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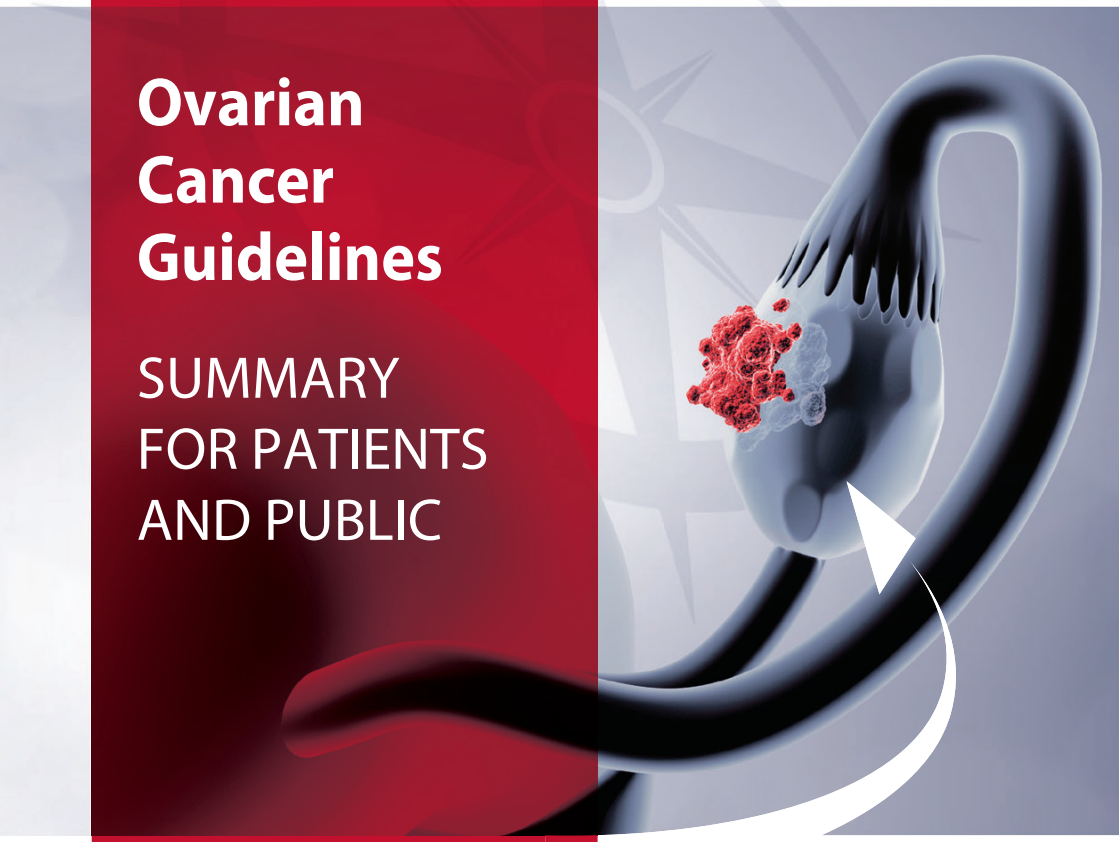
ESGO European Network of Gynaecological Cancer Advocacy Groups

Ovarian Cancer Guidelines

SUMMARY FOR PATIENTS AND PUBLIC



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OVARIAN CANCER GUIDELINES

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The European Society of Gynaecological Oncology (ESGO) is a non-profit organization dedicated to management and prevention of gynaecological cancer. If you wish to donate, please contact adminoffice@esgo.org. Your support will be appreciated and acknowledged.

Dear patient,

This document sets out the adapted guideline for the treatment of ovarian cancer. This is an up-to-date adaption for lay people (patients, but also a patient's relatives and friends) that has been modified from the European Society for Gynaecological Oncology (ESGO) professional guidelines that your medical team use when managing ovarian cancer.

It may be that, despite the adaptation, the technical content and terms will be difficult to understand fully. However, our aim is to show you what a professional guideline is like. Excessive simplification, which would make things look "simple", has been avoided.

We hope that after reading this guideline you will understand why your doctors ask you certain questions, administer various tests, discuss results, change decisions, and advise you to undergo or to refuse particular medical procedures. You will also see how strong and specific these recommendations sometimes are. You will see how tremendous knowledge and experience need to come together so that your medical team can foresee all the factors, including complicated ethical and psycho-social factors, needed to avoid clinical or technical errors.

On the other hand, recommendations are not always adapted to individual cases. In addition, guidelines from other international or national learned societies are available. Whatever the guidelines, your doctor is not "obliged" to follow them, but must show knowledge of them, and must explain to you the reasoning if he or she does not strictly follow them. You will see how difficult it can be sometimes to maintain an individualised, personalised attitude while simultaneously following the approved recommendations.

Finally, modern medicine is a close collaboration between doctor and patient. We must make common decisions to fight for your health, taking into account each other's opinions, experiences, feelings, and conditions. So, this adapted version of the professional guidelines is not only simple educational material about the disease but a real tool that can improve your understanding of the very serious work you and your doctor's team are undergoing to save your life and hopefully defeat the cancer definitively.

Sincerely,

Eka Sanikidze (GE), Dina Kurdiani (GE), Murat Gultekin (TR),
Karina Dahl Steffensen (DK), Esra Urkmez (USA), Denis Querleu (FR),
Nicoletta Cerana (IT), Elisabetta Ricotti (IT)

These guidelines from the European Society of Gynaecological Oncology (ESGO www.esgo.org) are focused on the role, objectives, and standards of the surgical management of diagnosed epithelial ovarian cancer, cancer of the fallopian tube (the pair of tubes along which eggs travel from the ovaries to the uterus), and the peritoneum (the serous membrane lining the cavity of the abdomen and covering the abdominal organs).

The objectives of these guidelines are to improve and standardise the management of patients with ovarian cancer.

The European Society of Gynaecological Oncology (ESGO www.esgo.org) is a non-profit organization dedicated to the treatment and prevention of gynaecologic cancers. If you wish to donate, please contact adminoffice@esgo.org. Your support will be appreciated and acknowledged.

The European Network of Gynaecological Cancer Advocacy Groups (ENGAGe) is a network of European patient advocacy groups established by ESGO in 2012, representing all gynaecological cancers, particularly ovarian, endometrial, cervical, vulvar, and rare cancers.

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1. DIAGNOSIS AND PREOPERATIVE WORKUP

- ✔ Clinical examination, including abdominal, vaginal, and rectal examinations; assessment of the breast, groins, axilla, and supraclavicular (above the clavicle) areas; and auscultation of the lungs (listening to the lungs through a stethoscope) should be performed.
- ✔ Routine pelvic transvaginal and transabdominal (through the vagina and abdomen) ultrasound should be used as a primary workup tool in any adnexal mass (lump in tissue of the adnexa, i.e., the fallopian tubes, ovaries, and ligaments of the uterus).
- ✔ Specialized pelvic, abdominal, and thoracic complementary imaging should be performed in case of suspected carcinoma of the ovary, or indeterminate or suspicious masses at routine ultrasound examination.
- ✔ There are some proteins known as cancer antigens that serve as markers for cancer. Our bodies make these normally, but when the proteins are present in high amounts they could indicate a tumour. One particular marker is when the protein CA125 is present at more than 35 kU/mL. Therefore, a tumour marker assessment should be performed for at least CA 125 levels. Levels of HE4 have also been proposed as a marker. Additional markers can be useful in specific circumstances, including when a patient is relatively young or if imaging suggests a non-epithelial (mucinous) tumour such as young age, or imaging suggesting a mucinous, or non-epithelial, or tumour of extra-adnexal origin.

2. OVARIAN CANCER STAGING

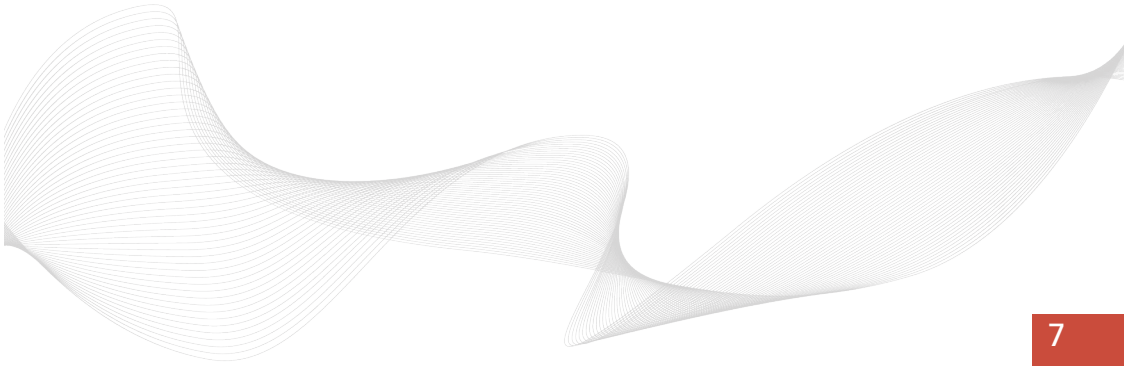
When doctors diagnose a patient with cancer, they use a scoring system to assess the spread of the cancer, if any, and assign it to a stage. This stage is then referenced to help the medical care team plan treatment. The most commonly used staging guide for ovarian cancer is the scoring system presented by the International Federation of Gynecology and Obstetrics (abbreviated **FIGO**). The system is regularly revised and updated. See **www.figo.org** for more information.

3. SPECIALISED MULTIDISCIPLINARY DECISION-MAKING

1. Women with non-emergency clinical presentation and suspected adnexal/peritoneal malignancy should be referred to a specialist in gynaecologic oncology.

✔ Surgery in low-volume and low-quality centres is discouraged. The existence of an intermediate care facility and access to an intensive care unit management are required. Participation in clinical trials is a quality indicator.

2. Treatment should be preoperatively planned at a multidisciplinary team meeting, after a workup aimed at ruling out (1) unresectable (unable to be removed with surgery) metastases and (2) secondary ovarian and peritoneal metastasis from other primary malignancies when family history, symptoms, radiological features, or Ca125/CEA (another marker for cancer) ratio is suggestive. Informed consent of the patient must be obtained.



4. SURGICAL MANAGEMENT FOR STAGE I–II OVARIAN CANCER

Midline laparotomy, a surgical incision into the abdominal cavity, for diagnosis or in preparation for major surgery, is recommended to surgically manage early ovarian cancers.

The availability of frozen section may allow the necessary surgical assessment to be completed at the time of initial surgery. It is understood that frozen section may not be conclusive, and that definitive pathology is the gold standard of diagnosis.

✔ In the absence of frozen section or in the case of an inconclusive frozen section a two-step procedure should be preferred.

✔ Total hysterectomy—a surgical operation to remove all or part of the uterus and bilateral salpingo-oophorectomy (removal of tubes and ovaries) are standard.

Fertility-preserving surgery (unilateral salpingo-oophorectomy) should be offered to selected premenopausal patients who wish to later become pregnant.

Laparoscopic restaging is an acceptable approach if performed by a gynaecologic oncologist with adequate expertise to perform a comprehensive assessment.

✔ Visual assessment of the entire peritoneal cavity is recommended.

When no suspicious implants are found in the pelvis, beside the colon, or under diaphragmatic areas, blind peritoneal biopsies (removal of tissues for checking) are recommended.

When early carcinoma is incidentally found at surgery for a suspected 'benign' condition, a second surgical procedure will be required when the patient has not been comprehensively staged.

5. SURGICAL MANAGEMENT FOR STAGE III–IV OVARIAN CANCER

✔ Midline laparotomy is required to manage stage III–IV ovarian cancers.

Complete resection of all visible disease is the goal of surgical management. Voluntary use of incomplete surgery (upfront or interval) is discouraged.

Primary surgery is recommended in patients who can be debulked (removal of as much of a tumour as possible) upfront until there is no residual tumour left with a reasonable complication rate.

Interval debulking surgery (secondary surgery which is performed after 2–4 cycles of neoadjuvant chemotherapy) should be proposed to patients fit for surgery with response or stable disease compatible with complete resection.

✔ If a patient did not have the opportunity of surgery after 3 cycles, then a delayed debulking after more than 3 cycles of neoadjuvant chemotherapy (chemotherapy before surgery) may be considered on an individual basis.

✔ A patient with an inoperable tumour who progresses during neoadjuvant chemotherapy should not be operated unless for palliative reasons that cannot be managed conservatively.

6. MINIMUM REQUIRED INFORMATION

✔ All necessary information about sites and size of the disease, tumour dissemination patterns, resections performed, and residual disease should be available in the operation protocol.

✔ The operation protocol should be systematically structured. Tumour dissemination patterns with site and size of the tumour lesions should be described at the beginning of the operation protocol.

✔ All areas of the abdominal and pelvic cavity should be evaluated and described.

✔ All the completed surgical procedures should be mentioned.

✔ If any, the size and location of residual disease should be described at the end of the operation protocol. Reasons for not achieving complete cytoreduction (When performed for curative intent, surgical debulking of tumors is known as cytoreduction) must be defined.

✔ At the minimum, the information contained in the ESGO operative report must be present.

✔ The pathology report should contain all necessary information.

✔ Surgical morbidity and mortality should be assessed and recorded, and selected cases should be discussed at morbidity and mortality conferences.

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ENGAGe would like to thank the authors, the contributors, and ENGAGe Executive Group members for their work and constant availability.

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Access the full ESGO Guidelines

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