



AUSTRALIA NEW ZEALAND
GYNAECOLOGICAL ONCOLOGY GROUP



CONFERENCE BOOKLET

The Emerging Face of Gynaecological Oncology

The Australia and New Zealand Gynaecological Oncology Group invite you to be part of the ANZGOG 07 Conference – The Emerging Face of Gynaecological Oncology – to be held at the Sheraton, Noosa Queensland from Thursday 15 March • Saturday 17 March 2007.

Principal Sponsor:

 Schering-Plough Pty Ltd

Session: Friday 16 March 2007

**Presenters: Amanda Spurdle: The Australian National Endometrial Cancer Study (ANECS) - progress to date.
Suzanne Garland: Natural History and Immunology of HPV and Vaccination
Paul Mitchell: Cancer Vaccines**

Session Abstract: The Australian National Endometrial Cancer Study (ANECS) - progress to date

Presenter: Amanda Spurdle

The Australian National Endometrial Cancer Study aims to establish an integrated approach to endometrial cancer research by collecting epidemiological and clinical data and biological samples from a nationwide population-based group of approximately 1500 women newly diagnosed with endometrial cancer, a comparable group of cancer-free women, and approximately 400 selected relatives of cases reporting a family history of cancer. Specific aims of the currently funded study are: to clarify existing and identify new modifiable risk factors, and their interaction with genetic factors, by subtype; to examine the genetic basis to disease within multiple-case families; to establish and maintain a biorepository and epidemiological, molecular and clinical database for ongoing studies. An update of study progress, including recruitment and results from genetic testing, will be presented.

Session: Natural History and Immunology of HPV and Vaccination

Presenter: Suzanne Garland

Professor Garland, has been a leader in the role of patient self-collected genital sampling in the detection by molecular techniques (polymerase chain reaction (PCR) of reproductive tract infections, particularly those sexually transmitted, such as *Chlamydia trachomatis*, *Neisseria gonorrhoeae*, *Trichomonas vaginalis* and herpes simplex virus and have published extensively on clinical epidemiology of sexually transmitted infections in Australia.

Session: Cancer Vaccines

Presenter: Paul Mitchell



Session: Friday 16 March 2007
Recurrent Ovarian Cancer

Presenters / Jim Nicklin: Secondary Cytoreduction
Topics: Paul Vasey: Chemotherapy for Recurrent Disease
Amit Oza: New Biological Options

Session Abstract: Secondary Cytoreduction

Presenter: Jim Nicklin

Secondary cytoreductive surgery (SCS) for epithelial ovarian cancer is defined as surgical debulking of recurrent malignancy after clinical remission is achieved by primary treatment. Recurrent ovarian cancer is rarely curable, therefore careful consideration should be given to both survival and quality of life. Disease often recurs in the peritoneal cavity or in the retroperitoneal nodes and is often amenable to surgical resection. There is no data from randomised studies of SCS, however a phase III GOG study is about to commence. From retrospective series it is apparent that SCS is feasible with morbidity and mortality rates comparable to primary surgery. The optimal goal of surgery is complete resection of all macroscopic disease. Regarding disease free interval (DFI), surgery within 6 months is of no demonstrable benefit. Surgery following a DFI of 6-12 months is marginal and >12 is of probable benefit. The greater the DFI the greater the potential benefit of surgery. Ascites, low performance status and carcinomatosis are bad prognostic features. Hepatic disease is not an absolute contraindication to SCS. There is potentially an important place for PET scan in the work-up of patients with recurrent ovarian cancer. The results of further studies are eagerly awaited.

Session Abstract: Chemotherapy for Recurrent Disease

Presenter: Paul Vasey

Following initial surgery and chemotherapy, the vast majority of women with advanced ovarian cancer will relapse and require further treatment. Recurrences are generally (and conveniently, if occasionally misleadingly) bracketed into separate groups called 'platinum-sensitive' or 'platinum-resistant' recurrences, and the treatment modalities differ somewhat between these groups, although there are overlaps. There are many other patient-, tumor- and treatment-related factors to take into account when deciding on the optimal program for an individual patient. Although treatment for relapsed ovarian cancer is essentially palliative in nature, significant survival improvements can be obtained with appropriate drug and regimen selection, and it is the duty of the oncologist to ensure that these are not accrued at the expense of quality of life or significant treatment-related toxicity.



Session:	Friday 16 March 2007
Presenter/ Topics	Michael Quinn: Chris Milross: Chemotherapy or radiotherapy for advanced endometrial cancer? Andreas Obermair: Uterine Papillary Serous Carcinoma

Session: Gestational Trophoblastic Disease

Presenter: Michael Quinn

Session: Chemotherapy or radiotherapy for advanced endometrial cancer?

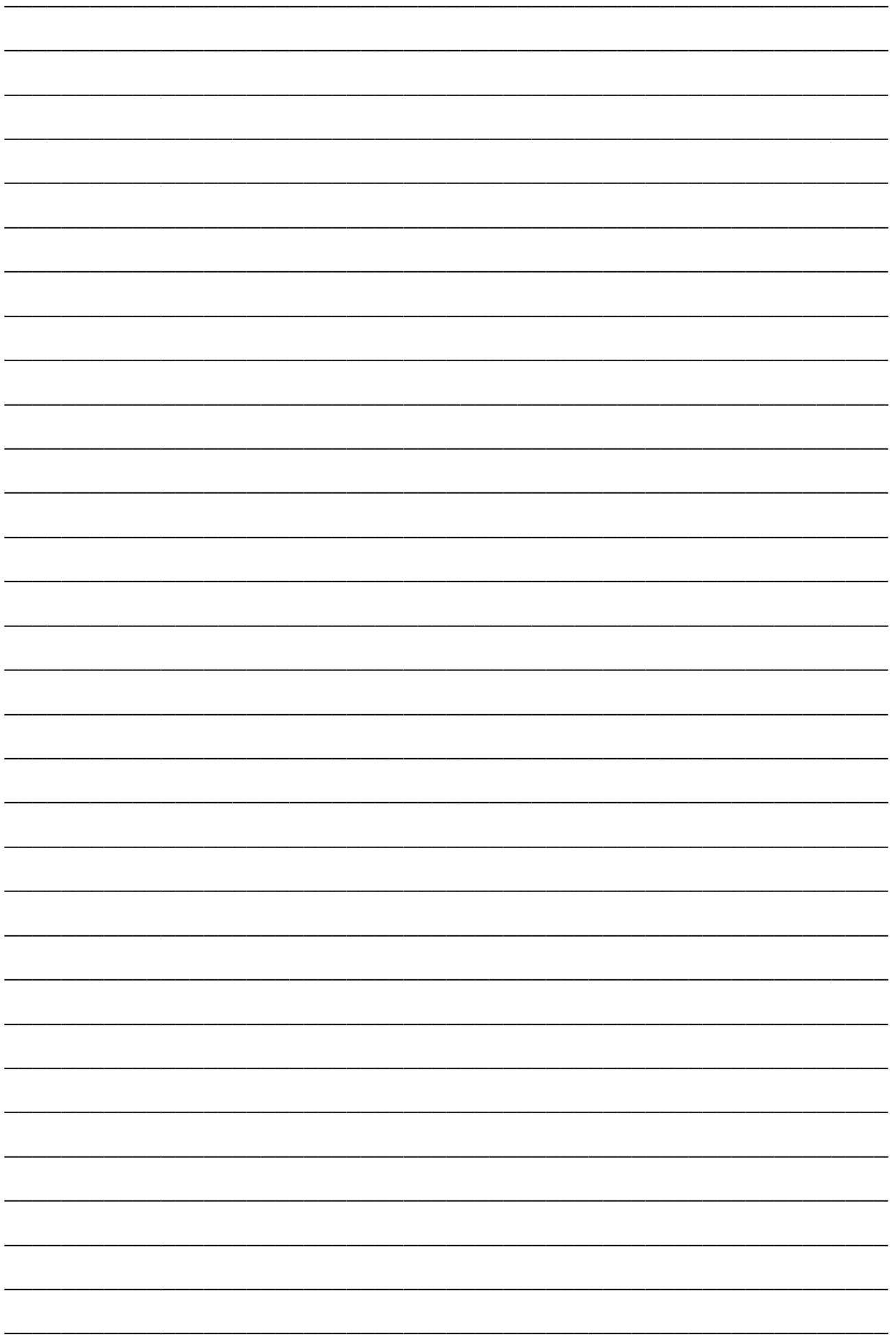
Presenter: Chris Milross

Session: Uterine Papillary Serous Carcinoma

Presenter: Andreas Obermair

Uterine Papillary Serous Carcinoma (UPSC) is uncommon and accounts for less than 5% of all uterine cancers. Due to the low incidence, research papers on UPSC include low numbers of cases with most reports being retrospective series. Patients in these series are always incoherently treated and conclusions about treatment cannot accurately be drawn on the basis of such series. Overall the prognosis of patients with UPSC is poor and local as well as distant failures are common. In our own series based on 94 patients with stage I to IV UPSC patients the overall survival rate at 5 years was 60-80% in patients with stage 1 or 2 disease, and dropped to 20-30% in patients with stage 3 or 4 disease. Chemotherapy and radiotherapy seem to be beneficial to improve prognosis and, interestingly the rate of local relapse seems to be significant even in patients with advanced disease.

Session Notes:



Session: Friday 16 March 2007
Hereditary Gynaecological Cancer

**Presenters/
Topics** Georgia Chenevix-Trench: BRCA 1 and 2
Yoland Antill: HNPCC
Yee Leung: Clinical Options

Session: BRCA 1 and 2

Presenter: Georgia Chenevix-Trench

Up to 15% unselected ovarian cancer cases carry a *BRCA1* or *BRCA2* mutation. Although mutations can usually be identified in women with a strong family history of breast and ovarian cancer, many occur in women with a much weaker family history but their rarity in such women makes mutation screening cost ineffective. Unlike *BRCA1/2*-related ovarian cancer, breast cancers due to mutations in these genes have a distinctive histopathology and gene expression profile. **We are currently developing methods to analyse this gene expression profile in archival paraffin blocks, in order to identify breast cancer cases that are likely to carry *BRCA1/2* mutations.** The aim is to then extend this to ovarian cancer, using the Australian Ovarian Cancer Study, because identification of these cases would allow their unaffected carrier relatives to reduce their risk considerably by bilateral salpingo-oophorectomy.

Session: HNPCC

Presenter: Yoland Antill

Mutations in the mismatch repair (MMR) genes (*hMLH1*, *hMSH2*, *hMSH6* and *hPMS2*) result in the syndrome Hereditary Nonpolyposis Colon Cancer (HNPCC). Females with mutations in these genes are at thought to be at increased risk for developing gynaecological as well as colorectal cancers and at an earlier age than in the general population. Previous estimations suggest that with HNPCC, a woman's lifetime risks for endometrial cancer is 60% and 12% for ovarian cancer development compared to a 3% and 1% respective lifetime risk for women in the general population (Aarnio 1999, Dunlop 1997) The clinical presentation of HNPCC, has shown striking variations over time and between countries, implying that environmental or lifestyle factors may play an important role in determining clinical outcomes.

LO1 The risks of gynaecological cancers associated with HNPCC

