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# The Burden of Symptoms among Gynaecological Cancer Patients in a Tertiary Health Center in Ilorin

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## ABSTRACT

**Objective:** This study was conducted to assess symptom burden among gynaecological cancer patients accessing care in a tertiary health institution in Nigeria. **Methods:** All patients with gynaecologic cancers presenting at the clinics and ward over a period of 6 months were recruited into the study. The patients completed an interviewer administered symptom assessment tool which assesses a 7-day prevalence and distress/frequency of 32 physical/psychological symptoms. Demographics, cancer types and stages were obtained from case notes. **Results:** Forty-nine gynaecological cancer patients were studied. Over 90% (45/49) of them had advanced disease. The mean number of symptoms among the patients was 8.1 + 4.6. The 5 most common symptoms were weight loss (67.3%), pain (65.3%), worrying (53.1%), feeling sad (51.0%) and lack of energy (46.9%). The most distressing symptoms were vaginal bleeding/discharges, pain and poor body image. **Conclusions:** This study shows significant physical and psychological symptom burden among gynaecological cancer patients. Pain is one of the most common and together with vaginal discharge were the most distressing symptoms among gynaecological cancer patients. **Synopsis:** Gynecological cancer patients have significant physical and psychological symptoms. Pain, weight loss, worrying and feeling sad are common symptoms among these patients.

**Keywords:** Gynaecological cancer, symptoms prevalence, distressing symptoms

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## Introduction

Gynaecological cancers encompass a diverse group

of tumours with different epidemiological features, clinical presentation and treatment strategies.<sup>1,2</sup>

These tumours include cancer of the cervix, body of the uterus, ovarian, vagina, fallopian tubes, vulva and gestational trophoblastic tumours. According to the 2012 global cancer estimates, there were 735,200 new cases of gynaecological cancers in the developing countries, constituting 19.2% of all cancers in women.<sup>3</sup> This is double the incidence of cases in developed countries where only 9.5% of all cancers in women were of gynaecological origin.<sup>3</sup>

Studies in gynaecological cancers in Nigeria have been retrospective with reports mainly on the cancer types and clinical presentations and treatment challenges.<sup>4,5</sup> Some others have reported on the histologic types of the cancers.<sup>6</sup> Gynaecological cancer patients in the developing countries report for diagnostic and treatment services at advanced stage of their disease. Studies<sup>4,5,7</sup> have reported on poor treatment outcomes and challenges with treatment due to scarce radiotherapy facilities and costly chemotherapy.<sup>8</sup> These imply significant symptom prevalence and associated burden. Symptom prevalence studies among gynaecological cancer patients in Nigeria are scarce. The aim of this study was to prospectively explore symptom profiles among gynaecological cancer patients accessing care at a tertiary health center with the view to identify the symptoms burden that would inform management decisions and lead to improvement in patients' care.

### Methodology

The study was a descriptive cross-sectional hospital-based survey. The study population was adult gynaecology cancer patients admitted into the gynaecology ward and similar patients attending gynaecology outpatient clinics of the University of Ilorin teaching hospital over a 6-month period from 20th October 2015 to 15th of April, 2016. A written consent was obtained from all participants.

The data collection tool consisted of a participant data sheet that was used to record

socio-demographic details, cancer types and the stage; and a validated 32-item tool- The Memorial Symptom Assessment Scale Short Form (MSAS-SF)<sup>9</sup> that was used to document symptoms experienced in the preceding 7 days prior to interview. It has provision for additional symptoms that may be present. Participants are required to answer yes to symptoms that are present and then describe how distressing the symptoms were.

### Data Analysis

Data were entered into SPSS version 20.0. Tables were used to report descriptive statistics. Categorical variables such as stage of disease and symptoms documented for the patients were presented as frequencies. Means, median and standard variations were computed for continuous variables.

### Ethical Considerations

Ethical approval for the study was obtained from the Human Research Ethics Committee of the University of Cape Town and the ethical committee of University of Ilorin Teaching hospital, Ilorin, Nigeria.

### Results

#### - Sociodemographic & clinical information

Forty-nine gynaecology cancer patients were studied. The mean age of the study population was 59.76 + 11.85; median age was 60 years and the age range was 35 to 85 years. Over a third (36.4%) of the patients had no formal education while less than a fifth (18.4%) of them had tertiary level of education (Table 1). Cervical cancer was the most common, occurring in more than 50% of the patients studied while vulva cancer was the least (2%).(Table 1)

Over 90% of the patients had at least stage 3 diseases. No patient had stage 1 disease and only 4 had stage 2 diseases. Palliative care referral was done for less than a fifth of the studied population.

**Table 1: Socio-demographic and clinical information of the study population**

Factor	N (%)
<b>Age</b>	
Mean + standard deviation	59.76 + 11.85
Median	60
Range	35-85
<b>Educational level</b>	
None	19 (38.8)
Primary	12 (24.5)
Secondary	9 (18.4)
Tertiary	9 (18.4)
<b>Type of cancer</b>	
Cervix	27 (55.1)
Ovary	12 (24.5)
Endometrial	9 (18.4)
Vulva	1 (2.0)
<b>Stage</b>	
I	0 (0.0)
II	4 (8.2)
III	36 (73.5)
IV	9 (18.4)

**Number of symptoms based on MSAS-SF**

Table 3 shows the average number of symptoms using the MSAS-SF. The number of symptoms on the MSAS-SF including additional symptoms

ranged from 0-17. The mean number of MSAS-SF symptoms together with additional symptoms was  $8.06 \pm 4.63$ .

**Table 3: Average number of symptoms on the MSAS-SF.**

Factor	N (%)
Number of symptoms on MSAS-SF	$7.12 \pm 4.64$
Total number of symptoms with additional (MSAS-SF plus)	$8.1 \pm 4.6$

**Symptoms prevalence**

The top 5 symptoms (table 4) in the studied patients were weight loss 33 (67.3%), pain 32 (65.3%), worrying 26 (53.1%), feeling sad 25 (51.0%) and lack of appetite 25 (49.0%). There were additional symptoms which were not listed in

the MSAS-SF but frequently described by the patients.

Among the studied patients, 34 patients had one additional symptom: vaginal bleeding (18), vaginal discharge (7), abdominal swelling (3), gait problem (1), headache (1), vulva swelling (1) and

continuous leakage of urine (1). A second additional symptom was mentioned by 12 patients: vaginal discharges (11) and discharging

vulva sinuses (1). Combined together, these additional symptoms were actually the most frequent symptoms in the patients (69.4%).

**Table 4 : Symptom Prevalence**

Symptoms	N (%)
Additional 1	34 (69.4)
Weight loss	33 (67.3)
Pain	32 (65.3)
*Worrying	26 (53.1)
* Feeling sad	25 (51.0)
Lack of appetite	25 (51.0)
Lack of energy	23(46.9)
Difficulty sleeping	21(42.9)
Numbness	16(32.7)
Don't look like myself	14(28.6)
Constipation	14(28.6)
*Feeling nervous	12(22.5)
Additional 2	12(22.5)
Change in taste of food	12(24.5)
Cough	11(22.4)
Dry mouth	11(22.4)
Nausea	10(20.4)
Problem with urination	10(20.4)
Dizziness	8(16.3)
Feeling bloated	7(14.3)
Shortness of breath	6(12.2)
Swelling arms/legs	6(12.2)
Vomiting	6(12.2)
*Feeling irritable	4(8.2)
Difficulty swallowing	3(6.1)
Sweats feeling drowsy	3(6.1)
Itching	2(4.1)
Change in skin	1(2.0)
Problem with sexual interest/activity	1(2.0)
Diarrhoea	1(2.0)
Mouth sores	0(0.0)
Difficulty in concentration	0(0.0)

**The topmost distressing symptoms.**

Table 5 shows the topmost distressing symptoms among the patients. The most distressing symptoms for which >50% of the patients rated as "quite a bit/very much were problem with urination (70.0%), don't look like myself (64.3%), difficulty sleeping (57.1%), and pain (50.0%). The

additional symptoms rated as highly distressing (over 70.0%) included vaginal bleeding, vaginal discharge, abdominal swelling, vulva swelling, discharging sinuses and abnormal posturing. All the psychological symptoms were also not rated as highly distressing.

**Table 5: Topmost distressing symptoms among the patients**

Symptoms	Not at all/ Little bit (%)	Somewhat (%)	Quite a bit/ Very Much (%)
Pain	7(21.9)	9(28.1)	16(50.0)
*Additional symptom 1 (mainly vaginal bleeding)	2(5.9)	7(20.6)	25(73.5)
Difficulty sleeping	3(14.3)	6(28.6)	12(57.1)
Don't look like myself	2(14.3)	3(21.4)	9(64.3)
*Additional symptom 2 (mainly vaginal discharge)	0(0.0)	1(8.3)	11(91.7)
Problem with urination	2(20.0)	1(10.0)	7(70.0)

\* Additional symptoms are not in the original MSAS tool

**Discussion**

This study was carried out in order to explore the symptom prevalence among gynaecological cancer patients in a tertiary health care institution in Nigeria. It is the first Nigerian study to prospectively survey symptom prevalence among gynaecological cancer patients.

**Demographics**

Patients with gynaecological cancers in this study were much older than previous studies in similar patient population. The peak age range of 60-69 years with a mean age of 59.76 was slightly higher than 54 years reported by Nnadi et al<sup>10</sup> and 44.2 years reported by Kyari et al.<sup>11</sup> Apart from the larger sample sizes, these other studies encompassed a wider spectrum of gynaecological cancers which were not present in this study. The only four types of cancers captured in this study were cervical cancers, endometrial cancers, vulva and ovarian

cancers. There were choriocarcinoma, germ cell ovarian cancers, vaginal cancers, and fallopian tube cancers reported by Nnadi et al and Kyari et al.<sup>10,11</sup> Cervical cancer occurs commonly in younger women of about 35-45 years, while ovarian and most especially, endometrial cancers are essentially postmenopausal diseases.<sup>1</sup> This study however suggests a higher age range for cervical cancer in the population studied with a mean age of 59 years despite cervical cancer patients constituting more than 50% of the study population. Over 40% of gynaecological cancers in this study were ovarian and endometrial cancer patients. This also may explain the higher mean age and peak age obtained in this study.

**Stage of Disease**

An advanced stage of disease at presentation to hospital, as was found in this study, is very common for many cancers in the developing countries.<sup>12,13</sup>

More than 80% of patients were at stage 3 or 4 of their disease. This conforms to previous studies in Africans that have shown that patients present in advanced stages of cancer.<sup>4,12</sup> Only one tenth of the patients had stage 2 diseases and none had stage 1 disease. Comparing stage of disease with the educational status, patients with lower educational levels presented at more advanced stages of diseases than those well-educated. Studies<sup>4,14</sup> in cancer patients have also reported more advanced stages of disease in patients with lower socio-economic class. However, among the educated patients, a higher proportion of those with tertiary level of education actually presented at more advanced stage disease compared to those with secondary level of education. This was similar to the findings by Anyanwu et al<sup>21</sup> who reported similarly advanced stage of disease in their population of highly literate patients managed for breast cancer. Poor knowledge about cancer both by the educated and the uneducated people is common in our setting.<sup>15,16</sup> Cancer screening centers are also scarce in many African settings, including Nigeria<sup>17</sup> and the available ones are poorly maintained and underutilized.<sup>4,18</sup> All these contribute to late presentation of cancer cases to the hospital. Continuous public enlightenment by providing accurate information and embarking on awareness campaigns on cancer, training and retraining of health care providers, creating more cancer screening centers as well as rejuvenating the existing ones are needed in order to reduce the number of patients presenting in advanced stage of disease.

### Symptom Prevalence

The prevalence of symptoms in this study ranged from 0-17. This was lower than a range of 0-25 reported by Portenoy (9) but comparable to 1-18 symptoms reported by Tsai<sup>19</sup> both of which were studies conducted in similar cancer population. About 20% of patients in this study had 0 or 1 symptom only. The heterogeneity of patients in terms of stage of disease may explain the wide symptom prevalence.

The overall mean number of symptoms was

based on the symptom assessment tool used with availability for inclusion of additional symptoms not enlisted in the tool. Considering the additional symptoms were important in this study because some patients had none of the 32 symptoms listed in the MSAS-SF tool but had other symptoms. Many of such patients had only vaginal bleeding and foul-smelling vaginal discharge as their only symptoms. The mean number of symptoms was 7.12+4.6 but slightly higher at 8.1+4.6 when additional symptoms were considered. The result is comparable with that obtained for a cancer population studied in London<sup>20</sup> but it was much lower than that reported in a similar group of patients studied in Africa.<sup>21</sup> These mean numbers of symptoms were much lower than 18+6.6 reported by Harding<sup>21</sup> and also 10.2+5.8 reported by Lidston.<sup>20</sup> It was however slightly higher than the mean of 5 symptoms reported by Potter.<sup>22</sup> Harding<sup>21</sup> study was conducted in patients already referred for palliative care intervention, signifying advanced cancer in all of their patients, and this alone may explain the higher mean number of symptoms. Also, patients with HIV infection also constituted a significant proportion of Harding et al study population and this also may explain the higher number of symptoms in their study population. Although HIV was not the focus in this study, three of the patients had HIV infection documented in their case notes. But these three are much lower in comparison to the number of HIV infected patients in Harding's study.

### Common symptoms

The top most physical symptoms in this study were pain, weight loss, lack of appetite, lack of energy, difficulty in sleeping, numbness, body image issues, constipation, change in the taste of food and cough. Other notable symptoms were nausea and problem with urination. These symptoms are general and not specific to gynaecological cancer patients and some of them have been reported by other studies on cancer patients (6,23). Vaginal bleeding is a common symptom in gynaecological cancer patients. It is commonly found in cancers of the cervix, endometrial cancers and vaginal

cancers, but less common with ovarian cancers.<sup>2</sup> Other symptoms common to gynaecological cancers are vaginal discharge, constipation, diarrhea, nausea, vomiting and pain.<sup>2</sup> Some pathological states arising from gynaecological cancers include symptomatic anaemia, obstructive uropathy, deep vein thrombosis, lymphedema, bowel obstruction, rectovaginal and vesicovaginal fistulae.<sup>24</sup> Some of the manifestations of these pathological states such as dizziness, urinary symptoms, numbness, swollen arms/legs and gastrointestinal symptoms have been well demonstrated in this study.

Psychological issues of feeling sad and worrying have featured prominently in this study. Both of these constituted 40% of the 5 most prevalent symptoms in this study. Psychological symptoms are commonly overlooked in patients with advanced cancer.<sup>24</sup> This study has shown that with the use of a symptom assessment tool that ensures questioning about psychological symptoms, they have been shown to be prevalent. This shows that psychological symptoms assessment needs to be incorporated into the evaluation of gynaecological cancer patients. Many oncologists agree that cancer patients need comprehensive cancer care which usually is multi-

disciplinary involving psychologist, psychiatry and palliative care providers. Oncologists often claim to be rendering these services, but evidence show that it is either not done at all or it is inadequately done.<sup>23</sup> This is important information for the primary physician managing cancer in many developing countries, who most of the time manage cancer patients alone without the involvement of palliative care physicians or the psychiatrist/psychologists.

More than two-thirds of the gynaecological cancer patients had additional symptoms that were not captured in the 32 symptoms listed in the MSAS-SF. This may imply that the present MSAS-SF symptom assessment tool require modifications in order to adequately accommodate gynaecological cancer patients' symptom profiles.

### Conclusion

This study has shown that gynecological cancer patients frequently have physical and psychological symptoms. These are pointers to the need for palliative care in the majority of patients accessing health facilities for cancer care. There is the need for the primary physicians attending to cancer patients to be trained in palliative care provision.

### References

1. Shafi MI, Earl H, Tan LT. Gynaecological Oncology. Second Edition ed. New York: Cambridge University Press; 2010.
2. Mishra K. Gynaecological malignancies from palliative care perspective. *Indian J Palliat Care* 2011 Jan;17(Suppl):S45-51.
3. Torre LA, Bray F, Siegel RL, Ferlay J, Lortet-Tieulent J, Jemal A. Global cancer statistics, 2012. *CA: a cancer journal for clinicians* 2015;65(2):87-108.
4. Anorlu RI. Cervical cancer: the sub-Saharan African perspective. *Reprod Health Matters* 2008 11;16(32):41-49.
5. Oguntayo AO, Zayyan M, Akpar M, Kolawole AO, Adewuyi SA. The burden of gynecological cancer management in Northern Nigeria. *Open Journal of Obstetrics and Gynecology* 2013;2013.
6. Yakasai I, Ugwa E, Otubu J. Gynecological malignancies in Aminu Kano Teaching Hospital Kano: A 3 year review. *Nigerian journal of clinical practice* 2013;16(1):63-66.
7. Iyoke CA, Ugwu GO, Ezugwu EC, Ezugwu FO, Lawani OL, Onyebuchi AK. Challenges associated with the management of gynecological cancers in a tertiary hospital in South East Nigeria. *Int J Women's Health* 2014 Jan 24;6:123-130.
8. Abdel-Wahab M, Bourque J, Pynda Y, Iżewska J, Van der Merwe D, Zubizarreta E, et al. Status of radiotherapy resources in Africa: an International Atomic Energy Agency analysis. *The Lancet Oncology* 2013 4;14(4):e168-e175.
9. Portenoy R, Thaler H, Kornblith A, Lepore JM, Friedlander-Klar H, Coyle N, et al. Symptom prevalence, characteristics and distress in a cancer

- population. *Quality of Life Research* 1994;3(3): 183-189.
10. Nnadi DC, Singh S, Ahmed Y, Siddique S, Bilal S. Histo-pathological features of genital tract malignancies as seen in a tertiary health center in north western Nigeria: a 10 year review. *Annals of medical and health sciences research* 2014;4(3): 213-217.
  11. Kyari O, Nggada H, Mairiga A. Malignant tumours of female genital tract in North Eastern Nigeria. *East Afr Med J* 2004;81:142-145.
  12. Anyanwu SN. Temporal trends in breast cancer presentation in the third world. *Journal of Experimental & Clinical Cancer Research* 2008;27(1):1-6.
  13. Tebeu P, Petignat P, Mhaweche-Fauceglia P. Gynecological malignancies in Maroua, Cameroon. *International Journal of Gynecology & Obstetrics* 2009;104(2):148-149.
  14. Ijaiya M, Aboyeji P, Buhari M. Cancer of the cervix in Ilorin, Nigeria. *West Afr J Med* 2005;23(4):319-322.
  15. Anyanwu SN, Egwuonwu OA, Ihekwoaba EC. Acceptance and adherence to treatment among breast cancer patients in Eastern Nigeria. *The Breast* 2011;20:S51-S53.
  16. Anya SE, Oshi DC, Nwosu SO, Anya AE. Knowledge, attitude, and practice of female health professionals regarding cervical cancer and Pap smear. *Niger J Med* 2005 Jul-Sep;14(3):283-286.
  17. Sankaranarayanan R, Budukh AM, Rajkumar R. Effective screening programmes for cervical cancer in low-and middle-income developing countries. *Bull World Health Organ* 2001;79(10):954-962.
  18. Ezem BU. Awareness and uptake of cervical cancer screening in Owerri, South-Eastern Nigeria. *Ann Afr Med* 2007 Sep;6(3):94-98.
  19. Tsai J, Wu C, Chiu T, Hu W, Chen C. Symptom patterns of advanced cancer patients in a palliative care unit. *Palliat Med* 2006;20(6):617-622.
  20. Lidstone V, Butters E, Seed PT, Sinnott C, Beynon T, Richards M. Symptoms and concerns amongst cancer outpatients: identifying the need for specialist palliative care. *Palliat Med* 2003 Oct;17(7):588-595.
  21. Harding R, Selman L, Agupio G, Dinat N, Downing J, Gwyther L, et al. The prevalence and burden of symptoms amongst cancer patients attending palliative care in two African countries. *Eur J Cancer* 2011;47(1):51-56.
  22. Potter J, Hami F, Bryan T, Quigley C. Symptoms in 400 patients referred to palliative care services: prevalence and patterns. *Palliat Med* 2003 Jun;17(4):310-314.
  23. Reilly CM, Bruner DW, Mitchell SA, Minasian LM, Basch E, Dueck AC, et al. A literature synthesis of symptom prevalence and severity in persons receiving active cancer treatment. *Supportive Care in Cancer* 2013;21(6):1525-1550.
  24. Ell K, Sanchez K, Vourlekis B, Lee PJ, Dwight-Johnson M, Lagomasino I, et al. Depression, correlates of depression, and receipt of depression care among low-income women with breast or gynecologic cancer. *J Clin Oncol* 2005 May 1;23(13):3052-3060.