

Optimal care pathway for women with ovarian cancer

Quick reference guide



Please note that not all women will follow every step of this pathway:

Support: Assess supportive care needs at every step of the pathway and refer to appropriate health professionals or organisations.

Step 1

Prevention and early detection

Prevention: For women at potentially high risk of ovarian cancer, general/primary practitioner referral to a familial cancer clinic is recommended for risk assessment, possible genetic testing and management planning (which may include risk reducing surgery).

For women who are considering risk-reducing surgery, the surgeon should provide clear information about the objective of the procedure, discuss management of menopausal symptoms and other long-term side effects, and discuss the factors influencing psychosocial wellbeing post surgery.

Risk factors: A small proportion of women develop ovarian cancer as a result of inherited risk. These women may be identified by individual, family history or tumour pathology characteristics.

Step 2

Presentation, initial investigations and referral

Signs and symptoms:

Symptoms are vague and non-specific, but persistent symptoms should be investigated, particularly in older women or those with family history. Symptoms may include:

- abdominal bloating
- increased abdominal girth
- abdominal and/or pelvic pain
- indigestion
- lack of appetite
- feeling full after only a small amount of food
- weight gain or weight loss
- change in bowel habits
- fatigue

- urinary frequency or incontinence
- feeling of pressure in the abdomen.

General/primary practitioner investigations:

- a general and pelvic examination
- pelvic ultrasound (preferably trans-vaginal)
- use of a risk of malignancy index and other algorithms such as the ADNEX model
- CT scan if appropriate
- routine blood tests and CA 125.

Results should be available and the woman reviewed by the general practitioner within one week of the investigations.

Referral: If the diagnosis can be confirmed with initial tests, then referral to a gynaecological oncologist is optimal. Optimally, the specialist appointment should be within two weeks of suspected diagnosis.

Communication – lead clinician to:

- explain to the woman/carer who they are being referred to and why, and the expected timeframe for appointments
- support the woman while waiting for the specialist appointment.

Step 3

Diagnosis, staging and treatment planning

Diagnosis: After a thorough medical history and examination, the following sequence of investigations may be considered:

- pelvic ultrasound (preferably trans-vaginal)
- routine blood and tumour marker tests
- chest x-ray
- contrast-enhanced computed tomography (CT) scan or magnetic resonance imaging (MRI) abdomen/pelvis.

Other investigations may be considered including fluid aspiration for cytology (pleural or peritoneal) and CT-guided biopsy. Investigations should be completed within two weeks of specialist review.

Staging: Staging for ovarian cancer is generally pathological following surgery.

Treatment planning: All newly diagnosed women should be discussed in a multidisciplinary

team meeting so that a treatment plan can be recommended. Referral to a fertility expert for premenopausal women should be considered.

All women diagnosed with epithelial ovarian cancer who are aged 70 years or younger should be offered genetic testing for BRCA1/2 and should be referred to a familial cancer centre.

Research and clinical trials: Consider enrolment where available and appropriate.

Communication – lead clinician to:

- discuss a timeframe for diagnosis and treatment with the woman/carer
- explain the role of the multidisciplinary team in treatment planning and ongoing care
- provide appropriate information or refer to support services as required.

1 Lead clinician – the clinician who is responsible for managing patient care.

The lead clinician may change over time depending on the stage of the care pathway and where care is being provided.

Step 4

Treatment:

Establish intent of treatment:

- curative
- anti-cancer therapy to improve quality of life and/or longevity without expectation of cure
- symptom palliation.

Treatment options

Surgery: Surgery can be used as a therapeutic modality and also to adequately stage the disease.

The type of surgery offered will depend on a number of factors: the stage of the disease, the age and performance status of the woman and the desire to retain fertility.

Except for early-stage and well-differentiated disease, women are usually treated with surgery and chemotherapy.

Chemotherapy and other systemic therapy:

Chemotherapy or drug therapy may be appropriate as neo-adjuvant or adjuvant treatment, or as a primary treatment modality.

Radiation therapy: Some women may benefit from radiation treatment for symptomatic relief and palliation of metastatic or recurrent disease; selected cases may also be considered as part of primary treatment.

Loss of fertility following treatment that might induce a premature menopause, requires sensitive discussion.

Palliative care: Early referral can improve quality of life and, in some cases, survival. Referral should be based on need, not prognosis.

Communication – lead clinician to:

- discuss treatment options with the woman/carer including the intent of treatment and expected outcomes
- discuss advance care planning with the woman/carer where appropriate
- discuss the treatment plan with the woman's general practitioner.

For detailed information see <http://canceraustralia.gov.au/publications-and-resources/cancer-australia-publications/>

Step 5

Care after initial treatment and recovery

Ongoing assessment of the effects of surgical menopause is required.

The woman/carer and her general practitioner should be provided with the following to guide care after initial treatment.

Treatment summary outlining:

- diagnostic tests performed and results
- tumour characteristics
- type and date of treatment(s)
- interventions and treatment plans from other health professionals
- supportive care services provided
- contact information for key care providers.

Follow-up care plan outlining:

- medical follow-up required
- care plans for managing the late effects of treatment
- a process for rapid re-entry to medical services for suspected recurrence.

Communication – lead clinician to:

- explain the treatment summary and follow-up care plan to the woman/carer
- inform the woman/carer about secondary prevention and healthy living
- discuss the follow-up care plan with the general practitioner.

Step 6

Managing recurrent, residual and metastatic disease

Detection: Most cases of recurrent disease will be detected by routine follow-up or when the woman presents with symptoms.

Treatment: Where possible, refer the woman to the original multidisciplinary team. Treatment will depend on the location, the extent of recurrence, previous management and patient preferences.

Palliative care: Early referral can improve quality of life and, in some cases, survival. Referral should be based on need, not prognosis.

Communication – lead clinician to:

- explain the treatment intent, likely outcomes and side effects to the woman/carer.

Step 7

End-of-life care

Palliative care: Consider referral to palliative care if not already involved. Ensure that an advance care plan is in place.

Communication – lead clinician to:

- be open about the prognosis and discuss palliative care options with the woman/carer
- establish transition plans to ensure the woman's needs and goals are addressed in the appropriate environment.

Visit www.cancerpathways.org.au for consumer friendly guides. Visit www.cancer.org.au/OCP for the full clinical version and instructions on how to import these guides into your GP software.