Is there a role for palliative surgery?

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The feasibility of an operation is not the best indication for its performance

Henry Cohen 1900-1977
Palliative Surgery

The lesser the indication, the greater the complication.

Moshe Schein
Palliative Surgery

Affording relief, not cure....reduce severity of

• Surgery to relieve symptoms knowing in advance that all of the tumour cannot be removed

• Resection with gross or microscopic residual tumour left in-situ

• Resection for recurrent or persistent disease after primary treatment failure

Latter two – definitive, preop. intent is cure and increased survival, often also relieve symptoms
Palliative Surgery

• **Palliative (relief symptoms)**
  - Relief obstruction/bleeding/fistula
  - Drain effusions
  - Pain control
  - Debulk/toilet/devascularise

• **Supportive (part of multidisciplinary plan)**
  - Tissue sampling
  - Vascular access
  - Enteral feeding tubes
46-year female. Rectal Ca at 8cm. CT - large rectal mass with perirectal LNs, two lesions - 2cm each- in the IV and VI hepatic segments.

Planned to deal first with her rectum and then 6 months later repeat CT/PET and to decide what to do with hepatic mets. Six weeks of chemoRT+ six weeks of waiting and fighting with leukopenia, vomiting, anorexia etc. Repeated CT - tumor shrunk, hepatic lesions same.

At laparotomy for LAR - firm enlarged periaortic lymph nodes between IMA and renal arteries. Frozen - metastatic adenocA. Intraop US+ core biopsy of hepatic lesions - mets. She doesn't bleed, she is not obstructed. What now?

80 patients, stage IV, resectable rectal primary LAR 65, APR 11, Hartmann’s 4. Chemo and no RT
15% complication, 5% reoperation, 1 death
LR 6% with median time to LR of 14 months
Median survival 25 months, extent of mets and chemosensitivity determinants of survival
Palliative bowel resection for incurable stage IV colorectal cancer: prognostic variables for asymptomatic patients—Ruo et al, MSKCC. 87th Annual ACS Clinical Congress 2001

Op mortality 5%, morbidity 30%

Not operated - median survival 9 months, no survival difference; 8.7% subsequently required op., 1/3 for obstruction

Selection - Liver only, less than 25% involved, one site only

30 patients with incurable colorectal cancer

16 resections - median op time 170 min, LOS 8 days, survival 12 months

11 stoma creation - median op time 60 min, LOS 7 days, survival 8 months, 2 op mortality

3 conversion

No port-site recurrence
Management of Bowel Obstruction in Patients with Abdominal Cancer

• Benign, carcinomatosis, or intraluminal recurrence?
• Partial, intermittent, high-grade total, or even strangulation?
• Patient’s level of function, tumour burden and projected survival?

Bowel obstruction

Occurs in 5-43% of patients with advanced primary or metastatic intraabdominal malignancy

May be single, or multiple sites due to carcinomatosis

Benign causes are found in 3-48% of patients with malignant disease

Carcinomatosis - op mortality 13%, median survival 10 months, duration of symptom relief 2 months
Bowel obstruction

Favourable factors

• Well-nourished
• Early stage, low-grade initial lesion

Genitourinary malignancy

Odds of benign obstructive process higher in the 12-18 months after resection if extensive carcinomatosis not initially present

• Long interval from first operation - more than 5 years
Bowel obstruction

Unfavourable factors

- Carcinomatosis
- Multiple level obstruction with prolonged transit
- Previous RT to abdomen or pelvis
- Palpable masses
- Ascites requiring frequent drainage
- Cachetic, older patients (5x higher op mortality)
- Poor performance status, low albumin
- Liver and distant metastases
Non-operative options

• Laser
• Endoluminal stent
• Radiotherapy
• Palliative medicine
Evaluation of endpoints

• Primary
  QOL - relief/prevent symptoms
  Morbidity of procedure, relative to estimated survival
  Morbidity of not doing procedure
  Mode of death with and without intervention

Cost analysis

• Secondary
  Survival benefit
  QOL of caregivers with and without intervention
Conclusions

• There is a definite role for palliative surgery
• Palliative surgery must be safe and efficacious
• The key is patient selection:
  Patient factors - op. risk, QOL, estimated survival
  Disease factors - tumour burden
  Technical factors
Primum non nocere

Decisions are made one patient at a time

Cut to Cure
Care and Comfort