

Abstracts

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Opening Plenary Session I

Thursday, March 23, 2006 12:30–2:00 PM

Oasis 2-PSCC

Moderator Abstracts 1–4: Robert S. Mannel, M.D.,
University of Oklahoma, Health Sciences Center,
Oklahoma City, OK.

1

What factors predict comprehensive surgical treatment of ovarian cancer patients?

Barbara Goff, Eric Larson, Barbara Mathews, Holly Andrilla, Denise Lishner, Laura-Mae Baldwin, Michelle Lackey, Howard Muntz. University of Washington School of Medicine, Seattle, WA, Centers for Disease Control, Atlanta, GA, Virginia Mason Medical Center, Seattle, WA.

Objective: Optimizing surgical treatment for women with ovarian cancer is one of the most effective ways to improve ovarian cancer outcomes. Our goal was to describe the surgical care and identify the factors associated with comprehensive surgical care of women with ovarian cancer.

Methods: Using 1999–2002 hospital discharge data for nine states from the Health Care Utilization Project (HCUP), a total of 10,432 women with a primary diagnosis of ovarian cancer who underwent at least an oophorectomy were identified by means of ICD-9-CM diagnosis and procedure codes. Surgeries were categorized as comprehensive, indeterminate, or non-comprehensive based on surgical and diagnostic codes. Univariate and logistic regression analyses were used to determine patient, environmental, hospital, and physician factors associated with surgical care and complications.

Results: Twenty-five percent of patients were treated by surgeons who perform only one ovarian cancer surgery per year, and 33% were cared for in low-volume hospitals (one to nine cases per year). Numerous factors were independently associated with significantly higher levels of comprehensive surgical care in logistic regression analysis: age (21–50 > 71–80 and 81+); race (Caucasian > African-American and Hispanic); payer (private insurance > Medicaid); cancer stage (advanced > early); surgeon and hospital volume; and surgeon

specialty (gynecologic oncologists > obstetrician gynecologists or general surgeons). Factors associated with lymph node dissection were age, race, payer, teaching hospital, hospital and surgeon volume, and surgeon specialty ($P < 0.002$ for all observations). Colostomies were performed by general surgeons in 13% of cases compared with 2.6% for gynecologic oncologists ($P < 0.001$). Complications were similar for low- and high-volume hospitals and surgeons. However, in high-volume settings, significantly more patients underwent debulking, lymph node dissection, and resection or destruction of other organs ($P < 0.001$ for all observations).

Conclusions: Comprehensive surgical care is associated with patient sociodemographic characteristics as well as volume, surgeon, and hospital. Many women in the United States are not receiving care in the systems most likely to provide recommended care. Minority, poor, and elderly women are at even higher risk. Given that comprehensive surgery is associated with improved survival, efforts should be made to ensure that all ovarian cancer patients are referred to centers or surgeons from whom they are more likely to receive optimal surgery.

2

Barriers to enrolling patients with ovarian cancer in clinical trials in the state of Oregon

Analene Pentopoulos, Tanja Pejovic, Jeanne-Marie Guise, Jeffrey Jensen, Jillian Romm, Joanna M. Cain, Fabio Cappuccini. Oregon Health and Science University, Portland, OR.

Objectives: Currently, only 2% of adults diagnosed with cancer enroll in clinical trials. Our objective was to determine the factors that influence a woman's decision to accept or decline enrollment in clinical trials after being diagnosed with ovarian cancer.

Methods: The Oregon Cancer Registry database was searched for women diagnosed with ovarian cancer in Oregon between 1999 and 2003. A letter was sent to the physicians of all living patients to obtain consent. After consent, a survey was mailed to eligible women collecting demographic information and information regarding type of physician involved in care and care received. Patients who were offered clinical trials at the time of diagnosis and/or recurrence were asked to rank factors

that influenced their decision to enroll. Descriptive and comparative statistics were analyzed using SPSS.

Results: Between 1999 and 2003, 1262 cases of ovarian cancer were reported in Oregon. Five hundred sixty surveys were sent and two hundred forty-two completed surveys received. The mean age was 60.67. Among respondents, 45% were diagnosed in the Portland Metro area, and 98% (239/242) underwent surgery for the cancer. A gynecologic oncologist was involved in 60% of the surgeries, and 79% of subjects received chemotherapy. At the time of diagnosis, 25% of patients had knowledge about clinical trials, 61% of whom had heard about clinical trials from their physician. However, only 13.2% (32/232) of patients were offered entry into a clinical trial, with 56% (18/32) accepting. Their main reasons for accepting were a desire to help future patients and ovarian cancer research, a doctor's recommendation, and receiving a thorough explanation of the trial. The women who declined did so mainly because they did not know which treatment they would receive, the trial was inconvenient, and they felt that the trial was a gamble. Twenty-nine percent of subjects had a recurrence of their cancer; 12.5% of these patients were offered entry into a clinical trial and 67% (6/9) accepted. Their reasons were similar to those of women who entered a trial on initial diagnosis, although the hope for better treatment in a trial was an important factor.

Conclusions: Most women with ovarian cancer do not know about clinical trials and are not offered enrollment in clinical trials by their physicians. Many patients are interested in learning more about clinical trials and may be interested in participating if given the opportunity.

3

A new prognostic model for FIGO stage 1 epithelial ovarian cancer

Andreas Obermair, Lee Tripcony, Arlan Fuller, Elisa Lopez-Varela, Toon Van Gorp, Ignace Vergote, Lynne Eaton, Jeffrey Fowler, Michael Quinn, Ian Hammond, Donald Marsden, Anthony Proietto, Jonathan Carter, Margaret Davy, Nadeem R. Abu-Rustum. Royal Brisbane and Women's Hospital, Brisbane, Australia, Massachusetts General Hospital, Boston, MA, Catholic University of Leuven, Leuven, Belgium, Ohio State University, Columbus, OH, University Hospital, James Cancer Hospital, Columbus, OH, Royal Women's Hospital, Melbourne, Australia, King Edward Memorial Hospital for Women, Perth, Australia, Royal Hospital for Women, Sydney, Australia, John Hunter Hospital, Newcastle, Australia, Royal Prince Alfred Hospital, Sydney, Australia, Royal Women's Hospital, Adelaide, Australia, Memorial Sloan-Kettering Cancer Center, New York, NY.

Objectives: The goals of this study were to evaluate the impact of preoperative CA125 on overall survival in patients with surgical stage 1 epithelial ovarian cancer (EOC) and to establish a prognostic index that allows identification of patients in different risk categories (low, medium, high).

Methods: Data on 600 surgically staged patients with FIGO stage 1 EOC treated in seven Australian, three US, and one European gynecologic cancer center were analyzed. Patients

with borderline tumors and with nonepithelial ovarian cancers were excluded, as were women in whom CA125 had not been determined preoperatively, women who had not undergone surgical staging, and women with incomplete data on follow-up. Preoperative CA125 values were compared with other prognostic factors, such as age at diagnosis, substage, grade, and histologic cell type. Univariate and multivariate Cox models were calculated. A prognostic score (ECO-1) was constructed from 456 patients with complete data sets.

Results: CA125 levels >30 U/mL were associated with higher-grade, substage 1B and 1C, nonmucinous histologic cell type. Multivariate analysis confirmed preoperative serum CA125 level >30 U/mL (OR 2.7) and age at diagnosis >70 (OR 2.6) as the only independent predictors of overall survival, whereas substage and grade failed to attain statistical significance. ECO-1 is a score based on the sum of individual scoring points. Scoring points are given for CA125 >30 U/mL (3 points), age >70 (3 points), substage 1C (1 point), and grade 2 or 3 (1 point). Patients with ECO-1 scores of 0 to 2 ($n = 120$, 26.3%), 3 to 6 ($n = 296$, 64.9%), and 7 to 8 ($n = 40$, 8.7%) had 5-year survival rates of 97, 89, and 73%, respectively (log rank $P < 0.0001$).

Conclusions: The ECO-1 score identifies patients with extremely good survival more accurately than do histologic type, substage, and grade. Patients with ECO-1 scores ≤ 2 experience very good survival and do not benefit from adjuvant chemotherapy. Enrollment into clinical trials on adjuvant therapy in surgical stage 1 EOC should be limited to patients at medium to high risk.

4

The detection of early-stage epithelial ovarian carcinoma

David Fishman, Jill Whyte, Gordon Whiteley, Lance Liotta, Emanuel Petricoin. New York University School of Medicine, New York, NY, National Cancer Institute, Frederick, MD, George Mason School of Medicine, MD.

We previously reported that low-resolution MS proteomic pattern profiling was an effective tool in segregating cancer from noncancer. Subsequently, it was found that the diagnostic features were associated with carrier proteins such as albumin and that purification of carrier proteins followed by peptide dissociation yielded a rich source of information. We used the proTOF orthogonal MALDI analyzer for direct analysis of the albumin-enriched fraction purified from serum. The albumin was separated using a modification of the published protocol developed by the FDA-NCI Clinical Proteomics Program. After purification of the albumin fraction, peptides were dissociated and spotted on a disposable target for MALDI-MS analysis. Among 618 novel candidates sequenced, 215 were found only in stage I cancer, 127 were found only in stage III–IV cancer, and 30 were found in all stages of ovarian cancer. Compared with sera from women with high-risk or stage III disease, sera from women with stage I ovarian cancer appeared to have a larger total number of carrier protein-bound proteins, which fell into the following physiologic categories: cell signaling proteins, receptors and channels, and apoptosis. Ninety-six of the novel proteins that fall into putative functional categories

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