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Sommario/riassunto

"For many patients with locally advanced primary or locally recurrent pelvic malignancy, pelvic exenteration (PE), involving radical multivisceral resection of the pelvic organs, represents the best treatment option. The first report of PE was in 1948 by Alexander Brunschwig of the Memorial Hospital (New York City, USA), as a palliative procedure for cervical cancer. 1 Due to high morbidity and mortality rates many considered palliative exenteration too radical, and initially it was performed only in a small number of centers in North America.2 Technologic advancements, surgical innovations and improved perioperative care facilitated the evolution of safer and more radical exenterative techniques for the treatment of advanced gastrointestinal and urogynaecological malignancies.3 Worldwide collaborative data 4, 5 have demonstrated that a negative resection margin is crucial in predicting survival and quality of life after surgery. Carefully selected patients who undergo en-bloc resection of all contiguously involved anatomic structures with R0 resection margins can now expect good long-term survival with acceptable levels of morbidity. 4, 5"--