

Disclaimer: This algorithm has been developed for MD Anderson using a multidisciplinary approach considering circumstances particular to MD Anderson’s specific patient population, services and structure, and clinical information. This is not intended to replace the independent medical or professional judgment of physicians or other health care providers in the context of individual clinical circumstances to determine a patient’s care. This algorithm should not be used to treat pregnant women.

ELIGIBILITY

**CONCURRENT
COMPONENTS
OF VISIT**

DISPOSITION

Ovarian cancer
5 years
post-treatment
and NED

SURVEILLANCE

Annual history and physical exam with:

- Pelvic exam
- CA-125
- Other markers based on pathology¹

Suspected
new primary
or recurrent
disease?

Yes

No

Return to primary treating physician
• **Primary Oncologist** to discuss Goal Concordant Care (GCC) with patient or if clinically indicated, with Patient Representative²

Continue survivorship monitoring

**MONITORING FOR
LATE EFFECTS**

Consider the following:

- Colonoscopy
- Bone Health (see [Survivorship - Gynecologic Cancer: Bone Health algorithm](#))
- Sexual health (see [Ovarian Toxicity Monitoring algorithm](#))

Refer or consult as indicated

RISK REDUCTION/EARLY DETECTION

PSYCHOSOCIAL FUNCTIONING

CHRONIC HEALTH MAINTENANCE

See [Page 2](#)

NED = no evidence of disease

¹ • Choriocarcinoma (ovarian) and Gestational trophoblastic disease – BHCG
• Mucinous type (ovarian) – CEA
• Granulosa cell tumor (ovarian) – Inhibin A and B
• Dysgerminoma – AFP, BHCG, and LDH
• Sertoli-Leydig cell tumor – BHCG, AFP, and testosterone

² GCC should be initiated by the **Primary Oncologist**. If Primary Oncologist is unavailable, Primary Team/Attending Physician to initiate GCC discussion and notify Primary Oncologist. Patients, or if clinically indicated, the Patient Representative should be informed of therapeutic and/or palliative options. GCC discussion should be consistent, timely, and re-evaluated as clinically indicated. The Advance Care Planning (ACP) note should be used to document GCC discussion. Refer to [GCC home page](#) (for internal use only).

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ELIGIBILITY

CONCURRENT
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DISPOSITION

Ovarian cancer
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post-treatment
and NED
(continued from
previous page)

RISK REDUCTION/
EARLY DETECTION

- Patient education, counseling, and screening:
- Lifestyle risk assessment¹
 - Cancer screening²
 - Vaccinations³ as appropriate
 - HPV vaccination as clinically indicated (see [HPV Vaccination algorithm](#))
 - Screening for Hepatitis B and C as clinically indicated (see [Hepatitis B Virus \(HBV\) Screening and Management](#) and [Hepatitis C Virus \(HCV\) Screening](#) algorithms)
 - Consider cardiovascular screening (see [Survivorship – Adult Cardiovascular Screening algorithm](#))
 - Genetic screening⁴ (see [Genetic Counseling algorithm](#))

PSYCHOSOCIAL
FUNCTIONING

- Assess for:
- Distress management (see [Distress Screening and Psychosocial Management algorithm](#))
 - Social support
 - Financial stressors

CHRONIC HEALTH
MAINTENANCE

- Confirm primary care provider (PCP) or recommend establishing care with a local PCP
- PCP responsible for assessment and management of non-cancer chronic health conditions (hyperlipidemia, diabetes, hypertension, *etc.*) or refer as indicated

Refer or consult
as indicated

¹ See [Physical Activity, Nutrition, Obesity Screening and Management](#), and [Tobacco Cessation Treatment](#) algorithms; ongoing reassessment of lifestyle risks should be a part of routine clinical practice

² Includes [breast](#), [cervical](#), [colorectal](#), [liver](#), [lung](#), [pancreatic](#), and [skin](#) cancer screening

³ Based on [American Society of Clinical Oncology \(ASCO\) guidelines](#)

⁴ Consider genetic counseling if there has been a significant family history change since the last genetic consult, or if the patient has not previously had BRCA1/BRCA2 genetic testing and ovarian cancer histology is high grade non-mucinous epithelial

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SUGGESTED READINGS

- de Vos, F. Y. F. L., Nuver, J., Willemse, P. H. B., van der Zee, A. G. J., Messerschmidt, J., Burgerhof, J. G. M., . . . Gietema, J. A. (2004). Long-term survivors of ovarian malignancies after cisplatin-based chemotherapy: Cardiovascular risk factors and signs of vascular damage. *European Journal of Cancer*, 40(5), 696-700. <https://doi.org/10.1016/j.ejca.2003.11.026>
- Gaffan, J., Holden, L., Newlands, E. S., Short, D., Fuller, S., Begent, R. H. J., . . . Seckl, M. J. (2003). Infertility rates following POMB/ACE chemotherapy for male and female germ cell tumours—a retrospective long-term follow-up study. *British Journal of Cancer*, 89(10), 1849-1854. <https://doi.org/10.1038/sj.bjc.6601383>
- Gershenson, D. M., Miller, A. M., Champion, V. L., Monahan, P. O., Zhao, Q., Cella, D., & Williams, S. D. (2007). Reproductive and sexual function after platinum-based chemotherapy in long-term ovarian germ cell tumor survivors: A Gynecologic Oncology Group Study. *Journal of Clinical Oncology*, 25(19), 2792-2797. <https://doi.org/10.1200/JCO.2006.08.4590>
- Guidozzi, F., & Daponte, A. (1999). Estrogen replacement therapy for ovarian carcinoma survivors: A randomized controlled trial. *Cancer*, 86(6), 1013-1018. [https://doi.org/10.1002/\(SICI\)1097-0142\(19990915\)86:6<1013::AID-CNCR17>3.0.CO;2-1](https://doi.org/10.1002/(SICI)1097-0142(19990915)86:6<1013::AID-CNCR17>3.0.CO;2-1)
- Heflin, L. H., Meyerowitz, B. E., Hall, P., Lichtenstein, P., Johansson, B., Pedersen, N. L., & Gatz, M. (2005). Cancer as a risk factor for long-term cognitive deficits and dementia. *Journal of the National Cancer Institute*, 97(11), 854-856. <https://doi.org/10.1093/jnci/dji137>
- Kaldor, J. M., Day, N. E., Band, P., Choi, N. W., Clarke, E. A., Coleman, M. P., . . . Storm, H. H. (1987). Second malignancies following testicular cancer, ovarian cancer and Hodgkin's disease: An international collaborative study among cancer registries. *International Journal of Cancer*, 39(5), 571-585. <https://doi.org/10.1002/ijc.2910390506>
- Kamboj, M., Bohlke, K., Baptiste, D. M., Dunleavy, K., Fueger, A., Jones, L., . . . Kohn, E. C. (2024). Vaccination of adults with cancer: ASCO guideline. *Journal of Clinical Oncology*, 42(14), 1699-1721. <https://doi.org/10.1200/JCO.24.00032>
- Laurell, G., Beskow, C., Frankendal, B., & Borg, E. (1996). Cisplatin administration to gynecologic cancer patients: Long term effects on hearing. *Cancer*, 78(8), 1798-1804. [https://doi.org/10.1002/\(SICI\)1097-0142\(19961015\)78:8<1798::AID-CNCR22>3.0.CO;2-S](https://doi.org/10.1002/(SICI)1097-0142(19961015)78:8<1798::AID-CNCR22>3.0.CO;2-S)
- Liavaag, A. H., Dørum, A., Bjørø, T., Oksefjell, H., Fosså, S. D., Tropé, C., & Dahl, A. A. (2008). A controlled study of sexual activity and functioning in epithelial ovarian cancer survivors. A therapeutic approach. *Gynecologic Oncology*, 108(2), 348-354. <https://doi.org/10.1016/j.ygyno.2007.10.009>
- Markman, M., Rothman, R., Hakes, T., Reichman, B., Lewis, J. L., Rubin, S., . . . Hoskins, W. (1991). Late effects of cisplatin-based chemotherapy on renal function in patients with ovarian carcinoma. *Gynecologic Oncology*, 41(3), 217-219. [https://doi.org/10.1016/0090-8258\(91\)90311-R](https://doi.org/10.1016/0090-8258(91)90311-R)
- Mehnert, W. H., Haas, J. F., Kittelmann, B., Staneczak, W., Möhner, M., Kaldor, J. M., & Day, N. E. (1986). A case-control study of leukaemia as a second primary malignancy following ovarian and breast neoplasms. *IARC Scientific Publications*, 78, 203-221. Retrieved from <https://europepmc.org/article/med/3583391>
- National Comprehensive Cancer Network. (2025). *Ovarian Cancer* (NCCN Guidelines Version 2.2025). Retrieved from https://www.nccn.org/professionals/physician_gls/pdf/ovarian.pdf
- National Cancer Institute, Division of Cancer Control and Population Sciences. (2025). National Standards for Cancer Survivorship Care. Retrieved from <https://cancercontrol.cancer.gov/ocs/special-focus-areas/national-standards-cancer-survivorship-care>
- Salani, R., Backes, F. J., Fung, M. F. K., Holschneider, C. H., Parker, L. P., Bristow, R. E., & Goff, B. A. (2011). Posttreatment surveillance and diagnosis of recurrence in women with gynecologic malignancies: Society of Gynecologic Oncologists recommendations. *American Journal of Obstetrics and Gynecology*, 204(6), 466-478. <https://doi.org/10.1016/j.ajog.2011.03.008>
- Stava, C., Beck, M., & Vassilopoulou-Sellin, R. (2005). Cataracts among cancer survivors. *American Journal of Clinical Oncology*, 28(6), 603-608. <https://doi.org/10.1097/01.coc.0000175291.51232.48>
- The National Lung Screening Trial Research Team. (2011). Reduced lung-cancer mortality with low-dose computed tomographic screening. *The New England Journal of Medicine*, 365(5), 395-409. <https://doi.org/10.1056/NEJMoa1102873>
- Travis, L. B., Curtis, R. E., Boice, J. D., Platz, C. E., Hankey, B. F., & Fraumeni Jr, J. F. (1996). Second malignant neoplasms among long-term survivors of ovarian cancer. *Cancer Research*, 56(7), 1564-1570. Retrieved from <https://cancerres.aacrjournals.org/content/56/7/1564.full-text.pdf>

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DEVELOPMENT CREDITS

This survivorship algorithm is based on majority expert opinion of the Gynecologic Survivorship workgroup at the University of Texas MD Anderson Cancer Center. It was developed using a multidisciplinary approach that included input from the following:

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