Ovarian cancer is the leading cause of death among gynecologic cancers and the fifth-most-common cause of cancer death in women in the United States. In 2010, 21,900 women were diagnosed with ovarian cancer in the United States and 13,900 died of the disease.

Ovarian cancer is known as a “silent tumor.” Patients often present with vague symptoms, such as abdominal discomfort, pelvic pain or bloating. By the time patients are diagnosed, the majority have advanced stage disease. Even with meticulous cytoreductive surgeries and aggressive chemotherapy, only about 20 to 40 percent of advanced patients achieve long-term survival.

Much research in recent years has been aimed at identifying women at risk for ovarian cancer, diagnosing them earlier and defining surgical intervention along with better chemotherapy agents.

The incidence of ovarian cancer increases with age. Epidemiologic studies have identified nulliparity, or older age at first childbirth, as being associated with increased risk. Use of exogenous hormones may also increase risk. Younger age at childbirth and use of oral contraceptives are associated with decreased risk. In recent years, studies have documented increased risk in patients with a strong family history of breast cancer and other cancers. There has been extensive research using various blood tests and procedures to detect ovarian cancer earlier.

The stage at diagnosis determines the patient’s treatment and is a major prognostic factor. At the earliest stage, the tumor may involve one or two ovaries only. As the disease progresses it may invade adjacent tissues within the pelvis. In advanced stages, the tumor invades the abdominal space, causing fluid accumulation and invasion of the bowel and other organs.

There are several different pathological types of ovarian cancer. Most (about 80%) are epithelial in origin. Less common tumor types include germ cell neoplasms and sarcomas. The latter tumors have different behavior patterns and generally are treated differentially.

Over the last decade, national standards of care have evolved for the treatment of ovarian cancer. At SwedishAmerican we analyzed our 23 ovarian patients diagnosed from 2008 to 2010. We are able to compare our patient data to the most complete information available in the National Cancer Data Base, from 2008.

Below are charts comparing our patients to national statistics for age at diagnosis and tissue type. The majority of our patients were diagnosed over the age of 50 (82% of the SwedishAmerican group and 79% of the national group). Our patients had the typical variety of histologies, with adenocarcinomas being the most common. Our pathologists identified more patients with endometrioid adenocarcinoma. They also identified more uncommon tumors including granulosa cell tumors.
The following charts show comparison of stage at presentation and types of treatment. Of our patients from 2008 to 2010, 56 percent presented with advanced disease (Stages III and IV), compared to 58 percent nationally. These data also compare treatment patterns at SwedishAmerican with national patterns. Sixty-five percent of SwedishAmerican patients were candidates for and underwent multimodality treatment with surgery and chemotherapy. This compares well with the national data of 53 percent.
We were able to analyze a smaller cohort of patients from 2010 more thoroughly. Of the ten patients from 2010 we were able to specifically identify their presenting symptoms, method of diagnosis, referral to specialty surgery and course of treatment. Five out of 10 patients presented with a chief complaint of abdominal pain. Five presented with abdominal swelling. Nine of 10 patients presented to their primary care providers, or the
Emergency Room. The diagnosis was made with CT scan in nine patients and by transvaginal ultrasound in one.

Eight patients went on to have debulking surgeries. Two were considered to be too ill for surgery. Five of the eight surgical patients were seen and underwent operations at tertiary gynecologic oncology centers. The remaining patients chose to stay close to home for surgery or had limiting co-morbid problems. Eight of 10 patients had systemic chemotherapy. One patient had surgery only, and one declined chemotherapy.

This analysis shows that our treatment at SwedishAmerican compares favorably with national standards for ovarian cancer care. We offer the most up-to-date diagnostic procedures. We are working to identify those patients with strong family histories, who may have BRCA 1 and BRCA 2 genotypes, and families with HNPCC. These patients could benefit from close monitoring and prophylactic oophorectomy. Although there are not now specific blood tests or procedures to screen for ovarian cancer in the general population, we continue to explore new research and clinical protocols with tertiary centers whenever possible. We aggressively refer our patients to multiple tertiary gynecologic oncology surgery centers in the Midwest. All of these factors allow us to provide an excellent standard of care for the ovarian cancer patient in Rockford, Illinois.