Role of Palliative Surgery in Ovarian Cancer

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Dr. William Hoskins: “Good morning, thank you very much for the invitation to speak. I’m going to be skipping some slides because we’ve decided to try to cut the time a little bit to allow time for questions so just pardon me if I do cut some of the slides.

When we talk about surgery in ovarian cancer, we have a variety of procedures that have entered our practice - initial site of reduction, interval site of reduction, site of reduction following neoadjuvant chemotherapy, second-look surgery, extent of disease reassessment usually by laparoscopy, secondary site of reductive surgery, and finally, surgery for palliation. This is the area that I’m going to address today - surgery for palliation. Palliative surgery in ovarian cancer is to relieve symptoms or manage complications, and these are patients who usually have had multiple chemotherapies, are refractive to therapy, and the most common problem that we see is intestinal obstruction. We have to remember that our goal in the surgery for palliation for ovarian cancer is to try to improve the quality of life in a patient that usually has a very limited life expectancy. One of the things that we try to do is to prevent local complications from patients that are unresponsive or have become refractive to chemotherapy. Often times this is combined with local radiation to control local complications, and examples are cutaneous metastasis, either supraclavicular or inguinal, and abdominal wall implants.

With radiation therapy, you can often times control this disease and provide palliation but before you can do that, you need to resect the disease. Obstruction - either of the urinary tract or the intestine and occasionally just to improve function and relieve pain. Cutaneous lesions - resect localized nodal metastasis or abdominal wall disease and then use local radiation to prevent recurrence of the local problem. To relieve pain or improve function - occasionally patients will have very large liver metastasis that cause a lot of pain that can be managed palliatively either by cryosurgery or embolization to help to relieve pain. Often times the rare patient who gets a brain metastasis will benefit from resection and radiation for palliation, and on rare occasions, we’ve actually performed pleurectomy for patients with refractory pleural effusions. Most ureteral obstruction can be managed by placing stents, on occasion resection of a local lesion followed by radiotherapy will help the obstruction, and rarely for patients who have fistulae diversion is necessary.

The biggest problem, however, is obstruction of the intestine and that’s where I’m going to really concentrate my time. The obstruction can involve the large intestine and the small intestine or both and characteristic of ovarian cancer is multiple sites of obstruction. High obstructions that involve the distal duodenum or proximal jejunum are usually best managed by putting in a percutaneous endoscopic gastrostomy rather than a surgical procedure. These patients often times, even if you can relieve a distal obstruction, are quite miserable. Occasionally you’ll have a patient who just has a lot of dysfunction secondary to involvement of the mesentery and in those patients also a percutaneous gastrostomy is the therapy of choice. I’m going to go through this relatively quickly and just come to the summary at the end but, basically, the literature reports about surgical palliation are quite numerous.

The majority of the patients discussed were refractive to chemotherapy, the goal of the surgery was palliation and, generally, the success of the operation was the ability for the patient to go home with enough oral intake to sustain themselves. We’ll just go through a few of these quickly. Castaldo in 1981, 25 operations and, again, the definition of the survival of palliation was described as survival of greater than 8 weeks and you can see that he was about 80% successful, however, notice the post-operative mortality. Krebs in 1981, 118 operations in 98 patients and, again, using the same
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Definition of palliation that is survival greater than 8 weeks was 65%. Note that about 2 of the patients despite the surgery had unrelieved obstruction, 20% re-obstructed, and the post-operative mortality was about 12%. Solomon in 1983 was very similar, noting that about 14% were unsuccessful, about 10% re-obstructed, and post-operative mortality of 5%. Redman in 1988, 26 patients and again, the same definition of palliation and he was, again, about 60% successful. Note again about 15% of the patients re-obstructed and he had a 38% post-operative mortality. This is a paper from Memorial Sloan Kettering from 1989, Steve Rubin, 52 patients, 29% of the patients were unsuccessful, in other words, despite the operation the obstruction could not be relieved, 79% of the patients who had the surgery were discharged on a low residue diet, and 9% post-operative mortality. If you look at the morbidity, I think this is the most important thing to remember and several of the other authors have reported on this, and that is the most significant morbidity is fistula because if you do not relieve the obstruction and you get an intestinal fistula, then that means the patient is basically going to live with that fistula for the remainder of their life. Median survival in this group of patients was 6.8 months, and I think another thing that you have to point out is that about half of these patients had some form of stoma, either a colostomy or ileostomy. I'm just going to skip some of these now in the interest of time, they're all very similar but I do want to talk a little bit about the summary. You can see that there's quite a bit surprisingly in the literature, and this is the part I think that we need to look at. Beginning in 1981, looking at the various reports that we have seen in the literature, not an insubstantial number of patients, this is the first of a couple of slides. You can see the success rate is pretty common to be somewhere in the 60%-70% range, also note a very high operative mortality and a very high operative morbidity with a relatively short survival somewhere in the range of 3-6 months. Just continuing from 1989-1994, you see again a very similar success rate, very high operative mortality and morbidity, and a relatively short survival, and the same thing here. So if we put all of this literature that has been reviewed together and combine all of the data, we're looking at reported literature of about 614 patients. The average success, in other words, the average ability to send the patient home with some type of oral intake is about 60%, somewhere around 17% of the patients will die from the operation, a very high number will have morbidity and recall that this morbidity is often times intestinal fistulae, and if we put it all together the average survival is about 4 months. So we can say that the chances of a patient leaving the hospital on a regular diet or a low residue diet is about 60% and they have about a 17% chance of dying in the hospital. The chances of a significant complication and here the most significant is fistula is about 30%, and many of the patients who have successful surgery, somewhere between 30%-50% in the literature, will have a permanent ostomy - either an ileostomy or a colostomy. The average survival of these patients is between 3.5 and 4 months and most of these patients will develop recurrent intestinal obstruction and die from that.

I think it's very important that when we talk to patients and their families who have refractory ovarian cancer that we tell them that the operation has grave risks both for death as well as for complications, particularly fistulae. If you consider the surgical recovery time of being on the average one month, the patients may realize that what we're talking about is somewhere in the range of 2-3 months of palliation before they are re-obstructed. I think that we also have to look at the alternatives because with modern endoscopy it's relatively easy to place a percutaneous gastrostomy, and these patients can often then be managed with intravenous fluids at home. This results in a patient who can take oral liquids for comfort reasons and can close the PEG and walk around and be ambulatory. I think we have to consider this as an option when we look at the very unsatisfactory results of the surgical procedure. I think it was best summed up by Steve Rubin recently in an editorial when he said, 'As with most difficult medical decisions where management options are not clearly defined, the best course is to present the reasonable alternatives to the patient and her family as clearly and as objectively as possible and let the patient decide.' I certainly don't want to imply that there is no role for palliative surgery in ovarian cancer but I certainly do think that you have to be very honest with the patient about the very limited success of such procedures and the relatively high mortality and morbidity.

Thank you very much."