MAKING IT REAL:

APPLYING THE THEORY IN YOUR DAILY PRACTICE

GYNECOLOGICAL CANCER EDUCATIONAL PROGRAM

MARCH 02, 2018

FACILITATOR: MARK KRISTJANSON

PRESENTER DISCLOSURE

- Faculty/Speaker: Mark Kristjanson
- Relationships with financial sponsors: Employee of CCMB

MITIGATING POTENTIAL BIAS

- Not Applicable

LEARNING OBJECTIVES

1. **The management of malignant bowel obstruction from ovarian cancer**
2. **Decisions regarding treatment options in the aging patient with recurrent or progressive gynecologic malignancy**
3. **The management of atrophic vaginitis after treatment for ovarian, endometrial, vulvar, or cervical cancer.**

CASE 1: KINDA HERTZ, AGE 62

- Endometrial biopsy for post-menopausal bleeding last year: insufficient sample.
- Referral to a gynecologist
- Continued bleeding
- Pelvic ultrasound
- Repeat endometrial biopsy, normal.
- D&C hysteroscopy: FIGO Grade 2 endometrial adenocarcinoma, endometrioid-type.

CASE 1: KINDA HERTZ, AGE 62

- **Mrs. Hertz is referred by her gynecologist to Gynecologic Oncology.**
- **Mrs. Hertz, in conversation with a friend, hears about Cancer Navigation Services.**
- **She wants to know more about their services**
- **Nurses: Can Mrs. Hertz refer herself to CNS?**
- **CNS: Where on the CCMB website can she find contact information?**
- **CNS: What questions will you have for Mrs Hertz?**
- **Can you help her? In what way?**
- **What will you advise Mrs. Hertz?**

CASE 1: KINDA HERTZ, AGE 62

- TAH/BSO and lymph node sampling.
- Stage IB endometrial adenocarcinoma was diagnosed.
- Wants to be sexually active
- Vaginal dryness, pain with intercourse
- Atrophic vaginitis
- Long-acting lubricant advised
- Mrs. Hertz wants to know if there is anything that can be done so she doesn't have to use lubricants

CASE 1: KINDA HERTZ, AGE 62

1. **Can Mrs. Hertz use a topical estrogen?**

Yes, e.g. Conjugated estrogen cream i applicator full PV at h.s. and applied sparingly on a daily basis to the labia.

2. Can she take oral estrogens?

Yes, Mrs. Hertz can safely use oral estrogens, e.g. conjugated estrogens 0.625 mg daily. She has no need for a progestin, as she has no uterus.

3. What would your answers to the above be if she had been diagnosed with a Stage III endometrioid adenocarcinoma of the endometrium and had completed six cycles of carboplatin and paclitaxel two months ago?

Mrs. Hertz could still use HRT.

CASE 1: KINDA HERTZ, AGE 62

4. Pharmacists: list other products, equivalent to conjugated estrogens 0.625 mg daily, which Mrs. Hertz could use.

CASE 2: LOTTA SPUNK, AGE 72

- **Former triathlete**
- **5’8’’ tall and 145 lbs, well-muscled.**
- **Has gradually scaled back on her fitness routine**
- **Training for the half-marathon**
- **c/o irritative bladder symptoms**
- **Mass in the right adnexum**
- **Ultrasound - large septated lesion**
- **Ca-125 = 617**
- **TAH/BSO, washings and lymph node dissection**
- **Stage IC low grade carcinoma**
- **No chemotherapy.**

CASE 2: LOTTA SPUNK, AGE 72

- two weeks post op
- resume jogging?
- half marathon in three months?
- wants to bulk up lower limbs & strengthen core
- your advice on weight lifting?

CASE 2: LOTTA SPUNK, AGE 72

- F/U ovarian cancer
- One year post-op
- Ran half marathon eight months ago
- UTI Sx x 3 months
- Constant dull ache in the pelvis and low back.
- Walks 1 mile/day
- Constipation x 1 week
- Crampy pains prior to bowel movements
- Ca-125 = 842.

CASE 2: LOTTA SPUNK, AGE 72

- CT pelvis & abdomen: pelvic mass
- Tumor implants rectum and bladder
- Moderate ascites
- Enlarged retroperitoneal nodes.
- Right hydroureter and hydronephrosis
- Creatinine last year was 62, now 84
- Hb is 116 g/L, normal indices.

CASE 2: LOTTA SPUNK, AGE 72

Mrs. Spunk has recurrent ovarian cancer which is symptomatic and an eGFR of 58.

- **Is she well enough to receive chemotherapy?**
- **What tools can you use to assess her fitness for chemo?**

CARG SCORE

Risk Factors for Grade 3-5 toxicity	OR(95% CI)	Score
Age ≥ 72 years	1.8(1.2-2.7)	2
GI/GU cancer	2.2(1.4-3.3)	2
Standard dose	2.1(1.3-3.5)	2
Poly-chemotherapy	1.8(1.1-2.7)	2
Hemoglobin(<110 male, <100 female)	2.2(1.1-4.3)	3
CrCl (Jeliffe-ideal wt) < 34cc/min	2.5(1.2-5.6)	3
1 or more falls in last 6 months	2.3(1.3-3.9)	3
Hearing impairment (fair or worse)	1.6(1.0-2.6)	2
Limited in walking 1 block (MOS)	1.8(1.1-3.1)	2
Assistance required in med intake	1.4(0.6-3.1)	1
Decreased social activity (MOS)	1.3(0.9-2.0)	1

ASSESSING FRAILTY

Clinical Frailty Scale*

1 **Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 **Well** – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

3 **Managing Well** – People whose **medical problems are well controlled,** but are **not regularly active** beyond routine walking.

4 **Vulnerable** – While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up", and/or being tired during the day.

5 **Mildly Frail** – These people often have **more evident slowing,** and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 **Moderately Frail** – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7 **Severely Frail** – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 **Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. **Terminally Ill** - Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail.**

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

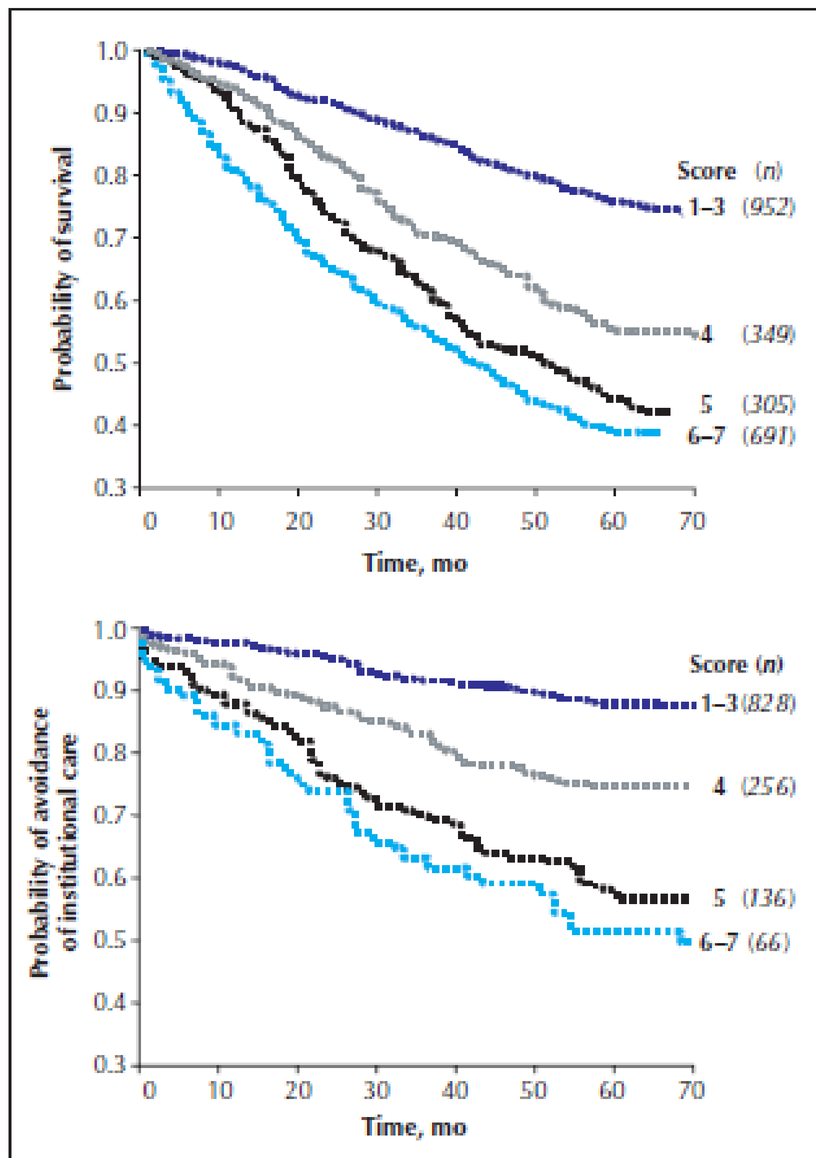


Fig. 1: Kaplan–Meier curves, adjusted for age and sex, for study participants (*n*) over the medium term (5–6 years), according to their scores on the CSHA Clinical Frailty Scale. Some scores were grouped. Top: Probability of survival. Bottom: Probability of avoidance of institutional care.

CHEMOTHERAPY & RISK OF TOXICITY

http://www.mycarg.org/Chemo_Toxicity_Calculator

PREDICTION TOOL

Gender:	Select	
Patient's Age:		
Patient's Height:	Select	Select
Patient's Weight:	Select	Select
Cancer Type:	Choose	
Dosage:	Choose *	
Number of chemotherapy agents:	Choose	
Hemoglobin:	Select a value	
How is your hearing (with a hearing aid, if needed)?:	Choose	
Number of falls in the past 6 months:	Choose	
Can you take your own medicines?:	Choose	
Does your health limit you in walking one block?:	Choose	
During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?:	Choose	
Select Serum Creatinine:	Choose	
Creatinine Clearance:	**	
	Submit	
Toxicity Score:		
Risk of Chemotherapy Toxicity:		
	What does this mean?	

* Dose delivered with first dose for chemotherapy

** Jeliffe formula

ESTIMATING ANTICHOLINERGIC BURDEN

http://www.anticholinergicscales.es/

CASE 3: BARB WIRE, AGE 57

- Mrs. Wire presents to ER with ++ abdominal pain.
- 18 months ago: TAH/BSO, tumor debulking and pelvic node dissection for Stage III ovarian cancer.
- Dose-dense carboplatin & paclitaxel, did well initially.
- 6 months ago CT showed recurrent tumor in the pelvis.
- Back on carboplatin and paclitaxel,
- Due for cycle 6 medications in three days.

CASE 3: BARB WIRE, AGE 57

- **Over the past week her bowels have slowed**
- **Tylenol #3, 4-6 tablets/day for lower abdo & back pain**
- **PEG powder 17 g daily. Stools - soft.**
- **Yesterday - crampy bilateral lower abdominal pain, nausea**
- **Today - pain all over abdomen, vomiting**

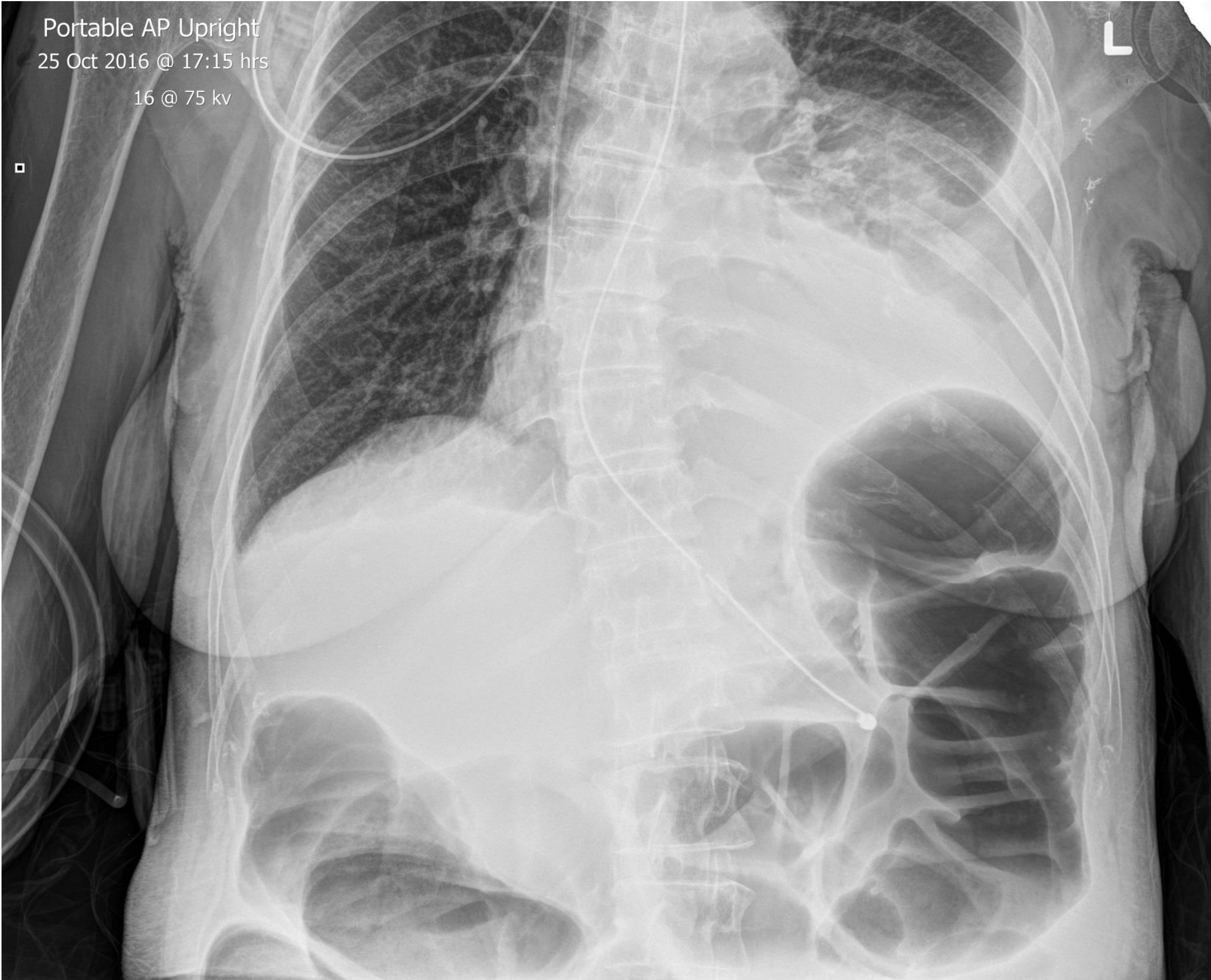
CASE 3: BARB WIRE, AGE 57

On examination:

- Distressed,
- T 36.8 C, P 102, BP 144/92, O2 sats 98%, RR 22.
- Color normal.
- Abdomen distended
- Bowel sounds groaning and tinkling.
- Irregular firmness lower quadrants
- No hepato- or splenomegaly.
- Fluid wave & shifting dullness.

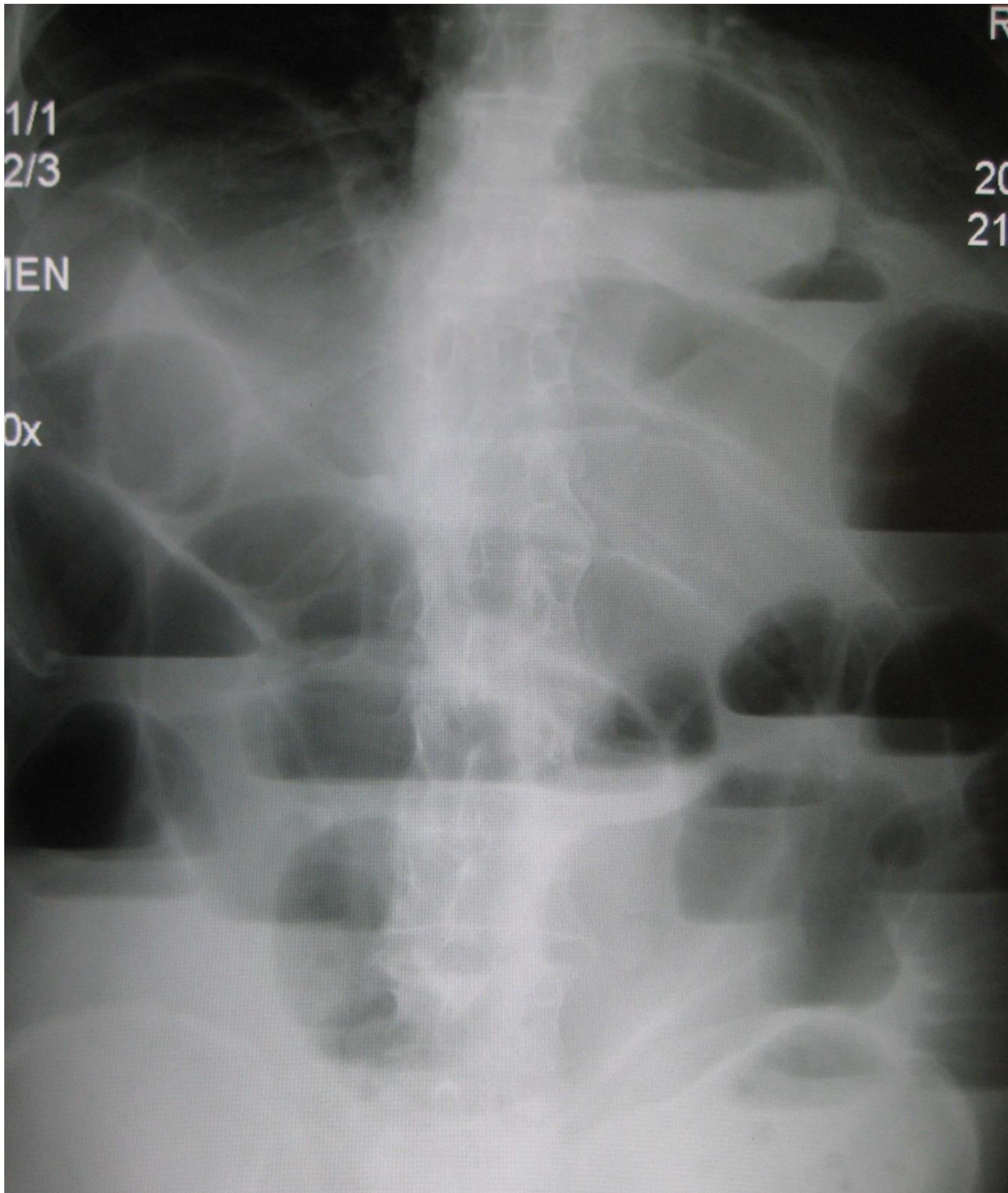
LABORATORY VALUES

- **WBC 14.4**
- **ANC 10.2; no shift**
- **Hb 128 g/L, platelets 377**
- **Corrected Ca++ 2.68 mmol/L**
- **Albumin 26 g/L**
- **BUN is 14.8 mmol/L**
- **Creatinine 176**
- **Liver enzymes elevated, < 2x ULN.**
- **X-ray could have looked like this…..**

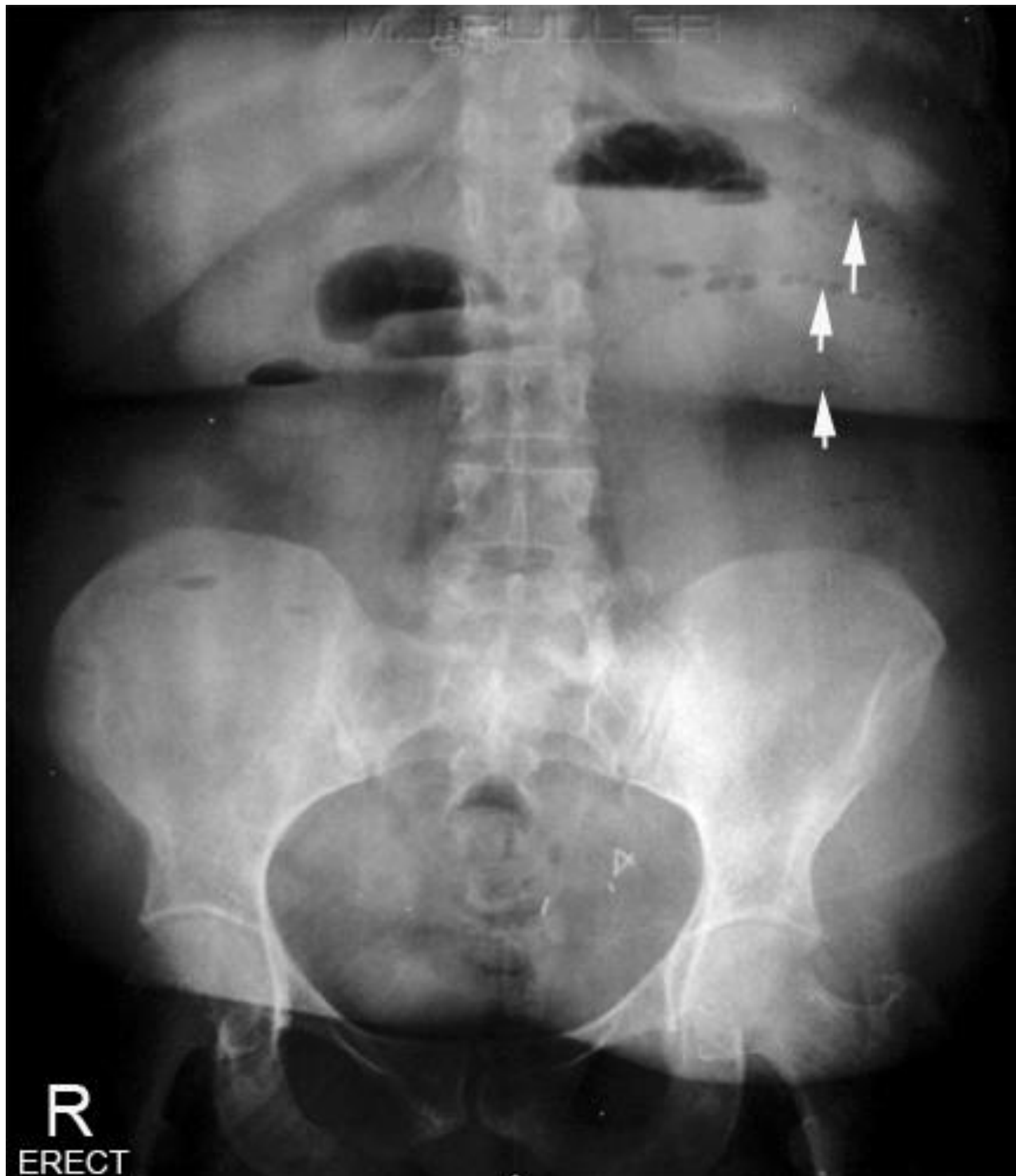

Portable AP Upright
25 Oct 2016 @ 17:15 hrs
16 @ 75 kv
L

CASE 3: BARB WIRE, AGE 57

But actually looked like this…



James Heilman, MD



FROM WIKI RADIOGRAPHY: STRING OF PEARLS SIGN (SMALL BOWEL OBSTRUCTION)

CASE 3: BARB WIRE, AGE 57

What is wrong with Mrs. Wire?

How can you help her?

BOWEL OBSTRUCTION

A mechanical or functional impediment to the normal movement of the products of digestion through the GI tract

Differential diagnosis

- **Adhesions**
- **hernias**
- **Volvulus**
- **Intussusception**

BOWEL OBSTRUCTION

- **Inflammatory bowel disease**
- **Tuberculosis**
- **Appendicitis**
- **diverticulitis**
- **Ileus (e.g. bowel contusion)**
- **Constipation**

MALIGNANT BOWEL OBSTRUCTION

Diagnostic criteria:

- **clinical evidence of bowel obstruction**
- **distal to the Treitz ligament**
- **presence of primary intra-abdominal, or**
- **extra-abdominal cancer with peritoneal involvement, and**
- **absence of reasonable possibilities for a cure**

MALIGNANT BOWEL OBSTRUCTION

Malignant bowel obstruction

Global prevalence - 3% to 15% of Ca patients

5-51% of ovarian cancers

Consider surgery

Early disease

Good performance status

single level of occlusion

BOWEL OBSTRUCTION

Mechanical or functional?

Large or small?

Fit for surgery, or palliation only?

Complications

- Ischemia
- Perforation
- Sepsis

How to decide?

By KGM007 Public Domain,
https://commons.wikimedia.org/w/index.php?curid=948365

CASE 3: BARB WIRE, AGE 57

Antibiotics?

Fluids?

Antiemetics?

Pharmacy: what antiemetics? What doses?

Steroids?

CASE 3: BARB WIRE, AGE 57

Mrs. Wire is feeling much improved after:

- 1 liter of IV normal saline
- 8 mg of dexamethasone
- 2 mg of IV haloperidol
- 8 mg of IV ondanstron
- 2 mg of IV hydromorphone.

MBO: SURGERY?

Consider palliative surgery in selected patients with:

- **good performance status**
- **longer treatment-free interval**
- **absence/small volume ascites**
- **single-site disease,**
- **good albumin level**

What next?

CASE 3: HOSPITAL DAY 1

- **Admit; NPO**
- **IV @ 100 mL/hour**
- **ondansetron 8 mg IV Q8H**
- **haloperidol 1 mg IV Q 12H & 1 mg Q6 H prn**
- **hydromorphone 1 mg IV Q1H prn**
- **dexamethasone 4 mg IV BID.**
- **Her pain is "1"/10. Nausea tolerable.**
- **Her main complaint: uncomfortable distension**

PARACENTESIS

What are the indications for paracentesis?

- **Diagnosis of etiology of ascites**
- **relief of uncomfortable distension**
- **respiratory compromise from large volume ascites**

PARACENTESIS

https://www.google.ca/search?q=youtube+paracentesis+nejm&rlz=1C1CHWA_enCA630CA630&oq=Youtube+paracentesis+&aqs=chrome.1.69i57j0l3j69i64.14487j0j8&sourceid=chrome&ie=UTF-8

Length: 3.092 cm

16.2 cm

2D: G: 50

DR: 0

SonoSite

CASE 3, HOSPITAL DAY 1

Bedside ultrasound:

- **large volume ascites, but**
- **Many small pockets**
- **distended loops of bowel**
- **air fluid levels**
- **Paracentesis deferred**

CASE 3: HOSPITAL DAY 2

The next morning at rounds:

- **Mrs. Wire says she vomited once overnight.**
- **pain ranges from 2-3/10**
- **four doses of IV hydromorphone in the past 10 hours, two prn haloperidol doses.**
- **No flatus or stool**
- **Can’t do chemo**

CASE 3: HOSPITAL DAY 2

BY THE END OF YOUR OFFICE DAY

When you repeat your rounds, Mrs. Wire

- **is slightly drowsy**
- **pain free on hydromorphone 1 mg IV ~ Q4H**
- **denies nausea**
- **has passed gas**

You advise

- **sips of water**
- **diet might be advanced next am if she is doing well.**

CASE 3: HOSPITAL DAY 3

THE NEXT MORNING

Mrs. Wire is

- **feeling tired**
- **no pain or nausea on hydromorphone 1 mg subcut Q4H**

You increase her oral intake but keep her on clear fluids.

Within an hour of taking some gelatin and a cup of coffee

- **abdominal cramping**
- **vomiting**

CASE 3: HOSPITAL DAY 3

NEXT STEPS

- **Discussion with Gyne Onc**
- **CT: disease progression throughout the pelvis and some enlarging intraabdominal and retroperitoneal nodes, and multiple tumor deposits on the small and large bowel serosa and mesentery**
- **Queried small, walled off perforation of transverse colon**
- **What is your next course of action?**
- **What decisions need to be made?**

CASE 3: HOSPITAL DAY 3

The consultant advises

- No chemo
- Consider venting gastrostomy; no other surgery
- Enrollment on Palliative Care program.
- Tentatively - home with Home care

But -

- Still nauseated
- No gas nor stool, now five days into her admission
- Would accept sedation over nausea, pain or delirium

DELIRIUM?

- Don’t wait for delirium to negotiate goals of care
- Speak with patient and family in advance
- Treat aggressively
- Moans, startles are common & not painful
- CAM (fluctuating, illogical, can’t concentrate)

CASE 3: HOSPITAL DAY 6

- Declines venting gastrostomy
- octreotide 100 ugm subcutaneously Q8H; increased to 150 ug Q8H
- Good control of nausea & pain
- dexamethasone 4 mg subcut BID
- hydromorphone 1 mg Q 4H plus Q1H prn (~10 mg/day)
- haloperidol 1 mg Q8H subcut
- Low-residue snacks
- Occasional emesis

CASE 3: HOSPITAL DAY 7

- Increase in abdominal pain
- No N/V
- Fever
- Tachycardia
- Hypotension
- Diffuse abdominal tenderness ++
- Declines antibiotics
- Hydromorphone increased 2 mg Q4H + Q1H prn
- By that afternoon - pain improved

CASE 3: HOSPITAL DAY 8

Restless, disoriented, can’t focus

Jumps whenever touched, anywhere

Are you having pain? – Yes

Are you comfortable? - Yes

Are you in Las Vegas? - Yes

Still febrile

RR 24

Worsening hypotension

No myoclonus

No emesis

CASE 3: HOSPITAL DAY 8

Continue

- hydromorphone subcut 2 mg Q 4H + Q 1H prn
- haloperidol 1 mg Q8H subcut

Add

- Methotrimeprazine (Nozinan) 5 mg subcut Q4H scheduled
- + 2.5 mg Q2 H prn
- titrate up as needed

Consider opioid rotation if OIN:

- Increasing pain with increasing opioid
- Delirium
- myoclonus

TAKE HOME MESAGES

1. **Malignant bowel obstruction:**

   A. if surgery is an option, it's (usually) the better one

   B. otherwise, anti-emetics; analgesia; steroids; diet manipulation; venting gastrostomy +/or octreotide if all else fails.

2. **Negotiate GOC proactively (vomiting is better than nausea; sleep is better than delirium or pain)**
3. **HRT after surgery for endometrial cancer: yes**
4. **Older patient? Consider screening tool +/- CGA prior to chemo decision.**