COLORECTAL CANCER LIST SERV
SCENARIO 5:
ASSESSING THE QUALITY OF SURGERY AND PATHOLOGY OF RECTAL CANCER

LEARNING OBJECTIVES
1. Discuss the adequacy of total mesorectal excision (TME) surgery – including distal margins, and radial margins and nodes.
2. Discuss adequacy of pathological assessment of TME specimen.

INVESTIGATIONS

Surgery
- Anterior resection performed incorporating the tattooed area

Pathology
- 8 cm segment of bowel removed
- no residual cancer-slight hyperplastic change overlying tattoo
- distal margin <1 cm from the inked area
- 0/4 lymph nodes (LN) involved

CASE PRESENTATION

52 year old female who had a screening colonoscopy
- 1 cm sessile polyp at the rectosigmoid
- Pathology showed villous adenoma with high grade dysplasia
  - one focus of invasive adenocarcinoma-1 mm from the cauterized margin
- Endoscopist rescoped the patient and identified an area of “scar tissue” at 15 cm which was injected with India ink

Surgery
- Anterior resection performed incorporating the tattooed area

Pathology
- 8 cm segment of bowel removed
- no residual cancer-slight hyperplastic change overlying tattoo
- distal margin <1 cm from the inked area
- 0/4 lymph nodes (LN) involved

QUESTIONS FOR DISCUSSION

1. Should the surgeon and patient be concerned that no cancer was identified?
2. Discuss the adequacy of the resection - should a total mesorectal excision have been performed?
3. Do you have concerns about the fact that only 4 lymph nodes were identified? What should be done?
4. How should the absence of tumor in 4 lymph nodes affect further management (clinical and pathological)?

GUIDELINE INFORMATION

“Optimization of Surgical and Pathological Quality Performance in Radical Surgery for Colon and Rectal Cancer: Margins and Lymph Nodes”
http://www.cancercare.on.ca/pdf/pebc17-4s.pdf

For key evidence, see page 5 of the Evidentiary Base (Section 2) of the guideline.

FOLLOW-UP

MANAGEMENT
- Follow-up colonoscopy 1 year later revealed stenosis at the anastomosis
- Biopsy showed adenocarcinoma
- CT scan showed some thickening at the anastomosis

QUESTIONS FOR DISCUSSION

1. How would you manage the recurrence?
2. Should the patient receive radiation? And if so, pre-operatively or post-operatively?
KEY LEARNING POINTS

Pre-operative
1. Case should have been reviewed at multidisciplinary tumour board prior to offering surgery.
2. It is important to balance the risk of lymph node involvement and the likelihood that the polyp has been removed completely, against the risks of an operation, in making a decision about whether to recommend an operative or non-operative approach. Patients should be then be given this information in order to make an informed decision regarding surgery.
3. Patients with malignant sessile polyps should generally be treated with resection regardless of other adverse factors (ie. poor differentiation, lymphovascular invasion) because by definition they are a Haggitt 4, and therefore the risk of LN involvement is higher.
4. Irrespective of whether the patient is treated operatively or non-operatively, routine surveillance with colonoscopy should be performed.

Post-resection
5. A very low LN count ought to prompt a collegial discussion between surgeon and pathologist to discuss reasons why.
6. Patients should have an adequate resection margin and an adequate mesorectal excision; otherwise, an inadequate surgical procedure may be an antecedent contributor to recurrence.
7. After the recurrence was noted, most agreed to proceed with neo-adjuvant treatment, likely both radiation and chemotherapy, followed by surgery, which might be difficult.

Other key discussion points
8. Malignant polyp cases are challenging in regards to decision-making, and often benefit from direct communication between specialists in the context of multidisciplinary cancer conferences.
9. Not many pathologists on the List Serv routinely report Haggitt levels (as they are not part of the College of American Pathologists’ (CAP) checklist and may only be applied confidently in a small number of cases).
10. Synoptic reporting of malignant polyps would help clarify and standardize discussion, and should possibly include: Haggitt level (depth of invasion), differentiation, angiolymphatic invasion, size of malignant focus, and distance from margin.
11. Pathologists are often challenged by orientation and specimen fragmentation in assessing features of malignant polyps, and it maybe impossible for a pathologist to assess margin and Haggitt level if the polyp was submitted piecemeal.