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Colorectal resection in patients with ovarian and primary peritoneal carcinoma

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KEY WORDS

Ovarian cancer
Colorectal resection
Bowel

Objective: This study examines the operative details and complications of colorectal resection in patients with ovarian and primary peritoneal carcinoma.

Study design: Patients who underwent colorectal resection for ovarian and primary peritoneal cancer were identified in our surgical database for the period 1988 through 2002.

Results: Of the 125 patients who were identified, 73% were undergoing primary cytoreduction; 18% were undergoing secondary cytoreduction, and 7% were undergoing interval cytoreduction. The mean length of colon that was removed was 15.7 cm. The method of anastomosis was stapler in 63% and hand sewn in 22%; 15% patients had no anastomosis performed. A protective ostomy was used in 13% of patients. Optimal cytoreduction (<1 cm) was achieved in 74%. Operative complications occurred in 37% of patients, with the most common being hemorrhage (25%). Anastomotic leaks occurred in 2.5% of the patients, and the most common postoperative complication was ileus (28%). Postoperative bowel function returned to normal in 71% of patients.

Conclusion: To obtain optimal cytoreduction in patients with ovarian cancer, colorectal resection often is necessary. Colorectal resection can be performed with a low risk of anastomotic complications, and patients frequently have the return of normal bowel function.

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Optimal cytoreductive surgery (<1-2 cm) and platinum-based chemotherapy are the most important components in the treatment of advanced ovarian cancer.¹⁻⁵ Because of the pattern of spread, ovarian cancer often involves the bowel and other peritoneal structures. The rates of bowel resection for advanced ovarian cancer

have increased in recent years to 40% to 90%.⁶⁻⁸ This more aggressive approach to ovarian cancer stems from reports that show improved survival for patients with microscopic and <1-cm residual disease.⁹

The most common areas of bowel involvement are the rectosigmoid, followed by the ileocecum and transverse colon.¹⁰ Local extension of ovarian cancer explains the frequent involvement of the rectosigmoid colon and the ileocecum. The transverse colon is typically involved because of bulky omental metastasis.¹⁰ We reviewed our experience with colorectal resection and focused on operative details and complications in patients with advanced and recurrent ovarian cancer.

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Material and methods

Patients who underwent colorectal resection for ovarian cancer were identified in our gynecologic oncology surgical database for the period 1988 through 2002. During this time period, there were a total of 866 and 74 patients who underwent primary (stage I excluded) and secondary cytoreductive surgery, respectively. Colorectal resections were performed for 173 patients in the primary cytoreduction and for 33 patients in the secondary cytoreduction groups. There were 125 patients for whom adequate follow-up information was available, and they are the subjects of this study. Patients who were excluded from analysis had limited postoperative follow-up time (<30 days) because of relocation or returning to a medical oncologist for chemotherapy. The charts were reviewed, and data were collected regarding patient demographics, surgical management, preoperative evaluation, perioperative complications, and pathologic findings.

All patients underwent operation at our institution by board certified gynecologic oncologists who were assisted by gynecologic oncology fellows. Disease was staged according to the International Federation of Gynecology and Obstetrics, and optimal cytoreduction was defined as residual disease of <1-cm maximum diameter.

Patient follow-up information consisted of further care at our institution and letters to patients who had gone elsewhere for care. Bowel function was assessed in patients who had reanastomosis by physician inquiry at each follow-up visit. Institutional review board approval was obtained before the study was initiated, and statistical analysis was performed with SPSS software (SPSS Inc, Chicago, IL).

Results

There were 125 patients identified with a median age of 67 years (range, 23-89 years) and a median body mass index of 26.1 kg/m² (range, 16-42 kg/m²). Forty-eight percent of the patients had other medical comorbidities (besides cancer) such as hypertension, diabetes mellitus, coronary artery disease, and chronic obstructive pulmonary disease. The median preoperative albumin level was 3.7 g/dL (range, 1.6-4.9 g/dL). All patients were given perioperative antibiotics, thromboprophylaxis before the operation, and mechanical bowel preparation, except in the case of bowel obstruction.

The operative characteristics are summarized in Table I. Obstruction was defined by radiographic studies, patient symptoms, and intraoperative evaluation. Colorectal anastomosis was performed (at the discretion of the attending surgeon) in 84.6% of patients. Indications for both a protective and permanent colostomy were thickened and inflamed bowel wall, perforation or infected operative field, coloanal anastomosis, poor nutrition status, and previous irradiated bowel and when the integrity of the anastomosis was in question.

Table I Operative characteristics

Characteristic	Measure
Estimated blood loss (mL)*	1200
Operative time (hr)*	4.4
Indication for surgery (%)	
Primary debulking	75
Interval debulking	7.3
Secondary debulking	17.7
Indication for colorectal resection (%)	
Tumor encasing bowel	82.9
Tumor involving the mesentery	4.1
Obstruction	13
Reanastomosis (%)	
Stapler	63
Hand sewn	22
Not performed	15

* Median value listed.

Patients who did not have a reanastomosis performed were not included in the anastomotic leak rate analysis. Of the hand-sewn anastomoses, 59% were double layers, and 41% were single layer. A protective ostomy was used in 13% of the patients in whom an anastomosis was performed. The protective ostomies that were used included transverse loop colostomies in 80% and ileostomies in 20% of the patients. Forty-two percent of these protective ostomies were later reversed during the follow-up period. Median length of colon removed was 15 cm (range, 3-47 cm), and the level of anastomosis averaged 8.7 cm (range, 4-15 cm) from the anal verge. The data on the length of colon that was removed were available for all patients; however, data on the level of anastomosis were available for 50% of patients. Of those patients for whom the level of anastomosis was available, 37% had a low rectal anastomosis (defined as ≤ 7 cm from the anal verge). The splenic flexure was mobilized in 59% of patients to obtain a tension-free anastomosis.

Optimal cytoreduction (<1 cm) was achieved in 67% of patients with primary cytoreduction, 86% of patients with interval cytoreduction, and 95% of patients with secondary cytoreduction. Patients with suboptimal cytoreduction had colorectal resections performed for symptomatic relief (eg, those patients with obstruction or severe encasement of the rectosigmoid). The final pathologic findings revealed serous cell type in 81%, mucinous in 10%, endometrioid in 5%, clear cell in 2%, and sarcoma in 2%. Two percent of the patients had grade I tumors; 34% of the patients had grade II tumors, and 64% of the patients had grade III tumors. The colon pathologic findings are shown in Table II. The extent of colonic invasion was not known in 22 patients. In 55% of the patients, ascites were present at the time of surgery (defined as peritoneal fluid >500 mL). Of patients with primary disease, there were 2% stage

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