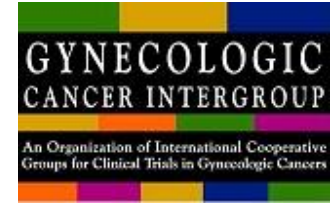




# **Ovarian cancer: clinical practice – the Arabic perspective**



**Experience of Hôtel-Dieu de France University  
Hospital (Beirut, LEBANON) in supraradical surgery  
for ovarian cancer**

**David ATALLAH M.D. M.Sc.**

**Associate Professor at Saint Joseph University  
Gynecologic oncologist and breast surgeon at  
Hôtel-Dieu de France University Hospital**

# Ovarian cancer

- **Standard of care=**
- **Primary cytoreductive surgery followed with chemotherapy based on platins and paclitaxel**

Ozols RF, Bundy BN, Greer BE, et al. **Phase III trial of carboplatin and paclitaxel compared with cisplatin and paclitaxel in patients with optimally resected stage III ovarian cancer: a gynecologic oncology group study.** J Clin Oncol 2003;21(17):3194–200.

# Rationale of cytoreductive surgery

J Gynecol Oncol. 2015 Jul 17. [Epub ahead of print]

## **Role of aggressive surgical cytoreduction in advanced ovarian cancer.**

Chang SJ<sup>1</sup>, Bristow RE<sup>2</sup>, Chi DS<sup>3</sup>, Cliby WA<sup>4</sup>.

### **+ Author information**

#### **Abstract**

Ovarian cancer is the eighth most frequent cancer in women and is the most lethal gynecologic malignancy worldwide. The majority of ovarian cancer patients are newly diagnosed presenting with advanced-stage disease. Primary cytoreductive surgery and adjuvant taxane- and platinum-based combination chemotherapy are the standard treatment for advanced ovarian cancer. A number of studies have consistently shown that successful cytoreductive surgery and the resultant minimal residual disease are significantly associated with survival in patients with this disease. Much has been written and even more debated regarding the competing perspectives of biology of ovarian cancer versus the value of aggressive surgical resection. This review will focus on the current evidences and outcomes supporting the positive impact of aggressive surgical effort on survival in the primary management of ovarian cancer.

**Impact on survival !**

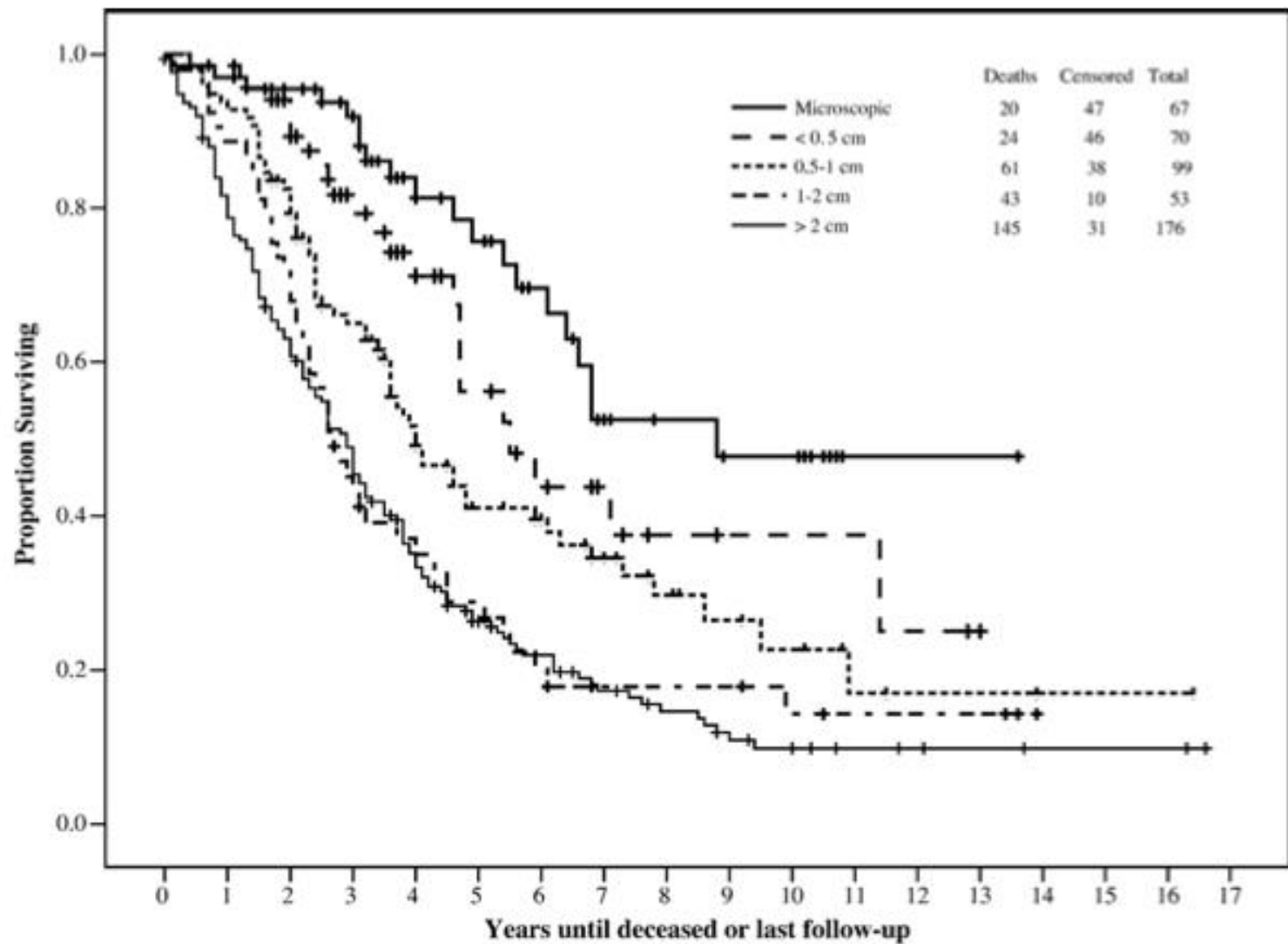


Fig. 1. Overall survival, stage IIIc ovarian cancer, 1989–2003.

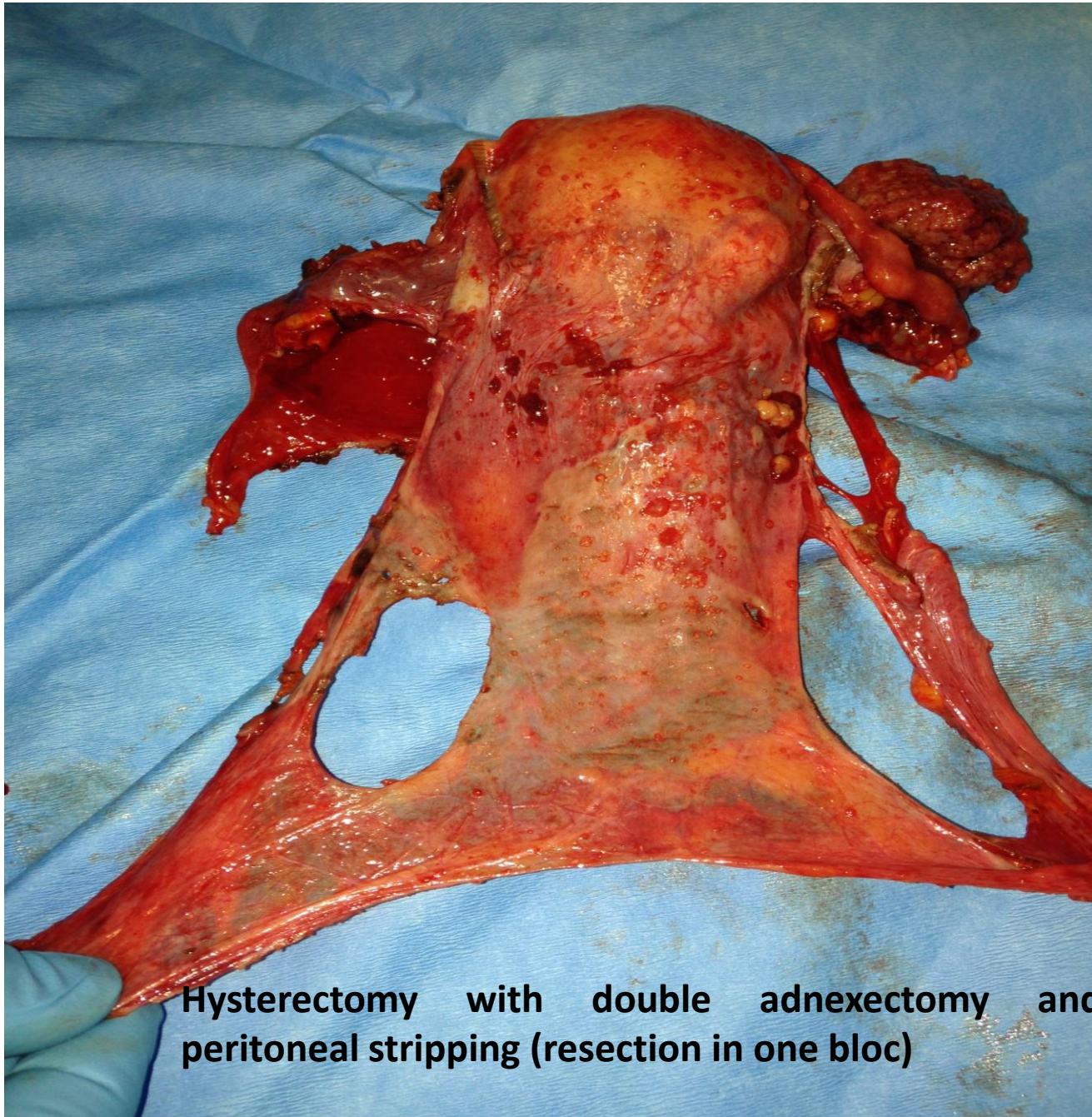
# Cytoreductive Surgery : Principles

- Complete Resection of the carcinosis (R0)
- Pelvic exenteration in one bloc
- Bowel resection
- Upper abdominal surgery (supramesocolic)
- 
- Extensive lymphadenectomy

## Pelvic exenteration/ Cytoreduction

- Resection in one bloc without tumor spillage , free margins
  - Radical hysterectomy with bilateral adnexectomy
  - Ureteral dissection
  - Rectosigmoid resection
  - Peritoneal stripping

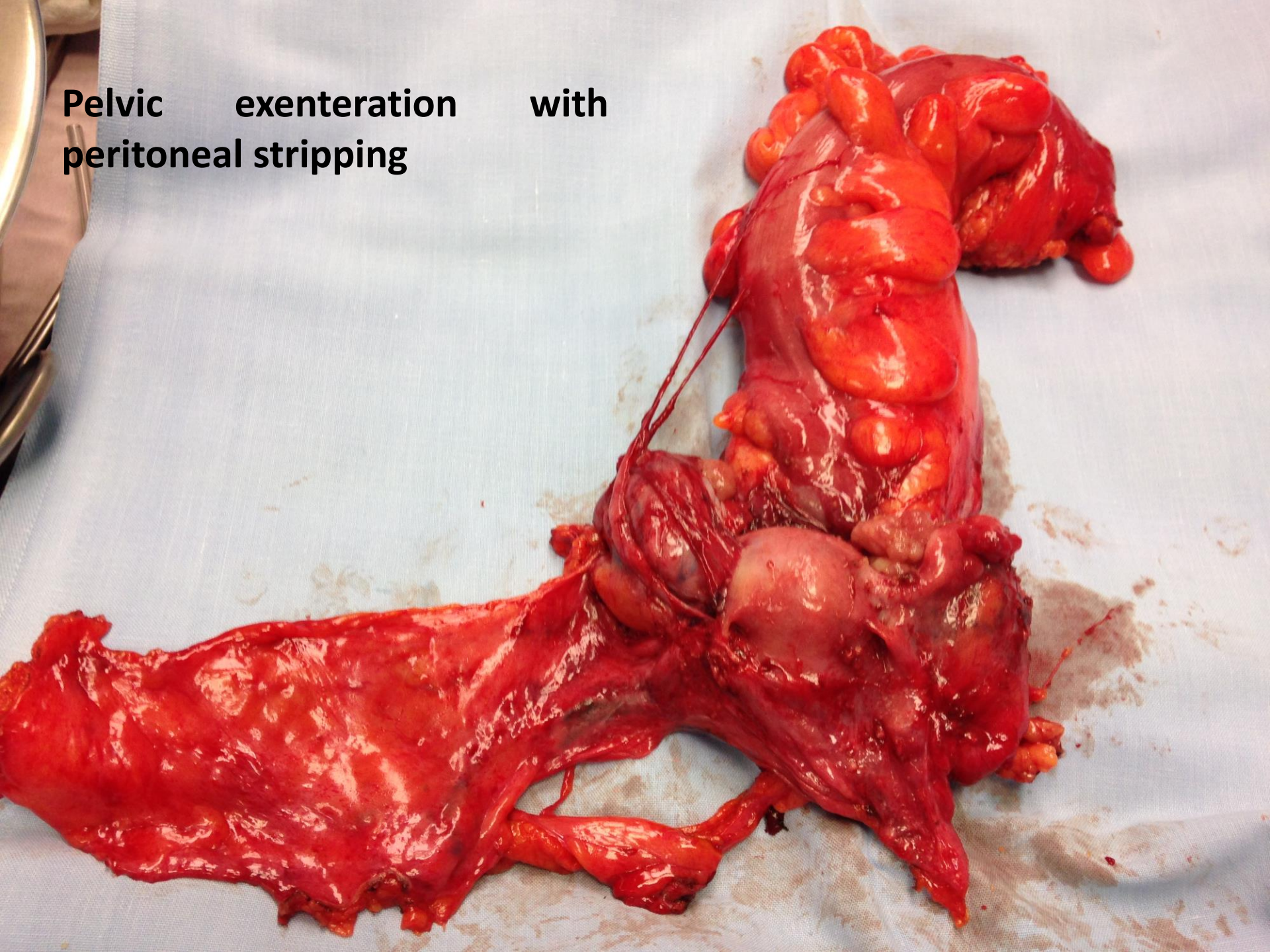




**Hysterectomy with double adnexectomy and peritoneal stripping (resection in one bloc)**

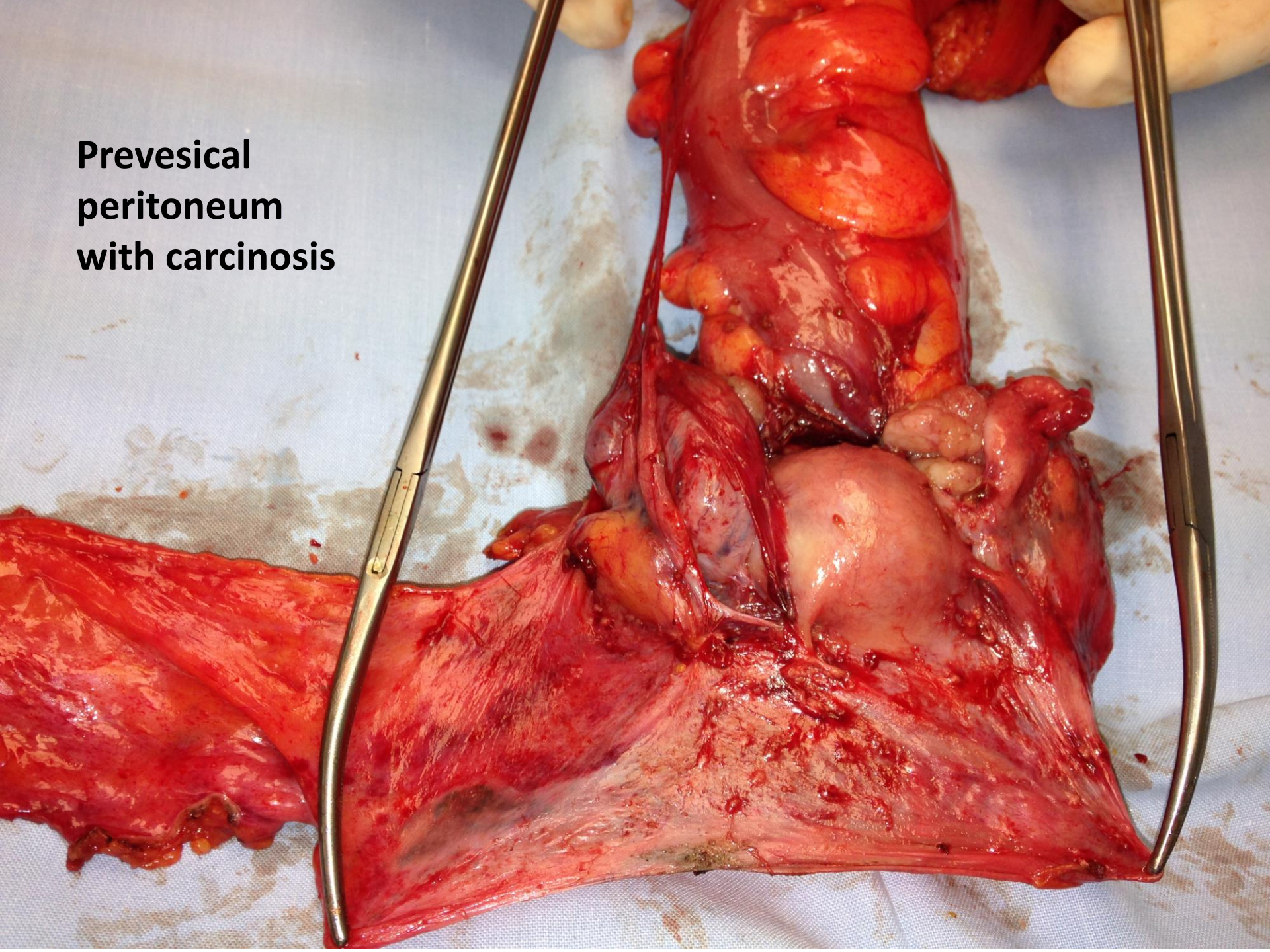


**Pelvic exenteration with  
peritoneal stripping**

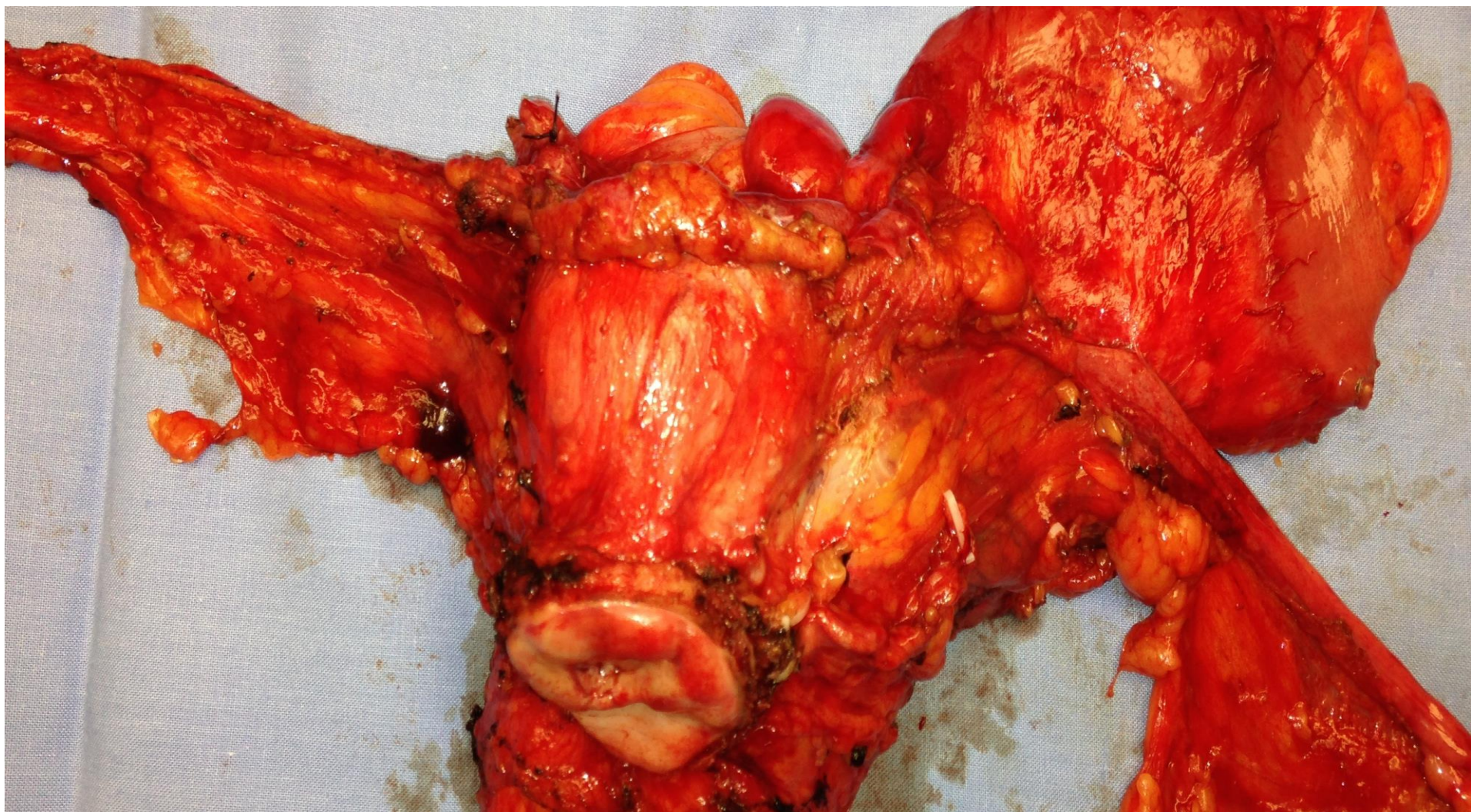




**Prevesical  
peritoneum  
with carcinosis**

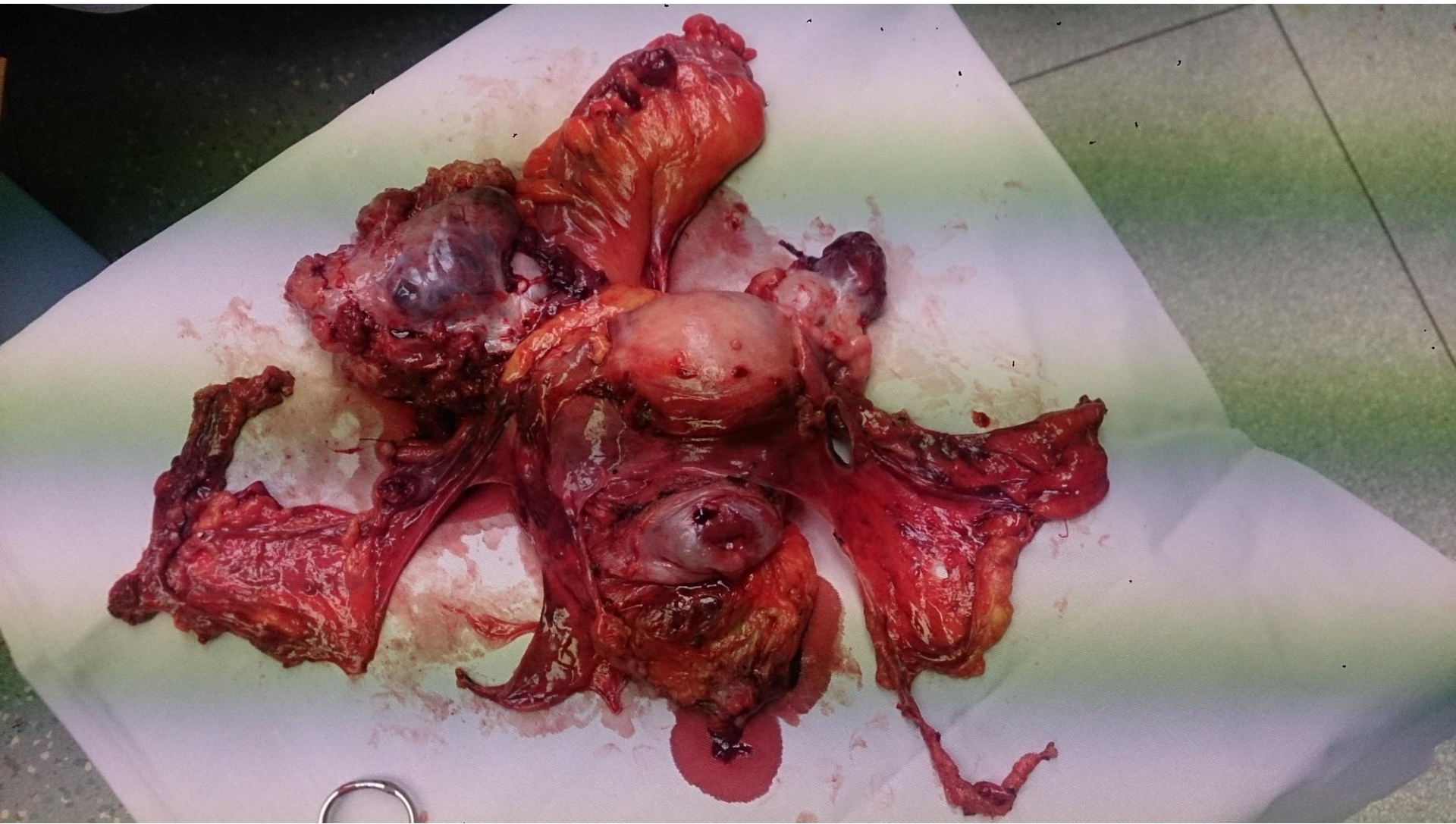






**Posterior exenteration with peritoneal stripping**





**Pelvic exenteration with peritoneal stripping in one bloc**

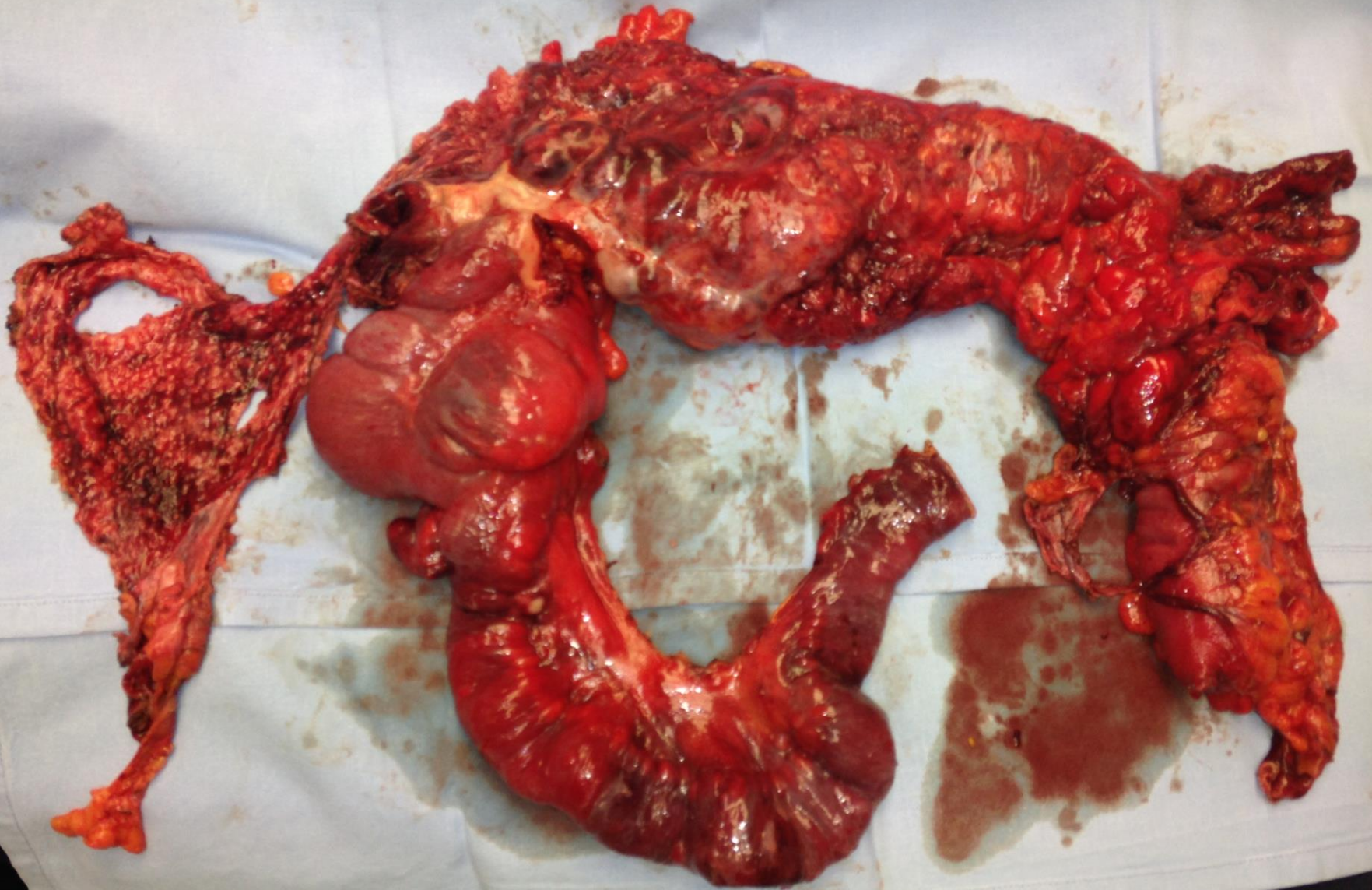


# Bowel resection





**Total colectomy with ileal resection**

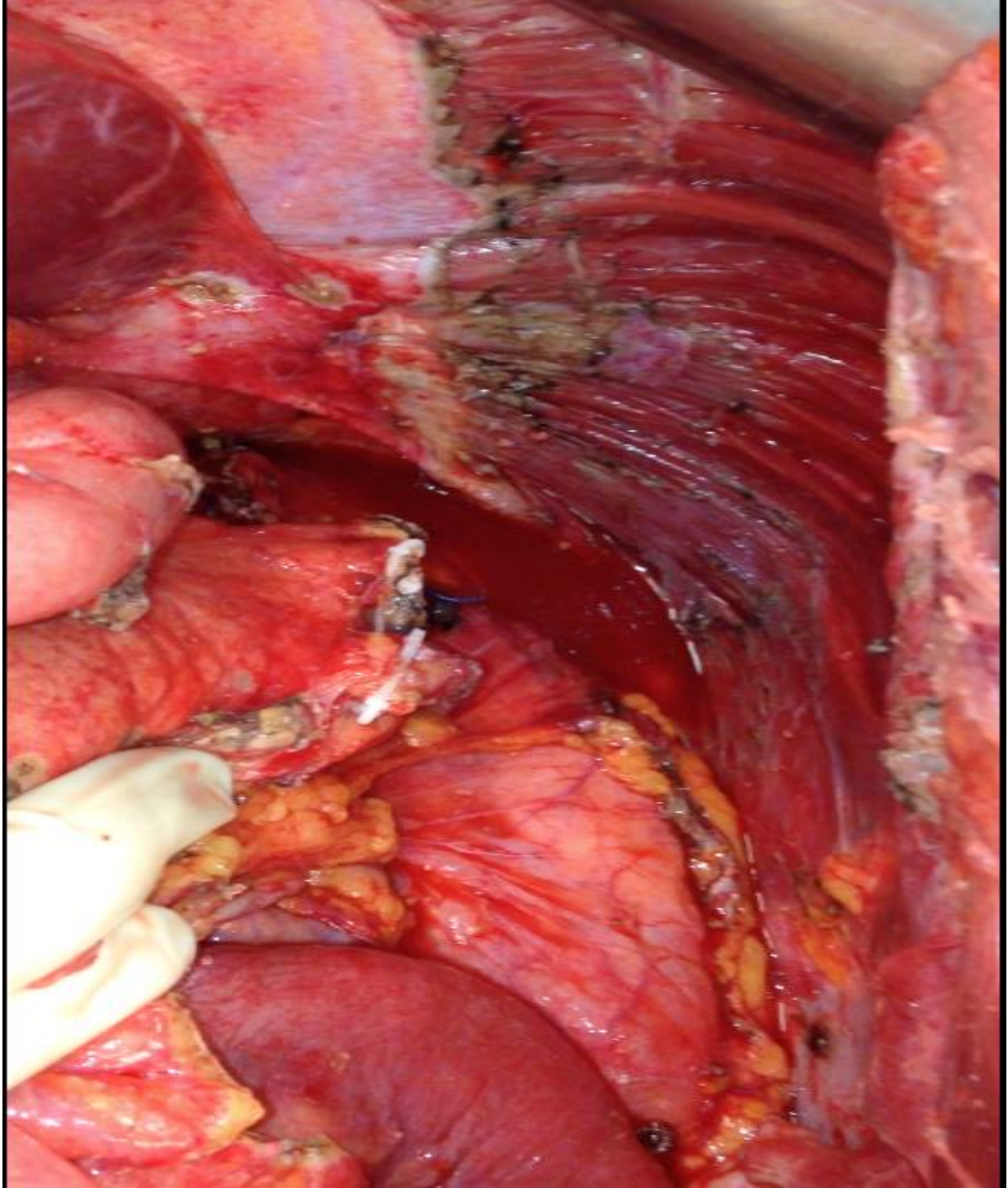


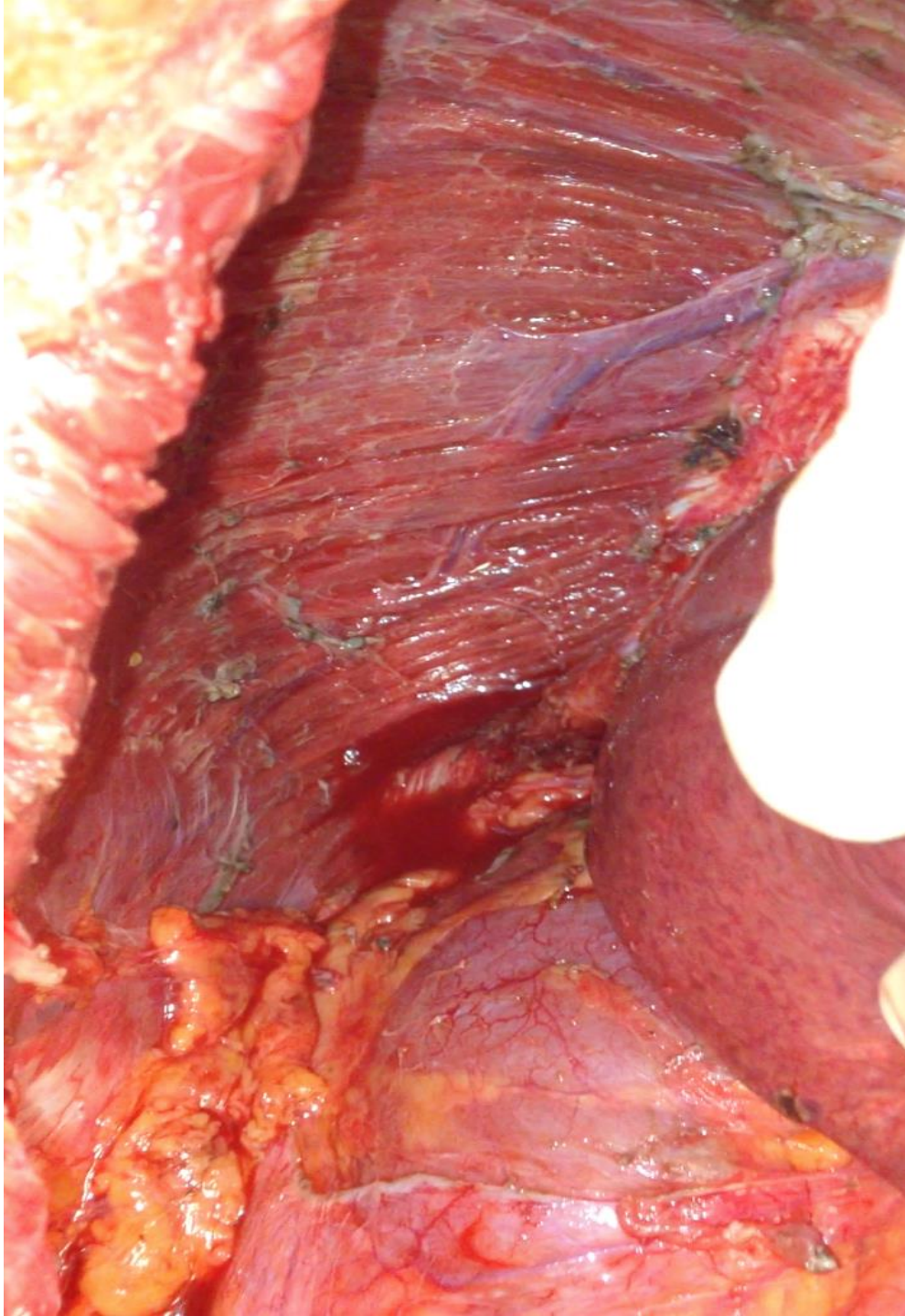
# Upper abdominal surgery

- Diaphragm Stripping
- Splenectomy with caudal pancreatectomy
- Omentectomy



**Left diaphragmatic  
cupola after  
stripping and  
splenectomy**

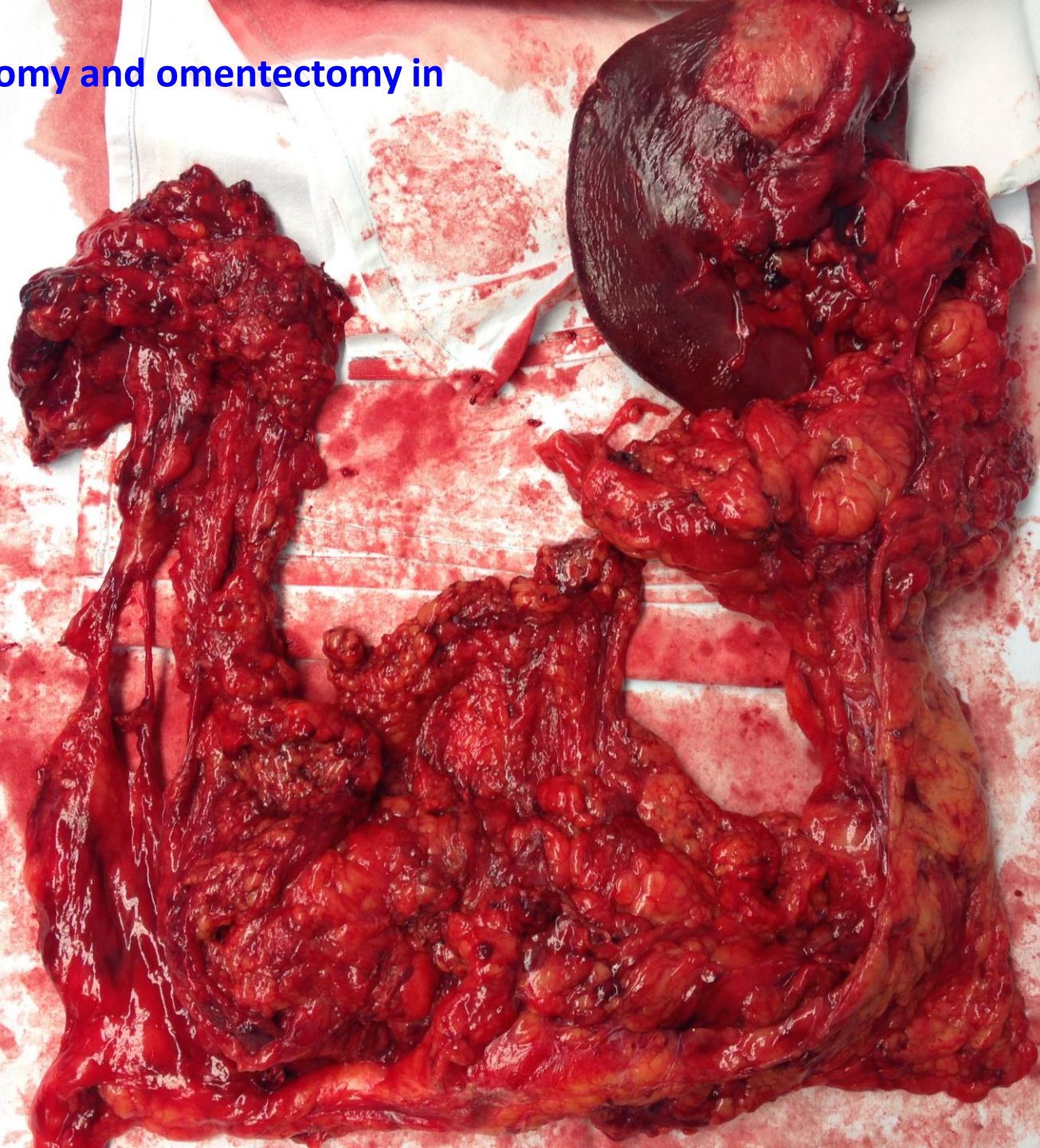




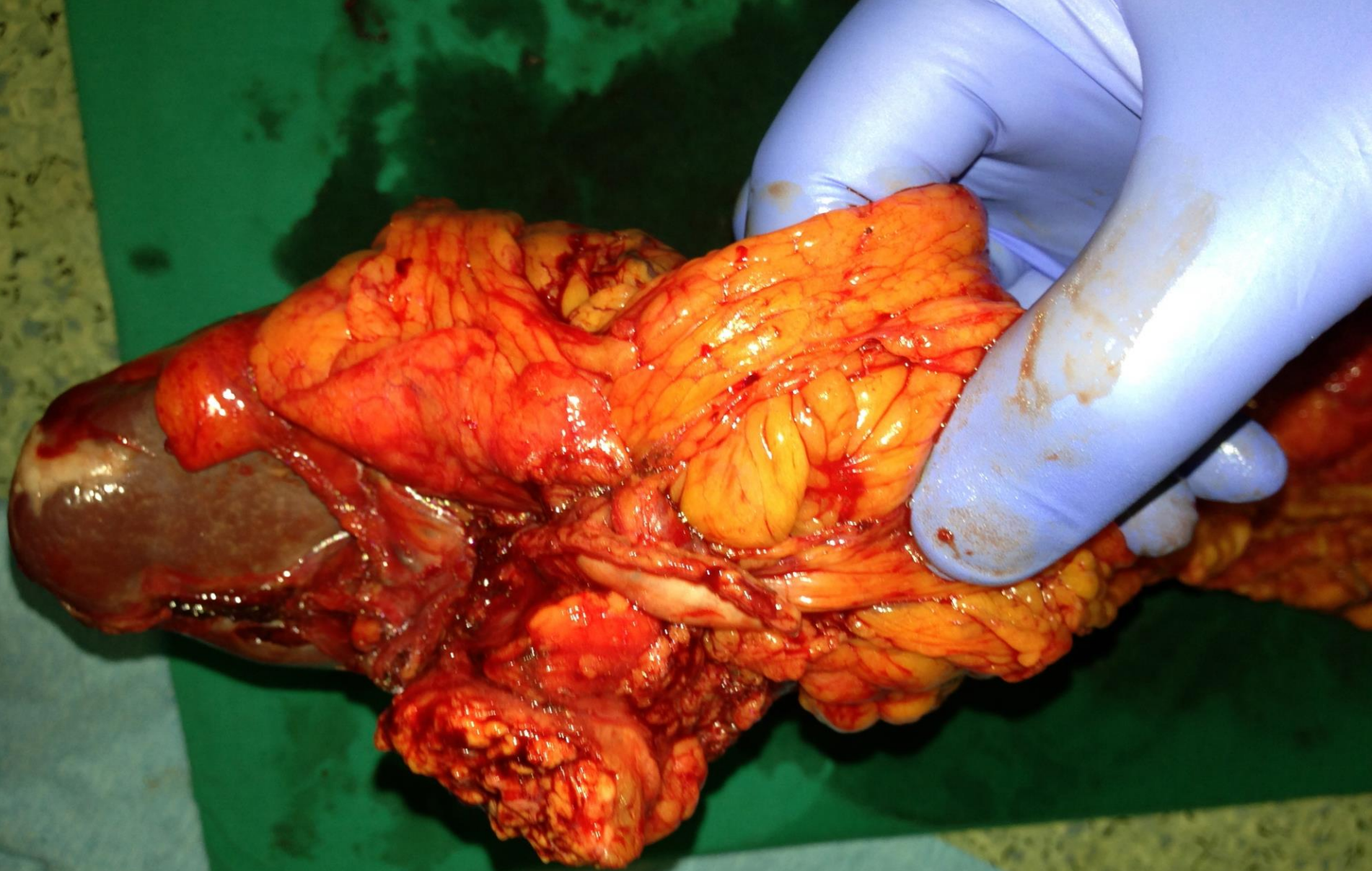
**Right  
diaphragmatic  
cupola after  
stripping**



**Splenectomy and omentectomy in  
one bloc**



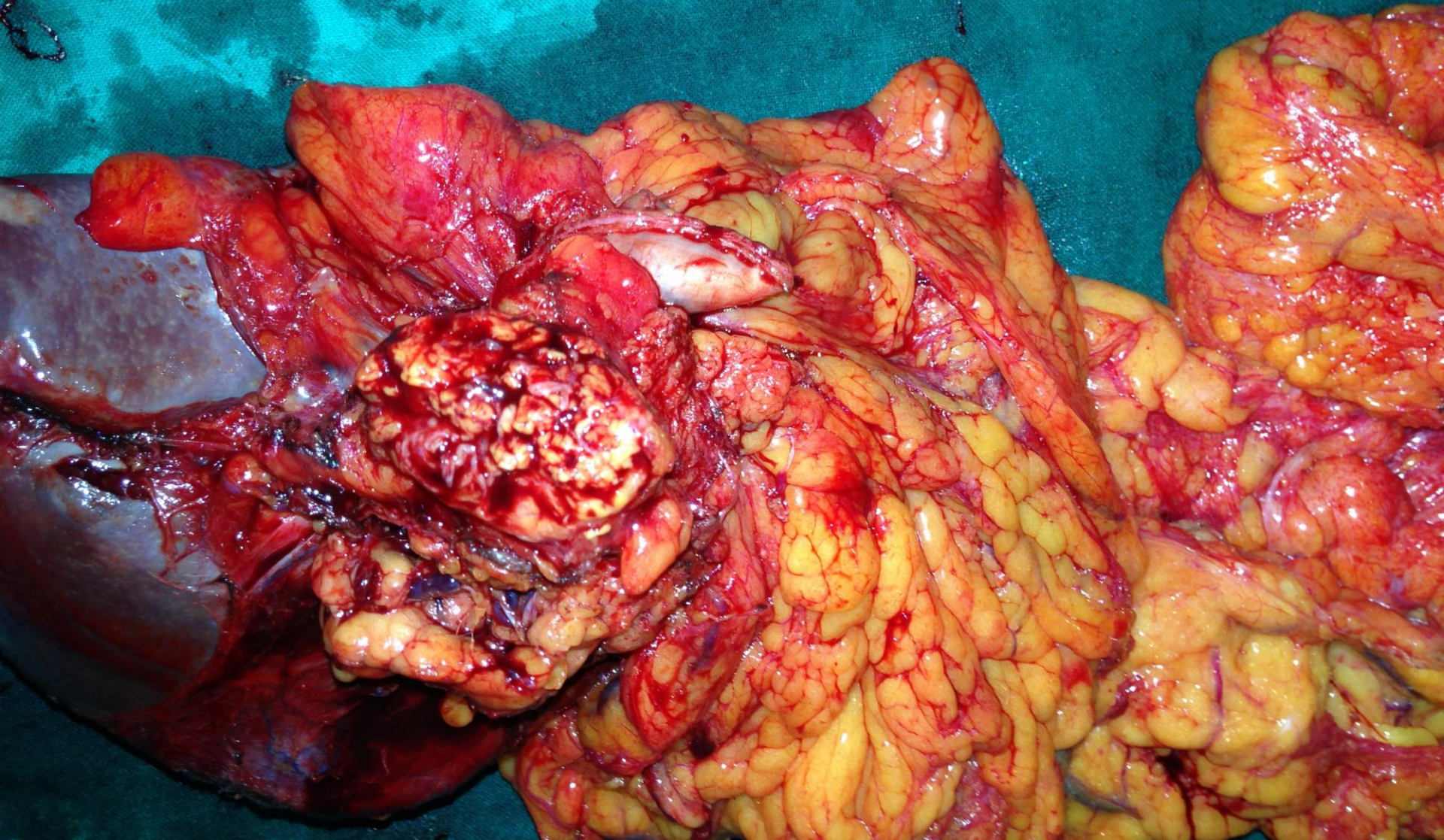




**Splenectomy and caudal pancreatectomy**



## Splenectomy and caudal pancreatectomy



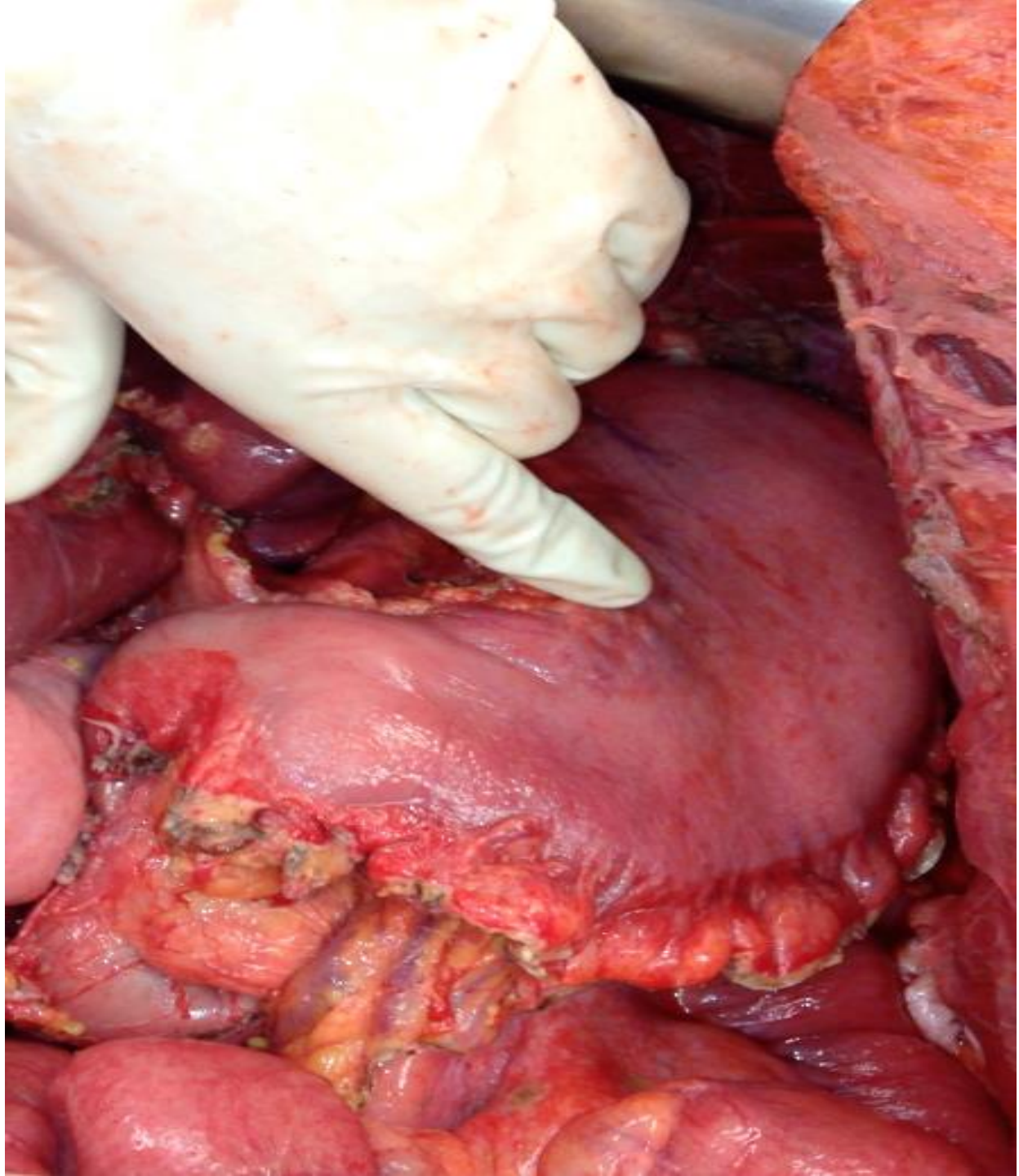


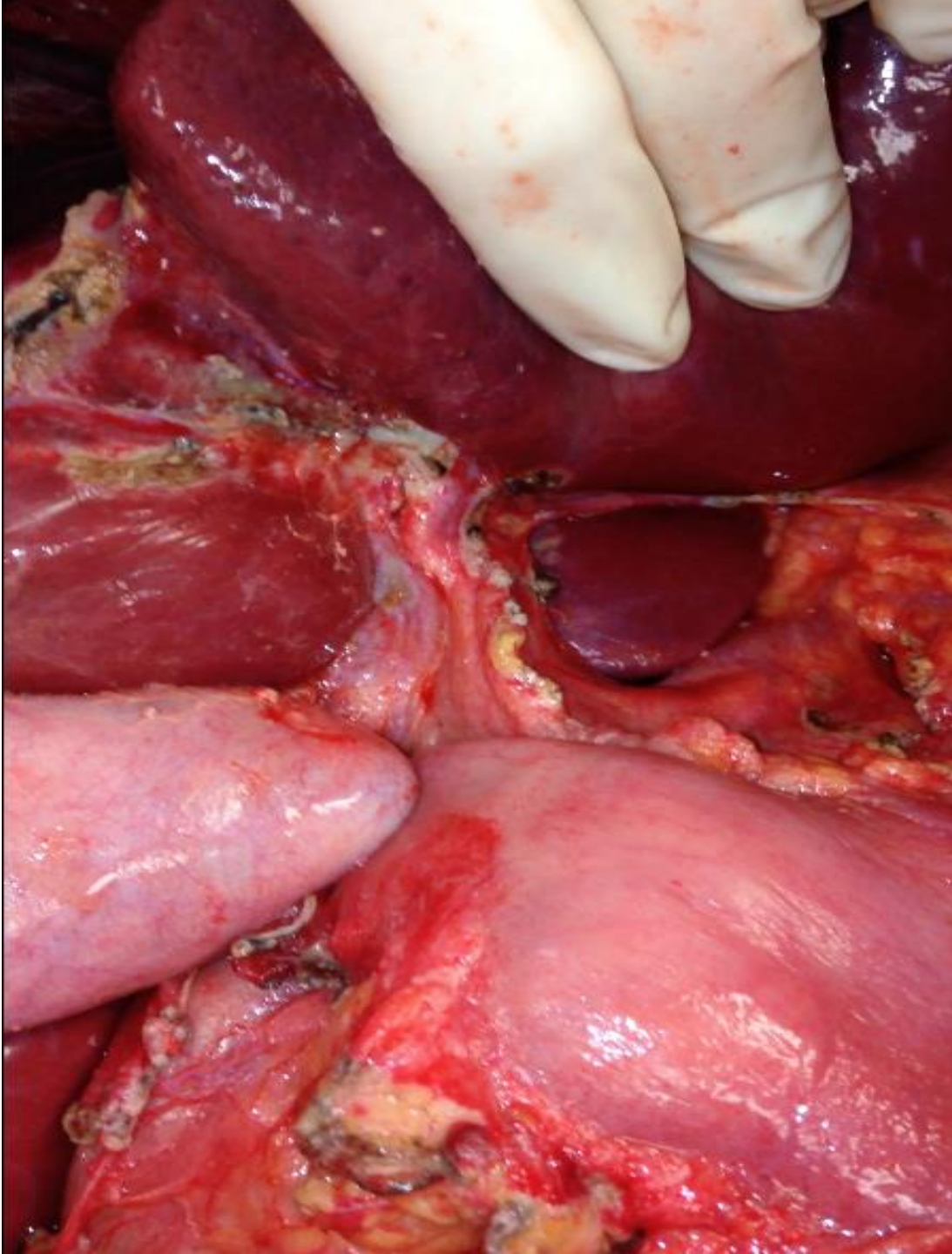


**Infragastric omentectomy**



**Great  
curvature of  
the stomach  
after  
infragastric  
omentectomy**

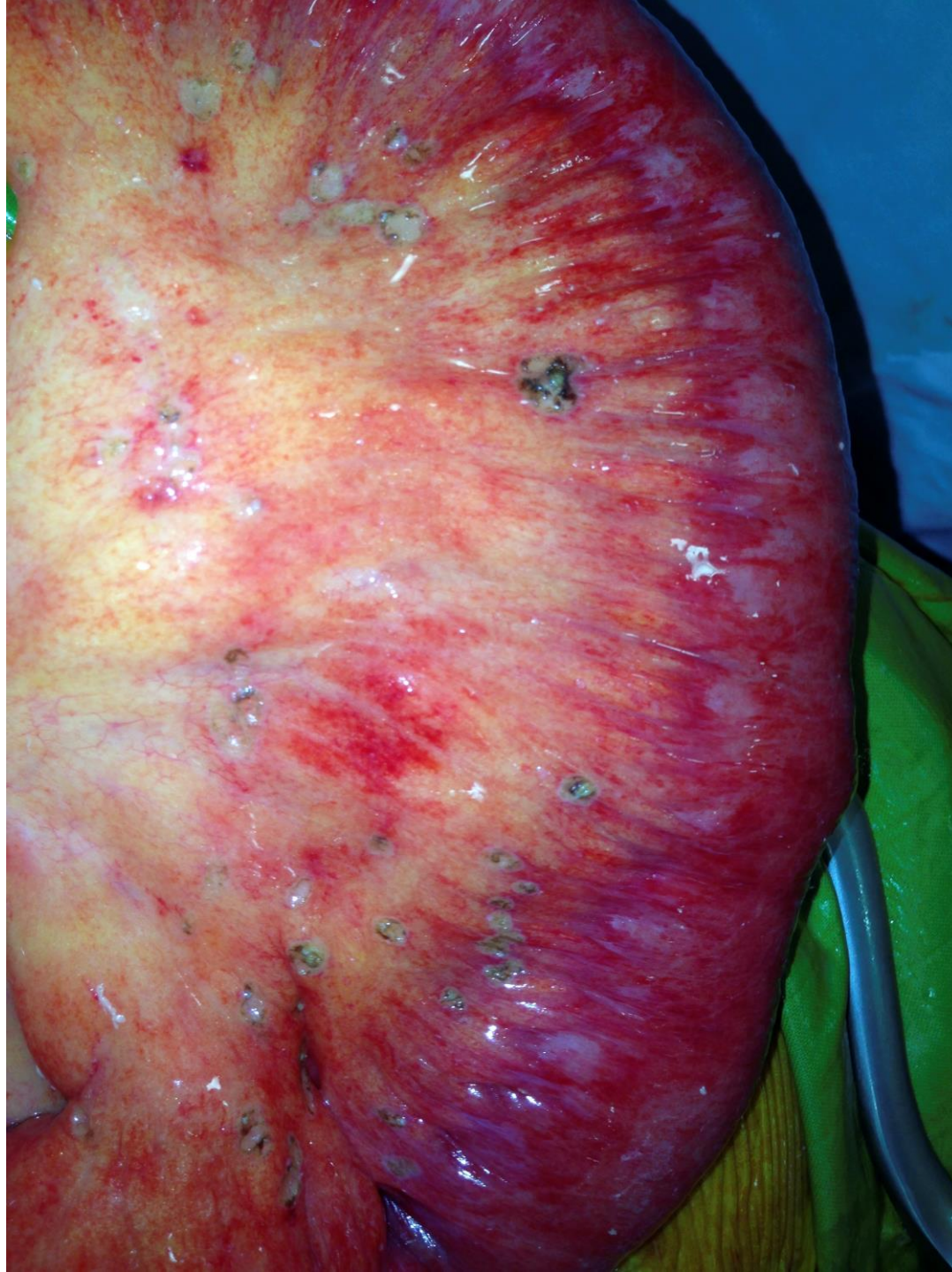




**Lesser curvature  
of the stomach  
after resection of  
carcinosis at the  
level of lesser  
omentum**



**Control of  
disease and  
resection of  
micronodules  
at the level of  
the mesentery**

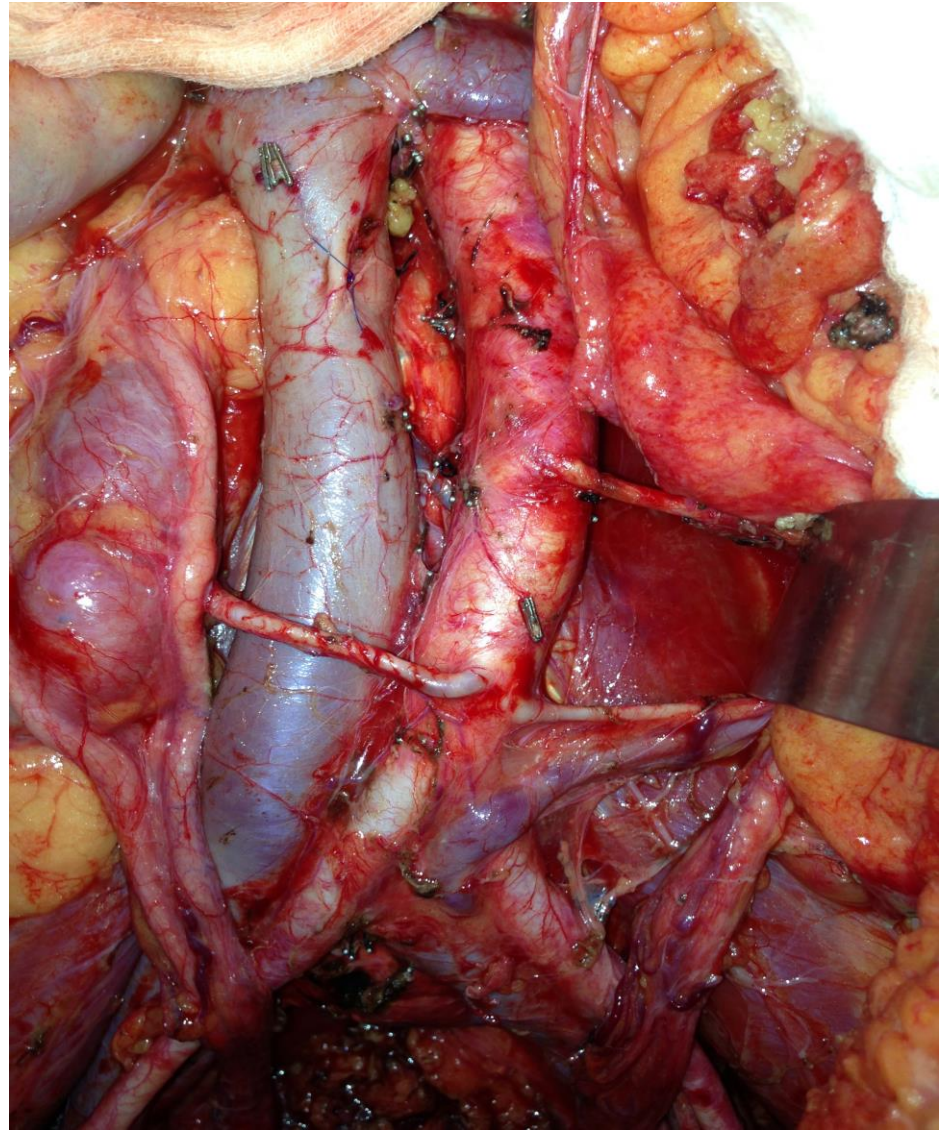
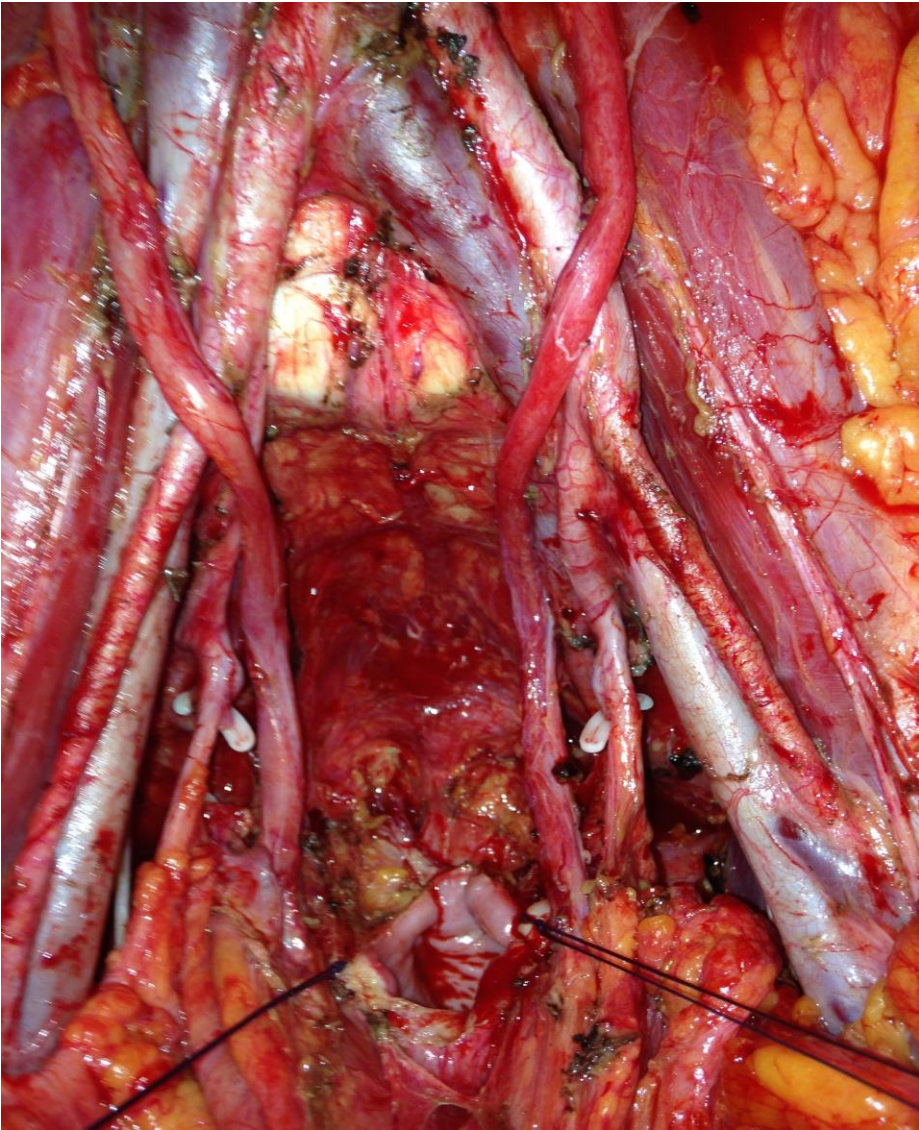








# Pelvic and para-aortic lymphadenectomy



## Our study

- Retrospective study
- Concerning 139 patients
- Undergoing cytoreductive surgery for primary or recurrent disease
- Primary or interval debulking
- Between January 2004 and September 2017 at Hôtel-Dieu de France University Hospital

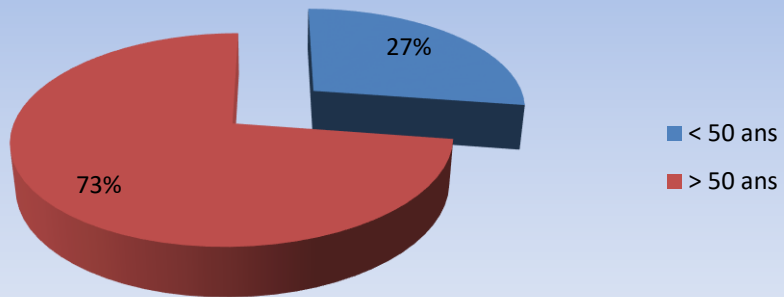
# Objectives

- To define predictive factors of better survival and delayed recurrence in ovarian cancer patients undergoing a cytoreductive surgery

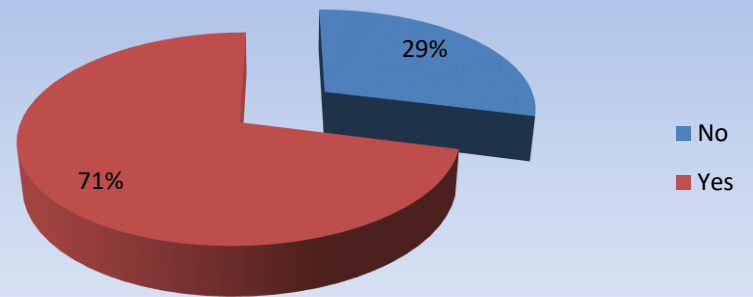


# Results

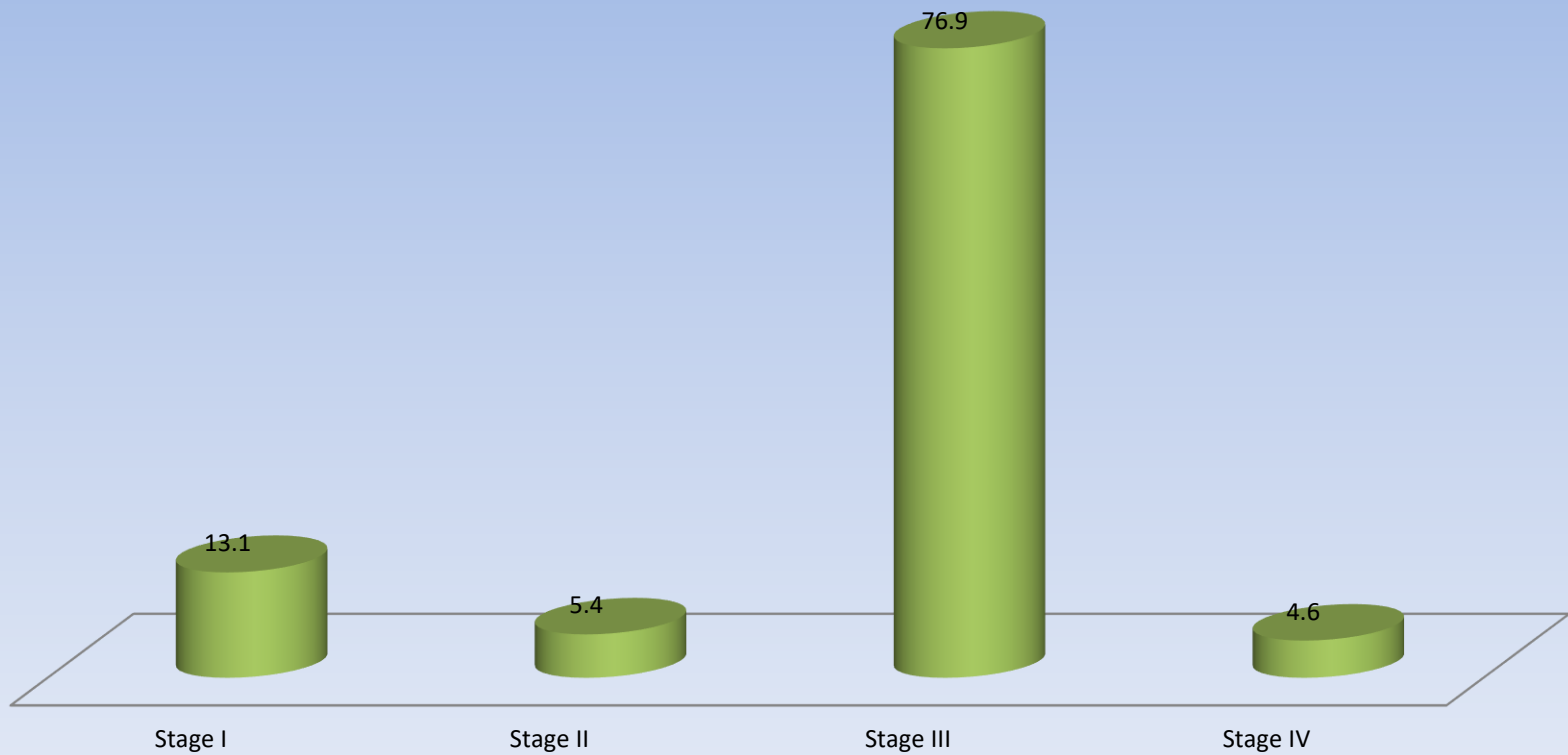
## Age



## Menopause

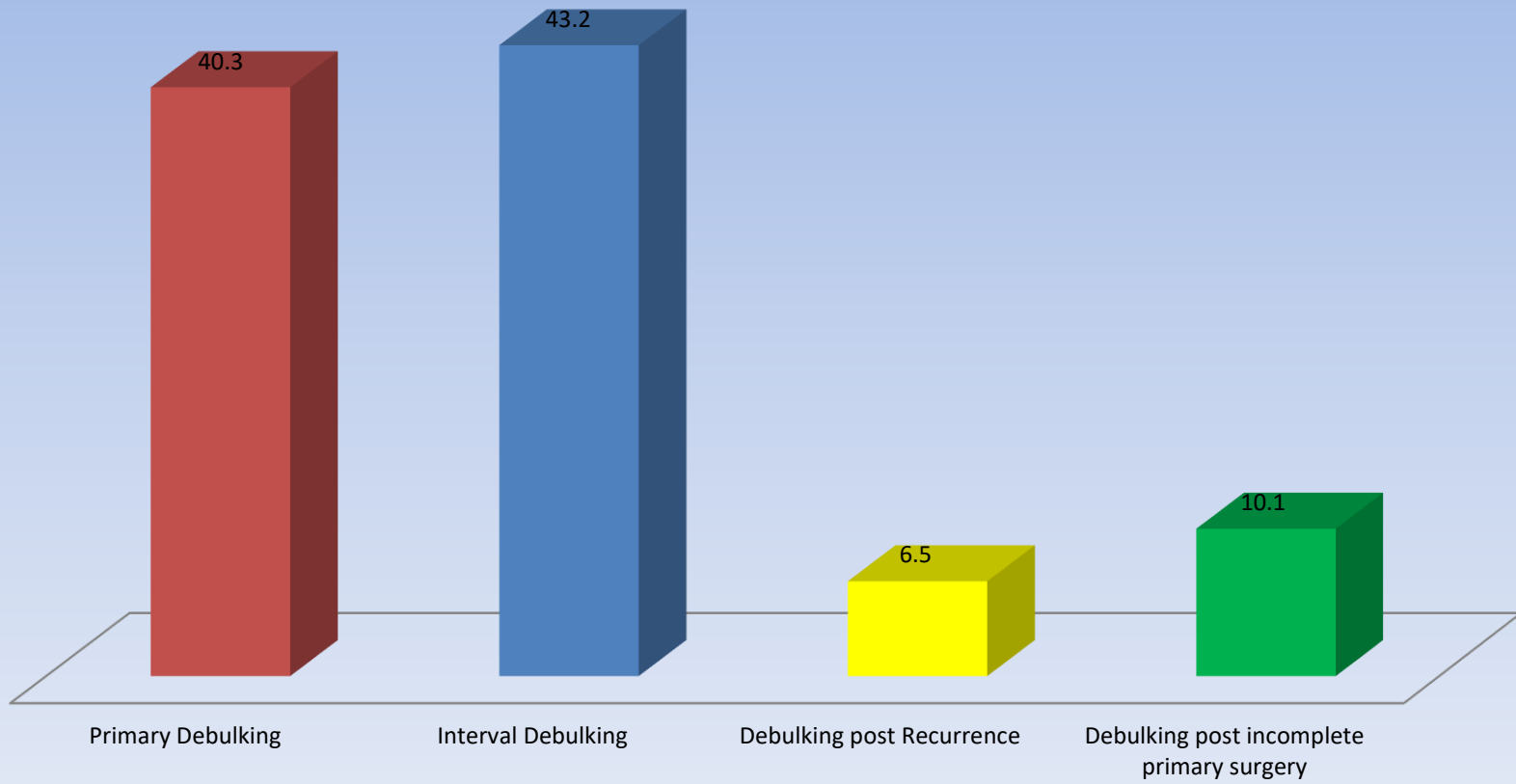


## Stage

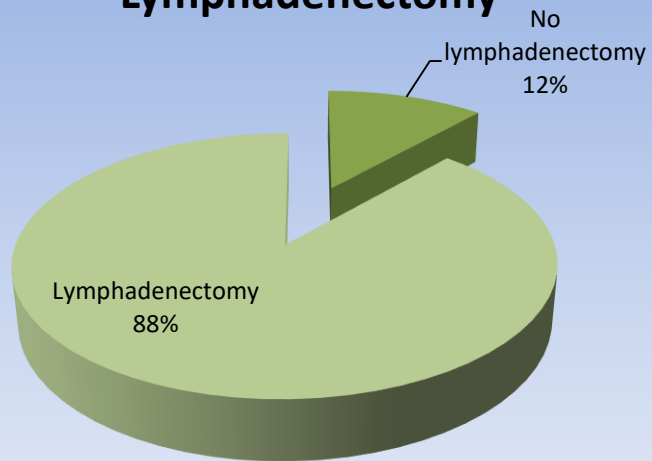




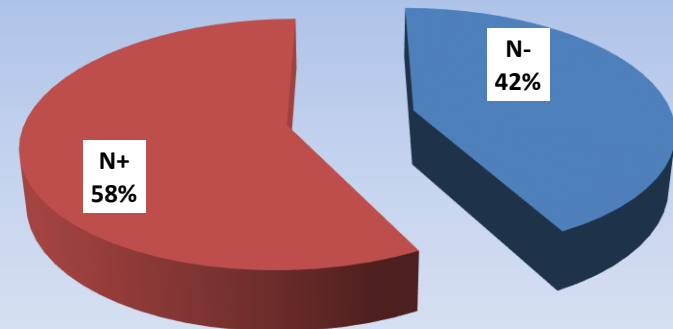
## Debulking



**Lymphadenectomy**



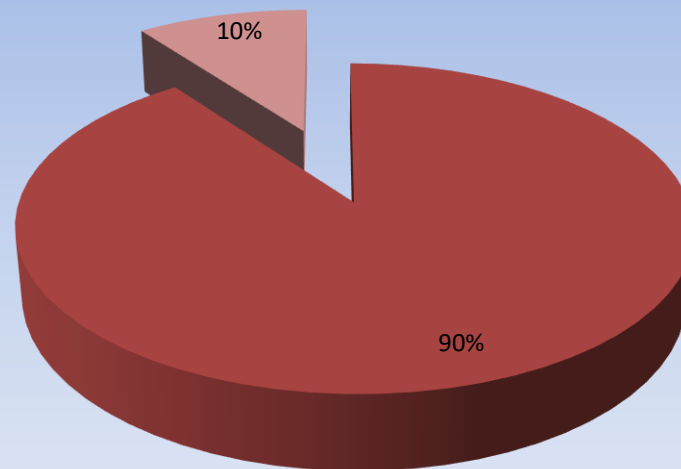
**Lymph node**



Mean number of removed lymph nodes (pelvic and para-aortic) = 57 LNs



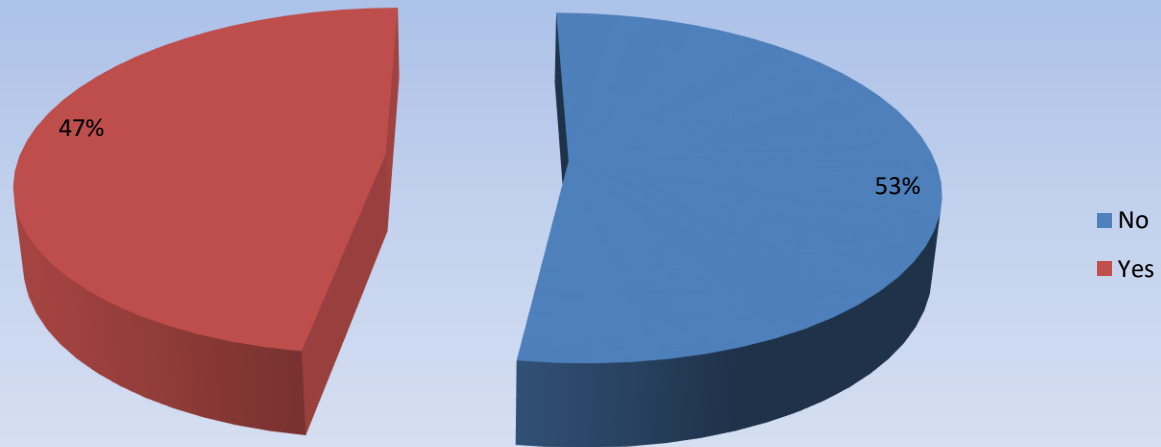
## Clearance Ratio



■ < 0.25

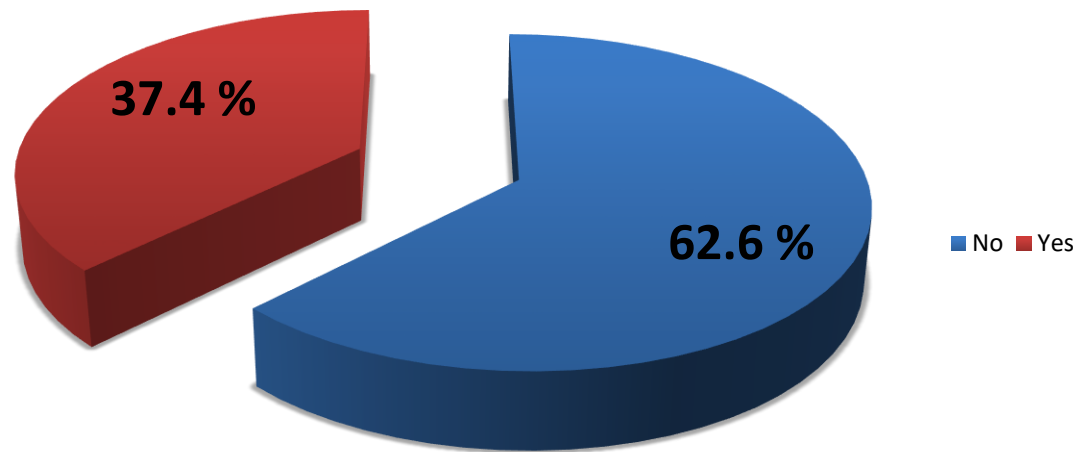
■ > 0.25

## Bowel resation

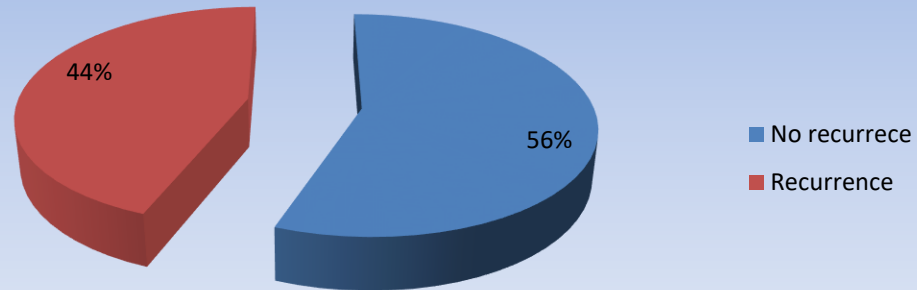




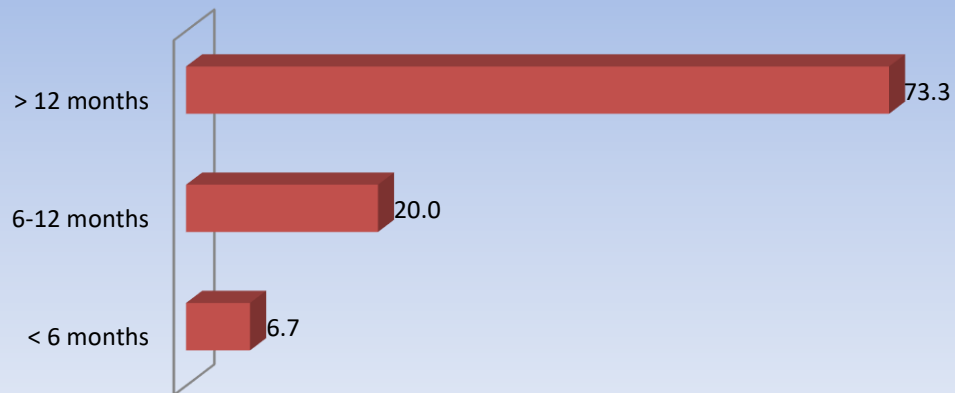
## Upper abdominal surgery



## Recurrence

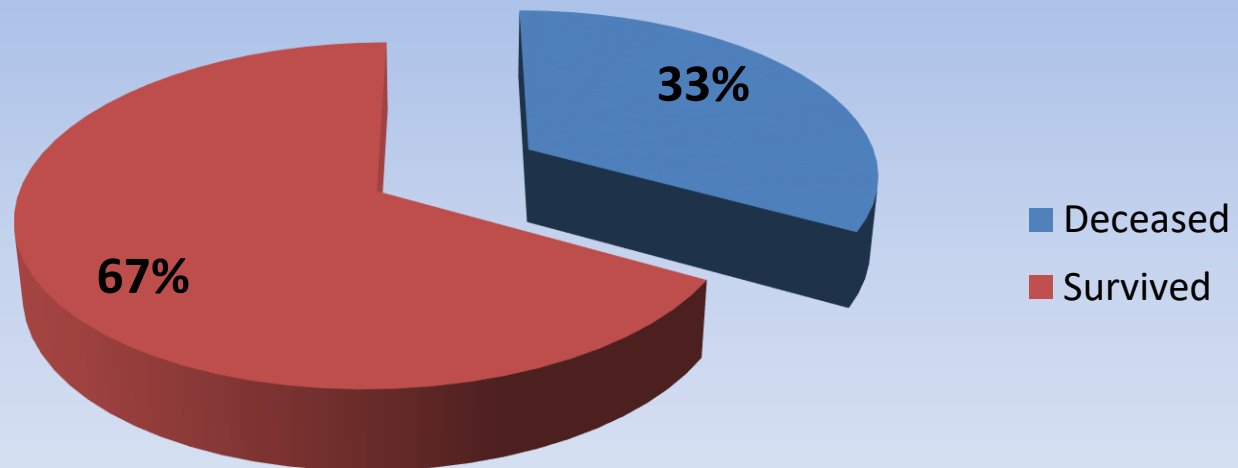


## Interval of recurrence

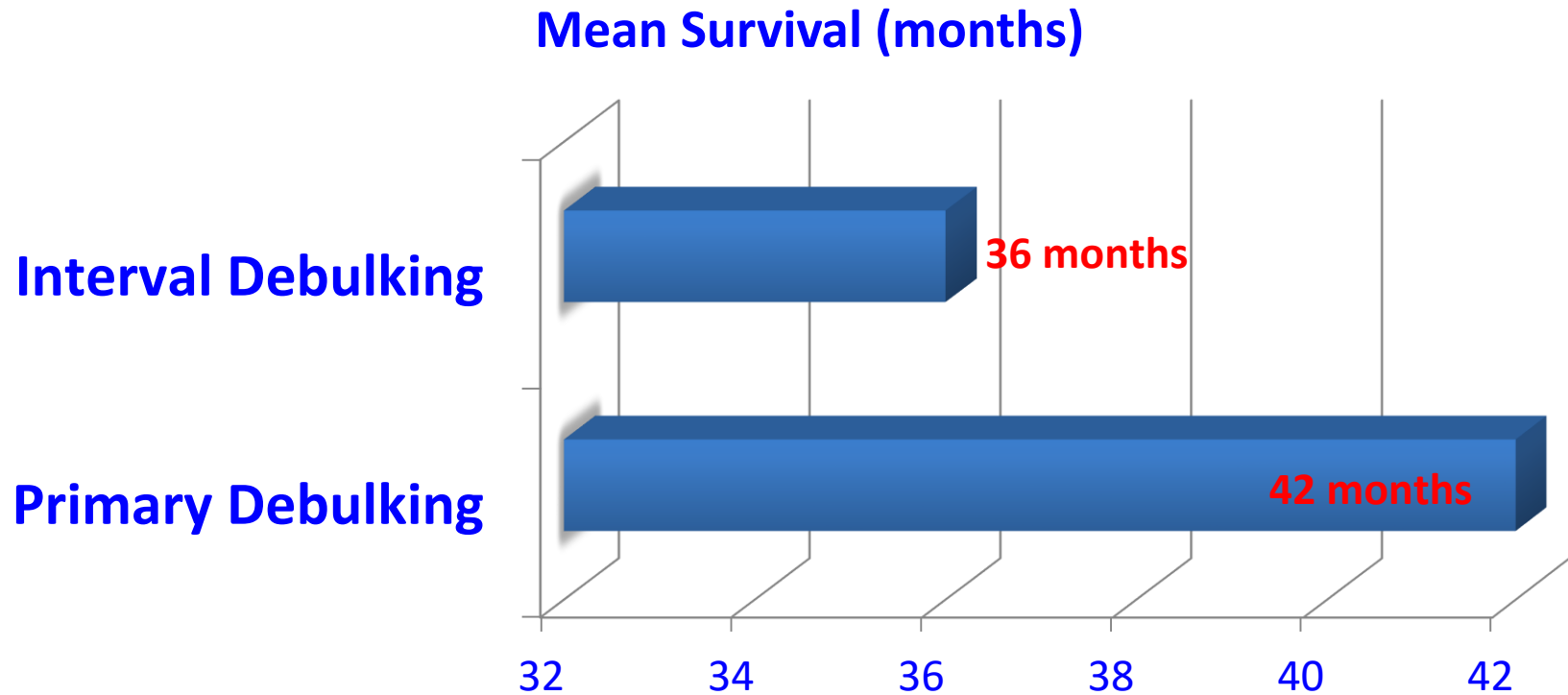




## Survival



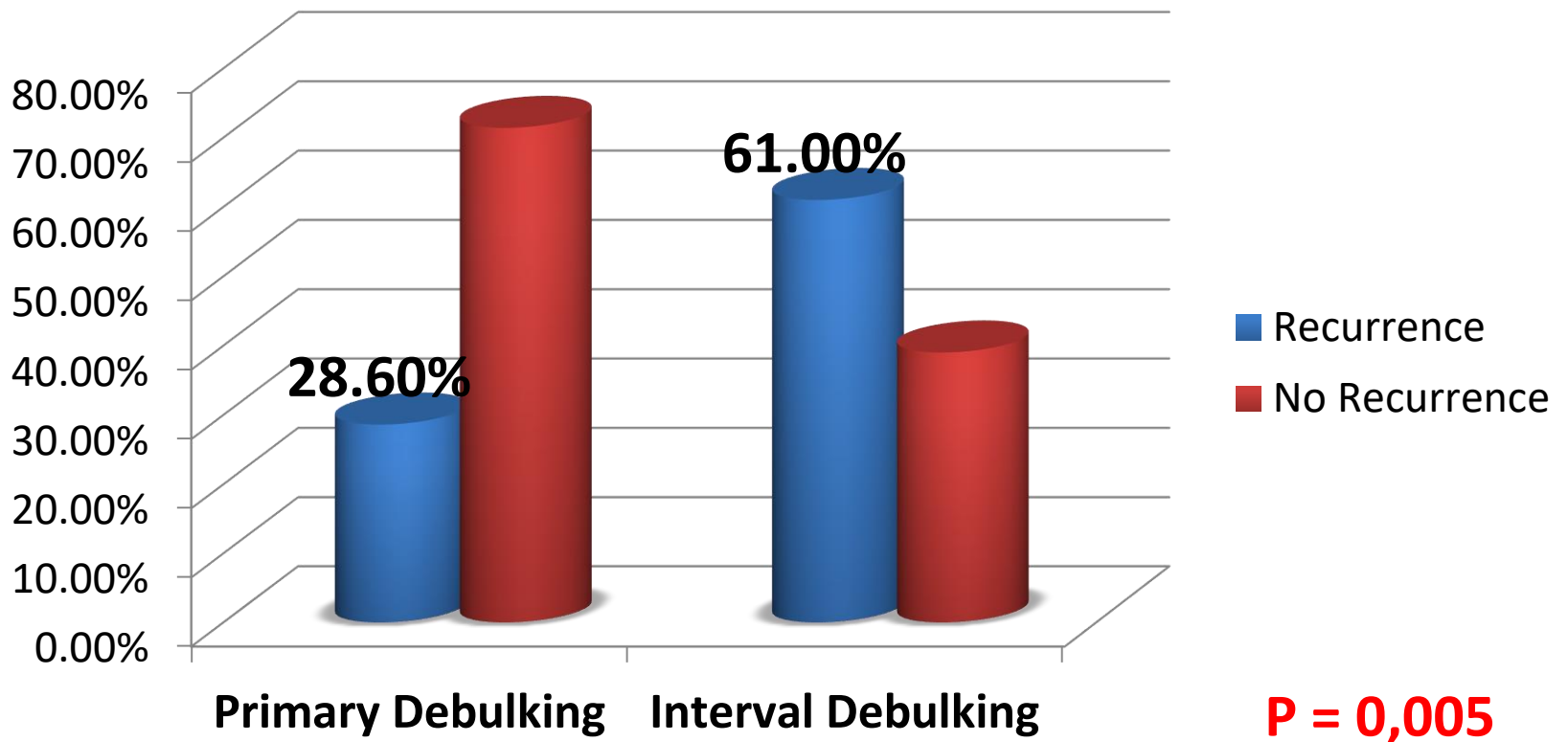
# Primary vs. interval debulking



P = 0.63



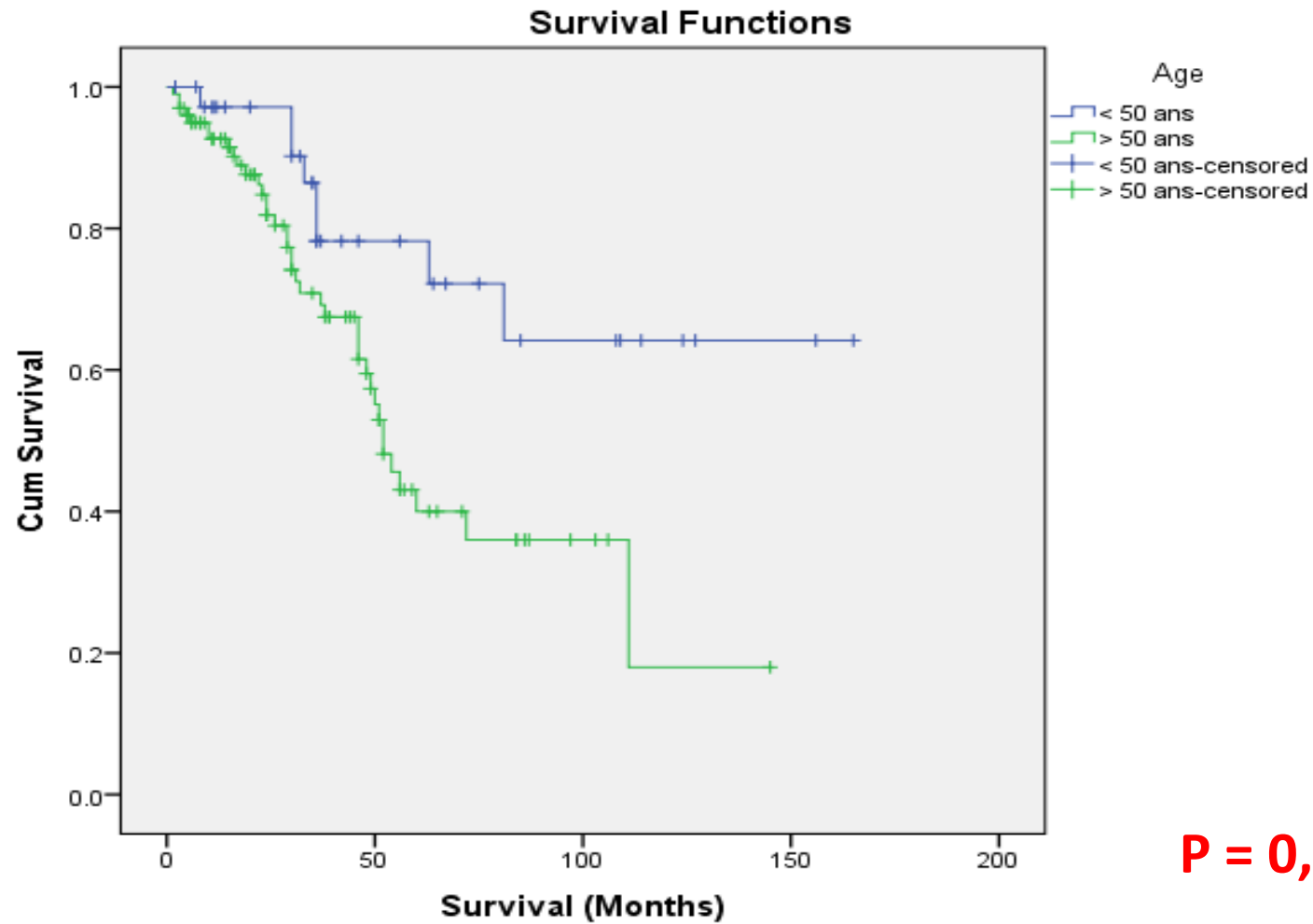
## Primary vs. interval debulking



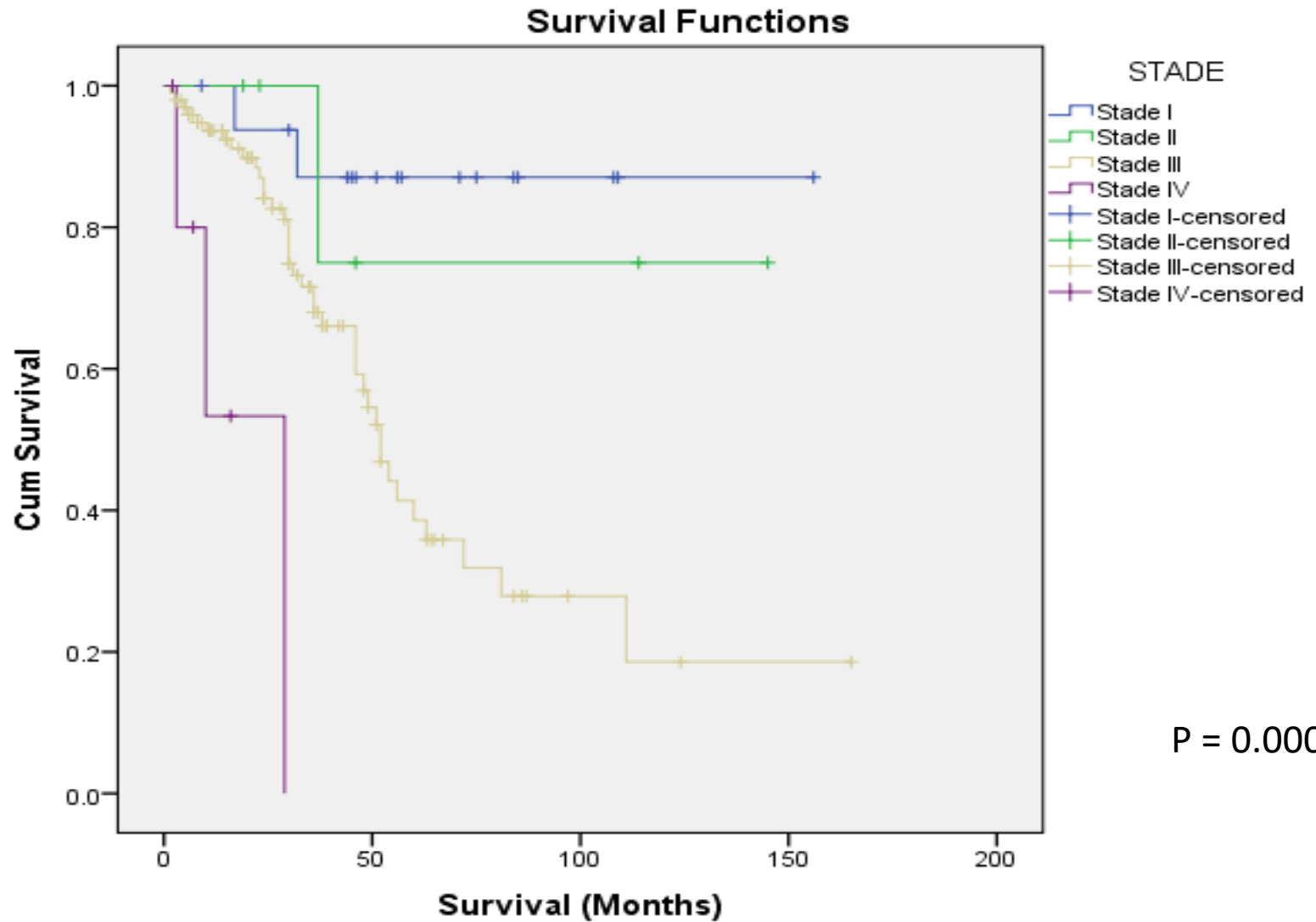
Factors for survival



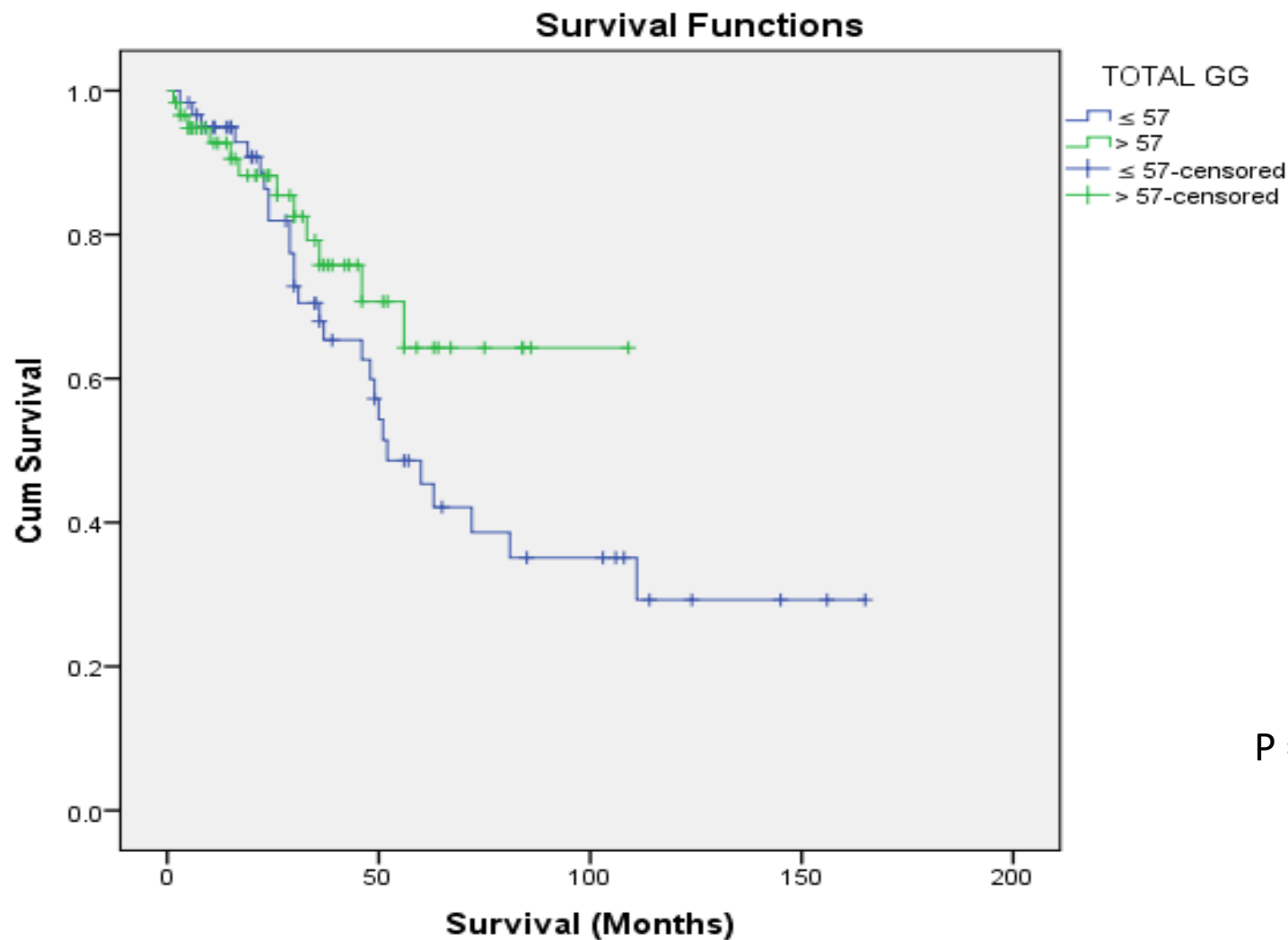
# Survival and age



# Survival and stage of disease

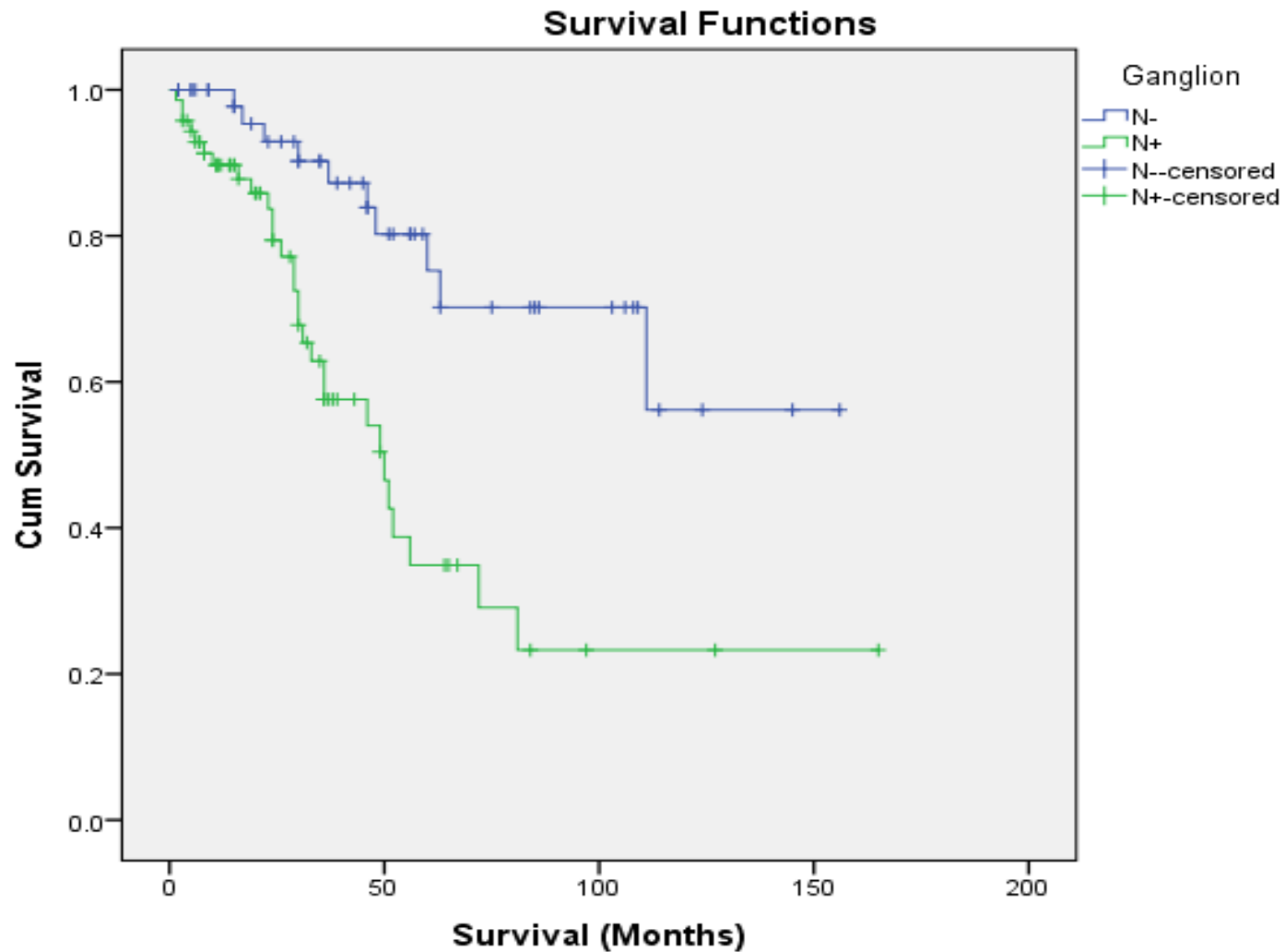


# Total number of removed lymph nodes

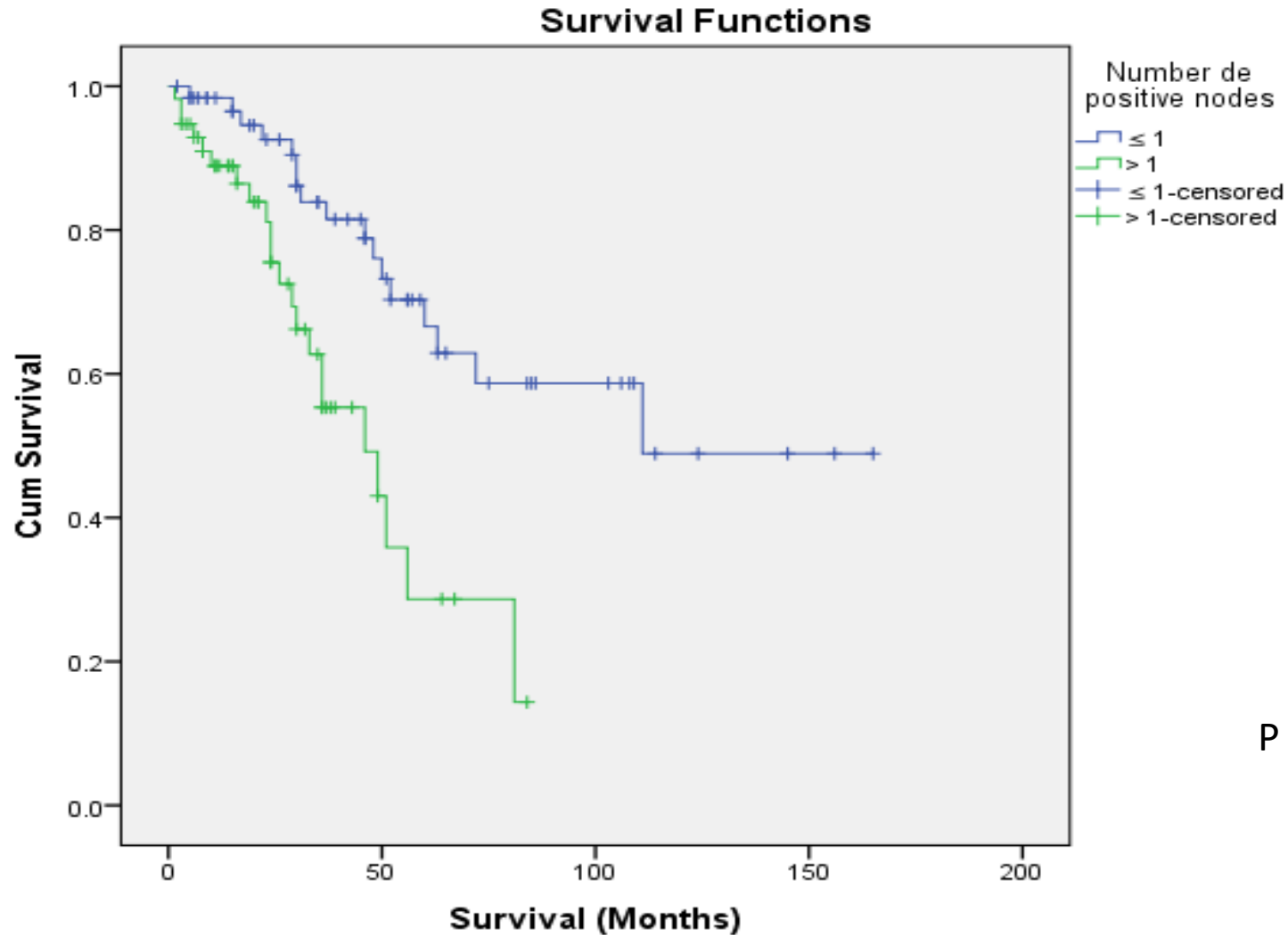




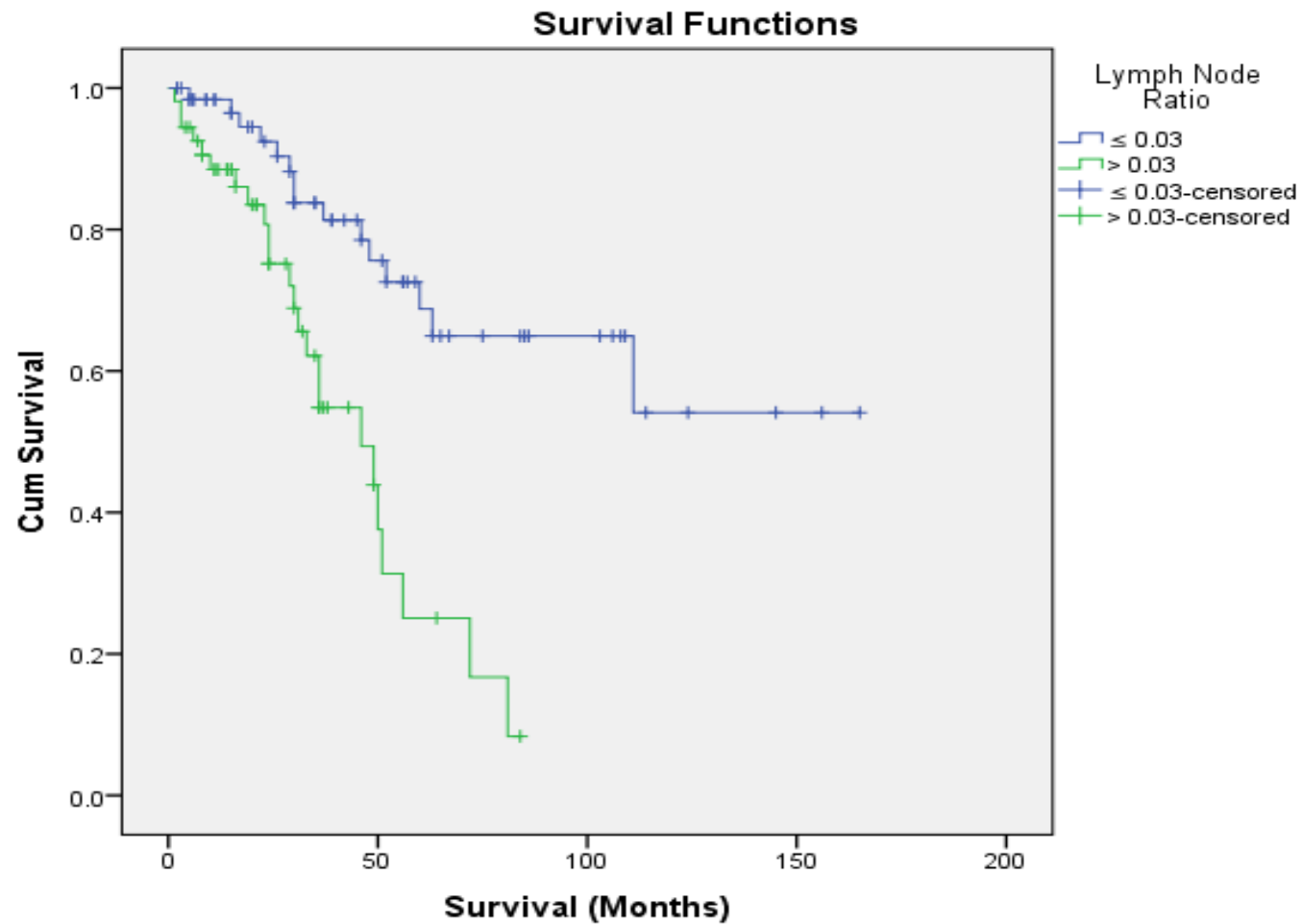
# Survival and nodal status



# Number of positive lymph nodes



# Lymph node ratio

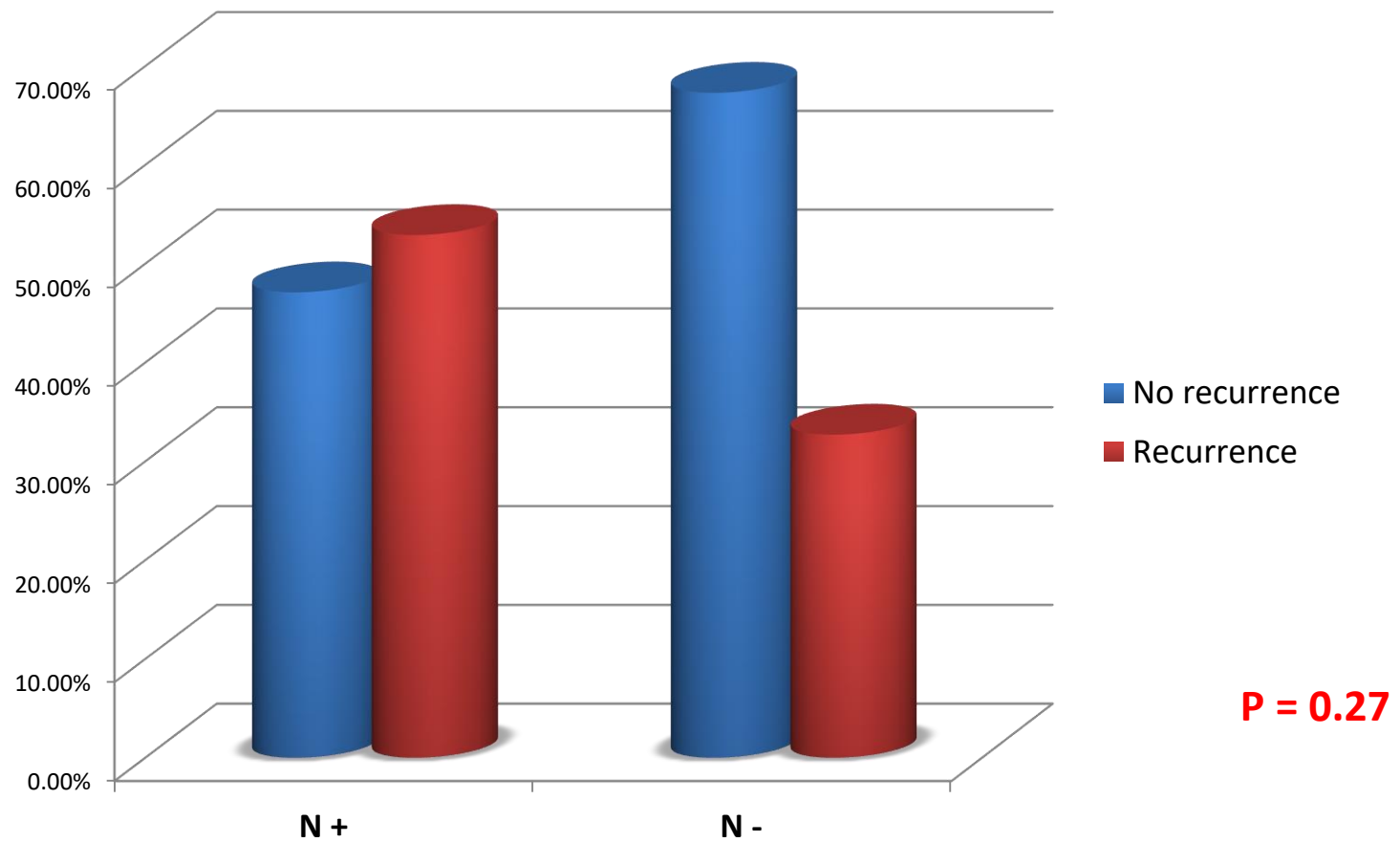


P = 0.000

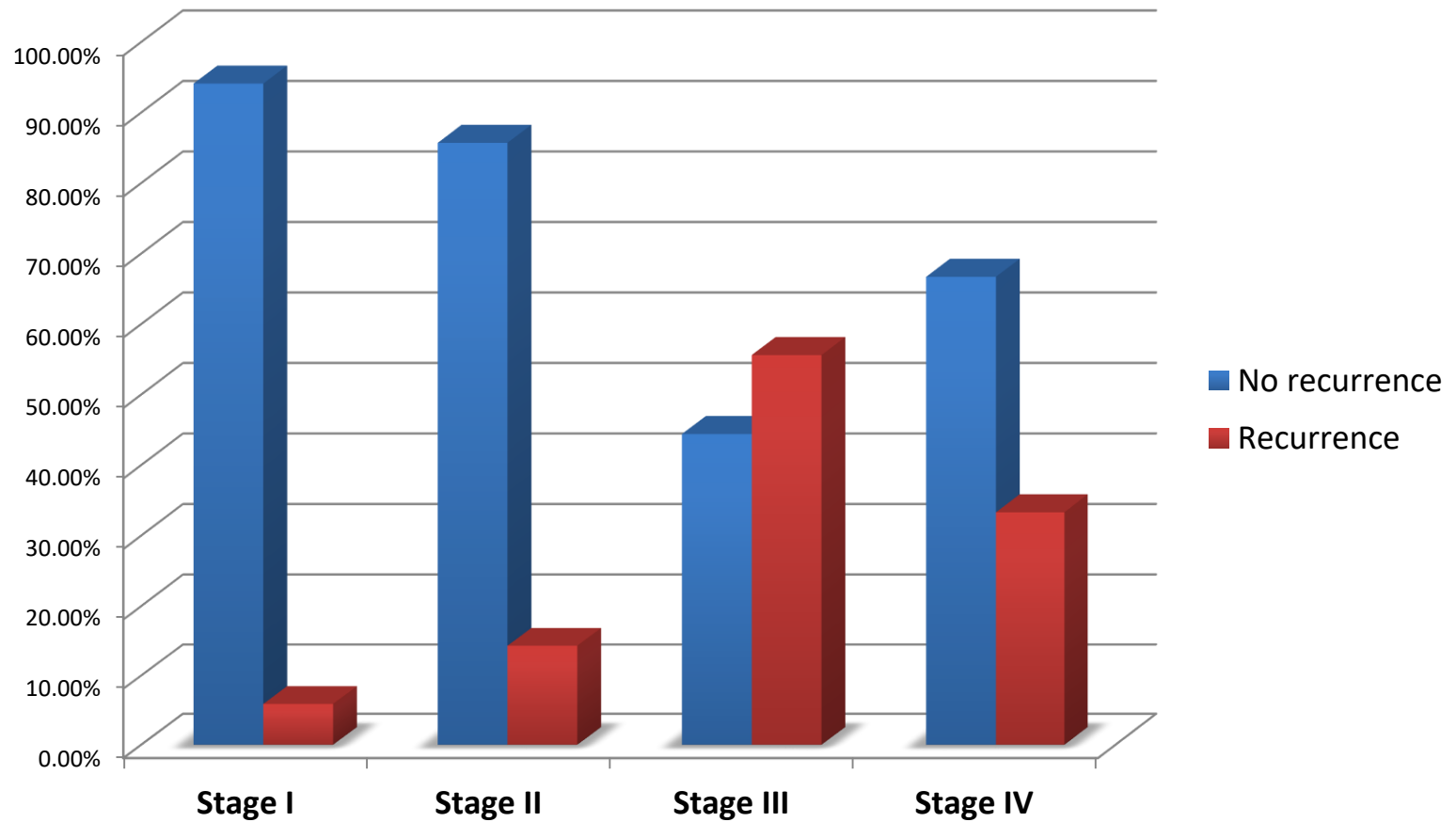


Recurrence

# Recurrence and nodal status



# Recurrence and stage of the disease



**P = 0.000**

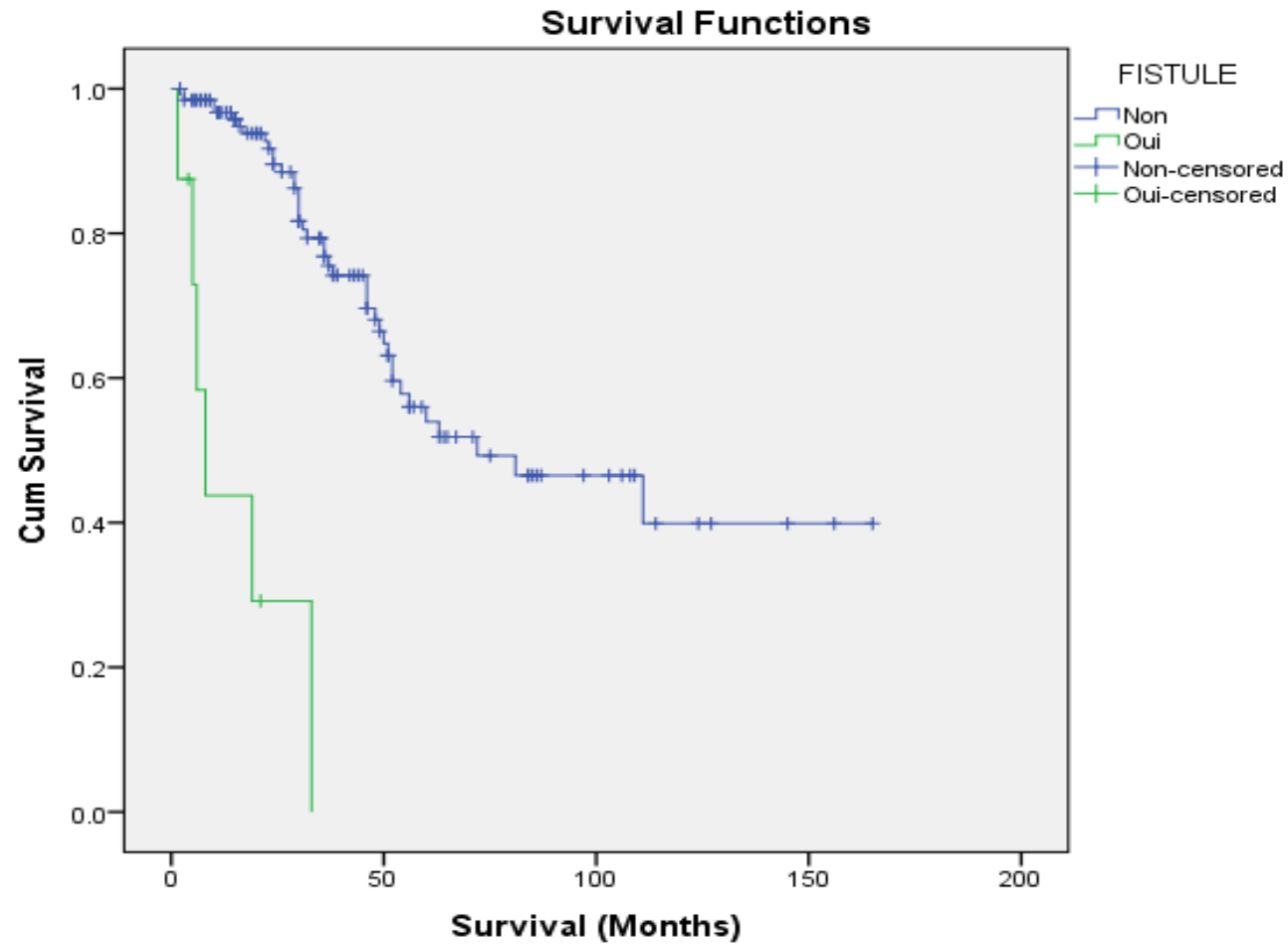


Complication factors

# Lymphadenectomy

	Lymphadenectomy	No Lymphadenectomy	P-value
postoperative complications rate	45%	50%	0.69
mean Transfusion (Nb units)	2.58	2.69	0.845
mean operative time (hours)	7.3	5	0.000

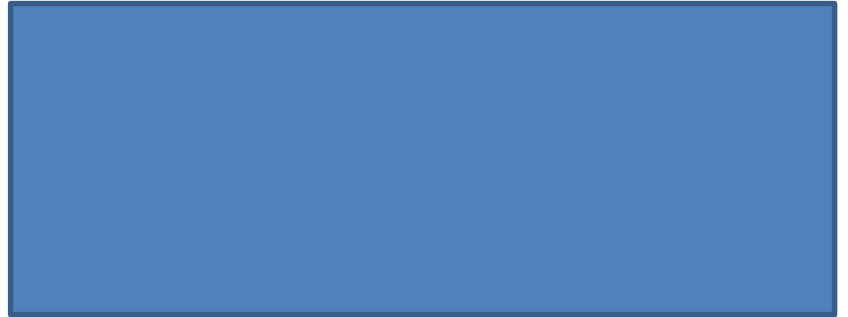
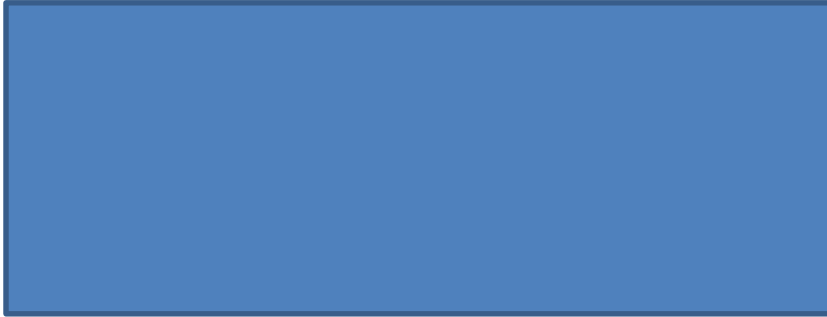
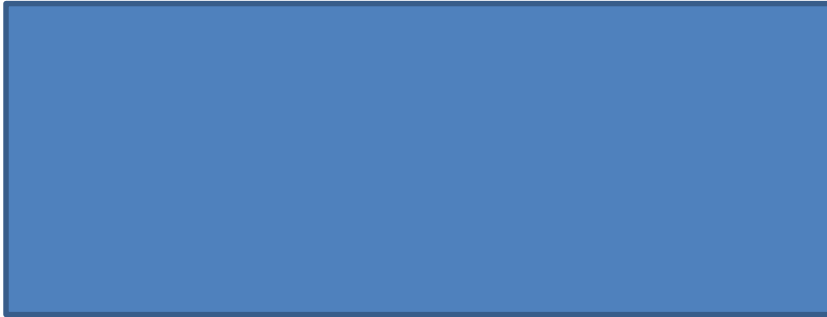
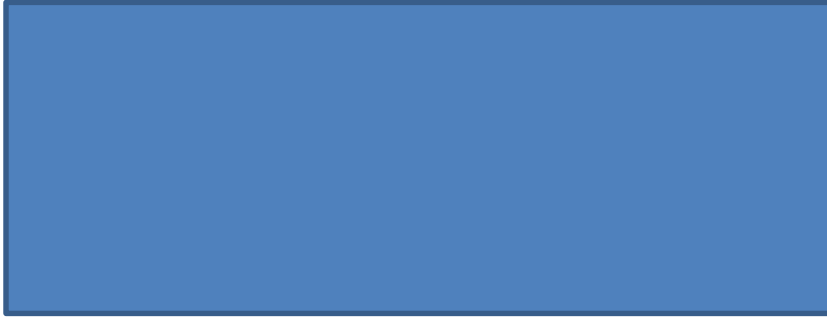
# Impact of fistula on survival



$P = 0.015$



## Predictive factors of fistula



# Conclusion

- Better survival were seen :
  - In younger patients
  - in case of primary (upfront) cytoreductive surgery
  - In early stages
  - When more than 57 lymph nodes were removed
  - In the presence of only one positive lymph node
  - In case of Lymph node ratio  $\leq 0.03$
  - In case of negative lymph node status

Thank You