FONDAZIONE POLIAMBULANZA
Istituto Ospedaliero

Brescia, 7 Giugno 2017

ORDINE
MEDICI CHIRURGHI
E ODONTOIATRI
DELLA PROVINCIA
DI BRESCIA

COMMISSIONE CULTURA
Coordinatore: Dott. Germano Bettoncelli

Corso di Aggiornamento

MINI-INVASIVITÀ IN CHIRURGIA ONCOLOGICA

Sala Conferenze Ordine Medici ed Odontoiatri - Via Lamarmora n. 167 (Palazzo il Diamante) - Brescia

7 giugno 2017 - ore 19.00

PAZIENTE CON NEOPLASIA GINECOLOGICA

FONDAZIONE POLIAMBULANZA Istituto Ospedaliero

Brescia, 7 Giugno 2017

BASIC RULES PER L'UTILIZZO DELLA LAPAROSCOPIA IN ONCOLOGIA GINECOLOGICA

1. Pressione intra addominale
2. CO2
3. Port sites metastasi
4. Radicalità
5. Tecnica oncologica

- Lavorare con bassa pressione
- Evitare perdite di gas
- Minimizzare il cambio degli strumenti
- Fissare bene i trocar
- Scaldare la CO2 insufflata

- (Gasless laparoscopy?)

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Brescia, 7 Giugno 2017

BASIC RULES PER L'UTILIZZO DELLA LAPAROSCOPIA IN ONCOLOGIA GINECOLOGICA

1. Pressione intra addominale
2. CO_2
3. Port sites metastasi
4. Radicalità
5. Tecnica oncologica

- Utilizzare protezione sulle ferite
- Minimizzare la manipolazione del tumore
- Ridurre le perdite di CO_2 e le desufflazioni improvvise
- Irrigare gli strumenti ed i trocar prima della rimozione
- Usare endobag
- Chiudere tutti gli strati della parete addominale

- Mancano solide evidenze per la prevenzione e per il trattamento

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Brescia, 7 Giugno 2017

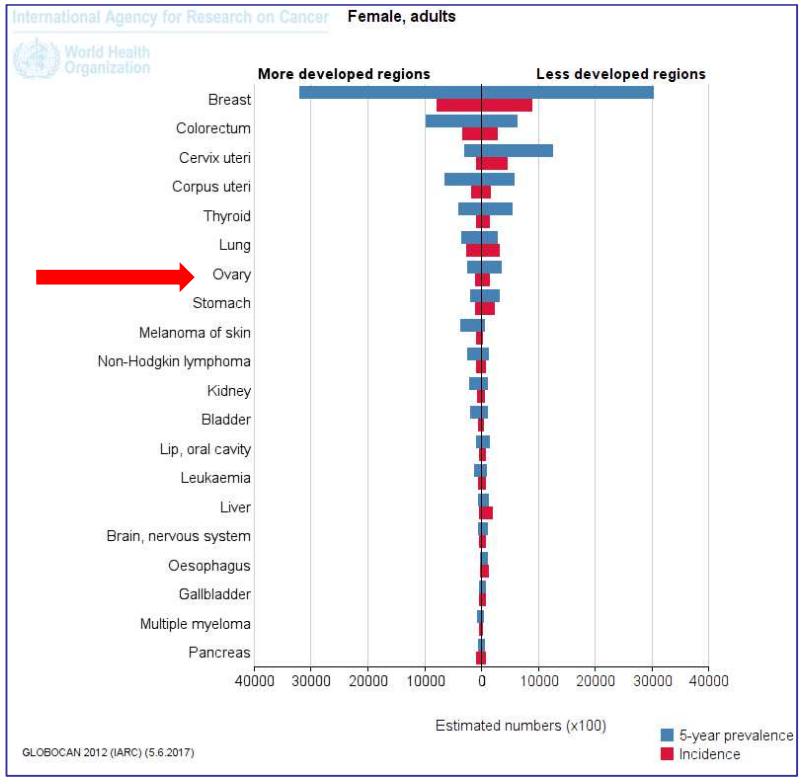
BASIC RULES PER L'UTILIZZO DELLA LAPAROSCOPIA IN ONCOLOGIA GINECOLOGICA

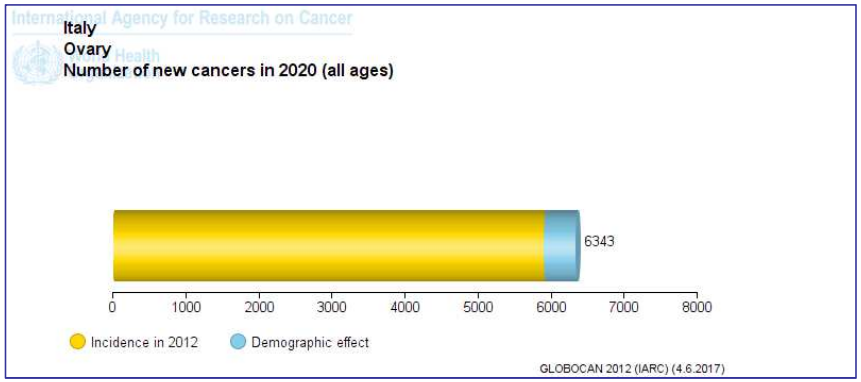
1. Pressione intra addominale
2. CO2
3. Port sites metastasi
4. Radicalità
5. Tecnica oncologica

- Medesima radicalità
- Medesimi numeri di linfonodi asportati

- Immediata legature dei vasi (in particolare per tumori a diffusione ematogena)
- Evitare spillage
- Meticolosa aspirazione di sangue e liquido pertoneale

PAZIENTE CON NEOPLASIA GINECOLOGICA: CANCRO OVARICO





PAZIENTE CON NEOPLASIA GINECOLOGICA: CANCRO OVARICO

Brescia
Ovaio

	Maschi	Femmine
Numero di nuovi casi per anno (incidenza 2002–2006)	–	94
Proporzione sul totale dei tumori eccetto cute non melanoma (%)	–	3.2
Rischio di avere un tumore prima degli 85 anni (%)	–	1.5
Tasso standardizzato per età (E)	–	13.4
– Cambiamento annuale stimato negli ultimi 5 anni (%)	–	2.6[–8.2;14.8]
Numero di morti per anno (2002–2006)	–	59
Proporzione dei decessi oncologici (%)	–	4.6
Rischio di morire per la malattia prima degli 85 anni (%)	–	1
Tasso standardizzato (E)	–	7.2
– Cambiamento annuale stimato negli ultimi 5 anni (%)	–	+8.7[2;15.7]
Sopravvivenza relativa (%) con [95% IC] (2000–2004) standardizzata per età		
1–anno	–	81[73–86]
5–anni	–	46[39–53]

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PAZIENTE CON NEOPLASIA GINECOLOGICA: CANCRO OVARICO

Gynecologic Cancers (RJ Morgan, Section Editor)

Current Recommendations for Minimally Invasive Surgical Staging in Ovarian Cancer

Anna Fagotti, MD, PhD[1,*]
Federica Perelli, MD[2]
Luigi Pedone, MD[3]
Giovanni Scambia, MD[3]

Address

- Stadi iniziali
- Stadi avanzati
  - Chirurgia primaria
  - Interval Debulking surgery
- Recidiva
- Risk Reducing Surgery

CANCRO OVARICO: STADI INIZIALI

Contents lists available at ScienceDirect

Gynecologic Oncology

journal homepage: www.elsevier.com/locate/ygyno

Laparoscopic staging of apparent early stage ovarian cancer: Results of a large, retrospective, multi-institutional series

V. Gallotta [a,*], F. Ghezzi [b], E. Vizza [c], V. Chiantera [d], M. Ceccaroni [e], M. Franchi [f], A. Fagotti [g], A. Ercoli [h], F. Fanfani [a], C. Parrino [a], S. Uccella [b], G. Corrado [c], G. Scambia [a], G. Ferrandina [a]

- **EBL**
  - Significantly lower than that in laparotomy (p=0-013)
- **COMPLICATIONS**
  - Only one case of port-metastasis reported
- **UPSTAGING**
  - Overall rate 22.6% (18.1-27.9%)
- **CONVERTION TO LPT**
  - Overall rate 3% (0.6-8.9%)
- **TUMOR RUPTURE:**
  - Overall rate 25.4% (17.7-35.1%)
- **RECURRENCE RATE:**
  - Median FU ≥ 19 months overall rate 9.9% (6.7-14-4%)

✓ ***Complication rate was very low (12.7%), mainly consisting of moderate lymphorrea***

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CANCRO OVARICO: STADI INIZIALI

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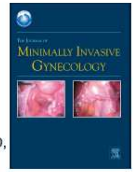

Minimally invasive surgical staging in early stage ovarian carcinoma: a systematic review and meta-analysis

Giorgio Bogani, MD, PhD, Chiara Borghi, MD, Umberto Leone Roberti Maggiore, MD, Antonino Ditto, MD, Mauro Signorelli, MD, Fabio Martinelli, MD, Valentina Chiappa, MD, Carlos Lopez, MD, Ilaria Sabatucci, MD, Cono Scaffa, MD, PhD, Alice Indini, MD, Simone Ferrero, PhD, Domenica Lorusso, MD, PhD, Francesco Raspagliesi, MD

Authors	Year	Principal Institution(s) involved	Study design	Study period	Minimally invasive staging	Laparotomy	Level of recommendation (GRADE)	Level of evidence (ACOG)
Chi[12]	2005	Memorial Sloan-Kettering Cancer Centre, New York, USA	Retrospective	2000-2003	20	30	MQ	B
Park[13]	2008	Asan Medical Center Seoul, Korea	Retrospective	2004-2007	19	33	MQ	B
Park[14]	2008	National Cancer Center, Goyang, Gyeonggi, Korea	Retrospective	2001-2006	17	19	MQ	B
Lee[15]	2011	Yonsei University College of Medicine, Seoul, Korea	Retrospective	2005-2010	26	87	MQ	B
Liu[16]	2014	Southern Medical University, Guangzhou, Guangdong, China	Retrospective	2002-2010	35	40	MQ	B
Bogani[17]	2014	University of Insubria, Varese, Italy	Retrospective	2003-2010	35	32	MQ	B
Gallotta[18]	2016	Catholic University, Rome, Italy	Retrospective	2000-2013	60	120	MQ	B
Minig[19]	2016	HM Hospital, Madrid, Spain Hospital Italiano de Buenos Aires, Argentina	Retrospective	2006-2014	50	58	MQ	B
Melamed[20]	2016	National Cancer Data Base	Retrospective	2010-2012	1096	1096	MQ	B
Lu[21]	2016	Chao Yang Hospital, Beijing, China	Retrospective	2002-2014	42	50	MQ	B
Ditto[22]	2016	National Cancer Institute, Milan, Italy	Retrospective	2005-2015	50	50	MQ	B

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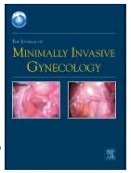

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- LPS minor perdite ematiche
- LPS minor tasso di trasfusioni
- LPS minor ospedalizzazione
- LPS minor tasso di complicanze

Authors	Year	Principal Institution(s) involved	Surgical approach (n)	Operative time (minutes)	Estimated blood loss (ml)	Blood transfusions	Intraoperative complications	Conversion to open surgery	Hospital stay (days)
Chi[12]	2005	Memorial Sloan-Kettering Cancer Centre, New York, USA	MIS (n=20)	321 (±64)	235 (±138)	NR	0 (0%)	0 (0%)	3 (±1)
			OPEN (n=30)	276 (±68)	367 (±208)	NR	0 (0%)	-	5 (±2)
Park[13]	2008	Asan Medical Center, Seoul, Korea	MIS (n=19)	221(±83)	240 (±228)	1 (5.3%)	1 (5.3%)	0 (0%)	9 (±6)
			OPEN (n=33)	275 (±63)	568 (±452)	10 (30.3%)	0 (0%)	-	14 (±5)
Park[14]	2008	National Cancer Center, Goyang, Gyeonggi, Korea	MIS (n=17)	304 (±85)	231 (±118)	0 (0%)	2 (11.8%)	0 (0%)	9 (±4)
			OPEN (n=19)	290(±120)	505 (±280)	2 (10.5%)	1 (5.3%)	-	14 (±4)
Lee[15]	2011	Yonsei University College of Medicine, Seoul, Korea	MIS (n=26)	227(±106)	230 (±184)	0 (0%)	0 (0%)	1 (3.8%)	6 (±2)
			OPEN (n=87)	184(±61)	475 (±329)	20 (23%)	1 (1.1%)	-	12 (±5)
Liu[16]	2014	Southern Medical University, Guangzhou, Guangdong, China	MIS (n=35)	210(±18)	197(±98)	2 (5.7%)	0/35	0 (0%)	16 (±6)
			OPEN (n=40)	201(±21)	345(±166)	5 (12.5%)	0/40	-	22 (±5)
Bogani[17]	2014	University of Insubria, Varese, Italy	MIS (n=35)	335 (±74.7)	415 (±512)	1 (3%)	0 (0%)	0 (0%)	5 (±5)
			OPEN (n=32)	230 (±54)	429 (±288)	7 (22%)	0 (0%)	-	6 (±3)
Gallotta[18]	2016	Catholic University, Rome, Italy	MIS (n=60)	Longer for LPS vs LPT	Lower for LPS vs LPT	NR	NR	0 (0%)	3 (2-7)
			OPEN (n=120)			NR	NR	-	7 (2-31)
Minig[19]	2016	HM Hospital, Madrid, Spain Hospital Italiano de Buenos Aires, Argentina	MIS (n=50)	225 (180-240)	200 (200-225)	3 (6%)	3 (6%)	1 (2%)	2 (1.5-3)
			OPEN (n=58)	220 (180-240)	500 (300-1000)	15 (34%)	5 (8.6%)	-	5 (4-6.3)
Melamed[20]	2016	National Cancer Data Base	MIS (n=1096)	NR	NR	NR	NR	NR	3 (1-4)
			OPEN (n=1096)	NR	NR	NR	NR	-	4 (3-5)
Lu[21]	2016	Chao Yang Hospital, Beijing, China	MIS (n=42)	200 (150-460)	110 (50-450)	1 (2.4%)	0 (0%)	0 (0%)	3 (2-14)
			OPEN (n=50)	240 (180-570)	370 (20-1000)	2 (4%)	1 (2%)	-	7 (3-10)
Ditto[22]	2016	National Cancer Institute, Milan, Italy	MIS (n=50)	207 (±72)	150 (±53)	1 (2%)	0	0	4 (±2.6)
			OPEN (n=50)	180 (±47)	340 (±226)	3 (6%)	1 (2%)	-	6 (±1.6)

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CANCRO OVARICO: STADI INIZIALI

NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®)

Ovarian Cancer

Including Fallopian Tube Cancer and Primary Peritoneal Cancer

Version 1.2017 — April 12, 2017

NCCN.org

NCCN Guidelines for Patients® available at www.nccn.org/patients

Continue

MIS approaches may be employed by an experienced surgeon to achieve the surgical staging in EOC pts

Level of evidence: IIB

NCCN National Comprehensive Cancer Network®

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Epithelial Ovarian Cancer/Fallopian Tube Cancer/ Primary Peritoneal Cancer & Less Common Histopathologies

NCCN Guidelines Index
Ovarian Cancer TOC
Discussion

PRINCIPLES OF SURGERY (1 of 4)[1]

General considerations

- An open laparotomy including a vertical midline abdominal incision should be used in patients with a suspected malignant ovarian/Fallopian tube/primary peritoneal neoplasm in whom a surgical staging procedure, a primary debulking procedure, an interval debulking procedure, or secondary cytoreduction is planned.
- Intraoperative pathologic evaluation with frozen sections may assist in management.
- For select patients, a minimally invasive surgical approach may be employed by an experienced surgeon to achieve the surgical staging and debulking principles subsequently described.
- Patients who are unable to be optimally debulked using minimally invasive techniques should be converted to an open procedure.
- Minimally invasive surgical approaches may be useful when evaluating whether maximum cytoreduction can be achieved in patients with newly diagnosed or recurrent ovarian cancer. If clinical judgment indicates that maximum cytoreduction cannot be achieved, neoadjuvant chemotherapy should be considered.
- It is recommended that a gynecologic oncologist perform the appropriate surgery.

Operative reports

- Surgeons should describe the following in the operative report:
  - Extent of initial disease before debulking pelvis, midabdomen, or upper abdomen (cutoffs: pelvic brim to lower ribs).
  - Amount of residual disease in the same areas after debulking.
  - Complete or incomplete resection; if incomplete, indicate the size of the major lesion and total number of lesions. Indicate if miliary or small lesions.

Continued on OV-A (2 of 4)

[1]Fleming GF, Seidman J, Lengyel E, et al: Epithelial ovarian cancer. In Barakat RR, Berchuck A, Markman M, et al. (eds): Principles and Practice of Gynecologic Oncology, 6th ed, Philadelphia, Lippincott Williams & Wilkins, 2013:757-847. Amended by panel.

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.

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CANCRO OVARICO: STADI AVANZATI

NCCN National Comprehensive Cancer Network®

NCCN Guidelines Version 3.2014
Epithelial Ovarian Cancer/ Fallopian Tube Cancer/ Primary Peritoneal Cancer

PRINCIPLES OF SURGERY

Every effort should be made to achieve maximal cytoreduction

AGO ARBEITSGEMEINSCHAFT GYNÄKOLOGISCHE ONKOLOGIE E.V.

Standard therapy to treat AEOC consists of PDS to achieve macroscopic complete resection

NICE accredited www.nice.org.uk/accreditation

When performing surgery for AEOC the objective should be complete resection of all macroscopic disease

Median PFS at PDS
RT = 0cm: 29 mts
RT ≤ 1 cm: 14 mts
RT > 1 cm: 13 mts

Median PFS at IDS
RT = 0cm: 15 mts
RT ≤ 1 cm: 14 mts
RT > 1 cm: 10 mts

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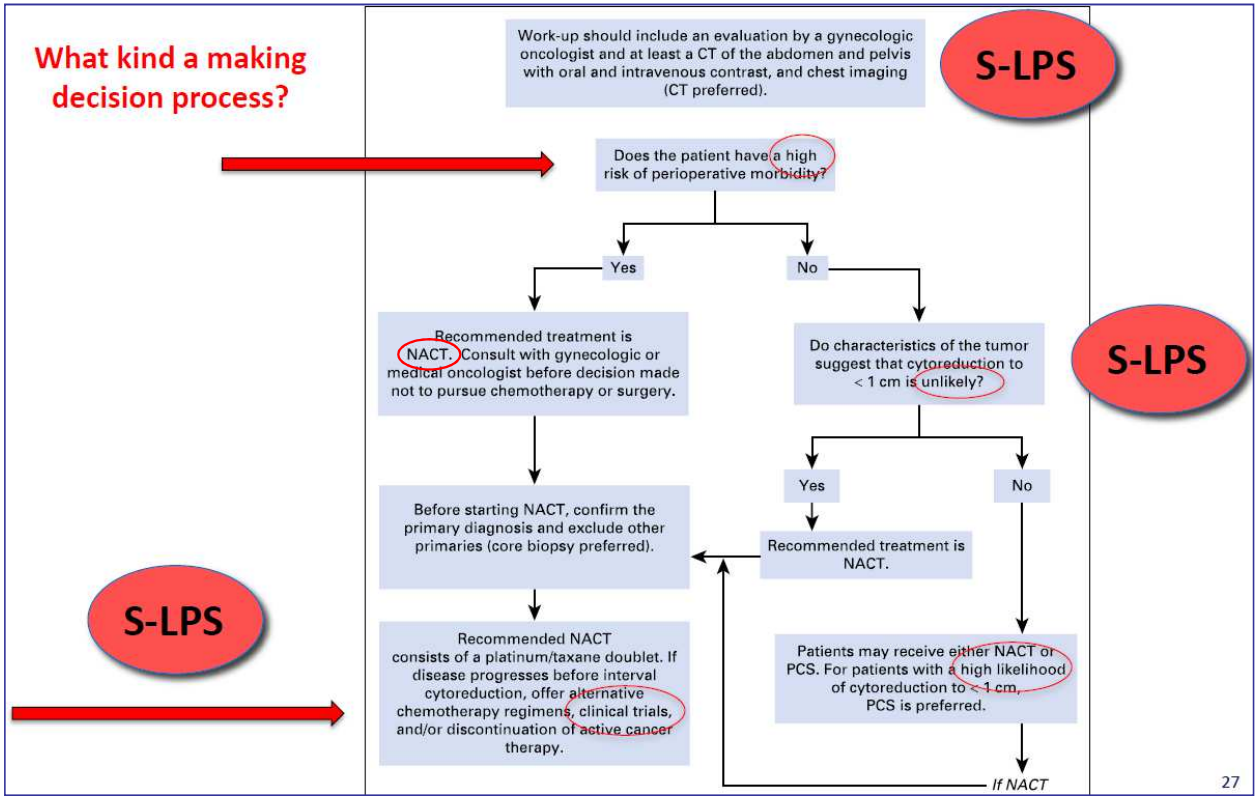
CANCRO OVARICO: STADI AVANZATI

JOURNAL OF CLINICAL ONCOLOGY

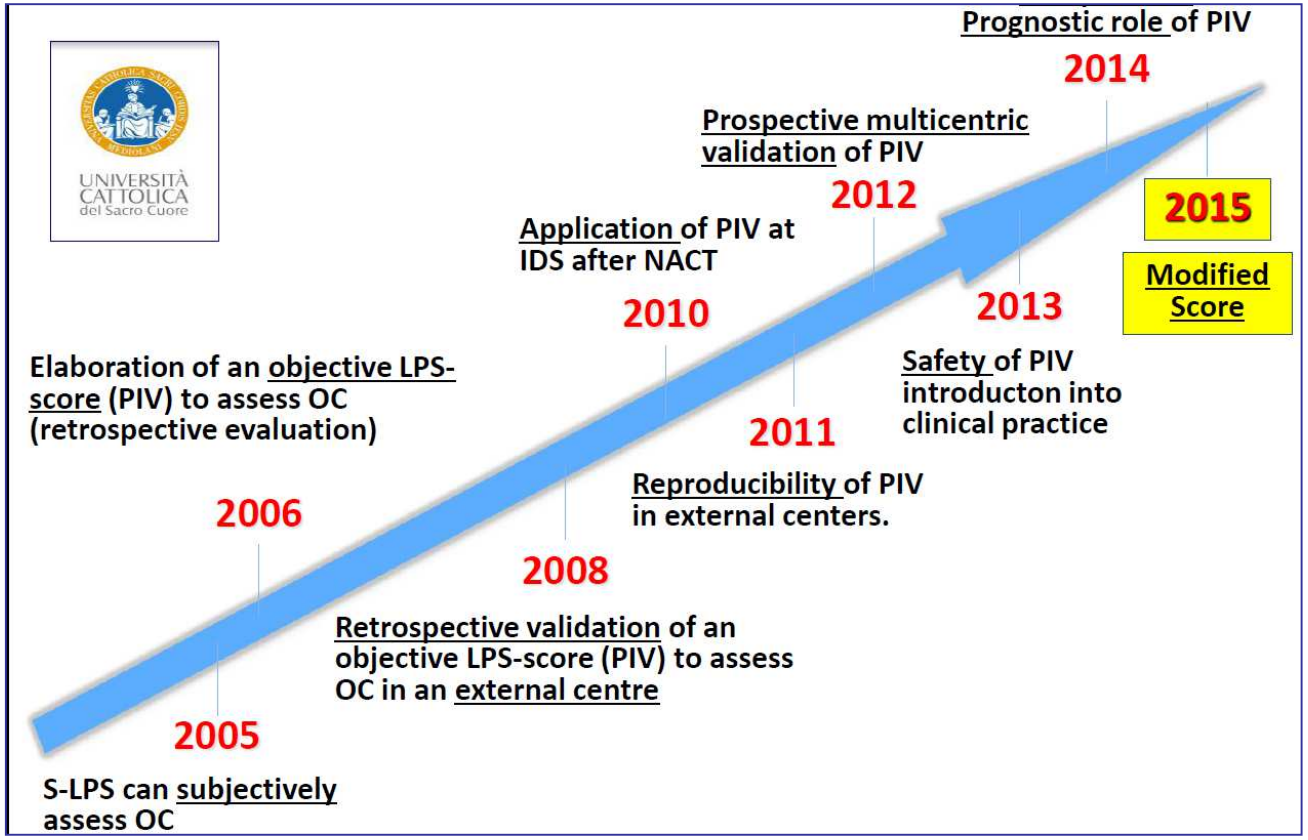
ASCO SPECIAL ARTICLE

Neoadjuvant Chemotherapy for Newly Diagnosed, Advanced Ovarian Cancer: Society of Gynecologic Oncology and American Society of Clinical Oncology Clinical Practice Guideline

What kind a making decision process?



CANCRO OVARICO: STADI AVANZATI

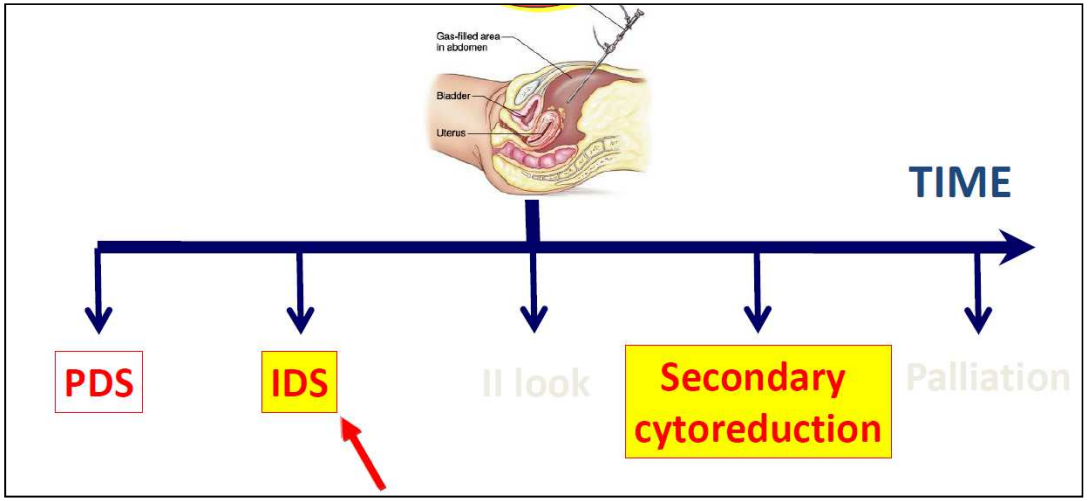


- **Fagotti laparoscopic score (2008)**
  - Omental cake
  - Peritoneal carcinomatosis
  - Diaphragmatic carcinomatosis
  - Mesenteric retraction
  - Stomach infiltration
  - Liver metastases

CANCRO OVARICO: STADI AVANZATI

TABLE 5. Changes in ovarian cancer management

	T1 (2000-2003), n = 14	T2 (2004-2007), n = 26	T3 (2008-2011), n = 41	*P*
Age, y	54 (40–82)	56 (13–76)	55 (20–80)	0.75*
BMI, kg/m^2	23.1 (18.8–35.6)	24.2 (18–33.7)	21.8 (16.6–39.2)	0.15†
Previous abdominal surgery	4 (28%)	10 (38%)	14 (34%)	0.81*
Charlson comorbidity index ≥3	0 (0%)	2 (8%)	5 (12%)	0.36*
Histotype				
Epithelial	11 (79%)	24 (92%)	39 (95%)	0.16*
Nonepithelial	3 (21%)	2 (8%)	2 (5%)	
Grade (for epithelial tumor)				
G1 and 2	5 (45%)	9 (38%)	15 (38%)	0.89*
G3	6 (55%)	15 (62%)	24 (62%)	
FIGO stage				
I	10 (71%)	17 (65%)	22 (54%)	0.41*
>II	4 (29%)	9 (35%)	19 (46%)	
Approach				
Laparoscopy	1 (7%)	15 (60%)	36 (88%)	<0.001‡
Open surgery	13§ (93%)	11 (40%)	5 (12%)	
Conversions	0	0	2 (5%)	0.99*
LND (PL+ PA LND)	14 (100%)	26 (100%)	41 (100%)	>0.99*
Lymph node count	20 (8–37)	27 (8-58)	30 (10–59)	0.04‖
Positive lymph node	1 (7%)	4 (15%)	9 (22%)	0.42*
Cysts rupture	3 (21%)	1 (4%)	4 (10%)	0.2*
Operative time, min	136.3 (95–280)	325 (115–480)	267 (105–420)	<0.001¶
Estimated blood loss, mL	400 (100–700)	300 (50–3000)	275 (50–1000)	0.32*
Hospital stay, d	6 (3–11)	6 (2–30)	4 (1-12)	0.01#
Transfusions	1 (7%)	2 (8%)	1 (2%)	0.57*
Intraoperative complications	0 (0%)	1 (4%)	0 (0%)	0.34*
Postoperative complications**	0 (0%)	1 (4%)	0 (0%)	0.34*
Readmission	1 (7%)	0 (0%)	1 (2%)	0.39*
Adjuvant therapy (chemotherapy)	9 (64%)	22 (85%)	38 (93%)	0.03††



Studi clinici controllati

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Continue

MIS approaches may be useful when evaluating whether maximum cytoreduction can be achieved in newly diagnosed and recurrent OC[109,122,123,135,136]

Level of evidence: IIB

122. Liu CS, Nagarsheth NP, Nezhat FR. Laparoscopy and ovarian cancer: a paradigm change in the management of ovarian cancer? J Minim Invasive Gynecol 2009;16:250-262. Available at: http://www.ncbi.nlm.nih.gov/pubmed/19321390.

135. Fagotti A, Vizzielli G, De Iaco P, et al. A multicentric trial (Olympia-MITO 13) on the accuracy of laparoscopy to assess peritoneal spread in ovarian cancer. Am J Obstet Gynecol 2013;209:462 e461-462 e411. Available at: http://www.ncbi.nlm.nih.gov/pubmed/23891632.

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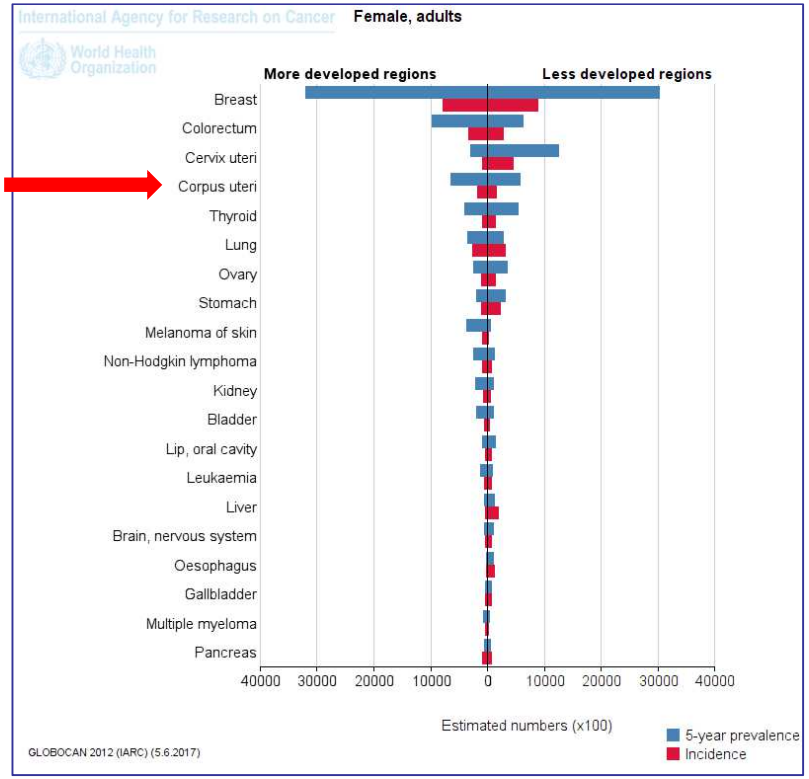
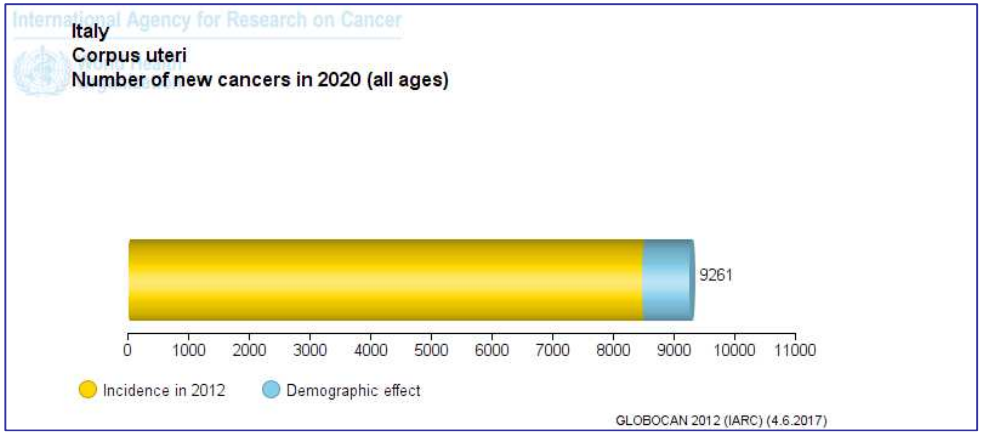
PAZIENTE CON NEOPLASIA GINECOLOGICA: CANCRO DELL'ENDOMETRIO





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PAZIENTE CON NEOPLASIA GINECOLOGICA: CANCRO DELL'ENDOMETRIO

L.A.C.E. TRIAL

Tracking Information	
First Received Date ICMJE	November 9, 2004
Last Updated Date	September 26, 2016
Start Date ICMJE	October 2005
Primary Completion Date	April 2016 (Final data collection date for primary outcome measure)
Current Primary Outcome Measures ICMJE (submitted: March 3, 2008)	Disease free survival [Time Frame: 4.5 years from surgery]
Original Primary Outcome Measures ICMJE (submitted: June 23, 2005)	Quality of Life (QoL) measured preoperative at 1 week, 1 month, 3 months and 6 months postoperative.
Change History	Complete list of historical versions of study NCT00096408 on ClinicalTrials.gov Archive Site
Current Secondary Outcome Measures ICMJE (submitted: March 3, 2008)	• Intra/Peri/Post-operative and long-term morbidity [Time Frame: 30 days from surgery] • Patterns of recurrence [Time Frame: 4.5 years from surgery] • Pain and analgesia [Time Frame: 1 week, 1 month, 3 months and 6 months postoperative.] • Quality of Life [Time Frame: Measured at baseline, then again 1 week, 6 weeks, 3 months and 6 months postoperatively.]
Original Secondary Outcome Measures ICMJE (submitted: June 23, 2005)	Intra/Peri/Post-operative and long-term morbidity; Patterns of recurrence; transfusion requirements; Pain and analgesia
Current Other Outcome Measures ICMJE	*Not Provided*
Original Other Outcome Measures ICMJE	*Not Provided*

FONDAZIONE POLIAMBULANZA Istituto Ospedaliero

Brescia, 7 Giugno 2017

PAZIENTE CON NEOPLASIA GINECOLOGICA: CANCRO DELL'ENDOMETRIO

Original Investigation

March 28, 2017

Effect of Total Laparoscopic Hysterectomy vs Total Abdominal Hysterectomy on Disease-Free Survival Among Women With Stage I Endometrial Cancer

A Randomized Clinical Trial

Monika Janda, PhD[1]; Val Gebski, MStat[2]; Lucy C. Davies, MSc[2]; et al

» Author Affiliations

JAMA. 2017;317(12):1224-1233. doi:10.1001/jama.2017.2068

Publications automatically indexed to this study by ClinicalTrials.gov Identifier (NCT Number):

Janda M, Gebski V, Davies LC, Forder P, Brand A, Hogg R, Jobling TW, Land R, Manolitsas T, Nascimento M, Neesham D, Nicklin JL, Oehler MK, Otton G, Perrin L, Salfinger S, Hammond I, Leung Y, Sykes P, Ngan H, Garrett A, Laney M, Ng TY, Tam K, Chan K, Wrede CD, Pather S, Simcock B, Farrell R, Robertson G, Walker G, Armfield NR, Graves N, McCartney AJ, Obermair A. Effect of Total Laparoscopic Hysterectomy vs Total Abdominal Hysterectomy on Disease-Free Survival Among Women With Stage I Endometrial Cancer: A Randomized Clinical Trial. JAMA. 2017 Mar 28;317(12):1224-1233. doi: 10.1001/jama.2017.2068.

Belavy D, Janda M, Baker J, Obermair A. Epidural analgesia is associated with an increased incidence of postoperative complications in patients requiring an abdominal hysterectomy for early stage endometrial cancer. Gynecol Oncol. 2013 Nov;131(2):423-9. doi: 10.1016/j.ygyno.2013.08.027. Epub 2013 Sep 3.

Kondalsamy-Chennakesavan S, Janda M, Gebski V, Baker J, Brand A, Hogg R, Jobling TW, Land R, Manolitsas T, Nascimento M, Neesham D, Nicklin JL, Oehler MK, Otton G, Perrin L, Salfinger S, Hammond I, Leung Y, Sykes P, Ngan H, Garrett A, Laney M, Ng TY, Tam K, Chan K, Wrede DH, Pather S, Simcock B, Farrell R, Robertson G, Walker G, McCartney A, Obermair A. Risk factors to predict the incidence of surgical adverse events following open or laparoscopic surgery for apparent early stage endometrial cancer: results from a randomised controlled trial. Eur J Cancer. 2012 Sep;48(14):2155-62. doi: 10.1016/j.ejca.2012.03.013. Epub 2012 Apr 12.

Janda M, Gebski V, Brand A, Hogg R, Jobling TW, Land R, Manolitsas T, McCartney A, Nascimento M, Neesham D, Nicklin JL, Oehler MK, Otton G, Perrin L, Salfinger S, Hammond I, Leung Y, Walsh T, Sykes P, Ngan H, Garrett A, Laney M, Ng TY, Tam K, Chan K, Wrede CD, Pather S, Simcock B, Farrell R, Obermair A. Quality of life after total laparoscopic hysterectomy versus total abdominal hysterectomy for stage I endometrial cancer (LACE): a randomised trial. Lancet Oncol. 2010 Aug;11(8):772-80. doi: 10.1016/S1470-2045(10)70145-5. Epub 2010 Jul 16.

Conclusions and Relevance Among women with stage I endometrial cancer, the use of total abdominal hysterectomy compared with total laparoscopic hysterectomy resulted in equivalent disease-free survival at 4.5 years and no difference in overall survival. These findings support the use of laparoscopic hysterectomy for women with stage I endometrial cancer.

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L.A.P. 2 TRIAL

Tracking Information	
First Received Date ICMJE	November 1, 1999
Last Updated Date	May 27, 2015
Start Date ICMJE	April 1996
Primary Completion Date	March 2010 (Final data collection date for primary outcome measure)
Current Primary Outcome Measures ICMJE (submitted: May 27, 2015)	• Duration of disease-free interval [Time Frame: Up to 5 years] The usual logrank test or a proportional hazards model will be used to assess the equality of the hazard rates between the surgical procedures. • Frequency of aborting LAVH in order to perform an TAH/BSO [Time Frame: Up to 5 years] • Frequency of major surgical complications, graded according to the NCI CTC and classified as either less than grade 2 or grade 2 or worse [Time Frame: Up to 5 years] • Length of hospitalization following surgery [Time Frame: From the date of surgery to the date of discharge, assessed up to 5 years] A proportional odds model will be used to estimate the treatment difference while adjusting for potential confounding factors. • Self assessed quality of life scores as measured by FACT-G, Physical Function Subscale from the MOS SF-36, Wisconsin Brief Pain Inventory, Fear of Relapse/Recurrence scale, and Personal Appearance scale [Time Frame: Up to 6 months]
Original Primary Outcome Measures ICMJE	*Not Provided*
Change History	Complete list of historical versions of study NCT00002706 on ClinicalTrials.gov Archive Site
Current Secondary Outcome Measures ICMJE	*Not Provided*
Original Secondary Outcome Measures ICMJE	*Not Provided*
Current Other Outcome Measures ICMJE	*Not Provided*
Original Other Outcome Measures ICMJE	*Not Provided*

GOG #LAP-2

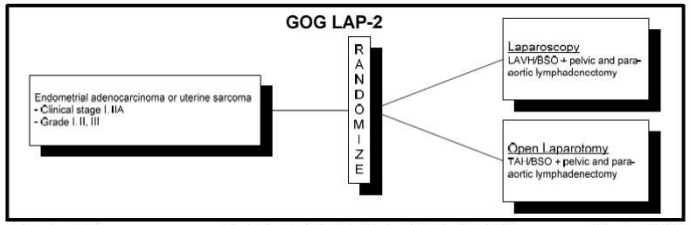
GOG PROTOCOL #LAP-2

PROTOCOL **A Phase III Randomized Clinical Trial of Laparoscopic Pelvic and Para Aortic Node Sampling with Vaginal Hysterectomy and BSO Versus Open Laparotomy with Pelvic and Para Aortic Node Sampling and Abdominal Hysterectomy and BSO in Endometrial Adenocarcinoma and Uterine Sarcoma, Clinical Stage I, IIA, Grade I, II, III**

Study Chairs GOG: Joan Walker, MD, John Schlaerth, MD, Gregory Spiegel, MD and Alice Kornblith, PhD
ECOG: Higinia R. Cardenes, MD, PhD

Statistician Marion Piedmonte, MA and Helen Huang, MS (QOL)

Data Coordinator Sandra Dascomb, MS



Activated 4/1/96 **Revised** 8/19/96, 10/21/96, 11/18/96, 7/14/97, 12/5/97, 3/9/98, 5/24/99, 5/15/00, 4/9/01, 5/28/01, 6/3/02 **Closed** 9/12/05

No Study Results Posted on ClinicalTrials.gov for this Study

About Study Results Reporting on ClinicalTrials.gov

Study Status:	This study has been completed.
Study Completion Date:	*No date given*
Primary Completion Date:	March 2010 (Final data collection date for primary outcome measure)

PAZIENTE CON NEOPLASIA GINECOLOGICA: CANCRO DELL'ENDOMETRIO

ORIGINAL STUDY

Improving Standard of Care Through Introduction of Laparoscopy for the Surgical Management of Gynecological Malignancies

Giorgio Bogani, MD, Antonella Cromi, PhD,* Maurizio Serati, MD,* Edoardo Di Naro, MD,† Jvan Casarin, MD,* Ciro Pinelli, MD,* Ilario Candeloro, MD,* Davide Sturla, MD,* and Fabio Ghezzi, MD**

TABLE 3. Changes in endometrial cancer management

	T1 (2000-2003), n = 145	T2 (2004-2007), n = 153	T3 (2008-2011), n = 195	*P*
Age, y	65 (34–93)	68 (38–90)	65 (30–92)	0.02*
BMI, kg/m^2	28.2 (19–68)	27.2 (19–46)	28 (15.8–50.8)	0.39†
Previous abdominal surgery	83 (57%)	74 (48%)	94 (48%)	0.19†
Charlson comorbidity index ≥3	6 (4%)	10 (7%)	28 (14%)	0.003‡
Histotype				
Endometrioid	127 (88%)	132 (86%)	167 (86%)	0.87†
Nonendometrioid	18 (12%)	21 (14%)	28 (14%)	
FIGO grade				
1 and 2	115 (79%)	104 (68%)	146 (75%)	0.07§
3	30 (21%)	49 (32%)	49 (25%)	
FIGO stage				
I	120 (83%)	120 (78%)	168 (86%)	0.16†
>II	25 (17%)	33 (22%)	27 (14%)	
Approach				
Open surgery	114 (79%)	51 (33%)	17 (9%)	<0.001‖
Laparoscopy	19 (13%)	95 (62%)	158 (81%)	
Vaginal surgery	12 (8%)	7 (5%)	20 (10%)	
Conversions	0 (0%)	3 (2%)	2¶ (1%)	0.22†
LND (PL ± PA LND)	74 (51%)	105 (69%)	114 (58%)	0.007#
Lymph node count	17 (3–60)	16 (5–39)	18 (2–40)	0.56†
Positive lymph nodes	12 (17%)	13 (12%)	9 (8%)	0.26†
Operative time, min	125 (25–330)	150 (30–375)	115 (30–300)	<0.001**
Estimated blood loss, mL	200 (10–1400)	100 (10–2000)	100 (10–1800)	<0.001††
Hospital stay, d	6 (1–34)	3 (1–20)	2 (1–19)	<0.001‖
Transfusions	13 (9%)	13 (8%)	10 (5%)	0.32†
Intraoperative complications	3 (2%)	4 (3%)	2 (1%)	0.53†
Postoperative complications‡‡	14 (10%)	3 (2%)	2 (1%)	<0.001§§
Readmissions	8 (6%)	3 (2%)	3 (2%)	0.06†
Adjuvant therapy	33 (23%)	49 (32%)	47 (24%)	0.14†
Radiotherapy	21 (64%)	28 (57%)	23 (49%)	0.41†
Chemotherapy	8 (24%)	13 (27%)	21 (44%)	0.08†
Combined regimen	4 (12%)	8 (16%)	3 (6%)	0.31†

FONDAZIONE POLIAMBULANZA Istituto Ospedaliero

Brescia, 7 Giugno 2017

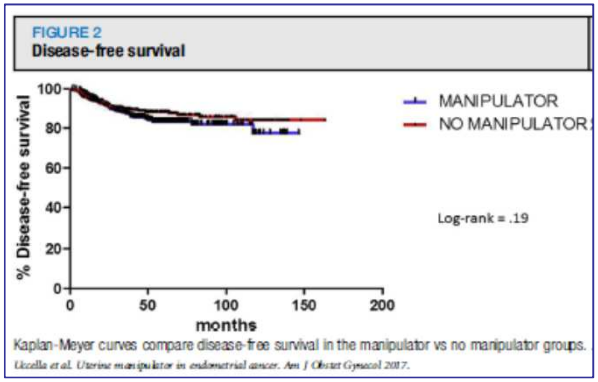
PAZIENTE CON NEOPLASIA GINECOLOGICA: CANCRO DELL'ENDOMETRIO

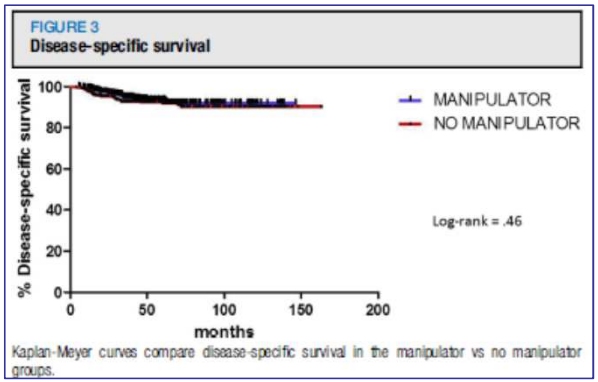
Original Research ajog.org

GYNECOLOGY

The effect of a uterine manipulator on the recurrence and mortality of endometrial cancer: a multi-centric study by the Italian Society of Gynecological Endoscopy

Stefano Uccella, MD, PhD; Matteo Bonzini, MD; Mario Malzoni, MD; Francesco Fanfani, MD; Stefano Palomba, MD; Giovanni Aletti, MD; Giacomo Corrado, MD; Marcello Ceccaroni, MD; Renato Seracchioli, MD; Fevzi Shakir, MD; Annamaria Ferrero, MD; Roberto Berretta, MD; Raffaele Tinelli, MD; Enrico Vizza, MD; Giovanni Roviglione, MD; Lucia Casarella, MD; Eugenio Volpi, MD; Ettore Cicinelli, MD; Giovanni Scambia, MD; Fabio Ghezzi, MD





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PAZIENTE CON NEOPLASIA GINECOLOGICA: CANCRO DELL'ENDOMETRIO

NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®)

Uterine Neoplasms

Version 2.2017 — April 25, 2017

NCCN.org

Continue

National Comprehensive Cancer Network®

NCCN Guidelines Version 2.2017
Endometrial Carcinoma

NCCN Guidelines Index
Table of Contents
Discussion

PRINCIPLES OF EVALUATION AND SURGICAL STAGING

Principles of Surgical Staging for Endometrial Cancer[1-14]

- Total hysterectomy, bilateral salpingo-oophorectomy (TH/BSO), and lymph node assessment is the primary treatment of apparent uterine-confined endometrial carcinoma, unless patients desire (and are candidates for) fertility-sparing options (See ENDO-8).[1-3] Select patients with metastatic endometrial carcinoma are also candidates for hysterectomy. (See Hysterectomy and Pathologic Evaluation [ENDO-B1])
- Endometrial carcinoma should be removed en bloc to optimize outcomes; intraperitoneal morcellation or tumor fragmentation should be avoided.
- TH/BSO and lymph node assessment may be performed by any surgical route (eg, laparoscopic, robotic, vaginal, abdominal), although the standard in those with apparent uterine-confined disease is to perform the procedure via a minimally invasive approach. Randomized trials, a Cochrane Database Systematic Review, and population-based surgical studies support that minimally invasive techniques are preferred in this setting due to a lower rate of surgical site infection, transfusion, venous thromboembolism, decreased hospital stay and lower cost of care, without compromise in oncologic outcome.[4-9]
- The lymph node assessment includes evaluation of the nodal basins that drain the uterus, and often comprises a pelvic nodal dissection with or without aortic nodal dissection. This continues to be an important aspect of surgical staging in women with uterine-confined endometrial carcinoma, as the procedure provides important prognostic information that may alter treatment decisions.
- Pelvic lymph nodes from the external iliac, internal iliac, obturator, and common iliac nodes are frequently removed for staging purposes.
- Para-aortic nodal evaluation from the inframesenteric and infrarenal regions may also be utilized for staging in women with high-risk tumors such as deeply invasive lesions, high-grade histology, and tumors of serous carcinoma, clear cell carcinoma, or carcinosarcoma.
- Sentinel lymph node (SLN) mapping may be considered in select patients. (See pages 2-4 of ENDO-C)
- Excision of suspicious or enlarged lymph nodes in the pelvic or aortic regions is important to exclude nodal metastasis.
- Some patients may not be candidates for lymph node dissection.
- Visual evaluation of the peritoneal, diaphragmatic, and serosal surfaces with biopsy of any suspicious lesions is important to exclude extrauterine disease.
- Some patients may not be candidates for lymph node dissection.
- While peritoneal cytology does not impact staging, FIGO and AJCC nonetheless recommend that surgeons continue to obtain this during the TH/BSO.
- Omental biopsy is commonly performed in those with serous carcinoma, clear cell carcinoma, or carcinosarcoma histologies.

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.

Continued

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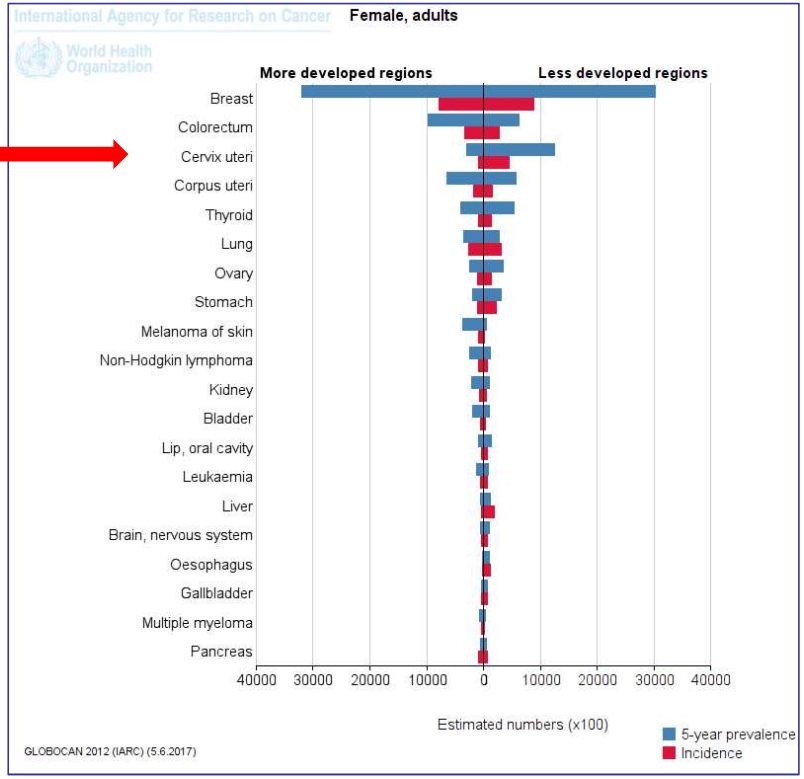
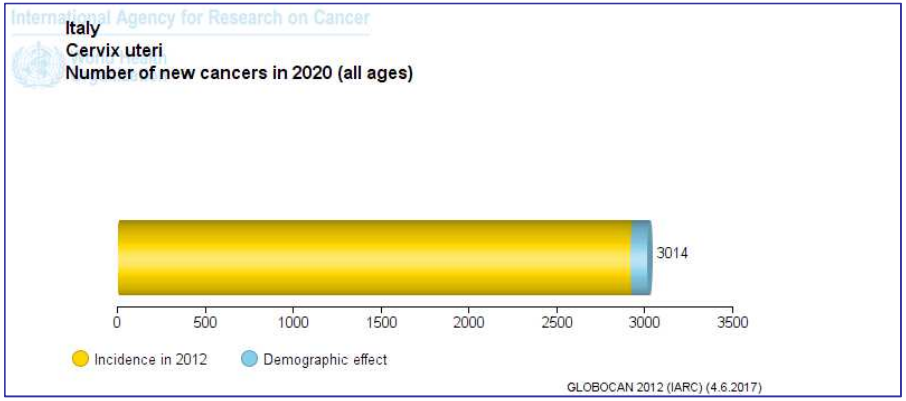
PAZIENTE CON NEOPLASIA GINECOLOGICA: CANCRO DELLA CERVICE UTERINA





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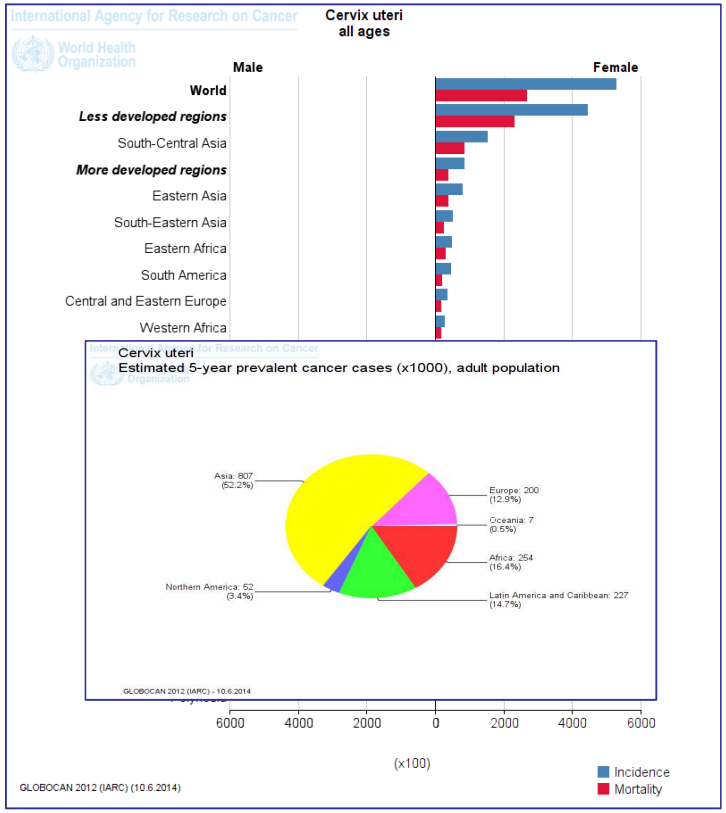
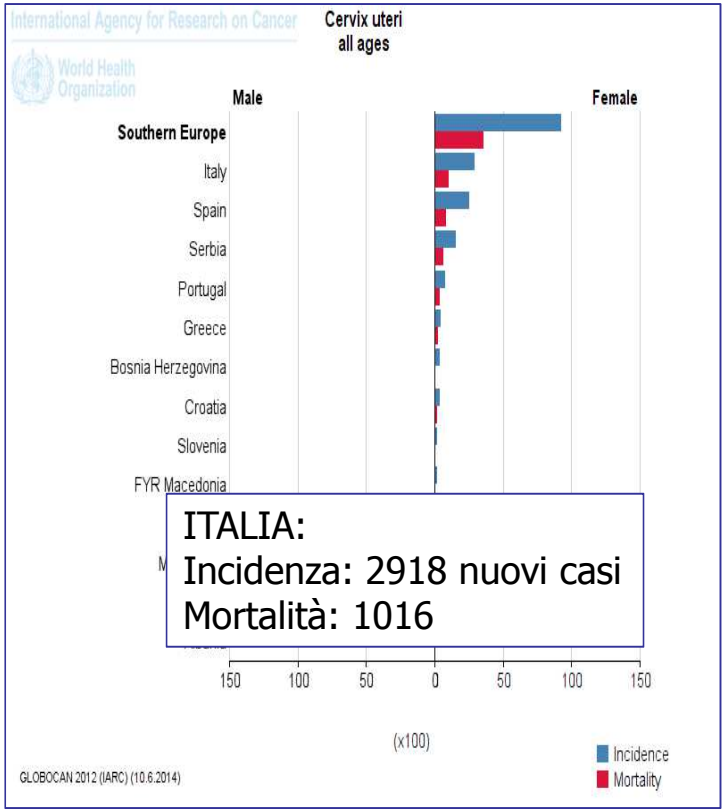
PAZIENTE CON NEOPLASIA GINECOLOGICA: CANCRO DELLA CERVICE UTERINA

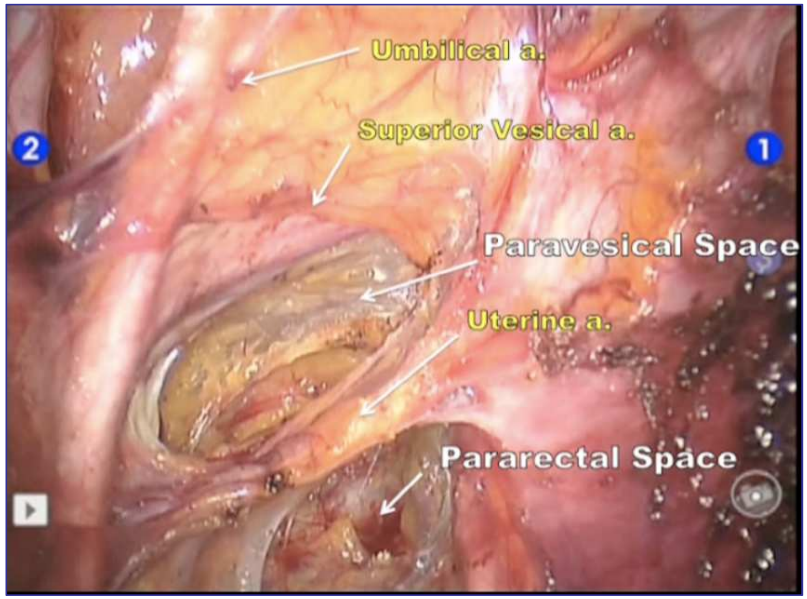


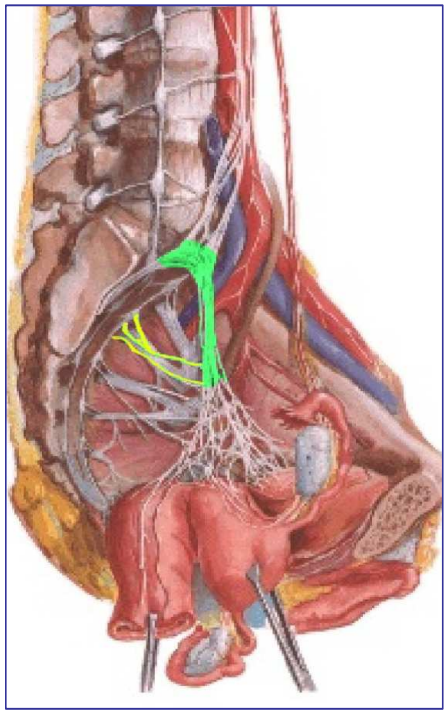


ITALIA:
Incidenza: 2918 nuovi casi
Mortalità: 1016

CANCRO DELLA CERVICE UTERINA E LPS

- Traditional approach
  - Wertheim's radical abdominally hysterectomy : 1898
    - 1950's Meigs, Magara
  - Schautas radical vaginal hysterectomy : 1902
    - 1920 Amreich, Stoeckel
- Laparoscopic approach
  - Laparoscopic hysterectomy : H Reich 1989
  - Laparoscopic Wertheim : M. Canis 1991
  - Laparoscopically assisted Schauta : D. Dargent 1992/1995





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Brescia, 7 Giugno 2017

CANCRO DELLA CERVICE UTERINA: STADI CHIRURGICI

ORIGINAL STUDY

Improving Standard of Care Through Introduction of Laparoscopy for the Surgical Management of Gynecological Malignancies

Giorgio Bogani, MD, Antonella Cromi, PhD,* Maurizio Serati, MD,* Edoardo Di Naro, MD,† Jvan Casarin, MD,* Ciro Pinelli, MD,* Ilario Candeloro, MD,* Davide Sturla, MD,* and Fabio Ghezzi, MD**

laparoscopy from a single institution.

In conclusion, the present study indicates the feasibility of the gradual implementation of laparoscopic approach in the management of apparent early stage gynecological malignancies. We observed that through the introduction of laparoscopy, we can reduce the length of stay, complication, and blood transfusion rates, without neglecting medium-term outcomes, thus improving standard of care of patients affected by gynecological cancers. Further attempts are needed to reduce the rate of unnecessary open procedures, thus improving both patients' care and workload.

TABLE 4. Changes in cervical cancer management

	T1 (2000-2003), n = 45	T2 (2004-2007), n = 53	T3 (2008-2011), n = 64	*P*
Age, y	51 (27–78)	46 (24–69)	49 (23–77)	0.33*
BMI, kg/m^2	24 (19.6–52.5)	23.8 (17.4–39)	24.2 (15.8–45.9)	0.55*
Previous abdominal surgery	19 (42%)	22 (41%)	25 (39%)	0.93*
Charlson comorbidity index ≥3	0 (0%)	2 (4%)	3 (5%)	0.35*
Histotype				
Squamous	38 (85%)	44 (83%)	42 (66%)	0.03†
Adenocarcinoma	6 (13%)	5 (9%)	19 (30%)	
Other	1 (2%)	4 (8%)	3 (4%)	
Grade				
G1 and 2	32 (71%)	34 (64%)	49 (77%)	0.33*
G3	13 (29%)	19 (36%)	15 (23%)	
Stage of disease‡				
Early stage	36 (80%)	40 (75%)	47 (73%)	0.72*
Locally advanced stage after NACT	9 (20%)	13 (25%)	17 (27%)	
Approach				
Laparoscopy	1 (2%)	31 (59%)	53 (83%)	<0.0001§
Open surgery	42 (93%)	22 (41%)	8 (12%)	
Vaginal	2 (4%)	0 (0%)	3 (5%)	
Conversions	0 (0%)	1 (2%)	1 (2%)	0.66*
Type of hysterectomy[25]				
A/B	11 (25%)	11 (11%)	10 (16%)	0.51*
C/D	34 (75%)	42 (79%)	54 (84%)	
LND (PL ± PA LND)	38 (84%)	46 (87%)	57 (89%)	0.78*
Lymph node count	35 (5–56)	20 (12–53)	22 (3–37)	<0.001‖
Positive nodes	14 (31%)	10 (19%)	23 (36%)	0.12¶
Parametrial width, mm#	3.5 (1.4–6)	3.4 (1–7)	3.5 (0.7–7)	0.64*
Operative time, min	285 (70–930)	282 (65–375)	220 (30–320)	<0.001**
Estimated blood loss, mL	400 (100–2000)	300 (10–1000)	200 (30–1200)	<0.001††
Hospital stay, d	9 (6–15)	5 (2–14)	4 (1–9)	<0.001‡‡
Transfusions	15 (33%)	5 (9%)	3 (4%)	<0.001§§
Intraoperative complications	2 (4%)	2 (4%)	1 (2%)	0.65*
Postoperative complications‖‖	9 (20%)	5 (9%)	1 (2%)	0.005¶¶
Readmissions	6 (13%)	4 (8%)	2 (3%)	0.12*
Adjuvant therapy	14 (31%)	23 (43%)	28 (42%)	0.02##

FONDAZIONE POLIAMBULANZA Istituto Ospedaliero

Brescia, 7 Giugno 2017

CANCRO DELLA CERVICE UTERINA: STADI CHIRURGICI

Review

Surgical and clinical safety and effectiveness of robot-assisted laparoscopic hysterectomy compared to conventional laparoscopy and laparotomy for cervical cancer: A systematic review and meta-analysis

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Accepted 14 July 2016
Available online ■ ■ ■

- LPS e Robot superiori a LPT
- Outcome oncologici sovrapponibili

Outcomes	Studies	Participants	Pooled estimates	95% CI	P	I^2 (%)
Length of stay (days)						
Studies with MP	4[12,29,30,33]	251	WMD −3.23	−5.70, −0.76	<0.00001	95
Studies without MP	3[14,25,36]	356	WMD −5.60	−6.06, −5.13	<0.00001	12
Concurrent cohort studies	1[14]	68	WMD −6.60	−8.03, −5.17	<0.00001	NA
Non-concurrent cohort studies	6[12,25,29,30,33,36]	539	WMD −3.95	−5.78, −2.12	<0.00001	96
Only studies with more than 90% stage I in both groups	5[12,29,30,33,36]	499	WMD −3.72	−5.76, −1.68	0.0004	97
Blood loss (ml)						
Studies with MP	5[12,19,29,30,33]	362	WMD −384.34	−490.00, −206.68	<0.00001	92
Studies without MP	3[14,23,25]	168	WMD −536.03	−1079.24, 7.18	<0.00001	97
Concurrent cohort studies	1[14]	68	WMD −1022.30	−1221.03, −823.57	<0.00001	NA
Non-concurrent cohort studies	7[12,19,23,25,29,30,33]	462	WMD −326.72	−440.31, −213.12	<0.00001	90
Only studies with more than 90% stage I in both groups	5[12,19,29,30,33]	362	WMD −348.34	−490.00, −206.68	<0.00001	92
Operative time (min)						
Studies with MP	5[12,19,29,30,33]	351	WMD 35.08	−19.05, 89.21	0.20	96
Studies without MP	7[14,20,23,25,27,34,36]	640	WMD 3.15	−30.00, 36.30	0.85	94
Concurrent cohort studies	2[14,34]	132	WMD −24.20	−194.32, 145.92	0.78	98
Non-concurrent cohort studies	10[12,19,20,23,25,27,29,30,33,36]	859	WMD 24.71	−3.73, 53.14	0.09	95
Only studies with more than 90% stage I in both groups	8[12,19,20,27,29,30,33,36]	759	WMD 24.33	−8.23, 56.88	0.14	96
Blood transfusion						
Studies with MP	4[12,19,29,30]	290	RR 0.12	0.05, 0.28	<0.00001	22
Studies without MP	6[14,24,25,27,28,34]	249	RR 0.12	0.05, 0.28	<0.00001	0
Concurrent cohort studies	4[14,24,28,34]	161	RR 0.11	0.04, 0.28	<0.00001	0
Non-concurrent cohort studies	6[12,19,25,27,29,30]	378	RR 0.13	0.06, 0.28	<0.00001	0
Only studies with more than 90% stage I in both groups	6[12,19,27–30]	352	RR 0.13	0.06, 0.29	<0.00001	0
Total LNs						
Studies with MP	4[12,19,29,30]	290	WMD 1.67	−6.40, 9.74	0.69	89
Studies without MP	5[14,25,27,32,36]	431	WMD −0.07	−3.63, 3.49	0.97	82
Concurrent cohort studies	1[14]	68	WMD 1.20	−4.24, 6.64	0.67	NA
Non-concurrent cohort studies	8[12,19,25,27,29,30,32,36]	653	WMD 0.51	−3.12, 4.13	0.78	86
Only studies with more than 90% stage I in both groups	6[12,19,27,29,30,36]	586	WMD −0.16	−4.86, 4.53	0.95	86

MP: matched populations

CANCRO DELLA CERVICE UTERINA: LACC

Razionale:

- metastasi linfonodali paraortiche 21% Stadio IIb; 31% Stadio III; 13% Stadio IVa
- stato linfonodale impatta sulla prognosi ad ogni stadio
- imaging tradizionale e PET gravati da alto tasso di falsi negativi (20-50% e 13%)
- RT in regione lomboaortica comporta potenziali benefici ma alta morbidità
- stato linfonodale può indurre a cambiare iter terapeutico
- potenziale ruolo terapeutico della linfadenectomia paraortica

Contro:

- morbidità intra e post operatoria
- ritardo nell'inizio del trattamento

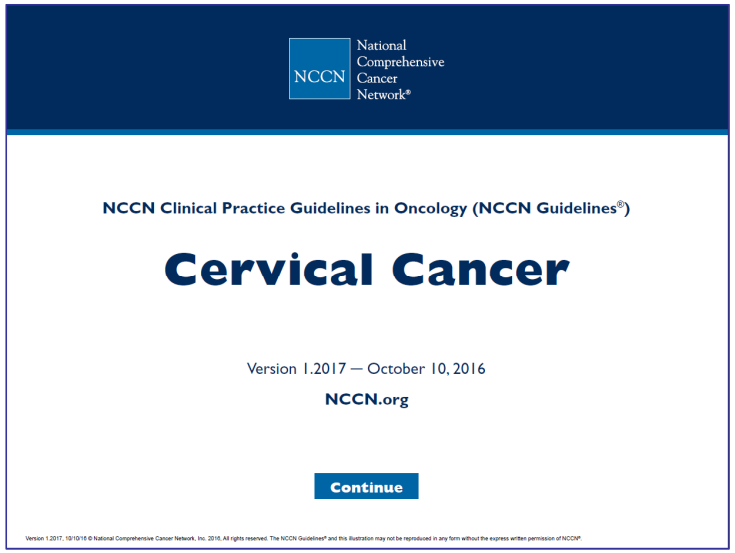
CANCRO DELLA CERVICE UTERINA: LACC

- Cosin 1998 (266 pazienti): rimozione di linfonodi bulky migliora la prognosi
- GOG 85 – GOG 120 – GOG 165 (685 pazienti): stadiazione chirurgica ha un effetto prognostico su OS e PFS e riduce recidive paraortiche
- Leblanc 2007: probabile impatto sulla sopravvivenza se staging (positivo ed inferiore a 5 mm) seguito da RT
- Uzan: necessarie 4600 pazienti per dimostrare un OS benefit del 4% a 5 anni della stadiazione chirurgica (non realistico)
- Laparoscopia (extraperitoneale) gravata da minore morbidità

FONDAZIONE POLIAMBULANZA Istituto Ospedaliero

Brescia, 7 Giugno 2017

PAZIENTE CON NEOPLASIA GINECOLOGICA: CANCRO DELLA CERVICE UTERINA



National Comprehensive Cancer Network®

NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®)

Cervical Cancer

Version 1.2017 — October 10, 2016

NCCN.org

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Cervical Cancer

NCCN Guidelines Index
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Discussion

PRINCIPLES OF EVALUATION AND SURGICAL STAGING

TABLE 1: Resection of Cervical Cancer as Primary Therapy*

	Comparison of Hysterectomy Types			Comparison of Trachelectomy Types	
	Simple/Extrafascial Hysterectomy (Type A)**	Modified Radical Hysterectomy (Type B)**	Radical Hysterectomy (Type C)**	Simple Trachelectomy	Radical Trachelectomy***
Indication	Stage IA-1	Stage IA-1 with LVSI and IA-2	Local disease without obvious metastasis, including: Stage IB-1 and 2 Selected Stage IIA	HSIL and stage IA-1	Stage IA-2 and Stage IB-1 if ≤2 cm diameter and squamous histology
Intent	Curative for microinvasion	Curative for small lesions	Curative for larger lesions	Curative for microinvasion Fertility preserved	Curative for select stage IB-1 and IA-2 Fertility preserved
Uterus	Removed	Removed	Removed	Spared	Spared
Ovaries	Optional removal	Optional removal	Optional removal	Spared	Spared
Cervix	Removed	Removed	Removed	Removed	Removed
Vaginal margin	None	1–2 cm margin	Upper 1/4 to 1/3 of vagina	None	Upper 1/4 to 1/3 of vagina
Ureters	Not mobilized	Tunneled through broad ligament	Tunneled through broad ligament	Not mobilized	Tunneled through broad ligament
Cardinal ligaments	Resected at uterine and cervical border	Divided where ureter transits the broad ligament	Divided at pelvic sidewall	Resected at cervical border	Divided at pelvic sidewall
Uterosacral ligaments	Divided at cervical border	Partially resected	Divided near sacral origin	Divided at cervical border	Divided near sacral origin
Bladder	Mobilized to base of cervix	Mobilized to upper vagina	Mobilized to middle vagina	Mobilized to peritoneal reflection	Mobilized to peritoneal reflection
Rectum	Not mobilized	Mobilized below cervix	Mobilized below middle vagina	Mobilized to peritoneal reflection	Mobilized to above peritoneal reflection
Surgical approach	Laparotomy or laparoscopy	Laparotomy or laparoscopy or robotic laparoscopy	Laparotomy or laparoscopy or robotic laparoscopy	Vaginal	Vaginal or laparotomy or laparoscopy, or robotic laparoscopy

*Data from Chi DS, Abu-Rustum NR, Plante M, Roy M. Cancer of the cervix. In: TeLinde's Operative Gynecology, 10th ed. Rock JA, Jones HW, eds. Philadelphia: Lippincott Williams and Wilkins;2008:1227.

**The Querleu and Morrow surgical classification system describes the degree of resection and nerve preservation for radical hysterectomy in three-dimensional planes and updates the previously used Piver-Rutledge classifications.

***Fertility-sparing radical trachelectomy is most validated for lesions ≤2 cm in diameter. Small cell neuroendocrine histology and adenoma malignum are not considered suitable tumors for this procedure.

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.

Continued

FONDAZIONE POLIAMBULANZA
Istituto Ospedaliero

Brescia, 7 Giugno 2017

ORDINE
MEDICI CHIRURGHI
E ODONTOIATRI
DELLA PROVINCIA
DI BRESCIA

COMMISSIONE CULTURA
Coordinatore: Dott. Germano Bettoncelli

Corso di Aggiornamento

MINI-INVASIVITÀ IN CHIRURGIA ONCOLOGICA

Sala Conferenze Ordine Medici ed Odontoiatri - Via Lamarmora n. 167 (Palazzo il Diamante) - Brescia

7 giugno 2017 - ore 19.00

SECONDA SESSIONE

ore 22.10 ***TAVOLA ROTONDA: Mini-invasività chirurgica: aspetti organizzativi e sostenibilità economica***

CONDUTTORI:
Dott. FABIO RAMPINELLI - Dott. ROBERTO FARFAGLIA

- Dott. UBERTO FUMAGALLI ROMARIO
- Dott. ALESSANDRO ANTONELLI
- Prof. GUIDO ALBERTO MASSIMO TIBERIO
- Dott. EDOARDO MATTEO ROSSO
- Dott. FEDERICO QUAGLIA
- Dott. MICHELANGELO TOSANA
- Dott. DANILO ZANI

ore 23.20 ***Conclusioni scientifiche***
Dott. GERMANO BETTONCELLI
Prof. CLAUDIO SIMEONE

GRAZIE PER L'ATTENZIONE