台灣婦癌醫學會會訊

2011 年 9,10 月

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學會網址: www.tago.org.tw
學會 E-mail address: tago.gyn@gmail.com
學會地址：333 桃園縣龜山鄉復興街 5 號林口長庚醫院兒童大樓 B2 婦產部轉
學會電話：(03) 328-1200 ext 8290; 傳真/電話：(03) 318-7501
學會秘書: 葉君苓小姐

壹、 會務報告

一、 近期國內外婦癌相關活動一覽表

日期	活動名稱	活動地點
2011/11/4-11/5	2nd ASGO biennial meeting	Seoul, Korea
2011/11/11	TGOG 月例會	台北馬偕總院 12043 室
2011/11/26 W 六	南區婦癌學術研討會及第七次理監事會議	台南奇美醫院

2012/10/13-10/16	14th IGCS (http://www2.kenes.com/igcs2012/Pages/home.aspx)	Vancouver, Canada

二、學會網站誠徵文稿

歡迎各位會員踴躍賜稿，以充實學會的網站內容。來稿請e-mail至 tago.gyn@gmail.com

貳、近期文獻摘錄

CERVICAL

@@ Cervarix 若沒打完 3 劑,則效果如何呢?

對於一開始沒感染 HPV type 16/18 者, Cervarix 即使沒打完 3 劑,也依然有效 (Ref 1 ; J Natl Cancer Inst. 2011 Oct 5;103(19):1444-1451)

@@ 神奇的 Laterally Extended Parametrectomy (LEP)

有三分之二的 pelvic LN (+) stage IB cervical cancer 患者, 可藉此手術達到優秀的存活, 而不需 adjuvant treatment (Ref 2 ; Gynecol Oncol. 2011 Nov;123(2):337-41)

@ IUD use 可減少 risk of cervical cancer

此篇 Lancet Oncology 的 pooled analysis 顯示, IUD use 雖不能減少 HPV infection, 但可減少 cervical cancer ! (Ref 3 ; Lancet Oncol. 2011 Oct;12(11):1023-31)

@ Persistent HPV infection 與 cervical cancer

臺灣發表於 JNCI 的研究 (Ref 4 ; J Natl Cancer Inst. 2011 Sep 21;103(18):1387-96)

@ Negative liquid-base cytology with positive HPV

追蹤兩年, 有 24.3%變成 CIN1, 2.4%變成 CIN2+ (含 endocervical adenocarcinoma) (Ref 5 ; Gynecol Oncol. 2011 Aug;122(2):291-6)

@@ CIN treatment 與早產

此篇 meta-analysis 顯示, 除了 excisional treatment 較易致早產, 有些 ablative treatment 可能也有些許早產之風險 (Ref 6 , OG. 2011 Aug;118(9):1031-41).

@ 先 neoadjuvant chemotherapy 再 vaginal radical trachelectomy

對於想 fertility-sparing 但 cervical tumor diameter 較大 (3-4.5cm, Stage IB-IIA1)之患者; Preliminary result 似乎不差 (Ref 7 ; Gynecol Oncol. 2011 Sep;122(3):484-90).

@ Single-port extraperitoneal paraaortic lymphadenectomy

Technically feasible (Ref 8; Gynecol Oncol. 2011 Nov;123(2):329-32)

UTERINE

@@@ Uterine tumor morcellation 可能的恐怖後果

Morcellation of uterine leiomyosarcoma 顯著有較差的 overall survival 與較多的 abdomino-pelvic dissemination (Ref 9 ; Gynecol Oncol. 2011 Aug;122(2):255-9)

@@ Cytoreduction 於 stage IV endometrioid endometrial carcinoma

本篇 Memorial Slian-Kettering 的研究顯示, 對於這些 patients 若能 cytoreduction to no gross residual lesion, 則 survival 顯著較佳 (Ref 10 ; Gynecol Oncol. 2011 Sep;122(3):608-11)

@ ESMO endometrial cancer 的 guideline

(Ref 11 ; Ann Oncol. 2011 Sep;22 Suppl 6:vi35-9)

Uterine + Ovarian

@@ MMMT 的新 chemotherapy regimen

Carboplatin + paclitaxel + ifosfamide. 對於 uterine 或 adnexal 的 MMMT 效果頗佳 (Ref 12 ; Br J Cancer. 2011 Sep 27;105(7):897-902)

@@ 同時有 endometrial 與 ovarian cancer 時

可考慮用 mitochondrial DNA genotyping 來協助判斷其 synchronous nature (Ref 13 ; Gynecol Oncol. 2011 Aug;122(2):457-8)

OVARIAN

@@ First-line 或可使用 carboplatin + pegylated liposomal doxorubicin

MITO-2 phase III trial 顯示, 若患者無法忍受 carboplatin + paclitaxel, 則或可用 carboplatin + pegulated liposomal doxorubicin 來取代 (Ref 14 ; J Clin Oncol. 2011 Sep 20;29(27):3628-35)

@@ Carboplatin + pegylated liposomal doxorubicin 比較不會 hypersensitivity

此乃選用 carboplatin + pegylated liposomal doxorubicin 的另一項好處 (Ref 15 ; Gynecol Oncol. 2011 Aug;122(2):226-32)

@@@ Chemotherapy 盡量不要延宕或減量

Epithelial ovarian cancer 之 chemotherapy in primary treatment 若延宕或減量, 則其 progression free survival 顯著較差 (Ref 16 ; Gynecol Oncol. 2011 Sep;122(3):532-5)

@@ Ovarian cancer with CNS involvement

積極處理(surgery + RT + chemotherapy) ovarian cancer 之 brain metastasis

有助於延長存活 (Ref 17 ; Int J Gynaecol Obstet. 2011 Aug;114(2):133-6); 此篇與我們 TGOG study 的結果相互呼應.

@ PID 和 Ovarian cancer 竟然有顯著相關

臺灣發表於 Lancet Oncol 的研究 (Ref 18 ; Lancet Oncol. 2011 Sep;12(9):900-4)

@@ Lymphadenectomy 有益於 early ovarian cancer 之 survival

有作 lymphadenectomy 之 patient, 其 survival 顯著較佳 (Ref 19 ; Gynecol Oncol. 2011 Apr;121(1):94-9)

@@ Lymphadenectomy 無益於 early germ cell tumor

對early ovarian germ cell tumor 作lymphadenectomy 並無助於survival(Ref 20 ; Br J Cancer. 2011 Aug 9;105(4):493-7)

@@ 關於 clear cell carcinoma, lymphadenectomy, 及 paclitaxel

MITO-9 的分析顯示, lymphadenectomy 有其 survival significance, 然而 paclitaxel 似乎無益 (Ref 21 ; Int J Gynecol Cancer. 2011 Aug;21(6):1063-70)

@@ 放射科醫師來裝 intraperitoneal chemotherapy catheter

裝設 intraperitoneal chemotherapy catheter 之另一種方式. (Ref 22 ; Gynecol Oncol. 2011 Nov;123(2):342-5)

@ Modified intraperitoneal chemotherapy

GEICO 制定了他們的 intraperitoneal chemotherapy guideline. GEICO study 把 IV paclitaxel 改成 175 mg/m2 in 3 hours, 卻發現多達 61%的 patients 可完成 6 cycles (Ref 23 ; Int J Gynecol Cancer. 2011 Aug;21(6):1048-55)

@ Hyperthermic intraperitoneal chemotherapy: 於 primary treatment

似乎 promising (Ref 24 ; Gynecol Oncol. 2011 Aug;122(2):215-20)

@ Hyperthermic intraperitoneal chemotherapy: 於 platinum-sensitive recurrence

Optimal debulking 後, 此 HIPEC protocol 之 median DFS 24 months, median OS 38 months (Ref 25 ; Gynecol Oncol. 2011 Aug;122(2):221-5)

OTHERS

@@ Vulvar melanoma 是否該視為 cutaneous melanoma ?

因為其 survival 與 vular cancer surgery 的 radicality 無關, 但和 2002 modification of the AJCC staging system for cutaneous melanoma 顯著相關 (Ref 26 ; Gynecol Oncol. 2011 Sep;122(3):612-7)

@@ 婦癌患者可否使用 hormonal replacement therapy ?

本篇 Johns Hopkins 之 review 顯示, 根據現有的 observational data 與小型的 prospective trial, HRT 似乎與 GYN cancer 之 recurrence 無關 (Ref 27 ; Gynecol Oncol. 2011 Aug;122(2):447-54)

@@ Pegfilgrastim: Day 2 vs. Day 4

Chemotherapy 後第 4 天再使用 pegfilgrastim, 對於矯正 leukocytopenia 的效果優於 chemotherapy 後第 2 天即使用 (Ref 28 ; Ann Oncol. 2011 Aug;22(8):1872-7)

@ ESMO cancer pain 的 guideline

(Ref 29 ; Ann Oncol. 2011 Sep;22 Suppl 6:vi69-77)

@@@ Parenteral nutrition 之時機

此篇大規模 randomized trial 顯示, 對於 critically ill adults, 較晚予以 parenteral nutrition, 患者的 outcome 較好 (Ref 30 ; N Engl J Med. 2011 Aug 11;365(6):506-17)

@ 少見之 chemotherapy 相關 emergencies

本篇為 Lancet Oncology 的 review article (Ref 31 ; Lancet Oncol. 2011 Aug;12(8):806-14)

REFERENCES

Ref 1 J Natl Cancer Inst. 2011 Oct 5;103(19):1444-1451.

Proof-of-Principle Evaluation of the Efficacy of Fewer Than Three Doses of a Bivalent HPV16/18 Vaccine.

Kreimer AR, Rodriguez AC, Hildesheim A, Herrero R, Porras C, Schiffman M, González P, Solomon D, Jiménez S, Schiller JT, Lowy DR, Quint W, Sherman ME, Schussler J, Wacholder S; for the CVT Vaccine Group.

Source

Division of Cancer Epidemiology and Genetics, National Cancer Institute, National Institutes of Health, 6120 Executive Blvd, EPS/7084, Rockville, MD 20852. kreimera@mail.nih.gov.

Abstract

Background Three-dose regimens for human papillomavirus (HPV) vaccines are expensive and difficult to complete, especially in settings where the need for cervical cancer prevention is greatest. Methods We evaluated the vaccine efficacy of fewer than three doses of the HPV16/18 vaccine Cervarix in our Costa Rica Vaccine Trial. Women were randomly assigned to receive three doses of the HPV16/18 vaccine or to a control vaccine and were followed for incident HPV16 or HPV18 infection that persisted in visits that were 10 or more months apart (**median follow-up 4.2 years**). After excluding women who had no follow-up or who were HPV16 and HPV18 DNA positive at enrollment, 5967 women received three vaccine doses (2957 HPV vaccine vs 3010 control vaccine), **802 received two doses** (422 HPV vs 380 control), and **384 received**

one dose (196 HPV vs 188 control). Reasons for receiving fewer doses and other pre- and post-randomization characteristics were balanced within each dosage group between women receiving the HPV and control vaccines. Results Incident HPV16 or HPV18 infections that persisted for 1 year were unrelated to dosage of the control vaccine. **Vaccine efficacy** was **80.9%** for three doses of the HPV vaccine (95% confidence interval [CI] = 71.1% to 87.7%; 25 and 133 events in the HPV and control arms, respectively), **84.1%** for two doses (95% CI = 50.2% to 96.3%; 3 and 17 events), and **100%** for one dose (95% CI = 66.5% to 100%; 0 and 10 events). Conclusion Four years after vaccination of women who appeared to be uninfected, this nonrandomized analysis suggests that **two doses of the HPV16/18 vaccine, and maybe even one dose, are as protective as three doses**.

Ref 2 Gynecol Oncol. 2011 Nov;123(2):337-41.

Surgical treatment of lymph node metastases in stage IB cervical cancer. The laterally extended parametrectomy (LEP) procedure: Experience with a 5year follow-up.

Ungár L, Pálfalvi L, Tarnai L, Horányi D, Novák Z.

Source

Department of Obstetrics, Gynecology and Gynecologic Oncology, St. Stephen Hospital, Budapest, Hungary.

Abstract

INTRODUCTION:

In 2003, we published our preliminary experience with the use of an operative technique (**laterally extended parametrectomy**, the **LEP** procedure) **without adjuvant therapy**, in the treatment of 29 **stage IB, cervical cancer patients with pelvic lymph node metastases**. In our present paper, by an extended recruiting period, with a completed **5year follow up**, we studied the outcome of LEP operations, used with the same indications.

METHODS:

In **70 out of 106** LEP-Wertheim operated patients, no adjuvant treatment was used. In 36 patients, where histology suggested tumor spread beyond the threshold of our surgery, adjuvant chemo-radiotherapy was advised. 5year follow up was completed (without any patient lost for follow up) for the whole cohort of patients.

RESULTS:

In 70 patients treated by LEP procedure alone, the overall 5-year survival was 91.4%. For those 36 patients, who were excluded due to disease spread above study criteria, 5year survival was 44%. **Complications in 10%** of the cases necessitated a second operation. Apart from transient hyper continence and one case of permanent incontinence, no severe quality of life consequence of the operation was observed.

CONCLUSIONS:

Our results suggest that in **two-thirds of pelvic lymph node positive, stage IB cervical cancer cases surgery alone could provide equal or better survival** (without the toxicity of chemo-radiotherapy), than any kind of multimodality treatment alternatives. LEP procedure should be considered a treatment option for stage IB cervical cancer patients with pelvic lymph node metastases.

Ref 3 Lancet Oncol. 2011 Oct;12(11):1023-31.

Intrauterine device use, cervical infection with human papillomavirus, and risk of cervical cancer: a pooled analysis of 26 epidemiological studies.

Castellsagué X, Díaz M, Vaccarella S, de Sanjosé S, Muñoz N, Herrero R, Franceschi S, Meijer CJ, Bosch FX.

Source

Unit of Infections and Cancer, Cancer Epidemiology Research Program, Institut Català d'Oncologia, Bellvitge Biomedical Research Institute, L'Hospitalet de Llobregat, Catalonia, Spain; Biomedical Research Centre Network for Epidemiology and Public Health (CIBER-ESP), Spain.

Abstract

BACKGROUND:

Intrauterine device (IUD) use has been shown to reduce the risk of endometrial cancer, but little is known about its association with cervical cancer risk. We assessed whether IUD use affects cervical human papillomavirus (HPV) infection and the risk of developing cervical cancer.

METHODS:

We did a pooled analysis of individual data from two large studies by the International Agency for Research on Cancer and Institut Català d'Oncologia research programme on HPV and cervical cancer; one study included data from ten case-control studies of cervical cancer done in eight countries, and the other included data from 16 HPV prevalence surveys of women from the general population in 14 countries. 2205 women with cervical cancer and 2214 matched control women without cervical cancer were

included from the case-control studies, and 15 272 healthy women from the HPV surveys.

Information on IUD use was obtained by personal interview. HPV DNA was tested by PCR-based assays. Odds ratios and 95% CIs were estimated using multivariate unconditional logistic regression for the associations between IUD use, cervical HPV DNA, and cervical cancer.

FINDINGS:
After adjusting for relevant covariates, including cervical HPV DNA and number of previous Papanicolaou smears, a strong inverse association was found between ever use of IUDs and cervical cancer (odds ratio 0·55, 95% CI 0·42-0·70; p<0·0001). A protective association was noted for squamous-cell carcinoma (0·56, 0·43-0·72; p<0·0001), adenocarcinoma and adenosquamous carcinoma (0·46, 0·22-0·97; p=0·035), but not among HPV-positive women (0·68, 0·44-1·06; p=0·11). No association was found between IUD use and detection of cervical HPV DNA among women without cervical cancer.
INTERPRETATION:
Our data suggest that **IUD use might act as a protective cofactor in cervical carcinogenesis.** Cellular immunity triggered by the device might be one of several mechanisms that could explain our findings.

Ref 4 J Natl Cancer Inst. 2011 Sep 21;103(18):1387-96.

Persistence of type-specific human papillomavirus infection and increased long-term risk of cervical cancer.

Chen HC, Schiffman M, Lin CY, Pan MH, You SL, Chuang LC, Hsieh CY, Liaw KL, Hsing AW, Chen CJ; CBCSP-HPV Study Group.
Source
Genomics Research Center, Academia Sinica, 128 Academia Rd Section 2, Nankang, Taipei 11529, Taiwan. cjchen@ntu.edu.tw
Abstract
BACKGROUND:
Human papillomavirus (HPV) persistence is the pivotal event in cervical carcinogenesis. We followed a large-scale community-based cohort for 16 years to investigate the role of genotype-specific HPV persistence in predicting cervical cancer including invasive and in situ carcinoma.
METHODS:
At the baseline examination in 1991-1992, **11,923 participants** (aged 30-65 years) consented to HPV testing and cytology; 6923 participants were reexamined in 1993-1995. For HPV testing, we used a polymerase chain reaction-based assay that detected **39 HPV types**. Women who developed cervical cancer were identified from cancer and death registries. Cumulative risks for developing cervical cancer among infected and persistently infected women were calculated by the Kaplan-Meier method.
RESULTS:
Of 10,123 women who were **initially cytologically normal**, 68 developed cervical cancer. The 16-year **cumulative risks of subsequent cervical cancer** for women with HPV16,

HPV58 (without HPV16), or other carcinogenic HPV types (without HPV16 or HPV58) were 13.5%, 10.3%, and 4.0%, respectively, compared with 0.26% for HPV-negative women. Women with type-specific persistence of any carcinogenic HPV had greatly increased risk compared with women who were HPV-negative at both visits (hazard ratio = 75.4, 95% confidence interval = 31.8 to 178.9). The cumulative cervical cancer risks following persistent carcinogenic HPV infections increased with age: The risks were 5.5%, 14.4%, and 18.1% for women aged 30-44 years, 45-54 years, and 55 years and older, respectively. However, newly acquired infections were associated with a low risk of cervical cancer regardless of age.

CONCLUSIONS:

HPV negativity was associated with a very low long-term risk of cervical cancer. Persistent detection of HPV among cytologically normal women greatly increased risk. Thus, it is **useful to perform repeated HPV testing following an initial positive test**.

Ref 5 Gynecol Oncol. 2011 Aug;122(2):291-6.

Follow-up outcomes for a large cohort of US women with negative imaged liquid-based cytology findings and positive high risk human papillomavirus test results.

Zhao C, Chen X, Onisko A, Kanbour A, Austin RM.

Source

Department of Pathology, Magee-Womens Hospital of University of Pittsburgh Medical Center, Pittsburgh, PA, USA. zhaoc@upmc.edu

Abstract

OBJECTIVE:

This study aimed to follow a large group of US women with negative computer-imaged liquid-based cytology (LBC) and positive high risk (hr) HPV DNA results.

METHODS:

Negative LBC and positive hrHPV cases were identified between July 1, 2005 and December 31, 2009. Cytologic and histopathologic follow-up results, repeat HPV results, and prior history were analyzed.

RESULTS:

1099 Patients with negative LBC and positive hrHPV results were identified. Eight hundred sixty-nine had repeat Pap or histopathologic follow-up results. Average age was 41.2 years. **Average follow-up** was 23.2 months. Two hundred ninety of 869 had colposcopic examination and biopsies, including 33 diagnostic excisional procedures and 10 hysterectomies. Cervical intraepithelial neoplasia (CIN) 1 and low-grade squamous intraepithelial lesions (**CIN1/LSIL**) and more severe lesions (CIN1/LSIL+) were detected in 211 of 689 (**24.3%**). **CIN2+** was diagnosed in 21 (**2.4%**) (1 VAIN3, 2

adenocarcinoma in situ, 1 invasive cervical adenocarcinoma). Six hundred six had repeat HPV tests and 200 had multiple repeat HPV tests. More LSIL/CIN1+ was identified with repeat positive HPV results than with repeat negative HPV results (P<0.001). LSIL/CIN1+ was detected more often with a history of LSIL/CIN1+ than with a history of negative Paps (P<0.001). Eight of 105 (7.6%) cytology-negative HPV-positive patients tested positive for HPV 16 and/or HPV 18.

CONCLUSION:

This is the largest study documenting follow-up on US cytology-negative hrHPV-positive patients screened with now widely utilized FDA-cleared methods of ciLBC and hrHPV testing. Of 869 patients followed for an average of almost 2 years, 20 cases of high grade intraepithelial neoplasia (2.3%) and one case of endocervical adenocarcinoma were detected. 90.5%(190/210) of intraepithelial neoplasias detected during follow-up were CIN1.

Ref 6 OG. 2011 Aug;118(9):1031-41.

The risk of preterm birth following treatment for precancerous changes in the cervix: a systematic review and meta-analysis.

Bruinsma FJ, Quinn MA.

Source

Mother & Child Health Research, La Trobe University, Melbourne, Vic, Australia. f.bruinsma@latrobe.edu.au

Abstract

BACKGROUND:

Studies investigating the association between treatment for precancerous changes in the cervix and risk of preterm birth have used a variety of comparison groups.

OBJECTIVES:

To investigate whether treatment for precancerous changes in the cervix is associated with preterm birth (<37 weeks) and to examine the impact of the type of comparison group on estimates of risk.

SEARCH STRATEGY:

PubMed, Embase and CENTRAL were searched for studies pubished between 1950 and 2009.

SELECTION CRITERIA:

Eligible studies were those that reported preterm birth outcomes for excisional and ablative treatments separately and included a comparison group.

DATA COLLECTION AND ANALYSIS:

Pooled relative risks (RR) and 95% confidence intervals were computed using a random effects model.

MAIN RESULTS:

Thirty eligible studies were located. **Excisional treatment** was associated with an increased odds of preterm birth, when compared with an external (RR 2.19, 95% CI 1.93-2.49) or internal (RR 1.96, 95% CI 1.46-2.64) comparison group. In comparison with women who were assessed but not treated, the risk estimate was smaller (RR 1.25, 95% CI 0.98-1.58). **Ablative treatment** was associated with an increased risk of preterm birth when an external comparison group (RR 1.47, 95% CI 1.24-1.74) but not an internal comparison group (RR 1.24, 95% CI 0.73-2.10) or untreated comparison group (RR 1.03, 95% CI 0.90-1.18) was used.

AUTHORS' CONCLUSIONS:

Excisional treatment was associated with a significantly increased risk of preterm birth. It provides new evidence that **some types of ablative treatment may also be associated with a small increased risk**. The type of comparison group used is an important consideration when comparing the outcomes of studies.

Ref 7 Gynecol Oncol. 2011 Sep;122(3):484-90.

Neoadjuvant chemotherapy and vaginal radical trachelectomy for fertility-sparing treatment in women affected by cervical cancer (FIGO stage IB-IIA1).

Marchiole P, Tigaud JD, Costantini S, Mammoliti S, Buenerd A, Moran E, Mathevet P.

Source

Department of Obstetrics and Gynaecology, Ospedale Villa Scassi-ASL 3 Genovese, Corso O.Scassi 1, 16149 Genoa, Italy. pierangelo.marchiole@asl3.liguria.it

Abstract

OBJECTIVES:

The aim of the present report is to support the feasibility and the safety of a new fertility-sparing treatment in young women affected by bulky cervical cancer.

METHODS:

Between February 2007 and October 2010, **seven patients** presenting **large IB-IIA1 tumors (30-45 mm)** were scheduled for conservative treatment. All patients underwent neoadjuvant chemotherapy (NACT) followed by laparoscopic pelvic lymphadenectomy and vaginal radical trachelectomy (VRT).

RESULTS:

One patient presented hematological toxicity during NACT (grade 3). All patients showed complete disappearance of tumor (n=4/7) or partial response (a 50% or more decrease in total tumor size, n=3/7) to neoadjuvant treatment, and they were all treated with pelvic lymphadenectomy and VRT. Additional treatment (interstitial brachytherapy) was offered to only one woman because of a persistent parametrial tumoral lesion. After a

mean follow up of 22 months (range 5-49), **no relapse** was observed. To date, only one woman in our study attempted to conceive and she is currently **pregnant**.
CONCLUSIONS:
Neoadjuvant chemotherapy for fertility sparing treatment is an innovative approach which is potentially quite interesting for many young women affected by bulky cervical cancer. These women, i.e. those with tumors larger than 2 cm (2-5 cm), are traditionally not offered fertility sparing treatment, thus the preliminary data we report here might have a promising impact. Nevertheless, for these patients it may be suitable to use the more radical, and time-tested, conservative surgical approach to allow for a complete and conservative excision of the residual tumor after neoadjuvant treatment. Studies with a larger number of patients and adequate follow-up are required to validate this conservative approach and to define clearly the good indications for this treatment.

Ref 8 Gynecol Oncol. 2011 Nov;123(2):329-32.

Single-port laparoscopy and extraperitoneal para-aortic lymphadenectomy: About fourteen consecutive cases.

Gouy S, Kane A, Uzan C, Gauthier T, Gilmore J, Morice P.

Abstract
OBJECTIVE:
To report the feasibility and reproducibility of single port extraperitoneal para-aortic lymphadenectomy in locally advanced cervical cancer.
METHODS:
The same single port was used for the transperitoneal step and the extraperitoneal approach used thereafter (in the absence of peritoneal disease) for the lymphadenectomy. Para-aortic lymphadenectomy was performed via a left-sided extraperitoneal approach.
RESULTS:
Fourteen consecutive patients with cervical cancer underwent a laparoscopic staging procedure (3 stage IB2, 10 IIB and 1 stage IVA). No patient had para-aortic FDG uptake on PET/CT. In one case lymphadenectomy was unfeasible because of vascular anomalies of the renal vessels (low insertion of 2 left renal arteries). The median operative time was 190min (range, 135-250). The median **number of lymph nodes** removed was 14 [range, 2-23]. The definitive pathological analysis revealed that three patients had metastatic disease. No conversion to conventional multiport laparoscopy was necessary.
CONCLUSIONS:
This series reports that para-aortic lymphadenectomy technique via the extraperitoneal approach with a multichannel single port is **feasible and reproducible**.

Ref 9 Gynecol Oncol. 2011 Aug;122(2):255-9.

The impact of tumor morcellation during surgery on the prognosis of patients with apparently early uterine leiomyosarcoma.

Park JY, Park SK, Kim DY, Kim JH, Kim YM, Kim YT, Nam JH.

Source

Department of Obstetrics and Gynecology, University of Ulsan College of Medicine, Asan Medical Center, Seoul, Korea.

Abstract

OBJECTIVE:

Uterine leiomyosarcoma (LMS) is usually diagnosed after **surgery for leiomyoma**; thus **tumor morcellation frequently occurs**. We evaluated the impact of tumor morcellation during surgery on the prognosis of patients with apparently early uterine LMS.

METHODS:

Outcomes were **retrospectively compared between patients who underwent total abdominal hysterectomy without tumor morcellation** and those who underwent surgery that included abdominal, vaginal or laparoscopic tumor morcellation.

RESULTS:

We assessed 56 consecutive patients with stage I and II uterine LMS between 1989 and 2010, **25 with and 31 without tumor morcellation**. There were no significant between group differences in age, parity, menopausal status, body mass index, stage, mitotic count, tumor grade, lymph node dissection, adjuvant therapy, and follow-up duration. However, tumor size was significantly smaller (9.8 cm vs. 7.3 cm, P=0.022) and ovarian tissue was more frequently preserved (38.7% vs. 72%, P=0.013) in patients with tumor morcellation. In univariate analysis, only tumor morcellation was significantly associated with poorer disease-free survival (DFS) (odds ratio [OR], 2.59; 95% confidence interval [CI], 1.03-6.50; P=0.043), and higher stage (I vs. II; (OR, 19.12; 95% CI, 1.19-307.11; P=0.037)) and tumor morcellation (OR, 3.07; 95% CI, 1.05-8.93; P=0.040) were significantly associated with poorer overall survival (OS). **In multivariate analysis**, higher stage (OR, 20.34; 95% CI, 1.27-325.58; P=0.033) and **tumor morcellation (OR, 3.11; 95% CI, 1.07-9.06; P=0.038)** were significantly associated with **poorer OS**. The percentage of patients with **abdomino-pelvic dissemination**, as shown by peritoneal sarcomatosis or vaginal apex recurrence, was significantly greater in patients with than without tumor morcellation (**44% vs. 12.9%, P=0.032**).

CONCLUSION:

Tumor morcellation during surgery increased the rate of abdomino-pelvic dissemination and adversely affected DFS and OS in patients with apparently early uterine LMS.

Ref 10 Gynecol Oncol. 2011 Sep;122(3):608-11.

Surgical cytoreduction in stage IV endometrioid endometrial carcinoma.

Shih KK, Yun E, Gardner GJ, Barakat RR, Chi DS, Leitao MM Jr.

Source

Gynecology Service, Department of Surgery, Memorial Sloan-Kettering Cancer Center, New York, New York 10065, USA.

Abstract

OBJECTIVE:

To evaluate the role of surgical cytoreduction and the amount of residual disease in patients with newly diagnosed stage IV endometrioid endometrial carcinoma (EC).

METHODS:

Patients with stage IV EC of endometrioid histology who underwent surgery at our institution from 1977 to 2003 were identified. Patients with microscopic stage IV disease were excluded. Progression-free survival (PFS) and overall survival (OS) were estimated using Kaplan Meier method and compared with log-rank test.

RESULTS:

A total of **58 patients** were identified, of which 9 (15.5%) had no gross residual (NGR) after surgery, 11 (19.0%) had residual disease ≤1 cm, 32 (55.1%) had residual disease >1 cm, and 6 (10.3%) had no cytoreduction attempted. The median PFS was 11.1 months (95% CI, 9.8-12.3) and the median OS was 19.2 months (95% CI, 8.5-29.9) for the cohort. **The median PFS was 40.3 months (95% CI, 0-93.9) for patients with NGR disease**, 11 months (95% CI, 9.9-12.1) for patients with any residual disease, and 2.2 months (95% CI, 0.1-4.2) for patients who did not have attempted cytoreduction **(P<0.001)**. **The median OS was 42.2 months (95% CI, not estimable) for patients with NGR disease**, 19 months (95% CI, 13.9-24.1) for patients with any residual disease, and 2.2 months (95% CI, 0.1-4.2) for patients that did not have attempted cytoreduction **(P<0.001)**.

CONCLUSION:

Though stage IV endometrioid EC has a poor prognosis, surgical cytoreduction to no gross residual disease in a highly select group of patients is associated with improved survival.

Ref 11 Ann Oncol. 2011 Sep;22 Suppl 6:vi35-9.

Endometrial cancer: ESMO Clinical Practice Guidelines for diagnosis, treatment and follow-up.

Colombo N, Preti E, Landoni F, Carinelli S, Colombo A, Marini C, Sessa C; ESMO Guidelines Working Group.

Source

Division of Gynecologic Oncology, European Institute of Oncology, Milan, Italy.

Ref 12 Br J Cancer. 2011 Sep 27;105(7):897-902.

Paclitaxel-ifosfamide-carboplatin combination chemotherapy regimen in advanced uterine and adnexal malignant mixed Mullerian tumours.

Kosmas C, Vorgias G, Tsakonas G, Politis P, Daladimos T, Panagiotidi E, Papachrysanthou T, Moschovis D, Kalinoglou N, Tsavaris N, Karabelis A, Mylonakis N.

Source

Second Division of Medical Oncology, Department of Medicine, Metaxa Cancer Hospital, Piraeus, Greece. ckosm1@ath.forthnet.gr

Abstract

BACKGROUND:

Malignant mixed Mullerian tumours (**MMMTs**) of the **uterus and adnexa** represent aggressive gynaecologic malignancies with a high rate of loco-regional and distant failure. For that reason, we evaluated the paclitaxel-ifosfamide-carboplatin (TICb) combination in patients with advanced MMMTs.

METHODS:

Female patients with advanced MMMTs, WHO-PS 0-2, **no prior chemotherapy** for systemic disease, unimpaired haemopoietic and organ function were eligible. Chemotherapy was administered at the following doses; **paclitaxel: 175 mg m(-2) on day 1, ifosfamide: 2.0 g m(-2) day(-1)--days 1 and 2, and carboplatin at a target area under the curve 5 on day 2, with prophylactic G-CSF from day 3**.

RESULTS:

Forty patients of a median age 61 (45-72) years, performance status 0-2 with advanced MMMTs of the uterus (n=34), tubes (n=2) or ovary (n=4) have entered and all were evaluable for response and toxicity. **Responses** were as follows: 27 out of 40 (**67.5%**) evaluable patients responded, with 11 complete responses and 16 partial responses, while 10 had stable disease, and 3 developed progressive disease. The median response duration was 9 months (range, 4-40 months), median progression-free survival 13 months (range, 3-42 months), while median overall survival 18 months (range, 4-48 months). Grade 3/4 neutropenia was recorded in 22 out of 40 (55%)--with 13 developing grade 4 (≤7 days) and 7 out of 40 (17.5%) of patients at least one episode of febrile neutropenia.

CONCLUSION:

In this study, it appears that the TICb combination, **yielded important activity with manageable toxicity i**n females with advanced MMMTs warranting further randomised comparison with current standard regimens.

Ref 13 Gynecol Oncol. 2011 Aug;122(2):457-8.

Mitochondrial DNA genotyping reveals synchronous nature of simultaneously detected endometrial and ovarian cancers.

Guerra F, Kurelac I, Magini P, Cormio A, Santini D, Ceccarelli C, Gasparre G.
Source
Dip. di Scienze Ginecologiche, Ostetriche e Pediatriche, U.O. Genetica Medica, Pol. Universitario S.Orsola-Malpighi, 40138, Bologna, Italy.

Abstract
Simultaneous independent primary tumors of the female genital tract occur in 1-2% of gynecological cancer patients, 50-70% of which are synchronous tumors of the endometrium and ovary. Guidelines for determining the nature of simultaneously detected tumors, based on surgical and histopathological findings, are often ambiguous and may require further molecular analyses. Such approach is necessary to indicate correct prognosis and hence treatment. We here demonstrate how **mitochondrial DNA sequencing** may provide a **cheap and useful** tool to contribute to indisputably recognize the synchronous nature of simultaneously detected endometrial and ovarian carcinomas. We further confirm our findings by means of Comparative Genomic Hybridization array analysis, which strengthens the informative potential of mitochondrial DNA genotyping in diagnosing synchrony.

Ref 14 J Clin Oncol. 2011 Sep 20;29(27):3628-35.

Carboplatin plus paclitaxel versus carboplatin plus pegylated liposomal doxorubicin as first-line treatment for patients with ovarian cancer: the MITO-2 randomized phase III trial.

Pignata S, Scambia G, Ferrandina G, Savarese A, Sorio R, Breda E, Gebbia V, Musso P, Frigerio L, Del Medico P, Lombardi AV, Febbraro A, Scollo P, Ferro A, Tamberi S, Brandes A, Ravaioli A, Valerio MR, Aitini E, Natale D, Scaltriti L, Greggi S, Pisano C, Lorusso D, Salutari V, Legge F, Di Maio M, Morabito A, Gallo C, Perrone F.
Source
Istituto Nazionale Tumori, via Mariano Semmola, 80131 Napoli, Italy.
sandro.pignata@gmail.com

Abstract
PURPOSE:
Carboplatin/paclitaxel is the standard first-line chemotherapy for patients with advanced ovarian cancer. Multicentre Italian Trials in Ovarian Cancer-2 (MITO-2), an academic multicenter phase III trial, tested whether carboplatin/pegylated liposomal doxorubicin (PLD) was more effective than standard chemotherapy.
PATIENTS AND METHODS:
Chemotherapy-naive patients with stage IC to IV ovarian cancer (age ≤ 75 years; Eastern

Cooperative Oncology Group performance status ≤ 2) were randomly assigned to carboplatin area under the curve (AUC) 5 plus paclitaxel 175 mg/m(2) or to **carboplatin AUC 5 plus PLD 30 mg/m(2), every 3 weeks for six cycles**. Primary end point was progression-free survival (PFS). With 632 events in 820 enrolled patients, the study would have 80% power to detect a 0.80 hazard ratio (HR) of PFS.
RESULTS:
Eight hundred twenty patients were randomly assigned. Disease stages III and IV were prevalent. Occurrence of PFS events substantially slowed before obtaining the planned number. Therefore, in concert with the Independent Data Monitoring Committee, final analysis was performed with 556 events, after a median follow-up of 40 months. **Median PFS** times were 19.0 and 16.8 months with carboplatin/PLD and carboplatin/paclitaxel, respectively (HR, 0.95; 95% CI, 0.81 to 1.13; P = .58). **Median overall survival** times were 61.6 and 53.2 months with carboplatin/PLD and carboplatin/paclitaxel, respectively (HR, 0.89; 95% CI, 0.72 to 1.12; P = .32). Carboplatin/PLD produced a similar response rate but **different toxicity** (less neurotoxicity and alopecia but more hematologic adverse effects). There was no relevant difference in global quality of life after three and six cycles.
CONCLUSION:
Carboplatin/PLD was **not superior to** carboplatin/paclitaxel, which remains the standard first-line chemotherapy for advanced ovarian cancer. However, given the observed CIs and the different toxicity, **carboplatin/PLD could be considered an alternative** to standard therapy.

Ref 15 Gynecol Oncol. 2011 Aug;122(2):226-32.

Decreased hypersensitivity reactions with carboplatin-pegylated liposomal doxorubicin compared to carboplatin-paclitaxel combination: analysis from the GCIG CALYPSO relapsing ovarian cancer trial.

Joly F, Ray-Coquard I, Fabbro M, Donoghoe M, Boman K, Sugimoto A, Vaughan M, Reinthaller A, Vergote I, Ferrandina G, Dell'Anna T, Huober J, Pujade-Lauraine E.
Source
Centre François Baclesse, Medical Oncology Department, Caen, France.
f.joly@baclesse.fr
Abstract
OBJECTIVE:
To describe and analyze observed hypersensitivity reactions (HSR) from the **randomized, multicenter phase III CALYPSO trial** that evaluated the efficacy and safety of the combination of carboplatin and pegylated liposomal doxorubicin (CD) compared with standard carboplatin-paclitaxel (CP) in patients with platinum-sensitive relapsed ovarian

cancer (ROC).
METHODS:
HSR documented within case report forms and SAE reports were specifically analyzed. Analyses were based on the population with allergy of any grade and for grade >2 allergy.
RESULTS:
Overall 976 patients were recruited to this phase III trial, with toxicity data available for 466 and 502 on the CD and CP arms, respectively. There was a **15.5% HSR rate associated with CD (2.4% grade >2)** versus **33.1% with CP (8.8% grade >2), p<0.001**. HSRs occurred more often **during first cycle** in the CD (46%) arm than in the CP arm (16%). Multivariate predictors of allergy were chemotherapy regimen and age; patients randomized to CD and patients ≥ 70 years old on CP had less allergy. Few patients (<6%) stopped treatment due to allergy. Allergy rates were higher in patients who did not receive prior supportive treatment; however there was no relationship between allergy and the type of carboplatin product received, or response rate.
CONCLUSIONS:
Use of PLD with carboplatin instead of paclitaxel and older age were the only 2 factors predicting a low rate of HSRs in patients with ROC. CD has previously demonstrated superior progression-free survival and therapeutic index than CP. Taken together these data support the use of CD as a safe and effective therapeutic option for platinum-sensitive ROC.

Ref 16 Gynecol Oncol. 2011 Sep;122(3):532-5.

Prognostic significance of the relative dose intensity of chemotherapy in primary treatment of epithelial ovarian cancer.

Fauci JM, Whitworth JM, Schneider KE, Subramaniam A, Zhang B, Frederick PJ, Kilgore LC, Straughn JM Jr.
Source
University of Alabama at Birmingham, Department of Obstetrics and Gynecology, Division of Gynecology Oncology, Birmingham, AL 35249, USA.
Abstract
OBJECTIVE:
Relative dose intensity (RDI) is the ratio of delivered dose intensity of chemotherapy to standard dose intensity. In this study, we sought to determine the prognostic significance of RDI in patients with epithelial ovarian cancer (EOC).
METHODS:
A **retrospective analysis** of chemotherapy naïve patients treated between 2001 and 2008 with intravenous taxane and platinum was performed. RDI was calculated as the

delivered dose intensity (total dose delivered/total time of therapy) divided by standard dose intensity calculated for each regimen and compared to progression-free survival (PFS). Multivariate recursive partitioning survival analysis was utilized.
RESULTS:
138 EOC patients completed initial taxane/platinum-based chemotherapy following surgical cytoreduction. The most common reasons for dose delays and reductions were thrombocytopenia (38%) and neutropenia (31%). 24% of treatment delays were due to social reasons such as transportation constraints or scheduling conflicts. The average RDI was 90% (range, 24-126%). The mean PFS was 31 months (range, 3-117). Patients that achieved an **RDI between 70% and 110%** had a **mean PFS of 32 months** compared to **20 months** in patients with an **RDI of <70% or >110% (p=0.046)**. 14 patients (10%) had a RDI of <70%.
CONCLUSIONS:
RDI is a significant predictor of survival in patients with EOC. Effort should be made to achieve an RDI of at least 70%. **Dose reductions and treatment delays could be minimized by utilizing prophylactic colony stimulating factors** and educating patients about the importance of adhering to their treatment schedule.

Ref 17 Int J Gynaecol Obstet. 2011 Aug;114(2):133-6.

Changes in the management and outcome of central nervous system involvement from ovarian cancer since 1994.

Cormio G, Loizzi V, Falagario M, Lissoni AA, Resta L, Selvaggi LE.
Source
Department of Gynecology, Obstetrics and Neonatology, Gynecologic Oncology Unit, University of Bari, Bari, Italy. n.cormio@gynecology2.uniba.it
Abstract
OBJECTIVE:
To identify differences in the management and outcome of patients with central nervous system metastases from epithelial ovarian cancer.
METHODS:
The clinical and pathologic characteristics, treatment, and outcome of 23 patients with brain metastases from epithelial ovarian cancer who were treated during 1982-1994 were compared with those of 20 patients treated during 1995-2010 at the same center.
RESULTS:
No differences were found in terms of primary tumor characteristics, time interval from ovarian cancer diagnosis to brain involvement diagnosis, sites of metastasis, and presence of extracranial disease. The main difference between the 2 groups was the therapeutic approach. During 1982-1994, most patients received **radiotherapy only**, whereas most

patients during 1995-2010 underwent **surgical resection followed by radiotherapy and/or chemotherapy**. The duration of survival during 1982-1994 was **5 months**, which was significantly shorter than the duration of survival (**18 months**) during 1995-2010.
CONCLUSION:
An aggressive multimodal treatment approach might prolong the survival of patients with brain involvement from ovarian cancer.

Ref 18 Lancet Oncol. 2011 Sep;12(9):900-4.

Risk of ovarian cancer in women with pelvic inflammatory disease: a population-based study.

Lin HW, Tu YY, Lin SY, Su WJ, Lin WL, Lin WZ, Wu SC, Lai YL.
Source
Department of Mathematics, Soochow University, Taipei, Taiwan.
Abstract
BACKGROUND:
Ovarian cancer is commonly fatal and incidence has persistently risen in Taiwan over the past 20 years. Prevention strategies, however, are limited. Pelvic inflammatory disease (PID) has been suggested to increase the risk of developing ovarian cancer, but the results of studies have been inconsistent. Therefore, we investigated whether PID increases the risk of developing ovarian cancer in a large, nationwide cohort.
METHODS:
From **the Longitudinal Health Insurance Database 2005 (LHID2005) in Taiwan**, we obtained data for women aged 13-65 years for whom a diagnosis of PID, confirmed by multiple episodes, had been recorded between Jan 1, 2004, and Dec 31, 2005. We also obtained data for two controls per patient, matched for age and the year of first entry into the LHID2005. All patients were followed up from the date of entry in the LHID2005 until they developed ovarian cancer or to the end of 2006, whichever was earlier. We used Cox's regression models to assess the risk of developing ovarian cancer, with adjustment for age, comorbid disorders, and socioeconomic characteristics.
FINDINGS:
We identified **67,936 women with PID and 135,872 controls**. Among these 90 had developed ovarian cancer during the 3-year follow-up period (42 patients with PID and 48 controls, incidence 2·78 and 1·44 per 10,000 person-years, respectively). The adjusted hazard ratio for ovarian cancer in patients **with PID was 1·92 (95% CI 1·27-2·92)** compared with controls, which **rose to 2·46 (1·48-4·09) in women who had had at least five episodes of PID**. The adjusted hazard ratio was slightly higher for women aged 35 years or younger with PID than in older women with PID (2·23, 1·02-4·79 vs 1·82, 1·10-3·04).

INTERPRETATION:
We found an association between PID and ovarian cancer. PID might, therefore, be a useful marker for ovarian cancer, and early treatment could help to improve prognosis. Whether pelvic inflammation itself accelerates the growth of ovarian cancers or affects cancer-cell differentiation in ways that adversely alter prognosis needs to be investigated.

Ref 19 Gynecol Oncol. 2011 Apr;121(1):94-9.

Surgical staging of early stage epithelial ovarian cancer: results from the CDC-NPCR ovarian patterns of care study.

Cress RD, Bauer K, O'Malley CD, Kahn AR, Schymura MJ, Wike JM, Stewart SL, Leiserowitz GS.

Source

California Cancer Registry, Public Health Institute, Sacramento, CA, USA.
rcress@ccr.ca.gov

Abstract

OBJECTIVES:
The objectives of this study were to determine the adequacy of surgical staging performed on surgically treated epithelial ovarian cancer (EOC) patients with apparent early stage disease and to determine if receipt of surgical staging had an influence on survival.

METHODS:
Detailed surgical staging information was collected from medical records for 721 patients diagnosed between 1998 and 2000 with EOC. Patients resided in California or New York and were identified through population-based cancer registries.

RESULTS:
Nearly 90% of patients had removal of the omentum and evaluation of bowel serosa and mesentery but only 72% had assessment of retroperitoneal lymph nodes and the majority of patients did not receive biopsies of other peritoneal locations. **Only lymph node assessment (as well as node assessment combined with washings and omentectomy) had a statistically significant association with improved survival.** The 5-year survival for women with node sampling was 84.2% versus 69.6% for those without this surgical procedure, and patients who did not have lymph node assessment had nearly twice the risk of death as those who did. When patients were stratified by receipt of chemotherapy, lack of node sampling had an effect only on patients who also had no chemotherapy (adjusted HR=2.2, CI=1.0-4.5).

CONCLUSIONS:
The results of this population-based study confirm the prognostic importance of surgical staging for women with EOC, and the important role of gynecologic oncologists in

treating these patients. Adjuvant chemotherapy does not appear to further improve survival for those women who receive adequate surgical staging.

Ref 20 Br J Cancer. 2011 Aug 9;105(4):493-7.

Prognostic impact of lymphadenectomy in clinically early stage malignant germ cell tumour of the ovary.

Mahdi H, Swensen RE, Hanna R, Kumar S, Ali-Fehmi R, Semaan A, Tamimi H, Morris RT, Munkarah AR.

Source

Department of Obstetrics and Gynecology, University of Washington School of Medicine, Seattle, WA 98195, USA.

Abstract

BACKGROUND:

The aim of this study was to determine the impact of lymphadenectomy and nodal metastasis on survival in clinical stage I malignant ovarian germ cell tumour (OGCT).

METHODS:

Data were obtained from the National Cancer Institute registry from 1988 to 2006. Analyses were performed using Student's t-test, Kaplan-Meier and Cox proportional hazard methods.

RESULTS:

In all, 1083 patients with OGCT who have undergone surgical treatment and deemed at time of the surgery to have disease clinically confined to the ovary were included 590 (54.48%) had no lymphadenectomy (LND-1) and 493 (45.52%) had lymphadenectomy. Of the 493 patients who had lymphadenectomy, 441 (89.5%) were FIGO surgical stage I (LND+1) and 52 (10.5%) were upstaged to FIGO stage IIIC due to nodal metastasis (LND+3C). The 5-year survival was 96.9% for LND-1, 97.7% for LND+1 and 93.4% for LND+3C (P=0.5). On multivariate analysis, lymphadenectomy was not an independent predictor of survival when controlling for age, histology and race (HR: 1.26, 95% CI: 0.62-2.58, P=0.5). Moreover, the presence of lymph node metastasis had no significant effect on survival (HR: 2.7, 95% CI: 0.67-10.96, P=0.16).

CONCLUSION:

Neither lymphadenectomy nor lymph node metastasis was an independent predictor of survival in patients with OGCT confined to the ovary. This probably reflects the **highly chemosensitive** nature of these tumours.

Ref 21 Int J Gynecol Cancer. 2011 Aug;21(6):1063-70.

Surgical and medical treatment of clear cell ovarian cancer: results

from the multicenter Italian Trials in Ovarian Cancer (MITO) 9 retrospective study.

Magazzino F, Katsaros D, Ottaiano A, Gadducci A, Pisano C, Sorio R, Rabaiotti E, Scambia G, Cormio G, Scarampi L, Greggi S, Savarese A, Marinaccio M, Scollo P, Pignata S.

Source

II Ginecologia e Ostetricia, Azienda Ospedaliera Policlinico, Bari, Italy.

Abstract

OBJECTIVE:

Clear cell ovarian carcinoma has a poorer prognosis compared with other histological subtypes.

MATERIALS AND METHODS:

The Multicenter Italian Trials in Ovarian Cancer (MITO) 9 study **retrospectively** assessed an Italian cohort of patients with clear cell ovarian cancer observed in the years 1991-2007 in 20 Italian centers.

RESULTS:

A total of **240 patients** with ovarian cancer were analyzed. Forty-five percent of the patients had stage I disease. In 62.9%, clear cell histology was pure, whereas in the other cases, a mixed population was evident. Most of the cases underwent standard surgery, whereas in 7.1% of the patients, a fertility-sparing surgery was given. Lymphadenectomy was performed in 47.9% (115/240) of the patients (54.3% in stages I and II; 39.2% in advanced stage). Most of the patients were treated with platinum-based chemotherapy including paclitaxel in 52.9%. Disease-free survival was longer in patients undergoing lymphadenectomy at surgery (P = 0.0001), both in early stages (P = 0.0258) and in stage III and IV diseases (P = 0.0037). The impact of lymphadenectomy was also evident on overall survival in patients with advanced-stage disease. At multivariate analysis, lymphadenectomy (done vs not done) and stage (I and II vs III and IV) were independently associated with longer disease-free and overall survival, whereas front-line chemotherapy (with vs without taxanes) was not significant.

CONCLUSION:

This analysis suggests that **lymphadenectomy has a strong prognostic role for clear cell ovarian cancer influencing disease-free survival and overall survival**. The addition of **paclitaxel** to platinum-based chemotherapy **does not affect** the outcome.

Ref 22 Gynecol Oncol. 2011 Nov;123(2):342-5.

It's not just for laparoscopy anymore: Use of insufflation under ultrasound and fluoroscopic guidance by Interventional Radiologists for percutaneous placement of intraperitoneal chemotherapy catheters.

Henretta MS, Anderson CL, Angle JF, Duska LR.
Source
Department of Obstetrics and Gynecology, Division of Gynecologic Oncology, University of Virginia Health System, Charlottesville, VA, USA.
Abstract
OBJECTIVES:
While intraperitoneal (IP) chemotherapy has shown significant survival benefits, the ability to successfully deliver IP chemotherapy has been limited. In GOG 172, surgically-placed IP catheters had a reported complication rate of 34%. In addition, IP catheters have to be placed surgically. We have developed a novel percutaneous placement technique for IP catheters in patients without ascites.
METHODS:
This study was a retrospective analysis of all patients receiving percutaneously-placed IP catheters from 12/2008 to present. Catheters were placed using a **two-step technique** under conscious sedation. IP access was gained using **ultrasound-guided peritoneal puncture** over the **right lobe of the liver**. A 5 Fr catheter was placed into the peritoneal cavity and the abdomen **insufflated with carbon dioxide** (CO(2)). Access was gained in the RLQ once distention separated the bowel from the abdominal wall. A 14.5 Fr multi-side hole catheter was coiled in the pelvis, and a reservoir tunneled onto the lower anterior chest wall. For this analysis, abstracted data included patient demographics, indication for catheter placement, complications (procedural and with chemotherapy delivery), **fluoroscopy** time, and timing/indication of catheter removal.
RESULTS:
Eleven patients received IP catheters. The mean age was 58years, mean body mass index was 27.1, and mean number of days from surgical debulking was 38. There were two stage 2, and eight stage 3 patients. Two patients had fallopian tube, and nine patients had ovarian cancer. All patients had an optimal debulking procedure. Seven of 11 patients also obtained central intravenous access when the IP port was placed. Follow-up data were as follows: Average fluoroscopy time was 9min. One patient (9%) had an intra-procedural complication but the catheter was successfully placed. Zero patients had catheter-related complications in the course of receiving chemotherapy. Five of the 11 patients (45%) completed the planned IP chemotherapy treatments, with three additional patients (27%) currently receiving therapy. The remaining three patients (27%) discontinued chemotherapy for reasons unrelated to IP catheter function: two due to chemotherapy side effects, and one with sepsis from a perforated diverticulum.
CONCLUSIONS:
Thus far, our experience with percutaneous placement of IP catheters is associated with a **low risk of catheter-related complications** and high technical success rates. CO(2) insufflation may make peritoneal puncture easier and potentially safer. This procedure

offers an alternative to surgical placement, even in patients without clinically significant ascites.

Ref 23 Int J Gynecol Cancer. 2011 Aug;21(6):1048-55.

Feasibility of a modified outpatient regimen of intravenous/intraperitoneal chemotherapy in optimally debulked stage III ovarian cancer patients: a GEICO study.

Oaknin A, Roda D, González-Martín A, Chiva L, García-Donas J, de Juan A, Redondo A, Martínez S, García Y, Catot S, Ponce J, Del Campo JM, Cervantes A, Poveda A.

Source

Medical Oncology Department, Vall d'Hebron University Hospital, Barcelona, Spain. amoaknin@vhebron.net

Abstract

OBJECTIVES:

The objective of the study was to assess the feasibility, toxicity, and reasons for early discontinuation of a modified outpatient intraperitoneal/intravenous (IP/IV) chemotherapy regimen for the treatment of patients with optimally debulked stage III ovarian cancer.

METHODS:

Between February 2006 and November 2008, 51 consecutive patients from Institutions of the Spanish Ovarian Cancer Group (GEICO) were treated with a modified outpatient IP chemotherapy regimen. Patients received **IV paclitaxel 175 mg/m over 3 hours** on day 1, followed by IP cisplatin 100 mg/m (or 75 mg/m according to the principal investigator's criteria) on day 2. On day 8, patients received IP paclitaxel 60 mg/m. To homogenize the IP administration and supportive measures, **a GEICO guideline for IP chemotherapy was established**. Patients were treated with the intention to receive 6 courses of chemotherapy every 21 days.

RESULTS:

The median age of the patients was 49 years (range, 36-75 years), and most of them had papillary serous ovarian cancer (78%), International Federation of Gynecology and Obstetrics stage IIIC (76%). Thirty-nine patients completed 4 or more IP cycles, and 28 (**61%) completed all 6 IP cycles**. Twenty-two patients discontinued the IP/IV treatment, mainly because of chemotherapy toxicity (10 patients) and catheter-related complications (5 patients). The most prevalent grade 3/4 toxicities were neutropenia (14 patients; 30%) and gastrointestinal events (12 patients; 26%).

CONCLUSIONS:

The GEICO outpatient modified regimen **resulted in a lesser toxicity and a greater rate of treatment completion** than previously reported. The accurate selection of patients and

the administration following well-defined guidelines can increase the feasibility of IP chemotherapy administration.

Ref 24 Gynecol Oncol. 2011 Aug;122(2):215-20.

Cytoreductive surgery and hyperthermic intraperitoneal chemotherapy as upfront therapy for advanced epithelial ovarian cancer: multi-institutional phase-II trial.

Deraco M, Kusamura S, Virzì S, Puccio F, Macrì A, Famulari C, Solazzo M, Bonomi S, Iusco DR, Baratti D.

Source

Peritoneal Surface Malignancy Program, Department of Surgery, National Cancer Institute, via Venezian 1, 20133 Milan, Italy. marcello.deraco@istitutotumori.mi.it

Abstract

OBJECTIVE:

The primary end-point of this multi-institutional phase-II trial was to assess results in terms of overall survival after cytoreductive surgery (CRS) and hyperthermic intraperitoneal chemotherapy (**HIPEC**) in treatment-naive epithelial ovarian cancer (EOC) with advanced peritoneal involvement. Secondary end-points were treatment morbi-mortality and outcome effects of time to subsequent adjuvant systemic chemotherapy (TTC).

METHODS:

Twenty-six women with stage III-IV EOC were prospectively enrolled in 4 Italian centers to undergo CRS and **closed-abdomen HIPEC with cisplatin and doxorubicin**. **Then they received systemic chemotherapy** with carboplatin (AUC 6) and paclitaxel (175 mg/m(2)) for 6 cycles.

RESULTS:

Macroscopically **complete cytoreduction** was achieved in 15 patients; only **minimal residual disease** (≤2.5 mm) remained in 11. **Major complications** occurred in four patients and **postoperative death** in one. After a median follow-up of 25 months, **5-year overall survival** was 60.7% and 5-year progression-free survival 15.2% (median 30 months). Excluding operative death, all the patients underwent systemic chemotherapy at a median of 46 days from combined treatment (range: 29-75). The median number of cycles per patient was 6 (range: 1-8). The time to chemotherapy did not affect the OS or PFS.

CONCLUSIONS:

In selected patients with advanced stage EOC, **upfront CRS and HIPEC provided promising results** in terms of outcome. Morbidity was comparable to aggressive cytoreduction without HIPEC. Postoperative recovery delayed the initiation of adjuvant

systemic chemotherapy but not sufficiently to impact negatively on survival. These data warrant further evaluation in a randomized clinical trial.

Ref 25 Gynecol Oncol. 2011 Aug;122(2):221-5.

HIPEC in recurrent ovarian cancer patients: morbidity-related treatment and long-term analysis of clinical outcome.

Fagotti A, Costantini B, Vizzielli G, Perelli F, Ercoli A, Gallotta V, Scambia G, Fanfani F.

Source

Division of Gynecologic Oncology, Catholic University of the Sacred Heart, Rome, Italy. anna.fagotti@rm.unicatt.it

Abstract

OBJECTIVE:

To evaluate morbidity and mortality rates associated with the use of hyperthermic intraoperative intraperitoneal chemotherapy (HIPEC) after **optimal cytoreduction** (CRS) in a large single-institutional series of **platinum-sensitive recurrent** ovarian cancer patients. Moreover, disease free (DFS) and overall survival (OS) of previously studied patients have been assessed after a longer follow-up period.

METHOD:

From May 2005 to October 2010, recurrent ovarian cancer patients with a platinum-free interval of at least 6 months have been prospectively enrolled in a protocol of CRS plus HIPEC with **oxaplatinum (460 mg/m(2)) heated to 41.5 °C for 30 min, followed by 6 cycles of systemic chemotherapy with taxotere 75 mg/m(2) and oxaliplatin 100 mg/m(2).**

RESULTS:

Forty-one patients experienced 43 procedures (CRS+HIPEC). An optimal cytoreduction was achieved in all cases (CC-0 95.3%; CC-1 4.7%). A complication rate of 34.8% was registered, with no case of intraoperative death or within 30 days after surgery. Survival curves have been calculated in a group of 25 patients with a minimum follow-up of 18 months, obtaining a **median DFS and OS of 24 (range 6-60) and 38 months (range 18-60)**, respectively.

CONCLUSION:

In recurrent platinum-sensitive ovarian cancer patients, the use of CRS plus HIPEC represents a **safe treatment**, able to significantly influence the survival rates compared to chemotherapy alone or surgery plus standard chemotherapy.

Ref 26 Gynecol Oncol. 2011 Sep;122(3):612-7.

Malignant melanoma of the vulva: an extension of cutaneous melanoma?

Moxley KM, Fader AN, Rose PG, Case AS, Mutch DG, Berry E, Schink JC, Kim CH, Chi DS, Moore KN.

Source

Division of Gynecologic Oncology, University of Oklahoma HSC, Oklahoma City, OK, USA. katherine-moxley@ouhsc.edu

Abstract

OBJECTIVE:

To determine the prognostic significance of the 2002 revisions of the American Joint Committee on Cancer (AJCC) Staging System for cutaneous melanoma in melanoma of the vulva and review the current surgical utilized for treatment of this neoplasm.

METHODS:

Demographic, surgical and outcomes data were obtained from the records of vulvar melanoma patients treated from 1990 to 2006 at five academic medical centers. The **2002 modifications of the AJCC staging system for cutaneous melanoma**, Breslow thickness and Clark level, were applied to all subjects. Kaplan-Meier Modeling and Linear Regression analysis were utilized for data analysis. Statistics were performed with SAS v 9.1.

RESULTS:

Seventy-seven patients were identified with a median age of 62 years. 73% had Stage I/II disease. **Surgical radicality did not impact recurrence rates or survival**. Breslow thickness was associated with recurrence (p=0.002) but not survival. **Only the 2002 modified AJCC staging criteria were predictive of overall survival** (p=0.006) in patients with malignant melanoma of the vulva.

CONCLUSIONS:

In the largest multi-site series of vulvar melanoma, the AJCC-2002 staging system for cutaneous malignant melanoma appears to be applicable to primary vulvar melanoma. Moreover, surgical radicality was associated with significant morbidity but not with improvement in survival. Utilization of standard operative staging and resection principles in cutaneous melanoma should be used for all vulvar melanoma patients. Moreover, these patients should also be considered for enrollment in cutaneous melanoma clinical trials.

Ref 27 Gynecol Oncol. 2011 Aug;122(2):447-54.

Hormone replacement therapy in gynecologic cancer survivors: why not?

Ibeanu O, Modesitt SC, Ducie J, von Gruenigen V, Agueh M, Fader AN.

Source
Division of Gynecologic Oncology, Greater Baltimore Medical Center and Johns Hopkins Medical Institutions, Baltimore, MD, USA.
Abstract
PURPOSE:
As a result of treatment, many women with gynecologic malignancies will go through menopause and display climacteric symptoms at an earlier age than occurs naturally. Iatrogenic menopause may adversely affect quality of life and health outcomes in young female cancer survivors. Hormone replacement therapy (HRT) has often been withheld from women with gynecologic cancer because of concern that it might increase the risk of relapse or the development of new primary cancers. The purpose of this review was to examine the published literature on menopause management in gynecologic cancer survivors and highlight the risks and benefits of conventional and alternative HRT in this population.
METHODS:
A comprehensive literature search of English language studies on menopause management in gynecologic cancer survivors and women with a hereditary predisposition to a gynecologic malignancy was performed in MEDLINE databases through December 2010.
RESULTS:
Both our review and a 2008 Cochrane review of randomized trials on the effects of long-term HRT demonstrate that for menopausal women in their 40s or 50s with and without gynecologic cancer, the absolute risks of estrogen-only HRT are low. Several prospective observational studies and randomized trials on HRT use in women with a genetic predisposition for or development of a gynecologic malignancy suggest benefits in quality of life with no proven adverse oncologic effects as a result of short-term HRT use.
CONCLUSION:
In select women, it is reasonable to discuss and offer conventional HRT for the amelioration of menopausal symptoms and to improve quality of life. **HRT does not appear to increase the risk of gynecologic cancer recurrences**; however, this conclusion was largely **based on observational data and smaller prospective studies**.

Ref 28 Ann Oncol. 2011 Aug;22(8):1872-7.

Randomized comparison of pegfilgrastim day 4 versus day 2 for the prevention of chemotherapy-induced leukocytopenia.

Zwick C, Hartmann F, Zeynalova S, Pöschel V, Nickenig C, Reiser M, Lengfelder E, Peter N, Schlimok G, Schubert J, Schmitz N, Loeffler M, Pfreundschuh M; German

High-Grade Non-Hodgkin Lymphoma Study Group.
Source
Department of Oncology, Saarland University Medical School, Homburg, Germany.
carsten.zwick@uks.eu
Abstract
BACKGROUND:
To study the effects of deferring pegfilgrastim until day 4 on the reduction of chemotherapy-induced leukocytopenia.
PATIENTS AND METHODS:
Patients of age 61-80 years with **aggressive lymphoma** were **randomly assigned** to receive 6 mg pegfilgrastim on day 2 or 4 of a 2-week chemotherapy regimen (R-CHOP-14).
RESULTS:
Two hundred and ninety-two and 313 chemotherapy cycles were evaluable in 103 patients. Post-nadir pegfilgrastim serum levels were higher after day 4 than after day 2 application. This was associated with an attenuated leukocyte nadir after day 4 pegfilgrastim and there were fewer days with leukocytes <2 × 10(3)/mm(3) compared with day 2 pegfilgrastim. Grade 3 and 4 leukocytopenias (70% versus 43.3%; P < 0.001) and grade 4-only leukocytopenias (47% versus 20.5%; P < 0.001) were more frequent after day 2 pegfilgrastim. There were more chemotherapy cycles with grade 3 and 4 infections after day 2 than day 4 pegfilgrastim (9.4% versus 6.0%; P = 0.118). Interventional antibiotics were given more often after day 2 than after day 4 pegfilgrastim (30.7% versus 21.9% of cycles; P = 0.008). There were five deaths during leukocytopenia after day 2 and none after day 4 pegfilgrastim (P = 0.027).
CONCLUSIONS:
Administration of pegfilgrastim **on day 4 was more effective** in reducing severe leukocytopenias and resulted in fewer deaths during leukocytopenia. Pegfilgrastim should

be given on day 4 to better exploit its myeloprotective potential.

Ref 29 Ann Oncol. 2011 Sep;22 Suppl 6:vi69-77.

Management of cancer pain: ESMO Clinical Practice Guidelines.

Ripamonti CI, Bandieri E, Roila F; ESMO Guidelines Working Group.

Source

Supportive Care in Cancer Unit, IRCCS Foundation, National Cancer Institute of Milano, Milan, Italy.

Ref 30 N Engl J Med. 2011 Aug 11;365(6):506-17.

Early versus late parenteral nutrition in critically ill adults.

Casaer MP, Mesotten D, Hermans G, Wouters PJ, Schetz M, Meyfroidt G, Van Cromphaut S, Ingels C, Meersseman P, Muller J, Vlasselaers D, Debaveye Y, Desmet L, Dubois J, Van Assche A, Vanderheyden S, Wilmer A, Van den Berghe G.

Source

Department of Intensive Care Medicine, University Hospitals of the Catholic University of Leuven, Leuven, Belgium.

Abstract

BACKGROUND:

Controversy exists about the timing of the initiation of parenteral nutrition in critically ill adults in whom caloric targets cannot be met by enteral nutrition alone.

METHODS:

In this **randomized**, multicenter trial, we compared **early initiation of parenteral nutrition (European guidelines)** with **late initiation (American and Canadian guidelines)** in adults in the intensive care unit (ICU) to supplement insufficient enteral nutrition. In **2312 patients**, parenteral nutrition was initiated **within 48 hours** after ICU admission (**early-initiation group**), whereas in 2328 patients, parenteral nutrition was **not initiated before day 8 (late-initiation group)**. A protocol for the early initiation of enteral nutrition was applied to both groups, and insulin was infused to achieve normoglycemia.

RESULTS:

Patients in the late-initiation group had a relative increase of 6.3% in the likelihood of being discharged alive earlier from the ICU (hazard ratio, 1.06; 95% confidence interval [CI], 1.00 to 1.13; P=0.04) and from the hospital (hazard ratio, 1.06; 95% CI, 1.00 to 1.13; P=0.04), without evidence of decreased functional status at hospital discharge. Rates of death in the ICU and in the hospital and rates of survival at 90 days were similar in the two groups. Patients in the late-initiation group, as compared with the early-initiation

group, had fewer ICU infections (22.8% vs. 26.2%, P=0.008) and a lower incidence of cholestasis (P<0.001). The late-initiation group had a relative reduction of 9.7% in the proportion of patients requiring more than 2 days of mechanical ventilation (P=0.006), a median reduction of 3 days in the duration of renal-replacement therapy (P=0.008), and a mean reduction in health care costs of €1,110 (about $1,600) (P=0.04).
CONCLUSIONS:
Late initiation of parenteral nutrition was associated with **faster recovery and fewer complications**, as compared with early initiation.

Ref 31 Lancet Oncol. 2011 Aug;12(8):806-14. Epub 2011 Jan 26.

Management of uncommon chemotherapy-induced emergencies.

Morgan C, Tillett T, Braybrooke J, Ajithkumar T.
Source
Department of Clinical Oncology, Velindre Cancer Centre, Cardiff, UK.
Abstract
Chemotherapy can induce various clinical emergencies. Prompt recognition and management of these adverse events are important for avoiding further morbidity and mortality. Some events such as hypersensitivity and extravasation are quite common, whereas emergencies such as **neutropenic typhlitis**, **pancreatitis**, and **acute haemolysis** are very rare. Little information exists on the management of rare chemotherapy-induced emergencies that affect fewer than 1% of patients. We review these uncommon chemotherapy-induced life-threatening emergencies, their pathogenesis and management, and **recommendations for rechallenge with the offending chemotherapy**.