The protocol of operable ovarian cancer treatment — comment

Surgical operation is the key element of treatment in patients with ovarian cancer. It enables us to make histological diagnosis, assess the clinical stage, exert an immediate palliative effect, and decrease the tumour's volume, which together increase the effectiveness of anticancer drugs [1]. Despite controversies regarding tolerability of expansive cytoreductive operations, radicality of surgery is — after staging according to the FIGO (*Fédération internationale de gynécologie et d'obstétrique*) system — the most important prognostic factor in patients with ovarian cancer [2, 3]. It is already known that independently of the mentioned factors the **burden of peritoneal disease and preoperative tumour volume** influence the survival [4, 5]. Similarly, the **volume of free peritoneal fluid** correlates with the intensity of cancer as well as the probability of achieving complete cytoreduction [6–8]. Recently, numerous operation's protocols for ovarian cancer patients do not include such important data, which makes the treatment even more difficult, especially when the treatment is conducted in another clinical centre. Thus, the Board of the Polish Gynaecological Oncology Society proposes to unify and possibly simplify the operation's protocol for all sites leading surgical treatment of ovarian cancer patients.

The value of detailed description, localisation, and size of neoplastic lesions revealed during primary operation (exploratory laparotomy as well as diagnostic laparoscopy) could not be overestimated during planning of further treatment of those patients. The decision about interval cytoreductive surgery or its abandonment, diagnosis of signs and symptoms of ovarian cancer patients, use of adjuvant and supportive therapy, as well as potential decisions regarding a secondary cytoreductive procedure, are based on this information. Because intraoperative assessment of the magnitude of residual cancer is in many cases underestimated, it seems expedient to perform computed tomography (CT) every 4–6 weeks during postoperative follow-up [9]. Of note, the results of CT imaging are currently essential for qualification of patients with advanced ovarian cancer to bevacizumab therapy, according to the Ministry of Health drug program [10].

The proposed protocol is readable and simple to complete. It allows the provision, in a very simple way, of comprehensive information regarding all peritoneal fields that could be potentially affected by cancer. Based on this, patients with ovarian cancer after suboptimal surgical treatment have a chance for well prepared, interval cytoreductive surgery in a reference centre as well optimal adjuvant treatment.

Additionally, a full version of the protocol is available electronically at www.ptgo.pl and as an App Store application (Protokół leczenia PTGO), and shortly it will be available in hard copy in all obstetrics and gynaecology wards in Poland.

On behalf of the Board
of the Polish Gynaecological Oncology Society

prof. dr hab. n. med. Paweł Blecharz,
Board Secretary

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PROTOCOL OF OVARIAN CANCER OPERATION version 1. 2015

Patient's name and surname: . . . . . **PESEL:** ☐☐☐☐☐☐☐☐☐☐☐

Diagnosis: . . . . . .

Type of operation:

❑ Primary operation ❑ Interval operation ❑ Secondary operation (treatment of recurrence, non-cured cancer) ❑ Others ❑ Laparoscopy ❑ Laparotomy

Duration of the operation (min.) . . . . . **Operation's description** Date: . . . . . Operator: . . . . . .
1 Assist: . . . . . 2 Assist: . . . . . .

Operation's description . . . . . .
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LOCALISATION OF CANCER LESIONS BEFORE OPERATION	SIZE OF RESIDUAL LESIONS (the greatest size in cm, if > 0)
Fluid:. . . . . ml	
PELVIS:	
❑ Right adnexa	. . . . . cm
❑ Left adnexa	. . . . . cm
❑ Uterus	. . . . . cm
❑ Sigmoid colon and rectum	. . . . . cm
❑ Pouch of Douglas	. . . . . cm
❑ Vesico-uterine pouch	. . . . . cm
❑ Parietal peritoneum	. . . . . cm
❑ Others	
MESOGASTRIC:	
LARGE BOWEL:	
❑ Ascending colon	. . . . . cm
❑ Transverse colon	. . . . . cm
❑ Descending colon	. . . . . cm
❑ Mesentery surface	. . . . . cm
❑ Mesentery root	. . . . . cm
SMALL BOWEL:	
❑ Intestinal loops	. . . . . cm
❑ Mesentery surface	. . . . . cm
❑ Mesentery root	. . . . . cm
GREATER OMENTUM:	
❑ Subcolon	. . . . . cm
❑ Gastrocolic ligament	. . . . . cm
❑ Gastrosplenic ligament	. . . . . cm
PERITONEUM:	
❑ Left upper quadrant of abdomen	. . . . . cm
❑ Right upper quadrant of abdomen	. . . . . cm
EPIGASTRIC:	
❑ Peritoneum of diaphragm's copula	. . . . . cm
❑ Left ❑ Right	. . . . . cm
❑ Glisson's capsule/liver	. . . . . cm
❑ Spleen	. . . . . cm
❑ Hepatic hilus/gall bladder	. . . . . cm
❑ Lesser omentum/stomach/duodenum	. . . . . cm
❑ Others	. . . . . cm
LYMPH NODES:	
❑ Pelvic	. . . . . cm
❑ Periaortic	. . . . . cm
❑ Others	. . . . . cm

LOCALISATION OF CANCER LESIONS BEFORE OPERATION	SIZE OF RESIDUAL LESIONS (the greatest size in cm, if > 0)
Fluid:. . . . . ml	
PELVIS:	
❑ Right adnexa	. . . . . cm
❑ Left adnexa	. . . . . cm
❑ Uterus	. . . . . cm
❑ Sigmoid colon and rectum	. . . . . cm
❑ Pouch of Douglas	. . . . . cm
❑ Vesico-uterine pouch	. . . . . cm
❑ Parietal peritoneum	. . . . . cm
❑ Others	
MESOGASTRIC:	
LARGE BOWEL:	
❑ Ascending colon	. . . . . cm
❑ Transverse colon	. . . . . cm
❑ Descending colon	. . . . . cm
❑ Mesentery surface	. . . . . cm
❑ Mesentery root	. . . . . cm
SMALL BOWEL:	
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❑ Others	. . . . . cm
LYMPH NODES:	
❑ Pelvic	. . . . . cm
❑ Periaortic	. . . . . cm
❑ Others	. . . . . cm

Intraoperative staging according FIGO 2014 classification . . . . . **Maximal size of gross residual disease after cytoreduction** . . . . . cm

Intraperitoneal catheter: YES ❑ NO ❑ **Results of intraoperative assessment** . . . . . .

Name and stamp of the centre

Stamp and signature of physician

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