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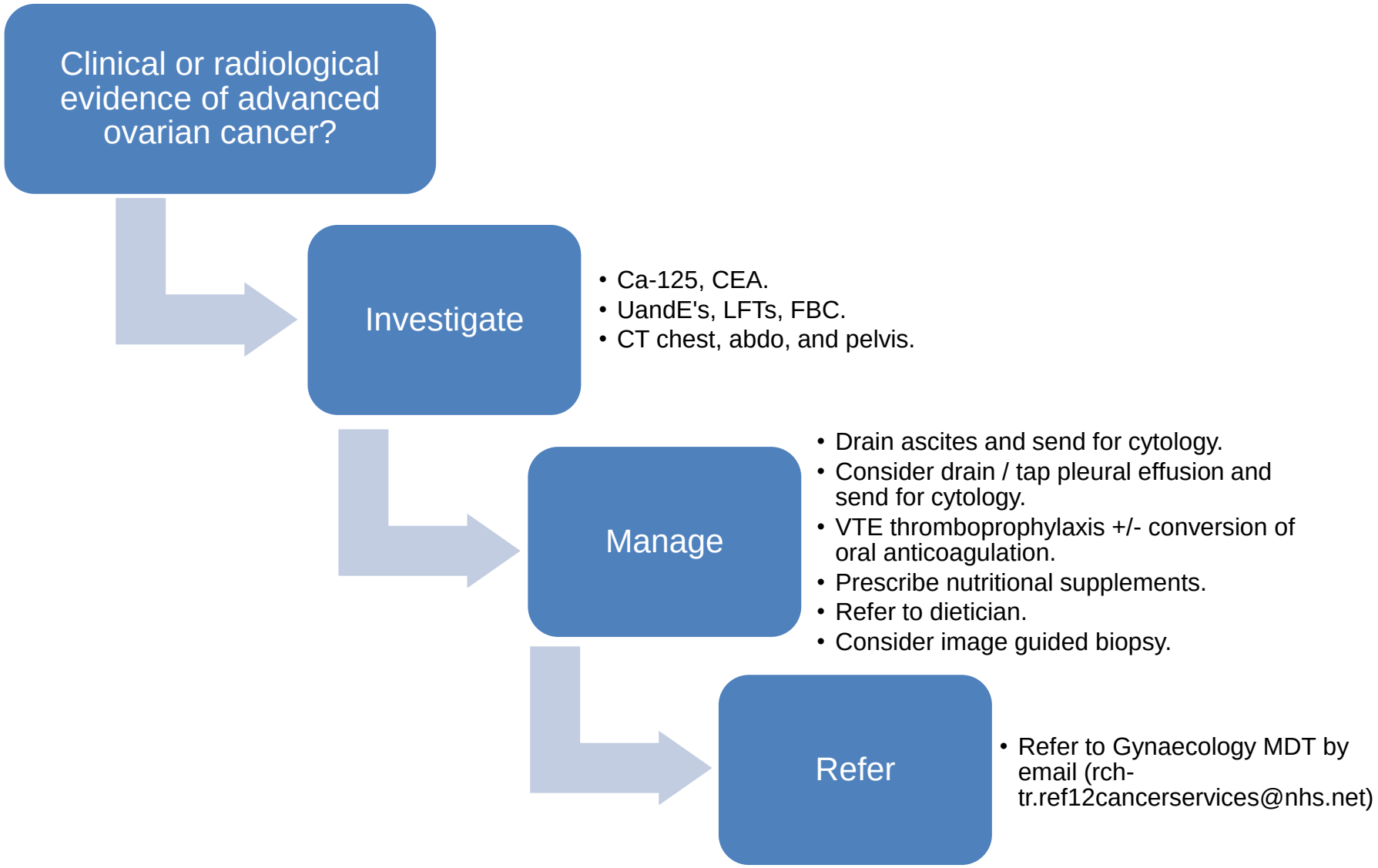
Royal Cornwall Hospitals NHS Trust

Inpatient Management of Women With Suspected Advanced Ovarian Cancer Clinical Guideline

V2.0

June 2023

Summary


Clinical or radiological evidence of advanced ovarian cancer?
Investigate
• Ca-125, CEA.
• UandE's, LFTs, FBC.
• CT chest, abdo, and pelvis.
Manage
• Drain ascites and send for cytology.
• Consider drain / tap pleural effusion and send for cytology.
• VTE thromboprophylaxis +/- conversion of oral anticoagulation.
• Prescribe nutritional supplements.
• Refer to dietician.
• Consider image guided biopsy.
Refer
• Refer to Gynaecology MDT by email (rch-tr.ref12cancerservices@nhs.net)

1. Aim/ Purpose of this Guideline

1.1. To provide guidance to clinical staff on the necessary investigations and initial management for women with suspected advanced ovarian cancer admitted to hospital.

1.2. This version supersedes any previous versions of this document.

Data Protection Act 2018 (General Data Protection Regulation – GDPR) Legislation

The Trust has a duty under the Data Protection Act 2018 and General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

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Royal Cornwall Hospital Trust rch-tr.infogov@nhs.net

2. The Guidance

2.1. Background

2.1.1. Ovarian cancer is the fifth most common cancer in women, with a lifetime risk of around 2% in the UK. Despite improvements in treatment and survival, prognosis remains poor with a 35-40% survival rate at 5 years. It is therefore the leading cause of death from gynaecological cancer in the UK.

2.1.2. The stage of disease is one of the most important factors affecting outcome. Unfortunately, most women present with advanced disease, because symptoms are often non-specific, and presentation is delayed. Often secondary delays occur between presentation to the GP and specialist referral. The patient's general health at the time of presentation is also an important factor as a poor performance status will impact on the treatments that can be offered.

2.1.3. Due to late presentation and rapid deterioration of health it is especially important that these women experience a streamlined service to optimise outcomes. This guideline has been designed to help ensure patients have the appropriate work-up prior to being discussed at the gynae-oncology MDT (Multi-Disciplinary Team) so that all possible information is available to the team and treatment can commence without further delays.

2.2. History and Examination

2.2.1. History should include:

2.2.1.1. The presenting symptoms:

- Abdominal distension / bloating.
- Early satiety or loss of appetite.
- Dietary intake.
- Pelvic or abdominal pain.
- Increased urinary frequency or urgency.
- Post menopausal bleeding.
- Weight loss.
- Fatigue.
- Change in bowel habit, especially in those over the age of 50.

2.2.1.2. Assessment for risk factors:

- First degree relative with ovarian cancer and/or breast cancer and/or bowel.
- Known carrier of genetic mutations such as BRCA 1, BRCA2 or mismatch repair genes such as Lynch II syndrome.
- Nulliparity.

2.2.1.3. Assessment for protective factors:

- Oral Contraceptive pill use.
- Parity.
- Sterilisation and hysterectomy.

2.2.2. History should also include any relevant past medical and surgical history, current medications, allergies, nutritional intake and VTE assessment.

2.2.3. Physical examination should include assessment for:

- Ascites.
- Pelvic or abdominal masses, assess for tenderness, mobility,

and nodularity.

- Pleural effusion.
- Venous Thromboembolism (VTE).
- BMI.

2.3. Investigations

2.3.1. Bloods, please take:

- FBC (full blood count), U and Es (Urea and Electrolytes), LFTs (liver function test).
- Group and save.
- CA125 and CEA.
    - Ca125 is raised in up to 80% of epithelial ovarian cancer cases but not raised in most primary mucinous ovarian cancers.
    - Non-malignant gynaecological conditions that can cause a raised Ca125 include: pelvic inflammatory disease, fibroids, acute events in benign cysts (e.g., torsion or haemorrhage) and endometriosis.
    - Other primary tumours that metastasise to the peritoneum such as breast, pancreas, lung, and colon cancer can also cause a raised Ca125.
    - Non-gynaecological conditions that cause peritoneal irritation can also cause a raised Ca125, these include tuberculosis, cirrhosis, any cause of ascites, hepatitis, pancreatitis, peritonitis, and any cause of pleural effusion.
    - Where CA125 is elevated, a preoperative CA125/CEA ratio <25, may indicate peritoneal carcinomatosis from a gastrointestinal tumour and bi-directional gastrointestinal endoscopy should be considered prior to upfront primary debulking surgery.
- Other tumour markers (e.g., Ca-153, Ca19-9) should only be done if requested by the gynae-oncology team as there is not enough evidence to support their routine clinical use.

2.4. Imaging

2.4.1. CT Chest / abdomen / pelvis

2.4.1.1. If ultrasound scan (USS), serum ca125 and clinical status suggest ovarian cancer a CT chest, abdomen and pelvis should be performed to establish extent of disease.

2.4.1.2. The CT establishes whether there is presence of omental and peritoneal disease, pelvic or para-aortic lymph node enlargement, hepatic metastases, obstructive uropathy, pleural effusions.

2.4.1.3. The CT will also help establish whether ovarian cancer is the most likely diagnosis over other alternative primary cancer sites such as pancreas or colon.

2.4.2. Transvaginal USS (TVUSS)

2.4.2.1. Do not routinely request TVUSS if there is evidence of disseminated disease on CT.

2.4.2.2. Transvaginal/transabdominal USS is required for those where an ovarian cyst is seen incidentally on CT without metastatic disease.

2.4.2.3. USS features which will raise the index of suspicion for ovarian cancer includes irregular solid tumours, complex solid/cystic masses >10cm, bilateral lesions, multi-loculated cysts, at least 4 papillary projections, evidence of metastasis and / or ascites.

2.4.2.4. Please note that ultrasound identification of a simple cyst in postmenopausal women is consistent with a benign process in 95–99%. However, follow up is recommended in postmenopausal women found to have ovarian cysts ≥3cm – (see RCHT guideline; Initial Management of Ovarian Cysts after the Menopause).

2.4.3. MRI (Magnetic resonance imaging)

MRI should only be used as a second-line imaging modality when USS is inconclusive and further characterisation of the ovarian cyst is necessary in women who wish to retain their fertility.

2.5. Referral to the MDT

Patients should be referred to the gynae-oncology MDT via the email address, rch-tr.ref12cancerservices@nhs.net

2.5.1. Information should include:

- Patient's name.
- Hospital number.
- Date of birth.
- Current diagnostic information.

- WHO Performance status:

  0 - Able to carry out all normal activities.

  1 - Restricted in physical activity.

  2 - Able to walk and self-care.

  3 - Capable of only limited self-care.

  4 - Completely disabled.

- Comorbidities

2.5.2. At the MDT the case will be discussed and decisions made regarding further investigations, primary treatment and planning of future management.

2.5.3. Please also discuss with one of the Gynaecological Oncology Consultants to help expedite any further investigations whilst awaiting MDT discussion.

2.6. Tissue diagnosis

2.6.1. Always consider whether the patient is clinically fit enough to receive chemotherapy or surgery prior to organising any further investigations.

2.6.2. In patients with a suspected ovarian cancer who may not be fit enough for primary surgery but will be suitable for chemotherapy, tissue diagnosis is required for a definitive diagnosis. Where possible a histopathological tissue biopsy should be obtained rather than cytology.

2.6.3. If there is large volume of ascites this will require drainage prior to the biopsy. Please see below for referral to the Paracentesis service.

2.6.4. Discuss the request for biopsy with the interventional radiology (IR) team to ensure the omental or peritoneal disease lesion is accessible. Most lesions will be accessible with use of ultrasound, occasionally a CT guided biopsy will be necessary.

2.6.5. Avoid biopsy of a solitary pelvic mass as this could potentially upstage disease by means of intraabdominal seeding.

2.6.6. Ensure patient has stopped anticoagulation if relevant.

2.6.7. Place requests for Interventional Radiology on Maxims.

2.6.8. Request that **2 core samples** are obtained, one for histopathology and one for BRCA mutation testing of the tumour.

2.6.9. If IR guided biopsy is not feasible or an inadequate sample is

obtained the management will be discussed in the gynaecology MDT and if necessary, a laparoscopic biopsy will be arranged.

2.7. Inpatient management

2.7.1. VTE / DVT (Deep Vein Thrombosis)

2.7.1.1. Whilst admitted, women with suspected ovarian cancer should be prescribed low molecular weight heparin (LMWH) (see Thromboprophylaxis guideline) and TED stockings to reduce the risk of VTE.

2.7.1.2. If the patient is deemed very high risk of VTE, such as low albumin, obesity, previous VTE please consider discharging the patient home with prophylactic dose LMWH until treatment is commenced.

2.7.1.3. If the patient is already on long-term oral anticoagulation, then conversion to treatment-dose LMWH will be required in order to have correct coagulation prior to surgery or image-guided biopsy.

2.7.2. Nutrition

2.7.2.1. Patients with advanced ovarian cancer often have reduced appetite and early satiety for months prior to diagnosis. They are often nutritionally deplete on admission.

2.7.2.2. Prescribe nutritional supplement drinks, 2-3 times a day (e.g., Ensure).

2.7.2.3. A referral to the dieticians should be made as further nutritional supplements may be necessary to optimise the patient for ongoing treatment.

2.7.3. Paracentesis

2.7.3.1. If there is clinical or radiological evidence of ascites and the patient is symptomatic the ascites should be drained to dryness.

2.7.3.2. The paracentesis service accepts referrals through Maxims (patient internal referrals list, search “par”). Please request insertion of ascetic drain in order to drain the ascites to dryness.

2.7.3.3. Request and send cytology of the drain fluid.

2.7.3.4. Microbiology is normally not required unless there is a doubt to the underlying diagnosis.

2.7.3.5. The drain should remain in situ until dry. Do not clamp the

drain as this delays drainage and increases hospital stay and infection rates.

2.7.3.6. To prevent infection do not leave the drain in for longer than 24 hours unless discussed with a Gynaecology Oncology Consultant.

2.7.3.7. Human Albumin solution should not be given as there is no clinical evidence of benefit.

2.7.4. Pleural effusion drainage / pleural tap

2.7.4.1. Commonly patients with ovarian cancer have pleural effusions.

2.7.4.2. If the patient is symptomatic with shortness of breath or asymptomatic but there is a moderate or large pleural effusion refer the patient for a Respiratory Pleural Opinion through Maxims (patient internal referrals list, search “ple”).

2.7.4.3. Drainage of the pleural effusion may be required if the patient is undergoing primary debulking surgery as this will help optimise them for surgery and prevent postoperative complications.

2.7.4.4. A minimum of 80mls of pleural effusion should be sent to cytology.

2.7.4.5. Microbiology and protein analysis is normally not required unless there is a doubt to the underlying diagnosis.

2.8. Patient communication

2.8.1. Being admitted and investigated for a potential advanced ovarian cancer is extremely distressing for patients.

2.8.2. Ensure that communication had been effective and that the patient has had opportunity to ask questions.

2.8.3. Refer to the Gynaecology Oncology CNS team (01872 252037) who will be able to provide further advice and provide patient with the CNS contact card (stored in Eden ward-clerk desk or in gynaecology outpatients).

2.8.4. On discharge, please reassure the patient that they have been referred to the Gynaecology MDT and that the team will contact them for an outpatient appointment as soon as possible.

3. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Number of patients with advanced ovarian cancer referred to gynaecology MDT.
Lead	Gynaecology MDT.
Tool	Adherence to guidelines will be monitored as part of the ongoing audit process on a WORD or Excel template.
Frequency	Yearly Gynaecology Cancer Audit.
Reporting arrangements	Peninsular Gynaecology Cancer Group.
Acting on recommendations and Lead(s)	Gynaecology MDT. As required.
Change in practice and lessons to be shared	Required changes to practice will be identified and actioned within 3 months, immediately if required. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant staff/stakeholders.

4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the Equality Diversity And Inclusion Policy or the Equality and Diversity website.

4.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Inpatient Management of Women with Suspected Advanced Ovarian Cancer Clinical Guideline V2.0
This document replaces (exact title of previous version):	Inpatient Management of Women with Suspected Advanced Ovarian Cancer Clinical Guideline V1.0
Date Issued/Approved:	June 2023
Date Valid From:	June 2023
Date Valid To:	June 2026
Directorate / Department responsible (author/owner):	Jane Borley; Consultant Gynaecological Oncologist
Contact details:	01872 252729
Brief summary of contents:	Guidance for health care professionals on the inpatient management of women with suspected advanced ovarian cancer.
Suggested Keywords:	Ovarian cancer
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** No
Executive Director responsible for Policy:	Chief Medical Officer
Approval route for consultation and ratification:	Gynaecology Directorate Meeting West Peninsula Gynaecology MDT
Manager confirming approval processes:	Caroline Chappell
Name of Governance Lead confirming consultation and ratification:	Caroline Amukusana
Links to key external standards:	None required
Related Documents:	British Gynaecological Cancer Society (BGCS) Epithelial Ovarian / Fallopian Tube / Primary Peritoneal Cancer Guidelines: Recommendations for Practice

Information Category	Detailed Information
	https://www.bgcs.org.uk/wp-content/uploads/2019/05/BGCS-Guidelines-Ovarian-Guidelines-2017.pdf
Training Need Identified?	No
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical/ Gynaecology

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
25.02.2020	V1.0	Initial version.	K West and J Borley
24.04.2023	V2.0	Updated. Pleural effusion to be drained if symptomatic.	J Borley

All or part of this document can be released under the Freedom of Information Act 2000

All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus 6 years.

This document is only valid on the day of printing.

Controlled Document

This document has been created following the Royal Cornwall Hospitals NHS Trust The Policy on Policies (Development and Management of Knowledge Procedural and Web Documents Policy). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity, and Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	Inpatient Management of Women With Suspected Advanced Ovarian Cancer Clinical Guideline V2.0
Directorate and service area:	Gynaecology
Is this a new or existing Policy?	Existing
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Jane Borley; Consultant Gynaecological Oncologist
Contact details:	01872 252729

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	To provide evidence based guidance to clinical staff on the necessary investigations and initial management for patients with suspected advanced ovarian cancer admitted to hospital.
2. Policy Objectives	To standardise management and ensure high quality care and consistent management for patients with advanced ovarian cancer.
3. Policy Intended Outcomes	To ensure patients with advanced ovarian cancer are medically optimised, reach a definitive diagnosis and start appropriate treatment in a timely manner.
4. How will you measure each outcome?	Cancer pathway and treatment targets.
5. Who is intended to benefit from the policy?	Patients with suspected advanced ovarian cancer and clinicians responsible for their care.

Information Category	Detailed Information
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/ visitors: No • Local groups/ system partners: No • External organisations: No • Other: No
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/ groups:** West Peninsula Gynaecology MDT Gynaecology Directorate meeting
6c. What was the outcome of the consultation?	Approved- 16 May 2023
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff, or patient surveys:** No

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	
Race	No	Any information provided should be in an accessible format for the patient's needs – i.e., available in different languages if required/access to an interpreter if required

Protected Characteristic	(Yes or No)	Rationale
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	Those patients with any identified additional needs will be referred for additional support as appropriate - i.e., to the Liaison team or for specialised equipment. Written information will be provided in a format to meet the family's needs e.g., easy read, audio etc
Religion or belief	No	All staff should be aware of any beliefs that may impact on the decision to treat
Marriage and civil partnership	No	
Pregnancy and maternity	No	
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Jane Borley

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis