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Treatment of locally recurrent rectal cancer

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Abstract

Surgical resection is the cornerstone of curative therapy for patients with potentially resectable rectal cancer. CRTh is often administered preoperatively for: clinically staged T3 or T4, or node-positive tumors, for distal tumors or mesorectal fascia invasion. (total mesorectal excision [TME]) is also associated with lower local failure rates. Despite refinements in surgical techniques (such as TME), with optimal use of neoadjuvant & adjuvant therapies, the incidence of locoregional relapse after treatment is, still 4 to 8 %.These Patients form a very heterogeneous group, ranging from: focused anastomotic recurrence , involvement of adjacent soft tissue organs & the bony structures of the pelvis. Without treatment, these patients have a short life expectancy . The clinical nature & prognosis have changed since the introduction of preoperative (RTh), which reduces local recurrence all subsites. Many patients who present with a local recurrence after prior RT, have simultaneous distant metastases,& the long-term outcomes, seem to be worse, after local recurrence in previously irradiated patients, as compared with patient treated initially with surgery alone. Approximately one-third of patients may be asymptomatic the time of recurrence, with the recurrence discovered during a routine postoperative follow-up evaluation. Anastomotic recurrence can present with: rectal bleeding, or alteration of bowel habits, Pain is a more concerning symptom, that may be associated with involvement ,or compression of organs, bone, & nerves. Local recurrence after an APR can present with: a nonhealing perineal wound, a perineal mass, pelvic pain, or bowel obstruction. Up to 74 % of the patients , after combined modality therapy, will present with synchronous distant metastatic disease. the assessment of fitness for major surgical intervention, staging of the tumor, to ascertain the anatomy & the extent of local & distant disease. It is challenging to manage, particularly in patients who have received prior RTh, & must be reffered to MDT. All patients with the suspicious diseae, should undergo a full clinical staging evaluation, to exclude the presence of distant metastatic disease, including: CT CAP , (PET) scan, CEA level, Locally recurrent, or metastatic disease, should be confirmed by biopsy.

Biography

Haitham Saimeh is General Surgery, Assistant consultant, Colorectal department, King Feisal speciality Hospital Research, KFSH-RC, Jeddah, Saudi Arabia. Academic Qualifications: MBBS in Medicine & Surgery 3 years practicing in Al Assad University Hospital, Teshreen University, Syria, in all departments (Internal Medicine, General Surgery, Paediatrics, Dermatology, Ophthalmology, ENT, ER) from1988-1990Training in Jordan University Hospital in Internal Medicine Dept., for one month, Summer vacation 1986. Training in Al Mubarak Al Kabeer Hospital in Kuwait for one month, in summer vacation, 1987. Training in AlSabah General Hospital in Kuwait, in General Surgery for two months during the summer holidays, 1988. Internship, Al Bashir Governmental Hospital – Amman, Jordan 21/1/1992 – 25/12/1992, the rotation was for one year in General Surgery, Internal Medicine, Pediatrics, Obs. & Gyne, Conference of Jordnian surgical society 2017-2018 [speaker] conferences of Jordanian Surgical society 2021-2022 [speaker] conferences of Saudi society.