Commentary (Childers): Laparoscopy in Gynecologic Malignancies

By Joel M. Childers, MD

Dr. Chi very nicely reviews the history of operative laparoscopy in gynecologic oncology and covers most of the applications currently considered to be useful.

Pelvic lymphadenectomy is the foundation of surgical staging, and the ability to accomplish this procedure laparoscopically paved the way for investigations on the role of operative laparoscopy in gynecologic oncology early in the 1990s. Although data have indicated that this approach has limitations (particularly in obese patients, and early in a surgeon's learning experience), there have been no reported discoveries of positive pelvic lymph nodes at laparotomy following laparoscopic lymphadenectomy.

Furthermore, the pelvic sidewall recurrence rate in patients with early cervical cancer who are managed with open lymphadenectomy and radical hysterectomy is identical to that in patients managed with laparoscopic lymphadenectomy and radical vaginal hysterectomy.[1] Most physicians who have performed a large number of laparoscopic lymphadenectomies feel that the visualization at laparoscopy allows one to assess whether an adequate procedure has been performed. Even if the laparoscopic lymphadenectomy is adequate, how can laparoscopy be utilized in the management of gynecologic malignancies? Classifying presumed stage I carcinoma of the ovary requires a para-aortic lymphadenectomy and omentectomy, both of which are laparoscopically feasible. Compared to laparotomy, both of these laparoscopic procedures generally require increased operative times and excellent, expert surgical assistants. It is true that the laparoscope may allow for better inspection of certain intraperitoneal areas than does laparotomy, but the reverse is also true. Patients who are staged laparoscopically can go home the same day or after an overnight stay, whereas those who have undergone laparotomy usually stay in the hospital for 2 or 3 days.

Laparoscopic Radical Hysterectomy and Radical Trachelectomy

The data clearly prove that a laparoscopic radical hysterectomy is feasible, but the operative time is prohibitive and rates of genitourinary tract complications are very high during the initial experience of laparoscopic surgeons. Furthermore, an experienced, expert surgical assistant is required, which is not necessarily true of open radical hysterectomy. In my own experience, hospital stays are shortened by only a day or two (if at all) when radical hysterectomies are performed laparoscopically, and recovery time is approximately the same.

Laparoscopic lymphadenectomy followed by a Schauta procedure (a radical vaginal hysterectomy) is an ideal application for patients with localized cervical carcinomas 4 cm or smaller. The same is true for radical trachelectomy in patients who desire to preserve their fertility. Covens and Shaw in Toronto, Plante and Roy in Quebec, and Dargent et al in Lyon, France, have all shown promising preliminary results with radical trachelectomy.[2-4]

But how many gynecologic oncologists have the necessary skills to perform a Schauta procedure? How many have the time to travel to Canada or France to learn the operation and the motivation and volume of patients to continue performing the procedure in their communities?

Role of Operative Laparoscopy in Clinical Practice

If you are a gynecologic oncologist who has not mastered the Schauta operation and whose surgical assistants are qualified to do laparoscopic procedures, how does operative laparoscopy fit into your clinical practice? This depends on the type of practice you have and your philosophy regarding the management of certain malignancies.
The management of presumed stage I endometrial carcinoma is an attractive application for the laparoscope, unless the only patients referred to you are obese. A simple hysterectomy can be performed during this operation, and, therefore, operative time is not prohibitive. Staging the previously unstaged endometrial carcinoma will probably spare many of your patients from undergoing adjuvant radiation.

If “suspicious” adnexal masses are a large part of your practice, this is an ideal way to avoid laparotomy in most of your patients with masses < 10 cm, since the malignancy rate is fairly low in these patients (< 15% in the absence of prior premenopausal breast carcinoma).

If you have a proclivity to stage locally advanced or bulky cervical cancer in order to tailor treatment recommendations, laparoscopic staging may offer some advantages to your patients. The same can be said for assessing patient eligibility for pelvic exenteration. Plante and Roy have eloquently espoused the virtues of exenterative procedures,[5] but they are probably best left to those centers where ample volumes of these procedures are performed.

Operative laparoscopy simply may not have a place in the practices of some gynecologic oncologists. For other clinicians, practice characteristics, management predilections, and surgical assistance may all permit the generous use of operative laparoscopy.

Laparoscopy is certainly not a panacea for physicians or for patients with gynecologic malignancies. However, it can be a valuable tool by which some physicians can minimize morbidity and individualize therapy for some of their patients.

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