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DEBULKING SURGERY

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FOR PATIENTS, RELATIVES AND HOSPITAL PERSONNEL

Introduction

This information sheet has been provided to help answer some of the questions you may have about debulking surgery for advanced stage ovarian cancer,

According to the latest Cancer Research UK website, there were 7,116 new cases of ovarian cancer in 2011. In the UK between 2009-2011, three-quarters (75%) were diagnosed in women aged 55 and over. It is the 4th most common cause of death among females in the UK accounting for 6% of all female deaths from cancer. In 2011, there were 4,272 deaths from ovarian cancer in the UK.

Most women who have ovarian cancer present with advanced disease and the outcome is generally poor, with an overall 5-year survival rate of 35%. The stage of the disease at diagnosis is the most important factor, affecting outcome and is defined by the International Federation of Gynecology and Obstetrics (FIGO) system.

The main treatments for ovarian cancer are surgery and chemotherapy. Surgery usually involves bilateral salpingo-oophorectomy, total abdominal hysterectomy and omentectomy. Potentially curative surgery requires resection of all macroscopic disease. More commonly, the goal is to reduce the diameters of the remaining pieces of tumour tissue to less than 1 cm (optimal debulking) or complete debulking with no visible disease.

Various studies, although non-randomized have consistently showed significantly improved overall survival in women who have had optimal or complete tumour debulking compared to those with bulky residual disease after surgery.

England has the lowest survival rate for ovarian cancer in Europe. It is estimated that in the UK, if survival rates matched the best survival rates in Europe, 500 women's lives would be saved every year. According to a recent government-funded research, women who are diagnosed with advanced ovarian cancer are less likely to survive in the UK than in other Western countries around the world. It also suggests that their treatment may not always be as good as in these other affluent countries where survival is much better.

The UK's record on ovarian cancer was compared with that of four other countries: Australia, Canada, Denmark and Norway. Overall in the UK, 69% of women survived for more than a year after diagnosis, compared with 72% in Denmark and 74-75% in the other three countries.

But survival in the UK was lower for those women diagnosed with advanced cancer. In women over 70, only 35% with late stage cancer survived for a year, compared with 45% in Canada.

The results of the study were described as "disturbing" by Cancer Research UK. They show clearly that the poor survival rates are not due to women delaying going to their GPs with their symptoms, as has often been suggested. That happens just as much in some other countries such as Denmark, where survival is better than in the UK.

Instead, it looks likely that the issue is with the care some women receive – and more likely about the standard of surgery than about drugs since chemotherapy is more or less a standard approach. The only non-standardized treatment is the surgical management. It has long been recognized that the UK gynaecological oncology surgeons are more conservative in the radical surgical management of advanced ovarian cancer.

Data from more than 20,000 women between 2004 and 2007 showed that all five countries had similar proportions of patients being diagnosed at each stage of the disease suggesting that late presentation is not the reason why women are less likely to survive here. The only variable factor is surgical management. As a result, many Cancer Centres in the UK are playing catch-up and adopting ultra-radical surgery either as primary or delayed surgical approach in the management of carefully selected group of patients with advanced ovarian/fallopian tube/primary peritoneal cancer.

NICE STATEMENT

Over the last 2 years, many major Cancer Centres across the UK have started a move to encourage ultra-radical surgery in women who have good performance status but with an advanced stage ovarian cancer. Hence, in 2013, NICE issued a document on the guidelines for performing ultra-radical surgery (IP 964). The aim of ultra-radical surgery for advanced ovarian cancer is to remove all visible disease and thereby improve survival compared with standard, less radical surgery.

Extensive or ultra-radical surgery for advanced ovarian cancer is a development and extension of standard surgery. In addition to techniques used in standard and radical surgery (including hysterectomy, bilateral excision of ovary and fallopian tubes), ultra-radical surgery incorporates at least 1 of the following:

1. extensive peritonectomy, including partial resection of the diaphragm
2. resection of subcapsular liver metastases, cholecystectomy
3. plenectomy, resection of the tail of the pancreas
4. other bowel resections, partial gastrectomy

The NICE document critically appraised current studies looking at the benefits of ultra-radical surgery and came up with recommendations and guidance as follows:

1. This procedure should not be done except with special arrangements for clinical governance, consent and audit or research (with the objective of publishing outcomes for all patients having this procedure)
2. Clinicians wishing to undertake ultra-radical surgery for advanced ovarian cancer should take the following actions:
    - Inform the clinical governance leads in their NHS trusts
    - During the consent process, inform patients clearly about alternative treatment options, and about their benefits and risks compared with ultra-radical surgery for advanced ovarian cancer. Clinicians should provide patients with clear written information
    - Clinicians should submit data on all patients having this procedure to the national register when it becomes available and review clinical outcomes locally
    - Selection of patients should be done by a specialist gynaecological cancer multidisciplinary team
    - Ultra-radical surgery for advanced ovarian cancer should be done by collaboration between surgeons with appropriate expertise (such as specialists in gastrointestinal and hepatobiliary surgery) and/or by specialists in gynaecological cancer surgery

REFERENCES

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