

In this report 51 patients affected by microinvasive carcinomas with a follow-up of at least 5 years, were retrospectively analyzed. Treatment modalities included conization in 9 patients, removal of the cervical stump in 1, hysterectomy in 23 patients (3 had also lymphadenectomy) and radical hysterectomy plus lymphadenectomy in 18 cases.

Emphasis was given to the preoperative assessment of microcarcinoma, underlining how a presumptive diagnosis can be achieved by the combination of cytology, colposcopy evaluation and histologic examination of colposcopically directed biopsies. However, it is advisable to proceed with conization of the cervix to assess the presence of a microinvasive carcinoma. In our series conization was performed in 9 cases and histological diagnosis was consistent with 1 high grade SIL, Stage IA2 microcarcinoma with negative cone margins and 7 Stage IA1 lesions of which 4 had positive margins. Of these 9 patients, 4 had no further treatment. Of the other 5 patients, in one case conization was repeated and diagnosis of Stage IA1 with negative cone margins was made. 3 patients with Stage IA1 carcinoma showing "non in sano" margins and 1 with Stage IA2 microcarcinomas underwent hysterectomy and microscopic examination did not show any residual disease. Status of cone margins seems to be a relevant parameter in selecting patients for conservative therapy.

Tumor histotype appears of no importance in the prognosis of the lesion. Conversely, tumor grade correlated with depth of stromal invasion. Microscopic lymph-vascular invasion was related to depth of stromal invasion being absent in Stage IA1 cases and evident in 7 of 30 Stage IA2 microcarcinoma.

There were lymphnode metastases in 2 of the 21 patients with dissected nodes (9.5%) and they were present in patients with Stage IA2 lesion.

Recurrences occurred in 3 patients with Stage IA2 microcarcinoma and lymph-vascular involvement. Two of these had also lymphnode metastases and died of disease. Available data from the literature, as well as our experience, identify depth of invasion as a variable strongly related to lymphnode metastases and recurrences.

The treatment of microcarcinoma of course, is intended to satisfy the need of reducing the morbidity due to a radical therapeutic approach while attaining complete cure. Although other and our reports do not provide unquestionable proof that a specific therapeutic measure is the most appropriate one, some recommended guidelines for behaviour may be suggested.

In Stage IA1 microcarcinoma, non radical therapy may be safely performed. Caution should be exercised in Stage IA2 microcarcinoma and lymph-vascular involvement should be meticulously evaluated. Lesions of < 3 mm depth of invasion without lymph-vascular involvement might be treated by simple hysterectomy. In any of the other lesions that fall into the Stage IA2 category, radical or modified radical surgery with pelvic node dissection appears mandatory.

PERSONAL EXPERIENCES WITH EXENTERATIONS IN PATIENTS WITH GYNECOLOGIC MALIGNANCIES

H. G. BENDER
Frankfurt, Germany

While exenterations have been widely performed in centers for gynecologic oncology in the United States the acceptance of this procedure has been considerably less in European Countries.

Frequently arguments have been used against exenterations claiming that these procedures are dangerous and connected with a high mortality and morbidity, ineffective and mutilating.

This report deals with 71 exenterations that have been performed in the time-period from 1977-1992 in the Department of Ob./Gyn., University of Düsseldorf (1977-1989, n=61) and the Department of Gynecology, University Frankfurt/Main (1989-1992, n=10).

The primary tumor sites were uterine cervix (n=48), vagina (n=7), vulva (n=6) and endometrium (n=10).

Twenty two of the patients (31%) were treated primarily, 49 (69%) were treated for recurrent tumors after failing radiotherapy. The age-distribution was between 27-71 years of age with a mean of 52 years. The procedures that were performed were 34 anterior exenterations, 15 posterior exenterations and 22 total exenterations. Among the 56 patients with anterior and total exenterations 28 received an ileum-conduit, 12 a Kock-pouch procedure, 8 a colon-conduit and 7 a ureterocutaneostomy. Since one patient died intraoperatively the sum amounts to 55 patients only.

The types of bowel surgery selected in patients with posterior and total exenterations (n=37) were as follows.

In 19 patients fecal continence could be maintained by establishing a low anastomosis, 8 patients received a permanent colostomy and 9 were treated by a loop colostomy maintaining the chance of reestablishing anal continence.

The blood-loss amounted to a range between 500-6500 cc with the mean of 2560 cc. Blood transfusions were necessary in 64 patients (90.1%).

The main complications were 1 intraoperative death due to coagulation problems, and 2 patients died postoperatively due to diabetic and cardio-vascular problems in 1 patient, and pulmonary insufficiency in another young patient who had preoperatively severe pulmonary problems due to marked scoliosis.

Six patients experienced a severe intraoperative arterial hypotension that could be managed by infusions; interestingly enough intra- and postoperatively we had 15 cases with arterial hypertension. In 4 patients we observed postoperative bleeding that could be controlled by gauze-packings and reinterventions. Secondary healing occurred in 4 patients, 5 patients developed postoperative deep vein thrombosis.

Bowel obstruction had to be treated by reintervention in 3 patients. Two patients suffered from a postoperative pneumonia, 2 from a bowel-fistula, 3 from a urine-leakage, 1 from a transitory psychotic syndrome.

Neurologic defects (motoric or sensoric) developed in 3 patients and 3 showed a lymphedema of one or both legs.

Out of 52 patients with a follow-up of more than 5 years, 25 are alive (NED) a figure expressing a 48% 5 year survival.

From our own experiences and our data presented we conclude that for a selected group of patients with extremely difficult disease situations exenterations are an important therapeutic option for the following reasons:

They are combined with an acceptable mortality and morbidity, offering a high cure rate for a patient population with no treatment alternative. The procedures can be increasingly performed with maintenance or restoration of function (bowel, urinary tract, vagina). As long as we do not have treatment alternatives, which may develop in the field of interventional radiotherapy or the development of new specific drugs like monoclonal antibodies against growth factors or similar compounds, we should offer exenterations with the perspective of cure for patients with resectable lesions.