

Post Treatment Surveillance for Women with Epithelial Ovarian Cancer

Goal: Surveillance is meant to identify recurrence. There are treatment options for recurrent disease though they are not curative. Early detection of recurrence does not change outcome. Therefore surveillance should be flexible.

- These guidelines apply to women who have completed primary therapy (surgery with removal of both ovaries plus Platinum based chemotherapy) and are without evidence of disease.
- Germ cell tumors and stromal tumors of the ovary are rare and have different treatment options as well as different serum markers. Those patients will require modification of the guideline.
- Borderline tumors of the ovary have a better prognosis and are treated surgically both for primary and recurrent disease. Effective treatment for recurrence raises the value of surveillance for these patients.
- Patients who had conservative management of a low stage ovarian malignancy with preservation of an ovary will require modified surveillance.
- Ca-125 will be a useful marker for most epithelial ovarian cancers. If the serum marker was not elevated at diagnosis it may not be useful in follow up.
- Ca-19-9, Inhibin, AFP and Beta-HCG can all be useful markers for specific uncommon types of ovarian cancer. Many tumors have no useful marker.
- Most ovarian cancer is of an advanced stage when diagnosed. There is no recommended screening test for ovarian cancer.
- Metastatic primary and recurrent disease is usually confined to the abdomen.
- Though most of these patients eventually die of their cancer, current treatment that includes tumor reductive surgery followed by chemotherapy achieves complete response in 2/3 of patients. This translates to a disease free interval of two to three years for most patients.
- If the cancer recurs curative treatment is rarely possible and therapy should focus on palliative goals.
- Both 2^o debulking surgery and 2^o chemotherapy may have significant benefit to patients with recurrence even when they are not curative, particularly for those patients who had a long disease free interval after 1^o therapy.
- Screening for other malignancies and options for hormone replacement are not altered with this diagnosis.

Scheduled follow up

Clinical Exam 3-4 times each year for the first 5 years

1. Pelvic with Pap and general Physical
2. History focused on abdominal symptomatology (pain, bloating, dyspepsia, frequency)
3. Ca-125 or applicable marker

Imaging Studies none scheduled routinely

1. CT of Abd/Pelvis based on Clinical Exam
2. Yearly ultrasound for patients with an ovary

Consultation with Gynecologist or Gynecologic Oncologist

1. OB/Gyn staff is available for follow up visits in field clinics and at ANMC X 2years
2. At least yearly for patients with no evidence of disease
3. When recurrence is diagnosed or suspected
4. Whenever treatment plan or follow up is changed

Reference:

Johnson, FE, Virgo KS, Edge SB. *Cancer Patient Follow-up*. St. Louis: Mosby Yearbook. 1997