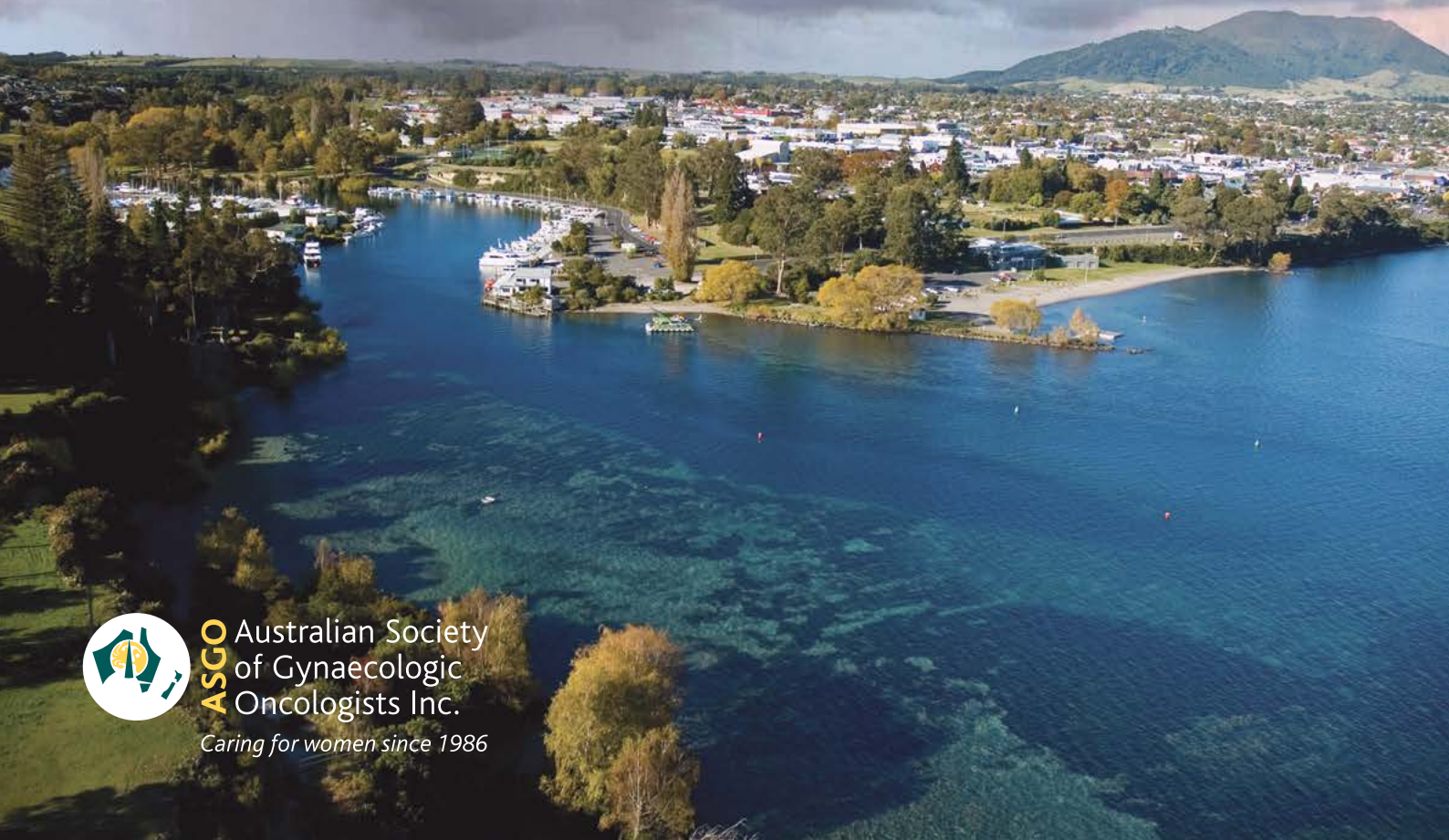
TAUPO

4TH - 7TH JULY

NEW ZEALAND

Hilton Lake Taupo

ASGO ASM 18



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2018 ORGANISING COMMITTEE

Al Ling Tan (Chair), Bryony Simcock, Peter Sykes

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INVITED SPEAKERS

Professor Karen Lu

Dr. Lu is Senior Vice President and Chief Clinical Officer ad interim, in the Department of Deputy President & COO. She is Professor in the Department of Gynecologic Oncology and Reproductive Medicine and holds the J. Taylor Wharton Distinguished Chair in Gynecologic Oncology. Her main clinical interests include the surgical and medical treatment of women with ovarian and endometrial cancers, as well as the management of women at genetically high risk for these cancers.

She serves as Co-Director for the MD Anderson Clinical Cancer Genetics Program and Director of the High Risk Ovarian Cancer Screening Clinic. She is a national leader in the cancer genetics field and has published seminal articles on hereditary gynecologic cancers. In addition, she serves as Director of the Uterine Cancer Research Program (UCRP) and Principal Investigator of the NCI-sponsored Uterine Cancer Specialized Program of Research Excellence (SPORE)

Professor Frédéric Amant

Frédéric Amant, MD, PhD (°1967), received his medical degree from the University of Leuven (KU Leuven), Belgium in 1992, completed his specialty training as an obstetrician/ gynecologist in 1998, and his subspecialty training in gynecologic oncology in 2000. He is professor at the KU Leuven in Belgium and at the University of Amsterdam in the Netherlands. He is a specialist in Gynecologic Oncology at the University Hospitals Leuven (UZ Gasthuisberg), Belgium and at Antoni van Leeuwenhoek – Netherlands Cancer Institute (Center for Gynecologic Oncology Amsterdam). At KU Leuven he heads the scientific section of this specialty.

Frédéric Amant heads the International Network on 'Cancer, Infertility and Pregnancy' (INCIP) of the European Society of Gynecologic Oncology (ESGO) (www.cancerinpregnancy.org). He chairs the Endometrium Tumor Site Committee of the European Organization for Research and Treatment of Cancer (EORTC), Gynecologic Cancer Group.

SECRETARIAT

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

Wednesday 4th July	12.30pm – 5.00pm	Hilton
Thursday 5th July	8.00am – 4.00pm	Hilton
Friday 6th July	7.00am – 1.00pm	Hilton
Saturday 7th July	8.00am – 3.00pm	Hilton

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Mob: 0420 944 268 (Amy)

SOCIAL PROGRAM

Wednesday 4th July

Welcome Reception
Bistro Lago, Hilton
7.00 - 9.30PM
Dress: Smart Casual

Thursday 5th July

Free Night in Taupo

Friday 6th July

Casual Dinner
The Terraces, Hilton
7.30 - 11.00PM
Dress: Smart Casual

Saturday 7th July

ASGO Black Tie Dinner
The Kinloch Club
7.00 - 10.00PM
Dress: Black-tie
Transfers: Coach departs at 6.30pm for 7.00pm start

FRIDAY AFTERNOON SOCIAL ACTIVITIES

Optional afternoon activities for delegate and spouses.

Lake Taupo Fishing Charter & Cruise

Venue: Lake Taupo
Time: 1.00pm – 4.00pm
Transfers: Coach departs at 12.45pm from the Hilton and returns at 4.00pm - (pre-booking essential)

Huka Prawn Farm

Time: 1.00pm – 4.00pm
Transfers: Coach departs at 12.45pm from the Hilton and returns at 4.00pm - (pre-booking essential)

Wairakei Terraces Thermal Hot Pools

Time: 1.00pm – 4.00pm
Transfers: Coach departs at 12.45pm from the Hilton and returns at 4.00pm - (pre-booking essential)

Craters Mountain Bike Park

Time: 1.00pm – 4.00pm
Transfers: Coach departs at 12.45pm from the Hilton and returns at 4.00pm - (pre-booking essential)

ASGO Annual Tennis Tournament

Venue: Hilton Taupo Tennis Court
Time: 1.00pm – 4.00pm

Golf

Venue: Wairakei Golf Club
Time: Tee off at 12.24pm - (pre-booking essential)
Transfers: Taxi to depart Hilton at 11.30am

NEW GARDASIL® 9 AVAILABLE NOW TO HELP PROTECT AGAINST HPV CANCERS & DISEASES[1*]

*** GARDASIL 9 is indicated for:[1]**

– Females 9 to 45 years for the prevention of cervical, vulvar, vaginal and anal cancer, dysplasias, genital warts, and infection due to vaccine HPV types.^

– Males 9 to 26 years for the prevention of anal cancer, dysplasias, external genital lesions and infection due to vaccine HPV types.^

HPV = Human papillomavirus. ^Vaccine HPV types = 6, 11, 16, 18, 31, 33, 45, 52, 58.

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Before prescribing, please review the Product Information available at www.seqirus.com.au/PI

MINIMUM PRODUCT INFORMATION. GARDASIL® 9 [Human Papillomavirus 9-valent (Types 6, 11, 16, 18, 31, 33, 45, 52, 58) vaccine,Recombinant] **Indications:** GARDASIL 9 is indicated in females aged 9 to 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, 18, 31, 33, 45, 52 and 58. GARDASIL 9 is indicated in males 9 to 26 years of age for the prevention of anal cancer, precancerous or dysplastic lesions, external genital lesions and infection caused by HPV types 6, 11, 16, 18, 31, 33, 45, 52 and 58. *Evidence of vaccine efficacy is based on core efficacy population of females 16 to 26 years of age. Immunogenicity studies have been conducted to link efficacy to younger populations (females and males 9 to 15 years of age). Currently there are no data from studies of GARDASIL 9 relating to females over 26 years of age. **Contraindications:** Hypersensitivity to the active substances of GARDASIL 9 or GARDASIL or to any of the inactive ingredients of either vaccine. Individuals who develop symptoms indicative of hypersensitivity after receiving a dose of GARDASIL 9 or GARDASIL should not receive further doses of GARDASIL 9. **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, sometimes associated with falling, has occurred after HPV vaccination. Vaccinees should be carefully observed for approximately 15 minutes after administration of GARDASIL 9. Immunologic response may be diminished in immunocompromised individuals. **Use in Pregnancy (Category B2):** Not recommended for use in pregnant women. Pregnancy should be avoided during the vaccination regimen for GARDASIL 9. **Use in Lactation:** May be administered to lactating women. **Interactions with other medicines:** May be administered concomitantly with Menactra, Adacel Repevax, and Poliomyelities (inactivated) Vaccine. Use of hormonal contraceptives did not appear to affect the immune responses to GARDASIL 9. Immunosuppressive therapies may reduce the immune responses to vaccines. **Adverse Effects:** Injection site (pain, swelling, erythema, bruising, pruritis, mass, haemorrhage, induration, hematoma, warmth, reaction), headache, fever, nausea, dizziness, fatigue, diarrhoea, myalgia, influenza, upper respiratory tract infection, oropharyngeal and upper abdominal pain. **Post-marketing experience:** The following adverse experiences have been spontaneously reported during post-approval use of GARDASIL and may also be seen in post-marketing experience with GARDASIL 9: Cellulitis, idiopathic thrombocytopenic purpura, lymphadenopathy, acute disseminated encephalomyelitis, dizziness, Guillain-Barré syndrome, headache, syncope sometimes accompanied by tonic-clonic movements, nausea, vomiting, arthralgia, myalgia, asthenia, chills, fatigue, malaise, 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. Alternatively, in individuals 9 through 14 years of age, GARDASIL 9 can be administered according to a 2-dose schedule; the second dose should be administered between 5 and 13 months after the first dose. If the second vaccine dose is administered earlier than 5 months after the first dose, a third dose should always be administered. Based on Approved Product Information dated 5 June 2017.

References: 1. GARDASIL® 9 Approved Product Information, June 2017. Seqirus (Australia) Pty Ltd. ABN 66 120 398 067, 63 Poplar Road Parkville, Victoria 3052. www.seqirus.com.au. Medical Information: 1800 642 865. Distributor for Merck, Sharp and Dohme (Australia) Pty Ltd. GARDASIL® 9 is a registered trademark of Merck & Co. Inc Whitehouse Station, NJ, USA. Seqirus™ is a trademark of Seqirus UK Limited or its affiliates. Date of preparation: December 2017. GAR9/1017/0008. 14650-B-A4.

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

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Wednesday 4th July

12.30PM – 1.30PM	Registration and Lunch	
1.30 – 4.00PM	Fellows Education Session	Chair - **Nimithri Cabraal**
	Pathology - **Jim Scurry**	
	Radiation Oncologist - **David Bernshaw**	
	Medical Oncologist - **Michelle Vaughan**	
4.00 – 5.00PM	Mock OSCE and Exam Workshop	

Thursday 5th July

8.00 – 8.30AM	Trade Exhibition Open	
8.30 – 8.40AM	Opening of Meeting by ASGO President - **Penny Blomfield** Welcome by Chair ASGO 2018 - **Ai Ling Tan**	
	Session 1: Keynote Presentations	Chair: Ai Ling Tan
8.40 – 9.20AM	Lynch syndrome - universal testing, screening, and therapeutic implications - **Karen Lu**	
9.20 – 10.00AM	Fertility preservation for gynaecological cancers - **Frédéric Amant**	
10.00 – 10.30AM	Morning Tea & Trade Exhibition	
	Session 2: Surgical Talks	Chair: Bryony Simcock
10.30 – 10.55AM	Liver Surgery - Perioperative considerations in liver surgery - **Adam Bartlett**	
10.55 – 11.20AM	Cardiothoracic - Above the diaphragm demystified Biopsy, thorascopic surgery and lung resection (epicardial node) - **David Shaw**	
11.20 – 11.45AM	Reflections after a year in a peritonectomy unit - **Rhonda Farrell**	
	Session 3: Perioperative Decision Making	Chair: Peter Sykes
11.45AM – 12.10PM	Communicating risk with patients - **Michelle Vaughan**	
12.10 – 12.35PM	Cardiopulmonary risk assessment and optimization anaesthetizing the obese patient - **Nicola Broadbent**	
12.35 – 1.00PM	Who and when to operate controversies in interval debulking - **Jim Nicklin**	
1.00 – 2.00PM	Lunch & Trade Exhibition	
	Session 4: Fellows Presentations & Free Communications	Chair: Peter Sykes
2.00 – 2.12PM	Surgical morbidity in the management of cervical cancer in low and middle-income countries: A systematic review and meta-anaylsis - **Emma Allanson**	
2.12 – 2.24PM	Risk factors for local vulval recurrence of vulval squamous cell carcinoma among women who have received sentinel lymph node biopsy - **Pip Shirley**	
2.24 – 2.36PM	A pilot study of the prognostic value of serum HE4 levels in the management of endometrial cancer - **Niveditha Rajadevan**	
2.36 – 2.48PM	Why a broken-heart (syndrome) matters to the Gynaecological Oncologist. Two case studies of cardiac arrest occurring in patients undergoing radical hysterectomy - **Bernd Schmid**	
2.48 – 3.00PM	Cytokeratin 14 and its role in ovarian cancer cell adhesion and metastasis - **Nicole Krzys**	
3.00 – 3.30PM	Afternoon Tea & Trade Exhibition	

3.30 – 3.42PM	Patients' and professionals' views on sentinel node procedure in low and intermediate risk endometrial cancer management: a vignette study - **Annemijn Aarts**
3.42 – 3.54PM	Impact of Perioperative Blood Transfusion (POBT) and Ovarian Cancer (OC) survival– A systematic Review - **Nooraishah Yasin**
3.54 – 4.06PM	Trends in overall survival rates in women with advanced ovarian cancer in a single tertiary center in New Zealand - **Sara Yeoh**
4.06 – 4.18PM	Pathological chemotherapy response score predicts survival in patients with advanced ovarian cancer receiving neoadjuvant chemotherapy: An individual patient meta-analysis - **Paul Cohen**

Friday 6th July

7.30 – 8.20AM	Breakfast Session	*Sponsored by* Seqirus
7.30 – 7.40AM	Welcome	
7.40 – 8.00AM	HPV vaccination with Gardasil 9 - Implementation, Opportunities and Impact - **Cecile Bergzoll**	
8.00 – 8.20AM	Impact of HPV vaccination on rates of high grade cervical cell abnormalities and HPV genotypes associated with CIN2 in young New Zealand women - **Carrie Innes**	
8.00 – 8.30AM	Trade Exhibition Open	
	Session 5: Clinical Challenges	Chair: Penny Blomfield
8.30 – 9.00AM	Cancer in pregnancy - **Frédéric Amant**	
9.00 – 9.30AM	Obesity and endometrial cancer - **Karen Lu**	
9.30 – 9.50AM	Update on Medical Treatments for Gynae Cancer - **Philip Beale**	
9.50 – 10.20AM	Morning Tea & Trade Exhibition	
10.20 – 11.30AM	Tumour Board	
	Gynaecological Oncologist - **Andy Garrett**	
	Radiologist - **Helen Moore**	
	Pathologist - **Rachael Van Der Griend**	
	Radiation Oncologist - **David Bernshaw**	
	Medical Oncologist - **Michelle Vaughan**	
	Gynaecological Oncologist - **Kym Reid**	
	Session 6: Free Presentations - Surgical	Chair: Cecile Bergzoll
11.30 – 11.42AM	The Anatomy of a Radical Hysterectomy and Pelvic Lymphadenectomy in the Management Early Cervical Cancer - **Naven Chetty**	
11.42 – 11.52AM	Peritonectomy and heated intraperitoneal chemotherapy (HIPEC) for advanced ovarian cancer: What do gynaecological oncologists really think? - **Rhonda Farrell**	
11.52AM – 12.04PM	A multi-disciplinary approach to surgical cytoreduciton of supra-diaphragmatic and upper abdominal disease in epithelial ovarian cancer - **Nisha Jagasia**	
12.04 – 12.16PM	Robot "please save my better half" - **Felix Chan**	
12:16 – 1:15PM	Lunch & Trade Exhibition	
1:15 – 4:00PM	Afternoon Activities	
	Fishing Charter & Cruise	*Golf*
	Huka Prawn Farm	*Tennis*
	Thermal Hot Pools	*Mountain Biking*

Saturday 7th July

8.00 – 8.30AM	Trade Exhibition Open	
	Session 7: The Bottom End	Chair: Nimithri Cabraal
8.30 – 8.55AM	Vulval Cancer, Lichen Sclerosis DVN and HPV: Implications for management - **Lois Eva**	
8.55 – 9.20AM	The Surgical Side of the Melenoma MDM - **Jeremy Simcock**	
9.20 – 9.45AM	Reflections on vulva cancer over 40 years - **Neville Hacker**	
	Free Communications	
9.45 – 9.57AM	Management of lichen sclerosus and vulval cancer - **Jennifer Bradford**	
9.57 – 10.09AM	The Australia and New Zealand audit of sentinel node biopsy in Vulval cancer - **Peter Sykes**	
10.09 – 10.21AM	Progress towards a National Gynaecological Oncology Registry (NGOR) - **Robert Rome**	
10.30 – 11.00AM	Morning Tea & Trade Exhibition	
	Session 8: Gynae Cancer in the Pacific	Chair: John Whittaker
11.00 – 11.20AM	How could we improve outcomes for pacific women with gynaecological cancer	
11.20 – 11.40AM	Opening the doors for pacific island women - **Abel Smith**	
11.40 – 11.50AM	IGCS Training program for under resourced countries - **Ai Ling Tan**	
11.50AM – 12.10PM	An Australian focus on inequity in gynaecological cancer - **Penny Blomfield**	
12.10 – 1.05PM	**ASGO Debate**	
	Hipec em all (All women with HGSOC should be offered Hipec)	
	FOR	AGAINST
	Geoff Otton	**Michelle Vaughan**
	Karen Lu	**Frédéric Amant**
1.05 – 1.35PM	Lunch & Trade Exhibition	
1.35 – 3.30PM	ASGO AGM	

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

Posters

Does the size and topography of high grade squamous intraepithelial lesions (HGSIL) vary with age in women referred following high grade squamous cervical cytology: A retrospective case series - **Elizabeth Goulding**

Malignant Ovarian Germ Cell Tumours in the Post-Menopausal Population - **Jessica Robertson**

Determining a suitable follow-up period after diagnosis of a complete molar pregnancy - **Gaithri Mylvaganam**

Follow up after treatment of high grade cervical dysplasia - **Rhett Morton**

Steroid cell tumour, NOS in Pregnancy. Reflection of a rare case and review of the literature - **Jennifer Weishaupt**

Intravenous Leiomyomatosis with Intracardiac extension - **Sarah Lyons**

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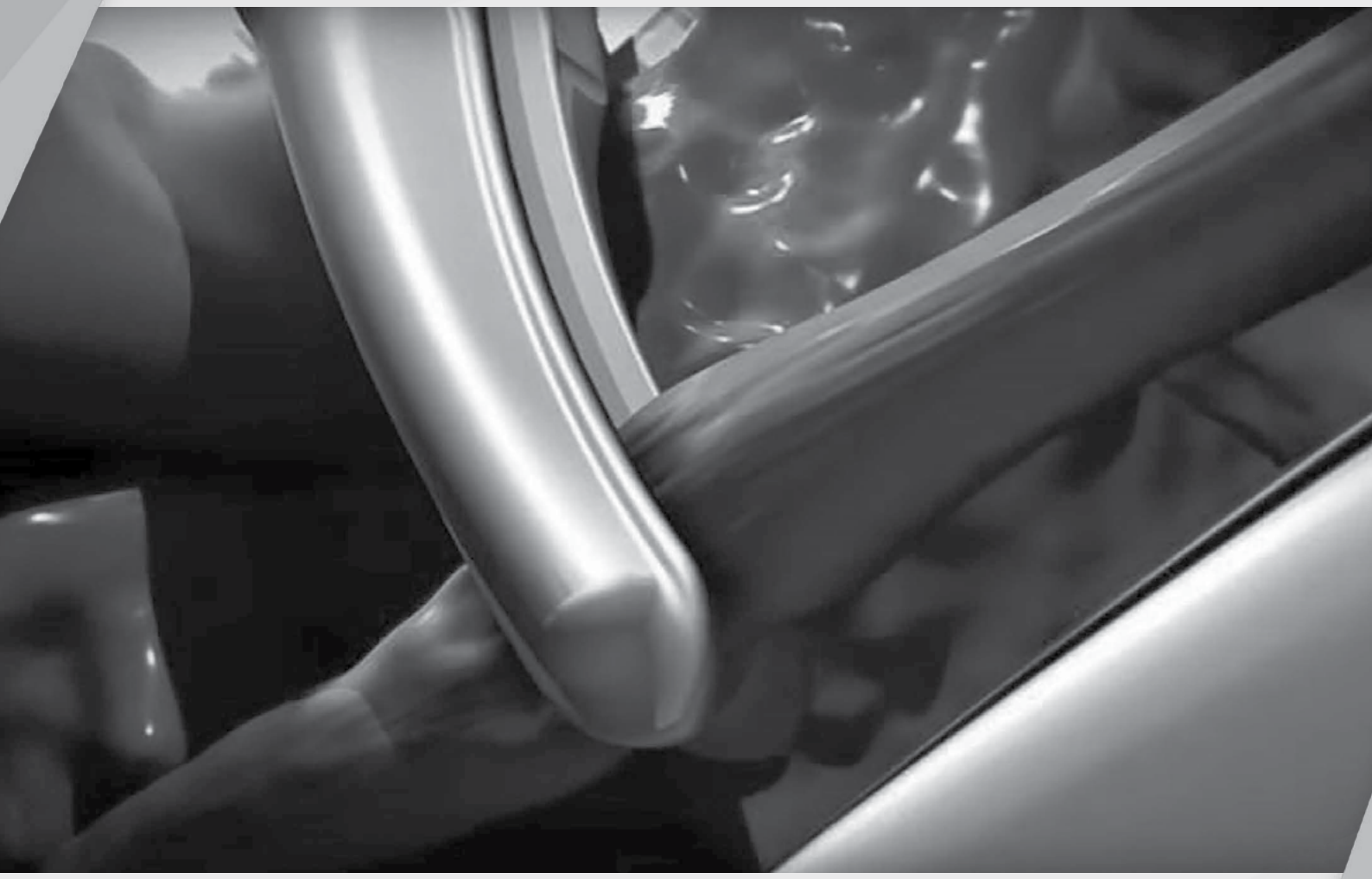

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Applied Medical

Wednesday 4th July 2018

Fellows Education Session
Presenters: Jim Scurry, David Bernshaw and Michelle Vaughan
Time: 1.30pm – 4.00pm
Chair: Nimithri Cabraal

Notes:

Wednesday 4th July 2018

Mock OSCE and Exam Workshop
Time: 4.00pm – 5.00pm
Chair: Nimithri Cabraal

Notes:

Thursday 5th July 2018

Session 1: Keynote Presentations
Presenters: Karen Lu & Frédéric Amant
Time: 8.40am – 10.00am
Chair: Ai Ling Tan

Lynch syndrome - universal testing, screening, and therapeutic implications

Karen Lu

Lynch syndrome is a hereditary cancer syndrome which results in an increased risk of primarily colon and endometrial cancers. In the last decade, there have been important advances in our understanding of Lynch syndrome associated endometrial cancers. Gynecologic oncologists play a critical role in the identification of Lynch syndrome in their endometrial cancer patients, and universal screening for Lynch syndrome has been recommended for endometrial cancer patients. In addition to the impact of preventing future cancers in our patients and their family members, we now have approval of checkpoint blockade as a treatment for recurrent Lynch-associated endometrial cancer.

Notes:

Fertility preservation for gynaecological cancers

Frédéric Amant

Fertility preservation before or during cancer treatment in young women has become an important health issue because of delayed motherhood and improved survival rates. It is a major determinant of quality of life after cancer remission for women who may not have achieved their ideal family size.

Endometrial cancer

For endometrial cancer, a conservative management approach could be considered in patients with a histological diagnosis of grade 1 endometrial carcinoma (or premalignant disease such as AH).(1) The optimal method to obtain these histologic characteristics is dilatation and curettage (D&C); this procedure is superior to pipelle biopsy in terms of accuracy of the tumour grade. The histological diagnosis should be reviewed by an expert pathologist to improve the accuracy of histological assessment (endometrial carcinoma or AH) and the reliability of tumour grading (1), whereas the initial stage should be confirmed by enhanced pelvic magnetic resonance imaging (MRI) to exclude overt myometrial invasion, as well as adnexal or pelvic node involvement. Patients should be informed that this is a non-standard approach and they should be willing to accept close follow-up during and after the treatment. They should also be informed of the need for future hysterectomy in case of failure of the treatment and/or after pregnancies. Conservative medical treatment for endometrial cancer is based on progestins with medroxyprogesterone acetate (MPA; 400–600 mg/day) or megestrol acetate (MA; 160–320 mg/day). Few papers have addressed the use of LNG-IUD but preliminary data using such treatment (added to gonadotropin-releasing hormone [GnRH] analogues) seem to demonstrate similar remission and recurrence rates as oral progestins. Assessment of response must be performed at 6 months with a new D&C and imaging.(1) Response rates associated with the conservative management of endometrial carcinoma are around 75%, but recurrence rates are 30–40%. Standard surgery with hysterectomy should be proposed to non-responders while maintenance treatment for a further 6 months can be considered in responders who wish to delay pregnancy.

Borderline ovarian cancer

Borderline ovarian tumours (BOTs) are recognised as a unique entity of ovarian tumours that do not exert infiltrative destructive growth or stromal invasion. Prognosis of BOT is much better compared to the more common invasive epithelial ovarian cancer. Over the last decades, the management of borderline ovarian tumors (BOTs) has changed from radical surgery to more conservative therapy as a result of the need for fertility-sparing surgery and the increasing use of laparoscopy.(2) Proper staging is defined as an exploration of the entire abdominal cavity with peritoneal washings, infracolic omentectomy, and multiple peritoneal biopsies as the cornerstone of a successful treatment. For stage I disease, conservative surgery consisting of unilateral salpingo-oophorectomy or cystectomy in case of bilateral ovarian involvement or when the disease develops in the only remaining ovary is a valuable alternative in a number of young patients who want to preserve their fertility. In a recent study, du Bois et al (2013) looked into 950 patients, two thirds had serous borderline ovarian tumour and 30.5% mucinous borderline ovarian tumour.(3) Most were diagnosed in stage I (82.3%); 7.6% and 10.1% had stages II and III, respectively. Overall, 74 patients (7.8%) experienced relapse and 43 (4.5%) died within the observation period. Multivariate analysis revealed higher stage, incomplete staging, tumour residuals, and organ preservation as independent prognostic factors for disease recurrence. Neither microinvasion nor micropapillary growth pattern showed any significant impact. Of 74 relapsed patients, 30% had malignant transformation to invasive ovarian cancer with five-year progression-free survival and overall survival of 12% and 50%, respectively. Prognosis of borderline ovarian tumour correlates with tumour-related as well as surgery-related factors. The balance between recurrence risk and organ preservation and fertility-sparing surgery is an important issue deserving further research. So far, cystectomy for stage I borderline cancer is related to recurrent disease though without impact on overall survival.

Cervical cancer

For early stage cervical cancer, a conisation with or without lymphadenectomy depending on stage, allows to preserve fertility. The standard treatment of stage Ib1 2-4 cm cervical cancer in women who wish to preserve fertility is an abdominal radical trachelectomy (removal of the uterine cervix and parametrium followed by surgical re-connection of uterus to vagina and application of a cerclage) with pelvic lymph node dissection. Removal of the uterine cervix can lead to fertility problems and women are prone to preterm labour due insufficiency of the neo-cervix (due to mechanical weakness and this neo-cervix has a poor protection against vaginal bacteria leading more easily to chorio-amnionitis). The numbers of take home babies after completing this procedure is still below 10%. Because these poor take home baby numbers are reported and poor pregnancy outcomes are caused by the radical surgery performed to the uterine cervix and supporting tissue, less radical surgery, including cervical conisation or portio amputation, is warranted To enable conservative surgery and maintain favourable oncologic outcomes, neo-adjuvant chemotherapy (NACT) has been incorporated to reduce tumour size. Pregnancy numbers with NACT seem increased (take home baby rate 31%). Therefore, after documentation of lymph node negativity, paclitaxel-carboplatin chemotherapy is initiated and followed by conservative surgery. This strategy needs further investigation though is the best way to reduce the obstetrical problems associated with
trachelectomy. In higher stages of cervical cancer, fertility sparing options are too experimental to implement.

General

We evaluated the necessity and the efficacy of fertility preservation, with a focus on actual pregnancy wish and outcome after fertility preservation and cancer treatment. In one of the first studies reporting real-life experience in centers for fertility preservation, we found that, within 5 years following the end of cancer treatment, only one third of patients in remission attempted to become pregnant, with a pregnancy rate of 55%, mostly after spontaneous conception.(4)

The fertility preservation services and strategy currently available, highlight issues of oncofertility worldwide.(5) For these patients in complex situations, health networks are essential to improve coordination of care, and the strengthening of this coordination is a major challenge to improve the performance of the health system. Two international networks have been created in order to foster scientific exchange between countries and to standardize the oncofertility healthcare circuit. However, the paucity of referral nationwide networks lead to a structural gap in health care policies. Thus, management strategies of oncofertility in the world are still fragile and uneven. To structure the oncofertility sector, a multidisciplinary project allowing teams to collaborate is of utmost importance particularly in low and middle-income countries.(5)

As part of education and informed consent before cancer therapy, health care providers (including medical oncologists, radiation oncologists, gynecologic oncologists, urologists, hematologists, pediatric oncologists, and surgeons) should address the possibility of infertility with patients treated during their reproductive years (or with parents or guardians of children) and be prepared to discuss fertility preservation options and/or to refer all potential patients to appropriate reproductive specialists. Although patients may be focused initially on their cancer diagnosis, the Update Panel encourages providers to advise patients regarding potential threats to fertility as early as possible in the treatment process so as to allow for the widest array of options for fertility preservation. The discussion should be documented. Sperm and embryo cryopreservation as well as oocyte cryopreservation are considered standard practice and are widely available.(6) The OPTION trial showed that goserelin reduced the risk of ovarian failure in women treated with chemotherapy for early breast cancer, with particular efficacy in women aged ≤40 years old.(7) GNRH can be added now to cryopreservation.(7) Other fertility preservation methods should be considered investigational and should be performed by providers with the necessary expertise.
In addition, we aim to emphasise that contraception counselling is just as important as fertility counseling.(8) Of the patients registered in our Cancer in Pregnancy database, 29 (3%) became pregnant during cancer staging or treatment. Median age was 34 years (range 16–48). Median gestational age was 6 weeks (3–26) at discovery of pregnancy. Pregnancy was identified during staging (n=3, 10%), before start of treatment (n=8, 28%), during treatment (n=17 [four at hormone treatment, three at radiotherapy, four at surgery, four at chemotherapy, and

LYNPARZA™ (olaparib 50mg) capsules. Prescription Medicine. Approved Indication: Olaparib is indicated as monotherapy for the maintenance treatment of patients with platinum-sensitive relapsed *BRCA*-mutated (germline or somatic) high grade serous epithelial ovarian, fallopian tube or primary peritoneal cancer who are in response (complete response or partial response) after platinum-based chemotherapy. Prior treatment must have included at least two courses of platinum-based regimens. **Dosage and Administration:** Recommended dose is 400 mg (eight 50 mg capsules) taken twice daily, equivalent to a total daily dose of 800 mg. LYNPARZA should be taken on an empty stomach and patients should refrain from eating for 2 hours. *Dose adjustments:* Treatment may be interrupted to manage adverse reactions such as nausea, vomiting, diarrhoea, and anaemia and dose reduction can be considered, see full Data Sheet. *Co-administration with CYP3A inhibitors:* Concomitant use of strong or moderate CYP3A inhibitors is not recommended and alternative agents should be considered. If a strong or moderate CYP3A inhibitor must be co-administered, a dose reduction is recommended, see full Data Sheet. *Special patient populations:* For patients with moderate renal impairment, the recommended dose of LYNPARZA is 300mg twice daily. LYNPARZA is not recommended in patients with severe renal impairment, end stage renal disease or in patients with severe hepatic impairment. For more information, see full Data Sheet. **Contraindications:** Hypersensitivity to the active substance or to any of the excipients. **Warnings & Precautions:** *Haematological toxicity* is common in patients treated with LYNPARZA and usually mild-moderate (CTCAE Grade 1 or 2). Grade 3 or higher events of anaemia (decrease in haemoglobin) occurred in 7.4% of patients in Study 19, and one patient died from a haemorrhagic stroke associated with thrombocytopenia. Patients should not start treatment with LYNPARZA until they have recovered from haematological toxicity caused by previous anti-cancer therapy. A baseline complete blood count followed by monthly monitoring is recommended for the first 12 months of treatment and periodically after this. If a patient develops severe haematological toxicity or blood transfusion dependence, treatment with LYNPARZA should be interrupted and appropriate haematological testing should be initiated. *Myelodysplastic syndrome/Acute Myeloid Leukaemia* (MDS/AML) has been reported (incidence <1.5% of patients treated in clinical trials with LYNPARZA monotherapy, including long-term survival follow-up) and the majority of events had a fatal outcome. All patients had potential contributing factors for the development of MDS/AML. If MDS and/or AML are confirmed while on treatment with LYNPARZA, it is recommended that LYNPARZA should be discontinued and the patient be treated appropriately. *Pneumonitis* has been reported in <1% of patients treated with LYNPARZA monotherapy in clinical studies. Reports of pneumonitis had no consistent clinical pattern and were confounded by a number of pre-disposing factors. When LYNPARZA was used in clinical studies in combination with other therapies there have been events with a fatal outcome. If patients present with new or worsening respiratory symptoms, LYNPARZA treatment should be interrupted and prompt investigation initiated. If pneumonitis is confirmed, LYNPARZA treatment should be discontinued and the patient treated appropriately. *Use in pregnancy:* Category D. Lynparza should not be used during pregnancy due to the teratogenic and genotoxic potential of olaparib. Women of childbearing potential must use effective contraception during treatment and for 1 month after receiving the last dose. *Use during lactation:* Breast feeding should be avoided in women receiving Lynparza and for 1 month after the last dose. *Use in Men:* Not indicated. *Children or adolescents:* Not indicated. *Effects on ability to drive and use machinery:* Asthenia, fatigue, and dizziness have been reported and patients who experience these symptoms should observe caution when driving or using machines. **Adverse Effects:** Decreased appetite, headache, dysgeusia, dizziness, nausea, vomiting, diarrhoea, dyspepsia, stomatitis, upper abdominal pain, fatigue, anaemia, neutropenia, thrombocytopenia, leukopenia, lymphopenia, rash, cough, mean corpuscular volume elevation and creatinine increase. **Interactions:** Combination with other anticancer drugs associated with myelosuppressive toxicity; co-administration with strong and moderate CYP3A inducers or inhibitors should be avoided; foods that inhibit CYP3A enzymes such as star fruit, grapefruit and Seville oranges should be avoided; caution when combined with sensitive CYP3A substrates or substrates with a narrow therapeutic margin; induction of CYP1A2, 2B6 has been shown in vitro; inhibition of P-gp, OATP1B1, OCT1, OCT2, OAT3, MATE1 and MATE2K has been shown in vitro; caution should be exercised if Lynparza is administered in combination with any statin; for further details, see full Data Sheet. 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two at immunotherapy], 59%), and at an unknown stage (n=1, 3%). Pregnancy outcome was termination of pregnancy (n=9, 31%), spontaneous abortion (n=2, 7%), extrauterine pregnancy (n=1, 3%), and livebirth (n=17, 59%). At pregnancy diagnosis, contraception had been absent (n=13, 45%), had failed (n=7, 24% [three using condoms, two using hormonal contraception, one using ovarian ablation with goserelin, and one using radiosterilisation]), or was unknown (n=9, 31%). We therefore propose that all young women diagnosed with cancer should have an appointment with a gynaecologist to discuss both fertility preservation and contraception before start of treatment.

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Notes:

Thursday 5th July 2018

Session 2: Surgical Talks
Presenters: Adam Bartlett, David Shaw & Rhonda Farrell
Time: 10.30am – 11.45am
Chair: Bryony Simcock

Liver Surgery- Perioperative considerations in liver surgery

Adam Bartlett

Gynaecological oncology surgery has become increasing complex as a result of taking on cases with greater disease burden. The outcome for these patients is determined not only by the disease biology but has been demonstrated to be related to the extent and complexity of surgery and surgical approach. Taking a multi-disciplinary approach to the management of these patients, including involving different surgical sub-specialities, to utilise different areas of expertise is imperative to minimise peri-operative complications and improve patient outcomes.

Notes:

Cardiothoracic - Above the diaphragm demystified Biopsy, thorascopic surgery and lung resection (epicardial node)

David Shaw

Abstract not provided.

Notes:

Reflections after a year in a peritonectomy unit

Rhonda Farrell[1]

1. *RHW, Coogee, NSW, Australia*

In January 2017 I began an extended sabbatical working 3-4 days a week in a peritonectomy unit at St George Hospital in Sydney. The unit is led by Professor David Morris, who set up the first peritonectomy unit in Australia for treatment of peritoneal carcinomatosis in 1995. Over the past twenty years he and his team have performed over 1200 peritonectomy procedures, most with HIPEC, for conditions including pseudomyxoma peritonei, appendiceal and colorectal cancer, mesothelioma, ovarian cancer, and some unusual and less common peritoneal diseases. This experience gave me invaluable exposure to a wide range of surgical procedures and techniques, particularly in relation to surgery in the upper abdomen. I learnt to use an open technique to administer HIPEC. It gave me greater knowledge and judgement about selection of cases for radical surgery, the peri-operative management of the acute surgical patient, and the importance of working within a cohesive and well-trained surgical team to perform radical but safe surgery. It also taught me about the potential benefits and life-long rewards of pursuing a career in academic surgery.

Notes:

Thursday 5th July 2018

Session 3: Perioperative Decision Making
Presenters: Michelle Vaughan, Nicola Broadbent & Jim Nicklin
Time: 11.45am – 1.00pm
Chair: Peter Sykes

Communicating risk with patients

Michelle Vaughan[1]

1. *Canterbury District Health Board, Christchurch, CANTERBURY, New Zealand*

Scary conversations:
Does talking to your patients about the fact they have a life limiting illness make them depressed? Does it make them lose hope, do they die more quickly? Do they lose faith in you and like you less? The answers to these questions and all the evidence behind them will be discussed, along with simple, practical, evidence-based strategies on how to discuss prognosis.

Notes:

Cardiopulmonary risk assessment and optimization anaesthetizing the obese patient

Nicola Broadbent[1]

1. *Auckland City Hospital, Auckland, New Zealand*

This talk will discuss perioperative preparation of the gynae-oncology surgical patient from an anaesthetic perspective. I will focus on two specific issues which are relevant to this specific cancer population.

- Assessment and implications of morbid obesity
- Potential effects of neo-adjuvant chemotherapy on cardiorespiratory function including recent evidence of decline in cardiopulmonary exercise (CPEX) testing.

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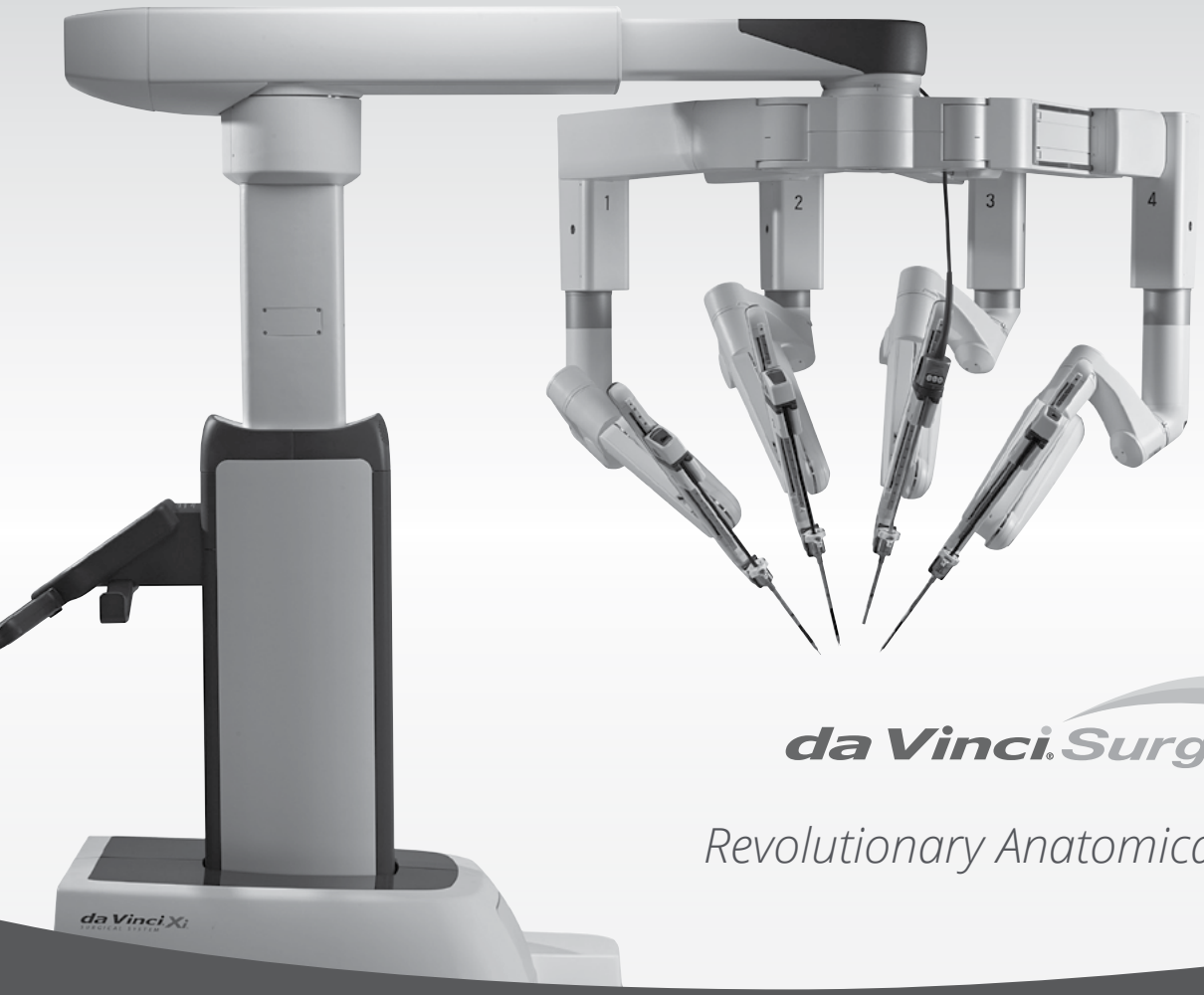

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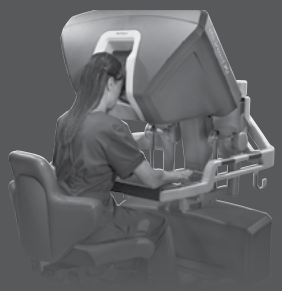

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Who and when to operate controversies in interval debulking

Jim Nicklin [1]

1. *Queensland Centre for Gynaecologic Cancer (QCGC), Brisbane, Queensland, Australia*

There are scores of retrospective studies (Level 2C evidence) which demonstrate a survival advantage for patients with advanced ovarian cancer (EOC) treated with primary debulking surgery (PDS) compared with neoadjuvant chemotherapy (NACT) and interval debulking surgery (IDS). This is the basis of clinical guidelines by published by ASCO, SGO and ESGO. There are however four randomised prospective trials (Level 1 evidence) which demonstrate a statistically significant reduction in peri-operative morbidity and mortality and non-inferior survival (trend to improved survival) with NACT + IDS. Data from QCGC over the last three decades have demonstrated a steady increase in the use of NACT to >50% and a steady rise in overall (PDS + IDS) optimal debulking rate to no macroscopic residual (R0) to >60%. Over this time there has been no decrease in 5 year survival, but rather a steady increase to 45% 5ys in what is a large, state-wide, community based service. These world standard survival results, which are superior to the published trials, likely reflect multiple factors. At the very least, it is unlikely that the increase in NACT is compromising survival. Suggestions for improved clinical guidelines and crucial future research questions will be presented.

Notes:

Thursday 5th July 2018

Session 4: Fellows Presentations & Free Communications
Presenters: Emma Allanson, Pip Shirley, Niveditha Rajadevan, Bernd Schmid & Nicole Krzys
Time: 2.00pm – 3.00pm
Chair: Peter Sykes

Surgical morbidity in the management of cervical cancer in low and middle-income countries: a systematic review and meta-analysis

Emma R Allanson[2, 1], Aime Powell[3], Hong Lim Lee[4], Lynette Denny[5], Yee Leung[1], Paul Cohen[6, 1]

1. *Division of Obstetrics and Gynaecology, Faculty of Medicine and Health Sciences, University of Western Australia, Crawley, WA, Australia*
2. *Department of Gynaecologic Oncology, Chris O'Brien Lifehouse, Camperdown, NSW, Australia*
3. *Institute for Health Research, University of Notre Dame Australia, Fremantle, WA, Australia*
4. *Obstetrics and gynaecology, Joondalup Health Campus, Joondalup, WA, Australia*
5. *Health Sciences, University of Cape Town, Cape Town, South Africa*
6. *Department of Gynaecological Oncology, Bendat Family Comprehensive Cancer Centre, St John of God, Subiaco, WA, Australia*

Background
As the fourth most common malignancy in females globally, cervical cancer performs poorly in objective measurements of management outcomes in less-developed countries. Lack of comprehensive databases in these settings limits ability to advocate for, or monitor impact of, health-care programs. This review summarizes reported surgical morbidity in primary surgical management of cervical cancer in low and middle-income countries.

Methods
Studies from 2000-2017 from PubMed/Medline, EMBASE, Cochrane Register, LILACS, and CINHAL assessed. Data extracted on studies meeting inclusion criteria, and meta-analysis performed (random-effects model).

Results
56 studies (6916 abstracts) included. Data were available on 12705 patients (9887 open, 2703 laparoscopic). The pooled estimate of blood transfusions was 27% (95% CI 16-38%), urinary tract injury 2% (95% CI 1-2%), fistula 2% (95%CI 1-3%), and thromboembolic events 1% (95% CI 1-2%).

Conclusions
This is the first systematic review and meta-analysis of surgical morbidity in cervical cancer in low and middle-income countries. Complications were comparable to high-income settings.

Notes:

Risk factors for local vulval recurrence of vulval squamous cell carcinoma among women who have received sentinel lymph node biopsy

Pip Shirley

In 2008 the authors of the GROINSS-V study concluded that sentinel node dissection should be part of the standard treatment in selected patients with early stage vulval cancer1. They went on to evaluate the long-term follow-up of the patients regarding recurrences and survival and found a vulval recurrence rate of 24.6% and 36.4% at 5 and 10 years respectively for sentinel lymph node-negative patients and 33.2% and 46.4% for sentinel lymph node-positive patients2. A prospective audit of sentinel node biopsy for vulval carcinoma in Australia and New Zealand is being conducted with the aim to document the safety of sentinel node biopsy as replacement for formal groin node dissection in women with early vulval carcinoma in Australia and New Zealand. The risk factors for recurrence of vulval carcinoma are poorly understood and heterogeneity in the literature does not allow evidence-based clinical decision making3. Whilst no individual risk factor has been consistently and reliably associated with an increase in vulval recurrence, a combination may be. Possible risk factors for recurrence of vulval carcinoma have been reviewed within the dataset of the Australian and New Zealand audit of sentinel node biopsy for vulval carcinoma. These descriptive results will be presented.

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Notes:

A pilot study of the prognostic value of serum he4 levels in the management of endometrial cancer

Nivedeitha Rajadevan

Background and Aims:

Human Epididymis Protein 4 (HE4) has been shown to be increased in patients with endometrial cancer (EAC). Furthermore increased levels of HE4 may be associated with myometrial invasion and poorer prognosis. The aim of this study is to assess the feasibility of using HE4 - alongside other modalities including MRI - to accurately guide treatment in apparent early-stage endometrial cancer.

Methods:

A single site prospective pilot study of 100 patients with a histologically confirmed diagnosis of EAC or complex atypical hyperplasia. All patients underwent pre-operative measurements of HE4 and Ca125 and a pre-operative MRI to assess depth of invasion, nodal status and tumour size. Correlation was sought between serum levels of HE4, Ca125 and MRI findings with tumour type, grade and stage.

Results:

Median HE4 and Ca125 levels were higher in stage III and IV tumours ($p<0.000$) and in tumours with deep myometrial invasion ($p<0.000$). HE4 - but not Ca125 - was also increased in patients with poorly differentiated disease in comparison to those with well or moderately differentiated disease ($p=0.508$). Table 1 demonstrates the sensitivity and specificity of HE4 in predicting deep myometrial invasion in comparison to pre-operative MRI.

Conclusion:

These findings demonstrate the utility of serum HE4 in the management of endometrial cancer. Pre-operative HE4 levels may be used to determine which patients are likely less to have high grade disease or outer half myometrial invasion and so have a lower risk of lymph node metastases thus potentially avoiding lymphadenectomy.

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REFERENCES: 1. Preclinical test of distal tip bleeding (ENSEAL® vs Impact-LF4318) in thick porcine mesentery base ($p<0.001$). (C2169). **2.** Preclinical testing on porcine carotids (ENSEAL® vs Impact-LF4318) that measured mean max lateral thermal damage via histology ($p=0.005$). (C2155). **3.** (C2114). **4.** (C2160). **5.** (C2158).

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Why a broken-heart (syndrome) matters to the Gynaecological Oncologist. Two case studies of cardiac arrest occurring in patients undergoing radical hysterectomy.

Bernd C Schmid[1], Rex Yuan[2], Leonie Watterrson[2], Jennifer Yu[3], Neville Hacker[4]

1. *Gold Coast University Hospital, Southport, QLD, Australia*
2. *Department of Anaesthesiology, Royal Hospital for Women, Sydney Randwick, NSW, Australia*
3. *Department of Cardiology, Prince of Wales Clinical School, Sydney Randwick, NSW, Australia*
4. *Royal Hospital for Women Sydney, Randwick, NSW, Australia*

Background

Takotsubo cardiomyopathy also known as broken heart syndrome is a form of stress cardiomyopathy characterized by acute reversible ventricular dysfunction that can occur in the perioperative period. In the acute operative situation, it is usually indistinguishable from an acute coronary syndrome. Preceding emotional or physical stress has been described as one cause.

Methods and Results

We report two cases of patients with cervical cancer undergoing radical hysterectomy with no history of heart disease or other comorbidities. Both patients had an intraoperative cardiac arrest potentially caused by preoperative emotional stress. Successful resuscitation and stabilisation of the patients made it possible to continue and finish the procedures. Takotsubo cardiomyopathy was diagnosed in one patient postoperatively.

Conclusion

Takotsubo cardiomyopathy should be considered in any patient showing significant preoperative stress, even in seemingly uncomplicated patients. Awareness of surgical and anaesthesiology team may improve outcome.

Notes:

Cytokeratin 14 and its role in ovarian cancer cell adhesion and metastasis

Nicole Krzys[1], Andrew Stephens[1], Maree Bilandzic[1], Tom Jobling[1]

1. *Monash Health, Richmond, VICTORIA, Australia*

Background and Objective: Cytokeratin 14 (CK14) is an intermediate filament protein, expressed by various malignant cells with the ability to migrate to and invade other tissue types. It has been found in vivo to be expressed in a subpopulation of epithelial ovarian cancer (EOC) cells which are located peripherally on cancer spheres. It is postulated to be essential in the attachment to and invasion of extracellular matrix (ECM) on mesothelium. Our group aimed to investigate the role of CK14 in the peritoneal spread of EOC.

Method: Using a novel mouse model, immunofluorescent tagged EOC cells were inoculated into the capsule of the ovary. The progression of EOC was observed for both regular tumour cell lines and a CK-14 knockout (KO).

Results: There was no difference between control and KO in tumour proliferation at the primary site however subsequent peritoneal spread was not observed in KO mice. Peritoneal spread in the control mice with normal CK14 expression was extensive and eventually lethal.

Conclusion: CK14 appears to play an essential role in the capacity for EOC to migrate and metastasize. Further characterisation of the function and structure of CK14 may eventually lead to novel therapeutics for EOC.

Notes:

Thursday 5th July 2018

Session 4: Fellows Presentations & Free Communications Contd.
Presenters: Annemjin Aarts, Nooraishah Yasin, Sara Yeoh & Paul Cohen
Time: 3.30pm – 4.18pm
Chair: Peter Sykes

Patients' and professionals' views on sentinel node procedure in low and intermediate risk endometrial cancer management: a vignette study

Annemijn Aarts[2, 1], Lara Burg[2], Jenneke Kasius[3], Ai Ling Tan[1], Petra Zusterzeel[2]

1. *Gynaecological Oncology Department, ADHB, Auckland, New Zealand*
2. *Obstetrics and Gynaecology, Radboudumc University Medical Center, Nijmegen, The Netherlands*
3. *Gynaecology Oncology Department, Royal Marsden, London, United Kingdom*

INTRODUCTION

Standard treatment for low and intermediate risk endometrial cancer consists of surgery. Indications for adjuvant therapy is based on a risk asssessment consisting of factors such as tumor characteristics (grade, myometrial invasion, LVSI) and age. Evaluation of lymph nodes is not part of the risk selection, while it is considered to be an important risk factor. Routinely performance of lymphadenectomy is subject of discussion. On the one hand, routine lymphadenectomy has not shown improvement of survival rates. On the other hand, lymph node involvement is known to be an important risk factor and might be the case in around 10% of these patients. Adding a sentinel node procedure instead might improve identification of those patients that need adjuvant therapy based on lymph node involvement. Compared to lymphadenectomy, sentinel node procedures are associated with a lower risk on complications and might lead to better staging of disease. The latter is particularly the case when the pathologists applies ultrastaging to the sentinel node specimen. Recent studies showed that sentinel node procedures have high sensitivity and specificity in patients with low stage endometrial cancer. It is also shown that it leads to a higher stage of disease in a fair amount of patients and consequently addition of adjuvant therapy (radiotherapy) to the treatment plan. It is, however, not known if this impacts disease free and overall survival.

Addition of a sentinel node procedure is not standard care in the Netherlands and New Zealand. It might impact the organization of care, as patients now treated in regional hospitals might need to be referred to a gynaecology oncology center.

Importantly, it is unknown what the views of patients and gynaecologists are with respect to the introduction of the sentinel node procedure to standard surgical treatment of low and intermediate risk endometrial cancer.

Primary objective: Which determinants find patients and gynaecologists important when considering a sentinel node procedure in low and intermediate endometrial cancer?

Secondary objective: What is the difference between patients and gynaecologists in what they consider important determinants when deciding for adding sentinel node procedure in the treatment of low and intermediate risk endometrial cancer?

METHODS

Study design

We will perform a vignette study among previous endometrial cancer patients and gynecologists in the Netherlands and New Zealand to examine their preferences regarding the addition of a sentinel node procedure to surgical treatment in patients with low and intermediate risk endometrial cancer. We examine the relative weight patients and gynaecologists place on different aspects through a questionnaire with choice sets representing hypothetical but realistic scenarios. We will ask participants to choose for each choice set if they would choose for or against treatment including a sentinel node procedure. Each choice set consists of 6 attributes in which the value/level of the 6 attributes varies over 3 different levels.

The choice of the 6 attributes and the varying levels in the scenarios had been based on focus groups with patients, expert meeting with gynaecologists and a literature search.

Table 1. Final set of attributes and corresponding levels

Attributes	Levels
Chance on finding a metastasis in sentinel lymph node	5% 10% 15%
Hospital where surgery takes place	Own (regional) hospital Other hospital < 1 hour travel time Other hospital > 1 hour travel time
Risk on complications due to the sentinel node procedure (e.g. vascular trauma, postoperative neurological disorders, ureteral injury, infection, anaphylactic shock)	<1% 3% 5%
Extra time added to the surgery due to the sentinel node procedure (longer time of anaesthesia)	15 minutes 30 minutes 60 minutes
Overall survival gain	No survival gain 1 year 3 years
Chance of severe complications (grade 3 and 4) due to adjuvant radiotherapy if a metastasis is found	1% 5% 15%

The combination of 6 attributes and their respective levels results in 729 (36) possible scenarios, which cannot be all included in the questionnaire. Previous studies have indicated that respondents can handle up to 18 choice sets (e.g. Sculpher et al, 2004). Therefore, the final number of choice sets will be randomly divided over several questionnaire versions. We reduced the number to 18 using an orthogonal main effects design. This design provides a subset of all possible combinations of characteristics and allows estimations of the relative weights for each level of the presented characteristics on the preference score.

The questionnaire has been pilot tested among gynaecologists and patient representatives to improve language, wording and understanding.

Table 2. Example of Vignette/case description – patient version.

Imagine you are diagnosed with low stage endometrial cancer (on scans no metastasis found). There are two options for treatment: Hysterectomy including ovaries or Hysterectomy, ovariectomy AND sentinel node procedure.

This is the situation:

Chance that a metastasis found in sentinel node:	5%
Hospital where surgery takes place:	Other regional hospital
Risk on complications due to sentinel node procedure:	<1%
Extra time added to the surgery:	15 minutes
Overall survival gain:	1 year
Chance of complications due to adjuvant radiotherapy if metastasis is found:	5%
Chance that a metastasis found in sentinel node:	5%

How strong is your preference for undergoing a sentinel node procedure in this case ?

1	2	3	4	5	6	7
No SN			No preference		Strong preference for SN	

How strong is your preference for adding a sentinel node procedure to the treatment in this situation?

1	2	3	4	5	6	7
No SN			No preference		Strong preference for SN	

Study population

Patients: We use a retrospective cohort of patients that have been surgically treated for low or intermediate risk endometrial cancer between 2012 and 2015 either in the region of Nijmegen, the Netherlands, or in Auckland region, New Zealand.

Gynaecologists: All gynaecological oncologists and gynaecologists with interest in oncology that are member of the Dutch working group for Gynaecological oncology (WOG) will be invited to complete the survey. New Zealand gynaecological oncologists and gynaecologists working the Auckland region within the Gynaecology Oncology network are invited to complete the survey.

Based on sample size calculations we aim at at least 50 patients and 50 gynaecologists to complete the survey.

Data collection and analysis

Data will be collected using an online survey. Participants' preferences regarding the sentinel node procedure can be analysed using generalized estimating equations, an optimal method in cases of correlated responses (i.e. multiple choices per individual) (Burton et al., 1998). Binary logistic regression analysis to calculate coefficients for all attributes can be calculated, representing the change in benefit for a one-unit change in the attribute level (Louviere et al., 2007).

This way we can calculate what trade offs patients and gynaecologists make when deciding about the addition of a sentinel node procedure to surgical treatment. For instance, for what chance of finding a metastasis in a

sentinel node patients are willing to undergo a sentinel node procedure: 5, 10 or 15%. In addition, preferences of gynaecologists and patients are compared.

RESULTS

At the moment of submission of this abstract, data collection is still ongoing, but results will be available during the ASGO conference.

Notes:

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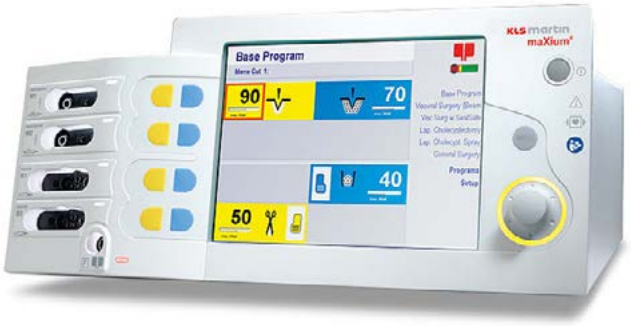

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Impact of Perioperative Blood Transfusion (POBT) and Ovarian Cancer (OC) survival– A systematic Review

Nooraishah Yasin[1], A Rigby, R Sirisena, E Ludington, G Kichenadasse, S Paramasivam

1. *Flinders Medical Centre, Adelaide, South Australia, Australia*

Introduction:

POBT are associated with increased rates of disease recurrence in patients with colorectal and cervical cancers. Cytoreductive surgery for OC is often extensive with associated bleeding requiring POBT. This literature review aims to investigate the impact of POBT on survival outcomes of women with OC.

Methods:

A systematic review of the literature from EMBASE, PubMed, Cochrane and Web of Science was performed.

Results:

Only four studies focussed on POBT and outcomes in patients with OC. All were retrospective, single-centre studies. Three studies included advanced OC.

Two studies by Morgansten Warner (2013) and Abu Rustam (2005) reported that there was no difference in overall survival associated with POBT. However, Oliveira (2011) and Altman (2013) concluded that POBT were associated with a reduced recurrence free time and overall survival.

Conclusion:

Evidence regarding the long term effects of POBT in ovarian cancer is conflicting and prospective multi-centre studies are needed.

Notes:

Trends in overall survival rates in women with advanced ovarian cancer in a single tertiary center in New Zealand

Sara Yeoh[1], Bryony Simcock[1], Peter Sykes[1]

1. *Christchurch Hospital, Christchurch City, CHRISTCHURCH, New Zealand*

Overall survival rates for women diagnosed with ovarian cancer are much poorer than other gynaecological cancers and greatly depend on stage of diagnosis. A recent publication showed over time there has been no improvement in the 5 year survival rate for those diagnosed with ovarian cancer in New Zealand compared to Australia, which has instead shown a significant improvement.

There has been much debate about the best treatment, especially for advanced ovarian cancer in the last few decades. Studies are now showing that neoadjuvant chemotherapy has equivalent survival rates but with less morbidity than primary surgery, which has caused a shift in treatment methods in some countries already.

This is an observational retrospective review of all women diagnosed with advanced ovarian cancer and related cancers in Christchurch Women's Hospital, to compare the 5 year overall survival rate between two time periods 10 years apart. The review will also look at changes in patterns of care over time.

Notes:

Pathological chemotherapy response score predicts survival in patients with advanced ovarian cancer receiving neoadjuvant chemotherapy: an individual patient meta-analysis

Paul Cohen, Steffen Bohm[1], Aimee Powell[2, 3], Tarek M Meniawy[4], Colin J.R Stewart[5], Max Bulsara[6], Blake Gilks[7], Naveena Singh[8]

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5. *Division of Obstetrics and Gynaecology, Faculty of Medicine and Health Sciences, University of Western Australia, Crawley, Western Australia, Australia*
6. *Institute for Health Research, The University of Notre Dame Australia, Fremantle, Western Australia, Australia*
7. *Department of Anatomic Pathology, Vancouver General Hospital, Vancouver, BC, Canada*
8. *Department of Cellular Pathology, Barts Health NHS Trust, London, United Kingdom*

Background and aims

The chemotherapy response score (CRS) is recommended for uniform recording of histological tumor response to neoadjuvant chemotherapy (NACT) in high-grade serous ovarian carcinoma (HGSC)1. CRS reproducibly stratifies patients into complete/near-complete (CRS3), partial (CRS2), and no/minimal (CRS1) response2. Single-center studies have shown an association between CRS and progression-free survival (PFS) but not overall survival (OS)3-6. Our objective was to perform an individual patient data (IPD) meta-analysis for further prognostic validation.

Methods

Data from 14 centers in 10 countries were analysed. Eligibility criteria were: stage III/IV HGSC, 3/4 NACT cycles, locally determined CRS, minimum 6-month follow-up, known survival outcomes. Meta-analysis techniques for IPD with random effects were used to derive combined odds ratios (ORs).

Results

Data from 813 patients fulfilled eligibility criteria. 486 (59.8%) and 327 (40.2%) patients had stages III and IV disease respectively. Median follow up was 28 months. OS was 28.0 months. 621 (76%) and 362 (45%) patients relapsed and/or died. 549 patients (67.5%) showed CRS1/2 and 264 (32.5%) showed CRS3. Adjusting for age, stage and residual disease, PFS was significantly improved (21.9 vs. 14.5 months, OR 0.5, 95% confidence interval (CI) 0.45–0.67, p = <0.001) for patients showing CRS3 compared to patients with CRS1/2. OS was significantly improved for patients showing CRS3 (53.8 vs. 37.8 months, OR 0.70, 95% CI 0.50–0.99, p = 0.041) compared to patients with CRS1/2.

Conclusions

CRS3 significantly predicted improved PFS and OS compared to CRS1/2. This robust biomarker can be incorporated into therapeutic decision-making and clinical trial design.

Notes:

Friday 6th July 2018

Breakfast Session
Presenters: Cecil Bergzoll & Carrie Innes
Time: 7.30am – 8.20am

HPV vaccination with Gardasil 9 - Implementation, Opportunities and Impact

Cecile Bergzoll[1]

1. *Auckland City Hospital, Royal Oak, AUCKLAND, New Zealand*

Covering the seven most common high risk HPV subtypes (16, 18, 31, 33, 45, 52 and 58), the nonavalent HPV vaccine has the potential to prevent up to 90% of cervical cancers world-wide versus around 70% with the quadrivalent version. In women aged 16-26 who are naïve to the vaccine HPV types, a 3-dose schedule of 9vHPV vaccine is effective at 96.7% at preventing high-grade cervical, vulvar and vaginal disease associated with these HPV subtypes. This efficacy drops to about 52% in a population already exposed to HPV, emphasising the importance of vaccinating prior to HPV exposure. Nevertheless, modelling data has shown that vaccination of catch up (older) cohorts produces better, faster herd protection.
The nonavalent vaccine has replaced the quadrivalent one since February 2018 in a new two-dose schedule in the Australian National Immunisation Program (NIP) for boys and girls aged 12-13. A 3-dose schedule is recommended if commencing vaccination after age 15, due to lower immunogenicity in this population. The presence of boys in the program is based on 2 advantages: prevention in individual males of HPV infection and of ENT/anal/penile HPV related lesions, as well as herd protection, benefitting both genders if population coverage is 50% or more. Catch up vaccination is funded till age 19 in Australia.
In New Zealand, HPV vaccine is on the National Immunization Schedule at age 12 years or School Year 8 but is funded from age 9 years. The first dose of HPV vaccine must be administered before a person turns 27 years of age to receive a funded course of vaccine.

Notes:

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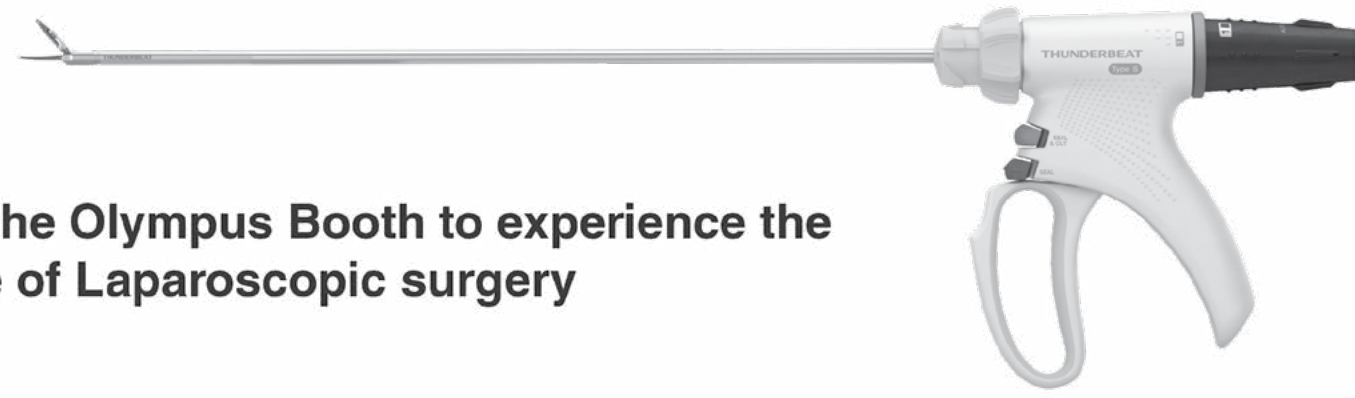

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Impact of HPV vaccination on rates of high grade cervical cell abnormalities and HPV genotypes associated with CIN2 in young New Zealand women

Carrie Innes [1], Prof Peter Sykes[1], Bryony Simcock[1], Jonathan Williman[1], Phil Hider[1], Bev Lawton[1]

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

In 2008, a quadrivalent human papillomavirus (HPV) vaccination (genotypes 6, 11, 16, 18) became available in New Zealand. We have undertaken research investigating the impact of HPV vaccination on high-grade cervical cell abnormality rates and HPV genotypes associated with CIN2 in NZ women aged 20-24 years. Based on an audit of National Cervical Screening Programme data matched with vaccination data from the National Immunisation Register, we found that receiving at least one quadrivalent HPV vaccine dose led to a decrease in high grade cervical abnormality rate of at least 31% in young women. In a separate 3-centre study, we found that while CIN1 and CIN2 rates have remained steady over time, CIN3 rates are decreasing in young women. It is concerning, however, to note that CIN3 is remaining disproportionately high in young Maori women diagnosed with CIN. In a third study, we observed a decrease in HPV 16 and 18-related CIN2 in young women. While vaccinated women had the lowest rates of HPV16/18 positive CIN2 lesions across time, a decrease in HPV16/18 positivity was also observed in unvaccinated women which may be due to a herd effect. Overall, our data demonstrate a positive impact of HPV vaccination on HPV16/18-related high grade cervical disease. A decreased mean age of HPV vaccination over time, the recent introduction of the nonavalent vaccination, and inclusion of boys in the programme, are likely to lead to an even greater impact of vaccination on rates of cervical cell abnormalities in young women in the future.

Notes:

Friday 6th July 2018

Session 5: Clinical Challenges
Presenters: Frédéric Amant, Karen Lu & Philip Beale
Time: 8.30am – 9.50am
Chair: Penny Blomfield

Cancer in pregnancy

Frédéric Amant

Breast cancer, hematological malignancies, ovarian and cervical cancer are the most commonly encountered malignancies during pregnancy.(1) Reports on the incidence of breast cancer in pregnancy (BCP) vary from 2.4 to 7.3 per 100,000 deliveries, depending on study population and definitions used.(2) Andersson et al (2009) found an increase in the incidence of PABC between 1963 and 2002, in a population-based cohort study from Sweden.(3) This supports the expected increase of BCP as later age at first birth becomes more common.

In the most recent INCIP (International Network of Cancer, Infertility and Pregnancy) interim analysis, 1170 patients were included in the analysis and 779 (67%) received treatment during pregnancy. Over the years, the proportion of patients with cancer during pregnancy who received antenatal treatment increased, especially treatment with chemotherapy.(1)

Diagnosis

History and Physical Examination

The basis of a thorough staging evaluation starts with a careful (family) history and physical examination. Patients with BCP almost always present with a palpable mass. Breast cancer detection is more difficult, due to physiologic pregnancy and lactation related changes in breast tissue, including engorgement, hypertrophy and nipple discharge. Overall, patient's and doctor's delay is common, due to more difficult interpretation of clinical findings, gestational symptoms and reluctance to apply diagnostic tools.

Imaging of the breast during pregnancy

Breast ultrasonography is the most accurate examination to determine whether the suspect area is based on a true mass (both solid or cystic) or normal parenchyma.
Magnetic resonance imaging (MRI) is applied widely during pregnancy, for obstetric (e.g. fetal evaluation) and non-obstetric indications. However, the use of MRI for breast evaluation has not yet been established. Talele et al (2003) reported a higher gadolinium uptake in the lactating breast due to increased vascular permeability, causing difficulty to recognize malignancies.(4) It is also recommended that during pregnancy, gadolinium-based contrast agents should only be used if absolutely essential. Studies have demonstrated that gadolinium can pass through the placental barrier and enter the fetal circulation. This is eliminated into the amniotic fluid, it is still unknown how long the gadolinium-chelate molecules remain in the amniotic fluid before finally being reabsorbed and eliminated.(5)

Staging

Concerning radiological examinations, the potential harm to the fetus should be kept in mind but in general, the expected radiation effects, such as intrauterine growth restriction, mental retardation, organ malformations and childhood cancer, probably only arise above a threshold dose of 0.1-0.2 Gy. The estimated dose to the fetus resulting from most conventional radiograph examinations is less than 0.01 Gy.(6) Chest radiography can be safely performed, as long as abdominal shielding is used to minimize the scattered radiation that reaches the uterus. Computed tomography (CT) is associated with higher levels of radiation exposure and should only be performed if it may provide significant diagnostic information that would change the treatment plan. With adequate shielding reduction of fetal exposure can be decreased. Examinations without radiation exposure are still preferred during pregnancy. Abdominal ultrasound can be easily used for the detection of liver metastases.

MRI is a valuable tool in the diagnosis of brain and bone metastases, in patients with high probability of metastasis or clinical symptoms.

In 20 pregnant cancer patients, whole-body diffusion-weighted MRI (WB-DWI/MRI) was feasible for single-step non-invasive staging of cancer during pregnancy with additional value for conventional imaging procedures.(7)

Treatment

Surgical Treatment During Pregnancy

Surgery is widely applied during pregnancy, in most cases for benign disease. A general rule is that when one cares for the mother during anaesthesia, one also cares for the fetus. Also laparoscopy is safe when the intraabdominal pressure is appropriate, an open procedure is used and when the surgeon is experienced. Tocolytics are only used in case of uterine manipulation.
Concerning surgery in the treatment of local breast cancer, both radical modified mastectomy and breast conserving surgery with axillary or sentinel lymph node dissection are feasible options during pregnancy. The major difference between these two surgical modalities is the need for radiotherapy after breast conserving surgery to avoid local recurrence. On the other hand, chemotherapy is usually indicated in this age group, and radiotherapy can then be postponed to the postpartum period. Therefore, breast conserving surgery is an option during pregnancy.(8)
Sentinel lymph node biopsy (SLNB) has become a valid method for axillary staging in nonpregnant patients with cT1-2 breast tumors and unsuspicious lymph nodes. The injected 99mTC sulphur colloid is concentrated only in the injection site and in the lymph nodes with negligible irradiation to other tissues and organs. Less than 2% of injected activity is found in the maternal circulation and excreted by the urinary system. The fetal absorbed dose in pregnant patients undergoing breast lymphoscintigraphy with 92.5 MBq of 99mTC sulphur colloid tends to be minimal in all scenarios. Injection on the day of surgery is recommended in order to minimize the dosage. The use of isosulfan blue dye has a possible risk of maternal anaphylaxis, which can also be harmful to the fetus. In 145 patients, SLN biopsy during pregnancy has a comparably low axillary recurrence rate as in nonpregnant women. Therefore, this method can be considered during pregnancy instead of standard ALND for early-stage, clinically node-negative breast cancer.(9)

Radiotherapy During Pregnancy

Radiotherapy has been utilized during pregnancy in the treatment of breast cancer, Hodgkin's disease, brain tumors and head and neck cancer. During the first 8 weeks of gestation, dosage above 0.05 Gy are associated with malformations, microcephaly, growth retardation and mental retardation (deterministic effects, dose related). In the first trimester, there is a risk of miscarriage and teratogenic effects. The exposure to radiation increases when the fetus is growing and the distance between the RT field and the fetus decreases. Next to the deterministics effects, there is a greater risk of secondary malignancies (stochastic effects).
The dose to the fetus comes from 3 principle sources, photon leakage through the treatment head of the machine, radiation scattered from the collimators and beam modifiers, and radiation scattered within the patient from the treatment beams.(10) Concerning the first 2 sources of radiation reaching the fetus, the dose can be reduced by a factor of two to four by proper shielding. The American Association of Physicists in Medicine (AAPM) published guidelines on the estimation and reduction of the fetal dose.(10) In a recent cohort describing pediatric outcome of antenatal exposure to oncologic treatment, only 11 children (of 129) was exposed to RT.(11) Large studies on fetal safety and outcome are not available.

Systemic Treatment During Pregnancy

Chemotherapy is contra-indicated in the first trimester of gestation to avoid interference with the normal organogenesis in early pregnancy. From 12-14 weeks gestation, the administration of some chemotherapeutic agents is feasible.(12) It is advised to treat with standard chemotherapy if possible.
The current standard chemotherapy for breast cancer is an anthracycline-based combination therapy of doxorubicin or epirubicin and cyclophosphamide. Addition of taxanes offers a survival advantage for women with high-risk breast cancer and has also become standard for non-pregnant patients in the last decade. For

gynaecological cancers, the combination of paclitaxel and carboplatin is most widely used. The transplacental passage of chemotherapy was studied in a pregnant baboon model. Fetal baboon plasma concentrations of doxorubicin, epirubicin, 4-hydroxy-cyclophosphamide and paclitaxel averaged 7.5%, 4.0%, 25% and 1.5% of maternal concentrations, respectively. This preclinical model demonstrates a variable concentration of chemotherapy in the fetal plasma.(13)
Trastuzumab, a monoclonal antibody used for treating tumors overexpressing the HER2 receptor, is contraindicated during pregnancy since it has been associated with oligohydramnios. Trastuzumab blocks epidermal growth factor receptors expressed in the fetal kidney, decreasing kidney cell proliferation. In a systemic review of 17 studies (18 pregnancies, 19 newborns), 61% of the pregnancies was complicated by oligo/anhydramnios and only in 52,6% a healthy neonate was born.(14) The children exposed in the first trimester were all healthy. Therefore, administration of trastuzumab should be avoided in pregnancy. Women who become accidentally pregnant during trastuzumab administration can continue their pregnancy.(15) In the absence of valid data and given the problems with trastuzumab, the use of lapatinib is also contraindicated.

Obstetric Considerations

The pregnancy needs to be carefully monitored by an experienced obstetrician. Determination of gestational age and expected delivery date are important factors in planning the oncological treatment. Also in later stages of pregnancy, careful evaluation of fetal morphology and growth is required. Obstetrical complications such as miscarriages, fetal malformations and death, growth restriction, prematurity, oligohydramnios and neurological problems have been observed in the course of treatment.(16)
Although termination of pregnancy can be considered during treatment planning, it has not been proven to influence maternal prognosis.
Concerning timing of delivery, an interval of at least 3 weeks between chemotherapy and the anticipated delivery prevents myelosuppression in the parturient and neonatus, consequently minimizing the risks of haemorrhage and sepsis. Furthermore, commencing chemotherapy during pregnancy can be a means to prevent iatrogenic prematurity, and the associated neonatal morbidity. In the analysis of 215 patients with cancer in pregnancy, delivery was induced in 71.7% of pregnancies and 51.2% of the neonates were admitted to a neonatal unit, mainly because of prematurity.(16)

Our most recent data indicate that babies exposed to antenatal chemotherapy might be more likely to develop complications, specifically small for gestational age and NICU admission, than babies not exposed. We therefore recommend involving hospitals with obstetric high-care units in the management of these patients.(1) The long term consequences of (iatrogenic) prematurity should not be ignored. Cognitive development is not influenced by the administration of chemotherapy, but is strongly related to gestational age at birth.

Maternal Prognosis

Most series in all types of cancer are insufficiently large to draw solid conclusions. Since numbers are largest for breast cancer, the best evidence is derived for this tumortype. A large international study in 447 women and 865 controls did not find a worse prognosis regarding disease recurrence or overall survival in BCP patients after adjusting for age, stage, grade, (immuno)histology and treatment.(17) However, the subgroup of patients who received chemotherapy during pregnancy was too small to study the effect of chemodilution.

Conclusion

The International Network on Cancer, Infertility and Cancer (INCIP) acts under the umbrella of ESGO and aims to facilitate international collaboration in further studies of cancer in pregnancy. International registration of cases is possible through www.cancerinpregnancy.org.

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Notes:

Obesity and endometrial cancer

Karen Lu [1]

Abstract not provided.

Notes:

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Update on Medical Treatments for Gynae Cancer

Philip Beale

1. *Sydney Local Health District, Camperdown, NSW, Australia*

Platinum and paclitaxel have the backbone of chemotherapy treatment for ovarian cancer since 1996 with the publication of GOG111.

The treatment today for newly diagnosed ovarian cancer is still carboplatin and paclitaxel. However there has been a raft of trials that have now looked at new targets.

Some of these trials have reached a conclusion and there are options to use them in clinical practice. Others are being trialled on the back of the increased profiling of cancers that allow for new targets to be identified.

The goal is to produce better outcomes for all patients via improved precision medicine

Notes:

Friday 6th July 2018

Tumour Board

Presenters: Andy Garrett, Helen Moore, Rachael Van Der Griend, David Bernshaw, Michelle Vaughan & Kym Reid

Time: 10.30am – 11.30am

Notes:

Friday 6th July 2018

Session 6: Free Presentations – Surgical
Presenters: Naven Chetty, Rhonda Farrell, Nisha Jagasia & Felix Chan
Time: 11.30am – 12.16pm
Chair: Cecile Bergzoll

The Anatomy of a Radical Hysterectomy and Pelvic Lymphadenectomy in the Management Early Cervical Cancer.

Naven Chetty[1], Tong Pearl[1], Nisha Jagasia[1]

Radical hysterectomy and pelvic lymphadenectomy is an integral part of the management of early cervical cancers.

The ability to perform an open radical hysterectomy and pelvic lymphadenectomy is a fundamental skill of the Gynaecological Oncologist.

Over the last 5-10 years this operation has been increasingly performed via minimally invasive techniques.

In our unit the introduction of laparoscopic and robotic radical hysterectomies has seen a reduction in patient pain and length of stay.

With the aid of video footage we would like to demonstrate and contrast our techniques for open, laparoscopic and robotic radical hysterectomy and pelvic lymphadenectomy.

Notes:

Peritonectomy and heated intraperitoneal chemotherapy (HIPEC) for advanced ovarian cancer: What do gynaecological oncologists really think?

Rhonda Farrell

Background: Peritonectomy and heated intraperitoneal chemotherapy (HIPEC) is increasingly being used in centres around the world to treat advanced epithelial ovarian cancer (EOC). There is considerable interest yet significant equipoise towards this approach by gynaecological oncologists (CGOs) in Australia and New Zealand. The future of this treatment approach will, to a large part, be determined by willingness of gynaecological oncologists to work with or refer to such units. Aims: To survey all practicing CGOs in Australia and New Zealand on their opinion about peritonectomy and HIPEC for advanced EOC. **Materials and Methods:** A questionnaire was sent to all 53 CGOs in Australia and New Zealand in July 2017 assessing their willingness to refer women with advanced EOC for a peritonectomy procedure, or treatment with HIPEC. They were asked to specify which cases they would, or would not, recommend this treatment. The influence of surgeon demographics and individual surgical practices on the decision to recommend peritonectomy or HIPEC was investigated using logistic regression analysis. **Results:** Response rate was 89%. Only 13% of CGOs would refer a case of primary stage 3 EOC for peritonectomy even if they predict they cannot themselves completely resect the tumour. This was due to concerns around morbidity, and preference for neoadjuvant chemotherapy. In regards to HIPEC, 61 % of CGOs were unsure about using it, due to concerns about lack of evidence and potential morbidity. CGOs were more likely to refer cases of recurrent EOC, particularly low grade tumours, than primary EOC or high grade tumours, for peritonectomy and HIPEC. Conclusions: Only a minority of CGOs would refer women with advanced EOC for peritonectomy, or recommend HIPEC. Concerns around potential morbidity, and lack of evidence for improved outcomes, would need to be addressed for CGO's to recommend this treatment. A potential ANZ HIPEC trial concept will be discussed.

Notes:

A multi-disciplinary approach to surgical cytoreduciton of supra-diaphragmatic and upper abdominal disease in epithelial ovarian cancer.

Nisha Jagasia[1], Naven Chetty[1], Lewis Perrin[1], Paul Peter[2], Mehan Siriwardhane[3]

1. *Gynaecological Oncology, Mater Adults Hospital, Brisbane, Queensland, Australia*
2. *Cardiothoracic Surgery, Mater Hospital, Brisbane, QLD, Australia*
3. *Hepatobiliary Surgery, Mater Hospital, Brisbane, QLD, Australia*

We present a case of advanced epithelial ovarian cancer which underwent multi-disciplinary surgical cytoreduction of multiple aberrant sites of disease including pericardial and portal/peri-pancreatic lymph nodes.

Literature supporting the prognostic and therapeutic significance of finding and treating supra-diaphragmatic lymphadenopathy and lesser sac disease will be discussed with relevant clinical scenarios.

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Notes:

Robot “please save my better half”

Felix Chan[1]

1. *Liverpool Hospital, Tennyson Point, NSW, Australia*.

A 32yo nulliparous woman presented with irregular vaginal bleeding and found to have endometrial cancer. She was also found to have uterine didelphys and the cancer affected the left uterus. This lady has two well develop cervix and vagina. The right uterus was normal.

Magnetic resonance imaging confirmed normal size ovaries and there was no evidence of metastatic disease on staging imaging.

After careful counseling, the patient elects to retain her normal uterus for fertility purpose.

The presentation describes a technique of hemi-hysterectomy and sentinel node biopsy using robotic approach. The patient was discharged within 24 hours without surgical complication.

Notes:

Saturday 7th July 2018

Session 7: The Bottom End
Presenters: Lois Eva, Jeremy Simcock, Neville Hacker,
Time: 8.30am – 9.45am
Chair: Nimithri Cabrall

Vulval Cancer; Lichen Sclerosus, DVIN and HPV: Implications for management

Lois Eva [1]

1. *Dept of Gynae Oncology Auckland City Hospital, Auckland, AUCKLAND, New Zealand*

Traditionally vulval cancer has been classified by histopathological type and vulval squamous cell carcinoma (VSCC) has been treated as a single entity. It is now recognised that there are 2 distinct pathways to development of VSCC, a HPV dependent route associated with HSIL of the vulva and a HPV independent route associated with lichen sclerosus and differentiated VIN. There is increasing evidence that these 2 types of VSCC have different behaviour and outcomes, and consideration should be given to aligning prevention, management and follow up strategies according to individual risk.

Notes:

The Surgical Side of the Melanoma MDM

Jeremy Simcock [1]

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

The management of cutaneous melanoma has changed markedly in the last few years. What could be relevant to vulvar melanoma? The benefits of chemotherapy including checkpoint inhibitors have been well promoted.

How has the surgical management of melanoma been changing and where could it be heading? Areas of discussion include:

1. Margins of excision of thick melanomas in difficult sites.
2. How to stage thick primary melanoma – PET or SLNB or neither?
3. The role of sentinel node biopsy and completion lymphadenectomy following the reporting of the MSLT2 trial.
4. Nodal clearance in the setting of metastatic disease
5. Neoadjuvant systemic therapy prior to lymphadenectomy
6. Adjuvant therapy for Stage III melanoma

I will present a surgical perspective on these MDM discussions.

Notes:

Reflections on vulvar cancer over 40 years

Neville Hacker[1]

1. *Gynaecological Cancer Centre, Royal Hospital for Women, Randwick, NSW*

When I commenced training in Gynaecological oncology in 1978 at the University of California, Los Angeles (UCLA), vulvar cancer was generally treated by radical vulvectomy, bilateral inguinal-femoral lymphadenectomy, and pelvic lymphadenectomy if the groin nodes were positive. This provided good cure rates but was physically and psychologically morbid. A separate incision approach for the groin nodes had become standard of care at three of the four hospitals in the UCLA Fellowship program, so I researched and reported the first 100 cases in 1981. This approach significantly improved acute morbidity, and was slowly accepted as standard of care, without ever undergoing any randomised trial. The long-term morbidity of lymphoedema remained, and several unsuccessful attempts to safely omit or modify the groin dissection have been made over the past 40 years. Many lives have been lost because of groin recurrence. Sentinel node biopsy is the best option to reduce the risk of lymphoedema but has false-negative rates that are unacceptably high for most patients, particularly for lesions over 2 cm diameter. Radical vulvectomy was shown to be associated with high psychological morbidity and has been slowly replaced by radical local excision for all unifocal cancers. For advanced disease, pre-operative radiation has replaced primary surgery for patients who would otherwise require a stoma, and resection of bulky nodes only and post-operative groin and pelvic radiation should replace complete inguinal-femoral lymphadenectomy for patients whose bulky nodes are shown to be positive on frozen section.

Notes:

Saturday 7th July 2018

Free Communications
Presenters: Jennifer Bradford, Peter Sykes & Robert Rome
Time: 9.45am – 10.21am
Chair: Nimithri Cabrall

Management of lichen sclerosus and vulval cancer

Jennifer Bradford

Vulval lichen sclerosus has a 1:20 risk of subsequent malignancy, and accounts for 50-60% of all vulval SCCs. New data shows that this risk can be minimised by continuously suppressing the skin inflammation. Patient cohorts randomise themselves intofully-compliant or partially-compliant groups, making comparison straightforward.

Primary prevention of lichen sclerosus-associated SCC and dVIN is therefore potentially achievable in most compliant patients. Secondary prevention may be possible, using the same regimen as for primary prevention. A proposed protocol will be presented.

Notes:

The Australia and New Zealand audit of sentinel node biopsy in Vulval cancer

Peter Sykes

1. *Department of Gynaecologic Oncology, Royal Hospital for Women, Randwick, NSW , Australia*

Objective

To determine the feasibility, safety, and groin recurrence rate associated with sentinel node biopsy for Vulval cancer in routine clinical practice in Australia and New Zealand.

Methods

Participating centres prospectively enrol patients who are undergoing sentinel node biopsy for Squamous cell vulval cancer. Inclusion criteria are as recommended by the GROINSS collaboration although we include patients who have undergone local excision biopsy. Methods of the procedure are as described in the GROINSS V study. Follow up is as per routine clinical practice with CRFs returned to study centre for 3 years.

Outcomes

10 treatment centres have participated in the audit and 126 patients have been registered for the study. However, surgery and pathology data is available for 119 patients at this date.

Of the registered patients, n=118 completed the sentinel node protocol. There were n=4 adverse intraoperative events.

Following surgery, it was determined that n=13 no longer met the criteria for sentinel node biopsy (n=3 tumour size > 4cm, n=9 multifocal disease, or n=1 <1mm invasion).

Of the remaining women, sentinel nodes were reported on histology in 104/105 women. The mean number of sentinel nodes identified was 2.8 (range 0 – 12). 21/104 women had at least 1 positive sentinel node.

100 women have completed at least 3 months follow up (median of 19.1 months, range 3 – 36 months). This included 80 women with negative sentinel nodes and 20 women with positive sentinel nodes. 8/20 women with positive sentinel nodes have recurred 3 vulval, 2 groin and 3 distant. 6/80 women with negative sentinel nodes have recurred. 4 vulval, 2 groin and 0 distant. Importantly, the 2 nodal recurrences in women with negative sentinel nodes were both associated with failure to adhere to the pathological component of the sentinel node protocol.

Conclusion

Sentinel node biopsy is feasible in routine clinical practice in Australia and New Zealand. Particular attention needs to be paid to the pathology component of the sentinel node protocol. Ongoing monitoring is required to confirm the safety of sentinel node biopsy in routine clinical practice.

Notes:

Progress towards a National Gynaecological Oncology Registry (NGOR)

Robert Rome

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

In 2016 we obtained substantial funding to initiate a pilot study to establish an Ovarian Cancer Quality Clinical Registry pilot. This is now underway with 10 sites in Vic, NSW and Tas. Clinical Quality Indicators (CQIs) have been defined and agreed upon. Costs have been minimised by using data generated from existing databases. The presentation will give a brief update on the ovarian pilot project and the problems that we encountered.

The time has come to look forward and consider extending the ovarian CQR to other states and jurisdictions but also consider expanding the quality registry to include all the other gynaecological cancers. The presentation will also provide an update on what other gynae oncology groups have done to establish quality registries. A proposal will be made for the establishment of a National Gynaecological Oncology Registry (NGOR), and suggestions offered as to how this can be progressed.

Notes:

Saturday 7th July 2018

Session 8: Gynae Caner in the Pacific
Panel: Abel Smith, Ai Ling Tan & Penny Blomfield
Time: 11.00am – 12.10pm
Chair: Bryony Simcock

How could we improve outcomes for pacific women with gynaecological cancer

TBC

Abstract not provided.

Notes:

Opening the doors for pacific island women

Abel Smith

1. *Auckland and Waitemata DHB, Otahuhu, AUCKLAND, New Zealand*

This Zen presentation will focus on discussing strategies, practices and pathways to improve access and opportunities for Pacific Island women and their families in Women's Health Services and care. This presentation will present some findings of a greenbelt study at Auckland DHB looking into the issues Pacific women articulate as challenges that they encounter accessing Women's Health Services. Recommendations from the study include some suggestions to improve their engagement with follow up care and future directions for the improved access and opportunities for Pacific women and communities.

Notes:

IGCS Training program for under resourced countries

Ai Ling Tan

The presentation is to introduce the IGCS training initiative of providing gynaeoncology training in low-income countries by buddying them with teams from countries with certified gynaecology oncologists. The aim is for trainees to do the bulk of their training in their own countries but the training has to be as good as they would get in developed countries, perceived as such, but flexible enough to meet local needs.

Pilot sites have started in 2017 and so far feedback has been positive. How the program is run will be explained. Any interest in participation is encouraged.

Notes:

An Australian focus on inequity in gynaecological cancer

Penny Blomfield

Abstract not provided.

Notes:

ASGO Debate – Hipec em all (all women with HGSIC should be offer hipec)

For: Geoff Otton & Karen Lu

Against: Michelle Vaughan & Frédéric Amant

Time: 12.10pm – 1.05pm

Chair: Bryony Simcock

Notes:

Does the size and topography of high grade squamous intraepithelial lesions (HGSIL) vary with age in women referred following high grade squamous cervical cytology: A retrospective case series.

Elizabeth Goulding[1], Petr Otahal, Eileen Long, Penny Blomfield

1. *Chris O'Brien Lifehouse, Newtown, NEW SOUTH WALES, Australia*

Background

HGSIL are heterogenous lesions with potential for malignancy.[1] Clinicians are challenged to adequately excise HGSIL whilst minimising morbidity. Despite older age (≥50) being a risk factor for recurrent disease there is little published on the histopathological extent of CIN3 across different ages. This study aimed to quantify this.

Results

We reviewed demographic and clinical data of 80 women (19 aged 20-29, 22 aged 30-39, 22 aged 40-49 and 17 aged ≥50) referred with high grade squamous cervical cytology. The PPV of a HGSIL Pap smear for predicting CIN3 in women ≥50 was 0.72. Lesions were measured and the extent quantified. Older women were more likely to have discrepant colposcopic findings, invasive malignancy (18%), endocervical gland involvement (65%), deeper involved crypts, paradoxical maturation, necrosis and positive margins however their volume of disease was second to that in the 30-39 age group.

Discussion

As women age they are more likely to have microinvasive disease. In our cohort women ≥50 had a greater volume of disease than those aged 20-29 and 40-49 however women in the 30-39 age group had the highest volume of disease.

1. Sherman, M.E., Wang, S.S., Tarone, R., et al. Histopathologic extent of cervical intraepithelial neoplasia 3 lesions in the atyprical squamous cells of undetermined significance low-grade squamous intraepithelial lesion triage study: implications for subject safety and lead-time bias. Cancer Epidemiology, Biomarkers & Prevention 2003; 12: 372-379.

Malignant Ovarian Germ Cell Tumours in the Post-Menopausal Population

Jessica A Robertson[1], Karen Sanday[1], James L Nicklin[1]

1. *Queensland Health, Herston, QLD, Australia*

Background: Malignant ovarian germ cell tumours (MOGCT) are uncommon in the general population and very rare in post-menopausal women.1

Aims: To evaluate the demographics, treatment and survival of post-menopausal women with MOGCT treated at the Queensland Centre for Gynaecological Cancer (QCGC).

Materials and Methods: Retrospective analysis was performed of the QCGC database from January 1981 until December 2016. The disease course of post-menopausal women was compared with pre-menopausal women and the world literature.

Results: There were seven post-menopausal women with MOGCT treated at the QCGC compared with 166 pre-menopausal women. In the post-menopausal group of women, there was no mortality directly attributed to germ cell ovarian disease compared with 14 (8.4%) in the pre-menopausal group.

Conclusions: MOGCT is a very rare condition in post-menopausal women. Despite some suggestion in the world literature that survival outcomes are worse in this population, this was not found in our study.

1. Brown, J., Friedlander, M., Backes F.J., et al. Gynecologic Cancer Intergroup (GCIG) Consensus Review for Ovarian Germ Cell Tumors. Int J Gynecol Cancer 2014; 24: S48-S54.

Determining a suitable follow-up period after diagnosis of a complete molar pregnancy

Gaithri Mylvaganam[1], Emma Allanson[2, 3], Jonathan Carter[2], Trevor Tejada-Berges[2]

1. *Obstetrics and Gynaecology, Royal Prince Alfred Hospital, Camperdown, NSW, Australia*
2. *Department of Gynaecologic Oncology, Chris O'Brien Lifehouse, Camperdown, NSW, Australia*
3. *Division of Obstetrics and Gynaecology, Faculty of Medicine and Health Sciences, University of Western Australia, Crawley, WA, Australia*

Background**:** Guidelines recommend six months beta-hCG monitoring post evacuation of a complete molar pregnancy (CMP). A shorter follow-up period may be safe and result in a shorter pregnancy interval for women desiring fertility.

Aim: To determine time course and trends in beta-hCG following surgical evacuation of CMP

Method: Data on all patients presenting to Royal Prince Alfred Hospital with a histopathological diagnosis of a CMP 2010-2017 were collected.

Results: 60 patients were diagnosed with CMP from 2010-2017. 10 patients were lost to follow-up. 10 patients had persistently raised beta-hCG requiring; chemotherapy (6), hysterectomy (3) or repeat curettage (1). 40 patients achieved spontaneous normalisation of beta-hCG post evacuation, 25 within 8 weeks. None of these 40 patients had a subsequent rise in their beta-hCG.

Conclusion: The risk of persistent molar pregnancy after normalisation of beta-hCG within 8 weeks of evacuation of a complete molar pregnancy in our data appears very low.

Follow up after treatment of high grade cervical dysplasia

Rhett Morton[1], King Man Wan, Sam Saidi

1. *Royal Prince Alfred Hospital / Chris O'Brien Lifehouse, Annandale, NSW, Australia*

Background: New guidelines omit 6 month cytology/colposcopy and 12 month colposcopy for followup of treated high grade (HG) dysplasia.

Aim: To determine whether 6 month colposcopy/cytology, and 12 month colposcopy was useful in followup compared to a 12 month co-test.

Method: Retrospective review of all patients treated for HG dysplasia from 2012 to 2017 at Chris O'Brien Lifehouse, Sydney.

Results: 428 patients were included. At 6 months, 3% had HG colposcopy, half with concordant cytology, with 2 patients retreated. At 12 months, 5 patients had HG colposcopy, 1 had concordant cytology and was HPV positive. Of 14 patients with HG cytology, only 1 had HG colposcopy. Three patients all with positive co-tests ultimately underwent hysterectomy for persistent dysplasia. No cases of carcinoma developed.

Conclusion: Clinical management and outcome was not significantly altered by 6 month cytology and 6 and 12 month colposcopy.

Steroid cell tumour, NOS in Pregnancy. Reflection of a rare case and review of the literature.

Jennifer Weishaupt[1], Unine Herbst[1]

1. *Gynaecology Oncology, Liverpool Hospital, Liverpool, NSW, Australia*

AIM

In the literature only a few cases of steroid cell tumours have been described, here we present a rare case of a steroid cell tumour arising from the ovary in early pregnancy. Aspects of her presentation, diagnosis, and treatment of this tumour are discussed.

BACKGROUND

Steroid cell tumours are rare sex cord tumours that account for approximately 0.1 % of all ovarian tumours and are subdivided into 3 types: Stromal luteoma, Leydig cell tumours and steroid cell tumours NOC. Steroid cell tumours are the most common subtype accounting for about 60% of these tumours which can occur at any age but usually develop in adults with an average age of 42years. They often present as a unilateral solid, well circumscribed tumours and occasionally as cystic tumours.

Clinically 60% of these tumours show virilisation or androgenic changes. They may be associated with estrogen section in 6-23% and may also present as Cushing syndrome. They are clinically malignant in a third of cases.

CASE REPORT

A 32 year old, G2P1, presented at 9 weeks gestation for antenatal care. She was clinically well other than some early pregnancy nausea. She had no other significant medical history and no other symptoms. She has had 1 previous normal vaginal delivery 9 years ago with no complications.

The dating ultrasound confirmed a 6cm x 5cm x4cm well circumscribed ovarian mass with only a small amount of free fluid. A CT scan ordered 2 months prior unbeknown to a very early pregnancy showed a left ovarian cyst 10 x 8 x8 cm, with solid nodules along the cyst wall, no ascites and a normal right ovary, no lymphadenopathy or peritoneal enhancement. The Ca 125 was 265 at the time.

There was consensus to perform a laparoscopic cystectomy ideally in the second trimester.

Whist awaiting for her pregnancy to continue she presented to the emergency department at 14 weeks gestation with ascites and associated abdominal pain and her Ca 125 increased to 1700.

An ascitic tap showed no malignant cells.

The initial laparoscopy was converted to a midline laparotomy and a left salpingo- oopherectomy , omental biopsy and removal of cystic mass was performed. Her post-operative recovery was uneventful and she was referred to the high risk antenatal clinic for ongoing perinatal care and 3 monthly follow up in the gynaecology oncology clinic.

RESULTS

Histology and immunostains confirmed a steroid cell tumour, NOS. There was no invasion to suggest malignancy.

CONCLUSION

This case report contributes to our knowledge of steroid cell tumours and helps to inform us of the extremely rare nature of such a tumour particularly in pregnancy. Remarkably she did not present with any virilising features however we ought to be mindful that the fetus may also present with such features. These tumours are primarily managed surgically in our case conservatively to preserve fertility. There is little consensus on adjuvant therapy for advanced disease.

Intravenous Leiomyomatosis with Intracardiac extension

Sarah Lyons[1], Neville F Hacker[1]

1. *Department of Gynaecologic Oncology, Royal Hospital for Women, Randwick, NSW , Australia*

Case report: Intravenous leiomyomatosis with Intracardiac Extension

This is an interesting case of a 28 year old woman presenting with abdominal pain whilst awaiting gynaecologic oncological review due to a rapidly enlarging abdominal mass and pulmonary nodules. She had a myomectomy 18 months prior and had rapid regrowth of this mass despite hormonal treatment. CT imaging demonstrated a large pelvic mass with a mass/thrombus within the IVC from right iliac veins into the right atrium and multiple pulmonary nodules.

A smooth mass arising from the inferior vena cava was removed from the right atrium at thoracotomy. Histopathology demonstrated a leiomyoma.

Subsequently the patient underwent a subtotal hysterectomy, bilateral salpingectomy, opening of IVC and resection of intravenous leiomyomatosis from presacral and uterine veins. The enlarged cervix was then resected.

She has recovered well, however pulmonary lesions remain present.

Notes:

Notes:

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