



Extraperitoneal Paraaortic Lymphadenectomy Preserving Superior Hypogastric Plexus

Mikel Gorostidi Pulgar^{1*} and Antonio Gil-Moreno²

¹Hospital Universitario Donostia, Spain

²Hospital Universitario Vall d'Hebron, Spain

*Corresponding author: Gorostidi M, Basque Country University, Hospital Universitario Donostia, Basque Country, Spain, Tel: +34-943-00-7000; E-mail: mgorostidi@sego.es

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To Editor,

Superior Hypogastric Plexus (SHP) is frequently transected at paraaortic gynecological lymphadenectomy. We know very little about clinical implications of SHP transections, but we do know it can produce constipation as well as voiding and sexual disorders [1]. Morbidity at this level doesn't seem to be very severe, but there is no neurologic network in the body with no function, and if we cut them we have to be aware of the clinical implications of this action; perhaps clinical implications at this level, due to interrupting this complicated network of sympathetic fibers may not be important, or maybe paravertebral sympathetic trunk can supply some of these fibers through the splanchnic nerves, connecting both sympathetic nervous systems.

Nerve sparing surgery has demonstrated better outcomes in some settings, such as nerve sparing radical hysterectomy. Preserving inferior hypogastric nerve at colposacropexy is important as well, inasmuch as injury over sacral promontory close to PHS has been associated with postoperative obstructed defecation syndrome [2]. This neurologic preserving surgery has been possible thanks to each and every day better visualization of the pelvic structures with modern endoscopy allowing great visibility of all pelvic nerves and plexuses, and has evolved surgical oncological morbidity to thousands of patients in the world, overcoming many of the limits we had in the past.

But this question is still open at paraaortic lymphadenectomy [3]. We really need further research in this area, processing all available data and trying to obtain more prospective data, mainly affecting de-novo constipation or impaired arousal or orgasm in these patients. This can only be obtained through laparoscopic neuro-navigation and selective neuromodulation [4,5] and with a thorough pre and

postoperative anamnesis of the patients. If there is any clinical benefit of its preservation it's worthwhile doing some effort for it, if there is no clinical morbidity then its preservation has no sense.

SHP seems to be more feasible spared and with little effort at extraperitoneal paraaortic lymph node dissection, where the SHP is visualized at the roof the dissection and can therefore be more easily preserved [3]. It's really very difficult to preserve SHP at a transperitoneal dissection, where these fibers are in the middle of the surgical field, and are almost always cut, being most of the times not even visible. Future research must give appropriate answers to these questions.

Quality of life and consequences of surgery are being increasingly investigated. We have to think that everything we cut has a price, nothing is free in surgery, and we have to try to have the best results with the less prize for our patients.

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