Letter to the Editor

I read with interest the interview on *Neoadjuvant chemotherapy versus primary debulking surgery in the treatment of advanced ovarian cancer: for and against,* published in CBN 2014, Vol. 2 N. 1.

If I were a patient I would be very upset with this interview. Is it possible having such a different approach, depending on which referral Institution I'm going to be treated? Is any synthesis between the two positions possible?

After the publication of the European Organization for Research and Treatment of Cancer (EORTC) trial, Vergote and du Bois wrote a consensus paper to find an agreement on the management of advanced epithelial ovarian cancer (AEOC). In this paper, they clearly stated the anatomical criteria of unresectability precluding optimal cytoreduction in AEOC, and the agreement was about 80% [1]. However, we might miss something important if we reduce AEOC management to a mere technical problem. Tumor load has been demonstrated to be an independent prognostic factor even in the series of very aggressive surgeons [2]. More recently it was confirmed, when measured with a minimally invasive scoring system [3].

It has been recently demonstrated that women primarily managed with staging laparoscopy (S-LPS) show a median progression-free survival (PFS) of 25 months in case of complete resection at primary debulking surgery (PDS) [4], which is in the range (24.0–25.9 months) observed in the contemporary literature [5, 6], including international and prospective GOG studies [7, 8]. The other interesting fact is that patients not receiving complete cytoreduction at PDS, and those undergoing neoadjuvant chemotherapy (NACT) followed by interval debulking surgery (IDS) have super imposable survival rates. Again, this result does not appear in contrast with those reported by other institutional series [5, 6], although only marginally mentioned. Finally, these data are in contrast with the EORTC trial [9], where PFS and overall survival (OS) were shorter and similar for PDS and NACT/IDS groups. Taken together, these evidences suggest that S-LPS may represent a very promising tool to discriminate patients who may really benefit of complete PDS. In this context, the results of the on-going SCORPION trial (NCT01461850) randomly assigning patients with advanced disease to receive PDS or NACT followed by IDS, after laparoscopic evaluation of disease extension, will be useful to define the most appropriate therapeutic algorithm.

However, in the era of target therapy and molecular characterization of the disease to monitor the occurrence of chemoresistance, surgery might play a marginal role in the next future. In the meantime, I would try to personalize cancer treatment as much as possible, by integrating different strategies at their best. In this context, the potential of any clinical, radiological, molecular or surgical method to characterize the disease should be fully exploited.

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