Original Article

Treatment of Recurrent Ovarian Cancer: Survey of Practice among Thai Gynecologic Oncologists

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Objective: To survey the practice among Thai gynecologic oncologists in the treatment of recurrent epithelial ovarian cancer.

Materials and Methods: This study was a part of the Thai Gynecologic Cancer Society (TGCS) national survey about the practice among Thai gynecologic oncologists. Their responses to 21 questions about the treatment of epithelial ovarian cancer were analysed.

Results: Among 258 gynecologic oncologists who met the inclusion criteria, 170 responded to the questionnaires (65.9%). Almost half of Thai gynecologic oncologists who participated in this survey reported that they performed surgery after recurrence of ovarian cancer, but in only 10% of their patients. Combination of platinum and paclitaxel was the most preferable regimen (90%) in recurrent platinum-sensitive epithelial ovarian cancer. The most common second-line chemotherapeutic regimen for recurrent platinum-resistant or platinum-refractory epithelial ovarian cancer patients was gemcitabine (53.5%) followed by pegylated liposomal doxorubicin (42.4%) and single paclitaxel (4.1%). Best supportive care was given more frequently after a failure from 2 or more regimens. If the patients did not respond to more than 3 chemotherapy regimens, 70% of the responders offered the best supportive care to their patients. The responders prescribed targeted therapy with the median number of 5% for their patients.

Conclusion: Chemotherapy was the most common treatment for recurrent ovarian cancer. Reimbursement by the Thai Universal Health insurance limited using various chemotherapeutic agents including targeted therapy. Best supportive care was wildly chosen as the treatment option in recurrent platinum-resistant epithelial ovarian cancer patients who failed more than 3 chemotherapy regimens.

Keywords: Chemotherapy, Cytoreductive surgery, Gynecologic oncologist, Recurrent ovarian cancer, Survey

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The health budget allocation and policy of health coverage are conformed to the national financial status and health needs of the people. Thailand is a developing country, which was ranked according to the World Bank categorization in 2018 as upper middle-income countries[1]. Nowadays, the National Health Insurance system covers to the whole Thai population of 66.3 million persons. There are three different schemes of the health insurance system: the civil servants' medical benefit scheme, covering 5.7 million people; the social security scheme, covering 12.3 million people; and the universal coverage scheme, covering 47.8 million people or 72% of the population[2]. Thailand's policy on universal health coverage has made good progress since its inception in 2002[3]. An extension of coverage to high-cost services, such as cancer treatment, has improved financial protection for patients[4]. However, only a few numbers of high-cost chemotherapy are reimbursable in a certain setting which demonstrated significant improvement in survival with cost effectiveness.

In 2013 to 2015, ovarian cancer ranked as the 6th most common female cancer, with age-standardized incidence rate of 5.7 per 100,000 women-year in Thailand[5] Almost 80 to 90% of ovarian cancers are of epithelial origin. Primary surgery is the main primary treatment. After surgery, majority of the patients require adjuvant chemotherapy. Even with the optimal cytoreductive surgery and appropriate chemotherapy, more than half of the patients relapsed within 2 years[6].

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After recurrence, the aim of treatment is palliation. One of the clinical factors that must be concerned is platinum-sensitivity status. A group of patients with recurrence after 6 months of the completion of platinum-based chemotherapy is defined as platinum-sensitive, whereas those relapse during or within 6 months after the platinum therapy is defined as platinum-resistance[7]. The patients with platinum-sensitive disease are generally have platinum-based chemotherapy reinduction. On the contrary, those with platinum-resistance will receive other second-line chemotherapy. Previous clinical trials, reported similar response rates of several second-line drugs: 20% of topotecan, 19% of gemcitabine, 26% of pegylated liposomal doxorubicin (PLD), and 27% of oral etoposide[8,9]. Currently, targeted therapy for epithelial ovarian cancer (EOC) have been incorporated with standard chemotherapy. With its extremely high cost, the prescription of targeted agent has been constrained.

The national survey study conducted on behalf of Thai Gynecologic Cancer Society (TGCS) was to evaluate the clinical practice of the Thai gynecologic oncologists regarding management of gynecologic cancer in various aspects. This study aimed to assess the surgical treatment for recurrent EOC patients as well as medical treatment options including chemotherapy and targeted agents.

Materials and Methods

After the approval by the ethical committees for human research of each participating institution (COA, Faculty of Medicine Ramathibodi Hospital, MURA2020/764; COA, Faculty of Medicine, Chulalongkorn University, IRB No. 323/63; COAs: Rajavithi Hospital, 104/2562; Faculty of Medicine Chiang Mai University, OBG-2562-06506; Faculty of Medicine Vajira Hospital, 097/2562), the web-based anonymous online survey (https://forms.gle/e1WsBLcX5jVsXVgG8) was conducted to evaluate various aspects of practice of Thai gynecologic oncologists on the 3 most common gynecologic cancers: cervical cancer, endometrial cancer, and EOC. All registered members in data base were invited to participate in this survey during the annual meeting which was held in August 2019 and on the society website. This survey was open for response during August 2nd to October 31st, 2019. Data of each cancer were separately analysed and presented elsewhere.

This study retrieved the responders' characteristics including age, gender, experience after training, number of gynecologic oncologists in the hospital, and their hospital setting. Their workload particularly number of EOC patients per month was also collected. Data of recurrent EOC treatment included surgery and chemotherapy regimen being used as the second-, third-, fourth- and fifth-line regimen. In the questionnaire, the 5 drugs listed were gemcitabine, PLD, topotecan, weekly paclitaxel, best supportive care, and other open-ended options. The responders were requested to select each drug or option of treatment in order of preference. The use of targeted therapy was queried for the average frequency of prescription and settings of treatment.

Statistical analyses were performed using STATA version 16.1 (StataCorp, College Station, Texas, USA). Descriptive statistics were summarized by frequency and percentage, mean and standard deviation (SD), or median and interquartile range (IQR), according to the distribution of data. The univariate analysis was applied by Pearson's Chi-squared or Fisher's exact test for categorical data. A *p*-value of 0.05 was considered as the level of statistical significance.

Results

A total of 170 among 258 Thai gynecologic oncologists completed this survey (65.9%). Mean age was 41.1±8.3 years and 63.5% of them were female. Median duration of practice was 5 years (IQR 2, 12). Almost of 90% of responders worked in government hospitals and 83.5% of them in tertiary care hospitals. Approximately half (50.6%) of the responders worked in the hospital with gynecologic oncology fellowship training program. According to the number of staff, median number of the gynecologic oncologists in the responders' hospitals were 6 (IQR 3, 10). Median number of ovarian cancer patients per month was 10 patients (IQR 5,20).

The median percentage of cytoreductive surgery performed in the recurrent setting was only 10 (IQR 5, 20). On the other hand, nearly half of Thai gynecologic oncologists (45.3%) performed surgery more frequently than 10%. The responders whose age were above 41 years and had duration of practice more than 5 years tend to perform surgery significantly more frequent than the other comparative groups (Table 1).

Chemotherapy regimens in recurrent EOC patients varied upon the platinum sensitivity (Table 2). For platinum-sensitive diseases, platinum-based chemotherapy was more commonly administered than single agent, with platinum and paclitaxel (90%) as the most common.

For recurrent platinum-resistant EOC, all second-line chemotherapeutic regimens were single agent. Gemcitabine was prescribed significantly more frequent among the responders who worked in the hospitals with less than 6 gynecologic oncologists, whereas PLD was more frequently given among the responders who had more than 6 gynecologic oncologists (Table 3). Topotecan, oral etoposide, targeted therapy, hormonal treatment and best supportive care were the options for the patients after failure from all of the 3 drugs previously described. Best supportive care was given more frequently after the failure of 2 or more regimens; the percentages consecutively increased from 10.6% after a failure of 2 regimens, 42.2% after a failure of 3 regimens and as high as 70% of patients after a failure of 4 regimens, respectively (Table 2). No characteristic feature of the responders or their working features was associated with the setting in which best supportive care was offered instead of further treatment with chemotherapy (data not shown).

One hundred and forty-four (84.7%) of the responders had ever prescribed targeted therapy. The responders who used to prescribe targeted therapy reported the median frequency of 5% (IQR 1,10) in their patients. There were 51 responders (35.4%) used it ≤5% of their

Table 1. Factors affected decision for surgical treatment in recurrent ovarian cancer

Factors	Surgical treatment ≤10% of patients, n (%)	Surgical treatment >10% of patients, n (%)	*p*-value
Age (years)			<0.001
≤41	70 (66.0)	36 (34.0)	
>41	23 (35.9)	41 (64.1)	
Gender			0.058
Male	28 (45.2)	34 (54.8)	
Female	65 (60.2)	43 (39.8)	
Experience (years)			0.001
≤5	59 (67.1)	29 (32.9)	
>5	34 (41.5)	48 (58.5)	
Hospital sector			0.939
Government	83 (54.6)	69 (45.4)	
Private	10 (55.6)	8 (44.4)	
Hospital competency			0.777
Secondary	16 (57.1)	12 (42.9)	
Tertiary	77(54.2)	65 (45.8)	
Fellowship training center			0.062
No	52 (61.9)	32 (38.1)	
Yes	41 (47.7)	45 (52.3)	
Number of gynecologic oncologists			0.471
≤6	45 (57.7)	33 (42.3)	
>6	48 (52.2)	44 (47.8)	

patients and 93 responders (64.6%) used it more frequently (>5%). Half of them prescribed targeted therapy along with first-line chemotherapy as adjuvant treatment. One the other hand, only less than half of responders (44.1%) prescribed targeted therapy for recurrent platinum-sensitive EOC patients and 24.1% for platinum-resistant patients. Among 144 responders who answered the questions about the factors affected prescription of targeted therapy (Table 4), the responders who worked in private sector and no fellowship training prescribed targeted therapy significantly more frequent than the others.

Discussion

Despite improvement in surgical technique and novel adjuvant treatments, overall survival in EOC does not improve dramatically. Although, most patients respond to the first-line treatment with platinum-based chemotherapy, up to 60 to 80% of them develop recurrence within the first 2 years with median progression-free survival of only 18.2 months[10].

In recurrent EOC, surgical treatment may have some roles in selected patients. However, this option was uncommon among Thai gynecologic oncologists who responded to the questionnaire. Only half of the responders performed cytoreductive surgery at recurrence, and in less than 10% of their patients. This might probably be from the inconclusive of the benefit of secondary cytoreductive surgery for recurrent EOC. One large population-based retrospective study from Surveillance, Epidemiology and End Results(SEER)-Medicare data showed significantly increased survival about 1.3 years in patients receiving secondary surgery with chemotherapy compared with those receiving chemotherapy alone[11]. However, GOG213, a large randomized controlled trial in recurrent platinum-sensitive ovarian cancer patients recently reported that secondary cytoreductive surgery followed by chemotherapy did not have significantly prolonged progression-free survival and overall survival compared to chemotherapy alone[12]. In the other hand, another trial, DESKTOP III, showed a benefit regarding progression-free survival at the interim analysis in the overall population[13]. The difference of these trials' results was hypothesized from the benefit of the adjuvant treatment from added bevacizumab in GOG213 trial. Aside from the inconsistent data on benefit of secondary surgery, limited number of recurrent epithelial ovarian cancer patients who were good candidates for secondary cytoreductive surgery may be another explanation for the uncommon practice among our responders. Proper selection of real candidates by a predictive marker for complete cytoreduction is crucial for an optimal benefit, e.g., having long disease-free interval, complete resection at first surgery, good performance status, young age and less co-morbidities. Disease presentation such as no unresectable lesions and no ascites or ascites not more than 500 cc is also important. Moreover, surgeons' skills and know-how, experience and expertise and personal motivation are necessary and important to make it a successful procedure[14]. As found in this survey that the gynecologic oncologists who had been practiced in this field more than 5 years were more likely to perform secondary cytoreductive surgery.

The prescription of chemotherapy for patients with recurrent ovarian cancer depends on platinum sensitivity.

Table 2. Treatments in recurrent EOC

Treatments	Number (percent)
Recurrent platinum sensitive EOC	
Paclitaxel/platinum	153 (90.0)
PLD/platinum	117 (68.8)
Single carboplatin	89 (52.4)
Gemcitabine/platinum	85 (50.0)
Single paclitaxel	40 (23.5)
Recurrent platinum resistance or refractory EOC	
First choice	
Gemcitabine	91 (53.5)
PLD	72 (42.4)
Paclitaxel weekly	7 (4.1)
Second choice	
Gemcitabine	62 (36.5)
PLD	53 (31.2)
Paclitaxel weekly	48 (28.2)
Topotecan	6 (3.5)
Best supportive care	1 (0.6)
Third choice	
Paclitaxel weekly	76 (44.7)
PLD	32 (18.8)
Topotecan	30 (17.7)
Best supportive care	18 (10.6)
Gemcitabine	14 (8.24)
Fourth choice	
Best supportive care	72 (42.4)
Topotecan	62 (36.5)
Paclitaxel weekly	24 (14.1)
PLD	7 (4.1)
Gemcitabine	5 (2.9)
Fifth choice	
Best supportive care	119 (70.0)
Topotecan	42 (24.7)
Paclitaxel weekly	5 (2.9)
PLD	3 (1.8)
Gemcitabine	1 (0.6)
Other regimens	
Oral etoposide	72/103 (69.9)
Targeted therapy (Bevacizumab, PARP inhibitors)	15/103 (14.6)
Hormonal treatment (megestrol acetate, tamoxifen)	8/103 (7.8)

Along with evidence-based data, reinduction with platinum chemotherapy or combination with other agents is recommended for platinum-sensitive diseases, and platinum combined with paclitaxel is the most common regimen in this setting. Combination of platinum with other agents such as pegylated liposomal doxorubicin or gemcitabine and single agent with carboplatin or paclitaxel are also alternative options[15-18]. However, the response rate to reinduction with platinum agent is not satisfactory high to 100%. Another important factor aside from the platinum sensitivity status is the length of platinum-free interval. The probability of the response may be above 60% if the interval is more than 12 months. But the probability of response decreases to 30 to 40% if the interval is between 6 to 12 months[19].

The remaining patients who were platinum-refractory or platinum-resistant, second- or higher- line of chemotherapeutic agents were administered. However, there is no evidence to support which regimen is superior to the others. Response rates typically are low, clinical response rates range from 0% to 60% and progression-free survival is short and ranged from only 1 to 10 months[20].

Among the Thai gynecologic oncologists who responded, the most common second line chemotherapeutic agent was gemcitabine, followed by PLD and paclitaxel. Topotecan, oral etoposide, targeted therapies, and hormone treatment were less common and served as later subsequent options. With similar response rates yielded from these drugs as described earlier, many other factors may be taken into consideration in clinical practice, e.g., the remaining side effects from prior treatment, toxicity of the recently prescribed agents, patients' performance status, co-morbidities, financial status, health coverage, and physician preference. Although the efficacy of PLD is not inferior to gemcitabine in terms of time to progression, PLD has significantly better quality of life and tends to have more favorable overall survival than gemcitabine[8]. This issue may not take precedence in some scenarios. For examples, health coverage or reimbursement by Thai National Health insurance is probably a more major concern in this country. As demonstrated in this survey that gemcitabine was more frequently selected among the responders than PLD because only gemcitabine and paclitaxel can get reimbursement by universal health coverage scheme. On the other hand, PLD is covered only by the civil servants' medical benefit scheme. As a result, gemcitabine is significantly more common to use as second-line chemotherapy among Thai gynecologic oncologists. However, the responders with more than 6 gynecologic oncologists favored PLD more than gemcitabine and paclitaxel as second-line chemotherapy. More number of gynecologic oncologists may work in the larger hospitals than the less number. These hospitals usually are referral centers and academic settings.

If the patients receive more than 3 lines of chemotherapy, response rate and survival outcome become progressively decreased[10]. In this survey, best supportive care was offered to recurrent platinum-resistant ovarian cancer patients at the rate of 10% after they failed 2 lines of non-platinum chemotherapy and it increased to 42% and 70% if they failed more than 3 and 4 lines, respectively. Previous survey in recurrent ovarian cancer patients reported that they preferred to switch from salvage chemotherapy to palliative care if, median survival with chemotherapy was shorter than 5 months[21]. The American Society of Clinical Oncology recommends that chemotherapy should be avoided at the end of life, this option of management can improve patient care and reduce costs[22]. Therefore, the patient's and physician's choice between chemotherapy and palliative treatment should be discussed in all aspects

Table 3. Factors affected prescription of second-line chemotherapeutic regimens

Factors	Gemcitabine n (%)	PLD n (%)	Paclitaxel n (%)	*p*-value
Age (years)				0.210
≤41	60 (56.6)	40 (37.7)	6 (5.7)	
>41	31 (48.4)	32 (50.0)	1 (1.6)	
Gender				0.751
Male	31 (50.0)	28 (45.2)	3 (4.8)	
Female	60 (55.6)	44 (40.7)	4 (3.7)	
Experience (years)				0.186
≤5	47 (53.4)	35 (39.8)	6 (6.8)	
>5	44 (53.7)	37 (45.1)	1 (1.2)	
Hospital sector				0.191
Government	85 (55.9)	61 (40.1)	6 (4.0)	
Private	6 (33.3)	11 (61.1)	1 (5.6)	
Hospital competency				0.383
Secondary	14 (50.0)	14 (50.0)	0 (0.0)	
Tertiary	77 (54.2)	58 (40.9)	7 (4.9)	
Fellowship training center				0.223
No	50 (59.5)	30 (35.7)	4 (4.8)	
Yes	41 (47.7)	42 (48.8)	3 (3.5)	
Number of gynecologic oncologists				0.004
≤6	52 (66.7)	23 (29.5)	3 (3.8)	
>6	39 (42.4)	49 (53.3)	4 (4.3)	
Percentage of optimum debulking				0.476
≤65	36 (50.0)	34 (47.2)	2 (2.8)	
>65	55 (56.1)	38 (38.8)	5 (5.1)	

Table 4. Factors affected prescription of targeted therapy

Factors	Prescription ≤5% of patients, n (%)	Prescription >5% of patients, n (%)	*p*-value
Age (years)			0.988
≤41	29 (35.4)	53 (64.6)	
>41	22 (35.5)	40 (64.5)	
Gender			0.522
Male	17 (32.1)	36 (67.9)	
Female	34 (37.4)	57 (62.6)	
Experience (years)			0.896
≤5	23 (34.8)	43 (65.2)	
>5	28 (35.9)	50 (64.1)	
Hospital sector			0.033
Government	50 (38.2)	81 (61.8)	
Private	1 (7.7)	12 (92.3)	
Hospital competency			0.694
Secondary	8 (32.0)	17 (68.0)	
Tertiary	43 (36.1)	76 (63.9)	
Fellowship training center			0.014
No	16 (24.6)	49 (75.4)	
Yes	35 (44.3)	44 (55.7)	
Number of gynecologic oncologists			0.491
≤6	20 (32.3)	42 (67.7)	
>6	31 (37.8)	51 (62.2)	
Percentage of optimum debulking			0.428
≤65	26 (38.8)	41 (61.2)	
>65	25 (32.5)	52 (67.5)	

including toxicity profiles, quality of life, and cost-effectiveness. The quality of death in Thailand is ranked 44th among 80 countries[23]. Although much has been achieved, palliative care provision in Thailand must be improved to meet the Universal Health Coverage goals of the World Health Organization[24].

Two clinical settings wherein targeted therapy either bevacizumab or PARP inhibitors plays certain role in recurrent epithelial ovarian cancer; (1) monotherapy or combination with non-platinum chemotherapy in platinum-resistant recurrent ovarian cancer and (2) maintenance treatment in platinum-sensitive recurrent ovarian cancer. However, there are some limitations. Although bevacizumab with chemotherapy showed some efficacy in platinum-resistant recurrent ovarian cancer, the progression-free survival and overall survival gains were only of marginal benefit. Only 3 months prolonged progression-free survival (6.7 months versus 4.7 months) and similar overall survival (16.9 months both) were found with the combination compared to chemotherapy alone[25,26]. PARP inhibitors as a monotherapy which showed significant benefit in platinum-resistant recurrent ovarian cancer, however the efficacy was demonstrated only in patients who had *BRCA* mutation[27,28]. Maintenance treatment with targeted therapy in platinum-sensitive recurrent ovarian cancer has been rapidly emerged in clinical practice since it extends the progression of disease after completion of chemotherapy and may prolonged overall survival. Both bevacizumab and PARP inhibitors have strong evidence to support this benefit in platinum-sensitive recurrent ovarian cancer. However, PARP inhibitors have most significantly prolonged progression-free survival in patients with *BRCA* mutation or homologous recombination repair defect[29]. The survey found that only 15% of Thai gynecologic oncologists had never used targeted therapy in the treatment of EOC. Among the responders who had experience, this was limited to only 5% of their patients. At the time of this survey, the PARP inhibitors (olaparib®) has just been approved by Thai FDA. Therefore, targeted therapy in this survey may represent only bevacizumab. The most common timing for its prescription was as first-line agent in the primary treatment followed by at the recurrence with platinum-sensitive status. The reasons for limited use of targeted therapy in Thai gynecologic oncologists should be from the high cost of targeted therapy and reimbursement issue. As this result, the gynecologic oncologists who practiced in private sector prescribed targeted therapy more frequently than those worked in government sector.

Although this study was Thailand's first national survey in the treatment of recurrent EOC with a remarkable number of respondents, there were some limitations. Our results were quantitatively collected in only frequencies of preference practice. Further inquiries regarding the rationale of their decisions such as qualitative study should be explored to better understand the situations. Moreover, the future research information about treatment outcomes, patients' quality of life and health economic assessment in Thai context might be essential for the oncologists' decision.

In conclusion, almost half of Thai gynecologic oncologists who participated in this survey reported that they performed surgery after recurrence of ovarian cancer, but in only 10% of their patients. This was probably due to the inconclusive evidence regarding the benefit of secondary cytoreductive surgery in recurrent setting. Furthermore, selection of an optimal candidate was probably another issue. Chemotherapy is the most common treatment for recurrent ovarian cancer in Thailand. Platinum combined with taxane was the most common regimen for platinum-sensitive recurrent EOC, whereas gemcitabine, PLD and paclitaxel were the 3 most common regimens for platinum-resistant recurrent EOC. Thai gynecologic oncologists had ever prescribed targeted therapy for less than 5% of their patients. Reimbursement by Thai Universal Health insurance was a major factor limiting the use of various chemotherapeutic agents including targeted therapy. Nevertheless, Thai gynecologic oncologists were aware of the futility of aggressive treatment. Toxicities from cytotoxic drugs, quality of life and cost-effectiveness should be discussed. Best supportive care might be considered when life expectancy was unfavorably short.

What is already known on this topic?

There was an inconclusive evidence of the surgical role as a treatment option for recurrent EOC. Cytoreductive surgery was limited in the recurrent setting because of the identification of the proper candidates, and the experience of surgeons in this surgical complexity. Chemotherapy was the preference in recurrent setting. Platinum combined with taxane, as the first-line treatment, was the most common regimen for platinum-sensitive recurrent EOC. For the platinum resistance, gemcitabine, PLD, paclitaxel, oral etoposide, and topotecan were comparable in the treatment response and defined as second-line treatment. Beyond the second-line treatment, best supportive care was an alternative option. Targeted therapy, bevacizumab and PARP inhibitor, also provided roles as additional or maintenance treatment to chemotherapy in recurrent platinum sensitive EOC. Mentioned above content was a common practice in current worldwide including in Thailand. However, the sequence of chemotherapy use in different settings after failure from the first-line drugs was unclear.

What this study adds?

In Thailand, cytoreductive surgery in recurrent ovarian cancer has been performed by half of the gynecologic oncologists but in less than 10% of their patients. Chemotherapy is the most common treatment for recurrent ovarian cancer. Platinum combined with taxane was the most common regimen for platinum-sensitive recurrent EOC, whereas gemcitabine, PLD and paclitaxel were the 3 most common regimens for platinum-resistant recurrent EOC. Thai gynecologic oncologists have ever prescribed targeted therapy for less than 5% of their patients. Best supportive care might be given when the failure of second-line chemotherapy occurred.

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Potential conflicts of interest

The authors declare no potential conflict of interest.

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การดูแลรักษาผู้ป่วยมะเร็งรังไข่ชนิดเยื่อบุผิวที่มีการกลับเป็นซ้ำ: การสำรวจแนวปฏิบัติของแพทย์มะเร็งนรีเวชไทย

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วัตถุประสงค์: เพื่อสำรวจและศึกษาแนวปฏิบัติของแพทย์มะเร็งนรีเวชไทยในการดูแลรักษาผู้ป่วยมะเร็งรังไข่ชนิดเยื่อบุผิวที่มีการกลับเป็นซ้ำ

วัสดุและวิธีการ: การศึกษานี้เป็นส่วนหนึ่งของการสำรวจระดับประเทศเรื่องแนวปฏิบัติสำหรับแพทย์มะเร็งนรีเวชไทยในการดูแลผู้ป่วยมะเร็งนรีเวช ซึ่งจัดการสำรวจและศึกษาโดยสมาคมมะเร็งนรีเวชไทย โดยคำถามเกี่ยวกับมะเร็งรังไข่จำนวน 21 ข้อได้ถูกนำมาวิเคราะห์

ผลการศึกษา: แพทย์มะเร็งนรีเวชในประเทศไทยที่เข้าเกณฑ์คัดเข้าสำหรับงานวิจัยนี้มีจำนวนทั้งสิ้น 258 คน มีผู้ตอบแบบสอบถามทั้งสิ้น 170 คน คิดเป็นร้อยละ 65.9 ผลการวิจัยพบว่า ประมาณครึ่งหนึ่งของแพทย์มะเร็งนรีเวชที่ตอบแบบสอบถามให้การรักษาผู้ป่วยมะเร็งรังไข่ชนิดเยื่อบุผิวที่มีการกลับเป็นซ้ำของโรคด้วยการผ่าตัด คิดเป็นสัดส่วนเพียงร้อยละ 10 ของผู้ป่วยมะเร็งรังไข่ที่มีการกลับเป็นซ้ำทั้งหมด แพทย์มะเร็งนรีเวชร้อยละ 90 เลือกให้ยาเคมีบำบัดซึ่งได้แก่ ยากลุ่ม platinum ร่วมกับ paclitaxel ในผู้ป่วยมะเร็งรังไข่ที่มีการกลับเป็นซ้ำที่มีสถานะ platinum-sensitive ในผู้ป่วยที่มีสถานะ platinum-resistant หรือ platinum-refractory แพทย์มะเร็งนรีเวชเลือกใช้ยาเคมีบำบัดกลุ่ม second-line ดังต่อไปนี้เป็นขนานแรก โดยแพทย์ร้อยละ 53.5 ใช้ยา gemcitabine ร้อยละ 42.4 ใช้ยา liposomal doxorubicin และร้อยละ 4.1 ใช้ paclitaxel เมื่อพบว่ายาเคมีบำบัดตั้งแต่ 2 ขนานไม่ได้ผลในการรักษา แพทย์จะให้การรักษาแบบประคับประคองหรือรักษาตามอาการ และเมื่อเคมีบำบัดมากกว่า 3 ขนานไม่ได้ผล แพทย์ร้อยละ 70 เลือกที่จะให้การรักษาแบบประคับประคองเพียงอย่างเดียว เมื่อสำรวจเรื่องการรักษาด้วยยาแบบพุ่งเป้าพบว่า แพทย์มะเร็งนรีเวชมีการใช้ยาดังกล่าวที่ค่ามัธยฐานร้อยละ 5

สรุป: การรักษาด้วยยาเคมีบำบัดเป็นวิธีการรักษาที่ถูกเลือกใช้มากที่สุดในผู้ป่วยมะเร็งมะเร็งรังไข่ชนิดเยื่อบุผิวที่มีการกลับเป็นซ้ำ การเบิกจ่ายจากรัฐในสิทธิการรักษาแบบประกันสุขภาพถ้วนหน้า มีผลต่อการจำกัดการใช้เคมีบำบัดหลายชนิดรวมถึงการรักษาด้วยยาแบบพุ่งเป้า การรักษาแบบประคับประคองเป็นทางเลือกที่ใช้อย่างกว้างขวางในการดูแลผู้ป่วยมะเร็งรังไข่ชนิดเยื่อบุผิวที่มีการกลับเป็นซ้ำ และมีสถานะ platinum-resistance ซึ่งดื้อต่อยาเคมีบำบัดอย่างน้อย 3 ขนาน