INAUGURAL MEETING - MALAYSIAN COLORECTAL SOCIETY

Is there a role for palliative surgery?

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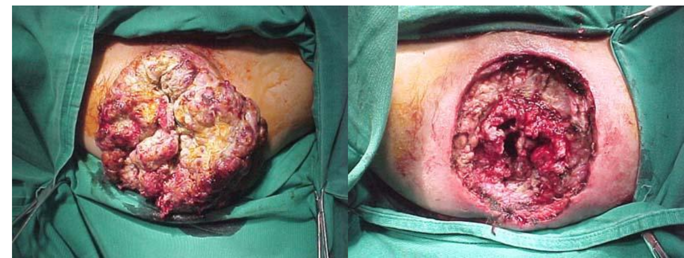
Adding years of healthy life



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

Henry Cohen 1900-1977

The lesser the indication,
the greater the complication.

Moshe Schein

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

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

Tissue sampling
Vascular access
Enteral feeding tubes

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

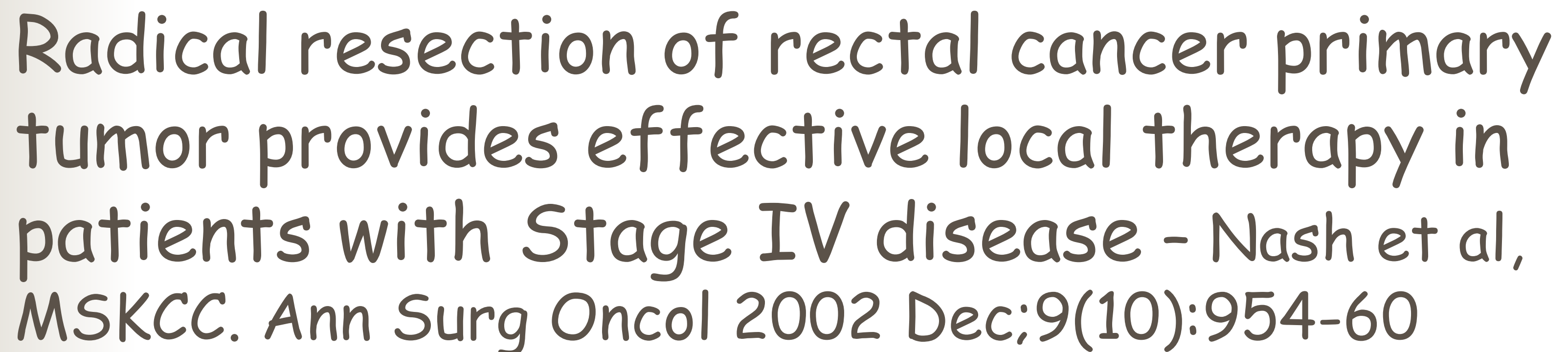
Enteral feeding tubes

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?



Radical resection of rectal cancer primary tumor provides effective local therapy in patients with Stage IV disease - Nash et al, MSKCC. Ann Surg Oncol 2002 Dec;9(10):954-60

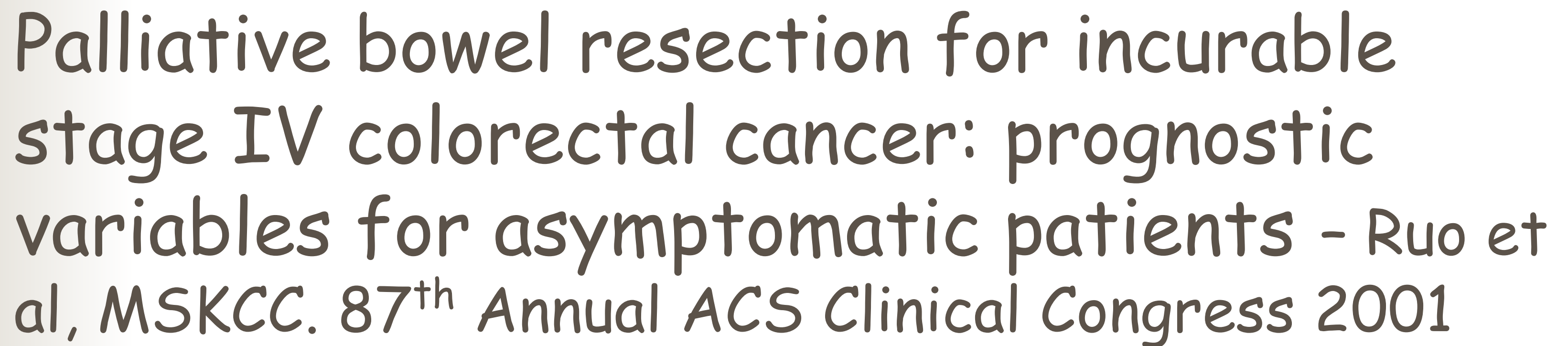
80 patients, stage IV, resectable rectal primary

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

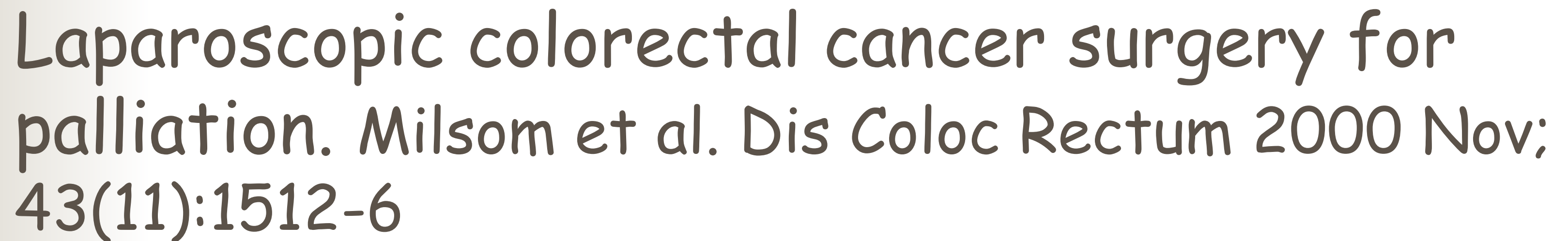
Median survival 25 months, extent of mets and chemosensitivity determinants of survival



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



Laparoscopic colorectal cancer surgery for palliation. Milsom et al. Dis Coloc Rectum 2000 Nov; 43(11):1512-6

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?

Woolfson et al, Arch Surg 1997;132(10):1093-7

- 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

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 initally present

- Long interval from first operation – more than 5 years

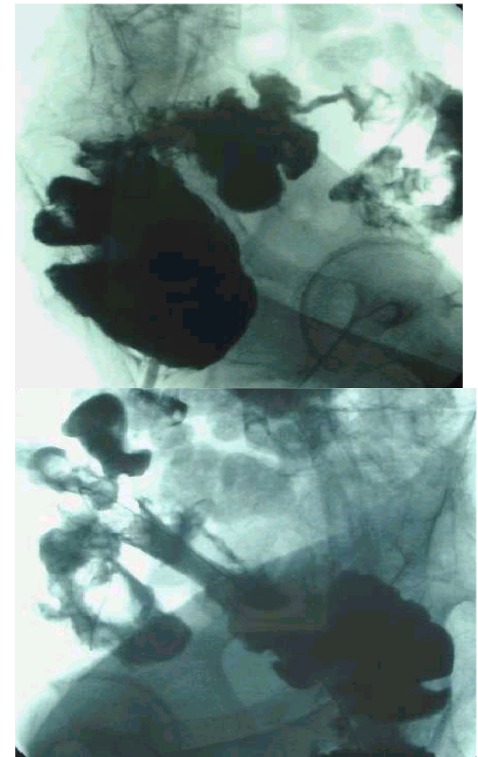
Bowel obstruction

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



- 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

- 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

Decisions are made one patient at a time

Cut to Cure

Care and Comfort