Prof Andreas Obermair

gynaecological oncology news

WINTER EDITION 2019

Welcome

Establishing a practice in gynaecological oncology gave me the opportunity to organise it in such a way how I would like to see my family or me treated. There are 3 things patients and doctors specifically like about our practice.

- Patients get seen quickly. Usually we see patients within a week.
- Our treatment approach is based on the latest scientific knowledge even before it becomes mainstream.
- We call it as it is. In dealing with cancer or the threat of it, there is no room for pretending.

In this newsletter we discuss a sensitive topic – the inadvertent finding of cancer. How can we avoid it?

Best wishes,

Andreas Obermair

feMMe

The feMMe trial has enrolled 151 of 165 women with endometrial cancer or endometrial hyperplasia with atypia. Your patient is eligible if she has a body mass index of 30 kg/m2 or higher and if her CA125 is 30 U/ml or less.

The results to date are spectacular. Approximately 7 of 10 patients can avoid a hysterectomy. This is relevant to fertility patients or to elderly women with multiple comorbidities.
For more info email **rooms@obermair.info**

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.

Phone 07 3128 0800 | rooms@obermair.info

www.obermair.info

How to avoid an unexpected gynaecological cancer diagnosis

(AND THE ANGST IT CAUSES)

Recently, I have been contacted a few times by gynaecological colleagues who were upset that they operated on a patient with presumed benign disease but the histopathology showed cancer. In Australia, the overall risk of an unexpected malignancy after gynaecological surgery is 0.4%.[1] If my colleagues would have known or suspected that the patient had cancer, they would have managed the patient differently.

I hope you will find useful some simple hints we all can use to minimise the risk of stumbling into cancer unexpectedly; or if cancer is found, do as little harm as possible.

Ovarian Cancer

Review the actual pelvic ultrasound and CT scan images

If you only read the written medical imaging report, you may not be able to discern the seriousness of an ovarian lesion. Some radiologists are better than others in warning gynaecologists about the risk of an ovarian malignancy.

As a rule of thumb:

- Cystic lesions without any solid areas are likely benign;
- Lesions that contain fat tissue are often dermoids (benign);
- Any lesions with solid elements require your judgement call;
- Any solid lesions in postmenopausal women should make you cautious.

Make your judgement not on tumour markers alone

Negative tumour markers are not a guarantee for the presence of a benign tumour. While CA125 is expressed in the majority of high-grade serous ovarian cancers, it is commonly not elevated in patients with clear cell, endometrioid or mucinous types of tumours.

At laparoscopy, always use an extraction bag to remove all specimens

Keep in mind that your diagnosis of a benign ovarian cyst or fallopian tube is presumptive only. For example, in women who request bilateral salpingectomy to reduce their risk of ovarian cancer, we all presume the tubes will be benign. However, the risk of finding occult fallopian tube cancer is around 2%. Therefore, removal of fallopian tubes through laparoscopic ports without an extraction bag will harm one in 50 women.

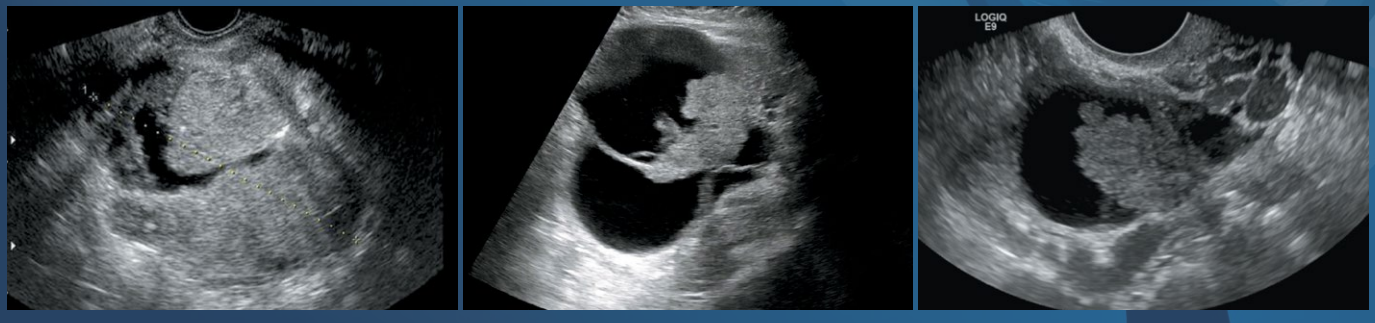
Avoid ovarian cystectomies in postmenopausal women (higher risk, no gain)

The risk of finding ovarian cancer is much higher in postmenopausal than in premenopausal women (higher risk). While in premenopausal women we can justify preserving ovarian tissue to avoid premature menopause, this is not valid in postmenopausal women (no gain).

Avoid a vaginal hysterectomy in women with an ovarian mass/cyst

In women with presumed benign ovarian cysts, we always inspect the pelvic and abdominal cavity. A comprehensive inspection of the pelvis and abdomen is impossible if surgery is performed through a vaginal approach.

Below: This is what a suspicious mass looks like.



Uterine cancer

Any abnormal bleeding – even in young women – requires an endometrial assessment. Uterine cancer does develop in young women, too

Menorrhagia is one of the most common indications for hysterectomy in Australian women. Generally, women are offered treatment with intrauterine progestins, but some women request a hysterectomy upfront.

If a hysterectomy is performed and uterine cancer is found unexpectedly, many women will require additional surgery to remove lymph nodes and/or the ovaries that may have been preserved.

If a diagnosis of uterine cancer is known, the patient can be offered sentinel node biopsy, which removes only one node on either side instead of many nodes. Those women benefit from a reduced risk of lymphoedema in the long-term.

Never morcellate a uterus without using a confinement or containment bag

Keep in mind that our diagnosis of a benign condition is presumptive only. Even with a negative D&C, a malignancy (e.g., sarcoma) may escape our diagnostic tests. Uterine sarcomas are typically diagnosed only after surgery.

Up until ten years ago, vaginal morcellation of a hysterectomy specimen was commonly performed. The case of an American anaesthetist who had a hysterectomy, unprotected morcellation, dissemination of sarcoma tissue into the abdominal cavity and who later died from her disease, changed that view.

Since then, confinement systems (large bags) have become available that can be introduced into the pelvis, the specimen (ovaries, uterus) can be moved into the bag and then can be morcellated through port sites or the vagina without tissue spillage.

Unprotected morcellation without using confinement systems is outdated, should not be performed and can lead to litigation.

Cervical cancer

Every woman who is scheduled for a hysterectomy should be up to date with her cervical cancer screen

Sometimes, women who request a hysterectomy for CIN or AIS don't understand why these lesions need to be investigated before they can have a hysterectomy.

If a cervical biopsy returns CIN or AIS, perform a LLETZ or a cone biopsy before the hysterectomy. You can go ahead with a hysterectomy if the LLETZ shows CIN/AIS only when all margins are clear

1 To check out how often you encounter an unexpected cancer diagnosis compared to your colleagues, gynaecologists use SurgicalPerformance.com

Otherwise, the risk of a cervical cancer in a patient with a biopsy-proven CIN or AIS is between 3% and 5%.

If the patient with presumed CIN or AIS has a "standard" hysterectomy and cervical cancer (stage 1a2, 1b1/2) is found "unexpectedly", there is a high chance she is undertreated. The issue of paracervical tissue margins (parametria) and regional lymph nodes will need to be addressed and may require additional surgery or radiation treatment. Unfortunately, further surgery can only be performed once the inflammation from the initial surgery has settled, which may take 6 to 8 weeks. Radiation is associated with risks of damage to the bowel and the bladder, which can worsen over the years and cause poor quality of life in the long term.

Would the cancer have been known beforehand, the patient could have been offered a "radical" hysterectomy and pelvic node dissection, likely without requiring radiation treatment.

Vulval cancer

Any suspicious vulval lesion should get a punch biopsy before you excise it

If patients are diagnosed with vulval cancer based on a wide local excision, far more often than not, the surgical resection margins (should be 1 cm) are involved or insufficient. In this case, the patient requires a return to the operating theatre for a surgical re-excision.

Unfortunately, further surgery can only be performed once the inflammation from the initial surgery has settled, which may take several weeks. Vulval wounds can heal very slowly and have a high risk of getting infected.

Infected wounds obliterate the lymphatic vessels and a sentinel node biopsy may become infeasible. In such a case, the patient will require a full groin node dissection, which leaves the majority of patients with significant lymphoedema.

In contrast, if the diagnosis is made on a punch biopsy, there is only a very small risk of infection or delay of treatment.

If cancer is found incidentally...

If you come across an incidental finding of a malignancy that was not expected, it may be worthwhile reflecting on the case once the emotions settle. I suggest you check your file notes and even write down the key facts and dates. In hindsight, could have the case been managed differently? Are there any learning points that you would consider if this or a similar patient presents the next time?

Sometimes it is even worthwhile discussing the case with a friendly colleague who might be able to provide an unbiased view. Commonly, learning points can be identified to help you reduce the risk of this happening again.

Preoperative Medical Imaging

In my surgery, we arrange for medical imaging of the pelvis, abdomen and chest preoperatively. In the last month alone, we found:

- 1 woman with incidental (early stage) lung cancer;
- 1 woman with multiple pulmonary emboli;
- 1 woman with suspected lung metastases on X-ray that turned out to be harmless granulomas on a CT scan.

The woman with lung cancer has a high chance of cure because it was found incidentally at an early stage.

The woman with multiple pulmonary emboli required urgent surgery for a symptomatic, very large pelvic mass that caused pain. She had a laparotomy after an IVC filter was inserted and she recovered well.

Everest Base Camp trek 2019

I had the amazing opportunity to trek to Everest Base Camp as part of a fundraiser for the Cherish Women's Cancer Foundation.

Together with 11 other passionate patients and health professionals, we trekked for 16 days to Base Camp and back. The trek was physically strenuous but I am very grateful that I had the chance to tackle it. We raised $166,000, which will directly go towards gynaecological cancer research.

The scenery was amazing and mind-blowing. To watch a 3-minute video about impressions of the trek, go to the Cherish Facebook page.

We also got to know the people of Nepal who live in very basic conditions without heating, power or running water. I still think of that when I take a hot shower every night.

Cherish will organise another fundraising hike next year – The Larapinta Trail. It is moderate hike, takes 6 days through the red centre of Australia and is considered one of the epic hiking treks in the world. Trekkers need to carry a light day pack only. Please consider joining me **andreas@cherish.org.au.**

Prof Andreas Obermair MDVIE, FRANZCOG, CGO

Gynaecological Oncology Laparoscopic & Pelvic Surgery

Phone 07 3128 0800 | rooms@obermair.info | **www.obermair.info**

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/**