Primary Care
Women's Health Society

Further reading

Ovarian cancer

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Why does this matter?

Ovarian cancer is the 6th commonest UK cancer, with incidence predicted to rise by 5% between 2024-2026 and 2038-2040[1]. The 7700 UK diagnoses per year make up 2% of all new cancer cases and the lifetime risk of a woman developing ovarian cancer is 1 in 50[2]. 50% of diagnoses are made at stage 3 or 4 – five-year survival is 95% at stage 1 and only 15% at stage 4. The different types of ovarian cancer are shown in table 1[2,3].

Type of cancer	Percentage
Epithelial (serous, mucinous, endometrioid, clear cell, transitional cell and squamous).	90% of primary cancers.
Non-epithelial (germ cell, sex cord, stromal cell).	10% of primary cancers.
Metastatic (mainly from the endometrium, breast and GI tract).	10 – 25%.

Table 1 – types of ovarian cancer

How does ovarian cancer present?

Red flag - beware of diagnosing irritable bowel syndrome for the first time over the age of 50; you might miss other pathology, including ovarian cancer[4].

Ovarian cancer can present with any of the following symptoms[5]:

- Persistent abdominal distention (bloating).
- Abdominal or pelvic pain.
- Early satiety (feeling full) and/or loss of appetite.
- Urinary symptoms (increased urgency and/or frequency).
- New onset symptoms suggestive of irritable bowel syndrome in women aged over 50.
- Weight loss, malaise or fatigue.
- Altered in bowel habit.
- Abnormal or postmenopausal bleeding[6].
- Shortness of breath (consider pleural effusions).
- Gastrointestinal symptoms such as nausea, dyspepsia and bowel obstruction.

Have a low threshold for considering ovarian cancer when symptoms start over the age of 50; but remember that 1/6 cases of ovarian cancer are diagnosed under the age of 50[1].

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Remember to take a family history

- Women with a close relative affected with ovarian cancer may have a slightly increased risk of around 4–5%[6].
- NICE[7] advises that all women with a first- or second-degree relative with ovarian cancer should be referred to a genetics clinic.
- The risk of ovarian cancer is greatly increased by genes such as BRCA (details in table 2), RAD51C, RAD51D, BRIP1 and PALB2. The risk can increase from the 40s for those with a BRCA mutation[8].
- If diagnosed with a mutation, a woman may be offered a bilateral salpingo-oophorectomy, usually done in the 40s (depending on the age of cancers diagnosed in her family). If your patient has had this, remember to discuss HRT, particularly if her surgery was done under the age of 45. This surgery reduces risk to <5%[9].
- Those of Jewish origin are more likely to have a BRCA mutation (background risk 1/400 compared to 1/140 for Sephardi Jews and 1/40 for Ashkenazi Jews)[9]. Following a successful pilot of on-demand BRCA testing for those with at least one Jewish grandparent, a permanent service is expected to be in place by 2027[10].
- Other genetic conditions such as Lynch syndrome and Peutz-Jeghers syndrome increase the risk of ovarian cancer[11,12]. Lynch syndrome also increases the risk of cancers of the ovary, GI tract, skin, brain, kidney and bladder[13].

Cancer type	Unaffected women	BRCA 1	BRCA 2
Breast	12.5%	72%	69%
Ovarian	2%	44%	17%

Table 2 – lifetime cancer risks

My patient wants to be screened for ovarian cancer – why don't we do that?

- The UKCTOCS study[14] looked at whether using a CA125 and transvaginal ultrasound scan could be used as part of a national screening programme.
- Results showed that ultrasound tests couldn't detect ovarian cancers earlier or save lives. The CA125 blood test did detect cancers earlier, but this didn't lead to saving lives. The conclusion was that these tests couldn't be used as screening tests in the general population.
- Therefore, ovarian cancer has no reliable early detection test[15] and does not meet the National Screening Committee criteria for screening[16], so no routine screening programme exists.
- Large studies have shown that even high-risk women, including those with BRCA gene mutations, do not benefit from screening. Instead, the focus is on symptom awareness and diagnostic testing for high-risk individuals[8].

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When should we refer for suspected ovarian cancer?

- NICE[5] advice is as follows:
    - Make a suspected cancer referral for ascites or a pelvic/abdominal mass which isn't obviously fibroids.
    - Carry out tests for women who are aged 39 or under with persistent symptoms (or on a frequent basis – particularly more than 12 times per month) that suggest ovarian cancer:
        - Do not use a serum CA125 measurement in isolation, as it is not accurate in this age group.
        - Arrange an urgent ultrasound scan of the abdomen and pelvis.
        - If an ultrasound scan suggests ovarian cancer, refer to gynaecology using a suspected cancer pathway referral.
        - If the ultrasound scan is normal, look for other causes for symptoms and investigate as appropriate
        - If no other cause is found, safety-net and advise the patient to come back if the symptoms become more frequent or persistent, or both.
    - For women aged 40 and over with persistent symptoms that suggest ovarian cancer:
        - Measure CA125
        - Arrange an urgent ultrasound scan of the abdomen and pelvis depending on age and serum CA125 measurement according to the thresholds shown in table 3.
    - If an ultrasound scan suggests ovarian cancer, refer to gynaecology using a suspected cancer pathway referral.
    - If the serum CA125 does not meet the threshold outlined in the table below, or meets the threshold but the ultrasound scan is normal:
        - Identify any other potential causes of the symptoms and investigate as appropriate.
        - If no other cause is identified, safety net and advise a return to the GP if the symptoms become more frequent or persistent, or both.

Age group	CA125 threshold
40 – 49	≥ 35 IU/mL
50 – 59	≥ 31 IU/mL
60 – 69	≥ 24 IU/mL
70 - 79	≥ 25 IU/mL
≥ 80	≥ 31 IU/mL

Table 3 – NICE CA125 thresholds for an urgent pelvic ultrasound

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So what do I do for a patient with a raised CA125 but a normal pelvic scan?

- Make a clinical assessment with other causes of her symptoms and of a raised CA125 in mind (see tables 4 and 5).
- If you are concerned about another malignant cause, refer on the appropriate suspected cancer pathway, or via a rapid diagnosis clinic if the organ system is not clear.
- If you are not concerned, consider repeating the CA125 in 6-8 weeks and referring if there is an upward trend[17].

Benign conditions causing raised CA125	Malignant conditions causing raised CA125
Physiological conditions: ovulation, pregnancy, menstruation **Benign gynaecological conditions**: endometriosis, benign ovarian cysts (torsion, rupture or haemorrhage), fibroids , PID **Autoimmune disease**: polyarteritis nodosa, SLE, sarcoidosis, Sjogrens syndrome **GI conditions:** diverticulitis, colitis **Liver conditions**: chronic active hepatitis, cirrhosis **Other**: heart failure, pericarditis, pancreatitis, renal disease, recent surgery, ascites, pleural effusion	**Gynaecological malignancy**: ovarian, cervical, endometrial cancers **Other malignant conditions:** breast, lung, bowel, pancreatic cancer (any site involving pleural, pericardial and peritoneal surfaces), can occur in non-Hodgkin's lymphoma,

Table 4 – other causes of a raised CA125[17]

Symptom(s)	Possible causes
Early satiety	Gastric cancer
Urinary frequency/urgency	Recurrent urinary tract infections
Altered bowel habit	Irritable bowel syndrome, constipation, coeliac disease, inflammatory bowel disease, gastrointestinal infection or antibiotic-associated diarrhoea.

Table 5 – non-exhaustive list of other causes for symptoms suggestive of ovarian cancer

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What is the GP's role for a patient with ovarian cancer?

- Holistic support – this may be with symptoms related to the cancer or its management, the psychological sequelae of cancer, or signposting for practical help such as with finances.
- Managing the menopause:
    - Surgery for ovarian cancer will usually involve a total abdominal hysterectomy, bilateral salpingo-oophorectomy and omentectomy.
    - This will cause acute menopausal symptoms in pre-menopausal women, requiring support and help with symptom control. It is important to take holistic approach considering the whole woman physically and psychologically. She may have a diagnosis of premature ovarian insufficiency if her ovaries are removed under the age of 40, or early menopause, if her ovaries are removed between 40-45 years. These diagnoses require careful management and advice about hormone replacement therapy, in order to support her symptoms and future health[18,19,20,21].
    - Non-hormonal options include:
        - Fezolinetant, SSRIs, Oxybutynin and gabapentin[22].
        - Vaginal moisturisers and lubricants.
        - Low dose localised vaginal oestrogen treatments[23,24,25].

Resources for patients

- Target Ovarian Cancer:
    - Nurse support line.
    - Online support community.
- Ovarian Cancer Action:
    - Hereditary cancer risk prediction tool
- Cancer research UK:
    - Ovarian cancer.
    - Information on current trials looking at genetics of ovarian cancer.
- Eve Appeal:
    - Ovarian cancer.
    - Inherited cancer risks.
- Macmillan Cancer Support:
    - Ovarian cancer.
    - Money, finance and insurance.
- Maggie's charity.
- Menopause and cancer podcast.

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Resources for clinicians

- PCWHS. The menopause after gynaecological cancer, or in women at increased genetic risk of cancer – what do GPs need to know?
- BMS. Management of menopausal symptoms following treatment of gynaecological cancer.
- NICE CKS. What symptoms are suggestive of gynaecological cancers?
- NICE CKS. Ovarian cancer.
- NICE. NG241. Ovarian cancer: identifying and managing familial and genetic risk. March 2024.
- NICE. NG12. Suspected cancer: recognition and referral. April 2026.

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21) BMS. Prescribable alternatives to HRT. March 2026.
22) PCWHS. Genitourinary syndrome of the menopause. May 2025.
23) BMS. Management of menopausal symptoms following treatment of gynaecological cancer. Aug 2024.
24) BMS. Genitourinary Syndrome of the Menopause. Nov 2025.

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