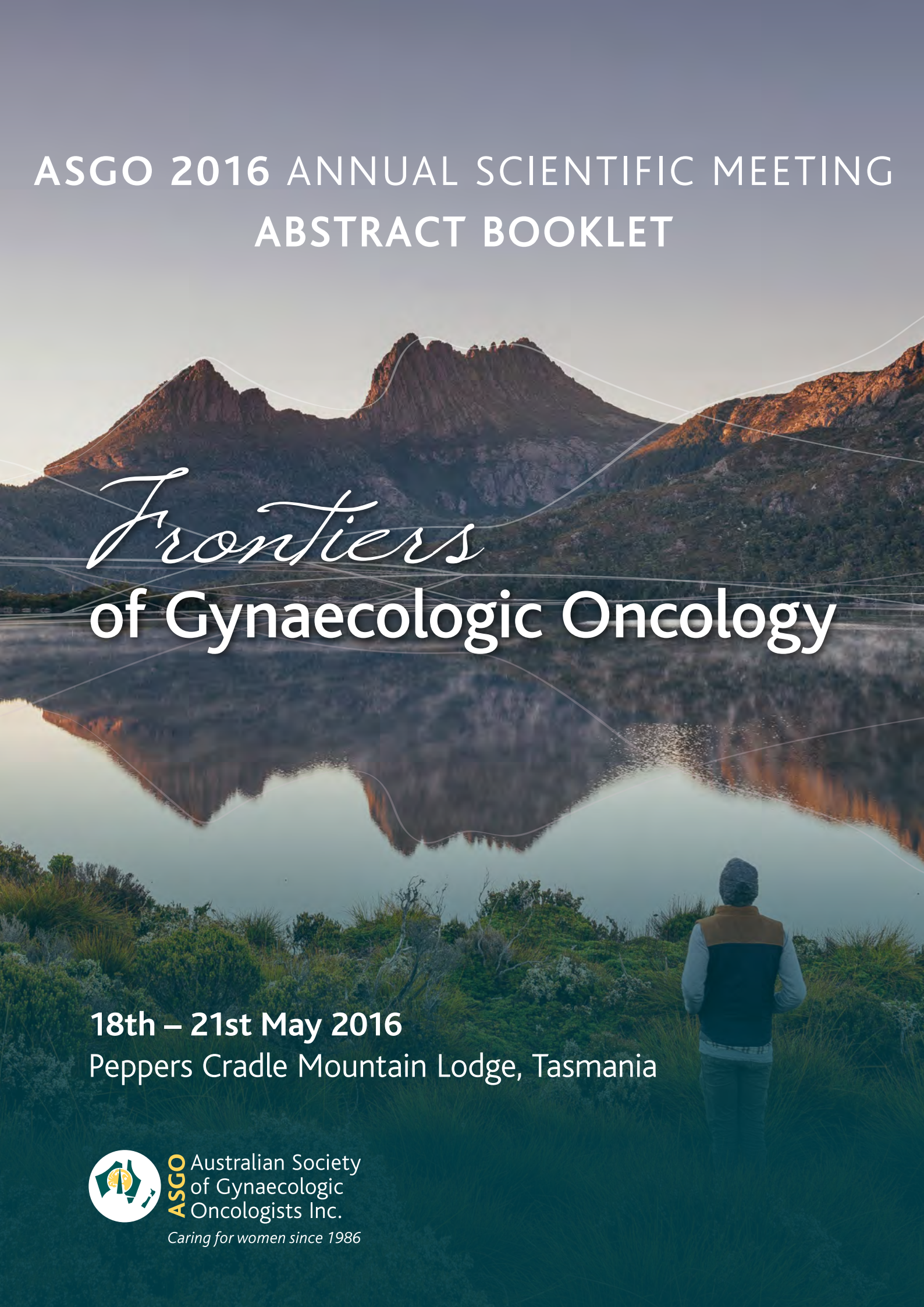
ASGO 2016 ANNUAL SCIENTIFIC MEETING
ABSTRACT BOOKLET



Frontiers
of Gynaecologic Oncology

18th – 21st May 2016
Peppers Cradle Mountain Lodge, Tasmania

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Speaker Bios

Dr Emma Rossi

Assistant Professor, University of North Carolina, Division of Gynecologic Oncology

Dr Emma Rossi originates from Brisbane, Australia where she completed her undergraduate and medical school training at the University of Queensland. She graduated from an OBGYN residency at Northwestern University in Chicago, followed by a fellowship in Gynecologic Oncology at the University of North Carolina, at Chapel Hill. Following fellowship, Dr Rossi served as Assistant Professor of Obstetrics and Gynecology at Indiana University where she was an Interim Fellowship Program Director in Gynecologic Oncology. In 2015 she returned to the University of North Carolina where she is faculty and Assistant Professor with the department of Obstetrics and Gynecology.

Dr Rossi has research and clinical interest and expertise in the minimally invasive surgical management of gynecologic cancers, with particular focus on robotic surgery and the development of novel techniques in sentinel lymph node mapping for endometrial and cervical cancers. She has published original articles in this subject matter, and serves as the principle investigator of the FIRES trial, which is a multi-institutional study, the largest of its kind, measuring the accuracy of sentinel node biopsy in diagnosing metastatic endometrial and cervical cancer. Dr Rossi has served as an invited speaker and surgeon nationally and internationally in robotic surgery and novel surgical techniques and has a passion for educating others regarding novel surgical techniques and minimally invasive surgery.

Professor Michael Seckl

Director of the Charing Cross/ Imperial College Trophoblastic Disease Service and Supraregional Tumour Marker Assay Service

Michael trained at University College London obtaining a BSc in Immunology in 1983 and his MBBS in 1986. He did his general professional and specialist medical oncology training on the London circuit becoming initially a member and then a fellow of the Royal College of Physicians. He obtained his PhD in biochemistry in 1995 from the London Research Institute/University College London and was that year appointed as a Senior Lecturer/honorary consultant in medical oncology at Charing Cross Hospital which subsequently became part of Imperial College London. He then established his own research groups working on cell signalling in cancer and trophoblastic disease supported by grants from Cancer Research UK, the Medical Research Council, Wellcome Trust, Wellbeing, Industry and others. He was promoted to Reader in 2002 and the Professor of Molecular Oncology in 2004 when he also took on the directorship of the Charing Cross Gestational Trophoblastic Disease Centre and the supraregional Tumour Marker Assay Service. In 2007 he initiated a process to develop a new national service for malignant ovarian germ cell tumours and in 2012 became head of this service. Professor Seckl also leads the Imperial College Experimental Cancer Medicine Centre, runs the London Lung Cancer Alliance, is on the editorial board of several journals, chairs and sits on several grants committees, is the president elect of the European Organisation for the Treatment of Trophoblastic Disease, treasurer of the International Society for the Study of Trophoblastic Disease and holds an honorary professorship with the Peking Union Medical College. Educationally, he is Director of Postgraduate Studies for the department of Surgery and Cancer with overall responsibility for 200 MSc/MRes and 400 PhD students.

Speaker Bios

Professor Greg Woods

Principal Research Fellow, Menzies Institute for Medical Research, University of Tasmania

Eureka Prize Awarded Researcher, Professor Greg Woods completed his undergraduate degree in 1978, a BSc (Hons) at Monash University, PhD at the University of Tasmania, in 1984 and was awarded a founding Fellowship of the Faculty of Science, Royal College of Pathologists of Australasia in 2011.

He has worked as a research scientist in Toronto, London, and Edinburgh. Current Appointments with the University include; Principal Research Fellow, Menzies Research Institute and Professor of Immunology, School of Medicine.

He teaches immunology to medical and medical research students and supervises postgraduate and research students. His research interests have included, Photoimmunology, specifically the effect of sunlight on the developing skin's immune system and the influence of vitamin D.

Today, most of his research is now on Devil Facial Tumour Disease (DFTD) where progress has been made in understanding the immune system of the Tasmanian devil and how this cancer escapes immune recognition. This research is paving the way towards a vaccine against DFTD. In 2011 as part of the five-member team 'The Devil's Advocates' he was awarded the Sherman Eureka Award for Environmental Science.

In the past ten years, Professor Woods has been awarded more than $2 million in research funding, including NHMRC and ARC grants. He has published over 90 peer-reviewed scientific papers and has supervised approximately 20 PhD students to completion.

In 2015 his life-long contribution to research was recognised by the Australian Society for Medical Research when he was awarded their 'Certificate in Recognition of the Distinguished Service to Medicine, Science and Community.'

Professor Anna deFazio

Anna deFazio holds the Sydney-West Chair in Translational Cancer Research, University of Sydney at Westmead Hospital and is on the executive of the Sydney-West Translational Cancer Research Centre. She heads the Gynaecological Oncology Research Laboratory, Centre for Cancer Research, Westmead Institute for Medical Research, and has a long-standing commitment to translational research with an emphasis on improving treatment outcome for women with ovarian cancer. The focus of her research is on understanding the clinico-genomic parameters that underlie resistance and response to chemotherapy and novel targeted agents.

ASGO General Information

ASGO Committee of Management
Chairman: Jim Nicklin
Executive: Robert Rome (Immediate Past Chairman), Ken Jaaback (Chairman Examination Committee/Written), Deborah Neesham (Chairman Examination Committee/Oral), Tom Manolitsas (Immediate Past Secretary), Rhonda Farrell (Chair of CGO Committee)
Professional Conference Organiser: Mary Sparksman

ASGO Organising Committee
Conference Co-chairs: Michael Bunting and Penny Blomfield

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

Wednesday 18th May	12.30pm – 5.00pm	Mantra Charles, Launceston
Thursday 19th May	8.15am – 12.30pm	Josef Chromey
Friday 20th May	8.00am – 5.30pm	Peppers Cradle Mountain Lodge
Saturday 21st May	8.00am – 3.30pm	Peppers Cradle Mountain Lodge

Invited Speakers: Dr Emma Rossi, Prof Michael Seckl, Prof Greg Woods, Prof Anna DeFazio, Dr Peter Grant

Social Program

Wednesday 18th May	**6.00pm – 9.00pm**	**Welcome Reception** **Location:** Mud Restaurant, buses depart Mantra Charles at 6.00pm **Dress:** Smart casual
Thursday 19th May	**6.30pm – 10.00pm**	**Casual Dinner** Includes games night, sponsor Pictionary presentations and followed by old movies **Location:** Cradle Mountain Lodge Tavern **Dress:** Casual
Friday 20th May	**7.00pm – 10.30pm**	**Casual Dinner** Includes quiz night with Dr Rob McIntosh **Location:** Highland Restaurant, Peppers Cradle Mountain Lodge **Dress:** Smart casual
Saturday 21st May	**8.30am – 11.30am**	**Dove Lake Walk or Park Explorer Guided Tour** **8.30am:** Depart for Dove Lake Walk, 2hr duration **9.00am:** Depart for Park Explorer Guided Tour, 1.5hr duration ***Walking shoes, warm clothes & wet weather gear are required.***
Saturday 21st May	**7.00pm – 11.00pm**	Black Tie Dinner **Location:** Highland Restaurant, Peppers Cradle Mountain Lodge **Dress:** Black tie

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

Frontiers of Gynaecologic Oncology

2016 ASGO PROGRAM

WEDNESDAY 18TH MAY 2016

12.30 – 1.30pm	*REGISTRATION AND LUNCH*
1.30 – 3.00pm	**FELLOWS EDUCATION SESSION**
1.30 – 2.00pm	Radiology for CGO Fellows – Interventional Radiologist, Royal Hobart Hospital – ***Robin Harle***
2.00 – 2.30pm	Medical Oncology for CGO Fellows – Medical Oncologist, Launceston General Hospital – ***Sharad Sharma***
2.30 – 3.00pm	Radiation Oncology for CGO Fellows – Radiation Oncologist, Royal Hobart Hospital – ***Raef Awad***
3.00 – 3.45pm	Interactive Session ***Sponsored by Applied Medical***
3.45 – 4.00pm	*AFTERNOON TEA*
4.00 – 5.00pm	*MOCK OSCE AND EXAM WORKSHOP – **Julie Lamont***
6.00 – 9.00pm	Mud Restaurant – Transfers depart Mantra Charles at 6.00pm

THURSDAY 19TH MAY 2016

7.45am	*BUSES DEPART FOR BREAKFAST AND SESSIONS AT JOSEF CHROMY*
	MORNING SESSIONS SPONSORED BY: THE OR COMPANY
8.45 – 10.45am	**SESSION 1** ***Session Chair: Michael Bunting and Penny Blomfield***
8.45am	Welcome Introduction and opening of Meeting ***– Jim Nicklin (Chair of ASGO) and Michael Bunting (Co-chair 2016 ASM)***
8.55 – 9.40am	Keynote: Gestational trophoblastic disease. State of the Art ***– Michael Seckl***
9.40 – 10.25am	Keynote: Can sentinel lymph node biopsy accurately diagnose metastic endometrial cancer? – Results of the FIRES trial and summary of reported accuracy of the technique ***– Emma Rossi***
10.25 – 10.45am	Moving forward with STATEC ***– Alison Brand***
10.45 – 11.15am	*MORNING TEA*
11.15 –12.50pm	**SESSION 2 Session Chair: Jim Nicklin**
11.15 – 11.45am	Final survival data from the LACE study ***– Andreas Obermair***
11.45 – 11.57am	Fallopian tube intraluminal tumour cells in high grade endometrial cancer: Associations and outcomes ***– Emma Allanson (Trainee)***
11.57 – 12.09pm	Retrospective audit of fast cancer treatment pathway for post-menopausal bleeding at Waikato Hospital ***– Michael Burling (Trainee)***
12.09 – 12.21pm	Minor clear cell and serous components in stage 1, grade 1 & 2 endometrioid adenocarcinomas; Do they affect prognosis? – ***Nimithri Cabraal (Trainee)***
12.21 – 12.33pm	Analysis of the outcomes of patient's with stage IV uterine papillary serous adenocarcinoma. Is there a role for neo-adjuvant chemotherapy? ***– Murad Al-Aker (Trainee)***
12.35 – 12.50pm	Effect of pre-surgical body mass index on surgical safety after laparoscopic surgery for apparent early stage endometrial cancer ***– Monika Janda***
12.50 – 1.50pm	*LUNCH*
2.00pm	**Buses depart for Cradle Mountain**
6.45 – 10.00pm	Casual dinner Cradle Mountain Lodge Tavern – Including Pictionary Presentations from ASGO Sponsors, movies in Cradle Room and games in Lounge

FRIDAY 20TH MAY 2016

7.00am onwards	*BREAKFAST TO BE SERVED IN HIGHLAND RESTAURANT*
8.00 – 8.30am	*REGISTRATION AND TRADE EXHIBITION OPEN*
8.30 – 10.30am	**SESSION 3 Session Chair: Greg Robertson**
8.30 – 9.15am	Keynote: High risk gestational trophoblastic disease and placental site tumour: State of the art ***– Michael Seckl***
9.15 – 09.45am	Hydatidiform mole in Victoria: A 30 year history ***– Deborah Neesham***
9.45 – 10.15am	Trials and tribulations of developing a statewide GTD service ***– Andy Garrett***
10.15 – 10.30am	Discussion: Australia Should we have an Australian GTD registry? ***– Yee Leung***
10.30 – 11.00am	*MORNING TEA AND TRADE EXHIBITION*
11.00 – 1.00pm	**SESSION 4 Session Chair: Andy Garrett**
11.00 – 11.30am	Keynote: Sentinel lymph node mapping for endometrial cancer – Technique optimization with different technologies, small volume disease & the role of lymphadenectomy for endometrial cancer ***– Emma Rossi***
11.30 – 12.15pm	Keynote: From genomics to clinical care in women with gynaecological malignancy: News from the benches ***– Anna deFazio***
12.15 – 12.30pm	The crucial nature of pathology in sentinel node biopsy procedures for vulval cancer ***– Peter Sykes***
12.30 – 12.42pm	Retrospective clinical audit assessing patient outcomes following treatment for vulva over the last 15 years for patients at the Royal Women's Hospital in Melbourne ***– Nivenditha Rajadevan (Trainee)***
12.42 – 12.54pm	Perivascular epithelioid tumours ***– Antonia Jones (Trainee)***
1.00 – 2.00pm	*LUNCH AND TRADE EXHIBITION*

2.00 – 4.00pm	**SESSION 5 Session Chair: Alex Crandon**
2.00 – 2.30pm	Keynote: Making a difference: Palliative care for the gynaecological oncologist – ***Peter Grant***
2.30 – 2.42pm	Outcome of extended VTE prophylaxis in women undergoing gynaecological surgery for suspected or confirmed malignancy – ***Alison Brand***
2.42 – 2.54pm	Enhanced recovery after surgery (ERAS) for ovarian cancer – a systematic review to identify candidate interventions – ***Kristine Lindemann (Trainee)***
2.54 – 3.06pm	Clinicopathological study of ovarian carcinoid tumours – ***Shaun McGrath (Trainee)***
	SURGEONS CORNER
3.06 – 3.18pm	An Australian experience of laparoscopic radical trachelectomy from inception to birth – ***Vinita Rajadura (Trainee)***
3.18 – 3.30pm	A novel solution to leaking intestinal stoma sites – ***Paige Tucker (Trainee)***
3.30 – 3.42pm	A novel method to facilitate uterine delivery at robotic hysterectomy – ***Shih-Ern Yao (Trainee)***
3.42 – 3.54pm	Pushing the limits of minimally invasive surgery – ***Helen Green (Trainee)***
4.00 – 4.30pm	*AFTERNOON TEA*
4.30 – 5.30pm	**SESSION 6 Session Chair: Michael Bunting**
	Keynote: The tassie devil story – ***Greg Woods***
7.00 – 10.30pm	*CASUAL DINNER IN HIGHLAND RESTAURANT & QUIZ NIGHT WITH ROB MCINTOSH*

SATURDAY 21ST MAY 2016

7.00am onwards	*BREAKFAST TO BE SERVED IN HIGHLAND RESTAURANT*
8.00 – 8.30am	*TRADE EXHIBITION OPEN*
8.30 – 11.30am	Visit Cradle Mountain Wilderness & Dove Lake walk – Walking shoes, warm clothes & wet weather gear required
11.30 – 12.40pm	**SESSION 7 Session Chair: Vivek Arora**
11.30 – 12.00pm	Keynote: Fertility preservation and management of malignant ovarian germ cell tumours – ***Michael Seckl***
12.00 – 12.12pm	Intraperitoneal chemotherapy in patients with optimally debulked ovarian cancer – The Westmead experience – ***Kristine Lindemann (Trainee)***
12.12 – 12.24pm	Histopathological analysis between the tubo-ovarian interface in women undergoing risk reducing bilateral salpingo-oophorectomy – ***Chloe Ayres (Trainee)***
12.24 – 12.36pm	Uptake of prophylactic BSO in women at risk of tubo-ovarian malignancy in Tasmania – ***Penny Blomfield***
12.40 – 1.20pm	*LUNCH*
1.20 – 3.10pm	**SESSION 8 Session Chair: Julie Lamont**
1.20 – 1.50pm	Keynote: Sentinel lymph node mapping for cervical cancer – ***Emma Rossi***
1.50 – 2.02pm	Efficacy of sentinel node mapping in in South African cervix cancer patients – ***Tom de Greve (Trainee)***
2.02 – 2.22pm	Sentinel node detection in operable cervical cancer- a proposal for a prospective ASGO study – ***Vivek Arora***
	Neoadjuvant chemotherapy followed by fertility sparing surgery for early cervical cancer (1B1 2-4cm) – Research proposal – ***Vivek Arora***
2.22 – 2.34pm	Why rebrand the most successful brand in gynecology, the pap smear? – ***Bernd C Schmid (Trainee)***
2.34 – 3.10pm	Brave New World: Update on the Cervical Screening Program – ***Andy Garrett***
3.10 – 3.30pm	*AFTERNOON TEA*
3.30 – 5.00pm	ASGO AGM – Members only
7.00 – 11.00pm	Black-Tie dinner in Highland Restaurant

SUNDAY 22ND MAY

7.00 – 9.00am	*BREAKFAST TO BE SERVED IN HIGHLAND RESTAURANT*
9.00am	**Guests to depart by coach for Launceston Airport**

POSTER PRESENTATIONS

Intravenous leiomyomatosis with intracardiac extension "case presentation" – ***Murad Al-Aker (Trainee)***

Discussing sexuality in women considering risk reducing salpingoopherectomy:
An international survey of current practice in gynaecologic oncology – ***Paige Tucker (Trainee)***

Management of stage 1B1 cervical adenocarcinoma: What would you do? – ***Shih-Ern Yao (Trainee)***

Predictors of early discharge after open gynaecological surgery in the setting of an ERAS protocol – ***King Man Wan (Trainee)***

Clear cell carcinoma arising from a previous caesarean section scar – ***Pearl Tong (Trainee)***

Development of a tertiary gynae-oncology centre – a step wise approach – ***Cecile Bergzoll (Trainee)***

ASGO members will be emailed program updates as they arise.

Program Disclaimer: *The information contained in this brochure is correct at time of printing. The ASGO Committee and YRD (Aust) Pty Ltd reserve the right to alter or delete items from the program as circumstances dictate and take no responsibility for any errors, omissions or changes. The program will be updated on the Society's website as details are finalised.*

Wednesday 18th May 2016

SESSION:	Fellows Education Session
Presenters:	Robin Harle, Sharad Sharma and Raef Awad
Time:	1.30pm – 3.00pm
Chair:	Michael Bunting

Wednesday 18th May 2016

SESSION:	**Interactive Session Sponsored by Applied Medical**
Time:	3.00pm – 3.45pm
Chair:	Michael Bunting

Wednesday 18th May 2016

SESSION:	Mock OSCE and Exam Workshop
Time:	4.00pm – 5.00pm
Chair:	Julie Lamont

Thursday 19th May 2016

SESSION:	Session 1
Presenters:	Michael Seckl, Emma Rossi and Alison Brand
Time:	8.45am – 10.45am
Chair:	Michael Bunting and Penny Blomfield

Gestational trophoblastic disease. State of the art.

Michael Seckl

Gestational trophoblastic disease (GTD) is a spectrum of disorders including the pre-malignant complete (CHM) and partial hydatidiform moles (PHM) through to the malignant invasive mole, choriocarcinoma and rare placental site and epithelioid trophoblastic tumours (PSTT/ETT). The malignant forms are collectively referred to as gestational trophoblastic neoplasia (GTN). In addition to these forms of GTD, more recently we have realised that atypical placental site nodules (APSNs) and possibly also typical PSNs may be a precursor or be associated with PSTT/ETT. This presentation will focus on the epidemiology, aetiology and risk factors for developing GTD with a focus on molar pregnancies and their management. Topics covered will include twin pregnancies comprising a CHM and normal co-twin, repetitive hydatidiform mole syndrome, indications for chemotherapy, scoring of GTN and the treatment of low risk disease with either single agent methotrexate or actinomycin D. As human chorionic gonadotrophin (hCG) measurements are essential in the management of GTD we will explore whether the assay used is important using an illustrative case presentation. Finally the talk will cover the follow-up of patients, the relapse risk, prospects of future successful pregnancies, when to initiate these and discuss the duration of hCG monitoring.

Notes:

Can sentinel lymph node biopsy accurately diagnose metastic endometrial cancer? – Results of the FIRES trial and summary of reported accuracy of the technique

***Emma Rossi*[1]**

1. *University of North Carolina, North Carolina, United States*

Sentinel lymph node (SLN) biopsy is now standard of care in the surgical management of several cancers (such as breast, melanoma, and vulvar) particularly in clinical stage I disease. It promises to find occult metastatic disease, while minimizing morbidity for the patient by sparing them of a radical complete lymphadenectomy and the morbidity of lymphedema. The role of and extensiveness of lymphadenectomy for endometrial cancer is controversial. However, it may serve to better guide adjuvant therapy, particularly the addition of systemic therapy for those with metastatic disease.

SLN biopsy for endometrial cancer was initially described in large single institution specialist centers with retrospectively reported series. European sites produced multi-center results with comprehensively staged patients, (SENTI-ENDO), however, this study was underpowered to answer the question of accuracy of the technique in detecting metastatic disease. In this lecture we will discuss the results of the FIRES trial (Fluorescence Imaging for Robotic Endometrial cancer Sentinel lymph nodes), the largest multi-center clinical trial for endometrial cancer SLN mapping. It was developed to definitively address the false negative rate of the technique, and its statistical design was based on that of GOG 173 (which serves as the definitive accuracy study in vulvar cancer). It is closed for enrolment after meeting statistical endpoints.

18 surgeons across 10 US centers participated. SLN mapping was performed by cervical injection of ICG and all patients underwent completion lymphadenectomy. Negative SLN's on H&E sections were ultrastaged with immunohistochemistry for cytokeratin. The trial was designed to yield a type 1 error rate of 0.05 and power of 0.8 if the true sensitivity is 90%.

359 patients received attempted SLN mapping. Pelvic lymphadenectomy was performed in 343 patients (96%) and PA lymphadenectomy in 199 patients (56%). 296 patients (82%) had successful mapping of at least one SLN. Bilateral SLN's were identified in 116 of these patients (60%). A mean of 20 (range 0-61) total lymph nodes were removed per patient. 41 (11.4%) patients had stage IIIC disease, 36 of whom mapped a SLN. Nodal metastases were correctly identified in the SLN's of 35 of these 36 cases yielding a sensitivity of 97.2% (95% CI 85, 100) and a NPV of 99.6% (95% CI 97.9, 100). The false negative rate is 0.4% (95% CI 0.0, 2.1).

SLN's identified with ICG have a high degree of diagnostic accuracy in detecting endometrial cancer metastases. Patients undergoing SLN biopsy in the absence of complete lymphadenectomy should be counseled about the potential small risk for false negative results.

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Moving forward with STATEC

Alison Brand[1]

1. *Department of Gynaecological Oncology, Westmead Hospital, Westmead, NSW, Australia*

STATEC is international, randomised, multi-centre, non-inferiority surgical trial, in patients at high risk endometrial cancer, randomised pre-operatively to either no LAD or to pelvic and para-aortic LAD. The primary aim of the study is to determine whether staging LAD, used to restrict adjuvant therapy to node positive women only, is non-inferior to adjuvant therapy given routinely to all women in this patient population (as determined by uterine risk factors).Secondary aims are to determine PFS and relapse rate (pelvic and distant), treatment side effects, including quality of life measures, cost effectiveness, the accuracy rates of sentinel node biopsy compared to complete node dissection, including whether it is prognostic in terms of survival, and the contribution of lymphadenectomy and adjuvant therapy (with or without lymphadenectomy) to incidence of lymphoedema.

Thirteen centres in Australia and New Zealand have expressed interest in this trial, which will have an accrual of approximately 2000 patients from the UK, Netherlands, and ANZ. Norway and Korea have also expressed interest.

Key inclusion criteria are high grade endometrial cancers, with surgery to be performed within 5 weeks of randomization and patients able to undergo adjuvant treatment with XRT AND chemotherapy within 8 weeks of surgery. Exclusion criteria are grossly enlarged nodes on pre-op imaging, invasion of cervical stroma, macroscopic disease outside uterus on imaging, and small cell carcinoma with neuroendocrine differentiation. Patients will be randomised preoperatively and adjuvant treatment will be prespecified for all patients for each site, from a list of evidence based options.

Notes:

Thursday 19th May 2016

SESSION:	Session 2
Presenters:	Andreas Obermair, Emma Allanson, Michael Burling, Nimithri Cabraal, Murad Al-Aker and Monika Jander
Time:	11.15am – 12.50am
Chair:	Jim Nicklin

Disease-free and overall-survival after total laparoscopy versus open abdominal hysterectomy for early stage endometrial cancer: results from the LACE trial.

Andreas Obermair[1], Val Gebski[2], Lucy Davies[2], Alison Brand[3], Russell Hogg[3], Thomas W Jobling[4], Russell Land[5], Tom Manolitsas[4], Marcelo Nascimento[5], Deborah Neesham[6], James L Nicklin[5], Martin K Oehler[7], Geoff Otton[8], Lewis Perrin[5], Stuart Salfinger[9,17], Ian Hammond[10], Yee Leung[11], Peter Sykes[12], Hextan Ngan[13], Andrea Garrett[5], Michael Laney[12], Tong Yow Ng[13], Karfai Tam[13], Karen Chan[13], David H Wrede[6], Selvan Pather[14], Bryony Simcock[12], Rhonda Farrell[15], Gregory Robertson[15], Graeme Walker[6], Anthony McCartney[17] and Monika Janda[18]

1. *University of Queensland, School of Medicine, QLD, Australia*
2. *University of Sydney NHMRC Clinical Trials Centre, Sydney, NSW, Australia*
3. *Westmead Hospital, Department of Gynaecologic Oncology, Sydney, NSW, Australia*
4. *Department of Gynaecologic Oncology, Monash Medical Centre, Melbourne, VIC, Australia*
5. *Queensland Centre for Gynaecological Cancer, QLD, Australia*
6. *Royal Women's Hospital, Melbourne, VIC, Australia*
7. *Royal Adelaide Hospital, Adelaide, SA, Australia*
8. *John Hunter Hospital, Newcastle, Australia*
9. *King Edward Hospital, WA, Australia*
10. *St John of God Hospital, Perth, WA, Australia*
11. *School of Women's and Infants' Health, University of Western Australia, WA, Australia*
12. *Christchurch Women's Hospital, Christchurch, New Zealand*
13. *Department of Obstetrics and Gynecology, Queen Mary Hospital, Hong Kong*
14. *Royal Prince Alfred Hospital, Sydney, NSW, Australia*
15. *Royal Hospital for Women, NSW, Australia*
16. *Royal Infirmary of Edinburgh, Scotland*
17. *St John of God Hospital, Perth, WA, Australia*
18. *Queensland University of Technology, School of Public Health, Institute of Health and Biomedical Innovation, QLD, Australia*

Background and aims: The LACE trial aims to assess equivalence between Total Abdominal Hysterectomy (TAH) and Total Laparoscopic hysterectomy (TLH) in patients with apparent stage 1 endometrioid endometrial cancer in disease-free survival. Previously, the GOG-LAP2 trial failed to demonstrate non-inferiority of patients undergoing laparoscopic hysterectomy for uterine cancer.

Methods: Between 2005-2010, 760 patients were enrolled in the multicentre, randomised clinical LACE trial, and 753 who completed at least 6 week's assessment were followed for 4

years. Pelvic/aortic lymph node dissection was at the surgeons' discretion. Presence of recurrent disease was proven by clinical assessment, radiological work-up ± histological confirmation. Sample size calculations for 90% power, at a 5% Type I error level, required 755 patients to declare non-inferiority with a margin of 7% or less at 4.5 years.

Results: The median follow-up at study closure was 4.53 years; 404 patients were assigned to TLH and 349 to TAH; 126 (17%) relapses were recorded, 71 (17%) in the TLH group, and 55 (16%) in the TAH group (about half due to endometrial cancer, half due to other causes in both groups). Of all patients, 367 (48.0%) underwent lymph node dissection, 161 (40.0%) in the TLH and 206 (58.0%) in the TAH group ($p<0.001$). Results on disease-free and overall survival for the LACE trial will be presented, and meta-analysed with GOG-LAP-2.

Conclusion: If TLH is non-inferior to TAH, the standard treatment of early stage endometrial cancer should change to TLH, as it has better surgical recovery, pain and health care costs outcomes.

Notes:

Fallopian tube intraluminal tumour cells in high grade endometrial cancer: Associations and outcomes

***Emma R Allanson*[1], *Colin Stewart*[1], *Heidi Shukralla*[1], *Stuart Salfinger*[1, 2], *Jason Tan*[1, 2], *Yee Leung*[1]**

1. *King Edward Memorial Hospital, Subiaco, Western Australia*
2. *St John of God Hospital, Subiaco*

Objective: We aimed to investigate the correlation of intra-luminal tumour cells (ILTCs) with clinicopathological parameters and outcomes in 247 consecutive high-grade endometrial carcinomas.

Results: ILTCs were identified in 66 (27%) cases. There was no relationship with the histological subtype of carcinoma. There was a correlation between ILTC and tumour stage ($p<0.001$). ILTCs were associated with positive PFC (OR 3.97, 95%CI 2.68-5.89, $p<0.001$). There was a negative correlation between prior hysteroscopy with curettage and the presence of ILTCs (OR 0.57, 95% CI 0.38-0.86, $p=0.016$). This relationship persisted when adjusted for tumour stage, subtype, mode of surgery and the experience level of the surgeon (OR 0.51, $p=0.038$). There was no significant association between the presence of ILTCs and the type of surgery or the experience of the primary surgeon.

Conclusion: Hysteroscopy significantly reduces the likelihood of finding ILTCs. ILTC remains a potential histological consideration in predicting patient outcomes in high-grade endometrial cancer.

Notes:

Retrospective audit of fast cancer treatment pathway for post-menopausal bleeding at Waikato Hospital

***Michael J Burling*[2, 1], *Anthony Stock*[3]**

1. *Women's Health, Auckland City Hospital, Auckland, New Zealand*
2. *Auckland Hospital, Wattledowns, AUCKLAND, New Zealand*
3. *Obstetrics and Gynaecology, Waikato Hospital, Hamilton, New Zealand*

On 1st of October 2014 the New Zealand Government released Faster Cancer Treatment Program targets. Standards included 85 percent of patients have a first specialist appointment (FSA) within 14days of referral and receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer by July 2016 [1]. A retrospective audit was done between 1st October 2014 and March 31 2015 of all women referred with postmenopausal bleeding (1 of 7 high suspicion of cancer definition [2]) to Waikato DHB. 35 patients indentified, only 31% of patients were seen within 14days and of those who had cancer (n=9) NONE were treated within the 62days target. Analysis to identify where delays in the process identified (incorrect referral, triaging, clerical processes, delay from FSA to hysteroscopy, investigations for MDM and treatment), and helped the department to obtain funding in addressing these issues.

1. National Gynaecological Cancer Tumour Standards Working Group. (2013). Standards of Service Provision for Gynaecological Cancer Patients in New Zealand. Wellington, New Zealand: Ministry of Health.
2. Faster Cancer Treatment: High suspicion of cancer definitions. September 2015. Wellington, New Zealand: Ministry of Health.

Notes:

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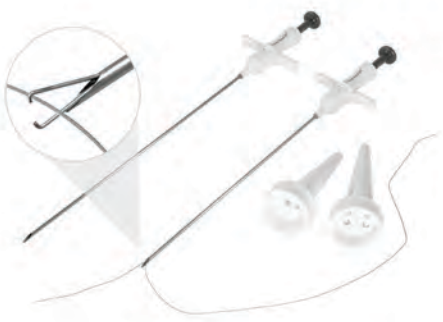

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Minor clear cell and serous components in stage 1, grade 1/2 endometriod adenocarcinomas; Do they affect prognosis?

Nimithri Cabraal[1]

1. *Gold Coast University Hospital, Biggera Waters, QLD, Australia*

Background
Minor components of clear and serous type carcinomas are reportedlyfound in otherwise low grade endometriod type adenocarcinomas. The WHO recommends that any percentage greater than 5% be reported and that this may affect patient prognosis
Objectives
To determine the percentage of minor componenets of clear cell and serous carcinomas in otherwise low grade endometriod carcinomas and to also determine whether the presence of minor components of clear cell and serous carcinoma adversely affect outcomes
Method
A list of stage 1 endometrial adenocarcinoma patients presented at Tumour Board at John Hunter Hospital between 2006 and 2010 was obtained. Chart and slide review was undertaken for patients that met selection criteria. The presence and percentage of clear cell or serous components was recorded where found and subsequently further immunohistochemistry (IHC) was performed
Results
100 cases were reviewed. 18 had identifiable clear or serous like components. IHC did not support a diagnosis of clear or serous components in any case. Prognosis did not appear to be adversely affected by the presence of these components.

Notes:

Analysis of the outcome of patients with stage IV uterine papillary serous adenocarcinoma. Is there a role for neo-adjuvant chemotherapy The Queensland Centre for Gynaecological cancer experience

***Murad Al-Aker*[1], *K Sunday*[2], *Jim Nicklin*[2]**

1. *Royal Brisbane and Women's Hospital, Kelvin Grove, QLD, Australia*
2. *Queensland Centre for Gynaecological cancer , Brisbane*

Background:
Stage IV uterine papillary serous carcinoma (UPSC) is rare and usually mimic advanced ovarian cancer in its presentation and disease distribution. The standard for treatment is primary cytoreductive surgery (PCS) followed by adjuvant chemotherapy. The use of neoadjuvant chemotherapy (NAC) has gained more popularity in recent years based on evidence extrapolated from ovarian cancer research and from small retrospective studies.

Objectives:
The primary objective was to analyze the clinicopathological factors and to determine the progression-free survival (PFS) and overall survival (OS) in patients with stage IV UPSC treated at Queensland Centre for Gynaecological cancer (QCGC). A secondary objective was to compare the survival outcomes of women with stage IV UPSC treated with NAC and interval cytoreduction with women treated with primary cytoreductive surgery PCS followed by adjuvant chemotherapy

Material and Methods:
The study is a retrospective cohort review. We used the database of QCGC to review medical and pathological records. Women diagnosed with Stage IV UPSC at QCGC between January 2005 and December 2014 were reviewed. Demographics and surgical outcomes were analysed. PFS and OS were estimated by using Kaplan-Meier methods. A sub analysis was made to compare the outcomes of women with Stage IV UPSC who were treated with NAC and women who were treated with PCS. Comparison between study groups was tested by log-rank statistics

Results:
We identified and reviewed 50 with stage IV UPSC who were treated at QCGC between Jan 2005 and Dec 2014. 37 patients underwent primary cytoreductive surgery. Nine patients received neoadjuvant chemotherapy, Eight underwent interval debulking, and one did not due to progressive disease. Four patients received no active treatment and were referred to palliative care. Patients who underwent NAC when compared to patients who underwent PCS were older (72.1 Vs 71), more likely to have multiple medical co-morbidites (> 3) (77.8 % Vs 48.6 %), had a higher chance of optimal debulking surgery (77.8% Vs 67.6 %) and Lower complication rates (11.1 Vs 16.2%). The PFS for patients who underwent NAC was lower than patients who underwent PCS (Median of 9.5 months Vs 12.2 months) and the OS was lower (Median of 20.0 months Vs 24.5 months)

Conclusion:
In our series, patients with stage IV UPSC had poor prognosis. Neodjuvant chemotherapy compared to primary cytoreductive surgery was associated with less favourable outcome which might reflect the surgeon's preference to offer NAC to more sick patients with more advanced disease.

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Effect of pre-surgical body mass index on surgical safety after laparoscopic surgery for apparent early stage endometrial cancer

Andreas Obermair[1], Nigel R Armfield[1], Val Gebski[2], Alison Brand[3], Russell Hogg[3], Thomas W Jobling[4], Russell Land[5], Tom Manolitsas[4], Marcelo Nascimento[5], Deborah Neesham[6], James L Nicklin[5], Martin K Oehler[7], Geoff Otton[8], Lewis Perrin[5], Stuart Salfinger[9], Ian Hammond[10], Yee Leung[11], Peter Sykes[12], Hextan Ngan[13], Andrea Garrett[5], Michael Laney[12], Tong Yow Ng[13], Kafari Tam[13], Karen Chan[13], David H Wrede[6], Selvan Pather[14], Bryony Simcock[12], Rhonda Farrell[15], Gregory Robertson[15], Graeme Walker[16], Monika Janda[17]

1. *University of Qld, QCGC, Greenslopes, QLD, Australia*
2. *University of Sydney NHMRC Clinical Trials Centre, Sydney*
3. *Dept of Gynaecologic Oncology, Westmead Hospital, Sydney*
4. *Dept of Gynaecologic Oncology, Monash Medical Centre, Melbourne*
5. *Queensland Centre for Gynaecological cancer , Brisbane*
6. *Royal Women's Hospital, Melbourne*
7. *Royal Adelaide Hospital, Adelaide*
8. *John Hunter Hospital, Newcastle*
9. *King Edward Hospital, Perth, WA*
10. *St John of God Hospital, Perth, WA*
11. *School of Women's and Infants' Health, University of WA, Perth, WA*
12. *Christchurch Women's Hospital, Christchurch, New Zealand*
13. *Dept of Obstetrics and Gynaecology, Queen Mary Hospital, Hong Kong*
14. *Royal Prince Alfred Hospital, Sydney, NSW*
15. *Royal Hospital for Women, Sydney, NSW*
16. *Royal Infirmary of Edinburgh, Scotland*
17. *School of Public Health, Institute of Health and Biomedical Innovation, QUT, Brisbane, QLD*

Objective: To compare surgical safety and quality of life (QoL) among women with a lower (<30) versus higher (>=30) body mass index (BMI), who received a total laparoscopic hysterectomy (TLH) for apparent early stage endometrial cancer.

Methods: Between October 2005 and June 2010, 760 women were enrolled in a multi-centre, randomized clinical trial (LACE) comparing outcomes following TLH or total abdominal hysterectomy. Here we use data from the TLH arm only (n=404), and compare adverse events (AE), hospital length of stay (LoS), conversion from laparoscopy to laparotomy, and QoL measured by EQ-5D. Postoperative AEs were graded according to Common Toxicity Criteria (CTC) v3, and those grade >=3 are reported here.

Results: While there was no difference in intraoperative AEs, or post-operative LoS between the two groups, the relative risk of at least one post-operative AE CTC Grade 3+ was significantly higher for women with BMI>=30, compared to leaner women (BMI 30>= 15.6% vs BMI<30 6.2%; RR = 2.49, 95% CI 1.24 – 5.0, p=0.01). Mean operating time was on average 9 minutes longer for women with BMI 30>= (95% CI 1.0 – 17.3, p=0.03). Of the 21 women who required a conversion from TLH to TAH, 16 (76%) had a BMI of >=30. At four weeks post-surgery a significantly greater proportion of women in the higher BMI group still reported problems with mobility (4.8%) and self-care (22.2%; p<0.05) compared to patients with in the lower BMI group (0% and 12.8%, respectively; p<0.05). Long term quality of life did not differ significantly between groups.

Conclusions: Compared to patients with a BMI of <30, women with higher BMI who present for hysterectomy have a significantly greater risk of post-operative adverse events, even if they are treated with minimally invasive surgery. These data can be used to inform patients about their

increased risk. In addition, non-surgical treatment alternatives need to be investigated for patients at greatly increased surgical risk.

This work is conducted in dedication to the late Anthony McCartney.

Notes:

Friday 20th May 2016

SESSION:	Session 3
Presenters:	Michael Seckl, Debra Neesham, Andy Garrett and Yee Leung
Time:	8.30am – 10.30am
Chair:	Greg Robertson

High risk gestational trophoblastic disease and placental site tumour: State of the art.

Michael Seckl

High risk gestational trophoblastic neoplasia can present in many different ways and so clinicians should always consider measuring the hCG in any woman of childbearing age who has developed unexplained metastatic disease. Investigations should include an MRI head and pelvis, CT chest and abdomen all with contrast. A biopsy is not essential and can promote life threatening haemorrhage, so should only be undertaken where the diagnosis is in doubt and where vascular control is possible. Genetics may be helpful to exclude a non-gestational cancer. We will cover EMA/CO chemotherapy and how to manage relapse /drug resistant disease including TE/TP, EP/EMA, high dose chemotherapy, novel agents and surgery. We will also examine what makes a patient ultra-high risk and how to prevent early deaths with low dose induction etoposide and cisplatin therapy. Brain and/or liver involvement requires special adaptation of therapy. Whole brain radiotherapy is advocated by some but likely adds to both short and long term toxicity without enhancing cure rates so is not recommended. PSTT/ETT grow more slowly, spread later, secrete less hCG, involve lymphatics and are more chemoresistant than choriocarcinomas. The FIGO scoring system is less valuable and instead stage adapted therapy is required. The key prognostic factor is an interval >4 years from the last known or causative pregnancy. In early stage disease hysterectomy is the therapy of choice but fertility conserving approaches are being piloted and will be discussed.

Notes:

Hydatidiform mole in Victoria: A 30 year history

Deborah Neesham [2], Orla McNally [1]

1. *Royal Women's Hospital, Parkville, VIC, Australia*
2. *Royal Women's Hospital, Melbourne, Australia*

Australia's first gestational trophoblastic disease registry was established in 1978 following a visit by Professor Ken Bagshawe from Charing Cross Hospital, London, in 1978. Established at The Royal Women's Hospital, Dr Alynn Long was the first director and was succeeded by Prof Michael Quinn in 1983. A database "HyMol" was developed in early to support the registry. For the last seven years A/Professor Orla McNally has been the director supported by the multi-disciplinary gynae-oncology team.

The presentation will provide an overview of the registry over the last almost 40 years and the current challenges often presented in the management of this extraordinary condition.

Notes:

Trials and tribulations of developing a statewide GTD service

Andrea Garrett [1]

1. *Wesley Hospital, Toowong, QLD, Australia*

Development of a state wide centralised service for the management of women with Gestational Trophoblastic Disease (GTD) in Queensland began in 2009. This presentation highlights the steps taken to establish a registry including a review of the historical registry, results from a clinician survey, development of workshops and committees and development of a clinical database. The Queensland Trophoblast Centre (QTC) was established in 2012 and has been running effectively since then. A discussion of the obstacles in provision of this service will be presented as well as our results and achievements to date.

Notes:

Australia: Should we have an Australian GTD registry?

Yee Leung

This discussion will consider the following areas:

- Caseload in Australia
- State based or National
- Funding source
- Medicolegal risk
- Monitoring and follow-up including long term

Notes:

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Friday 20th May 2016

SESSION:	Session 4
Presenters:	Emma Rossi, Anna DeFazio, Peter Sykes, Nivenditha Rajadevan and Antonia Jones
Time:	11.00am – 1.00pm
Chair:	Andy Garrett

Sentinel lymph node mapping for endometrial cancer - Technique optimization with different technologies, small volume disease & the role of lymphadenectomy for endometrial cancer.

***Emma Rossi*[1]**

1. *University of North Carolina, North Carolina, United States*

Approximately 20% of patients with clinical stage I endometrial cancer will have lymph node metastases on comprehensive surgical staging. Evaluations of large clinical databases have suggested that there is improved survival with lymphadenectomy with greatest benefit associated with larger yields of lymph nodes at the time of surgery. However, randomized controlled trials from Europe have shown no survival benefit among patients who have undergone pelvic lymphadenectomy. However, were these studies appropriately designed and powered to answer the question definitively? Perhaps the most important role of lymphadenectomy is in its ability to tailor adjuvant therapy: ensuring those with systemic disease receive systemic therapy and avoiding the unnecessary prescription of whole pelvic radiation to unstaged patients. SLN biopsy may offer an alternative to comprehensive lymphadenectomy that preserves the informative role lymph node histology provides, while minimizing the immediate and long term risk to the patient of a lymphadenectomy.

In this lecture we will explore the variety of techniques available for SLN mapping in endometrial cancer. We will discuss the dosing, benefits and pitfalls of different tracers (blue dyes, radiolabelled colloids and ICG). We will also explore the controversy behind injection sites (cervical, versus endometrial, versus serosal). Finally we will discuss the definitions of metastatic volume to the lymph nodes, and the questions that loom over the clinical significance of micro metastatic lymph node volume. At the end of this lecture, we will propose algorithms for safely employing SLN mapping in endometrial cancer, and provide a suggested method to proceed from counseling, to tracer choice and administration, to pathology review and determination of adjuvant therapy.

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From genomics to clinical care in women with gynaecological malignancy: News from the benches

Anna DeFazio

1. *Center for Cancer Research, Westmead Millennium Institute, University of Sydney, Westmead, NSW, Australia*

Epithelial ovarian cancer is a poor-prognosis malignancy. While patients are commonly initially sensitive to chemotherapy, most patients eventually relapse with drug resistant disease and overall survival rates are low. We are now beginning to understand that ovarian cancer is a heterogeneous disease by several criteria, and that mechanisms of chemo-resistance differ from patient to patient. Improvements in outcome are likely to require individualization of treatment rather than the current 'one-size-fits-all' approach. We have undertaken a series of genetic and genomic studies to examine alterations that contribute to treatment response and whole genome sequence analysis to survey structural variation at high resolution.

The majority of serous ovarian carcinomas are considered to be high-grade by histological criteria and have TP53 driver mutations. Just over 50% of this sub-type have defects in BRCA-related homologous recombination DNA repair pathways, which contribute to improved chemo-response and patient survival. However, reversion events and loss of BRCA1 promoter methylation can lead to acquired chemotherapy resistance. Low-grade serous ovarian cancer (LGSC) is a completely different entity, from a molecular perspective. LGSC are TP53 wild-type and are intrinsically resistant to platinum-based chemotherapy. Mutations in the Ras pathway are found in ~50% of LGSC and new, targeted agents are being tested in clinical trials. However, trials in LGSC are challenging as it is relatively rare, and the subtype is not completely defined at a molecular level.

Collectively our findings underscore the complexity of the ovarian cancer genome. Understanding the molecular drivers and mechanisms of treatment response is an important step forward in improving clinical outcomes through individualization of cancer care.

Notes:

The crucial nature of pathology in sentinel node biopsy procedures for vulval cancer

Peter Sykes[1]

1. *University of Otago, Christchurch, New Zealand*

This is an early report from a prospective audit of sentinel node procedures performed for women with early stage vulval cancer at gynaecological oncology centres in New Zealand and Australia. As of 14/1/2016 fifty four women with apparently early stage vulval cancer were enrolled in the Audit from 8 participating centres. Following surgery 5 women were found either to have multifocal disease or a tum size greater than 4 cm and are excluded from further analysis. Of the remaining women sentinel nodes were identified and removed in all but 1 patient. 36 women had negative sentinel nodes 28 of these women have had greater than 12 months follow up. 4 of these women with negative sentinel nodes have developed recurrent disease. 2 experienced recurrence primarily in the groin. On review of pathology specimens in both these women the recommended pathology protocol was not followed and in both cases on further sectioning micro-metastases were identified. All pathology specimens for women with negative sentinel nodes were reviewed. A number of further deviations from protocol were identified in several centres. Following re-examination of these cases no further micro metastasis were identified. We conclude that groin failure may be associated with micro-metastasis in a removed sentinel node. Strict adherence to pathology protocol is an essential step for patient safety in the utilisation of this technique. Appropriate steps have been taken in participating centres to ensure protocol adherence.

Notes:

Retrospective clinical audit assessing patient outcomes following treatment for vulval cancer over the last 15 years at the Royal Women's Hospital, Melbourne

***Niveditha Rajadevan*[1], *Orla McNally*[1]**

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

A retrospective clinical audit was undertaken to assess patient outcomes following treatment for vulval cancer for all patients treated over the last 15 years at the Royal Women's Hospital. 112 patients were identified. Outcomes assessed included: recurrence, disease free survival and quality of life. For all recurrences, histopathology reports were reviewed for predisposing risk factors including evidence of premalignant conditions and presence of lymphovascular space invasion. Of the 112 patients treated, 17 (15.5%) recurred; 7 local, 5 groin and 4 both local and groin. One patient recurred with only distant disease. All patients who recurred only at the groin were sentinel lymph node positive at the time of initial treatment. Time to recurrence varied from months to years. The low rate of recurrence is likely attributable to only short-term follow-up data being available for some patients. Histopathological features including premalignant conditions were frequently seen in patients who recurred.

Notes:

Perivascular epithelioid tumours (PEComas) of gynaecological origin

Antonia Jones[1]

1. *Gynaecology Oncology, Mercy Hospital for Women, Heidelberg, Vic, Australia*

PEComas are rare tumours of the gynaecological tract only recognised and described in the last 20 years.

These tumours occur at many sites and are characterised by the presence of an epitheloid cell of mixed myomelanocytic immunophenotype. Whilst the exact cell of origin has not been unequivocally established, embryonal studies suggest a neural-crest stem cell that is capable of myoid and melanocytic differentiation. The tumour family includes previously recognised entities such as angiomyoplioma, clear cell 'sugar' tumours of the lung and lymphangioleiomyomatosis. This talk aims to highlight the current knowledge of PEComas of extra-gynaecological tract origin including histology, morphology, immunohistochemistry and genetics and then to summarise all reported cases of gynaecological PEComas to date. It will discuss some of the issues with PEComa prognostic classification and examine the performance of several prognostic classification systems for malignancy in these tumours.

Notes:

Friday 20th May 2016

SESSION:	Session 5
Presenters:	Peter Grant, Alison Brand, Kristine Lindemann and Shaun McGrath
Time:	2.00pm – 4.00pm
Chair:	Alex Crandon

Making a difference: Palliative care for the gynaecological oncologist

Peter Grant

Gynaecological Oncology developed as a subspecialty to offer women a society of physicians who are trained in the comprehensive management of women with female reproductive cancers. Whilst we have moved our focus as CGO's to the predominantly surgical aspects of the subspecialty, our commitment to comprehensive care should still involve us in the decision making process at all points along the treatment.

Some of our patients will die of their cancer and an involvement in advance care planning and palliative care for these women and their families should be part of our commitment to comprehensive care. The assumption that this can and will be done by someone else is not borne out in the Australian health data.

Patients with cancer in their last 3 months of life will on average have more than 3 attendances to an emergency department, at least one admission to an acute care hospital and more than 50% will die in an acute care setting. The opportunity for early acute care planning and involvement with palliative care services is an important part of the care we should offer. On occasions the management of some of the acute palliative care problems can and should be dealt with by Gyn Oncologists.

Involvement in this aspect of care can be emotionally challenging but is enormously rewarding, for us and our patients and we owe it to them to be involved.

Notes:

Outcome of extended VTE prophylaxis in women undergoing gynaecological surgery for suspected or confirmed malignancy

***Alison Brand*[1], *Ahila Thiru*[1], *Letitia Lancaster*[1], *Kerry Hitos*[1]**

1. *Department of Gynaecological Oncology, Westmead Hospital, Westmead, NSW, Australia*

Aims: To determine the incidence of venous thromboembolism (VTE) in gynae-oncology patients receiving extended LMWH prophylaxis, the complication rate and patient compliance.
Methods: A prospective cohort audit was conducted on women undergoing major gynaecological surgery for confirmed or suspected malignancy from July 2014 to April 2015, in whom 4 weeks VTE prophylaxis was planned. Patients were followed-up by telephone at 6 weeks and 3 months to determine VTE rate, complications and compliance.
Results: 92 patients entered the study. Three patients developed a VTE at 21, 28 and 83 days post-operatively, all of whom were compliant with VTE prophylaxis. There were no major postoperative bleeding complications secondary to extended VTE prophylaxis. Eighty-seven percent of patients completed extended VTE prophylaxis.
Conclusion: The introduction of extended LMWH prophylaxis reduced the VTE incidence to 2.2% at 6 weeks (previously 4%[1]), without increasing the risk of post-operative bleeding complications. Compliance with extended VTE prophylaxis was good.

1. Sidhu V, Lancaster L, Elliott D, Brand A. Implementation and audit of 'Fast-Track Surgery' in gynaecological oncology surgery. Aust N Z J Obstet Gynaecol. 2012. 52 (4). 371- 376.

Notes:

Enhanced recovery after surgery (ERAS) for ovarian cancer – A sytematic review to identify candidate interventions

***Kristina Lindemann*[1, 2, 3], *Peey-Sei Kok*[1, 2], *Martin Stockler*[1], *Ken Jaaback*[4], *Alison Brand*[2, 5]**

1. *NHMRC Clinical Trials Centre, Camperdown, NSW, Australia*
2. *Australian New Zealand Gynecological Oncology Goup (ANZGOG), Camperdown, NSW*
3. *Crown Princess Mary Cancer Centre, Westmead, NSW*
4. *Department of Gynaecological Oncology, John Hunter Hospital, Newcastle, NSW*
5. *Department of Gynaecological Oncology, Westmead Hospital, Westmead, NSW*

Objective: To summarize the evidence of ERAS interventions in ovarian cancer.
Methods: MEDLINE/Cochrane Library were systematically searched for studies ≥1 ERAS interventions in ovarian cancer patients. Studies were included irrespective of design and references were hand reviewed for completeness.
Results: Of 23 studies, nine observational studies reported on complete ERAS protocols. Fourteen studies reported on single interventions e.g. early feeding, omission of pelvic drains, early orogastric tube removal, doppler guided fluid management, and patient-controlled epidural anaesthesia. Most of the 10 randomized controlled trials studied early feeding protocols.
Conclusion: Most studies including ovarian cancer patients were susceptible to bias. The strongest evidence exists on early feeding protocols, however, definition of early feeding varied. The larger scope of surgery and patients' comorbidities challenge the extrapolation of evidence of ERAS from other surgical disciplines. We propose an innovative randomised trial to determine the feasibility, safety and effectiveness of ERAS in ovarian cancer.

Notes:

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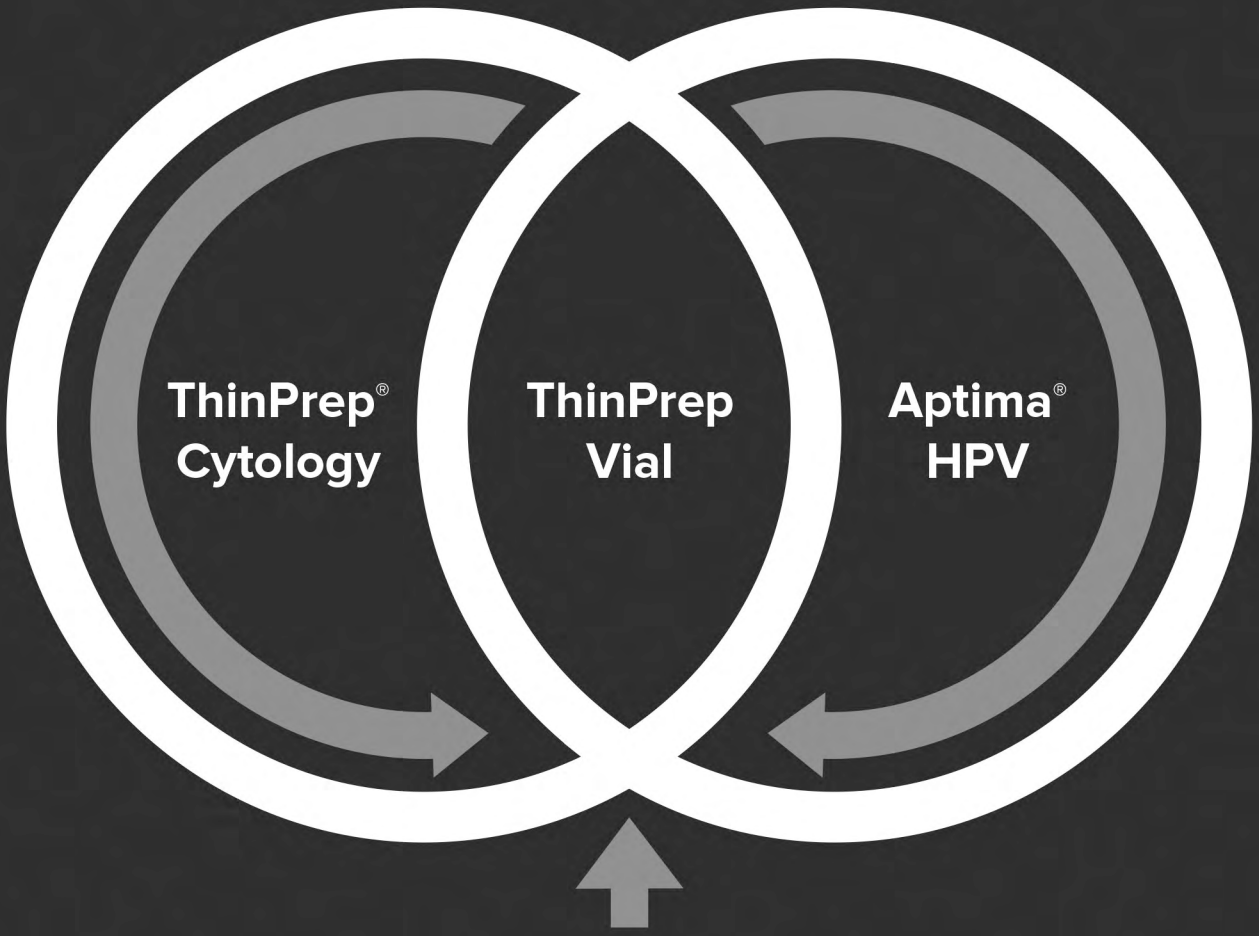

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1. J Doorbar, Clinical Science 2006; 110: 525-541, 2. References available at www.hologic.com, 3. Aptima HPV Assay Package Insert #503744EN Rev A 2012, Table 22

Clinicopathological study of ovarian carcinoid tumours

Shaun McGrath [1, 2]***, James Nicklin*** [3, 2]

1. *Royal Brisbane and Women's Hospital, Brisbane, Australia*
2. *School of Medicine, University of Queensland, Brisbane, Australia*
3. *Queensland Centre for Gynaecological Cancer, Brisbane, Australia*

Objectives*:* To describe the clinical features, course, treatment modalities, follow up and survival rates of women diagnosed with ovarian carcinoid tumours.

Methods: Retrospective chart review of all patients diagnosed with primary ovarian carcinoid, managed by the Queensland Centre for Gynaecological Cancer over a 32 year period.

Results: 18 patients were identified. 14/18 were stage 1, 2/18 stage 3 and 2/18 stage 4. Carcinoid syndrome was present in 2/18. All underwent surgical management. Follow up varied significantly for early stage disease. 5 year survival was 100% for stage 1 disease, 25% for stage 3 and 4 disease.

Conclusions: The majority of carcinoid tumours are diagnosed as an incidental finding. Prognosis for early stage disease is excellent, whether conservative or definitive surgery with staging was performed, and intensive follow up versus discharge does not appear to impact survival. Optimal treatment for advanced disease remains unknown and requires further study.

Notes:

An Australian experience of laparoscopic radical trachelectomy from inception to birth

Helen Green[1] , Vinita Rajadurai[1] , Jason Tan[1]

1. *King Edward Memorial Hospital, Cottesloe, WA, Australia*

The first Australian experience of laparoscopic radical trachelectomy was presented at this meeting 5 years ago.

Today we will demonstrate our technique and discuss common surgical pitfalls, our approach to the management of fertility concerns (including cerclage) and post-operative optimization strategies.

The delivery of a successful twin pregnancy will help to highlight the full spectrum of issues pertaining to the management of these women.

Notes:

A novel solution to leaking intestinal stoma sites using 3-D imaging, AutoCad and printing techniques

***Paige P Tucker*[1], *Paul A Cohen*[1], *Jason JS Tan*[1]**

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

Background: Creating an intestinal stoma is an important component of gynaecological oncology surgery. However, despite careful pre-operative planning, extensive experience, and precise surgical technique, complications occur in high frequency. Leaking stomas and peristomal skin complications are the most common complications, with rates ranging from 18-60%. The psychological and financial consequences of these complications can be considerable for the patient, as well as incurring significant morbidity. Current management of leaking stomas may involve adjustment of the appliance and the use of accessories including seals, fillers, skin protectors and creams. In 2013 these products cost the Australian government over $19 million. However, notwithstanding these resources and optimal management by a stoma nurse, some patients may find their leaking stomas refractory to treatment.

Method: We describe the use of a novel and innovative method, which has been used in a series of patients with complex stoma sites, resulting in complete resolution of leakage.

Notes:

A novel method to facilitate uterine delivery at robotic hysterectomy

Shih-Ern Yao

Following completion of robotic hysterectomy, the uterus is usually delivered via the vagina. Where the vaginal capacity is inadequate, or uterine size is too great, vaginal delivery may not be possible. The surgeon then has a number of options including uterine morcellation, enlargement of the vaginal introitus by Schuchardt Incision or abdominal delivery of the specimen. Uterine morcellation is contraindicated in cases of malignancy or suspected malignancy due to the risk of dissemination of malignant cells and destruction of the anatomical structure of the specimen.. Another method, previously unreported in the literature, is to enlarge the vaginal vault be making a full thickness linear incision down the midline of the anterior vaginal wall, posterior wall, or both.

The surgical technique will be described and outcomes of 17 cases provided. Alternatively a narrated, edited video can be presented.

Notes:

Pushing the limits of minimally invasive surgery

***Helen Green*[1], *Jason Tan*[1]**

1. *King Edward Memorial Hospital, Cottesloe, WA, Australia*

In a series of two videos we will show themed complications of gynaecologic oncology surgery and demonstrate management via a minimally invasive approach.
Our video will demonstrate that surgical principles can be safely translated from open surgery. We will discuss the elements of surgical anatomy, patient selection, patient preparation (including port placement), instrument selection and the principles of managing the complications. Patient benefits and post-op care relating to a minimally invasive approach will also be presented.

Notes:

Friday 20th May 2016

SESSION:	Session 6
Presenters:	Greg Woods
Time:	4.30pm – 5.30pm
Chair:	Michael Bunting

The Tassie Devil Story

Greg Woods [1]

1. *Menzies Research Institute Tasmania, Hobart, TAS, Australia*

The Tasmanian devil (Sarcophilus harrisii) is a carnivorous marsupial only found in Tasmania. Devil facial tumour disease (DFTD) refers to transmissible cancers in Tasmanian devils. Cytogenetics has established that DFTD is a clonal neoplasm. DFTD is a transmissible cancer originating from a Schwann cell. It is transmitted by biting and is invariably fatal. DFTD has killed more than 80% of the Tasmanian devil population.

Once the DFTD cells have been transmitted, they develop into a cancer without inducing an immune response. But how can the transmitted cancer cells avoid activating an allogeneic immune response? Multiple immunological tests indicate that the Tasmanian devil has a competent immune system. The DFTD cancer cells avoid allogeneic recognition because they do not express MHC-I molecules on the cell surface.

Devils immunised with killed DFTD tumour cells in the presence of adjuvants can produce an immune response against the DFTD cells. This has been refined to overcome the down-regulation of MHC-I, which is expressed when DFTD cells are treated with IFN-γ. Preliminary results provide encouraging evidence that devils immunized with DFTD cells treated with IFN-γ consistently produce an immune response. This has led to the world's first trial of devils vaccinated against DFTD and released into the wild.

Although transmissible cancers are extremely rare we recently discovered a second transmissible cancer in Tasmanian devils. This second cancer is grossly indistinguishable from those caused by the original DFTD. However, this second cancer bears no detectable genetic, cytogenetic or histological similarity to DFTD.

Notes:

Saturday 21st May 2016

SESSION:	Session 7
Presenters:	Michael Seckl, Kristine Lindemann, Chloe Ayres and Penny Blomfield
Time:	11:30am – 12:40pm
Chair:	Vivek Arora

Fertility preservation and management of malignant ovarian germ cell tumours

Michael Seckl

Ovarian germ cell tumours comprise the benign/pre-malignant conditions of dermoids/mature cystic teratomas and grade I/II immature germ cell tumours through to the malignant dysgerminomas, non-dysgerminomatous germ cell tumours, mixed germ cell tumours and immature grade III germ cell tumours. The malignant forms are collectively known as malignant ovarian germ cell tumours (MOGCT). Whilst dermoids are relatively common they should not be ignored as they can continue to grow and can also differentiate into MOGCT or nasty cancers including squamous and adenocarcinomas that once outside the ovary are incurable. MOGCT by contrast are rare comprising less than 5% of all ovary cancers and may be bilateral in 5-10% of cases. They can occur from childhood to late adult life but peak incidence is in the mid-late teens. The tumours can grow rapidly so presenting symptoms may be of short duration. Measurement of hCG and AFP can provide vital clues to the diagnosis whilst LDH and CA125, being less specific, may still help in detection of response and relapse. The presentation will cover fertility sparing surgery, early stage disease, surveillance verses adjuvant chemotherapy to detect/prevent relapse, late stage disease and the value of neoadjuvant chemotherapy followed by surgery verses surgery and then chemotherapy. We will also touch on management of relapsed disease following first line chemotherapy and the use of high dose chemotherapy. Finally, we will examine the fertility prospects of patients with one ovary who either did or did not need subsequent chemotherapy.

Notes:

Intraperitoneal chemotherapy in patients with optimally debulked ovarian cancer – The Westmead experience

Christina Girgis [1] , Alison Brand [2] , Gerard Wain [2] , Russell Hogg [2] , Paul Harnett [1] , Kristina Lindemann [1]

1. *Department of Medical Oncology, Crown Princess Mary Cancer Centre, Westmead Hospital, Westmead, NSW, Australia*
2. *Department of Gynaecological Oncology, Westmead Hospital, Westmead, NSW, Australia*

Objectives: To evaluate clinical outcomes and tolerability of IP chemotherapy in ovarian cancer patients.
Methods: A retrospective review was conducted of all patients from 2006 and 2015 with optimally debulked ovarian cancer (≤1cm residual disease) in whom IP chemotherapy was planned.
Results: 64 patients with a median age of 54.5 years were included. 80.6% had Stage III/IV disease. 56.3% had no macroscopic residual disease after surgery. 62 patients received ≥1 cycle of IP chemotherapy (mean 4.1). Half completed their intended IP treatment. The main reasons for non-completion were port-related (32.8%). After median follow-up of 50.5 months, 55% had disease recurrence and 39% had died. Median progression free survival was 25 months. Median overall survival was 57 months.
Conclusion: IP chemotherapy was generally well-tolerated and showed good overall clinical outcomes, in keeping with those reported in the literature. Initially, catheter-related problems rather than toxicity resulted in a switch to intravenous chemotherapy.

Notes:

HELP PROTECT

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Histopathological analysis between the tubo-ovarian interface in women undergoing risk reducing bilateral salpingo-oopherectomy (BSO)

Chloe F Ayres [1] ***, Michael Quinn*** [2] ***, Gayanie Ratnayake*** [2] ***, Orla McNally*** [2]

1. *The Royal Hospital for Women - Randwick, Randwick, NSW, Australia*
2. *Royal Women's Hospital, Parkville, VIC, Australia*

Opportunistic bilateral salpingectomy is now promoted for women at the time of hysterectomy for benign gynaecological disease. This is the result of the fallopian tube, particularly the fimbral end, emerging as the primary site of carcinogenesis in high grade serous ovarian cancers. In BRCA positive women, BSO offers the greatest risk reduction for ovarian cancer, however, bilateral salpingectomy with delayed oophorectomy may be a more effective strategy in overcoming the quality of life issues associated with oophorectomy in pre-menopausal women.

We know there is no direct connection between the ovary and its adjacent fallopian tube, however we often find intra-operatively remnants of the fimbria adherent to the ovary. We performed a pilot study on 20 women undergoing risk reducing surgery to demonstrate this tubo-ovarian interface exists microscopically and challenge the practice that bilateral salpingectomy alone may not be an effective risk reducing strategy.

Notes:

Uptake of prophylactic BSO in women at risk of tubo-ovarian malignancy in Tasmania

Penny Blomfield, Jo Burke. M Bunting, S Kearton, K Wills

Uptake of prophylactic surgery to reduce tubo-ovarian cancer risk by women with BRCA mutations is variable. Australian publications have suggested uptake by 38-56% of mutation carriers.

We explored the uptake of risk reducing surgery amongst 231 women with known BRCA mutations who were under the care of the Tasmanian Clinical genetics service using a postal questionnaire and chart review where possible.

Uptake of prophylactic BSO was 71.9% in this population. This is higher than reported in other Australian populations and we have tried to explore what factors are influencing women's choices in this regard.

Notes:

Saturday 21st May 2016

SESSION:	Session 8
Presenters:	Emma Rossi, Tom de Greve, Vivek Arora, Bernd Schmid, Alison Brand
Time:	1.20pm – 3.00pm
Chair:	Julie Lamont

Sentinel lymph node mapping for cervical cancer

Emma Rossi [1]

1. *University of North Carolina, North Carolina, United States*

Lymphadenectomy, in some form, for early stage cervical cancer is a widely accepted standard. Its role is predominantly diagnostic, particularly in determining which patients might benefit from chemotherapy and radiation, and potentially in identifying when to omit or abort hysterectomy. Preoperative imaging, for exampled with PET/CT, has not proven to be an adequately reliable (or accessible) tool. Sentinel lymph node (SLN) mapping for cervical cancer has emerged over the past two decades and a potential alternative, and in some countries is considered a standard approach. In general, however, the technique has been explored with smaller series and definitive accuracy studies are lacking.

In this lecture we will explore the available data with focus on larger, multi-institutional series such as SENTICOL and FIRES. We will explore the optimal patients for whom this technique can be considered, such as patients with <2cm tumors and the choices in tracer that are available. Should we consider conization with SLN biopsy as the ultimate in minimally invasive surgery for microinvasive cervical cancer? We will discuss the role, and limitations, of intraoperative frozen section for decision-making. The previously presented results from SENTICOL-2 will be discussed, including the morbidity data that demonstrates a reduction in lymphedema when SLN biopsy is employed. Finally we will discuss some of the challenges with interpreting the SLN biopsy results including micro metastatic volume and whether completion lymphadenectomy should follow positive results.

Notes:

Efficacy of sentinel node mapping in South African cervix patients

***Tom De Greve*[1, 2], *Leon Snyman*[1]**

1. *Gynaecological Oncology, University of Pretoria, Kalafong Tertiary Provincial Hospital, Pretoria, Gauteng, South Africa*
2. *Gynaecological Oncology Unit, Queensland Centre for Gynaecological Cancer, Brisbane, Queensland, Australia*

Knowledge with regards to lymph node status is essential in the management of women with cervical cancer. Identifying women in whom lymphadenectomy can be safely avoided will result in less morbidity without compromising overall and disease free survival. Data is limited with regards to the role of sentinel lymph node (SLN) mapping in cervical cancer patients in low resource setting where the prevalence of HIV and other gynaecological infections are high. A prospective cohort study in a referral hospital in Pretoria was performed. Sentinel lymph node mapping was performed on 20 patients with a combination of blue dye and a radioactive tracer. The HIV prevalence was 50%. 13 of the patients had a successful mapping, with 9 of patients having bilateral SLN mapping. Possible reasons for a low mapping rate could be the high rate of HIV, pelvic adhesion secondary to previous infections and enlarged lymph nodes.

Notes:

Sentinel node detection in operable cervical cancer - a proposal for a prospective ASGO study

***Vivek Arora*[1, 2], *Archana Rao*[3]**

1. *Gynaecological Oncology, Royal Women's Hospital, Melbourne, VIC, Australia*
2. *Western Health, Melbourne, VIC*
3. *Gynaecologic Oncology, Royal Hospital for Women, Randwick, NSW, Australia*

Lymph node status is considered to be the most important prognostic factor in women diagnosed with cervical cancer. Lymph node positivity is associated with halving of survival, even with post-operative adjuvant treatment.

There is mounting interest in the role of sentinel nodes in cervical cancer. The reasons for increased interest include: possibility of limited nodal excision if validated and hence reduced morbidity; and probability of increased detection of micro metastases and identification of high-risk group who may benefit from adjuvant treatment. Based on the pooled results from the current literature, the sensitivity and the detection rate of sentinel nodes in cervical cancer approaches 90%. However, little is known about the false negative rate with this approach but has reportedly been as high as 10-20%. This is a proposal for a prospective ASGO study.

1. Holman LL, Levenback CF, Frumovitz M. Sentinel Lymph Node Evaluation in Women with Cervical Cancer. The Journal of Minimally Invasive Gynecology. Elsevier Ltd; 2014 Jul 8;21(4):540–5.
2. Cormier B, Diaz JP, Shih K, Sampson RM, Sonoda Y, Park KJ, et al. Establishing a sentinel lymph node mapping algorithm for the treatment of early cervical cancer. Gynecologic Oncology. 2011 Aug;122(2):275–80.
3. Cibula D, Abu-Rustum NR, Dusek L, Zikan M, Zaal A, Sevcik L, et al. Gynecologic Oncology. Gynecologic Oncology. Elsevier Inc; 2012 Mar 1;124(3):496–501.
4. Kadkhodayan S, Hasanzadeh M, Treglia G, Azad A, Yousefi Z, Zarifmahmoudi L, et al. ScienceDirect. European Journal of Surgical Oncology. Elsevier Ltd; 2015 Jan 1;41(1):1–20.
5. Hertel H. Cervical Cancer and the Role of Lymph Node Staging Cons Sentinel Concept. International Journal of Gynecological Cancer. 2010 Oct;20:S37–8.

Notes:

Neo-adjuvant chemotherapy followed by fertiity sparing surgery for early cervical cancer (IB1 2-4 cm) - review of literature and research prospects

Vivek Arora [1 2] ***, Jeffery Goh*** [3]

1. *Royal Women's Hospital, Melbourne, Ascot Vale, VIC, Australia*
2. *Western Health, Melbourne, VIC*
3. *Medical Oncology, Royal Brisbane and Women's Hospital, Brisbane, QLD, Australia*

Cervical cancer is the third most common malignancy in women and has a bimodal distribution with first peak in reproductive age group. Fertility sparing surgery in the form of radical trachelectomy is offered only to women with tumours less than 2 cm in size and negative lymph nodes. Women with tumour size 2-4 cm are referred for chemoradiation or radical hysterectomy in most instances due high incidence of positive margins or positive lymph nodes resulting in loss of fertility and possible impact on future sexual functioning and quality of life (QOL). There are reports of successful downsizing this group of tumours with neo-adjuvant chemotherapy (NACT) in as high as 70-80% of patients allowing the possibility of a fertility sparing procedure. However, the data in the literature is from small series of patients treated at individual centres with a wide variation in the chemotherapeutic regimens and criteria for response.

Notes:

Why rebrand the most successful brand in gynaecology, the Pap Smear?

***Bernd C Schmid*[2, 1], Günther A Rezniczek [3], Jamie Carlson [4], Benjamin Luca[5], Anthony Proietto [1], Kenneth Jaaback[1]**

1. *Department of Gynaecological Oncology, John Hunter Hospital, New Lambton Heights , NSW, Australia*
2. *The Royal Women's Hospital Melbourne, Melbourne, VIC, Australia*
3. *Department of Obstetrics and Gynecology, Ruhr-Universität Bochum (Marien Hospital Herne), Herne, NRW, Germany*
4. *University of Newcastle, Newcastle Business School, Faculty of Business and Law , Newcastle, NSW, Australia*
5. *School of Business and Economics, Department of Marketing & Supply Chain Management, and Business Intelligence and Smart Services Institute (BISS), Maastricht University, Maastricht, The Netherlands*

Objective. To assess the preferred term for cervical cancer screening ("HPV test" versus a hypothetical "New Pap smear"), the proportion of women who consider cervical cancer to be caused by a sexually transmitted disease, and what role brand perception in women towards the brand "Pap smear" might have.
Methods. A Web-based survey was conducted. Responses from 769 Australian and 704 U.S. women were analyzed.
Results. The majority of women (70%) preferred the New Pap smear over the HPV test (30%). 68% do not consider cervical cancer to be caused by a STD.
Conclusion. Pap smear is accepted and trusted by patients as a screening test for cervical cancer. It is essential that success of the transition from cytology to HPV test-based cervical screening is optimized and participation is not only maintained but improved. If we change the brand we stand to lose the trust of women which has taken decades to develop.

Notes:

Brave new world: Update on the Cervical Screening Program

***Andrea Garrett*[1]**

1. *Wesley Hospital, Toowong, QLD, Australia*

In May 2017, the National Cervical Screening Program (NCSP) will change from 2-yearly cervical cytology testing to 5-yearly HPV testing for women aged 25–74. HPV testing every 5 years is more effective, just as safe and is expected to result in a greater than 20% reduction in incidence and mortality from cervical cancer in Australian women, compared with the program it replaces, which is based on two yearly Pap smears. As a result, the 2005 guidelines for the management of screen detected abnormalities have been reviewed and updated to incorporate evidence relevant to primary HPV testing and liquid-based cytology triage.

The new guidelines will address the current epidemiology of cervical cancer in Australia, the benefits and harms of cervical screening, the natural history of cervical HPV infection, the terminology for HPV testing, liquid-based cytology, cervical histology and colposcopy, management of older women and those undergoing exit testing, management of women with positive HPV test results, colposcopy, management of histologically confirmed squamous and glandular abnormalities, women in special circumstances, women who are transitioning from the old into the new program, psychosocial and economic issues. For the first time, guidance regarding the management of symptomatic women has been included, with a particular focus on those with signs or symptoms suggestive of cervical cancer or its precursor lesions.

Integral to the success of the NCSP will be the Quality Framework developed by the Quality and Safety Monitoring Committee which is charged with ensuring quality assurance of all aspects of the program, including colposcopy.

Notes:

Anti-angiogenesis with Avastin (bevacizumab)[1]

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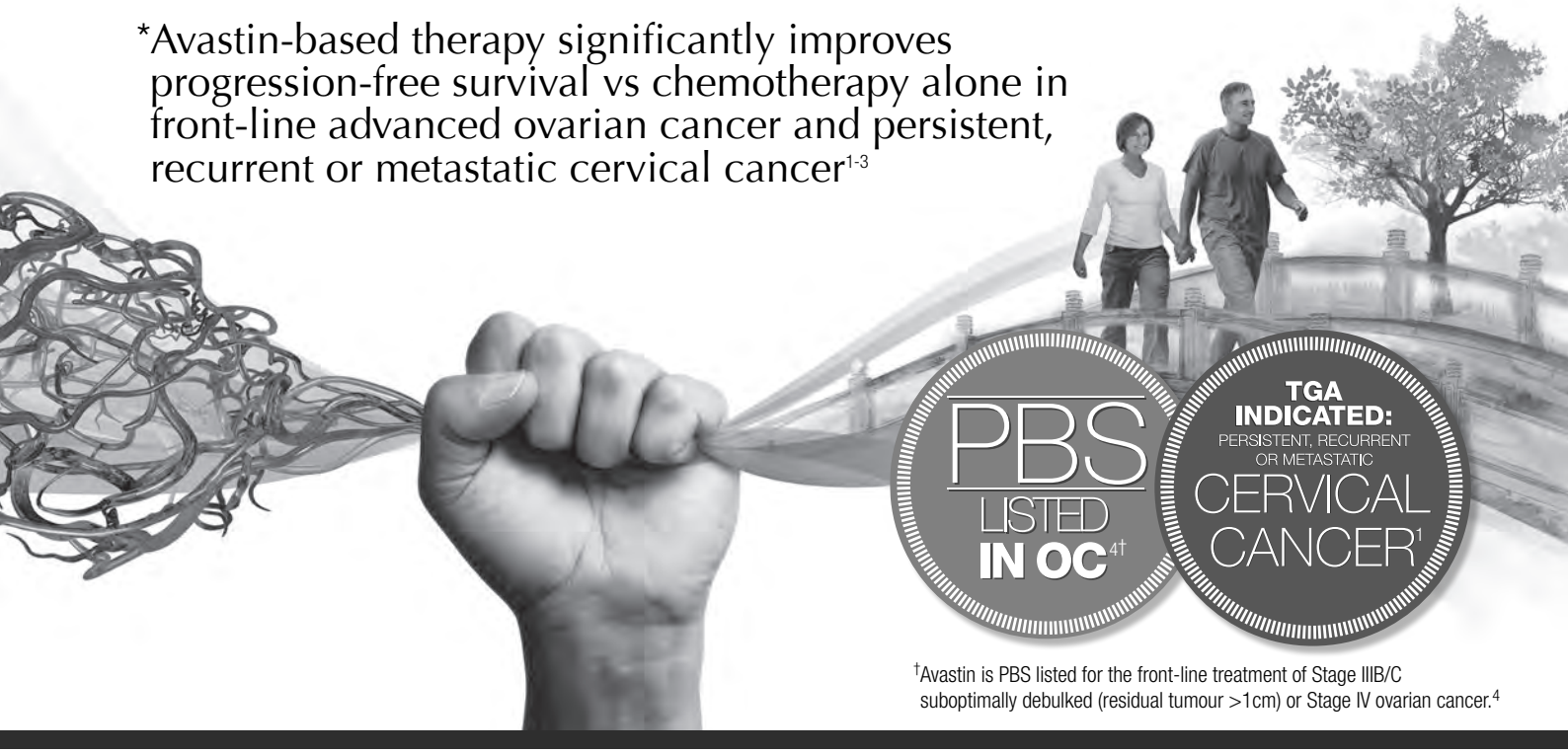
Control angiogenesis.[1] Continue what matters.*

*Avastin-based therapy significantly improves progression-free survival vs chemotherapy alone in front-line advanced ovarian cancer and persistent, recurrent or metastatic cervical cancer[1-3]



†Avastin is PBS listed for the front-line treatment of Stage IIIB/C suboptimally debulked (residual tumour >1cm) or Stage IV ovarian cancer.[4]

PBS Information: Ovarian cancer. Authority Required (STREAMLINED).
Refer to PBS Schedule for full authority information. Cervical cancer. This product is not listed on the PBS.

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MINIMUM PRODUCT INFORMATION AVASTIN® (bevacizumab) Indications: mCRC: in combination with fluoropyrimidine-based chemotherapy; **mBC:** in combination with paclitaxel, first-line, when anthracycline-based therapy is contraindicated; **RCC:** in combination with interferon alfa-2a; **NSCLC:** in combination with carboplatin and paclitaxel; **Relapsed Grade IV glioma:** as a single agent; **First-line advanced epithelial ovarian (EO), fallopian tube (FT), or primary peritoneal cancer (PPC):** in combination with carboplatin and paclitaxel; **Recurrent, platinum-sensitive EO, FT or PPC:** in combination with carboplatin and gemcitabine in patients who have not received prior bevacizumab or other VEGF-targeted angiogenesis inhibitors; **Recurrent, platinum-resistant EO, FT or PPF:** in combination with paclitaxel, topotecan or pegylated liposomal doxorubicin (PLD) in patients who have received no more than two prior chemotherapy regimens, and have not received any prior anti-angiogenic therapy including bevacizumab; **Persistent, recurrent or metastatic cervical cancer:** in combination with paclitaxel and cisplatin, or paclitaxel and topotecan, where cisplatin is not tolerated or not indicated. **Dosage and Administration:** Administered as an IV infusion. Not for intravitreal use. Initial dose over 90 min, if well tolerated, subsequent infusions may be over 60 or 30 min. **mCRC (first-line):** 5 mg/kg/2 weeks or 7.5 mg/kg/3 weeks; **(second-line):** 10 mg/kg/2 weeks or 15 mg/kg/3 weeks. **mBC:** 10 mg/kg/2 weeks or 15 mg/kg/3 weeks. **RCC:** 10 mg/kg/2 weeks in combination with IFN alfa-2a (9 MIU three times a week). **NSCLC:** 15 mg/kg/3 weeks. **Relapsed Grade IV Glioma:** 10 mg/kg/2 weeks or 15 mg/kg/3 weeks. **First-line EO, FT or PPC:** 15 mg/kg/3 weeks in combination with carboplatin and paclitaxel for up to 6 cycles, followed by continued use as single agent for a total of 15 months therapy or until disease progression, whichever occurs earlier; **Recurrent, platinum-sensitive EO, FT or PPC:** 15 mg/kg/3 weeks in combination with carboplatin and gemcitabine for 6 cycles (up to 10 cycles), followed by continued use as single agent until disease progression; **Recurrent, platinum-resistant EO, FT or PPC:** 10 mg/kg/2 weeks in combination with one of the following agents – paclitaxel or topotecan (given weekly) or PLD. Alternatively, 15 mg/kg/3 weeks when administered in combination with topotecan given on days 1-5, every 3 weeks; **Persistent, recurrent or metastatic cervical cancer:** 15 mg/kg of body weight given once every 3 weeks. **Contraindications:** Hypersensitivity to Chinese hamster ovary cell products or other recombinant human/humanised antibodies. **Precautions:** Control pre-existing hypertension; monitor BP. Proteinuria has been reported; discontinue in event of nephrotic syndrome or Grade 4 proteinuria. History of hypertension may increase risk of proteinuria; testing prior to treatment is recommended. GI and gallbladder perforation (including GI fistulae and abscess); Patients treated for recurrent platinum-resistant ovarian cancer should not have a history or symptoms of bowel obstruction, abdominal fistulae or clinical or radiological evidence of recto-sigmoid involvement. Patients treated with AVASTIN for persistent, recurrent, or metastatic cervical cancer may be at increased risk of fistulae between the vagina and any part of the GI tract (GI-vaginal fistulae). Wound healing complications (major surgery < 28 days); serious wound healing complications, including anastomotic complications, have been reported, some of which had a fatal outcome. Necrotising fasciitis (rare), usually secondary to wound healing complications. Discontinue AVASTIN in patients who develop necrotising fasciitis and initiate appropriate treatment promptly. Arterial and venous thromboembolism (TE), including pulmonary embolism; haemorrhage (including tumour-associated and mucocutaneous haemorrhage); congenital bleeding diathesis or acquired coagulopathy; monitor patients for signs and symptoms of CNS bleeding (discontinue treatment in cases of intracranial bleeding); pulmonary haemorrhage/haemoptysis (NSCLC only); > 1/2 teaspoon red blood should not be treated (see full PI); infusion/hypersensitivity reactions (observe closely during and following infusion, discontinue infusion if a reaction occurs); Posterior Reversible Encephalopathy Syndrome (PRES); clinically significant CV disease or pre-existing CHF; increased risk of arterial thromboembolic events during therapy in patients receiving AVASTIN plus chemotherapy who have a history of ATE, diabetes or are greater than 65 years of age; serious ocular adverse events (including infectious endophthalmitis and other ocular inflammatory conditions) following unapproved intravitreal use; osteonecrosis of the jaw (ONJ) (associated with prior or concomitant intravenous bisphosphonates); impaired female fertility, discuss fertility preservation strategies with women of child-bearing potential prior to treatment; Pregnancy Category D (do not use); use appropriate contraception during treatment and 6 months after last dose; do not breast feed during treatment and 6 months after last dose; use with caution in children, adolescents, patients with renal or hepatic impairment and > 65 years (risk of arterial TE, including cerebrovascular accidents, transient ischaemic attacks and MI, higher frequency of Grade 3/4 toxicities); **INTERACTIONS:** Sunitinib malate: reports of microangiopathic haemolytic anaemia (MAHA). Platinum- or taxane-based chemotherapies: increased rates of severe neutropenia, febrile neutropenia, or infection with severe neutropenia (including some fatalities). Exacerbation of common chemotherapy AEs when combined with chemotherapeutic agents including palmar-plantar erythrodysaesthesia syndrome with PLD or capecitabine; peripheral sensory neuropathy (PSN) with paclitaxel or oxaliplatin; nail disorders or alopecia with paclitaxel. **ADVERSE EFFECTS:** GI perforations; gallbladder perforations; haemorrhage including pulmonary haemorrhage/haemoptysis; arterial and venous TE; cardiac failure congestive; supraventricular tachycardia; severe neutropenia; febrile neutropenia; leucopenia; thrombocytopenia; lymphopenia; anaemia; hypertension; fatigue/asthenia; arthralgia; myalgia; diarrhoea; abdominal, pelvic or back pain; stomatitis; fever; dyspnoea; headache; PSN; dysarthria; proteinuria; dysphonia; GI ulcer; hypersensitivity/infusion reactions (dyspnoea/difficulty breathing, flushing/redness/rash, hypotension or hypertension, oxygen desaturation, chest pain, rigors and nausea/vomiting); ovarian failure; ONJ (mainly in association with prior or concomitant use of bisphosphonates); cellulitis; proctalgia; decreased weight. **AEs reported from unapproved intravitreal use:** eye disorders (some cases leading to permanent blindness); increased risk for cataract surgery; increased risk for haemorrhagic stroke, overall mortality and serious systemic adverse events (most of which resulted in hospitalisation). Please review the complete Product Information before prescribing, available from Roche Products Pty Limited (www.roche-australia.com/productinfo/avastin). Roche Products Pty Limited ABN 70 000 132 865 4-10 Inman Road, Dee Why, NSW 2099. Medical enquiries: 1800 233 950. Date of preparation: 14 October 2015. **References:** 1. Avastin (bevacizumab) Approved Product Information. Available at: www.roche-australia.com/productinfo/avastin 2. Burger R *et al. N Engl J Med* 2011;365:2473-2483. 3. Tewari K *et al. N Engl J Med* 2014;370:734-743. 4. Department of Health. Pharmaceutical Benefits Scheme; Available at: www.pbs.gov.au/ ®Registered Trademark EMVAVA0796 MN37557218 PreparedApr16

AVASTIN bevacizumab

Poster Presentations

Presenters: Murad Al-Aker, Paige Tucker, Shih-Ern Yao, King Man Wan and Pearl Tong

Intravenous leiomyomatosis with intracardiac extension "Case presentation"

Murad Al-Aker[1] , Jim Nicklin[2]

1. *Royal Brisbane and Women's Hospital, Kelvin Grove, QLD, Australia*
2. *Queensland Centre for Gynaecological cancer , Brisbane*

Background: Intravenous leiomyomatosis with intracardiac extensions in a rare pathological progression of uterine leiomyomata. It is histologically benign but it presents a challenging diagnostic dilemma and could interfere with cardiac function and present with marked cardiovascular compromise.
Objectives: To present an illustrative case and give a review of the clinical presentation, preoperative assessment, operative approach and pathology.
Case summary: 41-year-old women who presented with episodes of fainting and pre-syncope. Had an Echocardiogram which showed an intracardiac lesion extending from the right atrium to the right ventricle. An MRI tracked down the lesion through the IVC down to the pelvis. PET scan was negative. Underwent an extended vertical midline incision with a sternotomy extension, resection of intravenous leiomyomatosis, and total abdominal hysterectomy. Recovered completely with no early or later complications.

Discussing sexuality with women considering risk-reducing salpingo-oophorectomy: An international survey of current practice in gynaecologic oncology

Paige E Tucker[1], Max Bulsara[2], Stuart G Salfinger[1], Jason Tan[1], Helena Green[3], Paul Cohen[1]

1. *St John of God Hospital Subiaco, Subiaco, WA*
2. *Institute for Health Research, University of Notre Dame, Fremantle, WA, Australia*
3. *Women Centre, West Leederville , WA*

Background: The negative effects of risk-reducing salpingo-oophorectomy (RRSO) on sexuality have been recognised, and women who receive pre-operative counselling regarding this possibility may experience less sexual distress following the operation. Despite a majority of women indicating they would like to discuss sexuality with their surgeon, the actual rates of discussions by gynaecological oncologists in this setting appear to be low.
Objectives: To determine how frequently gynaecologic oncologists discuss sexuality with women considering RRSO, and to assess the availability of resources, and barriers to discussing sexuality.
Methods: Members of the Australian Society of Gynaecologic Oncologists (ASGO), International Gynecologic Cancer Society (IGCS) and Society of Gynecologic Oncology (SGO) were invited to complete an online survey regarding their beliefs and practices.

Management of stage 1B1 cervical adenocarcinoma: What would you do?

Shih-Ern Yao[1], Tom Manolitsas[1]

1. *Monash Medical Centre, Moorabbin, Victoria*

The modern management of early stage cervical cancer has been influenced significantly by the advent of improved imaging modalities, surgical technology and the patient's fertility desires. This case of a 33 year-old nulliparous woman with Stage 1B1 cervical adenocarcinoma presents a sequence of management dilemmas for the gynaecology oncologist pertaining to reliance on metastatic imaging and oncofertility.

Predictors of early discharge after open gynaecological surgery in the setting of an enhanced recovery after surgery protocol

King Man Wan[1], Jonathan Carter[1], Shannon Philp[1]

1. *Gynaeoncology, Chris O'Brien Lifehouse, Camperdown, NSW, Australia*

Aims: To determine the characteristics of patients undergoing open gynaecological surgery in an ERAS protocol that can be discharged home by on or by Day 3 postoperatively (early discharge).
Methods: Retrospective review of patients between January 2008 and April 2013. Patients who completed early discharge were compared to patients who had a longer admission.
Results: 454 consecutive patients were identified and included in the study. No patients were excluded. 335 patients (73.8%) were successfully discharged home within 3 days. Patients who had an early discharge were significantly less likely to have a malignancy (OR 0.59(0.36–0.97);p=0.038), ICU admission (OR 0.59(0.36–0.97);p=0.046), vertical midline incision (OR 0.28(0.07–0.82)p=0.018), complications (OR 0.21(0.09-0.49);p=0.0003) and FIGO Stage III/IV disease (OR 0.39(0.23-0.67)p=0.001). Prior abdominal surgery, BMI>25 and lymph node dissection length of hospital stay.
Conclusions: Malignancy, advanced stage disease, ICU admission, vertical midline incision and perioperative complications are significantly associated with longer hospital stays.

Clear cell carcinoma arising from previous caesarean section scar

Pearl Tong[1], Selvan Pather[1], Peter Lee[1], Philip Rome[1], Jonathan Carter[1]

1. *Chris O Brien Lifehouse, Camperdown, NSW, Australia*

Clear cell carcinomas are known to arise from malignant transformation of endometriotic deposits, though such occurrences are uncommon. There are also documented cases of seeding of endometrial tissue lining in Caesarean section scars, giving rise to symptoms arising from cyclical bleeding into the scar tissue. We present a case of clear cell carcinoma of the abdominal wall, likely to have arisen from a previous Caesarean section 22 years previously. Fortunately, the tumour was limited to the abdominal wall, though extensive, a complete surgical

resection which included excision of part of the symphysis pubis, was achieved with clear margins. A biologic mesh was used to close the abdominal wall defect and bilateral tensor fascia lata flaps were harvested to provide the skin cover. Her clinical course will be described, as well as a review of similar cases.

Development of a tertiary gynae-oncology centre- a step wise approach

Cecile Bergzoll

Since 2010, the NZ Ministry of Health has financed several projects to improve care for the 1000 women diagnosed yearly with gynaecological malignancies. These led to the development of a 3 centre model and a set of Standards of care.

Wellington tertiary centre serves a 1 million population, in 7 DHBs. The Centre was developed from 2013 to 2016 in a series of 5 steps. First, multidisciplinary meeting functioning improvement. Second, increasing of theatre resources. Third, improvement of regional coordination to streamline secondary and tertiary referrals. Fourth, development of a business case, to adequately resource the team. Fifth, auditing of the Standards.

A cohort of 140 patients with a newly diagnosed gynaecological cancer in 2014 was selected. Data showed that the Standards were only partially met in 2014. Most of the issues may improve when the Wellington business case goes through, with additional resourcing available to deliver high quality care.

Notes:

ASGO ASM 2017

Cable Beach Club Resort & Spa
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