

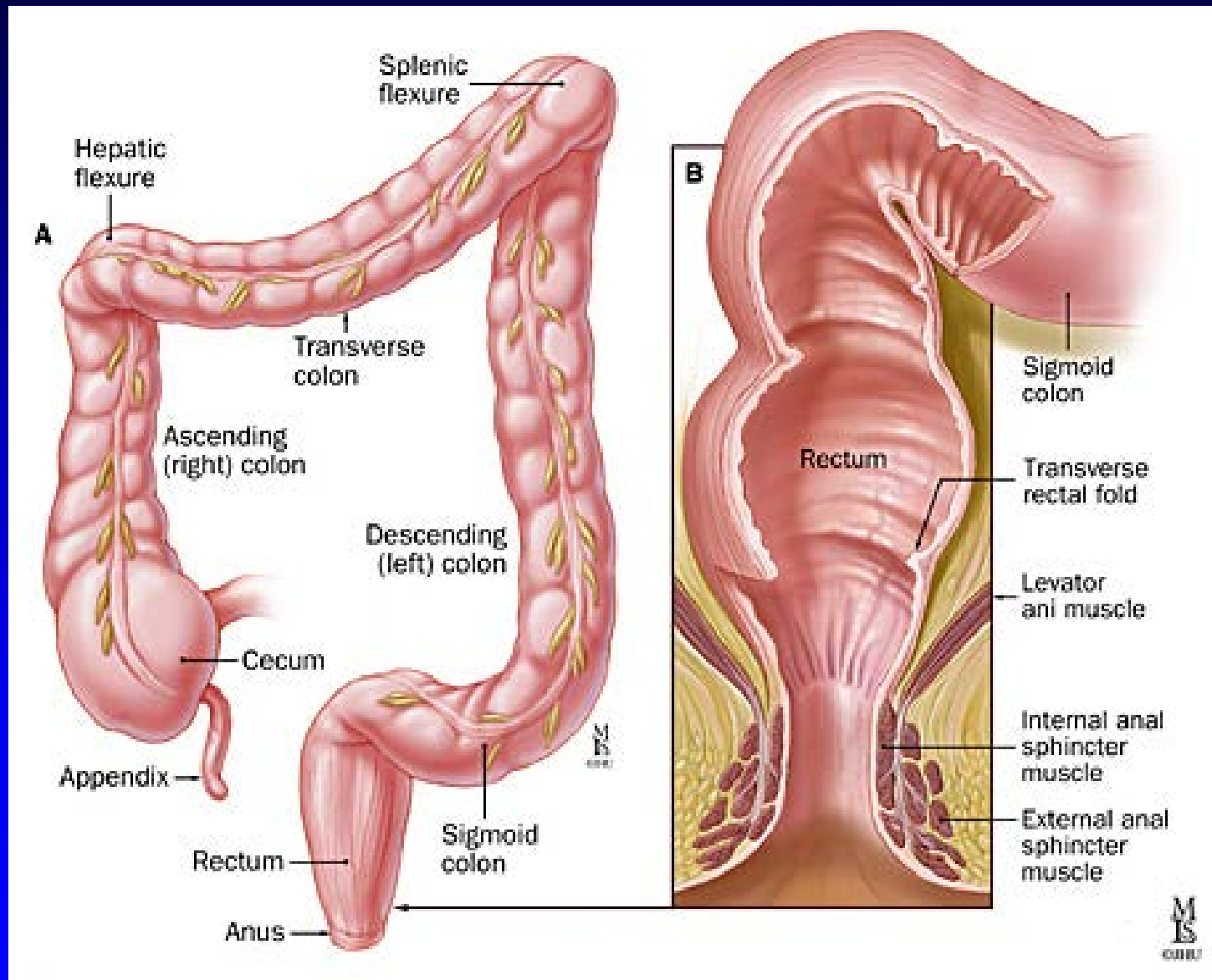
Management of Rectal Cancer



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Disclosures: NONE

Anatomy of the Colon and Rectum



Rectal Cancer

- Defined as <12 cm from the anal verge by rigid proctoscopy.
- Distinct clinical management issues:
 - Increased local recurrence
 - Use of adjuvant radiation therapy
 - Use of neoadjuvant therapy and need to stage prior to surgery
 - Sphincter preservation
 - Concerns of urinary and sexual dysfunction

Goals of Rectal Cancer Surgery

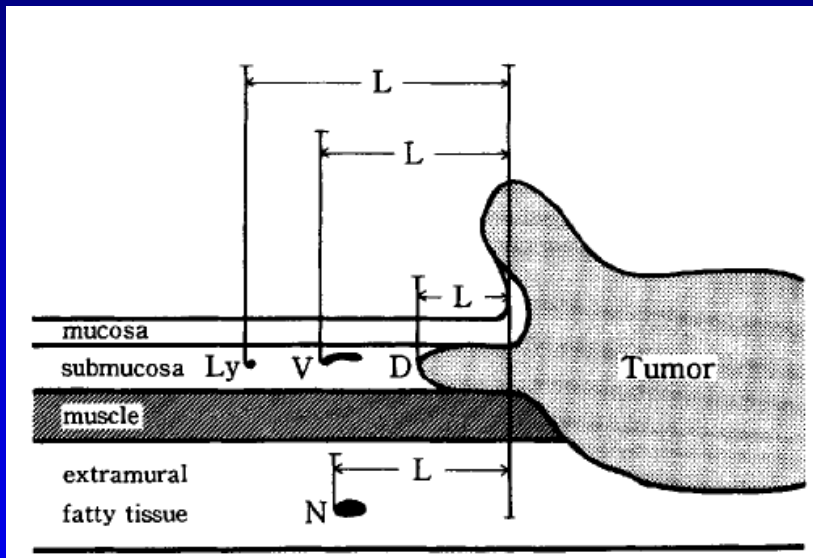
- Improved local control
- Improved overall survival
- Maintaining quality of life
- Sphincter preservation
- Satisfactory bowel function
- Maintain genitourinary function
- Maintain sexual function

Sphincter Preservation for Rectal Cancer

OUTLINE

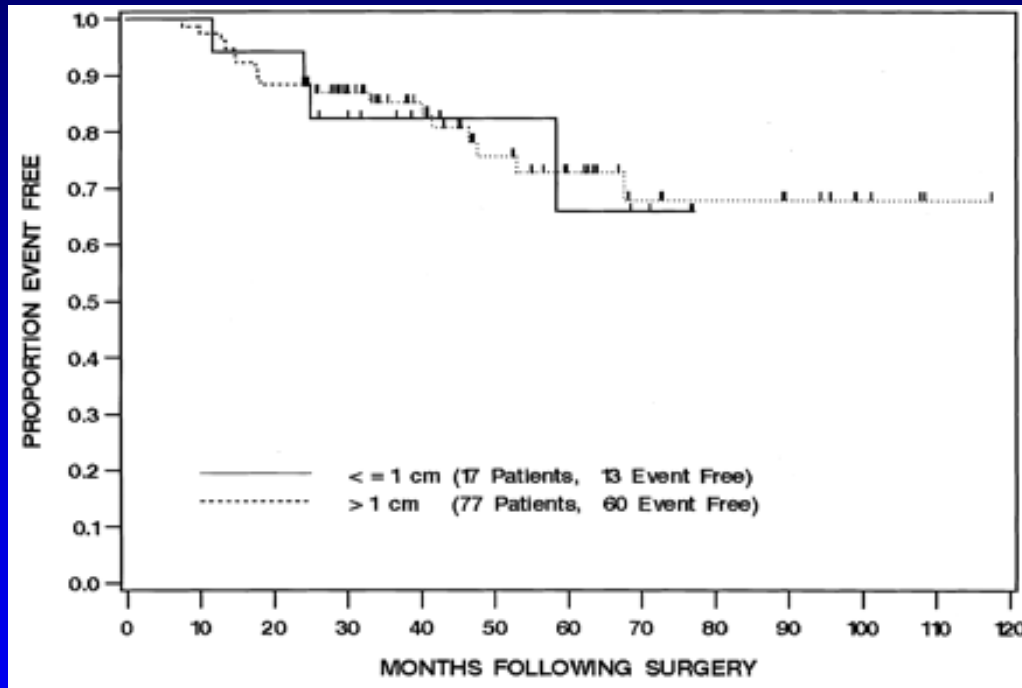
1. What is the minimal distal margin bowel margin?
2. Importance of the circumferential margin and total mesorectal excision.
3. Impact of neoadjuvant therapy on sphincter preservation.
4. Reconstruction techniques & laparoscopy.
5. Role of diverting ileostomy.
6. Transanal local excision.

Distal Intramural Spread of Rectal Cancer: End of the “5-cm Rule”

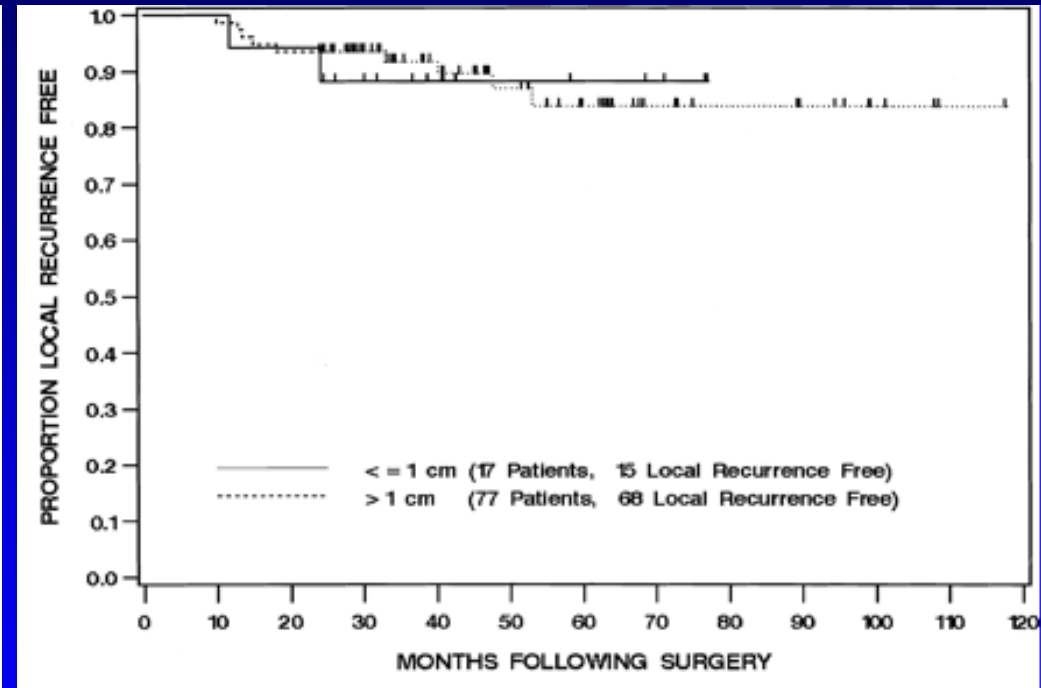


Stage	None	Distal Spread		
		<1cm	1-2cm	>2cm
I (n=150)	100%	0	0	0
II (n=162)	98.8%	1.2%	0	0
III (195)	90.2%	5.1%	2.1%	

Adequacy of Even ≤ 1 -cm Distal Margin After Neoadjuvant Therapy?

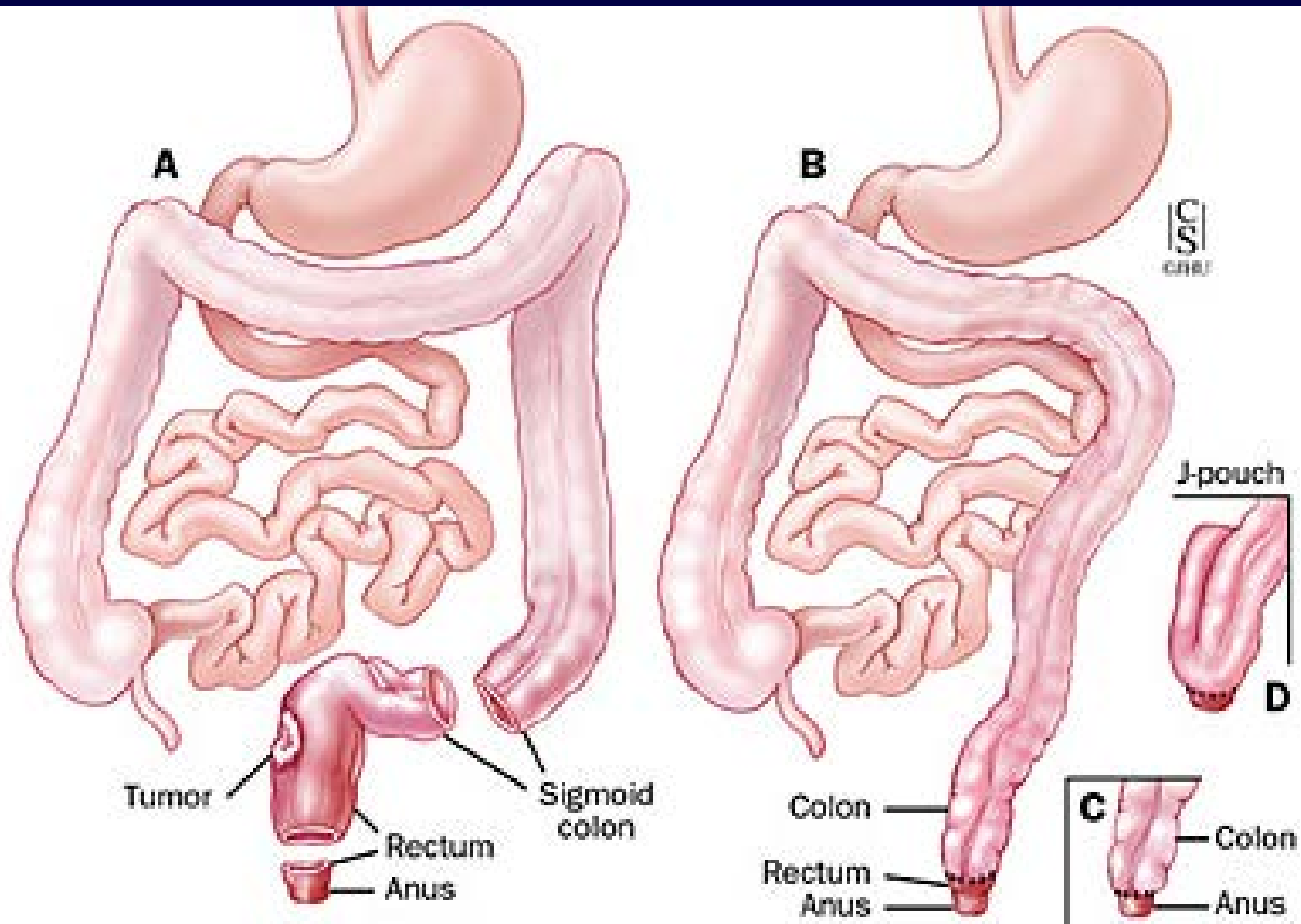


Disease Free Survival

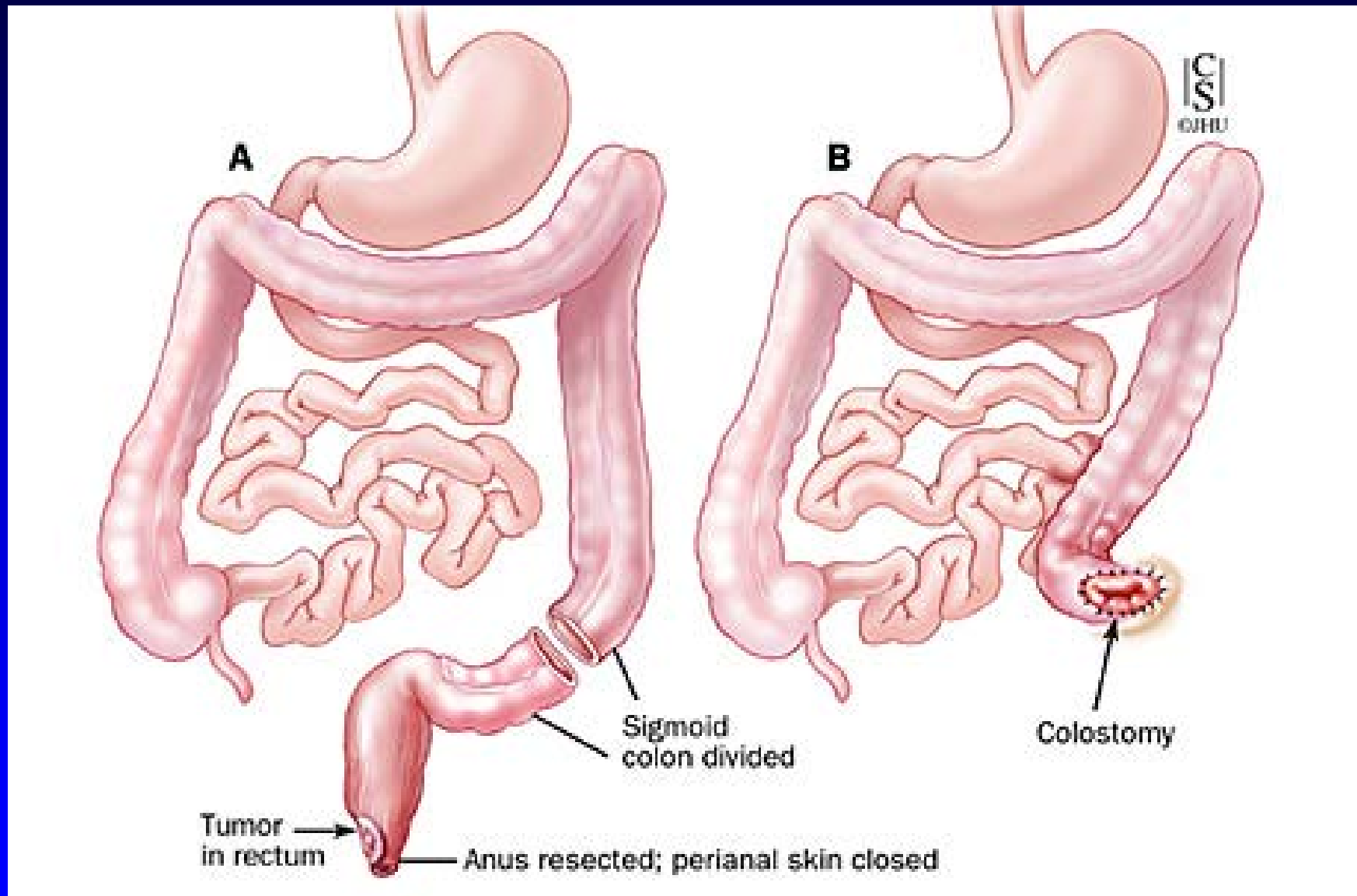


Local Recurrence

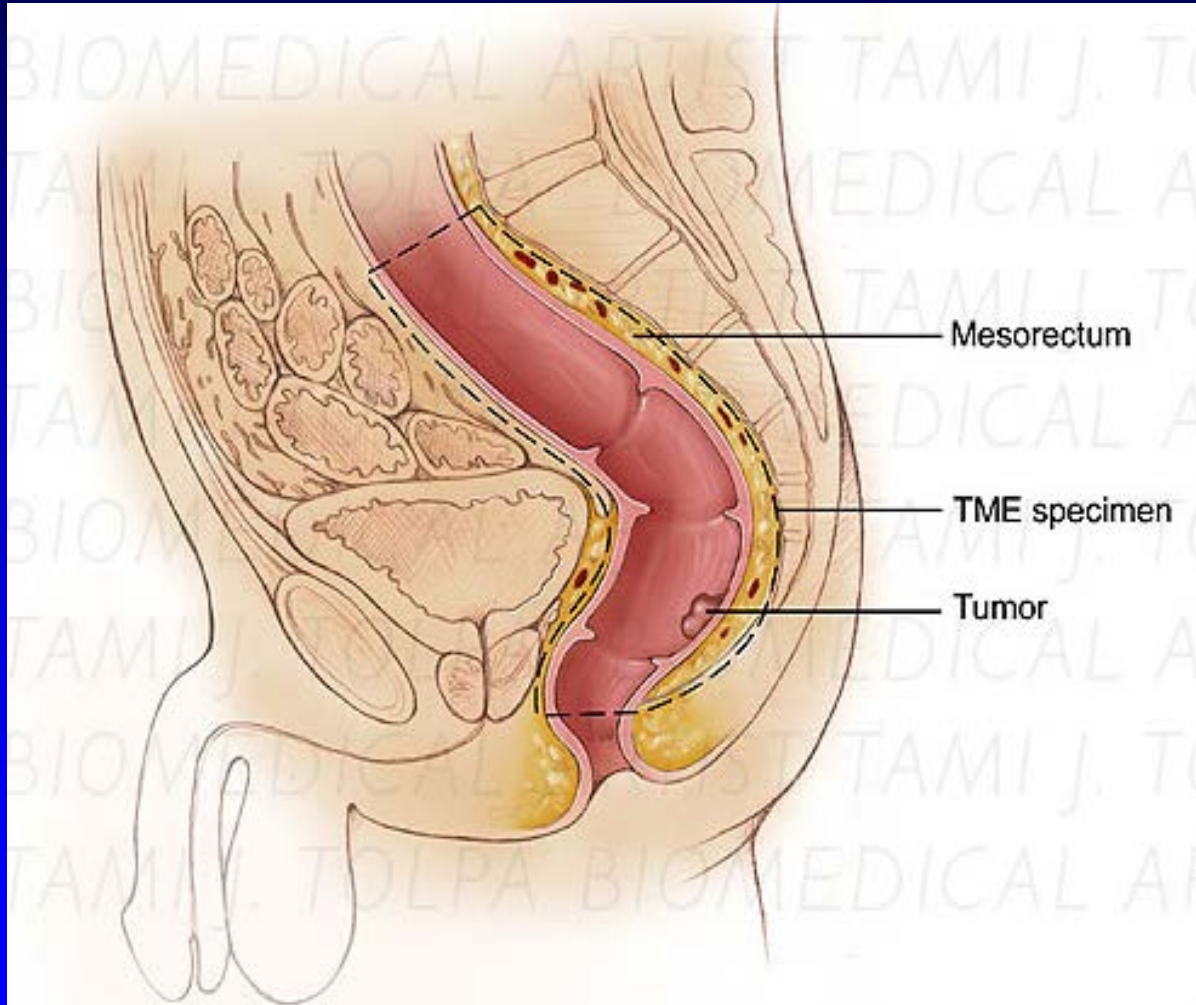
Low Anterior Resection (LAR)



Abdominoperineal Resection (APR)



Total Mesorectal Excision

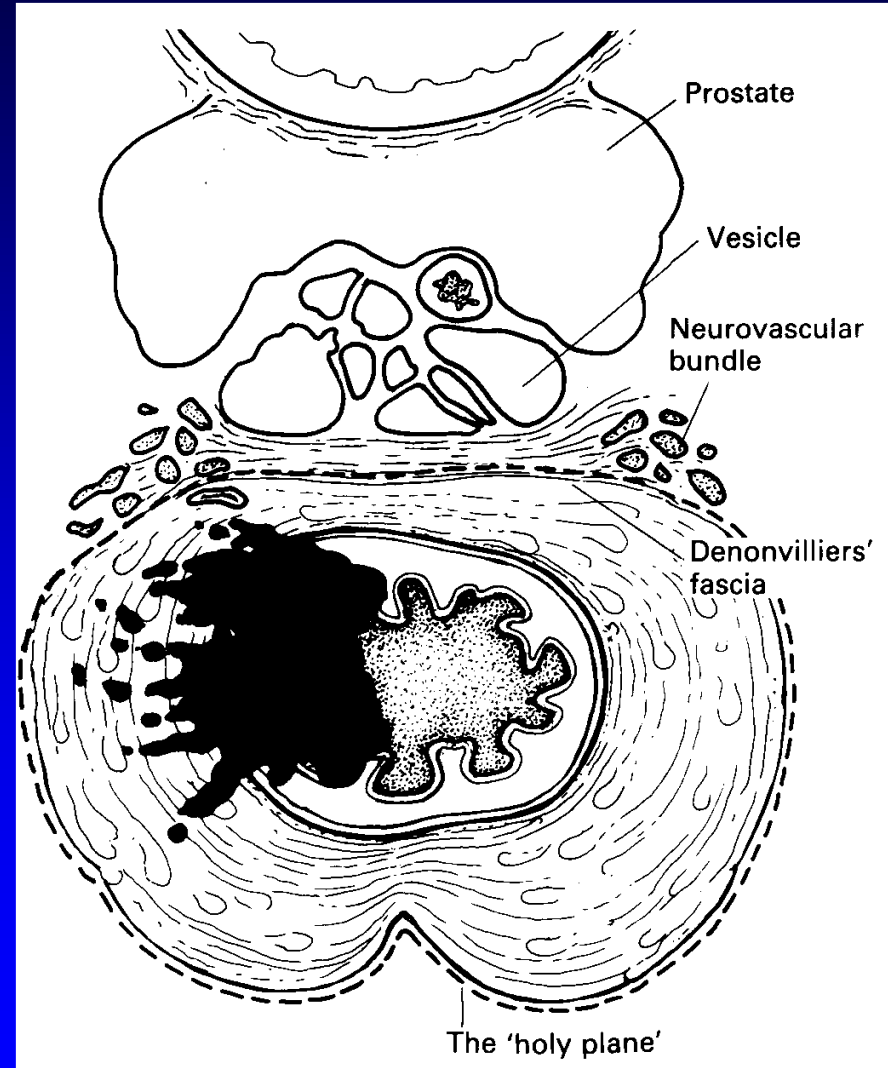


Importance of the Radial Margin

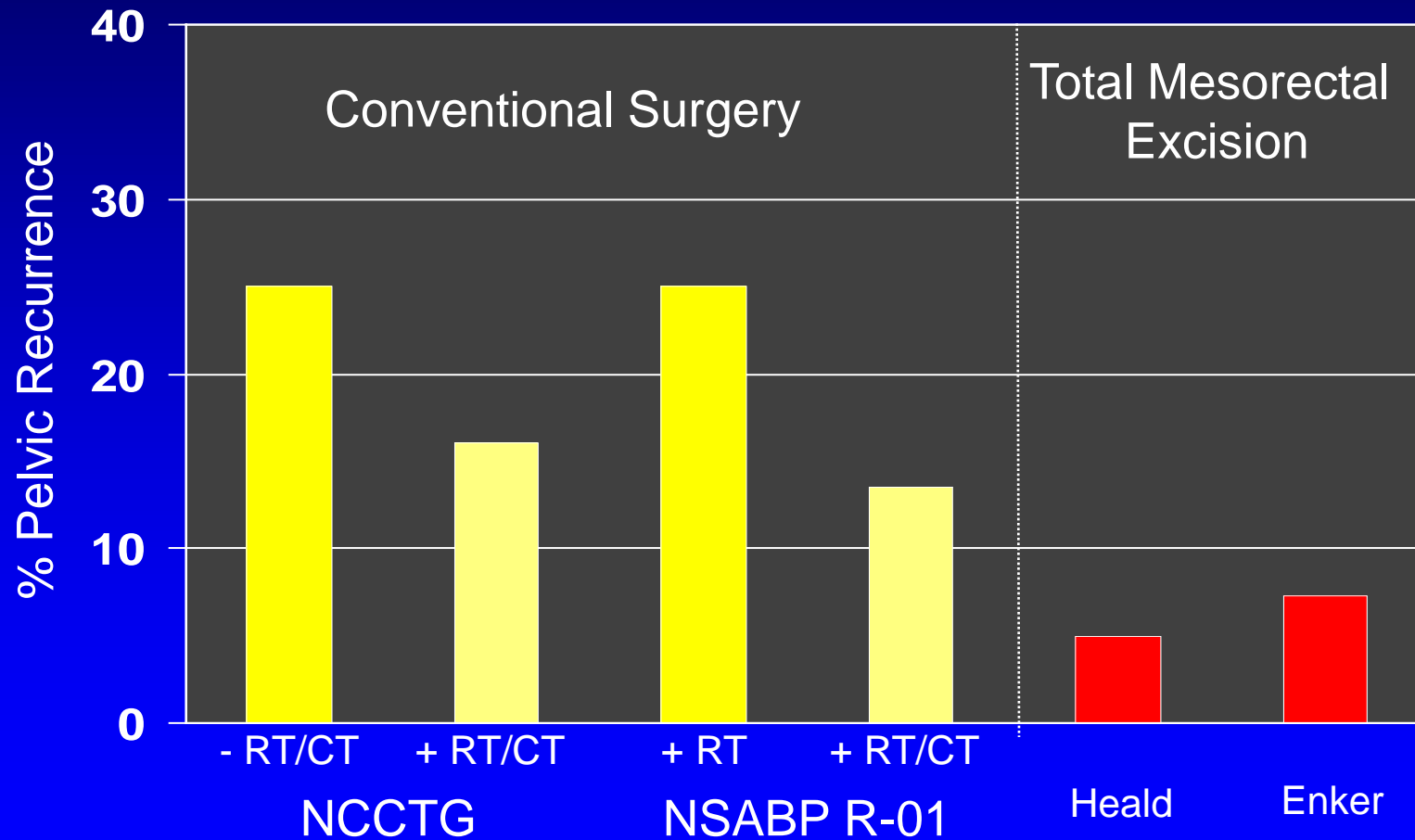
52 patients, 1983-1985
transabdominal resections
whole-mount pathologic evaluation
of radial resection margin
prospective follow-up

Results:

- 27% with positive radial margin
- 12 of 14 with positive margins developed local pelvic recurrence (85%)
- 1 of 38 with negative margins developed LR (3%)



Pelvic Recurrence Rates Following Curative Resection for Rectal Cancer



Preoperative vs. Postoperative

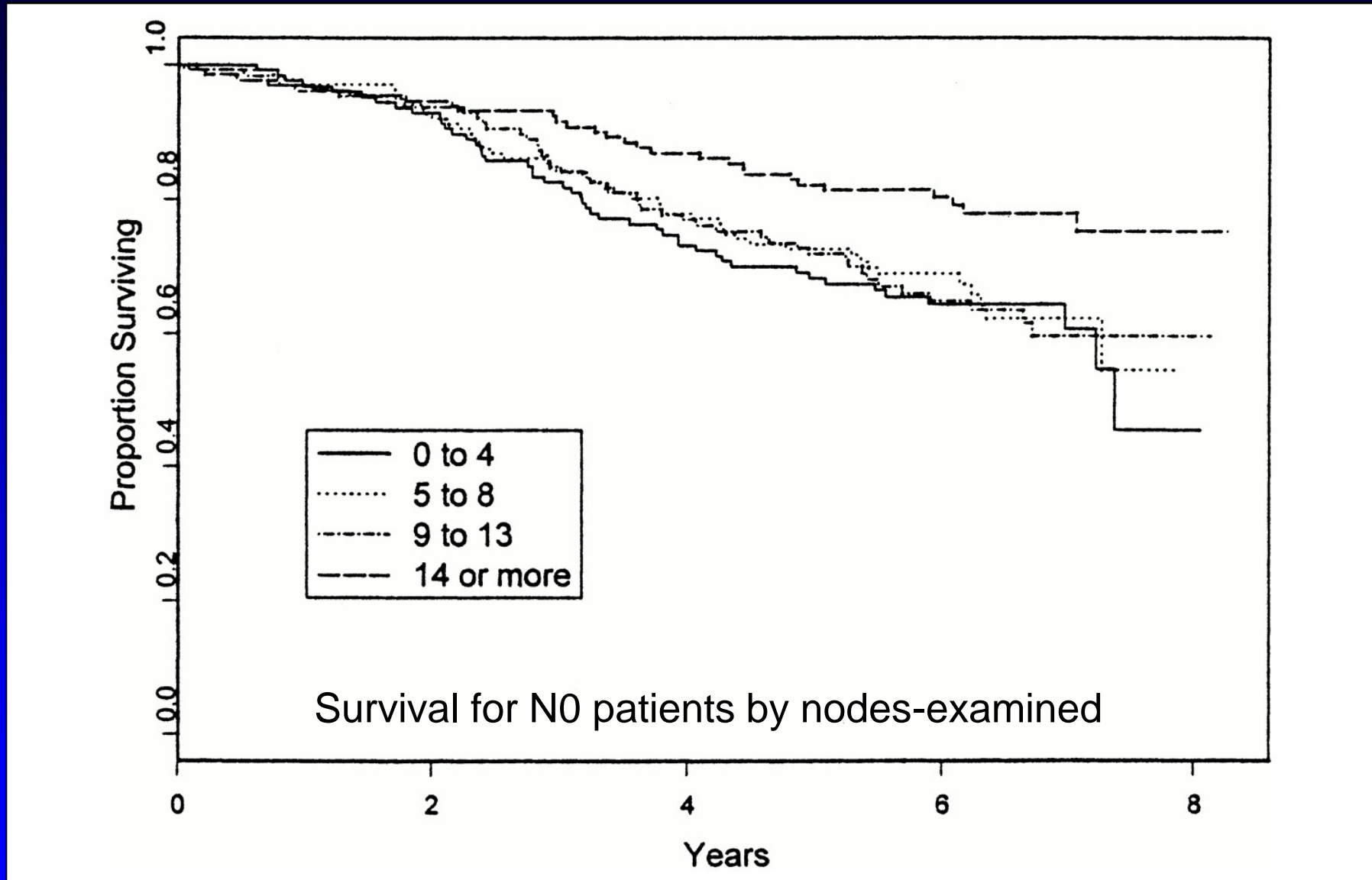
POTENTIAL ADVANTAGES:

- Conversion to sphincter-preservation
- Less irradiated small bowel
- Improved late bowel function
- Earlier systemic therapy

POTENTIAL DISADVANTAGES:

- Staging uncertainty
- Overtreatment in some patients
- Delay in surgical therapy
- Increased operative complications?

Importance of an Adequate of Lymph Node Harvest



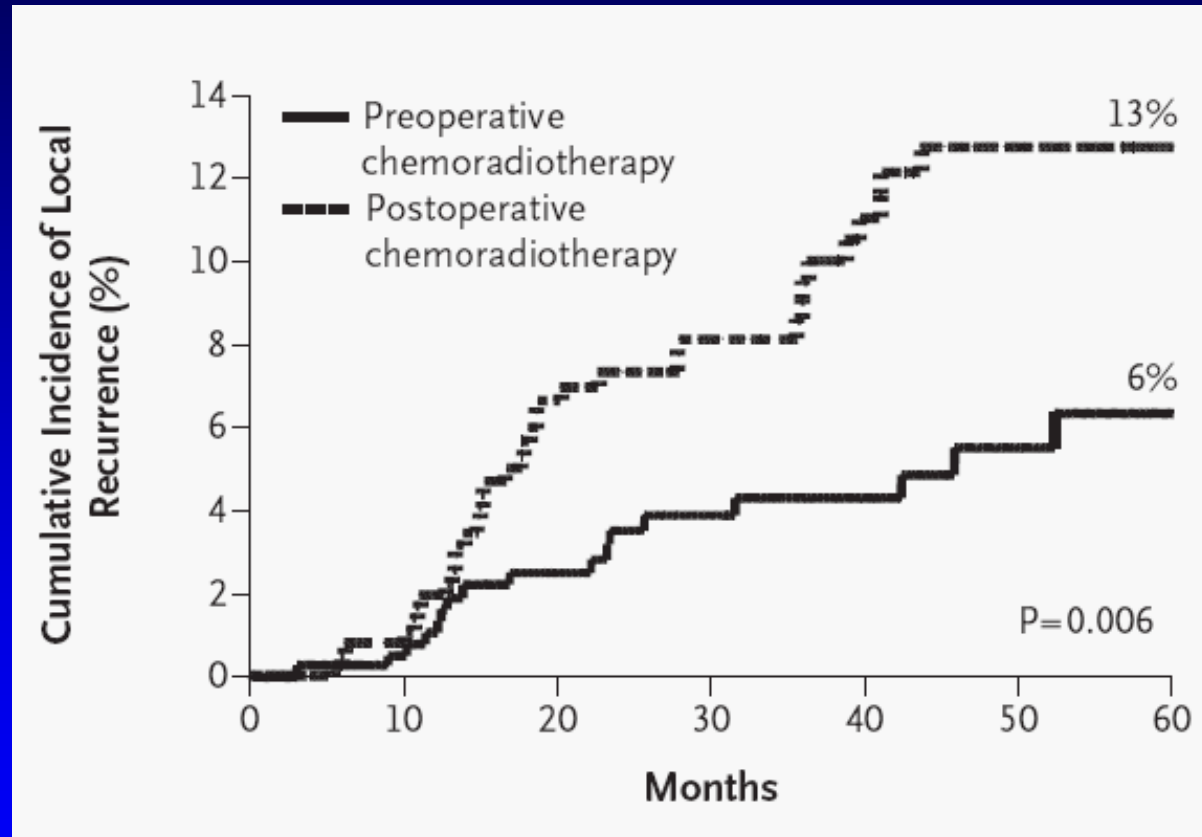
Neoadjuvant Chemoradiation

German Rectal Cancer Study Group

- Randomized trial preop vs. postop CRT
- Conventional therapy

RESULTS:

- Improved local control
- Less toxicity
- No difference in survival



Neoadjuvant Chemoradiation

German Rectal Cancer Study Group

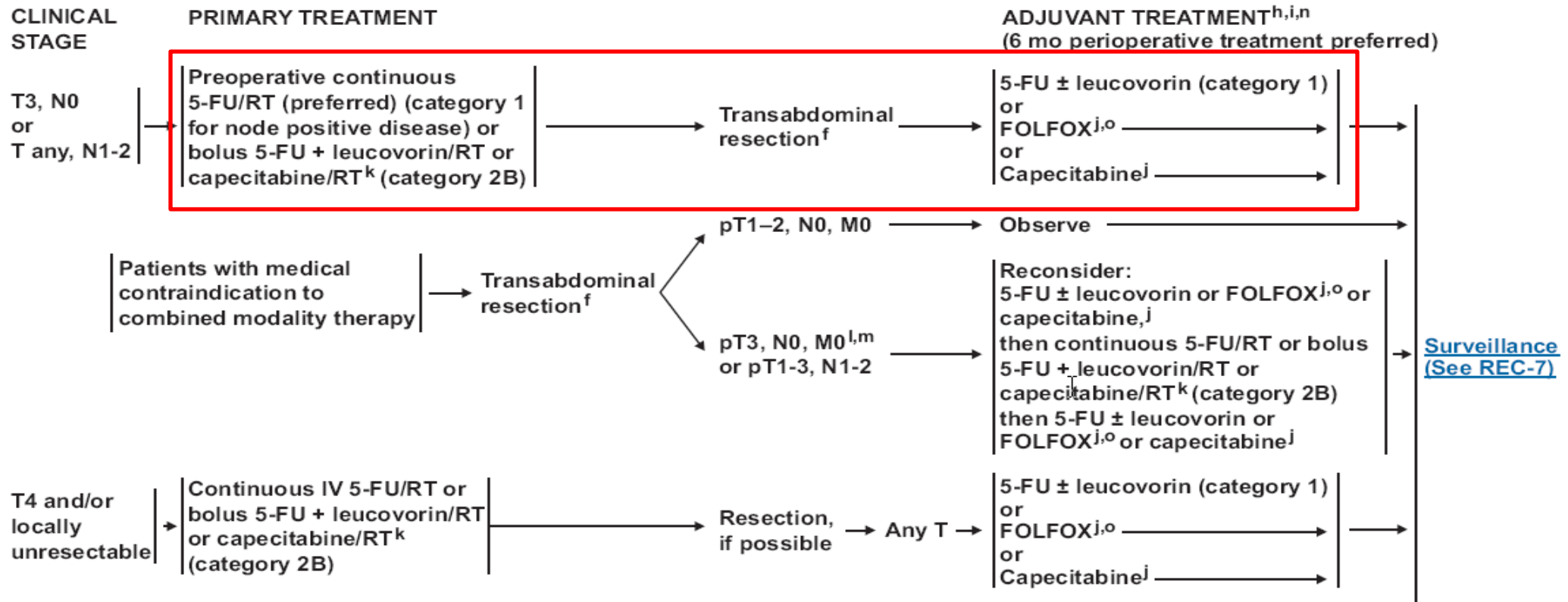
Table 4. Rates of Sphincter-Sparing Surgery in 194 Patients Determined by the Surgeon before Randomization to Require Abdominoperineal Resection, According to Actual Treatment Given.

Variable	Preoperative Chemoradiotherapy (N=415)	Postoperative Chemoradiotherapy (N=384)	P Value
Abdominoperineal resection deemed necessary — no. (%)	116 (28)	78 (20)	
Sphincter-preserving surgery performed — no./total no. (%)	45/116 (39)	15/78 (19)	0.004

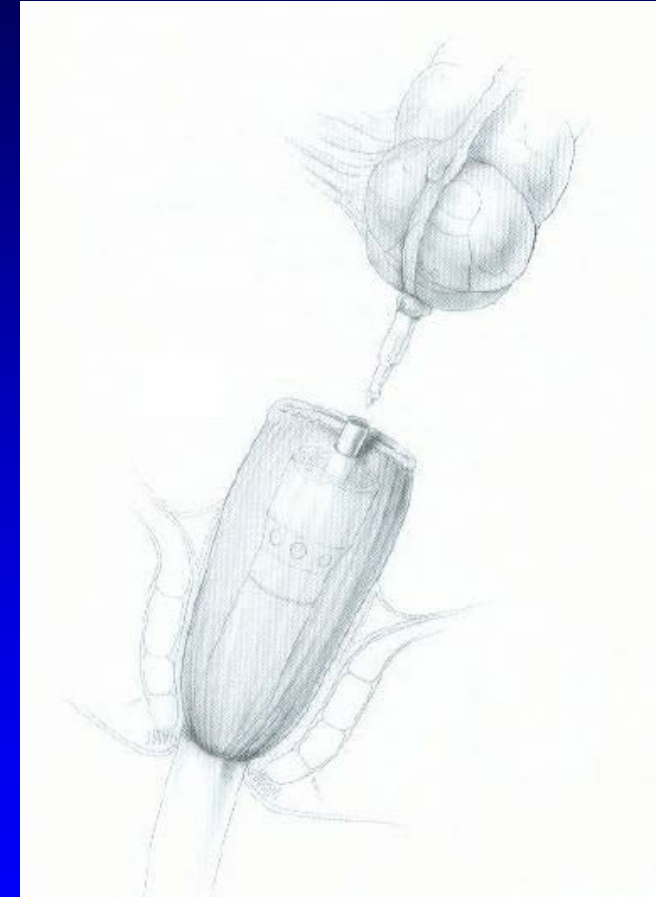
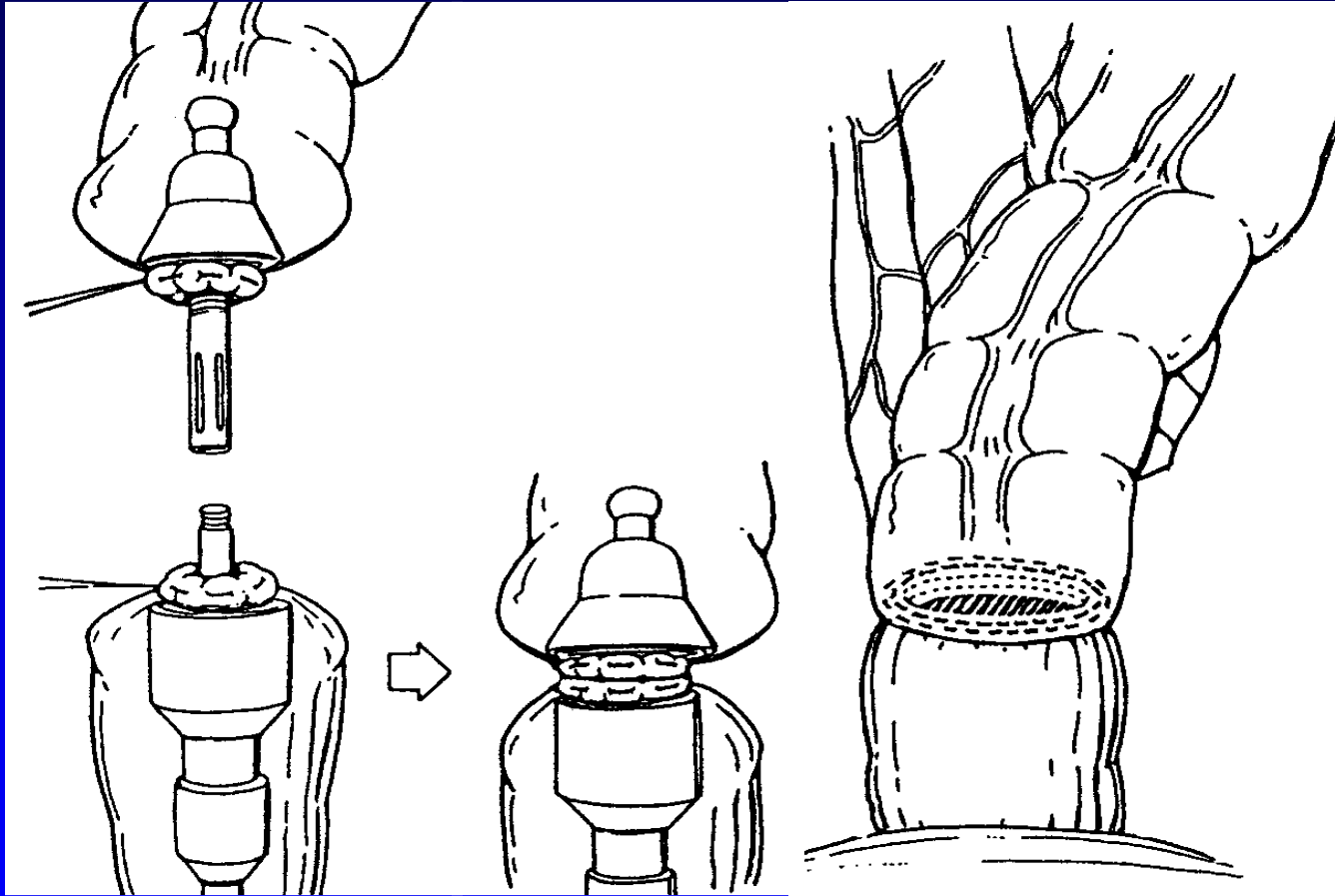
Neoadjuvant Short-Course Radiotherapy vs. Conventional Chemoradiation Therapy for Rectal Cancer

Polish randomized trial (n=316)

	Short Course RT	CRT
Sphincter preservation	61.2%	58.0%
Path CR	0.7%	16.1%*
Circum margin positive	12.9%	4.4%*
Late toxicity	28.3%	27%
Local recurrence	10.6%	15.6%

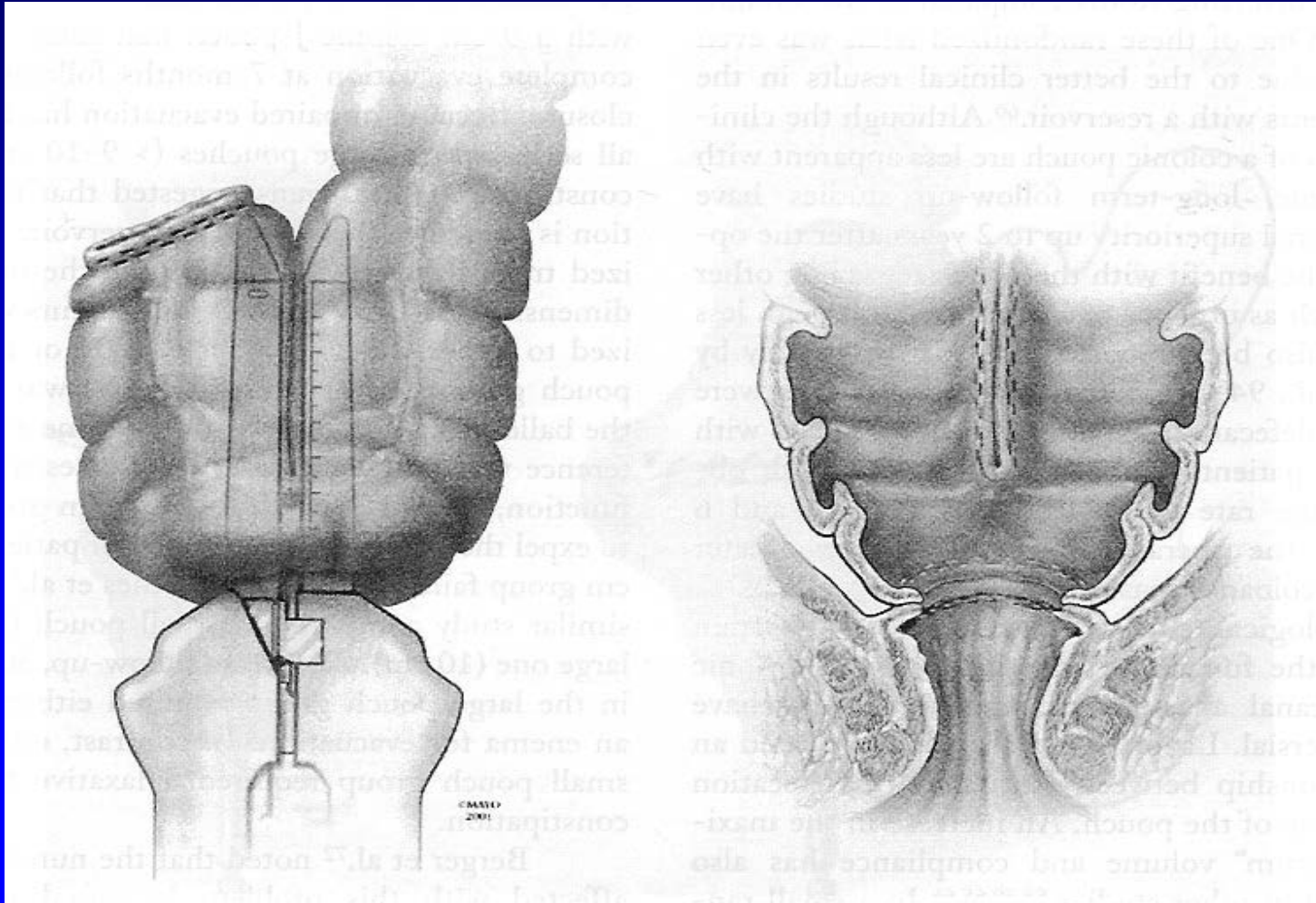


Restorative Proctectomy



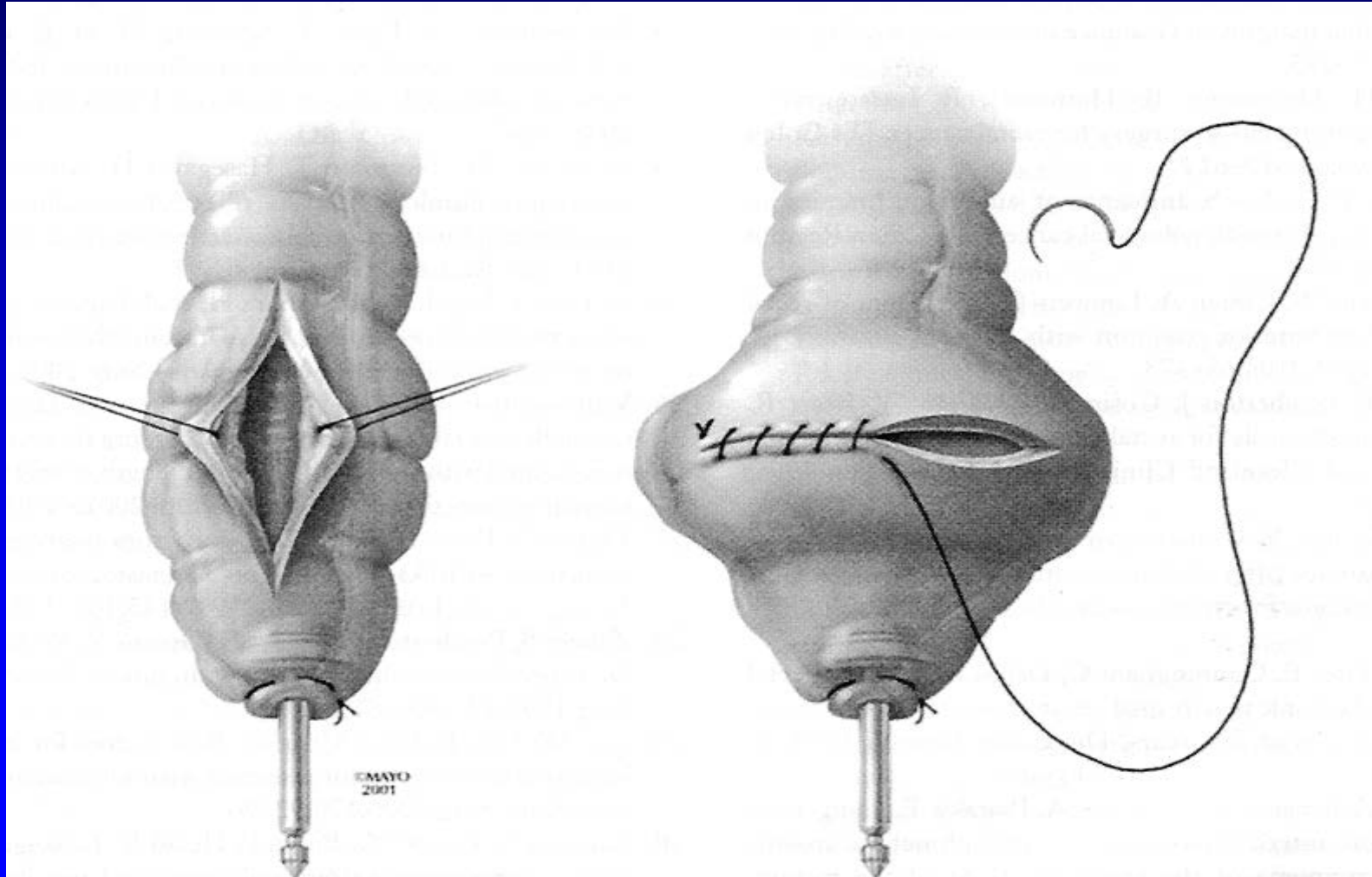
Restorative Proctectomy

Colonic J-pouch



Restorative Proctectomy

Coloplasty



Laparoscopic Rectal Cancer Resection

144 patients

5.5 cm (range 1–12) from the anal verge

123 patients received preoperative radiotherapy

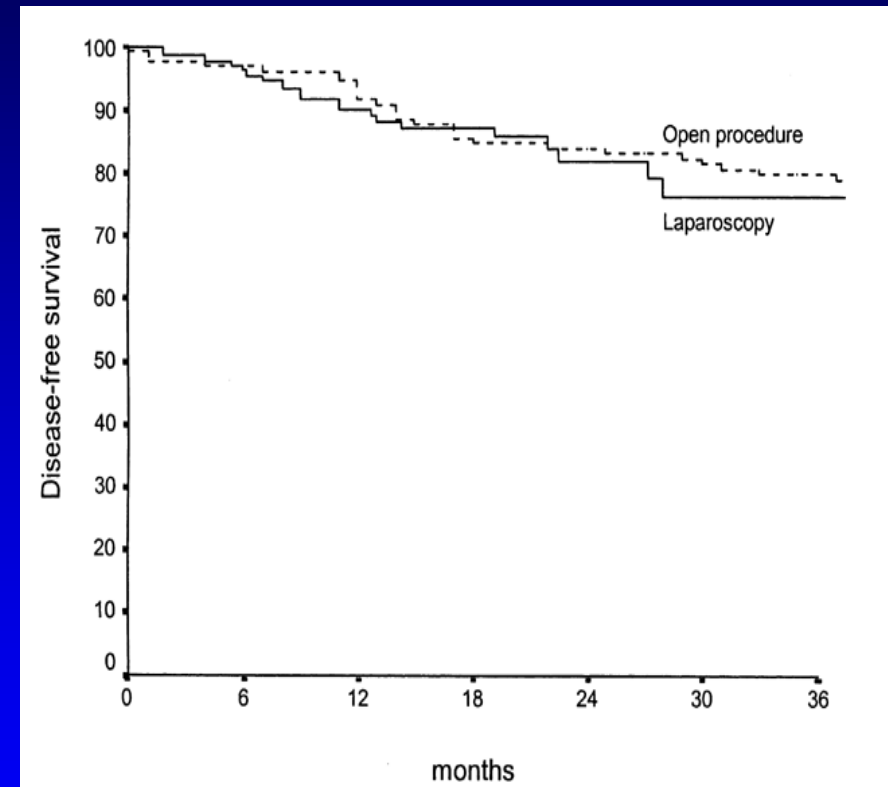
Results

Mortality & morbidity were 1% and 34%

Conversion was 14% ($n = 20$)

Intact mesorectum in 88% of the cases

Compared to matched open group, no difference in margin status, local recurrence or overall survival.



Local Excision: Selection Criteria

Lesion amenable to local excision

- Within reach of technique
- Full thickness
- Nonfragmented
- Negative margins

No adverse pathologic criteria

- High grade lesion
- lymphovascular invasion
- Signet-ring cells
- Colloid histology

uT1 or ?uT2 on ERUS

No evidence of lymph node metastases

Patient not a candidate for LAR or APR



Incidence of Positive Lymph Nodes by Pathologic Features

T-Stage	n	T1	T2	T3	T4
Nelson (1987)	76		20%	67%	
Morson (1979)	2084	11%	12%	58%	
Minsky (1989)	168	0%	28%	36%	53%
Brodsky (1992)	154	12%	22%		
Differentiation	n	Well	Mod	Poor	
Cohen (1980)	247	29%	32%	63%	
Nelson (1987)	76	38%	57%		
Minsky (1989)	168	0%	30%	50%	
Brodsky (1992)	154	0%	24%		

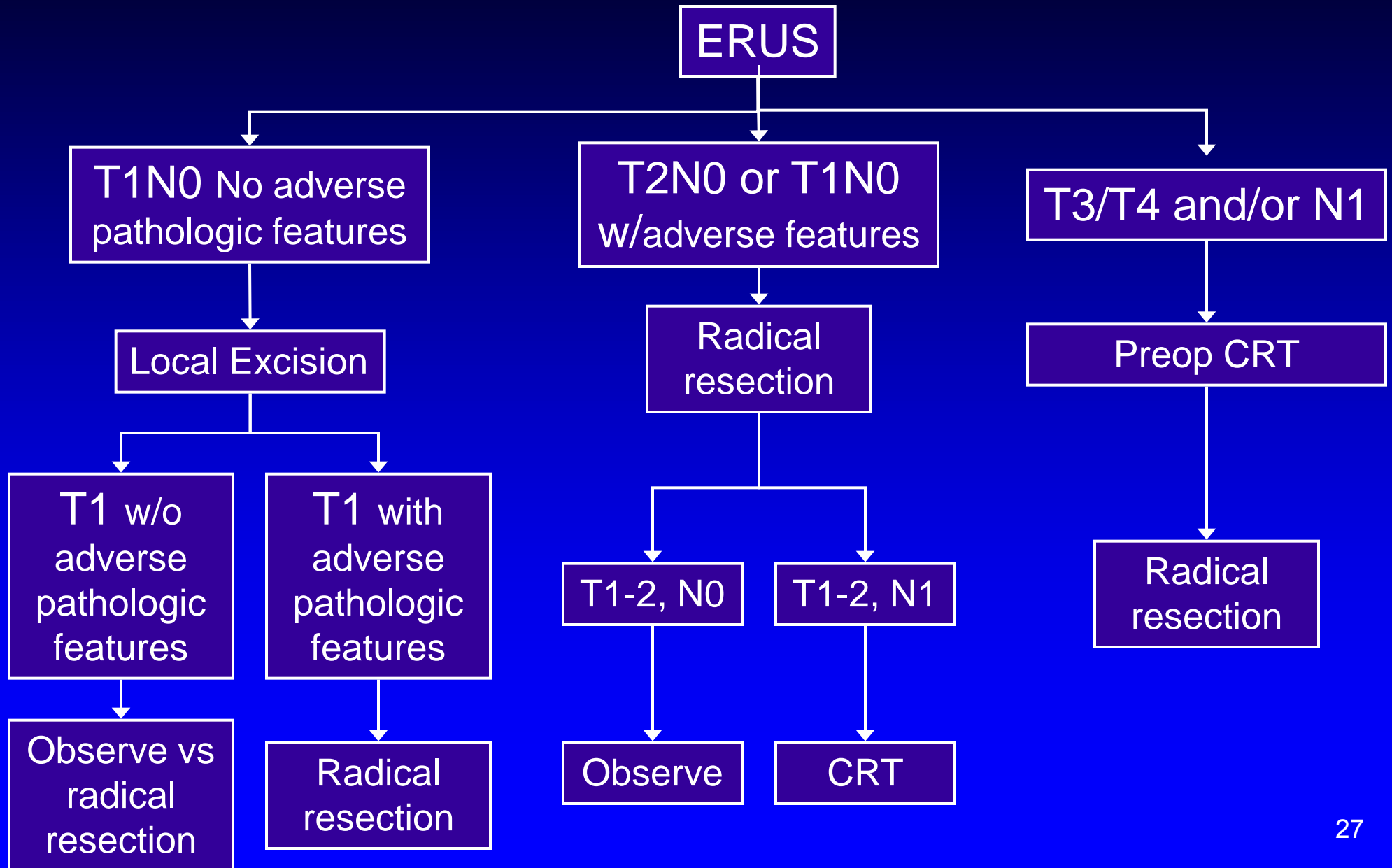
Outcomes Following Transanal Excision of Rectal Cancer

STUDY (yr)	N	FU (mo)	LR (%)	OS (%)
Chakavarti (99)	52	52	11 (T1) 62 (T2)	66
Steele (99)	110	48	7 (T1) 20 (T2)	87 (T1) 85 (T2)
Mellgren (00)	108	53	17 (T1) 46 (T2)	69
Paty (02)	125	80	17 (T1) 26 (T2)	74 (T1) 72 (T2)
Madbouly (05)	52	55	29 (T1)	89 (T1)

Local Excision for Rectal Carcinoma Followed by Radiation Therapy

Study	Local Control	Survival
Princess Margaret Hospital	76%	80% 6-yr median
Fox Chase Cancer Center	81%	75% 5-yr DFS
MSKCC	82%	79%
CALBG	98%	96% 2-yr

Management of Rectal Cancer



Temporary Ileostomy: When is it Necessary?

- Arguments in favor of ileostomy:
 - “protects” from anastomotic leaks
 - Allows time for healing before bowel restoration
- Routine covering stoma has not been shown to be necessary
- Considered to be useful in patients at higher risk for anastomotic leak
 - Neoadjuvant radiotherapy
 - Coloanal anastomosis
 - Several comorbidities
- Take down is best performed after the completion of adjuvant therapy

Protective Defunctioning Stoma in Low Anterior Resection for Rectal Carcinoma

German prospective study (2000-2001)
881 of 2729 LAR pts received protecting ostomy

	Stoma	No stoma	p
Anastomotic leak	14.5%	14.2%	ns
Leak req. reoperation	3.6%	10.1%	<0.001
Mortality	0.9%	2.0%	0.037
Stomal closure complications:			
Colostomy	15.3%		
Ileostomy	22.4%	(p=0.031)	

Patient Case

A 55 yr. old college professor reports a 2 month history of narrow stools and occasional rectal bleeding. Colonoscopy demonstrates a mass 7 cm from anal verge and biopsy shows moderately differentiated adenocarcinoma.

Patient Case

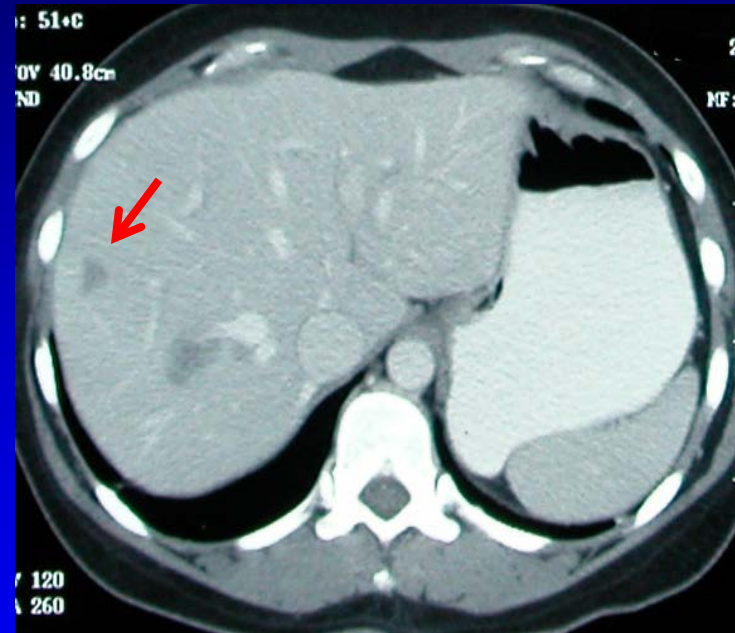
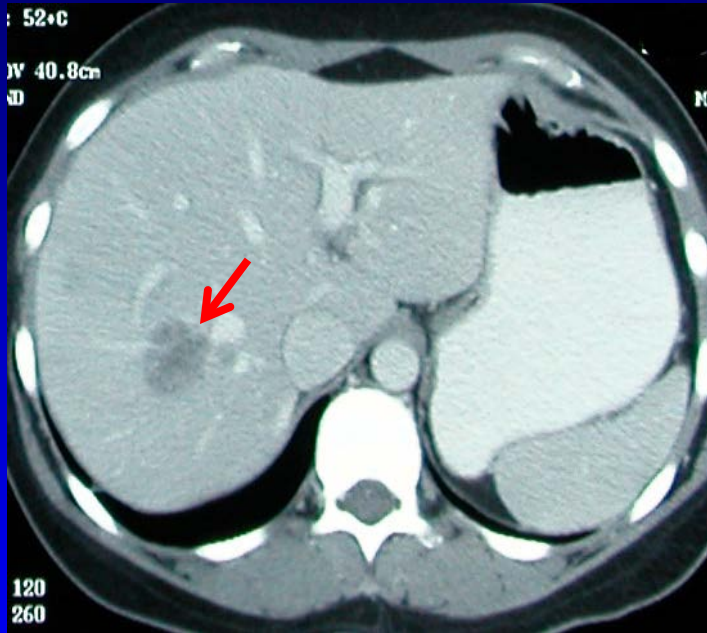
Appropriate staging work-up includes:

- a) CT scan chest, abdomen & pelvis
- b) Endorectal ultrasound
- c) FDG-PET scan
- d) pelvic MRI

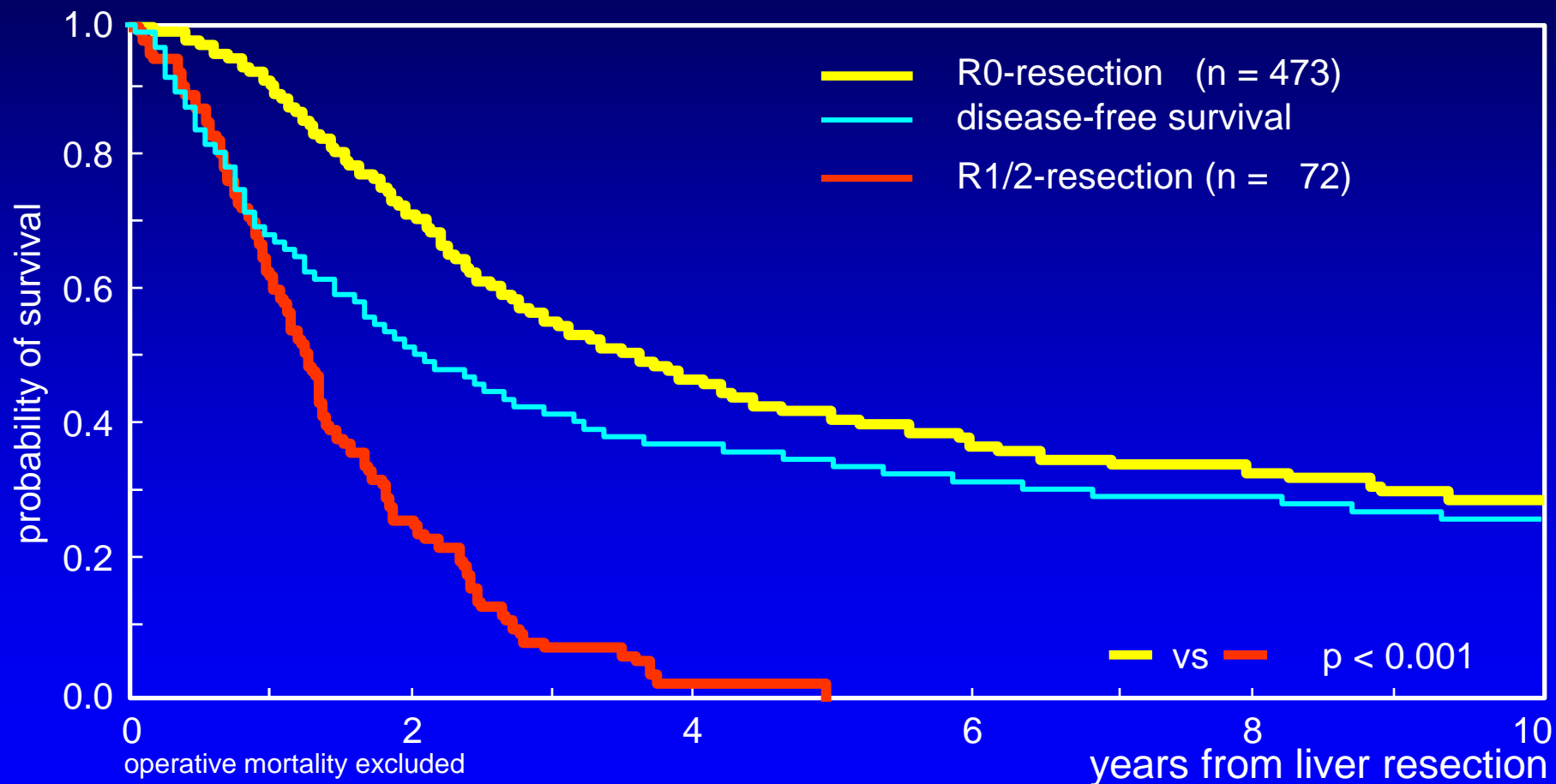
Patient Case

The imaging studies show that the tumor invades into the bowel wall (T₂) and that there is a single 2-cm perirectal node. What management options best pertain to this case?

- a) Low anterior resection; postoperative adjuvant chemoradiotherapy if nodes positive
- b) Neoadjuvant chemoradiotherapy using 5FU 300 mg/d CIV 5 days per week to coincide with radiotherapy, followed by surgery
- c) Neoadjuvant chemoradiotherapy using capecitabine 825 mg/m² po bid. continuously during RT, followed by surgery



Outcomes Following Hepatic Resection for Metastatic Colorectal Cancer

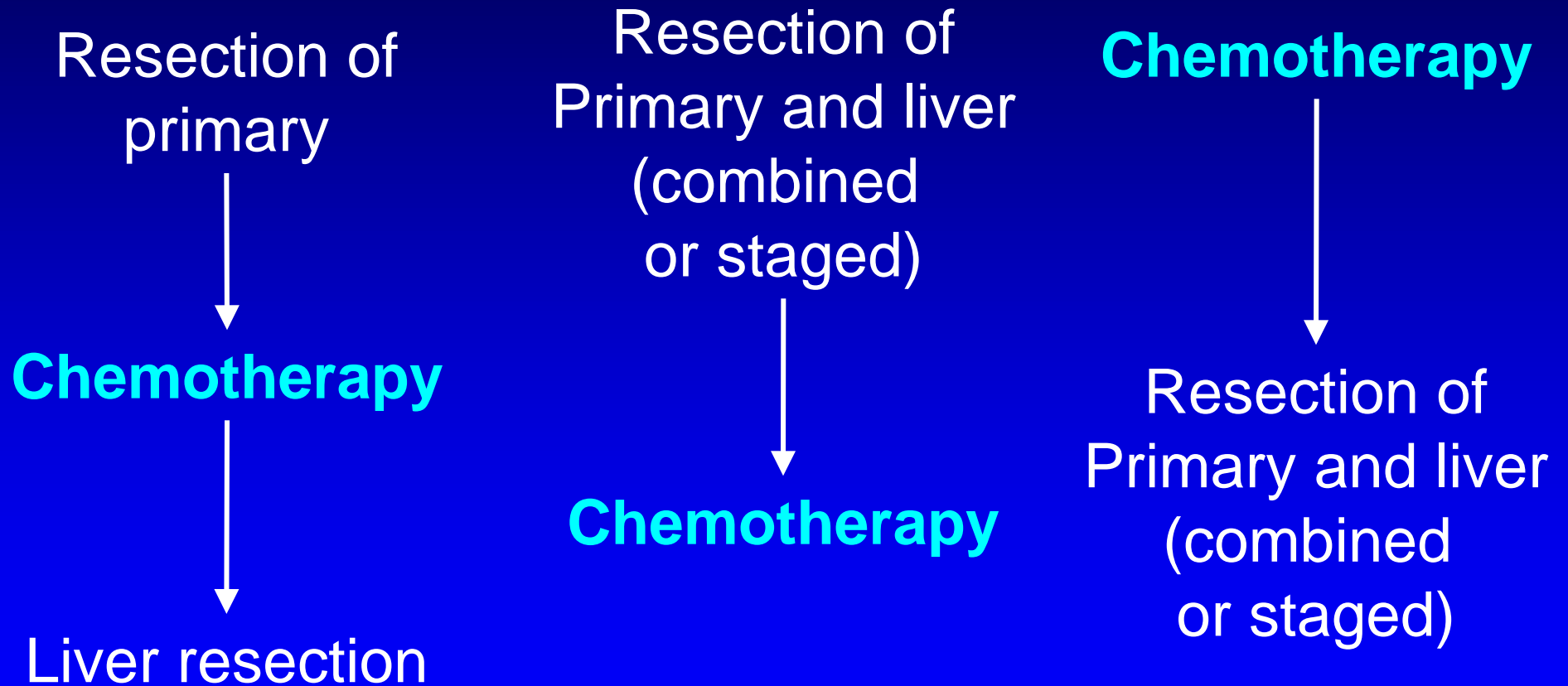


Colorectal Cancer with Hepatic Metastases

- Approximately 30% to 40% of patients will have liver-only metastases at time of recurrence
- Approximately 20% to 30% will have liver-only metastases on initial evaluation

**25-30,000 patients with
liver-only metastases**

Management Options for Synchronous Colorectal Cancer and Resectable Liver Metastases



Summary

1. Sphincter preservation and surgical technique
2. Importance of TME
3. Preoperative staging
4. Neoadjuvant therapy
5. Selected role of local excision for early disease
6. Management of Stage IV rectal cancer

Management of Rectal Cancer

CONCLUSIONS

1. Better understanding of the importance of circumferential vs distal margin and TME
2. Preoperative chemoradiation therapy
3. Refined surgical techniques
 - stapled low bowel attachment
 - coloanal reconstruction
 - J-pouch and coloplasty
 - local excision in selected cases