

Left Retroaortic Renal Vein and Superior Mesenteric Artery Vascular Lesion Risk

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Abstract:

To highlight the importance of preoperative assessment of imaging studies to rule out vascular abnormalities involving high bleeding risk in para-aortic lymphadenectomy for gynecological cancer.

Keywords: left retroaortic renal vein; superior mesenteric artery; vascular lesion

Design:

Demonstration of the measures to be taken and the areas of maximum danger to avoid an injury, as well as the steps taken to evidence a para-aortic sentinel lymph node, with narrated video footage.

Setting:

The left retroaortic renal vein has a prevalence of 3% of cases [2]. Other venous anomalies such as anomalous venous drains mainly in the left infrarenal area, double vena cava, left vena cava, arterial abnormalities, such as APRA (Polar Renal Artery)[3] or anatomical anomalies such as horseshoe kidney can cause severe intraoperative lesions[4]. that it is essential to rule out with a correct preoperative evaluation.

Interventions:

A 69-year-old woman IAG1 endometrial adenocarcinoma (EC), stratified as low risk EC, was operated by sentinel node (SN) biopsy, laparoscopic total hysterectomy and bilateral salpingo-oophorectomy with frozen section.

Video Legend: The video shows the para-aortic node dissection to identify the para-aortic sentinel node, without identifying the left renal vein, but the upper mesenteric artery, as its upper limit.

<https://we.tl/t-oqCZawJ9rw>

Dual cervical and transcervical fundal ICG injection for paraortic and pelvic SN detection was performed as part of an ongoing study in our institution already published [1].

The dissection stopped when a thick arterial vascular structure compatible with the superior mesenteric artery was found. There was bilateral SN pelvic detection and aortic detection

Final histological results upgraded the case to high risk EC due to SN positivity: FIGO IIIC2 endometrioid EC G1, 3 cms, with no lymphovascular invasion.

Conclusion:

Multiple vascular anomalies and other non-diagnosed congenital malformations can be identifiable in preoperative imaging tests, but not reported in the radiological report. It is of vital importance the knowledge and preoperative assessment by the surgeon himself to avoid severe intraoperative complications.

None of the authors have any conflict of interest.

IRB approval was not needed for the purpose of this manuscript.

Inform consent was obtained directly from the patient.

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