Assessment of Adult Women with Ovarian Masses and Treatment of Epithelial Ovarian Cancer: ASCO Resource Stratified Guideline
Summary of Recommendations by Resource Setting

### Diagnosis

#### Imaging
- **Basic**
  - Clinical assessment
  - Combination of transabdominal, pelvic, and transvaginal ultrasound
- **Limited**
  - Basic setting recommendations
  - Contract-enhanced CT of abdomen and pelvis (± thorax)
- **Enhanced**
  - Basic & Limited setting recommendations
  - Clinicians may add MRI

#### Biomarkers
- **Basic**
  - May use CA-125 to assist diagnosis
  - Should use CA-125 in evaluation of post-menopausal women
- **Limited**
  - Basic setting recommendations
- **Enhanced**
  - Basic setting recommendations

#### Heritable Risk
- **Basic**
  - Should discuss family history and provide or refer to appropriate counseling
- **Limited**
  - Should discuss family history and provide or refer to appropriate counseling for high risk groups
  - Should follow existing evidence-based guidelines for BRCA, if testing/follow-up available
- **Enhanced**
  - Limited setting recommendations
Minimally Invasive Techniques For Histologic Diagnosis

- No role for minimally invasive techniques*
- Should obtain histologic confirmation for diagnosis; minimally invasive technique could be a CT-guideline biopsy
- May be a role for minimally invasive surgery such as laparoscopy for initial histological diagnosis if planning for NACT for appropriate selected patients
- When a biopsy cannot be performed, cytologic evaluation combined with a serum CA-125 to CEA ratio > 25 can confirm the primary diagnosis

Limited setting recommendations

Staging and Surgery

- Elective surgical staging for ovarian cancer is not recommended on a routine basis*
- Patients with apparent stage I ovarian cancer should be referred to a higher-level care center with trained experts to perform appropriate surgical staging
- Metastatic workup and referral for staging surgery
- If sufficient expertise exists, may perform staging surgery
- Metastatic workup and staging surgery
### Staging and Surgery (cont.)

#### Fertility-Sparing and Laparoscopic Surgery

<table>
<thead>
<tr>
<th>Recommendation</th>
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<tbody>
<tr>
<td>No role for fertility-sparing surgery in early-stage disease</td>
</tr>
<tr>
<td>Elective laparoscopic surgical staging for apparent stage I ovarian cancer is not recommended</td>
</tr>
<tr>
<td>Fertility sparing surgery or referral to higher-level cancer center</td>
</tr>
<tr>
<td>Basic setting recommendation</td>
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<tr>
<td>Elective minimally invasive laparoscopic surgery may be performed for select patients with apparent stage I ovarian cancer</td>
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#### Surgery for Stage III/IV

<table>
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<tr>
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<tbody>
<tr>
<td>Evaluated for surgical management taking into account tumor burden, FSA, comorbidity</td>
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<tr>
<td>Counsel patients on treatment options and refer them to a cancer treatment center with specialized surgical services</td>
</tr>
<tr>
<td>If unable to travel to a distant health center, refer to palliative care recommendations</td>
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<tr>
<td>Interval debulking is not recommended*</td>
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<tr>
<td>Complete tumor cytoreduction to no gross residual disease/remove all macroscopic visible disease OR refer to higher-level cancer center</td>
</tr>
<tr>
<td>NACT and interval debulking in FIGO stage IIIC or IV, in expectantly high morbidity surgery and patients with poor PS or unresectable disease OR refer to higher-level cancer center</td>
</tr>
<tr>
<td>If performed with curative intent, maximal effort cytoreductive surgery with the aim to remove all intra-abdominal macroscopic tumor.</td>
</tr>
<tr>
<td>NACT and interval debulking in FIGO stage IIIC or IV, in expectantly high morbidity surgery and patients with poor PS or unresectable disease</td>
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**Staging and Surgery (cont.)**

**Surgery after NACT for Stage III/IV**

- Not feasible*

  - Interval cytoreductive surgery after ≤ 4 cycles of NACT for women with stage III/IV where there is a response to chemotherapy or stable disease

- In patients with progressive disease on NACT, there is little role for surgery unless for palliation

  - Limited setting recommendations

**Adjuvant/Systemic Therapy**

**Adjuvant/Systemic Therapy for Stage I**

- Should not administer adjuvant chemotherapy to patients with early-stage ovarian borderline or LMP tumors or early-stage micro-invasive borderline tumors

- Basic setting recommendation

  - Assess patient’s eligibility for adjuvant chemotherapy

  - Surgically staged, pathologic confirmed epithelial, ovarian, fallopian tube, or peritoneal cancer

  - If pathology confirmation not possible, cytologic confirmation, CA-125 & imaging

- Basic & Limited setting recommendations
Clinicians may refer to higher-level cancer center for adjuvant chemotherapy.

May discuss combination adjuvant chemotherapy.

Combination chemotherapy with paclitaxel and carboplatin.

Single-agent chemotherapy for those unfit for combination therapy.

Optimum number of 6 cycles of chemotherapy in the adjuvant setting. For combination therapy, customize tolerability etc. to patient for 6 cycles.

Optimal sequence of surgery first followed by chemotherapy or refer to higher-level cancer center.

Limited setting recommendations.

Optimal sequence of surgery first followed by chemotherapy.
Adjuvant/Systemic Therapy for Stage II/III Who Have Received Surgery & No Chemotherapy

- No role for adjuvant chemotherapy
- No role for intraperitoneal chemotherapy
- No role for targeted therapy

**Basic setting recommendation**
- Combination platinum adjuvant therapy for patients with stages II or III and PS 0-2 unless patients have contraindications
- Single-agent carboplatin for PS >2 and/or contraindications to combination therapy

**Limited setting recommendations**
- Targeted therapy is not recommended in limited settings on a routine basis for patients with stage III

**Assess patients with stage III for appropriate evidence-based targeted therapy, all patients with high risk features, and PS 0-2**

**Patients referred to be assessed for appropriate evidence-based intraperitoneal chemotherapy, following optimal debulking, where there are resources & expertise to manage toxicities**
Adjuvant/Systemic Therapy for Stage IV Who Have Received Surgery & No Chemotherapy

- **Refer to higher-level cancer center for systemic chemotherapy, symptomatic therapy, and pain control**
  - Targeted therapies are not cost effective in most resource-constrained regions unless patients are being treated at enhanced or maximal level
  - **No role for targeted therapy**

- **Carboplatin + paclitaxel for six cycles OR refer to higher-level cancer center**
  - Combination platinum adjuvant therapy for patients with stages II or III and PS 0-2 unless patients have contraindications
  - **Basic setting recommendation**
  - Focus on symptom management for patients who are: extremely frail and not fit for surgery/have substantial complications of surgery; poor PS >3; medically unfit for chemotherapy
  - **Targeted therapy is not recommended in limited settings on a routine basis for patients with stage IV**

- **Carboplatin + paclitaxel for six cycles**
  - Limited setting recommendations
  - Cost-effectiveness data are emerging, awaiting outcomes for primary therapy maintenance settings for PARPi
  - **Limited setting recommendation**
  - Assess patients with stage IV for appropriate evidence-based targeted therapy, all patients with high risk features, and PS 0-2
**Maintenance Systemic Therapy**

**Maintenance Systemic Therapy for Stage III/IV**

- No role for maintenance systemic therapy

**Recurrent Ovarian Cancer**

**Surgery for Recurrent Epithelial Ovarian Cancer**

- Not feasible*

**Maintenance systemic therapies (anti-angiogenic, targeted therapies) are not recommended for patients who have received surgery and prior chemotherapy**

**For select patients with a small volume platinum-sensitive recurrent disease, may refer to higher level cancer center for surgical consideration**

**May discuss maintenance systemic therapies (e.g. anti-angiogenic, targeted therapies) for patient who have received surgery and prior chemotherapy**

**For guidance regarding the use of PARPi, refer to the ASCO guideline**

**For select patients with a small volume platinum-sensitive recurrent disease, may perform complete secondary cytoreductive debulking surgery**
Systemic/Palliative Treatment for Recurrent Ovarian Cancer

<table>
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<tr>
<th>Recurrent Ovarian Cancer (cont.)</th>
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- **Best supportive care**

**Clinicians may recommend treatment with second-line chemotherapy to patients with platinum-sensitive and platinum resistant/refractory ovarian cancer OR refer to higher-level cancer center**

**Combination chemotherapy with carboplatin preferably for patients with platinum-sensitive recurrent ovarian cancer OR refer to higher-level cancer center**

**Single-agent non-platinum chemotherapy or best supportive care for patients with platinum resistant/refractory recurrent ovarian cancer OR refer to higher-level cancer center**

**No systemic treatment is recommended for tumor marker-positive (CA-125) only recurrent ovarian cancer in the absence of symptoms**

**Clinicians may recommend treatment with second-line chemotherapy to patients with platinum-sensitive and platinum resistant/refractory ovarian cancer**

**Combination chemotherapy with carboplatin preferably for patients with platinum-sensitive recurrent ovarian cancer**

**Single-agent non-platinum chemotherapy ± bevacizumab or best supportive for patients with platinum resistant recurrent ovarian cancer**

**Single-agent non-platinum chemotherapy with biologic agent (bevacizumab) to patients with platinum refractory cancer**

**Limited setting recommendation**
Palliative Care

Clinicians should offer palliative care, including cancer pain and symptom management, to all patients diagnosed with ovarian cancer.

Early referral to palliative care where available

Basic setting recommendations

Notes. *Due to current gaps in health system and human resource availability † Clinicians should offer carboplatin + paclitaxel (or single-agent carboplatin) every three weeks for six cycles

Abbreviations. CA-125, cancer antigen 125; CEA, carcinoembryonic antigen; CT, computed tomography; FIGO, International Federation of Gynecology and Obstetrics; FSA, functional status assessment; LMP, low malignant potential; MRI, magnetic resonance imaging; NACT, neoadjuvant chemotherapy; PARPi, poly (ADP-ribose) polymerase inhibitor; PS, performance status