

ESMO SUMMIT LATIN AMERICA 2019

Gynecological cancer – Clinical Cases

Eduardo Paulino, MD

INCA, Grupo Oncoclínicas





Case 1

Case 1

- ◆ ID: 59 y/o, no comorbidities, 3 children, former smoker, no family history of cancer.
- ◆ History: In the Q1 of 2015 the patient begun with abdominal discomfort evolving with pelvic pain. In the Q2 2015, she initiated with new symptoms and developed constipation and abdominal distension.

Last Mammogram (3/2014): BIRADS 2

Last Cervical Screening (10/2014): inflammatory findings.

She was assessed by her general physician in the Q2/2015

- ◆ Physical exam: ECOG PS 1, mild abdominal distention and pelvic mass on her left lower quadrant.

Case 1

- ◆ It was requested pelvic and abdominal CT scan and serum exams
- ◆ Abdominal/Pelvic CT scan (Jun/2015): Moderate ascites, 7 cm left pelvic mass with contrast enhancement and rectosigmoid involvement, signs of peritoneal carcinomatosis, paraaortic lymph node enlargement (2.5 cm), absence of hepatic parenchymal lesions, absence of signs of mesenteric infiltration or involvement of the hepatic hilum.
- ◆ Serum Exams Jun/2015: normal hemogram, no renal or hepatic impairment. CA 125 1250, CEA 3,2 (ratio Ca 125/CEA 390), normal CA 19-9 and CA 15-3

Case 1



- ◆ She was referred to the oncologic surgeon for a diagnostic and therapeutic approach.

- ◆ Question:
 1. What are the criteria of unresectable disease?
 2. How the best approach to assess resectability?

Case 1



- ◆ The patient had a laparotomy in August/2015
- ◆ Intraoperative findings:
 - ➔ Moderate ascites (500 ml), peritoneal implants (lesions of 5 cm), left pelvic mass attached to rectosigmoid (10cm) , right peritoneal diaphragmatic lesions, paraaortic lymph node enlargement (2,5 cm), partial small bowel involvement.
- ◆ Surgical outcome:
 - ➔ Frozen biopsy: Adenocarcinoma
 - ➔ Pelvic mass resection en bloc with rectosigmoid, omentectomy, resection of the bulky paraortic nodes, resection of the implants in small bowel, right diaphragmatic stripping
 - ➔ All macroscopic disease resected.

Case 1



- ◆ Final Pathologic report:
 - ➔ High grade endometrioid adenocarcinoma of the ovary, FIGO IIIC.

The patient was referred to medical oncologist for adjuvant decision.

It was not requested BRCA status at this time.

Case 1

Summary:

- 59 y/o, no comorbidities, ECOG PS 1
- High grade endometrioid carcinoma of the ovary, FIGO IIIC
- Successful primary debulking surgery with no residual macroscopic disease
- BRCA 1 status unknown

Case 1



Questions:

- 1) Who should be tested for BRCA mutation ?
- 2) In case of unresectable disease, neoadjuvant bevacizumab is safe ? Any data regarding efficacy and safety ?
- 3) After ICON8 and GOG 252, dose dense and IP still have a role in ovarian cancer?
- 4) What is the current scenario of HIPEC in ovarian cancer?
- 5) Any predictive marker of response to bevacizumab ?
- 6) Are large or small bowel resection contraindications for the use of Bevacizumab?
- 7) Should we use bevacizumab only in the ICON 7 high-risk subgroup ?

Case 1



- ◆ The patient received 6 cycles of **Carboplatin/Paclitaxel/Bevacizumab** and **maintenance with Bev until Jun/2017** with normalization of the CA 125.
- ◆ In August/2017 (TFIp 18 months), she had CA 125 elevation (55).
- ◆ Physical exam: ECOG PS 0, still NED
- ◆ Pelvic/Abdominal CT (Sep/2017): no signs of recurrent disease, no ascites, no other findings.

Case 1



- ◆ In December/2017 (TFI_p 22 months), she begun with pelvic discomfort on her left lower quadrant and a higher elevation of CA 125 (55 => 135).
- ◆ Physical exam: ECOG PS 1, pelvic pain on her left lower quadrant
- ◆ Pelvic/Abdominal CT (Sep/2017): pelvic mass of 5 cm suggesting recurrent disease, no ascites, no other findings.
- ◆ BRCA requested: **somatic BRCA2 mutation.**

Case 1

- ◆ Questions:
 - 1) Is there a role for secondary cytoreduction in this patient?
 - 2) How can we confront the DESKTOP III data against GOG 213 ?
 - 3) What's the best combo in platinum sensitive disease?
 - 4) Any different approach in case of BRCA mutation?
 - 5) In patient with symptomatic recurrent PSOC and mBRCA, should we add bevacizumab to increase ORR ?
 - 6) How to choose between antiangiogenic and iPARP in patients with recurrent PSOC?
 - 7) Can we combine both in the maintenance?

Case 1



- ◆ She was reassessed by the surgical oncologist and was opted to offer secondary cytoreduction since the patient had positive AGO score.
- ◆ She had secondary cytoreduction in Dec/2017 with resection of the pelvic mass (no macroscopic disease was left)
- ◆ After surgery she received 6 cycles of Carboplatin + pegylated doxorubicin until May/2018 with good tolerance. She started maintenance with Olaparib capsules (400 mg twice daily)
- ◆ During the second month of Olaparib maintenance she developed anemia/fatigue G3, nausea G2



Case 2

Case 2



- # 65 y/o women, postmenopausal, 3 children, no comorbidities, ECOG PS 1, obesity
- # History of vaginal bleeding for 3 months in the Q1/2018.
- # Assessed by the gynecologist and requested a transvaginal US

- # TVUS: endometrium of 12 mm with suspected of miometrium invasion

Case 2



- ◆ Hysteroscopy with biopsy:
 - ◆ Endometrioid adenocarcinoma grade 3
- ◆ Referred to the Brazilian NCI
- ◆ Chest X-Ray: NED
- ◆ Pelvic and abdominal MRI: lesion infiltrating less than 50% of the myometrium, no signs of metastatic disease, including pelvic and paraortic nodes.

Case 2

- ◆ Videolaparoscopy surgery in 03/2018:
 - ◆ Hysterectomy + bilateral salpingooforectomia + bilateral SLN
- ◆ Final pathology report:
 - ◆ Endometrioid adenocarcinoma grade 3, LVSI present, FIGO IB
 - ◆ 3 SLN negative
 - ◆ P53 positive, L1CAM positive. POLE not performed
 - ◆ MSS

Case 2



- ◆ Could SLN be considered standard of care ? Do we need to go further and perform systematic lymphadenectomy ?
- ◆ What is the best adjuvant approach for this patient after the results of PORTEC 3 and GOG 249?
- ◆ Are we ready to use molecular classification to guide adjuvant treatment ?

Case 2

- ◆ It was decided to offer adjuvant carboplatin plus paclitaxel for 6 cycles and adjuvant brachytherapy



Case 3

Case 3

35 y/o, no children, no comorbidities, ECOG PS 1,

Pregnant (week 13)

This patient initiated with transvaginal bleeding in october/2018. She went to her gynecologist who diagnosed a cervical tumor and performed a biopsy.

She was referred to a tertiary center (NCI)

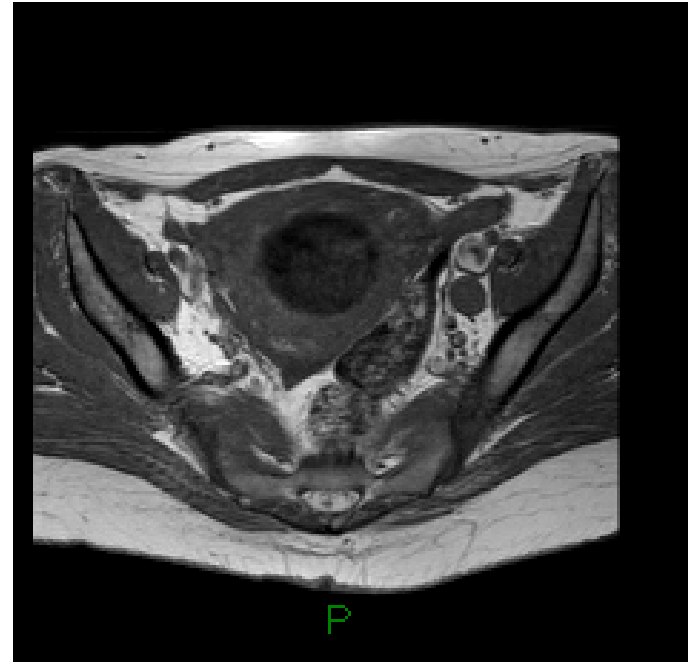
→ Cervical biopsy: Adenocarcinoma G1

At the NCI, Gyn Oncol evaluation: cervical tumor with suspected left parametrial invasion – FIGO 2018 IIB

Pelvic MRI requested

Case 3

- Pelvic MRI (Oct/2018): Parametrial invasion with suspected left pelvic node



Case 3



Summary:

35 y/o, ECOG OS 1

Adenocarcinoma of the uterine cervix FIGO 2018 IIIC1

Pregnant (13th week)

Staged with pelvic MRI

Case 3



Questions and Discussion:

- ◆ What exams are safe during pregnancy ?
- ◆ How this patient should be managed ?