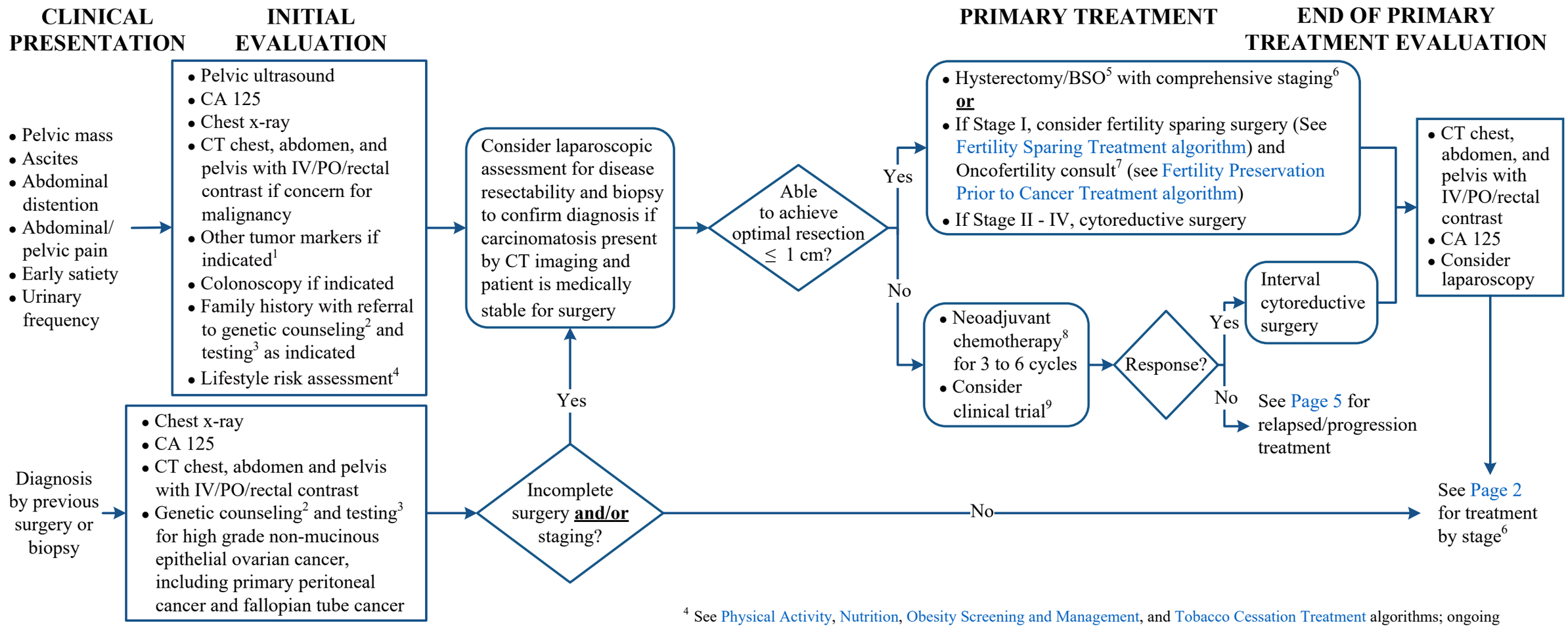
Epithelial Ovarian Cancer

Note: If available, clinical trials should be considered as preferred treatment options for eligible patients (Gynecologic Oncology Clinical Trials). Other comorbidities are taken into consideration prior to treatment selection.



BSO = bilateral salpingo-oophorectomy

[1] Consider *HE4* in patients with normal CA 125

[2] See Genetic Counseling algorithm to assess criteria for referral

[3] Consider both germline and somatic mutation testing (including HRD testing if *BRCA* germline or somatic mutation are negative). Consider testing at initial diagnosis or at the time of surgery.

[4] 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

[5] If Stage I and patient desires fertility preservation, consider unilateral salpingo-oophorectomy (USO) and staging

[6] Refer to Prat, J., & FIGO Committee on Gynecologic Oncology. (2014). Staging classification for cancer of the ovary, fallopian tube, and peritoneum. *International Journal of Gynecology & Obstetrics*, *124*(1), 1-5. doi:10.1016/j.ijgo.2013.10.001

[7] Refer to Reproductive Endocrinologists

[8] See Appendix A: Systemic Therapy Regimens

[9] See Gynecologic Oncology Clinical Trials

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Epithelial Ovarian Cancer

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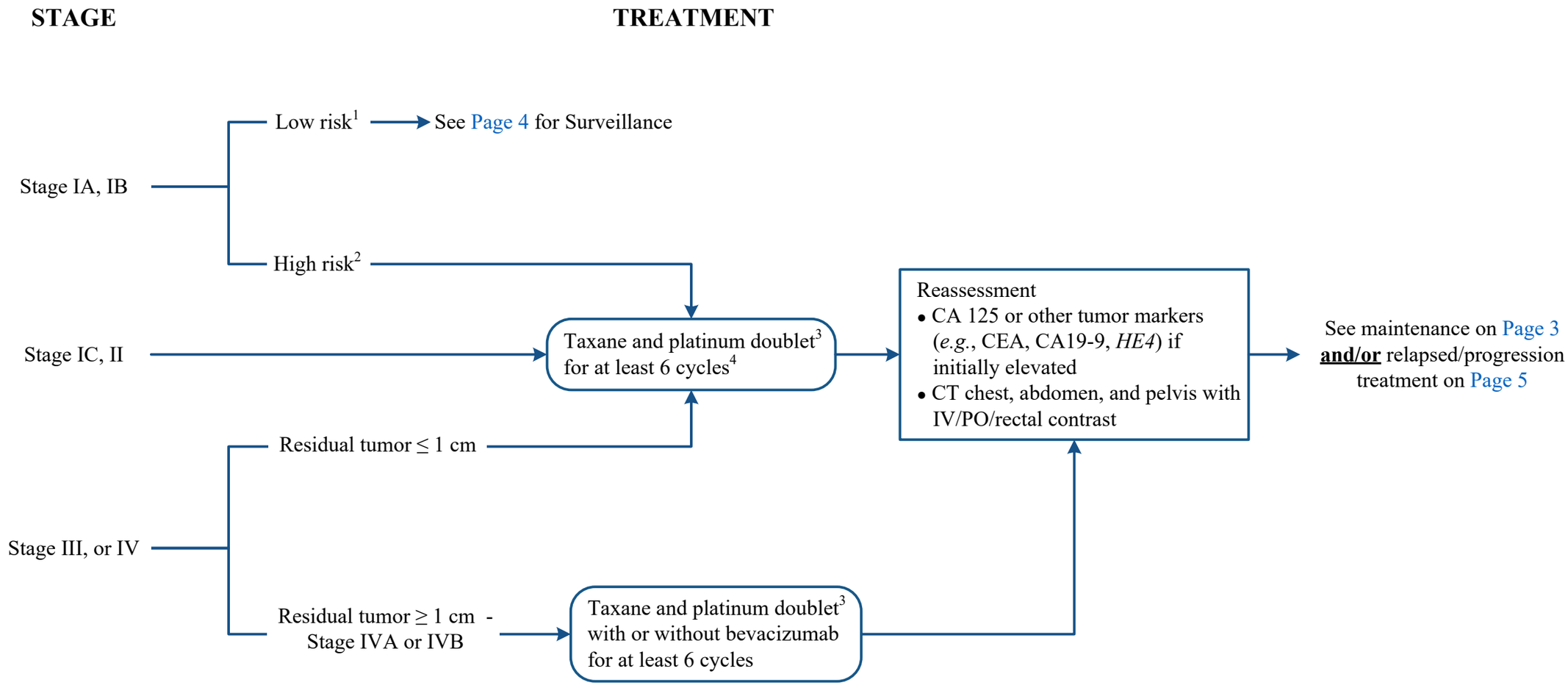

[1] Low risk - Grade 1 endometrioid or low grade serous histology
[2] High risk - Grade 2 or 3 endometrioid, high grade serous, clear cell, or carcinosarcoma
[3] See Appendix A: Systemic Therapy Regimens
[4] Three cycles may be considered in patients with non-high grade serous histologies

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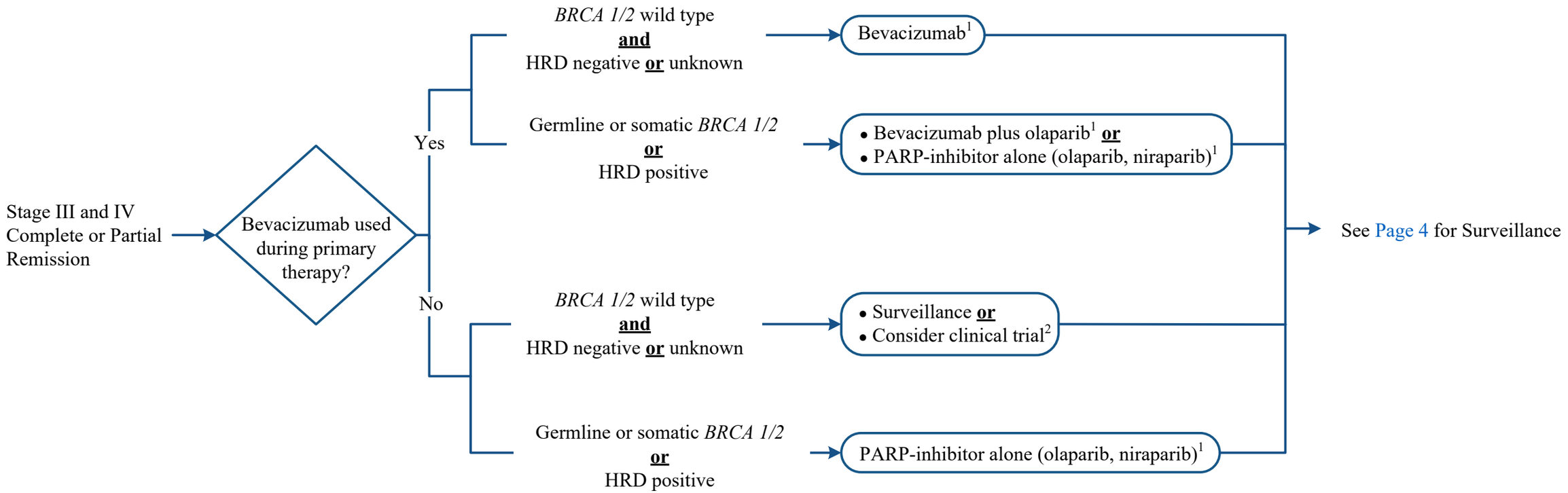
MAINTENANCE TREATMENT



HRD = homologous recombination deficiency
[1] See Appendix A: Systemic Therapy Regimens
[2] See Gynecologic Oncology Clinical Trials

Note: If available, clinical trials should be considered as preferred treatment options for eligible patients (Gynecologic Oncology Clinical Trials). Other comorbidities are taken into consideration prior to treatment selection.

SURVELLIANCE

Surveillance to include the following:
- Review of symptoms (pain, persistent headache, shortness of breath, vaginal bleeding and/or discharge, chronic cough, and change in bowel or bladder habits)
- Pelvic exam during clinic visits
- CA 125 or other tumor markers if initially elevated
- Pap test is *not* recommended
- Routine diagnostic imaging is *not* recommended

Recommended surveillance schedule:
- Year 1: Every 3 months
- Year 2: Every 3-4 months
- Years 3-5: Every 6 months
- For patients 5 years post-treatment and NED see Survivorship - Ovarian Cancer algorithm

NED = no evidence of disease

Epithelial Ovarian Cancer

Note: If available, clinical trials should be considered as preferred treatment options for eligible patients (Gynecologic Oncology Clinical Trials). Other comorbidities are taken into consideration prior to treatment selection.

RELAPSED/PROGRESSION TREATMENT

- Progression or no response on primary chemotherapy[1] **or**
- Relapse < 6 months after stopping platinum-based chemotherapy[1] (taxane and platinum resistant)

→
- Discuss Goal Concordant Care (GCC) with patient or if clinically indicated, with Patient Representative[2]
- Consider supportive care for selected patients
- Salvage chemotherapy/biotherapy[1] with or without bevacizumab
- Hormonal therapy for patients with low-grade ovarian cancer
- Trimetinib for patients with low-grade ovarian cancer
- NGS, *MSI* by PCR, and HLA testing for primary tumor
- IHC for *HER2/neu* and *FOLR1*
- Clinical trial[3]

Relapse ≥ 6 months after stopping platinum-based chemotherapy[1]

→ Serially rising CA 125 →
- Delay until clinical or radiologic relapse or treat as clinically indicated
- *BRCA* testing, if not already performed
- HRD tumor testing if germline *BRCA* testing negative
- NGS, *MSI* by PCR, and HLA testing for primary tumor
- IHC for *HER2/neu* and *FOLR1*
- Clinical trial[3]
- Discuss Goal Concordant Care (GCC) with patient or if clinically indicated, with Patient Representative[2]
- Consider supportive care for selected patients

→ Clinical or radiologic relapse → Consider cytoreductive surgery **or** radiation therapy in selected patients →
- Platinum-based doublet with or without bevacizumab[1] plus bevacizumab maintenance therapy **or**
- Platinum doublet followed by PARP inhibitor maintenance therapy[1]
- *BRCA* testing, if not already performed
- HRD tumor testing if germline *BRCA* testing negative
- NGS, *MSI* by PCR, and HLA testing for primary tumor
- IHC for *HER2/neu* and *FOLR1*
- Clinical trial[3]
- Discuss Goal Concordant Care (GCC) with patient or if clinically indicated, with Patient Representative[2]
- Consider supportive care for selected patients

HRD = homologous recombination deficiency
MSI = microsatellite instability
HLA = human leukocyte antigen
IHC = immunohistochemistry

[1] See Appendix A: Systemic Therapy Regimens

[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).

[3] See Gynecologic Oncology Clinical Trials

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Epithelial Ovarian Cancer

APPENDIX A: Systemic Therapy Regimens

<table>
<tr><td>Adjuvant Therapy</td><td colspan="2">• Paclitaxel 135 mg/m^2 IV over 3 hours on Day 1 with cisplatin 75-100 mg/m^2 IP on Day 2 and paclitaxel 60 mg/m^2 IP on Day 8 every 3 weeks for 6 cycles
• Paclitaxel 175 mg/m^2 IV over 3 hours with carboplatin AUC 5-6 IV over 1 hour every 3 weeks for 6 cycles
• Docetaxel 75 mg/m^2 IV over 1 hour with carboplatin AUC 5 IV over 1 hour every 3 weeks for 6 cycles
• Paclitaxel 175 mg/m^2 IV over 3 hours with carboplatin AUC 5-6 IV over 1 hour every 3 weeks for 6 cycles. Starting Day 1 of Cycle 2 give bevacizumab 15 mg/kg IV over 30 minutes every 3 weeks.
• Option for patients with mucinous ovarian cancer:
◦ Oxaliplatin 130 mg/m^2 IV over 2 hours on Day 1 and capecitabine 850 mg/m^2 PO twice daily on Days 1 through 14 followed by 7 day rest period every 3 weeks</td></tr>
<tr><td>Neoadjuvant Therapy</td><td colspan="2">• Paclitaxel 175 mg/m^2 IV over 3 hours with carboplatin AUC 5-6 IV over 1 hour every 3 weeks for 3 to 6 cycles
• Docetaxel 75 mg/m^2 IV over 1 hour with carboplatin AUC 5 IV over 1 hour every 3 weeks for 3 to 6 cycles
• Paclitaxel 175 mg/m^2 IV over 3 hours with carboplatin AUC 5-6 IV over 1 hour and bevacizumab 15 mg/kg IV over 30 minutes every 3 weeks for 3 to 6 cycles. Bevacizumab should not be given in the cycle prior to surgery.</td></tr>
<tr><td>Maintenance Therapy</td><td colspan="2">• Bevacizumab 15 mg/kg IV over 30 minutes every 3 weeks for up to 22 cycles
• Approved PARP inhibitor therapy until progression (BRCA positive or HRD positive); olaparib for 2 years or niraparib for 3 years
• Aromatase inhibitors (low-grade serous ovarian cancer)</td></tr>
<tr><td rowspan="2">Recurrence Therapy</td><td colspan="2">All systemic chemotherapy agents[1] can be given alone or with bevacizumab (until progression/toxicity)</td></tr>
<tr><td>Platinum Sensitive</td><td>Platinum Resistant</td></tr>
<tr><td>• Paclitaxel and carboplatin
• Carboplatin and weekly paclitaxel
• Carboplatin and docetaxel
• Carboplatin and gemcitabine
• Carboplatin and gemcitabine
• Carboplatin and liposomal doxorubicin
• Carboplatin single agent
• Bi-weekly cisplatin and gemcitabine
• Approved PARP inhibitor therapy (BRCA positive) until progression/toxicity
• Trimetinib for low-grade ovarian cancer
• Fam-trastuzumab deruxtecan-nxki for HER2/neu 2-3+</td><td>• Docetaxel
• Oral etoposide
• Gemcitabine
• Liposomal doxorubicin
• Weekly paclitaxel
• Bevacizumab single agent until progression/toxicity
• Hormonal therapy for low-grade ovarian cancer
• Approved PARP inhibitor therapy (BRCA positive or HRD positive) until progression/toxicity
• Aromatase inhibitor (low-grade serous ovarian cancer)
• Trimetinib for low-grade ovarian cancer
• Fam-trastuzumab deruxtecan-nxki for HER2/neu 2-3+
• Bi-weekly cisplatin and gemcitabine
• Oral cyclophosphamide
• Topotecan
• Vinorelbine
• Mirvetuximab [folate receptor alpha (FRα) positive]</td></tr>
</table>

[1] Excludes PARP inhibitors

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