

2019 Annual Report (2018 Data)

Oncology Services



2019 Chairman's Report

The Oncology Program at Texas Health Presbyterian Hospital Dallas is committed to providing quality cancer care with a holistic approach to meet the overall needs of the patients. The program is a five-time recipient of the American College of Surgeons' Commission on Cancer Outstanding Achievement Award, the highest level of approval from the Commission on Cancer. Additionally, the breast cancer program is recognized and accredited by the National Accreditation Program for Breast Center and the lung cancer program is recognized as a Center of Excellence by the GO2 Foundation for Lung Cancer.

The program's comprehensive treatment approach is led by a multidisciplinary team that includes nurse navigation, genetic counseling services, medical oncology, radiation oncology, physical and occupational therapy, a prehab and aftercare program, imaging services, spiritual support services, palliative care, genetic counseling, and community support and survivorship services.

The oncology healthcare team at Texas Health Dallas recognizes the importance of screening, early detection, and education

in the community. Throughout the year, they have continued to reach out to the community in the form of risk assessments, education about prevention and early detection, and screening events.

The members of the multidisciplinary healthcare team routinely engage in case conferences and ongoing continuing education to ensure that they are equipped with the latest knowledge and advances in cancer treatment. The dedication and involvement of our care providers makes the difference at Texas Health Dallas. The Cancer Committee conducts quality improvement studies each year. The data from these studies are used to identify opportunities for improvements in services, and as a result, best practices are implemented as standard of care for our oncology patients.

Over the past few years, Texas Health Dallas has collaborated with the University of Texas Southwestern Medical Center (UTSW), a NCI-designated cancer center, to find ways to work together to grow and enhance the oncology care both organizations provide. Most notably, Texas Health Dallas has joined with UTSW to bring their renowned genetic counseling program to our cancer center.

Texas Health Resources is also aligned with UTSW via an integrated network, Southwestern Health Resources. This network offers expanded, coordinated care throughout North Texas for a comprehensive range of needs, from primary care to highly specialized areas such as oncology.

The Texas Health Dallas oncology program continues to evolve to meet the needs of the cancer patients in the communities we serve. We are enthusiastic about our program and the comprehensive, individualized, and patient-centered oncology care we provide.

Sincerely,

Pat Fulgham, M.D.

*Medical Director of Surgical Oncology Services
Chairman, Cancer Committee*



Management of Early Stage Cervical Cancer

Dustin B. Manders, M.D.
Gynecologic Oncology

Overview

A new diagnosis of cervical cancer is expected to be made in approximately 13,000 women in the United States in 2019. Women with local cancers (stages IA1-IB2) are candidates for surgical management. Confirmation that the tumor is confined to the cervix is necessary, and the NCCN provides recommendations for imaging evaluation. For all but microscopic cervical cancers, the recommended studies include pelvic MRI to evaluate the local extent of disease (particularly for tumors >2 cm in diameter) as well as a CT of the chest, abdomen, and pelvis or whole-body PET/CT to evaluate for metastatic disease. Assuming a stage I cancer is confirmed, the recommended surgical treatment is a radical hysterectomy (or radical trachelectomy, if fertility preservation is an option).

Historically, radical hysterectomies were performed via laparotomy. However, minimally-invasive techniques, including conventional laparoscopy and robotic-assisted laparoscopic surgery, have been

used with increasing frequency since the early 2000s since minimally-invasive techniques are associated with lower operative morbidity. The assumption, based largely on retrospective, single-institution case series, has been that oncologic outcomes of minimally-invasive surgery are equivalent to (or at least no worse than) the open technique.

The results of a paradigm-changing, prospective, randomized, multi-national clinical trial were published in 2018. The data were first presented at the annual meeting of the Society of Gynecologic Oncology (SGO) in March, 2018. They were subsequently published in The New England Journal of Medicine (NEJM) in October, 2018. In this trial, patients with stage I cervical cancers were randomized to either minimally-invasive radical hysterectomy or open radical hysterectomy. Unexpectedly, the rate of disease-free survival at 4.5 years was 86% in the minimally-invasive group and 96.5% in the open group, and this corresponded to a statistically significant decrease in both disease free and overall survival. This triggered early closure of the trial, and it led to many centers changing their standard practice to open radical

hysterectomy for early stage cervical cancer.

Following surgical treatment for early stage cervical cancer, patients are stratified by pathologic factors into three risk categories: high risk, intermediate risk and low risk. The “risk” is the estimated risk of recurrence where high risk is associated with an approximately 40% risk of recurrence and intermediate risk with an approximately 28% risk of recurrence assuming no adjuvant treatment is administered. In these cases, adjuvant pelvic radiation is recommended, and this is associated with an approximately 50% or greater reduction in risk of recurrence. It is, however, associated with significant additional short- and long-term toxicities beyond those attributable to surgery. For this reason, preoperative assessment is aimed at identifying patients who are likely to be in the intermediate- or high-risk categories so that they can be recommended for primary chemoradiation rather than surgery.

Data

For this study, we reviewed our pattern of care for early stage cervical cancer. For 2018, we identified 9 women who opted for primary surgical management of stages IA1 through IB2 cervical cancers (Table 1). Cases where surgery was performed following primary radiation therapy were specifically excluded.

Clinical (Preop) Stage	Number of Patients
IA2	3 (33%)
IB1	5 (56%)
Unknown	1 (11%)
Total	9 (100%)

Table 1

The initial evaluation of these patients included a history and physical and laboratory evaluation in all cases as well as a review of any pathology obtained prior to referral. Imaging was ordered at the discretion of the treating physician (Table 2).

Imaging Modality	Number of Patients
MRI	0 (0%)
CT or PET/CT	7 (78%)
None	2 (22%)
Total	9 (100%)

Table 2

Radical hysterectomy (or in one case, radical trachelectomy) was performed in all cases. The surgical approach was either robotic-assisted laparoscopic or open (Table 3).

Surgical Approach	Number of Patients
Minimally-Invasive	5 (56%)
Open	4 (44%)
Total	9 (100%)

Table 3

Final pathology was reviewed at the post-operative visit to assess the risk of recurrence and need for radiation therapy. These data are shown in Table 4.

Risk of Recurrence	Number of Patients
Low	5 (56%)
Intermediate	2 (22%)
High	2 (22%)
Total	9 (100%)

Table 4

Discussion

The small number of patients with early stage cervical cancer treated at our institution is consistent with the relative rarity of this disease. Additionally, prospective studies have shown equivalent cure rates between primary radiation and primary surgery for stage I

cervical cancers. It is likely, therefore, that more patients were technically eligible for radical surgery by virtue of their stage but were nevertheless treated with radiation. Reasons could include poor health status, morbid obesity (which limits the radicality of the surgical procedure) or the patient opting for radiation after a discussion of the risks and benefits of each treatment.

Regarding preoperative workup, we found that the majority of patients had at least a CT or PET/CT (78%). One patient did not because she had a microscopic tumor that was completely excised with a LEEP procedure prior to referral to our institution. The single patient with no preoperative imaging was assigned a preoperative stage of IB1, and post-operatively she was given a pathologic stage of IIA2 due to parametrial involvement. She was referred for adjuvant radiation.

Interestingly, no patients had a pelvic MRI. This modality has been shown to better evaluate pelvic lymph nodes and parametria than standard CT. Two patients were found to have high risk disease, one by virtue of lymph node involvement (multiple nodes were positive; her preop workup included a standard CT and not a PET/CT) and the other (mentioned above)

due to parametrial involvement. Although the sample size is small, 2 of 9 (22%) patients were ultimately found to have more advanced disease than suspected based on preoperative evaluation. It is reasonable to question whether the addition of MRI to the preoperative workup would have identified this and saved these two patients from combined modality treatment.

Surgical management was split roughly evenly between minimally-invasive surgery and open surgery. Of the five women treated with minimally invasive radical surgery, one had no residual disease after a prior cervical conization (considered appropriate even after the NEJM publication), two had surgery prior to the presentation of the practice-changing data at the annual meeting of the SGO, and two had surgery after the meeting but before the publication of the data in the NEJM. It will be noted that the initial presentation at the SGO postulated that patients with clinical tumor size of <2 cm diameter fared no worse in the minimally invasive arm compared to open. Our two patients who had laparoscopic radical hysterectomies after the SGO annual meeting had clinical tumor diameter of <2 cm.

Adjuvant radiation was recommended for the four patients who had intermediate and high-risk disease. Three of the four completed radiation; one patient refused and was lost to follow up.

Summary

Based on this review of our treatment of patients with operable cervical cancer, we have adhered well to the standards of care related to surgical management and recommendations for adjuvant treatment. The main area of potential improvement is in preoperative imaging. While evaluation of metastatic disease with PET/CT or standard CT was nearly universal, evaluation of local extent of disease was universally absent. Although it is impossible to know with certainty if their more advanced disease would have been discovered by MRI, two patients potentially could have been spared the combined morbidity of radical surgery and pelvic radiation. Recognition that the NCCN guidelines state a preference for pelvic MRI in patients with a clinical tumor diameter >2 cm should guide our preoperative evaluation in the future.