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составил 42 ± 8 лет. Размер опухоли составил 2,3 ± 0,9 см, а в 94,1% хирургические поля были свободны от болезней. Среднее время работы составило 341 ± 65 минут и кровопотеря 107 ± ml, no patient needed a blood transfusion and there was no case of a case to open the operation. The average length of hospital stay was 2.7 days (range: 2-7 days). There were no intraoperative or postoperative complications. Conclusions: LRH is a safe and reliable alternative to treating early stage UCC. Keywords: cervical cancer; Cervical cancer; Early stage; Early stage; Laparoscopic radical hysterectomy; Radical hysterectomy. A blood-thighed radical hysterectomy and pelvic lymphadenectomy (Wertheim-Meigs surgery and variants) remains standard surgical treatment for cervical cancer in the FIGO IA2, IB1 and IIA stages. This intervention can also be performed on locally advanced tumors that have successfully responded to neoadjuvant chemotherapy (FIGO IB2-IIIB stages)1. Technological advances have made it possible to perform this surgery entirely laparoscopically (complete laparoscopic radical hysterectomy). The first series were published by Canis et al2 and Nezhat et al3 in the early 1990s. Since then, other groups have published their experiences demonstrating the feasibility and safety of the procedure. The introduction of a new surgical technique in oncology also requires that the survival rates obtained be comparable to conventional treatments. Currently, there are several bibliographic references concerning the long-term survival of cervical cancer patients operated by laparoscopy. There are also no randomized studies comparing laparoscopic access to the laparotomy standard. However, there are undoubtedly benefits of minimally invasive access provided by laparoscopy in terms of cosmetics, better visualization of the surgical field, lower blood loss, lower perioperative morbidity and faster recovery. To these common benefits should be added the possibility offered by increasing laparoscopic imaging to perform precise surgical gestures in anatomical areas of difficult lapanomic access, such as nervous sparring 4. The purpose of this study is to assess the feasibility, perioperative morbidity and medium-term survival of general laparoscopic radical hysterectomy in a series of 31 consecutive cases of cervical cancer. MATERIAL AND METHODSA 31 consecutive patients of invasive cervical cancer assessed by the oncology gynaecological department of Son Lietzer Hospital (Palma de Mallorca) from May 2003 to September 2006 were included in the study. In all cases, a full laparoscopic radical hysterectomy and bilateral pelvic lymphadenectomy were shown. All cases were evaluated, operated on, and then by the same group. All patients had a cervical biopsy or conization squamous cell carcinoma histology with infiltration of more than 3 mm (n x 21) or adenocarcinoma (n. 9). Clinical production was carried out with the help of chest X-rays, pelvic MRI and liver ultrasound. Clinical stage distribution was: IA2 4 cases (13%), IB1 21 cases (70.1%), IIA 2 cases (7.6%) and IB2 3 cases (10%). Radical hysterectomy HYVER II (proximal parameter section and uterosaur and uterosca and 1 cm vaginal cuff) was performed at the stages of microinfiltration of cervical cancer FIGO IA2. In other cases, radicalism was PIVER III with distal parameterization and uterosaurs, as well as vaginal cuff 2-3 cm (rice. 1.) 5. Cases of tumors measuring more than 4 cm (FIGO IB2) were operated on after the preliminary completion of laparoscopic prearotic therapy with confirmation of the absence of ganglion metastases and the introduction of 2-3 cycles of neoadjuvant chemotherapy. Figure 1. Detail of the general laparoscopic radical hysterectomy of the surgical part with the radicalism of PIVER III. Surgical techniqueC describes the evolution of surgical technique for 3 years, including the study. The uterus was mobilized with the uterine manipulator Clermond-Ferrand (Storz). In the first cases, four entrance ports with the following location were used: 1 10 mm umbilical trocar for optics, 2 5 mm trocar in both sub-pits and the fourth trocar, 10 mm, located between the trocar of the left sub-fist and the umbilical cord. Subsequently, it was transferred to the classic location of 4 entrance ports in the diamond location: 1 out of 10 mm umbilical cord for optics and 3 ports of accessories on 5 mm (both in the sub-pits, and in the head-and-floor area). This arrangement improved tweezers triangulation, which improved the comfort and efficiency of autopsy maneuvers on both sides of the pelvis. The intervention began with a distal section of the round ligaments and the development of paravesical pits to the fascia of the endolysis and bilateral pelvic lymphadenectomy fork of the primitive subvial artery. The nodes were deposited in endoboles, which was removed vaginally at the end of the intervention. The effect of the pararectal pit on the lifting muscle of the anus (Figure 2) was then performed. In the last 14 cases, splical nerves, located on posteroinferior face parameterization, have been dissected to preserve the parasymphathetic injector rectum and bladder (Figure 3). The area of the uterine artery was then performed by its origin and radical resection of the parameter with bipolar clamp (Ligasure) or harmonic scalpel (ultracision) for the spleen nerves previously exposed (Figure 4). In early cases the parameters were made in bulk using mechanical endocotortors, followed by 10 mm Ligasure (Atlas, Tyco). As experience gained, he delved into the dissection of anatomical parametrium structures, en making it possible to individualize these structures including, downstream, uterine artery, uterine uterine, vesico evening drainage veins, and the middle rectal artery. Hemostyia and section were performed with 5 mm instruments (Ligasure or ultracision). Figure 2. Detail of pararectal pit: outer sub-swirl vein (1); pelvic wall (2); shutter nerve (3); the anterior trunk of the inner hamstring (4); Upper artery of the bladder (5); uterine artery (section at its source) (6); pararectal pit (below visualized roots of the film nerve) (7); paravesic pit (8) and uterus (9). Figure 3. Details of nerve roots after parameter section: uterus (1); Straight (2); Paravesic pit (3); Pararectal pit (4); pelvic wall (5) and parametric lines of section (6). Figure 4. Detail of the left ligament of the uterus: the back of the cervix (1); Ureter (2); the outer sheet of the uterosauro ligament containing the lower hypogastric plexus (3); rectovaginal space (4); The inner sheet of the ligament is uterozed to be resected (5), and the anterior part of the rectum (6). The dissection of the rectovaginal space has spread widely on both sides of the rectum, individually exposing the arons of the rectum and the ligaments of the uterosacro. A radical resection of the ligaments of uteroscras was carried out and rectal arons were preserved, which vehiculate rectal irrigation (arteries and hemorrhoids). Approaching the bladder pole is one of the limiting steps to perform the procedure completely laparoscopy. However, accurate anatomical knowledge combined with increased imagery allows the section of the bladder pillar to be performed safely, avoiding frequent bleeding, which is often abundant and difficult to control in a conventional abdominal radical hysterectomy6. First, a wide autopsy of the vesicovaginal space was carried out and the release of the uterine artery from the roof of the salvaged parameter. Pulling the bladder column upwards allows you to expose the arch or tunnel of the ureter. By blunt autopsy we can identify the vesicuter veins that cross the abtuce over the ureter (Figure 5). After the clotting and section of these veins, the sub-Ureteria fibrous tissue section was continued. In this area is the middle vein of the bladder, which can be identified and sections individually. The section of vesicovaginal fibrous tissue continued down to expose the amount of vaginal cuff I wanted to dry. At that time the ureter was completely released before it entered the trigon, the anterior vaginal fascia and dry parameters hanging from the piece. Figure 5. Detail of the right vesicuter ligament: the back of the bladder (1); vaginal front face (2); bladder column (the path of vesicocer veins can be seen) (3); Ureter (4); paravesic pit (5) and paravesic fabric (6). In initial cases, the vaginal cuff section was performed on the colpotomiser of the uterine manipulator. The inability to perform vaginal touch without removing the manipulator, combined with the need to push the uterus forward, is due to the difficult and sometimes controlled section of the vaginal cuff. In recent cases, the fallopian manipulator has been removed to perform vaginal touch and orient part of the vaginal cuff, which is performed on a gauze fork placed for this purpose. This maneuver allowed for full control of the vaginal section. The vagina was snoucially (in these cases the vagina is reduced and the vaginal stitch is usually more comfortable along the way than the laparoscopic route). The abdominal cavity was reinsuffle, hemostasis was checked, a suprapubic bladder catheter was placed, and breathing intraabdominal drainage raid remained. Histological examination of the pelvic nodes was carried out lazy. In cases of ganglion metastases, transperitoneal laparoscopic lymphadenectomy was scheduled 7-10 days before additional treatment. The Postoperative Management Patients began mobilizing and verbal tolerance the next day. At the 2.o-3.er day of the postoperative period, a suprapubic catheter was painted and the volume of residual urine was measured after spontaneous urination. When the volume of residual urine was 100 ml, bladder drainage was maintained and a new definition of residual urine was performed at 24-48 hours. If large amounts of residual urine are retained, the patient has been instructed to process intermittent catheterization itself after each urination of up to 100 ml of zlt; achieved. The function of the bladder has been evaluated in a month, 6 months and 12 months of intervention in terms of normal urinary tract function, reduced filling and emptying sensations, and the need for abdominals associated with intermittent autocateterism or not. Subsequent cancer treatmentIn indication of additional chemotherapy or radioterpal treatment was based on an association of risk factors Tumor size is 2 cm, unfavorable histology, lymphovascular infiltration, deep stromal penetration, near surgical edges (It; 5 mm), vaginal infiltration, endometrial or parameteration, and ganglion metastases7. Subsequents will be held every 4 months for the first 3 years. The average follow-up time was 26 months with a range of 6-48 months. Between May 2003 and December 2006, 31 consecutive cases of cervical cancer were planned as part of laparoscopy. The average age was 47.7 years (range: 30-77 years) and body mass index was 26.1 (range: 15-44). The FIGO stage and histological characteristics of tumors are reflected in Table 1. 3 cases of ib2 stage (tumor size x 4 cm) correspond to young patients with an average age of 37.1 years. In these cases, a transperitoneal laparoscopic laparoscopic lymphaden ectomy ectomy was performed and received an average of 11.2 knots, negative in all cases. Radical hysterectomy was programmed after 2-3 cycles of neoadjuvant chemotherapy, with a favorable response (tumor reduction of more than 50%), except for one programmed case; feasibility study was 96%. This case was for a patient with significant centipetal obesity, in which it was not possible to obtain adequate surgical field laparoscopy, so the procedure was chosen by laparotomy. : in 2 cases, a laparoscopic seam was performed, and in another case, Pfannenstiel's laparotomy at the end of the intervention, for the seam of bladder damage located in the trigon; it was also necessary to re-implant one of the urethers in the vicinity of the injury. No other related operational complications were reported. The average operating time was 258 minutes, with a range of 180-360.La the corresponding postoperative level of complications was 17% with 5 cases: 1 one-sided hydronephrosis, which was solved with cystoscopic creation of the double diure catter; 1 sepsis of a urinary tract infection that required hospitalization in the intensive care unit for 3 days and 3 vesicovaginal fistulas (2 of which were resolved with permanent bladder tube maintenance for 1 month, and another case required laparotomy for seam). It was the only case that required surgery. The level of blood transfusion during the stay in the hospital was 13% (4 patients). The overall average hospital stay was 7.8 days (range: 2-29 days), for simple cases was 5.2 days and for cases with complications - 16.1 days (19%). In 84% of cases operating parts had a free surgical margin (n. 25); in the remaining 16% (n.5) they had resection fields close to less than 5 mm from tumor. The average tumor size was 26.5 mm (range: 4-68 mm); 4.75 mm for FIGO IA2 stadiums, 28.1 mm for FIGO IB1/IIA stadium; 57.7 mm for IB2 stadiums. vaginal infiltration was against 2 (7%) parameters in 2 (7%) endometrium in 2 (7%) infiltration of lymphoed eye space by 8 (27%) cases (table 1). The average number of pelvic nodes received was 19 (range: 6-31). The positive ganglion speed was 17% (5 cases), 4 of which corresponds to IB1 stadiums and 1 case at the IB2 stadium, FIGO IB1. In these cases, transperitoneal laparoscopic lymphadenectomy was performed and an average of 9.5 nodes were obtained; Found 1 (20%) case with ganglion metastases. No corresponding perioperative complications have been reported; the average stay was 1.5 days for this procedure. The introduction of a technical nerve-preservation manoeuvre in the last 13 cases meant an increase in total working time of approximately 30 minutes (table 2). At the time of discharge from the hospital, 30% of patients were supported by bladder atony with residual volumes of urine more than 100 ml and were sent to their home with a permanent bladder catheter. The probe was removed within 7-10 days of outpatient consultation. By the month of the intervention, 72% had restored myactor reflexes. The remaining 28% of patients supported the hypotension of the derusor, which requires abdominal pressure for accidental urination or female catheterization. By 6 months, 60% of these patients had normalized urination; the rest urinated spontaneously, though he had little filling and emptying sensation. By 12 months, 80% had normalized urination, and the rest had partially restored the feeling of miration, except in one case, with the persistence of the hypotension of the derusor, which required rehabilitation measures. In our experience, while faster recovery of the sensations of myation was evaluated in cases where nerve retention was performed, long-term differences were not significant. It is noteworthy that 4 patients had urinary incontinence under stress de novo; 2 of them were treated by placing a group free of TVT stress, and the other 2 were treated conservatively (rehabilitation). Three (10%) patients reported severe constipation after surgery and required a digestive unit evaluation. It was pointed out that due to risk factors, treatment 12 (40%) Cases. The average follow-up time was 26 months (range: 6-48 months); Five patients were outraged, and the overall survival rate without disease was 83.4%. The HIV-free survival rate at the FIGO stage was 100% for the IA2 stage, 82.6% for the IB1/IIA (n.4) stadium and 66.7% for the IB2 stadium (n. 1). Disease-free survival curves are reflected in Table 3.Relapses were located in the pelvis (3 cases), retroperitoneal nodes (1 case) and epiplone and spleen (1 case) (table 3). Rescue surgery was shown in 3 patients consisting of ganglion cytore duct (1 case), radical omentectomy with splenectomy (1 case) and laparotomy to assess pelvic extosion (1 case). In this case, exantering was interrupted by intraoperative histological confirmation of pelvic wall tumor infiltration. At the time of completion of the study, 2 patients died of relapse, 2 are alive with the disease and 1 patient is alive and free of visible diseases, and the overall survival rate is 93.3%. DISCUSSION In our experience we see that general laparoscopic radical hysterectomy is a feasible method in most cases (96%), with lower perioperative morbidity and medium-term survival rates comparable to those mentioned in the scientific literature for the laparotomic standard. Guangyi et al1 recently published (2006) a comparative observation with 90 cases of general laparoscopic radical hysterectomy against 35 cases of abdominal radical hysterectomy. According to other published series, they relate to a significant increase in the laparoscopic path time (262 vs. 217 minutes). The incidence of intraoperative complications was 8.9% (4 venous lesions and 4 random cystotomy) and 40% for postoperative complications (29 urine retention, 2 urinary fistulas, 1 intestinal obstruction and 4 lymphocysts). They found no significant differences in blood loss, the number of removed pelvic cells and the time to restore bladder function in the abdominal cavity. Another recently published series (2006) is that of Ramirez et al, of md Anderson Cancer Center, about 20 cases of general laparoscopic radical hysterectomy. The opening time was 332 minutes (range: 275-442 minutes). Link 3 (15%) perioperative complications (1 random cystotomy, 1 pulmonary embolism and 1 mediatic emphysema) and 2 (10%) postoperative complications (1 vaginal evisceration and lymphocysts). One patient (5%) required blood transfusion and the range of hospital stay was 1-5 days. One of the most numerous series of full laparoscopic radical hysterectomy was published by Spiros et al9; refers to the 94% feasibility of the method for 78 consecutive cases of cervical cancer. Five cases require conversion to laparotomy: 2 for bleeding, 1 for repair of cystotomy, 1 for placing a urethron catheter and 1 case for inability to maintain pneumoperiton. The average working time was 205 minutes. The postoperative level of complications was 9.1%: 1 urinary fistula, deep vein thrombosis, 1 urinary sepsis, 1 vaginal abscess and 2 lymphocysts. The transfusion rate was 1.3% (1 case) and the average stay was 2.9 days (range: 1-7 days). In the Abu-Rustum et al10 series, with 19 cases of laparoscopic general radical hysterectomy, two transformations into laparotomy (one for bleeding and one for bladder shinglear) are reported. The feasibility rate was 89%. There are no appropriate perioperative complications, except for one case of fever of unknown origin. The transfusion rate was 5% and the average stay was 4.5 days (range: 3-11 days). In the Pomel et al11 series, in which 50 cases of cervical cancer, of which 31 received previous brachytherapy, the average time was 258 minutes. In two cases, a surgical reburial was required: 1 urinary fistula and 1 genitourinary stenosis. The average rest was 7.5 days. In our country, Gil-Moreno et al12 published a series of 27 cases of total laparoscopic radical hysterectomy in cervical cancer with the radicality of PIVER II (n. 4) and PIVER III (n. 23), mentioned in feasibility 92%, average working time of 285 minutes, no corresponding surgical complications and postoperative complication level 31%, they are all of lesser. The transfusion rate was 7% and the average stay was 5 days (range: 4-10 days). In these common laparoscopic radical hysterectomy series, low perioperative blood transfusion (1-15%) is particularly significant. Compared to the historical series of abdominal radical hysterectomy (40-80%)13. The specific problem with radical hysterectomy is the risk of functional urinary tract sequelae, This problem is directly related to surgical radicalization and is observed in the 15-20% historical series PIVER III14 abdominal radical hysterectomy, bladder, which may curb the need for intermittent self catheterization and rehabilitation measures. The increase provided by the laparoscopic image allows to identify and preserve part of the autonomous vegetative system responsible for regulating the function of the urinary tract: (a) the roots of the splinter nerves (parasympathetic system) located in the lower third of the parameter (nerve parsa) and b) the lower hypogastric plexus (sympathetic system) attached to the side of the uterus. However, the autopsy of terminal nerve fibers that are inert bladder has not yet been determined. These fibers, efferent from the lower hypogastric plexus, work in the thickness of suburethral paracervical fibroadipos tissue and cross the bladder of the vesiyary abutment. Radical resection of vaginal cuff and paravarvic tissue is necessary in type III radical hysterectomy and necessarily includes a section of these terminal nerve fibers15. The preservation of these tissues is likely to lead to a significant reduction in bladder incidence; however, this would call into question the radicality of the surgical procedure oncology, as these tissues are potential pathways for local spread of the disease. Therefore, full nerve preservation surgery should be carefully evaluated based on the potential for the local spread of the tumor. In our experience, partial nerve preservation performed at the roots of spical nerves and lower hypogastric plexus has not demonstrated a significant reduction in long-term bladder incidence (12 months). The rate of relapse and, finally, survival are the defining elements that must prove the effectiveness of the new surgical technique in oncology. Therefore, it is important that the survival results of the new technique be comparable to conventional surgical treatment. However, there are no promising and randomized studies comparing laparoscopic pathway with abdominal pathway in radical cervical cancer hysterectomy. Statistically significant results (r zlt; 0.05), taking into account 12% of relapses and 8% mortality, 1,400 patients should be recruited (beta x 0.1 and alpha x 0.05)1. Even in the countries with the highest incidence, such multicenter studies are likely to be prohibitive. In all, several series have been published so far, including more than 200 cases of full laparoscopic radical hysterectomy with medium-term follow-up. The results are comparable to abdominal radical hysterectomy. The largest series corresponds to Guangyi et al1, with 90 cases, which 12 cases of IB2 stage tumors (4 cm of tumors). With an average subsequent rate of 26 months (range: 5-84 months), they refer to a relapse rate of 13.8% and a mortality rate of 10%, similar to their abdominal series of 35 cases (12 and 8%, respectively). Spiros et al9 provide a series of 78 consecutive cases of cervical cancer stage IA2 and IB1, followed by an operation of at least 3 years; relapse rate was 10.3 per cent and the mortality rate was 3.5 per cent. Pomel et al11 provides a series of 50 phased IA2 and IB1 cases (31 of them treated with brachytherapy prior to intervention), with a relapse of 6% and an overall survival rate of 96.8%. In the Gil-Moreno12 series of 27 inconsistent cases of general laparoscopic radical hysterectomy in cervical cancer at stages IA2 (n.4) and IB1 (n. 23), with an average tumor diameter of 26 mm, and with an average follow-up of 32 months, no recurrence was reported. In our series of 30 patients, which includes 3 ib2 stage cases, with an average follow-up time of 26 months, we received a relapse rate of 16.6%, with a total disease-free survival rate of 83.4%. These rates of relapse and survival are comparable, in general, with results published for the historical series of abdominal radical hysterectomy. LEADING laparoscopic radical hysterectomy is a feasible technique in most patients with cervical cancer. The effectiveness and safety of the method is comparable to the standard of the abdominal cavity. The laparoscopic route approach requires more work time, but has a lower perioperative morbidity than the abdominal pathway due to intraoperative complications, blood transfusion needs and hospital stays. It also has the overall benefits of minimally invasive surgery in relation to cosmetics, abdominal wall complications, faster recovery and less intestinal adhesive formation. In a published series of observational studies, the results of relapses and medium-term survival are comparable to abdominal results. However, in the absence of direct clinical data based on prospective and randomized trials, a more broad indirect clinical evidence, with more multiple series and long-term follow-up, will be required to consistently establish the role of full laparoscopic radical hysterectomy in the surgical management of cervical cancer. Cervical. hysterectomia radical laparoscopica tecnica quirurgica. videos hysterectomia radical laparoscopica. hysterectomia radical laparoscopica video

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