







Laparoscopic posterior pelvic exenteration using the abdominal perineal resection (APR) technique for management of tumor invading both vagina and rectum

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Laparoscopic posterior exenteration is a complex and rarely done procedure. This technique enables en bloc resection of the vagina and rectum via a small incision. Because of the high risk of morbidity, most posterior exenteration terminates above the levator ani muscle.¹ Abdominal perineal resection (APR) is widely used for the management of rectal cancer and anal canal cancer, but it has broader applications.^{2,3} In [Video 1](#), we demonstrate how we combined the abdominal perineal resection technique with laparoscopic posterior exenteration for radical management of a vaginal malignant tumor that had invaded the rectum.


A 40-year-old woman was referred to our hospital because of irregular bleeding and defecation from the vagina. Colposcopy showed a 5 cm tumor on the lower third of the posterior wall of the vagina. Biopsy of the vagina and rectum both suggested adenocarcinoma of the tumor, possibly originating from the vagina. Colonoscopy showed that the tumor had occupied half of the lumen and also revealed a tiny fistula opening to the vagina. No other macroscopic tumors around the abdomen or in the retroperitoneal space or elsewhere in the body were identified by positron emission tomography/computed tomography (PET/CT). After obtaining informed consent, we

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Video 1 Laparoscopic posterior pelvic exenteration using the abdominal perineal resection (APR) technique for management of a vaginal tumor

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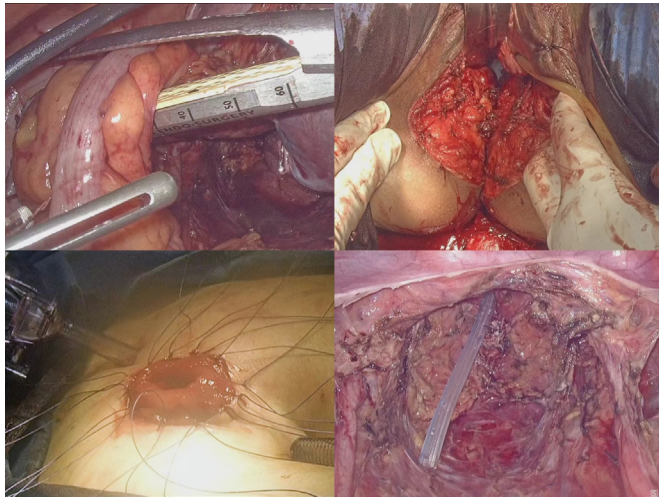


Figure 1 Hybrid image illustrating the key surgical techniques employed. Upper left image: sigmoid colon transected by an endoscopic linear cutter. Upper right image: complete resection and removal of the vagina, uterus, and rectum as a whole from the perineum. Lower left image: view showing how the terminal colostomy was performed. Lower right image: abdomen after en bloc resection of the vagina, uterus, and rectum.

performed posterior exenteration in the patient. First, the vagina and rectum were dissociated to the level of the levator ani under laparoscopy. Next, we performed perineal resection, which included operating from the perineum and cutting through the levator ani to meet with the intra-abdominal part of the vagina and rectum. The bilateral cut edge of the levator ani and adipose tissue were then closed with sutures. Finally, we performed terminal colostomy using the proximal end of the sigmoid colon.

The whole surgery was performed by gynecological oncologists without assistance from gastrointestinal surgeons. The uterus, vagina, rectum, and anus were resected as a whole. The

surgery lasted for 5 hours and 50 min. There were no major post-operative complications. The pathology confirmed adenocarcinoma of vaginal origin. The patient received 28 fractions of radiotherapy and four cycles of adjuvant chemotherapy after surgery. To date, the follow-up after surgery has been 18 months. Our video shows that en bloc posterior pelvic exenteration performed by gynecologic oncologists using minimally invasive technology combined with perineal resection is feasible and safe. This technique can be used for tumors invading both the vagina and rectum.

Contributors QJ wrote and edited the video article. MC reviewed the article and narration. LeY and LiY performed the surgery. LiY is responsible for the overall content as guarantor.

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