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Management of peritoneal carcinomatosis of ovarian origin

Evgenia Halkia
Department of Gynecology, Tzaneio General Hospital Afendouli, Greece

Epithelial ovarian cancer (EOC) is the second most common genital malignancy in women and the most lethal gynecological malignancy with an estimated five-year survival rate of 39%. Despite efforts to develop an effective ovarian cancer screening method, 60% of patients still present with advanced disease, and will ultimately develop recurrent disease or show drug resistance; The eventual rate of curability is less than 30%.

Cytoreduction has a more significant influence on survival than the extent of metastatic disease before surgery. The surgically-attained maximum diameter of residual disease is inversely proportional to survival outcome. Consequently, primary cytoreductive surgery offers the best opportunity for achieving extended survival. Even in patients with un-resectable liver metastasis, optimal de-bulking of extra-hepatic disease is associated with a significant survival advantage.

Incorporating extensive upper abdominal debulking procedures with standard pelvic cytoreduction (sigmoid resection, peritoneal stripping, diaphragm stripping, extensive bowel resection, splenectomy, partial gastrectomy and resection of liver and kidney) in the use of HIPEC (Hyperthermic intraperitoneal chemotherapy) and cytoreductive surgery in a specific setting of patients, has been a promising approach and should be encouraged for long-term survival.

Initial surgery for ovarian cancer is most appropriately done by gynecological oncologists preferably in centers with expertise in the multidisciplinary management of the disease.

drhalkia@yahoo.com