



Iris Raquin (French). *Camargue Marshes*. Oil, 40" × 32".

Nursing Perspectives on Patient Management During Chronic Therapy for Relapsed Ovarian Cancer

Sheryl Redlin Frazier, RN, ONC

*Past President, Society of Gynecologic Nurse Oncologists
Vanderbilt University Medical Center
Nashville, Tennessee*

The treatment of advanced ovarian cancer has evolved over the past 20 years. Although effective early diagnosis continues to be elusive and the management of relapsed ovarian cancer does not offer a cure, new therapeutic advances offer many women longer disease-free intervals and improved quality of life with disease.

The focus of this program has been to explore the management of advanced ovarian cancer in ways that would promote optimum disease response to various antitumor agents and maximize quality of life during the disease trajectory.

For the Nonresponsive or Platinum-Refractory Patient

In patients who either do not achieve a clinical response to their initial therapy or who progress while on primary therapy and are considered refractory to platinum, it is clear that standard therapy is not useful. Because of widely metastatic disease sites in these patients, they also present difficult medical management issues. The roles of surgery, chemotherapies, and novel therapies are varied and depend on the health status of the individual patient. Palliative care options are usually the primary goal of care, and in this discussion it was the consensus that women in this disease state should be counseled carefully about the meaning of refractory ovarian cancer, the value of quality of life considerations, and the psycho-social impact of this revelation.

In this setting, the roles of the oncology nurse are support and education. Women in this disease state need referrals to home health or hospice, and identifi-

cation of support services that are helpful in managing the many social and psychological issues which arise. In addition, many times financial assistance will be required for medications and other comfort care issues.

For the Partial Responder

Women who complete six or more cycles of initial therapy and have a partial clinical response as evidenced either radiographically or biologically (CA125) are classified as partial responders. There is considerable variance in management philosophies for such patients, ranging from continuing the same therapies beyond the sixth cycle vs introducing a new second-line therapy that would extend the platinum-free interval or introducing an investigational therapy by a clinical trial. There is likely a psychologic disadvantage for a patient not having a "normalized" CA125, but the prognostic significance of this has not been substantiated by scientific evidence. Few studies have looked at whether the number of cycles of therapy beyond six shows benefit. To date there is no striking evidence to support such a conjecture. Observation is not a popular management choice. It is worthwhile to consider the benefit-to-risk ratio for patients who have experienced adverse effects of therapy when planning additional treatment.

The nursing management of partial responders focuses on management of untoward adverse effects with paclitaxel, such as peripheral neuropathy, and the risks of adverse effects with continued carboplatin therapy, such as myelosuppression and hypersensitivity reactions. Also, one must consider such social aspects as continued disability determinations. In this context, nursing utilizes continuing patient education that helps

prepare the patient for long-term treatment, and the impact of long-term treatment on the psycho-social and physiologic domains of life.

For the Complete Responder

In women who experience a complete clinical response to initial therapy, there is debate about what management techniques are best. Some oncologists believe that with the high rate of recurrence in ovarian cancer, additional therapy should be considered following a complete clinical response. The additional therapy might be consolidation therapy, second-look laparotomy, or even high-dose therapy with stem cell rescue. In the absence of a clinical trial, most oncologists will agree that second-look surgery has not been proven to extend long-term survival. However, there is a consensus that using surgery to manage bulky recurrent disease may offer benefit and may eventually assist in defining the role of chemo-resistance testing.

Nursing efforts should focus upon educating the patient and her family, based on the treatment recommendations. For example, if debulking surgery is anticipated, the patient should receive preoperative teaching and help in planning the postoperative recovery.

For those women who are in an “observation management” mode, a surveillance strategy is developed. In general, disease surveillance includes clinical examinations and CA125 testing every 3 to 4 months during the first 2 years, every 6 months during the next 3 years, and annually after 5 years. The use of radiographs in follow-up is reserved for changes noted during clinical examinations, subjective symptoms, and CA125 results. Meanwhile, the oncology nurse focuses on patient education and counseling on the CA125 test results.

During observation, there is considerable variance in the use of the CA125 as a tool influencing treatment decisions. Many oncologists do not treat for a rising CA125 in the absence of other physical symptoms or clinical evidence. Some will treat based on two consecutive values greater than 35 U/mL, and others will wait for the value to exceed 100 U/mL. Oncologists often experience pressure from their patients to treat rising CA125s in spite of the lack of scientific evidence to support survival or disease response advantages.

The oncology nurse participates in this discussion regarding the value of CA125. In many cases, it is the nurse who will give the patient the results of

the test and will share in the dialogue. The unified physician and nurse team is especially important in presenting consistent information to support the patient and her family through the difficult transition from active treatment to observation.

For Patients Receiving Chronic Therapy

Women who experience a recurrence of ovarian cancer will eventually succumb to the disease. For many years, this has been referred to as the “salvage therapy” setting. The term “salvage therapy” is an unpleasant descriptive and was unanimously deemed in this discussion to be a poor term to describe this disease and setting. The term “chronic therapy” is preferred.

Chronic treatment of recurrent ovarian cancer can be stratified into two different groups: treatment-free interval (TFI) and disease-free interval (DFI). The TFI can be used as a predictor of response duration; the DFI is a predictor of return of platinum sensitivity. Good clinical data support the use of nonplatinum therapies such as topotecan, gemcitabine, oral etoposide, and liposomal doxorubicin to prolong the time during which the tumor is not exposed to platinum. This gives the tumor time to replicate cells that are not clones resistant to platinum. Thus, when platinum-based treatment is reintroduced, tumor response may be improved. This treatment approach has been successful in certain groups of patients and promotes the treatment paradigm of the chronicity of the ovarian cancer disease trajectory.

The oncology nurse is pivotal in assisting the oncologist in this phase of treatment, managing patients by implementing patient education about side effects, expected and unexpected; the role of growth factors for support during myelosuppressive events; and through TFI and DFI phases during which patients are particularly anxious about disease response and remission. Indeed, certain aspects of patient care are incremental to physician management. Those aspects are performance status, proximity of the patient to the treatment center, prior toxicity experience (considering that the number of previous therapies are not necessarily predictive), reimbursement issues, and the utilization of evidence-based clinical practice. The oncology nurse helps to identify many of these aspects, implements patient education, makes transportation arrangements, completes disability determinations, assists in applications for medications and other reimbursement issues, and helps in gathering the historical data to determine total doses and previous therapies utilized.

For Patients Receiving Palliative Care

For patients who are in a palliative mode of care, management of symptoms that interfere with quality of life are given priority. Radiation therapy has an occasional role in specific situations such as recurrent small-volume disease or a single tumor mass. Adverse effects from radiation therapy may preclude the use of additional surgery to relieve effects of progressive disease, as in chronic small bowel obstructions. The use of total parenteral nutrition and intravenous fluid hydration are helpful in some patients if clear goals and endpoints are identified from the beginning. The management of effusions, pleural and ascitic, become real end-of-life problems. The focus of care is relief of symptoms and optimizing quality of life.

In this setting, the oncology nurse makes the referrals to agencies which provide supportive care, but additionally provides psychological support throughout the palliative care focus. The nurse provides continuing patient and family education regarding the side effects of treatment and surgical interventions which may be used to provide relief of symptoms, such as a gastrostomy tube for relief of bowel obstructions.

Conclusion and Summary

There is an art as well as a science to managing the chronic nature of recurrent ovarian cancer. There is a Zen of management — or at least, an attempt at peaceful coexistence between the woman and the disease.

To achieve this objective, the oncology nurse joins the physician in a team approach to disease management using ongoing patient education and support, assessing quality of life utilizing the physiologic, psychologic, sociologic, and spiritual domains, and implementing plans of care using evidence-based clinical practice to support treatment choices.