Radical Surgery is a superior option to Transanal Excision of Rectal Cancer

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Oxymoron

- **oxymoron**
  noun
- conjoining contradictory terms
  - as in 'deafening silence’
  - ‘early/superficial rectal cancer’

Which operation is best?

- Patient factors and tumour factors

The ‘good risk’ patient

The best choice

- TME surgery
  - J-pouch
  - no radiation
  - Good oncological result
    - Addresses locoregional lymph nodes (up to 40% positivity)
    - 90%+ cure rate
  - Good functional result
    - 1-3 BMs/day

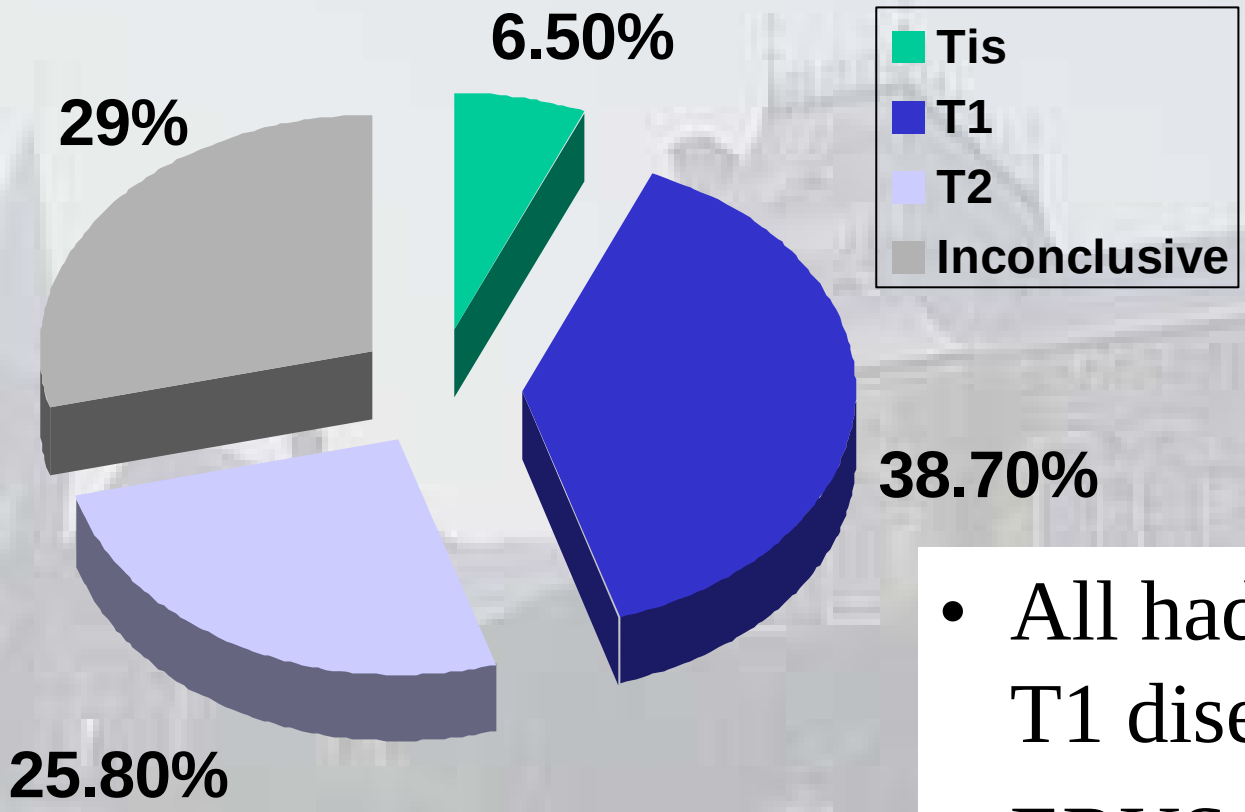
1. TAE addresses the “T”, not the “N”

- TAE doesn’t address the lymph nodes
  - Lymph node disease causes some/?many LR
- It may be T1 but is it N0?
- Rate of regional nodal metastasis in:
  - T1 Rectal Cancer – 15-25%
  - T1 Colon Cancer – 3-8%

“Do you feel lucky?”

Nascembeni R et al. DCR 2002
Okabe S J Gastrointest Surg 2004

2. We are not good at selecting “appropriate cases”



- All had pathologic T1 disease
- ERUS is imperfect
  - Cleveland Clinic
    - DCR 2005

3. TAE is a clinically relevant compromise: Local failure rates are high

- **Garcia-Aguilar et al (Minnesota)**
  - 82 patients with T1 (n=55) and T2 (n=27)
  - Well selected patients
    - Fully staged, with most (n=59) having ERUS
    - Surgical and Pathology protocol – 1 cm margin, full thickness, pinned, inked and carefully analyzed
    - Negative margins, well-moderate differentiation, no LVI, no mucinous componnent
  - 54 months of follow-up
  - T1 = 18% recurrence
  - T2 = 37% recurrence
- **Radical surgery**
  - 10% (absolute) better local control

Mount Sinai Hospital, U of T

(42 patients who had TAE)

Depth of Invasion	Local Recurrence	5 year Disease Free Survival
T1 (31)	19.4%	90.4%
T2 (10)	30%	59.0%
T3 (1)	0%	100%

Fenech et al 2006

4. It's worse in a population-based sample! Ontario 1997-2000

Table 2a – Preoperative Work-up – Entire Cohort	
Investigation	% Performed (x)[1]
Sample Size (n)	256
DRE	64.8 (166)
TRUS	15.6 (40)
CT	10.6 (27)
MRI	0.4 (1)
Endoscopy	81.3 (208)

Notes:

- 35% of all TRUS were done at one centre

Calvin Law et al. Manuscript in preparation

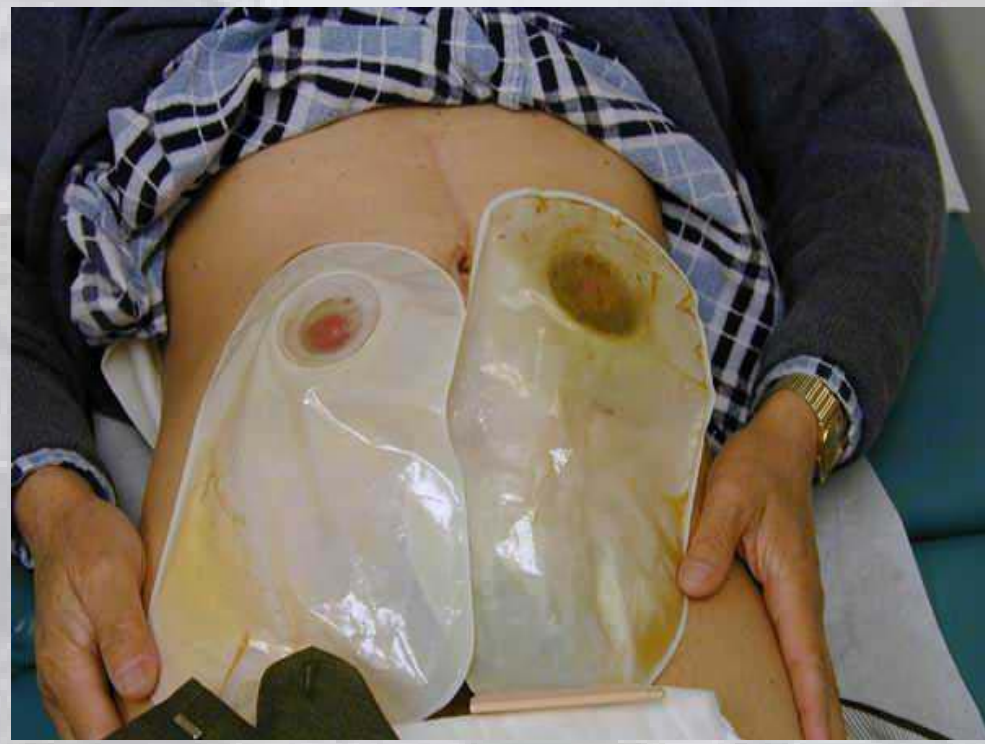
Table 3a – Pathology Data – Entire Cohort	
Pathological Feature	% (n)
Size (cm)	2.5cm
Mobility[1]	
Mobile	31.3 (80)
Fixed	1.6 (4)
Other	8.2 (21)
Not Available	59.0 (151)
T stage	
Tx	13.9 (35)
Tx maybe Tis	10.8 (27)
T1	36.3 (91)
T2	25.9 (65)
T3	5.6 (14)
Degree of Differentiation	
Poor	5.2 (12)
Moderate	59.7 (139)
Well	12.9 (30)
Other	2.15 (5)
Not Available	20.2 (47)
Margin Status	
R0	49.6% (116)
Specimen Handling	% (n)
Orientation / pinning	17.6%

Local Recurrence > 18%

5. Salvage of Recurrences: not great!

MSKCC

- 50 patients who underwent salvage following TARE
- Median time to salvage was 20 months (range: 4-70 months)
- 40% were symptomatic; 40% were asymptomatic; 20% unknown
- 55% required en-bloc multiviserceral resection
- 5 year OS = 53%



DCR 2005

TME

- TME
- improved local control
- overall survival
- maintaining quality of life
- preserving sphincter, genitourinary, and sexual function.

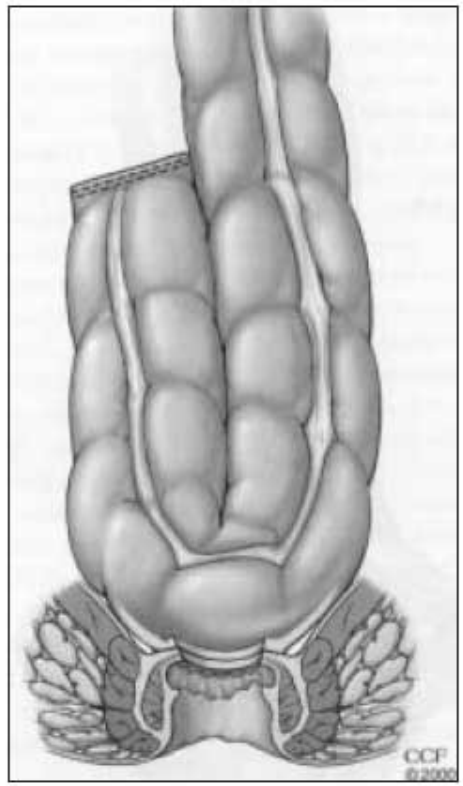


Figure 1: Colonic J-pouch anastomosis

TAE for superficial rectal cancer

- Gambling with a sinister disease
- Poorly conceived cancer operation
- Inferior oncological outcomes for T1 and T2
- Salvage/cure is often morbid or not possible following recurrence
- The alternate operation is good, especially if no XRT