

Stent for palliation of advanced colorectal cancer



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ARTICLE INFO

Keywords:
Colorectal obstruction
SEMS
palliation
advanced cancer

ABSTRACT

In palliation of advanced colorectal cancer, self-expanding metal stent (SEMS) can be an alternative to surgical resection for malignant obstruction proximal to the splenic flexure. SEMS is recommended as the preferred treatment for palliation of left-sided advanced malignant colonic obstruction with a high quality of evidence, except in patients (1) with a presumed long life expectancy (> 1 year) and (2) treated or considered for treatment with antiangiogenic drugs (ie, bevacizumab). The validity of the recommendation that palliative stenting is contraindicated in patients with a presumed long life expectancy (> 1 year) because of late stent-related complications is debatable and might be an erroneous conclusion. It is recommended that each institution should decide a clear strategy for this palliative group of long-term survivors. Understanding the risks of surgery is important for both patients and surgeons in the shared decision-making process, and it is recommended to implement a surgical risk prediction system. Patients who have undergone palliative stenting can be safely treated with chemotherapy without antiangiogenic agents. Given the high risk of colonic perforation, it is not recommended to use SEMS as palliative decompression of obstructions if a patient is being treated or considered to be treated with antiangiogenic therapy (ie, bevacizumab).

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1. Introduction

Colorectal cancer is one of the most common cancers worldwide, particularly in the economically developed world [1]. Overall, 8%–13% of patients with advanced colonic cancer develop large bowel obstruction [2,3]. There is still some controversy regarding the management of this severe clinical condition, and multiple articles have been published on the subject of colonic stenting for malignant colonic obstruction, including randomized controlled trials and systematic reviews [4]. Evaluation of treatment outcomes in patients with incurable or advanced colorectal cancer is different from that in curable patients. In patients with advanced cancer, minimal invasive therapy, hospital stay, interval to chemotherapy, risk of complications, life expectancy, and quality of life are important criteria when offering treatment. Decision making in patients with advanced cancer is important, but the task remains difficult. Prediction of survival or life expectancy is necessary to make the best decision in the treatment of patients with advanced cancer. It has been shown that performance status, American Society of Anesthesiologists class, carcinoembryonic antigen level, metastatic load, extent of primary tumor, and chemotherapy are

important variables to include in the prediction especially in patients symptomatic with obstruction [5,6].

This article summarizes the indications, therapeutic efficacy, and outcomes of self-expanding metal stents (SEMSs) for the palliation of advanced colorectal cancer.

2. Palliation of advanced (incurable) colorectal cancer obstruction in proximal colon

In a curative setting, surgical resection is the treatment of choice for malignant obstruction of the proximal colon. In a palliative setting, SEMS can be an alternative. Stenting malignant strictures proximal to the splenic flexure have been shown to be feasible in retrospective series [7,10,12–14]. However, these data show conflicting results regarding SEMS outcome when compared with stent placement in the left colon [7–12,15,16]. Considering the relative low risk and favorable outcome of a primary ileocolic anastomosis, right hemicolectomy is still the treatment of choice for proximal malignant colonic obstruction (Figure) [4,17,18]. Several factors could indicate that surgical resection is the best option even in a palliative setting. If patients with incurable colorectal cancer have a low surgical risk score, have a presumed long life expectancy (> 1 year), and are considered for treatment with antiangiogenic drugs (ie, bevacizumab), then surgery should be considered.

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<http://dx.doi.org/10.1016/j.tgie.2014.09.002>

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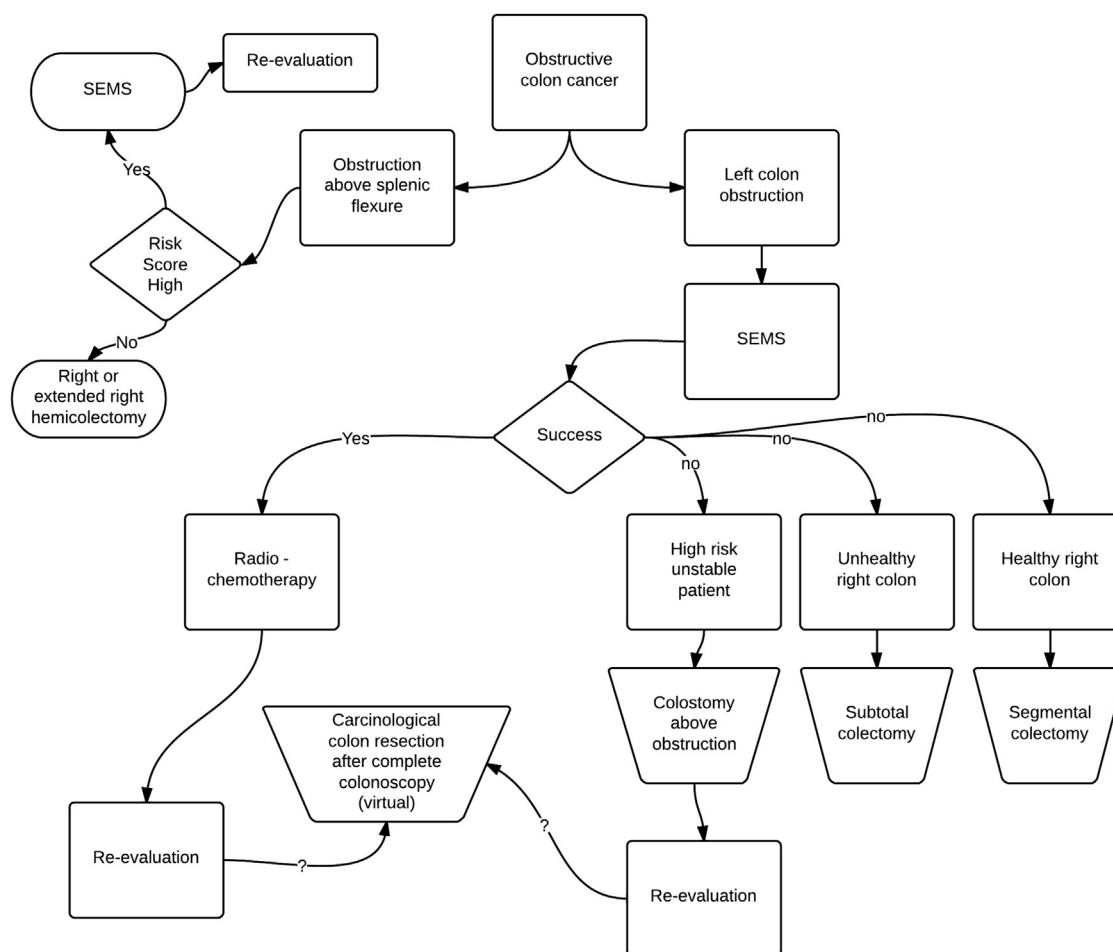


Fig. Decision algorithm for SEMS treatment of advanced colonic cancer.

3. Palliation of advanced (incurable) colorectal cancer obstruction in left colon

Owing to the high mortality and morbidity in emergency surgery for colonic obstruction, SEMSs have been recommended as the preferred treatment for incurable colorectal cancer obstruction. However, the published literature from the past 2-3 years indicate that this is not completely true. As for right-sided obstructions, several factors could indicate that surgical resection in some cases might be a better choice even in a palliative setting. SEMS is recommended as the preferred treatment for palliation of left-sided malignant colonic obstruction with a high quality of evidence, except in patients (1) with a presumed long life expectancy (> 1 year) and (2) treated or considered for treatment with antiangiogenic drugs (ie, bevacizumab).

There are 2 meta-analyses, including randomized and non-randomized comparative studies, that have compared SEMS ($n = 195$ and 404) and surgery ($n = 215$ and 433) in the setting of palliation for malignant colonic obstruction [20,21]. The technical success of stent placement ranged from 88%–100% [22,23]. Initial clinical success (relief) of obstruction was significantly higher after palliative surgery compared with stent placement at approximately 100% vs 93%, respectively [10,21]. Both meta-analyses showed a lower 30-day mortality rate for SEMS, but it was statistically significant only in the meta-analysis that included the highest number of patients (4% vs 11%) [21]. There was no difference in overall survival. As expected, stent placement was significantly associated with a lower rate of stoma formation (13% vs 54%) and a shorter hospital stay (10 vs 19 days) [20,21]. Overall morbidity was the same: 34% in the stent

group compared with 38% for surgery in the largest meta-analysis [21]. Short-term complications occurred more often in the palliative surgery group, whereas late complications were higher in the SEMS group. Stent-related complications mainly include colonic perforation (10%), stent migration (9%), and reobstruction (18%) [21]. The results from the meta-analysis are supported by other recently published literature, including a randomized controlled trial that was not included in meta-analyses [8,19,24–30].

The recommendation that palliative stenting is contraindicated in patients with a presumed long life expectancy because of late stent-related complications seems to be based on a relative high level of evidence but should be accepted as true with caution. It might be a misleading conclusion, because the SEMS itself may have contributed to the prolonged life expectancy. The absolute 6% initial difference in hospital mortality with the significant differences in hospital stay (–50% days) and intensive care unit admission (–17%) in favor of stent placement are probably more important than the small long-term risk of perforation (stent migration and reobstruction is not a severe complication and is usually easily resolved by revisional stenting). Chemotherapy administration is started much earlier after SEMS placement, which may also contribute to increased life expectancy.

4. Palliation of advanced (incurable) colorectal cancer obstruction due to peritoneal carcinomatosis

Some studies have investigated the clinical outcomes of SEMS between patients with colorectal cancer and those with

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