



Prof Andreas Obermair

gynaecological oncology news

SEPTEMBER 2017

Welcome

These are truly exciting times in gynaecological oncology and with this newsletter I wanted to share some of the most exciting innovations in our specialty.

The first article is about **sentinel node dissection**, which is a technology we already and routinely use for breast and vulval cancer as well as for treatment of melanoma. The second article is about **genetic testing** and how accessible and affordable it has become over the last few years.

The **QCGC Symposium** will be held on 9 SEP 2017 with Prof Ian Hammond from Perth presenting and all QLD gynaecological oncologists are involved in this program. The National Cervical Cancer Screening will come into effect on 1 DEC this year with many important changes that GPs and O&G Specialists need to know about.

Finally, a reminder about the **feMMe trial** that enrolls patients with endometrial hyperplasia with atypia or with endometrial cancer. This clinical trial offers an effective alternative to hysterectomy.

I hope you enjoy this edition of my newsletter. As always, please **feel free to be in touch with me** at anytime if you wish to discuss a particular patient or scenario with me.

Regards,

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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NEW

Technology - Sentinel node dissection for uterine cancer

Until recently, the majority of patients with endometrial cancer had to have frozen section examinations to determine the depth of invasion of cancer. That information influenced the decision if any, and how many, lymph nodes had to be removed.

The significant problems with this approach were twofold:

1. Frozen sections are not always accurate. Sometimes, we did not remove lymph nodes based on tumours that appeared superficially invasive on frozen section, but were upgraded to a deeply invasive cancer when more sections had been taken by the pathologist.
2. The more lymph nodes are taken, the higher is the risk of postoperative lymphedema. In one of our recent publications we determined that the risk of lymphedema is as high as 35%.

A solution may have become available with sentinel node dissection. In brief, the sentinel node is the first node to drain cancer cells from the primary tumour. In essence, we try to remove only that node, instead of many nodes. The advantages are that we gain more accurate clinical information, decrease the risk of lymphoedema and achieve that in a shorter operating time for patients.

Immediately before surgery, Indocyanine Green (ICG) is injected into the cervix. A specially designed laparoscopy equipment will be able to visualize sentinel nodes through a special camera. The sentinel node then will stain up bright green (as shown on the image).

The false negative rate for sentinel nodes with ICG is low, according to two research papers from the USA (Chapel Hill, North Carolina; MD Anderson Cancer Center, Texas) resulting in a negative predictive value of 99.6%, which is a rather encouraging result making SLND an attractive option for surgical staging in uterine cancer.

Sentinel nodes will be removed prior to hysterectomy. If a sentinel node cannot be identified, I still arrange for a frozen section that may then require a full node dissection. Also, any suspicious nodes should also be removed at the time of surgery.

There is a learning curve to that technique and initially surgeons will remove the sentinel node first and then (for quality assurance purposes) resect more lymph nodes to be sure. Overall, it is anticipated that a sentinel node can be identified in 80% of patients on one side) and in 50% on both sides. With increasing experience, we will be able to increase those numbers.

The concept of sentinel node techniques is not new because sentinel node techniques are already established for breast cancer, melanoma and vulval cancer.

I am thrilled to being able to offer sentinel node dissections to an increasing number of patients with endometrial cancer. This technology may allow gynaecological oncologists to advance the discussion about the need for node dissection in endometrial cancer.

I will continue to keep an eye on this space and will keep you posted.



NEW

BRCA and Lynch testing

One in 7 patients with high-grade serous carcinoma (ovarian, fallopian tube or primary peritoneal cancer) will test positive for BRCA1 or BRCA2. In addition, we assume that one in 20 patients diagnosed with endometrial cancer will be positive for Lynch syndrome. Unfortunately, only a minority of patients (and doctors) are aware.

The risk of carrying BRCA1/2 includes the risk of subsequent cancers in the affected patient; moreover, 1st degree relatives carrying the genes will have a 50% risk of developing cancers as well. How can we prevent these cancers from developing?

If a patient knows her BRCA/Lynch status she can take steps to prevent subsequent primary cancers and also inform her family so that family members can be tested to find out whether they have the gene mutation or not.

In the past, the biggest problem with genetic testing was access to genetic testing and its considerable cost. A few years ago, the cost of genetic testing was more than \$3500. Now, a genetic test is available for \$400, which is far more

affordable. The entire amount is paid to the genetic testing company (not to me).

At present, genetic testing is available for free for woman with ovarian cancer (except mucinous cell type) who are under the age of 70 years; or who are over 70 years AND have a family history of breast and ovarian cancer through Genetic Health QLD (public). Wait times may be considerable.

Testing is also available privately through a US-based company (color.com) at \$400. As an accredited provider, I can request a genetic test for my patients online. In brief, after I requested the test, the patient will receive an email with information and a weblink to order her test, which will be posted to her. Payment is made through

the patient over the internet. After a couple of weeks, the patient will receive the test kit in the mail. She will need to provide a sputum sample (3 ml) and send the test back to the company. A result will be provided to the patient and to me within 4 weeks.

Ideal patients for genetic testing are:

1. New patients diagnosed with ovarian cancer (including fallopian tube and peritoneal cancer);
2. Ovarian cancer survivors

I hope that the low cost and the convenience of ordering the genetic test from home will decrease the barriers of genetic testing even further. As a consequence, the incidence of preventable secondary cancers will be reduced.

feMMe trial

Many of you may be aware that the feMMe trial allows patients with

- Endometrial hyperplasia or
- Endometrioid endometrial cancer (FIGO grade 1)

to avoid a hysterectomy and be treated with a hormone-releasing IUD instead. The feMMe trial enrolls patients who are morbidly obese, who have serious medical comorbidities or young women who wish to retain fertility.

The feMMe trial is organized through the Queensland Centre for Gynaecological Cancer Research (**QCGC Research**) and also runs in Victoria and Western Australia, as well as in New Zealand. To date the feMMe trial enrolled 104 patients (target 165 patients).

The trial has been received enthusiastically by patients and gynaecological oncologists.

Avoiding surgery in high-risk patients is associated with a much lower risk of adverse treatment events.

We estimate that 70% of patients will have a complete resolution of their endometrial hyperplasia with atypia or endometrial cancer after 6 months.

QCGC Symposium

Every two years, the Queensland Gynaecological Oncologists organise a symposium to share new developments in gynaecological cancer surgery.

This year, the symposium will have two areas of interest.

1. With the introduction of the new National Australian Cervical Cancer Screening Program on 1 December 2017, we will provide most valuable information for GPs and gynaecologists. Amongst other presenters, we have been able to secure Prof Ian Hammond as speaker. Prof Hammond chaired the Government Advisory Committee on cervical cancer screening.
2. The other part of the symposium will focus on News in Gynaecological Cancer Surgery, such as surgery on obese women, laparoscopic management of large pelvic masses and HRT after gynaecological cancer.

This symposium is a unique chance to get updates on everything you need to know about the new Cervical Cancer Screening program as well as updates on news in gynaecological cancer surgery.

To view the program and to register click here:

<https://yrd.currinda.com/register/event/1118>

Gynaecologists will receive 6 CPD points. The attendance fee is \$110 for the whole day.

My colleagues and I look forward to welcoming you at the symposium.

For more information, please phone Kate Murphy from YRD on 3368 2422.



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If you are experiencing any issues or wish to discuss a particular case, please contact my staff on the above number from 8.00am – 4.30pm weekdays or phone me on my mobile 0411 800 029.

Patient care and providing a timely has always been my top priority and I strive to continually improve the quality of the service my team and I deliver, to meet the needs of our patients.

Thank you in advance for your support to date. Stay up to date by subscribing to my blog at obermair.info or LIKE my Facebook page <https://www.facebook.com/drobermair/>