Plenary 2: Oncology

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Plenary 2: Oncology

Moderator: Cecelia H. Boardman
Co-Moderators: Douglas N. Brown, Linus T. Chuang

Faculty: Jong Woon Bae, Joel Cardenas-Goicoechea, Joong Sub Choi, Tamara N. Finger, Alexandra Konopacka

Course Description

This session focuses on minimally invasive surgery in gynecologic oncology. Presentations on the outcomes of laparoscopic radical vaginal hysterectomy for cervical cancer, comparisons of laparoscopic and robotic surgery in endometrial cancer, pre-operative assessment of adnexal masses, the use of MIS in ovarian cancer, and laparoscopic lymphadenectomy for gynecologic malignancies are included.

Course Objectives

At the conclusion of this session, the participant will be able to: 1) Evaluate the feasibility of laparoscopic lymphadenectomy for gynecologic malignancies; 2) contrast robotic and laparoscopic staging for endometrial cancer; and 3) assess the accuracy of intra-operative frozen section to assess adnexal masses.

Course Outline

12:05 Comparison of Survival and Adverse Events between Women with Stage IB1 and Stage IB2 Cervical Cancer Treated by Laparoscopic Radical Vaginal Hysterectomy

J.S. Choi

12:15 Survival and Operative Outcome Analysis of Robotic Assisted Versus Laparoscopic Surgical Staging for Endometrial Cancer

J. Cardenas-Coicoechea


T.N. Finger

12:35 Assessing Adnexal Masses for Malignancy: A Comparison of Four Diagnostic Modalities

A. Konopacka

12:45 Laparoscopic Lymphadenectomy for Gynecologic Malignancies: Evaluation of the Surgical Approach and Outcomes over a Seven Year Experience

J.W. Bae

12:55 Discussion

1:05 Adjourn
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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).
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Other: Proctor - Intuitive Surgical
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Linus T. Chuang*

Asterisk (*) denotes no financial relationships to disclose.
Comparison of Survival and Adverse Events between Women with Stage IB1 and Stage IB2 Cervical Cancer Treated by Laparoscopic Radical Vaginal Hysterectomy

Joong Sub CHOI, Jin Hwa HONG, Jung Hun LEE, Chang Eop SON, Seung Wook JEON, Jong Woon BAE, Jeong Min EOM

Division of Gynecologic Oncology and Gynecologic Minimally Invasive Gynecology
Department of Obstetrics and Gynecology
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Disclosure
I have no financial relationships to disclose.

Introduction
The ideal management of stage IB2 cervical cancer, which has different surgicopathologic characteristics compared with stage IB1, is the subject of considerable controversy. Various approaches have been tried in many centers. Treatment modalities performed in patients with stage IB2 include:

Primary CCRT
Neoadjuvant chemotherapy before radiation therapy or hysterectomy
Adjuvant surgery after primary radiation therapy
Radical hysterectomy and/or adjuvant radiation therapy or CCRT

Objective
To evaluate the operative feasibility and survival for patients with stage IB2 cervical cancer who undergo laparoscopic radical hysterectomy (LRH) compared with those with stage IB1 cervical cancer.

Materials and Methods
We identified 90 patients who were eligible to participate in the study through retrospective analysis of medical records from March 2003 to June 2010.

Patients with stage IB1 cervical cancer were divided into two groups by a cutoff value of 2 cm for tumor size. Data regarding surgicopathologic risk factors, surgical outcomes, and survival rates were compared among three groups (two with stage IB1 and one with stage IB2).

Port-placement system (Choi’s 4-trocar method)
Results

To evaluate the operative feasibility and survival for patients with stage IB2 cervical cancer who undergo laparoscopic radical hysterectomy (LRH) compared with those with stage IB1 cervical cancer.

Table 1. Patients’ clinical characteristics

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>IB1 (n=50)</th>
<th>IB2 (n=20)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>50±14</td>
<td>52±12</td>
<td>0.834</td>
</tr>
<tr>
<td>BMI</td>
<td>22±3</td>
<td>24±4</td>
<td>0.243</td>
</tr>
<tr>
<td>Tumor size</td>
<td>2.0±0.5</td>
<td>2.5±1.0</td>
<td>0.127</td>
</tr>
<tr>
<td>Lymph node</td>
<td>0±0</td>
<td>0±2</td>
<td>0.250</td>
</tr>
</tbody>
</table>

Table 2. Surgical outcomes.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>IB1 (n=50)</th>
<th>IB2 (n=20)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating time (min)</td>
<td>120±30</td>
<td>130±40</td>
<td>0.343</td>
</tr>
<tr>
<td>Blood loss (mL)</td>
<td>200±50</td>
<td>250±60</td>
<td>0.127</td>
</tr>
<tr>
<td>Length of hospital stay</td>
<td>5±2</td>
<td>7±3</td>
<td>0.033</td>
</tr>
<tr>
<td>Overall complications</td>
<td>5%</td>
<td>10%</td>
<td>0.087</td>
</tr>
</tbody>
</table>

Table 3. Intra- and postoperative complications.

<table>
<thead>
<tr>
<th>Type of complication</th>
<th>IB1 (n=50)</th>
<th>IB2 (n=20)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bladder injury</td>
<td>1%</td>
<td>2%</td>
<td>0.586</td>
</tr>
<tr>
<td>Urinary tract injury</td>
<td>1%</td>
<td>2%</td>
<td>0.586</td>
</tr>
<tr>
<td>Vascular injury</td>
<td>0%</td>
<td>0%</td>
<td>1.000</td>
</tr>
</tbody>
</table>

Conclusion

LRH for stage IB2 cervical cancer can be performed with similar safety and survival rates compared to stage IB1 cervical cancer. Overall, LRH is feasible for the treatment of stage IB2 cervical cancer.
Thank you so much for your time !!!
Survival and operative outcome analysis of robotic versus laparoscopic surgical staging for endometrial cancer: a preliminary report.

Most common gynecologic malignancy
- Incidence 2012:
  47,130 new cases
  8,010 deaths
- Surgical procedures
  Laparotomy
  Laparoscopic-assisted
  Robotic-assisted

Objectives
- To compare survival
  - Overall survival
  - Disease free survival
  - Recurrence
- To compare peri- and post-operative complications.
  - Intra-operative.
  - Intra-hospital.
  - Post-discharge.

Methods:
- Design:
  - Retrospective
  - 2003-2010
- Criteria:
  - Inclusion:
    - Endometrial cancer who underwent surgical staging exclusively.
    - At least 4-month follow up
  - Exclusion:
    - Carcinosarcoma.
    - Additional surgery.
### Survival and operative outcome analysis of robotic versus laparoscopic surgical staging for endometrial cancer: a preliminary report

#### RESULTS

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Robotic</th>
<th>Laparoscopic</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>35 (85.2%)</td>
<td>32 (79.5%)</td>
<td>0.42</td>
</tr>
<tr>
<td>BMI</td>
<td>26.8 (7.9)</td>
<td>27.9 (7.9)</td>
<td>0.42</td>
</tr>
<tr>
<td>Comorbid conditions</td>
<td>108 (68.9%)</td>
<td>141 (86.9%)</td>
<td>0.001</td>
</tr>
<tr>
<td>Previous surgery</td>
<td>71 (51%)</td>
<td>85 (52.3%)</td>
<td>ns</td>
</tr>
<tr>
<td>Adjuvant therapy</td>
<td>52 (36.1%)</td>
<td>60 (37.9%)</td>
<td>0.68</td>
</tr>
<tr>
<td>Radiation/Chemotherapy</td>
<td>55 (39%)</td>
<td>61 (39.1%)</td>
<td>0.85</td>
</tr>
<tr>
<td>Follow up</td>
<td>64 (43%)</td>
<td>57/61 (43%)</td>
<td>&lt;0.01</td>
</tr>
</tbody>
</table>

#### RECURRENCE DISEASE

<table>
<thead>
<tr>
<th>Variable</th>
<th>Robotic</th>
<th>Laparoscopic</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>71 (41.8%)</td>
<td>79 (42.3%)</td>
<td>ns</td>
</tr>
<tr>
<td>Advanced age (&gt;65 years)</td>
<td>54 (23.3%)</td>
<td>54 (27.6%)</td>
<td>0.015</td>
</tr>
<tr>
<td>Adverse histology</td>
<td>51 (30%)</td>
<td>50 (27.6%)</td>
<td>ns</td>
</tr>
<tr>
<td>Pelvic nodes</td>
<td>36 (15.4%)</td>
<td>45 (21.3%)</td>
<td>0.015</td>
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<td>Paraaortic nodes</td>
<td>143 (84.1%)</td>
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Survival and operative outcome analysis of robotic versus laparoscopic surgical staging for endometrial cancer: a preliminary report

Strength
- Large number of patients.
- Similar preoperative clinical characteristics
- Two academic centers.
- Same surgeon

Weakness
- Retrospective design.
- Potential selection bias.
- Follow up interval.
- Two academic centers.
- Same surgeon

Conclusion
Robotic assisted surgery yields equivalent oncologic outcomes when compared to laparoscopic surgery for endometrial adenocarcinoma. Although operating time is longer, blood loss and hospital stay is less in robotic assisted surgery.

Reference
Comparison of complication rates between videolaparoscopic versus robotic-assisted laparoscopy in the evaluation and management of early, advanced and recurrent stage ovarian, fallopian tube and primary peritoneal cancer

Tamara Finger MD, Lauren Averbuch, Reza Radjabi MD, Jason Sternchos, Farr Nezhat MD
Division of Minimally Invasive Surgery
St. Lukes Roosevelt Hospital New York, NY

I have no financial relationships to disclose.

Objectives

- Compare the complications of videolaparoscopy (VALS) versus robotic-assisted laparoscopy(RALS) in the evaluation and management of early, advanced and recurrent ovarian, fallopian tube and primary peritoneal cancer
- Identify the applicability of VALS and RALS in ovarian, fallopian and peritoneal cancer

Introduction

- In United States, ovarian cancer will affect approximately 22,280 women in 2012
- 15,500 estimated deaths
- >65% present with advanced stage disease

Traditional Approach

- Vertical skin incision
- Cytologic washings
- Intact tumor removal
- Complete abdominal exploration
- Aggressive cytoreduction
- Omentectomy
- Lymphatic evaluation
- Liberal peritoneal biopsies

Introduction

- Early:
  - Diagnosis and Staging
- Advanced:
  - Optimal cytoreduction to microscopic disease
- If disease not optimally resectable, use of neoadjuvant chemotherapy to reduce tumor load can allow for interval surgical debulking
Advantages of video and robotic-assisted laparoscopy

- Smaller incisions
- Shorter hospital stay
- Less blood loss
- Less need for analgesics
- Better Visualization
- More rapid recovery
- Earlier ambulation
- Shorter interval to Chemotherapy (if indicated)

The Safety and Efficacy of Laparoscopic Surgical Staging and Debulking of Apparent Advanced Stage Ovarian, Fallopian Tube and Primary Peritoneal Cancers.

- Laparoscopy can be used for diagnosis, triage, and debulking of patients with advanced ovarian, fallopian tube, or primary peritoneal cancer and is technically feasible in a well-selected population with similar recurrence rates to laparotomy

Laparoscopic management of early ovarian and fallopian tube cancers: surgical and survival outcome

- One of largest series and longest follow-ups of laparoscopic staging for early-stage adnexal tumors
- Laparoscopic staging appears feasible and comprehensive without compromising survival

The Safety and Efficacy of Video Laparoscopic Surgical Debulking of Recurrent Ovarian, Fallopian Tube and Primary Peritoneal Cancers

- In a well-selected population, laparoscopy is technically feasible and can be utilized to optimally cytoreduce patients with recurrent ovarian, fallopian, or primary peritoneal cancers

Objective

- To examine the complications of videolaparoscopy (VALS) versus robotic-assisted laparoscopy (RALS) in the evaluation and management of early, advanced and recurrent ovarian, fallopian tube and primary peritoneal cancer

Methods

- Retrospective analysis of a prospectively maintained database
- 7/2008 to 7/2012
- Same board certified gynecologist oncologist assisted by a minimally invasive gynecological surgical fellow
- VALS or RALS performed for management of early, advanced and recurrent ovarian, fallopian tube and primary peritoneal cancer
### Sloan-Kettering Cancer Center Surgical Secondary Events Grading System

<table>
<thead>
<tr>
<th>Complication</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No events observed within 30 days after operation</td>
</tr>
<tr>
<td>1</td>
<td>Use of oral medications, bedside interventions to treat an event</td>
</tr>
<tr>
<td>2</td>
<td>Use of intravenous medications, limited procedural activity, intravenous lines, or blood transfusions or transfusion-related event</td>
</tr>
<tr>
<td>3</td>
<td>Interventional radiology, therapeutic endoscopy, intubation, or operation required to treat an event</td>
</tr>
<tr>
<td>4</td>
<td>Resulted in lasting disability that required major rehabilitation or organ resection</td>
</tr>
<tr>
<td>5</td>
<td>Event that results in death of patient</td>
</tr>
</tbody>
</table>


### Methods
- 76 surgeries:
  - 19 early stage disease (<FIGO IC)
  - 57 advanced and/or recurrent disease  
    - 40 advanced and 17 recurrent

### Results

#### Early
- 19 surgeries early stage disease:
  - Mean Age: 47yrs (range 25-72)
  - VALS: 8
  - RALS: 9
  - Laparoscopy converted to laparotomy (LP): 2
    - Large fibroid uterus
    - Large pelvic mass not accessible via laparoscopy

#### Advanced/Recurrent
- 57 Cases:
  - Mean Age: 61 years (range: 29-92)
  - VALS: 37
  - RALS: 12
  - LP: 8
    - 7 diagnostic video-assisted laparoscopy
    - None converted due to intraoperative complication

#### Post-operative complications:
- 2/9 RALS (22.2%)
- Grade 2
  - Wound infection
  - Fever of unknown origin resolved with IV antibiotics


Results
Advanced/Recurrent

- Post Operative Complications:
  - VALS: 8/36 (22%)
    - 2 re-operations:
      - Anatomical stricture
    - RALS: 3/12 (25%)
    - 1 reoperation:
      - Bowel perforation

- Postoperative Complications:
  - VALS:
    - 57
    - RALS: 3/12 (25%)
    - LP:
    - 2 operations:
      - Anastomotic stricture
      - Vaginal cuff dehiscence

- Intra Operative Complication:
  - LP: 1/7 (14%)
    - Injury to the right external iliac artery

Complications by type in RALS, VALS and LP groups

- Major Complications
  - Myocardial Infarction
  - CVA
  - CHF
  - Pulmonary Embolus
  - Bowel perforation
  - Anastomotic complication
  - Bowel obstruction treated surgically
  - Placement of a device
  - Wound dehiscence
  - GU fistula
  - GI fistula
  - Death within 30 days

- Minor Complications
  - DVT
  - Neuropathy
  - Lymphocyst
  - Unexpected ICU admission
  - Fever
  - UTI
  - Wound Separation
  - Wound infection
  - Wound cellulitis
  - Atrial Fibrillation/EKG changes
  - Acute Delirium
  - Ileus
  - Bowel obstruction treated medically
  - Hydroureter
  - Postoperative transfusion

- Results
Advanced/Recurrent

- 17 surgeries in 14 patients for recurrences
  - VALS: 12
  - RALS: 3
  - LP: 2

- Postoperative complications:
  - VALS: 2/12 (17%)
  - RALS: 1/3 (33%)
  - LP: 1/2 (50%)

- Results
Advanced

- 40 surgeries in 31 patients
  - VALS: 25
  - RA: 9
  - LP: 6

- Postoperative complications:
  - LRS: 7/25 (28%)
  - RA: 1/9 (11%)
  - LP: 1/6 (17%)
Results

• VALS vs RALS Postoperative Complications
  - No difference
  - Fisher exact p=0.82

• Major Complication Rate (Grade 3-5):
  - VALS: 7%
  - RALS: 10%
  - EP: 10%
  - VALS vs RALS
  - No difference
  - Fisher p=0.8

• No grade 4 or 5 complications
• No perioperative or intraoperative deaths

Conclusion

• Complication rates are comparable between VALS and RALS in both early and advanced/recurrent disease making VALS and RALS an acceptable approach in selected patients

References


Thank You

• Dr. Farr Nezhat
• Dr. Amir Radjabi
• Dr. Jason Sternchos
• Lauren Averbuch

Questions?
Assessing adnexal masses for malignancy: A comparison of four diagnostic modalities

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Alexandra Konopacka, M.D. 1
Tamara Finger, M.D. 1
Jason Sternchor, M.D. 1

1Department of Obstetrics and Gynecology
St. Luke's-Roosevelt Hospital, New York, NY, United States, 10019.

Disclosure
I have no financial relationships to disclose.

Objective
At the conclusion of this activity, the participant will be able to list and compare the value of four modalities for the diagnosis of malignancy in a suspicious adnexal mass.

Adnexal Mass
- Women lifetime risk of ovarian neoplasm: 1 in 10
- Hospitalization: 300,000
- Surgical evaluation: 270,000
- Ovarian cancer: 21,550

Management of Adnexal Masses
- Relief of Symptoms
  - Pain, Compressive symptoms
- To Rule Out Malignancy

Ovarian Cancer
Statistics
- U.S. 2009
  - 21,550 new cases
  - 14,600 deaths
- Worldwide
  - 204,200 new cases
  - 124,700 deaths

Incidence of ovarian cancer: age-standardised rates (world) per 100,000 (all ages)

Ovarian Cancer

- 30% diagnosed at Stage I ..... Better prognosis
- However 50% ovarian cancers diagnosed early stage need another surgery (unexpected diagnosis) and most are Endometrioid and Clear cell carcinoma
- >60% diagnosed in advanced stages (majority are papillary serous)

Introduction

- A 1992 study by Nezhat et al shows that frozen section combined with intraoperative impression has the best diagnostic performance when differentiating malignant pelvic masses from benign lesions.

Study Design

- Prospective observational study
- Data collected from June 2009 to March 2012
- Laparoscopic procedures performed by Gynecologic Oncologists at St. Luke’s-Roosevelt Hospital (majority of cases were performed by a single surgeon)
- 131 patients enrolled
- Masses at least 4 centimeters in size or solid and/or complex in appearance (septations, cystic and solid, mural nodularity), referred for evaluation
- 4 Methods of Evaluation: Tumor marker, Imaging, Intraoperative assessment, and Frozen section
- Definitive Diagnosis: Final Pathology

Methods and Materials

- 131 patients
- Average Age: 45 +/- 14.6 yrs
  → >50 y.o.: 28%

Procedures

- 131 total procedures
- 121 Laparoscopic Procedures
- 10 Robotic-assisted Laparoscopic Procedures
- 7 Conversions to Laparotomy – 5.3% (7/131)
  - 3 Dense adhesions
  - 3 Large size of mass
  - 1 Co-existing abdominal hernia requiring repair
Histology of 107 Benign Masses

- Endometrioma: 38.1%
- Dermoid: 11.5%
- Serous cystadenoma: 7.6%
- Simple cyst: 3.3%
- Mucinous cystadenoma: 4.8%
- Cystadenofibroma: 4.8%
- Hydatidiform: 3.3%
- Brenner Tumor: 3.3%
- Corpus Luteum cyst: 2.3%
- Struma Ovarii: 1.5%
- Ovarian Remnant: 0.8%
- Thecofibroma: 0.8%
- Other: 6.1%

Histology of 24 Malignant Gynecologic Masses

- Pap/Serous: 31.2%
- Borderline Pap/Serous: 11.5%
- Borderline Mucinous: 3.8%
- Pap/Serous Fallopian Tube: 2.5%
- Leydig cell: 0.8%
- Ovarian MMMT: 6.1%
- Clear Cell: 0.8%
- Primary Peritoneal: 0.8%
- Other: 2.5%

Histology – Malignant Masses

- 24 malignancies – 18.3% (24/131)
- 95.8% (23/24) gynecologic malignancies
- Non-gynecologic malignancy
  - Malignant mesothelioma

Four diagnostic modalities

- Imaging (ultrasound, CT, MRI): 127/131 patients
- Tumor marker analysis (Ca125): 44/131 patients
- Intraoperative assessment: 129/131 patients
  - by experienced gynecologic oncologist
- Frozen section: 87/131 patients

Comparing the Different Modalities

<table>
<thead>
<tr>
<th>Modalities</th>
<th>Sensitivity</th>
<th>Specificity</th>
<th>Positive Predictive Value</th>
<th>Negative Predictive Value</th>
<th>Accuracy</th>
</tr>
</thead>
<tbody>
<tr>
<td>CA 125 (CA)</td>
<td>64.3%</td>
<td>83.9%</td>
<td>64.3%</td>
<td>84.0%</td>
<td>77.8%</td>
</tr>
<tr>
<td>Diagnostic Imaging (DI)</td>
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<tr>
<td>Intraoperative Assessment (IA)</td>
<td>82.6%</td>
<td>100%</td>
<td>100%</td>
<td>96.0%</td>
<td>96.9%</td>
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<tr>
<td>Frozen Section (FS)</td>
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Combining Intraoperative Assessment with Frozen Section

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<td>96.0%</td>
<td>95.4%</td>
</tr>
<tr>
<td>Frozen section + IA</td>
<td>91.7%</td>
<td>99.1%</td>
<td>95.7%</td>
<td>98.0%</td>
<td>97.7%</td>
</tr>
</tbody>
</table>
Comparing results to final pathology

- Using frozen section alone, 1 benign lesion was misclassified as malignant (mucinous cystadenoma); 3 malignant masses were misclassified as benign (serous carcinoma, borderline mucinous tumor, seromucinous borderline tumor arising in a fallopian tube).
- Using intraoperative impression alone, no benign lesions were misclassified as malignant; 4 malignant lesions were misdiagnosed as benign (serous carcinoma, leydig cell tumor, 2 serous borderline tumors).
- Using frozen section in combination with intraoperative impression, 1 benign lesion was misdiagnosed as malignant (mucinous cystadenoma); 2 malignant lesions were misclassified as benign (serous carcinoma, leydig cell tumor).

Summary

- Intraoperative Assessment + Frozen Section yields highest specificity AND sensitivity (91.7% and 99.1%) along with high PPV and NPV.
- Laparoscopy is a feasible method for evaluating and treating suspicious adnexal masses.

References:

Laparoscopic lymphadenectomy for gynecologic malignancies; evaluation of the surgical approach and outcomes over a seven year experience

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2 Department of Obstetrics and Gynecology, Kangbuk Samsung Hospital, Sungkyunkwan University School of Medicine
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4 Department of Obstetrics and Gynecology, Korea University Guro Hospital, Korea University College of Medicine

I have no financial relationships to disclose.

Objectives

- To evaluate the feasibility and efficacy of laparoscopic lymphadenectomy in patients with gynecologic malignancies and improve upon the existing published data regarding laparoscopic lymphadenectomy.

Methods & Materials

- A retrospective chart review of 225 patients with gynecologic malignancies.
- 176 patients with cervical and endometrial cancer.
- Laparoscopic pelvic lymphadenectomy (LPL) and/or laparoscopic para-aortic lymphadenectomy (LPAL).
- Kangbuk Samsung Hospital between November 2003 and October 2010.

Extant of Lymphadenectomy in Cervical cancer

<table>
<thead>
<tr>
<th>Procedures</th>
<th>Indications (FIGO stage)</th>
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<tbody>
<tr>
<td>LPL alone</td>
<td>IA1 with positive LV SI, IB1, IB2, IB1 less than 2 cm with negative pelvic lymph node metastases</td>
</tr>
<tr>
<td>LPL and LPAL, up to the 3MA level</td>
<td>IB1 larger than 2 cm with negative pelvic lymph node metastases</td>
</tr>
<tr>
<td>LPAL up to the left renal vein</td>
<td>IB1 with positive pelvic lymph node metastases</td>
</tr>
<tr>
<td>LPL alone</td>
<td>IB2, IB3, IB4</td>
</tr>
</tbody>
</table>

Port placement

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19
**Technique of LPAL**

- During LPAL, the large vessels are arranged in the same direction on the monitor as that viewed by the surgeon during the laparotomy.
- For this purpose, the first assistant gradually rotates the telescope 180 degree clockwise from the pelvic cavity toward the upper abdominal cavity during the procedure.

**Results**

- Ten (5.6%) cases of laparoscopic lymphadenectomy-related complications.
- Four cases of major vessel injuries
- Laparoscopic intracorporeal suturing using 5-0 polypropylene
- Two cases of symptomatic lymphocysts
- Two cases of lymphedemas
- Two cases of chylous ascites

**Conclusion**

- Laparoscopic lymphadenectomy can be considered a technically feasible and safe procedure
- To perform a successful laparoscopic transperitoneal systemic lymphadenectomy:
  - Adequate surgical view by proper port placement
  - Adequate gynecologic oncologic and laparoscopic experience of the surgeon
  - Good surgical teamwork
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.