Aortic utero-ovarian sentinel nodes and left infrarenal aortic lymph node dissection by ICG supported navigation

Kimmig, Rainer; Rusch, Peter; Buderath, Paul; Aktas, Bahriye

This text is provided by DuEPublico, the central repository of the University Duisburg-Essen. This version of the e-publication may differ from a potential published print or online version.

DOI: http://dx.doi.org/10.1016/j.gore.2017.02.003
URN: urn:nbn:de:hbz:464-20180108-141444-8
Link: https://duepublico.uni-duisburg-essen.de:443/servlets/DocumentServlet?id=45112

License: This work may be used under a Creative Commons Attribution-NonCommercial-NoDerivatives 4.0 International license.

Source: Gynecologic Oncology Reports, 2017, 20, 22-23; available online 9 February 2017
1. Abstract

Lymphatic spread in endometrial cancer occurs along two major pathways: the uterine vascular mesometrium to the pelvic iliac lymph compartment and via the ovarian mesonephric pathway (infundibulopelvic ligament) to the paraaortic nodes visualized in (Kimmig et al., 2016a,b). However, it could be shown that in pelvic negative nodes following pelvic lymphadenectomy and even pelvic sentinel node excision the incidence of positive paraaortics is as low as 1–2% (Abu-Rustum et al., 2009; Kim et al., 2016; Holloway et al., 2016; Zahl Eriksson et al., 2016). Thus, it could be reasonable to omit paraaortic and even pelvic systematic lymphadenectomy in patients with negative sentinels to reduce morbidity (Tschernichovsky et al., 2016). However, in patients with pT1b/G2 and 3 tumors percentage of isolated positive paraaortic nodes may be significantly higher (Kumar et al., 2014): paraaortic sentinel node resection may be useful to identify their risk correctly. In addition, ICG-guided navigation could also support the resection of the complete paraaortic compartment in case of proven positive nodes. In this video, the visualization of the lymphatic paraaortic drainage of the uterine corpus has been achieved by application of 4 × 0.5 ml of a 1.66 mg/ml solution of indocyanine green (ICG Pulsion®) intracorporal into the uterine fundus and midcorporal, right and left. It was injected via an Iowa-trumpet transcervically in about 0.5 cm myometrial depth, each.

The video defines the technique of “en bloc” resection of paraaortic nodes together with the connecting ovarian lymph vessels isolated from their attachment to the colonic mesentry and preserving the inferior mesenteric plexus. It will also be basis for identification of paraaortic sentinel nodes in an international multicenter study under consideration (Kimmig et al., unpublished data).

Appendix A. Supplementary data

Supplementary data to this article can be found online at http://dx.doi.org/10.1016/j.gore.2017.02.003.

References


Kumar, S., Podratz, K.K., Bakkum-Gamez, J.N., Dowdy, S.C., Weaver, A.L., McGree, M.E., Cliby, W.A., Keeney, G.L., Thomas, G., Mariani, A., Jan 2014. Prospective assessment
