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A surgical perspective on the management of ovarian cancer: A video presentation

Background: Many unknowns exist in the optimal management of ovarian cancer. However, one management strategy that has been accepted as the best treatment is surgical removal of all or nearly all the visible evidence of disease within the abdomen and pelvis. This may occur as a primary cytoreduction before other treatments are initiated or as an interval cytoreduction after neoadjuvant chemotherapy has been completed. At both of these time points complete surgical removal is always the goal of optimal treatment. This extensive surgery must occur in the absence of serious complications which would delay the other crucial treatment modality which is chemotherapy with cisplatinum and paclitaxel.

Materials & Methods: Through a long midline abdominal incision, the abdomen and pelvis are widely exposed using skin traction sutures followed by a self-retaining retractor. Peritonectomy procedures and visceral resections are used to remove diseased organs that are layered by cancer. After chemotherapy washing, a reconstruction of the gastrointestinal tract occurs.

Results: With the wide exposure, dissections proceed using ball-tip electrosurgery so that peritoneal surfaces layered by cancer can be completely removed in the absence of blood loss. Also, dissection techniques for greater omentectomy allow a rapid and bloodless removal of this organ which is heavily involved by the infiltration of ovarian cancer. Peritonectomy of the right upper quadrant, left upper quadrant, and both paracolic sulci proceed under direct vision. Pelvic peritonectomy is combined with hysterectomy, oophorectomy, and left colectomy to extirpate large volumes of disease from the lower abdomen and pelvis. Hyperthermic intraperitoneal chemotherapy (HIPEC) is administered using cisplatinum, doxorubicin and systemic ifosfamide for 90 minutes at 42°C. Intestinal anastomoses and then abdominal wall reconstruction proceed after the HIPEC. An intraperitoneal port is placed in order to facilitate long-term normothermic intraperitoneal chemotherapy (NIPEC).

Conclusions: The goal of complete or near-complete removal of ovarian cancer which optimizes the initial treatment of this disease can be accomplished through cytoreductive surgery. This requires a long midline abdominal incision for wide exposure of the contents of the abdomen and pelvis, meticulous hemostasis and a plan of management that involves peritonectomy procedures, visceral resections and HIPEC.

Biography

Paul H Sugarbaker has completed his college education at Wheaton College in Illinois. He graduated from Cornell University Medical College in New York (USA) and from there he went for his surgical training at the Peter Bent Brigham Hospital in Boston (MA, USA), now known as Brigham and Women's Hospital. He received a Master's degree in Immunology at the Harvard School of Arts and Sciences in 1983. At the NIH he was a Senior Investigator from 1976 to 1986. After a brief stay in Atlanta at the Emory Clinic he moved back to Washington (DC, USA) to become the Medical Director of the Washington Cancer Institute. He has been at the Washington Cancer Institute since 1989. Currently, he is the Director for the Program in Peritoneal Surface Oncology. His interests are in gastrointestinal cancer, gynecologic malignancy and mesothelioma. For many years his work focused on liver metastases. Currently, his clinical and investigative work is directed at the peritoneal surface component of gastrointestinal cancer dissemination, referred to as peritoneal metastases. He is a strong critic of surgical tradition; he believes that major changes in the technology of cancer resection are necessary. His theme, 'it's what the surgeon doesn't see that kills the patient', summarizes the concepts behind many of his publications both in the peer-reviewed medical literature and in the lay press. In his opinion, perioperative intravenous and intraperitoneal chemotherapy are an essential planned part of many cancer interventions.

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