stage II to IV low-grade serous histology, maintenance hormonal therapy can be discussed; the data are limited, and there is no clearly documented OS benefit at the time of this writing.[39] As new information continues to evolve, future updates of this and other ASCO guidelines will discuss other new agents including PARPi, following enough evidence of efficacy. The major limitation to maintenance therapy such as PARPi in resource-constrained settings is lack of access to biomarker testing, including identification of patients with homologous recombination repair deficiency (HRD) and, more specifically, patients with tumors exhibiting *BRCA* mutation. Where biomarker testing results indicate treatment, continuous access to medication and cost-effectiveness analysis specific to resource settings must be ensured.

Limited-resource settings. In limited-resource settings, maintenance therapy with antiangiogenic agents is not recommended because of cost limitations and clinician experience in toxicity management.

Enhanced-resource settings. In enhanced-resource settings, clinicians may discuss maintenance therapy with antiangiogenic agents with select patients (those with stage III/IV disease) and potentially PARPi (for latter, see ASCO PARPi guideline, *JCO*, 2020).[21] Institutions that use maintenance treatment with antiangiogenic and/or PARPi agents need capacity for evaluation and management of side effects.

OVERARCHING CLINICAL QUESTION D

What is the optimal therapy for women with recurrent EOC? (see Table 7 and Appendix Figures A5, A6, and A10)

Discussion

Despite the initial success with first-line surgery and chemotherapy for ovarian cancer, most patients will develop recurrent disease.[12] The risk of recurrence is highest with advanced and high-grade or clear cell disease. Recurrent ovarian cancer is stratified into platinum-sensitive or platinum-resistant on the basis of the length of time to relapse ($\geq$ 6 months *v* $<$ 6 months, respectively) from the end of treatment with first-line platinum-based chemotherapy. Chemotherapy is the primary intervention for recurrent disease; where chemotherapy is not feasible for any reason, palliative care, if not already invoked, should be initiated.

(Source: BCGS, OH-CCO, SIGN)

Surgery for recurrent EOC (Recommendation 4.0)

Recommendations on surgery for patients with recurrence are in Table 7.

TABLE 7. Summary Treatment of Recurrent EOC Recommendations by Setting

Recommendation No.	Population	ASCO Resource Levels (B)	ASCO Resource Levels (L)	ASCO Resource Levels (E)	Strength of Recommendation
4.0	Recurrent small-volume platinum-sensitive disease EOC	Because of health system gaps, not feasible in the basic setting	Refer to higher-level cancer center for surgical consideration	Perform complete secondary cytoreductive debulking surgery	Moderate: L/E
4.1/4.4	Recurrent EOC who have received prior systemic treatment	Best supportive care	Early palliative care	Early palliative care	Strong
4.1/4.2	Recurrent platinum-sensitive, platinum-resistant, platinum-refractory EOC—who have received prior systemic treatment, PS 0-2	N/A	Treatment with second-line chemotherapy or refer to higher-level cancer center	Treatment with second-line chemotherapy	Moderate: L Strong: E
4.2	Platinum-sensitive EOC	N/A	Platinum-sensitive: combination chemotherapy with carboplatin	Platinum-sensitive: combination chemotherapy with carboplatin with or without bevacizumab	Strong: L/E
	Platinum-resistant EOC	N/A	Single-agent nonplatinum chemotherapy or best supportive care	Single-agent nonplatinum chemotherapy with or without bevacizumab or best supportive care	Resistant Strong: L/E
	Platinum-refractory EOC	N/A		Single-agent nonplatinum chemotherapy with or without biologic agent (bevacizumab)	Refractory Moderate: E

Abbreviations: B, basic; E, enhanced; EOC, epithelial ovarian cancer; L, limited; N/A, not available; PS, performance status.