619-ONC: Oncology for the Non-Oncologist
Professional Education Information

Target Audience
This educational activity is developed to meet the needs of surgical gynecologists in practice and in training, as well as other healthcare professionals in the field of gynecology.

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# Table of Contents

Session Program (Description, Learning Objectives and Course Outline) ................................................... 1
Disclosure ...................................................................................................................................................... 2

Peritoneal & Retroperitoneal Anatomy: Not Only for The Oncologist
P. Escobar-Rodriguez .......................................................... 3

Management of the Adnexal Mass
J. Brown .................................................................................................................. 11

What Should Everybody Know About Ovarian Cancer?
A.T. Tsunoda ...................................................................................................................... 20

Updates in Surgical Management Endometrial Cancer
N. Fleming ....................................................................................................................... 38

Perioperative Enhanced Recovery Programmes for Gynaecological Cancer Patients
A.L. da Silva Filho ........................................................................................................... 45

Cultural and Linguistic Competency ................................................................................... 51
619-ONC: Oncology for the Non-Oncologist

Co-Chairs: Audrey T. Tsunoda and Agnaldo Lopes da Silva Filho

Faculty: Jubilee Brown, Pedro Escobar, Nicole Fleming

This course provides a broad review of the current oncologic principles for the non-oncologist. Application of advanced anatomical understanding in non-oncologic cases, management of endometrial and ovarian cancer cases, and ERAS protocols will be discussed and demonstrated. Evidence-based summaries and a diversity of videos will en base the rationale behind oncological cases and lessons learned for a safety and efficient general practice.

Learning Objectives: At the conclusion of this course, the participants will be able to: 1) Describe how to master oncologic principles that are applicable for the general practitioner with better surgical results; 2) indicate adequate initial surgical management for adnexal masses, ovarian and endometrial cancer; and 3) perform the pelvic approach by oncologists and its usefulness in benign cases.

COURSE OUTLINE
2:30 pm Welcome, Introduction and Course Overview
2:35 pm Peritoneal & Retroperitoneal Anatomy: Not Only for The Oncologist P. Escobar-Rodriguez
3:00 pm Management of the Adnexal Mass J. Brown
3:25 pm What Should Everybody Know About Ovarian Cancer? A.T. Tsunoda
3:50 pm Updates in Surgical Management Endometrial Cancer N. Fleming
4:15 pm Perioperative Enhanced Recovery Programmes for Gynaecological Cancer Patients A.L. da Silva Filho
4:40 pm Questions & Answers
5:00 pm Adjourn
PLANNER DISCLOSURE
The following members of AAGL have been involved in the educational planning of this workshop (listed in alphabetical order by last name).
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Linda D. Bradley, MD, Medical Director, AAGL*  
Erin T. Carey, MD, MSCR  
Honorarium: Teleflex Medical, MedIQ  
Mark W. Dassel, MD  
Contracted Research: Myovant Sciences  
Linda Michels, Executive Director, AAGL*  
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Consultant: Medtronic, Lumenis  
Erinn M. Myers, MD  
Speakers Bureau: Laborie Medical Technologies, Teleflex Medical  
Other: Unrestricted educational grant to support NC FPMRS Fellow Cadaver Lab: Boston Scientific Corp. Inc.  
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Speaker: Allergan  
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Jim Tsaltas, MBBS, FRANZCOG  
Education Partner and Fellowship Funding: Covidien  
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Speakers Bureau: Medtronic, CooperSurgical, Merck & Co., AstraZeneca, Roche  
Linda Michels, Executive Director, AAGL*

FACULTY DISCLOSURE
The following have agreed to provide verbal disclosure of their relationships prior to their presentations. They have also agreed to support their presentations and clinical recommendations with the “best available evidence” from medical literature (in alphabetical order by last name).
Jubilee Brown, MD*  
Agnaldo Lopes da Silva Filho, MD  
Consultant: Johnson & Johnson, Bayer HealthCare, Zodiac, MSD, Abbott Laboratories, Sanofi-Aventis, Roche  
Johnson Pedro Escobar, MD*  
Nicole Fleming, MD  
Consultant: Tesaro, GlaxoSmithKline  
Audrey T. Tsunoda, MD, MPH  
Speakers Bureau: Medtronic, CooperSurgical, Merck & Co., AstraZeneca, Roche

Content Reviewers have nothing to disclose.

Asterisk (*) denotes no financial relationships to disclose.

All relevant financial relationships noted have been mitigated.
Peritoneal & Retroperitoneal Anatomy: Not Only For The Oncologist

Pedro F. Escobar, MD, MHL, FACOG, FACS
Associate Professor
Gynecologic Oncology
University of Puerto Rico
School of Medicine

Disclosure
“I have no financial relationships to disclose”

Objectives

• Understand the relative anatomy of vessels and nerves of the anterior abdominal wall

• Understand the anatomy of the retroperitoneal spaces

Anterior Abdominal Wall

• Relationship of the vessels & nerves to potential entry sites for trocars

Relationship of the umbilicus to vessels

Ideal Weight
BMI < 25 kg/m²

Overweight
BMI 25–30 kg/m²

Obese
BMI > 30 kg/m²
Left Upper Quadrant Insertion

- 2-cm below the subcostal margin mid-Clavicular line
- Organs
  - Aorta-11 cm
  - Spleen-12cm
  - Stomach-4.4cm
  - Liver-4.0cm
  - Left kidney 13.2cm
Retroperitoneal Anatomy: Pelvic Sidewall

- 3 layers
  - Ureter
  - Branches of the int. iliac artery
  - Muscle & nerve

Pelvic Sidewall: ureter

- Pelvic brim
  - over the common or external iliac
  - under ovarian vessels
- Courses anterior to the internal iliac
  - UNDER THE OVARY
  - 1.5-2 CM LATERAL UTERO-SACRAL LIGAMENTS
- Cervix
  - WITHIN 2CM
Pelvic Sidewall: Blood vessels - Artery & veins

- Internal iliac artery
- Anterior & posterior division
- Umbilical artery
  - Obliterated
  - Medial umbilical ligament
  - Relationship to the uterine artery
Acknowledgments
• Tommaso Falcone, MD – Cleveland Clinic

References

Benign Gynecologists’ Approach to the Adnexal Mass

Jubilee Brown, M.D.
Professor and Division Director
Department of Gynecologic Oncology
Levine Cancer Institute at Atrium Health
Charlotte, NC

November 2021

Disclosures

• No relevant disclosures

Objectives

• To incorporate scientific data into the management of adnexal masses
• To integrate anatomic knowledge and improve surgical technique
• To avoid surgical spill in the management of adnexal masses and to understand the consequences of such spill

Adnexal Masses

• Preoperative evaluation and risk of malignancy
• Criteria for referral
• Operative considerations (rupture, contained extraction)
• When to send a frozen
• What if it’s cancer?
• What if it’s a borderline tumor?
• What if you see disseminated disease?
• What if she is pregnant?

Preoperative Evaluation and Risk of Malignancy

• Evaluation of pelvic mass - characterization and markers
  • CA-125 and CEA
  • Other tumor markers where appropriate
  • Inhibin A or B, AFP, LDH, AMH, beta-hCG
• Transvaginal US is most cost effective imaging modality
• Routine CT, MRI, or PET/CT is NOT indicated
Preoperative Evaluation and Risk of Malignancy

Criteria for referral

- Pre-menopausal: Refer if
  - Premenarchal with elevated tumor markers
  - Reproductive age with
    - CA-125 > 100
    - Ascites
    - Evidence of abdominal or distant metastases
    - Ovarian or breast cancer in first degree relative
- Post-menopausal: Refer if
  - Same as above with ANY elevation in CA-125
  - Nodular or fixed pelvic mass

Criteria for genetics referral – Hereditary Cancers

- Known family mutation
- Ovarian cancer at any age
- Breast Cancer
  - < 45 yo
  - < 50 yo with a
    - Second primary cancer, or
    - Relative with breast, ovarian, pancreatic, high grade prostate
  - < 60 yo with TNBC
  - History of male breast cancer

SGO Clinical Practice Statements

Genetic Testing for Ovarian Cancer: October 2014
- Women diagnosed with epithelial ovarian, tubal, and peritoneal cancers should receive genetic counseling and be offered genetic testing, even in the absence of a family history.

Screening for Lynch Syndrome in Endometrial Cancer: March 2014
- All women diagnosed with endometrial carcinoma should undergo systematic clinical screening (review of personal and family history) and/or molecular screening for Lynch syndrome, a hereditary cancer syndrome.
- Endometrial carcinomas can be screened for Lynch syndrome using immunohistochemistry (IHC) for the four mismatch repair proteins (MLH1, MSH2, MSH6, PMS2), microsatellite instability (MSI) analysis, and MLH1 hypermethylation testing.
Criteria for genetics referral – Hereditary CA

- Known family mutation
- Ovarian cancer at any age
- Breast Cancer
  - < 45 yo
  - < 50 yo with a
    - Second primary cancer, or
    - Relative with breast, ovarian, pancreatic, high grade prostate
  - < 60 yo with TNBC
  - History of male breast cancer

If a hereditary mutation is found, should you do RRSO?

- RRSO is fine for benign gyn to do! Just follow the rules:
  - Skeletonize the ovarian vessels for complete removal
  - Inspect peritoneal surfaces and biopsy anything suspicious
  - Peritoneal washings
  - Identify patient as high risk to pathology (complete sectioning)
  - Remove the adnexa in a bag to preserve epithelium
  - There is a chance of finding cancer at the time of surgery - particularly in older women with BRCA1

If a hereditary mutation is found, should you include a hysterectomy?

- YES

Access Retroperitoneum (think triangle)

- YES

Restore Normal Anatomy and Find Ureter

Ureter on medial leaf of peritoneum
Deep in pelvis as you move caudad
Above all, know your anatomy (Right side)

Operative considerations: Rupture

- Overall rate of rupture = 25%
- Risk factors: Endometriosis, adhesions, clear cell CA, grade, non-mucinous histology
- Tumor size is NOT associated with rupture risk
- Most reports suggest that LSC is NOT associated with increased risk of rupture
- Conversion from IA to IC does not necessarily portend a worse prognosis
- Clear Cell CA, epithelial ovarian CA, Pediatric ovarian neoplasms: No difference in any outcome as long as chemotherapy administered
- Risk of death is increased in borderline ovarian tumors

Summary of Rupture Risk: Meta-Analysis

- Preop involvement is worse than intraop rupture (HR 1.47; 1.01-2.14)
- Intraop rupture is worse than no rupture at all (HR 2.41; 1.74-3.33)
- Intraop rupture is no different that no rupture at all if patients are completely staged and receive chemotherapy if needed (HR 1.49; 0.45-4.95)

Operative considerations: Contained Extraction

Risk of relapse is increased in granulosa cell tumors


Suh 2015; Kumar 2015; Kim EJSO 2013; Liu Int J Gynecol Cancer 2014; Desfeux Gynecol Oncol 2005; Gallotta Gynecol Oncol 2015; Romagnolo Gynecol Oncol 2006; Higashi Gynecol Oncol 2011; Wilson Gynecol Oncol 2015
Choose the right bag and site of exit for your mass

Operative considerations:
When to send a frozen?

- When it will change your management or counseling

Choose the right bag and site of exit for your mass

Operative considerations:
What if it's cancer?
Operative considerations: What if it’s cancer?
- Consult gyn onc if possible
- Remove the mass
- Do washings
- Take copious pictures
- Biopsy suspicious lesions
- Do NOT open
- Get out of Dodge
- Peritoneal bx
- +/- omental bx

Operative considerations: What if it’s a borderline tumor?
- Call Gyn Onc if possible
- Complete your procedure
- Take washings
- Take copious pictures
- Do NOT open
- Sample suspicious areas
- Peritoneal and omental bx

Operative considerations: What about disseminated disease?
- Call Gyn Oncology if possible
- Biopsy and stop
- Do not open
- Take a lot of pictures
Why send to Gyn Onc? They do better.

• Stage I-II disease (GO vs Gyn vs GenSurg)
  • More likely to have LND: 60% vs. 36% vs. 16%
  • More likely to be debulked: 58% vs. 51% vs. 40%
  • Better survival (hazard ratio 0.85 and 0.86 compared with general surgeons)

• Improved survival by stage (GO vs Gyn)
  • 86% vs. 70% in Stage I-II patients
  • 21% vs. 13% in Stage III-IV patients
  • More patients achieved no residual disease

Why send to Gyn Onc? They do better.

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  • 21% vs. 13% in Stage III-IV patients
  • More patients achieved no residual disease

SCORPION Trial

Fagotti A, SGO 2019

• MIS was completed without conversion in 44/53 patients (83%)
  – 9 converted to open (17%)
  – 25 required a hand port/minilap (47%)
  – 19 Laparoscopy only (36%)

Results of MIS vs. Open Interval Cytoreduction after NACT

Drury L, Gynecol Oncol 149(3):620, 2018

• 10% of patients had a complete pathologic response to NACT (13% MIS and 8% Lap, p=0.494)

<table>
<thead>
<tr>
<th></th>
<th>MIS</th>
<th>Open Surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>R0</td>
<td>32 (60.4%)</td>
<td>43 (44.3%)</td>
</tr>
<tr>
<td>Optimal</td>
<td>19 (35.9%)</td>
<td>41 (42.3%)</td>
</tr>
<tr>
<td>Suboptimal</td>
<td>2 (3.8%)</td>
<td>13 (13.4%)</td>
</tr>
</tbody>
</table>

p = 0.07

No Difference in PFS or OS

Drury L, Gynecol Oncol 149(3):620, 2018

PFS: 27 vs. 29m p=0.45
OS: 37 vs. 35m p=0.74
What if she’s pregnant?

- Early 2nd trimester: 17-19 weeks
  - Progesterone supplementation required if corpus luteum removed prior to 8 weeks
  - Optimal timing is early second trimester (14-19 weeks) although safe throughout pregnancy
- VTE Prophylaxis: Intra- and postop SCD’s, early ambulation; unfractionated heparin: no data
- Document fetal heart tones before and after procedure
- Also monitor for contractions before & after if viable
- No support for prophylactic tocolysis
- Obstetric consultation if preterm labor ensues to determine utility of tocolysis
- Suggest multidisciplinary team approach
What if she's pregnant?

THANK YOU!

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What should everybody know about Ovarian Cancer?

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Hospital Erasto Gaertner
PPGTS / Pontifícia Universidade Católica do Paraná
Hospital Israelita Albert Einstein, IOP e Pilar Hospital

Disclosure
• Stock and Other Ownership Interests: No
• Consulting or Advisory Role: AstraZeneca, MSD, GSK
• Speakers’ Bureau: AstraZeneca, Roche, MSD, Medtronic, Cooper Surgical
• Travel, Accommodations, Expenses for lectures/educational activities: AstraZeneca, Roche, MSD

Objectives
● To review prognostic factors in EOC surgical management
● To illustrate surgical techniques for early and advanced stage EOC
● To recommend evidence-based therapeutic options in the surgical management of EOC

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Renato Moretti Marques, MD, PhD - Hospital Israelita Albert Einstein
Claudiane Ligia Minari, MD - Hospital Erasto Gaertner
Danila Hubbie, MD - Hospital Erasto Gaertner
Sérgio B B Hatschbach, MD - Hospital Erasto Gaertner
José Clemente Linhares, MD, MSc - Hospital Erasto Gaertner and IOP
Which are the main prognostic factors in HGS EOC (high grade serous epithelial ovarian cancer)?

a) Grade, resources (ICU bed, advanced anesthesia, energy, stapler, devices), optimal cytoreduction

b) Stage, multidisciplinary team aligned with NCCN guidelines, surgeon with more than 10 cases/year, complete cytoreduction

c) Tumor load, genetic cancer, high-income country, total abdominal MRI with high definition, experienced surgeon

Question 1

n=9491
SEER
Stage III/IV EOC
1995-2007

2472 (26%) died in the first 90 days after diagnosis.
Impact of surgery and hospital ovarian cancer surgical case volume on in-hospital mortality and related short-term outcomes

Robert E. Bristow, M., Mariana L. Zalubski, Teresa P. Moreno, Robert L. Giannelli, Deborah E. Armstrong

The study presents findings from a retrospective analysis of hospital and patient outcomes for primary ovarian cancer cases in the United States. The data were obtained from the National Cancer Database, which provides comprehensive information on cancer cases treated in hospitals and outpatient settings. The study aimed to identify the impact of hospital ovarian cancer surgical case volume on in-hospital mortality and related short-term outcomes.

**Methodology**
- **Data Source:** National Cancer Database
- **Study Population:** Patients with ovarian cancer treated in hospitals
- **Outcome Measures:** In-hospital mortality and related short-term outcomes

**Results**
- **Hospital Case Volume and Outcomes:** Higher hospital ovarian cancer surgical case volume was associated with lower in-hospital mortality and shorter hospital stays for patients with ovarian cancer.
- **Patient Characteristics:** The study controlled for patient characteristics such as age, stage of disease, and comorbidities.

**Conclusion**
- Surgical volume is a critical factor in improving outcomes for patients with ovarian cancer. Hospitals with higher ovarian cancer surgical case volumes can achieve better outcomes for patients.

**Implications**
- Hospitals should strive to maintain or increase their surgical case volumes to improve patient outcomes.
- Further research is needed to understand the mechanisms behind the observed associations between surgical volume and outcomes.

**Tables**

<table>
<thead>
<tr>
<th>Category</th>
<th>In-hospital Mortality</th>
<th>Related Short-term Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Case Volume</td>
<td>Lower Mortality</td>
<td>Shorter Hospital Stay</td>
</tr>
<tr>
<td>Patient Characteristics</td>
<td>Controlled</td>
<td>Controlled</td>
</tr>
</tbody>
</table>

**Figures**

- **Figure 1:** Distribution of hospital ovarian cancer surgical case volumes across the study population
- **Figure 2:** Impact of surgical volume on in-hospital mortality and related short-term outcomes

**References**


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**Selected NT/F**

- **Cancer surgery saves lives by directly improving cancer cure rates**
- **Good surgery is as inexpensive as average surgery**

**Tables**

<table>
<thead>
<tr>
<th>Surgery</th>
<th>In-hospital Mortality</th>
<th>Related Short-term Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Case Volume</td>
<td>Lower Mortality</td>
<td>Shorter Hospital Stay</td>
</tr>
<tr>
<td>Patient Characteristics</td>
<td>Controlled</td>
<td>Controlled</td>
</tr>
</tbody>
</table>

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**Figure 1:** Distribution of hospital ovarian cancer surgical case volumes across the study population

---

**Figure 2:** Impact of surgical volume on in-hospital mortality and related short-term outcomes

---

**References**

Clinical exam - FIGO Stage
- Imaging
- Performance status and comorbidities
- Age and fertility desire
- Consolidated options (NCCN)
- Counseling

Considerations:
- Especialist
- MIS (resectability, recurrence)
- MIS for selected R0 procedures
- Laparotomy if necessary (*R0)
- Frozen section

Surgical report:
- Before and after
Surgical - FIGO

- Peritoneal washing
- Peritoneal biopsy
- Adnexectomy with frozen section
- Total hysterectomy with contralateral salpingo-oophorectomy
- Omentectomy
- Pelvic and para-aortic lymphadenectomy
- Peritoneal biopsies
- Appendectomy

http://www.sron.nl/professionals/physician_group/ovarian.pdf
A 45yo patient, ECOG0-1, brings you a pathology report with a 2.2cm HGS tumor, LVSI+, in a tube with free margins, capsule intact, after a total hysterectomy with right salpingo-oophorectomy for benign condition (CINII) 25 days ago. Your next step would be:

A. Adjuvant chemotherapy, platin based (i.e. carbo-taxol)

B. Complete surgical staging with left salpingo-oophorectomy, omentectomy, peritoneal biopsies, and nodal sampling (preference for conventional laparotomy)

C. CA125, imaging (thorax, abdomen and pelvis TC and/or MRI), for treatment planning
Post operative results and decisions

12/56 positive nodes
No peritoneal disease

Adjuvant therapy with carboplatine and taxol (21d)
Recurrent ascites during adjuvant chemo

NED for 9 years
COMPLETE CYTOREDUCTION
MACROSCOPIC DISEASE AT THE END OF

How can we predict if the cytoreduction will be complete?

Imaging

Fagotti Score

Sugarbaker Score - PCI

PCI > 20: chance reduzida de citorredução completa

Prognostic features of 51 colorectal and 130 appendiceal cancer patients with peritoneal carcinomatosis treated by cytoreductive surgery and intraperitoneal chemotherapy.

Sugarbaker PH, Jablonski KA.
A 60yo patient with 155kg (BMI=68) comes to your office complaining of initial satiety and constipation. She has the impression she cannot eat half of the food she was used to up to 3 months ago, with a significant reduction of bowel movements (frequency and volume). ECOG 0, central obesity. Your next step would be:

A. Referral for bariatric surgery - with urgency

B. Clinical exam followed by abdominal imaging, and endoscopy + colonoscopy

C. Referral to endocrinology and gastroenterology, for further investigation

Question 3
#4

Team Work
is a must!
NCCN adherent: 35.7%

Specific OS (months)
- NCI-CCC (8.1%): 77.9
- Non-NCI HVH: 51.9
- LVH: 43.4

Impact of National Cancer Institute Comprehensive Cancer Centers on ovarian cancer treatment and survival.


PMID: 25840536

Surgical Team

Predictors of comprehensive surgical treatment in patients with ovarian cancer.

Goff BA, Matthews BJ, Larson EH, Andrilla CH, Wynn M, Lishner DM, Baldwin LM.
Primary chemotherapy versus primary surgery for newly diagnosed advanced ovarian cancer (CHORUS): an open-label, randomised, controlled, non-inferiority trial.

- n=550
- III-IV OC
  - 72 centros britânicos + 2 NZ
  - tempo cirúrgico = 120 minutos

HIPEC and EOC?

IT'S TIME!

HIPEC and EOC?

IT'S TIME!

NACT with IDS followed by HIPEC
Stage III (extensive disease)
PS 0-2
8 centers

PDS NACT/IDS

<table>
<thead>
<tr>
<th></th>
<th>(n=329)</th>
<th>(n=339)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Postoperative mortality (&lt;28d)</td>
<td>2.7%</td>
<td>0.6%</td>
</tr>
<tr>
<td>Postoperative fever G3-4</td>
<td>8%</td>
<td>2%</td>
</tr>
<tr>
<td>Fistula (bowel/GU)</td>
<td>1.2% / 0.3</td>
<td>0.3 / 0.6</td>
</tr>
<tr>
<td>Operative time (min)</td>
<td>180</td>
<td>180</td>
</tr>
<tr>
<td>Red blood cell transfusion</td>
<td>51%</td>
<td>53%</td>
</tr>
<tr>
<td>Haemorrhage (G 3/4)</td>
<td>7%</td>
<td>1%</td>
</tr>
<tr>
<td>Venous (G 3/4)</td>
<td>2.4%</td>
<td>0.3%</td>
</tr>
</tbody>
</table>

- n=550
- OS = 24 months
- Reduced morbidity with NACT
- 15% R0 upfront
n=245

ITT RFS

2nd endpoints

OS
Toxicity
QOL

April 2007 and April 2016

n=245

OS = 33.9 x 45.7 months

Comparable Morbidity

Table 1: Adverse Events from Randomisation to 6 Weeks after Completion of Last Cycle of Chemotherapy

<table>
<thead>
<tr>
<th>Adverse Event</th>
<th>n (%)</th>
<th>Grade 1-4</th>
<th>Grade 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nausea</td>
<td>14 (5)</td>
<td>1.36</td>
<td>9.62</td>
</tr>
<tr>
<td>Abdominal pain</td>
<td>21 (8)</td>
<td>1.36</td>
<td>9.62</td>
</tr>
<tr>
<td>Nausea</td>
<td>2 (0)</td>
<td>0.08</td>
<td>0.08</td>
</tr>
<tr>
<td>Vomiting</td>
<td>3 (1)</td>
<td>0.13</td>
<td>0.13</td>
</tr>
<tr>
<td>Diarrhoea</td>
<td>5 (2)</td>
<td>0.20</td>
<td>2.00</td>
</tr>
<tr>
<td>Fatigue</td>
<td>31 (12)</td>
<td>1.36</td>
<td>2.00</td>
</tr>
<tr>
<td>Constipation</td>
<td>2 (0)</td>
<td>0.08</td>
<td>0.08</td>
</tr>
<tr>
<td>Dyspepsia</td>
<td>2 (0)</td>
<td>0.08</td>
<td>0.08</td>
</tr>
<tr>
<td>Pruritis</td>
<td>2 (0)</td>
<td>0.08</td>
<td>0.08</td>
</tr>
<tr>
<td>Anorexia</td>
<td>6 (2)</td>
<td>0.25</td>
<td>1.00</td>
</tr>
<tr>
<td>Paresthesia/lower weight</td>
<td>5 (2)</td>
<td>0.20</td>
<td>1.00</td>
</tr>
<tr>
<td>Arthralgia</td>
<td>2 (0)</td>
<td>0.08</td>
<td>0.08</td>
</tr>
</tbody>
</table>

The incidence of major complications after the performance of extensive upper abdominal surgical procedures during primary cytoreduction of advanced ovarian, tubal, and peritoneal carcinomas

n=141

- III-IV with upper abdominal procedures
- 30% CC0, 60% CC1, 10% CC2
- 22% of major complications (Grades 3-5)
- Deaths = 1.4%
- C55: 57 months

Fig. 4: Overall survival for the entire 141 patient cohort.
Tumor burden correlates with OS
Complete cytoreduction improves OS in all groups
6.6% high tumor burden PS>2 and age>75yo morbidity 66%

A laparoscopic risk-adjusted model to predict major complications after primary debulking surgery in ovarian cancer: A single-institution assessment

S > 2
Ascites > 500 cc
A125 > 1000 UI
Tumor burden ≥ 8
Is cytoreduction really necessary

What should everybody know about EOC?

- Complete surgical debulking offered in a referral center, performed by a specialist, has a significant prognostic impact
- MIS is feasible in early stage EOC, and is an interesting tool to predict resectability

What should everybody know about EOC?

- Some evidence-based recommendations:
  - Upfront cytoreduction is the recommendation for early stage EOC and up to Stage IIIB
  - Interval debulking may be a good option for selected stage IIIC and IV, with reduced morbidity
  - Multidisciplinary approach is paramount
What should everybody know about EOC?

**Oncological Principles**

- TEAM WORK
- Patient Selection
- Harmony

Focus on a goal

---

**Thank you!**

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**References**

References


Updates in Surgical Management of Endometrial Cancer
Nicole D. Fleming, MD
Associate Professor
Department of Gynecologic Oncology
The University of Texas MD Anderson Cancer Center

@nicoleflemingmd AAGL2021

Disclosure

- I have the following disclosures:
  - Consultant: GSK, Tesaro

Objectives

- Describe the advances in the surgical management of endometrial cancer
- Describe techniques for sentinel lymph node (SLN) mapping and biopsies
- Review the impact of SLN biopsies in management of endometrial cancer

Staging for Endometrial Cancer

- Total hysterectomy, +/- BSO, pelvic and para-aortic lymphadenectomy
- Most early uterine cancers are node negative
- Associated with high-risk co-morbidities
- Options:
  - Comprehensive staging for all patients
  - Algorithms to determine who needs staging based on frozen section

National Comprehensive Cancer Network®

PCCCN Guidelines Version 4.2021
Endometrial Carcinoma

- Principles of sentinel lymph node mapping in endometrial cancer staging (2021)
- Sentinel lymph node mapping is a minimally invasive technique that can be used to identify patients with occult metastatic disease. The technique involves the identification and biopsy of lymph nodes draining the primary tumor, and these nodes are subsequently assessed for the presence of cancer.
- The diagnosis of sentinel lymph node (SLN) involvement is important for determining the appropriate management of endometrial cancer patients. Sentinel lymph node biopsy can play a role in identifying patients with disease that is confined to the uterus and avoiding unnecessary extensive surgery.
- The identification of SLN involvement may also have implications for adjuvant therapy decisions.

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Mayo Criteria

No lymphadenectomy needed if:

• Grade 1, 2, or 3 with no myometrial invasion
  OR
• Grade 1 or 2
  • Less than 50% myometrial invasion
  • Less than 2 cm tumor

Lymphadenectomy in Endometrial Cancer

• DIAGNOSTIC
  • Node status is the most important predictor of survival
  • Aids in determining adjuvant therapy

• THERAPEUTIC
  • Therapeutic value of lymphadenectomy unknown

Why is SLN a great idea in EC?

• Most early uterine cancers are node negative
• Nodal status is an important predictor of survival
• Aids in determining adjuvant therapy
• Maximize the identification of node positive patients while minimizing the risk of lymphadenectomy
Modern Sentinel Lymph Node Concept

SN Team: DI, Surg, Path

Sentinel node: first site of metastasis

Injection of dye or radioactive colloid around tumor

Modern Technology

Modern Technology

Mapping with a Cervical Injection

Open Technique

Sentinel Lymph Node Ultra-staging Protocol

- Processing
  - SLN ≤ 0.5 cm, bivalve
  - SLN > 0.5 cm, 2 mm intervals
- H&E for each section
- Pan-cytokeratin stain if H&E negative
- Classification
  - Macro metastasis ≥ 3 mm
  - Micro metastasis 2 mm but ≤ 0.2 mm
  - Isolated tumor cells – single tumor cells or clusters of < 200 cells

Sentinel Nodes and Endometrial Cancer

- SLN is safe and feasible
- Bilateral detection rate as high as 95%
- Increase positive node detection

Using the SLN Algorithm

- High sensitivity
- High negative predictive value
- Low false negative rate
Sentinel lymph node mapping and staging in endometrial cancer: A Society of Gynecologic Oncology literature review with consensus recommendations


SLN mapping with adherence to a surgical algorithm and pathologic ultrastaging is a reasonable staging strategy that provides information on nodal metastasis and potentially reduces morbidity in patients with apparent uterine-confined endometrial cancer.

SGO Consensus Recommendations

1. For patients with endometrial cancer, SLN mapping by clinical inspection of Cancer is currently performed for the presence of pelvic lymph node metastasis and has a low false-negative rate where the NECN surgical algorithm is closely followed. It is recommended that completion lymphadenectomy be performed as an “adjuvant” surgical technique to minimize the risk of occult cervical, pelvic, and peritoneal disease.

2. Use of SN mapping in conjunction with pathologic ultrastaging has led to the development of a microstaging approach to pelvic lymph nodes which is considered an acceptable approach. Where feasible, cervical or pelvic lymph nodes are resected at the time of initial surgery. Sentinel nodes are performed in those with an abnormal PET scan, clinical staging or prior pelvic radiation.

3. Patients with low-grade endometrial adenocarcinoma (grade 1 or 2) may be treated based on the recommendations of the NCCN guidelines (Mechanism). Determining the nature of the disease can be performed on these patients to determine whether the disease is confined to the pelvis and potentially laparoscopic lymphadenectomy is appropriate.

4. SN mapping remains the most powerful determinant of outcome compared to nodal metastatic staging. As in all cancers, the procedure should be considered regarding the potential risk to assess occult disease using SLN biopsy for staging endometrial cancer.

Fires Trial

- Prospective, multicenter trial (18 surgeons, 10 centers)
- N=385
- Required pelvic LAD, 58% also had PA nodes
- 86% successful mapping
- Sensitivity 97.2%
- NPV 99.6%

High diagnostic accuracy of detecting positive nodes

Primary Objective

Estimate false negative rate of sentinel lymph node mapping in the detection of positive lymph nodes in women with high-risk endometrial cancers

Study Plan

Eligibility:
- High risk histology
- Clinical stage 2
- Grade 1 or 2 with suspected deep invasion
- Surgical candidate

Pre-operative PET/CT  
Intraoperative SLN Mapping  
Pelvic and PA lymphadenectomy for the renal vessels
Prospective Validation Study In High Risk EC

• Single institution (14 surgeons)
• N = 101
• Pelvic and PA nodes required
• 89% successful mapping
• Sensitivity 95%
• NPV 98.6%
• FNR 1/23 = 4.3%

Sentinel lymph node mapping with staging lymphadenectomy for patients with endometrial cancer increases the detection of metastasis

• Review of 780 presumed early-stage EC cases
  • LAD (n=661) versus SLN and LAD (n=119)
  • No difference in histologic subtypes, DOI, LVSI
  • Higher incidence of +LN in SLN group (14.7% vs. 30.3%)
  • Macro metastasis 11% in each group
  • Difference was in micro and ITCs (8.4% and 10% in SLN)
  • SLN was only positive node in 51.4% of cases

SLN accurate in high-risk endometrial cancer

SLN and High-Risk Endometrial Cancer

<table>
<thead>
<tr>
<th>Author, year</th>
<th>Study Design</th>
<th>High risk Patients (N)</th>
<th>SLN Detection Overall (Bilateral)</th>
<th>LAD performed</th>
<th>Positive Nodes</th>
<th>False negative with SLN?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ehrisman et al. 2015</td>
<td>Retrospective</td>
<td>36</td>
<td>83% (56%)</td>
<td>Pelvic +/- PA</td>
<td>25%</td>
<td>0%</td>
</tr>
<tr>
<td>Barocchi et al. 2017</td>
<td>Retrospective</td>
<td>75</td>
<td>85% (60%)</td>
<td>Pelvic + PA</td>
<td>27%</td>
<td>4.3%</td>
</tr>
<tr>
<td>Tushar et al. 2017</td>
<td>Retrospective</td>
<td>128</td>
<td>90% (63%)</td>
<td>Pelvic +/- PA (46%)</td>
<td>32%</td>
<td>2.4% (1/41)</td>
</tr>
<tr>
<td>Soliman et al. 2017</td>
<td>Prospective</td>
<td>101</td>
<td>89% (58%)</td>
<td>Pelvic + PA</td>
<td>23%</td>
<td>4.3% (1/23)</td>
</tr>
<tr>
<td>Rossi et al. 2017</td>
<td>Prospective, multi-institution</td>
<td>102/340</td>
<td>86% (52%)</td>
<td>Pelvic +/- PA (74%)</td>
<td>22%</td>
<td>2.8% (1/36)</td>
</tr>
</tbody>
</table>

Diagnostic Value of Sentinel Nodes in Endometrial Cancer

• In 50% cases, SLN is the only positive node
• Studies with completion LAD prove the high sensitivity and low false negative rates
• Detection of positive nodes is higher with SLN compared to complete lymphadenectomy
  • 11% macro metastasis
  • 8.4% micro metastasis
  • 10% isolated tumor cells

Unanswered Questions

• What do we do with a positive sentinel node?
• Do we treat ITCs and micro metastasis as positive nodes?
  • 14% treated with adjuvant therapy based on ITCs
  • 52% treated with adjuvant therapy based on micro metastasis
• How does this impact our choices for adjuvant therapy?
**Patient Characteristics**

<table>
<thead>
<tr>
<th></th>
<th>NAD/ VBT (n=76)</th>
<th>Pelvis radiation N=21</th>
<th>Chemotherapy +/- radiation n=76</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (range)</td>
<td>62 (34 - 91)</td>
<td>65 (51 - 80)</td>
<td>63 (36 - 78)</td>
<td>0.64</td>
</tr>
<tr>
<td>Stage IA</td>
<td>47 (62)</td>
<td>3 (14)</td>
<td>35 (46)</td>
<td>0.01</td>
</tr>
<tr>
<td></td>
<td>(34-54)</td>
<td>(4-7)</td>
<td>(29-44)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6 (9)</td>
<td>4 (19)</td>
<td>11 (15)</td>
<td></td>
</tr>
<tr>
<td>Stage IB</td>
<td>12 (57)</td>
<td>3 (14)</td>
<td>22 (29)</td>
<td>0.02</td>
</tr>
<tr>
<td></td>
<td>(9-54)</td>
<td>(3-16)</td>
<td>(16-30)</td>
<td></td>
</tr>
<tr>
<td>Stage II</td>
<td>4 (5)</td>
<td>3 (14)</td>
<td>1 (5)</td>
<td>0.01</td>
</tr>
<tr>
<td></td>
<td>(3-5)</td>
<td>(3-16)</td>
<td>(1-3)</td>
<td></td>
</tr>
<tr>
<td>Positive SLN</td>
<td>1 (1 - 4)</td>
<td>1 (1 - 5)</td>
<td>11 (1 - 4)</td>
<td>0.009</td>
</tr>
<tr>
<td></td>
<td>(1 - 4)</td>
<td>(1 - 5)</td>
<td>(1 - 4)</td>
<td></td>
</tr>
<tr>
<td>Grade 1</td>
<td>52 (68)</td>
<td>11 (52)</td>
<td>27 (47)</td>
<td>0.05</td>
</tr>
<tr>
<td></td>
<td>(39-54)</td>
<td>(2-10)</td>
<td>(17-50)</td>
<td></td>
</tr>
<tr>
<td>Grade 2</td>
<td>16 (21)</td>
<td>3 (14)</td>
<td>27 (47)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(11-18)</td>
<td>(2-10)</td>
<td>(17-50)</td>
<td></td>
</tr>
<tr>
<td>Grade 3</td>
<td>2 (3)</td>
<td>3 (14)</td>
<td>2 (3)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(2-3)</td>
<td>(2-10)</td>
<td>(2-3)</td>
<td></td>
</tr>
<tr>
<td>LVSI</td>
<td>40 (53)</td>
<td>15 (71)</td>
<td>63 (82)</td>
<td>0.003</td>
</tr>
<tr>
<td></td>
<td>(32-58)</td>
<td>(8-64)</td>
<td>(48-86)</td>
<td></td>
</tr>
</tbody>
</table>

**Recurrence Pattern by Adjuvant Tx**

<table>
<thead>
<tr>
<th>Overall</th>
<th>NAD/ VBT</th>
<th>Pelvis radiation</th>
<th>Chemotherapy +/- radiation</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n = 76</td>
<td>N = 21</td>
<td>n = 76</td>
<td>0.64</td>
</tr>
<tr>
<td>Recurrence</td>
<td>No</td>
<td>46 (60.5)</td>
<td>19 (90.5)</td>
<td>17 (58.6)</td>
</tr>
<tr>
<td>(range)</td>
<td>35 (50-80)</td>
<td>20 (95-90)</td>
<td>50 (50-70)</td>
<td></td>
</tr>
<tr>
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<td>1 (1-4)</td>
<td>1 (1-5)</td>
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<td>42 (53)</td>
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<td>63 (82)</td>
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**Isolated Tumor Cells and Outcomes**

- 9/175 (5.1%) recurrence
- 3-year RFS: 93%
- 5-year RFS: 91%
- Time to recurrence – 17.8 months (range 10.5-50.5)

**Conclusions**

- Risk of retroperitoneal/distant recurrence is low (4.6%) if SLN ITCs only
- Adjuvant therapy does not significantly affect RFS or recurrence patterns
- No difference +/- full lymphadenectomy
- Longer follow up time and more patients are needed

**Summary**

- SLN detection rates are similar across studies
- SLN accurately identifies patients with positive nodes and increases detection rates
- SLN is considered standard of care for endometrial cancer
- Further study is needed to look at long term outcomes and the impact on adjuvant therapy choices

**Thank you!**

nfleming@mdanderson.org
6. Backes FJ et al. Sentinel lymph node (SLN) isolated tumor cells (ITCs) in otherwise stage I/II endometrioid endometrial cancer: To treat or not to treat? Gynecol Oncol 2021;161:347-352.
Perioperative Enhanced Recovery Programmes For Gynaecological Cancer Patients

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Full Professor of Gynecology at UFMG, Brazil
Current President of FEBRASGO
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Disclosure
- Received compensation for CME material development and presentations from Bayer, MSD, Zodiac, Abbott, J&J, Roche and Sanofi. Attended advisory board meetings organized by Bayer.

Objectives
- ERAS concept
- Implementation of the program
- Evidence in gynecological surgeries
- Practical aspects
- ERAS and Gynecologic Oncology
- Conclusions

Enhanced recovery after surgery (ERAS)
- Traditionally
  - Postoperative management - surgeon's individual preferences and personal experience
  - Wide variations in perioperative care

Advanced recovery after surgery (ERAS)
- Best practices implemented with the aim of standardizing perioperative care

ERAS
- Surgical stress
  - Highly catabolic state
  - Surgical stress
  - Increased morbidity
  - Extended recovery

Organic dysfunction
- Inflammation
- Hypoxia and tissue damage

ERAS:
- Attempt to maintain normal perioperative physiology

Interventions that minimize the surgical stress response

ERAS
- From pre-admission to postoperative
**Implementation**

Evidence-based research/practices
Updated guidelines

[https://erassociety.org](https://erassociety.org)

**ERAS**

* Evidence-based research/practices
* Implementation
  * Continuous audit of the assistance process
  * Minimally invasive surgery
  * Multimodal and multidisciplinary approach

**Goals**

- Accelerate functional recovery
- Improve post-operative results
- Reduce hospital stay
- Reduce overall health care costs
- Improve patient satisfaction without increasing complications and/or hospital readmission rates

**ERAS and Gynecological Surgery**

Enhanced Recovery After Surgery (ERAS) Society recommendations — 2019 update

**ERAS and Gynecological Surgery**

Enhanced Recovery Pathway in Gynecologic Surgery

Improving Outcomes Through Evidence-Based Medicine

Guidelines for perioperative care in gynecologic oncology: Enhanced Recovery After Surgery (ERAS) Society recommendati...
ERAS and Gynecological Surgery

**Preoperative**
- Preoperative guidance and counseling
- Minimize preoperative fasting
- Avoid bowel preparation
- Preemptive analgesia
- Nausea and vomiting prophylaxis

**Intraoperative**
- Personalized anesthesia focusing on short-acting anesthetics and regional anesthesia
- Fluid management to obtain perioperative euolemia
- Intraoperative normothermia

**Postoperative**
- Early oral intake
- Early mobilization
- Early removal of catheters
- Preference for non-opioid analgesics
- Preventive use of laxatives

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Interventions

**ERAS**
- Liquids up to 2 hours before surgery
- Avoid fluid overload
- Maintain adequate intravascular volume
- Early ambulation

**Postoperative ileum**

**Multifactorial pathogenesis**
- Immobility, opioids, anesthesia, intestinal manipulation

**Rates of ileus**
- Secondary to intestinal edema
- < rates of ileus secondary to intestinal edema

**Early ambulation**
- < ileum and thromboembolism rate

**Laxatives**
- ERAS: consider in PO
- But... limited data on its effectiveness in reducing ileum rate

**Pre-op Tips and Tricks**
- Preoperative counseling
- Fasting: light meal up to 6 hours before and ingestion of clear liquids up to 2 hours before elective procedures that require general or regional anesthesia, or sedation/analgesia
- Carbohydrate drinks
- Bowel preparation: routine use is not recommended in gynecological surgery

**Pre-Op**
- Preemptive analgesia: preoperative use of gabapentin, oral or IV cyclooxygenase (COX)-2 inhibitors (eg celecoxib) and oral or IV paracetamol
- If increased risk of VTE: dual mechanical prophylaxis (socks and pneumatic compression) and chemoprophylaxis with low molecular weight heparin or unfractionated heparin
Short-acting anesthetics
- Continuous infusion of propofol / short-acting opioid analgesics / total IV anesthesia with propofol / regional anesthesia with or without concomitant general anesthesia
- Thermal blankets and fluid heating IV. Continuous monitoring of core body temperature
- Maintain euvolemia: goal-directed therapy
  - Minimize the use of colloids and increase the use of crystalloids / if hypotension but euvolemia, consider use of vasoconstrictor instead of liberal administration of crystalloids

Tips and Tricks

Intra-op
- Prevention of post-op nausea and vomiting
  - Intra-op use of at least 2 antiemetic agents of different classes
    - 5HT3 antagonists (ondansetron), NK-1 antagonists (aprepitant), corticosteroids (dexamethasone), antihistamines (dimenhydrinate), anticholinergics (scopolamine), butyrophenones (haloperidol) and phenothiazines (chlorpromazine)
- Limited use of drains, tubes and catheters and, if necessary, use for the shortest duration required

Intra-op
- Resumption of oral intake of liquids and solids within 24 hours after surgery
- Encourage fluid intake when recovering from anesthesia
- Consider high protein diets
- Early mobilization

Post-op
- Removal of the urinary catheter within 24 hours after surgery
- Multimodal pharmacological system for pain (2 or more drugs) and regional analgesia
  - Combination of NSAIDs with paracetamol
  - Thoracic epidural analgesia, transverse abdominal blocks, wound infiltration with local anesthetic and intraperitoneal local anesthetic

Post-op
- If increased risk of VTE: dual mechanical prophylaxis (socks and pneumatic compression) and chemoprophylaxis with low molecular weight heparin or unfractionated heparin
  - Extended chemoprophylaxis (28 days post-operative) for patients who meet high-risk criteria
- Euvolemia
  - Stop IV fluids when ability to maintain oral hydration (at least 500 mL of oral fluids)
  - In the immediate post-op period, IV fluids kept at least not more than 1.2 mL/kg
- Perioperative glucose levels should be kept below 200 mg/dL (diabetic and non-diabetic)
ERAS and Gynae-oncology

Special focus is given to patients with gynecological cancer, since for these patients, returning to the basal physiological level or close to it is essential, as it allows the realization of planned adjuvant therapies without delay, resulting in better oncological outcomes.


Non-randomised control trial, evaluating morbidity outcomes, before and after implementation of ERAS programme.

99 patients followed ERAS versus 99 historic controls

No differences:
• Level of surgery and 30 days post-operative complication and readmission rates

Favors to ERAS
• Post-operative length of hospital stay (4.29 ± 2.78 days versus 7.23 ± 5.68 days, p < 0.001).
• Patients who underwent abdominal surgery and followed ERAS benefited the maximum (LOS: 5.09 ± 2.74 days versus 8.70 ± 5.75, p<0.001).

ERAS programme is feasible and safe in Gynae-oncology

This demonstrates the feasibility and safety of implementing the ERAS program in Gynae-oncology


Data from 454 respondents representing 62 countries were analyzed.

Overall, 37% reported that ERAS was implemented at their institution.

The regional distribution was: Europe 38%, Americas 33%, Asia 19%, and Africa 10%.

Well adhered (>80%): deep vein thrombosis prophylaxis, early removal of urinary catheter after surgery, and early introduction of ambulation.

Poor adherence: the use of bowel preparation, adoption of modern fasting guidelines, carbohydrate loading, use of nasogastric tubes and peritoneal drains, intra-operative temperature monitoring, and early feeding.

Efforts are required to decrease the variation in perioperative care that exists in order to improve clinical outcomes for patients with gynecologic cancer globally

Implementation challenges

Lack of resources and resistance to change among providers
Define strategies for adopting improved perioperative recovery programs in different settings

Development of Mob-ERAS: a gamified application based on the Enhanced Recovery After Surgery (ERAS) protocol, with the objective of monitoring postoperative progress.

Implementation challenges

- ERAS has revolutionized the peri-operative care of patients undergoing major elective surgery over the last two decades;
- The ERAS principles are applicable to all surgical specialties and constant innovation must be the keynote to allow the improvement of processes;
- The implementation of the ERAS program represents a paradigm shift in the perioperative management of the surgical patient, and is a multidisciplinary approach based on scientific evidence management;

Take-home message (1)

- The program is clinically effective and impacts patient outcomes, offering a safe, high-quality, cost-effective perioperative care approach;
- In addition, a successful program can lead to faster and safer recovery and better quality of life and patient satisfaction;
- Therefore, the ERAS program should become standard practice for all women undergoing elective gynecological surgery.

Take-home message (2)

- It is not enough to know what to do in theory; it is the continued practical implementation of ERAS that is essential.
- The benefits of ERAS are recognized, the concepts need to be taught more widely...
- We have come a long way in the last 20 years from the concept popularized by Henrik Kehlet, but safe, quality care is always the goal – as Kehlet himself says: “First do it better, then do it quicker”.

Enhanced recovery after surgery pathways in gynecologic surgery: great strides already, but more still to come

Williams J. et al.

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GRAPHIC ELEMENTS – PLEASE USE AS NEEDED

50th Global Congress on MIGS

AGL2021

November 14-17, Austin, Texas
Cultural and Linguistic Competency

Assembly Bill 1195 was signed into law on July 1, 2006 requiring local CME providers, such as the AAGL, to assist in enhancing the cultural and linguistic competency of California’s physicians (researchers and doctors without patient contact are exempt). This mandate follows the federal Civil Rights Act of 1964, Executive Order 13166 (2000) and the Dymally-Alatorre Bilingual Services Act (1973), all of which recognize, as confirmed by the US Census Bureau, that substantial numbers of patients possess limited English proficiency (LEP). It is the intent of the Legislature to encourage physicians and surgeons, continuing medical education providers located in California, and the Accreditation Council for Continuing Medical Education to meet the cultural and linguistic concerns of a diverse patient population through appropriate professional development.

Linguistic Competence: Providing readily available, culturally appropriate oral and written language services to limited English proficiency (LEP) members through such means as bilingual/bicultural staff, trained medical interpreters, and qualified translators.

Cultural Competence: A set of congruent behaviors, attitudes, and policies that come together in a system or agency or among professionals that enables effective interactions in a cross-cultural framework.1

Cultural and Linguistic Competence: The ability of health care providers and health care organizations to understand and respond effectively to the cultural and linguistic needs brought by the patient to the health care encounter.

Cultural competence requires organizations and their personnel to:
- Value diversity.
- Assess themselves.
- Manage the dynamics of difference.
- Acquire and institutionalize cultural knowledge.
- Adapt to diversity and the cultural contexts of individuals and communities served.

California Business & Professions Code §2190.1(c)(3) states that associations that accredit continuing medical education courses shall develop standards before July 1, 2006, for compliance with the cultural competency requirements. The associations may update these standards, as needed, in conjunction with an advisory group that has expertise in cultural and linguistic competency issues. Cultural competency means a set of integrated attitudes, knowledge, and skills that enables a health care professional or organization to care effectively for patients from diverse cultures, groups, and communities. At a minimum, cultural competency is recommended to include the following: (A) Applying linguistic skills to communicate effectively with the target population. (B) Utilizing cultural information to establish therapeutic relationships. (C) Eliciting and incorporating pertinent cultural data in diagnosis and treatment. (D) Understanding and applying cultural and ethnic data to the process of clinical care, including, as appropriate, information pertinent to the appropriate treatment of, and provision of care to, the lesbian, gay, bisexual, transgender, and intersex communities.

Title VI of the Civil Rights Act of 1964 prohibits recipients of federal financial assistance from discriminating against or otherwise excluding individuals on the basis of race, color, or national origin in any of their activities. In 1974, the US Supreme Court recognized LEP individuals as potential victims of national origin discrimination. In all situations, federal agencies are required to assess the number or proportion of LEP individuals in the eligible service population, the frequency with which they come into contact with the program, the importance of the services, and the resources available to the recipient, including the mix of oral and written language services. Additional details may be found in the Department of Justice Policy Guidance Document: Enforcement of Title VI of the Civil Rights Act of 1964 http://www.usdoj.gov/crt/cor/pubs.htm.

Executive Order 13166, “Improving Access to Services for Persons with Limited English Proficiency”, signed by the President on August 11, 2000 http://www.usdoj.gov/crt/cor/13166.htm was the genesis of the Guidance Document mentioned above. The Executive Order requires all federal agencies, including those which provide federal financial assistance, to examine the services they provide, identify any need for services to LEP individuals, and develop and implement a system to provide those services so LEP persons can have meaningful access.

Dymally-Alatorre Bilingual Services Act (Assembly Bill 305) requires that state agencies that serve a substantial number of non-English-speaking people employ a sufficient amount of bilingual persons in order to provide certain information and render certain services in a language other than English.