

CHEMOTHERAPY (Contd.)

- In relapsed disease:
 - the optimal agents in platinum-resistant disease have yet to be defined and treatment should be based on specialist judgement
 - cautious clinical judgement should be used when considering the use of platinum and paclitaxel in patients with symptomatic platinum-sensitive cancer recurrence after a treatment free interval of 6-12 months.
- B** If erythropoetin is used to treat anaemia it should only be when the haemoglobin concentration is ≤ 10 g/dL and the dose should not exceed 450 units/kg/week.
- Intraperitoneal therapy should not be routinely offered outwith clinical trials.
- D** Administration of chemotherapy:
 - staff should be experienced, trained in the safe administration of chemotherapy and be involved in on going continuing professional development and reappraisal
 - hospital based administration should take place during the working day in designated areas equipped to deal with any medical emergencies.
- D** Women should be given accurate information on their likely response to chemotherapy, including adverse effects, so that they can make an informed decision on whether or not to proceed.
- D** The impact of chemotherapy toxicities on patients' quality of life must be balanced against their anticipated response to treatment.

FOLLOW UP

- Patients who are not in clinical trials should be followed up within local multidisciplinary specialist clinics.
- The primary care team should be made aware of the follow up protocol for those patients not in trials.

MANAGEMENT OF MALIGNANT BOWEL OBSTRUCTION

- C** Surgery for malignant bowel obstruction in patients with advanced ovarian cancer must be justified on the basis of achieving a significant benefit.
- C** Symptoms of bowel obstruction can be relieved by using the following drug categories either alone or in combination:
 - antiemetic
 - antisecretory
 - analgesic
 - corticosteroids.

SPECIALIST PALLIATIVE CARE

- B** Patients with advanced ovarian cancer require a coordinated, multiprofessional approach with access to a specialist palliative care team.
 - D** Patients with persistent poorly controlled symptoms should be referred to specialist palliative care.
- INFORMATION FOR PATIENTS**
- C** Patients should be offered verbal and written information throughout their journey of care and should be made aware of support mechanisms in place and how to access them.
 - C** Structured emotional support should be available to all patients and carers.
 - Voluntary sector agencies can be used to expand the levels of support available to patients and carers.

SOURCES OF FURTHER INFORMATION FOR PATIENTS AND CARERS

CANCERBACUP SCOTLAND
Suite 2, 3rd floor, Cranston House
104-114 Argyle Street, Glasgow G2 8BH.
Tel: 0141 223 7676, Fax: 0141 248 8422.
Freephone help line: 0808 800 1234, available 9am to 7pm,
Monday to Friday
www.cancerbacup.org.uk

MAGGIE'S CENTRES SCOTLAND
www.maggies.ed.ac.uk
maggies.centre@ed.ac.uk

TAK TENT CANCER SUPPORT SCOTLAND
Flat 5, 30 Shelley Court, Gartnavel Complex
Glasgow, G12 0YN.
Tel: 0141 211 0122, Fax: 0141 211 3988
www.taktent.org.uk
email: tak.tent@care4free.net

OVACOME
Elizabeth Garrett Anderson Hospital
Huntley Street, London, WC2E 6DH.
Office is staffed Monday to Friday 9am to 4pm
Tel: 020 7380 9589
www.ovacome.org.uk/
email: ovacome@ovacome.org.uk



Epithelial ovarian cancer

This Quick Reference Guide provides a summary of the main recommendations in the SIGN guideline on epithelial ovarian cancer

This guideline contains recommendations for effective practice based on current evidence.

The recommendations are graded **A B C D** to indicate the strength of the supporting evidence.

Good practice points are provided where the guideline development group wishes to highlight specific aspects of accepted clinical practice.

Details of the evidence supporting these recommendations can be found in the full guideline, available on the SIGN website: www.sign.ac.uk

SCREENING

Women with a family history that appears to put them at high risk of developing ovarian cancer should be offered referral to a Clinical Genetics Service for assessment and confirmation of their family history. They may then be eligible for referral for screening via a research trial.

Close collaboration between primary care and specialist cancer genetics services should be developed and encouraged so that genetic cancer risk assessment can be carried out efficiently.

Primary care clinicians should formally enquire about the woman's family history.

D Screening for ovarian cancer in high risk groups should only be offered in the context of a research study designed to gather data on:

- sensitivity and specificity of the screening tool
- FIGO stages of cancers detected through screening
- residual risk of primary peritoneal cancer following prophylactic oophorectomy.

D Screening programmes for women at increased risk of ovarian cancer should include mechanisms for providing emotional and psychological support.

C Women with genetic mutations of BRCA1 or BRCA2 genes should be counselled regarding prophylactic oophorectomy and removal of Fallopian tubes at a relevant time of their life.

High risk women in whom mutations have not been identified should be counselled at around the age of 40 years regarding prophylactic oophorectomy.

Women who decide to have prophylactic oophorectomy should be offered counselling, support and information before and after surgery.

DIAGNOSIS

GPs should include ovarian cancer in the differential diagnosis when women present with recent onset persistent non-specific abdominal symptoms (including women whose abdominal and pelvic clinical examinations appear normal).

D Women with a pelvic mass should be referred to gynaecology irrespective of the CA125 test result.

C

- The RMI scoring system is the method of choice for predicting whether or not an ovarian mass is likely to be malignant.
- Women with an RMI score >200 should be referred to a centre with experience in ovarian cancer surgery.

SURGERY

C Preoperative bowel preparation in ovarian cancer patients should be undertaken where clinical findings and imaging reveal that advanced disease with bowel involvement is present.

B Patients for whom preoperative bowel preparation is indicated should see a trained stoma nurse for counselling and potential stoma site marking.

D Serum CA125 levels are useful in predicting disease bulk and should be assayed preoperatively in women with pelvic masses.

D Routine preoperative CEA estimation should not be performed in patients with ovarian cancer.

D To minimise the need for a second operative staging procedure, intraoperative frozen section assessment can be used to diagnose malignancy and to exclude metastatic disease.

In early disease:

- staging should be through a mid-line incision to allow palpation of all peritoneal surfaces
- assessment of peritoneal cytology, hysterectomy, removal of ovaries and Fallopian tubes and infracolic omentectomy should be performed
- capsular rupture during surgery should be avoided
- aim to exclude disease involving the liver, spleen, peritoneum, retroperitoneal nodes, appendix and diaphragm by close clinical inspection and palpation
- cases where only the ovarian cyst was removed should be discussed within the multidisciplinary team and if there is concern that there is a likelihood of metastatic disease restaging is recommended.

In women who wish to conserve their fertility a unilateral salpingo-oophorectomy may be performed if the contralateral ovary appears normal.

C In advanced disease:

- if aggressive cytoreduction is not possible then optimal cytoreduction is the recommended surgical procedure if performance status allows this to take place.

D In advanced disease:

- patients with stage III disease should be operated on by a gynaecological oncologist rather than a general gynaecologist or a general surgeon.

In advanced disease:

- bowel surgery should only be performed where obstruction is imminent or where it enables optimal cytoreduction or aggressive cytoreduction to be achieved.

C Interval debulking surgery is recommended, if performance status allows, where there is evidence of response to chemotherapy as determined by CA125 and imaging.

Patients should be given their diagnosis of ovarian cancer after surgery in the presence of a nurse who is a fully integrated member of the clinical team. If a nurse specialist is not available this should be a dedicated named nurse or link nurse.

Patients with ovarian cancer should have access to an appropriately trained nurse, who is an integral member of the gynaecological cancer team, throughout their journey of care.

CHEMOTHERAPY

Chemotherapy should be started no later than eight weeks after surgery.

B Carboplatin can be offered to all early stage epithelial ovarian cancer patients.

Chemotherapy for patients with disease confined to the ovaries where the tumour is well differentiated (FIGO stage 1a grade 1 and FIGO stage 1b grade 1, see Annexes 1 and 2), may be deferred if optimal surgery has been performed.

In advanced disease:

A

- first line chemotherapy treatment should include a platinum agent either in combination or as a single agent, unless specifically contraindicated
- carboplatin is the platinum of choice in both single and combination therapy
- paclitaxel is recommended in combination therapy with platinum in first line post-surgery treatment where the potential benefits justify the toxicity of the therapy
- patients who choose less toxic therapy or who are unfit for taxanes should be offered single agent carboplatin
- cyclophosphamide is not recommended in first line chemotherapy treatment.
- anthracyclines are not recommended in first line chemotherapy treatment outside RCTs.

In relapsed disease:

B

- chemotherapy for recurrent ovarian cancer should be regarded as palliative in intent and should be reserved for symptomatic recurrence of disease
- symptomatic platinum-sensitive cancer recurrence should be treated with further platinum and paclitaxel.

In relapsed disease:

C

- Tamoxifen should be considered in patients for whom chemotherapy is not appropriate.