Plenary 2: Oncology

MODERATOR
Rebecca L. Stone, MD, MS

DISCUSSANTS

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Samar Nahas, MD, MPH, FRCSC
David B. Redwine, AB, MD
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Amanda M. Hill, MD
Matthew T. Siedhoff, MD, MSCR

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David M. O’Malley, MD
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Kerac N. Falk, MD
Paul M. Magtibay, MD
Yanzhou Wang, MD
Professional Education Information

Target Audience
This educational activity is developed to meet the needs of surgical gynecologists in practice and in training, as well as other healthcare professionals in the field of gynecology.

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Plenary 2: Oncology

Moderator: Rebecca L. Stone

Discussants: Linus T. Chuang, Martin A. Martino, Samar Nahas, David M. O’Malley, David B. Redwine, Abdulrahman K. Sinno

Faculty: Masaaki Andou, Kerac N. Falk, Amanda M. Hill, Paul Magtibay, Matthew T. Siedhoff, Yanzhou Wang

This course will explore the impact of the 2014 FDA power morcellator warning on practice and outcomes of minimally invasive hysterectomy, risk reducing surgery for patients with increased risk of gynecologic and breast cancer, sentinel lymph node mapping for gynecologic malignancies and advances in laparoscopic nerve sparing radical hysterectomy as well as urinary reconstructive surgery.

Learning Objectives: At the conclusion of this course, the participant will be able to: 1) Assess the current role of morcellation in minimally invasive hysterectomy; 2) discuss the surgical management of women with increased risk of gynecologic and breast cancer; and 3) describe the technique and value of sentinel lymph node mapping, nerve sparing radical hysterectomy and urinary reconstructive surgery in minimally invasive operative interventions for gynecologic malignancies.

Course Outline

12:10 Practice Changes in Power Morcellation Among Gynecologic-Oncologists Since 2014
K.N. Falk

12:16 Discussant
M.A. Martino

12:20 Laparoscopic Nerve Sparing Anatomical Radical Hysterectomy with Fascia Space Dissection Technique for Early Stage Cervical Cancer: Techniques, Application and Results
Y. Wang

12:26 Discussant
S. Nahas

A.M. Hill

12:36 Discussant
L.T. Chuang

12:40 Laparoscopic Hysterectomy with Morcellation versus Abdominal Hysterectomy for Presumed Uterine Leiomyomata: An Updated Decision Analysis
M.T. Siedhoff

12:46 Discussant
A.K. Sinno

12:50 Video: Radical Ureteral Reconstruction After Extensive Resection for Recurrent Gynecologic Cancer
M. Andou

12:56 Discussant
D.B. Redwine

1:00 Video: Sentinel Lymph Node Mapping
P.M. Magtibay

1:06 Discussant
D.M. O’Malley

1:10 Adjourn
PLANNER DISCLOSURE
The following members of AAGL have been involved in the educational planning of this workshop (listed in alphabetical order by last name).
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Amber Bradshaw
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Sarah L. Cohen
Consultant: Olympus
Erica Dun*
Joseph (Jay) L. Hudgens
Contracted Research: Gynesonics
Frank D. Loffer, Medical Director, AAGL*
Suketu Mansuria
Speakers Bureau: Covidien
Karen C. Wang*
Johnny Yi*

SCIENTIFIC PROGRAM COMMITTEE
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Consultant: CONMED Corporation, Teilex
Stock Ownership: Titan Medical
Karen C. Wang*

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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Amanda M. Hill*
Paul M. Magtibay*
Martin A. Martino*
Samar Nahas
Consultant: Medtronic
David M. O’Malley
Other: Advisory Board: AstraZeneca, Janssen
Other: Advisory Board and Guest Speaker: Clovis
David B. Redwine*
Matthew T. Siedhoff
Consultant: Applied Medical, Intuitive Surgical, Olympus, Teleflex Medical
Abdulrahman K. Sinno*
Rebecca L. Stone*
Yanzhou Wang*
Content Reviewer has no relationships.

Asterisk (*) denotes no financial relationships to disclose.
Practice Changes in Power Morcellation Among Gynecologic-Oncologists Since 2014

Presenter: Dr. Kerac Falk MD

Icahn School of Medicine at Mount Sinai, New York, NY

Disclosures

• I have no financial relationships to disclose.

Objective

Discuss how gyn-oncologists feel about power morcellation in light of FDA warning, whether they have changed their practice and how this will affect patient care.

Background

• Index case: 2013 power morcellation of uterine sarcoma
  ➔ media attention
  ➔ FDA response: black box warning Nov 2014 due to the risk of inadvertent spread of an undiagnosed malignancy, quoting a sarcoma risk of 1/352

Purpose

• How do gyn-oncologists feel about power morcellation in light of FDA warning?

• How have they changed their practice or technique?

• How will this affect patient care?

Methods

• 34 question survey sent to all members of SGO

• Question content: demographic information, practices prior to the FDA warning, practice changes since the warning, institutional changes and regulation, and attitudes

• Statistics: students t-test and chi square for continuous or discrete variables
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### Results

- 100% gyn- oncologists (199)
- 47.74% (95/199) reported doing LSH

Since FDA warning...

- 12.5% decreased and 38.75% discontinued use of power morcellation

### Factors affecting decreased/discontinued use

![Bar chart showing factors affecting decreased/discontinued use: Media, patient request, FDA warning, patient selection, perioperative evaluation, consent, physician discretion, institutional policy.]

### Results

- Men more likely to decrease/discontinue use than women 58.46% vs 19.35%, p=.0015
- No differences in change of use based on region of practice, years in practice, or institution type
- 41% changed surgical technique to minimally invasive without power morcellation
- 20.54% report changing to laparotomy

### Results

- Other changes:
  - more rigorous consent process 38.67%
  - patient selection criteria 37.5%
  - perioperative evaluation 30.14%
  - 20.54% added preoperative MRI

### Conclusion

- 20% of gyn oncologists previously using power morcellation have switched to laparotomy
- driven by media, patient request, and FDA rather than physician choice
- however, many have sustained use and made alterations in patient selection, perioperative evaluation, and consent process, either by physician discretion or necessitated by institutional policy
References


Acknowledgements

Shyama Mathews MD, Linus Chuang MD
Icahn School of Medicine at Mount Sinai, New York, NY
Laparoscopic nerve sparing anatomical radical hysterectomy with fascia space dissection technique for early stage cervical cancer: Techniques, application and results

Presenter: Yanzhou Wang
Department of Obstetrics and Gynecology, Southwest Hospital, Third Military Medical University Chongqing, China

I have no financial relationships to disclose

OBJECTIVES

• Describe laparoscopic nerve-sparing anatomical radical hysterectomy with fascia space dissection technique
• Assess the feasibility and safety of the procedure, as well as its impact on voiding function.
• Establish a new operative procedure based on the precise anatomy of the structures surrounding the cervix.

Fascia Space Dissection Technique

• Illustration indicates the space around cervix, para-vesical space (PvVs), para-vaginal space (PvVs), para-rectal space (PrSs), ureter (U), hypogastric nerve (HN).

• Illustration indicates the dissection of the uterine deep vein, the vesico vein and the inferior hypogastric plexus.

Uterine deep vein (UDV)
MAIN RESULTS

• No difference for age, body weight, tumor size, clinical stage, Mean operation time, Intra-operation complications, Lymph nodes, Length of vaginal in both groups of patients
• Removal of the urethral catheter in the LNSRH and the LRH groups were 163.52 ± 34.47 min and 132.13 ± 31.42 min, respectively
• Follow-up of 52.3 (12-72) months was adhered to. The overall disease-free survival was 95.2% for Ia2, 89.5% for Ib1, and 84.5% for IIa1 respectively

Conclusions

• The technique described in this preliminary study appears to be safe, feasible, and easy in our population, with satisfactory recovery of voiding function and oncological outcome.

REFERENCES


Acknowledgements

Gongli Chen, Huicheng Xu, Yong Chen, Cheng Chen, Zhiqing Liang
Department of Obstetrics and Gynecology, Southwest Hospital, Third Military Medical University, Chongqing, China

Thank You

Amanda M. Hill, MD, FACOG
Arizona Gynecology Consultants, Phoenix, AZ
University of Arizona/Banner University Medical Center - Phoenix
45th AAGL Global Congress on Minimally Invasive Gynecology
Rosen Hotel & Convention Center at Shingle Creek in Orlando, Florida
November 16, 2016

Objectives

• At the conclusion of this activity, the participant will be able to:
  • Identify patients who would benefit from risk reducing surgery
  • List and compare surgical options for risk reduction in patients with BRCA1/2
  • Recommend timing of surgery to patients
  • Employ a protocol to adequately assess for occult malignancy at the time of risk reducing surgery
  • Recognize the importance and effectiveness of risk reducing surgery
  • Prepare patients for the side effects of surgical menopause and recommend appropriate treatments

Methods

• Literature search
  • Patients: Women with high risk of gynecologic or breast cancer
    • BRCA1/2 mutations, Lynch Syndrome
  • Questions:
    • Who? - Which patients benefit from prophylactic BSO
    • What? - Role of hysterectomy and staged salpingectomy before oophorectomy
    • When? - Timing of surgery
    • Where? - Facilities and resources necessary
    • How? - Surgical techniques and principles
    • Why? - Evidence that risk reducing BSO is beneficial

Background

• BRCA1 and BRCA2
  • Autosomal dominant mutations in tumor suppressor genes
  • Mutations found in 10% of ovarian cancer patients
  • 39-46% risk of ovarian cancer (BRCA1), 12-20% risk (BRCA2)
  • Mean age 54 (BRCA1), 62 (BRCA2)
  • 65-74% risk of breast cancer
  • Lynch syndrome
    • Autosomal dominant mutations in DNA mismatch repair genes (MLH1, MSH2, MSH6, PMS2)
    • 16-61% risk of endometrial cancer
    • 5-10% risk of ovarian cancer
    • 18-61% risk of colon cancer

1: ACOG Practice Bulletin No. 103; 2: ACOG Practice Bulletin No. 147

Who

• Women with BRCA1/2 mutations
  • Individualized care for variants of undetermined significance
    • Surveillance, chemoprevention, salpingectomy (Garzia et al 2014)
    • Less likely to undergo prophylactic surgery (Garzia et al 2014)
  • Lynch Syndrome
  • Hormone receptor positive breast cancer

Disclosures

I have no financial relationships to disclose
**What**

- Risk reducing BSO for BRCA
  - Standard of care
  - Risk reducing for ovarian & breast cancer (Kramer 2005)
- Tubal ligation: 57% risk reduction in BRCA1 (Antoniou et al 2009)
- Salpingectomy with interval oophorectomy for BRCA (Kwon et al 2013, Schenberg et al 2014, Swanson et al 2016)
  - No data – Quality of life
  - Fallopian tube origin of serous ovarian cancer, STIC lesions
- Hysterectomy with BSO for Lynch Syndrome (Adachi et al 2014)

**When**

- Society of Gynecologic Oncology:
  - BSO between 35 and 40 years in patients with BRCA1/2 mutations (Lancaster et al 2015)
- Role for fertility preservation in young women
- Ovarian cancer risk increases after age 40 in BRCA1, 50 in BRCA2 (Antoniou et al 2003, Signorelli et al 2016)
- Greater breast cancer risk reduction if BSO premenopausal (Kramer 2005)
- Lynch: When childbearing is completed, usually early to mid 40s (ACOG Practice Bulletin No. 147)

**Where**

- Surgery should be performed in a facility with Gyn/Onc backup or by a Gyn-Oncologist
  - Unexpected malignancy - 5 of 60 in one report (Colgan et al 2001)
- Pathologist must have expertise in processing specimens from high-risk patients to avoid missing occult malignancy
  - Reported in 2 – 10% of specimens in BRCA patients (Kauff et al 2007)
  - Optimal tissue fixation, thin tissue slicing, detailed microscopic evaluation (Rabban et al 2013)
  - Entire fimbriae plus additional serial sectioning of the entire fallopian tube 2- to 3-mm intervals (Kauff et al 2007, Powell et al 2005, Walker et al 2015)
  - p53 and Ki67 immunohistochemical stains – subtle changes (Walker et al 2015)

**How - BRCA**

- Laparoscopy
- Single-port laparoscopy (Angioni et al 2015)
- Examine all peritoneal surfaces (Signorelli et al 2016)
- Remove the entire fallopian tube, ovary, and IP ligament
  - Requires retroperitoneal dissection (Kauff et al 2007)
  - Avidal ovarian remnant
- Salpingectomy: fimbria, may require partial oophorectomy (Walker et al 2013)
- Omental biopsy, peritoneal biopsies can be considered (Powell et al 2005)
- Frozen section if appears grossly abnormal / nodule >5 mm AND ability to do complete staging (Rabban et al 2011)

**How - Lynch**

- Laparoscopic or vaginal
- Preoperative endometrial sampling
- Intraoperative evaluation of the endometrium
- May be done synchronously with colorectal surgery

**Why – Risk reducing BSO**

  - 70% to 85% reduction in ovarian cancer
  - 37% to 54% reduction in breast cancer
  - Reduction in cancer-related mortality and overall mortality
  - HR 0.38 - 0.69 for all cause mortality
  - HR 0.07 - 0.76 for breast cancer specific mortality
- Quality of life: less cancer-specific worry (Finch et al 2013)

ACOG Practice Bulletin No. 147
Postoperative Recommendations

- Increased risk of cardiovascular disease, osteopenia and osteoporosis, and non-cancer mortality if done before age 45 (Walker et al 2015)
- Consider BRCA 1-2 years after BSO (Chapman et al 2011)
- Worsening of vasomotor symptoms, decline in sexual functioning (Finch et al 2011)
- No increase in breast cancer in BRCA patients on HT (Eisen et al 2008)
- Progestin IUD if uterus retained
- Hysterectomy + BSO for Lynch syndrome leads to less cancer worry but increase in menopausal symptoms (Maldovan et al 2015)

Summary

- Risk-reducing surgery for BRCA1/2 and Lynch Syndrome is effective, low risk, and well accepted
- Adequate surgical skills and institutional resources are necessary
- BSO by age 40 is standard of care for BRCA
- Consider staged salpingectomy \(ightarrow\) oophorectomy for BRCA
- Consider hysterectomy for BRCA
- Hysterectomy + BSO once childbearing completed is standard of care for Lynch Syndrome
- Hormone therapy is recommended for menopausal symptoms after risk reducing BSO

References


Thank you!

- Dr. Masoud Azodi
- Yale School of Medicine
- Yale New Haven Health – Bridgeport Hospital
- Banner University Medical Center – Phoenix library staff
- AAGL and the Selection Committee
Laparoscopic Hysterectomy with Morcellation versus Abdominal Hysterectomy for Presumed Uterine Leiomyomata: An Updated Decision Analysis

Presenter: Matthew Siedhoff, MD MSCR

Disclosures
Consultant: Applied Medical, Intuitive Surgical, Olympus, Teleflex Medical

Objectives
• Discuss and update our decision analysis on LH with morcellation vs. AH
• Use studies published since the FDA communications to provide newer, higher-quality estimates of risk.
• Determine the effect of age which recent data suggests has a significant impact on the risk of malignancy among women undergoing surgery for presumed benign fibroids

Decision Analysis
• Clinical decisions involve careful weighing of risks and benefits, often with competing influences
• Requires construction of a Decision Tree: illustrates all plausible relationships, alternatives and outcomes involved with a given decision
• Each step has a corresponding probability and outcome value
• Inputs: RCTs > systematic reviews > observational studies > expert opinion
• Conclusion of model expressed in average expected result
• Clinical outcomes, cost, quality-of-life
  – Quality-adjusted life years (QALYs)
  – Inputs are health state utilities, 0 = death and 1 = year of life in perfect health
  – Each year of life spent at that health state quantified in QALYs
  – Utilities and duration determined from published literature, clinical experience
• Sensitivity analysis:
  – Test the "robustness" of the model by testing the range of possible inputs for probabilities and outcome values

Decision Analysis: LH with morcellation v. AH
• 100,000 subject hypothetical cohort
  – Of the 200K hysterectomies for fibroids in the US, assumed half would be large enough to require morcellation if done laparoscopically
  – 5-year time horizon
• Decision: AH vs LH with morcellation
• Outcomes:
  – Transfusion, wound infection, cuff dehiscence, VTE, hernia
  – Leiomyosarcoma
  – Death from leiomyosarcoma
  – Assumed occult LMS cases would be FIGO stage I-II (59% death 5-yr)
  – Assumed morcellation would escalate to FIGO stage III (72% death 5-yr)
  – Death from hysterectomy
• Utilities
  – Value and duration determined from literature, 1-mo increments

Clinical outcomes, cost, quality-of-life
  – Quality-adjusted life years (QALYs)
  – Inputs are health state utilities, 0 = death and 1 = year of life in perfect health
  – Each year of life spent at that health state quantified in QALYs
  – Utilities and duration determined from published literature, clinical experience
• Sensitivity analysis:
  – Test the “robustness” of the model by testing the range of possible inputs for probabilities and outcome values
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<td>Kadowaki</td>
<td>2011</td>
<td>2009-2011</td>
<td>USA Not reported</td>
<td>1</td>
<td>4,231</td>
<td>0.0016</td>
</tr>
<tr>
<td>Leung</td>
<td>2012</td>
<td>1999-2005</td>
<td>France 60-77</td>
<td>3</td>
<td>505</td>
<td>0.0040</td>
</tr>
<tr>
<td>Seidman</td>
<td>2012</td>
<td>1999-2010</td>
<td>USA Not reported</td>
<td>1</td>
<td>1,091</td>
<td>0.0009</td>
</tr>
<tr>
<td>Theben</td>
<td>2013</td>
<td>2005-2010</td>
<td>Germany 83</td>
<td>2</td>
<td>5,104</td>
<td>0.0016</td>
</tr>
</tbody>
</table>

### Problems with FDA numbers

- Studies span several decades, countries, criteria to define LMS
- Some women were identified preoperatively and some included older, postmenopausal women
- Population therefore does not necessarily reflect those at risk

### Results

<table>
<thead>
<tr>
<th>Outcome</th>
<th>LH Source case [n]</th>
<th>AH Source case [n]</th>
<th>Incremental Difference (LH-AH)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leiomyosarcoma cases</td>
<td>120</td>
<td>120</td>
<td>n/a</td>
</tr>
<tr>
<td>Leiomyosarcoma deaths</td>
<td>86 [50-135]</td>
<td>71 [41-289]</td>
<td>15</td>
</tr>
<tr>
<td>Hysterectomy-related deaths</td>
<td>12 [20-32]</td>
<td>0 [0-0]</td>
<td>12</td>
</tr>
<tr>
<td>Total deaths</td>
<td>198 [100-304]</td>
<td>183 [90-294]</td>
<td>15</td>
</tr>
<tr>
<td>Transfusion</td>
<td>4,700 [4,300-4,700]</td>
<td>2,400 [1,300-3,500]</td>
<td>2,300</td>
</tr>
<tr>
<td>Vaginal cuff dehiscence</td>
<td>290 [150-600]</td>
<td>640 [200-890]</td>
<td>350</td>
</tr>
<tr>
<td>Abdominal wound infection</td>
<td>6,300 [6,300-9,800]</td>
<td>1,500 [55-1,500]</td>
<td>4,800</td>
</tr>
<tr>
<td>Hernia</td>
<td>4,500 [4,500-9,800]</td>
<td>710 [140-900]</td>
<td>8,090</td>
</tr>
</tbody>
</table>

**Quality-adjusted life years**

- LH experience 0.85 additional QALYs (1.02) over 5 years

### Studies Published following 2014 FDA Safety Communications

<table>
<thead>
<tr>
<th>Pub Year</th>
<th>Study Nms</th>
<th>Study Period</th>
<th>Study Details</th>
<th>LR Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>Tan-Kim</td>
<td>2001-2012</td>
<td>LH with morcellation 1:314 (0.0032)</td>
<td>0.0032</td>
</tr>
<tr>
<td>2016</td>
<td>Raine-Bennett</td>
<td>2006-2013</td>
<td>Hyst for presumed benign fibroids 1:429 (0.0023)</td>
<td>0.0023</td>
</tr>
<tr>
<td>2015</td>
<td>Graebe</td>
<td>2005-2013</td>
<td>LH with power morcellation 1:454 (0.0022)</td>
<td>0.0022</td>
</tr>
<tr>
<td>2015</td>
<td>Mao</td>
<td>2008-2011</td>
<td>Pts undergoing hysterectomy or myomectomy, SEER California registries 1:585 (0.0017)</td>
<td>0.0017</td>
</tr>
<tr>
<td>2015</td>
<td>Paul</td>
<td>2004-2014</td>
<td>LH with vaginal morcellation 1:594 (0.0017)</td>
<td>0.0017</td>
</tr>
<tr>
<td>2016</td>
<td>Rodriguez</td>
<td>2002-2011</td>
<td>LSH for fibroids among US insurance claims 1:763 (0.0013)</td>
<td>0.0013</td>
</tr>
<tr>
<td>2015</td>
<td>Pritts</td>
<td>1984-2014</td>
<td>Meta-analysis of 133 studies on myomectomy or hysterectomy. Required histopathology to be explicitly reported, included studies where cancer was not found. 1:1961 (0.00051)</td>
<td>0.00051</td>
</tr>
<tr>
<td>2016</td>
<td>Kho</td>
<td>2010-2014</td>
<td>Hysterectomies at a single institution 1:2023 (0.00049)</td>
<td>0.00049</td>
</tr>
<tr>
<td>2015</td>
<td>Bojahr</td>
<td>1998-2014</td>
<td>LSH with morcellation 1:5400 (0.00019)</td>
<td>0.00019</td>
</tr>
<tr>
<td>2016</td>
<td>Picerno</td>
<td>2004-2015</td>
<td>LH or laparoscopic myomectomy with morcellation 0</td>
<td>0</td>
</tr>
</tbody>
</table>
Strengths

- More modern and diverse set of publications used to inform our model
- Large number of subjects included in the series
- Decision-analytic model - helpful in situations where randomized trials not feasible
- No major swing in the conclusions of the model with integration of the expanded and improved data adds credibility to our original model
- Mortality from the procedure itself LH vs. AH was one of the most challenging clinical outcomes to assess in our original decision analysis
- Newly-published study provided very similar numbers to the original inputs, helpful in situations where randomized trials not feasible
- Mirror the primary literature search
- Variation in LMS reporting strategies
- Some populations were those undergoing any fibroid surgery, some just hysterectomy, and some only those who underwent morcellation
- Our broad inclusion criteria, use of sensitivity analyses, and the large sample size of many studies, however, may help address the influence of these differences in model outcomes.
- Not all studies included an age-based analysis
- Cut-off of 50 years
- Roughly corresponding to the average age of menopause
- Unable to account for duration of fibroid presence or symptoms
- Impact of women of even more advanced age (e.g., >60) who may be influencing LMS incidence estimates within this sub-population
- Potential differences in mortality from the procedure itself based on age, older women may have a higher death rate after AH
- Difference in procedure mortality would further favor LH, making our model conservative in its estimations.

Limitations

- Not all studies included an age-based analysis
- Mirror the primary literature search
- Variation in LMS reporting strategies
- Some populations were those undergoing any fibroid surgery, some just hysterectomy, and some only those who underwent morcellation
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Age Stratification

- LMS rates <50yo ranged from 0.0011 to 0.0013 < 0.0012 < 50base-case
- LMS rates >50 ranged from 0.0005 to 0.0008 – Based on the number of observations in each study > 0.0007 >50 base-case
- Results
  - <50 group: mortality favored the LH arm
  - >50 more deaths secondary to LMS
  - But 21 fewer deaths due to the procedure itself
  - Overall difference of 5 fewer deaths in the LH arm
  - >50 group: mortality favored the AH arm
  - >91 more deaths secondary to LMS in the LH arm
  - Overall difference of 71 fewer deaths with AH

Summary

- Overall, we demonstrated consistency with our original findings:
  - Mortality is not significantly different between AH and LH
  - Potential higher death rate due to LMS morcellation in the LH group, counterbalanced by a higher procedural mortality rate in the AH group.
  - Varying the rates of LMS incidence and hysterectomy mortality, most scenarios favored laparoscopy
  - Risk associated with morcellation is significantly higher in women >50

Results

- Based on the number of observations in each study
- Roughly corresponding to the average age of menopause

Limitations

- Mirror the primary literature search
- Variation in LMS reporting strategies
- Some populations were those undergoing any fibroid surgery, some just hysterectomy, and some only those who underwent morcellation
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References


Objective: To describe the potential of laparoscopic reconstructive surgery techniques.

Design: Demonstration of techniques using narrated video footage.

Setting: Recurrent gynecologic condition with extensive surgery, which is often very invasive. Laparoscopic interventions when performed with reconstructive techniques, can have a great impact on decreasing the invasiveness of the surgery, improve the post-operative quality of life of the patient and prevent the delay of administering adjuvant therapy.

Interventions: Case one suffered recurrent cervical cancer, originally undergoing TLH for CIS but pathology revealed 1B OCC 3mmx8mm adenocarcinoma. The patient opted for laparoscopic intervention for right ureteral obstruction for recurrence at the right parametria and ovary. We performed radical parametrectomy and reconstruction- Boari flap and psoas hitch. The patient could quickly undergo chemo-radiation, the primary therapy.

Case two had recurrence at the right parametria and vagina, discovered three years after hysterectomy for stage 1A endometrial cancer. As the ureter was near the recurrent tumor, we resected part of the bladder and lower ureter with the right parametria and vagina. Reconstruction included ileal substitution. The patient underwent chemotherapy post-operatively and is healthy 9 years after surgery. Neither case had blood transfusion, anastomotic leak or stenosis.

Conclusion: Laparoscopic radical ureteral reconstruction after extensive resection for recurrent gynecologic cancer assists in early administration of adjuvant therapy.
Sentinel Lymph Node Mapping

Presenter: Paul M. Magtibay, M.D.
Mayo Clinic Arizona, Phoenix, Arizona

**Objective:** To demonstrate sentinel lymph node mapping and excision for surgical staging of endometrial and cervical carcinomas.

**Design:** Stepwise demonstration of identification and removal of a sentinel lymph node.

**Setting:** The sentinel lymph node is the first chain node that receives primary lymphatic flow from the organ of interest. If this node is negative for metastatic disease, then other lymph nodes in the lymphatic basin are expected to be negative as well. Ultrastaging of the sentinel lymph node can be used during surgical staging of endometrial and cervical carcinomas. When compared to full lymphadenectomy, sentinel lymph node mapping and excision is associated with significantly lower blood loss, decreased surgical time, and reduced lymphedema without compromising oncologic outcomes.

**Interventions:** Sentinel lymph node mapping can be completed with cervical injection of either 1% methylene blue or combined indocyanine green and near-infrared fluorescence imaging. Intraoperatively, the retroperitoneum is accessed and areolar tissue is separated. This allows lymphatic channels and the sentinel lymph node to be visualized. Monopolar energy, traction, and countertraction are used to fully excise the sentinel lymph node.

**Conclusion:** Sentinel lymph node mapping and excision is a safe and effective technique that is potentially preferred for endometrial and cervical carcinoma staging.
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.