

## ARTICLES

# Ovarian Cancer: Early Symptom Patterns

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**Purpose/Objectives:** To examine early symptom and diagnostic-seeking experiences of women newly diagnosed with ovarian cancer.

**Design:** Longitudinal descriptive.

**Setting:** Homes of families.

**Sample:** Purposive; 19 families were obtained by referrals.

**Methods:** Interviews and questionnaires; descriptive analysis.

**Main Research Variables:** Early symptoms and delays in diagnosis.

**Findings:** Families were 88% Caucasian and 12% African American.

Almost two-thirds had annual incomes of \$25,000 or more. The ages of the patients with cancer ranged from 28–73 years ( $\bar{X}$  = 56 years). Delay between initial symptoms and diagnosis was  $\bar{X}$  = 14 weeks. Early symptoms experienced by 95% of women were abdominal bloating, vague abdominal pain and “spots,” indigestion problems, fatigue, and urinary problems.

**Conclusions:** Women usually experience a cluster of symptoms, unrecognized and discounted, which delays diagnosis.

**Implications for Nursing:** Pelvic assessments should be reformulated to conceptualize early symptoms, risk factors, and family cancer history as a dynamic, interconnected whole to guide and interpret ovarian health.

Ovarian cancer is depicted as a reproductive malignancy that presents few, if any, early symptoms. When diagnosis occurs, the cancer is usually in the late stages of development. Early undifferentiated symptoms long have been reported; however, their clinical significance has been largely unrecognized as a diagnostic indicator. The research reported in this article was part of a large study that examined selected aspects of the lived experiences of families that had members recently diagnosed with ovarian cancer. One aspect was information about the presence of pre-diagnostic symptoms. The purpose of this article is to report this early symptom experience in the context of the diagnosis-seeking process and examine its significance.

Ovarian cancer occurs most frequently in women aged 55 and older. The incidence is highest among Caucasian women in North America and northern Europe. The next most vulnerable group is African Americans, followed by Asian Americans. Native Americans have the lowest incidence (Daly & O Abrams, 1998). This malignancy accounts for an estimated 14,300 deaths and 25,400 new cases each year (Jemal et al., 2003). The high mortality rate results, in large part, from delays in diagnosis. When the diagnosis is made in stage I, 90% of patients can be cured with therapies that

### Key Points . . .

- ▶ Healthcare professionals must conceptualize their assessment framework to use early symptom data as early warning signals.
- ▶ Gynecologic examinations must routinely include early symptoms.
- ▶ Women can be taught to self-monitor their ovarian health.

currently are available (Bast, Fishman, Smith, & Skates, 2003).

Primary prevention approaches for ovarian cancer in asymptomatic women have focused on the use of the CA125 blood test, transvaginal sonography, and bimanual pelvic examinations (American Cancer Society, 2001; National Cancer Institute, 2001; National Institutes of Health, 1994). As yet, neither blood nor sonographic approaches have been found to be sensitive or cost-effective enough to serve as standards in primary prevention programs.

Chemoprevention approaches and selected surgical interventions have not been recommended as primary prevention strategies (Barnes, Grizzle, Grubbs, & Partridge, 2002). Secondary prevention approaches focus on early detection and diagnosis. Strategies include the identification and minimization of risk factors, development of protective factors, bimanual pelvic examinations, and specialized consultation as needed. Ovarian health education and self-monitoring of reproductive structures and functions by women are key activities in early detection. Grimes (1993) noted that aggressive screening was essential. Jennings-Dozier and Mahon (2000) have cited this area as the next frontier in oncology nursing leadership and service.

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