



## Robotic Surgery for Gynecologic Cancers

Webcast

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Barbara Goff, M.D.

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### **Introduction**

#### **Andrew Schorr:**

About 81,000 women in the most recent year we have statistics for, 2007, were diagnosed with gynecologic cancer, and there are various types, and there are new approaches for some of them including robotic surgery. We'll hear all about robotic surgery coming up with a leader in the field. It's all next on Patient Power.

#### **Andrew Schorr:**

Hello and welcome to Patient Power sponsored by the Seattle Cancer Care Alliance. I'm Andrew Schorr. Well, there are about 81,000 women who are diagnosed with gynecologic cancers. We're going to learn about what those cancers are and also about where new surgical approaches can help and also what are the causes of these cancers, where we know. A leader in the field is Dr. Barbara Goff. She's director of gynecologic oncology at the University of Washington and the Seattle Cancer Care Alliance.

Dr. Goff, thank you for joining us once again on Patient Power. When we talk about gynecologic cancers, what are the cancers we're speaking about?

#### **Dr. Goff:**

Well, the most common gynecologic cancer is actually endometrial cancer, which is a cancer that arises from the inside lining of the uterus, and there are about 40,000 women each year who get endometrial cancer.

The second most common cancer would be ovarian cancer, and that is a cancer that arises from the ovary itself. And about 20,000 women each year get ovarian cancer.

The third most common cancer is cervical cancer, and a lot of women are familiar with cervical cancer because we go in regularly to get our pap smears, which screen for cervical cancer. And there are about 15,000 women each year who get cervical cancer.

And then there are cancers of the vagina, cancers of the vulva, cancers of the fallopian tube, and these cancers are much more rare.

#### **Andrew Schorr:**

When we talk about endometrial cancer, the most common, do we have any idea

what causes it?

**Dr. Goff:**

Well, it's actually predominantly due to estrogen excess, either because people take exogenous estrogen and they may take too much of it without a balance of progesterone, or their own body makes too much estrogen. And what a lot of people don't realize is that when we are overweight that that actually can result in elevated estrogen levels in our body, so that if women are more than 50 pounds overweight their risk of getting endometrial cancer is about 10 times that of a woman who has a normal weight.

**Andrew Schorr:**

So what would be the symptoms? Let's say, if you were developing this most common kind of gynecologic cancer, endometrial, what would be the symptoms?

**Dr. Goff:**

Well, most endometrial cancers occur after the menopause, and fortunately there is a fairly early warning sign, and that would be any bleeding that occurs after the menopause is abnormal and should be promptly evaluated. There are a small percentage of women who develop endometrial cancer prior to menopause, and for these women it would be heavier than normal bleeding, periods that last, you know, more than seven days, people who are passing clots or having bleeding in between their periods. Those would also be signs of potentially endometrial cancer.

**Andrew Schorr:**

Now, some younger women have endometriosis. Is there any connection?

**Dr. Goff:**

No, there doesn't appear to be a connection with endometriosis and endometrial cancer, although there has been some connection between endometriosis and ovarian cancer. So if you had extensive endometriosis it's important to inform your physician about that because that could potentially be a risk factor for ovarian cancer.

**Andrew Schorr:**

Dr. Goff, in many surgical areas now you're able to use a robotic approach, and we'll talk about the advantages of that, but where does that fit in now with gynecologic cancers and maybe especially endometrial cancer treatment?

**Dr. Goff:**

Well, I would say that the majority of endometrial cancers now can be treated surgically with the robot, and I would estimate at our institution, you know, where we tend to see some of the more difficult cases and the more advanced cases we're still able to manage about 80 percent of our endometrial cancers through a robotic approach. Also, the vast majority of cervical cancers can be treated with a robotic approach, and even some early ovarian cancers can be treated that way, although predominantly I would say that the robot has really made its biggest impact in both endometrial cancer and in cervical cancer surgery.

**Andrew Schorr:**

All right. What does that mean, this robotic approach? What does it mean versus the way you used to do it?

**Advantages of Robotic Surgery**

**Dr. Goff:**

Well, the old-fashioned way of doing surgery is that we would make a large incision in someone's abdomen, typically starting at the pubic bone and going up to the bellybutton and sometimes even going above the bellybutton depending on how large patients were and how big the cancers were.

Now with the robot we typically can put five tiny incisions in the upper abdomen, and the incisions are no wider than my thumb, which is not very wide, but about a centimeter are most—is the size of these incisions. You put five little incisions in, and the surgery is actually done laparoscopically, but what's really great about the robot is that you put in these special instruments through the laparoscopic ports. These instruments are hooked up to a robot and it allows a great degree of precision when you're doing surgery. So the robotic arms can mimic a human wrist, so we have all of the ability to do the very fine and technical procedures that we could use to only do when we had an open case. We can now do them through a minimally invasive approach, and so rather than a very large incision people now wake up with five little Band-Aids on their abdomen, and it's great for patients.

**Andrew Schorr:**

All right. What about when they get to go home versus before and just general recovery?

**Dr. Goff:**

Yeah, so what's really nice about having the minimally invasive approach is that the pain for patients is dramatically reduced. I've had some patients who I've done robotic surgery, I've done a hysterectomy and I've taken out lymph nodes and done an extensive staging, and they've never even needed a pain pill other than a Tylenol or a Motrin, and that's pretty much unheard of with the old-fashioned surgery.

The other great advantage is most people get to go home the next day. They have a very quick recovery. Most people are back at work within a couple weeks. The other nice thing is that for many patients who get endometrial cancer they are overweight, they may be diabetic, they may have hypertension, and those people are really prone to wound infections and complications—infectious complications with surgery. When you do the robot you really minimize the risk of infection. And so it used to be that, you know, approximately 20, 30 percent of patients would develop very bad wound infections following surgery, and with the robotic approach that's almost reduced down to zero.

The other advantage is that there is very little blood loss with robotic surgery. We

see much, much less blood loss and so much less risk of needing transfusion.

And as far as we can tell from the preliminary studies that have been done the cancer outcomes are the same. So you don't, you know, you don't sacrifice the cure rate or the ability to do the appropriate surgery with the robotic approach, which is why this is such an exciting advance for patients.

**Andrew Schorr:**

Wow. That's all good news. Now, with anything, though, of course you worry is there a downside. Any downsides you see with the robotic approach? I know sometimes—do the procedures take longer? Does that mean more anesthesia?

**Dr. Goff:**

Yeah, I mean that is—I guess that would be the one downside is that the surgeries do typically take a little bit longer than the open approach, and so people tend to be under anesthesia for approximately 20 percent longer. But as far as we can tell that doesn't seem to affect the overall recovery. As I said the vast majority of patients go home the next day where it used to be with the old fashioned laparotomy where we make the big incision in the belly is that patients would typically stay in the hospital three to five days following a big operation just because of the pain and the bowel dysfunction and all the other things that went along with doing those large surgeries. So, yes, there's more anesthesia but that doesn't seem to result in any long-term consequences for patients, which is really good news.

**Andrew Schorr:**

Dr. Goff, of course not every institution has a robotic approach, and not every surgeon is experienced at doing it. So, first of all, what's your own experience with it, and what counsel would you give women who are hearing this who could be in the Seattle area but they could be anywhere as far as if they're thinking of this making sure it's done right.

**Dr. Goff:**

Yeah, well, it is important—there's definitely a learning curve with any new surgical technology, and so—the nice thing about the robotic surgery is that it wasn't a totally new technology. We were doing these procedures laparoscopically before, we just didn't have the advantage of the robot. So for many surgeons it was just a transition from a more difficult technology to an easier technology. So that was one nice thing about robotics.

But it is, for patients, it's very important to be treated not only by a physician who has expertise in these procedures but also an institution where the entire team has expertise. Because the robot is a very complex instrument and so it's important that there be the right nursing staff, the right technical support and that everybody knows how to use the robot appropriately and safely. There are some special things with anesthesia. And so it's really important to be in a center where people are doing a lot of these, particularly when we're talking about cancer therapy.

You know, with cancer surgery you usually have one opportunity to get it right because when cancers come back they're very difficult to treat, and so we want to make sure that everything is done right the first time and that you've got the right expertise. So generally I advise my patients, you know, if they're—if they're in Seattle or they're elsewhere if you can get into a comprehensive cancer center like the SCCA you're going to have a better outcome.

### **Rosemary's Story**

#### **Andrew Schorr:**

Dr. Goff, let's meet one of your patients who has benefitted from this. Rosemary Moothart, 63 years old, joins us from Redmond. She works in the automated retail industry, kiosks that you can see in the supermarket, where you can dump in your change and have it be counted or you can get a movie right there, and so she's director of investor relations. She's got a busy job.

But going back to December of 2010, Rosemary, I understand you just weren't feeling well.

#### **Rosemary:**

That's correct. Actually, in along about the end of October, November I wasn't feeling well and scheduled an appointment with my gynecologist to see what was going on.

#### **Andrew Schorr:**

And what happened was—and I think maybe you also maybe had a little bit of abnormal bleeding. I take it at 63 you had gone through you menopause, so bleeding would be unusual.

#### **Rosemary:**

That's right, but—I had gone through menopause but, you know, women so often think maybe this is normal. You know, you hadn't gone through this before, so I thought maybe this is a little bit normal, the cramping, but then as it was becoming bleeding I thought this is something I need to talk to the doctor about.

#### **Andrew Schorr:**

Absolutely. Well, important. Now, unfortunately you got a call a few days later and you were told this was serious, an endometrial cancer, and you were being referred to a gynecologic oncologist, and you picked our guest today, Dr. Barbara Goff from the Seattle Cancer Care Alliance. So you went to see her. So meanwhile the process had been set up. I understand that you were scheduled for a hysterectomy?

#### **Rosemary:**

That's correct. I was told on December 10th that I had the cancer by my regular gynecologist, and she gave me two choices of doctors. I selected Seattle Cancer Care Alliance and Dr. Goff. And she said the first step is a hysterectomy, so we're going to go ahead and schedule that for you, and in the meantime then you will see your gynecol—oncology doctor surgeon in a week.

**Andrew Schorr:**

So that happened. Now, you've known other people who have had hysterectomies, older, younger. When the word "hysterectomy" comes up traditionally women have thought of a long recovery. Had anybody said that to you, like oh, no.

**Rosemary:**

Yes, absolutely. First of all, when they told it to me I thought of hysterectomies as they cut you, you're in bed for a long time. You can't work for weeks. You're tired. And that was based on one of my best friend's experience about 15 years ago, and she's much younger than I am. And I was thinking if that happened to Carolynn what was it going to be like for me at 63.

**Andrew Schorr:**

So you see Dr. Goff. She says yes, we do need to do that surgery, and look around and do what we need to do to get all the cancer, but she described something new, this robotic approach we've been talking about. How did that sound to you?

**Rosemary:**

You know it was fascinating actually. I had never heard of it, and she explained to me about how they make these incisions and it's done by this special equipment and they don't have to do this big cut across the abdomen, and they're able to pull the organs out and the recovery—that's the best part, the recovery is going to be so much different. It will be quick. You won't be as tired. You'll be able to work. You'll be up on your feet, and that was very important to me.

**Andrew Schorr:**

So you had the surgery on a Wednesday.

**Rosemary:**

Yes.

**Andrew Schorr:**

Tell us about what you were doing just a few days later, on a Monday.

**Rosemary:**

Well, it happened to be a very, very critical time at my work. So this is—December 29th I had the surgery and of course there's the holiday weekend with New Year's, and Monday was actually a holiday for our company, January 3rd, 2011, but I needed to do some work. It was an important time relative to what I do, and I was working from home and not—experiencing very little discomfort and feeling pretty good.

**Andrew Schorr:**

Wow. Now, there's one other point we should make. You have a daughter, Kristen.

**Rosemary:**

Yes.

**Andrew Schorr:**

And she was there as you woke up in the recovery room after the surgery, and the key thing of course in any of this is you want to cut out the cancer. And what did she say to you?

**Rosemary:**

Well, she actually woke me up in the recovery room, and she had such a huge smile on her face. She said, Dr. Goff said the surgery was perfect, and they think they got it all. So she was so excited about this kind of surgery, you know, that they could get it all and that my recovery wasn't going to be very long, and that was exciting for me because it meant we could proceed to chemotherapy without a lot of complication.

**Andrew Schorr:**

Right. True medical progress. You want to beat the cancer but obviously have the least trauma you could and let you go on with your life. So you had the chemotherapy. You had the radiation. And now we're a few months down the road. You had a visit with Dr. Goff. She took a look at how you were doing. What did she say?

**Rosemary:**

She said no detectable cancer.

**Andrew Schorr:**

Wow. Those are—those are pretty important words.

**Rosemary:**

Absolutely.

**Andrew Schorr:**

Dr. Goff, first of all, you must be delighted to hear the stories that the patients are expressing of how a robotic approach has benefitted them.

**Dr. Goff:**

Absolutely. I think that's just been one of the driving forces as to why we try to have more and more patients done robotically because when you hear people who have had minimal pain, who are able to get back to work, you know, quickly, were able to do the things that they love and be minimally impacted, you know, by this cancer and by this cancer therapy, I just think that that's—it's such an exciting advance for me. And it's so fun to be practicing medicine when you get to see advances like this that really make a huge difference for patients.

**Pre-Surgery Evaluation**

**Andrew Schorr:**

Dr. Goff, let's back up for a minute. So the first question of course, whether it's robotic or not, is someone a candidate for surgery. So how do you evaluate that?

And let's start with endometrial. You want to beat the cancer, so how do you know is it at a stage where surgery makes sense and it can be curative or certainly knock the cancer back to a great extent?

**Dr. Goff:**

Yeah, with endometrial cancer, fortunately, most cancers actually do present in stage I when the disease is confined to the uterus, and that's because, as we talked about earlier, there are these early warning symptoms, you know, the abnormal bleeding or the bleeding after menopause. So the vast majority of women are diagnosed in stage I. And with stage I the primary treatment for cure is to do a hysterectomy, remove the uterus, cervix, tubes and ovaries and then to do a staging operation to see if the cancer has spread. So as long as there's not gross evidence of spread at the time that the patient presents, and for the majority of patients, probably 90 percent of patients, surgery is going to be the right approach. And as I said about 80 percent of those 90—90 percent of those 90 percent of patients are going to be able to be treated with a robotic approach.

So that really should be, you know, the—anybody who's approaching someone with a—with a patient with endometrial cancer it really should be, you know, we should try to do this through a robotic approach and give the patient, you know, the best surgical outcome that we can.

**Andrew Schorr:**

All right. Let me take you through some of the others. Cervical cancer, you say you use the robot there. When is it appropriate?

**Dr. Goff:**

So that would be appropriate with early stage disease. When the cancer is still confined to the cervix and it has not spread beyond the cervix, then that is when we use the robot to treat patients and to do a hysterectomy in that setting. Once—in cervical cancer once the cancer has spread beyond the cervix, then it's more appropriate to use a combination of radiation and chemotherapy in those patients.

**Andrew Schorr:**

All right. Let's take it further. Now, unfortunately, and I know you've done so much work in this, ovarian cancer is often not discovered early. Does this come into play there?

**Dr. Goff:**

Well, with patients who have early stage of ovarian cancer, again, patients whose disease is confined to the ovary and the ovary is not large, in those situations you can potentially use a robotic approach. The problem with ovarian cancer is that about 70 percent of cases are not detected until the disease has already spread throughout the abdomen, and so I would say for the majority of patients with ovarian cancer, the old-fashioned laparotomy unfortunately is still the best approach for the majority of these patients.

**Andrew Schorr:**

And other cancers, vaginal, vulvar?

**Dr. Goff:**

Those generally are not going to need any sort of incision in the abdomen. Those are typically treated through local excisions or using radiation and chemotherapy. So there would be less of an issue of using robotic surgery in those cases.

**Prevention**

**Andrew Schorr:**

We should talk for a minute about prevention because obviously people would like to avoid this if they could at all or for family members. It sounds like with endometrial, losing weight would be one approach.

**Dr. Goff:**

Yeah, absolutely. I don't think people really have been educated about the correlation of weight and cancer, and it's something I think people need to pay a little bit more attention to. We all know that losing weight is a good thing, but I think sometimes if people realize the risk that they put themselves at in terms of developing a disease like endometrial cancer that might give people a little bit more motivation to lose weight.

I think one other thing I'd like to just comment on is that there are some hereditary types of endometrial cancer, so it is always important to know your family history. And people who have family history particularly of colon cancer, endometrial cancer, prostate cancer, it's important to talk about family history with your physician and decide whether or not seeking some genetic counseling might be a good idea as well.

**Andrew Schorr:**

Dr. Goff, you spoke about in advance with robotic surgery. Are you encouraged that we can do better? Now, we're talking about a range of different cancers and they show up at different stages, but do you feel encouraged?

**Dr. Goff:**

Absolutely. You know, what's really exciting about being an oncologist or in oncology today and treating cancers is that there is such a rapid pace of new developments. We've got a lot of new chemotherapeutic options that are coming out. We've got a lot of new targeted therapies, which I just think are very exciting that target specific enzymes, specific pathways, that really make treatments less toxic for patients and more effective. So I'm just—I'm very encouraged with cancer treatment in 2011.

**Andrew Schorr:**

So one of the things that you mentioned earlier, and I just want to cover it off for people, is related to a hereditary connection. So certainly women who have been diagnosed with breast cancer, ovarian cancer, they're aware that in a limited number of cases there could be a family connection, and there's a test for that.

Where are we with awareness of these other gynecologic conditions beyond ovarian cancer where there could be this hereditary connection? And is there any further kind of test or what do we do?

**Dr. Goff:**

Yeah, there are—there is testing that is available for a syndrome that we call Lynch syndrome, which is the syndrome that predisposes men and women to having hereditary colon cancer, but in particular it predisposes women to develop endometrial cancer. So I think we've really learned in the last decade not only with the breast and ovarian cancer story but also with the colon and endometrial cancer story the importance of understanding or knowing your family history particularly when it comes to cancer because we are developing—we are discovering these new—these new syndromes which really does allow us to prevent cancers.

And we now recommend prophylactic surgery for people who have genetic predispositions to breast and ovarian cancer. We're recommending prophylactic surgery for women who have predispositions for endometrial cancer so that we can prevent people from ever the getting these cancers in the first place, which is ultimately—you know, the best way to treat a cancer is to never get it in the first place.

**Andrew Schorr:**

Absolutely. So for one of your patients who is being treated robotically probably with endometrial cancer, then that's part of the discussion is family history and looking at could someone else be affected and hopefully has not had cancer but is there some action maybe to be taken.

**Dr. Goff:**

Yeah, absolutely. And it's really important not only for other family members but sometimes for the patient as well. So for example for somebody who has endometrial cancer who, you know, potentially has a family history that would put her at risk for this Lynch syndrome, well, that patient herself is going to need extra screening for colon cancer because she may be at elevated risk for colon cancer. She may be at elevated risk for other cancers, and so it helps us not only direct screening for the patient herself in terms of what other cancers she may be at risk for, but then we can help notify other members of the family that they may be at risk for the same sort of cancers as well.

And I think the other thing that's really important is sometimes people think if it's a gynecologic cancer it's only my mother's side that contributes to me being at risk for getting these cancers, and that's not true. You get half of your genes from your father, half of your genes from your mother, and so what happened on your father's side is equally important in terms of the risk for gynecologic cancer as it is for what happened on your mother's side, and a lot of people don't realize that.

**Andrew Schorr:**

Well, as I listen to all this, the advance with robotic surgery that is so helpful for people and also understanding where did the cancer come from, are you at risk for

another cancer, is another family at risk, all of that I really believe suggests that you should be, our listeners, discussing these issues with someone who has really specialized in this care. Certainly Dr. Goff is. She spoke about you consulting with a comprehensive cancer center such as the Seattle Cancer Care Alliance. And then should you need surgery certainly, Dr. Goff, it seems like, as we've underscored here, the robotic approach is a real advance.

**Dr. Goff:**  
Absolutely.

### **Closing Comments**

**Andrew Schorr:**

All right. Dr. Barbara Goff who is director of gynecologic oncology at the University of Washington and Seattle Cancer Care Alliance, thanks so much for being with us.

**Dr. Goff:**  
You're welcome.

**Andrew Schorr:**

Let's give the last word to your patient who has benefitted from this care. Rosemary, so here we are. Dr. Goff has clearly explained where we are now with these cancers, endometrial in particular, which you were diagnosed with, and the robotic approach now. What would you say to other women who may be listening who maybe they've had the symptoms you did, maybe they've hesitated going to the gynecologist, and they fear, you know, maybe they'd need a big surgery like they used to have to do? What would you advise them?

**Rosemary:**

Well, first of all, I would tell women that it's very, very important that they listen to their own bodies and go see a doctor. Dr. Goff did tell me that a lot of women wait very long. They wait months and even years and then by the time they see her they're in a very serious situation. But if you listen to your body, you get to a doctor and you have the option for this type of surgery, I'd absolutely, whether or not it's related to cancer, encourage women to consider it and go forward and trust their doctors. It's just amazing how quickly you can be back on your feet.

**Andrew Schorr:**

Wow. Now, you are of course celebrating every day with that no detectable cancer ringing in your ears.

**Rosemary:**  
Yes.

**Andrew Schorr:**

And I understand coming up in December of 2011, about a year after you were diagnosed, is a big event you're very much looking forward to. What's that?

**Rosemary:**

My daughter is expecting her first child, a little girl.

**Andrew Schorr:**

Wow. Well, you want to hold that baby in your arms. And my wish for you, Rosemary, is that you can watch that baby grow and just celebrate your grandchildren. You got to dance at their weddings, okay?

**Rosemary:**

Absolutely. Thank you.

**Andrew Schorr:**

Rosemary Moothart, who is a wonderful example of somebody who got state-of-the-art care for endometrial cancer, new robotic use of that for surgery and is doing well.

This is what we do on Patient Power is connect you with leading experts, really inspiring, unforgettable stories like Rosemary's and help you make the right decisions for your own care. I'm Andrew Schorr. Thanks for joining us. Remember, knowledge can be the best medicine of all.

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