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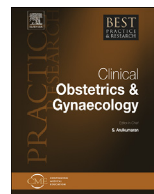

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Surgery for recurrent ovarian cancer: Options and limits

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Cytoreductive surgery is the backbone of the multimodal therapy in primary ovarian cancer patients. Despite the effect of various tumor biological factors such as grading and histological subtype, the surgical outcome is the most important prognostic factor for both progression free- and overall survival.

In contrast, the management of recurrent situation has long remained a subject of an emotional international discussion. To date, only few prospective studies have focused on the effect of surgery in relapsed ovarian cancer. The available retrospective data associate complete cytoreduction with prognosis improvement. However, the selection of patients eligible for surgery in recurrent situation is the essential issue. The establishment of predictive factors for complete tumor resection and defining the patient group with recurrent disease who might profit from this approach are crucial. The available predictors of complete resection depend on the results of primary surgery and the current patient's situation. Women who underwent primary complete cytoreduction are in good performance status, and those who have only minimal ascites volume (less than 500 ml) in the recurrent situation have 76% likelihood of undergoing complete resection and survival prolongation. Moreover, the complete cytoreduction in the tertiary cytoreductive approach has been evaluated and showed a potential positive influence on patients' survival.

This review concentrates on the recent data and highlights the need of further randomized trials to develop and incorporate operative standards in recurrent ovarian cancer.

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Introduction

Epithelial ovarian cancer (EOC) is a gynecologic malignancy that accounts for approximately 150,000 deaths occurring worldwide annually [1]. Around 70% of EOC cases are diagnosed as an advanced International Federation of Gynecology and Obstetrics (FIGO) stage, resulting in poor 5-year survival rates [2]. Despite the high remission rate reaching 80%, most of the patients develop recurrence [2]. The standard therapy in primary ovarian cancer is surgery followed by systemic chemotherapy with carboplatinum plus paclitaxel. In recurrent situation, an operative approach remains a subject of the international emotional discussion. Several effective chemotherapy regimens dependent on the platinum-free interval are commonly used, despite the fact that most of these regimens have failed to improve the overall survival (OS). In phase III trials with chemotherapies alone or in combination with targeted therapies, only a minority underwent salvage surgery prior to the trials [3–10]. Therefore, a subgroup analysis of the cohort of patients who were operated before entering these trials was statistically insufficient.

Retrospective studies of multicenter cohorts report a potential survival benefit after complete cytoreduction in patients with platinum-sensitive first relapse patients [11]. However, the selection of patients eligible for the surgery is an essential issue. The palliative/salvage approach versus cytoreduction attempt, direct systemic therapy, or best supportive care should be well considered. Therefore, it is necessary to have clear definitions of different clinical situations as well as types and objectives of surgery in relapsed ovarian cancer. The decision between the surgical approach and/or systemic treatment should be a result of clinical situation, general condition, and patient's perception and preferences.

The goal of the surgery should be discussed with the patient in detail and should be fully transparent. Patients seem to decide between surgery and chemotherapy, which is not true. In most situations, it is more likely that the decision is made between surgery plus systemic platinum-based chemotherapy and systemic platinum-based chemotherapy alone. In our opinion, no surgery with the goal of influencing the progression-free survival or OS can be indicated without defining the total cancer treatment strategy, including the systemic approach.

This review concentrates on the recent data and highlights the need of further randomized trials to develop and incorporate operative standards in recurrent ovarian cancer.

Surgery and recurrent ovarian cancer

The benefit of surgery on progression-free survival and OS in recurrent ovarian cancer remains debatable. The available data are based on various collectives in different clinical situations. The enrolment of patients with recurrence as well as patients with persistent or progressive disease in trials was not an uncommon proceeding [12]. Consequently, moderate survival rates and relatively high morbidity revealed the surgical approach as controversial [13]. The different patient selection and definition of relapse and surgical outcome limit the interpretation of the available literature significantly (12)

Defined subgroups and nomenclature used with regard to surgical approach remain a subject of discussion. The Gynecologic Cancer InterGroup has introduced the current definition of optimal debulking as a complete resection of all visible tumor manifestations in primary ovarian cancer [14–18]. This nomenclature is also usually used with regard to secondary cytoreductive surgery; however, published data are lacking.

The pattern of tumor spread in relapse situation shows peritoneal carcinomatosis with the involvement of the upper abdomen in many patients. Our working group presented the differences in tumor spread between primary and recurrent situation in a prospective study. The highest tumor burden in primary ovarian cancer was localized in the lower abdomen in comparison to the recurrent situation in which it was localized in the upper abdomen [19]. Consequently, the higher complexity of surgical approach in these cases requires experienced gynecologist oncologist, developed infrastructure, interdisciplinary cooperation, established logistic processes, and quality management. The typical change in the tumor pattern from the lower into the upper part of the abdomen must be always considered for the planning of any surgery in relapsed ovarian cancer (Fig. 1–3).

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