Optimal care pathway for women with ovarian cancer

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 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.

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 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:

- 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.

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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.

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


This work is available at: [www.cancer.org.au/ocp](http://www.cancer.org.au/ocp)