ISSN: 2755-0117

Journal of Oncology Research Reviews & Reports

SCIENTIFIC Research and Community

Case Report

Open Access

A New Approach for Pelvic Tumors Invading the Rectum

António Gentil Martins

Department of Children's and Adolescents Oncology, Portuguese Cancer Institute Francisco Gentil, Lisboa, Portugal

ABSTRACT

Objective: Sometimes pelvic tumors invade the rectal wall, needing removal

Design: An alternative technique of radical/conservative surgery (trying to preserve as much as possible the muscular complex) is presented, inspired by De La Torre treatment of Hirschprung's disease. The lower rectum is only partially resected on the non-involved side, where only mucosa is removed, followed by a lower end to end rectal anastomosis

Results: Normal defecation

Conclusion: A good surgical alternative

***Corresponding author**

António Gentil Martins, Department of Children's and Adolescents Oncology, Portuguese Cancer Institute Francisco Gentil, Lisboa, Portugal. Tel: 315 939555162. E-mail: agentilmartins@gmail.com

Received: July 20, 2021; **Accepted:** July 24, 2021; **Published:** July 30, 2021

Keywords: Pelvic Tumors, Rectal tumors, De la Torre, Hirschsprung's Disease

Introduction and Objectives

To show a new technique for excision of tumors invading the lower rectum, through the presentation of a recurring presacral tumor which had invaded the posterior rectal wall [1].

Material and Methods

Patient operated aged 6 years (in 2003) for a presacral Teratoma, surgery being followed by chemotherapy (Carboplatino 600 mg/sqm, VP16 120mg/sqm and Bleomycin 15 mg/sqm x 4). Tumor markers (CEA, CA125, alpha-fetoprotein and BHCG were negative. Excision was considered "complete".

3 years later (2006) a recurrence appeared slightly over the left side, sized 3x3cms, adherent to the anus but moderately mobile. The Patient was given preoperative chemotherapy with Pei (VP16 120mg/sqm, Cisplatino 10mg/sqm and Ifosfamide 1.135 mg/sqm x 5) with a size reduction of about 70%. A small inguinal left node proved to be free of disease [2-3].

The recurrence was excised through a posterior midline approach, requiring excision of part of the muscular complex and of the rectal muscular wall. Bone scintigraphy was normal and tumor markers remained negative.

February 2008 a further recurrence appeared, as well as bilateral lung metastases that were removed by open thoracotomy.

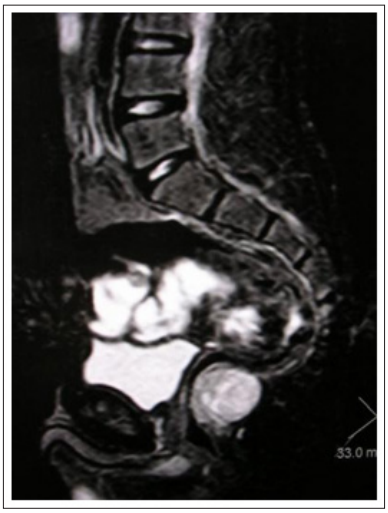

Figure 1: MRI of the recurrent tumor (second recurrence (2008)

He had chemotherapy (with Gemcitabine and Oxaliplatin x 2) that led to veno-occlusive disease, from which he completely recovered with Di-fibrotide). He was then given Gemcitabine (150mg/sqm), and Paclitaxel (1.500mg/sqm) x3, with no significant improvement in the recurrent tumor but with some improvement in the lung metastases. It was then decided to remove the recurrence as well as the lung metastases. Considering the bad prognosis, a permanent colostomy was to be avoided in order to improve the quality of his expected short life.

Surgical Technique

Again a posterior midline incision was used. The recurrence was found to invade the whole posterior rectal wall. Inspired in De La Torre's technique for Hirschsprung's Disease, the rectal wall was individualized above the tumor and sectioned at that level, followed by the removal of the invaded lower part of the rectum, although anteriorly removing only the mucosa and maintaining the muscular rectal wall, in order to try to preserve , at least, part of the muscular complex.

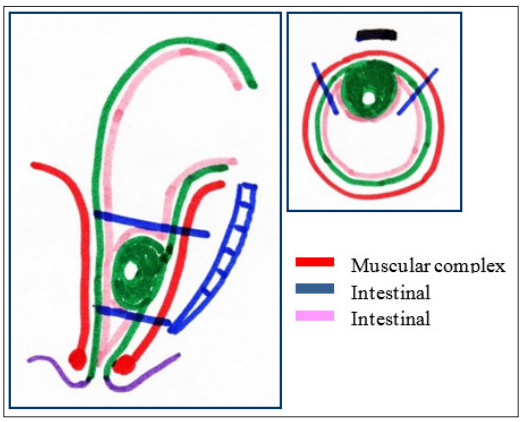

Figure 2: Schematic view of the excisions to be

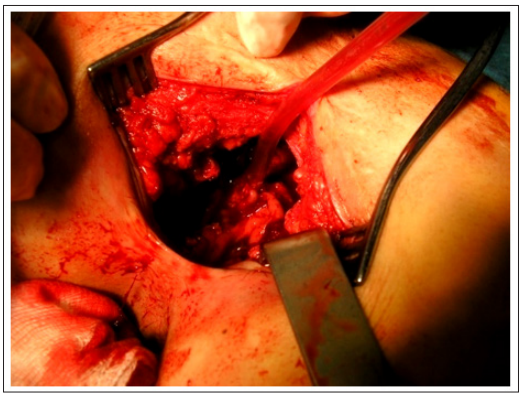

Figure 3: Anus split with the upper midline incision and appearance of the pelvic cavity where the tumor was contained

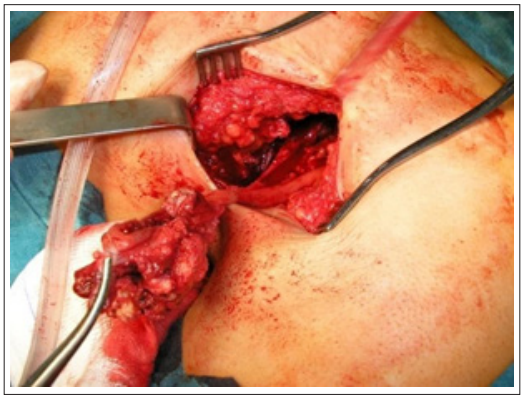

Figure 4: The muscular complex of the rectum , opposing the tumor, to be stripped of mucosa, but preserving, at least partially, the muscular wall.

Then the right colon was pulled down, as in De La Torre's technique for Hirschsprung´s Disease, the lowered rectosigmoid being anastomosed inferiorly to the rectum, at the level of the pectineal line.

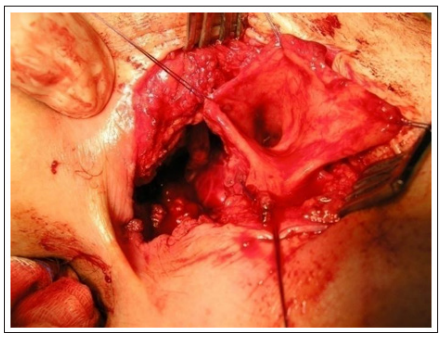

Figure 5: Colon to be pulled down as in De La Torre for Hirschsprung´s disease.

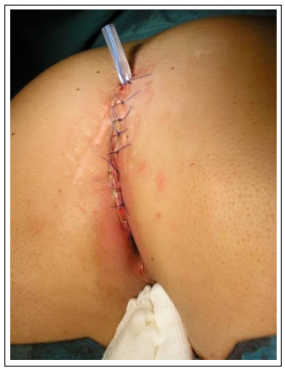

Figure 6: Final appearance of the surgical approach

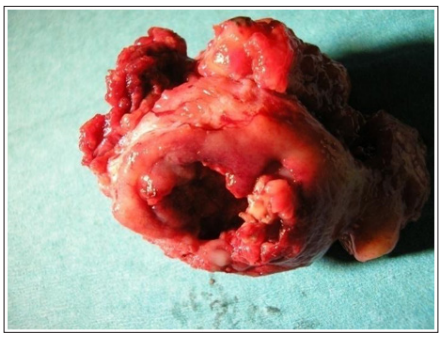

Figure 7: Operative specimen

Discussion and Results

Histology showed the tumor to be a bi-germinal immature Teratoma, with predominance of neuro-epithelial elements, grade III, again with an apparently complete excision. 36 Grays were then administered locally,

The Patient recovered satisfactory social continence (controlled feces and flatus) He was treated again with Chemotherapy (PEI, with the already quoted dosages x 4). 3 lung metastases were removed on the right side, and 5 (smaller) on the left. His general health, post-operatively, was quite satisfactory, although unfortunately the bad prognoses remained.

Conclusion

Considering the Patient's quality of life, the described technique may be a good alternative for the removal of presacral tumors in general, and even the best choice to use in one of the extremely difficult situations that surgeons sometimes have to face [4-5].

Disclaimer: This Paper is a single author piece and presents no conflict of interests

References

1. Altmann RP, Randolph JG (1974) Sacrococcygeal teratoma: American Academy of Pediatrics Surgical Section Survey, Lilly JR Journal of Pediatric Surgery 9 : 389-98.
2. Angel CA, Murillo C, Mayhew J (1998) Experience with vascular control before excision of giant, highly vascular sacro-coccigeal teratomas in NeoNates, Journal of Pediatric Surgery 33: 1840-1842.
3. ASHCRAFT kw, Holder TM (1974) Hereditary presacral teratoma Journal of Pediatric Surgery 9: 961-72.
4. De la Torre-Mondragon L, Ortega Salgado JA (1998) Transanal endorectal pull-through for Hirschsprung's Disease - J Pediatric Surgery 33: 1283-1286.
5. Groff DB (2001) Pelvic Neoplasms in children Journal of Surgical Oncology 7: 65-71.