North of Scotland Clinical Management Guideline (CMG): Ovarian Cancer

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For symptoms of suspected Gynaecological cancer, please refer to the Scottish Referral Guidelines for Suspected Cancer

Contents

Staging

All patients with a confirmed diagnosis of ovarian cancer will have their cancer staged using the FIGO system as documented on Page 8 of this CMG.

Cancer staging will allow a clinical decision on treatment options to be made in accordance with the guidance provided by this CMG in the management of patients aged 18 years and older with ovarian cancer.

General Principles

Referrals should be vetted in accordance with the Scottish Referral Guidelines for Suspected Cancer.
All patients must be discussed at MDT meetings throughout their patient journey as required.
All patients referred for investigation of symptoms potentially indicative of ovarian cancer should receive an appointment to a specialist outpatient gynaecology clinic.
All patients should be considered for surgery at MDT using the exclusions / inclusions on Page 5 to determine suitability.
Where available, clinical trials should always be considered as the preferred option for all eligible patients and consideration given to national referral.
Patients must be involved in all decision-making relating to their care with informed consent required for patients undergoing treatment.
A list of SACT regimens is provided (page 9).
Full regional SACT Protocols will be developed and linked to from this document.
Patients in follow-up will have access to a clinical nurse specialist throughout their follow-up and post-discharge for any further symptoms relating to treatment for ovarian cancer.
Patients will have a Holistic Needs Assessment undertaken as part of their pathway.

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Pre-Referral Investigations undertaken in Primary Care

Urgent Suspicion of Ovarian Cancer Referrals

Abnormal ultrasound scan and/or CA125 level
Ascites and/or ultrasound-confirmed pelvic or abdominal mass (that is not obviously uterine fibroids, gastrointestinal or urological in origin

Good Practice Points: An abdominal palpation should be undertaken, CA125 blood serum level measured and urgent pelvic ultrasound scan carried out in:
any woman over 50 years who has experienced new symptoms within the last 12 months that suggest irritable bowel syndrome or women (especially those over 50 years) with one or more unexplained and recurrent symptoms (most days) of:
- Abdominal distension or persistent bloating
- Feeling full quickly or difficulty eating
- Loss of appetite
- Pelvic or abdominal pain
- Increased urinary urgency and/or frequency
- Change in bowel habit

Primary care managment

Symptoms (as above) persisting or worsening for any woman who has a normal CA125 with normal ultrasound, assess for other clinical causes and investigate as appropriate or refer to appropriate secondary care services, depending on local arrangement.
Refer urgently or routinely, if symptoms persist, depending on the symptoms and the degree of concern about cancer.

Diagnosis of Ovarian Cancer

All Patients: Initial Investigations

Full medical history
Physical examination including Pelvis
Routine blood screen (Full Blood Count, biochemistry, CA125 and CEA; other germ cell tumour markers if indicated for women under 40)
If germ cell tumour, follow national guidelines for female germ cell tumour

All Patients: Further Investigations (if indicated)

Paracentesis
CT Chest, Abdomen & Pelvis*
Image guided biopsy of disease
Laparascopy if indicated
Calculate RMI** score
** as per guidelines on imaging of Gynaecological Malignancy*
*** RMI is a product of the ultrasound scan score, the menopause status and the serum CA125 level (IU/ml)*

All Patients: Other Considerations

Fertility expectations should be discussed.
All patients should be referred to identified Clinical Nurse Specialist (CNS) for assessment and ongoing support and advice. This is in addition to specialist referrals for clinical reasons.

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Evaluation	Treatment	Follow-Up

Suspected diagnosis of ovarian cancer with pathological / radiological evidence

Registration at regional Gynaecology MDT

If not already undertaken, CT or MRI staging imaging

All patients discussed at MDT before treatment decision

All Stages 1, 2, 3, 4

All patients considered for surgery according to NCA Guidelines for surgery decision-making *(see page 5)*

Yes - Up Front Surgery

Debulking surgery
TAH
BSO
Omentectomy
Peritonectomy
Bowel Surgery
Pelvic washings
Pelvic and retroperitoneal lymphadenectomy
Splenectomy
Liver surgery (surface / parenchymal)
Groin lymph nodes
Pelvic exenteration
Any other surgery

Histopathology report completed post-surgery

Consider SACT (see page 9)

CT & MDT DECISION RE: SURGERY AFTER 3 CYCLES

Yes - Interval Debulking Surgery

Ensure Histological / Cytological diagnosis obtained

NACT (see page 9)

No

Consider SACT (see page 9)

Consider IDS

Ensure Histological / Cytological diagnosis obtained

Follow-up at Gynaecology clinics for physical examination and imaging as required.

Support available from CNS for any symptomatic problems experienced including post-discharge.

(See page 7 for further information on follow-up)

Note: Patients to be considered for germline and somatic testing BRCA1+2 and HRD extended testing for Stage III and IV patients

1: Decision-making for Up Front Surgery (UFS)

INCLUSIONS	EXCLUSIONS

• Patients of all stages considered (able to be resected to <1cm residual disease)Biopsy proven low grade or clear cell advanced ovarian cancer (chemo resistant) should have primary surgery where feasible
• All extra-abdominal metastases (stage IV) should be considered potential indications for NACT/IDS, not primary surgery, except for the following:
  • Resectable inguinal lymph nodes
  • Pleural fluid that contains cytologically malignant cells without proof of the presence of pleural tumours (IVA).
  • Where considering the clinical significance of cardiophrenic nodes
	• Abdominal exclusion criteria:
	• Involvement of the root of the small bowel mesentery
	• Diffuse and confluent carcinomatosis of the stomach and/or small bowel that involves such large parts that resection would lead to a short bowel syndrome or a total gastrectomy
	• Intrahepatic metastases
	• Infiltration of the porta hepatis, duodenum and/or pancreas and/or the large vessels of the hepatoduodenal ligament or coeliac trunk
	• Patient characteristics:
	• Impaired performance status and comorbidity that does not allow a maximal surgical effort to achieve a complete resection;
	• Patients' nonacceptance of potential supportive measures, such as blood transfusions or temporary stoma
	• Significant recent arterial or venous clot <3months e.g. CVA, PE
	• Disease requiring ultra-radical surgery (NICE guidance 470) i.e. multiple resections of the bowel, liver resection, partial gastrectomy, cholecystecomy, (currently assessed by radiology but may need laparoscopy).
	•

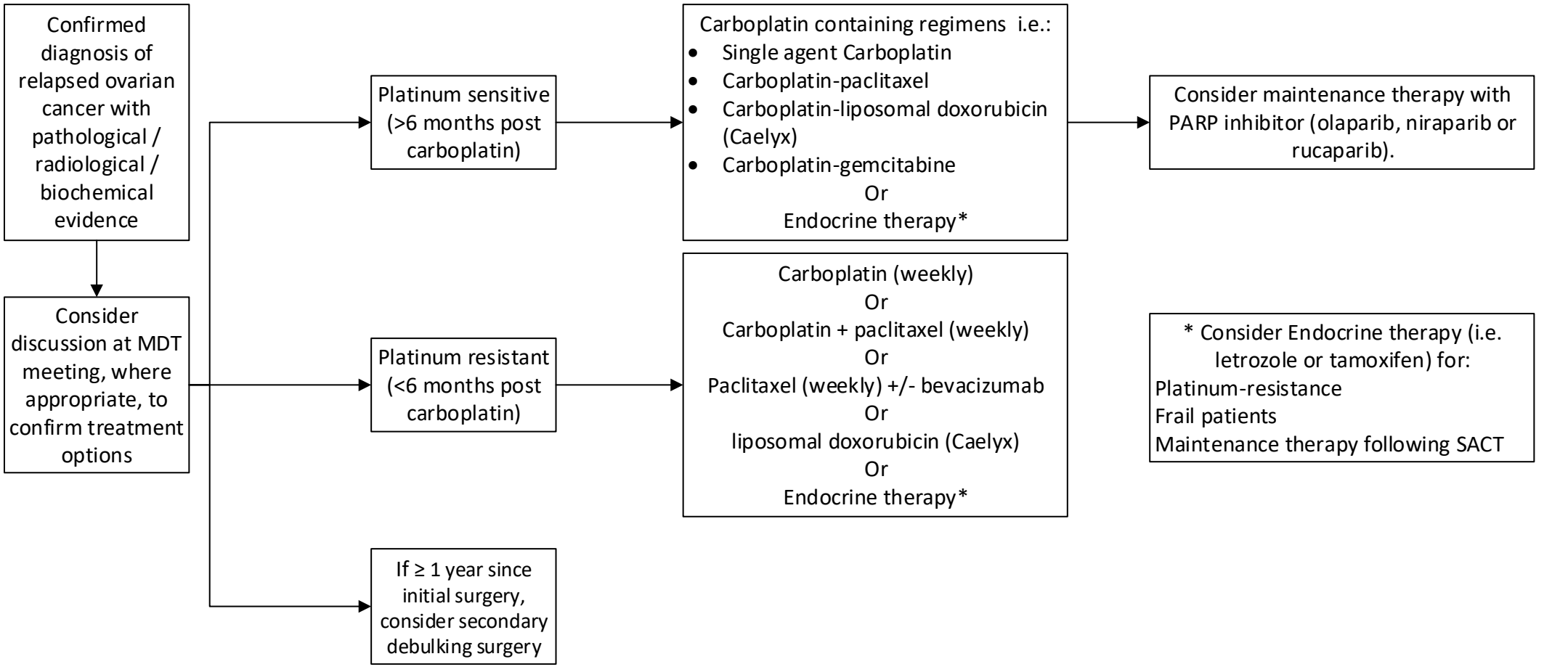
2: Decision-making for Interval Debulking Surgery (IDS) following NACT

INCLUSIONS	EXCLUSIONS
• 3 to 4 cycles of neoadjuvant platinum based chemotherapy (no published role after 6 cycles), or equivalent • No progressive disease (poor prognosis) • In the case of proven non-nodal extra-abdominal disease at diagnosis, the extra-abdominal disease should be resectable • Performance status and comorbidity that allows a maximal surgical effort to no residual disease • Able to have at least 2 cycles of chemotherapy after surgery	• Likely RD >2cm (which can be difficult to determine preoperatively and warrants attempt but to consider to stop surgery if at laparotomy becomes clear likely RD >2cm). Patients with symptomatic large masses may still benefit from surgery for symptom benefit. • No / minimal response to neoadjuvant chemotherapy • Progressive disease • Patient characteristics (relative contraindication) • Impaired performance status & comorbidity that does not allow a maximal surgical effort to achieve a complete resection • Patients' nonacceptance of potential supportive measures, such as blood transfusions or stoma • Significant recent arterial or venous clot <3months e.g. CVA, PE • No increase in CA125 • Disease requiring ultra-radical surgery (NICE guidance 470) i.e. multiple resections of the bowel, liver resection, partial gastrectomy, cholecystectomy

3: Decision-making for Secondary Debulking Surgery post-SACT

INCLUSIONS	EXCLUSIONS
• Only one line of previous chemotherapy • complete resection at first surgery • Performance status zero • Ascites < or = 500mls OR – any clear cell histology ovarian cancer relapse resectable to zero	• Under 6 months since last platinum chemotherapy (platinum resistant) • Symptomatic from relapse (not PS 0) • Comorbidity precluding maximal surgical effort • Radiological evidence of metastases not accessible to surgical removal (i.e. complete resection not deemed possible)

North of Scotland Clinical Management Guideline (CMG): Relapsed Ovarian Cancer Last Updated 05/04/2024



Multiple lines of treatment may be required. Choice will depend on a number of factors including previous response, duration of response, previous toxicities and patient preference.

North of Scotland Clinical Management Guideline (CMG): Follow-up to Ovarian Cancer Last Updated 05/04/2024

The follow-up schedules for Ovarian Cancer patients in the North of Scotland are indicative-only. Clinical judgement will determine the requirement for follow-up including any further imaging required depending upon patient factors and treatments undertaken.

Ovarian Cancer (Stage 1-4)

Years 1 & 2	Every 3 months at Gynae-oncology Clinic
Year 3 - 5	Every 6 months at Gynae-oncology Clinic

Consider discharge at 60 months if no evidence of disease recurrence.

Ongoing access to Gynaecology Clinical Nurse Specialist for symptomatic problems experienced ongoing post-discharge in each North of Scotland board.

Follow-Up to consist of physical exam at Gynae-Oncology Clinic and imaging as clinically indicated.

CA125 should not be performed routinely unless evidence of disease recurrence.

Where there is a recurrence in Ovarian disease, patient follow-up returns to Year 1 after subsequent treatment.

Where appropriate, consider patient initiated follow-up or extended follow-up.

The International Federation of Gynaecology and Obestrics (FIGO) staging (January 2014)

FIGO Staging			
1A	Tumour limited to 1 ovary, capsule intact, no tumour on surface, negative washings.		
1B	Tumour involves both ovaries otherwise like IA.		
1C	*[Tumour limited to 1 or both ovaries]*		
	1Ci	Surgical spill	
	1Cii	Capsule rupture before surgery or tumour on ovarian surface	
	1Ciii	Malignant cells in the ascites or peritoneal washings	
2A	Extension and/or implant on uterus and/or Fallopian tubes		
2B	Extension to other pelvic intraperitoneal tissues		
3A	[Positive retroperitoneal lymph nodes and /or microscopic metastasis beyond the pelvis]		
	3A1	Positive retroperitoneal lymph nodes only	
		3A1(i)	Metastasis ≤ 10 mm
		3A1(ii)	Metastasis > 10 mm
3A2	Microscopic, extrapelvic (above the brim) peritoneal involvement ± positive retroperitoneal lymph nodes		
3B	Macroscopic, extrapelvic, peritoneal metastasis ≤ 2 cm ± positive retroperitoneal lymph nodes. Includes extension to capsule of liver/spleen		
3C	Macroscopic, extrapelvic, peritoneal metastasis > 2 cm ± positive retroperitoneal lymph nodes. Includes extension to capsule of liver/spleen.		
4A	Pleural effusion with positive cytology		
4B	Hepatic and/or splenic parenchymal metastasis, metastasis to extra-abdominal organs (including inguinal lymph nodes and lymph nodes outside of the abdominal cavity)		

Neoadjuvant Carboplatin-paclitaxel (+/- bevacizumab if stage 4 disease) Carboplatin (if not suitable for/intolerant of taxanes)	**Primary SACT** Carboplatin-paclitaxel + bevacizumab (6 cycles) then bevacizumab (maintenance) + Olaparib (SMC 2368 - homologous recombination deficiency (HRD) positive status defined by either BRCA1/2 mutation and/or genomic instability) Carboplatin or Carboplatin-paclitaxel
Adjuvant Carboplatin-paclitaxel Carboplatin (if not suitable for/intolerant of taxanes) Carboplatin-liposomal doxorubicin	**Additional treatment options for advanced disease** Topotecan (weekly) Topotecan (days 1-5) Cisplatin Cisplatin-etoposide (Rotterdam) Liposomal doxorubicin (Caelyx)
Maintenance therapy after response to platinum based treatment (platinum sensitive) Olaparib (relapsed disease :- SMC 1047/15/SMC 2367- BRCA mutated) Olaparib (SMC 2368) plus bevacizumab Olaparib (newly diagnosed, advanced - SMC 2209) Rucaparib (relapsed disease - SMC 2224) Niraparib (relapsed disease - SMC 1341/18) Niraparib (advanced disease - SMC 2338)	**Relapsed disease** **(Platinum sensitive i.e. > 6 months post carboplatin)** Carboplatin Carboplatin-paclitaxel Carboplatin-liposomal doxorubicin Carboplatin-gemcitabine
Relapsed disease **(Platinum resistant i.e. < 6 months post carboplatin)** Carboplatin (weekly) Carboplatin – paclitaxel (weekly) Liposomal doxorubicin (Caelyx) Paclitaxel (weekly) Paclitaxel (weekly) + bevacizumab	For carboplatin allergy, consider a cisplatin-containing regimen. For paclitaxel allergy or intolerance, options include docetaxel containing regimen, e.g. carboplatin-docetaxel.

Endocrine therapy can be considered at all stages if ER positive

Definitions

BSO	Bilateral Salpingo Oophorectomy
CT	Computerised Tomography
IDS	Interval Debulking Surgery
MDT	Multidisciplinary Team Meeting
MRI	Magnetic Resonance Imaging
NACT	Neo-adjuvant Systemic Anti-Cancer Therapy
NCA	North Cancer Alliance
RMI	Risk of Malignancy Index
SACT	Systemic Anti-Cancer Therapy
TAH	Total Abdominal Hysterectomy
UFS	Up Front Surgery