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 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.

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.

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

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.