

Editorial

by Professor Franco Guidozi,

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In this edition of *MENOPAUSE UPDATE* there are four articles pertaining to gynaecologic cancer. The message of the first three articles is that even though the general gynaecologist will be called upon to assess and confirm the diagnosis of ovarian and vulval cancer in their patients, or the presence of recurrent gynaecologic cancer during the routine follow-up of patients who have previously had their surgery, with or without adjuvant therapy, these patients must then all be referred to a gynaecologist who has expertise in managing these patients. Particularly with view to surgical management, be it their primary or secondary surgery.

Recurrence of gynaecologic cancer

Professor Greta Dreyer deals with the very unfortunate patient who presents with a recurrence following conventional treatment for gynaecologic cancer. It is inevitable that recurrences will occur and in general the prognosis of these patients is especially poor irrespective of further treatment offered. The earlier the recurrence, the more disseminated the disease, the poorer the performance status and the greater the fixity of the recurrence to surrounding organs, particularly bone, the greater the detrimental impact on these very unfortunate patients. One of the most difficult management decisions is when to withhold any further treatment and simply treat the patient with supportive therapy only.

Professor Dreyer provides an overview of the subject and emphasises the appropriate definitions of likely case scenarios. It is important to bear in mind that the prognosis in a patient who develops a recurrence and has not had adjuvant therapy, is significantly different to the patient who has completed her adjuvant therapy and then develops the recurrence. The patient who develops her recurrence during her adjuvant therapy will generally have a poor outcome irrespective of the vast majority of treatment options offered.

Central pelvic recurrences of cervical and endometrial cancers that are small, mobile, not fixed to bone, not associated with sciatic-like pain and there is no associated unilateral oedema of one of the lower limbs, are amenable to surgery, although it may require an anterior or a posterior exenteration or both.

In some cases, surgery in recurrent ovarian cancer should only be undertaken if there is second line chemotherapy. If not, any surgical attempt is palliative only and should only be performed to alleviate obstructive symptoms i.e bowel obstruction.

Early ovarian cancer

Dr Robbie Soeters emphasises that the diagnosis of early ovarian cancer and its staging is surgical and hence made at laparotomy. Incorporating a morphologic score during an ultrasound investigation of any adnexal mass may raise ones suspicions of malignancy. The features of the morphologic score include size and consistency of the mass, thickness of the cystic wall, presence or absence of vegetations within the cyst and whether the mass is unilateral or bilateral. In the postmenopausal woman a low resistance index (<0.47) will support neovascularisation, a feature suggestive of malignancy. Any woman with an adnexal mass must have a rectal examination. Hard non-tender nodules in the pouch

of Douglas, the so-called "fist full of knuckles" again should raise suspicion of possible malignancy.

Nevertheless, the definitive diagnosis, and the extent of surgery to be offered, is determined at laparotomy, remembering that the definition of successful maximal cytoreductive surgery is that ovarian disease implants after the surgery must not exceed 1.5 cm in diameter. Having said this however, a cystectomy or unilateral oophorectomy can be offered in patients with stage 1 disease who are desirous of maintaining fertility and who have been staged appropriately at laparotomy. In cases with early stage disease, I do believe that pelvic and para-aortic lymphadenectomy is very important.

HPV and cervical cancer

The last article deals with the exciting concept of trying to combat cervical cancer using the HPV vaccine. Cervical cancer is still the commonest cancer amongst our black women and is the second commonest cancer amongst women globally. It is responsible for significant morbidity, suffering and years of lost life among the young.

Screening the cervix for cervical cancer and treatment of premalignant lesions has failed dismally in sub-Saharan Africa and the option of using the HPV vaccine as a means to decrease the incidence of cervical cancer needs more attention. More and more is being understood about the aetiology of cervical cancer and at present there is no doubt about the role of HPV in causing cervical cancer. About 99% of cervical cancers are associated with all type HPV, although further analysis has shown that HPV 16 AND HPV 18 account for about 70% of cervical cancers globally. It is this knowledge that has led to the development of the bivalent and quadrivalent vaccines. When these vaccines are injected in women they lead to the development of neutralising antibodies which block the entry of the HPV 16 and 18 into the host cell and as a result decrease the incidence of cervical cancer by 70%. Professor Guidozi deals with some of the practical aspects pertinent to the possible implementation of the vaccine in South Africa.

Vulval cancer

Vulval cancer is thankfully uncommon. Treatment in the past was mutilating and sexual dysfunction was a common complication. Dr Trudy Smith highlights that surgical interventions offered today have moved away from the radical "butterfly" en-bloc vulvectomy and bilateral inguinal lymphadenectomy.

Today, in comparison, surgical treatment is conservative and conserves as much of the vulva as is possible. At present the 3 incision bilateral inguinal lymphadenectomy and simple vulvectomy of centrally situated vulval cancers or wide excision of laterally situated vulval cancers, provided it is possible to have a 2.5 cm disease free border around the cancer, is advocated and performed in the majority of centres treating gynaecologic cancer. Preservation of the clitoris is also an acceptable option provided it is tumour free. Incorporating this surgical approach to manage even advanced stage vulval cancer has not affected survival but has made postoperative recovery much easier and has tried to minimise the impact on sexual function both physically and psychologically.