Autoethnographic Research; Diagnosis and Treatment Process of Borderline Ovarian Tumors and Nursing Care Experiences

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Abstract

Cancer is one of the most important public health problems in today's world and is closely associated with mortality. Considering the aging population of the world, women constitute half of the population, and gender-based cancer risks are being discussed in current scientific studies. In the literature, it has been established that one in every 20 women is diagnosed with cancer and one in every 33 women dies due to cancer. Borderline ovarian tumors are quite significant, as they account for 15% of ovarian cancers observed in women. Borderline ovarian tumors are most diagnosed in women between the ages of 30 and 50, usually in young women under the age of 40. All treatment stages are important processes in which the woman and her family change together. Struggling with a difficult disease like cancer, which evokes fear even at the mention of its name, can lead to problems in a patient's adaptation to daily life, and crises can be experienced both in her family and social dimensions. It is well-known that providing effective healthcare services to women and their families helps them adapt to this process.

This article was written to convey all my experiences during the operation and chemotherapy process following the diagnosis of a borderline ovarian tumor, from a biopsychosocial perspective. In this process, I addressed all my physiological, psychological, and social needs; my efforts to obtain information; the limitations in accessing adequate information; and the uncertainties, alongside existing medical knowledge, in an autoethnographic manner through my personal experiences as a daughter, spouse, mother, nurse, and academician, to share with others in the community who have the same diagnosis.

Keywords: Autoethnographic research, borderline ovarian tumors, nursing care experiences

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Arrival date: 11 July 2024 • Acceptance date: 2 September 2025
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Research Article

http://federgi.ankara.edu.tr
federgi • 2025 • 17(2) • 80-107
DOI: 10.46655/federgi.1514601

Otoetnografik Çalışma; Borderline Over Tümörlerinin Tanı ve Tedavi Süreci ile Hemşirelik Bakımı Deneyimleri

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Öz

Bugünün dünyasında en önemli halk sağlığı sorunlarından bir tanesi kanserdir ve ölümle yakından ilişkilidir. Dünyanın yaşlanan nüfusuna bakıldığında, kadınlar nüfusun yarısını oluşturmakta ve günümüz bilimsel çalışmalarında cinsiyete dayalı kanser riskleri tartışılmaktadır. Literatürde her 20 kadından birinin kansere yakalandığı, her 33 kadından birinin ise kanser nedeni ile hayatını kaybettiği belirlenmiştir. Borderline over tümörleri de kadınlarda görülen over kanserlerinin %15'ini oluşturması nedeni ile oldukça önemlidir. Borderline over tümörleri en sık 30-50 yaş aralığında, genellikle 40 yaş altı genç kadınlarda teşhis edilmektedir. Tüm tedavi aşamaları kadın ve ailesinin birlikte değişim gösterdiği önemli süreçlerdir. Toplum içerisinde adı duyulduğunda bile korku duyulan, adı kanser olan zor bir hastalıkla mücadele etmek, hasta bireyin günlük yaşama uyumunda sorunlara neden olabilmekte ve hem bireysel hem ailesel hemde toplumsal boyutta krizler yaşanabilmektedir. Kadın ve ailesine verilen etkili sağlık bakım hizmetlerinin, bu sürece uyumlarını kolaylaştırdığı bilinmektedir.

Bu makale, borderline over tümörü teşhisinin ardından geçirdiğim operasyon ve kemoterapi sürecinde tüm yaşadıklarımı biyo-psiko-sosyal boyutları ile aktarmak amacıyla yazılmıştır. Bu süreçte tüm fizyolojik, psikolojik ve sosyal gereksinimlerimi, bilgi edinme çabalarımı, yeterli bilgiye erişim sınırlılıklarımı ve bilinmezlikleri, mevcut tıbbi bilgilerle birlikte, toplum içerisinde benimle aynı teşhise sahip kişilere anlatmak için bir evlat, bir eş, bir anne, bir hemşire ve bir akademisyen olarak kişisel deneyimlerimle otoetnografik olarak ele aldım.

Anahtar Kelimeler: Otoetnografik araştırma, borderline over tümörleri, hemşirelik bakımı deneyimleri

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Geliş tarihi: 11 Temmuz 2024 • Kabul tarihi: 2 Eylül 2025
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Araştırma Makalesi

http://federgi.ankara.edu.tr

federgi • 2025 • 17(2) • 80-107
DOI: 10.46655/federgi.1514601

Introduction

In history and academic literature, the visibility of women's identity in nursing has emerged because of numerous feminist methods and efforts. When the search for meta-dialogical methods in women's studies is examined, the narrative techniques related to women and ways of obtaining methodological information are discussed through feminist methods. In ethnomethodological methods, the feminist research approach, which is evaluated qualitatively based on women's personal experiences, places women at the center both as researchers and participants in the field. It also supports the sociological, historical, political, cultural, communicative, and philosophical fields that include women-specific experiences derived from empirical knowledge based on everyday life. With postmodernism, the period in which the other gained value and began to have their voice heard was particularly significant (Turgut 2022).

Postmodernism has had both positive and negative impacts on nursing. During this period, the epistemology and ontology of nursing have been affected, and new concepts such as feminism, interpretation, and phenomenology emerged in the field. Nurses focused on holistic care and individual empowerment. They also rejected the positivist paradigm. In short, postmodernism made nursing practices more creative and engaging. The negative reflection, however, is the indifference of the patriarchal and capitalist systems to the pressures on nurses and their lack of intervention (Özcan, Benli & Alkan 2023).

In addition to the reflections of postmodernism on nursing, new fields of study have also emerged. Especially in ethnography, linguistic, interpretive, and intensive descriptive approaches have given rise to a new type of narrative and expression. This type of narrative, considered as the story starting from oneself in the field, is “autoethnography”, characterized by the notion “I am the narrator, but we are the narrated” (Turgut 2022).

In this autoethnography, I aim to make my voice heard, share my experiences, and guide women and nurses who are going through the same path with me and looking for information. In my journey, I had difficult access to information, and I aimed to make the difficult paths easier. As a mother, nurse, and woman, I want to remind you of the importance of recognizing the changes in our own bodies and participating in health screenings.

Autoethnography

Autoethnography is a qualitative research method that combines the elements of autobiography and ethnography. The term was first used by anthropologist Karl Heider in his study “What Do People Do? Dani Auto-Ethnography,” published in 1975, was defined as “a research, writing, storytelling, and method that connects the autobiographical and personal to the cultural, social, and political" by the well-known autoethnographer Carolyn Ellis (2004). Ellis and Bochner (2000) studied autoethnography as a tripartite model. It is an autoethnographic research process that uses personal experience (auto) to define (ethno) and interpret (graphy) cultural experiences, beliefs, and practices (Ellis 2004; Adams, Ellis & Jones 2017; Ağca-Varol et al. 2022; Fulya 2024). Autoethnography is regarded as feminist methodology because its approach acknowledges and accommodates subjectivity and emotionality. The influence of the researcher on the research reveals axes of discrimination and transcends the top-down and masculine view of positivist science (Ellis et al. 2010; Fulya 2024).

When we talk about autobiography, about ourselves or others, we often use memory to reflect on past experiences, and we analyze photographs, personal diaries, and texts. We may also examine news reports, blogs, and archives of life events. Ethnographers then textualize these experiences to describe how they felt in relation to cultural structures (Goodall 2006; Ellis 2004). In ethnography, we textualize culture or cultural experiences such as body image, parenting, caring, death, etc. by participating in and observing them. In ethnography, ethnographers approach the phenomena of cultural societies inductively, allowing observations to guide their writing and findings. They then relate their findings to the results of formal research. In summary, they create an example of cultural practice that creates a sense of familiarity for those who are not members of the culture. In this context, a vivid and concrete narrative is provided that gives the reader a sense of being there. The processes, principles, and practices of autobiography and ethnography together contribute to the realization of the goals and objectives set for autoethnographic research (Adams, Ellis & Jones 2017).

Individuals who share their personal experiences autoethnographically believe that these experiences are imbued with political/cultural norms and expectations. However, they utilize a detailed self-reflection, termed 'reflexivity,' to identify and interrogate the intersections between the self and social life. At the very core of autoethnography, they aim to show that people are in the process of understanding what to do, how to live, and the meaning of their struggles. When we look at the purpose and application areas of autoethnography in society, it is stated that the first thing we encounter is to fill the gaps in existing research and to offer different perspectives with the personal experience narratives of autoethnographers. In these narratives, it can show how to mask important details of cultural problems such as eating disorders, depression, social class and appearance, desire, and body norms. The second aim of autoethnography is to gain insider knowledge of cultural experience. Here the author argues that he can inform readers about different aspects of cultural life and different perspectives that are unknown to researchers. Individuals who have experienced situations such as racism, loss, illness, or cultural problems contribute to existing knowledge with different approaches (Adams, Ellis & Jones 2017; Bochner & Ellis 2006; Tillmann 2009; Jago 2002; Hodges 2014; Berry 2007).

The third aim of autoethnography is to show how researchers relate to their observations and conclusions, and to encourage writing against harmful ethnographic explanations made by cultural outsiders or utilizing different cultures. At this point, many ethnographers perceive lived situations as social research, not just as academic work but as activities that occur in a range of political and social conditions (Smith 1999; Adams, Ellis & Jones 2017). These stories and activities are closely linked to feminist principles and are based on discussing the author's motivation and sense of writing, disseminating experiential and narrative evidence, and taking a transformative or interventionist political stance (Blair, Brown, Baxter 1994; Crawford 1996; Holman Jones 2005; Adams, Ellis, & Jones 2017).

Apart from these purposes, another important point to be emphasized is that autoethnographies focus on personal experiences. They can also tell the memories of daily experiences with more traditional research methods. They focus on the fact that everything seen, heard, thought, and felt is part of the 'field.' Another critical point is the creation of accessible texts for the masses of society outside academic environments. Therefore, autoethnography is a method that can be used to communicate with both academic and non-academic audiences (Adams, Ellis & Jones 2017; Erdoğan 2022; Bektaş Ata 2016).

As a qualitative research method, autoethnographic studies are of great importance for nursing science. It is believed to contribute to the nursing profession and the quality of nursing care with the development of nursing theories and the increase in research culture (Strandås & Bondas 2018). Holistic and humanistic approaches, which are the building blocks of qualitative research, and naturality, individual experiences, communication, and interaction are in harmony with basic nursing philosophy and values. In both, individuality is at the center and has an important place in understanding and empathizing with the patient and diagnosing their needs more easily for sensitive nursing practices. Autoethnographers can be healthcare members and clinicians, as well as researchers who study patients' experiences as health research (Batch & Windsor 2015; Richard 2008).

In this article, as an academic nurse who was diagnosed with a borderline ovarian tumor, underwent surgery, and received chemotherapy, I aimed to share my experiences in the diagnosis, treatment, and follow-up processes by combining my experiences with medical knowledge and offering a new approach to autoethnography in the hope of benefiting all women and their families in the community who have gone through the same process. In this context, I tried to explain what borderline ovarian tumors are, how diagnosis and staging are performed, what the treatment methods are, in which cases and how chemotherapy is performed, and perhaps most importantly, the effects on the psychology of the patient and the approach to these patients and the principles of nursing care for these patients in light of the literature.

Encountering the Borderline Ovarian Tumor

In the life cycle that begins with birth and ends with death, it is what we experience that shapes who we are. And the profession I chose changed and shaped my life perspective over the years without me realizing it. Hospitals were like the summary of life for me. There you could see all the emotions a human being can experience, which are health, illness, excitement, peace, happiness, fear, anxiety, worry, birth, and death. Life began with birth in the hospital and ended with death at the very same place. While working as a nurse, I always wanted to leave positive impressions on people's lives. Those hospitalized could have been my loved ones. But then I realized that I had never thought I could be the patient.

In fact, for some time, I had intermittent pain in my right abdomen, and there were times when I felt tired and weak. As a nurse who has worked in various fields in hospitals for years, I thought about what could be associated with the pain, and many diagnoses came to my mind. I postponed the examination because I had given birth to a baby. When the pain in my abdomen did not go away, I was examined by an internal medicine physician. The tests revealed anemia, hypothyroidism, and nephrolithiasis. Thinking that this would explain the pain and fatigue, I started the treatment and decided to visit an obstetrician at the appropriate time. I didn't go for a check-up after childbirth. I didn't... 7-8 months passed, and the abdominal pain became more frequent. During that time, I noticed that the pain in my abdomen increased during the ovulation period. I believed it was time for an appointment, but I *postponed it again. I had just started my PhD and was in the first semester. It was the final week. I thought I could go when the finals were over. However, one night when my daughter accidentally hit my abdomen, I felt severe pain, and when I went to the toilet, for the first time, I felt pressure hitting the anal and vaginal area. Something was not right...*

*I was examined in a private hospital. The gynecologist explained that there was a mass in the ovary, a 9*8 cm mass, but it was on the left side. Whereas my pain was on the right side. It was as if something was wrong. She asked for tumor markers and USG (ultrasound) control from radiology. She explained that they performed total abdominal hysterectomy and bilateral salpingo-oophorectomy (TAH and BSO) surgery with the diagnosis of borderline ovarian tumor and then applied adjuvant chemotherapy treatment to such masses seen at that age. When my friend and I left the examination room, my friend asked me if I was okay, and I said I was fine. I still didn't think it was a very important mass because there was no cancer in our family, and I didn't think it was likely. Anyway, my pain was on the right side. I said to myself that it would become clear when the tumor markers were revealed. On the whole abdominal USG, it was stated to be an ovarian or Krukenberg tumor, a dense pelvic fluid with dense content. When I left the hospital to meet my daughter and husband, I looked at the results on the phone, and I saw that all tumor markers were very high. I had cancer... Ca19-9, Ca 15-3, and Ca 125 were very high. The cancer was present, and according to these values, it had metastasized everywhere. Ovarian cancer, breast cancer, pancreatic cancer... These were the values that had been examined. I wondered where else they might be seen when the PET (Position Emission Tomography) imaging was done. The highest value was for ovarian cancer, and when I came home, I started researching the new diagnosis that the doctor told me: borderline ovarian tumor.*

Borderline ovarian tumors (BOT) were first defined as “semi-malignant” ovarian tumors by Taylor in 1929 and were reported as 15% of all ovarian cancers (Fang et al. 2018; Hart 2005; Sozen et al. 2019). The annual prevalence of BOT was determined to be 1.8-4.8/100,000 (Fang et al. 2018). They constitute intermediate lesions between benign ovarian cysts and invasive carcinomas with different histopathologic characteristics (Carbonnel et al. 2021; Hart 2005; Sozen et al. 2019). BOT, most observed in women aged 30-50 within the reproductive age group, is diagnosed in approximately one-third of cases before the age of 40. The rate of BOT, which also accounts for 15-20% of epithelial ovarian cancers on average, shows an increasing trend (Wang and Liu 2022; Carbonnel et al. 2021). Although it has a favorable prognosis, it is reported to recur in the same or opposite ovary (Carbonnel et al. 2021).

Borderline ovarian cancers carry the risk factors and characteristics of epithelial ovarian cancer, except for the age of onset (Topfedaisi Özkan & Güngör 2015; Tropé et al. 2009). The risk of BOT is found to be higher in primary infertility and nulliparous patients, and it was reported to be associated with the use of infertility drugs (Sancı et al. 2014). Although oral contraceptives, pregnancy, and breastfeeding are considered protective factors, some studies showed that hormonal contraceptives had no protective effect (Fischerova et al. 2012; Tropé et al. 2012). Endometriosis and polycystic ovarian syndrome (PCOS) were also reported to increase the incidence of BOT (Fischerova et al. 2012). It was observed that hysterectomy surgeries performed with salpingectomy and high daily caffeine consumption (>828 mg caffeine) reduced the incidence of ovarian cancer and BOT. It was also reported that the incidence of BOT decreased by 7% for every 100 mg of caffeine taken daily (Gosvig et al. 2015).

When I was researching borderline ovarian tumors, I started to think *about the factors that could have caused cancer. I found myself receiving a nursing diagnosis from myself. I was 35 years old and was not obese. I did not smoke or drink alcohol. I gave birth and breastfed my baby. I did not have any systemic, chronic disease, nor was I on any medication. I had never had surgery. There was no history of cancer in my family. While thinking that genetic factors might lead to diabetes, asthma, and kidney-related diseases in my later years, I ended up with cancer. So, what was the factor that caused cancer?*

Diagnosis and Staging of Borderline Ovarian Tumor

Now that I had finished investigating the causes, I needed to know which stage I was in. The hospital I visited was not an institution that could cover all my treatment. We started looking for a new hospital and reached out to the head of the gynecology department at a training and research hospital. The physician on the phone said that he didn't think it was a serious situation at this age and invited me for an examination. When we visited him, he was really surprised to see the mass. He referred us to the division of gynecologic oncology. As a patient there, I realized that some people should not be health providers. They did not even take anamnesis and just examined and asked for tests. Tumor markers were requested again. Stating that ovarian cancers usually originate from the breast or gastrointestinal system, they asked for gastroscopy-colonoscopy and positron emission tomography (PET) imaging. The information and care were inadequate.

In tumor markers, my CA 19-9 value increased from 1900 to 20000, and we panicked. We thought that everything would suddenly get worse and called the first physician we consulted in that institution. He told us that the result was good, only the mass and marker in the ovary were significant, and there might not be anything serious in other areas. Accordingly, we continued *with the tests. A gastroscope-colonoscopy was performed. There was no mass, lesion, or tumor/cancer-suggestive image. A PET scan was performed.*

We went back to the gynecologic oncology clinic with the results and were told that we would see the head of the department. But later, we learned that he was out of the institution that day. When we searched for his name on our way home, we saw that he was in a private hospital. We made an appointment and went directly to him, telling him that we could continue our treatment there. However, he said, "You first went to the training and research hospital because I cannot treat you here. You should go there." According to him, we did not have the right to choose a physician and an institution. The method of examination was based on an outdated approach, not in line with modern medicine, and was reminiscent of the methods used in the 1950s. The physician stated that he planned to remove the intestine and plan a colostomy without any report. However, there was no pathological finding in my gastroscopy and colonoscopy results. When I stated that the results were clean, the physician confirmed this and said, 'You are not needed.' I considered it an advantage that I was a nurse, as I could recognize a wrong medical approach because of my professional knowledge and awareness.

Our search for a new hospital emerged, and with the support of my doctor friend, we found a gynecologic oncology physician in another training and research hospital. He immediately called me for an examination, took anamnesis, and listened to me. I was very surprised when the nurse told me to calmly explain everything in order because no one had listened to me until then. He evaluated all the results and examined me. He said, "In fact, all systemic examinations seem to be conducted, but only an imaging to identify the mass has not been performed." There had really been no intervention for the mass. With his guidance, we underwent a mammography with magnetic resonance imaging (MRI) to identify the type of mass. PET results came out *on the same day. In my opinion, there was no problem other than the mass in the ovary. We sent all the results to him, and he said that he would present all the data to the council and would get back to us with the final verdict. He was indeed a caring, knowledgeable, ethical, and well-equipped physician, and we decided to continue the treatment with him.*

Since the serum tumor markers and imaging of BOT are non-specific, it is very difficult to make a definitive diagnosis (Wang & Liu 2022). In this context, a speculative diagnosis can be made based on clinical findings, tumor markers, and imaging examinations (Sun et al. 2020). Clinical findings showed that approximately 30% of patients had no symptoms before diagnosis, and approximately 50-60% reported non-specific symptoms such as abdominal pain and bloating, nonspecific bleeding, and sexual discomfort (Gershenson 2017; Sun et al. 2020). Ovarian tumors appearing with rich solid tissue on imaging are considered malignant, and BOT can be diagnosed as a malignant tumor due to its solid appearance. While imaging of such solid ovarian tumors is most commonly performed with ultrasound (USG), imaging with secondary features such as magnetic resonance imaging or computerized tomography (MRI or CT) should be preferred. These imaging modalities help to diagnose solid components to characterize invasive peritoneal implants and tumor types (Zheng et al. 2021; Kim 2019; Wang & Liu 2022). However, for a definitive diagnosis, a pathologic examination indicating abnormal epithelial cell proliferation and the presence of microinvasion is necessary (Sun et al. 2020; Ushijima et al. 2015).

Depending on the type of tissue undergoing abnormal growth, BOTs are classified as mucinous borderline ovarian tumors (MBOTs), serous borderline ovarian tumors (SBOTs), endometrioid borderline tumors, clear cell borderline tumors, borderline Brenner tumors, and others (Sun et al. 2020; Hauptman et al. 2017).

Treatment of Borderline Ovarian Tumors

We were looking forward to the day of the council. Our physician called and informed us and invited us to the hospital for a detailed discussion. He said, "Dear Emek, there does not seem to be a problem except for the mass in the ovary. Your pancreas and colon examinations were repeatedly performed, and we did not find any findings that would explain the tumor markers." The tumor markers were secondary to the ovarian mass, and the PET images supported this result. However, the mass in the ovary was not a known type of mass, and our physician shared the MRI images with a radiologist in Ankara whose knowledge and experience he trusted very much. As a result, he said, "I discussed with five different physicians, and we were able to determine five different preliminary diagnoses." He emphasized three conditions, meaning three different treatment options. Plan 1: if an infection, simple adenoma, or mass was detected, an oophorectomy could be performed. Plan 2: if it were a malignant tumor, depending on the type, a fertility-sparing surgery or TAH+BSO+pelvic lymphadenectomy and omentectomy would be carried out. Plan 3: if it were a borderline ovarian tumor, depending on the case, TAH+BSO or oophorectomy+omentectomy+lymphadenectomy would be the solution. He also indicated that appendectomy and hyperthermic intraperitoneal chemotherapy (Heated Chemotherapy - HIPEC) could also be performed. He claimed that the intraoperative frozen section would determine the outcome. We agreed. Finally, he requested another contrast-enhanced abdominal MRI and infection parameters, and we had all of them done. There was no infection at all. It was as if I were going to war. In fact, wasn't this a fight for survival? I had experienced everything I wanted to live. I was at peace with my family, had experienced the joy of motherhood, and had a beautiful baby. My biggest motivation was not to let her grow up without a mother...

The decision taken at the last preoperative meeting was to proceed *according to the frozen result, and we stated that we accepted the TAH+BSO option if there was a possibility of recurrence. The physician prepared a complete list of what could be done: Debulking + TAH + BSO + omentectomy + pelvic-paraaortic lymphadenectomy + hemicolectomy (if epithelial ovarian carcinoma + appendiceal carcinoma were detected, but it was a low possibility) + HIPEC. HIPEC was a diagnosis I had never heard of before. When I was working at the hospital, we cared for chemotherapy patients together with the chemotherapy nurse for a long period in our clinic. But HIPEC was not a concept I had ever heard of.*

The treatment of BOT is based on many important elements. Early diagnosis, surgical scope and management, fertility preservation functions in patients with planned pregnancies, and the necessity of chemotherapy and in vitro fertilization (IVF) treatments should be considered (Wang & Liu 2022). Since BOT is characterized by a favorable prognosis with early diagnosis and treatment, the involvement of a multidisciplinary team is necessary to prepare an individual management plan on a case-by-case basis, to perform optimal and up-to-date treatment, and to minimize the risk of recurrence in this group of patients (Carbonnel et al. 2021). Current treatment for BOT includes TAH, unilateral or bilateral salpingo-oophorectomy, omentectomy, peritoneal biopsy and fluid sample, removal of all lesions, and appendectomy for mucinous BOTs. Although fertility-sparing surgery is gaining importance for BOTs seen at young ages, it was found that this approach increases the risk of recurrence but does not impact overall survival (Bostancı et al. 2014; Guvenal et al. 2013; Sun et al. 2020; Du Bois et al. 2016).

HIPEC is the intraperitoneal administration of chemotherapeutic agents heated to 41-43°C during surgery. In this context, while hyperthermia enhances the penetration of chemotherapeutic agents into the peritoneal surface, low plasma drug concentrations can reach all peritoneal surfaces, thereby reducing the risk of systemic toxic effects in the peritoneal cavity with intraperitoneal administration (Minareci et al. 2020; Jewell, McMahon & Khabele 2018).

Chemotherapy After Borderline Ovarian Tumors

All of that happened within 15 days. I underwent surgery less than a month after the diagnosis. The general surgeon who performed a physical examination before the surgery said that there were two umbilical hernias in the right abdomen. Then things fell into place. The pain I felt on the right side was hernia pain. The surgery was successful. However, uncertainties remained. The frozen result could only indicate that it was adenocarcinoma of ovarian origin. Our physician performed TAH+BSO+Omentectomy+Lymphadenectomy+Appendectomy surgeries and said that there was no need for HIPEC. All tumor markers regressed after surgery. It was time to wait for the pathology result. The pathology result showed mucinous adenocarcinoma. Our physician wanted to repeat the pathology and move on with chemotherapy. We asked for the pathology samples from the institution where I had surgery and were surprised to learn that some of them had been thrown away. We took the remaining samples and ran them again, but the staining processes they wanted could not be performed. The decision was up to medical oncologists. We consulted several medical oncologists, and all gave the same response: "Let us review your file and evaluate it at the council." The answer was never clear. Chemotherapy treatment was necessary for 50% and not necessary for the other half. I told them to tell me the 51%, and when I asked how they dealt with patients in this situation, I learned that they had never encountered such a case before. Even the literature seemed surprised by the situation. I was really exhausted and frustrated. Not the disease but the process was really tiring. We compiled all the results and consulted the oncology physician at the hospital where I had worked previously. His explanation was really *reassuring: "Emek, this is already a borderline ovarian tumor. It cannot be clearly diagnosed because it is an in-between type of tumor. It is suitable for all kinds of chemotherapy." When I told him that the pathology reports I had showed different results, his explanation was clear: "A report is what people look at and write what they see. This one looked at it and wrote this; that one looked at it and wrote that. They didn't look at the same sample anyway." So, what did I need to do? "Let us check the tumor markers first," he said. The treatment needed to be set with the results. Tumor markers tended to decrease significantly. With the recommendation of him and the physician who performed my surgery, we started chemotherapy. The same day, I asked him how many cycles I must have. He told me that everything should go step by step. First, the treatment would start, and after 3 cycles, CT, MRI, and tumor markers would determine the continuation of the treatment. When the tests following the third cycle were positive, the fourth cycle of chemotherapy was given, and adjuvant therapy was completed. That was an appropriate medical approach, I thought. Two times two does not always equal four in healthcare, and I knew that. It was a process. I was fortunate to be a nurse and had the opportunity to connect with the right physicians. However, I couldn't help thinking about the condition of people who lacked medical knowledge of such health problems.*

The necessity of planned chemotherapy, radiotherapy, and hormone therapies after BOT is a matter of debate in the literature. Recently, adjuvant treatment of BOTs has been performed with adjuvant platinum-based chemotherapy regardless of histopathologic subtypes; however, chemotherapy, radiotherapy, and hormone therapies are not recommended due to the excessive side effects and cases that do not benefit from postoperative adjuvant treatment involving invasive and non-invasive implants (Seong et al. 2015; Vasconcelos et al. 2015).

Psychosocial Aspects in Borderline Ovarian Tumors

It was time to continue our lives from where we left off with routine checks. At the request of my family, we applied to a psychiatrist. When he asked why I came, I said it was because my family wanted it. He thought that I would refuse the treatment. This process was not easy. I was really surprised when I realized it. However, my priority had to be the path I would follow. Yes, I was sad and scared, and I cried, but I completed the treatment. I thought a lot about what others would go through if I, as a mother and a nurse, could not overcome it. It had to happen, it happened, and it was over. It could have ended differently... It was an opportunity for me to question my life, and I questioned everything... Where I was, where my life was going... I was a mother, and I had a baby to raise. I had to be there for my daughter just like my mother was there for me throughout the whole process. Giving up was never an option for me...

Gynecological cancers cause significant changes in people's lives, and patients and their families may have complex emotional and behavioral reactions at various stages of the disease, such as diagnosis, treatment, recurrence, or palliative period (Eker & Aslan 2017; Karabinis et al. 2015). Many factors affect these reactions, and the most important of these are depression, body image, sexuality, fertility, infertility, spirituality, quality of life, family, and social support (Karabinis et al. 2015). In this regard, it is important to determine the psycho-social status and reactions and to meet the psycho-oncological treatment needs of these patient groups to ensure adaptation to the process. The focus of psycho-social care and treatment should aim to increase the patient's and family's adaptation to the disease by improving coping skills. Since chronic diseases affect the lives of individuals and their families in every aspect, a long-term follow-up is necessary (Eker & Aslan 2017).

Nursing Interventions in Borderline Ovarian Tumors

I questioned the nursing profession that I had practiced for years. In the car, on the way to the surgery, I thought, "I want to be cared for as much as I cared for others." No more, no less... The peace of mind was quite extraordinary. When I looked back, I realized that I slept with a clear conscience for years. I told the psychiatrist that I was open to treatment if he had *any suggestions. And he claimed that what I was going through was normal and did not plan any treatment. He ended the interview by telling me that I could reach him whenever I needed. Now it was time to rest...*

While questioning my profession, I also questioned the nursing care in my individual process. As a patient, I observed that I needed a nurse's counseling at every stage. I did not have any contact with any nurse during the examination and subsequent diagnosis. In the surgical process, nurses were experienced and knowledgeable in pre-operative and post-operative care. However, there was no intervention in terms of education and support during the discharge. I completed the chemotherapy process in a private oncology hospital and felt the importance of that care. Before chemotherapy, the training nurse would train you and explain the whole process. This ensured compliance with the treatment and let you know what to expect. Even if you were a nurse, you needed this explanation. I experienced the same situation during childbirth. Our pediatrician said, "I will tell you everything because now you are not only a nurse but also a new mother," and lightened the burden on me and reminded me of what I knew. At that point, I felt the same emotion. After the treatment, the process was completed with training on what to pay attention to, exercise, smoking, alcohol, nutrition, etc. I think the absence of nurse support where patients can receive counseling after discharge is also a big deficiency.

In the literature, it was reported that patients with gynecological cancer have information needs at every stage of the disease. Especially the course of the disease, future situations related to it, examinations before diagnosis, the diagnosis-treatment stage, and post-treatment, as well as medical, surgical, or oncological treatments, are among the most important information needs. In this context, information about the treatment and the process will positively affect the patient's compliance with the process. In cases of gynecological cancer, a multidisciplinary approach is necessary for the treatment and follow-up, and the education and counseling roles of nurses are very important (Beesley et al. 2018; Eker & Aslan 2017; Klafke et al. 2016). The purpose of the surgical procedure, the benefits of the treatment, and all complications that may develop afterward should be clearly explained to the patient and their family. In addition, meeting the patient's physiological care needs during the pre-operative and post-operative periods, as well as during radiotherapy and chemotherapy, is also an important element of care. Moreover, detecting, intervening, and preventing complications at an early stage are the basic scope of nursing care given to these patients (Eker & Aslan 2017; Klafke et al. 2016).

Conclusion

It has been about 4 years since those experiences with routine check-ups. When I look back, I see that correct diagnosis, treatment, and psychological support are fundamental in cancer. The paths to be followed were clear, and what to do during the period of uncertainty was explained in the literature. However, to realize them, we had to collaborate with an average of 60 physicians and 6-7 institutions in my experience. Not everyone may have had such a chance, and I was saddened by thinking about the patients and their families who would not have the chance to leave the institution where I had a negative experience. On the other hand, there were healthcare professionals who did not listen, understand, follow the right scientific approach, and guide.

However, we had health providers who understood, listened, guided, and were open to collaboration, helping me to go through that period comfortably… and I realized that the patients whose pain I shared for years would make my own process bearable...

Cancer, with the diagnosis and treatment, is an important process in which the patient and their family are affected multidimensionally and go through together. Uncertainty and cancer together are a challenging period. The role of nurses as members of the healthcare team in supporting the patient and their family is crucial. First and foremost, developing healthy lifestyle behaviors for the preservation and enhancement of health, and then planning necessary check-ups for cancer prevention, early diagnosis and treatment, and ensuring compliance with the diagnosis should be prioritized. It is among the roles of the nurse to continue the treatment appropriately and provide educational counseling and support for individuals diagnosed with cancer. It is believed that when qualified support is provided with such care, the adaptation of the patient and their family to the disease will be easier, and they will go through the process more comfortably. It is believed that when qualified support is provided with such care, the adaptation of the patient and their family to the disease will be easier, and they will go through the process more comfortably. In this context, autoethnography stands out as an important method, since it allows the voices, emotions, and lived experiences of both patients and healthcare professionals to be reflected in a way that traditional research methods may overlook.

By integrating personal narratives with scientific inquiry, autoethnography offers a unique perspective that contributes to a deeper understanding of the multidimensional effects of cancer and enriches the provision of holistic, patient- and family-centered care. In this regard, utilizing autoethnographic approaches can guide nurses and other healthcare providers in developing more empathetic, context-sensitive, and sustainable support practices throughout the cancer journey.

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