Role of Exenteration Surgery

September 07, 2006
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OBGYN.net Conference Coverage INTERNATIONAL FEDERATION of GYNECOLOGY & OBSTETRICS:
Washington DC, USA

Laszlo Ungar: "Ladies and gentlemen, I will talk today on a topic which has gone through a very exciting history within the last fifty years. The first famous publication of Alexander Brunschwig from 1948 triggered gynecology to become a subspecialty, and I think it is possible to say that his presence and his surgery made Memorial Sloan-Kettering the institution of significance that it is today. If we try to look at what has happened since that time then we see a thirty year advancing period then the indications of the procedure has been clarified, the morbidity and mortality rate gone down significantly since then, and within that period of time one major improvement in the technique used in pelvic exenteration - rectal anastomosis was introduced.

In the last couple of years one new procedure has appeared as a variety of exenterative surgery, the so-called CORT procedure which all of you probably know about. This is the best-known diagram, which has a series of pelvic exenterations that you can look at. This slide comes from St. Stephens Hospital in Iran where I am, it is an analysis of 149 pelvic exenterations done in a 7-year period, and there's a minimum 3-year follow-up so it's covering that period of time. The upper clearly showing the general survival but the lower diagram is more important. If you divide our patient population into three groups - group A is the good prognosis group. They're all three major prognostic factors - the size of the recurrent disease, relapse time, and the distance adherence to the pelvic side wall is optimum then we can expect an excellent survival similar to your primary procedure. If all three prognostic factors are on the bad side then the recurrence is large at the end to the pelvic sidewall and relapse time is less than one year. Then all of our patients eventually will die of their disease but most of the patients are not as lucky as the very best ones and not as unlucky as very worst ones, and the survival in this group of patients is around 50%.

When Brunschwig started his procedure, all gynecologists thought that they were fighting a heroic fight against a deadly disease, and the disease is still here. It is still a deadly disease but somehow the enthusiasm regarding this procedure has decreased. The number of procedures in large centers decreased. If we look at the literature, we practically cannot find scientific publications about pelvic exenteration, and if we look at the figures just in the U.S.A. nearly 5,000 women are dying of cervical cancer annually. This means that it is around 35% of cervical cancer patients, and if we look honestly at pelvic exenteration as a tool to fight against cervical cancer, you have to realize that in these statistics the significance of pelvic exenteration is nil. Who is the possible loser? In the primary treatment of cervical cancer in a well-functioning healthcare system, about every second patient will go through primary surgery and about 20% of these patients will develop recurrent disease sooner or later. Most of these patients will go through a second line treatment, which is usually radiotherapy.

So out of these patients who receive radiotherapy, they're the candidates for pelvic exenteration. Every second patient will receive radiotherapy as a primary treatment, and with this group of patients the recurrence rate is about 50%. Follow-up of cervical cancer following radiotherapy is difficult. A special difficulty is that normally patients who are treated primarily by radiotherapists are followed up by radiotherapists who are not terribly interested in second line or salvage or exenterative surgery. Is there a potential for improvement? If you try to find out why the numbers of pelvic exenteration is going down, we might think there's one reason - the improved local control at
the primary treatment but as we have seen in the figures, the results are not convincing. In this 35% death rate, I'm sure that a significant ratio is going through a local recurrence phase sooner or later and most of these patients will develop distant metastasis but a large proportion of these patients are having a period of time when they have local recurrence only. Is there a disappearing enthusiasm of the referring physicians? I think there is, and the reason for this disappearing enthusiasm most likely is the quality of life issue, it is not a very cheerful prospect for the patient living with stomas.

How effective is the recurrence screening? We don't know. If you look at the program of FIGO 2000, we cannot see a single presentation about screening of recurrent disease. What's the way to go? The CORT procedure, yes, this is a very exciting issue. It's good for a very, very highly selected group of patients and since it is extremely complicated, has a very high morbidity rate, and needs a very sophisticated cooperation between surgeons and radiotherapists, this procedure will need a hyper-centralized care. Quality of life issue - yes, I think this is a very important issue. We come back again and again to the same plans point. Is it possible to provide patients a no stoma surgery? As I have mentioned, low rectal anastomosis has become a widely accepted procedure but what about the urinary diversion, is it possible to escape? While we may look at the option of trying to avoid a urostomy, we have to remember that urostomy is still the gold standard. And even if we approach the surgery trying to avoid it, we still have to be able to complete a urostomy if it becomes necessary during the course of the surgery.

If we look at the history of bladder replacement, we can see billions of techniques used, and I'm not going to go through all that. But if you look at the group of irradiated recurrent cervical cancer patients, we can define some difficulties which are very specific for this problem - the female ureter is short, site of a possible anastomosis has been irradiated, there is an oncological risk if we try to save the internal opening of the urethra, and we have to face that some of our patients will need a reoperation for a breakdown on anastomosis between neobladder and the urethra. When we started operating with bladder replacements, we could find only one publication with this group of patients published by Mr. Shepherd who will be the next speaker. We tried to create a urinary bladder replacement technique, which is relatively easy to create and which can be converted into a urostomy if the anastomosis between the pouch and the urethra breaks down. This is a drawing of a picture of the pouch that we are using. This is the terminal ileum, ureters are harvested onto the oral end of the terminal ileum, cecum is left intact, it is anastomosed to the ureter, and the ascending colon is used to create a pouch. This is a very simple urinary pouch, and if the anastomosis breaks down, then we just cut off the pouch and make a cecostomy and the whole thing will function as a breaker conduit. So the main advantage of this technique is that it is very easy to convert to a traditional urinary diversion if it fails.

There are some criteria, of course, for the use of this method, and it's quite obvious criteria that we have. Just look at the results, it was a four-year period and 15 out of 77 patients were fit for this procedure. One of the patients died very shortly after the procedure and evaluation of the bladder replacement was not possible, and 12 out of 15 patients had a successful bladder replacement. The success for patients of the daytime continent and nighttime incontinence was quite frequent. They all void voluntarily without residual and no hyper continence was seen in this group of patients. Two out of the three unsuccessful cases went through a refashioning of the urostoma and functioning as a breaker conduit, one patient has refused any further surgery. Here are some pictures of the procedure; this is the piece of ball that is used for creating the pouch and this is what the procedure looks like, it's not terribly interesting. This is how it looks on an x-ray picture. Just coming back to the original question about the role of pelvic exenteration in the treatment of recurrent cervical cancer, it has been shown that pelvic exenterations did help us to become gynecologic oncologists and the series of Brunschwig of nearly 700 patients will probably never be repeated. If we try to define the future, the goal will be to improve referral and give patients this chance for being cured, and these are the patients that are candidates for that kind of a referral. I'm sure that if we can offer a good quality of life procedure in general then radiotherapists will become more enthusiastic, and they will try to refer their patients early and, hopefully, the screening for persistent and recurrent disease will again be an important issue and the topic of the next FIGO meeting.

Thank you for your attention."