FOLLOW-UP GUIDELINES
Ovarian Cancer
March 2021

These guidelines are intended to assist in follow-up care and are not to replace individual physician's judgment with respect to particular patients or special clinical situations. Guidelines should be carried out with assistance of family physician and other healthcare professionals as required. Important goals of ovarian follow-up include:

- To ensure that complications post surgery or other therapy are identified and managed.
- To possibly identify recurrent disease which is rarely amenable to salvage therapy but from which patients may have significant response.
- To detect and provide palliative therapy to patients with symptomatic recurrence. Such patients will usually present with symptoms, rather than being detected on routine follow-up.

These recommendations are consistent with the individual disease's natural history and the chances of detecting potentially curable recurrent cancer. Specifically:

- Despite achievement of a complete clinical response following primary treatment, recurrence rates are high, occurring in 25% of patients with early-stage disease and >80% with advanced disease.
- A rising CA-125 often precedes the clinical detection of disease by 2 to 5 months. 80% of epithelial tumours have an elevated CA-125 at time of diagnosis.
- There is no evidence that re-initiating chemotherapy in the face of a rising CA-125 but in advance of detecting clinically symptomatic recurrence achieves any improvement in overall response. This was studied with an RCT by the EORTC and reported in 2009.

Follow-Up for All Patients

- Patients to be followed by a gynecologic oncologist every 3-4 months for 2 years, then every 6 months for the next 3 years, then yearly for a total of 10 years from diagnosis.
- Follow-up examination includes physical examination, and pelvic exam. A decision as to whether to routinely determine CA 125 with each return visit should be individualized following a realistic discussion of the pros and cons of such monitoring between the patient and physician as outlined earlier.
- No recommendation for routine imaging tests. The decision to image should be based on clinical suspicion of relapse and need for treatment. When a recurrence is suspected based on symptoms, examination or CA-125 level, a CT scan of the chest, abdomen and pelvis should be obtained to determine extent of disease. PET scan may be useful adjunct when CT scans are indeterminate.

NOTE: Routine CBCs, liver function tests, chest x-rays, CT scans or other imaging studies are NOT recommended unless clinically indicated.

References

BC Cancer Agency
http://www.bccancer.bc.ca/HPI/ChemotherapyProtocols/default.htm

NCCN Guideline
https://www.nccn.org/professionals/physician_gls/default.aspx#site

Last Update: Jan 12, 2021 – Available free login but you must create an account

Society of Gynecologic Oncologists:
Salani, R., Khanna, N., Frimer, M., Bristow, R., Chen, L. An update on post-treatment surveillance and diagnosis of relapse in women with gynecologic malignancies: Society of Gynecologic Oncology (SGO) recommendations. Gyn Onc 146 (2017): 3-10.

Cancer Care Ontario
https://www.cancercareontario.ca/en/guidelines-advice/types-of-cancer/gynecologic?f%5B0%5D=field_type_of_cancer%3A626&f%5B1%5D=field_type_of_cancer%3A641

EORTC
C.J. Rustin, ME van der Berg, on behalf of MRC and EORTC collaborators, A randomized trial in ovarian cancer (OC) of early treatment of relapse based on CA125 level alone versus delayed treatment based on conventional clinical indicators (MRC OV05/EORTC 55955 trials). J. Clin. Oncol. 27(2009).

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