Plenary 2 - Oncology

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Professional Education Information

Target Audience
This educational activity is developed to meet the needs of residents, fellows and new minimally invasive specialists in the field of gynecology.

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Plenary 2 - Oncology

Moderator: Amanda Nickles Fader, Edward J. Tanner

Faculty: Masaaki Andou, Afshin Fazel, Temeka Kincy, Jamie Kroft, Shailesh P. Puntambekar, Stephanie Ricci

In this session, a variety of studies are presented and provide new information regarding how issues of morcellation, obesity and surgical staging techniques impact both benign gynecologic and gynecologic oncology surgical settings.

Learning Objectives: At the conclusion of this course, the participant will be able to: 1) Examine North American trends in the advancement of minimally invasive endometrial cancer surgery; and 2) determine how novel surgical techniques, including LESS, OASIS and extraperitoneal procedures, impact the surgical management of cervical and endometrial cancers.

Course Outline

12:05 Incidence and Outcome of Uterine Sarcomas Diagnosed in a Continuous Cohort of Patients Referred for Treatment of Uterine Fibroids by Minimally Invasive Procedures A. Fazel


12:25 Extraperitoneal Endoscopic Total Retroperitoneal Lymphadenectomy – No Bowel Surgery M. Andou

12:32 Occult Uterine Malignancy Uncommon in Reproductive Age Women Undergoing Uterine Surgery and Morcellation S. Ricci

12:42 Radical Hysterectomy Duplication of Conventional Multiport Laparoscopic Steps: with Other Minimal Access Modalities (Robotic, LESS, OASIS) S.P. Puntambekar

12:40 Trends over Time and Regional Variation in the Use of Laparoscopic Hysterectomy for the Treatment of Endometrial Cancer in the Province of Ontario, Canada J. Kroft

1:05 Adjourn
PLANNER DISCLOSURE
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Speakers Bureau: Ethicon Endo-Surgery
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Stephanie Ricci*
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Asterisk (*) denotes no financial relationships to disclose.
Incidence and Outcome of Uterine Sarcomas Diagnosed in a Continuous Cohort of Patients Referred for Treatment of Uterine Fibroids by Minimally Invasive Procedures

Afshin FAZEL, MD, PhD
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Objectives
- Recent issues with electromorcellation of sarcomas are questioning 20 years of MIS developments
- The differential diagnosis between fibroids and sarcomas could be very challenging
- Very few studies exist including incidence, modalities of diagnosis and outcomes of sarcomas among a population of patients with fibroids
- Based on one of the largest series of sarcomas diagnosed among fibroids the objective of the study is to give some tools to avoid morcellation of a malignancy and still practicing MIS with the highest standards

The Challenges
- Pre operative differentiation of sarcomas, from fibroids and their variants, adenomyomas and endometrial cancers
- Tissue extraction of large benign masses during Minimally Invasive Surgery
- Avoiding complications: intraoperative (injuries) and post operative (tissue reimplantation and peritoneal metastasis)

The Setting
University hospital
Tertiary referral center
- 1st fibroid embolization 1989
Lancet, 1995; 346 : 671-672 Ravina et al,
- Advanced MIS (1kg club)
- Expert Center in Gyn Oncology (InCa)

The Method
Clinical examination
Pap Smear
Pelvic US

Risk Factors
- Endometrium >4 mm
- .ALL
- > 40-45

Office HSC
Fibroids assessment

- Initiated in 2000
- Referred patients of over 20 # ethnical origins
- Origin Black (African, Caribbean) (55,6%)
- Gyn. Examination, PAP-Smear, mammogram
- MRI: MANDATORY for mapping
- +/- ES, +/- office HSC
- Multidisciplinary decision (Surgeon, Interventional radiologist, Oncology radiologist)

MRI

- Large size
- High signal intensity
- No calcifications
- Ill-defined margins
- Central necrosis
- Change in size
- Gd-DTPA) MRI + LDH 3

Multidisciplinary Team Work

- Afshin FAZEL
- Olivier Le Dref
- Denis JACOB
- Vinviane PLACE
- Sandra BENDAVID
- Jean Pierre PELAGE
- Jean Philippe BROULAND
- Françoise CORNELIS
- Anne THOURY
- Aude RICBOURG
- Yann DELPECH
- Jean Louis BENIFLA

Risk Factors for Sarcomas

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Risk Factors for sarcoma than</th>
<th>Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>Metastasis diagnosis 40-60</td>
<td></td>
</tr>
<tr>
<td>Size</td>
<td>Prolonged high risk areas ECOG (96)</td>
<td></td>
</tr>
<tr>
<td>Histology</td>
<td>Prolonged survival, if defined in the years more (71)</td>
<td></td>
</tr>
<tr>
<td>Pelvic invasion</td>
<td>Association is especially strong for carcinomas (73)</td>
<td></td>
</tr>
<tr>
<td>Soft tissue sarcoma and Neurofibromatosis (NF 1&amp;2)</td>
<td>Sarcoma sarcomarcoma associated with NF1&amp;2</td>
<td></td>
</tr>
<tr>
<td>Infections of childhood origin</td>
<td>Higher risk for sarcomas in general, including sarcoma (73)</td>
<td></td>
</tr>
</tbody>
</table>

Classical diagnosis of Sarcoma

- Clinical: bleeding, pelvic pain/pressure, rapidly growing pelvic mass? Fibroids!
- Examination findings: Large mass! Fibroids!
- ES?
- Metastatic disease

AAGL Practice Report: Morcellation During Uterine Tissue Extraction JMRG Volume 23, Issue 4, July–August 2014, Pages 517-530
2824 patients hospitalized from 2002 to 2013 for “Fibroids”

- 743 patients were treated by laparoscopy
- 510 resection by hysterectomy
- 336 patients with a vaginal procedure
- 262 patients by UAE

66% of Minimally Invasive procedures

Case 4

47Y acute pelvic pain, Tense abdomen HRT 147, BP 150/85, temperature 38°C, Hb level at 6.7g/dl and a CRP at 147.

Emergency laparotomy

Hemoperitoneum of 32 l

Large uterus of 1200 gr high grade spontaneous ruptured leiomyosarcoma of 21 x 12.5 cm. Bundles of interlacing highly cellular smooth muscle, with 45 mitotic figures per 10 HPF

Take home message

- The diagnosis of sarcoma should be approached by all means: Clinical, ES, HSC, MRI...
- None of them alone is sufficient!
- In our series 7 sarcomas among 2824 patients referred for fibroids: Incidence: 1/400 fibroids!
- NO LAPAROSCOPIC M Morcellation
- 80% Preop suspicion of sarcoma
- M And M’s approach

MRI Assumption of malignancy and Multidisciplinary decision may avoid uterine morcellation by MIS

References


What level of obesity affects results of surgery?
A cohort study of robotics and laparotomy for staging of endometrioid endometrial cancer among patients with BMI 40 and above.

Temeka Kinsey, MD
Department of Gynecologic Oncology
St. Vincent Indianapolis Hospital
Indianapolis, Indiana

Disclosures
- I have no financial relationships to disclose.

Background
- Obesity is an epidemic in the United States
- Major risk factor for endometrial cancer is obesity
- Obesity results in more difficult surgeries with increased risks
- Randomized study of laparotomy and laparoscopy (LAP2) showed a 57% conversion rate when BMI was > 40 Walker et al. 2009

Objectives
- Determine how obesity affects results of surgical staging depending on the type of surgery performed and level of BMI
- Compare complications between robotic surgical staging and laparotomy in endometrial cancer patients with BMI > 40

Materials and Methods
- Retrospective cohort study
  - 83 patients reviewed
    - Included all patients who underwent surgical staging for endometrioid endometrial cancer with a BMI of 40 and above between 2 different surgeons
  - Study period: May 1, 2011 through April 30, 2013.
  - One surgeon performed only total abdominal hysterectomies and the other performed robotic assisted laparoscopic hysterectomies (RALH). Patients did not cross between the two surgeons
- Data was analyzed according to procedure type and level of BMI. BMI was used as a continuous variable in regards to frequency of lymph node removal.
- Complications were recorded up to 90 days post operatively from medical records as well as office charts
Demographics

<table>
<thead>
<tr>
<th></th>
<th>Robotics N=56</th>
<th>Laparotomy N=27</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>61.5</td>
<td>60.19</td>
<td>0.451</td>
</tr>
<tr>
<td>BMI</td>
<td>47</td>
<td>44.5</td>
<td>0.469</td>
</tr>
<tr>
<td>Co-Morbidities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-2</td>
<td>29 (51.8)*</td>
<td>16 (59.3)</td>
<td></td>
</tr>
<tr>
<td>&gt;3</td>
<td>27 (48.2)</td>
<td>10 (37)</td>
<td></td>
</tr>
</tbody>
</table>

Prevalent Co-Morbidities

Operative Results

<table>
<thead>
<tr>
<th></th>
<th>Robotic N=56</th>
<th>Laparotomy N=27</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of patients with pelvic LNs removed</td>
<td>94.8</td>
<td>88</td>
</tr>
<tr>
<td>% of patients with para-aortic LNs removed</td>
<td>74.1</td>
<td>64</td>
</tr>
<tr>
<td>EBL (ml)</td>
<td>150</td>
<td>600</td>
</tr>
<tr>
<td>LOS (days)</td>
<td>1</td>
<td>5</td>
</tr>
</tbody>
</table>

LN=lymph nodes, EBL=estimated blood loss, LOS= hospital length of stay

Common Complications

<table>
<thead>
<tr>
<th>Complications</th>
<th>Robotic N=56</th>
<th>Laparotomy N=27</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fever</td>
<td>4 (7.1)</td>
<td>2 (7.4)</td>
</tr>
<tr>
<td>Ileus</td>
<td>1 (1.8)</td>
<td>4 (14.8)</td>
</tr>
<tr>
<td>Major</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute respiratory failure*</td>
<td>1 (1.8)</td>
<td>4 (14.8)</td>
</tr>
<tr>
<td>Wound/vaginal cuff dehiscence</td>
<td>1 (1.8)</td>
<td>1 (3.8)</td>
</tr>
<tr>
<td>Pelvic/Abdominal Abscess</td>
<td>4 (7.1)</td>
<td>1 (3.8)</td>
</tr>
</tbody>
</table>

*Acute respiratory failure= unable to be extubated immediately after procedure ends. All patients go to the ICU for ventilator management in the care of the critical care physicians.
Discussion

- In high volume surgical centers, with a specialized team, robotic surgery for endometrioid cancer staging can be performed safely in patients with a BMI > 40.

- With increasing BMI, robotic surgery seems to result in a similar ability to perform lymph node dissection (LND) while the ability to perform LND with laparotomy decreases.

- Robotic surgery can decrease EBL and hospital length of stay.

Bernardini et al., Seamon et al., Subramaniam et al. and Tang et al.

Further Direction

- Continue data accrual and analysis of a larger cohort of women.

- Identify risk factors associated with prolonged/overnight intubation

References


Extraperitoneal Endoscopic Total Retroperitoneal Lymphadenectomy – No Bowel Surgery

Masaaki Andou, M.D.
Kurashiki Medical Center, Kurashiki-shi, Okayama-ken, Japan

Study Objective: We will present an ultra-minimally invasive retroperitoneal lymphadenectomy using the extraperitoneal approach. This technique has been developed to make oncologic surgery less invasive and a more patient friendly procedure.

Design: A description of our surgical technique, based on retrospective analysis of patients who underwent surgery for endometrial cancer.

Setting: Community hospital.

Patients: 322 Women who underwent endoscopic extraperitoneal paraaortic and pelvic lymphadenectomy for endometrial cancer from Jan 2001 to Dec 2013.

Interventions: We access the retroperitoneal space with an Endotip visual access cannula, which easily creates peritoneal tenting. After expanding the extraperitoneal space by blunt dissections with forceps, carbon dioxide is infused. The upper limit of our dissection is the renal vein and the lower limit is the iliac circumflex vein.

We can achieve a total retroperitoneal dissection, both paraaortic and pelvic, including the infrarenal zone, via our extraperitoneal approach. The mean number of retrieved lymph nodes was 42 in the paraaortic area and 38 at the pelvic area. Mean surgical time was 180 minutes and the mean estimated blood loss was 50ml for paraaortic dissection and 120ml for pelvic dissection.

Conclusion: This procedure is focused on the barrier-free nature of working in the retroperitoneal space; meaning, a space, which is not hindered by the invasion of the bowel or other intraperitoneal structures.
Occult Uterine Malignancy Uncommon in Reproductive Age Women Undergoing Uterine Surgery and Morcellation

Stephanie Ricci, MD
Fellow, Gynecologic Oncology
Johns Hopkins University

Disclosure

I have no financial relationships to disclose

Objectives

- Identify risk factors for cancer incidence in presumed benign gynecologic cases
- Assess outcomes of morcellation in distinct patient populations
- Provide preliminary patient safety guidelines for the morcellation technique

Background

- Minimally invasive surgery has greatly improved outcomes for women undergoing hysterectomy/myomectomy
- Smaller incisions make removing the uterus difficult if it cannot be removed intact vaginally
- Morcellation of the uterus/fibroid allows removal through a 12mm port site

Methods

- A retrospective study
- Academic center with a high volume of minimally invasive surgery (MIS)
- Conducted from 2005-2014
- All patients (pts) underwent either MIS hysterectomy or myomectomy +/- morcellation for presumed benign indications
- Morcellation was performed via a power morcellator or by hand morcellation +/- the use of an endoscopy bag
- Cases were stratified by patient age (<50 and ≥50 years)
Results

- 424 pts were identified
- 314 uterine specimens were morcellated with a power morcellator and 60 were hand morcellated
- Median patient age was 42 (range, 20–66 years), and 86.7% were <50 years old
- Median uterine weight was 296 grams, and was significantly higher in the postmenopausal women (385.5 grams versus 298 grams, p=0.04)
- Most common indication for surgery: leiomyomas (29%)

In women <50 years old, no cases of occult uterine malignancy occurred after MIS and uterine morcellation
- Occult cancers occurred in 2 women ≥55 years old
- Cautions should be exercised when considering morcellation in postmenopausal women with large uteri
- Comprehensive preoperative assessments and patient risk stratification for occult malignancy may optimize patient safety and reduce the risk of preventable harm associated with morcellator-associated dissemination of an unrecognized uterine cancer
- No occult uterine or adnexal cancers were identified in women ≥50 years old (n=426 pts)
- 2 invasive cancer cases were identified:
  - Stage 1b cervical adenocarcinoma in a 55-year-old woman with pelvic pain and hematometra
  - Myoid leiomyosarcoma was identified in a 36-year-old woman with leiomyomas
  - The former patient experienced a recurrence which responded to treatment
  - Both pts are currently without evidence of disease with a median overall survival of 6 months and 14.6 months, respectively.

References

Lap Radical Hysterectomy Duplication of Conventional Multiport Laparoscopic Steps with Other Minimal Access Modalities (Robotic, LESS, OASIS)

Dr. Shailesh Puntambekar
Medical Director, Galaxy CARE Laparoscopy institute, Pune, HOD (MAS) BLK hospital, New Delhi, Honorary consultant, Columbia Asia hosp, Pune, Honorary consultant, Cape town university, South Africa

Disclosure
I have no financial relationships to disclose.

Pune Technique

This is a Pivers’ Type III radical hysterectomy

• Step 1: Posterior ‘U-cut’
• Step 2: Para rectal space dissection and the clipping of uterine arteries
• Step 3: Anterior ‘U-Cut’
• Step 4: The dissection of ureteric tunnel:
• Step 5: Colpotomy

Nerve sparing LRH

Anatomy of the pelvic nerves
Aim

• To prove the technical feasibility of performing a laparoscopic nerve sparing radical hysterectomy

• To show that a Type III hysterectomy is possible with nerve sparing

Demographic data

• Average age (years)  50.42 (29-58)

• Body mass index (kg/m2)  25

• Stage of disease
  Ca cervix- FIGO stage Ia1- Ib1 (n=6)
  Ca endometrium (n=1)

Pathological Results

• HPE- squamous cell carcinoma (n=5)
  adenocarcinoma (n=2)

  Parametrial margin - 2.5 +/- 0.25 cm

  Vaginal margin - 3 +/- 0.5 cm

  Lymph node yield - 15

Surgical Results

  Operative time - 160 +/- 20 min

  Blood loss - 250 ml

  No intra/ post operative complications

Functional Results

Time for return of bladder function:

48 hrs - 4 patients

7 days - 2 patients

14 days - 1 patients

Conclusions

• The technique is different from that of classical laparoscopic radical hysterectomy.

• The nerve sparing is easier done laparoscopically

• The results of laparoscopic nerve sparing are encouraging.

• The lateral margin status and lymph node yield is comparable to that of conventional procedures.
Identification of hypogastric nerve

Dissection of pararectal space

Identification of the uterine vein

Identification of parasympathetic nerves

Preserved parasympathetic nerves

Selective cutting of the uterine branches
Cutting of the cervical branches, lateralization of the ureter

Preserved bladder nerves

Van Frankenhauser’s Plexus

OASIS
• Its Orifices Assisted Small Incision Surgery.
• A novel technique that may incorporate benefits of single-incision and natural-orifice surgery while minimizing instrument crowding and interaction of optical access with operative instrumentation.
• In our multiple-site series a total of 14 patients (5 with benign disease and 9 with oncologic disease) underwent the procedures.

Surgeries
• Total laparoscopic hysterectomy
• Laparoscopic supracervical hysterectomy
• Laparoscopic myomectomy
• Laparoscopic radical hysterectomy with pelvic lymph node dissection

Procedure
• The optical access is gained via posterior cul-de-sac by placing endoscope through a port at this location.
Advantages

- Procedure safety completed.
- Oncologic clearance was consistent with specialty norms.
- Operating time ranged from 60 to 150 minutes, and
- Estimated blood loss ranged from 10 to 500 mL.
- So the procedure seems to be a safe and feasible addition to the advanced minimally invasive surgeons' armamentarium for both benign and oncologic cases.

LESS

- It is Laparoendoscopic Single Site Surgery
- We duplicated the steps of our laparoscopic nerve-sparing radical hysterectomy procedure to perform a nerve-sparing radical hysterectomy via LESS using conventional ports and instruments.
- Oncologic clearance was comparable to that in conventional laparoscopic radical hysterectomy. Bladder function recovered completely after removal of the Foley catheter.
- The oncologic clearance and functional results are comparable to those in the multiport variant.

Procedure

- **Primary port (10mm)**: This is at umbilicus for telescope.

- **Accessory ports (5mm)**:
  1. Right- This is for energy source, suctioning and scissors
  2. Left- This is for graspers.

Advantages

- Exact duplication of original steps.
- Less operative time around 120 min.
- Less blood loss around 50 ml only.
- Less incisional hernias.
- Wound healing faster.
- Cosmetically better.
- Less postoperative pain.
- Early ambulation.
Robotic surgery fills the gap between having skills and not having one.
A surgeon with limited skills can still perform robotic surgery with knowledge of operative steps and the anatomy. This leads to added advantage both to the patient as well as the surgeon.
In April 2005, Da Vinci robot was FDA cleared for gynaecologic procedures.

• 12 mm camera port: just above umbilicus.
• 8 mm right port: 10 cm lateral and 5 cm caudal to camera port
• 8 mm left port: This is mirror image of right port.
• Two assistant 10 mm ports: These are placed pararectally at the level of camera port.

Features
• Minimal operative time.
• Blood loss is less than 50 ml.
• Depth and magnification is excellent
• Return of bowel activity is faster.
• Surgeon fatigability is less.
• Patient acceptability
• Only problems is the cost.

Thanks
TRENDS OVER TIME AND REGIONAL VARIATION IN THE USE OF LAPAROSCOPIC HYSTEROECTOMY FOR THE TREATMENT OF ENDOMETRIAL CANCER IN THE PROVINCE OF ONTARIO, CANADA

Jamie Kroft, MD, MSc, FRCSC
Sunnybrook Health Sciences Centre
University of Toronto

Plenary Session 2: Oncology, November 19, 2014

Disclosures

I have no financial relationships to disclose.

Objectives

- At the completion of this talk, participants will be able to:
  - Illustrate the benefits of laparoscopy for the treatment of endometrial cancer versus laparotomy based on the literature
  - Interpret the population data from the Province of Ontario in Canada to demonstrate how the utilization of laparoscopy for treatment of endometrial cancer has changed and what factors have influenced utilization
  - Assess the benefits of laparoscopy versus laparotomy on a population level for treatment of endometrial cancer
  - Formulate hypotheses on how utilization of laparoscopy can be increased and the possible benefits this could have on a population level

Background

- Endometrial Cancer (EC) is the fourth most common cancer in Canadian women
- 68.2% of EC is surgically treated in Ontario by general gynecologists (GG), 26.2% by gynecologic oncologists (GO)
  - In 80% of cases GG perform hysterectomy and bilateral salpingoophorectomy (BSO)
  - In 44.5% of cases GO perform hysterectomy and BSO and in 48.8% ALSO perform lymphadenectomy (LN)
- GG or GO can complete surgical management for grade 1 EC
- NO difference in recurrence-free and overall survival between patients with pre-op centrally reviewed grade 1 EC that have LN vs those that do NOT

Background

- Laparoscopic management of EC vs abdominal/laparotomy:
  - Decreases complications, blood loss, shortens hospital stay, improved short-term quality of life, better cosmesis, improved cost effectiveness, yields similar lymph node counts
  - Fewer post-op adverse events and shorter hospitalization, no difference in overall detection of advanced stage disease
Study Objectives

- To determine the rates of laparoscopy compared to laparotomy for the treatment of endometrial cancer in the province of Ontario, Canada
- To determine factors associated with having laparoscopic surgery

Study Methods

- Population-based retrospective cohort study
- Ontario healthcare administrative databases used
- Incident cases of endometrial cancer from April 2002-March 2011 were identified in the provincial cancer registry
- Record linkages were made with other healthcare databases to determine type of hysterectomy (laparoscopic or abdominal +/- staging), year of diagnosis, comorbidities, location of residence, surgeon and hospital type
- Regression analysis used to determine factors associated with having laparoscopic surgery

Results

Abdominal Surgery (N=9988)  Minimally Invasive Surgery (N=2116)

<table>
<thead>
<tr>
<th>Age (mean, SD, range)</th>
<th>62.5 (+/-11) (27-98)</th>
<th>63.1 (+/-11.3) (28-93)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACG Score (mean, SD, range)</td>
<td>7.82 (+/- 4.60) (0-24)</td>
<td>6.54 (+/- 4.59) (0-20)</td>
</tr>
</tbody>
</table>

**Histologic Type**

| Endometrioid | 8312 (83.2%) | 1860 (87.9%) |
| High Risk Endometrial | 1287 (12.9%) | 214 (10.6%) |
| Sarcoma | 389 (3.9%) | 32 (1.5%) |

**Staging**

| Yes | 2147 (21.5%) | 595 (28.1%) |
| No | 7841 (78.5%) | 1321 (71.9%) |

**Surgeon Type**

| Gynecologic Oncologist | 3304 (33.1%) | 937 (44.3%) |
| General Gynecologist | 6286 (62.9%) | 792 (37.4%) |
| Not found | 398 (4.0%) | 387 (18.3%) |

**Residence**

| Rural | 1448 (14.5%) | 218 (10.3%) |
| Urban | 8530 (85.4%) | 1896 (89.6%) |

**Type of Hospital**

| Community | 5499 (55.1%) | 796 (37.6%) |
| Academic | 4489 (44.9%) | 1320 (62.4%) |

Results: Effect of Year of Diagnosis

- Effect of Year of Diagnosis: P=0.02
- Year Effect: Estimate 30.2%
- Year Effect: Estimate 6.5%

Results: Length of Hospital Stay

- Mean LOS (Days)
  - Abdominal Surgery
  - Minimally Invasive Surgery

Results: Readmission to Hospital

- Year of Diagnosis
Regional Variation: LHIN Map

Results: Regional Variation

Results: Regression
- Independent factors predictive for laparoscopic surgery on multivariate analysis were:
  - Surgeon and hospital type (combined) $p = 0.0007$
  - Year of diagnosis $p = 0.02$
  - Age, comorbidity score (ACG score), staging, income quintile were NOT significantly associated with probability of laparoscopy
  - Gynecologists in academic centres and gynecologic oncologists were more likely to perform laparoscopic surgery than gynecologists in community hospitals (OR 2.25 (95% CI 1.02-4.98) and 2.35 (95% CI 1.29-4.28) respectively)

Summary
- Laparoscopic treatment of endometrial cancer was more likely over time
- Patients were more likely to be treated laparoscopically by gynecologic oncologists and general gynecologists at an academic hospital
- Length of hospital stay and hospital readmission rates were lower in patients treated laparoscopically
- Rates of laparoscopic treatment varied widely depending on location of residence

Discussion
- This study demonstrates benefits of laparoscopic treatment of endometrial cancer on a population level
- Although there has been an increased utilization of laparoscopy for treatment of endometrial cancer over time, significant regional variation exists and provincial overall rate is still relatively low
- Targeted education-based initiatives, knowledge translation strategies and/or policy changes are needed to improve patient access to care and decrease morbidity

References
CULTURAL AND LINGUISTIC COMPETENCY

Governor Arnold Schwarzenegger signed into law AB 1195 (eff. 7/1/06) requiring local CME providers, such as the AAGL, to assist in enhancing the cultural and linguistic competency of California’s physicians (researchers and doctors without patient contact are exempt). This mandate follows the federal Civil Rights Act of 1964, Executive Order 13166 (2000) and the Dymally-Alatorre Bilingual Services Act (1973), all of which recognize, as confirmed by the US Census Bureau, that substantial numbers of patients possess limited English proficiency (LEP).

California Business & Professions Code §2190.1(c)(3) requires a review and explanation of the laws identified above so as to fulfill AAGL’s obligations pursuant to California law. Additional guidance is provided by the Institute for Medical Quality at http://www.imq.org

Title VI of the Civil Rights Act of 1964 prohibits recipients of federal financial assistance from discriminating against or otherwise excluding individuals on the basis of race, color, or national origin in any of their activities. In 1974, the US Supreme Court recognized LEP individuals as potential victims of national origin discrimination. In all situations, federal agencies are required to assess the number or proportion of LEP individuals in the eligible service population, the frequency with which they come into contact with the program, the importance of the services, and the resources available to the recipient, including the mix of oral and written language services. Additional details may be found in the Department of Justice Policy Guidance Document: Enforcement of Title VI of the Civil Rights Act of 1964 http://www.usdoj.gov/crt/cor/pubs.htm.

Executive Order 13166, “Improving Access to Services for Persons with Limited English Proficiency”, signed by the President on August 11, 2000 http://www.usdoj.gov/crt/cor/13166.htm was the genesis of the Guidance Document mentioned above. The Executive Order requires all federal agencies, including those which provide federal financial assistance, to examine the services they provide, identify any need for services to LEP individuals, and develop and implement a system to provide those services so LEP persons can have meaningful access.

Dymally-Alatorre Bilingual Services Act (California Government Code §7290 et seq.) requires every California state agency which either provides information to, or has contact with, the public to provide bilingual interpreters as well as translated materials explaining those services whenever the local agency serves LEP members of a group whose numbers exceed 5% of the general population.

If you add staff to assist with LEP patients, confirm their translation skills, not just their language skills. A 2007 Northern California study from Sutter Health confirmed that being bilingual does not guarantee competence as a medical interpreter. http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=2078538.