Ovarian Cancer - Established

Disclaimer

This pathway is about specialist management of ovarian cancer. See also:

- Familial Breast or Ovarian Cancer Syndromes
- Ovarian Cyst
- Ovarian Cancer Follow-up

Contents

Disclaimer 1

Background 2

About ovarian cancer 2

Assessment 2

Complications and side-effects 2

Management 3

Follow-up schedule 3

Cancer treatment summary letter 3

Intention of treatment 4

Prognosis 4

Histological type 4

Curative treatment 4

Non-hormonal or hormonal treatments 5

Side-effects of radiation or chemotherapy 5

Referral 6

Information 7

For health professionals 7

For patients 7

References 7

Background

About ovarian cancer

- *Ovarian cancer accounts for 3% of female deaths and the incidence increases with age.*
- *Late diagnosis is common in part due to vagueness of symptoms and lack of viable screening.*
- *The ovaries are made up of 3 main kinds of cells. Each type of cell can develop into a different type of tumour:*
  - *Epithelial tumours (85 to 95% of ovarian cancers) start from the cells that cover the outer surface of the ovary.*
  - *Germ cell tumours (5 to 8%) start from the cells that produce the ova.*
  - *Stromal tumours (5 to 8%) start from structural tissue cells that hold the ovary together and produce the female hormones oestrogen and progesterone.*
- *Metastasis can occur to ovaries i.e. Krukenberg tumour. Typically, metastases are from breast or gastrointestinal primary sites.*
- *The specialist team takes responsibility for diagnosis, staging, and management of cancer treatment. This pathway aims to improve general practitioner understanding of the patient's treatment course.*

Assessment

1. Take a history, ask:
   - about appetite, weight change, nausea, vaginal bleeding, vomiting, and abdominal, bowel, and urinary symptoms.
   - about ***complications and side-effects*** specific to ovarian cancer. Sensitive enquiry at an appropriate pace is essential – allow the patient to guide the timing and depth of enquiry.

Complications and side-effects

Consider asking about:

- *premature menopause – night sweats, hot flushes, reduced libido, reduced bone density, and vasomotor symptoms. Symptoms can be:*
  - *severe, especially after surgical menopause.*
  - *induced by surgery, radiotherapy, or chemotherapy.*
- *sexual dysfunction – vaginal dryness, vaginal bleeding, stenosis, dyspareunia, atrophic vaginitis, and pain.*
- *bowel and bladder function, particularly bowel or bladder incontinence, rectal bleeding, and haematuria.*

Sensitively explore feelings about:

- *any loss of fertility.*
- *other symptoms associated with treatment.*
- *surgically or chemically induced menopause.*

2. Record the patient's weight and vital signs.

3. If consistent with advice by the treating specialist, check for lymphadenopathy and perform a careful pelvic examination, including:
    - abdomen and radiation fields, and
    - abdomen for ascites.

4. Perform examination for:
    - metastases, especially liver and lungs.
    - signs of pleural effusion.

5. Only arrange CA 125 serum or other markers if requested by the gynaeoncology team, or there are new symptoms including bloating, decreased appetite, or pain. It may cause more harm than good.

6. Screen for other medical and psychosocial late effects associated with post-cancer treatment e.g. sexual intimacy issues.

Management

Management is guided by the ***cancer treatment summary letter*** from oncology services. See the ***follow-up schedule.***

Follow-up schedule

Year/s	Frequency	By
1 to 2	Every 3 months	Medical and gynaecological oncology multidisciplinary team
2 to 4	Every 4 to 6 months	Medical and gynaecological oncology multidisciplinary team
5	Every 6 months	Medical and gynaecological oncology multidisciplinary team
> 5 years	Annually	General Practitioner

Cancer treatment summary letter

Most importantly should include:

- *risk of recurrence and intentions of treatment.*
- *goals and quantitative benefit of proposed treatment.*
- *risks of treatment.*
- *what the patient has been told.*

Usually includes:

- *diagnostic tests performed and results.*
- *tumour characteristics and other factors determining prognosis.*
- *type and date of treatments and a treatment summary.*
- *expectations of disease course, including expected discharge from oncology services.*
- *interventions and treatment plans from other health professionals.*
- *a process for rapid re-entry to specialist medical services for suspected recurrence.*
- *a list of symptoms that might need prompt investigation.*
- *a list of supportive care services provided and a plan for community care services, including what each service is to provide.*
- *contact information for key care providers.*

1. If signs of bowel obstruction, symptomatic ascites, or pleural effusion, arrange immediate transfer to the nearest Emergency Department.
2. Refer for gynaecological oncology review if:
    - signs or symptoms suggestive of a recurrence, including bloating, decreased appetite, or pain.
    - unexplained weight loss or general malaise.
    - new or enlarging abdominal mass.
    - rise in CA 125 above normal.

3. Inform patient about management options and discuss the ***intention of treatment*** and long-term ***prognosis*** as outlined in the ***cancer treatment summary letter***. Discuss the recommendations from the gynaeoncology team, including ***histological type***, as this has a bearing on the preferred treatment.

Intention of treatment

- *Curative*
- *Improved longevity or life quality*
- *Palliative*

Prognosis

- *An individual's prognosis depends on the type and stage of cancer as well as their age and general health at the time of diagnosis.*
- *In Australia, the overall 5 year survival rate for women diagnosed with ovarian cancer is approximately 43%.*[3]
- *In 2013, there were 949 deaths caused by ovarian cancer in Australia.*[3]

Histological type

- *Epithelial ovarian cancer is commonly treated with:*
    - *surgery*
    - *chemotherapy*
    - *radiotherapy – in rare cases*
- *Non-epithelial ovarian cancer (only 2 to 4% of ovarian cancers) are usually treated with surgery and/or chemotherapy.*
- *Borderline tumours are usually treated with surgery only.*

4. If early stage cancer is diagnosed in a young woman, discuss fertility preservation or ova storage before definitive surgery and refer as appropriate.

5.

- For ***curative treatment***, manage treatment complications:

Curative treatment

Includes surgery and chemotherapy.

Surgery:

- *Staging surgery is performed and typically involves hysterectomy, omentectomy, and bilateral salpingo-oophorectomy.*

- *If the cancer is confined to 1 ovary, and fertility is important, the conservation of uterus, 1 ovary, and its fallopian tube is common in early stage cancer.*
- *Staging may also involve:*
  - *peritonectomy.*
  - *lymph node sampling.*

- *Cytoreductive surgery:*
  - *Usually done in preparation for chemotherapy, or after 3 cycles of chemotherapy (interval debulking surgery or IDS).*
  - *Debulking the tumour may involve:*
    - *partial removal of involved intra-abdominal organs.*
    - *omentum and/or diaphragmatic stripping.*

There is strong evidence to suggest that surgeons who undertake a high volume of resections have better clinical outcomes for complex surgery such as ovarian resections.[4]

Chemotherapy:

- *Usually consists of a platinum plus a taxane (carboplatin and paclitaxel is the most common regime).*
- *Is the usual or preferred choice for:*
  - *adjuvant (postsurgical) management, except when the prognosis is especially favourable e.g. early or well differentiated carcinoma.*
  - *neo-adjuvant (presurgical) management of advanced stage III or IV ovarian cancer.*
  - *peritoneal disease without an identified primary tumour (primary treatment).*

- Menopausal symptoms – a common complication of treatment.
- Vaginal dryness – ***non-hormonal or hormonal treatments.***

Non-hormonal or hormonal treatments

- *Non-hormonal treatments, such as Replens vaginal moisturiser, are strongly preferred.*
- *Vaginal oestrogen should be reserved for those patients who are unresponsive to non-hormonal remedies.*
- *Discuss with oncologist before commencing vaginal oestrogen.*
- *Data has not shown an increase in risk for local agents, but data based on HRT studies would suggest a cautious approach.*
- *Vaginal oestrogens are not contraindicated in hormone receptor negative tumours.*

- Fevers and possible infections from chemotherapy – discuss with the treating team immediately.
- ***Side-effects of radiation or chemotherapy*** and their sequelae of treatment – generally managed by the treating tertiary unit.

Side-effects of radiation or chemotherapy

- *Gastrointestinal sequelae, nausea, vomiting, diarrhoea, rectal bleeding, proctitis, incontinence.*
- *Hair loss (not carboplatin), skin rashes, mouth ulcers.*
- *Bladder problems, irritability, incontinence, haematuria.*
- *General symptoms, fatigue, lethargy, anorexia, mood, and cognition disturbance.*
- *Easy bruising or bleeding (consider FBE).*
- *Peripheral neuropathy.*

6. Use ***non-curative treatments*** for metastatic and palliative care patients. For control of palliative symptoms, refer to a specialist palliative care service.

   Non-curative treatments

   - *Palliative care of ovarian cancer targets complications of local or metastatic disease.*
   - *Radiation therapy may have a role in residual disease after surgery, or for palliative tumour mass reduction.*

7. Monitor medication compliance and side-effects.
8. Manage co-morbidities and intercurrent illnesses.
9. Avoid or defer minor procedures e.g. routine cervical screening during chemotherapy treatment.
10. For all patients, provide ongoing care, lifestyle advice, and support:
    - Patient information and support materials.
    - General advice on:
      - lifestyle changes
      - psychological needs
      - financial, legal, and practical needs
      - managing physical sequelae
      - cancer care services.
    - Consider:
      - counselling support
      - Advance Care Planning
      - Chronic Disease Management Items (CDM)
      - physiotherapy
      - a dietitian.

Referral

- If signs of bowel obstruction, symptomatic ascites, or pleural effusion, arrange immediate transfer to the nearest Emergency Department.
- Refer for gynaecological oncology review if:
  - signs or symptoms suggestive of a recurrence, including bloating, decreased appetite, or pain.
  - unexplained weight loss or general malaise.
  - new or enlarging abdominal mass.
  - rise in CA 125 above normal.
- For non-hormonal treatments, discuss with oncologist before commencing vaginal oestrogen.
- For control of palliative symptoms, refer for palliative care assessment.
- For follow-up, consider:
  - counselling support
  - physiotherapy
  - a dietitian.

Information

For health professionals

Further information

- Cancer Australia – Gynaecological Cancers: A Handbook for Aboriginal and Torres Strait Islander Health Workers and Health Practitioners
- Cancer Council Australia – Optimal Care Pathway for Women with Ovarian Cancer
- NICE Guideline – Ovarian Cancer: Recognition and Initial Management

For patients

- Australian Government, Cancer Australia:
  - Epithelial Ovarian Cancer: Understanding Your Diagnosis and Treatment
  - What is Ovarian Cancer?
- Cancer Council:
  - Cancer: What to expect
  - What to Expect: Ovarian Cancer
- Cancer Council Victoria – Aboriginal Communities: Information
- National Indigenous Cancer Network – About Cancer

References

1. Rustin G, van der Burg M. A randomized trial in ovarian cancer (OC) of early treatment of relapse based on CA125 level alone versus delayed treatment based on conventional clinical indicators (MRC OV05/EORTC 55955 trials). Asco University. 2009.
2. Esselen KM, Cronin AM. Use of CA-125 Tests and Computed Tomographic Scans for Surveillance in Ovarian Cancer. JAMA Oncology. 2016.
3. Cancer Australia. Cancer Australia, Australian Government. [place unknown]: Cancer Australia, Australian Government; Ovarian Cancer Statistics (C56). 2017. [cited 2017 Feb 01].
4. Bristow RE, Peiretti M, Gerardi M, Zanagnolo V, Ueda S, Diaz-Montes T, et al. Secondary cytoreductive surgery including rectosigmoid colectomy for recurrent ovarian cancer: operative technique and clinical outcome. Gynecol. Oncol. 2009 Aug;114(2):173-7.

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