Resecting the unresectable primary locally advanced colorectal cancer.

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- CRC is the most common gastrointestinal cancer worldwide.
- The 3rd most commonly diagnosed malignancy and 4th cause of deaths due to neoplasms.
- Men are more susceptible to develop CRC than women.
- in 2017 135,430 new patients were diagnosed with CRC worldwide.

• 5-year survival rates

- reach nearly 90% in The localized disease which is found in less than 40% of primary diagnoses.
- over70% in the regionally advanced (spread to regional lymph nodes).
- less than 14% (or even less in rectal cancer cases) in stage IV with distant metastases(more than 20% of primary diagnoses).

- Long-term survival exceeding 5 years in disease with distant metastases was 9% when treated
  - only with palliative chemotherapy.
  - And
- 36% when SURGICAL and SYSTEMIC treatment was combined

- In 2013, a consensus of multidisciplinary management of CRC has been achieved and EURECCA guidelines have been published. Together with 2016 ESMO guidelines and ASCRS guidelines, they provide a standard of colorectal cancer treatment.

- it is crucial to assess the resectability criteria

• The Resectability Criteria

- localization,
- size of the primary tumor and
- all metastases as well as
- patient’s general health condition should be considered

• localization of metastases

- influences survival rates. Patients with only lung metastases have signifcantly better OS than those with liver metastases,
- patients peritoneal spread have the worst prognosis.
- patients with one-organ non-peritoneal metastases have the best prognosis.
- the worst concerns patients with non-isolated peritoneal metastases

- **metastases are synchronous or metachronous**

  - **metachronous hepatic and pulmonary resection**

  - **has significantly better survival**

  - **compared to the synchronous.**

- **Metastasectomy (if R0 resection can be achieved)**

- has been performed to cure metastatic disease in the liver and lung more frequently for colorectal cancer metastases than for any other malignant neoplasms

- **combining both**

extensive and multivisceral surgical resections

with

preoperative or perioperative systemic drugs

can lengthen survival in the majority of patients and even permanent cure in some cases is possible

• RECURRENT DISEASE

- Managing with recurrent disease is a challenge for today surgeons; however, it is inherent and inevitable part of advanced cancer treatment.
- This leads to a conclusion that all attempts should be undertaken to achieve R0 resections, and surgical intervention should be done as it affects patients' survival.

•TREATMENT OF UNRESECTABLE DISEASE

- In approximately 65% of patients with stage IV CRC, a radical surgery is not possible.
- 6% of stage IV CRC patients represent emergency conditions, such as active or occult bleeding, perforation or mechanical bowel obstruction. require surgical intervention.
- That may prolong survival or improve patients' general health condition and enable subsequent palliative systemic treatment.

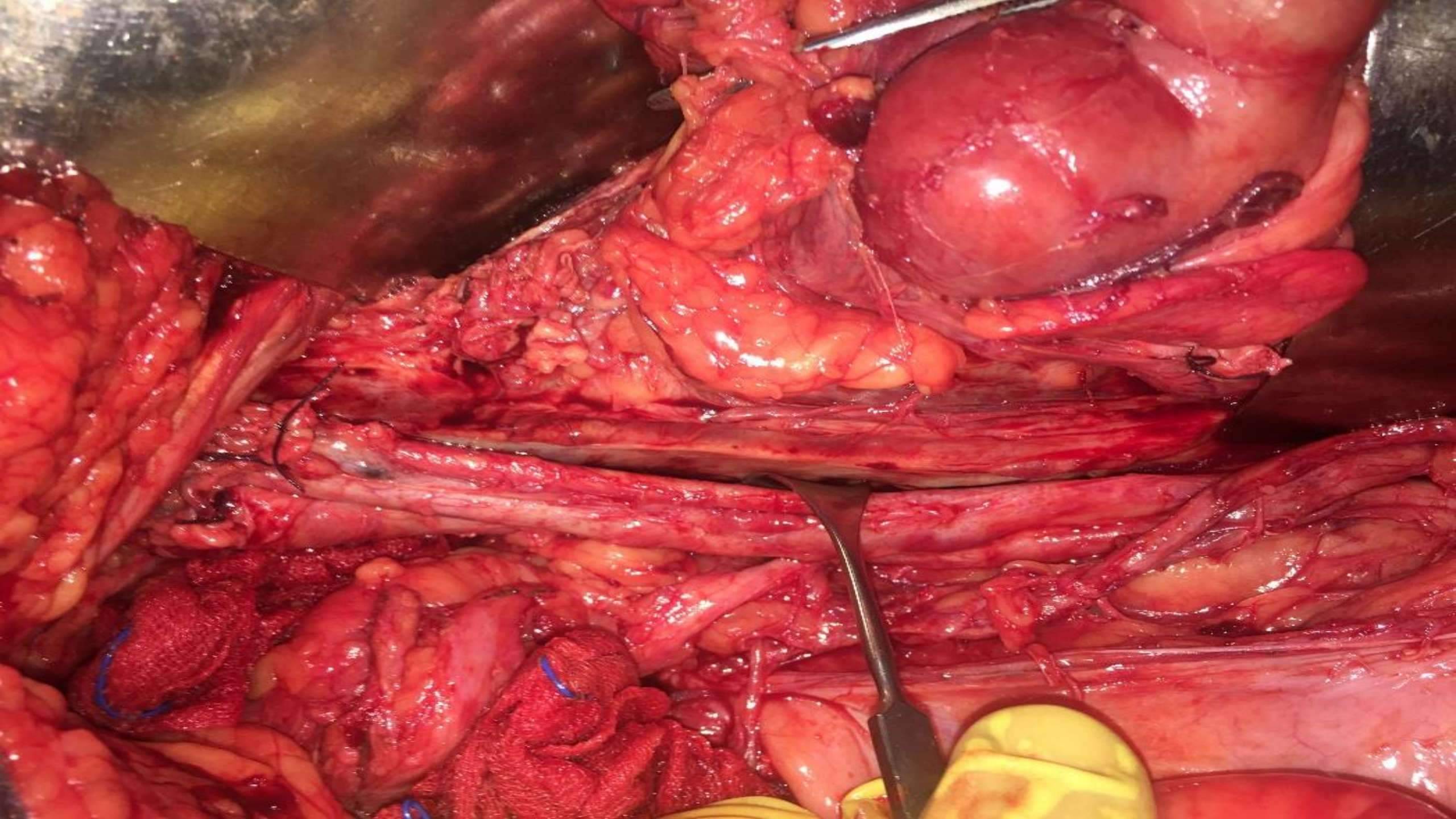
• LOCALLY ADVANCED DISEASE

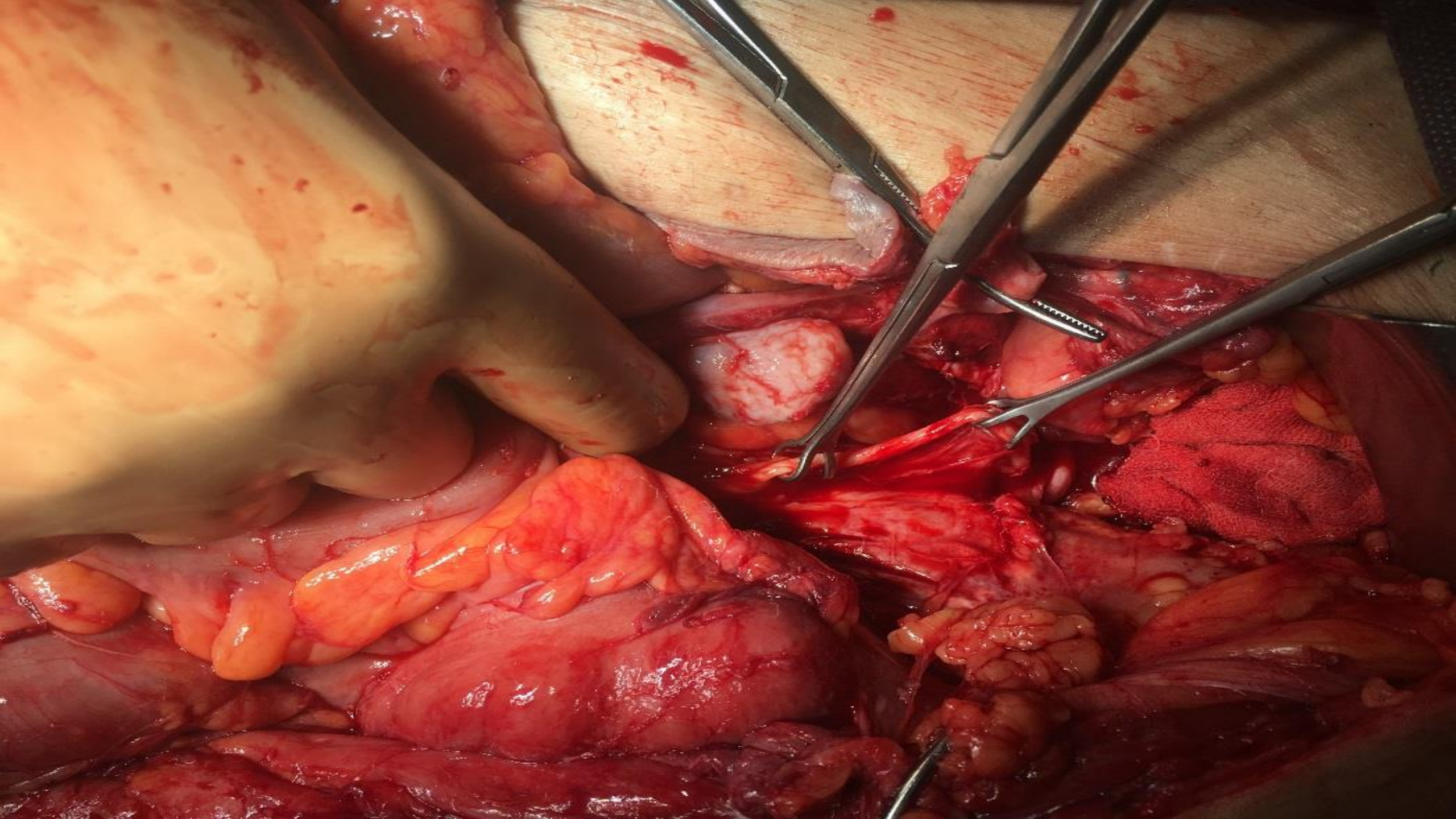
- represent a majority of case presentation in developing countries and mandates a skillful ultra-major surgery to achieve radical tumor resection.
- This critical intraoperative decision has an impact on survival and quality of life.
- It is directly dependent on operative factors (blood loss, surgical experience and performance status of the patient)

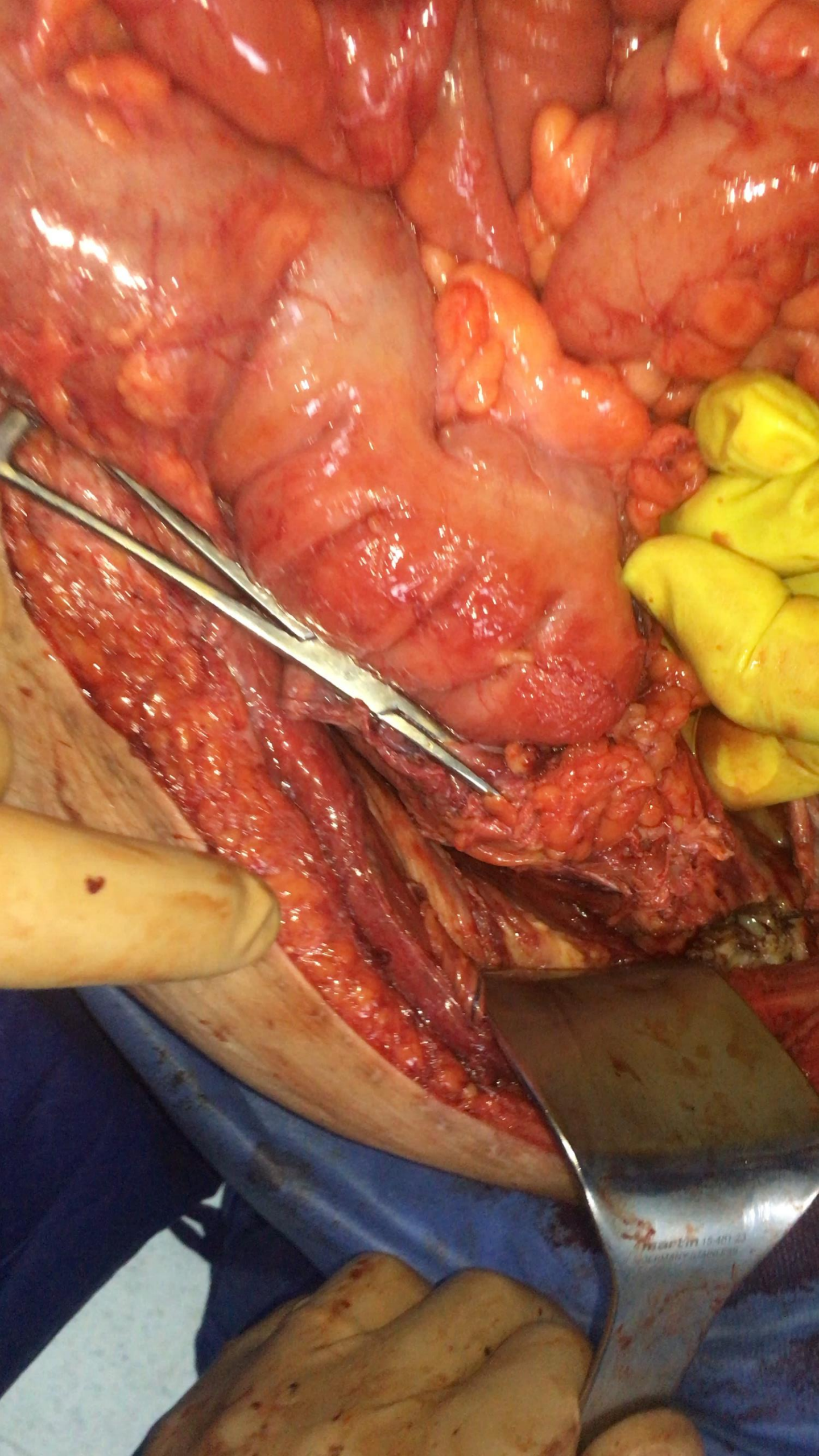
OUR EXPERIENCE

- We reviewed data of 33 locally advanced CRC Pts. presented between February 2014 and November 2017.
- With median age of 54 years.
- We compared between two groups of Pts.
- Group I were 11 Pts received chemoradiotherapy and underwent palliative surgeries without radical resection.

- Group II were 22 Pts underwent the ultra-major radical resection (RR) including adjacent affected organs.
- divided in two categories
- (A) were eight Pts received Neoadjuvant chemoradiotherapy or chemotherapy alone and then RR,
- (B) were 14 Pts underwent upfront surgery.
- We analyzed data to compare the survival outcomes between the two groups.







RESULTS

- Eight Pts of group I experienced further tumor progression and needed secondary palliative procedures and median survival was 6.9 mo.
- For group II in the subgroup (A) younger (58 vs 64) Pts was associated with longer median survival: 18.9 mo. vs 14.9 mo.
- Subgroup (B) showed a significantly longer median survival 23.9 mo. Postoperative rates of complications and death was 13.5%.

- **A potentially curative resection was possible in 80% of Pts.**

  histologic tumor infiltration to the adjacent resected structures found in 44% of patients with RR.

- **After curative resection, the local recurrence rate was 13%.**

CONCLUSIONS

- Radical ultra-major surgeries for locally advanced CRC is safe,
- and a significant long-term survival benefit after RR is similar to that after standard resection.
- every effort should be made to achieve complete tumor resection.
- Surgical experience, performance status of the patient and blood loss are important prognostic factors.

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