ESMO MANAGEMENT AND TREATMENT ADAPTED RECOMMENDATIONS IN THE COVID-19 ERA: EPITHELIAL OVARIAN CANCER

Cancer patient prioritisation

Priorities for ovarian cancer

Documented multidisciplinary tumour team (MDT) decision making, taking into account patient condition (vulnerable patients)* and available resources [Intensive Care Unit (ICU) support for surgery]. If not adequate, refer to or discuss with an Oncological Hub for gynaecological cancers.

Patients and family should be adequately informed about the risk/benefit ratio of each intervention with clinicians taking into account of national therapeutic or interventional guidelines or national specialty recommendations in relation to COVID-19.

*vulnerable patients: >65 years, pre-existing cardiovascular disease, pre-existing respiratory disease

Outpatient visit priorities

- Potentially unstable (acute abdominal pain, intestinal obstruction, complications during post- surgery recovery
- Symptomatic new patient (symptomatic ascites or pleural effusion, intestinal obstruction)

- Newly diagnosed asymptomatic patients, no prior surgery
- Post-operative patients with no complications
- Patients continuing on chemotherapy – telemedicine where possible
- Established patients with new problems or symptoms from treatment – convert as many visits as possible to telemedicine appointments

- Follow-up visit on PARPi maintenance; most can be managed through telemedicine with scheduled blood tests and imaging done close to home. Explore postal drug delivery
- For maintenance bevacizumab, if facilities exist to continue, supervision can be performed by telemedicine, ensuring BP and urinalysis are monitored
- Survivorship visits off study

For patients on clinical trials, seek information about changes in management for individual studies from the co-ordinating trials unit – treatment frequency; blood investigations and imaging.

Priorities for ovarian cancer: Imaging (CT scan)

- Symptomatic patient (intestinal obstruction, abdominal perforation)

- Diagnostic imaging for clinical suspicion of ovarian cancer (clinical, US)

- Follow-up visit out of study
- Follow-up visit on PARPi maintenance

Priorities for ovarian cancer: Surgical oncology

- Radiologically confirmed intestinal obstruction in newly diagnosed patient
- Bowel perforation, peritonitis
- Post-surgery complications (perforation, anastomotic leak)
- Pelvic mass with torsion or causing urinary or intestinal obstruction

- Establishment of cancer diagnosis when high suspicion exists (e.g. diagnostic laparoscopy)
- Primary cytoreductive surgery
- Possible interval debulking surgery following review by multidisciplinary team. Continuation of first-line therapy with postponement of surgery should be considered as an option
- Symptomatic patients with inoperable primary or recurrent cancer requiring palliative cancer procedures (e.g. diverting colostomy, venting PEG tubes)

- Risk-reducing surgery for genetic predisposition to gynaecological cancer
- Benign-appearing ovarian cysts/masses
- Recurrent cancer requiring palliative resection
- Oligometastatic first relapse where complete resection is feasible

Priorities for ovarian cancer: Medical oncology – advanced disease

- NACT in symptomatic patients
- Post-operative ChT or continuation of post-operative ChT for high-grade serous/endometrioid tumours. Importance of BRCA testing continues as these patients are eligible for PARP inhibitors and should be considered for shortened ChT cycles
- Continuation of treatment in the context of a clinical trial

- First-line post-operative ChT in advanced-stage clear cell or mucinous tumours
- ChT for high-grade serous/endometrioid symptomatic platinum-eligible recurrent patients)

- ChT for high-grade serous/endometrioid platinum non-eligible symptomatic recurrent patients
- Symptomatic slowly growing recurrent disease
- ChT for recurrent low-grade serous tumours

Priorities for ovarian cancer: Medical oncology – early disease

- Adjuvant ChT for stages I-IIA high-grade serous/endometrioid
- Continuation of treatment in the context of a clinical trial

- Adjuvant ChT for stages IC-IIA infiltrative mucinous

- ChT for IC IIA low-grade serous/endometrioid/clear cell/expansile invasion mucinous
- IC low-grade serous endometrioid/expansile/invasion mucinous, ChT possible option, considered less essential and to be discussed with the patient, taking into account the risk/benefit ratio

Chemotherapy in advanced disease:

- Platinum-based therapy, in combination where feasible: carboplatin/paclitaxel every 3-4 weeks (to reduce visits and risk of myelotoxicity). Consider 4-6 cycles depending on response and prognostic factors. Consider reduced number of cycles (4-5) in responding patients before adding PARP inhibitor. Consider early discontinuation of paclitaxel for toxicity
- GCS support to prevent leukopaenia
- Limit dexamethasone to reduce immunosuppression
- Caution with bevacizumab because of the associated hypertension which may worsen COVID-19 outcome, and use of resources with maintenance therapy
- Maintenance with PARP [poly (ADP-ribose) polymerase] inhibitors in high-grade serous/endometriod cancers with a BRCA mutation responding to platinum-based therapy
- In patients who have a BRCA mutation and are PARP naïve, consider rucaparib monotherapy in situations where platinum therapy cannot be given
- Non platinum-based therapies are low priority (above) and should only be used after careful review of the risk/benefit

Chemotherapy in early disease

- 3-6 cycles carboplatin/paclitaxel (6 cycles in high-grade serous/endometrioid/clear cell)
- Carboplatin 6 cycles

Dose adaptation or single-agent carboplatin (AUC5 every 4 weeks) in vulnerable* patients.

*vulnerable patients: >65 years, pre-existing cardiovascular disease, pre-existing respiratory disease

List of abbreviations: BP, blood pressure; ChT, chemotherapy; CT, computed tomography; NACT, neoadjuvant chemotherapy; PARP, poly (ADP-ribose) polymerase; PARPi, poly (ADP-ribose) polymerase inhibitor; PEG, percutaneous endoscopic gastrostomy; US, ultrasound.

References

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