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Update

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Upper Abdominal Disease Cephalad to the Greater Omentum and the Impact on Progression-Free Survival in Patients with Stage IIIC Ovarian Cancer

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Surgery for advanced-stage ovarian cancer, termed “tumor debulking”, is defined as an attempt to maximally resect all visible and palpable disease. This concept is a rare surgical strategy in the field of oncology, because it is restricted to merely minimizing the tumor burden as opposed to achieving a complete pathologic resection (with negative margin status); this approach is neither applicable nor justified for the majority of other solid tumors. It is debatable whether it is the surgical procedure itself that is responsible for the superior outcome associated with smaller residual disease or whether the ability to achieve minimal residual disease simply identifies a biologically more favorable patient subgroup with excellent response to postoperative systemic chemotherapy.

Upper abdominal disease cephalad to the greater omentum (UAD) is defined as metastatic implants

involving the diaphragm, liver, porta hepatis, spleen, pancreas, stomach, celiac axis, and lesser sac. UAD is frequently seen in patients with stage IIIC ovarian cancer. The presence and volume of UAD can be used as a general marker for intra-abdominal tumor burden because it is associated with adverse prognostic and tumor-volume factors such as large-volume ascites, highly elevated serum CA125 levels, and a higher rate of suboptimal cytoreduction.

We aimed to analyze the effect of optimal cytoreduction on progression-free survival (PFS) in patients with Interna-

tional Federation of Gynecology and Obstetrics (FIGO) stage IIIC ovarian cancer stratified by the presence and volume of UAD found at the time of exploration. We identified 526 evaluable patients. Group 1 included patients who were found to have no visible or palpable UAD (Region A) at the time of exploration. Group 2 consisted of patients who were found to have minimal UAD (≤ 1 cm), and Group 3 consisted of patients who were found to have bulky UAD (>1 cm in size) (Figure 1). Optimal versus suboptimal cytoreduction was significantly associated with improved median PFS in patients with no UAD (30 versus 14 months, $P < 0.001$), minimal UAD (≤ 1 cm) (21 versus 12 months, $P < 0.001$), and bulky UAD (>1 cm) (19 versus 13 months, $P = 0.02$). Patients with bulky UAD who underwent optimal cytoreduction had a 28% decreased risk of relapse compared to patients who underwent suboptimal cytoreduction (Hazard Ratio, 0.72; 95% Confidence Interval, 0.53-0.99; $P = 0.04$).

The results of this study suggest that the presence of large-volume disease found at the beginning of surgery does not eliminate the benefit of optimal cytoreduction. The findings support the management strategy of maximizing surgical efforts with increasing tumor burden in patients with stage IIIC ovarian cancer.

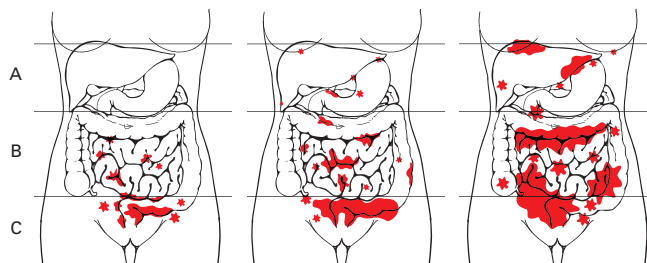


Figure 1. Three different groups of patients presenting with FIGO stage IIIC ovarian carcinoma (uterus, fallopian tubes/ovaries, and omentum removed) and their peritoneal disease distribution at the beginning of the operative procedure.