1. Introduction

Ovarian cancer is the second most common gynaecologic malignancy but accounts for more deaths than all others combined. It is the 5th leading cause of cancer mortality for women. In Ontario, there are 1000 new ovarian cancers diagnosed each year.

There are three major subtypes of ovarian cancer: epithelial, germ cell and stromal cell. The most common, epithelial, account for 85% of all ovarian cancers and 95% of the deaths. These cancers affect women between the ages of 40 and 80. Most of these cancers are detected in late stages because they tend not to be symptomatic until they have spread to the abdomen. Treatment includes a combination of surgery and chemotherapy and in some situations radiation. Advanced ovarian cancer is difficult to cure but in the last 10 years overall survival rates are improving.

Epithelial ovarian cancers are in some situations hereditary. Fifteen to 20% of serous epithelial ovarian cancers are related to BRCA 1 and 2 germline mutations. All women diagnosed with this type of cancer are referred for genetic testing. Relatives of individuals who test positive for a BRCA gene mutation are also eligible for testing and are encouraged to participate in screening and prevention programs at Princess Margaret Cancer Centre. Individuals with BRCA germline mutations are also at high risk of developing breast cancer.

Germ cell tumours affect children and young women. In general, they are eligible for fertility sparing surgery and almost all of these cancers can be cured with a combination of surgery and chemotherapy.

Stromal cell cancers are uncommon, representing <5% of all ovarian tumors. They are usually slow growing and are generally treated with surgery and in some situations adjuvant radiation.

On occasion, the ovary can be the site for metastatic disease, most commonly from the stomach, colon, and breast.

2. Prevention

There are no effective strategies to prevent ovarian cancer in the general population. Epidemiologic studies have shown that the use of birth control pills and pregnancy reduce the risk of developing ovarian cancer.

In women with a BRCA 1 or 2 germline mutation, surgery to remove the ovaries and tubes has been shown to prevent ovarian cancer. It has also been shown to reduce the risk of breast cancer as much as 50% when done in premenopausal women.
3. Screening

In 2011, CPAC reviewed the literature on ovarian cancer screening and published a report which is available on its website.


Below is their summary statement on ovarian cancer screening.

There is considerable interest in screening for ovarian cancer because the disease is highly lethal and currently most often detected in its advanced stages. If screening could detect more early-stage ovarian cancers, the hope is that survival rates would improve.

Ovarian cancer is a complex disease and not all of its histologies act in the same way. While some are detected more often in early stage, serous histology, the most common ovarian cancer usually presents as Stage 3 or 4.

The evidence to date has not demonstrated that ovarian cancer screening reduces mortality from ovarian cancer. The most recent study, conducted by the PLCO, evaluated transvaginal ultrasound and CA 125 as screening tests for post-menopausal women aged 55-74 for ovarian cancer. The study involved 78,216 women of which 39,105 were screened (study arm) and 39,111 were followed routinely (control arm). Women in the study arm were offered annual testing over 6 years. All study participants were followed for a maximum of 13 years. 212 women in the study arm and 176 in the control arm were found to have ovarian cancer. There were 118 deaths from ovarian cancer in the study arm compared to 100 in the control arm. There were no statistically significant differences between the study and control arms in these outcomes.
4. Diagnosis

### FIGO Staging for Ovarian Cancer 2006

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1</td>
<td>Tumour limited to ovaries (one or both)</td>
</tr>
<tr>
<td>1A</td>
<td>Tumour limited to one ovary; capsule intact, no tumour on ovarian surface. No malignant cells in ascites or peritoneal washings</td>
</tr>
<tr>
<td>1B</td>
<td>Tumour limited to both ovaries; capsules intact, no tumour on ovarian surface. No malignant cells in ascites or peritoneal washings</td>
</tr>
<tr>
<td>1C</td>
<td>Tumour limited to one or both ovaries with any of the following: capsule ruptured, tumour on ovarian surface, malignant cells in ascites or peritoneal washings</td>
</tr>
<tr>
<td>Stage 2</td>
<td>Tumour involves one or both ovaries with pelvic extension</td>
</tr>
<tr>
<td>2A</td>
<td>Extension and/or implants on uterus and/or tube(s). No malignant cells in ascites or peritoneal washings</td>
</tr>
<tr>
<td>2B</td>
<td>Extension to and/or implants on other pelvic tissues. No malignant cells in ascites or peritoneal washings.</td>
</tr>
<tr>
<td>2C</td>
<td>Pelvic extension and/or implants with malignant cells in ascites or peritoneal washings</td>
</tr>
<tr>
<td>Stage 3</td>
<td>Tumour involves one or both ovaries with microscopically confirmed peritoneal metastasis outside the pelvis</td>
</tr>
<tr>
<td>3A</td>
<td>Microscopic peritoneal metastasis beyond pelvis (no macroscopic tumour)</td>
</tr>
<tr>
<td>3B</td>
<td>Macroscopic peritoneal metastasis beyond pelvis 2cm or less in greatest dimension</td>
</tr>
<tr>
<td>3C</td>
<td>Peritoneal metastasis beyond pelvis more than 2cm in greatest dimension and/or regional lymph node metastasis</td>
</tr>
<tr>
<td>Stage 4</td>
<td>Distant metastasis (excludes peritoneal metastasis)</td>
</tr>
</tbody>
</table>

### RMI 2 – Risk of Malignancy Index

*To estimate the risk of malignancy in a pelvic mass
- RMI = US score x Menopausal status x CA125 u/ml

<table>
<thead>
<tr>
<th>Feature</th>
<th>RMI Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ultrasound features:</td>
<td></td>
</tr>
<tr>
<td>Multilocular cyst</td>
<td>0 = none</td>
</tr>
<tr>
<td>Solid areas</td>
<td>1 = one abnormality</td>
</tr>
<tr>
<td>Bilateral lesions</td>
<td>4 = two or more abnormalities</td>
</tr>
<tr>
<td>Ascites</td>
<td></td>
</tr>
<tr>
<td>Intra-abdominal metastases</td>
<td></td>
</tr>
<tr>
<td>Pre-menopausal</td>
<td>1</td>
</tr>
<tr>
<td>Post-menopausal</td>
<td>4</td>
</tr>
<tr>
<td>CA 125</td>
<td>u/ml</td>
</tr>
</tbody>
</table>

- RMI score >200 – refer to gynecologic oncologist

Last Revision Date – July 2015
The RMI index (3 versions exist) is a tool used to evaluate the likelihood that a pelvic mass is malignant. It includes menopausal status, ultrasound findings and CA-125. A score greater than 200 is suggestive of malignancy and should prompt a referral to a gynecologic oncologist.

Evaluation:
History and physical exam
Laboratory: include CA-125, CEA, CA19-9 as indicated
Imaging: Ultrasound pelvic/transvaginal, CT of thorax, abdomen and pelvis, MRI
Cytology of ascites and/or pleural effusion, or biopsy of omentum, peritoneal disease for diagnosis.

5. Pathology

75% of ovarian malignancies are of epithelial origin – most common being serous histology, germ cell tumors represent 15-20% and stromal tumors are uncommon (5%).

Epithelial tumors: most common histology is serous.
6. Management

6.1 Management Algorithms

Primary treatment of epithelial ovarian cancer

- Early stage disease:
  - TAH BSO with comprehensive staging OR Unilateral salpingo-oophorectomy, clinical stage 1A or 1B, all grades if patient desires fertility
  - Stage 1A, 1B:
    - Grade 1: Observe
    - Grade 2: Observe / IV Chemotherapy + Radiation for Clear Cell and Endometrioid
    - Grade 3: IV Chemotherapy + Radiation

- Advanced stage disease:
  - Debulking / Cytoreductive surgery:
    - Stage 1C:
      - Grade 1: Observe / IV Chemotherapy + Radiation for Clear Cell and Endometrioid
    - Grade 2/3: IV Chemotherapy + Radiation

- Pre-operative assessment without previous staging:
  - Patient not fit for surgery or tumour not resectable
  - Neo Adjuvant Chemotherapy for 3-4 cycles
  - Debulking / Cytoreductive Surgery assessment:
    - Stage 2:
      - Chemotherapy + Radiation for Clear Cell and Endometrioid
    - Stage 3A:
      - IP / IV Chemotherapy
    - Stage 3B, 3C, or 4:
      - Optimal Debunking
      - Suboptimal Debunking
      - IV Chemotherapy
      - Consider for IDS

- OR Candidate:
  - Delayed primary surgery
  - Not fit but responding
  - No response
  - Consider biopsy
  - Complete chemo

- Not OR candidate:
  - No response
  - Consider biopsy
  - Complete chemo
  - Clinical trial
### Incomplete previous staging or surgery

<table>
<thead>
<tr>
<th></th>
<th>Suspected Stage 1A / 1B</th>
<th>Suspected Stage 1C</th>
<th>Stage 2, 3, 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suspected residual</td>
<td>Suspected no residual</td>
<td>Suspected no</td>
<td>Suspect</td>
</tr>
<tr>
<td>disease (on imaging)</td>
<td>disease (on imaging)</td>
<td>residual disease</td>
<td>unresectable</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(on imaging)</td>
<td>residual disease (on imaging)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>fit for surgery/not fit for surgery</td>
</tr>
<tr>
<td><strong>Grade 1</strong></td>
<td>Surgical Staging</td>
<td></td>
<td>Chemotherapy: Carbo / Paclitaxel (consider completion surgery after 3-4 cycles followed by postoperative chemotherapy)</td>
</tr>
<tr>
<td><strong>Grade 2</strong></td>
<td>Completion Surgery / Surgical Staging</td>
<td>Completion Surgery / Surgical Staging</td>
<td>Debulking Surgery (Goal is 0 visible residual disease)</td>
</tr>
<tr>
<td><strong>Grade 3</strong></td>
<td>Chemotherapy OR Completion Surgery / Surgical staging</td>
<td>Chemotherapy OR Completion Surgery / Surgical staging</td>
<td></td>
</tr>
</tbody>
</table>

### Patient adequately staged

<table>
<thead>
<tr>
<th></th>
<th>Stage 1A / 1B</th>
<th>Stage 1C</th>
<th>Stage 2, 3, 4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Grade 1</strong></td>
<td>Observe</td>
<td>Observe or IV Chemotherapy or XRT</td>
<td>IP Chemotherapy OR IV Chemotherapy (Carbo/Paclitaxol)</td>
</tr>
<tr>
<td><strong>Grade 2</strong></td>
<td>Observe / IV Chemotherapy (Carbo/Paclitaxol)</td>
<td>IV Chemotherapy (Carbo/Paclitaxol)</td>
<td>IV Chemotherapy (Carbo/Paclitaxol) OR Completion Surgery</td>
</tr>
<tr>
<td><strong>Grade 3</strong></td>
<td>IV Chemotherapy (Carbo/Paclitaxol)</td>
<td>IV Chemotherapy (Carbo/Paclitaxol)</td>
<td></td>
</tr>
</tbody>
</table>

Previously staged/previous surgery for epithelial ovarian cancer
Recurrence of epithelial ovarian cancer

Ovarian Recurrence
(For all recurrences;
In cases of limited sites,
and/or a long time interval
from last treatment,
surgery should be
considered.)

Low grade
- Clinical trial
- Surgery

High grade

Asymptomatic
- Increased CA-125
  - Imaging negative
    - < 6 months
    - > 6 months
  - Imaging positive
    - < 6 months
    - > 6 months

Symptomatic
- < 6 months
- > 6 months

Observe or clinical trials
Observe or platinum based combination chemotherapy or clinical trials of 2nd surgery (isolated or limited sites of recurrence ± long time interval since treatment)
Primary treatment for clear cell ovarian cancer

1. Clear cell ovarian cancer
   - Surgery at UHN
   - Apparent advanced stage (2,3,4)
     - Staging Surgery
     - Chemotherapy/Clinical Trial + Pelvic Rads
     - Observation (confirmed stage 1) or Radiation or Chemo + Radiation
     - Chemotherapy + WAR
   - Apparent early stage
     - Staging Surgery
   - Observation or Pelvic XRT + Chemotherapy

2. Surgery at another centre
   - Apparent early stage
   - Not staged
     - Staging
     - Observation or Radiation + Chemotherapy
     - Chemotherapy + Radiation
   - Apparent advanced stage (2,3,4)
Primary treatment for borderline epithelial ovarian cancer

Diagnosis of low malignant potential (LMP) lesion

- Previous surgical staging was comprehensive
- Incomplete surgical staging

Fertility desired

- No invasive implants or unknown
- Invasive implants at previous surgery

Fertility sparing surgery + comprehensive surgical staging or Observe or Treat as Epithelial Ovarian Cancer

- No desire to maintain fertility

- No invasive implants or unknown
- Invasive implants at previous surgery

Observe or Comprehensive Surgical Staging

Comprehensive surgical staging
Recurrence of borderline epithelial ovarian cancer

Clinical recurrence → Assessment to see if debulking surgery is appropriate

- Non-invasive disease: Observe
- Invasive disease: Treat as epithelial ovarian cancer
Primary treatment of germ cell tumour

Pre-operative assessment:
+ Beta-hCG, Alpha feto Protein
+ LDH, CA-125, CT/US

Germ cell tumour

Tumour limited to one ovary
- USO
- Omentectomy
- Biopsy of lymph nodes for dysgerminoma or teratoma

Dysgerminoma Grade 1 Immature
- Observation

Stage 1A Yolk Sac Tumour

Stage 1A Immature Teratoma Grade 2 or 3 (if nodes negative consider observation)

Consider fertility sparing surgery

Germ cell tumour

Chemotherapy: BEP

Metastatic tumour
Primary treatment of malignant sex-cord stromal tumours

- Malignant sex-cord stromal tumours
  - Apparent early stage/surgery elsewhere
  - Surgery at UHN
    - Surgical staging/Debulking
    - CT Scan
      - No disease
        - Observation
      - Disease
        - Surgery (go to surgery at UHN)
        - Observation
      - Stage 1 - low risk
        - Observation
      - Stage 1 - high risk
        - Observation or platinum based chemotherapy
      - Stage 2,3,4
        - Local radiation or chemotherapy (BEP)
        - Consider hormone therapy
          - Tamoxifen/Megace
          - Lupron
          - Letrosol
6.2 Surgery

Surgical staging operation includes:

- Aspiration of ascites or washings for cytology
- Inspection and palpation of all peritoneal surfaces
- Hysterectomy and bilateral salpingo-oophorectomy
- Infracolic omentectomy
- Staging biopsies of:
  - All suspicious macroscopic lesions and adhesions
  - All locations to which the ovarian tumour is adherent
- Biopsies of the peritoneum from the pouch of Douglas, bladder peritoneum, pelvic sidewalls, paracolic gutters, diaphragm.
- Pelvic and para aortic lymph node dissection

Debulking Surgery; for patients with clinically advanced (stage 2, 3, 4) disease who are suitable for surgery.
The aim of debulking surgery is to remove all visible tumour (complete cytoreduction) Surgery consists of hysterectomy, bilateral salpingo-oophorectomy, infracolic omentectomy and removal of all visible tumour. To achieve complete cytoreduction, surgery many need to include: 1. Pelvic Peritoneectomy (bladder and cul de sac) 2. Peritoneectomy in other sites including paracolic gutters, diaphragm, surface of liver 3. Bowel resection may include small bowel, large bowel, or a low anterior. In some situations, debulking surgery may require consultation with other surgical specialists including hepatobiliary, thoracic, urologic and general surgery. When optimally debulked, IP Chemotherapy is the preferred treatment.

6.3 Chemotherapy

Chemo Carboplatin/Paclitaxel
Postoperative adjuvant chemotherapy consists of 6 cycles of Paclitaxel 175 mg/m2 in 3 hrs and carboplatin AUC 6 every three weeks for 6 cycles.

Neo-adjuvant chemotherapy
Some patients with ovarian cancer will not be eligible for debulking surgery as initial treatment if:
1. tumour is likely unresectable because of extent of disease and location
2. patient’s co-morbidities do not allow for surgery at this time; this may change after 3-4 cycles of chemotherapy
3. poor performance status

Prior to starting neoadjuvant chemotherapy it is recommended that the patient has
1. CA 125 and relevant blood work
2. Cytology or histology confirming presence of malignancy
3. Baseline imaging – CT scan of thorax, abdomen and pelvis

After 3-4 courses of carbo/paclitaxel the patient should be assessed with a combination of physical exam, CT scans of thorax, pelvis and abdomen and serial CA125, to determine if surgical intervention – delayed primary surgery – is feasible. If the patient is deemed surgical, surgery should take place 4 weeks after completion of chemotherapy. The intent of the surgery is to debulk to microscopic disease.

If the patient’s medical condition is not suitable for surgery and/or she has not responded to treatment it is recommended to continue chemotherapy to a total of 6 cycles. In some situations chemotherapy can be extended to 8 cycles if the patient is continuing to respond.

If the patient is not responding to neoadjuvant chemotherapy, or progressing on chemotherapy:
   1. re-evaluate diagnosis
   2. consider second line chemotherapy
   3. consider clinical trial
**CARBOPLATIN/PACLITAXEL CHEMOTHERAPY**

Regimen: GY-PACLICARBO
PACLITAX 175MG/M2 + CARBO AUC=6  
Repeat: 21 Days

<table>
<thead>
<tr>
<th>DAY</th>
<th>DRUG</th>
<th>DOSE</th>
<th>UNIT</th>
<th>MAX</th>
<th>RTE</th>
<th>VOL</th>
<th>FLUID</th>
<th>TYPE</th>
<th>FRQ</th>
<th>DUR</th>
<th>QTY</th>
<th>REFILL</th>
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<tbody>
<tr>
<td>1</td>
<td><strong>DEXAMETHASONE SOD PHOSPHATE</strong></td>
<td>20</td>
<td>mg/FIX</td>
<td></td>
<td>IV</td>
<td>50ML</td>
<td>NS</td>
<td>O</td>
<td>ONCE</td>
<td></td>
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<tr>
<td></td>
<td>INFUSE IV OVER 15 MINUTES PRE-PACLITAXEL (45 MINS BEFORE PACLITAXEL)</td>
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<tr>
<td>1</td>
<td><strong>DIPHENHYDRAMINE HCL</strong></td>
<td>50</td>
<td>mg/FIX</td>
<td></td>
<td>IV</td>
<td>50ML</td>
<td>NS</td>
<td>O</td>
<td>ONCE</td>
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<tr>
<td></td>
<td>INFUSE IV OVER 30 MINUTES, STARTING 30 MINUTES BEFORE PACLITAXEL.</td>
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<tr>
<td>1</td>
<td><strong>FAMOTIDINE</strong></td>
<td>20</td>
<td>mg/FIX</td>
<td></td>
<td>IV</td>
<td>50ML</td>
<td>D5W</td>
<td>O</td>
<td>ONCE</td>
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</tr>
<tr>
<td></td>
<td>INFUSE IV OVER 15-30 MINUTES, STARTING 30 MINUTES BEFORE PACLITAXEL</td>
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<tr>
<td>1</td>
<td><strong>PACLITAXEL</strong></td>
<td>175</td>
<td>mg/M2</td>
<td></td>
<td>IV</td>
<td>500ML</td>
<td>NS</td>
<td>O</td>
<td>ONCE</td>
<td></td>
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</tbody>
</table>
|     | USE GRADUATED RATE FOR FIRST TWO CYCLES. IF NO REACTION, INFUSE NEXT DOSES OVER 3 HOURS. GIVE BEFORE CARBOPLATIN.  
USE NON-PVC EXCEL BAG AND TUBING WITH 0.22 MICRON IN-LINE FILTER. |      |        |     |      |      |       |      |       |     |     |        |
| 1   | **ONDANSETRON**                     | 8    | mg/FIX |     | PO   |      |       | O    | ONCE PRN |     |     |        |
|     | GIVE ONCE IF PT DID NOT BRING OWN SUPPLY. TAKE FROM PYXIS |      |        |     |      |      |       |      |       |     |     |        |
| 1   | **DIPHENHYDRAMINE HCL**             | 50   | mg/FIX |     | IV   | 50ML | NS    | O    | ONCE PRN |     |     |        |
|     | GIVE PROPHYLACTICALLY IF PT HAS HAD 6 OR MORE CYCLES OF CARBOPLATIN OR HAS HAD PRIOR REACTIONS TO CARBOPLATIN.  
ADMINISTER IV OVER 15 MINUTES |      |        |     |      |      |       |      |       |     |     |        |
| 1   | **CARBOPLATIN**                     | 6    | mg/AUC | 800mg| IV   | 250ML| D5W   | O    | ONCE  |     |     |        |
|     | INFUSE IV OVER 30 MIN |      |        |     |      |      |       |      |       |     |     |        |
| 1   | **DIPHENHYDRAMINE HCL**             | 50   | mg/FIX |     | IV   | 50ML | NS    | O    | Q4H PRN |     |     |        |
|     | |      |        |     |      |      |       |      |       |     |     |        |
ADMINISTER IV OVER 15-30 MINUTES EVERY 4 HOURS AS NEEDED.
MAXIMUM DAILY DOSE OF DIPHENHYDRAMINE ALLOWED IN CHEMO DAYCARE FOR ALLERGIC REACTIONS IS 200 MG.

1 HYDROCORTISONE SOD SUCCINATE 100 mg/FIX IV 50ML NS O ONCE PRN
INFUSE IV OVER 5 MINUTES AS REQUIRED FOR GRADE 3 OR 4 REACTION NOT RESOLVED WITH ABOVE PRN MED.

1 MAGNESIUM SULFATE 2 g/FIX IV 250ML NS O ONCE PRN
GIVE IV OVER 1HR ONLY IF MAGNESIUM LEVEL=0.51-0.65MMOL/L.
CALL PHYSICIAN FOR MAGNESIUM LEVEL LESS THAN OR EQUAL TO 0.5MMOL/L.

POST REGIMEN
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<table>
<thead>
<tr>
<th>DAY</th>
<th>DRUG</th>
<th>DOSE</th>
<th>UNIT</th>
<th>MAX</th>
<th>RTE</th>
<th>VOL</th>
<th>FLUID</th>
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<th>QTY</th>
<th>REFILL</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 ONDANSETRON</td>
<td>8 mg/FIX PO</td>
<td>H</td>
<td>BID</td>
<td>1 Days</td>
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<td></td>
</tr>
<tr>
<td>2 DEXAMETHASONE</td>
<td>4 mg/FIX PO</td>
<td>H</td>
<td>BID</td>
<td>2 Days</td>
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<tr>
<td>1 PROCHLORPERAZINE MALEATE</td>
<td>10 mg/FIX PO</td>
<td>H</td>
<td>Q6H PRN</td>
<td>10 Days 30</td>
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</tbody>
</table>

THREE A DAY FOR 1 DAY STARTING THE DAY AFTER CHEMOTHERAPY (DAY 2).

TWICE A DAY WITH FOOD FOR 2 DAYS STARTING THE DAY AFTER CHEMOTHERAPY (ON DAYS 2-3).

EVERY 6 HOURS AS NEEDED FOR NAUSEA OR VOMITING
Regimen Notes:

==============

Per Oncology Subcommittee Feb 27, 2009:
For patients who have had 6 or more cycles of carboplatin, or have had prior reactions to carboplatin,
diphenhydramine (Benadryl) 50 mg IV will be given prophylactically prior to carboplatin infusion.
Benadryl 50 mg IV and hydrocortisone (Solucortef) 100 mg IV may be given for carboplatin reactions as necessary.
Pharmacist may add the above drugs to CURRENT OPIS orders that do not have the drugs pre-built into the regimen.

Per Oncology Subcommittee Nov 7, 2005:
Carboplatin doses are calculated using the Cockcroft-Gault and Calvert formulae. Actual Serum Creatinine (SCr),
rather than a minimum value of 90, will be used for calculation. Carboplatin doses will be capped at 800mg; higher doses
may be prescribed pending GFR determined by renogram.
Physician or Pharmacist to recalculate Carboplatin dose for SCr changes greater than 25%.

BLOOD WORK (Unless otherwise specified in the comment field)
Proceed with chemo if ANC equal to or greater than 1.5 x 10^9/L and Platelets equal to or greater than 150 x 10^9/L
If parameters are outside of acceptable range, contact the physician for further orders.
   For Serum Creatinine greater than 120 micromol/L or more than 20% increase from baseline, consult physician.
   For Mg level between 0.51-0.65 mmol/L, see order for Magnesium Sulfate 2g IV bolus.
   For Mg level less than or equal to 0.5 mmol/L, contact physician for further orders.

MONITORING GUIDELINE
For patients who have had 6 or more cycles of carboplatin, or have had prior reactions to carboplatin,
observe 30 minutes post carboplatin infusion.
BEP CHEMOTHERAPY for GERM CELL TUMOURS of OVARY

Regimen: GERM-BEP 5 DAYS BLEOMYCIN/ETOPOSIDE/CISPLATIN 5 DAY
Repeat: 21 Days

<table>
<thead>
<tr>
<th>DAY</th>
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<th>UNIT</th>
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<td>1</td>
<td>ONDANSETRON</td>
<td>8 mg/FIX</td>
<td>PO</td>
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<td>PRN</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
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Last Revision Date – July 2015
MAXIMUM DAILY DOSE OF DIPHENHYDRAMINE ALLOWED IN CHEMO DAYCARE FOR ALLERGIC REACTIONS IS 200 MG.

4 ONDANSETRON 8 2 mg/FIX PO O GIVE ONCE IF PT DID NOT BRING OWN SUPPLY OF GRANISETRON. TAKE FROM PYXIS

4 DEXAMETHASONE 8 mg/FIX PO O ONCE PRN GIVE ONCE IF PT DID NOT BRING OWN SUPPLY. PT SHOULD TAKE WITH FOOD. TAKE FROM PYXIS

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9 BLEOMYCIN SULFATE 30 unit/FIX IV 100ML NS O ONCE
INFUSE IV OVER 10 MINUTES

16 DEXAMETHASONE 8 mg/FIX PO O ONCE PRN
GIVE ONCE IF PT DID NOT BRING OWN SUPPLY. PT SHOULD TAKE WITH FOOD. TAKE FROM PYXIS

16 BLEOMYCIN SULFATE 30 unit/FIX IV 100ML NS O ONCE
INFUSE IV OVER 10 MINUTES

Regimen Notes:
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BLOOD WORK (Unless otherwise specified in the comment field)
On Day 1: Proceed with chemo if ANC greater than 0.5 x 10^9/L and Platelets greater than 100 x 10^9/L
Proceed with Bleomycin on Day 9 and 16 regardless of ANC and Platelet counts.
If patient exhibits signs and symptoms of bleeding and/or has temperature >38, hold chemotherapy and notify physician.

***AMENDMENTS***
Sep 13, 2006: Revised Midline Catheter Procedures (Clinical Policy # 3.60.003; July 2006)
(v.2) July 25, 2006: Added NS 500 mL hydration post cisplatin (Dr. Berthold/Moore)
(v.3) Nov 30, 2006: Revised Bloodwork Parameters (Drs. Moore/Duran)
(v.4) March 8, 2007: Changed Bleomycin from IV push to 10 minute IV infusion in 100 mL NS.
(v.5) April 16, 2007: Changed Pharma Sig for Etoposide to include non-PVC bag and tubing as per policy change.
(v.6) July 17th, 2009: Conversion of all IV anti-emetic premedications to ORAL take home scripts.
All additional changes made as per Oncology Subcommitte (May 26, 2009) and GERM disease site head approval.
(v.7) December 1, 2009: Added Benadryl 50 mg IV Q4H PRN for reactions to OPIS regimens containing docetaxel, etoposide,

Last Revision Date – July 2015 23
liposomal doxorubicin (Caelyx), paclitaxel and trastuzumab as per Oncology Subcommittee

(November 24, 2009)

(v.8) March 17, 2010: Maximum daily dose of diphenhydramine allowed in Chemo Daycare for allergic reactions is 200 mg as per Oncology Subcommittee approval January 26th, 2010.

-------------------------------------------------------------------------------------

****HEPARIN IS ABSOLUTELY CONTRAINDICATED IN PATIENTS WITH HEPARIN-INDUCED THROMBOCYTOPENIA (HIT)****
CONSULT PHYSICIAN FOR ALTERNATIVE MEASURES.
-------------------------------------------------------------------------------------

START IV or access patient’s central venous access device with IV solution.
If patient has a central venous access device, follow orders adjacent to identified Central Venous Access Device or Midline Catheter:
Tunnelled Open Ended Catheters (eg. Hickman) and PICC Single Lumen Catheters:
  lock with Heparin 3 mL (100 units/mL solution) per lumen after each use or weekly if not in use.
PICC Double Lumen Catheters:
  lock with Heparin 3 mL (100 units/mL solution) per lumen after each use or Monday, Wednesday, and Friday if not in use.
Implanted Ports (eg. Port-a-cath):
  lock with Heparin 5 mL (100 units/mL solution) per port after each use or every 4 week if not in use.
Closed Ended Catheters (e.g. Groshong):
  lock with 10 mL of Sterile Normal Saline per lumen after each use or weekly if not in use.
Midline Catheter:
  lock with Heparin 3 mL (100 units/mL solution) per lumen after each use and daily.
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### POST REGIMEN

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6 HOURS AS NEEDED FOR NAUSEA OR VOMITING

| 6   | ONDANSETRON     | 8 mg/FIX | PO   | H   | BID  | 1 Days |       |       |       |

THREE A DAY FOR 1 DAY STARTING THE DAY AFTER CHEMOTHERAPY (DAY 6).

| 6   | DEXAMETHASONE | 4 mg/FIX | PO   | H   | BID  | 3 Days |       |       | TWICE |

A DAY WITH FOOD FOR 3 DAYS STARTING THE DAY AFTER CHEMOTHERAPY (DAYS 6-8).
6.4 Radiation Therapy
   o Includes all relevant details of radiotherapy treatment as outlined in algorithms, organized according to stages of cancer
   o Includes rationale and specifics

6.5 Other Therapy
   o Hormone therapy, radioisotopes, interventional radiology, etc.

6.6 Oncology Nursing

Refer to *general oncology nursing practices*

7. Supportive Care

7.1 Patient Education

Refer to *general patient education practices*

7.2 Psychosocial Care

Refer to *general psychosocial oncology care guidelines*

7.3 Symptom Management

Refer to *general symptom management care guidelines*

7.4 Clinical Nutrition

Refer to *general clinical nutrition care guidelines*

7.5 Palliative Care

Refer to *general oncology palliative care guidelines*
8. Follow-up Care

Epithelial ovarian cancer:

*For stages I-4 with complete response:*
Every 3-4 months for 2 years after completion of treatment then every 3-6 months for 1 year, then annually after 5 years
+ CA-125 every visit
+ CT scan Abdomen / Pelvis ± Chest at completion of Chemo
± MRI
± PET scan
± Chest XRay
Serous should all be referred for genetic counselling

*Progression, stable or persistent disease after Chemotherapy:*
Clinical Trials or Supportive/Palliative Care or Chemotherapy or 2nd Debulking/Palliative Surgery

Patients who progress on two consecutive therapy regimens without evidence of clinical benefits have diminished likelihood of benefitting from additional therapy.

Decisions to offer clinical trials, palliative care only, or additional therapy should be made on an individual basis.

**Recurrence**
Recurrent epithelial ovarian cancer is divided into platinum sensitive and platinum resistant disease.

- **Platinum resistance:** Recurrence within 6 months of completion of chemotherapy
  Treatment includes caelyx, clinical trial and or gemcitabine
- **Platinum sensitive:** Recurrence after 6 months of completion of chemotherapy.
  Treatment includes re challenging with carboplatin/paclitaxel

Borderline epithelial ovarian cancer:
Every 3-6 months for up to 5 years, then annually afterwards
+ Physical Exam - Abdominal/Pelvic exam
± CA-125 every visit if initially elevated
± Consider completion surgery after childbearing in patients who underwent USO
± Ultrasound