Anterior pelvic exenteration and laterally extended pelvic resection: a step by step procedure

Manon Daix,1,2 Martina Aida Angeles,3 Hélène Leray,3 Kelig Vergriete,3 Alejandra Martinez4,5 Gwenael Ferron5

1Surgery, IUCT Oncopole, Toulouse, France
2Department of Gynecology, Centre Hospitalier Chretien - MontLegia, Liege, Belgium
3Department of Surgical Oncology, IUCT Oncopole, Toulouse, France
4Department of Surgical Oncology and INSERM CRCT Team 1, Tumor Immunology and Immunotherapy, IUCT Oncopole, Toulouse, France
5Department of Surgical Oncology and INSERM CRCT Team 19, Oncogenesis of Sarcomas, IUCT Oncopole, Toulouse, France

Correspondence to
Dr Gwenael Ferron, Department of Surgical Oncology and INSERM CRCT Team 19, Oncogenesis of Sarcomas, IUCT Oncopole, Toulouse 31100, France; ferron.gwenael@iuct-oncopole.fr

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SUMMARY

Since the initial description of extended pelvic surgery for gynecological cancer recurrences, lateral involvement of the pelvic side wall has been considered an absolute contraindication for pelvic exenteration. Previous irradiation of the pelvis, and involvement of major vascular structures, nerves, or pelvic bones impacted the success of the surgery and resulted in a poor oncological outcome.

In 1999, Höckel focused his interest on a pelvic side wall resection technique and provided a thorough description of laterally extended endopelvic resection with a curative intent.1 This newly developed concept was adopted by most surgical teams and rebranded as laterally extended pelvic resection. This en bloc pelvic resection allows tumor free margins to be obtained in the case of lateral pelvic side wall involvement, with acceptable mortality rates and improved overall survival in a selected group of patients for whom palliative therapy would be the only alternative. This complex and ultraradical surgical technique allows negative margins to be achieved in more than 75% of patients when it is performed by expert teams in highly selected patients. However, these procedures are associated with a high rate of postoperative complications.2

In this video, we present an open anterior pelvic exenteration and laterally extended pelvic exenteration for cervical cancer involving the right pelvic wall.
chemoradiotherapy. At the end of this treatment, she presented a large symptomatic vesicovaginal fistula with residual tumor. The reconstructive surgery was carried out, performing a continent urinary diversion with a Miami pouch and deep inferior epigastric perforator flap for vaginal reconstruction.

Twitter Manon Daix @manon_daix, Martina Aida Angeles @AngelesFite and Alejandra Martinez @Alejandra

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ORCID iDs Manon Daix http://orcid.org/0000-0001-8986-8655
Martina Aida Angeles http://orcid.org/0000-0003-4401-3084
Alejandra Martinez http://orcid.org/0000-0002-7633-3536

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