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To study the clinical profile of pelvic malignancies and its impact on quality of life

Medicine

KEYWORDS: pelvic malignancies, clinical profile, quality of life, EORTC QLQ-C30 Version 3.0

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ABSTRACT

Aims and objective-To study the clinical profile of pelvic malignancies and its impact on quality of life. Material and Methods- Study was conducted in the Department of Medicine, Surgery and Gynaecology ,Himalayan Institute of Medical Sciences, Swami Ram Nagar, Dehradun, over a period of 12 months prospective .

INCLUSION CRITERIA: -

1) The patients with primary malignancy of pelvic organs attending n Department of Medicine , Surgery and Gynecology.
2) Patients with histo-pathogical or cytological confirmation of malignancy

EXCLUSION CRITERIA

1) Patients with secondaries to the pelvis.
2) Patients with bone and soft tissue malignancy
3) Patients with extra pelvic urogenital malignancy

Written informed consent was taken before including the study.

METHODS

All the patients were subjected to detailed history and clinical examination .Relevant investigations for the confirmation of diagnosis and staging was done. Quality of life assessment of the subjects was done. Quality of life score was recorded as per EORTC QLQ-C30 Version 3.0 (European organization for research into the treatment of cancer).

The questionnaire scales and items covered-

1) Functional scales
2) Symptom scales/ items
3) Global health status

EORTC QLQ-C30 Version 3.0 Version 3.0 of the QLQ-C30 differs from version 2.0 in that it has point scales for the first five items (QLQ-C30 (V3)) these are coded with the same response categories as items 6 to 28 namely "Not At All", "A Little", "quite a Bit" and "Very much". To allow for these categories question 4 has been re-worded as "Do you have to stay in a bed or a chair during the day?". Version 3.0 has been tested in EORTC field studies.

Version 3.0 is currently the standard version of the QLQ-C30, and was used for all new studies, various modules have been developed by the EORTC for standing quality of life in various cancer.,Conclusion- We studied 85 cases of pelvic malignancies and Quality of life was accessed in them. After pre and post treatment, we found that maximum adverse effect was seen in patients of ovarian carcinoma. They were having poor Functional scale high Symptom scale and poor quality of life. Otherwise ,quality of life was better in post treatment patients.

INTRODUCTION

Cancer is generic term for a large group of diseases that can affect any part of the body. Other terms used are malignant tumors and neoplasms. Metastases are the major cause of death from cancer . Cancer is the second leading cause of death in developed countries 60% of all cancers are diagnosed in people who are older than 65 years of age. Cancer account for 7.9 million death and 13% of mortality worldwide. More than 60% of cancer death occur in developing regions particularly in India and China like country due to their large population [1].

Worldwide most common cause of death in male is Trachea Bronchus and lung cancer (22.5%), colon and rectum is 4th most common cause, prostatic is 6th most common cause of death. In female breast cancer is most common cause of death (15%), colorectal 4th (9.4%) utero-cervix 5th and ovary 9th most common cause of death [2].

Most common site of cancer in men is Lung and Bronchus in Mumbai, Delhi and Bhopal, Stomach cancer in Banglore and Chennai, hypophrangeal cancer in Bashi. Cancer of uterine cervix followed by breast cancer is most common site in women in all registries excepts in Mumbai, Delhi, Banglore where the two sites inter changes and in Uttarakhand breast cancer is most common and cervix is 2nd in rank [3]

Globaly Rectosigmoid cancers are the 4th commonest malignancy after lung and breast cancer. It is equally prevalent in men & women and most commonly presents at 60-70 years of age [4]. A diet lower in fiber and folic acid & diet rich in fat is known to be associated with rectal cancer [5]. Grossly rectal cancer can be annular or stenosing involving whole of the circumference with ulcerated or ulceroproliferative surface which are more likely to cause intestinal obstruction than any other form. [6]. Patients with rectal cancers can have broad range of clinical presentations. Most commonly presenting complain is constipation or change in the bowel habits either diarrhea or constipation. Other symptoms are bleeding per rectum, tenesmus, colicky pain in abdomen, Weight loss fever, malaise and Anorexia. Rectal bleeding can be mixed with stools or may coat the surface of stools or separate from stools. It can be bright red in colour. There can be increased frequency or decreased caliber of stools, mucus with stools or mucus with diarrhea and pain. Advanced tumors include a permanent sense of fullness. When the tumors invades the sacral plexus of nerves pain radiate down the perineum & thighs. Invasion of the anal canal and anal sphincter may lead to incontinence and may lead to fistula- in-ano [7].

Prostate cancer is the third most common neoplasm world wide in man and it is the most common visceral malignant Neoplasm is U.S. in men since 1984. Life time risk is 17.6% in whites and 20.6% in African Americans with risk of death of 2.8% and 4.7% respectively [8]. Prostate cancer rarely causes symptoms early in the cause of the disease because majority of adenocarcinomas arise in the periphery

of the gland distant from the urethra. The presence of systemic symptoms (e.g. Bone pain, renal failure, anemia) as a result of prostate cancer suggest locally advanced or widely metastatic disease growth of prostate cancer into urethra as bladders Neck can result in obstructive and irritative voiding symptoms. Prostate cancer can also be an incidental pathologic finding when tissue is removed at the time of trans urethral reflection for obstructive Prostatic symptoms [9].

Patient of urinary bladder malignancy usually present with painless hematuria, unexplained frequency and irritative voiding symptoms. Transurethral resection of bladder tumor with or without drug therapy is the mainstay of treatment.

Gynecological malignancies are most often diagnosed in post menopausal womens but these malignancies can also arise in pre menopausal women.Globally cervical cancer is the 2nd most common site in female.

In India it is the most common site of cancer in women except in Chennai, Mumbai, Delhi, Banglore where breast cancer is the most common. In Uttarakhand cervical carcinoma is 2nd most comman site [10,11].

Ca cervix early invasive cancers may be asymptomatic, others presents with postcoital, intermenstrual or post menopausal bleeding, mal odorous vaginal discharge, dyspareunia or cramping pelvic pain lower extremity swelling or problem with micturation or defecation in advanced regional diseases. Constitutional symptoms are anorexia and weight loss. For the treatment of cervical cancer, conization, wertheim's radical hysterectomy, chemotherapy, radiotherapy and chemo radiation can be used.

Endometrial cancer most often occur in the sixth and seventh decades of life, at an average age of 60 years. 75% cases occur in woman older than 50 years of age [12].

About 90% of women with endometrial carcinoma have vaginal bleeding or discharge. Some woman experience pelvic pressure as discomfort and about 5% women diagnosed with endometrial cancer are asymptomatic.

Ovarian cancer is the fifth most common cause of death from malignancy in women, A woman's risk at birth of having ovarian cancer some time her life is 1-1.5%. In India it is 3rd most common site in Chennai, Delhi, Mumbai, Bhopal and in Banglore it is 5th site of Cancer in female and in Uttarakhand 4th most common site [13].

Clinically ovarian cancers patients may present with abdominal discomfort, bloating, urinary tract symptom, ascitis and abdominal mass.

EORTC QLQ

Quality of life may be defined as subjective well being. There is evidence that cancer patients suffer psychological ill health. Consequently, increasing attention is being paid to the emotional and physical will being (Quality of life) of patients [14,15].

In 1986, the European organization for research and treatment of cancer (EORTC) initiated a research program to develop on integrated modular approach for evaluating the quality of life of patients in international clinical trials. The QLQ-C30 consists of nine multi- item scales: five functional scales and 3 symptom scales.

MATERIAL AND METHODS

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OBSERVATION

Colorectal Carcinoma

In study of pelvic malignancies 66 cases of colorectal carcinoma were taken.

Table 1 Distribution of cases according to age

S.No	Age Group	No. of patients	Percentage
1	< 30	7	10.16 %
2	31 – 40	12	18.18 %
3	41 – 50	15	22.72 %
4	51 – 60	10	15.15 %
5	61– 70	17	25.75 %
	> 70	3	4.54 %

Table 2 Clinical presentation

S.No	Symptom	No. of patients	Percentage
1	Bleeding PR	47	71.21%
2	Altered Bowel Habit	39	59.09%
3	Pain abdomen	34	51.51%
4	Discharge Per vaginal	2	3.03%
5	Discharge per urethral	3	4.54%
6	Abdominal mass	10	15.15%
7	Constipation	30	45.45%

Prostate cancer

This study includes 31 patients of prostatic cancer, out of various pelvic malignancies.

Table 1 : Age distribution

S.No	Age Group	No. of patients	Percentage
1	< 60	1	3.22%
2	60 – 69	8	25.80%
3	70 – 79	10	32.25%
4	80 – 89	9	29.03%
5	> 90	3	9.67%

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Patients presented with following symptoms

Table 2 : Distribution by symptoms

S.No	Presenting symptoms	No. of patients	Percentag
1	Retention of Urine	24	77.41%
2	LUTS	26	83.87%
3	Haematuria	8	25.80%
4	Bone pain	13	41.93%
5	Chest Pain	2	6.45%

Most of the patients presented with lower urinary tract symptoms. Other common symptoms are retention of urine and bone pain .

Urinary Bladder

For study of clinicopathological profile of pelvic malignancy, 40 cases of bladder carcinoma were taken which included prospective study.

Table 1 : Distribution according to age

S.No	Age Group	No. of patients	Percentage
1	< 40	1	2.5
2	40 - 49	4	10
3	50 – 59	10	25
4	60 – 69	11	27.5
5	70 – 79	13	32.5
6	>80	1	2.5

Patient presented with various complications grouped according to symptoms as follow.

Table -3 Clinical Presentation

S.No	Presenting symptoms	No. of patients	Percentage
1	Haematuria	38	95
2	Recurrent UTI	15	37.5
3	ROU	22	55
4	Pelvic Pain	17	42.5
5	Weight Loss	21	52.5

Ovary

In the study of pelvic malignancies 35 cases of ovarian neoplasm were taken.

Table 1: Distribution of cases according to age

S.No	Age Group	No. of patients	Percentage
1	< 35	2	5.71
2	35 – 44	5	14.29
3	45 – 54	7	20
4	55 – 64	11	31.42
5	65– 74	8	22.85
	> 75	2	5.71

Table 2 : Clinical Features

S.No	Presenting symptom	No.of patients	Percentag
1	Abdominal distension	30	85.71%
2	Abdominal Pain	10	28.57%
3	Urinary symptom	5	14.29%
4	Constipation	7	20%
5	Back pain	9	25.71%
6	Bloating	24	68.57%

In our study majority of patients presented with abdominal distension 30(85%); Urinary symptoms were present in14%patients, bloating was present in 24(68%) patients; 26% were having back pain (Table 2).

Uterocervix

For Clinicopathological study of pelvic malignancies, 57 cases of uterocervix carcinoma were taken which included carcinoma of uterus alone or together with carcinoma of cervix

Table 1 : Distribution of cases according to age

S.No	Age Group	No. of patients	Percentage
1	< 35	1	1.75
2	35-44	14	25.56
3	45-54	15	26.32
4	55-64	17	29.82
5	65-74	7	12.28
6	>75	4	7.02

Table 2: Distribution of case according to clinical features

S.No	Type	No. of patients	Percentage
1	Vaginal bleeding	46	80.70
2	Abnormal discharge	32	56.14
3	Weight loss	23	40.35
4	Abdominal pain	11	19.30
5	Abdominal mass	6	10.53

Radial Hysterectomy is main operation in our institute, radical hysterectomy was done in 21 patients .when disease was in advance stage and nonopereble, chemoradiation was given in 17 patients and conization was done in two cases who has minimal disease (Table 5).

DISCUSSION

Quality of life

EORTC has developed a module to study the quality of life in cancer patients . Initialy they developed QLQ-C36 module to study the quality of life in cancer patients but now- a -days it is outdated and EORTC QLQ-C30 module has been developed for better understanding the quality of life in cancer patients. It has three versions and in todays practice version 3 is most commonly used

In our study we used QLQ-CX24 to study the quality of life in cervical carcinoma along with QLQ-C30. In other type of carcinoma we used only QLQ-C30 to study the Functional scale, Symptom scale and Global health status scores. Questions were asked according to module then Raw score was calculated. Functional, symptom and global health status score was then calculated from Raw Score .High functional score denotes high functional capacity and low score means less functional capacity. High symptom scale indicates that patient is more in problem while low symptom scale is good indicator of health.

In our study various scale were calculated prior to treatment and after the treatment .We found that functional scale was more than 50 in 54 patients and below 50 in 31 patients prior to treatment and was more than 50 in 69 patients and below 50 in16 patients after the treatment .

Symptom score was high in 30 patients and below 50 in 55 patients before treatment and was above 50 in 14 patients and below 50 in 71 patients after treatment. High symptom score indicates that patients is more symptomatic while low score denotes that patient is more comfortable. Global health status score was more than 50 in26 patients and below 50 in 59 patients before the treatment and after treatment global health status score was above 50 in 71 patients and below 50 in 14 patients which indicates that quality of life of patients has improved after treatment.

Seiden Feld J 2000 and Beduk et al 2007 studies showed that there was no statistically significant survival advantage or a small difference in overall survival at 5 years as compared between surgical and medical castration [16,17]

CONCLUSION

We studied cases of pelvic malignancies attending medicine, surgery and gynae OPD and Quality of life was accessed in them. After pre and post treatment, we found that maximum adverse effect was seen in patients of ovarian carcinoma. They were having poor Functional scale high Symptom scale and poor quality of life. Otherwise ,quality of life was better in post treatment patients.

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