Ovarian Cancer
Including Fallopian Tube Cancer
and Primary Peritoneal Cancer

Version 1.2015

一、本共識依下列參考資料修改版本：

NCCN Clinical Practice Guidelines in Oncology- Ovarian -Fallopian Tube -Primary Peritoneal Cancer V.2.2015

2009年Revised FIGO staging for carcinoma of the Ovarian -Fallopian Tube -Primary Peritoneum

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Ovarian -Fallopian Tube -Primary Peritoneal Cancer
Clinical Guidelines
in Oncology, FEMH – v.1.2015

CLINICAL PRESENTATION → **WORK-UP** → **PRIMARY TREATMENT** [g,h,I,j]

Suspicious [a]/palpable pelvic mass detected on abdominal/ pelvic exam and/or ascites, abdominal distention, and/or
Symptoms such as bloating, pelvic or abdominal pain, difficulty eating or feeling full quickly or urinary symptoms (urgency or frequency)[b] without other obvious source of malignancy

→

- Obtain family history[c] and consider family history evaluation[c,d]
- Abdominal/ pelvic exam
- GI evaluation as clinically indicated
- Ultrasound and/or abdominal/ pelvic CT as clinically indicated[e]
- 礤 Chest imaging
- CA-125 , or other tumor markers as clinically indicated[f]
- Complete blood count (CBC), chemistry profile with liver function test (LFTs)

→

Laparotomy/ Total abdominal hysterectomy (TAH) / Bilateral salpingo- oophorectomy (BSO) with comprehensive staging[j] or unilateral salpingo-oophorectomy (USO) (Clinical Stage IA or IC, all grades with comprehensive staging if patient desires fertility)
or
Cytoreductive surgery[j] if clinical stage II, III,Ⅳ
or
Consider neoadjuvant chemotherapy[k] (category 1)/primary interval cytoreduction[h] (diagnosis by fine-needle aspiration [FNA],biopsy, or paracentesis) for patients with bulky stage III/ Ⅳ who are poor surgical candidates due to high-risk comorbidity conditions or disease factors.

→ **See Pathologic Staging (OV-3)**

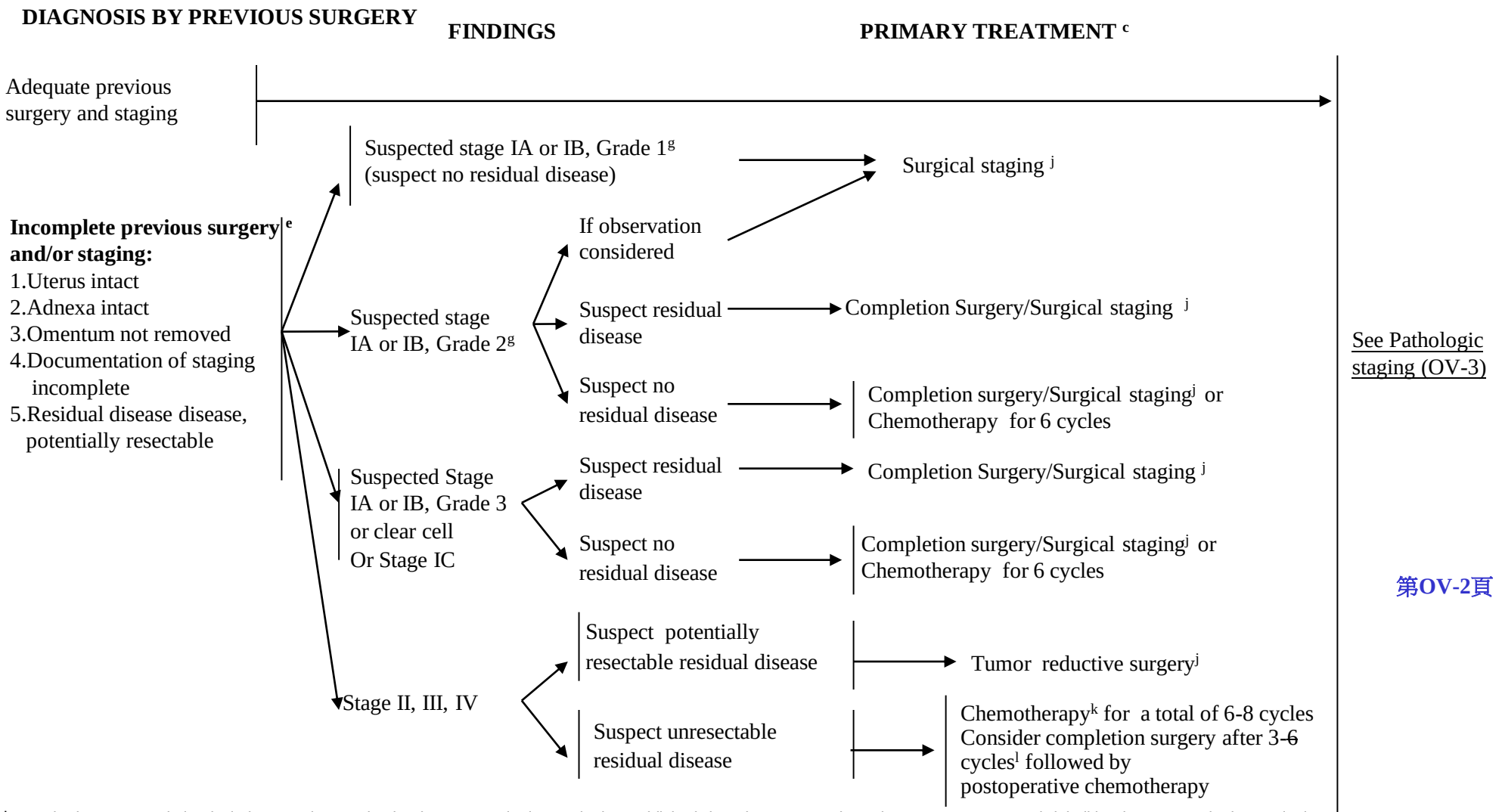
Diagnosis by previous surgery or tissue biopsy (cytopathology)

→

- Obtain family history and consider family history evaluation
- Ultrasound and/or abdominal/pelvic CT/MRI as clinically indicated[e]
- Chest imaging
- CA-125 or other tumor markers as clinically indicated[f]
- CBC, chemistry profile with LFTs
- Institutional pathology review
- Refer for genetic risk evaluation[c,d]

→ **See Findings and Primary Treatment (OV-2)**

[a] Im SS, Gordon AN, Buttin BM, et al. Obstet Gynecol 2005;105:35-41. See Discussion.
[b] Goff BA, Mandel L,Drescher CW, et al. Cancer 2007;109:221-227.
[c] **See NCCN Guidelines for Genetic/Familial High-Risk Assessment: Breast and Ovarian and NCCN Guidelines for Genetic/Familial High-Risk Assessment: Colorectal.**
[d] Primary treatment should not be delayed for a genetic counseling referral.
[e] PET/CT scan or MRI may be indicated for indeterminate lesions if results will alter management.
[f] See Discussion for usefulness of diagnostic tests.
[h] Standard recommendation includes a patient evaluation by a gynecologic oncologist prior to initiating chemotherapy. Published data demonstrate that primary assessment and debulking by a gynecologic oncologist result in a survival advantage. Patients being evaluated for neoadjuvant chemotherapy should be seen by a fellowship-trained gynecologic oncologist prior to being considered a poor surgical candidate. A referral to a gynecologic oncologist is also recommended for management of occult serous tubal intraepithelial carcinomas.
[i] All women undergoing surgery for ovarian cancer should be counseled about the clinical benefit associated with combined IV and IP chemotherapy administration prior to surgery. **NCI Clinical Announcement.**
[j] **See Principles of Surgery (OV-A).**
[k] **See Principles of Chemotherapy (OV-B)** and **Management of Drug Reactions (OV-C).**



h Standard recommendation includes a patient evaluation by a gynecologic oncologist. Published data demonstrate that primary assessment and debulking by a gynecologic oncologist result in a survival advantage. Patients being evaluated for neoadjuvant chemotherapy should be seen by a fellowship-trained gynecologic oncologist prior to being consider a poor nonsurgical candidate.

j **See Principles of primary Surgery (OV-A).**

k **See Principles of Chemotherapy (OV-B) and Management of Drug Reactions (OV-C).**

l Based on clinical judgement of gynecologic oncologist, surgery may be performed after considered a poor nonsurgical candidate.

m Completion surgery after 3 cycles is preferred; however, surgery may be performed after 4–6 cycles based on the clinical judgment of the gynecologic oncologist.

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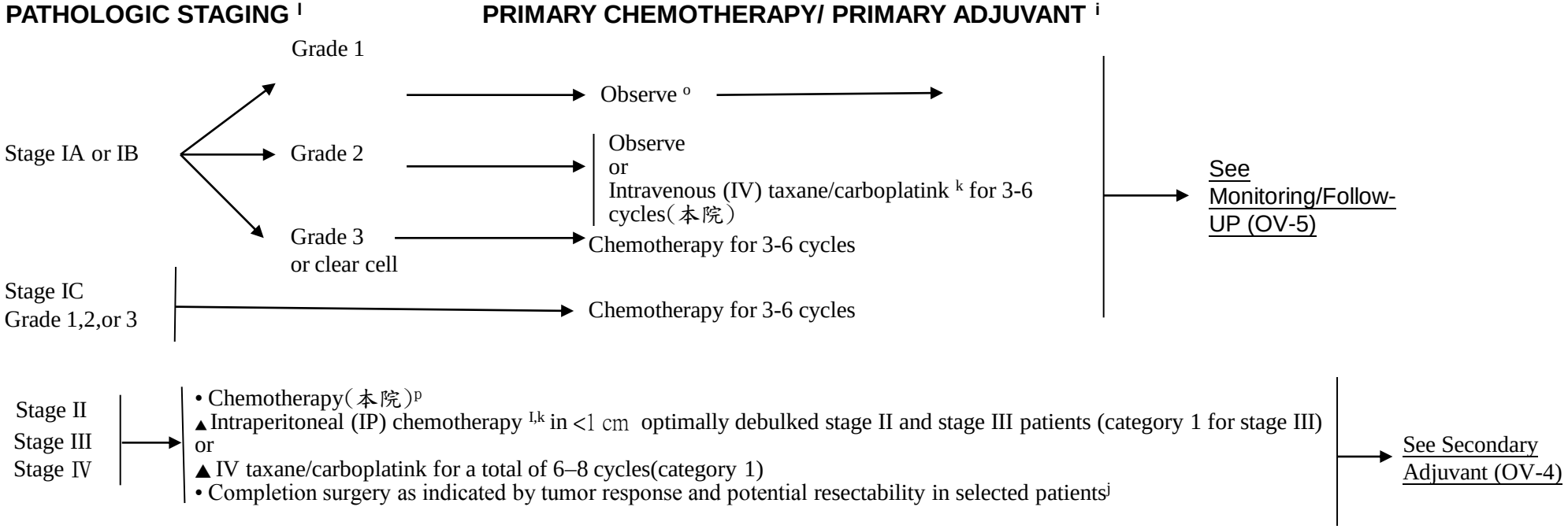


[i] All women undergoing surgery for ovarian cancer should be counseled about the clinical benefit associated with combined IV and IP chemotherapy administration prior to surgery.

[j] See Principles of primary Surgery (OV-A).

[k] See Principles of Chemotherapy (OV-B) and Management of Drug Reactions (OV-C).

[l] Some pathologists recommend that ovarian cancer be graded either low-grade (most grade 1 serous tumors) or high-grade (most grade 2 or 3 serous tumors). See FIGO Guidelines (ST-5).

[n] Patients receiving primary chemotherapy will be monitored as follows:
1.Pelvic exams at least every 2 cycles
2.Interim CBC with platelets as indicated
3.Chemistry profiles if indicated
4.CA-125 levels or other tumor markers as clinically indicated prior to each cycle of chemotherapy
5.Radiographic imaging if indicated.

[o] See Discussion for more details about treatment of low-grade tumors.

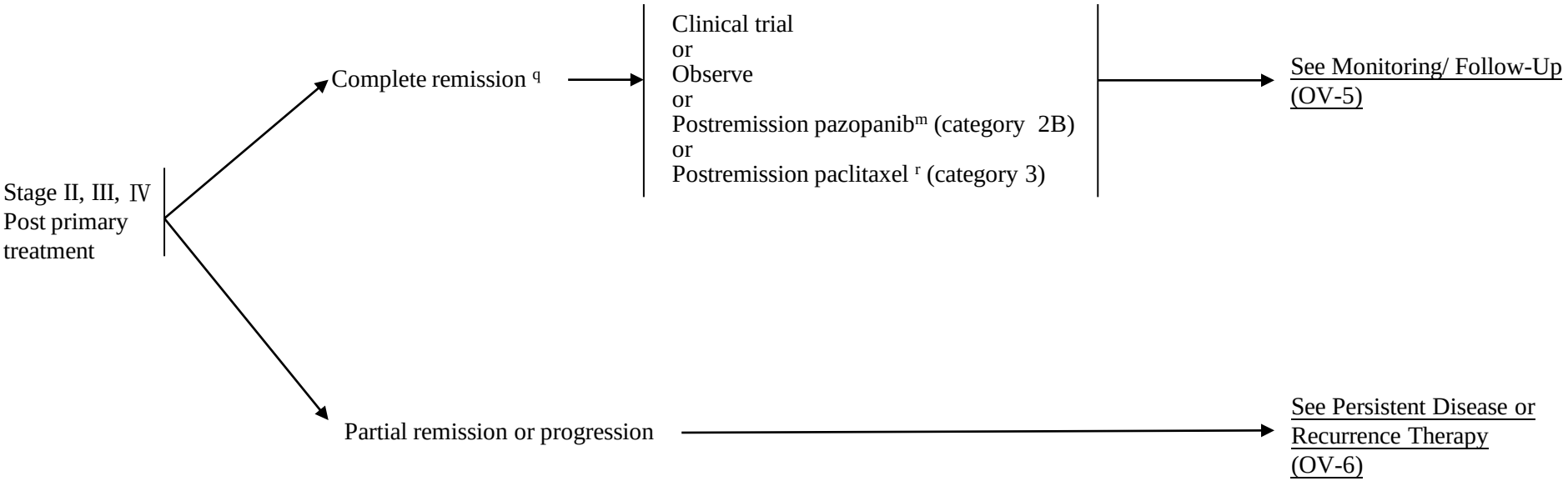
[p] See specific regimens on Primary Chemotherapy/Primary Adjuvant Therapy Regimens for Stage II-IV (OV-B 3 of 3)

第OV-3頁

Note:All recommendations are category 2A unless otherwise indicated.

STAGE II, III, Ⅳ
POST PRIMARY TREATMENT

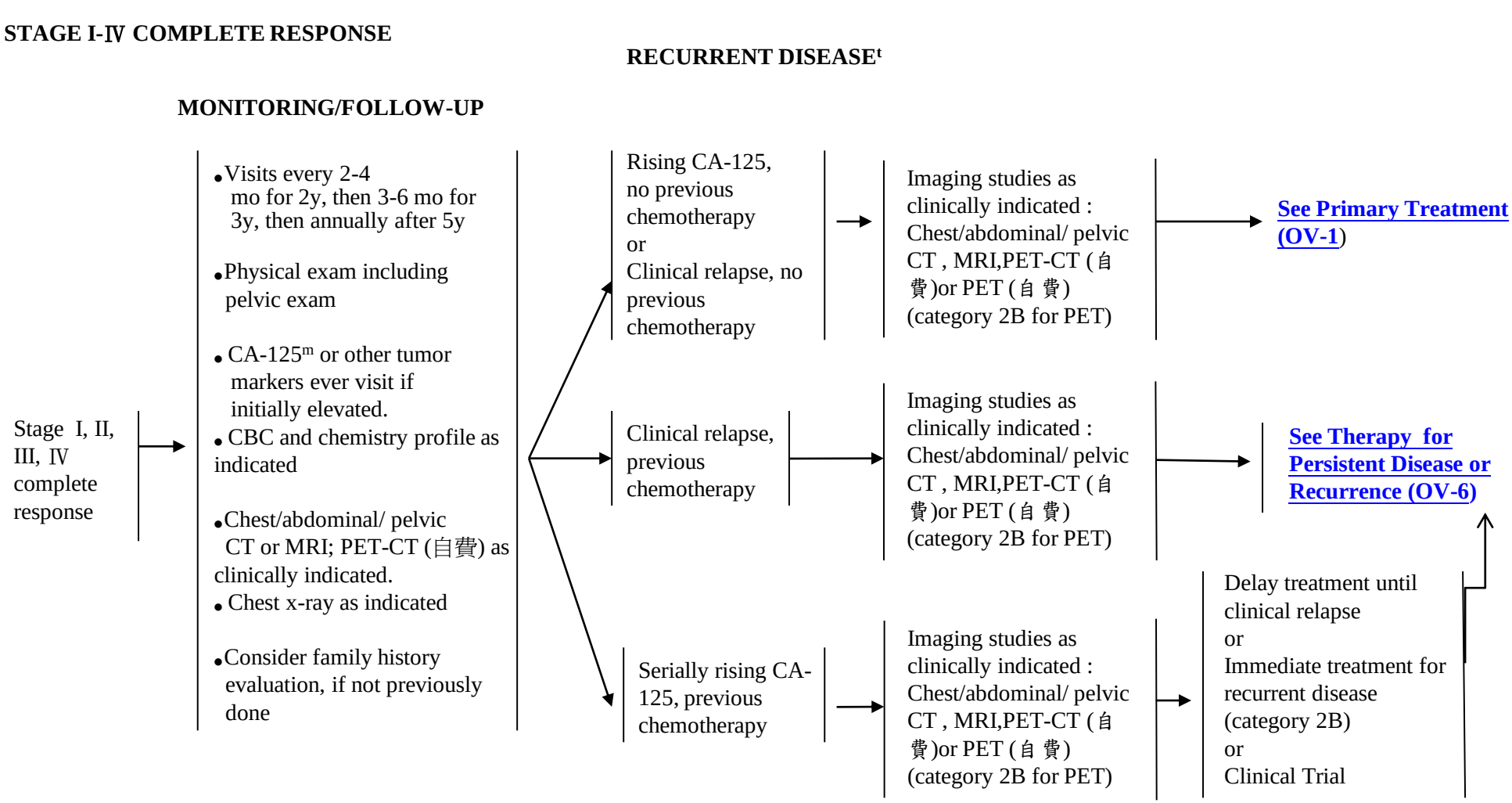
SECONDARY ADJUVANT



第 OV- 4頁

q No objective evidence of disease (ie, negative physical exam, negative CA-125, negative CT with < 1 cm lymph nodes).

r **See Discussion** for doing.

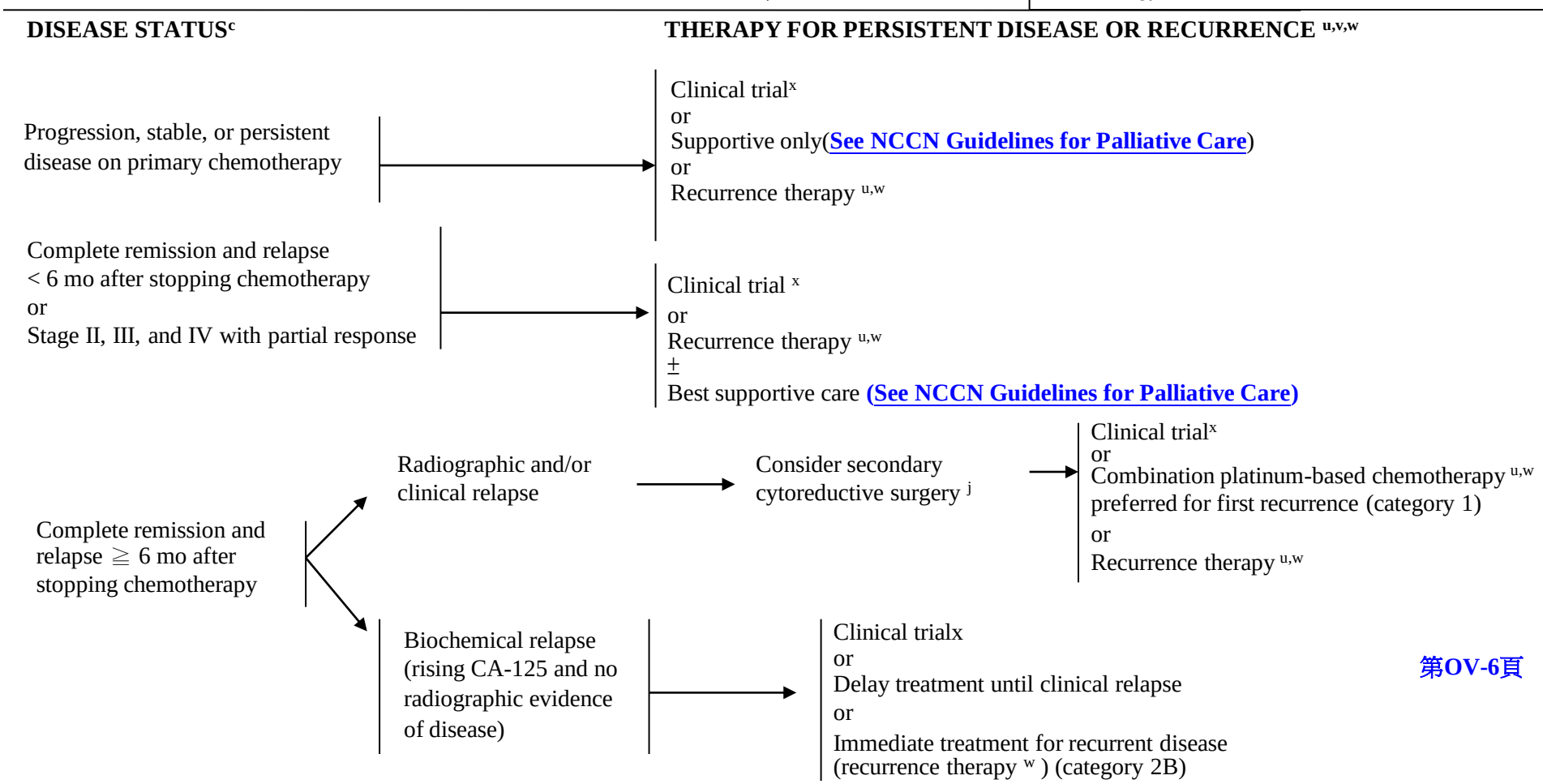


第OV-5頁

[c] See NCCN Guidelines for Genetic/Familial High-Risk Assessment: Breast and Ovarian and NCCN Guidelines for Genetic/Familial High-Risk Assessment: Colorectal.

[s] There are data regarding the utility of CA-125 for monitoring of ovarian cancer after completion of primary therapy. See The Society of Gynecologic Oncology (SGO) position statement and Discussion.

[t] Consider symptom management and best supportive care. See NCCN Guidelines for Palliative Care. Refer for palliative care assessement, if appropriate.

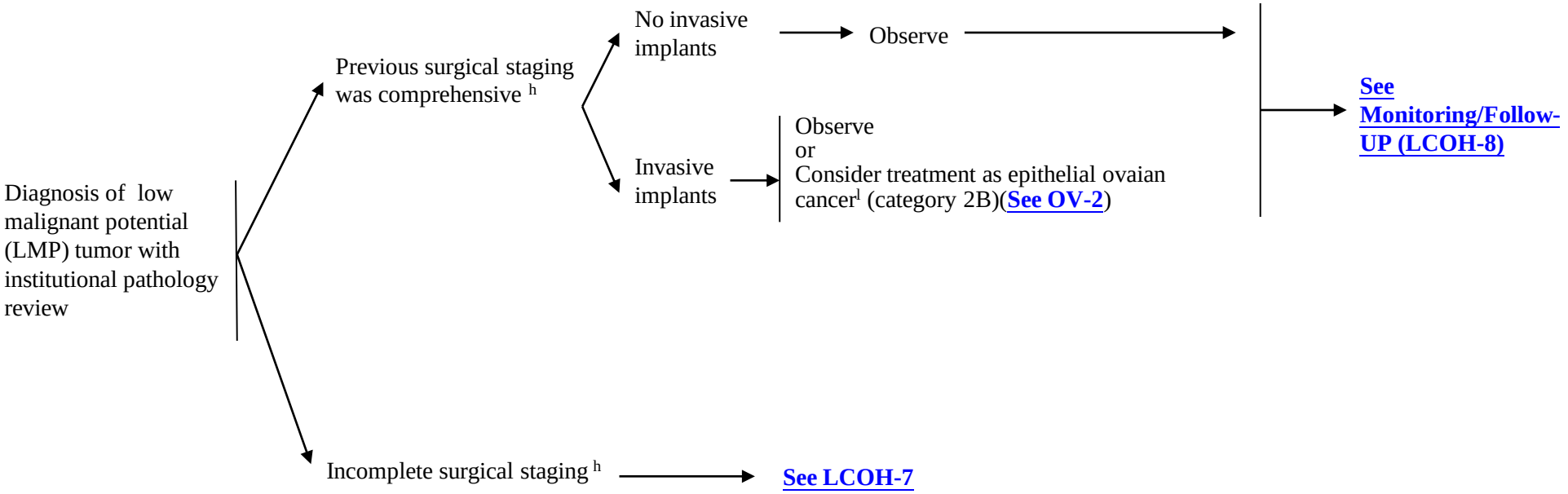


第OV-6頁

[c] See NCCN Guidelines for Genetic/Familial High-Risk Assessment: Breast and Ovarian and NCCN Guidelines for Genetic/Familial High-Risk Assessment: Colorectal.
[j] See Principles of Surgery (OV-A).
[u] Patients who progress on 2 consecutive therapy regimens without evidence of clinical benefits have diminished likelihood of benefitting from additional therapy. Decisions to offer clinical trials, supportive care only, or additional therapy should be made on a highly individual basis.
[v] See Ancillary Palliative Surgical Procedures in Principles of Surgery (OV-A 3 of 3).
[w] See Acceptable Recurrence Therapies (OV-D).
[x] Clinical trials with newer agents should be strongly considered.

CLINICAL PRESENTATION

PRIMARY THERAPY[k]



第LCOH-6頁

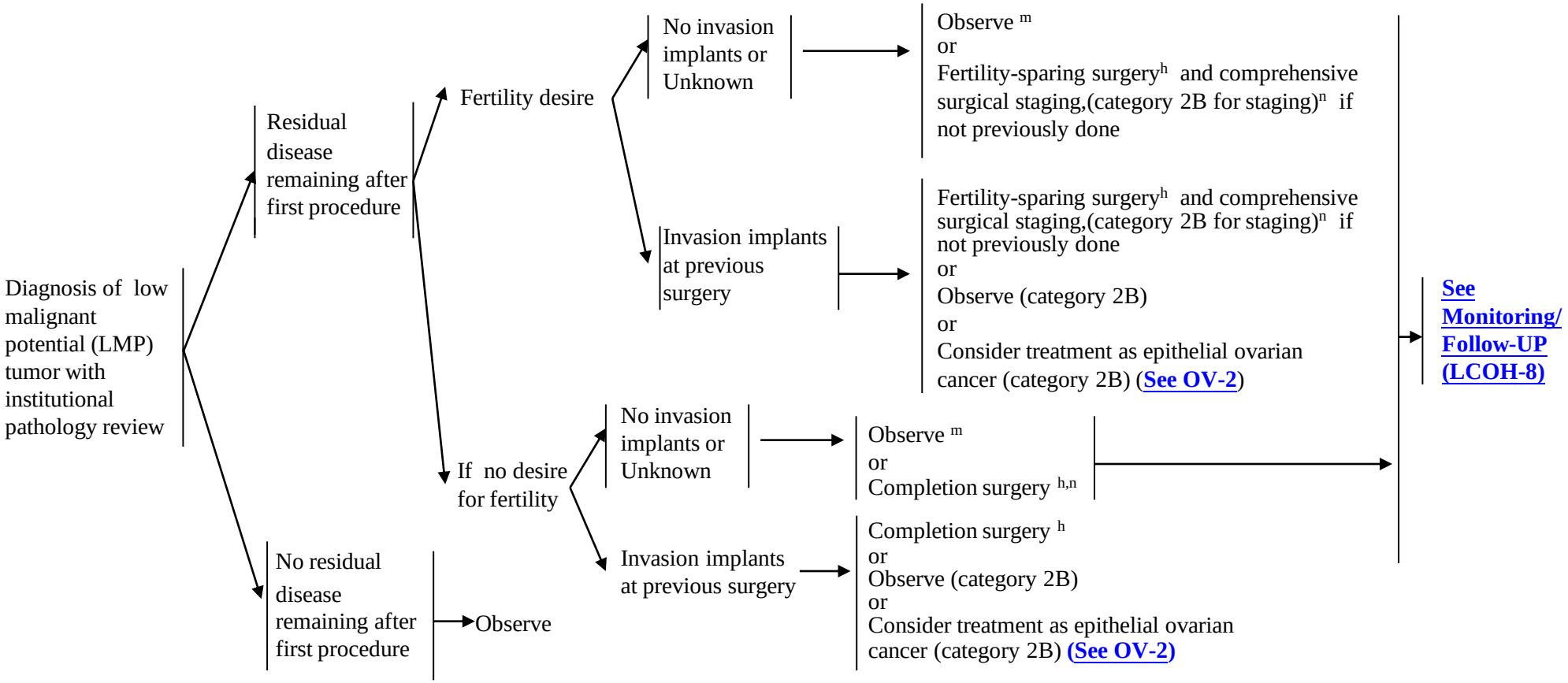
[h]See Principles of Surgery (OV-A).

[k]Standard recommendation includes a patient evaluation by a gynecologic oncologist.

[l]Chemotherapy (IV or IP) has not been shown to be beneficial in ovarian low malignant potential tumors (borderline epithelial ovarian tumors).

CLINICAL PRESENTATION

PRIMARY THERAPY[k]



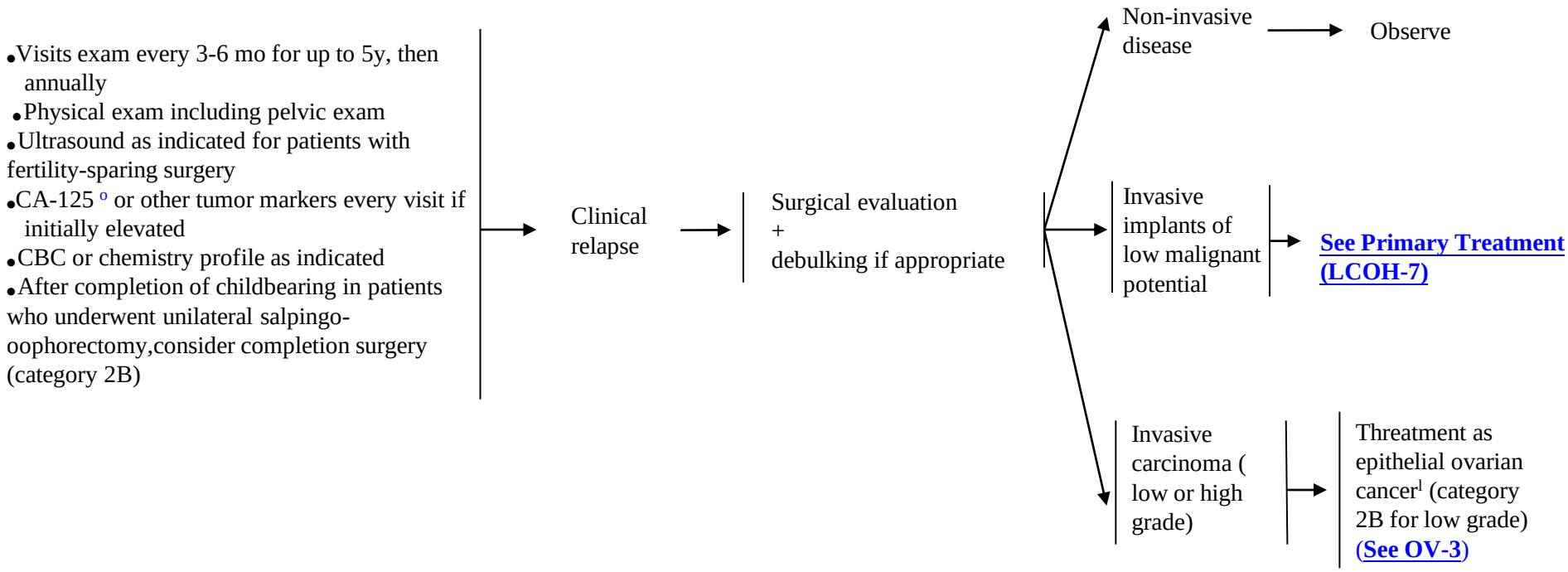
[h] See Principles of Surgery (OV-A).

[k] Standard recommendation includes a patient evaluation by a gynecologic oncologist.

[l] Chemotherapy (IV or IP) has not been shown to be beneficial in ovarian low malignant potential tumors borderline epithelial ovarian tumors).

[m] Observation is a reasonable option regardless of whether fertility is desired.

[n] For pathologically proven LMP, lymph node evaluation may be considered on a case-by-case basis.



第LCOH-8頁

[l]Chemotherapy (IV or IP) has not been shown to be beneficial in ovarian low malignant potential tumors (borderline epithelial ovarian tumors).

[o]There are data regarding the utility of CA-125 for monitoring of ovarian cancer after completion of primary therapy. See The Society of Gynecologic position statement and Discussion.

Staging

Table 1

American Joint Committee on Cancer (AJCC); TNM and FIGO Staging for Ovarian and Primary Peritoneal Cancer (7th ed.,2010)

TNM	FIGO	Surgical-Pathologic Findings
TX		Primary tumor cannot be assessed
T0		No evidence of primary tumor
T1	**I**	Tumor limited to ovaries (one or both)
T1a	**I A**	Tumor limited to one ovary; capsule intact, no tumor on ovarian surface. No malignant cells in ascites or peritoneal washings.
T1b	**I B**	Tumor limited to both ovaries; capsule intact, no tumor on ovarian surface. No malignant cells in ascites or peritoneal washings.
T1c	**I C**	Tumor limited to one or both ovaries with any of the following; capsule ruptured, tumor on ovarian surface, malignant cells in ascites or peritoneal washings.
T2	**II**	Tumor involves one or both ovaries with pelvic extension.
T2a	**IIA**	Extension and/or implants on uterus and/or tube(s). No malignant cells in ascites or peritoneal washings.
T2b	**IIB**	Extension and/or implants on other pelvic tissues. No malignant cells in ascites or peritoneal washings.
T2c	**IIC**	Pelvic extension and/or implants (T2a or T2b) with malignant cells in ascites or peritoneal washings.
T3	**III**	Tumor involves one or both ovaries with microscopically confirmed peritoneal metastasis outside the pelvis.
T3a	**III A**	Microscopic peritoneal metastasis beyond pelvis (no maroscopic tumor).
T3b	**III B**	Microscopic peritoneal metastasis beyond pelvis 2 cm or less in greatest dimension.
T3c	**III C**	Peritoneal metastasis beyond pelvis more than 2 cm in greatest dimension and/or regional lymph node metastasis.

Regional Lymph Nodes (N)		
Nx		Regional lymph nodes cannot be assessed
N0		No regional lymph node metastasis
N1	III C	Regional lymph node metastasis

Distant metastasis (M)		
M0		No distant metastasis
M1	IV	Distant metastasis

Note: Liver capsule metastasis is T3/Stage III; liver parenchymal metastasis, M1/Stage IV. Pleural effusion must have positive cytology for M1/Stage IV.

第ST-1頁 Continued

Staging

Table 1 (Continued)
American Joint Committee on Cancer (AJCC);
TNM and FIGO Staging for Ovarian and Primary Peritoneal Cancer (7th ed.,2010)

Stage Groping

Stage	**I**	**T1**	**N0**	**M0**
Stage	**IA**	**T1a**	**N0**	**M0**
Stage	**IB**	**T1b**	**N0**	**M0**
Stage	**IC**	**T1c**	**N0**	**M0**
Stage	**II**	**T2**	**N0**	**M0**
Stage	**IIA**	**T2a**	**N0**	**M0**
Stage	**IIB**	**T2b**	**N0**	**M0**
Stage	**IIC**	**T2c**	**N0**	**M0**
Stage	**III**	**T3**	**N0**	**M0**
Stage	**IIIA**	**T3a**	**N0**	**M0**
Stage	**IIIB**	**T3b**	**N0**	**M0**
Stage	**IIIC**	**T3c**	**N0**	**M0**
		Any T	**N1**	**M0**
Stage	**IV**	**Any T**	**AnyN**	**M1**

The staging system for ovarian and primary peritoneal cancer is also used for malignant germ cell tumors, malignant sex cord-stromal tumors, and carcinosarcoma (malignant mixed Müllerian tumors).

Note: For histologic grade and histopathological type, see AJCC staging manual.

第ST-2頁

Staging

Table 2

American Joint Committee on Cancer (AJCC); TNM and FIGO Staging for Fallopian Tube Cancer (7th ed.,2010)

TNM	FIGO	Surgical-Pathologic Findings
TX		Primary tumor cannot be assessed
T0		No evidence of primary tumor
Tis*		Carcinoma in situ (limited to tube mucisa)
T1	**I**	Tumor limited to the fallopian tube(s)
T1a	**I A**	Tumor limited to one tube, without penetration the serosal surface; no ascites.
T1b	**I B**	Tumor limited to both tubes , without penetration the serosal surface; no ascites.
T1c	**I C**	Tumor limited to one or both tubes with extension onto or through the tubal serosa, or with malignant cells in ascites or peritoneal washings.
T2	**II**	Tumor involves one or both fallopian tubes with pelvic extension.
T2a	**IIA**	Extension and/or metastasis to the uterus and/or ovaries.
T2b	**IIB**	Extension to other pelvic structures.
T2c	**IIC**	Pelvic extension with malignant cells in ascites or peritoneal washings.
T3	**III**	Tumor involves one or both fallopian tubes, with peritoneal implants outside the pelvis.
T3a	**III A**	Microscopic peritoneal metastasis outside the pelvis.
T3b	**III B**	Microscopic peritoneal metastasis outside the pelvis 2 cm or less in greatest dimension.
T3c	**III C**	Peritoneal metastasis outside the pelvis and more than 2 cm in greatest diameter.

Regional Lymph Nodes (N)		
Nx		Regional lymph nodes cannot be assessed
N0		No regional lymph node metastasis
N1	III C	Regional lymph node metastasis
Distant metastasis (M)		
M0		No distant metastasis
M1	IV	Distant metastasis (excludes metastssis within the peritoneal cavity)

* Note: FIGO no longer includes Stage 0 (Tis)

Note: Liver capsule metastasis is T3/Stage III; liver parenchymal metastasis, M1/Stage IV. Pleural effusion must have positive cytology for M1/Stage IV.

第ST-3頁

Continued

Staging

Table 2 (Continued)
American Joint Committee on Cancer (AJCC);
TNM and FIGO Staging for Fallopian Tube Cancer (7th ed.,2010)

Stage Groping

Stage	**0**	**Tis**	**N0**	**M0**
Stage	**I**	**T1**	**N0**	**M0**
Stage	**IA**	**T1a**	**N0**	**M0**
Stage	**IB**	**T1b**	**N0**	**M0**
Stage	**IC**	**T1c**	**N0**	**M0**
Stage	**II**	**T2**	**N0**	**M0**
Stage	**IIA**	**T2a**	**N0**	**M0**
Stage	**IIB**	**T2b**	**N0**	**M0**
Stage	**IIC**	**T2c**	**N0**	**M0**
Stage	**III**	**T3**	**N0**	**M0**
Stage	**IIIA**	**T3a**	**N0**	**M0**
Stage	**IIIB**	**T3b**	**N0**	**M0**
Stage	**IIIC**	**T3c**	**N0**	**M0**
		Any T	**N1**	**M0**
Stage	**IV**	**Any T**	**Any N**	**M1**

第ST-4頁

* Note: FIGO no longer includes Stage 0 (Tis)
Note: For histologic grade and histopathological type, see AJCC staging manual.

六、Updated on 2015/08/27

內容: