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Optimizing the management of advanced ovarian malignancy using cytoreductive surgery plus regional and systemic chemotherapy

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Background: Ovarian cancer presents in a majority of patients with cancer dissemination widely distributed on the peritoneal surfaces of the abdomen and pelvis. In a substantial proportion of patient's not only peritoneal metastases but also lymph nodal metastases will be present at the time of diagnosis.

Methods: The procedures required for complete surgical removal of all clinical evidence of ovarian cancer is pursued using complete cytoreductive surgery (CRS). This may be performed either before or after neoadjuvant systemic chemotherapy. At the time of surgery hyperthermic intraperitoneal chemotherapy (HIPEC) is used to improve the control of peritoneal metastases. As the patient recovers from CRS plus HIPEC, combined intraperitoneal and systemic chemotherapy are initiated for a six month interval.

Results: Cytoreductive surgery is associated with marked improvement in survival especially when all visible evidence of disease is removed. In addition, HIPEC has been shown in randomized controlled trials to improve survival, primarily by limiting the recurrence of peritoneal metastases. Also, long-term normothermic intraperitoneal chemotherapy (NIPEC-LT) combined with systemic chemotherapy has been shown in randomized trials to show significant benefits.

Conclusions: Combinations of complete CRS, HIPEC combined in the operating room with CRS and then NIPEC-LT plus systemic chemotherapy will optimize the long-term survival of patients with advanced ovarian malignancy. The clinical evidence for these benefits can be organized into an evidence-based treatment plan for this disease.

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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