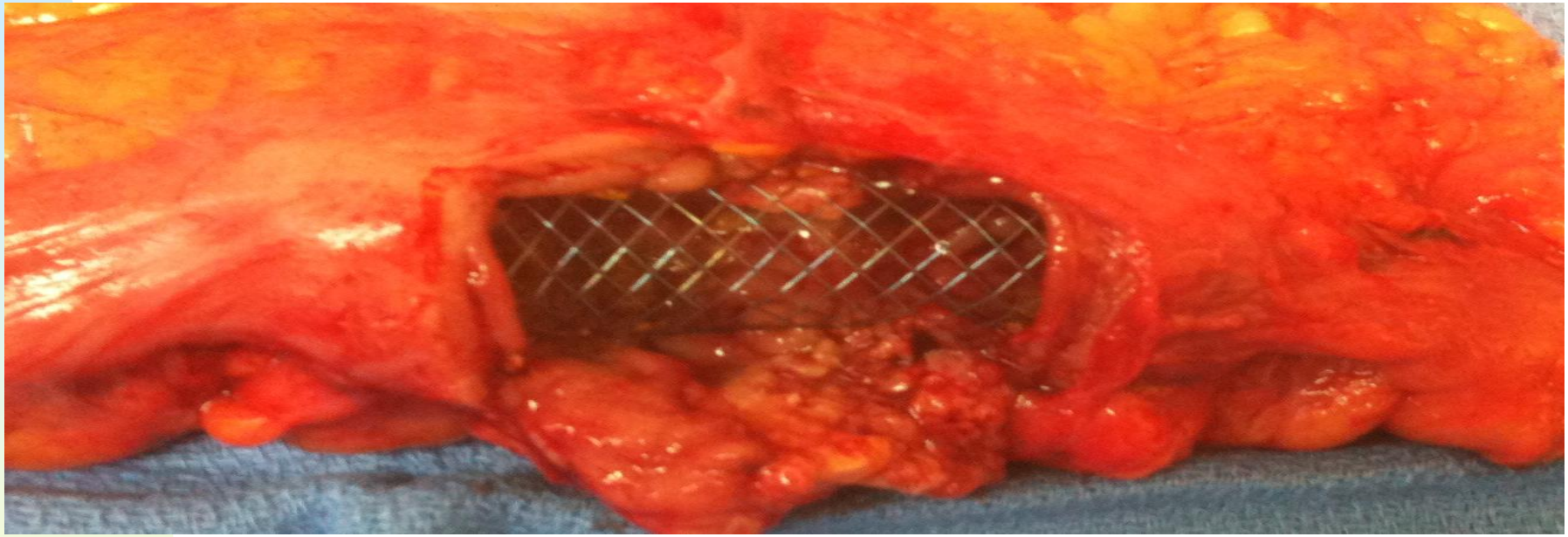
Prise en charge de l'occlusion colique tumorale



Dr F. BROWET

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Association Picarde de Cancérologie Digestive
Novembre 2012

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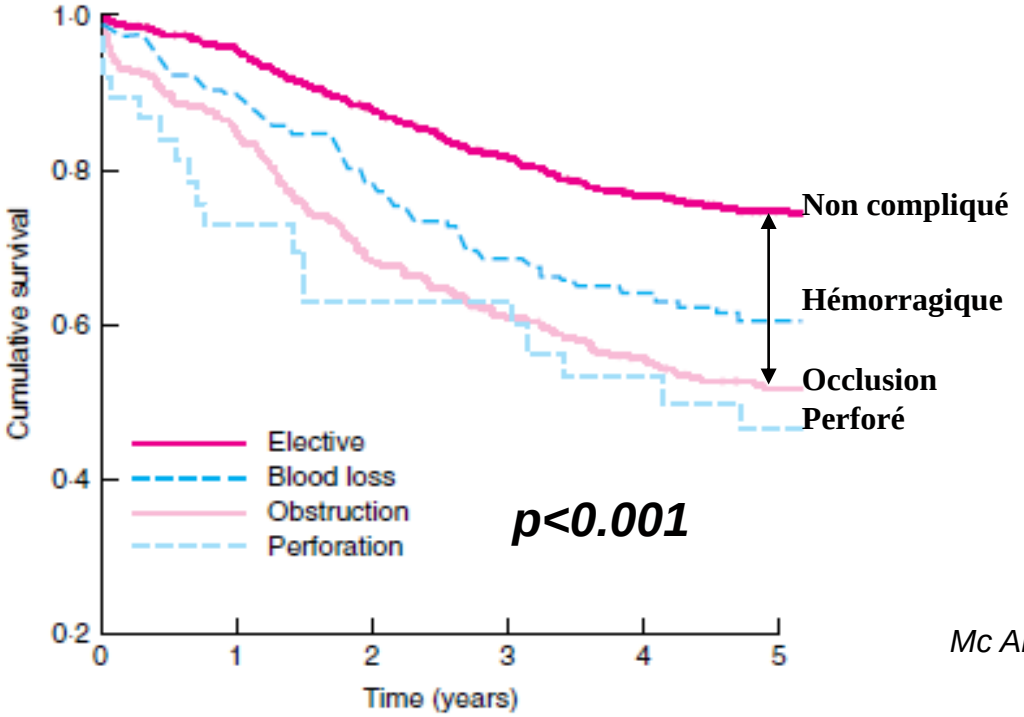
Introduction

- **Cancer du colon en occlusion (CCO)**

  ✓ **Fréquent** (15% des CCR, 5000 cas/an)

  ✓ **Pronostic « moins bon »** (mortalité postopératoire, survie globale et spécifique)

Champault et al, J Chir 1983



Mc Ardle et al, Brit J Surg 2006

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Introduction

- **Prise en charge complexe**

  - Urgence: la nuit, centre de proximité
  - Carcinologique (T4, N+, M+)
  - Patient: mortalité postopératoire (âge, ASA, dénutrition, comorbidité…)
  - Chirurgien/endoscopiste: expertise

Mac Ardle et al, Brit J Surg 2006

De **es**

2007

2009
2007

Décider seul d'un geste en urgence qui doit s'intégrer dans une stratégie multimodale

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Perforation du caecum?

- **Urgence diagnostic et thérapeutique**
  - ✓ Perforation diastatique du caecum (mortalité postopératoire 30%)

Faivre et al, DCR 2009

REVIEW Open Access

Guidelenines in the management of obstructing cancer of the left colon: consensus conference of the world society of emergency surgery (WSES) and peritoneum and surgery (PnS) society

WJES WORLD JOURNAL OF EMERGENCY SURGERY

2010

Conclusions: Loop colostomy and staged procedure should be adopted in case of dramatic scenario, when neoadjuvant therapy could be expected. Hartmann's procedure should be performed in case of high risk of anastomotic dehiscence. Subtotal and total colectomy should be attempted when cecal perforation or in case of

Ansaloni et al, World J Emerg Surg 2010
Faivre et al, Gastroenterol Clin Biol 1998

Malade en mauvais état général

Evaluation chirurgien/anesthésiste/endoscopiste/réanimateur

- **Scores prédictifs de mortalité postopératoire**
  - ✓ Score Tekkis (âge, ASA, délai) *Tekkis et al, Ann Surg 2004*
  - ✓ Score Ceriati (IRC, ATCD cardio, Albu, perforation) *Ceriati et al, Hepatogastroenterology 2002*
- **Quels geste en urgence?**

	Stent	Colostomie	Hartmann
Mortalité	5%	14%	13%
Morbidité	20%	53%	66%

Le stent est supérieur à la chirurgie
(pas de différence entre stomie et hartmann)

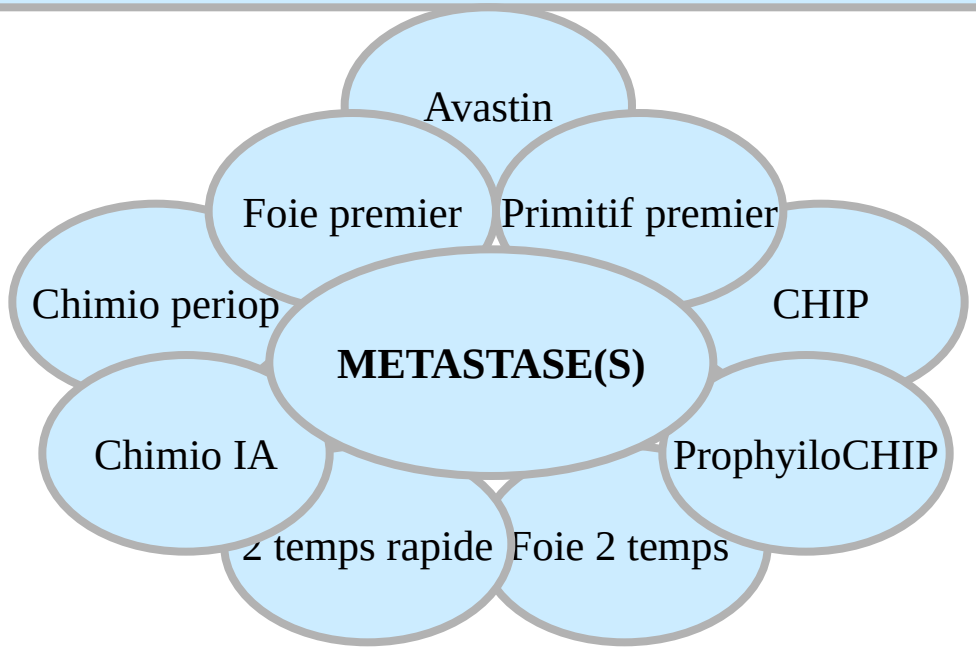
Kromborg et al, Int J Colorectal Dis 1995
Zhang et al, Surg endosc 2011

Résécabilité des métastases?

Résécables | **Potentiellement résécables** | **Jamais résécables**

Limites floues entre curatif et palliatif

Folprecht et al, Lancet Oncol 2010



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Résécabilité du primitif?

Evaluation scannographique

Résection R0

Décider d'un geste en urgence qui doit s'intégrer dans une stratégie multimodale

Uretère
Vessie
Vx iliaques

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Primitif résécable, traitement curatif

REVIEW Open Access

Guidelenines in the management of obstructing cancer of the left colon: consensus conference of the world society of emergency surgery (WSES) and peritoneum and surgery (PnS) society

WJES WORLD JOURNAL OF EMERGENCY SURGERY

2010

Résection segmentaire/anastomose ou stent

Ansaloni et al, World J Emerg Surg 2010

Conférence de consensus française

Colostomie de proche amont

Faivre et al, Gastroenterol Clin Biol 1998

Chirurgie *vs.* Stent

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Primitif résécable, traitement curatif

Self-expanding metallic stent as a bridge to surgery versus emergency surgery for obstructive colorectal cancer: a meta-analysis

Yi Zhang · Jian Shi · Bin Shi · Chun-Yan Song · Wei-Fen Xie · Yue-Xiang Chen

Faisabilité

Taux d'hémorragie 2%
Taux de perforation 6% (Amiens 4,2%)

Efficacité

2. Taux de stomie définitive

Qualité de vie: pas de différence

Van Hooft et al, Lancet Oncol 2011

Le stent c'est faisable et bénéfique à cout terme…

mais au sein d'une équipes experte.

Evaluation médico-économiques: stent

Sagar et al, Cochrane Database Syst Rev 2011
Tan et al, Brit J Surg 2012
Watt et al, Ann Surg 2007
Breitenstein et al Brit J surg 2007
Sebastian et al, Am J Gastroenterol 2004
Khot et al , Brit J Surg 2002

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Govindarajan et al, Dis Colon Rectum 2007
Xinopoulos et al, Surg endosc 2004

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Primitif résécable, traitement curatif

Le stent à long terme...

Original article

Tumour cell dissemination following endoscopic stent insertion

K. Maruthachalam[1,2], G. E. Lash[2], B. K. Shenton[2] and A. F. Horgan[1]

Results: Circulating CK20 mRNA was detected in 13 of 38 patients who had a colonoscopy and eight of 20 patients with stent insertion. CK20 mRNA expression was increased following stent insertion ($P = 0{\cdot}007$) but not after staging colonoscopy ($P = 0{\cdot}454$). CEA mRNA was detected in one patient who had colonoscopy and two who had a stent inserted. Neither CEA nor CK20 mRNA was found in blood samples from controls.

Conclusion: Endoscopic insertion of colonic stents but not staging colonoscopy results in increased levels of CK20 mRNA in the peripheral circulation.

CK_{20} mRNA non lié au pronostic

Wong et al, Clin Cancer Res 2009

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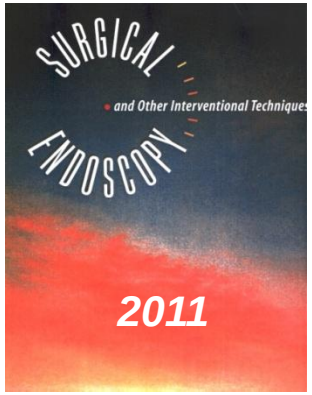
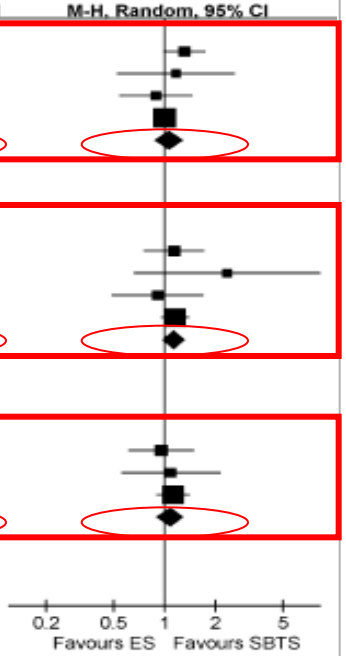
Primitif résécable, traitement curatif

Self-expanding metallic stent as a bridge to surgery versus emergency surgery for obstructive colorectal cancer: a meta-analysis

Yi Zhang · Jian Shi · Bin Shi · Chun-Yan Song · Wei-Fen Xie · Yue-Xiang Chen



Study or Subgroup	SBTS Events	SBTS Total	ES Events	ES Total	Weight	Risk Ratio M-H, Random, 95% CI
1-Year Survival						
Saida 2003	36	44	25	40	13.27%	1.31 [0.99, 1.73]
Pessione 2007	6	9	4	7	1.82%	1.17 [0.53, 2.57]
Dastur 2008	11	19	15	23	4.70%	0.89 [0.55, 1.44]
Xu 2010	59	62	177	186	80.21%	1.00 [0.94, 1.07]
Subtotal (95% CI)	**112**	**134**	**221**	**256**	**100.00%**	**1.07 [0.87, 1.31]**
Test for heterogeneity: Chi² = 5.50, df = 3 (P = 0.14), I² = 45.5%						
Test for overall effect: Z = 0.65 (P = 0.51)						
2-Year Survival						
Saida 2003	25	44	20	40	18.00%	1.14 [0.76, 1.70]
Pessione 2007	6	9	2	7	1.95%	2.33 [0.66, 8.22]
Dastur 2008	9	19	12	23	8.01%	0.91 [0.49, 1.68]
Xu 2010	46	62	120	186	72.04%	1.15 [0.96, 1.38]
Subtotal (95% CI)	**86**	**134**	**154**	**256**	**100.00%**	**1.14 [0.98, 1.34]**
Test for heterogeneity: Chi² = 1.78, df = 3 (P = 0.62), I² = 0%						
Test for overall effect: Z = 1.65 (P = 0.10)						
3-Year Survival						
Saida 2003	21	44	20	40	19.85%	0.95 [0.62, 1.48]
Dastur 2008	9	19	10	23	8.87%	1.09 [0.56, 2.12]
Xu 2010	41	62	110	186	71.28%	1.12 [0.90, 1.39]
Subtotal (95% CI)	**71**	**125**	**140**	**249**	**100.00%**	**1.08 [0.90, 1.31]**
Test for heterogeneity: Chi² = 0.41, df = 2 (P = 0.81), I² = 0%						
Test for overall effect: Z = 0.86 (P = 0.39)						



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Primitif résécable, traitement curatif

✓De Janvier 19

✓ADK du colon

✓Etude bi centr

✓En intention d

ée au cancer

récidive

✓Li

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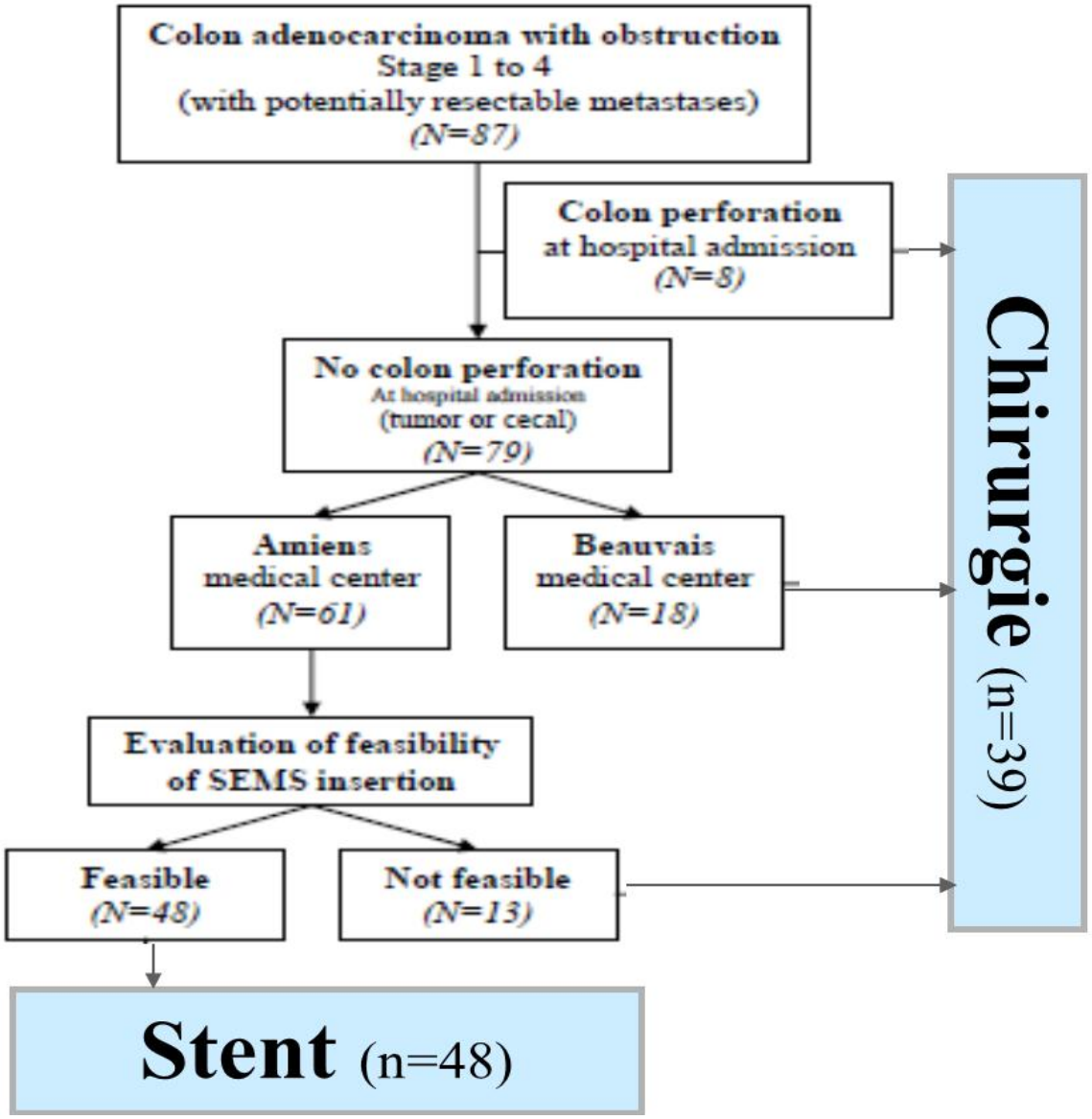
✓Me

g et al, Biometrika 1983

lyse de survie

i variée



Frazer et al, N Engl
Farzadfar et al, La
Landrum et al, J Clin

al, Cancer 2012
al, JAMA 2012
e et al, JAMA 2012

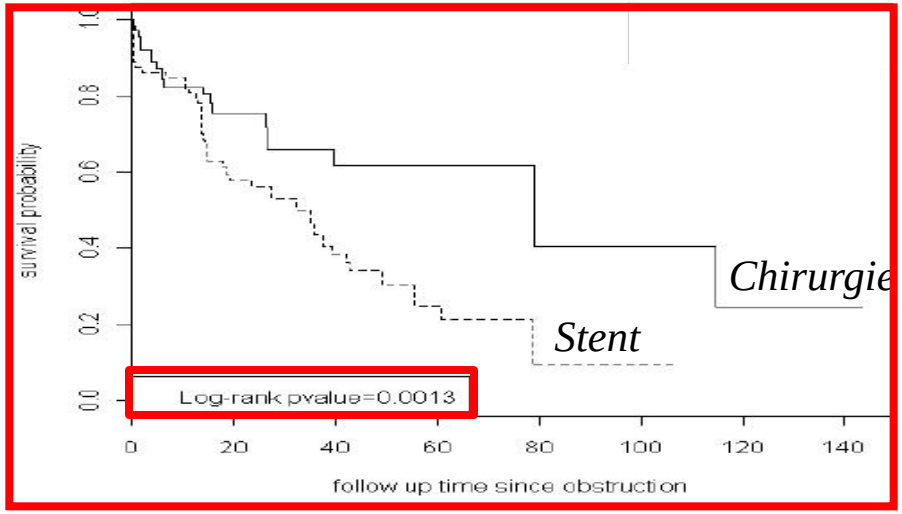
Primitif résécable, traitement curatif

Résultats +/- métastases, +/- perforation

PS (âge, score AFC, perforation caecale, Stades III/IV)

Data for overall population		SEMS group (intention to treat with SEMS) (N=48)	Surgery group (N=39)	*p*
Overall survival (%) (Propensity score analysis)	At 1 year	82 ± 4	67 ± 5	0.02*
	At 3 years	44 ± 6	55 ± 6	0.19
	At 5 years	25 ± 6	62 ± 7	0.0003*
Cancer-specific mortality (%)	At 1 year	6 ± 4	0	0.13
	At 3 years	35 ± 7	15 ± 7	0.43
	At 5 years	48 ± 8	21 ± 9	0.02*
Disease-free survival (%)	At 1 year	67 ± 5	66 ± 6	0.90
	At 3 years	40 ± 5	49 ± 6	0.25
	At 5 years	22 ± 5	32 ± 7	0.24
Recurrence rate (%)		33	20	0.18
Mean time to recurrence (months)		15.5 ± 12.2	26.2 ± 17.5	0.92
Site of recurrence	liver	6 (54)	4 (50)	0.18
	lung	3 (27)	2 (25)	0.82
	peritoneum	2 (18)	3 (37)	0.66
	other	3 (27)	2 (25)	0.83
Chemotherapy access rate after recurrence (%)		56	37	0.66
Mean follow-up period (months)		27.5 ± 20.25	32.44 ± 38.72	0.21

Sabbagh et al, Ann Surg (sous presse)



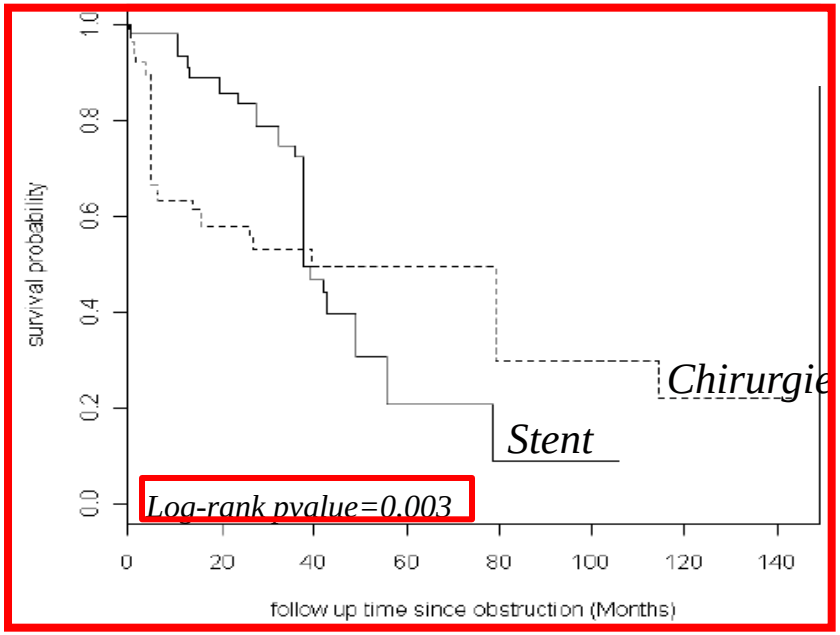
Variables		Univariate analysis HR (95%CI)	Univariate analysis *p* value	Multivariate analysis HR (95%CI)	Multivariate analysis *p* value
Stent (yes/no)		1.44 [0.78 – 2.66]	0.24	2.422 [1.13 – 5.18]	0.02*
PS		Not applicable		0.317 [0.09 – 1.10]	0.07
Age		1.03 [1.01 – 1.05]	0.009*	Not tested because included in the PS	
Gender		0.88 [0.48 – 1.50]	0.56	Not tested	
ASA score [37]		1.63 [1.08 – 2.45]	0.02*	1.877 [1.26 – 2.79]	0.002*
Predictive postoperative mortality AFC-score [32]		1.54 [1.10 – 2.15]	0.01*	Not tested because included in the PS	
Colon perforation (yes/no)	tumor	4.17 [1.23 – 14.09]	0.02*	5.964 [1.70 – 20.95]	0.005*
	cecum	2.95 [1.04 – 8.36]	0.04*	Not tested because included in the PS	
Synchronous metastasis (yes/no)		2.23 [1.21 – 4.11]	0.01*	Not tested because included in the PS	

Primitif résécable, traitement curatif

Résultats sans métastase et sans perforation

PS (âge, score AFC, perforation caecale, Stades III/IV)

Data for patients with no perforations or metastases at diagnosis		SEMS group (intention to treat with SEMS) (N=29)	Surgery group (N=28)	p
Overall survival (%) (analysis with propensity score)	At 1 year	81 ± 5	88 ± 5	0.32
	At 3 years	51 ± 7	74 ± 7	0.02*
	At 5 years	30 ± 7	67 ± 8	0.001*
Cancer-specific mortality (%)	At 1 year	0	0	NA
	At 3 years	23 ± 9	15 ± 8	0.51
	At 5 years	29 ± 10	22 ± 10	0.62
Disease-free survival (%)	At 1 year	73 ± 6	85 ± 5	0.12
	At 3 years	49 ± 7	64 ± 7	0.13
	At 5 years	27 ± 7	43 ± 9	0.16
Recurrence rate (%)		34	28	0.78
Mean time to recurrence (months)		19.9 ± 13.6	26.2 ± 17.5	0.63
Chemotherapy access rate after recurrence (%)		60	37	0.64
Mean follow-up period (months)		30.6 ± 22.8	37.9 ± 39.9	0.4



Sabbagh et al, Ann Surg (sous presse)

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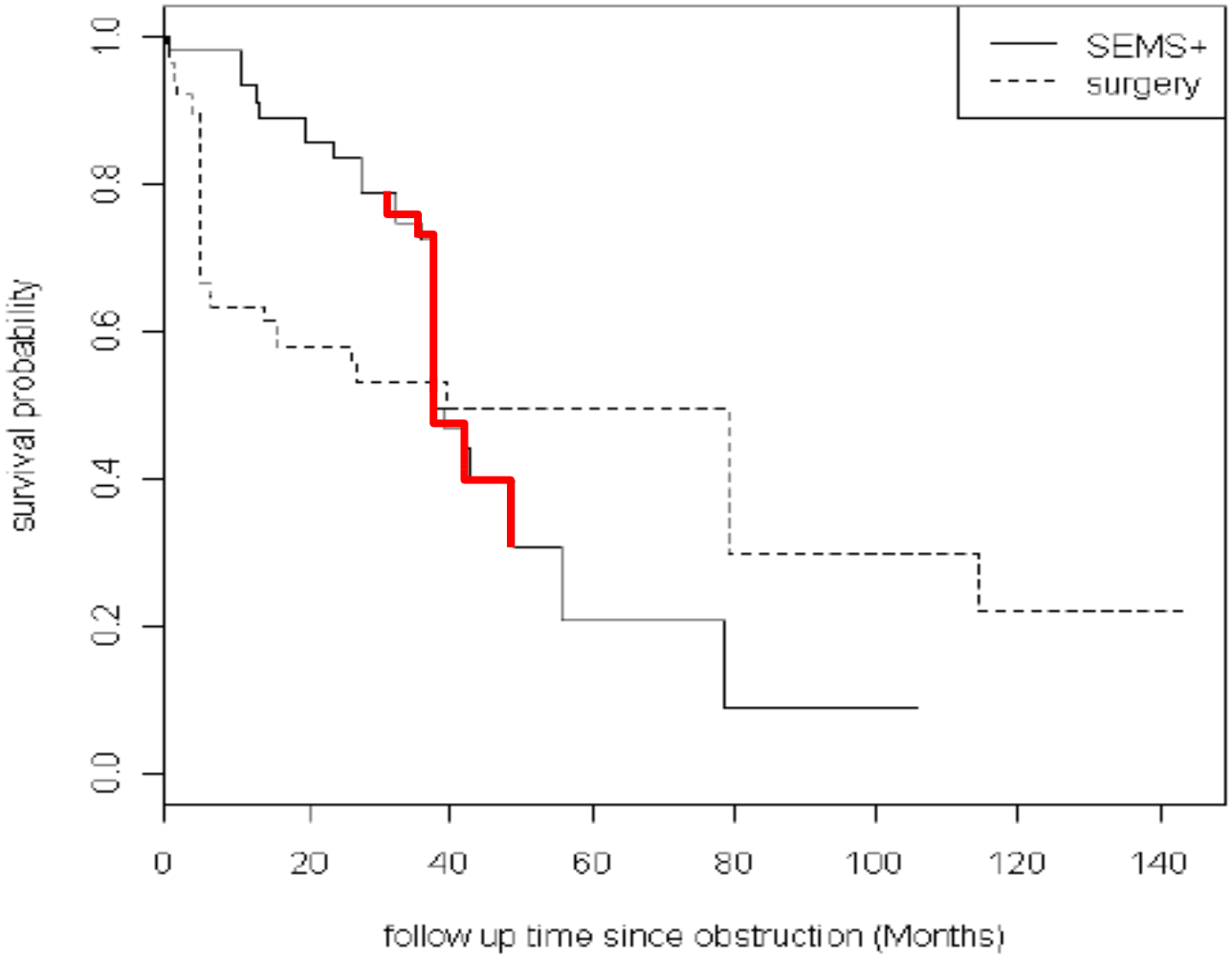
Primitif résécable, traitement curatif



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Primitif résécable, traitement curatif

Le stent modifie-t-il l'anatomopathologie?

Le stent à but curatif semble impacter le pronostic à long terme

✓Ulcérat
✓Ulcérat
✓Embole
✓Embole

Mortalité chirurgicale prévisible élevée
Survie prévisible inférieure à 3 ans

Chirurgie ↔ Stent

Sabbagh et al, Surg endosc (soumission)

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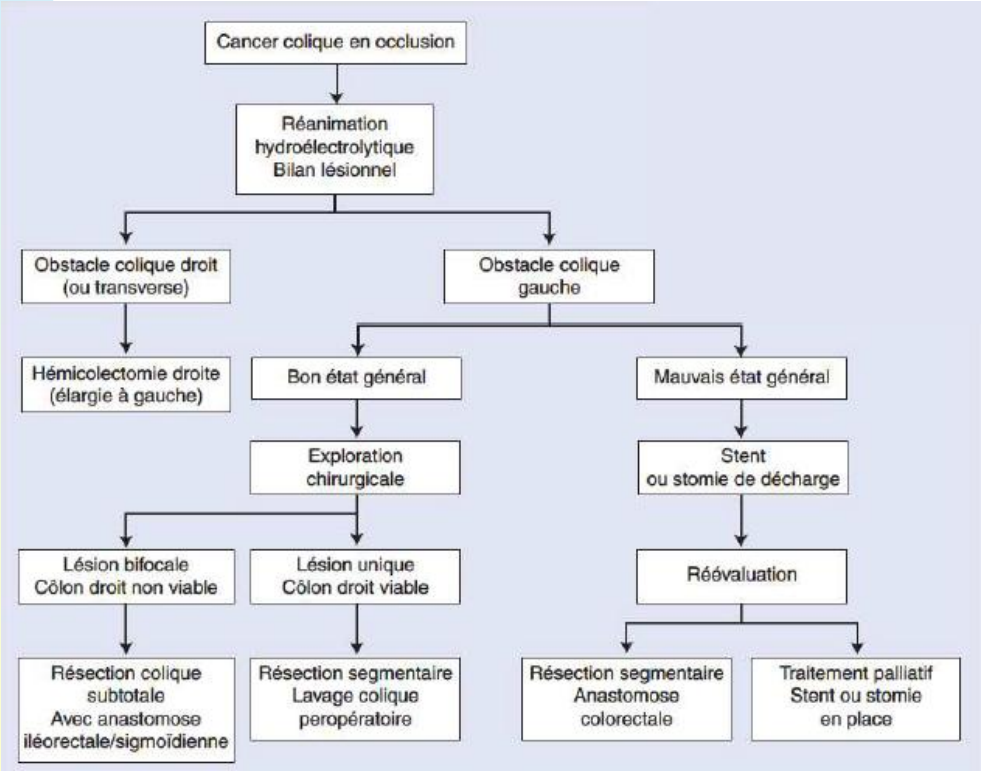
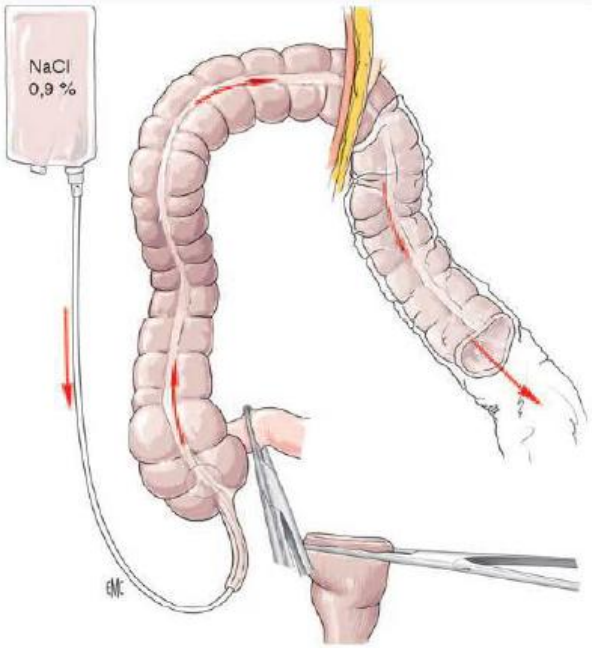
Primitif résécable, traitement curatif

Cancers du côlon en occlusion

D. Brachet, E. Lermite, S. Mucci-Hennekinne, J.-P. Arnaud

ELSEVIER MASSON
EM|consulte
L'accès à tous les contenus Elsevier Masson





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Primitif résécable, traitement curatif

Anastomose

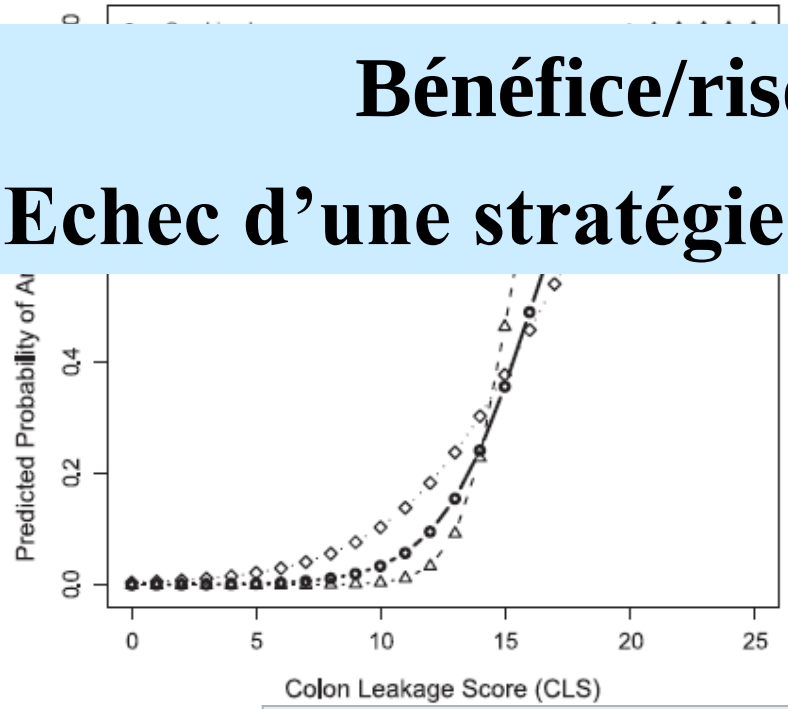
Predicting the Risk of Anastomotic Leakage in Left-sided Colorectal Surgery Using a Colon Leakage Score

Jan Willem T. Dekker, M.D.,*,[1] Gerrit Jan Liefers, M.D., Ph.D.,* Johan CA de Mol van Otterloo, M.D., Ph.D.,† Hein Putter, Ph.D.,‡ and Rob A. E. M. Tollenaar, M.D., Ph.D.*

*Department of Surgery, L… aglanden, The Netherland…

Bénéfice/risque

Echec d'une stratégie multimodale



Colon Leakage Score (CLS) Points Per Variable Between Brackets References are Shown for Each Variable

	Score
Age (y) [2;29;57]	
<60	0
60–69	1
70–79	2
≥80	4
Gender [3;17;19;29;30;37;41;43;44;67;68]	
Female	0
Male	1
ASA [10;28;42;45;67]	
I	0
II	1
III	3
	6
	0
	1
mo)	3
	0
	1
	1
	4
No	0
Radiotherapy [15;17;28;35]	1
Chemoradiation [39;43;58;66]	2
Emergency surgery [2;11;13;21;34;45-47]	
No	0
Bleeding	2
Obstruction	3
Perforation	4
Distance of anastomosis to anal verge (cm) [9;15;17;19;20;22;24;26;28;29;31;32;37;39;41;47;48;54;57;64]	
>10	0
5–10	3
<5	6
Additional procedures	
No	0
Yes	1
Blood loss (cc) [28;37;41;57;68] blood transfusion [11;13;22;36;46;47]	
<500	0
500–1000	1
1001–2000	3
>2000	6
…uration of operation (h:min) [3;13;21;40;42;65]	
<2:00	0
2:00–2:59	1
3:00–3:59	2
≥4:00	4

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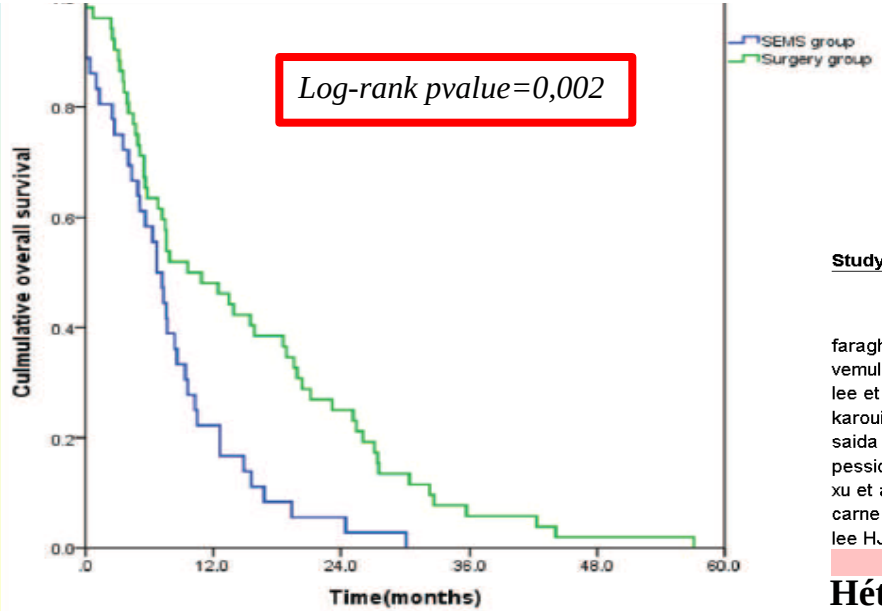
Primitif résécable, traitement palliatif

The outcome after stent placement or surgery as the initial treatment for obstructive primary tumor in patients with stage IVU colon cancer

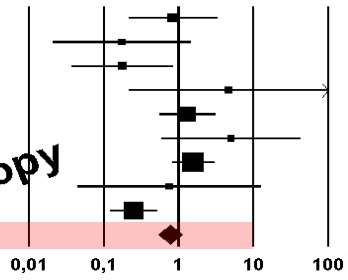
Won-Suk Lee, M.D., Ph.D.,[a] Jeong-Heum Baek, M.D., Ph.D.,[a,*] Jin Mo Kang, M.D.,[a] Sangtae Choi, M.D.,[a] Kwang An Kwon, M.D., Ph.D.[b]



Palliatif

Pas de conclusion

Study name	Odds ratio	Lower limit	Upper limit	Z-Value	p-Value
faragher et al, 2008	0,840	0,214	3,301	-0,250	0,803
vemulapalli et al, 2010	0,173	0,021	1,452	-1,616	0,106
lee et al, 2011	0,176	0,037	0,838	-2,182	0,029
karoui et al, 2007	4,661	0,214	101,466	0,979	0,327
saida et al, 2003	1,316	0,557	3,110	0,625	0,532
pessione et al, 2007	5,000	0,584	42,797	1,469	0,142
xu et al, 2010	1,581	0,831	3,009	1,396	0,163
carne et al, 2004	0,750	0,044	12,816	-0,199	0,842
lee HJ et al, 2011	0,251	0,121	0,524	[illegible]	0,000
	0,779	0,537	[illegible]	-1,314	0,189



Hétérogénéité (I^2)=67%

Evaluation Copy

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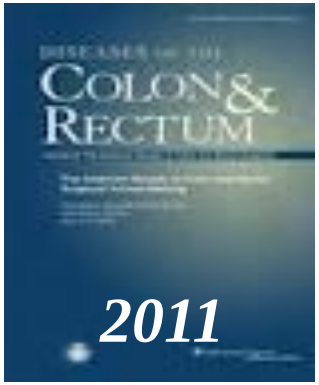
Primitif résécable, traitement palliatif

ORIGINAL CONTRIBUTION

Primary Colectomy in Patients With Stage IV Colon Cancer and Unresectable Distant Metastases Improves Overall Survival: Results of a Multicentric Study

Mehdi Karoui, M.D., Ph.D.[1] • Françoise Roudot-Thoraval, M.D.[2]
Farida Mesli, M.D.[1] • Emmanuel Mitry, M.D., Ph.D.[3]
Thomas Aparicio, M.D., Ph.D.[4] • Gaetan DesGuetz, M.D., Ph.D.[5]
Christophe Louvet, M.D., Ph.D.[6] • Bruno Landi, M.D., Ph.D.[7]
Emmanuel Tiret, M.D.[6] • Iradj Sobhani, M.D., Ph.D.[1]



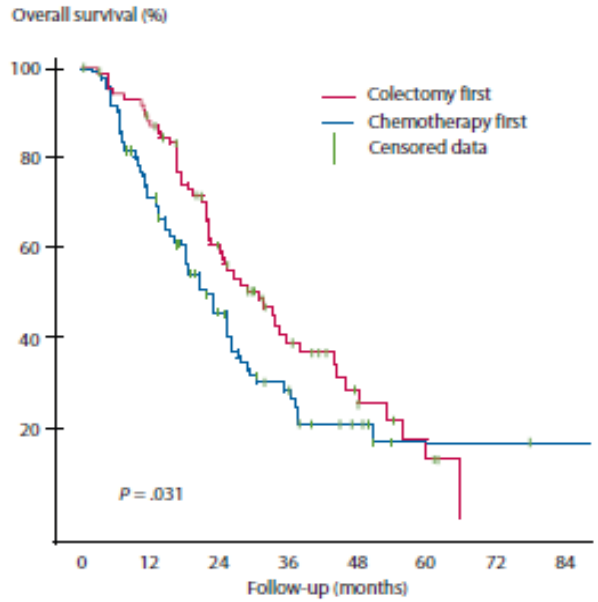


TABLE 3. Factors related to overall survival: univariate analysis

	Median (95% CI)	P
First-line management		
First-line colectomy (85)	30.7 (22.2–39.3)	.031
First-line chemotherapy (123)	21.9 (16.1–27.7)	
Secondary curative resection		<.001
Yes (53)	46.2 (33.3–59.0)	
No (155)	20.6 (17.6–23.6)	
Primary tumor differentiation		
Poor (16)	10.9 (0–22.4)	
Moderate (120)	25.7 (20.9–30.4)	<.001
Well (69)	30.8 (16.9–44.6)	
Metastasis location		
Liver-only (127)	27.1 (22.5–31.6)	
Nodes / peritoneum (37)	24.1 (15.0–33.2)	.027
Lung and others (44)	18.2 (14.5–21.9)	
Colonic stent insertion		.009
Yes (42)	18.3 (13.9–22.7)	
No (166)	25.7 (21.9–29.5)	
Addition of an anti-VEGF therapy		.001
Yes (45)	Not reached[a]	
No (163)	22.3 (19.7–24.9)	
Addition of an anti-EGFR therapy		.013
Yes (44)	34.4 (21.0–47.8)	
No (164)	22.3 (18.6–26.1)	

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Conclusions

Fréquent et grave

Prise en charge complexe (malade, maladie, urgence et expertise)

- ✓Perforation colique
- ✓Etat général du malade
- ✓Résécabilité métastases
- ✓Résécabilité primitif

Geste adapté en urgence/stratégie multimodale

Perforation
Colectomie subtotale sans anastomose

Mauvais état général		
Stomie	Hartmann	Stent

Primitif résécable/curatif	
Stomie	Résection/anastomose

Primitif résécable/palliatif		
Stomie	Résection/anastomose	Stent

Primitif non résécable/curatif
Stomie

Primitif non résécable/palliatif	
Stomie	Stent

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Merci de votre attention

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