THE CANADIAN ASSOCIATION OF GENERAL PRACTITIONERS IN ONCOLOGY
CAGPO
L'ASSOCIATION CANADIENNE DES MÉDECINS OMNIPRATICIENS EN ONCOLOGIE
ACMOO

OVARIAN CANCER CASES

Ovarian Cancer Case 1

Mrs. S. is a 56-year-old woman referred to you for consideration of treatment options regarding her recently diagnosed ovarian cancer. She presented to her family doctor with a complaint of abdominal bloating, early satiety and weight gain. Symptoms had been present for about 4 months. Abdominal and pelvic ultrasounds were completed and showed multiseptated cystic and solid pelvic masses bilaterally measuring 6 cm on the left, and 10 cm on the right. She subsequently was referred to a gynaecological oncologist.

1. How common is ovarian cancer?

2. What age group most commonly presents with this cancer?

3. What are the major histologies with respect to ovarian cancer?

4. Is there a precursor lesion for ovarian cancer?

5. Which of the histological subtypes of ovarian cancer have the best and the worst prognoses in terms of response to chemotherapy and survival rates?

6. What is the difference in outcomes (PFS, OS, QofL) with neoadjuvant chemotherapy and interval debulking surgery versus upfront surgery and adjuvant chemotherapy?

7. Does intraperitoneal chemotherapy offer improvement in PFS and OS versus IV chemotherapy?

8. What surgical intervention should this patient receive, and who should do the surgery?

Mrs. S. underwent a TAH BSO, omentectomy, peritoneal washings, pelvic and para-aortic node biopsies, as well as pelvic and abdominal biopsies. Histology is of a serous cystadenocarcinoma, grade 2. Peritoneal washing, nodes and multiple biopsies were all negative. Pathology reported that there was no surface involvement of the ovaries. The surgeon "ran" the bowel, examined the under surface of the diaphragm, and felt the liver without finding any gross disease. The surgeon did not rupture the ovarian capsules. From the pathology report, and review of the surgical note, you conclude that Mrs. Stewart has been "optimally debulked". Her pre-surgical CA 125 is 350.

9. What stage of disease does this patient have?

10. What does "optimal debulking" refer to?

11. What treatment options would you discuss with Mrs. Stewart?

12. If you conclude she does not require systemic therapy, for which patients with stage 1 disease would you recommend adjuvant systemic therapy?

13. How useful is CA 125 as a tumor marker? Does it have any prognostic significance?

14. What is the most important prognostic factor for ovarian cancer survival?

15. How would you follow Mrs. S. with respect to frequency of follow-up, imaging, lab work?

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Ovarian Cancer Case 2

Mrs. J. is a 43-year-old woman referred with a diagnosis of ovarian cancer.

On reviewing the pathology and surgical note you conclude that she has Stage 3A papillary serous carcinoma, grade 3. At the time of surgery, she was debulked to less than 1 cm of tumor left behind. Peritoneal washings were positive. Her preoperativeCA 125 is 23. Her gynaecologist has already done a post-operative CT scan of the abdomen and pelvis, which shows no residual disease.

On speaking to Mrs. J., you learn that she presented with irregular menstrual bleeding. She had been under a great deal of stress due to her job as a bank manager, and ignored the spotting initially. But, when it didn't resolve after 2 cycles, she presented to her family doctor. Her initial investigations consisted of a Pap smear, and pelvic examination. No gross abnormalities were detected. She also had a pelvic ultrasound, which showed a pelvic mass and fluid in the cul-desac.

She subsequently underwent a TAH BSO, omentectomy, peritoneal washings and biopsies, as well as pelvic and para-aortic node biopsies. Mrs. S. is quite upset. Her mother died of ovarian cancer at age 53. Her maternal aunt died of breast cancer at age 45. Mrs. J. is an otherwise healthy single mother with 2 teenage children. She wants to be as aggressive as possible, to 'beat this' and see her children grow up.

1. Has Mrs. J. had appropriate surgery?

2. What is the difference in outcomes (PFS, OS, QofL) with neoadjuvant chemotherapy and interval debulking surgery versus upfront surgery and adjuvant chemotherapy?

3. When is a post-operative CT scan required?

4. What chemotherapy treatment options are available to Sally (discuss the role for systemic and intraperitoneal chemotherapy as well as dose dense chemotherapy)?

5. How is a durable response to first line platinum-based chemotherapy defined? What is the definition of platinum-resistent or platinum-refractory ovarian cancer?

6. Does intraperitoneal chemotherapy offer improved PFS and improved OS versus IV chemotherapy?

7. What side effects are commonly associated with these chemotherapy regimens?

8. How effective is chemotherapy in preventing recurrence and curing this stage of disease?

9. Is there any role for radiation therapy?

10. How would you advise her regarding genetic counselling given her family history?

11. What preventataive and risk reduction strategies are available currently for ovarian cancer? Which testing is not recommended for ovarian cancer screening?

12. What percentage of ovarian cancers is familial and what genetic linkage has been found? List the 3 hereditary patterns that have been identified.

13. What recommendations do you make to her regarding follow up (frequency of visits, laboratory investigations and radiological investigations)?

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