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Palliative Management of Advance Ovarian Malignancy

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This stage of the disease and this state of the patient and family is very difficult to manage. The reason being that the patient, family and physician have passed a long way together, surgical procedure, chemotherapy and radiotherapy has been done with the hope the disease will be cured, or at least arrested to prolong the survival. But now all the modalities and efforts are exhausted, patient is weak, depressed with lot of side effects of treatments. Family is psychologically and economically crippled. Physician Incharge is exhausted with all the explantations and disappointment. The patient's condition is downhill. How one should manage such patients.

Objective

* Psychological Acceptance
* Patient Family
* Nutritional status.
* Pain Relieving
* Treatment of Associated Complications

Psychological Acceptance

There are three main spots when the cancer patients gets disappointment.

* first when doctor tells the patient that you have cancer.
* second when the first sign and symptoms suggesting of recurrence may be difficult to consciously perceive or once so perceived may be psychologically difficult for the patient to acknowledge and to do some thing about. Then patient gets different treatment modality, but patient and family goes through different series of reactions the cure is now less likely than once expected.

When disease continues to progress even with all treatment modalities, this is the third psychological Trauma. Patient and family loses hope, they may loose confidence in doctor. There will be certain chain reactions which requires careful and sympathetic handling by the doctors, nurses and paramedical personnel which will help in further management. A consultation by 2nd specialist or Psychologist will be more appropriate in these circumtances. Dr. Elizabeth Kubler Ross, describe the understanding of a dying patient.

Psychology Of Dying Patient

(Dr. Elizabeth Kubler Ross)

Stage I	Denial
Stage II	Anger
Stage III	Bargaining
Stage IV	Depression
Stage V	Acceptance

1st stage. Denial and Isolation.

It is human nature to say no, not me it cannot be true, she is searching the doctor eyes for expression of help.

2nd stage. Anger

The resentment is aggressive and hostile, the patient makes her opinion apparent, Doctors, nurses and paramedical personnel should respond in kindness.

3rd stage. Bargaining

Accepting the inevitable, knowing that anger and isolation has not achieved their objectives, patient often concludes that the result may be more favourable if they behave nicely.

4th stage. Depression

The patient realizes that disease is progressively innevocable. She is getting weak, and thinner, it is better to permit her to express her sorrow as a step towards final acceptance. She remain quite.

5th stage. Acceptance

The patient has reached the point of being neither depressed nor angry about her fate, she has an increased need for sleep during this period and dozes off frequently. The Psychological management by a

skillful personnel is very important. Also it depends upon the patient personality, family support and their religious background.

NUTRIONAL STATUS

* Diet selection (Dietician)
* Tube feeding
* Feeding Gastrostomy/jejunostomy
* Parenteral Nutrition
  * Concenterated Glucose Solution
  * Crystalline Amino Acid
  * Hyperalimentation

Because of

* Advance CA
* surgical procedures
* Chemotherapy + radiation and associatea complication.

* *Nausea and vomiting*

These patients are nutritionally depleted. They get weak and had muscle loss. The nutritional status should be watched carefully, periodically weighing is importance.

* *Diet selection*

Consultation by Dietician to have high caloric diet and contain adequate amount of protein , fat, carbohydrate and daily requirement of vitamins in semi solid to liquid diet.

* *Tube Feeding*

If epitite is not good, too weak to chew or to take feeding, Tube feeding should be started with special prepared food.

* *Feeding Gastrostomy/jejunostomy*

If Gastrointestinal tract is intact and tube feeding is discomfortable for patient. then Gastrostomy or Jejunostomy should be performed and inject well balance specially prepared food.

* *Parenteral Nutrition*

If Gastroinstestinal tract is not functional well. (Partial or complete bowel obstruction) Then parenteral nutrition should be started.

  * Concenterated Glucose Solution.
  * Crystalline Amino Acid.
  * Hyperalimentation.
  * Specialized prepared, Balance Nutrition solution given by CVP line (subclavian Vein)

Pain Relieving

* Medication
  Pethedine.
  Pethedine + Phenergen
  Morphine Sulphate

When death is near one of the greatest challenges for physician and family is avoiding, heroic and discomforting measures while keeping the patient as comfortable as possible. It is important to identify the factor causing pain and then to correct it, if it is infection then antibiotic should be started. the cause of pain by cancer is two fold one local pressure pain on surrounding organ, second infiltrating tumor mass along pelvic nerves.

Medication

* Medication dose should be adequate to relieve pain without side effect like respiratory depression.
* Medication dose should be such that it can be repeated more frequently as needed.
* Habituation and addiction should be concern of only if the palliation is for a long time, then medication should be changed after adequate interval to avoid building up tolerance and decreasing the effectiveness.

Neuro surgical interruption

Interruption of sensory spinal pathways may required to control pain in advance cancer patient. This must be given very careful consideration before it is offered. It is important to make sure that the pain is not replaced by something equally as disturbing to patient, such as urinary or fecal incontience.

Treatment of associated Complications

Anemia	Blood Transfusion Anabolic steroids.
Dyspnea	Pleural effusion, taps or bleomycin Injection.
Intermittent bowel obstruction	Conservative management I.V. Fluids + Electrolytes. Nasogastric tube/Cantor tube. By Pass Operation
Sepsis	Antibiotic coverage.
Deep vein Thrombosis (prevention)	

Exercise .
Ted Stocking (long)
Heparinization ?
Pulmonary Embolism
Local Invasion
Bladder
Rectum
Blood Vessels.

Cause of death

Primary Tumor	23.6%
Complication of Therapy	20.8%
Bowel obstruction	23.6%
Pulmonary Embolus	11.1%
Ureteral obstruction	4.2%
Other Medical disease	12.5%

Bowel obstruction

Bowel obstruction partial or complete is the commonest complication in advanced ovarian cancer and one of the leading cause of death in these cases. The management is conservative. The decision to operate with Bowel obstruction in advance ovarian cancer must be weighed heavily, and individualized but certain, finding are related to poor prognosis.

Poor prognosis signs

* Extreme weight loss.
* Rapidly recurring pleural and ascitic effusion.
* High obstruction.
* Early failure with primary Chemotherapeutic agents.
* Infection of tumor
* Associated large Bowel Obstruction.
* Internal fistulae.
* Multiple Tumor sites
* Retro Peritoneal and mesenteric involvement with tumor.

Unfortunately there are multiple sites of intestinal obstruction, retroperitoneal tumor implants interfere with the normal autonomic function of small bowel. By pass surgery should be performed when conservative measures fails. Colostomy is planned to relieve large bowel obstruction. The entire small bowel should be explored at the time of surgery to preclude coexistence of small bowel obstruction. Operative correction of intestinal obstruction to secondary progressive ovarian cancer is associated with significant morbidity and mortality.

Major complications	31.43%
Post operative death	12.15%
No improvement of obstruction	12.18%
survival shortened	2.5-9 months

The symptomatic treatment continued. Try tobe very conservative and as less traumatic as possible.