

DEVELOPING STANDARDS FOR THE TREATMENT OF RECTAL CANCER

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This issue of the journal (pages 352 to 362) contains papers presented at a symposium on rectal cancer presented by the Canadian Society of Surgical Oncology in Toronto in April 1996. My task was to present the results of surgery alone for rectal cancer. At the time there was some scepticism about the role of total mesorectal excision (TME) in reducing the need for adjuvant therapies by minimizing local recurrence to 5% at 5 years¹ (a current update with an additional 115 cases shows that this number is now 3%). Since my presentation, a number of important reports have appeared in the literature that have helped to define the optimal therapy for rectal cancer.

There can be no doubt that TME is now the standard for surgery in this disease. A symposium in Oslo,² a leading article in the *British Journal of Surgery*,³ a collective review in the *Journal of the American College of Surgeons*,⁴ a meta-analysis from Australia,⁵ and papers from the United States,⁶ Italy,⁷ Sweden⁸ and most recently Japan⁹ all support TME as producing local recurrence rates of less than 10% in curative resections. These reports indicate increasing acceptance of the importance of meticulous surgical dissection of the mesorectal tis-

ues as paramount in improving the results of surgery for rectal cancer. Traditional methods of blunt dissection in the pelvis are simply no longer acceptable, especially as they result in local recurrence rates ranging from 20% to 30%.⁵

The use of adjuvant radiotherapy has been studied extensively in Sweden, and a recent report¹⁰ of the Scandinavian trial supports short-course radiotherapy preoperatively as effectively reducing local recurrence to 11%. This trial began before surgery was standardized, and thus the Dutch randomized trial of TME, with or without short-course radiotherapy (Professor C.J.H. van de Velde, Chairman of the Dutch Colorectal Cancer Group, Leiden University Medical Centre, Leiden, The Netherlands: personal communication, 1997), is extremely important in our understanding of the ultimate place of radiotherapy in the management of patients with rectal cancer.

The use of chemotherapy alone as an adjuvant to surgery for rectal cancer has been disappointing, with only the National Surgical Adjuvant Breast and Bowel Project¹¹ and the Gastrointestinal Tumor Study Group¹² studies showing modest improvements in 5-year disease-free survival (from 30% to 42% [in men only] and from 47% to

55% respectively). No effect on local recurrence was seen in either trial.

All other reported studies combine chemotherapy and radiotherapy post-operatively. The most encouraging results have been reported by Krook and associates.¹³ In this randomized trial, the best response was seen in the combination therapy arm where local recurrence was 13.5% and overall 5-year survival was 58.5%. However, these figures do not match those of the combined series of TME,⁵ suggesting that optimal combination chemotherapy and radiotherapy cannot "tidy up" after inadequate surgery.

The setting of standards is a rare event in any surgeon's lifetime. I have been privileged to be associated with 2 such experiences: the National Surgical Adjuvant Breast Project partial mastectomy trial (protocol B-06)¹⁴ has set conservative breast cancer surgery as the current treatment of choice and collaboration with R.J. Heald in Basingstoke gave me the opportunity of setting a second standard of treatment, TME for rectal cancer.

Because of the importance of local control on the overall outcome of the patient with cancer, it is incumbent on all surgeons to learn and practise TME as the procedure of choice for rectal cancer. The technique, although time-

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consuming, has the attraction of combining meticulous anatomic dissection with the removal of the complete disease package yet preserving the important pelvic nerve plexuses and their corresponding genitourinary functions. TME has the potential to reduce the need for complex, costly adjuvant therapies to a few select patients. The final description of optimal adjuvant treatment awaits the results of trials incorporating TME as the standard for surgery. Only then will we be able to offer effective and efficient care to our patients with rectal cancer.

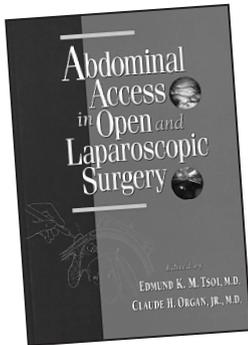
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