2015 ASGO ANNUAL SCIENTIFIC MEETING

Together we eradicate Gynaecologic Cancer: An AustralAsian collaboration

Golden Sands Resort, Penang, 8th to 11th July 2015

Abstract Booklet

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2015 ASGO Scientific Program

Wednesday 8th July

12.30pm – 1.30pm	*Registration and Lunch* **Room:** Cassia Room & Garden Cafe
1.30pm – 4.00pm	**Fellows Education** **Facilitator:** Sellva Paramasivam **Room:** Bunga Raya Ballroom
1.30pm – 2.15pm	Pathology **Presenter:** Jim Scurry
2.15pm – 3.00pm	Radiation Oncology **Presenter:** Pearly Khaw
3.00pm – 3.45pm	Medical Oncology **Presenter:** Ganessan Kichenadasse
3.45pm – 4.00pm	Climate Module **Presenter:** Andrea Garrett
4.00pm – 4.45pm	**Mock OSCE and Exam Workshop** Sellva Paramasivam, Ken Jaaback & Ganendra Mohan
7.00pm – 10.30pm	**Welcome Reception** Sigi's Outdoor, Golden Sands Resort

Thursday 9th July

8.15am – 8.45am	*Trade Exhibition Open* **Room:** Cassia Room
8.45am – 10.30am	**Plenary Session** **Chair:** Sellva Paramasivam **Room:** Bunga Raya Ballroom
8.45am – 9.00am	**Welcome by Chair ASGO 2015** – Sellva Paramasivam **Opening of Meeting by ASGO President** – Jim Nicklin
9.00am – 9.45am	**Keynote Presentation:** Sentinel node mapping in Endometrial cancer **Presenter:** Richard Barakat
9.45am – 10.30am	**Keynote Presentation:** Therapeutic HPV vaccination: Ready for Prime Time? **Presenter:** Warner Huh
10.30am – 11.00am	*Morning Tea and Trade Exhibition* **Room:** Cassia Room
11.00am – 12.15pm	**Plenary Session Continued** **Chair:** Martin Oehler **Room:** Bunga Raya Ballroom
11.00am – 11.45am	**Keynote Presentation** The Anatomy of Complications: a personal reflection on 30 years of surgical practice **Presenter:** Ian Hammond
11.45am – 12.15pm	**Keynote Presentation:** Radical Surgery in Ovarian Cancer **Presenter:** Richard Barakat
12.15pm – 1.10pm	**Free Paper Presentations** **Chair:** John Miller Hyperthermic Intraperitoneal Chemotherapy (HIPEC) and Cytoreductive Surgery (CRS) in Ovarian cancer: A Systematic Review and Meta-analysis – *Anthony Richards* Telehealth – Improving Care for Rural Gynaeoncology Patients? – *Nimithri Cabraal* Pelvic Tuberculosis: A Great Mimic of Ovarian Malignancy – *Arivendran Raja* Clinical and contactability characteristics of young women at risk for cervical dysplasia and malignancy – *Helen Green*
1.10pm – 2.00pm	*Lunch, Trade Exhibition and Poster Presentations* **Room:** Cassia Room **Poster titles:** Flinders Ovarian Cancer Group Support (Fogs) – Building A Cancer Support Group. What Works? – *Helen Gray* "Life, not cancer" – a pilot of community based survivorship care delivery in Southern Adelaide – *Michael Fitzgerald, Melinda Richardson, Catherine Hughes, Bogda Koczwara* Supporting Return to Employment after Cancer in Disadvantaged Communities – *A Marshall, V Knott, M Bareham, P Ward, J Emery, J Fallon-Ferguson, I Olver, B Koczwara* Helping women with ovarian cancer make difficult treatment decisions: the development and evaluation of two decision aids – *Ilona Juraskova, Carissa Bonner, Gabriella Heruc, Caroline Anderson, Kathryn Nattress, Jonathan Carter*
2.00pm –3.20pm	**Free Paper Presentations** **Chair:** John Miller Peutz Jeghers Syndrome: A Diagnostic and Treatment Challenge for Gynaecological Oncologists – *Chloe Ayres* Uterine conserving strategies in management of choriocarcinoma – *Pearl Tong* Mathematical prognostic models for predicting survival in ovarian cancer patients – A meta-analysis of validation studies for prognostic indices and nomograms – *Maximilian Klar* Hypoxia-induced microRNAs in whole blood as a novel biomarker for epithelial ovarian cancer – *Adam Pendlebury* Desseminated Leiomyomatosis Peritonei – *Kristen Moloney* Single stoma formation in total pelvic exenterative surgery for recurrent gynaecological malignancy: the double-barreled wet colostomy – *Michelle Harris*
3.30pm – 5.30pm	**Games for Delegates and Families** Golden Sands Resort

Friday 10th July

8.00am – 8.30am	*Trade Exhibition Open* **Room:** Cassia Room
8.30am – 10.50am	**Plenary Session** **Chair:** Jim Nicklin **Room:** Bunga Raya Ballroom
8.30am – 9.00am	**Keynote Presentation:** Primary HPV Screening for Cervical Cancer: Why and How **Presenter:** Warner Huh
9.00am – 9.30am	**Keynote Presentation:** The Times They Are A-changin': Renewal in Australia **Presenter:** Ian Hammond
9:30am – 10:50am	**Asian Society Symposia on Cervical Cancer** Changing Concepts in Early Stage Cervical Cancer Surgery – *Jong-Yeol Park, University of Ulsan College of Medicine, Korea* Robotic nerve-sparing radical hysterectomy for cervical cancer – *Masaki Mandai, Kinki University School of Medicine, Japan* Neoadjuvant chemotherapy for locally advanced cervical cancer – *Yin Nin Chia, KK Women's and Children's Hospital, Singapore* Gynaecological Oncology Services in Malaysia – *Suresh Kumarasamy*
10.50am – 11.10am	*Morning Tea and Trade Exhibition* **Room:** Cassia Room
11.10am – 12.30pm	**Plenary Session Continued** **Chair:** Tom Jobling **Room:** Bunga Raya Ballroom
11.10am – 11.45am	**Keynote Presentation** Robotic surgery in Gynaecologic Cancer **Presenter:** Richard Barakat
11.45am – 12.30pm	**Keynote Presentation:** An Update on HPV Vaccination – The Impact of Nonavalent Entry HPV vaccine **Presenter:** Warner Huh
12.30pm – 12.40pm	**Sponsor Presentations**
12.40pm – 1.30pm	*Lunch, Trade Exhibition and Poster Presentations (poster titles are displayed on previous page)* **Room:** Garden Cafe
1.30pm – 3.00pm	**Free Paper Presentations** **Chair:** Sue Valmadre **Room:** Bunga Raya Ballroom Single site robotic procedures for Gynaecological Oncology – *Felix Chan* Sentinel lymph node biopsy in early stage Endometrial Cancer: An exploration of different dyes and routes of administration – *Orla McNally* Comparison of cold knife cone biopsy and loop electrosurgical excision procedure in the management of cervical adenocarcinoma in situ: What is the gold standard? – *Yee Leung* Loco-regional disease control and survival in epithelial cancers – *Kailash Narayan* Cervix Carcinoma treated with Radiotherapy in the Elderly: Patterns of Management and Outcomes from Peter MacCallum Cancer Centre 1998-201 – *Ming Yin-Lin*
7.00pm	**Penang Hawkers Sarong Party** Raintree Garden, Rasa Sayang

Saturday 11th July

8.00am – 9.00am	*Trade Exhibition Open* **Room:** Cassia Room
9.00am – 10.30am	**Free Paper Presentations** **Chair:** Yee Leung **Room:** Bunga Raya Ballroom HE4, CA125, ROMA and RMI - a prospective comparison in the pre-operative evaluation of adnexal and pelvic masses in an Australian population – *Anthony Richards* Screening for ovarian cancer with any degree of reliability is at this time non existent – *Thomas Jobling* Autoantibodies for early diagnosis of ovarian cancer – *Martin Oehler* Structured Surgical Records: The Time Has Surely Arrived! – *Robert Rome* Discussing sexual function in women considering risk-reducing salpingo-oophorectomy: self-reported rates amongst Gynaecological Oncologists in Australia and New Zealand & Sexuality and quality of life after risk-reducing salpingo-oophorectomy: a retrospective study – *Paige Tucker* Metastatic choriocarcinoma in pregnancy: a case report – *Shih-Ern Yao*
10.30am – 11.00am	*Morning Tea and Trade Exhibition* **Room:** Cassia Room
11.00am – 12.00pm	**Surgeons Corner & Best Presentation will be awarded the Tony McCartney Surgical Innovation Prize** **Chair:** Sellva Paramasivam **Room:** Bunga Raya Ballroom Combined mini-laparotomy and laparoscopy for the ovarian cystic mass >10cm – *Paige Tucker* A Novel Technique to Remove Tumour Deposits on Bowel, Peritoneal and Mesentery Surfaces to Achieve Optimal Cytoreductive Surgery in Cases of Advance Ovarian Cancer – *Arivendran Raja* Management of an obturator lymphocyst – *Penny Blomfield* Suction curette assisted laparoscopic hysterectomy for endometrial cancer – *Chloe Ayres* Conversion of a Gastric Band into an Intraperitoneal Port in a Patient with Optimally Debulked Stage 3C Serous Ovarian Carcinoma – *Paige Tucker*
12.00pm – 1.00pm	**Tumour Board** **Chair:** John Miller **Presenters:** Simon Hyde, Martin Oehler & Russell Hogg **Room:** Bunga Raya Ballroom
1.00pm – 1.30pm	*Lunch and Trade Exhibition* **Room:** Garden Cafe
1.30pm – 3.30pm	**ASGO AGM** **Room:** Bunga Raya Ballroom
7.00pm	**Gala Dinner** Eastern & Oriental Hotel

ASGO General Information

ASGO Committee of Management

Chairman: Jim Nicklin

Committee Members: Greg Robertson, Rob Rome

Professional Conference Organiser: Mary Sparksman

ASGO Organising Committee:

Conference Chair: Sellva Paramasivam

Committee Members: John Miller, Martin Oehler

Secretariat

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

Wednesday 8th July	12.30pm – 4.45pm
Thursday 9th July	8.15am – 3.30pm
Friday 10th July	8.00am – 3.00am
Saturday 11th July	8.00am – 1.30pm

Mary Sparksman and Emily Adams
YRD Event Management
PO Box 717
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Mobile: +447452247718
+61 418 877 279

Invited Speakers

Dr Richard Barakat
Prof Warner K Huh
Prof Ian Hammond

Social Program

Wednesday 8th July	7.00pm to 10.30pm	Welcome Reception/Beach BBQ (Family Friendly) Dress: Smart Casual Sigi's Outdoor, Golden Sands Resort
Thursday 9th July	From 3.30pm onwards	Games for Delegates and Families Dress: Active Wear Free night to explore the night markets and local restaurants of Batu Ferringhi
Friday 10th July	7.00pm to 10.30pm	Penang Hawkers Sarong Party (Family Friendly) Dress: Smart Casual (Please wear your sarong) Raintree Garden, Shangri-La's Rasa Sayang Resort and Spa
Saturday 11th July	7.00pm to 11.00pm	Gala Dinner, Wine, Dine & Dance and Closing Ceremony Dress: We encourage male delegates to wear the Malaysian Batik shirt (long or short sleeve) or any smart casual shirt. Tie is not essential. Female delegates can dress cocktail or any traditional attire. Eastern & Oriental Hotel, Penang

Disclaimer:

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

Wednesday 8th July 2015

SESSION: Fellows Education
Presenters: Jim Scurry, Pearly Khaw, Ganessan Kichenadasse, Andrea Garrett
Time: 1.30pm – 4.00pm
Facilitator: Sellva Paramasivam

Pathology

Jim Scurry

Notes:

Radiation Oncology

Pearly Khaw

Notes:

Medical Oncology

Ganessan Kichenadasse

Notes:

Climate Module

Andrea Garrett

Notes:

Mock OSCE and Exam Workshop

Sellva Paramasivam, Ken Jaaback & Ganendra Mohan

Notes:

Thursday 9th July 2015

SESSION: Keynote Presentations
Presenters: Richard Barakat, Warner Huh
Time: 9.00am – 10.30am
Chair: Sellva Paramasivam

Sentinel Node Mapping in Endometrial Cancer

Richard Barakat[1]

1. *Memorial Sloan-Kettering Cancer Centre, New York*

Since the pioneering study by Burke et al. From the MD Anderson Cancer Center, which was published in 1996, numerous investigators have explored the concept of sentinel node mapping for endometrial cancer. Detecting nodal metastasis can guide the need for adjuvant therapy which is critical in the management of patients with endometrial cancer, while avoiding the morbidity of radical lymphadenectomy. We will review the role of image guided surgery in the detection of nodal metastasis in women with endometrial cancer.

Notes:

Therapeutic HPV vaccination: Ready for Prime Time?

Warner Huh[1]

1. *University of Alabama, Birmingham*

Cervical neoplasia is the ideal disease process for immunotherapy given the majority of cases are associated with HPV. With its ubiquitous presence, researchers have a common target to create immunotherapeutic approaches. This presentation will discuss the natural history of cervical neoplasia, the rationale and unmet clinical need for non-surgical treatment options, and known limitations and concerns associated with therapeutic HPV vaccination. Finally, the presentation will review recent clinical trial data and discuss whether we really need a non-surgical option.

Notes:

Thursday 9th July 2015

SESSION: Keynote Presentations
Presenters: Ian Hammond, Richard Barakat
Time: 11.00am – 12.15pm
Chair: Martin Oehler

The Anatomy of Complications: A personal reflection on 30 years of surgical practice

Ian Hammond [1]

1. *National Cervical Screening Program, Department of Health, Australia*

Very few, if any, gynaecologic oncologists or gynaecologists will complete their career without experiencing complications of surgery. I am no exception and my reflections on clinical practice; surgical training; prevention and management of complications; communication style; and the role of clinical audit, may be of interest. I will consider 5 areas related to my clinical practice.

Complications

The practical management of complications, both intra and postoperative, will be considered in the context of responsibility for the problem and communication with the patient and colleagues. Intraoperative complications are usually unexpected, always upsetting and may be life threatening.

Acceptance of responsibility for the complication and subsequent management is the role of the 'clinician in charge' of the case, no matter who is actually technically responsible.

Ascertain and clarify your role when called to the operating theatre to help a colleague in trouble. It is crucial to determine your role (primary surgeon or assistant) on arrival. Failure to ascertain and clarify your role may be hazardous for all concerned including the patient. Disclosure and appropriate communication, with the patient and her family, regarding a complication is essential and should not be delegated to the most junior member of the team. Learning how to communicate in this fraught situation is important and should be specifically taught by example and team discussions.

The Anatomy of Complications Workshop

Since 2000 there have been over 100 workshops held in Australia, Singapore, Hong Kong and New Zealand. The objective is to provide practical education for O&G specialists and trainees about the prevention and management of complications in O&G surgery. The role of the AC workshop in contemporary practice will be presented and critically reviewed.

Surgical Training

In 2015 limitation of surgical experience, training and competencies of 'new' O&G specialists is of concern. Surgical teaching is an important part of the gynaecologic oncologist's role and should be structured, educationally sound and constructively critical, ensuring a nurturing and enjoyable positive learning environment. Criticism should be avoided in the operating room and saved for private discussion at a later time.

Audit

Clinical audit (established in one hospital where I worked), based on the ACHS Clinical Indicator Program was interesting but not particularly helpful if specific complications were to be measured, addressed and improvements made. Other systems including the Clavien-Dindo classification may be more relevant. Today, there is little reason for surgeons not to engage in a comprehensive computerized surgical audit, both in private and public domain, though many public hospitals fail to support this initiative with financial support. If you can't measure it, you can't manage it.

Communication

Patient understanding and involvement in decision-making and consent is increasingly recognized as a necessary, but sometimes inconvenient and challenging, part of clinical practice. Communication skills are critical for this aspect of practice, especially 'active listening' and even more important when one is involved in open disclosure about a complication.

Finally, some aphorisms consequent on my reflections will be presented.

Notes:

Radical Surgery in Ovarian Cancer

Richard Barakat[1]

1. *Memorial Sloan-Kettering Cancer Centre, New York*

Surgery for advanced stage ovarian cancer, also termed "tumor debulking", is defined as an attempt to maximally resect all visible and palpable disease. This concept is a rare surgical strategy in the field of oncology, because it is restricted to merely minimizing the tumor burden as opposed to achieving a complete pathologic resection (with negative margin status) and it is not applicable, nor justified for the majority of other solid tumors. It is debatable whether it is the surgical procedure itself that is responsible for the superior outcome associated with smaller residual disease, or whether the ability to achieve minimal residual disease simply identifies a biologically more favorable patient subgroup with excellent response to postoperative systemic chemotherapy. Controversy exists as to how much surgical effort should be undertaken to achieve optimal residual disease status before reaching the point of subjecting the patient to the morbidity of a surgical procedure that is of no or only minimal oncologic benefit. We will address role of radical surgery in advanced ovarian cancer.

Notes:

Thursday 9th July 2015

SESSION: Free Paper Presentations
Presenters: Anthony Richards, Nimithri Cabraal, Arivendran Raja, Helen Green
Time: 12.15pm – 1.10pm
Chair: John Miller

Hyperthermic Intraperitoneal Chemotherapy (HIPEC) and Cytoreductive Surgery (CRS) in Ovarian cancer: A Systematic Review and Meta-analysis

Anthony Richards [1] , *Ya Ruth Huo* [1 2] , *Winston Liauw* [3] , *David L Morris* [1 2]

1. *Department of Surgery, St George Hospital, University of New South Wales, Kogarah, Sydney*
2. *St George Clinical School, University of New South Wales, Sydney*
3. *Cancer Care Centre, St George Hospital, Kogarah, Sydney*

PURPOSE: Emerging evidence suggests that hyperthermic intraperitoneal chemotherapy (HIPEC) with cytoreductive surgery (CRS) shows a survival benefit over CRS alone for patients with epithelial ovarian carcinoma (EOC). This systematic review and meta-analysis will assess the safety and efficacy of HIPEC with CRS for EOC.

DESIGN: Searches of five databases from inception to 17/02/15 was performed. Clinical outcomes were synthesized, with full tabulation of results.

RESULTS: A total of 9 comparative studies and 28 studies examining HIPEC+CRS for primary and/or recurrent EOC were included. Meta-analysis of the comparative studies showed HIPEC+CRS+chemotherapy had significantly better 1-year survival compared with CRS+chemotherapy alone (OR: 3.76, 95% CI 1.81-7.82). The benefit of HIPEC+CRS continued for 2-, 3-, 4-, 5- and 8-year survival compared to CRS alone (OR: 2.76, 95% CI 1.71-4.26; OR: 5.04, 95% CI 3.24-7.85; OR: 3.51, 95% CI 2.00-6.17; OR: 3.46 95% CI 2.19-5.48; OR: 2.42, 95% 1.38-4.24, respectively). Morbidity and mortality rates were similar. Pooled analysis of all studies showed that among patients with primary EOC, the median, 1-, 3-, and 5-year overall survival rates are 46.1 months, 88.2%, 62.7% and 51%. For recurrent EOC, the median, 1-, 3-, and 5-year overall survival rates are 34.9 months, 88.6%, 64.8% and 46.3%. A step-wise positive correlation between completeness of cytoreduction and survival was found.

CONCLUSION: The addition of HIPEC to CRS and chemotherapy improves overall survival rates for both primary and recurrent EOC.

Notes:

Telehealth – Improving Care for Rural Gynaeoncology Patients?

Nimithri Cabraal [1]

1. *John Hunter Hospital, NSW*

Background

Hunter New England Centre for Gynaecological Cancer in Newcastle provides a service for women in an area encompassing 132 000 km2 in New South Wales, Australia. For many women there are significant emotional and financial stressors related to time and travel costs.

Objectives

To determine whether patients are satisfied with video conferencing of new patient consultations and also to determine whether there is any impact on clinical decision making for surgery as a result of video rather than in person consultations.

Method

A retrospective patient satisfaction survey was undertaken of a 100 video conference patients. A retrospective review was undertaken of all new patient consultations resulting in surgery (both video and in person) in a 12 month period. The aim of the review was to look at whether there was a difference in between the 2 groups in the planned vs actual surgery undertaken.

Results

Screening of the first 100 patients showed 100% overall patient satisfaction. There was no significant difference in alteration of surgical plans between the groups.

Notes:

Pelvic Tuberculosis: A Great Mimic of Ovarian Malignancy

Arivendran Raja[1]

1. *Gynaecology Onclogy , Hospital Sultan Ismal, Johor Bahru, Malaysia*

Tuberculosis is very prevalent in South East Asia especially in Malaysia. According to the World Health Organization there were 9 million new cases in 2013. The incidence of Extrapulmonary Tuberculosis is approximately 15 to 20 percent. The proportion of extrapulmonary in all active cases has increased in recent years. Thus in countries where Tuberculosis is prevalent, it would not be uncommon for gynaecologist to have patients with pelvic Tuberculosis whose symptoms clinically mimic ovarian cancer due to the presence of an adnexal mass, ascites, and raised CA-125 levels.

We would like to present such a case of an adolescent girl who initially presented with generalized tonic clonic seizures. She was also noted to have progressive abdominal distension with a pelvic mass. Radiological images were suggestive of an advance ovarian malignancy with brain metastases. This was supported with elevated tumour markers. Her seizures were controlled with antiepileptics, however her abdominal distension was progressively increasing associated with discomfort. The primary diagnosis was stage 4 primary ovarian tumour with brain metastases. After a multi-disciplinary meeting and a lengthy discussion with her parents regarding surgery and fertility issues an exploratory laparatomy was performed. Intraoperatively she was noted to have advance disease with tumour deposits all over the peritoneum and almost the entire length of small and large bowel. Histopathological examination of the tumour deposits showed caseating granulomatous inflammation of tuberculous etiology. She was subsequently started on antituberculosis medication and responded well to treatment.

In conclusion, pelvic Tuberculosis can present with findings similar to ovarian malignancy, including an adenexal mass, ascites and raised tumour markers. Clinical findings, radiographic imaging and biochemical markers have very poor specificity and usually unhelpful in differentiating the two. A thorough history including risk factors and exposure can help us gyanecologist have a high index of suspicion in dealing with these patients. However rare pelvic tuberculosis is, we must always remember it is a great mimic of ovarian malignancy.

Notes:

Clinical and contactability characteristics of young women at risk for cervical dysplasia and malignancy.

Helen Green, Marcelo Nascimento, Gordon Wright, Angela Lin

Aim:

To describe clinical and contactability features of 350 women <28yrs treated at the Gold Coast University Hospital for cervical dysplasia/cancer and compare these to:

a) contactability features of a control group of same-age women accessing public health care for a non-gynaecological reason; and

b) clinical features of same-age women from state and national data.

Methodology:

Chart review of eligible women treated from 1.1.12 to 31.12.14 was performed. Contactability questionnaire was mailed to study and control groups.

Results:

A description of high-risk clinical features of the study group and a comparison to state and national data will be presented.

Data from mailed contactability questionnaire will be presented. Preliminary contactability data from follow up phone survey will be presented.

Notes:

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- Digene® HC2
- Roche cobas® HPV Test

CT/NG TESTING

- APTIMA® Combo 2 Assay
- BD ProbeTec™ Chlamydia trachomatis (CT)
- BD ProbeTec™ Neisseria gonorrhoeae (NG)
- Roche cobas® CT/NG

TRICHOMONAS TESTING

- APTIMA® Trichomonas Assay

References: 1. Data on file. Hologic, Inc.

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Thursday 9th July 2015

SESSION:	Free Paper Presentations
Presenters:	Chloe Ayres, Pearl Tong, Maximilian Klar, Adam Pendlebury, Kristen Moloney, Michelle Harris
Time:	2.00pm – 3.20pm

Peutz Jeghers Syndrome: A Diagnostic and Treatment Challenge for Gynaecological Oncologists

Chloe Ayres [1] , Gregory Gard [1] , Jayne Maidens [1]

1. *Department of Obstetrics and Gynaecology, Royal North Shore Hospital, Sydney, NSW, Australia*

Background and aims: PJS is an extremely rare autosomal dominant condition. Of interest to Gynaeoncologists, women with this syndrome are at increased risk of two rare malignancies requiring regular surveillance – adenoma malignum of the cervix and ovarian sex cord tumours with annular tubules (SCTAT). Not only are there limited case reports of PJS and its associated gynaeoncological malignancies, but the literature is controversial in terms of treatment and prognosis. We present the diagnostic and treatment challenge of a woman with PJS and a review of the current literature.

Methods: Our patient was followed closely from diagnosis with regular clinical review and various imaging modalities.

Results: Regular surveillance subsequently diagnosed adenoma malignum of the cervix, incidental SCTAT and a rectal SCC. After initial surgery and chemoradiation she currently remains radiologically free of disease.

Conclusion: This case emphasizes the diagnostic and treatment challenge of PJS and its associated gynaeoncological malignancies.

Notes:

Uterine conserving strategies in management of choriocarcinoma

Pearl Tong [1] , A Ilancheran

1. *Gynaecologic oncologic fellow , National University Hospital, Singapore*

Choriocarcinoma has been traditionally treated with chemotherapy. Hysterectomy is indicated in the following circumstances- in reducing tumour burden in cases where disease is limited to the uterus, there is inadequate response to single-agent chemotherapy and/ or the patient has already completed her family. In our case series of 4 patients treated by a gynaecologic oncologist with a special interest in gestational trophoblastic neoplasia in our institution, we illustrate the possibility of a uterine-conserving strategy, even when the disease is confined to the uterus, or when there is inadequate response to chemotherapy in terms of a lack of decrease in the human chorionic gonadotropin levels. In one of the cases, a nulliparous young lady diagnosed with choriocarcinoma in her uterus, responded to local excision of the disease foci followed by chemotherapy. Conservation of her uterus had allowed her the option of future fertility, without compromising success of treatment of the choriocarcinoma.

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Mathematical prognostic models for predicting survival in ovarian cancer patients – A meta-analysis of validation studies for prognostic indices and nomograms

Maximilian Klar [1], *M K Oehler* [1]

1. *Department of Gynaecological Oncology, Royal Adelaide Hospital, Adelaide, SA*

Background:

Decisions about curative or palliative therapies in ovarian cancer patients rely substantially on the assessment of prognosis and future events. For various malignancies, prognostic models have shown superiority in comparison to conventional staging systems.

Methods:

We performed a systematic literature review and meta-analysis of studies between 2005 and 2015 that validated prognostic models of survival in ovarian cancer patients. Inclusion criteria were internal or external validation studies which presented discrimination and/or calibration measures to assess the performance of the individual model. Exclusion criteria were development studies and studies which described independent prognostic factors without including these in a new prognosis model.

Results:

We identified 32 studies which validated internally or externally a prognostic index or a nomogram in ovarian cancer patients. The *concordance (c)* indices of these models ranged between 0.60 and 0.74 compared to 0.54 and 0.62 for FIGO stage.

Conclusion:

The assessed prognostic models appeared to be superior when compared with conventional FIGO staging for prognosis assessment. Some models have the potential to significantly improve patient stratification in clinical trials and patient counselling.

1. *Please refer to external document*

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Hypoxia-induced microRNAs in whole blood as a novel biomarker for epithelial ovarian cancer

Adam Pendlebury [1 2] , *P Grant* [1] , *S Tong* [1] , *C Whitehead* [1 3]

1. *Mercy Hospital for Women, Heidelberg, VIC, Australia*
2. *King Edward Memorial Hospital, Subiaco, WA, Australia*
3. *Women's and Children's Hospital, North Adelaide, SA, Australia*

Introduction: Epithelial ovarian cancer (EOC) is not diagnosed until an advanced stage due to lack of reliable screening tests. MicroRNAs are involved in the initiation and progression of cancer, and may be ideal biomarkers for EOC. Hypoxia is key to the pathogenesis of EOC and hypoxia-induced microRNAs are dysregulated in EOC tissue. We hypothesized that hypoxia-induced microRNAs may be dysregulated in the blood with EOC, and be an ideal biomarker for EOC.

Methods: Whole blood was collected from 8 cases of EOC and 5 controls with benign masses. mRNA and miRNA were extracted using the PAXgene system and RT- PCR performed using Taqman miRNA and mRNA assays.

Results: Both hypoxia mRNAs and microRNAs were detectable in whole blood. There was no difference in the expression hypoxia-induced mRNA in HIF1μ or HIF2μ. The expression of hypoxia-induced microRNAs (miR 200a, miR 200b, miR 200c, miR 21, miR201 and miR424) increased in women with EOC compared to benign ovarian masses.

Conclusions: The miRNAs examined in this study show promise as biomarkers of EOC. Further validation studies are required to verify this result in a larger cohort of women with ovarian masses.

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Desseminated Leiomyomatosis Peritonei

Kristen Moloney, Simon Hyde

Disseminated leimyomatosis peritonei (DLP) is a rare clinical entity of uncertain aetiology. Though benign, this condition can demonstrate quasi-malignant disseminative activity and significant burden of disease.

We discuss a case of DLP in a 47yo female requiring novel multi-disciplinary management. Our patient presented with closed loop small bowel obstruction, requiring laparotomy and bowel resection. Her disease then evolved to adhesive large bowel obstruction managed via venting ascending colostomy. Definitive management was via induction of menopause, debulking laparotomy and high anterior resection.

Less than 200 cases of DLP have been described, with no consensus regarding management. Though not applicable to our case, some evidence does suggest increased frequency of DLP with morcellation.

This case highlights the serious sequelae of a conventionally "benign" condition; stimulates discussion of management options and lends weight to necessity for review of current surgical protocols to prevent intra-perintoneal disseminaton of gynaecologic tumor, be it benign or malignant.

Notes:

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Single stoma formation in total pelvic exenterative surgery for recurrent gynaecological malignancy: the double-barreled wet colostomy

Michelle Harris [1], DPJ Barton [1], J Ash [1], A Fernandes [1], A Thompson [1]

1. *Department of Gynaecological Oncology and Department of Urology, The Royal Marsden Hospital, London*

Patients undergoing total pelvic exenteration for recurrent gynaecological malignancy face an extraordinarily long surgical procedure, with a significant risk of perioperative complications and a prolonged recovery phase. Robust preoperative counseling and multidisciplinary planning is fundamental, and this should include discussion of options for urinary and faecal diversion.

Increasingly, we are finding a role for the double-barreled wet colostomy in these cases. From the surgical perspective the operating time is shortened, and the number of anastomoses is reduced. Both of these factors have the potential to decrease complication rates. The patient has only one stoma to contend with post-operatively, and this may ease the physical and psychological burden of recovery.

The literature is reviewed and a series of cases presented.

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Friday 10th July 2015

SESSION: Keynote Presentations
Presenters: Warner Huh, Ian Hammond
Time: 8.30am – 9.30am
Chair: Jim Nicklin

Primary HPV Screening for Cervical Cancer: Why and How

Warner Huh[1]

1. *University of Alabama, Birmingham*

On April 24th 2014, the United States Food and Drug Administration (FDA) approved high risk HPV (hrHPV) testing for primary cervical cancer screening in the United States (US). This was following unanimous support (13-0) from the FDA Medical Devices Advisory Committee Microbiology Panel Meeting, which included numerous US experts in the area of cervical cancer screening and prevention, in March 2014. This approval was based and supported from data derived from the ATHENA (Addressing the Need for Advanced HPV Diagnostics) trial. ATHENA, the largest cervical cancer screening study conducted in the US, was a registration study sponsored by Roche Molecular Systems that utilized the cobas® 4800 system. The public announcement of an FDA application by Roche for a primary HPV screening claim triggered the creation of an interim guidance panel to review recent evidence and address specific questions and concerns regarding using a hrHPV test for primary screening, including ATHENA and data relevant to the primary HPV screening labeling. This presentation will discuss the rationale of primary HPV screening, the known limitations of cytology, and the performance of screening in a vaccinated population.

Notes:

The Times They Are A-changin': Renewal in Australia

Ian Hammond [1]

1. *National Cervical Screening Program, Department of Health, Australia*

Background: Since 1991,the extremely successful National Cervical Screening Program (NCSP) has offered routine screening with Pap smears every 2 years for women between the ages of 18 and 69 years. The incidence and mortality rates for cervical cancer have decreased by approximately 50 per cent, but have plateaued since 2002. In 2011 the Australian Government commenced the Renewal of the NCSP to ensure the continuing success of the program and that all Australian women, HPV vaccinated and unvaccinated, have access to a cervical screening program that is based on current evidence and best practice.

Outcomes: After a rigorous and transparent process, the Medical Services Advisory Committee considered the Evidence and Economic Modeling reviews. In April 2014 they recommended:

o Five yearly cervical screening using a primary HPV test with partial HPV genotyping and reflex liquid based cytology (LBC) triage, for HPV vaccinated and unvaccinated women 25 to 69 years of age, with exit testing of women up to 74 years of age

o Self collection of an HPV sample, for an under-screened or never-screened woman

o Invitations and reminders to be sent to women 25 to 69 years of age and exit invitations to be sent to women 70 to 74 years of age

These changes will result in up to 22% reduction in incidence and mortality of cervical cancer in Australia

Controversies: Some potentially controversial issues including later commencement age of screening, post vaccination decreased screening participation, self collection of samples for HPV testing, equity of costs, maintaining current workforce through transition to new program, will be discussed.

Implementation: The Australian Health Ministers Advisory Council (AHMAC) accepted these recommendations in September 2014 and implementation is planned for May 2017. The Steering Committee for the Renewal Implementation Project has oversight of this complex and innovative program. The Cervical Renewal Taskforce, at the Department of Health, will manage the project.

The Implementation Project has 5 core activities:

- MBS Items: Additions (HPV and LBC tests)/Deletions (Pap test) and Transition
- Registers: develop a system capability for a national approach to registers
- Workforce and Practice Change: cytologists, laboratories, registers and test collectors
- Safety and Quality: monitoring the program, including colposcopy data collection by the register
- Communication and Information: health professionals and consumers

This presentation will offer insight into the process, outcome, controversies and implementation of Renewal and what it means for you and your patients.

Documents can be accessed at www.cervicalscreening.gov.au *(Evidence and economic modeling documents and MSAC report)*

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Friday 10th July 2015

SESSION: Asian Society Symposia on Cervical Cancer
Presenters: Jong-Yeol Park, Masaki Mandai, Yin Nin Chia, Suresh Kumarasamy
Time: 9.30am – 10.50am
Chair: Jim Nicklin

Changing Concepts in Surgery of Early Stage Cervical Cancer (Korea)

Jong-Yeol Park

1. *Asian Medical Centre, Seoul*

Notes:

Robotic nerve-sparing radical hysterectomy for cervical cancer (Japan)

Masaki Mandai

1. *Kinki University School of Medicine, Osaka*

Notes:

Neoadjuvant chemotherapy for locally advanced cervical cancer (Singapore)

Yin Nin Chia

1. *KK Women's and Children's Hospital, Singapore*

Notes:

Gynaecological Oncology Services in Malaysia

Suresh Kumarasamy[1]

1. *Asian Society of Gynaecological Oncology*

Notes:

Friday 10th July 2015

SESSION:	Keynote Presentations
Presenters:	Richard Barakat, Warner Huh
Time:	11.10am – 12.30pm
Chair:	Tom Jobling

Robotic surgery in Gynaecologic Cancer

Richard Barakat[1]

1. *Memorial Sloan-Kettering Cancer Centre, New York*

Ongoing technological advances have transformed virtually every aspect of cancer care, but nowhere has that impact been more pronounced—or has the potential to touch so many lives—as in the field of surgery. Nearly 80 percent of all cancer patients undergo surgery as part of their care, and the development of minimally invasive procedures, including recent exciting developments in robotically assisted surgery, offer patients important benefits in terms of reduced pain and discomfort, faster recovery times, and more efficient and cost-effective treatments Memorial Sloan-Kettering Cancer Center has been a leader in revolutionizing the practice of cancer surgery. It was one of the first institutions in the world to acquire an advanced robotic platform, and, over the past decade, growing numbers of patients with gynecologic cancer have undergone robotic procedures as the technology has become more refined. We will review the role of robotic surgery for patients with gynecologic cancer with a focus on our experience at Memorial Sloan-Kettering Cancer center.

Notes:

An Update on HPV Vaccination – The Impact of Nonavalent Entry HPV vaccine

Warner Huh

1. *University of Alabama, Birmingham*

Notes:

Friday 10th July 2015

SESSION:	Free Paper Presentations
Presenters:	Felix Chan, Orla McNally, Yee Leung, Kailash Narayan, Ming–Yin Lin
Time:	1.30pm – 3.00pm
Chair:	Sue Valmadre

Single site robotic procedures for Gynaecological Oncology

Felix Chan [1]

1. *Director of Gynaecological Oncology , Southwest Sydney Area Health Service , NSW*

Single site laparoscopic procedure have used in benign gynaecology. It faces the difficulties of lack in triangulation, crashing of instruments, poor ergonomic and prolonged theatre time. With the development of robotic assisted instrumentation, complex gynaecological procedures and early stage gynaecological cancer can be managed with this surgical approach.

In this presentation, I describe the instrumentation and how it can be used for oncological application. Hysterectomy bilateral slapping-oophorectomy for risk reduction, early stage endometrial cancer, cervical cancer can be carried out using single incision resulting in patient can be discharged within 24 hours and with no significant complications and readmission.

Notes:

Sentinel lymph node biopsy in early stage Endometrial Cancer: An exploration of different dyes and routes of administration

Orla McNally [1] *, Ami Munro* [1] *, Shunit Armon* [1] *, Chloe Ayres* [1] *, Deborah Neesham* [1] *, Vivek Arora* [1]

1. *Royal Women's Hospital, Melbourne, Australia*

Introduction: The role of lymphadenectomy remains controversial in endometrial cancer. Sentinel lymph node biopsy (SLN) has been established in the management of breast, melanoma and vulval cancer but in endometrial cancer is proving to be more challenging in terms of technique and anatomical relationship of the sentinel node to the site of primary disease.

Objectives:

To prospectively assess the feasibility of currently available dye techniques.

Methods:

A prospective audit of the use of patent blue and fluorescent indocyanine green to detect the sentinel nodes in women with endometrial cancer and complex atypical hyperplasia was performed.

Results:

During a 6 month period 24 patients had sentinel lymph node assessment at the beginning of surgery. All 24 patients had blue dye injected into the cervix. Eleven patients had blue and indocyanine green (ICG) injections. At least one sentinel node was detected in 14 patients (detection rate 58% per patient). Fluorescence was noted in 10 of 11 patients who had ICG with bilateral node detection in 4 patients. When a fundal ICG injection was given and mapped to the pelvis, the location of the blue node was the same (N=6).

Conclusion:

Sentinel lymph node detection in endometrial cancer is acceptable and feasible. It should continue to be evaluated as there are challenges in perfecting the technique before becoming a substitute for pelvic and/or para-aortic lymphadenectomy.

Notes:

Comparison of cold knife cone biopsy and loop electrosurgical excision procedure in the management of cervical adenocarcinoma in situ: What is the gold standard?

*A Munro , **Yee Leung** , K Spilsbury , C.J.R. Stewart , J Semmens , J Codde , V Williams , P O'Leary , N Steel , P Cohen*

Objective. To compare the outcomes of patients with cervical adenocarcinoma in situ (ACIS) treated with cold knife cone (CKC) biopsy or loop electrosurgical excision procedure (LEEP) for the treatment of cervical adenocarcinoma in situ (ACIS).

Study design. This is a retrospective, population-based cohort study of Western Australian patients with ACIS diagnosed between 2001 and 2012. Outcomes included pathological margin status and the incidence of persistent or recurrent endocervical neoplasia (ACIS and adenocarcinoma) during follow-up (b12 months) and surveillance (≥12 months) periods.

Results. The study group comprised 338 patients including 107 (32%) treated initially by LEEP and 231 (68%) treated by CKC biopsy. The mean age was 33.2 years (range 18 to 76 years) and median follow-up interval was 3.6 years (range b1 year to 11.8 years). Overall, 27 (8.0%) patients had ACIS persistence/recurrence while 9 (2.7%) were diagnosed with adenocarcinoma during the follow-up and surveillance periods. No patient died of cervical cancer within the study period. There were no significant differences in the incidence of persistent and/or recurrent endocervical neoplasia according to the type of excisional procedure. Patients with positive biopsy margins were 3.4 times more likely to have disease persistence or recurrence.

Conclusions. LEEP and CKC biopsy appear equally effective in the treatment of ACIS for women wishing to preserve fertility. Patients undergoing conservative management for ACIS should be closely monitored, particularly if biopsy margins are positive in initial excision specimens. Patients and their clinicians should be aware of the potential risks of residual and recurrent disease.

Notes:

Loco-regional disease control and survival in epithelial cancers

Kailash Narayan [1], *Ming-Yin Lin* [1]

1. *Peter MaCallum Cancer Centre, Melbourne, VIC, Australia*

Introduction and Purpose:

A recently published Phase 3 study (RTOG 0617) involving 544, stage 3 lung cancer patients were randomize to receive standard chemo-radiotherapy (60Gy) or high-dose chemo-radiotherapy (74 Gy) with or without Cetuximab, an epidermal growth factor receptor (EGFR) inhibitor. It concluded that; 74 Gy with concurrent chemotherapy was not better than 60 Gy plus concurrent chemotherapy. Addition of Cetuximab and consolidation treatment provided no benefit in overall survival. In fact loco-regional control, toxicity and survival were worse in experimental arm.

This prompted us to look for the effects of loco-regional control on patterns of failure in cervix and endometrial cancer patients. Any possible modulating effects of dose intensification (using conformal brachytherapy, surgery and chemo-radiotherapy), histology, LVSI and nodal status was also analysed with respect to loco-regional control and survival.

Results: One thousand three hundred and thirteen patients with histologically proven cervix or endometrial cancer were treated and with curative intent between 1998 and 2010 were analysed. Almost all patients received either radical radiotherapy or adjuvant radiotherapy. Four prognostic groups were formed based on the invasive characteristics such as LVSI or corpus invasion, present or absent and lymphnode metastases either present or absent. Analyses showed that local and pelvic control of the disease was achieved in 94% and 87% of patients, failure rates in para-aortic and distant sites were 17% and 21%. Failures related to LVSI/corpus invasion and lymphnode metastasis and were independent of loco-regional control or histological types.

These observations suggest the possibility of mechanical tumour disruption and consequent dissemination during and because of treatment. Relevant observation in support of this hypothesis and ways of its investigation will be presented.

Notes:

Cervix Carcinoma treated with Radiotherapy in the Elderly: Patterns of Management and Outcomes from Peter MacCallum Cancer Centre 1998-201

Ming-Yin Lin [1] , *David Bernshaw* [1] , *Pearly Khaw* [1] , *Srinivas Kondalsamy-Chennakesvan* [2] , *Kailash Narayan* [2]

1. *Gynae-Oncology Unit, Department of Radiation Oncology, Peter MacCallum Cancer Centre , East Melbourne, VIC*
2. *Rural Clinical School, School of Medicine, The University of Queensland, Toowoomba, QLD*

Introduction

There is a paucity of data on the patterns of care, treatment toxicity and the outcomes of elderly patients with cervix cancer in comparison to younger patients. The number of elderly individuals is likely to increase in the future with the increasing average lifespan of the population. This information would be helpful in guiding patient selection for management of cervix cancer in the elderly population.

Aims

The primary objective is to determine the management patterns of elderly patients, aged 75 years and above referred for primary radiotherapy of cervix cancer and their outcomes, in terms of Overall survival (OS), Relapse-Free Survival (RFS) and treatment toxicity.

Results

From 1998 to 2010, 126 patients aged >= 75 treated at Peter MacCallum Cancer Centre met our inclusion criteria. Median (IQR) age was 80 (77-84). Median follow-up was 37 months. 81 of 126 had definitive radiotherapy, 10 had adjuvant radiotherapy and 35 had palliative radiotherapy. 71% of patients had a Figo stage 2b or below. 73% of patients had an ECOG score of 0 or 1. OS at three and five years among those treated with curative intent (after excluding palliation) were 66.6(55.9-75.3)% and 54.5(43.4-64.2)%, respectively. RFS at three and five years were 75.9(65.1-83.7) and 71.6(60.2-80.2), respectively. In all patients, bladder, bowel and vaginal toxicity of at least 2 or above were noted among 5%, 11% and 27% of patients, respectively. Seven patients had severe (3 or 4) bowel toxicity and four had severe vaginal toxicity.

Conclusion

Following appropriate patient selection, elderly patients treated with curative radiotherapy for cervix carcinoma have similar treatment outcomes and toxicity profile in comparison to younger patients.

Notes:

Compass is a randomised controlled trial currently underway comparing 2.5 yearly cytology based screening with 5 yearly Human Papillomavirus (HPV) screening in Australian women aged 25-69 years.

It is the first large scale clinical trial internationally to assess these screening tests in an HPV vaccinated population. The Compass trial is being carried out in the state of Victoria by VCS Inc. in collaboration with Cancer Council NSW.

To learn more about the Compass Trial go to www.compasstrial.org.au
Phone 1800 611 635

Saturday 11th July 2015

SESSION:	Free Paper Presentations
Presenters:	Anthony Richards, Thomas Jobling, Martin Oehler, Robert Rome, Paige Tucker, Shih-Ern Yao
Time:	9.00am – 10.30am
Chair:	Yee Leung

HE4, CA125, ROMA and RMI - a prospective comparison in the pre-operative evaluation of adnexal and pelvic masses in an Australian population

Anthony Richards [1] *, U Herbst , J Manalang , S Pather , S Saidi , T Tejada-Berges , K Tan , P Williams , J Carter*

1. *Department of Surgery, St George Hospital, University of New South Wales, Kogarah, Sydney*

Background

Human epididymis protein 4 (HE4) has been proposed as a novel biomarker for the diagnosis of epithelial ovarian cancer. Using HE4 and CA125, the Risk of Malignancy algorithm (ROMA) has been shown to be effective in the stratification of epithelial ovarian cancer risk1-3.

Aims

To determine the effectiveness of HE4 and ROMA in the diagnosis of malignancy of women presenting with a complex pelvic mass in an Australian population and compare it to CA125 and the risk of malignancy index (RMI).

Methods

Prospective recruitment of patients was conducted between October 2012 and March 2014 (n=50). CA125 and HE4 serum concentrations were collected with sensitivities, specificities, PPVs and NPVs were calculated for HE4, CA125, ROMA and the RMI. ROC-AUC were also calculated for comparison.

Results

There was a higher HE4 level in patients with ovarian cancer as compared to patients with benign pathology (p=0.008) and this was seen in benign versus stage 1 ovarian cancer patients (p=0.025). HE4 had a better specificity than CA125 for the diagnosis of ovarian cancer in all patients (p=0.022) and this effect was also observed in premenopausal patients (p=0.012).

Furthermore, the ROC-AUC for HE4 was better than CA125 in all patients (p=0.045). The ROMA algorithm was not inferior to the RMI calculation in this population.

Conclusions

In an Australian population, HE4 and ROMA are useful in the diagnosis of epithelial ovarian cancer.

1. Karlsen MA et al. Evaluation of HE4, CA125, risk of ovarian malignancy algorithm (ROMA) and risk of malignancy index (RMI) as diagnostic tools of epithelial ovarian cancer in patients with a pelvic mass. Gynecol Oncol 2012; 127: 379-83.
2. Van Gorp T et al. HE4 and CA125 as a diagnostic test in ovarian cancer: prospective validation of the Risk of Ovarian Malignancy Algorithm. Br J Cancer 2011; 104: 863-70.
3. .Wu L et al. Diagnostic value of serum human epididymis protein 4 (HE4) in ovarian carcinoma: a systematic review and meta-analysis. Int J Gynecol Cancer 2012; 22: 1106-12.

Notes:

Screening for ovarian cancer with any degree of reliability is at this time non existent

Thomas Jobling

Screening for ovarian cancer with any degree of reliability is at this time non existent. Our group is investigating a number of markers for early stage ovarian cancer, and one of these warrants further investigation. CXCL10 is a protein known to be a Kine kind for T cell and NK cells in inflammatory processes but has been identified as being increased in epithelial ovarian cancer. The antagonistic form of CXCL10 has been identified as being increased in early stage ovarian cancer and may represent a novel marker for early stage disease. Our data will be presented in regard to its sensitivity and specificity.

Notes:

Autoantibodies for early diagnosis of ovarian cancer

Martin Oehler

1. *Royal Adelaide Hospital, Adelaide*

Notes:

Structured Surgical Records: The Time Has Surely Arrived!

Robert Rome [1] *, Ken Jaaback , Greg Robertson*

1. *Immediate Past C airman, Australian Society of Gynaecologic Oncologists Inc, .*

There is increasin "traffic" in the recent literature about structured/synoptic sur ical records (SSRs) especially in sur ical oncolo y. All published papers have identified deficiencies with written and/or dictated reports. SSRs are important components of a comprehensive ynaecolo ic cancer database and also inte ral to developin a quality re ister.

The SSR can be become the patient record (whether it be paper or electronic) for the hospital and private clinician. Letters can be enerated to referrin doctor(s). Data can be exported to a comprehensive ynaecolo ic cancer database and a quality re ister. Data entry need only occur once.

Other modules that that lend themselves to structured records are patholo y, radiotherapy and medical treatment. In both the comprehensive database and quality re ister datasets will need to be defined and a reed upon. Data will need to ali n with that required by FIGO and other bodies.

Examples of SSRs will be presented for 4 ynaecolo ic cancer roupin s.

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Discussing sexual function in women considering risk-reducing salpingo-oophorectomy: sel - reported rates amongst Gynaecological Oncologists in Australia and New Zealand

Paige E Tucker [1] *, Paul Co en* [1]

1. *St Jo n of God Hospital Subiaco, Subiaco, WA*

Background: Bilateral risk-reducin salpin o-oophorectomy (RRSO) is the most effective treatment to decrease the risk of ovarian cancer in hi h risk women. Decline in sexual function has been reported as a common problem followin RRSO yet the sexual sequelae of this procedure are often not discussed with patients prior to sur ery.

Aim: The aim of this study was to determine:

i) How frequently Consultant Gynaecologic Oncologists in Australia and New Zealand discuss the potential consequences of RRSO on sexual function at the pre-operative consultation

ii) Factors which might influence the frequency of such a discussion

iii) Identifiable barriers to communication about sexual function.

Method: Consultant Gynaecological Oncologists were asked to complete a self-administered online questionnaire.

Notes:

Sexuality and quality of life after risk-reducing salpingo-oophorectomy: a retrospective study.

Paige Tucker [1] , *Jason Tan* [1] , *Stuart Salfinger* [1] , *Paul Cohen* [1]

1. *St John of God Hospital Subiaco, Subiaco, WA*

*Background:*Bilateral risk-reducing salpingo-oophorectomy (RRSO) is the most effective risk reducing treatment for women at increased risk of ovarian cancer. Current recommendations for such women are that they should undergo RRSO at age 35-40, if they have completed their childbearing. The potential deleterious effects of RRSO on sexual function are widely accepted, however there is limited data on the prevalence and severity of sexual dysfunction and no data regarding serum androgen levels and sexual function in women after RRSO.

Aims: The primary objective of this study was to determine the prevalence and severity of specific sexual problems encountered by women following RRSO and whether there are factors which affect sexual function and/ or quality of life. We also aimed to ascertain if there was a correlation between post-RRSO serum testosterone levels and sexual function.

Methods: A retrospective cohort study was performed. All women who had undergone RRSO at our centre in the past 6 years were invited to participate in the study. Outcomes were measured by validated questionnaires on sexual function, quality of life, body image, menopausal symptoms, relationship status and impact of event. Women were also tested for levels of free testosterone, sex-hormone binding globulin and free androgen index.

Notes:

Metastatic choriocarcinoma in pregnancy: a case report

Shih-Ern Yao [1]

1. *Monash Medical Centre, Moorabbin, Victoria*

Background:

Choriocarcinoma represents the most aggressive type of gestational trophoblastic neoplasia characterised by high levels of human chorionic gonadotropin (hCG), early vascular invasion and widespread metastases. It is most commonly seen following a prior molar pregnancy, and in women over 40 and of Asian, American Indian and African ethnicity. This report details the unusual case of metastatic choriocarcinoma presenting as massive renal haemorrhage at 38 weeks' gestation.

Case:

A 32 year-old G2P0, with a history of molar pregnancy, presented to the pregnancy assessment unit for a week-long history of persistent lower back pain and associated nausea and vomiting in an otherwise previously uncomplicated pregnancy.

Investigations confirmed fetal wellbeing and surprisingly found acute anaemia due to bilateral renal haemorrhages. Further imaging demonstrated multiple pulmonary lesions consistent with metastatic choriocarcinoma.

After multidisciplinary discussion, a live female was delivered in good condition via caesarean section after prophylactic renal artery balloon catheter insertion.

At time of writing, the patient had completed 2 cycles of chemotherapy and was doing well.

Notes:

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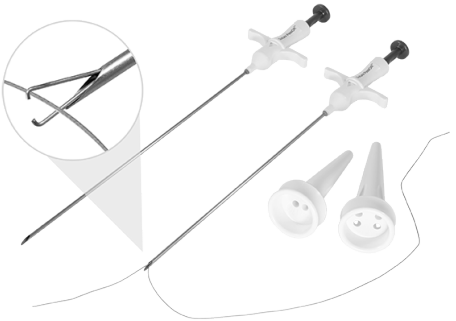

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Saturday 11th July 2015

SESSION:	Surgeons Corner & Best Presentation will be awarded the Tony McCartney Surgical Innovation Prize Chair
Presenters:	Paige Tucker, Arivendran Raja, Penny Blomfield, Chloe Ayres
Time:	11.00am – 12.00pm
Chair:	Sellva Paramasivam

Combined mini-laparotomy and laparoscopy for the ovarian cystic mass >10cm

Paige Tucker [1 2] *, Paul Cohen* [1 2] *, Tingmin Li 3 , Jason Tan 1 2*

1. *St John of God Hospital Subiaco, Subiaco, WA*
2. *Women Centre, West Leederville , WA*
3. *King Edward Memorial Hospital, Subiaco, WA*

Laparoscopic resection of ovarian cysts greater than 10 cm can be technically challenging due to limited visualisation and difficulty in specimen retrieval without spillage. There may also be concerns regarding risk of malignancy and laparotomy is therefore often the preferred surgical approach. Minimal access surgery in gynaecology has been compared to laparotomy in the management of both benign and malignant conditions, and has been shown to result in shorter patient hospital length of stay, reduced post-operative pain and faster return to routine activities. Our aim was to assess the feasibility of a novel surgical technique using a combination of both laparoscopy and mini-laparotomy in the surgical management of ovarian cystic masses >10cm. Short-term outcomes including hospital length of stay, return to usual activities, post-operative complications and patient satisfaction were also assessed.

Notes:

A Novel Technique to Remove Tumour Deposits on Bowel, Peritoneal and Mesentery Surfaces to Achieve Optimal Cytoreductive Surgery in Cases of Advance Ovarian Cancer

Arivendran Raja [1] *, Daniel R*

1. *Gynaecology Onclogy , Hospital Sultan Ismal, Johor Bahru, Malaysia*

Ovarian cancer carries the highest mortality among all gynaecological malignancies. Optimal debulking of these tumours is integral, as the size of residual tumour after surgery has been shown to be an important prognostic factor. In advance disease, we often encounter tumour deposits on bowel, mesentery, bladder and peritoneum. We would like to introduce a technique of removing these deposits with ease and without compromising the organ's integrity or vascular supply.

The technique uses a colposcopy loop used in cervical excision procedures. The beauty of the loop is that it is a fine thin wire, allowing us to remove the tumour with adequate tissue margin without compromising the vasculature and tissue integrity below. The procedure is quick, highly effective, and easy to teach and learn with minimal complications.

Primary optimal cytoreductive surgery should be our goal as it would definitely improve a patient's prognosis, outcome and survival.

Notes:

Management of an obturator lymphocyst

Penny Blomfield [1]

1. *Royal Hobart Hospital, Hobart*

Notes:

Suction Curette Assisted Laparoscopic Hysterectomy for Endometrial Cancer.

Chloe Ayres [1], *Debra Neesham* [1], *Orla McNally* [1]

1. *Department of Gynaecological Oncology, The Royal Women's Hospital, Victoria, Australia*

Endometrial cancer (EC) is the most commonly diagnosed gynaecological malignancy in Australia. Previous studies have shown that minimally invasive surgery compared to open surgery for the management of EC has many benefits including reduced post-op complications, less blood loss, shorter length of hospital stay, improved short term QOL with faster return to work and improved cosmesis. Similar rates of lymph node sampling are achieved and there is no difference in disease free or overall survival. Given these advantages, utilizing suction curettage to evacuate the uterine contents prior to or during a laparoscopic hysterectomy for EC may enable those patients with a uterine size larger than usually amenable to laparoscopic removal avoid an open procedure. Here we present a video demonstration of this novel technique.

Notes:

Conversion of a Gastric Band into an Intraperitoneal Port in a Patient with Optimally Debulked Stage 3C Serous Ovarian Carcinoma

Paige E Tucker [1 2], *Paul Cohen* [1 2], *Jason Tan* [1 2]

1. *St John of God Hospital Subiaco, Subiaco, WA*
2. *Women Centre, West Leederville , WA*

Intraperitoneal (IP) chemotherapy in women with optimally debulked stage 3 ovarian cancer improves overall survival and progression-free survival, and its use has been encouraged in the adjuvant treatment of appropriately selected patients. As the number of bariatric surgical procedures increases in line with obesity rates, gynaecologic oncologists may more frequently encounter gastric bands at laparotomy in patients with advanced ovarian cancer. We describe a case in which a previously inserted adjustable gastric band was converted to an IP chemotherapy port during a laparotomy for advanced ovarian cancer.

Notes:

Saturday 11th July 2015

SESSION: Tumour Board
Presenters: Simon Hyde, Martin Oehler & Russell Hogg
Chair: John Miller

Tumour Board

Notes:

Poster Presentations

"Life, not cancer" – a pilot of community based survivorship care delivery in Southern Adelaide.

Michael Fitzgerald RN, Melinda Richardson RN, Catherine Hughes (SAHA), Bogda Koczwara BMBS FRACP

Cancer Services, Southern Adelaide Local Health Network (SALHN), Flinders Medical Centre (FMC)

Background

Cancer survivors have poorer long term health than non- cancer survivors. Often their needs are not addressed adequately by health services. Comprehensive approaches to meet the needs of cancer survivors that focus on health, well-being and self- management plans may improve the health of cancer survivors. Engaging health professionals at the primary prevention level is critical in supporting healthy living choices, long term late effects monitoring and prevention and monitoring of cancer recurrence. Self- management and chronic disease management is well evidenced as a platform for managing long term health and health effects of disease or treatment.

The objective of this pilot is to develop a model of cancer survivorship care that can be developed and implemented by a variety of health care professionals across acute and community settings.

Method

With the support of the Southern Adelaide Health Alliance (SAHA) – an initiative aimed at developing innovative programs and partnerships with providers outside acute health facilities, we have established contact with interested providers in order to examine needs, consider potential models of care and identify or develop resources to support them. The outcome measures will include uptake of survivorship care, acceptability to users and problems and needs addressed.

Results

Senior cancer nurses (including tumour specific nurses) have been identified as pivotal in partnering with to increase capacity for development of survivorship care plans. Four GP practices indicated their willingness to be involved. These practices vary in size and infrastructure which will serve as an excellent test for applicability of any proposed model. A critical component identified by GP's is access to timely communication and guidelines that enable clarity of care planning events. They also identified a desire to have a central contact point for clarification of issues. Results of stakeholder consultation and conceptual model development will be available at the time of presentation with final implementation and evaluation planned for the remainder of 2015.

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FLINDERS OVARIAN CANCER GROUP SUPPORT (FOGS) BUILDING A CANCER SUPPORT GROUP WHAT WORKS?

Helen Gray, Gynaecology Oncology Nurse Coordinator, Flinders Centre for Gynaecological Cancer
Flinders Medical Centre, Adelaide , South Australia, June 2015

Introduction

The Support Group at FMC has been conducted since March 2009

One of the main aims of the group was to identify the key principles or 'success factors' of effective cancer support groups

One of the main issues was to evaluate and measure the outcomes by which the group's effectiveness can be identified and measured to provide evidence

Research

Unequivocal evidence about 'what works' for people affected by cancer-both generally and for specific sub-groups with identified needs-would better inform the development of support groups(and other interventions)

Many researchers have highlighted the need for more research that will, to quote one" address the issues of how and for whom specific interventions do or do not carry positive effects"

Attempts to compare the benefits or outcomes of different types of groups have been hindered by the lack of agreed definitions of different types of interventions

Meta-analyses and reviews of the literature suggest that-"Educational programmes are superior"

And "Structured groups are better"

Also "longer durations may be more beneficial than short programs"

Durations of more than 12 weeks were significantly more effective than shorter interventions

Conclusion

The Flinders Ovarian Group Support has run continuously since March 2009 and been well attended by patients, consumers, friends and relatives. The group is conducted every 12 weeks at the hospital and the guest speakers are requested by the patients

The evaluation of the group is being undertaken at the present time utilising a feed- back questionnaire from all key participants within the group-For presentation in the seminar poster

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Supporting Return to Employment after Cancer in Disadvantaged Communities -

Marshall, A; Knott, V; Bareham M, Ward, P; Emery, J; Fallon-Ferguson, J; Olver, I; Koczwara, B.

Background: Maintenance of employment has substantial benefits to an individual in enhancing a sense of personal worth and identity as well as providing financial security. Despite these benefits, cancer survivors have difficulties returning to work, are at greater risk of unemployment after cancer and the risk increases with lower socioeconomic status. Currently there are limited resources available to cancer survivors to assist them in returning to employment after cancer treatment.

This project aims to improve return to work of cancer survivors by developing a suite of resources that support return to work (RTW) with a particular emphasis on disadvantaged communities, and to disseminate these resources widely via Cancer Council Australia's existing Wiki-platform and other relevant networks.

Methods: The project will conduct a number of focus groups purposefully sampled from rural and outer metropolitan areas with a high prevalence of socioeconomic disadvantage and evidence of poorer cancer outcome. We will invite cancer survivors, their carers and health care providers from diverse disciplines, along with experts on employment/RTW to discuss barriers to RTW as well as gaps in preferences for intervention and support with regard to RTW. We will then convene an Expert Consensus Group who will determine the content and format of the resources, informed by the results of the focus groups and information from extant RTW literature and an audit of available RTW resources.

Outcomes: This project will result in the development of a suite of RTW resources comprised of key evidence-based recommendations, practical resources and tools presented as a series of digital modules accessed via Cancer Council Australia's existing wiki-platform. Modules will be tailored to address the diverse cancer-related RTW needs identified for disadvantaged consumer groups, with resources provided for consumers, oncology professionals, general practitioners and employers.

Notes:

Helping women with ovarian cancer make difficult treatment decisions: the development and evaluation of two decision aids

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Background: Women with ovarian cancer (OC) face difficult treatment decisions with uncertain quality of life and survival outcomes. Decision Aids (DAs) can improve informed decision-making, but no such tools are available to women with OC. Study 1 involves an RCT to evaluate the effectiveness of a previously piloted DA for asymptomatic women with rising tumour marker (CA-125) following initial treatment; Study 2 involves a pilot study of a DA for women with resistant or refractory recurrent OC.

Methods: The DAs contain evidence-based information about the risks and benefits of each treatment option, and values clarification exercises. In Study 1, 178 women with rising CA-125 are randomised to receive either the DA or a general OC booklet, and complete standardised measures at baseline and 4-month follow-up. This DA helps women to make a decision about further treatment. In Study 2, 30 women with resistant or refractory recurrent OC provide feedback on the newly developed DA via a questionnaire and telephone interview. This DA helps women decide whether or not to continue active treatment.

Results: Overview and current progress on both studies will be presented.

Conclusion: This research program addresses a neglected area in the management of women with OC. It is anticipated that the two DAs will lead to improved understanding of treatment options, reduced decisional conflict and regret, and increased satisfaction with the decision making process. If effective, this relatively simple intervention has the potential to improve the clinical care, and ultimately quality of life, of women with OC.

Notes:

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