Meet the Expert Sessions

ME01

RADICAL HYSTERECTOMY AND NERVE SPARING SURGERY

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For rectal cancer locoregional recurrences and late sequelae from intraoperative pelvic autonomic nerve damage could be minimized by total mesorectal excision (TME). We claim to achieve similar improvements in the surgical treatment of cervical carcinoma with a corresponding concept and technique. We developed the total mesometrial resection (TMMR) to remove the uterus and proximal vagina together with their integral mesentery (mesometrium) as an ontogenetic entity by consequent sharp preparation along embryologically derived tissue planes with minimal traumatization. Pelvic lymph node dissection is extended to be therapeutic. Since 7/1998 we prospectively study the outcome in patients treated with TMMR for cervical carcinoma FIGO stages IB, IIA and selected IIB. Patients with tumors >/=5 cm receive preoperative chemotherapy. By 7/2002 70 patients with cervical cancer stages (y)pT1b1 (n = 48), (y)pT1b2 (n = 8), pT2a (n = 3), (y)pT2b (n = 11) underwent TMMR without (neo)adjuvant radiation. Median pathological tumor size was 2.5 cm (0.7–10 cm). Twenty percent of the patients had (y)pN1, (y)pM1(LYM) stages. At a median observation period of 24 months two patients relapsed locally, two patients developed pelvic and distant and two patients only distant recurrences. TMMR did not lead to grade 3 or 4 complications. Grade 1 and 2 complications occurred in 5 resp. 15 patients. No severe long-term impairment of pelvic visceral functions related to autonomic nerve damage was observed. Based on these preliminary results TMMR without (neo)adjuvant radiation achieves a very promising therapeutic index in the treatment of early stage cervical cancer. Indications of more advanced disease for TMMR and the role of preoperative hemotherapy need to be defined by further study.

ME02

NERVE-SPARING TOTAL MESORECTAL EXCISION AND LATERAL PELVIC LYMPHADENECTOMY FOR ADVANCED RECTAL CANCER IN WESTERN PATIENTS

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The total nerve sparing procedure was introduced by Japanese Surgeons for a complete preservation of the superior hypogastric plexus, hypogastric nerves and pelvic plexuses without compromising radicality of surgical resection in patients with early stage rectal cancer not requiring lateral pelvic lymphadenectomy. For advanced rectal cancer at or below the peritoneal reflexion, Japanese authors propose an extended approach by Total Mesorectal Excision plus Lateral Pelvic Lymphadenectomy with resection of one or more autonomic nervous segments up to complete removal of pelvic autonomic nervous plexuses according to depth of parietal infiltration and metastatic involvement of regional lymph nodes. However, the criteria for extention of nerve sparing/excision are not well established. The possibility of a continuous neoplastic infiltration along nerves far from the primitive tumor is still unclear. The high incidence of diabetes, obesity and perivasculitis and the higher morbidity rate expected after Lateral Pelvic Lymphadenectomy in western patients justify the scepticism among European and North American surgeons who consider lymph nodes as prognostic indicators, and favour the Total Mesorectal Excision with or without adjuvant radio-chemoterapy as the standard treatment for advanced rectal cancer. However, the recurrence and survival rates after Total Mesorectal Excision are often not as good as those reported by Heald and Karanjia. The video shows our surgery for advanced rectal cancer by Total Mesorectal Excision plus Lateral Pelvic Lymphadenectomy with Total Nerve Sparing procedure: the autonomic pelvic nerves are resected only in case of evidence of neoplastic involvement.

ME03

PROSTATE CANCER AND NERVE SPARING SURGERY

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Prostate cancer has become the most common malignancy in men in Western Europe and is the second cause of cancer death. Radical prostatectomy is the standard treatment for localised prostate cancer. The surgical technique of radical prostatectomy has dramatically improved since the description of the anatomic retropubic radical prostatectomy by Pat Walsh, John Hopkins, United States. Not only was the average blood loss of the procedure substantially decreased, but also the exact localisations of the neurovascular bundles enabled to perform nerve sparing operations. When the patient presents with a prostate confined tumour (T1c-T2), it is possible to perform a total prostatectomy while sparing one or two neurovascular bundles. Although patients are mostly impotent immediately after the surgery, because of elongation of the neurovascular bundles, spontaneous erectile function can recover after nine months and then improve until 1,5–2 years after the procedure. Many different techniques for nerve sparing radical prostatectomy have been described and are actually in use. Also nerve grafting has been described in a few centres. With the increasing incidence of younger patients that are confronted with the diagnosis of localised prostate cancer, quality of life issues in general and erectile function issues become more and more important. If well performed, nerve sparing radical prostatectomy must be able to guarantee persistence or regain of erectile function.

ME04

NEWS ON ULTRASONOGRAPHIC TECHNIQUES FOR PELVIC MALIGNANCIES

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Objective: To provide an update on ultrasound based research and computer modeling relevant to gynecologic oncology.

Methods: A selection is made of studies using different morphological and color Doppler parameters for assessing 1) pre-operative prediction of myometrial invasion in patients with endometrial cancer 2) pre-operative discrimination between malignant and benign adnexal tumors.

Results: 1) In patients with endometrial cancer single morphological or color Doppler ultrasound parameters cannot reliably predict the depth of myometrial invasion. Moreover, the Doppler ultrasound parameters do not contribute in this prediction. A study on multivariate logistic regression analysis retained 4 variables: the double endometrial thickness and endometrial volume, the degree of differentiation, and the number of fibroids. In one study the logistic regression model was significantly better than the subjective assessment of a gynecologist to predict depth of myometrial invasion. 2) In patients with adnexal masses a multimodal

approach is better than any single morphological scoring system or color Doppler ultrasound parameters to distinguish between malignant and benign tumors.

Conclusion: Computer modeling seems to be able to assist in the preoperative diagnosis and staging of pelvic malignancies. However, most prospective studies result in lower performances. This is due to a variety of factors, which will be discussed, together with strategies to overcome these problems. Prospective validation studies are always needed to test the usefulness of computer modeling in clinical practice.

ME05

TUMOR DISSEMINATION AND LAPAROSCOPY

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The incidence of the spread of cancer after laparoscopic surgery is unknown. The prognosis incidence of a trocar site metastasis without peritoneal dissemination is not known. Data from general surgeons in prospective studies from a single institution suggested that in colon cancer the risk is low, whereas it seems to be much higher in multicentric studies of undiagnosed gallbladder cancer. Experimental studies suggested that laparoscopy has advantages and disadvantages. However, the risk of dissemination is high when a large number of malignant cells and a carbon dioxide pneumoperitoneum are present, a situation encountered when managing adnexal tumors with large vegetations or when rupturing a malignant cyst, if numerous malignant cells were present in the fluid. In the future, the main advantage of laparoscopy is that the peritoneal environment may be changed and adapted to each clinical situation (cancer, peritoneal infertility, endometriosis). It will be possible to change the gas, the temperature, the light Such changes were impossible by laparotomy. The ovary is an intraperitoneal organ and ovarian cancer a peritoneal disease, so the risk of peritoneal spread may be higher in ovarian cancer than in other gynecological cancers. A careful preoperative evaluation appears to be the best way to prevent these risks. It should be used to choose which surgical team should operate which patient. The second step is a careful and cautious surgical management. The laparoscopic management of gynecological cancers remains controversial and would need to be evaluated in prospective randomized studies.

ME06

ADVANTAGES OF LAPAROSCOPY

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Laparoscopic techniques are increasingly used for staging and treatment of gynecologic cancer. In cervical cancer laparoscopic lymphadenectomy and intraabdominal evaluation is used to evaluate operability by histopathologic staging which leads in 22% to a change of treatment plans. In patients with negative lymph nodes and absence of extracervical tumor spread laparoscopic assisted radical vaginal hysterectomy (LARVH) can be performed. In patients with positive lymph nodes laparoscopic lymph node debulking allows preservation of the blood supply and is followed by chemoradiation. Candidate patients for exenteration with recurrent disease may undergo laparoscopic staging. Thus, aborted laparotomies are avoided in 50%. Combined laparoscopic vaginal techniques allow an individualized risk adapted rationale: Nerve sparing LARVH helps to preserve the motoric function of bladder and rectum. In patients with early cervical cancer laparoscopic assisted radical trachelectomy allows preservation of fertility. The sentinel concept can be performed by laparoscopy in 90% of patients with a sensitivity of 90% and negative predictive value of 95%. In endometrial cancer laparoscopic lymphadenenctomy combined with laparoscopic assisted vaginal hysterectomy leads to less intra- and postoperative morbidity compared with open surgery. The oncologic outcome is similar for laparoscopic and conventional surgical treatment. In early ovarian cancer laparoscopic staging and treatment is feasible and can, if indicated, be used for fertility preserving intervention.

ME07

HORMONE REPLACEMENT THERAPY FOLLOWING ENDOMETRIAL CANCER

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Estrogens are strongly associated with the risk of endometrial cancer. Theoretically this could be the same for recurrence. For this reason it has been stated, for centuries now, that E/HRT is contraindicated for women with a history of endometrial cancer. Yet there is no single evidence to support this theory! Uterine cancer is the fourth most common cancer in women and it has a 5-years survival of more than 75%. The survivors will suffer from climacteric symptoms. Is it still justifiable to withhold all these patients from hormone therapy? The current available data is only retrospective. It encompasses almost a thousand patients and does not indicate poorer survival or an increased risk of recurrence for women taking hormone therapy after being treated for endometrial cancer. This seems to be regardless of stage and differentiation grade. Also the questions when to start and whether or not it should be combined with progesterone does not seems to be of any relevance. However these data have to be confirmed in a prospective randomised double blind study. The Gynaecologic Oncology Group and the National Cancer Institute currently perform this study, unfortunate data will only be available within 1 to 2 years. At present patients have to be selected on the basis of their complains and the risk they are willing to take. In this day and age of informed consent and medical legal pressure, patients have to be informed about the advantage and disadvantages. At the end of the day they themselves have to decide. Withholding a luxury product, as hormone therapy, is not the task of a clinician.

ME08

NON HORMONAL ALTERNATIVES FOR HRT FOLLOWING BREAST AND ENDOMETRIAL CANCER

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Many women treated for breast and endometrial cancer report vasomotor symptoms with hot flushes and sweating. Adjuvant endocrine therapy even increases these symptoms. Traditionally hormone replacement therapy (HRT) with estrogens and progestagens is contraindicated in breast cancer patients due to a suspected increased risk of recurrence of the disease, albeit a number of observational studies do not support this view. Also many women with endomaterial cancer are recommended not to use estrogens, although addition of progestagens should be beneficial. Prospective randomized studies are the only way to establish the actual risk of recurrence of breast cancer during HRT. Such studies are ongoing, but there is a need for effective 'non-HRT' therapies. Some such alternatives, like clonidine, vitamin E, soy products, serotonine-noradrenaline reuptake inhibitors, behavioral therapy and acupuncture, have been suggested and will be discussed.