COMMENTARY

Importance of the tumor board

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Thank you very much for the opportunity to make comments on my previous publication entitled "Myasthenia as a paraneoplastic manifestation of ovarian cancer" [1]. It is an opportunity for me to give some information regarding patient outcomes and decision-making about this rare manifestation of the disease. I would like to emphasize the importance of the tumor board decision on the chemotherapy choice and therapeutic strategies adopted.

The tumor board has an important role in improving the quality of patient care [2,3] and progressively integrating more specialties [4], as well as molecular medicine [5], which could be included in the meetings. Tumor boards in gynecologic oncology have already been described in some previous studies and the potential to change the treatment plan reaches more than 40% of the discussed cases [3]. Major changes regarding the treatment plan include change of modality (radiotherapy/chemotherapy/surgery) or addition of them and reach 10% of the cases [3]. It is important to review the images, tumor stage, pathologic reports, as well as the available therapeutic options. Each case review normally takes 10 minutes, according to a previous publication [3]. At our institution, each case takes 20 minutes because a mini literature review normally is presented in conjunction with the cases.

A multidisciplinary approach helps to understand the potential effect of each field on global patient health and to improve what is suitable. Discussions with oncologists, radiologists and pathologists optimize the treatment [6]. Other specialists, such as psychologists, nutritionists and physiotherapists should also participate in the regular meetings.

The gynecologic tumor boards frequently discuss ovarian cases in meetings and possibly the discussion could improve the discouraging prognosis related to this neoplasm [6-8].

Each case normally has important issues regarding the pathologic report, as well as alternative performance improvement and therapeutic options [6]. Most ovarian cases at our institution are selected for discussion by tumor boards and often the therapeutic plan is changed. There are two main possible approaches for advanced stage ovarian cancer: primary debulking surgery or interval debulking surgery, after 3 cycles of chemotherapy [9,10]. As described by the National Comprehensive Cancer Network (NCCN) [11], we normally offer interval debulking surgery for patients with worse performance or, in high-risk cases, for non-optimal cytoreduction. The poor performance related to a myasthenic crisis was the reason for starting treatment with chemotherapy. According to the tumor board decision, we selected cyclophosphamide because of its qualities in controlling the myasthenic crisis and also treating ovarian cancer. The change to carboplatin AUC5 D1 and paclitaxel 175 mg/m^2 D1 every 21 days also contributed to the good response in the patient. We believe that the good patient performance after some cycles allowed us to make an interval R0 cytoreduction.

Unfortunately, eight months after the end of the treatment, and after submission of the original paper, the patient developed a disseminated peritoneal recurrence. This pattern of recurrence is frequent among patients with aggressive manifestation of ovarian neoplasms [12]. The amount of disease was not suitable for a secondary debulking surgery. Our group opted for the introduction of carboplatin AUC4 D1, gencitabine 1000 mg/m^2 D1, D8 plus bevacizumab 15 mg/kg D1 every 21 days. Choosing platin-based chemotherapy for recurrent ovarian cancer is suitable for cases with at least 6 months of disease-free survival [13]. All efforts should be made to improve the multidisciplinary approach, regardless of the aggressiveness and recurrent pattern of the ovarian neoplasm. Integrating other specialties effectively changes the therapeutic choices and potentially improves treatment.

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