

# Surgery to reduce the risk of ovarian cancer

## INFORMATION FOR PATIENTS

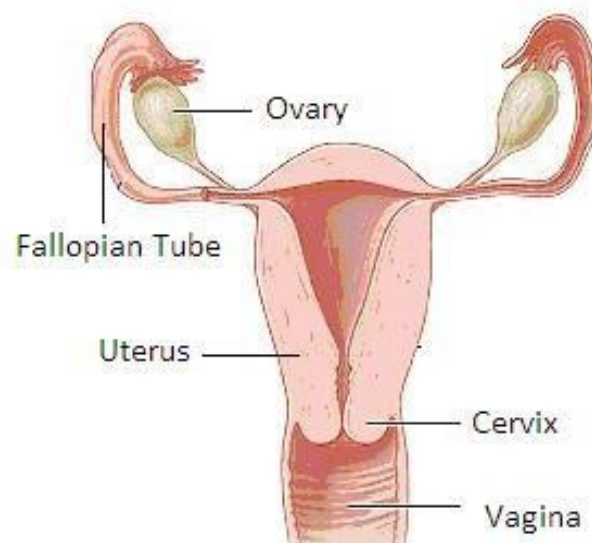
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This leaflet is designed to answer questions you may have about surgery to reduce your risk of ovarian cancer. You may be considering this surgery if you are considered to be at increased risk of ovarian cancer due to your family history of cancer,

The information in the leaflet describes the short and long term implications of having risk-reducing surgery. Being aware of all the available facts will help you make an informed decision about whether this type of surgery is right for you.

The surgery involves removing your ovaries (oophorectomy) and fallopian tubes (salpingectomy). It is called **Risk Reducing Salpingo-Oophorectomy (RRSO)**.

The aim is to remove the tissue in which ovarian cancer can develop. A diagram of the ovaries and fallopian tubes is shown below.



### AM I SUITABLE FOR RRSO?

You may be considered suitable, if you have been assessed to be at increased risk of developing ovarian cancer on the basis of your family history and, when possible, results of genetic testing. It is important that your risk is established before you consider surgery.

Your health will also be assessed to ensure you are physically fit for surgery.

#### WHAT ARE THE MAIN ADVANTAGES OF UNDERGOING SURGERY?

It reduces the risk of ovarian cancer by 98%, leaving a 2% risk of peritoneal cancer (a cancer very similar to ovarian cancer).

For the vast majority of women having RRSO before the natural menopause could also reduce breast cancer risk.

It prevents benign disease of the ovaries (e.g. cysts).

#### WHAT ARE THE MAIN DISADVANTAGES OF UNDERGOING SURGERY?

You will not be able to become pregnant once your ovaries have been removed.

The surgical removal of both ovaries will result in an abrupt onset of menopause, if you have not already reached it. If this is the case, you may begin to experience menopausal symptoms, e.g. hot flushes, night sweats, mood swings, tiredness, vaginal dryness and loss of libido (sex-drive). The symptoms of menopause may be helped by hormone replacement therapy (HRT).

You may be at increased risk of osteoporosis (thinning of the bones) and heart disease if you have the operation done before you have reached a natural menopause. Again, these risks are reduced by taking HRT if you are suitable for this.

There is a small risk of complications associated with having surgery (see page 4).

## IS THERE A CHANCE THAT CANCER CAN BE FOUND?

When your ovaries and tubes are removed they are sent to the laboratory for checking and, very occasionally, a very early microscopic cancer is found. The chance of this occurring is approximately 3% (1 in 33).

In this situation, you may need to undergo further surgery during the next few weeks. This usually involves a hysterectomy (removal of the womb), which is routine in the treatment of ovarian and tubal cancer.

## CAN THE SYMPTOMS OF MENOPAUSE BE CONTROLLED?

Hormone replacement therapy (HRT) can control most of the symptoms of menopause. It is important that women below the age of 50 who have this surgery consider taking HRT to minimise menopause symptoms and prevent bone and heart disease.

Women with an increased risk of ovarian cancer may also have an increased risk of breast cancer and therefore may be concerned about using HRT. If you are concerned, it is important to be aware that the situation is very different for women who have reached the menopause compared with women who have not reached the menopause. *If you have already had breast cancer, you may not be able to take HRT.*

### **Women who have not reached the menopause**

If HRT is taken after removal of the ovaries, it replaces hormones that would have been naturally produced by the ovaries until the menopause (average age 51 years). Use of HRT in this situation has not been shown to increase risk of breast cancer.

### **Women who have reached the menopause**

A woman is considered to have reached the menopause if she has not had a period for at least 12 months. Studies have shown that HRT use for over five years slightly increases the risk of breast cancer in postmenopausal women. Routine HRT use after the menopause is not recommended, particularly in women at increased risk of breast cancer. However, occasionally the symptoms of the menopause may be so

marked that the benefits of HRT outweigh this concern. In these circumstances use of HRT may be agreed after careful consideration and discussion with your doctor.

## WHAT DOES THE SURGERY ITSELF INVOLVE?

RRSO can be carried out in one of two ways, keyhole surgery or open surgery.

### **Keyhole Surgery (laparoscopy)**

Three or four small cuts (called incisions) are made on your tummy (abdomen). These normally measure 0.5 to 1cm in length. One is hidden in the tummy button (umbilicus); another may be placed just above the bikini line and one on either or both sides of the tummy.

The surgeon places a special telescope in the tummy button incision. This relays pictures of the inside of your abdomen to a television screen, so the surgeon can see what they are doing. Surgical instruments are then passed through the other incisions. The ovaries and fallopian tubes are then removed via the incisions.

### **Open Surgery**

This is a more traditional method and involves a bikini line incision or occasionally, an up and down incision.

Sometimes it is not possible to perform RRSO by the keyhole method and a small number of women (around 1 in 100) who opt for this method of surgery have an open incision performed instead. This could be for any number of reasons including technical problems during surgery, obesity, scarring from previous operations, or bleeding during the procedure. Women who have had previous abdominal surgery are also more likely to need an open incision.

The average hospital stay associated with keyhole surgery is 1-2 days, compared with five days for open surgery. After keyhole surgery it is possible to return to normal activity in 2-3 weeks. With open surgery the average return to normal activity is six weeks.

## IS IT NECESSARY TO REMOVE MY WOMB AS WELL?

A small number of women in the increased genetic risk group have an underlying condition called Lynch syndrome. This condition increases the risk of cancer of the

womb (endometrial cancer). Unless you are thought to have Lynch syndrome, the risk of you developing cancer of the womb is **not** high enough to justify removing the womb as a precaution.

Hysterectomy is a more major operation than removal of the ovaries and fallopian tubes and therefore has a higher chance of causing complications. Hysterectomy should only be done if a woman is thought to have Lynch Syndrome, or if she has symptoms due to benign problems with her womb which can't be treated by simpler means. If you think this may apply to you, please discuss hysterectomy with your surgeon before you come in for surgery.

### WHAT ARE THE COMPLICATIONS OF RRSO?

All surgery carries the risk of minor complications. Minor complications include those that have no long-term effects but may delay recovery. Wound infections, urine infections and a chesty cough are among the more common examples. There is a small chance that a woman might need a blood transfusion following RRSO or develop a blood clot in the leg (deep vein thrombosis or DVT).

Serious complications that can occur during the operation include damage to the bowel, bladder or a blood vessel. Should this happen during keyhole surgery, the operation may be converted to an open procedure in order to repair any damage. It is possible for injuries to go unnoticed at the time of surgery because the injury is so small or it has occurred outside the field of vision. This is extremely rare, but should it happen, a second operation might be required.

There is a very small risk of death from any operation. This is more likely to occur in women who have medical or surgical problems before the operation.

It is important to bear in mind that the vast majority of women do not experience any serious complications at all and have an uneventful operation and post-operative recovery.

If you are concerned about any complications, please speak to the doctor and nurses in the ward who will give you more information.

## APART FROM SURGERY, WHAT ELSE CAN I DO TO MANAGE MY RISK OF OVARIAN CANCER?

Ovulation is the production of 'eggs' by the ovaries. It is thought that preventing ovulation offers protection from ovarian cancer. Oral contraceptive pill (OCP) use, pregnancy or breast feeding can have this effect on ovulation. Research has shown that 5 years of OCP use reduces the risk of developing ovarian cancer by half.

Taking the OCP is often a simple and safe way to try to reduce the risk of ovarian cancer. There may however be a small increased risk of developing breast cancer with the OCP.

If you are known to carry an alteration in your BRCA1 or BRCA2 genes, we would suggest you have a discussion with a specialist if you are considering taking the OCP as a way of managing your ovarian cancer risk.

## SOURCES OF FURTHER INFORMATION

### **Ovarian Cancer**

Macmillan Cancer Support

Tel: 0808 808 0000

Ovacome

Tel: 0800 008 7054

[www.ovacome.org.uk](http://www.ovacome.org.uk)

Adapted from UKFOCSS information leaflet.