ISP-10-3 Clinicopathologic characteristics of primary peritoneal carcinoma—A retrospective analysis of single institute experience

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[Objective] Primary peritoneal carcinoma is a rare malignancy. The aim of this study was to evaluate clinicopathologic characteristics in Japanese patients with primary peritoneal carcinoma. [Methods] We retrospectively analyzed patients with primary peritoneal carcinoma treated at our institute from October 2002 to May 2012. [Results] We identified a total of 9 Japanese patients with median age 61.4 (range: 54–67) years. All patients were histopathologically diagnosed as serous adenocarcinoma. One patient was classified as FIGO stage 3b and 8 patients were stage 3c. One patient had a family history of breast cancer. All patients demonstrated abnormal elevation of CA125 levels and mean value was 3186 (range: 21–15088) IU/ml. Although all patients were underwent primary surgery, only one patient achieved optimal cytoreduction. All patients received postoperative chemotherapy and 2 (22.2%) patients attained disease-free alive during median follow-up period 49 months. Median survival period was 12.7 months. [Conclusion] Although primary peritoneal carcinoma was diagnosed as advanced stage, optimal cytoreductive surgery combined with postoperative taxan/platinum chemotherapy would be improved patient's prognosis.

ISP-10-4 MRI and FDG-PET/CT in the clinical evaluation of patients undergoing secondary debulking (cytoreduction) surgery for gynecologic malignancy

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[Objective] To compare the use of MRI with FDG-PET/CT in the evaluation of patients with gynecologic malignancy for secondary debulking (cytoreduction) surgery. [Methods] Eighteen patients with recurrent gynecologic carcinoma (4 cervical: 6 uterine: 8 ovarian) underwent secondary debulking surgery. All patients had MRI and PET/CT during 90 days before surgery. The median treatment-free interval was 7 months. [Results] Following surgical debulking 78% of patients (14/18) had negative surgical resection margins: in 22% (4/18), positive surgical resection margins were confirmed histologically. Surgical resection of adjacent organs was required in 33% (6/18). The median tumor diameter in cases that required adjacent organ resection was greater than that in cases that did not (8.2 cm vs. 3.9 cm: p=0.06). In 89% (24/27) of post-operative tumor nodules showing FDG uptake, recurrent cancer was found histologically. Using MRI, the sensitivity and specificity of detecting adjacent organ invasion were 100% and 80%, respectively: the sensitivity and specificity of detecting pelvic wall invasion were 25% and 83%, respectively. [Conclusion] In patients undergoing secondary debulking surgery for gynecologic malignancy, PET/CT was of clinical value in the diagnosis of recurrent tumor nodules. MRI was a more sensitive method of detecting tumor invasion of adjacent organs but not pelvic wall invasion.

ISP-10-5 End of life care at a general gynecology unit

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[Objective] To assess treatment patterns of end of life care in a gynecology unit. [Methods] A retrospective study of patients who received palliative care at a single institution and died during 2013 and 2014 was performed. Approval for the data acquisition was obtained from the institutional review board. [Results] We identified 19 patients. The median survival time after the last chemotherapy was 3 months during 2013 and 2 months during 2014. During 2013, all patients received intervention by a palliative care team, of which 63% for treatment with opioids. During 2014, 75% of patients received intervention, of which 25% for treatment with opioids. There was not a significant difference concerning selection of opioids, corticosteroids between patients who were referred to a palliative care team and patients who were not. Frequency of neurologic pain and delirium treatments were higher in the group which were referred to a palliative care team. [Conclusion] There was improvement in treatment with opioids before receiving intervention by a palliative care team during 2014. There was not a significant difference concerning symptom relief between patients who were referred to a palliative care team and patients who were not. The factors contributing to this may be continual education of the gynecology staff on palliative care and appropriate consultation to the palliative care team.