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A large broad ligament uterine fibroid: Successful myomectomy with robotic assisted laparoscopic myomectomy

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Uterine leiomyomata, or myomas, are one of the most common benign tumors of the reproductive tract, affecting more than 70% of women in their lifetime. Definitive surgical treatment of myoma is hysterectomy while myomectomy is the treatment for those women who have symptomatic myomas and desire uterine or fertility preservation. Leiomyomas can arise from any tissue including the broad ligament, the incidence of broad-ligament leiomyoma is <1%. Myomectomy of large broad ligament fibroid presents certain challenges due to anatomical distortion, leading to higher incidence of ureteric injury and excessive bleeding. Still most of the myomectomies are done abdominally, this is due to the complexity and the necessity of extensive suturing for the desired multi-layered uterine closure, which is technically hard to do laparoscopically. The introduction of robotic surgery has allowed more surgeons to perform complex laparoscopic procedures.

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Learning curve for laparoscopic staging of early and locally advanced cervical and endometrial cancer

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Background: Laparoscopic staging is rapidly evolving as an important surgical approach in the field of gynecology oncology. However, the specific learning curve associated with this approach remains poorly investigated. This study aimed to evaluate the learning curve for laparoscopic staging of uterine cancers.

Methods: A series of 28 consecutive laparoscopic hysterectomies with or without pelvic and/or para-aortic lymph node sampling for the treatment of early and locally advanced endometrial or cervical cancer were performed between July 2008 and January 2011. The analyses of the learning curves of the institution were performed for 20 patients who had undergone pelvic lymphadenectomy and/ or para-aortal lymph node sampling. The learning curve period has also been compared with the last 26 patients who received laparotomy staging ("open" group) due to the same diagnosis and by the same surgical team. To assess the short and long-term outcomes, we used validated questionnaires to record the clinical and follow-up results, any complaints or subjective reports from the patients, and details of their quality of life. All data were collected prospectively in a database and reviewed retrospectively. The learning was evaluated using the cumulative sum (CUSUM) method.

Results: The CUSUM learning curve consisted of two distinct phases: phase 1 (the initial 9 cases) and phase 2 (the subsequent cases) which presented the mastery phase, with the operative time of 397.7 ± 63.5 versus 300.6 ± 19.4 min ($p > 0.0001$). The significance of the difference between the two phases and "open" group changed in terms of number of lymph nodes retrieved, intra-operative blood loss and hospital stay. The conversion rate of phase 1 was higher than phase 2 [2 (22.2%) and 1 (9%), respectively].

Conclusion: This series confirms previous study findings concerning the feasibility and the safety of laparoscopic staging and provides information for surgeons in single centers considering adopting an endoscopic strategy to monitor the different aspects of outcomes during the implementation process for internal benchmarking. The operative outcome of laparoscopic staging intervention improves with experience. The data reported in this article suggest that after a learning curve of 9 patients, a relevant improvement at least regarding the duration of the operation can be achieved for experienced surgeons who start performing laparoscopic staging of uterine cancers. However, due to the limited number of patients as well as number of para-aortic lymph node sampling procedures, further studies are required for firm conclusions to be drawn.

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