Cancer de ovario epitelial pdf

Main article: Ovarian Cancer Epithelial Ovarian TumorClassification and External Resources Oncology SpecialtyCI-10 C56, D27CIE-9 183.0, 220PubMed Search Medline using PubMed Synonyms Epithelial Ovarian Tumors Medical Notice (edit data on Wikidat) Epithelial ovarian tumors are a type of ovarian neoplasm that can be both benign and malignant (cancer). It is believed that neoplasmics in this group come from the epithelial surface, which covers the surface of the ovary (a modified type of peritoneus) or from the ectopic tissue of the endometrium, i.e. immoderate. This group of tumors corresponds to 65-70% of ovarian tumors. CA-125, a tumor marker, is often high in these cases, although it is not a useful marker in assessing the progress of therapy after diagnosis. Classification of superficial epithelial ovarian tumors is classified depending on the type of epithelial cell, the relative amount of epithelial and stroma, the presence of papillary processes and the location of epithelial elements. Microscopic pathological characteristics determine whether the epithelial tumor in question is benign, suspicious or malignant, based on stromal inocation or other malign characteristics. Suspicious tumors have an uncertain potential for malignancies. This group of tumors consists of serous, mucous, endometrioid, pure cells or Brenner tumors (transitional tumors, although sometimes there are mixed tumors, undifferentiated tumors and unclassified types. Serous tumors These tumors vary in size, from very small and almost imperceptible to large tumors that can fill the abdominal cavity. These are the most common epithelial tumors (60% of cases), 75% of them benign or suspicious and 25% malignant. bilateral (affects both ovaries). Malignant tumors, on the other hand, have a cystic type of adenocarcinoma forming 40% of all malignant ovarian carcinoma, usually observed in older women, often associated with family cases and 66% of ovarian malignancies are bilateral. The likelihood of malignancies in epithelial ovarian tumors increases with the number of solid areas present, including nipple structures and necrotic tissues. The pathology of epithelial ovarian tumors usually consists of high, column and hairy cells filled with serous fluid, which usually occupies the surface of the ovary. Separation of benign, malignant or suspicious tumors is successful in observation: cellular atimia, i.e. whether individual cells The tumor looks normal; Invasion of the surrounding strome, i.e. whether tumor cells invaded the molten tissues; The presence of pzammoma organs, which are characteristic findings in cystic adenocarcinomas, the prognosis of the prognosis of serous tumors, like any neoplasm, depends on: the degree of differentiation of tumor cells, i.e. which both resemble normal ovarian tissue: a well-differentiated tumor is usually benign and resembles normal ovarian tissue. A tumor with poorly differentiated cells is usually malignant and has no resemblance to the normal ovarian cells that have sprung up of it. A tumor with moderately differentiated cells looks in some respects like normal local cells, but is usually largely malignant. Tumor degree to other structures: Especially with malignant serous, the presence of progress to other abdominal tissues is important for determining the patient's prognosis. The five-year survival range of malignancies or suspected ovaries is only close to 70% and 100% respectively. If peritoneum affects, survival drops to 25% and 90% respectively. Although 5-year survival has a very high degree of success in suspicious tumors, this does not indicate treatment because they often appear after a few years. The mucous tumor is similar in some respects to serous tumors, although they are less common, taking 25% of all ovarian neoplas. They occur mainly in adult women, being very rare before puberty and after menopause. Only 15% are malignant, among which cystic adenocarcinomas are relatively rare (about 10% of cases). They are characterized by a cystic appearance of variable size, rarely occupying the surface of the ovary, as serous do. Rarely they are bilateral (only 5% of cases), they occupy the largest masses, with an extreme weight of more than 25 kg. Tumors are filled with sticky or gelatinous content. The pathology of benign mucous tumors is characterized by high-polar epithelial cells with atypical mucin and not hairy, very similar to epithelial cells in the cervix or intestines. Mucous malignancies contain stronger patterns with malignant characteristics, i.e. cellular atilium and stratification, loss of normal tissue architecture and necrosis. They can resemble colon cancer and usually invade the ovarian structure, which distinguishes it from benign and suspicious tumors. 10-Year Survival Forecast for Suspected Tumors only in the ovaries non-invasive malignancies and invasive malignancies more than 95%, 90% and 66% respectively. Because mucous tumors are usually one-sided (one affected ovaries) cases of bilateral mucinous tumors require the exclusion of non-ovarian tumors. Endometrioid tumors of endometrioid tumors occupy 20% of ovarian cancer and mostly malignant (endometrioid carcinomas). They are produced by tubular glands, which are very similar to normal or malignant endometriums. 15-30% of endometrial cancers occur in people with endometrial cancer, and these patients take the best prognosis. They resemble other epithelial tumors, with solid and cystic areas. 40% of these tumors are bilateral, in which case metastases are common. The pathology of the glands bear a strong resemblance to the endometrium glands. Benign tumors, seemingly mature glands are surrounded by fibrous stromal. Suspicious tumors have a complex pattern of consequences that invade the strobe. Malignant tumors have invasive glands topped by atypical cells and with frequent ongoing mitosis. With less differentiation, the tumor becomes firm. Prediction once again, the prognosis depends on the degree of tumor invasion, as well as the degree of differentiation of the cells that make up it. The overall prognosis is somewhat worse than serous and mucous tumors, with a 5-year survival rate with tumors limited to ovaries by about 75%. Pure cell tumors These tumors are characterized by large epithelial cells with clear and abundant cytoplasm and are often associated with endometriosis or ovarian endometriid carcinoma and with a great resemblance to clear endometrial carcinoma. They can be predominantly hard or cystic if solid, clean cells are usually arranged in sheets or tubulations. In the cystic variety, neoplastic cells confroman the shell of a cyst. Prognosis These tumors are usually aggressive with 65% survival in cases where the tumor has not left the ovary. If the tumor has invaded other tissues, the prognosis is frankly worse. Brenner Brenner's tumors are rare, with epithelial cells of transition type characterizing each other's tumors. That's why they look like bladder epithelium. These tumors can vary in size, they can be solid or cystic. The gisto logically tumor consists of transient cell nests in the surrounding tissues, very similar to normal ovaries. Brenner's tumors can be both benign and malignant depending on the number intrusion of surrounding tissues. Kumar Links: Robbins and Cotran: Pathological Basis of the Disease, 7th ed. The bibliography of Kumar, et al., ed. Robbins and Cotran Pathological Foundation disease, 7th edition, Elsevier-Saunders, 2005. Brownwald, et al. Harrison Principles of Internal Medicine, 15th edition, McGraw-Hill, 2001. Haber, et al, Differential Diagnosis in Surgical Pathology, Saunders, 2002. External References Epithelial Ovarian Cancer: Treatment (PD®) National Cancer Institute Data: No 7645976 Received from AUTHOR: Dr. Josep Ma. each woman has two ovaries on either side of the uterus. The ovary is an organ, therefore, intrapelvic (located in the pelvis), in the form of almonds and the maximum length is 2 to 4 centimeters. The ovaries play two important functions that are: Production of female gamete (oocyte). Each month, during ovulation, the ovary releases an egg that passes through a tube (a small tube that transmits the ovary with the uterus) to the uterus. Secretion of female hormones. The ovary is the main source of estrogen and progesterone, which are female hormones involved in various processes such as menstrual cycle regulation, pregnancy, and breast growth among others. During menopause, the ovaries stop producing eggs and female hormones. There are three types of ovarian cancer: epithelial carcinoma, germ cell tumors, stromal tumors. Epithelial carcinoma: represents 85-90% of ovarian cancer and will be the one we are talking about moving forward. Tumors of germ cells. Very rare stromal tumors. Even more often. Epithelial cancer is the leading cause of gynecocomological cancer mortality. This is due to the fact that, as we will see later, the majority of patients (70-80%) diagnosed at an early stage of the disease. Worldwide, it accounts for 3% of tumors in women and is the fourth leading cause of cancer death in women after lung, breast and colon cancer. The high mortality rate from ovarian cancer is due to two reasons: the lack of specific symptoms at the beginning, which motivates most patients to present the majority of patients with a scattered disease when diagnosed (which is harder to cure), and the lack of effective and proven screening methods. There are geographical differences in the incidence of the disease, which is more common in industrialized countries. In terms of age of representation, ovarian cancer is a more common disease in postmenopausal women, with the highest incidence between the ages of 50 and 75 (on average 63). The causes and risk factors Cause ovarian cancer remains unknown. Ovarian cancer, like other malignancies, occurs as a result of the accumulation of genetic changes that cause uncontrolled growth and spread of epithelial cells, but the mechanism (s) that cause such changes remain unknown. Several epidemiological studies have identified some factors that may increase the risk of disease: There are some studies that show that a diet high in fat and exposure to talc are risk factors, but there is no conclusive research. Instead, the link between ovarian cancer and certain hormonal factors and factors associated with reproduction is known. Thus, women who have not had children have an increased risk of developing the disease. In contrast, the risk of ovarian cancer is reduced in women who have used oral contraceptives. About 20% of ovarian cancers are inherited, most commonly associated with mutations of the BRCA 1 and BRCA 2 genes. These genes are part of a group of tumor genes and contain information for the production of proteins involved in DNA repair and therefore in the full maintenance of the genome. Other genes involved seem to exist, to a greater or lesser extent, and the role they play in the development of ovarian cancer is still considered uncertain. It is important to note that not all women with BRCA mutations will develop ovarian or breast cancer. There is also evidence that patients carrying these mutations have better survival. Among the reasons is the fact that they are women with more control and that they can be diagnosed at the electronic senior stage of the disease. The criteria for clinical diagnosis of hereditary breast cancer of the Working Group of the Spanish Society of Medical Oncology are: the case of breast cancer is less or equal to 40 years. Diagnosis of breast and ovarian cancer in the same patient. Two or more cases of breast cancer, one of which is bilateral or under the age of 50. Breast cancer cases in women under the age of 50 or bilateral, as well as cases of ovarian cancer in relatives of the first or second degree. Three cases of breast and ovarian cancer (at least 1 case of ovarian cancer) in relatives of the first or second degree. Two cases of ovarian cancer in relatives of the first or second degree. A case of breast cancer in men and at least 1 family member of the first or second degree with breast or ovarian cancer. We encourage you to contact an oncologist or the Genetic Counseling Department if you meet any of the criteria Signs and symptoms usually in the early stages of ovarian cancer usually occur without symptoms, or with very mild symptoms that go unnoticed and confused with benign processes. In the abdominal cavity the tumor can grow and spread silently, so when it causes symptoms, it usually already spreads. Even the early symptoms in the later stages are usually rather vague in the form of non-specific abdominal discomfort, so they are often ignored or confused with benign processes such as dyspepsia or gases. Therefore, ovarian cancer is difficult to diagnose in the early stages, and this is the main cause of its high mortality. As the tumor grows some symptoms such as loss of appetite, feeling full after eating (even if it is modest), or weight loss may begin to appear. In general, fluid usually accumulates in the abdominal cavity causing what we call ascites, which can be very important, and cause bloating. In addition, fluid can accumulate in the pleura around the lungs and cause shortness of breath or shortness of breath. On the other hand, the increase in ovarian mass in the pelvis can affect neighboring structures, mainly the bladder and rectum causing symptoms such as frequent diuretic, diarrhea or constipation, and abdominal or pelvic pain. Table 1 lists some of the symptoms that should motivate a doctor's appointment, especially without persistent and/or unusual: Table 1. Symptoms that should motivate you to see your doctor to start studying and progressive bloating. There is also a constant feeling of fullness with food, even in small amounts. - discomfort in the pelvis and/or abdominal cavity, which persists and has no logical explanation. Discomfort in urination and/or deposition that persist and are not explained by other causes. Inappropriate vaginal bleeding. Diagnosis Of suspected ovarian cancer, the first thing that needs to be done for the patient is a general assessment consisting of: A complete medical history and a thorough physical examination with a pelvic examination and gynecological examination performed by a gynecologist. Blood tests and chest x-rays are also usually done. Other tests that need to be issued are radiological scans, i.e. image tests. The radiological scans that are usually performed are: Gynecological ultrasound: it involves the introduction of a vaginal ultrasound probe. This allows you to accurately identify the ovaries and detect ovarian tumors, as well as the presence of free fluid in the pelvic cavity. This test is necessary. Computerized axial tomography and the pelvis: CT gives us abundant information about the size and location of the tumor in the pelvis, the presence of regional lymph nodes involved, the presence of ascites (free fluid in the abdominal cavity) and the presence of visceral metastases in the spleen or liver (which are usually rare in this disease). CT can also detect abdominal implants (tumor implants in the abdominal cavity), which are very common in ovarian cancer. However, CT will usually not detect implants less than 1-2 centimeters, so there are often more diseases in the later stages than CT detects. CT image of the tumor magnetic resonance imaging of the right ovary (MRI): This is usually not an ordinary test. It may be more useful than CT to detect pelvic infiltration (such as bladder or rectum) tumors. It is rare to have an MRI. PET-TAK: PET-TAK is tested to determine the extent

of the disease after being diagnosed with ovarian cancer. Sometimes you can give more information before deciding on treatment. Cystoscopy is sometimes performed to find out if your bladder or rectoscopy has penetrated to see if your rectum has penetrated before planning surgery. The CA 125 tumor marker should also be quantaed. This test consists of a blood test that measures the protein in the patient's serum, as it usually increases in patients with ovarian cancer. However, there are patients who do not have CA 125 height, and in addition, it can also be increased in benign diseases that occur with ascites (fluid in the abdominal cavity) or abdominal inflammation. The main usefulness of this test is to monitor diseases, as there is usually a correlation between the level of 125 CA and the activity of diseases. In every patient clinically diagnosed with an ovarian tumor, laparotomy should be performed for biopsy consumption, as this is a test that will serve us to perform both the final diagnosis and staging of the disease. Laparotomy may be preceded by a laparoscopy by a researcher to better determine the best options for surgery. The final diagnosis of ovarian cancer is established by your pathological anatomy doctor after microscopy of an ovarian tumor or implant sent to you by your surgeon. More than 90% of ovarian cancers have epithelial origin, and we will develop treatment later on them. There are several subtypes of epithelial ovarian cancer called Seroso Undifferentiated Mucinous Clear Cells In turn, depending on the degree of differentiation classified in: Well differentiated or class 1 moderately differentiated or class 2 Poorly differentiated or Class 3 Degree of differentiation determined by the appearance of cells, those with more mature appearance with the formation of glandular structures are well differentiated, while the most aggressive and less differentiated promising cells are those of high degree or grade 3. Image of serous papillary ovarian carcinoma. Provided by the Pathology Anatomy Service of the Ramon Hospital y Cajal Although this classification is one that is widely used, today we know that each of the subgroups is also determined by different models of gene expression. Serous tumors are the most common (70%) and among them high-quality (also classified as type 1) have different molecular characteristics than low-grade (type 2), with therapeutic effects. Probably, today we know that in the gray-papillary type of high degree we find different subtypes: mesenchymal, differentiated, immunoreactive and proliferative, taking into account its different expression of genes. Palmirotta R, et al. Crete Rev Oncol Gematol. 2017;117: 12-29. Staging the First Surgery of Ovarian Cancer: Diagnostic and Staged Laparotomy In the Face of Clinical Suspicion of Ovarian Cancer, the first diagnostic and therapeutic maneuver should consist of laparotomy (surgical opening of the abdominal cavity) for diagnostic, staged and therapeutic purposes. However, previous laparoscopy may sometimes be recommended to determine if a recommended surgery is possible, as well as to allow for an appropriate biopsy. The final diagnosis of ovarian cancer requires histopathological analysis (by pathological anatomy service) of ovarian tumors. In addition, unlike other tumors, staging (determining the extent of the disease) of ovarian cancer is surgical, as direct imaging of the entire abdominal cavity is required. Such scans should be performed by a gynaecologist who has experienced ovarian cancer. The staging of laparotomy of intervention is a complex intervention in which a thorough examination of the abdominal and pelvic cavity, as well as lymph nodes, must be performed in order to determine the exact extent of the disease. After this first approximation, the gynaecologist usually removes the ovary or tissue sample, so that the pathologist (a doctor specializing in pathological anatomy) makes the first diagnosis during the intervention (diagnosis If the pathologist confirms that it is ovarian cancer, the gynaecologist will continue the operation, as the initial treatment for ovarian cancer is surgical. Stages, as in other tumors, ovarian cancer is classified in several stages depending on the degree of the disease (table 2). The most important predictive factor is the stage of the disease (its degree of enlargement). Thus, patients with tumors in the early stages (stages I and II) have a higher survival rate than patients with late tumors (stages III and IV), and a lower likelihood of recurrence after treatment (table 3). Table 2: Surgical staging of ovarian cancer (FIGO stages) I Tumor limited to ovarian IA Tumor limited to ovaries or fallopian tubes, no ascites, no implants on the surface of the ovary and with ovarian capsules intact. Tumor IB is limited as ovaries or tubes, without ascites, without implants on the surface of the ovary and with ovarian capsules intact. The IC tumor is limited to one or both ovaries or tubes, with one of the following: IC1: Surgical spread. IC2: The capsule is broken either with implants on the surface of the ovaries or tubes. IC3: Neoplastic cells in ascites or abdominal flushing. II Tumor affects one or both ovaries with enlargement to oganosa or pelvic structure of primary peritoneal cancer IIA uterine enlargement or fallopian tubes. Expansion of IIB to other pelvic tissues. III Tumor in one or both ovaries or tubes, with implants outside the pelvic and/or in the retroperitoneal pelvic or paraaorthal lymph nodes IIIA1 IIIA2 Tumor involving only retroperitoneatic nodes (historically confirmed). IIIA1i: node size up to 10 mm. IIIA1ii: Size more than 10 mm. Tumor with microscopic implants outside the pelvis (in the abdominal cavity), with or without retroperitoneal ganglion involvement. MACRSCOPIC tumor IIIB with implants 2 cm or less outside the pelvis (in the abdominal cavity), with or without affected retroperitonear nodes. IIIC macroscopic tumor with implants 2 cm or more, outside the pelvis (in the abdominal cavity), with or without affected retroperitonear nodes. Includes enlargement of the liver capsule or spleen. IV The presence of remote metastases. Includes pleural effusion, liver or spleen parenchyma, groin or non-blood-ennemal nodes, invasion of the transmural intestine. VAT: The presence of pleural effusion with neoplastic cells. IVB: Expansion outside the abdominal cavity (except pleural effusion) or in the liver and/or spleen of parenchyma, groin or extra-bdomine nodes, invasion of the transmural intestine. Prognosis Are the two most important predictive stage factors and residual tumor after surgery. Other factors to consider, such as are: younger age, good functional condition, serosoloppilar cell type, well-differentiated tumor, lack of abdominal fluid, presence of BRCA mutation. The overall survival rate of ovarian cancer is close to 50%, however, it varies depending on the various predictive factors mentioned above, the main of which is the expansion of the disease to diagnosis. Table 3 shows the expected 5-year survival of epithelial ovarian cancer depending on the stage. (Cancer statistics should be carefully evaluated. Table 3. Estimated 5-year survival according to FIGO Stage I. Tumor is limited to ovaries 90% Stage II. Tumor has spread to neighboring organs 65-70% stage III and IV. Remote extended tumor treatment 20-30% ovarian cancer treatment involves a combination of surgery with surgical removal of all visible existing tumors and then chemotherapy. The general concept of ovarian cancer treatment is part of a team of specialists consisting mainly of gynaecologists-surgeons and medical oncologists. The treatment of this patient depends on several factors, the most important of which are the degree of prolongation of the disease and the clinical situation of the patient. Treatment of ovarian cancer involves surgical removal of the entire existing, visible tumor. What is known as optimal surgery. After most of the time chemotherapy. The treatment is explained in more detail below, from a theoretical point of view, depending on whether they are in the early or late stages. For a specific case, it is recommended that you talk to your doctor to explain the options for your case. TREATMENT OF INITIAL STAGES When a patient with suspected ovarian cancer intervenes, the gynaecologist finds a mass in the ovary without any signs of the disease scattered all over the abdomen or pelvis, the first thing she performs is the removal of the ovary and directs it to the pathologist. Once confirmed to be ovarian cancer, the surgeon continues the procedure in order to complete the staging of the disease to know in detail whether the disease was able to spread beyond the ovary. This staged process is performed by a surgical protocol that includes the following: removal of other ovaries and uteruses. Removing some of the fat in front of the intestines (oment). Taking samples (biopsies) in several abdominal cavity and in any suspicious area. Taking lymph node biopsies. Pathological analysis of all these samples will determine the final staging of the disease (see table 2). At most stage I patients (the tumor is limited to the ovaries), surgery gets the disease cured. However, there are 20-30% of patients who have had a recurrence of the disease and who could theoretically benefit from complementary treatments. Factors that have been associated with an increased risk of relapse are: Histological degree: Patients with grade 3 tumors have a lower survival rate than class 1 patients. Stage: survival 5 years after surgery without additional treatment is more than 90% at the IA-IB stages and is about 70-80% at the IR stages. Tear the capsule of the ovaries, either during or before surgery. Based on these predictive factors, patients were divided into two large groups (table 4): 1) low-risk patients who have survival of 5 years more than 90% and do not require additional treatment after surgery, and 2) high-risk patients who are the ones who are most likely to relapse in 5 years (risk of relapse 20-40%) and may benefit from additional treatment. Table 4. Risk groups in the initial ovarian cancer UNDER HIGH RISK IA-IB Class 1 Class 2-3 IC-II Clear Cells No Signs of Additional Chemotherapy IF indication of additional chemotherapy there are data from clinical trials showing that the introduction of cisplatin-based or carboplatin-based chemotherapy increases the survival rate of women working in early stages of ovarian cancer who have some poor prognosis factor. The best chemotherapy regimen in this situation and the optimal number of cycles are not defined. A scheme containing carboplatin or cisplatin should be used and at least 3-4 cycles are injected. The most commonly used method of treatment is paclitaxel and carboplatin. Finally, to avoid relapse and increase survival, most patients are often treated additionally with chemotherapy based on paklitaxel and carboplatin. Only in patients with very early stage low-grade tumors IA-IB (class 1) is recommended exclusively for follow-up, as the operation itself is almost curative. TREATMENT OF ADVANCED STAGES Extended Stage Surgery What a gynaecologist usually finds when opening the abdominal cavity in patients with late stages, is that the tumor has spread beyond the ovaries and has several implants of different sizes in the cavity And the pelvis. In these patients, in addition to the surgical procedure performed in the early stages (removal of the uterus, ovaries and fat before the bowel-ommentectomy), should be removed as much visible tumor as possible. The goal is to try to remove all visible tumors, as it is known that patients with no macroscopically visible tumor are left with more survival than those in which the residual tumor remains. This type of surgery is called cytoreafior and, unlike other malignancies, there is a correlation between the quality of surgery and the survival of the patient. When there are no visible residual diseases, it is said that optimal cytoreduction has been achieved, and in these cases an increase in survival options is achieved. Extended stage of chemotherapy depending on the time of the start of chemotherapy due to surgery, two therapeutic options are derived: Neoadjuvant Chemotherapy It determines that chemotherapy treatment is performed before surgery. It should be considered only in those patients at very late stages with a very bulky or extensive tumor, in which the surgeon already foresees the impossibility of obtaining optimal surgery (without a residual tumor). Treatment regimens and drugs, these are the same as in the case of adjuvant chemotherapy, discussed below. Usually three or four procedures are performed. Neoadjuvant chemotherapy is designed to achieve tumor reduction, enough for the surgery to be performed, with larger options to achieve optimal cytorudulation. Surgery performed after neoadjuvant chemotherapy is called interval surgery. Adjuvant chemotherapy Current and mostly used standard treatment is a combination of paclitaxel and carboplatin, administered intravenously every 21 days for 6 cycles. Paclitaxel can also be provided on a weekly schedule. However, we call this scheme dense doses. It has not been proven to exceed standard treatment. The most common side effects of the combination of paclitaxel and carboplatin are: nausea and vomiting. Alopecia. Falling white blood cells (leukopenia), platelets (thrombopenes) and red blood cells (anemia), which rarely cause episodes of fever from reduced protection or bleeding from platelets descent. Sensitive neuropathy consisting of sensitive changes in the legs and hands using gloves and sock distribution is characterized: tingling, lacing, pain, loss of sensitivity ... 2-5 days after the introduction of paclitaxel and is usually resolved spontaneously for 3-4 days. Intraperitoneal chemotherapy intraperitoneal chemotherapy involves chemotherapy directly in the abdominal cavity through a catheter. This type of treatment is based on several principles: ovarian cancer is a disease limited by the abdominal cavity almost throughout its evolution. Drugs injected directly into the abdominal cavity, achieve a much higher concentration inside the cavity than with intravenous administration. There is a link between the dose of chemotherapy and the reaction in ovarian cancer. Intraperitoneal chemotherapy takes place in a few millimeters in the tumor, so this procedure can only be used in patients with ovarian cancer progress, where full cytorduction (leaving no tumor residue) or residual implants less than 10 mm is achieved. Restrictions on intra-peritoneal chemotherapy are largely associated with complications associated with catheter and procedure: obstruction of the flow or poor distribution of treatment. Infection: peritonitis, abdominal wall or catheter. Intestinal perforation. There are data from comparative clinical trials showing increased survival with intra-peritoneal chemotherapy compared to intravenous in patients with ovarian cancer progress after complete cytorduction (leaving no tumor residue) or with residual implants less than 10 mm). The scheme, which showed a clearer advantage consists of paclitaxel injected for one day intravenously, cisplatin is administered intraperitoneally on the second day and paclitaxel is administered intraperitoneally on day 8o, repeating cycles every 21 days. These studies have also shown that intra-peritoneal chemotherapy regimens are now significantly more toxic than intravenous regimens. This only makes patients who have a good overall clinical situation that allows them to endure treatment to be candidates for this treatment system. In fact, with the aforementioned scheme, only 40% of patients can complete 6 procedures. The rest should be left early due to side effects. Side effects that are most common in intraperitoneal chemotherapy include: leukopenia, nausea and vomiting, abdominal pain, infections, fatigue, peripheral neuropathy, kidneys and metabolic disorders. Currently, intra-peritoneal chemotherapy is considered a standard option in patients with optimal cytorudulation due to the increased survival rate shown. It's an alternative that should be specialized centers for patients with good general condition and adequate surgery. Additional treatments associated with standard chemotherapy antiangigenic treatment for antiangigenic treatment include the introduction of drugs that block the development of blood vessels that the tumor needs to develop and spread. The only approved antiangiogenic drug in ovarian cancer is bevacizumab for use in connection with chemotherapy in patients with advanced epithelial ovarian cancer. or approval in the initial treatment is recommended for patients with the worst prognosis (stages IV, or in cases with residual disease after surgery. Bevacizumab is a monoclonal antibody that blocks the growth factor of vascular endothelial (VEGF) and is administered intravenously every 21 days. Its combination with chemotherapy (paklitaxel and carboplatin) and then the treatment period bevacizumab itself for several months in patients with the progress of ovarian cancer showed a moderate increase in the period of time with the controlled disease. The main side effects associated with bevacizumab are hypertension and proteinuria (loss of urine proteins). Other serious but fortunately rare effects are thrombosis, bleeding, intestinal perforations or fistulas. PARP inhibitors have in recent years developed new drugs called PARP inhibitors, especially for those patients with ovarian cancer who have changes in so-called DNA repair roads. These changes occur especially in women carrying mutations in the BRCA genes. Approximately 20% of ovarian cancer patients have these mutations, but an additional 20-30% have some changes in the way DNA is repaired. PARP inhibitors are particularly active in both the first and second. There are three approved drugs: Olaparib, Niraparib and Rucaparib, but for the moment approval is limited to patients who have recurrences of their disease. However, the excellent results of recent studies of this type of drugs related to initial chemotherapy make anticipates of upcoming approval in our country for the first line of treatment after surgery. (Olaparib has been approved by the European Medicines Agency (EMA). 70% of ovarian cancer patients are diagnosed in late stages (stages III and IV. Despite adequate initial treatment and the effectiveness of the drug, a large number of patients (50 to 90%) are diagnosed. have relapses. Is it patients to have multiple insasures and therefore require different treatments for each one. In most patients, relapse treatment is again based on chemotherapy related, if possible, with bevacizumab or PARP inhibitors. The aim of the treatment is to prolong patient survival, improve the symptoms they can present, and maintain quality of life. Rescue surgery can also occur in individual patients (those with relapse in multiple places and/or later, and with a good overall clinical situation). There are several drugs and combinations of drugs that have been shown to be useful in treating relapse in patients with ovarian cancer. The choice of a treatment is based on various clinical criteria, among which it is worth noting: the presence or presence of BRCA mutations. Reaction to pre-treatment with chemotherapy. The time interval from the end of such treatment, taking into account how much and the type of procedures received (platinum, non-paid, biological and type). Residual toxicity of pre-treatment. The patient's situation. The physical condition of the patient. The likelihood of a reaction to the second or further line of treatment in relapses depends on the above factors mentioned above. Patients who initially responded to platinum and enjoyed untreated intervals of more than 6-12 months are more likely to respond to reintroduction combinations with platinum, in the absence of toxicity or intolerance. In addition, there are options without platinum. The schemes that currently have the greatest scientific approval (derived from comparative clinical studies) are: paclitaxel-carboplatin, carboplatin-gemcitabine and pegilized liposuction carboplatin-doxorubicin. In contrast, the reintroduction of platinum in patients with early relapses gives few answers, and then it is necessary to choose other drugs or recommend participation in some clinical trials. It is logical that in this group of patients the main goal of treatment is to control the symptoms associated with the disease, trying not to worsen their quality side effects of treatment. Treatment Bevacizumab in relapse In addition to the approval in the first line of treatment, as indicated in the previous section, Bevacizumab is included in the relapse treatment, as the end (platinum sensitive) or early (platinum sustained) relapse situation. In both cases combined with chemotherapy. Bevacizumab in combination with chemotherapy receives a larger and longer response, compared to chemotherapy alone. Your recommendation may exclude some patients are not eligible to use, according to the criteria, followed for approval. In patients with recurrence of the disease and who again respond to platinum treatment and who are carriers of mutations in the genes BRCA1 and BRCA2 (20%) or there are any mutations in this way, a great advantage is observed in the treatment of PARP inhibitors. Currently, three drugs are approved for patients with relapses that support platinum sensitivity: Olaparib, Niraparib and Rucaparib. All of them receive as supportive treatment after responding to platinum chemotherapy. Its level of effectiveness is very similar and has some side effects. There may also be small differences between them, depending on the mutation characteristics of patients. Clinical trials of ovarian cancer Overall results of current ovarian cancer treatment are not fully satisfactory, either because it is diagnosed at an advanced stage or because treatment is effective, sometimes limited. Clinical trials, with new drugs, explore new treatments or therapeutic strategies in order to increase the rate of healing. Clinical trials developed by people who are experts in the treatment of ovarian cancer are conducted through strict protocol under the supervision of a qualified team and require the permission of health authorities and ethics committees. The latest supplement already available in our country was PARP inhibitors. In the study phase, other molecules are found, such as those that are associated with immunotherapy. In addition, in an advanced phase, various combinations of antianggiogenics with PARP inhibitors and the latter with immunotherapy are being investigated. Through clinical trials, we know which of the new drugs that appear actually serve to improve the survival of ovarian cancer patients. Ovarian. cancer de ovario epitelial seroso. cancer de ovario epitelial y germinal. cancer de ovario epitelial tipos. cancer de ovario epitelial mas frecuente. cancer de ovario epitelial sintomas. cancer de ovario epitelial slideshare. cancer de ovario epitelial que es. cancer de ovario epitelial pdf