CNE Objectives and Evaluation Form appear on page 332.

The Medical-Surgical Nurse's Guide to Ovarian Cancer: Part II

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This *Cancer: Caring and Conquering* column is the second in a two-part series highlighting ovarian cancer. Part I was published in the August 2007 issue of *MEDSURG Nursing*. The need for this column was brought to mind when a dear friend of mine died recently from ovarian cancer and it was clear that more information was needed concerning this insidious disease. Therefore, this column is dedicated to Loretta O'Leary for her courage during a 2-year struggle with ovarian cancer.
— Linda H. Yoder

Ovarian cancer is the deadliest gynecologic cancer in the United States. In 2007, an estimated 22,430 new cases of ovarian cancer will be diagnosed, and 15,280 deaths will occur from the disease in the United States (Jemal et al., 2007). The tragedy of ovarian cancer is that the initial symptoms, typically insidious and vague, often are dismissed by patients and other health care providers. By the time a definitive diagnosis is made, the disease is usually already at an advanced stage. Treatment options typically include a combination of surgery and chemotherapy, which can have many complications and side effects. Expert symptom management is paramount throughout the trajectory of this often difficult illness, and the nurse plays a critical role in providing education and support to the woman with ovarian cancer and her family.

Treatment

The treatment for ovarian cancer depends on the patient's age, performance status, the stage of

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disease, and the histologic grade and volume of tumor (Berek, 2005).

Surgery. The main goal of surgery for ovarian cancer is to stage the tumor accurately and to debulk (remove) as much of the tumor as possible (Mutch, 2002). Accurate surgical staging is extremely important because it dictates treatment options and determines prognosis. The most common surgical procedures performed for ovarian cancer include an initial staging laparotomy and a second-look laparotomy.

Surgical staging by exploratory laparotomy should be performed to determine how far the cancer has spread. A mid-line abdominal incision is recommended to improve access to the upper abdomen. Suspicious tissue is removed and a frozen section is sent to histology while the patient is in the operating room. If this initial tissue analysis is positive for ovarian cancer, the surgeon proceeds with more extensive surgery with the goal of obtaining clean surgical margins and establishing an accurate staging of the disease (Berek, 2005). The initial *cytoreductive* (debulking) *surgery* commonly involves a total abdominal hysterectomy, bilateral salpingo-oopherectomy, and omentectomy (removal of the fat pad covering over the peritoneum), along with peritoneal biopsies and washings for cytologic evaluation (Baker, 2001). If the disease surrounds the colon, resection of that portion of the colon may be necessary. A woman who wishes to preserve fertility, and has no spread of cancer beyond the affected ovary, may keep her uterus and non-affected ovary but will need close follow up (Berek, 2005). Postoperative complications of exploratory laparotomy can include bleeding, ileus, infections, bowel injuries, and pulmonary embolus (Christy & Dixon, 2004).

Chemotherapy. Chemotherapy in ovarian cancer is used to treat tumor that cannot be removed surgically (called *residual tumor*) and to control metastatic disease. Almost all patients with ovarian cancer will require chemotherapy, except for the rare Stage I patient. Combination chemotherapy with the agents carboplatin (Paraplatin®) and paclitaxel (Taxol®) is the standard for first-line treatment for epithelial ovarian cancer and traditionally is given in combination every 21 days in 6-8 divided courses (Berek, 2005; Pujade-Lauraine, 2003; Thigpen, 2006).

Administering chemotherapy by the intraperitoneal (IP) route has increased survival rates for patients with ovarian cancer (Coleman & Monk, 2006). IP chemotherapy is administered directly into the peritoneal cavity through a port or catheter, allowing the chemotherapy to dwell in the peritoneum and then be absorbed by the body. IP chemotherapy, however, can be associated with increased side effects as compared to traditional intravenous chemotherapy, including catheter or port obstruction, abdominal distention, pain, intestinal obstruction, and infections (Coleman & Monk, 2006).

Although advanced ovarian cancer can respond well to standard therapy of paclitaxel and carboplatin, as many as 75% of women will have their cancer recur and require additional chemotherapy for disease stabilization (Baker, 2001; Berek, 2005). Common second-line or third-line chemotherapy agents can include cisplatin (Platinol®), docetaxel (Taxotere®), topotecan (Hycamtin®), etoposide (VP-16, VePesid®), liposomal doxorubicin (Doxil®), gemcitabine (Gemzar®), epirubicin (Ellence®), and 5-fluorouracil (fluorouracil, Adrucil®) with leucovorin (citrovorum factor, folinic acid) (Berek, 2005).

Biologic therapy. Biologic agents are not used routinely to treat ovarian cancer; however, researchers are exploring cytokines, monoclonal antibodies, vaccines, and gene therapy as possible treatment modalities for ovarian cancer (Ozols, 2002). The response rate for intraperitoneal immunotherapy (interferon and interleukin) is the same as IV chemotherapy at about 28%-50%; however, both are considered experimental second-line therapies (Berek, 2005).

Role of the Nurse

Nurses are integral health care providers for the ovarian cancer patient and her family. Nursing care must be individualized based upon the stage of illness, how the patient is coping emotionally and physically, and the type of treatment the patient is receiving (Christy & Nixon, 2004). The two most common types of treatment for ovarian cancer are surgery and chemotherapy.

Surgery. Patients may be in the hospital days to weeks for the initial staging laparotomy. The hospital length of stay may be increased due to a variety of complications, such as paralytic ileus. One priority of nursing care is the prevention and early recognition of potential postoperative complications, including bleeding, pulmonary emboli, wound or urinary tract infections, dehydration, and fluid/electrolyte imbalances. Additional issues that may affect the patient include anxiety, pain, and compromised nutrition (Christy & Dixon, 2004). Preoperative education, along with assessment of coping mechanisms and level of understanding about the surgery, may decrease the patient's anxiety. Education and support need to occur from the preoperative phase through discharge from the hospital. Preoperative education should include information about diagnostic tests, bowel preparation, and the surgical procedure.

Postoperative instructions should be introduced to the patient and family at the preoperative appointment, but reinforce-

ment will be needed after surgery. Postoperative nursing care often includes routine assessments, such as vital signs and pain management, urethral catheters, nasogastric tubes, surgical incisions and drains, hydration, use of anti-embolic stockings, ambulation, and incentive spirometry. The nurse should explain the role of incentive spirometry in preventing atelectasis and pneumonia, and have the patient perform a return demonstration of spirometer use. Appropriate postoperative discharge instructions should be provided in a method appropriate for the patient and family and generally should include written instructions on care issues, such as monitoring for and reporting elevated temperature, monitoring for signs and symptoms of infection (pain, warmth, redness, swelling, drainage), taking analgesics as directed, following strategies to avoid constipation, maintaining nutrition and hydration, and gradually increasing activity (ambulating and avoiding abdominal exercises). The patient also should be instructed to avoid inserting anything into the vagina, such as tampons or douches; intercourse should be avoided for at least 6 weeks after surgery. The patient must have a contact phone number for a designated provider for any problems or questions that arise after hospital discharge, and should be scheduled for postoperative outpatient follow-up appointments prior to discharge from the hospital (De Gaetano & Lichtman, 2004).

Pain management is extremely important in the postoperative period, especially in the first 24-48 hours after surgery. Adequate pain management will allow the patient to participate more effectively in her postoperative recovery. The nurse needs to evaluate pain intensity, pain location, and the patient's description of the pain using tools approved by the specific institution. Pain should be evaluated at least once an hour in the first 24-48 hours after surgery. Pain medications are generally administered intravenously for the first few days, and the patient is transitioned to oral opioids after she begins to tolerate oral liquids. The nurse must be alert to possible side effects of opioid therapy, such as constipation, urinary retention, itching/rash, nausea, or excessive sedation. The nurse also must evaluate the effectiveness of the analgesic regimen and document all results in the patient's chart. Specific patient instructions regarding the use of patient-controlled analgesia or epidural analgesia may be needed. It is important to teach the patient to ask for pain medication before the pain reaches an intolerable level (Christy & Nixon, 2004; De Gaetano & Lichtman, 2004).

Dehydration and compromised nutritional intake may be issues after surgery. Results of the patient's CBC and basic metabolic panel are monitored, and intravenous fluids are administered as ordered, based on the patient's fluid status. Monitoring intake and output and daily weights is important to evaluate fluid balance postoperatively. The nurse should instruct the patient to take ample fluids and increase other nutritional intake after the return of bowel function, as indicated by positive bowel sounds and flatus. If the patient does not experience return of bowel function, total parenteral nutrition may be indicated. A nutrition consult in particular can be beneficial by providing an evaluation of nutritional status, and offering the patient education and interventions to improve nutrition. Because postoperative nausea may limit the patient's ability to eat, anti-emetics should be available and administered as needed (Girard, 2005; Stone, Cantwell, & Compher, 2005).

One potential complication of surgery is bleeding. Monitoring hemoglobin, hematocrit, and platelet count is crucial after surgery, as is checking the surgical incision site dressing and drains for excessive drainage or bleeding (Girard, 2005).

Another possible postoperative complication is venous thromboembolism (VTE), seen as either pulmonary embolism (PE) or deep vein thrombosis (DVT). Use of pneumatic compression devices (foot wrap or leg compression sleeves) on both legs, administration of prophylactic doses of anticoagulants, and early ambulation are important prevention strategies. The nurse should be alert to signs and symptoms that suggest a clot in the leg (unilateral swelling and pain) or lung (dyspnea, increased oxygen needs, anxiety). Some DVTs are asymptomatic without any clinical signs of leg swelling or pain. However, a PE can still occur (Brashers, 2006). Finally, the patient's hypercoagulable state due to the underlying cancer disease process also increases risk for postoperative VTE (Christy & Dixon, 2004).

Postoperative infections in the patient with ovarian cancer most commonly involve the respiratory or genitourinary tract. Therefore, the nurse should assess the patient routinely and carefully for any signs of infection, such as a fever; redness, swelling, or increased drainage from the incision; pain or burning when urinating after the urethral catheter has been discontinued; and any difficulty breathing. Typically, the lungs are auscultated and vital signs are monitored every 2-4 hours. The patient should be instructed to turn, cough, and deep breathe, and to use an incentive spirometer every hour while awake to decrease the risk for atelectasis and pneumonia. Urinary catheters are inserted in the operating room and usually remain in place for 24-48 hours. An extensive surgery may

have involved the bladder; if the bladder was injured or surgically incised, the patient may need an indwelling urethral catheter for a longer period of time and will be taught how to care for the catheter at home (Christy & Dixon, 2004). The patient should ideally have the catheter secured to her leg to prevent urethral trauma and/or irritation.

Psychosocial support for the patient and the family is a critical role for the nurse during the perioperative period. The patient may be particularly vulnerable because she is newly diagnosed or facing surgery related to disease recurrence. Social services and case management should be consulted to evaluate the patient for emotional and social support needs as well as discharge planning. In the rare instance where the woman is premenopausal, the surgery induces menopause and can cause infertility for the patient; providing information and emotional support for these two issues is extremely important (De Gaetano & Lichtman, 2004).

Chemotherapy. Adjuvant (meaning *after surgery*) chemotherapy is the treatment of choice for most patients with ovarian cancer (Berek, 2005). The chemotherapy usually is given in the outpatient setting and commonly involves treatment with the drugs carboplatin and paclitaxel. The nurse should be familiar with the specific chemotherapy agent, know how to administer it safely, educate the patient about the chemotherapy (see Table 1), and manage effects and side effects of the therapy. The patient and family must have an after-hours contact number in case questions or concerns arise after their chemotherapy treatment (Itano & Taoka, 2005).

Table 1.
Side Effects of Chemotherapy

Side Effects	Educate the Patient to...
Neutropenia	Avoid others with infections. Check temperature every day.
Nausea	Use prescribed antiemetics. Eat small frequent meals.
Diarrhea	Decrease fiber and roughage. Increase fluids. Take prescribed medication.
Constipation	Increase fluids. Increase mobility. Take prescribed medication.
Alopecia	Educate patient about timing of hair loss and regrowth of hair. Provide prescription for wig and brochures for head coverings.
Pain	Urge patient to report pain. Educate about pain medication and its side effects.
Fatigue	Educate patient that fatigue will occur. Teach energy conservation strategy.
Altered Body Image/Role Change	Encourage verbalization of concerns. Assist in coping. Assess need for referrals for additional home care support, support group, and counseling.

Source: De Gaetano & Lichtman, 2004.

Disease Recurrence and Complications of Advanced Illness

Ovarian cancer can recur after completion of treatment (National Comprehensive Cancer Network & American Cancer Society, 2004). When this happens, there are three primary clinical management options: a second debulking surgery, additional chemotherapy, and a clinical trial or novel therapy (Fields, Jones, Thomas, & Runowicz, 2001). Although the patient with recurrent disease may not respond fully to treatment, she may remain stable for months with improved survival. Support for the patient with advanced ovarian cancer and her loved ones may best be provided by a palliative care or a hospice team, and the nurse can be instrumental in offering information to them about these resources (Egan & Labyak, 2006).

Bowel obstruction. The patient with ovarian cancer may develop bowel obstructions at any time during her illness, but she is especially susceptible to this problem during periods of disease recurrence. The obstruction may be from a mechanical blockage, such as tumor pressing extrinsically on the small intestine, from a paralytic ileus, or from tumor invasion of the neural plexus (Berek, 2005). After an abdominal x-ray confirms small bowel obstruction, initial management includes bowel rest, correcting any electrolyte imbalances, aggressively treating the symptoms of nausea/vomiting, and possibly placing a nasogastric tube to low intermittent suction to decompress the bowel and relieve the accumulation of gastric secretions. Surgical interventions, such as an intestinal resection, colostomy diversion, or palliative venting gastrostomy, may be performed depending on the patient's clinical status and goals of care. However, surgery to cor-

rect a bowel obstruction may have a 10% mortality rate and a 30% complication rate for women with ovarian cancer (Berek, 2005).

Ascites. Ascites is the abnormal accumulation of fluid in the peritoneal space. It can occur in many types of cancers, but is particularly associated with ovarian cancer. Over 30% of patients with ovarian cancer will have ascites at time of diagnosis, and over 60% will have ascites at the time of death. The presence of ascites in ovarian cancer at time of diagnosis is not always a grim finding, but ascites that occurs later in the disease continuum is a poor prognostic sign (Kichian & Bain, 2005). Symptoms of ascites include a bloated feeling, abdominal pain, a need for larger-waisted clothes belts, a weight increase, nausea, heartburn, or in the more advanced stages, shortness of breath caused by large-volume ascites exerting pressure on the diaphragm (Economou, 2006; Kichian & Bain, 2005).

The first diagnostic step is to identify the cause of the ascites; it can occur for other reasons than cancer, such as pre-existing liver disease, congestive heart failure, or pancreatitis (Economou, 2006). A diagnostic paracentesis (inserting a needle into the peritoneal space to obtain a sample of fluid) is performed to identify the cause of the ascites. The most helpful tests to evaluate paracentesis fluid include cytology, cell count, gram stain with culture, and protein concentrations. Abdominal x-rays, CT scans, and ultrasound also can be useful diagnostic tools to evaluate the extent and location of the ascitic fluid (Kichian & Bain, 2005).

Malignant ascites that does not improve in response to treatment for the underlying cancer can be very difficult to manage and can have a profound, negative impact on the patient's quality of life. The most common management interventions include paracentesis (removal of 5-10 liters of fluid at one time by placing a needle in the peritoneal space), light diuresis with a potassium-sparing diuretic (for example, spironolactone [Aldactone®]), and fluid restriction (Economou, 2006; Kichian & Bain, 2005). Repeated paracentesis may be necessary in patients who are experiencing significant distress from recurrent malignant ascites. Other more invasive management interventions have been tested, such as the placement of special shunts that drain fluid from the peritoneal space into the internal jugular vein, or other aggressive surgical or biotherapy treatments. However, these techniques are rarely appropriate or well tolerated by seriously ill patients (Kichian & Bain, 2005).

Ovarian cancer can be a devastating diagnosis for the patient and family.

The nurse can help the patient with malignant ascites by providing education to the patient and family about the etiology and management of the symptom, advocating for the patient to the medical team regarding the patient's symptoms and comfort, and by offering emotional support for the patient and family. The nurse should be aware that significant hypotension can occur after large volume paracentesis, and IV albumin may be ordered. The nurse also must assess for dyspnea secondary to the patient's ascites, and offer opioids or benzodiazepines as ordered to help manage this symptom. Loose clothing and comfortable positioning of the patient also are very helpful. Vigilant skin care is essential because prolonged abdominal distention can lead to skin breakdown (Economou, 2006).

Lymphedema. Lymphedema is the abnormal accumulation of protein-rich interstitial fluid within the skin and subcutaneous tissue (Wyatt & Pirbaz, 2004). Significant pelvic and lower-extremity lymphedema can occur in advanced ovarian cancer and can be difficult to manage. Lymphedema in ovarian cancer may be caused by cancer treatments, such as surgery and radiation, or from tumor pressure that obstructs the normal drainage of lymph fluid from the surrounding tissue (National Lymphedema Network [NLN], 2006). The nurse has an important role in educating the patient and family about preventing and managing lymphedema. When lymphedema is caused by progressive tumor burden, prevention is not possible and symptom management becomes the priority. The NLN (2006) recently published lymphedema management practices that include good skin hygiene to reduce infection and injury to tissues, appropriate activity level, avoidance of constrictive clothing, and use of compression garments as appropriate to promote lymph return. Treatment can include complete decongestive therapy, which involves manual lymph drainage, multi-layer stretch compression bandaging, exercise, skin care, education, and elastic compression garments (Lacovara & Yoder, 2006; NLN, 2006). Unfortunately, these measures are not always optimally effective for patients with advanced ovarian cancer, and nursing interventions such as positioning, impeccable skin care, and emotional support can be extremely helpful.

Conclusion

Ovarian cancer can be a devastating diagnosis for the patient and family. The woman coping with ovarian cancer will have a variety of physical, psychological, and spiritual needs that the nurse is in an excellent position to

Table 2.
Ovarian Cancer Resources

American Cancer Society
(800) ACS-2345
1599 Clifton Road NE
Atlanta, GA 30329-4251
www.cancer.org
A nationwide, community-based, voluntary health organization dedicated to eliminating cancer as a major health problem. The ACS has materials in Spanish and Chinese.

Association of Cancer Online Resources
www.acor.org
The heart of ACOR is a large collection of cancer-related Internet resources which delivers e-mail messages to subscribers. In addition to supporting the mailing lists, ACOR develops state-of-the-art, Internet-based knowledge systems that allow the public to find and use credible information relevant to their illness.

Bone Marrow Transplant Newsletter
(800) 597-7674
2900 Skokie Valley Road, Suite B
Highland Park, IL 60035
www.bmtnews.org
Publications, attorney referrals for insurance problems, patient-to-survivor link, directory of transplant centers.

Cancer Care, Inc.
(800) 813-HOPE
275 Seventh Avenue
New York, NY 10001
www.cancercare.org
A national nonprofit agency dedicated to providing emotional support, information, referral, and practical assistance to people with cancer and their loved ones at no charge.

C-Change
(202)-756-1600
(202) 756-1512 (fax)
1776 Eye Street NW, 9th Floor
Washington, DC 20006
C-Change is comprised of the nation's key cancer leaders from government, business, and nonprofit sectors. These cancer leaders share the vision of a future where cancer is prevented, detected early, and cured, or is managed successfully as a chronic illness.

***Conversations!* The Newsletter for Those Fighting Ovarian Cancer**
(806) 355-2565
PO Box 7948
Amarillo, TX 79114-7948
www.ovarian.news.com
A monthly newsletter written by an ovarian cancer survivor, which reports on treatment options, clinical trials, coping skills, and early detection strategies. *Conversations* offers humor and an upbeat tone. A networking service to match women in similar circumstances is available.

Coping with Cancer Magazine
(615) 791-3859
PO Box 682268
Franklin, TN 37068-2268
www.copingmag.com
A bi-monthly, nationally distributed consumer magazine for people whose lives have been touched by cancer. Offers knowledge, hope, and inspiration.

Dream Foundation
(805) 564-2131
621 Chapala Street, Suite D
Santa Barbara, CA 93101
www.dreamfoundation.com
Wish-granting organization for adults over the age of 18 who are emotionally, financially, and physically devastated by terminal illness.

FORCE: Facing Our Risk of Cancer Empowerment
(954) 255-8732
email: info@facingourrisk.org
www.facingourrisk.org
FORCE: Facing Our Risk of Cancer Empowerment is an Internet-based nonprofit organization offering unbiased support and information for women at risk of hereditary breast and ovarian cancer due to BRCA mutation or family history of cancer and families in which this risk is present.

Gilda Radner Ovarian Cancer Familial Registry
(800) OVARIAN
Roswell Park Cancer Institute
Elm and Carlton Streets
Buffalo, NY 14263
www.ovariancancer.com
Tracks families with a history of ovarian cancer, and offers a help-line, education, information, and peer support for women with high risk (family history) of ovarian cancer.

Gilda's Club
(888) 445-3248
195 West Houston Street
New York, NY 10014
www.gildasclub.org
Provides a place where people living with cancer, their families, and friends can join others to build social and emotional support as a supplement to medical care.

Gynecologic Cancer Foundation (GCF)
(800) 444-4441
230 W. Monroe, Suite 2528
Chicago, IL 60606
www.thegcf.org
The GCF is a not-for-profit fundraising organization established by the Society of Gynecologic Oncologists (SGO) to support ovarian cancer research, training of cancer specialists in laboratory research, and a variety of programs for patient education and public awareness of gynecologic cancers. Calls will enable an individual to obtain a list of nearby specialists in gynecologic oncology, a nationwide directory of all SGO members, and information literature.

Table 2. (continued)
Ovarian Cancer Resources

Kids Konnected
(800) 899-2866
27071 Cabot Road, Suite 102
Laguna Hills, CA 92653
www.kidskonnected.org
Provides friendship, education, understanding and support to kids who have a parent with cancer.

Marsha Rivkin Ovarian Cancer Research Center
(800) 328-1124
1221 Madison Street
Seattle, WA 98104
www.marsharivikin.org
Promotes prevention, research, detection, and awareness.

National Coalition for Cancer Survivorship (NCCS)
(877) NCCS-YES
(877) 622-7937
1010 Wayne Avenue, #770
Silver Spring, MD 20910
www.canceradvocacy.org
Raises awareness of cancer survivorship though its publications, quarterly newsletters, education to eliminate the stigma of cancer, and advocacy for insurance, employment, and legal rights for people with cancer.

National Ovarian Cancer Association
(formerly Corinne Boyer Fund)
(877) 413-7970
(416) 962-2700
27 Park Road
Toronto, ON
Canada M4w2n2
www.ovariancanada.org
Founded by Patrick Boyer in memory of his wife Corinne, the fund embraces a two-fold mission: raising awareness about cancer of the ovary and increasing financial and educational resources to medical and personal efforts to prevent and successfully treat ovarian cancer.

National Ovarian Cancer Coalition (NOCC)
(888) OVARIAN
(561) 393-0005
500 NE Spanish River Boulevard, Suite 8
Boca Raton, FL 33431
www.ovarian.org
Largest ovarian cancer organization whose mission is to raise awareness about ovarian cancer and to promote early detection and education about the disease. The coalition is committed to improving the overall survival rate and quality of life for women and families living with the disease. Sponsors professional education seminars for health care providers and educational forums for the lay community. Over 60 divisions in many states provide local programming and resources.

National Cancer Institute (NCI)
(800) 4-CANCER
www.cancer.gov
Provides a nationwide telephone service for cancer patients and their families and friends, to the public, and health care professionals to answer cancer-related questions. NCI sends booklets and information about cancer.

Ovarian Cancer National Alliance
(202) 331-1332
910 17th Street, NW, Suite 413
Washington, DC 20006
www.ovariancancer.org
A national umbrella organization that works to increase public and professional understanding of ovarian cancer, and to advocate for more effective diagnostics, treatments, and cure. Members include survivors and family members, local and national organizations, and health care providers. Materials include awareness information and national policy issue papers. The alliance sponsors an annual advocacy conference.

Ovarian Cancer Research Fund, Inc. (OCRF)
(800) 873-9569
14 Pennsylvania Plaza, Suite 1400
New York, NY 10122
www.ocrf.org
Devoted to the formation of early diagnostic treatment programs and research toward the ultimate conquest of ovarian cancer. As OCRF strives to find a cure, it also provides educational outreach programs and public awareness projects, including videos about ovarian cancer and resource materials.

Patient Advocate Foundation (PAFP)
(800) 532-5274
753 Thimble Shoals Boulevard, Suite B
Newport News, VA 23606
www.patientadvocate.org
Provides patient education relative to managed care terminology and policy issues that may affect coverage, legal intervention services, and counseling to resolve job discrimination and/or insurance issues.

R.A. Bloch Cancer Foundation, Inc.
(800) 433-0464
4435 Main Street, Suite 500
Kansas City, MO 64111
www.blochcancer.org
Provides a hotline that matches newly diagnosed cancer patients with someone who has survived the same kind of cancer. Offers free information, resources, and support groups. Also supplies three books at no charge. *Fighting Cancer, Cancer... There's Hope,* and *Guide for Cancer Supporters.*

Table 2. (continued)
Ovarian Cancer Resources

SHARE: Self-Help for Women with Breast or Ovarian Cancer
(866) 891-2392
(212) 719-1204
1501 Broadway, Suite 1720
New York, NY 10036
www.sharecancersupport.org
A not-for-profit organization providing information hotlines for breast and ovarian cancer in English and Spanish; peer-led support groups; wellness, education, and advocacy programs. SHARE contributes to awareness regarding research, prevention, and early detection.

Support Connection, Inc.
(866) 532-4290
(914) 962-6402
360 Underhill Avenue
Yorktown Heights, NY 10598
www.supportconnection.org
A not-for-profit organization offering free and confidential support services to people affected by breast or ovarian cancer. Services include peer-led support groups, wellness, education, and advocacy programs, one-on-one peer counseling, and a 24-hour toll-free hotline. The support provided enables women to help each other and become their own health care advocates.

The Blanton-Davis Ovarian Cancer Research Program
(formerly The Sandra G. Davis Ovarian Cancer Research Program)
(800) 392-1611
The University of Texas
M.D. Anderson Cancer Center
1515 Holcombe Boulevard
Houston, TX 77030
www.mdanderson.org
Established at the University of Texas M.D. Anderson Cancer Center in 1996 to develop effective screening methods and a cure for ovarian cancer through innovative research into causes, prevention, detection, and treatment. The program is a multidisciplinary integration of patient care and research initiatives and comprises three parts: clinical care, community relations, and research.

The Wellness Community
(888) 793-WELL
919 18th Street NW, Suite 54
Washington, D.C. 20006
www.thewellnesscommunity.org
Provides free psychosocial support to people fighting to recover from cancer as an adjunct to conventional medical treatment.

Women's Cancer Network (GCF)
(312) 644-6610
(800) 444-4441
c/o Gynecologic Cancer Foundation
230 W. Monroe, Suite 2528
Chicago, IL 60606
www.wcn.org
An interactive Internet site. It offers understandable medical information about gynecological cancers, treatment options, and experimental programs. By answering specific questions a woman will be told her risk for developing specific cancers such as gynecologic, breast and colon cancers, and how to change those risks.

address. The nurse should deliver individualized and holistic care to the woman diagnosed with ovarian cancer, in part by providing appropriate education and support along the illness continuum. The nurse possesses the education and skills to expertly support the patient and family from the time of diagnosis through the potential stages of recurrence, advanced illness, palliative care, and death, to help ease the burden of this often difficult and insidious disease. Table 2 provides comprehensive resources for patients with ovarian cancer. ■

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Answer/Evaluation Form:
The Medical-Surgical Nurse's Guide to Ovarian Cancer: Part II

This test may be copied for use by others.

COMPLETE THE FOLLOWING:

Name:____

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Answer Form:

1. If you applied what you have learned from this activity into your practice, what would be different?

____

____

____

____

Evaluation	**Strongly disagree**				**Strongly agree**
2. By completing this activity, I was able to meet the following objectives:					
a. Identify the treatment options available to the patient with ovarian cancer.	1	2	3	4	5
b. Discuss the nurse's role in providing treatment to the patient with ovarian cancer.	1	2	3	4	5
c. Describe disease recurrence and complications of advanced ilness associated with ovarian cancer.	1	2	3	4	5
3. The content was current and relevant.	1	2	3	4	5
4. The objectives could be achieved using the content provided.	1	2	3	4	5
5. This was an effective method to learn this content.	1	2	3	4	5
6. I am more confident in my abilities since completing this material.	1	2	3	4	5

7. The material was (check one) ___new ___review for me

8. Time required to complete the reading assignment: _____minutes

I verify that I have completed this activity: _______________________

Comments

____

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Objectives

This continuing nursing educational (CNE) activity is designed for nurses and other health care professionals who care for and educate patients and their families regarding ovarian cancer. For those wishing to obtain CNE credit, an evaluation follows. After studying the information presented in this article, the nurse will be able to:

1. Identify the treatment options available to the patient with ovarian cancer.
2. Discuss the nurse's role in providing treatment to the patient with ovarian cancer.
3. Describe disease recurrence and complications of advanced illness associated with ovarian cancer.

CNE Instructions

1. To receive continuing nursing education credit for individual study after reading the article, complete the answer/evaluation form to the left.
2. Photocopy and send the answer/evaluation form along with a check or credit card order payable to **AMSN** to *MEDSURG Nursing*, CNE Series, East Holly Avenue Box 56, Pitman, NJ 08071–0056.
3. Test returns must be postmarked by October 31, 2009. Upon completion of the answer/evaluation form, a certificate for 1.3 contact hour(s) will be awarded and sent to you.
4. This activity provides 30 minutes of pharmacology hours.
5. CNE forms can also be completed online at www.medsurgnursing.net.

This independent study activity is co-provided by **AMSN** and **Anthony J. Jannetti, Inc. (AJJ)**.

AJJ is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation (ANCC-COA).

Anthony J. Jannetti, Inc. is a provider approved by the California Board of Registered Nursing, Provider Number, CEP 5387.

This article was reviewed and formatted for contact hour credit by Dottie Roberts, MSN, MACI, RN, CMSRN, OCNS-C, ***MEDSURG Nursing*** Editor; and Sally S. Russell, MN, CMSRN, AMSN Education Director.