Original Article

Laparoscopic Surgery for Endometrial Cancer: Survey of Practice among Thai Gynecologic Oncologists

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Objective: To elucidate the current practice of laparoscopic surgery in endometrial cancer obtained from the Thai Gynecologic Cancer Society (TGCS) Survey.

Materials and Methods: The present study was a part of the national practice survey by the Thai Gynecologic cancer Society on the management of gynecologic cancer. All Thai Gynecologic Oncologists were invited to respond to the web-based online survey which was opened from August to October, 2019. Data regarding the practice of laparoscopic surgery in endometrial cancer were abstracted and analyzed.

Results: Of 170 respondents, 60 (35.3%) reported performing laparoscopic surgery for endometrial cancer. Nine (15.0%) performed laparoscopic surgery in all patients whereas the remaining applied some criteria for patient selection. Significantly higher percentages of respondents who worked in training hospitals or who had worked for ≥5 years performed laparoscopic surgery compared to the respondents from a non-training hospital or had shorter practice duration: 44.2% versus 26.2% (p = 0.014) for the hospital setting and 45.5% versus 21.1% (p = 0.001) for the duration of practice, respectively. The financial issue was the most common barrier for laparoscopic surgery reported in this survey (81.7%).

Conclusion: Only one-third of the Thai gynecologic oncologists performed laparoscopic surgery in treatment for endometrial cancer patients. The procedure was performed more frequently among the respondents working in a training hospital or who had a longer duration of work.

Keywords: Uterine neoplasm, Laparoscopy, Minimally invasive surgery, Practice, Survey

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Laparoscopic surgery has played an increasingly important role in the surgical management of endometrial cancer. There is mounting evidence to suggest that laparoscopic procedure as a surgical approach in endometrial cancer is technically feasible[1-3]. Compared to the laparotomy, laparoscopic surgery had lower perioperative complication rates, less blood loss, and shorter hospital stay as well as a better quality of life and comparable long-term oncological outcomes[4-6].

Nevertheless, a few drawbacks of laparoscopic surgery, aside from longer operative time, have also been recognized. The laparoscopic procedure required skill of the surgical team, so there is a learning curve of the operator to gain experience[1]. Operative difficulties were additionally encountered especially in overweight and obese patients. Conversion rates increase directly with the body mass index of the patients[1]. A previous multicenter study conducted in Italy reported 13.9% conversion rate of laparoscopic surgery for endometrial cancer; however, the conversion did not confound the oncological outcome[7]. Laparoscopic surgery has advantages over laparotomy, but its advantages compared to robotic surgery, which is the most recent technique of minimally invasive surgery (MIS), have not been demonstrated[8].

Despite the benefit of minimally invasive surgery for women with endometrial cancer, one major concern is the availability of the instrument and the cost of the procedure. One study from the United States (USA) reported that open laparotomy had the highest total average cost, followed by robotic-assisted surgery and laparoscopic surgery, respectively[9]. Another study from the United Kingdom (UK), which took operative time, blood loss, length of hospital stays and societal costs into consideration, also reported robotic surgery or laparoscopic surgery was more cost-effective than the laparotomy procedure[10].

The role and practice of laparoscopic surgery in the low/medium Human Development Index (HDI) countries

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may be different from those in the high/very high HDI regions. The differences lie mainly in the cost and availability of the instrument, which in turn, affect the operative skill development and practice of the surgeon.

The purpose of the present study was to elucidate the current practice of laparoscopic surgery in endometrial cancer among Thai gynecologic oncologists. Factors that have influenced the choice between laparoscopic versus open surgery in patients with endometrial cancer were also assessed.

Materials and Methods

This cross-sectional study was a part of the national practice survey on the management of gynecologic cancer undertaken by the Thai Gynecologic Cancer Society (TGCS). This study was approved by the Ethical Review Committee of all affiliations involved in the study (COAs/IRBs: Faculty of Medicine Vajira Hospital, 097/2562; Rajavithi Hospital, 104/2562). The full description of survey methods and details of the questionnaire were presented in the main report of the project[11]. Briefly, the participants were Thai gynecologic oncologists who had worked for at least one year and were currently working in the country. The research project was solicited during the 2019 TGCS annual meeting to invite members to participate in the study. A web-based questionnaire was opened for response from August to October, 2019.

The questionnaire covered personal and demographic data related to work and various aspects of the management of gynecologic cancer. This study abstracted the survey data regarding the practice of laparoscopic surgery for the treatment of endometrial cancer.

To determine factors that might influence the patterns of practice, the respondents were grouped according to the type of their working hospitals and duration of practice. The hospitals were classified by setting or administration and ownership (governmental versus private), by level (secondary versus tertiary), and by type of service (fellowship training versus non-training or service only). The duration of gynecologic oncology practice with a cut-off value at 5 years was applied as a factor indicating the experience of respondents. The adequacy of the number of other consulting specialists in the treating team (i.e. urologists, anesthesiologists, colorectal surgeon, etc.) was arbitrarily reported based on self-assessment of the respondents.

Statistical analyses were performed using SPSS computer software version 22 (IBM Corporation, Armonk, NY, USA). Descriptive statistics were used to report patterns of practice in each aspect. Differences between the comparison groups were determined by using the χ^2 and Fisher's exact test, whenever appropriate. All statistical tests were two-sided and a *p*-value of less than 0.05 was considered statistically significant.

Results

Among 305 registered members, a total of 170 gynecologic oncologists responded to the questionnaires (65.9% response rate). Details of the number and reasons for exclusion as well as basic demographic features of the respondents were described in the main report[11].

Of 170 gynecologic oncologists, 60 (35.3%) reported performing laparoscopic surgery for endometrial cancer. The rate of laparoscopic surgery performed ranged from 1% to 100% with a median of 25%. Among the 60 respondents who performed laparoscopic surgery, nine (15.0%) performed the procedure in all endometrial cancer patients whereas the remaining 51 respondents applied selective criteria for the laparoscopic surgery (Table 1).

The use of laparoscopic surgery and selective criteria for laparoscopic surgical staging for endometrial cancer according to the type of institution is shown in Table 2. The respondents who worked in training hospitals and those who had worked for ≥5 years were significantly more likely to perform laparoscopic surgery than respondents from the non-training hospital and respondents with shorter practice duration: 44.2% versus 26.2% ($p = 0.014$) for the type of service and 45.5% versus 21.1% ($p = 0.001$) for the duration of practice, respectively.

Histopathology and tumor grade were the two features taken into consideration significantly more frequent among the respondents from the tertiary than secondary-level hospitals: 45.8% versus 8.3% ($p = 0.020$) for histopathology and 43.8% versus 8.3% ($p = 0.041$) for tumor grade, respectively. No significant differences in other selection criteria were found among the respondents with different working features. Obesity was also taken into the planning of the surgical approach more frequently among the respondents in the tertiary- than the secondary-level hospital, 45.8% versus 16.7%; however, the difference was not statistically significant ($p = 0.1$).

The problems or barriers in practice to perform laparoscopic surgery were also assessed. Two gynecologic oncologists did not report any problems whereas the other 58 responders stated ≥1 problems. The financial issue was the most common barrier to laparoscopic surgery for endometrial cancer reported (Table 3).

The problems or barriers to perform laparoscopic

Table 1. Selective criteria for laparoscopic surgery for endometrial cancer and barriers of not performing (n = 51)

Criteria to select patients for laparoscopic surgery	Number (%)
Size of uterus	42 (70.0)*
Proportion of uterus and vagina	42 (70.0)*
Tumor grade	22 (36.7)
Histological type	23 (38.3)
Obesity	24 (40.0)
Others**	10 (16.7)

* May be the same or different respondents
** Others included financial or reimbursement (6), stage and pelvic findings (3), no contraindication (1)

surgery were also studied by the respondents' hospital features and their duration of practice (Table 4). The respondents working in the non-training hospital were significantly more likely than respondents in the comparison groups to report the limited team/instruments/administration as barriers to performing laparoscopic surgery: 45.5% versus 18.4% ($p = 0.025$). Likewise, the surgical skill was reported to be a problem significantly more frequent among the respondents who had worked for less than 5 years compared to those with longer duration of practice: 33.3% versus 8.9% ($p = 0.036$). Although the respondents who worked in a training hospital tended to report financial restriction or reimbursement problems more frequently than those in service only hospitals, this difference, however, was not statistically significant ($p = 0.080$).

Discussion

This survey study found approximately one-third of the Thai gynecologic oncologists performed laparoscopic surgery for endometrial cancer patients. Factors affecting the use of laparoscopic surgical approach consisted of the characteristics of the institution and the experience of the respondents.

There has been a marked increased use of MIS, which comprised of laparoscopic and robotic surgery, for endometrial cancer in recent years. According to the Surveillance, Epidemiology and End Results (SEER)-Medicare database, the performance of MIS for endometrial cancer staging in the USA increased from 9.3% in 2006 to 61.7% in 2011[12]. Among these, robot-assisted procedures accounted for 62.3% of the minimally invasive operations[12]. Another analysis using the American College of Surgeons' National Surgical Quality Improvement Project's database including 17,692 endometrial cancer patients treated from 2010 to 2015, as high as 67.1% (11,878 patients) underwent laparoscopic surgery[13]. This trend was notably observed in a teaching hospital[14]. One retrospective cohort study conducted in the Gynecological Oncology Center South reported a gradual increase rate of laparoscopic surgery for early-stage endometrial cancer from 11% in 2006 to 85% in 2015.

Despite the overwhelming evidence to support MIS as a quality measure in uterine cancer care, the use of MIS or laparoscopic surgery may differ across the countries. One cohort study from Taipei Medical University Hospital reported surgical approach among 365 endometrial cancer patients: 41.1% underwent laparoscopic surgery during 2005 to 2013 and 23.4% had robotic surgery during 2011 to 2013[13]. This national survey of the Thai gynecologic oncologists' practice revealed that only 35.3% of the respondents performed laparoscopic surgery for endometrial cancer. A disparity of this surgical procedure among the working features and duration of practice or experience of the respondents was observed. The previous study, which analyzed the U.S. Healthcare Cost and Utilization Project-National (Nationwide) Inpatient Sample database, reported the influence of hospital geography and cancer volumes on the pattern of surgical care[15]. The patients were less likely

Table 2. Frequency and selective criteria for laparoscopic surgical staging for endometrial cancer by working fetures of the respondents

Features	Laparoscopic surgery for endometrial cancer and selective criteria									
	LPS performing		uterine size or uterus vagina proportion		Low tumor grade		Histopathology		Obesity	
	n = 60 (%)	*p*-value	n = 49 (%)	*p*-value	n = 22 (%)	*p*-value	n = 23 (%)	*p*-value	n = 24 (%)	*p*-value
Hospital setting		0.390		0.647		0.698*		0.698*		0.702*
Government, n = 152	52 (34.2)		42 (80.8)		20 (38.5)		21 (40.4)		20 (38.5)	
Private, n = 18	8 (44.4)		7 (87.5)		2 (25.0)		2 (25.0)		4 (50.0)	
Level of hospital		0.360		0.677*		0.041		0.020*		0.100*
Secondary, n = 28	12 (42.9)		9 (75.0)		1 (8.3)		1 (8.3)		2 (16.7)	
Tertiary, n = 142	48 (33.8)		40 (83.3)		21 (43.8)		22 45.8)		22 (45.8)	
Type of service		0.014		0.189*		0.088		0.180		0.126
Training, n = 86	38 (44.2)		33 (86.8)		17 (44.7)		17 (44.7)		18 (47.4)	
Service only, n = 84	22 (26.2)		16 (72.7)		5 (22.7)		6 (27.3)		6 (27.3)	
Practice duration		0.001		0.442*		0.757		0.646		0.224
<5 years, n = 71	15 (21.1)		11 (73.3)		5 (33.3)		5 (33.3)		8 (53.3)	
≥5 years, n = 99	45 (45.5)		38 (84.4)		17 (37.8)		18 (40.0)		16 (35.6)	

* The *p*-value by Fisher exact test

to undergo open surgery in high-volume compared with low-volume hospitals (51.8% compared to 58.1%, respectively) and in urban teaching hospital compared with rural hospital (51.1% compared to 75.6%, respectively)[16]. This was also found in our survey that laparoscopic surgery was more frequently performed among the respondents who worked in the training hospitals which almost all were tertiary (high volume) and located in the big cities (urban area).

Another finding from this survey was more frequent laparoscopic surgery performed among the respondents who had worked for ≥5 years. This finding was most likely due to the 2-year gynecologic oncology fellowship program in Thailand. Because experience is certainly crucial for laparoscopic surgery, a limited training period did not adequately cover laparoscopic surgery training. Post-fellowship training or practice of laparoscopic surgery requires some time before an individual could gain experience and confidence.

Among the respondents who performed laparoscopic surgery, the two most common features considered for the type of surgical approach were the size of the uterus and its proportion to the vagina. These features were similarly considered among the respondents in various hospital features and experiences (Table 2). This might be because these 2 features were generally the key indicators of success in laparoscopic surgery[17,18]. On the other hand, histopathology of the endometrium including the type and grade of the tumor were considered more frequently in the respondents working in a tertiary hospital. This finding might be explained by the real situation that the tertiary hospitals generally had a high number of patients in service, so more rigid criteria were applied to perform laparoscopic surgery only in the patients who had less aggressive cancer.

Regarding the barriers for laparoscopic surgery, financial problem was an important issue reported by the Thai gynecologic oncologists. To date, the three systems of healthcare coverage in Thailand including social security, comptroller general and universal coverage do not include the costs of laparoscopic surgery in their reimbursement plan. Unsurprisingly, reimbursement or financial issue was reported to be the main barrier to laparoscopic surgery for endometrial cancer across the respondents in the different institutions. In contrast, barriers secondary to limited instrument/team or administration were more frequently reported among the respondents in the non-training hospitals. This finding was probably due to the allocation of government budget which had additional funding for education and training which could support the development of this special surgical equipment and personnel. Regarding the barriers secondary to the limitation of surgical skill, the only significant factor associated with this barrier was the duration of practice. Although the number of respondents on this issue was small which might preclude any meaningful conclusion, the same explanation was that the limited period of gynecologic oncology training and the short duration practice might be inadequate to cover this special surgical skill.

The major criticisms of this study are the nature of the survey study. The results were simply the insights of the

Table 3. Problems related to laparoscopic surgery for endometrial cancer

Barriers of not performing laparoscopic surgery (n = 58)	Number (%)
Reimbursement/financialissues	49 (81.7)
Inadequate surgical team/ instrument/administration	17 (28.3)
Limited surgical skill	9 (15.0)

* Two responders who performed LPS did not report any problems

Table 4. Problems related to LPS for endometrial cancer by working features of gynecologic oncologist (n = 58)

	Reimbursement/financial		Team/instrument/ administration		Surgical skill	
	n = 49 (%)	*p*-value	n = 17 (%)	*p*-value	n = 9 (%)	*p*-value
Hospital setting		0.631*		1.000*		1.000*
Government, n = 152	43 (82.7)		15 (28.8)		8 (15.4)	
Private, n = 18	6 (75.0)		2 (25.0)		1 (12.5)	
Level of hospital		0.677*		0.726*		0.671*
Secondary, n = 28	9 (75.0)		4 (33.3)		1 (8.3)	
Tertiary, n = 142	40 (83.3)		13 (27.1)		8 (16.7)	
Type of service		0.080		0.025		1.000*
Service/training, n = 86	34 (89.5)		7 (18.4)		6 (15.8)	
Service only, n = 84	15 (68.2)		10 (45.5)		3 (13.6)	
Experience		1.000*		0.743*		0.036*
<5 years, n = 71	12 (80.0)		5 (33.3)		5 (33.3)	
≥5 years, n = 99	37 (82.2)		12 (26.7)		4 (8.9)	

* The *p*-value by Fisher exact test

respondents themselves, without data verification. Another limitation was a lack of specific information regarding treatment outcomes which were not included in the survey. Future studies may focus on actual data collection to represent more tangible findings. Nevertheless, this was the first national survey of practice with a relatively high response rate. The results could represent the current practice landscape among Thai Gynecologic Oncologists.

In summary, most findings in this survey might be readily encountered in a real clinical practice; however, data from this survey represented the objective findings in the country. All involved parties, for example, the policymakers may adjust the budget and reimbursement system to cover the costs of laparoscopic surgery to overcome the barrier of this up-to-date surgical procedure. The Thai Gynecologic Cancer Society and the Royal College of Obstetrics and Gynecology may consider adding the course of laparoscopic surgery in the curriculum of gynecologic oncology training programs aside from the postgraduate training program which had been recently settled.

What is already known on this topic?

Laparoscopic surgery nowadays becomes an operation of choice for women with endometrial cancer. The use of this advanced procedure has been increasingly popular across the regions with acceptable short-term and long-term oncological outcomes.

What this study adds?

Only one-third of the Thai gynecologic oncologists performed laparoscopic surgery for endometrial cancer patients. Factors affecting the use of laparoscopy as the surgical treatment of endometrial cancer consisted of the characteristics of the institution and the experience of the respondents. The procedure was performed more frequently among the respondents working in a training hospital or who had a longer duration of work.

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Potential conflicts of interests

The authors declare no conflicts of interest.

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การผ่าตัดผ่านกล้องสำหรับมะเร็งเยื่อบุโพรงมดลูก: การสำรวจแนวปฏิบัติของแพทย์มะเร็งนรีเวชไทย

จิติมา ติยายน, ศรัญญา ชาญพานิชกิจโชติ, ชำนาญ เกียรติพีรกุล, กมล ภัทราดูลย์, มรุต ญาณารณพ, ศิริวรรณ ตั้งจิตกมล, สมาคมมะเร็งนรีเวชไทย

วัตถุประสงค์: เพื่อสำรวจการรักษามะเร็งเยื่อบุโพรงมดลูกโดยวิธีผ่าตัดผ่านกล้องและปัจจัยที่สัมพันธ์กับการเลือกใช้วิธีการผ่าตัดดังกล่าวในแพทย์มะเร็งนรีเวชไทย

วัสดุและวิธีการ: การศึกษานี้เป็นส่วนหนึ่งของการสำรวจระดับประเทศของสมาคมมะเร็งนรีเวชไทยเกี่ยวกับการดูแลรักษามะเร็งนรีเวช ทำการเชิญแพทย์มะเร็งนรีเวชไทยให้ตอบแบบสอบถามผ่านเว็บซึ่งเปิดให้ตอบตั้งแต่เดือนสิงหาคมถึงเดือนตุลาคม พ.ศ. 2562 นำข้อมูลของแนวปฏิบัติเกี่ยวกับการใช้วิธีการผ่าตัดผ่านกล้องเพื่อรักษามะเร็งเยื่อบุโพรงมดลูกและปัจจัยที่เกี่ยวข้องมาศึกษาวิเคราะห์

ผลการศึกษา: ผู้ตอบแบบสำรวจ 60 ราย จากทั้งหมด 170 ราย (ร้อยละ 35.3) รักษาผู้ป่วยโรคมะเร็งเยื่อบุโพรงมดลูกด้วยวิธีผ่าตัดผ่านกล้อง โดยในกลุ่มนี้ 9 ราย (ร้อยละ 15.0) รักษาโดยวิธีดังกล่าวในผู้ป่วยทุกราย ส่วนอีก 51 ราย เลือกผ่าตัดโดยมีข้อบ่งชี้ ผู้ตอบแบบสำรวจที่ปฏิบัติงานในโรงพยาบาลที่มีการฝึกอบรมแพทย์เฉพาะทางและผู้ที่มีประสบการณ์ในสาขามะเร็งวิทยานรีเวชตั้งแต่ 5 ปีขึ้นไป ทำผ่าตัดผ่านกล้องในผู้ป่วยโรคมะเร็งเยื่อบุโพรงมดลูกมากกว่าผู้ที่ปฏิบัติงานในโรงพยาบาลที่ไม่มีการฝึกอบรมหรือมีประสบการณ์น้อยกว่า 5 ปี อย่างมีนัยสำคัญทางสถิติที่ ร้อยละ 44.2 ต่อ ร้อยละ 26.2 (p = 0.014) และ ร้อยละ 45.5 ต่อ ร้อยละ 21.1 (p = 0.001) ในแต่ละปัจจัยตามลำดับ และพบว่าสิ่งที่เป็นอุปสรรคต่อการเลือกตัดผ่านกล้องในผู้ป่วยมะเร็งเยื่อบุโพรงมดลูกมากที่สุด คือ ปัญหาค่าใช้จ่าย (ร้อยละ 81.7)

สรุป: เพียงหนึ่งในสามของผู้ตอบแบบสำรวจรักษาผู้ป่วยโรคมะเร็งเยื่อบุโพรงมดลูกโดยการผ่าตัดผ่านกล้อง โดยผู้ที่ปฏิบัติงานในโรงพยาบาลที่มีการฝึกอบรมแพทย์เฉพาะทางและมีประสบการณ์การทำงานมานาน มีแนวโน้มจะใช้วิธีการผ่าตัดผ่านกล้องในการรักษามากขึ้น