Prof Andreas Obermair

gynaecological oncology news

SUMMER EDITION 2020

Welcome

Before we go into the hot topics of the new year, I would like to thank you for trusting me and my small team, including Dr Huttenmeister, Rebecca and Tonya, with your patients. We put a lot of effort into patient care, some of that is visible and much of it remains invisible to patients.

Did you make a New Year's resolution? One of mine is to avoid getting into situations where my energy levels are depleted. How do I plan to do that?

- Sleep enough
- Take regular physical exercise
- Eat food worth eating
- Nourish family and social relationships
- Read, research, write and nourish the mind in many ways

In this edition of my newsletter I would like to highlight a few topics that are relevant to almost every patient with gynaecological cancer.

First, I would like to announce that the feMMe trial enrolled its target of 165 women with endometrial cancer or endometrial hyperplasia with atypia. I would like to express my sincere gratitude to all of you who asked me to consider enrolling your endometrial patients in this trial. All patients require follow up and I anticipate that by June 2020 we will be able to run statistical tests.

Best wishes,

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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Free BRCA testing

All patients with ovarian cancer are eligible for cost-free BRCA1 and BRCA2 testing through a generous program developed by Astra Zeneca (AZ) Australia. The company subsidises the genetic testing program throughout Australia. All testing is performed at the PeterMac Cancer Centre in Melbourne.

When I see patients with ascites, omental caking and other hallmarks of ovarian cancer, I perform a laparoscopy to obtain a decent tissue sample. Some other gynaecological oncologists prefer to arrange a CT-guided biopsy, which is less invasive but too frequently not enough tissue is obtained.

In my practice, I refer to genetic testing once histopathology is reported. I complete a request form; the patient needs to sign a consent form; and after the forms are submitted, I will receive a report from PeterMac in Melbourne within 4 to 6 weeks.

In the last 12 months I have had only 1 patient with inconclusive results. This was a patient who had surgery after neoadjuvant chemotherapy in 2014. Only scant tumour was left and it was insufficient to perform genetic testing.

Several patients returned positive results for BRCA1 or BRCA2. The implications include:

- The patient is eligible for PARP inhibitors, a relatively new class of medication with significant advantages over other commonly used chemotherapy drugs, including much improved survival rates.
- The patient is aware of her high breast cancer risk. I always offer a referral to one of my friendly breast cancer surgeons for a discussion about screening and prevention options.
- The patient is aware that her first-degree relatives have a 50% risk of also carrying BRCA1 or BRCA2. These people are eligible for free genetic testing through QLD Health.

As the scientific program chair of the Australian Society of Gynaecological Oncologists' annual conference in May 2020 in Byron Bay, I have invited Dr Victoria Beshay, leader of the germline genetics diagnostic laboratory at PeterMac to present on the diagnostic aspects of BRCA. I will keep you posted.

Lymphoedema

Many women, who require surgery for suspected or proven gynaecological cancer, are concerned about developing lymphoedema postoperatively. I share with you the 8 most remarkable facts that you might wish to know about lymphoedema; some of this knowledge comes from our internationally recognized research at the Queensland Centre for Gynaecological Cancer in collaboration with Prof Sandra Hayes at Griffith University.

1. In some patients swelling of the lower limbs exists even before surgery (preexisting).
2. Sometimes, patients who have a hysterectomy for a benign condition will develop leg and abdominal swelling for a while. Typically this will resolve after a few weeks without intervention.
3. Extent of surgery increases the risk of lymphoedema. The more lymph nodes that are removed the higher the risk, and removing less than 4 lymph nodes is associated with the smallest risk. Postoperative radiation treatment or chemotherapy increase the risk of lymphoedema.
4. Leg swelling is one of the most bothersome symptoms associated with gynaecological cancer surgery. Symptoms include a feeling of heaviness in the legs; leg swelling but also puffiness around the lower abdomen and pubic area. Most patients develop symptoms within 12 months from initial treatment.
5. Risk factors
   a. Patients with vulval or uterine cancer are at particular high risk of postoperative leg swelling. The risk of lymphoedema is smaller in patients treated for cervical or ovarian cancer.
   b. Patients with increased body mass index (>30 kg/m^2) have a vastly increased risk of lymphoedema.
6. Prognosis: The prognosis of patients diagnosed with endometrial cancer who developed lymphoedema is worse than the prognosis of patients without lymphoedema. It is unknown if reversal of lymphoedema reverses the poor prognostic effect.
7. Prevention of leg swelling needs to be balanced against the benefits of gynaecological cancer treatment. The transition from full to sentinel node dissection in endometrial and vulval cancer reduced the risk of patients developing leg swelling markedly. In the majority of ovarian cancer patients an extensive lymph node dissection can be avoided. For cervical cancer patients the risk of leg swelling can be minimized by treating patients either by surgery or by chemoradiation but avoiding a combination of surgery followed by radiation treatment.
8. Treatment includes garments and regular lymph drainage. I am personally disappointed that no progress has been made in the treatment of leg swelling since I began practice in this field.

Endometrial hyperplasia with atypia

The majority of patients diagnosed with endometrial hyperplasia with atypia (EHA) on endometrial sampling or a curette will only have a precancerous condition, which does require treatment, but patients can expect very good long-term outcomes.

Unfortunately, up to 40% of patients with EHA on a curette will harbour an occult endometrial cancer.

Of those, some patients will have high-risk endometrial cancer – these require more extensive surgery and histopathology review to guide intraoperative decisions and postoperative management than a simple hysterectomy.

Some gynaecologists refer patients with EHA for surgical management through a gynaecological oncologist to minimise the risk of compromise to their patients' outcomes.

Identifying patients who are likely to have endometrial cancer is challenging. Knowing prior to hysterectomy who will have cancer and who won't would be very helpful as the differences in surgical treatment and follow up are significant.

	EHA	ENDOMETRIAL CANCER
BSO	Unnecessary in young women	Recommended
Sentinel lymph node dissection	Not required	Recommended
Postoperative radiation treatment or chemotherapy	Not required	Recommended for 15% of high-risk patients or for some patients who did not have a sentinel node dissection
Follow up (5 years)	Not required	Recommended for patients except those with Grade 1 tumours not invading into the myometrium
Genetic testing	Not required	Recommended

A new study *[Vetter MH: Am J Obstet Gynecol 2020]* published a few weeks ago examined preoperative predictors of endometrial cancer.

The aim of the study was to determine if preoperative factors can predict the presence of concurrent endometrial cancer at the time of hysterectomy in patients with EHA.

The authors from Cleveland Clinic (Ohio) reviewed 1055 charts of patients who had surgery between 2004 and 2015. 169 patients were eligible and included; of those, 82 patients (48%) were ultimately diagnosed with endometrial cancer.

Endometrial thickness of ≥2 cm was associated with a 4-times higher risk of endometrial cancer. Age over 65 years was associated with a 2.3 times higher risk of endometrial cancer.

LEARNING POINT: Referral to a gynaecological oncologist may be warranted in EHA patients ≥ 65 years of age or in patients with an endometrial thickness of ≥2 cm.

Patient-Reported Outcomes

Late last year, we started capturing Patient-Reported Outcomes of all patients who had surgery with me.

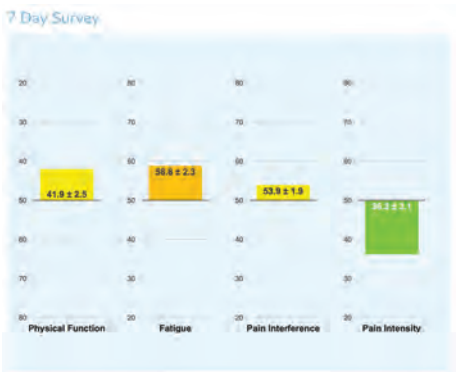
Surgical recovery can be different from patient to patient. Even if patients recover without a complication, some patients find their recovery slow, tedious and unexpected and often we have no explanations for that.

In my practice, we collect Patient-Reported Outcomes (PROS) to quantify the recovery of our patients. We collect information on pain, nausea, fatigue and the ability to perform daily activities. The system I use (surgicalperformance.com) uses standard and validated questionnaires so that benchmarking is possible. We collect the information 1 week, 1 month and 6 months after surgery.

The survey is sent to a patient's smartphone and it takes 5 minutes to answer the standardised questions.

The below images are an example of one patient(s) with PROS results at 7 days and again at 30 days from surgery. Amber coloured columns indicate intermediate results; green columns indicate a good recovery.

LEARNING POINT: I can now identify patients who recover from surgery slowly. I can make sure they are OK by giving them a quick call ("just checking on you"). To date I have had numerous patients who expressed their appreciation for that call.



Larapinta trail hike

With my family, I will take part in a fundraising hike, the Larapinta trail. It is one of the most outstanding Australian hikes in the red centre of Australia.

Experienced guides ensure that we are safe, well fed, comfortable overnight and that our luggage is transferred for us. Hikers raise a minimum of $3500 for gynaecological cancer research and can opt for a 3 or 6 day hike.

If you are interested in participating, please drop me a line at **rooms@obermair.info.**

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