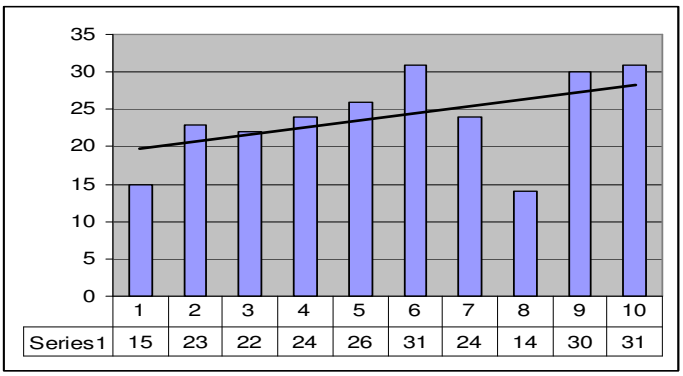
Gynaecological Oncology News

A/Prof. Andreas Obermair October 2006

Primary Peritoneal Carcinoma on the rise

Early Diagnosis is the Challenge

Primary Peritoneal Carcinoma (PPC) is a rare condition. It resembles ovarian cancer, arises from the peritoneal lining and does not involve the ovaries. Over the last 10 years PPC has shown a slow but steady increase with a peak of 31 cases in 2005 (see graph below). The Trendline (*black*) outlines this increase.



PPC arises from peritoneal cells and only occurs in females. The mesothelium of the peritoneum and the germinal epithelium of the ovary arise from the same embryologic origin; therefore, the peritoneum may retain the multipotentiality of the Müllerian system, allowing the development of a primary carcinoma.

PPC is thought to be associated with hereditary factors in 25 to 30%; Those hereditary factors are mainly BRCA1 or 2 mutations, which cause ovarian cancer in up to 40% of female carriers. BRCA1 or 2 carriers are strongly advised to have both ovaries and fallopian tubes removed (bilateral salpingo-oophorectomy; BSO) after the age of 35 years. However, there is a small risk of developing PPC after bilateral salpingo-oophorectomy, which is less than 2% according to current literature.

PPC usually presents with most unspecific abdominal symptoms, such as bloating, pain and other nonspecific symptoms secondary to ascites. Clinical examination can be very helpful as the tumour nodules often can be felt in the Pouch of Douglas. Ultrasound or CT scanning often are insensitive and may reveal no major abnormalities if ascites is not predominant. Sometimes an omental cake or nodules of cancer can be found can be imaged on the peritoneal surfaces under the diaphragm on CT. The serum marker CA-125 is extremely elevated. Finally, patients will need a surgical exploration, which leads to a histological diagnosis. At surgery, the peritoneum is often coated with a layer of cancer throughout the pelvis and the abdomen.

Histologically, PPC is indistinguishable from serous epithelial ovarian carcinoma; however, primary ovarian cancer can be excluded because in PPC the ovaries appear of normal in size and are not the primary source of the cancer.

Treatment: Similar to ovarian cancer, cytoreductive surgery followed by chemotherapy is the treatment of choice. Surgery will be aggressive including as much cytoreduction as possible. Statistically, patients with no residual tumour after surgery do much better than patients with even 1 cm of tumour left behind. Carboplatin plus paclitaxel is associated with a high response rate and improvement of median survival.

Internationally, common survival rates are 0% at 5 years but in Queensland the survival at 5 years is 29%.

More than 100 patients in LACE Trial

Stage 1 of the LACE trial heading towards completion

The LACE trial (**L**aparoscopic **A**pproach to **C**arcinoma of the **E**ndometrium) randomizes between laparoscopy and laparotomy since November 2005 very successfully. Stage 1 aims to recruit 180 patients, which will be achieved in April or May 2007. Then we will decide if we want the trial go into stage 2, with enrollment of another 470 patients.

The trial recruits patients from QLD, NSW, VIC and WA. An expansion into New Zealand and the U.K. is likely at the end of this year.

At present the LACE trial is the best treatment option for patients with endometrial cancer

In QLD the trial has been so successful because it is supported by all gynaecological oncologists. The trial is most popular with patients and referring doctors and provides state-of-the-art treatment under safe conditions.

Please contact me if I can answer questions about the topics raised above or if you require advice about a patient.

A. Obermair, www.obermair.info; ☎ 07 3847 3033