

Managing ovarian cancer

A good screening tool seems to offer the best hope, but meanwhile best possible care includes definitive staging and surgery by experienced specialist teams

OVARIAN CANCER is the leading cause of death from gynaecological cancer in Australia, and indeed most Western countries. In the absence of effective primary prevention strategies and screening for early disease, the best possible management of patients with suspected or established ovarian cancer assumes critical importance if inroads are to be made in reducing morbidity and mortality from this disease.

In this issue of the Journal (*page 11*), Grossi et al have reviewed the management of women with ovarian cancer diagnosed in Victoria during the period 1993 to 1995.¹ Despite methodological difficulties with research of this type in terms of accurately defining variables

such as stage and residual disease, the study is valuable for reflecting what actually happens in everyday clinical life. It shows that more than one in five patients did not undergo a laparotomy, which is required both to make a definitive diagnosis and to adequately stage

the disease. Furthermore, a large proportion of patients with this disease are treated by specialists who are not specifically trained in gynaecological oncology, or are treated outside major teaching institutions. This problem is by no means confined to Victoria or indeed Australia. In a recent review of patterns of care of patients with ovarian cancer in the United States, Carney et al found that, of 848 patients with epithelial ovarian cancer, only 333 (39.3%) were seen (not necessarily treated) by a gynaecological oncologist "at some time during their cancer diagnosis and/or treatment".² The situation in Victoria, as reported by Grossi et al, compares favourably with the US experience. However, both studies clearly demonstrate that significant change is required if women with this kind of gynaecological cancer are to receive the best possible treatment.

The Victorian survey suggests that triage of patients to appropriately staffed and equipped gynaecological cancer centres is inadequate. In some measure this may be the result of the relatively low number of patients who had imaging (such as ultrasound) and tumour marker studies (such as carcinoma antigen [CA] 125). These investigations are important in patients who present with a pelvic mass, as, if they suggest a significant risk of malignancy, appropriate referrals can be arranged. This issue is especially important, as Grossi et al have shown that less adequate surgery adversely affects outcomes. Somewhat disturbing is the finding that, even in the hands of trained subspecialist gynaecological oncologists, fewer than half of the patients with apparently early disease had adequate staging performed. For women with early-stage disease the outlook is excellent, and every effort should be made to perform adequate surgery so as to avoid overtreatment those whose outcome is not improved by adjuvant chemotherapy and to select those who might benefit from additional therapy.

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Epithelial ovarian cancers may occur in young women, and in many cases it is possible to both adequately treat the cancer and preserve reproductive function.³

Also revealed by the Victorian survey is the apparent inadequacy of cytoreductive surgery, even when performed by subspecialist gynaecological oncologists. Although residual disease did not appear to be significant in the Victorian survey, other studies have shown that the amount of residual disease at the end of cytoreductive surgery has a major influence on survival,⁴ and it is accepted that every effort should be made to "debulk" the tumour to the minimum

size possible. This can require major resection of bowel or other organs and it can be a formidable undertaking for both the patient and the treating team. Such extensive surgery should only be performed by appropriately trained teams in major centres. Many gynaecological oncology centres both in Aus-

tralia and overseas report rates of "optimal debulking" of over 70%.^{5,6} The article by Grossi and colleagues demonstrates that it is a major challenge to ensure that patients with ovarian cancer have timely access to these facilities.

What else can be done to improve the outcome for women with ovarian cancer? Ultimately, prevention would be the ideal solution. For women with familial forms of ovarian cancer appropriately timed oophorectomy may offer a high degree of protection. However, for most women, the development of a reliable and acceptable screening method to detect early-stage disease offers the best hope. Currently, there is no acceptable screening method available, but some studies using CA125 and transvaginal ultrasound as screening tools have shown promise.⁷ A number of large international trials are currently under way to determine if screening will have a significant impact on the mortality of this disease.

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