ASGO ASM 2019

InterContinental Sydney, June 5th - 9th

IT WILL BE ***VIVID***

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CRS & HIPEC Workshop

SURGEONSCHOICE INNOVATION BY DESIGN

2019 *Organising Committee*

Selvan Pather
Trevor Tejada Berges
Sam Saidi

Prof Brendan Moran

Brendan Moran is a Consultant Surgeon and Academic Lead in the Peritoneal Malignancy Unit, Basingstoke, UK. He is a Senior Lecturer, University of Southampton Cancer Sciences Division. He is Honorary Professor of Surgery, Royal Prince Alfred Hospital, University of Sydney and President of the Association of Coloproctology of Great Britain and Ireland (ACPGBI). He is Past President of the Section of Coloproctology, The Royal Society of Medicine and Executive and Member of Council of the RSM and the ACPGBI. He has delivered 10 named Lectures and over 200 other contributions to International societies

A/Prof Kathleen Schmeler

Schmeler is an associate professor in Gynecologic Oncology and Reproductive Medicine at The University of Texas MD Anderson Cancer Center. She provides care to women with gynecologic malignancies, including surgery, chemotherapy and preventive services. Dr. Schmeler is also the director of the colposcopy clinics at MD Anderson and its partner public institution, Lyndon B. Johnson Hospital, where she treats women with preinvasive cervical, vulvar and vaginal diseases.

Secretariat

The registration desk will be open throughout the conference to answer any questions you may have. We will be located outside the James Cook Ballroom on level 2.

Mary Sparksman & Amy Theodoros

YRD (AUST) Pty Ltd
PO Box 717
INDOOROOPILLY QLD 4068
AUSTRALIA

M: 0418 877 279 (Mary)
M: 0420 944 268 (Amy)

Wednesday 5th June: 9:00am – 5:00pm

Thursday 6th June: 8:00am – 5:30pm

Friday 7th June: 7:00am – 2:00pm

Saturday 8th June: 8:00am – 1:30pm

LIFE CAN CHANGE UNEXPECTEDLY

RECOMMEND GARDASIL® 9 to female patients up to 45 years of age[1]

Importantly, vaccinated women should continue with cervical screening

- Modelling suggests that **25% of cervical cancer cases** are attributable to HPV infections acquired **after 30 years of age**[2§]
- **Australian Women aged 30-45 years (as of 2019) are largely unvaccinated:**[3]
  - 31% 3-dose coverage in women aged 30-38 years[3]
  - Women aged **39-45 years have never been offered a funded HPV vaccine**[3]
  - Consider GARDASIL® 9 for all women aged 30-45 years[1]
- While the most effective time to vaccinate is before exposure to HPV, **there remains a benefit in sexually active women**[1]

§Model simulating natural history of cervical cancer; assumes no HPV vaccination or screening[2]

HPV = Human Papillomavirus

GARDASIL® 9
[Human Papillomavirus 9-valent Vaccine, Recombinant]

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. **2.** Burger E *et al. Clin Infect Dis* 2017; 65(6):893–99. **3.** Brotherton JM *et al. Commun Dis Intell* 2009: 33(4);426-30. Seqirus (Australia) Pty Ltd. ABN 66 120 398 067, 63 Poplar Road Parkville, Victoria 3052 www.seqirus.com.au. Distributor for Merck, Sharp and Dohme (Australia) Pty Ltd. GARDASIL® 9 is a registered trademark of Merck Sharp & Dohme Corp., Rahway, NJ, USA. Seqirus™ is a trademark of Seqirus UK Limited or its affiliates. Seqirus Medical Information: 1800 642 865. Date of preparation: May 2019. SEQ/GAR9/0519/0052. 15549.

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

Seqirus™

PBS Information: This product is listed on the National Immunisation Program (NIP) as part of the school based program. Refer to NIP Schedule. This product is not listed on the NIP for individuals over 19 years of age.

Lynparza®
olaparib
tablets

I have high grade serous ovarian cancer

TEST ME

for BRCAm

If I am positive

TREAT ME

with Lynparza®*

*as maintenance therapy for PSR disease, in response after platinum-based chemotherapy (must have ≥2 courses)[1]

BEFORE PRESCRIBING, PLEASE REVIEW FULL PRODUCT INFORMATION AVAILABLE ON REQUEST FROM ASTRAZENECA ON 1800 805 342 OR www.astrazeneca.com.au/PI

MBS item 73295: Detection of germline BRCA1 or BRCA2 gene mutations, in a patient with platinum-sensitive relapsed ovarian, fallopian tube or primary peritoneal cancer with high grade serous features or a high grade serous component, and who has responded to subsequent platinumbased chemotherapy, requested by a specialist or consultant physician, to determine whether the eligibility criteria for olaparib under the Pharmaceutical Benefits Scheme (PBS) are fulfilled.

PBS Information: Lynparza Tablets. Authority Required. For maintenance treatment of germline BRCA mutated platinum-sensitive relapsed high-grade serous ovarian, fallopian tube or primary peritoneal cancer for patients who have responded to prior platinum based chemotherapy. Refer to PBS schedule for full authority information.

LYNPARZA® (olaparib) Tablets Minimum Product Information INDICATIONS: Monotherapy for the maintenance treatment of adult patients with platinum-sensitive relapsed high grade 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 2 courses of platinum-based regimens. **Monotherapy for the treatment of adult patients with germline BRCA-mutated HER2-negative metastatic breast cancer who have previously been treated with chemotherapy in the neoadjuvant, adjuvant or metastatic setting. Germline BRCA mutation (gBRCAm) status should be determined by an experienced laboratory using a validated test method.* **DOSAGE AND ADMINISTRATION: Important Administration Information** LYNPARZA is also available as a 50 mg capsule. DO NOT substitute LYNPARZA tablets (100 mg and 150 mg) with LYNPARZA capsules (50 mg) on a milligram-to-milligram basis due to differences in the dosing and bioavailability of each formulation. See full PI for LYNPARZA capsules for specific capsule dosing. **Dosage in adults** LYNPARZA is available as 100 mg and 150 mg tablets. The recommended dose of LYNPARZA is 300 mg (two 150 mg tablets) taken twice daily, equivalent to a total daily dose of 600 mg. The 100 mg tablet is available for dose reductions only. LYNPARZA tablets can be taken with or without food; they should be swallowed whole and not chewed, crushed, dissolved or divided. *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 PI. *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 PI. *Special patient populations:* For patients with moderate renal impairment, the recommended dose of LYNPARZA is 200mg twice daily. LYNPARZA is not recommended in patients with severe renal impairment or end stage renal disease, patients with moderate or severe hepatic impairment. *Women of childbearing potential:* See PRECAUTIONS. For more information, see full PI. **CONTRAINDICATIONS:** Hypersensitivity to the active substance (olaparib) or to any of the excipients. **PRECAUTIONS:** *Haematological toxicity* is common in patients treated with olaparib and is generally 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 (haemoglobin, platelet, and neutrophil levels should be ≤CTCAE grade 1). 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. **Female partners of male patients taking LYNPARZA should also avoid pregnancy.* Women of childbearing potential must use effective contraception during treatment and for 1 month after receiving the last dose. **Male patients and their female partners of childbearing potential should be advised that they must use effective contraception during LYNPARZA treatment and for 3 months after receiving the last dose of LYNPARZA. For more information, see full PI. Use during lactation:* Breast feeding should be avoided in women receiving LYNPARZA and for 1 month after the last dose. *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. **INTERACTIONS:** Olaparib co administration with strong and moderate CYP3A inducers or inhibitors is not recommended. 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. Addition of LYNPARZA and other anticancer agents has been shown to potentiate and prolong myelosuppressive side effects. **ADVERSE REACTIONS**: *Very common (≥10%): anaemia, *neutropenia,* decreased appetite, dizziness, headache, dysgeusia, **cough,* vomiting, diarrhoea, nausea, dyspepsia, fatigue; *Common (≥1% to <10%):* thrombocytopenia, leukopenia, **lymphopenia,* rash, stomatitis, upper abdominal pain, increase in creatinine; for other listed adverse reactions, see full PI. **Date of first approval:** 23 May 2018 **Date of Revision:** 7 August 2018.

**Please note changes in Product Information*

Reference: 1. Lynparza Approved Product Information. Lynparza® is a registered trademark of the AstraZeneca group of companies. Registered user AstraZeneca Pty. Ltd. ABN 54 009 682 311. 66 Talavera Road, Macquarie Park, NSW 2113. www.astrazeneca.com.au. For Medical Information enquiries: 1800 805 342 or medinfo.australia@astrazeneca.com. To report an adverse event: 1800 805 342 or via https://aereporting.astrazeneca.com. AU-5997, WL301811, May 2019

AstraZeneca

ANNUAL SCIENTIFIC MEETING PROGRAM

WEDNESDAY 5TH JUNE 2019

9.30am – 10.00am	Registration & Morning Tea	
	Fellows Education Day *Premiers Room*	**Examiners Workshop** *Boardroom 3*
10.00am - 12.00pm	Pathology - **A/Prof Jim Scurry** Rad Onc - **Prof Kailash Narayan**	
12.00pm – 12.30pm	Lunch	
12.30pm – 2.00pm	Med Onc - **Dr Michelle Vaughan**	
2.00pm – 2.30pm	International Fellowship Opportunities and how to prepare for them - **Dr Andrea Garrett & Dr Emma Allanson**	**Examiners Workshop** *Boardroom 3*
2.30pm – 3.00pm	Exam Workshop: The How-to's for the written and oral exam	
3.00pm -3.15pm	Afternoon Tea	
3.15pm - 5.15pm	Mock OSCE - **Dr Deborah Neesham**	"So, you want to be a CGO?" **Dr Andrea Garrett & Dr Archana Rao** *Boardroom 3*

THURSDAY 6TH JUNE 2019

8.00am - 8.30am	Registration	
8.30am - 8.35am	Welcome from Organising Committee & Welcome to Country - **A/Prof Selvan Pather**	
8.35am - 8.40am	Opening of Meeting by ASGO President - **A/Prof Penny Blomfield**	
	SESSION 1: KEYNOTE PRESENTATIONS *Chair: A/Prof Trevor Tejada-Berges*	*James Cook Ballroom*
8.40am - 9.25am	Minimally Invasive Surgery for Early Cervical Cancer. Where are we in 2019? - **A/Prof Kathleen Schmeler**	
9.25am - 10.10am	Setting up a Peritonectomy Unit – The RPA Experience - **Prof Brendon Moran**	
10.10am - 10.40am	Morning Tea & Trade Exhibition	
	SESSION 2: OBESITY AND THE SURGEON *Chair: Prof Martin Oehler*	*James Cook Ballroom*
10.40am - 11.00am	The Impact of Obesity on Gynaecologic Cancer and Surgical Outcomes - **Dr Tom Manolitsas**	
11.00am - 11.20am	Laparoscopic Surgery in Patients with Obesity – Tips and Tricks - **Dr Cecile Bergzoll**	
11.20am - 11.40am	Robotic Hysterectomy in Patients with Obesity – An Evidence Based Outcome - **Dr Peter Lim**	
11.40am - 12.00pm	The Role of Pre-Hysterectomy Bariatric Surgery - **Dr David Yeo**	
12.00pm - 12.20pm	Anaesthetic Aspects in Surgery for Patients with Obesity – "No you cannot have more Trendelenburg" - **Dr Michael Paleologus**	
12.20pm - 12.30pm	Questions	
12.30pm - 1.30pm	Lunch & Trade Exhibition	
	SESSION 3: EARLY RECOVERY AFTER SURGERY (ERAS) *Chair: A/Prof Penny Blomfield*	*James Cook Ballroom*
1.30pm - 1.50pm	ERAS an Evidence Based Intervention - **A/Prof Paul Cohen**	
1.50pm - 2.10pm	ERAS in Gynecologic Oncology Patients - A 10 Year Experience - **Dr Thijs Roelofsen**	
2.10pm - 2.30pm	ERAS and Colorectal Surgery - **Dr Peter Lee**	
2.30pm - 2.50pm	Research Opportunities in ERAS - **A/Prof Alison Brand**	
2.50pm - 3.00pm	Questions	
3.00pm - 3.30pm	Afternoon Tea & Trade Exhibition	
	SESSION 4: THE SURGEON'S WELLBEING *Chair: Dr Greg Gard*	*Sponsored by* Avant mutual *James Cook Ballroom*
3.30pm - 3.50pm	Dealing with Stress - **Dr Louise Nash**	

3.50pm - 4.10pm	Medico-legal Aspects of the MDT - **Allyson Alker**	
	SESSION 5: FELLOWS PRESENTATIONS	
	Chair: Dr Amy Tang	*James Cook Ballroom*
4.10pm – 4.22pm	Validation of the new FIGO cervical cancer staging on women in Queensland - **Dr Shih-Ern Yao (KFP)**	
4.22pm – 4.34pm	Sentinel Lymph Node Biopsy in High Risk Endometrial Cancer; A literature review and the Royal Women's Hospital experience. - **Dr Antonia Jones (KFP)**	
4.34pm – 4.46pm	Sentinel node biopsy for Endometrial cancer staging using the ICG dye: The Western Australian experience. - **Dr King Man Wan (KFP)**	
4.46pm – 4.58pm	Post-treatment HPV surveillance & vaccination - A survey of current practice. - **Dr Kristen Moloney (KFP)**	
4.58pm – 5.10pm	Low grade serous ovarian cancer managed by the Canterbury District Health Board, New Zealand: A 10 year retrospective review. - **Dr Elizabeth Goulding (KFP)**	
5.10pm – 5.22pm	K14 leader cells are enriched in response to chemotherapeutics and mark a population of cells resistant to chemotherapy. - **Dr Nicole Krzys (KFP)**	
5.22pm – 5.34pm	An Australian, Single Cancer Centre study of surgical management outcomes for early stage cervical cancer - **Dr Jennifer Weishaupt**	

FRIDAY 7TH JUNE 2019

7.30am - 8.15am	Breakfast Session	*Sponsored by*
	HPV vaccination in adult women - **Prof Rachel Skinner** The utility of HPV vaccination in women treated for CIN2+ to prevent recurrence - **A/Prof Paul Cohen**	Seqirus™ A CSL Company
8.00am - 8.30am	Trade Exhibition Open	
	SESSION 6: PERITONECTOMY	
	Chair: Dr Deborah Neesham	*James Cook Ballroom*
8.30am - 8.50am	Principles of Surgical Peritonectomy - **Prof Brendan Moran**	
8.50am - 9.05am	Peritonectomy and HIPEC in Ovarian Cancer – The Evidence thus Far - **A/Prof Lewis Perrin**	
9.05am - 9.20am	HIPEC – A Medical Oncologist Perspective - **Dr Kate Mahon**	
9.20am - 9.35am	Peritonectomy and Ovarian Cancer – Scope for National Clinical Trials - **Dr Rhonda Farrell**	
9.35am – 9.55am	Peritonectomy for Pseudomyxoma – The Basingstoke Experience - **Prof Brendan Moran**	
9.55am - 10.30am	Morning Tea & Trade Exhibition	
	SESSION 7: OCCUPATIONAL HEALTH FOR SURGEONS	
	Chair: A/Prof Selvan Pather	*James Cook Ballroom*
10.30am – 10.50am	Prevention of Injury in the Laparoscopic Surgeon - **Margaret Land**	
10.50am – 11.10am	Facilitating the Wellbeing of our Trainees - **Dr Andy Garrett**	
11.10am – 11.30am	Mindfulness for Patients and Health Care Providers - **Michael Dash**	
	SESSION 8: GYNAECOLOGIC ONCOLOGY IN THE DEVELOPING WORLD	
	Chair: A/Prof Trevor Tejada- Berges	*James Cook Ballroom*
11.30am – 11.50am	Gynaecologic Oncology in the Developing World - Can we do more? - **A/Prof Kathleen Schmeler**	
11.50am – 12.10pm	Gynaecologic Oncology Initiatives in the Pacific Region - **Dr Ai Ling Tan**	
	SESSION 9: FREE COMMUNICATIONS	
	Chair: Prof Peter Sykes	*James Cook Ballroom*
12.10pm – 12.22pm	Screening for Lynch Syndrome in women with endometrial Cancer in Auckland, New Zealand. - **Dr Silipa Lock**	
12.22pm – 12.34pm	Patterns of recurrence in Low-Risk Endometrial Cancer- Evidence for a change in follow-up. - **Dr Yael Naaman**	
12.34pm – 12.46pm	Exploring attitudes to conception in partners and young women with gynecological cancers treated by fertility sparing surgery. - **Dr Prue Standen**	
12.46pm – 12.58pm	Accuracy of frozen section for ovarian masses in a single tertiary center. - **Dr Sara Yeoh**	
12.58pm – 1.10pm	HSIL and comorbid lichenoid deramtosis - **Dr Angela Lin**	
1.10pm – 1.20pm	National Gynae Oncology Registry - **Natalie Heriot**	
1.20pm – 2.00pm	Lunch & Trade Exhibition	
2.00pm – 5.00pm	**CRS and HIPEC Workshop**	Free Afternoon in Sydney
3.20pm – 3.40pm	Afternoon Tea	

SATURDAY 8TH JUNE 2019

	Trade Exhibition Open
	SESSION 10: GENETICS *Sponsored by AstraZeneca* *Chair: Prof Peter Sykes* *James Cook Ballroom*
8.00am - 8.15am	Identifying Patients with Genetic Mutations – Role of the Pathologist - **A/Prof Lyndal Anderson**
8.15am - 8.30am	Towards Germline and Somatic Mutation Testing for all Patients - **Dr Annabel Goodwin**
8.30am - 8.45am	Role of Industry in Facilitating BRCA Testing - **Diana Nielson**
8.45am - 9.05am	PARP Inhibitors – An Update - **Dr Michele Vaughan**
9.05am - 9.30am	ANZGOG Trials Update - **Prof Philip Beale**
9.30am - 10.00am	Morning Tea & Trade Exhibition
	TUMOUR BOARD *Chair: Dr Greg Gard* *James Cook Ballroom*
10.00am - 11.20am	Gynaecological Oncologists - **Prof Young Tae Kim/ A/Prof Kathleen Schmeler/ A/Prof Jim Nicklin** Radiologist - **Dr Yu Xuan Kitzing** Pathologist - **A/Prof Lyndal Anderson** Radiation Oncologist - **Prof Kailash Narayan** Medical Oncologist - **Prof Philip Beale**
	SESSION 11: FREE COMMUNICATIONS *Chair: Dr Andrea Garrett* *James Cook Ballroom*
11.20am – 11.32am	Pelvic Anatomy Knowledge among participants of the Anatomy of Complications Workshop (Singapore). - **Dr Nooraishah Yasin**
11.32am – 11.44am	The role of a virtual reality tool to reduce pain and anxiety levels in patients undergoing colposcopy. A pilot study. - **Dr Gaithri Mylvaganam**
11.44am – 11.56am	Retrospective review of sentinel lymph node mapping in endometrial cancer using indocyanine green and near infra-red fluorescence imaging during minimally invasive surgery- Mater Hospital experience. - **Dr Woraphot Chaowawanit**
11.56am – 12.08pm	Evaluation of the accuracy of MRI in staging of low risk endometrial cancers at Waikato Hospital. - **Dr Tina Ngorora**
	SESSION 12: ASGO DEBATE *Moderator: Dr Geoff Otton* *James Cook Ballroom*
12.08pm - 12.45pm	ASGO Debate: Minimally invasive surgery is contra-indicated in patients with early stage cervical cancer - **For: A/Prof Kathleen Schmeler & Dr Simon Hyde** **Against: A/Prof Sam Saidi & Dr Jim Nicklin**
12.45pm - 1.30pm	Lunch
1.30pm - 3.30pm	ASGO AGM
3.30pm	Close of Conference

*Program correct at time of printing and subject to change without notice.

Above: Vivid Light Festival, Courtesy of Destination NSW

POSTERS

1. The "Kangaroo" pouch. Enhancing lymph node retrieval in gynaecological malignancies. - **Dr Antonia Jones**
2. Inguinal nodal metastasis arising from a vulval basal cell carcinoma - **Dr King Man Wan**
3. Endometrial stromal sarcomas and NTRK (Tropomyosin Receptor Kinase) gene fusions: a case report and review of literature. - **Dr Yu-Ting Huang**
4. Hysteroscopic treatment of Uterine tumor resembling ovarian sex cord tumor (UTROSCT): A Case report. - **Dr Alon Tal**
5. A surgical approach to management of a large cervical leiomyoma with fertility preservation. - **Dr Sara Yeoh**
6. A Retrospective Audit of the Management of Atypical Hyperplasia at Waikato Hospital over a 5 year period. - **Dr Tina Ngorora**
7. Coexistence of sarcoidosis and growing teratoma syndrome: a diagnostic challenge (case report). - **Dr Huan Xie**
8. A rare tumours first description in Pregnancy. - **Dr Leon Foster**
9. Ovarian carcinoid tumour resulting in severe valvular heart disease. A Case report and literature review. - **Dr Elizabeth Goulding**
10. Endosalpingiosis in Lymphadenectomies for Endometrial Carcinoma. Mimic of Metastases on both Fluorodeoxyglucose Positron Emission Tomography/Computed Tomography and Sentinel Lymph Node Detection with Indocyanine Green - A Case Report. - **Dr Hong Lim Lee**

2019 ASGO SOCIAL PROGRAM

Wednesday 5th June	**Welcome Reception** Venue: Treasury Room, Intercontinental Sydney Time: 6:00pm – 9:00pm Dress Code: Smart Casual
Thursday 6th June	**Free night in Sydney to enjoy Vivid**
Friday 7th June	**Breakfast Session** (Sponsored by Seqirus with logo) Venue: James Cook Ballroom, Intercontinental Sydney Time: 7:30am – 8:15am Dress Code: Smart Casual
	Casual Dinner Venue: Park Hyatt, Sydney Time: 7.00pm – 10:00pm (Please meet in hotel lobby by 6.45pm to walk to Park Hyatt as a group) Dress Code: Smart Casual
Saturday 8th June	**ASGO Black Tie Dinner** Venue: Intercontinental Sydney Time: 7:00pm – 11:00pm Dress: Cocktail

*Program correct at time of printing and subject to change without notice.

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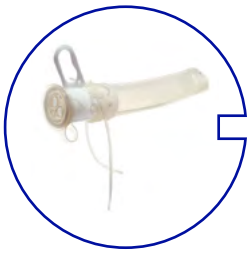
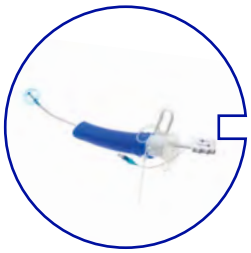
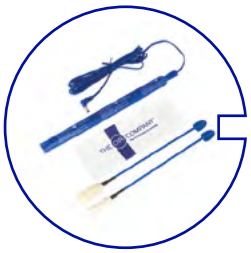


McCARTNEY TUBE™

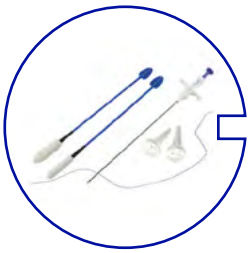
UTERINE ELEVAT O.R. PRO with OccludOR Balloon™



COLPOTOMIZ O.R. TUBE SYSTEM™



SCOPE HELP O.R.™



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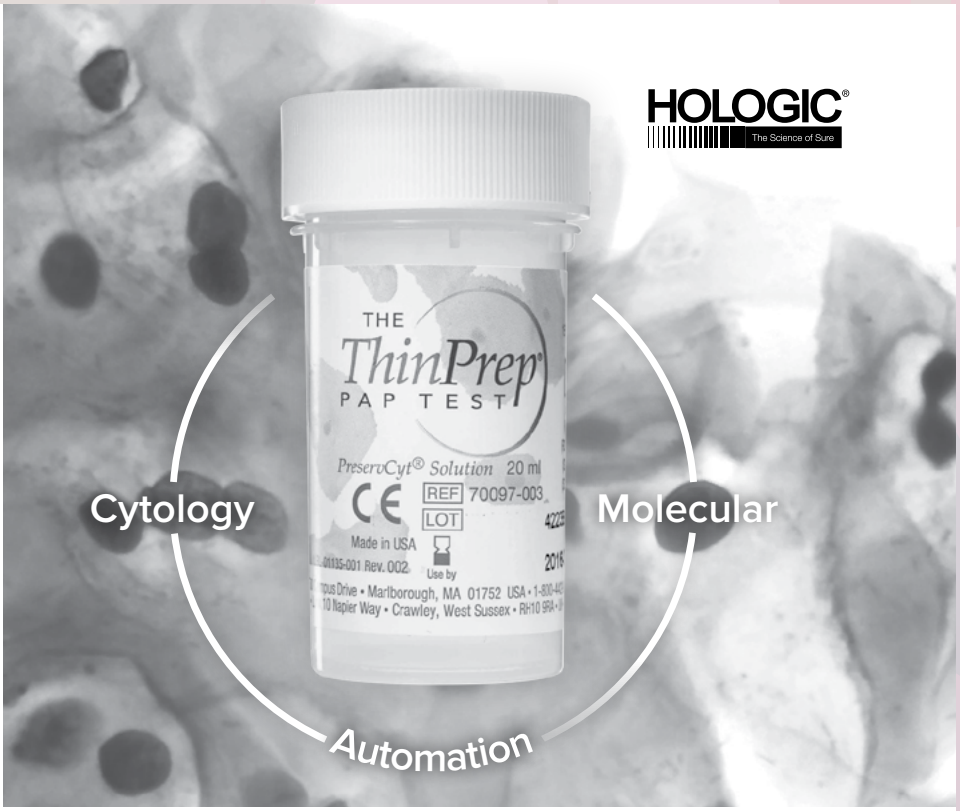

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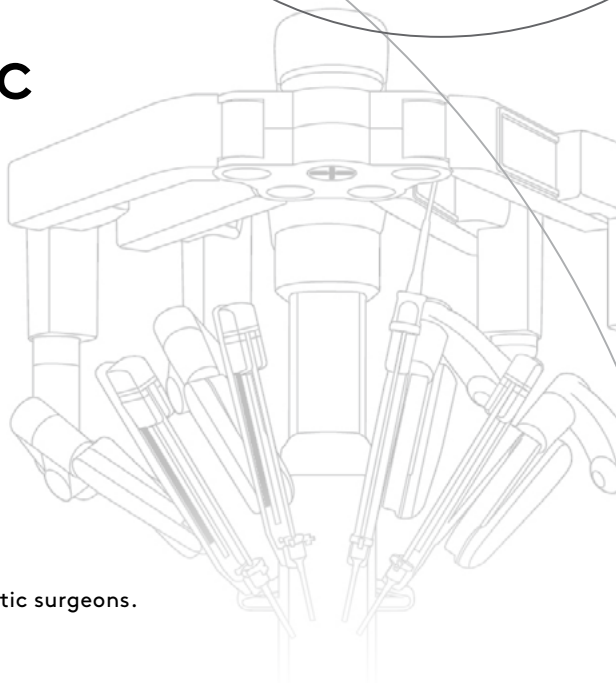

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Thursday 6th June 2019

Session 1: Keynote Presentations

Presenters: A/Prof Kathleen Schmeler & Prof Brendan Moran

Time: 8.40am – 10.10am

Chair: A/Prof Trevor Tejada-Berges

Minimally Invasive Surgery for Early Surgical Cancer. Where are we in 2019?

Kathleen Schmeler[1]

1. The University of Texas MD Anderson Cancer Center, United States

In November 2018, the results of the LACC trial were published in the *New England Journal of Medicine*. This prospective randomized trial compared women with early stage cervical cancer who underwent laparoscopic or robot-assisted radical hysterectomy (minimally invasive surgery) vs. open abdominal radical hysterectomy (open surgery). The results showed minimally invasive radical hysterectomy was associated with lower rates of disease-free survival and overall survival than open abdominal radical hysterectomy, changing the standard of care. In addition, ongoing and recently completed studies (ConCerv, SHAPE) are also evaluating the use of a conservative surgery for women with early stage cervical cancer with favorable pathologic features. The presentation will discuss the findings and implications of these pivotal studies.

NOTES:

Setting up a Cytoreducutive Surgery (CRS) and HIPEC (Hyperthermic Intra Peritoneal Chemotherapy) Program: The RPA Experience.

Brendan Moran[1]

1. Peritoneal Malignancy Unit, Basingstoke, UK

Whilst "Peritonectomy" seems to be an Australian term in common use to encompass the treatment of peritoneal malignancy, peritonectomy is but one element of what the strategy involves. A more comprehensive term, used globally, is CRS (cytoreductive surgery), encompassing removal of macroscopic tumour by a series of peritonectomies and resection of non-vital organs such as the omentum, spleen, gall-bladder, colon, rectum, parts of the small bowel etcetera. In the context of peritoneal malignancy, CRS is generally used in combination with (HIPEC) hyperthermic intra-peritoneal chemotherapy to treat minimal residual small volume and microscopic disease.

Principles

There are a number of key issues mainly around planning

" To fail to plan is to plan to fail"

Key elements include

1. Identifying need, capacity, resources, personnel – This require over- all project management by a senior manager and appropriate clinician. Identifying adequate funding is crucial and often neglected in the enthusiasm to proceed.
2. Training and appointing clinical leaders – they will usually be subspecialty clinicians, predominantly gastro-intestinal tract surgeons or gynaecological oncologists
3. Building a team – A large multisciplinary team is required, encompassing skilled nursing personnel, anaesthetics, theatre management, intensive care, radiology, pathology, oncology, palliative care, administration, research etc.
4. Involving skilled team members form established units – Trying to avoid "Re-inventing the wheel"

In this context a need was identified for a second centre in NSW by NSW Healthcare and units were asked to apply. RPA had an established National and International pelvic exenteration service and by mutual agreement the clinical lead of this service, and I, collaborated in production of a business case, based on similar successful business cases in Birmingham, UK and Dublin, Ireland. After a competitive process the contract was awarded to RPA. Surgeons, anaesthetists, senior nurses and management personnel from RPA travelled to Basingstoke for training and experience, including a one year fellowship for a senior trainee.

The senior advisor travelled to Sydney and registered with the AMC and APRHA and has been able to assist in development, surgical procedures and general oversight and administration. The senior advisor reviews the details of all patients discussed at two weekly MDT and provides written comments and advice by internet prior to MDT discussion.

Ongoing evaluation, training and research has been initiated and is continuing.

NOTES:

Thursday 6th June 2019

Session 2: Obesity and the Surgeon

Presenters: Dr Tom Manolitsas, Dr Cecile Bergzoll, Dr Peter Lim, Dr David Yeo & Dr Michael Paleologus

Time: 10.40am – 12.30pm

Chair: Prof Martin Oehler

The Impact of Obesity on Gynaecologic Cancer and Surgical Outcomes

Tom Manolitsas

Abstract not yet received.

NOTES:

Laparoscopic Surgery in Patients with Obesity – Tips and tricks

Cecile Bergzoll

Abstract not yet received.

NOTES:

Robotic hysterectomy in patients with obesity. Evidence base outcome.

Peter Lim[1]

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

Surgical management for obese women is exceedingly challenging due to the presence of co morbid conditions such as hypertension, diabetes mellitus, obstructive sleep apnea, and hypercholesterolemia. In addition, the body habitus of obese women may limit proper surgical exposure thus preventing the intended procedure to be accomplished. Open gynecologic surgery in obese women for benign and malignant conditions is often associated with increased risk for surgical site infection, venous thromboembolism, wound complications, possible intraoperative organ injury and latent complications such as incisional hernias. The role for minimally invasive surgery in obese patient is quite appealing as it is often associated with shorter hospitalization and faster recovery which minimizes intraoperative and postoperative complications. Vaginal hysterectomy is the optimal minimal invasive surgical procedure for obese women provided that the pathology lends itself to be successfully completed. However, surgical management for large fibroids, pelvic masses, endometrial and cervical cancers may not be amenable to a vaginal approach thus laparoscopic or robotic approaches are alternative minimally invasive surgical modalities. An evidence based outcome for the role of robotic hysterectomy in obese patients for management of benign and malignant conditions will be presented.

NOTES:

The Role of Pre-Hysterectomy Bariatric Surgery

David Yeo

Abstract not yet received.

NOTES:

Anaesthetic Aspects in Surgery for Patients with Obesity - "No you cannot have more Trendelenburg"

Michael Paleologos[1]

1. Royal Prince Alfred Hospital, Sydney, Australia

Approximately one third of the Australian adult population is obese, with 3% morbidly obese. By 2025 it is predicted that 15% of the female population will be morbidly obese. Obesity is a recognised risk factor for a number of cancers; of particular relevance to the female population, endometrial and ovarian cancer. Therefore, a significant proportion of the patients presenting with these malignancies are obese. It is well established that minimal access surgery (laparoscopic and robotic) offers improved outcomes for obese patients requiring surgery for these malignancies (less blood loss, less transfusion, lower analgesia requirements, fewer wound infections, earlier mobilisation and resumption of oral intake, and shorter LOS). There are a number of physiological changes associated with obesity that superimpose upon the physiologic stresses of the pneumoperitoneum and Trendelenburg positioning. The combination of these factors increase the difficulties of managing the patients intra-operatively and increase the risks of post-op cerebral oedema, airway compromise, neuropathies and visual deficits. Although these complications are rare, they can be devastating for the patient. Understanding the physiological perturbations helps the clinician to adjust practice in an attempt to minimise the risk. Moreover, an appreciation of the higher baseline risk of obese and morbidly obese patients assists with stratifying patients for higher level care post-operatively. Suggested strategies for reducing the physical and physiological stress placed on the patient include care with positioning, using the minimum degree of Trendelenburg required (visualisation during Trend positioning Trend), adjusting the Trendelenburg during the operation once practical to do so, utilising good neuromuscular blockade to facilitate the minimum degree of intra-abdominal pressure, and having the most experienced surgeon undertake the operation. Finally the diagnosis of a malignancy offers a “teachable moment” for patients, where recommendations regarding diet, exercise, smoking and weight loss are more likely to be adhered to, and will further reduce the peri-operative risk if given enough time to be effective pre-operatively.

Suggested Reading:

1. Robotic Surgery in Supermorbidly Obese Patients with Endometrial Cancer. Stephan JL, *et al*. American Journal of Obstetrics and Gynaecology 2015;213:49 e1-8
2. Obesity in Laparoscopic Surgery. Afors K, *et al*. Best Practice and Research Clinical Obstetrics and Gynaecology 2015;29:554-64
3. Trendelenburg Position in Gynecologic Robotic-Assisted Surgery. Ghomi A, *et al*. Journal of Minimally Invasive Gynecology 2012;19:485-9
4. Blinded Measure of Trendelenburg Angle in Pelvic Robotic Surgery. Gould C, *et al*. Journal of Minimally Invasive Gynecology 2012 19:465-8
5. Controversies in Perioperative Anesthetic Management of the Morbidly Obese: I am a Surgeon, Why Should I Care? Obesity Surgery 2015;25:879-87
6. Complications of Robotic-Assisted Laparoscopic Surgery Distant from the Surgical Site. Maerz *et al*. British Journal of Anaesthesia 2017;118:492-503

NOTES:

Thursday 6th June 2019

Session 3: Early Recovery after Surgery (ERAS)

Presenters: A/Prof Paul Cohen, Dr Thijs Roelofsen, Dr Peter Lee & A/Prof Alison Brand

Time: 1.30pm – 3.00pm

Chair: A/Prof Penny Blomfield

ERAS an Evidence Based Intervention

Paul Cohen

Abstract not yet received.

NOTES:

Enhanced recovery after open gynecological surgery: A 10 year experience

Thijs Roelofsen[1], Jonathan Carter[1]

1. Lifehouse Gynecological Oncology Group, Sydney, Australia

Objective

The purpose of this study was to determine patient and surgical factors that may allow ultra early hospital discharge and to evaluate outcome regarding complications and hospital readmissions in patients undergoing open surgery for suspected or confirmed gynecological malignancy who were managed according to a standardized ERAS protocol.

Methods

Patients managed by the ERAS protocol after open surgery in a tertiary gynecological oncology center in the period between January 2008 and October 2018 were included. Data on patient characteristics were collected prospectively. Regression analyses were used to investigate the association of patient and surgical characteristics and length of stay (LOS), complications and hospital readmissions.

Results

During the study period 702 patients were included of which 77.2% were discharged home within 3 days and 52.3% of patients were suitable for "ultra early discharge" within 2 days after surgery. Mean length of stay was 3.4 days with a 6.4% complication rate and 3.6% hospital readmission rate. Using multivariable analyses, age, operating time and malignancy on final histopathology were significantly and independently associated with LOS > 2 days. Furthermore, age, BMI, operating time and LOS > 3 days were significantly and independently associated with complications whereas lymphadenectomy and total amount of blood loss were significantly and independently associated with hospital readmission.

Conclusion

Over 50% of all patients were suitable for ultra early discharge after open gynecological surgery. Advanced age, extended total operating time, lack of using Cox-2 inhibitors and malignancy on final histopathology were significantly and independently associated with a prolonged LOS > 2 days. Ultra early discharge within 2 days after surgery was not associated with an increased risk for complications or hospital readmissions.

NOTES:

ERAS and Colorectal Surgery

Peter Lee

Abstract not yet received.

NOTES:

Research Opportunities in ERAS

Alison Brand

Abstract not yet received.

NOTES:

Thursday 6th June 2019

Session 4: The Surgeon's Wellbeing (Sponsored by Avant)
Presenters: Dr Louise Nash & Allyson Alker
Time: 3.30pm – 4.10pm
Chair: Dr Greg Gard

Dealing with Stress

Louise Nash

Abstract not yet received.

NOTES:

Medico-legal Aspects of the MDT

Allyson Alker

Abstract not yet received.

NOTES:

Thursday 6th June 2019

Session 5: Fellows Presentations

Presenters: Dr Shih-Ern Yao, Dr Antonia Jones, Dr King Man Wan, Dr Kristen Moloney, Dr Elizabeth Goulding, Dr Nicole Krzys & Dr Jennifer Weishaupt

Time: 4.10pm – 5.34pm

Chair: Dr Amy Tang

Validation of the new FIGO cervical cancer staging on women in Queensland

Shih-Ern Yao[1]

1. Queensland Centre for Gynaecological Cancer, Herston, QLD, Australia

In 2018, FIGO introduced an updated cervical cancer staging system which expanded on the longstanding clinical staging system. The inclusion of high-level radiological imaging and pathological diagnosis has the potential to change work-up, assessment and treatment options for women referred to units with access to such resources. We have conducted a retrospective audit on cervical cancer cases over the past 10 years at the QCGC investigating the impact which the new FIGO cervical cancer staging has on management decisions, including imaging preference and surgical case selection.

NOTES:

Sentinel Lymph Node Biopsy in High Risk Endometrial Cancer; A literature review and the Royal Women's Hospital experience.

Antonia Jones[1], **Yael Naaman**[1], **Tony Richards**[1], **Deborah Neesham**[1], **Orla McNally**[1]

1. Gynaecology Oncology, RWH, Melbourne, Vic

This talk aims to summarise the current literature on sentinel lymph node biopsy (SLNBx) in high risk endometrial cancer (HR EC) and present the Royal Women's Hospital data to date.

Numerous studies have demonstrated the feasibility, safety and efficacy of SLNBx in apparent stage I low risk endometrial cancer, however the efficacy in high risk endometrial cancer is less established (where the risk of lymphatic metastasis is higher and so concern exists that the false negative rate might be underestimated in this patient population). Early data, however, suggest high sentinel lymph node detection rate and NPV with increased nodal positively with a sentinel lymph node approach (versus standard pelvic lymphadenectomy).

Since the introduction of SLNBx at the RWH in 2015, over 250 women with endometrial cancer have had the SLN algorithm1. We present the detection rate per patient and assess the proportion of patients adequately staged and the impact of SLNBx on staging compared to conventional methods.

Questions remain including whether there is any benefit in favour of systemic lymphadenectomy after positive SLN and the optimal regimen of adjuvant therapy.

Sentinel node biopsy for Endometrial cancer staging using the ICG dye: The Western Australian experience.

King Man Wan[1], Lachlan Baxter[1], Chloe Ayres[1], Yee Leung[1], Paul Cohen[1], Raj Mohan[1]

1. Gynaecologic Oncology, King Edward Memorial Hospital, Perth, WA, Australia

Since the publication of FIRES Trial in March 2017, sentinel lymph node biopsies for endometrial cancer staging is being widely practised in various Gyn Onc centres around Australia.The role of pelvic lymphadenectomy in the management of patients with endometrial cancer is however still controversial.In WA we utilise frozen sections intra-operatively for the assessment of depth of invasion which helps decide whether pelvic lymphadenectomy is performed for low to intermediate grade cancers. Pelvic lymphadenectomy has generally been performed for all high grade cancers in our centre.Since December 2018 we have been performing sentinel lymph node biopsies for all our patients and we report our initial experience.

NOTES:

"Post-treatment HPV surveillance & vaccination - A survey of current practice"

Kristen L Moloney[1], Rachel O' Sullivan[1]

1. Department of Gynaecologic Oncology, John Hunter Hospital , Newcastle, NSW, Australia

For those patients in whom cervix cancer is treated with curative intent, a schedule of follow-up or post-treatment surveillance is usually recommended. This follow-up aims at early detection of recurrence with a view to improving survival[1]. Whilst a number of international guidelines are available recommending approaches to surveillance[2,3,4,5], a paucity of evidence for benefit remains. Neither a guideline, nor consensus statement, is currently available in Australia.

Cervico-vaginal cytology is often incorporated into surveillance regimens, but is limited in both specificity/sensitivity as well as evidence for benefit. Additionally, interpretation of cytology on specimens collected from the irradiated field is difficult. Post-treatment surveillance of pre-invasive squamous disease has taught us that negative HPV co-testing or 'test-of-cure' equates to low risk of recurrence, thus the National Cervical Screening Program recommendation for return to normal screening after two consecutive negative co-tests[6].

HPV co-testing may also have utility in follow-up of invasive disease. Evidence is emerging to suggest that persistence of high-risk sub-types is predictive of disease recurrence[7,8].

We present the results of our survey delivered to CGO's and Fellows across Australia and New Zealand. The results of this survey will provide a platform for review of current practices in post-treatment surveillance and discussion around the evidence for such practice. We anticipate identifying the need for a consensus statement regarding cervical cancer follow-up, and intend for our results to inspire contemporaneous discussion around incorporation of HPV co-testing in such a regimen.

Finally, evidence for the role of HPV vaccination post-treatment of pre-invasive disease is emerging[9]. Results of our survey will indicate current uptake of this practice.

NOTES:

Low grade serous ovarian cancer managed by the Canterbury District Health Board, New Zealand: A 10 year retrospective review

Elizabeth A Goulding[1], Bryony Simcock[1], Peter Sykes[1], Carrie Innes[1], Rachael van der Griend[1]

1. Christchurch Hospital, Christchurch, CANTERBURY, New Zealand

Low grade serous ovarian cancer (LGSOC) and high grade serous ovarian cancer (HGSOC) have different clinical and molecular pathways. Pivotal clinical trials predominantly represent HGSOC and women are typically managed comparably.[1] It is important to recognise LGSOC distinctly as clinical course, optimal management, and therapeutic targets differ.

Retrospective analysis of data from women with LGSOC managed by the Canterbury District Health Board multi-disciplinary meeting (2008-2018) was undertaken (n=36). Central histopathology review was performed to confirm diagnosis. Women had a mean age of 56.7 years at diagnosis; ethnicity was 75% NZ European, 8% European, 8% Maori, 5% Fijian, 2% African; 66.6% had stage III disease; 83% had an elevated Ca125 (mean 363.8); 100% had surgery, 86.1% were staged (52.8% without LND), 41.6% had residual disease; 63.9% had adjuvant therapy, 40.6% had chemotherapy (all <2016) and 31.25% hormonal therapy. For those with 5 years follow-up (n=19), five-year survival was 58%. Trends of Ca125 in relation to disease progression and treatment were also analysed.

1. 1. Kaldawy A., Segev Y., Lavie O., et al. Low-grade serous ovarian cancer: A review. Gynecologic Oncology 2016; 143: 433-438.

NOTES:

K14 leader cells are enriched in response to chemotherapeutics and mark a population of cells resistant to chemotherapy.

Nicole Krzys[1]

1. Monash Health, Richmond, VICTORIA, Australia

K14 leader cells are enriched in response to chemotherapeutics and mark a population of cells resistant to chemotherapy.

Dr Nicole Krzys, Dr Andrew Stephens, Dr Maree Bilandzic, Professor Tom Jobling.

Hudson Institute of Medical Research and Monash Health

Background: Cytokeratin 14 (K14) is an intermediate filament protein, expressed in a subpopulation of epithelial ovarian cancer (EOC) cells termed "Leader Cells" (LCs) which are located peripherally on cancer spheres. At ASGO 2018 we presented early data demonstrating that EOC cells with K14 knockouts ($K14^{KO}$), lack the capacity to migrate and metastasize within mouse peritoneum. Further characterising K14+ LCs may therefore present novel therapeutic targets for EOC.

In more recent studies, this group has shown that increased K14 expression is negatively associated with progression-free survival and response to therapy in ovarian cancer patients. Similar correlations are observed across multiple epithelial tumour types, with K14 expression enriched in chemoresistant breast and bladder cancer cells. At ASGO 2019 we would like to present the results of a series of experiments demonstrating that it is the K14+/LC sub-population which are enriched in response to chemotherapy, resistant to treatment and are able to repopulate following chemotherapeutic intervention.

Methods and Results: By flow cytometry we demonstrate the K14+ subset of cells accounts for 1-15% of the total cell population and co-expresses known chemo resistance and immune suppression markers STAT3 and PDL1 **(FIG1A)**.

Using immune-fluorescent tagged K14 cell lines under both 2D and 3D culture conditions we show K14+ cells are significantly enriched in response to cisplatin treatment **(FIG1B)**. We further demonstrate this enriched K14+ population are less susceptible to platinum drug-induced death, with apoptotic cells exclusively K14 negative in 2D and 3D culture **(FIG1B)**. The overexpression of K14 ($K14^{OE}$) rendered cells 2-fold more resistant to cisplatin over the wild type (WT) cell line, conversely $K14^{KO}$ lines had a 2-fold greater sensitivity to cisplatin over the WT control **(FIG1C)**. Long-term real time cell assay assessments demonstrated both WT and $K14^{OE}$ cell lines assume a recovery profile following chemotherapeutic treatment, a profile that is not observed for the $K14^{KO}$ lines which fail to recover **(FIG1D)**.

Conclusions: K14 marks a subpopulation of ovarian cancer cells that plays a significant role in metastatic potential and chemoresistance. K14 may serve as an attractive target to monitor treatment response and disease recurrence. Targeting the K14 subpopulation has promising potential as a therapeutic target to prevent metastatic spread and to reduce chemoresistant relapse in ovarian cancer patients.

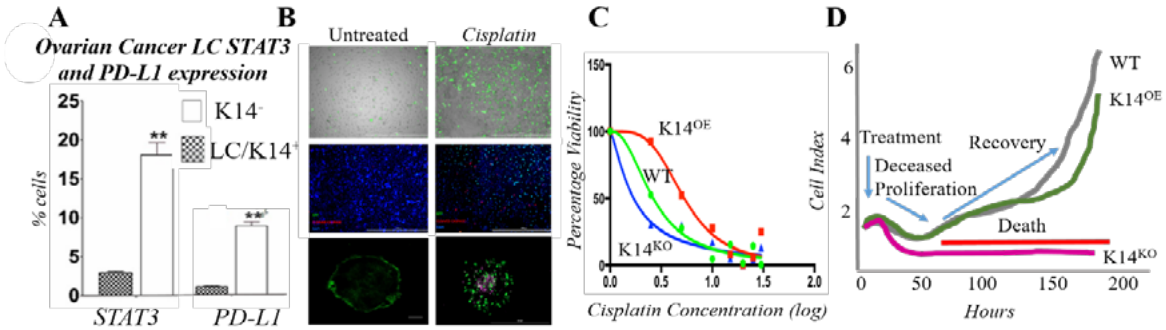

Figure 1. K14+ cells are enriched in response to chemotherapy and are associated with suppressive immune profiles *in vivo*. A) $K14^{+}$ cells co-express PD-L1 and STAT3. **B)** Chemotherapy enhances K14+/LC expression in both monolayer and spheroid culture. Apoptotic cells (purple) do not express K14**. C)** Chemosensitivity assays demonstrate $K14^{KO}$ cells are more sensitive to chemotherapy over WT and overexpressing lines**. D)** $K14^{KO}$ cells do not assume a recovery profile following chemotherapy treatment.

NOTES:

An Australian, Single Cancer Centre study of surgical management outcomes for early stage cervical cancer.

Jennifer Weishaupt[1], Jonathan Carter[1], Sam Saidi[1], Selvan Pather[1], Trevor Tejada-Berges[1]

1. Gynaecology Oncology, Chris O'Brien Lifehouse, the University of Sydney, Camperdown, Sydney, NSW, Australia

Objective:

The Laparoscopic Approach to Cervical Cancer (LACC) trial by Ramirez et al, is the first phase 3 randomized, multicentered trial to compare oncologic outcomes associated with minimally invasive vs abdominal radical hysterectomy for treatment of early cervical cancer. The purpose of our study was to critically evaluate the replicability of these findings in our patients and review clinical practice for all early cervical cancer treatment.

Methods:

Eligibility criteria included all early stage (1A1 with LVSI,1A2, 1B1) cervical cancer women planned for surgery between January 2008 and December 2018 at our tertiary cancer center. Data was retrieved from a prospectively collected database.

Results:

Forty-six women were eligible and of the 42 women included, most women (90.5%) had stage 1B1 disease, 24 had a squamous cell carcinoma, 15 had an adenocarcinoma and 3 had an adenosquamous carcinoma of the cervix with a median age of 45 years.

8 total laparoscopic radical hysterectomies, 27 abdominal radical hysterectomies,6 abdominal radical trachelectomies and 1 robotic radical trachelectomy were performed with a mean follow-up of 4.8 years (range, 6months-10 years). All 42 women had a pelvic lymph node dissection, 9 women had nodal metastases and 14 patients received adjuvant chemoradiation.

Two of the 8 women (25%) in the laparoscopic radical hysterectomy group had a recurrence. Both had adenocarcinoma, stage 1B1 disease. No recurrences in the abdominal radical hysterectomy group or fertility sparing, radical trachelectomy groups. There were two successful live births.

Conclusion:

Our data has reflected the results of the LACC trial, that minimally invasive surgery was associated with a lower disease-free survival than the abdominal radical hysterectomy group.

1. Ramirez PT et al. Minimally Invasive versus Abdominal Radical Hysterectomy For cervical Cancer. N Engl J Med 2018; 379: 1895-1904

NOTES:

Friday 7th June 2019

Breakfast Session (Sponsored by Seqirus)
Presenters: Prof Rachel Skinner & A/Prof Paul Cohen
Time: 7.30am – 8.15am
Session Chair: Dr Deborah Neesham

HPV vaccination in adult women

Rachel Skinner

NOTES:

The utility of HPV vaccination in women treated for CIN2+ to prevent recurrence

Paul Cohen

NOTES:

Friday 7th June 2019

Session 6: Peritonectomy

Presenters: Prof Brendan Moran, A/Prof Lewis Perrin, Dr Kate Mahon & Dr Rhonda Farrell

Time: 8.30am – 9.55am

Session Chair: Dr Deborah Neesham

Principles of CRS (Cytoreducutive Surgery) and HIPEC (Hyperthermic Intra Peritoneal Chemotherapy) for Peritoneal Malignancy

Brendan Moran[1]

1. Peritoneal Malignancy Unit, Basingstoke, UK

Whilst "Peritonectomy" seems to be an Australian term in common use to encompass the treatment of peritoneal malignancy, peritonectomy is but one element of what the strategy involves. A more comprehensive term, used globally, is CRS (cytoreductive surgery), encompassing removal of macroscopic tumour by a series of peritonectomies and resection of non-vital organs such as the omentum, spleen, gall-bladder, colon, rectum, parts of the small bowel etcetera. In the context of peritoneal malignancy, CRS is generally used in combination with (HIPEC) hyperthermic intra-peritoneal chemotherapy to treat minimal residual small volume and microscopic disease.

Basic principle "Decisions more important than incisions"

Principles

Pre-op

1. Full history, clinical examination and appropriate haematological and imaging investigations. Awareness that neither CT, MRI nor PET-CT accurately stages low volume disease.
2. Consent of the patient and full disclosure of risks and benefits to the patient and next of kin. This includes risk of mortality of 1-2% even in experienced units, significant morbidity in 10-20% and possibility of a prolonged ITU or hospital stay. The possible need for a stoma is outlined and pre-op marking of optimal stoma sites.
3. Anaesthetic assessment and pre-op optimization

Intra- op

1. Full midline incision
2. Assessment of whole peritoneal cavity.
3. Up to 6 peritonectomy procedures and organ resections as needed
4. HIPEC administration
5. Re-construction of bowel if appropriate and stoma if needed
6. Careful closure of abdominal wound "Closure time is not coffee time"

Post-op

1. ITU or HDU management
2. High index of suspicion for post-op complications such as bleeding and sepsis- liberal use of appropriate imaging
3. Full organ support including parenteral nutrition routinely

Team work is crucial and to "Fail to plan is to plan to fail"

NOTES:

Peritonectomy and HIPEC in Ovarian Cancer – The Evidence thus Far

Lewis Perrin

Abstract not yet received.

NOTES:

HIPEC – A Medical Oncologist's Perspective

Kate Mahon[1]

1. The Chris O'Brien Lifehouse, Camperdown

Heated intraperitoneal chemotherapy at the time of cytoreductive surgery has been employed for over 2 decades in the management of a range of malignancies. This talk will provide an overview of the cytotoxic agents used and their biological activity with a particular focus on ovarian cancer. Promising novel agents for future study will also be discussed.

NOTES:

Peritonectomy and Ovarian Cancer – Scope for National Clinical Trials

Rhonda Farrell

Abstract not yet received.

NOTES:

Peritonectomy for Pseudomyxoma – The Basingstoke Experience

Brendan Moran

Abstract not yet received.

NOTES:

Friday 7th June 2019

Session 7: Occupational Health for Surgeons
Presenters: Margaret Land, Dr Andy Garrett & Michael Dash
Time: 10.30am – 11.30am
Session Chair: A/Prof Selvan Pather

Prevention of injury in the laparoscopic surgeon

Margaret Land[1]
1. NSW, Australia

This presentation will provide a brief overview of the importance of setting up the theatre environment to suit you the surgeon. I will then provide some tips and exercises to ensure your longevity in what we know is a very physically demanding form of surgery.

NOTES:

Facilitating the Wellbeing of our Trainees

Andy Garrett

Abstract not yet received.

NOTES:

Mindfulness for Patients and Health Care Providers

Michael Dash[1]

1. Concord Hospital, Concord, NSW, Australia

This presentation will provide a brief overview of the history and development of mindfulness based interventions. Core proposed mechanisms of mindfulness such as decentering will be outlined as well as results from recent meta-analyses and systematic reviews of the application of mindfulness within health care settings.

NOTES:

Friday 7th June 2019

Session 8: Gynaecologic Oncology in the Developing World

Presenters: A/Prof Kathleen Schmeler & Dr Ai Ling Tan

Time: 11.30am – 12.10pm

Session Chair: A/Prof Trevor Tejada- Berges

Gynaecologic Oncology in the Developing World – Can we do more?

Kathleen Schmeler[1]

1. The University of Texas MD Anderson Cancer Center, ., United States

In May 2018, the Director-General of the World Health Organization (WHO) announced a global call to action towards the elimination of cervical cancer. The focus of this initiative is on low- and middle-income countries (LMICs), where >85% of cervical cancer cases occur. Current challenges include limited screening coverage, lack of public education and few health care providers trained to diagnose and treat precancerous lesions. In addition, many of the women who test positive are being lost to follow-up and not receiving the necessary procedures to diagnose and treat precancerous lesions. As a result, cervical cancer rates in LMICs remain high and the majority of women present with advanced stage disease with limited options for treatment or palliative care. This presentation will focus on initiatives by the WHO, MD Anderson Cancer Center, the International Gynecologic Cancer Society (IGCS) and others to address the global cervical cancer burden. This will include innovative approaches to improving access to screening; training and education programs; and new technologies for cervical cancer screening and diagnosis for LMICs.

NOTES:

Gynaecologic Oncology Initiatives in the Pacific Region

Ai Ling Tan

Abstract not yet received.

NOTES:

Friday 7th June 2019

Session 9: Free Communications

Presenters: Dr Silipa Lock, Dr Yael Naaman, Dr Prue Standen, Dr Sara Yeoh & Dr Angela Lin

Time: 12.10pm – 1.10pm

Session Chair: Prof Peter Sykes

Screening for Lynch Syndrome in women with endometrial Cancer in Auckland, New Zealand

Silipa Lock Sam Naiqiso[1], Joanne Moses[2], Ai Ling Tan[3]

1. Royal Hospital for Women, Randwick, NSW, Australia

2. Anatomic Pathology Service LabPLUS, Auckland District Health Board, Auckland, New Zealand

3. Department of Gynaecology Oncology, Auckland District Health Board, Auckland, New Zealand

Introduction

Universal testing for Lynch Syndrome (LS) for endometrial cancer (EC) patients was introduced in Auckland, NZ in January 2017. This study assesses the results of the first 19 months post implementation.

Method

This is a retrospective study of all consecutive women referred with a new diagnosis of EC to our Centre from 1/1/17 to 31/12/18. Data was extracted from electronic records. Descriptive statistics were performed.

Results

Results from 1/1/17 to 1/8/19, N=362 diagnosed with EC, 81.5% (n=295/362) underwent MMR IHC testing, 14.6% (43/295) had abnormal MMR IHC result, followed by MLH1 promoter methylation testing in 55.8% (n= 24/43 with MLH1/PMS2 loss). 11 patients were referred to the Genetic clinic and Germline testing was performed in 8 cases. LS confirmed in 6 patients (2%).

Conclusion

Preliminary results of Lynch Syndrome in our population is comparable to other populations.[1 2] Implementation of universal screening has improved with education of all stakeholders.

Patterns of recurrence in Low-Risk Endometrial Cancer- Evidence for a change in follow-up.

Yael Naaman[1], Taylor Hodge[1], Anthonia Jones[1], Tony Richards[1], Deborah Neesham[1], Orla McNally[1]

1. The Royal Women's Hospital, melbourne, Victoria., Parkville, VICTORIA, Australia

Objective: To describe the patterns of recurrence in low-risk endometrial cancer and provide reassurance for a non-hospital-based follow-up program for women with increasingly common cancer.

Methods: All patients with low-risk endometrial cancer (FIGO 2009 stage 1A, grade 1-2) from 1981 to July 2018 after primary surgery were retrospectively audited using electronic databases and review of clinical notes. Demographics, site of recurrence, salvage treatment and long-term outcomes were analysed.

Results: 1577 patients with stage I endometrial cancer were identified. Final results to follow and to be presented at the 2019 ASGO conference.

NOTES:

Exploring attitudes to conception in partners and young women with gynecological cancers treated by fertility sparing surgery

Prue Standen[1, 2], Paul Cohen[3, 6, 4, 5], Yee Leung[2], Raj Mohan[2], Stuart Salfinger[3], Jason Tan[7], Caroline Bulsara[5]

1. Department of Obstetrics and Gynaecology, Western Health, Sunshine, VIC, Australia

2. King Edward Memorial Hospital, Subiaco, WA, Australia

3. St John of God Subiaco, Subiaco, WA, Australia

4. Division of Obstetrics and Gynaecology, Faculty of Medicine and Health Sciences, Crawley, WA, Australia

5. Institute for health research, University of Notre Dame, Fremantle, WA, Australia

6. King Edward Memorial Hospital, Subiaco, WA, Australia

7. WOMEN Centre, West Leederville, WA, Australia

Introduction: Approximately 20% of women diagnosed with a gynecological cancer are under 40 years of age and fertility preservation is a priority for many of these patients. With delayed childbearing, many women may be diagnosed before their first pregnancy. We aimed to explore attitudes to conception in partners and young women, following fertility preserving treatment for gynecological cancers.

Methods: A total of 16 telephone interviews were conducted with a purposive sample of patients who had had an early stage gynecological cancer treated by fertility sparing surgery in Western Australia between January 1st, 2005 to December 31st, 2016. The interviews were audio recorded and transcribed. Thematic analysis was performed.

Results: 5 main themes were identified: Emotions at diagnosis and perception of information given; Decisions regarding treatment; Fertility and factors affecting childbearing; Role of partners in decision making and relationship pressures; Overall experience and regret.

Discussion: Regret and relationship breakdown were commonly reported.

Practice Implications: Women need appropriate support including inviting their partners into the clinic. Some women may need several appointments prior to treatment as there is a high rate of regret amongst women who opt for completion surgery.

NOTES:

Accuracy of frozen section for ovarian masses in a single tertiary center

Sara Yeoh[1, 2], Vanessa Bowden[1], Sarah Cuddihy[1], Carrie Innes[1], Peter Sykes[1], Rachael van der Griend[1], Dianne Harker[1], Bryony Simcock[1]

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

2. Royal Adelaide Hospital, Adelaide, SOUTH AUSTRALIA, Australia

Ovarian masses are common, but it can be difficult to determine whether they are benign or malignant prior to surgery, despite investigation with multiple imaging modalities and tumour markers. A frozen section is an intra-operative procedure that provides a preliminary diagnosis. Therefore, we can perform or avoid unnecessary surgical staging in one procedure.

Previous studies show a sensitivity of 90% and specificity of 99.5% for frozen sections on ovarian masses[1,2,3]. However, there is less accuracy with borderline and mucinous tumours[1]. We need to recognise the limitations of frozen sections as misdiagnosis can lead to understaging or overstaging.

This is a retrospective review to determine the accuracy of frozen section in our institution and evaluate which factors lead to better accuracy, to aid the clinical decision making process and appropriately counsel patients. This presentation includes a brief survey on the use of frozen section in Australia/New Zealand and a literature review.

1. Ratnavelu ND, Brown AP, Mallet S, Scholten FJ, Patel A et al. Intraoperative frozen section analysis for the diagnosis of early stage ovarian cancer in suspicious pelvic masses. Cochrane Database syst rev. 2016 March
2. Abdudukadeer A, Azam S, Zunong B, Mutailpu AZ, Huijun B et al. Accuracy of intra-operative frozen section and its role in diagnostic evaluation of ovarian tumours. Eur J Gynaecol Oncol. 2016:37(2):216-20
3. Md Arhad NZ, Ng BK, Md Paiman NA, Abdullah Mahdy Z, Modh Noor R. Intra-operative frozen sections for ovarian tumours - A tertiary center experience. Asian Pac J Cancer Prev. 2018 Jan 27:19(1):213-18

HSIL and comorbid lichenoid deramtoses

Angela Lin[1], Tania Day[1], Jim Scurry[1, 2]

1. John Hunter Hospital, Hunter New England Health, New Lambton, NEW SOUTH WALES, Australia

2. Pathology North, New Lambton, NSW, Australia

Objective: Describe high grade squamous intraepithelial lesion (HSIL) of the lower genital tract (LGT) comorbid with lichen sclerosus (LS) and/or lichen planus (LP).

Study design: Inclusion required specimens obtained during 2008-2019 that yielded HSIL of the LGT supported by p16, and vulval LS and/or LP. p53 was obtained on archived blocks.

Results:

Of 36 cases, disease was separate in 36% and co-located in 64%. LS was present in 75%, comorbid LS and LP in 14%, and erosive LP in 11%. HSIL morphology was basaloid in 80%, keratinising in 14%, and differentiated VIN-like in 6%. HSIL displayed basal layer degeneration in 11% and sclerosis in 25%. p16 was nuclear block-positive in 94%; 2 cases had cytoplasmic staining and positive HPV 16/18 DNA. The p53 pattern was suprabasilar-dominant in 79% or diffuse in 21%.

Conclusion:

HSIL comorbid with LS/LP demonstrates several morphologic variants, making p16 and p53 essential components of pathologic assessment.

NOTES:

National Gynae Oncology Registry

Natalie Heriot

NOTES:

Saturday 8th June 2019

Session 10: Genetics (Sponsored by AstraZeneca)

Presenters: Prof Lyndal Anderson, Dr Annabel Goodwin, Diana Nielson, Dr Michele Vaughan & Prof Philip Beale

Time: 8.00am – 9.30am

Session Chair: Prof Peter Sykes

Identifying Patients with Genetic Mutations - Role of the Pathologist

Lyndal Anderson[1]

1. Royal Prince Alfred Hospital, Sydney, Camperdown, NEW SOUTH WALES, Australia

The Pathologist plays a critical role in tumour diagnosis and identification of appropriate patients for genetic testing. We will briefly touch on three scenarios by way of example.

BRCA mutations are associated with around 20% of all high grade serous ovarian carcinomas of fallopian tube, ovary or primary peritoneal origin and may be associated with a readily identifiable precursor lesion termed serous tubal in-situ carcinoma (STIC). All patients <70 years of age with high grade serous (non-uterine) carcinomas should be considered for BRCA testing, with the suspicion increasing for serous tumours with atypical clear cell areas.

Lynch syndrome accounts for around 3% of all endometrial and ovarian cancers. Screening can be performed by the pathologist with use of the mismatch repair enzymes MLH1, PMS2, MSH2 and MSH6. In many cases the gynaecological malignancy precedes the development of other malignancies such as colon cancer by up to 5 years and can guide effective ongoing patient surveillance.

Hereditary leiomyomatosis renal cell carcinoma (HLRCC) syndrome is a recently recognized phenomenon. Appropriate identification of suggestive morphological features in atypical leiomyomas can guide referral to a familial cancer care service for testing of fumarate hydratase gene deficiency. The diagnosis of the deficiency in the uterine tumour may precede the development of a renal cell carcinoma.

Effective team communication between surgeons, pathologists, medical oncologists and geneticists is essential in ensuring all patients receiving appropriate genetic testing where indicated.

NOTES:

Towards Germline and Somatic Mutation Testing for all Patients

Annabel Goodwin

Abstract not yet received.

NOTES:

Role of Industry in Facilitating BRCA Testing

Diana Nielson[1]

1. AstraZeneca, North Ryde, NSW, Australia

Performing a Tumour BRCA test at diagnosis of ovarian cancer improves the BRCA mutation detection rate by identifying both germline and somatic mutations. These results are then available in time to inform treatment decisions including eligibility for targeted treatment (such as PARPi).

Current Australian Medicare funding provides reimbursement for germline BRCA mutation testing for women with High Grade Serous Ovarian, Fallopian or Primary Peritoneal Cancer, however does not cover tumour BRCA testing. To support early detection of those patients harbouring either somatic or germline BRCA mutations, AstraZeneca Australia has initiated a National Tumour BRCA testing program. This is being run in conjunction with both the Peter MacCallum Cancer Centre Laboratory in Melbourne and NSW Health Pathology, North (formerly HAPS) in Newcastle.

The tumour BRCA test is performed on either fresh/frozen or paraffin embedded (FFPE) samples collected at diagnosis or during primary de-bulking surgery. The tissue is then sent to the testing laboratory and results are provided to the requesting clinician within 4-8 weeks. This is a co-payment program, with AstraZeneca covering 50% of the cost of testing and the patient or institution covering the balance.

To further support health care professionals, AstraZeneca has developed an App which aids in identifying patients eligible for medicare rebatable germline BRCA mutation testing. BRCAssess is a digital form of the Manchester Scoring System and informs users if their patient meets the >10% risk threshold of harbouring a pathogenic germline BRCA mutation.

NOTES:

PARP Inhibitors – An Update

Michele Vaughan

Abstract not yet received.

NOTES:

ANZGOG Trials Update

Philip Beale

Abstract not yet received.

NOTES:

Saturday 8th June 2019

Tumour Board

Presenters: Prof Young Tae Kim, A/Prof Kathleen Schmeler, A/Prof Jim Nicklin, Dr Yu Xuan Kitzing, A/Prof Lyndal Anderson, Prof Kailash Narayan & Prof Philip Beale

Time: 10.00am – 11.20am

Session Chair: Dr Greg Gard

Gynaecologic Oncologists – Prof Young Tae Kim, A/Prof Kathleen Schmeler & A/Prof Jim Nicklin

Radiologist – Dr Yu Xuan Kitzing

Pathologist -A/Prof Lyndal Anderson

Radiation Oncologist – Prof Kailash Narayan

Medical Oncologist – Prof Philip Beale

NOTES:

Saturday 8th June 2019

Session 11: Free Communications

Presenters: Dr Nooraishah Yasin, Dr Gaithri Mylvaganam, Dr Woraphot Chaowawanit & Dr Tina Ngorora

Time: 11.20am – 12.20pm

Session Chair: Dr Andrea Garrett

Pelvic Anatomy Knowledge among participants of the Anatomy of Complications Workshop (Singapore)

Nooraishah Yasin[1], Mandi Lee[2], Paul G McMenamin[3], Ian Hammond[4], Rajendran K[2], Ida S Ismail-Pratt[1], Joseph Ng[1], Pearl SY Tong[1], Arunachalam Ilancheran[1], Jeffrey JH Low[1]

1. Gynaecology Oncology, National University Hospital, Singapore

2. National University of Singapore, Singapore

3. Anatomy and Developmental Biology, Monash University, Melbourne, VIC, Australia

4. Division of Obstetrics and Gynaecology, University of Western Australia, Subiaco, WA, Australia

Introduction

Anatomical knowledge is one of the essential components in specialist training for safe surgical and clinical practice. Previous studies have shown that Obstetrics and Gynaecology (O&G) trainees are not satisfied with their learning and knowledge of anatomy, possibly due to insufficient clinical pelvic anatomy exposure either at medical school or within the specialist training programme. The Anatomy of Complications Workshop (ACW) is an educational model that was developed in Western Australia in 2000. Since November 2007, the National University Hospital Singapore, Division of Gynaecology Oncology has conducted the ACW in Singapore. The staff is made up of local and international gynaecologic oncologists, gynaecologists, colorectal surgeons, urologists and anatomists.

Objective

1. To objectively identify the areas of deficiencies in anatomical knowledge among workshop participants between August 2009 to August 2018
2. To identify areas of stronger anatomical knowledge among workshop participants

Methods

Prior to the workshop, participants are given a written course handout with relevant anatomy teaching. Participants complete a multiple-choice question (MCQ) pre-test at the start of the workshop and the same test is repeated after conclusion of the formal anatomy teaching. Answers provided by participants are anonymous. Results from the pre and post-tests were used to identify participants' strongest and weakest areas of pelvic anatomical knowledge. Median scores across all questions and cohorts were analysed, with Wilcoxon Signed Ranks test to compare the pre and post-test results.

Results

There were 240 participants who attended the ACW Singapore over the last 10 years. The median (interquartile range) scores across all cohorts for the pre-tests were 60% (IQR 53%-63%). Post-test result was 85% (IQR 81%-89%). There was a statistically significant improvement seen after formal teaching with $z = -3.72$, $p < 0.001$.

	PreTest	**Post Test**
Lowest Performed Questions	Median score (IQR)	Median score (IQR)
Q29: Superior hypogastric autonomic plexus	27% (21%-32%)	57% (48%-68%)
Q19: Identification of the Inferior Gluteal Artery	30% (26%-35%)	35% (21%-53%)
Q 20: Identification of S1 Nerve Root	29% (20%-43%)	61% (50%-67%)

Highest Performed Questions

Q1: Identification of the Anterior Superior Iliac spine	96% (94%-100%)	100% (96%-100%)
Q21: Identification of the Internal Iliac Vein	91%(88%-100%)	100% (94%-100%)
Q8: Identification of the Obturator Nerve	91% (81%-96%)	100% (95%-100%)

Conclusion

The median score of participants pre-workshop was 60% with a statistically significant improvement to 85% after formal teaching. Participants were least likely to identify deep pelvic nerves such as the S1 nerve root and superior hypogastric plexus. Among the three lowest scored questions, improvement in the identification of the inferior gluteal artery was minimal, possibly related to a relative lack of clinic-surgical relevance to general O&G specialist. Anatomical teaching at the ACW should appropriately emphasise clinically relevant and important surgical anatomy.

NOTES:

The role of a virtual reality tool to reduce pain and anxiety levels in patients undergoing colposcopy. A pilot study

Gaithri Mylvaganam[1], Angela Cong[1], Selvan Pather[1, 2], Trevor Tejada-Berges[1, 2], Sam Saidi[1, 2], Rhonda Farrell[1, 3], Robyn Sayer[1], Jonathan Carter[1, 2]

1. Department of Gynaecological Oncology, Chris O'Brien Lifehouse, Camperdown, NSW, Australia

2. School of Medicine, Univeristy of Sydney, Camperdown, NSW, Australia

3. School of Medicine, University of New South Wales, Kensington, NSW, Australia

Aim: To assess the feasibility of using a virtual reality device to reduce anxiety in women undergoing outpatient colposcopy.

Background: Virtual reality devices transport the user to a safe and calming environment using 3D visual and auditory stimuli. It has been used in paediatric and cancer patients for IV placement, chemotherapy, dental procedures and burns care to reduce pain and anxiety. There is no data for its use in gynaecological ambulatory and colposcopy procedures.

Methods: Ethical approval was obtained from the local health district to carry out a pilot study on the role of the Oculus VR® device and a Samsung galaxy smartphone ®. Participants requiring outpatient colposcopy and possible biopsy were asked to use the VR device during their procedure after informed consent . Anxiety pre and post procedure was assessed using the Spielberger State Trait Anxiety Inventory (STAI-T and STAI- S). Pain was measured using a 100mm visual analogue scale. Participants assessed their experience of VR reporting any side effects, ease of use and how immersed they were in the VR.

Results: 20 women participated in the study. Preliminary results showed that women were enthusiastic to use the VR device and found it easy to use with minimal side effects. The majority of women were also willing to use the device again in future colposcopies and were immersed in the VR. The results of the anxiety scores and reduction in anxiety scores will be presented.

Conclusion: VR is an acceptable, practical and useful tool to reduce pain and anxiety in women requiring an outpatient colposcopy and treatment. The use of this device in routine practice awaits a large randomised controlled trial which we plan to carry out later this year.

NOTES:

The "Kangaroo" pouch. Enhancing lymph node retrieval in gynaecological malignancies.

Antonia Jones[1], Yael Naaman[1], Tony Richards[1], Deborah Neesham[1], Orla McNally[1]

1. Gynaecology Oncology, RWH, Melbourne, Vic

With the increasing use of sentinel lymph node biopsy to optimise staging in endometrial and cervical cancer it is essential that the lymph nodes are clearly identified but also retrieved without fragmentation of tissue to allow for accurate pathological assessment. A number of methods have been previously described such as the introduction of a number of endocatch bags to store lymph node tissue prior to colpotomy and subsequent delivery of the nodes through the vagina without the need to introduce larger ports.

We describe a novel technique for the storage of sentinel lymph nodes at the beginning of the staging procedure which allows later retrieval without the need to introduce larger ports or extra laparoscopic accessories.

NOTES:

Retrospective review of sentinel lymph node mapping in endometrial cancer using indocyanine green and near infra-red fluorescence imaging during minimally invasive surgery- Mater Hospital experience

Woraphot Chaowawanit[1, 2], Vicki Campbell[1], Emily Wilson[1], Naven Chetty[1], Lew Perrin[1], Nisha Jagasia[1], Sinead Barry[1]

1. Gynaecologic oncology unit, Mater hospital, Brisbane, Queensland, Australia

2. Gynecologic oncology unit, Department of obstetrics and gynecology, Navamindradhiraj university, Bangkok, Thailand

Objective: To determine the feasibility of sentinel lymph node (SLN) mapping in early endometrial cancer.

Methods: 120 women with histologically confirmed endometrial cancer, treated with a minimally invasive hysterectomy, BSO and SLN mapping were included.

Results: 83 patients (70%) had a laparoscopic procedure and 37 patients (30%) had robotic surgery. The overall and bilateral SLN detection rates were 85.8% and 72.5%, respectively. BMI < 35 kg/m2 was a significant predictor of successful detection. 50% of SLNs were detected in the external iliac region, while 15% were found outside the routine lymphadenectomy zone. In terms of overall detection, laparoscopy was significantly superior to robotic surgery. Seven patients (5.8%) had positive SLNs. Adjuvant treatment was changed in 11% due to SLN status.

Conclusion: SLN mapping can reliably detect the SLN in early-stage endometrial cancer. The information attained from SLN pathology can alter the prescription of adjuvant therapy.

NOTES:

Evaluation of the accuracy of MRI in staging of low risk endometrial cancers at Waikato Hospital.

Tina E Ngorora[1], Tavaziva J Mudzamiri[1]

1. Waikato DHB, Hamilton Lake, HAMILTON, New Zealand

Objective

Magnetic resonance imaging (MRI) is an essential imaging modality in the evaluation and treatment planning of endometrial carcinomas (EC).[1.2.3.4.5.6] Women at Waikato Hospital with a moderate or high risk EC are referred to Auckland DHB for surgery by a Gynaeoncologist. This study aims to assess the value of MRI in the preoperative staging of EC and to compare sensitivity with rates with those quoted in literature.[1.2]

Design

This study is a retrospective audit approved by the Waikato Hospital Clinical Audit Support Unit. It looked at all patients diagnosed with a low risk EC on endometrial biopsy and MRI findings since the introduction of a regional Multidisciplinary Cancer Network.

Method

A search of histology results identified 67 patients diagnosed with EC from 01/01/17 to 31/12/18. The preoperative MRI MDM opinion on stage was documented following discussion at the regional multidisciplinary meeting (MDM). 29 patients were considered to have a low risk cancer. Following surgical treatment the final surgical and histopathological stage (FIGO system) was ratified by the MDM and documented.

Results

43% the cases reviewed met the criteria for a low risk cancer. The sensitivity of MRI in diagnosing a low risk cancer was 82% with a positive predictive value of 96% and negative predictive value of 3.5 %.

Conclusion

The sensitivity is in keeping with quoted international rates of 80-89%.[1.5, 6] and these results demonstrate the importance of pre-operative assessment with MRI.[2.4.5.6]

1. Imaging in endometrial cancer. Best Practice & Research: Clinical Obstetrics & Gynaecology, 2014-07-01 Elisabeth Epstein, Lennart Blomqvist
2. Diagnostic Value of Pelvic MRI for Assessment of the Depth of Myometrial Invasion and Cervical Involvement in Endometrial Cancer: Comparison of New Versus Old FIGO Staging Iran J Radiol. 2012 Nov; 9(4):202-8. doi: 10.5812/iranjradiol.5276. Epub 2012 Nov 20. F Zamani et al
3. Magnetic resonance imaging in pre-operative staging of endometrial cancer. Indian Journal of Cancer, January –March 2016 Shrivastava S,et al
4. Role of preoperative magnetic resonance imaging and histological assessment in identifying patients with a low risk of endometrial cancer: a Korean Gynecologic Oncology Group ancillary study. Oncotarget. 2017 Nov 20;8(62):106009-106016. doi: 10.18632/oncotarget.22520. eCollection 2017 Dec 1. Lee JY et al
5. Staging of endometrial carcinoma by magnetic resonance imaging: correlation with surgery and histopathology Journal of the Pakistan Medical Association · September 2009 Fatima Mubarak et al
6. Local-Regional Staging of Endometrial Carcinoma: Role of MR Imaging in Surgical planning: Radiology. 2004 May;231(2):372-8. Epub 2004 Mar 18 Riccardo Manfredi et al

NOTES:

Inguinal nodal metastasis arising from a vulval basal cell carcinoma

Anna Dalton[1], King Man Wan[1], Martin Oehler[1]

1. Gynaecologic Oncology, Royal Adelaide Hospital, Adelaide, SA, Australia

Metastatic vulval basal cell carcinoma (BCC) is extremely rare. We present the 10th reported case in the literature of a 70 year old woman who presented with a 2 year history of persistent vulva lesion with biopsy confirmed BCC. Staging CT of her abdomen and pelvis showed a mildly enlarged left inguinal lymph node. She underwent a radical vulvectomy and bilateral inguinal node sampling confirming metastatic disease to the left inguinal node. We will also present a literature review and summary of the previous reported metastatic vulval BCC.

Endometrial stromal sarcomas and NTRK (Tropomyosin Receptor Kinase) gene fusions: a case report and review of literature

Yu-Ting Huang[1], Samuel Vo[2], Russell Hogg[1]

1. Royal North Shore Hospital, St Leonards, NSW, Australia

2. Nepean Hospital, Kingswood, NSW, Australia

We report a case of a 63 year old postmenopausal woman who presented with a four week history of nausea, vaginal bleeding, and left lower abdominal pain. Computed tomography imaging revealed a large complex uterine mass, with biopsy showing malignant spindle cell tumour. At time of surgery, a large uterine tumour adherent to the small bowel in the right abdominal wall and pelvic peritoneum was found. Therefore, a modified radical hysterectomy, small bowel resection, and staging biopsies were performed. Histopathology revealed high grade sarcoma with NTRK gene rearrangement. Postoperative positron emission tomography scan showed rapidly progressive intra-abdominal disease. The patient was referred for consideration for larotrectinib, a selective NTRK inhibitor.

Literature regarding the effect of larotrectinib on NTRK gene fusion positive tumours has been reviewed and found to be limited. Given the potential of larotrectinib as a therapeutic agent for NTRK gene fusion tumours, it is an area worthwhile investigating.

Hysteroscopic treatment of Uterine tumor resembling ovarian sex cord tumor (UTROSCT): A Case report

Alon Tal[1], Shabtai Romano[1], Yehuda Ben-David[1]

1. Emek medical center, Ginegar, ISRAEL, Israel

INTRODUCTION

A nulliparous 24 years old woman, was referred from an outpatient fertility clinic due to 14 months primary infertility and a 30mm suspected submucosal endometrial fibroid which was diagnosed by Ultrasound. The woman underwent a Hysteroscopic resection of an intrauterine mass presumed as type-1 submucosal Fibroid. Histology workup revealed characteristics supporting the diagnosis of UTROSCT, reaching the borders of the resection.

WHAT ARE UTROSCT's?

Uterine tumors resembling ovarian sex cord tumors (UTROSCTs) are extremely rare types of uterine neoplasms, mostly documented as case reports. To date, around 100 cases have been reported in the literature.

According to the WHO, UTROSCTs are classified in the group of endometrial stromal and related tumors, which are divided into two groups: Endometrial stromal tumors with sex cord-like elements (ESTSCLEs), involving endometrial stromal neoplasms with focal areas (<50%) resembling ovarian sex cord elements, and UTROSCTs, corresponding to uterine tumors with predominant (>50%) pattern similar to ovarian sex cord tumors.

While ESTSCLEs has a tendency for recurrence and metastasis, UTROSCTs are considered to be of low-grade malignant potential, and usually exhibit a more benign behavior.

The patients typically present with a bleeding disorder and/or a uterine mass, which could be either submucosal, intramural or sub-serosal. These tumors are usually well-demarcated myometrial nodules with sharp borders that

can mimic endometrial polyps or fibroids. The mean age of patients with UTROSCTs is 50 years, although approximately 25% are aged 40 or less.

OUR MANAGEMENT

After considering the patient's age, her desire for future fertility and the growing evidence that fertility preservation can be considered in UTROSCTs, a decision to preserve the uterus was made.

A post-procedure Ultrasound suggested a small (7X6 mm) residual tumor, but a second look hysteroscopy revealed normal uterine cavity, with a non-pathological biopsy.

A post operative MRI of the uterus was performed without evidence of residual mass or recurrence.

8 months after the tumor resection, the patient was confirmed to be pregnant, with di-chorionic twins, after been treated with clomiphene citrate elsewhere. She is currently 24 weeks pregnant, has undergone normal nuchal translucency testing and normal growth follow-ups for both twins.

DISCUSSION

This case is the fifth case in the literature, describing a pregnancy after a resectoscopic surgery for an endometrial stromal tumor with sex-cord-like differentiation.

The preferable treatment of UTROSCTs is surgery, but the exact type of surgery is controversial.

The decision to preserve the uterus in a young nulliparous woman with such an extremely rare tumor is challenging. In the past, due to potential recurrence and limited experience, these tumors were mainly treated by hysterectomy. Updated literature reviews shows that the recurrent rate of UTROSCTs are lower then thought previously, and are presumed to be around 6%.

From recent literature reviews, the Disease Free Survival (DFS) is slightly higher is patients that underwent hysterectomy versus uterus sparing surgery (5 year DFS 96% Vs. 85% respectively), but no patients have been known to die of the disease to date.

Due to this growing evidence of the benign nature of UTROSCTs, recently, more authors have proposed conservative surgical management for women wishing to preserve fertility, but no established treatment protocol exists to date. Among the questions which remain open are whether a hysterectomy should be performed after completing family planning , is there any possible effect on pregnancy, and what kind of follow-up should be done after delivery.

1. Recurrence in Uterine Tumors with Ovarian Sex-Cord Tumor Resemblance: A Case Report and Systematic Review; Günsu KIMYON CÖMERT et Al.; Turk Patoloji Derg 2018, 34:225-233. 2. Clinical characteristics and outcomes of UTROSCT: a systemic review of literature; Erin A. Blake et Al. European Journal of Obstetrics and Gynecology and reproductive Biology, 181 (2014) 163-170.

A surgical approach to management of a large cervical leiomyoma with fertility preservation

Sara Yeoh[1, 2], Bryony Simcock[1], Peter Sykes[1]

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

2. Royal Adelaide Hospital, Adelaide, SOUTH AUSTRALIA, Australia

Cervical leiomyomas are rare and account for <5% of uterine leiomyomas[1]. Whilst surgical excision, with a hysterectomy can be readily performed, the management of cervical leiomyomas in women of childbearing age with desired fertility is a challenge.

Traditionally, fertility preserving procedures, such as myomectomy are performed with leiomyomas within the uterine body, but little is known about the surgical management of those originating in the cervix. The surgery is often more challenging as there can be poor access to the operative field and usually distortion of the pelvic anatomy, which can result in an increased risk of blood loss and possible need to perform an emergency hysterectomy.

This presentation will highlight the difficulty with diagnosis and management of a 12cm cervical leiomyoma originating from the ectocervix in a 21 year old nulliparous woman. It will also describe a surgical approach that resulted in fertility preservation and include a literature review.

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A Retrospective Audit of the Management of Atypical Hyperplasia at Waikato Hospital over a 5 year period

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Objective

There are limited guidelines on the management of atypical endometrial hyperplasia (AH).[1,3] This is a precursor to endometrial cancer (EC) and as many as 50% of women with AH have a concurrent EC. A survey of gynaecologists in the United Kingdom[3] found that 83% would offer a hysterectomy as the first line treatment for AH. This study aims to review the current management of AH at Waikato Hospital.

Design

This study is a retrospective audit looking at the management all patients with a histological diagnosis on endometrial biopsy of atypical endometrial hyperplasia[1.2.3.4.5.6.7].

Method

A total of 85 women had a histological diagnosis of AH on laboratory records held at Waikato Hospital from 01/06/13 to 31/05/18. These were identified through laboratory records and their clinical records were reviewed. After excluding those with cancer, private patients and those without complete records 66 women were eligible to have their management audited against 10 standards set in the Royal College of Obstetricians and Gynaecologists Green-Top Guideline.[1]

Results

Only 2 standards were met. These were that all women who had surgical management, had a total hysterectomy and that no woman with a histological diagnosis of AH had endometrial ablation. 41% of the hysterectomies were completed laparoscopically. Of the 9 women who received medical management only 1 had an MRI and 2 had an MDM review prior to having medical management.

Conclusion:

There appears to be no standard care for women with AH at Waikato hospital and a local guideline may help to standardise care, in particular for women undergoing medical management.

1. Royal College of Obstetricians and Gynaecologists (RCOG)(February 2016) Green-Top Guideline No:67 Management of Endometrial Hyperplasia
2. Society of Gynaecologic Oncology: Committee Opinion Number 631(2017) Endometrial Intraepithelial Neoplasia
3. Current Management of endometrial Hyperplasia- a survey of United Kingdom consultant gynaecologists ID Gallos et al European Journal of Obstetrics and gynaecology and reproductive Biology158 (2011) 305-307
4. Endometrial Hyperplasia and the risk of progression to carcinoma James V Lacey Jr et al Maturitas 63(2009) 39-44
5. Resectoscopic surgery may be an alternative to hysterectomy in high-risk women with atypical Endometrial hyperplasia F Edris et al: Journal of Minimally Invasive Gynaecology (2007) 14,68-73

Coexistence of sarcoidosis and growing teratoma syndrome: a diagnostic challenge (case report)

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We report on a challenging case of sarcoidosis and growing teratoma syndrome (GTS) developing in a patient with a history of an immature ovarian teratoma. A 39-year-old was diagnosed with a stage 3B immature ovarian teratoma and received adjuvant chemotherapy (BEP x 4 cycles) with normalisation of alpha foetoprotein. A post-chemotherapy PET scan showed FDG activity in mediastinal and porta hepatis lymph nodes, pulmonary nodules, spleen and abdominal and pelvic masses. A differential diagnosis included progressive disease versus GST. An image-guided biopsy of mediastinal lymph nodes returned as granulomatous reaction. The case was discussed at MDT and debulking surgery was recommended. GTS was confirmed involving the abdominal mass, peritoneum, and abdominal wall tissue. Surprisingly, other specimens including the spleen, liver nodules, porta hepatis and para-aortic lymph nodes and bladder peritoneum returned as granulomatous reaction. New onset sarcoidosis has made the diagnosis and management in a rare case of GSC challenging.

1. Castrellon et al. Sarcoid like reaction following adjuvant chemotherapy of breast cancer. Oncol Cancer Case Rep 2016, 2:3
2. Mi Hun Kim, Kwangha Lee, Ki Uk Kim et al. Sarcoidosis mimicking cancer metastasis following chemotherapy for ovarian cancer. Cancer Res Treat. 2012; 45 (4): 354-358
3. Marc A. Judson, Brett M. Elicker, Thomas V. Colby et al. The development of sarcoidosis in patients receiving daclizumab: A case series from multiple clinical trials. Respiratory Medicine. 2019; 149 : 23-27
4. Ayesha Saba, Rozilla Sadia Khan, Humea Ismail. Growing teratoma syndrome in ovarian germ cell tumours -- a diagnostic challenge, two case reports. J Pak Med Assoc. 2018 Jun;68(6):945-946.
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A rare tumours first description in Pregnancy

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3. Gynaecology Oncology, Chris O'Brien Lifehouse, Sydney, NSW, Australia

A live male infant was delivered by emergency caesarean section for pre-eclampsia without severe features at 37 weeks and 4 days gestation. Induction of labour was not attempted secondary to previous extensive hysteroscopic myomectomy. The caesarean section was complicated by haemorrhage from an antenatally identified submucosal fibroid onto which the placenta had implanted. This was removed intraoperatively and histopathological assessment is undertaken. The infant was born with transient tachypnoea of the newborn and micropenis was identified. It was transferred to the referral hospital for assessment. Investigation confirmed an XY genotype with suppressed testosterone which returned to the normal range within 10 days of birth. Final histopathology confirmed a Uterine Tumour Resembling Ovarian Sex Cord Tumour (UTROSCT) which stained strongly positive for inhibin. The subsequently normalising neonatal androgens and phenotype were explained by a neoplastic neuroendocrine suppression of foetal androgen and failure of sexual development. This is the first reported case of a placental implanting on an UTROSCT and of tumour hormone secretion leading to suppression of foetal development.

This presentation will provide ultrasonographic images of the development of this rare tumour during pregnancy and a description of the tumour, its aetiology, diagnosis, investigation and management. Histological features will be identified. The paraneoplastic effects on the newborn will be discussed.

Ovarian carcinoid tumour resulting in severe valvular heart disease. A Case report and literature review.

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Carcinoid tumours are neuroendocrine tumours with an incidence of 1-2 cases per 100 000.[1] Commonly they arise from the enterochromaffin cells of the gastrointestinal tract and bronchopulmonary system and produce large amounts of vasoactive peptides metabolised by the liver.[2] Primary ovarian carcinoid tumours are rare, representing less than 0.1% of all ovarian neoplasms and 1% of carcinoid tumours.[3] They are unique as unlike other carcinoid tumours causing carcinoid syndrome in the setting of liver metastasis, due to the venous drainage of the ovary carcinoid syndrome occurs in approximately one third of patients.[4] We present the case of a 58 year-old woman who presented with carcinoid heart disease, an exceedingly rare complication, in the setting of a primary ovarian carcinoid tumour.

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Endosalpingiosis in Lymphadenectomies for Endometrial Carcinoma. Mimic of Metastases on both Fluorodeoxyglucose Positron Emission Tomography/Computed Tomography and Sentinel Lymph Node Detection with Indocyanine Green - A Case Report

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A 47 year old patient was referred to a gynaecological oncologist with Grade 1 endometrioid endometrial carcinoma on endometrial curettings following a 3 month history of irregular vaginal bleeding. Preoperative Positron emission tomography/computed tomography (PET/CT) showed intense uptake in uterus, moderate uptake in one right eternal iliac node measuring 9mm, one node at aortocaval area at renal hilum measuring 7mm and one low uptake node at a previously biopsied right upper lung area. Histology of the nodule revealed adenocarcinoma with a lepidic pattern, consistent with primary lung cancer. Patient underwent modified radical hysterectomy, bilateral salpingo-oopherectomy, sampling of peritoneal washings and sentinel node debulking with indocyanine green (ICG). In total of two enlarged ICG positive nodes were found at L1/2 behind the duodenum and right proximal external iliac artery. Final histology revealed Grade 1 endometrioid adenocarcinoma with 10/26mm myometrium involvement, LVSI and peritoneal washings negative. Both removed ICG positive nodes only showed endosalpingiosis. This case report highlights the rarity of simultaneous false positivity of two modality (PET/CT and ICG) in detecting lymph node metastases in the context of low grade endometrial carcinoma. The pathological significance of endosalpingiosis and its detection alongside gynaecological malignancies is discussed.

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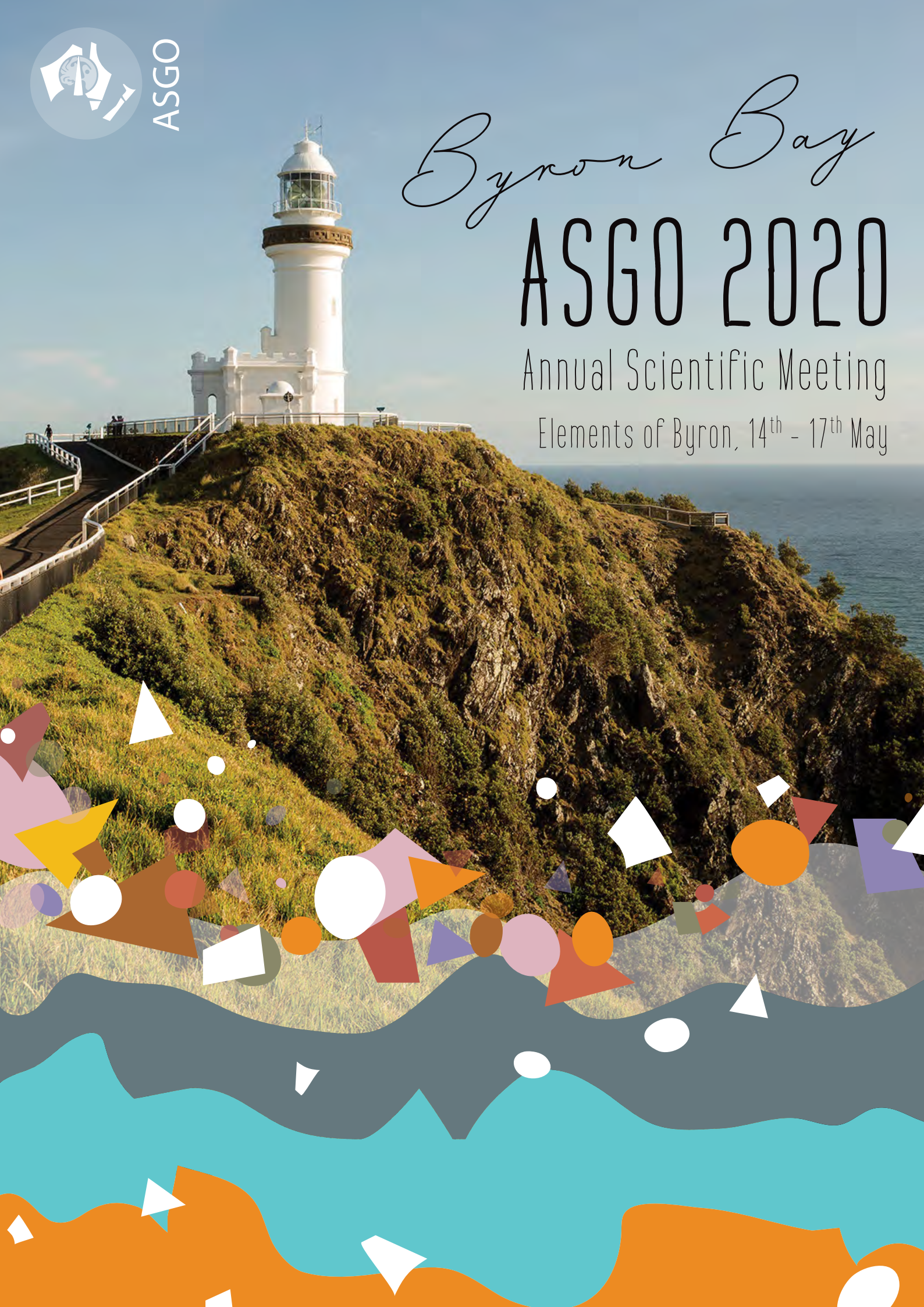
NOTES: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