Australian Society of Gynaecologic Oncologists Inc.

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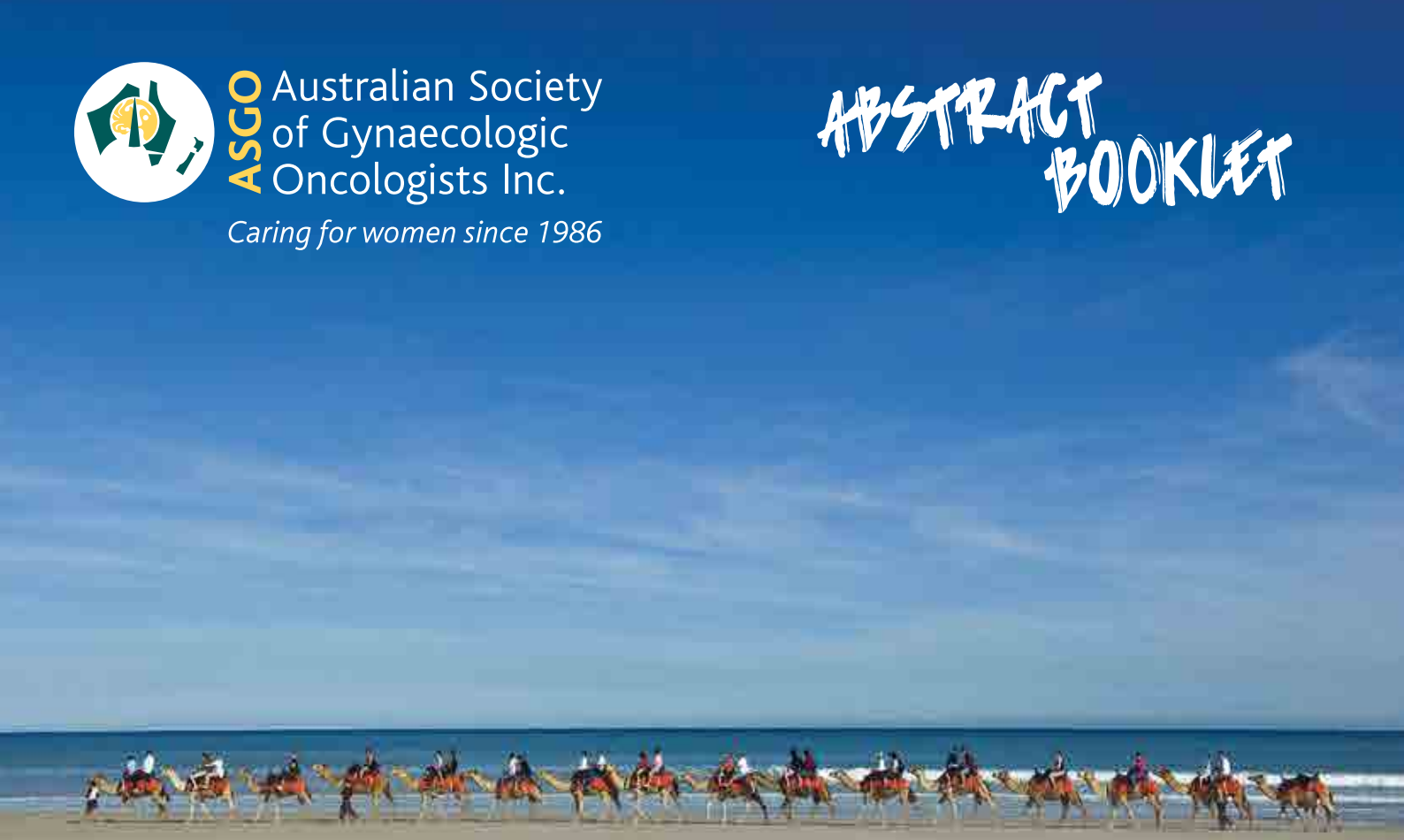
ABSTRACT BOOKLET



ASGO ASM 2017

Cable Beach Club, Broome WA

3RD - 7TH MAY 2017

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INVITED SPEAKERS

Dr Peter Lim

Medical Director Center of Hope & Robotic Institute at Renown Regional Medical Center

Graduated from Hahnemann University, completed internship and residency in Obstetrics & Gynecology at Women's and Children's Hospital at L.A. County, University of Southern California, and Fellowship in Gynecologic Oncology at Mayo Clinic. He is currently the Medical Director of Gynecologic Oncology and Robotic Surgery at Center of Hope and Robotics and Minimally Invasive Surgical Institute at Renown Regional Medical Center. He is also appointed Clinical Professor in Department of Obstetrics and Gynecology at the University of Nevada School of Medicine. Dr. Lim has published in peer reviewed journals and presented at International meetings on topics of Robotics and Minimally Invasive surgery. He was the recipient of Robotics Technology paper award at the AAGL 2009, 2011, and 2012. He has been an invited speaker at International meetings and has performed live surgical demonstration in robotic surgery. He has been named one of the 5 Epicenter Surgeons in Gynecologic Oncology in the United States. He has approached nearly 3000 robotic procedures.

Dr Shailesh Puntambekar

Professor, OncoSurgeon & Consultant, Medical Director at the Galaxy CARE Laparoscopy Institute

Dr Shailesh Puntambekar is a cancer surgeon specialising in laparoscopic cancer surgery and heads the Galaxy Care Laparoscopy Institute, centre for advanced laparoscopy and Robotic Surgery in Pune. He has developed laparoscopic radical hysterectomy for cancer cervix known world over as the "Pune Technique".

He is a faculty at the AAGL (American Association of Gynaecological Laparoscopy) and member of the AAGL Oncology Committee. He has won the prestigious "Golden Telescope Award" for the best video at AAGL thrice (In the yrs 2005, 2009 & 2012) and is the only Indian surgeon to do so. He has also won the Kurt Semm Award for the Best Video in the Category of Laparoscopic Surgeries for "Laparoscopic Transvesical Approach to Vesicovaginal Fistula (VVF) Repair"

Dr Tarek Meniawy

Medical Oncologist and a clinician scientist at the University of Western Australia

Dr Tarek Meniawy is a Medical Oncologist and a clinician scientist at the University of Western Australia. His areas of clinical and research interest are in gynaecological cancers, malignant melanoma, and early drug development, with a focus on novel immunotherapy and targeted therapy approaches. He holds a Consultant appointment at Sir Charles Gairdner Hospital, King Edward Memorial Hospital and St John of God Subiaco Hospital, Western Australia. He is also a Clinical Senior Lecturer at the University of Western Australia.

Dr Meniawy completed his medical degree at Cairo University, before undertaking postgraduate physician training in Brisbane, then further subspecialty training in Medical Oncology. He has been awarded a Doctor of Philosophy (PhD) degree by the University of Western Australia, where he studied the effects of targeted therapies on the immune system.

Dr Meniawy has a keen interest in teaching and research, and is actively involved in clinical trials, acting as a Principal Investigator or co-investigator on more than 20 active studies, including trials of targeted therapies and immunotherapies, large multi-national trials, as well as grant-funded, investigator-initiated research. He is a member of the WA Melanoma Advisory Service as well as the WA Gynaecological Cancer Service. He is involved in several grant-funded translational studies as Chief or Principal Investigator in the areas of gynaecological cancer and melanoma, with a focus on immunotherapy and novel molecular targets. His work has been published in peer-reviewed journals, book chapters and conference papers, and has presented regularly at local, national and international conferences

ASGO GENERAL INFORMATION

ASGO COMMITTEE OF MANAGEMENT

Chairman:	Penny Blomfield
Secretary/ Treasurer:	Julie Lamont
Executive:	Andy Garrett, Jim Nicklin and Greg Robertson
Professional Conference Organiser:	Mary Sparksman

2017 ASGO ASM ORGANISING COMMITTEE

CONFERENCE COMMITTEE

Stuart Salfinger (Convenor), Paul Cohen, Helen Green, Yee Leung, Ganendra Raj Mohan and Jason Tan

SECRETARIAT

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

Wednesday 3rd May	12.30pm – 5.00pm	Cable Beach Club
Thursday 4th May	7.45am – 12.30pm	Cable Beach Club
Friday 5th May	8.00am – 1.30pm	Cable Beach Club
Saturday 6th May	8.00am – 3.00pm	Cable Beach Club

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HELP PROTECT

AGAINST HPV RELATED CANCER AND DISEASES[1]

GARDASIL® is indicated for females aged 9 through 45* years for the prevention of cervical, vulvar, vaginal and anal cancer, precancerous or dysplastic lesions, genital warts, and infection caused by HPV types 6/11/16/18.[1]

GARDASIL is indicated in males aged 9 through 26* years for the prevention of anal cancer, precancerous or dysplastic lesions, external genital lesions and infection caused by HPV types 6/11/16/18.[1]

*Immunogenicity studies have been conducted to link efficacy in females and males aged 16 to 26 years to the younger populations.

GARDASIL®
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Importantly, women should continue with regular Pap smears.

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GARDASIL® [Quadrivalent Human Papillomavirus (Types 6, 11, 16, 18) Recombinant vaccine] **INDICATIONS:** GARDASIL is indicated in females aged 9 through 45 years* for the prevention of cervical, vulvar, vaginal and anal cancer, precancerous or dysplastic lesions, genital warts, and infection caused by Human Papillomavirus (HPV) Types 6, 11, 16, and 18 (which are included in the vaccine). GARDASIL is indicated in males aged 9 through 26* years for the prevention of anal cancer, precancerous or dysplastic lesions, external genital lesions and infection caused by Human Papillomavirus (HPV) Types 6, 11, 16, and 18. *Immunogenicity studies have been conducted to link efficacy in females and males aged 16 to 26 years to the younger populations. **CONTRAINDICATIONS:** Hypersensitivity to vaccine, including excipients. **PRECAUTIONS:** Febrile illness, impaired immune response, thrombocytopenia or any coagulation disorder. This vaccine is not intended to be used for active treatment. Routine cervical screening and detection and removal of cervical lesions should be continued in individuals who receive the vaccine. Syncope (fainting) may follow any vaccination, especially in adolescents and young adults. Syncope, sometimes associated with falling, has occurred after vaccination with GARDASIL. Therefore, vaccines should be carefully observed for approximately 15 minutes after administration of GARDASIL. **Use in Pregnancy (Category B2):** GARDASIL is not recommended for use in pregnant women. **Use in Lactation:** GARDASIL may be administered to lactating women. **ADVERSE REACTIONS:** Injection site (pain, swelling, erythema, bruising, pruritis), headache, fever and very rarely, bronchospasm. **Post-marketing Reports:** The following adverse experiences have been spontaneously reported during post-approval use of GARDASIL. Because these experiences were reported voluntarily from a population of uncertain size, it is not possible to reliably estimate their frequency or to establish a causal relationship to vaccine exposure. Infections and infestations: cellulitis. Blood and lymphatic system disorders: idiopathic thrombocytopenic purpura, lymphadenopathy. Nervous system disorders: acute disseminated encephalomyelitis, dizziness, Guillain-Barré syndrome, headache, syncope sometimes accompanied by tonic-clonic movements. Gastrointestinal disorders: nausea, vomiting. Musculoskeletal and connective tissue disorders: arthralgia, myalgia. General disorders and administration site conditions; asthenia, chills, fatigue, malaise. Immune system disorders: Hypersensitivity reactions including anaphylactic/anaphylactoid reactions, bronchospasm, and urticaria. **DOSAGE AND ADMINISTRATION:** Administered intramuscularly at day 0 and then at 2 and 6 months after initial dose. In clinical studies, efficacy has been demonstrated in individuals who have received all 3 doses within a 1-year period. Based on TGA approved Product Information. Date of most recent amendment: 4 February 2016. **REFERENCE: 1.** GARDASIL® Product Information, February 2016. Seqirus (Australia) Pty Ltd, ABN 66 120 398 067, 63 Poplar Road, Parkville VIC 3052, distributor for Merck Sharp & Dohme (Australia) Pty Ltd. ™ Seqirus is a trademark of Seqirus UK Limited or its affiliates. ® GARDASIL is a registered trademark of Merck & Co., Inc., Whitehouse Station, NJ, USA. Medical Information 1800 642 865. Date of preparation: January 2017. GARD/0416/0023. 14057.

PBS Information: This product is listed on the National Immunisation Program (NIP) as part of the school based program. Refer to the NIP Schedule.

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2017 ASGO SCIENTIFIC PROGRAM

Wednesday 3rd May

12.30pm – 1.30pm	Registration and Lunch
	FELLOWS EDUCATION SESSION
1.30pm – 2.15pm	Pathology Review ***Presenter: Jim Scurry***
2.15pm – 3.00pm	Radiation Oncology Update ***Presenter: Adeline Lim***
3.00pm – 3.45pm	Medical Oncology for the CGO: What you need to know beyond "carbotaxol" ***Presenter: Tarek Meniawy***
3.45pm – 4.15pm	Afternoon Tea
4.15pm – 5.15pm	**MOCK OSCE AND EXAM WORKSHOP - *Ken Jaaback***

Thursday 4th May

7.45am – 8.20am	*Trade Exhibition Open*
	SESSION 1 – Emerging Technology in Gynaeoncology
	Session Chair: Stuart Salfinger & Penny Blomfield
8.15am – 8.30am	Introduction and Opening of Meeting ASGO Chair 2017
8.30am – 9.15am	**Keynote Speaker:** Laparoscopic pelvic exenteration ***Presenter: Shailesh Puntambekar***
9.15am – 10.00am	**Keynote Speaker:** Robotic Surgery in Gynecologic Oncology: Updates and Innovations ***Presenter: Peter Lim (Sponsored by Device Technologies)***
10.00am – 10.45am	Surgeons Corner and Panel ***Presenters: Felix Chan, Russell Land, Nisha Jagasia***
10.45am – 11.15am	Morning Tea, Trade Exhibition and Poster viewing
	SESSION 2 – Cervical Cancer
	Session Chair: Ganendra Raj Mohan & Julie Lamont
11.15am – 12.00pm	**Keynote Speaker:** Laparoscopic radical hysterectomy-the duplicable steps ***Presenter: Shailesh Puntambekar***
12.00pm – 12.15pm	HPV Vaccination /National Cervical Screening Program *(Sponsored by Seqirus)* ***Presenter: Penny Blomfield***
12.15pm – 12.45pm	**Keynote Speaker:** Immunotherapy for gynaecological cancers: are we there yet? ***Presenter: Tarek Meniawy***
12.45pm – 1.45pm	Lunch, Trade Exhibition and Poster viewing
1.45pm – 3.10pm	**FELLOWS PRESENTATIONS**
	Fellows Presentations 1 ***Session Chair: Jonathan Carter & Simon Hyde***
1.45pm	The demographics and outcomes of women with Stage II endometrial carcinoma managed in Australia (2005-2007) — ***Pearl Tong***
1.57pm	Clear Cell Carcinoma of the Ovary: A retrospective review of clinic-pathological characteristics — ***Yvette Ius***

2.09pm	The Case for Pre-Operative Very Low Calorie Diets (VLCDs) in Obese Endometrial Cancer Patients	***Chloe Ayres***
2.21pm	Uterine carcinosarcoma: the 22-year Monash experience	***Shih-Ern Yao***
2.33pm	Endometrial cancer survival, cardiovascular risk factors and cause of death	***Philippa Shirley***
2.45pm	Pre-operative and intra-operative assessment in endometrial cancer: the role of magnetic resonance imaging and frozen section	***Niveditha Rajadevan***
2.57pm	The use of a Modified Caprini Score in Gynaecological Oncology patients	***King Man Wan***
3.10pm – 3.40pm	Afternoon Tea, Trade Exhibition and Poster viewing	
3.40pm – 5.00pm	**FELLOWS PRESENTATIONS**	
	Fellows Presentations 2 / Free Communications ***Session Chair: Orla McNally & Martin Oehler***	
3.40pm	The impact of universal referral for women with high grade serous carcinoma (HGSC) of ovary, tube or peritoneum in the Northern Cancer network (NCN)- Is there a change in referral patterns for genetic counseling?	***Michael Burling***
3.52pm	Laterally extended endopelvic resection (LEER): a discussion of technique and case studies	***Nimithri Cabraal***
4.04pm	"Using 'SHARP' tools in the operating room...Beyond the scalpel".	***Kirsten Moloney***
4.16pm	Stage IV ovarian cancer; response to treatment and patterns of disease recurrence.	***Amy Jamieson***
4.28pm	Changing Patterns of Referrals and outcomes of genetic participation in Gynaecological Oncology Multidisciplinary care	***Hanoon Pokharel***
4.40pm	Surgical management of a retroperitoneal pelvic desmoid tumour involving the sacrifice of external iliac vein and internal iliac vessels.	***Elizabeth Goulding***
4.52pm	Examining Word Association Networks: A Cross-Country Comparison of Women's Perceptions of HPV Testing and Vaccination	***Bernd Schmid***
5.10pm – 5.30pm	Smoking Ceremony	
5.30pm – 6.00pm	BRCam testing in Ovarian Cancer – The evolving role of Gynae-Onc Team-Discussion	

Friday 5th May

8.00am – 8.30am	*Trade Exhibition Open*
	SESSION 3 – Ovarian Cancer
	Session Chair: Alison Brand & Jason Tan
8.30am – 9.15am	**Keynote Speaker:** The role of laparoscopy in ovarian cancers ***Presenter: Shailesh Puntambekar***
9.15am – 9.45am	**Keynote Speaker:** PARP inhibitors: which patient, when and how should they be used in 2016 and beyond ***Presenter: Tarek Meniawy***

9.45am – 10.15am	**FREE COMMUNICATIONS**	
	Session Chair: Alison Brand & Jason Tan	
9.45am	Prevalence, incidence and risk factors of lymphoedema following gynaecological cancer: results from a longitudinal cohort study	***Monika Janda***
10.05am	Ovarian Cancer Clinical Quality Registry Pilot Project	***Robert Rome***
10.15am – 10.45am	Morning Tea, Trade Exhibition and Poster viewing	
	SESSION 4 – Endometrial & Other Cancer	
	Session Chair: David Allen & Yee Leung	
10.45am – 11.25am	**Keynote Presentation:** Changing concepts in laparoscopy	
	Presenter: Shailesh Puntambekar	
11.25am – 11.55am	**Keynote Presentation:** Practical tips on robot-assisted radical hysterectomy	
	Presenter: Peter Lim (Sponsored by Device Tecnologies)	
	SESSION 5 – Indigenous Health in the Kimberley	
	Session Chair: John Miller & Helen Green	
11.55am – 12.25pm	Culture and the Indigenous patients experience	
	Presenter: Amy Tang Wei	
12.25pm – 12.45pm	Diseases and access to services: Cultural and population health perspectives	
	Presenter: Jeanette Ward	
12.45pm – 1.10pm	Service access and delivery in the Kimberley	
	Presenter: Jared Watts	
1.10pm – 2.00pm	Lunch, Trade Exhibition and Poster viewing	
1.30pm	Willie Creek Pearl Farm Tour	

Saturday 6th May

8.30am – 9.00am	*Trade Exhibition Open*	
	SESSION 6 – Surgical Education	
	Session Chair: Paul Cohen & Helen Green	
9.00am – 9.45am	**Keynote Presentation:** Development of robotic training program	
	Presenter: Peter Lim (Sponsored by Device Technologies)	
9.45am – 10.15am	Management of Colorectal Complications – Leaks, Fistulas, Stomas	
	Presenter: Lew Perrin	
10.15am – 10.35am	Challenges of surgical education	
	Presenter: Stuart Salfinger	
10.35am – 11.05am	CGO Trainee View	
	Presenter: Adam Pendlebury, Cecile Bergzoll	
11.05am – 11.30am	Morning Tea, Trade Exhibition and Poster viewing	
11.30am – 12.30pm	**Panel Discussion:** Training and the scope of gynae-oncology	
	Chairs: Stuart Salfinger & Paul Cohen	
	Panel: Peter Lim, Lew Perrin, Stuart Salfinger, Adam Pendlebury, Cecile Bergzoll	

12.30pm – 1.30pm	ASGO Debate – Future of colorectal surgery performed by the CGO For: ***Alison Brand, Tom Manolitsas*** Against: ***Russell Land, Bryony Simcock***
1.30pm – 2.30pm	Lunch and Trade Exhibition
2.30pm – 4.45pm	ASGO AGM

*** Please note that this program is correct at time of printing and is subject to change without notification***

POSTERS

3D Reconstruction from Diagnostic Imaging in Gynaecological Oncology - is Virtual Reality Ready for Prime Time?	***Paige Tucker***
Evaluating pre-surgical ultrasound in diagnosing ovarian masses and its prediction of laparoscopic approach to ovarian mass surgical management	***Jennifer Weishaupt***

SOCIAL PROGRAM

Wednesday 3rd May	7.00pm – 9.30pm	**Welcome Reception** Okari Deck Cable Beach Resort Dress code: Smart casual
Thursday 4th May	7.00pm - 10.00pm	**Poolside dinner** Ocean Pool Cable Beach Resort Dress code: Smart casual
Friday 5th May (optional activities)		**Option 1:** 1.30pm – 5.00pm Willie Creek Pearl Farm Tour Coach departs at 1.30pm and returns at 5.00pm (pre-booking essential) **Option 2:** 2.00 – 5.00pm ASGO Annual Tennis Tournament Cable Beach Resort **Option 3:** Free afternoon to explore Broome **Option 4:** 1.30pm Tee off ASGO Golf Tournament, Broome Golf Club
Friday 5th May	6.30pm - 10.00pm	**Mangrove Hotel dinner** Mangrove Hotel Coaches departing at 6.30pm Dress code: Smart casual
Saturday 6th May	7.00pm - 11.00pm	**ASGO Gala Dinner** Club Restaurant Cable Beach Resort Dress code: Black-tie

Notes:

Wednesday 3rd May 2017

SESSION: Fellows Education Session
Presenters: Jim Scurry, Adeline Lim and Tarek Meniawy
Time: 1.30pm – 3.45pm

Notes:

Wednesday 3rd May 2017

SESSION: Mock OSCE and Exam Workshop
Time: 4.15pm – 5.15pm
Chair: Ken Jaaback

Notes:

Thursday 4th May 2017

SESSION: Session 1 – Emerging Technology in Gynaeoncology
Presenters: Shailesh Puntambekar, Peter Lim, Felix Chan, Russell Land and Nisha Jagasia
Time: 8.30am – 10.00am
Chair: Stuart Salfinger and Penny Blomfield

Laproscopic pelvic exenteration

Shailesh Puntambekar

This presentation helps to understand the definition of radical laparoscopic surgeries and to recognize the extreme situation with multiorgan involvement wherein various types of exenteration surgeries are essential. Laparoscopic exenterative surgery can be achieved safely with comparable oncological results. For performing a laparoscopic pelvic exenteration, understanding the pelvic anatomy and the anatomical landmarks is of paramount importance. It is essential to master the theory of laparoscopic strategy and surgical rules for performing anterior or posterior or total exenterative surgeries with diversions. Exenterations have had a good prognosis and the chances of recurrence are minimal and it is one of the most effective palliative surgeries.

Notes:

Robotic Surgery in Gynecologic Oncology: Updates and Innovations

Peter Lim[1]

1. *Center for Hope, Renown Robotics Surgical Institute, Nevada, USA*

Robotic surgery platform was approved for gynecologic surgery in 2005. Since that time it has completely revolutionized and shifted the surgical paradigm to minimally invasive surgery. The rate of open hysterectomy in the United States has nearly decreased from 60% to 40% while the rate of robotic surgery has increased to nearly 30%. The biggest adopter of robotic surgical platform has been in the field of gynecologic oncology.

Surgical treatment for gynecologic malignancy involves complex surgical procedures that requires open incision that is associated with high morbidity and prolong recovery period. The introduction of laparoscopic pelvic lymphadenectomy by Dargent along with radical vaginal hysterectomy for treatment of cervical cancer has certainly initiated the revolution of minimally invasive surgery. However, application of laparoscopic surgery in these complex surgical procedures can be quite a challenge. Thus the advent of robotic surgical technology and it's 3-dimensional camera vision, superior precision and dexterity with EndoWristed instruments, elimination of operator tremor has shifted the paradigm of minimally invasive surgery in gynecologic oncology.

Since the approval of robotic surgical platform for gynecologic surgery, there have been four generations of robotic surgical platform that have been developed. The robotic Si system has introduced a single site incision to perform uncomplicated hysterectomy without the need for multi incisions. Along with this advancement, there have been development of instrumentations such as the vessel sealer. This instrumentation has multifunctional purpose such as grasping, dissecting, skeletonizing, sealing and cutting which have allowed (procedures including but not limited) to robotic assisted nerve sparing radical hysterectomy and robotic pelvic exenteration to be performed more efficiently . Robotic stapler facilitates sigmoid resection and small bowel resection and anastomosis in the setting of advance ovarian cancer. The Firefly technology allows sentinel node sampling in endometrial cancer where a full pelvic lymphadenectomy may be avoided.

Lastly, the development of 4th generation Robotic platform the Xi system, have revolutionized the robotic surgery. The Xi system relies on laser guided docking which facilitates docking. The Xi robotic arms are suspended on a boom mounted system which allows for 360 degree rotation. This feature allows the surgeon to perform multiquadrant surgery much more efficiently which is critical as part of the surgical staging or ovarian cancer debulking. The redesigned robotic Xi arms are much thinner, lighter, and the implementation of the extra joint minimizes arms clashing and allows for much greater extension to operative field. These features circumvent the limitation of patient's body habitus. Lastly, the new endoscope that is for the Xi system is a much lighter endoscope that doesn't require draping and calibration. The new endoscope allows a feature of "port hopping". This technology allows the endoscope to be placed in any of the robotic ports which allows much more flexibility which is required in complex multiqudrant surgery.

Notes:

Surgeons Corner & Panel

Felix Chan, Russell Land and Nisha Jagasia

Notes:

Thursday 4th May 2017

SESSION: Session 2 – Cervical Cancer
Presenters: Shailesh Puntambekar, Penny Bloomfield and Tarek Meniawy
Time: 11.15am – 12.45pm
Chair: Ganendra Raj Mohan and Julie Lamont

Laparoscopic radical hysterectomy- The Duplicable Steps

Shailesh Puntambekar

The aim of this presentation is to emphasize the easy and duplicable steps of Laparoscopic Radical Hysterectomy required for complete clearance of cervical malignancy. At our centre using the duplicable "PUNE TECHNIQUE " we are able to achieve tumour free margin and adequate lymph node dissection by maintaining the integrity of both ureters by using Energy sources (Bipolar/Harmonic/Ligasure) and Scissors along with the vascular clips. Visualization of pelvic anatomy, reduced lateral spread of energy sources and the ability to minimize blood loss along with dynamic access to the uterine vessels, vagina, and rectum is its added advantage. The standardisation of the steps and predictive anatomy and minimal variability of pelvic anatomy makes this procedure lucid and duplicable with minimal complication.

Notes:

HPV Vaccination /National Cervical Screening Program

Penny Blomfield

Notes:

Immunotherapy for gynaecological cancers: are we there yet?

Tarek Meniawy[1]

1. *Department of Medical Oncology, Sir Charles Gairdner Hospital, Nedlands, WA*

Targeting the immune system to treat cancer has been a long sought goal that has only recently reached the clinic as a novel class of promising agents in the armamentarium against cancer. Indeed, immunotherapy was designated 'Breakthrough of the Year' by Science magazine in 2013. Improvements in outcomes have been demonstrated with the use immune checkpoint inhibitors in an increasing number of malignancies, including melanoma, lung, head and neck, renal and bladder cancers. More recently promising data as emerged in gynaecological cancers, including endometrial cancer with deficiency in mismatch repair mechanisms, cervical cancer and recurrent ovarian cancer.

This session will provide an overview on the background and development of immunotherapy as an anti-cancer treatment, and the evolving evidence in gynaecological cancers. Future directions on the development pathway for this class of drugs, including how to identify patients more likely to respond, optimising potential combination strategies will also be reviewed.

Notes:

Thursday 4th May 2017

SESSION: Fellows Presentations 1
Time: 1.45pm – 3.10pm
Chair: Jonathan Carter and Simon Hyde

The demographics and outcomes of women with Stage II endometrial carcinoma managed in Australia (2005-2007)

Pearl Tong[1] , Rebecca Asher[1], Penelope M Webb[2] , Selvan Pather[1] (for the ANECS group)

1. *Chris O Brien Lifehouse, Sydney*
2. *QIMR Berghofer Medical Research Institute, Queensland*

Stage II endometrial cancer comprises approximately 15% of all uterine cancers. Given the relative rarity of this disease, clinical management is guided by small cohorts and retrospective series. Current guidelines recommend primary surgery with staging and adjuvant therapy tailored to surgical and histopathological findings. Classification of Stage II endometrial cancer was refined in 2009 after critical review of the old classification in terms of accuracy, reproducibility and its utility in

discriminating clinical outcomes. The previous stage included glandular involvement however this has been replaced with a staging system which includes cervical stromal involvement only. The administration of radiation therapy (RT) has not been shown to impact survival but may reduce loco regional recurrences. Many centers use both external beam radiation therapy (EBRT) and vaginal brachytherapy (VBT) as part of their treatment protocols, especially for Stage II disease due to cervical involvement being viewed as a strong predictor of vaginal recurrence.

Our primary objective is to study the demographics, patterns of recurrence and survival for patients with stage II endometrial carcinoma in Australia. Our secondary objective is to study the impact of the new FIGO classification in terms of progression free survival and overall survival, compared to the old system, and to study the accuracy of pre-operative diagnosis of cervical stromal invasion in cases of endometrial carcinoma. This data will add significantly to the current literature and will guide existing local and national protocol development.

The study will be done through retrospective review of individual-level data from the Australian National Endometrial Cancer Study (ANECS) conducted between 2005-2007 at the QIMR Berghofer Medical Research Institute. Eligible women will be all Stage II Endometrial Cancer patients (by the old and new FIGO classification) who had surgical treatment. Patient demographic details, investigations and treatment undertaken, pre and post surgical pathology data, records of recurrences and survival outcomes will be presented and compared between the 2 groups staged by the old and new system. Survival outcomes will be compared using Kaplan-Meier curves and the log-rank test and the univariate association of baseline variables with overall and progression free survival were investigated using proportion hazards models, and the survival probability at 2 and 4 years post surgery calculated.

Notes:

Clear Cell Carcinoma of the Ovary: A retrospective review of clinic-pathological characteristics

Yvette M Ius [1 2]

1. *Royal Hospital for Woman, Randwick, NSW, Australia*
2. *John Hunter Hospital, Newcastle, NSW, Australia*

This is a dual centre 2:1 retrospective matched control study where patients in the control group have been matched for age and FIGO stage with clear cell carcinoma. The control group consists of patients with high grade serous ovarian, peritoneal or fallopian tube cancers. Clinico-pathological characteristics have be obtained such as Ca125, and pattern of disease spread including cytology, presence of ascites, and nodal disease. The incidence of disease occurrence on a background of known endometriosis will be explored, as well as a summary of surgical findings and pattern of disease spread, such as capsule rupture, nodal disease and cytology. Prognostic factors of CCC and an anlaysis of the outcomes of treatment will be presented.

Notes:

The Case for Pre-Operative Very Low Calorie Diets (VLCDs) in Obese Endometrial Cancer Patients

Chloe Ayres [1]

1. *King Edward Memorial Hospital, Randwick, NSW, Australia*

Endometrial cancer is the most common gynaecological malignancy in Australia and the incidence is rising coinciding with a national epidemic of obesity. Fortunately studies have shown an inverse relationship between BMI and tumor biology with obese women having a tendency towards MSI negative, early stage, lower grade tumours. Surgery is the mainstay of endometrial cancer treatment, however, obesity poses significant challenges to the performance of safe surgery by any technique, whether open or minimally invasive. Despite improvements in anaesthesiology and surgical techniques obesity remains a risk factor for surgery and in some cases delaying surgery until a patient has lost weight may be advisable. Non-surgical treatment of low grade endometrial malignancies with morbid obesity and comorbidities has been directed at restoring the oestrogen-progesterone balance, typically through the addition of progestins. Yet these therapies do little to relieve the cardiovascular and endocrine consequences of morbid obesity. Very Low Calorie Diets (VLCDs), however, can provide safe rapid weight loss in the period immediately preceding surgery and may reduce the perceived perioperative difficulties associated with surgery. This method of short term dietary therapy is often overlooked. VLCDs provide 800kcal per day and rank second after bariatric surgery in their ability to help overweight or obese adults lose weight. VLCDs safely and effectively achieve significant reductions in body weight, liver volume and visceral adipose tissue. Many of the metabolic and physiologic effects of VLCDs are also beneficial, such as improvement in insulin sensitivity and fasting plasma glucose levels enabling a reduction or even cessation of diabetic medications, lowering of blood pressure and serum triglyceride values. VLCDs are also conducive to ketosis which can help suppress hunger and preserve lean muscle tissue. Pre-operative VLCDs such as Optifast® have been used successfully to reduce the perceived technical difficulty and perioperative complications in bariatric surgery, general surgery and more recently in laparoscopic cholecystectomy. The compliance rate for short term VLCD's is surprisingly high at 86-96%. Despite the growing popularity of VLCDs, the recruitment feasibility of VLCDs have not been investigated pre-operatively in the low risk obese (BMI ≥35) endometrial cancer population which this study aims to do.

Notes:

Uterine carcinosarcoma: the 22-year Monash experience

Shih-Ern Yao [1]

1. *Monash Medical Centre, Moorabbin, Victoria*

Background: Uterine carcinosarcoma (UC) is a rare and aggressive subtype of endometrial carcinoma associated with late diagnosis and poor prognosis. Due to the low incidence of cases and variations in standard adjuvant therapy, the optimal management of these patients following primary surgical treatment remains uncertain.

Aim: To review the characteristics, treatment and outcomes of a cohort of cases of uterine carcinosarcoma.

Methods: 92 cases of uterine carcinosarcoma were identified retrospectively across 4 centres, from 1994 to 2016 inclusive, through the combination of public and private cases from the four gynaecology oncologists operating at Monash Health. Patient characteristics, histopathology results, type(s) of adjuvant therapy, episodes of recurrence and survival status were extracted from patient records and tabulated. Staging was determined based on histopathology reports using the 2009 revised International Federation of Gynecology and Obstetrics (FIGO) staging system for uterine carcinomas.

Results: 33(36%) patients were diagnosed with Stage I, 15(16%) with Stage II, 27(29%) with Stage III and 17(18%) with Stage IV UC. There was an overall recurrence rate of 14% and death rate of 50%. More patients underwent dual adjuvant therapy than chemotherapy or radiotherapy alone, and were more likely to have either Stage I or III disease. Dual adjuvant therapy was associated with lower recurrence and higher survival rates than either chemotherapy or radiotherapy alone. Death rates increased with increasing stage, with a trend towards shorter intervals from diagnosis to death.

Conclusion: Dual adjuvant therapy was associated with favourable outcomes in our patient population and warrants further prospective trials to ascertain its role in the treatment of UC.

Notes:

Endometrial cancer survival, cardiovascular risk factors and cause of death

Philippa Shirley [1] , Peter Sykes [1] , Bryony Simcock [1] , Suzanne Stainer [2] , Kelly MacDonald [3]

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2. *Department of Obstetrics & Gynaecology, Canterbury District Health Board, Christchurch, New Zealand*
3. *University of Otago, Christchurch School of Medicine & Health Sciences, Christchurch, New Zealand*

In 2009, New Zealand had the third highest obesity rate in the OECD[1]. Data from the 2011/12 NZ Health Survey demonstrated that 29% of women were obese[1]. Obesity is an independent risk factor for endometrial cancer (EC) and cardiovascular disease. Ward et al demonstrated that EC patients were nearly twice as likely to die from cardiovascular disease than from EC[2]. Stage of disease was found to be a predictor of cause of death with those having localised EC more likely to die from cardiovascular disease and those having advanced stage EC more likely to die from EC[2]. We hypothesised that EC patients in Christchurch have higher rates of cardiovascular comorbidity and are at increased risk of cardiovascular death compared with women in the general population. This retrospective study analysed 461 women diagnosed and treated for EC at Christchurch Women's Hospital between 1997-2007. Information on stage, cause of death, comorbidities and ethnicity was collected from a gynaeoncology database, patient files and clinical coding summaries. EC patients were found to have higher rates of comorbidities than women in the general New Zealand population. They have over double the rate of hypertension; 39.3% vs 17.2% and four times the rate of cardiovascular disease; 20.4% vs 5%. There were 129 deaths recorded, 72 (55.8%) of which were due to EC and 32 (24.7%) from cardiovascular causes. 87.5% of women who died from EC were within 5 years of follow-up and 37 had stage 3-4 disease. Those who died from cardiovascular disease were more likely to be beyond 5 years follow-up and 90% had stage 1-3a disease. A large proportion of EC survivors who had low stage disease die from cardiovascular disease rather than EC. There is opportunity to apply cardiovascular risk reduction prevention within the EC follow-up/ survivorship programme.

1. The Health of New Zealand Adults 2011/12: Key findings of the New Zealand Health Survey
2. Ward KK, Shah NR et al. Cardiovascular disease is the leading cause of death among endometrial cancer patients. Gynae Oncol 126 (2012) 176-9.

Notes:

Pre-operative and intra-operative assessment in endometrial cancer: the role of magnetic resonance imaging and frozen section

Niveditha Rajadevan [1] , Orla McNally [1]

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

A prospective study was undertaken to evaluate the negative and positive predictive value of pre-operative assessment via endometrial biopsy and magnetic resonance imaging (MRI) and intra-operative assessment via frozen section in patients with newly diagnosed endometrial cancer at a single Australian institution. Characteristics evaluated included pre-operative endometrial biopsy grade, depth of myometrial invasion and nodal status identified on MRI and frozen section grade and myometrial invasion alongside final histopathologic findings.

The findings of this study will be further evaluated alongside pre-operative levels of HE4 in an aim to assess the utility of HE4 as a serum biochemical marker – alongside pre-operative endometrial biopsy and MRI and intra-operative frozen section – in patients with endometrial cancer. HE4 levels will be correlated with Ca125 levels, pre-operative MRI findings including depth of invasion, nodal status and tumour size and correlated with final histopathology including FIGO stage, depth of invasion and tumour grade.

Notes:

The use of a Modified Caprini Score in Gynaecological Oncology patients.

King Man Wan [1] , Samir Saidi [1] , Trevor Tejada-Berges [1] , Selvan Pather [1] , Jonathan Carter [1]

1. *Chris O'Brien Lifehouse, WESTMEAD, NSW, Australia*

BACKGROUND: Extended thromboprophylaxis after major abdominal or pelvic surgery with low molecular weight heparin (LMWH) has been proven to decrease the incidence of venous thromboembolism. In September 2014, we introduced the modified Caprini Score to increase the prescription of extended thromboprophylaxis in our gynaecological oncology service.

AIM: To assess the effect of introducing a modified Caprini Score on the use of extended thromboprophylaxis in women who had laparoscopic or open gynaecological surgery.

METHODS: A retrospective cohort study was performed. All patients after September 2014 to July 2016 who had a laparoscopic or open abdominal surgery were included (Post-Caprini). This group was compared to patients in the last 12 months prior to September 2014 (Pre-Caprini). Post-Caprini group patient had their modified Caprini Score calculated at the time of surgery and then the prescription of extended thromboprophylaxis was based on individual surgeon's discretion. The Caprini score was retrospectively calculated in the Pre-Caprini group. Primary outcomes measured were rates of extended thromboprophylaxis use, symptomatic venous thromboembolisms (VTE) and postoperative haemorrhage.

RESULTS: 826 patients were identified and included in the study. 258 patients in the pre-Caprini group and 568 patients in the post-Caprini group. No patients were excluded. The introduction of Caprini score significantly increased the rate of extended thromboprophylaxis use overall from 6.2% to 21.8% ($p<0.0001$) and in high risk patients from 15.6% to 52.4% ($p=0.0007$). Overall symptomatic VTE rates were low with only 1 patient in either cohort. Haemorrhage rates were also similar in the Pre-Caprini group compared to the Post-Caprini group (1.6% vs 0.9%, $p=0.47$).

CONCLUSION: The introduction of a modified Caprini Score increased the prescription of extended thromboprophylaxis in patients whom had major gynaecological surgery without a significant increased risk of postoperative haemorrhage. However, extended thromboprophylaxis did not result in a decrease in symptomatic VTE.

Notes:

Thursday 4th May 2017

SESSION: Fellows Presentations 2 / Free Communications
Time: 3.40pm – 5.00pm
Chair: Orla McNally and Martin Oehler

The impact of universal referral for women with high grade serous carcinoma (HGSC) of ovary, tube or peritoneum in the Northern Cancer network (NCN)- Is there a change in referral patterns for genetic counseling?

Michael Burling [1] , Ai Ling Tan [2] , Kimberley Gamet [3] , Lois Eva [2]

1. *Chris O'Brien Lifehouse, Redfern, NSW, Australia*
2. *Gynaeologic oncology, Auckland Hospital, Auckland, New Zealand*
3. *Genetic Services, Auckland Hospital, Auckland, New Zealand*

Objective: To determine the proportion of eligible patients with HGSC of ovary, tube or peritoneal origin identified at gynaecologic oncology multidisciplinary meetings (MDM) referred for genetic counseling pre and post national guidelines implementation in 2013;to ascertain the rate for non attendance at genetics clinics and the rate of positive germline BRCA mutations.

Methods: Eligible cases were identified from gynaecologic oncology MDM between 1Janurary 2012 to 31 December 2014. Genetic referrals were checked against the records of genetic services database to ascertain that referrals were received. Outcomes including attendance, genetic testing and results were identified.

Results: 60 patients were identified. Referral rates increased over the 3- year period from 18% in 2012 to 40% in 2014. Of the 19 patients that attended genetic counseling,16 patients underwent BRCA mutation testing. 21.1% tested positive for a germline BRCA mutation.

Conclusion: Referral rates increased since the implementation of the national guidelines. Patients with HGSC have a high rate of BRCA mutation.

Notes:

Laterally extended endopelvic resection (LEER): a discussion of technique and case studies

Nimithri Cabraal [1]

1. *Gold Coast University Hospital, Greenslopes, QLD, Australia*

Background: Pelvic exenteration for gynaecological cancer is a method of surgical salvage used to treat locally recurrent pelvic malignancy. Consideration for this ultra-radical procedure is usually given to offer a last chance of cure when other options such as pelvic radiation, chemotherapy or less radical surgery have been exhausted.

Summary: The technique of laterally extended endopelvic resection (LEER) is discussed with reference to 2 cases undertaken at the Gold Coast University Hospital in the last 12 months.

Notes:

"Using 'SHARP' tools in the operating room...Beyond the scalpel".

Kristen Moloney [1] , Simon Hyde [1]

1. *Gynaecologic Oncology, Mercy Hospital for Women, Melbourne, VIC, Australia*

The current surgical education environment imposes numerous challenges on both trainees and their teachers. Restricted working hours, demands for improved operating room efficiency and increased complexity of surgical procedures undertaken on patients with more co-morbidities and higher expectations ostensibly translates to an 'apprenticeship under pressure'. Volume of exposure can no longer guarantee the acquisition and maintenance of surgical expertise. This contention that current surgical training systems are inadequate is supported by an international body of evidence across a variety of specialties.

How can we navigate this educational climate change where opportunity for experiential learning is markedly less than that of our forebears? At least some of the answers lie in the use of evidence-based educational stratagem where every clinical encounter permits maximal learning.

First is Anders Ericsson's concept of 'deliberate practice' which has been identified as a critical factor in attainment of expertise and is directly applicable to surgical training. Students of deliberate practice are given tasks with well defined goals, are motivated to improve, are subject to structured feedback and are provided with opportunities for repetition and gradual refinements of their performance.

The second answer to our question lies in feedback. Although widely acknowledged to be critical to the learning process, feedback can be variable in its effects. In order for feedback to be constructive, the learner must address three fundamental questions – (1) what is my goal?, (2) how am I going?, and (3) where to next?. The Imperial College's evidence-based 'SHARP' acronym functions as an aide memoire for the teacher and trainee thus facilitating provision and receipt of exactly this type of structured feedback. Complementary to the 'SHARP' tool is 'OSAD', an assessment tool used for determining whether the feedback was delivered according to best practice.

The Gynaecologic Oncology Unit at Mercy Hospital for Women are working to achieve deliberate practice. We have incorporated both the 'SHARP' and 'OSAD' tools into our operating room environment and have undertaken a qualitative review of our experience.

1. Ericsson, K.A., 2015. Acquisition and maintenance of medical expertise: a perspective from the expert- performance approach with deliberate practice. Academic medicine : journal of the Association of American Medical Colleges, 90(11), pp.1471–1486.
2. Imperial College London, 'The London Handbook for Debriefing – enhancing performance debriefing in clinical and simulated settings'.

Notes:

Stage IV ovarian cancer; response to treatment and patterns of disease recurrence.

Amy Jamieson [1] , Bryony Simcock [2] , Peter Sykes [2] , Lois Eva [3] , Cecile Bergzoll [4]

1. *Westmead Hospital, Sydney , NSW, Australia*
2. *Gynaecologic Oncology , Christchurch Women's hospital , Christchurch , New Zealand*
3. *Gynaecologic Oncology, Auckland Hospital , Auckland, New Zealand*
4. *Gynaecologic Oncology, Wellington Hospital , Wellington , New Zealand*

Aim: To compare treatment response and patterns of disease recurrence in stage IV epithelial ovarian cancer**.**
Methods: Retrospective analysis of stage IV ovarian cancer between 2008 and 2012 in three gynaecologic oncology centres in New Zealand.
Results: Patients were divided into three patterns of stage IV disease; pleural effusion, parenchymal metastases or extra-abdominal nodal metastases. 124 patients were analysed, 58 pleural effusions, 38 parenchymal metastases, 28 extra-abdominal nodes. There was no significant difference in overall survival between these three groups of stage IV disease. The most common site of first or any recurrence in all three groups was the abdomen with only a small number of recurrences arising in extra-abdominal sites.
Conclusion: The site of extra-abdominal disease did not alter prognosis or pattern of disease recurrence in stage IV epithelial ovarian cancer, with most recurrences in the abdomen suggesting controlling abdominal disease with surgery is important in all stage IV disease.

Notes:

Changing Patterns of Referrals and outcomes of genetic participation in Gynaecological Oncology Multidisciplinary care

Hanoon P Pokharel [1] , Neville F Hacker [1] , Lesley Andrews [2]

1. *Royal Hospital For Women, Sydney, Australia, Sydney, NSW, Australia*
2. *Hereditary Cancer Clinic, Prince Of Wales Hospital, Sydney, NSW, Australia*

Genetic participation in gynaecological oncology multidisciplinary team meetings (MDT) may identify the sentinel cancer in women with hereditary breast-ovarian cancer syndrome or Lynch syndrome.

Aims: To identify the changing patterns of genetic referral from 2010 to 2014 and the outcomes of referrals through clinical MDT case review.

Materials and Methods: Medical records of cases of gynaecological cancer presented at the MDT meetings and genetics databases were reviewed to determine the frequency and outcomes of recommendations for genetic referral between 2010 and 2014.

Results: Four hundred and sixty-two women of 2523 cases reviewed were recommended for referral, increasing from 8% in 2010 to 25% in 2014. However, 167 of 462 patients (36%) had not registered with a Hereditary Cancer Clinic in NSW/ACT, including 11 women with high-grade serous ovarian cancer and seven women with abnormal MMR immunohistochemistry. Mutations were identified in 40 of 165 women (24%) undergoing breast cancer BRCA1/2 testing and in ten of 25 women (40%) who underwent MMR genetic testing. Eighty-one first- or second-degree relatives of these women have undergone predictive testing, identifying 48 mutation carriers and 33 non-carriers.

Conclusion: Changing indications and increased participation by a genetic consultant in the weekly MDT meeting has led to increasing genetic referrals over the last five years. Follow up of referrals needs to be addressed. With decreasing costs of genetic testing and use of readily transportable DNA collected through saliva or mouth swabs, we propose that distance should not be a barrier to this model being extended to all centres providing care to gynaecological cancer patients.

Notes:

Surgical management of a retroperitoneal pelvic desmoid tumour involving the sacrifice of external iliac vein and internal iliac vessels.

Elizabeth Goulding [1] , Michael Bunting [1] , Robin Harle [1] , Penny Blomfield [1]

1. *Royal Hobart Hospital, Hobart*

Retroperitoneal pelvic desmoid tumours are rare, with limited reports in the literature. They are benign locally aggressive neoplasms associated with significant morbidity and mortality. They are not normally considered during the differential diagnosis of a pelvic mass. Management is commonly wide local excision, which is frequently challenging and associated with high morbidity, mortality and recurrence.

We present a case of a 65-year-old woman presenting with a complex adnexal lesion. Intra-operatively a diagnosis of a retroperitoneal pelvic tumour was made and excision required the sacrifice of the distal common iliac vein, left external iliac vein and left internal iliac vessels. Intra-operative decision making was challenging. Post-operatively our patient has had minimal morbidity and no evidence of recurrence. She does not have Familial Adenomatous Polyposis, a condition commonly associated with these tumours.

This case illustrates the challenge pelvic desmoid tumours may pose for the Gynaecological Oncologist and summarises the literature regarding them.

Notes:

Examining Word Association Networks: A Cross-Country Comparison of Women's Perceptions of HPV Testing and Vaccination

Bernd Schmid [1] , Benjamin Luan [2] , Jamie Carlson [3] , Kenneth Jaaback [4] , Gunther Rezniczek [5] , Jessica Wyllie [3] , Filip Vewncovsky [6]

1. *Royal Hospital for Women Sydney, Randwick, NSW, Australia*
2. *School of Business and Economics, Maastricht University, Netherlands*
3. *University of Newcastle, Newcastle Business School, Faculty of Business and Law , Newcastle, NSW, Australia*
4. *Department of Gynaecological Oncology, John Hunter Hospital, New Lambton Heights , NSW, Australia*
5. *Department of Obstetrics and Gynecology, Ruhr-Universität Bochum (Marien Hospital Herne), Herne, Germany*
6. *Faculty of Informatics and Statistics, University of Economics Prague, Prague, Czech Republic*

In this study, we examined the perceptual associations women hold with regard to cervical cancer testing and vaccination across two countries, the U.S. and Australia. In a large-scale online survey, we presented respondents with 'trigger' words, and asked them to state sequentially other words that came to mind. We used this data to construct detailed term co-occurrence network graphs, which we analyzed using basic topological ranking techniques. Our findings suggest that women hold divergent perceptual associations regarding trigger words relating to human papillomavirus testing and vaccination, which was found to be consistent across the country groups studied. Our findings are critical in optimizing public health branding strategies to minimize misperceptions relating to human papillomavirus testing and vaccination in order to maximize adoption, and reduce health-related expenditure.

Notes:

Friday 5th May 2017

SESSION: Session 3 – Ovarian Cancer
Presenters: Shailesh Puntambekar and Tarek Meniawy
Time: 8.30am – 9.45am
Chair: Alison Brand and Jason Tan

The role of laparoscopy in ovarian cancers

Shailesh Puntambekar

The diagnosis and management of advanced ovarian cancer is one of the greatest challenges in oncology. The primary goal of surgery is to achieve maximum cytoreduction followed by chemotherapy. Published studies have proven a beneficial role of Laparoscopic Interval Debulking after NACT as well.

Laparoscopy has achieved the oncological clearance comparable to open along with its added benefit of prevention of rupture and spillage due to reduced handling along with magnification, precision and documentary evidence. This presentation emphasizes on feasibility of laparoscopic surgery for staging as well as ileo-obturator and para-aortic lymph node clearance.

Notes:

PARP inhibitors: which patient, when and how should they be used in 2016 and beyond

Tarek Meniawy [1]

1. *Department of Medical Oncology, Sir Charles Gairdner Hospital, Nedlands, WA*

In 1990, BRCA1 was localised to chromosome 17q, and a few years later BRCA2 was localised to chromosome 13q. Although pre-clinical data emerged in the early 2000's, it wasn't until 2010 that the first proof-of-concept study demonstrated that a PARP inhibitor can induce synthetic lethality in patients with BRCA1 or BRCA2 mutations, with demonstrated safety and efficacy in this population. Further studies have led to the US FDA approval of three PARP inhibitors in recurrent ovarian cancer, with olaparib being the first such agent to be approved in Australia by the TGA. This session will provide an overview on the mechanism of action of PARP inhibitors, the evidence for their efficacy in different clinical settings, and future directions to their potential use in ovarian cancer in both BRCA-mutated and 'BRCA-like' patients.

Notes:

Friday 5th May 2017

SESSION: Free Communications
Time: 9.45am – 10.15am
Chair: Alison Brand and Jason Tan

Prevalence, incidence and risk factors of lymphoedema following gynaecological cancer: results from a longitudinal cohort study

Monika Janda [1] , Sandi Hayes [1] , Andreas Obermair [2]

1. *Queensland University of Technology, Kelvin Grove, QLD, Australia*
2. *Gynaecological Oncology, Queensland Centre for Gynaecological Cancer, Brisbane, QLD, Australia*

Lymphoedema following gynaecological cancer is associated with adverse physical and psychosocial consequences. Our objectives were to prospectively determine prevalence and incidence of lymphoedema up to 24 months post-treatment, and to examine the effect of personal, diagnostic and behavioural characteristics on lymphoedema risk. A representative sample of Australian women with recently diagnosed, invasive gynaecological cancer were evaluated at regular intervals (up to 3-monthly) using bioimpedance spectroscopy (lymphoedema was diagnosed when the ratio of arm to leg impedance values on the same side were >1 standard deviation above normative data), leg circumferences (lymphoedema was diagnosed when there was a >=5% increase in sum of leg circumferences from baseline), self-reported leg swelling and receipt of a clinical diagnosis. 16% of women reported leg swelling at baseline, while 26% had pre-treatment lymphoedema according to the bioimpedance spectroscopy method of diagnosis. By 24-months post-surgery, at least one in three women had developed measurable swelling (according to the bioimpedance spectroscopy and/or circumference method) and 48% self-reported lower-limb swelling; although only 24% had received a clinical diagnosis. Risk of lymphoedema post-treatment was higher for those with more extensive lymph node dissection, receipt of radiotherapy and chemotherapy, diagnosis of vulvar/vaginal cancer, older age, presence of baseline swelling, higher body mass index and low or no physical activity levels. These findings are derived from a high quality, prospective, cohort study that used objective, self-report and clinical assessments of lymphoedema. Results highlight that lymphoedema is common and persistent following gynaecological cancer. Given the known implications of lymphoedema on function and quality of life, ensuring standard of care includes systematic surveillance for earlier detection and management of lymphoedema is important.

Notes:

Ovarian Cancer Clinical Quality Registry Piolet Project

Robert Rome [1]

1. *Epworth HealthCare, East Melbourne, VIC, Australia*

We have been successful in obtaining substantial funding to conduct a pilot study for a Clinical Quality Registry (aka CQR) in ovarian, tubal and peritoneal (aka OTP) cancer. We have been working with the Cancer Registry program at Monash University and a project officer has been appointed. It is expected that the pilot project will take 15 months. We decided to start with a pilot project involving 14 gynaecological oncologists working in 5 public units in NSW, Tasmania, and Victoria and one private unit in Victoria.

Considerable progress has been made towards identifying the clinical quality indicators to be used. These currently include -

- Adequacy of staging of apparent early stage (I, II and IIIA) OTP cancer.
- Optimal debulking in advanced stage (IIB, IIIB, IIIC and IV) OTP cancer.
- Optimal debulking in interval OTP cancer surgery
- Intraoperative complications and events.
- Surgical adverse events <30 days.
- MDT presentation and discussion.
- Cytopathology or histopathology prior to neo-adjuvant chemotherapy.
- Use of platinum-based chemotherapy.

Others CQIs are which are under consideration are -

- Referral of patients with high-grade serous cancers to an FCC or for genetic testing
- Reasons for interval surgery documented
- Interval from diagnosis to chemotherapy
- Death within 30 days of chemotherapy

Data will be collected on co-morbidities and other risk factors for risk-adjustment. Consideration is currently being given to definitions and data alignment. The data will be generated by participant's databases and transmitted to the Registry in de-identified format. In due course, data will be identified and full ethics committee approval will be necessary. Linkage with cancer registries may provide an opportunity to conduct a patient reported outcomes study and to add disease-specific survival as an outcome measure. Other matters which are being considered include governance and how to deal with outliers.

The project aims to eventually include more gyn oncologists and to extend to the other gynaecological cancer sites. Just as it is for all quality clinical registries, the major challenge is long-term funding.

Notes:

Friday 5th May 2017

SESSION: Session 4 – Endometrial & Other Cancer
Presenters: Shailesh Puntambekar and Peter Lim
Time: 10.45am – 11.55am
Chair: David Allen and Yee Leung

Changing concepts in laparoscopy

Shailesh Puntambekar

This presentation illustrates the importance of anatomical and neuro-vascular landmarks as seen by laparoscopy. The anatomical landmarks encountered during laparoscopic surgery will help the surgeon do better surgery. This presentation also gives the tips to achieve good surgical planes. The aim of this work was to describe the pelvic anatomy and its application in day to day laparoscopic gynaecological surgeries. Laparoscopy provides magnification and thus better precision with minimum handling of tissues leading to understanding the constant changing concepts in pelvic anatomy. This will help to understand the preservation of nerves while doing endometriosis and radical hysterectomy. The demonstration of superior and inferior hypogastric plexus along with hypogastric nerve is also elaborated to understand the point at which suture should be taken for different gynaecological procedures.

Laparoscopic view of anatomy with the current camera systems in an excellent tool to demonstrate and teach pelvic anatomy which can be applied to surgical principles in difficult benign and oncological cases.

Notes:

Practical tips on robot-assisted radical hysterectomy

Peter Lim [1]

1. *Center for Hope, Renown Robotics Surgical Institute, Nevada, USA*

The first radical hysterectomy was performed by Clark in 1895. Wertheim in 1898 developed the total radical hysterectomy with removal of the pelvic lymph nodes and parametrial tissue. Radical hysterectomy, together with pelvic and / or para-aortic lymphadenectomy, is used to treat cervical cancer stage 1a2 to 1b1 and selected patimmmments with stage 1b2 and 2a1. It is also one treatment option for patients with stage 2 uterine cancer. Open total radical hysterectomy is often associated with high morbidity with significant blood loss and potential late sequelae of urinary tract system. Minimal invasive approach such as total radical vaginal hysterectomy (Schauta's procedure), laparoscopic assisted radical vaginal hysterectomy or total laparoscopic radical hysterectomy have been well described and proposed to minimize morbidity. These minimal invasive approach have limitations due to a steep learning curve that is required to achieve proficiency particularly the critical steps of the radical hysterectomy; the parametrial dissection. The advent of robotic technology with its 3-dimensional camera vision, superior precision and dexterity (EndoWrist instrumentation) circumvent the limitations.

With the introduction of robotic system, robot-assisted radical hysterectomy (RRH) have been increasing adopted. Querlue and Morrow reclassified the different types of radical hysterectomies in 2008. The cornerstones for the success of RRH are a thorough knowledge on the pelvic anatomy particulary the parametrial or cardinal ligament complex as it relates to ureteric tunnel, anterior, lateral and posterior uterovesicle ligaments and uterine artery. The 12 steps of robotic assisted total radical hysterectomy with pelvic lymph node dissection procedure and similarly identification of the hypogastric and pelvic splanich nerves in Nerve-sparing radical hysterectomy will be outlined along with the tips and tricks in performing this procedure proficiently.

Notes:

Friday 5th May 2017

SESSION: Session 5 – Indigenous Health in the Kimberley

Presenters: Amy Tang Wei, Jeanette Ward and Jared Watts

Time: 11.55am – 1.10pm

Chair: John Miller and Helen Green

Culture and the Indigenous patients experience

Amy Tang Wei

Notes:

Diseases and access to services: Cultural and population health perspectives

Jeanette Ward [1]

1. *WA Country Health Services, Kimberley Region*

As sub-specialists in gynaecological oncology, ASGO members have unique influence in health system design and health policy. Using epidemiology as the population starting point, this presentation will describe contemporary approaches to Aboriginal health in the Kimberley with potential for other settings. Public health strategies to accelerate Aboriginal advancement with relevance for participants as influential leaders in their own workplaces will be suggested.

Notes:

Service access and delivery in the Kimberley

Jared Watts

Providing a gynaecological service in the Kimberley is unique and challenging. The area is vast, being three times the size of England, over 2000km (or 2 plane flights) from tertiary hospitals and many of the 100 communities and towns can be cut off, even from air services during the wet season. 40% of the population identify as Aboriginal and have a high burden of disease, as well as face many social issues. This presentation will discuss gynaecological services in the Kimberley using a recent Gynae-Onc patient as a case study, to demonstrate the local challenges and difficulties for both patients and health professionals.

Notes:

Saturday 6th May 2017

SESSION: Session 6 – Surgical Education

Presenters: Peter Lim, Lew Perrin, Stuart Salfinger, Adam Pendlebury and Cecile Bergzoll

Time: 9.00am – 11.05am

Chair: Paul Cohen and Helen Green

Development of robotic training program

Peter Lim [1]

1. *Renown Regional Medical Center,, United States*

Open, vaginal or laparoscopic surgery has been traditionally taught by an apprentice model, where a skilled mentor directs and instructs the apprentice on how to develop the operative field and dissectional plane so that surgical procedure can be performed safely. The advent of robotic surgery has shifted the paradigm of surgery since FDA approved its technology for gynecologic surgery in 2005.

Unlike conventional open, vaginal or laparoscopic surgery where surgical training requires knowledge of conventional surgical instruments for utilization, robotic surgery not only requires understanding of the utilization the surgical instruments but one must also have a knowledge of the advance technological equipment. In addition, robotic surgery requires a team approach that consist of not only the surgeon and apprentice but also nurses, surgical assistants and anesthesiologist.

Robotic surgery requires the knowledge of docking, the interaction of robotic arms, port placement in addition to performing actual procedures. The learning curve can be complex. The development of robotic training program is critical to the success of robotic surgery from the standpoint of efficiency and outcomes. Factors which are important in development of robotic training program will be presented and discussed.

Notes:

Management of Colorectal Complications – Leaks, Fistulas, Stomas

Lewis Perrin [1]

1. *Mater Hospital, South Brisbane, QLD, Australia*

Anastomotic leakage after colorectal surgery occurs in 4-10% of cases. This complication is one of the one of the most feared when performing radical pelvic surgery. Today's presentation will discuss minimizing the risks, the diagnosis and management of anastomotic leaks.

Some controversial areas will be addressed, including bowel preparation, role of proximal diversion and trans-anal tubes post-op.

Early diagnosis and management of anastomotic risk is critical in minimizing morbidity and mortality.

Discussion of stoma formation and management of fistulas will be covered.

Communication and teamwork are paramount in achieving optimal outcome for our patients.

Notes:

Challenges of surgical education

Stuart Salfinger

Notes:

CGO Trainee View

Adam Pendlebury and Cecile Bergzoll

Notes:

Saturday 6th May 2017

SESSION: Panel Discussion – Training and the scope of gynae-oncology
Panel: Peter Lim, Lew Perrin, Stuart Salfinger, Cecile Bergzoll and Adam Pendlebury
Time: 11.30am – 12.30am
Chair: Stuart Salfinger and Paul Cohen

Notes:

Saturday 6th May 2017

SESSION: ASGO Debate – Future of colorectal surgery performed by the CGO

Panel: Alison Brand and Tom Manolitsas

Time: 12.30pm – 1.30pm

Chair: Stuart Salfinger and Paul Cohen

Notes:

Poster Presentations

Presenters: Paige Tucker and Jennifer Weishaupt

3D Reconstruction from Diagnostic Imaging in Gynaecological Oncology – is Virtual Reality Ready for Prime Time?

Paige Tucker , Paul Cohen , Ganendra Raj Mohan , Jason Tan

Background:

We describe a method of utilizing virtual reality modeling to create a three-dimensional reconstruction of the peritoneal cavity from computed tomography (CT) and magnetic resonance imaging (MRI) studies

Methods:

CT or MRI studies were acquired as 3D fast gradient-recalled echo sequences covering the whole abdomen and pelvis (matrix 512 x 512; field of view, 24 x 26 cm; slice thickness, 1 - 2 mm). Computed tomography (CT) with contrast enhancement was acquired as axial contiguous series with 0.5-mm to 0.8-mm slice thickness. VR model preparation, including 3D segmentation of imaging data, was performed by the operating surgeon. MRI or CT data were transferred in DICOM (Digital Imaging and Communications in Medicine) format to the planning station via portable media. Co-registration and volumetric reconstruction of MRI and CT data were performed automatically. A variety of software tools were available for thresholding, colouring, and transparency modulation. Manual segmentation tools allow the 3D delineation of structures that cannot be segmented by grayscale thresholds.

Conclusions:

A three-dimensional VR environment has the potential to enhance the spatial understanding of anatomy, determine the extent and distribution of disease, and may facilitate appropriate case selection. This technology may have utility in gynaecological oncology, prospective studies are required to assess this.

Notes:

Evaluating pre-surgical ultrasound in diagnosing ovarian masses and its prediction of laparoscopic approach to ovarian mass surgical management

Jennifer Weishaupt [1] , Wellington Martins [2] , Uche Manakaya [1] , George Condous [1 3] , Shannon Reid [3]

1. *Acute Gynaecology, Early Pregnancy and Advanced Endoscopic Surgery Unit. , Nepean Hospital Sydney, Sydney Medical School Nepean, University of Sydney, Kingswood, NSW, Australia*
2. *Medicina Reprodutiva e Ultrassonografia, de São Paulo, Brasil*
3. *LaSGeG (Laparoscopic Surgery for General Gynaecologists), Sydney*

AIM: To assess the accuracy of pre-surgical ultrasound by subjective assessment of ovarian masses and pre-surgical ultrasound in predicting whether the surgery can be accomplished by laparoscopy.

METHOD: Prospective observational study in 103 women, where a detailed pre-operative transvaginal ultrasound, using IOTA morphological parameters was compared with the data obtained from histology post laparoscopy. The agreement, kappa coefficient, the sensitivity and specificity were determined.

RESULTS: 8 women were excluded from the study. The agreement between ultrasound and histology regarding benign vs. malignant/borderline was 77% (73/95), with a Kappa coefficient = 0.62 (95%CI=0.52-0.72). The sensitivity for malignancy/borderline was 78% (14/18) and the specificity was 90%. The agreement between US and surgery whether the surgery could be accomplished by laparoscopy was 99%, with a Kappa coefficient = 0.97 (95%CI=0.94-0.97). The sensitivity for laparotomy was 95% and the specificity was 100%.

CONCLUSION: The pre-surgical subjective assessment by an experienced sonologist using IOTA parameters has a moderate performance on distinguishing vs. malignant/borderline ovarian masses and a very good performance on identifying the need for laparotomy.

Notes:

Notes:

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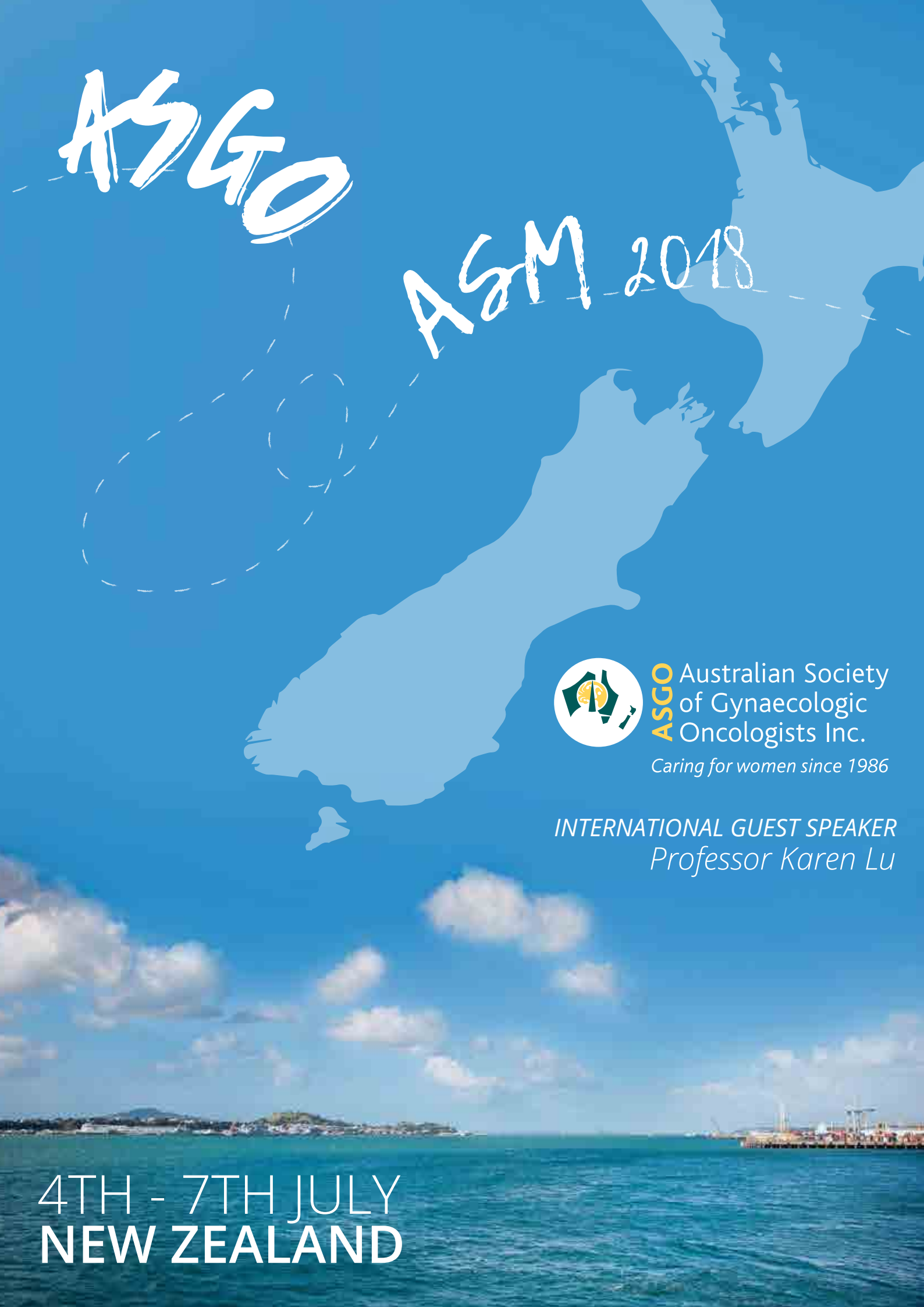

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Professor Karen Lu

4TH - 7TH JULY

NEW ZEALAND