

## Discussion

GEORGE W. MORLEY, M.D.

*University of Michigan Hospitals, Department of Obstetrics and Gynecology, Ann Arbor,  
Michigan 48109*

Received March 30, 1987

I take this opportunity to compliment Drs. Rubin, Hoskins, and Lewis on this well-designed retrospective study and to congratulate them on a significant contribution assessing the role of radical hysterectomy for recurrent carcinoma of the cervix following initial therapy with pelvic irradiation. Most of us whose professional lives span the years when some form of radical pelvic surgery was the treatment of choice for recurrent carcinoma of the cervix treated previously with X-ray therapy need the results of this review for making therapeutic decisions in the future. The conclusions are (a) that there is a 57% survival with a median follow-up of 73 months following radical surgical therapy and (b) that 47.6% of the patients developed some type of excretory fistulization.

It is hoped that with improved modern day radiotherapeutic techniques we will encounter central recurrences less frequently in the future; however, we must be prepared to make appropriate recommendations when this situation does arise as to the advisability of radical hysterectomy versus pelvic exenteration—especially when one considers the morbidity related to exenterative therapy. From this study, it appears that criteria can be established which will assist the experienced radical pelvic surgeons in this decision-making process.

The three most significant sentences in the manuscript are as follows: (1) Of the 11 patients with cervical tumors 2 cm or less in diameter, no patient experienced recurrence, with a mean follow-up of 82 months. (2) Of the 7 patients whose initial clinical stage was IB or IIA, none has had a recurrence. (3) Ten of the 21 patients developed postoperative fistulae with 9 of the 10 requiring surgical diversion of either the urinary or urinary and intestinal tract. Parenthetically, essentially 100% of the patients undergoing pelvic exenteration have at least one excretory diversion.

In view of a greater than 50% survival in the overall series, it appears that if we now use as criteria the initial staging of Stage IB or Stage IIA coupled with a recurrent tumor measurement of 2 cm or less, survival following radical hysterectomy would be significantly improved. Furthermore, if one adds the histologic type of squamous cell carcinoma to the criteria, yes, it would further limit the indications but it *might* still further improve the survival!

Being a discussant motivates one to look at his own series since anecdotal recall can often be misleading and inaccurate. From 1958 to 1985, 15 patients were treated in a similar manner at the University of Michigan Medical Center. All patients had had previous pelvic irradiation. Three patients developed fistulae; 1 vesicovaginal–vesicocutaneous and 2 ureterovaginal fistulae while 3 patients developed significant urinary incontinence. The disease-free actuarial survival at 3 and 5 years is 57 and 24%, respectively. The disease-free actuarial survival in patients *without regional metastases* was 45% at 5 years. I thank Dr. Keith Terada for his active participation in this review.

In a comparable review of 64 consecutive patients with recurrent carcinoma of the cervix in the same institution treated with some form of pelvic exenteration, there was an overall 59.6% 5-year survival rate. If one evaluates those patients with only squamous cell carcinoma of the cervix, the survival rate is 63.8%. The question to all of us then is, “Would pelvic exenteration have significantly improved the salvage in these patients treated with radical hysterectomy?” It is obvious that there is no one answer; however, if the newer criteria developed from this study were to be used, the answer would probably be, “No” in this select group.

In conclusion, I agree with the authors that this procedure should be undertaken by only the most experienced of radical pelvic surgeons who might adhere to the new criteria set forth in this paper. We must be careful, however, to not be too conservative!

Finally, since a discussant represents those in attendance and since we should benefit from the closing comments by the presentor, I have forwarded five questions, in advance, to Dr. Rubin for his review. The following questions raised are

1. Were any other surgically corrective measures taken to repair the fistulae short of diversion?
2. Realizing the median survival was 73 months, what was the 5-year survival rate?
3. What were the survival rates of the subsets of disease, epidermoid, adenocarcinoma, and adenosquamous?
4. Were the lesions in the six surviving Stage IIB patients 2 cm or less?
5. Were any of the fistulae disease related?

I appreciated the opportunity to review this paper and I again congratulate the authors on this significant contribution.