IS-41 INTERNATIONAL FIGO STAGING OF METASTATIC DISEASE: Proposed International Classification for Named Gynaecological Cancers with Metastasis? At Diagnosis and Upon Recurrence

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Objective: To propose FIGO international classification for gynaecological cancers with metastasis for pattern/failure analysis, directed surveillance and strategising treatment. Treatment for early FIGO stage disease is effective; time now is to relook at more advanced disease as results are getting better in selected patients. Methods: Currently FIGO Stage 4 disease is summated to Stage 4A and 4B (no further data accruable). This precludes detailed analysis and thence treatment analysis. Proposal: 4A Bladder/Rectum involvement. 4B = specify 4B what organs (lung—diastinal,hilar,apical,peripheral,parenchyma,pleural based nodule,others; liver—segments,stage,shape,number; spleen—cortical,parenchymal,number; bone—state bone,level; Other organs—specify). State if recurrence or at diagnosis. State method of diagnosis (liver/bone biopsy, CT Thorax, pleural/pericardial fluid cytology). Conclusion: FIGO Staging for metastatic disease is heretic but it will systematize study of disseminated disease. This is a step to further audit of primary treatment, adjuvant treatment or lack of (as more conservative adjuvant regimes apply), rendition/templating of data and subanalysis of components of therapy leading to better accrual with enabled impact analysis.

IS-42 Intermediate Term Report: Are we giving the correct carboplatin dose in neoadjuvant/adjuvant setting in gynaecological oncology utilizing two different calculations in a tertiary university centre?

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Objective: To demonstrate two different calculated carboplatin dosages based on Cockroft formula and 24 hours urinary creatinine clearance and actual given dose. Methods: 93 common—pool patients undergoing chemotherapy for gynaecological malignancy in the institutional first cycle had their actual dose given (ADG), Cockroft (Ckft) and 24hour urine urinary creatinine clearance (24hr CrCl) carboplatin dosages analysed as to dose differentiation between actual dose given versus the other 2 calculated doses. Results: 93 patients included of which 2/93 were neoadjuvant setting, 48/93 single agent regime, 11/93 recurrent disease. The ADG—Ckft (mean = 523.17, range = 251.16—1502.41) : ADG—24hr CrCl (<13.26, >362 to 278). Age of patients (mean = 55, median = 55, range = 25—79 SD 11.3). 24hr CrCl (1.51, 1.13—2.21). Body surface area (mean = 1.515, median = 1.5, range = 1.13—2.214). Race: Malays 27, Chinese 30, Indians 15, Others 1. Significant difference exists between absolute ADG, Ckft and 24hr CrCl dosages (p<0.01). Conclusion: There are dose differences in carboplatin dosages calculated but there is no current guide internationally which denotes which dose to choose. This affects effectiveness of dose delivered, toxicity, resistance, combinational toxicity, physician fancy, need for GCSF, cure and recurrence rates. This issue needs to be addressed and answers sought.

IS-43 A CONCEPT PAPER: OPERATIVE ONCOLOGICAL STERILITY DOCTRINE IN GYNAE-ONCOLOGICAL SURGERY IN EARLY AND LATE FIGO STAGE DISEASE IN THE UNIVERSITY OF MALAYA, KUALA LUMPUR

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Objective: To introduce the concept and surgical practice parlance of oncological sterility in gynaecological surgery. Methods: Oncological sterility denotes the bacteriological equivalent of "non-touch", "clean field versus dirty field" and direct containment of tumour tissue, suspected tumour tissue and benign tissue at surgery especially in early stage disease. Can contaminated surgical gloves and instruments that have handled tumour tissue implant on healthy tissue? Is instrument and surgical gloves change for the entire team once specimen has been delivered crucial? Levels of tissue handling: via instruments (1st. level): via gloved hands (2nd. level): specimens in Galley pot (3rd. level): untouched by scrub nurse possibly metastatic pelvic lymph nodes? (4th. Level): unknowing reuse of preused internal suture material for closure or drains (5th. Level). These implantations can affect early stage or late stage disease and explain early surgical failure despite absent negative prognostic factors with clear margins. Results: Adoption of these techniques as part of routine surgical practice in 19 gynaecological cancer patients operated by the author. Conclusion: The concept of oncological sterility should be tested in animal tissue implantation trials and randomized controlled trials to determine its effects on progression free survival, recurrence and overall survival in patients with gynaecological cancers especially in those with early FIGO stage where tissue implantation has greater impact versus non—oncological sterility methods. Its universal adoption in everyday parlance may be one crucial surgical landmark practice.