Medical News

Remove the Fallopian Tubes If the Opportunity Arises, ACOG Says in New Ovarian Cancer Prevention Guidance

Linda Rodgers

New clinical guidance from a major medical society recommends what may seem like a radical strategy to help prevent ovarian cancer: remove the fallopian tubes if the opportunity presents itself.

But as it turns out, the term *ovarian cancer* is a misnomer.

"It's been known for quite a while that most epithelial ovarian cancers start in the fallopian tube," said David I. Shalowitz, MD, MSHP, director of cancer care delivery at Corewell Health in Grand Rapids, Michigan. In fact, roughly 80% of the most common, and most aggressive, cancer cells (known as high-grade serous carcinomas) start in the fimbriae, the finger-like protrusions at the end of each tube that bump up against the ovaries and then shed onto the ovaries as well as the peritoneal cavity, he explained.

Multimedia

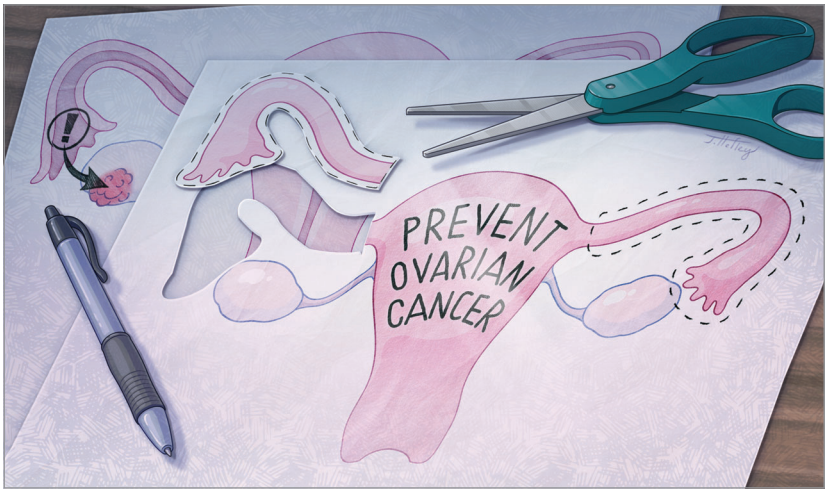
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For patients with above-average risk of ovarian cancer—those with a family history of the disease or who have one of its pathogenic variants—the recommendations from the National Comprehensive Cancer Network have been to remove 1 or both fallopian tubes as well as the ovaries to prevent ovarian cancer, depending on the specific gene variant and the patient's preferences, Shalowitz said.

But for patients without a hereditary risk, who account for the majority of cases, the implications have been less clear, Shalowitz noted.

That's now changing. Today, there's solid evidence that removing both fallopian tubes during a previously scheduled surgery—a procedure known as an opportunistic bilateral salpingectomy—may be the best way to dramatically cut the risk of ovarian cancer for all women.

That evidence has prompted the American College of Obstetricians and Gynecologists (ACOG) to update its clinical guidance on opportunistic salpingectomy procedures for patients with an average lifetime risk.



Stronger Evidence, Stronger Recommendations

Even though the lifetime risk of ovarian cancer is low for those with an average risk, it's still one of the leading causes of cancer deaths among women. Last year, there were nearly 13 000 ovarian cancer deaths in the US alone.

The overall 5-year relative survival rate is only 52%, according to the National Cancer Institute's Surveillance, Epidemiology, and End Results (SEER) Program, and it's about 31% for patients whose cancer has metastasized. There are no reliable screening tests and symptoms are typically vague and nonspecfic, reasons why nearly three-quarters of cases are caught after the cancer has spread to the lymph nodes and beyond.

Salpingectomy is an opportunity "to reduce the risk of this deadly, costly disease," said Shalowitz, who coauthored the updated guidance. ACOG has previously published 2 committee opinions on the procedure. The main difference since the last update in 2019 is that "the strength of the recommendation for how clinicians should approach considering removal of the fallopian tubes for the primary purpose of preventing epithelial ovarian cancer has changed," Shalowitz said.

As of this February, the European Society of Gynaecological Oncology recommends that clinicians discuss with eligible women opportunistic salpingectomy for ovarian cancer prevention. ACOG's new advice, called a Clinical Practice Update, is endorsed by the Society of Gynecologic Oncology, a group with a primarily US membership. And the update notes that the American Cancer Society also supports consideration of opportunistic salpingectomy for ovarian cancer prevention consistent with the guidance, which is based on research published since 2019 that looked at the risk-benefit profile of these procedures for women with an average risk of the disease.

A systematic review and meta-analysis of studies through 2021 found the odds of ovarian cancer were cut by about half (48%) in patients who'd undergone a bilateral salpingectomy. Two large cohort studies from British Columbia, published in 2022 and 2026 in *JAMA Network Open*, found even greater benefits. The 2026 study followed up about 86 000 patients—roughly 40 000 who'd undergone an opportunistic bilateral salpingectomy and 45 000 who had a hysterectomy alone or tubal ligation—and found a nearly 80% reduced risk of developing ovarian cancer after a median of about 5 years. As for the procedure's safety, comprehensive studies have found it carries minimal complications.

"If patients are already undergoing a surgery, then there's no additive risk of,

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for example, the anesthesia because the addition of a salpingectomy to another abdominal surgery is 10 minutes or less and there is no evidence of a significant increase in complications," Shalowitz explained.

The updated guidance has 4 recommendations covering different surgical scenarios for scheduled gynecologic and nongynecologic procedures. (Because of the importance of counseling, these recommendations don't apply to emergency surgeries, when a patient of reproductive potential wouldn't have the time to decide on the procedure.)

- Obstetricians and gynecologists (OB/GYNs) should routinely remove a patient's fallopian tubes at the same time as they're performing a hysterectomy, with the patient's informed consent.
- For patients who are finished with childbearing or don't want or can't have children, OB/GYNs should recommend salpingectomies when these patients are planning other types of gynecologic surgeries, including procedures to remove ovarian cysts and uterine fibroids as well as cesarean deliveries.
- For patients considering permanent surgical contraception, completely removing both fallopian tubes instead of tubal ligation is the preferred method after obtaining informed consent.
- OB/GYNs can collaborate and support other clinicians in counseling patients and offering to perform a salpingectomy during a nongynecologic surgery, such as gallbladder removal or even bariatric procedures.

"We're not at the point of recommending that everybody who has their gallbladder out have their tubes out," Shalowitz noted about the last point. "It's an area of active interest and collaboration between OB/GYNs and non-GYN surgical specialists to start to counsel patients and offer removal of the tubes when they're having nongynecological surgeries."

The recommendations also cover standalone salpingectomy for cancer prevention. If a patient with no future reproductive plans wants the procedure, the balance between the benefits and minimal risks of the procedure suggests that it's reasonable for clinicians to have that discussion, according to Shalowitz. But there's still not enough long-term research to make a blanket recommendation on stand-alone procedures for everyone, he added.

"There are not a lot of data out there on optimal timing for this procedure," Shalowitz said, citing some research that found removing the fallopian tubes before age 50 years was more effective in cancer risk reduction than removing them after that age.

There are other questions that require more research as well, including ones on ovarian function. "The available evidence does not show any negative impact on ovarian function, but these are mostly short-term studies," said Kara C. Long, MD, MSc, a gynecologic oncologist and surgeon at Memorial Sloan Kettering Cancer Center in New York City.

This may have something to do with the role of the fallopian tubes. Although they "have a vital function in becoming pregnant naturally, they don't have a hormonal function," Long explained. But they do share a blood supply with the ovaries and so removing them could theoretically damage that supply, she noted.

"Most experts believe long-term ovarian function will be unchanged after salpingectomy," Long said. "But we all agree we need to track salpingectomy outcomes long-term."

During the preoperative process, it's important to counsel patients and come to a shared decision about salpingectomy. That includes discussing practical considerations such as the additional operative time, as well as the fact that it's a form of permanent contraception. Clinicians should also let patients know that while salpingectomy is safe and has a real benefit in lowering risk, "it doesn't 100% reduce their risk of ovarian cancer and it's important to still be evaluated for symptoms in the future," said Katharine M. Esselen, MD, MBA, a gynecologic oncologist and surgeon at Beth Israel Deaconess Medical Center in Boston.

Why These Recommendations Matter

According to Shalowitz, the new guidance represents the strongest published recommendations in favor of performing a risk-reducing salpingectomy. Coming from a professional society, they may be hugely impactful, said clinicians interviewed for this article who were not involved in writing them.

On a clinical level, the updates "more strongly encourage OB/GYN clinicians who are doing their surgeries to use salpingectomy less as a consideration, more of a recommendation," said Esselen.

The guidance also encourages "conversion of old practices into new, like converting all the tubal ligations into salpingectomies," Long said. And at an institutional level, the guidance may provide logistical and material support to clinicians that would directly affect operating room time, equipment, and opportunities for cross-collaboration, she added.

That support for cross-collaboration is already taking place at Beth Israel Deaconess Medical Center, where gynecologic oncology surgeons have trained some of the general and colorectal surgeons to do the procedure, Esselen said.

"They've already started counseling their patients having colon resections, cholecystectomies, and other types of abdominal laparoscopic procedures and are now offering this procedure to them either in collaboration with us or on their own," she said. "So even in our single institution, we've already expanded access to this for patients with pretty minimal training, intervention, or time commitment."

ACOG's recommendations may also be able to influence policymakers and health insurance companies. There is still no reliable insurance coverage for these procedures, explained Long, who is part of the Outsmart Ovarian Cancer Collaborative, a multi-institutional group of clinicians and other health care professionals who have come together to try to expand primary prevention of the disease.

For example, emphasizing that salpingectomy is the preferred method for permanent sterilization could expand Medicaid access in more states, said Larissa A. Meyer, MD, MPH, a professor of gynecologic oncology at the University of Texas MD Anderson Cancer Center in Houston. "If you have Medicaid and Medicaid doesn't reimburse or recognize bilateral salpingectomy as a form of tubal sterilization, then you may not get that option."

"To me, it's important that we have equitable access to cancer prevention strategies," Meyer continued. "This strong wording is going to help move the needle towards having this be recognized and reimbursed as the appropriate permanent tubal sterilization procedure."

One logistical issue, at least, is already resolved: last year, the *International Statistical Classification of Diseases and Related Health Problems, Tenth Revision*, added a code for salpingectomy for ovarian cancer risk reduction in people without genetic or familial risk.

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How to Change Practice

There's still much work to be done in translating these recommendations "to ensure equitable access and make sure that access is paired with patient education, appropriate consent—all of the nuances to implementing this properly," Long noted.

That may require changing the language so that patients and nongynecologists alike are more aware that most ovarian cancer starts in the fallopian tubes—using the phrase "tubular ovarian cancer" instead of "ovarian cancer," Long suggested. Another idea is to update contraception posters in clinics to include salpingectomies as a cancer prevention option, she added.

OB/GYNs can also work together with nongynecologic surgeons to teach the procedure as well as how to counsel patients and engage in a shared and informed decision-making process. That last skill may be more of a heavier lift for nongynecologic surgeons, noted Meyer. OB/GYNs are comfortable having discussions about fertility, loss of fertility, and what a patient's options are, whereas many nongynecologic surgeons may not be, she added.

"I think that's where we have work to do," Meyer said. "For example, having workshops at the American College of Surgeons or rural health meetings, you name it, but go to where the surgeons are and train in that aspect so that people feel comfortable and confident in having that discussion."

It's also critical to include a diverse range of voices to help educate patients, Long remarked. Salpingectomy procedures, she pointed out, are a form of sterilization, making consent particularly necessary. "We don't want anyone to think that we are pushing sterilization," she said. "There's a dark history of that in our country already. This is something that we want people to have access to if they want and choose it in a well-counseled way."

But that's why all types of clinicians have a role to play in getting the word out that removing the fallopian tubes can have a huge effect on lowering the risk of future cancer cases, Shalowitz said. That includes primary care physicians, health care professionals who counsel patients on contraception and cancer prevention, and surgeons who operate in the peritoneal cavity.

"We don't want somebody to learn about this for the first time when they're facing another surgery," Long said. "We want them to have heard about this many times so that if they are there getting their gallbladder or their appendix or whatever out, they can say, 'Hey, I learned about this a long time ago and can we get my fallopian tubes out at the same time?'" ■

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