Welcome

• Session Outline
  • Case Presentations with Panel Discussion
  • Didactic Presentation with Panel Discussion
  • Moderated Q&A/Discussion
    • Submit questions or discussion topics live via the Q&A feature

• ECHO etiquette
  • Panelists will be the only ones able to speak during the session
  • Attendee microphones are muted

• Recording will be available on the IGCS website
Case Presenter

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Radiation Oncologist
Assistant Professor of Radiation Oncology
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Case & Didactic Lecturer

Michael Pearl
Gynecologic Oncologist
Professor & Director of the Division of Gynecologic Oncology, Palliative Care Specialist
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Panelist Introduction

David Atallah
Chairman, Department of Obstetrics & Gynecology
Professor of Obstetrics & Gynecology
Saint Joseph University
Lebanon

Benjamin Odongo Elly
Gynecologic Oncologist
Moi Teaching and Referral Hospital/Moi University
Kenya

Dicey Jackson Scroggins
IGCS Director of Global Outreach & Engagement
and a 23-year ovarian cancer survivor
United States

Alexey Shevchuk
Gynecologic Oncologist
Chief of the Department of Oncogynecology
N. N. Blokhin National Medical Research Center of Oncology
Russia
PLEASE NOTE that Project ECHO® case consultations do not create or otherwise establish a provider-patient relationship between any International Gynecologic Cancer Society (IGCS) volunteer clinician and any patient whose case is being presented in a Project ECHO® setting. Responsibility for the patient remains with the Medical Team who cares for the Patient at the Presenting Institution.
Vulvar cancer
- 82yo with a left labial bump and occasional bleeding x 1 year
- Grew in size for 4 months, then stabilized
- PMHx: HTN, hypothyroidism
- Soc Hx: Current smoker
- Exam: ~6 cm vulvar mass of the left labia minora, within 5 mm of the anus. Shoddy nodes palpated in left groin.
- Vulvar biopsy: p16+ invasive squamous cell carcinoma
  - HR HPV+ (negative for 16/18/45)
4.1 x 1.5 cm irregular soft tissue extending posteriorly into gluteal fold (SUV 11.2-18). Mild hypermetabolic activity in L groin (SUV 1.7-2.7) corresponding to borderline-enlarged L inguinal LN. No pelvic or inguinal lymphadenopathy.
PET CT scan

1.1 cm RUL lesion (SUV 7.3-10.5). Additional small scattered pulmonary nodules below the size resolution of PET imaging (3 mm LUL and 3 mm RLL nodules). Emphysematous changes of the lungs. No mediastinal or hilar lymphadenopathy.

Concurrent Stage II vulvar cancer + Stage I NSCLC
- 3/27–4/8/20: Received 10 Gy x 5 using SBRT to RUL lesion
- 4/13/20: Pt asked to delay her RT due to feeling unwell
- 4/19/20: Admitted due to severe SOB at home. O2sat 84% on room air
  → 94% on 6L NC nonrebreather
- SARS-CoV-2 RT-PcR positive

Discussion:
- When to begin cancer-directed treatment?
  - Limited evidence suggests NSCLC pts w/ COVID-19 may be most vulnerable to death (Yu J et al, JAMA Oncology 2020; doi:10.1001/jamaoncol.2020.0980)
- ChemoRT vs. RT alone?
Case Discussion
• Medically inoperable endometrial cancer
  • 51yo woman w/ multiple comorbidities including HIV, Hepatitis C and cirrhosis

• 1/27/20: Underwent lab for vaginal bleeding; Hb 4.9. MCV 79. Platelets 33K

• 1/30/20: Endometrial biopsy: Endometrioid adenocarcinoma with focal clear cell component.

• 2/1/20: MRI abdomen/pelvis – Abnormally thickened and inhomogeneous endometrium measuring over 2.3 cm in thickness. Indistinct junctional zone & sub-endometrial enhancement. Abnormal soft tissue extending into the cervical canal. Abnormal enhancement in the left parametrial region. No ascites or lymphadenopathy.
IGCS COVID-19 TUMOR BOARD

- MRI Sagittal view

MRI Axial view
2/4/20: Exam: No vaginal lesions or active bleeding

2/26–4/22/20: Received 24 out of 25 fractions to the pelvic nodes, uterus and vagina w/ consideration of surgery after completion
  • Began EBRT prior to declaration of COVID-19 pandemic.
  • Hgb ~7-7.8 & platelets ~60-80K
• Now nearing completion of EBRT but w/ Hgb drop to 4.8 & platelets 48K

Discussion
• What boost technique to use?
• Brachytherapy?
• Any alternatives i.e. evidence for SBRT?
Radiation Therapy – CTV Uterus & vagina
Case Discussion
Introduction

• Long Island, New York, USA
  • 29,476 documented cases
  • 926 deaths

• Gynecologic oncology consult requested
  • Person under investigation (COVID-19?)
  • Findings consistent with advanced gynecologic malignancy
ED Presentation History

- 77 year old postmenopausal Caucasian woman
  - Worsening cough and shortness of breath x 2-3 days
  - Nausea and vomiting x 2-3 weeks
  - Bloating, epigastric pain, alternating diarrhea/constipation, 3+ lb weight gain x 6 weeks
  - Denied fever, chills, chest pain, bleeding, ill contacts
- Initially presented to her nephrologist
  - Abdominal distension with palpable mass, decreased right breath sounds, a. fibrillation
  - Advised to go to the Emergency Department immediately
Past Medical History

- Renal cell carcinoma; radical nephrectomy 1996, no adjuvant therapy
- Chronic kidney disease; Cr typically ~1.75
- High output heart failure
- Type II diabetes; Hgb A1c 6's
- GERD

Medications/Allergies
- enalapril, hydrochlorothiazide-losartan, linagliptin, omeprazole, verapamil
- Allergies: morphine, azithromycin

Non-smoker, denied alcohol or drug abuse, no family history

Review of remaining systems non-contributory
Admission Exam (by ED staff)

- Alert white woman in no acute distress
  - T: 36.9, P: 102 reg, RR: 18, BP: 165/93, SpO2 (RA): 89%
  - Decreased breath sounds and dullness, right lung
  - Abdominal distension, shifting dullness and fluid wave, palpable mid-abdominal firm mass, no rebound tenderness or guarding
  - Pelvic/rectal examination not performed

- Pertinent labs:
  - WBC 6.93, Hgb 11.6, Hct 34.8%, Plt 327K, Glu 139, Alb 3.2, T. protein 5.9
  - CPK 48, LDH 287, D-dimer 3110, CRP 4.4, Procalcitonin 0.11, ESR 33
  - PT 10.8, INR 1.0, PTT 27.0
  - Na 154, K 3.9, Cl 110, Cr 2.08, ALT 13, AST 23, HgbA1c 6.3
  - SARS CoV-2 PCR pending, CA 125 4511, CEA 0.5
IMPRESSION:
1. **Large unilateral right pleural effusion**, given the extensive changes of peritoneal carcinomatosis the pleural effusion may be malignant in nature.
2. No definitive mass is identified in the chest.
3. **Moderate amount of ascites** in combination with extensive omental masslike thickening and peritoneal implants are consistent with peritoneal carcinomatosis. Etiology remains indeterminant.
4. Status post left nephrectomy; a low-attenuation lesion in the upper pole of the right kidney is noted which is indeterminate however overall appearance is suggestive for a benign lesion.
5. The **uterus and ovaries are poorly delineated due to the peritoneal abnormalities extending into the pelvis**.
6. **Extensive sclerotic bony abnormalities mainly involving the vertebral bodies remain indeterminate; bony metastasis cannot be entirely excluded**
Non-Contrast CT Scan
Initial Management (Medicine Service)

- Admitted with telemetry (sinus tachycardia with PACs) and COVID precautions/isolation
- Low flow oxygen (2L/min) via nasal cannula
- IV fluids
- Medications adjusted secondary to acute kidney injury (dehydration)
- Thoracentesis, paracentesis, CT-guided biopsy by IR arranged
- Gynecologic Oncology consult requested
  - We were not permitted to enter her room but we could call
A: Pleural Fluid:
DIAGNOSIS:
Positive for Malignancy
- Consistent with metastatic adenocarcinoma, favor high-grade serous type

A: Ascitic Fluid:
DIAGNOSIS:
Positive for Malignancy
- Consistent with metastatic adenocarcinoma, favor high-grade serous type

DIAGNOSIS
A. Omentum, omental nodule, CT-guided biopsy:
- High grade serous carcinoma, favor primary ovarian/peritoneal origin;
- Comment: Immunohistochemical studies performed on tissue block A1 with adequate controls show that tumor cells are strongly and diffusely positive for p53 and CK7, positive for ER and weakly positive for WT1. Proliferation index marker (ki-67) is estimated 40-50%. The neoplastic cells are negative for PR, CK20 and CDX2. The results are supportive of the above diagnosis.
IT DOESN'T LOOK GOOD.

DON'T BUY INTO THE MEDIA HYPE.
Issues for Discussion

- How to perform consult
- Management
- Resource utilization

Ethics

"You have an unusual complaint. Just sit there while I consult one of my textbooks."
Ethical Principles

• Autonomy
• Beneficence
• Non-maleficence
• Justice
• Veracity

Application is complex
Autonomy

Patient self-determination

Near absolute right for patient to refuse recommendation.

Does not entail an obligation to grant any or all requests for continued therapy.

“He won the right to die without dignity.”
Beneficence
Promote the health and welfare of the patient
Obligated to do what is best for the patient

"Good news, hon. Your doctor now has the right to recommend treatment."

IGCS INTERNATIONAL GYNECOLOGIC CANCER SOCIETY
Non-maleficence

“First, do no harm”

May prohibit the provision of therapy that carries substantial side effects with no probable benefit

Medical Futility: “…treatments that serve no physiologic, quantitative or qualitative purpose.”

von Gruenigen VE and Daly BJ. Futility: Clinical decisions at the end-of-life in women with ovarian cancer. Gynecol Oncol 97:638-644, 2005
Justice

Treat patients fairly

Using resources for therapy that serves no meaningful purpose denies access to those resources for others who might derive benefit.
Veracity
Tell the truth

Lack of honesty, even if well-meaning, may rob patients and families of opportunity to make an informed choice. It also jeopardizes the foundation of the physician-patient relationship.
“Death is a natural and inevitable end to life; helping patients achieve an appropriate and easy passage to death is one of the most important and rewarding services that a physician can provide.”

American Academy of Hospice and Palliative Medicine
Discussion
Closing Notes

• Series continued monthly
• COVID-19 Discussion Forum
• Recording on IGCS website within 24 hours


• COVID-19 Resources www.igcs.org/covid-19
Thank You

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website
igcs.org