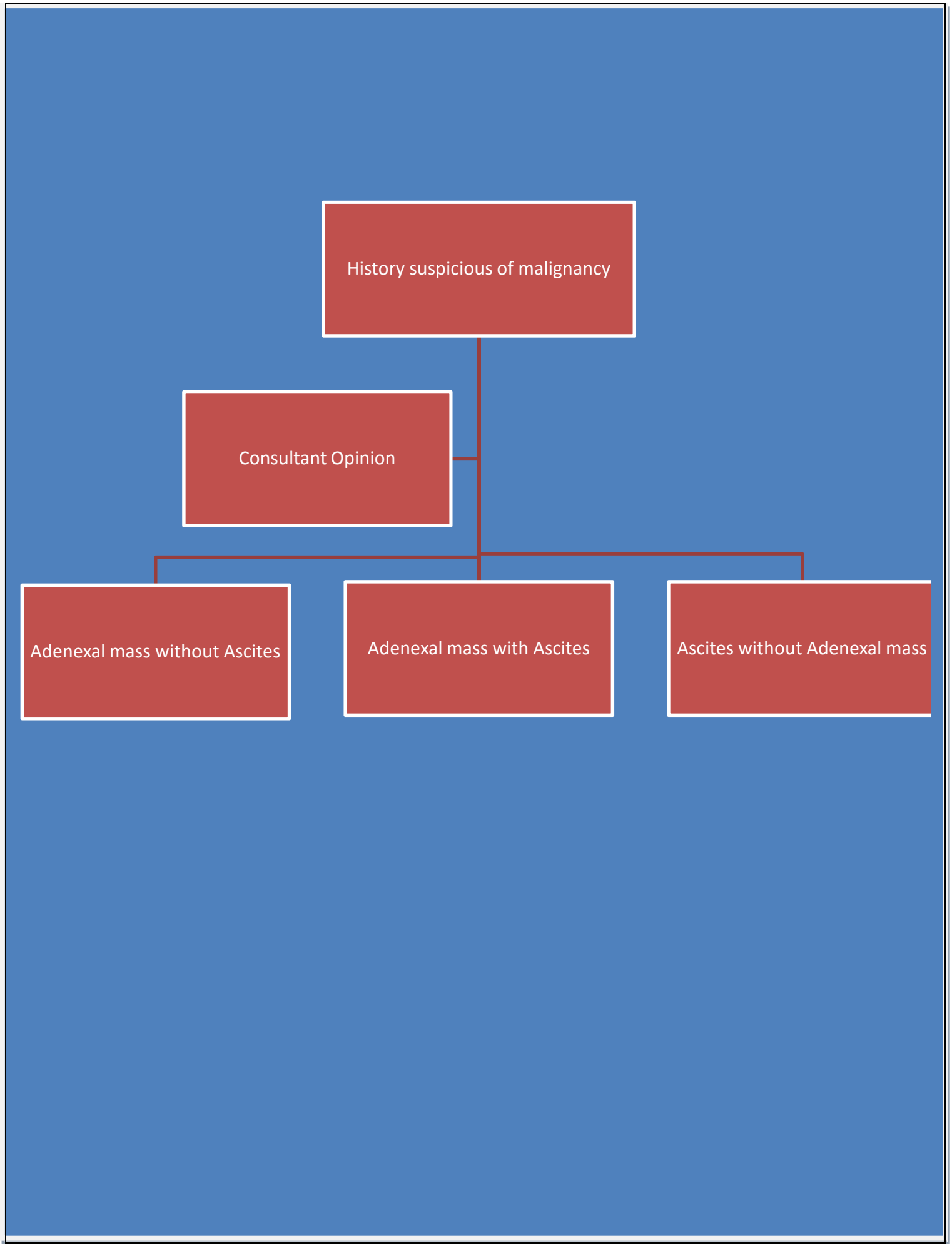
Institutional Protocol for Ovarian Cancer

PGIMER, CHANDIGARH

2016

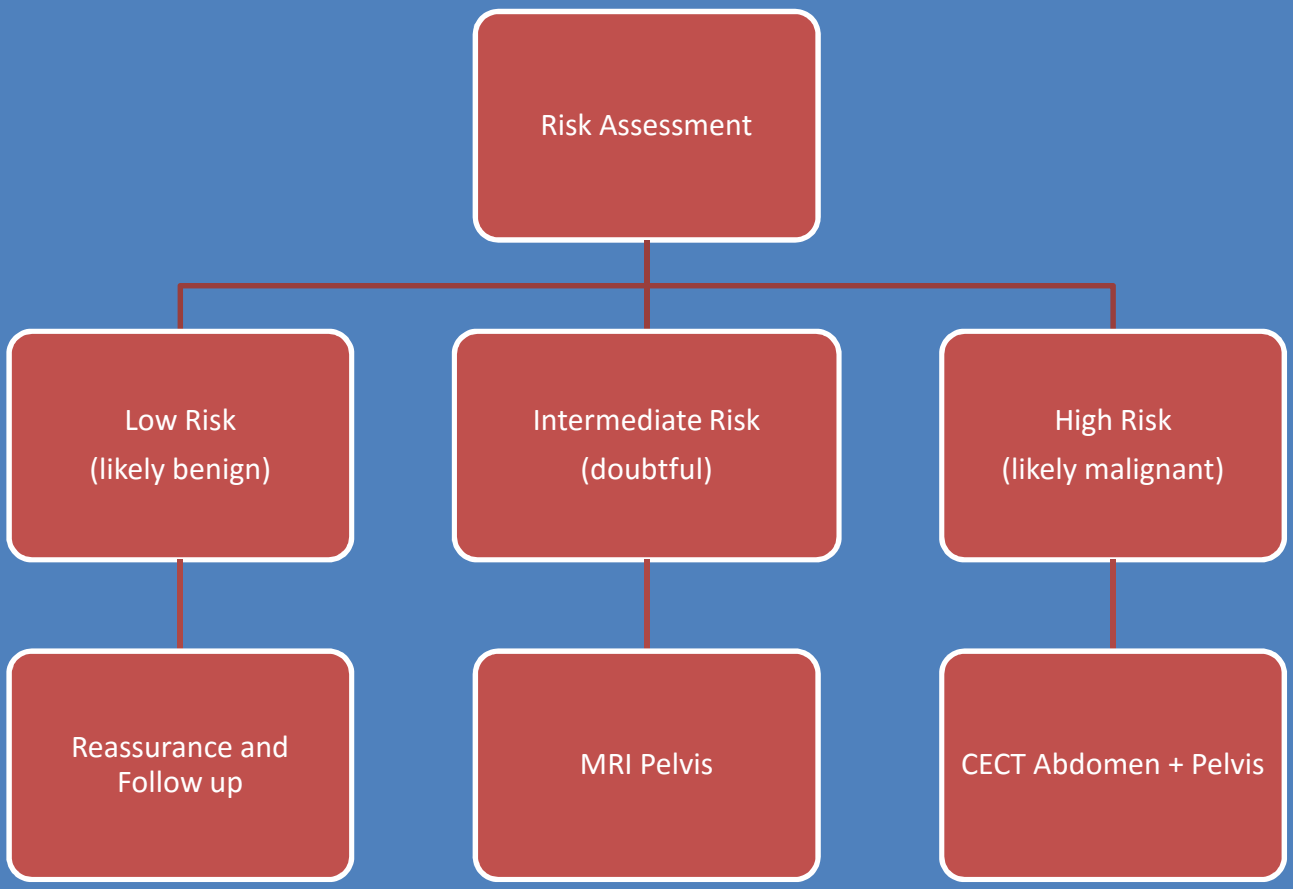
Consensus Guidelines

Department Radiotherapy,Regional Cancer Centre; Department of Gynaecology; Department of Pathology; Department of Radiodiagnosis


History suspicious of malignancy
Consultant Opinion
Adenexal mass without Ascites
Adenexal mass with Ascites
Ascites without Adenexal mass

ADENEXAL MASS WITHOUT ASCITES

- Complete Physical Examination (including evaluation of GIT and Breast)
- Detailed family history (pedigree chart)
- Trans Abdominal Ultrasound (Preferably from PGIMER)
- Trans Vaginal Ultrasound (Preferably from PGIMER)
- Request for Ultrasound score for calculation of Risk of Malignancy
- Appropriate Tumor Markers, based on clinical judgment (CA125/AFP/BHCG/LDH/CEA/CA 19.9)
- CBC, LFT, KFT, Stool for Occult Blood
- Chest X ray
- Calculate Risk of Malignancy Index
- Biopsy from adnexal mass under Ultrasound guidance preferred; If not feasible, FNA with mandatory cell block is acceptable. On either, IHC to be performed for confirmation of primary Ovarian carcinoma



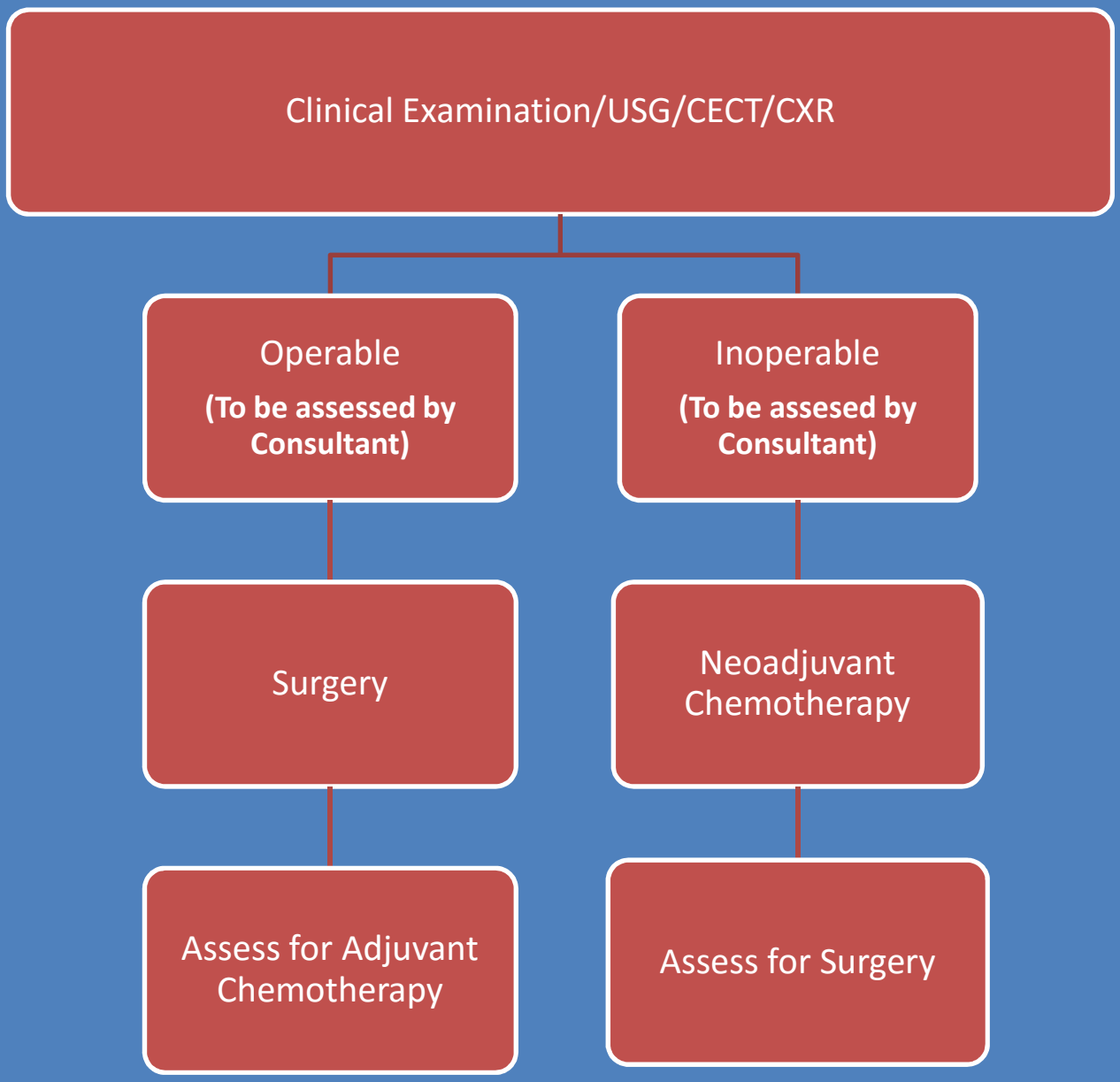
ADENEXAL MASS WITH ASCITES

- Complete Physical Examination (including evaluation of GIT and Breast)
- Trans Abdominal Ultrasound (Preferably from PGIMER)
- Trans Vaginal Ultrasound (Preferably from PGIMER)
- Request for Ultrasound score for calculation of Risk of Malignancy
- Appropriate Tumour Markers, based on clinical judgment (CA125/AFP/BHCG/LDH)
- CECT Abdomen + Pelvis
- Chest X ray, and diagnostic thoracentesis, if pleural effusion detected
- Biopsy from adnexal mass under Ultrasound guidance preferred; If not feasible, FNA with mandatory cell block is acceptable. On either, IHC to be performed for confirmation of primary Ovarian carcinoma
- Paracentesis (Optional for patients being considered for upfront surgery)
- Repeat diagnostic paracentesis, if initially negative for malignant cytology

ASCITES WITHOUT ADENEXAL MASS

- Evaluate Ascites as per protocol
- If reported as Malignant on Cytology, Repeat tap and send at least 50ml for cytology with request for cell block and IHC for confirmation of Ovarian Primary
- Consider Endoscopy (UGIE + LGIE), especially if
    - GIT related symptoms
    - Occult blood in stool
    - Elevated CEA levels
    - CEA/CA125 ratio < 25
    - Bilateral tumours (mobile)
    - Suspicious family history
    - Neo-adjuvant chemotherapy is planned (without surgical assessment)

ALL RADIOLOGICAL (FILMS) AND PATHOLOGICAL (SLIDES/BLOCKS) INVESTIGATIONS DONE OUTSIDE SHOULD BE REVIEWED IN DEPARTMENTS OF RADIOLOGY AND PATHOLOGY, PGIMER



OPERABLE CASES

STAGING LAPAROTOMY

Goal of Surgery: R0 resection

Optimal debulking: Total post operative residual disease < 1cm

USE PROFORMA / PICTORIALS FOR CHECK LIST AND DOCUMENTATION

- Vertical midline incision for sufficient exposure of abdominal and pelvic cavities
- Systematic examination (inspection and palpation) of the abdomen and pelvis, including the undersurface of diaphragm
- Record volume of ascitic fluid, and label separately (preferably 25ml) for Cytology
- If no ascitic fluid, saline washings (100ml) from
    - *cul-de-sac*
    - bilateral paracolic gutters
    - undersurfaces of bilateral domes of diaphragm
- Examine for capsular breech, surface excrescences
- TAH + BSO + Infracolic Omentectomy
- Bilateral pelvic and para-aortic lymph nodal sampling; To label the samples according to the site
- Random peritoneal biopsies; To label the samples according to the site
- Note the amount of residual disease left in situ

Utility of frozen section:

- Likely benign : Conservative surgery
- Likely malignant: Complete staging
- Suspicious / questionable: Wait for the final histology report

Special scenarios:

- Omental wedge biopsy may be sufficient for suspected early stage germ cell tumours and sex cord-stromal tumours; Lymphadenectomy may be omitted
- Supracolic omentectomy may be considered for advanced stage patients
- Appendectomy for mucinous tumours
- Fertility sparing surgery may be considered for patients with:
    - Age < 40 years
    - No gonadal dysgenesis
    - Desirous of fertility, with incomplete family size
    - Compliant for close follow up and completion surgery after fertility
    - Borderline tumours
    - Stage 1A epithelial cancers
    - Early stage germ cell tumours

- Inform the pathologist regarding relevant intra operative findings
- Standard data sets to be used for pathological reporting

ADJUVANT CHEMOTHERAPY

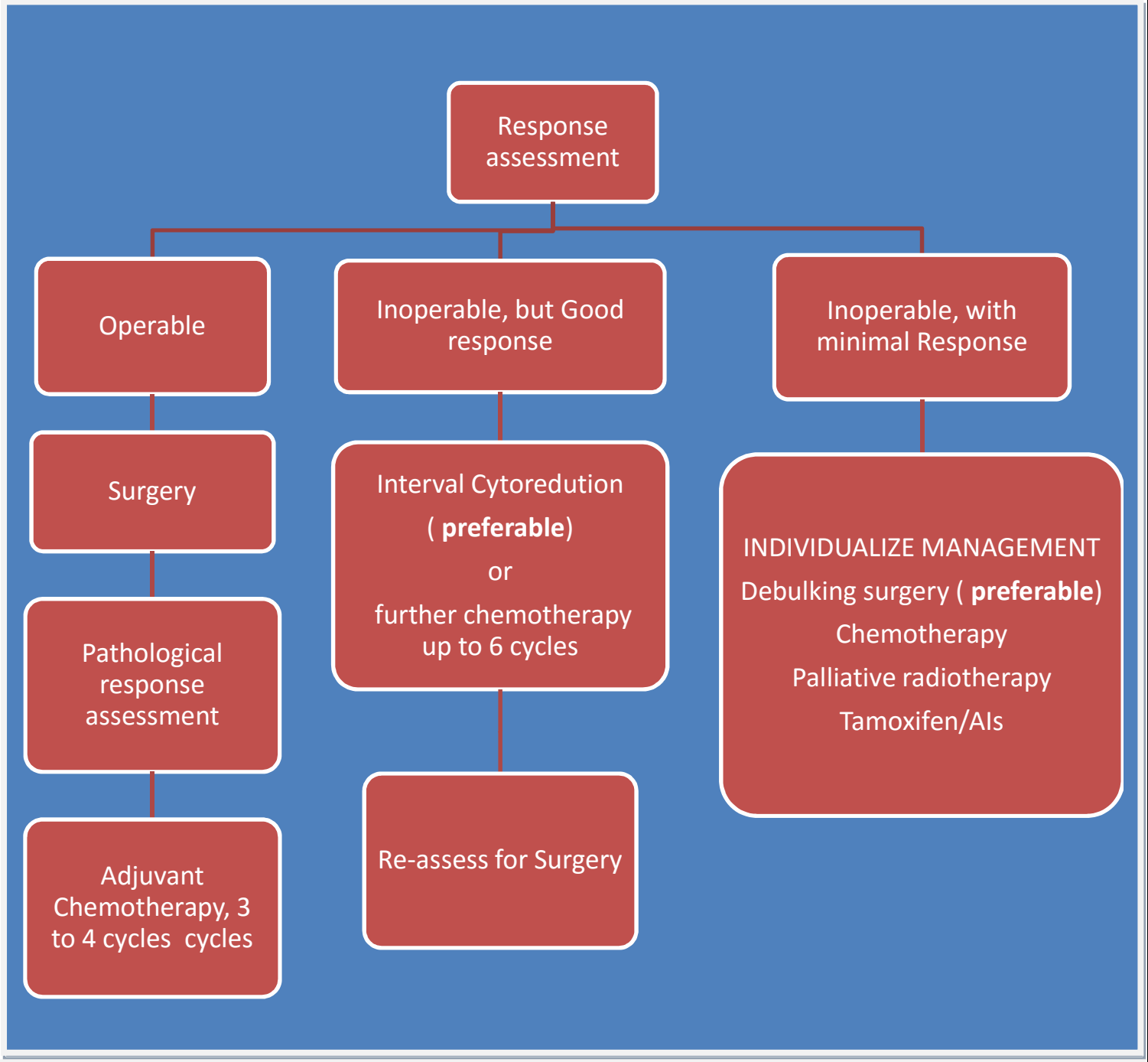
- Indications:
  - Suboptimal resection
  - Stage Ic
  - High grade
  - Pathological stage II, III

- Post operative CA 125 levels should be done 3 – 4 weeks of after surgery
- Chemotherapy should be initiated within 3 – 4 weeks weeks of surgery
- Paclitaxel (175mg/sq.m) and Carboplatin (5 – 7 AUC), is the recommended regime, to be given three weekly, for 6 to 8 cycles
- CECT abdomen and pelvis, and CA 125 should be done 4 weeks after completion of chemotherapy

INOPERABLE CASES

NEO ADJUVANT CHEMOTHERAPY

- Apart from technical inoperability, all patients of stage III disease with > 3 cm deposits and stage IV disease may be considered for neo-adjuvant chemotherapy
- For patients without ascites, image guided biopsy or FNAC with cell block with IHC confirmation of 'ovarian' primary is necessary
- For patients with ascites positive for adenocarcinoma, and elevated CA 125 levels, if FNA / biopsy of adnexal mass is not possible or if there is no well visualized mass, then cell block from ascitic fluid must be prepared and IHC is mandatory for confirmation of ovarian primary before initiating neoadjuvant chemotherapy; IHC for WT1, p53, PAX8, etc on cell block taken from ascitic fluid (at least 50ml) may be contributory for differentiating primary ovarian tumours from secondary metastatic deposits
- Neoadjuvant chemotherapy with Paclitaxel (175mg/sq.m) and Carboplatin (5 to 7 AUC) will be given, at three weekly intervals, for three cycles
- Response assessment will be done after 3 cycles of neoadjuvant chemotherapy, with clinical examination, CECT chest + abdomen + pelvis, and CA125 levels.
- Interval Cytoreduction to be done within 3 to 6 weeks of chemotherapy, after 3-4 cycles of chemotherapy.
- Inform the pathologist regarding neo-adjuvant chemotherapy, for reporting



FOLLOW UP AND EVALUATION OF RECURRENCE

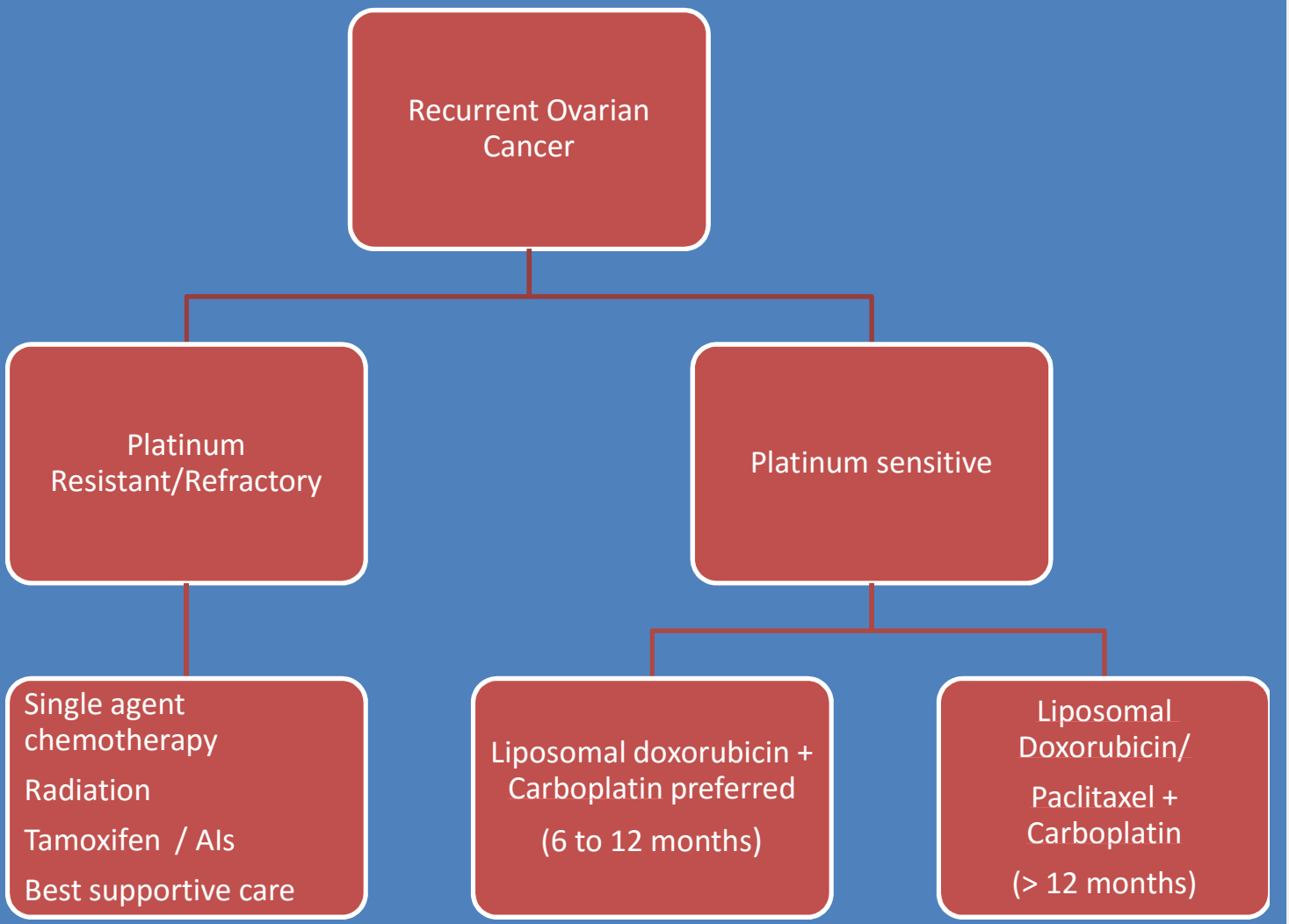
- Clinical examination and CA 125:
  - Once in every 2 - 3 months for the first two years
  - Once in every 4 – 6 months till 5 years
  - Yearly thereafter
- CECT chest + abdomen + pelvis, at first clinical / biochemical (2 fold rise) suspicion of recurrence
- Pathological confirmation of recurrence as described above

MANAGEMENT OF RECURRENCE

Interval between last cycle of adjuvant chemotherapy and first suspicion of recurrence (clinical or radiological or biochemical)

- 0 (progression during chemotherapy) : Platinum Refractory relapse
- < 6 months : Platinum Resistant relapse
- > 6 months : Platinum Sensitive relapse

Secondary cyto-reduction may be considered for appropriate cases



Standard Data Set for Reporting "Ovarian' [Ovarain/ tubal / Peritoneal] cancer as per ICCR guidelines should be followed

Request form sent for histopathology must contain information on Type of Specimen and Chemotherapy received

SEE FIM protocol must be performed on all TAHBSO specimen and guidelines followed for primary site assignment

Peritoneal Cytology findings must also be incorporated in the report

Preliminary FIGO stage may be assigned based on available data at the time of HPE signout

In cases who have received Neoadjuvant chemotherapy, Chemotherapy Response Score as per ICCR guidelines should be included in the HPE report.

Recommended IHC panel for confirmation of ovarian high grade serous carcinoma primary is WT1, PAX8 and p53. Other markers to be added as per discretion of the pathologist and based on morphological findings.