Iris Raquin (French). *Spring Bouquet.* Oil, 40″ × 36″.

Introduction and Overview

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The treatment of advanced ovarian cancer has become both more effective and better tolerated over the past 25 years. The introduction of aggressive debulking surgery followed by aggressive chemotherapy with platinum complexes and the taxanes has increased the expected survival of patients with ovarian cancer from 6 to 12 months during the 1970s and 1980s to 3 to 5 years at the turn of the century (Fig 1).[1,2]

Unfortunately, while ovarian cancer is considered a "chemo-responsive" disease with high initial response rates, curative treatment continues to be elusive. About 30% to 50% of patients will not achieve a complete response to first-line chemotherapy, and even among those who do achieve a complete response, a majority will eventually relapse and succumb to their disease after a long clinical course.

There is a growing perception among those who care for ovarian cancer patients that many patients with relapsed ovarian cancer can be successfully managed through a complex sequence of treatments, frequently resulting in years of high-quality life and enjoyable lifestyle. There is also a growing realization that a significant proportion of patients with relapsed ovarian cancer can be managed in a clinically stable disease

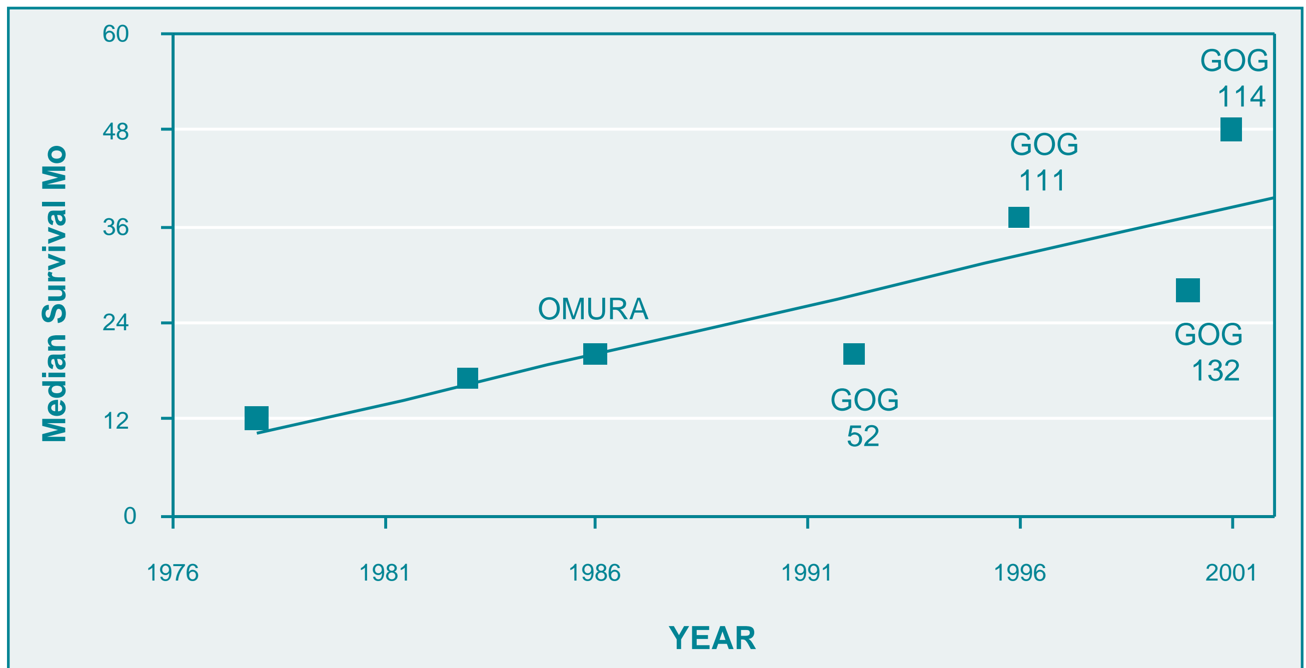

Fig 1. — Progress in ovarian cancer. Median survival of advanced ovarian cancer patients participating in phase III clinical trials over the past 25 years.[2]

state that responds to chronic treatment, analogous to several other common illnesses that are more conventionally considered as chronic diseases such as rheumatoid arthritis or diabetes. In this new paradigm, patients with relapsed ovarian cancer require improved long-term therapies — "chronic therapies" — that minimize the risks of cumulative toxicity and loss of function (Table 1).

Objectives and Participants

The program that follows is based on a roundtable discussion in which the participants review, analyze, and interpret some of these concepts as they relate to the long-term management of advanced ovarian cancer — that is, the treatment of ovarian cancer as a chronic disease. We focus particularly on considerations of chemotherapy and other treatments that are most applicable in the community setting.

In addition to myself, as chairman of the discussion, the participating physicians include:

- **Deborah K. Armstrong, MD**, Assistant Professor of Oncology and Gynecology and Obstetrics at Johns Hopkins Oncology Center in Baltimore

- **Charles J. Dunton, MD**, Professor, Department of Gynecologic Oncology, Thomas Jefferson University in Philadelphia

- **Thomas J. Herzog, MD**, Assistant Professor, Division of Gynecologic Oncology, Washington University School of Medicine in St. Louis

- **Ira R. Horowitz, MD**, Willaford Ransom Leach Professor and Vice Chairman, Department of Gynecology and Obstetrics, Emory University School of Medicine, and Director, Division of Gynecologic Oncology, Winship Cancer Institute in Atlanta

- **Ursula A. Matulonis, MD**, Assistant Professor, Harvard Medical School, and medical oncologist at the Dana-Farber Cancer Institute in Boston

Also participating in this program, by offering her nursing perspectives and commentary on the long-term management of patients with ovarian cancer, is **Sheryl Redlin Frazier, RN, ONC**, of the Vanderbilt University Medical Center in Nashville. She is also the past president of the Society of Gynecologic Nursing Oncology. See "Nursing Perspectives on Patient Management During Chronic Therapy for Relapsed Ovarian Cancer," page 19.

Table 1. — Redefining Treatments and Disease States in Patients With Ovarian Cancer

Term	Definition
Primary therapy	Treatment administered after confirmation of the diagnosis. Includes initial de-bulking surgery and chemotherapy.
Primary refractory disease	Progressive disease during the primary chemotherapy with a platinum and a taxane (indicating a particularly poor prognosis).
Persistent disease	Characterized by either stable disease or a partial response following primary therapy. Patients with persistent disease may have elevated CA125 levels, radiographic findings, or positive pathologic evidence of disease at the time of second-look assessment.
Recurrent disease	Follows a period of complete response without clinical evidence of cancer. Recurrent disease is characterized by unequivocal confirmation of recurrence of ovarian cancer.
Salvage therapy	A term applied to all treatment that follows primary therapy. In ovarian cancer, this term should be avoided for several reasons. First, the initial use of "salvage therapy" was coined in the lymphoproliferative diseases where a second curative attempt was administered; this does not apply to ovarian cancer. Second, the term is insufficiently precise in ovarian cancer and often encompasses the treatment of women with very different prognoses. Third, "salvage" is considered offensive by some patients and their physicians. Given the long clinical course of many patients with ovarian cancer, the term "chronic therapy" is preferred.
Chronic therapy	Treatments administered to patients who relapse following primary therapy. Compared to "salvage therapy," it is a better and more inclusive description of this phase of the treatment program, which leads to palliative care.
Palliative therapy	Administered at the approach of the end of life.

Adapted from Markman M, Hoskins W. Responses to salvage chemotherapy in ovarian cancer: a critical need for precise definitions of the treated population. *J Clin Oncol.* 1992;10:513-514.

Audiotape and Posttest

This program, offered as a continuing medical education activity by the H. Lee Moffitt Cancer Center & Research Institute and the University of South Florida College of Medicine, is the result of our discussion.

As part of the learning program, an audiotape cassette accompanies this supplement to *Cancer Control*. Although this supplement contains and expands on most of the highlights and salient points of our discussion, including literature citations, the audiotape provides additional commentary and insight regarding the strength and conviction of our views — collectively and independently. In addition, the audiotape contains discussions on several relevant topics that are not included within this publication. Therefore, because the two media do not completely overlap, I encourage you to listen to the tape.

Finally, after reading the publication and listening to the tape, you may wish to make use of the posttest starting on page 22.