Multidisciplinary Approach to Recurrent/ Unresectable Rectal Cancer: How to Prepare for the Extent of Resection

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KEYWORDS

- Recurrent rectal cancer • Intraoperative radiation
- Pelvic exenteration • Abdominosacral resection

Despite advances in surgical techniques and the use of chemoradiation, local recurrence is still a significant problem in the management of cancer of the rectum. Locally recurrent rectal cancer (LRRC) can be debilitating and potentially lead to a poor quality of life (QOL). In the last decade, the incidence of local recurrence after curative resection for rectal cancer has been reported to be between 5% and 17%.[1–8] At the time of diagnosis, approximately 50% of the patients with LRRC will have metastatic disease, but between 30% and 50% of patients will die with local disease alone.[7,9–11] Prognosis among patients with LRRC can be poor because the majority of these patients will not be candidates for salvage surgical resection. The median survival in untreated patients has been reported to be about 8 months.[12] Radiotherapy with or without chemotherapy increases survival to about 11 to 15 months. With aggressive multimodality therapy, for LRRC, the overall 5-year survival rate is 25% to 54%, with higher survival rates for those patients resected with negative margins.[7,13–16] In this article, the multidisciplinary approach to the management of patients with recurrent rectal cancer is discussed.

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CLINICAL PRESENTATION

The vast majority of local recurrences occur within the first 2 to 3 years after curative surgery.[17,18] Nevertheless, local recurrence can occur after longer intervals. In fact, in patients treated with local excision with or without chemoradiation, local recurrences have been reported at intervals of more than 6 years after primary treatment.[19,20] The majority of patients who develop local recurrence will be symptomatic. The most common symptoms include new onset of pelvic or perineal pain, change in bowel habits, rectal bleeding, and urinary symptoms. In patients who have undergone an abdominoperineal resection, a nonhealing wound could be a sign of locally recurrent disease.

EVALUATION AND IMAGING

For the group of patients who may be candidates for potential surgical resection, careful staging and treatment planning should be performed by a multidisciplinary team. This team includes the surgeon, medical oncologist, radiation oncologist, urologist, plastic and reconstructive surgeon, radiologist, pathologist, enterostomal nurses, social workers, and at times a psychiatrist. A thorough evaluation should be performed to select patients in whom a complete surgical resection can be achieved with negative margins, because these patients will be the ones most likely to benefit. Surgical salvage procedures for LRRC include en bloc resection of adjacent organs or structures, such as total pelvic exenterations (TPE) and abdominosacral resection (AR), which are highly morbid, and thus could lead to worse quality of life for patients than symptomatic management.

A careful history and physical examination should be performed. In patients presenting with pain, the quality and characteristics of the pain are important in determining the potential for resectability. Patients with LRRC presenting with pain radiating to the back of the leg will most likely have involvement of the sciatic nerve and most likely will not be amenable to resection as opposed to patients presenting with just pelvic discomfort. It is important to elicit symptoms and signs regarding adjacent structures, such as pneumaturia, fecaluria, vaginal bleeding, abdominal pain with cramps, recurrent fever or chills, and weight loss, among others. Once a careful history has been taken, a physical examination, including rectal and vaginal examination and proctoscopy (in those patients who have had a sphincter-saving procedure), should be performed. This examination will allow evaluation for whether or not the recurrence is fixed, and may give the clinician an idea of the extent of the recurrence, such as involvement of the bladder or prostate, vagina, perineum, and on occasion metastatic disease to the groins. An effort should be made to obtain prior medical records, including operative reports, radiation therapy treatment plans and dosage given, as well as documentation regarding chemotherapy administered. As discussed later, patients with LRRC are candidates for reirradiation, and thus, prior radiotherapy records are important in planning re-treatment. At times it is difficult to evaluate patients in the office or clinic setting, and thus, an examination under anesthesia is necessary. In the authors' practice, every effort is made to tissue document a local recurrence before embarking in the multimodality treatment of a local recurrence.

Evaluation of patients with locally recurrent rectal cancer should include

- History and physical examination (obtain previous medical records, including operative reports, radiation schedule and portals, and chemotherapy schedules)
- Proctoscopy
- Colonoscopy

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