Survivorship – Ovarian Cancer (Includes Fallopian Tube and Peritoneal Primary)

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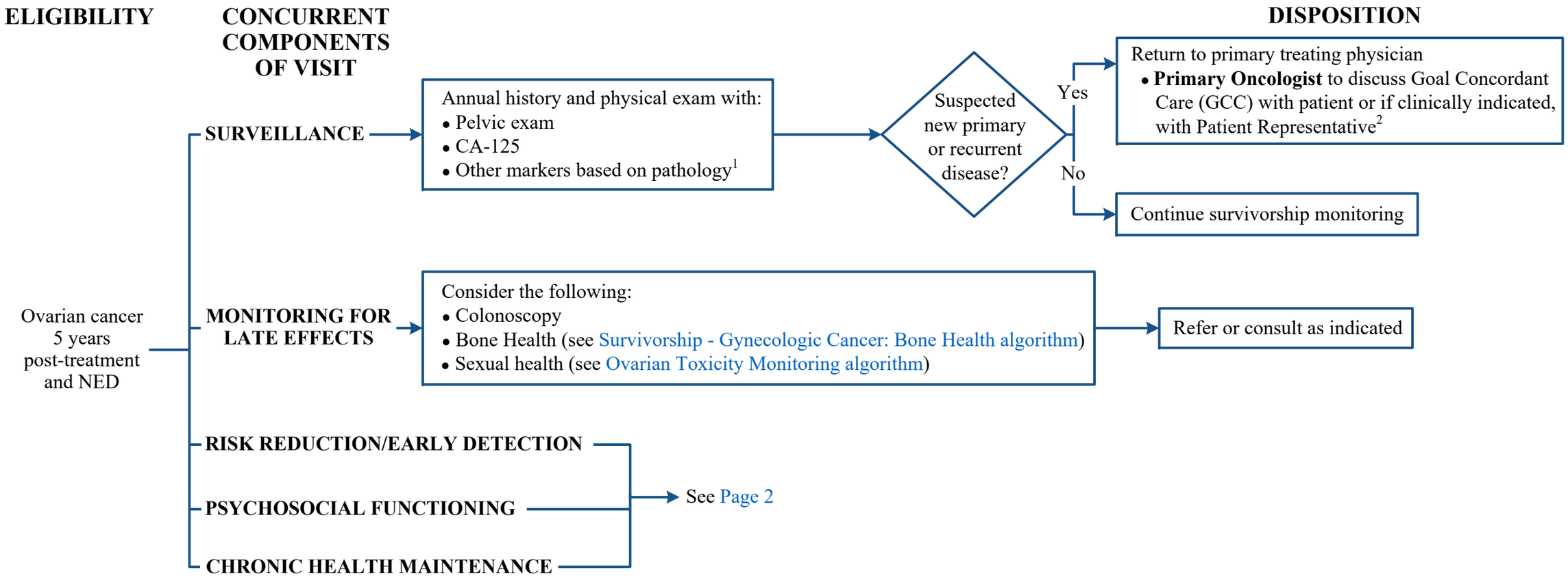

NED = no evidence of disease

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

[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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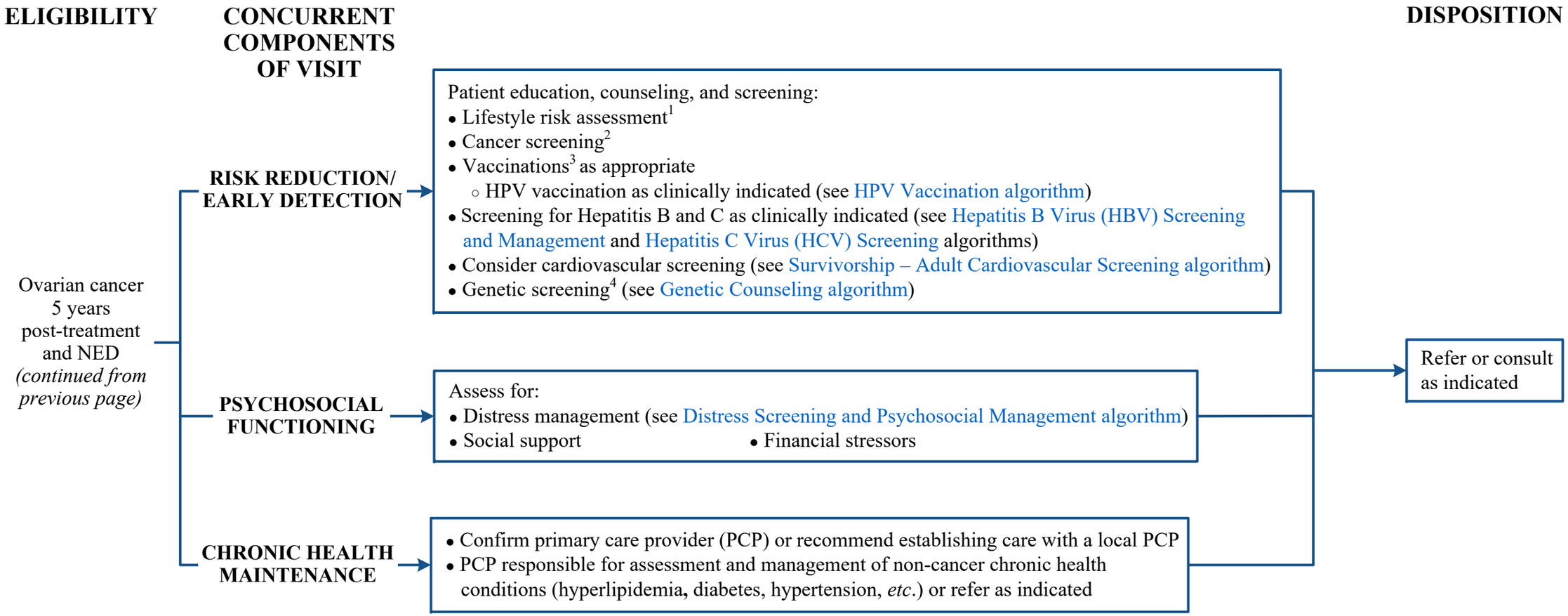

[1] See Physical Activity, Nutrition, Obesity Screening and Management, and Tobacco Cessation Treatment algorithms; ongoing reassessment of lifestyle risks should be a part of routine clinical practice
[2] Includes breast, cervical, colorectal, liver, lung, pancreatic, and skin cancer screening
[3] Based 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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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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