

'Salvage cytoreductive surgery for pelvic side wall recurrent endometrial cancer: robotic combined laterally extended endopelvic resection (LEER) and laterally extended pelvic resection (LEPR) debulking'

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Endometrial cancer is the most common gynecological malignancy, and most patients present at an early-stage. However, approximately 15% of confined-uterus endometrial cancer patients will see their cancer return. Treatment options for recurrent endometrial cancer depend on the patient's level of fitness, tumor dissemination and prior treatment. For localized resectable pelvic disease, salvage cytoreductive surgery may improve survival.¹ Laterally extended endopelvic resection, en-bloc resection of the pelvic tumor and sidewall structures, represents an option for salvage treatment in cases of isolated recurrence involving the pelvic side wall.^{2,3}

In this video we present a robotic combined laterally extended endopelvic resection and laterally extended pelvic resection for recurrent endometrial cancer.

The patient was a 59-year-old woman with a first endometrial cancer recurrence. The initial diagnosis was a well-differentiated non myoinvasive endometrioid adenocarcinoma, staged with hysterectomy and bilateral salpingo-oophorectomy. The patient received no adjuvant treatment and 9 years later experienced the recurrence. No comorbidities were reported. Imaging showed an isolated lateral relapse in the right obturator fossa involving the ureter, obturator nerve, pelvic muscles, bones side wall and complete infiltration of the external iliac vein and internal iliac vascular compartment. After multidisciplinary tumor board discussion, we performed a robotic-laparoscopic assisted debulking, with en-bloc resection of the external iliac vein, internal iliac

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Video 1 Robotic-assisted laparoscopic surgery with complete removal of isolated pelvic lymph node recurrence involving pelvic side wall.

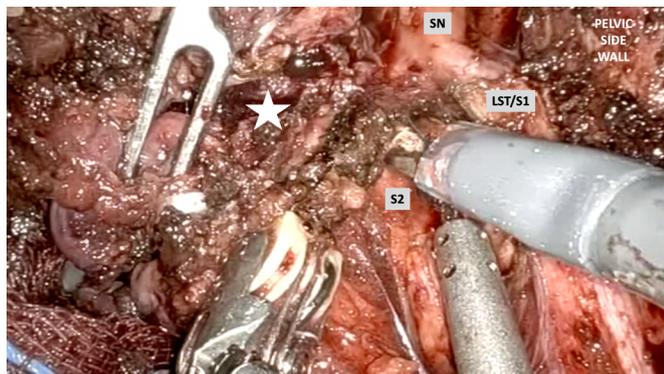


Figure 1 Robotic-assisted laparoscopic surgery with complete removal of isolated pelvic lymph node recurrence involving pelvic side wall.

compartment, obturator nerve, partial sacral plexus fibers, and partial pelvic muscles and periosteum pelvic bones. Complete removal of macroscopic disease was achieved. No intraoperative or post-operative complications were observed. Adjuvant chemotherapy was administered.

Salvage surgery for selected isolated endometrial cancer recurrence with a robotic approach may be a valid alternative for a complete debulking procedure. The robotic approach represents a technological advance over traditional laparoscopy, allowing radical surgery even in complex cases of recurrence involving the pelvic side wall.⁴

Robotic surgery could be offered in highly selected patients with endometrial cancer recurrence (anticipated resectable peritoneal and lymphnode disease) in referral oncological centers.

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Contributors MCD: manuscript preparation, data collection, patient recruitment, participant at surgery, narrative voice and video preparation. GC: manuscript

preparation, data collection, patient recruitment, and video preparation. GZ: manuscript preparation, data collection, patient recruitment and video preparation. ASL: manuscript preparation, data collection, data analysis and patient recruitment. GS: conception of the video, and data analysis and interpretation. VC: conception of the video, data analysis and interpretation, patient recruitment, responsible surgeon and guarantor.

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Competing interests None declared.

Patient consent for publication Not applicable.

Ethics approval This study involves human participants but in our center, institutional review board approval was not required because the study involved analysis of existing data. Informed consent was obtained from the patient for the anonymized insertion of the data regarding her treatment and oncologic outcome in our research databases. The ethic committee approved the collection of data for research purposes.

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