Prof Andreas Obermair

gynaecological oncology news

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Welcome

While 2022 has well and truly begun, I still wish you a prosperous and happy New Year. Specifically, I hope we will see an end of the COVID pandemic that haunted us for more than 2 years and caused enormous sickness and 5.5 million deaths worldwide so far. In Queensland we have been very fortunate to continue services to cancer patients without interruption. In my practice, I even saw patients from interstate.

In this issue of Gynaecological Oncology News I would like to keep you updated on new developments. Many colleagues have referred patients for whom these developments have already been implemented.

Sentinel node biopsy for uterine (endometrial) cancer came to Australia some 5 years ago. In March 2018, I went to the Memorial Sloan Kettering Cancer Centre in New York to fine tune my surgical skills and during my stay I realised that this new surgical technique is beautiful to perform but its benefit to patients (and its associated detriments) are yet to be shown. On the next page, I describe the ENDO3 trial that will answer those questions.

Secondary cytoreduction for ovarian cancer has been hotly debated last year. Two large clinical trials, only published only two years apart, came to contradicting conclusions. Here, I offer an explanation of the results and how those results can be reconciled so that they lead to beneficial patient outcomes.

I hope you will enjoy the read, and as always, please feel free to call or drop me a line if needed.

Sincerely,

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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Sentinel Node Biopsy in uterine cancer – ENDO3 trial

Sometimes surgical innovations are declared standard clinical practice without high-level evidence demonstrating the pros (patient benefit) and cons (complications, cost) of the procedure.

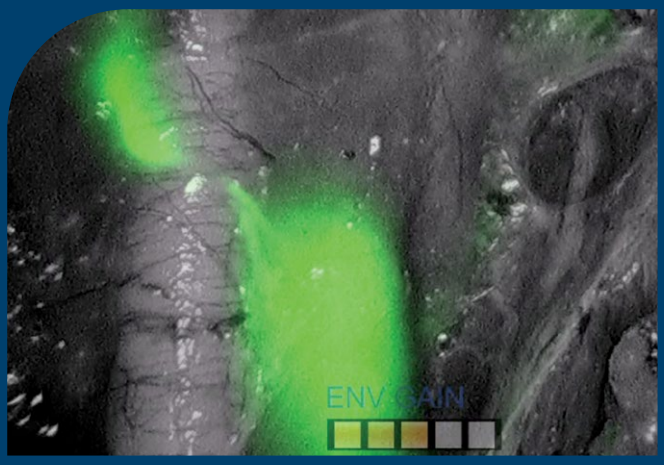
Removal and histological assessment of lymph nodes ("surgical staging") is such an example. Introduced in the United States of America in the 1980s, it is current standard practice in uterine cancer surgery but its benefit to patients is yet to be shown.

Nowadays surgical staging is performed through a procedure called Sentinel Node Biopsy (SNB) that requires specific technology and takes approximately 30 to 40 minutes to complete. A tracer is injected into the cervix and gets transported via the local lymphatic channels to the pelvic nodes. After a few minutes, a laparoscopic, near infra-red camera can identify the highlighted lymph nodes. Only one node (the closest to the uterus) is excised surgically and submitted for histology assessment. If this node is negative and cancer-free, we presume all other nodes will also be negative.

Evidence demonstrates that SNB is as accurate as a full node dissection. However, the percentage of patients with positive nodes after SNB is higher because modern pathology techniques (e.g., immunohistochemical stains against cytokeratins) will detect lymph node involvement (tiny foci of tumour) that would have been missed by conventional pathology techniques. Whether the detection of such small cancer cells or small cancer clusters < 2mm actually impact on patients survival remains unknown.

It is unknown: if SNB improves survival of patients requiring surgery for uterine cancer; to what degree it increases the risk of intra- or postoperative complications; to what degree it causes lymphoedema; how many more patients will be referred to radiation treatment or chemotherapy. Despite SNB being the current standard surgical treatment, it is also unknown whether SNB is cost effective and should be generally offered to patients.

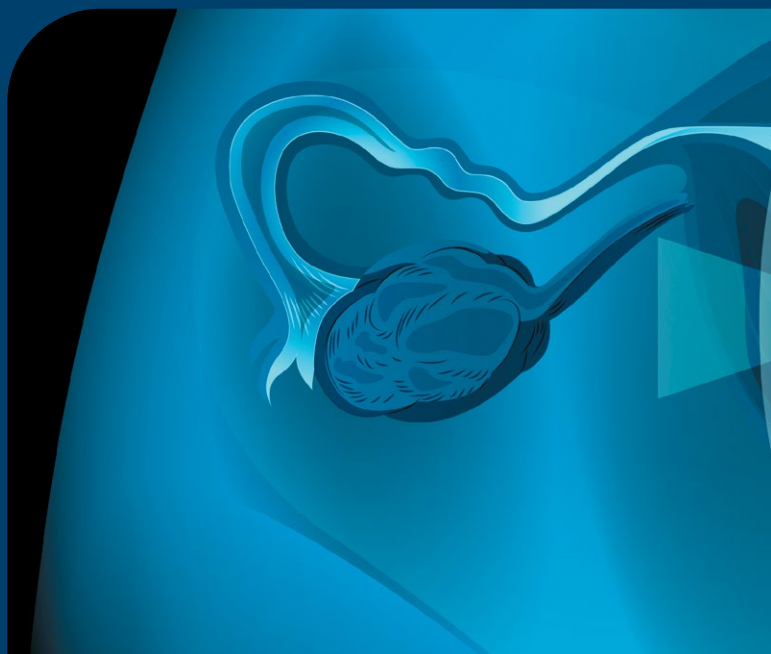
For those reasons, my colleagues and I started the ENDO3 trial to determine whether patients requiring surgery for uterine cancer will actually benefit from the SNB procedure. This trial is a phase 3 randomized controlled clinical trial (RCT). Half of patients will be randomized to SNB followed by laparoscopic hysterectomy and BSO. The other half of patients will only have a laparoscopic hysterectomy and BSO.



All surgeons must pass a comprehensive, independent surgical competency assessment before they can take part in this trial. Once surgeons pass accreditation and qualify for the trial, quality control will continue throughout the trial to make sure we deliver a stellar surgical procedure.

The ENDO3 trial started at RBWH, St Andrew's Hospital, the Wesley Hospital and the Mater Hospital (all in Queensland) in 2021 and more than 60 patients have been enrolled to date. From 2022 onwards, ENDO3 will also enrol patients from NSW and Victoria. Following surgery, patients are seen for follow up as usual. A total of 760 are planned to be enrolled.

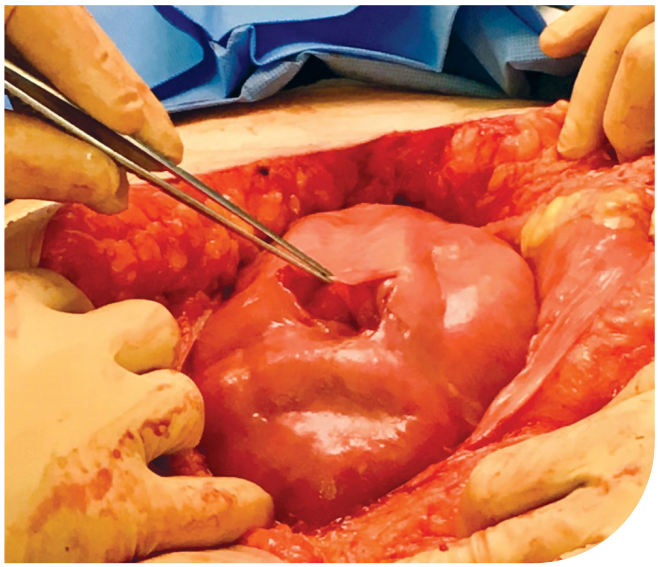
Our experience so far suggests that the quality of surgery we deliver is outstandingly high. Complication rates in both arms are low. Most patients are very willing to take part in medical research to help finding better and more effective ways to treat the next generation of women not only in Australia but worldwide. We anticipate that the ENDO3 trial will continue to enrol patients for another 3 years.



Secondary cytoreduction for ovarian cancer

Unfortunately, the majority of patients with advanced ovarian cancer will experience recurrence sooner or later. Whether surgery to remove the recurrence followed by chemotherapy or chemotherapy alone yields a survival benefit, has been a hotly debated issue.

Recently, two large RCTs were published and both examined if surgical removal of recurrence improves a patients' ovarian cancer survival chances. The trial from the USA enrolled 485 patients and found no survival advantage for surgery. The other trial comes from Europe, enrolled 407 patients and found a distinct survival advantage for patients randomized to the surgery followed by chemotherapy arm compared to chemotherapy alone.

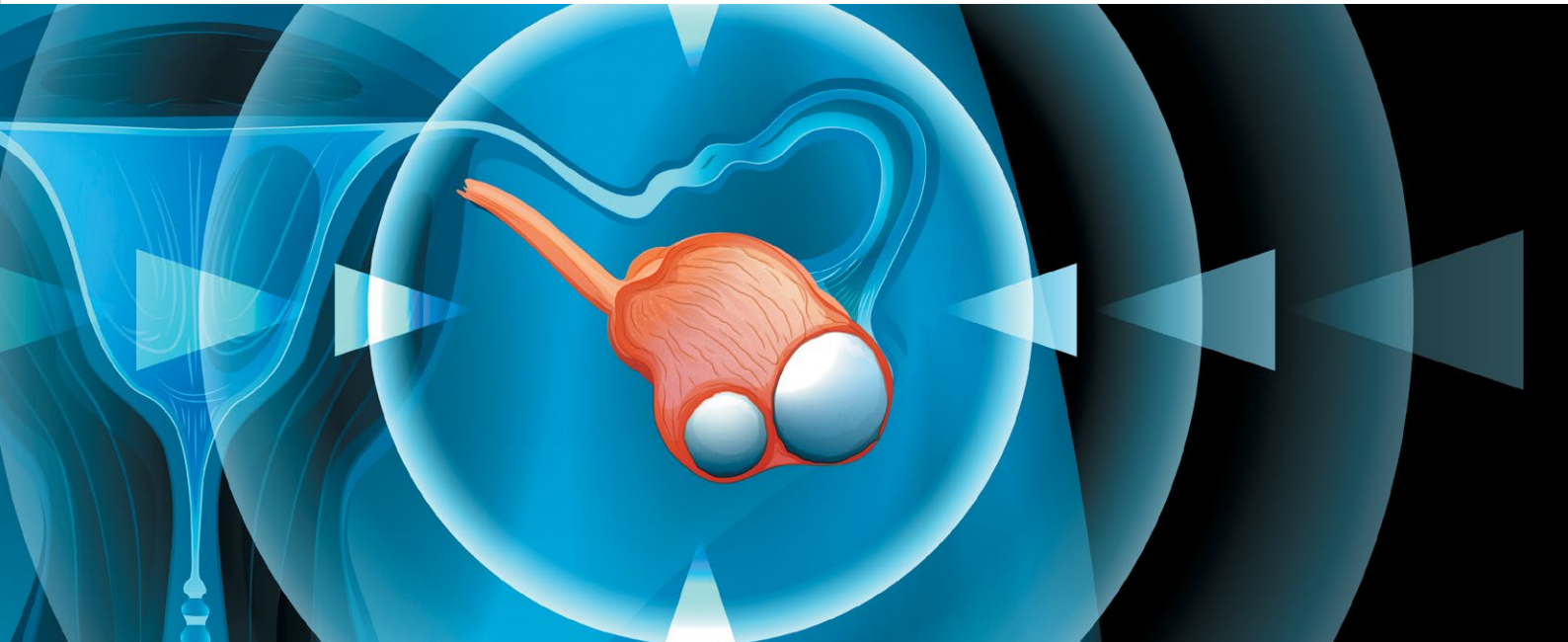


How can two trials examining the same research question come to contrary outcomes and conclusions?

In the European trial, the researchers were very strict in who was offered trial participation and who was offered a chance of surgery. Only patients with a *long disease-free interval*, patients who were in *excellent general medical health* and who had *no residual tumour at the initial surgery* were considered. In 75% of those patients no residual disease was left at the second surgical procedure. The median survival was 54 months compared to 46 months if patients only had chemotherapy without surgery.

In both trials, where all tumour could not be removed, patients were actually harmed by surgery due to the post-operative delay in commencing chemotherapy, which was the beneficial treatment that those patients required.

In summary, we need to be aware that only a selected group of patients will benefit from secondary cytoreduction for ovarian cancer recurrence. If there is a strong possibility that patients don't qualify for secondary cytoreductive surgery because they do not meet one or more of the above criteria, there is a high probability that will not benefit from a surgical intervention and should have systemic chemotherapy instead.



Working as teams

Complex surgery is a team activity and it is critically important that the members of the team work well together.

I am very fortunate that I work with excellent teams not only in my rooms where we see patients but also in the operating theatres. In particular, I am very grateful to my colleagues in general surgery, urology, vascular surgery, intensive care, general medicine, medical and radiation oncology, medical imaging, pathology and palliative care for their massive support.

Cherish Women's Cancer Foundation

In 2012 I co-founded the Cherish Women's Cancer Foundation.

Over the last 10 years, Cherish has donated almost $1 million to support gynaecological cancer research. The 2021 Larapinta appeal raised enough funds to employ Dr Eva Baxter, an experienced scientist, for 2 years. I look forward to keeping you updated on the progress we undoubtedly will make and you can also follow us on Facebook, Twitter and LinkedIn.

Left image: Dr Eva Baxter

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