

Fact Sheet 2

About ovarian cancer

Ovacome is a national advice and support organisation that works to connect patients, their family and friends; provide information on treatments, screening and research; raise awareness and support and give a voice to all those affected by ovarian cancer.

Diagnosis

There is a glossary with this fact sheet, to explain words you may not be familiar with.

There are about 6800 new cases of ovarian cancer each year in the UK. The ovaries are tucked deep in the pelvis which is why this cancer can be difficult to diagnose. Symptoms can be similar to other conditions, which can delay diagnosis.

At the moment, researchers are looking for the best way of finding or screening for ovarian cancer at an early stage. It will be some years before the results of these trials are known.

At the moment ovarian cancer can be found with an ultrasound scan or CT scan. These scans are painless tests that create pictures of the inside of your body. Sometimes the cancer is found during an operation. The result of a blood test called CA125 can also suggest that you may have cancer.

What are the different types of ovarian cancer?

There are many types of ovarian cancer. Ovarian cancer can be divided into three main groups – epithelial, germ cell or sex-cord stromal tumours – depending on the type of ovarian cells they are made up of.

Epithelial ovarian cancer

This is the most common type of ovarian cancer, making up 90% of cases. Epithelial ovarian cancer develops from cells that cover or line the ovaries. All epithelial ovarian cancers are grouped by how they look under a microscope. Although they may act slightly different, they are usually treated in the same way. This type of ovarian cancer can be subdivided into serous, mucinous, endometrioid, clear cell and borderline.

Serous tumours make up 70% of cases.

Mucinous tumours make up 10% of cases.

Endometrioid tumours make up 5% of cases. They are more likely to be associated with disease in the uterus (womb). Sometimes an ovary is found to be affected when a woman is diagnosed with endometrial cancer.

Clear cell tumours make up 3% to 5% of epithelial ovarian cancers and are nearly always malignant. This means they can spread to other parts of the body. Clear cell tumours tend to appear in women between 40 and 80 years old.

You can get more information in our fact sheet 'Clear cell tumours'.

Borderline tumours are also epithelial tumours, but behave differently. They make up 10% to 15% of cases and tend to grow slowly and have less chance of spreading. Often surgery is the only treatment needed. They grow on the outside of the ovary and do not tend to spread inside it.

This means that borderline tumours often have a better result than other ovarian tumours.

You can get more information in our fact sheet 'Borderline ovarian tumours'.

Germ cell tumours

Germ cell tumours make up 3% of ovarian cancers. They are made up of the cells that produce the eggs in the ovaries and are more common in young women. They can include dysgerminomas and non-dysgerminomas tumours. Not all germ cell tumours are malignant (cancer).

Sex-cord stromal tumours

Sex-cord tumours are made up of the cells that produce hormones and support cells in the ovary. They make up 5% of ovarian cancers. The most common type is granulosa cell tumour and others include sertoli leydig.

You can get more information in our fact sheet 'Rare ovarian tumours'.

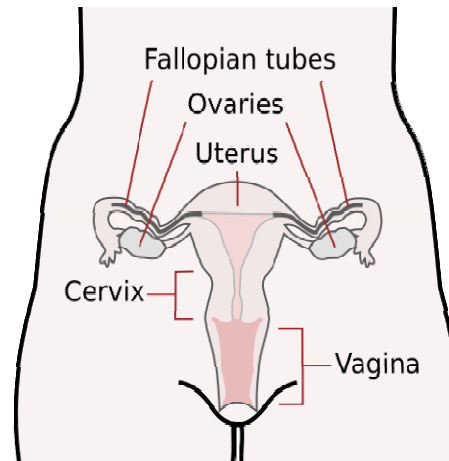


Diagram of the female reproductive system

What is staging?

The treatment and prognosis (outcome of the disease) depends on the type and stage of the cancer.

The stage describes where the cancer has spread at the time it is diagnosed. This is decided at the first operation or during scans.

Stage 1

The cancer is on or in one or both ovaries and has not spread

Stage 2

The cancer has spread outside the ovary to the lining of the pelvis and can involve the uterus, fallopian tubes, bladder and rectum.

Stage 3

The cancer has spread to the lining of the abdomen, the surface of the bowel, the omentum and the lymph glands in the pelvis or around the aorta.

Stage 4

The cancer has spread beyond the abdomen to the liver and lungs.

The stages are then classified further with the letters a, b and c. You can get more information in our fact sheet 'The stages of ovarian cancer'.

You may also find that your doctor mentions 'grade' or 'differentiation' when talking about your cancer. The grade and differentiation of a tumour is decided by how the cancer cells look under the microscope. Grading is divided into three groups: one (low), two (intermediate) and three (high). It is a prediction of how your tumour may behave.

Treatments

There are two main treatments for ovarian cancer – surgery and chemotherapy. If your cancer has been found using a scan, a surgeon will look at the results with the multidisciplinary team (MDT). They will discuss which option is best for you. You may be offered one of these treatments or a combination of both.

Important questions to ask

- Will I be referred quickly to a medical team that specialises in diagnosing and treating gynaecological cancers?
- Will medical professionals discuss the surgery and chemotherapy with me before my treatment starts?
- Will the surgery be done by a gynaecologist trained in managing gynaecological cancers?
- Will my chemotherapy be carried out by staff with a special interest in gynaecological cancers?
- Can I see a specialist nurse or counsellor and a symptom-control (palliative care) team?
- Can I and my family get information on support services?
- Will I get information on any ongoing clinical trials?

Surgery

In most cases, surgery is needed. A specially qualified surgeon (a gynae-oncologist) should do this operation, which is called a staging laparotomy. Laparotomy means to operate on the abdomen. The surgeon will take samples from around your abdomen and send them to a laboratory to find out how far the cancer has spread

The aim of the operation is to remove as much of the tumour as possible, but cause as little damage as possible to your surrounding organs. Sometimes it is not possible to remove all the tumour. Where possible, the surgeon will do a hysterectomy (remove your womb) and a salpingo-oophorectomy (surgical removal of ovaries and fallopian tubes).

Your surgeon will discuss your operation and give you the chance to ask as many questions as you want to. You will be asked to sign a consent form to give your permission for the operation.

Many surgeons prefer to do the operation first. However, in some cases it is better to try and reduce the size of the tumour with chemotherapy and operate later. You should discuss any advantages and disadvantages of this option with your surgeon.

If you are a younger woman and the cancer is at an early stage, your surgeon may try to adapt the operation so that you may still be able to have a baby.

After surgery you are likely to be in hospital for about a week and you will have to take it easy at home for several weeks. You should avoid lifting and driving for four to six weeks.

Chemotherapy

In most cases, you will be advised to have chemotherapy, either to prepare for surgery or to kill any cancer cells left after surgery.

Chemotherapy is a type of drug that kills cancer cells. A doctor called an oncologist prescribes it. There are many different types of chemotherapy and your oncologist will discuss the various options.

Most chemotherapy for ovarian cancer is given as an intravenous treatment (via a tiny small tube into your vein) at hospital. The side effects of different chemotherapy vary. We can give you fact sheets to explain the different types of chemotherapy and the side effects.

Remission and relapse

In most cases, chemotherapy is able to shrink the tumour until there is no sign of cancer left. This is called a complete remission. Sometimes a small amount of cancer is still left at the end of treatment. This is called a partial remission. In a small number of cases, the chemotherapy does not kill the cancer and the disease does not improve. If this happens, the oncologist will change the type of chemotherapy.

After the treatment, you will be closely monitored and need to visit the hospital regularly to check that the cancer has not come back. Gradually the time between checks will get longer. If you have any worries, you can see your oncologist between appointments.

Although ovarian cancer is frequently controlled by chemotherapy (in remission), it may come back. This is called a relapse or recurrence. It is difficult to predict how long the benefits of the chemotherapy will last. For some women it only lasts a few months, for others remission continues for a lot longer.

If your cancer comes back after the initial (first line) chemotherapy, your oncologist will suggest another course (second line). The aim is to achieve as long a remission as possible. Some women go on to have successful third- and fourth-line treatment, sometimes more. Your wishes will always be taken into account.

You can get more information in our fact sheet 'Treatment for relapsed ovarian cancer'.

Many new ways of treating cancer are being investigated, as well as studies of how to use existing treatments more effectively. If you would like to take part in a trial, you should discuss this with your doctor.

If you would like more information or you would like to discuss anything about ovarian cancer, phone our support line on 0845 371 0554 Monday to Friday from 10.00 hrs to 17.00hrs.

Alternatively, you can visit our website at www.ovacome.org.uk.

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Disclaimer:

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The information provided here is not a substitute for professional medical care. If you suspect you have cancer you should consult your doctor as quickly as possible.

Ovacome cannot accept liability for any inaccuracy via third party information from sources to which we link.

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