Editorial ESGO

Gynaecologic Oncology: looking back and moving ahead

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Honorary Founding President

Ladies and gentlemen, dear colleagues and friends, welcome to Venice. I wanted to say that I am very happy and proud to be among you once again in Venice where our European International Meeting began exactly 22 years ago in April 1979. But it is not true because I am very deeply saddened by the loss of my dear friend, Jan Bonte. I remember and will remember for all my life, his enthusiastic participation in the life of our society, his very precious scientific contributions, and his dynamic activity as a scientist and oncologist. Now in the second issue of our journal (March-April 2001) two very important contributions by Jan Bonte have been published. One is an ESGO editorial "Recent data about endometrial carcinoma: potential of anti-aromatase agents" and an ESGO consensus document on cervical cancer screening [1, 2]. Never did he stop working and giving us the contribution of his deep culture and knowledge. Thank you very much Jan.

Of course, I'd like to thank the president of the European Society and of this 12th ESGO meeting, Professor Tiziano Maggino, for having nominated me as honorary president of this meeting and for having the honor of the opening lecture. I'd like to congratulate my pupil and friend, Professor Maggino for his success in the activity as the president of our Society and for the organization of this scientific meeting. The topics of this meeting cover every field of our discipline, including the most recent advanced research in gene therapy, innovative treatments, adequate management of female genital cancer, avoiding over and under treatment and useless mutilation, particularly in young women. Some of the greatest experts in gynecological oncology are here from every European and many overseas countries and their scientific contributions will be important for every participant and also for myself.

I am an old gynecologist-oncologist and I thank God to be here after a half century of working in this field. Our discipline is very young and its role and aims have year by year become richer and richer in the goals which qualify it. The results we have achieved are very important but nevertheless today too the management of female genital cancer is still a very difficult challenge for the scientist. We now know better the complexity of the problems, the pathogenesis, the aggressiveness factors, local and distant diffusion by adequate staging, slow and quick evolution and so on of every gynecological cancer. Undoubtedly there has been great progress but the most impressive success has been reached by prevention and early diagnosis, particularly by mass screening in developed countries. Even with all of this, gynecological oncology is a very young discipline which acquired its identity during the sixties when the period of pioneering and the virtuosity of great surgeons was over. Before the sixties female genital cancers were treated with surgery and/or radiotherapy by general gynecologists and surgeons, some of whom set out to break new ground in gynecological oncology. After the fundamental experience in surgical radicality led by Wertheim and by Shauta, and in radiotherapy often in combined treatment, many gynecologists in Europe and in the United States have tried to improve the management of female genital cancer with new techniques. A more extensive radicality or radio-surgical sequence and combined treatments with chemotherapy have been tried. I remember some of the scientists like Amreich in Austria, Novak in Slovenia, Inguilla in Italy, Richter in Germany, Brunschwig, Meigs, Barber and Rutledge in the USA. We have lived the experience of radical and ultraradical operations of Brunschwig and every new attempt to control the aggressivity of genital cancer with every methodology. However we have learned a lot, year by year, and today the best results can be achieved, in my opinion, with personalized treatment on the basis of surgical stage, aggressiveness factors and so on. With early diagnosis we can reach the best success not only for survival but for the quality of

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life. In subsequent years and today growing attention is being focused on investigating the biology and natural history of such tumors. An adequate interdisciplinary approach with surgery, radiotherapy, chemotherapy and immunotherapy has evolved.

The progress in our field has been possible not only due to the advances in science but also to the organizing of gynecological oncology in a superspecialized discipline. I'd like to stress that only in the last 30-40 years has gynecological oncology acquired its own identity including gynecologists, pelvic surgeons, radiotherapists, oncologists and pathologists who work only in the female genital cancer field. The first society of gyencological-oncologists was founded in the United States in 1969 and the official recognition of the subspecialization was given by the American Board of Obstetrics and Gynecology in 1970. Its first objective and purpose was "to improve the care of patients with gynecological cancer" and the objective of the gynecological oncology department was "to improve the health care" of women with neoplastic diseases of the reproductive organs" [3]. In Europe too, the history of gynecological oncology began early mostly in France, Germany, Austria and Norway. In our country following the pioneering experience and teaching of Felix Rutledge, a department of gynecological oncology began to operate in the Gynecological Institute of Padua University in 1961. I'd like to remember here my professors, Mario Raso, pathologist, Luigi Musaio, pharmacologist, G. B. Revoltella and Giuseppe Vecchietti, gynecologists, who led me step by step to face the new discipline. I remember my first experience in oncological surgery in France (Villejuif), my first experience in chemotherapy in Germany with Domagk and the United States at the Memorial Sloan Kettering Institute with Sutjura and my clinical experience in Houston with Rutledge.

Many years of my scientific life I have spent following the progress in diagnosis, staging, diagnostic imaging, lymphography, arteriography, systemic, endoarterial and intraperitoneal chemotherapy, isotopotherapy, radiotherapy, radical surgery and non-mutilant operations all over the world. The first results of our experience were published in a monographic book in 1963 [4], and in 1966 the first Italian and European course on "Advances in gynecologic oncology" was held in Padua organized by my professor Vecchieti and myself. In our Institute the researches in many fields of female genital cancers were carried out and followed for years, with very interesting results [6-18]. In Italy a Gynecologic Oncology Society was founded in 1976 by some gynecologists among whom I remember A. Bompiani, L. Carenza, P. Marziale, G. De Palo, F. Gasparri, P. Bettocchi and myself. I was the first president. After, in 1979 the International meetings in Venice began with a large participation of gynecological-oncologists from European and overseas countries. I'd like to recall that in Venice we held the International Gynecological Oncology meetings in 1979 [19], 1982 [20], 1983 [21], 1985 [22], 1987 [23] and 1991 [24]. The topics were very interesting and ahead of their time – like prophylaxis, prevention and early detection in gynecological oncology (20 years ago) – new surgical trends and related therapy in cervical, ovarian, breast, endometrial, vulvar and trophoblastic neoplasias – surgical staging in gynecological malignancy (16 years ago). We proposed the surgical pathological staging to avoid under or overtreatments to reach personalized management. Since 1988 FIGO has followed the surgical staging which is the only way to have a precise evaluation of the pelvic invasion of genital cancers [25].

And so, in this fever of research, meetings, discussions and enthusiatic debating the European Society of Gynecological Oncology was founded here in Venice in 1983 by a group of oncologists, gynecologists, chemotherapists, radiologists, radiotherapists, pathologists, endocrinologists and pelvic surgeons. I remember the strong discussions among us and the founders of our Society; J. Bonte, Louvain - O. Dapunt, Innsbruck - S. Dexeus, Barcelona - J. de Brux, Paris - I. C. Dragenscu, Bucarest - F. Gasparri, Florence - A. Gerbaulet, Villejuif - E. Gitsch, Vienna - A. Gorins, Paris - J. L. Hayward, London - H. K. Hollman, Paris - C. A. F. Joslin, Leeds - O. Kaser, Basel - P. Kolstad, Oslo - J. Kovacic, Lubiana - P. Stoll, Mannheim - E. Wilstshaw, London - T. Maggino, Padua and myself. Otto Kaser was the honorary president and I the first president [26].

The goals and purposes of our Society were "to promote international and cultural communication among gynecologists, pathologists, surgeons, oncologists, radiotherapists and other specialists of disciplines related and pertaining to gynecologic oncology and to promote clinical and basic research, investigations and spreading of knowledge in gynecological oncology in Europe". The meetings of our Society in Paris 1989 [27], Barcelona 1993 [28], Knokke 1995 [29], Coimbra 1997 [30], Budapest 1999 [31], were very successful. During the last meeting in Budapest the European Academy of Gynecological Cancer was founded by Peter Bosze as an educational branch of ESGO. Its aim was to set up gynecological oncology training programmes including recognized subspeciality training and continuous medical education in Europe. Now

we are again in Venice for the ESGO 12 Meeting [32]. The program is very fascinating and the scientific level very high. Thank you again, Prof. Maggino, for your very skillful and well done organisation.

What about gynecological oncology today in Europe? The hyper- or subspecialization in gynecologic oncology is now officially recognised by OEMS in the European Community, and in many countries it is already working. The collaboration and control of qualified centers for subspeciality training is planned by the European Board and College of Obstetricians and Gynaecologists in order to analyze the general principles of postgraduate education and the specific aspects of our hyper-specialization. As is well known, the surgical training is a very important and qualifying experience which must be done in adequate clinical centers led by skilled gynecological surgeons for the management of every pelvic problem (urologic, vascular and bowel surgery) and of breast cancer too. Gynecological oncology training centers need common requirements in order to provide quality care, adequate fellowship training and sufficient material for clinical and basic research [33]. Our society is deeply involved in this problem and I hope that it will lead to the development of standardized Europe an training assessment guidelines.

I'd like to remind you that in the past the strong engagement of Jan Bonte in the "Europe against cancer program" led our Society to improve cervical and breast cancer prevention by mass screening in many countries of the European community. I remember the meeting of our Society promoted by Jan Bonte in 1988 in Leuven under the auspices of the European Community "Cancer prevention by mass screening for gynaecologic cancers in the European Community" with a large participation of experts from Western countries [34]. It has proved that the implementation of cytologic screening programs in recent years, has brought about a major reduction in the incidence and mortality of cervical cancer. In fact, in developed countries a woman's risk of cervical cancer is currently estimated at 1% compared to 5% in developing countries which do not have screening programs [35].

Nevertheless, it has been established that instituting such programs is difficult and requires expertise in cytology and skill in colposcopy. Colposcopy, using target-biopsies and electric loop excision has revolutionized the treatment of CIN with simple outpatient procedures. In this way, advanced stages and heavy mutilation can be avoided respecting the quality of life of the patient. Due to the screening and consequently the prevention and early diagnosis, treatment can be adequate in the cost-benefit balance to assure the patient, not only a long survival, but also a satisfactory quality of life. All over the world now, useless mutilations for breast, cervical and vulvar cancer can be avoided in young women [36].

I'd like to recall the enlarged cervicotomy proposed by Novak (Ljubiana) in the sixties for early stages of cervical cancer in order to preserve the fertility of young women. I remember also the radical non-multilant vulvectomy proposed by myself at the first meeting in Venice in 1979 [16] contemporaneously with the clinical experience of DiSaia in California, for early vulvar cancer in young women [37].

Our society has its own official publication in the "European Journal of Gynaecological Oncology" founded in 1980, the second journal of gynaecological oncology in the world after "Gynecological Oncology" founded in 1973 in the USA. At the beginning the goal of our journal was to spread the knowledge and progress of our discipline and to improve the scientific collaboration in all European countries. At that time scientific communication, information and collaboration among oncological departments were rare and difficult in Europe, particularly between Eastern and Western countries. Now the journal is largely diffused all over the world and in recent years with the collaboration of my friend, Peter Bosze, has reached a high scientific and cultural level, particularly with the "Distinguished Expert Series". Our society has another very important editorial activity with the "CME Journal of Gynecologic Oncology", an international journal for continuing medical education on basic and clinical gynecologic oncology edited by Peter Bosze and George D. Wilbanks. This is a great contribution for the scientific level of our hyper-specialization. I am happy and proud of the results we have accomplished and I am sure that the progress in our discipline will always be greater and greater. We now know better the complexity of oncological problems, the pathogenesis, aggressiveness factors and so on of every gynecological cancer but the way in front of us is very, very long and the results we have achieved in one century are, in my opinion, not completely satisfactory. One century is a long time for human life but a very short time for medical science particularly in the malignancy field. We must go ahead but I am old and I believe that our young colleagues, who are numerous in this meeting, will continue with the same enthusiasm and engagement we had when the discipline of gynecological oncology began.

I hope that your stay in Venice will be pleasant, not only for the scientific activity but also for social and cultural activity which involves a very long friendship, particularly among the pioneers of the Venetian

meetings, many of whom are present today. Jan Bonte is not here and this is a terribly sad note of this meeting. Nevertheless in his memory we must go ahead. We hope to meet Jan in the eternal world, where nothing begins or finishes, where he has just arrived.

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