Impact of multiparametric MRI on staging and management of patients with suspected or confirmed ovarian cancer Short title: MR in Ovarian Cancer (MROC study)

Record Status
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Citation
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Authors' objectives
Ovarian cancer causes more deaths in the UK than all other gynaecologic cancers combined. In >60% of patients, the cancer has already spread inside the abdomen by the time patients are diagnosed. The best treatment option at this time is surgical removal of all or most of the disease. Currently, a simple test called a CT scan (or Cat Scan) is used to identify where the disease is located and if surgery would be a suitable treatment option. However, CT cannot always separate diagnosis of benign (not cancer) from malignant (cancer) masses nor can it always reliably identify when it would be beneficial to operate, nor how far the cancer has spread. Because clinicians want to offer patients the chance of surgery when possible, women are given the benefit of any doubt if there is any uncertainty on the CT scan whether subsequent surgery will be successful; this means that 15-40% of patients are found to have inoperable disease at the time of surgery, gaining little benefit from surgery and chemotherapy is delayed. Additionally, in up to 30% of cases, suspected ovarian cancer turns out not to be cancer at all, and these women could have undergone less complex surgery or even avoided surgery and associated psychological distress if the CT scan was more accurate. It is possible that a different type of scan, called MR scan, may be more accurate than CT, especially a newer version multi-parametric MR (mpMR). Small studies suggest mpMR is better at discriminating ovarian cancer from non cancer (benign ovarian masses) and in seeing how much the disease has spread. This is important for planning the type of surgery and whether surgery will be successful in removing disease. Our study aims to determine whether women would benefit from having a pre-operative mpMR compared to CT scan recommended in NICE guidelines. We will approach women to have an extra mpMR scan if fit for surgery, aiming to recruit 645 women across 10 specialist NHS centres over 48 months. We will use MR methods and scanners that are available in the NHS. To prove that we can recruit women to the study, we will first pilot our research in 3 centres, progressing only if our minimum targets are met. We will determine how many women have important differences in disease stage and extent which would lead to different treatment planning if mpMR had been used instead of (or in combination with) standard CT. We have considered ethical issues arising if patients and their doctors are denied potentially important information from the mpMR scan done for research; this issue arose prominently in our patient consultation when planning our study. While mpMR is novel and unproven, and therefore the CT will determine the care for the patient primarily (as recommended by NICE), we will present the critical mpMR results to the doctors before surgery. We will give clear information when mpMR shows an important critical additional finding that could be used to benefit participants. We will undertake a cost-effectiveness analysis to understand the balance of cost to NHS & to patient benefit and will fund separately a psychological evaluation of women’s perceptions, expectations, and experience of the tests, as supported by our patient questionnaire. We have an excellent team, many having worked successfully together on other multi-center MRI studies (e.g.STREAMLINE, MAPPING). Senior support by HTA trialists, statistician and economist combines with world-class clinicians.

Project page URL
http://www.nets.nihr.ac.uk/projects/hta/143104

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