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CASUISTRY

Pelvic exenteration for gynecologic malignancies: Postoperative complications and oncologic outcomes[☆]

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KEYWORDS

Pelvic exenteration;
Gynecological
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Complications

Abstract

Introduction and objective: To evaluate complications, morbidity and oncologic outcomes of pelvic exenteration as treatment for gynecologic malignancies.

Materials and methods: Between 2008 and 2015, a total of 35 patients underwent pelvic exenteration, due to recurrence of gynecological cancer. Surgical outcomes, early and late postoperative complications, and recurrence/survival outcomes were assessed.

Results: Mean patient age was 53.8 years. Anterior exenteration was done in 20 patients, while 15 were total exenterations. Ileal conduit was done in 24 patients, while 8 received a neobladder and 3 a cutaneous ureterostomy. Postoperative complications were divided in 2 groups, early (<30 days) and late complications (>30 days). A total of 25 patients (71.4%) had one or more early complications; 16 (45.7%) had fever due to a urinary tract infection, pyelonephritis or intra-abdominal collection; 2 (5.7%) developed a vesicovaginal fistula; 4 (11.4%) a rectovaginal fistula; 3 (8.5%) acute kidney failure and one (2.85%) uronephrosis. Regarding to late complications, 8 patients (22.8%) had fever. Six (17%) presented with uronephrosis, and 5 (14.2%) with ureteral-pouch stricture. Five patients (14.2%) had acute renal insufficiency, 3 (8.6%) rectovaginal fistula and one (2.85%) urinary fistula. Mean follow up time was 20.3 month (2–60). A total of 22 patients (62.8%) were free of disease. Another 13 (37.1%) patients relapsed. Only 4 (11.4%) patients died after pelvic exenteration due to underlying disease.

Conclusion: Pelvic exenteration has a high rate of complications and morbidity, but can be the last curative opportunity in patients with recurrent or persistent gynecologic malignancies.

This procedure should be performed by multidisciplinary, experienced teams in a tertiary medical center.

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PALABRAS CLAVE

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Exenteración pélvica para neoplasias ginecológicas: Complicaciones postoperatorias y resultados oncológicos

Resumen

Introducción y objetivo: Evaluar las complicaciones, morbilidad y resultados oncológicos de la exenteración pelviana como tratamiento para los tumores ginecológicos.

Materiales y métodos: Entre enero de 2008 y diciembre de 2015, 35 pacientes fueron tratadas mediante exenteración pelviana debido a recurrencia de cáncer de origen ginecológico. Se evaluaron resultados quirúrgicos, complicaciones postoperatorias tempranas y tardías, recurrencia y sobrevida.

Resultados: La edad media de las pacientes fue de 53,8 años. Se realizó exenteración anterior en 20 pacientes, mientras que en 15 se realizó exenteración total. En 24 pacientes se realizó derivación urinaria de tipo Bricker, neovejiga ileal en 8 y ureterostomía cutánea en 3.

Las complicaciones postoperatorias se dividieron en 2 grupos: tempranas (<30 días) y tardías (>30 días).

Un total de 25 pacientes (71,4%) tuvieron una o más complicaciones tempranas; 16 (45,7%) tuvieron fiebre debido a infección urinaria, pielonefritis o colección intraabdominal; 2 (5,7%) evolucionaron con fístula vesicovaginal; 4 (11,4%) con fístula recto vaginal; 3 (8,5%) con insuficiencia renal aguda y uno (2,85%) con uronefrosis. Con respecto a las complicaciones tardías, 8 pacientes (22,8%) tuvieron fiebre. Seis (17%) se presentaron con uronefrosis y 5 (14,2%) con estenosis uretero-*pouch*. Cinco pacientes (14,2%) tuvieron insuficiencia renal aguda, 3 (8,6%) fístula recto vaginal y una (2,85%) fístula urinaria. El tiempo de seguimiento medio fue de 20,3 meses (rango 2-60). En total, 22 pacientes (62,8%) permanecieron libres de enfermedad. Otras 13 pacientes (37%) recayeron y 4 pacientes (11,4%) murieron luego de la exenteración pelviana debido a la enfermedad de base. No hubo muertes relacionadas a la cirugía.

Conclusión: La exenteración pelviana tiene una alta tasa de complicaciones, pero puede ser la última oportunidad curativa en pacientes con tumores ginecológicos.

Este procedimiento debería llevarse a cabo por equipos multidisciplinarios, con experiencia, en centros médicos de alta complejidad.

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Introduction

In 1948, Brunschwig first described the pelvic exenteration (PE) procedure with purely palliative intent.¹ This initial technique is known nowadays as PE, which can be total, anterior (bladder, uterus and proximal vagina) or posterior (uterus, posterior vaginal wall and rectum).²

Complete resection is the most important prognostic factor in surgery for pelvic tumors.³ In locally advanced and recurrent pelvic malignancies, radical margins are sometimes difficult to achieve because of proximity or invasion of adjacent organs and structures.

Some published studies report a perioperative mortality of 25% and a 5-year survival of 17%.⁴ This can be explained because in its origin, this surgery was indicated as a palliative procedure. In recent years, there has been a shift in the indication, in order to attempt a curative surgery.^{5,6}

The main indication for PE is nowadays the treatment of recurrent or persistent cervical cancer previously treated with exclusive or concomitant chemoradiation. Even though there is less global experience, PE has also been well described in the treatment of primary ovarian cancer and recurrent endometrial cancer.⁷ Those reports consistently describe high rates of surgery-related complications. High surgical morbidity remains the most important barrier to the widespread use of this procedure.⁸

The main objective of this study is to evaluate postoperative complications as well as oncologic outcomes (survival and time to recurrence) after anterior or total pelvic exenteration in patients with gynecological pelvic tumors.

Materials and methods

After obtaining ethics committee approval, a retrospective review was conducted on patients who underwent anterior or total pelvic exenteration secondary to gynecological cancer. All the information was obtained from the electronic medical records.

Inclusion criteria were: female patients, ≥ 18 years old, who underwent anterior or total pelvic exenteration for gynecological tumors in our institution between January 1, 2008 and December 31, 2015.

Patients with primary rectum or bladder cancer and patients with incomplete data in the medical history were excluded.

Preoperative variables assessed were: age, type of gynecological tumor, previous treatments received.

Intraoperative variables were: type of pelvic exenteration, type of urinary diversion, and surgery time.

Postoperative variables were: hospital stay, including intensive care unit (ICU) time, and postoperative complications, which were divided into early and late

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