MANAGING PELVIC MALIGNANCIES

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The three most comm
gynaecological canc
affecting New Zealand wom
are endometrial, ovarian
cervical cancer. But a diagn
doesn't mean a death senten
Here, we give a straightforw
guide to these cancers – the
factors, symptoms to look
and possible treatme
For each, the messag
clear: The earlier
diagnosis, the gre
the chance
full recov

ENDOMETRIAL CANCER = 350
OVARIAN CANCER = 290
CERVICAL CANCER =177

LACK OF AWARENESS (CANCERS)

- 10% of all cancer cases in NZ
- 10% of all cancer deaths in NZ
- Cancer Society Survey---→1/3 of women could not identify a single symptom
- Most ignorant group 20-29 year olds
- EDUCATION

LACK OF AWARENESS (GYNAECOLGICAL ONCOLOGIST CGO)

MODEL OF CARE

TUMOR BOARD (MULTIDISCIPLINARY MEETING) -WHAT IS IT?

- Periodic multidisciplinary meetings where management of cancer patients are discussed.

- Vehicle for treatment planning, follow up care and education in oncology

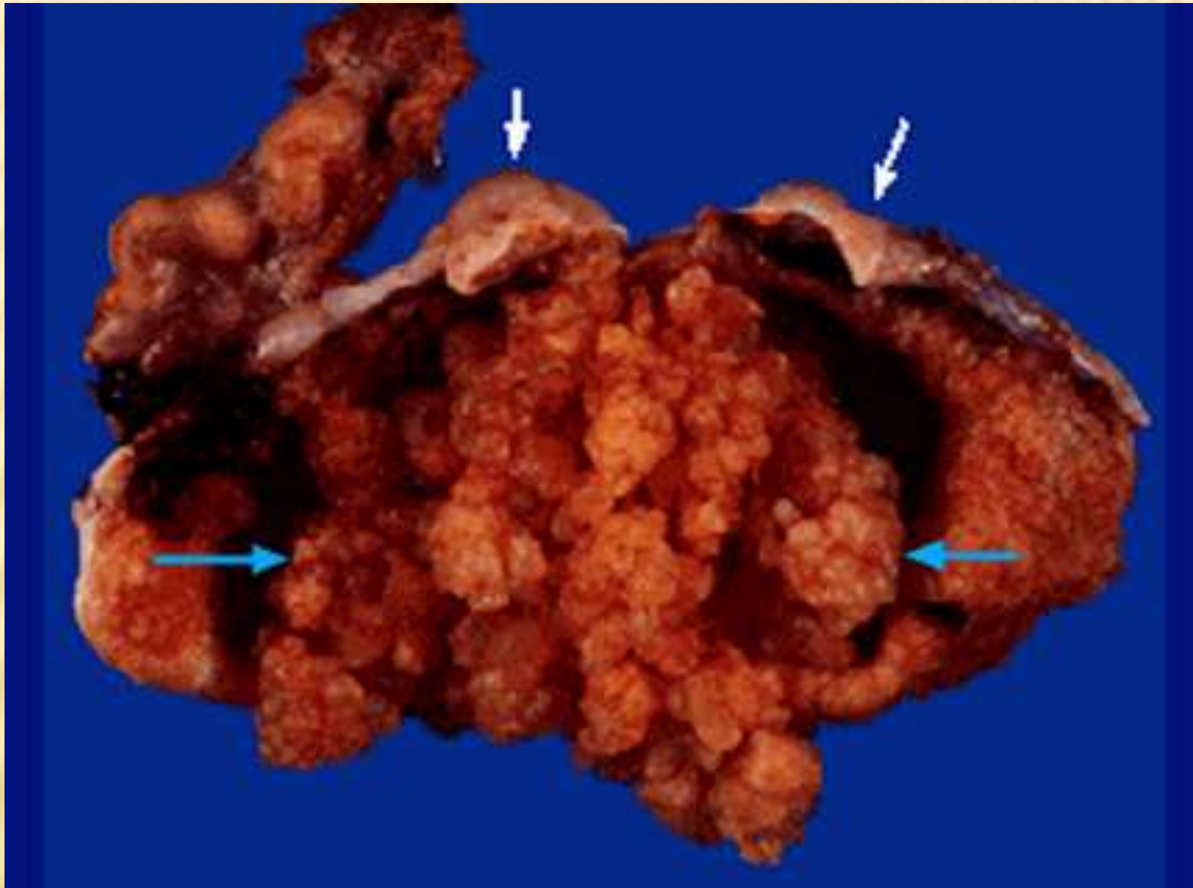
TUMOR BOARD – WHO GOES?

- Pathologists
- Radiologists
- Gynaecological Oncologists
- Medical Oncologists
- Radiation Oncologists
- Nurses

TUMOR BOARD –DOES IT HELP?

- Identification of significant major diagnostic discrepancies that altered patient care and optimized treatment planning. Tan 2009,santoso 2004
- Evidence to suggest that the outcomes for women with ovarian cancer are improved if managed by a multidisciplinary care team Junor 1999, Chafe 2000

OVARIAN CANCER



OVARIAN CANCER SYMPTOMS

- Pelvic and abdominal pain
- Increased abdominal size and bloating
- Urinary frequency/urgency
- Difficulty eating/feeling full

Ovarian Cancer Australia
Symptom diary

Please tick a box on each day that you experience symptoms

	Week one	Week two	Week three	Week four	Rate symptoms
Pelvic/ abdominal pain	Monday	Monday	Monday	Monday	How would you rate your symptoms? (1 is mild and 10 severe)
	Tuesday	Tuesday	Tuesday	Tuesday	
	Wednesday	Wednesday	Wednesday	Wednesday	
	Thursday	Thursday	Thursday	Thursday	
	Friday	Friday	Friday	Friday	
	Saturday	Saturday	Saturday	Saturday	
	Sunday	Sunday	Sunday	Sunday	Rate
Increased abdomen size/bloating	Monday	Monday	Monday	Monday	How would you rate your symptoms? (1 is mild and 10 severe)
	Tuesday	Tuesday	Tuesday	Tuesday	
	Wednesday	Wednesday	Wednesday	Wednesday	
	Thursday	Thursday	Thursday	Thursday	
	Friday	Friday	Friday	Friday	
	Saturday	Saturday	Saturday	Saturday	
	Sunday	Sunday	Sunday	Sunday	Rate
Urinary frequency/ urgency	Monday	Monday	Monday	Monday	How would you rate your symptoms? (1 is mild and 10 severe)
	Tuesday	Tuesday	Tuesday	Tuesday	
	Wednesday	Wednesday	Wednesday	Wednesday	
	Thursday	Thursday	Thursday	Thursday	
	Friday	Friday	Friday	Friday	
	Saturday	Saturday	Saturday	Saturday	
	Sunday	Sunday	Sunday	Sunday	Rate
Difficulty eating/ feeling full	Monday	Monday	Monday	Monday	How would you rate your symptoms? (1 is mild and 10 severe)
	Tuesday	Tuesday	Tuesday	Tuesday	
	Wednesday	Wednesday	Wednesday	Wednesday	
	Thursday	Thursday	Thursday	Thursday	
	Friday	Friday	Friday	Friday	
	Saturday	Saturday	Saturday	Saturday	
	Sunday	Sunday	Sunday	Sunday	Rate

Additional symptoms & notes

Some women experience symptoms additional or different to the four key symptoms above. Tick the box next to any of the other symptoms listed here if you have experienced them in the last 4 weeks and note how frequent or severe they are.

You can also use the space here to describe how any of your symptoms are affecting your daily life, or to include anything else you want your doctor to know.

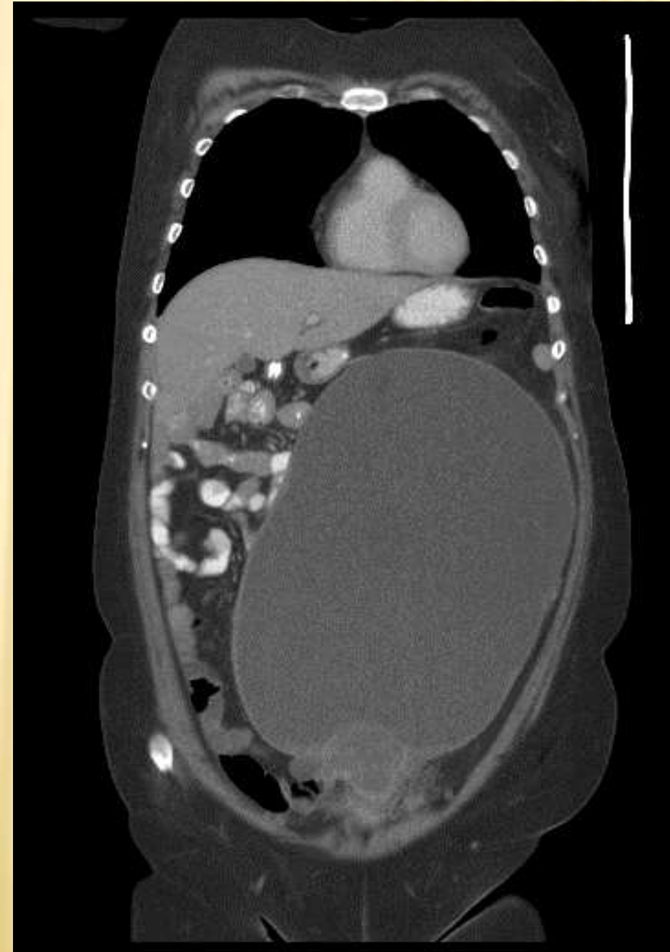
Symptom	How often?	How severe?
☐ Changes in your bowel habits		
☐ Unexplained weight gain or loss		
☐ Bleeding in-between periods or after menopause		
☐ Back pain		
☐ Indigestion or nausea		
☐ Excessive fatigue		

Beat Ovarian Cancer

- B is for Bloating (it is persistent and doesn't come and go)
- E is for Eating (difficulty eating & feeling full more quickly)
- A is for Abdominal (and pelvic pain you feel most days)
- T is for Talking (tell your GP)

GENERAL PRACTICE

GYNAE ONCOLOGY



APPROPRIATE TRIAGE OF OVARIAN MASSES IS IMPORTANT

- Proper surgical staging tailors adjuvant treatment - major factor in long-term survival of patients
- Surgery performed by gynaecologic oncologists confers survival advantage. *Nguyen et al, Kehoe et al*
- Facilitates optimisation of resources.

RISK OF MALIGNANCY INDEX

Using a cut off value of 200 to discriminate benign from malignant masses, there is good correlation

Sensitivity = 87%

Specificity = 97%

Useful triage tool when considering referral

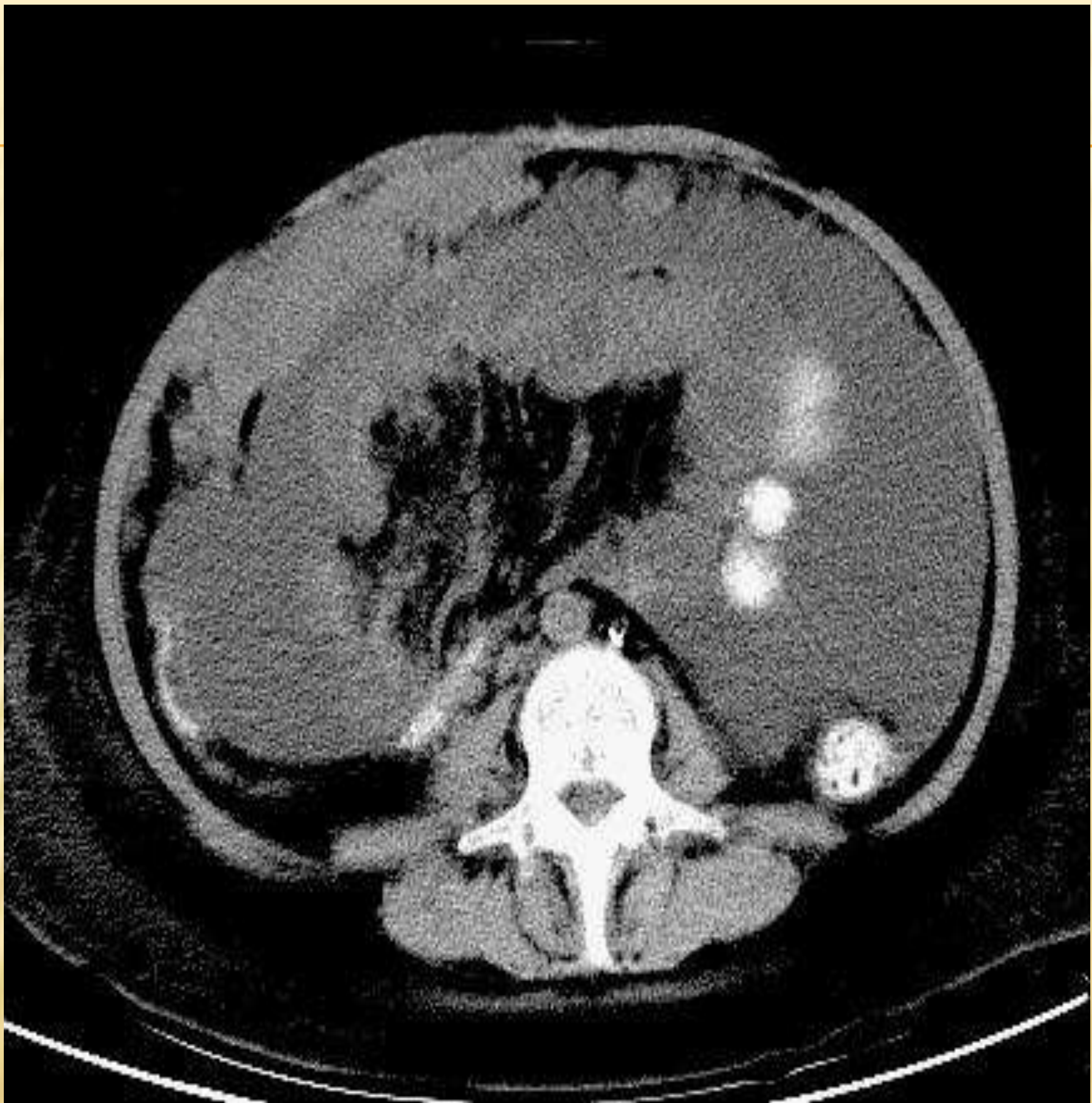
RISK OF MALIGNANCY INDEX

Criteria	Scoring system	Score
Menopausal status Premenopause postmenopause	 1 3	A(1 or 3)
USS features Multiloculated Solid areas Ascites Bilateral metastases	No features=0 One feature=1 >1 feature =3	B(0,1,3)
Serum ca125	Absolute level	C
RMI		AxBxC

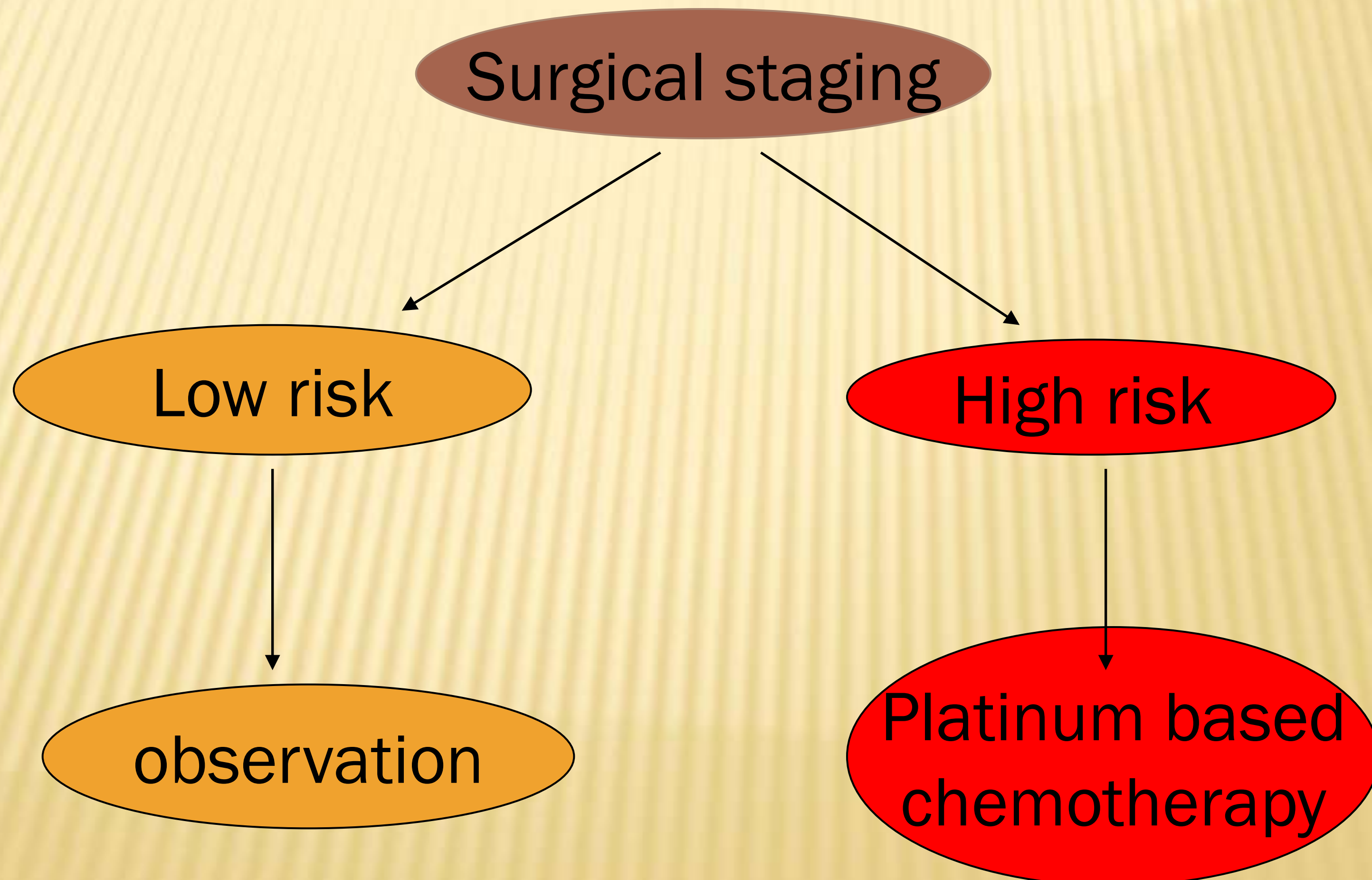
CASE

MRS EL is a 65 year old woman who presents with increasing abdominal pain, constipation and nausea.

Ca125 =2530



OVARIAN CANCER
EARLY CANCER



OVARIAN CANCER
ADVANCED DISEASE

- Primary cytoreduction(SURGERY) followed by CHEMOTHERAPY
- Neoadjuvant chemotherapy

OVARIAN CANCER
ADVANCED DISEASE

Neoadjuvant chemotherapy (unfit for primary cytoreduction)

- Poor performance status (PATIENT)
- Tumour not completely debulkable(TUMOUR)

OVARIAN CANCER
ADVANCED DISEASE

- 3 cycles of platinum based therapy and offer interval debulking only in those that respond (TRIAGE)

- Overall survival and progression free survival = to those with primary cytoreduction

- Morbidity is decreased

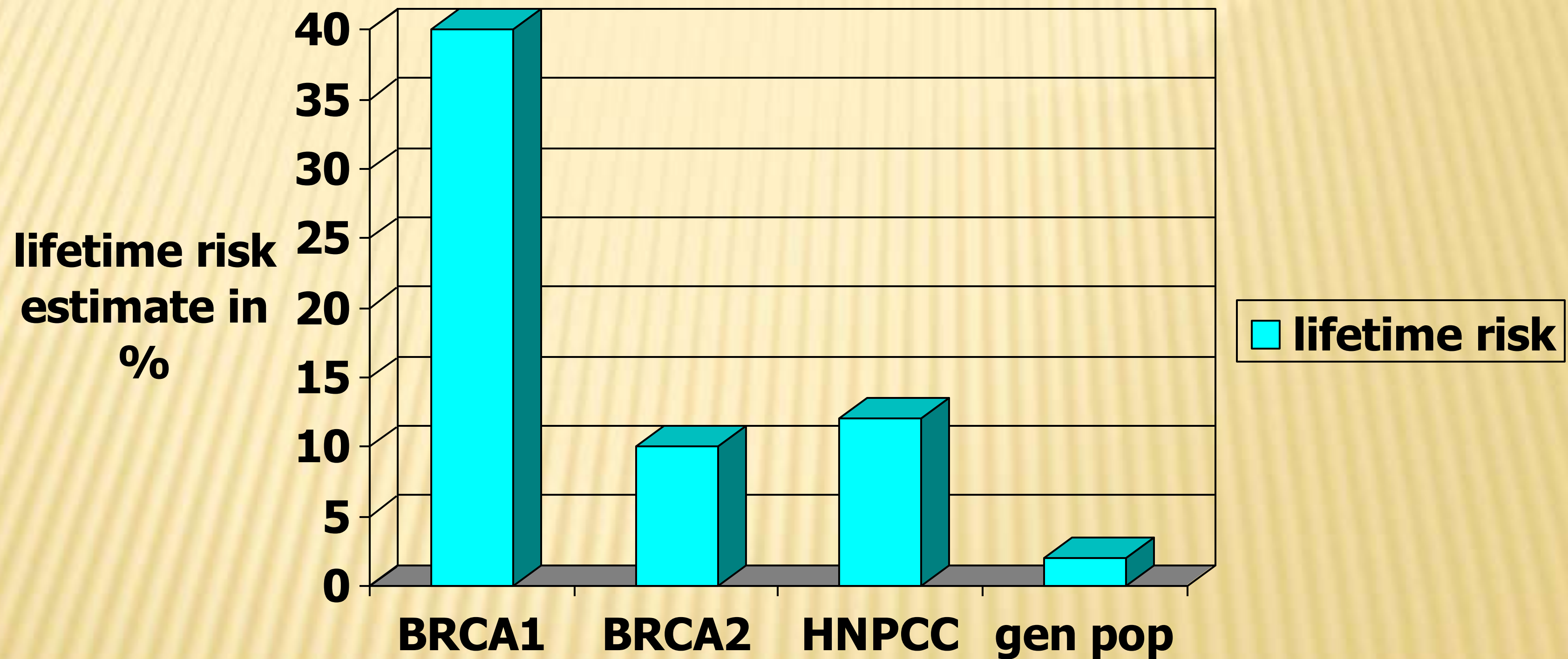
5 YEAR SURVIVAL RATES

Stage 1	93%
Stage 2	70%
Stage 3	37%
Stage 4	25%

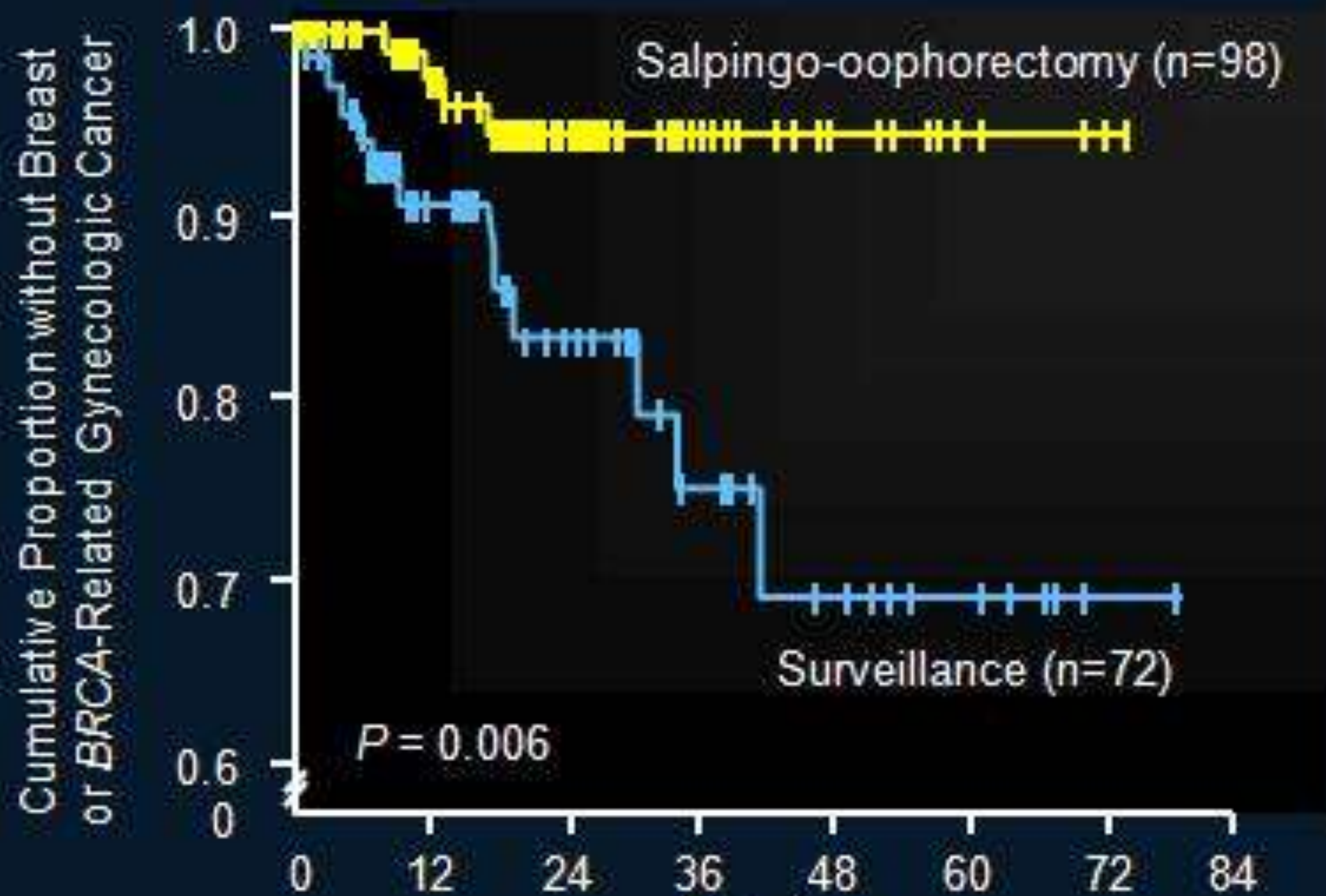
BRCA MUTATION CARRIERS

- 15% of EOC are due to mutations in BRCA1 or 2
- BRCA related ovarian cancer- more favourable prognosis, respond differently to chemotherapy

OVARIAN CANCER LIFETIME RISK ESTIMATES



RRSO Protects Against Breast & Gynecologic Cancers



No. at Risk							
Salpingo-oophorectomy	98	69	36	17	11	4	0
Surveillance	72	44	28	16	9	5	1

Kauff, ND, et al. N Eng J Med 2002;346:1609

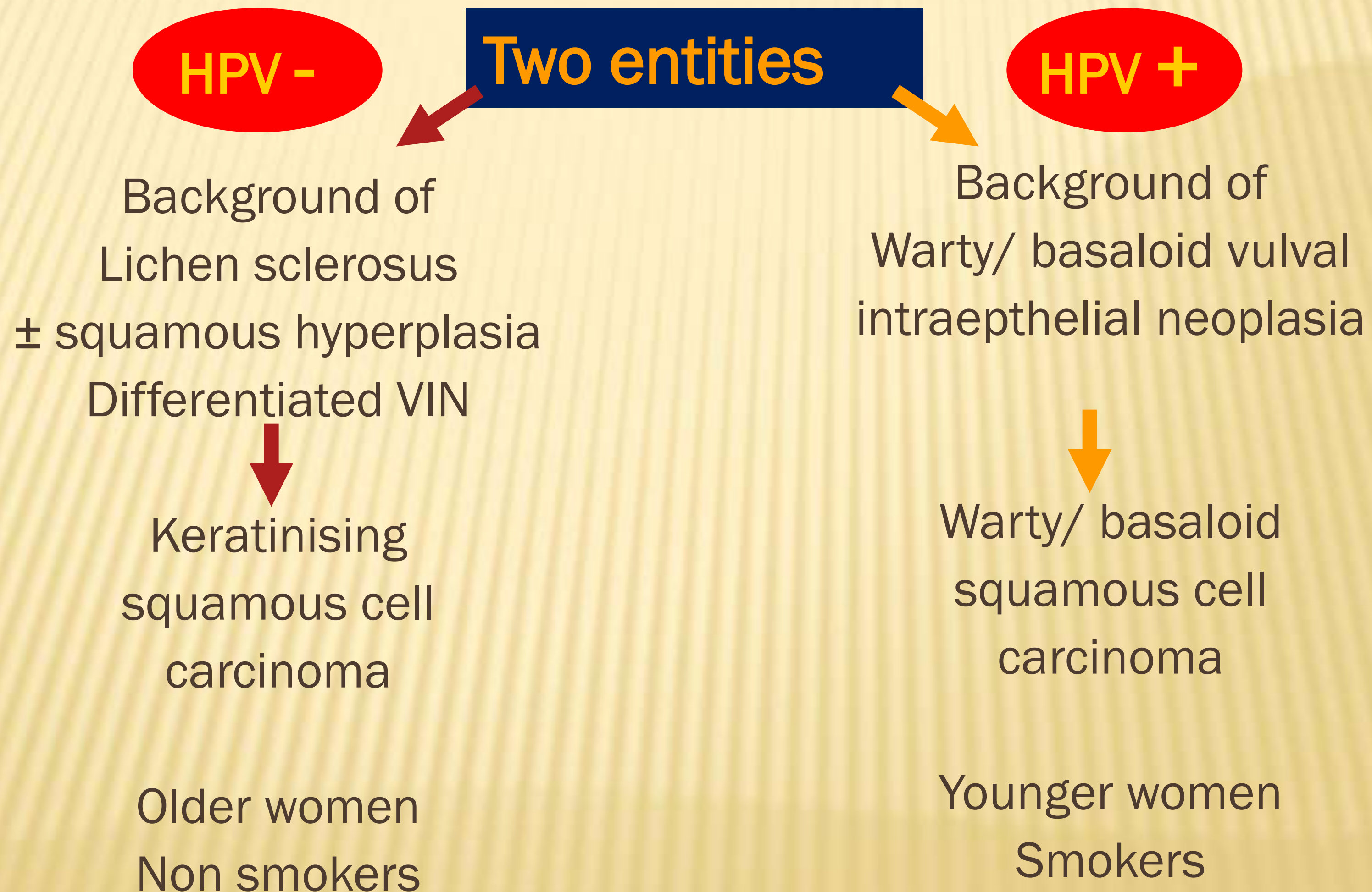
PRIMARY FALLOPIAN TUBE MALIGNANCIES IN BRCA+VE WOMEN UNDERGOING RRSO

CALLAGHAN MJ ET AL J CLIN ONCOL 2007;25:3985

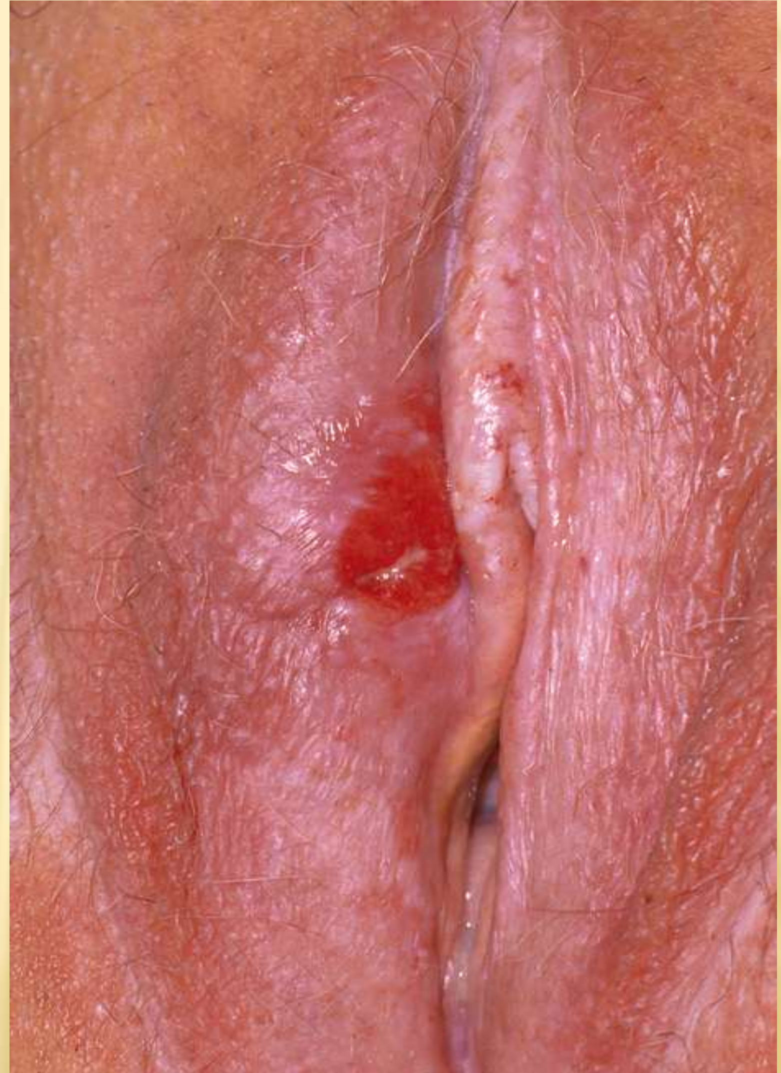
- Distal fallopian tube appears to be the dominant site of origin for early malignancies detected in women undergoing RRSO
- Explains failure of screening!

CARCINOMA OF THE VULVA

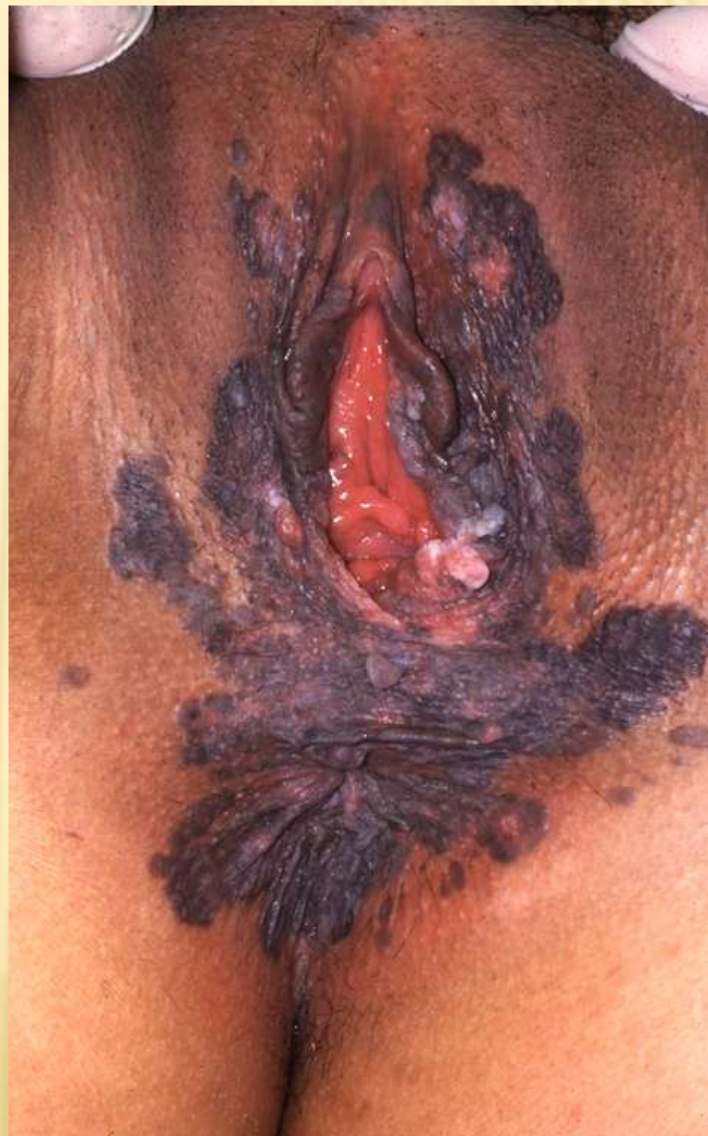
VULVAR CARCINOMA



HPV -VE



HPV +VE



HPV PREVALENCE:
VIN WARTY/ BASALOID

HPV 16	80%	(CIN	3	50%)

Hillemans, Wang. Gynecol Oncol 2006; 100:276

HETEROGENEOUS CLINICAL FEATURES VIN

- Unifocal or multifocal
- Flat or Papular
- Red, White, Pigmented
- May involve perianal or urethral skin

VIN

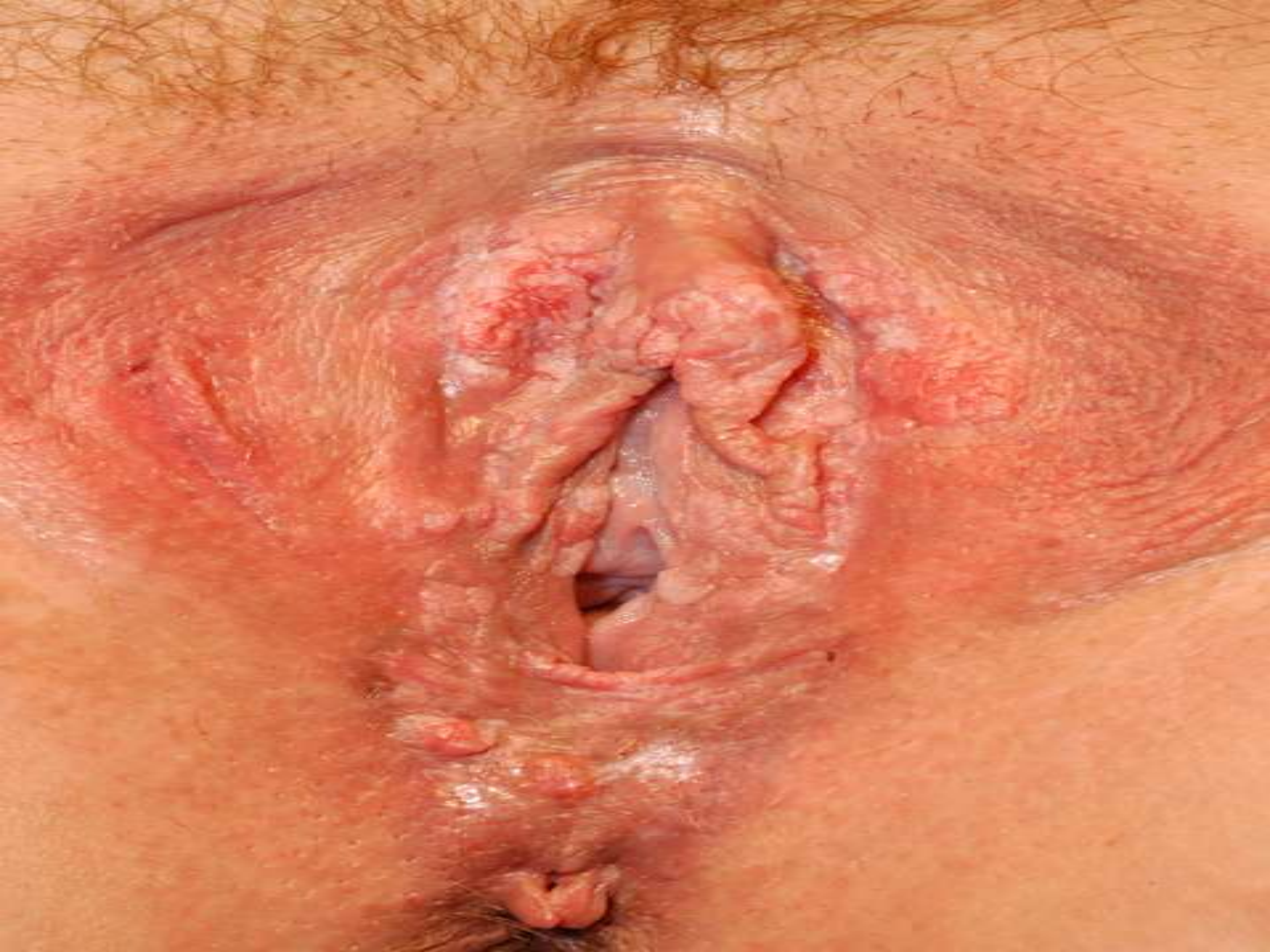
- Spontaneously regress
- Persist unchanged indefinitely
- Progress to invasive cancer

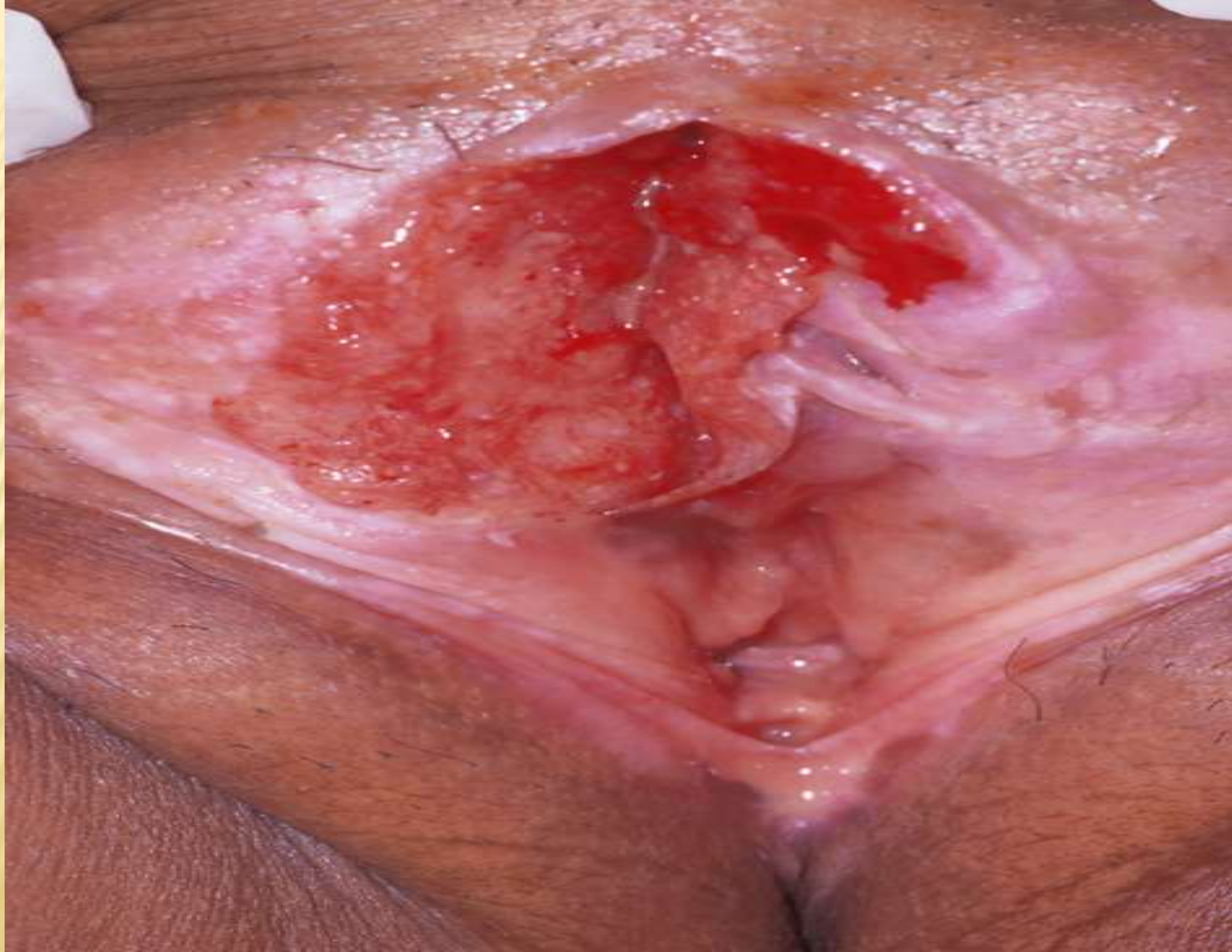
CLINICAL FEATURES OF INVASIVE VULVA CANCER

- **Lump/Mass**
- **Pruritis**

R/S analysis (1989-1996) of women presenting with scc of vulva to NWH

- 94% presented with pruritis
- 87% had symptoms >6 months,28% >5 years
- 30% of women had 3 or > consultations
- Skin around the vulva is abnormal in 85% cases





DIAGNOSIS

Wedge biopsy specimen

- Surrounding skin
- Some dermis and connective tissue

Allow pathologist to work out depth of invasion

MODERN MANAGEMENT OF VULVAR CANCER

- Should be delivered by experienced multidisciplinary team in tertiary referral centres

  80% of cases rx in the community do not have a node dissection and survival data was worse for all stages

- Paradigm shift in surgical approaches to the disease

  = Individualized, more conservative

  = Disease occurring in younger women

  =Concerns about morbidity and psychosexual consequences

MANAGEMENT OF EARLY VULVAR CANCER SURGERY

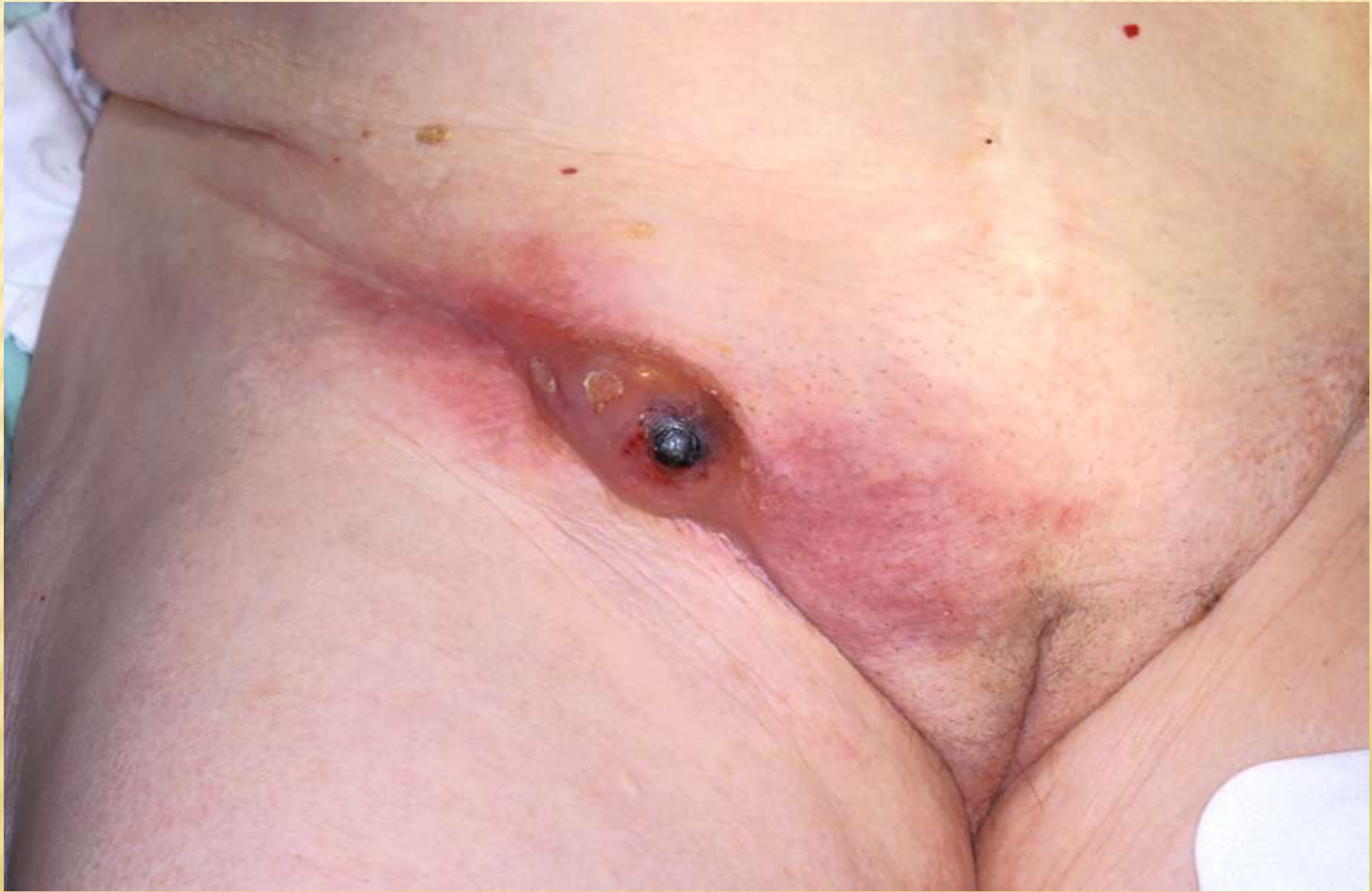
Management of the primary lesion

Radical local excision (RLE)= Rx for a localized lesion in otherwise normal vulva.

Recurrence rate of RLE (1 cm tumor free margins) = radical vulvectomy

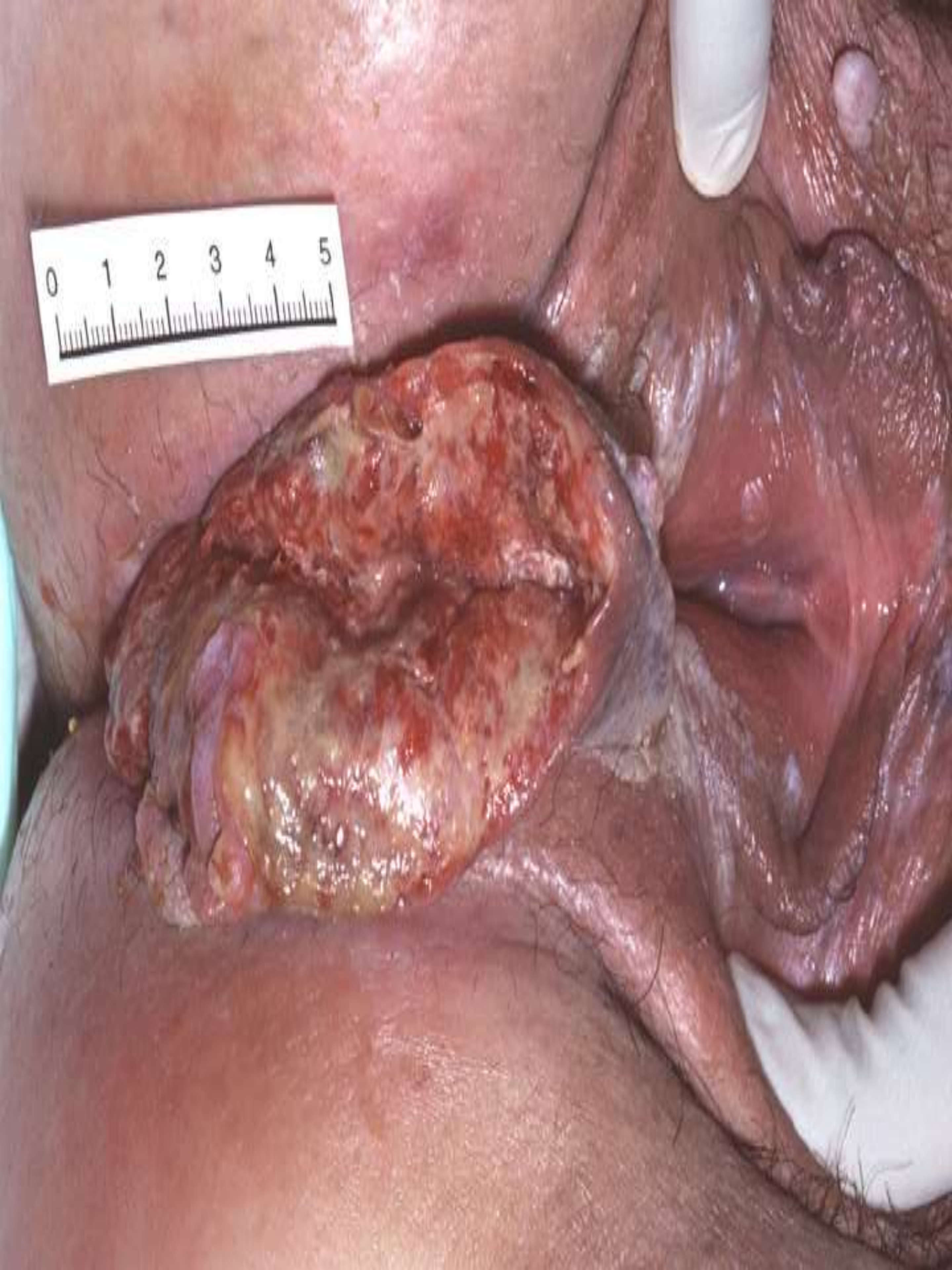
Management of groin lymph nodes

- Recurrence in an undissected groin has 92% mortality rate
- Unilateral primary lesion → unilateral groin dissection, because risk of contralateral nodes with –ve ipsilateral nodes <1%



MANAGEMENT OF LARGE PRIMARY LESIONS(COMBINATION THERAPY)

- UltraRadical **Surgery** → primary **RT /chemoRT**+ bilateral groin LND
- After primary Rx, tumor bed resected. 50% did not have residual disease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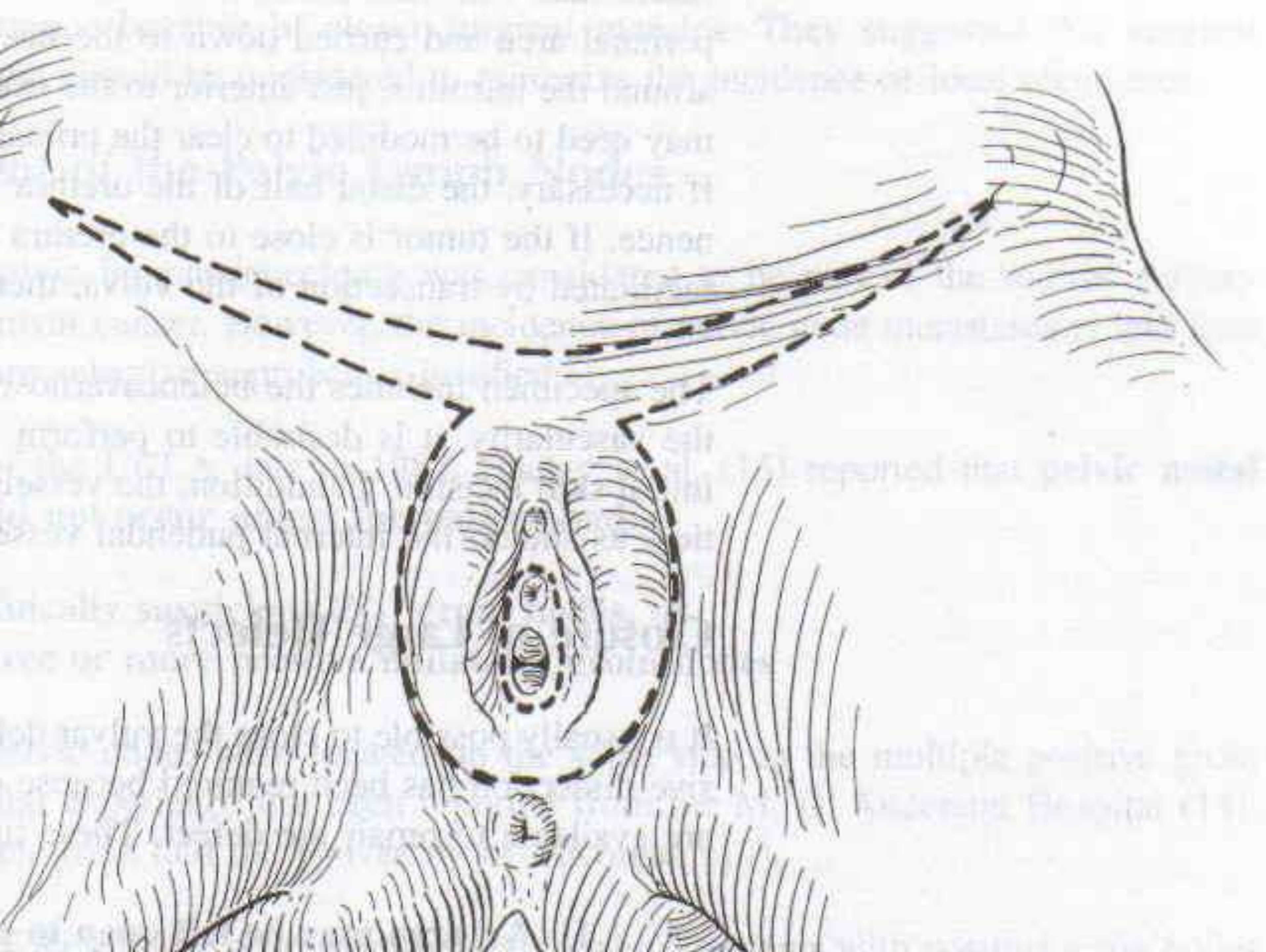
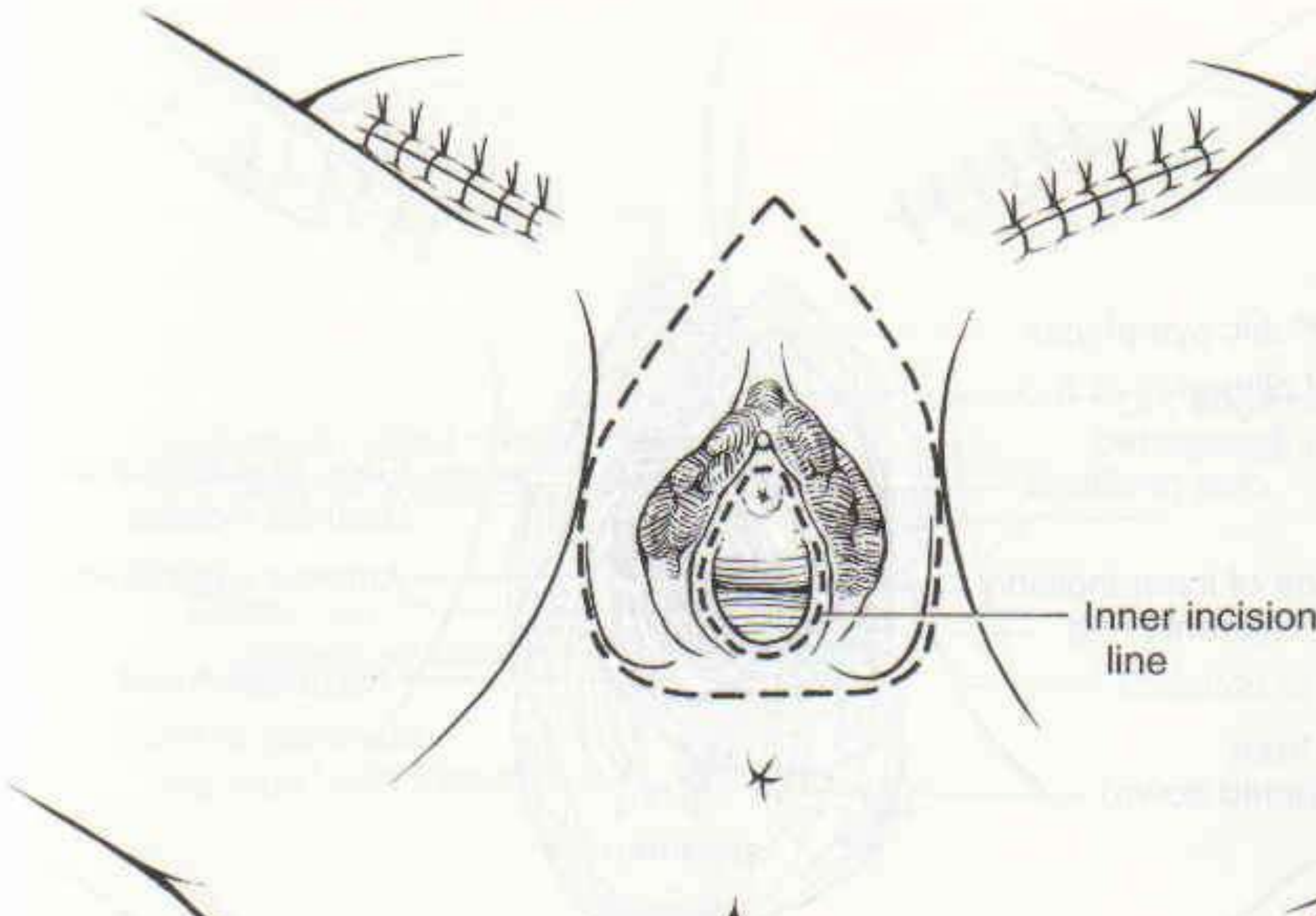
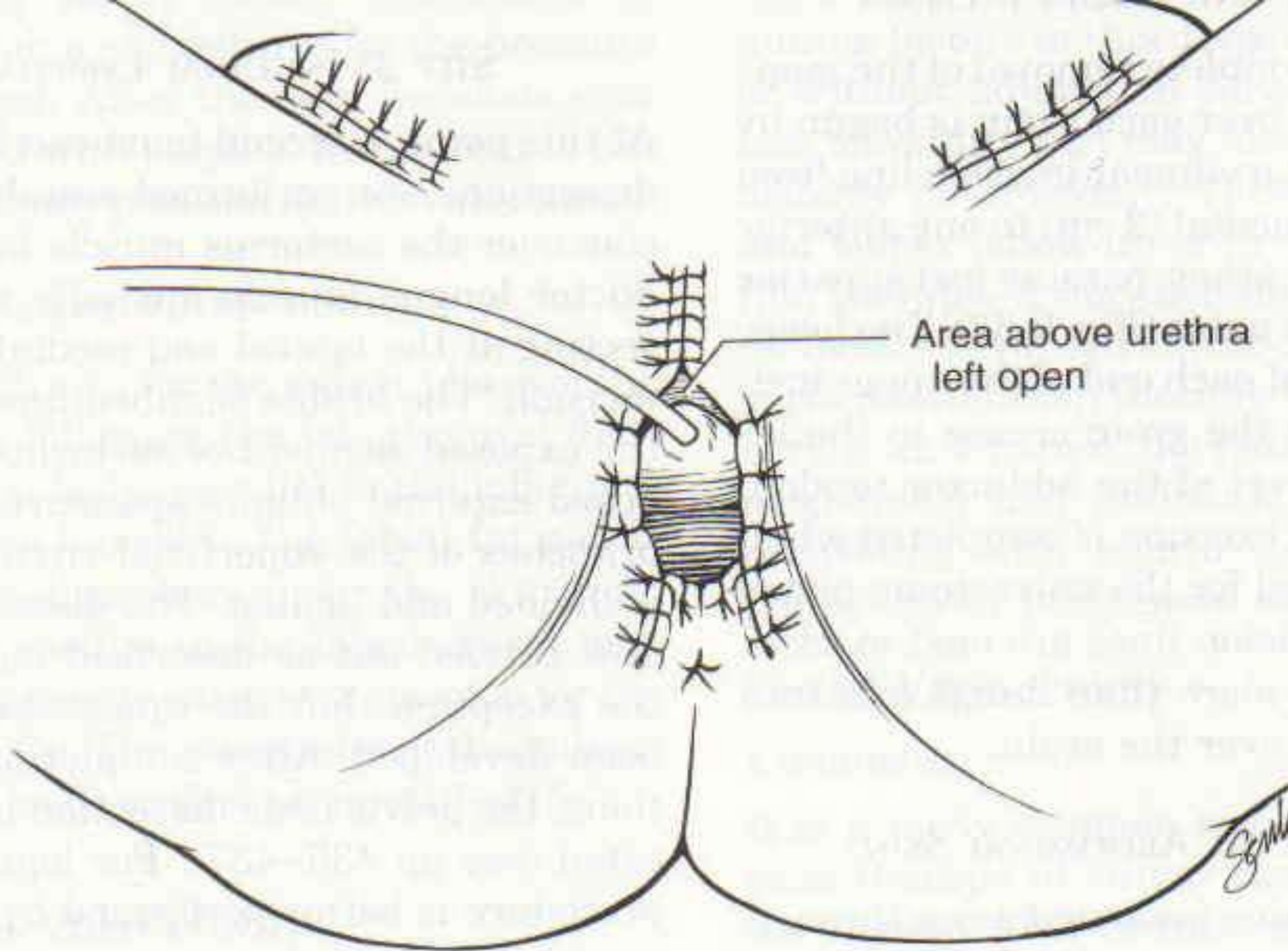



Inner incision
line


Area above urethra
left open

COMPLICATIONS WITH VULVAR SURGERY

Early

- Wound infection
- Wound breakdown
- Wound necrosis
- UTI
- Seroma in femoral triangle
- DVT,PE
- Bleeding

Late

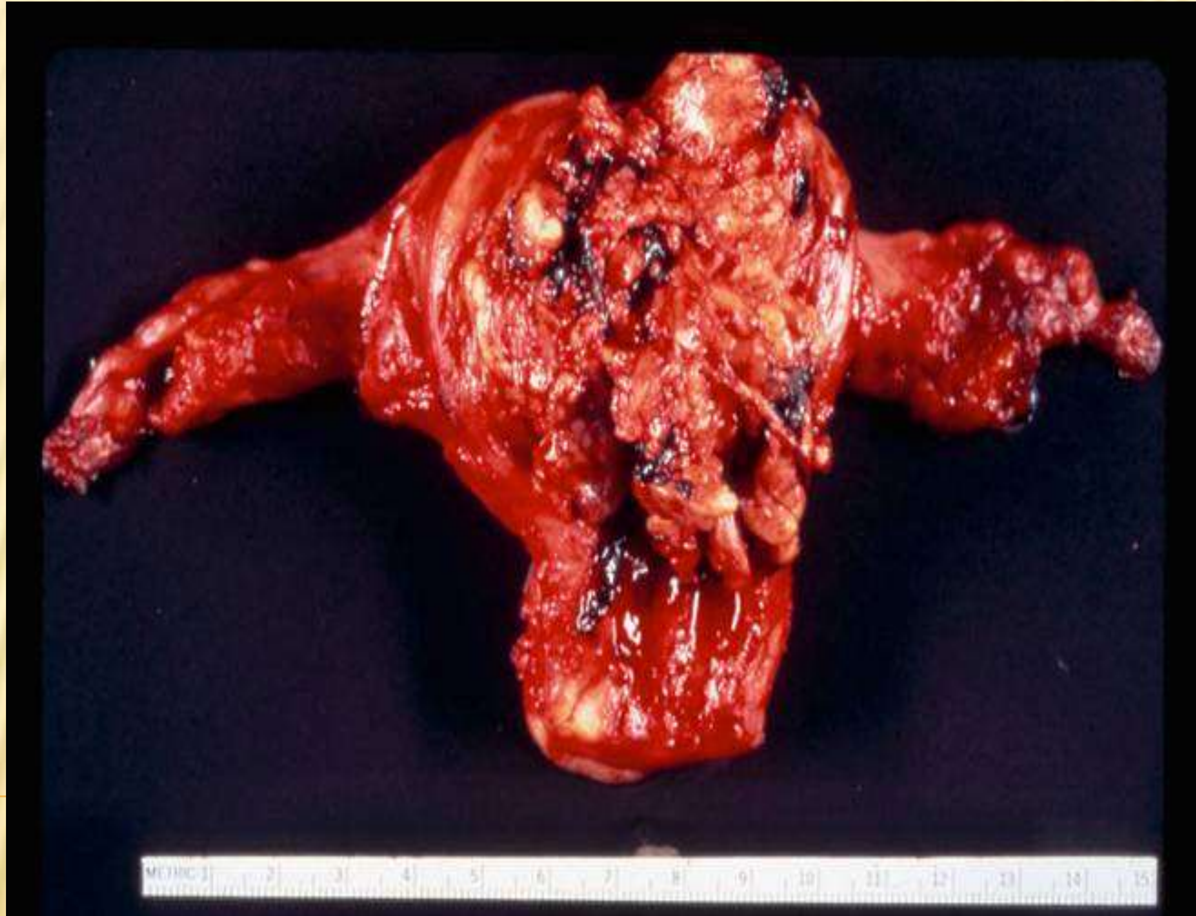
- Lymphadema
- Lymphangitis
- Urinary stress incontinence
- Prolapse
- Introital stenosis
- Femoral hernia

CHRONIC LEG EDEMA

- RHW IN SYDNEY –INCIDENCE OF CHRONIC LEG EDEMA = 62%
- 50% ONSET WITHIN 3 MONTHS
- 85% ONSET WITHIN 12 MONTHS

Ryan,hacker et al

CARCINOMA OF THE ENDOMETRIUM



CARCINOMA OF THE ENDOMETRIUM

TYPE 1 (E related)

- 2/3 patients
- Mean age = 59y
- Indolent
- Develop from N epith under E influence
- Endometriod
- Low stage, good prognosis

TYPE 2

- Older women
- Aggressive subtype
- Deep myometrial invasion, extrauterine disease
- Poor outcome

CLINICAL FEATURES

90% have abnormal bleeding

Patients in whom endometrial cancer should be excluded:

- Post menopausal bleeding
- Perimenopausal women with IMB or increasing heavy periods
- Premenopausal women with abnormal irregular bleeding, especially with anovulation

DIAGNOSIS

- All patients suspected of having endometrial cancer should have an **endometrial biopsy and endocervical curettage**

- False –ve =10%, a **negative biopsy** in the face of **a symptomatic patient** should be followed by a **definitive D+C**

PREOPERATIVE INVESTIGATIONS

<u>MRI</u>

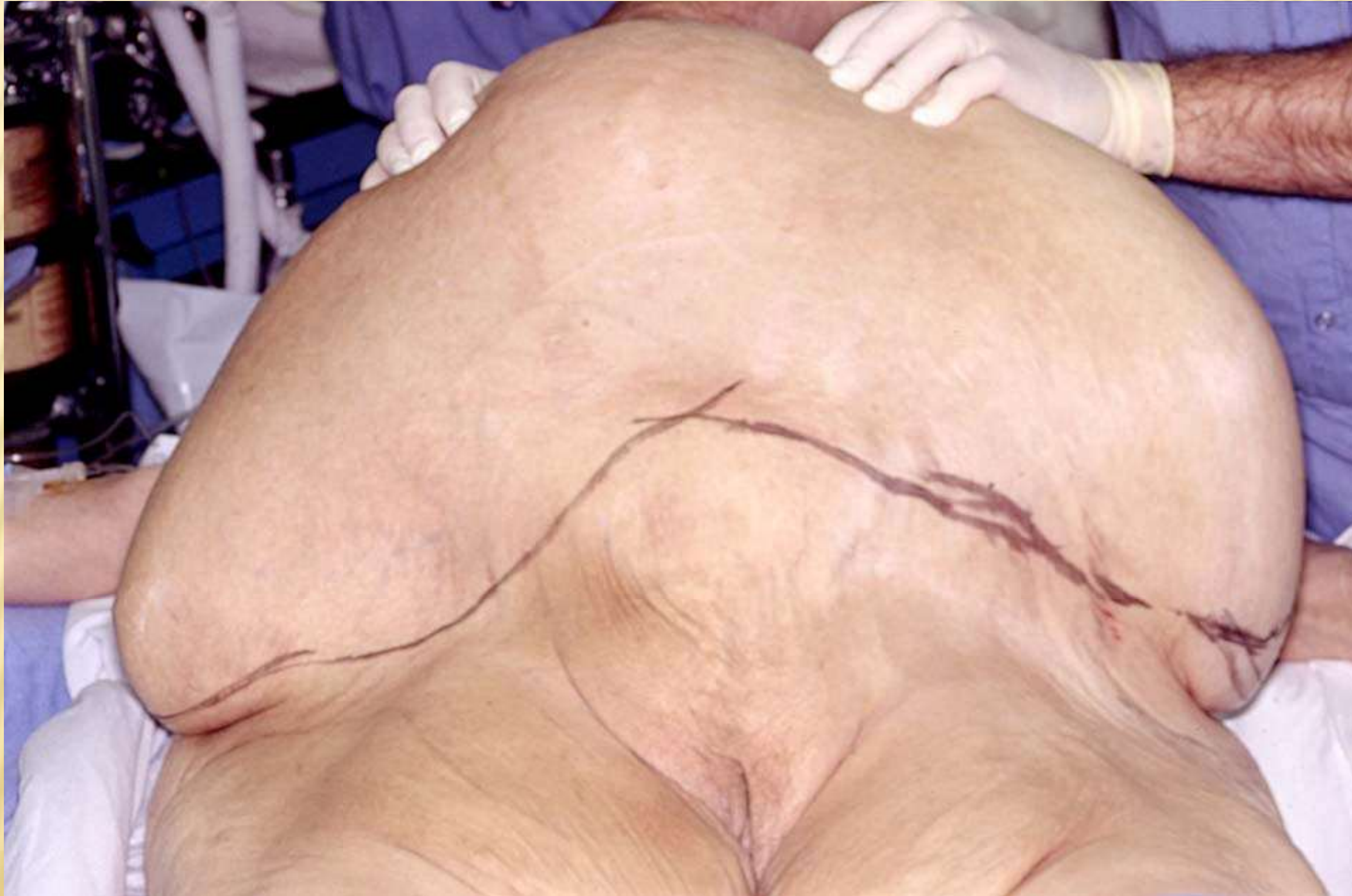
accuracy for assessing myometrial invasion =86%,

Triage where patient has surgery

ENDOMETRIAL CANCER
(EARLY DISEASE)

- Total abdominal hysterectomy, bilateral salpingo-opherectomy +/- staging(SURGERY)
- (RADIOTHERAPY)

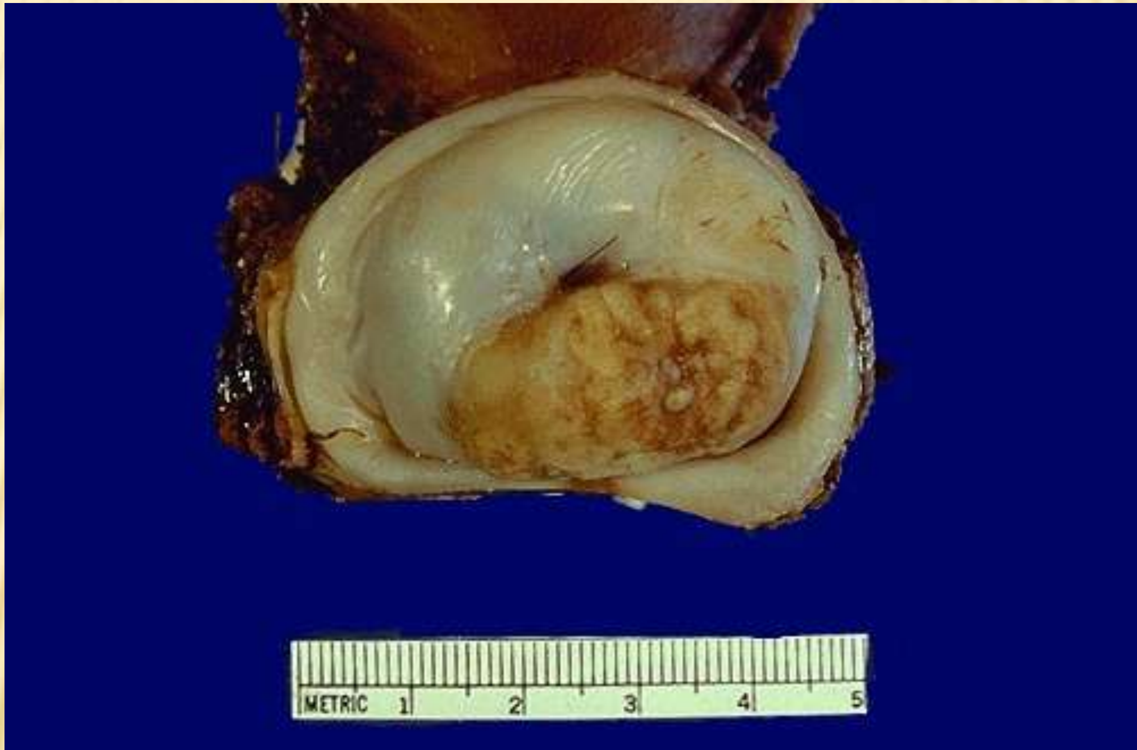
NOT IN THIS PATIENT!!



ENDOMETRIAL CANCER (ADVANCED DISEASE)

- Individualised
- Hysterectomy even in the presence of metastatic disease can offer symptom control and improve quality of life
- Palliation with progesterones, radiotherapy

CERVICAL CANCER

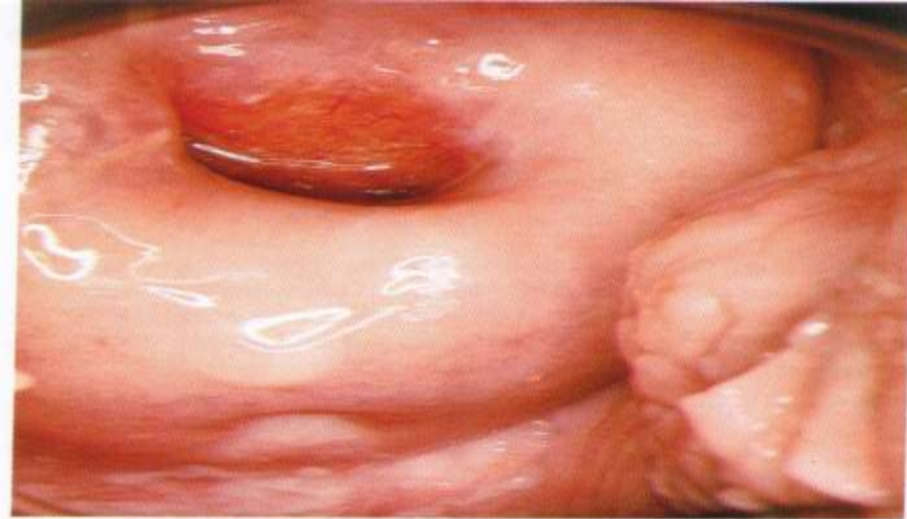


PRESENTATION

- ASYMPTOMATIC – eg routine smear report of HSIL strongly suspicious of SCC

- SYMPTOMATIC

You are here



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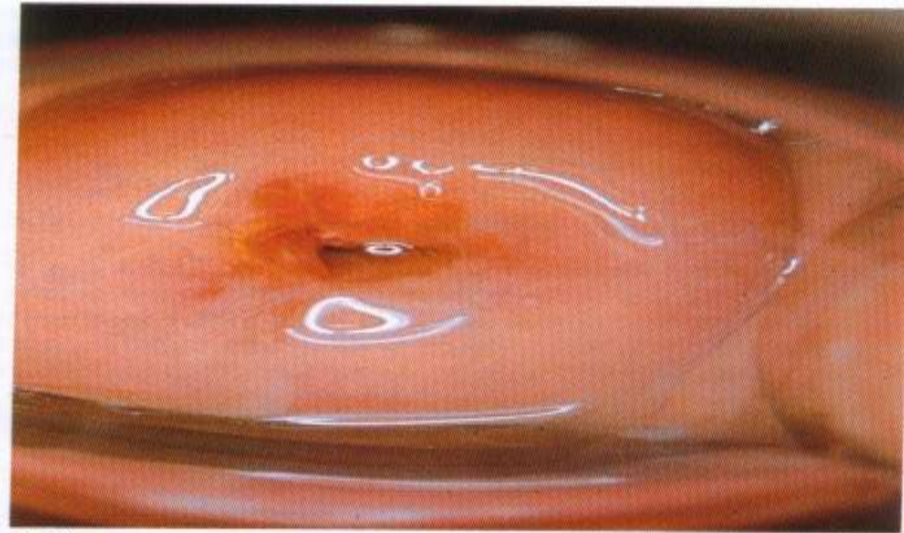

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CYTOLOGY

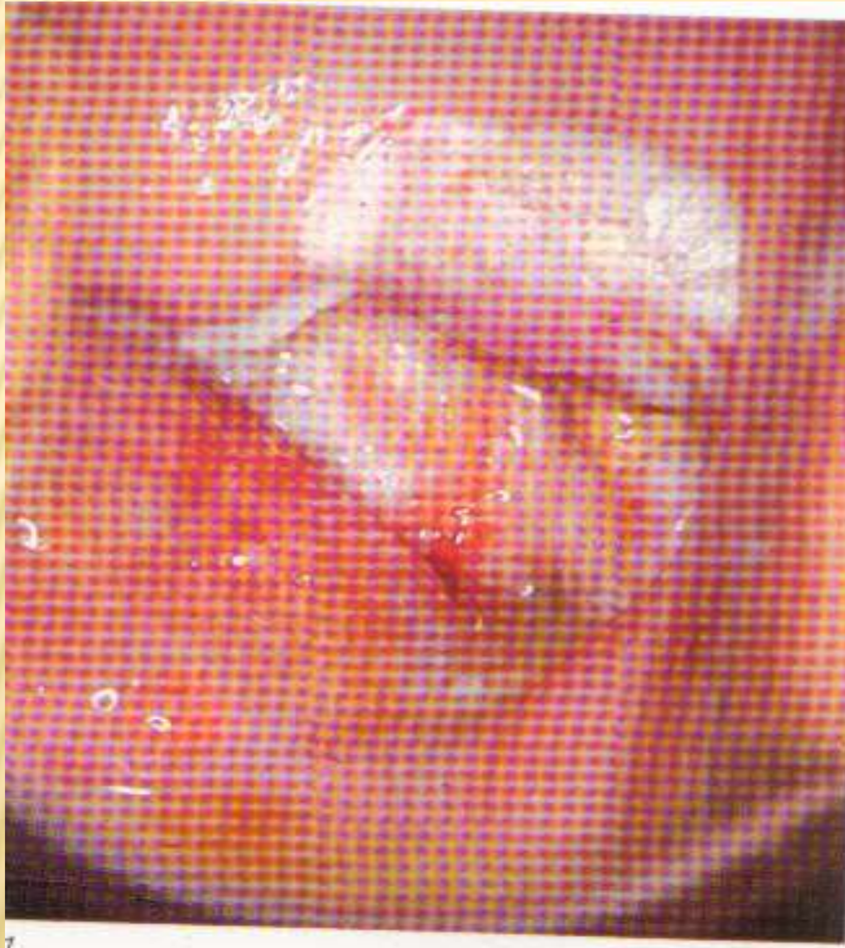
False –ve rate for a Pap smear in the presence of invasive cancer

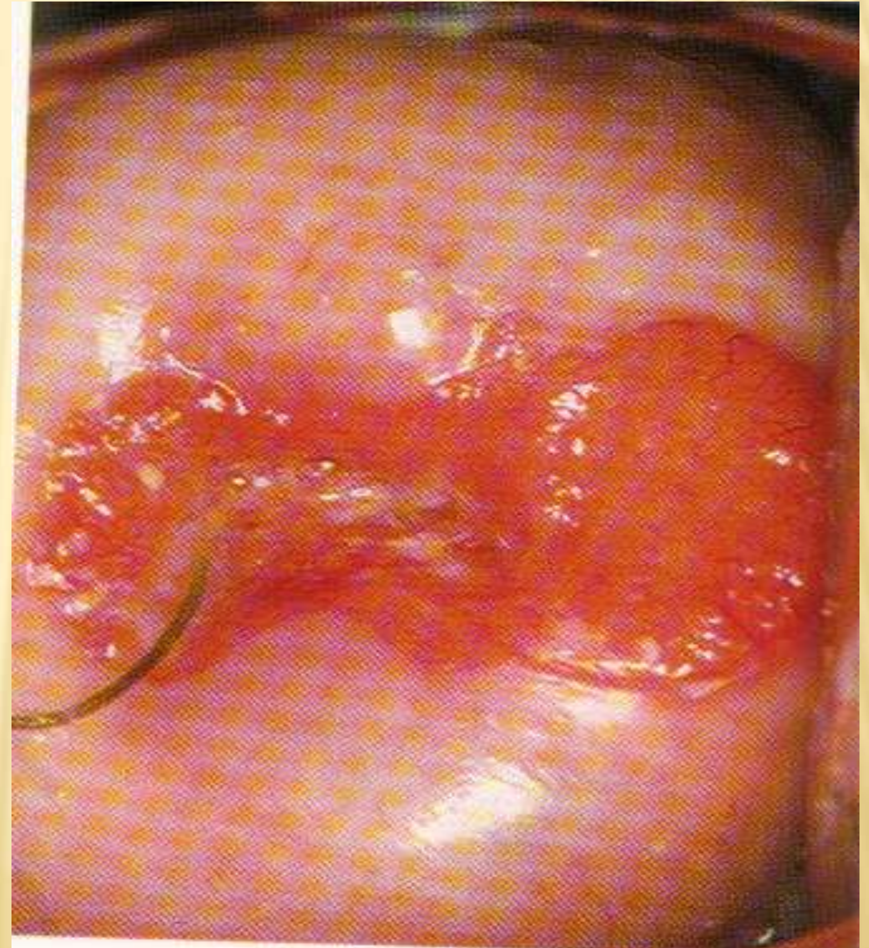
is up to 50%,

SO –ve Pap smear should never

be relied on in a SYMPTOMATIC patient

CERVICAL CANCER



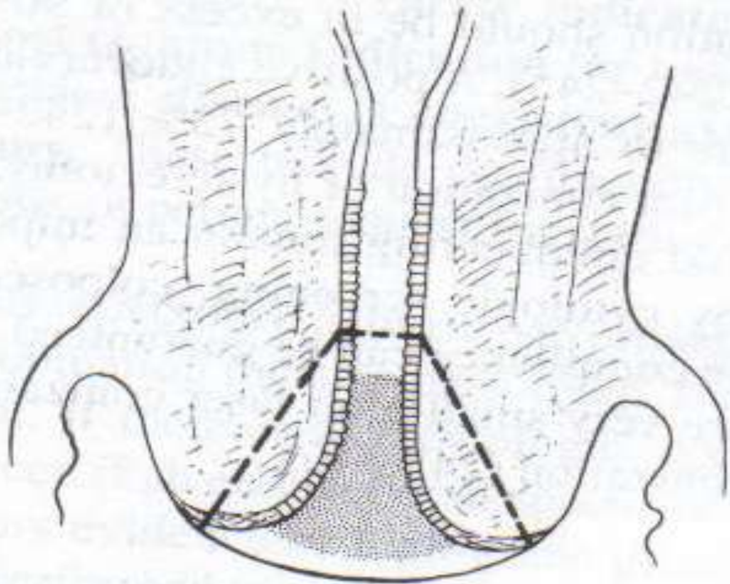


SYMPTOMS

- **Abnormal vaginal bleeding** = most common presenting symptom . If sexually active, includes postcoital bleed (56%)
- Not sexually active, asymptomatic until quite advanced
- **Malodorous discharge** (4%)
- **Pelvic pain, pressure symptoms** of bowel and bladder (4%)

DIAGNOSIS

- Biopsy obvious tumor
- Cervix that is unusually firm or expanded should undergo biopsy and endocervical curettage
- Diagnostic cone biopsy may be necessary for definitive diagnosis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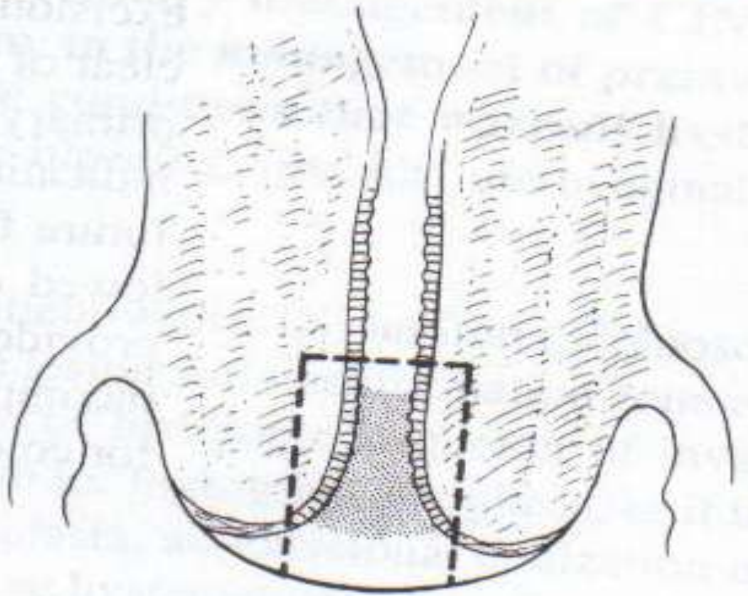
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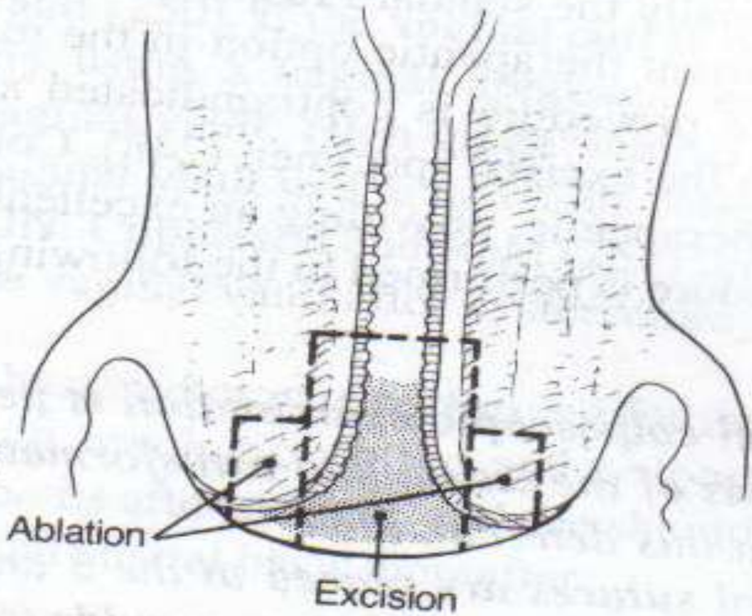
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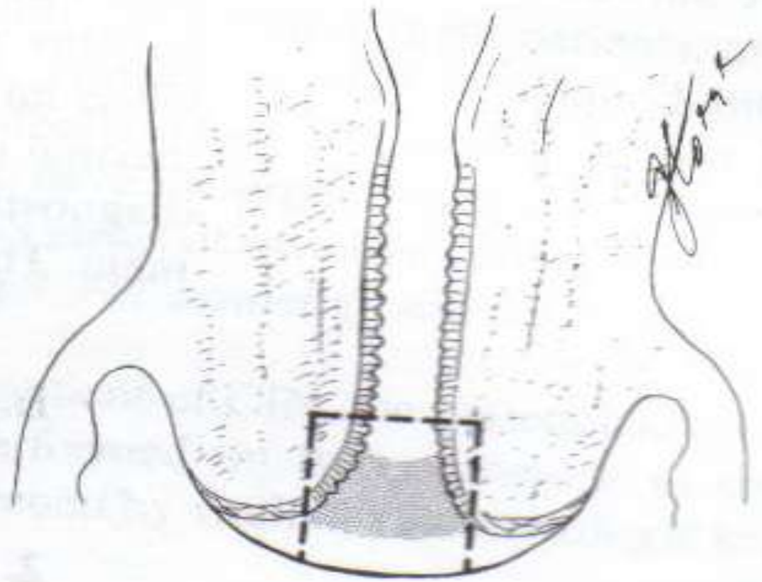
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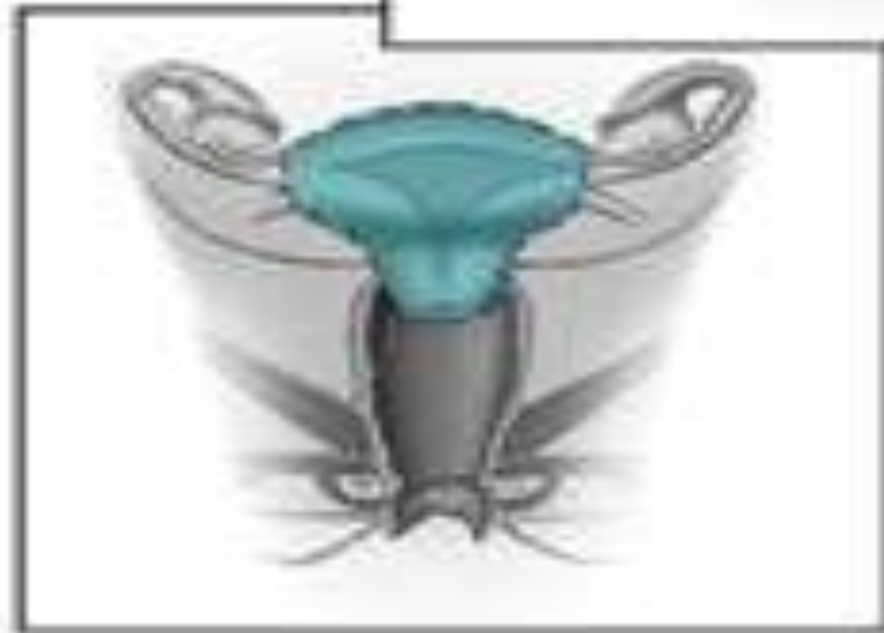
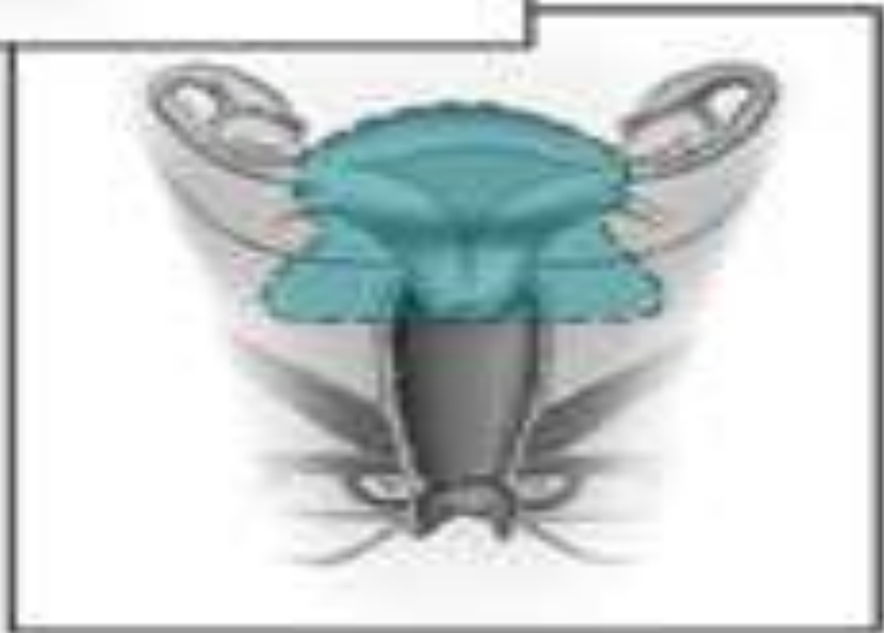
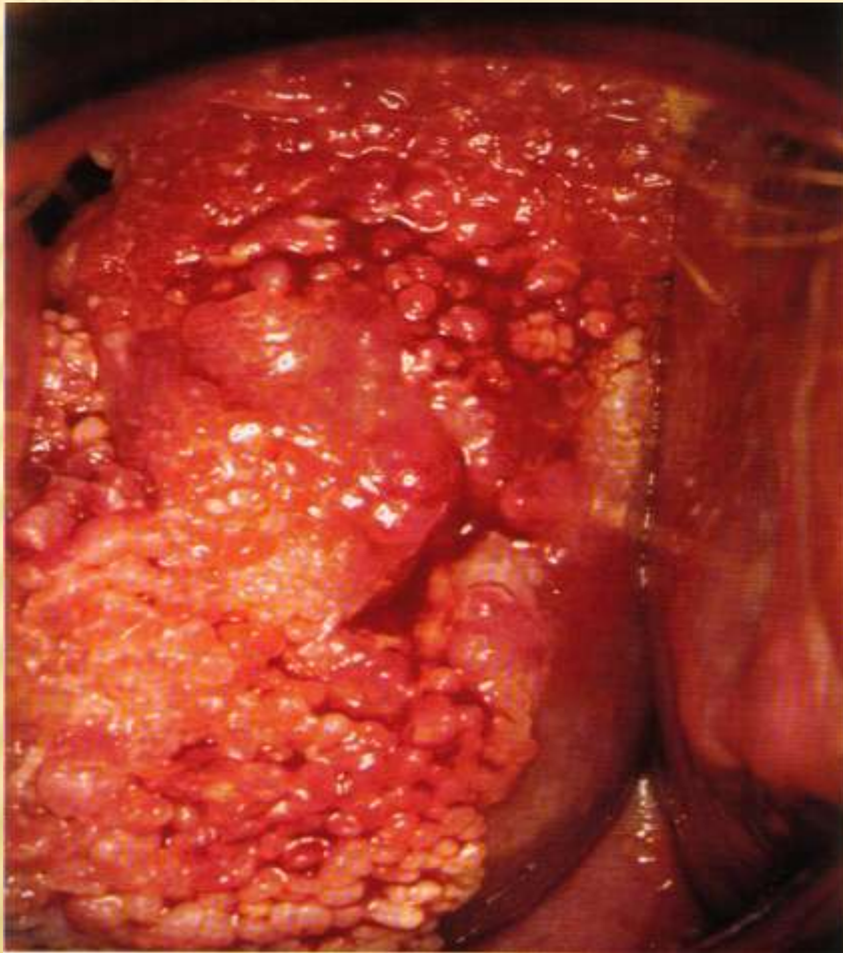
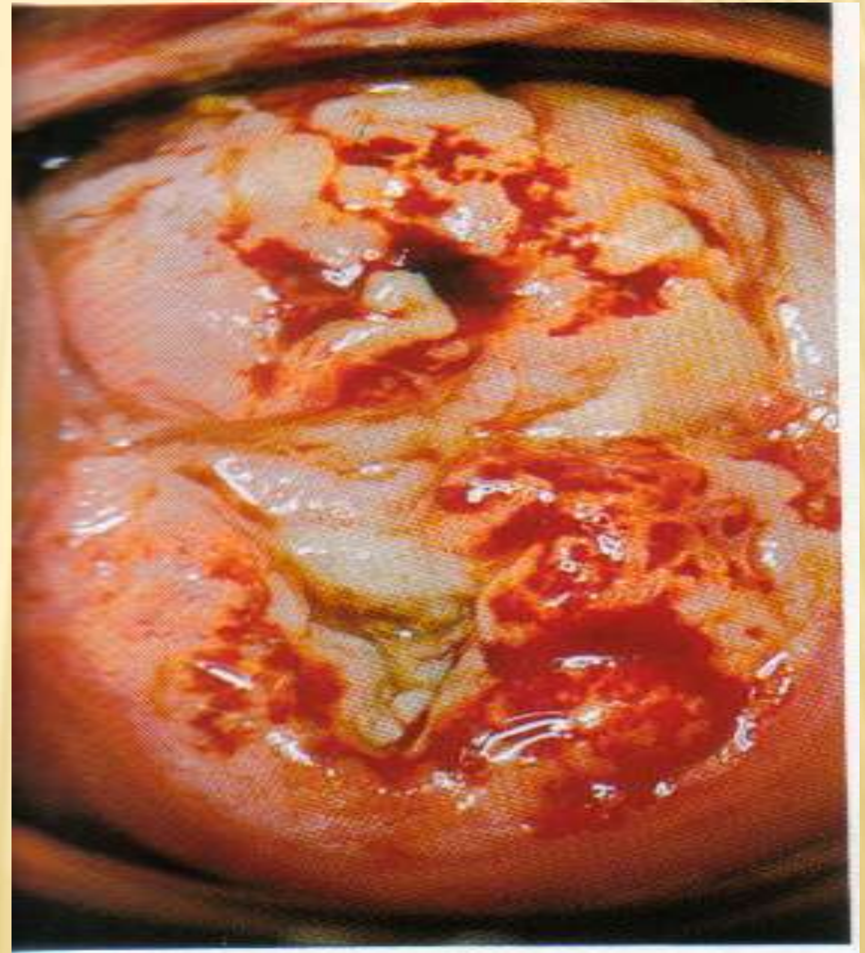



CERVICAL CANCER





ADVANCED STAGE DISEASE

- External beam pelvic radiation therapy
- Weekly cisplatin at 40mg/m2 during the radiation treatment
- Intracavitary radiation treatment at the conclusion of external beam

http://hatw.net