4° CORSO DI TECNICA CHIRURGICA LAPAROSCOPICA DEL COLON-RETTO

Strategie terapeutiche nel paziente con carcinoma del retto extraperitoneale

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WWW.CHIRURGIALAPAROSCOPICA.EU

Team Multidisciplinare e risultati…

Il controllo della qualità del lavoro

Rilettura critica dell'esame istologico

Follow up oncologico a distanza

Follow up funzionale a distanza

le fonti…

LINEE GUIDA TUMORI DEL COLON RETTO

AIOM

Come leggere le raccomandazioni LG Colon Retto 2013

I. **Raccomandazioni prodotte valutando i livelli di evidenza con la scala suggerita dallo Scottish Intercollegiate Guidelines network (SIGN**)**

National Cancer Institute
at the National Institutes of Health

We Can Answer Your Questions
1-800-4-CANCER

SEARCH

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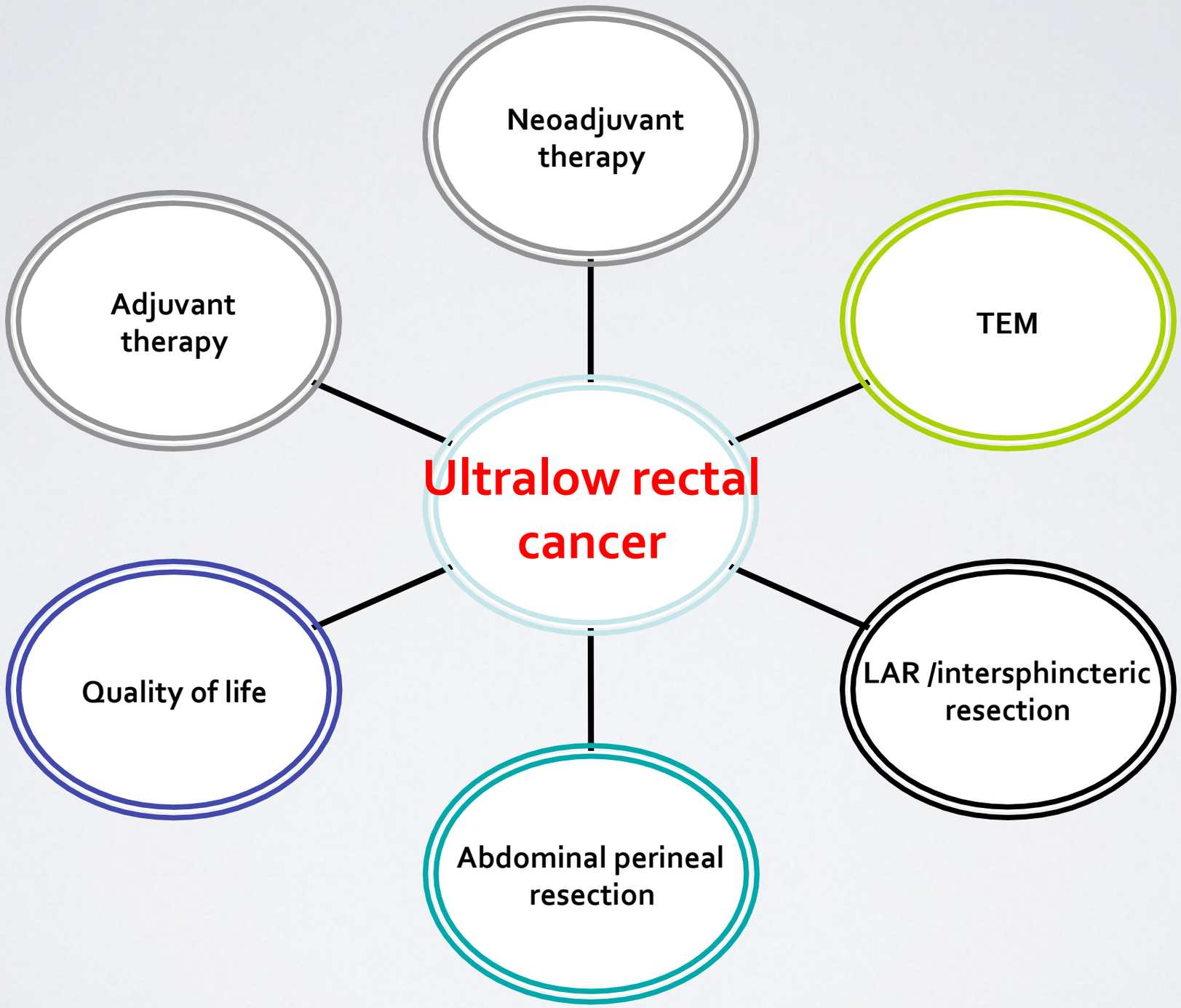
Rectal Cancer Treatment (PDQ®)

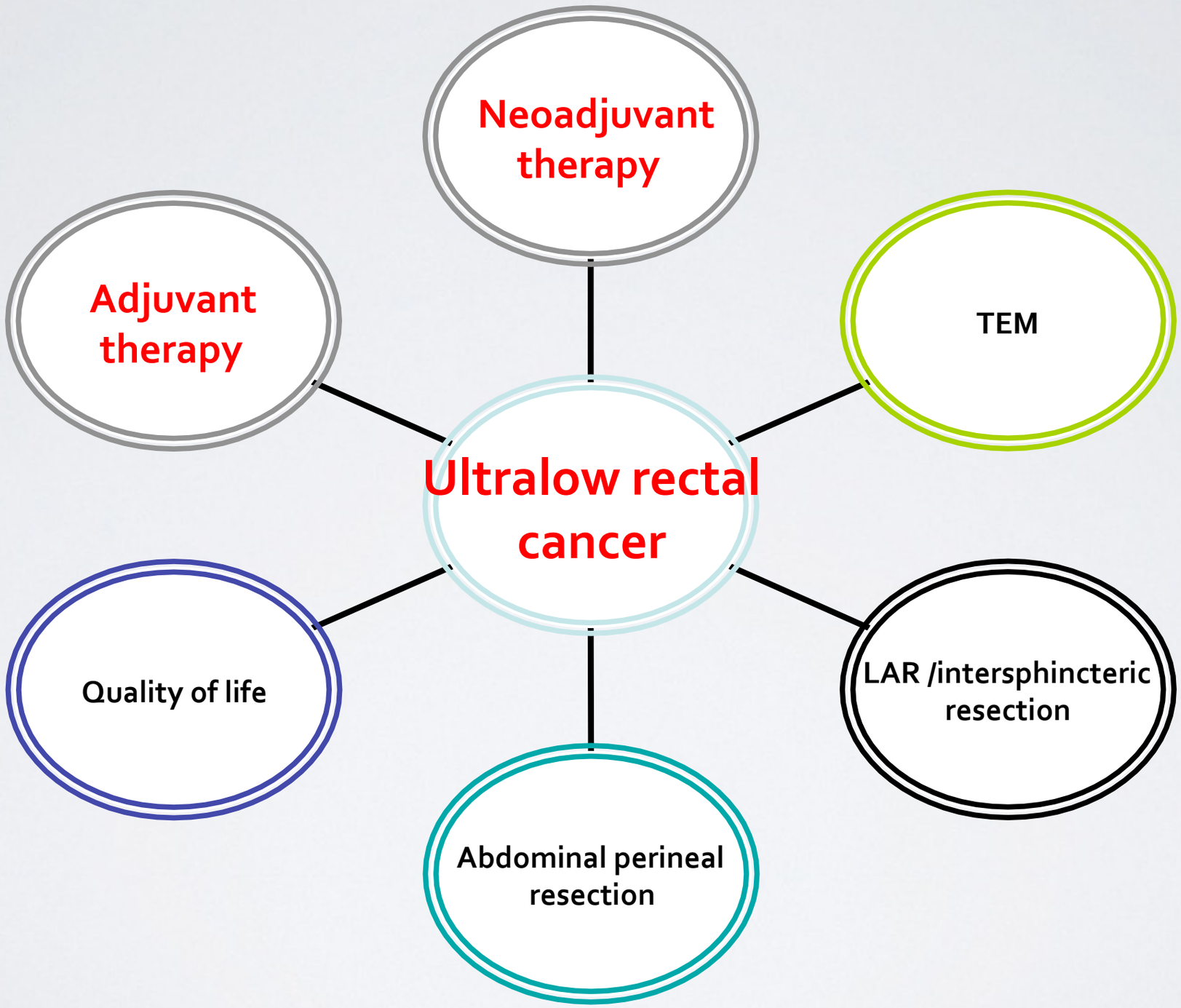
Patient Version | Health Professional Version | En español

Last Modified: 02/08/2013

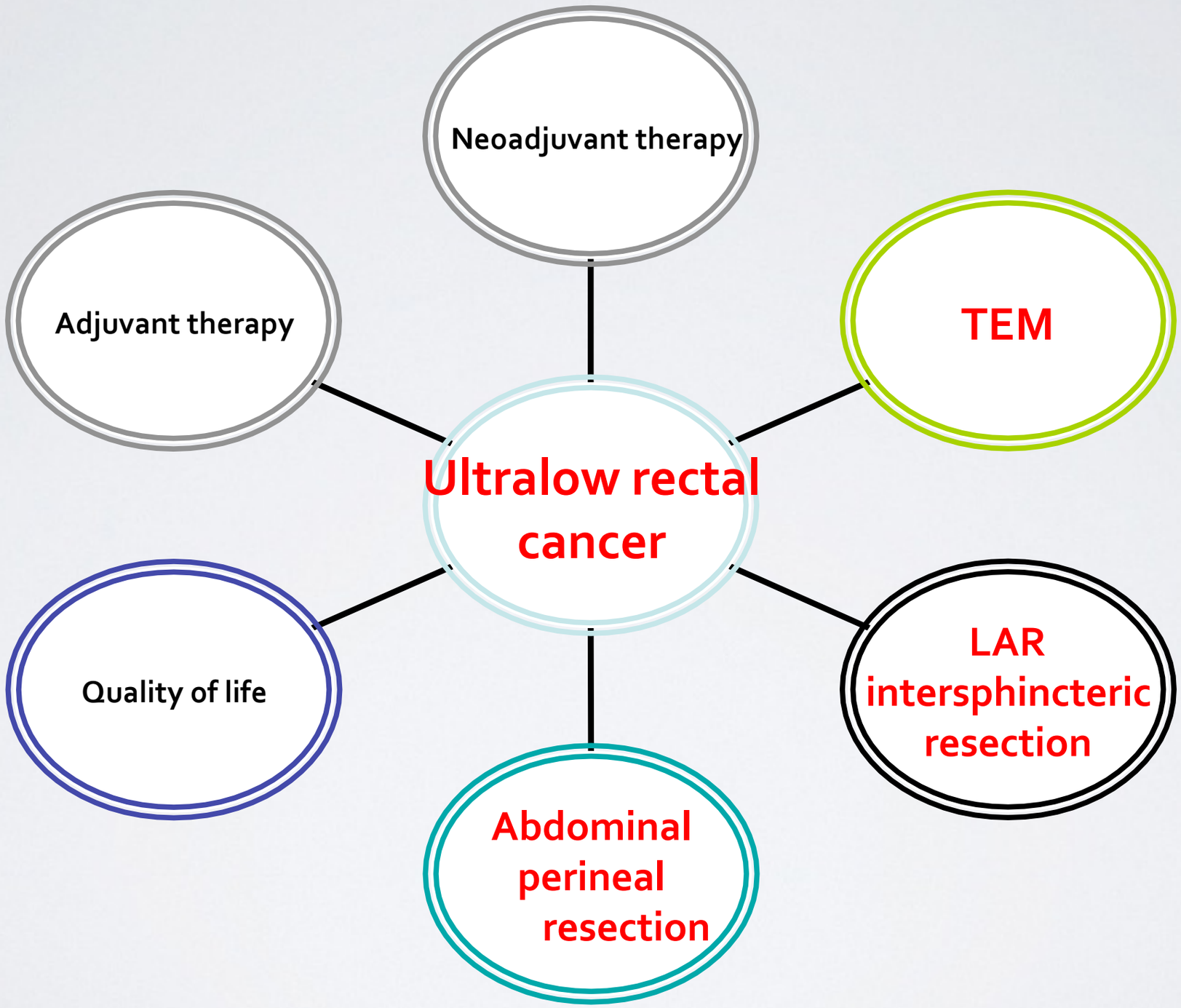
Punti di discussione



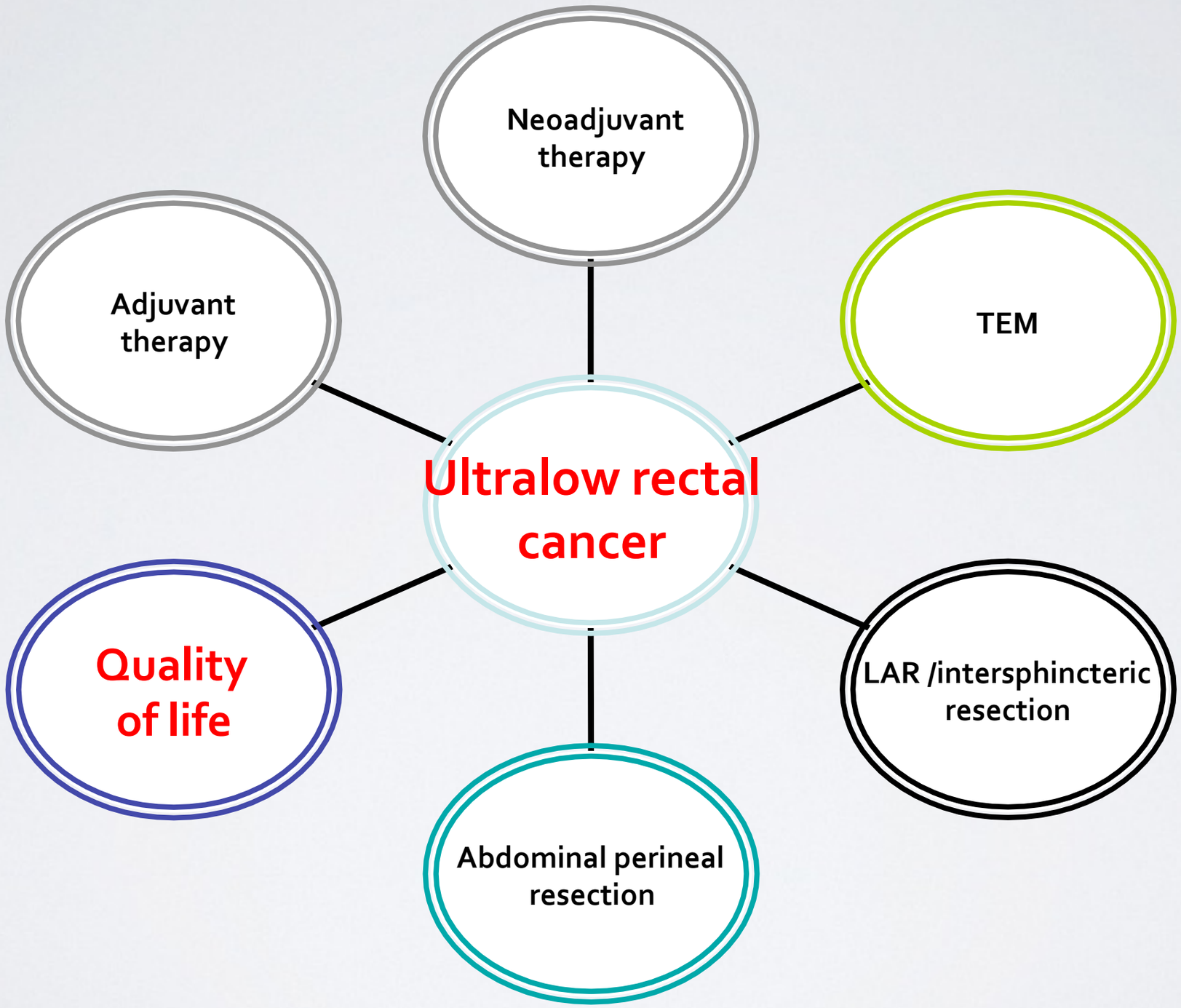
Punti di discussione



Punti di discussione



Punti di discussione



Come migliorare i risultati

Overall Survival

Disease free Survival

Quality of life

Neoadjuvant therapy

Select right surgery

Quality of surgery

Adjuvant therapy

Come migliorare i risultati

…il ruolo del chirurgo

Neoadjuvant therapy

1- SELEZIONE

2- TECNICA

Adjuvant therapy

I-SELEZIONE - Definizione

- Selezione del tipo corretto di procedura
- Selezione del paziente
- Selezione del corretto timing

I-SELEZIONE

Perché è così importante?

1. La chirurgia demolitiva del retto extra-peritoneale ha importanti sequele funzionali anche quando ben fatta
2. La recidiva locale condiziona severe sequele
3. La tecnologia amplia la scelta terapeutica

TNM classification

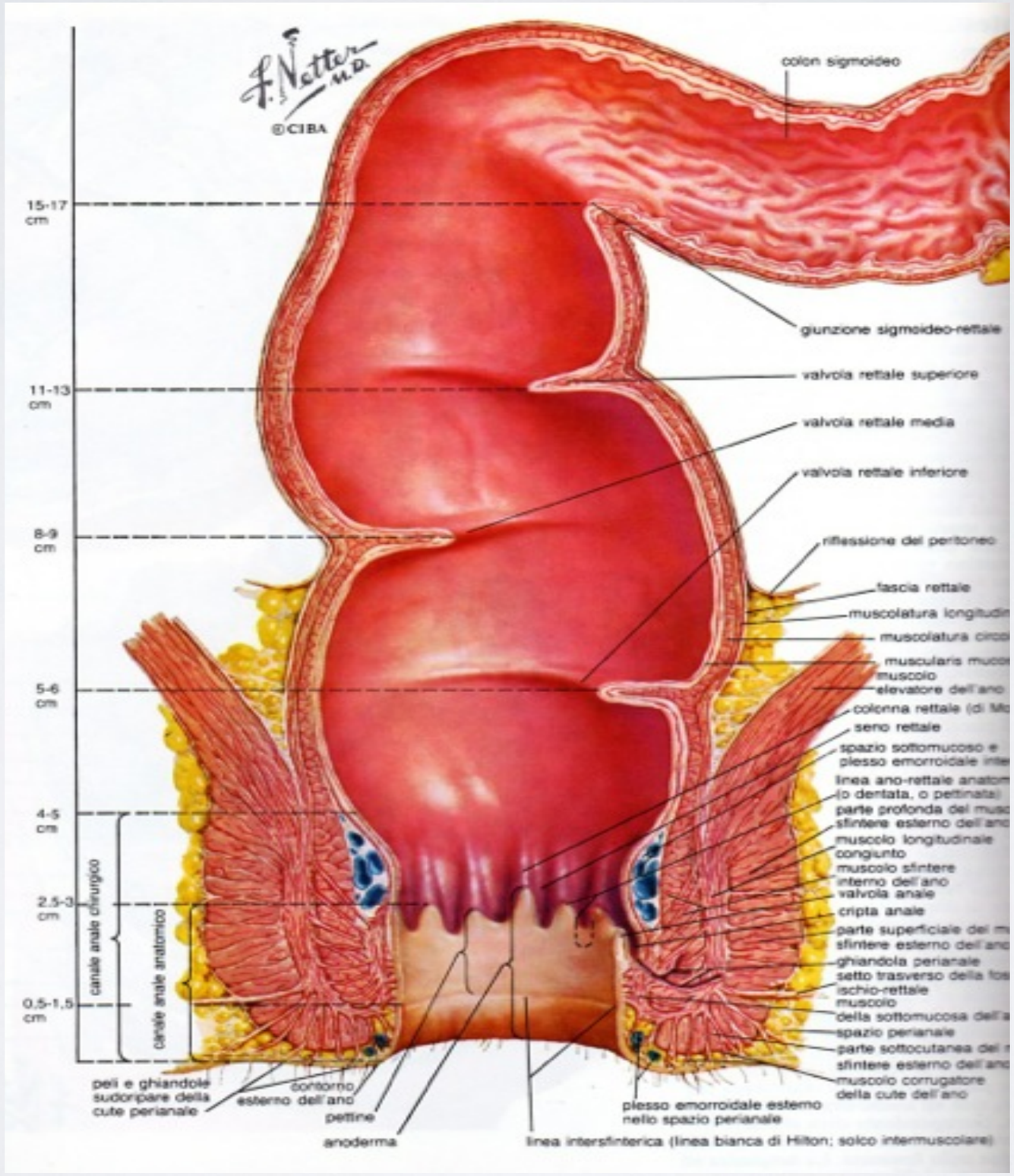
Rectal cancer: ESMO Guidelines Ann Oncol 2010

TNM	Stage	Extension to	
Tis N0 M0	0	Carcinoma *in situ*: intraepithelial or invasion of lamina propria	
T1 N0 M0	I	Submucosa	
T2 N0 M0	I	Muscularis propria	
T3 N0 M0	IIA	Subserosa/perirectal tissue	
	Substaging[a]	T3a	<1 mm
		T3b	1–5 mm
		T3c	5–15 mm
		T3d	15+ mm
T4 N0 M0	IIB	Perforation into visceral peritoneum (b) or invasion to other organs (a)[b]	
T1–2 N1 M0	IIIA	1–3 regional nodes involved	
T3–4 N1 M0	IIIB	1–3 regional nodes involved	
T1–4 N2 M0	IIIC	≥4 regional nodes involved	
T1–4 N1–2 M1	IV	Distant metastases	

[a]This subclassification based upon an evaluation using MRI before treatment decision is clinically valuable, and used in these recommendations. It can be used also in the histopathological classification but is not validated and not incorporated in any of the TNM versions (5–7).

[b]This is the subclassification in TNM 5. It has been reversed in TNM 6 and 7.

Classificazione topografica



e nella pratica?

Stadiazione nella pratica clinica

Very early (some cT1)

Early (cT1, cT2, some cT3)

More advanced (some cT2, cT3, some cT4, N+)

Disseminated disease

Stadiazione nella pratica clinica

Very early (some cT1)

Early (cT1, cT2, some cT3)

More advanced (some cT2, cT3, some cT4, N+)

Disseminated disease

Very early

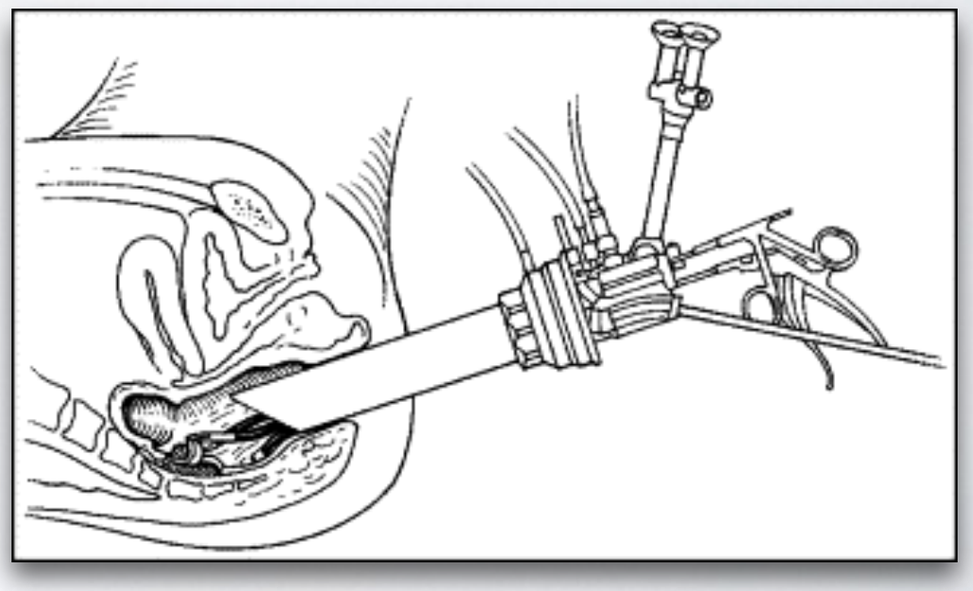
Risk-adapted treatment

- **T1 Haggitt 1-3 sm1 (-2)**
- **No**

Rischio meta linfonodali <2%

Local procedure

TEM vs TAE



The T I submucosal classification

N +	Sm1	Sm2	Sm3
Kikuchi et al	0%	10%	25 %
Asaku et al	0 %	22 %	
Mayo clinic	2 %		23 %

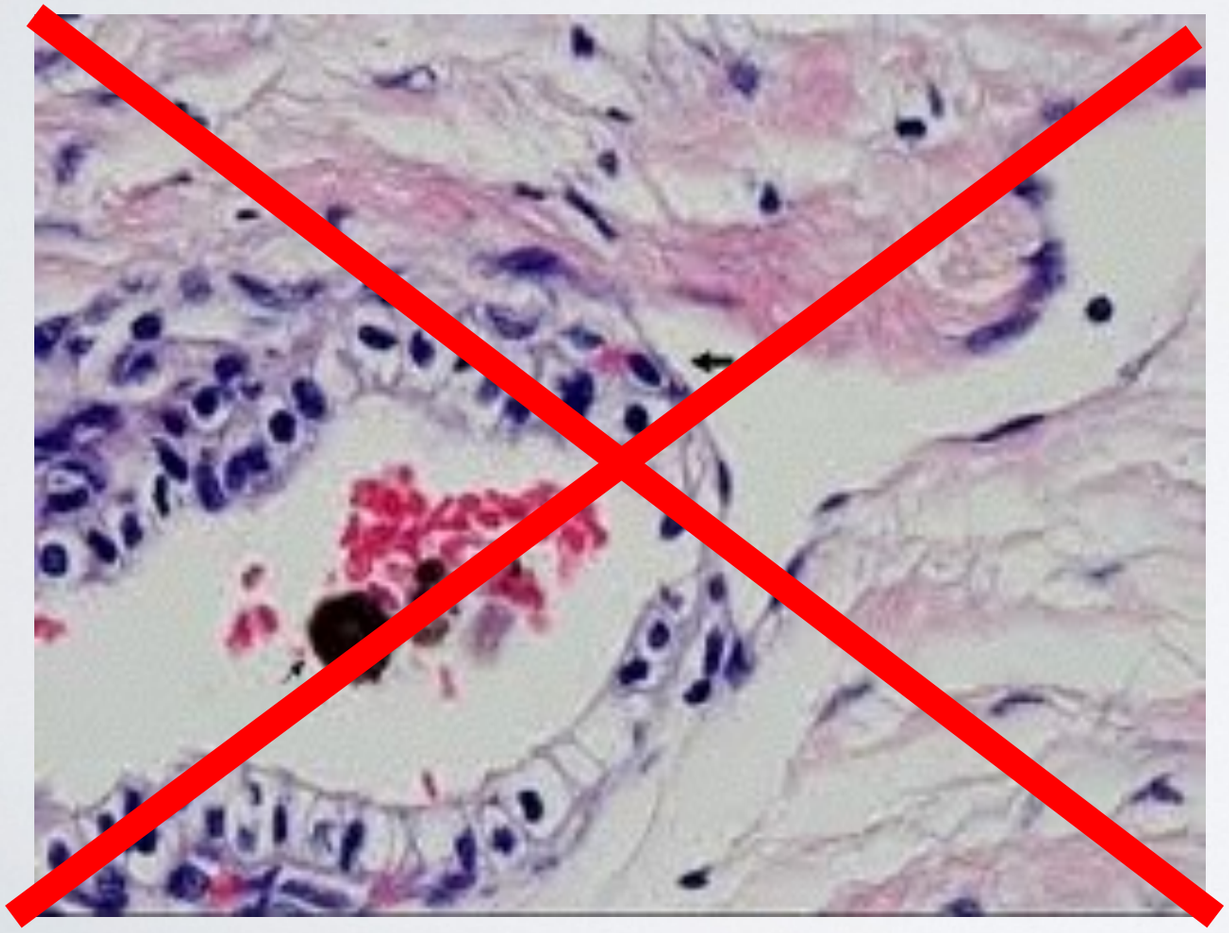
T1 sm3 = T2

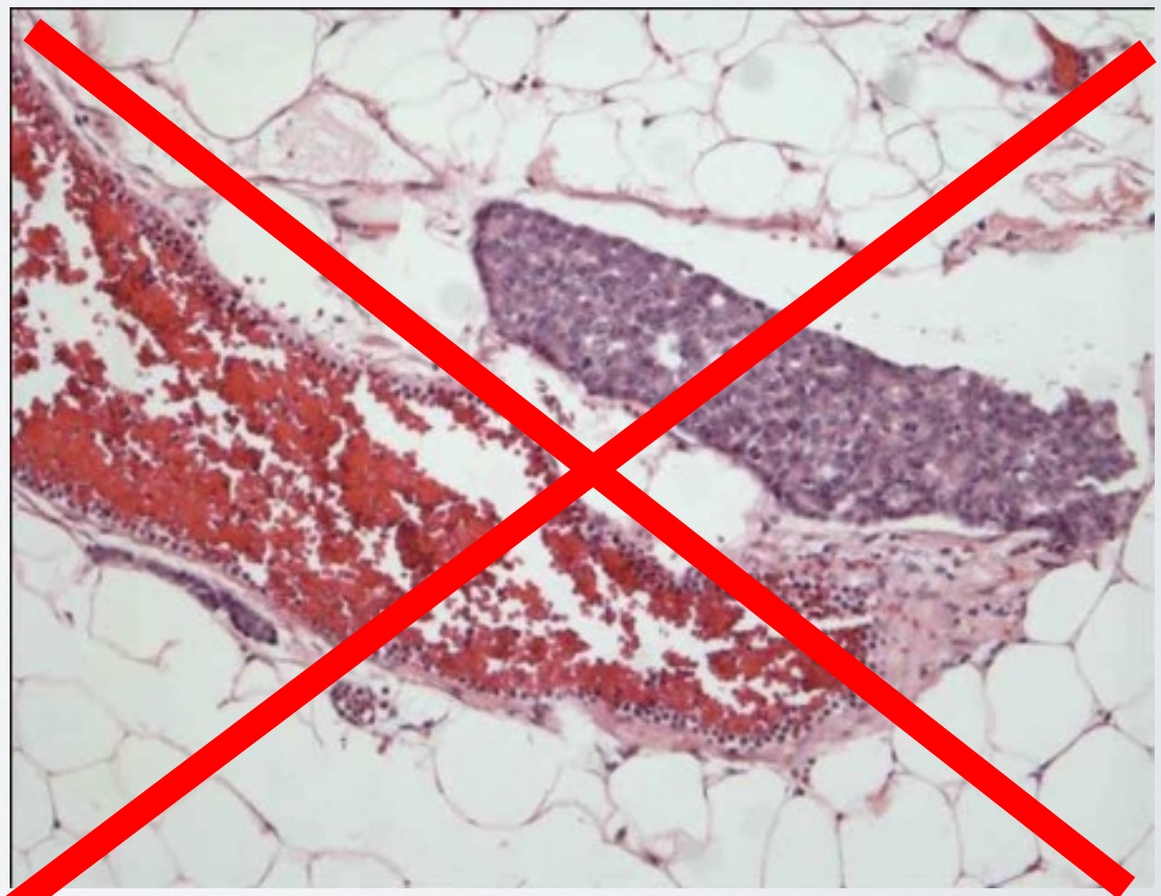
Very early

Risk-adapted treatment

MA

La resezione deve essere RADICALE e non ci deve essere invasione microvascolare o alto grading





Very early

TEM procedure

< 3 CM

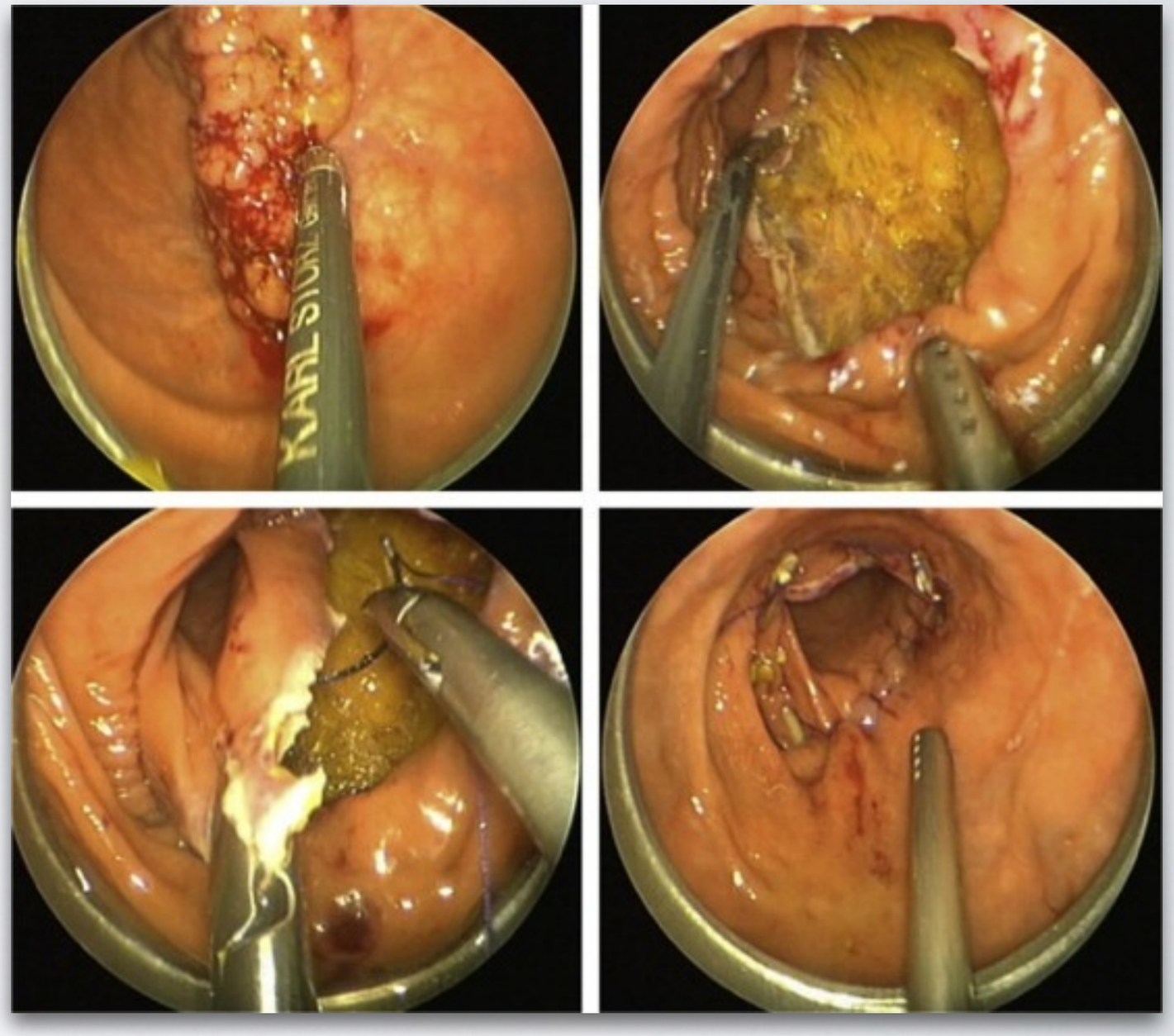
G 1-2

< 1/3

CIRCONFERENZA

FINO AL GRASSO

PERIRETTALE



Very early

TAE vs TEM

*Meta-analisi pT1

		RL
TAE	959 pz	14%
TEM	616 pz	5,5%

p<0,05

^Revisione pT1-2

TAE	89 pz	27%
TEM	82 pz	5%

p<0,05

*Cataldo, Buess et al. Transanal Endoscopic Microsurgery Principles and Tecniques. Springer 2009;

^Moore et Cataldo; Dis Colon Rectum 171 pts 2008

Stadiazione nella pratica clinica

Very early (some cT1)

Early (cT1, cT2, some cT3)

More advanced (some cT2, cT3, some cT4, N+)

Disseminated disease

Early

Risk-adapted treatment

- **T1 Haggitt 4 sm 3 (–2)**
- **T2**
- **good T3 (cCRM-) sopra gli elevatori**
- **N0**

rischio meta linfonodali > 10%

Chirurgia radicale e CRT postoperatoria

RESEZIONE ULTRABASSA e anastomosi coloanale
RESEZIONE INTERSFINTERICA e anastomosi coloanale
TME

Level II-1

Early

TEM procedure

IN CONSIDERAZIONE DEL

"PESO DELLA CHIRURGIA "

SI STANNO VALUTANDO STRADE

ALTERNATIVE

Long term results in patients with T2-3 N0 distal rectal cancer undergoing radiotherapy before transanal endoscopic microsurgery

Br.J.Surg.2005;92(12):1546-52

Lezoche et al

La sopravvivenza libera da malattia ad un f-up di 90 mesi fu dell'89 % e la sopravvivenza complessiva del 79%.Miles di salvataggio in 3 pz.

Stadiazione nella pratica clinica

Very early (some cT1)

Early (cT1, cT2, some cT3)

More advanced (some cT2, cT3, some cT4, N+)

Disseminated disease

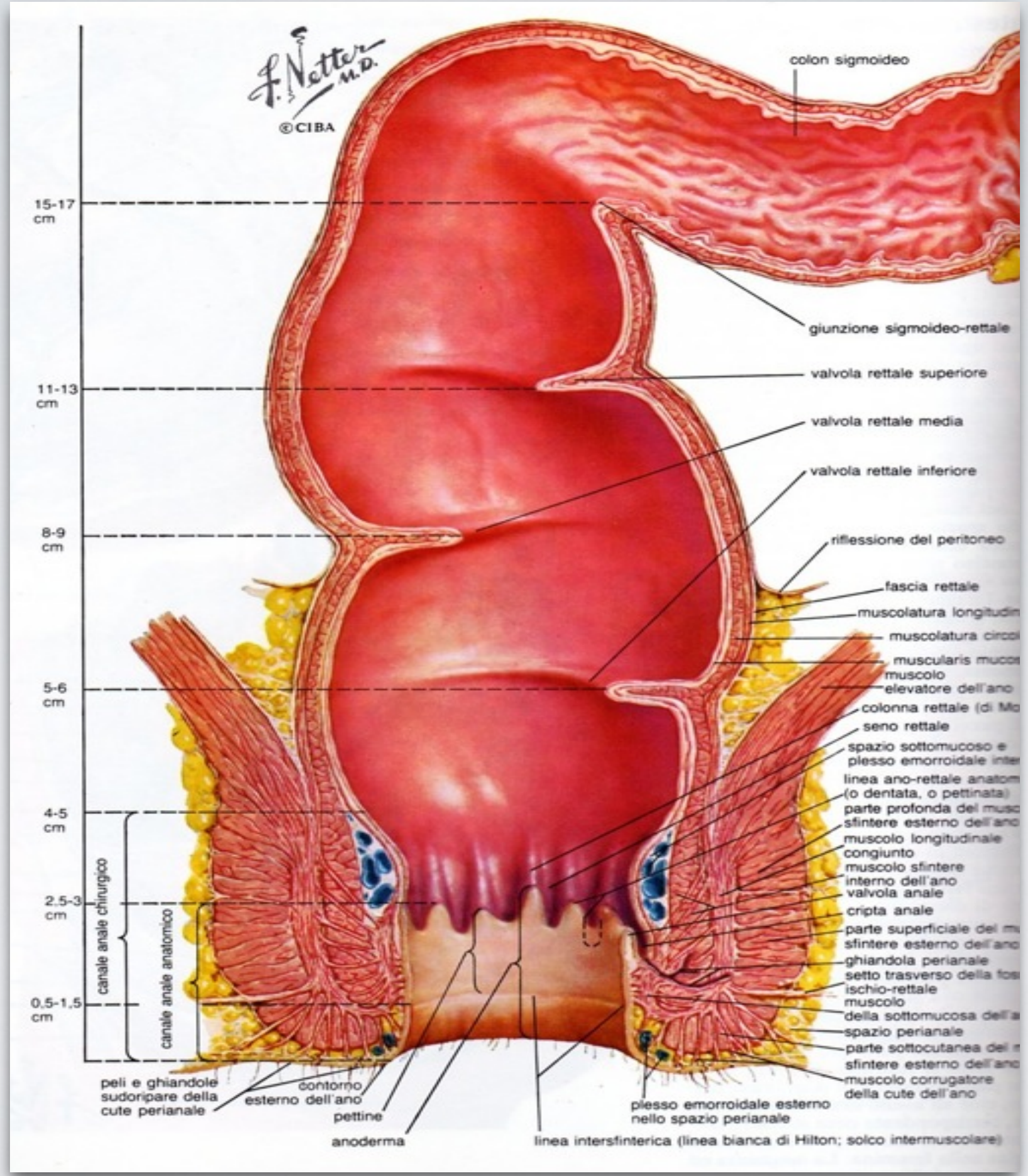
More advanced

Risk-adapted treatment

- **T3**
- **T4** infiltrazione organi vicini e non resecabili upfront
- **Bad T2 (cCRM+)** tumori < 5 cm dove la distanza dalla fascia mesorettale potrebbe essere < 1mm Level III
- **Any T N +**

CRT preoperatoria e chirurgia radicale

RESEZIONE ULTRABASSA e anastomosi coloanale
RESEZIONE INTERSFINTERICA e anastomosi coloanale
AMPUTAZIONE ADDOMINO PERINEALE
TME technique


F. Netter M.D.
©CIBA
colon sigmoideo
15-17 cm
11-13 cm
8-9 cm
5-6 cm
4-5 cm
2,5-3 cm
0,5-1,5 cm
canale anale chirurgico
canale anale anatomico
giunzione sigmoideo-rettale
valvola rettale superiore
valvola rettale media
valvola rettale inferiore
riflessione del peritoneo
fascia rettale
muscolatura longitudin
muscolatura circol
muscularis mucos
muscolo elevatore dell'ano
colonna rettale (di Mo
seno rettale
spazio sottomucoso e plesso emorroidale inte
linea ano-rettale anatom (o dentata, o pettinata)
parte profonda del musc sfintere esterno dell'ano
muscolo longitudinale congiunto
muscolo sfintere interno dell'ano
valvola anale
cripta anale
parte superficiale del m sfintere esterno dell'ano
ghiandola perianale
setto trasverso della fos ischio-rettale
muscolo della sottomucosa dell'a
spazio perianale
parte sottocutanea del m sfintere esterno dell'ano
muscolo corrugatore della cute dell'ano
peli e ghiandole sudoripare della cute perianale
contorno esterno dell'ano
pettine
anoderma
plesso emorroidale esterno nello spazio perianale
linea intersfinterica (linea bianca di Hilton; solco intermuscolare)

Il "problema" dei cCR dopo CRT

Risk-adapted treatment

Post CRT neoadiuvante si assiste ad una risposta patologica completa di circa 15-20%

p-CR miglior prognosi

c-CR ≠ **p-CR**

c-CR 30% p-CR

La sfida è come prevedere clinicamente una p-CR

Chua YJ 2010, Berho M 2009, Glynne-Jones R 2007, Tulchinsky H 2006, Stipa F 2004, Zmora O 2004, Onaitis MV 2001

Il "problema" dei cCR dopo CRT - Definizione di cCR

Risk-adapted treatment

Dis Colon Rectum. 2010 Dec;53(12):1692-8. doi: 10.1007/DCR.0b013e3181f42b89.

Complete clinical response after neoadjuvant chemoradiation therapy for distal rectal cancer: characterization of clinical and endoscopic findings for standardization.

Habr-Gama A[1], Perez RO, Wynn G, Marks J, Kessler H, Gama-Rodrigues J.

Una cCR prevede al massimo

Sbiancamento della mucosa, teleangiectasie con mucosa integra

Ulcerazioni, irregolarità del viscere e noduli devono essere valutati per un approccio chirurgico

Chua YJ 2010, Berho M 2009, Glynne-Jones R 2007, Tulchinsky H 2006, Stipa F 2004, Zmora O 2004, Onaitis MV 2001

Il "problema" dei cCR dopo CRT - Il trattamento dei cCR

Risk-adapted treatment

1-TME

2-ESCISSIONE LOCALE

3-WATCH &WAIT

Clinical COMPLETE RESPONSE

RESEZIONE CHIRURGICA TME o ESCISSIONI LOCALI (LE/TEM)

Pochi studi CONFRONTABILI con c-CR

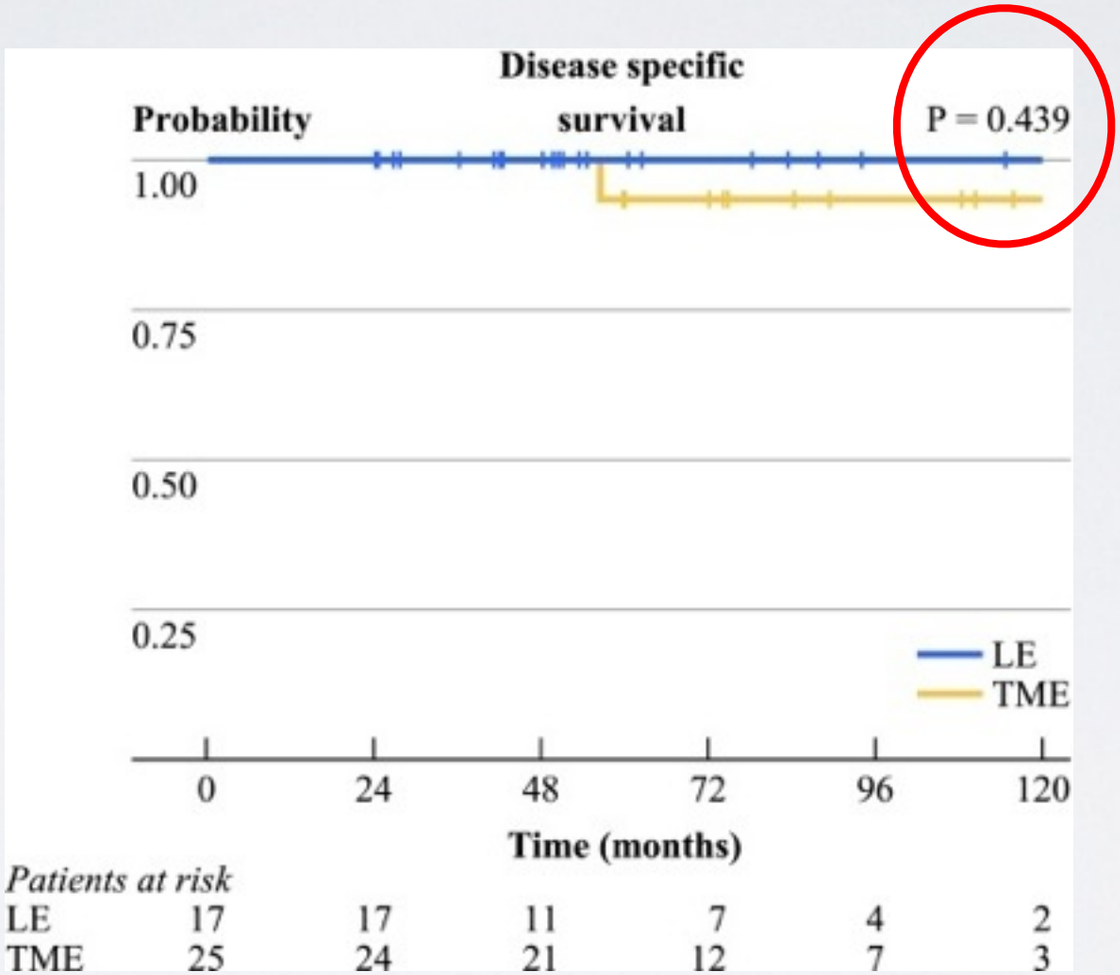
Opinioni e casi isolati nel contesto di casistiche storiche (Liv. III)

Risultati oncologici della TME in p-CR >> ai non p-CR

Bujko K 2010, Valentini V 2008 , O'Dwyer St 2005, Stipa F 2004, Bujko 2004, Crane CH 2003

Clinical COMPLETE RESPONSE

RESEZIONE CHIRURGICA TME o ESCISSIONI LOCALI (LE/TEM)



[total mesorectal excision (TME) surgery vs. full-thickness local excision (LE)]
in 42 cT3 rectal cancer patients with complete pathologic response (ypCR) to neoadjuvant chemoradiation

Clinical COMPLETE RESPONSE

WATCH AND WAIT

Complete Response (CR)
NON ALTRA TERAPIA
STRETTO MONITORAGGIO PER I PRIMI 5 ANNI

IPOTESI

METASTASI LINFONODALI SIANO STATE ERADICATE
PARALLELAMENTE AL TUMORE

Leading article

Non-operative management of rectal cancer after neoadjuvant chemoradiation

A. Habr-Gama[1] and R. O. Perez[2]

[1]Emeritus Professor, University of São Paulo School of Medicine, São Paulo, Brazil, [2]Department of Gastroenterology, University of São Paulo School of Medicine, São Paulo, Brazil, [1,2]Joaquim & Angelita Research Institute, Hospital Alemão Oswaldo Cruz, Sao Paulo, Brazil
(e-mail: gamange@uol.com.br)

Published online in Wiley InterScience (www.bjs.co.uk). **DOI:** 10.1002/bjs.6470

Operative Versus Nonoperative Treatment for Stage 0 Distal Rectal Cancer Following Chemoradiation Therapy

Long-term Results

Angelita Habr-Gama, MD, Rodrigo Oliva Perez, MD,* Wladimir Nadalin, MD,†*
*Jorge Sabbaga, MD,† Ulysses Ribeiro Jr, MD,‡ Afonso Henrique Silva e Sousa Jr, MD,**
Fábio Guilherme Campos, MD, Desidério Roberto Kiss, MD,* and Joaquim Gama-Rodrigues, MD‡*

Original article

Assessment and management of the complete clinical response of rectal cancer to chemoradiotherapy

A. Habr-Gama

University of São Paulo School of Medicine, São Paulo, Brazil

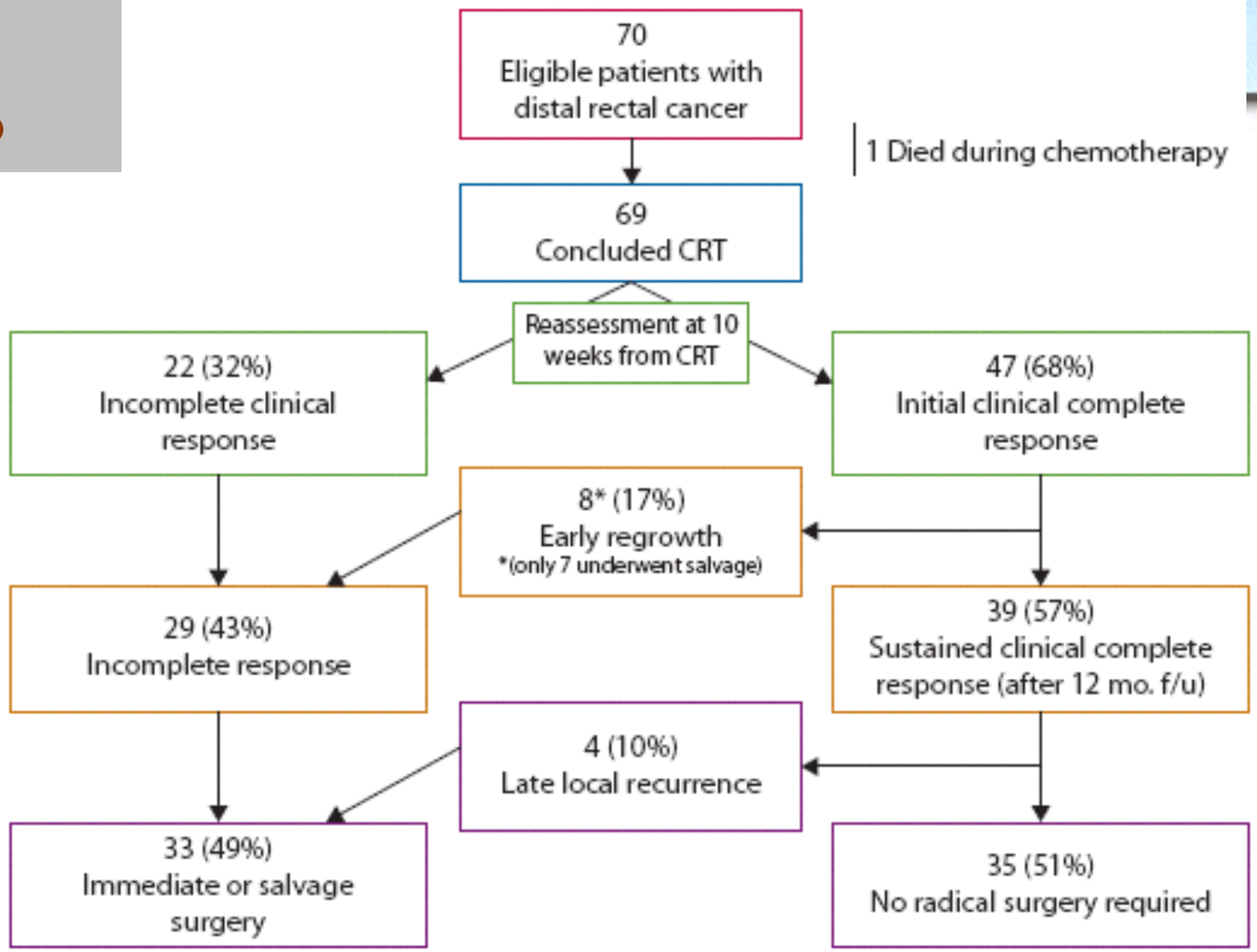
Received 10 March 2006; accepted 8 May 2006

3 - CLINICAL CR E WATCH & WAIT

Ccr 3 YRS

Os 90%

Dfs 72%



Habr-Gama A,
Dis Colon Rectum. 2013

Come migliorare i risultati

…il ruolo del chirurgo

Neoadjuvant therapy

1- SELEZIONE

2- TECNICA

Adjuvant therapy

2 - TECNICA - Requisiti oncologici

-Linfoadenectomia

linfonodi origine AMI

-Gestione T4

resezione en bloc degli organi infiltrati

-Perforazione

peggior prognosi, >> recidive locali

2 - TECNICA - Requisiti oncologici

Escissione totale
del mesoretto

Rectal Cancer

The Basingstoke Experience of Total Mesorectal Excision, 1978-1997

Richard J. Heald, MChir, FRCS; Brendan J. Moran, MCh, FRCS; Roger D. H. Ryall, FRCR; Rosemary Sexton, BSc; John K. MacFarlane, MD

Objective: To examine the role of total mesorectal excision in the management of rectal cancer.

Design: A prospective consecutive case series.

Setting: A district hospital and referral center in Basingstoke, England.

Patients: Five hundred nineteen surgical patients with adenocarcinoma of the rectum treated for cure or palliation.

Interventions: Anterior resections (n = 465) with low stapled anastomoses (407 total mesorectal excisions), abdominoperineal resections (n = 37), Hartmann resections (n = 10), local excisions (n = 4), and laparotomy only (n = 3). Preoperative radiotherapy was used in 49 patients (7 with abdominoperineal resections, 38 with anterior resections, 3 with Hartmann resections, and 1 with laparotomy).

Main Outcome Measures: Local recurrence and cancer-specific survival.

Results: Cancer-specific survival of all surgically treated patients was 68% at 5 years and 66% at 10 years. The local recurrence rate was 6% (95% confidence interval, 2%-10%) at 5 years and 8% (95% confidence interval, 2%-14%) at 10 years. In 405 "curative" resections, the local recurrence rate was 3% (95% confidence interval, 0%-5%) at 5 years and 4% (95% confidence interval, 0%-8%) at 10 years. Disease-free survival in this group was 80% at 5 years and 78% at 10 years. An analysis of histopathological risk factors for recurrence indicates only the Dukes stage, extramural vascular invasion, and tumor differentiation as variables in these results.

Conclusions: Rectal cancer can be cured by surgical therapy alone in 2 of 3 patients undergoing surgical excision in all stages and in 4 of 5 patients having curative resections. In future clinical trials of adjuvant chemotherapy and radiotherapy, strategies should incorporate total mesorectal excision as the surgical procedure of choice.

Arch Surg. 1998;133:894-899

THE LANCET

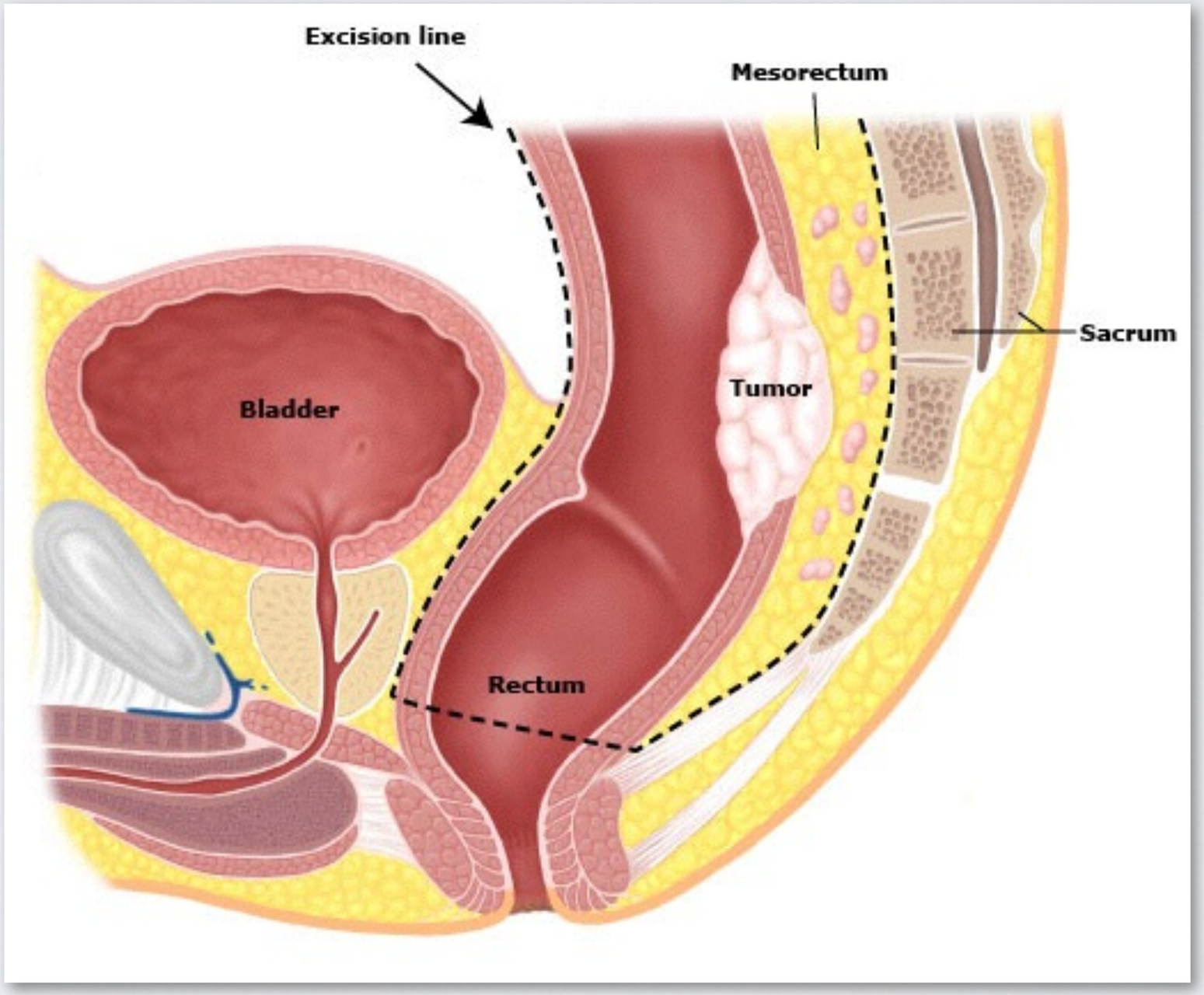
The Lancet, Volume 327, Issue 8496, Pages 1479 - 1482, 28 June 1986
doi:10.1016/S0140-6736(86)91510-2

RECURRENCE AND SURVIVAL AFTER TOTAL MESORECTAL EXCISION FOR RECTAL CANCER

R.J Heald , R.D.H Ryall

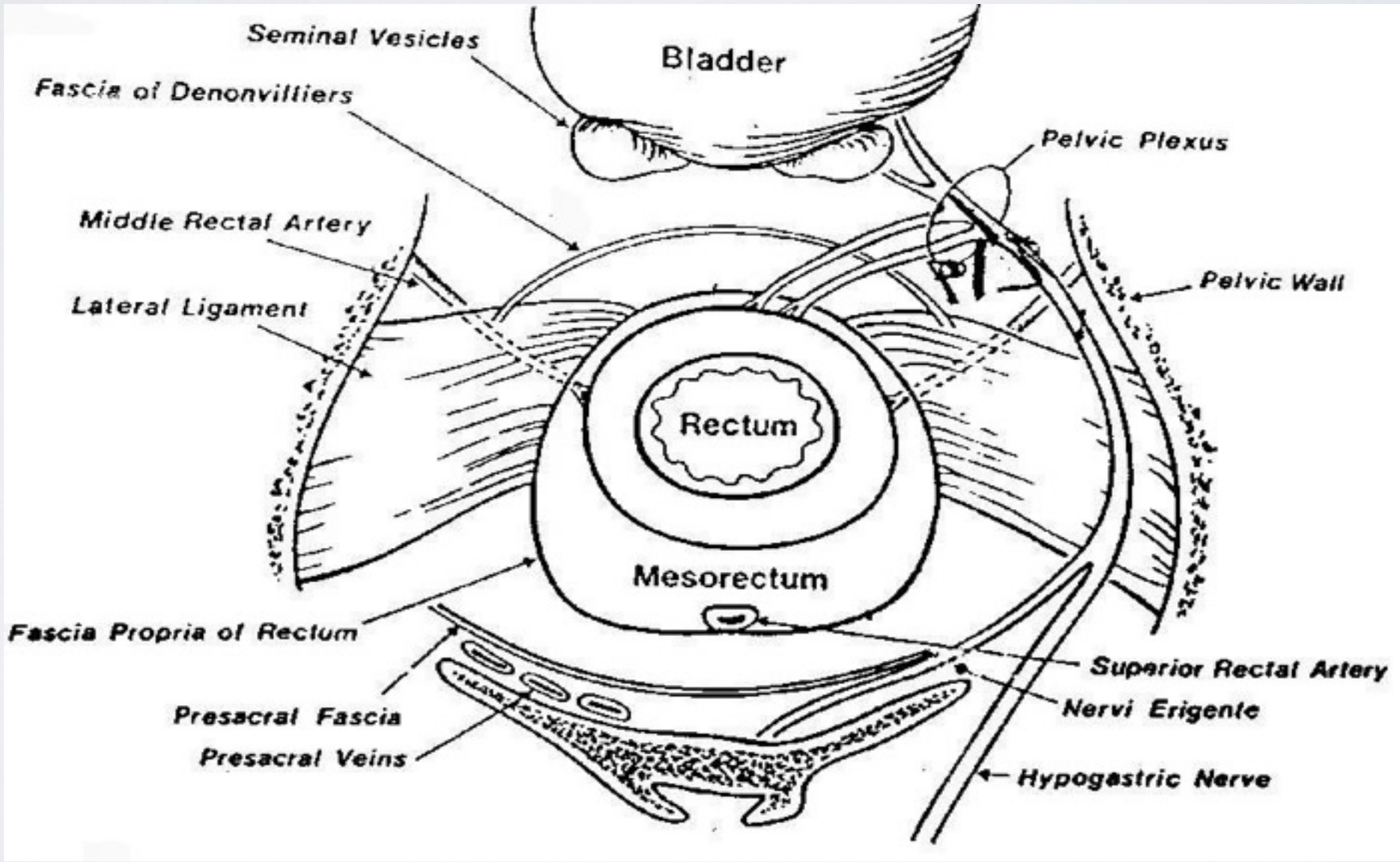
2 - TECNICA - Requisiti oncologici

Escissione totale del mesoretto



2 - TECNICA - Requisiti oncologici

Escissione totale del mesoretto



2 - TECNICA - Requisiti oncologici

-Margini di resezione prossimale e distale

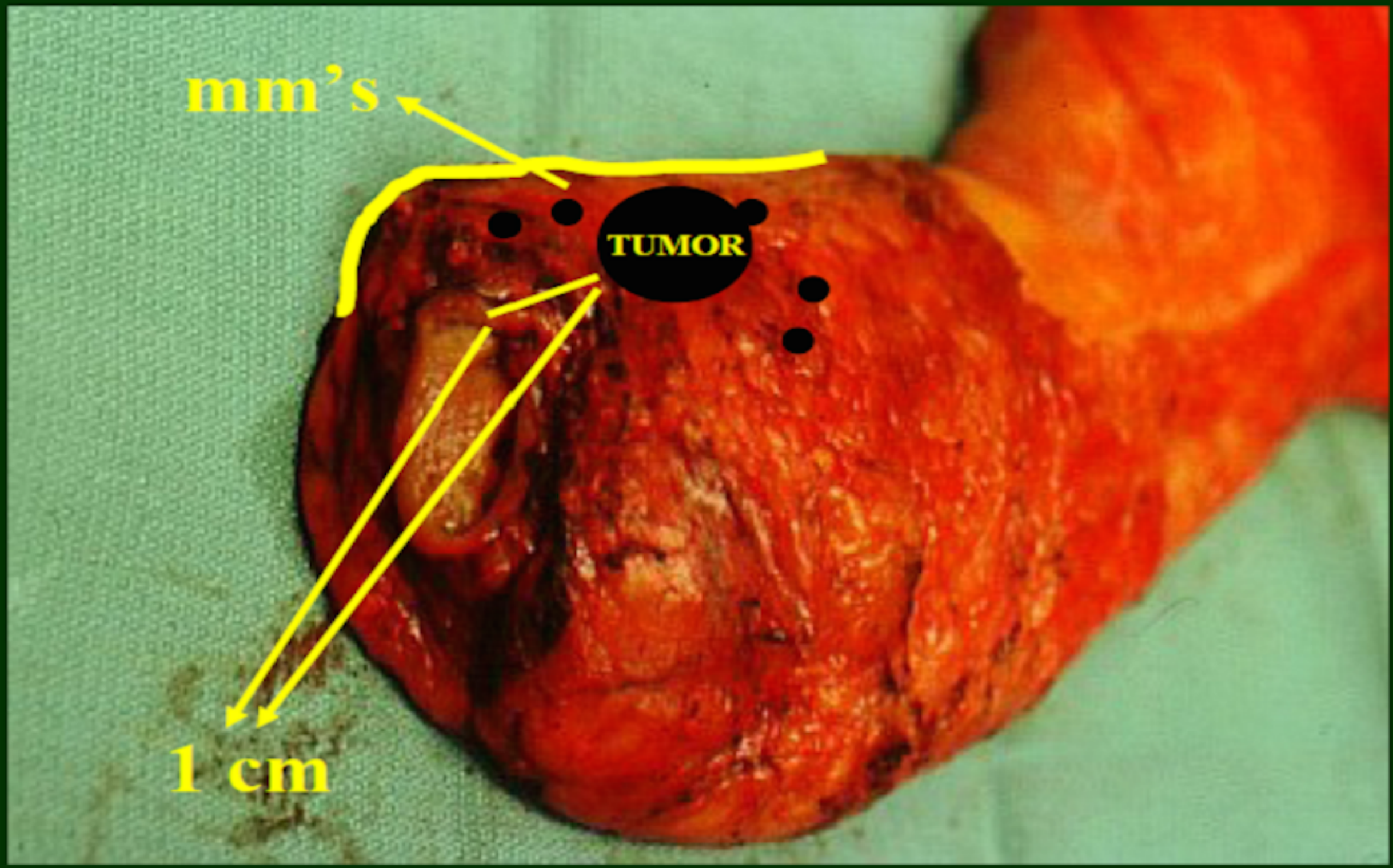
> 2cm

> 0.5 cm margine distale nei CRT ev estemporaneo

-Margine resezione circonferenziale

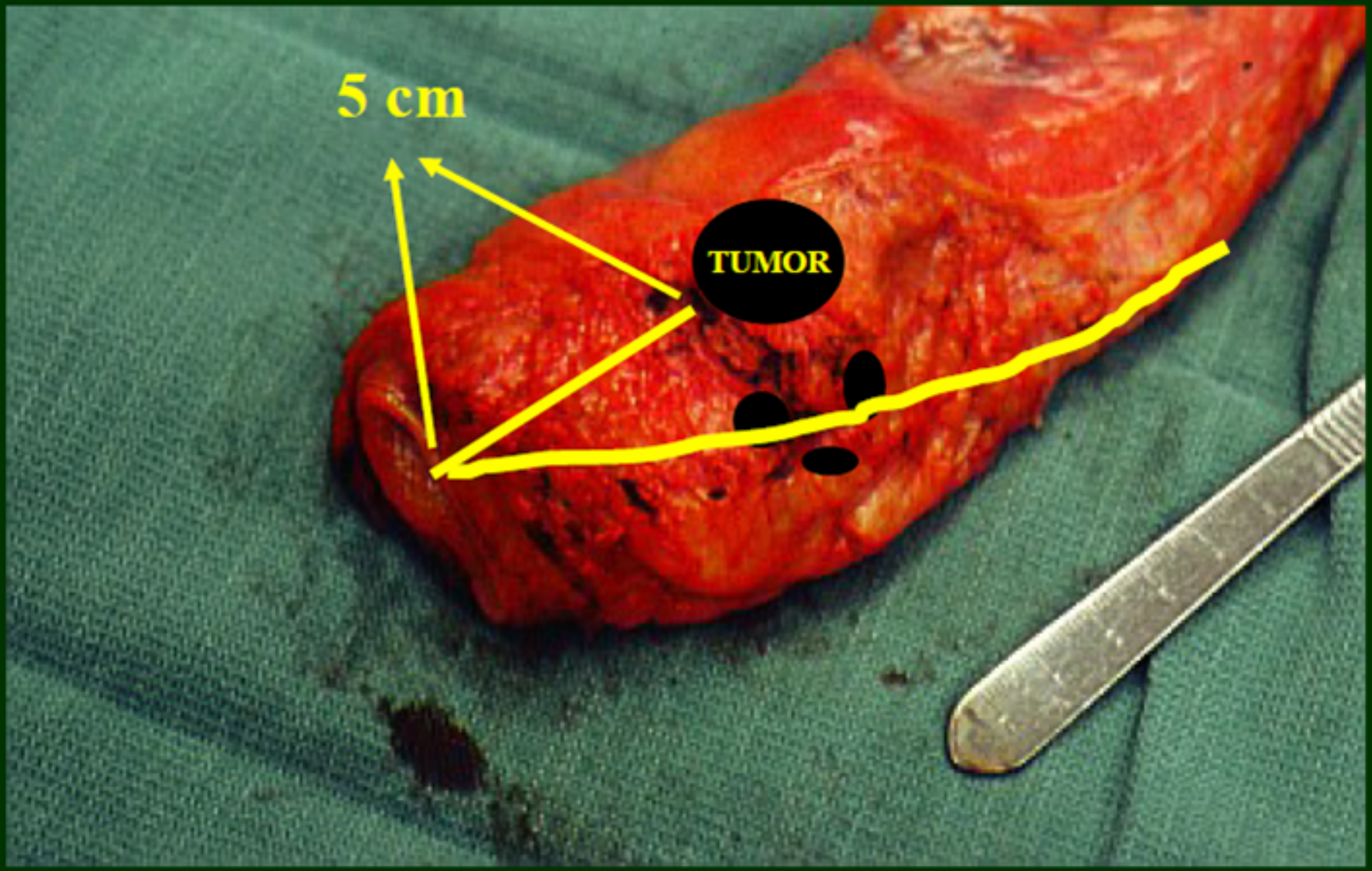
> 1mm distanza tra neoplasia e fascia mesorettale

This is how local recurrence is avoided, even with a narrow distal margin.



Distal margin and deep margin are adequate!

This is how local recurrence happens.



Distal margin is adequate: deep margin is not!

2 - TECNICA

…un pò di storia

1908	Miles	Amputazione A.P.
1948	Dixon	Resezione anteriore bassa
1978	Heald	Total Mesorectal Excision
1980	Knight-Griffen	I° anastomosi meccanica T.A.

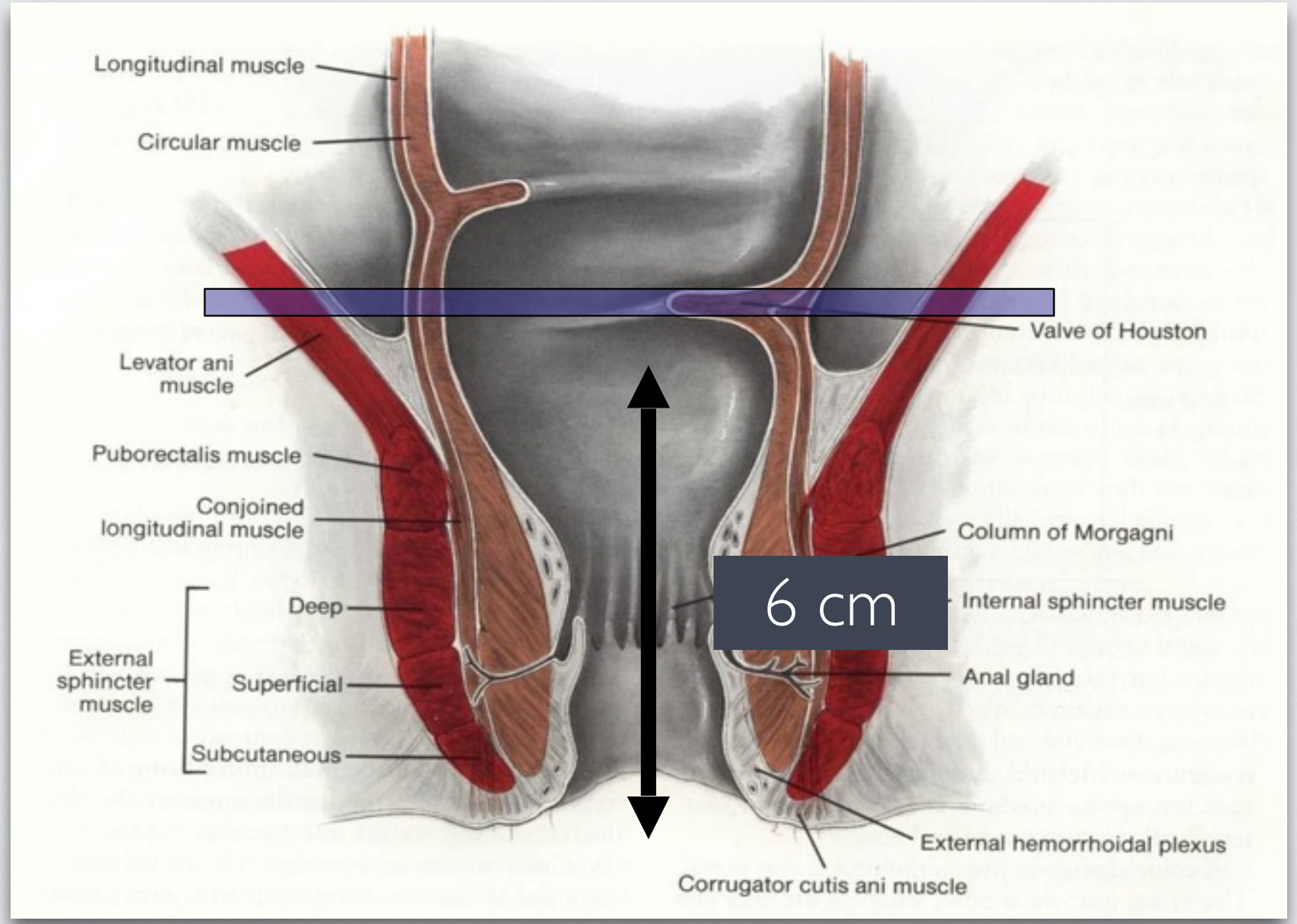
2 - TECNICA

demolizione

- Resezione Anteriore Bassa
- Resezione Intersfinterica
- Amputazione Addominoperineale

Resezione anteriore bassa

livello del piano degli elevatori preservando l'apparato sfinteriale



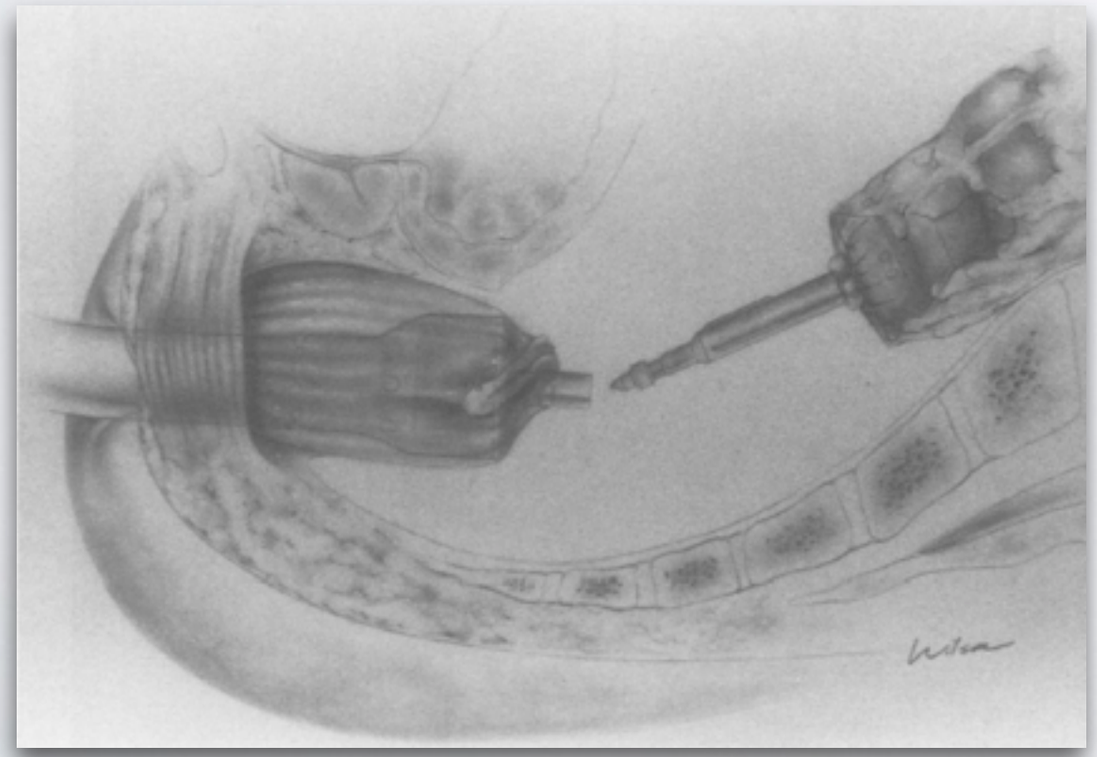
Resezione anteriore bassa

Ricostruzione Knight-Griffen

Rende più agevole e rapida l'anastomosi bassa e ultrabassa

Non apre il moncone rettale

Permette l'anastomosi tra segmenti di calibro diverso



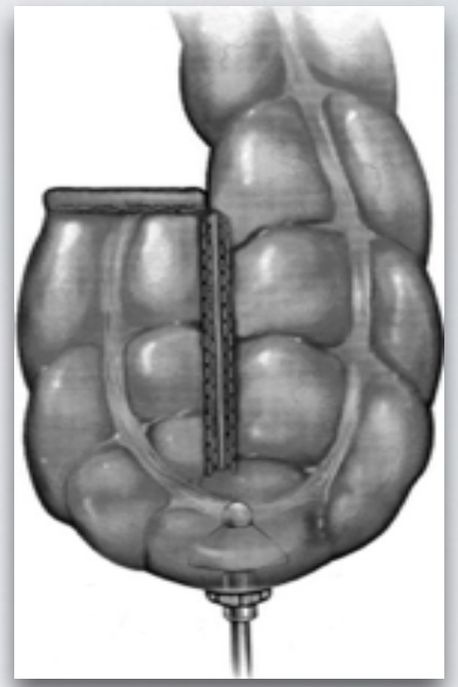
Fistola: 2.7-13%
Stenosi: 2.7-6.7%

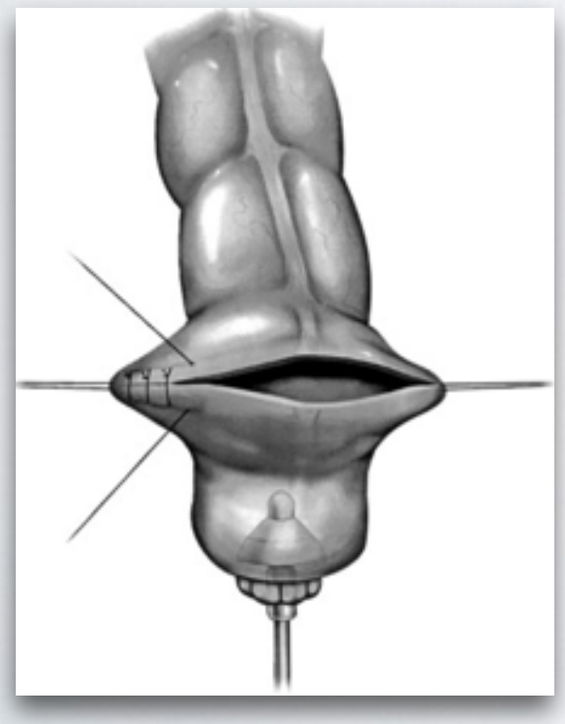
DIFETTI:
"anterior resection syndrome":
urgence, frequenti evacuazioni,
incompleto svuotamento

Resezione anteriore bassa

Ricostruzione con Neoampolla

-Latero – terminale (side to end)
-J Pouch colica
-Coloplastica trasversale





MAGGIORE COMPLESSITA'

BENEFICIO FUNZIONALE
SOLO NEI PRIMI 12 MESI

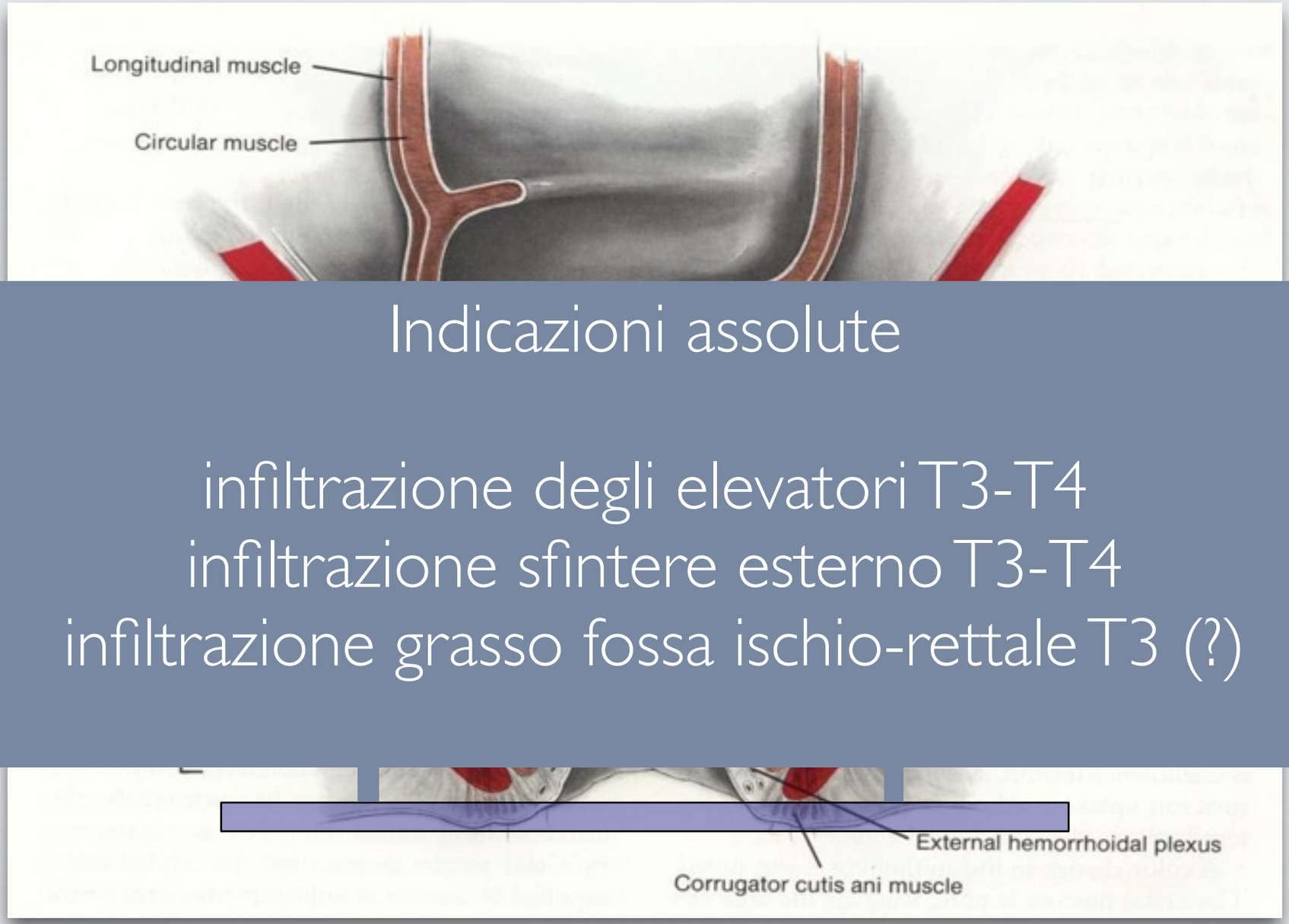
Resezione anteriore bassa

Hartmann

- Demolizione senza ricostruzione
- Non infiltrazione sfinteriale in paziente che deve guarire in poco tempo e con malattia avanzata (M+)
- Non infiltrazione sfinteriale in pazienti in scadenti condizioni generali che non tollererebbero complicanze sull'anastomosi

Amputazione addomino-perineale

Asportazione retto mesoretto ano ed apparato sfinteriale
Stoma definitivo



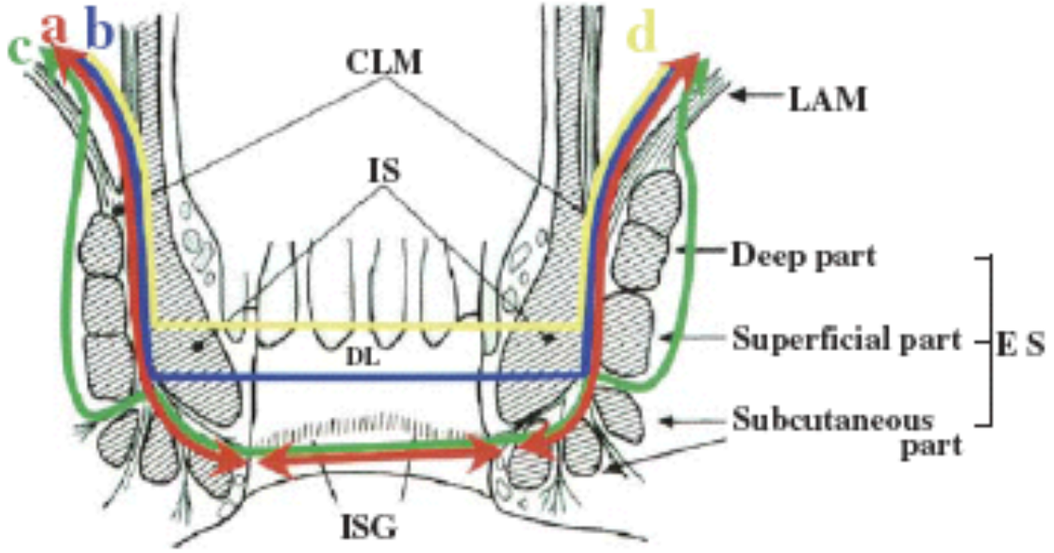
Indicazioni assolute

infiltrazione degli elevatori T3-T4
infiltrazione sfintere esterno T3-T4
infiltrazione grasso fossa ischio-rettale T3 (?)

Resezione intersfinterica

Sotto al piano degli elevatori preservando parzialmente l'apparato sfinteriale

- **Tumor location** lower rectum and anal canal
- **Local spread** restricted to the rectal wall or internal sphincter
- **Grading** GI – II
- **Sphincter function**
- **Consenso dettagliato**

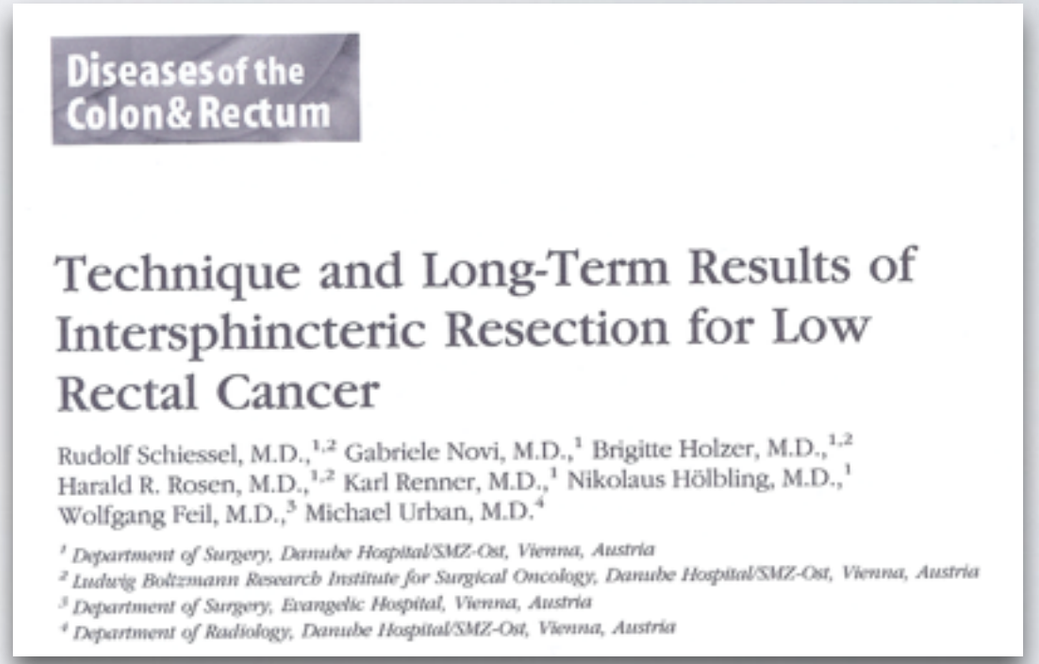


Type of ISR	Anastomotic line	Sacrificed sphincter
Partial	Just on DL or within 1cm oral side from DL	Partial IS
Subtotal	Between DL and ISG	Almost all of IS
Total	Just on ISG	Total IS without or with partial ES

Resezione intersfinterica

anastomosi

- Coloano anastomosi manuale
- Pull through



Diseases of the Colon & Rectum

Technique and Long-Term Results of Intersphincteric Resection for Low Rectal Cancer

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- Anticipando il tempo perineale al tempo addominale laparoscopico.
  Semplificazione- riduzione dei tempi della TME: migliore trazione verso l'alto del moncone rettale già mobilizzato
- Estrazione del pezzo per via transanale senza necessità del Pfannestiel

RAB vs ISR

risvolti funzionali

Sphincter-Saving Resection for All Rectal Carcinomas

The End of the 2-cm Distal Rule

Eric Rullier, MD, Christophe Laurent, MD,* Frédéric Bretagnol, MD,* Anne Rullier, MD,†*

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	Anterior resection	Low anterior resection	Intersphincteric resection	
Never	17 (77%)	35 (49%)	3 (21%)	
Rarely	2 (9%)	9 (13%)	2 (7%)	
Sometimes	1 (5%)	13 (18%)	6 (21%)	
Usually	2 (9%)	11 (15%)	10 (36%)	
Always				
Incontinence – gas				
Never				
Rarely				
Sometimes				
Usually				
Always				
Wearing pads				
Never				
Rarely				
Sometimes				
Usually				
Always	7 (32%)	19 (26%)	11 (39%)	
Lifestyle alterations				<0.0001
Never	12 (55%)	23 (32%)	2 (7%)	
Rarely	3 (14%)	5 (7%)	3 (11%)	
Sometimes	–	11 (15%)	1 (4%)	
Usually	6 (27%)	19 (26%)	11 (39%)	
Always	1 (5%)	14 (19%)	11 (39%)	

	Low			
Warning period				0.030
None	0	8 (11%)	6 (21%)	
Reduced	14 (36%)	20 (28%)	12 (43%)	
			0 (36%)	
				ns
			2 (7%)	
			8 (29%)	
			8 (64%)	
				ns
			6 (21%)	
			5 (18%)	
None	3 (14%)	41 (57%)	17 (61%)	
Patient satisfaction				ns
None	2 (9%)	12 (17%)	5 (18%)	
Partial	2 (9%)	12 (17%)	3 (11%)	
Total	18 (82%)	48 (67%)	20 (71%)	

However, in our opinion, the technique of ISR is justified because recent improvement in surgical management of fecal incontinence permits us to treat patients after surgical injury.[29]

K. E. Matzel et al.
2003 Blackwell Publishing Ltd. *Colorectal Disease*, **5**, 458–464

In conclusione

- La chirurgia del retto extraperitoneale è ad alta complessità
- La strategia terapeutica non può prescindere dalla qualità di vita

Grazie per l'attenzione