For those who have uterine cancer

gynkreftforeningen

Each year, 1700 Norwegian women are diagnosed with a form of gynaecological cancer, and around 800 of them have cervical cancer. Most patients who are affected are over age 60.

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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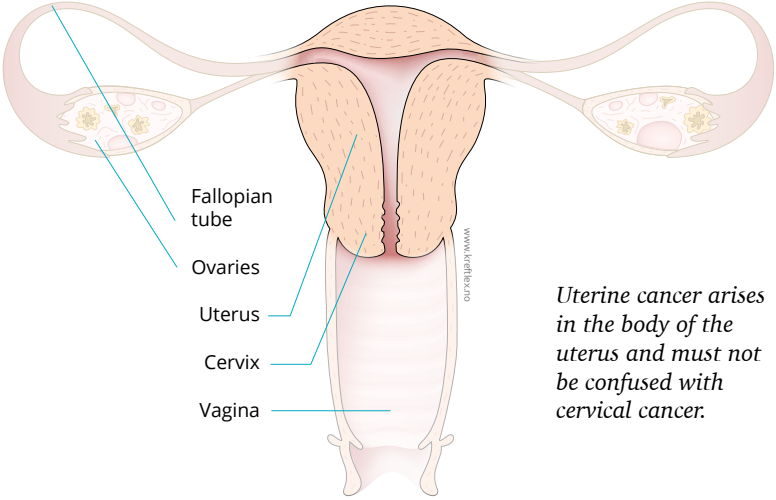
800
women in Norway are diagnosed with uterine cancer each year

Uterine cancer originates in the inner lining of the uterine cavity. Uterine cancer is usually detected at an early stage and successfully treated. However, it is crucial that the symptoms are taken seriously and that the doctor performs a thorough examination. Although uterine cancer usually occurs in women who have reached menopause, it may also occur in women who are still menstruating. Uterine cancer in younger women is often linked to a hereditary predisposition. If there are other cases of cancer in the immediate family, it may be wise to be especially observant, especially if these cases arose in relatively young adults.

Treatment of uterine cancer is largely centralised at centres for gynaecological oncology at the four regional hospitals. The structure may vary between health authorities.



Uterine cancer arises in the body of the uterus and must not be confused with cervical cancer.

Symptoms

Symptoms may vary, but typically involve unexpected bleeding with or without pain. It is therefore often possible to identify the disease at an early stage.

Symptoms may include:

- ○ Uterine bleeding through the vagina after menopause
- ○ Pus-like or coloured, watery discharge
- ○ Bleeding between menstrual periods or especially heavy bleeding in younger women who have not reached menopause

Pain in the lower abdomen without bleeding is less common, but that does not rule out uterine cancer. Bleeding or discoloured discharge in women after menopause must always be examined and assessed for cancer. Always contact a doctor if this occurs, even if it is only a brief episode of bleeding. Abnormal bleeding between menstrual periods or discoloured discharge in younger women should never be shrugged off.

Causes and prevention

Uterine cancer has become the most rapidly increasing form of gynaecological cancer. Although cancer is often a case of "bad luck", research shows that certain factors may increase the risk of uterine cancer.

- Late menopause
- Few or no childbirths
- Long-term use of the female sex hormone oestrogen without the simultaneous use of progesterone may increase the risk. Modern hormone therapy for menopausal symptoms therefore has a combination of oestrogen and progesterone to protect against cancer in the endometrium.
- Previous radiation therapy to the pelvic region.
- If several people in your family have had cancer, especially at a young age, you may have a higher risk of familial predisposition to cancer of the uterus and other organs, such as the ovaries, breasts or colon.

Birth control pills that contain oestrogen and progestin may reduce the risk of developing uterine cancer. The same applies to hormonal IUDs that contain progestin. Should you need hormone supplements in connection with menopause, you should always take both oestrogen and progestin. You can take pure oestrogen in combination with a progestin IUD.

One simple piece of advice:

Maintain a lifestyle that does not lead to high blood pressure or obesity. Obesity causes the fat tissue to produce and release oestrogen-like hormones. Such hormone disruptions may increase the risk of cancer or precancerous conditions that result in endometrial carcinoma.

Hereditary factors

Hereditary factors may pose a higher risk of developing uterine cancer. In families with hereditary cancer diseases, the disease often arises at a relatively young age, where several family members – often across generations, develop cancer. The type of cancer may not always be the same.

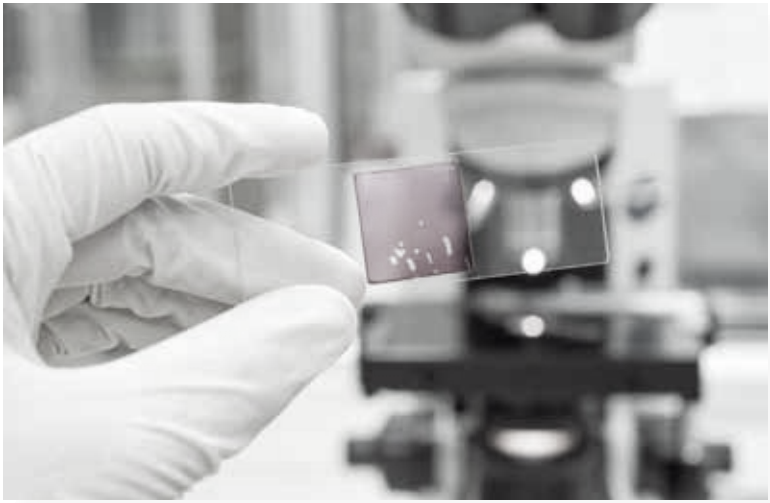
Assessment

If you are experiencing symptoms, you should contact your doctor for a referral to a gynaecologist.

In addition to a routine gynaecological examination, the gynaecologist can also perform an ultrasound to study the thickness of your endometrium. If uterine cancer is suspected, the gynaecologist will take a tissue sample from the uterine lining. This examination can be done without anaesthesia in the doctor's office. If it is not possible to take a tissue sample, a gynaecological examination under mild general anaesthesia can be done to make the diagnosis. The samples will then be sent for a microscopic examination to make a diagnosis.

Other examinations: A pelvic MRI to determine the spread of the cancer in the uterus and pelvis may be appropriate. A CT scan of the abdomen, pelvis and lungs are done to look for metastases.

This makes it possible to assess the risk group prior to surgery and adapt the treatment based on this.



Treatment

Treatment of uterine cancer depends on the extent of the disease and the type of cancer cells. In most cases, the uterus is surgically removed. Around 75 percent of patients are diagnosed at an early stage and can fully recover after the uterus is removed during surgery.

Uterine cancer is divided into the following stages:

Stage I: The tumour is only present in the uterine cavity

Stage II: The tumour has spread into the cervix

Stage III: The tumour has infiltrated the uterine wall to the surrounding tissue, to the ovaries, vagina, or to the lymph nods of the pelvis or back of the abdominal wall.

Stage IV: The tumour has infiltrated the bladder, into the rectum, or has spread to other parts of the body

Surgery

If the cancer is at an early stage (Stage I), it may be sufficient to perform surgery to remove the entire uterus (hysterectomy), usually keyhole surgery, possibly robot-assisted. If the cancer belongs to a subgroup with an increased risk of metastasis or recurrence, the lymph nodes will also be removed. Lymph nodes will also be removed if the tumour has spread into the cervix (Stage II). The ovaries are generally removed at the same time for two reasons: Oestrogen, the female sex hormone that is produced in the ovaries can have a stimulating effect on uterine cancer. In addition, around 5 percent of all cases will have metastases to the ovaries, and sometime this is not immediately visible. In a few cases of high-risk uterine cancer, the omentum (a fold of fat tissue over the surface of the peritoneal organs) will also be removed.

In recent years, a new method of removing lymph nodes has been developed. This is known as a sentinel lymph node dissection and is used when the lymph nodes appear normal prior to surgery. With this technique, surgeons can safely settle for removing a few lymph nodes, thus significantly reducing the risk of lymphoedema.

After surgery, the uterus and other removed structures will be examined under a microscope. If the results show that the person belongs to a low-risk group, no further treatment will usually be offered. Those in a high-risk group will be offered subsequent (adjuvant therapy) chemotherapy.

During surgery for cancer at stages III–IV, all visible tumour tissue is removed. If this is considered unrealistic, the patient will be offered chemotherapy (neoadjuvant therapy) with subsequent surgery or radiation therapy.

Chemotherapy and radiation therapy

For advanced stage cancer that has spread outside the uterus, where surgery is no longer a suitable treatment, chemotherapy will be offered, possibly in combination with radiation therapy.

The type of cancer cells, how deep the tumour has infiltrated the uterine wall, and the extent of the cancer (i.e. which risk group it belongs to) will determine whether additional treatment is necessary.

Side effects

Different types of chemotherapy can give different types of side effects, which vary from person to person. Preventive medicine can alleviate most of the side effects, apart from hair loss.

Common side effects of chemotherapy include:

- Moderate nausea
- Fatigue and pain
- Hair loss
- Weakened immune system

Treatment of recurrence or metastases

Radiation therapy is preferred for recurrence that is limited to the pelvis. Recurrence outside the pelvis will usually be treated with chemotherapy or hormone therapy. Since the disease may be oestrogen-dependent, another female sex hormone, progesterone, may be administered instead. This will often have an inhibitory effect on 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 uterine cancer are generally scheduled as follows:

- First two years: check-up every 3 months
- From the 2nd through the 5th year: about every 6 months

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. A blood test to measure cancer markers may be useful in some cases. If, after your cancer treatment, you experience any symptoms between check-ups that could indicate a relapse, you must contact your doctor.

During check-ups, a blood test will often be taken to measure cancer markers.

Late effects

The entire body and its 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. Following treatment for uterine cancer, it is common to experience early menopause, vaginal dryness, reduced sexual desire, and fatigue.

Early menopause

In women who have not reached menopause, surgery that involves the removal of the ovaries will trigger menopause and result in infertility. This is a process that normally takes place over a long period, where the woman gradually loses hormones produced in the ovaries.

- Less oestrogen results in 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.
- The ovaries normally produce some testosterone.
- If your body is no longer producing testosterone, this may affect your sex drive. Many will notice reduced libido and less interest in being sexually active. 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 get the right hormonal treatment, adapted to your individual needs. Regardless of your complications, It is not uncommon to need time to regain the energy for, and interest in sex. This is for physical, hormonal and/or psychological reasons, and may be due to the stress and strain you have been through, and because you may be exhausted. Take your time, be patient with yourself and your partner, and be open about the problems. Begin this slow process at an early stage. Talk to your doctor, sexologist, or counsellor to learn more about the medical aids and devices you can use, such as lubricants and a vibrator.

Radiation-induced injuries

Radiation therapy is offered to only a few uterine cancer patients. Most patients will make a full recovery after surgery, possibly with chemotherapy. Radiation-induced injuries are therefore rarely a problem for the group as a whole. Brachytherapy may be an effective treatment if the cancer returns at the top of the vagina (vault), although this may result in radiation-induced injuries to the pelvis. Gynaecological radiation therapy may result in dry, sore and irritated mucous membranes in the genital area. This can cause bleeding, increased discharge, foul-smelling discharge, swelling, infection and pain. Radiation therapy may made the vagina less elastic and cause the walls of the vagina to stick together if you do not use a dilator or have sexual intercourse. The vagina may also be shortened.

Lack of sexual drive and interest in sex due to these problems is common.

To prevent the walls of the vagina from sticking together after radiotherapy, you should use a vaginal dilator kit if you do not resume sexual intercourse the first few months.

The purchase of sexual assistive devices for this purpose is covered by NAV. NAV has a separate form for this, and all doctors with Norwegian authorisation can order or prescribe a dilator kit and other assistive devices from authorised suppliers who have an agreement with NAV. Dry vaginal mucous membranes may be remedied by hormone tablets, vagitories, or special lubricants.

Talk to your doctor, a sexologist, or a counsellor to learn more about the medical aids and devices you can use.

After radiation therapy, your body will need time to heal from the wounds to the healthy tissue. The effect of radiation will continue for several weeks after treatment, and it will therefore take time for the side effects to subside.

Radiation-induced injuries to the bladder

The bladder and urinary tract are located close to the radiation field. Radiation therapy may irritate the mucous membranes of the bladder, causing problems that resemble cystitis, with frequent urination, burning, pain and bleeding. Usually, these problems will gradually improve. However, the bladder may become more stiff and less elastic, which may lead to a frequent urge to urinate, burning, pain, and the feeling that you cannot empty your bladder.

Radiation-induced injuries to the gastrointestinal tract

Some women may experience gastrointestinal problems, often in the form of diarrhoea, gas pain or food intolerance. Around 15 percent experience persistent diarrhoea, either mild or severe, and intestinal bleeding may occur. There is ongoing research on methods of improving radiation therapy to reduce radiation to healthy tissue. This would ensure a higher targeted dose to the tumour while reducing side effects. A clinical dietician can provide good advice.

Fingers and feet are especially vulnerable to nerve damage after chemotherapy.

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 subside 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 this 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 uterine 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 cervical cancer consists of gynaecological oncologists, a care pathway coordinator and radiologist. If necessary, doctors will consult an oncologist with specialist training in radiotherapy, and possibly a gastrosurgeon.

Learn more about patient care pathways for diagnostics, treatment and follow-up of uterine cancer.
See www.helsedirektoratet.no/pakkeforlop/ Uterine cancer

CURRENT RESEARCH

Currently, research is focusing on more precise molecular diagnostics of cancerous tumours. This will enable doctors to tailor the treatment to a larger extent, to avoid both overtreatment and undertreatment. Today, we see that some patients are overtreated and thus suffer unnecessary and long-lasting late effects such as fatigue and neuropathy. On the other hand, we do not want to end up in a situation where patients who need more comprehensive treatment to prevent recurrence and ensure survival do not receive it. Researchers want to find molecular markers that can categorise the risk profile of the tumours to the extent this is possible.

In the treatment of uterine cancer, there is special focus on the group with metastases at the time of diagnosis, and on the group with recurrences. In recent years, several new drugs for cancer treatment have come on the market. The most well-known are immunomodulatory drugs, and several studies show that uterine cancer with unstable DNA responds favourably to immunotherapy. There are also promising results of drugs that inhibit signalling pathways within the cells – called protein kinase inhibitors. We expect that these drugs will be approved in Norway in the near future. As always, new treatments must be assessed against harmful side effects, and so far these appear to be acceptable.

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 is 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. It's 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 would 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 from the time a drug has been granted marketing authorisation in Norway, it takes an average of 333 days 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.

Late effects have forced Jorun to slow down

In the summer of 2018, Jorun Nilsen Stallemo (age 60) was diagnosed with uterine cancer. Although she is thankful that now, three years later, there is no sign of recurrence, her cancer diagnosis and the treatment she underwent has had a strong impact on her life.

In the spring of 2018, Jorun noticed some spotting, which she found puzzling, because at her last gynaecological check-up in January, everything had been fine. “It's probably a urinary tract infection,” said her GP. But antibiotics had no effect. Her GP referred her to a urologist who found nothing, but who felt that this should be examined further and sent her back to the gynaecologist. There a few samples were taken for tests and Jorun was told that the results would be ready within six weeks. Fortunately, the urologist had been vigilant and requested that Jorun be quickly admitted to the hospital in Kristiansand. Jorun's samples were therefore examined much sooner, and in June, she was informed of the cancer diagnosis.

Long summer

“I got the phone call when I was at work. Luckily I was with a colleague who took care of me, because I couldn't quite understand that it was me they were talking about. I had considered that it might be cancer, but I tried to push the thought away.

Late effects of cancer treatment has had an impact on Jorun’s daily life. “I’m not quite the person I was before I became ill. I've always been a high-energy person, and I’m not like that any longer.

Jorun had a tumour in her uterus. An MRI showed that it was more than 50 mm in size and was leaning against the uterine wall. This meant that she had to go to Radiumhospitalet for surgery. If the tumour had been less than 50 mm, she could have had surgery in Kristiansand. The doctors believed that surgery would be enough and that she wouldn't need chemotherapy.

“It took six weeks from the time I was diagnosed until my operation. They were the longest six weeks of my life. I phoned Radiumhospitalet often to check when it was time for the surgery, in addition to checking alternative hospitals. But it was summer and there were fewer staff members. It felt as if I was being punished for getting sick during the summer.”

Change of plans

Finally it was Jorun's turn. During the operation, surgeons removed her uterus and ovaries, in addition to nine lymph nodes.
“This was major surgery and it took time to recover. My menopause was already well underway by the time of my surgery, but afterwards, it was as if it started all over again. Among other things, I had colossal hot flashes.”

After her surgery, Jorun was told she would be starting chemotherapy, and she began her first round. Shortly after, she was told that an analysis of the tumour indicated traces of neuroendocrine cells, which is a rare form of cancer that arises in hormone-producing cells of the body. Jorun was put on another type of chemotherapy that was much stronger than the first, and that was tailored specifically to her tumour.

“I was given three rounds a week, which in itself was really tough. I also had to cope with an entirely new scenario. No only did I have to have chemotherapy after surgery, but it was a much stronger treatment. I was very frightened. Was I ever going to get well?”

Jorun received chemotherapy three days a week, every three weeks for three months.

“I felt sick, nauseous and completely exhausted. Losing my hair was also stressful. When I was finished, I was totally exhausted. I don't think I've ever felt that tired and worn out. At the same time, it was a relief to know that the tumour was gone and that my body had tolerated the chemotherapy well, so I could complete the rounds of treatment as planned.”

After the chemotherapy, Jorun has been followed up with check-ups every three months.

No energy left

“When my treatment was completed, I felt I had been left to cope on my own. During the time that followed, I felt a lot of worry and fear of a recurrence. Fortunately, all the check-ups so far have been fine.”

Jorun has noticed late effects of the chemotherapy she has undergone.

Before she became ill, Jorun was on the city council for Mandal municipality, in addition to a full-time job as union representative with the Norwegian Postal Service. Today, she is back to work full time, which has been important to her. It gives her more energy in her daily life. Her political career, however, has been shelved.

“I’m not quite the person I was before I became ill. I've always been a high-energy person, and I’m not like that any longer. I’m not able to concentrate as well, I quickly become stressed, I am more sensitive to noise, especially loud noises, and I have aches and pains. I therefore have to sort out what I want to spend time on in my life. The psychological stress of the cancer diagnosis and treatment is not something to scoff at. Even when you're healthy and thankful for that, you live with this constant fear of cancer and thoughts about what will happen if you become ill again. That is something I deal with every day.”

Exercise and family are important

Jorun is married and has four children and seven grandchildren. Family plays a huge role in her life, and family members have been important throughout her illness.

“When I got cancer, it was a huge strain on all of my loved ones. But we stood together, supported each other, and dealt with good times and bad times. It's been good.”

In addition to singing and music, which are two of Jorun's favourite hobbies, exercise is something that gives her energy.

“Exercise is one of the best things I can do for myself. I push myself to get out into nature and often go for walk. That is the best medicine for me. Even when you're tired, I believe that going for a walk, either short or long, has a positive effect on both your energy level and mental health.”

The content of this brochure has been quality assured by Erik Rokkones, head of the Department of Gynaecological Oncology at Radiumhospitalet and senior consultant.

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.kreftforeningen.no/om-kreft/kreftformer/livmorkreft/
www.kreftlex.no/Gyn-livmorkreft

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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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