Local Excision for Rectal Cancer: An Uncertain Future

Drs. Weber and Petrelli review much of the literature regarding patient outcomes after local excision alone, as well as local excision plus chemoradiotherapy, in patients with various stages of low rectal adenocarcinoma. The authors apparently were unaware that the Radiation Therapy Oncology Group (RTOG) experience with local excision plus chemoradiation, which antedated the Cancer and Leukemia Group B (CALGB) study, will soon be in print to provide further multi-institutional support for these methods along with much greater follow-up. They also omitted our long-term data (median follow-up of survivors is 67 months) showing the very low locoregional recurrence rates in patients with T2 cancers treated by local excision and chemoradiotherapy.[1]

The authors correctly emphasize the conundrum resulting from the unresected (and thus unexamined) regional lymph nodes in patients with low rectal cancer. Some patients will have positive nodes even if they have a T1 cancer, and thus surgical excision alone will be doomed to failure. Many more patients with T2 and T3 cancers will have positive nodes; we have no specific information about whether these nodes will be controlled by chemoradiotherapy. Since reported recurrence rates after local excision and chemoradiotherapy are considerably lower than percentages of nodal positivity reported from large series of patients with radical rectal and mesorectal excision, it is likely that chemoradiotherapy will control those metastases in at least some, and probably many, of these patients.[1-5] Perhaps the major problem with the technique is that we cannot identify patients with positive nodes, and, thus, we cannot provide adjuvant chemotherapy to those who should be receiving it.

Local vs Radical Excision or Excision Alone vs Excision Plus Chemoradiation

Weber and Petrelli conclude that local excision has not been proven to be as effective as radical rectal excision, nor has postexcisional chemoradiotherapy been proven to be superior to excision alone. The former comparison will, undoubtedly, never be subjected to the scrutiny of a phase III trial. However, there are enough phase II studies of local excision of T1 tumors with low-risk histology to indicate that local excision is equivalent to abdominoperineal excision and certainly has less toxicity.

The latter comparison also probably will never be tested in a randomized trial because it is highly unlikely that most patients with a T2 cancer will be as well served by local excisional surgery alone as they would by combined-modality therapy. The authors point to a statement taken out of context from an article by Willett et al as indicating that there is no difference between these therapies.[6] However, the groups compared in this study were by no means equivalent. (Those with deeper and less differentiated lesions were given chemoradiotherapy.)

Identifying Positive Lymph Nodes

Ideally, carcinoembryonic antigen-labeled radioantibodies could be administered to the patient prior to any manipulation of the tumor (other than transrectal ultrasound), and any "hot" nodes identified in the mesorectum could either be biopsied or assumed to contain cancer and be given appropriate treatment, such as abdominoperineal resection or very low anterior resection with total mesorectal excision. Patients who are unable or unwilling to undergo major surgery could theoretically have full-thickness transanal excision followed by chemoradiotherapy and 6 months of systemic chemotherapy. However, it is unlikely that available radioantibodies can provide high enough
target-to-background activity to be recognized by currently available radiodetection devices. Perhaps sentinel node technology could identify positive nodes in these patients, but this would probably involve at least transcoccygeal approaches, which, in turn, might jeopardize curability by radical excision should positive lymph nodes be found.

**Treatment Recommendations**

In the absence of such technology, we believe that patients with T1 lesions and high-risk histology (poor differentiation, lymphovascular invasion) should receive chemoradiotherapy or radical excision, and those with T2 lesions and high-risk histology should receive both chemoradiotherapy and post-radiation adjuvant chemotherapy or radical excision. All patients with T2 lesions should be treated with chemoradiotherapy after local excision. Patients with involved margins or margins within 1 to 2 mm of the cancer should either undergo transanal re-excision for wider margins, or radical resection with total mesorectal excision and coloanal anastomosis or abdominoperineal resection.

There are simply too few reported patients with T3 cancers who have had local excision plus chemoradiotherapy to be able to definitively evaluate the procedure, although most available reports suggest that great caution should be exercised. If we had an effective method to determine regional nodal positivity in these patients and were able to provide wide margins around the tumors (small tumors, minimal mural penetration), a trial of local excision plus chemoradiotherapy plus adjuvant chemotherapy would seem to be a logical course of action. Without such a method to detect involved lymph nodes, however, only patients who are unable or unwilling to undergo major rectal surgery should be offered such therapy, and then only after transrectal ultrasound has demonstrated no enlarged lymph nodes.

**Salvage Therapy for Locoregional Recurrence After Local Excision**

Finally, to add to the scant information provided about salvage therapy for patients with locoregional recurrence after local excision, we should point to our review, and provide slightly more information on the six patients whom we have treated.[7] Two died of distant metastases 6 and 30 months following radical resection, while four remain alive (three of whom are free of recurrence 41, 72, and 83 months after resection of the locoregional recurrence, and one of whom developed pelvic and lung recurrences 81 months after resection of the recurrence).

**References:**


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