**Edessy ovarian cancer score (EOCS) in prediction of malignant ovarian masses**

Mahmoud Sayed El Edessy, Hesham Saleh mohammed, and Abd Alsttar Alwaziry

Obstetrics and Gynecology Department, Al-Azhar University, Assuit, Egypt

Abdalsttar.alwaziry@gmail.com

**Abstract: Background:** recognizing cancer means that treatment is not delayed and appropriate staging can be carried out in specialized surgical centers. **Objective:** The aim of this study was to evaluate the risk factors of ovarian cancer and to find out an ovarian cancer score. **Methods:** This is a prospective study of 200 women admitted to the Department of Obstetrics and Gynecology of El Maadi Military Medical compound & Oncology institute after obtaining informed patients' consent for surgical exploration of pelvic masses. To diagnose malignant ovarian tumors and calculate Edessy ovarian cancer score for every case. **Results:** Using a cut-off level more than 5 to indicate malignancy, the suggested score gave sensitivity of 83%, specificity of 79.1%, PPV of 54.9%, and NPV of 93.8%, there were statistical significance increase in number of cases showed malignancy in cases with score more than 5 and significant increase in cases with benign lesions in those had score from 0 to 5. **Conclusion:** We concluded that the suggested score can be used for selection of cases for optimal therapy. This score is a simple technique that can be used even in less­specialized gynecology clinics to facilitate the selection of cases for referral to an oncology unit. Recommendations: Giving multiple score points for ultrasonographic features may significantly improves the results of next studies aiming to find out a good new score.

[Mahmoud Sayed El Edessy, Hesham Saleh mohammed, and Abd Alsttar Alwaziry. **Edessy ovarian cancer score (EOCS) in prediction of malignant ovarian masses.** *N Y Sci J* 2017;10(3):75-79]. ISSN 1554-0200 (print); ISSN 2375-723X (online). <http://www.sciencepub.net/newyork>. 11. doi:[10.7537/marsnys100317.11](http://www.dx.doi.org/10.7537/marsnys100317.11).

**Keywords:** Ovarian cancer, Pelvic mass, Ovarian cancer score

**1. Introduction**

Ovarian cancer is the leading cause of death from gynecologic malignancy in the united states. Approximately 21,990 cases are diagnosed annually, and there are 15,460 deaths attributed to ovarian cancer each year *(Siegel R et al., 2011)*. Most patients present with advanced disease where the prognosis is poor. Although early-stage ovarian cancer is highly curable with conventional treatment, it is estimated that only 15% of patients have the disease confined to the ovary at the time of diagnosis*) Jelovac et al., 2011).*

Most clinicians agree that the preliminary evaluation of a complex ovarian tumor should include a careful history, physical examination, laboratory studies including biomarker analysis, and appropriate imaging study *(Myers et al., 2006).* Many investigators believe that in order to have a significant impact on reducing ovarian cancer mortality, we must place more emphasis on the development and testing of methods for early detection of the disease. It has been estimated, for example, that if 75% of ovarian cancer cases could be detected with stage I or II disease, the number of women dying of this cancer would be reduced by one half. One approach to early detection of ovarian cancer is to screen women at risk for the disease before the onset of symptoms*) Havrilesky et al., 2011).*

The risk of malignancy index (RMI) in [ovarian tumours](https://radiopaedia.org/articles/ovarian-tumours) is a validated clinical tool used for risk stratification of ovarian lesions, to guide further management *(Meys et al., 2016).*

Mean survival time for women with ovarian malignancy is significantly improved when managed within a specialist gynaecological oncology service. Hence early diagnosis and referral is important. As the risk of malignancy increases, the appropriate location for management changes. Therefore, while women with a low risk of malignancy (RMI I less than 200) may be managed in a general gynaecology or cancer unit, those who are at higher risk (RMI I greater than or equal to 200 and suspicious CT findings) should be discussed by a multidisciplinary team *(Geomini et al., 2011).*

The purpose of this study was to evaluate the risk factors of ovarian cancer and to evaluate the ability of the suggested score to discriminate a benign from a malignant pelvic mass and to evaluate its performance.

**2. Materials and Methods**

We conducted a prospective study of 200 women admitted to the Department of Obstetrics and Gynecology of El Maadi Military Medical compound & Oncology institute after obtaining informed patients' consent for surgical exploration of pelvic masses. between April 2013 and December 2015. The study was approved by the Ethics Committee of Faculty of Medicine, Al-Azhar university, Assuit. We included patients who met the following criteria; 1) age of 35 years or older 2) having adnexal mass diagnosed by an ultrasound evaluation by either an abdominal transducer or a transvaginal probe 3) having preoperative measurement of serum levels of CA 125 by using a radioimmunoassay and 4) laparotomy for excision of ovarian mass and histopathology. The exclusion criteria were the patients with incomplete medical record, Any contraindication to operative interference or who already had histological diagnosis of malignant ovarian cancer.

Table 1 Edessy ovarian cancer score (EOCS)

|  |  |  |  |
| --- | --- | --- | --- |
| Score ValueParameter | Value = 0 (low risk) | Value = 1 (high risk) | Value =2 (very high risk) |
| Sonographic features (U) | Unilateral –Unilocular cyst | Unilateral - Multilocular cyst - Solid areas | Ascites or Bilateral lesions or Intra-abdominal metastases |

|  |  |  |  |
| --- | --- | --- | --- |
| Age (A) | 35: 44 years | 45: 55 years | 56: 62 years |
| Serum CA 125 level (C) | 35 U/ml> | 35: 65 U/ml | 65 U/ml ˃ |
| BMI (B) | < 25 Kg /m2 | 25: 35 Kg /m2 | ˃ 35 Kg /m2 |
| Parity (P) | 3rd para or more | 1st or 2nd para | Nullipara |

Edessy ovarian cancer score (EOCS)was calculated for all patients together with the sensitivity, specificity and positive and negative predictive values of the suggested score. We used cut-off level of more than 5 for indicating malignancy. The methods for Edessy ovarian cancer score calculation were as follows: EOCS = U + A + C + B + P. The collected data were computerized and statistically analyzed using SPSS program (Statistical Package for Social Science) version 18.0. Qualitative data were represented as frequencies and relative percentages. Chi square test was used to calculate difference between qualitative variables in different groups. Reliability data were calculated using: Sensitivity, Specificity, Accuracy & positive predictive and negative predictive value. P value less than 0.05 was considered statistically significant. The histopathological diagnosis was considered as the gold standard for defining the outcomes. Tumors were classified according to World Health Organization definitions (1973).

**3. Result**

The suggested score had a good negative predictive value in comparison with its positive predictive value making this score to be used as a good negative test in prediction of ovarian cancer and improving preoperative diagnosis. In our study we found that the suggested score had a good sensitivity and specificity when compared with other scores. We think that malignancy risk indices is more reliable than the menopausal status, serum CA­125 levels, ultrasound features and tumor size separately in detecting malignancy.

There were 200 women included in the study. Table 2 shows patients’ characteristics. For the histological examination, 47 of 200 patients (23.5%) had malignant, and 153 (76.5%) had benign disease. The distribution of histological diagnoses is shown in Table 3.

Table (2): Demographic data of the studied group:

|  |  |
| --- | --- |
| Variable | (*n*=200) |
| Age | *35: 44 years N(%)**45: 55 years N(%)**56: 62 years N(%)* | 77 (38.5%)89 (44.5%)34 (17%) |
| Residence | *Rural N(%)**Urban N(%)* | 106 (53%)94 (47%) |
| Parity | *Nullipara N(%)**1st or 2nd para N(%)**3rd para or more N(%)* | 108 (54%)40 (20%)52 (26%) |
| Smoking | *N(%)* | 13 (6.5%) |

Table (3): Pathology results among the studied group:

|  |  |
| --- | --- |
| Variable | N (%) |
| Benign*Serous cyst adenoma**Mucinous cyst adenoma**Simple serous cyst**Endometriotic cyst**Dermoid cyst**Tubo-ovarian abcess**Retension cyst**Fibroma**Luteoma**Polycystic ovary* | (n=153)53(34.6%)24(15.7%)24(15.7%)19(12.4%)9(5.9%)8(5.2%)8(5.2%)3(2.0%)3(2.0%)2(1.3%) |
| Malignant*Serous adenocarcinoma**Mucinous adenocarcinoma**Papillary cyst-adenocarcinoma**Undifferentiated carcinoma**Poorly differentiated serous adenocarcinoma**Clear cell carcinoma**Endometroid carcinoma* | (n=47)21(44.7%)16(34.0%)5(10.6%)2(4.3%)1(2.1%)1(2.1%)1(2.1%) |

Univariate analysis showed that there were statistically significant differences between the benign, and malignant group in these factors: Parity, BMI, and CA 125. The results of evaluation by EOCS are summarized in Table 4. By using a cut-off level more than 5 to indicate malignancy, the EOCS gave sensitivity of 83%, specificity of 79.1%, positive predictive value of 54.9%, and negative predictive value of 93.8% (Table 5). Table 6 shows after application of binary Logistic regression analysis for detection of significant risk factors of malignant ovarian lesions it was found that the significant risk factors were nulliparity, smoking, abdominal enlargement, CA 125 level more than 35 U/ml, ascites, lesions more than 10 cm, very high risk by US and score more than 5.

**Table (4): Comparison between benign and malignant cases in studied parameters:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Variable | Total (n=200) N (%) | Benign (n=153) N (%) | Malignant (n=47) N (%) | P# |
| Age | 35: 44 years45: 55 years56: 62 years | 77 (38.5%)89 (44.5%)34 (17%) | 65 (42.5%)64 (41.8%)24 (15.7%) | 12 (25.5%)25 (53.2%)10 (21.3%) | 0.04\*0.170.37 |
| Residence | RuralUrban | 106 (53%)94 (47%) | 87 (56.9%)66 (43.1%) | 19 (40.4%)28 (59.6%) | 0.04\* |
| Parity | Nulli-para1st or 2nd para3rd para or more | 108 (54%)40 (20%)52 (26%) | 72 (47.1%)32 (20.9%)49 (32.0%) | 36 (76.6%)8 (17.0%)3 (6.4%) | <0.001\*\*0.56<0.001\*\* |
| Smoking |  | 13 (6.5%) | 3 (2.0%) | 10 (21.3%) | <0.001\*\* |
| History | Pelvic painAbdominal painAbdominal bloatingMenstrual irregularityConstipationDyspareuniaAbdominal enlargement | 112 (56%)75 (37.5%)110 (55%)115 (57.5%)67(33.5%)70 (35%)92 (46%) | 91(59.5%)53(34.6%)76(49.7%)83(54.2%)51(33.3%)52(34.0%)59(38.6%) | 21(44.7%)2(46.8%)234(72.3%)32(68.1%)16(34.0%)18(38.3%)33(70.2%) | 0.070.130.006\*\*0.090.930.59<0.001\*\* |
| Comorbidity | DMHPT | 23 (11.5%)42 (21%) | 16 (10.5%)33 (21.6%) | 7 (14.9%)9 (19.1%) | 0.720.40 |
| BMI | ˂ 25 Kg /m225: 35 Kg /m2˃ 35 Kg /m2 | 82 (41%)77 (38.5%)41 (20.5%) | 71 (46.4%)57 (37.3%)25 (16.3%) | 11 (23.4%)20 (42.6%)16 (34.0%) | <0.001\*\*0.51<0.001\*\* |
| Abdominal Mass | 51 (25.5%) | 33 (21.6%) | 18 (38.3%) | 0.02\* |
| CA 125 | ˂ 35 U/ml35: 65 U/ml˃ 65 U/ml | 92 (46%)87 (43.5%)21 (10.5%) | 81 (52.9%)63 (41.2%)9 (5.9%) | 11 (23.4%)24 (51.1%)12 (25.5%) | <0.001\*\*0.23<0.001\*\* |
| Sonograhic feature | UnilateralBilateral | 133(66.5%)67(33.5%) | 120(78.4%33(21.6%) | (27.7%)13(72.3%)34 | <0.001\*\* |
| UnilocularMultilocular | 45(22.5%)155(77.5%) | 40(26.1%)113(73.9%) | 5(10.6%)42(89.4%) | 0.03\* |
| Solid area | 7 (3.5%) | 4(2.6%) | 3(6.4%) | 0.22 |
| Ascities | 9 (4.5%) | 1(0.7%) | 8(17%) | <0.001\*\* |
| Metastasis | 2(1%) | 0(0%) | 2(4.3%) | 0.04\* |
| Size | ˂ 6 cm6: 10 cm˃ 10 cm | 37(18.5%)93(46.5%)70(35%) | 34(22.2%)74(48.4%)45(29.4%) | 3(6.4%)19(40.4%)25(53.2%) | 0.01\*0.340.002\*\* |
| Sonographic risk | Low riskHigh riskVery high risk | 36 (18%)93 (46.5%)71 (35.5%) | 34 (22.2%)85 (55.6%)34 (22.2%) | 2 (4.3%)8 (17.0%)37 (78.7%) | 0.005\*\*<0.001\*\*<0.001\*\* |
| Score point | 0 – 5 (n=129)6 – 10 (n=71) | 129 (64.5%)71 (35.5%) | 121 (93.8%)32 (45.1%) | 8 (6.2%)39 (54.9%) | <0.001\*\* |

Table 5

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Cut off | Sensitivity | Specificity | PPV | NPV | Accuracy | AUC | P value |
| > 5 | 83 | 79.1 | 54.9 | 93.8 | 80 | 0.86 | <0.001\*\* |

**Table -6 Logistic regression analysis for detection of significant risk factor of malignant ovarian lesions:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | B | S.E. | Wald | Sig. | Exp(B) | C.I. |
| Risk factor | Lower | Upper |
| Age(35-44 years)Urban residence | 0.060.70 | 0.440.53 | 0.981.73 | 0.190.19 | 1.052.02 | 0.630.71 | 4.155.74 |
| Nullipara | 1.32 | 0.65 | 4.13 | 0.04\* | 3.73 | 1.05 | 13.24 |
| Smoking | 3.12 | 0.86 | 13.07 | <0.001\*\* | 22.73 | 4.18 | 123.61 |
| Abdominal bloating | 0.72 | 0.55 | 1.75 | 0.19 | 2.06 | 0.71 | 5.98 |
| Abdominal enlargement | 1.87 | 0.68 | 7.52 | 0.006\*\* | 6.48 | 1.70 | 24.6 |
| BMI >25 Kg/m2 | 0.60 | 0.76 | 0.57 | 0.06 | 2.13 | 0.45 | 1.34 |
| Abdominal mass | -0.35 | 0.67 | 0.28 | 0.56 | 0.70 | 0.19 | 2.59 |
| CA 125 > 35 U/ml | 3.01 | 0.69 | 12.14 | 0.01\* | 2.75 | 6.71 | 18.63 |
| Bilateral lesion | -0.06 | 1.59 | 0.001 | 0.97 | 0.95 | 0.04 | 21.5 |
| Multilocular lesion | 0.58 | 0.84 | 0.47 | 0.5 | 1.78 | 0.34 | 9.22 |
| Ascites | 2.03 | 0.89 | 8.02 | 0.02\* | 6.95 | 2.70 | 24.6 |
| Metastasis | 0.75 | 0.57 | 1.85 | 0.09 | 2.4 | 0.74 | 4.08 |
| Size > 10 cm | 3.9 | 0.72 | 11.23 | 0.01\* | 2.98 | 8.90 | 20.5 |
| Very high risk | 3.6 | 0.67 | 4.41 | 0.01\* | 13.41 | 1.507 | 54.72 |
| Score> 5 | 1.34 | 0.72 | 3.47 | 0.04\* | 3.83 | 2.933 | 15.7 |

**4. Discussion**

Correctly discriminating between benign or malignant adnexal masses is the essential starting point for optimal management. Most women with an adnexal mass do not have cancer (Menon et al., 2009).

Estimating the risk of malignancy is essential in the management of adnexal masses. An accurate differential diagnosis between benign and malignant masses will reduce morbidity and costs due to unnecessary operations, and will improve referral to a gynecologic oncologist for specialized cancer care, which improves outcome and overall survival *(Meys et al., 2015).*

Currently, the standard tools for detecting ovarian cancer are pelvic ultrasonography and measuring serum cancer antigen 125 (also called carbohydrate antigen 125; CA-125) levels, which could be combined with the menopausal status to calculate the risk malignancy index (RMI) and is considered a simple and affordable test *(Al-Musalhi et al., 2015).*

the present study aimed to evaluate the risk factors of ovarian cancer and to find out an ovarian cancer score. To achieve this target, we recruited 200 women presented with non-recurrent adnexal masses. They were subjected to careful history taking, thorough clinical examination, ultrasound examination, CA 125 assessment. We formulated a predictive score comprising ultrasound features, age, serum CA 125 levels, body mass index and parity.

In the current study, comparison between patients with benign and malignant tumors revealed that patients with malignant tumors are significantly older than patients with benign tumors. Also, they had higher frequency of BMI ≥ 35 kg/m2. In addition, they had higher frequency of nulliparity.

Also, we noted that patients with malignant tumors had significantly higher frequency of sonographic findings suggestive of malignancy when compared with patients with benign tumors.

The EOCS had a good sensitivity and specificity when compared with other scores. Also it had a good negative predictive value in comparison with its positive predictive value making this score to be used as a good negative test in prediction of ovarian cancer and improving preoperative diagnosis.

**References**

1. Al-Musalhi K, Al-Kindi M, Ramadhan F, Al-Rawahi T, Al-Hatali K, Mula-Abed WA. Validity of Cancer Antigen-125 (CA-125) and Risk of Malignancy Index (RMI) in the Diagnosis of Ovarian Cancer. Oman Med 2015. Nov;30(6):428-434. 10.5001/omj.2015.85.
2. Geomini PM, Kruitwagen RF, Bremer GL, Massuger L, Mol BW Should we centralise care for the patient suspected of having ovarian malignancy? Gynecol Oncol 2011; 122:95–9.
3. Havrilesky LJ, Sanders GD, Kulasingam S, et al. Development of an ovarian cancer screening decision model that incorporates disease heterogeneity. Cancer. 2011;117:545–553.
4. Jelovac D, Armstrong DK. Recent progress in the diagnosis and treatment of ovarian cancer. CA Cancer J Clin. 2011;61:183–203.
5. Menon U, Gentry-Maharaj A, Hallett R, Ryan A, Burnell M, Sharma A, Lewis S, Davies S, Philpott S, Lopes A, Godfrey K, Oram D, Herod J, Williamson K, Seif MW, Scott I, Mould T, Woolas R, Murdoch J, Dobbs S, Amso NN, Leeson S, Cruickshank D, McGuire A, Campbell S, Jacobs I. Sensitivity and specificity of multimodal and ultrasound screening for ovarian cancer, and stage distribution of detected cancers: results of the prevalence screen of the UK Collaborative Trial of Ovarian Cancer Screening (UKCTOCS). Lancet Oncol 2009; 10: 327–340.
6. Meys EM, Rutten IJ, Kruitwagen RF, Slangen BF, Bergmans MG, Mertens HJ, Nolting E, Boskamp D, Beets-Tan RG, van Gorp T. Investigating the performance and cost-effectiveness of the simple ultrasound-based rules compared to the risk of malignancy index in the diagnosis of ovarian cancer (SUBSONiC-study): protocol of a prospective multicenter cohort study in the Netherlands. BMC ancer. 2015 Jun 26;15:482. doi: 10.1186/s12885-015-1319-5.
7. Meys EM, Kaijser J, Kruitwagen RF et-al. Subjective assessment versus ultrasound models to diagnose ovarian cancer: A systematic review and meta-analysis. Eur. J. Cancer. 2016;58: 17-29.
8. Myers ER, Bastian LA, Havrilesky L, et al. Management of Adnexal Mass Evidence Report/ Technology Assessment No130 (Prepared by the Duke Evidence-based Practice Center under Contract No 290-02-0025) AHRQ Publication No 06-E004.
9. Rockville, MD: Agency for Healthcare Research and Quality; 2006.
10. Siegel R, Ward E, Brawley O, Jemal A. cancer statistics, 2011: The impact of eliminating socioeconomic and racial disparities on premature cancer deaths. CA cancer J Clin 2011;61:212-236.

3/15/2017