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The satisfaction level in cases with gynecologic cancer

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ABSTRACT

The aim of this study was to determine the level of satisfaction in gynecological cancer patients and to increase the awareness of the disease in the community. This descriptive study was carried out on 280 patients treated at our Gynecological Oncology Center between May 2018 and January 2019. As a data collection tool, descriptive information and satisfaction questionnaire were prepared by the researchers based on the literature and the demographic parameters of the patients were asked. In the analysis of the data: descriptive statistics, t test, Mann Whitney U Test and Spearman correlation coefficient were used in SPSS 25.0 statistical program. It was understood that 51.4% of the participants did not hear this type of cancer before being diagnosed. It was learned that 61.4% of the participants did not have any routine screening program against cervical and/or breast cancer. 42.1% of the participants did not know the tests and 39.3% of them did not know that they did not have access. 85.7% of the cancer patients who participated in the study received the disease-related diagnosis from the gynecologist. 33.4% of the patients stated that it took a long time to diagnose. 46.4% of the patients stated that they had not been informed by the doctor about their illness and options. In addition, 49.3% of the patients were not satisfied with the approach taken in this information and 50.7% wanted to obtain more effective and comprehensive information. Patients' expectations from the doctors are more understanding, better communication with the patient, receiving emotional support, and decision-making about the disease and treatment is also the time for the doctor to support the patient, to respect him, to spend more time. The patients think that the health personnel have difficulty in giving information about the treatment process and its side effects, the likelihood of recurrence of the disease, the effects of the disease on the psychological state, prognosis, how long the treatment will take and what the disease is and why. For this reason, patients feel themselves lacking. It is important for health personnel to inform the patient, to listen to the patient and to support them in all stages of the disease and treatment, and to support the survival of this chronic disease.

1. Introduction

Nowadays cancers are the most common diseases. It is very important not only because it causes a decrease or a loss in the reproductive ability of the woman, but also because it affects many functions of the woman as a whole (Saevarsdottir et al., 2010). Therefore, health practitioners serving gynecological oncology patients have many responsibilities. Gynecologic oncology patients are now oncology patients after uneventful postoperative period. After that, a quality care service should be provided to the oncology patients.

Gynecology oncology doctors apply the best protocols by performing the operations required by their disciplines in the best way. However, it should be kept in mind that they are family physicians who make the first diagnosis of the woman, who will best understand the woman. Besides, medical oncology doctors who follow the treatment processes and the palliative care team are parts of required elements. All of this team, need to determine its approach by wholly examining the gynecological cancer diagnosed women, taking into account the sensitivity of the disease and the patient (Catt et al., 2005). If we examine the studies that contribute to studies in gynecologic oncology; it appears that the studies are mostly about discharged times, cost effectiveness studies and work towards solving psychosocial problems. However, studies that include evaluations in terms of patient satisfactions are rare. Changes in mood changes in women in the gynecological cancer treatment process can be seen depending on many factors. Factors such as uncertainty about the treatment process, the risk of spreading to other organs and fears of death, female identity, changes in body image and sexuality, and difficulty in activities of daily living can cause anxiety (Sang et al., 2007). In addition to mood changes that may occur due to lack of emotional support, radical hysterectomy may also present as symptoms of genitourinary atrophic disorders and psychiatric symptoms due to the loss of estrogen and ovarian menopause. Women may experience intense sadness especially after hysterectomy because of their belief in the effect they have on the woman's identity and the meaning they attach to the uterus. For many women in traditionally dependent societies, the uterus is still a symbol of womanhood, sexuality, fertility and motherhood. When the ovaries are removed, the woman fears that her sexual desire and will decrease and that she will get older (Steele and Fitch, 2008).

It is known that cancer patients need information, during the diagnosis, treatment and follow-up period, is widespread. Patients have suspicions about future conditions, diseases, examinations and treatment. How healthcare professionals define the limit, type and path of information to be given to patients, is an important issue (Catt et al., 2005; Saevarsdottir et al., 2010). Defining communication and information needs of patients will be guiding in practice. The timely treatment and prevention of side effects in cancer treatment will improve the quality of patient care, if the patient's supportive care needs are met. The mood disorders and sexual dysfunctions associated with the cancer treatment process are important problems that should be considered in terms of affecting the quality of life, physical, social and emotional health. The majority of women in the post-treatment period with gynecological cancer, stated psychosocial and sexual problems as primary necessities. The importance of employment for people with cancer appears to go beyond meeting the financial requirements and makes women feel good in every sense.

Identification and management of unmet supportive care needs of patients is the main component of health care. Cancer causes different effects on all levels of life of both the patient and the family (Evans et al., 2006). Effective, high-quality cancer care cannot be limited to the implementation or treatment of surgical treatment alone. Care refers to a more holistic approach, individualized care and closeness to oncology patients and their families. It is seen that the material and emotional needs of cancer patients during the diagnosis period are not investigated adequately, in the diagnosis, treatment and post-treatment period. There are still difficulties in the diagnosis of patients' needs, standardization of measurements and determination of unmet supportive care needs and levels (Bekar et al., 2013). Lack of studies on this subject has also been identified in gynecologic oncology patients. In our study, we investigated gynecologic oncologic cancer patients who had undergone surgical operation and are still under treatment, their sources of information, their information needs, their expectations from the health personnel and the effect of cancer on these parameters.

2. Material and methods

The European Society of Gynaecological Oncology (ESGO) is the leading European organisation with more than 2.500 professionals involved in prevention, treatment, care and research of gynaecological cancers. Our study group consisted of patients diagnosed with gynecologic cancer in 5-year period and admitted to gynecologic oncology outpatient clinic between May 2018 and January 2019 at Tepecik Education and Research Hospital, which is accredited by ESGO (n=280). The patients over 18 years of age and could be communicated easily, were included in the study. The Local Ethics Committee approved the study. The universal principles of the Helsinki Declaration were implemented. The patients were first told to study and to collect data, all patients were given a sociodemographic information form and satisfaction questionnaire including age, educational status, marital status, duration of disease, diagnosis of cancer. While responding to the questions, patients were asked to respond in a closed room, in order to prevent them from being directed. After the data were collected, the data were recorded by a different person without patient names. After the questions containing the demographic data, the main survey questions were passed. The questions in the awareness and prevention subgroup indicated whether they had information about gynecologic cancers and whether they had any tests on these cancers. The subgroup form of the patients' expectations from the health personnel was prepared by the researchers based on the literature. The questionnaire included 8 questions about the sociodemographic characteristics of the patients (age, gender, BMI, number of pregnancies, educational status, economic status, working status, marital status). 9 questions about the characteristics of the disease (diagnosis, stage, when diagnosis was made, current health status, how to obtain information about the disease, the type of cancer, the methods of screening for cancer, whether or not the screening, the causes of the disease, how and by whom the diagnosis was made), 2 questions about whether the health institution sends educational articles, 2 questions about whether the treatment is late, 7 questions about how the medical personnel evaluate the communication, 2 questions about the complementary help during diagnosis, 1 question about the impression of the healthcare team in the patient, 1 question to determine the information requirements, 25 questions about the expectations of the patients from the health care personnel, 1 question about whether they are aware of the scientific studies, and a total of 58 questions. Three experts received their opinions for the questionnaire. Five cancer patients were pre-applied to the questionnaires. There are five options in the form of I strongly disagree, disagree, neither agree nor disagree, agree, absolutely agree. The corresponding scores are 1, 2, 3, 4,5 respectively. The total score is calculated by summing the points given for each item. The total score is between 14 and 35, and the scores from each of the subscales range from 1 to 5. When the total score is calculated, the high scores indicate that the satisfaction level is high. The respondent is asked to mark a single score for each item.

Evaluation of data

Statistical analysis of the data obtained in our study was performed with SPSS (Version 25.0, SPSS Inc., Chicago, IL, USA). Descriptive statistics were expressed as mean ± standard deviation or median (min-max) for continuous variables according to data distribution, number and percentage for categorical data. Normality distribution was evaluated by Shapiro-Wilk and Kolmogorov-Smirnov tests. Student t test was used for comparison of two independent variables when Gaussian distribution was proved, and nonparametric Mann-Whitney U test was used for comparison of independent variables these parameters could not be met. This study is limited to adult patients in the various cancer diagnostic groups and who give consent to participate in the trial. In the study, the relationship between satisfaction questionnaire score and age, educational status, social support status, duration of disease and clinical features were evaluated by Spearman correlation coefficient and test.

3. Results

As shown in Table 1, 9.6% of the participants were between the ages of 30-39 and 23.5% were over 60 years of age. The mean age of the participants was 52.32 ± 9.69 (min: 30- max: 73). 80.7% of those examined were married; 62.1% were graduated from primary school, 19.3% were university graduates. 58.9% of the participants were retired and 13.6% were employed. 33.2% of the respondents had a household income of $ 500-1000 and participants with a household income of more than 1500 dollars were 19.3%. It was found that 89.3% of the participants were multiparous. According to the BMI of the participants, 52.5% were overweight and 3.2% were obese. Table 2 presents the distribution of the characteristics of the participants. Of the participants, 12.1% were diagnosed with cervical cancer, 20.7% with ovarian cancer, 3.6% with vulva cancer, 0.7% with vagina cancer, 60% with endometrial cancer, 2.9% with tubal cancer. 56.1% of the cancer was found in the second stage. 20.4% of the participants received diagnoses and treatment one year ago, 26.7% of them 1 year-3 years ago, 52.9 of them received 3 years-5 years ago. It was learned that 93.6% of the patients continued their treatments.

In Table 3, the distribution of the disease levels, information levels and diagnostic characteristics of the participants were presented. It was determined that 51.4% of the participants did not hear this type of cancer before the diagnosis and that from the cancer prevention tests they were aware of mostly Pap smear test which is a cervical cancer screening test with rate of 27.9% and ovarian cancer markers with 56.4%. It was learned that 61.4% of the participants did not undertake any routine screening program against both cervix and breast cancer. It was determined that 42.1% of the participants didn't do it because they didn't know about the tests and 39.3% of them didn't do it because they didn't have access. It was understood that 39.3% of the cancer diagnosis of the participants was recognized because of their continuous health problems. A large proportion (85.7%) was diagnosed by a gynecologist. Table 4 presents the distribution of the expectations of the participants from the doctors and nurses in the diagnosis and treatment of their diseases.

The majority of the participants (36.4%) stated that the first speech after the diagnosis was good but was in a great shock to evaluate the information given; 92.1% stated that no written document was sent after speech and 83.6% stated that it would be beneficial to send the written document. There was no statistically significant relationship between the expectation and duration of disease in patients (p> 0.05). 44.3% of the participants stated that the family physician could not diagnose the disease and 34.3% stated that it took a long time to diagnose. 52.1% of the participants stated that they had to wait 1-2 months for diagnosis. 20% of the participants disagreed with the section 'I was very informed about the disease and options by my doctor/nurse at the hospital', 20% of the participants did not agree with the section 'My doctor explained all possible side effects of the treatment and / or all possible effects', 18.6% did not agree with the section 'my doctor / team told us about the possible recurrences and symptoms of the disease', 17.2% did not agree with teh section 'I am satisfied with the communication with my doctor', 15.7% did not agree with 'I think that I have answered all my questions and concerns', 35% were undecided to 'I'm sure of my doctor choice'. 16.5% did not agree with the section 'my doctor was understanding to me and the difficulties I had experienced'. 46.4% of the participants stated that they were offered many treatment options, 60% said that they were offered psychological support, 57.9% said that the team made them feel safe, 45.7% said that psychological support was incomplete and diagnosis and treatment helped them feel better, 9.3% stated that their needs were not met. All of the patients stated that they did not know if there was any ongoing clinical study in the duration of the illness and did not receive a clinical study proposal, and would like to participate if there was any such study. 35% of the participants stated that the oncologist should have had spent more time explaining the side effects of the treatment, and 44.3% stated that they had no desire or regret, they were satisfied with the team's choices. 39.3% of the participants stated that they wanted the nurses to spend more time for each patient, that it was not their options, but that the lack of time negatively affected. Patients would like to receive information primarily about the side effects of treatment (35%), the likelihood of recurrence (6.4%), regular follow-up (2.9%), duration of treatment (6.4%). In our study, it was determined that the

Table 1. The distribution of some descriptive and demographic characteristics of the participants.

	Number (n=280)	(%)*
Age Groups		
30-39	27	9.6
40-49	94	33.5
50-59	93	33.2
60 years and older	66	23.5
Marital status		
Married	226	80.7
Single	16	5.7
Divorced	38	13.6
Education status		
Primary school graduate	174	62.1
Middle school high school graduate	52	18.6
Graduate from a university	54	19.3
Operating status		
Full time work	38	13.6
Working part-time	32	11.4
Does not work due to health condition	45	16.1
Retired	165	58.9
Monthly total household income		
Up to $ 500	49	17.5
$ 500- $ 1000	93	33.2
$ 1000- $ 1500	84	30
More than $ 1500	54	19.3
Pregnancy		
Multiparous	250	89.3
Primipar	30	10.7
Body mass index (BMI kg/m^2)		
Normal (BMI 18-24 kg/m^2)	124	44.2
Overweight (BMI 25-29 kg/m^2)	147	52.5
Obese (BMI 30-34 kg/m^2)	9	3.2

Table 2. The distribution of the characteristics of the participants related to their diseases is presented.

	Number (n=280)	(%)*
Type of cancer		
Cervical cancer	34	12.1
Ovarian cencer	58	20.7
Vulvar cancer	10	3.6
Vagina cancer	2	0.7
Edometrial cancer	168	60.0
Tuba cancer	8	2.9
Cancer stage		
Stage 1	100	35.7
Stage 2	157	56.1
Stage 3	23	8.2
How many years ago have you been diagnosed?		
Less than 1 year	57	20.4
1-3 years	75	26.7
3-5 years	148	52.9
What is your current health condition?		
I'm under treatment	262	93.6
My treatment is complete	2	0.7
My disease has relapsed	16	5.7

Table 3. The distribution of knowledge and diagnostic characteristics of the participants of the study.

	Number (n=280)	(%)*
Have you heard of this cancer before the diagnosis?		
Yes	136	48.6
No	144	51.4
Have you heard of any of the following screening or methods to help prevent the type of cancer you are caught?		
Cervical cancer HPV test	2	0.7
Cervical cancer HPV vaccine	4	1.4
Cervical cancer HPV DNA test	4	1.4
Pap smear test for cervical cancer	78	27.9
Weight control for endometrial cancer	22	7.9
Ultrasonography control for endometrial cancer	12	4.3
Tumor markers for ovarian cancer	158	56.4
BRCA test for ovarian cancer	0	0
Have you done any routine screening programs for cervical or breast cancer?		
I had cervical and breast cancer tests.	24	8.6
I only had breast cancer	12	4.3
I had both cervical and breast cancer tests	72	25.7
I didn't have a cervical or breast cancer routine scan.	172	61.4
If you never had any of the routine screening programs for cervical or breast cancer, what is the main reason?		
I didn't know them	118	42.1
I knew it, but I didn't have access	110	39.3
I knew them, but I'm not good enough	10	3.6
I knew these things, but I didn't see myself worthy.	42	15.0
How were you diagnosed with cancer?		
Self-examination and suspicion	94	33.6
Due to persistent health problems	110	39.3
Through regular inspection / scanning	76	27.1
Who puts the diagnosis?		
Family doctor	38	13.6
Gynecologist	240	85.7
Surgeon	0	0
Radiologist	2	0.7

Table 4. The distribution of the expectations of doctors and nurses in the diagnosis and treatment process related to the diseases of the participants.

	Number (n=280)	(%)*
How would you describe your first conversation with your doctor / nurse / health care team?		
They told me everything about my good and very clear disease and treatment.	94	33.6
Good but not clear - information was not clear	76	27.1
It's not very clear and clear.	8	2.9
Good, but I'm too shocked to evaluate the information.	102	36.4
Did your health care provider send a written instructor document after your first conversation?		
Yes	22	7.9
No	258	92.1
Do you think these tutorials would be useful if they were sent?		
Yes	234	83.6
No	46	16.4
Have you experienced any of the following problems?		
Diagnosis took a long time	96	34.3
Family physician couldn't diagnose my disease	124	44.3
I'm not satisfied with my doctor, I changed my doctor	16	5.7
I had to wait for the tests	42	15.0
I was not satisfied with the health institution and I had to change	2	0.7
How long did you have to wait for your treatment?		
Less than a week	6	2.1
1-2 weeks	16	5.7
Up to 1 month	50	17.9
1-2 months	146	52.1
More than 2 months	62	22.1
I was well informed about my illness and options by my doctor at the hospital		
I strongly disagree	0	0
I do not agree	12	4.3
Neither agree nor disagree	44	15.7
I agree	130	46.4
Absolutely I agree	94	33.6
My doctor explained all possible side effects and / or delayed effects of treatment		
I strongly disagree	0	0
I do not agree	10	3.6
Neither agree nor disagree	46	16.4
I agree	134	47.9
Absolutely I agree	90	32.1
My doctor / team explained the possible recurrence and symptoms of the disease		
I strongly disagree	0	0
I do not agree	14	5.0
Neither agree nor disagree	38	13.6
I agree	134	47.9
Absolutely I agree	94	33.6
I am satisfied with the communication with my doctor		
I strongly disagree	0	0
I do not agree	10	3.6
Neither agree nor disagree	38	13.6
I agree	138	49.3
Absolutely I agree	94	33.6
I think you answered all my questions and concerns		
I strongly disagree	0	0
I do not agree	10	3.6
Neither agree nor disagree	34	12.1
I agree	142	50.7
Absolutely I agree	94	33.6

I'm sure about my choice of doctor.		
I strongly disagree	0	0
I do not agree	14	5
Neither agree nor disagree	84	30
I agree	152	54.2
Absolutely I agree	30	10.7
My doctor was sympathetic to me and the difficulties I had.		
I strongly disagree	0	0
I do not agree	8	2.9
Neither agree nor disagree	38	13.6
I agree	134	47.9
Absolutely I agree	100	35.7
Which of the following options is suitable for your diagnosis and treatment?		
Many treatment options were offered to me	130	46.4
I was offered to see another specialist doctor against my illness	44	15.7
The following procedures were described after my treatment	106	37.9
Have you been offered any complementary help?		
Psychological support	168	60.0
Social support	72	25.7
Nutritionist assistance	24	8.6
Sexual counseling	2	0.7
Rehabilitation program	0	0
Palliative care of existing patient organizations or support programs	0	0
Patient organizations	14	5.0
How did your doctor and doctor's team make you feel?		
Safe	162	57.9
Guilty	30	10.7
Frightened	26	9.3
Uncertain	20	7.1
Confused	42	15.0
Responsible / accountable	0	0
Not alone	0	0
Do you think any of the options below are missing and will help you better diagnose and treat?		
Suggestions about sexuality	40	14.3
Social support suggestions	56	20.0
Dietary recommendations	16	5.7
Psychological support	128	45.7
Information on treatment options and steps	40	14.3
Which of the following options is suitable for your treatment? My doctors: my medical team:		
She talked to me about my emotional tide.	68	24.3
He offered to help me during my treatment	40	14.3
He offered to help me after my treatment	40	14.3
He offered to help me improve my life	10	3.6
He offered me and / or my wife psychological help and counseling	15	5.4
She offered to help me cope with the personal side effects of my illness / delayed side effects	30	10.8
He talked to me about possible sexual dysfunction following treatment of my illness	19	6.8
He offered regular follow-up after my treatment was completed	32	11.4
Followed my needs	26	9.3
Do you know if there is any ongoing clinical study during your illness?		
Yes	0	0
No	100	100
Have you been offered to participate in a clinical trial?		
Yes	0	0
No	280	100
If yes, how would you describe the information you received about it?		
I received very detailed information and I think I decided based on information.		
I got some information, but I still have a lot of questions in my mind and I don't think I've decided based on knowledge.		
I didn't get a lot of information, but I did a lot of research and I trust my decision.		
I didn't get much information, but it doesn't matter. I was ready to participate in any clinical study.		
Would you agree if a clinical trial was offered?		
Yes	280	100
No		
What would you like your doctor to do differently?		
I would like my family physician to listen to me more carefully when I first consult with him about the problem.	12	4.3
I'd like him to spend more time telling the side effects of my oncologist.	98	35.0
My oncologist. I'd like him to tell me how long my treatment is going to take.	18	6.4
After my treatment was complete, I felt lonely. I'd like to give me regular follow-up.	8	2.9
I would like more support for delayed side effects.	2	0.7
I'd like to know about the possibility of disease recurrence.	18	6.4
I am not satisfied with the choice of the team that provided me the treatment.	124	44.3
What would you like the nurses to do differently?		
I would like the nurses to be more careful when giving my medication with more focus on what I am treated for.	2	0.7
I would like nurses to spend more time for each patient. I realized this was not in their possession, but the lack of time affected me negatively.	110	39.3
I would like the nurses to talk more clearly to me about all the effects of my illness, such as psychological and even death / life expectancy.	30	10.7
I didn't want them doing anything different. The nurses have always been attentive to my needs and I am very satisfied with the nursing team that provides me treatment.	138	49.3

satisfaction scores of the patients were above the middle level. As seen in Table 5, there is a statistically significant ($p < 0.05$) relationship between the satisfaction survey questions of cancer patients and the income status, on the other hand there was no significant relationship between the general satisfaction score and age, marital status, cancer stage, level of education, work status, sick leave, and disease duration variables ($p > 0.05$).

4. Discussion

Gynecological cancers are one of the most important causes of mortality and morbidity in women after breast cancer. Although the incidence of gynecologic cancers increases all over the world, the most important reason for the decrease in the mortality rate in recent years is the development of early diagnosis and treatment methods (Steele and Fitch, 2008). One of the most important problems caused by the diagnosis and treatment methods applied during the treatment of gynecologic cancers is the problems that can occur after the surgery and these problems can negatively affect the quality of life of women both during the treatment phase and when they start their daily lives (Wenzel et al., 2003). The perception of gynecological cancers as a chronic disease causes lifestyle changes in women. These changes in women's lifestyle can lead to psychological difficulties and problems that may cause emotional, mental, and behavioral reactions. Generally, uncertainties of cancer may cause confusion, panic and fear in patients. The requirements of the patients from all health teams are multidimensional and determining these requirements will reduce the patient's stress, poor quality of life, and dissatisfaction with care; prevent the use of health services and increase the cost (Evans et al., 2006; Steele and Fitch, 2008). While supportive care is used to describe care given to those with conventional disease in oncology, the applicability to the gynecological cancer patients who are increased in numbers in recent years, in every stage of the disease, should be considered in recent years.

Surgical interventions such as radical hysterectomy, vulvectomy, total pelvic exenteration in gynecologic cancer; treatments such as radiotherapy and chemotherapy lead to significant health problems that adversely affect a woman's life. Parker et al. (2003) reported that women diagnosed with gynecological cancer had lower well-being than other cancer diagnoses (Parker et al., 2003). In a study of gynecological cancer patients whose primary treatment was completed and at least one year after diagnosis, unmet requirement rate was found to be 55.6% (Urbaniec et al., 2011). In our study, the unfulfilled expectation rate was 9.3%. The reason for this low rate may be due to computerization of follow-ups and reduction of delays and disruptions during follow-up. In addition, thanks to the careful work of the archivist and oncology nurse of our gynecology oncology clinic, regular follow-up of the follow-up process is ensured. Similar to our study, Vellone et al. (2019) found no significant relationship between the expectation level and duration of disease in patients (Vellone et al., 2019). Another study suggests that oncologists patients should be sensitive to what the patients want to hear during the treatment of cancer and help patients to define their expectations and they discuss an approach to this issue (Evans et al., 2006). In our study, no relationship was found between the patients' operation durations and expectations. The fact that there was no statistically significant relationship between the expectation and duration of the disease in the patients suggests that the positive or negative effects obtained during the treatment period of the disease may not have been clearly perceived by the patients. This finding may be interpreted as the fact that cancer patients are always open to encouraging hope and can be referred to this issue.

In another study conducted in gynecological cancer patients, general well-being and quality of life of the women were examined and it was observed that the most adverse effects were in emotional and social terms in functional situations (Anderson and Lutgendorf, 1997). In our study, it was reported that most of the patients' needs, especially psychosocial needs, were not handled by the treatment team in gynecologic cancer patients and the necessity to address them in the early period was revealed. In our study, psychological and emotional need ratio was 45.7%. In studies of women with ovarian cancer who received cancer treatment, psychological and emotional needs were reported in 57-63% of patients. The need to talk to someone about irritability, sadness, fear and feelings is expressed in order (Fitch et al., 1999). Psychosocial care and more information are among the most frequently reported requirements. Care that helps the patient and his family cope in the course of diagnosis, during treatment, in follow-up or in advanced stage, palliation during terminal period, is supportive care (Ekman et al., 2004). This care includes activities and health services that help the patient to maximize the benefits of treatment and to live as high as possible with the effects of the disease.

In our study, it was determined that the satisfaction scores of the patients were above the middle level. It was also found that patients had higher satisfaction scores as their income levels increased. This suggests that the level of income and the ability to reach the doctor may also affect the patients' coping behaviors and hence the level of hope. Felder et al. (2004) found that patients' levels of hope were high in studies in which they investigated the level of hope in cancer patients (Felder, 2004). Jo et al. (2004) found that patients with cancer maintained their hopes in the disease process (Jo and Son, 2004). The results of these studies are consistent with the results of our study. Cancer patients do not have low level of hope. In our study the rate of meeting of patients' expectations with follow-ups was high.

Another important issue; the patients stated that the lack of communication and information as their unmet needs and their dissatisfactions. Sutherland et al. (2009) found in their study that the unmet supportive care needs of patients diagnosed with various cancers are related mostly to the lack of information about testing, treatment and side effects (Sutherland et al., 2009). Information has functions of gaining control, reducing anxiety, improving cohesion, determining realistic expectations, participating in self-care and raising morale, feeling safe. In many studies related to the subject, it has been shown that the patient's biggest complaint is the need for information about disease, prognosis and treatment (Sanson-Fisher et al., 2000; Hodgkinson et al., 2007). Supportive active participation in the decision rather than the submissive attitude, unlike the beliefs that the decision should be made by the physician as in the previous years and considering the treatment as a partnership between the patient and the professional worker, increase patients' need of information. At this stage, health professionals need to feel responsible for diagnosing patients' information needs and meeting their individual knowledge needs, as well as other needs of patients. It is understood that patients need information in every period and this is not frequently met (Sanson-Fisher et al,. 2000). Harrison et al. (2009) reported in their rewiev, information (11-97%), psychosocial (21-89%), daily living activities (4-89%), supportive care (13-86%), psychological (18-85%).) physical (21-70%), sexuality (49-63%), communication (2-57%) and economic (13- 54%) requirements of cancer patients were not met during the treatment period (Harrison et al., 2009). These results indicate that the needs of cancer patients are multidimensional and variable. These unmet needs should be identified and approached by a team work in order to optimize the care that will be offered to these patients. In this context, other health professionals (psychologists, physiotherapists, nutritionists and dieticians, etc.) should take part in this process as well as their main duties in the diagnosis and treatment processes of physicians.

In our study, the general well-being and quality of life of the women were examined and it was seen that there were mostly emotional and social negative effects in functional situations. In the study conducted by Harrison et al. (2011) it is indicated that unmet needs and rates of the patients were activities of daily living (41-47%), communication (30%); economic (5-13%), information (6-83%), physical (26-52%), psychosocial (8-17%), supportive care (38-53%) and sexuality (33-34%) (Harrison et al., 2011). In our study, 57.9% of the patients who had gynecologic oncology surgery stated that they were safe and 64.9% of them stated that they were satisfied with the choice of doctor. In their study conducted with 199 patients who had surgery 1-8 years before and survived in order to assess long-term psychosocial outcomes and supportive care needs two-thirds (68%) reported a positive quality of life and relationship adjustment. However, approximately one third (29%) of them reported symptoms of anxiety at the clinical level, and about 90% reported a 4-fold increase in their unmet needs in such a diagnosis. In the study that Beesley et al. (2013) evaluated the women with ovarian cancer from 6 months to 2 years after the diagnosis it is reported that system / information, patient care and sexuality requirement scores decreased by 2 years, psychological and physical requirements continued (Beesley et al., 2013). Browall et al. (2004) reported that patients with ovarian cancer had little change in information requirements at the time of diagnosis, after completion of therapy, and 6 months after completion of therapy and found that they need information about the most likely improvement in all measurements, stage and spread of the disease, different treatment options (Browall et al., 2004).

Although the initial stage of the disease is important in adherence to the whole process, the supportive care needs and meeting status of newly diagnosed cancer patients in this period have not been adequately investigated in terms of treatment and post-treatment period. When we look at the studies in the literature, it is seen that physical, psychosocial and information requirements are common. It is seen that most cancer patients have physical supportive care needs related to the symptoms during the diagnosis period. The patient who had to wait more than 2 months for the initiation of treatment was 22.1% and the rate of participants who expressed their discomfort regarding the diagnosis of the patients was long was 33.4% in our study. This can be attributed to the inconvenience of organizations and the inadequacy of oncology hospitals in the diagnosis and treatment phase. In another study conducted by Billet and Crossing (2003), the problems related to the organization of treatment in the opinions of the women who are receiving breast cancer treatment were the delay of the treatment process, meeting with different doctors at each control, long waiting time in the clinic, inadequate coordination of treatment (Billett and Crossing, 2003).

Among all the needs of women with gynecological cancer, it is seen that the needs of the sexual field are mentioned at the forefront. It is reported that cancer treatments affect sexuality but both patients are uncomfortable in expressing this need and health professionals do not ask questions about their sexual needs. In our study, the need for sexuality was 14.3%. Crothers et al. (2005) investigated the relationship between social support and hope in cancer patients, and found that patients' satisfaction with their support was statistically significantly associated with their hope (Crothers et al., 2005). Consistent with these findings, Dansuk et al. (2002) found that hopelessness and loneliness level increased as family and social support decreased in patients with cancer (Dansuk et al., 2002). In our study, the need for social support was 20% and no effect of the need for social support on satisfaction scores was found statistically.

In a study conducted by Steele and Fitch (2008) with gynecological cancer women; 69% of women fear that the cancer will recur, 66% fear that the cancer will spread, 54% fear of the uncertainty about the future

(Steele and Fitch, 2008). Concerns about uncertainty about the future due to the fear of recurrence and spread of cancer in gynecologic cancer patients cause anxiety and sadness. In our study, 7.1% of the patients stated that their status was uncertain and 9.3% stated that they were scared. There is a positive correlation between income level and expectations of patients. It was emphasized that people with low incomes have many obstacles for screening programs, not only screening programs are sufficient and timely monitoring is very important when abnormal test results are obtained (Bierman et al., 2012). For the above reasons, health research and cancer screening programs should be systematically disseminated to the whole society. In our study, it was observed that satisfaction ratio increased as income level increased.

It was found that patients who quit their jobs needed more psychological support. In the study conducted by McCorkle et al. (2006) it is found that 21% of women diagnosed with cervical cancer suffered from depression and women who experienced changes in the terms of spouses, work and finance tend to be more prone to depression (McCorkle et al., 2006). One month after the start of treatment, patients usually expressed profession loss as job loss, loss of connection with employer, loss of work purpose or permanent loss of ability to work. While the cancer does not allow the individuals to earn money, the need for resources increases due to the cost of treatment and can cause cancer patients and their families to experience financial crisis (Amir et al., 2007). Apperently, studies about cancer and financial requirements are not enough in numbers. After the diagnosis and treatment of cancer, which has significant effects on the financial situation, the experience of change in work life (reducing working hours, interruption of work, change of workplace, etc.) or stopping the work was determined as 70% (Spelten et al., 2002). The need for financial resources increases for unemployed and / or patients who are inadequate to meet their daily lives. Patients with low socio-economic status find it more difficult to meet financial needs (Amir et al., 2007). Although the cost of cancer treatment imposes a large financial burden on the state economy, only a small part of this burden is imposed on patients.

The rate of patients seeking information about side effects and protection against side effects was 20%. Among the biological problems that cause anxiety and anxiety in women during the gynecological cancer process are abnormal metabolic processes that may develop due to the side effects of their treatment. In the process of coping with cancer; women should be informed about the characteristics of the cancer such as stage, diagnosis time, location, symptoms, treatment methods and their ability to combat should be supported (Steele and Fitch, 2008). In our study, 0.7% of the patients discontinued follow-up from their own treatment center and 5.7% of the patients changed their first doctor. Unsatisfactory requirements arise when there is a mismatch between perceived needs of cancer patients and the appropriateness of the service provided. The level of meeting the health care needs is directly related to the low level of patient satisfaction and quality of life. The level of meeting the health care needs is directly related to the low level of patient satisfaction and low quality of life. Studies on supportive care needs of cancer patients have shown that unmet needs are high (Harrison et al., 2009; Polikandrioti and Ntokou, 2011). In addition, patients' perceptions about unmet needs can vary throughout the cancer process, at all stages of cancer, and according to different types of cancer, stages, and age of the individual. We could not find any relationship between age, different types of cancer, duration, stages and satisfaction score.

Our positive contributions with this cross-sectional descriptive study; diagnosing unmet needs can provide impetus for improving resources for patients with cancer in improving resources and rescheduling services. Considering the lack of gynecological oncology centers and the patient statements indicating that they are in search of a more reliable health institution and the institutions where these services are provided well, there are still deficiencies at the point of meeting the abovementioned needs of this institution shows that it is important to investigate this issue. The sharing of information to be obtained through such studies with oncology centers and the more active sharing of non-governmental organizations on cancer in this subject will lead to possible impaired self-esteem in gynecological cancer patients and the presence of healthy body perception. These results suggest that it is important to maintain the expectation level that supports positive prognosis in cancer patients and to plan appropriate approaches of health care professionals during the diagnosis, treatment and follow-up of gynecological cancer patients.

In our study, firstly, although we have a retrospective design, we compare a homogeneous situation. We have limited the duration of cancer to 5 years in order to prevent the patients from remembering the events that occurred many years ago and also to avoid biased and incorrect information. Patients whose history and obstetric and gynecological history were not reassuring, especially those, whose file and information were inconsistent, were excluded. There are several other values in the context of the possible outcome of the present study. All subjects were analyzed by the same doctor throughout the study period and for the entire study group. These factors are less likely to affect the outcome of the study, as the above exclusion criteria are applied perfectly and exclusion of such cases. There were some limitations in our study, which were conducted in a single institution. The performance of multicentre studies on this subject will strengthen our results.

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