2013 ASGO XXVIII
Annual Scientific Meeting
Darwin

PROGRAM BOOKLET

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Darwin Convention Centre

Dates
3rd to 7th July 2013

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Chair:	Alex Crandon (Chair)
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Professional Conference Organiser:	Mary Sparksman

SECRETARIAT

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

Wednesday	12.00pm – 5.00pm
Thursday	7.45am – 4.00pm
Friday	8.00am – 2.15pm
Saturday	8.00am – 2.30pm

Mary Sparksman and Kate Murphy
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INVITED INTERNATIONAL SPEAKER

William A. Cliby MD, Mayo Clinic

EXHIBITOR OPENING HOURS

Thursday 4th	7:45am – 4:00pm
Friday 5th	8:00am – 2:00pm
Saturday 6th	8:00am – 2.15pm

SOCIAL PROGRAM

Wednesday 3rd July **6.00pm to 9.00pm**	**Welcome Reception** (family friendly evening) *il lido waterfront kitchen* *Darwin Waterfront Precinct*
Thursday 4th July **6.00pm to 9.00pm**	**Crocosaurus Cove** (family friendly evening) *58 Mitchell Street (A short 10 minute walk from the Vibe and Medina)*
Friday 5th July **2.15pm to 4.15pm**	**Darwin Harbour Cruise (**family friendly afternoon) Departs Darwin Jetty
Friday 5th July **6.30pm to 11.00pm**	**M*A*S*H Party** *Buses depart the Vibe and Adina at **6.30pm** for a mystery destination.* *Dress for a **M*A*S*H** party as Trapper John McIntryre, Hawkeye Pierce, Frank Burns or Margaret Houlihan or join the fun in the style of the 'Andrews Sisters'.*
Saturday 6th July **6.30pm to 11.00pm**	**ASGO Black Tie Dinner** *Pee Wees Restaurant* *Buses depart the Vibe and Adina at 6.30pm and return from 10.30pm*

2013 ASGO SCIENTIFIC PROGRAM

Wednesday 3rd July

12.30 – 1.30pm	*Registration and Lunch*
1.30pm – 2.45pm	***Fellows Education Session -*** *Session* Chair: Andy Garrett ***Pathology*** *Presenter:* ***Di Cominos***
2.45pm – 3.30pm	***Radiation Oncology*** *Presenter:* ***Gerard Adams***
3.30pm – 4.00pm	***Medical Oncology*** *Presenter:* ***Geraldine Goss***
4.00pm – 5.00pm	***Mock OSCE and Exam Workshop*** *Presenter:* ***Greg Robertson***

Thursday 4th July

7.45am – 8.20am	*Trade Exhibition Open*
8.20am – 8.30am	***Welcome and Opening of Meeting by ASGO President -*** *Session* Chair: Alex Crandon
8.30am – 9.30am *Sponsored by:* *Johnson and Johnson*	***Keynote Presentation*** ***Surgical resection of diaphragm disease and En bloc recto sigmoid resection for ovarian cancer*** *Presenter:* ***William A. Cliby, MD, Mayo Clinic***
9.30am – 10.10am	***Infectious Diseases at the Frontier*** *Presenter:* ***Bart Currie, Darwin***
10:10am – 10:20am	***Discussion and Questions***
10.20am – 10.50am	*Morning Tea and Trade Exhibition*
10.50am – 11.20am	***EIN: What is it and is it any better than the current classification -*** *Session* Chair: Amy Tang *Presenter:* ***Peter Nguyen, Melbourne***
11.20am – 12.30pm *Sponsored by:* ***Janssen***	***Fellows Presentations*** ***Archana Rao –*** *Venous thromboembolism (VTE) prophylaxis in patients undergoing surgery for gynaecological malignancy – a survey of current practice of Certified Gynaecologic Oncologists (CGO's) in Australia and New Zealand* ***Adam Pendlebury -*** *Incisional hernias in women of reproductive age* ***Nisha Jagasia -*** *Survival and patterns of recurrence after radiotherapy for isolated nodal and non-nodal recurrences of Epithelial Ovarian Cancer* ***Tony Richards -*** *Complex vulval defects- A single institutional experience of a novel reconstructive technique; The Singapore flap* ***Michelle Harris –*** *Stage IIIC endometrial cancer - standard pelvic radiotherapy or extended field?*
12.30pm – 1.30pm	*Lunch and Trade Exhibition*
1.30pm – 3.30pm *Sponsored by: Roche*	***Free Communications -*** *Session* Chair: Naven Chetty ***Penny Blomfield –*** *After TRIPOD, are we still using intraperitoneal chemotherapy? A survey of Australian practice* ***Donal Brennan –*** *Serum HE4 as a Prognostic and Predictive Marker in Endometrial Cancer – a Population Based Study* ***Rhonda Farrell –*** *Stage 1B2 Cervical Cancer: Primary Surgical Management with tailored adjuvant chemoradiation* ***Kailash Nararyan –*** *Tumor control, late toxicities, and survival in locally advanced cervix cancer patients treated by conformal high-dose-rate (HDRc) brachytherapy as a part of curative radiotherapy* ***Peter Sykes –*** *Gynaecological Cancer Services In New Zealand. Where are we and where are we going?* ***Monika Janda –*** *Cost effectiveness of Total Laparoscopic Hysterectomy compared to Total Abdominal Hysterectomy: Results from the randomised LACE trial* ***Andreas Obermair –*** *Analgesic requirements and surgical outcomes in patients with and without epidural analgesia in early Endometrial Cancer: results from the randomised LACE trial.* ***Peter Sykes –*** *Supporting Gynaecological cancer management in the pacific & Lymphadectonomy Trial Update* ***Pongkasem Worasethsin –*** *Total laparoscopic radical hysterectomy for early stage cervical cancer*
3.30pm – 4.00pm	*Trade Exhibition and Afternoon Tea*

*** Please note this program is subject to change without notification***

Friday 5th July	
8.00am – 8.30am	*Trade Exhibition Open*
8.30am – 9.00am *Sponsored by: Sanofi*	***Keynote Address -*** *Session* Chair: Andreas Obermair ***Quality Improvement in Gynaecologic Surgery*** *Presenter:* ***William A. Cliby, MD, Mayo Clinic***
9.00am – 09.40am *Sponsored by: Hologic*	***Informed Consent for Major Gynaecologic Oncology Surgery*** *Presenter:* ***Les McCrimmon from William Forster Chambers, Darwin***
09:40am – 10:40am	***Trainee Presentations*** ***Andreas Hackethal –*** *An advanced instrument for intraoperative documentation of ovarian cancer: the ovarian Peritoneal Cancer Index (oPCI)* ***Donal Brenan*** *– The Potential Role of Statins in the Treatment of Ovarian Cancer* ***Murad Al Aker*** *- Preoperative use of Gabapentin as an adjuvant for postoperative analgesia in women undergoing Laparotomy for treatment of malignant or suspected malignant Gynecologic diseases* ***Yvette Ius -*** *A Retrospective Review of the Role of Vaginal Smears in the Diagnosis of Recurrent Endometrial Cancers including cost benefit analysis* ***Helen Green*** *- Vaginal vault recurrence in endometrial cancer: treatment options and outcomes*
10.40am – 11.10am	*Morning Tea and Trade Exhibition*
11.10am – 1.00pm *Sponsored by: GateHealthcare*	***Trainee Presentations -*** *Session* Chair: Piksi Singh ***Rashi Kalra -*** *The role of surveillance PET in patient selection for salvage hysterectomy* ***Nirmala Kampan -*** *Outcome of molar pregnancies in Malaysia: a tertiary centre experience* ***Shilpa Narula -*** *Adjuvant Radiotherapy of Intermediate-High Risk Endometrial Cancer; where less is more* ***Shina Oranratanaphan -*** *Characteristic and treatment outcome of the patients who had malignant transformation arising from mature cystic teratoma of the ovary in King Chulalongkorn Memorial Hospital* ***Jina Rhou -*** *Direct hospital cost of total laparoscopic hysterectomy compared to fast track open hysterectomy at a tertiary hospital. A case controlled study* ***Suzanne Stainer*** *- Reporting Outcomes from Endometrial Cancer Follow Up; Endometrial Cancer Recurrence, Mortality and Cardiovascular Death* ***RamaishThangamani -*** *Achieving "no residual disease" at surgery for newly diagnosed ovarian cancer* ***Vanessa Hughes –*** *Is hormone receptor status in primary Ovarian cancer a reliable predictor of receptor status in recurrent disease?* ***Rachel O'Sullivan*** *- An evaluation of Gestational Trophoblastic Disease in the Hunter New England Area over the last 15 years.*
1:00pm – 2:00pm	*Lunch and Trade Exhibition*
Saturday 6th July	
8.00am – 9.00am	*Trade Exhibition Open*
8.00am - 09:00am	***Breakfast Session*** ***Investigators Meeting*** ***A Phase II Randomised Clinical Trial of Mirena® ± Metformin ± Weight Loss in Patients with Early Stage Cancer of the Endometrium*** *Presenters:* ***Kristy Mann, NHMRC Clinical Trials Centre, Sydney, Andreas Obermair, Monika Janda***
9.00am – 10.30am *Sponsored by: Olympus*	***ASGO DEBATE –*** *Session* Chair: Jim Nicklin ***Para aortic lymphadenectomy should be a routine part of staging for endometrial cancer*** *Supporting:* ***Orla McNally, William Cliby, Tom Manolitsas*** *Against:* ***Bryony Simcock, Russell Land, Greg Robertson***
10.30am – 11.00am	*Morning Tea and Trade Exhibition*
11.00am – 12.30pm *Sponsored by: Device Technologies*	***Surgeons Corner &Tumour Board –*** *Session* Chair: Russell Land ***Andreas Hackethal –*** *Considerations for safe and effective Gynaecological Laparoscopic Surgery in obese cancer patients* ***Cindy Pang*** *– Radical Modified hysterectomy, pelvic lymphadenectomy using ligasure - the modified PUNE technique* ***Cindy Pang*** *– A Port in the Storm - an innovative use of laparoscopy in an unusual case of uterine rupture*
12.30pm – 1.30pm	*Lunch and Trade Exhibition*
1.30pm – 2.15pm	***ASCO Update –*** *Session* Chair: Marcelo Nascimento *Presenter****: Michael Frielander***
2.15pm – 4:45pm	***ASGO AGM***

Wednesday 3rd July, 2013

Session One: Fellows Education Session - Pathology

Time: 1.30pm – 2.45pm

Presenter: Di Cominos, *Pathology*

Session Chair: Andrea Garrett

Notes:

Wednesday 3rd July, 2013

Session Three: Radiation Oncology

Time: 3.30pm – 4.00pm

Presenter: Gerard Adams

Notes:

Wednesday 3rd July, 2013

Session Four: Medical Oncology

Time: 3.30pm – 4.00pm

Presenter: Geraldine Goss

Notes:

Wednesday 3rd July, 2013

Session Five: Mock OSCE and Exam Workshop

Time: 4.00pm – 5.00pm

Presenter: Greg Robertson

Notes:

Thursday 4th July, 2013

Keynote Address: Surgical resection of diaphragm disease and En bloc recto sigmoid resection for ovarian cancer

Time: 8.30am – 9.30am

Presenter: William A. Cliby, MD, Mayo Clinic **Session Chair: Alex Crandon**

Session Sponsored by Johnson & Johnson MEDICAL

Abstract:

This talk will be directed toward the gynecologic oncologist and will be technically oriented to cover the rationale, approach, anatomy, techniques and complications related to these 2 procedures. Where available evidence for efficacy will be provided. We will focus on the 2 areas most commonly involved in metastatic ovarian cancer: the pelvis and the Right upper quadrants. Having an ability to remove tumor thoroughly in these 2 locations will vastly improve the rates of 'no residual' disease during debulking surgery. The talk will include lecture and video formats.

Notes:

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2. Data on file E392: 21% shorter transection times measured in porcine labs vs HARMONIC ACE® Shears without Adaptive Tissue Technology (4.5s vs 5.7s; P<0.001).

 FR4395/05/13. E201305_84

Thursday 4th July, 2013

Infectious Diseases at the Frontier

Time: 9.30am - 10.10am

Presenter: Bart Currie

Notes:

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Thursday 4th July, 2013

EIN: What is it and is it any better than the current classification?

Time: **10.50am - 11.20am**

Presenter: **Peter Nguyen, Melbourne**

Abstract:

Based on Kurman's classic 1985 study, the 1994 WHO classification of endometrial hyperplasia is widely accepted and has been validated by numerous studies. However it has some weaknesses and in particular has been shown to be poorly reproducible. A newer Endometrial Intraepithelial Neoplasia (EIN) classification which was initially defined by computerised morphometry but now has standard light microscopic criteria has been developed. Its proponents argue that the EIN system better reflects modern understanding of the genetics of endometrial precancer, is more reproducible and is a better predictor for progression to endometrial carcinoma, although the latter claim in particular is controversial and the literature is mixed. This presentation details what EIN is, how it was developed, how it is diagnosed and why it may replace the current system.

Notes:

Thursday 4th July, 2013
Fellows Presentations **Time:** 11.20am – 12.30pm

Abstract: Venous thromboembolism (VTE) prophylaxis in patients undergoing surgery for gynaecological malignancy – a survey of current practice of Certified Gynaecological Oncologists (CGO's) in Australia and New Zealand.

Presenter: Archana Rao

Authors: Archana Rao[1], Jonathan Carter[2]

Aims: To document the current practice of CGO's with regards to VTE prophylaxis for patients undergoing surgery for gynaecologic malignancy.

Methods: Current practicing CGO's were identified from the Australian Society of Gynaecologic Oncologists database, and invited to participate in an on-line survey regarding their current practice with regards to the prevention of VTE in patients undergoing surgery for gynaecological malignancy. Institutional ethics approval was obtained for conduct of the research.

Results: A total of 30 CGO's participated in the survey. Results demonstrate that a range of methods is used for VTE prophylaxis including compression stockings, pneumatic calf compression devices, and pharmacological prophylaxis. We present details of various methods, including timing of initiation and duration of use, risk stratification factors, and a comparison of VTE prophylaxis for patients undergoing laparotomy vs laparoscopy.

Conclusions: VTE prophylaxis is widely used amongst CGO's. Variations exist with regards to methods and timing of prophylaxis, and according to the type of surgery being performed. This survey provides guidance for possible future research in this area.

Notes:

Abstract: Incisional hernias in women of reproductive age

Presenter: Dr Adam Pendlebury

Authors: Adam Pendlebury[1,2] , Sumudu Samarasekara [2], Julie Lamont[1,2]

Incisional hernias are a known late complication of abdominal surgery. Surgery to repair these defects is often performed months or years following the original operation. Frequently, these hernias are not repaired by the original surgeon. The original surgeon may not be aware that this complication has occurred. The absolute incidence of incisional hernia in gynaecological surgery is not known. In this study, all incisional hernias repaired at a major metropolitan tertiary hospital in a five year period were reviewed. 92 cases were identified. The majority of incisional were associated with obstetric and gynaecological surgery. An analysis of comorbidities, incision type, size of defect and specifics of repair will be presented. An analysis of these cases will provide insight into possible strategies for incisional hernia prevention.

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Abstract: Survival and patterns of recurrence after radiotherapy for isolated nodal and non-nodal recurrences of Epithelial Ovarian Cancer

Presenter: Dr Nisha Jagasia

Authors: Nisha Jagasia[1], Orla McNally[1], Deborah Neesham[1], Michael Quinn[1] David Bernshaw[2], Pearly Khaw[2] and Kailash Narayan[2]

The use of tamoxifen and progestagens is based on the observed expression of their corresponding receptors in epithelial and stromal ovarian cancers. Response rates of 15-20% have been reported in uncontrolled series when tamoxifen is used in recurrences of well differentiated ovarian cancers. This rate is variable, likely due to the heterogeneity of the women treated.

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Abstract: Complex vulval defects- A single institutional experience of a novel reconstructive technique; The Singapore flap

Presenter: Dr Tony Richards

Authors: Dr Anthony Richards, Assoc Prof Selvan Pather, Prof Jonathan Carter

Vulval carcinoma represents 3-5% of all gynaecological malignancies with wide resections requiring consideration of reconstructive options. A variety of local flaps have been described, many that are based on the internal pudendal artery: pudendal thigh flap, lotus leaf flap and gluteal fold flap. We describe the procedure, usefulness and institutional experience of the Singapore Fascio-cutaneous flap. Patient details from fours cases are presented. It is a useful addition to the management of complex vulval surgery, especially in patients with previous pelvic irradiation and previous reconstructions.

Notes:

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REFERENCES: 1. Pujade-Lauraine E et al. J Clin Oncol 2010;28(20):3323-3329. Janssen Pty Ltd. ABN 47 000 129 975, 1-5 Khartoum Road, Macquarie Park NSW 2113, Australia. PO Box 9222, Newmarket, Auckland, New Zealand.
Date of preparation: May 2013 JANS0663/EMBC AU-CAE0027

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Abstract: Stage IIIC endometrial cancer - standard pelvic radiotherapy or extended field

Presenter: Dr Michelle Harris

Harris M, Thompson SR, Ng C, Vinod S, Jackson M, Robertson G, Farrell R and Hacker NF
Gynaecological Cancer Centre, Royal Hospital for Women, Randwick, New South Wales, Australia
Department of Radiation Oncology, Prince of Wales Hospital, Randwick, New South Wales, Australia
Cancer Therapy Centre, Liverpool Hospital, Liverpool, New South Wales, Australia
Prince of Wales Clinical School, University of New South Wales, Randwick, Australia
School of Women's and Children's Health, University of New South Wales, Randwick, Australia

Endometrial cancer patients with positive pelvic lymph nodes have a 50% risk of involved para-aortic nodes, according to surgical staging studies. A more recent study suggests that the risk of occult para-aortic lymph node metastases may be closer to 70% with ultrastaging. Some authors advocate a systematic para-aortic lymphadenectomy for all high risk patients. Resection of any enlarged nodes with adjuvant extended field radiotherapy is another approach in the management of para-aortic nodes in endometrial cancer. This approach aims to decrease the potential significant morbidity associated with systematic para-aortic lymphadenectomy in patients who are often elderly and obese. When treated with extended field radiation therapy, approximately 40% of patients with positive para-aortic nodes may be expected to achieve long-term disease-free survival.
We have looked retrospectively at all cases of Stage IIIC endometrioid endometrial cancer, treated with at least hysterectomy, bilateral salpingo-oophorectomy, and pelvic lymph node sampling, followed by adjuvant radiotherapy, in two centres over a fifteen year period. The two sites take a different approach to adjuvant therapy in this situation, with one preferring standard pelvic radiotherapy and the other extended field. Fifty-four cases were identified and reviewed – 34 patients received standard adjuvant pelvic radiotherapy, while 20 received extended field. An outcome comparison is made between the two patient groups. Pattern of recurrence, late toxicity, disease-free and overall survival, are considered.

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Thursday 4th July, 2013
Free Communications **Time:** 1.30pm – 3.30pm **Session Chair: Naven Chetty**

Abstract: After TRIPOD, are we still using intraperitoneal chemotherapy? A survey of Australian practice

Presenter: Dr Penny Blomfield

Authors: A Brand1, P Blomfield2, H Cahill3, M Friedlander4

BACKGROUND: Intraperitoneal (IP) chemotherapy has been reported to be superior to standard IV chemotherapy for the treatment of advanced epithelial ovarian cancer (EOC) in three randomised controlled trials. The ANZGOG TRIPOD study was a phase 2 trial designed to assess the feasibility of administration of IP chemotherapy in the Australian/New Zealand setting.

OBJECTIVE: To determine the uptake of IP chemotherapy post TRIPOD in Australia.

METHODS: An email survey was sent to the head of each gynaecological oncology unit (n=14) in Australia and to the corresponding lead medical oncologists. The survey asked about use of IP chemotherapy in patients with optimally debulked EOC, any concerns about IP chemotherapy, reasons it was not used and what alternative chemotherapy regimens were used. A follow-up email and/or telephone call was made 4 weeks later.

RESULTS: Response rate was 83%, with 3 incomplete responses. Half the centres recommended IP chemotherapy to optimally cytoreduced patients. The most common reasons stated for not offering it routinely included concerns regarding toxicity for individual patients and logistical reasons. The TRIPOD protocol was used almost exclusively. For those units who were not using IP chemotherapy, the most common reasons stated were that they were not convinced about its superiority, not set up for IP chemotherapy or that dose dense chemotherapy was a better alternative.

CONCLUSIONS: IP chemotherapy in Australia is offered in half the gynaecological cancer centres. Concerns remain regarding toxicity and logistics, even amongst those who use it on a regular basis.

Notes:_____

Abstract: Serum HE4 as a Prognostic and Predictive Marker in Endometrial Cancer – a Population Based Study

Presenter: Dr Donal Brennan

Authors: Donal J. Brennan[1], Andreas Hackethal[1], Alex M. Metcalf[2], Jermaine Coward[3], Kaltin Ferguson[2], Martin Oehler[4], Michael A. Quinn[5], Monika Janda[6], Yee Leung[7], Michael Freemantle[8], ANECS Group[2], Penelope M. Webb[2], Amanda B. Spurdle[2] and Andreas Obermair[1*]

Background
HE4 has emerged as a promising biomarker in gynaecological oncology. The purpose of this study was to evaluate serum HE4 as a predictor for high-risk disease in a population-based endometrial cancer cohort.

Methods
Peri-operative serum HE4 and CA125 were measured in 373 patients identified from the prospective Australian National Endometrial Cancer Study (ANECS). Receiver operator curves (ROC), Spearman rank correlation coefficient, chi-squared and Mann Whitney tests were used for statistical analysis. Survival analysis was performed using Kaplan-Meier and Cox multivariate regression analysis.

Results
Median CA125 and HE4 levels were higher in stage III and IV tumours (p<0•001) and in tumours with outer-half myometrial invasion (p<0•001). ROC analysis demonstrated that HE4 (Area under the curve (AUC)=0•76) was a better predictor of outer-half myometrial invasion than CA125 (AUC=0•65), particularly in patients with endometrioid histology (AUC 0•76 vs 0•62 for CA125). Cox multivariate analysis demonstrated that elevated HE4 (using the 75th percentile as a threshold) was an independent predictor of recurrence-free survival particularly in the endometrioid subtype.

Conclusion
These findings demonstrate the utility of serum HE4 as a predictive and prognostic biomarker in endometrial cancer in a population-based study. In particular they highlight the utility of HE4 for pre-operative risk stratification to identify low risk groups who could avoid lymphadenectomy.

Notes:_____

Abstract: Stage 1B2 Cervical Cancer: Primary Surgical Management with tailored adjuvant chemoradiation

Presenter: Rhonda Farrell

Background:. Optimal management of patients with stage 1B2 cervical cancer is controversial, with primary chemoradiation, primary surgery and tailored postoperative radiation, and neoadjuvant chemotherapy followed by radical hysterectomy all having proponents.

Methods: We reviewed our experience with 93 patients with stage 1B2 cervical cancer treated with primary surgery at the Royal Hospital for Women in Sydney from 1988-2008. All patients underwent radical hysterectomy and pelvic lymphadenectomy. If bulky positive nodes were encountered, they were resected without complete lymphadenectomy. Post-operative radiation was tailored to the histological findings.

Results: The mean age of the patients was 46 years, and 70% had squamous cell carcinomas. Tumor invaded into the outer third of the cervical stroma in 73 cases (78.5%), occult parametrial extension occurred in 15 cases (16.9%), and vascular space invasion in 65 cases (69.9%). Positive pelvic nodes were present in 42 patients (45.2%) and bulky positive paraaortic nodes in 5 (5.4%). Some type of post operative adjuvant (chemo) radiation was given to 74 patients (79.6%). With a median follow-up of 96 months, the overall 5-year survival was 80.7%, being 85% for patients with negative nodes and 75% for those with positive nodes (HR:2.63; 95% CI: 1,5.6 p=0.045). The major long term surgical morbidity was lymphedema, which occurred in 8 patients (8.6%). Serious long term radiation morbidity (RTOG grade 3) occurred in 3 cases (3.2%).

Conclusions: Primary radical hysterectomy with tailored post operative adjuvant radiation for patients with Stage IB2 cervical cancer gives good survival, with acceptably low morbidity.

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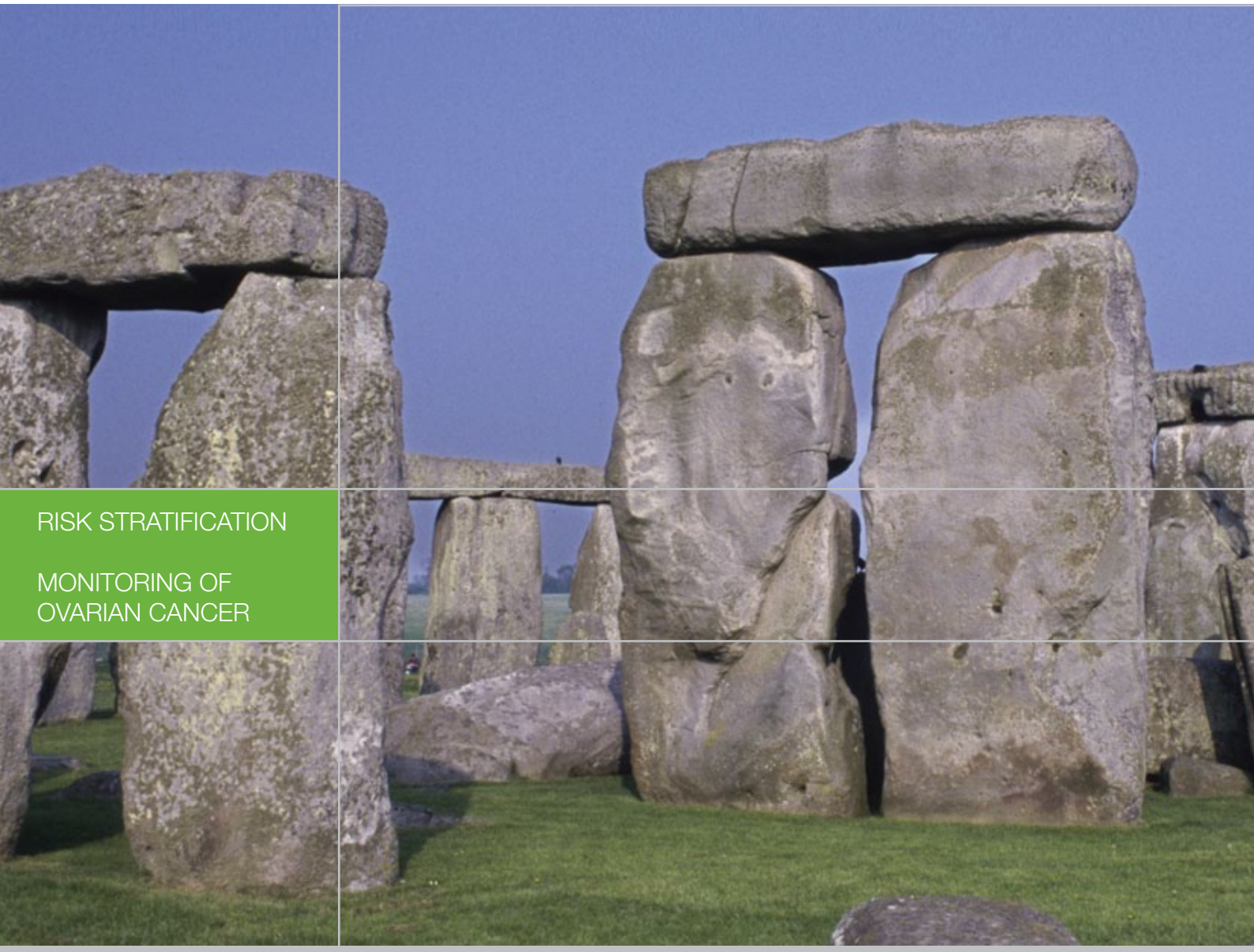

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Abstract: Tumour control, late toxicities, and survival in locally advance cervix cancer patients treated by conformal high-dose-rate (HDRc) brachytherapy as a part of curative radiotherapy

Presenter: Kailash Narayan

Authors: K Narayan, D Bernshaw and S Kondalsamy-Chennakesavan

Methods: Analyses of a prospective dataset of 292 newly diagnosed advanced cervix cancer patients treated with curative radiotherapy and HDRc between 1999 and 2008 at PeterMac. All patients were staged using FIGO criteria and most had pretreatment MRI and PET and were treated with concurrent cisplatin chemoradiotherapy. Brachytherapy dose was prescribed to the residual tumor volume measured by trans-abdominal ultrasound. Point A dose was recorded for reference.

Results: Median dose to point A was 68.2 Gy. Local and any failure rates were 13% and 35% respectively. Pretreatment tumor volume was associated with primary failure (p=0.0001), however, a higher Point A dose was associated with higher relapses at primary site and did not relate to tumor volume. Grade 3 and 4 bladder and GI toxicities were 4.7% and vaginal toxicity was 3%. Seventy two percent patients had either grade 1 toxicity or were asymptomatic.

Notes:

Abstract: Gynaecological Cancer Services In New Zealand. Where are we and where are we going?

Presenter: Peter Sykes

Outside Auckland and Christchurch, Specialist Gynaecological Cancer services in New Zealand have been slow to develop. We have a population of 4 million distributed over a relatively large and sometimes rugged geography, there are a variety of services offering a variety of treatments for women with gynaecological malignancy. Over the past several years professionals caring for women with Gynaecological cancer, have been in communication with the ministry of health regarding a national plan for gynaecological cancer services. A report was commissioned and published in 2011, Standards of Service Provision for Women with Gynaecological Cancer have been drafted and further discussion on implementation of these standards and the service framework are underway. Unfortunately in some regions a lack of trained gynae oncologists is hampering service development. In this talk I will outline the current situation and initiatives and discuss future developments.

Notes:

Abstract: Cost effectiveness of Total Laparoscopic Hysterectomy compared to Total Abdominal Hysterectomy: Results from the randomised LACE trial

Presenter: Monika Janda

Authors: A Obermair, M Janda, V Gebski, N Graves

Objective: to summarise how costs and health benefits will change with the adoption of total laparoscopic hysterectomy compared to total abdominal hysterectomy for the treatment of early stage endometrial cancer.
Design: cost-effectiveness modelling using information from a randomized controlled trial.
Participants: two hypothetical modelled cohorts of 1000 individuals undergoing total laparoscopic hysterectomy and total abdominal hysterectomy.
Outcome measures: surgery costs; hospital bed days used; total healthcare costs; quality adjusted life years; and net monetary benefits.
Results: for 1000 individuals receiving total laparoscopic hysterectomy surgery costs were $509,575 higher, 3,548 hospital fewer bed days were used and total health services costs were reduced by $3,746,221. There were 39.13 more quality adjusted life years for a five year period following surgery.
Conclusions: the adoption of total laparoscopic hysterectomy is almost certainly a good decision for health services policy makers. There is 100% probability it will be cost saving to health services, a 86.8% probability if will increase health benefits and a 99.5% chance it returns net monetary benefits greater than zero.

Notes:

Abstract: Analgesic requirements and surgical outcomes in patients with and without epidural analgesia in early Endometrial Cancer: results from the randomised LACE trial

Presenter: Andreas Obermair

Authors: Jannah Baker, Monika Janda, David Belavy, Andreas Obermair

Objectives: Women with early stage endometrial cancer in Australia require either total laparoscopic hysterectomy (TLH) or total abdominal hysterectomy (TAH) as primary treatment. Within a randomised trial, this study compared post-operative analgesic requirements between the two treatment arms and the risk of surgical complications in patients who had a TAH with and without epidural analgesia.

Methods: Between 2005 and 2010, 760 patients were enrolled in an international, multicentre, prospective randomised trial (LACE) comparing TLH or TAH for treatment of apparent stage I endometrial cancer. Postoperative epidural, opioid and non-opioid analgesic requirements were collected until ten months after surgery and compared between the treatment arms. We also conducted a subgroup analysis in patients who had a TAH through a vertical midline incision and compared outcomes of patients who had and who did not receive epidural analgesia.

Results: Baseline demographics and analgesic use were comparable between treatment arms. TAH patients (n=353) were more likely to receive epidural analgesia (33% vs 0.5%, p<0.001) than TLH (n=407) patients during the early postoperative phase. Although opioid use was comparable in the TAH vs TLH groups during postoperative 0-2 days (99.7% vs 98.5%, p 0.09), a significantly higher proportion of TAH patients required opioids at 3-5 days (70% vs 22%, p<0.0001), 6-14 days (35% vs 15%, p<0.0001), and 15-60 days (15% vs 9%, p 0.02) post-surgery. Opioid use was comparable at 61-150 days (6% vs 6%, p 0.98) and 151-310 days (3% vs 3%, p 0.78) post-surgery. Mean pain scores were significantly higher in the TAH versus TLH group one (2.48 vs 1.62, p<0.0001) and four weeks (0.89 vs 0.63, p 0.01) following surgery.
In the subgroup of patients who had a TAH through a vertical midline incision, those who received an epidural required opioid analgesia for longer compared to patients who did not have an epidural. Postoperative complications (any grade) occurred in 86% of patients with and 66% without an epidural (p<0.01). Epidural analgesia was associated with increased length of stay without any difference in postoperative quality of life up to six months after surgery.

Conclusion: Treatment of early stage endometrial cancer with TLH is associated with less frequent use of epidural analgesia, lower post-operative opioid requirements and better pain levels than TAH. Epidural analgesia may be associated with increased postoperative complications and length of stay after abdominal hysterectomy.

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Abstract: Supporting Gynaecological cancer management in the pacific

Presenter: Peter Sykes

Authors: Peter Sykes, Bryony Simcock, James Fong.

Following a request from gynaecologists in Fiji, and a gentle prod from a pacific Island Doctor based in Christchurch, in 2010 we commenced a voluntary program of assistance to the gynaecology services treating cancer in Fiji. The project is supported by Health Specialists NZ ltd and funding is sourced from NZ aid. We have gathered a team of Gyn Oncologists and other health professionals and have arranged visits every 3 months. The aim is very much to support Fiji to offer the best care that it can for its patients rather than take over the service delivery. In this talk we will outline the challenges, our experiences and our ongoing vision for this project. With careful coordination and cooperation we believe the Australian and New Zealand Gynaecological oncology community has the ability to assist in the improved outcomes for the many pacific island women who develop gynaecological cancer.

Notes:

Abstract: Lymphadenectomy Trial Update

Notes:

Abstract: Total laparoscopic radical hysterectomy for early stage cervical cancer.

Presenter: Pongkasem Worasethsin

Authors: Worasethsin P, Tresukosol D.

INTRODUCTION: Total laparoscopic radical hysterectomy (TLRH) is becoming a standard treatment for early stage cervical cancer. We performed 23 cases of TLRH, from January 2010 to February 2013. Mean operative time and estimated blood loss were 182 min (120-300), and 308 ml (50-1200) respectively. Mean lymph nodes retrieval of left: 9.6 (4-25) and right: 8.5 (4-21) pelvic nodes. The vaginal length anterior: 2.3 cm (1.0-4.0), and posterior: 2.3 cm (1.0-4.0). The left parametrium was 2.3 cm (1.5-3.0), and 2.4 cm (1.0-4.0). Three cases had post-operative radiation: one with deep stromal invasion and the others with positive pelvic nodes. No abdominal conversion is required. CONCLUSION: Total laparoscopic radical hysterectomy with pelvic lymphadenectomy is safe and effectiveness in the treatment of early stage cervical cancer.

Notes:

SPONSOR PRESENTATION BY ROCHE

Friday 5th July, 2013

Keynote Address: Quality Improvement in Gynaecological Surgery

Time: 8.30am – 9.00am

Presenters: William A. Cliby, MD, Mayo Clinic

Abstract:

This talk will be directed to all medical providers with examples drawn from the gynecologic surgery and oncology practice. The focus will be on meaningful quality improvement: moving beyond administrative metrics forced upon us by outside regulations, to changes that are driven from providers that genuinely improve care. Examples will range from methods to improve surgical cytoreduction rates to programmed perioperative care that drastically reduces length of stay while improving outcomes. Lecture format.

Notes:

Notes:

Friday 5th July, 2013
Informed Consent for Major Gynaecologic Oncology Surgery **Time:** 9.00am – 9.40am **Presenter:** Les McCrimmon from William Forster Chambers

Notes:

SPONSOR PRESENTATION BY SANOFI AVENTIS

Friday 5th July, 2013

Trainee Presentations

Time: 9.40am – 10.40am

Abstract: An advanced instrument for intraoperative documentation of ovarian cancer: the ovarian Peritoneal Cancer Index (oPCI).

Presenter: Andreas Hackethal

Authors: Andreas Hackethal, Archana Rao, Donal Brennan, Russell Land, Andrea Garrett, Naven Chetty, Alex Crandon, Lew Perrin, Jim Nicklin, Andreas Obermair

Background
Surgical debulking to maximal achievable cytoreduction remains the most important predictor for overall survival in ovarian cancer patients. However, the extent and distribution of disease, surgical radicality, and residual disease is often not systematically and objectively documented. So far, the Peritoneal Cancer Index (PCI) is the furthest evaluated assessment tool, that has been introduced by general cancer surgeons.

Methods
We adjusted the PCI to previously evaluated ovarian cancer tumour sizes. The oPCI was used by Consultants or Fellows at the start and end of ovarian cancer debulking surgery. 13 defined abdominal regions were allocated a score depending on tumour size.

Findings
We present the rationale for the oPCI, the documentation system and prelimary results of documentation. Potentially easier documentation systems are discussed and conclusions regarding the use of the oPCI in routine practice and further research are drawn.

Notes:

Abstract: The Potential Role of Statins in the Treatment of Ovarian Cancer

Presenter: Donal Brennan

Authors: Donal Brennan[1], Andreas Hackethall[1], Lewis Perrin[1], Georgia Chenevix-Trench[2], Jim Coward[3]

A recent large population based study demonstrated that statin use is associated with a decreased mortality in patients suffering from cancer(1). Statins inhibit 3-hydroxy-3methylglutharyl-coenzyme A reductase (HMG-CoAR) ,which acts as a rate-limiting enzyme in the mevalonate pathway. We have previously demonstrated that HMG-CoAR expression is an independent predictor of prolonged RFS in primary epithelial ovarian cancer (EOC)(2), and is also an important predictor of tamoxifen response in breast cancer (3). In addition we have recently completed a genome wide association study (GWAS) which identified a gene with a key role in cholesterol metabolism as a predictor of platinum response. Taken together these data raise the intriguing possibility that the combination of statins and well-established chemotherapeutic agents may improve response to standard EOC chemotherapy regimens, The aim of this study was to assess the ability of statins to reverse platinum resistance in vitro and develop biomarkers of response to statin therapy in EOC. Using a panel of different EOC cell lines we demonstrate that simvastatin can reverse platinum resistance however this effect is limited to cell lines that harbour a k-ras mutation. As k-ras is frequently mutated in low-grade serous carcinoma of the ovary, we believe that this subgroup of patients may be suitable for a statin-based trial.

Notes:

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REFERENCE: 1. GARDASIL® Approved Product Information, December 2011. bioCSL (Australia) Pty Ltd, ABN 66 120 398 067, 63 Poplar Road, Parkville VIC 3052, distributor for Merck Sharp & Dohme (Australia) Pty Ltd. bioCSL™ is a trademark of CSL Limited. ® GARDASIL is a registered trademark of Merck & Co., Inc., Whitehouse Station, NJ, USA. Medical Information: 1800 642 865. Date of preparation: May 2013. 11092. DC5893.

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Abstract: Preoperative use of Gabapentin as an adjuvant for postoperative analgesia in women undergoing Laparotomy for treatment of malignant or suspected malignant Gynaecologic diseases.

Presenter: Murad Al Aker

Authors: Murad Al-Aker 1,Selvan Pather 1, Stephen Gibson 2, Jonathan Carter1

Background : Gabapentin is an anticonvulsant that has postoperative analgesic effect. Numerous RCT's has shown that the use of perioperative Gabapentin produced better post-operative analgesia and rescue analgesics sparing compared placebo. It was introduced as a component of the Fast Track Surgery (FST) program at Royal Prince Alfred Hospital in September 2012Objectives: Data was collected to evaluate the effect of Gabapentin as an adjuvant to perioperative analgesia on the postoperative pain and morphine consumption and report potential side effects.

Material and Methods : From September 2012 to March 2013, 60 consecutive patients including patients underwent laparotomy for the diagnosis, treatment, and management of gynaecologic/oncologic diseases at a single institution (Royal Prince Alfred Hospital). All patients were followed our Fast Surgery Track (FST) protocol, which included a single dose of Gabapentin 1-2 hours prior to surgery . 48 patients received 900 mgs of Gabapentin, 5 patients didn't receive Gabapentin as per protocol and 7 patients received 600mg's following a Protocol change on March 2013. Data collected included visual pain assessment, overall opioid consumption (opioids used in this study were converted to equi-analgesic morphine equivalent (ME) doses based on the following conversion scale: 100:1 for fentanyl, 1:10 for tramadol, and 1:1.5 for oxycodone), sedation score, narcotic side effects and length of stay. A control group was extracted from medical records of 50 patients underwent Laparotomy before the introduction of Gabapentin.

Results : There was significant reduction in opioid consumption intra-operatively, which was 28.1 mg's (ME) in the Gabapentin group and 56.2 mg's (ME) in the non Gabapentin group and as a total postoperatively between the Gabapentin group 54.4 mg's (ME) and the non Gabapentin group 89.0 mg's (ME) . Pain scores were not statistically different, but there was significant increase in sedation score at 0 and 2 hours postoperatively in the Gabapentin group, 3 patients suffered from significant sedation in the 900mg's Gabapentin group, 2 of them necessitated respiratory monitoring in ICU. The overall length of stay was comparable with 2 patents in the Gabapentin group were discharged home on day 1 postoperatively after meeting the discharge criteria.

Conclusion : Single dose of Gabapentin 1-2 hours prior to surgery significantly decrease the use of postoperative opioids . The proper dose of Gabapentin to be used need further investigation, A 900 mgs dose was associated with significant risk of postoperative sedation and respiratory depression. A 600mgs dose is likely to have fewer side effects

Keywords: Gabapentin, Laparotomy, Gynecologic oncology , Opioids consumption.

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Abstract: A Retrospective Review of the Role of Vaginal Smears in the Diagnosis of Recurrent Endometrial Cancers including coast benefit analysis

Presenter: Yvette Ius

Authors: Dr Yvette Ius

OBJECTIVE:
To examine the clinical and economical role of vaginal smears in diagnosis of recurrent endometrial cancer.

METHODS:
All patients diagnosed and treated for recurrent endometrial cancer during a 16 year period (1996 – 2011) were retrospectively identified from the tumour registry database. Data regarding demographics, risk factors, stage/grade of tumour, time till recurrence and method of recurrence diagnosis was extracted from the clinical notes and pathology database.

RESULTS:
Endometrial cancer reoccurred in 93 patients. Mean age at diagnosis was 66.7 years, with an average of 703 days between initial diagnosis, till diagnosis of recurrence. Only one patient (1.07%) was diagnosed from a positive vaginal smear without associated signs or symptoms. During this period, 244 smears were performed to diagnose one recurrence.

CONCLUSIONS:
There is no clinical or economical justification for the use of vaginal smears in the routine follow-up in patients with endometrial cancer.

Notes:_____

Abstract: Vaginal vault recurrence in endometrial cancer: treatment options and outcomes

Presenter: Helen Green

Authors: Helen Green, Vinicius Nascimento, Jim Nicklin, Marcelo Nascimento

Aim:
To assess incidence, treatment options, and survival rates in patients who developed vaginal vault recurrence after primary treatment for Endometrial Cancer (EAC).

Methodology:
5-year chart review of patients treated for EAC at the QCGC was performed.

Results:
114 patients were treated for VVR. 65 patients had isolated VVR or vault in association with other sites. 50 patients (78%) had early stage and 13 (14%) had advanced disease. The mean time to relapse was 17.89 months in early stage and 5.46 months in advanced disease.
Treatment was individualized based on previous therapy, histopathological features, co-morbidities and recurrence patterns. The majority (86%) of patients with early stage disease had isolated VVR. Of 13 patients who had advanced disease, 10 developed isolated VVR. 17 patients (34%) with recurrent early stage disease and 8 patients (62%) with recurrent advanced disease died in the follow up period. PFS and OS curves will be reported.

Notes:_____

SPONSOR PRESENTATION BY HOLOGIC

Friday 5th July, 2013	
Trainee Presentations	
Time: 11.10am – 1.00pm	**Session Chair:** Piksi Singh

Abstract: The role of surveillance PET in patient selection for salvage hysterectomy

Presenter: Rashi Kalra

Authors: Rashi Kalra, Kailash Narayan

Twenty eight patients of cervix cancer were selected for either completion or salvage hysterectomy out of 497 patients treated with curative radiotherapy between 1996 - 2008 at PeterMacullum Cancer Centre Melbourne. In six of these patients hysterectomy was abandoned, 3 due to disease progression, in one a second PET became negative and two were not suitable to undergo surgery. Of the remaining 21 patients, 12 returned negative histology at surgery. Of these twelve, 4 patients have since relapsed with disease outside pelvis and died and 4 have developed grade 4 toxicities. Nine patients returned positive histology, of these, only three have remained disease free, one with grade 3 bladder toxicity and another patient with grade 4 vaginal toxicity. The remaining 6 patients all relapsed outside pelvis and have since died. Ten hysterectomies were performed before 2004 and 11 after 2004 when surveillance PET became available. The role of surveillance PET in patient selection for salvage hysterectomy will be discussed here today.

Notes:

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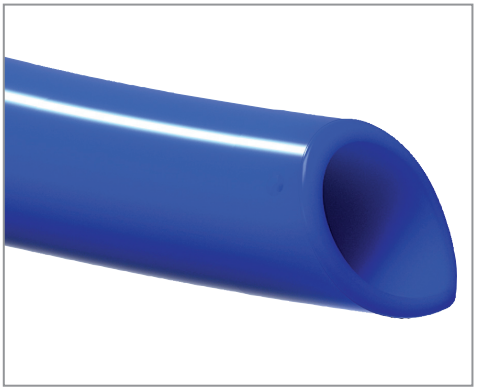

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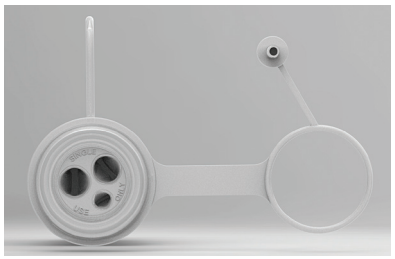

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Abstract: Outcome of molar pregnancies in Malaysia: a tertiary centre experience

Presenter: Nirmala Kampan

Authors: Nirmala CK, Harry SR, Nor Azlin MI, Lim PS, Nur Azurah Abd Ghani, Omar MH, Hatta MD.

Hormonal therapy is usually prescribed in the recurrent setting based on receptor status taken at diagnosis. There is however, little information as to whether hormone receptor status of the primary corresponds to the recurrent tumour. We have conducted a study to review the clinical response to hormonal therapy in recurrent ovarian cancer. The ER/PR status of matched primary and recurrent tumour from patients enrolled in the Australian Ovarian Cancer Study will be reported to determine if the ER/PR status in the primary tumour reflects receptor status in the setting of recurrence.

Notes:

Abstract: Adjuvant Radiotherapy of Intermediate-High Risk Endometrial Cancer; where less is more

Presenter: Shilpa Narula

Intermediate risk node negative endometrial cancer (IRNNEC) patients are traditionally treated with adjuvant vaginal vault brachytherapy (VBT).

Recently, lymphovascular space invasion (LVSI) has emerged as an important prognostic feature. To further improve the treatment outcomes in IRNNEC patients, a small group received central pelvic field radiotherapy (CPFRT). Secondarily, we have also applied GOG node negative high risk cervix cancer criteria in endometrial cancer to further define a subset of higher risk among the IRNNEC patients.

Results showed:
A) Similar survival among the VBT and CPFRT patients,
although LVSI was associated with higher distant failure rates.
B) GOG score (using cervix criteria) showed significant difference in survival between first and the 4th quartile suggesting that the GOG cervix cancer
score can be applied to further select higher risk patients among
intermediate risk node negative endometrial cancer patients.

Notes:_____

Abstract: Characteristic and treatment outcome of who had malignant transformation arising from mature cystic teratoma of the ovary in King Chulalangkorn Memorial Hospital

Presenter: Shina Oranratanphan

This retrospective review was conducted in order to evaluate characteristics, cell types, treatment and outcome of malignant transformation arising from dermoid cyst in our institute.
Charts of 11 patients in 10 years interval was reviewed. Mean age was 41.18 years. Primary surgical staging was performed in 4 patients (36.4%). Re - staging was operated in the other 4 patients. Squamous cell CA was found in 36.4% (4 cases). Mucinous cancer was found in 36.4%. More than half of them were stage Ia (54.5%, 6 cases). All patients whose stage more than Ia were received chemotherapy (45.5%). Mean of disease free survival was 5.53 years.
Data from our institute is quite different from other reviews in the aspect of cell types. Mucinous cell type is as common as squamous cell type. More than half of the cases are early stage. For this reason, our disease free survival is quite impressive.

Notes:

Abstract: Direct hospital cost of total laparoscopic hysterectomy compared to fast track open hysterectomy at a tertiary hospital. A case controlled study.

Presenter: Jina Rhou

Authors: Rhou YJG, Pather S, Loadsman J, Campbell N, Philp S, Carter J

Aims: To assess the direct intraoperative and post operative costs in patients undergoing total laparoscopic hysterectomy and fast track open hysterectomy

Methods: A retrospective review of the direct hospital related costs in a matched cohort of patients undergoing total laparoscopic hysterectomy and fast track open hysterectomy at a tertiary hospital. All costs were calculated including the cost of advanced energy devices. The effect of the learning curve in laparoscopic hysterectomy was also assessed as was the hospital case weighted cost which was compared to the actual cost.

Results: 50 patients were included in each arm of the study. TLH had a higher intraoperative cost but a lower postoperative cost than FTOH ($3877 vs. $2776 $p<0.001$, $3965 vs $6233 $p<0.001$) The total cost of TLH was not different from FTOH ($7842 vs $9009 $p=0.068$) but after a learning curve, TLH cost less than FTOH ($6797 vs. $8647, $p<0.001$). The use of high energy devices did not impact on the cost benefit of TLH and hospital case weight based funding was poorly correlated with actual cost.

Conclusion: Despite the use of fast track recovery protocols, TLH remains cost effective after a learning curve is cheaper than open hysterectomy even with a fast track protocol. Judicious use of advanced energy devices does not impact on the cost and hospital case weight based funding model in our hospital is inaccurate when compared to directly calculated hospital costs.

Notes:

Abstract: Reporting Outcomes from Endometrial Cancer Follow Up; Endometrial Cancer Recurrence, Mortality and Cardiovascular Death.

Presenter: Suzanne Stainer

Authors: Suzanne Stainer, Bryony Simcock, Peter Sykes.

Endometrial Cancer is the most common gynaecological cancer in New Zealand women. Studies have shown that these women are also at increased risk of cardiovascular disease, and that the mortality risk from cardiovascular disease may exceed the risk of death from Endometrial Cancer five years from diagnosis.

We have a series of 461 women diagnosed with Endometrial Cancer and treated at Christchurch Women's Hospital or Christchurch Hospital between 1997 and 2007. We would like to review the outcomes of these women with regards to recurrence, mortality from endometrial cancer, and mortality from cardiovascular causes, and compare this to the general population.

Notes:

Abstract: Achieving “no residual disease” at surgery for newly diagnosed ovarian cancer’

Presenter: Ramaish Thangamani

Authors: Ramaish Thangamani, Nisha Jagasia, Deborah Neesham, Michal Quinn, Orla McNally

Background
The prognosis for women with ovarian cancer is directly related to the amount of disease that is left at the end of surgery, often referred to as ‘debulking’ surgery. The rate limiting factor in achieving an ‘optimal debulk’ is usually disease left in the upper abdomen, particularly on the diaphragms. Many Gynae-oncology units have developed teams to work in the upper abdomen as a result. A recent EORTC study has shown that where optimal debulking is unlikely to be possible upfront, giving neoadjuvant chemotherapy does not compromise outcome in terms of survival and indeed appears to be associated with less morbidity.
The aims of this audit are to evaluate amount of disease that is left at the end of surgery in ovarian cancer treated with primary surgery or neoadjuvant chemotherapy, and to analyze outcome and barriers to the treatment.

Methods
Between January 2009 and December 2012, 286 patients with stage I – IV ovarian cancer underwent treatment at the Gynae-oncology unit of The Royal Women’s Hospital. Primary surgery was performed when complete cytoreduction was considered feasible, while the other patients received neoadjuvant chemotherapy followed by interval debulking surgery.

Results
A previous audit in this unit suggested that one woman presenting to the oncology unit each month would have benefitted from an attempt at optimal cytoreduction
Following a larger 4 year review we have found that more patients were treated with primary surgery (n=249) while (n=37) patients received neoadjuvant chemotherapy. In patients treated with primary surgery, complete cytoreduction was achieved in 74% of patients, and 26 % had residual tumour of sizes ≤ 5 mm(10%), 5-15mm(4%), > 15 mm (12%).

Conclusion
Achieving ‘no residual disease’ is a challenging goal which we are aiming for. We present results of an expanded audit in order to identify barriers to achieving "no residual disease" at surgery. We also explore the resource implications for providing such a service.

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Abstract: Is hormone receptor status in primary Ovarian cancer a reliable predictor of receptor status in recurrent disease?

Presenter: Vanessa Hughes

Authors: Vanessa Hughes, Nisha Jagasia, Deborah Neesham, Michael Quinn, David Bowtell, Jan Pyman, Orla McNally

Hormonal therapies such as tamoxifen and progestagens are used to treat ovarian cancer, particularly in recurrent and late stage disease where side effects of chemotherapy may not be justified. They are also appealing in asymptomatic disease where no survival benefit has been observed with chemotherapy.

Notes:

Abstract: An evaluation of Gestational Trophoblastic Disease in the Hunter New England Area over the last 15 years.

Presenter: Rachel O'Sullivan

Authors: O'Sullivan R1, Jaaback K1, [1]Hunter Centre for Gynaecological Cancer, John Hunter Hospital Newcastle

Background:

Gestational trophoblastic disease (GTD) refers to the rare group of tumours that develop from trophoblastic cells after fertilization. The incidence of GTD in Australia is estimated to be between 1 in 800 to 1 in 1500 pregnancies. The role of chemotherapy in persistent/malignant disease is well established. Hysterectomy is often performed in women no longer desirous of fertility.

Objectives: The aim of this study was to review gestational trophoblastic disease over a 15 year period in the Hunter New England region of New South Wales. The second part of the study was to review the literature regarding the surgical management of GTD and present an interesting case to highlight the variation in management between specialised centres.

Results: During the period between 1998 and 2013, there were 29 cases of gestational trophoblastic disease treated at the Hunter New England Centre for Gynaecological Cancer in Newcastle. Of these, 6 were confirmed as choriocarcinoma, and 10 women had persistent gestational trophoblastic neoplasia. 52% of women required chemotherapy and 13.7% of women had evidence of metastases at presentation. There was a recurrence rate of 3%. There were no deaths.

Conclusion: Chemotherapy remains the mainstay of treatment for malignant or persistent GTD.

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Saturday 6th July, 2013

Investigators Meeting – A Phase II Randomised Clinical Trial of Mirena® ± Metformin ± Weight Loss in Patients with Early Stage Cancer of the Endometrium

Time: 8.00am – 9.00am

Presenters: Kristy Mann, NHMRC Clinical Trials Centre, Sydney,

Andreas Obermair and Monika Janda

Notes:

Saturday 6th July, 2013

ASGO DEBATE

That para aortic lymphadenectomy should be a routine part of staging for endometrial cancer

Time: 9.00am – 10.30am **Session Chair:** Jim Nicklin

Supporting: Orla McNally, William Cliby, Tom Manolitsas

Against: Bryony Simcock, Russell Land, Greg Robertson

Notes:

SPONSOR PRESENTATION BY OLYMPUS

Notes:

Saturday 6th July, 2013		
Surgeons Corner & Tumour Board – Best Presentation will be awarded the Tony McCartney Surgical Innovation Prize		
Time:	11.00am – 12.30pm	
Presenters:	Andreas Hackethal, Cindy Pang	**Session Chair:** Russell Land

Abstract: Considerations for safe and effective Gynaecological Laparoscopic Surgery in obese cancer patients

Presenter: Dr Andreas Hackethal

Authors: Andreas Hackethal, Donal Brennan, Archana Rao, Russell Land, Andrea Garrett, Alex Crandon, Lew Perrin, Jim Nicklin, Andreas Obermair, Naven Chetty

Background
The number of obese and morbidly obese patients with gynaecologic cancers is dramatically increasing within the last 20 years. Apart from demographical changes, obese patients are especially prone to have estrogen dependent neoplasias, of which laparoscopic treatment should be the standard of care. The increasing number of patients with BMI>40 is concerning, making it necessary to summarise considerations for safe and effective Gynaecological Laparoscopic Surgery.

Considerations
The sequel to successful laparoscopic surgery in obese patients compromises an interdisciplinary appreciation of laparoscopy. Successful laparoscopic surgery in the obese patients requires a multidisciplinary approach.
Preoperatively, anaesthetics and medical review is suggested to optimise treatment of comorbidities (i.e. infections and blood sugar levels), and reduce complications. Bowel preparation allowing for decompression of the recto-sigmoid is important to improve pelvic exposure.

Barriatric operating table, strips, instruments and standing platforms adds to safety of the procedure for the patient, as well as minimising injury to staff.
Positioning of the patient should consider anti-slip options and pannus fixation to ease laparoscopic access and decrease pressure to the chest. Reducing thoracic pressure is vital to allow safe ventilation pressures and thereby allows for appropriate Trendelenburg position- as pelvic laparoscopy is not possible without a 'head down' position.

There is no standard port placement in obesity laparoscopy, landmarks have to be the bony structures of the pelvis and ribs. Care should be taken to position ports towards the pelvis, so the that surgeon does not have to push against the port in order to direct an instrument toward the pelvis. Retraction of the bowel is essential and mobilisation of the sigmoid with dissection of the sigmoid reflection, fan retractors or endoloops can accomplish adequate vision. 30° scopes can be considered for vision „around the obstacle". An experienced assistant with anticipation of surgical steps is favourable for successful surgery completion.

Intraoperatively, good surgical techniques are essential. Vessel sealing systems reduce the need for instrument changes and may be helpful in following visualised tissue planes. A transvaginal vault closure may be advantageous compared to laparoscopic closure and Endostiches may be preferred to close the fascia of large trocar sites under vision.

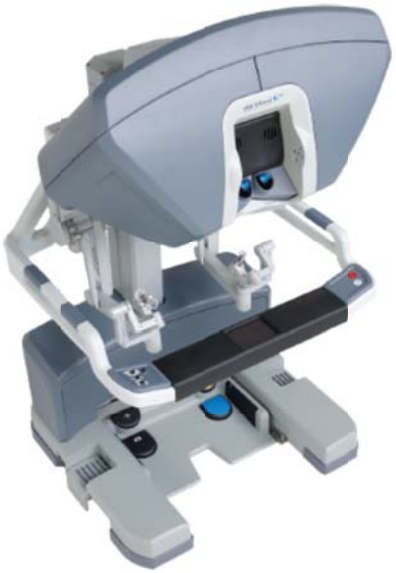
Notes:

da Vinci Surgery

HYSTERECTOMY

FOR EARLY STAGE GYNAECOLOGIC CANCER

Enables precise, comprehensive minimally invasive surgery for early stage gynaecologic cancer



The visualisation, dexterity and control allows surgeons:

- To treat early stage gynaecologic cancer in a minimally invasive, reproducible way that follows an open surgical technique
- Greater access, precision and control for improved dissections with lower EBL[1,2]
- Improved radicality, margins and lymph node harvest or a more comprehensive cancer surgery & staging procedure[1,2]
- Control of the camera and all three operative arms for the ultimate in surgical autonomy and efficiency
- The potential to improve practice efficiency with simplified post-operative care

[1]Source: Statement from Dr John F. Boggess, reference PN 87139. [2]Source: Statement from Dr John F. Boggess, SGO 2007 Debate "Radical Hysterectomy: Robotic versus Laparoscopy".

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Abstract: Radical Modified hysterectomy, pelvic lymphadenectomy using ligasure – the modified PUNE technique

Presenter: Cindy Pang

We performed a radical modified hysterectomy, pelvic lymphadenectomy for a patient with stage 1B1 perivascular epithelioid cell tumor (PEComa) of the uterine cervix. The highlights of our technique include dissection of the pararectal space and retrovaginal space the start of the surgery for ureterolysis and ligation of the uterine artery, as well as the use of ligasure (Covidien) for blunt dissection of the spaces and ureteric tunnels.

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Abstract: A Port in the Storm - an innovative use of laparoscopy in an unusual case of uterine rupture

Presenter: Cindy Pang

Authors: Dr Cindy Pang MBBS MRCOG, Dr Stephen Lee MBBS (Melb) MBA FRANZCOG, Dr Jason Tan MBBS FRANZCOG CGO

This video presentation demonstrates the surgical technique employed to reattach the uterus and cervix to the vagina followed by the repair of the significant uterine rupture via a laparoscopic approach with the novel application of everyday surgical tools.
The 30 year old had undergone an urgent ventouse extraction for prolonged fetal bradycardia in the second stage of labour.
Immediately following delivery, fatty tissue was extruded through the vagina. Bimanual examination revealed a large anterior full thickness uterovaginal tear with communication with the peritoneal cavity.
As the patient was clinically stable, a decision was made to perform a diagnostic laparoscopy to assess the injury.
Findings were of a detached uterus from the vagina with narrow intact vagina posteriorly, as well as this a longitudinal midline uterine rupture extending toward the uterine fundus was also observed.
Due to the minimally invasive surgical approach, the patient underwent an uncomplicated postoperative recovery and was able to be discharged home on day 3 postoperatively.

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Saturday 6th July, 2013

Keynote Address: ASCO Update

Time: 1:30pm – 2:15pm

Presenter: Michael Frielander **Session Chair:** Marcelo Nascimento

Notes:

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