For those who have ovarian cancer

gynkreftforeningen

Each year, 1700 Norwegian woman are diagnosed with gynaecological cancer. Around 450 of them have cancer of the ovaries, fallopian tubes, and/or peritoneum. The average age at the time of diagnosis is 68.

Today, around 22,000 women in Norway are living with a form of gynaecological cancer or have undergone treatment for this.

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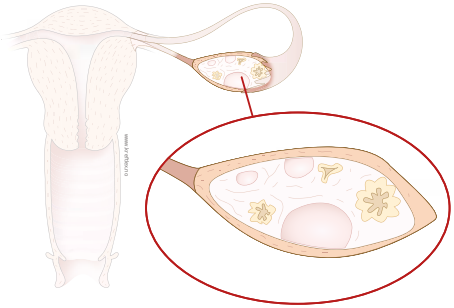
450

women in Norway are diagnosed with ovarian cancer each year

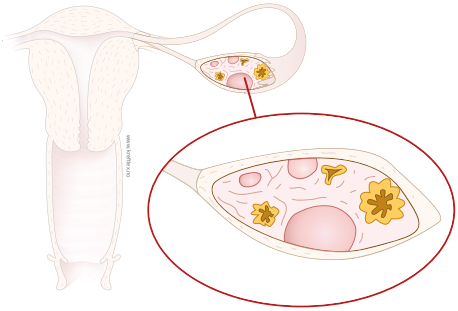
Ovarian cancer is a collective term for a cancer disease originating from ovaries, fallopian tubes or peritoneum. The ovaries and fallopian tubes are located close to one another and close to the peritoneum. Cancer that arises here can therefore easily spread between these organs.

Ovarian cancer is typically detected at a later stage. This is because the symptoms of the disease are diffuse and uncharacteristic. Symptoms will often not appear until the cancer has spread. In about 70 percent of women diagnosed with ovarian cancer, the cancer will have spread before they are diagnosed.



Epithelial ovarian tumours develop from cells in the outer surface of the ovary.

Ovarian cancer starts as a tumour in one or both of the ovaries. This may involve several different types of tumours. There is a distinction between epithelial and non-epithelial ovarian cancer. About 90 percent of all ovarian cancers emanate from the surface (epithelial) layer of the ovary.



Non-epithelial ovarian cancer originates from germ cells or sex cord-stromal tumours (SCSTs).

Symptoms

Symptoms will vary from person to person, and will depend on where the tumour is located and the extent of the cancer in the rest of the body. What is typical for these forms of cancer is that the symptoms appear relatively late.

Symptoms may include:

- ○ Changes in bowel and urination patterns – may occur because the tumour is pressing on the bladder or intestines
- ○ Poor general condition
- ○ Nausea and abdominal pain may occur if the tumour is so large that it presses on the surrounding organs, or if there is fluid retention in the abdominal region
- ○ A feeling of abdominal pressure and bloating, or a growing abdomen, which may be due to fluid retention in the abdomen or the tumour itself
- ○ Weight loss or weight gain
- ○ Fatigue
- ○ Shortness of breath upon activity
- ○ Vaginal bleeding

Causes and prevention

Today, we are aware of several factors that pose a higher risk of developing ovarian cancer.

- Factors that contribute to many ovulations throughout life:
  – Ovarian cancer occurs more often in women who have not given birth.
  – Young age at first menstruation, as well as late menopause.
- Genetic/hereditary causes: Changes in the BRCA genes or Lynch syndrome.
- Endometriosis may present a higher risk of certain types of ovarian cancer.
- Radiation therapy for previous cancer.
- Women who have previously had breast cancer are at a higher risk.

There are also factors that reduce the risk:

Women who have BRCA mutations and who are at risk of developing ovarian cancer will be offered the option of removing their ovaries and fallopian tubes as a preventive measure. Approx. 15 percent of all ovarian cancers are due to a genetic mutation in either the BRCA1 or BRCA2 genes.

Assessment

An assessment and diagnosis is based on several different examinations. Surgery is often necessary to determine the type of cancer the patient has.

Gynaecological examinations

A gynaecological examination with ultrasound both inside the vagina and outside the abdomen.

Blood tests

Blood tests are taken partly to measure cancer markers CA 125 and HE4 in the blood. These are often, but not always elevated with ovarian cancer. Measurement of the cancer marker CEA is sometimes used to rule out metastases from bowel cancer, i.e. To see if the cancer is coming from the bowels. Blood tests are also used to measure markers for more rare cancerous tumours.

CT scans

X-ray examinations with contrast of the lungs, abdomen and pelvis to assess the spread of disease.

Additional examinations

- Tissue samples of tumour tissue may be necessary in some cases. (This can be done with a local anaesthetic or with keyhole surgery that is sometimes used to assess the spread of cancer).
- Draining fluid (ascites) from the abdominal cavity or the lungs (pleural fluid) may be appropriate if this is a symptom upon diagnosis.
- Colonoscopy (bowel examination) is sometimes done to rule out gastrointestinal cancer, or to check for bowel cancer.

Once the diagnosis has been made, you will likely be offered genetic testing with a blood test to determine whether there is a hereditary risk of ovarian cancer. This may have implications for potential targeted therapy. If a genetic mutation is detected that is associated with a higher risk of cancer, you and your family will be offered genetic counselling.

It may also be relevant to do genetic tests on the tumour itself. This may be done if you have a certain type of ovarian cancer and are in an advanced stage of the disease. This would only be done if you do not have a hereditary form of cancer (BRCA mutation). It could indicate whether targeted treatment with a PARP inhibitor might be effective for you. Currently, testing is only done if a BRCA mutation is found in the tumour.

Treatment

Treatment of ovarian cancer is determined by the stage and size of the tumour. The most common forms of treatment are surgery and chemotherapy.

Ovarian and fallopian tube cancer is divided into the following stages:

Stage I: The cancer is limited to the ovaries or fallopian tubes

Stage II: Spreading limited to pelvic or primary peritoneal cancer

Stage III: Cancer has spread to the abdominal cavity or to the lymph nodes in the abdominal cavity, or along the aorta

Stage IV: Cancer has spread to other places in the body (liver, lungs).

Surgery

If the disease is discovered at an early stage, surgery may be sufficient. In young women who want to preserve their ability to have children, the healthy ovary and uterus may be left intact in a few cases. There must be a low risk of recurrence, and the cancer must be limited to one ovary. Usually the ovaries, the uterus, and the omentum (a fold of fat tissue over the surface of the peritoneal organs) are removed. Lymph nodes are also removed in certain cases, both in the pelvis and along the major blood vessels of the abdomen. If there is extensive spreading of the disease, all the cancerous tissue that can be surgically excised will be removed. In some cases, this will mean removing part of the intestine, part of the peritoneum, spleen, or parts of the stomach or liver. It may therefore be necessary to create an opening in the intestines to remove body waste (stoma). Some patients will first undergo surgery and then begin chemotherapy, while others will start with chemotherapy and then have surgery. In cases where a major operation is considered too risky or the tumour is in a location that makes it difficult to remove, the patient will only be given chemotherapy.

Chemotherapy

Chemotherapy is given to nearly all patients after surgery to remove any remaining tumour tissue or to reduce the risk of recurrence. Some patients will be given chemotherapy in addition to a drug that inhibits the formation of new blood vessels to the tumour (Bevacizumab, Avastin®). Sometimes it may be necessary to administer chemotherapy before surgery. The aim of this treatment is to shrink the tumour and make it easier to surgically remove. This type of treatment may be appropriate if you have several other diseases, if your general condition is significantly affected by the cancer disease, or if the tumour has spread to such an extent that it is not possible to remove it initially.

Side effects

Different types of chemotherapy can give different types of side effects, which vary from person to person. Common side effects of chemotherapy include:

- Nausea
- Fatigue
- Hair loss
- Weakened immune system

Radiation therapy

Radiation therapy is rarely used to treat ovarian cancer. It may be appropriate as a palliative treatment to keep the disease at bay and to reduce the symptoms caused by the cancer.

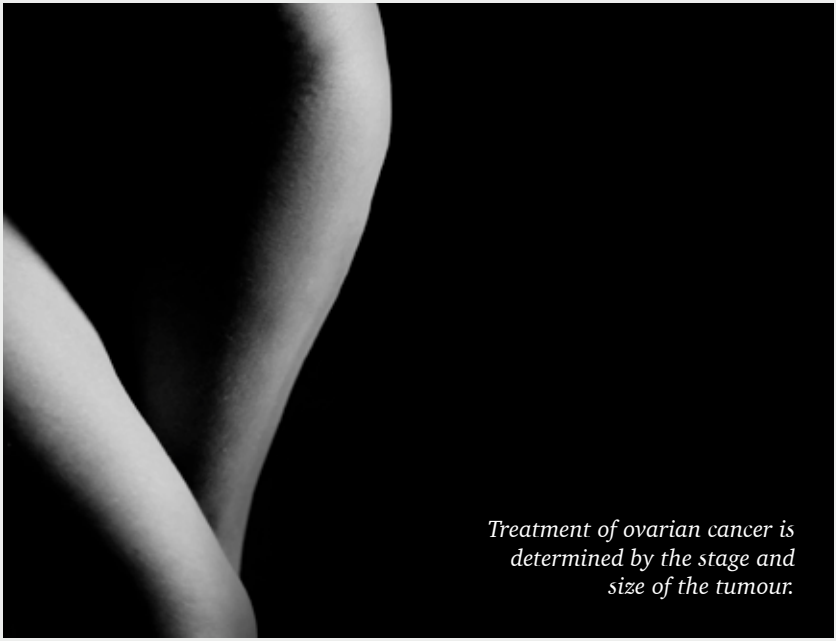
Targeted therapy:

PARP inhibitors are known as a targeted therapy. Thus far, it appears that patients with a BRCA mutation have the greatest benefit from this type of therapy, but it may also be effective for patients without this mutation. PARP is a protein that plays a role in repairing DNA in cells. When the PARP protein is blocked, the cancer cell must use other mechanisms to repair DNA changes or mutations. If there is a BRCA mutation (or a genetic disorder with similar effect), the cancer cells will be unable to repair the damage using other mechanisms, which means that the cancer cells will die. This is the aim of the therapy. PARP inhibitors will likely be most effective if the patient has benefited from chemotherapy with platinum compounds such as carboplatin®.

The Norwegian Decision Forum decided in May 2020 to introduce two PARP inhibitors for treatment of ovarian cancer:

- Niraparib (Zejula) has been introduced for maintenance treatment of patients with a recurrence of BRCA-negative, platinum-sensitive, high-grade serous ovarian, fallopian, or primary peritoneal carcinoma, with complete or partial response to platinum-based chemotherapy.
- Olaparib (Lynparza) is used as monotherapy for maintenance treatment of patients with a recurrence of platinum-sensitive, high-grade serous ovarian carcinoma (BRCA-negative).

Bevacizumab, (Avastin®), is a drug that inhibits the growth of blood vessels to the tumour (VEGF-inhibitors). This is used, among other things, to treat certain patients with ovarian cancer. Treatment is repeated every two to three weeks. Avastin is often given in combination with chemotherapy, and administered directly into the bloodstream (intravenously), through a needle in the vein of the patient's arm. Usually, this medication will be administered if you are receiving



Treatment of ovarian cancer is determined by the stage and size of the tumour.

neoadjuvant chemotherapy, or if it was not possible to surgically remove all visible tumour tissue. Bevacizumab is also used in certain cases of recurrent ovarian cancer.

Treatment of recurrence

Should the cancer later return, it is often treated with chemotherapy. It will also be determined whether the tumour is operable, but only a few patients will benefit from this. This is decided by the doctors who are treating you. Chemotherapy will be administered again after surgery.

In patients that have no BRCA gene mutation, but who have had a positive effect of chemotherapy (carboplatin®) will be offered maintenance treatment with a PARP inhibitor after chemotherapy for potential recurrence. This treatment is meant to delay the recurrence of the cancer.

Check-ups

Follow-up after completion of treatment must be adapted to the individual, depending on the risk of recurrence, age and general condition. It is the doctor who is responsible for treatment at the hospital and who will outline a plan for follow-up and check-ups afterwards.

Follow-up visits for patients treated for ovarian cancer are generally scheduled as follows:

- First year: check-up every 3 months
- From the 2nd through the 4th year: about every 6 months
- After 5 years: yearly check-ups

At each check-up, the doctor will usually perform a thorough examination and ask you how you are doing. A gynaecological examination with ultrasound will also be conducted. Blood tests to measure cancer markers are usually included. If, after your cancer treatment, you experience any symptoms between check-ups that could indicate a relapse, you must contact your doctor.

Late effects

Both the body's cells and organ functions may be affected by cancer treatment. Side effects and late effects will vary from person to person, depending on the type of treatment, your age and general condition, and on any other illnesses you may have.

Early menopause

Surgery that involves the removal of the ovaries will trigger menopause in women who have not yet reached menopause. Removal of the ovaries also results in infertility. This is a process that normally occurs over a long period, where the woman gradually loses hormones produced in the ovaries.

- A lower oestrogen level means less moisture in the mucous membranes, which may make sexual intercourse painful or uncomfortable.
- It is common to experience hot flashes, dry and sore mucous membranes in the vagina, and mood swings. You may also experience fatigue, sadness, depression, poor appetite and hair loss.
- If your body is no longer producing testosterone, this may affect your sex drive. Many will notice reduced libido and less interest in sexual activity. You may experience fewer sexual dreams and lack of interest in sex, but will still feel the need for intimacy.

Studies show that women who have had their ovaries removed can continue to enjoy a sex life similar to other women in the same age group. It is important to find the right hormone treatment adapted to the individual. Counselling and therapy, preferably with a partner, can also be helpful.

Nerve damage (polyneuropathy)

Chemotherapy may in some cases cause minor damage to the nerves, especially in the fingers and feet. These symptoms may appear gradually during treatment, but will often go away once treatment is concluded. Sometimes these symptoms persist or become chronic. Such nerve damage is often described as numbness in the fingers and under the feet, or a stinging, burning sensation.

Lymphoedema

Lymphoedema is a swelling in one or both legs, as the lymphatic system is unable to properly drain fluid from the body. Some patients will experience this after surgery. This is especially true for patients who have had lymph nodes in the pelvic region removed during surgery. Your doctor can refer you to a physiotherapist with expertise in the treatment of lymphoedema.

Fatigue

Fatigue is a frequent side effect of radiation therapy or chemotherapy. Around 10 to 35 percent of cancer patients experience fatigue. This is a feeling of exhaustion that does not improve with sleep or rest. There is no quick and effective cure for this. Many patients find that fatigue gradually subsides after a shorter or longer period.

Fatigue that lasts more than six months after the end of treatment, when there are no longer signs of active disease, is called chronic fatigue. Those who experience fatigue may also feel depressed, have trouble concentrating, have trouble with short-term memory, and will generally have little energy.

Fatigue that arises within a limited period of time and subsides when treatment is finished is called acute fatigue.

Rehabilitation

Municipal health services are responsible for providing rehabilitation where you live. Most municipalities offer multidisciplinary services, with an occupational therapist, physiotherapist, nurse and social worker. Should you need assistive devices or adaptations to your home, the municipality can help you with this.
Although municipalities and health trusts are still developing local and regional rehabilitation services, many patients have found it helpful to participate in a rehabilitation programme with other cancer patients over a period of several weeks. Such programmes provide a good atmosphere and group dynamics.

By participating in a rehabilitation programme after cancer treatment, you can meet others who are in a similar situation. These programmes also offer better insight and tools to help you adjust to your "new life". Most patients find that life is not quite the same as before. Rehabilitation programmes are also for patients who had cancer many years ago, and who are still struggling with the long-term effects of treatment.
At www.helsenorge.no, you can find more information about rehabilitation services and how to apply. Search for "rehabilitering kreft" ("rehabilitation cancer") and your region or health trust.

Many municipalities have local cancer coordinators who have an overview of the services and opportunities in your local area. Here you can find an overview of municipal cancer coordinators:

www.kreftforeningen.no/tilbud/kreftkoordinator-i-kommunen/

See our website for an overview of rehabilitation services
www.gynkreftforeningen.no/2022/01/rehabiliteringstilbud/

Patient care pathway

A standard patient care pathway describes how assessment, treatment, communication and dialogue with the patient and family members, distribution of responsibilities, and specific trajectory schedules are all organised. The purpose of a patient care pathway is to ensure that cancer patients receive a well-organised, comprehensive and predictable trajectory without unnecessary delays in assessment, diagnostics, treatment and rehabilitation. Among other things, a patient care pathway for ovarian cancer ensures that all hospitals treating this specific type of cancer will have regular decision-making meetings with a multidisciplinary team (MDT) to ensure quality assurance of assessments and treatments. The multidisciplinary team who assess and treat ovarian cancer consists of gynaecologists with specialist training in gynaecological oncology, a coordinator, radiologist, a dedicated gastrosurgeon, and possibly a pathologist.

Learn more about patient care pathways for diagnostics, treatment and follow-up of ovarian cancer. See:

https://www.helsedirektoratet.no/pakkeforlop/eggstokkreft

CURRENT RESEARCH

There are always research studies being conducted in this field. In recent years, most clinical trials have been aimed at the identification of new patient groups that may benefit from PARP inhibitors and Bevacizumab (Avastin®). Studies in recent years have also looked at the length of drug therapies. This is important both for avoiding overtreatment and undertreatment. Various combinations have also been tested. Based on such studies, combination therapy with bevacizumab and PARP inhibitor was approved in November 2021 for some primary care patients. Several studies have also attempted to identify patients who may benefit from immunotherapy, and several of these studies are still ongoing. Unfortunately, the results have so far been disappointing. Cancer vaccine studies have also been initiated. Quality of life studies are important contributions to improving routines for the follow-up and treatment of cancer patients who have completed treatment or who are experiencing recurrence. Current clinical trials in Norway are listed on the hospital's websites.

CLINICAL TRIALS AND APPROVAL

Clinical trials

Clinical trials must always be conducted before a new drug or treatment method can be approved for use. In these trials, drugs are tested on patients with the disease in question. Participation in a clinical trial is not a right, and it is always voluntary. Participants in clinical trials are given the opportunity to test new medicines, which will contribute to better knowledge and research progress. Generally, the physician responsible for the patient's treatment will have an overview of relevant clinical trials, and can therefore request that the patient be considered for participation in the trial at the hospital conducting the study.

Occasionally, a patient will come across a clinical trial. Patients can also contact the physician in charge of the study directly. Patients participating in a clinical trial must always fit the criteria set by the researchers for the study, such as the appropriate age, diagnosis and prior treatment.

An updated overview of current clinical trials in Norway can be found at helsenorge.no, or on the websites of various university hospitals.

You can also check the website of the Norwegian National Centre of Competence for Gynaecological Oncology:

www.oslo-universitetssykehus.no/fag-og-forskning/nasjonale-og-regionale- tjenester/nasjonal-kompetansetjeneste-for-gynekologisk-onkologi

Impress-Norway

IMPRESS-Norway is a large Norwegian study open to all patients with advanced cancer who have undergone standard treatment and have no remaining treatment options. IMPRESS was initiated in early 2021. Its aim is to offer extended molecular diagnostics and potential targeted treatment for several Norwegian cancer patients. This is done by taking drugs that are already approved for certain cancer diagnoses and applying these to other types of cancer, based on genetic changes in the cancer cells (molecular profile). Patients who are referred to these clinical trials undergo a screening process, where their cancer cells are examined for more than 500 genes to determine molecular or genetic alterations. If genetic alterations are identified that might have a consequence for treatment recommendations, this is discussed at a national meeting for the research group, held weekly. If the patient is eligible for another ongoing clinical trial in Norway, they will be referred to this study. If a molecular profile is identified that is suitable for a drug through the IMPRESS study, the patient may be assessed for inclusion in an IMPRESS clinical trial. A separate treatment arm will then be created for this specific combination of diagnosis, genetic alteration and drug therapy.

Expert Panel

In 2018, the Norwegian regional health authorities established an Expert Panel scheme. The aim of the Expert Panel scheme is to provide patients who have a life-shortening disease with a new and thorough assessment of treatment options, after established treatment has been attempted and is no longer effective. One important aspect of the Expert Panel is to help patients and their family members feel secure in knowing that all relevant treatment has been considered. The physician in charge of the patient's treatment can request a new assessment by the Expert Panel.

The Expert Panel will assess and advise on the following:

1. Assess whether adequate established treatment has been provided, or if further established treatment is appropriate, either in Norway or abroad.
2. Assess and advise on whether there are relevant clinical trials or experimental treatment in Norway or abroad, preferably in the Nordic region. Experimental treatment must be within approved protocols with criteria for participation and documented effect.
3. Assess and possibly advise on off-label treatment with drugs that have a documented effect. Off-label refers to marketed drugs that are used to treat diseases for which the drugs have not been approved.
4. Assess and possibly advise on undocumented treatment that the patient has obtained information about and wishes to have assessed.

Approval of new medicines

In Europe, a medicine is first approved by the European Medicines Agency (EMA), which grants European marketing authorisation for the medicine. The medicine must then be granted Norwegian marketing authorisation (MT) by the Norwegian Medicines Agency (SLV). In order for an approved drug to receive public funding as a "blue prescription", or for use in hospitals, it must be value assessed. This process can take time, and it is not always easy to gain a good overview of the process. Medicines that are to be financed by hospitals must be sent for assessment by the Norwegian Decision Forum for new health technologies with specialist health services in Norway. This is governed by the four regional health authorities. This Decision Forum is comprised of the directors of the four regional health authorities. It is these four individuals who decide which methods specialist health services can or cannot use. Once the Decision Forum has approved a drug, it can be used by the hospitals. This process takes time. Figures from 2018 show that it takes an average of 333 days from the time a drug has been granted marketing authorisation in Norway until it can be introduced for use. The National System for Managed Introduction of New Health Technologies is currently under evaluation, partly due to criticism of its use of time.

Vibeke is living with ovarian cancer

Vibeke Øvrebø (age 60) from Askøy outside Bergen was diagnosed with ovarian cancer in 2016. After surgery, many tough rounds of chemotherapy and treatment with Avastin, she is now on immunotherapy – which has given promising results.

For a long time, Vibeke saw a gynaecologist once a year. The year before her diagnosis, she had decided to go every two years.

“This is something I try not to dwell on, but if I had continued with my yearly examinations, the cancer would have been discovered in the spring of 2016.”

Vague symptoms

“I started to feel that something was wrong in the summer of 2016. It was as though I was ovulating, and the discomfort came and went. I contacted my gynaecologist, but he was about to go on holiday. He asked me if it was urgent, but I thought it could probably wait until he returned a month later.”

During the summer, she had the feeling her ovaries were growing. She could almost feel them on the outside of her abdomen, but she thought perhaps they were cysts. And she didn’t feel as fit as she usually did.

“I've always cycled a lot and have been in good physical condition. That summer, my physical condition was significantly worse. I thought it was because I hadn't cycled enough, and that I needed more fitness training to get in shape for cycling. I was also very tired and had less energy near the end of the holiday, but I didn't give it much thought.”

Vibeke has always enjoyed cycling and has been in good physical condition, but in the summer of 2016, she noticed that something was not right.

When Vibeke saw the gynaecologist after the summer, he clearly did not believe these were harmless cysts. The results of the blood tests the gynaecologist had taken came back the day after the examination, and they confirmed the suspicions. The cancer markers were elevated and Vibeke was sent right in for a patient care pathway for cancer.

Lengthy assessment

"I had never thought of myself in relation to cancer. Getting the news was a numbing experience. Suddenly I found myself in a life crisis. I was anxious, frightened and very distraught. My future became very uncertain – did I even have a future?"

Vibeke was further assessed at the Women's Clinic at Haukeland Hospital. The assessment took time due to uncertainty as to where the cancer had originated. Eventually, she received disheartening results. She was diagnosed with stage IV ovarian cancer. In her case, this meant spreading to the spleen, liver, lymph nodes and both lungs.

"When I was told that it was ovarian cancer, it was almost a relief, oddly enough. Now I knew who my enemy was. At the same time, it was unbelievably difficult to process the severity of it all."

Starting treatment

Vibeke was started on the standard treatment for ovarian cancer with chemotherapy. The aim was to shrink the tumours in order to surgically remove them. From September to November, she was given rounds of chemotherapy.

"The surgeons removed my ovaries, uterus, peritoneum and spleen. Afterwards, they were optimistic. The abdomen was "clean" with no sign of metastases to the intestines. This gave me more hope that it would go well."

Three weeks after surgery, there were new rounds of chemotherapy until February 2017. By the end of the chemotherapy, Vibeke was also given two doses of Avastin. However, her white blood cell count was too low. This meant that she had to stop taking Avastin.

On and off treatment

The next six months went fairly well, but a new check-up in late summer showed that the metastases had grown. She was put on a new round of chemotherapy – a different type than the last one. However, her white blood cell count fell again, and the doctors discontinued her treatment.

"It was stressful to know that I couldn't have chemotherapy due to my low blood count."

After a break, she was put on a new round of chemotherapy in combination with Avastin.

She continued with chemotherapy until March 2018, and continued with Avastin until December 2018.

"2018 was a good year. The hospital did the main work and my job was to make sure I got physical activity, the right diet

and reduced my stress. I went out for walks, short or long, regardless of how I was feeling."

Went private for immunotherapy

A new CT scan in January 2019 showed that metastases in the lungs, liver and lymph nodes had started growing again. Vibeke was started on chemotherapy again, this time a different type. Unfortunately she did not tolerate it well and had an allergic reaction. She was taken off the chemotherapy and went without treatment until May, when she was put on a type of chemo she had been on before. The chemotherapy was discontinued in October the same year, and she continued again without treatment.

"By autumn, my partner and I talked to the senior consultant of the Women's Clinic and asked about other treatment options for my disease. Some samples were taken from the primary tumour that showed I was PDL1 positive, which meant that I might benefit from immunotherapy. However, this was not a treatment the hospital could offer."

Vibeke contacted Aleris and paid for the immunotherapy herself.

After ten months and more than 1 million NOK, a new CT scan showed that she had responded so well that she applied for funds from the Expert

"I've learned that you have to learn to live with cancer, and I am doing what I can to give cancer as little space as possible in my daily life, and I try to focus on what works."

Panel, with assistance from Haukeland Hospital.

Fortunately, the Expert Panel concluded that my response to immunotherapy was so good that it would continue to be the best treatment for me. The Hospital Director at Haukeland Hospital supported the Expert Panel's conclusion, and since autumn 2020, I have been receiving immunotherapy with public funding, where the Women's Clinic is responsible for treatment."

Due to immunotherapy, Vibeke no longer has metastases in her liver, and there is only a small tumour left in one lung, as well as a few smaller tumours in the lymph nodes.

"I've been on immunotherapy for two years and have been told that I can continue with it as long as I am responding well and don't have any major side effects. Given that the aim of treatment at the start of the immunotherapy was stability, what has happened so far is fantastic."

Little room for cancer in daily life

Support from her partner, children, family and close friends through all of the ups and downs, and tough rounds of treatment has been crucial. Physical activity has also meant a great deal to Vibeke.

"Now I do weight training and aerobic exercise, and I often go for walks, and I do cycling and skiing. A good diet is also important to me. I'm far from a fanatic, but it's good to know that I can do little things that help me feel a bit better."

Vibeke works as a manager in the field of mental health and substance abuse in Bergen municipality. Her background and education has been useful during her cancer treatment.

"I am quite strong mentally, and I've been able to use the knowledge I have about mental health on myself. Throughout this ordeal, the biggest challenge has been to mentally tackle the strain. I've learned that you have to learn to live with cancer, and I am doing what I can to give cancer as little space as possible in my daily life, and I try to focus on what works. Now I've come to the point where I can start planning my future, and this helps me to normalise my daily life. Although my life has changed, the life I'm now living has many good qualities."

The content of this brochure was quality assured by gynaecologist Cecilie Fredvik Torkildsen, senior consultant at the Women's Clinic of Stavanger University Hospital (SUS) and a fellow at the University of Bergen (UiB).

Peer support services

Through our peer support services, those who have or have had cancer, and their family members, have the chance to talk to someone in the same life situation. The principle of peer support is that people who have been ill themselves can share their experiences with others, yet at the same time be a person who understands and provides support outside the healthcare system. We have certified peer support persons all over the country. Most are patients themselves, but some are also family members. All of our peer support persons have a duty of confidentiality.

You can contact our peer support persons directly. See the overview of all peer support persons on our website:

gynkreftforeningen.no/likepersonstjenesten

Sources:
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www.kreftlex.no/Gyn-eggstokk-og-eggleder kreft

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About the Norwegian Gynaecological Cancer Society

The Norwegian Gynaecological Cancer Society is a patient association for women who have or have had gynaecological cancer, women who have been treated for gynaecological precancerous conditions, and women who have been diagnosed with a genetic risk of gynaecological cancer, and their family members. The Norwegian Gynaecological Cancer Society has over IOOO members. We have local chapters and peer support persons all over the country, and our association is run by volunteers – women who have or have had gynaecological cancer. Our main focus is the patient and generating knowledge about what should be improved in healthcare services with regard to treatment, rehabilitation and follow-up.

Join our community – become a member of the Norwegian Gynaecological Cancer Society:
gynkreftforeningen.no

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