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1. Immunisation of African pre-teen/adolescent girls and young women with the HPV16/18 AS04-adjuvanted vaccine

^aKiviati N, ^{b,c}Watson-Jones D, ^dSalif Sow P, ^eDavid M-P, ^fThomas F, ^gChangalucha J, ^hDescamps D

^aUniversity of Washington, Department of Pathology, Harborview Medical Centre

^bDepartment of ITD, London School of Hygiene and Tropical Medicine

^cNational Institute for Medical Research

^dCHU Fann, Service des Maladies Infectieuses

^eGlaxoSmithKline Biologicals, Wavre, Belgium

E-mail: nbk@u.washington.edu

Introduction: African countries have some of the highest incidence and mortality rates for cervical cancer worldwide. The human papillomavirus (HPV)-16/18 AS04-adjuvanted vaccine has been shown to be highly immunogenic and well-tolerated in subjects aged 10–25 years from diverse geographic situations. We present preliminary results from a Phase IIIb study, specifically conducted in Senegal and Tanzania, which evaluates the immunogenicity and safety of the HPV16/18 vaccine in HIV-negative adolescent girls and young women aged 10–14 and 15–25 years (NCT00481767).

Methods: Subjects (Senegal n = 342 and Tanzania n = 334) were randomised (2:1) to receive three doses of HPV16/18 vaccine or Al(OH)₃ control at 0, 1 and 6 months. Immunogenicity was assessed using ELISA at 0, 2 and 7 months.

Results: After vaccination (month 7), most subjects in the according-to-protocol immunogenicity cohort (100% in Senegal and ≥ 97.8% in Tanzania) showed seroconversion for anti-HPV16 and -18 antibodies with high geometric mean titres (GMTs) in both countries. In Senegal, anti-HPV16 and -18 antibody GMTs in subjects seronegative at baseline were higher in 10–14 year-olds [16 813.2 (95% CI 13 765.2–2 0536.1) and 6 864.2 (5 484.5–8 590.9) EL.U/ml, respectively] compared with 15–25 year-old subjects [11 022.1 (9 518.3–12 763.5) and 3 684.0 (3 325.0–4 081.8) EL.U/ml,

respectively]. Findings in Tanzania were similar [10–14 year-olds: 17 785.5 (12 987.6–24 355.9) and 5 405.7 (3 967.0–7 366.2); 15–25 year-olds: 7 287.8 (5 082.8–10 449.4) and 3042.6 (2285.1–4051.1 0)]. The vaccine was generally well tolerated in both study populations.

Conclusion: Data from this study indicate that the HPV16/18 AS04-adjuvanted vaccine was highly immunogenic and generally well tolerated when administered to HIV-negative African women.

2. Upper abdominal surgery for ovarian cancer

Dreyer G

Professor and Head: Gynaecologic Oncology Unit, Department of Obstetrics and Gynaecology, University of Pretoria

E-mail: gretad@mweb.co.za

It is clear that complete cytoreduction is associated with improved outcome. It is also accepted that surgical radicality and the completeness of tumour resection is associated with the specialisation level of surgeon and unit. Thus it can be derived that surgical effort and expertise determine cancer-specific survival in ovarian cancer.

In the upper abdomen, major surgical morbidity has to be weighed against the desire to improve long-term outcome. Feasible procedures include splenectomy, partial colectomy and partial resection of the stomach, pancreatic tail and liver. These procedures will be discussed.

Resection and ablation of diaphragmatic disease is now commonly done, but has acknowledged complications. Resection of lymph node disease is also often indicated and malignant nodes are often situated in the para-aortic area, mesentery and below the left kidney. Methods to minimise surgical morbidity, and to help with the selection of patients for these procedures, will be discussed.

3. Advanced cancer: limits of treatment prospects

Dreyer G

Professor and Head: Gynaecologic Oncology Unit, Department of Obstetrics and Gynaecology, University of Pretoria
E-mail: gretad@mweb.co.za

Advanced cancer is often associated with poor performance and nutritional status and sometimes also with advanced age. Medical co-morbidities and heavy pre-treatment status are also important limitations to anti-neoplastic treatment.

In most cancers, the number of treatment events determines survival. The other side of this coin is that therapeutic complications will also increase. Thus, quality-of-life assessments and the addition of treatment-free months to life are important measures of outcome.

The decision on whether a patient can benefit from treatment in a case of metastatic or advanced cancer is a difficult one. It requires expert knowledge and experience of the natural course of the disease without therapy, as well as the expected outcome and treatment-related morbidity and mortality of the different therapeutic options.

These different options must be considered carefully. In my view, the medical expert must have an own opinion about the optimal approach before the open-minded and honest counselling process is initiated. The wishes of the patient and her relatives are then the final determinant of the treatment decision.

In cases of advanced cancer, where the limits of treatment are being tested, treatment decisions must be repeatedly re-evaluated, with a willingness to change these as the needs of the patient and her clinical situation change

4. Screening for and early detection of cervical cancer

Denny L

Professor and Head: Division of Gynaecological Oncology, Groote Schuur Hospital and University of Cape Town
E-mail: lynette.denny@uct.ac.za

Historically, cervical cytology has been used for the secondary prevention of cervical cancer and in those countries with organised, national screening programmes, cervical cancer has been rendered a rare disease. Currently, over 80% of cervical cancers worldwide are diagnosed in women living in developing countries that lack screening programmes.

Competing health needs, lack of resources, the overwhelming poverty and many other factors have prevented most developing countries from tackling the issue of cervical cancer prevention. In the past 15 years, significant research, including randomised controlled trials, has evaluated alternative screening methods and protocols for the prevention of cervical cancer in low-resource settings. These have included visual inspection with acetic acid (VIA), HPV DNA testing, and a range of optically based techniques. Initial cross-sectional studies of VIA and HPV DNA testing showed relatively good test performance. However, once subjected to randomised trials, it soon became clear that VIA has a minimal impact on reduction of either cervical cancer or its precursors and that HPV testing linked to treatment is significantly better, although it has a lower specificity and positive predictive value (PPV) compared to cytology. The ideal test does not yet exist; however, it has been scientifically established that HPV DNA testing linked to immediate treatment is an effective intervention and should be implemented where feasible. Data on alternative approaches will be presented.