FOLLOW UP OF QUALITY OF LIFE AND SEXUAL WELLBEING IN GYNAECOLOGICAL CANCERS: A CROSS SECTIONAL STUDY

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ABSTRACT:

Background: *Gynaecologic cancers are malignancies that starts in women's reproductive organs including; cervical cancer, ovarian cancer, uterine cancer, vaginal cancer, and vulvar cancer. Relatively little is known about the determinants of QOL in women with gynaecologic malignancies and what can impact it, including matters of sexuality and intimacy. Vast amount of evidence exists showing that cancer dramatically impacts woman's sexuality and sense of self where sexual functioning can be affected by illness, pain, anxiety, stressful circumstances and medications. With improvements in early detection, surgery and adjuvant therapy, long term survival and cure are becoming possible, thus quality of life is becoming a major issue for patients and should be addressed by providers.*

Aim of the Work: *To follow up the quality of life and sexual dysfunction in women undergoing treatment or on follow-up for gynaecologic cancers .*

Patients and Methods: *In this cross sectional study Data were collected from patients attending the chemotherapy and gynaecological outpatient clinic in the clinical oncology department Ain Shams University Hospitals. Patients were chosen according to the inclusion and exclusion criteria. 66 Patients agreed to participate and were questioned privately, an informed consent was obtained from all participants.*

Result: *There was a strong positive significant correlation between the quality of life and sexual functioning, few patient's demographics were found to have significant effect on sexuality and quality of life where lubrication was significantly affected by female genital mutilation, age was significantly correlated to both the SWB and EWB, also the SWB was affected by marital years*

Conclusion: *Quality of life is strongly correlated to sexual functioning which is considered an integral part of patient's lives that must be followed for all gynecological cancer patients as patients don't get to express their concerns about their sexual health*

Keywords: *Quality of life; sexual wellbeing; gynaecological cancers.*

INTRODUCTION:

Gynaecological cancers including cervical, ovarian, uterine, vaginal and vulvar cancer represent around 1 in 5 of all cancers diagnosed in women [(1)].

As regard to their prevalence, cervical cancer is more common in premenopausal

women while uterine and ovarian cancers percent prevalence increases in perimeno-pausal women[2] unlike vaginal and vulvar cancers which are uncommon and mostly affect elderly women[3].

Despite the high morbidity and mortality rate of gynaecological cancers, cervical and uterine cancers have a high chance of survival[4].

Variables as medical, sociodemographic factors and patient perceptions of their illness and their ability to cope with illness and treatment were discussed as an influencing domains that potentially affect the QOL [5].

QOL ratings in early stage gynaecologic malignancies have ranged from normal limits [6] to substantially impaired [7] but unfortunately less is known about distress and QOL affection in more advanced cases at time of diagnosis.

Elevated anxiety, depression and decrements in QOL domains have been reported among patients who have been extensively treated or who have poorer prognoses[8,9]. For example, persistent decrements in QOL have been reported among cervical carcinoma patients as much as two years following radiotherapy[10] and substantial distress has been noted for at least 5 years after diagnosis among women with cancers of the cervix and vulva[11]. Other reports have indicated that levels of functioning and symptomatology were related to treatment free intervals and treatment modality[12].

Although during the past decade there have been great advances in the treatment of cancer, treatment strategies still are debilitating patients' life as they cause decreasing cardio-respiratory capacity, pain, fatigue, and suppressing immune function. In addition, psychological stress, anxiety, depression, fear of recurrence and sleep dysfunction are the other symptoms after cancer treatment that worsen quality of life in these patients [2,13]. As such some influencing organizations recommended that the goal of treatment of any cancer in addition to improved survival should be improvement in quality of life [14].

The success of gynaecological cancer prevention in addition to great strides in early identification and successful medical and surgical treatment has allowed gynaecologic oncologists to focus efforts on quality of life after diagnosis and treatment including sexual health as an integral aspect of quality of life during and after treatment[15].

FSAD (Female Sexual Arousal Disorder) may exist as a result of surgical procedures, medication effects, or changes in hormone levels [16].

The reported rates of sexual dysfunction among women with a diagnosis of gynaecologic cancers during the course of treatment and recovery range from 40 to 100% [17], which is higher than the reported rate in the general female population (43%) [18]. As the effectiveness of cancer treatments continues to improve, the number of female survivors will continue to rise [19], therefore the potential sexual impact is expected to increase.

Therapy for gynaecological cancers often impacts the hormonal milieu of the woman, either through direct surgical exploration, radiation therapy, or chemotherapy. Acute disruption of oestrogen and testosterone production, produces significant menopausal symptomatology [16].

Many patients who receives radiation therapy in addition to surgery suffer from vaginal stenosis as well as atrophic symptoms. It is often very difficult to quantify what proportion of sexual issues are brought about or exacerbated by such systemic symptoms as hot flushes, sleep disorders, and atrophic vaginal problems [16].

The National Comprehensive Cancer Network (NCCN) presented guidelines for survivorship and highlighted sexual health originally in 2013 as an important part of an individual's overall physical and emotional wellbeing. In the 2022 NCCN guidelines for Sexual Function, it is suggested that healthcare providers ask about sexual function at regular intervals.[20]

There are a number of studies on quality of life in gynaecological cancers. Indeed, it is argued that the disease has both short- and long-term effects on patients' quality of life. The short-term effects usually are health-related, while long-term effects in addition to general well-being, includes psychosocial and work-related issues. For instance, a recent study on long-term quality of life in women with gynaecological cancer reported that the main determinants of poor health related quality of life were comorbidities, lack of availability and satisfaction with social support, and psychological outcomes [21]. Overall studies on quality of life in patients with gynaecological cancer are limited [22]. It seems that more studies are needed to provide sufficient evidence on quality of life in women who suffer from gynaecological cancer [23], with focus on sexual wellbeing.

AIM OF THE WORK:

The aim of this study is to follow up the quality of life and sexual dysfunction in women undergoing treatment or being seen in follow-up for gynaecologic cancers in Clinical Oncology department Ain Shams University.

PATIENTS AND METHODOLOGY:

Patients and Data Collection:

In this cross sectional study data were collected from females attending the chemotherapy and gynaecological outpatient clinic in the clinical oncology department at Ain Shams University Hospitals. Patients were chosen according to the inclusion and exclusion criteria and were asked to participate in the research. We chose patients who were equal or below 65 years old, histo-pathologically proven to have gynaecological cancer, married, stage 1 to stage 4, patients receiving any active treatment or on follow up, we excluded patients who didn't have any Oncological management, Patients with history of other malignancies and those who were unable to answer questionnaires due to cognitive reasons.

Sampling method was by convenient sampling, 66 Patients agreed to participate and were questioned privately, an informed consent was obtained from all participants.

Ethics The Research Ethics Committee, Faculty of Medicine, Ain Shams University approved our study with Federal Wide Assurance no. FWA 000017585 and FMASU MS 12/2016.

An informed consent was obtained from the participants. Patients were offered 2 questionnaires the Functional Assessment of Cancer Therapy (FACT-G) and the Female sexual function index (FSFI) questionnaire, the questionnaire items were explained to the patients in private only with the investigator In a separate room.

Instruments:

The quality of life was assessed by using The Functional Assessment of Cancer Therapy – General (FACT-G) questionnaire the 4th version which is provided and translated to Arabic by FACIT.org [24,25]

Female sexual function index (FSFI) questionnaire in it's validated Arabic version was used to measure sexual functioning in women. [26]

The-endpoints of the study were to Follow up quality of life and sexual health in patients with gynaecological cancers undergoing or finished treatment.

Statistical analysis:

Statistical analysis was performed using MedCalc® Statistical Software version 20.106 (Med Calc Software Ltd, Ostend, Belgium; https://www.medcalc.org; 2022). Description of continuous variables: mean + standard deviation or median + range. Description of categorical variables: number and percentage. Then appropriate statistical analyses were applied. P value <0.5 was considered significant.

RESULTS

The median age of the patients was 51 years, 80.3% were housewives, ECOG 1, with no comorbidities and living in urban areas. 87.9 % of the patients were post menapausal and 59.1 % were circumcised. Only 47 % attended university, 25.8% were illiterate, 12.1% with education level below high-school level and 15.2% had education of high-school level as shown in table (1).

Table (1): Patients characteristics

		Median	**Range**
Age in years		51.5	32-65
Years of marriage		30	2-48
No. of offspring		3	0-7
		No.	**%**
Employment	Employed	13	19.7
	Housewife	53	80.3
Residence	Rural	16	24.2
	Urban	50	75.8
Education	Illiterate	17	25.8
	< high school	8	12.1
	High school	10	15.2
	University	31	47
ECOG performance status	1	62	93.9
	2	4	6.1
Co-morbidities	No	37	56.1
	Yes	29	43.9
Genital surgery	Circumcision	39	59.1
	None	27	40.9
Menstrual status	Menstruating	8	12.1
	Post menaupausal	58	87.9

Regarding the disease characteristics; 27.3% of the patients were stage I, 15.3,21.2% and 12.1 % were stage 2,3 and 4 respectively and 24.2% represent recurrent cases. Regarding the treatment; 63.6 % of patients underwent TAH&BSO. 39.4% received radiotherapy either EBRTH (external beam radiotherapy) or brachy-therapy and 90.9% of the patients received systemic treatment as described in table (2).

Table (2): Treatment protocols received by the studied patients.

		No.	%
Surgery TAH&BSO	YES	42	63.6
	NO	24	36.4
EBRTH	YES	26	39.4
	NO	40	60.6
BRACHYTHERAPY	YES	12	18.2
	NO	54	81.8
Radiotherapy	Yes	26	39.4
	No	40	60.6
Current treatment	CCRTH	2	3
	Chemotherapy	26	39.4
	Hormonal	1	1.5
	Monoclonal antibodies	1	1.5
	EBRTH	2	3
	Brachy-therapy	1	1.5
	None	33	50

CCRTH; concurrent chemo and radiotherapy , EBRTH; external beam radiotherapy .

Generally, for the 66 patients, the mean for each scale of the FACT-G was calculated as shown in table (3).

Table (3): FACT-G of the whole group

FACT-G scores	Mean	SD
PWB	19.53	5.13
SWB	20.28	4.8
EWB	13.06	5.27
FWB	17.28	4.49
Total	**70.16**	15.16

PWB (physical well-being), SWB (social well-being), EWB (emotional well-being),FWB(functional well-being)

We also calculated the FSFI score for the 66 patients, with a mean of 13.11 for the total score reflecting sexual dysfunction, out of the 66 patients 60 of them had sexual dysfunction representing 90% of sample population as described in table (4)

Table (4): FSFI of the whole group

FSFI scores	Mean	SD
Desire	2.63	1.06
Arousal	1.87	1.65
Lubrication	1.95	1.65
Orgasm	1.92	1.73
Satisfaction	2.27	1.63
Pain	2.44	2.24
Total	**13.11**	9

We studied the effect of multiple demographics against the FSFI score as the correlation between age, residence, comorbidities, education as well to the marriage years and circumcision with FSFI scores. There was no statistically significant correlation found, except between circumcision and the lubrication domain where there was statistically significant correlation noticed with a P value of 0.04 as shown in table (5).

Table (5): Correlation between FSFI and circumcision

FSFI scores	Circumcision		
	Non (27)pt	Yes(39)pt	P value
	Median		
Desire	2.4	2.4	0.33
Arousal	2.4	1.5	0.13
Lubrication	2.4	1.8	**0.043**
Orgasm	2.4	1.6	0.12
Satisfaction	2.4	1.2	0.10
Pain	2.4	1.2	0.2
Total	16	11.2	0.06

Correlations were studied between the different diagnosis of primary gynaecological cancer origins among patients and their FSFI scores but no significant statistical correlation was noticed. We studied the correlation between patients who had TAH &BSO and sexual functioning; there was no statistically significant difference concerning the total FSFI score and all subdomains.

The different domains of the FACT-G which include (physical well-being (PWB), social/family well-being (SWB), emotional well-being (EWB) and functional well-being (FWB))were assessed in relation to the patients factors age, residence, comorbidities, level of education, marry years and circu-mciseion Significant statistical correlateions were found in the age group (having the cut-off of age assessment equal to 50 years) in relation to both the SWB and EWB with P values equal to 0.025 and 0.026 respectively, also there were significant correlation between the marriage years and the SWB with P value of 0.023 as shown in table (6)

(6): Correlations between FACT-G and patient demographics (age and years of marriage)

FACT-G	AGE			Marital years	
	<50 or = 50 years 30 pt	>50 years 36 pt	P value	coefficient of correlation(r)	P value
	Mean				
PWB	18.5	19.05	0.6	-0.03	0.78
SWB	17.98	21.08	**0.025**	0.27	**0.023**
EWB	11.5	14.36	**0.026**	0.077	0.5
FWB	17	17.5	0.6	0.014	0.9
Total	66.4	73.3	0.06	0.12	0.33

Correlations were studied between the different diagnosis of primary gynaecological cancer origins among patients and their FACT-G scores but no significant statistical correlation was noticed, also we studied the correlation between patients who had TAH &BSO and QOL; there was no statistically significant difference concerning the total score and all subdomains.

We studied as well the relation between radiotherapy received either EBRTH or brachytherapy to quality of life domains in FACT-G questionnaire, no significant statistical correlation was found.

Finally correlations between the FACT-G total score for QOL assessment and FSFI domains was done where statistically significant correlation was found between FACT-G and FSFI as well as to each separate domain.

Table (7): Correlation between FACT-G total scores & FSFI domains

FSFI scores	FACT-G total score	
	Spearman's coefficient of rank correlation (rho)	P value
Desire	0.355	0.003
Arousal	0.375	0.0019
Lubrication	0.267	0.030
Orgasm	0.36	0.0029
Satisfaction	0.36	0.0024
Pain	0.30	0.011
FSFI Total	0.382	0.0016

DISCUSSION:

Though the definition of sexuality is very broad and not precise, it is agreed that sexuality is a multi-dimensional phenomenon that is affected by several factors such as psychological, physiological and social factor[27].

Unfortunately, in many countries of the Arab world, including Egypt, culture prohibits discussing sexual matters, which, in turns, makes females shy or reluctant to talk about their sexual problems [28]. During our study a lot of female patients refused to discuss such topic and didn't participate just for that reason we had to ask over 100 patient if they could answer our questionnaire but only 66 agreed to participate

Few studies described the effect of gynaecological cancers on quality of life and sexuality. But unfortunately, to the best of our knowledge we found no studies dealt with this topic in Egypt. Owing to the importance of this issue, our research seeks to analyze the effect of treatment on quality of life and sexuality among Egyptian gynaecological cancer patients.

In our study the only demographic that had significant correlation with FSFI domains was circumcision, patients who had such a procedure done had significantly lower values in lubrication domain however it didn't lead to significant difference in total score of female sexual function index

Previously the effect of female genital mutilation was assessed in different studies one of them was a study done in Alexandria, Egypt in 2015 although this study was conducted on healthy females it revealed a significant association between female sexual mutilation and female sexual function, where reduction of all aspects was obtained Another study that was conducted in Ismailia, Egypt, in 2011 as well to the previous one was also conducted on healthy females, proved that women with female genital mutilation have higher rates of dyspareunia and lack of sexual desire [29,30].

Using the FSFI; our collective results indicated sexual dysfunction in total, in addition to each domain separately. This might be due to the cancer treatment or due to other demographic factors.

According to Ibrahim et al, Female sexual dysfunction is highly prevalent in Egypt with more dysfunction in the desire and orgasm subdomains and a direct correlation with age, post-menopausal status, years of marriage and circumcision. He also reported that that the prevalence of circumcised females was 71.9% [28]. But this was not the case in our study, where 59.1% of our patients were circumcised. We have to note that the study done by Ibrahim et al, was conducted in 2014, so This difference in results might be due to the socio-demographic characteristics of patients who seek medical advice at Ain Shams University Hospital and the time difference from these results and our study.

We calculated the total QOL mean score in our study and found it to be 70.16, Penny S. Brucker et al, Feinberg School of Medicine at Northwestern University Center of Research and Education (CORE), had study conducted to access the QOL in both General Population And Cancer Patient Norms Using The Functional Assessment Of Cancer Therapy– General (FACT-G).. Cella, Hahn, and Dineen (2002) published the baseline means and standard deviations for FACT-G subscales and FACT-G total score for a sample of 308 patients with mixed cancer diagnoses. These mean scores were compared to the normative mean scores found in the general U.S. healthy adult population, patients with cancer in Cella, Hahn, and Dineen's (2002) study had comparable scores to the general U.S. adult population sample. Small differences in PWB, EWB, FWB, and total FACT-G scores were noted where the mean scores were equal to 21.6, 18.1,18.8 for PWB, EWB and FWB in Cella, Hahn, and Dineen's (2002) and 22.7,19.9, 18.5 for PWB, EWB and FWB in general us population. There was a meaningful difference (i.e., > 2 points) on the SWB subscale between Cella, Hahn, and Dineen's (2002) sample (M = 22.3) and the general U.S. adult population norms (M = 19.1). This suggests that the people with cancer from Cella, Hahn, and Dineen's (2002) study may actually be comparable to those in the general population in regard to physical, emotional, functional, and overall well-being, in this comparison the mean QOL value in the normal population was 80.1 vs 80.4 for 2002 study sample of cancer patients [31,32], in our study the mean scores in gynaecologic cancer patients were 20.28, 19.53, 13.06, 17.28 for SWB,PWB,EWB and FWB respectively with total QOL score equal to 70.16, the difference between the quality of life in mean score between these results and our study can be attributed to the different demographic factors and the social status of our sample, also our results are specific only for gynecological cancer patients unlike these studies.

In our study There was a significant correlation between the patient age with the emotional and social well-being where patients more than 50 years had higher mean value for both, the mean of SWB in patients >50 was 21.08 vs 17.98 in patients < or = to 50 years, as regard to EWB the mean was 14.36 for > 50 years patient while those = or <50 it was 11.5, Also there was significant correlation between the marriage years and SWB.

This is compatible with the results of the pilot study of Miller et' al which was conducted on Eighty-five patients at least 6 months after treatment for a gynecologic malignancy, Responses were compared to 42 unmatched healthy women who were seen for standard gynecologic screening exams using the fact-g questionnaire this study carried place in Wake Forest University School of Medicine, Winston-Salem, North Carolina in 2002 our results were compatible as regard to the emotional well-being but this wasn't the case as regard to the social well-being where at Miller's study older patients had lower values for social –well being[33].

A Chinease study conducted for cervical cancer patients showed that Patient's age had a significant impact on the experience of QOL, where Older patients had poorer social relationships than younger patients [34]. This is opposite to what we found in our study where the patient age had significant impact on social well being and older patients more than 50 years had better social life.

Although at our study no significant correlation was found between level of education and quality of a study conducted by Department of Obstetrics and Gynecology, Mahidol University, Bangkok, Thailand. conducted from 2005 till 2008 on gynaceological cancer survivors showed that Higher levels of education were significantly

related to higher QoL. The differences were evident mainly in the functional and social well-being subscores [35].

Miller et al. also found that the most significant difference in quality of life was seen among US patients who had not completed high school, Lower levels of education were associated with less supportive social environment, limited knowledge regarding health issues and poor health[33].

In the current study we tried to find whether the different gyanecological malignancies diagnosis will affect the quality of life and sexual wellbeing, however no statistically significant correlation was found, This is contrary to the study done at the gynecological oncology clinics of Istanbul University (IU)between December 2001 and May 2002 Which revealed that the type of cancer had a large influence on patients' quality of life. When the quality of life was compared with the disease's diagnosis, the patients with endometrial cancer were found to have better physical, psychological, and social well-being than those with vulvar, cervical, and ovarian cancer respectively[36].

In an attempt to answer the question of whether QOL affects sexuality in gynaecological cancer patients,FACT-G results were compared to FSFI and significant positive correlation was found between the FACT-G and the FSFI total score as well as all its sub domains proving strong correlation between the quality of life and sexual well-being.

In our department similar study was made to asses sexual functioning and QOL of breast cancer patient owing to the fact that the body image can be one of the most affecting domains that affect the patients, Consistent with our findings whereby time from last chemotherapy did not affect sexual functioning as well but there was a significant correlations between QOL items and sexual function assessed through FSFI as found in our study where there was significant correlation between the quality of life and sexual function [37].

In general the studies that were conducted to follow up the QOL and sexual function in Egyptian cancer patients are few and those conducted for the gynaecologic cancer patients mainly are even fewer

Conclusion:

Overall a strong positive significant correlation was found between the quality of life and sexual function however there are some limitations in our study; it is cross sectional, limited to gynaecological cancer patients with no direct comparison to healthy women. The small sample size is not representative of the whole population, thus, data cannot be extrapolated. This study was also limited by the fact that different kind of gynecologic cancer with different kind of therapy were studied into each group Also data about the role of the husband and quality of the relationship would have provided better assessment. No comparison between the sexual functioning before and after gynaecologic cancer was done, as there is no validated Arabic questionnaire with such comparative aims, and therefore a prospective study is needed to answer this question. Also, participation in the study was completely voluntary and this cause bias, as patients who had better performance status with little stress were the ones able to complete the questionnaires.

Conflict of interest:

The authors declare that they have no conflict of interest.

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متابعة جودة الحياة والرفاه الجنسي في سرطانات الأعضاء الجنسية للنساء: دراسة مقطعية

هشام الغزالي ، عمرو شفيق ، ناجي سامي ، خالد عبد العزيز كمال ، داليا مدحت، الاء محمد توفيق.

قسم الأورام السريرية والطب النووي - كلية الطب - جامعة عين شمس

الخلفية: السرطانات النسائية هي أورام خبيثة تبدأ في الأعضاء التناسلية للمرأة بما في ذلك خمسة أنواع رئيسية وهي سرطان عنق الرحم وسرطان المبيض وسرطان الرحم وسرطان المهبل وسرطان الفرج. لا يُعرف سوى القليل نسبيًا عن محددات جوده الحياة لدى النساء المصابات بأورام خبيثة في الجهاز التناسلي للمرأة وما يمكن أن يؤثر عليها ، بما في ذلك الأمور الجنسية والعلاقة الحميمة. يوجد قدر كبير من الأدلة التي تظهر أن السرطان يؤثر بشكل كبير على النشاط الجنسي للمرأة ، والأداء الجنسي ، والعلاقات الحميمة والشعور بالذات حيث يمكن أن يتأثر الأداء الجنسي نفسه بالمرض والألم والقلق والظروف المجهدة والأدوية. مع التحسينات في الكشف المبكر والجراحة والعلاج المساعد لسرطانات الجهاز التناسلي للمرأة ، أصبح البقاء على قيد الحياة على المدى الطويل والعلاج ممكنًا ، وبالتالي أصبحت جودة الحياة مشكلة رئيسية للمرضى ويجب معالجتها من قبل مقدمي الخدمة.

هدف العمل: متابعة نوعية الحياة والضعف الجنسي لدى النساء اللواتي يخضعن للعلاج أو يتم رؤيتهن في متابعة لأمراض السرطان النسائية في قسم الأورام السريرية جامعة عين شمس.

المرضى والطرق: في هذه الدراسة المقطعية ، تم جمع البيانات من المريضات اللاتي يترددن على العلاج الكيميائي والعيادة الخارجية لأمراض النساء في قسم الأورام السريرية في مستشفيات جامعة عين شمس. تم اختيار المرضى وفقًا لمعايير التضمين والاستبعاد وطُلب منهم المشاركة في البحث. وافقت ٦٦ مريضَة على المشاركة وتم استجوابهم بشكل خاص ، وتم الحصول على موافقة مستنيرة من جميع المشاركين.

النتيجة: بشكل عام كان هناك ارتباط إيجابي قوي معنوي بين نوعية الحياة والأداء الجنسي ، ووجد أن القليل من التركيبة السكانية للمرضى لها تأثير كبير على النشاط الجنسي ونوعية الحياة حيث تأثر التشحيم بشكل كبير من خلال تشويه الأعضاء التناسلية للإناث ، وكان العمر مرتبطًا بشكل كبير بكلا من الكفاءة الاجتماعيه و الاسريه والكفاءة العاطفيه للمرضي ، كما تأثرت الكفاءة الاجتماعيه و الاسريه للمرضى بسنوات الزواج

الخلاصة: ترتبط جودة الحياة ارتباطًا وثيقًا بالأداء الجنسي الذي يعتبر جزءًا لا يتجزأ يجب تقييمه ومتابعته لمرضى سرطان النساء حيث لا يستطيع المرضى التعبير عن مخاوفهم بشأن صحتهم الجنسية.