

Endometrial Cancer

Overview

In the United States, the most common cancer of the female reproductive system is endometrial cancer. In endometrial cancer, cancerous cells grow in the endometrium (the lining of the uterus).

This year, about 41,200 women in the United States will be diagnosed with cancer of the uterus. More than 95 percent of these cancers will be endometrial cancers. Uterine sarcomas do not come from tissue of the endometrium. However, they can involve the endometrium. These types of cancers are not covered here because treatment and survival rates are different from endometrial cancer.

Most endometrial cancers develop over many years and may develop from less serious problems of the endometrium, such as hyperplasia. The survival rate across all stages of endometrial cancer is approximately 84 percent, but if the cancer is diagnosed at its earliest stage, survival is 90 to 95 percent.

Fortunately, most endometrial cancers are discovered early because of warning signs such as irregular or postmenopausal bleeding. Therefore, it is important that physicians and women be aware of the significance of these signs. Although the majority of endometrial cancers occur in postmenopausal women, up to 25 percent may occur before menopause so awareness is important throughout a woman's life.

Female Anatomy

The female reproductive system produces sex hormones, such as estrogen and progesterone, which maintain the reproductive cycle by sending signals to the reproductive organs. The ovaries respond to these signals by producing eggs, which proceed to the fallopian tubes. This is the site of conception. If conception occurs, the embryo moves on to the uterus and implants in the endometrium.

During a menstrual cycle, the endometrium changes so it is prepared for an embryo if conception occurs. Near the beginning of the cycle, hormones stimulate the endometrium to thicken so it can nourish an embryo. If pregnancy does not occur mid-cycle, the hormones change and the top layer of the lining begins to die. At the end of the cycle, the dead tissue is shed from the uterus and becomes the menstrual flow. This cycle repeats throughout a woman's life until she begins menopause.

Causes

Like all cancers, endometrial cancer develops when abnormal cells grow out of control. Cancer develops because of damage to a cell's DNA (a substance in every cell that directs all activities). Damaged DNA can be inherited or can result from an environmental exposure. Normally, when DNA becomes damaged, the body is able to repair it. In cancer cells, the damaged DNA is not repaired. It can grow and travel to other parts of the body and replace normal tissue. This is called metastasis (spread of cancer).

Risk Factors

Many factors influence the development of endometrial cancers, including:

- Obesity – Being overweight is a risk factor because having more fat tissue can increase a woman's estrogen levels.
- Estrogen Replacement Therapy (ERT) – This is used to offset the effects of menopause. Use of estrogen hormonal therapy without the use of progesterone increases a woman's risk of developing endometrial cancer.
- Tamoxifen – This is a drug used to treat breast cancer. Because the drug acts like estrogen in the uterus, it can cause the uterine lining to grow, increasing the risk of developing endometrial cancer.
- Personal/Family History – A personal or family history of colon, endometrial or ovarian cancer may indicate Lynch syndrome (hereditary nonpolyposis colorectal cancer). Women with Lynch syndrome have a very high risk of developing endometrial cancer.
- Age – As a woman ages, her chance of getting endometrial cancer increases. More than 95 percent of endometrial cancers occur in women over 40.
- Diabetes – This is a risk factor for endometrial cancer whether or not a woman is obese.
- Ovarian Diseases – Certain ovarian tumors produce estrogen and can cause an increase in estrogen levels.
- Complex Atypical Endometrial Hyperplasia – This is a precancerous condition that may become cancerous if left untreated. Simple hyperplasia rarely becomes cancerous and can go away on its own or with hormonal treatment.

Symptoms

Symptoms may vary from woman to woman. Many gynecological cancers, including endometrial, ovarian and cervical, have some of the same symptoms. If a woman has gone through menopause, it is especially important to report any unusual signs and symptoms. The most common symptoms of endometrial cancer are:

- Vaginal postmenopausal bleeding.
- Premenopausal or perimenopausal bleeding, spotting or bleeding between periods or heavy periods. It is common for women diagnosed with endometrial cancer to have some type of abnormal vaginal bleeding.
- Abnormal vaginal discharge.
- Pelvic pain or pressure, usually occurring in the later stages of the disease.
- Weight loss.

Most of these symptoms do not mean you have cancer, but if you notice one or more symptoms for more than two weeks, see your doctor.

Prevention

Although all cases of endometrial cancer cannot be prevented, there are certain things a woman can do that may lower her risk, including:

- Report any irregular bleeding or bleeding after menopause to your physician.
- See a physician to assess your risk of endometrial cancer, especially if you are taking tamoxifen or have a family history of endometrial or colon cancer.
- Maintain a healthy weight.
- Talk to a physician about ways to regulate your menstrual periods. Birth control pills and other hormonal methods of birth control can help regulate menstrual periods and can reduce the risk of endometrial cancer.
- Take the time to discuss risks with your healthcare provider, who can best advise you on the screening exams and risk-reduction strategies that are right for you.

Tests

Cancer screening tests are performed when a person has no symptoms, like the annual mammograms for women over 40. Unlike breast cancer, screening for endometrial cancer is not recommended for most women because the chances of having the disease are quite low. But for women with Lynch syndrome (hereditary nonpolyposis colorectal cancer), an annual endometrial biopsy is recommended beginning at age 35. For women at normal risk for endometrial cancer, the best defense is to pay attention to their bodies, know the symptoms and learn ways to decrease the risk of developing certain gynecological cancers.

If a woman is experiencing any irregular or postmenopausal vaginal bleeding or other symptoms of endometrial cancer, an endometrial biopsy should be done. An assessment of symptoms, risk factors, medical history and a routine physical and pelvic exam will be performed. If you are pregnant or think you might be pregnant or if you have recently been treated for a vaginal, cervical or pelvic infection, the doctor should be informed.

Testing for endometrial cancer may include the following:

- **Endometrial Biopsy** – In an endometrial biopsy, a small amount of tissue is removed from the endometrium by inserting a thin, flexible tube through the cervix and into the uterus. This tissue is sent to a pathologist who uses a microscope to look for abnormal cells. The biopsy takes just a few minutes. Most women experience, at most, some mild discomfort, similar to menstrual cramps. If needed, local anesthetic may be used to numb the cervix, and taking ibuprofen before the test may help prevent pain. An endometrial biopsy can be somewhat more difficult and painful for older women because the vagina or cervix may not be very elastic or may have a small opening, which can make it difficult to insert the instruments. Most women experience little discomfort after this procedure and may resume normal activities. Intercourse, douching, taking a bath and the use of tampons are usually not permitted for two days.
- **Dilation & Curettage (D&C)** – If the endometrial biopsy does not provide enough tissue or if a diagnosis of cancer is not definite, a dilation & curettage (D&C) may be done. D&C is a surgical procedure in which the cervix is dilated. The surgeon passes a small instrument, called a curette, through the cervix into the uterus and scrapes off a sample of the endometrium. D&C takes about an hour and is usually done as an outpatient procedure under general anesthesia, so the woman will be unconscious and feel nothing. For a few hours after the procedure, she may experience mild pelvic cramping and a slight vaginal discharge. Also, the next menstrual period may be early or late. Most women are able to return to normal activities within one to two days. Intercourse, douching and the use of tampons are usually not permitted for two weeks.
- **Hysteroscopy** – Hysteroscopy is a diagnostic test that is used to determine if there are any structural problems inside the uterus. It can be done along with a D&C. The procedure uses a thin, telescope-like device called a hysteroscope. The hysteroscope is inserted into the uterus through the vagina and cervix. A liquid or gas may be released through the hysteroscope to expand the uterus so the inside can be seen more easily. A light in the hysteroscope allows the doctor to see the inside of the uterus and the openings where the fallopian tubes enter the uterine cavity. A hysteroscopy can help locate abnormal growths. In addition to diagnosis, this procedure can also be used for treatment. If a surgical procedure is being done, tiny instruments will be inserted through the hysteroscope. A hysteroscopy may require local, regional or general anesthesia depending on what procedures are being done at the same time. Women may experience mild cramping or pain afterward. They may also have light vaginal bleeding and cramping for several days. Most women are able to return to normal activities within one to two days. Intercourse, douching and the use of tampons are usually not permitted for two weeks.

- Testing the Tissue (Pathology) – Once tissue is removed from the endometrium, a pathologist looks at it under a microscope to see if cancer cells are present. If cancer cells are present, the cells will be studied to learn more about the cancer and assign a grade of one to three. Grade one refers to a well-differentiated tumor that is less aggressive. Grade three refers to a poorly differentiated tumor that may act aggressively. Read more about grading in the section on treatment.

Other Tests

If the cancer appears advanced, doctors may recommend additional diagnostic testing, including:

- Chest X-Ray – This is a picture of the chest that shows your heart, lungs, airway, blood vessels and lymph nodes. A chest X-ray is performed to see if the endometrial cancer has spread to the lungs. It also shows the bones of your spine and chest, including your breastbone, ribs, collarbone and the upper part of your spine. A chest X-ray is the most common test used to find problems inside the chest. Usually two pictures are taken, one from the back and another from the side. However, doctors cannot always get the information they need from a chest X-ray to find the cause of a problem.
- Complete Blood Count – Blood tests will be conducted to ensure that individuals can safely undergo surgery. Many times, women who have lost blood from the uterus will have low red blood cell counts.

Though uncommon, other tests may include:

- Computerized Tomography (CT) Scan – This is a diagnostic test that uses an X-ray machine and a computer to create detailed pictures of the body, including 3-D images, and to detect disease or abnormal organ structure. CT scans can also be used to guide a biopsy needle into a mass. As part of a CT scan, you may be asked to drink contrast liquid or have an IV (intravenous) line for injection of a contrast dye. Contrast dye makes your organs more visible on the X-ray film.
- Magnetic Resonance Imaging (MRI) – This diagnostic test uses magnetic fields and radio (sound) waves to create computerized images of the brain, spine, bones and soft tissue, such as organs, muscle, cartilage, ligaments and tendons. You may have to be placed in a tube, which can feel confining for people with a fear of enclosed spaces. A contrast dye might be used. The MRI is very noisy while operating, so patients may be given ear plugs.
- CA 125 Blood Test – This test measures the amount of a protein (CA 125) found on the surface of many endometrial and ovarian cancers. High levels of this protein may suggest that the cancer has spread beyond the uterus.

Treatment

Once you are diagnosed with endometrial cancer, you should consult with a gynecological oncologist, a doctor who specializes in treating cancer. Endometrial cancer detected in its early stages can be cured with treatment and close follow-up. Your doctor will recommend a treatment plan depending largely on the stage of the disease.

Staging and Grading

Staging is the process of determining where a cancer is located and whether it has spread to other parts of the body. The stage of the cancer is an important factor in making treatment choices. Certain tests and procedures are used in the staging process. A hysterectomy (an operation in which the uterus is removed) with bilateral salpingo-oophorectomy and pelvic and para-aortic lymph node dissection will usually be done to help find out how far the cancer has spread. After looking at your test results, your doctor will tell you the stage and discuss the best treatment for you. Treatment choices may include surgery, radiation therapy, chemotherapy and/or hormone therapy.

The grade of the cancer refers to the appearance of the cells in the tumor and gives an idea of how aggressive the cancer is. Grade one is made up mostly of normal-looking cells. Grade two has more abnormal-looking cells. Grade three has a higher percentage of abnormal looking cells.

Stage I

In stage I, the cancer is found only in the uterus. Stage I is divided into stages IA, IB and IC based on how far the cancer has spread. Stage IA is in the endometrium only. Stage IB has spread into the inner half of the myometrium (muscle layer of the uterus). Stage IC has spread into the outer half of the myometrium. Stage I is often curable with a hysterectomy and bilateral salpingo-oophorectomy surgery. If you want to preserve your ability to have children, you may be able to have hormone therapy rather than a hysterectomy. However, it is not considered a standard treatment for stage I cancer. If you choose this form of treatment, your physician will probably recommend a hysterectomy when you are done having children. If cancer is found deep in the uterine muscle (myometrium), a hysterectomy may be followed by radiation therapy. The five-year survival rate for stage I is 90 to 95 percent. This means 90 to 95 percent of women with stage I endometrial cancer survive for at least five years after diagnosis.

Stage II

In stage II, the cancer has spread from the uterus to the cervix, but not outside the uterus. Stage II is divided into stages IIA and IIB based on how far the cancer has spread into the cervix. Stage IIA has spread to the glands where the cervix and uterus meet. Stage IIB has spread into the connective tissue of the cervix. Stage II may be treated with a radical hysterectomy (which removes the uterus, cervix, ovaries and structures that support the uterus) and pelvic and para-aortic lymph node removal (lymphadenectomy). In some cases, radiation therapy may be given after surgery. Because other medical problems may prevent surgery from being a treatment option, women with stage II endometrial cancer may be treated with radiation therapy only. The five-year survival rate for stage II is 75 percent.

Stage III

In stage III, the cancer has spread beyond the uterus and cervix, but has not spread beyond the pelvis. Stage III is divided into stages IIIA, IIIB and IIIC based on how far the cancer has spread within the pelvis. Stage IIIA has spread to the outermost layer of the uterus, the tissue just beyond the uterus and/or the peritoneum (the lining that covers the abdominal cavity and organs). Stage IIIB has spread beyond the uterus and cervix into the vagina. Stage IIIC has spread to lymph nodes near the uterus. Stage III is treated with surgery to remove the uterus, ovaries, fallopian tubes, cervix and all visible tumors. Chemotherapy or radiation may be used after surgery. Hormonal therapy, using progesterone, is also an option. Women with stage III endometrial cancer may be candidates for clinical trials of new treatment options. The five-year survival rate for stage III is 60 percent.

Stage IV

In stage IV, the cancer has spread beyond the pelvis. Stage IV is divided into stages IVA and IVB based on how far the cancer has spread. Stage IVA has spread to the bladder and/or bowel wall. Stage IVB has spread to other parts of the body beyond the pelvis, including lymph nodes in the abdomen or groin. Stage IV is treated with surgery to remove the uterus, ovaries, fallopian tubes, cervix and all visible tumors. Chemotherapy or radiation therapy may be used after surgery. Hormonal therapy, using progesterone, is also an option. The five-year survival rate for stage IV is 15 to 26 percent.

Other considerations in choosing the best treatment plan include your age, overall health, childbearing plans and other personal concerns.

Surgery

The main surgery done for endometrial cancer is a total hysterectomy with bilateral salpingo-oophorectomy. In this surgery, the uterus is removed along with both ovaries and fallopian tubes and sometimes the pelvic and para-aortic lymph nodes. In a radical hysterectomy, the surgeon removes the uterus, cervix, surrounding tissue, upper vagina and usually the pelvic and para-aortic lymph nodes.

A hysterectomy can be done through the abdomen or the vagina, depending on a patient's medical history and overall health. Hysterectomies are almost always done with general anesthesia.

In an abdominal hysterectomy, the uterus, ovaries and fallopian tubes are removed through an incision in the abdomen. The large opening in the abdomen allows the surgeon to see the organs easily and determine if and where the cancer has spread. The hospital stay is three to five days for this surgery. The incision leaves a scar on the abdomen, usually about five inches.

Laparoscopic or robotic hysterectomy removes the uterus and ovaries through an incision in the vagina. Surgeons use a laparoscope, a lighted viewing instrument, or robotic instruments, inserted through small incisions in the abdomen. The hospital stay is one to two days.

Following a hysterectomy, you will not be able to become pregnant. About four to six weeks after the hysterectomy, you will have a follow-up visit with your doctor and should be able to return to your normal activities, including sexual activity.

Lymphadenectomy, also called a lymph node dissection, is surgery used to remove the lymph nodes from the pelvic and para-aortic area. Examining the lymph nodes for cancerous cells lets doctors determine the exact stage and grade of the cancer. This surgery may be done as a part of a hysterectomy and can be performed through an abdominal incision or by laparoscope under general anesthesia. The time required for recovery depends on which procedure was used, but is typically shorter with a laparoscopic procedure.

Radiation Therapy

Radiation therapy uses high-energy rays to pinpoint and destroy cancer cells. Although radiation treatment is similar to having an X-ray, the dose of radiation is higher and given over a longer period of time. Radiation therapy may be used to treat endometrial cancer after a hysterectomy or as the primary therapy, especially when surgery is not an option. Depending on the stage and grade of the cancer, radiation therapy may also be used at different points of treatment. A radiation therapist delivers the prescribed treatment and will assist you before and after each session. You will not be radioactive after receiving radiation.

There are two types of radiation therapy, including:

- Brachytherapy (Internal Radiation Therapy) – Radioactive materials, called radioisotopes, are inserted through the vagina and placed in the uterus or other areas where cancer cells are found. The radioisotopes will remain there for two to three days. This type of therapy can be done during a hospital stay or as an outpatient. Placing the radioisotopes takes about 30 to 45 minutes under local or general anesthesia. Depending on your cancer, several treatments may be needed. Because brachytherapy delivers radiation to a local area with tiny pellets, there is little effect on nearby structures, such as the bladder or rectum. Once treatment is completed, removal of the radioisotopes is a straightforward procedure, but it can be painful.

- External Radiation – This is similar to an X-ray but takes longer. This treatment is usually done on an outpatient basis for four to six weeks, five days per week, for about 30 to 45 minutes each time. How much of the pelvic area that needs to be exposed to radiation depends on how far the cancer has spread. When radiation is ordered, patients will be given an appointment for a pretreatment simulation. The simulation involves X-rays of your pelvis and the placement of colored marks on the hips and lower back. While the simulation is painless, you will have to lie face down on a special table for at least one hour. You will need to keep the colored marks on your skin, so you should not take baths during the course of treatment. Sponge baths are better than showers. On the days of your actual treatment, you will lie on a treatment table. The radiation therapist will position you so the radiation will reach the right part of your body. Once you are positioned, do not move until the treatment is finished. Your position on the table will be same for each treatment. Your doctor will tell you when you can wash off your colored markings.

Radiation therapy may make sexual intercourse uncomfortable or painful. You may want to wait until treatment is finished to resume sexual intercourse. Other side effects may include:

- Fatigue.
- Dryness, itching, tightening and burning in the vagina.
- Red, dry, tender, itchy skin.
- Moist, weepy skin (later in treatment).
- Hair loss in the treated area.
- Loss of appetite.
- Diarrhea.
- Frequent and uncomfortable urination.
- Reduced white blood cell count.

Chemotherapy

Chemotherapy uses drugs to kill or stop cancer cells from dividing. There are two types of chemotherapy: systemic and regional. With endometrial cancer, systemic chemotherapy is used. This means the drugs are taken by mouth or injected into a vein or muscle. Drugs taken this way enter the bloodstream to reach cancer cells throughout the body. In regional chemotherapy, the drugs are placed directly into the spinal column, an organ or a body cavity, such as the abdomen, in order to target cancer cells in those areas. One or more chemotherapy drugs may be used in your treatment plan. Chemotherapy for patients with endometrial cancer is given on an outpatient basis and usually lasts three to four months. Each woman reacts differently to chemotherapy. Many women can continue their regular daily activities, including work.

Chemotherapy can have some side effects, but most of them go away once treatment is completed. Side effects will depend on the type of drugs given, the amount taken and how long the course of treatment lasts. Some side effects include nausea and vomiting, loss of appetite, hair loss, mouth sores, vaginal sores, infection due to low white blood cell count, bleeding or bruising from minor cuts or injuries because of low blood platelets and shortness of breath or fatigue from low red blood cell counts.

Hormone Therapy

Hormone therapy stops cancer cells from growing by blocking the action of hormones. Hormones are substances produced by glands in the body and circulated in the bloodstream. The presence of some hormones can cause certain cancers to grow. If tests show that the cancer cells have receptors where hormones can attach, drugs can be used to reduce the production of hormones or block them from working. In hormone therapy, progesterone-like drugs, known as progestins, are used to slow the growth of cancer cells, usually in a pill form or by injections.

New Treatments – Clinical trials

New treatments are always being tested in clinical trials and some women with endometrial cancer may want to consider participating in these research studies. These studies are meant to help improve current treatments or find new treatments for patients with cancer. When clinical trials show that a new treatment is better than the standard treatment, the new treatment may become the standard treatment.

For information about ongoing clinical trials, visit www.clinicaltrials.org. Clinical trials are taking place in many parts of the country. For more information, visit the National Cancer Institute's website at www.cancer.gov/clinicaltrials.

Follow-Up Visits

During the first three years after treatment, you should have follow-up visits every three to six months to ensure that changes in your health are monitored and problems are treated early. Your follow-up visits will include physical and pelvic exams and possible blood tests and X-rays. A pap test may also be done to look for cancer cells in the vagina. If the cancer does not return within three years, visits can be scheduled less often.

Menopause

If you have not gone through menopause, it will begin immediately after most treatments for endometrial cancer. If your uterus and ovaries have been removed or you have had radiation therapy, your body will have a decrease in estrogen, which is normal in menopause. The lack of estrogen can cause osteoporosis (brittle, thin bones) and other symptoms such as hot flashes and insomnia. Several medications and other treatments are available for preventing or treating menopausal symptoms, so talk with your doctor about your options.

Fertility

Before you begin a treatment plan for endometrial cancer, your doctor will discuss your fertility options. Women who have undergone a hysterectomy and bilateral salpingo-oophorectomy for endometrial cancer are infertile, meaning they will not be able to become pregnant.

Sexuality

As cancer care and survival rates have improved, issues that affect quality of life, such as sexual health, have become increasingly important. Often patients are not sure what to expect from health care providers in regard to talking about sexual health during and after cancer treatment.

Cancer treatment, such as surgery, chemotherapy, hormone therapy or radiation therapy, can decrease your level of sexual desire by slowing down the production of sex hormones. Side effects of treatment, such as nausea or fatigue, may also decrease your desire. Negative emotions, like depression, anger, fear or guilt, may keep you or your partner from wanting to have sex. Medications for pain, nausea, anxiety or depression, can also decrease desire. If you have experienced changes in your appearance as a result of treatment, you may feel self-conscious. All of these factors affect sexual desire.

Surgery or radiation treatment to the abdomen or pelvis may cause physical changes in blood circulation or nerve supply to the sex organs. Women who experience vaginal dryness as a result of surgery or radiation may use water-soluble lubricants or moisturizing suppositories available at any drugstore without a prescription. Some women may experience some shrinkage of the vagina as a result of radiation or surgery. A combination of learning to relax the vaginal muscles and gentle, gradual stretching of the vagina with dilators can overcome this problem. Finding positions that give the woman control over movement and minimize deep penetration can also help.

Your doctor can give you additional advice about sexual activity after radiation treatment or surgery. For more detailed information, request a copy of patient education information sheet *Sexuality and Your Cancer Treatment*.

If you are having chemotherapy, it is important to know what your platelet count is before engaging in sexual activity. If your platelet count is lower than 50,000 and you engage in sexual activity, you may be at risk for bleeding.

During chemotherapy, you are also at greater risk for getting an infection. For this reason, practice good personal hygiene and bathe daily. Wash your hands and genitals before and after sexual activity. If you are not in a monogamous sexual relationship (having only one partner) or you are not sure of your partner's faithfulness, you should practice safer sex, using latex condoms to avoid contact with your partner's body fluids. If you use a lubricant with latex condoms, choose one that is water-based and does not contain oil (e.g., baby oil or petroleum jelly), since such products can weaken the condom. Nonoxynol-9 is no longer recommended as an HIV preventive.

If you are the spouse or partner of the patient, you need not worry about getting cancer from sexual intercourse. Cancer is not passed from one person to another. Sexual activity does not cause cancer, nor does sexual activity increase the risk that cancer will return. The causes of cancer are complex, such as exposure to certain toxic chemicals, tobacco use or genetic factors. It is medically impossible to pass cancer from one person to another. However, some chemotherapy drugs can be present in semen or vaginal fluid. If your partner is receiving chemotherapy, use condoms for the first 72 hours after chemotherapy is finished to avoid any exposure to the drugs.

Treatment and Relationships

Cancer and cancer treatment can cause changes in your appearance. Side effects, such as hair loss, weight changes, scars or changes in skin color, may distress you. You may feel helpless and frustrated by changes beyond your control. The way you feel about your body and yourself can affect how you interact with others. At MD Anderson Cancer Center at Cooper we understand that complete cancer care means treating more than the disease, that's why we created the Behavioral Medicine Program. Through this program our patients learn the skills needed to cope with any psychological stress experienced throughout treatment into survivorship. Ask your health care team for more information or call 856.673.4254.

Anxiety about cancer and cancer treatment can cause a strain on any relationship. Anxiety can interfere with your ability to enjoy an activity and make it hard to share intimacy and affection. This commonly occurs when your need for closeness and intimacy are greater than ever. It is normal to experience these emotions during treatment and it's healthy to talk about them. Anxiety is a treatable condition.

Your doctor, nurse, social worker or chaplain is available to listen to your concerns and give you advice. Many people don't talk to health care professionals about their sexual relationships because they feel embarrassed, ashamed or afraid. Discuss your concerns with a health care provider that you trust and who cares about you. He or she can give you information and advice to help you maintain your sexual and emotional health during and after treatment.

Treatment and Family Expectations

You carry out different roles every day. You may be a friend, a parent, a daughter, a spouse, a lover, a sister, a worker and a breadwinner all at once. Each of these roles makes demands upon your time and energy. Fatigue and stress caused by your treatment may prevent you from taking care of duties that you once took for granted. If you are not able to meet these demands, you may feel guilty and become frustrated. You may not be able to do as much for your family as before, but you still have a lot to offer through your love, caring and friendship.

Because of your illness, your family and loved ones may try to protect you. Even though they mean well, you may feel like they are taking away your independence or your rights as an adult. After treatment, when you start feeling better, your loved ones may have become used to you in the role of a patient. You may need to sit down together and discuss how to switch back from the caretaker and sick person roles into your usual, more balanced roles.

Spiritual Well-Being

A diagnosis of cancer may raise spiritual questions, such as "Why did this happen to me?" and "Is God punishing me for past wrongs?" It is not unusual for people to feel shame or guilt as a result of having cancer. Scientists believe that a variety of factors cause cancer, such as toxic chemicals in the environment, the use of tobacco or heredity. However, the medical community does not yet have all the answers.

Your faith should inspire you and help you understand yourself. You may find it helpful to discuss your concerns with a priest, rabbi, minister or other spiritual advisor you trust.

End-of-Life Issues

In certain instances, when the cancer can no longer be controlled with available therapies or when patients can no longer tolerate treatments, doctors turn their focus to making the patient comfortable. This is called palliative care. The patient receives medications and treatments to control pain and other symptoms, such as constipation, nausea and shortness of breath. Some patients remain at home during this time, while others enter a hospital or other facility, like a hospice. Either way, services are available to help patients and their families with the medical, psychological and spiritual issues surrounding death.

The time at the end of life is different for each person. Each individual has unique needs for information and support. Any questions and concerns about end of life should be discussed with the health care team as they arise.