Cervical Cancer

Surgical training on GI procedure in Gynecologic oncology program

Parviz Hanjani

International professor of Gynecologic Oncology, Prof. Emeritus Temple

cytoreduction

- Inverse Relation of residual tumor volume & Pts. PFS & OS
- Optimal cytoreduction from less than 2cm, to less than1cm, to no residual disease (R0)
- extend of surgical resection expanded for Gynecologic Oncologists
- But pts. presentation, performance status
- Ability to achieve no gross residual disease

Achieving no residual disease

- Biology of tumor

  or

- Maximal surgical effort

Who is real Gynecologic Oncologist!

- Trained in advanced surgical procedures including small and large bowels, bladder and ureters
- Trained to plan and manage administration of chemotherapeutic agents
- To be well knowledgeable In types, physic and administration of radiotherapy

Who is real gynecologic oncologist

- Be able to function in the areas of basic, translational & clinical research
- Familiarity with diagnostic & therapeutic procedures
- Manage complications of surgery, chemotherapy, radiation
- Comprehensive management

GI problem in Gynecology Oncology

- In management of ovarian cancer
- Surgical treatment of recurrent cervical cancer
- Bowel obstruction after radiation and radiation GI complication
- Disease related GI problem & GI involvement with disease

Case in point

- 42 yrs. old woman on 06/10/1399
- On operating table for a suspicious pelvic mass in a hospital in Tehran
- Good Debulking was carried out. Close to R0
- Lower large bowel was locally tick due most likely Mets.
- Surgeon was called

Case in point

- Surgeon refused to come and said;

This was inflammation!

These findings are not primary GI tumor nor inflammation

they are due to OV.CA!

Later colonoscopy: lumen was normal

bowel surgery in Gyn. Oncology pts…..

- Advanced ovarian cancer

  Due to tumor involvement

  For debulking purposes

- Recurrent ovarian cancer for

  secondary debulking or

  Bowel obstruction

- Palliative bowel procedures

GI procedure small bowel

- Resection and reanastomosis
- Bypass procedure
- Mucous fistula formation
- Ileostomies: end or loop
- Repair of fistula

GI procedure large bowel

- Resection and reanastomosis
- Low anterior resection
- Bypass procedure
- Mucous fistula formation
- Colostomies: Hartman procedure with end colostomy, loop colostomy
- Sigmoidoscopies

Additional desirable training

- Appendectomy
- Splenectomy
- Diaphragmatic peritoneal striping
- Diaphragmatic resection
- Intraperitoneal port insertion

ABOG/Gynecology Oncology small bowel

- Placement of feeding jejunostomy / gastrostomy
- Resection and re-anastomosis of small bowel
- Bypass procedure of small bowel
- Mucous fistula formation of small bowel
- Ileostomies
- Repair of fistula

ABOG/ Gynecology Oncology large bowel

- Resection and re-anastomosis of large bowel
- Low anterior resection and re-anastomosis
- Bypass procedure of large bowel
- Mucous fistula formation of large bowel
- Colostomies
- Splenectomies, liver biopsies, diaphragmatic resection

Who is real gynecologic oncologist

- Be able to function in the areas of basic, translational & clinical research
- Familiarity with diagnostic & therapeutic procedures
- Manage complications of surgery, chemotherapy and radiation
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- How many of us are real Gynecologic Oncology??!!

summary

- GI surgery frequently requires for ovarian cancer
- Gyn. Oncologist should be trained in GI surgery
- Pts with suspicious pelvic mass should be informed and bowel prep be given
- **Colostomy not frequently required**

Problem!

- As trained Gynecologic Oncologist doing GI surgery:

  Invading other specialty territory

  Insulting surgeon egoism

  Invading other specialty pocketbook