LAPAROSCOPY and OVARIAN CANCER

J. DAUPLAT

1° - PROPHYLACTIC OOPHORECTOMY

2° - DIAGNOSIS

3° - EARLY STAGES: STAGING

4° - ADVANCED STAGES: ASSESSMENT OF RESECTABILITY

- SECOND LOOK

Laparoscopy and ovarian cancer

GENETIC RISK PREVENTION

- BRCA1-2 MUTATION 40 to 80% LIFETIME RISK
- M.M.R. MUTATION (HNPCC LYNCH II) 10 to 20% LIFETIME RISK

PROPHYLACTIC OOPHORECTOMY
RECOMMENDATIONS FOR PROPHYLACTIC OOPHORECTOMY

- PLURIDISCIPLINARITY APPROACH and INFORM CONSENT +++
- NEVER BEFORE 35 yo
- BEFORE 40 yo WITHOUT CHILDREN
- IF MUTATION RISK < 12.5%
- POSSIBLE IF MUTATION RISK ≥ 50%
- RECOMMENDED WHEN PROVEN MUTATION (35 - 40 yo)

TECHNICAL POINT OF VIEW FOR PROPHYLACTIC OOPHORECTOMY

- LAPAROSCOPY WITH CAREFULL EXAMINATION OF THE WHOLE PERITONEAL CAVITY
- CYTOLOGY
- BILATERAL SALPINGO-OOPHORECTOMY
- TOTAL HYSTERECTOMY IF - HNPCC
- $ BREAST + OVARY
- ENDOBAG ++

PROPHYLACTIC OOPHORECTOMY

- HISTOLOGY +++ - DYSPLASIA
- OCCULT CARCINOMA
- CRYOPRESERVATION OF OVARIAN TISSUE
- OESTROGEN REPLACEMENT POSSIBLE
- NO 100% PROTECTION (INFORM)
Ovarian Cancer Prevention

Oophorectomy during Abdomino pelvic surgery after 50 yo or MP + ?
- TAH
- Colorectal Cancer (8% Kruckenberg)

Patient inform

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Diagnosis
- Adnexal masses even suspicious (U.S.) are not always cancer and laparoscopic approach is authorized.
- A simple cyst can be malignant (M. Canis)
  - 1.8% - MP-
  - 7.6% - MP+

You can found an ovarian cancer during a laparoscopy

Laparoscopy and ovarian cancer

Diagnosis
- Risk of dissemination of the disease through the peritoneal cavity or the abdominal wall
  - Early stage
  - Advanced stage
- Option 1: Laparotomy
- Option 2: Unilateral salpingo-oophorectomy through endobag and restaging A.S.A.P.
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SURGICAL TREATMENT OF EARLY STAGES

1. - TAH + BSO or CONSERVATIVE FOR YOUNG WOMEN
2. - STAGING:
   - CAREFUL EXAMINATION OF THE WHOLE ABDOMINAL CAVITY + CYTOLOGY
   - INFRACOLIC OMENTECTOMY
   - APPENDECTOMY
   - PERITONEAL BIOPSIES: SUSPICIOUS AREAS or SYSTEMATIC
   - PELVIC AND PARA AORTIC LYMPHADENECTOMY

ALL THESE PROCEDURES HAVE BEEN DONE THROUGH THE LAPAROSCOPIC APPROACH AND CAN BE DONE BY EXPERIMENTS SURGERONS IN LAPAROSCOPY AND GYNECOLOGIC ONCOLOGY.

IF PRIMARY SURGERY INADEQUATE A RESTAGING PROCEDURE IS INDICATED AND IS FEASIBLE BY LAPAROSCOPY

30% UPSTAGING

ACTION TRIAL

BENEFIT FOR CHEMOTHERAPY ONLY IF SURGICAL STAGING INADEQUATE (NO BENEFIT IF ADEQUATE).

WHAT MUSHROOMS WOULD YOU CHOOSE TO EAT?
Laparoscopy and ovarian cancer
ADVANCED STAGES

NEW DEFINITIONS FOR CYTOREDUCTIVE SURGERY

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
<th>Definition</th>
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</thead>
<tbody>
<tr>
<td>OPTIMAL</td>
<td>No macroscopic residual disease</td>
<td>≥ 50%</td>
</tr>
<tr>
<td>SUBOPTIMAL</td>
<td>Residual disease ≤ 1 cm</td>
<td>35-50%</td>
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<tr>
<td>NON OPTIMAL</td>
<td>Residual disease &gt; 1 cm</td>
<td>&lt; 30%</td>
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Only patients with resectable tumor should be operated at first.

Séries 113 stages IIIc
Complete and optimal CRS ≤ 1 cm (N = 56)
30% COMPLICATIONS

Suboptimal CRS (N = 57)
(29 RS and SRS)
COMPLICATIONS 14%

ADVANCED STAGES
PATIENTS SHOULD BE SELECTED BEFORE PRIMARY CYTOREDUCTIVE SURGERY.
- PATIENTS WITH RESECTABLE TUMOR PRIMARY CYTOREDUCTIVE SURGERY
- PATIENTS WITH ESTIMATED NON RESECTABLE TUMOR PRIMARY CHEMOTHERAPY (3 to 4) FOLLOWED BY INTERVAL CYTOREDUCTIVE SURGERY
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**ADVANCED STAGES**

**HOW CAN WE ASSESS TUMOR RESECTABILITY?**

- CLINICAL EXAMINATION: AGE, PS
- BIOLOGY: CA-125
- TDM
- LAPAROSCOPY

**LAPAROSCOPY ASSESSMENT OF RESECTABILITY**

- BIOPSY FOR HISTOLOGY TYPE
- TUMOR VOLUME AND EXTENT OF CARCINOMATOSIS
  - TUMOR MASS > 1 kg
  - MORE THAN 100 PERITONEAL IMPLANTS
  - HIGH PERITONEAL SCORE

**ADVANTAGES OF INTERVAL SURGERY**

RESULTS OF EORTC TRIAL #55971

I. VERGOTE, IGCS Meeting Bangkok, Oct 24th 2008

- LOWER MORBIDITY
- LESS BOWEL RESECTIONS
- MORE OPTIMAL RESECTIONS
- NO SURVIVAL DISADVANTAGE (OS and PFS)

NEOADJUVANT CHEMOTHERAPY AND INTERVAL CYTOREDUCTIVE SURGERY CAN BE CONSIDERED AS PREFERRED TREATMENT FOR ADVANCED STAGE (III, IV) OVARIAN CANCER
Advanced stage ovarian cancer: strategy

- **CLIN BIOL TDM**
- **TUMOR RESECTABILITY**
  - yes
  - yes?
  - CRS
  - yes?
  - LAPAROSCOPY
  - RESPONSE
    - yes
    - Interval CRS
    - no?
    - CHEMO x 3
    - yes?
    - CHEMO x 6
    - no?
    - second line chemo

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**SECOND LOOK**
- No benefit
- Not recommended
- Laparoscopic second look acceptable
  - For current clinical trials
  - But difficult at risk and may be sometimes less accurate

**CONCLUSION**
Laparoscopy is useful at several stages of the management of ovarian diseases.
For ovarian cancer, it requires a good expertise in laparoscopy and in gynecologic oncology.