



Laparoscopic hysterectomy after concurrent radiochemotherapy in locally advanced cervical cancer compared to laparotomy: A multi institutional prospective pilot study of cost, surgical outcome and quality of life

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Abstract

Objective: Laparoscopy allows hysterectomies after chemoradiation to be performed without opening the abdominal wall. We measured the costs and quality of life for locally advanced cervical cancer patients operated on via laparoscopy compared to laparotomy.

Study design: We conducted an observational prospective multicenter study on locally advanced cervical cancer patients undergoing an extrafascial hysterectomy after concurrent chemoradiotherapy (CRT). We assessed the costs from the medical visit before surgery up to the first month after surgery from the providers' perspective and measured the quality of life using the EORTC QLQ-C30 and QLQ-CX24 up to six months.

Results: Sixty two patients (39 laparoscopy and 23 laparotomy) from December 2008 to November 2011 were included. There was no difference in operative time, or intraoperative and post-operative complication rates between the two groups. Intraoperative transfusion and abdominal drain were significantly lower in the laparoscopy group (respectively, $p = 0.04$ and $p < 0.01$), as well as the duration of hospital stay (7.3 d vs 5.7 d, $p < 0.001$). All patients who underwent laparoscopic hysterectomy were discharged to home, whereas 4 laparotomy

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patients used convalescence homes ($p = 0.01$). Mean costs at one month were €10,991 for laparotomy and €11,267 for laparoscopy ($p = 0.76$). Sexual activity is better for the laparoscopy group at six months ($p = 0.01$).

Conclusion: Laparoscopy for an extrafascial hysterectomy after CRT in locally advanced cervical cancer patients brought better quality of life with similar costs compared to laparotomy, and should therefore be the first choice for surgeons.

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Keywords: Advanced cervical cancer; Cost comparison; Laparotomy; Laparoscopy; Quality of life; Laparoscopic hysterectomy

Introduction

Cervical cancer is the second most frequent cancer in women, with approximately 500,000 new cases diagnosed, and 270,000 deaths annually worldwide.^{1,2} Although the incidence of cervical cancer has decreased in industrialized countries because of screening programs and progress in management of intraepithelial lesions, 60% of cases are at advanced stages at diagnosis. In France, the estimation of new cases in 2015 is 3060, with the highest incidence among women in their 40s, leading to nearly 1070 deaths and a 5-year survival rate of 17.2% in advanced stages.^{3,4}

The gold standard for treating patients with locally advanced cervical cancer (LACC) is concurrent chemoradiotherapy with or without brachytherapy (CRT).^{5,6} Significant survival advantages of chemoradiation in cases of LACC, have been demonstrated in a meta-analysis.⁷

The value of completion surgery after CRT in LACC however, still remains debatable,^{8–11} and few studies are available.^{12,13} Furthermore, hysterectomy after CRT remains a questionable treatment option, in particular in cases of partial response. Results from multicenter studies have demonstrated that residual disease after concurrent chemoradiation therapy and brachytherapy impact on disease free survival.^{14–16} Because the accuracy of imaging techniques are not sufficient to measure residual disease,^{17,18} surgery remains the current practice in many countries. Furthermore, completion surgery reduces residual pathological disease, which represents an important prognostic factor.^{19–23}

We previously assessed the consequences of hysterectomy by laparotomy after CRT and brachytherapy, and showed a high rate of grade 2/3 morbidity (26%), particularly due to urinary complications.¹⁴ The feasibility and consequences of laparoscopic hysterectomy after RCT for LACC have not been sufficiently assessed. In a retrospective series of 102 patients, Colombo et al.²⁴ studied 56 laparoscopic hysterectomies over a period of 8 years. The question arises as to whether this intervention improves the quality of life of these patients, and the efficiency cost and surgical outcome. A comparison of laparoscopy to laparotomy in terms of surgical outcome, cost and quality of life has not been prospectively assessed in the context of surgery after CRT in LACC. The treatment of cervical cancer is expensive and is estimated to total 44 million Euros annually in France, corresponding to a mean patient cost of €22,697 for stage III to €26,886 for stage V disease.²⁵

Our study was aimed at assessing the benefit of laparoscopy, in terms of cost, surgical outcome and quality of life.

Materials and methods

Study design and patient details

Between December 2008 and November 2011, 62 consecutive patients (39 laparoscopy and 23 laparotomy) from 13 French institutions were included in a prospective multicenter comparative observational non-randomized study.

Inclusion criteria were invasive cervical cancer proven by a core biopsy before treatment, stage IB2, and IIA, IIB (proximal), M0, preoperative external platinum based radiochemotherapy, +/- utero-vaginal brachytherapy, and extrafascial hysterectomy (+/- lymphadenectomy, pelvic and latero aortic), via laparoscopy or laparotomy, with the feasibility of a one year follow-up. The choice of the surgical approach was at the discretion of the surgeon. Each surgeon used one of the two techniques. Surgeons trained in laparoscopy performed laparoscopic extrafascial hysterectomy, plus lymphadenectomy, whilst surgeons less trained in laparoscopy performed these procedure by laparotomy. Observational study is more suitable to capture current practice in a real-world situation.

Hysterectomy was proposed in cases when tumor residual at the end of the treatment was suspected.

Initial staging was defined according to the International Federation of Gynecology and Obstetrics (FIGO) staging system. Staging was performed using a clinical pelvic examination, Magnetic Resonance Imaging (MRI), and Computed Tomography (CT).

Treatment

All patients received radiochemotherapy. Concomitant Cisplatin (CDDP) was given on the first day of each week of radiotherapy. Laparoscopic surgical staging of lymph node involvement, pelvic and/or aortic, was initially undertaken to set the field of external radiotherapy in some teams, in others it was a radiological stadification. Radiation therapy was administered at 1.8 Gy in 22–25 fractions according to international recommendations.²⁶

Surgery consisted of an extrafascial hysterectomy. Patients undergoing a laparoscopy were positioned in the Trendelenburg position, and a 0°-laparoscope (10-mm

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