LUMPECTOMY FOR RECTAL CARCINOMA ?

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Recently the experience using lumpectomy of rectal cancer followed by chemotherapy/radiation was updated and compared to standard techniques. Many consider the term lumpectomy when talking about breast cancer, but in fact a lump of cancer can be removed from many sites. It indicates a lesser degree of surgery.

There is a trend in oncology to preserve the body, that is, to avoid extensive surgery attempting often to use radiation and chemotherapy to make up for the more modest operative methods.

A recent analysis by Wagman looked at 39 patients who had local excision of rectal cancer only and were referred to a major cancer center for treatment . The reason standard surgical means are routinely used is that the technique is well-known and in general well-tolerated.

In certain cases a more limited surgery is attempted to preserve the anus thus avoiding colostomy. Often chemotherapy and radiation are used initially to shrink the cancer before proceeding with more modest surgery. A different approach was recently reported. In 39 patients treated at Memorial Sloan Kettering Cancer Center from 1986 on for nearly eleven years, rectal cancers were excised locally and given chemotherapy radiation afterwards. There were many different reasons for the limited degree of surgery performed.

Patients either had refused surgery or were felt to be to medically unstable to go through surgery. All had invasive cancers that were stage T2 or T3, thus defining the extent of disease or were TI with unfavorable characteristics. These would suggest more aggressive cancers.

Unfavorable characteristics included positive margins, that is the cancer extends to the margin or site of surgical resection, had cancer cells growing in the vessels in the specimen, was poorly differentiated or aggressive in appearance under the microscope.

Age of patients ranged from 32 to 80 with a median of 66 years. Follow-up was from 9 to 131 months with a median of 41 months. Three patients were lost to follow-up.

Positive margins were identified in eleven patients. Positive margins mean the cancer extended to the edge of the removed tissue. Two patients had a polyp and it was snared or pulled out through a colonoscope. One had a positive margin and another patient was left with a scar not visible for a second or more extensive excision of the cancer. Both were included.

Radiation was given using standard techniques. The dose ranged from 4580 to 4950 cGy with a median of 4680 and a cone down of 360 to 1080 with a median of 900. The patients with positive margins received 5580 cGy in general.

As well, the patients received what would be considered standard chemotherapy consisting of 5FU either as bolus or as continuous infusion. The five year disease-free survival was 77% with an overall survival of 70%. 5FU is a chemical used for decades in the treatment of bowel cancers.

Local failure rates were 27% at five years. This means about a quarter of the patients had recurrence. There was a 22% abdominal failure rate and a 23% distant failure rates. Abdominal failure means the cancer recurred in the abdomen while distant failure means it recurred far from the original position. The failure rates were higher in patients with positive compared to negative margins.

Eight patients had local failure. Here there was, as well, abdominal failure in 38% and distant failure or metastases in 50%. The time to local failure in these eight patients occurred at four, six,

eleven, thirteen, twenty, twenty-nine, thirty-five and forty-eight months after diagnosis. Five of the eight had abdominal peritoneal resection for salvage - or second line treatment - necessitating colostomy while one had the tumor fulgurated (or straped off only with no operation performed).

Two further patients did not have salvage therapy because of extent of disease at the time. Those patients who had salvage surgery were locally controlled at nine, thirteen, fifteen, twenty-four, and seventy nine months. One patient who had an abdominal-peritoneal resection for local failure had no cancer found in the specimen, however.

Excluding the seven patients who had local failure and underwent salvage surgery, 32 patients were evaluated for sphincter preservation. The sphincter function was said to excellent in 17 and good in 13. Half the patients required medication to control the frequency of bowel movements. Other complications including rectal stenosis or fissures.

The authors noted, "the crude rates of abdominal and distant failure in the eight patients who developed local failure (38% and 50% respectively) are high despite surgical salvage." When compared with standard techniques, "the subset of patients with unfavorable pathologic features (i.e. bladder, lymphatic vessel invasion, poor differentiation) the five year actuarial local recurrence rate was higher (33% local excision versus 11% APR) and disease free survival was lower, 57% local excision versus 79% APR."

The researchers concluded, "in contrast with our initial report local failure rates in patients with T2 disease have increased to 24% crude and 31% five actuarial, which is similar to results seen in T3 disease. However, for the total patient group, the five who underwent salvage APR were locally controlled.

Furthermore, the five year survival was 70%, and 93% of patients with an intact sphincter. The sphincter had good to excellent function in most. Local excision and post-operative therapy remains a reasonable alternative to APR in selected patients."

While not the greatest results, these statistics are important for physicians to have to be able to best advise patients about treatment options for rectal cancer.