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Quality of life among patients with gynecological Cancer Attending Woman's Health Hospital and their needs of palliative care

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Abstract

Palliative care is an interdisciplinary provider and a basic technique to care that improves quality of life and alleviates struggling for the ones residing with critical illness, irrespective of prognosis. **Aim of the study** was to assess quality of life for gynecological cancer patients managed at Women's Health Hospital and assess the needs of these patients for palliative care **Subjects and methods:** Descriptive cross sectional study was applied on 50 women who suffered from gynecological cancer, conducted at inpatients' gynecological oncology′s unit at Women Health Hospital, Assiut University**,** two tools were used structured interview questionnaire and FACIT-Pal questionnaire, the last one contained 46-item to degree of self-reported health-related quality of life**. Results:** About 46.0%, 22.0% and 32.0%of studied women had low, moderate and high quality of life respectively, and 68.0% of them need palliative care .**Conclusion:** Most patients of gynecological cancer need palliative care. **Recommendations**: Provision the Palliative care for all gynecologic cancer patients from the start of diagnosis.

Keywords: Gynecological Cancer, Palliative Care & Quality of Life.

Introduction

Gynecologic cancer is any cancer that begins off evolved in woman's reproductive organs .Five main kinds of most cancers have an effect on women reproductive organs that cervical, ovarian, uterine, vaginal and vulvar. As a group, they may be cited as gynecologic cancer. A 6th kind of gynecologic cancer is the very rare fallopian tube cancer **(Ledford & Lockwood, 2019).**

Patients with gynecologic cancer receiving remedy with curative cause with surgery, chemotherapy, and/or radiation frequently face many hard troubles in the course in their diseases,, starting from physical and psychological symptoms to advance care making plans in mild of a negative prognosis, that make compliance with treatment guidelines hard **(Karlin et al, 2018)** and can have an impact on negatively on quality of life of women and their relatives **(Terzioglu & Sahan, 2016).**

The World Health Organization describes palliative care as "an method that improves the standard of lifetime of patients and their families facing the issues related to life-threatening illness, through the prevention and alleviation of struggling through early identity and impeccable evaluation and treatment of pain and different troubles as physical, psychosocial, and spiritual **(WHO, 2020)**.

Globally forty million human beings are anticipated to want palliative care every year, but it's been anticipated that most effective 14% are in receipt of such care. Worldwide reviews forecast that call for for palliative care is about to increase over the following several decades, in reaction to alter demographics, longer disorder trajectories and extra co-morbidity **(Hasson. et al, 2020).**

The integration of palliative care into standard gynecological cancer treatment is associated with cost savings, increased survival, reduced symptom burden, and improved quality of life for patients and caregivers (**Lindemann, et al, 2020).**

Palliative care nurses paintings with individuals and relatives going through a life proscribing illness. Palliative care nurses paintings inside the interdisciplinary group, however will frequently coordinate care in session with clients, their caregivers and different group members. The interest of nursing is a complicated blend of many hands-on capabilities and private characteristics certain together into an eclectic field this is inherently hard to define. The notion of professional caring, the constructing of therapeutic relationships and also the practice of nursing as a regulated career with definable requirements consist of in imparting palliative care to patients **(Mazanec. et al, 2019).**

Being available in addition to a coordinator characterizes the nurse's function across healthcare systems. The nurse acts as a hyperlink among distinctive levels of health care, between different professions among affected patients and family, which make a contribution to make sure the quality of care to the individual patient.

Advocating for access to palliative care for the critically ill, culturally respectful care on the give up of life, and honoring values, practices, and ideals are essential roles of the nurse **(Sekse, et al, 2017).**

Significance of the study:

Gynecological cancer incidence in the world is estimated 1,309,165 new cases and 609,377 gynecological cancer deaths nearly 46% **(Bray et al, 2018).** The Estimated gynecological cancer at Egypt in 2020 will be 6205 case in an estimated population of 96,260,017 **(Ibrahim etal, 2014)**

Patients with gynecologic cancer face many hard problems in the route in their diseases, starting from physical symptoms to advance care-making plans in mild of bad prognosis. This evaluation examines the evidence supporting integration of palliative care early within the course of disease and symptom management, and gives a framework for hard conversations **(Roy & Ramchandran, 2020)**.

The mixing of palliative care into standard gynecologic cancer care is related to cost-savings, longer survival, decrease symptom burden, and improve quality of life for patients and caregivers **(Bruno, et al., 2020).**

Aim of the study:

- Assess the quality of life for gynecological cancer patients managed at Women's Health Hospital.
- Assess the need of these patients for palliative care.

Research question:

1. What are the levels of quality of life for gynecological cancer patients?
2. Do all gynecological cancer patients need palliative care or not?

Subjects and Methods of this study:

Subjects and methods of this study divided into four designs technical, operational, administrative and statistical design.

Technical design: Which involved research design, setting, sample and tools of the study

Study design: Descriptive cross sectional design was applied in this study.

Setting of the study: The setting involved two places, the first place; conducted at in patients' gynecology oncology's unit at Women Health Hospital, Assiut University. Oncology unit found in the fifth floor, which consisted of five rooms. Examinations room, pre-operative room, postoperative room, room for the director and the nursing room. The second place was the outpatients' clinic on the second floor at Women Health Hospital.

Sample size:

A convenient sample was used in this study. The total number of patients was 50 patient .The sample size as calculated by using the following formula.

$$n = \frac{N \times p(1-p)}{\left[\left[N-1 \times \left(d^2 \div z^2\right)\right] + p(1-p)\right]}$$

n= sample size

N= total patient population size of 50 who attended the gynecology department at Assiut university hospitals. During year 2019- 2020

Z = confidence levels is 0.95 and is equal to 1.96

D= the error ratio is = 0.05

P= the property availability ratio and neutral = 0.50

Inclusion criteria:

- Patient diagnosed with gynecologic cancer
- Patient's age >18 years.
- Patient accepts to participate in the study

Exclusion criteria:

- Patient has chronic mental illness and not on treatment.
- Disturbed conscious level patient.

Tools:

The researcher used two tools in this study to collect data

Tool (1):-

Structured interviewing questionnaire that contained the following:

Socio demographic data: such as name, age, educational levels, occupation, residence, marital status and telephone number.

Obstetric and Gynecological history: as gravidity, parity, abortion and any other gynecological diseases as polycystic ovary or uterine fibroid …..etc.

Current patient gynecological cancer data: which include type of cancer, stage, admission status if the patient inpatient or outpatient and therapeutic status as at diagnosis, in treatment.

Data regarding palliative care: such as palliative care need and type of palliative care referral as pain management, psychotherapy, physiotherapy, and symptoms control.

Tool (II)

(FACIT-Pal questionnaire) Assessment quality of life and need for palliative care Functional Assessment of Chronic Illness Therapy- Palliative Care (FACIT-Pal) questionnaire which includes: 46-item measure of self-reported health-related quality of life. It is adapted from **(Brady et al 1997).**

The questionnaire contains two parts:

I. The Functional Assessment of Cancer Therapy-General (FACT-G) 27-item which measures four domains of quality of life: physical well-being (seven items). Social/ family well-being (seven items), emotional well-being (six items) and functional well-being (seven items).
II. Included 19 items that provide the Palliative subscale.

FACIT-pal scoring system

The FACIT-Pal scored as the sum of item responses, which range from 0 = 'not at all' to 4 = 'very much'.)

- FACT –G 27 items ranged (0 -132).
- Palliative care subscale 19 items (0 – 76)
- The FACIT-Pal total score (0–184). Higher scores indicate better quality of life.

Scoring System

- **<50 % (<92)** low affection "good QOL"
- **50 - 70% (92- 129)** Moderate affection "average QOL"
- **>70% (>129**) High affection "poor QOL".

Validity of tools:

Tools reviewed by a panel of 3 experts in Maternity and Newborn Health Nursing at faculty of nursing, Assiut University. Each of experts was asked to examine tools for content coverage, clarity, wording, length, format and overall appearance.

Tools Reliability:

Cronbach Alpha done for two tools (questionnaire, and FACT-B scale), and founded that Cronbach Alpha were 0.745 and 0.867 respectively.

Operational design:

It was displayed in two phases piolet study and field work.

Pilot study

The pilot study carried out in October 2019 in order to test the feasibility and applicability of the tools. It was conducted on 10% of the sample (5patients) .The content and validity was done by expertise in medical and nursing field. After conducting a pilot study there weren't any modification on the tools and so the sample of the pilot study was included in the total sample.

Filed work:

The data collection started from first of October, 2019 to the end of September, 2020 (12month). This was achieved in three phases, pre intervention, intervention and post intervention phase:

Ethical Consideration:

- Research proposal was approved from ethical Committee in the faculty of nursing.
- There was no risk for study subject during application of the research.
- The study had followed common ethical principles in clinical research.
- Written consent was obtained from patients or guidance that was participated in the study, after explaining the nature and purpose the study.
- Confidentiality and anonymity assured.
- Study subject had the right to refuse to participate or withdraw from the study without any rational any time.
- Study subject privacy was considered during collection of data.

Pre intervention phase:

The researcher interviewed with the cancer's patients explained the nature of study and took her consent to be involved in the study.

Intervention phase:

All patients enrolled in women's Health Hospital accepted to participate in the study were included in the study. Patients were informed that completion of the study was completely voluntary. At first, the researcher greeted and introduced herself to the patient and her family (as a researcher of the current study), provide an explanation of the study including its purpose, use of results and anonymity of the tools, (maintain confidentiality).

The researcher met them in the women health hospital according to patient's status: outpatients or inpatients.

The researcher interviewed with patient that diagnosed with gynecological cancer by gynecologist. Each patient takes about 30-45 minutes to fill the tools. For more than 75% of cases, the questionnaire was read to patients and their family as they were illiterate then made a mark in front of their answers to assess what problems whatever physical, psychosocial, spiritual and or symptoms that the patient was experienced then make referral to specialist according to her problem.

Post intervention phase:

After determine the problem, the researcher were referred the patients to specialist according to her problem as the pain unit and the physical therapy unit at Assiut University Hospital and to symptom control by the unit doctor at Women's Health Hospital.

Administrative design:

This study was carried out under the approval of faculty of nursing's Ethical committee, Assiut University, also an official permission was obtained from the director of Woman Health Hospital, written consent was taken from each woman involved in the study, confidentiality was assured. The woman was freely to withdraw from the study at any stage.

Statistical design

Data analysis was performed using SPSS 20 statistical software. The qualitative variables were described using frequency and percentages, and quantitative variables were described using range, mean, and standard deviation. Chi-square test was used. P value <0.05 was considered significant.

Study strengths

The main strength is the current study was that it is the first study which was carried out to assess the quality of life and palliative care need for gynecological cancer patient at women health hospital at Assuit University.

Study limitations

- Most of the medical staff hasn't information about the palliative care.

- Difficulty in referral the patient to a specialist doctor relative to the out patients because most of the patients are from villages away from the Assiut University Hospital.

Results;

Table (1): Distribution of the studied women according to their personal Characteristics (n= 50)

Personal Characteristics	No.	%
Age (years):		
• 18-40	8	16.0
• 40-60	30	60.0
• >60	12	24.0
Age Mean ±SD	51.02±13.66	
Occupation:		
• House wife	38	76.0
• Working	12	24.0
Residence		
• Urban	8	16.0
• Rural	42	84.0
Educational level		
• Illiterate	38	76.0
• Basic education	7	14.0
• Secondary	3	6.0
• University	2	4.0
Marital status		
• Single	9	18.0
• Married	26	52.0
• Widowed	15	30.0
Admission status		
• Inpatient	33	66.0
• Outpatient	17	34.0

Table (2): Distribution of the studied women according to their obstetric history (n= 50).

Obstetric history	No.	%
Gravidity		
• Non	12	24.0
• Primi	6	12.0
• Multi	32	64.0
Parity		
• Non	12	24.0
• Primi	2	4.0
• Multi	36	72.0
Abortion		
• Yes	18	36.0
• No	32	64.0
Mode of delivery		
• Null	12	24.0
• Normal vaginal delivery	26	52.0
• Cesarean section	12	24.0

Table (3): Distribution of the studied women according to their current patient cancer data (n= 50).

Current patient cancer data	No.	%
Type of cancer		
• Uterine	19	38.0
• Ovarian.	28	56.0
• Cervical	3	6.0
Therapeutic status		
• At diagnosis	12	24.0
• In treatment	26	52.0
• <5 yrs. Since treatment	12	24.0
Stage of cancer		
• Stage I	10	20.0
• Stage II	7	14.0
• Stage III	9	18.0
• Stage IV	24	48.0

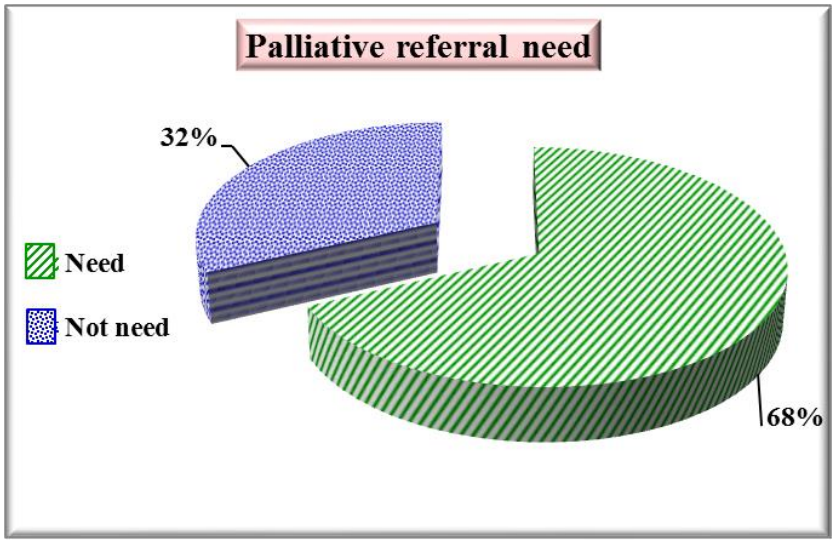

Figure (1): Distribution of the studied women according to palliative referral need.

Table (4): Distribution of the studied women according to their type of Palliative care needed.

Variable	No.	%
Type of palliative care referral if need		
Pain management		
• Yes	13	26.0
• No	37	74.0
Psychotherapy		
• Yes	4	8.0
• No	46	92.0
Physiothepy		
• Yes	8	16.0
• No	42	84.0
Symptoms control		
• Yes	22	44.0
• No	28	56.0

Some patients needed referral to more than one specialist.

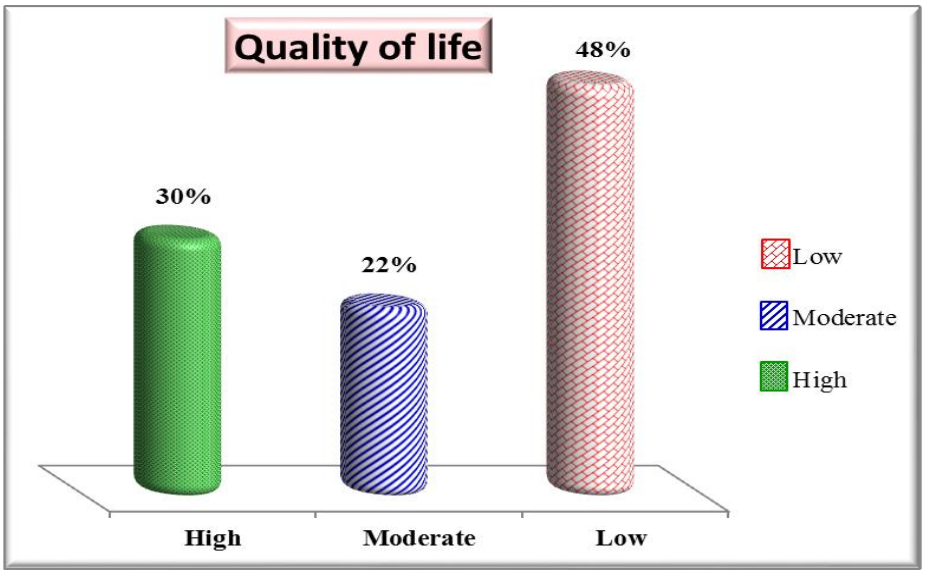

Figure (2): Distribution of the studied women according to their quality of life

Table (5): Relation between quality of life and personal characteristics

Personal characteristics	Quality of life						P –value
	High		Moderate		Low		
	N=15	%	N=11	%	N=24	%	
Age (years):							
• 18-40	6	40.0	0	0.0	2	8.3	
• 40-60	5	33.3	8	72.7	12	50.0	0.001**
• >60	4	26.7	3	27.3	10	41.7	
Occupation							
• House wife	10	66.7	9	81.8	19	79.2	0.591
• Working	5	33.3	2	18.2	5	20.8	
Residence							
• Urban	1	6.7	1	9.1	6	25.0	0.245
• Rural	14	93.3	10	90.9	18	75.0	
Educational level							
• Illiterate	8	53.3	8	72.7	22	91.6	
• Basic education	4	26.7	2	18.2	1	4.2	
• Secondary	1	6.7	1	9.1	1	4.2	0.001**
• University	2	13.3	0	0.0	0	0.0	

(**) highly statistically significant

Table (6): Relation between palliative care need with type of cancer, and stage of cancer.

Item	Palliative care				P –value
	Need		Not need		
	N=34	%	N =16	%	
Type of cancer					
• Uterine	13	26.0	6	12.0	0.998
• Ovarian.	19	38.0	9	18.0	
• Cervical	2	4.0	1	2.0	
Stage of cancer					
• Stage I	6	12.0	4	8.0	0.679
• Stage II	5	10.0	2	4.0	
• Stage III	5	10.0	4	8.0	
• Stage IV	18	36.0	6	12.0	

Table (7): Relation between quality of life and palliative care need

Palliative care need	Quality of life						P –value
	Low		moderate		High		
	N=34	%	N=11	%	N=15	%	
Type of palliative care need							
Need	21	87.5	8	72.8	5	33.3	0.002**
Not need	3	12.5	3	27.3	10	66.7	

(**) highly statistically significant

Table (1): Demonstrates personal characteristics of studied women and show that 60.0% of studied women's age ranged between (40-60yrs) with a mean age of 51.02±13.66 and 76.0% are housewives. Regarding women's residence 84.0% are from rural areas, 92.0% are Muslim. As for women's educational level 76.0% are illiterates. About 52.0% and 66.0% are married and inpatient respectively.

Table (2): Illustrates obstetric history of studied women and reports that 72.0% of women are multigravadia and 64.0% are multipara .About 64.0% of them have a history of abortion and 52% of them their previous mode of delivery were normal vaginal delivery.

Table (3): Clarifies current cancer data and finds that 56.0% of the studied women have ovarian cancer and 52.0% of them are in treatment. About 48% of them have a fourth (stage IV) of cancer.

Figure (1): Shows need of studied women to palliative referral and reports that 68.0% of the studied women need palliative care and 32% of them don't need palliative care.

Table (4): Reports type of palliative are needed of studied women and illustrates that 26% ,8% ,16% and 44% of women need to referral to pain management, psychotherapy, physiotherapy and symptoms control respectively.

Figure (2): Shows quality of life of studied women and clarifies that 48.0% of studies women have low quality of life, 22%moderte and 30% have high quality of life.

Table (5): Demonstrates relation between quality of life of studied women and personal characteristics and finds that there is highly statistically significant correlation between age and educational level and quality of life p-value are 0.001 for both, and there is not statistically significant correlation between occupation and residence and quality of life p-value are 0 0.591 and 0.245 respectively.

Table (6): Show Relation between Palliative care need and type of cancer and Stage of cancer and reports that there is no significant between Palliative care need and type of cancer and stage of cancer p-value are 0.998, and 0.679 respectively

Table (7): Reports relation between quality of life and palliative care needed and shows that there's highly statistical significant difference between quality of life and palliative care need p-value 0.002.

Discussion

Gynecological cancers are the most popular malignancies affecting women, which including cervical, ovarian, uterine, endometrial, vaginal, fallopian tube, vulvar , and placental cancer, accounting for 19% of all new women cancer cases **(Ma, et al, 2021).**

This study aimed to assess quality of life for gynecological cancer patients managed at Women's Health Hospital and to assess the need of these patients for palliative care.

As regard quality of life among studied women the existing study showed that less than one third, less than one half and less than one quarter of studied women had a high, moderate and low quality of life respectively.

These findings are consistent with **(Klapheke et al, 2019)**,who implemented their study to assess changes in health-related quality of life in older women after diagnosis with gynecological cancer in America and reported that less than one third of patients had a "poor" or "fair" quality of life. This support the importance of improving the quality of life of studied women affected by gynecological malignancy.

On the same line **(White et al, 2014),** who applied their study Chicago.to To examine the impact of pre-diagnosis depressive symptoms and mental health-related quality of life (HRQOL) on survival among older patients with multiple myeloma (MM) and reported that decreases in health related QOL were found among oncology patients regardless of time since diagnosis.

Regarding to palliative care need current study demonstrated that less than three quarter of studied women needs palliative care. It was supported by (**Afiyanti et al, 2018)**, who applied their study to assess the supportive care needs in predicting the quality of life among gynecological cancer in Canadia, and reported that less than tenth not need supportive care and the great majority of patients with some need .

Also **(Williams et al., 2018)**, who carried out their study to identify supportive care needs of Western Australian women experiencing gynecological cancer

and know their satisfaction with help and explore associations between participant's demographic characteristics and identified needs, and showed that the majority of cancer women need supportive care especially health system and information needs. In my opinion these similarity back to gynecological cancer need palliative care or supportive care need because of the disease and its treatment.

Concerning type of palliative care referral about more than one quarter need pain management and less than three quarter not need, less than one tenth need psychotherapy referral and the great majority not need, more than one sixth need physiotherapy referral and the majority not need and regarding symptoms control, more than two fifth need and more than one half not need.

On the same line (**Brenne et al, 2020),** who applied their study to identify fully integrated oncology and palliative care services at a local hospital in Mid-Norway: development and operation of an innovative care delivery model who demonstrated that about more than one quarter need pain management and less than one sixth need psychotherapy and less than one quarter need physiotherapy .This similarity support the importance of applying palliative care to all cancer patients.

On the other hand **(Johnson et al, 2018)**, who carried out their study in India to assess cancer specialists' palliative care referral practices and perceptions and found that most common causes for referral were: the need for symptom control, the presence of a serious illness or uncontrolled physical symptoms. Psychosocial issues less than half need palliative care referral and this support the importance of palliative care for gynecological cancer. Difference between current result and Johnson C. et al back to dissimilarity between both culture and traditions.

Also These findings disagree with **(Afiyanti et al, 2018**),who illustrated that physical patients :with no need(more than one sixth)Patients with some need (the majority),Psychological :Patients with no need (more than one quarter)Patients with some need (less than three quarters).Difference in type of referral back to change in setting that may back different traditions and needs

Regarding to the Relation between quality of life and palliative care need the present study reports that there's highly statistical significant difference between quality of life and palliative care need p-value 0.002.

This consistent with **(Silvaet et al., 2019),** who applied their study to assess the quality of life of patients with advanced cancer in palliative therapy and in palliative care in Brazil and reported that there was relation between general quality of life and palliative care p-value <0.05.

Also consistent with **(Mohammed et al, 2018),** who applied their study to assess the effectiveness of an educational program on quality of life improvement in women undergoing treatment for gynecological and breast cancer in El-Minia, and demonstrated that there was relation between quality of life and palliative care p-value 0.011.in my opinion similarity back to the culture and traditions.

On another hand this findings contracted with **(Krug et al, 2016)** ,who assess the correlation between patient quality of life in palliative care among breast cancer in German, and illustrated that the palliative care and patient quality of life not reach statistical significance p-value 0.07. This slightly difference back to working on breast cancer and not on gynecological cancer.

Regarding to the relation between quality of life and personal data, current study demonstrates that there is relation between age and educational level and quality of life p-value are 0.001 for both and there is no relation between occupation and residence and quality of life p-value are 0.591 and 0.245 respectively.

This supported by (**Tsai et al, 2018),**Who applied their study to examine the correlations among fear of cancer recurrence (FCR), illness representation (IR), self-regulation (SR), and quality of life (QOL) in gynecologic cancer survivors in Taiwan and demonstrated that there statistical significance difference between quality of life and age p-value 0.008 and level of education p-value 0.021, and no statistical significance difference between quality of life and employment status p-value 0.06 , marital status p-value 0.34 .

On the other hand (**Matos et al, 2017),** who applied their study to compare the quality of life and religious-spiritual coping of palliative cancer care patients with a group of healthy participants; assess whether the perceived quality of life is associated with the spiritual coping strategies and identify the clinical and sociodemographic variables related to quality of life and spiritual coping in America , and demonstrated that there was no statistical significance difference between quality of life and age p= 0.91 and education level p=0.13 . This difference back to difference on the study sample that Matos et al 2017 worked on to accomplish their study.

Regarding to the site of cancer more than one half of the studied women have ovarian cancer more than one third with uterine cancer, and less than one tenth with cervical cancer.These findings contracting with **(lee. et al., 2020)**, who illustrated that cancer diagnoses were cervical were more than one half, endometrial were less than one third, and ovarian were more than one sixth. In my opinion the large

number136 the main cause of this difference and culture difference.

Also (**Edianto, D., et al., 2019),** who applied their study to assess the quality of life for gynecologic cancer patients using functional assessment of cancer therapy-general (Fact-G) questionnaire at Haji Adam Malik hospital, and reported that involved female patients who have cervical cancer (more than one half), endometrial cancer (less than tenth), and ovarian cancer (more than one quarter). In my opinion this difference result from differ of culture and traditions.

Regarding to stage of cancer present study shows that early (Stage I and II) are more than one third and advanced (Stage III and IV) are more than one half.

This was nearly agreed with **(Atreya, 2017)**,Who implemented his study in India to assess a referral patterns of gynecological cancer patients to a palliative medicine unit: A 2 years retrospective analysis and showed that stage of caner III were one third and stage IV were less than one half.

On another hand this finding contracting with **(Afiyanti, et al, 2018)**, who found that early (Stage I and II) were less than three quarter and advanced (Stage III and IV) were less than one third. This difference back to change in setting and culture.

Regarding the therapeutic status of studied women, present study reports that more than one half is in treatment, less than one quarter at diagnosis, less than one quarter more than 5 years in treatment.

Near to previous finding **(Faller, et al, 2019)**, who applied their study in Germany to assess supportive care needs and quality of life in patients with breast and gynecological cancer attending inpatient rehabilitation and showed that the majority of studied women were in treatment with duration less than 5years and less than one tenth of them treated from more than 5 years.

Regarded to mode of delivery, present study reports that more than three quarter have normal delivery. on the same line **(Akinlusi, et al. 2020**),who applied their study to assess female urinary incontinence's prevalence, risk factors and impact on the quality of life of gynecological clinic attendees in Nigeria, and reported that nine in ten respondents had only vaginal deliveries (spontaneous or instrumental). In my opinion this similarity back to the culture and the country Nigeria.

As regard to personal characteristic, actual study shows that less than two thirds of the studied women's age between (40-60yrs) and the mean age ±mean of the women 51.02±13.66 , more than three quarters are housewives, more than three quarter are illiterates, one half were married, and the majority are from urban areas.

These findings are consistent with **(lee. et al., ,2020)**, who carried out their study in Taiwan to assess a diversity of sexual activity and correlates among women with gynecological cancer and demonstrated that the mean age of participants was 51.2 years ± 8.66 and the most of patients were married and the majority of them were illiterate.

While the current study finding was not in the same line with the study which done by **(Yeh, et al, 2020)** who applied their study to assess quality of life and its predictors among women with gynecological cancers in china ,who reported that under middle school were more than one quarter and less than three quarter were married .This difference comes from different of culture and country.

Conclusion

Based on the current study results, it was concluded that nearly half of gynecological cancer patients had a low quality of life and less than three quarter three of them need palliative care

Recommendations

The current study recommended that:

- The importance of planning and implementing necessary educational program about the palliative care for gynecological cancer to improve awareness of nurses and women and her family through different media.
- Training programs and workshops should be conducted for medical staff about how apply palliative care to improve gynecological cancer patients health and improve their quality of life.
- Implement a study to assess the effect of palliative care nursing on improvement of health status for gynecological cancer patients.

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