Plenary 2: Oncology

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Afshin Fazel, MD, PhD
Fabio Martinelli, MD
Karim ElSahwi, MD
Martin L. Hechanova, MD, MPH
Yanzhou Wang, MD
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.

Accreditation
AAGL is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

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Plenary 2: Oncology

Moderators: Emery Salom, Edward J. Tanner

Discussants: Sven Becker, David M. Boruta, Jubilee Brown, R. Wendel Naumann, Emery Salom, Edward J. Tanner

Faculty: Masaaki Andou, Karim ElSahwi, Afshin Fazel, Martin L. Hechanova, Fabio Martinelli, Yanzhou Wang

This course will explore the controversial topic of leiomyosarcoma incidence and MRI evaluation, Sentinel lymph node mapping with intrauterine injection of indocyanine green in endometrial cancer, and robotic surgery in ovarian and cervical cancer.

Learning Objectives: At the conclusion of this course, the clinician will be able to: 1) Discuss the incidence and utility of MRI in the detection of leiomyosarcomas, 2) describe the technique of hysteroscopic intrauterine injection of indocyanine green for sentinel node detection in endometrial cancer; and 3) assess the role of minimally invasive techniques in the management of cervical cancer and adnexal masses.

Course Outline

12:05 Risk of Occult Uterine Sarcoma in Women Undergoing Hysterectomy for Benign Indications
M.L. Hechanova

12:11 Discussant
R.W. Naumann

12:15 Sentinel Node Mapping in Endometrial Cancer By Using Hysteroscopic Injection of Indocyanine Green and Laparoscopic Near-Infrared Fluorescence Imaging: A Preliminary Experience
F. Martinelli

12:21 Discussant
S. Becker

12:25 Impact of MRI and a Comprehensive Strategy on a Continuous Cohort of 3056 Patients Referred for Fibroids to Diagnose Sarcomas
A. Fazel

12:31 Discussant
E. Salom

12:35 The Outcome of Laparoscopy Versus Laparotomy for the Management of Early Stage Cervical Cancer-Meta Analysis
Y. Wang

12:41 Discussant
D.M. Boruta

12:45 Video: Robotic Dissection of a Retroperitoneal Ovarian Neoplasm
K. ElSahwi

12:51 Discussant
J. Brown

12:55 Video: Reduced Port Size Nerve Sparing Radical Trachelectomy – The Least Invasive Fertility Sparing Radical Surgery
M. Andou

1:01 Discussant
E.J. Tanner

1:05 Adjourn
PLANNER DISCLOSURE
The following members of AAGL have been involved in the educational planning of this workshop and have no conflict of interest to disclose (in alphabetical order by last name).
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Speakers Bureau: Myriad Genetics Lab
Other: Proctor: Intuitive Surgical
Erica Dun*
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FACULTY DISCLOSURE
The following have agreed to provide verbal disclosure of their relationships prior to their presentations. They have also agreed to support their presentations and clinical recommendations with the “best available evidence” from medical literature (in alphabetical order by last name).
Masaaki Andou*
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David Boruta*
Jubilee Brown*
Karim El Sahwi
Afshin Fazel*
Martin L. Hechanova*
Fabio Martinelli*
R. Wendel Naumann*
Emory Salom*
Edward J. Tanner*
Yanzhou Wang*

Asterisk (*) denotes no financial relationships to disclose.
Risk of Occult Uterine Sarcoma in Women Undergoing Hysterectomy for Benign Indications

Martin Hechanova, MD, MPH

Department of Obstetrics and Gynecology
University of Texas Southwestern Medical Center
Dallas, Texas

I have no financial relationships to disclose.

Determine the frequency of unsuspected sarcoma identified postoperatively in women undergoing surgery for benign gynecologic indications at our institution.

Background

• Hysterectomy is the most commonly performed major abdominal procedure in the U.S.
• Approximately 400,000 hysterectomies performed yearly for benign indications
• Minimally invasive approaches have lower risks of perioperative complications and have quicker recovery

Background

• Morcellation, or tissue fragmentation into smaller pieces, helps to remove large specimens
• Electromechanical morcellation has come under scrutiny due to the concerns over the inadvertent dissemination of occult uterine malignancies
• FDA has discouraged the use of power morcellation
• Incidence of occult sarcoma in women undergoing hysterectomy ranges from 1.5 to 4.9 per 1000 women
• Risk estimates from FDA and ACOG range from 1:352 to 1:500 in their respective pooled analyses
Methods
• Retrospective review of all cases of hysterectomy performed for benign indications from 2000 – 2014 at the University of Texas Southwestern (UTSW) Medical Center and Parkland Memorial Hospital
• Occult sarcoma defined as cases where uterine sarcoma was confirmed on surgical pathology, but did not have pre-operative suspicion or indication of malignancy

Results
• 10,119 hysterectomies performed between 2000-2014 for benign indications
  – 59.4% abdominal
  – 21.6% laparoscopic/robotic
  – 18.9% vaginal
• 9 patients found to have unexpected uterine sarcoma: an overall rate of 0.089%
  – 5 leiomyosarcomas, 2 endometrial stromal sarcomas, 2 uterine adenosarcomas

Results
In the cohort of patients with occult sarcoma:
• Most common indications for hysterectomy: AUB (7/9) and leiomyoma (6/9)
• Median age at diagnosis: 39 (range 25 – 53)
• Ethnicity: 4 Hispanic, 3 Caucasian, 2 African American
• Median BMI: 27 (range 20 - 46)

Conclusions
• Occult uterine sarcoma occurs in less than 0.1% of hysterectomies (< 1 in 1000)
• Lower than the estimated 1 in 352 risk of occult sarcoma used by the FDA in their recommendations against morcellation
  – Largest study included 1429 patients
  – Hysterectomy AND myomectomy cases
  – Included patients referred to subspecialty care
Conclusions

- Although low, the risk of encountering occult sarcoma is real
  - Identify safer methods of tissue extraction
  - Improve pre-operative diagnosis
- Local rates of occult sarcoma may vary and should be considered during patient counseling and when developing clinical recommendations.
Sentinel node mapping in endometrial cancer by using Hysteroscopic injection of indocyanine green and Laparoscopic near-infrared fluorescence imaging: a preliminary experience

Fabio Martinelli, MD

Gynecologic Oncology Department
IRCCS Foundation - National Cancer Institute - Milan
fabio.martinelli@istitutotumori.mi.it

I have no financial relationships to disclose

OBJECTIVES

• Discuss detection rate (DR) of SLNs in Endometrial Cancer
  – Hysteroscopic
  – ICG
  – Laparoscopic near-infrared

What we know

<table>
<thead>
<tr>
<th>Site injection</th>
<th>Tracer</th>
<th>Detection rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cervical</td>
<td>Blue-dye and/or Tc</td>
<td>62-89 %</td>
</tr>
<tr>
<td>Hysteroscopic</td>
<td>Blue-dye and/or Tc</td>
<td>65-95 %</td>
</tr>
<tr>
<td>Cervical</td>
<td>ICG</td>
<td>95-97 %</td>
</tr>
</tbody>
</table>

Our experience

Prospective evaluation of EC patients scheduled for TLH and SLN mapping

• Tubal ligation (to avoid any spillage)
• Hysteroscopic injection 4ml - 5 mg ICG peritumoral (400mm, 22G needle)
• Laparoscopic NIR mapping

Results

<table>
<thead>
<tr>
<th></th>
<th>TOTAL</th>
<th>Old L-NIR</th>
<th>New L-NIR</th>
<th>New L-NIR</th>
<th>TOTAL</th>
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</thead>
<tbody>
<tr>
<td>Pts</td>
<td>32</td>
<td>16</td>
<td>16</td>
<td>29</td>
<td>45</td>
</tr>
<tr>
<td>DR</td>
<td>84% (27/32)</td>
<td>75% (12/16)</td>
<td>93.7% (15/16)</td>
<td>93.1% (27/29)</td>
<td>86.7% (39/45)</td>
</tr>
</tbody>
</table>

More than half mapped PA
1 pts isolated PA N+
1 pts pelvic and PA N+
Conclusions

Site injection | Tracer                  | Detection rate |
-------------|-------------------------|----------------|
Cervical     | Blue-dye and/or Tc      | 62.89%         |
Hysteroscopic| Blue-dye and/or Tc      | 65-95%         |
Cervical     | ICG                    | 95-97%         |
Hysteroscopic| ICG                    | 93%            |

- Comparable DR
- NO radiation
- NO colored surgical field
- Possibility to dissect SLN under NIR

Thanks

REFERENCES

Impact of MRI and a Comprehensive Strategy on a Continuous Cohort of 3056 Patients Referred for Fibroids to Diagnose Sarcomas

Afshin FAZEL, MD-PhD,
Hôpital Lariboisiere, PARIS, FRANCE

OBJECTIVES

- Discuss issues with electromorcellation of sarcomas are questioning 20 years of MIS developments
- Interpret the differential diagnosis between fibroids and sarcomas could be very challenging
- Clarify diagnosis of malignancy should be the key point before scheduling any morcellation
- Assessed on one of the largest series of sarcomas diagnosed among fibroids the objective of the study is to emphasize the role of MRI as a key investigation, to give some tips to avoid morcellation of a malignancy while still practicing MIS with the highest standards

MORCELLATIONS OF SARCOMAS.....


Where are we standing?

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 (French Cancer Institute)

I have no financial relationships to disclose...
The Method

Initiated in 2000
Over 20 # ethnic groups
Black Origin (55,6%)
Gyn. Examination, PAP-Smear

ES
Office
HSC

Multidisciplinary decision

OBGYN
- Jean Louis BENIFLA
- Anne Sophie CHEVALIER
- Yann DELPECH
- Aldine FAZEL
- Denis JACOB
- Irène LETENDRE
- Eva MARCHEAND
- Mathieu MEZZADRI
- Aude RICBOURG
- Jérémy SROUSI
- Anne THOURY
- Jean Philippe BOISLAND
- Françoise CORNELIS
- Jacqueline FERRAND
- Kamil HADDAD
- Caroline SHAARI-CHNEKES

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- Sandra BENAVIDEZ
- Mourad BOUDIAF
- Raphael DAUTRY
- Antony DOHAN
- Olivier le DREF
- Jean-Philippe GAVIN
- Yosef GUERRACHE
- Louisa HAMZI
- Philippe MALZY
- Jean-Pierre PELAGE
- Vinciane PLACE
- Natalia SHOR
- Philippe SOYER

Pathologists
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- Anne Sophie CHEVALIER
- Yann DELPECH
- Aldine FAZEL
- Denis JACOB
- Irène LETENDRE
- Eva MARCHEAND
- Mathieu MEZZADRI
- Aude RICBOURG
- Jérémy SROUSI
- Anne THOURY
- Jean Philippe BOISLAND
- Françoise CORNELIS
- Jacqueline FERRAND
- Kamil HADDAD
- Caroline SHAARI-CHNEKES

MRI

- LARGE SIZE
- HIGH DENSITY
- ILL-DEFINED MARGINS
- CENTRAL NECROSIS
- CHANGE IN SIZE

Classical diagnosis of Sarcoma

- Clinical: bleeding, pelvic pain/pressure, rapidly growing pelvic mass? Fibroids!
- Examination findings:
  - Large mass? Fibroids!
  - ES7 (detection rate 37% for LMS to 95% for AC)
- Metastatic disease

Sarcomas

<table>
<thead>
<tr>
<th>PATIENT</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
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<td>T</td>
<td>F</td>
<td>F</td>
<td>F</td>
<td>F</td>
<td>F</td>
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<td>F</td>
<td>F</td>
<td>G</td>
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<tr>
<td>MONTHS</td>
<td>60.9</td>
<td>164</td>
<td>45.2</td>
<td>83.1</td>
<td>75.6</td>
<td>94.9</td>
<td>58.2</td>
<td>11.9</td>
<td>16</td>
<td>17.5</td>
<td>12.9</td>
<td>58.2</td>
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<td>AGE</td>
<td>37.9</td>
<td>41.9</td>
<td>36.0</td>
<td>49.1</td>
<td>60.8</td>
<td>47.0</td>
<td>77.7</td>
<td>62.7</td>
<td>48.4</td>
<td>45.9</td>
<td>68.6</td>
<td>52.4</td>
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<tr>
<td>MRI</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>ER</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>100%</td>
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<td># tumors MRI</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
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<tr>
<td>OPERATION</td>
<td>M</td>
<td>H</td>
<td>M</td>
<td>ER</td>
<td>VH</td>
<td>H</td>
<td>H</td>
<td>VH</td>
<td>H</td>
<td>VH</td>
<td>H</td>
<td>H</td>
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<tr>
<td>TUMOR Ø (cm)</td>
<td>16.0</td>
<td>10.0</td>
<td>9.0</td>
<td>21.0</td>
<td>7.3</td>
<td>8.5</td>
<td>16.0</td>
<td>7.5</td>
<td>10.0</td>
<td>7.5</td>
<td>5.2</td>
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<tr>
<td>TUMOR V (cc)</td>
<td>875</td>
<td>470</td>
<td>266.5</td>
<td>1186</td>
<td>93.5</td>
<td>332</td>
<td>301.2</td>
<td>234</td>
<td>322</td>
<td>270</td>
<td>49</td>
<td>646.6</td>
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<td>UTER. V (cc)</td>
<td>263</td>
<td>933</td>
<td>176</td>
<td>1117</td>
<td>227</td>
<td>527</td>
<td>4707</td>
<td>473</td>
<td>162</td>
<td>430</td>
<td>234</td>
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<td>TRTMENT</td>
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<td>R</td>
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</table>

2002 -2014
3056 patients “Fibroids”

824 laparoscopies
630 hysteroscopies
353 Vaginal Hysterectomy
278 UAE

68% “Minimal Invasive”
2014

- **242 PATIENTS FIBROIDS**
- **4 SARCOMAS and 1 STUMP**
- Incidence of sarcomas 2014 1.6%!!
- **2 positive ES**
- All sarcomas diagnosed or suspected prior to surgery
- PPV, NPV, Se, Spe 100%

### HIGHLY CELLULAR FIBROIDS

<table>
<thead>
<tr>
<th>Pathology +</th>
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<tbody>
<tr>
<td>MRI + 242</td>
<td>PPV 86</td>
</tr>
<tr>
<td>MRI- 0</td>
<td>NPV 100</td>
</tr>
<tr>
<td># 15</td>
<td>Spe 225</td>
</tr>
<tr>
<td>Se 100</td>
<td></td>
</tr>
<tr>
<td>Spe 96</td>
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</table>

Out of 8 false positive MRI for high cellular fibroid, one extra laparotomy / LPSC

---

<table>
<thead>
<tr>
<th>Authors</th>
<th>Years</th>
<th>Cases</th>
<th>Preop</th>
<th>Sarcoma</th>
<th>Undiagnosed</th>
<th>Morcellated</th>
<th>Op</th>
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<td>FADEL</td>
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<td>3056</td>
<td>Clinical, US, ES, HSC, MRI</td>
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<td>0</td>
<td>LM, VH, AVH, TLH, UAE, AH</td>
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<td>KAMIKABEYA</td>
<td>1987-2008</td>
<td>1364</td>
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<td>1/714</td>
<td>2</td>
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<td>LEUNG</td>
<td>1996-2005</td>
<td>1297</td>
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<td>1/434</td>
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<td>AH, VH, LAVH</td>
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<td>ROWLAND</td>
<td>1985-2010</td>
<td>1115</td>
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<td>1/227</td>
<td>5</td>
<td>TLH</td>
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<td>SEIDMAN</td>
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<td>1091</td>
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<td>1/434</td>
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<td>TLH</td>
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**Take home message**

1. The diagnosis of sarcoma should be approached by all means: Clinical, ES, HSC, MRI...
2. None of them alone is sufficient!
3. In our series 11 sarcomas among 3065 patients referred for fibroids: Incidence: 1/286 fibroids
   **NO LAPAROSCOPIC MORCELLATION**
4. M And M’s approach

---

**References**

- Borgani G, et al, Impact of morcellation on survival outcomes of patients with unexpected uterine leiomyosarcoma: A systematic review and meta-analysis, Gynecol Oncol, 137; April 2015, 167–172
References

- Rowland, J. Occult uterine cancer in patients undergoing laparoscopic hysterectomy with morcellation
The Outcome of Laparoscopy Versus Laparotomy for the Management of Early Stage Cervical Cancer-Meta Analysis

Yan-zhou Wang
Southwest Hospital, Third Military Medical University, Chongqing China

OBJECTIVES

• Systematically review the comparative effectiveness between laparoscopic radical hysterectomy (LRH) and open radical hysterectomy (RH) in the treatment of cervical cancer based on the evaluation of the perioperative outcomes, oncological clearance, complications and long-term outcomes.

Database searching strategy

Inclusion and exclusion criteria

• Included criteria:
  – diagnosed with cervical cancer;
  – LRH versus RH as primary treatment;
  – FIGO stage IA1 with lymphovascular invasion to IIB.

• Excluded criteria
  – surgical approach used was laparoscopic assisted radical vaginal hysterectomy
  – bulky early stage (stage IB2 and IIA2) cervical cancer.

RESULTS

12
Results

• These benefits were at the cost of longer operative time (weighted mean difference = 26.9min (95 % CI 8.08-45.82).

Conclusions

• LRH shows better short term outcomes compared with RH in patients with cervical cancer. The oncologic outcome and 5-year survival were similar between the two groups.
Robotic Dissection of a Retroperitoneal Ovarian Neoplasm

Karim ElSahwi, MD, FACOG
Meridian Health, Neptune, NJ

Objective: To show the dissection of a retroperitoneal ovarian neoplasm using the da Vinci robotic platform.

Design: Stepwise demonstration of the technique with narrated video footage.

Setting: Ovarian cancer is most commonly diagnosed at advanced stages. While most may argue that it is a disease best cytoreduced through a laparotomy, there may be a role for minimally invasive surgery in the staging of clinically localized disease. The tumor however, may be densely adhered to adjacent structures and care must be taken to preserve them and to avoid rupture of the mass. The da Vinci robotic platform offers the tools to achieve such goals in a minimally invasive fashion.

Interventions: The video demonstrates the pelvic dissection portion of a staging procedure for a malignant ovarian neoplasm. Emphasis is placed on:

- Development of the retroperitoneal spaces
- Identifying and preserving vital structures
- Maintaining hemostasis
- Illustrating key dissection techniques utilized

Conclusion: The da Vinci robotic platform offers the tools to achieve safe and optimal dissection of localized retroperitoneal ovarian neoplasms. Knowledge of the natural history of the disease and the regional anatomy is key to completing this task.
Reduced Port Size Nerve Sparing Radical Trachelectomy – The Least Invasive Fertility Sparing Radical Surgery

Masaaki Andou, MD, PhD
Kurashiki Medical Center, Kurashiki, Okayama Prefecture, Japan

**Objective**: This procedure offers an ultra-minimally invasive alternative for patients who must undergo radical surgery and wish to preserve their fertility.

**Design**: Retrospective study.

**Setting**: Academic affiliated regional city hospital.

**Patients**: 7 patients wishing to preserve their fertility have undergone robotically assisted radical trachelectomy for stage IA2-IB1 cervical cancer (less than 2.5cm size disease).

**Interventions**: After creation of vaginal cuff to prevent the scattering of tumor cells, the laparoscopic procedure begins with the pelvic lymphadenectomy, mobilization of the ureter, then division of the cardinal ligament, sacrouterine ligament and the deep vesicouterine ligament. This is followed by the amputation of the cervix and finally reconstruction. Our technique requires two 2mm and two 5mm abdominal ports and a 12mm vaginal port. The ultra-fine instruments used are assembled inside the body.

**Measurements and main results**: Our total laparoscopic radical trachelectomy is characterized by the full resection of the cardinal ligament at the pelvic sidewall. This degree of radicality is performed to prevent the possibility of recurrence which, although rare, has been reported.

The patients recorded less postoperative pain, no patients required blood transfusion and no cases underwent conversion to laparotomy and no serious complications occurred.

This procedure has only been recently introduced and as yet no cases have experienced pregnancy or delivery to date, nor can we currently accurately assess the medium or long term oncologic outcomes. However, as this procedure is the less invasive counterpart of our standard laparoscopic technique, which has so far resulted in a delivery rate of 58%, we are optimistic that this surgery will produce a similar result. As for the oncologic outcome of our laparoscopic series, the death of recurrence rate currently stands at one patient in 75.

**Conclusion**: The demand for fertility sparing procedures has risen due to the increase in younger women contracting cervical cancer, making the development of fertility sparing and minimally invasive techniques important. By using ultra-fine instruments, we are able to reduce the invasiveness of the surgery by reducing the size of the ports, without increasing the degree of difficulty, as can be the case when the number of ports is decreased. Radical trachelectomy is an important procedure for patients wishing to preserve their fertility and this procedure offers the patient a minimally invasive, cosmetically appealing result.
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](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](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](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.

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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](http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=2078538).