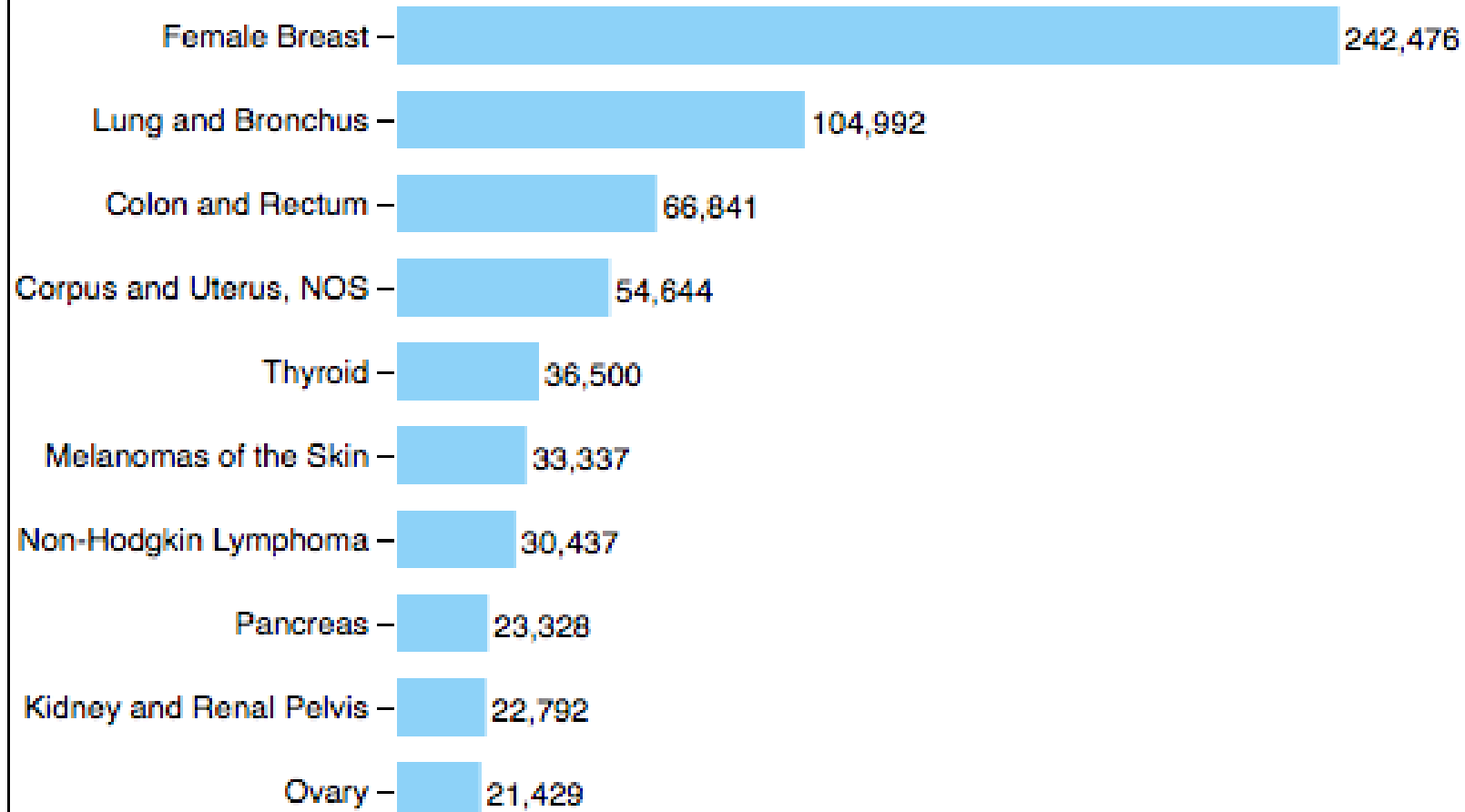
Chart



Table

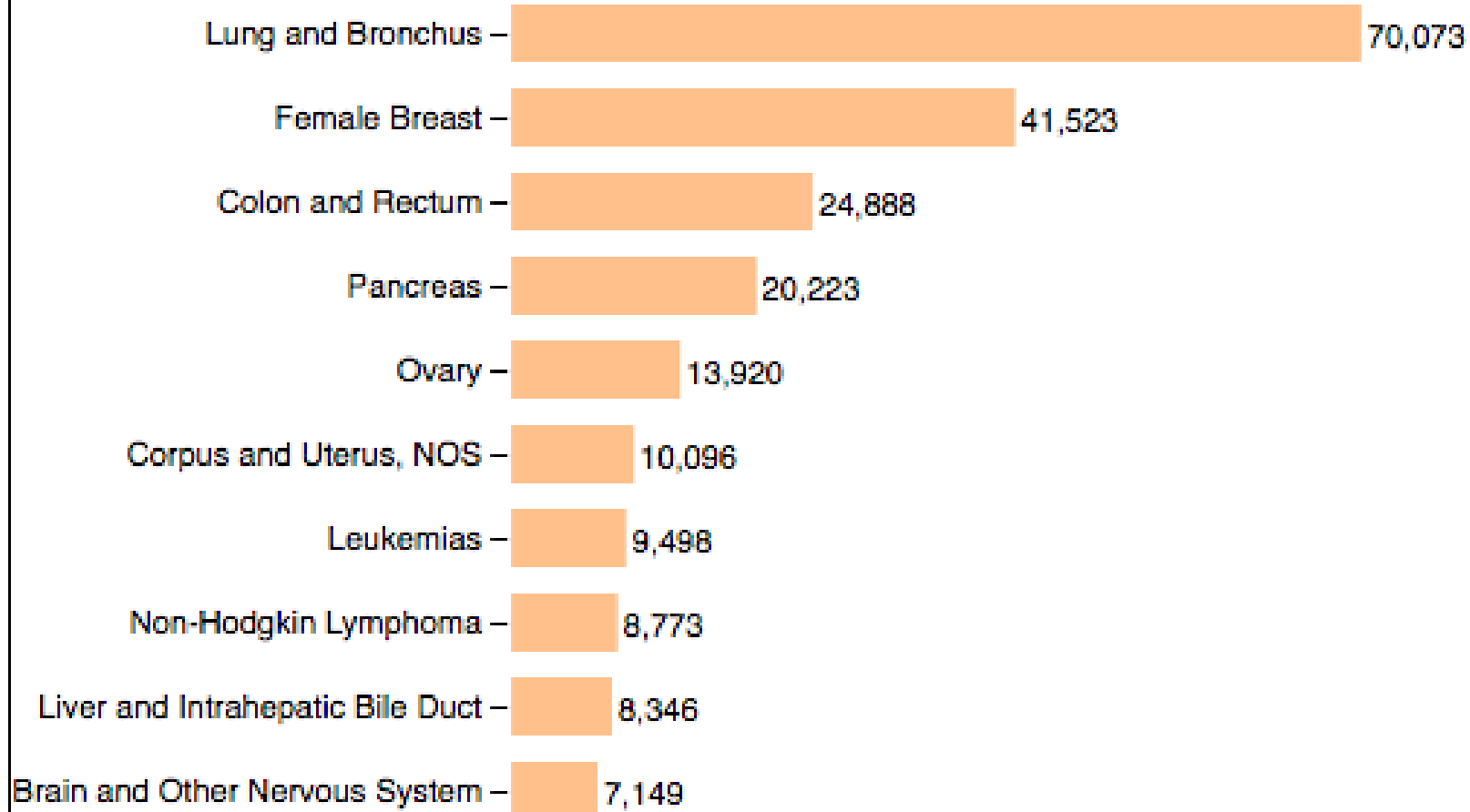


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Top 10 Cancers by Number of Cancer Deaths

United States, 2015, Female



Ovarian Cancer

- Causes more deaths than any gynecologic cancer
- Five-year survival rate: 47% (90% for early-stage, 5% for late stage)
- Risk factors: Older age, BRCA carrier, nulliparity, endometriosis, Lynch syndrome, family history
- Protective factors: OCP use, breastfeeding, parity
- A large reason for the higher mortality rate in ovarian cancer is because it is generally diagnosed at a later stage than other cancers

Cervical Cancer

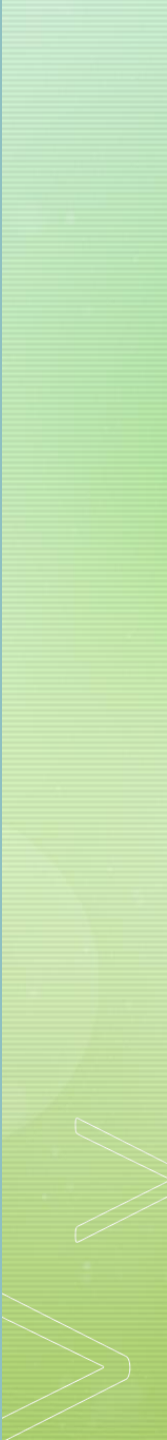
- Significant decline in new cases and deaths over the past 40 years
- Majority of cases (64%) occur in women who were never screened
- More common in developing countries
- Five-year survival: 72% (but up to 92% if diagnosed at stage I, as low as 15% for those diagnosed at stage IV)
- Risk factors: Not undergoing screening, immunosuppression, smoking, parity, exposure to HPV, OCP use

Vaginal Cancer

- Relatively rare (0.7 new cases per 100,000 women); for reference, breast cancer is 123.9 new cases per 100,000 women)
- Risk factors: HPV exposure, immunosuppression, *in utero* exposure to diethylstilbestrol
- DES is no longer used in pregnant women, but was used from 1940-1971
- Theoretically, a patient who is 49 years or younger should have no real likelihood of exposure; and DES-related cancer would generally occur before the age of 30 anyhow
- HPV vaccine can likely help prevent vaginal cancer



Vulvar Cancer

- Relatively rare (2.6 new cases per 100,000 women)
 - Five-year survival rate: 78% (90% for early-stage, 21% for late stage)
 - Risk factors: HPV exposure, immunosuppression
 - HPV vaccine can likely help prevent
- 

Uterine (Endometrial) Cancer

- Five-year survival rate: 81% (88% early-stage, 15% late-stage)
- Generally is caught at an earlier stage compared to other gynecologic cancers
- More common in developed countries
- Risk factors: obesity, exposure to unopposed estrogen, increased age, nulliparity, PCOS, early menarche, late menopause
- Protective factors: OCP use (combination estrogen/progesterone), smoking (??)
- Most commonly occurs after menopause
- Up to 40% of cases can be linked to obesity (incr adipose tissue → incr conversion of androstenedione to estrone → decr ovulation → higher levels estrogen exposure to endometrium)

Screening

- Ovarian – no recommendations for general population; BRCA carriers should be screened
- Cervical – Pap smears, HPV testing, colposcopy, etc.
- Vaginal – no recommended screening for general population; for DES-exposed women, annual pelvic exam / Pap smear
- Vulvar – no recommended screening
- Uterine – no recommended screening

Potential Initial Symptoms

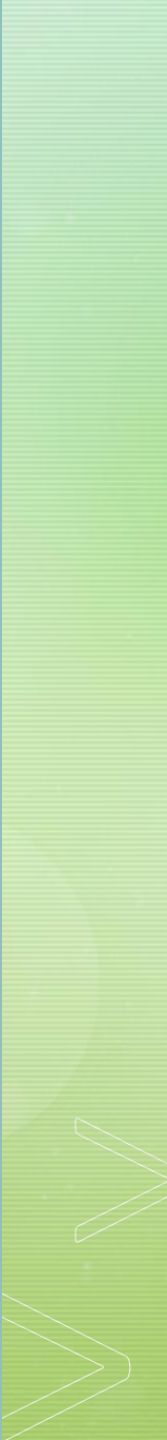
- Cervical – bleeding with intercourse, pain with intercourse, vaginal discharge
- Endometrial – non-menstrual vaginal bleeding
- Vaginal – usually no early symptoms; can eventually cause vaginal discharge, abnormal bleeding, pain, etc.
- Vulvar – itching, burning, bleeding of vulva, changes in the skin
- Ovarian – often asymptomatic at first; eventually bloating, general pelvic/abdominal pain or distension

Treatments

- Cervical -- surgeries (local i.e. LEEP or cone biopsy, or even hysterectomy), radiation, chemotherapy (often cisplatin)
- Uterine – surgeries (hysterectomy), radiation, adjuvant chemotherapy
- Vulvar – surgery, radiation (chemotherapy generally only if metastatic)
- Vaginal – radiation, possible surgery or chemotherapy
- Ovarian – Surgery, chemotherapy, radiation



Palliative Factors to Consider

- Often a larger range of difficult-to-control symptoms than the average cancer patient
 - Many gynecologic cancer patients become unable to take PO medications closer to the end of life due to higher likelihood of malignant bowel obstruction
 - For this same reason, many gynecologic cancer patients may require enteral feeding to extend their life
 - Many gynecologic cancer patients suffer from difficult-to-treat, complex complications of their cancer which may not be present in other cancers, i.e. malignant bowel obstruction, fistulas, etc.
- 

Symptom Management in Gynecologic Cancer Patients

- Common symptoms requiring management include pain, nausea, vomiting, constipation/obstruction, vaginal bleeding, edema, lymphedema, ascites, fatigue, weight loss / cachexia, appetite loss
- Many of these symptoms are present in many different types of cancer, but often the symptomatic burden is even more broad in the gyn-onc patient

Symptom Management in Gynecologic Cancer Patients

- The causes of nausea in the gyn-onc patient can be numerous and/or difficult to pin down:
- Chemotherapy side effects
- Radiation side effects
- Pain medication side effects
- Constipation (due to pain medications, decreased PO intake, decreased movement, etc.)
- Malignant bowel obstruction
- Anticipatory nausea / anxiety
- Ascitic fluid build-up

Symptom Management in Gynecologic Cancer Patients

- Some causes can have more specific treatments:
- Chemotherapy side effects – serotonin antagonists (i.e. ondansetron)
- Constipation (due to pain medications, decreased PO intake, decreased movement, etc.) – improved bowel regimen
- Malignant bowel obstruction – to be discussed later
- Anticipatory nausea / anxiety – benzodiazapenes or SSRIs, etc.
- Ascitic fluid build-up – frequent paracenteses / PleurX catheter placement

An Improved Bowel Regimen?

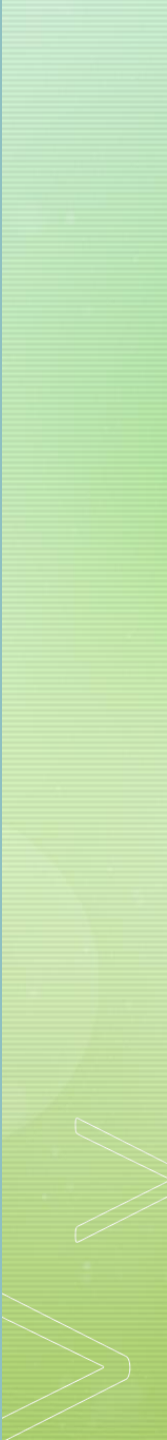
- Bowel stimulants (sennosides, Bisacodyl, methylnaltrexone and other selective opioid-antagonists)
- Osmotics (polyethylene glycol, milk of magnesia, magnesium citrate, lactulose)
- Suppositories / enemas

Is There a Good Plan on How to Treat Constipation?

- Assuming we are not dealing with obstruction...
- Senna 2 tabs BID, Miralax BID PRN to start, along with a suppository PRN (Bisacodyl would be just fine)
- No good evidence that docusate works in palliative patients
- Titrate up the senna or osmotic (or add a different osmotic) as needed
- Suppository or enema if not having stools at least every 3 days
- Consider a selective opioid-antagonist (such as methylnaltrexone) if you are pretty sure that the primary cause of the constipation is opioid use and if you know that there is no obstruction anywhere

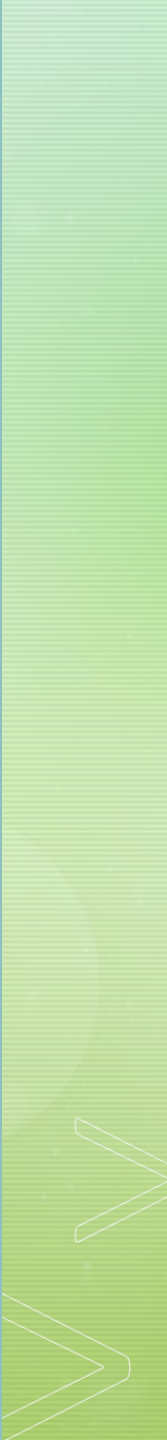


Malignant Bowel Obstruction

- A very difficult potential problem with any type of abdominal/pelvic cancer, or cancer that metastasizes to these areas
 - Literally refers to the physical obstruction of the large or small bowel by a tumor
- 



Malignant Bowel Obstruction

- Theoretically could be treated with surgical removal of the tumor, though this is more complicated than it would seem at first glance
 - Sometimes the symptoms can be alleviated with a venting G-tube, though this can also be more complicated
- 

Malignant Bowel Obstruction

- What if surgery is not an option?
- Steroids can help reduce inflammation surrounding the tumor, thus potentially shrinking the size of the obstruction
- Somatostatin analogues (i.e. octreotide) decrease gastric secretions by decreasing release of gastrin, CCK, insulin, glucagon, gastric acid, pancreatic enzymes. Can also decrease peristalsis.



Inability to take PO medications

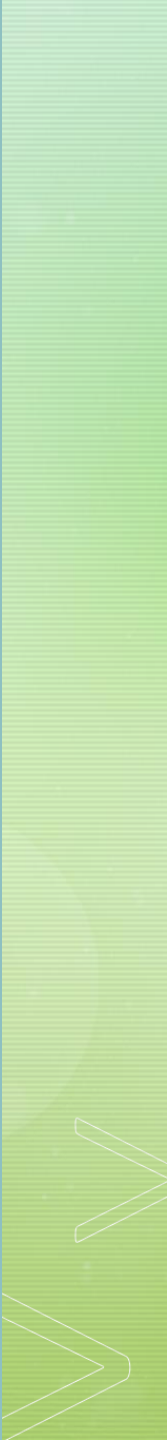
- Even with treatment of a malignant bowel obstruction, a patient may be unable to take PO medications due to continued obstruction or due to placement of venting G-tube.

Common Medications and their Non-PO Equivalents

- Opioid Pain Medications – morphine and methadone specifically come in a concentrated sublingual form. Fentanyl comes in patch form.
- Nausea medications – granisetron (serotonin-antagonist) comes in patch form. Other medications (metoclopramide and Compazine) can be given rectally.
- Benzodiazepenes – lorazepam comes in a concentrated sublingual form.

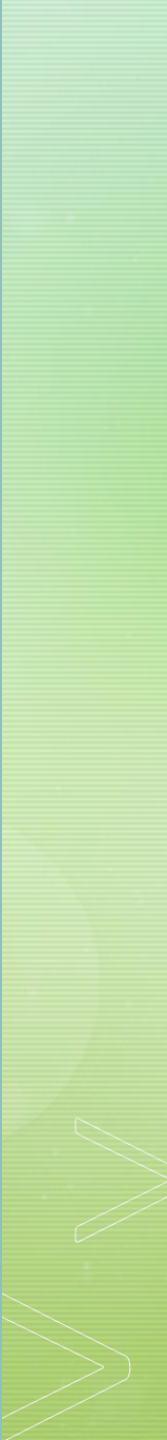


Issues with TPN

- For those patients who are no longer able to take in oral nutrition, TPN is a great alternative.
 - TPN does have potential side effects (for example, liver damage), but these are generally more over a long period of time. By the time a gyn-onc patient needs to use TPN, they typically will not live long enough to deal with the long-term effects of TPN
- 



Issues with TPN

- TPN is expensive – which is often okay, because insurance covers it. Typically a home health agency is contracted, delivers the bags of TPN, teaches the family how to hang the bags themselves, does any relevant blood labwork, etc.
 - Unfortunately, hospices generally do not cover TPN.
- 

A Brief Word on Hospice Expenses

- Per Medicare guidelines, hospice agencies are required to cover any medication or non-curative treatment that is related to the terminal diagnosis – i.e. pain medications, nausea medications, etc.
- Since TPN is expensive, hospices generally will not cover it, as they may be financially unable to do so on a regular basis.
- Medicare reimbursement per patient per hospice day (all patients for any diagnosis) = ~\$188
- TPN cost per day = ~\$281




TPN vs. Hospice

- Unfortunately, sometimes this turns into a question of does the patient receive the TPN that they want to continue extending their life? Or do they give that up in exchange for the extra support that they will likely need at home on hospice, knowing that their prognosis is likely no more than a couple of weeks?

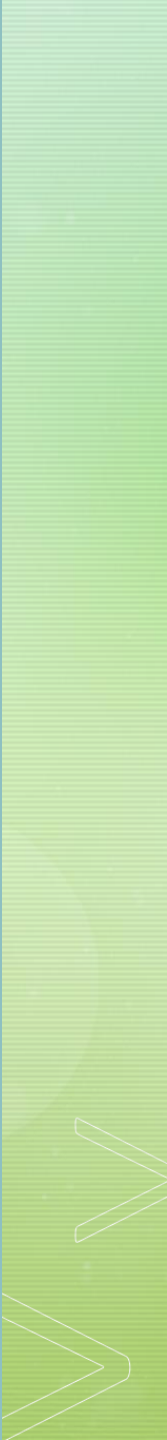


An Example Case

- 64 y/o F with endometrial CA, abdominal carcinomatosis, chronic malignant bowel obstruction. Was admitted to hospital with various complications of her disease. Not currently a candidate for any further surgeries, chemotherapies, radiation, etc. Did have a venting G-tube in place, which was working well. Was reliant on TPN for nutrition. Did not want to stay in the hospital anymore and wanted to be home. Did not want to come back to the hospital again.
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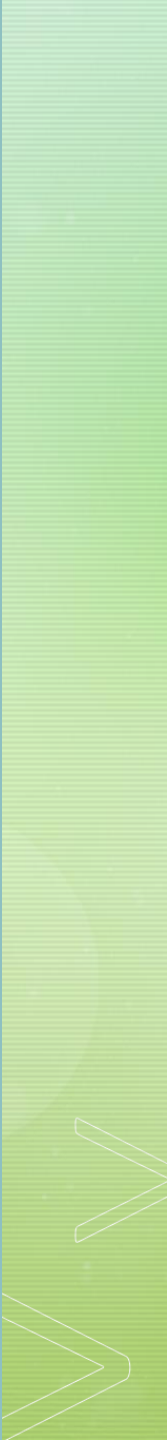


An Example Case

- After discussing the case with the local medical director of a large national hospice agency, and with the patient, we came up with a plan.
 - The hospice would provide TPN Lite (aka PPN) which does not require lab draws and is less expensive than TPN. The patient's primary goal was to go home and be "surrounded by my family for a few more weeks. When I'm ready to go, I'll stop the nutrition."
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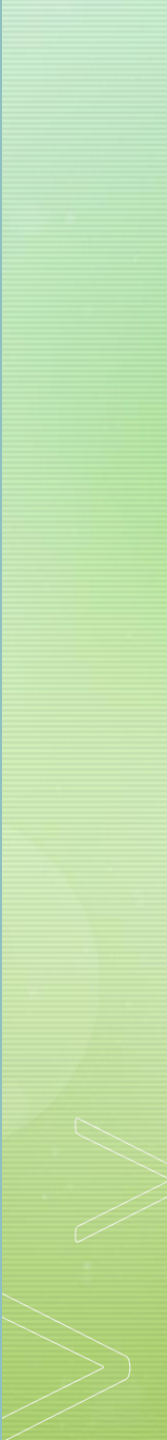


An Example Case

- She was discharged home, surrounded by her family (as well as a hired caregiver) who helped with her wound care, PPN, etc. After about two weeks, she felt that she was ready, and discontinued the PPN. A few days later, she had passed away, in her own home, surrounded by her family.
- 




Why Do We Do What We Do?

- When we think about the preventative aspect of women's health, it can be easy to think in terms of numbers more than individual patients.
 - When we see women at the end of their lives because of one of the cancers that can be screened for, we see the outcomes that we are actually trying to prevent.
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Everything is made to perish; the wonder of anything at all is that it has not already done so. No, he thought. The wonder of anything is that it was made in the first place.

--Paul Harding, *Tinkers*

Dedicated to Lisa L. and Jennifer F.

