Non-surgical treatment for **endometrial** cancer &

What's new in **ovarian** cancer management

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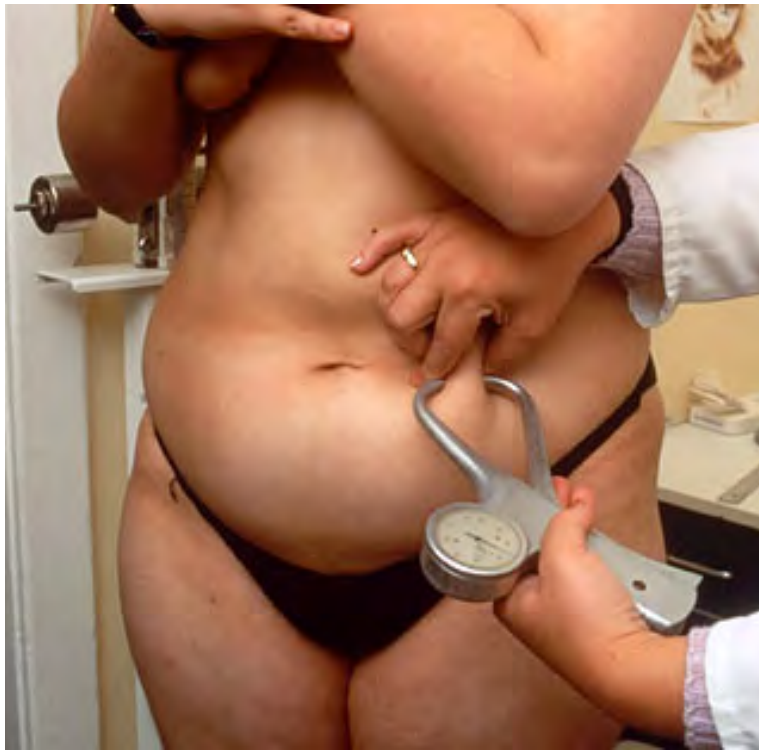
www.Obermair.info

NON-SURGICAL TREATMENT OF ENDOMETRIAL CANCER

Endometrial Cancer - Issues



Incidence: 2000 women/yr. (rising)

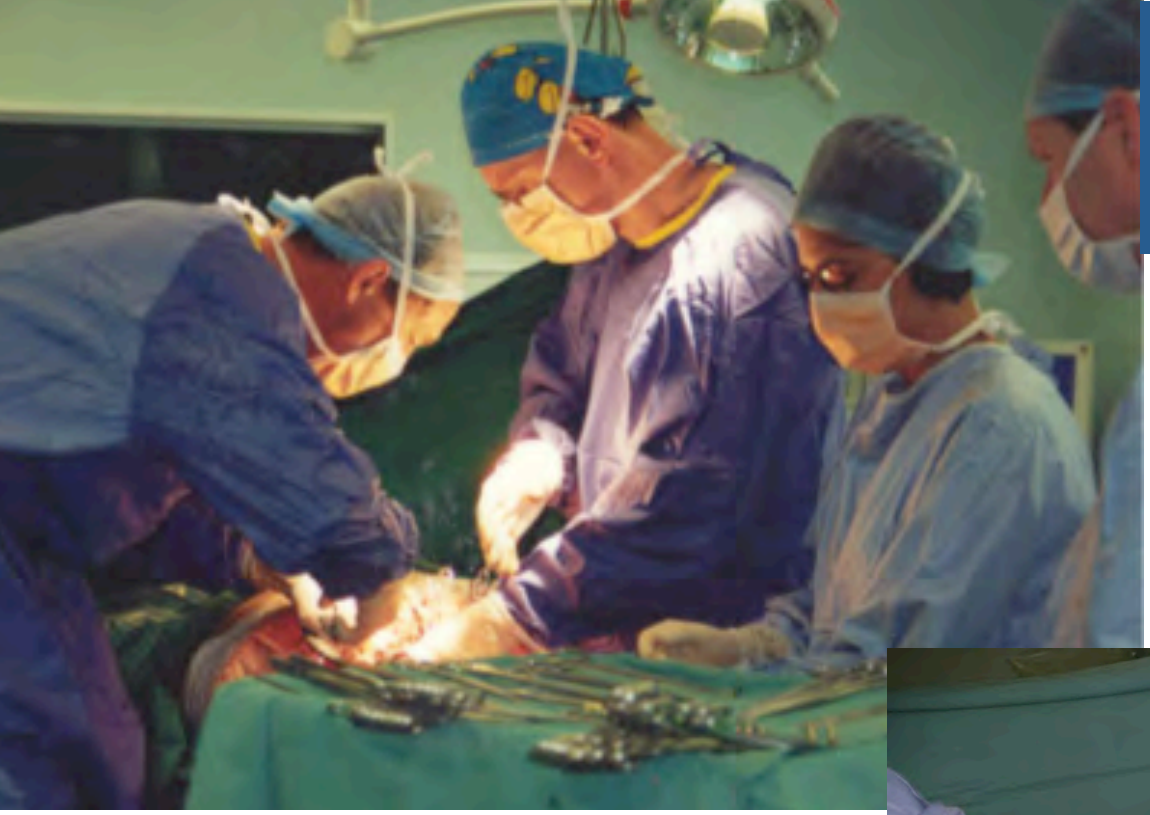
Risk factors: Obesity, DM/HTnsion, Lynch

Treatment: Total Hysterectomy

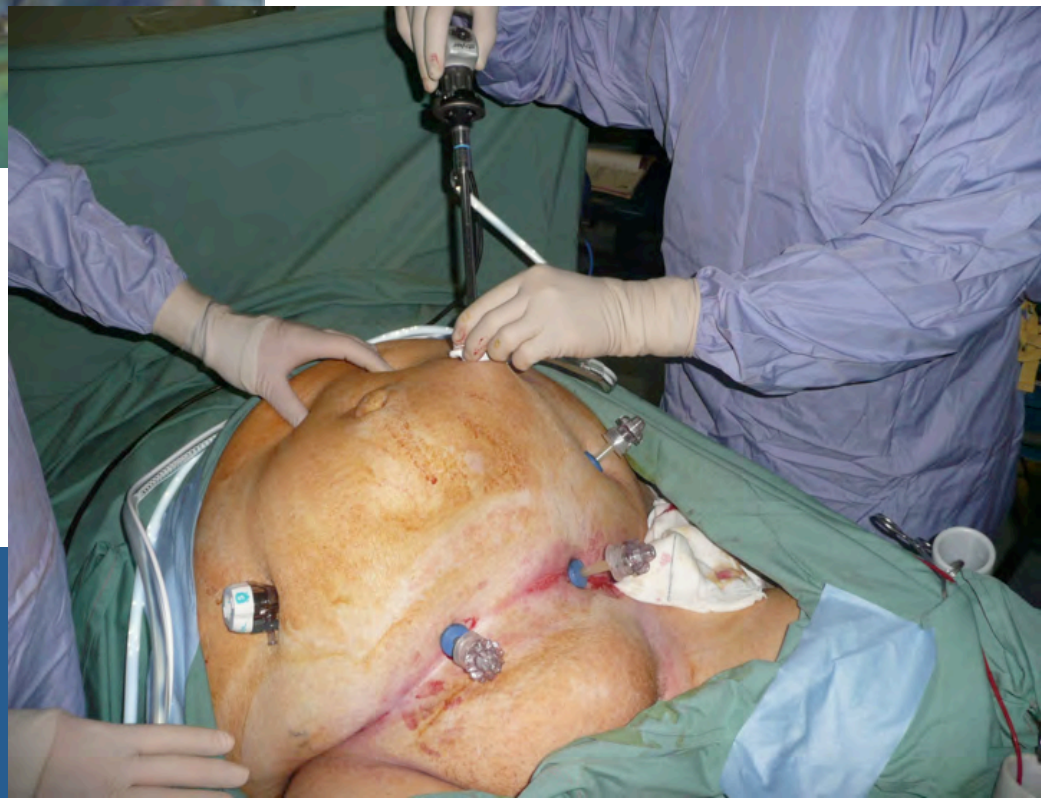
Surgical complications: Frequent

Costs: 14,000 bed days ($1000/ day); surgery costs $7000 per patient

Survival: >80% at 5 years



Before 2003
(open surgery)



From 2003
(laparoscopic surgery)

Laparoscopic vs. Open Hysterectomy
(for cancer and benign conditions)

- Discharge from hospital
  - 2 vs. 5 days
- Pain + need for analgesia
- Quality of Life
  - Functional QoL
  - Body Image
  - Personal wellbeing
- Surgical adverse events
  - reduced by 30% to 50%

Lap hysterectomy – 4 weeks

"I had a great week of skiing 4 weeks postop. No issues! The surgery pain was no worse than a strong menstrual cramp." Margaret

Open hysterectomy through an abdominal incision is outdated and should only be performed under exceptional circumstances.

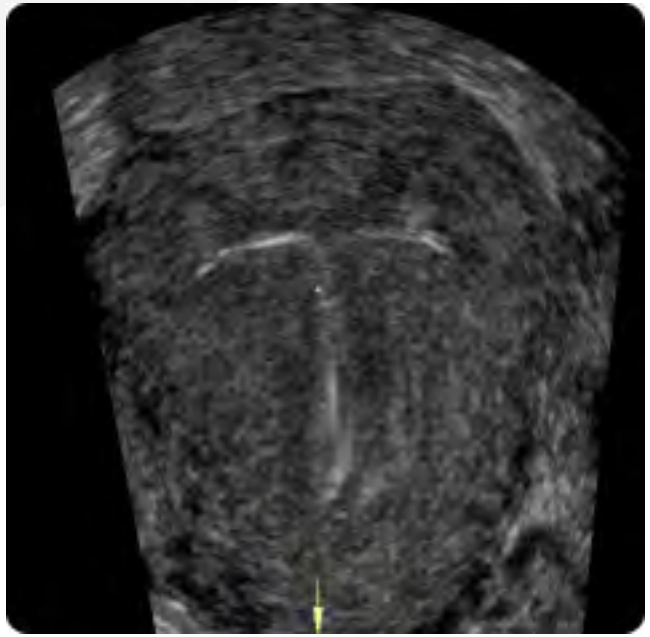
Hysterectomy – not great option for …

1. Elderly and medically compromised
2. Young & wishing to preserve fertility
3. Morbidly obese women

feMMe Trial

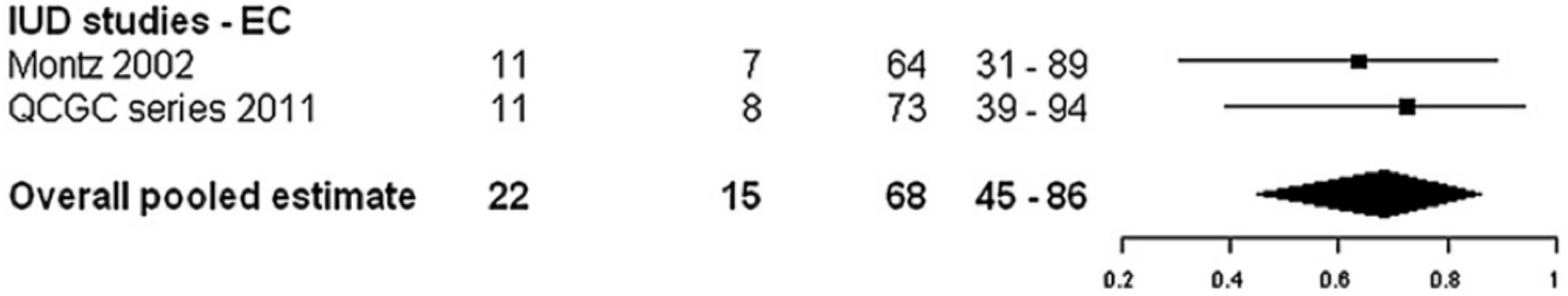
A Phase II Randomised Clinical Trial of Mirena® ± Metformin ± Weight Loss Intervention in Patients with Early Stage Cancer of the Endometrium (ANZGOG 1301)

Study Chair: Andreas Obermair
Lifestyle intervention: Monika Janda
Biomarker: Donal Brennan
Statistics: Val Gebski
Central pathology review: Jane Armes
Trial manager (central): Fiona Menzies
ANZGOG: Julie Martyn



Mirena

Mirena to treat endometrial cancer successfully:



Unclear:

1. Magnitude of the effect
2. In what patients is it effective?

Baker et al.: Gynecol Oncol 2012

feMME Trial - Study Design

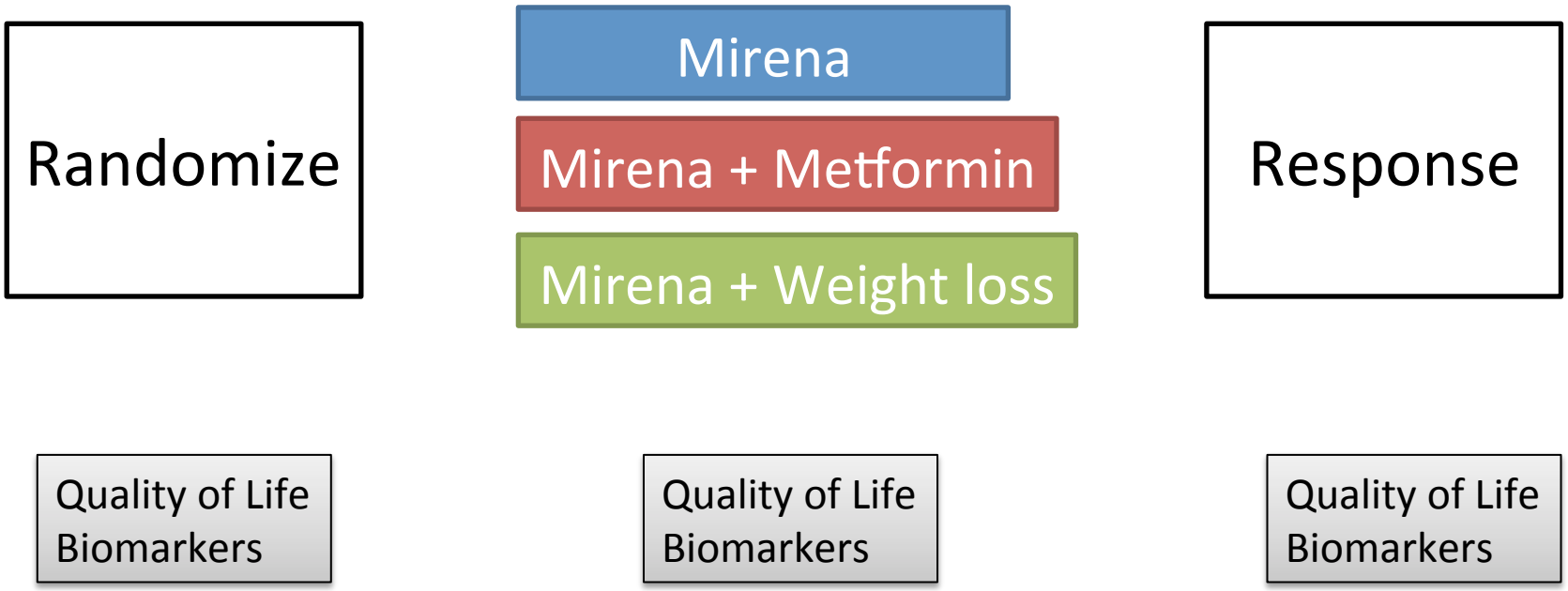
- Phase II, randomised clinical trial (165 women)
- Eligibility:
  - Complex endometrial hyperplasia with atypia or
  - Grade 1 endometrioid endometrial adenocarcinoma on a curette or endometrial biopsy.
- The participants will be randomised into one of three treatment arms;
    - Mirena®
    - Mirena® + Weight Loss Intervention
    - Mirena® + Metformin

feMME Trial - Inclusion Criteria

1. Elderly and medically compromised
2. Young & wishing to preserve fertility
3. Morbidly obese women

G1, minimally invasive EAC or EHA

feMME trial - Study Schema



feMME Trial – Anticipated Benefits

Objectives

- Efficacy: Pathological complete response (pCR) in endometrial cancer at 6 months.
  - Added effect of Metformin or Weight loss
- Prediction of treatment response through biomarkers.

Outcomes

1. Reduction of hospital stay: This trial will save 825 hospital bed days for 165 patients enrolled, equating to $ 1 million cost savings;
1. Reduction of surgical complications : This trial will save 50 women a major surgical complication during the time of this trial and save more than $ 1 million from saved complication costs;
2. Fertility: This trial will allow some women to retain the uterus and keep their reproductive option throughout cancer treatment.

How the GP can help

- Take a family history
  - Family history of endometrial + bowel cancer can be indicative of Lynch syndrome
  - Erratic bleeding needs to be investigated (Pipelle)
- Inform: Endometrial cancer does not necessarily imply loss of fertility;
- All postmenopausal bleeding needs to be investigated.

NEWS IN OVARIAN CANCER TREATMENT

THE BEACH VOLLEYBALL BATTLE AGAINST OVARIAN CANCER

The Battle Against Ovarian Cancer

› How to Register
› Sponsor a Friend
› How to Donate

23 FEB 2014

The Battle Against Ovarian Cancer 2014

Registrations open very soon!

Register your interest by emailing support@battleagainstovariancancer.com and we'll let you know the minute registrations are open. Then, register your team of five to ten players and we'll see you for an awesome day on the sand!

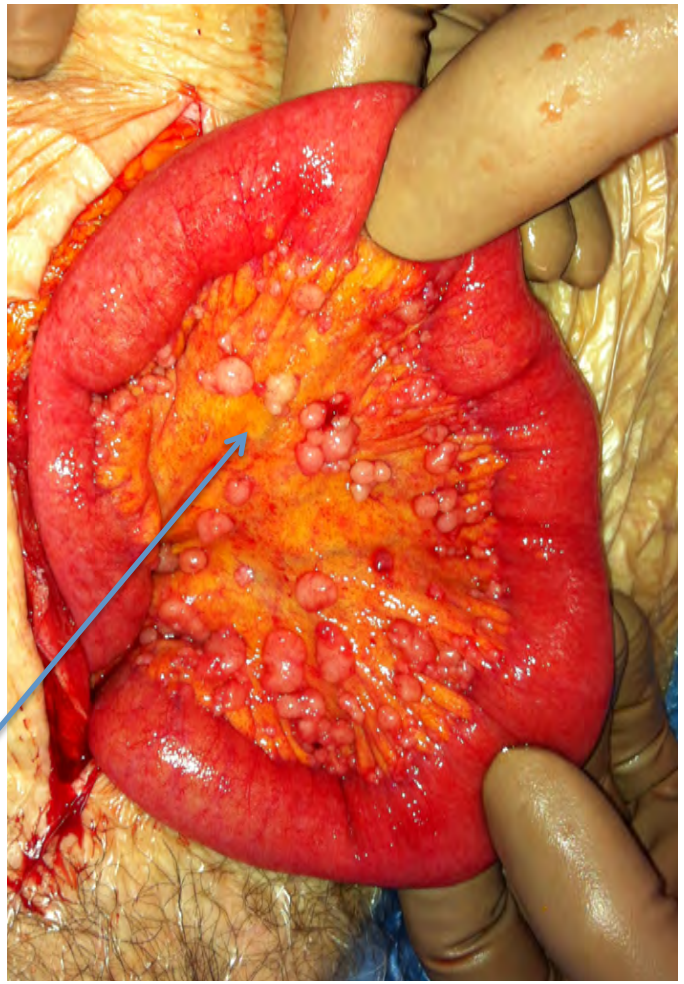
Battle Against Ovarian Cancer

The Battle against Ovarian Cancer

Surgery → **Chemotherapy**

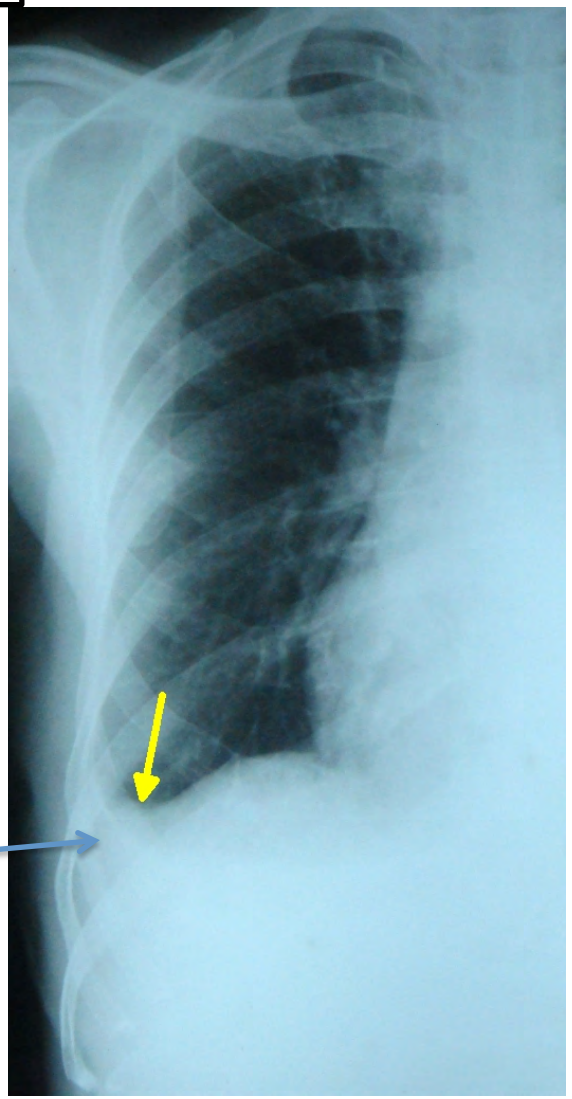
Conventional

- Aggressive surgery: remove all macroscopic tumour
- Ideal if tumour growth is limited
  - Mass, omental caking, disease in the pelvis
- Suboptimal if tumour growth is wide-spread
  - E.g., Bowel mesentery



Chemotherapy → Surgery

- Neoadjuvant chemotherapy
  - Shrink disseminated tumour
  - Evaluate if patient responds to chemo
- Ideal if …
  - Tumour wide spread on CT (involvement of bowel mesentery, diaphragmatic surfaces /liver)
  - Elderly patient
  - Patient is medically compromised
  - Pleural effusion
- Requires confirmation of ovarian cancer diagnosis (ascites tap or laparoscopy)



Evidence

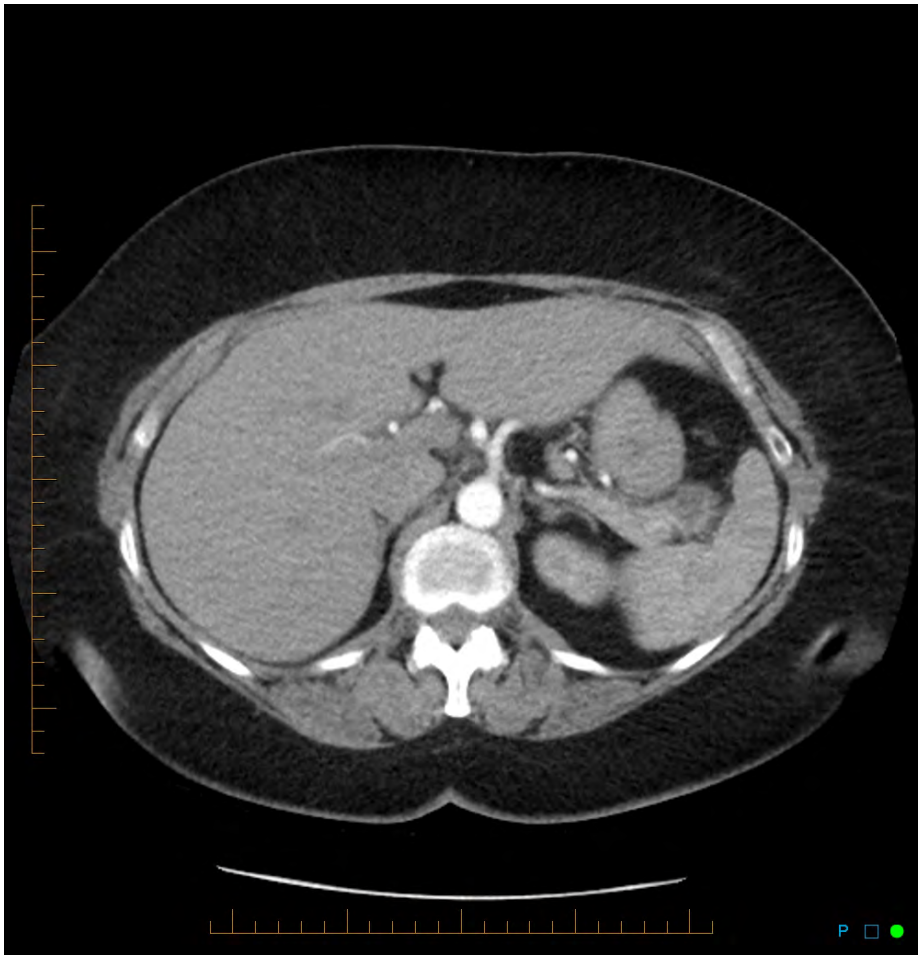
Neoadjuvant Chemotherapy or Primary Surgery in Stage IIIC or IV Ovarian Cancer

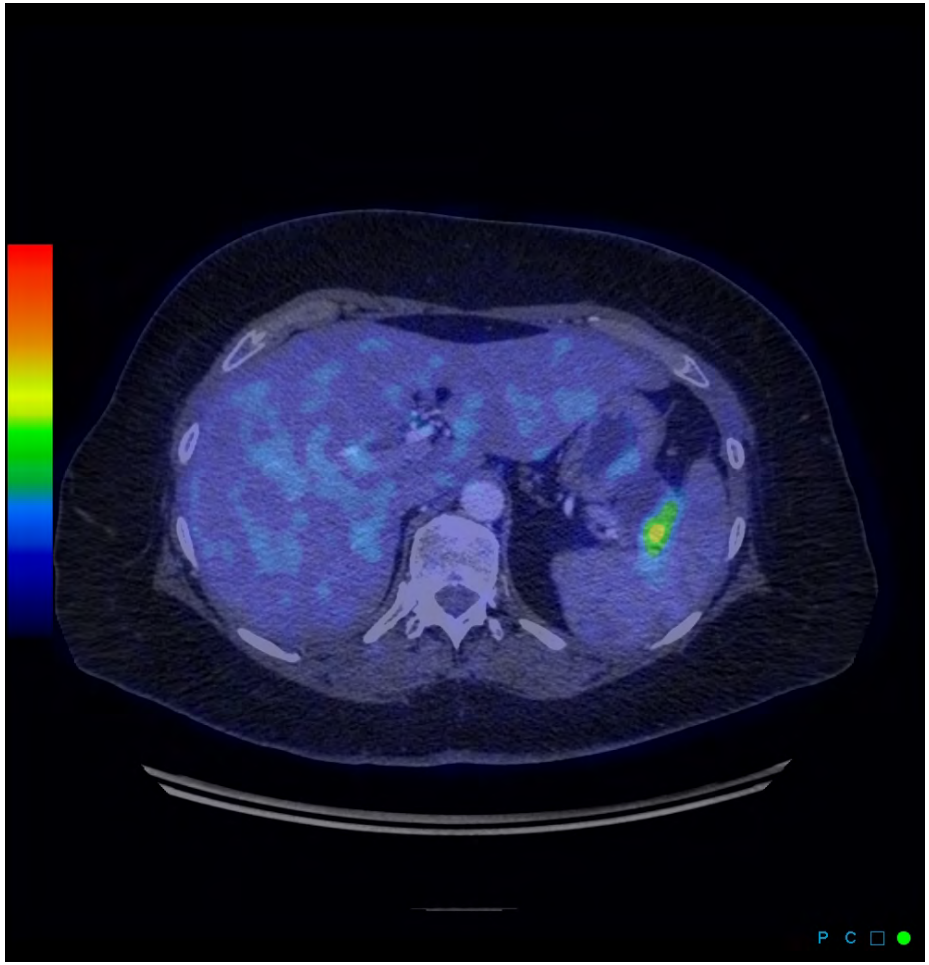
Ignace Vergote, M.D., Ph.D., Claes G. Tropé, M.D., Ph.D., Frédéric Amant, M.D., Ph.D., Gunnar B. Kristensen, M.D., Ph.D., Tom Ehlen, M.D., Nick Johnson, M.D., René H.M. Verheijen, M.D., Ph.D., Maria E.L. van der Burg, M.D., Ph.D., Angel J. Lacave, M.D., Pierluigi Benedetti Panici, M.D., Ph.D., Gemma G. Kenter, M.D., Ph.D., Antonio Casado, M.D., Cesar Mendiola, M.D., Ph.D., Corneel Coens, M.Sc., Leen Verleye, M.D., Gavin C.E. Stuart, M.D., Sergio Pecorelli, M.D., Ph.D., and Nick S. Reed, M.D. for the European Organization for Research and Treatment of Cancer–Gynaecological Cancer Group and the NCIC Clinical Trials Group — a Gynecologic Cancer Intergroup Collaboration

N Engl J Med 2010; 363:943-953 | September 2, 2010 | DOI: 10.1056/NEJMoa0908806

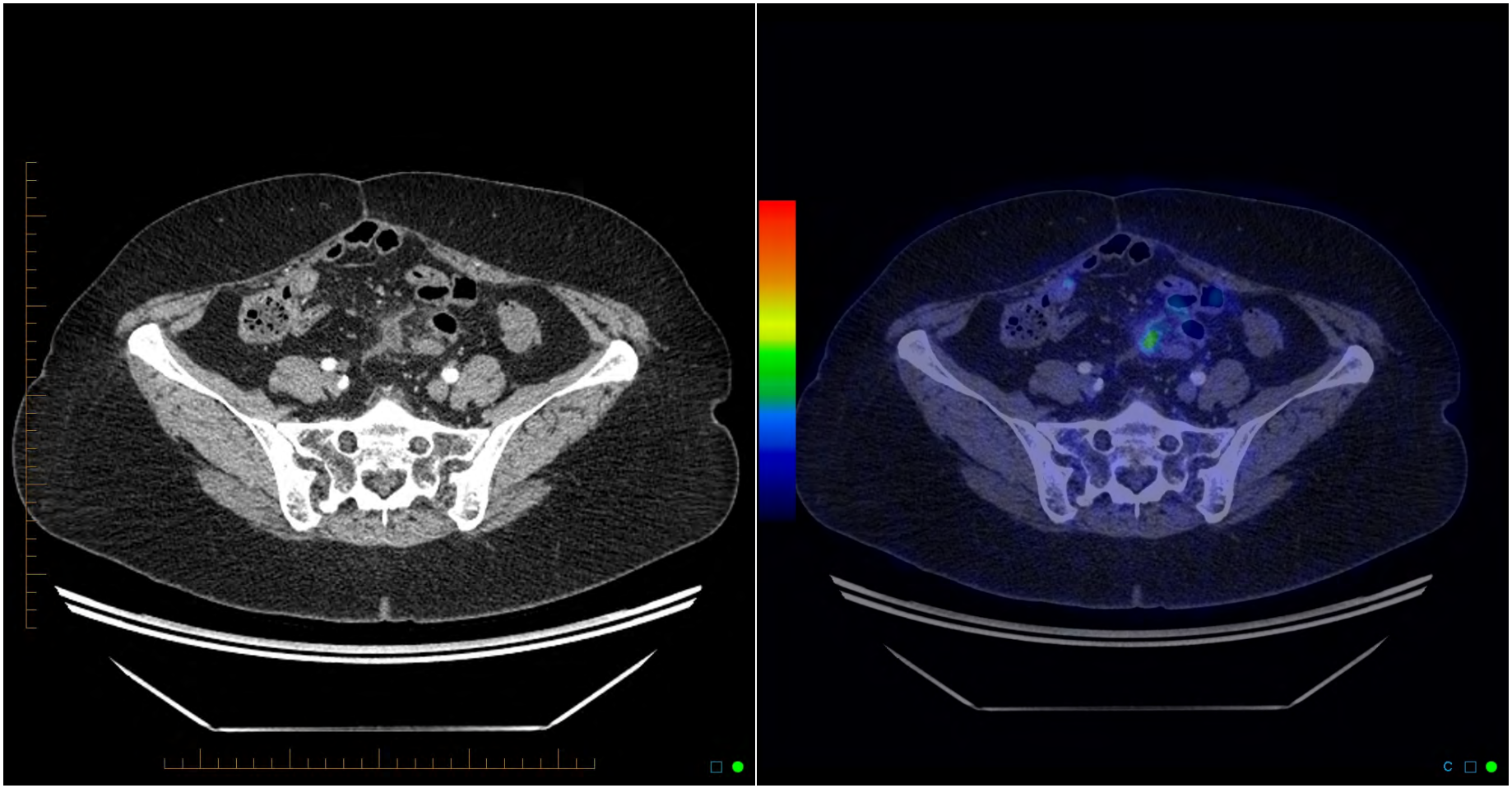
- Operations less extensive
- Residual tumour-free after surgery more likely
- Less surgical complications
- Hospital stay shorter

PET scan #1

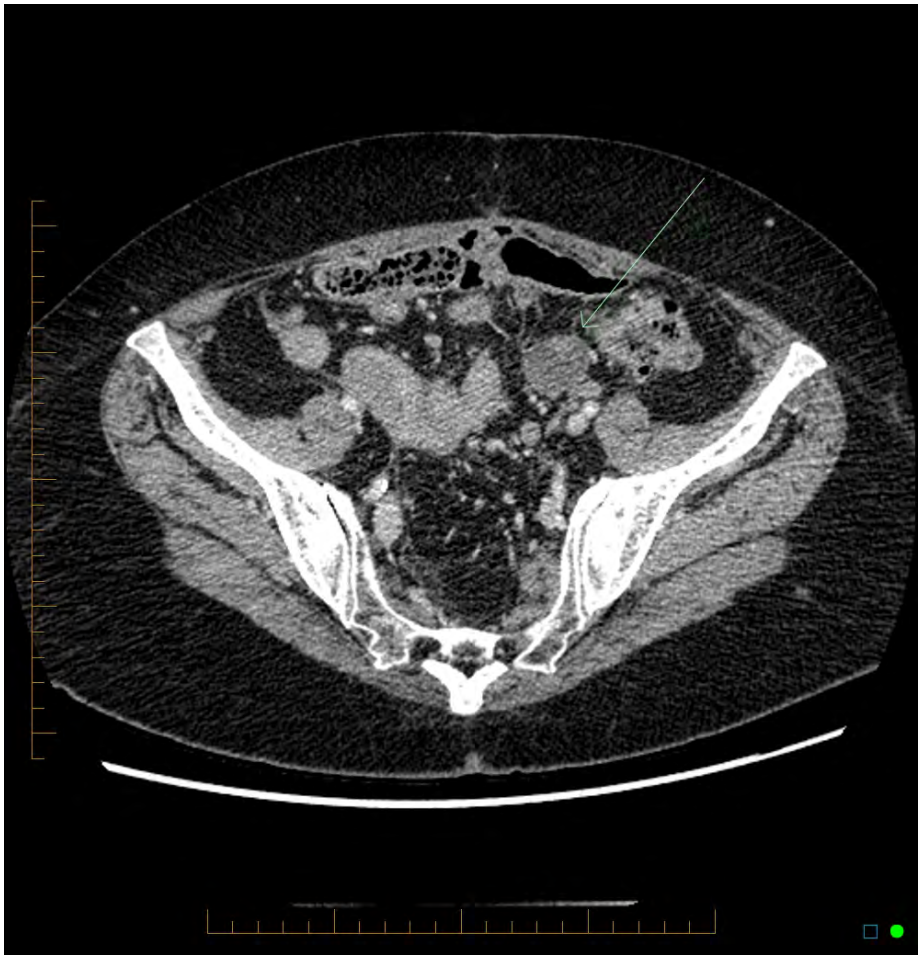


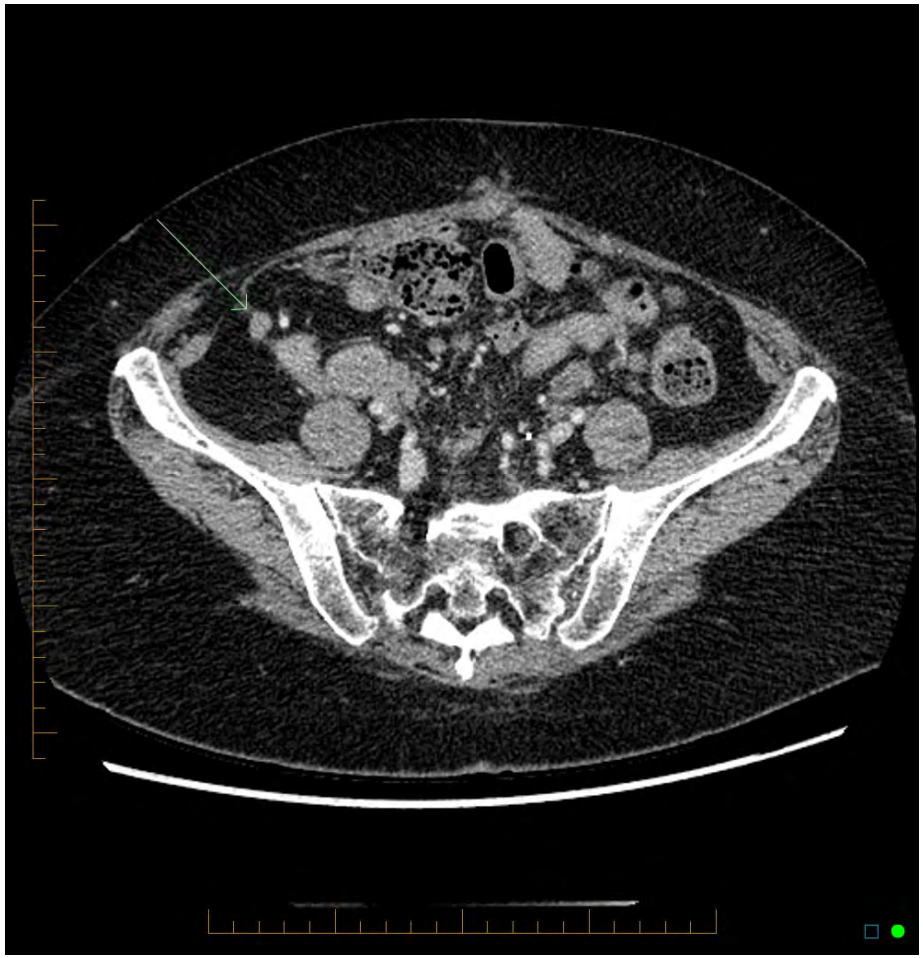


PET scan #2

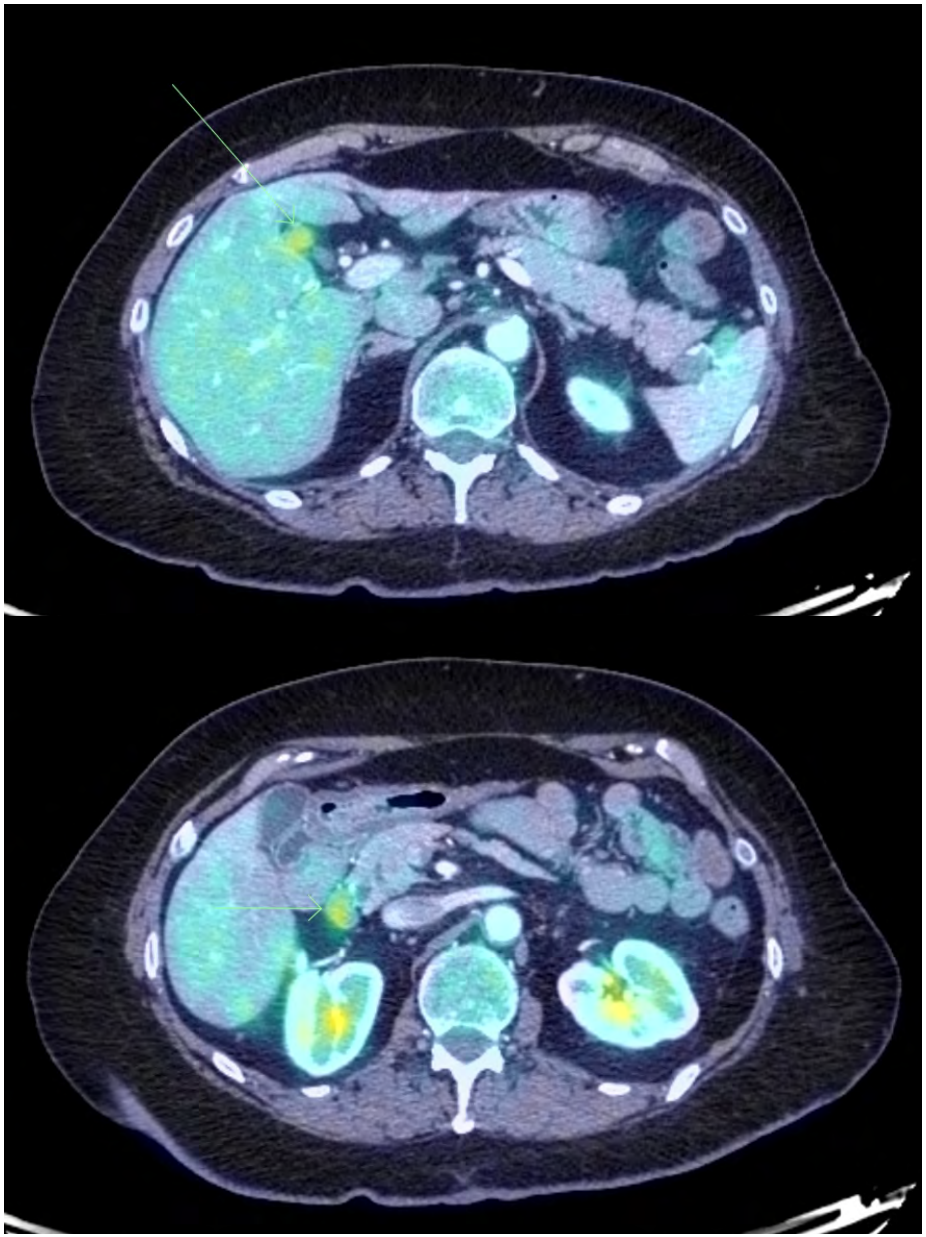


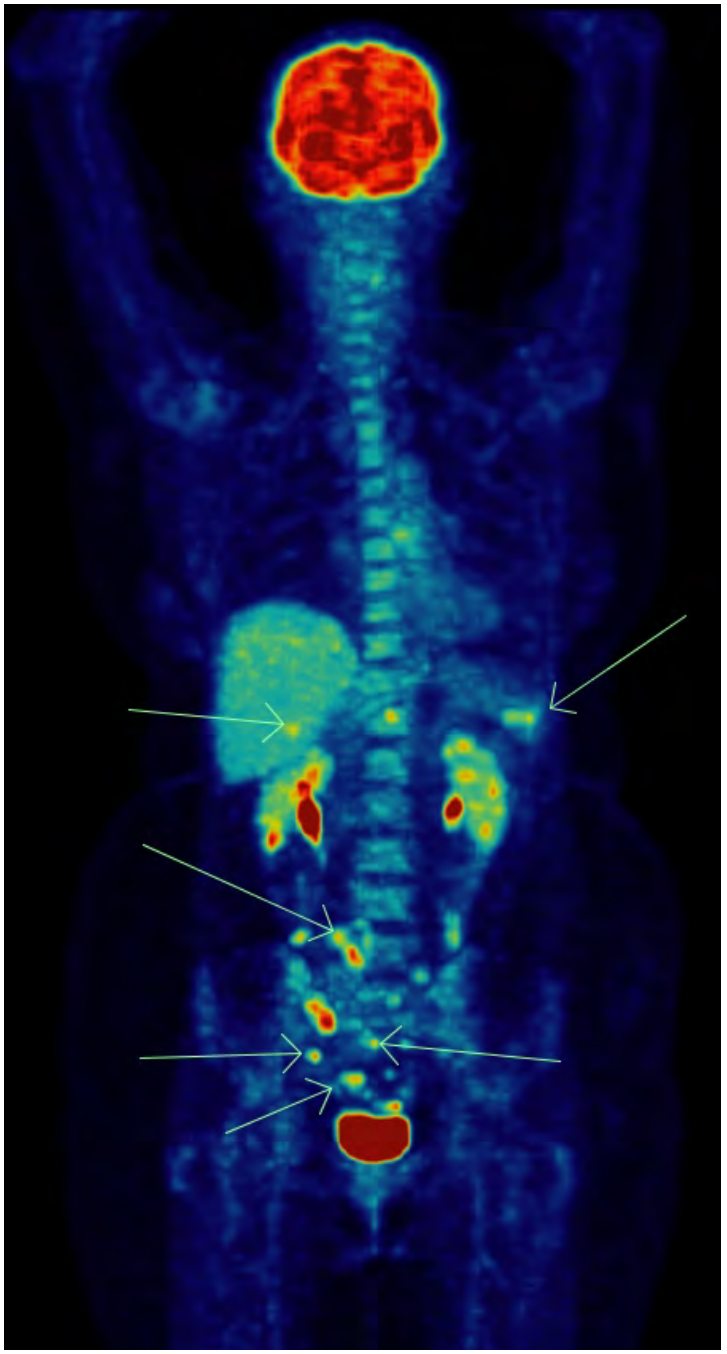
PET scan #3





PET scan #3





How the GP can help

- Investigate symptoms
  (Weight loss is not a hallmark of ovarian cancer)
- US > CT
- Tumour markers (CA125, HE4, CA19.9, CEA)
- Expedite referral
  - Privately: directly to a gynaecol. Oncologist
  - Publicly: RBWH, Mater H., Gold Coast H.

Medicare will only rebate a PET-CT referral from a specialist

Don’t biopsy or drain ascites.

Gynaecological Cancer Symptoms

Symptoms	%
Pain (abdomen, lower back pelvis)	19%
Increased abdominal size	17%
Urinary frequency	15%
Increased wind or constipation	13%
Difficulty eating/feeling full quickly	13%
Heavier/longer periods	12%
Pain/discomfort during sex	9%
Itching/pain/soreness of vulva	7%
Bleeding between periods	5%
Smelly or blood stained discharge	5%
Bleeding during/after sex	3%
Growth/lump/sore/ulcer on vulva	3%
Postmenopausal bleeding	1%

Low et al.: Br J Cancer 2013

How the GP can help

- Investigate symptoms

  (Weight loss is not a hallmark of ovarian cancer)
- US > CT (pelvis/abdomen/chest)
- Tumour markers (CA125, HE4, CA19.9, CEA)
- Expedite referral
  - Privately: directly to a Gynaecological Oncologist
  - Publicly: RBWH, Mater H., Gold Coast H.
- Don’t biopsy or drain ascites;
- For follow-up: PET-CT (needs specialist referral).

Professor
Andreas Obermair
MD$_{VIE}$, FRANZCOG, CGO

REFERRAL GUIDE FOR Health Professionals

MAKE AN Enquiry

Information » Gynaecological Cancer

- Gynaecological Cancer
  - Uterine Cancer
  - Ovarian Cancer
  - Cervical Cancer
  - Vulval & Vaginal Cancer
- Familial Cancers
- Hysterectomy
- Medical Imaging
- Tumour Markers
- Uterine Fibroids
- Adnexal (pelvic) masses & Ovarian cysts
- Adenomyosis
- Quality Control
- Useful Resources
- Links

Gynaecological Cancer

Uterine Cancer

In Australia, uterine cancer is the most common gynaecological cancer with more than 2000 women newly diagnosed every year. Typically it is a disease of postmenopausal women. Find out more information about the treatment and outcomes of uterine cancer.

www.obermair.info