Gynaecological Oncology News

Fertility-sparing surgery in Gynaecological Cancer

Dear Colleague,

This is the 2nd edition of the Gynaecological Oncology News to share latest trends and research in Gynaecological Oncology. As always, the news can also be downloaded from my website http://www.obermair.info/publications.shtml.

Fertility Sparing surgery in young women with gynaecological cancer: Fascinating data have been published recently to demonstrate that fertility-sparing treatment can be justified in a carefully selected group of young women with cervical, ovarian and endometrial cancer.

Nine per cent of ovarian cancer patients are younger than 40 years of age. In our Brisbane series, we compared the clinical course of 33 patients who had fertility-sparing surgery with 90 patients who had radical surgery. Fertility-sparing surgery included unilateral salpingo-oophorectomy, pelvic and aortic lymph node dissection, omentectomy, peritoneal biopsies and uterine curetting. The uterus and the contralateral ovary were preserved. Overall survival was 91% and 89% in our patients who had fertility-sparing surgery and radical surgery, respectively. Patients who will require chemotherapy postoperatively should receive Goserilin s.c. every 28 days. Goserilin induces menopause and its effect is reversible. It rests the ovaries and makes oocytes less susceptible to the toxic effects of chemotherapy. Patients with unilateral ovarian cancer might benefit from this approach.

Cervical cancer frequently occurs in young women and radical trachelectomy has been shown to be a true alternative to radical hysterectomy in selected patients. Radical trachelectomy involves removal of the uterine cervix plus the adjacent parametria while conserving the uterine body and the ovaries. The cancer must be contained within the cervix and pelvic lymph nodes must not be involved. In Europe, the U.K. and Canada radical trachelectomies are performed vaginally and promising birth rates have been reported[1]. I prefer an abdominal approach. After a pelvic node dissection, the uterine arteries are divided, the ureter is lateralised and the parametria are dissected as in a radical hysterectomy. The vagina is opened and the cervix is separated from the uterus at the cervical junction. The blood supply to the uterus comes exclusively from the ovarian pedicle. Finally, the vagina is re-attached to the uterine isthmus.

Endometrial cancer in younger patients is becoming increasingly common. Obesity and diabetes mellitus have increased among younger women and make women susceptible to endometrial cancer. I have used topical (intrauterine) progesterone (Mirena) with great success in carefully selected patients, especially in morbidly obese women with well differentiated endometrioid endometrial cancer arising in the background of endometrial hyperplasia. All patients do require a Re-Curette after 3 months of treatment to confirm the absence of disease progression. I am not aware about fertility rates as yet. Topical progesterone should not be used as a standard treatment for endometrial cancer.

While fertility-sparing procedures are still experimental and my carry risks we don't know yet, the first results are very encouraging. I feel very comfortable offering a fertility-sparing approach to selected patients with ovarian, cervical or endometrial cancer to whom it is very important to retain a chance to preserve fertility and have children.

I hope you enjoyed this information on latest developments in Gynaecological Oncology. Please feel free to contact me anytime if you wish more information on those topics or if you think that one of your patients might benefit from these new approaches.

Best wishes.

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[1] Ungar L et al.: BJOG. 2005 Mar;112(3):366-9; Plante M: Gynecol Oncol. 2004 Sep;94(3):614-23 (Review).