Follow-up of patients with epithelial ovarian cancer who are clinically disease -free after primary therapy: Evidence-Based Guidelines

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Disclosures

NO DISCLOSURES

Definitions

1. Clinically disease-free (or complete clinical remission) is defined as no objective evidence of disease:

    negative physical examination

    negative CA-125

    negative CT with <1 cm lymph nodes

2. Primary therapy includes surgery followed by 6 cycles of chemotherapy

Introduction

- The guidelines for ovarian cancer follow up after primary therapy have a weak evidence base, and as a result, practice varies

- The goals of follow-up of women who are clinically disease-free after primary Tx include:

  *identifying disease recurrence,

  *managing SE of primary Tx,

  *facilitating recruitment to clinical trials,

  *building a patient-HC provider relationship in anticipation of a subsequent recurrence

Follow up options

*Optimal method for F/U has not been established

*Possible F/U options could include the option of No F/U (Ontario)

*No evidence that routine F/U has any impact on outcomes

*F/U visits can be associated with stress, inconvenience, and cost

Follow up methods

1. Clinical evaluation with/without pelvic examination

2. Measurement of CA-125

3. Radiologic imaging: U/S, CT, MRI, PET, Doppler U/S

1. Clinical evaluation

- Update patient Hx, assess for symptoms of recurrence (abdominal pain being the most commonly reported symptom), determine need for psychosocial support

- Physical examination has low sensitivity for detecting early recurrence, as women do not present with physical findings alone

- Patients with abnormal findings on physical examination also have either suspicious symptoms or elevated CA-125 or both

2. CA-125 monitoring

*There is no evidence that monitoring CA-125 improves survival outcomes and it may worsen quality of life

*Ca-125 can fluctuate because of individual and assay variation

*Implications of stable, fluctuating and rising CA-125 should be discussed with patients

CA-125 monitoring (cont'd)

*Ca-125 can predict cancer recurrence several months (~4.5 months) before physical symptoms develop

*There was no difference between asymptomatic women who received early Tx based on elevated CA125 alone and women who waited for the appearance of clinical symptoms prior to initiating Tx

*QOL results showed that good global health scores were reported for longer by patients in the delayed treatment group than by those in the early Tx arm (9.2 months vs 7.2 months)

3. Radiologic imaging

- Not routinely done, but should be performed in the presence of clinical or Ca125 evidence of cancer recurrence
- U/S has not been shown to be more useful than a combination of clinical evaluation and CA125 testing
- CT and MRI have a role in Tx planning when a recurrence has been diagnosed
- PET scan and Doppler U/S roles are currently unclear

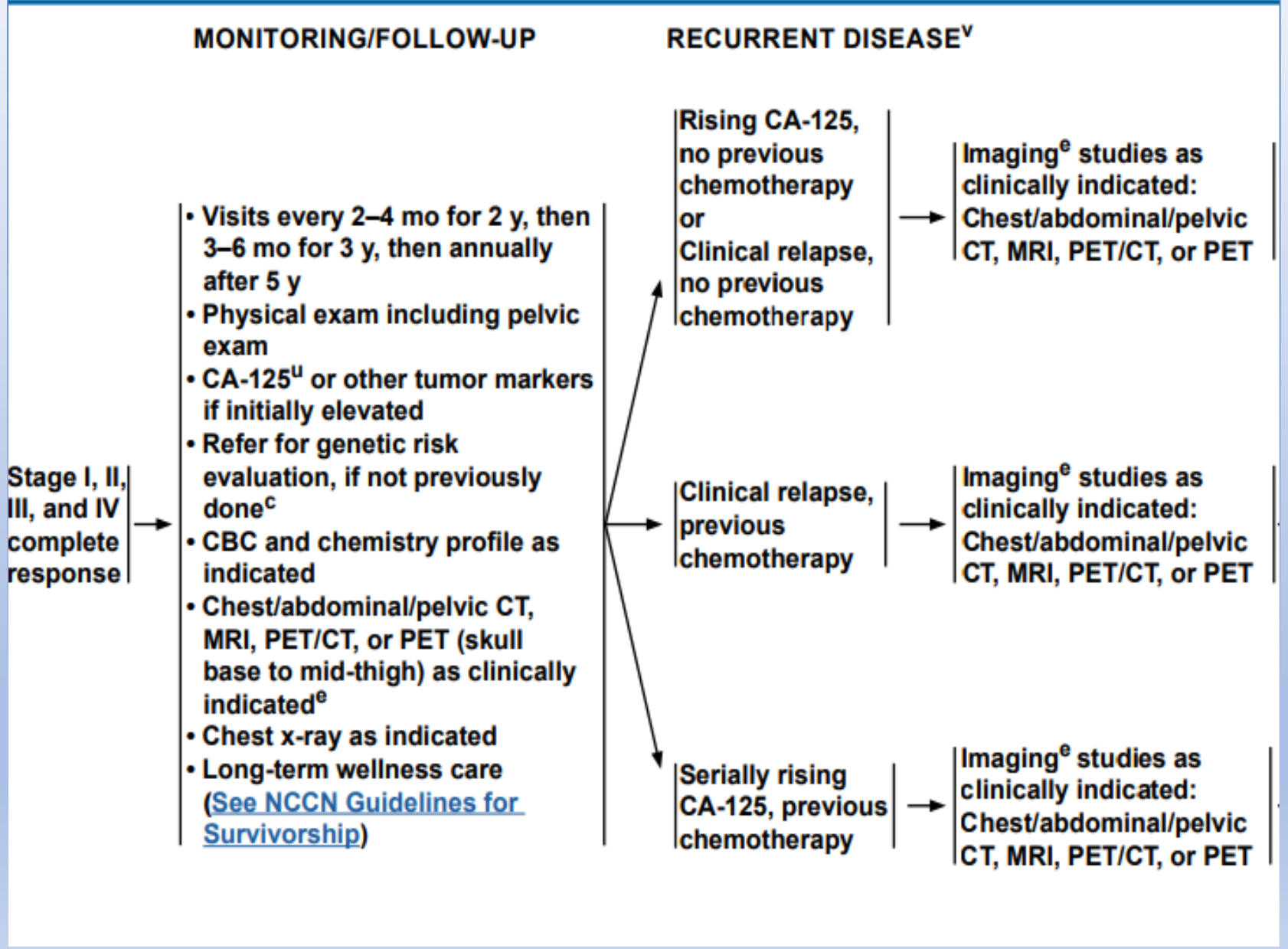
Guidelines currently available

- Existing guidelines should address F/U intervals, methods for detection of recurrence, survival rate, QOL and anxiety associated with surveillance
- National Comprehensive Cancer Network 2017
- Manitoba: Moving Forward after Gynecological cancer 2015
- BC Cancer Agency 2014
- European Society of Medical Oncology (ESMO) 2013
- Cancer Care Ontario (CCO): Program in Evidence-Based Care (PEBC)- Endorsement of Cancer Australia recommendations 2015

Level 2A evidence

NCCN National Comprehensive Cancer Network®

NCCN Guidelines Version 3.2017
Epithelial Ovarian Cancer/Fallopian Tube Cancer/ Primary Peritoneal Cancer



Manitoba

Moving Forward after Gynecological Cancer

_____ Cancer 5 Year Follow-Up Tests & Appointments for

Patient Label

Date of Last Treatment

(= Day 0 for schedule below): _____

		Procedure
YEAR 1	0 + 3 months	• Medical Appointment
	0 + 6 months	• Medical Appointment
	0 + 9 months	• Medical Appointment
	1 year	• Medical Appointment
YEAR 2		• Medical Appointment
	1 year + 6 months	• Medical Appointment
	1 year + 9 months	• Medical Appointment
	2 years	• Medical Appointment
YEAR 3	**2 years +**	• Medical Appointment
	2 years +	• Medical Appointment
	3 years	• Medical Appointment
YEAR 4	**3 years + 6 months**	• Medical Appointment
	4 years	• Medical Appointment
YEAR 5	**4 years + 6 months**	• Medical Appointment
	5 years	• Medical Appointment

CancerCare MANITOBA

5 Year Follow Up Recommendations for _____ Cancer

FOLLOW-UP RECOMMENDATIONS*

Cancer Question? Expert Help for Primary Care call·text ► 204-226-2262 email ► cancerquestion@cancercare.mb.ca

(after 5 years of surveillance, annual physical exam is recommended)

FOLLOW-UP	YEAR 1, 2,	YEAR 3	YEAR 4, 5
Medical Follow-Up Care Appointment: *Focused history & physical, bimanual pelvic and rectal exam*	Every 3 months	Every 4 or 6 months	Every 6 months
Bloodwork: *CA125 if initially elevated (Only If concerning symptoms are present)*	Not routine	Not routine	Not routine
CT Imaging (infused): *Chest / Abdomen / Pelvis (Only if concerning symptoms are present)*	Not routine	Not routine	Not routine
Monitoring: *Possible Side Effects of Treatment*	Sexual Function; Peripheral Neuropathy (nerve pain), Bowel and Bladder Function (including ostomy care), Memory and Concentration Issues		

Medical Appointments

- A focused history and physical with abdominal assessment including bimanual pelvic and rectal examination.
- Inquire about new symptoms such as abdominal, back, or pelvic pain or pressure, nausea/indigestion, abdominal bloating, increased abdominal size, anorexia or early satiety, urinary changes such as increased urgency and/or frequency, bowel changes such as constipation, diarrhea, or thin/pencil like stools.

Bloodwork

- Routine CA 125's have not been shown to improve overall survival therefore are routinely not done unless concerning symptoms arise. CA125 *may* be drawn at each visit in Years 1, 2 and 3, if initially elevated, however this is typically only if the patient requests it.
- For a CA125 result above the upper limit of normal, repeat the test in 4-6 weeks.
- Other blood tests, such as liver function tests (LFTs) and blood counts (CBCs) are NOT recommended for follow-up.

CT Imaging

- Follow-up CT imaging of the abdomen and pelvis is performed **only** for patients if symptomatic for recurrence or if indicated by physical exam.

Monitoring

- Chemotherapy induced peripheral neuropathy usually resolves with time, and can be treated by using tricyclics (desipramine, nortriptyline), anti-convulsants (gabapentin, pregabalin), opioids or SSNRI's (venlafaxine).

Referrals to CancerCare Manitoba

- Contact the Gyne-Oncology team at 204-787-2071 if you are concerned about symptoms of recurrence.
- Patient will be contacted in 2-3 working days (target) once referral is received. Please **do NOT send letters directly to the Oncologist,** as this may delay the patient's appointment if that doctor is unavailable for some reason.

BC Cancer Agency: Ovary-Epithelial Ca F/U

- Suggestions for F/U in asymptomatic individual:
- Year 1 & 2: Q4months
- Year 3-5 : Q6months
- Years 5+: Annually
- Review of any Sx
- Physical exam, including nodal areas (neck and groin), chest (for effusion), abdomen (for ascites&masses), pelvic (for masses)
- Routine tumour markers and imaging not needed during F/U visits, unless indicated by symptoms or signs on examination

ESMO

- Clinical examination with/without pelvic examination and CA125 measurement Q3months x 2 y, then Q4months during 3rd year, then Q6months during years 4&5 or until progression occurs
- It appears safe to delay chemo up to the appearance of sx when CA125 rising, provided patient is well, disease volume on CT is small and there is no evidence of compromised organ function
- Ca125 testing may be carried out as there is the possibility of missing surgically resectable recurrence. The results of ongoing trials will determine whether surgery for relapse improves survival*(DESKTOP III)*
- PET-CT→ selection of patients for secondary debulking surgery

Cancer Care Ontario (CCO): Program in Evidence-Based Care (PEBC)-Endorsement of Cancer Australia recommendations 2015

The reason for choosing these recommendations for endorsement is that they include the options for clinician-patient discussion regarding harms & benefits of surveillance, the limitations for recurrence detection, and patient preferences

1. Recommendations for F/U after treatment

At the completion of therapy, discuss possible options for follow up, as well as implications & consequences of those options

PEBC qualifying statement:

Women should be given the option of no F/U because there is no evidence for any impact of routine F/U on outcomes

2. Recommendation for CA-125 monitoring

Inform women that Ca125 monitoring has not been associated with improved survival rate and may adversely impact QOL

Discuss implications of monitoring progress and initiating Tx based on CA125 level, as well as limitations and potential harms of routine CA125 testing

PEBC qualifying statement:

Treatment based on rising CA125 alone is not recommended. Clinical and radiological confirmation should be obtained prior to initiation of treatment

3. Recommendations for timing of F/U consultations

Discuss regular F/U visits as well as no formal F/U based on patient's needs and wishes.

There is no recommended frequency for follow up; a mutually agreed schedule should be discussed with women, according to risk and individual characteristics

PEBC qualifying statement:

F/U visits may occur more frequently initially after Tx, then less often

4. Recommendations for Format of Follow-Up consultations

*The basic format is to update patient history, assess for symptoms of recurrence, determine psychosocial and supportive care needs, and perform physical examination, which may include pelvic examination

*Radiologic imaging should not be routine, but should be performed if there is clinical or Ca125 evidence of recurrence

PEBC qualifying statement:

Inform women that P/E may not detect early recurrence

5. Recommendations for models of follow up care

- F/U by gynecologic or medical oncologist in collaboration with women's PCP

- Alternate models for future research: PCP or nurse-led F/U, telephone F/U and patient-initiated care

PEBC qualifying statement:

- Women who opt out of routine F/U must be informed of ssx of recurrence and to contact oncologist/PCP when they appear

5. Recommendations for models of follow up care (cont'd)

- Fear of recurrence is the most important issue for women after completion of primary Tx
- Telephone-based nursing F/U has been shown to diminish anxiety and improve emotional well being
- Telehealth in remote areas of Ontario may be an appropriate model of F/U

Take home messages "putting it all together"

- Guidelines for ovarian cancer F/U have limited evidence
- Ca125 monitoring does not improve OS, and may reduce QOL. As new trial results become available, Ca-125 may be used for timing of secondary surgery
- P/E has low sensitivity in detecting early recurrence
- Imaging not routinely done
- F/U options , harms & benefits of surveillance should be discussed
- Fear of cancer recurrence is an important issue and telephone based F/U improves well being

References

1. T. Le, E.B. Kennedy, J. Dodge, L. Elit. Follow-up of patients who are clinically disease-free after primary treatment for fallopian tube, primary peritoneal, or epithelial ovarian cancer: a PEBC guideline adaptation. *Current Oncology, Vol. 23, No.5, October 2016; 343-350*

2. Rustin GJ, van der Burg ME, Griffin CL, et al. Early vs delayed treatment of relapsed ovarian CA (MRC OV05-EORTC-55955 trials): a randomized trial. *Lancet 2010;376:1155-63*