

بِسْمِ اللَّهِ الرَّحْمَنِ الرَّحِيمِ

A Prospective Randomized Comparative Study in
Management of Advanced Ovarian Carcinoma
(Stage III)

Incidence of Ovarian Cancer

- Among cancers of the female genital tract the incidence of ovarian cancer ranks below only carcinoma of the cervix and the endometrium. Ovarian cancer accounts for 6% of all cancers in the female and is the fifth most common form of cancer in women in the united states (excluding skin cancer).

Epithelial Tumors

- ***Parker et al., 1996*** reported that the vast majority of ovarian carcinoma are epithelial in origin and these account for more than (90%) of the estimated new cases of ovarian carcinoma.

Spread of Ovarian Cancer

- Transcelomic
- Heamatogenous
- Lymphatic
- Direct extension
- Distant Metastases

Staging of Ovarian Cancer

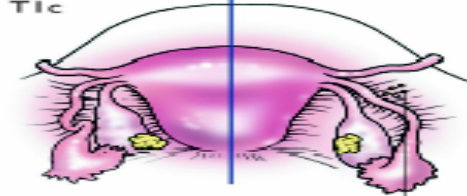
IA
T1a



IB
T1b

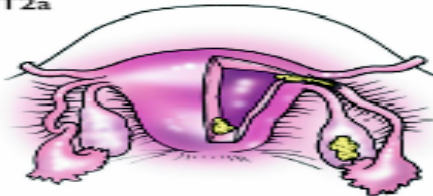


IC
T1c

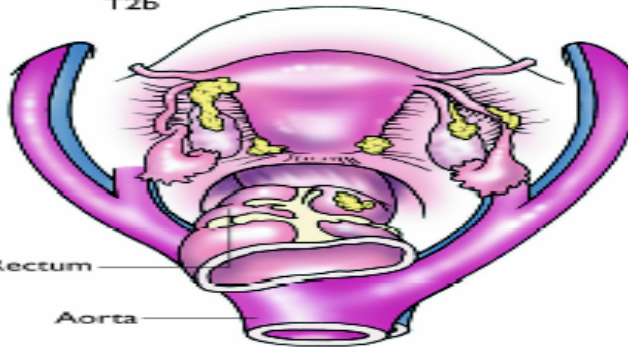


Malignant cells
in ascites

IIA
T2a



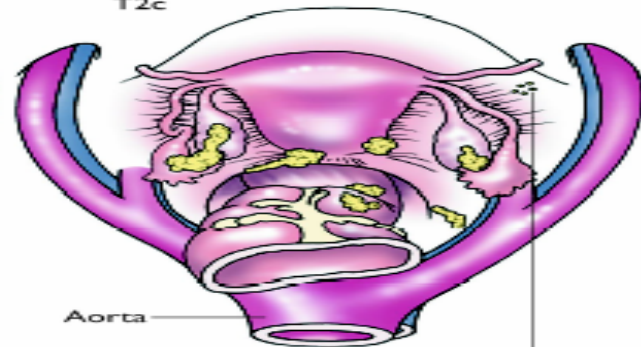
IIB
T2b



Rectum

Aorta

IIC
T2c

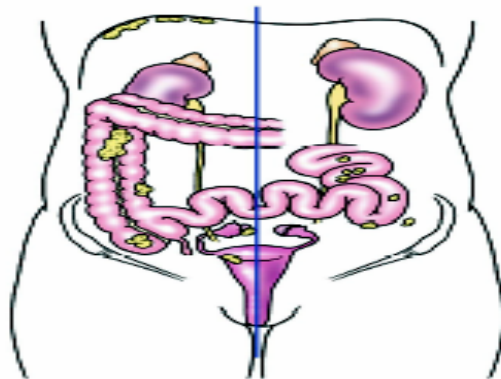


Aorta

Malignant cells
in ascites

III
T3

IIIC/3c
Peritoneal
metastases
≤ 2cm

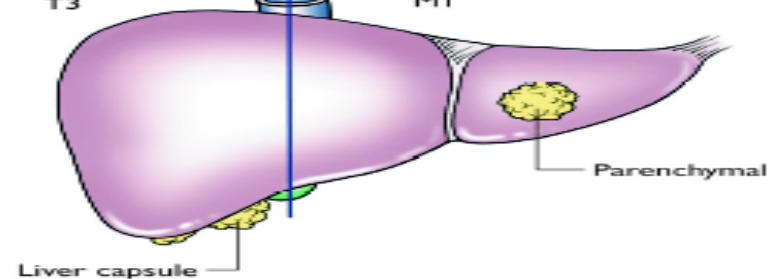


IIIA/3a
Microscopic only

IIIB/3b
Macroscopic
peritoneal
metastases
≤ 2cm

III
T3

IV
M1



Parenchymal

Liver capsule

Surgery in advanced ovarian cancer

- Primary cytoreductive surgery
- Interval cytoreductive surgery
- Secondary cytoreductive surgery
- Palliative surgery

- The theoretical benefits of cytoreductive surgery are to remove large necrotic tumors with poor blood supplies and to remove large tumors that are in slow growth phase, leaving behind tumors that are more sensitive to the effects of chemotherapy (*Hoskins, 1994*).

Neoadjuvant Chemotherapy

- It refers to the administration of chemotherapy before definitive surgery. Initially it was introduced for use in women who were medically unable to tolerate aggressive cytoreductive surgery. Subsequently, it was employed in women who, by diagnostic analysis, were unlikely to undergo successful optimal cytoreductive surgery (***Schwartz 2002***).

Benefits of Neoadjuvant Chemotherapy

- Increase the feasibility of optimal surgical cytoreduction
- Reduced blood loss and shorter operations, intensive care unit stay and overall hospitalization.
- A considerable improvement in the disease-free survival
- Currently it is most beneficial for women who are medically unfit and in women who are found to have such an aggressive cancer that optimal cytoreductive surgery does not appear to be possible (*Schwartz 2002*). Patients treated with neoadjuvant chemotherapy seem to have better but statistically insignificant difference Quality Of Life measurements than the patients treated conventionally (*Chan et al 2003*).

Prognosis

■ Pathological

■ Biological

■ Clinical

Comparative studies between Primary and Interval Debulking in terms of survival

Authors	Adj. N=	Neoadj. N=	Survival	Resectability	Comments
Chambers et al 1990	21	17	S=15 mths C=22 mths (median survival)	S=41.1%	No difference in survival between the two groups
Jacob et al 1991	C1=22 C2=18	22	S=16 mths C1=19.3 mths C2=18 mths (median survival)	S=77% C=39%	Higher rate if tumor resection
Vergote et al 1998	112	173	S=42% C=26% (crude for survival)	S=56% C=89%	Survival is higher and complication as well as mortality were lower
Schwartz et al 1999	206	59	S=1.07 yrs C=2.18 yrs (median survival)	S=69.4% C=51.3%	Blood loss, ICU and hospital stay were lower in the study group
Kuhn et al 2001	32	31	S=42 mths C=23 mths (median survival)	S=83% C=63%	Higher tumor resection and longer median survival

Authors	Adj. N=	Neoadj. N=	Survival	Resectability	Comments
Kayekcioglu et al 2001	160	45	S=30% C=29% (5 yrs survival)	S=75.6% C=63.9%	Larger number of optimal cytoreduction
Ansquer et al 2001		54	22 mths (median survival)	S=72%	Low number of aggressive mutilating procedures and large number of optimal procedures achieved
Mazzeo et al 2003		45	29 mths (median survival)	S=53.3%	Better survival in patients achieving optimal debulking and those showing good response to chemotherapy
Morice et al 2003	28	57	S=27 mths C=29 mths (median survival)	S=52% C=54%	Rates of aggressive surgical resection and morbidity were reduced in the study group
Fanfani et al 2003	111	73	S=26 mths C=3 mths (median survival)	S=47% C=49%	Interval debulking had no benefit over the primary surgical debulking in terms of the diseases-free survival

Aim of study

■ This is a prospective comparative study between 2 modalities of treatment in advanced ovarian carcinoma (stage III) aiming to elicit the most suitable protocol of treatment regarding the disease free survival from the following:

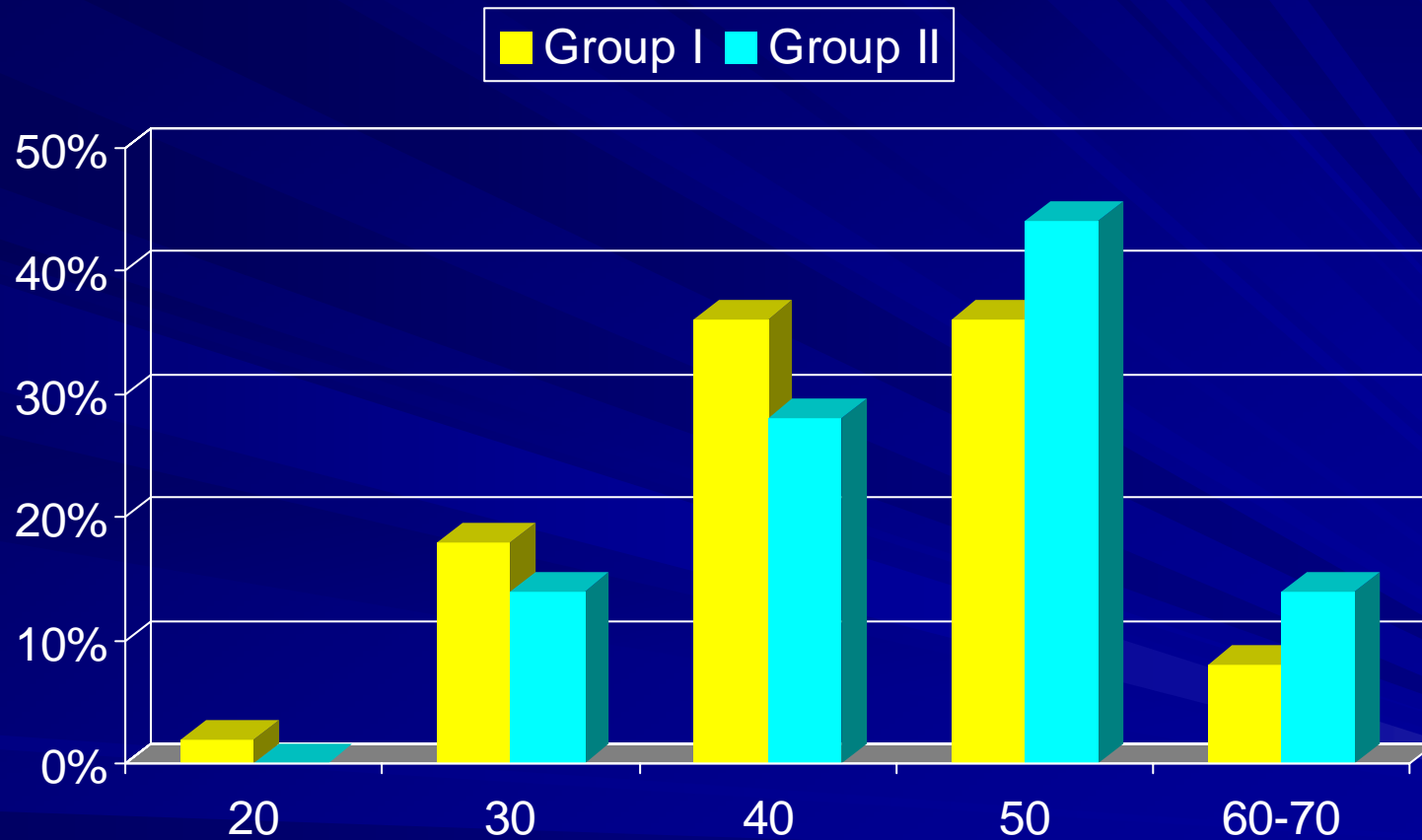
1 - Fifty patients: Neo-adjuvant chemotherapy (three courses) to be followed by surgery then complete another three courses of chemotherapy.

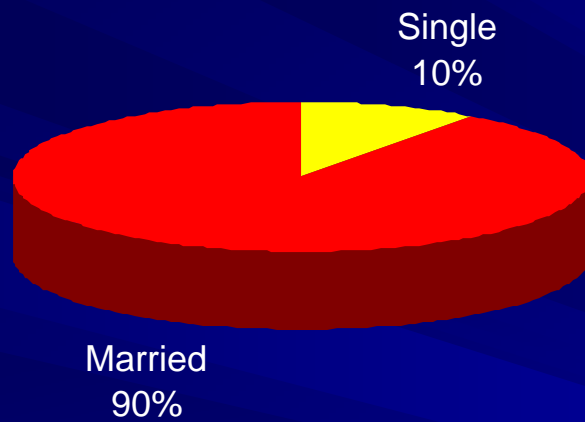
2 – Fifty patients: Surgery then full course of chemotherapy.

Patients and Methods

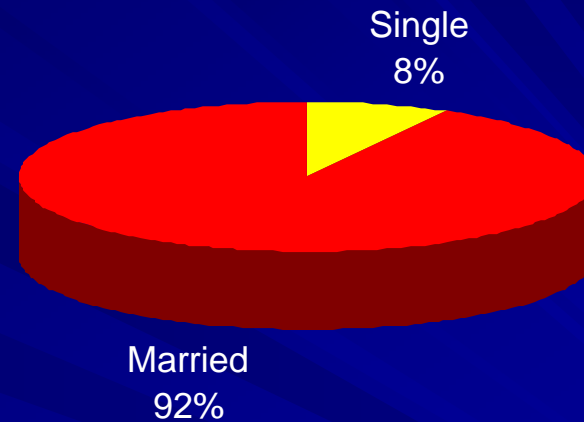
- In the period between Jan 2001 and Dec 2003
- One hundred patients were selected
- Group I included 50 patients
- Group II included another 50 patients
- Follow up periodically every three months for one year.

Comparison of age, among both groups under study





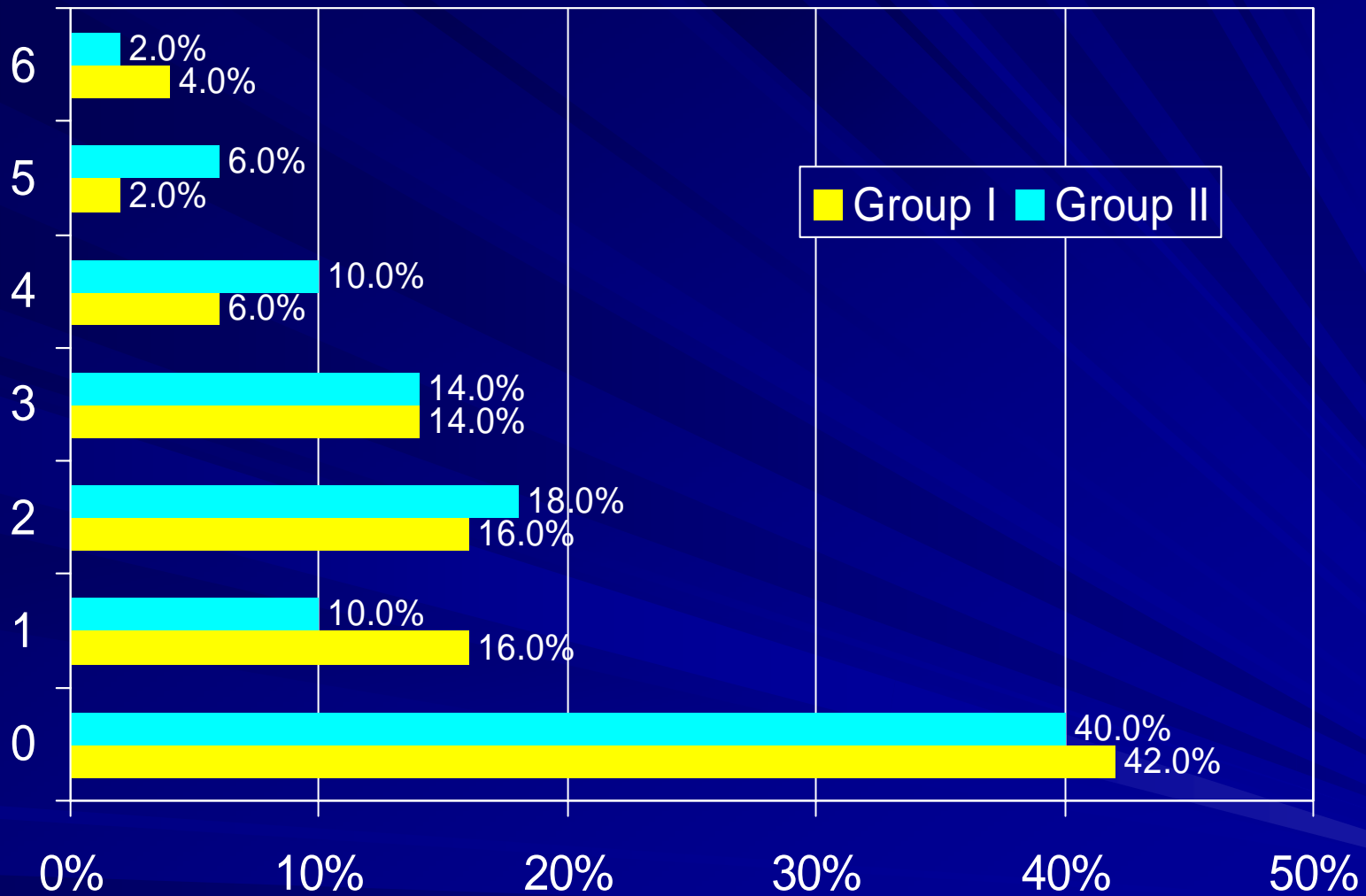
Group I



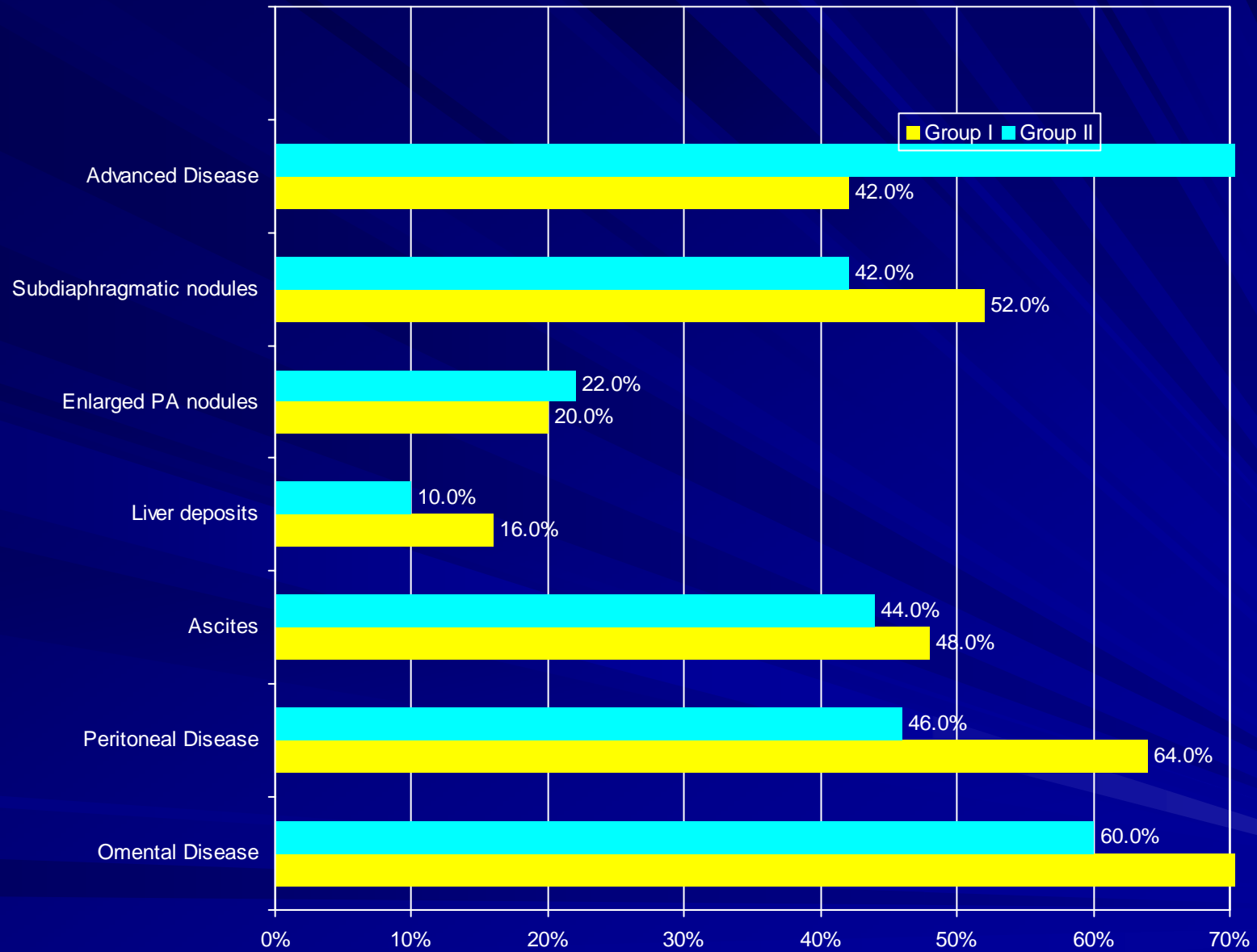
Group II

Comparison of martial status, among both groups under study

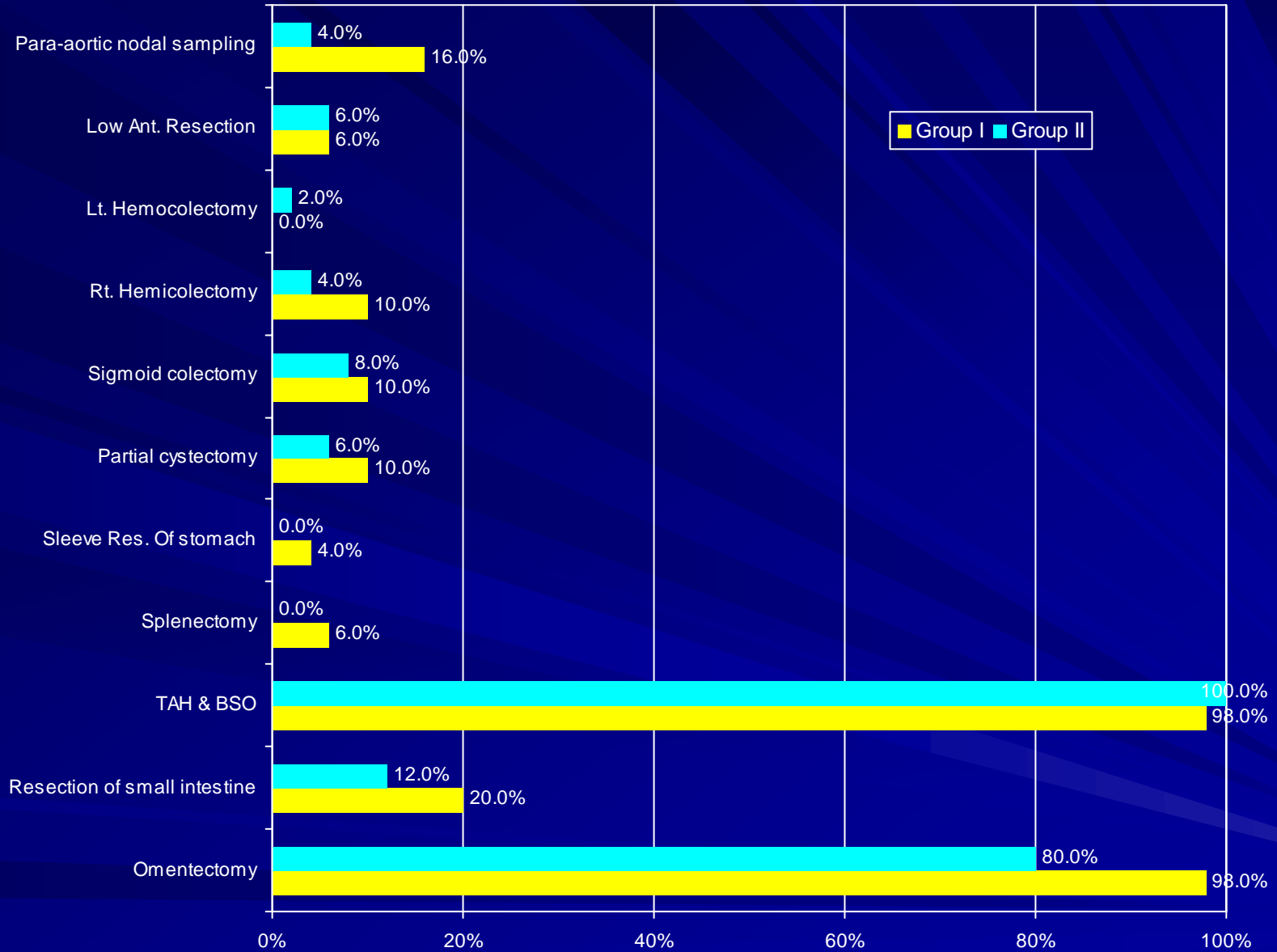
Parity



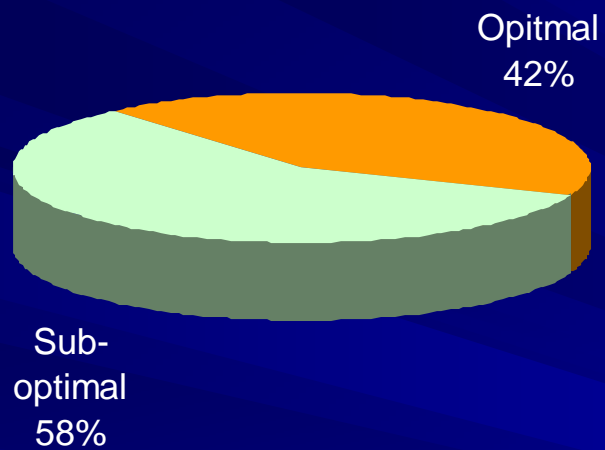
Comparison of Parity, among both groups under study



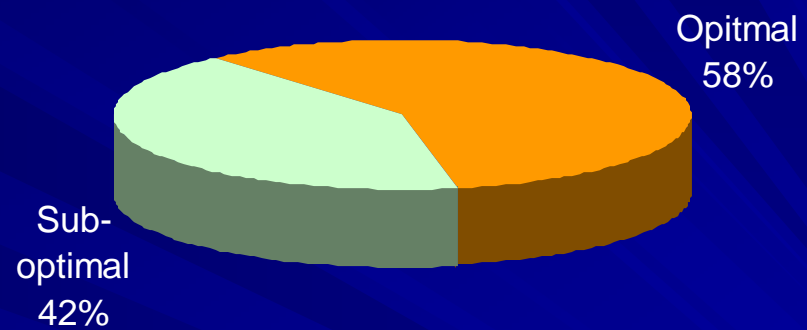
Comparison of laparotomy findings, among both groups under study



Comparison of procedure done among both groups under study

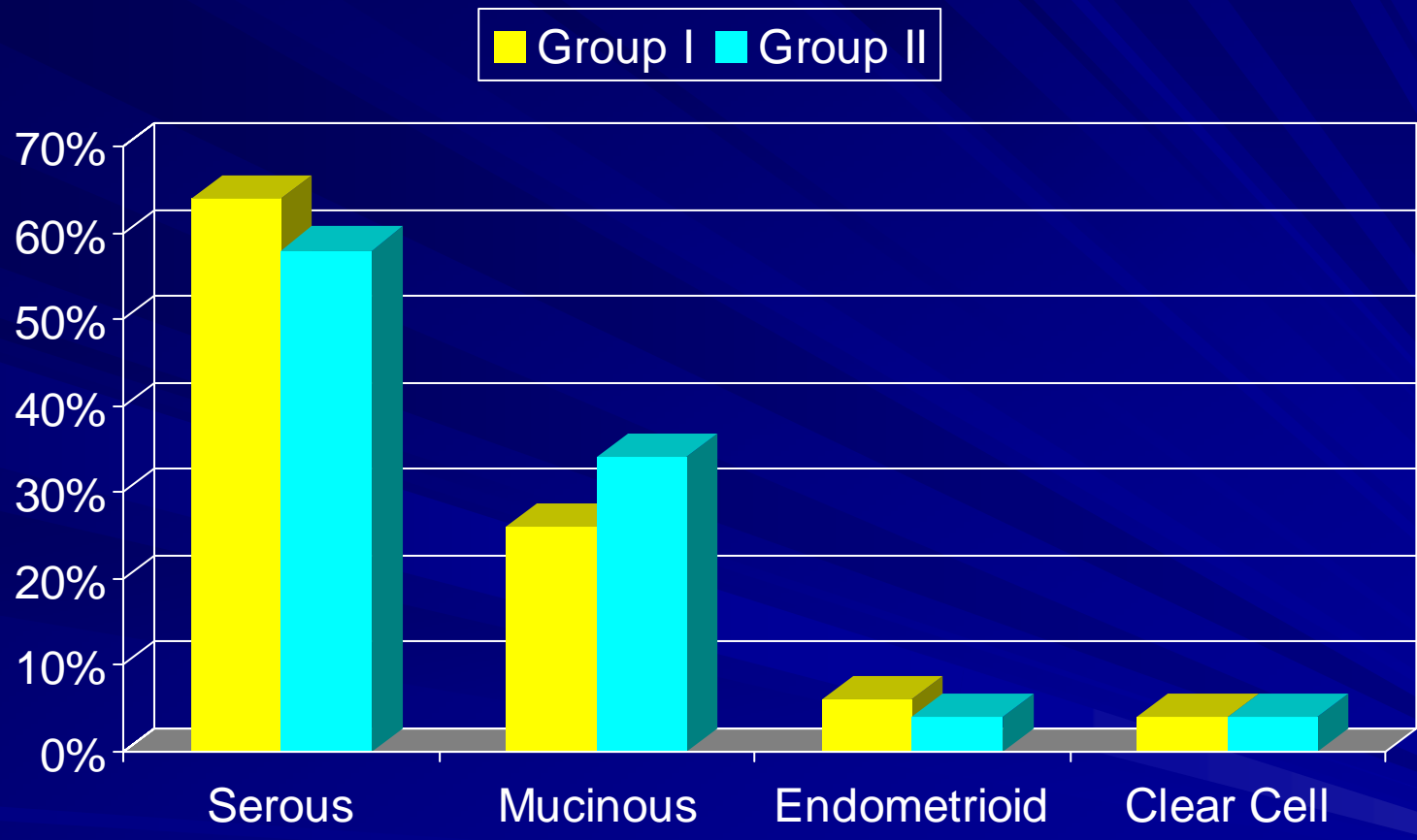


Group I

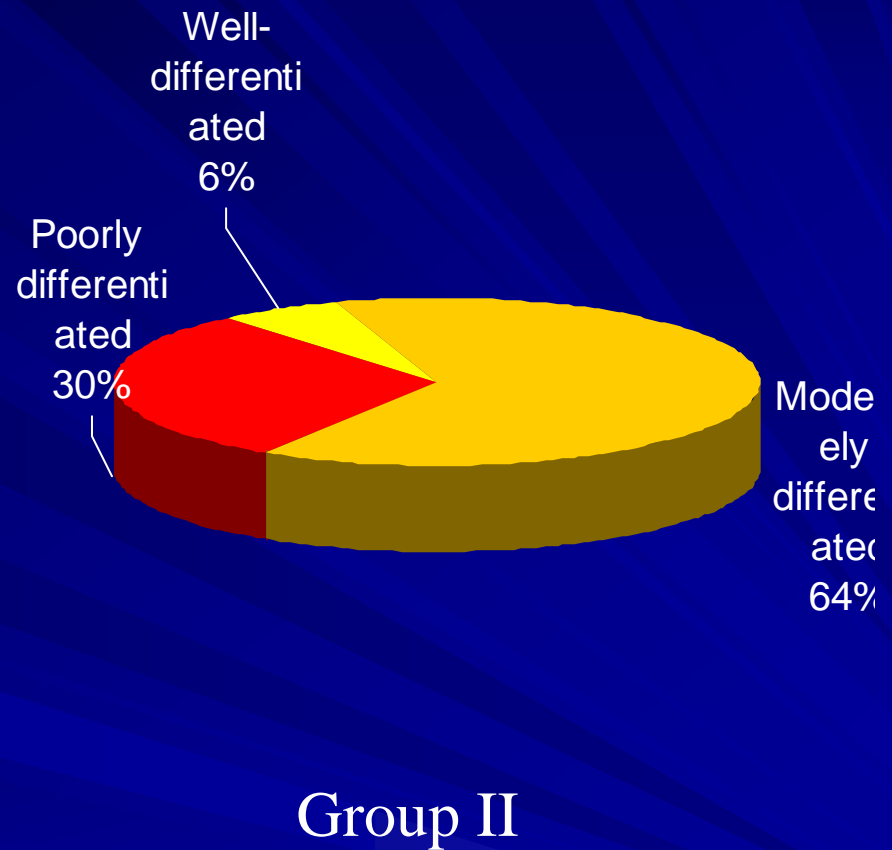
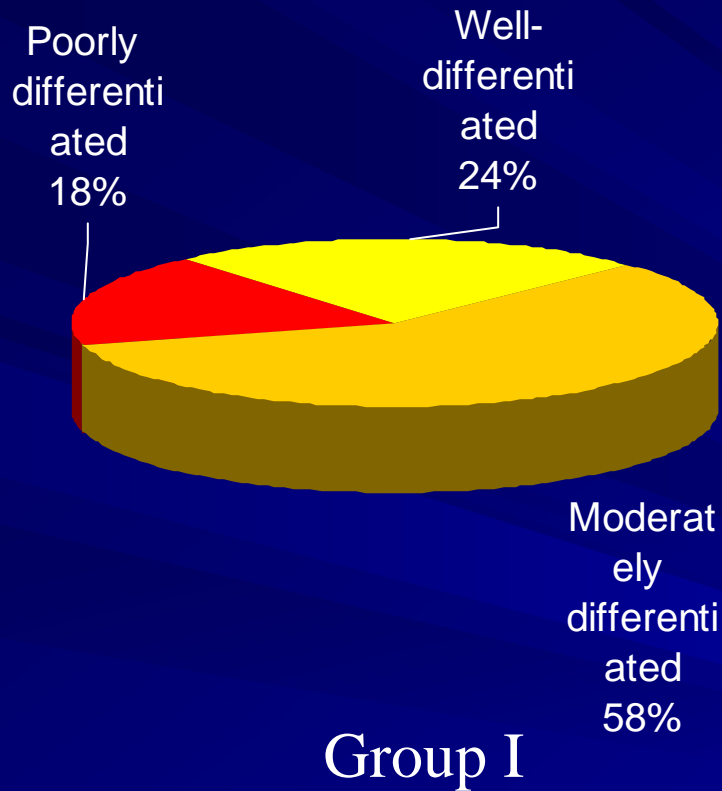


Group II

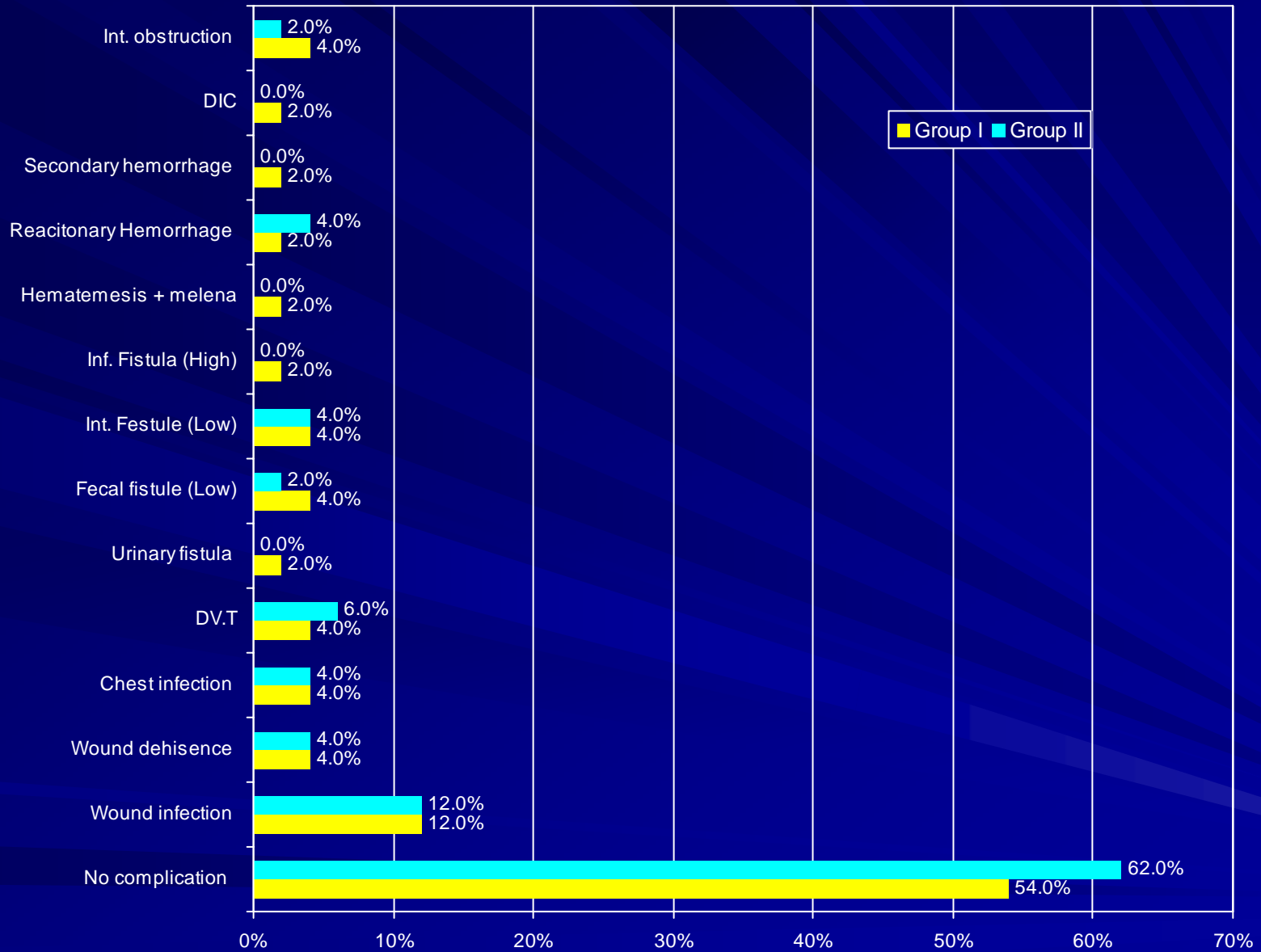
Comparison of degree of debulking, among both groups under study



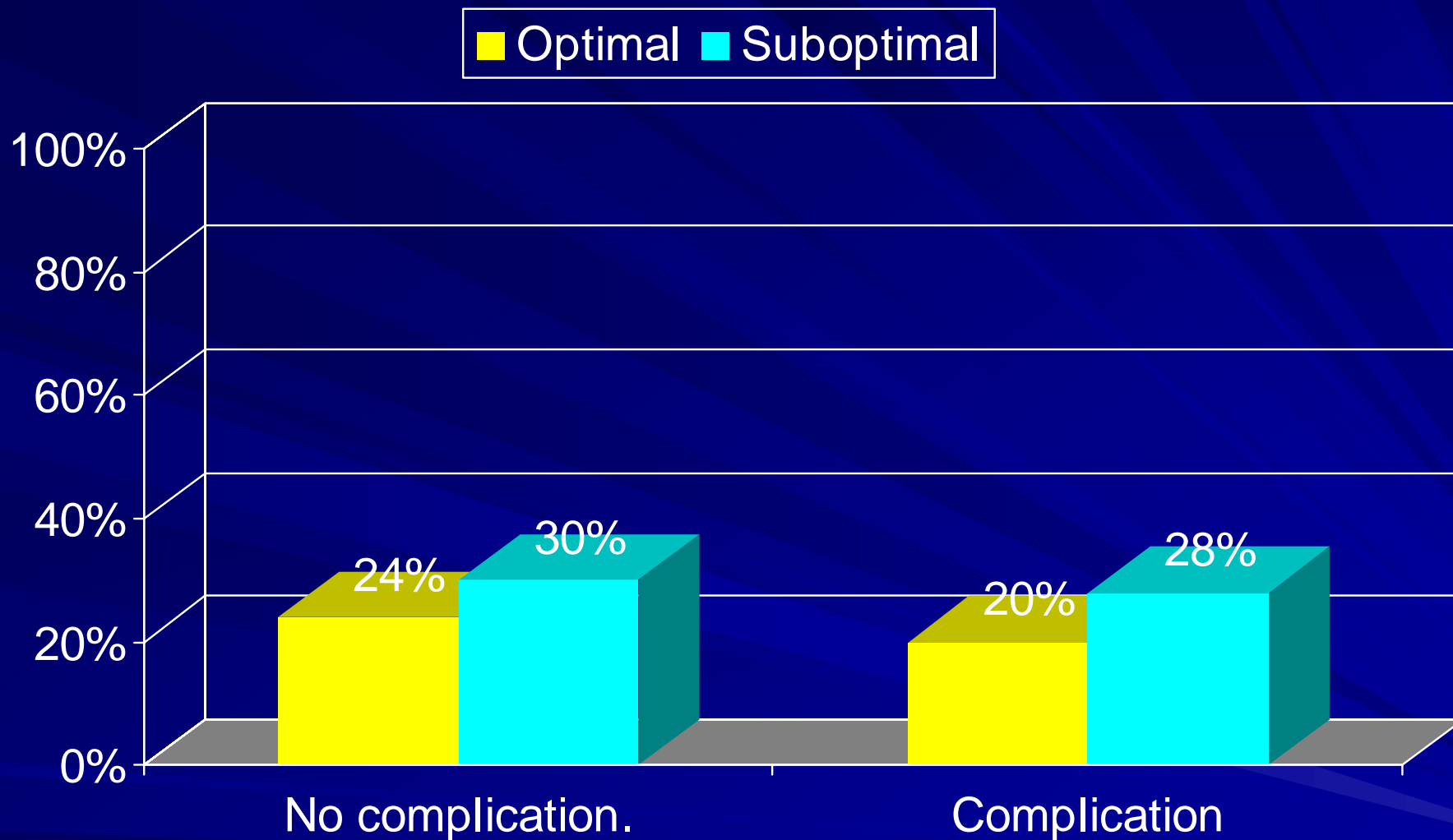
Comparison of pathology, among both groups under study



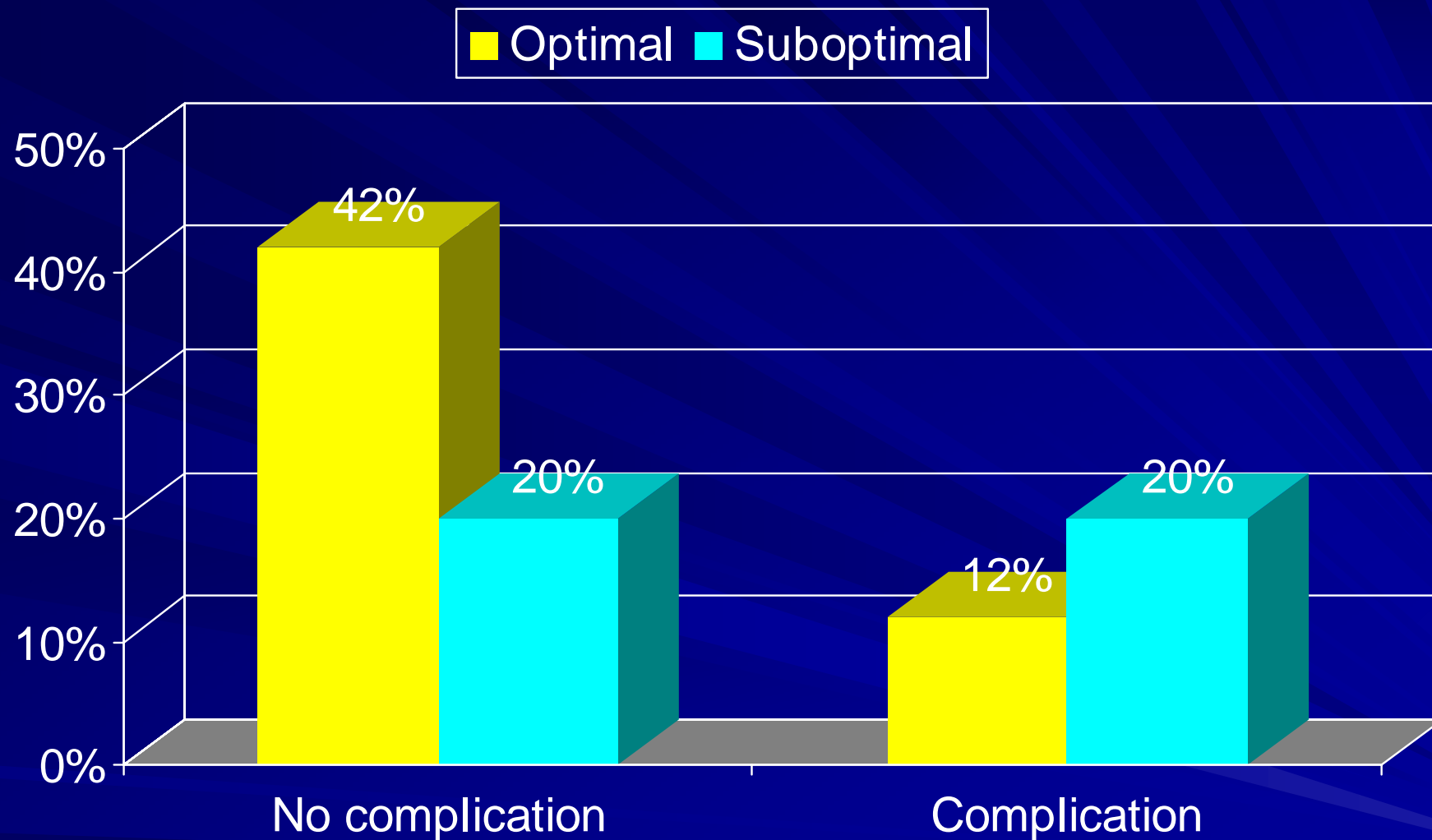
Comparison of histological findings, among both groups under study



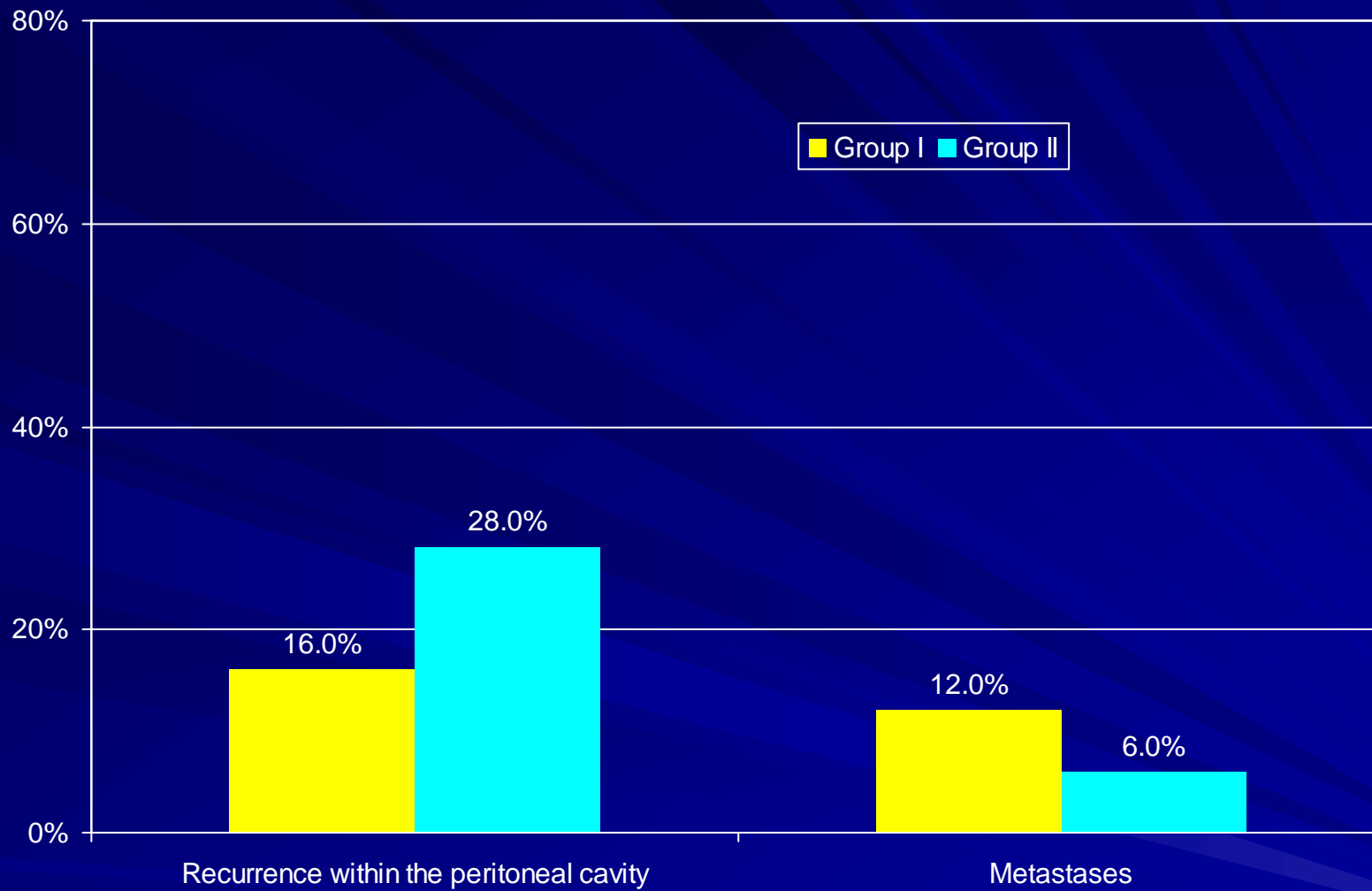
Comparison of complication after debulking, in both groups under study



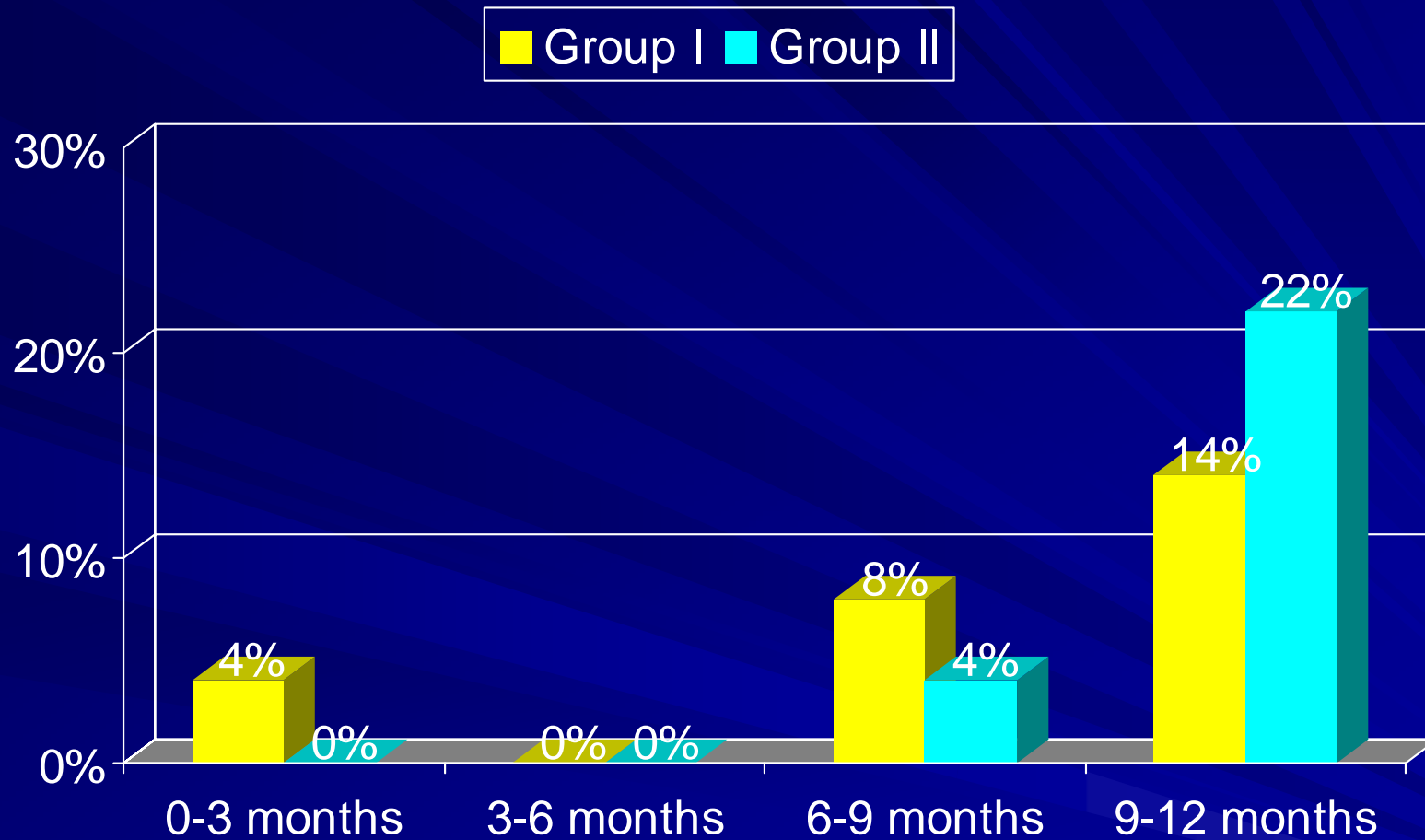
Correlation between postoperative complication and type of debulking in group I



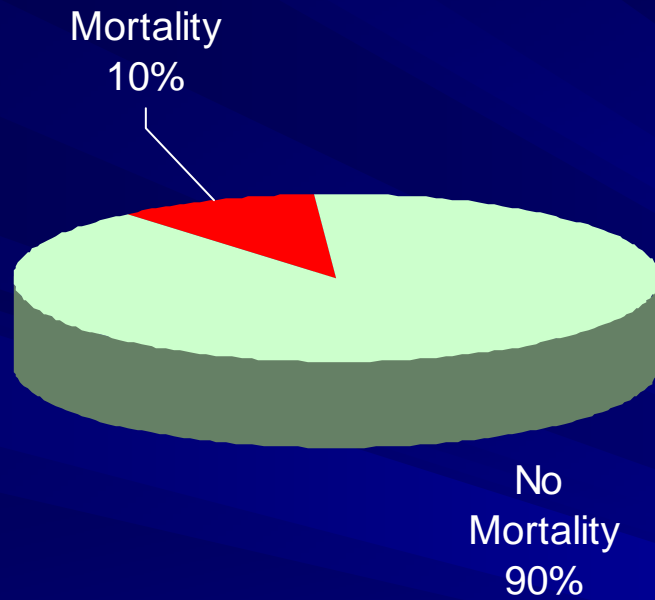
Correlation between postoperative complication and type of debulking in group II



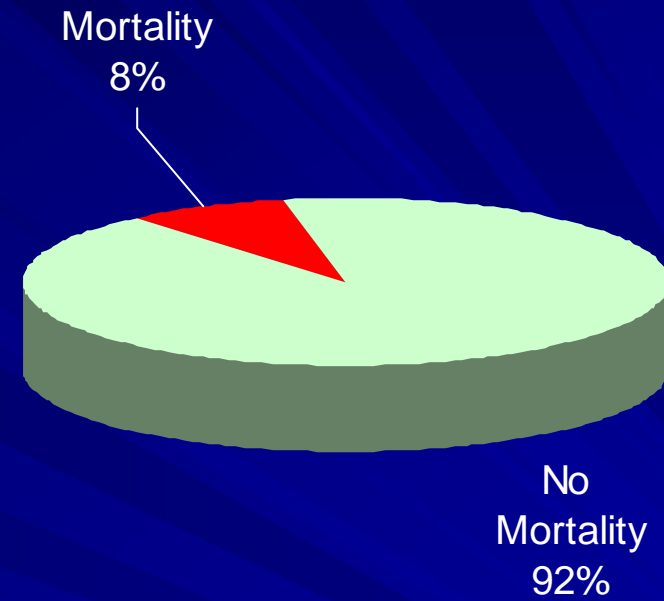
Comparison of disease detected during follow up in both groups



Frequency of disease detected during follow up for 1 year in both groups

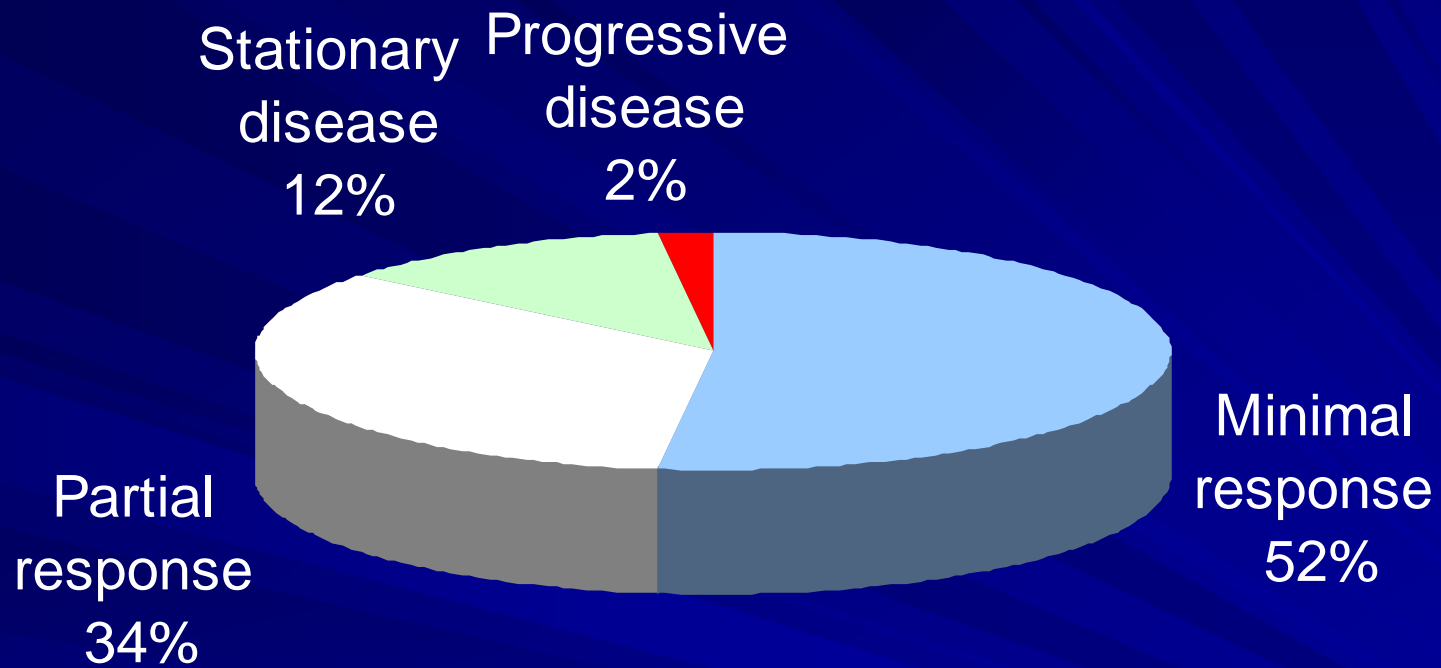


Group I

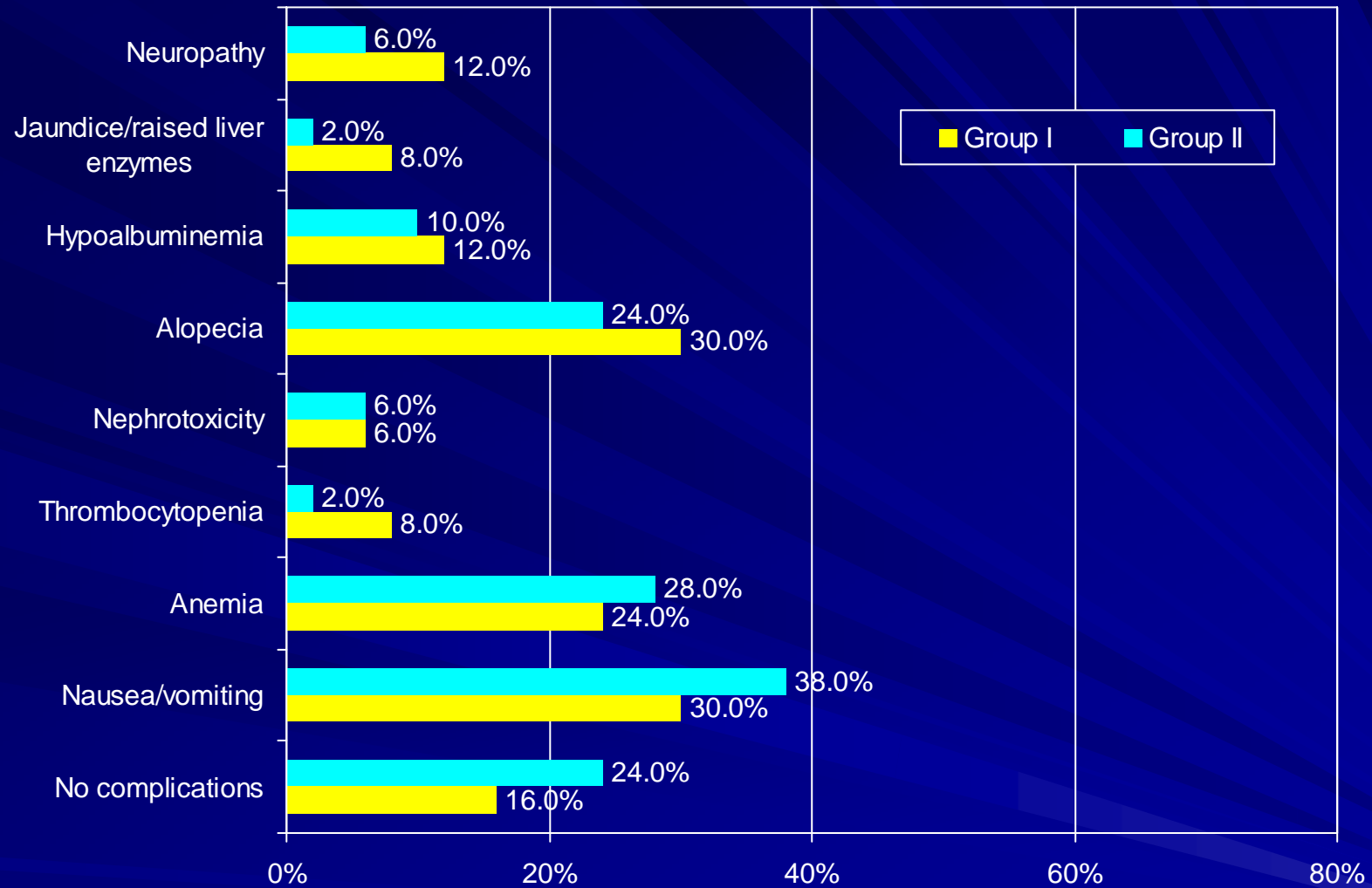


Group II

Comparison of Mortality, among both groups under study

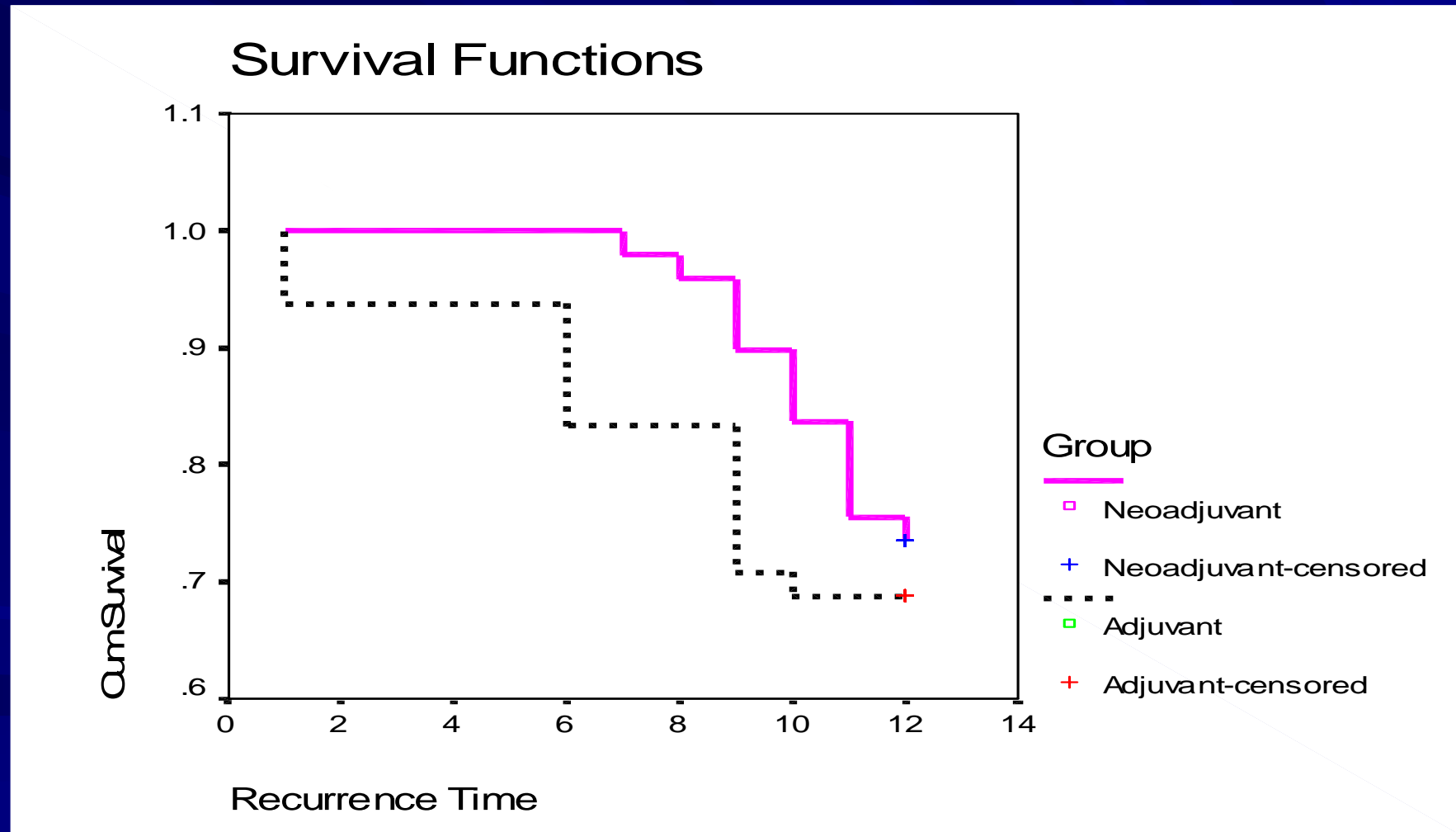


Response to chemotherapy before delayed primary debulking in group II



Comparison of complications during chemotherapy among both groups under study

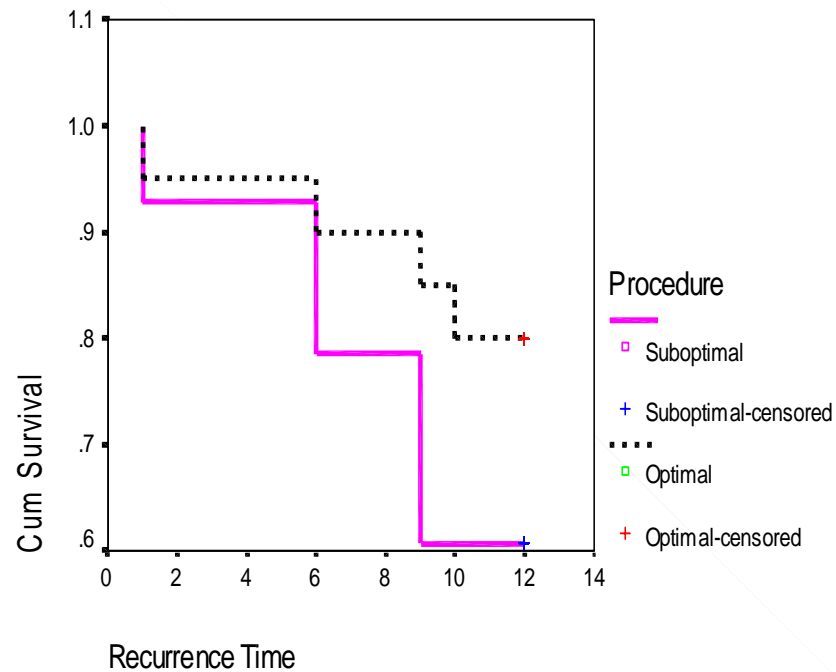
Analysis of disease-free survival in both groups



Analysis of disease-free survival according to the type of procedure

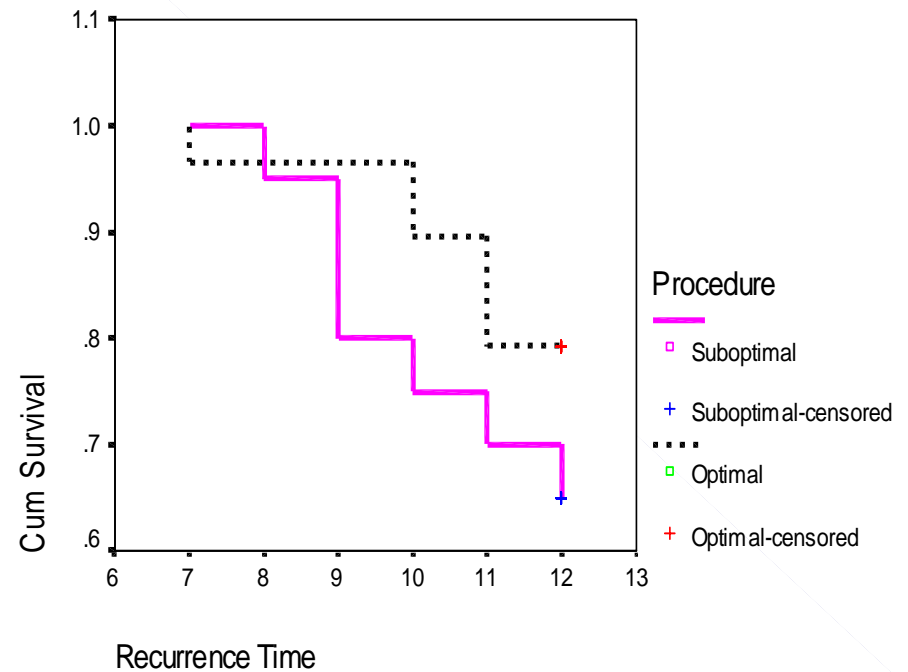
Survival Functions

GROUP: 1.00 Adjuvant



Survival Functions

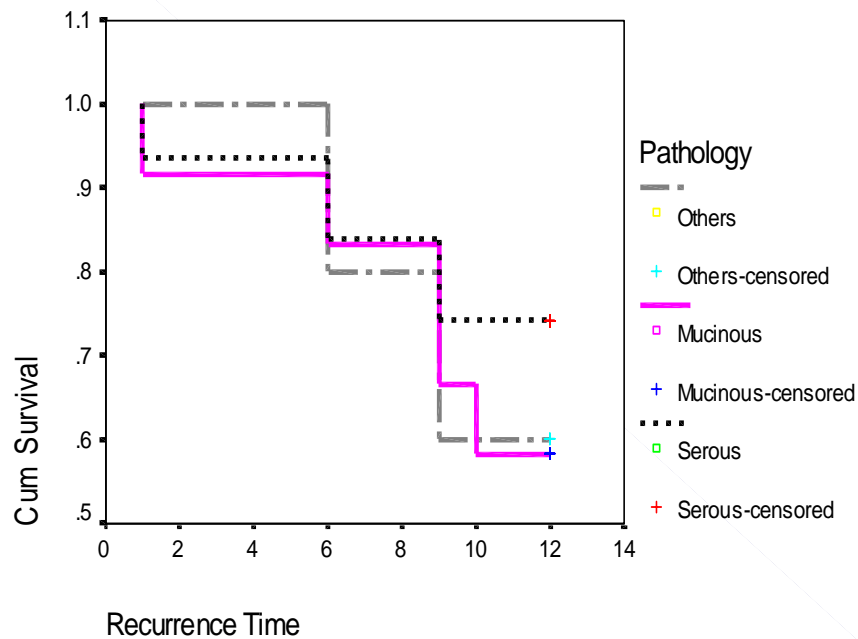
GROUP: 2.00 Neoadjuvant



Analysis of disease-free survival according to the pathology

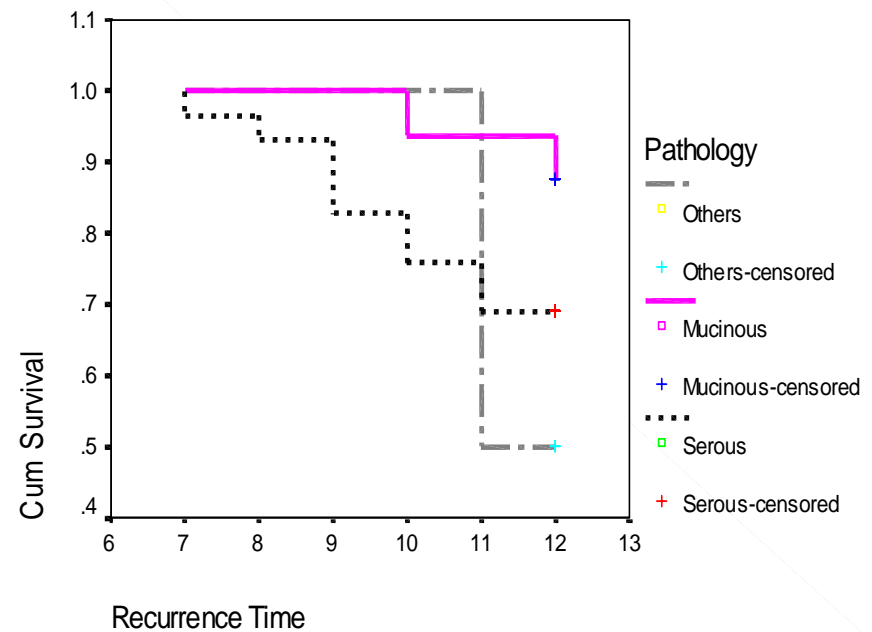
Survival Functions

GROUP: 1.00 Adjuvant

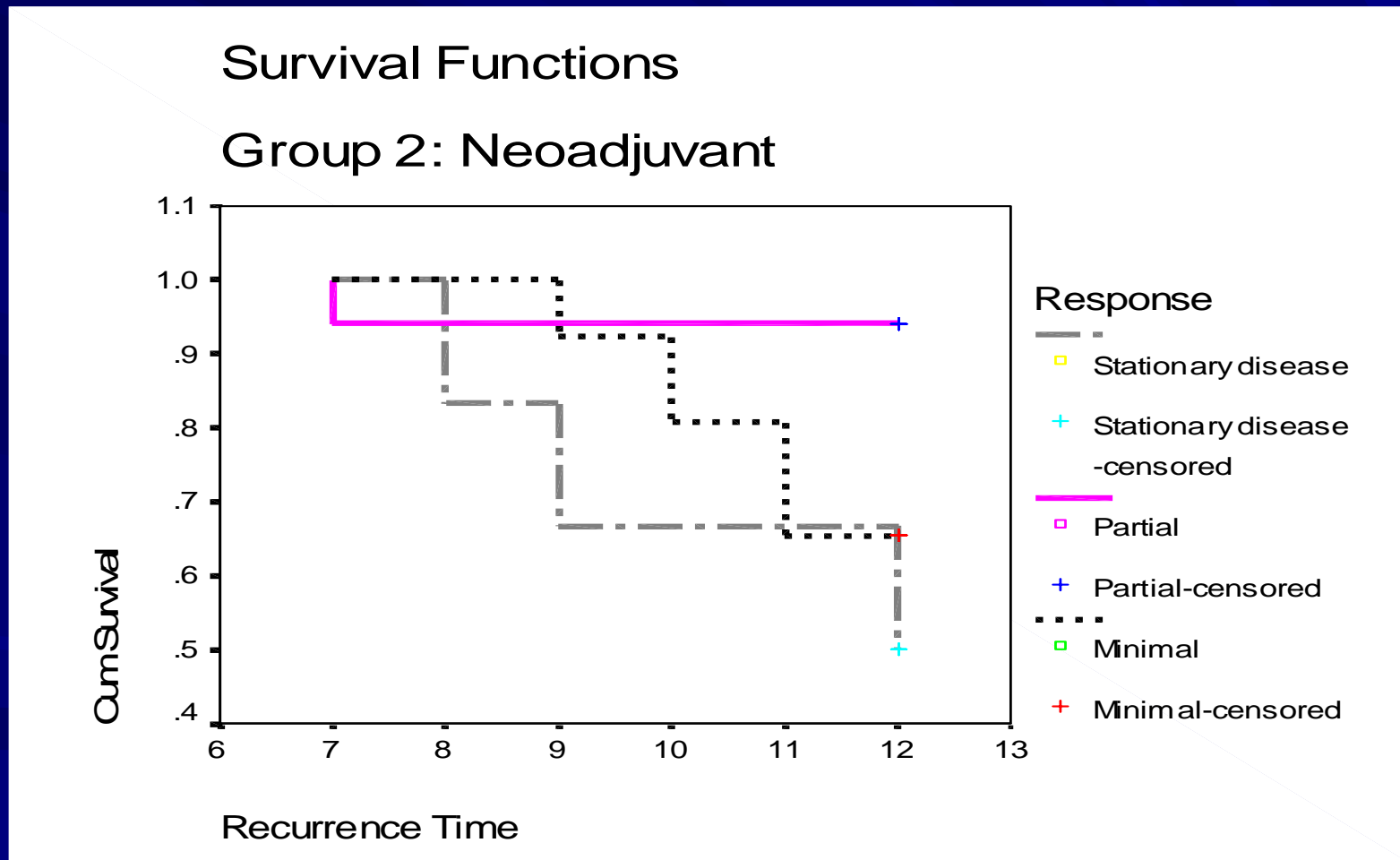


Survival Functions

Group 2: Neoadjuvant



Analysis of disease-free survival according to the response to chemotherapy



conclusion

Advanced unresectable cases have been converted to ■
resectable ones with optimal debulking by the successful
downstaging of neoadjuvant chemotherapy.

Peritoneal resection as well as large bowel resection to ■
achieve optimal debulking have been done with low
complication rate in the group receiving neoadjuvant
chemotherapy

This is a preliminary study and needs a longer follow-up ■
and larger sample size to clarify the benefits of
neoadjuvant chemotherapy and interval cytoreduction on
stage III ovarian cancer.

Thank you

The image features a dark blue background with a pattern of lighter blue diagonal lines radiating from the center. In the center, the words "Thank you" are written in a bold, italicized, sans-serif font. The text is rendered in a 3D style with a yellow-to-gold gradient and a dark shadow beneath it, giving it a sense of depth and movement.