15. PELVIC EXENTERATION IN THE TREATMENT OF RECURRENT CERVICAL CANCER.

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Ever since 1948, when Brunschwig (1) described the principles and methods of pelvic exenteration as a therapeutic approach to certain forms of pelvic malignancy, several technical changes have been advanced and many guidelines have been established in the over-all care of these patients. This has resulted in a significant improvement in survival. To maintain excellence in over-all survival, the established criteria must be adhered to when considering patients as candidates for pelvic exenteration therapy.

During the 16 year period from June 1, 1965 to June 1, 1981, approximately 90 patients have been treated with some type of pelvic exenteration at the University of Michigan Medical Center, Ann Arbor, Michigan. Our over-all survival rate has made this radical surgical procedure an acceptable approach to the treatment of recurrent carcinoma of the cervix. It also must be remembered that the primary goal of every surgeon performing this procedure is the control and cure of the existing disease, with palliation seldom an indication. Of the patients treated with this form of radical pelvic surgery, over 75% were treated with total pelvic exenteration; the remainder being treated with either resection of the bladder anteriorly or excision of the bowel posteriorly, depending on the location of the tumor. One must not be too conservative, however, in selecting the type of pelvic exenteration to be performed while trying to avoid more than one diversionary procedure. Such conservatism may not only lead to fistulous complications but may unfavorably affect survival, since microscopically extended disease cannot be seen by the naked eye or palpated by the examining finger.

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Type of disease

The lesions most suitable for pelvic exenterative surgery are those of squamous cell variety since spread of this type of tumor beyond the primary organ often occurs in continuity and in contiguity during the earlier stages of recurrence. For this reason, then, patients with recurrent squamous cell carcinoma of the cervix are the most ideal candidate for this treatment. Patients with carcinoma of the ovary are not to be considered candidates for this type of radical pelvic surgery since the pattern of recurrent growth in this disease is one of disorganized abdominal dissemination. Carcinoma of the endometrium, on the other hand, is a more favorable lesion than is carcinoma of the ovary; however, its pattern of growth is also unpredictable. A patient with primary squamous cell carcinoma of the vulva may very well be a candidate for some type of pelvic exenteration, primarily because of the geographic location of the primary lesion.

Extent of disease

Since it is our goal to perform a curative procedure - not a palliative one - the criteria used to determine whether or not a patient is a candidate for pelvic exenteration must be strictly adhered to with a thorough clinical evaluation and investigative work-up of the patient. Whereas, (1) an abnormal pyelogram; (2) lower extremity edema; and (3) sciatic distribution of pain have often been referred to as the "Triad of Trouble", they cannot always determine the candidacy of a patient for pelvic exenterative therapy. They suggest, however, that the recurrent lesion is inoperable. The presence of any one of these abnormalities suggests that there is pelvic lymph node or lateral pelvic wall involvement with tumor extending away from the central recurrent area. Again, whenever one is in doubt as to the resectability of a lesion and the curability of the disease, then exploratory laparotomy is indicated irrespective of the results of these studies. The court of last resort is in the operating room!