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European Society for Medical Oncology

ESMO Asia CME Partner Centre:
Colorectal Cancer Program

Management of Metastatic Rectal cancer- Unresectable Metastases

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Management of Metastatic Rectal cancer- Unresectable Metastases

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Facts

- Local recurrence is a peculiar problem of Rectal Cancer

  Reason: Lack of peritoneal covering

- Incidence: 25-50% of patients with T3/T4 &/ or node +Ve disease, lower rectal tumors

- TME has helped reduce local recurrence

Goals of treatment in

Unresectable Metastatic rectal cancer

- Prolongation of Survival
- Improving tumor related symptoms
- Stopping Tumor Progression
- ???? Cure
- Quality of Life

Types of Recurrence

A) **Synchronous** : simultaneously in primary & lung, Liver

v/s

Metachronous: Sequentially after primary surgery

B) **Early**: Within 12 months of primary Treatment

v/s

Late: Beyond 12 months of primary treatment

C) **Local** v/s **Systemic**

How to decide Intensity of Treatment

Clinical Situation	What is Needed ??	Treatment Intensity
1. Liver/Lung Metastases	•Maximum Tumor shrinkage •Control of Progressive Disease	Multiple Drugs Therapy including Biological agents
2. Multiple Mets with rapid progression & lot of symptoms		
3. Unresectable Mets, Minimal Symptoms, Co-Morbidity	• Tumor shrinkage is less relevant • Control of progressive disease and prevention of Toxicities	Single or Double agent Therapy

Appropriate candidates for Palliative chemotherapy

- Good Performance Status
- Good Bone Marrow Reserve
- Good Organ Function

FOLFOX v/s FOLFIRI

➢ same efficacy with decreased toxicity with FOLFOX

FOLFOX v/s IFL

➢ FOLFOX better in terms of Response rates,TTP & Survival

Duration of Chemotherapy:

3-6 months or treatment until progression or toxicity

Synchronous Metastases

- If asymptomatic for primary area:
  - To start combination chemotherapy +/- biological agents
- If symptomatic for primary area:
  - Endoscopically placed expandable metal stents for palliation OR

    for impending obstruction
- Role of Radiation is controversial

Synchronous Metastases contd..

- Palliative surgery especially in Extrapelvic metastatic disease is very small
- Ultimately, the treatment decision must be individualized
- The incidence of intestinal complications during primary chemotherapy is low (13%)
- Non Curative resection of primary tumor should not be attempted

- **Metachronous Metastases:**
  - Systemic Therapy
  - If the progression is within 12 Months of initial therapy of FOLFOX then FOLFIRI (Irinotecan-based chemotherapy) should be considered

- **Isolated pelvic Recurrence:**
  - RT+ 5FU if full course of RT was not given earlier
  - Resection with Intra- op RT/ Brachytherapy
  - Unresectable Pelvic Mass: Individualized Rx

Role of Biological Agents

- All trials of Colon cancer have also included rectal cancer so principles of colon cancer have been used for rectal cancer
- K-RAS wild type: Cetuximab
- Bevacizumab
- No phase III data for combining Anti-EGFR with Bevacizumab available

Queries ??????

THANK YOU