## Optimal care pathway for women with ovarian cancer

### Quick reference guide

**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.

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### Step 1: Prevention and early detection

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

### 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.

### 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 pre-menopausal 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:**

- 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

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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.
### 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.

### 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.

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### 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:**
- 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.

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### 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
- 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.

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### 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:**
- 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.

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This work is available at: www.cancer.org.au/ocp