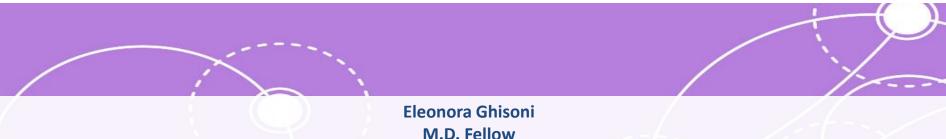


ESMO Preceptorship Programme

Ovarian Cancer - Prague, Czech Republic - 21-22 April 2017



Division of Medical Oncology-1
Institute of Cancer Research and Cure – IRCCS, Candiolo, Italy

NEOADJUVANT CHEMOTHERAPY FOR ADVANCED OVARIAN CANCER

CLINICAL PRESENTATION AND WORK-UP

- A 61 years old woman reporting from 6 months abdominal pain, increasing abdominal circumference, constipation and weight loss (5kg)
- No comorbidities and no family history of malignances
- **CA 125:** 324.5 U/ml
- **Us abdomen and pelvis**: left adnexal mass and ascites
- CT scan thorax-abdomen: left adnexal mass (5,5 x 7,8 cm), peritoneal nodes of

carcinosis, asci 1° day of admission

Hospit Fever and dyspnoea, oxigen desaturation

- Angio-CT: acute pulmonary thromboembolism
- Venous doppler-US: bilateral deep venous thromboembolism of the popliteal veins

Echocardiogram: floating thrombus (1,8 x 2,2 cm) in the right atrium pulmonar with moderate hypertension, EF 66%

February 2016



MULTIDISCIPLINARY GROUP DISCUSSION

- Cardiac Surgery Consult: not urgent indication to cardiac surgery considered the oncological pathology
- → The patient started treatment with LMWH
- Gynecologic consult: diagnostic laparoscopy not indicated
- US guided biopsy of one peritoneal node: high-grade serous ovarian carcinoma
- → The patient signed the informed consent to the BRCA1-2 genes analysis
- Considered the comorbidities and the tumor characteristics we commenced neodjuvant chemotherapy (NACT) with interval debulking surgery (IDS) after three cycles of platinum/taxane doublet



NEOADJUVANT CHEMOTHERAPY VS PDS

Neoadjuvant Chemotherapy for Newly Diagnosed Advanced Ovarian Cancer: Society of Gynecologic Oncology and American Society of Clinical Oncology Clinical Practice Guideline

Alexi A., et al., JCO 2016 Oct 1;34(28):3460-73

with oral and intravenous contrast, and chest imaging (CT preferred). Does the patient have a high risk of perioperative morbidity? Recommended treatment is Do characteristics of the tumor NACT. Consult with gynecologic or suggest that cytoreduction to medical oncologist before decision made < 1 cm is unlikely? not to pursue chemotherapy or surgery. No Before starting NACT, confirm the primary diagnosis and exclude other Recommended treatment is primaries (core biopsy preferred). NACT. Recommended NACT Patients may receive either NACT or consists of a platinum/taxane doublet. If PCS. For patients with a high likelihood disease progresses before interval of cytoreduction to < 1 cm. cytoreduction, offer alternative PCS is preferred. chemotherapy regimens, clinical trials, and/or discontinuation of active cancer therapy.

If NACT

Work-up should include an evaluation by a gynecologic oncologist and at least a CT of the abdomen and pelvis



INTERVAL DEBULKING SURGERY

3 cycles Carboplatin AUC5–Taxol 175mg/mg

(1° cycle during ac cardiac function)

Toxicities: nausea and G2, neutropenia G2, a CT torax-abdomen-pelvis:

PARTIAL RESPONSE (RP)

Dimensional and numeric reduction of peritoneal nodes, no

CA 125: 57,23 U/mL

IDS:

Bilateral hysteroannessiectomy, appendicetomy, omentectomy and peritoneal nodes removal

R > 1 cm

26/02 - 01/04/2016

11/04/2016 28/04/2016 19/05/2016 01/06/2016

Ca

Cardiopulmonary rehabilitation

(Mauriziano Hospitai Torino):

Thoracotomy with extracorporeal circulation and right atrial thrombus removal

ADDING BEVACIZUMAB





CONCLUSIONS

- Considered the hystory of venous thromboembolism we decided to NOT add Bevacizumab to chemotherapy
- 06/07 17/08/2016 the patient concluded 3 cycles Carboplatin AUC5 Taxol 175mg/mg (5° and 6° cycles -25% due to gastrointestinal and neurological toxicities)
- 31/08/2016 CT torax-abdomen and pelvis: NED
 - patient started FOLLOW-UP
 - genetic analysis: BRCA 2 mutation
- 07/12/2016: **1° follow-up visit** ...



Thank you for your attention



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