



Journal of Coloproctology

www.jcol.org.br



Original Article

Recurrence pattern of rectal cancer after surgical treatment. Analysis of 122 patients in a tertiary care center

Gustavo Sev-Pereira*, Roberta Nascimento Cypreste, Joaquim Jos Oliveira Filho, Sandra Pedroso de Moraes, Paula Buoizzi Tarabay

Hospital Municipal Mrio Gatti, Campinas, SP, Brazil

ARTICLE INFO

Article history:

Received 20 June 2017

Accepted 10 September 2017

Available online xxx

Keywords:

Recurrence

Rectal cancer

Surgery

ABSTRACT

Survival in rectal cancer has been related mainly to clinical and pathological staging. Recurrence is by far the most challenging issue when surgical treatment of rectal cancer is concerned. This study aims to establish a recurrence pattern for rectal adenocarcinoma submitted to surgical treatment between March 2003 and July 2016. After exclusion criteria were applied, one hundred twenty two patients were analyzed. Global recurrence was found in 22% of them, while 13.1% have had local recurrence. Disease-free survival was 23.9 months, in average, and medium follow-up was 34.13 months, varying from 6 to 115 months. Recurrence, in literature, is usually between 3 and 35% in 5 years, and shows a 5-years survival rate of only 5%. Around 50% of cases, recurrence is local, confined to pelvis. This data followed literature in most aspects evaluated, although finding a high rate of local recurrence remains a challenge in the seek for better surgical outcomes.

 2017 Sociedade Brasileira de Coloproctologia. Published by Elsevier Editora Ltda. This is an open access article under the CC BY-NC-ND license (<http://creativecommons.org/licenses/by-nc-nd/4.0/>).

Padro de recorrncia de cncer retal em seguida ao tratamento cirrgico. Anlise de 122 pacientes em um centro tercirio

RESUMO

A sobrevida de pacientes com cncer retal tem sido relacionada, sobretudo, aos estdios clnico e patolgico. De longe a recorrncia  o problema mais desafiador, no que concerne ao tratamento cirrgico do cncer retal. Esse estudo pretende estabelecer um padro de recorrncia para pacientes com adenocarcinoma retal submetidos a tratamento cirrgico entre maro de 2003 e julho de 2016. Aps a aplicao dos critrios de excluso, foram analisados 122 pacientes. Recorrncia global foi constatada em 22% dos pacientes, enquanto que 13,1% tiveram recorrncia localizada. A mdia para sobrevida livre de doena foi de 23,9 meses, e o acompanhamento mdio foi de 34,13 meses, com variao entre 6-115 meses. Na literatura, em geral a recorrncia se situa entre 3-35% aps 5 anos, com um

Palavras-chave:

Recorrncia

Cncer retal

Cirurgia

* Corresponding author.

E-mail: g.sevapereira@gmail.com (G. Sev-Pereira).

<https://doi.org/10.1016/j.jcol.2017.09.420>

2237-9363/ 2017 Sociedade Brasileira de Coloproctologia. Published by Elsevier Editora Ltda. This is an open access article under the CC BY-NC-ND license (<http://creativecommons.org/licenses/by-nc-nd/4.0/>).

percentual de sobrevida após 5 anos de apenas 5%. Em cerca de 50% dos casos a recorrência é localizada, ficando confinada à pelve. Os presentes dados acompanharam os achados da literatura na maioria dos aspectos avaliados, embora o achado de elevado percentual de recorrência localizada permaneça ainda um aspecto desafiador na busca de desfechos cirúrgicos mais satisfatórios.

© 2017 Sociedade Brasileira de Coloproctologia. Publicado por Elsevier Editora Ltda. Este é um artigo Open Access sob uma licença CC BY-NC-ND (<http://creativecommons.org/licenses/by-nc-nd/4.0/>).

Introduction

Colorectal cancer (CRC) is third more frequent non-melanoma neoplasm in Brazil and fourth in the world. Approximately one million new cases per year are diagnosed. Rectal carcinoma is responsible for 30–57% of all colorectal cancers. Mortality rate is estimated in up to 50% per year, and 5-years survival rate for all stages is about 70%.^{1–6}

In Brazil it has been estimated for 2016–2017 a total of more than 34,000 new CRC cases, being 16,660 men and 17,620 women.⁷

In the last decades there has been a decrease in mortality and morbidity rates in CRC patients, probably due to better diagnosis, polyp biology understanding and removal, pre and post-operative care and staging, surgical technique, pre-operative staging and neoadjuvant/adjuvant therapies. Oncological results, however, have not grown this good, keeping survival rates close to what used to happen decades ago.^{8,9}

Survival and disease-free survival in CRC has been related to many clinical, pathological, molecular, and genetic factors. This is why issues like early diagnosis, patient age, tumor location, histology, depth of invasion, lymph node invasion, levels of carcino-embriogenic antigen (CEA) and genetic expression gain importance when concerning evaluating prognosis.^{10,11} Above all this factors, pathological analysis of the surgical specimen is the most relevant information in order to establish prognosis.

Concerning surgical technique, the one most important technical detail in rectal cancer surgery is total mesorectal excision (TME), whereas other concepts like high ligation of mesenteric vessels and lateral pelvic dissection remain object of frequent debate.^{8,10,12,13}

Every healthcare professional dealing with rectal cancer treatment is still challenged by both local and metastatic recurrence which is by far the most import concern. It is responsible for a high morbidity and mortality. The best treatment that has also shown the best results in rectal cancer treatment includes neoadjuvant therapy when indicated, excision of rectum, together with mesorectum (TME), and adjuvant therapy, when needed.^{14–17}

Rectal cancer recurrence is local in more than 60% of recurrences,^{4,18} independent of low anterior or abdomino-perineal resection, and in about 50% of all recurrences, there is no tumor in any other organ. Local (or pelvic) recurrence after curative-intention surgery is an important cause of morbidity in these patients' follow-up. Three to 35% of patients operated of rectal cancer will have local recurrence.^{4,14,19} Which has been shown to follow mainly surgeries with inadequate

pelvic dissection, incomplete TME removal and affected surgical margins, but advanced stage tumor, tumor perforation and surgeon's experience can also count for it.¹⁴

Objective

Demonstrate the epidemiology and profile of patients submitted to surgical treatment of rectal carcinoma in a single surgical group, and analyze the recurrence pattern.

Methods

Data from patient files and from a database used to manage colorectal cancer patients were reviewed. All patients are from "Dr. Mario Gatti" City Hospital, a tertiary care facility in Campinas, SP, Brazil. Inclusion criteria were all patients submitted to surgery considered curative for primary rectal carcinoma, from up to 14 cm distant from anal verge, measured either by digital examination, rigid proctoscope or magnetic resonance images; and who had at least 6 months follow-up after surgery.

From an initial group of 134 patients, 12 were excluded from study because of metastatic disease (no matter whether resected or not) found at first surgery. Period of study was from June/2003 to July/2016. The following variables have been studied: age at surgery, gender, follow-up time, neoadjuvant therapy, adjuvance, histopathological features, TNM classification, recurrence and time for recurrence after surgery. Data is shown within simple frequency tables and graphics.

Results

From a group of 122 patients, 68 (55.7%) were female and 54 (44.3%) male. Rectal cancer occurred in this group from 23 to 86-years-old, with an average of 60.2 years (Fig. 1).

TME was performed in 113 patients, being 79 (64.7%) low anterior resection (LAR), 25 (20.5%) abdomino-perineal resection (APR), total proctocolectomy in 8 (6.5%) and 1 (0.8%) pelvic exenteration. The remaining 9 patients (7.4%) were treated with local resection. Open or laparoscopic surgery was chosen based on patient clinical conditions and laparoscopic equipment availability.

Every tumor described as pelvic, or below peritoneal fold, except for those elected for primary local excision, received neoadjuvant chemoradiation. The others did not get neoadjuvant treatment and went straight to surgery. All patients classified as T2 and T3 received radiotherapy at a total dose of 4500 cGy, during 5 weeks (180 cGy/week day). Chemotherapy

Download English Version:

<https://daneshyari.com/en/article/8834441>

Download Persian Version:

<https://daneshyari.com/article/8834441>

[Daneshyari.com](https://daneshyari.com)