NCG RESOURCE STRATIFIED GUIDELINES FOR OVARIAN CANCER

Table 1. Summary of Imaging and Management Recommendations for Optimal and Optional Resources Setting

Disease	**Optimal**	**Optional**	**Remarks**
Staging Work up			
FIGO Early Stage I/II	CECT Abdomen + Pelvis Chest Xray (CECT Thorax if indicated)	MRI Abdomen and Pelvis	MRI may help to better characterise benign from malignant ovarian lesion
Locally advanced Stage III/IV	CECT Abdomen + Pelvis Chest Xray (CECT Thorax if indicated)	Staging Laparoscopy to determine operability	
Recurrent	CECT Abdomen + Pelvis Chest Xray (CECT Thorax if indicated) USG abdomen and Pelvis	PET-CT	PET CT may be considered if planning secondary cytoreduction
Tumor Markers	CA 125, CEA, CA19.9 AFP, β hcg, LDH Inhibin B		AFP, β hcg, LDH Inhibin B as indicated
Other work up	CBC, LFT, RFT, Serum electrolytes, ECG	*SIron, TIBC,S Ferritin, B12, Folate 2DECHO	*if Clinically indicated
		*B/L Mammogram Upper GI endoscopy Lower GI endoscopy	*If clinically indicated to rule out Krukenberg tumor
Intervention Radiology		Image guided biopsy /FNAC if indicated	
Pathology	Ascitic fluid cytology in advanced cancers Grossing and complete reporting of the surgical specimen should be done	-Ascitic fluid cell block and IHC, -Biopsy/FNAC from mass (in advanced cancers) -Intra op Frozen in early cancers	

Genetic Testing		Genetic counselling and testing to be offered to all high grade serous carcinoma	
Epithelial Ovarian Cancer Management			
FIGO stage			
Early Stage			
Stage I/II			
Surgery	Primary Surgery (Peritoneal fluid cytology, systematic exploration of the abdomen and pelvis, multiple peritoneal biopsies, total abdominal hysterectomy with bilateral salpingo-oophorectomy, omentectomy, nodal staging with systematic pelvic and para aortic lymphadenectomy).	Conservative surgery i.e. unilateral salpingo-oophorectomy with preservation of the normal contralateral ovary and uterus may be considered in young patients desirous of child bearing with stage IA, low grade disease or borderline tumours.	
Adjuvant Chemotherapy	3/ 6 cycles of Paclitaxel and Carboplatin (High grade serous- 6 preferred) 6 cycles of Single Agent Carboplatin		
Advanced Stage			
Surgery	Interval Cytoreduction after 3 cycles of NACT OR Primary Cytoreduction		NACT vs Primary Surgery - similar survival outcome with less surgical morbidity with NACT In omental metastasis <5 cm or low grade tumors-Primary surgery preferred In advanced disease

			with low s albumin, poor performance status, pleural effusion interval cytoreductive surgery preferred optimal goal of cytoreductive surgery is to leave behind no visible or palpable residual disease but the minimum goal is to leave behind less than 1cm (preferably less than 0.5 cm) residual disease at any given site Pelvic and para-aortic lymphadenectomy has not shown to have any survival advantage.
Chemotherapy	6 cycles of Paclitaxel and Carboplatin (May go upto maximum 8 cycles) - Those with poor performance status or co morbidities single agent Carboplatin X 6 cycles	* -Intraperitoneal Chemotherapy -Bevacizumab in stage IV disease /those not optimally cytoreduced -PARP inhibitors(Germline BRCA mutated)	* Note-Are approved drugs but cost benefit ratio to be discussed with patients
			-
Recurrent			-
Observation	If asymptomatic		CT scan may be done in asymptomatic patients with rising CA125 and those without significant disease can be kept

			underobservation
Chemotherapy	Platinum Sensitive -Platinum based doublet –Paclitaxel/ liposomal doxorubicin/ Gemcitabine Platinum Resistant -Oral Etoposide -Liposomal Doxorubicin -Weekly Paclitaxel	*Bevacizumab PARP inhibitors *Bevacizumab PARP inhibitors Topotecan	*Are approved drugs but cost benefit ratio to be discussed with patients
Secondary Cytoredduction		Thosewith good PS, without /minimal ascites, long DFI, Single site of disease	
RT		Patients refractory to chemotherapy and with pelvic or nodal mass to be considered for radiation preferably for conformal techniques. In Oligoprogression and oligometastasic setting radiation may be added.	
Palliative Care	Palliative Care alone in those with advanced disease		
GERM CELL TUMORS Management			
Surgery	Fertility sparing surgery (Unilateral salpingo oophorectomy) + Staging Procedure • The staging procedure includes infracolic omentectomy, biopsy of the diaphragmatic peritoneum, paracolic gutters, pelvic peritoneum and peritoneal washings	• In postmenopausal women with advanced-stage disease or with bilateral ovarian involvement, abdominal hysterectomy and bilateral salpingo-oophorectomy could be carried out with	Fertility sparing surgery may be considered even in advanced cases

		careful surgical staging	
Chemotherapy	*3 -4 cycles of BEP OR 4 cycles of EP (early stage)		Avoid bleomycin in those greater than 40 *Stage IA Dysgerminoma and Stage IA GI teratoma No adjuvant chemotherapy -4 cycles of BEP in advanced stages III/IV
Sex Cord Stromal Tumor			
Granulosa Cell Tumor/Sertoli Leydig cell tumor			
Surgery	Fertility sparing surgery and staging (Stage I) TAH + BSO + Staging(Stage II-IV, IC)		
Chemotherapy	*3-4 cycles of BEP OR 4# EP OR 6 cycles of Paclitaxel + Carboplatin		*Granulosa Cell – Stage IA -IC1 – No chemotherapy IC2/3- May be kept on active surveillance/ chemotherapy Rest need adjuvant chemotherapy Sertoli Leydig cell Tumor- Stage IA – without poorly differentiated or heterologous elements _ Follow up ➢ IA with poorly differentiated and hetrologous

			elements and any stage >IA need chemotherapy