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Correspondence

Resurrection of the rectus abdominis musculoperitoneal flap for pelvic exenteration?

Dear Editor,

Becoming aware of the article of Cibula et al. (Cibula et al., 2017) entitled "Pelvic floor reconstruction by modified rectus abdominis myoperitoneal (MRAM) flap after pelvic exenterations" in Gynecologic Oncology made me curious: Has the rectus musculoperitoneal flap, a slimmed version of the transversus and rectus abdominis musculoperitoneal flap developed by us 20 years ago (Höckel, 1996; Konerding et al., 1997), resurrected as an effective adjuvant in pelvic exenterative surgery? Unfortunately, reading the complete paper was quite disappointing. The authors retrospectively compared 24 historical pelvic exenterations performed in their institution without pelvic floor reconstruction with 13 pelvic exenterations and 3 "ELSE" procedures that received "modified" rectus abdominis myoperitoneal flaps for pelvic floor reconstruction and found less reoperation and postoperative complication rates. Cibula et al. on one hand expect that the readers know what ELSE is and what is meant by the attribute "modified", although no literature references are provided. On the other hand, they assume that the readers are not familiar with the surgical principles and the anatomy of rectus abdominis myo(musculo-) peritoneal flaps despite previous publication in detail (Höckel, 1996; Konerding et al., 1997). Likewise, it is confusing that the authors use a "historic" (2007–2012?) cohort without pelvic floor reconstruction as control group. It is hardly imaginable that exenterative surgeons of the 21st century do not generally apply means to fill and cover the more or less empty pelvis. Transferring non-irradiated angiogenic tissue into the pelvic cavity and hiatus genitalis had been demonstrated decades ago as most effective way to reduce postoperative mortality and morbidity in exenterative surgery (Buchsbaum and White, 1973; Soper et al., 1989).

From our long-term experience with laterally extended endopelvic resection (LEER) for locally advanced and recurrent malignancies of the lower female genital tract we found omentum majus flaps combined with pudendal thigh, gracilis or gluteal thigh flaps most suitable to cover the pelvic side walls and fill completely any dead space - in addition to reconstruct the pelvic floor, cutaneous perineum, vulva and eventually vagina (Höckel et al., 2012; Höckel, 2015). Only in the rare situations of missing omentum majus we have applied and recommend rectus abdominis musculoperitoneal flaps. A prospective study with clearly defined endpoints using either omentum majus/thigh flap combinations versus abdominal wall musculoperitoneal flaps would have made the resurrection of the rectus abdominis musculoperitoneal flap more "believable".

Conflict of interest statement

The author declares to have no conflicts of interest concerning this manuscript.

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