NHS
National Institute for Health and Clinical Excellence

Quick reference guide

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Ovarian cancer

The recognition and initial management of ovarian cancer

NICE clinical guideline 122
Developed by the National Collaborating Centre for Cancer

About this booklet

This is a quick reference guide that summarises the recommendations NICE has made to the NHS in 'Ovarian cancer: the recognition and initial management of ovarian cancer' (NICE clinical guideline 122). This guidance updates and replaces recommendation 1.7.4 about ovarian cancer in 'Referral guidelines for suspected cancer' (NICE clinical guideline 27).

Who should read this booklet?

This quick reference guide is for healthcare professionals and other staff who care for women with ovarian cancer.

Who wrote the guideline?

The guideline was developed by the National Collaborating Centre for Cancer, which is based at the Velindre NHS Trust in Cardiff. The Collaborating Centre worked with a group of healthcare professionals (including consultants, GPs and nurses), patients and carers, and technical staff, who reviewed the evidence and drafted the recommendations. The recommendations were finalised after public consultation.

For more information on how NICE clinical guidelines are developed, go to www.nice.org.uk

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NICE clinical guidelines are recommendations about the treatment and care of people with specific diseases and conditions in the NHS in England and Wales.

This guidance represents the view of NICE, which was arrived at after careful consideration of the evidence available. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. However, the guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer, and informed by the summary of product characteristics of any drugs they are considering.

Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in this guidance should be interpreted in a way that would be inconsistent with compliance with those duties.

Contents

Introduction

Ovarian cancer is the leading cause of death from gynaecological cancer in the UK, and its incidence is rising. It is the fifth most common cancer in women.

The overall 5-year survival rate for women with ovarian cancer is below 35%. Most women present with advanced disease, having had symptoms for months before presentation, and there are often delays between presentation and specialist referral. There is a need for greater awareness of ovarian cancer, and for initial investigations in primary and secondary care that enable earlier referral and optimum treatment.

This guideline does not cover the entire care pathway for ovarian cancer. It focuses on areas where there is uncertainty or wide variation in clinical practice with regard to the detection, diagnosis and initial management of ovarian cancer. The guideline recommendations are applicable to women with epithelial ovarian cancer (the most common type of ovarian cancer), as well as women with fallopian tube carcinoma, primary peritoneal carcinoma or borderline ovarian cancer.

Patient-centred care

Treatment and care should take into account patients' individual needs and preferences. Good communication is essential, supported by evidence-based information, to allow patients to reach informed decisions about their care. Follow advice on seeking consent from the Department of Health or Welsh Assembly Government if needed. If the patient agrees, families and carers should have the opportunity to be involved in decisions about treatment and care.

Key priorities applicable to primary care are highlighted with GP

Key priorities for implementation

Awareness of symptoms and signs

- Carry out tests in primary care if a woman (especially if 50 or over) reports having any of the following symptoms on a persistent or frequent basis – particularly more than 12 times per month[1]:
  - persistent abdominal distension (women often refer to this as 'bloating')
  - feeling full (early satiety) and/or loss of appetite
  - pelvic or abdominal pain
  - increased urinary urgency and/or frequency. GP
- Carry out appropriate tests for ovarian cancer in any woman of 50 or over who has experienced symptoms within the last 12 months that suggest irritable bowel syndrome (IBS)[2], because IBS rarely presents for the first time in women of this age. GP

Asking the right question – first tests

- Measure serum CA125 in primary care in women with symptoms that suggest ovarian cancer. GP
- If serum CA125 is 35 IU/ml or greater, arrange an ultrasound scan of the abdomen and pelvis. GP
- For any woman who has normal serum CA125 (less than 35 IU/ml), or CA125 of 35 IU/ml or greater but a normal ultrasound:
  - assess her carefully for other clinical causes of her symptoms and investigate if appropriate
  - if no other clinical cause is apparent, advise her to return to her GP if her symptoms become more frequent and/or persistent. GP

Malignancy indices

- Calculate a risk of malignancy index I (RMI I) score[3] (after performing an ultrasound) and refer all women with an RMI I score of 250 or greater to a specialist multidisciplinary team.

Tissue diagnosis

- If offering cytotoxic chemotherapy to women with suspected advanced ovarian cancer, first obtain a confirmed tissue diagnosis by histology (or by cytology if histology is not appropriate) in all but exceptional cases.

Continued

[1] See also 'Referral guidelines for suspected cancer' (NICE clinical guideline 27; available at www.nice.org.uk/guidance/CG27) for recommendations about the support and information needs of people with suspected cancer.
[2] See 'Irritable bowel syndrome in adults' (NICE clinical guideline 61; available at www.nice.org.uk/guidance/CG61).
[3] See page 5 for details of how to calculate an RMI I score.

The role of systematic retroperitoneal lymphadenectomy

- Do not include systematic retroperitoneal lymphadenectomy (block dissection of lymph nodes from the pelvic side walls to the level of the renal veins) as part of standard surgical treatment in women with suspected ovarian cancer whose disease appears to be confined to the ovaries (that is, who appear to have stage I disease).

Adjuvant systemic chemotherapy for stage I disease

- Do not offer adjuvant chemotherapy to women who have had optimal surgical staging[4] and have low-risk stage I disease (grade 1 or 2, stage Ia or Ib).

Support needs of women with newly diagnosed ovarian cancer

- Offer all women with newly diagnosed ovarian cancer information about their disease, including psychosocial and psychosexual issues, that:
  - is available at the time they want it
  - includes the amount of detail that they want and are able to deal with
  - is in a suitable format, including written information.

Risk of malignancy index I (RMI I)

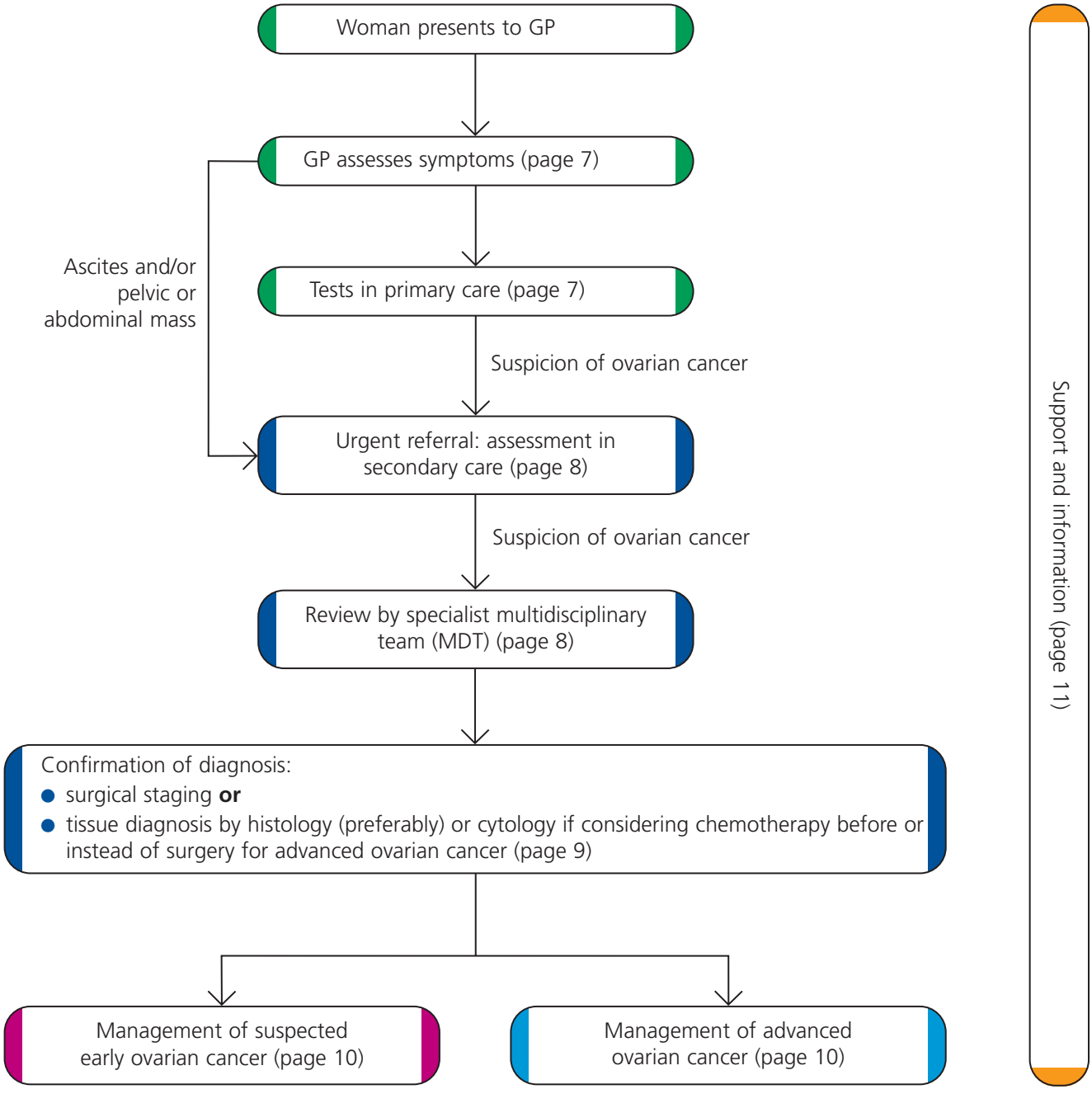
RMI I is a product of the ultrasound scan score (U), menopausal status (M) and serum CA125 level.

RMI I = U × M × CA125

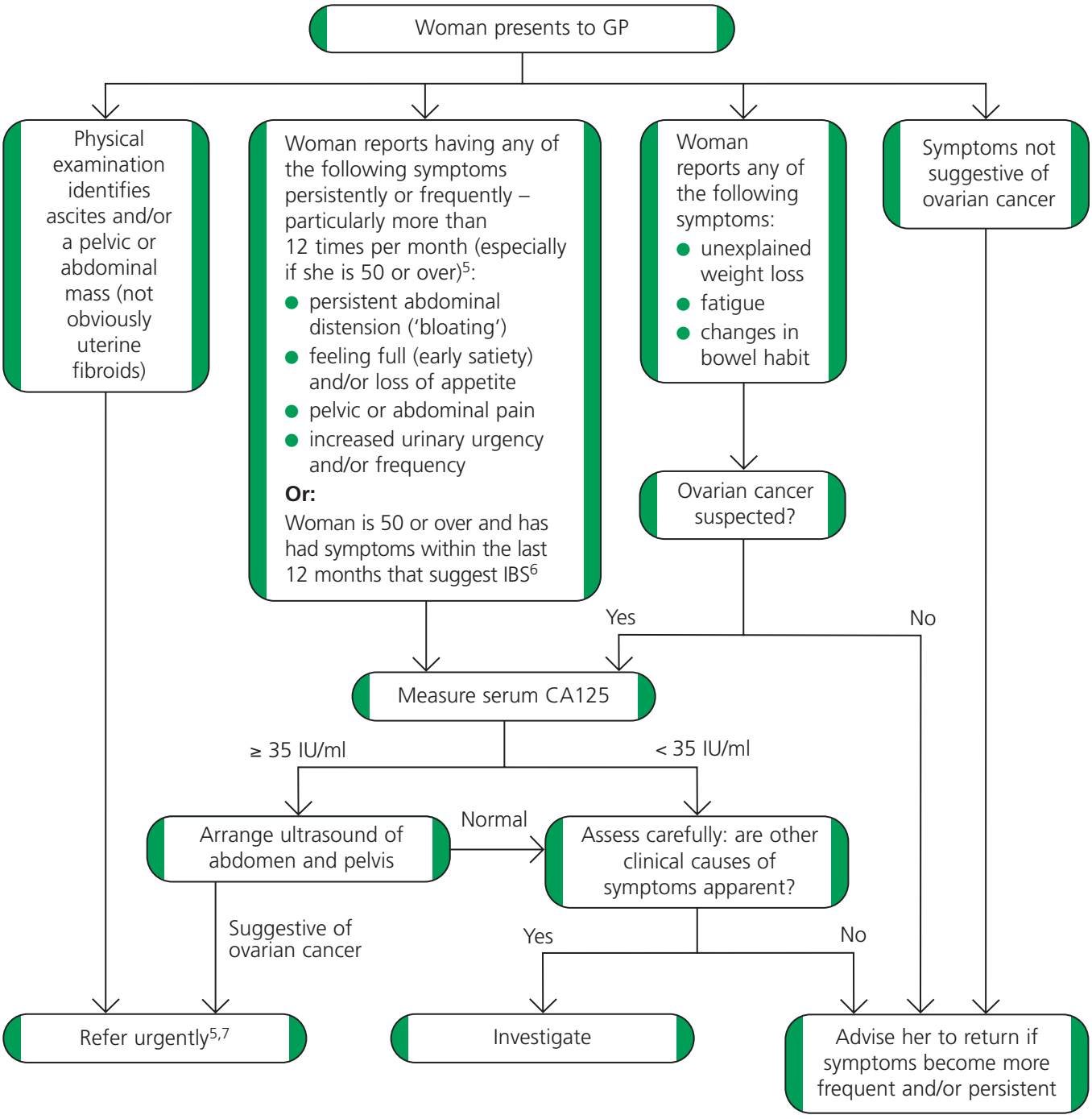
- The ultrasound result is scored 1 point for each of the following characteristics: multilocular cysts, solid areas, metastases, ascites, bilateral lesions. U = 0 for an ultrasound score of 0 points, U = 1 for an ultrasound score of 1 point, U = 3 for an ultrasound score of 2–5 points.
- Menopausal status is scored as 1 = pre-menopausal and 3 = post-menopausal. The classification of 'post-menopausal' is a woman who has had no period for more than 1 year or a woman over 50 who has had a hysterectomy.
- Serum CA125 is measured in IU/ml.

[4] Optimal surgical staging constitutes: midline laparotomy to allow thorough assessment of the abdomen and pelvis; a total abdominal hysterectomy, bilateral salpingo-oophorectomy and infracolic omentectomy; biopsies of any peritoneal deposits; random biopsies of the pelvic and abdominal peritoneum; and retroperitoneal lymph node assessment [Winter Roach BA, Kitchener HC, Dickinson HO (2009) Adjuvant (post-surgery) chemotherapy for early stage epithelial ovarian cancer. Cochrane Database of Systematic Reviews issue 3: CD004706].

Overview of pathway



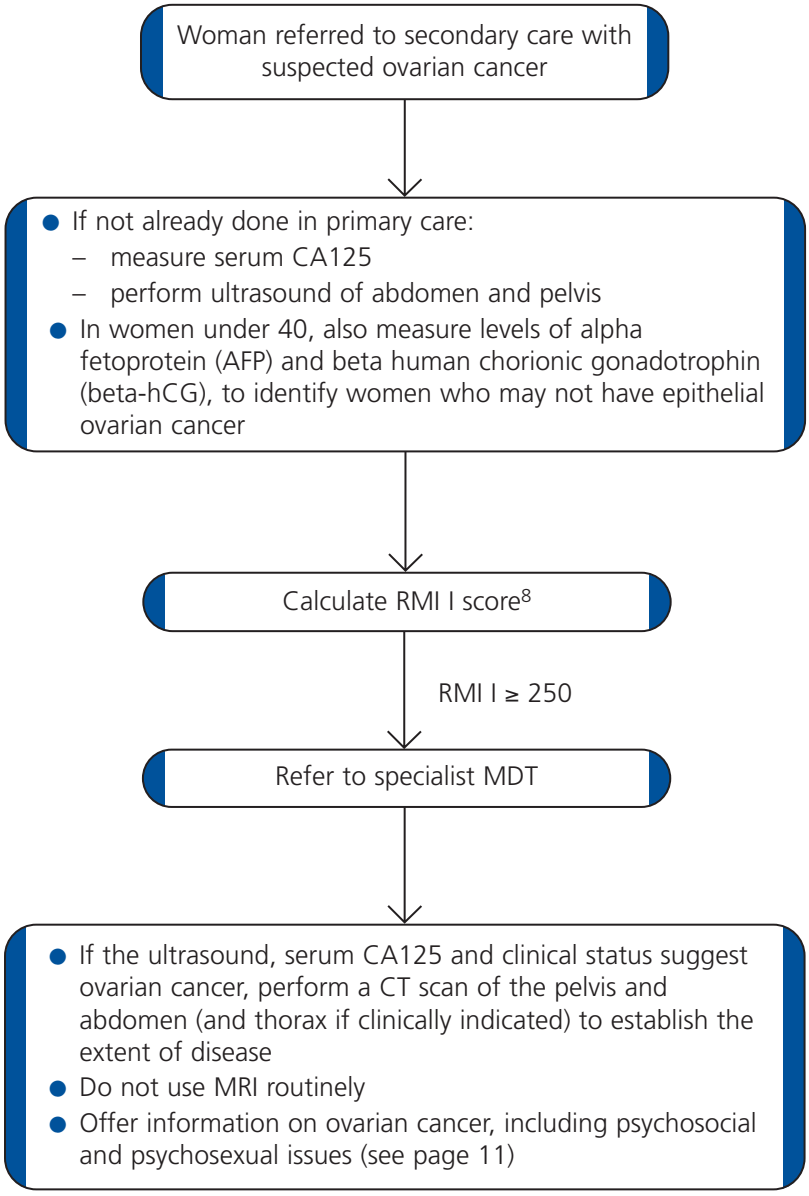
Detection in primary care



[5] See also 'Referral guidelines for suspected cancer' (NICE clinical guideline 27; available at www.nice.org.uk/guidance/CG27) for recommendations about the support and information needs of people with suspected cancer.
[6] See 'Irritable bowel syndrome in adults' (NICE clinical guideline 61; available at www.nice.org.uk/guidance/CG61). Irritable bowel syndrome (IBS) rarely presents for the first time in women of this age.
[7] An urgent referral means that the woman is referred to a gynaecological cancer service within the national target in England and Wales for referral for suspected cancer, which is currently 2 weeks.

Establishing the diagnosis in secondary care

Tests in secondary care



[8] See page 5 for details of how to calculate an RMI I (risk of malignancy index I) score.

Tissue diagnosis

Requirement for tissue diagnosis

- If offering cytotoxic chemotherapy to women with suspected advanced ovarian cancer, first obtain a confirmed tissue diagnosis by histology (or by cytology if histology is not appropriate) in all but exceptional cases.
- Offer cytotoxic chemotherapy without a tissue diagnosis (histology or cytology) only:
  - in exceptional cases, after discussion at the multidisciplinary team **and**
  - after discussing with the woman the possible benefits and risks of starting chemotherapy without a tissue diagnosis.

Methods of tissue diagnosis

- If surgery has not been performed, use histology rather than cytology to obtain a tissue diagnosis. To obtain tissue for histology:
  - use percutaneous image-guided biopsy if feasible
  - consider laparoscopic biopsy if percutaneous image-guided biopsy is not feasible or has not produced an adequate sample.

  Use cytology if histology is not appropriate.

Management of suspected early (stage I) ovarian cancer

The role of systematic retroperitoneal lymphadenectomy

- Perform retroperitoneal lymph node assessment[9] as part of optimal surgical staging[10] in women who appear to have stage I ovarian cancer.
- Do not include systematic retroperitoneal lymphadenectomy (block dissection of lymph nodes from the pelvic side walls to the level of the renal veins) as part of standard surgical treatment in women who appear to have stage I ovarian cancer.

Adjuvant systemic chemotherapy

- Do not offer adjuvant chemotherapy to women who have had optimal surgical staging[10] and have low-risk stage I disease (grade 1 or 2, stage Ia or Ib).
- Offer women with high-risk stage I disease (grade 3 or stage Ic) adjuvant chemotherapy consisting of six cycles of carboplatin.
- Discuss the possible benefits and side effects of adjuvant chemotherapy with women who have had suboptimal surgical staging[10] and appear to have stage I disease.

Management of advanced (stage II–IV) ovarian cancer[11]

Primary surgery

- If performing surgery for women with ovarian cancer, whether before chemotherapy or after neoadjuvant chemotherapy, the objective should be complete resection of all macroscopic disease.

Intraperitoneal chemotherapy

- Do not offer intraperitoneal chemotherapy to women with ovarian cancer, except as part of a clinical trial.

[9] Lymph node assessment involves sampling of retroperitoneal lymphatic tissue from the para-aortic area and pelvic side walls if there is a palpable abnormality, or random sampling if there is no palpable abnormality.
[10] Optimal surgical staging constitutes: midline laparotomy to allow thorough assessment of the abdomen and pelvis; a total abdominal hysterectomy, bilateral salpingo-oophorectomy and infracolic omentectomy; biopsies of any peritoneal deposits; random biopsies of the pelvic and abdominal peritoneum; and retroperitoneal lymph node assessment.
[11] Recommendations 1.1 and 1.2 in NICE technology appraisal guidance 55 ('Guidance on the use of paclitaxel in the treatment of ovarian cancer') are on first-line chemotherapy in the treatment of ovarian cancer.

Support needs of women with newly diagnosed ovarian cancer

- Offer all women with newly diagnosed ovarian cancer information about their disease, including psychosocial and psychosexual issues, that:
  - is available at the time they want it
  - includes the amount of detail that they want and are able to deal with
  - is in a suitable format, including written information.
- Ensure that information is available about:
  - the stage of the disease, treatment options and prognosis
  - how to manage the side effects of both the disease and its treatments in order to maximise wellbeing
  - sexuality and sexual activity
  - fertility and hormone treatment
  - symptoms and signs of disease recurrence
  - genetics, including the chances of family members developing ovarian cancer
  - self-help strategies to optimise independence and coping
  - where to go for support, including support groups
  - how to deal with emotions such as sadness, depression, anxiety and a feeling of a lack of control over the outcome of the disease and treatment.

Further information

Ordering information

You can download the following documents from **www.nice.org.uk/guidance/CG122**

- The NICE guideline – all the recommendations.
- A quick reference guide (this document) – a summary of the recommendations for healthcare professionals.
- 'Understanding NICE guidance' – a summary for patients and carers.
- The full guideline – all the recommendations, details of how they were developed, and reviews of the evidence they were based on.

For printed copies of the quick reference guide or 'Understanding NICE guidance', phone NICE publications on 0845 003 7783 or email publications@nice.org.uk and quote:

- N2504 (quick reference guide)
- N2505 ('Understanding NICE guidance').

Implementation tools

NICE has developed tools to help organisations implement this guidance (see **www.nice.org.uk/guidance/CG122**).

Related guidance

For information about NICE guidance that has been issued or is in development, see **www.nice.org.uk**

Published NICE guidance

- Irritable bowel syndrome in adults. NICE clinical guideline 61 (2008). Available from **www.nice.org.uk/guidance/CG61**
- Referral guidelines for suspected cancer. NICE clinical guideline 27 (2005). Available from **www.nice.org.uk/guidance/CG27**
- Improving supportive and palliative care for adults with cancer. Cancer service guidance (2004). Available from **www.nice.org.uk/guidance/csgsp**
- Guidance on the use of paclitaxel in the treatment of ovarian cancer. NICE technology appraisal guidance 55 (2003). Available from **www.nice.org.uk/guidance/TA55**

Other cancer service guidance

- Improving outcomes in gynaecological cancers. Cancer service guidance (1999). Department of Health, National Cancer Guidance Steering Group. Available from: **www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4083846.pdf**

Updating the guideline

This guideline will be updated as needed, and information about the progress of any update will be available at **www.nice.org.uk/guidance/CG122**

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