Quality of life after palliative pelvic exenteration for gynecologic malignancy

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CASE SUMMARY

Patient is a 44yo female with metastatic vulvar squamous cell carcinoma (SCC) diagnosed after 1-year history of a vulvar lesion, initially treated with radiation and radical vulvectomy. Following vulvectomy she developed an enlarging chronic wound, exposing her pubic ramus. Biopsies revealed recurrent SCC and osteomyelitis of the pubic ramus. Pain associated with the wound severely limited her ability to sit and ambulate. A tumor board decided to proceed with a palliative total pelvic exenteration 21 months after initial diagnosis of SCC for pain relief, including removal of the uterus, right fallopian tube and ovary, bladder, distal ureters, vagina, rectum, pubic symphysis, and pubic rami. Perineal reconstruction was completed with left pedicled anterolateral thigh flap with pedicled vastus lateralis flap. Unfortunately, she developed severe left hip pain due to persistent osteomyelitis and was diagnosed with locally recurrent SCC a few months after surgery.

CASE PHOTOS

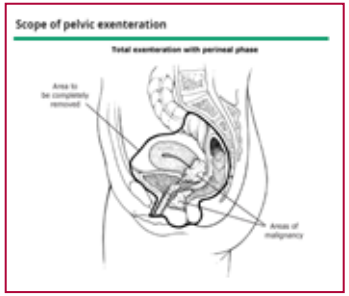

Fig. 1: Schematic representing pelvic organs to be removed in total pelvic exenteration with perineal phase. © 2021 UpToDate, Inc.

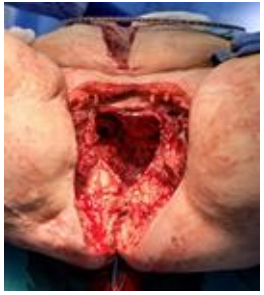

Fig. 2: Our patient after total pelvic exenteration with perineal phase, prior to reconstruction.

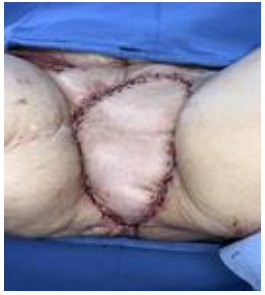

Fig. 3: Our patient following reconstruction with a pedicled anterolateral thigh flap with pedicled vastus lateralis flap.

CLINICAL SIGNIFICANCE

Pelvic exenteration is a complex operation with a high rate of complications and morbidity; however, it can be the final curative or palliative option for persistent gynecologic malignancies. For palliative cases, physicians and patients must determine whether the potential symptomatic relief from the operation outweigh the significant risks of morbidity, mortality, and decreased quality of life. Informed consent with pre-operative counseling is essential to make potential outcomes known to the patient. Increased consideration should be given to elderly patients undergoing this procedure as recovery of physical and social activity is significantly decreased when compared to baseline. Psychosocial support should be made available, especially within the first few months post-op when the patient is likely to experience the greatest decrease in QOL.

PELVIC EXENTERATION: THE PROCEDURE

Pelvic exenteration (PE) is a radical surgical procedure in which two or more visceral pelvic organs are removed en bloc, with or without the perineum[1]. It is performed for recurrent or locally invasive cancers of the cervix, uterus, vulva, or vagina, but may also be considered for colorectal or urological cancers. PE can be performed curatively or for palliative treatment of pain, bleeding, urinary or fecal incontinence or obstruction, fistula, malodor, fever, or pelvic sepsis[2]. The type of exenteration performed can be anterior, posterior, perineal, or total. Depending on the type of PE patients may end up with an ostomy or urinary conduit. Reconstruction options include primary closure but more commonly involve myocutaneous flap closure, particularly vertical rectus abdominus myocutaneous flaps and anterolateral thigh flaps[3]. Finally, some patients are candidates for creation of a neovagina as part of their reconstruction.

QUALITY OF LIFE DISCUSSION

- Physical function
  - Creation of non-continent bladder predictor of poor body image[4].
  - Continent group with lower median global health, quality of life, and self perception at 1 month post op, possibly due to the learning process of self-catheterization, but higher scores than noncontinent group at 1 year (not significant)[5].
  - Definitive colostomy and higher number of ostomies predictor of poor body image[4].
- Sexual function
  - Sexual function and sexual pleasure significantly decreased at 12 months post-op compared to baseline[5].
- Emotional distress
  - Body image declined from baseline to 12 months post-op[6].
  - Significant reduction of QLQ-C30 score at 1-month post-op assessment[7].
  - Improvements seen in social activity and physical activity at 12 months post-op when compared to baseline values in younger patients[7].
  - Elderly patients continue to have decreased social and physical activity at 12 months post-op[7].
- Complications
  - PE associated with 53% morbidity and 6.3% mortality during inpatient post-op period[2].
  - Most common complications include hemorrhage (31.8%), ileus/SBO (25.8%), wound complications (21.3%), respiratory failure (16.1%), AKI (13.8%), and sepsis/SIRS (8.4%)[1].
  - Major perineal wound complications during primary closure up to twice as likely when compared to myocutaneous flap closure, however similar rates of minor perineal wound complications, abdominal hernia, and reoperation[3].
- Overall satisfaction
  - Symptomatic relief in 79% of patients[2].
  - Most women were satisfied with their decision to undergo PE, and most would choose to have the operation again[6].

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