8012 POSTER

Results of Curative Concomitant Chemoradiotherapy in Patients With FIGO Stage IVB Cervical Cancer Presenting Para-aortic and Left Supraclavicular Lymph Nodal Metastases

E. Jwa[1], Y.S. Kim[1], J.H. Nam[2], Y.T. Kim[2], J.Y. Kim[3], S.S. Shin[4], E.K. Choi[1], J.H. Kim[1], S.W. Lee[1], S.D. Ahn[1]. [1]*Asan Medical Center, Radiation Oncology, Seoul, South Korea;* [2]*Asan Medical Center, Obstetrics and Gynecology, Seoul, South Korea;* [3]*National Cancer Center, Research Institute and Hospital, Goyang, South Korea;* [4]*GangNeung Asan Hospital, Radiation Oncology, GangNeung, South Korea*

Background: Contrary to the established role of curative extended-field chemoradiotherapy, the role of concurrent chemoradiotherapy(CCRT) still remains undefined in patients with FIGO stage IVB cervical cancer presenting para-aortic and left supraclavicular lymph node (LN) metastases. We performed the retrospective review to determine the efficacy and toxicity of aggressive chemoradiotherapy involving pelvic, para-aortic, and left supraclavicular fossa.
Materials and Methods: 24 women with cervical cancer presenting para-aortic and left supraclavicular LN metastases underwent cisplatin-based CCRT from 2002 to 2010. As a historic control group, we reviewed the clinical outcomes of 71 patients with cervical cancer who received extended-field chemoradiotherapy due to para-aortic LN metastasis without positive supraclavicular LN from 1998 to 2010. The patients in positive supraclavicular LN group received median external dose of 59.4 Gy to the para-aortic and left supraclavicular LNs and 50.4 Gy to the pelvis, followed by 30 Gy in 6 fractions of intracavitary radiotherapy(ICR). The patients in positive para-aortic LN without supraclavicular LN metastasis group received the same median external dose to the para-aortic LN, pelvis and the same median dose of ICR.
Results: Among 24 patients with positive supraclavicular LN, 3 patients did not complete full dose of chemotherapy and 5 did not finish planned radiotherapy because of acute toxicity. The most common acute toxicity was hematologic toxicity. Grade 3−4 hematologic toxicity was observed in 15 (63%) women. 17 (71%) patients suffered from grade 2 acute gastrointestinal toxicity, which was transient and self-limiting. A woman complained of grade 3 late genitourinary toxicity and another encountered grade 3 late soft tissue complication around supraclavicular fossa. 11 (46%) women showed a complete response encompassing the primary mass, and the metastatic pelvic, para-aortic and left supraclavicular LNs. With a median follow-up period of 20 months (35 months for surviving patients), 8 (33%) women had no evidence of disease, while 1 (4%) persistent disease, 6 (25%) distant failure, and 9 (38%) showed both in-field and distant failure. 3-year overall and disease-free survival rates were 41% and 37%, respectively. In comparison, 37 of 71 cases (51%) with para-aortic LN metastasis had no evidence of disease. 15 patients (21%) showed local recurrence, while 9 (13%) experienced distant failure, and 10 (14%) showed both local and distant failure. 3-year overall and disease-free survival rates were 65% and 50%, respectively.
Conclusions: Curative CCRT in the patients with FIGO stage IVB cervical carcinoma presenting para-aortic and left supraclavicular LNs metastases is feasible with acceptable late morbidity and high response rate despite its substantial acute toxicity. More intensive or further chemotherapy may be indicated for these patients, considering most treatment failures were distant metastases.

8013 POSTER

Intraperitoneal Chemotherapy for Stage III Epithelial Ovarian Cancer − Our Experience

R.C. Jaka[1], S. Zaveri[1], S.P. Somashekhar[1]. [1]*Manipal Comprehensive Cancer Center, Surgical Oncology, Bangalore, India*

Background: Trial GOG 172 has concluded improvement in survival with intraperitoneal (IP) chemotherapy but most of the patients had complications and only 40% could complete all the desired cycles by intraperitoneal route. Major complications were related to the chemoport. We undertook this study to find the means of reducing complications, along with increasing the benefits of IP chemotherapy.
Material and Methods: During January 2007 to December 2010, hundred consecutive patients of stage III epithelial ovarian cancer who had optimal cytoreduction at Manipal comprehensive cancer center underwent chemoport insertion during laparotomy. Initial 20 cases had 9.6F Bard IP chemoport, and later cases had venous port inserted intraperitoneally. Tunneling of the catheter was meticulous, single thrust without great disturbance to subcutaneous tissue. Entry point into the peritoneum was single, 6 cm lateral to the umbilicus and double purse-string suture taken around the catheter to prevent peri-catheter backflow of ascitic fluid or drug. Modified IP chemotherapy regimen (SWOG-9912 trial) was used.
Results: Age of the patient ranged from 34 years to 76 years. In total 600 cycles, 516 cycles (86%) were completed. Seventy patients received all the 6 cycles by IP route. Two patients in the initial 10 had vaginal leak, for whom first 2 cycles were given by IV route and then shifted to IP route. Subsequently all cases had double layer closure of vaginal vault. Catheter block was seen in 5 cases, of which 4 salvaged by heparin injection lock for 2 hours and in subsequent cases IV port access catheter with valve replaced the fenestrated IP catheter. None of the IV catheters had the block. Four cases had backflow of fluid around catheter collecting around the port chamber site. Two patients had severe abdominal pain due to dense adhesions and unequal distribution of drug on radionucleide scan, further cycles were completed by IV route. Cisplatin was replaced with carboplatin in 5 cases with severe toxicity. Longest follow-up is 4 years with median follow up of 1.8 years.70% are disease free on follow up. Local recurrence rate was 18 and systemic in 8 cases. Mortality rate is 4%.
Conclusion: Complications of IP ports are minimal when insertion is done meticulously with a dedicated team. With modified IP dose and drug regimen, side effects are less and most patients can complete all the desired cycles. Long term follow up study is required to assess the PFS and OS.

8014 POSTER

Adenocarcinoma and Squamous Cell Carcinoma of the Cervix: Should They Be Treated Differently?

I. Faustino[1], R. Catarino[2], L. Lombo[3], T. Figueiredo[3], L. Carvalho[3], L. Salgado[3], S. Sousa[1], R. Couto[1], N. Afonso[1], D. Pereira[1]. [1]*Portuguese Oncology Institute − Porto, Medical Oncology, Oporto, Portugal;* [2]*Portuguese Oncology Institute − Porto, Molecular Oncology Unit CI, Oporto, Portugal;* [3]*Portuguese Oncology Institute − Porto, Radiotherapy, Oporto, Portugal*

Background: The optimal management of adenocarcinoma (AC) of the cervix is still an issue in debate among clinicians, especially whether it should be different from squamous cell carcinoma (SCC).
The purpose of this study is to analyze the differences between AC and SCC in what respects response to treatment, recurrence and survival rates.
Material and Methods: In our retrospective study, we included patients (pts) with AC or SCC of the cervix treated in our institution with concurrent chemoradiotherapy. Data analysis was performed using SPSS version 18.0. Proportions among groups were compared with Pearson Chi-square test. A 5% level of significance was used in the analysis. Overall survival (OS) and disease free survival (DFS) were estimated by Kaplan–Meier analysis. Cox regression models were used to adjust for potential confounders.
Results: All pts were treated with radiotherapy plus concurrent weekly-cisplatin (40 mg/m^2). Results are summarized on table 1.

Table 1. Summary of results

	AC	SCC	*p*-value
Patients (n)	34	229	
Age (median, range)	48 (31−70)	49 (20−75)	
ECOG performance status (median, range)	0 (0−1)	0 (0−1)	
FIGO* stage (n/%)			
IB2	6 (17.6)	19 (8.3)	
IIA2	1 (2.9)	13 (5.7)	
IIB	25 (73.5)	133 (58)	
IIIA	0	5 (2.2)	
IIIB	1(2.9)	52 (22.7)	
IVA	1(2.9)	7 (3.1)	
Lymph nodes metastases	0	12	
Nr of chemotherapy cycles (median, range)	6 (4−6)	6 (1−6)	
External radiotherapy dose (median, range)	50 (42−50) Gy	50 (30−60) Gy	
Brachytherapy dose (median, range)	42 (30–50.4)	40 (30−45)	
Response to treatment (n; %)			
Complete	30(88.2)	165 (72.1)	
Partial	2(5.9)	47 (20.5)	$p = 0.124$
Stable disease	0	13 (5.7)	
Disease progression	2 (5.9)	4 (1.7)	
Recurrence (n/%)	4 (11.8)	33 (14.3)	$p = 0.685$
Median DFS	86.6	85.8	$p = 0.431$
Median OS**	88.3	80.9	$p = 0.158$

n = number of patients.
*According to revised FIGO staging 2009.
**HR = 0.421, 95% CI = 0.10–1.78, p = 0.240, using Cox regression analysis adjusted by tumour stage.

Conclusions: There were no statistically significant differences between AC and SCC in what respects to treatment response, patterns of recurrence and survival rates, suggesting that they should be treated equally. Differences between AC and SCC reported in some studies could