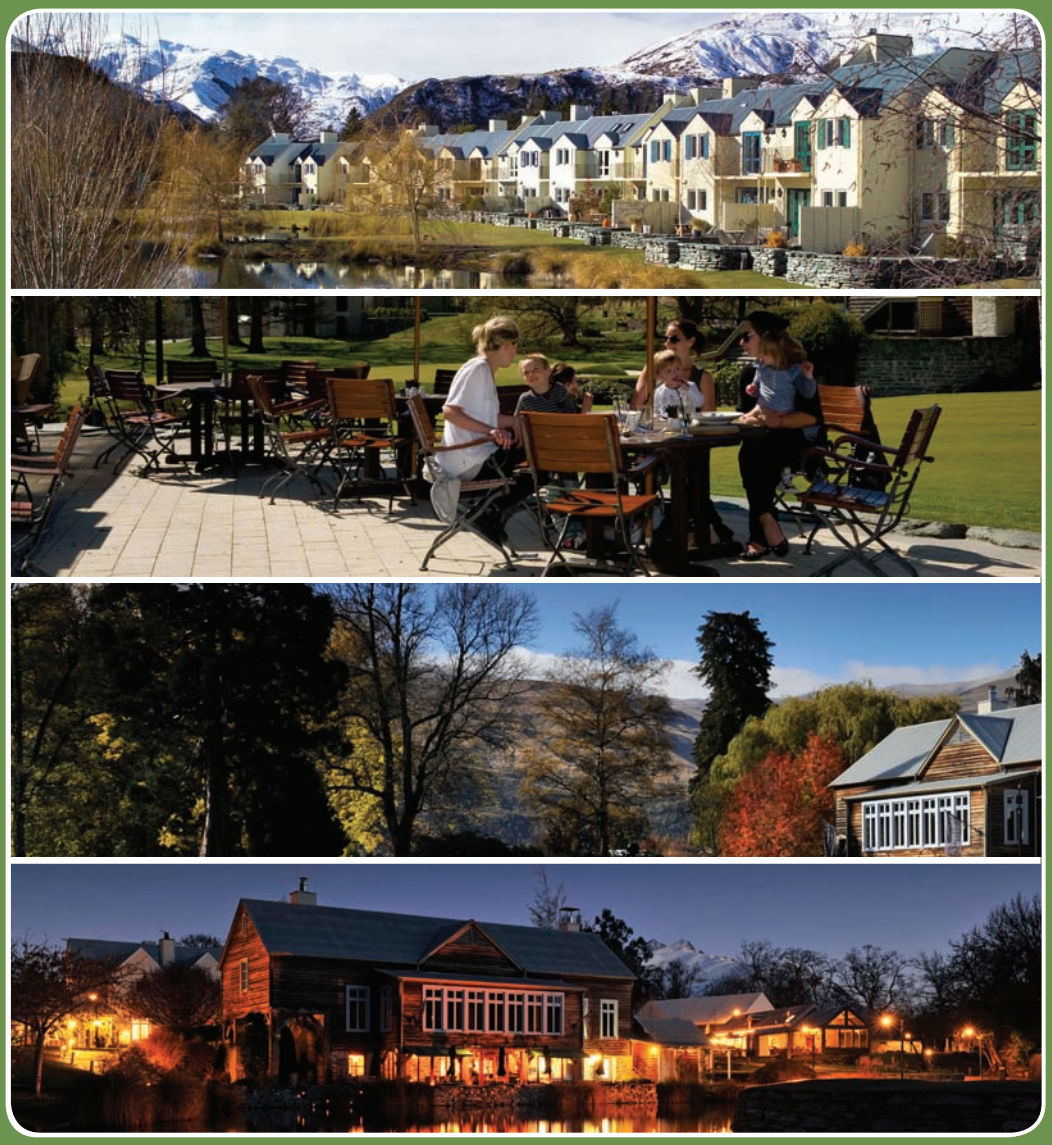
The Australian Society
of Gynaecologic Oncologists
26th Annual Scientific Meeting

GYNAECOLOGICAL CANCER SURGERY

THE NEXT GENERATION!

CONFERENCE ABSTRACT BOOKLET



6th to 9th July 2011
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The Australian Society of Gynaecologic Oncologists

26th Annual Scientific Meeting

ASGO 2011 ORGANISING COMMITTEE

President:	Peter Sykes
Committee Members:	Byrony Simcock
	Ai Ling Tan
	Lois Eva (Co-opted)
Professional Conference Organiser:	Mary Sparksman

SECRETARIAT

The registration desk will be open in the pavilion throughout the conference to answer any questions you may have.

Wednesday 6th July	11.30am - 5.00pm
Thursday 7th July	8.00am - 3.30pm
Friday 8th July	8.00am - 1.00pm
Saturday 9th July	8.00am - 3.15pm

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INVITED INTERNATIONAL SPEAKERS

Arnold P. Advincula, MD

Professor of Obstetrics & Gynaecology
University of Central Florida College of Medicine

Andy Nordin

Subspecialist Gynaecological Oncologist, East Kent Gynaecological Oncology Centre and Honorary Senior Lecturer at University College London.

SOCIAL PROGRAM

Function	Date	Time	Location
Welcome Reception & Casual Dinner	Wednesday 6th July	6:00pm – 9:00pm	Millbrook Clubhouse
Ceilidh Dinner Dance	Thursday 7th July	6.00pm – 6.30pm	Millbrook Clubhouse
		6.30pm – 10.00pm	Millbrook Pavilion
Mt Soho Black Tie Dinner	Saturday 9th July	Bus Departs Millbrook at 6.40pm – returns at 11.00pm	Mt Soho Winery

TRADE EXHIBITION OPENING HOURS

Thursday 7th July	7.30am – 8.00am	10.15am – 10.45am	12.30pm – 1.30pm
Friday 8th July	8.00am – 8.15am	10.30am – 11.00am	1.00pm – 1.45pm
Saturday 9th July	8.15am – 8.30am	10.30am – 11.00am	1.00pm – 1.45pm

Dislcaimer: This program is correct at the time of printing however the committee reserves the right to make changes.

The Australian Society of Gynaecologic Oncologists

26 th Annual Scientific Meeting

2011 DRAFT ASGO SCIENTIFIC PROGRAM

WEDNESDAY 6TH JULY

12.00 - 2.00pm	**Pathology for Fellows**	Jim Scurry, Diane Kenwright
3.00 - 5.00pm	**Mock OSCE and Assessment Workshop**	Jim Nicklin, Peter Sykes, Bryony Simcock, Deb Neesham

THURSDAY 7TH JULY

7.30 - 8.00am	Trade Exhibition Open	
8.00 - 8.15am	**Opening of meeting Jonathan Carter and Maori Welcome**	
8.15 - 10.15am	**Plenary Sessions - Chair: Peter Sykes**	Sponsored by:
	Developments in Robotic surgery	Arnie Advincula
	Debate: TLH BSO (without lymphadenectomy) should be the standard management for women with clinical stage 1 endometrial cancer.	**For:** Andreas Obermair, Bronwyn King **Against:** Andy Nordin, Jonathan Carter
10.15 - 10.45am	Morning Tea and Trade Exhibition	
10.45 - 12.30pm	**Free Presentations - Chair: Yee Leung**	
	Am I Doing What I Think I Am Doing? A clinical audit assessing outcomes after fast track surgical management of corpus cancer.	Jonathan Carter
	Quality of life detriments through self reported lower limb swelling after treatment for gynaecological cancer.	Monika Janda
	Surgery alone as management of 1B cervical cancer.	Naomi Saunders
	Analysis of prognostic variables, stratification of risk groups and patterns of failure in surgically treated FIGO early stage carcinoma of the cervix.	Piksi Singh
	Robotic Gynaecological Surgery at Epworth Eastern Hospital, Melbourne.	Tom Manolitsas
	Sentinel node biopsy and gynae cancer and a study proposal.	Peter Sykes and Bryony Simcock
	Roboter-driven technology articulates the instrument tips in laparoscopy. First experience in gynaecological surgery.	Andreas Hackethal
12.30 - 1.30pm	Lunch and Trade Exhibition	
1.30 - 3.45pm	**Scientific Sessions - Chair: Jim Nicklin**	
	Performance Management in Gynaecological: What, Who & How?	Andy Nordin
	Current and Future Assessment Processes in Gynaecological Oncology.	Deb Neesham
	Complications of laparoscopic surgery.	Arnie Advincula

Sponsored by:

FRIDAY 8TH JULY

8.00 - 8.15am	**Trade Exhibition Open**	
8.15 - 10.30am	**Fellow Presentations - Chair: Ai Ling Tan**	
	The feasibility and safety of sentinel node biopsy in the management of early stage vulvar cancer: QCGC's initial experience.	Ganendra Raj Kadi Ali Mohan
	Effects of previous surgery on the detection of sentinel nodes in women with vulvar cancer.	Donal O'Brien
	A case controlled study comparing Total Laparoscopic Hysterectomy and Fast Track Open Hysterectomy in a Gynaecological Oncology Unit.	Archano Rao
	Mucinous ovarian tumours: who should operate?	Vivek Arora
	The role of FOXL2 in ovarian granulosa cell tumours.	Paul Cohen
	Matrix Metalloproteinase 9 (MMP9) as a biomarker in early and late Epithelial Ovarian Cancer.	Julie Lamont
	Alternative Vaginal Stent in Vaginal Reconstruction.	Jegajeeva Rao
	Lymphomas of the female genital tract.	Premala Paramanathan

10:30 - 11:00am	Morning Tea and Trade Exhibition		
11.00 - 1.00pm	**Interactive session on Recurrent Disease - Chair: Bryony Simcock**		
	Recurrent Vulva Cancer	Lois Eva	
	Recurrent Ovarian Cancer	Peter Grant	
	Recurrent Endometrial Cancer Presenter	Penny Blomfield	
1.00pm	Lunch and Trade Exhibition		

SATURDAY 9TH JULY

7.15 - 8.15am	**Sanofi Breakfast Symposium**	Sue Valmadre	
8.15 - 8.30am	Trade Exhibition Open		
8.30 - 9.30am	**Scientific Sessions - Chair: Neville Hacker** Update on Medical Oncology in Ovarian Cancer.	Michelle Vaughan	Sponsored by: janssen
9.30 - 10.30am	**Free presentations - Chair: Neville Hacker**		
	Gynaecological Cancer Program, Cancer Australia.	Jane Francis	
	Patterns of p53 staining in Tubal Epithelium of Patients who carry a BRCA1/2 Mutation.	Christopher Smith	
	Program Development and Extended experience with a fast track surgery program.	Jonathan Carter	
	The Keystone Design Island Perforator Flap in Reconstructive Surgery of the Vulva.	Geoff Otton	
10.30 - 11.00am	Morning Teas and Trade Exhibition		
11.00 - 1.00pm	**Tumour Board - Chair: Greg Robertson**	Lew Perrin, Rhonda Farrell, Tom Manolitsas, Yee Leung, Peter Sykes, Jonathan Miller	
1.00 - 1.45pm	Lunch and Trade Exhibition		
1.45 - 3.15pm	**Vulval Flaps and Reconstruction - a practical interactive session - Chair: Geoff Otton**	Jeremy Simcock (Plastic Surgeon)	
3.15 - 5.00pm	**ASGO AGM** (members only)		

2011 ASGO SOCIAL PROGRAM

WEDNESDAY 6TH JULY

6.00pm - 9.00pm	Welcome Reception and Casual Dinner/Opening of Exhibition and Sponsor Presentations at Millbrook (Family friendly evening)

THURSDAY 7TH JULY

6.00pm - 10.00pm	Ceilidh Dinner Dance (Family friendly evening)

SATURDAY 9TH JULY

7.00pm - 11.00pm	Mt Soho Black Tie Dinner (Adults only)

This Program is correct at the time of printing, however, the Organising Committee reserves the right to alter the Program if deemed necessary.

WEDNESDAY 6TH JULY 2011

Session	**Pathology for Fellows**
Time	12.00 - 2.00pm
Presenters	Jim Scurry, Diane Kenwright

Session	**Mock OSCE and Assessment Workshop**
Time	3.00 - 5.00pm
Presenters	Jim Nicklin, Peter Sykes, Bryony Simcock and Deb Neesham

THURSDAY 7TH JULY 2011

Session	**Plenary Sessions**
Time	8.15 - 10.15am
Chair	Peter Sykes

Developments in Robotic surgery	Sponsored by:	DEVICE TECHNOLOGIES First Choice
Presenter	Arnie Advincula	

Abstract:

Robotics represents a disruptive technology that is changing paradigms in surgical training and care. Applications have been demonstrated across the gamut of gynecologic surgery, both benign and oncologic. Although advantages have been seen clinically with this enabling technology, disadvantages also exist.

Debate	**TLH BSO (without lymphadenectomy) should be the standard for women with clinical stage 1 endometrial cancer.**
Time	9.00 - 10.00am
Chair	Peter Sykes
Presenters	**For:** Andreas Obermair, Bronwyn King **Against:** Andy Nordin, Jonathan Carter

Session	**Free Presentations**
Time	10.45 - 12.30pm
Chair	Yee Leung

Am I Doing What I Think I Am Doing? A clinical audit assessing outcomes after fast track surgical management of corpus cancer.

Presenter Jonathan Carter

Authors Jonathan CARTER[1, 2], Shannon PHILP[1, 2]

[1]Sydney Gynaecological Oncology Group, Sydney Cancer Centre, Royal Prince Alfred Hospital

[2]The University of Sydney, Sydney AUSTRALIA

Abstract:

Introduction: Clinical audit is one of the fundamental principles of clinical governance, the process whereby clinicians improve the quality of the care they provide. The aim of the study was to audit the outcomes of patients with corpus cancer managed with a fast track surgery (FTS) program.

Methods: An Ethics Review Committee approved audit of the FTS database was undertaken.

Results: Over a 3 year audit period, 66 patients were operated upon whose median age was 59.5 years. Forty seven (71%) had stage I disease, 6 (9%) stage II, 9 (14%) stage III and 4 (6%) had stage IV disease. Twenty seven (41%) had lymph node sampling performed. Median operating time was 2.5 hours. Mean BMI was 30kg/m2 (Range: 18-47). Fifty patients (76%) were classified as overweight or obese. Twenty four patients (36%) had a “non-zero” performance status. Mean intraoperative EBL was 227ml. There were no intraoperative blood transfusions. Median LOS was 3.0 days. There were 3 (5%) intraoperative complications. There were no intraoperative ureteric, bowel or vascular injuries. Postoperatively, 12 (18%) patients experienced a total of 23 complications or adverse event. Only 2 (3%) patients experienced complications greater than grade 2.

Conclusion: This audit shows that in an unselected group of patients undergoing laparotomy as management for their uterine malignancy and managed by a FTS protocol, overall excellent results can be achieved and would appear to be comparable to minimally invasive techniques.

Quality of life detriments through self-reported lower-limb swelling after treatment for gynaecological cancer.

Presenter Monika Janda

Authors M. Janda[1], S.C. Hayes[1], H. Reul-Hirche[2], L. Ward[3], A. Obermair[4]

[1]School of Public Health, Queensland University of Technology, [2]Royal Brisbane and Women's Hospital, Physiotherapy, [3]Physiology, University of Queensland, [4]Royal Brisbane and Women's Hospital, Queensland Centre of Gynaecological Research, Brisbane, QLD, Australia

Abstract:

Background and aims: Lower limb swelling is a common side effect of treatment for gynaecological cancer. However, very limited prospective data is available on the incidence of and risk factors for lower limb swelling. We initiated a prospective cohort study in 2008 to assess lower limb selling and lymphoedema.

Methods: Overall, 656 patients were recruited. At the time of abstract submission, 554 (378 with gynaecological cancer, 176 benign controls) had complete data on self-reported swelling before treatment and at regular intervals up to two years after treatment available for analysis. Quality of life (QoL) was measured using the Functional Assessment of Cancer Therapy Scale (FACT-G) at each visit, and descriptive statistics and t-tests were undertaken to describe the prevalence of lower limb swelling and the impact of lower limb swelling on quality of life.

Results: Overall, up to 49% of patients with malignant disease, and 30% of patients with benign disease self-reported lower limb swelling at least once between baseline and two-year follow up. The QoL of patients with self-reported swelling was lower at all time periods, compared to patients without swelling, irrespective of the presence of malignancy. In patients who did not report swelling, QoL improved over time, while it remained stable in women with swelling (Table 1).

Discussion: Self-reported lower-limb swelling is common in patients treated for malignant or benign gynaecological conditions, and adversely influences QOL.

patient with malignant diagnosis (n=378)	no self-reported swelling Mean QOL (SD)	self-reported swelling Mean QOL (SD)	p-value
6weeks-3months	88.1 (14.7)	82.8 (15.1)	0.004
6-12months	92.6 (13.3)	82.2 (17.2)	<0.001
15-24months	90.7 (15.2)	84.8 (14.9)	0.04

Surgery alone as management of 1B cervical cancer

Presenter	Naomi Saunders
Authors	N Saunder, D Allen, T Jobling, M Quinn, K Narayan

Abstract:

Methods: A retrospective chart review of all cases of surgically managed 1B cervical cancer in Victoria between 1996 and 2006 was undertaken.

Results: 283 cases of 1B cervical cancer were identified. 118 patients received post-operative radiotherapy including 38 node positive and 80 node negative. These patients were excluded from the study.

165 underwent surgery alone. The average number of lymph nodes was 17.7 (range 2-40). Adenocarcinoma was seen in 77 cases, SCC 68, adenosquamous 10 and other histological subtypes 10.

Twelve patients were lost to follow-up. The mean length of follow-up of the remaining patients was 8 yrs. During the study period, 10 patients died, five as a result of cervical cancer. The overall survival was 93.4% with a recurrence rate of 5.8% (9/153) and cancer free survival of 90.8%.

The median time to recurrence was 20 months (range 10.3 - 44 months). Eighty percent occurred within two years. Five patients had recurrence at the vaginal vault, two recurred at the vault and distant nodal sites and two had a recurrence in the bowel.

Salvage treatment for vault recurrence involved combined surgery/radiation for two patients and chemoradiotherapy for three patients. Three of these patients remain disease free at between 2.6 and 4.8 years. Patients with distant recurrence received chemo/radiotherapy palliative treatment. PFS for these patients averaged 2.3 yrs (0.2-4.8).

Conclusion: The prognosis of subjects identified as low risk is good but additional measures are needed to identify a small subset at risk for relapse.

Analysis of prognostic variables, stratification of risk groups and patterns of failure in surgically treated FIGO early stage carcinoma of the cervix.

Presenter	Piksi Singh
Authors	Piksi Singh, MS, FRANZCOG, CGO, James Nicklin, FRANZCOG, CGO, Lee Tripcony, BSC

Abstract:

Objective: To evaluate clinicopathological prognostic variables in surgically treated International Federation of Obstetrics and Gynecology (FIGO) early stage (IA-IIA) cervical cancer, develop prognostic models, note role of adjuvant treatment, patterns of failure and salvage survival in each group.

Methods: Records of 542 patients who received primary surgical treatment for FIGO (IA-IIA) cervical cancer were reviewed. Ninety-eight patients who relapsed after primary treatment were identified and matched for stage and age with a control group. Clinico pathological prognostic variables were identified and used to develop prognostic models with 3 risk groups for overall (OS) & relapse free survival (RFS). Role of adjuvant treatment, relapse site and salvage free survival was noted in each group.

Results: The 5 year OS was 97% in the control group vs. 44% in the relapse group. The survival outcome was significantly affected in the presence of positive lymphovascular space invasion (LVSI) and increasing depth of invasion (DOI) >1/3 ($p<0.001$) in both univariate and the multivariate analysis. Positive lymph node status and tumor size (T size) >31 mm showed a trend towards significance in overall (OS) and relapse free (RFS) survival respectively. An additive model was constructed using the regression coefficients from the multivariate Cox model. The patients were stratified into, low, medium and high-risk groups. The probability of cancer recurrence, and OS was significantly different in all three groups ($p<0.001$). The salvage survival (SS) was better in the low risk group relative to the combined medium and high-risk groups, ($p=0.05$). More distant and loco regional relapses were noted in the medium & high-risk groups. Salvage survival was better in patients with a local recurrence than with a loco-regional or distant recurrence $p<0.001$). Adjuvant treatment was not significantly different for any risk group however better results were obtained for patients receiving combined chemoradiation rather than radiotherapy alone.

Conclusion: LVSI, >1/3,DOI, T-size >31mm, and positive lymphnode status are poor prognostic factors and should be considered while selecting primary treatment with an intention to minimize morbidity and treatment related adversities without compromising outcome. Prospective clinical trials could investigate the benefits of adjuvant treatment for particular risk groups.

Robotic Gynaecological Surgery at Epworth Eastern Hospital, Melbourne

Presenter | Tom Manolitsas

Abstract:

Robotic gynaecologic surgery has been undertaken at the Epworth Eastern Hospital since December 2007. In total, 99 robotic gynaecological surgical procedures have been undertaken at the Epworth Eastern Hospital. From Dec 2007 to Feb 2011 a total of 73 robotic cases have been undertaken by the author. A further 26 cases have been performed by a second gynaecologist (Dr Ken Leong), comprising 22 robotic hysterectomies and 4 robotic myomectomies.

The authors personal series of cases will be presented. The indications for surgery include: endometrial cancer 49 cases, other cancers 2 cases, fibroids 10 cases, benign ovarian cysts/adhesions 2 cases, persistent PMB 2 cases, endometrial hyperplasia 2 cases, familial cancer syndrome 2 cases, endometriosis 2 cases and one case each for benign polyps and menorrhagia. The most common procedure was Total Robotic Hysterectomy +/- BSO (TRH BSO):39 cases, followed by TRH BSO and pelvic lymph node dissection (TRH BSO PLND): 28 cases. Other procedures include BSO: 2 cases and BSO & PLND 2 cases, and Ureterolysis & PLND 2 cases. Two cases were converted to laparotomy. Data will be presented detailing these cases.

The DaVinci robot is an outstanding surgical tool. Its incorporation into more widespread use by gynaecologists and gynaecological oncologists has been hampered by 2 main factors. Small numbers of robots in Australia, limits the access to those existing facilities and results in restrictions in the number of surgeons (of all surgical specialties) who can be granted regular operating sessions. Secondly, the robotic technology does not come cheap and so various solutions have been sought to overcome this challenge and make robotic surgery financially sustainable for the hospital, surgeon and patient.

The majority of prostatectomies in the USA are now performed robotically. Recently gynaecology has overtaken urology surgery in the USA as the fastest growing robotic surgical specialty. Australia has not followed this pattern. So far few gynaecologists in Australia have incorporated robotic surgery into their routine practise. Two of these are at Epworth Eastern hospital, which has one of the most heavily utilised DaVinci robots in the world.

Sentinel node biopsy and gynae cancer and a study proposal

Presenter	Peter Sykes and Bryony Simcock

Roboter-driven technology articulates the instrument tips in laparoscopy. First experience in gynecological surgery.

Presenter	Andreas Hackethal
Authors	Hackethal A, Koppan M, Tinneberg H-R1

Abstract:

Introduction: The new roboter-driven technology articulates instrument tips and provides triangulation of the active part of the instrument. Kymerax just recently introduced to the European market consists of a generator allowing two handpieces to be connected. Each handpiece can be equipped with one of four available instrument tips which are reusable for ten times (Scissor, Maryland-dissector, Needle holder, L-hook). Kymerax was successfully used during a total laparoscopic hysterectomy.

Case: A 42 year old patient (IIG/IIP) with known history of hypermenorrhea and dysmenorrhea presented to hysterectomy. Because of previous caesarean section and to rule out further pathologies possibly associated to dysmenorrhea, the patient was prepared to a total laparoscopic hysterectomy. The worlds premiere of using Kymerax was discussed with the patient preoperatively.

Discussion: The first clinical use in gynecological laparoscopy proofed to be feasible with the new roboter-driven, articulating instrument. Kymerax closes the gap between the conventional laparoscopic surgery and the unrivalled Da-Vinic-Roboter system.

Possible benefits comprise the more precise dissecting ability while tissue can be dissected three dimensionally, ease in identifying and dissecting hard to reach tissue, advanced suturing ability within limited space, less traumatic, possible reduction of surgeons shoulder strain and reduction of possible abdominal incisions.

The fingertip activated tip control and the new freedom of articulation may be unaccustomed for the surgeon in the beginning. Novices will experience a learning curve in using and adopting to the articulating branches. Therefore a standardized curriculum for getting acquainted should be mandatory for new users of Kymerax. This may reduce maneuverability difficulties and support effectiveness and safety of articulating branches. The articulating instruments may be beneficial especially for advanced gynecological procedures.

Session	**Scientific Session**
Time	1.30 - 3.45pm
Chair	Jim Nicklin

Performance Management in Gynaecological: What, Who & How?

Presenter	Mr Andy Nordin, East Kent Gynaecological Oncology Centre, UK

Abstract

Working in a climate of increasing patient and public expectations, accountability and regulation, assessing clinical and surgical performance has become a crucial issue for gynaecological oncologists and their managers. Whilst there will undoubtedly be significant differences in the process of outcomes assessment between healthcare systems in different jurisdictions, common issues will likely predominate. In this presentation, I will discuss the experience of gynaecological oncologists in the United Kingdom, illustrating flaws in the data derived from our hospital data management systems and highlighting challenges for clinicians in assessing and collating valid data on surgical outcomes and complications. A national audit on the prospective collection of co-morbidity and surgical outcomes data (UKGOSOC) is generating detailed valid data on the rate of surgical complications in major UK gynae oncology centres, and should enable us to assess the validity of historical surrogate markers of performance (eg readmission rates). Ultimately the challenge is to integrate valid prospective clinician-led surgical complications and outcomes data collection into routine clinical practice, integrated with existing hospital management systems.

In any field of oncology, cancer survival is viewed as the most important outcome measure. Published data indicates that survival rates in the United Kingdom are generally poor in comparison with much of the developed world, and in an attempt to correct this deficiency, a major financial investment over the last 10 years supported reconfiguration and integration of UK cancer services. Multidisciplinary services are monitored by a formal external peer review inspection process, which rapidly developed into a costly bureaucratic exercise assessing process rather than outcomes. The National Cancer Intelligence Network was established with a remit of collating all existing data streams including cancer registries, hospital episode statistics and national audits, to analyse and disseminate clinical and survival data for all of the cancer disciplines. I will present some of the lessons learned from peer review and the NCIN, including the continual challenge to keep the clinical community central in these processes to ensure that published data is reliable, valid and clinically relevant.

Current and Future Assessment Processes in Gynaecological Oncology.

Presenter	Deb Neesham

Abstract:

Current training assessment relies heavily on the exit exam. However with changes in educational thinking, work based assessment is felt to be a fairer and more appropriate method of assessing our fellows. Unfortunately our subspecialty does not easily lend itself to this, due to the difficulty of having multiple assessments by independent examiners in the work place. After due consideration of all options, we have developed a combination approach which will be outlined in this presentation.

Complications of laparoscopic surgery

Presenter | Arnie Advincula

Sponsored by:

Abstract:

As technological advancements have been made, the ability of surgeons to treat a wider range of pathology in a minimally invasive fashion has expanded. One area where significant strides have been made is the use of energy-based devices in minimally invasive surgery. The associated complications have been implicated in delayed thermal injuries to abdominal and pelvic viscera as well as vaginal cuff issues. Additional topics pertinent to the management of complications encountered during laparoscopic surgery will be discussed.

FRIDAY 8TH JULY 2011

Session	**Fellows Presentations**
Time	8.15 - 10.30am
Chair	Ai Ling Tan

The feasibility and safety of sentinel node biopsy in the management of early stage vulvar cancer: QCGC's initial experience.

Presenter	Ganendra Raj Kadi Ali Mohan

Abstract:

Aim: To review the clinical data of vulvar cancer patients treated using sentinel node dissections and assess the feasibility and safety of this technique in clinical practise.

Methods: We retrospectively reviewed the clinical records of all patients with vulvar cancer treated at Queensland Centre for Gynaecological Cancer with sentinel lymph node biopsies from the year 2005 to 2010.In addition we reviewed the initial validation group of patients that had full lymphadenectomy performed after removal of sentinel nodes.

Results: Total 52 patients were identified, 18 in the validation group and 34 in the application group. Two patients recurred following a negative sentinel node biopsy giving us a recurrence rate of 5.8%.Both patients had lateral vulval lesions ,one recurred in the ipsilateral groin and the other in the contra lateral groin.

Conclusion: Sentinel node biopsy is a feasible and acceptable option of treatment for vulvar cancer patients with a groin node recurrence rate of 2.9 to 5.8%.However there isn't enough evidence to date for it to replace the gold standard full groin lymphadenectomy.

Keywords: sentinel node biopsy, vulvar cancer, groin recurrence, lymph oedema

Effects of previous surgery on the detection of sentinel nodes in women with vulvar cancer.

Presenter Donal O'Brien

Authors Donal J O'Brien[1], Tessa A. Ennik[1,2], David G. Allen[1], Simon E. Hyde[1], Peter T. Grant[1]

[1] Department of Gynecological Oncology, Mercy Hospital for Women, Melbourne, Australia.
[2] Department of Obstetrics and Gynecology, Radboud University Nijmegen Medical Center, Nijmegen, the Netherlands

Abstract:

Objective: There is a growing interest in applying the sentinel node (SN) procedure in the treatment of vulval cancer. Previous vulval surgery might decrease SN detection rates and increase SN false-negative rate. The aim of this study was to evaluate the SN detection rates at the Mercy Hospital for Women in Melbourne and to investigate whether previous vulval surgery affects SN detection rates.

Methods: Data on all patients with vulval cancer who underwent a SN procedure from November 2000 to July 2010, were retrospectively collected.

Results: Sixty-five SN procedures were performed. Detection rates in the group of patients who underwent previous excision of the primary tumor were higher compared to the group without previous surgery ($p<0.001$). None of the patients with a false-negative SN had undergone previous excision.

Discussion: Results indicate that previous excision of a vulval malignancy does not decrease SN detection rates or increase SN false-negative rate.

A case controlled study comparing Total Laparoscopic Hysterectomy and Fast Track Open Hysterectomy in a Gynaecological Oncology Unit.

Presenter	Archano Rao
Authors	Archana Rao, Selvan Pather, Shannon Philp RN, Jonathan Carter

Abstract:

Objectives: To assess whether Total Laparoscopic Hysterectomy is superior to open hysterectomy in the era of fast track post operative recovery.

Methods: Consecutive cases of total laparoscopic hysterectomy (TLH) carried out by a single surgeon (SP) were matched with cases of fast track open hysterectomy (FTOH) carried out by a second surgeon (JC). Patients were matched for age, body mass index (BMI), performance status, benign or malignant disease and extent of surgery. Patients in both groups were fast tracked postoperatively as described in a previous study from our institution. Primary outcome measures included length of stay (LOS), total theatre time (TT), total surgical time (ST) and complications. Student t test was used to compare data between groups. Institutional ethical approval was obtained.

Results: 50 patients were included in each group and the patient demographics in the TLH and FTOS groups were: mean age 56 vs 59 years (p=0.23); BMI 32 vs 31 kg/m2 (p=0.55), weight 82 vs 81 kg (p=0.85). 24 patients in each group had endometrial cancer and 26 patients benign disease. 43 patients had a hysterectomy and bilateral salphingo-oophorectomy (TAH/BSO) and 7 a TAH/BSO and pelvic lymphadenectomy. Patients undergoing a TLH had a significantly shorter LOS, but longer TT and ST (Table 1). Mean LOS, TT and OT were significantly shorter in the second 25 patients undergoing TLH than the first 25 cases (1.8 days vs 2.6 days (p=0.02); 137 min vs 173 min (p=0.04); 200 min vs 226 min (p=0.05). A comparison of the second 25 patients undergoing TLH with the matched cohort undergoing FTOH revealed a significantly shorter LOS, but no difference in TT or ST (1.8 days vs 3.4 days (p<0.001); 175 min vs 200 min (p=0.33); 137 min vs 144 min (p=0.48). 4 patients with cancer in the TLH group were converted to open procedures due to an enlarged uterus. There were no cases of visceral or ureteric injury. There were no readmissions in the TLH group however 1 in the FTOH group needed readmission for a wound infection and another for a small bowel obstruction, which settled on conservative treatment.

Conclusion: Despite fast track recovery protocols, TLH results in significantly shorter inpatient stay than FTOH and after an initial learning curve does not result in prolonged theatre or surgical times.

Parameter	TLH (n=50)	FTOH (n=50)	p value
Mean Length of stay (days)	2.20	3.40	0.001
Mean total theatre time(min)	213	171	<0.001
Mean total surgical time (min)	154	140	0.05

Table 1: Outcomes of Patients undergoing TLH and FTOH

Mucinous ovarian tumours: who should operate?

Presenter	Vivek Arora

Abstract:

Mucinous ovarian tumours present as large masses and are thus likely to be encountered by a general gynaecologist in a vast majority of cases. A significant proportion of women with ovarian cancer have their surgery performed by general gynaecologists and general surgeons in the first instance. There is evidence to suggest that women with ovarian cancer who have surgery carried out by a gynaecological oncologist have superior survival.

Objectives: We hypothesize that management of mucinous ovarian tumours by a gynaecological oncologist is associated with a reduced incidence of recurrence and an improved overall survival.

Methods: A retrospective review of all the cases of borderline and invasive mucinous ovarian tumours managed at the Royal Prince Alfred Hospital between 1979 and 2005 was carried out. Kaplan-Meier survival curves were generated to compare the survival for women who were operated upon by gynaecological oncologists and non-gynaecological oncologists.

Results: Significantly higher proportion of women diagnosed with mucinous ovarian tumours (both borderline and invasive) underwent a full staging procedure when a gynaecological oncologist carried out the surgery. The overall survival for both borderline and invasive mucinous ovarian tumours was significantly higher when a full staging procedure had been carried out. Women with previously unsuspected stage 3 borderline mucinous ovarian tumours were more likely to have a full staging procedure and better survival when a gynaecological oncologist carried out the surgery. Women with recurrent borderline mucinous tumours who underwent a repeat procedure were more likely to be diagnosed with an invasive recurrence. Late stage (stages 3 & 4) invasive mucinous ovarian tumours are associated with a poor prognosis irrespective of the surgeon performing the procedure.

The role of FOXL2 in ovarian granulosa cell tumours.

Presenter	Paul Cohen

Abstract:

FOXL2 is a transcription factor which plays a key role in regulating gene expression and is essential for normal ovarian development and function. A mutation in the FOXL2 gene has been identified in the majority of adult ovarian granulosa cell tumours but the functions of FOXL2 and its mutant gene have yet to be elucidated. Gene expression was studied in ovarian granulosa tumour cell lines using DNA microarray analysis following knockdown of FOXL2. It would appear that FOXL2 may act as a tumour suppressor gene in ovarian granulosa cell tumours.

Matrix Metalloproteinase 9 (MMP9) as a biomarker in early and late Epithelial Ovarian Cancer.

Presenter | Julie Lamont

Abstract:

Epithelial ovarian cancer is the leading cause of gynaecological cancer associated death in Australasian women. Biomarkers aim to identify ovarian cancer in its pre- or early clinical stage, when treatment confers an improved outcome.

Matrix Metalloproteinases (MMPs) play a critical role in cancer invasion, metastasis and tumorigenesis. MMPs are expressed in many human tumours; particularly in early lesions rather than in established carcinoma. This allows for the exploration of MMPs as a biomarker for early ovarian cancer.

A pilot study investigated postmenopausal women with early or late stage ovarian cancer, and controls. Samples from plasma, urine and uterine lavage were evaluated for levels of MMP9. MMP9 was significantly elevated in both plasma and uterine lavage from all cancer patients, and was especially elevated in the plasma samples of early cancer patients. Conversely there was a trend towards decreased levels of MMP9 observed in urine for cancer patients, but this was not significant.

Alternative Vaginal Stent in Vaginal Reconstruction

Presenter Jegajeeva Rao

Authors Rao, S. Jegajeeva[1,2], Nicklin, Sean[1,3] and Hacker NF[1]

[1]Gynaecological Cancer Centre, Royal Hospital for Women, Randwick, New South Wales, Australia.
[2]Faculty of Medicine, Universiti Teknologi MARA, Selayang, Selangor, Malaysia.
[3]Plastic Surgery Unit, Prince of Wales Hospital, Randwick, New South Wales, Australia.

Abstract:

Vaginal reconstruction is a relatively rare surgical procedure for radiation induced vaginal stenosis. McIndoe's split-thickness graft procedure originally described for vaginal atresia is commonly regarded as the gold standard for vaginal reconstruction. A four step procedure of vaginal resection, graft harvesting, graft fashioning and graft placement has been previously described from this centre. In the step for graft fashioning and graft placement, a vaginal obturator or vaginal stent plays an important role as the graft is firmly fashioned into a hollow cylinder over a mould to conform to the shape of the neovagina and placed in-situ. Various types of obturator or stent material have been described such as vulcanite in the original McIndoe procedure, foam rubber filled condom and various silicon stents. We present our experience of using an alternative inflatable vaginal stent in vaginal reconstruction which also modifies the third and fourth steps of graft fashioning and placement. We describe a patient with Poorly Differentiated FIGO Stage IIB Adenosquamous Carcinoma of the Cervix who underwent chemoradiation and diligently used vaginal dilators. In spite of this, she developed severe radiation related morbidities. Vaginal stenosis progressively developed until sexual intercourse became impossible. Vaginal length was 1.5cm with the remaining vagina completely obliterated prior to surgery. She had a successful vaginal reconstruction with 100% take and resumption of regular sexual intercourse about 2 ½ months after surgery.

Lymphomas of the female genital tract

Presenter Premala Paramanathan

Authors Paramanathan P, Grant P, Hyde S, Allen D
Mercy Hospital for Women, Heidelberg, Victoria

Abstract:

Malignant lymphomas in the female genital tract are rare, and those arising from this tissue system are extremely uncommon. Twenty five percent of malignant lymphomas arise at extra nodal sites and in only one percent of women with extra nodal tumours is the genital tract involved. Clinical symptoms are often non-specific and mimic other more common gynaecological malignancies.

We present a series of 12 patients who presented to this department with pelvic pathology. This was a retrospective study from 2001 to 2010. The adnexae were involved in 4 cases, followed by the vulva in 2 cases and 1 case involving the vagina. There were 3 cases of endometrial endometrioid adenocarcinoma with lymph nodes positive for lymphoma. Interestingly 2 cases presented as pelvic masses, one in the Pouch of Douglas and the other a soft tissue mass close to the external iliac vessels. Biopsies of these confirmed lymphomas. As expected, the majority of cases were of B phenotype.

Session:	**Interactive Session on Recurrent Disease**
Time	11.00 - 1.00pm
Chair	Bryony Simcock

Recurrent Vulva Cancer

Presenter	Lois Eva

Recurrent Ovarian Cancer

Presenter	Peter Grant

Recurrent Endometrial Cancer

Presenter	Penny Blomfield

Session	**Scientific Sessions**
Time	8.30 - 9.30am
Chair	Neville Hacker

Update on Medical Oncology in Ovarian Cancer Sponsored by: janssen PHARMACEUTICAL COMPANIES OF Johnson & Johnson

Presenter	Michelle Vaughan

Abstract:

Chemotherapy adds years to the average life expectancy of women with ovarian cancer, but clinical trials continue to add quality life years to the survival of women affected by this usually fatal disease.

This presentation will cover where we are with chemotherapy for ovarian cancer in first line and recurrent disease. It will also focus on emerging therapies and ongoing trials for this difficult cancer.

Session	**Free Presentations**
Time	9.30 - 10.30am
Chair	Neville Hacker

Gynaecological Cancer Program, Cancer Australia

Presenter	Jane Francis

Abstract:

In 2010-11 National Breast and Ovarian Cancer Centre (NBOCC) undertook a review of the Clinical practice guidelines for the management of women with epithelial ovarian cancer. Three topics were selected for revision - Management of women at high risk, Radical upper abdominal surgery for advanced ovarian cancer and Follow up for women with epithelial ovarian cancer. Information about the review process and preliminary evidence from the systematic reviews undertaken by NBOCC was presented at the 2010 ASGO meeting. This presentation will provide an update on the outcome of the topic-specific revisions.

In July 2011 NBOCC will amalgamate with Cancer Australia. This presentation will also provide an overview of the work program in ovarian cancer to be undertaken by Cancer Australia in 2011-2012.

Patterns of p53 staining in Tubal Epithelium of Patients who carry a BRCA1/2 Mutation.

Presenter	Christopher Smith
Authors	Smith C, Jensen D, Russell P, Valmadre S. Mater Hospital, Crows Nest, NSW

Abstract:

Introduction: There has been recent evidence to suggest that many high FIGO stage, high grade, "ovarian" serous carcinomas arise from lesions in the fallopian tube fimbria, so-called serous intraepithelial carcinomas or STIC lesions. This appears to be particularly relevant in women at high risk of developing "ovarian" cancer. While microcarcinomas or even in situ lesions are regularly detected in the tubal fimbriae of these women, it has been suggested that foci of benign appearing tubal epithelium with strong immunohistochemical over-expression of p53 (so-called "p53 signatures") may be an early and detectable precursor lesion in BRCA positive women.

Objective: To compare the p53 immunostaining staining patterns in fallopian tube fimbrial epithelium between BRCA positive and BRCA inconclusive women.

Methods and Results: 20 BRCA positive patients were identified as having had a bilateral "risk-reduction" salpingooophorectomy with or without a hysterectomy, with detailed examination of the tubal fimbriae according to a standard protocol. These were age-matched with 20 cases of bilateral salpingooophorectomy specimens, removed for non-malignant reasons in BRCA inconclusive women, collected prospectively and having the fallopian tubes examined according to the same protocol. P53 immunostaining of the fallopian tube fimbriae was then performed and findings recorded. Our results will be presented.

Program Development and Extended Experience with a fast track surgery program.

Presenter	Jonathan Carter
Authors	Jonathan CARTER[1, 2], Shannon PHILP[1, 2]

Abstract:

Introduction: Fast Track Surgery (FTS) programs have been developed in a number of specialties. They combine a variety of techniques to optimise patient outcomes and as a consequence minimise length of stay (LOS).

Methods: An overview of the development of the FTS program at our hospital is followed by an audit of the experience of 3 full years of patients managed by a FTS program.

Results: Over the 3-year audit period, 251 patients were operated upon. Seventy three in year 1, 99 in year 2 and 79 in year 3. Average age was 54, average weight 71.2 kg (range 38-192kg) and average BMI 27.5 (range 17-69). One hundred and thirty nine patients (55%) were considered overweight or obese. Two hundred and twenty four patients (89%) had VMIs performed and two hundred and fourteen patients (85%) had complex surgical procedures performed. Two hundred and twenty seven patients (90%) were able to tolerate early oral feeding and 215 (86%) received COX inhibitors. Average operating time was 2.3 hours (range 1-10) and 62 patients (25%) had non-zero performance status. Average EBL was 286 mL with average Hb change of 10.6g/L. Eight patients (3%) received intraoperative blood transfusions. Median LOS was 3 days for all patients, benign and malignant patients. Fifty eight (23%) were discharged on day 2. ALOS was 3.8 days, slightly longer in malignant patients (4.1 days) compared to benign patients (3.4 days). Average LOS declined from 4.2 days in year 1 to 3.7 days in year 3. Eleven patients (4%) were readmitted. Complications were deemed acceptable based upon RANZCOG Quality Indicators.

Conclusions: Our extended experience confirms the feasibility and safety of undertaking a FTS program in gynaecological oncology.

The Keystone design Island perforator flap in Reconstructive Surgery of the Vulva.

Presenter	Geoff Otton
Authors	Dr Geoff Otton, Dr Derek Adendorff

Abstract:

Premalignant and malignant disease of the vulva often requires radical surgery. In the setting of recurrent disease this can be even more challenging. The morbidity of surgery, in particular wound breakdown imposes a significant burden on the patient and community. Excessive wound tension is a predisposing factor for wound breakdown and may be reduced with the judicious use of skin flaps. A number of flaps have been described. No one flap is applicable to all wounds. The gyn oncologist needs to be familiar with a range of surgical options.

The Keystone Design Perforator Island Flap (KDPIF) was first described by Felix Behan in 2003. It is a curvilinear shaped trapezoidal design flap that is effectively two V-Y flaps. It has been used extensively in most areas of the body with success but there are no published cases where the technique has been applied to the vulva. In this study we present our experience with the use of the KDPIF.

Between April 2008 and October 2010, twenty-four Keystone flaps were performed on seventeen patients. No patient developed wound dehiscence or breakdown.

While this study was not designed to compare skin flaps and does not prove superiority to primary closure, the results are encouraging and may increase the options for gynaecologic surgeons who perform vulvar surgery. The authors' believe that further study and development of this flap is warranted.

Session:	**Tumour Board**
Time	11.00 - 1.00pm
Chair	Greg Robertson
Presenters	Lew Perrin, Rhonda Farrell, Tom Manolitsas, Yee Leung, Peter Sykes, Jonathan Miller

Session:	**Vulval Flaps and Reconstruction - A practical interactive session.**
Time	1.45 - 3.15pm
Chair	Geoff Otton
Presenter	Jeremy Simcock

Poster Presentation	**Endometrioid ovarian carcinoma in a woman with a history of infertility and multiple IVF treatment cycles.**
Presenter	Dr Anthony Richards, Department of Gynaecology Oncology, Sydney Cancer Centre, Missenden Road, CAMPERDOWN, NSW

Abstract:

Ovarian cancer is a rare event to be diagnosed during assisted reproduction. There have been several case reports and case series that describe its incidence within the infertile population well after the assisted reproductive process. We present a case of endometrioid adenocarcinoma that developed during the ovarian stimulation process and show corresponding ultrasound images of its development. To date, there has not been a published paper showing the evolution of an ovarian malignancy during in-vitro fertilisation in corresponding ultrasound images.

The Australian Society of Gynaecologic Oncologists

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Head of the Gynaecological Oncology Department
in the Teaching Hospital of the Charles University
Prague, Czech Republic

Prof Michael Solomon
Surgical Oncologist and Director
Surgical Outcomes Research Centre
University of Sydney

FOR FURTHER INFORMATION CONTACT

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