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.

• **over 70% 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 significantly 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's 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.
• 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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