Prof Andreas Obermair

gynaecological oncology news

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Welcome to Gynaecological News in 2025!

Gynaecological oncology is seeing some fascinating developments.

Semaglutide, widely used for weight loss, has significant interactions with surgery—yet many patients and clinicians remain unaware. See page 2 for details.

Fertility-sparing treatments are increasingly vital as gynaecological cancer rates in younger women rise at double the rate of older women. This issue explores the opportunities and limitations of fertility-sparing surgery for endometrial, cervical, and ovarian cancer.

A Cervical Screening Test (CST) and hysteroscopy D&C—both low-risk procedures—could prevent mistreatment in up to 2.5% of women scheduled for hysterectomy due to presumed benign abnormal uterine bleeding. More on page 4.

I hope you enjoy these articles. As always, feel free to reach out to discuss any patients.

Warm regards,

Andreas Obermair

Note: I recently enjoyed reading *Source Code*, Bill Gates' 2025 autobiography. I loved learning about his early struggles, his drive to understand the world and his journey into software. A thought-provoking read for lifelong learners!

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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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Semaglutide: Concerns about timing of surgery

with Dr Beth Veivers

Semaglutide (Ozempic) and Dulaglutide (Trulicity) are widely used for Type 2 Diabetes (PBS-subsidised) and off-label for weight loss. Over 175,000 Australians receive it through the PBS, with many more using it for weight loss. However, few patients—and even clinicians—are aware of the implications of these medications for surgery. Cases of delayed gastric emptying, reflux and aspiration under anaesthesia have led to significant morbidity and the lack of information in the community has led to last-minute surgery cancellations due to the risks of proceeding when these medications are continued. In this interview with Dr Beth Veivers, one of our most delightful anaesthetists, we discuss how my practice manages patients who are on Semaglutide to ensure safe surgical outcomes.

Q: Why does Semaglutide interfere with surgery?

Semaglutide, like other GLP-1 receptor agonists, slows down stomach emptying, which can lead to a full stomach even after standard preoperative fasting. This increases the risk of regurgitation and aspiration during anaesthesia—a potentially serious complication where stomach contents enter the lungs.

Q: How should we manage a patient who is on Semaglutide?

It depends on the indication: For patients taking Semaglutide or other long-acting GLP-1 agonist for weight loss, if possible it should be ceased 4 weeks before surgery. These medications have a very long half-life and take a long time to be eliminated from the body. For diabetes control it is not advised to stop for such a prolonged period without intercurrent diabetes management. Cessation for a week or two however is beneficial in order to mitigate risk of peri-procedure aspiration. If the Semaglutide is ceased for 1-2 weeks pre-operatively, blood sugar levels should be closely monitored, and alternative diabetes management medication, such as insulin or oral medications, may be needed temporarily.

Q: How do we manage a patient on Semaglutide who needs urgent surgery?

Urgent surgery poses a challenge because we can't always wait for the medication to be eliminated from the body. In these cases, we consider the patient "non-fasted" and provide anaesthesia as usual for a non-fasted patient; for example in such a case, I would perform a rapid-sequence induction or I might place a nasogastric tube to decompress the stomach. These measures whilst effective in risk reduction are not absolute and there is still a risk of aspiration and for this reason, we don't recommend relying on our modification of anaesthetic technique alone. Cessation of medication where possible and modification of fasting are critical components of risk minimisation.

Q: And how about non-urgent surgery?

For non-urgent procedures the safest approach is to postpone surgery until at least a week after stopping Semaglutide. This minimises aspiration risk and ensures safer anaesthesia. If delay isn't an option, modification of fasting, e.g. liquid diet for 24 hours, enhanced preoperative assessment and adjustments in anaesthesia technique are required.

Q: Would extending the fasting period from 6 to, let's say, 24 hours help?

Not necessarily. Because Semaglutide slows gastric emptying in a way that isn't fully predictable, some patients may still have food in their stomach even after prolonged fasting. A 24-hour fast could reduce —but not eliminate—risk. This is why stopping the drug in advance remains the preferred strategy.

Dr Veivers, thanks so much for your key insights and for being available to help managing my surgical patients throughout the year.

Fertility-sparing treatment in Gynaecologic Cancer: Opportunities and Limitations

Fertility-sparing treatment is a viable option for selected, early-stage endometrial, cervical and ovarian cancer patients. Balancing oncologic safety with reproductive goals is crucial. Primary care providers play a key role in early diagnosis and counselling, making awareness of fertility-preserving options essential for informed patient management.

Endometrial Cancer

Endometrial cancer, typically associated with postmenopausal women, is increasingly diagnosed in younger patients due to rising obesity rates and polycystic ovary syndrome. In carefully selected cases of early-stage, low-grade endometrioid adenocarcinoma, fertility-sparing treatment with intrauterine progestin therapy may be considered.

Opportunities

- Studies suggest response rates of up to 80%, with many patients achieving successful pregnancies after treatment.
- The levonorgestrel-releasing intrauterine device (IUD) offers a localised, effective option.

Limitations

- Requires close monitoring with regular endometrial sampling as recurrences are possible.
- Treatment failure may delay definitive surgery, but hardly ever increases the risk of disease progression.
- Not suitable for patients with high-grade tumours or deep myometrial invasion.

Cervical Cancer

Cervical cancer is one of the most common cancers in young women. When diagnosed at an early stage (stage IA1–IB1 with tumours <2 cm), fertility-preserving surgery such as radical trachelectomy (removal of the cervix while preserving the uterus) can be an option.

Opportunities

- Radical trachelectomy has been shown to achieve survival rates comparable to traditional radical hysterectomy.
- Patients who become pregnant require a caesarean section at around 37 weeks for delivery.

Limitations

- Not suitable for tumours >2 cm due to higher recurrence risk.
- Requires specialised surgical expertise, limiting access in some regions.
- Risk of preterm birth and pregnancy complications is increased after surgery.

Ovarian Cancer

Fertility-sparing surgery is considered for early-stage non-epithelial ovarian cancer types and borderline ovarian tumours. The approach involves removing the affected ovary while preserving the uterus and contralateral ovary when appropriate.

Opportunities

- Non-epithelial ovarian cancers and borderline tumours have high survival rates with fertility preservation.
- Advances in assisted reproductive technology improve post-treatment pregnancy chances.

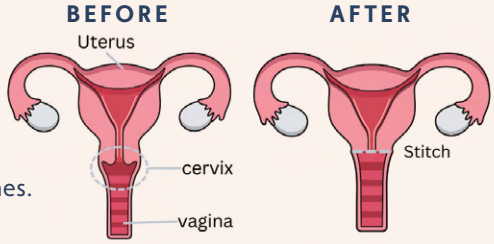
Limitations

- In epithelial ovarian cancer, even early-stage disease may have microscopic spread, raising recurrence risks.
- Requires careful patient selection and long-term surveillance.
- Risk of needing delayed radical surgery if recurrence occurs.

The Role of the GP.

GPs and general gynaecologists are often the first point of contact for young women with symptoms or a new cancer diagnosis. Your key roles include:

- **Diagnosing symptoms** like irregular bleeding, bloating, or pelvic discomfort (ensure cervical screening for abnormal bleeding).
- **Referring patients early** to a gynaecological oncologist.
- **Providing information** on treatment options, including fertility-sparing approaches.
- **Offering reassurance** during complex decision-making.
- **Supporting long-term follow-up** for treatment side effects, disease recurrence, and pregnancy planning.



D&C and CST:
Essential before hysterectomy for AUB

Abnormal uterine bleeding (AUB) is a common indication for hysterectomy, but it is crucial to rule out uterine or cervical cancer before proceeding.

If cancer is present, the surgical approach may need modification, such as performing a sentinel node biopsy or an extended (radical) hysterectomy for adequate safety margins. Ensuring an accurate diagnosis before surgery prevents undertreatment and optimises patient outcomes.

Cervical Cancer: Eradication not before 2080

Cervical cancer remains a significant health burden, with over 1,000 Australian women expected to be diagnosed in 2025. Despite HPV vaccination and screening, eradication in Australia is not projected until 2080. A simple Cervical Screening Test (CST) should be performed by the referring doctor for all women with AUB who are eligible for screening, even if their last test was normal.

Undiagnosed cervical cancer may be incidentally discovered during hysterectomy, leading to inadequate treatment. Identifying pathology preoperatively allows for appropriate planning, ensuring patients receive necessary oncologic surgery, including more extensive hysterectomy and lymph node evaluation if required.

D&C: Diagnosing Endometrial Pathology

While AUB often results from benign conditions like fibroids or adenomyosis, it can also be the first sign of uterine cancer. Studies indicate that 2-3% of women undergoing hysterectomy for AUB have an unexpected cancer diagnosis. Without histopathological confirmation, hysterectomy for presumed benign disease risks undertreatment.

If a surgeon performs 200 hysterectomies annually without assessing the endometrium, approximately five patients per year may receive inadequate treatment. Most would agree this is unacceptable. Some cancers, like uterine sarcomas, remain difficult to diagnose preoperatively, but avoiding tissue spillage through free morcellation without a containment device minimises risk.

Avoiding unnecessary surgery and optimising care

Not all women with AUB require hysterectomy. A D&C may identify benign conditions such as endometrial hyperplasia without atypia, which responds well to intrauterine progestin therapy. Confirming the absence of malignancy before surgery prevents the need for a second, more extensive procedure, reducing morbidity and healthcare costs.

How GPs and general gynaecologists can help

GPs and general gynaecologists play a critical role in ensuring optimal care by:

- Checking that patients' CST is up to date.
- Informing patients that a D&C may be recommended before hysterectomy to prevent unexpected complications.

These simple, low-risk investigations help minimise misdiagnosis, improve surgical outcomes, and enhance patient satisfaction.

Bhutan Cherish Challenge 2025

For 13 years, the Cherish Women's Cancer Foundation has funded vital gynaecological cancer research and continues to do so.

Cherish supported the feMMe clinical trial (see page 3), enabling young women to treat endometrial cancer without hysterectomy. The IMAGINE trial, also funded by Cherish, trained 10 general gynaecologists in laparoscopic hysterectomy across three Queensland hospitals, reducing adverse events by 30%.

Current Cherish-funded trials include ENDO3 (hysterectomy with or without sentinel node biopsy) and Australia's first randomised vulvar cancer trial, launching in June 2025.

I'm excited to join at least 10 participants in the **Bhutan Cherish Challenge** this October, trekking through breathtaking landscapes up to 4,500 metres, past snow-capped peaks and serene lakes. **My fundraising target is $16,000**.

Follow the Cherish Women's Cancer Foundation at **www.cherish.org.au** to learn more about the 2025 Bhutan Cherish Challenge.

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