

Optimal care pathway for women with ovarian cancer

Quick reference guide



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

The optimal care pathways describe the standard of care that should be available to all cancer patients treated in Australia. The pathways support patients and carers, health systems, health professionals and services, and encourage consistent optimal treatment and supportive care at each stage of a patient's journey. Seven key principles underpin the guidance provided in the pathways: patient-centred care; safe and quality care; multidisciplinary care; supportive care; care coordination; communication; and research and clinical trials.

This quick reference guide provides a summary of the *Optimal care pathway for women with ovarian cancer*.

Please note that not all patients will follow every step of the pathway.

Step 1: Prevention and early detection

Prevention

Some factors that **may** reduce the risk of developing ovarian cancer are:

- using an oral contraceptive pill
- giving birth and breastfeeding
- surgical procedures such as tubal ligation, salpingectomy, hysterectomy and risk-reducing salpingo-oophorectomy.

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. For women at potentially high risk of ovarian cancer, GP referral to a familial cancer service 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 after surgery.

Refer to the optimal care pathway for women with ovarian cancer for other risk factors.

Screening recommendations

Population-based screening is not appropriate for ovarian cancer.

Checklist:

- Recent weight changes discussed and the patient's weight recorded
- Alcohol intake discussed and recorded and support for reducing alcohol consumption offered if appropriate
- Smoking status discussed and recorded and brief smoking cessation advice offered to smokers
- Physical activity recorded
- Referral to a dietitian considered
- Referral to a physiotherapist or exercise physiologist considered
- Education on being sun smart considered

Step 2: Presentation, initial investigations and referral

Signs and symptoms

Symptoms for ovarian cancer 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
- unexplained weight gain or weight loss

- change in bowel habits
- fatigue
- urinary frequency or incontinence
- pressure in the abdomen.

Initial investigations include:

- a general and pelvic examination, including rectal examination
- pelvic ultrasound (preferably transvaginal)
- CT scan if appropriate
- routine blood and tumour marker tests (CA125, CEA and, in younger women, HCG, AFP, LDH).

Checklist:

- Signs and symptoms recorded
- Supportive care needs assessment completed and recorded, and referrals to allied health services actioned as required
- Patient notified of support services such as Cancer Council 13 11 20
- Referral options discussed with the patient and/or carer including cost implications

Step 2: Presentation, initial investigations and referral continued

Referral options

At the referral stage, the patient's GP or other referring doctor should advise the patient about their options for referral, waiting periods, expertise, if there are likely to be out-of-pocket costs and the range of services available. This will enable patients to make an informed choice of specialist and health service.

Communication

The GP's responsibilities include:

- explaining to the patient and/or carer who they are being referred to and why
- supporting the patient and/or carer while waiting for specialist appointments
- informing the patient and/or carer that they can contact Cancer Council on 13 11 20.

Timeframe

Symptoms that persist for **more than 4 weeks** should be investigated.

Symptoms persisting for **more than 1 week** after initial treatment initiated by the GP should be further investigated **within 2 weeks**.

If ovarian cancer is suspected, initial investigations by the GP should be completed and results reviewed by the GP with the patient **within 2 weeks** of the patient initially presenting with symptoms.

The specialist appointment should occur **within 2 weeks** of a suspected or confirmed diagnosis.

Step 3: Diagnosis, staging and treatment planning

Diagnosis and staging

After a thorough medical history and examination, the following investigations should be undertaken:

- pelvic ultrasound (preferably transvaginal) if not already done
- routine blood and tumour marker tests (CA125, CEA and, in younger women, HCG, AFP, LDH)
- chest x-ray
- contrast-enhanced CT scan, PET/CT scan or MRI of the abdomen/pelvis.

Other investigations may be considered including fluid aspiration for cytology (pleural or peritoneal) and image-guided biopsy.

Staging for ovarian cancer is generally pathological following surgery.

Genetic testing

All women diagnosed with high-grade serous epithelial ovarian cancer should be offered genetic testing to look for the presence of mutations (e.g. in the BRCA1/2 genes) and should be referred to a familial cancer service.

Treatment planning

The multidisciplinary meeting (MDM) should occur **within 2 weeks** of the suspected or confirmed diagnosis.

Referral to fertility and menopause experts for premenopausal patients should be considered.

Research and clinical trials

Consider enrolment where available and appropriate. Search for a trial <www.australiancancertrials.gov.au>.

Checklist

- Diagnosis confirmed
- Full histology obtained
- Performance status and comorbidities measured and recorded
- Patient discussed at an MDM and decisions provided to the patient and/or carer
- Clinical trial enrolment considered
- Supportive care needs assessment completed and recorded and referrals to allied health services actioned as required
- Patient referred to support services (such as Cancer Council) as required
- Treatment costs discussed with the patient and/or carer

Step 3: Diagnosis, staging and treatment planning continued

Communication

The lead clinician's¹ responsibilities include:

- discussing a timeframe for diagnosis and treatment options with the patient and/or carer
- explaining the role of the multidisciplinary team in treatment planning and ongoing care
- encouraging discussion about the diagnosis, prognosis, advance care planning and palliative care while clarifying the patient's wishes, needs, beliefs and expectations, and their ability to comprehend the communication
- providing appropriate information and referral to support services as required
- communicating with the patient's GP about the diagnosis, treatment plan and recommendations from MDMs
- inviting patients to participate in MDMs.

Timeframe

Diagnostic investigations should be completed **within 2 weeks** of specialist review.

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

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

Surgery: Surgery may be used to stage the cancer, and as a form of therapy. 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 or not to retain fertility.

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 therapy for symptomatic relief and palliation of metastatic or recurrent disease. In selected cases, it may also be considered as part of primary treatment.

Loss of fertility and/or premature menopause following treatment requires sensitive discussion.

Palliative care

Early referral to palliative care can improve quality of life and in some cases survival. Referral should be based on need, not prognosis. For more, visit the Palliative Care Australia website <www.palliativecare.org.au>.

Communication

The lead clinician and team's responsibilities include:

- discussing treatment options with the patient and/or carer including the intent of treatment as well as risks and benefits
- discussing advance care planning with the patient and/or carer where appropriate
- communicating the treatment plan to the patient's GP
- helping patients to find appropriate support for exercise programs where appropriate to improve treatment outcomes.

Checklist

- Intent of treatment established
- Risks and benefits of treatments discussed with the patient and/or carer
- Treatment plan discussed with the patient and/or carer
- Treatment plan provided to the patient's GP
- Treating specialist has adequate qualifications, experience and expertise
- Supportive care needs assessment completed and recorded, and referrals to allied health services actioned as required
- Early referral to palliative care considered
- Advance care planning discussed with the patient and/or carer

Timeframe

Surgery should be conducted **within 4 weeks** of the suspected or confirmed diagnosis and **within 2 weeks** of the MDM.

Neoadjuvant chemotherapy should start **within 2 weeks** of the MDM.

Adjuvant chemotherapy should start **within 4 weeks** of surgery.

Radiation therapy should start **within 4 weeks** of the MDM.

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 5: Care after initial treatment and recovery

Provide a treatment and follow-up summary to the patient, carer and GP outlining:

- the diagnosis, including tests performed and results
- tumour characteristics
- treatment received (types and date)
- current toxicities (severity, management and expected outcomes)
- interventions and treatment plans from other health professionals
- potential long-term and late effects of treatment and care of these
- supportive care services provided
- a follow-up schedule, including tests required and timing

- contact information for key healthcare providers who can offer support for lifestyle modification
- a process for rapid re-entry to medical services for suspected recurrence.

Ongoing assessment of the effects of treatment (e.g. surgical menopause) is required.

Communication

The lead clinician's responsibilities include:

- explaining the treatment summary and follow-up care plan to the patient and/or carer
- informing the patient and/or carer about secondary prevention and healthy living
- discussing the follow-up care plan with the patient's GP.

Checklist

- Treatment and follow-up summary provided to the patient and/or carer and the patient's GP
- Supportive care needs assessment completed and recorded, and referrals to allied health services actioned as required
- Patient-reported outcome measures recorded

Step 6: Managing recurrent, residual or metastatic disease

Detection

Most recurrent or metastatic disease will be detected via routine follow-up or by the patient presenting with symptoms.

Treatment

Evaluate each patient for whether referral to the original multidisciplinary team is appropriate. Treatment will depend on the location and extent of disease, previous management and the patient's preferences.

Advance care planning:

Advance care planning is important for all patients but especially those with advanced disease. It allows them to plan for their future health and personal

care by thinking about their values and preferences. This can guide future treatment if the patient is unable to speak for themselves.

Survivorship and palliative care

Survivorship and palliative care should be addressed and offered early. Early referral to palliative care can improve quality of life and in some cases survival. Referral should be based on need, not prognosis.

Communication

The lead clinician and team's responsibilities include:

- explaining the treatment intent, likely outcomes and side effects to the patient and/or carer and the patient's GP.

Checklist

- Treatment intent, likely outcomes and side effects explained to the patient and/or carer and the patient's GP
- Supportive care needs assessment completed and recorded, and referrals to allied health services actioned as required
- Advance care planning discussed with the patient and/or carer
- Patient referred to palliative care if appropriate
- Routine follow-up visits scheduled

Step 7: End-of-life care

Palliative care

Consider a referral to palliative care. Ensure an advance care directive is in place.

Communication

The lead clinician's responsibilities include:

- being open about the prognosis and discussing palliative care options with the patient

- establishing transition plans to ensure the patient's needs and goals are considered in the appropriate environment.

Checklist

- Supportive care needs assessment completed and recorded, and referrals to allied health services actioned as required
- Patient referred to palliative care
- Advance care directive in place

Visit our guides to best cancer care webpage <www.cancercareguides.org.au> for consumer guides. Visit our OCP webpage <www.cancer.org.au/OCP> for the optimal care pathway and instructions on how to import these guides into your GP software.