台灣婦癌醫學會會訊

2012 年 5,6 月

理事長: 陳祈安醫師
秘書長: 鄭文芳醫師
各委員會召集人:
章程委員會： 謝長堯醫師
國際事務委員會：楊育正醫師
會員資格審查委員會：張廷彰醫師
財務委員會：顏明賢醫師
醫療及倫理委員會：葉聯舜醫師
教育委員會：周振陽醫師
學術研究委員會：王功亮醫師
副秘書長：
陳子和醫師、陳子健醫師、陳啟豪醫師
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學會秘書: 蘇芳萱小姐

壹、 會務報告

一、第八屆第一次新舊任理監事聯席會議記錄

理監事委員會

第八屆理監事委員會及會務工作人員名單:

一、理事會

理　事　長	陳祈安
秘　書　長	鄭文芳
常 務 理 事	王功亮、余慕賢、顏明賢、簡婉儀、周振陽、張廷彰
理　　事	張志隆、周宏學、何志明、何師竹、洪耀欽、葉聯舜、楊育正、王鵬惠、劉文雄、劉復興、賴鴻政、謝長堯、鄭雅敏、林浩

二、監事會

常 務 監 事	屠乃方
監　　事	趙灌中、余堅忍、李耀泰、許博欽、許耿福、鄭丞傑

三、委員會

（一） 章程委員會

召　集　人	謝長堯
委　　員	何志明、何師竹、周振陽、陳祈安、楊育正

（二） 國際事務委員會

召　集　人	楊育正
委　　員	何志明、李耀泰、周宏學、鄭雅敏、鄭丞傑、余堅忍、張志隆、賴鴻政

（三） 會員資格審查委員會

召　集　人	張廷彰
委　　員	王功亮、余慕賢、陳祈安、葉聯舜、鄭文芳、顏明賢、林浩、劉文雄、張志隆

（四） 財務委員會

召　集　人	顏明賢
委　　員	余慕賢、張廷彰、簡婉儀、何志明、鄭雅敏、許博欽

（五） 醫療及倫理委員會

召　集　人	葉聯舜
委　　員	何志明、何師竹、鄭雅敏、簡婉儀、鄭丞傑、余堅忍、屠乃方

（六） 教育委員會　3

召　集　人	周振陽
委　　員	余慕賢、張廷彰、許耿福、葉聯舜、鄭文芳、顏明賢

（七） 學術委員會

召　集　人	王功亮
委　　員	余慕賢、周振陽、洪耀欽、陳祈安、劉復興、周宏學、王鵬惠、賴鴻政、趙灌中

四、會務人員

秘　書　長	鄭文芳
副 秘 書 長	陳子和、陳子健、陳啟豪
秘　　書	蘇芳萱

二、第八屆第二次理監事聯席會議記錄

一、新舊任理事長交接

二、秘書長會務報告

1. 財務狀況報告:基金為依據規定，盡可能是不能挪用。(王功亮常務理事:TGOG計畫經費目前於馬偕仍呈現試報的狀態，有許多會計科目不可核銷，所以部份的經費核銷，必須請學會協助。)

2. 各委員會、委員遴選

決議: 請歷任各委員會召集人繼續連任，各委員會成員由召集人邀請，最後交給秘書長。

三、IGCS 2012 事宜報告

決議: 2012 年 IGCS 時間為 10/13-10/16 於溫哥華舉行，**學會計畫安排 2 種方式前往開會，一為只參加會議，另一種為開會合併旅遊**，擬請旅行社報價完成後公告，讓會員自行選擇;**大會報名請會員自行報名**，本次會議地點附近有許多飯店可以選擇，建議可自行訂房。

四、**8/25 高雄長庚南區季會**

林浩理事: 會議室已向醫院預約,另外亦借了一間小型會議室供準會員口頭報告用。

三、關於尚未參加口頭報告的準會員

訓練期滿的準會員，尚未參加口頭報告，如名單所示

周振陽常務理事(第七屆教育委員會召集人)：根據98年11月14日第四次教育委員會開會決議，準會員的訓練及資格事宜修改要項包括

1. 自98年度起所有準會員每年至少要參加一次地方學術會議所舉辦之訓練內容口頭報告，內容如下

（A）臨床內容：手術、化學治療、放射線治療、陰道鏡、婦癌病理（用病例摘要格式)。

（B）參加之研究計畫及論文發表。

（C）個人未來訓練的規劃（包括個人目前婦癌專科訓練的狀況，心得，

遭遇的困難，以及需要的協助)。

(D) 報告時間約10～20 分鐘。

2. 擬邀請各準會員之指導醫師及教育委員們來參與評估其口頭會議報告。

3. 所有準會員，每年要繳交兩次書面報告，內容如上述口頭報告項目（使用病例摘要格式）繳交時間為1/31 及7/31。

4. 符合上述資格，包括繳交書面報告及口頭報告者，經教育委員會審核通過後發予通過證明，方能參加專科醫師甄審。

決議:準會員一年必須做一次口頭報告，在口頭報告前一個月前先繳交書面報告,兩週前繳交口頭報告 slide 至秘書處，共計報告 2 年(2 次)，方可由教育委員會決議是否通過;秘書處將通知所有準會員,如於三個月內未回覆者將停權。

四、 近期國內外婦癌相關活動一覽表

日期	活動名稱	活動地點
2012/6/30 (六)~7/1(日)	「亞洲新興婦女癌症」國際研討會 (by AGOG, Asian Gynecologic Oncology Group)	張榮發基金會國際會議中心(台北市中山南路11 號10 樓)
2012/7/5-7/6	Annual Scientific Meeting of the British Gynaecological Cancer Society (BGCS)	London
2012/8/4 14:00-17:00	TGOG 月例會	馬偕醫院12043 室
2012/8/25	南區婦癌學術研討會	高雄長庚醫院
2012/10/13-10/16	14th IGCS (http://www2.kenes.com/igcs2012/Pages/home.aspx)	Vancouver, Canada
2012/11/24	中區婦癌學術研討會	台中中國醫藥大學附設醫院

五、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

Ref 1 Bevacizumab 有益於 platinum-sensitive recurrent ovarian cancer 之治療 (OCEANS study) (p.7)

J Clin Oncol. 2012 Jun 10;30(17):2039-45.

OCEANS: A Randomized, Double-Blind, Placebo-Controlled Phase III Trial of Chemotherapy With or Without Bevacizumab in Patients With Platinum-Sensitive Recurrent Epithelial Ovarian, Primary Peritoneal, or Fallopian Tube Cancer.

Ref 2 Partially platinum-sensitive recurrent ovarian cancer: CD 優於 CP (p.7)

Ann Oncol. 2012 May;23(5):1185-9.

Carboplatin and pegylated liposomal doxorubicin versus carboplatin and paclitaxel in partially platinum-sensitive ovarian cancer patients: results from a subset analysis of the CALYPSO phase III trial.

Ref 3 常被患者問的問題 --- American Cancer Society 癌症 survivor 之營養與運動 guideline (p.8)

CA Cancer J Clin. 2012 Jul;62(4):242-74.

Nutrition and physical activity guidelines for cancer survivors.

Ref 4 KGOG 再一篇 JCO! (p.9)

J Clin Oncol. 2012 Jul 1;30(19):2369-74. Epub 2012 May 21.

Risk assessment tool for distant recurrence after platinum-based concurrent chemoradiation in patients with locally advanced cervical cancer: a korean gynecologic oncology group study.

Ref 5 High-grade endometrial cancer 可否用微創手術進行? (p.10)

Gynecol Oncol. 2012 Aug;126(2):180-5.

Minimally invasive surgery versus laparotomy in women with high grade endometrial cancer: A multi-site study performed at high

volume cancer centers.

Ref 6 Palliative sedation (p.11)

J Clin Oncol. 2012 Apr 20;30(12):1378-83.

Palliative sedation in end-of-life care and survival: a systematic review.

Ref 7 PET 時代 nodal-staging surgery 於 cervical cancer 之角色？(p.12)

Lancet Oncol. 2012 May;13(5):e212-20.

Nodal-staging surgery for locally advanced cervical cancer in the era of PET.

Ref 8 Advanced cx ca 的 paraaortic nodal metastasis, 有 1/3 會直接跳到 infra-renal (p.13)

Gynecol Oncol. 2012 May;125(2):312-4.

Location of aortic node metastases in locally advanced cervical cancer.

Ref 9 Advanced ovarian cancer 常有 diaphragm 以上之 lymph node metastasis (p.13)

Gynecol Oncol. 2012 Jul;126(1):64-8.

FDG PET/CT in staging of advanced epithelial ovarian cancer: Frequency of supradiaphragmatic lymph node metastasis challenges the traditional pattern of disease spread.

Ref 10 開 RH 時發現 gross nodal disease, 要否 abort RH？(p.14)

Gynecol Oncol. 2012 Jul;126(1):69-72.

Completed versus aborted radical hysterectomy for node-positive stage IB cervical cancer in the modern era of chemoradiation therapy.

Ref 11 最好不要在晚上開 cytoreduction for advanced ovarian cancer (p.15)

Gynecol Oncol. 2012 Jul;126(1):58-63.

Impact of operative start time on surgical outcomes in patients undergoing primary cytoreduction for advanced ovarian cancer.

Ref 12 Advanced ovarian adult granulose cell tumor 要打 6 次 BEP？(p.16)

Gynecol Oncol. 2012 Apr;125(1):80-6. Epub 2011 Dec 28.

Surgical staging and adjuvant chemotherapy in the management of patients with adult granulosa cell tumors of the ovary.

Ref 13 與 endometriosis 相關的 ovarian carcinoma subtypes (p.17)

Lancet Oncol. 2012 Apr;13(4):385-94.

Association between endometriosis and risk of histological subtypes of ovarian cancer: a pooled analysis of case-control studies.

Ref 14 HPV16 methylation 與 precancer (p.19)

J Natl Cancer Inst. 2012 Apr 4;104(7):556-65.

Methylation of human papillomavirus type 16 genome and risk of cervical precancer in a Costa Rican population.

Ref 1 Bevacizumab 有益於 platinum-sensitive recurrent ovarian cancer 之治療

J Clin Oncol. 2012 Jun 10;30(17):2039-45.

OCEANS: A Randomized, Double-Blind, Placebo-Controlled Phase III Trial of Chemotherapy With or Without Bevacizumab in Patients With Platinum-Sensitive Recurrent Epithelial Ovarian, Primary Peritoneal, or Fallopian Tube Cancer.

Aghajanian C, Blank SV, Goff BA, Judson PL, Teneriello MG, Husain A, Sovak MA, Yi J, Nycum LR.

Source

Gynecologic Medical Oncology Service, Memorial Sloan-Kettering Cancer Center,

300 East 66th St, New York, NY 10065; aghajanc@mskcc.org.

Abstract

PURPOSE This randomized, multicenter, blinded, placebo-controlled phase III trial tested the efficacy and safety of bevacizumab (BV) with **gemcitabine and carboplatin (GC)** compared with GC in platinum-sensitive recurrent ovarian, primary peritoneal, or fallopian tube cancer (ROC). PATIENTS AND METHODS Patients with **platinum-sensitive ROC** (recurrence ≥ 6 months after front-line platinum-based therapy) and measurable disease were **randomly assigned to GC plus either BV or placebo (PL) for six to 10 cycles**. **BV or PL, respectively, was then continued until disease progression**. The primary end point was progression-free survival (PFS) by RECIST; secondary end points were objective response rate, duration of response (DOR), overall survival, and safety. Results Overall, 484 patients were randomly assigned. PFS for the BV arm was superior to that for the PL arm (hazard ratio [HR], 0.484; 95% CI, 0.388 to 0.605; log-rank P < .0001); median PFS was 12.4 v 8.4 months, respectively. The **objective response rate (78.5% v 57.4%; P < .0001**) and **DOR (10.4 v 7.4 months; HR, 0.534; 95% CI, 0.408 to 0.698)** were significantly improved with the addition of BV. No new safety concerns were noted. **Grade 3 or higher hypertension (17.4% v < 1%) and proteinuria (8.5% v < 1%)** occurred more frequently in the BV arm. The rates of neutropenia and febrile neutropenia were similar in both arms. Two patients in the BV arm experienced **GI perforation** after study treatment discontinuation. CONCLUSION GC plus BV followed by BV until progression **resulted in a statistically significant improvement in PFS** compared with GC plus PL in platinum-sensitive ROC.

Ref 2 Partially platinum-sensitive recurrent ovarian cancer: CD 優於 CP

Ann Oncol. 2012 May;23(5):1185-9.

Carboplatin and pegylated liposomal doxorubicin versus carboplatin and paclitaxel in partially platinum-sensitive ovarian cancer patients: results from a subset analysis of the CALYPSO phase III trial.

Gladieff L, Ferrero A, De Rauglaudre G, Brown C, Vasey P, Reinthaller A, Pujade-Lauraine E, Reed N, Lorusso D, Siena S, Helland H, Elit L, Mahner S.

Source

Department of Medical Oncology, Institut Claudius Regaud, Toulouse, France. gladieff.laurence@claudiusregaud.fr

Abstract

BACKGROUND:

To perform a subset analysis of patients with partially platinum-sensitive recurrent ovarian cancer (ROC) who received either **CD [carboplatin-pegylated liposomal doxorubicin (PLD)]** or **CP (carboplatin-paclitaxel)** in the CALYPSO trial.

PATIENTS AND METHODS:
CALYPSO, an international phase III, non-inferiority trial, enrolled women with ROC that relapsed >6 months following first- or second-line therapy. Patients were randomized to CD or CP. Patients with a **treatment-free interval of >6 and ≤ 12 months** were evaluated for progression-free survival (PFS), the primary end point of CALYPSO trial, and safety.
RESULTS:
A total of 344 partially platinum-sensitive patients were included (N = 161, CD and N = 183, CP). The hazard ratio for **PFS** was 0.73 (95% confidence interval: 0.58-0.90; P = 0.004 for superiority) **in favor of CD**. Median PFS times were 9.4 months (CD) and 8.8 months (CP). **Toxicities more common with CP versus CD** included grade 3/4 neutropenia (50% versus 39%; P = 0.015), grade 2 alopecia (86% versus 9%; P < 0.001), neuropathy and hypersensitivity reactions. Hand-foot syndrome was more common with CD; however, grade 3/4 reactions were low (one patient in each arm).
CONCLUSION:
Carboplatin-PLD has a more favorable risk-benefit profile than CP in patients with partially platinum-sensitive ROC and should be considered an effective treatment option for these patients.

Ref 3 常被患者問的問題 --- American Cancer Society 的癌症 survivor 之營養與運動 guideline

CA Cancer J Clin. 2012 Jul;62(4):242-74.

Nutrition and physical activity guidelines for cancer survivors.

Rock CL, Doyle C, Demark-Wahnefried W, Meyerhardt J, Courneya KS, Schwartz AL, Bandera EV, Hamilton KK, Grant B, McCullough M, Byers T, Gansler T.
Source
Professor, Department of Family and Preventive Medicine, School of Medicine, University of California, San Diego, La Jolla, CA.

Abstract
Cancer survivors are often highly motivated to seek information about food choices, physical activity, and dietary supplements to improve their treatment outcomes, quality of life, and overall survival. To address these concerns, **the American Cancer Society (ACS)** convened a group of experts in nutrition, physical activity, and cancer survivorship to evaluate the scientific evidence and best clinical practices related to optimal nutrition and physical activity after the diagnosis of cancer. This report summarizes their findings and is intended to present health care providers with the best possible information with which to help cancer survivors and their families make informed choices related to nutrition and physical activity. The report discusses

nutrition and physical activity guidelines during the continuum of cancer care, briefly highlighting important issues during cancer treatment and for patients with advanced cancer, but focusing largely on the needs of the population of individuals who are disease free or who have stable disease following their recovery from treatment. It also discusses select nutrition and physical activity issues such as body weight, food choices, food safety, and dietary supplements; issues related to selected cancer sites; and common questions about diet, physical activity, and cancer survivorship.

Ref 4 KGOG 再一篇 JCO!

J Clin Oncol. 2012 Jul 1;30(19):2369-74. Epub 2012 May 21.

Risk assessment tool for distant recurrence after platinum-based concurrent chemoradiation in patients with locally advanced cervical cancer: a korean gynecologic oncology group study.

Kang S, Nam BH, Park JY, Seo SS, Ryu SY, Kim JW, Kim SC, Park SY, Nam JH.

Source

Department of Obstetrics and Gynecology, University of Ulsan College of Medicine, Asan Medical Center, 388-1, Poongnap-2 Dong, Songpa-Gu, Seoul, 138-736, Korea; jhnam@amc.seoul.kr.

Abstract

PURPOSE Our study aimed to develop a model to predict distant recurrence in locally advanced cervical cancer, which can be used to select high-risk patients in enriched clinical trials. PATIENTS AND METHODS Our study was a **retrospective analysis** of a multi-institutional cohort of patients treated between 2001 and 2009. According to the order of data submission, data from three institutions were allocated to a model development cohort (n = 434), and data from the remaining two institutions were allocated to an external validation cohort (n = 115). Patient information including [(18)F]fluorodeoxyglucose positron emission tomography (FDG-PET) data and clinical outcome was modeled using competing risk regression analysis to predict 5-year cumulative incidence of distant recurrence. Results The competing risk analysis revealed that the following **four parameters** were significantly associated with distant recurrence: **pelvic and para-aortic nodal positivity on FDG-PET, nonsquamous cell histology, and pretreatment serum squamous cell carcinoma antigen levels**. This four-parameter model showed good discrimination and calibration, with a bootstrap-adjusted concordance index of 0.70. Also, the validation set showed good discrimination with a bootstrap-adjusted concordance index of 0.73. **A user-friendly Web-based nomogram** predicting 5-year probability of distant recurrence was developed. CONCLUSION We have developed **a robust model** to predict the risk of distant recurrence in patients with locally advanced cervical cancer. Further, we discussed how the selective enrichment of the patient population could facilitate

clinical trials of systemic chemotherapy in locally advanced cervical cancer

Ref 5 High-grade endometrial cancer 可否用微創手術進行?

Gynecol Oncol. 2012 Aug;126(2):180-5.

Minimally invasive surgery versus laparotomy in women with high grade endometrial cancer: A multi-site study performed at high volume cancer centers.

Fader AN, Seamon LG, Escobar PF, Frasure HE, Havrilesky LA, Zanotti KM, Secord AA, Boggess JF, Cohn DE, Fowler JM, Skafianos G, Rossi E, Gehrig PA.

Source

Greater Baltimore Medical Center, Baltimore, MD, USA.

Abstract

OBJECTIVE:

The study aim was to compare outcomes in women with high-grade endometrial cancer (EC) who underwent surgical staging via minimally invasive surgery (MIS) versus laparotomy.

METHODS:

This is a **retrospective, multi-institutional** cohort study of patients with high-grade EC who were comprehensively surgically staged by either MIS or laparotomy. Demographic, surgical variables, complications, and survival were analyzed.

RESULTS:

Three hundred and eighty-three patients met criteria: 191 underwent laparotomy and 192 MIS (65% robotic, 35% laparoscopy). **Subgroups were well matched** by age (mean 66years), stage, body mass index, histology and adjuvant therapies. Median operative time was longer in the MIS group (191 vs. 135min; p<.001). However, the MIS cohort had a higher mean lymph node count (39.0 vs. 34.0; p=.03), shorter hospital stay (1 vs. 4days) and significantly fewer complications (8.4% vs. 31.3%; p<.001). There was no significant difference in lymph node count with laparoscopic versus robotic staging. With a median follow-up time of 44months, **progression-free (PFS) and overall survival were not significantly different** between the surgical cohorts. On multivariable analysis, stage, treatment were associated with PFS.

CONCLUSIONS:

Women with high grade endometrial cancers staged by minimally invasive techniques experienced **fewer complications and similar survival outcomes** compared to those staged by laparotomy. **As this population is elderly and most will receive adjuvant therapies, minimization of surgical morbidity is of interest**. When managed **by expert laparoscopists or robotic surgeons**, a high-risk histologic subtype is **not a contraindication** to minimally invasive surgery in women with apparent **early-stage** disease.

Ref 6 Palliative sedation

J Clin Oncol. 2012 Apr 20;30(12):1378-83.

Palliative sedation in end-of-life care and survival: a systematic review.

Maltoni M, Scarpi E, Rosati M, Derni S, Fabbri L, Martini F, Amadori D, Nanni O.

Source

Istituto Scientifico Romagnolo per lo Studio e lCura dei Tumori, Meldola, Italy. ma.maltoni@ausl.fo.it

Abstract

PURPOSE:

Palliative sedation is a clinical procedure **aimed at relieving refractory symptoms** in patients with advanced cancer. It has been suggested that sedative drugs may shorten life, but few studies exist comparing the survival of sedated and nonsedated patients. We present a systematic review of literature on the clinical practice of palliative sedation to assess the effect, if any, on survival.

METHODS:

A systematic review of literature published between January 1980 and December 2010 was performed using MEDLINE and EMBASE databases. Search terms included palliative sedation, terminal sedation, refractory symptoms, cancer, neoplasm, palliative care, terminally ill, end-of-life care, and survival. A manual search of the bibliographies of electronically identified articles was also performed.

RESULTS:

Eleven published articles were identified describing 1,807 consecutive patients in 10 retrospective or prospective nonrandomized studies, 621 (34.4%) of whom were sedated. One case-control study was excluded from prevalence analysis. The most frequent reason for sedation was delirium in the terminal stages of illness (median, 57.1%; range, 13.8% to 91.3%). **Benzodiazepines** were the most common drug category prescribed. Comparing survival of sedated and nonsedated patients, the sedation approach was **not shown to be associated with worse survival**.

CONCLUSION:

Even if there is no direct evidence from randomized clinical trials, palliative sedation, when appropriately indicated and correctly used to relieve unbearable suffering, does not seem to have any detrimental effect on survival of patients with terminal cancer. In this setting, **palliative sedation is a medical intervention that must be considered as part of a continuum of palliative care.**

Ref 7 PET 時代 nodal-staging surgery 於 cervical cancer 之角色 ?

Lancet Oncol. 2012 May;13(5):e212-20.

Nodal-staging surgery for locally advanced cervical cancer in the era of PET.

Gouy S, Morice P, Narducci F, Uzan C, Gilmore J, Kolesnikov-Gauthier H, Querleu D, Haie-Meder C, Leblanc E.

Source

Department of Gynaecological Surgery, Institut Gustave Roussy, Villejuif, France.

Abstract

Chemoradiation therapy is deemed the standard treatment by many North American and European teams for treatment of locally advanced cervical cancer. The prevalence of para-aortic nodal metastasis in these tumours is 10-25%. PET (with or without CT) is the most accurate imaging modality to assess extrapelvic disease in such tumours. **The true-positive rate of PET is high**, suggesting that surgical staging is not necessary if uptake takes place in the para-aortic region. Nevertheless, **false-negative results** (in the para-aortic region) have been recorded in **12%** of patients, rising to **22%** in those with uptake during PET of the pelvic nodes. In such situations, laparoscopic surgical para-aortic staging still has an important role for detection of patients with occult para-aortic spread misdiagnosed on PET or PET-CT, allowing optimisation of treatment (extension of radiation therapy fields to include the para-aortic area). **Complications** of the laparoscopic procedure were noted in 0-7% of patients. **Survival of individuals (missed by PET) with para-aortic nodal metastasis of 5 mm or less** (and managed by **extended field** chemoradiation therapy) seems to be similar to survival of those without para-aortic spread, **suggesting a positive therapeutic effect of the addition of staging surgery.** Nevertheless, the effect on survival of potential delay of chemoradiation owing to use of PET and staging surgery, and acute and late complications of surgery followed by chemoradiation therapy (particularly in case of extended field chemoradiation to para-aortic area), **need to be studied**.

Ref 8 Advanced cx ca 的 paraaortic nodal metastasis, 有 1/3 會直接跳到 infra-renal

Gynecol Oncol. 2012 May;125(2):312-4.

Location of aortic node metastases in locally advanced cervical cancer.

Gil-Moreno A, Magrina JF, Pérez-Benavente A, Díaz-Feijoo B, Sánchez-Iglesias JL, García A, Cabrera-Díaz S, Puig O, Martínez-Gómez X, Xercavins J.

Source

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Abstract

BACKGROUND:

To assess the location of aortic node metastasis in patients with locally advanced cervical cancer undergoing extraperitoneal aortic lymphadenectomy to define the extent of the aortic lymphadenectomy.

MATERIAL AND METHODS:

Between August 2001 and December 2010, 100 consecutive patients with primary locally advanced cervical cancer underwent extraperitoneal laparoscopic aortic and common iliac lymphadenectomy. The location of aortic node metastases, inframesenteric or infrarenal was noted.

RESULTS:

The mean number±standard deviation (SD) of aortic nodes removed was 15.9 ± 7.8 (range 4-62). The mean number ± SD of inframesenteric (including common iliac) nodes removed was 8.8 ± 4.5 (range 2-41) and the mean number ± SD of infrarenal nodes removed was 7.8 ± 4.1 (range 2-21). Positive aortic nodes were observed in 16 patients, and in 5 (31.2%) of them the infrarenal nodes were the only nodes involved, with negative inframesenteric nodes.

CONCLUSION:

Inframesenteric aortic nodes are negative in the presence of positive infrarenal nodes in about one third of patients with locally advanced cervical cancer and aortic metastases.

Ref 9 Advanced ovarian cancer 常有 diaphragm 以上之 lymph node metastasis

Gynecol Oncol. 2012 Jul;126(1):64-8.

FDG PET/CT in staging of advanced epithelial ovarian cancer: Frequency of supradiaphragmatic lymph node metastasis challenges the traditional pattern of disease spread.

Hynninen J, Auranen A, Carpén O, Dean K, Seppänen M, Kemppainen J, Lavonius M, Lisinen I, Virtanen J, Grénman S.

Source

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Abstract

OBJECTIVE:

Epithelial ovarian cancer (EOC) spreads intra-abdominally and to the retroperitoneal lymph nodes. A greater number of distant metastases are revealed by (18)F-fluorodeoxyglucose (FDG) positron emission tomography/computed tomography (PET/CT) compared to conventional imaging methods. We aimed to investigate the presence and anatomic distribution of supradiaphragmatic lymph node

metastasis (LNM) detected with pretreatment FDG PET/CT.
METHODS:
Thirty women with advanced stage (IIC-IV) EOC were scanned with whole body contrast-enhanced FDG PET/CT prior to surgery/neoadjuvant chemotherapy. We performed PET/CT analysis qualitatively and quantitatively. Additionally, contrast-enhanced CT was analyzed blinded to PET/CT scan. Intra-abdominal dissemination was verified by surgery and histopathology. Metabolically active lymph nodes were biopsied when possible. The clinical characteristics of patients with and without supradiaphragmatic LNM were compared.
RESULTS:
In **20/30patients (67%) FDG PET/CT** detected supradiaphragmatic LNM in one or more locations, whereas **conventional CT found LNM in 10 patients (33%)**. Fourteen patients had parasternal, 14 cardiophrenic, 8 other mediastinal, 6 axillar, and 1 subclavian LNM. Microscopy of all four biopsied lymph nodes (three axillar and one subclavian) confirmed metastatic dissemination. The patients with supradiaphragmatic LNM had significantly more ascites ($p<0.01$), higher CA 125 levels, and more frequent subdiaphragmal carcinomatosis ($p<0.03$) compared to patients without supradiaphragmatic LNM in preoperative FDG PET/CT.
CONCLUSIONS:
A significant number of patients with advanced EOC showed supradiaphragmatic LNM in pre-treatment PET/CT. Our findings suggest that the route of EOC cells from the peritoneal cavity to the lymphatic system permeates the diaphragm mainly to the cardiophrenic and continues to parasternal lymph nodes.

Ref 10 開 RH 時發現 gross nodal disease, 要否 abort RH ?

Gynecol Oncol. 2012 Jul;126(1):69-72.

Completed versus aborted radical hysterectomy for node-positive stage IB cervical cancer in the modern era of chemoradiation therapy.

Ziebarth AJ, Smith H, Killian ME, Nguyen NA, Durst JK, Subramaniam A, Kim KH, Leath CA 3rd, Straughn JM Jr, Alvarez RD.

Source
University of Alabama at Birmingham, Birmingham, AL, USA.
Abstract
OBJECTIVE:
Debate continues about optimal management of patients with node-positive stage I cervical cancer. Our objective was to determine if patient outcomes are affected by radical hysterectomy in the modern era of adjuvant chemoradiation.
METHODS:
Cervical cancer patients diagnosed from 2000 to 2008 were identified. Demographics,

therapy, clinicopathologic data, progression free survival (PFS), overall survival (OS), total radiation exposure, and grade 3-4 complications were analyzed by student t, Mann-Whitney, Fisher's exact, Kaplan-Meier, and log rank tests.
RESULTS:
This single-institution review evaluated forty-one of 334 (13.4%) patients scheduled to undergo radical hysterectomy that had **gross nodal disease** diagnosed intraoperatively. **15 underwent aborted** radical hysterectomy following lymphadenectomy; the remaining **26 underwent radical hysterectomy and lymphadenectomy.** Eleven patients undergoing radical hysterectomy underwent whole pelvic radiation therapy (WPRT) while 8 (30.7%) patients underwent WPRT and postoperative vaginal brachytherapy (BT) for local treatment secondary to close margins. All patients undergoing aborted radical hysterectomy underwent WPRT and BT. With mean follow-up of 42.3months, there were **no significant differences in** urinary, gastrointestinal, or hematologic **complications** between groups. When comparing those undergoing radical hysterectomy to aborted radical hysterectomy, there were **no significant differences in** local recurrence (11.5% vs 26.7%, p=0.39) or distant recurrence (19.2% vs. 33.3%, p=0.45), PFS (74.9months vs 46.8months, p=0.106), or OS (91.8months vs 69.4months, p=0.886).
CONCLUSIONS:
Treatment of patients with early stage cervical cancer and nodal metastasis may be tailored intraoperatively. **Completion of radical hysterectomy and lymphadenectomy decreases radiation exposure without apparently compromising safety or outcome** in the era of adjuvant chemoradiation.

Ref 11 最好不要在晚上開 cytoreduction for advanced ovarian cancer

Gynecol Oncol. 2012 Jul;126(1):58-63.

Impact of operative start time on surgical outcomes in patients undergoing primary cytoreduction for advanced ovarian cancer.

Tanner EJ, Long KC, Zhou Q, Brightwell RM, Gardner GJ, Abu-Rustum NR, Leitao MM Jr, Sonoda Y, Barakat RR, Iasonos A, Chi DS.
Source
Gynecology Service, Department of Surgery, Memorial Sloan-Kettering Cancer Center, USA.

Abstract
OBJECTIVES:
To evaluate the impact of **operative start time (OST)** on surgical outcomes in patients with advanced ovarian cancer.
METHODS:
All stage IIIB-IV serous ovarian cancer patients who underwent primary surgery at our

institution from 1/01 to 1/10 were identified. Fourteen factors were evaluated for an association with surgical outcomes including OST and OR tumor index (1 point each for carcinomatosis and/or bulky [≥1cm] upper abdominal disease). Univariate logistic regression considering within-surgeon clustering was performed for cytoreduction to ≤1cm versus >1cm residual disease. In patients with ≤1cm residual disease, univariate logistic regression considering within-surgeon clustering was performed for 1-10mm residual disease versus **complete gross resection (CGR**, 0mm residual). A multivariate logistic model was developed based on univariate analysis results in the ≤1cm residual disease cohort.

RESULTS:

Of 422 patients, residual disease was: 0mm, 144 (34.1%); 1-10mm, 175 (41.5%); >10mm, 103 (23.3%). OST was not associated with cytoreduction to ≤1cm residual disease on univariate analysis. In the ≤1cm residual disease cohort, albumin, CA-125, ascites, ASA score, stage, OR tumor index, and OST were associated with CGR on univariate analysis. **Earlier OSTs were associated with increased rates of CGR**. On multivariate analysis, CA-125 was independently associated with CGR. OST was associated with CGR in patients with an OR tumor index of 2 but not an OR tumor index<2.

CONCLUSIONS:

OST was not associated with cytoreduction to ≤1cm residual disease in patients with advanced serous ovarian cancer. In the cohort of patients with ≤1cm residual disease, later OSTs were associated with reduced rates of CGR in patients with greater tumor burden.

Ref 12 Advanced ovarian adult granulose cell tumor 要打 6 次 BEP ?

Gynecol Oncol. 2012 Apr;125(1):80-6. Epub 2011 Dec 28.

Surgical staging and adjuvant chemotherapy in the management of patients with adult granulosa cell tumors of the ovary.

Park JY, Jin KL, Kim DY, Kim JH, Kim YM, Kim KR, Kim YT, Nam JH.

Source

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Abstract

OBJECTIVE:

To analyze the role of surgical staging and adjuvant chemotherapy in patients with adult type granulosa cell tumor (GCT) of the ovary.

METHODS:

Patients were divided into those with early-stage (stages I-II, n=93) and advanced-stage (stages III-IV, n=13) GCT and analyzed separately in this retrospective

study.

RESULTS:

Of the **93 patients** with early-stage GCT, 30 were completely staged and 25 underwent lymph node dissection. After surgery, 17 patients received adjuvant chemotherapy with bleomycin/etoposide/cisplatin (BEP). None had lymph node metastasis. Completely staged patients had no recurrence or deaths. However, recurrences were observed in 9 of 63 patients (14.3%) who did not undergo complete staging, with four (6.3%) dying due to disease. The 5-year disease-free survival (DFS) rates of groups with and without complete staging were 100% and 84%, respectively (P=0.037). Adjuvant chemotherapy was not significantly associated with DFS (P=0.193). All patients with advanced-stage GCT underwent optimal cytoreduction and received adjuvant chemotherapy with BEP. **None of the 6 patients who completed 6 cycles of BEP had recurrence, whereas 5 of the 7 patients (71.4%) who received fewer than 6 cycles of BEP had recurrences** and 3 (42.9%) died due to disease. The 5-year DFS rates of these two groups were 100% and 50%, respectively (P=0.022), **with cycles of chemotherapy being the only significant factor for DFS** in patients with advanced-stage GCT.

CONCLUSIONS:

Complete surgical staging is recommended, but lymph node removal is not recommended for early-stage GCT. **Optimal debulking followed by six cycles of BEP chemotherapy is recommended for advanced-stage GCT.**

Ref 13 與 endometriosis 相關的 ovarian carcinoma subtypes

Lancet Oncol. 2012 Apr;13(4):385-94.

Association between endometriosis and risk of histological subtypes of ovarian cancer: a pooled analysis of case-control studies.

Pearce CL, Templeman C, Rossing MA, Lee A, Near AM, Webb PM, Nagle CM, Doherty JA, Cushing-Haugen KL, Wicklund KG, Chang-Claude J, Hein R, Lurie G, Wilkens LR, Carney ME, Goodman MT, Moysich K, Kjaer SK, Hogdall E, Jensen A, Goode EL, Fridley BL, Larson MC, Schildkraut JM, Palmieri RT, Cramer DW, Terry KL, Vitonis AF, Titus LJ, Ziogas A, Brewster W, Anton-Culver H, Gentry-Maharaj A, Ramus SJ, Anderson AR, Brueggmann D, Fasching PA, Gayther SA, Huntsman DG, Menon U, Ness RB, Pike MC, Risch H, Wu AH, Berchuck A; Ovarian Cancer Association Consortium.

Source

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Abstract

BACKGROUND:

Endometriosis is a risk factor for epithelial ovarian cancer; however, whether this risk extends to all invasive histological subtypes or borderline tumours is not clear. We undertook an international collaborative study to assess the association between endometriosis and histological subtypes of ovarian cancer.

METHODS:

Data from 13 ovarian cancer case-control studies, which were part of the Ovarian Cancer Association Consortium, were pooled and logistic regression analyses were undertaken to assess the association between self-reported endometriosis and risk of ovarian cancer. Analyses of invasive cases were done with respect to histological subtypes, grade, and stage, and analyses of borderline tumours by histological subtype. Age, ethnic origin, study site, parity, and duration of oral contraceptive use were included in all analytical models.

FINDINGS:

13 226 controls and 7911 women with invasive ovarian cancer were included in this analysis. 818 and 738, respectively, reported a history of endometriosis. 1907 women with borderline ovarian cancer were also included in the analysis, and 168 of these reported a history of endometriosis. **Self-reported endometriosis** was associated with a **significantly increased risk of clear-cell** (136 [20·2%] of 674 cases vs 818 [6·2%] of 13 226 controls, odds ratio 3·05, 95% CI 2·43-3·84, p<0·0001), **low-grade serous** (31 [9·2%] of 336 cases, 2·11, 1·39-3·20, p<0·0001), and **endometrioid invasive ovarian cancers** (169 [13·9%] of 1220 cases, 2·04, 1·67-2·48, p<0·0001). No association was noted between endometriosis and risk of mucinous (31 [6·0%] of 516 cases, 1·02, 0·69-1·50, p=0·93) or high-grade serous invasive ovarian cancer (261 [7·1%] of 3659 cases, 1·13, 0·97-1·32, p=0·13), or borderline tumours of either subtype (serous 103 [9·0%] of 1140 cases, 1·20, 0·95-1·52, p=0·12, and mucinous 65 [8·5%] of 767 cases, 1·12, 0·84-1·48, p=0·45).

INTERPRETATION:

Clinicians should be aware of the increased risk of specific subtypes of ovarian cancer in women with endometriosis. Future efforts should focus on understanding the mechanisms that might lead to malignant transformation of endometriosis so as to help identify subsets of women at increased risk of ovarian cancer.

Ref 14 HPV16 methylation 與 precancer

J Natl Cancer Inst. 2012 Apr 4;104(7):556-65.

Methylation of human papillomavirus type 16 genome and risk of cervical precancer in a Costa Rican population.

Mirabello L, Sun C, Ghosh A, Rodriguez AC, Schiffman M, Wentzensen N, Hildesheim A, Herrero R, Wacholder S, Lorincz A, Burk RD.

Source

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Abstract

BACKGROUND:

Previous studies have suggested an association between human papillomavirus type 16 (HPV16) genome methylation and cervical intraepithelial neoplasia grade 3 (CIN3) (ie, cervical precancer) and cancer, but the results have been inconsistent.

METHODS:

We designed a case-control study within a large prospective cohort of women who underwent multiple screenings for cervical cancer in Guanacaste, Costa Rica. Diagnostic specimens were collected at the time of CIN3 diagnosis (n = 30 case subjects) and persistent HPV16 infection (persistence; n = 35 case subjects), prediagnostic specimens at the first HPV16-positive screening visit (n = 20 CIN3 case subjects; n = 35 persistence case subjects), and control specimens from women with infection clearance within 2 years (n = 34 control subjects). DNA extracted from specimens (cervical cells) was analyzed for methylation levels at 67 CpG sites throughout the HPV16 genome using pyrosequencing. Benjamini-Hochberg method was used to account for multiple testing. Associations between methylation levels and risk of CIN3 or persistence were assessed using logistic regression models to estimate odds ratios (ORs) and 95% confidence intervals (CIs).

RESULTS:

Increased methylation in diagnostic vs control specimens at nine CpG sites, three in each L1, L2, and E2/E4 genomic regions, was associated with an increased risk of CIN3 (third tertile [high] vs first and second tertiles combined [low], OR = 3.29 [95% CI = 1.16 to 9.34] to 11.12 [95% CI = 2.29 to 76.80]) and persistence. High methylation at three of these CpG sites was associated with a much higher risk when combined compared with low methylation at these sites (OR = 52, 95% CI = 4.0 to 670). In prediagnostic vs control specimens, increased methylation at a CpG site (nucleotide position 4261) in L2 was associated with an increased risk of CIN3.

CONCLUSION:

In this HPV16-infected cohort, **increased methylation of CpG sites within the HPV16 genome before diagnosis and at the time of diagnosis was associated with cervical precancer**.