Extraperitoneal en bloc intestinal resection as palliative surgery for treatment refractory bowel obstruction in ovarian cancer relapse

Christina Fotopoulou, 1 Dimitrios Haidopoulos 2

Bowel obstruction represents a therapeutic dilemma in ovarian cancer relapse. Due to previous extensive surgical and systemic treatments, and also multilevel obstruction, dissection at palliative surgery is challenging and a simple stoma formation may not be feasible. 1 2 3 4 We present a video showing the palliative surgery for a multilevel bowel obstruction of a young patient, after all conservative attempts had failed.

A 43-year-old patient had a second relapse of a high grade serous ovarian cancer and a multilevel small and large bowel obstruction, radiologically demonstrated, 7 months after her last chemotherapy. Initial treatment with nasogastric tube, antisecretory medication and total parenteral nutrition failed, resulting in increasing abdominal pain and distension and continuous hospitalization. Eight weeks later the decision was made for palliative surgery, instead of gastrostomy tube placement, since the nasogastric tube had not resulted in symptom improvement, being aware of the risk of short bowel syndrome. No extra-abdominal disease was present. The patient had received bevacizumab as first line.

A midline laparotomy was performed in an extraperitoneal fashion to bypass extensive carcinosis-related bowel adhesions to the anterior abdominal wall. In this video (Video 1) we describe the extraperitoneal dissection of the intestinal package until the iliac and ureteric axis, off the bladder, stapling of the rectum 5 cm from the anus, and mobilization of the entire intestinum along the mesenteric axis, off the aorta and inferior vena cava to the duodenum, with subsequent Kocher maneuver for full exposure. The intestinal loops were subsequently dissected from each other to the first point of normally appearing and non-obstructed bowel, 90 cm from the ligament of Treitz. The entire small and large bowel distally to that point was removed and a terminal jejunostomy, without subsequent anastomosis, was placed. Operation time was 240 min, with an estimated blood loss of 200 mL. The patient was discharged home with long-term total parenteral nutrition. One week later her abdominal symptoms and pain had significantly improved and she commenced platinum monotherapy.

Ovarian cancer relapse-related bowel obstruction is often multi-level so that palliative surgery is only possible by extraperitoneal dissection of the entire intestinum until the first unobstructed loop, resulting in short bowel syndrome. Anatomical knowledge of the retroperitoneum, vascular intestinal supply and upper abdomen is crucial for a safe dissection.

Contributors Both authors operated on this patient and took part in her perioperative care. They also both edited and developed the video.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient consent for publication Not required.

Provenance and peer review Not commissioned; externally peer reviewed.

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