PIPADOR REVISION

MRCOG Part 1 Revision Notes

Ovarian Cancer

CLINICAL MANAGEMENT • LECTURE 503

VISUAL EXAMINATION REVISION NOTES

2026 Edition

503

MRCOG PART 1 REVISION NOTES | CLINICAL MANAGEMENT

Ovarian Cancer

Recognition, referral, staging, surgery, chemotherapy, maintenance, genetics and prevention of ovarian cancer (NICE CG122, BGCS)

CA-125 ≥ 35	RMI ≥ 250	No residual	PARP inhibitors
→ USS	Refer specialist MDT (NICE)	Surgical goal	Maintenance (BRCA/HRD)

■ KEY FACTS: Learning objectives

- Define epithelial ovarian cancer (including tubal and primary peritoneal), FIGO staging and cytoreduction terms.
- Describe recognition and referral (NICE CG122, NG12), investigation and the role of RMI and imaging.
- Describe surgery, chemotherapy, maintenance therapy, genetic testing, borderline tumours, recurrence and prevention.

503.1 Key definitions

Term	Definition
Ovarian cancer	Malignancy of the ovary, fallopian tube or peritoneum — ≈ 90% epithelial (high-grade serous ≈ 70%)
Primary cytoreductive surgery	Upfront surgery aiming to remove all visible disease
Neoadjuvant chemotherapy + interval debulking (NACT-IDS)	3 cycles of chemotherapy, then surgery, then further chemotherapy
Complete cytoreduction (R0)	No macroscopic residual disease — strongest modifiable prognostic factor
Platinum sensitivity	Time from last platinum to recurrence — ≥ 6 months = platinum-sensitive
HRD	Homologous recombination deficiency (BRCA1/2 or other) — predicts PARP inhibitor benefit
Borderline ovarian tumour	Epithelial proliferation without stromal invasion — excellent prognosis

■ IN PLAIN ENGLISH: Ovarian cancer

Ovarian cancer causes vague symptoms and is usually found **late** (stage III). Treatment combines **maximal surgery** and **platinum chemotherapy**, followed for many women by **maintenance tablets** (PARP inhibitors). Genetic testing matters for the woman and her family.

503.2 Recognition and referral

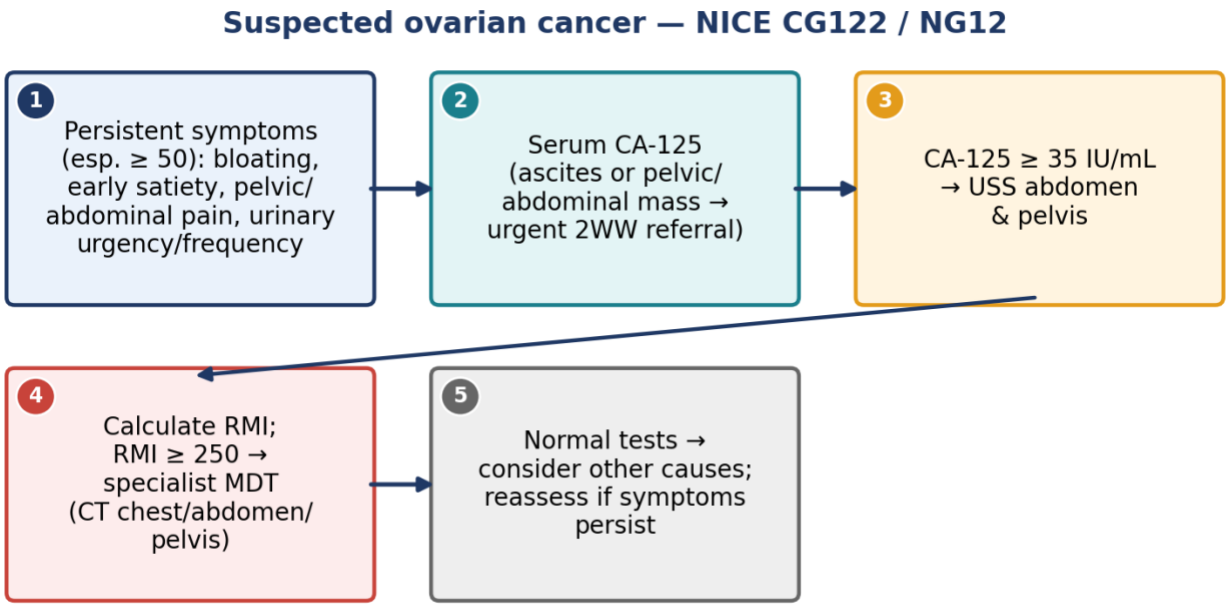


Figure 503.1 — Suspected ovarian cancer (NICE CG122/NG12)

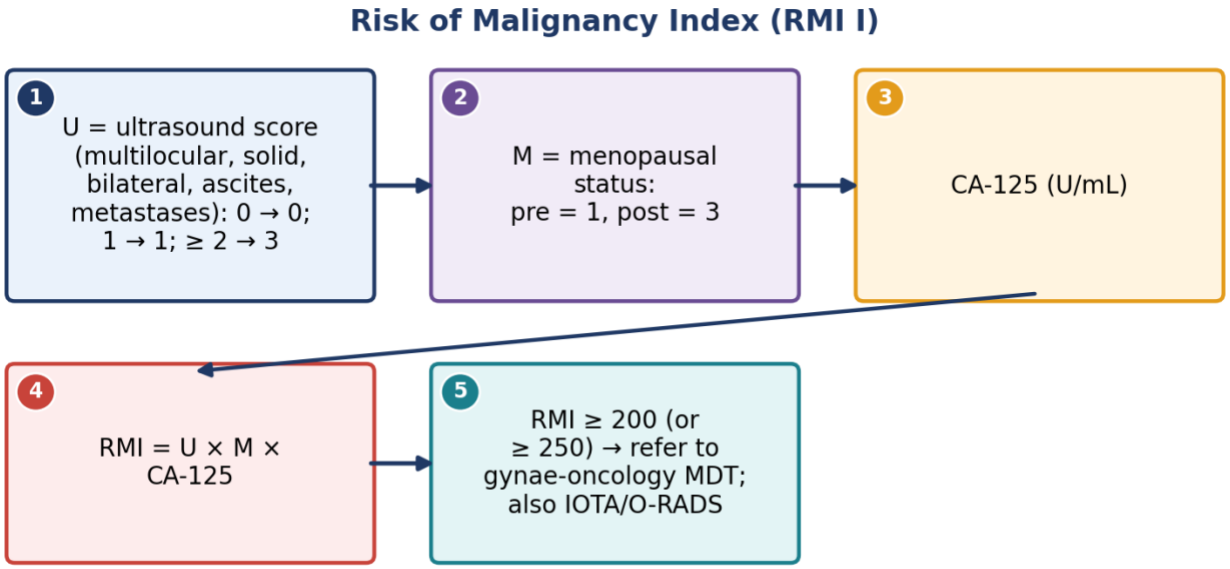


Figure 503.2 — Risk of Malignancy Index

- Women < 40 with complex masses: AFP, hCG, LDH (germ cell tumours); inhibin/AMH for sex cord–stromal tumours.
- Staging: CT chest/abdomen/pelvis
  - MRI for indeterminate masses
  - Tissue diagnosis (image-guided biopsy) before neoadjuvant chemotherapy
  - Ascitic/pleural cytology.
- Mucinous tumours: CEA/CA19-9 and GI evaluation to exclude a gastrointestinal primary.

503.3 Staging and treatment

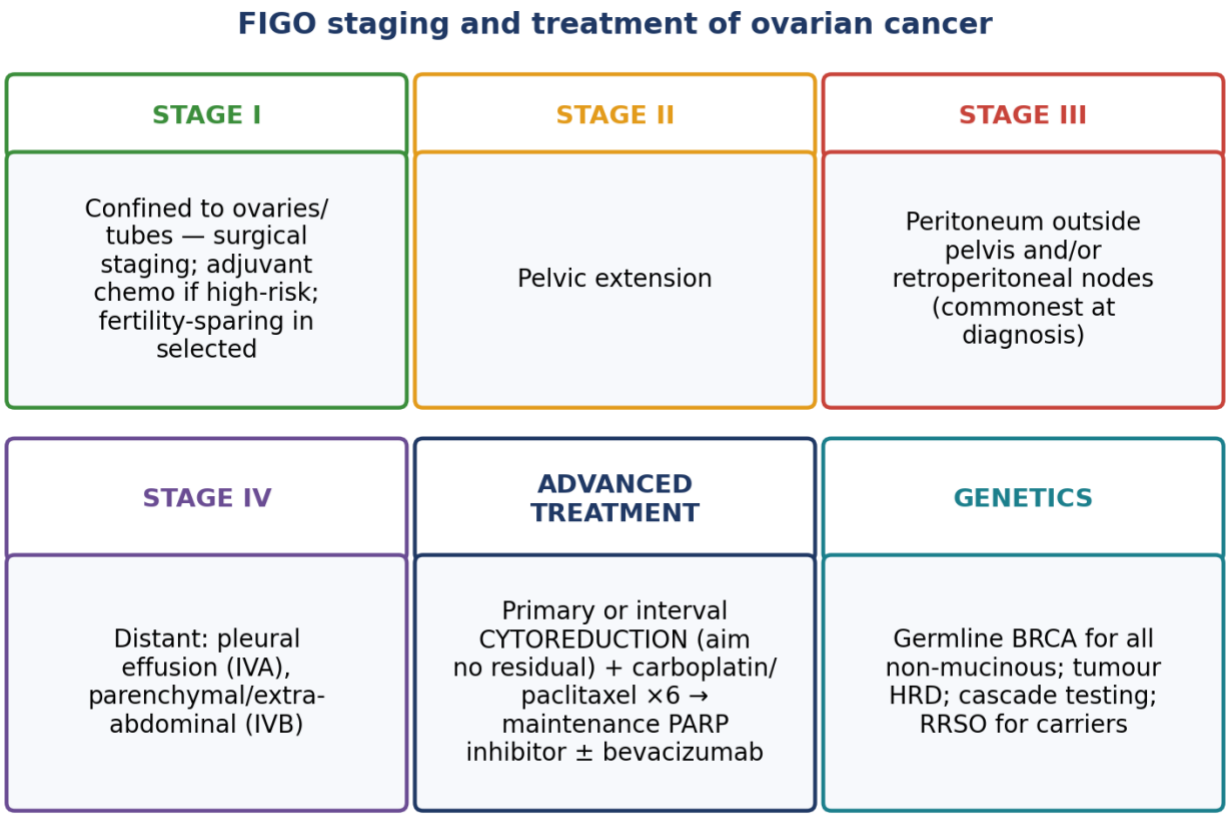


Figure 503.3 — FIGO staging and treatment

Topic	Management (BGCS / NICE)
Early stage (apparent I)	• Comprehensive surgical staging: TAH/BSO, omentectomy, peritoneal biopsies, washings, ± lymphadenectomy • Adjuvant carboplatin ± paclitaxel unless low-risk (e.g. stage IA/B low grade)
Fertility-sparing	Unilateral salpingo-oophorectomy + staging in young women with stage IA low-grade/borderline/germ cell tumours
Advanced (III–IV)	• Primary cytoreduction if complete resection achievable and woman fit • Otherwise NACT (3 cycles carboplatin/paclitaxel) → interval debulking → 3 further cycles
Chemotherapy	Carboplatin + paclitaxel 3-weekly × 6; ± bevacizumab in high-risk
Maintenance	PARP inhibitors (olaparib for BRCA-mutated; niraparib; olaparib + bevacizumab for HRD-positive) after response to platinum — per NICE TAs
Recurrence	• Platinum-sensitive: platinum-based doublet ± PARP maintenance, secondary surgery in selected (DESKTOP III) • Platinum-resistant: weekly paclitaxel, liposomal doxorubicin ± bevacizumab, trials • Palliative care (bowel obstruction, ascites)
Borderline tumours	• Surgery (fertility-sparing possible) • Usually no chemotherapy • Follow-up for recurrence

503.4 Genetics and prevention

- **Germline BRCA1/2 (and panel) testing for all women with non-mucinous epithelial ovarian cancer**
  - Tumour testing for BRCA/HRD
  - Cascade testing of relatives.
- Risk-reducing salpingo-oophorectomy: BRCA1 at 35–40, BRCA2 at 40–45 (after family completion)
  - HRT until ≈ 51 if no breast cancer
  - Lynch — hysterectomy + BSO.
- **Opportunistic salpingectomy** at hysterectomy/sterilisation reduces high-grade serous cancer risk.
- COC use reduces risk (≈ 50% after long use); no population screening (UKCTOCS showed no mortality benefit).

■ COMMON PITFALLS

Attributing persistent bloating to IBS in a woman ≥ 50 without checking CA-125.

Starting chemotherapy without tissue diagnosis.

Not offering germline genetic testing.

503.5 Must-know summary

■ EXAM TIP

- Persistent bloating/satiety/pain/urinary symptoms (≥ 50) → CA-125 → USS → RMI ≥ 250 → specialist MDT (NICE CG122).
- Staging CT; tissue diagnosis; FIGO I–IV (III commonest).
- Advanced: primary or interval cytoreduction (aim R0) + carboplatin/paclitaxel; maintenance PARP inhibitors (BRCA/HRD) ± bevacizumab.
- Germline BRCA testing for all non-mucinous EOC; RRSO for carriers; opportunistic salpingectomy; no screening.

■ MNEMONIC / MEMORY AID

Ovarian cancer — 'Cut it out (R0), Carbo-Taxol, then PARP'.