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Commentary

A Brief Note on Pelvic Exenteration

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DESCRIPTION

For patients with severe primary or recurring gynecological cancer, pelvic exenteration is a last resort treatment. Based on the anatomical extension of the procedures, pelvic exenteration can be split into several subgroups. The expanding use of minimally invasive surgery in gynecologic oncology surgery has opened up new possibilities. In terms of perioperative outcomes, minimally invasive surgery may provide significant benefits. Several cases of Robotic Assisted Laparoscopic Pelvic Exenteration have been reported in the literature since 2009. The introduction of robotic surgery has accelerated the global use of minimally invasive pelvic exenteration.

In patients with cancers secondary to the bladder, anterior pelvic exenteration involves partial or entire vaginal excision, removal of the genital organs and bladder, and finally partial or total excision of the urethra. In patients of rectum cancer, posterior pelvic exenteration entails partial or whole vaginal excision, removal of the sexual organs, and sigma rectum.

Total pelvic exenteration entails partial or complete vaginal excision, removal of the rectum, genital organs, and bladder, and finally partial or complete urethral exenteration. In pelvic exenteration, three radical monovisceral surgical surgeries (rectum resection, hysterocolpectomy, and cystectomy) are combined. Recurrent disease frequently infiltrates beyond the neighboring pelvic viscera, impacting anatomical elements outside of the "pelvic box," such as bones, muscles, and neurovascular components of the lateral wall of the pelvis. As a result, pelvic exonerative surgery must be adjusted based on tumor topography in three dimensions.

The increased use of minimally invasive surgery, particularly in urologic and oncological colorectal surgery, has opened up new possibilities in gynecologic oncology surgery. Following that, the introduction of robotic surgery added a new impetus to the global growth of minimally invasive pelvic exenteration. Lim performed a total evisceration with an ileal loop urine diversion and reported no postoperative problems in the first case of robot-assisted laparoscopic pelvic exenteration in 2009. Several cases of Robotic Assisted Laparoscopic Pelvic Exenteration have been reported in the literature since then. Complex surgical procedures can be performed even in the limited areas of the pelvis and in tough retroperitoneal conditions, such as in obese or radio-treated patients, thanks to the enlarged 3-dimensional vision and articulated movement of robotic instruments.

The decision to perform pelvic evisceration is one of the most contentious issues, and it must be In patients with cancers secondary to the bladder, anterior pelvic exenteration involves partial or entire vaginal excision, removal of the genital organs and bladder, and finally partial or total excision of the urethra. In patients of rectum cancer, posterior pelvic exenteration entails partial or whole vaginal excision, removal of the sexual organs, and sigma rectum.

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The decision to perform pelvic evisceration is one of the most contentious issues, and it must be based on a variety of considerations in order to avoid unnecessary treatment. In order to direct each patient toward the optimum therapeutic approach, past therapies, the presence of metastatic illness, and infiltration of unrespectable structures, general health conditions, nutritional status, and socioeconomic bedrock must all be considered. Peritoneal cancer, distant metastases, and invasion of the sciatic nerve and sacral plexus are all contraindications to pelvic exenteration. The initial pelvic eviscerations were performed on cervical cancer recurrences; later, the indication was expanded to include all gynecological neoplasms (endometrial, vulvar, ovarian carcinoma).

Pelvic exenteration is the last surgical option for diseases that have failed to respond to chemotherapy and have already been treated with pelvic radiation therapy. In this regard, the most important aspect of such a mutilating procedure is cautious patient selection. Although, when compared to traditional open surgery, the introduction of the minimally invasive approach has resulted in benefits in terms of reduced blood loss and shorter inpatient time.

In terms of long-term oncological outcomes, an essential step forward should be to study the potential equivalence between minimally invasive and laparotomic procedures.

In this field, prospective randomized studies are unlikely to be achievable; hence we must rely on limited case series.

Multicenter trials with a higher number of patients and extensive follow-up information will be required in this scenario.

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