Gyn. Oncologists Get Few Ovarian Ca Referrals

Ob.gyns. provide more referrals than internists, family physicians, but could improve their habits.

BY DAMIAN McNAMARA

FROM THE ANNUAL MEETING OF THE SOCIETY OF GYNECOLOGIC ONCOLOGISTS

ORLANDO – When a woman with a suspicious ovarian mass presents to a primary care physician, the majority of these doctors would not refer the patients directly to a gynecologic oncologist, even though early management by such specialists is associated with improved outcome, Dr. Barbara A. Goff said.

In all, 52% of 414 internists and 40% of 591 family physicians who responded to a mailed survey indicated that they would refer a patient with a suspicious pelvic mass directly to a gynecologic oncologist. Overall, 98% indicated that they would refer or consult with another physician, but half would initially refer to an ob.gyn., Dr. Goff said at the meeting.

"It's been shown in numerous studies that women who receive their care from gynecologic oncologists have a significantly higher likelihood of receiving NCCN guidelines [recommended] therapy, optimal cytoreduction, and better overall survival," Dr. Goff said. The National Comprehensive Cancer Network (NCCN) is a consortium of 21 leading cancer centers in the United States that regularly releases and updates clinical guidelines in oncology.

The survey findings suggest a need for greater awareness of the benefits of such direct referrals and, possibly, for incentives to get internists and family physicians to refer these women more often, said Dr. Goff, director of gynecologic oncology at the University of Washington, Seattle. "Promoting direct referral to gynecologic oncologists from primary care may be the best way to increase compliance."

VITALS

Major Finding: Some 52% of 414 internists, 40% of 591 family physicians, and 66% of 596 ob.gyns. surveyed indicated that they would refer a woman with a suspicious ovarian mass directly to a gynecologic oncologist.

Data Source: A vignette-based survey mailed to a random sample of 3,200 primary care physicians, with a 62% response rate.

Disclosures: Dr. Goff and Dr. Trope said they had no relevant financial disclosures. The study coauthors included researchers at the Centers for Disease Control and Prevention; the CDC provided funding for the survey.

A total of 596 ob.gyns. also responded to the vignette-based survey. Their answers differed from those of internists and family physicians when they were asked to consider how they would manage the same hypothetical patient. The scenario was a 57-year-old woman complaining of pelvic pain and bloating for 3 weeks, whose ultrasound reveals a 10-cm, complex, right adnexal mass with solid and cystic components and increased vascularity. Patient variables such as race and insurance status were changed in different versions of the survey.

About one-third of ob.gyns. (34%) indicated that they would perform surgery themselves. These ob.gyns. were significantly more likely to work in practices that were smaller and/or located in more remote places, according to a multivariate analysis. The other 66% responded that they would consult with or refer the woman to another physician, and 96% of these ob.gyns. would involve a gynecologic oncologist.

This combination of findings – that only about half of internists and family physicians would refer directly to a gynecologic oncologist, and about one-third of ob.gyns. would perform surgery themselves – may partially explain why many women with ovarian cancer in the United States do not receive comprehensive surgical care or get treated at a high-volume center, Dr. Goff said.

"Unfortunately, recent studies show that 30%-50% of women with ovarian cancer are not receiving care from gynecologic oncologists," Dr. Goff said. For example, 44% of 31,897 stage III/IV ovarian cancers were treated by a different type of physician (Gynecol. Oncol. 2010;117:18-22). Those women who were treated by a gynecologic oncologist had a 40% improvement in overall survival.

Dr. Goff also examined this phenomenon in her study that showed that 67% of 9,963 women with ovarian cancer who were admitted received comprehensive surgery (Cancer 2007;109:2031-42).

Dr. Goff and her associates looked for significant patient and physician factors that were associated with referral to a gynecologic oncologist. Private insurance was the only significant, unadjusted patient factor. Among the internists and family physicians, significant factors included female sex, internal medicine specialty, board certification, fewer years in practice, group practice, fewer patients seen per week on average, involvement in clinical teaching, and an urban practice location.

In a multivariate logistic regression, factors that were significantly associated with an internist or family physician's not referring directly to a gynecologic oncologist included male sex, family physician specialty, Medicaid insurance, providers with a weekly average number of patients greater than 91, solo practice, and rural location.

The 12-page survey was mailed to 3,200 primary care physicians who were randomly sampled from the AMA master file. A $20 bill was included as an incentive. The response rate was 62%.

"This is an important and provocative paper," said invited study discussant Dr. Claes Trope, head of the national gynecologic oncology center at Oslo University Hospital.

The sample size is large, there seems to be no selection bias because a random sample of physicians was surveyed, and the "62% response rate is quite impressive," she said. An inability to judge whether physician responses completely reflected what the clinicians would actually do in practice, compared with a "politically correct" response, is a potential limitation, Dr. Trope added. ■

Wider Role for Neoadjuvant Chemo in Ovarian Cancer

BY DAMIAN McNAMARA

FROM THE ANNUAL MEETING OF THE SOCIETY OF GYNECOLOGIC ONCOLOGISTS

ORLANDO – Neoadjuvant chemotherapy with interval debulking surgery yields similar overall and longer progression-free survival when compared with primary debulking surgery for women with stage IV epithelial ovarian cancer, according to a retrospective study.

"Our study suggests a potential wider role for neoadjuvant chemotherapy in management of stage IV ovarian cancer," Dr. Jose Alejandro Rauh-Hain said.

The researchers assessed 221 newly diagnosed women with stage IV ovarian cancer. Overall survival was not significantly different at a median of 33 months with neoadjuvant chemotherapy-interval debulking surgery group (NACT-IDS) and 29 months with primary debulking surgery, said Dr. Rauh-Hain, a clinical fellow in obstetrics and gynecology at Massachusetts General Hospital and Brigham and Women's Hospital, both in Boston.

VITALS

Major Finding: Overall survival was not significantly different at a median of 33 months with neoadjuvant chemotherapy-interval debulking surgery group (NACT-IDS) and 29 months with primary debulking surgery,

Data Source: Retrospective study of 221 women with newly diagnosed advanced ovarian cancer treated between 1995 and 2007.

Disclosures: Dr. Rauh-Hain said he had no disclosures. Dr. Rose is a member of the speaker's bureau for Lilly.

Median progression-free survival was 14 months for the 45 women in the NACT-IDS group, compared with 10 months among the 176 women treated with primary debulking only. Patient records were evaluated to subclassify stage IV disease, site of tumor, and dissemination at time of initial diagnosis.

The strengths of the study are a large number of patients, treatment based on physician discretion, and an optimal debulking surgery rate of 58%, which is similar to other studies, said invited discussant Dr. Peter Rose. A retrospective design; an unbalanced comparison (because the majority had primary debulking surgery); and a lack of uniform criteria to select neoadjuvant chemotherapy are limitations.

"It seems like we are mixing a lot of different tomatoes, big red ones and small green ones, and what we are getting is tomato sauce," said Dr. Rose, section head, department of obstetrics and gynecology at the Cleveland Clinic in Ohio.

Optimal cytoreduction, defined as residual disease smaller than 1 cm, was not significantly different between groups: 71% of the NACT-IDS and 58% of the primary debulking cohorts. The rate of complete resection to no residual disease was significantly higher among women who underwent NACT-IDS, 27%, vs. 7.5% of women treated with primary debulking.

Median follow-up was 28 months. The longest median overall survival was observed for women who had primary debulking surgery and no residual disease (72 months), but Dr. Rauh-Hain pointed out that "only 7.5% of these patients who underwent primary debulking had no residual disease." This success rate is similar to 8% of 360 women debulked to no residual disease in another report (J. Clin. Oncol. 2008;26:83-9). Median overall survival reached 32 months for the primary surgery group who had optimal cytoreduction and to 20 months if cytoreduction was suboptimal.

The researchers also evaluated median progression-free and overall survival rates by site of distant metastatic disease, including pleural effusion, liver, abdomen, distant lymph nodes, and spleen. The only significant difference was in median overall survival among women who had liver metastases and NACT-IDS, 43 months vs. 27 months with primary debulking. Median progression-free survival in this group was 15 months vs. 13 months. The superior overall survival with NACT-IDS among women who presented with parenchymal liver metastases suggests this therapeutic strategy may be the preferred option for these patients, Dr. Rauh-Hain said. The NACT-IDS group had a shorter mean length of hospital stay, 8 days vs. 12 days in the primary debulking surgery group. There also was a trend toward fewer postoperative complications in the NACT-IDS cohort, 15% vs. 27%. Also, no woman in the NACT-IDS group died within 30 days of their initial surgery compared with eight women (5%) of the primary debulking surgery group. ■