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Gynaecological Oncology News

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Upfront chemotherapy

An alternative to suboptimal surgery for ovarian cancer

Two of three patients with ovarian cancer present with very extensive disease not only involving the pelvis but also the upper abdomen.

Analysis of survival presented at the International Gynaecological Cancer Society Meeting in Bangkok last month supports an aggressive surgical approach. While in some European less surgically orientated centres the median survival for ovarian cancer patients is only 30 months, it is around the 60 months mark in Queensland and in some centres in the United States. If cytoreduction is feasible, we should aim leaving no macroscopic residual tumour behind.

Optimal surgery means that all macroscopic disease is surgically resected. This may include not only removal of uterus, tubes and ovaries but also small and large bowel, omentum, spleen and sometimes the distal pancreas but also the pelvic and abdominal peritoneum on the diaphragm. These operations may take long and are challenging.

However, sometimes aggressive surgical cytoreduction is not possible. Cancer encasing the small bowel mesentery, the aorta and the IVC above the level of the renal vessels and cancer encasing the porta of the liver are unresectable. In the past, gynaecological oncologists would have resected as much disease as possible, thus exposing the patient to significant postoperative risks in the presence of unresectable disease. Evidence presented at the conference suggests that aggressive surgery should only be performed if residual tumour less than 1 cm in diameter can be likely achieved.

In addition, elderly patients with poor nutritional status may do badly after surgery. A study presented by IGCS president Ignace Vergote at the aforementioned conference, suggested that upfront chemotherapy is worth a try in those selected patients. After chemotherapy, patients were taken back for delayed “interval surgery”, which was then far more successful. Chemotherapy was then completed with another 3 to 5 courses.

Patients who had upfront chemotherapy or upfront surgery had similar survival. However, the risk of postoperative complications and the postoperative residual tumour were significantly less in patients who had upfront chemotherapy.

Median survival of patients treated with upfront chemotherapy was 30 months, which is on the lower end of expected.

Last month’s IGCS conference made it very clear that only a combination of successful surgery and radical chemotherapy will keep patients chances intact to conquer advanced ovarian cancer successfully.

New Ovarian Cancer Test

A new test claims to detect ovarian cancer more accurately

If ovarian cancer could be diagnosed at an earlier stage, its long-term prognosis would hopefully be much better. Screening with ultrasound and CA-125 has returned disappointing results; half of patients with stage 1 ovarian cancer have normal CA-125 serum levels preoperatively.

A new test has been approved in Australia for use from OCT 29, 2008. It involves the measurement of several serum markers, including CA-125. The marketing company (ARL Pathology, Melbourne; www.arlaus.com.au) is expectedly extremely positive about the new test and claims 93.9 per cent specificity for stage 1 ovarian cancer (diagnostic efficiency). This relates to the differential diagnosis of a known pelvic mass.

In regards to screening, we need to be more cautious and look at the positive predictive value of a positive test result (true positive). For every 1000 positive test results, 997 will be falsely “positive” and the test will be truly positive in 2.7 cases for CA-125 alone and in 3.2 cases for the new OvPlex test (David Kanowski, S&N Pathology, Brisbane). The new test can therefore be considered marginally better than measurement of serum CA-125 alone.

The test will cost patients $200 (non-rebatable) plus a fee for blood collection and transport.

In my opinion, screening of asymptomatic women is one issue and differential diagnosis of women presenting with a pelvic mass is another issue. The new test may still not be the screening test for ovarian cancer we all have been hoping for. However, it may increase our accuracy of differentiating a benign mass from an ovarian cancer in the setting of a symptomatic patient. The accuracy is still only 93%, which in my opinion needs to be improved in years to come.

Merry Christmas and a great new year to you all! I am looking forward to working together again in 2009.

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