Liver resection

Liver resection

Single or multiple well-localised liver metastases can now be resected with relatively low mortality and morbidity . Provided the patients are carefully selected, a reasonable long-term survival rate can be achieved (approximately 40%). Such surgery is usually carried out in a specialised liver unit and may be performed synchronously at the time of anterior resection or as a delayed procedure (see Chapter 69). Radiotherapy Radiotherapy is now commonly used and may be given preop eratively (neoadjuvant) and less commonly postoperatively (adjuvant). In the neoadjuvant setting, radiotherapy is used to either ‘sterilise’ the operative field in cancers with suspected lymphovascular involvement, or to downstage locally advanced cancers with threatened circumferential resection margins. In the former instance, radiotherapy is often given as a ‘short course’ over 5 days with immediate surgery some 7–10 days later. On occasion, short-course radiotherapy can be combined with a delay before surgery (up to 12 weeks) to allow cancer regression. When radiotherapy is used to downstage a cancer, it is often combined with chemotherapy (chemoradiotherapy) and given over a period of 6 weeks with a 6-week recovery period befor surgery . Some 20% of cancers treated with chemoradiotherapy will show a complete pathological response, with a further 25–30% showing a partial response. Unfortunately , it is not yet possible to determine prior to treatment which patients will respond and therefore to tailor treatment accordingly . Occasionally , radiotherapy is used to palliate unresectable cancers that are causing symptoms due to pain, obstruction or bleeding. Jean Papillon , d. 1993, radiation oncologist, Centre Léon Bérard, Lyon, France. technique, in which intraca vity radiation is directed to the cancer in the form of ‘contact radiotherap y’ or else delivered by brachytherapy techniques. To date, the application of these techniques has been restricted to selected cases, usually in patients unfit for more radical surgery . Chemotherapy Chemotherapy is given either in combination with radio - therapy (chemoradiotherapy) to downstage a cancer prior to surgical resection or else in the postoperative setting to reduce the risk of disseminated disease. 5-Fluorouracil (5-FU)-based regimens remain the first-line therapy and are associated with a 10% improvement in disease-free survival in patients with node-positive rectal cancer. Second-line therapies include oxaliplatin and irinotecan, and biological agents such as cetuximab (see Chapter 12). Results of surgery for rectal cancer In specialised centres, the resectability rate for rectal cancer may be as high as 95%, with an operative mortality of less than 5%. Overall, the 5-year survival rate is about 50% and has not changed appreciably over the last decade. Survival rates are influenced by TNM/Dukes’ stage, with node-positive patients doing worse than those with node-negative lesions. However, with the introduction of national bowel cancer screening programmes, there is a shift to an earlier stage of disease presentation and consequently improved survival. Local recurrence Local recurrence after rectal excision represents a complex problem. The patient may be asymptomatic with recurrence diagnosed as part of a surveillance programme, including regular measurements of blood carcinoembryonic antigen - and cross-sectional radiological imaging. The presence of symptoms is often a poor prognostic feature. Persistent pelvic pain, which may radiate down the legs, is indicative of nerve root involvement. Bladder symptoms may

occur or there may be fistulating disease onto the perineum. Most local recurrences are situated extrarectally and are therefore not readily diagnosed on endoscopy examination and biopsy . CT and MRI scan are the best means for detecting local recurrence, but PET-CT is increasingly being used to di ff erentiate metabolically active cancer recurrence from metabolically inactive scar tissue. Local recurrence rates vary between 2% and 25% and are higher after abdominoperineal excision than after sphincter-saving resection. High-quality primary surgery with preservation of e the mesorectal ‘package’ and a clear circumferential resection margin are the most important factors in preventing local recurrence. Overall, 80% of local recurrences develop within 2 years following surgery , are very di ffi cult to treat and should be referred to a centre specialising in exenterative surgery . If the patient is radiotherapy naive then preoperative chemoradio - therapy may be of help. Surgical exenteration o ff ers the only hope of cure.

Figure 79.27 Radical pelvic exenteration, indicating the extent of the dissection and the viscera removed (shaded dark pink). (Redrawn with permission from Keighley MRB, Williams NS. Surgery of the anus, rectum and colon . London: WB Saunders, 1999.)

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