Questions to Ask Your HIPEC Surgeon

ABDOMINAL CANCERS ALLIANCE

How long have you been performing HIPEC? How many procedures have you done / do you perform annually?

- Your outcomes after surgery are directly related to your surgeon's ability to safely remove all of the tumors.
- This requires extensive experience to make safe decisions and have the best chances of achieving complete cytoreduction.
- Some studies have shown that CRS/HIPEC requires a long learning curve, necessitating surgeons to perform over 100 procedures to be considered experts.

Do you have any research publications? What are your results?

- Because of the complexity of the procedure, it is important that your surgeon is tracking and measuring their complications and results.
- A robust research program shows commitment to improving outcomes for their patients and expanding their knowledge to stay up to date on any advancements in the field.

Am I a candidate for HIPEC? Why or Why not?

- Your surgeon may use several tests to determine if you are a candidate, including a physical exam, radiographic imaging, and laboratory work.
- Performance status / comorbidities: Because CRS/HIPEC requires a prolonged recovery, patients must be in very good physical condition and have a solid support system at home to help them throughout the postoperative course.
- PCI cutoff: The PCI score measures the amount of disease in the abdomen, and some centers will not operate if that score is above a certain number (known as the PCI cutoff). Other centers do not use a strict cutoff, but rather make decisions on a case by case basis using multiple factors including PCI. With some exceptions (ex. gastric cancer), regardless of the extent of the tumor, if it can be removed, that is the best option for the patient. Finding a surgeon who is experienced in operating on patients with high disease burden will increase your chances of achieving a complete cytoreduction.

How long do you expect my surgery to take?

- Depends on amount/location of tumor, as well as history of prior abdominal surgeries.
- Expect that it should take 7-10 hours on average, and may require even longer.
- The time is needed to ensure that all tumor is removed throughout the entire abdominal cavity and accommodate a 90-minute HIPEC perfusion.
- The most important aspect is not the time spent, but the ability to do a complete removal of all visible tumor. Finding a surgeon who has a high "complete cytoreduction" rate (CC-0/CC-1), can give you confidence that they are committed to the goal, regardless of length of surgery.

What is the recovery like? (How long can I expect to be in the hospital after surgery? What are your most common complications?)

- The average hospital stay is 10-15 days.
- Due to the extent of the surgery, it takes 6-8 weeks to return to normal activity.
- A full recovery can take 2-3 months, and often even longer with the literature reporting up to 6-12 months.
- Common complications include gastrointestinal issues (like nausea/vomiting), hematologic abnormalities (like low hemoglobin or white blood cells), and infections (like abscesses and pneumonia). Other less common, but more serious complications, include blood clots, bleeding, and anastomosis leaks.
- Transparency about the postoperative recovery and complications demonstrates a commitment to safety, an ability to meet quality standards, and being proactive about monitoring and handling any deviations.

Will I need an ostomy?

- It will depend on the extent and location of the tumor. Usually, 20% to 25% may need a permanent colostomy to be able to remove all the tumor. That is usually in patients with previous extensive surgery or extensive involvement of the whole colon.
- A temporary ileostomy is sometimes needed for patients that had pelvic radiation or previous extensive pelvic surgery.

Will I need chemotherapy before or after surgery? Why?

- Your care should be managed by both a medical and a surgical oncologist, who will work together to decide on the best treatment course.
- Systemic chemotherapy may be recommended based on the type of tumor, lymph node involvement, the amount of disease, and history of other treatments.

- In general, patients with peritoneal carcinomatosis should have surgery first if it is possible to remove all visible tumor. The results of preoperative chemotherapy in patients with peritoneal carcinomatosis is limited and frequently leads to a delay on CRS/HIPEC that, if possible, leads to the best published outcomes to date.

How do you follow up on your patients? Will I need to come in for follow-up appointments after I have recovered from surgery?

- An initial follow-up should occur 2-3 weeks after discharge to remove the staples, review pathology results, and explain follow-up treatment and recommendations.
- Regular follow-up including physical exams, CT scans or MRIs, and tumor markers should occur every 6 months until year 5 and then yearly until year 10.
- While the initial recovery can take less than 1 year, it is important that you are followed closely by your oncologists to monitor for any recurrence.

(If you are traveling) Do you have patients from out of state? How is postoperative care managed if I live far away?

- If you live more than 1 ½ hours from the hospital that performed the CRS/HIPEC, it is recommended that you stay in town an extra week after discharge. The first 3-4 weeks after surgery are frequently the time when patients need more attention. Dehydration and low appetite with poor oral intake are common and may need readmission for hydration. Due to the misunderstanding by many physicians regarding peritoneal carcinomatosis, many physicians will refuse or have very negative outlook on patients with peritoneal carcinomatosis, which is why it is important that your surgeon is the one to follow you closely during this initial period.
- It is important that you and your surgeon have open communication with all of your local treating physicians to ensure a clear understanding of the follow-up plan. The patient and referring/treating physician should receive a clear plan and all of the information regarding your surgery, including the operative report, hospital stay, and follow-up plan.
- The surgical team should be available to respond to any questions that arise once patients return to their hometowns.
- Regardless of where they live, all patients should be followed every 6 months until year five, and yearly until year 10. If they cannot return for a variety of reasons, it will be important to have a clear follow-up plan by a local physician aware of the outcomes and treatment results of CRS/HIPEC.
- If the patient is scheduled to receive postoperative chemotherapy, it is very important that you and your surgeon have a discussion with your medical oncologist to make sure that the plan of treatment and response to a potential recurrence is aligned between all specialties.

Can I speak to one of your patients who underwent HIPEC?

- It is very important that a patient can have the opportunity to speak with other patients from the surgeon who have had a recent CRS/HIPEC, as well as with one who has survived several years. Only people who have been through it themselves can provide that unique perspective on what to expect and the important lessons they learned along the way.
- The patient can ask other patients about the care received, the potential recovery challenges that they faced, and recommendations on how to deal with it all.
- Caregivers participation is vital for good outcomes and your support team may also want to speak with other caregivers to get insight on what to expect, as well as support.