GEORGIAN MEDICAL NEWS

ISSN 1512-0112

NO 7-8 (364-365) Июль-Август 2025

ТБИЛИСИ - NEW YORK

ЕЖЕМЕСЯЧНЫЙ НАУЧНЫЙ ЖУРНАЛ

Медицинские новости Грузии

საქართველოს სამედიცინო სიახლენი

GEORGIAN MEDICAL NEWS

Monthly Georgia-US joint scientific journal published both in electronic and paper formats of the Agency of Medical Information of the Georgian Association of Business Press. Published since 1994. Distributed in NIS, EU and USA.

GMN: Georgian Medical News is peer-reviewed, published monthly journal committed to promoting the science and art of medicine and the betterment of public health, published by the GMN Editorial Board since 1994. GMN carries original scientific articles on medicine, biology and pharmacy, which are of experimental, theoretical and practical character; publishes original research, reviews, commentaries, editorials, essays, medical news, and correspondence in English and Russian.

GMN is indexed in MEDLINE, SCOPUS, PubMed and VINITI Russian Academy of Sciences. The full text content is available through EBSCO databases.

GMN: Медицинские новости Грузии - ежемесячный рецензируемый научный журнал, издаётся Редакционной коллегией с 1994 года на русском и английском языках в целях поддержки медицинской науки и улучшения здравоохранения. В журнале публикуются оригинальные научные статьи в области медицины, биологии и фармации, статьи обзорного характера, научные сообщения, новости медицины и здравоохранения. Журнал индексируется в MEDLINE, отражён в базе данных SCOPUS, PubMed и ВИНИТИ РАН. Полнотекстовые статьи журнала доступны через БД EBSCO.

GMN: Georgian Medical News – საქართველოს სამედიცინო სიახლენი – არის ყოველთვიური სამეცნიერო სამედიცინო რეცენზირებადი ჟურნალი, გამოიცემა 1994 წლიდან, წარმოადგენს სარედაქციო კოლეგიისა და აშშ-ის მეცნიერების, განათლების, ინდუსტრიის, ხელოვნებისა და ბუნებისმეტყველების საერთაშორისო აკადემიის ერთობლივ გამოცემას. GMN-ში რუსულ და ინგლისურ ენებზე ქვეყნდება ექსპერიმენტული, თეორიული და პრაქტიკული ხასიათის ორიგინალური სამეცნიერო სტატიები მედიცინის, ბიოლოგიისა და ფარმაციის სფეროში, მიმოხილვითი ხასიათის სტატიები.

ჟურნალი ინდექსირებულია MEDLINE-ის საერთაშორისო სისტემაში, ასახულია SCOPUS-ის, PubMed-ის და ВИНИТИ РАН-ის მონაცემთა ბაზებში. სტატიების სრული ტექსტი ხელმისაწვდომია EBSCO-ს მონაცემთა ბაზებიდან.

WEBSITE

www.geomednews.com

К СВЕДЕНИЮ АВТОРОВ!

При направлении статьи в редакцию необходимо соблюдать следующие правила:

1. Статья должна быть представлена в двух экземплярах, на русском или английском языках, напечатанная через **полтора интервала на одной стороне стандартного листа с шириной левого поля в три сантиметра**. Используемый компьютерный шрифт для текста на русском и английском языках - **Times New Roman** (**Кириллица**), для текста на грузинском языке следует использовать **AcadNusx.** Размер шрифта - **12**. К рукописи, напечатанной на компьютере, должен быть приложен CD со статьей.

2. Размер статьи должен быть не менее десяти и не более двадцати страниц машинописи, включая указатель литературы и резюме на английском, русском и грузинском языках.

3. В статье должны быть освещены актуальность данного материала, методы и результаты исследования и их обсуждение.

При представлении в печать научных экспериментальных работ авторы должны указывать вид и количество экспериментальных животных, применявшиеся методы обезболивания и усыпления (в ходе острых опытов).

4. К статье должны быть приложены краткое (на полстраницы) резюме на английском, русском и грузинском языках (включающее следующие разделы: цель исследования, материал и методы, результаты и заключение) и список ключевых слов (key words).

5. Таблицы необходимо представлять в печатной форме. Фотокопии не принимаются. **Все цифровые, итоговые и процентные данные в таблицах должны соответствовать таковым в тексте статьи**. Таблицы и графики должны быть озаглавлены.

6. Фотографии должны быть контрастными, фотокопии с рентгенограмм - в позитивном изображении. Рисунки, чертежи и диаграммы следует озаглавить, пронумеровать и вставить в соответствующее место текста **в tiff формате**.

В подписях к микрофотографиям следует указывать степень увеличения через окуляр или объектив и метод окраски или импрегнации срезов.

7. Фамилии отечественных авторов приводятся в оригинальной транскрипции.

8. При оформлении и направлении статей в журнал МНГ просим авторов соблюдать правила, изложенные в «Единых требованиях к рукописям, представляемым в биомедицинские журналы», принятых Международным комитетом редакторов медицинских журналов - http://www.spinesurgery.ru/files/publish.pdf и http://www.nlm.nih.gov/bsd/uniform_requirements.html
В конце каждой оригинальной статьи приводится библиографический список. В список литературы включаются все материалы, на которые имеются ссылки в тексте. Список составляется в алфавитном порядке и нумеруется. Литературный источник приводится на языке оригинала. В списке литературы сначала приводятся работы, написанные знаками грузинского алфавита, затем кириллицей и латиницей. Ссылки на цитируемые работы в тексте статьи даются в квадратных скобках в виде номера, соответствующего номеру данной работы в списке литературы. Большинство цитированных источников должны быть за последние 5-7 лет.

9. Для получения права на публикацию статья должна иметь от руководителя работы или учреждения визу и сопроводительное отношение, написанные или напечатанные на бланке и заверенные подписью и печатью.

10. В конце статьи должны быть подписи всех авторов, полностью приведены их фамилии, имена и отчества, указаны служебный и домашний номера телефонов и адреса или иные координаты. Количество авторов (соавторов) не должно превышать пяти человек.

11. Редакция оставляет за собой право сокращать и исправлять статьи. Корректура авторам не высылается, вся работа и сверка проводится по авторскому оригиналу.

12. Недопустимо направление в редакцию работ, представленных к печати в иных издательствах или опубликованных в других изданиях.

При нарушении указанных правил статьи не рассматриваются.

REQUIREMENTS

Please note, materials submitted to the Editorial Office Staff are supposed to meet the following requirements:

1. Articles must be provided with a double copy, in English or Russian languages and typed or compu-ter-printed on a single side of standard typing paper, with the left margin of **3** centimeters width, and **1.5** spacing between the lines, typeface - **Times New Roman** (**Cyrillic**), print size - **12** (referring to Georgian and Russian materials). With computer-printed texts please enclose a CD carrying the same file titled with Latin symbols.

2. Size of the article, including index and resume in English, Russian and Georgian languages must be at least 10 pages and not exceed the limit of 20 pages of typed or computer-printed text.

3. Submitted material must include a coverage of a topical subject, research methods, results, and review.

Authors of the scientific-research works must indicate the number of experimental biological species drawn in, list the employed methods of anesthetization and soporific means used during acute tests.

4. Articles must have a short (half page) abstract in English, Russian and Georgian (including the following sections: aim of study, material and methods, results and conclusions) and a list of key words.

5. Tables must be presented in an original typed or computer-printed form, instead of a photocopied version. **Numbers, totals, percentile data on the tables must coincide with those in the texts of the articles.** Tables and graphs must be headed.

6. Photographs are required to be contrasted and must be submitted with doubles. Please number each photograph with a pencil on its back, indicate author's name, title of the article (short version), and mark out its top and bottom parts. Drawings must be accurate, drafts and diagrams drawn in Indian ink (or black ink). Photocopies of the X-ray photographs must be presented in a positive image in **tiff format**.

Accurately numbered subtitles for each illustration must be listed on a separate sheet of paper. In the subtitles for the microphotographs please indicate the ocular and objective lens magnification power, method of coloring or impregnation of the microscopic sections (preparations).

7. Please indicate last names, first and middle initials of the native authors, present names and initials of the foreign authors in the transcription of the original language, enclose in parenthesis corresponding number under which the author is listed in the reference materials.

8. Please follow guidance offered to authors by The International Committee of Medical Journal Editors guidance in its Uniform Requirements for Manuscripts Submitted to Biomedical Journals publication available online at: http://www.nlm.nih.gov/bsd/uniform_requirements.html
http://www.icmje.org/urm_full.pdf
In GMN style for each work cited in the text, a bibliographic reference is given, and this is located at the end of the article under the title "References". All references cited in the text must be listed. The list of references should be arranged alphabetically and then numbered. References are numbered in the text [numbers in square brackets] and in the reference list and numbers are repeated throughout the text as needed. The bibliographic description is given in the language of publication (citations in Georgian script are followed by Cyrillic and Latin).

9. To obtain the rights of publication articles must be accompanied by a visa from the project instructor or the establishment, where the work has been performed, and a reference letter, both written or typed on a special signed form, certified by a stamp or a seal.

10. Articles must be signed by all of the authors at the end, and they must be provided with a list of full names, office and home phone numbers and addresses or other non-office locations where the authors could be reached. The number of the authors (co-authors) must not exceed the limit of 5 people.

11. Editorial Staff reserves the rights to cut down in size and correct the articles. Proof-sheets are not sent out to the authors. The entire editorial and collation work is performed according to the author's original text.

12. Sending in the works that have already been assigned to the press by other Editorial Staffs or have been printed by other publishers is not permissible.

Articles that Fail to Meet the Aforementioned Requirements are not Assigned to be Reviewed.

ავტორთა საყურადღებოდ!

რედაქციაში სტატიის წარმოდგენისას საჭიროა დავიცვათ შემდეგი წესები:

1. სტატია უნდა წარმოადგინოთ 2 ცალად, რუსულ ან ინგლისურ ენებზე,დაბეჭდილი სტანდარტული ფურცლის 1 გვერდზე, 3 სმ სიგანის მარცხენა ველისა და სტრიქონებს შორის 1,5 ინტერვალის დაცვით. გამოყენებული კომპიუტერული შრიფტი რუსულ და ინგლისურენოვან ტექსტებში - **Times New Roman (Кириллица)**, ხოლო ქართულენოვან ტექსტში საჭიროა გამოვიყენოთ **AcadNusx.** შრიფტის ზომა – 12. სტატიას თან უნდა ახლდეს CD სტატიით.

2. სტატიის მოცულობა არ უნდა შეადგენდეს 10 გვერდზე ნაკლებს და 20 გვერდზე მეტს ლიტერატურის სიის და რეზიუმეების (ინგლისურ, რუსულ და ქართულ ენებზე) ჩათვლით.

3. სტატიაში საჭიროა გაშუქდეს: საკითხის აქტუალობა; კვლევის მიზანი; საკვლევი მასალა და გამოყენებული მეთოდები; მიღებული შედეგები და მათი განსჯა. ექსპერიმენტული ხასიათის სტატიების წარმოდგენისას ავტორებმა უნდა მიუთითონ საექსპერიმენტო ცხოველების სახეობა და რაოდენობა; გაუტკივარებისა და დაძინების მეთოდები (მწვავე ცდების პირობებში).

4. სტატიას თან უნდა ახლდეს რეზიუმე ინგლისურ, რუსულ და ქართულ ენებზე არანაკლებ ნახევარი გვერდის მოცულობისა (სათაურის, ავტორების, დაწესებულების მითითებით და უნდა შეიცავდეს შემდეგ განყოფილებებს: მიზანი, მასალა და მეთოდები, შედეგები და დასკვნები; ტექსტუალური ნაწილი არ უნდა იყოს 15 სტრიქონზე ნაკლები) და საკვანძო სიტყვების ჩამონათვალი (key words).

5. ცხრილები საჭიროა წარმოადგინოთ ნაბეჭდი სახით. ყველა ციფრული, შემაჯამებელი და პროცენტული მონაცემები უნდა შეესაბამებოდეს ტექსტში მოყვანილს.

6. ფოტოსურათები უნდა იყოს კონტრასტული; სურათები, ნახაზები, დიაგრამები - დასათაურებული, დანომრილი და სათანადო ადგილას ჩასმული. რენტგენოგრამების ფოტოასლები წარმოადგინეთ პოზიტიური გამოსახულებით **tiff** ფორმატში. მიკროფოტოსურათების წარწერებში საჭიროა მიუთითოთ ოკულარის ან ობიექტივის საშუალებით გადიდების ხარისხი, ანათალების შეღებვის ან იმპრეგნაციის მეთოდი და აღნიშნოთ სურათის ზედა და ქვედა ნაწილები.

7. სამამულო ავტორების გვარები სტატიაში აღინიშნება ინიციალების თანდართვით, უცხოურისა – უცხოური ტრანსკრიპციით.

8. სტატიას თან უნდა ახლდეს ავტორის მიერ გამოყენებული სამამულო და უცხოური შრომების ბიბლიოგრაფიული სია (ბოლო 5-8 წლის სიღრმით). ანბანური წყობით წარმოდგენილ ბიბლიოგრაფიულ სიაში მიუთითეთ ჯერ სამამულო, შემდეგ უცხოელი ავტორები (გვარი, ინიციალები, სტატიის სათაური, ჟურნალის დასახელება, გამოცემის ადგილი, წელი, ჟურნალის №, პირველი და ბოლო გვერდები). მონოგრაფიის შემთხვევაში მიუთითეთ გამოცემის წელი, ადგილი და გვერდების საერთო რაოდენობა. ტექსტში კვადრატულ ფჩხილებში უნდა მიუთითოთ ავტორის შესაბამისი N ლიტერატურის სიის მიხედვით. მიზანშეწონილია, რომ ციტირებული წყაროების უმეტესი ნაწილი იყოს 5-6 წლის სიღრმის.

9. სტატიას თან უნდა ახლდეს: ა) დაწესებულების ან სამეცნიერო ხელმძღვანელის წარდგინება, დამოწმებული ხელმოწერითა და ბეჭდით; ბ) დარგის სპეციალისტის დამოწმებული რეცენზია, რომელშიც მითითებული იქნება საკითხის აქტუალობა, მასალის საკმაობა, მეთოდის სანდოობა, შედეგების სამეცნიერო-პრაქტიკული მნიშვნელობა.

10. სტატიის ბოლოს საჭიროა ყველა ავტორის ხელმოწერა, რომელთა რაოდენობა არ უნდა აღემატებოდეს 5-ს.

11. რედაქცია იტოვებს უფლებას შეასწოროს სტატია. ტექსტზე მუშაობა და შეჯერება ხდება საავტორო ორიგინალის მიხედვით.

12. დაუშვებელია რედაქციაში ისეთი სტატიის წარდგენა, რომელიც დასაბეჭდად წარდგენილი იყო სხვა რედაქციაში ან გამოქვეყნებული იყო სხვა გამოცემებში.

აღნიშნული წესების დარღვევის შემთხვევაში სტატიები არ განიხილება.

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Содержание:

GEORGIAN MEDICAL NEWS
No 7-8 (364-365) 2025

THE RESULTS OF LIFE QUALITY ASSESSMENT IN PATIENTS WITH PRIMARY OVARIAN CANCER DURING TREATMENT: EFFECT OF DIFFERENT TACTICS AND HIPEC

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Abstract.

Introduction: Ovarian cancer ranks first among gynaecological cancers in terms of mortality, mainly due to late detection and high recurrence rates. The standard treatment for late stages remains cytoreductive surgery combined with systemic chemotherapy. However, survival and quality of life for patients with the traditional approach remain unsatisfactory.

Aim: The aim of the study was to analyse the quality of life of patients with primary advanced ovarian cancer depending on the type of treatment tactics before the start of specialized treatment, after cytoreductive surgery in the early and late postoperative periods, during chemotherapy and after the end of specialized treatment.

Materials and methods: A comparative analysis of the results of clinical examination and treatment of 74 patients with primary serous adenocarcinoma of the ovary stages III–IV (FIGO 2015) was performed: Group IA – patients with primary ovarian cancer who underwent primary cytoreductive surgery (PDS) + adjuvant chemotherapy (ACT) – 43 patients; Group IB – patients with primary ovarian cancer who underwent neoadjuvant chemotherapy (NACT) + interval cytoreductive surgery (IDS) + adjuvant chemotherapy – 16 patients; IC group – patients with primary ovarian cancer who underwent primary cytoreductive surgery (PDS) + hyperthermic intraperitoneal chemotherapy (HIPEC) + adjuvant chemotherapy (ACT) – 15 patients.

Results and discussion: At baseline (before the start of special treatment), the mean physical health (PH) score was (47.4± 9.4) in the IA group, (46.9 ± 10.3) in the IB group, and (47.2± 9.8) in the IC group. The mean psychological health (MH) at baseline was (49.7 ± 11.2) in the IA group, (41.1± 10.7) in the IB group, and (43.9 ± 10.9) in the IC group. There was no statistically significant difference in PH and MH indicators among all groups with primary ovarian cancer before the start of special treatment ($p > 0.05$). In the early postoperative period, the mean PH value was (36.1± 9.7) in the IA group, (36.0 ± 7.8) in the IB group, and (32.6± 8.8) in the IC group ($t = 1.231$; $p = 0.224$); The mean MH was (38.9 ± 9.5), (39.8 ± 8.6) and (39.2± 10.1), respectively. In the late postoperative period, the mean PH value was (41.1 ± 9.3) in the IA group, (41.1± 10.2) in the IB group, and (41.9± 10.4) in the IC group; The average MH value was (39.0 ± 9.2), (38.7 ± 9.7) and (38.0 ± 7.6), respectively.

Conclusions: According to the authors, patients with primary ovarian cancer in the early postoperative period showed a marked decrease in physical functioning, pain intensity, general well-being, and role functioning due to their physical condition. Subsequently, there was a tendency towards a gradual increase in physical health indicators in all groups of patients with primary ovarian cancer in the late postoperative period and after adjuvant chemotherapy. At the same time, there was a moderate decrease in the scores of the scales of life activity, role functioning due to emotional state, social functioning and mental health during special treatment and partial recovery of these scores after the end of special treatment. Hyperthermic intraperitoneal chemoperfusion was accompanied by a decrease in physical health scales in patients, most significantly in the early postoperative period. When assessing the quality of life of patients with primary ovarian cancer using the SF-36 questionnaire, the results indicate no statistically significant negative effect of hyperthermic intraperitoneal chemoperfusion at all stages of treatment.

Key words. Ovarian cancer, surgical treatment, quality of life, chemotherapy, HIPEC.

Introduction.

Primary ovarian cancer remains one of the most aggressive forms of gynaecological oncology, with high mortality and late detection rates. Despite improvements in surgical approaches and the development of chemotherapy, most patients experience disease recurrence and a significant deterioration in quality of life (QoL) during treatment. In this regard, different treatment tacticsto therapy is becoming increasingly important in modern gynaecological oncology, taking into account not only the molecular and genetic characteristics of the tumour, but also the individual needs, expectations and psycho-emotional state of the patient [1-7].

The modern literature increasingly emphasises the importance of integrating quality of life assessment into clinical practice as one of the key indicators of the effectiveness of personalised treatment. It is known that QoL encompasses the physical, emotional, social and functional well-being of patients, which can vary significantly at different stages of treatment [3,5,8-10].

According to the results of multicentre studies, patients with ovarian cancer often suffer from severe fatigue, anxiety, depression and sexual dysfunction, especially during chemotherapy. However, individualised treatment selection (e.g., the use of BRCA-associated cancer inhibitors such as PARP) can reduce treatment toxicity and, consequently, improve overall QoL [6,7,11-15].

Studies incorporating the EORTC QLQ-C30, QLQ-OV28, FACT-O and other questionnaires have found that patients involved in treatment decisions demonstrate higher levels of satisfaction and adaptation to their diagnosis. In particular,

Gonzalez-Martin et al. (2020) indicate that supporting patient-centred communication increases treatment adherence and reduces the subjective stressfulness of the diagnosis [11,12,14].

Special attention is paid to the role of a multidisciplinary approach in the context of personalised care. Domestic and foreign authors note that the integration of psychological, nutritional, palliative and social support into the therapeutic plan improves the physical and emotional well-being of patients at all stages of treatment [3,5,6,8,16,17].

Thus, current literature data indicate that assessment and support of quality of life is an integral component of personalised ovarian cancer therapy, which should be implemented into routine practice alongside biomarkers and genetic profiling to achieve maximum treatment efficacy and patient satisfaction.

The aim of the study was to analyse the quality of life of patients with primary advanced ovarian cancer depending on the type of different treatment approach before the start of specialised treatment, after cytoreductive surgery in the early and late postoperative periods, during chemotherapy and after the end of specialised treatment.

Object and methods of the study.

A comparative analysis of the results of clinical examination and treatment of 74 patients with primary serous adenocarcinoma of the ovary in stages III–IV (FIGO 2015) who were treated at the University Clinic of Odessa National Medical University was performed:

Group IA – patients with primary ovarian cancer who underwent primary cytoreductive surgery (PDS) + adjuvant chemotherapy (ACT) – 43 patients;

Group IB – patients with primary ovarian cancer who underwent neoadjuvant chemotherapy (NACT) + interval cytoreductive surgery (IDS) + adjuvant chemotherapy – 16 patients;

IC group – patients with primary ovarian cancer who underwent primary cytoreductive surgery (PDS) + hyperthermic intraperitoneal chemotherapy (HIPEC) + adjuvant chemotherapy (ACT) – 15 patients.

The average age of patients with newly diagnosed advanced ovarian cancer was (58 ± 11.8) years: in group IA (PDS + ACT) – 57.7 ± 12.0 years, in group IB (NACT + IDS + ACT) – 60.3 ± 10.7 years, and in group IC (PDS + HIPEC + ACT) – 59.4± 9.1 years. Clinical, anamnestic, laboratory and instrumental examination of patients was carried out in accordance with the order of the Ministry of Health of Ukraine No. 554 of 17 September 2007 and the recommendations of the National Comprehensive Cancer Network, the European Society for Medical Oncology, European Society of Surgical Oncology and European Society of Gynaecological Oncology in accordance with Order No. 1422 of the Ministry of Health dated 29 December 2016.

During preoperative and intraoperative staging, the presence of ascites, peritoneal and omentum involvement, lymph node involvement, distant metastases and invasion of major vessels, and involvement of the digestive and urinary systems were determined to characterise the extent of the tumour process. The statistical homogeneity of the groups was determined for each indicator ($p > 0.05$).

The study of the quality of life of patients with ovarian cancer requires the use of a comprehensive approach to questioning, which includes both a general assessment of patients with chronic diseases and specific methods for studying the quality of life of cancer patients. A set of such methods was used in this study. In order to assess the impact of treatment on quality of life, patients in all groups IA (PDS + ACT), IB (NACT + IDS + ACT) and IC (PDS + HIPEC + ACT) were surveyed on health-related quality of life using the SF-36 general questionnaire.

Statistical data processing was performed using methods of variational statistics with the use of STATISTICA 13.0 software and Microsoft® Excel® 2010.

Results and Discussion.

Patients with primary ovarian cancer in all groups were analysed for the presence of concomitant pathology (mixed concomitant pathology, cardiovascular diseases, diseases of the respiratory and urinary systems, neuroendocrine pathology). Statistical homogeneity of the groups was determined for each indicator.

When studying the quality of life in patients with primary ovarian cancer using SF-36, scores were calculated on 8 scales, which allowed assessing the physical (PH) and psychological (MH) components of health. The range of indicators for each scale is 0–100. A higher score indicates a better health-related quality of life. The SF-36 questionnaire was administered to all groups of patients with primary and recurrent OC before special treatment, 3 days after surgery, 20 days after surgery, before the fourth cycle of chemotherapy, and 1 month after completion of chemotherapy. In group IB (NACT + IDS + ACT), an additional questionnaire was conducted after neoadjuvant chemotherapy.

The results of the SF-36 questionnaire for patients in the IA (PDS + ACT) group are presented in Table 1, for the IB (NACT + IDS + ACT) group in Table 2, and for the IB (PDS + HIPEC + ACT) group in Table 3 at each stage of treatment. At the initial level (before the start of special treatment), the mean PH value was (47.4± 9.4) in the IA group, (46.9 ± 10.3) in the IB group, and (47.2± 9.8) in the IC group. The mean MH value at baseline was (49.7 ± 11.2) in the IA group, (41.1± 10.7) in the IB group, and (43.9 ± 10.9) in the IC group. There was no statistically significant difference in PH and MH indicators among all groups with primary ovarian cancer before the start of special treatment ($p > 0.05$).

In the IB group after neoadjuvant chemotherapy, the mean PH value was (45.1 ± 10.2), and the mean MH value was (40.3 ± 9.9).

Quality of life was assessed in the early (on the 3rd day) and late postoperative period (on the 20th day). In the early postoperative period, the mean PH value was (36.1± 9.7) in group IA, (36.0 ± 7.8) in group IB, and (32.6± 8.8) in group IC ($t = 1.231$; $p = 0.224$); The mean MH was (38.9 ± 9.5), (39.8 ± 8.6) and (39.2± 10.1), respectively. In the late postoperative period, the mean PH value was (41.1 ± 9.3) in the IA group, (41.1± 10.2) in the IB group, and (41.9± 10.4) in the IC group; The average MH value was (39.0 ± 9.2), (38.7 ± 9.7) and (38.0 ± 7.6), respectively.

During adjuvant chemotherapy (before the 4th course of ACT), the average value of the physical component of health

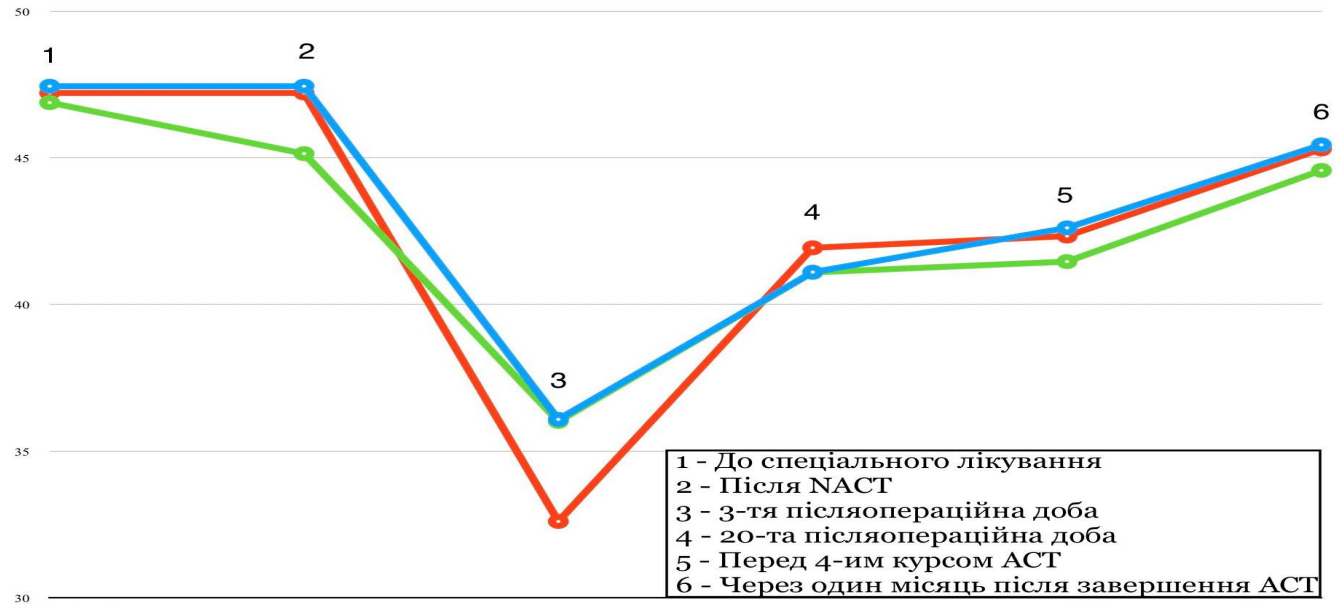

Figure 1. *Values of the physical component of health in patients in groups IA (PDS + ACT) – blue line, IB (NACT + IDS + ACT) – green line, IC (PDS + HIPEC + ACT) – red line at each stage of treatment.*

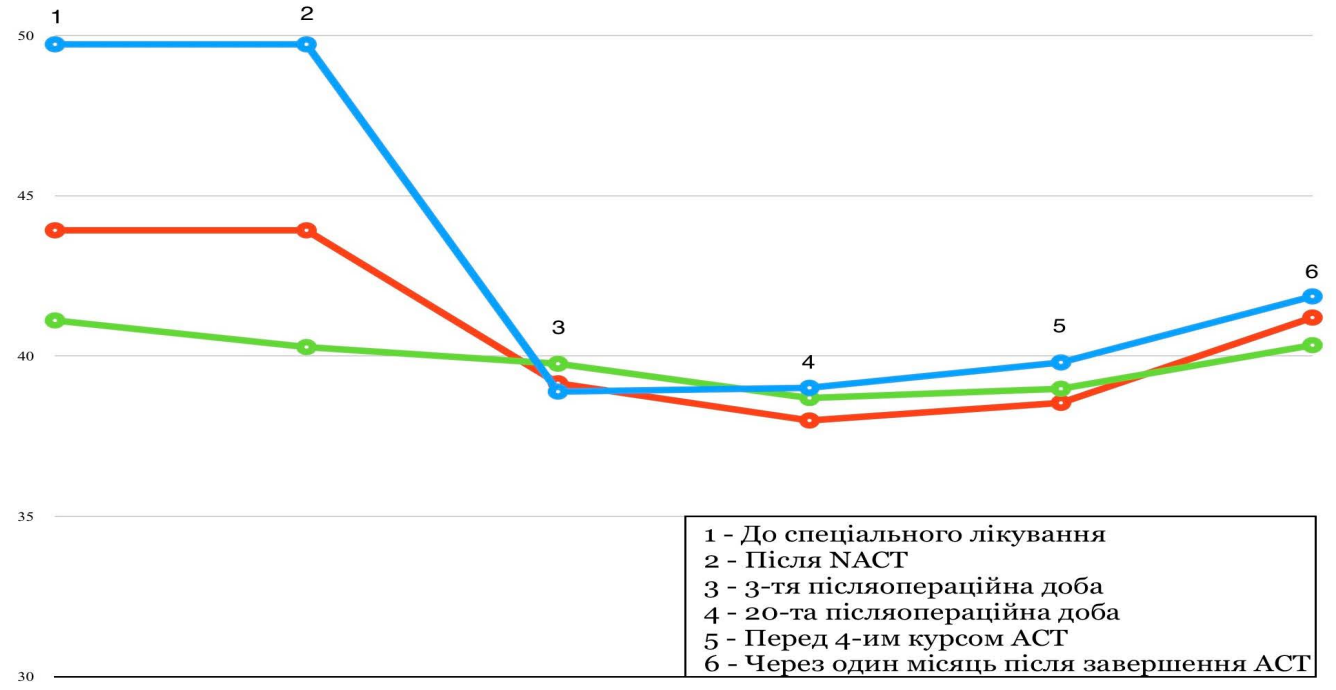

Figure 2. *The significance of the psychological component of health in patients in groups IA (PDS + ACT) – blue line, IB (NACT + IDS + ACT) – green line, IC (PDS + HIPEC + ACT) – red line at each stage of treatment.*

was (42.6 ± 10.3) in the IA group, (41.5± 9.4) in the IB group and (42.3 ± 9.1) in the IC group (Fig. 1); The average value of the psychological component of health was (39.8± 7.9), (39.0 ± 8.3) and (38.5± 9.6), respectively.

One month after completion of adjuvant chemotherapy, the mean PH was (45.4± 10.8) in the IA group, (44.6± 9.4) in the IB group, and (45.3 ± 9.7) in the IC group, while the mean MN was (41.9 ± 10.3), (40.3 ± 9.7) and (41.2 ± 8.5), respectively (Fig. 2).

For a comprehensive comparison of the physical and psychological components of health at all stages of treatment, Pearson's consistency criterion was used, which did not show any significant differences in the studied indicators ($p = 0.99$ and $p = 0.64$).

When comparing the physical component of health in the IA and IB groups, $\chi 2$ emp. = 0.36; $p = 0.98$ was obtained. When comparing the psychological component of health in the IA and IB groups, $\chi 2$ emp. = 0.75; $p = 0.94$ was obtained. The results demonstrate no significant difference in PH and MH indicators in patients with primary ovarian cancer in all groups.

It should be noted that the limited and unbalanced sample size significantly reduces the statistical significance for identifying any real differences in quality of life between treatment strategies, even if such differences exist. Our results, indicating no significant differences between the study groups, are likely due to the limited sample size (type II error) rather than the absence of real differences. When analysing the results, it is also worth noting the limited sample size and reduced statistical significance as limitations of this study. Patients reported a reduction in fatigue, nausea, and abdominal pain, which correlated positively with better overall well-being and activity levels. However, some aspects of quality of life remained critical, primarily anxiety, fear of recurrence, and sexual dysfunction, especially in younger patients. These data confirm the need to integrate psychological nd support at all stages of treatment. Compared to the literature [7,15,17], our results confirm a trend towards improved quality of life with the use of individualised treatment protocols, but also indicate the need for more systematic rehabilitation and support after completion of primary treatment. It is important to note that quality of life assessment is not only an auxiliary criterion for the effectiveness of therapy, but also an independent clinical indicator that should be taken into account when making decisions on treatment tactics, especially in older patients or those with comorbidities.

Conclusion.

1. In patients with primary ovarian cancer in the early postoperative period, there was a marked decrease in physical functioning, pain intensity, general well-being and role functioning scales due to physical condition. Subsequently, there was a tendency towards a gradual increase in physical health indicators in all groups of patients with primary ovarian cancer in the late postoperative period and after adjuvant chemotherapy.
2. At the same time, there was a moderate decrease in the scores of the scales of life activity, role functioning due to emotional state, social functioning and mental health during special treatment and partial recovery of these scores after the end of special treatment.
3. Hyperthermic intraperitoneal chemoperfusion was accompanied by a decrease in physical health scales in patients, most significantly in the early postoperative period.
4. When assessing the quality of life of patients with primary ovarian cancer using the SF-36 questionnaire, the results indicate no statistically significant negative effect of hyperthermic intraperitoneal chemoperfusion at all stages of treatment.

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