Quality of life in gynaecological oncology

C. ROMAGNOLO

Summary: In the last twenty years a new philosophy in the management of gynaecological cancer has begun: the goal of the therapy is now not only to save the life but also the patient's quality of life. To this end, on the basis of a century's experience and of progress in the oncologic field, therapies have been progressively personalized and modulated, considering both the surgical pathological staging and the effective possibilities in terms of survival and quality of life, in order to avoid over or undertreatments.

Moreover, in the last few years also the patients submitted to surgery for gynaecological malignancies are beginning to ask gynaecologists for access to hormonal replacement therapy in order to prevent the symptoms typical of menopause, and physicians have to decide when that is possible.

Consequently gynaecologist oncologists have to bear in mind the therapy's real cost/benefit balance for the patients, also from a psychological point of view, and in any case, treatments must be performed only if they are unquestionably useful and if they involve the patient's consciousness in choices and decisions.

The high malignancy of female genital cancer has inspired great therapeutical efforts at all times, all over the world in order to modify sad destinies but, first of all, to save the patient's lives.

Standardized enlarged surgery and/or heavy radiotherapy were systematically used in the past in every case, often without reliable staging and adequate evaluation of risk factors and correct follow-up in order to consider their real benefits and costs.

Until a few years ago for uterine cancers, for example, we had a high incidence of understaged or overstaged cases, because of the great difficulty in obtaining correct estimation of the cancer growth and diffusion.

Inadequate knowledge of the natural history of these tumors (uterine, cervical) and the over optimistic opinion on the therapeutical possibility of enlarged surgery and high radiotherapeutic dosage was responsible for treatment inadequate by defect or excess ([1]).

In that period the trend was favourable to overtreatment, wrongly believing that it was possible to improve the survival rate by stronger integrated therapies.

The philosophy was to treat every uterine cancer as if it were one stage further ahead, although with these strategies the quality of life was ruined even in early stages, as it would have been in advanced.

On the contrary in advanced cases even heroic treatments did not save the patients' lives but only spoiled the life that was left to them.

In both conditions (advanced and early stage) standardized therapies had an unfavorable cost-benefit balance. The fear of cancer and poor oncologic knowledge ju-

Gynaecologic Institute - University of Padua

stified any management, even tremendous ones, in the aim of trying to save a life.

Neverthless in the last twenty years the new philosophy has begun, regarding the respect not only of life but also of the quality of life.

The patients were to have the right to know the real cost of the treatment for their life-balance correlated to real benefit, particularly regarding the possibility of survival adequate in time and in dignity.

On the basis of a century's experience and of the progress in the oncologic fields, particularly in the last 30 years, we have progressively changed, reaching adequate personalized management, avoiding over or undertreatment in order to try to save life, but also to respect the «quality of life» ([2]).

If it is true that there is no quality of life without life, in our opinion it is also true that "there is no life without quality".

It has not been only medical progress but ethical and philosophical progress, correlated with the general improvement in social, familiar and physical quality of life.

With the economic and technical progress of our society everybody rejects physical imperfections and growing old: we all want to be agreeable, beautiful, happy, healthy and strong.

In the past, even young patients accepted Halsted's operation, maybe for early or minimal breast disease, accepted total vulvectomy even for simple leucoplasia, vulvar pruritis, small Paget's disease, while now even elderly women complain of the complex of mutilation, also for breats lumpectomy and quadrantectomy, for partial skin vulvectomy or for simple tumorectomy of the vulva ([3]).

In particular, concerning sexual life, the operations required for female genital cancers often determine a reduction of the sexual function, sometimes physical, other times psychological.

Only if we bear in mind the symbol that the human body represents for every individual, can we understand how easy it is to wound it.

With mastectomy a women is affected also from a sexual point of view, and she feels mutilated in those most outstanding attributes which are considered an element of social communication.

Furthermore with hysterectomy her reproductive capacity is abolished and consequently she is affected not only as a mother but even in her sexual life, because sexuality is intimately correlated with motherhood.

We also have to consider chemotherapy. A women is distressed by rapid hairloss, loss of weight and the progressive deterioration of her femininity.

Women need physicians to speak to them not only as patients, without hiding anything, but remembering their dignity, their personal reality, their capacity for social projection ([4]).

It is only in this context that a clear collaboration between patient and gynecologist can be fully realized in the search not only of health, but also for a good quality of life.

In the last few years a new approach to the menopause has been presented with the use of the hormonal replacement therapy. That is because of the possibility of preventing the dystrophic and dysmetabolic symptoms typical of this condition, together with the demonstration that the use of hormonal replacement therapy does not influence the risk of cancer in a negative sense.

Consequently, also patients submitted to surgery for gynecological malignancies, particularly if young, are beginning to ask gynecologists for the same treatment as other luckier women.

Until a few years ago this request was considered absurd: now instead, there is evidence that hormonal replacement therapy is possible even for these patients,

except in the case of hormone-dependent tumors [5].

It is easy to prophesy: in the near future this will be not only possible, but necessary in the management of gynecological oncology.

We are obliged to respect this situation because this is the life of our patients, unquestionably improved today, but at same time our diagnostic and therapeutic techniques have improved too.

The increasing incidence of preinvasive and early stages in some gynecological cancers allow us to respect both the survival rate and the quality of life in many patients.

This is the goal at present and will be more strongly sought in the future. In every country we must organize valid mass-screening services for female genital cancers, in order to have by the end of this century, or at the beginning of the next, only preinvasive or early cancers in the breast, vulva, vagina and uterus, because we shall already have this possibility [6, 7].

In fact, prophylaxis, prevention and early detection are possible for breast, vulva, vagina and uterine cancer, and must be well organized.

Only for ovarian cancer do we have a dramatic situation in which we are failing too, in the aim of saiving life, because of the very high incidence of the advanced stages.

Finally in early stages for every gynaecological neoplasia, ovarian included, we can easily respect the quality of life.

On the contrary, in advanced cases choices and decisions are still tragic, even today, for both patients and oncologists; the poor survival rate has remained practically unchanged in the last three decades, in spite of every therapeutic effort, in spite of a great many new trials association and so on.

We are disappointed, but we must be realistic and we must try not to delude our patients, submitting them to heavy and dangerous therapies when the possibilities of curing the diseases are very poor, while the possibilities of spoiling a life are sure.

In advanced cases we must stop following dangerous, hopeless managements to chose other therapies, even palliative, but which might be able to extended disease-free survival respecting the quality of life of unlucky patients.

In conclusion it is our firm belief that in any case, but particularly in advanced stages, treatments must be carried out only if in common experience they are unquestionably useful and if they involve the patients' consciousness in choices and decisions concerning their future and their quality of life.

We hope in new and effective scientific discoveries in the managements of female genital cancers because, at present, the situation is disappointing and the philosophy of the respect for the quality of life may be only a hypocritical alibi to justify our weakness in fighting the disease.

REFERENCES

1) Onnis A.: "Surgical experience in uterine cancer treatment ". *Eur. J. Gyn. Oncol. VIII, 4,* 315, 1989.
2) Onnis A.: "Surgical diagnosis and therapy in gynaecological oncology". *Eur. J. Gyn. Oncol. VIII, 4,* 298, 1989.
3) Di Paola G. R.: "Quality of life after treatment for vulvar cancer". *Eur. J. Gyn. Oncol. VIII, 4,* 363, 1989.
4) Sichel M. P.: "Valore e significato dell'immagine corporea". *Gin. Clin. VIII, 2,* 70, 1987.
5) Ploch E.: "Hormonal replacement therapy as one of the way of improvement the quality of life of patients for cervical cancer". *Eur. J. Gyn. Oncol. VIII, 4,* 374, 1989.
6) Onnis A.: "Clinical experience in gynaecological cancer, c) Cervical cancer". Report from the Gynecologic Institutes of Padua University (1963-1989). *Eur. J. Gyn. Oncol. XII, 1,* 11, 1991.
7) Onnis A., Marchetti M.: "Adequate staging for an adequate management in uterine cancers. Clinical experience". *Eur. J. Gyn. Oncol. XII, 2,* 99, 1991.