Ovarian, Fallopian Tube and Primary Peritoneal Cancers

Cancer Centre of Southeastern Ontario
Standard Management Guidelines

Intended for use by Clinicians and Health Care Providers involved in the Management or Referral of adult patients with epithelial ovarian, fallopian tube or primary peritoneal cancer

Section	Activity	Activity Description	Details	Reference(s)
AA	Cancer Centre Referrals		• Risk of Malignancy Index (RMI) score 200+ [defined by characteristics of the mass on imaging x menopausal status x CA125] • Solitary large complex mass (Query >10 cm) • Bilateral complex adnexal mass • Ascites • Imaging evidence of metastatic disease • Definitive surgical treatment should be performed by gynecologic oncologists, mandating referral to the Cancer Centre of Southeastern Ontario (CCSEO)	[1] [2] [7]
A	Diagnosis		• Ideally via histology: at primary surgery or Interventional Radiology (IVR) directed biopsy • In certain clinical presentations, malignant cytology with an elevated CA125 may suffice • If considering debulking surgery, IVR directed biopsy preferred to potentially allow clinical trial enrollment	
B	History and Physical Exam		• Symptomatology, constitutional symptoms • Family history of breast, ovarian, colorectal, or endometrial cancer • Bimanual internal and speculum examination • Breast exam	

Section	Activity	Activity Description	Details	Reference(s)
			• Assessment of chest for effusions • Assessment of the abdomen for organomegaly, masses, or ascites	

C	Investigations		• Blood work including CBC/diff, PT/INR, electrolyte, creatinine, albumin, creatinine, bilirubin, liver enzymes, and CA125
			• AFP, HCG, and LDH if considering a germ cell malignancy
			• Pelvic and transvaginal ultrasound
			• Imaging to be considered
			  o CT scan of abdomen and pelvis ± chest
			  o MRI not routinely required: decision to order MRI to be made at CCSEO
			  o No indication for PET scan at initial presentation
			• CT Chest/Abdomen/Pelvis if considering a germ cell malignancy	

D	Pathology of diagnostic specimen	Synoptic Report	• Pathology to be reviewed at CCSEO Multidisciplinary Cancer Conference (MCC) prior to management decisions or recommendations • CAP Ovary Protocol Version: Ovary 3.2.0.0	[2] [3]
E	Post-Investigation Management	Curative Intent	• Surgery to be performed at a Tertiary Care Centre • May be primary (staging and/or de-bulking) or secondary (interval debulking) surgery • In the absence of obvious extra-ovarian disease, complete	[2]

Section	Activity	Activity Description	Details	Reference(s)
			surgical staging should be performed and include: o Washings or ascites for cytology o Mid-line incision for adequate inspection o TAH-BSO (conservative surgery in selected cases*) o Subtotal omentectomy o Peritoneal biopsies – random and any suspicious lesions o Pelvic node dissection – ipsilateral ± contralateral as indicated o Para-aortic node dissection when indicated (when risk of PA involvement > 10%) o Appendectomy (in mucinous malignancies) o Assessment of the undersurfaces of the diaphragms (cytology or histology)	
			• Adjuvant chemotherapy in patients with proven extra-ovarian disease or high risk situations (e.g. high grade or dense adhesions) o Carboplatin with Paclitaxel every 21 or 28 days (CRBPPACL) [our centre routine is 28 days] o Carboplatin day 1 with Paclitaxel days 1, 8, 15, every 21 to 28 days (CRBPPACL(W)) o Or, other regimens as per CCO funded guidelines	[4] Adjuvant/Curative/Neo-adjuvant Ovarian Cancer Regimens

Section	Activity	Activity Description	Details	Reference(s)
			○ Typically 6 cycles, but may consider 8-9 cycles in cases of falling CA125, good chemotherapy tolerance • *Conservative surgery may be considered in: ○ Fertility preservation in selected patients with early stage disease ○ Patients with co-morbid conditions where goal is optimal debulking but with minimizing peri-operative risks **Prophylactic Surgery**: Prophylactic surgery (e.g. hysterectomy, BSO) may be offered based on supporting family history and patient preference. If surgery done by regional gynecologists, pathology review at CCSEO MCC is required.	

Section	Activity	Activity Description	Details	Reference(s)
		Curative Intent (Stage II or III)	Presence of obvious extra-ovarian disease • Attempt at optimal debulking (no macroscopic residual) • Placement of I.P. Port in patients optimally debulked or residual ≤1 cm in patients who are intraperitoneal chemotherapy candidates Candidates for I.P. Chemotherapy: • Carboplatin IP and Paclitaxel IV day 1 with Paclitaxel IP day 8 every 21 days for 6 cycles (CRBPPACL(IP)) • Alternative regimen PACL CARBO IP/IV ADJ Non I.P. chemotherapy candidates: • Carboplatin and Paclitaxel IV every 21 to 28 days for 6 cycles (CRBPPACL, CRBPPACL(W)) • OR, other regimens as per CCO funded guidelines	IP Policy 2015 [4] Adjuvant/Curative/Neo-adjuvant Ovarian Cancer Regimens
		Primary Peritoneal Cancer (ppc)	Patients with evidence of intra-abdominal carcinomatosis and ascites but without evidence of adnexal masses may have a diagnosis of ppc. These patients require management steps: • biopsy to confirm serous histology • CA125 tumour marker • Chemotherapy similar as for ovarian cancer, including CRBPPACL and CRBPPACL(W) • Patients with response to chemotherapy may be considered	

Section	Activity	Activity Description	Details	Reference(s)
			for interval debulking; these cases should be presented at MCC for discussion around surgical options.	
		Advanced Disease (Non-Curative Intent)	Chemotherapy in patients with proven extra-ovarian disease • Carboplatin with Paclitaxel every 21 or 28 days (CRBPPACL) • Carboplatin day 1 with Paclitaxel days 1, 8, 15 every 21 to 28 days (CRBPPACL(W)) • OR, other regimens as per CCO funded guidelines • Typically 6 cycles, but may consider 8-9 cycles in cases of falling CA125, good chemotherapy tolerance	[5] Palliative Ovarian Cancer Regimens
		Locally Recurrent Disease	In select cases, secondary debulking may be considered (recurrence after one year of completion of first line chemotherapy, solitary recurrence, no ascites) following MCC discussion	
		Recurrent Disease	Second line chemotherapy based upon platinum sensitivity (No disease progression on platinum and recurrence greater than 6 months from completion of chemotherapy Doublet chemotherapy if recurrence greater than 12 months following completion of chemotherapy and a good performance status • Carboplatin with Paclitaxel every 21 to 28 days (CRBPPACL) • Carboplatin on Day 1 with Paclitaxel on days 1, 8, and 15 every 21 to 28 days (CRBPPACL(W))	

Section	Activity	Activity Description	Details	Reference(s)
			• Patients with Carboplatin allergy with objective evidence of Platin sensitivity may be considered for Cisplatin desensitization Where the decision is to use single agent chemotherapy: • Carboplatin or Cisplatin until resistance or allergy • Paclitaxel days 1, 8, and 15 every 21 to 28 days • Caelyx every 28 days • Gemcitabine days 1, 8, and 15 every 21 to 28 days • OR, other regimens as per CCO funding guidelines Radiation may be considered in select cases with localized symptomatic disease The Palliative care team should be consulted for patients who have problematic cancer symptoms and for patients no longer on active treatment	
		Decision to forego further palliative chemotherapy	While this decision is predicated on discussion with patient and family, the DSG supports that chemotherapy should not be offered once a patient is platinum resistant and has not responded to two further lines of chemotherapy.	
		Palliative Care	Early referral to the palliative care team is encouraged in advanced	

Section	Activity	Activity Description	Details	Reference(s)
			cancer cases	
F	Follow-up with no Evidence of Disease		• Reassessments in the clinic every 3 to 4 months for 2 years • Followed by reassessments in the clinic every 6 months until 5 years from completion of chemotherapy • At follow-up visit, bimanual pelvi-rectal and speculum exam is considered routine, but vault cytology is not necessary in the absence of a mass lesion or visual changes. • In the absence of symptoms or clinical findings, there is no indication for routine imaging • Following CA 125 levels should not be routinely considered, as has not been shown to improve clinical outcomes	
		Management of Familial Issues	• Consider referral for: o All TIC (Tubal Intraepithelial Carcinoma) cases o Serous HG ovarian o Appropriate to family history Familial referrals should be managed in the context of the familial oncology program.	
G	Controversies	Borderline tumours of the	• Borderline ovarian tumours – not covered in detail by this	

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		Ovary	guideline; however, all cases to have pathology review at MCC to confirm diagnosis and determine follow-up recommendations • If surgery occurs in community (i.e. generalists), pathology to be reviewed at tertiary centre in conference	
		Prophylactic Bilateral-Salpingo-Oophrectomy (BSO)	• Systemic therapy is offered in the presence of TIC (3 cycles of adjuvant chemotherapy or opportunity for clinical trial)	
		Clear cell, mucinous histologic subtypes	• Certain histologies will require different approaches in the future (e.g. clear cell vs. mucinous)	
		Risk of Malignancy Index (RMI)	• Consider study using "Dr. Sauerbrei's system" (incorporates pathology & radiology, doesn't require CA125)	
H	Clinical Trials		• All patients should be offered the option of participating in active clinical trials that are applicable to their clinical situation if eligible	[6] Oncology Clinical Trials at Regional Cancer Centre of Southeastern Ontario

References

1. **Dodge, J, et al., et al.** *Management of a Suspicious Adnexal Mass.* Toronto (ON) : Cancer Care Ontario Program in Evidence-Based Care, 2011. 4-15.

2. **Fung-Kee Fung, M, et al., et al.** *Organizational Guideline for Gynecologic Oncology Services in Ontario.* Toronto (ON) : Cancer Care Ontario Evidence-Based Series, 2013. 4-11.

3. **College of American Pathologists (CAP).** Protocol for the Examination of Specimens From Patients With Carcinoma of the Ovary. *College of American Pathologists (CAP).* [Online] October 2013. [Cited: April 2, 2015.] http://www.cap.org/ShowProperty?nodePath=/UCMCon/Contribution%20Folders/WebContent/pdf/cp-ovary-fallopian-16protocol-1000.pdf

4. **Cancer Care Ontario (CCO) Systemic Treatment Program.** Adjuvant/ Curative/ Neo-Adjuvant Ovarian Cancer Regimens. *Systemic Treatment Funding Model.* [Online] February 2015. https://www.cancercare.on.ca/common/pages/UserFile.aspx?fileId=300148.

5. **Cancer Care Ontario (CCO) Systemic Treatment Program (STP).** Palliative Ovarian Cancer Regimens. *Systemic Treatment Funding Model.* [Online] February 2015. https://www.cancercare.on.ca/common/pages/UserFile.aspx?fileId=300150.

6. **Cancer Centre of Southeastern Ontario.** Oncology Clinical Trials. *Cancer Centre of Southeastern Ontario at the Kingston General Hospital.* [Online] Oncology Clinical Trials at Regional Cancer Centre of Southeastern Ontario

7. **Ueland FR, DePriest PD, Pavlik EJ, Kryscio RJ, van Nagell Jr JR**. "Pre-operative differentiation of malignant from benign ovarian Tumors: the efficacy of morphology indexing and Doppler flow sonography". Gynecologic Oncology 2003;91;46-50. [Back]

Revisions

- 2014/12/12: Gynae disease site group meeting to launch guidelines work
- 2015/04/01: Draft guideline completed
- 2015/05/20: Presented and discussed for approval at the Disease Site Group Chairs Council (2015/05/20)
- 2016/05/13 Reference added and IP policy document inserted