Adjunctive Surgery
Disseminated gynaecological cancer

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Gynaecological Oncology Unit
Department Obstetrics & Gynaecology
Introduction

• Adjunctive surgery definition

• Gynaecological cancers
  – Vulva
  – Vagina
  – Cervix
  – Uterus
  – Ovary and Fallopian tubes
Ovarian cancer

- Life time risk 1.4%
- Mean age 63 years
- 75% stage III when diagnosed
- FIGO staging
Staging ovarian and primary peritoneal carcinoma (TNM and International Federation of Gynecology and Obstetrics [FIGO])

### Primary tumor (T)*

<table>
<thead>
<tr>
<th>TNM categories</th>
<th>FIGO stages</th>
<th>Definition</th>
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<tbody>
<tr>
<td>TX</td>
<td></td>
<td>Primary tumor cannot be assessed</td>
</tr>
<tr>
<td>T0</td>
<td>I</td>
<td>No evidence of primary tumor</td>
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<tr>
<td>T1</td>
<td>IA</td>
<td>Tumor limited to ovaries (one or both)</td>
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<td>T1a</td>
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<td>Tumor limited to one ovary; capsule intact, no tumor on ovarian surface. No malignant cells in ascites or peritoneal washings.</td>
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<td>T1c</td>
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<td>Tumor limited to one or both ovaries with any of the following: capsule ruptured, tumor on ovarian surface, malignant cells in ascites or peritoneal washings</td>
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<tr>
<td>T2</td>
<td>II</td>
<td>Tumor involves one or both ovaries with pelvic extension</td>
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<td>T2a</td>
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<td>Extension and/or implants on uterus and/or tube(s). No malignant cells in ascites or peritoneal washings.</td>
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### Distant metastasis (M)
# Staging ovarian and primary peritoneal carcinoma (TNM and International Federation of Gynecology and Obstetrics [FIGO])

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Ovarian cancer

• Treatment
  – Primary surgery followed by adjuvant chemotherapy
  – NAC followed by interval debulking
What influences prognosis

• Stage
• Quality of cytoreduction
• Skills and attitude surgeon
• Place of surgery
Objective

• Disease staging

• Optimal cytoreduction
  – No macroscopic disease
  – <1cm
  – >1cm
Du Bois et al.
Cancer March 2009;115(6):1234-1244
Peiretti et al.
Gynecologic Oncology
PDS vs NACT and IDS

A Intention-to-Treat Analysis

Overall Survival [%]

Years

No. of Events

Primary Debulking Surgery (PDS) 253 336
Neoadjuvant Chemotherapy (NACT) 245 334

No. of Patients at Risk

189 62 14 2
195 46 13 2

B Per-Protocol Analysis

Overall Survival [%]

Years

No. of Events

PDS–Optimal 42 62
PDS–Suboptimal 52 74
PDS–Other 136 169
NACT–Optimal 100 152
NACT–Suboptimal 67 87
NACT–Other 41 53

No. of Patients at Risk

46 22 6 0
46 11 3 1
86 29 5 1
110 30 8 2
49 9 3 0
29 6 2 0

Place of surgery

• Specialised units
  – Improved survival
  – ↑ chance of optimal debulking
Skills and attitudes

• The surgeon
  – Impacts on survival
  – Chance of obtaining optimal debulking
Survival rates

• General surgeon: 42%
• General gynaecologist:
• Gynaecological oncologist:
Survival rates

- General surgeon: 42%
- General gynaecologist: 67%
- Gynaecological oncologist:
Survival rates

• General surgeon: 42%
• General gynaecologist: 67%
• Gynaecological oncologist: 87%
More data showing this


How extensive?

- As needed be
  - Bowel resection
  - Peritoneal stripping
  - Splenectomy +/- distal pancreatectomy
  - Diaphragmatic stripping
  - Liver resection
  - Cholescystectomy
Upper abdominal surgery

- ↑ blood loss
- ↑ operating time
- No ↑ in hospital stay or post-op mobility
Colon resection
Colon resection

• To achieve optimal debulking
• Improves survival

Hoffman, Zervose. Gynecol Oncol Volume 111, Issue 2, Supplement 2008 S56 - S65
Diaphragmatic

• Will be required in a substantial %

Other

• Splenectomy
• Small bowel resection
• Peritoneal stripping
• Liver resection
Recurrent ovarian cancer

- Recur mostly in abdomen
- Benefit of surgery unclear
  - Lack of good quality data
Secondary cytoreductive surgery

- Criteria
  - PFS at least 12 months
  - Potential for optimal cytoreduction
  - Response to 1\textsuperscript{st} line therapy
  - Good performance status
  - Local recurrence
Secondary cytoreductive surgery

- Beneficial:
  - No ascites
  - Platinum sensitivity
  - Initial FIGO stage <IV
  - Complete tumor resection

Secondary cytoreductive surgery

• Survival effect of optimal debulking
  – <1cm: 16 to 61 months
  – >1cm: 8 to 27 months

Tebes SJ et al. Gynecol Oncol. 2007;106(3):482.
Secondary cytoreductive surgery

- Complete resection
  - Most important factor for improved survival

- TTR time interval
  - The longer the better
Role of secondary cytoreductive surgery in ovarian cancer relapse: Who will benefit? A systematic analysis of 240 consecutive patients

Metastatic disease of ovary

- From colorectal cancer
  - Complete cytoreduction beneficial
  - Metastases limited to pelvis

Chung et al. J Surg Oncol 2009;100: 570-574
Overall survival of ovarian metastases from primary colorectal cancers: with or without peritoneal dissemination

Fujiwara et al. J Surg Oncol 102;6: 582-587
Overall survival of ovarian metastases from primary colorectal cancers: R0 resection versus R1/2 resection.

Fujiwara et al. J Surg Oncol 102;6:582-587
Palliative surgery

• Evidence is not good

• Patients should be individually assessed
Palliative surgery

• Bowel obstruction

• Absence of:
  – > 3 l ascites
  – Multifocal obstruction
  – Palpable bulky tumors
  – Pre-op weight loss > 9 kg

Ramirez et al. Cancer Control January 2011 Vol 18 No 1
Conclusion

• What is the role of the gynaecologist
Role of gynaecologist

- Primarily responsible for:
  - Appropriate care
  - Multi-disciplinary approach
  - Ensure maximum effort optimal cytoreduction
Role of gynaecologist

- Primarily responsible for:
  - Identification of women who will benefit from secondary cytoreduction after relapse
  - Appropriate palliative surgery where indicated
Thank you