

# Ovarian cancer

Quality standard

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[nice.org.uk/guidance/qs18](https://www.nice.org.uk/guidance/qs18)

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This standard is based on CG122, TA55, TA91 and TA222.

This standard should be read in conjunction with QS13, QS15 and QS124.

## Introduction and overview

This quality standard covers the recognition and initial management of ovarian cancer. For more information see the [scope](#) for this quality standard.

### *Introduction*

Ovarian cancer is the leading cause of death from gynaecological cancer in the UK, and its incidence is rising. It is the fifth most common cancer in women in England and Wales. It mostly affects women over the age of 50, but it can occur in younger women. There were more than 5500 new cases of ovarian cancer diagnosed in England in 2009. The outcome for women with ovarian cancer is generally poor, with an overall 5-year survival rate of less than 35%. This is because most women who have ovarian cancer present with advanced disease despite experiencing symptoms for, on average, 12 months.

The symptoms of ovarian cancer can be vague and similar to those associated with other conditions. However, there are a number of symptoms that do suggest ovarian cancer if they are experienced frequently and/or last a long time. Most women with ovarian cancer are treated with a combination of surgery and chemotherapy.

There is a need for greater awareness of the disease and also for initial investigations in primary and secondary care that enable earlier referral and optimum treatment.

This quality standard describes markers of high-quality, cost-effective care that, when delivered collectively, should contribute to improving the effectiveness, safety and experience of care for people with ovarian cancer in the following ways:

- Preventing people from dying prematurely.
- Enhancing quality of life for people with long-term conditions.
- Helping people to recover from episodes of ill health or following injury.
- Ensuring that people have a positive experience of care.

- Treating and caring for people in a safe environment and protecting them from avoidable harm.

The NHS Outcomes Framework 2011/12 is available from [www.dh.gov.uk](http://www.dh.gov.uk)

## *Overview*

The quality standard for ovarian cancer requires that services should be commissioned from and coordinated across all relevant agencies encompassing the diagnostic and initial management aspects of the ovarian cancer care pathway. An integrated approach to provision of services is fundamental to the delivery of high quality care to women with ovarian cancer.

## List of quality statements

Statement 1. Women aged 50 years or over reporting one or more symptoms occurring persistently or frequently that suggest ovarian cancer are offered a CA125 test.

Statement 2. Women with raised CA125 have an ultrasound of their abdomen and pelvis within 2 weeks of receiving the CA125 test results.

Statement 3. Women with normal CA125, or raised CA125 but normal ultrasound, with no confirmed diagnosis but continuing symptoms, are reassessed by their GP within 1 month.

Statement 4. Women with a risk of malignancy (RMI I) score of 250 or greater are referred to a specialist gynaecological cancer multidisciplinary team.

Statement 5. Women who are offered staging for ovarian cancer, following ultrasound, are offered computed tomography (CT) of the abdomen and pelvis as the initial staging investigation.

Statement 6. Women who have computed tomography (CT) for staging of ovarian cancer, have the results reported by a radiologist who is a core member of the specialist gynaecological cancer multidisciplinary team.

Statement 7. Women with an indeterminate adnexal mass on ultrasound are offered magnetic resonance imaging (MRI) for further characterisation.

Statement 8. Women with suspected stage I ovarian cancer have optimal surgical staging.

In addition, quality standards that should also be considered when commissioning and providing an ovarian cancer service are listed in [related NICE quality standards](#).

## Quality statement 1: Symptoms and CA125

### *Quality statement*

Women aged 50 years or over reporting one or more symptoms occurring persistently or frequently that suggest ovarian cancer are offered a CA125 test.

### *Quality measure*

**Structure:** Evidence of local arrangements to ensure all women aged 50 years and over reporting one or more symptoms occurring persistently or frequently that suggest ovarian cancer are offered a CA125 test.

**Process:** Proportion of women aged 50 years and over reporting at least one symptom occurring persistently or frequently that suggests ovarian cancer who receive a CA125 test.

Numerator – the number of women in the denominator receiving a CA125 test.

Denominator – the number of women aged 50 years and over reporting at least one symptom occurring persistently or frequently that suggests ovarian cancer.

### *What the quality statement means for each audience*

**Service providers** ensure systems are in place for women aged 50 years or over reporting one or more symptoms occurring persistently or frequently that suggest ovarian cancer to be offered a CA125 test.

**Healthcare professionals** offer a CA125 test to women aged 50 years or over reporting one or more symptoms occurring persistently or frequently that suggest ovarian cancer.

**Commissioners** ensure they commission services that provide CA125 tests for women aged 50 years or over reporting one or more symptoms occurring persistently or frequently that suggest of ovarian cancer.

**Women aged 50 years or over with one or more symptoms associated with ovarian cancer** that occur often (more than 12 times a month) or for a while (over a month) are offered a blood test called a CA125 test. The CA125 test measures the amount of a protein produced by some ovarian cancers in the blood. Symptoms associated with ovarian cancer include feeling 'bloated', loss of



appetite or feeling full quickly, pain in the abdomen or pelvic area, needing to pass urine urgently or more often than usual, and unexplained tiredness, weight loss or changes in bowel habit (for example, constipation or diarrhoea).

### *Source guidance*

[NICE clinical guideline 122](#) recommendations 1.1.1.2, 1.1.1.5, 1.1.2.1 (key priorities for implementation), 1.1.1.3 and 1.2.1.1.

### *Data source*

**Structure:** Local data collection.

**Process:** Local data collection. Contained in [NICE audit support for ovarian cancer](#) (NICE clinical guideline 122): primary care, criteria 2, 3 and 4.

### *Definitions*

The statement applies to women aged 50 years and over. However women under 50 years should be offered the CA125 test if clinically appropriate.

Symptoms suggestive of ovarian cancer include:

- persistent abdominal distension (women often refer to this as 'bloating')
- feeling full and/or loss of appetite
- pelvic or abdominal pain
- increased urinary urgency and/or frequency
- unexplained weight loss
- unexplained fatigue
- unexplained changes in bowel habit or
- symptoms that suggest irritable bowel syndrome if the woman is 50 years or over.

Persistent is defined as at least 1 month.

Frequent is defined as 12 times per month.

### *Equality and diversity considerations*

The statement includes women aged 50 years and over as they have a higher risk of developing ovarian cancer than women aged under 50 years based on the epidemiological profile of the disease. Over 80% of women diagnosed with ovarian cancer are aged over 50 years. The highest age-specific incidence rates are seen for women aged 80–84 years at diagnosis (69 per 100,000), dropping to 64 per 100,000 in women aged 85 and over ([Cancer Research UK](#)). However ovarian cancer can occur in women aged under 50 years, and incidence increases with age, with the highest age-specific incidence rates for women under 50 years occurring in those aged 45–49 years at diagnosis (19 per 100,000). Therefore women under 50 years should be offered the CA125 test if clinically appropriate.

## Quality statement 2: Ultrasound

### *Quality statement*

Women with raised CA125 have an ultrasound of their abdomen and pelvis within 2 weeks of receiving the CA125 test results.

### *Quality measure*

**Structure:** Evidence of local arrangements to ensure all women with raised CA125 have an ultrasound of their abdomen and pelvis within 2 weeks of receiving the CA125 test results.

**Process:** Proportion of women with raised CA125 who have an ultrasound of their abdomen and pelvis within 2 weeks of receiving the CA125 test results.

**Numerator** – the number of women in the denominator who have an ultrasound of their abdomen and pelvis within 2 weeks of receiving the CA125 test results.

**Denominator** – the number of women with raised CA125.

### *What the quality statement means for each audience*

**Service providers** ensure systems are in place for women with raised CA125 to have an ultrasound of their abdomen and pelvis within 2 weeks of receiving the CA125 test results. To meet the 2-week timescale, service providers ensure systems are in place for ultrasounds to be arranged directly from primary care.

**Healthcare professionals** ensure women with raised CA125 have an ultrasound of their abdomen and pelvis within 2 weeks of receiving the CA125 test results.

**Commissioners** ensure they commission services that provide an ultrasound of the abdomen and pelvis within 2 weeks of receiving the test results for women with raised CA125.

**Women with raised CA125 levels** in their blood have an ultrasound scan of their abdomen and pelvis within 2 weeks of receiving the results of their blood test.

## *Source guidance*

[NICE clinical guideline 122](#) recommendations 1.1.2.2 (key priority for implementation) and 1.2.3.1.

The Royal College of Radiologists. [iRefer: Making the best use of clinical radiology: referral guidelines](#) recommendation CA42 diagnosis (US).

## *Data source*

**Structure:** Local data collection.

**Process:** Local data collection. Contained in [NICE audit support for ovarian cancer](#) (NICE clinical guideline 122): primary care, criteria 5.

## *Definitions*

Raised CA125 is defined as 35 IU/ml or greater.

## Quality statement 3: Advice

### *Quality statement*

Women with normal CA125, or raised CA125 but normal ultrasound, with no confirmed diagnosis but continuing symptoms, are reassessed by their GP within 1 month.

### *Quality measure*

**Structure:** Evidence of local arrangements and written clinical protocols to ensure women with normal CA125, or raised CA125 but normal ultrasound, with no confirmed diagnosis but continuing symptoms, are reassessed by their GP within 1 month.

#### **Process:**

a) Proportion of women with normal CA125 and no confirmed diagnosis but continuing symptoms, who are reassessed by their GP within 1 month.

Numerator – the number of women in the denominator who are reassessed by their GP within 1 month.

Denominator – the number of women with normal CA125 and no confirmed diagnosis but continuing symptoms.

b) Proportion of women with raised CA125 but normal ultrasound and no confirmed diagnosis but continuing symptoms, who are reassessed by their GP within 1 month.

Numerator – the number of women in the denominator who are reassessed by their GP within 1 month.

Denominator – the number of women with raised CA125 but normal ultrasound, and no confirmed diagnosis but continuing symptoms.

### *What the quality statement means for each audience*

**Service providers** ensure systems and written clinical protocols are in place for women with normal CA125, or raised CA125 but normal ultrasound, with no confirmed diagnosis but continuing symptoms, to be reassessed by their GP within 1 month.

GPs proactively reassess women who have normal CA125, or raised CA125 but normal ultrasound, with no confirmed diagnosis but continuing symptoms, within 1 month.

Commissioners ensure they commission services that reassess women who have normal CA125, or raised CA125 but normal ultrasound, with no confirmed diagnosis but continuing symptoms, by their GP within 1 month.

Women with normal CA125 results, or raised CA125 but a normal ultrasound scan, with no confirmed diagnosis but continuing symptoms, are reassessed by their GP within 1 month.

### *Source guidance*

NICE clinical guideline 122 recommendations 1.1.2.4 (key priority for implementation) and 1.1.1.4.

### *Data source*

**Structure:** Local data collection.

**Process:** a) and b) Local data collection.

### *Definitions*

Normal CA125 is defined as less than 35 IU/ml.

Raised CA125 is defined as 35 IU/ml or greater.

1 month starts from receipt of the normal CA125 or normal ultrasound result.

Symptoms suggesting ovarian cancer include:

- persistent abdominal distension (women often refer to this as 'bloating')
- feeling full and/or loss of appetite
- pelvic or abdominal pain
- increased urinary urgency and/or frequency
- unexplained weight loss

- fatigue
- changes in bowel habit or
- symptoms that suggest irritable bowel syndrome if the woman is 50 or over.

Non-ovarian cancer reasons for raised CA125 (from the [United Kingdom Collaborative Trial for Ovarian Cancer Screening](#) protocol list):

Physiological conditions:

- ovulation
- pregnancy
- retrograde menstruation.

Benign gynaecological conditions:

- endometriosis
- benign ovarian cysts
- uterine leiomyomata (fibroids).

Other non-malignant disease:

- autoimmune disease (such as Sjogrens syndrome, polyarteritis nodosa, systemic lupus erythematosus)
- sarcoidosis
- benign gastrointestinal diseases (such as colitis, diverticulitis)
- chronic active hepatitis
- cirrhosis
- pericarditis
- pancreatitis (acute and chronic)
- renal disease with serum creatinine greater than 2.0.

Non-ovarian malignant conditions:

- malignant ascites
- disseminated malignancy (such as breast, lung)
- disseminated malignancies from any site involving pleural or peritoneal surfaces
- a proportion of:
  - non-Hodgkin's lymphoma
  - pancreatic cancers
  - cervical cancers
  - endometrial cancers.



## Quality statement 4: Malignancy indices

### *Quality statement*

Women with a risk of malignancy index (RMI I) score of 250 or greater are referred to a specialist gynaecological cancer multidisciplinary team.

### *Quality measure*

**Structure:** Evidence of local arrangements to ensure women with an RMI I score of 250 or greater are referred to a specialist gynaecological cancer multidisciplinary team.

**Process:** Proportion of women with an RMI I score of 250 or greater referred to a specialist gynaecological cancer multidisciplinary team.

**Numerator** – the number of women in the denominator referred to a specialist gynaecological cancer multidisciplinary team.

**Denominator** – the number of women with an RMI I score of 250 or greater.

### *What the quality statement means for each audience*

**Service providers** ensure systems are in place for women with an RMI I score of 250 or greater to be referred to a specialist gynaecological cancer multidisciplinary team.

**Healthcare professionals** ensure women with an RMI I score of 250 or greater are referred to a specialist gynaecological cancer multidisciplinary team.

**Commissioners** ensure they commission services for women with an RMI I score of 250 or greater to be referred to a specialist gynaecological cancer multidisciplinary team.

**Women with suspected ovarian cancer** have their 'risk of malignancy' or RMI I score calculated (using their CA125 and ultrasound results and whether they have had the menopause) to help find out if ovarian cancer is likely. Women with a high RMI I score (250 or more) are referred to a team of healthcare professionals who are experienced in treating women with ovarian cancer, called a specialist gynaecological cancer multidisciplinary team.

## Source guidance

[NICE clinical guideline 122](#) recommendation 1.2.2.1 (key priority for implementation).

## Data source

**Structure:** Local data collection.

**Process:** Local data collection. Also contained in [NICE audit support for ovarian cancer](#) (NICE clinical guideline 122): secondary care, criteria 3.

## Definitions

[NICE clinical guideline 122](#) defines how RMI I should be calculated in appendix D. RMI I combines three pre-surgical features: CA125, menopausal status (M) and ultrasound score (U). The RMI is a product of the ultrasound scan score, the menopausal status and the CA125 level (IU/ml).

$$\text{RMI} = \text{U} \times \text{M} \times \text{CA125}$$

The ultrasound result is scored 1 point for each of the following characteristics: multilocular cysts, solid areas, metastases, ascites and bilateral lesions. U = 0 (for an ultrasound score of 0), U = 1 (for an ultrasound score of 1), U = 3 (for an ultrasound score of 2–5).

The menopausal status is scored as 1 = pre-menopausal and 3 = post-menopausal. The classification of 'post-menopausal' is a woman who has had no period for more than 1 year or a woman over 50 who has had a hysterectomy.

CA125 is measured in IU/ml and can vary between 0 and hundreds or even thousands of units.

Specialist core members of a multidisciplinary team are described in the [National Cancer Peer Review Programme's Manual for Cancer Services](#) in gynaecology measure 11-2E-101.

## Quality statement 5: Initial staging CT

### *Quality statement*

Women who are offered staging for ovarian cancer, following ultrasound, are offered computed tomography (CT) of the abdomen and pelvis as the initial staging investigation.

### *Quality measure*

**Structure:** Evidence of local arrangements and written clinical protocols to ensure women who are offered staging for ovarian cancer, following ultrasound, are offered CT of the abdomen and pelvis as the initial staging investigation.

**Process:** Proportion of women who are offered staging for ovarian cancer, following ultrasound, who receive CT of the abdomen and pelvis as the initial staging investigation.

**Numerator** – the number of women in the denominator receiving CT of the abdomen and pelvis as the initial staging investigation.

**Denominator** – the number of women who are offered staging for ovarian cancer, following ultrasound.

### *What the quality statement means for each audience*

**Service providers** ensure systems and written clinical protocols are in place so that women who are offered staging for ovarian cancer, following ultrasound, are offered CT of the abdomen and pelvis as the initial staging investigation.

**Healthcare professionals** ensure women who are offered staging for ovarian cancer, following ultrasound, are offered CT of the abdomen and pelvis as the initial staging investigation.

**Commissioners** ensure they commission services that offer women who are offered staging for ovarian cancer, following ultrasound, a CT of the abdomen and pelvis as the initial staging investigation.

**Women who are offered investigations to find out the stage of the ovarian cancer, following ultrasound,** are offered a CT scan of the abdomen and pelvis as the first investigation.

## *Source guidance*

[NICE clinical guideline 122](#) recommendations 1.2.3.2 and 1.2.3.3.

The Royal College of Radiologists. [iRefer: Making the best use of clinical radiology: referral guidelines](#) recommendation CA43 staging (CT).

## *Data source*

**Structure:** Local data collection.

**Process:** [National Cancer Outcomes and Services Dataset](#) (in development), available from the National Cancer Intelligence Network.

Also contained in [NICE audit support for ovarian cancer](#) (NICE clinical guideline 122): secondary care, criteria 5.

## Quality statement 6: CT reporting

### *Quality statement*

Women who have computed tomography (CT) for staging of ovarian cancer have the results reported by a radiologist who is a core member of the specialist gynaecological cancer multidisciplinary team.

### *Quality measure*

**Structure:** Evidence of local arrangements and written clinical protocols to ensure that women who have CT for staging of ovarian cancer have the results reported by a radiologist who is a core member of the specialist gynaecological cancer multidisciplinary team.

**Process:** Proportion of women who have CT for staging ovarian cancer that have the results reported by a radiologist who is a core member of the specialist gynaecological cancer multidisciplinary team.

**Numerator** – the number of women in the denominator having their CT staging results reported by a radiologist who is a core member of the specialist gynaecological cancer multidisciplinary team.

**Denominator** – the number of women who have CT for staging of ovarian cancer.

### *What the quality statement means for each audience*

**Service providers** ensure systems are in place for women who have CT for staging of ovarian cancer to have it reported by a radiologist who is a core member of the specialist gynaecological cancer multidisciplinary team.

**Healthcare professionals** ensure women who have CT for staging of ovarian cancer have it reported by a radiologist who is a core member of the specialist gynaecological cancer multidisciplinary team.

**Commissioners** ensure they commission services in which CT for staging of ovarian cancer is reported by a radiologist who is a core member of the specialist gynaecological cancer multidisciplinary team.

Women who have a CT scan to find out the stage of the ovarian cancer, have the results reported by a radiologist who is a key member of the specialist gynaecological cancer multidisciplinary team.

### *Source guidance*

TEG consensus.

### *Data source*

**Structure:** Local data collection.

**Process:** Local data collection.

### *Definitions*

A core member of the gynaecological cancer multidisciplinary team is one who attends (or, if unable to attend, is represented by a colleague who attends) at least two thirds of the multidisciplinary team meetings.

Specialist core members of a multidisciplinary team are described in the [National Cancer Peer Review Programme's Manual for Cancer Services](#) in gynaecology measure 11-2E-101.

## Quality statement 7: Other imaging

### *Quality statement*

Women with an indeterminate adnexal mass on ultrasound are offered magnetic resonance imaging (MRI) for further characterisation.

### *Quality measure*

**Structure:** Evidence of local arrangements to ensure women with an indeterminate adnexal mass on ultrasound have MRI for further characterisation.

**Process:** Proportion of women with an indeterminate adnexal mass on ultrasound who have MRI for further characterisation.

Numerator – the number of women in the denominator who have MRI for further characterisation.

Denominator – the number of women with an indeterminate adnexal mass on ultrasound.

### *What the quality statement means for each audience*

**Service providers** ensure systems are in place for women with an indeterminate adnexal mass on ultrasound to have MRI for further characterisation.

**Healthcare professionals** ensure women with an indeterminate adnexal mass on ultrasound are offered MRI for further characterisation.

**Commissioners** ensure they commission services in which women with an indeterminate adnexal mass on ultrasound have MRI for further characterisation.

**Women with a mass, growth or lump next to their womb**, which usually arises from the ovary or fallopian tube, (called an adnexal mass), found by ultrasound, are offered an MRI scan to help find out if it is cancerous or non-cancerous.

### *Source guidance*

The Royal College of Radiologists. [iRefer: Making the best use of clinical radiology: referral guidelines](#) recommendations CA42 diagnosis (MRI) and CA43 staging (MRI).

## *Data source*

**Structure:** Local data collection.

**Process:** National Cancer Outcomes and Services Dataset (in development), available from the National Cancer Intelligence Network.



## Quality statement 8: Optimal surgical staging

### *Quality statement*

Women with suspected stage I ovarian cancer have optimal surgical staging.

### *Quality measure*

**Structure:** Evidence of local arrangements and written clinical protocols to ensure women with suspected stage I ovarian cancer have optimal surgical staging.

**Process:**

a) Proportion of women with stage I ovarian cancer that had optimal surgical staging.

Numerator – the number of women in the denominator who had optimal surgical staging.

Denominator – the number of women with stage I ovarian cancer.

b) Proportion of women with stage I ovarian cancer that had up-front systematic retroperitoneal lymphadenectomy.

Numerator – the number of women in the denominator who had up-front systematic retroperitoneal lymphadenectomy.

Denominator – the number of women with stage I ovarian cancer.

Up-front systematic retroperitoneal lymphadenectomy is not recommended for women with stage I ovarian cancer therefore an audit standard of 0% should be expected in this process measure.

### *What the quality statement means for each audience*

**Service providers** ensure systems are in place for women with suspected stage I ovarian cancer to have optimal surgical staging.

**Healthcare professionals** ensure women with suspected stage I ovarian cancer have optimal surgical staging.

**Commissioners** ensure they commission services in which women with suspected stage I ovarian cancer have optimal surgical staging.

**Women with suspected stage I ovarian cancer** (which is cancer that has not spread from the ovaries) have surgery (known as optimal surgical staging) that involves removing the cancerous tissue and making a full assessment of the stage of the cancer.

### *Source guidance*

[NICE clinical guideline 122](#) recommendations 1.3.1.2 and 1.3.2.1 (key priorities for implementation) and 1.3.1.1.

### *Data source*

**Structure:** Local data collection.

**Process:** a) and b) [National Cancer Outcomes and Services Dataset](#) (in development), available from the National Cancer Intelligence Network.

Also contained in [NICE audit support for ovarian cancer](#) (NICE clinical guideline 122): secondary care, criteria 9 and 10.

### *Definitions*

Optimal surgical staging does not include up-front systematic retroperitoneal lymphadenectomy. [NICE clinical guideline 122](#) states systematic retroperitoneal lymphadenectomy should not be included as part of standard surgical treatment for women who appear to have stage I disease.

[NICE clinical guideline 122](#) defines the constituents of optimal surgical staging as: midline laparotomy to allow thorough assessment of the abdomen and pelvis; a total abdominal hysterectomy, bilateral salpingo-oophorectomy and infracolic omentectomy; biopsies of any peritoneal deposits; random biopsies of the pelvic and abdominal peritoneum; and retroperitoneal lymph node assessment.

## Using the quality standard

It is important that the quality standard is considered by commissioners, healthcare professionals and patients alongside current policy and guidance documents including [Improving outcomes in gynaecological cancer](#) (Department of Health 1999) and the [Manual for cancer services: gynaecological measures](#) (National Cancer Peer Review Programme, [2008, updated 2011), listed in the evidence sources section.

## *Commissioning support and information for patients*

NICE has produced a [support document](#) to help commissioners and others consider the commissioning implications and potential resource impact of this quality standard. [Information for patients](#) using the quality standard is also available on the NICE website.

## *Quality measures and national indicators*

The quality measures accompanying the quality statements aim to improve the structure, process and outcomes of healthcare. They are not a new set of targets or mandatory indicators for performance management.

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so aspirational achievement levels are likely to be 100% (or 0% if the quality statement states that something should not be done). However, it is recognised that this may not always be appropriate in practice taking account of patient safety, patient choice and clinical judgement and therefore desired levels of achievement should be defined locally.

We have indicated where national indicators currently exist and measure the quality statement. National indicators include those developed by the NHS Information Centre through their [Indicators for Quality Improvement Programme](#). For statements where national quality indicators do not exist, the quality measures should form the basis for audit criteria developed and used locally to improve the quality of healthcare.

For further information, including guidance on using quality measures, please see '[What makes up a NICE quality standard](#)'.

## *Diversity, equality and language*

During the development of this quality standard, equality issues have been considered and equality assessments are published on the NICE website.

Good communication between health and social care professionals and women with ovarian cancer is essential. Treatment and care, and the information given about it, should be culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English. Women with ovarian cancer should have access to an interpreter or advocate if needed.

## Development sources

### *Evidence sources*

The documents below contain clinical guideline recommendations or other recommendations that were used by the TEG to develop the quality standard statements and measures.

[Ovarian cancer: the recognition and initial management of ovarian cancer](#). NICE clinical guideline 122 (2011; NHS Evidence accredited).

[Trabectedin for the treatment of relapsed ovarian cancer](#). NICE technology appraisal guidance 222 (2011; NHS Evidence accredited)<sup>[1]</sup>.

[Paclitaxel, pegylated liposomal doxorubicin hydrochloride and topotecan for second-line or subsequent treatment of advanced ovarian cancer](#). NICE technology appraisal guidance 91 (2005)<sup>[1]</sup>.

[Guidance on the use of paclitaxel in the treatment of ovarian cancer](#). NICE technology appraisal guidance 55 (2003)<sup>[1]</sup>.

The Royal College of Radiologists (2012; NHS Evidence accredited). [iRefer: Making the best use of clinical radiology: referral guidelines](#).

### *Policy context*

It is important that the quality standard is considered alongside current policy documents, including:

Department of Health (2011) [Improving outcomes: a strategy for cancer](#).

Department of Health (1999) [Improving outcomes in gynaecological cancers: the manual](#).

### *Definitions and data sources*

References included in the definitions and data sources sections can be found below:

Department of Health (2011) [The operating framework for the NHS in England 2011/12](#).

National Cancer Intelligence Network (expected publication July 2012) [National Cancer Outcomes and Services Dataset](#).

National Cancer Peer Review Programme (2008, updated 2011) [Manual for cancer services: gynaecological measures](#).

[NICE ovarian cancer audit support \(NICE clinical guideline 122\) \(2011\)](#).

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<sup>[1]</sup> NICE technology appraisal guidance 55, 91 and 222 were used in development only and were not used as evidence for the final standard.

## Related NICE quality standards

When commissioning and providing a high-quality service for ovarian cancer, the following related quality standards should also be considered:

Patient experience in adult NHS services. NICE quality standard 15 (2012).

End of life care for adults. NICE quality standard 13 (2011).

## The Topic Expert Group and NICE project team

### *Topic Expert Group*

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Coordinator

## About this quality standard

NICE quality standards are a set of specific, concise statements and associated measures. They set out aspirational, but achievable, markers of high-quality, cost-effective patient care, covering the treatment and prevention of different diseases and conditions. Derived from the best available evidence such as NICE guidance and other evidence sources accredited by NHS Evidence, they are developed independently by NICE, in collaboration with NHS and social care professionals, their partners and service users, and address three dimensions of quality: clinical effectiveness, patient safety and patient experience.

The methods and processes for developing NICE quality standards are described in the [healthcare quality standards process guide](#).

We have produced a [summary for patients and carers](#).

### Changes after publication

May 2015: Minor maintenance.

April 2015: Minor maintenance.

April 2013: Minor maintenance.

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## *Supporting organisations*

Many organisations share NICE's commitment to quality improvement using evidence-based guidance. The following supporting organisations have recognised the benefit of the quality standard in improving care for patients, carers, service users and members of the public. They have agreed to work with NICE to ensure that those commissioning or providing services are made aware of and encouraged to use the quality standard.

- [National Cancer Intelligence Network](#)
- [Royal College of Pathologists](#)
- [Royal College of Radiologists](#)
- [Society and College of Radiographers](#)