

Presumed Stage IA primary epithelial ovarian carcinoma: the role of complete staging surgery

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Summary

Purpose: Proper staging is warranted in any patient with primary epithelial ovarian carcinoma (PEOC), but sometimes it cannot always be performed. The prognosis of patients with and without complete staging surgery is to be determined.

Methods: We retrospectively evaluated 61 patients with presumed Stage IA PEOC between January 1970 and December 1993. Inclusion criteria were: being referred patients; no ascites; an intact ovarian tumor without extra-spillage or rupture before, during or after operation; conventional regular exploratory laparotomy without urgency; more than a 5-year follow-up, except for recurrent diseases; a detailed pathology review; and no other systemic disease. Tumors of lower malignant potential (LMP) and cystectomy for removing tumor were excluded. Of the 61 patients, 17 patients received a close observation (Group A), and the others (44 patients) received a re-exploratory laparotomy to complete the staging surgery (Group B).

Results: The mean follow-up time was 7.4 years, ranging between 5.4 and 11.1 years, in Group A, and 8.1 years, ranging from 5.6 to 12.7 years, in Group B. Two patients (11.8%) in Group A and seven patients (15.9%) in Group B suffered from recurrence. Two patients finally died of disease, and both were in Group B.

Conclusions: Based on the observation in this study that the recurrence rate of the two groups was not statistically different, close follow-up for patients with presumed Stage IA EOC, but without complete surgical staging surgery, might be acceptable when these patients are treated with postoperative adjuvant chemotherapy.

Key words: Primary epithelial ovarian carcinoma; Stage IA.

Introduction

In 1997, all Stage II, all Stage IC, and Stage IA and IB primary epithelial ovarian carcinoma (PEOC) cases with high-grade tumors were classified as a high-risk group, and all other types of early-stage tumors were grouped as low-risk. However, less is known than should be about how best to treat early-stage PEOC [1]. Furthermore, re-staging surgery is suggested for all patients who have inadequate staging for PEOC (borderline tumors excluded) before referral, but for various reasons, repeat surgical intervention cannot always be selected, especially when dealing with patients with presumed Stage IA PEOC. In addition, it is still uncertain whether adjuvant therapy increases survival [2]. Therefore, this study was designed to evaluate the effects after different therapeutic approaches, based on the analysis of outcome of patients with presumed Stage IA PEOC.

Materials and Methods

Sixty-one patients from 1970 to 1993 were analyzed retrospectively. These patients all fulfilled the following criteria: referred cases (initial operation was not performed in our institute); no ascites; removal of intact ovarian tumor without extra spillage or rupture before, during or after operation; conventional regular exploratory laparotomy without urgency; more than a 5-year follow-up, except for recurrent patients; detailed pathology review by one of the authors; and, no other systemic disease. Tumors of lower malignant potential (LMP) and cystectomy for removing tumors were excluded; patient character-

istics are shown in Table 1. Of the 61 patients, 17 did not receive further exploratory laparotomy for staging surgery (Group A) and the other 44 did (Group B). The mean follow-up time of Group A patients was 7.4 years (ranging between 5.4 and 11.1 years), compared to 8.1 years (ranging from 5.6 to 12.7 years) for Group B patients.

Results

The mean follow-up time was 7.4 years, ranging between 5.4 and 11.1 years, in Group A, compared with 8.1 years, ranging from 5.6 to 12.7 years in Group B. Two patients (11.8%) suffered from recurrent disease in Group A and seven patients (15.9%) had recurrent disease in Group B. All patients received intensive treatment, including exploratory laparotomy followed by multi-agent chemotherapy. Two patients from Group B died of disease; one was a 43-year-old woman with mucinous cystadenocarcinoma (moderate differentiation), and the other was a 21-year-old woman with serous cell carcinoma (poor differentiation).

Discussion

Ahmed et al. demonstrated that histologic types, the type of surgery, FIGO stage and intraoperative rupture of the tumor did not appear to influence outcome [2]. In this study, we further identified that re-exploratory surgery might not affect outcome. However, we still have some concerns about the poor differentiation of ovarian cancer in correlation with patient outcome [3, 4]. Clear cell carcinoma [5] and poor differentiation [2] are reported to be associated with a poorer outcome. The importance of

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Table 1. — Characteristics of patients with presumed Stage IA epithelial ovarian carcinoma.

Factors	Patients (No. 17) (Group A)	Patients (No. 44) (Group B)
Postoperative adjuvant		
C/T (cycles)		
(No)	1	9
(4-6)	11	34
(7-12)	5	1
Age (years of age)		
(Less than 20)	0	4
(20-30)	5	6
(30-40)	10	14
(More than 40)	2	20
Cell Types		
(Mucinous)	9	15
(Clear)	1	6
(Endometrioid)	3	9
(Serous)	4	14
Differentiation		
(Well)	11	7
(Moderate)	5	30
(Poor)	1	7

C/T: chemotherapy with CAP (cyclophosphamide 500 mg/m², adriamycin 50 mg/m², and cisplatin 50 mg/m² intravenously, every three weeks) regimen.

immediate adjuvant chemotherapy was highlighted in two recent large randomized trials [6-8]. One trial, the international collaborative ovarian neoplasm trial 1 (ICON1), randomly assigned 477 women with early-stage epithelial ovarian cancer to receive platinum-based adjuvant chemotherapy immediately after surgery or to receive no adjuvant chemotherapy until clinically indicated when further symptoms developed, and the results showed improved overall survival in the women treated with adjuvant chemotherapy after surgery (hazard ratio 0.66 (95% confidence interval 0.45 to 0.97)). This translates into a 9% increase in the five-year survival rate (70% vs 79%). Adjuvant chemotherapy also improved recurrence-free survival: 73% in the adjuvant treatment group compared with 62% in the other group (hazard ratio 0.65 (0.46 to 0.91)) [6]. The other was a European trial, using adjuvant chemotherapy with ovarian neoplasms, which randomized 448 women with early ovarian cancer to receive adjuvant chemotherapy or observation after surgery, and the results showed that recurrence-free survival was higher in the treatment group (hazard ratio 0.63 (0.43 to 0.92)), but not overall survival [7]. When the results from the two trials were combined, the improvement in survival after adjuvant chemotherapy was confirmed: overall survival at five years was 82% in the women given chemotherapy and 74% in the other women (hazard ratio 0.67 (0.50 to 0.90)), and recurrence-free survival at five years was also better with adjuvant chemotherapy (76% vs 65%) [8]. However, in this

study, we failed to demonstrate the benefits of immediate adjuvant chemotherapy because the majority of our patients received adjuvant chemotherapy whether they underwent completed surgical staging surgery or not.

In conclusion, although this study was retrospective and of small size, we still were able to acquire some information to work with when encountering patients who had inadequate staging for EOC before referral. In spite of different management protocols, the outcome would be the same. Re-staging surgery is standard treatment for patients with unexpected, but well capsulated epithelial ovarian carcinoma, but if physicians could provide very close follow-up or immediate adjuvant chemotherapy, an opinion of not performing re-staging surgery would be acceptable.

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