Prof Andreas Obermair

gynaecological oncology news

AUTUMN EDITION 2018

Welcome

I hope you had a good break over the Christmas and New Year period and you are starting the year energised.

In this Newsletter, I would like to cover two areas that are relevant to a large number of women.

- Many women and health professionals believe that a **hysterectomy** brings on pelvic floor trouble. A clinical trial that I have been involved with, has shown the opposite. A hysterectomy does not seem to trigger pelvic floor symptoms. The trial results have been published this months in the reputable American Journal of Obstetrics and Gynecology.
- Last year's article about **genetic testing** registered some response. In the follow up article, I explain the implications of genetic testing and how it works.

Finally, and in preparation for an exciting new year, I would like to share with you my anticipated **highlights for 2018.**

While our rooms are located centrally in Spring Hill, my theatre lists remain at both, Greenslopes Private Hospital and at St Andrews Hospital in the city.

My practice at the Sunshine Coast is fortnightly with consulting in the morning and operating in the afternoon at Buderim Private Hospital.

I hope you enjoy this edition of my newsletter. As always, please feel free to be in touch with me at any time if you wish to discuss a particular patient with me.

Andreas Obermair

Please don't hesitate to give me a call if you wish to discuss any aspect of the enclosed or a specific patient with me.

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Does a hysterectomy lead to pelvic floor symptoms?

The question whether a hysterectomy will bring about pelvic floor symptoms, such as urinary leakage has been discussed controversially for many years.

I was invited to present our original research on this topic to 3,000 gynaecological surgeons at the European Gynaecological Oncology Congress, in Vienna in November 2017. Our research used data from the international LACE trial.

The LACE trial that was initiated in Queensland, enrolled 760 patients with endometrial cancer and compared laparoscopic and open hysterectomy for the treatment of endometrial cancer (phase 3 RCT).

While the main outcome was disease-free survival, the LACE team saw an opportunity to examine pelvic floor functioning in a large cohort of women who needed a hysterectomy for endometrial cancer. Our team was also keen to explore if pelvic floor symptoms are more common after laparoscopic or open hysterectomy. The study results will be published in the reputable American Journal of Obstetrics and Gynecology this month.

More than 380 patients received and answered questionnaires to pelvic floor functioning, the Pelvic Floor Distress Inventory (PFDI) before treatment and in regular intervals up to 4.5 years thereafter. It is a 20-item questionnaire covering prolapse and incontinence.

Statistically, outcomes before and after treatment and outcomes between the two treatment arms (laparoscopic vs open hysterectomy) were compared as well.

The most interesting finding was that there was no change in pelvic floor symptoms from baseline to 4.5 years. There was a slight improvement from baseline to up to 6 months after surgery. But in the long-term (4.5 years) there was no difference and there was no difference between laparoscopic and open surgery either.

In my opinion, this study is important because it helps to answer a commonly asked question by patients: "Will a hysterectomy bring on pelvic floor symptoms?"

Now we can assure patients and say that using high-quality research methodology that a hysterectomy not necessarily brings on pelvic floor problems.

Only a minority of patients received chemotherapy or radiation treatment and from our data we will not be able to answer how adjuvant cancer treatment will affect pelvic floor function.

It also remains unclear whether the study results can be applied also to women who need a hysterectomy for benign conditions.

Genetic testing advances

Last year, my practice started offering genetic testing to patients in partnership with **COLOR.com**, a U.S.-based genetic testing company.

Mrs X.Y., 55 years, requested genetic testing. She has a strong family history of breast cancer and requested a prophylactic hysterectomy, BSO, regardless of the gene test.

The gene test revealed that she is negative for BRCA. But the test also confirmed she has a mutation in one of the other genes associated with breast and pancreatic cancer.

While she is negative for BRCA, she carries another less known mutation. Also, her first-degree relatives (siblings, children) require genetic testing (available with COLOR.com for only $50) because they have a 50% chance of also carrying this genetic mutation.

Would this patient have had a "normal" BRCA blood test, she would have been told that she is BRCA negative and she has nothing to be concerned about.

With the new COLOR.com test we achieved a much better result for her.

How does it work?

In brief, I will consult with patients and obtain consent for the genetic test. Back home and in their own time, they order the gene test online. The test is $US 249 at present and will be sent to the patient's home address. It requires 3 mL of sputum. Patients will post the sample back to the U.S. and I can track the status of the sample. The patient and I will be notified by COLOR.com by email. The patient will come and see me to discuss the test results.

The key features of this test are:

- The COLOR.com test measures not only BRCA1/2 or Lynch but checks on more than 30 genetic mutations;
- Patients do not need to wait for an appointment to have genetic testing;
- All patients are eligible (patients for genetic testing in other institutions need to meet certain, ever changing criteria);
- Patients do not need to attend a clinic (no blood needs to be taken);
- Avoids a venipuncture (great for people who are needle phobic like me .....);
- Test results are available promptly.

Before I order a genetic test, I make sure that patients understand the implications of genetic testing.

These are:

1. A negative result does not mean, there is guaranteed no genetic failure. It simply means that there is no mutation in one of the 30+ genes that were tested. Gene defects that are not yet discovered cannot be diagnosed.
2. A positive test result should be followed by a confirmatory blood test.
3. A positive test has implications not only for the patient but also for all first-degree relatives (siblings, children). Conversations about genetic faults can enhance family relationships but it can also cause a strain of those. It is up to the patient to determine what family members wish to be informed about a genetic test result and who prefers to remain in the unknown.

A recent study from Belfast re-tested 500 women who previously tested negative for BRCA. These women had a strong family history of breast and ovarian cancer. At re-testing a significant number of women tested positive for a mutation other than BRCA.

In my experience, all patients that I offered genetic testing were keen to know their genetic risk factors and appreciated the value of the information.

What will be the highlights of 2018?

1. BATTLE

As the chairman of the Cherish Women's Cancer Foundation and Director of Research of the Queensland Centre for Gynaecological Cancer, I support The Battle, which is a yearly beach volleyball event to raise fun and funds for gynaecological cancer research.

Last year, more than $120,000 was raised. Part of this money contributed to a matching, federal government grant that we were able to win. That research evaluates training of gynaecologists in advanced laparoscopic techniques so that gynaecologists are able to offer less invasive surgical options to their patients. I am very grateful to my colleagues who support this study.

This year's Battle fundraising will help to kick off the molecular studies of the feMMe trial. The feMMe trial offers elderly and medically impaired patients with endometrial cancer as well as young women diagnosed with endometrial cancer who wish to retain fertility a non-surgical option. Tissue and blood samples will be collected throughout the 6-months study period for each patient, making this trial an internationally unmatched resource for molecular research in endometrial cancer.

The "WayObermairHead" Cherish Women's Cancer Foundation Battle fundraising team

At the Battle, some 40 to 50 teams of 5 to 7 players put their hands up and nominate a team. This year, on 16 March 2018 at Sandstorm Beach Club the teams will get into the sand and play a few rounds of beach volleyball. Each team raises at least $750 but in reality, teams raise much more from family, friends and colleagues.

Please consider getting together and registering a team of 5 to 6 players to support gynaecological cancer research: **cherish.org.au/thebattle/**

My team *WayObermairHead* and I play volleyball once a year and we are looking forward to catching up with you in the sand.

2. Observership at Memorial Sloan Kettering Cancer Center in New York

In March 2018, I will spend a few days with my colleagues at the Memorial Sloan Kettering Cancer Center (MSKCC) in New York. I am in close contact with my colleagues from MSKCC for many years. We catch up at conferences, sit on boards together and propose health policy.

MSKCC is at the forefront of sentinel node dissection, a relatively new technology that I am fortunate enough to being able to use at St Andrews Hospital in Brisbane.

Sentinel node dissection limits the number of lymph nodes removed during surgery for uterine and cervical cancer and therefore limits the morbidity of surgery, including lymphedema.

I am looking forward to watching my colleagues in the operating theatres in New York, stealing with my eyes and bringing home tips and tricks how we can improve the service we provide to our Queensland patients. I will keep you posted ☺.

3. IGCS conference in Kyoto

In September 2018, I will attend the Meeting of the International Gynaecological Cancer Society (IGCS). As always, I will present results from our QCGC Research group, learn from internationally acclaimed leaders in gynaecological cancer and catch up with colleagues and friends from around the world. IGCS meetings are always multidisciplinary, which is fantastic because it is an opportunity not only to learn surgically but also to keep updated on areas such as genetics, medical imaging or palliative care.

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If you are experiencing any issues or wish to discuss a particular case, please contact my staff on the above number from 8.00am – 4.30pm weekdays or phone me on my mobile 0411 800 029.

Patient care and providing a timely has always been my top priority and I strive to continually improve the quality of the service my team and I deliver, to meet the needs of our patients.

Thank you in advance for your support to date. Stay up to date by subscribing to my blog at obermair.info or LIKE my Facebook page **https://www.facebook.com/drobermair/**