

# Minimally Invasive Surgery's Impact on Gynaecologic Cancers

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## Introduction

### Cervical Cancer

In the treatment of early-stage cervical cancer with uterine preservation and pelvic lymphadenectomy, the radical vaginal trachelectomy with pelvic lymphadenectomy is used. It entails a laparoscopic pelvic lymph node dissection followed by surgical excision of the upper vagina, the afflicted cervix with a sufficient margin, and the cardinal and uterosacral ligaments through a vaginal route [1]. After that, endocervical and endometrial sampling is performed above the radical trachelectomy specimen, with intraoperative pathologic examination of surgical margins. The patient must be of reproductive age, want fertility, and have a cervical lesion of less than 2 cm to be considered for radical vaginal trachelectomy. Although involvement of the lymph vascular space and histology are not definite contraindications to doing this treatment, all cases are presented before our weekly tumour board to assess the procedure's acceptability for each patient. With low recurrence rates and several healthy pregnancies, radical vaginal trachelectomy is becoming a viable option for people with precancerous cervical cancer who want to preserve their fertility [2].

### Endometrial Cancer

In patients with serous endometrial cancers, the laparoscopic staging technique involves a laparoscopically assisted or complete vaginal hysterectomy with pelvic and Para-aortic lymph node involvement, peritoneal wash cycles, and an omentectomy. Patients with endometrial cancer who were treated with a laparoscopic technique had decreased hospital expenditures. The laparoscopic method was compared to exploratory laparotomy for endometrial cancer staging. The results of a randomized, prospective clinical trial comparing laparoscopy vs. laparotomy for endometrial cancer survival. It's also not unusual for people with endometrial cancer to be staged incorrectly following their initial surgery [3].

### Minimally Invasive Surgery Considerations

The function of minimally invasive surgical continues to evolve, providing patients with gynaecologic malignancies with less intrusive treatment options. With more surgical experience, operating times have naturally improved. Demonstrated aortic lymphedema sampling by laparoscopy could be done safely and effectively. At the time of laparotomy, remnant tissue lateral to the common iliac vessel and distal external iliac vasculature was seen after laparoscopic pelvic lymphadenectomy. Since none of the laparoscopic surgeons was aware of the presence of this remaining tissue, it should be possible to fix this potential surgical flaw [4]. There was also fear that tumour implantation might become more widespread as a result of laparoscopy.

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Patients with severe peritoneal or pelvic metastatic disease, as well as increasing carcinomatosis, proved to be the most vulnerable. Obesity can make it difficult to use a minimally invasive strategy to treat early endometrial cancer. Complications in the obese category included pulmonary micro embolism, epigastric artery damage, bladder injury, profuse bleeding, and conversion to laparotomy. Finally, as the importance of minimally invasive surgery in the care of gynaecologic tumours grows, the assessment of consequences and conversion rate must be addressed [5].

## Conclusion

Minimally invasive surgery is improving and becoming a viable option for the surgical treatment of gynaecologic cancers. Patient pleasure, it appears, has aided the profession of minimally invasive surgery. Women with gynaecologic malignancies appreciate smaller incisions, less surgical discomfort, and shorter hospital stays. But, more crucially, science has kept pace with new minimally invasive procedures. Minimally invasive surgery has been proved to be safe and effective when used in conjunction with standard open procedures. Above all, this will assist to establish minimally invasive surgery as a viable option for treating gynaecologic cancers.

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