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EMILIA-ROMAGNA
Azienda Ospedaliero - Universitaria di Ferrara

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di Chirurgia Endoscopica
e Nuove Tecnologie

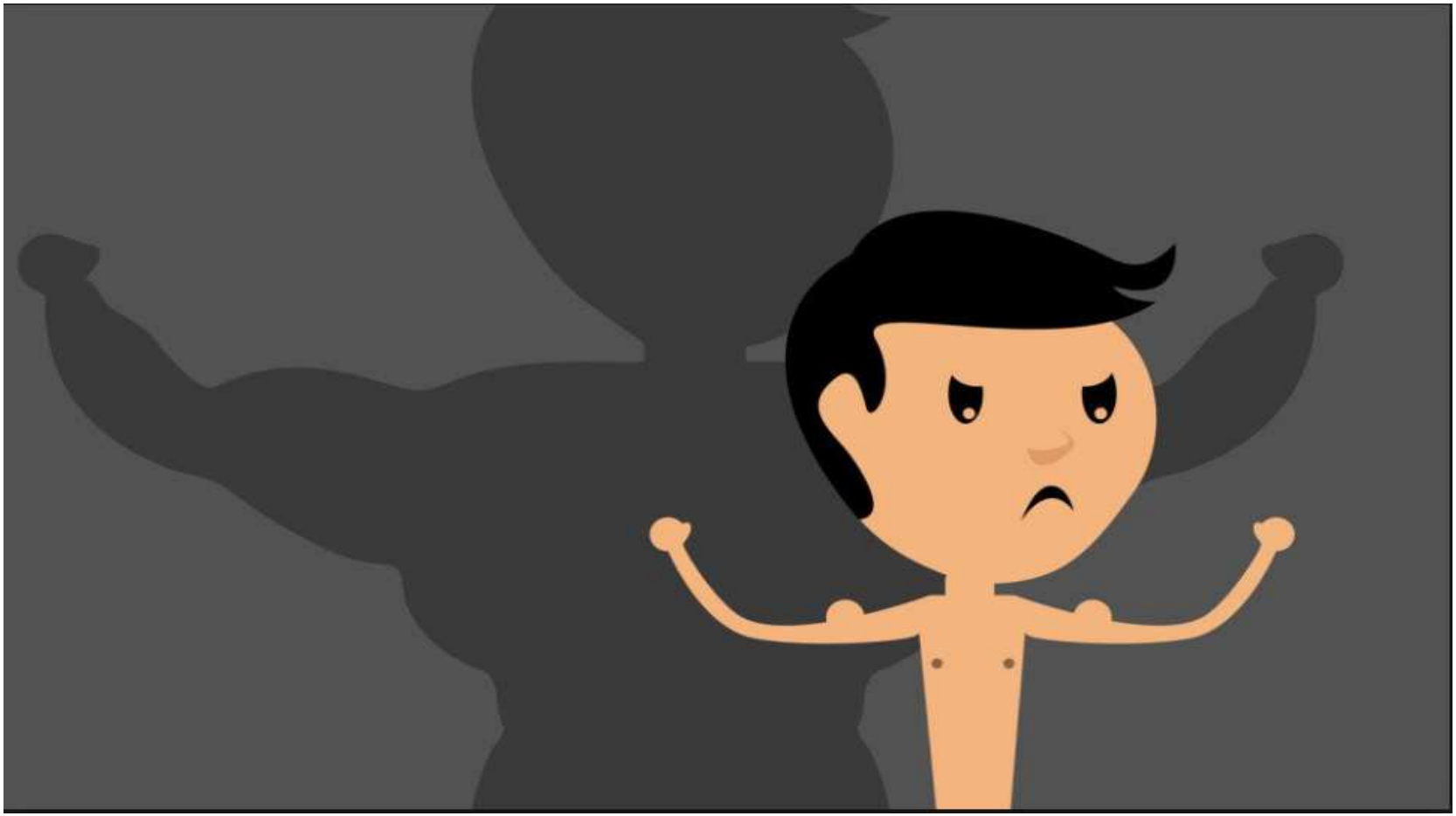
Finita la leadership del chirurgo nella cura del Ca del retto?

AOU S.Anna- Cona (FE)
U.O. Chirurgia 1

Dott. G. Resta
Dott.ssa C. Bombardini

Risposta difficile

L'EGO del CHIRURGO



Succedeva ….

perché?

Il tumore del retto è:

- Oncologicamente aggressivo
- Invalidante
- Occludente
- Sanguinante

Succedeva …. *e forse succede ancora*

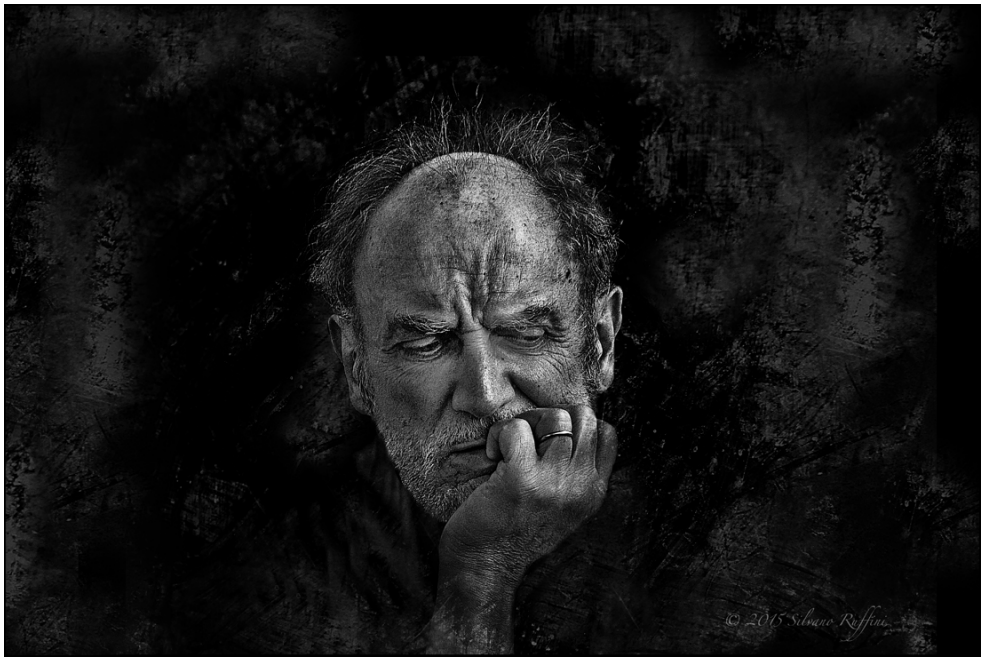
Diagnosi di tumore

Ricerca del Chirurgo

Minima stadiazione

Trattamento chirurgico

Oncologo



G Chir Vol. 24 - n. 10 - pp. 334-340
Ottobre 2003

editoriale

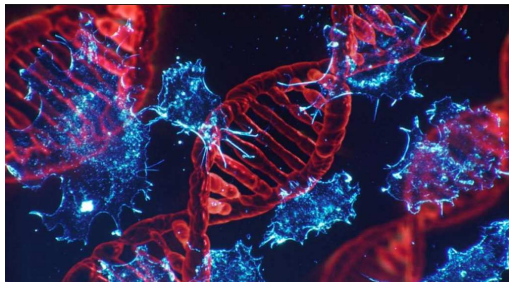
La chirurgia del cancro del retto nel terzo millennio

M. Nano
con la collaborazione di M. Ferronato e M. Solej

La chirurgia del cancro del retto ha seguito una strada diversa da quella della maggior parte degli altri organi. In quasi tutta la chirurgia l'evoluzione è consistita in un progressivo ampliamento dell'exeresi associato alle terapie integrate. Per il cancro del retto la chirurgia non si è caratterizzata per un particolare ampliamento ma per una pressoché totale rivoluzione delle sue basi anatomiche. Ci si è accorti infatti che le descrizioni degli autori classici di anatomia macroscopica spesso contenevano imprecisioni e in alcuni casi veri e propri errori. Il chirurgo è dovuto ritornare in sala settoria, ristudiare e correggere alcuni concetti, diventando egli stesso un anatomista. Sotto questo profilo la chirurgia oncologica del retto è stata una grande lezione di umiltà perhé ha ricordato al chirurgo che il suo primo dovere è quello di conoscere bene le strutture che si accinge ad operare. Anche nel terzo millennio la chirurgia è fedele alla sua etimologia: "arte di mano", una mano guidata da una mente colta.

- *Sopravvivenza media a 5 anni tra il 27 e il 42 %*
- *Recidiva locale del 20-30%*

Tutta colpa del Tumore



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Recurrent cancer after restorative resection of the rectum

SIR,—There is certainly no more important aspect of rectal cancer surgery than the incidence of local recurrence: this almost invariably leads to the death of the patient and reflects the worst variety of treatment failure. Mr John Maxwell Anderson's leading article (20 February, p 531), however, advocates the simultaneous introduction of all available treatments—that is, surgery, radiotherapy, and cytotoxic drugs—in the manner that is now frequently adopted in the United States. While regarding Mr Anderson's work most highly and quoting it frequently, we would like to take issue with this "broadside" approach.

Firstly, we cannot accept entirely the assertion that "most reports of recurrences underestimate the true incidence." With modern techniques the staple or suture line is within easy reach of the examining finger, and both pelvic wall and staple line recurrences can be felt, or seen and often biopsied.

Secondly, there is only slender evidence that either radiotherapy or cytotoxic drugs reduce local recurrence, despite extensive trials (of radiotherapy particularly) on both sides of the Atlantic.

Thirdly, the tenfold variation of local recurrence figures from different centres suggests that differences of surgical technique may themselves be important. To quote Mr Anderson in the *Scottish Medical Journal*, "The five-year incidence of local recurrence is 12-20% in special interest centres and about 40% in the country as a whole."[1]

We have preferred to concentrate on surgical tech… clear-… of … his explain why anterior resection is the only operative procedure in colorectal surgery which is followed by a significant suture-line or local recurrence rate? Results in our own series will be presented at the Association of Surgeons on 1 April. In essence these report 50 survivors of radical low anterior resection which has been combined with wide excision of the mesorectum, who have been followed for over two years, a… Our figures suggest that all but a minority of rectal cancers may be controlled locally by refinement of surgical technique. If this is so we might most profitably direct the adjuvant treatments towards the abortion of hepatic micrometastases in the manner which has been advocated by Taylor and others.[2]

It is surely desirable that we should approach this slow-growing and often localised disease in a stepwise manner and evaluate each modality in turn. In particular trials of adjuvant therapy are unlikely to bear fruit until the surgical technique has been standardised so that we may compare like with like.

R J HEALD
ROGER RYALL

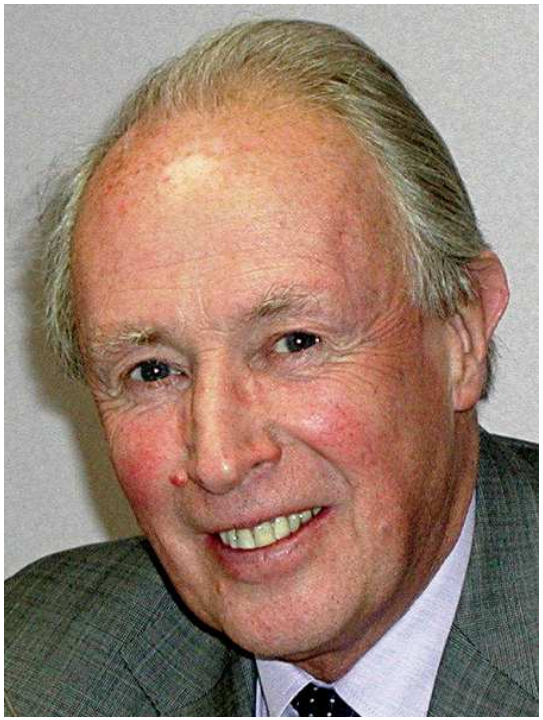
«we believe that the perirectal lymphatics in the mesorectum may be important…»

Br Med J (Clin Res Ed). 1982 Mar 13;284(6318):826-7.

Recurrent cancer after restorative resection of the rectum.

Heald RJ, Ryall R.

«50 survivors of radical anterior resection […] no case of disease after two years…»



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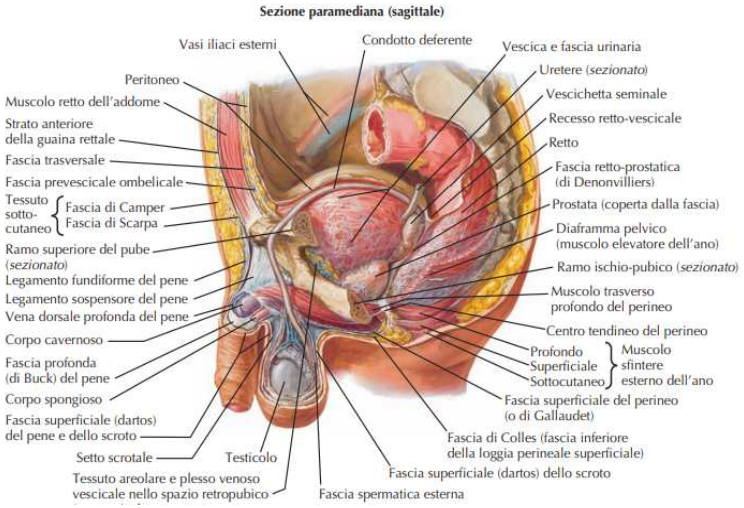

Roger P. Smith, MD
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NETTER
Atlante di Anatomia
Fisiopatologia e Clinica

Collana diretta da
Eugenio Gaudio

SECONDA EDIZIONE

Br. J. Surg. Vol. 69 (1982) 613–616 Printed in Great Britain

The mesorectum in rectal cancer surgery—the clue to pelvic recurrence?

Five cases are described where minute foci of adenocarcinoma have been demonstrated in the mesorectum several centimetres distal to the apparent lower edge of a rectal cancer. In 2 of these there was no other evidence of lymphatic spread of the tumour. In orthodox anterior resection much of this tissue remains in the pelvis, and it is suggested that these foci might lead to suture-line or pelvic recurrence. Total excision of the mesorectum has, therefore, been carried out as a part of over 100 consecutive anterior resections. Fifty of these, which were classified as 'curative' or 'conceivably curative' operations, have now been followed for over 2 years with no pelvic or staple-line recurrence.

R. J. HEALD, E. M. HUSBAND AND R. D. H. RYALL

Basingstoke Bowel Cancer Clinic, Basingstoke District Hospital, Basingstoke, Hampshire.

The incidence of locally recurrent disease is the most important measure of the success of any new operation for rectal cancer. Thus there has been anxiety (1) that the increase in sphincter-conserving surgery due to staplers might lead to more local recurrences. Four years ago, therefore, we combined the decrease in permanent colostomies in our unit with a change in the technique for pelvic dissection. In particular we determined that all cancers of the midrectum should be excised with the mesorectum intact. Thus the phase of dividing this during anterior resection, which is described in standard textbooks (2), was completely omitted and the whole mesorectum was encompassed by the plane of excision. In this way none of the usual 'block' of fatty lymphovascular tissue remains in the posterior half of the pelvis even though the anus, the levators, a small rectal reservoir and as much as possible of the nerve plexuses have been preserved.

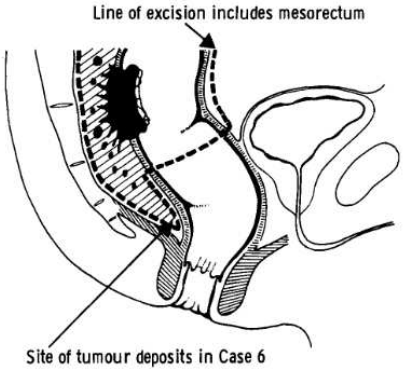

Fig. 1. *The suggested plane of excision is shown diagrammatically by the dashed line. The remnant from Case 6 which contained an isolated microscopic deposit is indicated by the arrow.*

Operative and histological methods

A full length abdominal incision was made from the xiphisternum to the pubis. The plane surrounding the left half of the colon was developed extensively with careful preservation of the autonomic nerve plexuses. Under direct vision with sharp scissor dissection this plane was extended down into the pelvis around the rectum, the tumour and particularly around the fatty mesorectum as far as the point of

Discussion

There are good reasons for suspecting that distal spread of rectal cancer is often initially confined, as in these cases, to the mesorectal tissues. First, local suture-line recurrences are most commonly found posteriorly and only from tumours of the

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Using population based analysis of relative survival (i.e. corrected for the average mortality at any age and sex [3]), in the countries analysed in the EUROCARE project, survival has markedly improved since the 1980s. From 1980 until 2000–2002, five-year survival for all patients increased from 51% to 60% in northern Europe; from 52% to 62% in western European registries and from 45% to 58% in southern European registries. Among females relative survival was

Aumento della sopravvivenza

Riduzione della recidive

Chirurgico

Radiologico

Oncologico

Radioterapico

Gastroenterologico

Anatomo-
patologico

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risolti e nuove speranze per il futuro. Fra i primi, il ruolo dell'amputazione addomino-perineale nel moderno bagaglio terapeutico, le indicazioni alla linfectomia estesa, i risultati a distanza delle anastomosi basse dirette *vs* la creazione di pouch o coloplastiche.

Le speranze per il futuro sono rivolte soprattutto agli studi genetici per una migliore comprensione dei fattori di rischio e per nuove classificazioni, ma vi è posto anche per progressi più "macroscopici" come l'impianto dello sfintere artificiale e le tecniche sempre più mirate di terapia locale (45, 46).

La conquista più grande però è probabilmente la creazione di team dedicati che hanno progressivamente coinvolto un numero sempre maggiore di specialisti. Dalle classiche collaborazioni con i radiologi per una sempre più precisa definizione pre-operatoria dei piani di clivaggio e per l'interpretazione di metastasi e recidive con gli anatomopatologi, gli oncologi e i radioterapisti, sono stati coinvolti i genetisti per l'individuazione e il controllo di pazienti a rischio, gli urologi non solo per la correzione delle disfunzioni urogenitali, ma per rieducazioni sempre più mirate (rieducazione funzionale della vescica, del pavimento pelvico), gli psicologi non solo per i problemi legati alle stomie, ma anche per l'impatto sulla vita sociale e di relazione provocato da profonde mutazioni delle funzioni alvine (ad es., nelle anastomosi ultrabasse o coloanali).

Il chirurgo, che sino a qualche anno fa era il primo attore nella terapia del cancro del retto e recitava un ruolo appreso dai suoi Maestri, oggi deve imparare ad interfacciarsi con molti altri specialisti e all'interno del proprio ambito ha dovuto reinventarsi la tecnica creando una nuova anatomia. Un magnifico esempio di duttilità di mente e di mano che ha così permesso al moderno chirurgo di mantenere il ruolo di leader nel team dedicato alla terapia del cancro del retto.

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Linee guida Europee nel 2014

European Journal of Cancer (2014) 50, 1.e1–1.e34

Available at www.sciencedirect.com

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journal homepage: www.ejcancer.com

Position Paper

EURECCA colorectal: Multidisciplinary management: European consensus conference colon & rectum ☆

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Abstract ***Background:*** Care for patients with colon and rectal cancer has improved in the last 20 years; however considerable variation still exists in cancer management and outcome between European countries.

Large variation is also apparent between national guidelines and patterns of cancer care in Europe. Therefore, EURECCA, which is the acronym of European Registration of Cancer Care, is aiming at defining core treatment strategies and developing a European audit structure in order to improve the quality of care for all patients with colon and rectal cancer. In December 2012, the first multidisciplinary consensus conference about cancer of the colon and rectum was held. The expert panel consisted of representatives of European scientific organisations involved in cancer care of patients with colon and rectal cancer and representatives of national colorectal registries.

Partecipazioni di molte società scientifiche

Methods: The expert panel had delegates of the European Society of Surgical Oncology (ESSO), European Society for Radiotherapy & Oncology (ESTRO), European Society of Pathology (ESP), European Society for Medical Oncology (ESMO), European Society of Radiology (ESR), European Society of Coloproctology (ESCP), European CanCer Organisation (ECCO), European Oncology Nursing Society (EONS) and the European Colorectal Cancer Patient Organisation (EuropaColon), as well as delegates from national registries or

- Caratteristiche del **paziente**
- Caratteristiche del **tumore** (sede, dimensioni, biologia)
- Strategie **diagnostiche**
- **Scelta terapeutica chirurgica** integrata in un programma **neoadiuvante** o **adiuvante**
- Terapia del paziente **metastatico** e **recidivo**
- Gestione del paziente **non operabile**

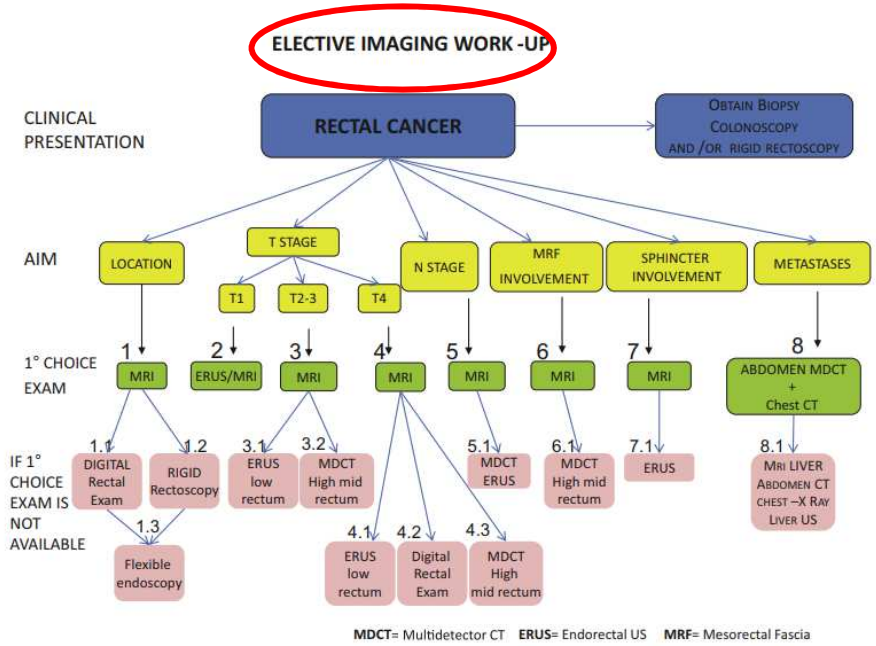
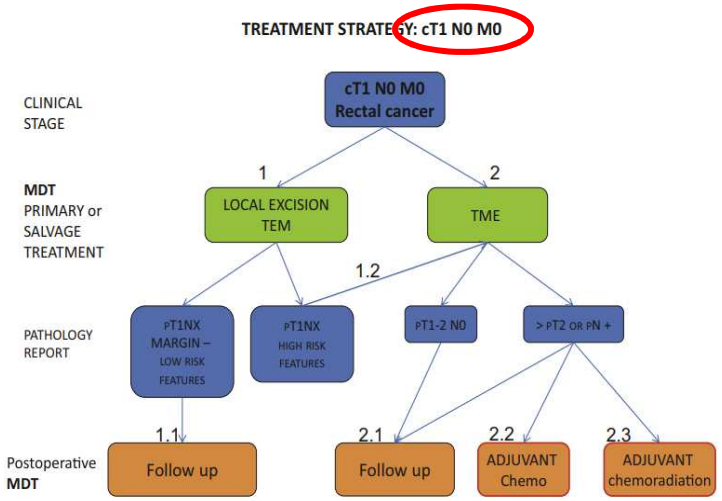


Fig. 4. Elective imaging work up algorithm for rectal cancer. Almost all imaging decisions achieved large consensus with exception of the two lesser choice exam decisions. Moderate consensus was achieved on imaging step 1.1 and moderate consensus on step 3.1.



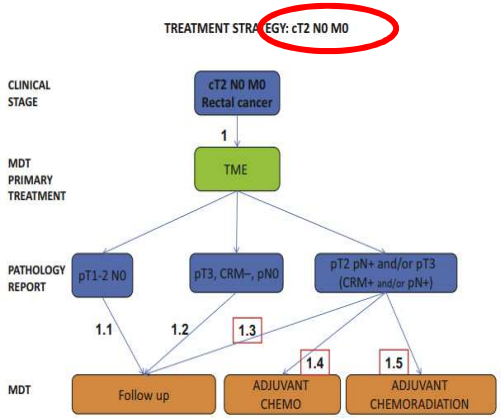


Fig. 6. Treatment strategy: cT2 N0, M0 rectal cancer. Three decisions in the clinical T2 stage treatment algorithm did not achieve large consensus, indicated with red lining; being minimum consensus for step 1.3 to go to follow up in case of positive nodal stage, positive CRM or pT3; and no consensus was achieved on step 1.4 and 1.5 to decide on postoperative chemotherapy and chemoradiation in these patients.

ecisions in the clinical stage 1 rectal cancer treatment algorithm did not achieve large
sus for step 2.2 to give adjuvant chemotherapy after primary TME or salvage TME
lecide on postoperative chemotherapy and radiation.

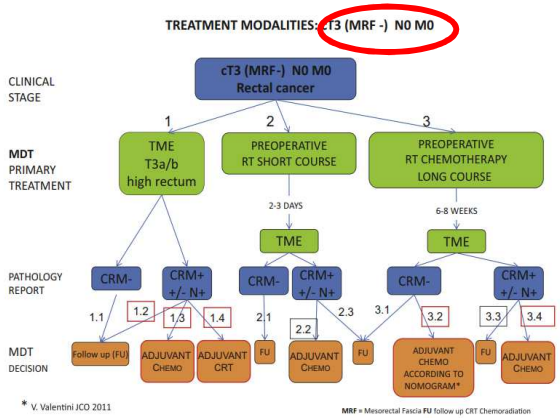


Fig. 7. Treatment strategy: cT3 N0, M0 rectal cancer. Nine decisions in the algorithm did not achieve large consensus. Indicated with red lining is the 'no consensus' for decision 1.3 and 3.2; and 'minimum consensus' for 1.2, 1.4 and 3.4. With moderate consensus it was agreed to decide on step 2, and 3, 2.2 and 3.3.

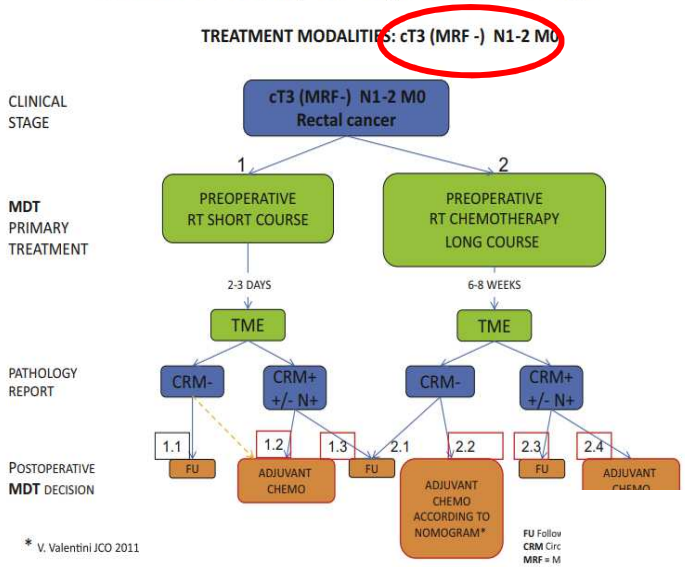


Fig. 8. Treatment strategy: cT3 N+, M0 rectal cancer Six decisions in the algorithm did not achieve larg being no consensus for decision 2.2 adjuvant chemotherapy according to the nomogram; minimum conse There was moderate consensus for decision 1.1. The large variation in agreement illustrates that there is litt

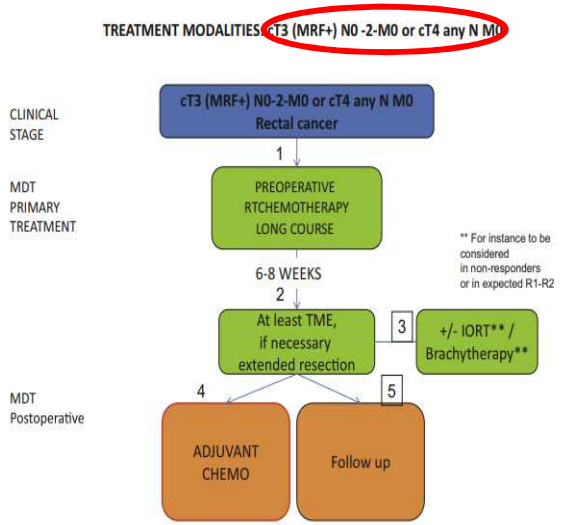


Fig. 9. Treatment modalities: cT3 (MRF+) any N M0 or cT4 any N Moderate consensus was achieved for step 3 and 5, minimum consensus indicated with red borders was achieved for step 4 in the decision making.

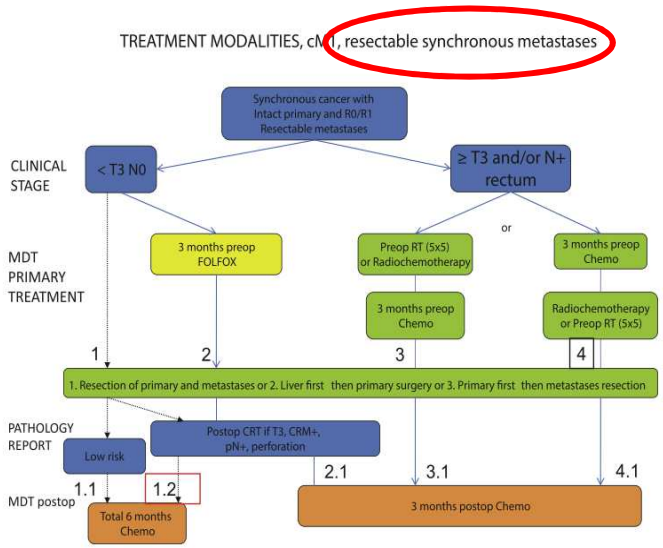


Fig. 11. Treatment modalities, cM1, resectable synchronous metastases For patients with resectable synchronous colorectal metastases, with moderate consensus it was agreed on decision 4; decision 1.2 was agreed with minimum consensus indicated by red borders.

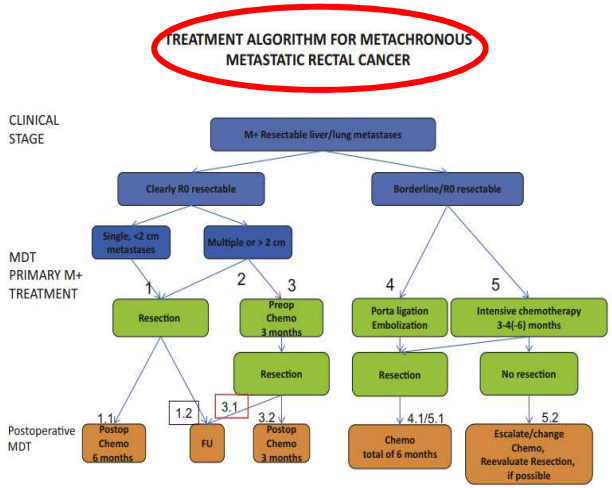


Fig. 10. Treatment algorithm for metachronous metastatic rectal cancer Moderate consensus was achieved for decision 1.2 and minimum consensus was reached for decision 3.1, indicated with red borders.

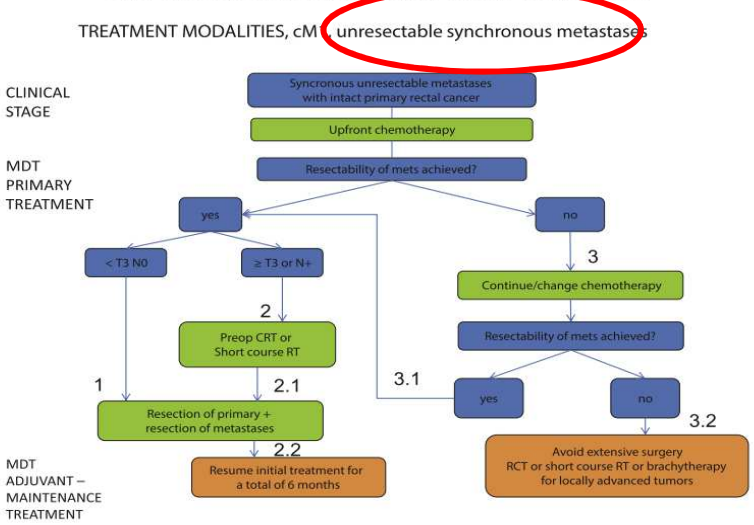


Fig. 12. Treatment modalities, cM+, unresectable synchronous metastases. All decisions were agreed with large consensus.

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Linee guida

NEOPLASIE DEL RETTO E ANO

Edizione 2018

Qualità Globale delle evidenze	Raccomandazione	Forza della raccomandazione clinica
Bassa	Il percorso di diagnosi e cura va pianificato nell'ambito di un gruppo multidisciplinare che comprenda tutte le figure coinvolte nel percorso indipendentemente dallo stadio di malattia. (1)	**Positiva forte**

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Linee guida

NEOPLASIE DEL RETTO E ANO

Edizione 2018

Qualità Globale delle evidenze	Raccomandazione	Forza della raccomandazione clinica
D	Le decisioni diagnostico-terapeutiche devono essere coerenti con le linee guida e qualora si verifichi uno scostamento è opportuno esplicitarne i motivi. (1-3)	Positiva forte
	Terminata la fase diagnostico-terapeutica deve essere fornita	

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Format: Abstract

Send to

J Gastrointest Cancer. 2018 Apr 14. doi: 10.1007/s12029-018-0100-9. [Epub ahead of print]

Treatment of Colorectal Cancer: a Multidisciplinary Approach.

Anania G[1], Resta G[1], Marino S[1], Fabbri N[2], Scagliarini L[1], Marchitelli I[3], Fiorica F[4], Cavallesco G[1].

Author information

Open/close author information list

Abstract

BACKGROUND: Colorectal cancer is the third most prevalent cancer in the world, preceded by prostate and lung cancers in men (10%) and breast and lung cancers in women (9.4%). Colorectal cancer is the fourth leading cause of death in men (7.6%) and the third in women (8.6%). A multidisciplinary approach has radically changed the way we deal with this disease among all specialist fields.

PURPOSE: In this study, we propose comparing the multidisciplinary experience group (started in 2012) of S. Anna Hospital (University of Ferrara) with the previous approach to rectal cancer before the advent of the multidisciplinary program.

RESULTS: We find that more study depth of neoplastic disease as well as of each individual patient leads to more accurate staging and to a weighted therapy based on the needs of the individual. All the studies were performed in accordance with the guidelines established by the European and Italian associations.

KEYWORDS: Colorectal cancer; Laparoscopic surgery; Multidisciplinary group

PMID: 29656351 DOI: 10.1007/s12029-018-0100-9

Risposta difficile?

Il chirurgo conserva un ruolo centrale ma non rappresenta più il team leader

Associazione Italiana di Oncologia Medica

Linee guida

NEOPLASIE DEL RETTO E ANO

Edizione 2018

Dettano i *modi*,

i tempi

...e le sedi


Le domande
alle quali
è più
difficile
rispondere
sono quelle la cui
risposta è più ovvia.
G. B. Shaw


grazie!