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Original article

Epithelial Ovarian Cancer: Epidemiological, Diagnostic, Therapeutic Aspects and Survival at the University Hospital of Brazzaville (Republic of the Congo)

Cancer épithélial de l'ovaire : aspects épidémiologiques, diagnostiques, thérapeutiques et survie au Centre Hospitalier Universitaire de Brazzaville (République du Congo)

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Résumé

Introduction : Le cancer de l'ovaire est une prolifération anarchique et incontrôlée des cellules de la glande sexuelle féminine. Il peut intéresser toutes les structures de l'ovaire, en occurrence les cellules du revêtement de surface. L'épithélium recouvrant les ovaires est à l'origine de 90 % des tumeurs ovariennes, qu'elles soient bénignes, frontières (borderline) ou malignes. Le cancer de l'ovaire est plutôt rare mais grave. Décrire les aspects épidémiologiques, diagnostiques, thérapeutiques et la survie des patientes opérées pour cancer épithélial de l'ovaire au Centre Hospitalier Universitaire de Brazzaville.

Méthodologie : Étude longitudinale descriptive monocentrique, menée du 31 octobre 2012 au 31 octobre 2021 au Centre Hospitalier Universitaire de Brazzaville, incluant les patientes ayant bénéficié d'une chirurgie initiale pour cancer épithélial de l'ovaire, confirmé histologiquement. Les variables étudiées ont été sociodémographiques, cliniques, paracliniques, thérapeutiques et liées à la survie. La date d'origine correspondait à la date de la chirurgie. La date de point a été fixée au 31 octobre 2021. L'événement étudié était le décès et le critère de jugement, la survie globale.

Résultats : Durant la période d'étude, 85 patientes porteuses d'une tumeur ovarienne suspecte de malignité ont été opérées. Quarante-cinq (53 %) de ces tumeurs étaient des cancers parmi lesquels, 40 (88,9 %) ont été des cancers épithéliaux de l'ovaire. Les patientes étaient d'un âge médian de 49 ans (40-59) et sans moyens financiers (n = 14 soit 42,4 %). Elles étaient majoritairement multipares (42,4 %), ménopausées (51,5 %) avec un état général conservé (54,6 %). Le diagnostic a été tardif dans 72,2 % de cas, fait aux stades III et IV de la FIGO. L'intervention

chirurgicale la plus réalisée a été l'hystérectomie totale non conservatrice associée à l'omentectomie et appendicectomie (30,3 %). Le résidu tumoral post-opératoire a été macroscopique (R2) dans la majorité des cas (69,7 %). Le délai médian d'obtention de l'histologie était de 4 semaines (2-8). Le cystadénocarcinome séreux était le type histologique le plus fréquent (60,6 %). Le délai médian de mise en route de la chimiothérapie adjuvante était de 8 semaines (5-12) associant Carboplatine et Paclitaxel (73,3 %). À la date de point, 26 (78,8 %) patientes étaient décédées, cinq (15,1 %) étaient en vie et deux (6,1 %) étaient perdues de vue. La survie globale médiane était de 16 mois et les taux de survie sans rechute à un, trois et cinq ans étaient respectivement de 59 %, 14 % et 3 %.

Conclusion : Le cancer épithélial de l'ovaire est une réalité au Centre Hospitalier Universitaire de Brazzaville. Toute tumeur ovarienne en période de la ménopause doit faire suspecter le cancer et faire l'objet d'une étude anatomopathologique. En raison de sa faible survie, la prise en charge du cancer épithélial de l'ovaire doit être collégiale et pluridisciplinaire.

Mots-clés : Cancer épithélial, Ovaire, Diagnostic, Traitement, Survie, Brazzaville.

Abstract

Introduction: Ovarian cancer is an uncontrolled and abnormal proliferation of cells in the female sex gland. It can affect all structures of the ovary, particularly the cells of the surface lining. The epithelium covering the ovaries is the source of 90% of ovarian tumors, whether benign, borderline, or malignant. Ovarian cancer is relatively rare but serious. To describe the epidemiological, diagnostic, therapeutic and survival aspects of patients operated on for epithelial ovarian cancer at the University Hospital of Brazzaville.

Methodology: Monocentric descriptive longitudinal study, conducted from October 31, 2012, to October 31, 2021, at the University Hospital of Brazzaville, including patients who underwent initial surgery for histologically confirmed epithelial ovarian cancer. The variables studied were sociodemographic, clinical, paraclinical, therapeutic and survival related. The original date corresponded to the date of surgery. The endpoint date was set at October 31, 2021. The event studied was death and the endpoint was overall survival.

Results: During the study period, 85 patients with an ovarian tumor suspected of malignancy were operated on. Forty-five (53%) of these tumors were cancers, of which 40 (88.9%) were epithelial ovarian cancers. The patients had a median age of 49 years (40-59) and no financial means (n=14 or 42.4%). They were mostly multiparous (42.4%), postmenopausal (51.5%) with a preserved general condition (54.6%). The diagnosis was late in 72.2% of cases, made at FIGO stages III and IV. The most performed surgical procedure was non-conservative total hysterectomy associated with omentectomy and appendectomy (30.3%). The postoperative tumor residue was macroscopic (R2) in most cases (69.7%). The median time to obtain histology was 4 weeks (2-8). Serous cystadenocarcinoma was the most common histological type (60.6%). The median time to initiation of adjuvant chemotherapy was 8 weeks (5-12) combining Carboplatin and Paclitaxel (73.3%). At the endpoint date, 26 (78.8%) patients had died, five (15.1%) were alive and two (6.1%) were lost to follow-up. The median overall survival was 16 months and the recurrence-free survival rates at one, three, and five years were 59%, 14%, and 3%, respectively.

Conclusion: Epithelial ovarian cancer is a reality at the University Hospital of Brazzaville. Any ovarian tumor during the menopausal period should raise suspicion of cancer and be subjected to anatomopathological study. Due to its low survival, the management of epithelial ovarian cancer must be collegial and multidisciplinary.

Keywords: Epithelial cancer, Ovary, Diagnosis, Treatment, Survival, Brazzaville.

Introduction

Ovarian cancer is an uncontrolled and abnormal proliferation of cells of the female sex gland [1]. It can affect all structures of the ovary, particularly the cells of the surface lining. The epithelium covering the ovaries is the source of 90% of ovarian tumors, whether benign, borderline, or malignant [2].

Ovarian cancer is relatively rare but serious. It ranks 7th among cancers worldwide but represents the 1st cause of death from gynecological cancer [3,4]. In Africa, data on ovarian cancer are very fragmented, most often arising from sectoral studies of a few countries. In Congo, ovarian cancer ranks 4th among cancers in women with 47 cases recorded in 2019 and represents the 3rd gynecological cancer [5].

Epithelial tumors represent the most widespread histological type and correspond to approximately 80-90% of ovarian cancers: serous (50-70%), endometrioid (10-25%), mucinous (5-10%), clear cell (5%), and three much rarer subtypes (transitional cell, undifferentiated, and mixed) [4]. Due to the anatomical location of the ovary, ovarian cancer is a disease that remains silent for a long time, making early diagnosis very difficult, with two out of three cancers discovered at an advanced stage (stage IIIB or IV). Furthermore, no satisfactory screening measure applicable to the entire female population exists to date. Early and optimal management of patients with ovarian cancer therefore remains the best option, combining in advanced forms complete excision surgery with platinum-based polychemotherapy [6]. However, ovarian cancer remains the gynecological cancer with the worst prognosis, with a 5-year survival below 45%, inversely proportional to the post-surgical tumor residue [7]. To this picture is added, in low-resource countries, delayed consultation due to the problem of access to health care and insufficient technical platform [8]. It is thus that the present study aimed to describe the epidemiological, diagnostic, therapeutic, and survival aspects of patients operated on for epithelial ovarian cancer at the University Hospital of Brazzaville.

Methodology

This was a descriptive longitudinal observational study conducted from October 31, 2012, to October 31, 2021, in the departments of Gynecology-Obstetrics and Oncology of the University Hospital of Brazzaville, including patients presenting with an ovarian tumor suspected of malignancy who underwent initial or first surgery as recommended by the European Society of Gynecological Oncology [9] and whose histological type was epithelial ovarian cancer or cystadenocarcinoma. All records were previously discussed and validated in multidisciplinary consultation meetings. Excluded were patients who had undergone interval surgery (surgery after neoadjuvant chemotherapy) for epithelial ovarian cancer and those who had presented a recurrence of this cancer. Cancer staging was performed per-operatively after laparotomy using the FIGO classification [10].

The variables studied were sociodemographic, reproductive, clinical, paraclinical, therapeutic, and survival-related. The origin date corresponded to the date of surgery. The endpoint date was set at October 31, 2021. The event studied was death and the endpoint was overall survival. A follow-up survey was conducted for patients who had interrupted their follow-up. This survey was carried out either by telephone call or through an investigator who visited the patients' homes to inquire about their state of health. In cases where they had died, information on the date and cause of death was recorded with an exact response rate of 100%.

Stata 13 software was used for statistical analysis. Our results were represented as proportions for qualitative variables. Quantitative variables were expressed as median and quartiles (q1 and q3). Survival curves were plotted using the Kaplan-Meier method.

Results

During the study period, we collected 85 patients with ovarian tumors suspected of malignancy, among

which 45 (53%) were cancers, including 40 (88.9%) of epithelial type. Among the epithelial ovarian cancers, 33 underwent initial surgery.

The patients were mostly postmenopausal and in good general condition (WHO performance status 0 and I) at the time of diagnosis (Table I).

The tumor was most often unilateral with radiological characteristics suggestive of malignancy (Table II). The CA 125 antigen was greater than 35 U/ml in all cases.

The diagnosis was late in the majority of cases, made at FIGO stages III and IV (Table III).

Surgery consisted of non-conservative total hysterectomy in 61% of cases (n=20). In all cases (n=33), omentectomy and appendectomy were associated (Figure 1). Surgery was non-carcinological in more than two-thirds of cases (Table III).

The median time to obtain histology was 4 weeks (2-8) with extremes of one and 64 weeks. The most frequent histological type (Figure 2) was serous cystadenocarcinoma (Table III). The histological grade was specified in 73.3% of cases (n=24).

Less than half of the patients benefited from adjuvant chemotherapy with a delay in initiation in two-thirds of cases. The most commonly used protocol insufficiently combined a platinum salt with a taxane. At the endpoint date, 26 (78.8%) patients had died, five (15.1%) were alive, and two (6.1%) were lost to follow-up.

The median overall survival was 16 months and the recurrence-free survival rates at one, three, and five years were 59%, 14%, and 3%, respectively (Figure 3).

Table I. Sociodemographic, Reproductive, and Clinical Characteristics

	Frequency (N=33)	**Percentage**
Age (years) median (q1-q3)	**49 (40-59)**	
Min - Max	23 - 74	
]20 - 40[	7	21.3
[40 - 60[	18	54.5
[60 - 80[	8	24.2
Lack of financial means	14	42.4
Median gravidity (q1-q3)	4 (1-6)	
Min - Max	0 - 10	
Median parity (q1-q3)	2 (1-4)	
Min - Max	0 - 11	
Nulliparous	7	21.2
Primiparous	5	15.2
Pauciparous	7	21.2
Multiparous	14	42.4
Postmenopausal	17	51.5
Comorbidity (1)	7	21.2
WHO Performance Status (2)		
PS 0	3	9.1
PS I	15	45.5
PS II	11	33.3
PS III	3	9.1
PS IV	1	3

(1) Hypertension, diabetes mellitus

(2) World Health Organization

Table II. Echographic Characteristics

	Frequency (N=33)	Percentage
Location		
Unilateral tumor	25	75.8
Bilateral tumor	8	24.2
Irregular contours	32	97.0
Thick wall	19	57.6
Content		
Solid	5	15.2
Fluid	3	9.1
Mixed	25	75.7
Septations	14	42.4
Vegetations	8	24.2
Hypervascularization		
Yes	2	6.1
Not specified	29	87.8
Ascites	24	72.7
Metastases		
Peritoneal	6	18.2
Visceral	11	33.3

Table III. Diagnostic and Therapeutic Characteristics

	Frequency (N=33)	Percentage
FIGO (1) and TNM Classification		
Stage I / T1N0M0	4	12.1
Stage II / T2N0M0	5	15.2
Stage III / T3N0M0	11	33.3
Stage IV / TxNxM1	13	39.4
Tumor residue size		
R0(2)	10	30.3
R2(3)	23	69.7
Histological type		
Serous cystadenocarcinoma	20	60.6
Mucinous cystadenocarcinoma	10	30.3
Mixed cystadenocarcinoma	3	9.1
Adjuvant chemotherapy	15	45.5
Delays(4) surgery - chemotherapy >= 6 weeks	11	73.3
Carboplatin/paclitaxel	11	73.3
Cisplatin/cyclophosphamide	3	20
Cisplatin/docetaxel	1	6.7
Number of cycles(5)		
[1-2]	1	6.7
[3-5]	9	60
[6-9]	5	33.3

(1) International Federation of Gynecology and Obstetrics [11]

(2) R0: no postoperative tumor residue

(3) R2: postoperative tumor residue > 2 cm

(4) Median surgery-chemotherapy delay (weeks): 8 (5-12); extremes [2-84]

(5) Median number of cycles: 4 (3-6); extremes [2-8]

* CFA Franc (African Financial Community franc)

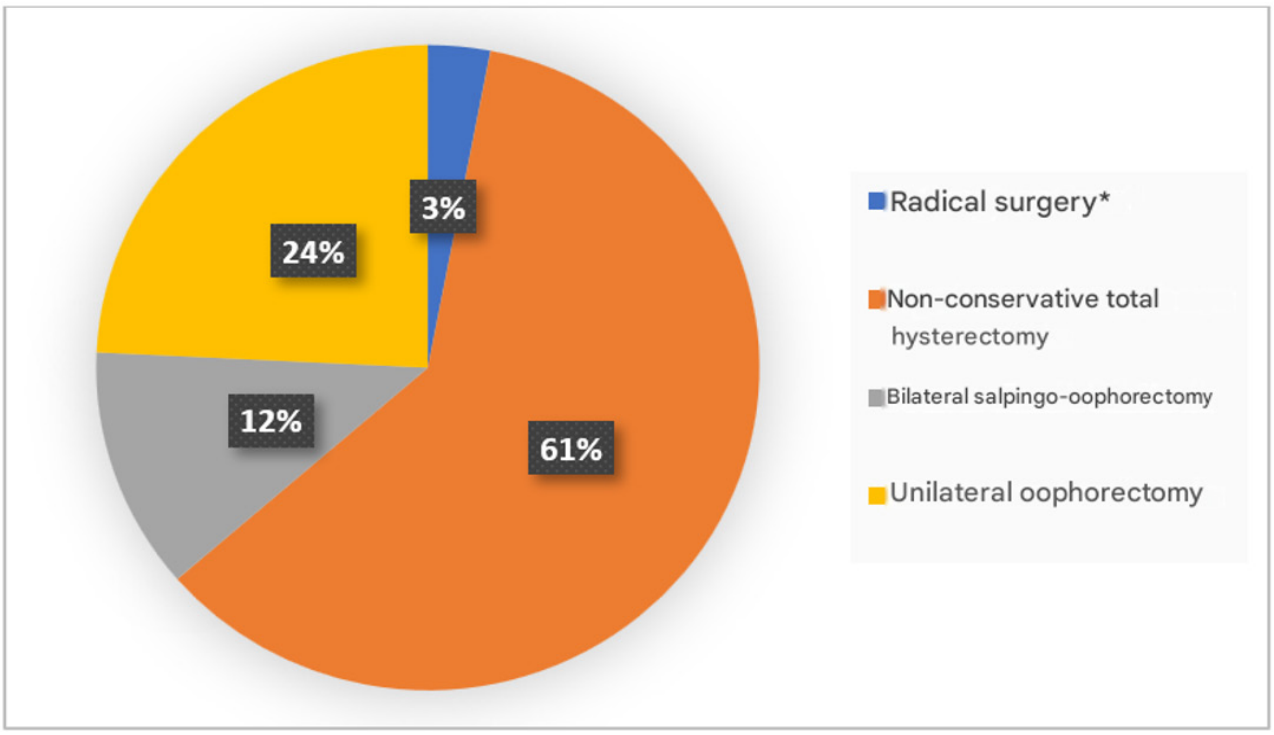

Figure 1. Type of Surgical Intervention

**Radical surgery = complete initial surgery (total non-conservative hysterectomy + appendectomy + omentectomy) and lymph node dissection and/or digestive resection*

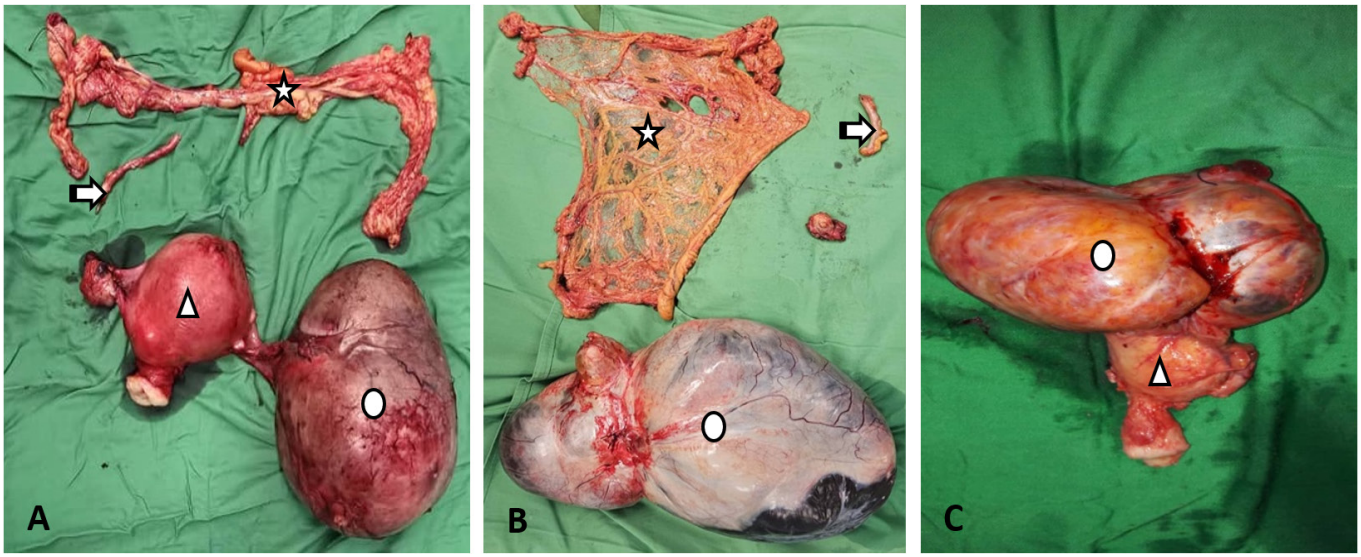

Figure 2. Surgical Specimens

A) Total hysterectomy specimens with salpingo-oophorectomy in one block, appendectomy and omentectomy

B) Oophorectomy, omentectomy, appendectomy specimens

C) Total hysterectomy specimen with salpingo-oophorectomy in one block

Arrowhead: uterus. Circle: ovarian tumor. Star: omentum. Arrow: appendix

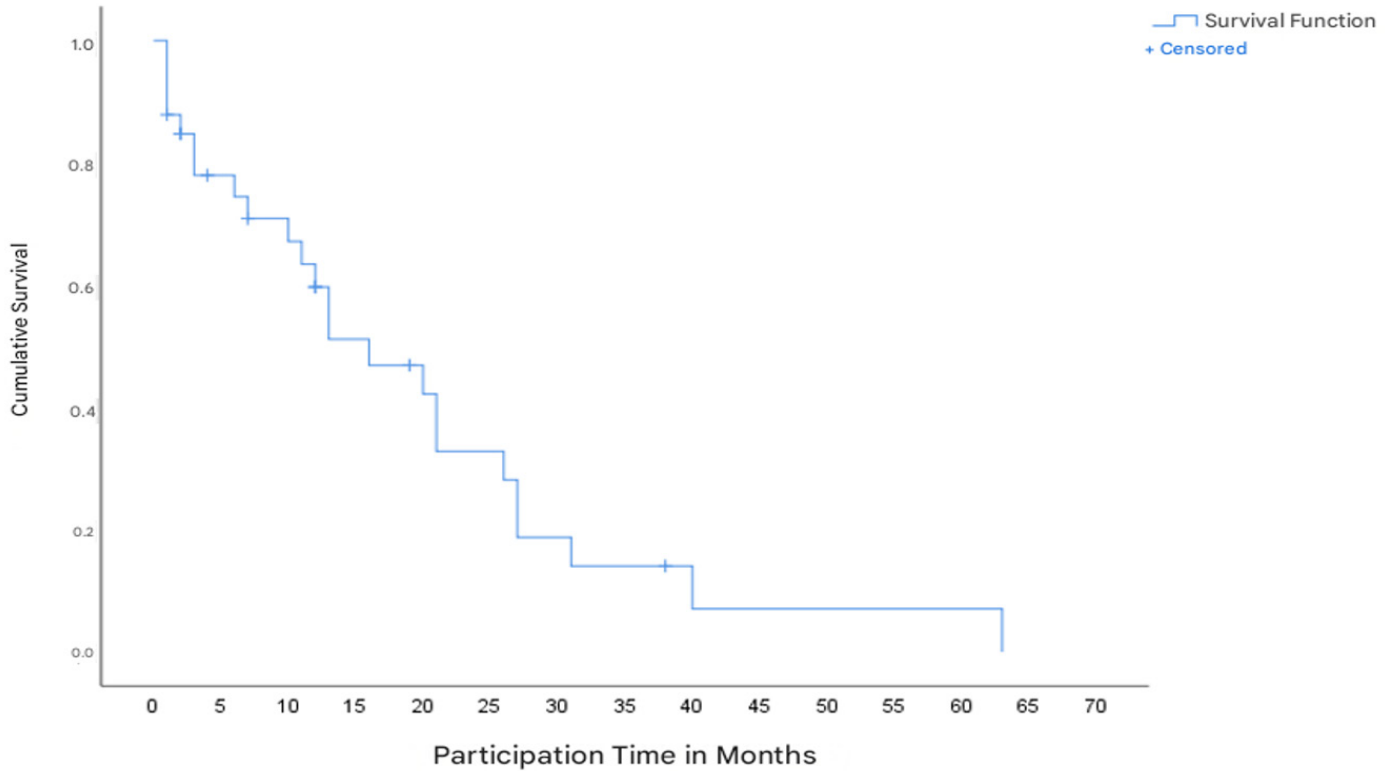

Figure 3. Survival Curve

Discussion

Two-thirds of patients with ovarian tumors suspected of malignancy were operated on and more than half of them were cancers. This is clearly higher than the observations of the Togo team [11], most likely explained by methodological differences. Indeed, our study concerned only tumors suspected of malignancy, unlike theirs in which all ovarian tumors were taken into account, whether benign or malignant. However, according to the Brazzaville cancer registry, ovarian cancer remains an exceptional pathology, although there is a noted increase in the number of incident cases from 196 cases between 1998 and 2009 to 47 cases in 2019, representing incidence rates of 2.3 and 4.8 per 100,000 per year, respectively [5,12]. Furthermore, a trend toward younger age at diagnosis is also observed [5,12].

The median age of the patients was 49 years with a predominance of the 40-59 age group. These data are superimposable to those of other African series [13,14]. Despite the young age in African series, contrasting with the very advanced age in European series [17,18], the patients were all perimenopausal and postmenopausal. Epithelial ovarian cancer mainly affects perimenopausal and postmenopausal women, with 80% to 90% occurring after 40 years [13,14]. In France, the median age at diagnosis in 2018 was 68 years. There is a significant increase in incidence rates from age 35, reaching a maximum value of 47.4 per 100,000 between 75 and 79 years [4].

Nulliparity is considered a risk factor for ovarian cancer through the anovulation theory [15]. However, only 21.2% of our patients were nulliparous. Indeed, ovarian cancer is of multifactorial origin, and certain factors such as genetic factors could explain the forms in young patients, especially in our context where genetic investigations are not often carried out due to lack of technical platform and financial means.

The management of ovarian cancer is burdensome and requires non-negligible financial means. Thus, as in the Ivorian and Malagasy series [16,17], nearly half of the patients in our series encountered difficulties in ensuring their medical care, certainly testifying to their inability to bear the costs of chemotherapy or any other treatment related to an additional pathology.

The general condition of the patients was generally preserved at the time of diagnosis.

Although not specific to ovarian cancer, the CA 125 tumor antigen was used to complement the diagnosis as recommended by the French National Cancer Institute [18]. The Human Epididymis protein 4 (HE4), a more specific marker appearing earlier in the course of epithelial ovarian cancer [19], is not used routinely as it is difficult to access. Although these various markers allow suspicion of the diagnosis, confirmation remains histological after initial laparoscopic surgery allowing staging and collection of samples for extemporaneous anatomopathological examination [9]. Extemporaneous examination may be proposed in case of surgery for a suspected ovarian mass if its result modifies the peroperative strategy; the concordance between the final examination and the extemporaneous examination varies according to the expertise in ovarian pathology of the pathologist [20]. Performed in our context in all cases after median laparotomy, simultaneously with the initial tumor excision, staging was complete in accordance with the recommendations of the European Society of Gynecological Oncology [9]. Indeed, complete staging significantly improves overall survival and recurrence-free survival compared to incomplete staging [21]. Stages III and IV were predominant, confirming the literature data. Unlike European series [21], lymph node dissection was not performed during standard non-carcinological surgery in more than half of the cases. Complete excision surgery without residue is recommended [9]. If complete upfront surgery is not feasible after initial assessment, interval surgery may be considered after three to four cycles of induction chemotherapy [6,9]. In our series, the incompleteness of the excision surgery would be explained by a reluctance of our surgical teams to carry out digestive resections and/or lymph node dissections due to lack of experience in oncological surgery.

As in African and European series, the most frequent histological type was serous cystadenocarcinoma. Conversely, the time to obtain histological results was longer than that found in the literature, probably due to our limited human and material resources.

According to clinical practice recommendations, for stage II to IV ovarian cancers, there is no difference in terms of median overall survival and recurrence-free survival between upfront cytoreduction and neoadjuvant chemotherapy followed by interval surgery (level of evidence B2) [23]. In the absence of results from ongoing trials, first-line chemotherapy should not substitute for an initial surgical effort allowing macroscopically complete resection [23].

Regarding adjuvant chemotherapy, the Carboplatin/Paclitaxel combination, the reference protocol [6,25], was the most used with longer initiation times than those recommended in the literature. For patients with advanced stages, the addition of anti-angiogenic treatment with Bevacizumab should be proposed as it allows better disease control (grade A) [25].

However, the small number of patients who benefited from systemic treatment as well as the lengthening of the time to initiation of adjuvant chemotherapy most likely contributed to reducing overall survival, clearly lower than that of other African and European series varying between 19 and 69 months [14,16,21]. Similarly, the low 5-year recurrence-free survival rate contrasts with that reported by Dem in Senegal [14] which was 13.3%; both are far below those of Western series [26]. Indeed, several factors influence the survival of patients with ovarian cancer, including age, stage, type of surgery, tumor residue size, histological type, prognostic grade, and chemotherapy [23,26].

Our study has certain limitations that should be noted for the interpretation of the survival results.

Firstly, the limited size of our cohort limits the statistical power of our analyses. In this context, the presence of 6.1% of patients lost to follow-up (2 cases) constitutes a potential bias. Although this rate is below the critical threshold of 20%, each patient represents a significant portion of the sample (approximately 3%). A “worst-case scenario” sensitivity analysis suggests that the occurrence of unfavorable events in these patients could significantly modify the overall survival curves, cautioning against generalization of

our survival rates.

Secondly, the systematic exclusion of patients who received neoadjuvant chemotherapy (NAC) induces a significant selection bias. This exclusion criterion was chosen to guarantee the homogeneity of the cohort and specifically evaluate the impact of primary surgical cytoreduction. However, this limits the external validity of our results to patients deemed operable upfront, generally presenting a lower tumor burden or better general condition. By excluding initially unresectable forms or the frailest patients directed toward NAC, our survival results could be overestimated compared to the overall population of ovarian cancers encountered in common clinical practice.

Conclusion

Epithelial ovarian cancer is a reality at the University Hospital of Brazzaville. Any ovarian tumor during the menopausal period should raise suspicion of cancer and be subjected to anatomopathological study. Due to its low survival, the management of epithelial ovarian cancer must be collegial and multidisciplinary.

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Conflict of interest : None

References

[1] Felngold J, Bonaiti C, Olschwang H, Sobol G, Thomas. Terminologie. In: Eisinger F, Lefranc JP, editors. Identification et prise en charge des prédispositions héréditaires aux cancers du sein et de l'ovaire. Paris: John Libbey; 2005. p. 4-8.

[2] Webb PM, Jordan SJ. Épidémiologie du cancer épithélial de l'ovaire. Best Pract Res Clin Obstet Gynaecol. 2017;41:3-14.

[3] Bray F, Ferlay J, Soerjomataram I, Siegel RL, Torre LA, Jemal A. Global cancer statistics 2018: GLOBOCAN estimates of incidence and mortality worldwide for 36 cancers in 185 countries. CA Cancer J Clin. 2018;68(6):394-424.

[4] Santé Publique France. Estimations nationales de l'incidence et de la mortalité par cancer en France métropolitaine entre 1990 et 2018 – tumeurs solides. Saint-Maurice: SPF; 2019 [consulté le 1 juin 2020]. Disponible sur: https://www.santepubliquefrance.fr/

[5] Peko JF, Moudiongui D, Ibara G. Registre des cancers de Brazzaville: rapport biennal 2018-2019. Brazzaville: African Cancer Registry Network; 2019.

[6] Classe JM, Guyon F, Falandry C, Devouassoux-Shisheboran M, Selle F, Joly F. Cancer de l'ovaire: prise en charge pluridisciplinaire en première ligne (recommandations Saint-Paul-de-Vence 2016). Bull Cancer. 2017;104:6-15.

[7] Chéreau E, Ballester M, Lesieur B, Selle F, Coutant C, Rouzier R, et al. Complications de la chirurgie radicale des cancers de l'ovaire de stade avancé. Gynecol Obstet Fertil. 2011;39(1):21-27.

[8] Organisation mondiale de la Santé. Assurer un financement durable de la couverture sanitaire universelle en Afrique [en ligne]. 2018 [consulté le 1 juin 2020]. Disponible sur: https://apps.who.int/iris/handle/10665/275168

[9] Querleu D, Planchamp F, Chiva L, Fotopoulou C, Barton D, Cibula D, et al. ESGO guidelines for ovarian cancer surgery. Int J Gynecol Cancer.

2017;27(7):1534-1542.

[10] Prat J; FIGO Committee on Gynecologic Oncology. FIGO staging classification for cancer of the ovary, fallopian tube, and peritoneum. Int J Gynaecol Obstet. 2014;124(1):1-5.

[11] Diarre T, Amegbor K, Aboubaraki A, Kounkpati K, Kouyaté M, Sonhaye L, et al. Tumeurs ovariennes au Togo: profil histo-épidémiologique à propos de 274 cas. Med Afr Noire. 2013;60(7):334-338.

[12] Nsondé Malanda J, Nkoua Mbon JB, Bambara AT, Ibara G, Minga B, Nkoua Epala B, et al. Douze ans de travail du registre du cancer de Brazzaville. Bull Cancer. 2013;100(2):135-139.

[13] Sando Z, Mboundou E, Fouoguet TJ, Nganwa G, Tchuendem J, Essame JL, et al. Profil clinique et anatomopathologique des cancers de l'ovaire à Yaoundé (Cameroun). Clin Mother Child Health. 2010;7(1):1183-1188.

[14] Dem A, Dieng MM, Ka S, Gaye PM, Diouf D, Gaye-Fall MC. Diagnostic et traitement du cancer épithélial de l'ovaire à Dakar. Bull Cancer. 2013;100(2):155-160.

[15] Rizzuto I, Behrens RF, Smith LA. Ovulation induction and risk of ovarian cancer. Cochrane Database Syst Rev. 2019.

[16] Touré M, Kouassi K, Oseni M, Abba O, Odo B, Kagambega A, et al. Difficultés de prise en charge des carcinomes épithéliaux de l'ovaire en Afrique subsaharienne. Rev Int Sci Med. 2018;20(4):283-287.

[17] Fanomezantsoa R, Solonirina DR, Nomeharisoa REH, Felantsoa AR, Florine R, Hery NRR. Étude rétrospective sur le cancer de l'ovaire avec un recul médian de 42 mois. Pan Afr Med J. 2015;20:211.

[18] Institut National du Cancer (INCa). Cancer de l'ovaire [en ligne]. 2010. Disponible sur: https://www.has-sante.fr/

[19] Chudecka-Glaz AM. ROMA algorithm in ovarian cancer. Clin Chim Acta. 2015;440:143-151.

[20] Devouassoux-Shisheboran M, Le Frère-Belda MA, Leary A. Biopathologie des carcinomes ovariens. Gynecol Obstet Fertil Senol. 2019;47(2):155-167.

[21] Liberale G, Pop CF, Polastro L, Kerger J, Moreau M, Chintinne M, et al. Cytoreductive surgery improves survival in advanced ovarian cancer. J Chir Visc. 2020;157(2):80-88.

[22] Querleu D, Planchamp F, Chiva L, Fotopoulou C, Barton D, Cibula D, et al. ESGO quality indicators for advanced ovarian cancer surgery. Int J Gynecol Cancer. 2016;26(7):1354-1363.

[23] Institut National du Cancer (INCa). Cancer de l'ovaire – traitement chirurgical [en ligne]. 2009. Disponible sur: http://www.e-cancer.fr/

[24] Morice P, Leblanc E, Rey A, Baron M, Querleu D, Blanchot J, et al. Conservative treatment of epithelial ovarian cancer. Hum Reprod. 2005;20(5):1379-1385.

[25] De La Motte Rouge T, Ray-Coquard I, You B. Traitements médicaux des cancers de l'ovaire. Gynecol Obstet Fertil Senol. 2019;47(2):222-237.

[26] Largillier R, Lescaut W, Ferrero JM, Guastalla JP. Facteurs pronostiques des tumeurs épithéliales malignes de l'ovaire. In: Guastalla JP, Ray-Coquard I, editors. Les cancers ovariens. Paris: Springer-Verlag; 2006. p. 113-124.

[27] Dettori JR. Loss to follow-up. Evid Based Spine Care J. 2011;2(1):7-10. doi:10.1055/s-0030-1267080.

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