Appendix 1. Information for Patients and Health Care Professionals

Information for Patients	Information for Health Care Professionals
• Individuals with *BRCA1*/*BRCA2* gene alterations have an 11-68% lifetime risk of developing ovarian cancer, compared with approx. 2% in the general population. • Risk-reducing salpingo-oophorectomy reduces the lifetime risk of ovarian cancer by at least 90%. • In order to be eligible for risk-reducing surgery, individuals should have completed their family and be aged over 35 years with *BRCA1* or over 40 years with *BRCA2* alterations. • There is a theoretical possibility of greater blood loss with risk-reducing surgery at the time of cesarean delivery because of large pelvic blood vessels in pregnancy. However, there is no evidence to suggest this is a significant risk. • Risk-reducing surgery, whenever performed, will result in infertility. However, assisted reproduction techniques with the option of pre-implantation genetic diagnosis, may be feasible as long as eggs are harvested prior to risk-reducing surgery. • Risk-reducing surgery will result in early menopause. Hormone replacement therapy is recommended until 51 years of age, unless there are contraindications (e.g. previous breast cancer).	• Patients with inherited *BRCA1* and *BRCA2* gene alterations should be offered risk-reducing surgery at appropriate ages. • Patients should be fully counseled about the risks of surgery, infertility, iatrogenic menopause and the need for HRT. • Ideally, cases should be discussed at a familial cancer multidisciplinary team meeting to confirm surgery is appropriate. • If the individual has had breast cancer, her oncology team should be consulted and be happy that surgery is appropriate and that her likely prognosis justifies the negative consequences of undergoing RRSO. • Patients should ideally have an up-to-date ultrasound scan of the pelvis to confirm no macroscopic tubo-ovarian disease. The adnexa should be visualised and commented on at each pregnancy scan until it is no longer possible to do so. Pre-operative serum CA125 is unreliable as it can be elevated in pregnancy. • Careful choice of appropriate surgical equipment is recommended for performing RRSO because of the engorged pelvic blood vessels in pregnancy.

Barker VE, Vlachodimitropoulou E, O'Brien P, Iskaros J, Rosenthal AN, et al. Combined bilateral salpingo-oophorectomy and cesarean delivery in *BRCA1/2* alteration carriers: a case series. Obstet Gynecol 2023;142.
The authors provided this information as a supplement to their article.

	• The pathologist should be made aware that the patient is a *BRCA*-carrier, and the SEE-FIM protocol should be followed to minimise the chance of missing an occult tubal/ovarian cancer. • Patients should be counseled that if histopathological assessment identifies cancer, they will likely need further staging surgery and chemotherapy. • Transdermal continuous combined HRT should be started 6 weeks postnatally (or later in those able and desiring to breast feed) and continued to the age of 51 years unless there are contraindications. • In patients with a history of breast cancer, there is a theoretical risk of HRT stimulating micro-metastases. The patient's oncology team should be consulted pre-operatively and a decision made regarding HRT usage based on risks and benefits. • Advice for emergency obstetric teams in the event of patient requiring emergency cesarean delivery prior to her planned cesarean delivery: Take intra-operative peritoneal washings for cytology using warm saline instilled around adnexae prior to uterine incision; to avoid contamination with liquor, suction bottle should then be changed. Place left and right adnexae in separately labelled formalin containing specimen pots and request SEE-FIM histopathology protocol.

Key: SEE-FIM = Sectioning and Extensively Examining the FIMbriated end, HRT = hormone replacement therapy.

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