



Patient Information

Surgery for Borderline Ovarian Tumour

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This fact sheet is for women diagnosed with a borderline ovarian tumour, sometimes called a tumour of low malignant potential or borderline ovarian cancer

It describes the best care for the small group of women who have more difficult cases of BOT (Borderline Ovarian Tumour).

Patient Information sheet

Borderline ovarian tumour is a condition in which abnormal cells form in the tissue covering the ovary. Their growth is much more controlled, and they are usually not able to spread. These tumours are usually found in early stage. However, even advanced stage borderline ovarian tumours are treated successfully.

This means that for women who have had surgery to remove early disease, the risk of it coming back is very small at less than 5% per cent

More difficult cases

There are three situations which can cause greater concern or uncertainty.

1. Borderline ovarian tumours which have spread beyond the ovary.
2. Mucinous borderline tumours involving the ovary, when tests suggest these could originate from a tumour in the appendix.
3. Stage1 borderline ovarian tumours in young women treated with limited surgery to keep an ovary. There could be an increased risk of the disease coming back in the ovary you have kept.



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Borderline ovarian tumours which have spread beyond the ovary

A small number of women with BOT (Borderline Ovarian Tumour) have disease which has spread, in the form of little seedlings, onto the peritoneal membrane covering other organs in the abdomen.

Surface seedlings

Most of these seedlings do not invade the underlying tissue, but are just sitting on the surface. They are sometimes referred to as “non-invasive implants”. It is rare for them to cause problems, even if they stay after surgery.

Most women with BOT (Borderline Ovarian Tumour) who have surface seedlings/non-invasive implants to the peritoneum (stage 2 or 3) have no other problems, and no treatment (such as chemotherapy or radiotherapy) is known to reduce the risk of problems.

At present, the best care involves regular follow-ups to check that these remaining seedlings have not grown.

Invasive implants

In a very small number of women the surface seedlings of BOT (Borderline Ovarian Tumour) show a tendency to invade the tissues. This behaviour is more like conventional ovarian cancer, suggesting more chance of a tumour growing in the future. For women with seedlings that have demonstrated an ability to invade the tissues the outlook is still generally much better than for women diagnosed with the equivalent stage of ordinary ovarian cancer, as the tumour still does not necessarily behave as cancer does. There is a question about treating women with invasive seedlings of BOT with chemotherapy immediately or waiting until there is definite evidence of the condition getting worse. Close observation and repeated scans often show that the condition hardly changes over time. This means that you may not need chemotherapy in the long term.

It is important to be aware of the limits of chemotherapy in treating stage 3 BOT (Borderline Ovarian Tumour) with invasive seedlings. The chance of there being a benefit is quite low, and the disease cannot be completely removed. This means it is reasonable to be cautious with chemotherapy and put off using it until it is needed.

Repeated surgery can be valuable in certain cases. Samples of tumours taken during an operation may show a change in how the tumour is behaving.



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Stage 1 borderline ovarian tumours in young women treated with limited surgery

If you are a young woman with a borderline ovarian tumour, you may want to keep an ovary so you can have children. In this situation, a surgeon may remove the affected ovary, but leave the apparently normal ovary and uterus (womb). The surgeon must examine the abdomen carefully, to check if any cancer has spread.

In about 20% per cent of these cases, the tumour comes back in the ovary that is left.

This means you need regular check-ups after surgery. Follow-ups include ultrasound examinations every six months for about two years, then yearly. Later it may be appropriate for women who have had their family to have the remaining ovary removed. This removes the risk of problems in the future.

Mucinous borderline ovarian tumours

Most borderline ovarian tumours are classified as 'serous' from their appearance under the microscope.

A smaller number have a different appearance and are called 'mucinous'. Sometimes a small, undetected mucinous tumour can develop in the appendix, and spread to the ovary. This can give the appearance of a primary ovarian tumour, when in fact it is a secondary tumour.

It is important to consider this possibility in all cases of mucinous borderline ovarian cancer, so that a separate appendix tumour is not left behind at surgery.

Surgery

The type of surgery depends on the size and spread of the tumour and the woman's plans for having children.

Surgery may include the following:

Surgery to remove one ovary and one fallopian tube if fertility is desired (**unilateral salpingo-oophorectomy**)

Surgery to remove both ovaries and both fallopian tubes (**bilateral salpingo-oophorectomy**)

Total hysterectomy (removing the womb and cervix) and removing both ovaries and tubes.

Surgery to remove part of one ovary or part of both ovaries (**Partial oophorectomy**)

Surgery to remove the omentum (the fat 'apron' in the abdomen) **Omentectomy**



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Alternative procedures:

Fertility sparing options

In certain cases it may be possible to preserve fertility, where the borderline tumour affects one ovary; removal of the affected ovary may be an option.

It may be recommended for you to have the other ovary removed with a hysterectomy at a later date after completing your family. The loss of fertility can have a huge emotional impact but reactions to this are very individual. You may feel the need to explore all the issues and any other options that may be available to you.

Risks and Complications

There are **risks and complications** associated with any major abdominal surgery.

It is important to realise that these risks and complications are rare. These will be discussed with you before your operation. The operation is carried out under general anaesthetic and the anaesthetist will visit you before your operation and discuss the anaesthetic with you.

You will have some blood loss at the time of your operation and blood transfusion is sometimes required in about one in five operations. Rarely, there may be internal bleeding after the operation, making a second operation necessary. As with any major operation involving the pelvic organs there is a small risk of injury to bladder or ureter, this is about three in 100, or injury to bowel one in 100. If this occurs the injury will be repaired. Also there is a small risk of developing an infection which may be in the chest (three in 100) wound (five in 100), pelvis (four in 100) or urine (ten in 100). To reduce this risk you will be given an antibiotic just before the start of the operation.

Occasionally patients may suffer from blood clots in the vein of the leg or the pelvis, rarely this can lead to a blood clot in the lungs. Moving around as soon as possible after your operation can help prevent this. The physiotherapist will visit you before and after your operation to give advice and to help with your mobility. To reduce the risk of blood clots you will also be given injections to thin your blood during your stay in hospital. With any type of operation there is a very small risk of death.

After your operation

Following surgery you may feel sleepy; this will allow you to rest and recover. It is important to tell a member of the nursing staff if you have pain or sickness.



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Pain control after surgery

You may be offered an epidural to relieve pain after surgery; an epidural is a type of anaesthetic. It does not make you drowsy but it controls the pain in your abdomen (stomach), pelvis and legs.

You will also be given medication to relieve the pain after your operation; this usually starts after stopping the epidural. You may also have a PCA (patient controlled analgesia) device where you control the amount of pain relief according to your needs.

You may also have a drain (tube) in your wound. This is so that any blood or fluid that collects in the abdomen can drain away safely and will help to prevent swelling. The tube will be removed when it is no longer draining any fluid, which can take several days.

A catheter (tube) will be inside your bladder to drain urine away and allow your bladder to rest. The catheter will need to stay in until you are taking oral fluids adequately and you are able to walk to the toilet (usually one to two days). If there has been difficulty with the operation, this may need to stay longer.

You may also have trouble opening your bowels or have some discomfort due to wind for the first few days after the operation. Mobility is encouraged as this helps with wind pain. This is temporary and we can give you medication if required.

Recovery

You may be in hospital for up to eight days; this will depend on your individual needs. Your Doctor will discuss the final results with you when they are available usually seven to ten days after your operation. You may come back to clinic to discuss further treatment options.

It can take up to three months to fully recover from your operation, sometimes longer. The ward staff will give you further information about your recovery prior to discharge from the ward.

Follow up

You will be given a follow up appointment before you leave the hospital. If you had removal of only one tube and ovary you will have regular follow ups with transvaginal scans, blood tests and clinical examinations. Further surgery may be considered once you complete your family.



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Emotions

We recognise that having surgery can be a very emotional time for both you and your family. If you need to talk about how you feel both the Medical team and the Nurse Specialists are available to discuss any concerns you may have.

Gynaecology/Oncology Clinical Nurse Specialists

Tel: 01793 604352 (Monday – Thursday 9.00 – 17.00 Wednesday 9.30 – 16.00)

From 1st January 2019 smoking will not be permitted on any NHS site in England. Smoking will not be permitted within any of our buildings or anywhere outside on our sites. Smoking facilities will not be provided. Please be considerate of others when vaping in hospital grounds

This information sheet is available to order in other languages and formats. If you would like a copy, please contact us on 01793 604031 or email gwh.pals@nhs.net

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