Recurrences Seen After Excision in Early Rectal Ca

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SAN FRANCISCO — Treating early-stage rectal cancer with local resection alone has become increasingly common but poses a considerable long-term risk of local recurrence, even in patients with T1 tumors, according to the results of a large retrospective cohort study.

Dr. Y. Nancy You, of the Mayo Clinic in Rochester, Minn., reported follow-up data from the National Cancer Data Base on 765 patients who underwent local excision and 1,359 patients who underwent standard resection for stage I rectal cancer between 1994 and 1996. She presented the data at a symposium sponsored by the American Society of Clinical Oncology.

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DR. YOU

patients with complete resection (R0; no residual tumor) were substantially higher among patients who had local excision alone, compared with standard abdominal resection. For patients with T1 tumors, defined as those that invade only the submucosa, recurrence rates were 13% for local excision alone versus 7% for standard abdominal resection. For patients with T2 tumors, defined as those extending into the muscularis propria, recurrence rates were 22% versus 15%, respectively.

At 8 years post diagnosis, the local recurrence rate for completely resected T1 tumors had climbed to 14.3% among patients who underwent local excision alone, Dr. You said.

The type of surgery did not significantly affect overall 5-year survival rates for patients with T1 tumors, although patients with T2 tumors were more likely to survive if they underwent the more radical surgery rather than local excision (77% vs. 68%, respectively).

A multivariate analysis found that overall survival was independently associated with age at diagnosis, number of comorbidities, and number of postoperative complications for patients with T1 or T2 tumors.

Local excision alone spares most patients perioperative morbidity and preserves the sphincter, Dr. You said. Her review found that patients selected for local excision tended to have low-lying, small, low-grade tumors.

Lower rates of rehospitalization and perioperative complications were found in the patients who underwent local excision than in those who underwent complete resection for stage I disease.

Dr. You and associates concluded that appropriately selected patients with T1 tumors, including the elderly and patients with comorbid conditions that would increase surgical risk, can expect "acceptable overall survival" from local excision. "However, they do face increased risk for a local recurrence in the long term, in exchange for a favorable perioperative course," she said at the meeting.

Caution should be used in treating patients with T2 tumors with local resection alone, she advised. "I would reserve local excision alone only for those patients [with T2 tumors] whose medical risks are prohibitive," Dr. You emphasized.

In an interview after the meeting, she said the gold standard for patients with T2 tumors remains a standard abdominal resection, which she generally recommends to her patients when discussing the risks and benefits of either procedure.

"However, if the tumor characteristics are favorable for local excision and [the] patient is reluctant to undergo a large procedure, I would strongly consider a clinical trial," she said.

Trials are underway to see whether chemoradiation in combination with local excision lowers the risk of local recurrence in patients with stage I disease.

Dr. Heidi Nelson, chair of the colon and rectal surgery division at the Mayo Clinic, was a coinvestigator on the study. Researchers from the University of Minnesota and the American College of Surgeons also contributed. The meeting was cosponsored by the American Gastroenterological Association, the American Society for Therapeutic Radiation and Oncology, and the Society of Surgical Oncology. ■