



**Sanremo 10 novembre 2012 - Teatro dell'Opera del Casinò**

**Presidente del Convegno: Antonio Amato**

**3° CONGRESSO TRI-REGIONALE S.I.C.C.R. LIGURIA, LOMBARDIA, PIEMONTE**

**Alberto Vannelli**

**Chirurgia Oncologica Gastroenterologica**

**Ospedale Valduce Como**



Bujko K, Rutkowski A, Chang GJ,  
Michalski W, Chmielik E, Kusnierz J.

*Is the 1-cm rule of distal bowel  
resection margin in rectal  
cancer based on clinical  
evidence? A systematic review*

**Ann Surg Oncol. 2012;19(3):801-8**

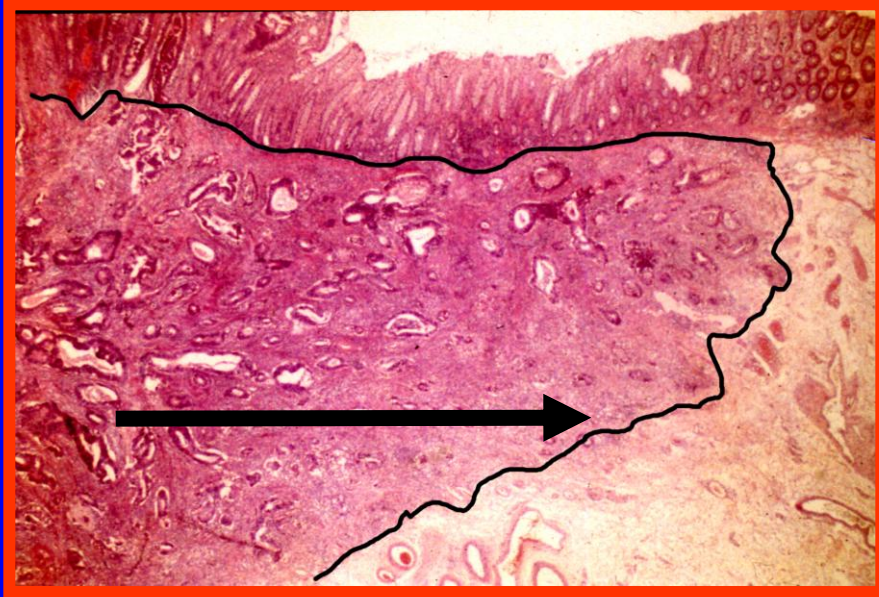
***Le nuove scoperte passano attraverso tre fasi. In primo luogo sono ridicolizzate, poi sono combattute pesantemente ed infine sono considerate come evidenti***

**Matthias Rath**

## BACKGROUND:

Distal intramural spread is present within 1 cm from visible tumor in a substantial proportion of patients. Therefore,  $\geq 1$  cm of distal bowel clearance is recommended as minimally acceptable. However, clinical results are contradictory in answering the question of whether this rule is valid. The aim of this review was to evaluate whether in patients undergoing anterior resection, a distal bowel gross margin of  $<1$  cm jeopardizes oncologic safety.

# DIFFUSIONE INTRAMURALE DISTALE



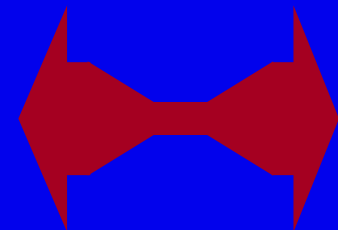
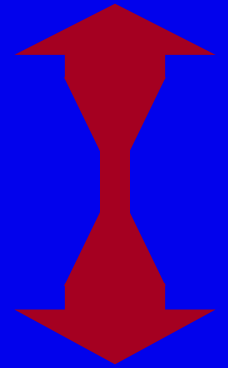
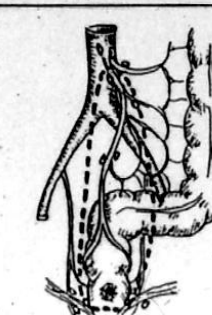
**DIS > 1 cm  
è presente nel  
5% dei casi**

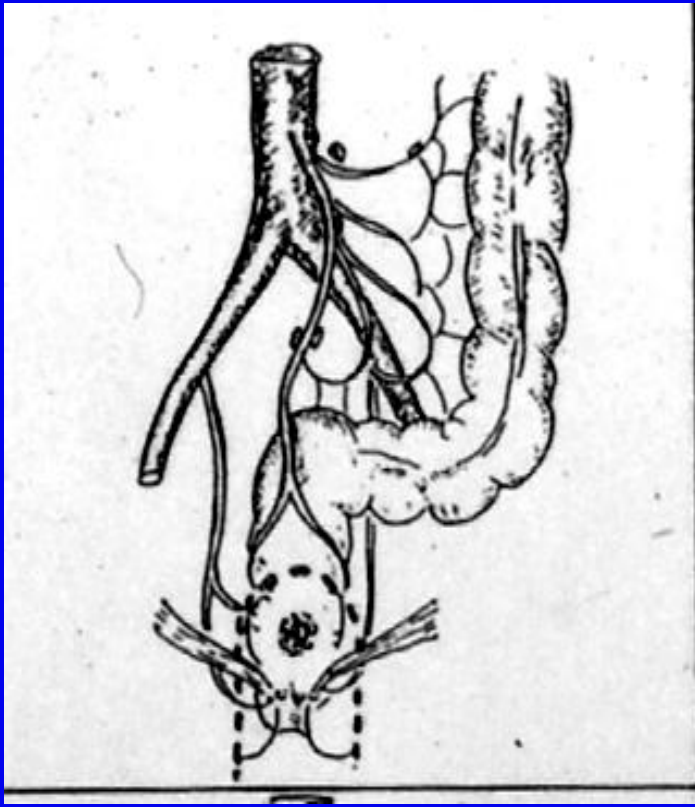
**DIS >1 cm è associato a invasione neoplastica mesorettale ed è indice di malattia avanzata**

1700

STORIA  
DELLA  
CHIRURGIA

OGGI

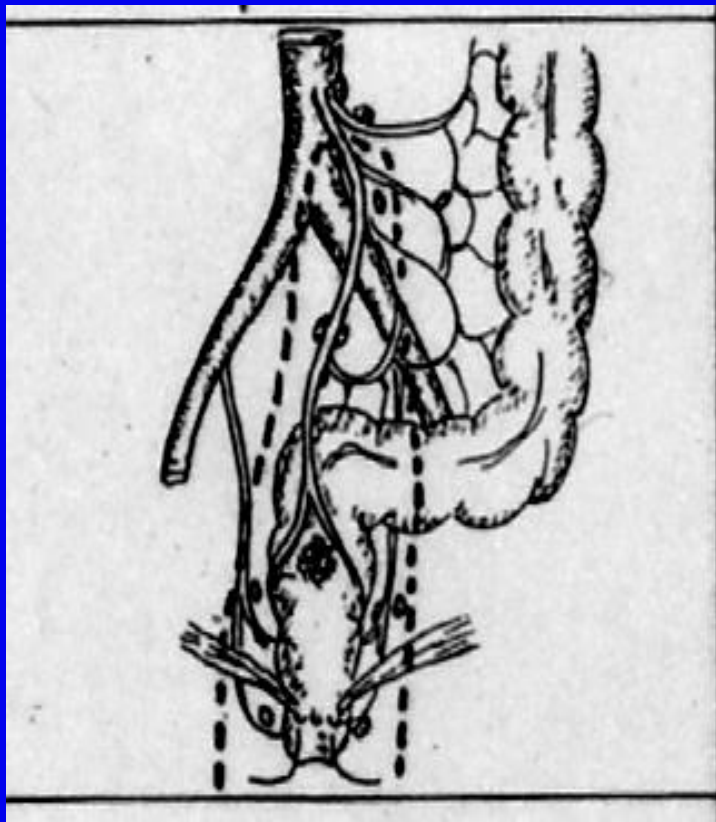




## Interventi limitati per via perineale

- Faget (1739)
- Lisfranc (1826)
- Verneuil (1873)
- Kraske (1885)
- Lockart-Mummery (1907)

## Proto-chirurgia



## Interventi per via laparotomica

- Miles (1908)
- Gray Turner (1920)
- Gabriel (1930)

**Fase eroica**

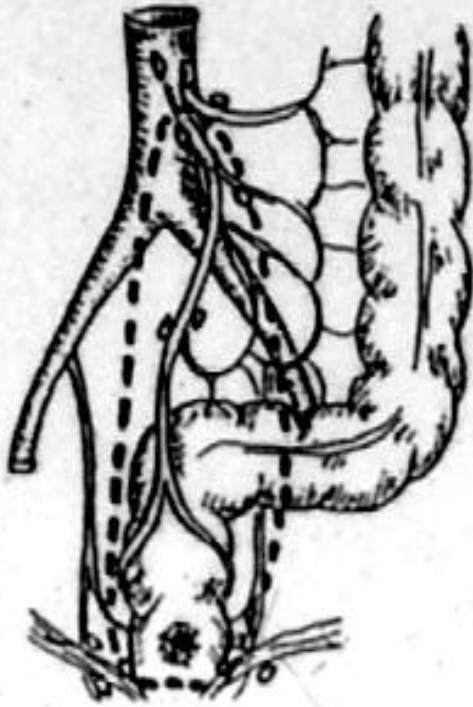




## Sphincter saving procedures

- Finserer (1941)
- Bacon (1945)
- Babcock (1947)
- Gabriel (1948)
- Lloyd-Davies (1950)
- D'Allaines (1956)
- Turnbull (1961)
- Figioni (1961)
- Localio (1961)
- Mason (1970)

**Evoluzione tecnologica**



## Resezione totale del retto e anastomosi colo-endoanale

- Parks (1982)
- Parc (1986)
- Mc Anema (1990)
- Leo (1990)

**Evoluzione culturale**

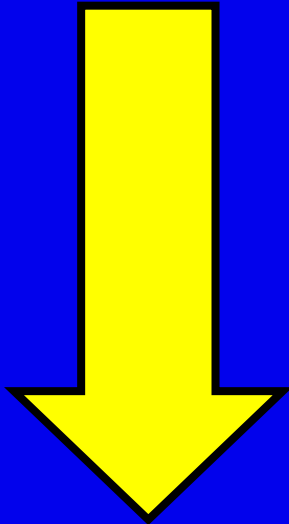
## METHODS:

A systematic review of the literature identified 17 studies showing results in relation to margins of approximately  $<1$  cm (948 patients) versus  $>1$  cm (4626 patients); five studies in relation to a margin of  $\leq 5$  mm (173 patients) versus  $>5$  mm (1277 patients), and five studies showing results in a margin of  $\leq 2$  mm (73 patients). In most studies, pre- or postoperative radiation was provided.

- Solo studi in lingua inglese
- Ricerca su PubMed database con keywords “rectal cancer” e “distal margin” o “distal clearance”
- Periodo dal 1982 (total mesorectal excision) fino a gennaio 2011.
- Dati estratti indipendentemente da due investigators tramite data collection form.
- Esclusi i pazienti con insemenzamento dell’anastomosi o con microinfiltrazione dell’anello anastomotico
- Contattati gli autori per dati mancanti

# LE BASI DELLA MODERNA CHIRURGIA RETTALE

**5 cm**



**< 1 cm**

1976	MANSON PM	>5 cm
1983	POLLET WG	<2 cm
1986	WEESE L	5 cm
1986	HOJO K	2 cm
1992	VERNAVA AM	1 cm
1995	SHIROUZU K	1 cm
2000	LEO E	<1 cm
2001	KUVSHINOFF B	<1cm*
2003	MOORE HG	≤1cm*

\*+CMT preop

## RESULTS:

A multifactorial process was identified resulting in selection of favorable tumors for anterior resection with the short bowel margin and unfavorable tumors for abdominoperineal resection or for anterior resection with the long margin. In total, the local recurrence rate was 1.0% higher in the <1-cm margin group compared to the >1-cm margin group (95% confidence interval [CI] -0.6 to 2.7;  $P = 0.175$ ). The corresponding figures for  $\leq 5$  mm cutoff point were 1.7% (95% CI -1.9 to 5.3;  $P = 0.375$ ). The pooled local recurrence rate in patients having  $\leq 2$  mm margin was 2.7% (95% CI 0 to 6.4).

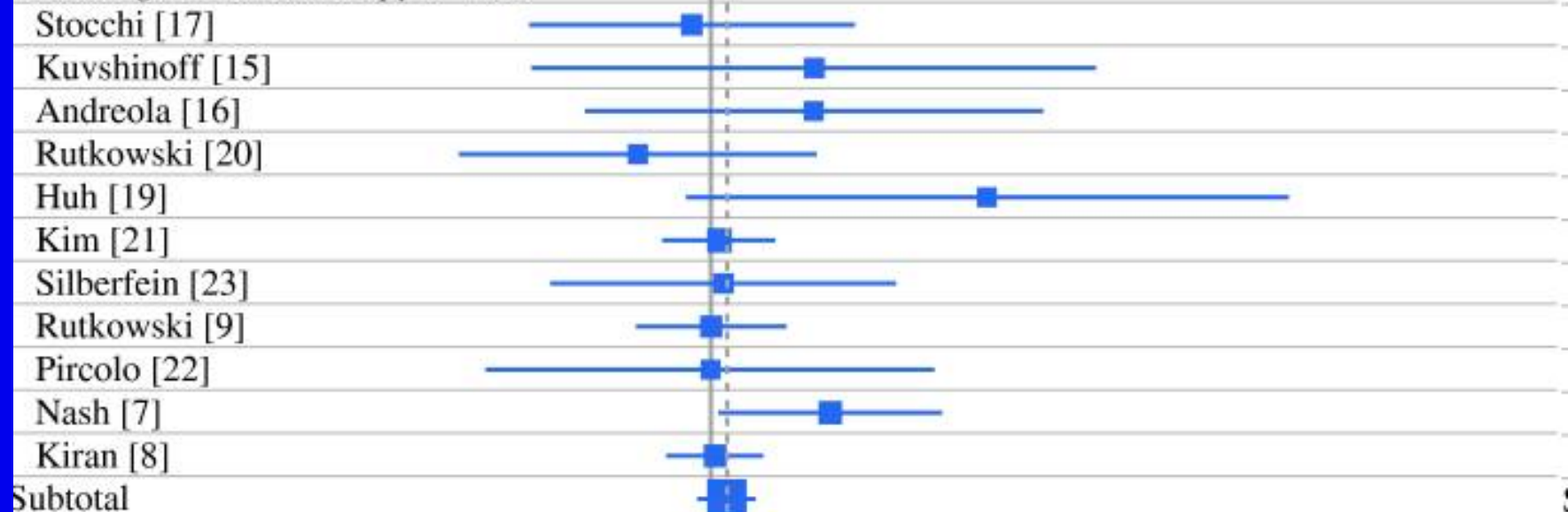
More recurrence in the  
> ~1cm margin group

More recurrence in the  
< ~1cm margin group

*Patients given radiotherapy < 10%*



*Patients given radiotherapy > 10%*

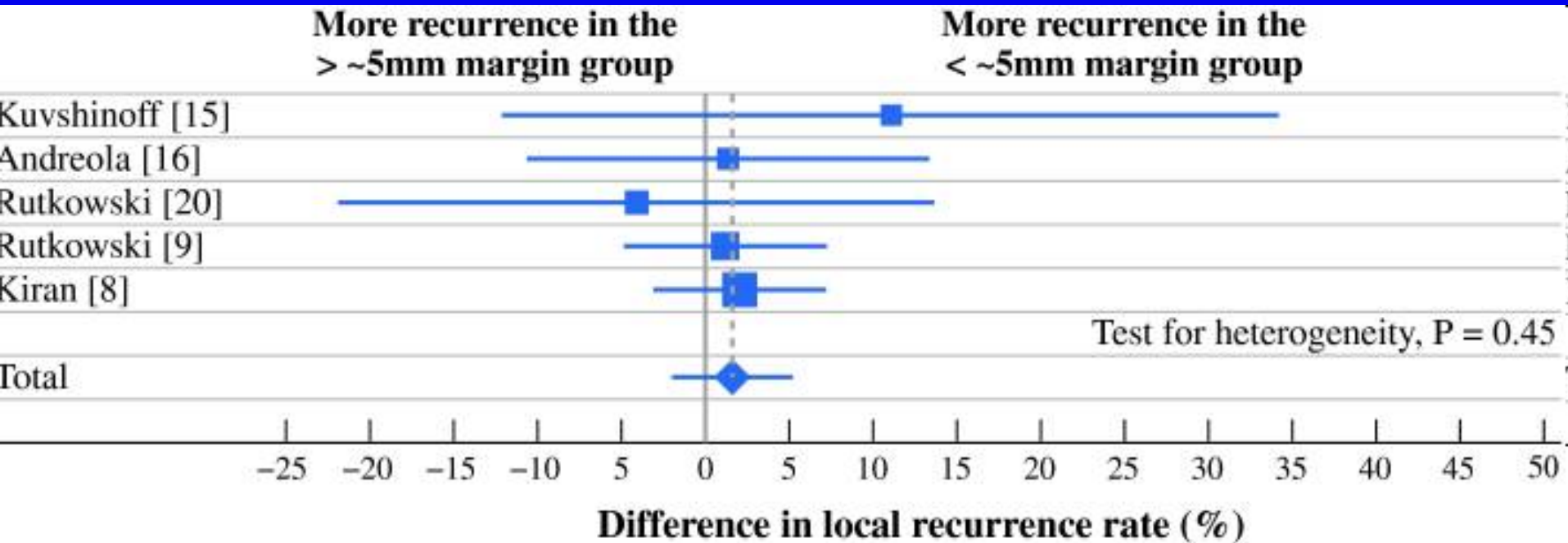


Test for heterogeneity, P = 0.35

Total

Difference in local recurrence rate (%)





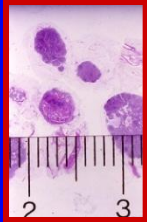
## Correlazione tra recidiva locale e altri fattori prognostici anatomopatologici

<b>Stato linfonodale</b>	<b>P: 0.002</b>
<b>Insemenzamento laterale</b>	<b>P: 0.76</b>
<b>Invasione linfatici</b>	<b>p: 0.347</b>
<b>Invasione vascolare</b>	<b>p: 0.197</b>
<b>Invasione perineuronale</b>	<b>p: 0.22</b>

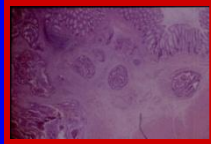
# Correlazione tra sopravvivenza globale e fattori prognostici anatomopatologici

<b>Infiltrato linfocitario</b>	<b>p: 0.0001</b>
<b>Stato linfonodale</b>	<b>p: 0.0028</b>
<b>Insemenzamento laterale</b>	<b>p: 0.0067</b>
<b>Invasione linfatica</b>	<b>p: 0.058</b>
<b>Invasione vascolare</b>	<b>p: 0.352</b>
<b>Invasione perineuronale</b>	<b>p: 0.0003</b>

# PRINCIPALI FATTORI PROGNOSTICI IDENTIFICATI



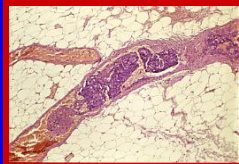
**Numero e dimensione dei linfonodi metastatici**



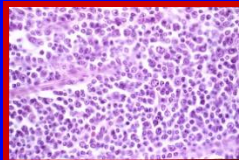
**Diffusione distale intramurale**



**Margine di resezione distale**



**Emboli neoplastici venosi**

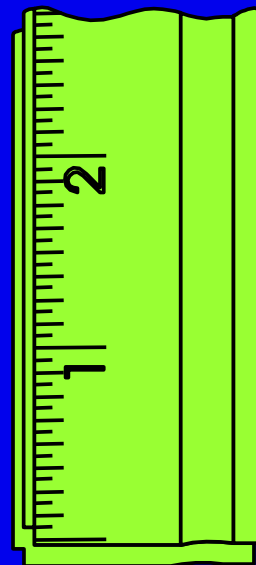


**Infiltrato infiammatorio**

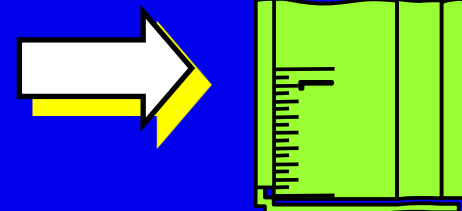
# ORIENTAMENTI ATTUALI SUL MARGINE DI RESEZIONE DISTALE



IL PASSATO



IL PRESENTE



## CONCLUSIONS:

“...Our findings support the practice of sphincter preservation in selected settings of close distal margins (<1 cm).... Our review could not find a statistically significant difference in either local control or survival with margins of <1 cm. ... margins as close as  $\leq 5$  mm—indeed negative—may be acceptable... the importance of patient and tumor selection for this approach must be emphasized.

**The precise rules for this selection have not been defined.** Therefore, further study is needed to identify the criteria for selecting patients....

**Risparmio sfinteriale**

**Strategia adiuvante o neoadiuvante**

**Esame istologico**

**Mesoretto**

**Pouch**

**Ottimale della chirurgia oncologica rettale**

**Tecnologia**

**Q<sub>of</sub>L**

**Linfoadenectomia**

**Nerve sparing**

**Risultato funzionale e riabilitazione**

**Esperienza chirurgica**

**IL CANCRO SI PUO'  
CURARE E DEBELLARE CON  
LA CULTURA E CON LA  
CONOSCENZA, NON CON I  
PEZZI DI FERRO**