

# Knowledge, practice, and barriers to opportunistic salpingectomy during non-gynaecological surgery: international survey

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Ovarian cancer causes over 200 000 deaths annually and its prognosis remains poor because it is usually diagnosed at an advanced stage<sup>1</sup>. Recognition that most high-grade serous carcinomas (HGSCs) originate in the fallopian tube has transformed ovarian cancer prevention strategies<sup>2</sup>. Major gynaecological societies now endorse opportunistic salpingectomy during elective surgery as a low-risk strategy to reduce future ovarian cancer risk<sup>3</sup>. In a commentary to these guidelines, the authors called for extension of these recommendations to non-gynaecological abdominal surgery. Non-gynaecological abdominal procedures are frequently performed in women aged over 40 years and provide direct intraoperative access to the adnexa, yet opportunistic salpingectomy is rarely performed in this context<sup>4</sup>. The TUBE (Tubal management Under Broad surgical Environments) study characterized current practices, knowledge, and barriers among abdominal surgeons.

Between April and May 2026, a cross-sectional survey was distributed electronically via REDCap tools hosted at the Geneva University Hospitals to abdominal surgeons internationally through surgical society mailing lists, professional networks, and direct personal contacts across Europe and beyond. Distribution was indirect through network contacts and society channels. Duplicate responses were prevented by REDCap session control. The questionnaire covered adnexal management practices, knowledge of HGSC pathogenesis, awareness of gynaecological guidance, and intention to change practice following a standardized educational prompt. Barriers were assessed using a five-point Likert scale (1, strongly agree; 5, strongly disagree).

Of 307 respondents, 277 completed the survey fully (median age 44 years, 81% men) (Table S1). The specialty distribution was general surgery 44%, gastrointestinal/ hepatopancreatobiliary

surgery 49%, and urology 5%. Most respondents worked in academic public hospitals (55%) and performed over 100 abdominal procedures annually (59%).

Knowledge of HGSC pathogenesis was limited across all groups (Table 1 and Table S2). Only 37% correctly identified the fallopian tube as the primary site of HGSC origin, and 41% recognized that opportunistic salpingectomy reduces ovarian cancer risk. Only 8% were familiar with existing gynaecological guidelines. Most surgeons (63%) had never performed elective salpingectomy opportunistically, and only 20% had ever offered risk-reduction adnexal removal to a patient. Following a standardized educational prompt, 53% expressed a willingness to discuss salpingectomy with eligible patients. Most respondents (87%) would consider salpingectomy if specialty-specific guidance were available. Lack of consent clarity (65%) and insufficient epidemiological evidence in abdominal surgery populations (61%) were the most frequently cited barriers (Table 1 and Table S3).

These findings reveal a critical knowledge gap across non-gynaecological surgical specialties regarding HGSC pathogenesis and the preventive potential of salpingectomy. The principal barriers appear to be structural rather than attitudinal. The absence of specialty-specific guidelines and clear consent frameworks, rather than reluctance among surgeons, is the major obstacle to implementation. Nearly one in four women diagnosed with HGSC has previously undergone abdominal or pelvic surgery during which salpingectomy was not performed, representing a quantifiable missed opportunity for prevention<sup>5</sup>. Development of abdominal surgery-specific recommendations, building on the recent European Society of Gynaecological Oncology consensus<sup>3</sup>, represents the most actionable intervention identified by this survey.

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**Table 1 Knowledge and barriers by surgical specialty group**

|                                                       | General surgery (n = 121) | GI/HPB (n = 136) | Urology (n = 13) |
|-------------------------------------------------------|---------------------------|------------------|------------------|
| <b>Knowledge (% correct responses)</b>                |                           |                  |                  |
| Fallopian tube as primary site of HGSC origin         | 33%                       | 40%              | 39%              |
| Salpingectomy reduces ovarian cancer risk             | 38%                       | 46%              | 31%              |
| <b>Barriers (% agree or strongly agree)</b>           |                           |                  |                  |
| Would consider if specialty-specific guidance existed | 88%                       | 86%              | 85%              |
| Lack of consent clarity                               | 66%                       | 69%              | 54%              |
| Insufficient epidemiological evidence                 | 60%                       | 65%              | 54%              |

Urology results should be interpreted with caution (13 respondents). GI/HPB, gastrointestinal and hepatopancreatobiliary (combining lower gastrointestinal, upper gastrointestinal, and hepatopancreatobiliary subspecialties); HGSC, high-grade serous carcinoma.

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## Disclosure

The authors declare no conflict of interest.

## Supplementary material

Supplementary material is available at *BJS Open* online.

## Data availability

Data are available from the authors upon reasonable request.

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