Istituto Nazionale Tumori
Fondazione G. Pascale

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Linfoadenectomia retroperitoneale nelle neoplasie del testicolo

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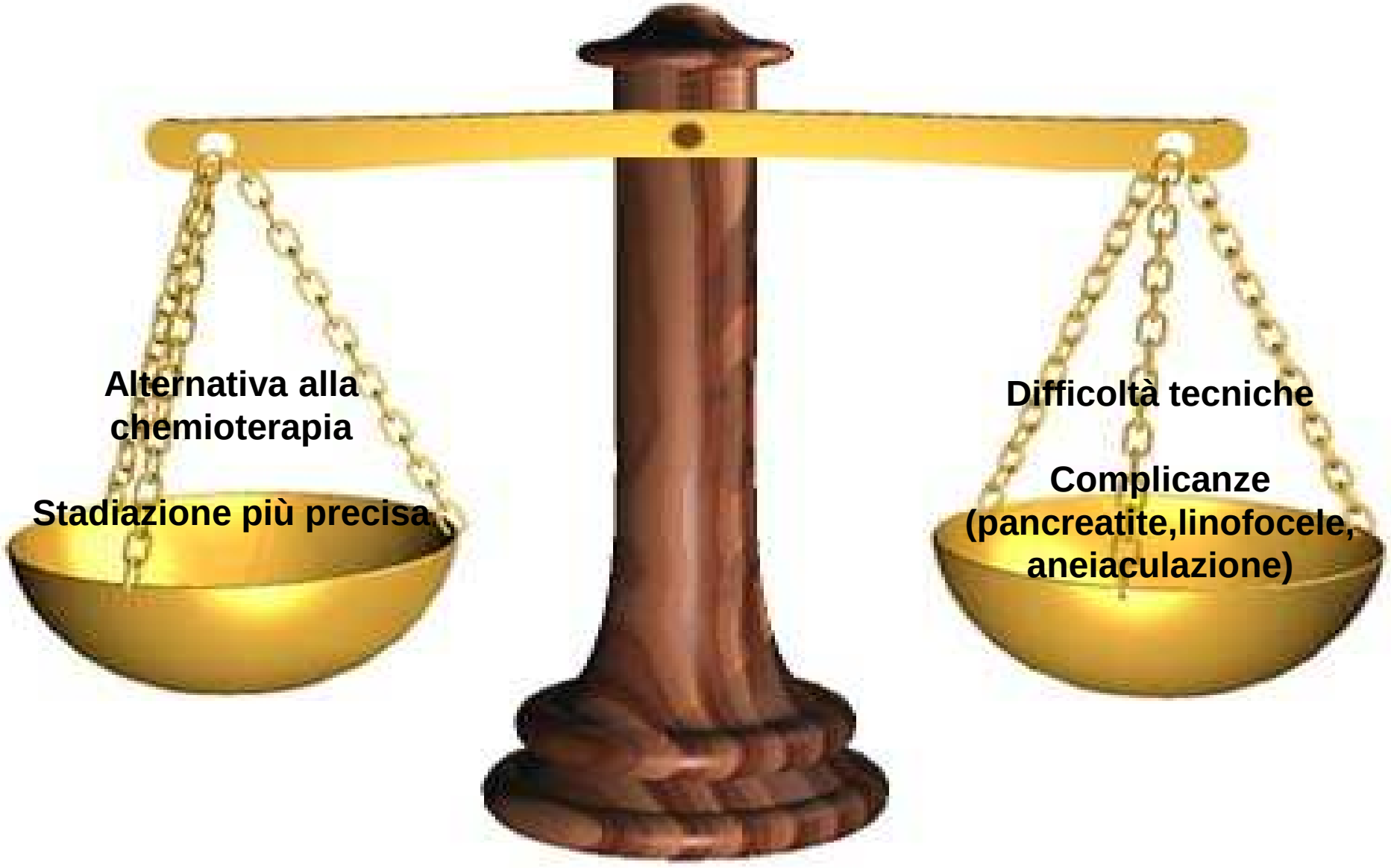
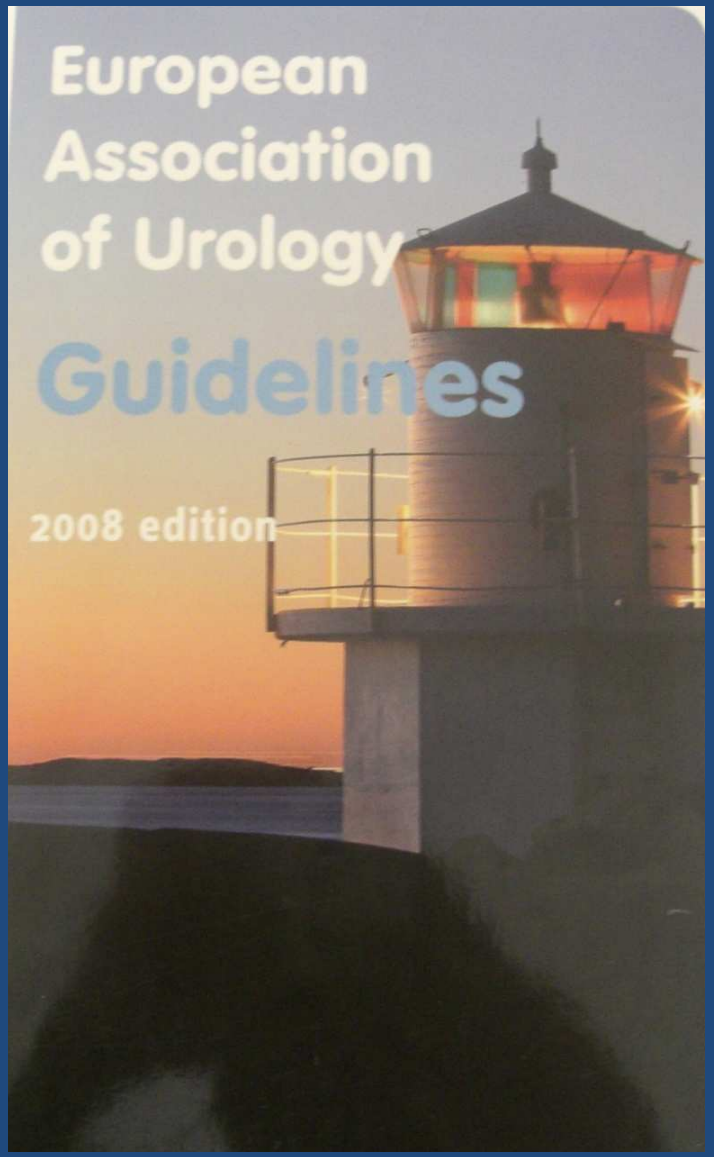
Tumore del testicolo

- Raro
- Il più comune 15 – 35
- Uno dei tumori solidi oggigiorno meglio curabili
- Approccio terapeutico multidisciplinare
- Ridimensionamento del ruolo di approcci chirurgici aggressivi in prima istanza

Linfoadenectomia RP





Guidelines on Testicular Cancer

P. Albers (chairman), W. Albrecht, F. Algaba,
C. Bokemeyer, G. Cohn-Cedermark,
A. Horwich, M.P. Laguna

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Association
of Urology

7.5 GUIDELINES FOR THE TREATMENT OF NSGCT STAGE I

CS 1
Risk-adapted treatments based on vascular invasion or surveillance are recommended treatment options (Grade of recommendation: B)

CS1A (pT1, no vascular invasion): low risk

1. If the patient is willing and able to comply with a surveillance policy and long-term (at least 5 years) close follow-up should be recommended (Grade of recommendation: B).

2. Adjuvant chemotherapy or nerve-sparing RPLND in low-risk patients remain options for those not willing to undergo surveillance. If RPLND reveals PN+ (nodal involvement) disease, chemotherapy with two courses of PEB should be considered (Grade of recommendation: A).

CS1B (pT2-pT4); high risk

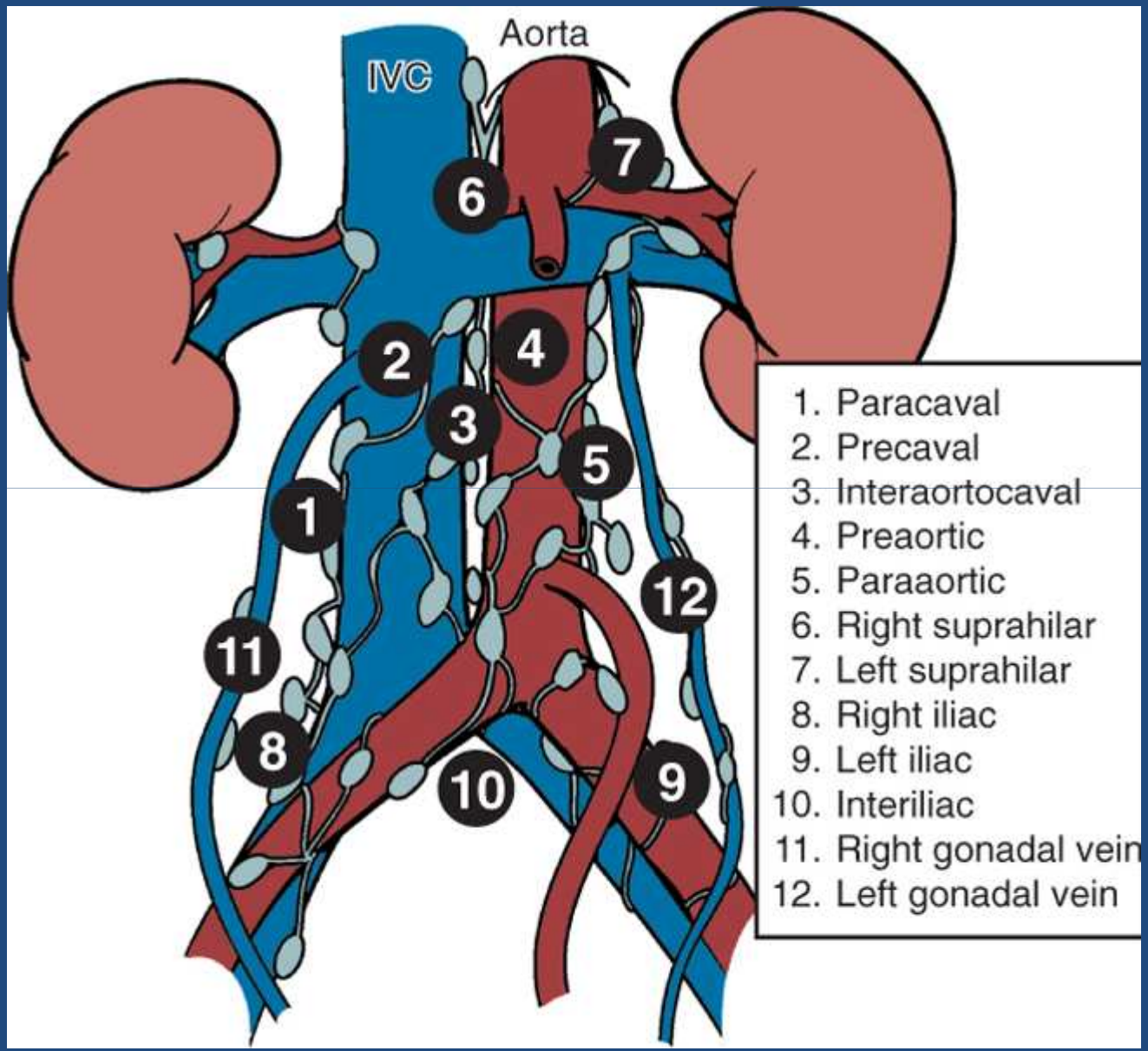
1. Primary chemotherapy with two courses of PEB should be recommended (Grade of recommendation: B).

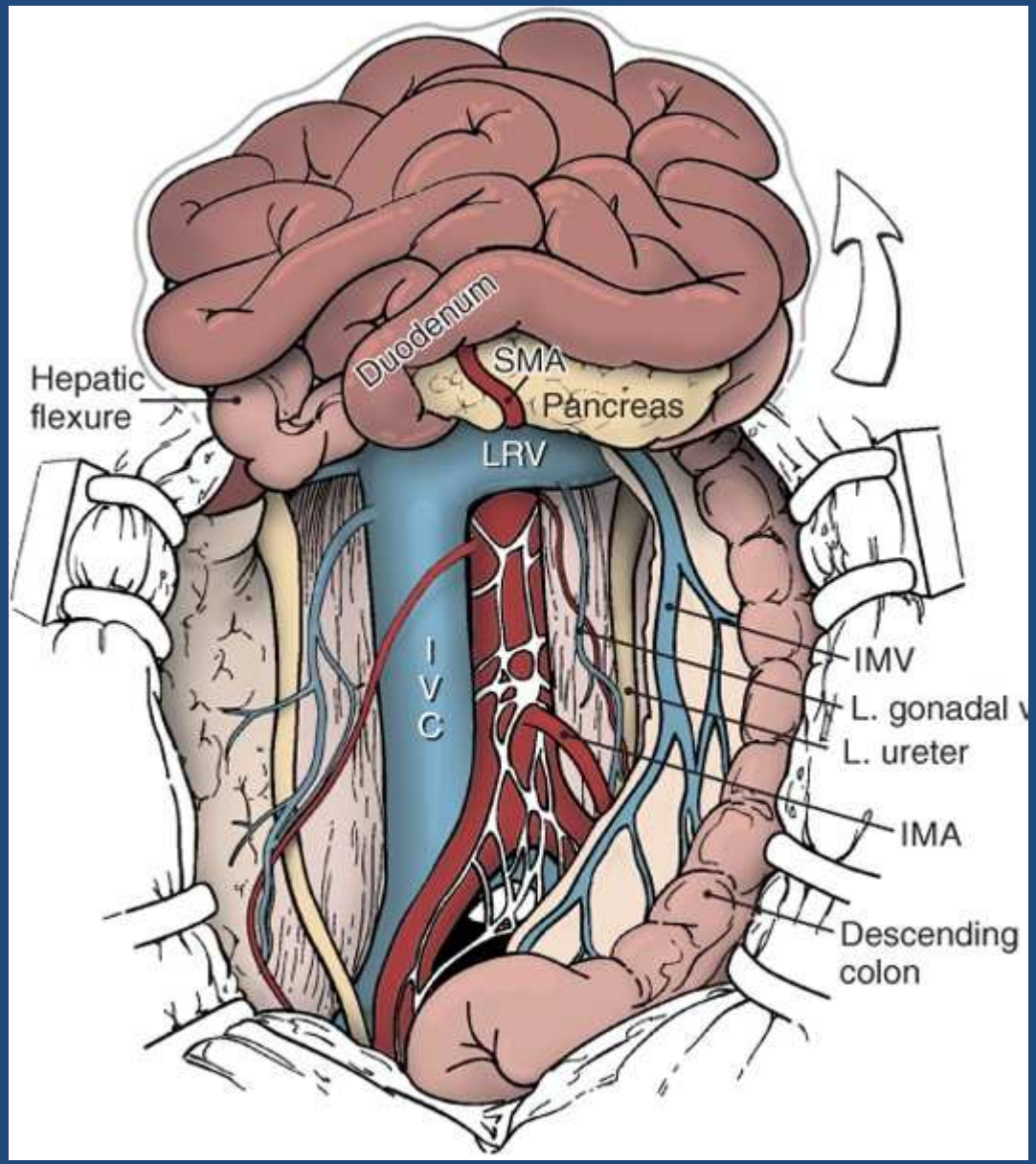
Surveillance or nerve-sparing RPLND in high-risk patients remain options for those not willing to undergo adjuvant chemotherapy. If pathological stage II is revealed at RPLND, further chemotherapy should be considered (Grade of recommendation: A).

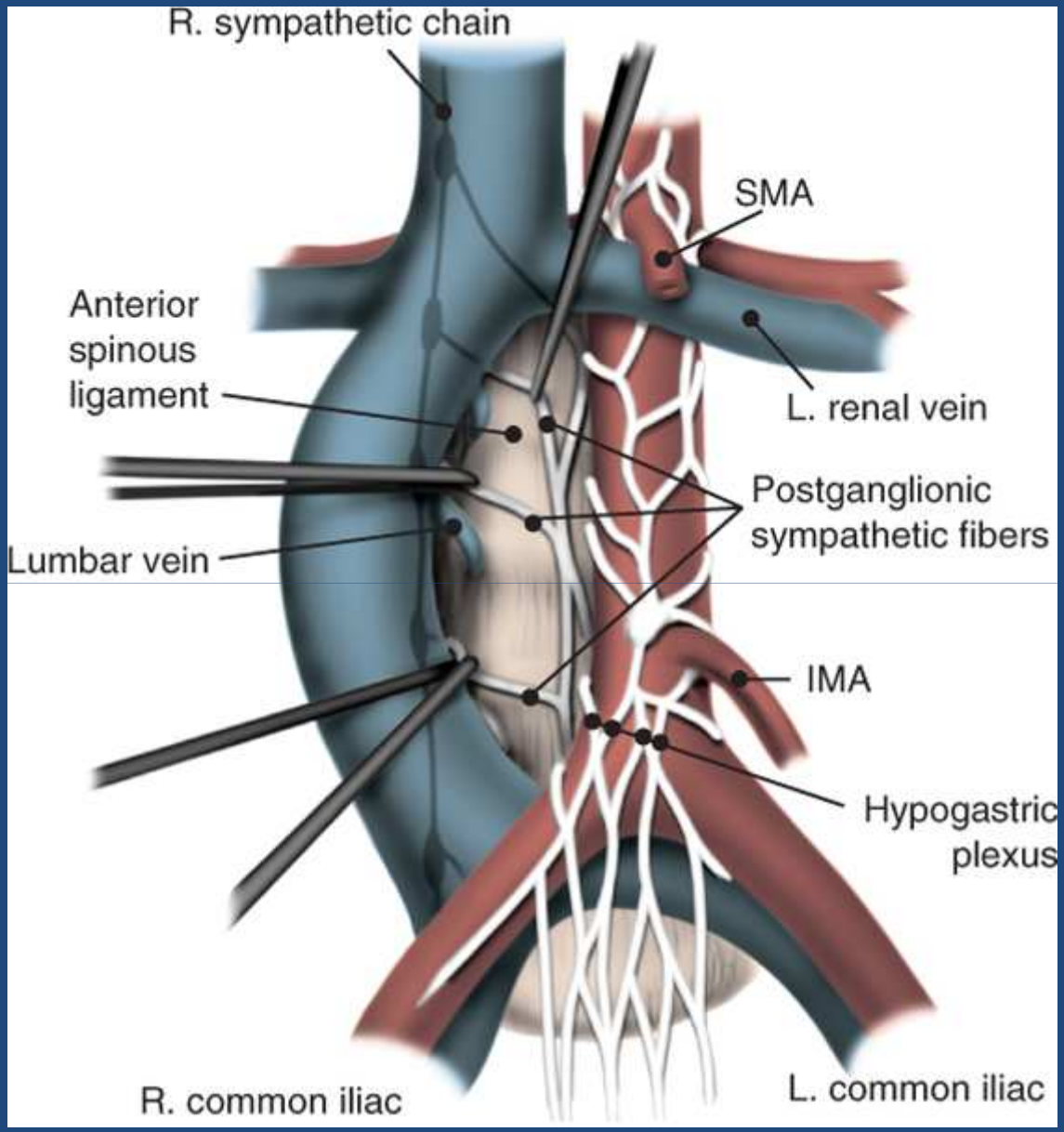
8.7 GUIDELINES FOR THE TREATMENT OF METASTATIC GERM CELL TUMOURS

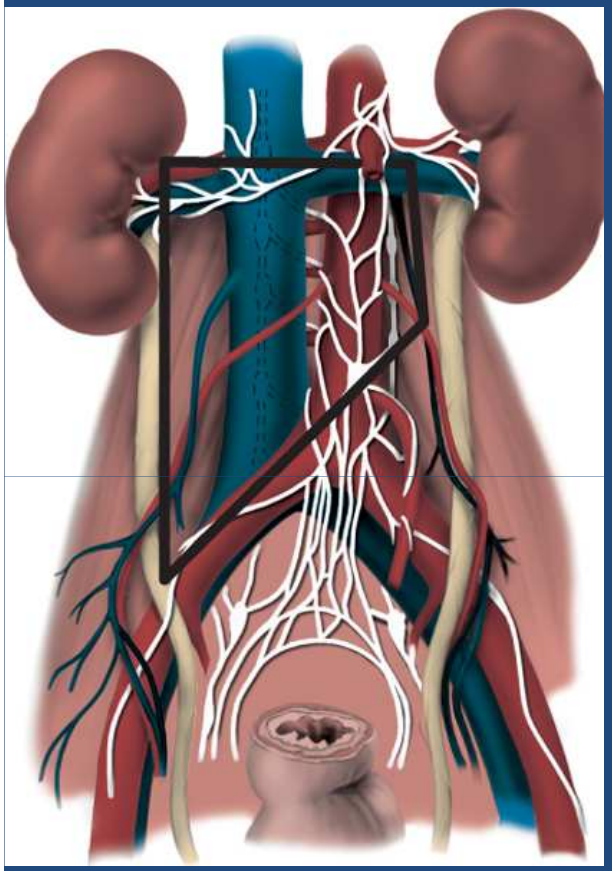
1. Low volume NSGCT stage IIA/B with elevated markers should be treated like 'good or intermediate prognosis' advanced NSGCT with 3 or 4 cycles of PEB. Stage II A/B without marker elevation can be treated either by RPLND or close surveillance.
2. In metastatic NSGCT (≥ stage IIC) with a good prognosis, three courses of PEB is the primary treatment of choice (Grade of recommendation: A).
3. In metastatic NSGCT with an intermediate or poor prognosis, the primary treatment of choice is four courses of standard PEB (Grade of recommendation: A).
4. Surgical resection of residual masses after chemotherapy in NSGCT is indicated in the case of visible residual masses and when serum levels of tumour markers are normal or normalizing (Grade of recommendation: B).
5. Metastatic seminoma with less than N3M1 disease can be treated initially with radiotherapy. When necessary, chemotherapy can be used as a salvage treatment with the same schedule as for the corresponding prognostic groups of NSGCT (Grade of recommendation: A).
6. Advanced seminoma (N3 or M1) should be treated with primary chemotherapy according to the same principles used for NSGCT (Grade of recommendation: A).

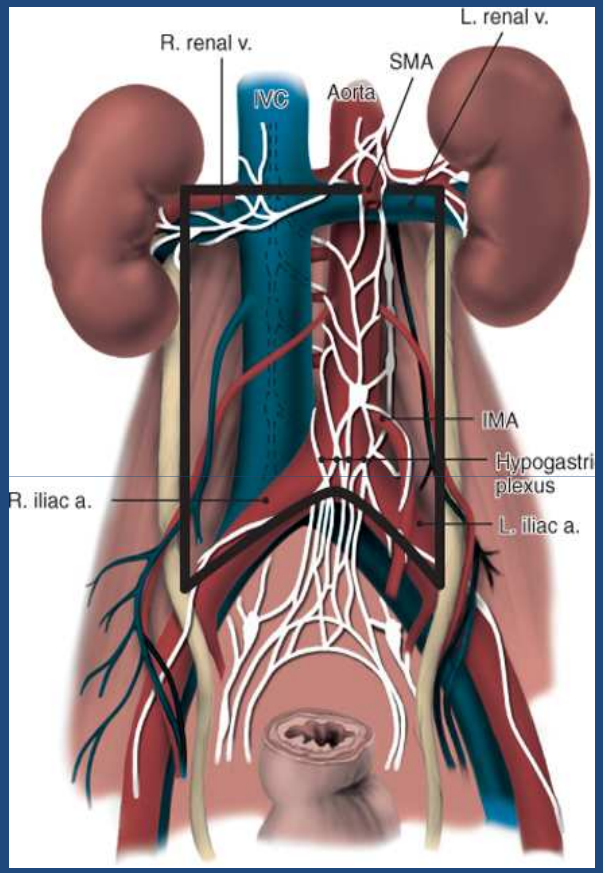
Regioni anatomiche del retroperitoneo

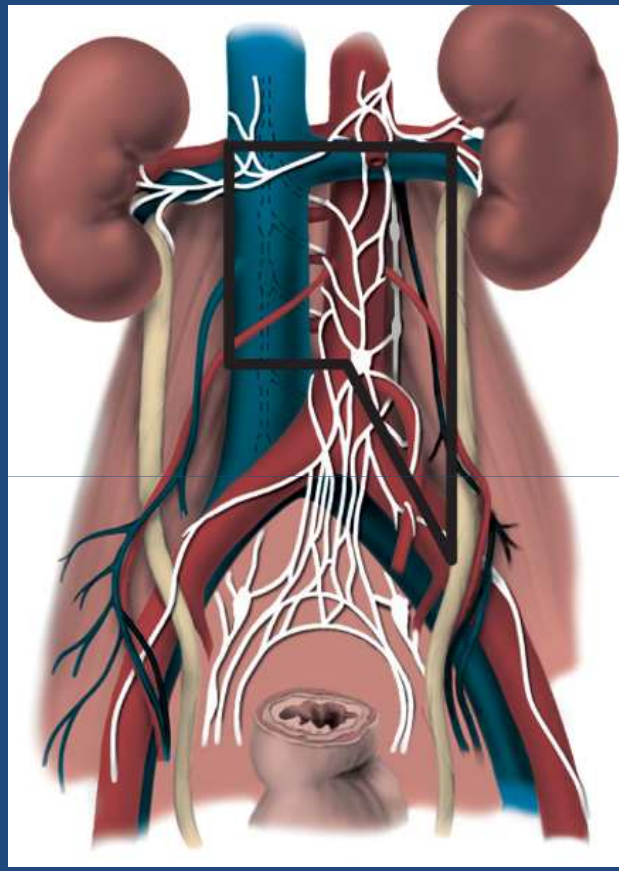



Hepatic flexure
Duodenum
SMA
Pancreas
LRV
IVC
IMV
L. gonadal v
L. ureter
IMA
Descending colon


R. sympathetic chain
SMA
Anterior spinous ligament
L. renal vein
Postganglionic sympathetic fibers
Lumbar vein
IMA
Hypogastric plexus
R. common iliac
L. common iliac




L. renal v.
R. renal v.
SMA
IVC
Aorta
IMA
Hypogastri
plexus
R. iliac a.
L. iliac a.



CASO CLINICO

- Paziente di 25 anni
- Ricovero: febbraio 2004
- Massa testicolare sinistra
- Noduli polmonari bilaterali 1.5 - 3 cm
- Linfoadenopatia metastatica massiva retroperitoneale (bulky desease)
- Alfafetoproteina: 140 ng/ml
- Beta HCG: >5000 mUI/ml
- LDH: Nella norma

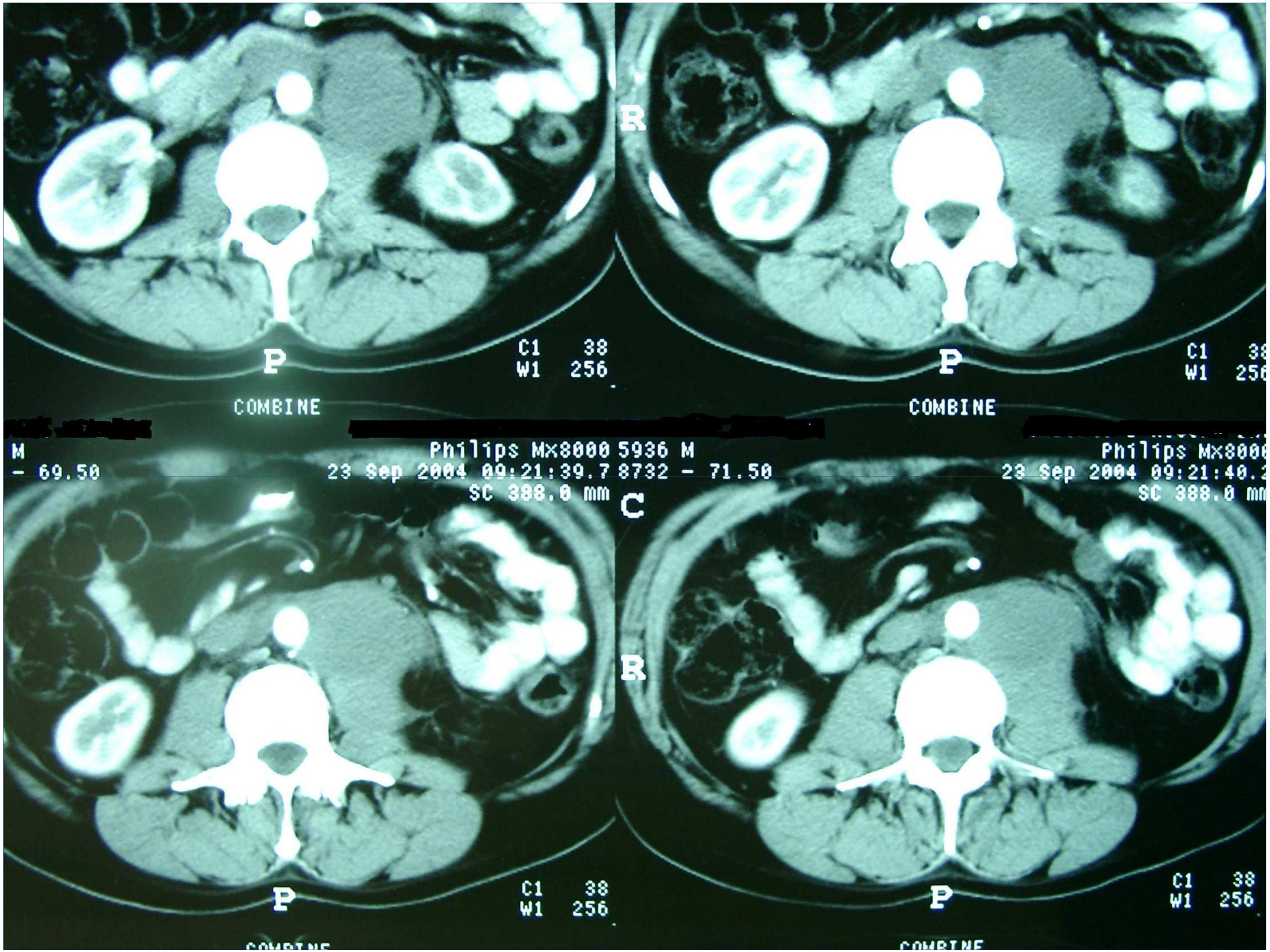
Orchifunicolectomia radicale sinistra

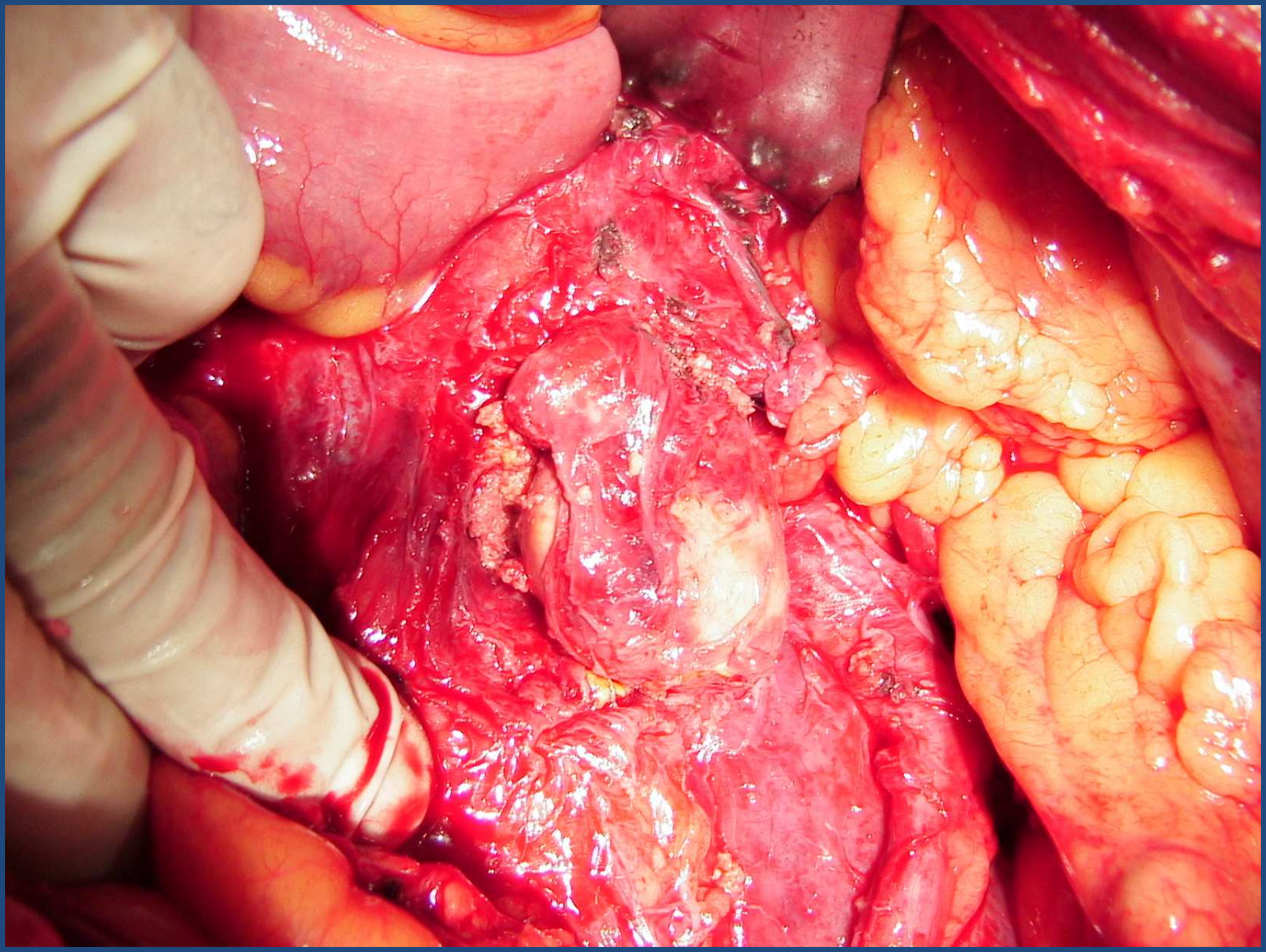
massa testicolare infiltrante il funicolo spermatico i vasi e i linfatici di origine mista: carcinoma embrionale 70% teratocarcinoma 30%

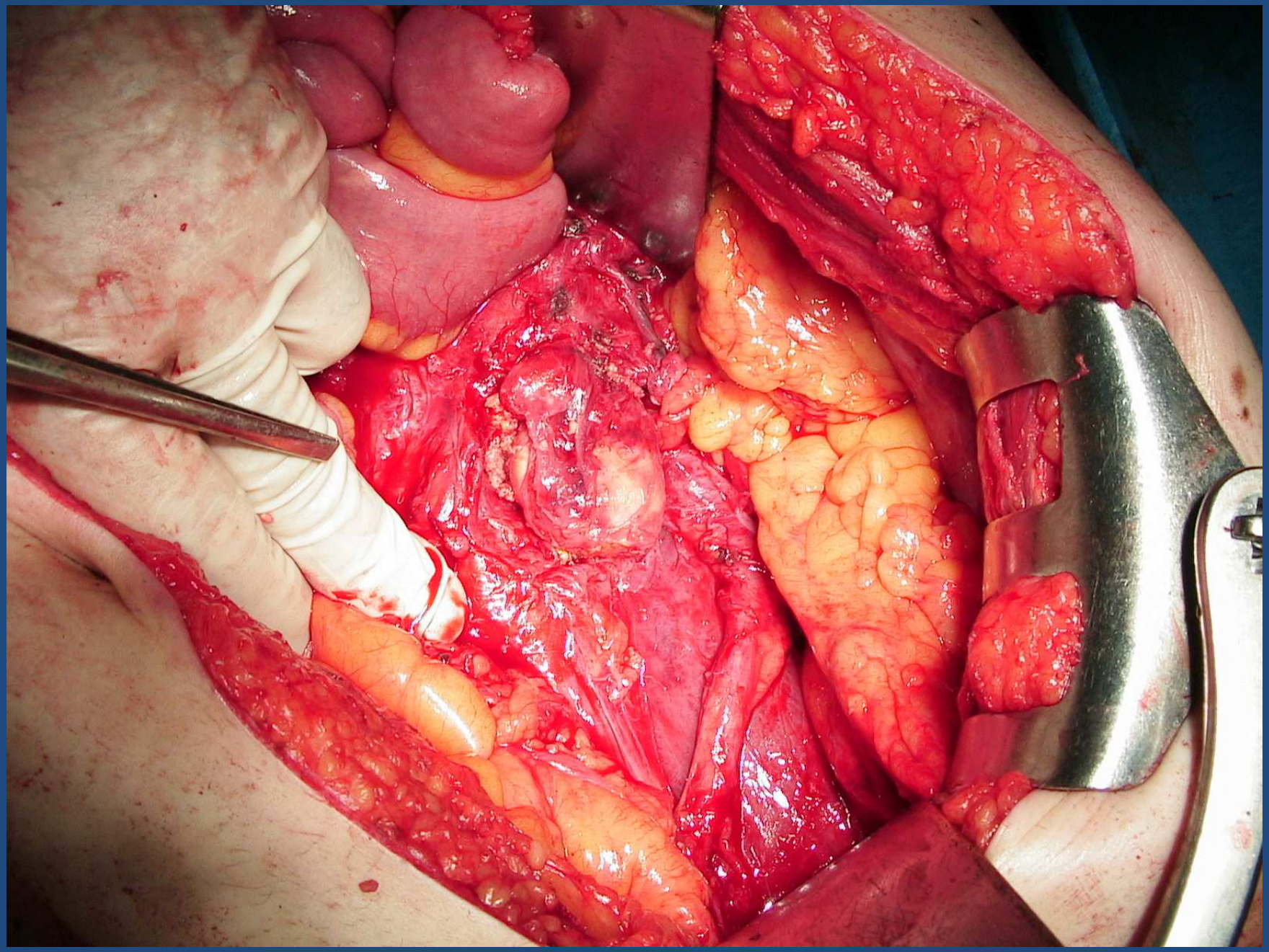
STAGING: Non seminoma T3 M1 N3 S2

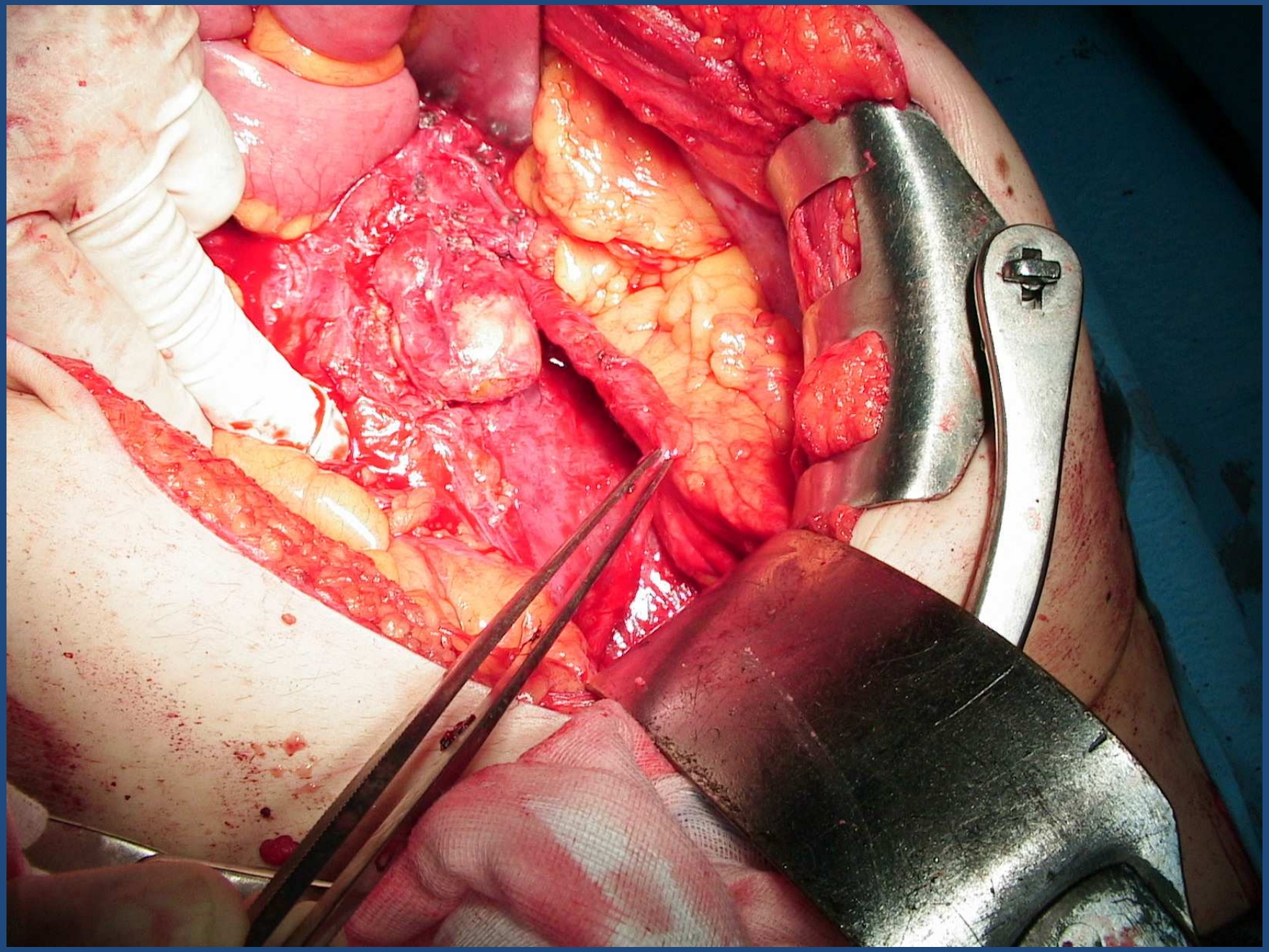
- Inizio chemioterapia: 3 cicli PEB
- Regressione totale dei noduli polmonari
- Alfafetoproteina: 25 ng/ml
- Beta HCG: 130 mUI/ml
- Lieve riduzione delle masse retroperitoneali

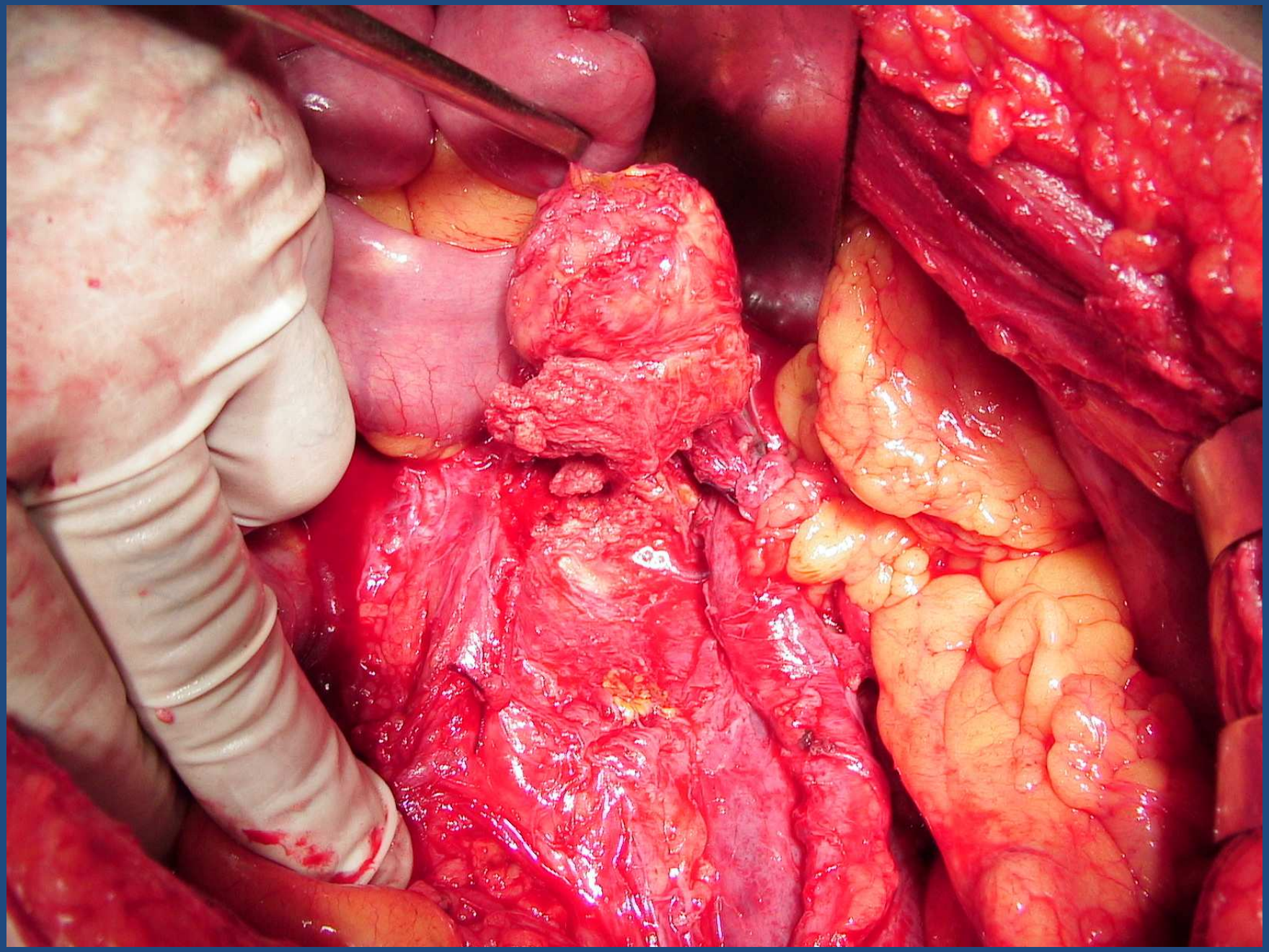
LINFOADENECTOMIA
“DI SALVATAGGIO”

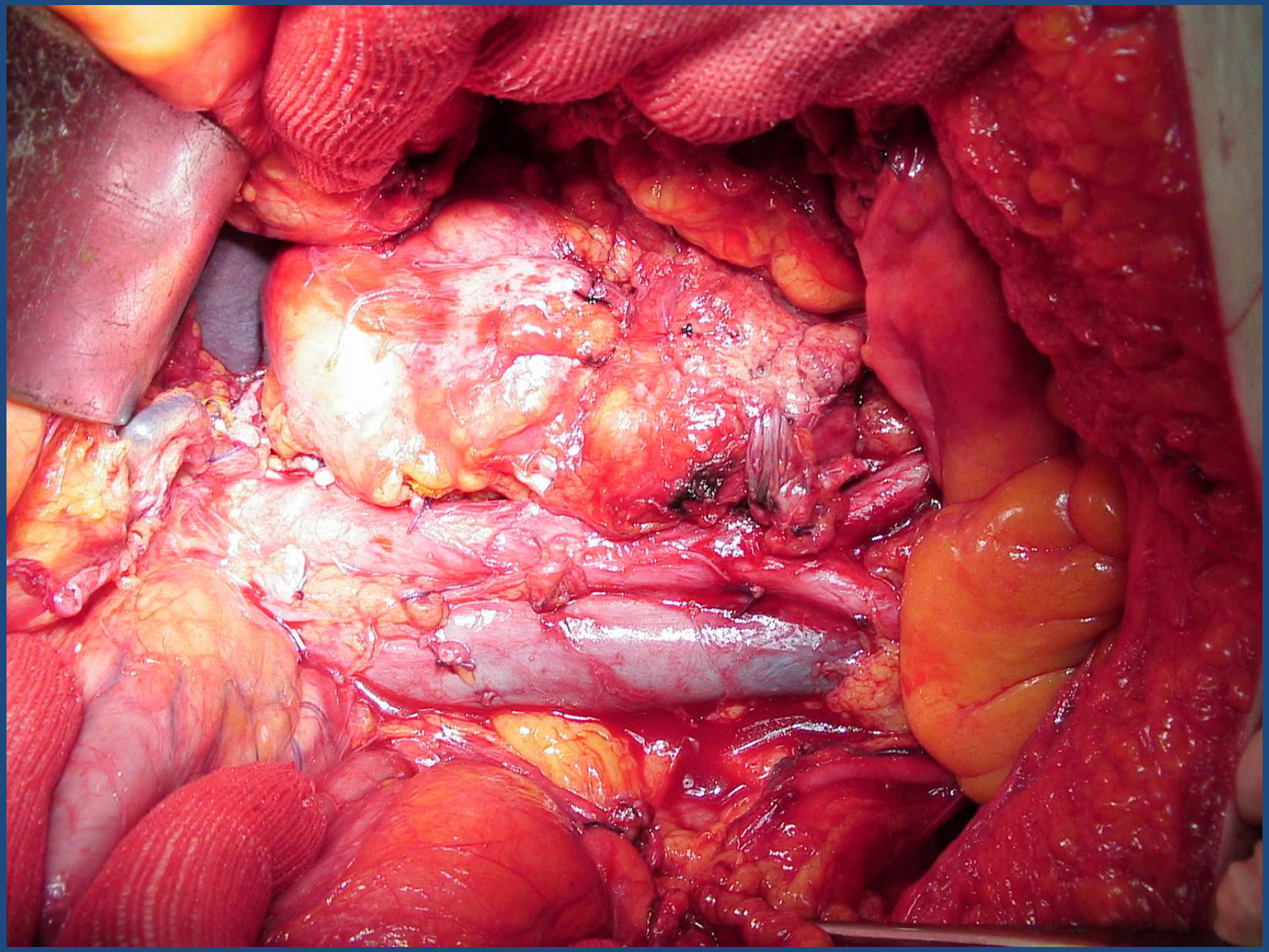

P
C1 38
W1 256
COMBINE
R
P
C1 38
W1 256
COMBINE
M
- 69.50
Philips MX8000 5936 M
23 Sep 2004 09:21:39.7 8732 - 71.50
SC 388.0 mm
C
Philips MX8000
23 Sep 2004 09:21:40.2
SC 388.0 mm
P
C1 38
W1 256
R
P
C1 38
W1 256

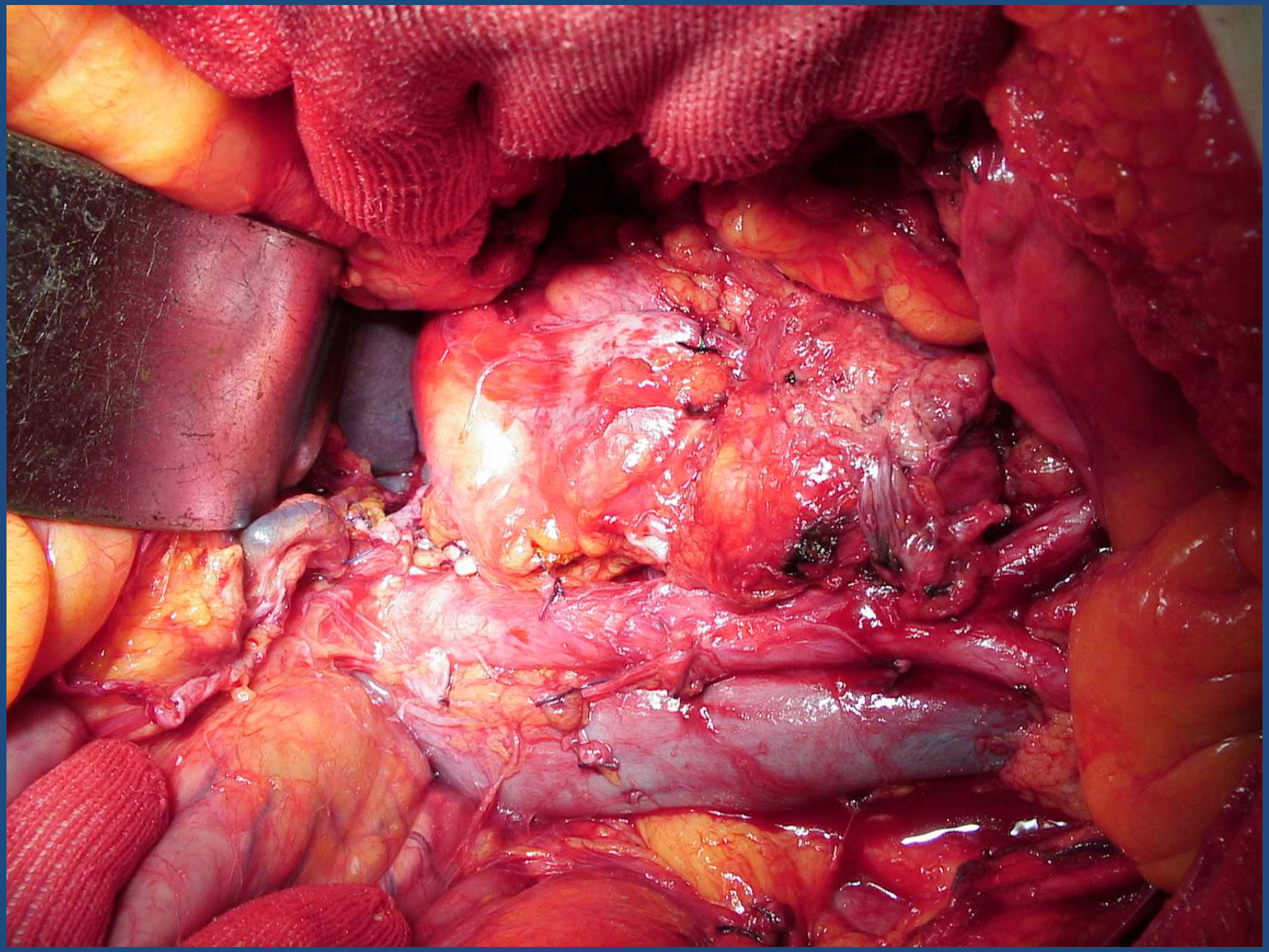


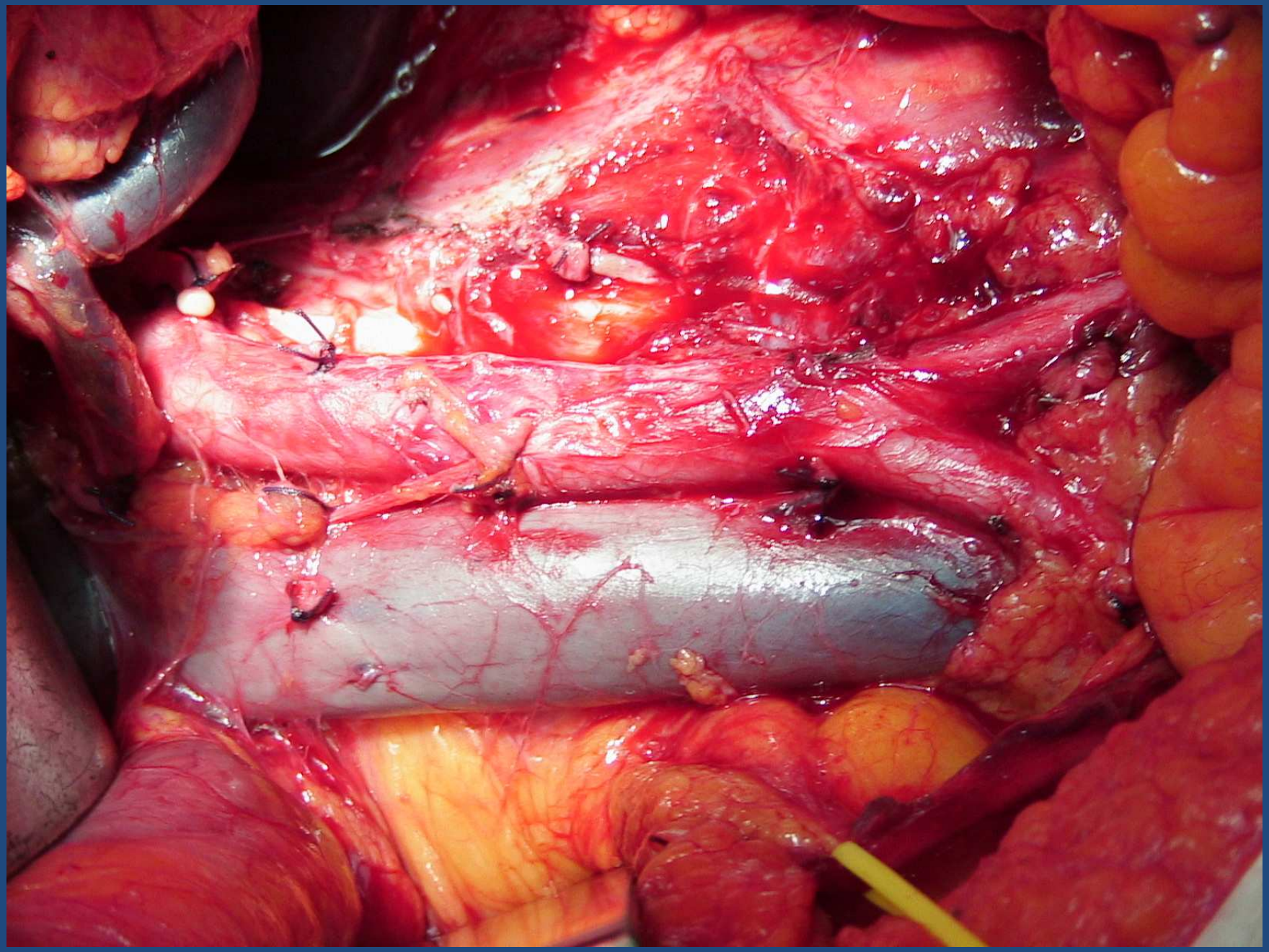


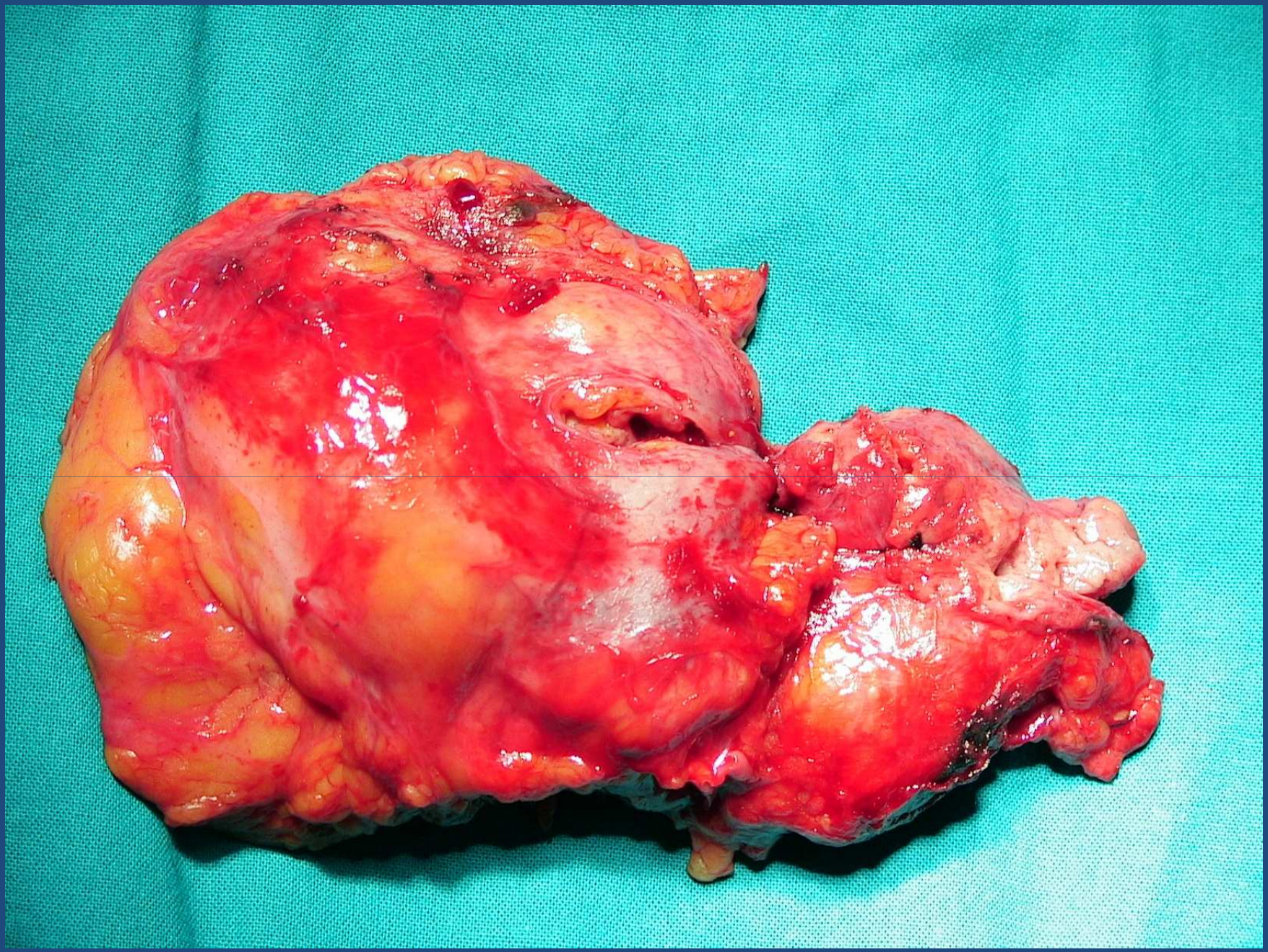


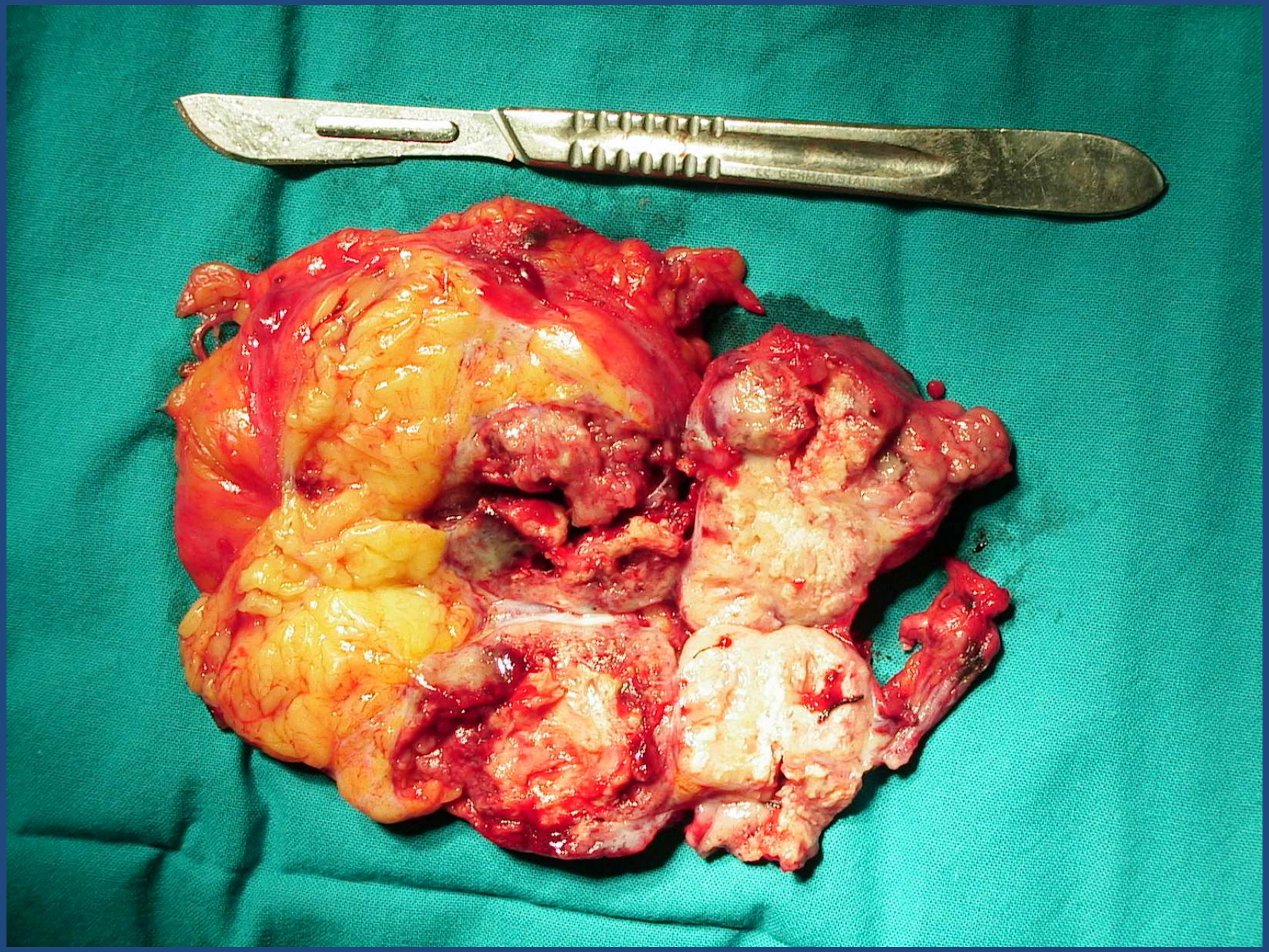


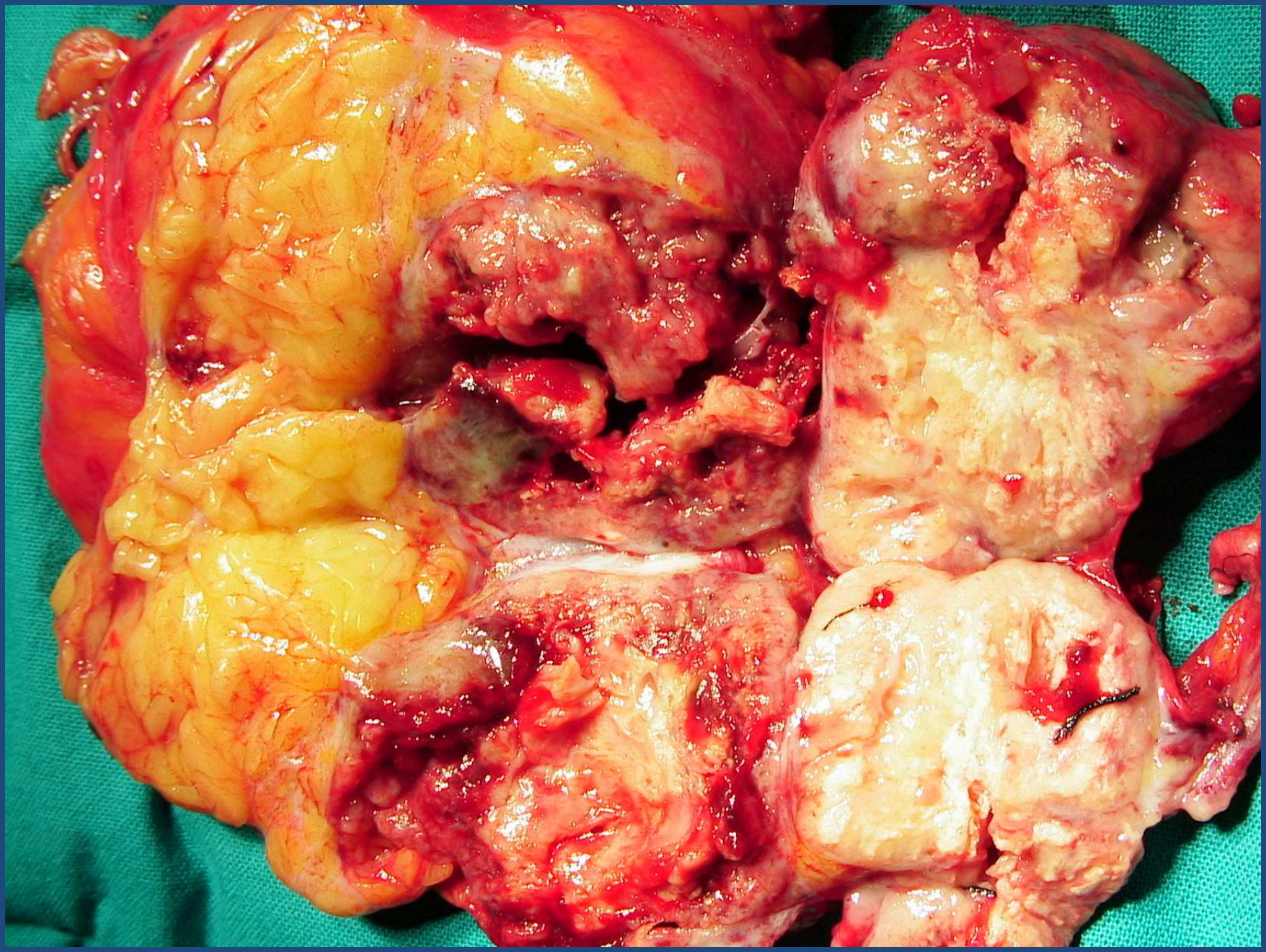












ESAME ISTOLOGICO SULLE MASSE ASPORTATE

- TERATOMA MATURO 90%
- CARCINOMA EMBRIONARIO 10%

- Trattamento chemioterapico di seconda linea (Vinblastina-Ifosfamide-Cisplatino)

- Follow up stretto

FOLLOW UP

- A 4 ANNI DI DISTANZA IL PAZIENTE E’ IN BUONE CONDIZIONI E LIBERO DA MALATTIA

- E’ PRESENTE ANEIACULAZIONE

CONCLUSIONI

NONOSTANTE LA CHEMIOTERAPIA SVOLGA UN RUOLO SEMPRE PIU' PREMINENTE NEL TRATTAMENTO DELLE NEOPLASIE TESTICOLARI AVANZATE, LA CHIRURGIA DI SALVATAGGIO SVOLGE UN RUOLO ANCORA OGGI INSOSTITUIBILE.

- la chirurgia laparoscopica e la preservazione dell'eiaculazione, non sono perseguibili in casi come questo

- la chirurgia radicale tradizionale basta da sola a salvare la vita del paziente

- …..e questo e' il compito principale cui, ancora oggi, e' chiamato l'urologo oncologo.

GRAZIE PER L’ ATTENZIONE