cytoreductive surgery alone was not defined. Similarly, the real impact of HIPEC per se to cure the non-visible microscopic tumour disease has yet to be determined. An ongoing randomized trial comparing HIPEC with no HIPEC after complete CRS (PRODIGE 7) will try and confirm the benefit of intraperitoneal chemotherapy after complete CRS. Considering the encouraging survival results obtained in the treatment of PC by CRS and HIPEC, one of the future indications of this specific approach might be its use in the very early development of PC. Early PC detection is very difficult and can only be ascertained during second look laparotomy. An ongoing trial (PROPHYLOCHIP) is currently comparing the benefits of this second look strategy with HIPEC to the usual simple survey in patients considered at risk of developing a PC.

30 INVITED

Peritoneal Mesothelioma

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Background: Peritoneal Mesotheliomas (PM) represent 10 to 30% of all Mesotheliomas. Diffuse Malignant Peritoneal Mesothelioma (DMPM) is the most frequent form while Well Differentiated Papillary Peritoneal Mesothelioma (WDPPM) and Multicystic Peritoneal Mesothelioma (MCMP) are very rare. With 9 to 15 months median survival, in historical case-series treated with standard therapy, DMPM is considered a lethal condition. Recently, few specialized centers have developed an innovative treatment consisting on Cytoreductive Surgery (CRS) that means a radical resection of the neoplasm associated with Hyperthermic Intraperitoneal Chemotherapy (HIPEC). Furthermore, we focused on new prognostic biomarkers as well as novel terapeutic targets identification.
Materials and Methods: From our data base we selected 134 patients with PM treated with CRS and HIPEC; from these patients, 115 were affected by DMPM and 19 with WDPPM or MCPM. To achieve a radical resection, a complete parietal peritonectomy with a median of 3 visceral resections were carried out. The HIPEC was performed with the closed abdmen technique with cisplatin (42.5 mg/L of perfusate) and doxorubicin (15 mg/L of perfusate) for 90 minutes at a temperature of 42.5ºC. Patients with DMPM received also neo adjuvant or adjuvant systemic chemotherapy. Telomerase Activity (TA), survivin and other members of the inhibitors of apoptosis proteins (IAP) family expression and tyrosin kinases (TKR) and their downstream effectors were studied.
Results: DMPM median survival grew from 12 months with the traditional treatment to 53 months with CRS + HIPEC + sCT with 50% 5 years overall survival (OS). Prognostic factors were: the epithelial subtype compared with the biphasic or sarcomatoid, the absence of lymph node metastasis, the radical surgery and the treatment with HIPEC. The WDPPM or MCPM 5-year OS and progression free survivals were 90% and 79%, respectively. Quality of life is satisfactory since 94% of patients have a resolution of ascites and related morbility and mortality acceptable with reasonable financial cost effectiveness. The TA resulted as a new biologic prognostic factor; while Survivin and other members of the inhibitors of apoptosis proteins (IAP) family as well as TKR and their downstream were overexpressed resulting potential target for targeted therapy.
Conclusion: Based on these findings, CRS with HIPEC is recommended as the optimal treatment to treat PM This methodology is now considered as standard treatment for PM.

31 INVITED

Pseudomyxoma Peritonei

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Pseudomyxoma peritonei (PMP) is a rare disease with a reported incidence of one case per million per year, characterized by the accumulation of mucinous ascites and mucinous peritoneal implants. The primary tumour in the vast majority of cases is a ruptured mucinous appendiceal neoplasm, although this might not be readily apparent. Exceptionally, PMP cases originating from a urachal mucinous tumour, ovarian teratoma or colon neoplasm have been reported.
PMP constitutes the perfect example of a peritoneal neoplastic disease that will only exceptionally metastasize outside of the peritoneal cavity. This peculiar biological behaviour and its slow progress over time make PMP a disease model in Peritoneal Surface Oncology, as it exemplifies the disease status that is amenable to a radical loco-regional therapy.
PMP has certainly played a key role in the development of cytoreductive surgery (CRS) combined with perioperative intraperitoneal chemotherapy (PIC) for peritoneal surface malignancies. Lessons learnt from the radical treatment of this disease have been successfully applied to selected cases of peritoneal carcinomatosis of colorectal or gastric origin, peritoneal mesothelioma or stage III ovarian cancer. These lessons include, among many more, early detection and treatment, multidisciplinary management and centralization in expert treatment centers.
Key prognostic issues in the management of PMP include histopathological grading of the disease and the completeness of cytoreduction, along with patient selection and team experience. Systemic chemotherapy on its own is not a treatment option in this disease except for palliative cases and/or as an adjuvant to complete CRS and PIC in high grade disease.
The scientific justification for the recognition of CRS and PIC as the standard of care for PMP will never come from randomized clinical trials, but it is well-based in the results of numerous phase II studies, some of them including hundreds of patients, that compare very favourably with those of historical controls treated with serial debulking. We must learn to admit that this will be the best possible evidence, and therefore sufficient to offer this treatment to patients. An ambitious international PMP registry project is underway, assembled and coordinated from the Peritoneal Surface Malignancy Program at St. George's Hospital in Sydney, Australia, which will certainly make another invaluable contribution to the knowledge of this disease and its treatment.

Special Session (Sat, 24 Sep, 14:15−15:15)
The Management of Penile Cancer

32 INVITED

Update in Penile Cancer: Facts

Abstract not received

33 INVITED

Surgery in Penile Carcinoma

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Introduction: Partial or radical penectomy are the surgical treatment for invasive penile carcinoma. Both achieve good local control. However these procedures are associated with significant psychosexual morbidity. Interest has therefore been in organ preserving procedures. Inguinal lymphadenectomy (ILND) is the standard procedure to control inguinal lymph-nodes but there is a great controversy regarding to the extent and the timing to perform it.
Material and Methods: The incidence of penile carcinoma is very low and there are no randomized trials available comparing different therapy approaches. The vast majority are retrospective or small prospective case series making impossible to obtain a high level of evidence. The literature was reviewed from 2000 to 2010.
Results: New information suggests that only negative margins instead of 2 cm might be adequate for localized penile tumour, encouraging the use of more conservative therapy strategies. Although local recurrence rate is greater after conservative therapies than amputative surgery, the increase does not seem to have had a negative effect on survival. Quality of life is superior in conservative therapies; however a psychological support is advisable for these patients. In selected patients after penectomy, penile reconstruction should be considered.
In patients with palpable nodes and positive percutaneous biopsy, a bilateral ILND should be performed. In cases of non palpable nodes, the probability of inguinal micrometastases can be estimated using risk groups stratification or nomograms. Surveillance is advisable in low and intermediate risk group with no lymphovascular invasion. Those patients have to complete regular follow-up. In intermediate risk group and motivated high risk patients, dynamic sentinel node biopsy should be recommended, especially in centers where this technology and expertise are available. In cases of positive biopsy, bilateral radical ILND should be performed and surveillance in case of negative biopsy. Modern modify ILND with frozen section is another option for these patients and if positive biopsies, ILND should be enlarged to radical template. In cases of 2 positive nodes, extracapsular extension, grade 3 or positive Cloquet node, pelvic LND should be performed. When fixed inguinal nodes or pelvic nodes are identified in imaging evaluation, induction chemotherapy should be administered followed by rescue LND. Endoscopic LND is a promising new approach in order to decrease LND morbidity but additional studies are required.
Conclusions: Although levels of evidence are low, penile preservation strategies can be considered a safe procedure and more selective LDN indications can be outlined.