



Ovarian Cancer Surgery Guidelines Early stage

(provisional document)



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Diagnosis & preoperative workup

Clinical examination including abdominal, vaginal and rectal examinations, assessment of the groin, axilla, and supraclavicular areas, lung and breast should be performed.

Routine pelvic (transvaginal) ultrasound and if needed suprapubic must be used as a primary workup tool in any adnexal mass.

Specialized pelvic and abdominal complementary imaging ultrasound and/or MRI and/or CT scan and/or PET - CT should be performed in case of undertermined or suspicious masses at routine ultrasound examination.

A thoraco-abdomino-pelvic imaging must be performed in patients with non emergency clinical presentation and suspected carcinoma of the ovary.

A blood sampling must be taken for blood markers assessment, at least CA 125 levels. Possible additional markers, including AFP, hCG, LDH, CEA, CA 19-9, inhibin B or AMH, estradiol, testosterone, must be taken in specific circumstances: young patient, or imaging suggesting a mucinous, or non epithelial, or extra-adnexal tumour.

Specialized multidisciplinary decision making

Patients with non emergency clinical presentation and suspected malignancy of the adnexa should be referred to a specialist in gynecologic oncology certified gynaecological oncologist or, in countries where certification is not organized, by a trained surgeon dedicated to the management of gynecologic cancer accounting for over 50% of his practice or having completed an ESGO accredited fellowship and discussed preoperatively in a multidisciplinary meeting.

All patients must be reviewed postoperatively at a gynaecological oncology multidisciplinary meeting.

Surgical management

Midline laparotomy is required to manage early ovarian cancers, with the exception of apparent stage I which can be managed laparoscopically by a gynaecological oncologist with specific expertise in laparoscopy, without rupture and without contamination of the abdominal cavity and wall.

Intraoperative rupture of a yet unruptured adnexal mass must be avoided.

Total hysterectomy and bilateral salpingo-oophorectomy is standard.

Fertility preserving surgery unilateral salpingo -oophorectomy should be offered to selected premenopausal patients with apparent stage IA¹

When early carcinoma is incidentally found at surgery for a suspected 'benign' condition, a second surgical procedure will be required. When the patient has not been comprehensively staged, a second surgical procedure must be considered routinely

Laparoscopic surgery is an acceptable approach if performed by a gynecologic oncologist with adequate expertise to perform a comprehensive staging.

¹ discussion on fertility must be mentioned in the patient record; final decision based on final stage and grade : fertility preservation is accepted in case of stage IA or IC1, low-grade serous or endometrioid carcinoma, or expansile type mucinous tumours; other stage I substages or pathologic subtypes, subject to individualized decision; uterine preservation with bilateral salpingo-oophorectomy, can be considered in selected young patients with apparent stage IB low risk invasive carcinoma and normal endometrial biopsy finding. However, there is very few data to support this policy.

Visual assessment of the entire peritoneal cavity is recommended.

Peritoneal washings or cytology, taken prior to manipulation of the tumour are recommended

Blind peritoneal biopsies from the pelvis, paracolic spaces, and the subdiaphragmatic spaces bilaterally are recommended.

At least infracolic omentectomy is recommended.

Bilateral pelvic and para-aortic lymph node dissection up to the level of the left renal vein with the exception of stage I expansile type mucinous adenocarcinomas are recommended.

Restaging for the only purpose of performing appendectomy is not mandatory even in case of mucinous histology if the appendix has been examined and found normal.

Role of frozen section

The availability of frozen section may allow the necessary surgical staging to be done at the time of initial surgery. It is understood that frozen section may not be conclusive and that definitive pathology is the gold standard of diagnosis.

In the absence of frozen section or in case of inconclusive frozen section, a two-step procedure should be preferred.