Palliative Pelvic Exenteration: Patient Selection and Results

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Drs. Finlayson and Eisenberg provide a timely, in-depth review of total pelvic exenteration in the palliation of incurable pelvic cancer. The authors conclude that total pelvic exenteration has a role as a palliative treatment for patients with recurrent pelvic cancer—a conclusion that I believe remains unproven.

The fact that total pelvic exenteration has cured many women with gynecologic cancer is not in dispute. The operation continues to have an important place in the arsenal of therapeutic options available to patients with pelvic cancer. The authors correctly point out that the efficacy of total pelvic exenteration was established not by a prospective clinical trial, but rather, by trial and error. The pioneers identified by the authors reached the conclusion that total pelvic exenteration has curative potential only when the tumor can be completely removed because patients with incomplete resection invariably die. Surgeons subsequently became much more selective regarding indications for this procedure, which, in turn, led to an increase in the proportion of survivors. At present, most gynecologic oncologists undertake total pelvic exenteration only if it is clear that the disease is completely resectable.

Associated Morbidity Still Significant
Total pelvic exenteration is an extremely traumatic procedure, and despite all of the advances in the care of surgical patients that have taken place during the last 50 years, this operation is still associated with significant morbidity. At The University of Texas M. D. Anderson Cancer Center, which has a long institutional experience with total pelvic exenteration [1-7], operating time ranges from 6 to 10 hours, minimum blood loss is 1,000 mL, significant morbidity develops in about half of patients, and a small number of deaths continue to occur. Minimum length of hospitalization is 10 days, and hospital stays of 2 to 4 weeks are common.

Despite the associated morbidity and mortality, we aggressively pursue total pelvic exenteration for patients who are in reasonable medical condition and have a realistic chance for cure, even if it is small. In patients with surgical findings revealing that the tumor is not completely resectable, we abandon the procedure.

Three Definitions of Palliative Exenteration
The authors offer three definitions of "palliative total pelvic exenteration." They differentiate between patients operated on specifically for symptom control, those operated on as part of salvage therapy, and those operated on with curative intent in whom surgical findings indicate incurable disease. The definition of "to palliate" is to "reduce the violence of," "abate," or "moderate the intensity of [8]." I believe that the medical literature on this subject would be clarified if the term "palliative total pelvic exenteration" were reserved for surgery performed in symptomatic patients with the intention of relieving these symptoms. Patients treated with total pelvic exenteration with the intention of extending survival should be in a different category. Standard clinical trial design could be used to test the efficacy of pelvic exenteration for this purpose.

The standard forms of palliation for patients with recurrent pelvic cancer are pain control with narcotic analgesics, antiemetics, surgical diversion of urine and/or stool, and perineal hygiene. Chemotherapy is another form of palliation, although, as the authors point out, response rates are low and toxicity is not always minor. The authors provide some evidence that total pelvic exenteration can relieve the symptoms of recurrent unresectable pelvic cancer in many patients during the immediate postoperative period. However, this fact alone is not sufficient to reach a conclusion that the operation is a desirable form of palliation for recurrent pelvic cancer.

A more important question is, how does total pelvic exenteration compare with the other standard
forms of palliation? Such factors as cost, toxicity, duration of symptom relief, and risk of symptom recurrence need to be considered. Since the cost and risks of total pelvic exenteration are high, compared with standard techniques, the benefits of this procedure must be clear and measurable to justify its use. Advocates of palliative exenteration must provide some form of comparative analysis to strengthen the argument that its indications should be extended to include palliation. Our philosophy is that a multidisciplinary team of physicians, nurses, and enterostomal therapists can provide an array of palliative treatments for patients with recurrent pelvic cancer, including chemotherapy, diversionary surgery, pain management, and wound and ostomy care. When surgical and chemotherapeutic options are exhausted, we refer patients for hospice care. Clear and candid explanations of the patient's prognosis, median survival, and the risks and benefits of various therapeutic options are vital if the patient is to reach a truly informed decision.

**Conclusion**

There is no doubt that recurrent pelvic cancer results in a great deal of pain and suffering, and that standard forms of palliation do not render patients free of symptoms in many cases. It is also true that many pelvic surgeons have the skill necessary to perform total pelvic exenteration with a respectable margin of safety. However, these facts do not justify replacing standard symptom management and palliative therapies with total pelvic exenteration in patients with incurable pelvic cancer. Until such time as data show that total pelvic exenteration compares favorably with standard treatment, it should be considered an unproven therapy for palliation of incurable pelvic cancer.

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