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Research Letter

Advances in pelvic exenteration surgery can support clear margin resection for metastatic non-pelvic primary malignancies

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Dear Editor

Surgical advances in pelvic exenteration (PE) have improved survival in patients with advanced and locally recurrent pelvic malignancy[1–3]. Surgical advances in PE, including minimally invasive surgery, higher and wider resections, improved training, and standardization of PE techniques, have all contributed to improved oncological outcomes. These developments have led to an increase in the complexity of cases that are successfully managed surgically, while balancing the intention of cure against the morbidity of surgery and quality-of-life implications[3,4]. A further potential benefit of these advancements may be the broadening of indications for surgery. Occasionally, non-pelvic tumours can metastasize to the pelvis. PE affords the opportunity to offer resectional surgery with curative intent for a broader repertoire of rare tumours, including non-intestinal and hepatobiliary malignancies.

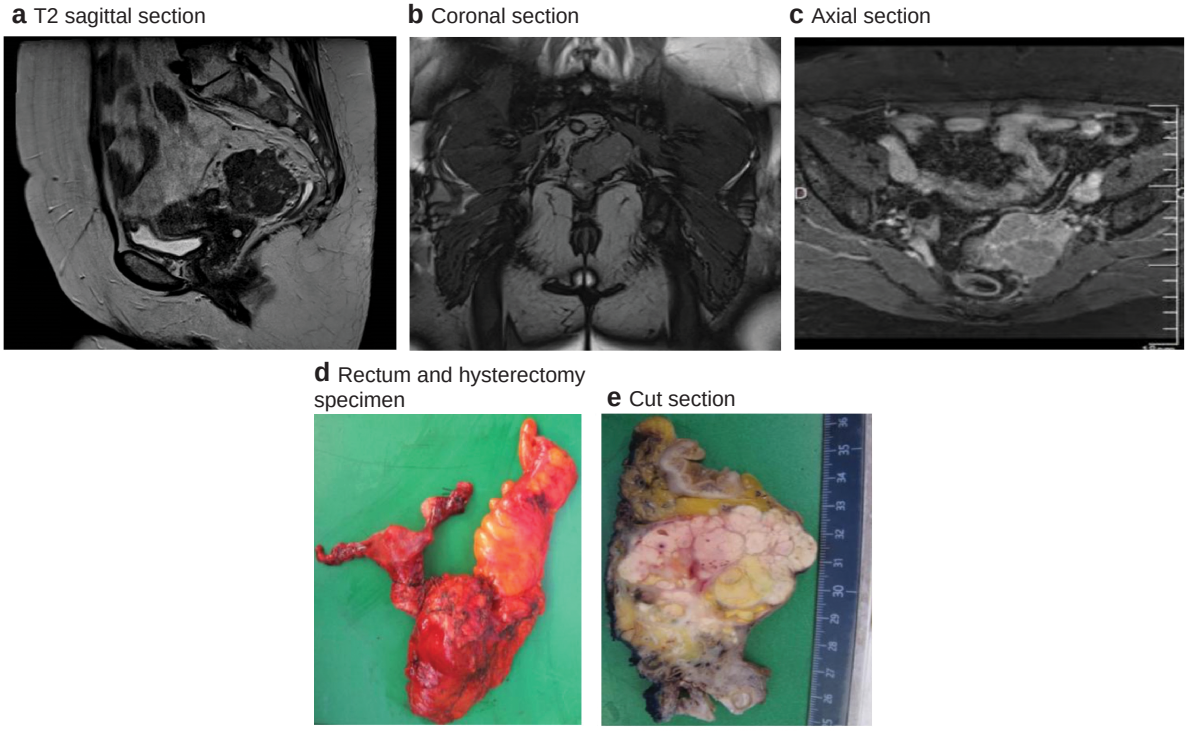

Fig. 1 Pelvic MRI and pathological specimens

Pelvic MRI demonstrating a heterogeneous hypodense tumour in the pelvis: **a** T2 sagittal section, **b** coronal section demonstrating tumour extension to the piriform muscle, and **c** axial section demonstrating proximity of tumour to internal iliac vessels. Macroscopic pathological specimen of *en bloc* resected mass: **d** rectum and total hysterectomy with bilateral salpingo-oophorectomy and, **e** cut section demonstrating multilobed tumour.

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Hepatocellular carcinoma (HCC) is an example of such a malignancy demonstrating this paradigm shift. Overall, 5-year survival rates in HCC can be less than 20 per cent. There have previously been two reported cases of HCC metastases to the rectum[5,6]. In the present authors' practice, a 68-year-old woman presented with abdominal pain and haematochezia 5 years after laparoscopic posterior liver segmentectomy for a solitary HCC lesion. CT and pelvic MRI demonstrated a large pelvic tumour abutting the rectum and uterus (without invasion) extending to the left internal iliac vein, piriformis muscle, and S2 nerve roots. Imaging characteristics and a raised α-fetoprotein serum level (up to 450 ng/ml) confirmed an isolated HCC pelvic metastasis.

After multidisciplinary discussion, arterial embolization was performed (for downsizing) followed by open posterior pelvic exenteration with *en bloc* left pelvic sidewall dissection (*Fig. 1*). This included *en bloc* resection of the rectum (to the level of the pelvic floor) and uterus, and bilateral salpingo-oophorectomy. Left lateral dissection was carried out beyond the total mesorectal excision plane along the left internal iliac vein and the obturator internus muscle, removing the fascia and fibres of the left piriformis muscle and including 2 cm of the distal left ureter. The left S2 nerve branch was also resected. A stapled coloanal anastomosis was fashioned and the distal left ureter reimplanted via a primary tunnelled uterovesical anastomosis. The omentum was pedicled and interpositioned between the vagina and coloanal anastomosis, and a temporary loop ileostomy fashioned. This was reversed on postoperative day 7 after CT with rectal contrast demonstrated an intact anastomosis. Histopathology confirmed a grade III HCC metastatic lesion with R0 resection. The patient remains disease-free 2 years after operation with ongoing oncological follow-up.

This patient highlights how experience and standardization in PE surgery can widen the indications for exenterative surgery. As a result, even non-pelvic tumours that may have been considered non-resectable previously can be treated surgically with curative intent. Continuing to refine PE surgical techniques, training, and perioperative care can also support improvement in curability for rare pelvic metastases.

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Disclosure

The authors declare no conflict of interest.

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European Colorectal Congress

28 November – 1 December 2022, St.Gallen, Switzerland

Monday, 28 November 2022

09.50
Opening and welcome
Jochen Lange, St.Gallen, CH

10.00
It is leaking! Approaches to salvaging an anastomosis
Willem Bemelman, Amsterdam, NL

10.30
Predictive and diagnostic markers of anastomotic leak
Andre D'Hoore, Leuven, BE

11.00
SATELLITE SYMPOSIUM
ETHICON

11.45
Of microbes and men – the unspoken story of anastomotic leakage
James Kinross, London, UK

12.15
LUNCH

13.45
Operative techniques to reduce anastomotic recurrence in Crohn's disease
Laura Hancock, Manchester, UK

14.15
Innovative approaches in the treatment of complex Crohn Diseases perianal fistula
Christianne Buskens, Amsterdam, NL

14.45
To divert or not to divert in Crohn surgery – technical aspects and patient factors
Pär Myrelid, Linköping, SE

15.15
COFFEE BREAK

15.45
Appendiceal neoplasia – when to opt for a minimal approach, when and how to go for a maximal treatment
Tom Cecil, Basingstoke, Hampshire, UK

16.15
SATELLITE SYMPOSIUM
Medtronic
Further,Together

17.00
Outcomes of modern induction therapies and Wait and Watch strategies, Hope or Hype
Antonino Spinelli, Milano, IT

17.30
EAES Presidential Lecture - Use of ICG in colorectal surgery: beyond bowel perfusion
Salvador Morales-Conde, Sevilla, ES

18.00
Get-Together with your colleagues
Industrial Exhibition

Tuesday, 29 November 2022

9.00
CONSULTANT'S CORNER
Michel Adamina, Winterthur, CH

10.30
COFFEE BREAK

11.00
SATELLITE SYMPOSIUM
INTUITIVE

11.45
Trends in colorectal oncology and clinical insights for the near future
Rob Glynne-Jones, London, UK

12.15
LUNCH

13.45
VIDEO SESSION

14.15
SATELLITE SYMPOSIUM
BD

15.00
COFFEE BREAK

15.30
The unsolved issue of TME: open, robotic, transanal, or laparoscopic – shining light on evidence and practice
Des Winter, Dublin, IE
Jim Khan, London, UK
Brendan Moran, Basingstoke, UK

16.30
SATELLITE SYMPOSIUM
Takeda

17.15
Lars Pahlman lecture
Søren Laurberg, Aarhus, DK

Thursday, 1 December 2022
Masterclass in Colorectal Surgery
Proctology Day

Wednesday, 30 November 2022

9.00
Advanced risk stratification in colorectal cancer – choosing wisely surgery and adjuvant therapy
Philip Quirke, Leeds, UK

09.30
Predictors for Postoperative Complications and Mortality
Ronan O'Connell, Dublin, IE

10.00
Segmental colectomy versus extended colectomy for complex cancer
Quentin Denost, Bordeaux, FR

10.30
COFFEE BREAK

11.00
Incidental cancer in polyp - completion surgery or endoscopy treatment alone?
Laura Beyer-Berjot, Marseille, FR

11.30
SATELLITE SYMPOSIUM
EVOLUZIONE DISPOSITIVI MEDICI

12.00
Less is more – pushing the boundaries of full-thickness rectal resection
Xavier Serra-Aracil, Barcelona, ES

12.30
LUNCH

14.00
Management of intestinal neuroendocrine neoplasia
Frédéric Ris, Geneva, CH

14.30
Poster Presentation & Best Poster Award
Michel Adamina, Winterthur, CH

15.00
SATELLITE SYMPOSIUM
OLYMPUS

15.45
COFFEE BREAK

16.15
Reoperative pelvic floor surgery – dealing with perineal hernia, reoperations, and complex reconstructions
Guillaume Meurette, Nantes, FR

16.45
Salvage strategies for rectal neoplasia
Roel Hompes, Amsterdam, NL

17.15
Beyond TME – technique and results of pelvic exenteration and sacrectomy
Paris Tekkis, London, UK

19.30
FESTIVE EVENING

Information & Registration **www.colorectalsurgery.eu**