Guideline 4-22

A Quality Initiative of the Program in Evidence-Based Care (PEBC), Cancer Care Ontario (CCO)

Follow-up of Patients who are Clinically Disease-free After Primary Treatment for Fallopian Tube, Primary Peritoneal, and Epithelial Ovarian Cancer

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Guideline 4-22: Section 1

Follow-up of Patients who are Clinically Disease-free After Primary Treatment for Fallopian Tube, Primary Peritoneal, and Epithelial Ovarian Cancer: Recommendations Summary

GUIDELINE OBJECTIVE
The objective of this guideline is to make recommendations for appropriate follow-up of women with confirmation of remission, after surgery and first-line chemotherapy, for fallopian tube, primary peritoneal, or epithelial ovarian cancer. Of interest are appropriate intervals and methods, as well as who should conduct the follow-up examinations.

TARGET POPULATION
Women who have received confirmation of clinical complete remission (i.e., are disease-free) after surgery and first-line chemotherapy for fallopian tube, primary peritoneal, or epithelial ovarian cancer. Disease-free status is determined according to the standard procedure at the unit where treatment was provided and may include negative clinical examinations, negative imaging investigations, and/or negative tumour marker results.

INTENDED USERS
The intended users of this guideline are clinicians who provide follow-up examinations to the target population, and may include gynecologic oncologists, medical oncologists, specialist nurses, gynecologists, family physicians, or other clinicians who deliver follow-up cancer care in the province of Ontario.

ENDORSEMENT OF CANCER AUSTRALIA RECOMMENDATIONS
After a systematic review found no new studies meeting the inclusion criteria, the authors of this guideline agreed to endorse recommendations from the Cancer Australia guidance document entitled Follow-up of Women with Epithelial Ovarian Cancer: A Systematic Review [1]. A general strength of these recommendations, and a reason that they were chosen for endorsement, is that they include recommendations for clinician-patient discussion regarding the harms and benefits of surveillance, a discussion of the limitations of recurrence detection, and consideration of patient preferences. The Working Group members identified key recommendations from that document, which are reproduced verbatim below with Program in Evidence-Based Care (PEBC) qualifying statements presented in italics. While the members of the Working Group chose to endorse the wording of the recommendations, the format and organization of the recommendations was altered to align with the PEBC guideline template. Recommendations are organized under the following headings:
RECOMMENDATIONS, KEY EVIDENCE, AND INTERPRETATION OF EVIDENCE

1. Recommendations for Follow-up Post-treatment
   a. While the optimal method of follow-up is not yet established, possible options for follow-up and the implications and possible consequences of these options should be discussed with the woman at the completion of primary treatment.
   b. Consideration should be given as to how anxiety might be lessened, such as scheduling tests before the visit so that test results are available for discussion at the time of the follow-up visit.

   PEBC Qualifying Statement: Based on feedback received in the PEBC review process, the members of the Working Group for this guideline would like to emphasize that women should clearly be given the option of no follow-up, as there is no evidence for the impact of this practice on outcomes, and follow-up appointments may be associated with stress, inconvenience, and cost. A further recommendation is to provide survivors with written information, potentially in the form of a fact sheet, outlining symptoms of concern (as described under recommendation #4), follow-up suggestions, and when and how to contact the appropriate specialist.

2. Recommendations for CA-125 in Follow-up
   a. Women should be informed that there is no evidence that monitoring cancer antigen 125 (CA-125) improves survival outcome, and that it may worsen quality of life. There should be a time provided for the woman and her clinician to discuss the implications of monitoring progress and initiating treatment based on CA-125 levels. Women can be advised that they have the option to have CA-125 levels tested at agreed intervals, or not at all. Women who choose to have CA-125 levels measured should be informed that CA-125 levels may fluctuate due to individual and laboratory assay variations, and the implications of stable, fluctuating, and rising levels should be discussed.
   b. Women should be fully informed of the limitations and potential harms of routine measurement of CA-125 during follow-up and supported to make an informed decision, considering the findings of the randomized controlled trial on follow-up after ovarian cancer [2].
   c. The decision to initiate re-treatment requires careful consideration based on the individual woman's situation, and factors including the nature of the recurrence and the wishes of the woman.

   PEBC Qualifying Statement: Treatment based on a rising CA-125 result alone is not recommended. Clinical or radiologic confirmation of disease progression should be obtained prior to reinitiation of treatment.

   PEBC Qualifying Statement: In the text of the Cancer Australia guidance document, it was recommended that women be advised of the pros and cons of routine measurement of CA-125 during follow-up. The members of the Working Group for this guideline have chosen to reword this recommendation to stress that the limitations and potential harms of routine measurement of CA-125 should be made explicit to patients, and to emphasize that monitoring with CA-125 has not been associated with improvements in survival rate, and may be associated with a decrease in quality of life.
3. Recommendation for Timing of Follow-up Consultations
   a. Women should be offered the opportunity to have regular follow-up. Discussion with the woman about follow-up could incorporate a schedule of follow-up appointments, including the possibility of no formal follow-up schedule, based on the identified needs and wishes of the individual.

   b. There is no recommended frequency of follow-up consultations, but a clear and mutually agreed arrangement should be negotiated with the women, tailored according to risk and to individual patient characteristics, which acknowledges the benefits of an ongoing relationship and the opportunity to deal with issues as they arise.

   c. Women residing in rural and regional areas face additional challenges of access to specialist clinicians for follow-up appointments. Individual circumstances should be considered when establishing a follow-up schedule.

   **PEBC Qualifying Statement:** No specific frequency of follow-up appointments is endorsed; however, if desired, follow-up visits may occur more frequently immediately following the completion of active treatment, and may occur less frequently after more time has passed since the completion of active treatment.

4. Recommendations for Format for Follow-up Consultations
   a. The basic format of consultation is to update the patient history, assess psychosocial and supportive care needs, and undertake physical examination, which may include pelvic examination.

   b. Women should be encouraged to report a range of symptoms, including nausea, vomiting, abdominal distension, cramping, pain, and shortness of breath, and any other concerning symptoms.

   c. Radiological imaging should not be done routinely, but should be performed if there is clinical or CA-125 evidence of recurrence. The rationale for not undertaking routine imaging should be discussed with the woman.

   **PEBC Qualifying Statement:** Patients should be informed that physical examination has a low level of sensitivity for detecting early cancer recurrences, particularly if the patient is also undergoing regular monitoring for CA-125.

   **PEBC Qualifying Statement:** In the case of transfer of care from the patient’s oncologist to a clinician such as a gynecologist, family physician, or nurse practitioner, a written, individualized plan should be developed by the oncologist in consultation with the patient and provided to the clinician to whom care has been transferred. This should include plans for patient care in the event of delayed or long-term treatment sequelae.

5. Recommendation for Models of Follow-up Care
   a. A woman may be reviewed by either a gynecologic oncologist or a medical oncologist. Communication with a woman’s primary care physician should be maintained throughout follow-up.

   b. The use of alternate models of care for women with ovarian cancer, such as primary care physician or nurse-led follow-up, telephone follow-up and patient-initiated care is an area for future research. Some of the issues that would need to be addressed in any future studies include patient and clinician preferences, the effectiveness and cost effectiveness of the alternative models, and the ability of health services to support them.
FURTHER QUALIFYING STATEMENTS

- The Working Group members stress that if women opt not to engage in routine follow-up, they must be fully informed about signs and symptoms of recurrence, and be instructed to contact their oncologist or primary care provider if signs and symptoms suggestive of recurrence appear.

- In some remote areas of Ontario, follow-up has been delivered via TeleHealth. This model of follow-up care for patients with ovarian cancer has not been studied; however, it may be a viable model for patients who live in geographically remote areas and who are not able to travel to a Cancer Centre.

- There are currently two ongoing randomized trials of secondary debulking surgery, DESKTOP III [3] and GOG-0213 (www.cancer.gov). This guideline should be reviewed for currency when the results of these trials have been published.