

Case Report

Pelvic exenteration surgical case

Haitham A. Saimeh*

Department of Surgery, King Faisal Hospital and Research Centre, Riyadh, Saudi Arabia

Received: 05 February 2021

Revised: 19 February 2021

Accepted: 20 February 2021

***Correspondence:**

Dr. Haitham A. Saimeh,

E-mail: haithamsaimeh@yahoo.com

Copyright: © the author(s), publisher and licensee Medip Academy. This is an open-access article distributed under the terms of the Creative Commons Attribution Non-Commercial License, which permits unrestricted non-commercial use, distribution, and reproduction in any medium, provided the original work is properly cited.

ABSTRACT

Recurrent rectal cancer management is yet considered challenging regardless the great advancement in the surgical field, however the best choice of surgery is pelvic exenteration which offers the best choice to afford a patient with better life expectancy. In this paper, I am presenting a case of recurrent rectal cancer presenting to our tertiary hospital and the means of management that was followed through our multidisciplinary team.

Keywords: Pelvic exenteration, Rectal cancer, Recurrent rectal cancer

INTRODUCTION

As a brief definition, pelvic exenteration involves resection of the anus, rectum, bladder, uterus, and pelvic reproductive organs. The main aim of this surgery is to achieve pathological free margins which is one of the most important prognostic factors after pelvic exenteration.

Pelvic exenteration is the preferred surgical option for locally advanced rectal cancer, associated with low mortality and morbidity. These patients nowadays have better long-term survival together with higher quality of life experienced compared to historical data in which pelvic exenteration were reported to have high mortality and morbidity rates.¹

CASE REPORT

A 51-year-old female patient was diagnosed with upper rectal cancer extending into the adjacent organs, to the left and right adnexas with the uterus, invading the right ureter with a picture of moderate right hydronephrosis.

Patient underwent full diagnostic pathway including colonoscopy, high resolution computed tomography (CT)

scan with pelvic magnetic resonance imaging (MRI) the patient was taken for the operating room.

The picture given in Figure 1 is a CT scan showing locally advanced rectal cancer, invading nearby structures as the bladder.



Figure 1: CT scan showing locally advanced rectal cancer.

From colorectal team side, Hartman's procedure was done, after complete resection of the huge rectal mass. The urological team did partial cystectomy and right ureteric reimplant with psoas with repair, extravesical ureteral reimplant with submucosal tunnel.

The gynecological team did total abdominal hysterectomy and bilateral salpingo-oophorectomy.

The histopathology was amazing, adenocarcinoma, moderately differentiated T3, N0, with all negative margins.

The patient was discharged in a good general condition, with no need for either chemotherapy or radiotherapy, and now she is with regular follow ups with the colorectal department.

DISCUSSION

Pelvic exenteration which is one of the most damaging surgeries, yet it's the only curable approach for treatment of choice for either recurrent or locally advanced rectal cancer. Both local and distant recurrent metastasis have declined due to the great progression done in the field of surgical management in rectal cancer due to adherence surgical techniques together with usage of neoadjuvant therapy.

During multidisciplinary team strategy planning, neoadjuvant therapy is always considered to downstages advanced tumor as a result this allows total mesorectal extraction with clear margins, since the radicality of the surgery is the most important predictive factor for surgical outcome.

The main principle corner stone in surgery is to have a clear R0 resection since this is considered the predictive factor of patient's long-term survival as well as postoperative quality of life. It is greatly emphasized not to leave any cancer remnant, because if the resection margins post pelvic exenteration had tumor involvement, this is highly associated with poor prognosis.

In certain cases, it is considered impossible to achieve R0 resection margins, this is when there is side wall involvement of sciatic foramen, external iliac vessels, obturator nerve or bone invasion. However, in other cases, complete resection should be aimed and done.^{2,3}

There are several postoperative complications graded according to Clavien–Dindo Classification. Complications that could be encountered include bowel obstruction, anastomotic leakage, ureteral fistula, this prolongs patient

hospitalization, as well as subjecting the patient to a secondary surgical intervention that increases the chance of poor outcome.

Based on previous structures conducted, pelvic exenteration is done to treat several cancers that include female reproductive organs as cervix, uterus, vagina, vulva cancer that has metastasized from the colon into adjacent structures, this surgery is only done when the cancer has not been spread to the pelvis.

As a balance between postoperative expenses together with positive outcomes a restricted list indications should be met before undergoing the surgery, taking into account the absence of any sort of effective mode of treatment that may reduce the patient symptoms or enhance their survival rate.⁴

CONCLUSION

Pelvic exenteration is now routinely performed as the treatment modality of choice for patients with advanced or recurrent rectal cancer, since this procedure offers the patient that otherwise would have undergone palliative therapy a higher chance of long survival and better quality of life.

Funding: No funding sources

Conflict of interest: None declared

Ethical approval: Not required

REFERENCES

1. Bacalbasa N, Balescu I. Pelvic exenteration--reconsidering the procedure. J Med Life. 2015;8(2):146-9.
2. Vermaas M, Ferenschild FT, Verhoef C, Nuyttens JJ, Marinelli AW, Wiggers T, Kirkels WJ, Eggermont AM, de Wilt JH. Total pelvic exenteration for primary locally advanced and locally recurrent rectal cancer. Eur J Surg Oncol. 2007;33(4):452-8.
3. Hsu TW, Chiang FF, Chen MC, Wang HM. Pelvic exenteration for men with locally advanced rectal cancer: a morbidity analysis of complicated cases. Asian J Surg. 2011;34(3):115-20.
4. Domes TS, Colquhoun PH, Taylor B, Izawa JI, House AA, Luke PP, Izawa JI. Total pelvic exenteration for rectal cancer: outcomes and prognostic factors. Can J Surg. 2011;54(6):387-93.

Cite this article as: Saimeh HA. Pelvic exenteration surgical case. Recurrence of colon cancer. Int Surg J 2021;8:1052-3.