מפגש משותף של החברה הישראלית לגינקולוגיה אונקולוגית
והחוג לרדיותרפיה של האיגוד הישראלי לאונקולוגיה קלינית ורדיותרפיה

יום שישי, 9 בדצמבר 2016

מועדי מפגשים -2017

7.2.2017 יום המתמחה - שרתון קראון פלזה

23-25.2.2017 כירורגיה בגינקולוגיה אונקולוגית - רמות

30.6.2017 Rare Tumors - בית מטי

24.11.2017 סרטן בהריון - בית מטי

The Israeli Society of Gynecologic Oncology
החברה הישראלית לגינקולוגיה אונקולוגית

להקרין או לא להקרין

טיפול אדג'וונטי בסרטן גינקולוגי

Rate of post operative adjuvant radiotherapy in multicenter Israeli studies

- **Endometrial cancer 31.4%** (265/843 patients)

  Gemer *et al* EJSO 2009

- **Cervical cancer 57.2%** (343/599 patients)

  Gemer *et al* Int J Gyn Cancer 2014

Endometrial cancer - guidelines

All staging in guideline is based on updated 2010 FIGO staging. (See ST-1)

CLINICAL FINDINGS	ADVERSE RISK FACTORS[m]	HISTOLOGIC GRADE/ADJUVANT TREATMENT[e,n,o] G1	G2	G3
Surgically staged: Stage I[d] — Stage IA (<50% myometrial invasion)	Adverse risk factors not present	Observe	Observe or Vaginal brachytherapy	Observe or Vaginal brachytherapy
	Adverse risk factors present	Observe or Vaginal brachytherapy	Observe or Vaginal brachytherapy and/or EBRT (category 2B for EBRT)	Observe or Vaginal brachytherapy and/or EBRT
Stage IB (≥50% myometrial invasion)	Adverse risk factors not present	Observe or Vaginal brachytherapy	Observe or Vaginal brachytherapy	Vaginal brachytherapy and/or EBRT or Observe (category 2B for observation)
	Adverse risk factors present	Observe or Vaginal brachytherapy and/or external beam radiation therapy (EBRT)	Observe or Vaginal brachytherapy and/or EBRT	EBRT and/or Vaginal brachytherapy ± chemotherapy[g,p] (category 2B for chemotherapy)

[d]The degree of surgical staging to assess disease status depends on intraoperative findings. Multidisciplinary expertise is recommended. See Principles of Evaluation and Surgical Staging (ENDO-B).
[e]See Principles of Radiation Therapy for Uterine Neoplasms (UN-A).
[g]See Systemic Therapy for Recurrent, Metastatic, or High-Risk Disease (ENDO-C).
[m]See Discussion for information on adverse risk factors.
[n]Adjuvant therapy determinations are made on the basis of pathologic findings.
[o]Initiate RT as soon as the vaginal cuff is healed, preferably no later than 12 weeks after surgery.
[p]The role of adjuvant chemotherapy in invasive, high-grade, uterine-confined disease is the subject of current studies. (Hogberg T, Signorelli M, de Oliveira CF, et al. Sequential adjuvant chemotherapy and radiotherapy in endometrial cancer--results from two randomised studies. Eur J Cancer 2010;46:2422-2431.) Hormonal therapy is not used for high-grade disease.

Note: All recommendations are category 2A unless otherwise indicated.
Clinical Trials: NCCN believes that the best management of any cancer patient is in a clinical trial. Participation in clinical trials is especially encouraged.

See Surveillance (ENDO-9)

ESMO-ESGO-ESTRO Consensus Conference on Endometrial Cancer Diagnosis, Treatment and Follow-up

Nicoletta Colombo, Carien Creutzberg, Frederic Amant, Tjalling Bosse, Antonio Gonza´lez-Martı´n, Jonathan Ledermann, Christian Marth, Remi Nout, Denis Querleu, Mansoor Raza Mirza,

Cristiana Sessa, and the ESMO-ESGO-ESTRO Endometrial Consensus Conference Working Group

TABLE 2. New risk groups to guide adjuvant therapy use

Risk group	Description	LOE
Low	Stage I endometrioid, grade 1–2, <50% myometrial invasion, LVSI negative	I
Intermediate	Stage I endometrioid, grade 1–2, ≥50% myometrial invasion, LVSI negative	I
High-intermediate	Stage I endometrioid, grade 3, <50% myometrial invasion, regardless of LVSI status	I
	Stage I endometrioid, 1–2, LVSI unequivocally positive, regardless of depth of invasion	II
High	Stage I endometrioid, grade 3, ≥50% myometrial invasion, regardless of LVSI status	I
	Stage II	I
	Stage III endometrioid, no residual disease	I
	Non endometrioid (serous or clear cell	I

“If there is no God, everything is permitted.”

Fyodor Dostoevsky

Which guidelines do you follow?

- NCCN?
- ESMO?

- Age 60
- Endometrial biopsy EEC 1
- LH+ BSO (no lymphadenectomy)

- **Final Histology : EEC G2 , Invading more than half**

- Recommendation?

- How would LVSI , LUSI, Age influence decision in this case?

- Age 60
- Endometrial biopsy EEC 1
- LH+ BSO, (no lymphadenectomy)

- **Final Histology : EEC G3 , Invading less than half**

- Recommendation?

- How would LVSI, LUSI, Age influence decision in this case?

- Age 60
- Endometrial biopsy EEC 1
- LH+ BSO, (no lymphadenectomy)

- **Final Histology : EEC G3 , no invasion**

- Recommendation?

- How would LUSI, Age influence decision in this case?

- Age 60
- Endometrial biopsy EEC 3
- LH+ BSO, pelvic + para-aortic node sampling

- **Final Histology : EEC 3 , Deep invasion, nodes negative**

- Recommendation?

- How would LUSI, Age influence decision in this case?

- Hysteroscopic polypectomy – uterine serous papillary
- LH, BSO, SLNB, infracolic omentectomy

- Final histology NED slnb- negative

- Recommendation?

- Final histology - USPC , no invasion, slnb- negative

- Recommendation?

- **Final histology - USPC , deep invasion, slnb- negative**
- Recommendation?

- Age 60
- Endometrial biopsy EEC G3
- LH BSO Bilateral pelvic lymphadenectomy

- **Final histology EEC G3 invasion less than half**
- **8 nodes on right – negative**
- **2 nodes on left – negative**

- How would minimal number of nodes affect recommendation?
- How would one sided nodes affect recommendation?

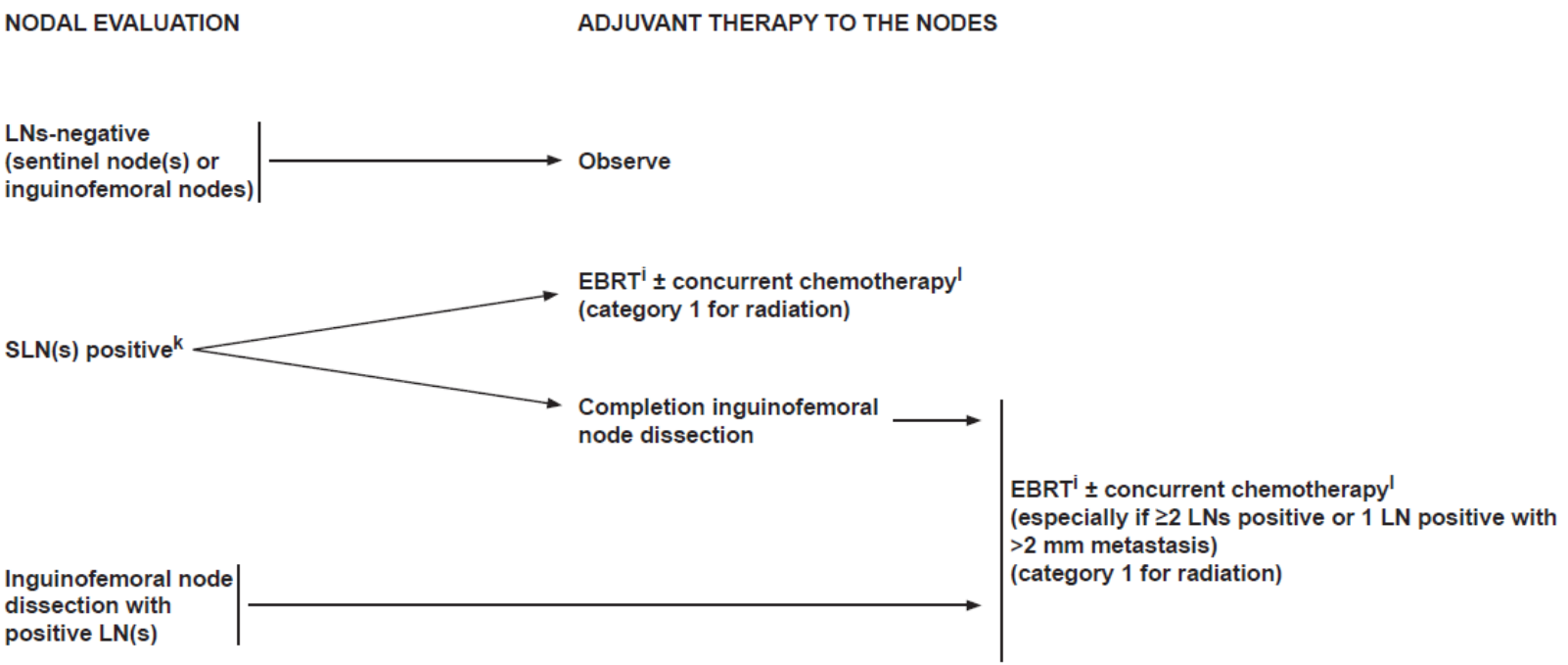
- Age 62
- Endometrial biopsy EEC G1
- LH BSO Bilateral SLNB

- **Final Histology: EEC G1 Deep invasion**
- **SN – Lt external iliac- micro metastasis**
- Recommendation?

- **SN – Lt external iliac- isolated tumor cells**
- Recommendation?

- **SN – Lt common iliac – metastatic tumor**
- Recommendation?

Vulvar cancer



[i] See Principles of Radiation Therapy (VULVA-C).
[k] See Principles of Surgery: Inguinofemoral Sentinel Lymph Node Procedure (VULVA-B 3 of 4).
[l] See Systemic Therapy (VULVA-D).

Note: For more information regarding the categories and definitions used for the NCCN Evidence Blocks™, see page EB-1.
All recommendations are category 2A unless otherwise indicated.
Clinical Trials: NCCN believes that the best management of any patient with cancer is in a clinical trial. Participation in clinical trials is especially encouraged.

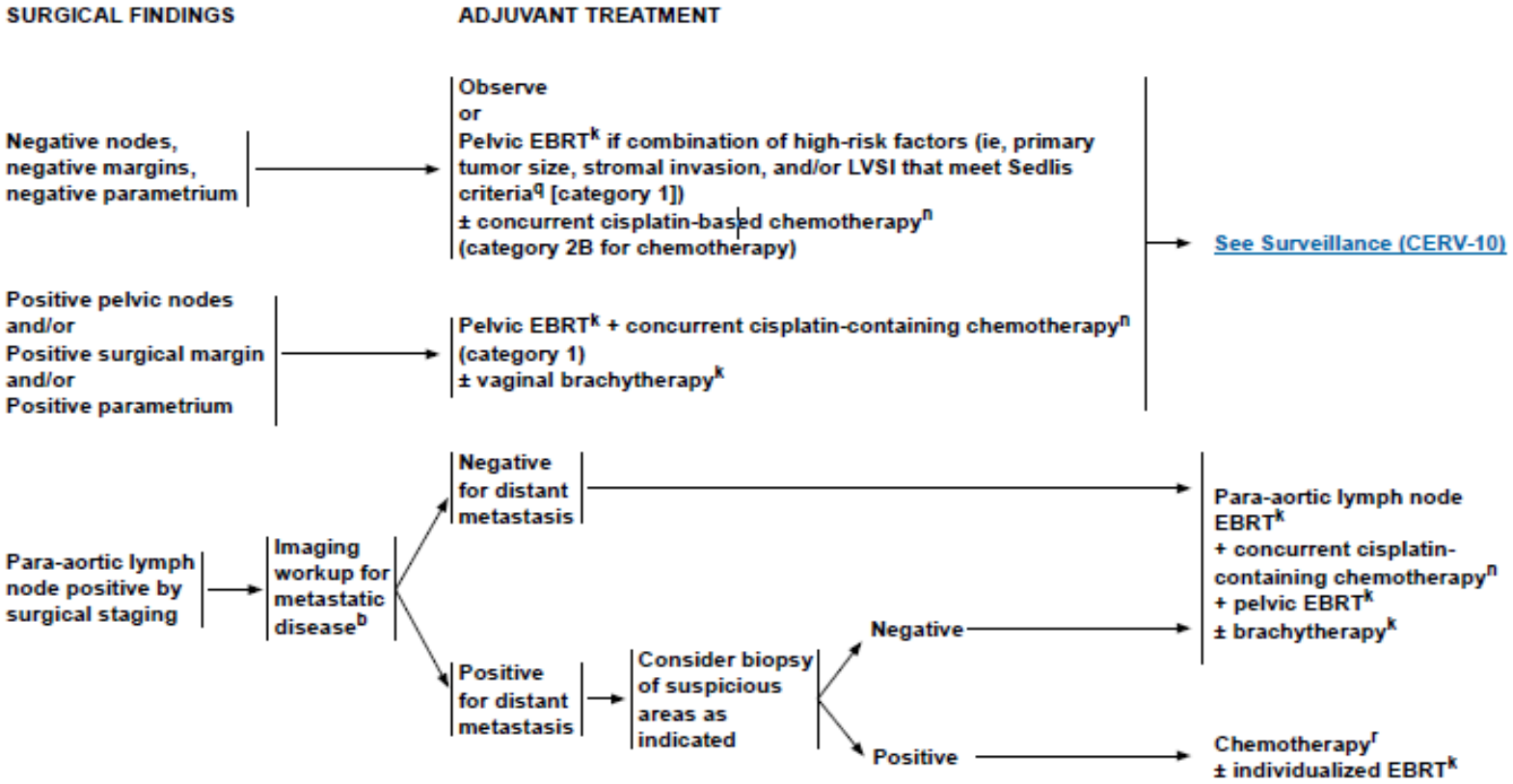
See Surveillance (VULVA-8)

- Age 79, vulvar cancer , Lt labial 3 cm tumor
- Severe obesity, Significant co-morbidities.
- Wide local excision, Lt SLNB

- **Sentinel node: negative on frozen, positive on final report**

- Recommendation?
- Formal lymphadenectomy? xrt?

Cervical cancer



[b] See Principles of Imaging (CERV-A).
[k] See Principles of Radiation Therapy for Cervical Cancer (CERV-C).
[n] Concurrent cisplatin-based chemotherapy with EBRT utilizes cisplatin as a single agent or cisplatin plus 5-fluorouracil.
[q] Risk factors may not be limited to the Sedlis criteria. See Sedlis Criteria (CERV-D).
[r] See Chemotherapy Regimens for Recurrent or Metastatic Cervical Cancer (CERV-E).

Note: All recommendations are category 2A unless otherwise indicated.
Clinical Trials: NCCN believes that the best management of any patient with cancer is in a clinical trial. Participation in clinical trials is especially encouraged.

See Surveillance (CERV-10)

- SCC CX IB1, RH PLN

- **Final histo Tumor 3.5 cm Deep invasion, LVSI negative, nodes negative**
- Recommendation?

- **Final histo Tumor 2 cm , invasion less than half, LVSI positive, nodes negative**
- Recommendation?

- **Final Histo : Tumor 4.5 cm , invasion less than half, lvsi negative , nodes negative**
- Recommendation?