1 Information about this Short Version

1.1 Editors
German Guideline Programme in Oncology (OL) of the Association of the Scientific Medical Societies in Germany (AWMF), the German Cancer Society (DKG) and German Cancer Aid (DKH).

1.2 Leading professional society
Germany Society for Gynaecology and Obstetrics (DGGG).

1.3 Funding
This guideline was funded by German Cancer Aid as part of the German Guideline Programme in Oncology.

1.4 Contact
Office of the German Guideline Programme in Oncology
c/o Deutsche Krebsgesellschaft e.V.
Kuno-Fischer-Straße 8
14057 Berlin, Germany
leitlinienprogramm@krebsgesellschaft.de
www.leitlinienprogramm-onkologie.de

1.5 Citation
The German Guideline Programme in Oncology (German Cancer Society, German Cancer Aid, AWMF): S3-Guideline on Diagnostics, Therapy and Follow-up of Malignant Ovarian Tumors, short version 1.0 (2013), AWMF registration number: 032–035OL, http://leitlinienprogramm-onkologie.de/Leitlinien.7.0.html

1.6 Note
Medicine is continually subject to a process of development and change so that all information, particularly all information on diagnostic and therapeutic treatments, can only reproduce the state of knowledge at the time of printing of this guideline on care. The greatest possible care was taken when compiling these recommendations on therapy and the choice and dosage of medications. Users are requested to consult the package leaflets and check the summary of product characteristics provided by manufacturers and, when in doubt, to consult a specialist. In the interests of all concerned, please contact the OL editorial office if you find discrepancies or controversial issues.

Users are responsible for all diagnostic and therapeutic applications, medications and dosages.

Registered trademarks (brand names) mentioned in this guideline have not been specifically labelled. When a specific indication lacks a trade name it should not be concluded that the brand name has not been registered. This guideline and all of its constituent parts is protected under copyright law. Any utilisation contrary to the provisions of copyright law without the written permission of the OL editorial office is prohibited and liable to prosecution. No part of this guideline may be reproduced in any form without the written permission of the OL editorial office. This applies in particular to copies, translations, microfilms and all storage, utilization and processing in electronic systems, intranets and the internet.
1.7 Additional guideline documents
The contents of this short version refer to the long version of the S3-Guideline on Diagnostics, Therapy and Follow-up of Malignant Ovarian Tumours available in German on the following websites:

- AWMF (http://www.awmf.org/leitlinien/aktuelle-leitlinien.html)
- German Guideline Programme in Oncology http://www.leitlinienprogramm-onkologie.de/OL/leitlinien.html
- German Cancer Society http://www.krebsgesellschaft.de/wub_llevidenzbasierd.120884.html
- German Cancer Aid (http://www.krebshilfe.de/)
- Guidelines International Network (www.g-i-n.net)
- Contributing German scientific medical societies (e.g. http://www.dggg.de/leitlinien/)

In addition to the short version, a number of other, supplementary documents are also available:

- Guideline report on the compilation of the guideline
- Long version
- Patient guideline

All of these documents will also be available on the websites listed above.

1.8 Responsibilities
1.8.1 Authors of the guideline

Editorial team

- Prof. Dr. Uwe Wagner (Co-ordinator, DGGG), Uni-Frauenklinik, Baldingerstraße, 35 043 Marburg, Germany
- Dr. Philipp Harter (DGGG), Kliniken Essen-Mitte, Henricistraße 92, 45 136 Essen, Germany
- PD Dr. Felix Hilpert (DGGG), Universitätsklinikum Schleswig Holstein, Campus Kiel, Klinik für Gynäkologie und Geburtshilfe, Arnold-Heller-Straße 3, Haus 24, 24 105 Kiel, Germany
- PD Dr. Sven Mahner (DGGG), Universitätsklinikum Hamburg-Eppendorf, Klinik für Gynäkologie, Martinistraße 52, 20 246 Hamburg, Germany
- Alexander Reuß, Koordinierungszentrum für Klinische Studien, Philippus-Universität Marburg, Karl-von Frisch-Straße 4, 35 043 Marburg, Germany

Participating scientific societies and authors

- Prof. Dr. Andreas du Bois – Arbeitsgemeinschaft Gynaekologische Onkologie e.V. (AGO) [Gynaecological Oncology Working Group]
- Prof. Dr. Edgar Petru – Arbeitsgemeinschaft für Gynaekologische Onkologie Austria (AGO AT) [Gynaecological Oncology Working Group Austria]
- Prof. Dr. Werner Meier – AGO Study Group
- Prof. Dr. Petra Ortner – Arbeitsgemeinschaft Supportive Maßnahmen in der Onkologie, Rehabilitation und Sozialmedizin (ASORS) [Working Group for Supportive Measures in Oncology, Rehabilitation and Epidemiology]
- Dr. Klaus König – Berufsverband der Frauenärzte e.V. (BVF) [Professional Organisation of German Gynaecologists]
- PD Dr. Katja Lindel – Deutsche Gesellschaft für Radioonkologie (DEGRO) [German Society for Radio-oncology]
- Prof. Dr. Dieter Grab – Deutsche Gesellschaft für Ultraschall in der Medizin e.V. (DEGUM) [German Society for Ultrasound in Medicine]
- Prof. Dr. Pompiliu Piso – Deutsche Gesellschaft für Allgemein- u. Viszeralchirurgie (DGAV) [German Society for General and Abdominal Surgery]
- Prof. Dr. Olaf Ortmann – Deutsche Gesellschaft für Endokrinologie (DGE) [German Society for Endocrinology]
- Prof. Dr. Ingo Runnebaum – Deutsche Gesellschaft für Gynäkologie und Geburtshilfe (DGGG) [Germany Society for Gynaecology and Obstetrics]
- Prof. Dr. Jacobus Pfisterer – Deutsche Gesellschaft für Gynäkologie und Geburtshilfe (DGGG) [Germany Society for Gynaecology and Obstetrics]
- PD Dr. Diana Lüftner – Deutsche Gesellschaft f. Hämatologie und Onkologie e.V. (DGHO) [German Society for Haematology and Oncology]
- Prof. Dr. Norbert Frickhofen – Deutsche Gesellschaft für Innere Medizin e.V. (DGIM) [German Society for Internal Medicine]
- Prof. Dr. Frank Grünewald – Deutsche Gesellschaft für Nuklearmedizin e.V. (DGN) [German Society for Nuclear Medicine]
- Dr. Bernd Oliver Maier – Deutsche Gesellschaft für Palliativmedizin e.V. (DGP) [German Society for Palliative Medicine]
- Prof. Dr. Joachim Diebold, Prof. Dr. Steffen Hauptmann, Prof. Dr. Friedrich Kommos – Deutsche Gesellschaft für Pathologie e.V. (DGP) [German Pathology Society]
- Prof. Dr. Günter Emmons – Deutsche Menopausegesellschaft e.V. (DMG) Deutsche Gesellschaft für Pathologie [German Pathology Society]
- Dr. Boris Radeleff – Deutsche Röntgengesellschaft (DRG) [German Radiology Society]
- Marion Gebhardt (patients’ representative) – Bundesverband der Frauenselbsthilfe nach Krebs e.V. [Federation of Women’s Self-help after Cancer Organisations]
- Prof. Dr. Norbert Arnold – Deutsche Gesellschaft für Humangetik (FGH) [German Society for Human Genetics]
- Dr. Gabriele Calaminus – Gesellschaft für Pädiatrische Onkologie und Hämatologie (GPOH) [Society for Paediatric Oncology and Haematology]
- Isolde Weisse – Konferenz Onkologischer Kranken- und Kinderkrankenpflege (KOK) [Conference for Oncologic Patient Care and Paediatric Patient Care]
- Prof. Dr. Joachim Weis – Arbeitsgemeinschaft für Psychosoziale Onkologie (PSO) [Psycho-social Oncology Working Group]
- Prof. Dr. Jalid Sehouli – Nord-Ostdeutsche Gesellschaft für Gynäkologische Onkologie (NOGGO) [Northeast German Society for Gynaecological Oncology]
- Prof. Dr. Daniel Fink – Schweizerische Gesellschaft für Gynäkologie und Geburtshilfe (SGGG) [Swiss Society for Gynaecology and Obstetrics]
- Dr. Alexander Burges – as an independent expert
- Prof. Dr. Annette Hasenburg – as an independent expert
- Dr. C. Eggert from the Medizinischen Dienst der Krankenversicherung in Hessen (MDK Hessen) [Medical Service of the Health Insurance Companies in Hesse] contributed to the discussions at the Consensus Conferences as an expert without voting rights.

Methodological Support

1. The German Guideline Programme on Oncology

- Prof. Dr. Ina Kopp, Marburg (AWMF)
- Dr. Markus Follmann MPH MSc, Berlin (DKG) [German Cancer Society]
- Dipl.-Soz.Wiss Thomas Langer (DKG) [German Cancer Society]
2. Introduction

2.1 Target audience

The guideline was compiled with the aim of providing high-risk groups with advice on diagnostics, surgical and systemic therapy in early and advanced stages of disease together with the treatment of rare histological subtypes. A lot of emphasis has been placed on follow-up care, rehabilitation, palliative therapy and psycho-oncological counselling. The recommendations are for physicians working both in hospitals and outpatient clinics, nursing staff and other medical partners involved in treating patients with malignant ovarian tumours. As it also covers the topics ‘Screening’ and ‘Follow-up’, registered physicians working in their own practice are also an important target audience of this guideline. It is additionally intended to offer guidance to affected patients and persons seeking more information as well as providing a basis for the gynaecological cancer centres currently being set up in Germany.

For the first time, scientific medical societies in Switzerland and Austria were also consulted, expanding the scope of this guideline.

2.2 Methodology

The methodological approach used to compile the guideline has been described in the guideline report. The guideline report is freely available online (in German), for example on the website of the German Guideline Programme in Oncology (http://leitlinienprogramm-onkologie.de/Leitlinien.7.0.html) and the pages of the AWMF (http://www.awmf.org/).

2.2.1 SIGN level of evidence system

To classify the risk of bias or confounding in the identified studies, this guideline has used the level of evidence system of the Scottish Intercollegiate Guidelines Network (SIGN, Version 2009) (http://www.sign.ac.uk/pdf/sign50.pdf) as described in Table 1 below.

2.2.2 System of grading recommendations

The OL methodology uses the grades of recommendation awarded by the authors of the guideline. The level of recommendation is decided on in a formal consensus process, using a multi-step nominal group technique moderated by the AWMF.

The guideline includes the level of evidence (SIGN, see 2.2.1) of the studies on which they are based as well as the strength of the recommendation (grade of recommendation) for all evidence-based statements (see chapter 2.2.3) and recommendations. This guideline has three different ‘strength of recommendation’ ratings (see Table 2 below), which are also reflected in the formulation of the recommendation.

2.2.3 Statements

Statements are expositions or explanations of specific facts or issues which do not constitute a call for action. They are approved in a similar manner to that used for recommendations in a formal consensus process and may be based either on study results or expert opinions.

2.2.4 Clinical consensus (CC)

Statements/recommendations which were drawn up on the basis of a consensus of experts from the guideline group are identified by the term “clinical consensus”. No symbols were used to grade the clinical consensus; the strength of the consensus is indicated by the formulations used (must, necessary/should/can) as described for the gradations in Table 2.

2.2.5 Independence and disclosure of possible conflicts of interest

German Cancer Aid provided the funding through the German Guideline Programme in Oncology (OL). Funds were used for staffing costs, office materials, literature and consensus conferences (costs of venue, the media technology required at conferences, catering, moderator’s fees, travelling expenses of participants). Travelling expenses were reimbursed in accordance with the German law on travel expenses when on company business or according to standard practice for the DKG [German Hospital Federation]. Editorial decisions and the compilation of the guideline were carried out entirely independent of the funding organisation. During the guideline process, all members provided a written disclosure of possible conflicts of interest. The conflicts

---

Table 1 | SIGN system for level of evidence grading (Version 2009).

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1++</td>
<td>High quality meta-analyses, systematic reviews of randomised controlled trials (RCTs), or RCTs with a very low risk of bias</td>
</tr>
<tr>
<td>1+</td>
<td>Well conducted meta-analyses, systematic reviews of RCTs, or RCTs with a low risk of bias</td>
</tr>
<tr>
<td>1−</td>
<td>Meta-analyses, systematic reviews of RCTs, or RCTs with a high risk of bias</td>
</tr>
<tr>
<td>2++</td>
<td>High quality systematic reviews of case-control or cohort studies, or high quality case control or cohort studies with a very low risk of confounding or bias (&quot;chance&quot;) and a high probability that the relationship is causal</td>
</tr>
<tr>
<td>2+</td>
<td>Well conducted case-control or cohort studies with a low risk of confounding or bias (&quot;chance&quot;) and a moderate probability that the relationship is causal</td>
</tr>
<tr>
<td>2−</td>
<td>Case-control or cohort studies with a high risk of confounding or bias (&quot;chance&quot;) and a significant risk that the relationship is not causal</td>
</tr>
<tr>
<td>3</td>
<td>Non-analytic studies, e.g. case reports, case series</td>
</tr>
<tr>
<td>4</td>
<td>Expert opinion</td>
</tr>
</tbody>
</table>

Table 2 | Grades of recommendations.

<table>
<thead>
<tr>
<th>Grade of recommendation</th>
<th>Description</th>
<th>Syntax</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>strongly recommended/ or not recommended</td>
<td>must/necessary</td>
</tr>
<tr>
<td>B</td>
<td>recommended/ or not recommended</td>
<td>should</td>
</tr>
<tr>
<td>0</td>
<td>neither recommended nor not recommended</td>
<td>can</td>
</tr>
</tbody>
</table>
of interest disclosed are included in the guideline report to this guideline (http://leitlinienprogramm-onkologie.de/Leitlinien.7.0.html). We would like to take this opportunity of thanking all contributors for their contribution to the project, which was entirely voluntary and unsalaried.

### 2.2.6 Period of validity and update process

This S3-guideline will remain valid until it is next updated; its estimated period of validity is 3 years. Regular updates are planned; if an urgent need for changes to the guideline occurs in between update times, these changes will be published separately. Comments and advice for the update process are expressly requested and should be sent to the following address:

Prof. Dr. Uwe Wagner, Klinik für Gynäkologie, gynäkologische Endokrinologie und Onkologie, Baldingerstraße, D-35043 Marburg, Germany; phone: 06421–58–66211, fax: 0642158–68969, e-mail: wagneru@med.uni-marburg.de.

### 2.3 List of abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Meaning</th>
<th>LoE</th>
<th>Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>AUC</td>
<td>Area under the Curve</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GR</td>
<td>Grade of Recommendation, A = strongly recommended, B = recommended, 0 = neither recommended nor not recommended</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIPEC</td>
<td>Hyperthermal Intraperitoneal Chemotherapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HT</td>
<td>Hormone Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CC</td>
<td>Clinical Consensus</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GL</td>
<td>Guideline</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LoE</td>
<td>Level of Evidence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OL</td>
<td>German Guideline Programme in Oncology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OP</td>
<td>Operation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ST</td>
<td>Statement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TVS</td>
<td>Transvaginal sonography</td>
<td></td>
<td></td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 3 Epidemiology, Screening and Diagnostics

#### 3.1 Screening

<table>
<thead>
<tr>
<th>No.</th>
<th>Recommendations/Statements</th>
<th>GR</th>
<th>LoE</th>
<th>Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>Screening with CA-125 and TVS has not resulted in any drop in mortality to date.</td>
<td>ST</td>
<td>1++</td>
<td>Guidelines: [1, 2] Primary studies: [3–9]</td>
</tr>
<tr>
<td>3.2</td>
<td>General screening is not necessary.</td>
<td>A</td>
<td>1++</td>
<td>Guidelines: [1, 2] Primary studies: [3–9]</td>
</tr>
<tr>
<td>3.3</td>
<td>Multidisciplinary consultation (gynaecologist and human geneticist) and genetic testing must be offered if a patient is in the at-risk population.</td>
<td>CC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.4</td>
<td>Screening with CA-125 and TVS was not proven to reduce mortality in risk groups.</td>
<td>ST</td>
<td>3</td>
<td>Guidelines: [1] Primary studies: [10–13]</td>
</tr>
<tr>
<td>3.5</td>
<td>Screening of groups at risk is not necessary.</td>
<td>A</td>
<td>3</td>
<td>Guidelines: [1] Primary studies: [10–13]</td>
</tr>
</tbody>
</table>

#### 3.2 Diagnostics

<table>
<thead>
<tr>
<th>No.</th>
<th>Statements</th>
<th>GR</th>
<th>LoE</th>
<th>Sources</th>
</tr>
</thead>
</table>
| 3.6 | Further examinations should be initiated if the following symptoms occur repeatedly and persistently, particularly in women above the age of 50:  
  ➤ Bloatedness  
  ➤ Flatulence  
  ➤ Vague abdominal pain or discomfort  
  ➤ Increased frequency of micturition | CC | | |
| 3.7 | If there is a suspicion of an ovarian mass, pelvic examination (palpation, speculum) must be carried out, followed by transvaginal sonography. | CC | | |
| 3.8 | No diagnostic examination exists which can take the place of operative staging for ovarian cancer and give a reliable assessment of the tumour’s operability. | CC | | |

#### 3.3 Diagnosis of recurrence

<table>
<thead>
<tr>
<th>No.</th>
<th>Recommendations</th>
<th>GR</th>
<th>LoE</th>
<th>Sources</th>
</tr>
</thead>
</table>
| 3.9 | Asymptomatic patients:  
  If, contrary to the recommendations of the guideline, there is a suspicion of recurrence based on increased CA-125 levels, the further procedure should be discussed with the individual patient. An early, pre-symptomatic start of treatment for recurrence is not associated with improved survival rates. | B | 1+ | Primary studies: [14] |
| 3.10 | Symptomatic patients:  
  If symptoms are present, additional diagnostic investigations can be initiated. We were unable to identify evidence which would indicate improved survival for any of the available procedures. | 0 | 2+ | Primary studies: [15–23] |
4 Patient Consent and Information

<table>
<thead>
<tr>
<th>No.</th>
<th>Statements</th>
<th>GR</th>
<th>LoE</th>
<th>Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1</td>
<td>The information provided by the physician to the patient must include information on the disease, the results of the examination(s), the course of treatment to date, the diagnostic and therapeutic options including expected side-effects as well as the assessment of the associated prognosis and the impact on the patient's life plans and quality of life. Written materials and other suitable media can be used to help explain all of this to the patient and as aids in decision-making.</td>
<td>CC</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 4.2 | Conveying this information and explaining it to the patient must be done based on the following principles of patient-centred communication:  
  - The physician must show empathy and use active listening  
  - Difficult topics must be touched upon directly and sensitively  
  - Avoid using specialised medical vocabulary; explain specialist terminology where necessary  
  - Use strategies to improve the patient’s comprehension (repetition, summarising of important information, use of diagrams and graphs)  
  - Encourage the patient to ask questions  
  - Permit and encourage the patient to express her feelings, particularly her worries and fears  
  - Offer further help | CC |     |                                             |
| 4.3 | The patient’s wishes about being involved in the process of medical decision-making must be taken into account. | CC |     |                                             |

5 Genetics, Prevention and Risk Factors

<table>
<thead>
<tr>
<th>No.</th>
<th>Recommendations/Statements</th>
<th>GR</th>
<th>LoE</th>
<th>Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1</td>
<td>Bilateral salpingo-oophorectomy is the most effective method to reduce the risk of developing the disease and to reduce mortality in patients with hereditary ovarian cancer.</td>
<td>ST</td>
<td>2+</td>
<td>Guidelines: [1, 2] Primary studies: [11, 24–39]</td>
</tr>
<tr>
<td>5.2</td>
<td>Patients with BRCA1/2 mutation should be offered prophylactic bilateral salping-oophorectomy; surgery should be done once the patient plans to have no more children, after the patient has either turned 40 years of age or 5 years prior to the youngest age at which a member of the patient’s family developed ovarian cancer.</td>
<td>B</td>
<td>2+</td>
<td>Guidelines: [2] Primary studies: [11, 24–39]</td>
</tr>
</tbody>
</table>

6 Pathological Diagnosis and Prognostic Factors

<table>
<thead>
<tr>
<th>No.</th>
<th>Recommendations/Statements</th>
<th>GR</th>
<th>LoE</th>
<th>Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1</td>
<td>To date, the evidence for an association between detected biochemical parameters and prediction/prognosis has been insufficient.</td>
<td>ST</td>
<td>2+</td>
<td>Primary studies: [40–50]</td>
</tr>
</tbody>
</table>
| 6.2 | The established prognostic factors for ovarian cancer listed below must be used:  
  - Tumour stage  
  - Postoperative residual tumour  
  - Age  
  - General condition  
  - Histological type  
  - Tumour grading  
  - Guideline-based therapy | CC |     |                                             |
7 Surgical Treatment

7.1 Surgical treatment of early ovarian cancer

<table>
<thead>
<tr>
<th>No.</th>
<th>Recommendations</th>
<th>GR</th>
<th>LoE</th>
<th>Sources</th>
</tr>
</thead>
</table>
| 7.1 | Optimal staging must include the following surgical steps:  
* Longitudinal laparotomy  
* Inspection and palpation of the entire abdominal cavity  
* Peritoneal cytology  
* Biopsies from all abnormal sites  
* Peritoneal biopsies from unremarkable regions  
* Bilateral excision of adnexa of uterus  
* Hysterectomy, using an extraperitoneal approach where necessary  
* Infracolic omentectomy  
* Appendectomy (for mucinous/unclear tumour types)  
* Bilateral pelvic and paraaortal lymphonodectomy | CC | |

7.2 If ovarian cancer is unexpectedly diagnosed, this must be confirmed histologically and the extent of spread described. The definitive treatment must then be carried out by a gynaecological oncologist.

7.3 In patients with unilateral FIGO I stage tumours, fertility-preserving surgery can be done if staging was adequate.

7.4 Patients with early stage ovarian cancer must be informed about the increased risk associated with fertility-preserving treatment, a risk which also depends on additional prognostic factors.

7.5 Laparoscopic staging must not be done outside of studies.

7.6 The goal of primary surgery to treat advanced ovarian cancer must be macroscopically complete resection.

7.7 Multivisceral resection must be carried out if complete resection (free of residual macroscopic tumour) can be achieved or if it can be used to remove an obstruction and is not contraindicated in this patient.

7.8 If advanced ovarian cancer is unexpectedly diagnosed, this must be confirmed histologically and the extent of spread described. The definitive treatment must then be carried out by a gynaecological oncologist in a suitable facility.

7.9 Patients obtain no benefit from primary chemotherapy followed by interval operation.

7.10 The sequence of therapy must consist first of primary surgery followed by chemotherapy.

7.11 Second-look operations must not be carried out.

8 Systemic Primary Therapy

8.1 Systemic primary therapy for early ovarian cancer

<table>
<thead>
<tr>
<th>No.</th>
<th>Recommendations</th>
<th>GR</th>
<th>LoE</th>
<th>Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.1</td>
<td>Patients with stage I A grade 1 ovarian cancer after complete operative staging must not receive adjuvant chemotherapy.</td>
<td>A</td>
<td>1+</td>
<td>Primary studies: [96–104]</td>
</tr>
<tr>
<td>8.2</td>
<td>Patients with stage I C or I A/B, grade 3 ovarian cancer must receive platinum-based chemotherapy (6 cycles).</td>
<td>A</td>
<td>1+</td>
<td>Primary studies: [96–104]</td>
</tr>
<tr>
<td>8.3</td>
<td>Patients with stage I A/G2, I B/G1/2 ovarian cancer can be offered platinum-based chemotherapy.</td>
<td>0</td>
<td>1+</td>
<td>Primary studies: [96–104]</td>
</tr>
</tbody>
</table>
| 8.4 | The therapy should include carboplatin and consist of 6 cycles. | B | 1+ | Guidelines: [1, 2]  
Primary studies: [67, 99, 105–117] |
8.2 Systemic primary therapy for advanced ovarian cancer

<table>
<thead>
<tr>
<th>No.</th>
<th>Recommendations</th>
<th>GR</th>
<th>LoE</th>
<th>Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.5</td>
<td>The first-line chemotherapy for patients with advanced ovarian cancer (IIb-IV) must consist of carboplatin AUC5 and paclitaxel 175 mg/m² for 3 h i.v. over a total of 6 cycles, with one cycle every 3 weeks.</td>
<td>A</td>
<td>1++</td>
<td>Guidelines: [118, 119] Primary studies: [120–131]</td>
</tr>
<tr>
<td>8.6</td>
<td>Additional therapy with bevacizumab can be considered in patients with advanced ovarian cancer (IIIB-IV).</td>
<td>0</td>
<td>1+</td>
<td>Primary studies: [132, 133]</td>
</tr>
<tr>
<td>8.7</td>
<td>Changes in dose density or intensity should only be done as part of a clinical trial.</td>
<td>B</td>
<td>1+</td>
<td>Guidelines: [2] Primary studies: [134–146]</td>
</tr>
<tr>
<td>8.8</td>
<td>No maintenance or consolidation therapies must be carried out after primary therapy has been completed.*</td>
<td>A</td>
<td>1+</td>
<td>Primary studies: [132, 133, 147–154]</td>
</tr>
<tr>
<td>8.9</td>
<td>Systematic recording of the patient’s quality of life can be helpful to identify difficulties during treatment.</td>
<td>CC</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Data on the effectiveness of consolidation or maintenance therapy to increase progression-free survival (PFS) is only available for bevacizumab (see 8.6.)

9 Treatment for Recurrence

9.1 Populations with recurrence

<table>
<thead>
<tr>
<th>No.</th>
<th>Statement</th>
<th>GR</th>
<th>LoE</th>
<th>Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.1</td>
<td><strong>Platinum-sensitive ovarian cancer:</strong> Disease responds primarily to platinum-based first-line chemotherapy with recurrence occurring at the earliest 6 months after conclusion of platinum-based chemotherapy. This also includes the subgroup of partially platinum-sensitive recurrences of ovarian cancer. In this subgroup, disease also responds primarily to platinum-based first-line chemotherapy but recurrence occurs between 6 and 12 months after concluding platinum-based chemotherapy. <strong>Platinum-resistant ovarian cancer:</strong> Disease recurs within the first 6 months after concluding initial platinum-based chemotherapy. This also includes the subgroup with platinum-refractory recurrence of ovarian cancer. In this subgroup, disease does not respond to platinum-based chemotherapy or disease progresses within 4 weeks after therapy has been concluded.</td>
<td>ST</td>
<td>1+</td>
<td>Guidelines: [1, 119] Primary studies: [14, 155–163]</td>
</tr>
</tbody>
</table>

9.2 Systemic therapy for recurrence

9.2.1 Platinum-resistant recurrence

<table>
<thead>
<tr>
<th>No.</th>
<th>Recommendations/Statements</th>
<th>GR</th>
<th>LoE</th>
<th>Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.2</td>
<td>Combination therapy offers no advantages compared to monotherapy.</td>
<td>ST</td>
<td>1+</td>
<td>Guidelines: [119] Primary studies: [155, 156, 158, 164–171]</td>
</tr>
<tr>
<td>9.3</td>
<td>Endocrine therapies are inferior to a monochemotherapy.</td>
<td>ST</td>
<td>1+</td>
<td>Guidelines: [119] Primary studies: [155, 156, 158, 164–171]</td>
</tr>
<tr>
<td>9.4</td>
<td>Patients with platinum-resistant and/or refractory recurrence of ovarian cancer must not receive platinum-based monotherapy, if chemotherapy is indicated. The following cytostatic drugs can be used: ▶ pegylated liposomal doxorubicin ▶ topotecan ▶ gemcitabine ▶ paclitaxel weekly</td>
<td>A</td>
<td>1+</td>
<td>Guidelines: [119] Primary studies: [155, 156, 158, 164–171]</td>
</tr>
</tbody>
</table>

9.2.2 Platinum-sensitive recurrence

<table>
<thead>
<tr>
<th>No.</th>
<th>Recommendations</th>
<th>GR</th>
<th>LoE</th>
<th>Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.5</td>
<td>Patients with platinum-sensitive recurrence of ovarian cancer should have platinum-based combination therapy if chemotherapy is indicated. The following combinations can be used: ▶ carboplatin + gemcitabine + bevacizumab* ▶ carboplatin + pegylated liposomal doxorubicin ▶ carboplatin + paclitaxel ▶ carboplatin + gemcitabine</td>
<td>CC</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* to treat patients with primary recurrence who did not have previous VEGF-targeted therapy
### 9.3 Surgery for recurrence

<table>
<thead>
<tr>
<th>No.</th>
<th>Recommendations</th>
<th>GR</th>
<th>LoE</th>
<th>Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.6</td>
<td>The value of surgery to treat ovarian cancer recurrence cannot be verified by data from prospective studies with a high level of evidence, but retrospective data indicate a potential clinical benefit.</td>
<td>A</td>
<td>2+</td>
<td>Guidelines: [1] Primary studies: [172–177]</td>
</tr>
<tr>
<td>9.7</td>
<td>The goal of surgery for recurrence should be macroscopically complete resection.</td>
<td>B</td>
<td>2+</td>
<td>Guidelines: [1] Primary studies: [172–177]</td>
</tr>
</tbody>
</table>

### 10 Follow-up Care, Rehabilitation, Psycho-oncology, Palliative Medicine

#### 10.1 Follow-up care and rehabilitation

<table>
<thead>
<tr>
<th>No.</th>
<th>Recommendations/Statements</th>
<th>GR</th>
<th>LoE</th>
<th>Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.1</td>
<td>Patients with ovarian cancer must be informed about the various options for rehabilitation and offered support from social counselling services; patients must be offered suitable options after their individual need has been assessed.</td>
<td>CC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.2</td>
<td>The goal of follow-up care is to detect and treat therapy-associated side-effects, to offer rehabilitation, psychosocial care and reintegration, to improve the patient’s quality of life and to detect any recurrence.</td>
<td>CC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.3</td>
<td>Routine use of the determination of CA-125 does not result in longer survival.</td>
<td>ST</td>
<td>1+</td>
<td>Guidelines: [1] Primary studies: [14, 178, 179]</td>
</tr>
<tr>
<td>10.4</td>
<td>Routine sophisticated diagnostics and determination of markers is not required during follow-up when patients are symptom-free.</td>
<td>A</td>
<td>1+</td>
<td>Leitlinien: [1] Primary studies: [14, 178, 179]</td>
</tr>
<tr>
<td>10.5</td>
<td>Follow-up must include detailed medical history, physical examination including gynaecological examination with speculum and palpation, rectal examination and vaginal sonography.</td>
<td>CC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.6</td>
<td>There is no reliable information about the safety of hormone therapy after treatment for ovarian cancer.</td>
<td>ST</td>
<td>2+</td>
<td>Primary studies: [180–183]</td>
</tr>
<tr>
<td>10.7</td>
<td>Hormone therapy cannot be recommended after treatment for ovarian cancer. It can be considered in individual cases, particularly in patients with considerable limitations in their quality of life.</td>
<td>0</td>
<td>2+</td>
<td>Primary studies: [180–183]</td>
</tr>
</tbody>
</table>

#### 10.2 Psycho-oncology

<table>
<thead>
<tr>
<th>No.</th>
<th>Recommendations</th>
<th>GR</th>
<th>LoE</th>
<th>Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.8</td>
<td>Psychosocial interventions have a positive impact on the patient’s quality of life, psychological condition and capacity to cope emotionally with the disease.</td>
<td>CC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.9</td>
<td>Psycho-oncological care of patients with ovarian cancer is an integral part of the oncological diagnosis, therapy and follow-up care and requires an interdisciplinary approach.</td>
<td>CC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.10</td>
<td>Psycho-oncological counselling and support should be offered to all patients and their family members based on their needs.</td>
<td>CC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.11</td>
<td>The topic of sexuality should always be actively explored to identify when further support is required and to provide additional support as required.</td>
<td>CC</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### 10.3 Palliative medicine

<table>
<thead>
<tr>
<th>No.</th>
<th>Recommendations</th>
<th>GR</th>
<th>LoE</th>
<th>Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.12</td>
<td>The right moment to initiate palliative medical care depends first and foremost on the patient’s needs and the individual stage of disease.</td>
<td>CC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.13</td>
<td>Patients who primarily require palliative medical care should be included in a programme of specialised palliative care.</td>
<td>CC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.14</td>
<td>Palliative medical care includes the medical control of symptoms, palliative care and psychosocial support till death. It is offered as needed in the form of general or specialised palliative care.</td>
<td>CC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.15</td>
<td>In a palliative setting all necessary measures taken must be geared to the patient’s individual therapeutic aims and aims in life.</td>
<td>CC</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### 11 Borderline Tumours (BOT)

<table>
<thead>
<tr>
<th>No.</th>
<th>Recommendations/Statements</th>
<th>GR</th>
<th>LoE</th>
<th>Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.1</td>
<td>Borderline tumours must be distinguished according to the WHO classification and categorised into subtypes. This should include the categorisation of any existing implants (invasive – non invasive) as well as information about microinvasion.</td>
<td>CC</td>
<td></td>
<td>[184]</td>
</tr>
<tr>
<td>11.2</td>
<td>Careful surgical staging is necessary and, in addition to complete removal of the tumour (including bilateral salpingo-oophorectomy), should include inspection of the abdomen with peritoneal wash cytology, resection of all abnormal areas, peritoneal biopsies of unremarkable areas and omentectomy. If mucinous borderline tumours, metastasis of extraovarian tumours must be excluded; an appendectomy is necessary to exclude a primary appendiceal neoplasm.</td>
<td>B</td>
<td>2+</td>
<td>Primary studies: [185–189]</td>
</tr>
<tr>
<td>11.3</td>
<td>There are some indications that performing cystectomy instead of ovariectomy and carrying out a fertility-preserving procedure instead of bilateral salpingo-oophorectomy is associated with higher rates of recurrence.</td>
<td>ST</td>
<td>2+</td>
<td></td>
</tr>
<tr>
<td>11.4</td>
<td>If the patient wishes to have children/wishes to preserve endocrine functions, a fertility-preserving procedure can be carried out. The patient must be informed about the increased risk of recurrence associated with this procedure.</td>
<td>0</td>
<td>2+</td>
<td>Guidelines: [2] Primary studies: [191]</td>
</tr>
<tr>
<td>11.5</td>
<td>There is no persuasive evidence for the effectiveness of adjuvant therapy for the treatment of borderline tumours.</td>
<td>ST</td>
<td>1+</td>
<td>Guidelines: [2] Primary studies: [192]</td>
</tr>
<tr>
<td>11.6</td>
<td>Patients with borderline tumours must not receive adjuvant therapy.</td>
<td>A</td>
<td>1+</td>
<td>Guidelines: [2] Primary studies: [192]</td>
</tr>
</tbody>
</table>

### 12 Ovarian Germ Cell and Stromal Tumours

<table>
<thead>
<tr>
<th>No.</th>
<th>Recommendations/Statements</th>
<th>GR</th>
<th>LoE</th>
<th>Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>12.1</td>
<td>The diagnosis of germ cell and stromal tumours must done in a similar manner as the diagnosis of ovarian cancer.</td>
<td>CC</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 12.2 | Optimal staging must include the following procedures:  
  - Lower median laparotomy  
  - Inspection and palpation of the entire abdominal cavity  
  - Peritoneal cytology  
  - Removal of the tumour with salpingo-oophorectomy  
  - For potentially malignant tumours (granulosa cell tumours, Sertoli-Leydig cell tumours G2/G3 or steroid cell tumours NOS):  
    - Definitive operative staging analogous to that for ovarian cancer.  
    - The benefit of systematic lymphonodectomy when lymph nodes are unremarkable has not been proven.  
    - If the uterus is not removed, hysteroscopy and curettage are recommended (to exclude endometrial hyperplasias or endometrial carcinoma). | A | 2+ | Primary studies: [193–196] |
| 12.3 | Fertility-preserving procedures should be considered when treating younger patients. | B | 2+ | Primary studies: [53] |
| 12.4 | The benefit of adjuvant radiotherapy, chemotherapy or endocrine therapy after complete resection has not been proven and is controversially discussed in the literature. | ST | 2+ | Primary studies: [197, 198] |
| 12.5 | Platinum-based chemotherapy should be considered for tumours which are stage IC or higher or if residual tumour is still present. | B | 2+ | Primary studies: [199–202] |

### 13 Ovarian Germ Cell Tumours

<table>
<thead>
<tr>
<th>No.</th>
<th>Recommendations/Statements</th>
<th>GR</th>
<th>LoE</th>
<th>Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>13.1</td>
<td>The diagnosis of ovarian germ cell tumours must done in a similar manner as the diagnosis for ovarian cancer.</td>
<td>CC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.2</td>
<td>The goal of surgical treatment is, in addition to histological typification, complete resection of the tumour and adequate staging while preserving fertility if the remaining genital area is unremarkable. The benefit of systematic lymphonodectomy when lymph nodes are unremarkable has not been proven.</td>
<td>ST</td>
<td>2+</td>
<td>Primary studies: [53, 203–212]</td>
</tr>
<tr>
<td>13.3</td>
<td>No adjuvant chemotherapy is required for stage IA tumours.</td>
<td>A</td>
<td>2+</td>
<td>Primary studies: [213]</td>
</tr>
<tr>
<td>13.4</td>
<td>For cancers &gt; FIGO IA, platinum-based risk-adapted chemotherapy must be carried out, consisting of 2–4 cycles of 2 or 3 cytostatic drugs*.</td>
<td>A</td>
<td>2+</td>
<td>Primary studies: [213, 214]</td>
</tr>
<tr>
<td>13.5</td>
<td>In patients with advanced stage tumours, primary chemotherapy can be administered to preserve fertility. Resection of the residual tumour and of residual metastases must be planned after 3 or 4 cycles of chemotherapy have been concluded.</td>
<td>CC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.6</td>
<td>In addition to standard follow-up examinations, follow-up must also include the determination of specific tumour markers.</td>
<td>CC</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Chemotherapy must always include platinum and etoposide. The 3rd cytostatic drug can be either bleomycin or ifosfamide.
14 Care Facilities

<table>
<thead>
<tr>
<th>No.</th>
<th>Recommendations/Statements</th>
</tr>
</thead>
<tbody>
<tr>
<td>14.1</td>
<td>Patients with ovarian cancer should be treated by a gynaecological oncologist (specialist) in a specialist facility which includes interdisciplinary diagnostic and therapeutic services.</td>
</tr>
</tbody>
</table>

15 Quality Indicators

<table>
<thead>
<tr>
<th>Quality indicator</th>
<th>Recommendation reference</th>
<th>Evidence base/additional information</th>
</tr>
</thead>
</table>
| Quality indicator 1: Operative staging of early ovarian cancer | Z: Number of pts. with operative staging using:  
  - laparotomy  
  - peritoneal cytology  
  - peritoneal biopsies  
  - bilateral excision of adnexa of uterus  
  - hysterectomy, using an extraperitoneal approach where necessary  
  - infracolic omentectomy  
  - bilateral pelvic and paraaortal lymphadenectomy  
N: All pts. with a primary diagnosis of ovarian cancer FIGO I – IIIA | Optimal staging must including the following procedures:  
  - longitudinal laparotomy  
  - inspection and palpation of the entire abdominal cavity  
  - peritoneal cytology  
  - biopsies from all abnormal sites  
  - peritoneal biopsies from unremarkable regions  
  - bilateral excision of adnexa of uterus  
  - hysterectomy, using an extraperitoneal approach where necessary  
  - infracolic omentectomy  
  - appendectomy (for mucinous/unclear tumour types)  
  - bilateral pelvic and paraaortal lymphadenectomy | a) Quality target  
Operative staging to be done as often as possible  
b) Evidence base  
Guidelines: NICE 2011 [118]  
Primary studies: [215–223] |
| Quality indicator 2: Intraoperative tumour rupture | Z: Number of pts. with intraoperative tumour rupture  
N: All pts. with a primary diagnosis of ovarian cancer FIGO IA or IB | Background text to 7.5.  
“When an unclear ovarian carcinoma is removed laparoscopically, complete removal is important with no tumour rupture.” | a) Quality target  
No intraoperative tumour rupture  
b) Evidence base  
Leitlinien: [1,2]  
Primärstudien: [139–143] |
| Quality indicator 3: Macroscopically complete resection of advanced ovarian cancer | Z: Number of pts. with macroscopically complete resection  
N: All pts. with a primary diagnosis of ovarian cancer ≥ FIGO IIB and surgical removal of the tumour | The goal of primary surgery must be to achieve macroscopically complete resection. | a) Quality target  
Macroscopically complete resection to be achieved as often as possible  
b) Evidence base  
CC  
Guidelines: [1,2]  
Primary studies: [75,83,174,224–236] |
| Quality indicator 4: Surgery for advanced ovarian cancer | Z: Number of pts. whose definitive surgery was done by a gynaecological oncologist  
N: All pts. with a primary diagnosis of ovarian cancer ≥ FIGO IIB after surgical therapy has been completed | The diagnosis for patients unexpectedly diagnosed with advanced ovarian cancer must be confirmed histologically and the extent of spread described. The definitive treatment must then be carried out by a gynaecological oncologist in a suitable facility. | a) Quality target  
Surgery to be performed as often as possible by a gynaecological oncologist  
b) Evidence base  
LoE 4, A  
Guidelines: [2]  
Primary studies: [73–89] |
| Quality indicator 5: Postoperative chemotherapy for advanced ovarian cancer | Z: Number of pts. who received postoperative chemotherapy  
N: All pts. with a primary diagnosis of ovarian cancer ≥ FIGO IIB and receiving chemotherapy | The sequence of therapy must consist of primary surgery followed by chemotherapy. | a) Quality target  
Postoperative chemotherapy to be administered as often as possible in patients with advanced stage ovarian cancer  
b) Evidence base  
LoE 1+, A  
Guidelines: [1]  
Primary studies: [90–95] |
| Quality indicator 6: No adjuvant chemotherapy for early ovarian cancer | Z: Number of pts. who received adjuvant chemotherapy  
N: All pts. with a primary diagnosis of ovarian cancer FIGO IA, G1 and complete operative staging | Patients with stage IA grade 1 ovarian cancer after complete operative staging must not receive adjuvant chemotherapy. | a) Quality target  
If possible, no adjuvant chemotherapy to be administered to patients with FIGO IA, G1 ovarian cancer who have had complete operative staging  
b) Evidence base  
LoE 1+, A  
Primary studies: [96–104] |

**Note:** Gynaecological oncologist = Medical specialist for gynaecology and obstetrics with a special focus on gynaecological oncology

14 Wagner U et al. S3-Guideline on Diagnostics, … Geburtsh Frauenheilk 2013; 73: 874–889
### Quality indicator 7: Platinum-based chemotherapy for early ovarian cancer

| Z: Number of pts. who received platinum-based chemotherapy | 8.2. | Patients with stage IC or IA/B and grade 3 ovarian cancer must receive 6 cycles of platinum-based chemotherapy. |
| N: All pts. with a primary diagnosis of ovarian cancer FIGO IC or IA/B and grade 3 | |

*Evidence base/additional information*
- a) Quality target
- Patients with a primary diagnosis of IC or IA/B and grade 3 ovarian cancer to receive platinum-based chemotherapy as often as possible
- b) Evidence base
- LoE 2+, A
- Primary studies: [96–104]

### Quality indicator 8: First-line chemotherapy for advanced ovarian cancer

| Z: Number of pts. who received 6 cycles of first-line chemotherapy carboplatin AUC5 and paclitaxel 175 mg/m² | 8.5. | First-line chemotherapy for patients with advanced ovarian cancer (IIb-IV) must consist of carboplatin AUC5 and paclitaxel 175 mg/m² for 3 h i.v. over a total of 6 cycles, with one cycle every 3 weeks. |
| N: All pts. with a primary diagnosis of ovarian cancer ≥ FIGO IIB | |

*Evidence base/additional information*
- a) Quality target
- Patients with a primary diagnosis of ovarian cancer ≥ FIGO IIB to receive 6 cycles of first-line chemotherapy with carboplatin AUC5 and paclitaxel 175 mg/m² as often as possible
- b) Evidence base
- LoE 1++, A
- Guidelines: [118]
- Primary studies: [120–131]

### Quality indicator 9: Chemotherapy for platinum-resistant and/or refractory primary recurrence

| Z: Number of pts. who received non platinum-based monotherapy with pegylated liposomal doxorubicin, topotecan, gemcitabine or paclitaxel weekly | 9.4. | Patients with platinum-resistant and/or refractory recurrence of ovarian cancer must receive non platinum-based monotherapy if chemotherapy is indicated. The following cytostatic drugs can be considered: pegylated liposomal doxorubicin, topotecan, gemcitabine, paclitaxel weekly |
| N: All pts. with platinum-resistant and/or refractory primary recurrence of ovarian cancer receiving chemotherapy for primary recurrence outside clinical trials | |

*Evidence base/additional information*
- a) Quality target
- Non platinum-based monotherapy (s. left) to be administered as often as possible to treat patients with platinum-resistant and/or refractory primary recurrence of ovarian cancer receiving chemotherapy for primary recurrence outside clinical trials
- b) Evidence base
- LoE 1++, A
- Guidelines: NHS TA91 [119]
- Primary studies: [155, 156, 157, 164–171]

### Quality indicator 10: Combination therapy for platinum-sensitive recurrence

| Z: Number of pts. receiving platinum-based combination therapy | 9.5. | Patients with platinum-sensitive recurrence of ovarian cancer must receive platinum-based combination therapy, if chemotherapy is indicated. The following combinations of cytostatic drugs can be considered: carboplatin/gemcitabine/bevacizumab, carboplatin/pegylated liposomal doxorubicin, carboplatin/paclitaxel, carboplatin/gemcitabine |
| N: All pts. with platinum-sensitive recurrence of ovarian cancer receiving chemotherapy for recurrence outside clinical trials | |

*Evidence base/additional information*
- a) Quality target
- Platinum-based combination therapy to be administered as often as possible to treat patients with platinum-sensitive recurrence receiving chemotherapy for recurrence outside clinical trials
- b) Evidence base
- CC
- Guidelines: [1]
- Primary studies: [155, 157, 171, 237, 238]

### Quality indicator 11: Counselling by social services

| Z: Number of pts who received counselling by social services | 10.1. | Patients with ovarian cancer must receive information about the available rehabilitation and support from social services and must be offerered suitable support based on their individual need. |
| N: All pts. with a primary diagnosis of ovarian cancer being treated in the facility | |

*Evidence base/additional information*
- a) Quality target
- Patients with a primary diagnosis of ovarian cancer to receive counselling from social services as often as possible
- b) Evidence base
- CC
- Guidelines: [1]
- Primary studies: [14, 178, 179]

### Quality indicator 12: No adjuvant therapy for BOT

| Z: Number of pts. with adjuvant therapy | 11.6. | Patients with borderline tumours must not receive adjuvant therapy. |
| N: All pts. with a primary diagnosis of BOT | |

*Evidence base/additional information*
- a) Quality target
- No adjuvant therapy to be given to patients with BOT
- b) Evidence base
- LoE 2+, A
- Guidelines: [2]
- Primary studies: [192]

*for patients with primary recurrence who did not previously receive VEGF-targeted therapy*
References

1 Scottish Intercollegiate Guidelines Network. SIGN #75: Epithelial ovarian cancer: A national clinical guideline. Scottish Intercollegiate Guidelines Network; 2003


5 Buys SS et al. Effect of screening on ovarian cancer mortality: the Prostate, Lung, Colorectal and Ovarian (PLCO) Cancer Screening Randomized Controlled Trial. JAMA 2011; 305: 2295–2303


13 van der Velde NM et al. Time to stop ovarian cancer screening in BRCA1/2 mutation carriers? Int J Cancer 2009; 124: 919–923


21 IQWIG. Positronenemissionstomographie (PET) und PET/CT bei Ovarialkarzinomen. 2011. www.iqwig.de


26 Haber D. Prophylactic oophorectomy to reduce the risk of ovarian and breast cancer in carriers of BRCA mutations. N Engl J Med 2002; 346: 1660–1662

27 Finch A et al. Salpingo-oophorectomy and the risk of ovarian, fallopian tube, and peritoneal cancers in women with a BRCA1 or BRCA2 Mutation. JAMA 2006; 296: 185–192


30 Parker WH et al. Ovarian conservation at the time of hysterectomy and long-term health outcomes in the nurses' health study. Obstet Gynecol 2009; 113: 1027–1037


33 Hallowell N. A qualitative study of the information needs of high-risk women undergoing prophylactic oophorectomy. Psychooncology 2000; 9: 486–495

34 Fry A et al. Prophylactic oophorectomy versus screening: psychosocial outcomes in women at increased risk of ovarian cancer. Psychooncology 2001; 10: 231–241


36 Bonadonna V et al. Cancer risks associated with germline mutations in MLH1, MSH2, and MSH6 genes in Lynch syndrome. JAMA 2011; 305: 2204–2310


54 Morice P et al. Conservative treatment in epithelial ovarian cancer: results of a multicentre study of the GCGCLC (Groupe des Chirurgiens de Centre de Lutte Contre le Cancer) and SFG (Societe Francaise d'Oncologie Gynecologique). Hum Reprod 2005; 20: 1379–1385


63 Schilder JM et al. Outcome of reproductive age women with stage IA or IC invasive epithelial ovarian cancer treated with fertility-sparing therapy. Gynecol Oncol 2002; 87: 1–7


65 Duska LR et al. Epithelial ovarian carcinoma in the reproductive age group. Cancer 1999; 85: 2623–2629


70 Fogotti A et al. Should laparoscopy be included in the work-up of advanced ovarian cancer patients attempting interval debulking surgery? Gynecol Oncol 2010; 116: 72–77


76 Gadducci A et al. Relationship between time interval from primary surgery to the start of taxane- plus platinum-based chemotherapy and clinical outcome of patients with advanced epithelial ovarian cancer: results of a multicenter retrospective Italian study. J Clin Oncol 2005; 23: 751–758


80 Vernooij F et al. The outcomes of ovarian cancer treatment are better when provided by gynecologic oncologists and in specialized hospitals: a systematic review. Gynecol Oncol 2007; 105: 801–812


82 Gerstein CC et al. The prediction of progression-free and overall survival in women with an advanced stage of epithelial ovarian carcinoma. BJOG 2009; 116: 372–380


88 Aletti GD et al. Identification of patient groups at highest risk from traditional approach to ovarian cancer treatment. Gynecol Oncol 2011; 120: 23–28


96 Winter-Rauch BA, Kitchener HC, Dickinson HO. Adjuvant (post-surgery) chemotherapy for early stage epithelial ovarian cancer. Cochrane Database Syst Rev 2009; (3): CD004706


103 Takano M et al. Less impact of adjuvant chemotherapy for stage I clear cell carcinoma of the ovary: a retrospective Japan Clear Cell Carcinoma Study. Int J Gynecol Cancer 2010; 20: 1506–1510


113 Skirnisdottir I, Sorbe B. Survival and prognostic factors in early-stage epithelial ovarian carcinoma treated with taxane-based adjuvant chemotherapy. Int J Gynecol Cancer 2007; 17: 1231–1237


121 ICON Collaborators. Paclitaxel plus carboplatin versus standard chemotherapy with either single-agent carboplatin or cyclophosphamide, doxorubicin, and cisplatin in women with ovarian cancer: the ICON3 randomised trial. Lancet 2002; 360: 505–515


127 Oo LS. Chemotherapy for ovarian cancer. Semin Oncol 1999; 26 (Suppl. 18): 34–40


141 Diazon DS et al. Two for good measure: six versus eight cycles of carboplatin and paclitaxel as adjuvant treatment for epithelial ovarian cancer. Gynecol Oncol 2006; 100: 417–421


mab with maintenance bevacizumab as first-line chemotherapy for paclitaxel and carboplatin compared with paclitaxel and carboplatin

Database Syst Rev 2010; (9): CD007414


Williams C, Simera I, Bryant A. Tamoxifen for relapse of ovarian cancer. Cochrane Database Syst Rev 2010; (3); : CD001034


Cantu MG et al. Randomized controlled trial of single-agent paclitaxel versus cyclophosphamide, doxorubicin, and cisplatin in patients with recurrent ovarian cancer who responded to first-line platinum-based regimens. J Clin Oncol 2002; 20: 1232–1237


Rustin GJ et al. Definitions for response and progression in ovarian cancer clinical trials incorporating RECIST 1.1 and CA 125 agreed by the Gynecological Cancer Intergroup (GCIG). Int J Gynecol Cancer 2011; 21: 419–423


Vergote I et al. Phase 3 randomised study of canfosfamide (Telyta, TLK286) versus pegylated liposomal doxorubicin or topotecan as third-line therapy in patients with platinum-refractory or -resistant ovarian cancer. 2008 [1879-0852 [Electronic]]

Ferrandina G et al. Phase III trial of gemcitabine compared with pegylated liposomal doxorubicin in progressive or recurrent ovarian cancer. J Clin Oncol 2008; 26: 890–896


Harter P et al. Prospective validation study of a predictive score for operability of recurrent ovarian cancer: the Multicenter Intergroup Study DESKTOP II. A project of the AGO Kommission OVAR, AGO Study Group, NOGGO, AGO-Austria, and MITO. Int J Gynecol Cancer 2011; 21: 289–295


Ursic-Vrscaj M, Bebar S, Zakelj MP. Hormone replacement therapy after invasive ovarian serous cystadenocarcinoma treatment: the effect on survival. Menopause 2001; 8: 70–75

Mascarenhas C et al. Use of hormone replacement therapy before and after ovarian cancer diagnosis and ovarian cancer survival. Int J Cancer 2006; 119: 2907–2915

WHO. Classification of Tumours. Pathology and Genetics of Tumours of the Breast and female genital Organs. 3rd ed. Switzerland: WHO- Press; 2003


204 Pectasides D, Pectasides E, Kassanos D.  
206 du Bois A, Ewald-Riegler N.  
192 Miller BE et al.  
191 Faluyi O et al.  
209 Nosov V et al.  
196 Zanagnolo V, Pasinetti B, Sartori E.  
198 Evans AT 3rd et al.  
212 Cushing B et al.  
200 Colombo N et al.  
202 Zambetti M et al.  
207 Cancer Treat Rev 2008; 34: 427  
2008; 110: 125  
199  
214  
203  
221 Young RC et al. Staging laparotomy in early ovarian cancer. JAMA 1983; 250: 3072–3076  
222 Piver MS, Barlow JJ, Lefe SB. Incidence of subclinical metastasis in stage I and II ovarian carcinoma. Obstet Gynecol 1978; 52: 100–104  
229 Voest EE, van Houwelingen JC, Neijt JP. A meta-analysis of prognostic factors in advanced ovarian cancer with median survival and overall survival (measured with the log (relative risk) as main objectives. Eur J Cancer Clin Oncol 1989; 25: 711–720  
237 Pfiester J et al. Gemcitabine plus carboplatin compared with carboplatin in patients with platinum-sensitive recurrent ovarian cancer: an intergroup trial of the AGO-OVAR, the NCIC CTG, and the EORTC GCG. J Clin Oncol 2006; 24: 4699–4707  

Deutschsprachige Zusatzinformationen online abrufbar unter: www.thieme-connect.de/ejournals/toc/gbfra