In reviewing the current issues in rectal cancer management the word specialist recurs again and again. The modern hospital requires consultants with special interest in each of the key stages of decision making: Clinical assessment – usually the surgeon MRI. Fine slice individually orientated phased array coil studies with a specially trained radiologist. CT – now routine for metastases Neo-adjuvant therapy. Special interest in the disease in both clinical and medical oncology is essential. Surgery: The challenges of the distal pelvis make it increasingly unacceptable for surgeons without a "special interest" to operate on mid and low cancer. Histopathology: The lessons of Professor Quirke have brought the specialised histopathologist out of his laboratory into the cruel role of "surgical auditor" – providing circumferential margin examination plus naked eye, TME quality assessment. This gives us two invaluable measurable short term goals improving the quality for surgical practice. When a hospital can provide special interest doctors in all these fields and when they co-operate in a constructive manner the modern colorectal MDT can lead the way for the whole field of cancer management. It remains a probability that the use of high definition improved quality video based teaching of surgical technique is the single most effective weapon that we have in our battle against this most challenging of malignanvies.

Key words: rectal cancer, surgical technique,

INTRODUCTION

Rectal cancer continues to provide a paradigm for the management of all the common solid tumours. It is increasingly considered to be both radio and chemosensitive whilst its anatomical situation makes it appropriate target for all neo-adjuvant therapies. This inaccessible fixed situation distal to the peritoneal cavity deep in the pelvis also poses a unique challenge for surgeons. The true anatomy of the live patient is only now being elucidated by the highly specialised dissection involved in total mesorectal excision (TME) surgery and in refinement of abdomino-perineal excision (APE). It is a fortunate reality that rectal cancer spread commonly remains loco-regional so as to make this difficult surgery the most rewarding in the whole field of cancer. The recognition of and presentation of the autonomic nerve plexuses is an ongoing challenge in the training of young surgeons. The laparoscope, in the best hands, is increasingly making every aspect of the surgery above the "true" or "small" pelvis more precise. It remains however questionable, at its present stage of development, whether the deep pelvic dissection can be effected as well with the laparoscope as with the optimal use of illuminated and optically curved variations on a theme of the St Mark’s retractor by the “specialist open” approach.

In the UK day-to-day management is now in the hands of multidisciplinary teams (MDTs). Surgeons must increasingly guard therefore against shirking their primary responsibility to the patients who have put their trust in them - the choices are becoming exceedingly complex and their consequences far reaching. At least half and probably two thirds of patients after proper fine slice MRI staging can most safely and with least morbidity be managed by skilful specialist surgery alone, so that pre-operative RT need not be given to everyone, as is tending to happen at present. Data from Stockholm has highlighted the co-morbidity that inevitably follows pelvic radiotherapy (RT) – short or long. After sphincter conservation impaired bowel function and incontinence are at least twice as common after RT, significant in at least half of all patients, whilst progressive autonomic dysfunction is also a significant risk.
All patients are rendered sterile by RT so it is especially desirable to avoid it in the young unless clear indication exists.

Modern practice enables us to identify in whom clinical plus specialist MRI assessment suggest that mesorectal fascia involvement on the surgical specimen or systemic failure, due to MRI recognisable high risk disease, are high probabilities. These must be considered by the MDT for long course chemo-radiotherapy (CRT). There is unlikely to be a ready solution to the arguments between short and long course RT, but it is a fact that no studies have been attempted that combine SRT (short) with chemotherapy. This puts the SRT routine at a fundamental disadvantage – no chance exists for such patients of developing a complete response (CR) or even of significant downstaging or down sizing to facilitate monobloc surgery with clear margins on the specimen. The possible advantages of a chemotherapy effect on micro-metastases at an early stage, before time and surgery have intervened, are also lost with the short course routine. There are at present wide differences in practice in different centres in the UK. At the Royal Marsden Hospital and in Basingstoke for example short course radiotherapy is reserved for the occasional frail patient, whilst in Manchester it is a standard routine. The only major issue that is now resolved beyond doubt is that radiation, when it is to be given, should be given before rather than after operation. The recent German study has succeeded in demonstrating this clearly. A major area of controversy however surrounds the choice of and timing of the drugs to be used in combination with RT, so ongoing confusion is inevitable for years to come.

One area of special interest to us in the Pelican Centre and at the Royal Marsden Hospital has followed the visit to the Pelican of Professor Angelita Habr-Gama from Sao Paulo in November 2005. Her robust and logical non-operative surveillance approach to the complete clinical response (cCR) situation is to be repeated by us using intensive fine slice MRI and CT studies in tandem with careful digital assessment by an experienced surgeon. It is our perception that combinations of modern chemo agents with radical RT may indeed be curative in 10 – 20% of cases and perhaps ultimately in more than this. We propose to follow the Habr-Gama routine at least as far as delaying surgery for as long as regression seems to be occurring with the ultimate hope that operation may perhaps be avoided altogether.

With increasing neo-adjuvant therapy controversy is intensifying between sphincter conservation and permanent colostomy. An "Extreme" sphincter conservation policy in as many as 90% of rectal carcinomas continues to be our stance at Pelican. TME results have shown consistently superior oncological outcomes in cases where it is technically feasible to avoid abdomino-perineal excision (APE). Our perception of the background reason for this is that the point of insertion of the ano-rectal muscle tube and its tapering mesorectum covering into the pelvic floor is an area of "oncological vulnerability" to surgery of any kind. This often forms a visible "waist" on an APE specimen whilst the two-ended nature of the operative procedure accentuates the risk of perforation or exposure of cancer at this point. We suspect that the ano-rectal muscle tube around 3-6cm from the anal verge is vulnerable in any operative procedure and particularly dangerous for anal procedures such a TEM. In a specialist referral practice it is all too frequent a tragedy to see incurable recurrence after ill-considered attempts at local excision in this region – and these tragedies frequently follow tumours, which were early and easily curable at initial presentation.

The APE operation is, in the UK at least, one which is more often performed sub-optimally than AR plus TME which has precisely defined objectives. Avoidance of the "waist" in APE has led to demands for "cylindrical specimens' often demanding replacement by musculo-cutaneous grafts. A personal view is that the new optimal definition for the APE "oncological specimen" should be that the dissection is "extra lavator" – rather that "cylindrical". Although less readily recognised than the "holy plane" around the mesorectum there is an "extra levator" plane which can be followed by the surgeon with a margin which is "MRI predictable". Whether the APE operation needs the patient to be turned to the prone jack-knife position remains to be determined, but the abandonment of synchronous combined excision does seem a clear and desirable current trend: the demanding nature of the disease makes the surgical activity on two fronts a fundamental sub-optimal approach.

SUMMARY

BOLJA HIRURGija I BOLJA SELEKCIJA ZA ADJUVANTNU TERAPIJU -JOŠ UVEK KLJUČ ZA POBOLJŠANJE ISHODA LEČENJA KARCINOMA REKTUMA.

Rektalni karcinom nastavlja i dalje je primer lečenja svih vrstih tumora. Sve više se smatra da je i radio i hemio senzitivan dok ga anatomska situacija čini odgovarajućim metom za neoadjuvantnu terapiju.

Key words: neo adjuvantna terapija, radioterapija, hemoterapija, hirurgija

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