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Original article

Results of Surgery for Pelvic Recurrence of Rectal Cancer. Experience in a Referral Center☆

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ABSTRACT

Introduction: The only curative treatment of pelvic recurrence of rectal cancer is radical resection. The aim of this paper is to analyze our experience in surgery for local recurrence of rectal cancer.

Methods: We performed a descriptive retrospective analysis of patients treated with curative intent for local recurrence of rectal cancer from May 2000 to January 2014. The presence of resectable liver or lung metastases was not an exclusion criterion. The descriptive results, overall survival and disease free survival are presented.

Results: A total of 35 patients were included. In 18 patients an abdominoperineal resection of the remaining rectum was performed. Two of them included excision of lower sacral vertebrae, while in 17 patients, sphincter sparing surgery was performed. The most frequent postoperative complications were pelvic collection and postoperative ileus. Seven patients required reoperation and one patient died. Overall survival at 1 year was 91.2%, at 2 years 75.6% and at 5 years 37%.

Conclusions: Local recurrence of rectal cancer is a disease with high curability rate. The only curative option is radical surgery, with acceptable mortality.

Resultados de la cirugía de la recidiva pélvica de cáncer de recto. Experiencia en un centro de referencia

Palabras clave:
Recidiva cáncer de recto
Resección curativa
Quimiorradioterapia

RESUMEN

Introducción: Actualmente, el único tratamiento curativo de la recurrencia pélvica del cáncer de recto es la resección radical. El objetivo de este trabajo es realizar un análisis de nuestra experiencia en la cirugía de la recidiva local del cáncer de recto.

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Métodos: Realizamos un análisis descriptivo retrospectivo de los pacientes intervenidos con intención curativa por recidiva local de cáncer recto desde mayo de 2000 hasta enero de 2014. La presencia de metástasis hepáticas o pulmonares resecables no fue criterio de exclusión. Se presentan los resultados descriptivos y los tiempos de supervivencia y libres de enfermedad.
Resultados: Se incluyó a 35 pacientes. En 18 pacientes se realizó una amputación del remanente del recto, en 2 de ellos con exéresis de vértebras sacras inferiores, y en 17 pacientes se realizó cirugía preservadora de esfínteres. Las complicaciones postoperatorias más frecuentes fueron la colección pélvica y el íleo paralítico postoperatorio. Siete pacientes requirieron reintervención y uno falleció. La supervivencia global al año fue del 91,2%, a los 2 años del 75,6% y a los 5 años del 37%.
Conclusiones: La recidiva local del cáncer de recto es una enfermedad con alta tasa de curabilidad. La única opción curativa es la cirugía radical, con una mortalidad aceptable.

Introduction

The locoregional recurrence of rectal cancer after curative treatment for the primary tumor is an important therapeutic challenge for colorectal surgeons, and radical resection is the only option for a cure.[1]

Over the last 2 decades, the incidence of local recurrence of rectal cancer has been decreasing thanks to the advances made in neoadjuvant treatment and in surgical technique.[2] Prior to total mesorectal excision (TME), recurrences ranged between 20% and 40%.[3,4] However, its association with neoadjuvant oncologic treatment has had an influence on the reduction in the recurrence rate to between 2.6% and 10%.[5–7] In the majority of cases, recurrence occurs within the first years after primary tumor surgery,[8] although it may present later in some 36% of cases.[9]

Furthermore, there has been a change in the location pattern of pelvic recurrences, as total mesorectal excision entails a lower risk for central relapse and a predominance of lateral or posterior recurrences.[10]

Mean survival after diagnosis of local recurrence is 7 months without treatment, and 5-year survival is less than 5%.[11] Nonetheless, overall survival under multidisciplinary treatment can reach 40%.[12] Between 15% and 20% of patients present metastasis at the time of diagnosis, and 30% will develop distant metastasis after radical surgery.[13]

Currently, the only curative treatment is radical resection in order to achieve complete excision (R0), which may or may not be associated with specific oncologic treatment.[2]

The objective of this study is to analyze our experience in surgery for local recurrence of rectal cancer. Special interest has focused on survival related to the residual tumor classification.

Methods

A retrospective descriptive analysis was conducted of all the local recurrences of rectal cancer treated surgically at our institution from May 2000 until January 2014.

The colorectal cancer unit at our hospital is comprised of a multidisciplinary team of surgeons specialized in colorectal surgery, oncologists, radiotherapists, a clinical nurse specialist, an administrative assistant, gastroenterologists and pathologists. Once a week, a session is held to decide on the treatment of all the patients with colorectal cancer in the reference population.

The inclusion criteria of the study were: patients with local recurrence of rectal cancer who could benefit from surgical treatment; patients with a second local recurrence of rectal cancer susceptible to radical resection. The presence of distant recurrence (hepatic or pulmonary) susceptible to radical resection was not considered an exclusion criterion.

Local recurrence was defined as the appearance of tumor cells originating from the primary cancer in the pelvis minor after surgery with curative intent.

In cases with suspected local recurrence of rectal cancer, diagnostic studies included computed tomography (CT) scans of the thorax, abdomen and pelvis as well as pelvic magnetic resonance imaging. Recently, we have also used positron-emission tomography (PET)/CT in cases with uncertain diagnosis as well as endoanal ultrasound in patients with previous sphincter-preserving surgery.

Biopsy was reserved for patients with uncertain diagnosis after diagnostic imaging studies whose lesions were accessible by CT-guided biopsy.

We classified recurrences in accordance with the Leeds group[14]: central (relapse located in the pelvic organs with no invasion of the lateral wall); lateral (contact with lymphovascular structures or with the lateral pelvic wall); sacral (posterior, invading the sacrum); mixed (sacrum and sidewalls).

As the pelvic lesions did not infiltrate vascular structures or sacral nerve roots at S2 or higher, we decided to treat the pelvic recurrences by surgery. In the first stage of sacral resection, we performed the necessary anterior dissection, closed the abdominal wall and completed the operation with the patient in prone position. A trauma surgeon specialized in spinal surgery collaborated in the approach of the sacral resection.

Once the operation was finalized, the surgeon classified the surgery macroscopically as R0 or R2. In the pathology study, R0 was considered a curative resection, R1 the presence of