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Inguino-abdominal combined approach for laterally extended pelvic resection: a step by step procedure

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SUMMARY

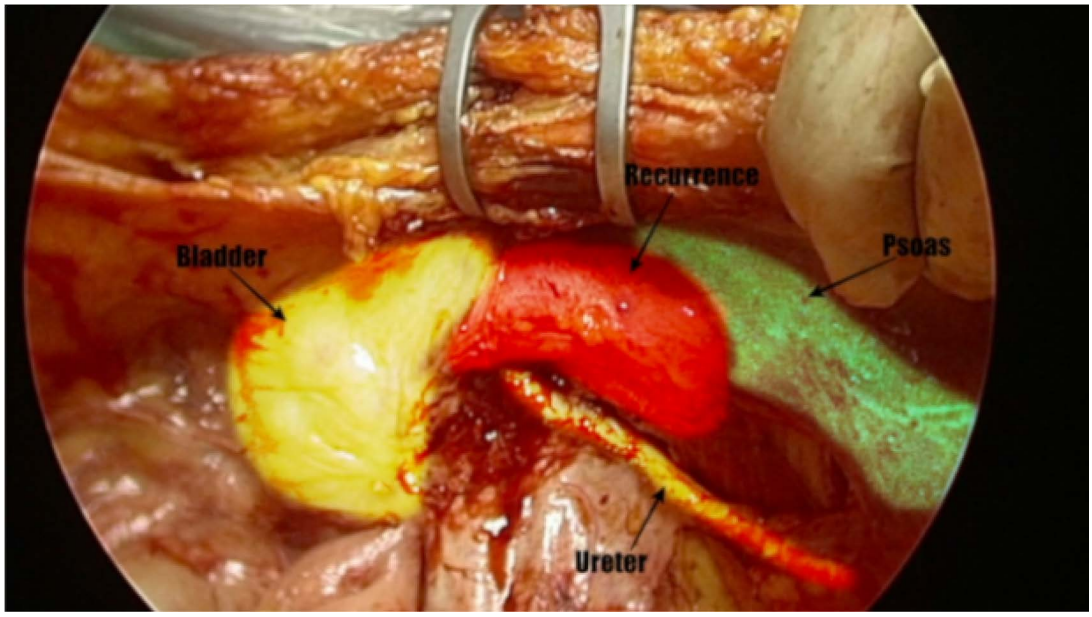
This video article demonstrates an inguino-abdominal combined approach for laterally extended pelvic resection, a major surgical procedure for locally advanced primary or recurrent gynecological cancer infiltrating the pelvic sidewall, for which palliative therapy is the only alternative.[1]

After local institutional review board approval (protocol No CICOG 02/03/62), we made a step by step surgical video of an inguino-abdominal combined approach for laterally extended pelvic resection Video 1, defined as an en bloc resection of a pelvic tumor with pelvic sidewall structures, including the iliopsoas and/or obturator internus muscles.[2 3]

The patient, a 48-year-old woman, diagnosed with single pelvic platinum resistant recurrence after five lines of chemotherapy for serous ovarian cancer G3, International Federation of Gynecology and Obstetrics (FIGO) stage IIIC, BRCA wild type. The preoperative positron emission tomography/computed tomography scan detected uptake on the right side at the level of the external iliac region and obturator fossa: the tumor surrounded the right external iliac vessels by more than 50% of their circumferences, with possible involvement of the vascular wall and venous vascular compression (Tinelli's score=4).[4] The tumor extended towards the obturator fossa, with possible involvement of the inguinal canal. Due to an uncertain pathological response, the size of the recurrence, and its close contiguity with the ureter and bowel, we decided to avoid radiation therapy as it could result in a ureteral or intestinal fistula. We performed a laterally extended pelvic resection, as shown step by step in the video.

The procedure was conducted until complete removal of recurrence (R0). Estimated blood loss was 1000 mL and total operative time was 240 min. The patient was discharged after 15 days; we reported a urinary infection, a likely postoperative complication. The pathology report described a lymphnodal relapse of ovarian cancer (diameter=6 cm) with infiltration of surrounding tissue and in the sano margins. Six months after surgery, the patient is alive without evidence of relapse.

The borders of pelvic surgical anatomy are continually extending, requiring surgeons to use a personalized approach and to continually update their anatomic knowledge. In this context, laterally extended pelvic resection could be a feasible surgical procedure, representing a salvage treatment in recurrent or persistent primary gynecological malignancies infiltrating the pelvic sidewall, when other approaches have failed. However, additional clinical trials are needed to confirm these results.[3]



Video 1

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