

— BITO HEALTH —

OVARIAN CANCER

A Complete Patient Guide to Diagnosis, Treatment, Surgery,
Recovery, Genetics, and Life After Treatment

Clear, compassionate, and medically grounded for patients, families, and caregivers



This ovarian cancer patient guide explains your diagnosis, staging, and treatment options in clear, everyday language. From CA-125 and BRCA testing to surgery, chemotherapy, and PARP inhibitor maintenance - it's here to help you understand what's happening, ask — the questions that matter, and make the choices that are right for you. —

OVARIAN CANCER: YOUR QUESTIONS, ANSWERED

Clear, evidence-based answers to the questions patients and families ask most - so you can move from uncertainty to a plan, with your care team beside you.

What exactly is ovarian cancer?

It begins when cells in the ovaries, fallopian tubes, or the lining of the pelvis (peritoneum) grow out of control. About 95% of cases start in epithelial tissue, which is why doctors now treat ovarian, tubal, and peritoneal cancer as one connected disease.

What are the early warning signs?

Persistent bloating, pelvic or abdominal pain, feeling full quickly, and urinary urgency are the most common signals. See a doctor if any of these are **new, occur almost daily, and last more than two to three weeks** - they're easy to dismiss, but worth checking.

Who is at higher risk?

Risk rises with age (most diagnoses occur near 63), a personal or family history of breast or ovarian cancer, endometriosis, and inherited **BRCA1, BRCA2**, or Lynch syndrome changes. Pregnancy, breastfeeding, and birth control pill use are linked to lower risk.

Is there a screening test I should ask for?

No blood test or ultrasound has yet been proven to reduce ovarian cancer deaths in average-risk women, so routine screening isn't recommended for most people. If you carry a hereditary risk gene, ask about a personalized surveillance plan instead.

How is it actually diagnosed?

Diagnosis is confirmed by examining tissue after surgery or biopsy; imaging and blood markers like **CA-125** help guide the workup but can't diagnose cancer alone. Outcomes improve when a gynecologic oncologist leads care from the start.

What treatments are available today?

Most patients have surgery to remove and stage the tumor, followed by chemotherapy; some receive chemotherapy first if that makes surgery safer. **PARP inhibitor** maintenance therapy, especially for BRCA-related cancers, is meaningfully extending remission.

Should I get genetic testing?

Yes - guidelines recommend genetic risk evaluation for **every** person diagnosed with ovarian, tubal, or peritoneal cancer, regardless of family history. Results can open the door to targeted drugs and help relatives understand their own risk.

What does the outlook look like now?

Care has genuinely advanced: earlier specialist referral, more precise surgery, and genetically-matched drugs are extending remission and quality of life. Many women live full, active lives during and after treatment, and research keeps moving the field forward.

"Knowledge is the antidote to fear."

Ralph Waldo Emerson

OVARIAN CANCER: AT A GLANCE

19,000-20,000

new cases / year

55 to 74

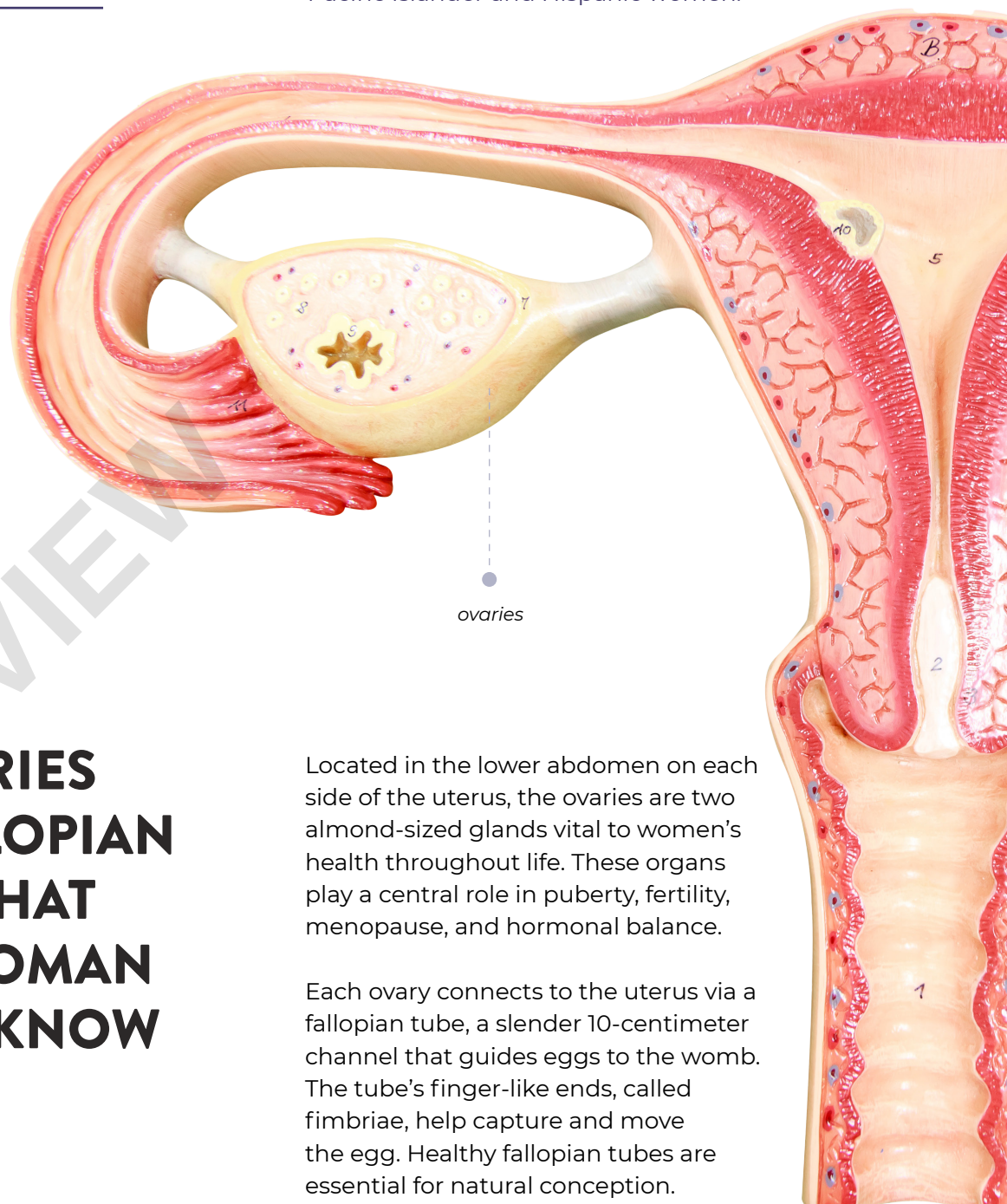
ages

63

average age

Ovarian cancer in the United States affects thousands of women each year, with about 21,000 new cases diagnosed annually. **It is most often diagnosed in women ages 55 to 74, with an average age at diagnosis of 63.**

Ovarian cancer occurs in women of all racial and ethnic backgrounds, though it is diagnosed more often in White women and less often in Asian and Pacific Islander and Hispanic women.



THE OVARIES AND FALLOPIAN TUBES: WHAT EVERY WOMAN SHOULD KNOW

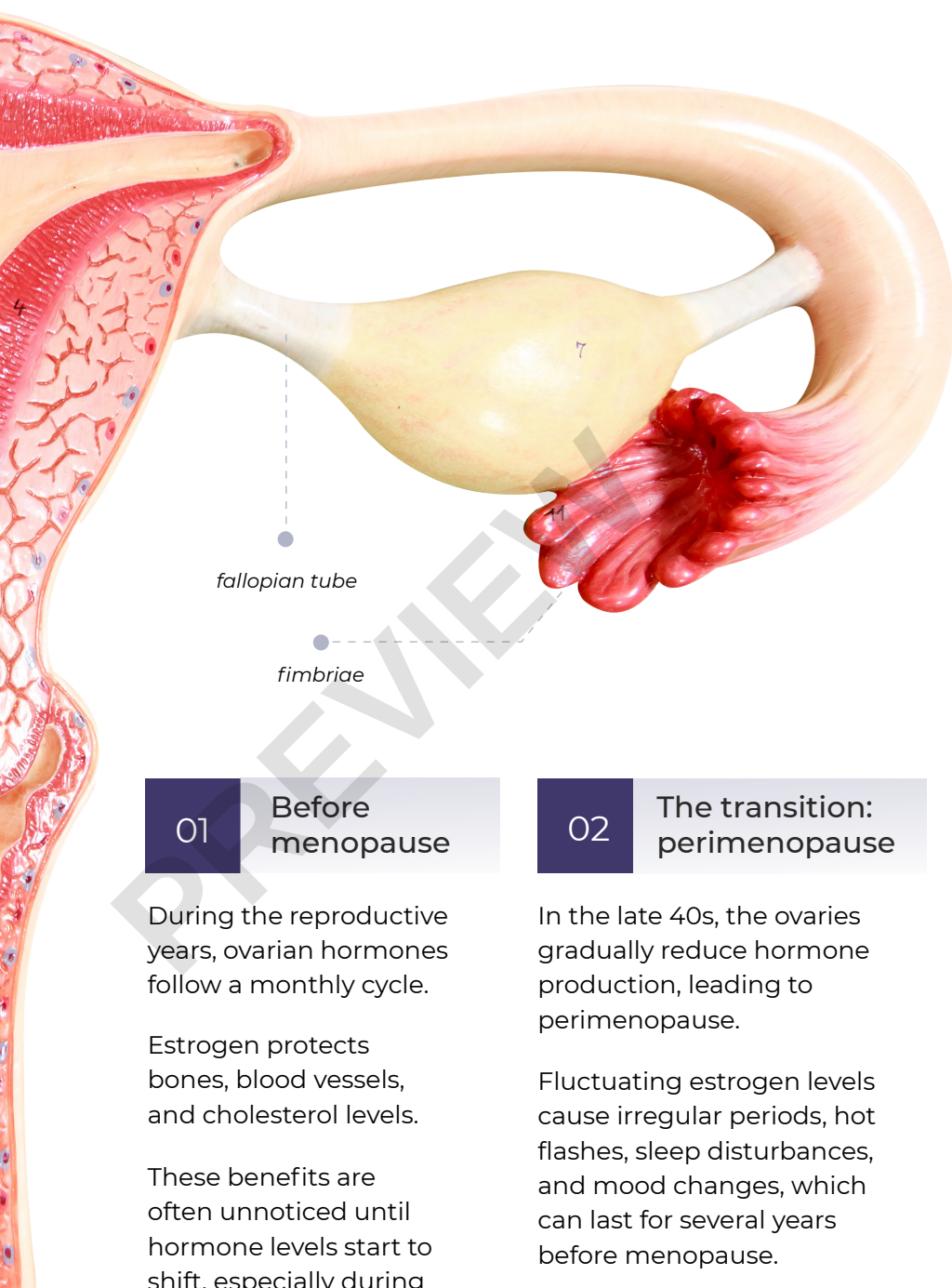
Located in the lower abdomen on each side of the uterus, the ovaries are two almond-sized glands vital to women's health throughout life. These organs play a central role in puberty, fertility, menopause, and hormonal balance.

Each ovary connects to the uterus via a fallopian tube, a slender 10-centimeter channel that guides eggs to the womb. The tube's finger-like ends, called fimbriae, help capture and move the egg. Healthy fallopian tubes are essential for natural conception.

What are the functions of the ovaries?

The ovaries store and release eggs and produce the hormones estrogen and progesterone. These hormones regulate the menstrual cycle, support bone health, protect the heart, and influence mood, energy, and sleep patterns. Balanced ovarian hormones are crucial for overall well-being.

Every month, one ovary releases a mature egg - a process called ovulation. If sperm fertilizes the egg in the fallopian tube, it travels to the uterus for implantation and pregnancy. If not, menstruation begins, marking a new menstrual cycle.



01

Before menopause

During the reproductive years, ovarian hormones follow a monthly cycle.

Estrogen protects bones, blood vessels, and cholesterol levels.

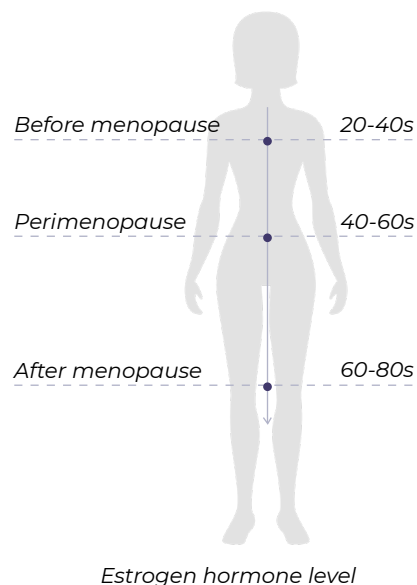
These benefits are often unnoticed until hormone levels start to shift, especially during perimenopause and menopause.

02

The transition: perimenopause

In the late 40s, the ovaries gradually reduce hormone production, leading to perimenopause.

Fluctuating estrogen levels cause irregular periods, hot flashes, sleep disturbances, and mood changes, which can last for several years before menopause.



03

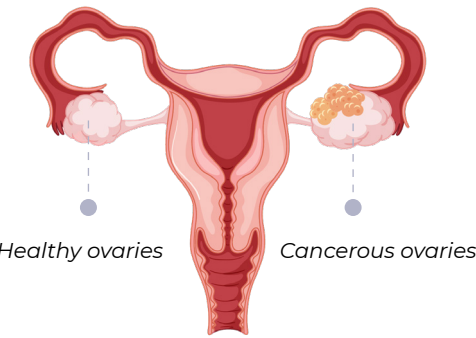
After menopause

Menopause is diagnosed after 12 months without a period. While the ovaries still make small amounts of hormones, the significant drop in estrogen increases risks to bone density and cardiovascular health. Adopting healthy lifestyle habits, balanced nutrition, and seeking medical advice can help protect long-term health after menopause.

Understanding how your ovaries work is essential for supporting women's health at every age. Stay informed to make the best choices for your reproductive and hormonal health.

UNDERSTANDING OVARIAN CANCER

What Is Ovarian Cancer?



Ovarian, Fallopian Tube, and Primary Peritoneal Cancer: Understanding Why They Are Treated Together

Ovarian cancer happens when abnormal cells grow out of control in or around the ovary, the fallopian tube, or the lining of the abdomen called the peritoneum. In modern gynecologic oncology, these cancers are often discussed together because many high-grade serous cancers appear to begin in the fallopian tube and behave very similarly once they spread within the abdomen.

National and international cancer organizations, including the National Cancer Institute (NCI), group epithelial ovarian cancer, fallopian tube cancer, and primary peritoneal cancer together. These cancers originate from closely related tissues, share similar risk factors, and are usually diagnosed, staged, and treated using the same approaches. This unified strategy improves treatment outcomes and streamlines patient care.

The most common group is epithelial ovarian cancer. These cancers are different from germ cell tumors and sex cord-stromal tumors, which are less common and often require different treatment strategies



For patients, this means your treatment plan might be referred to as ovarian cancer treatment, even if the pathologist later pinpoints the origin as the fallopian tube or peritoneum. Understanding these overlapping approaches helps patients make informed decisions about their care and prognosis.

Types of Ovarian Cancer Explained

95%

ovarian malignancies
epithelial

The majority of ovarian malignancies (95%) are epithelial; the remainder arise from germ cell or sex cord-stromal tumors. Among epithelial subtypes, serous carcinoma is the most common (~75% of epithelial carcinomas).

	Subtype	Estimated Frequency	Key Clinical Notes
1.	High-Grade Serous Carcinoma	~70% of epithelial ovarian cancers; ~65% of all ovarian cancers	The most common and most important subtype in routine practice.
2.	Low-Grade Serous Carcinoma	~5% of epithelial ovarian cancers	Usually slower growing and often managed differently from high-grade serous disease.
3.	Endometrioid Carcinoma	~10% of epithelial ovarian cancers	Can be low grade or higher grade; grade matters for treatment planning.
4.	Clear Cell Carcinoma	~10% of epithelial ovarian cancers	Less common, biologically distinct, and sometimes associated with endometriosis.
5.	Mucinous Carcinoma	~3–4% of epithelial ovarian cancers	Uncommon and sometimes difficult to distinguish from cancer that spread from the gastrointestinal tract.
6.	Borderline Ovarian Tumors	~10–15% of all ovarian tumors	Not the same as invasive epithelial ovarian cancer and often managed differently.
7.	Germ Cell & Sex Cord-Stromal Tumors	~5% of all ovarian malignancies combined	Uncommon ovarian cancers with separate treatment pathways.

What Causes Ovarian Cancer?

Risk Factors And Genetics

Most people with ovarian cancer do not have one single clear cause. Risk usually reflects a mix of age, inherited genetic susceptibility, reproductive history, and chance.

Important risk factors

1. **Older age.** Ovarian cancer becomes more common with age, and the median age at diagnosis in the United States is 63.
2. **Inherited mutations such as** BRCA1, BRCA2, Lynch syndrome genes, RAD51C, RAD51D, and BRIP1.
3. **Family history** of ovarian, breast, colorectal, endometrial, or related hereditary cancers.
4. **Never having been pregnant** or having a lifetime pattern of more ovulation.
5. **Endometriosis**, especially for some subtypes such as clear cell and endometrioid ovarian cancer.
6. Some risks remain uncertain or controversial, such as **obesity and talc exposure**.

Protective factors that may lower risk

1. Birth control pills used over time.
2. Pregnancy and breastfeeding.
3. Risk-reducing removal of the fallopian tubes and ovaries in selected high-risk patients after careful counseling

Why Genetics Matter in Ovarian, Fallopian Tube, and Primary Peritoneal Cancer

Leading cancer organizations recommend genetic risk evaluation and both germline and somatic biomarker testing for patients with ovarian, fallopian tube, or primary peritoneal cancer. Genetic testing results can influence treatment decisions, guide maintenance therapy, and provide crucial information for family counseling and cancer risk assessment.

OPPORTUNISTIC SALPINGECTOMY

What Leading Medical Bodies Want Every Woman to Know

Key Takeaways

1. Ovarian cancer has no reliable early screening test.
2. Up to 75% of cases are diagnosed at an advanced stage.
3. Most aggressive ovarian cancers now thought to begin in the fallopian tubes.
4. Salpingectomy may reduce risk by up to 65%, without causing menopause.
5. All four major gynecological bodies now support offering it at time of pelvic surgery.

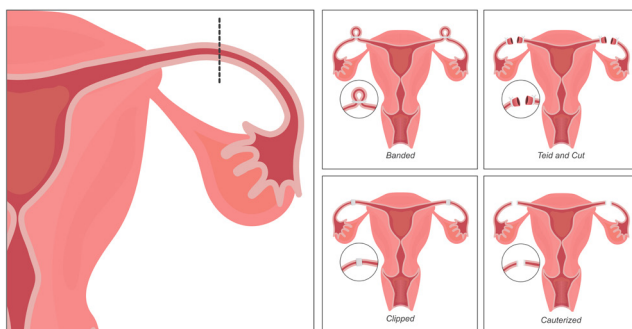
Major gynecological organizations now recommend discussing fallopian tube removal during routine pelvic surgery.

Here's what the evidence says - and what to ask your doctor.

If you are scheduled for pelvic surgery, such as a hysterectomy or tubal ligation, there is an important conversation worth having with your surgeon beforehand.

Major gynecological organizations recommend discussing salpingectomy, the removal of the fallopian tubes, during planned pelvic surgery to reduce ovarian cancer risk.

The reason is compelling: research now strongly suggests that the most common and deadly form of ovarian cancer does not begin in the ovaries at all. It starts in the fallopian tubes.



Why the fallopian tubes?

High-grade serous carcinoma, the most aggressive type of ovarian cancer, is now understood to originate in the lining of the fallopian tubes, migrating to the ovaries and surrounding tissue before it is detected. By the time symptoms appear, it is usually at an advanced stage.

Removing the fallopian tubes before this process begins could prevent many of these cancers from ever developing. Studies suggest bilateral salpingectomy may reduce the risk of high-grade serous ovarian cancer by up to 65%.

What the major guidelines say

Major organizations including ACOG, SGO, FIGO, and RCOG, recommend offering and discussing salpingectomy as a low-risk, cancer-preventing option to reduce ovarian cancer rates, especially since there is no reliable early screening and the procedure adds minimal risk during hysterectomy or sterilization.

Key benefits

1. Does not cause menopause - the ovaries remain intact and hormones are unaffected.
2. Adds little to operating time or recovery.
3. Provides permanent contraception when tubes are fully removed.
4. Recommended regardless of age for women undergoing planned pelvic surgery.
5. Particularly beneficial for women with a family history of ovarian or breast cancer.



Who should consider it?

Opportunistic salpingectomy is relevant for most women undergoing pelvic surgery who have completed their families. It is especially worth discussing if you:

1. Are having a hysterectomy for any reason.
2. Are seeking permanent contraception.
3. Have a family history of ovarian or breast cancer.
4. Carry a BRCA gene mutation but are not yet ready for full oophorectomy.

Does it affect hormones or fertility?

Unlike oophorectomy, removing the fallopian tubes alone does not affect hormone production. There is no surgical menopause and no impact on estrogen levels.

However, bilateral salpingectomy does end the possibility of natural conception, so women who have not completed their families should discuss this carefully before proceeding.

? Questions to ask your surgeon

1. Am I a suitable candidate for opportunistic salpingectomy?
2. Does my personal or family history affect this decision?
3. Will it significantly change my operating time or recovery?
4. Should I consider genetic testing before making this decision?