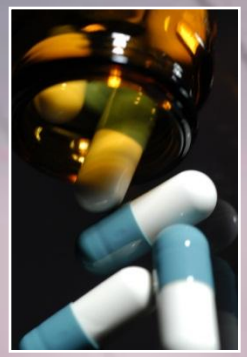


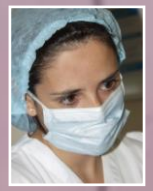
Situation difficile dans le cancer du côlon
La récidive ganglionnaire

F Dumont

Institut de cancérologie
GUSTAVE ROUSSY
VILLEJUIF - www.igr.fr

Les situations « difficiles »

Elles sont difficiles car le pronostic est médiocre, les diagnostics difficiles et les niveaux de preuve sont faibles


A. Récidive ganglionnaire abdominale isolée

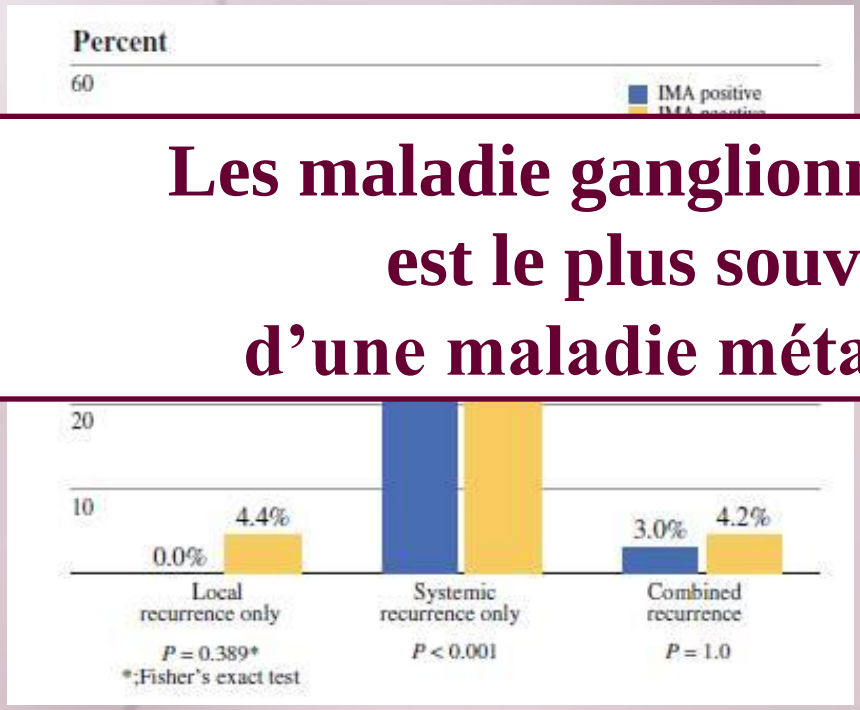
Traitement néo-adjuvant

Type de chirurgie

B. Récidive ganglionnaire abdominale associée à d'autres métastases viscérales

Généralités

- En cas de métastases à l'origine de l'artère mésentérique inférieur le risque de récidive systémique est de près de 50% contre 5% de récidive GG isolée[1]



- Les récidives ganglionnaires isolées représente moins de 7% de l'ensemble des récidives

Les maladie ganglionnaire métastatique est le plus souvent le reflet d'une maladie métastatique diffuse

Poumon	19.8
Péritoine	7.7
Locorégionale	6.6

1. *Kang J et al. Ann Surg Oncol 2011*
2. *Tsikitis VL et al., J Clin Oncol 2009*

Institut de cancérologie GUSTAVE ROUSSY
VILLEJUIF - www.igr.fr

Ann Nucl Med (2012) 26:551–558
DOI 10.1007/s12149-012-0609-0

ORIGINAL ARTICLE

The utility of FDG-PET/CT as an effective tool for detecting recurrent colorectal cancer regardless of serum CEA levels

Yasemin Sanli · Serkan Kuyumcu · Zeynep Gozde Ozkan · Leyla Kilic · Emre Balik · Cuneyt Turkmen · Duygu Has · Goknur Isik · Oktar Asoglu · Yersu Kapran · Isik Adalet

Table 3 Recurrence sites according to FDG-PET/CT results in Groups 1 and 2

	Group 1		Group 2		Chi-squared test	*p*
	Positive *n* (%)	Negative *n* (%)	Positive *n* (%)	Negative *n* (%)		
Local recurrence	35 (29.6)	83 (70.3)	48 (41.0)	69 (58.9)	3.321	0.068
Hepatic metastasis	26 (22.0)	92 (77.9)	44 (37.6)	73 (62.3)	6.812	0.009*
Extrahepatic metastasis	44 (37.2)	74 (62.7)	76 (64.9)	41 (35.0)	17.99	<0.001*
Lung metastasis	18 (15.2)	100 (84.7)	36 (30.7)	81 (69.2)	7.99	0.005*
Peritoneal implants	16 (13.5)	102 (86.4)	25 (21.3)	92 (78.6)	2.487	0.115
Abdominal lymph nodes	23 (19.4)	95 (80.5)	44 (37.6)	73 (62.3)	9.459	0.002*
Others (serebral, bone, adrenal)	3 (2.5)	115 (97.4)	8 (6.8)	109 (93.1)	2.43	0.119

* The numbers of patients with hepatic, lung and abdominal lymph node metastasis, detected with FDG-PET/CT were significantly lower in Group 1 than in Group 2

- La récidive ganglionnaire représente un tiers des récidives intra abdominale[2]
- Parmi les opérés la récidive ganglionnaire est isolé dans 50% des cas et associé à d'autres métastases dans 50% cas[3]

1. *Sanli Y et al., Ann Nucl Med 2012*
2. *Bowne WB et al., Dis Colon Rectum 2005*
3. *Dumont F et al., Eur J Surg Oncol 2012*

Pronostics

❖ Non opéré[1]

Pas de survie prolongé[1]

Médiane de survie 11-18 mois[2,7]

❖ Opéré[3,4]

Médiane de survie 33-49 mois

Médiane de survie sans récidive 17-21 mois

	Pathologie résécable	Résection R0	Intervalle primitif-récidive	Site de la récidive	Taille, Type ou nombre de GG
Dumont[4]	--	--	Non	--	GG
Shibata[5]	Oui	Oui	Oui	--	<5cm
Taylor[6]	--	Oui	--	--	--
Bowne[7]	Oui	Oui	Non	isolée	--
Min[2]	Oui	--	Non	Sous les Vx rénaux	--
Choi[8]	--	--	--	--	<2GG
Elias[9]	--	Oui	--	isolée	--

1. *Saltz LB. Oncology 2005*
2. *Min BS et al., J Surg Oncol 2008*
3. *Ho TW et al., Ann Surg Oncol 2012*
4. *Dumont F et al., Eur J Surg Oncol 2012*
5. *Shibata D et al., Dis Colon Rectum 2002*
6. *Taylor WE et al., Ann Surg Oncol 2002*
7. *Bowne WB et al., Dis Colon Rectum 2005*
8. *Choi PW et al., J Surg Oncol 2010*
9. *Elias et al., Hepatogatroenterology 2012*

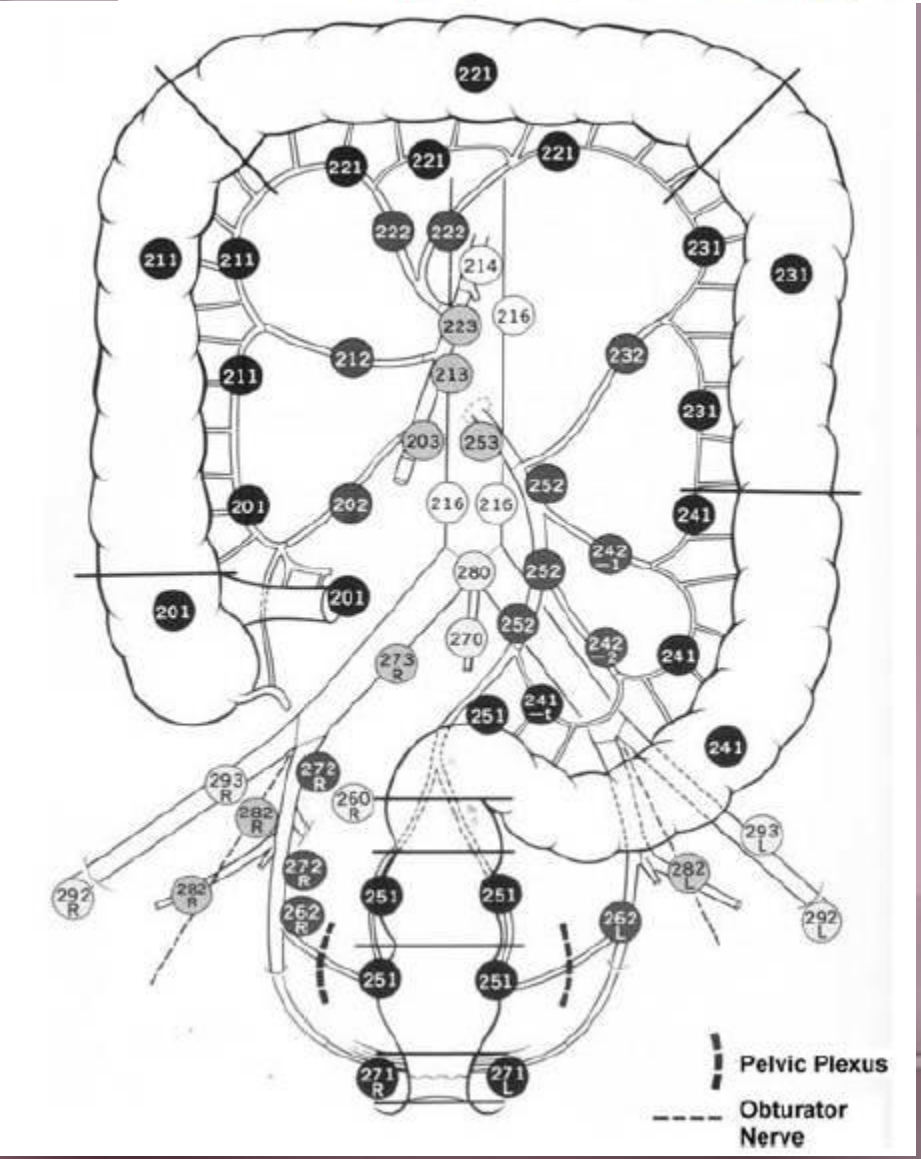
Récidives ganglionnaires abdominales isolées de cancer colique

Qui opérer?
Comment opérer ?(extension du curage, extension de la résection)

Institut de cancérolo
GUSTAVE ROUS
VILLEJUIF - www.ig

Oncologic Results of Laparoscopic D3 Lymphadenectomy for Male Sigmoid and Upper Rectal Cancer with Clinically Positive Lymph Nodes

Jin-Tung Liang, MD, PhD,[1] Kuo-Chin Huang, MD, PhD,[2] Hong-Shiee Lai, MD, PhD,[1] Po-Huang Lee, MD, PhD,[1] and Chia-Tung Sun, MD[3]



- N0 10%
- N1 44%
- N2 30%
- N3 14%

Qui opérer? Morbi-mortalité

The NEW ENGLAND JOURNAL of MEDICINE
ESTABLISHED IN 1812 JULY 31, 2008 VOL. 359 NO. 5

D2 Lymphadenectomy Alone or with Para-aortic Nodal Dissection for Gastric Cancer

Mitsuru Sasako, M.D., Takeshi Sano, M.D., Seiichiro Yamamoto, Ph.D., Yukinori Kurokawa, M.D., Atsushi Nashimoto, M.D., Akira Kurita, M.D., Masahiro Hiratsuka, M.D., Toshimasa Tsujinaka, M.D., Taira Kinoshita, M.D., Kuniyoshi Arai, M.D., Yoshitaka Yamamura, M.D., and Kunio Okajima, M.D., for the Japan Clinical Oncology Group

- Décès 0.8% vs 0.8%
- Morbidité majeure fistule anastomotique, abcès intrapéritonéale, pneumopathie NS.
- Morbidité mineure: Lymphorrée, iléus, diarrhée 20% vs 9.1% p<0.001

Les curages rétropéritonéaux ne sont pas source de morbidité majeure

Tab

No.			
Patients with complications (%)	5 (13)	15 (36)	<.02
No. of complications (%)	5	21	
Symptomatic lymphocysts or ascites (%)	3 (8)	11 (26)	<.05
Ureteral fistula	0	1	
Venous thrombosis	0	4	
Bowel obstruction	0	2	
Wound abscess or hematoma	1	3	
Wound dehiscence	1	0	
Asymptomatic lymphocysts (%)	19 (50)	15 (36)	NS
Pelvic lymphocysts	10 (26)	13 (31)	NS
Para-aortic with or without pelvic lymphocysts	9 (24)	2 (5)	<.05
Size of asymptomatic lymphocysts* (mm)	35 (15–90)	33 (15–60)	NS
Duration of hospital stay (d)*	9 (5–23)	11 (8–60)	<.03

NS = not significant.
* Data are the median (range).

Retroperitoneal Drainage After Complete Para-aortic Lymphadenectomy for Gynecologic Cancer: A Randomized Trial

PHILIPPE MORICE, MD, NATHALIE LASSAU, MD, PhD, PATRICIA PAUTIER, MD, CHRISTINE HAIE-MEDER, MD, CATHERINE LHOMME, MD, AND DAMIENNE CASTAIGNE, MD

Annals of Surgical Oncology **14**(7):1980–1990
DOI: 10.1245/s10434-007-9368-x

Oncologic Results of Laparoscopic D3 Lymphadenectomy for Male Sigmoid and Upper Rectal Cancer with Clinically Positive Lymph Nodes

Jin-Tung Liang, MD, PhD,[1] Kuo-Chin Huang, MD, PhD,[2] Hong-Shiee Lai, MD, PhD,[1] Po-Huang Lee, MD, PhD,[1] and Chia-Tung Sun, MD[3]

TABLE 5. *Genitourinary dysfunction after laparoscopic D3 dissection of rectosigmoid cancer*

Characteristic	Value
Foley removal (d) (mean ± SD)	21.4 ± 3.4
Voiding function after Foley removal	
Good	24/98 (24.5%)
Fair	68/98 (69.4%)
Poor	6/98 (6.1%)
Bladder dysfunction	
Transient	63/74 (85.2%)
Permanent	11/74 (14.8%)
Ejaculation	
Good	0/84 (0)[a]
Fair	7/84 (8.3%)
Poor	77/84 (91.7%)
Erection	
Good	44/84 (52.3%)
Fair	28/84 (33.4%)
Poor	12/84 (14.3%)

[a] The denominator is the number of patients accepting the evaluation of sexual function.

Qui opérer? Critères oncologiques

Operative Salvage for Locoregional Recurrent Colon Cancer After Curative Resection: An Analysis of 100 Cases

Wilbur B. Bowne, M.D.,[1] Byrne Lee, M.D.,[1] W. Douglas Wong, M.D.,[1] Leah Ben-Porat, M.S.,[2] Jinru Shia, M.D.,[3] Alfred M. Cohen, M.D.,[4] Warren E. Enker, M.D.,[5] Jose G. Guillem, M.D.,[1] Philip B. Paty, M.D.,[1] Martin R. Weiser, M.D.[1]

[1] *Department of Surgery, Memorial Sloan-Kettering Cancer Center, New York, New York*

Analysis of Factors Associated with Postsalvage Disease-Specific Survival

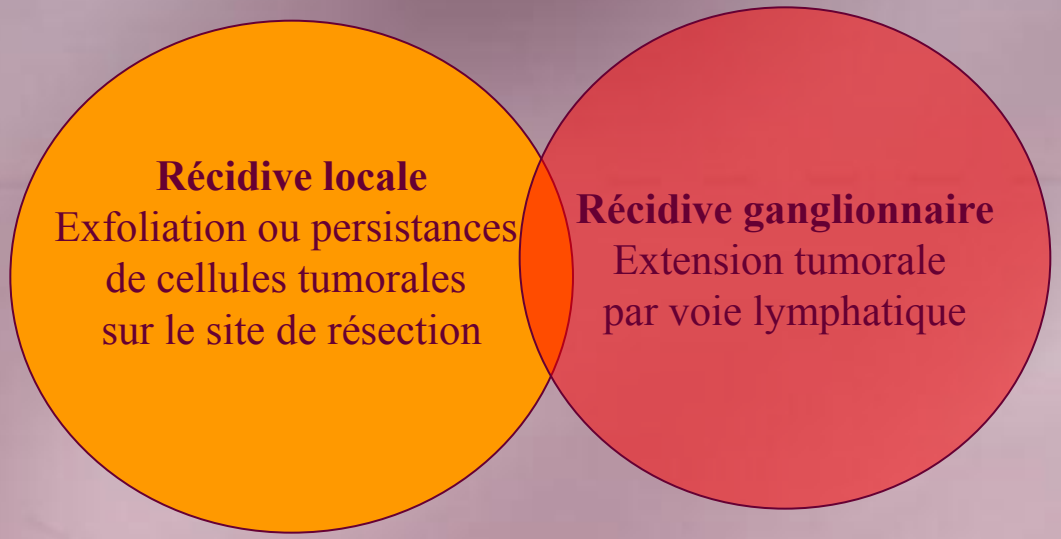
La résection R0 doit rester la règle

≥60	67	25 (20–31)			2.7 (1.4–5.0)
CEA level before salvage operation					
Normal (<5 μg/ml)	39	46 (29–NR)	0.02		
Elevated (≥5 μg/ml)	44	25 (17–30)			
Salvage operation					
Resection	86	37 (48–NR)	0.001		
No resection	14	11 (4–21)			
Type of resection					
Curative (R0) resection	56	66 (40–NR)	0.001	0.001	1.0
Marginal (R1) and incomplete (R2) resection	30	23 (7–26)			3.8 (2.0–7.3)
No resection	14	11 (4–21)			10.5 (4.6–24.4)

Shibata D et al., Dis Colon Rectum 2002
Taylor WE et al., Ann Surg Oncol 2002
Bowne WB et al., Dis Colon Rectum 2005
Elias et al., Hepatogatroenterology 2012

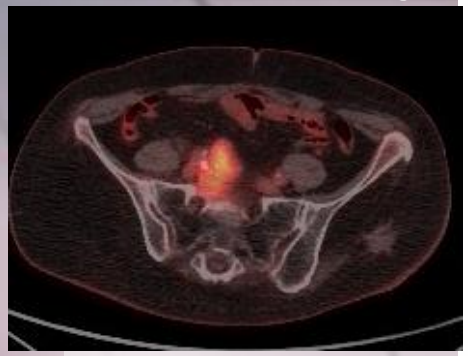
Qui opérer? Les « vrais » récidives ganglionnaires

Nouvelle croissance tumorale en dehors d'un organe plein au niveau ou proche du site de la tumeur primitive réséquée[1-3]



1. Guyot et al., Ann Oncol 2005
2. Sjövall et al., Ann Surg Oncol 2006
3. Elferink et al., Ann Surg Oncol 2012

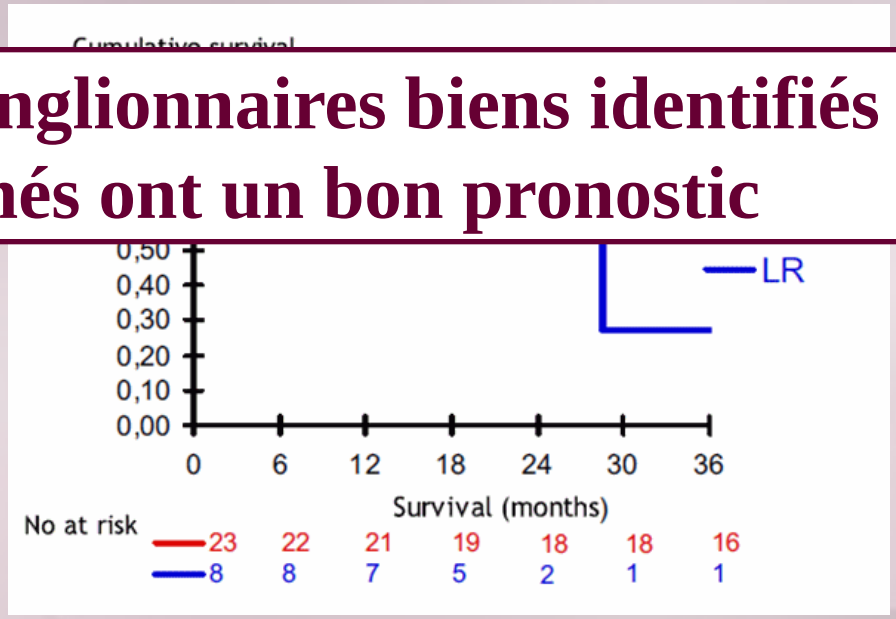
Qui opérer? Critères oncologiques



Available online at www.sciencedirect.com
SciVerse ScienceDirect
ELSEVIER
EJSO
the Journal of Cancer Surgery
www.ejso.com

Central retroperitoneal recurrences from colorectal cancer: Are lymph node and locoregional recurrences the same disease?

F. Dumont [a,*], K. Kothodinis [a], D. Goéré [a], C. Honoré [a], P. Dartigues [b], V. Boige [c], M. Ducreux [c], D. Malka [c], D. Elias [a]



Les récidives ganglionnaires biens identifiés et sélectionnés ont un bon pronostic

Qui opérer? Critères oncologiques

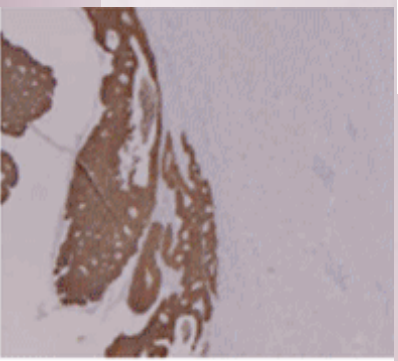
Ann Surg Oncol (2011) 18:1015–1022
DOI 10.1245/s10434-010-1435-z

Annals of SURGICAL ONCOLOGY
OFFICIAL JOURNAL OF THE SOCIETY OF SURGICAL ONCOLOGY

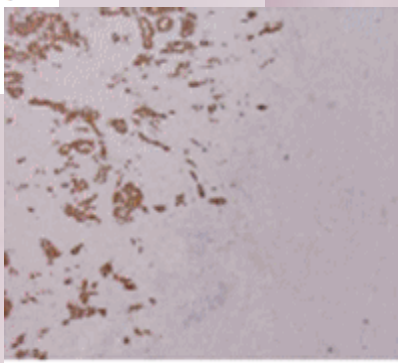
ORIGINAL ARTICLE – COLORECTAL CANCER

Clinicopathological Assessment of Locally Recurrent Rectal Cancer and Relation to Local Re-Recurrence

Mamoru Uemura, MD, PhD[1], Masataka Ikeda, MD, PhD[1], Hirofumi Yamamoto, MD, PhD[1], Kotaro Kitani, MD[1], Masayoshi Tokuoka, MD[1], Ken Matsuda, MD, PhD[2], Yuki Hata, MD[2], Tsunekazu Mizushima, MD, PhD[1], Ichiro Takemasa, MD, PhD[1], Mitsugu Sekimoto, MD, PhD[1], Ko Hosokawa, MD, PhD[2], Nariaki Matsuura, MD, PhD[3], Yuichiro Doki, MD, PhD[1], and Masaki Mori, MD, PhD[1]



A Expanding type



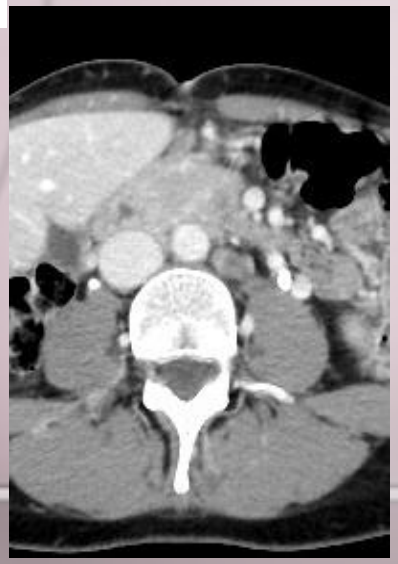
B Infiltrating type

Cellules tumorales distantes isolées

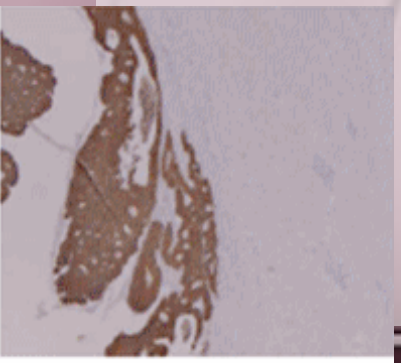
1/5 (20%) 8/16 (50%)

Re-récidive

0/5 (0%) p=0.0124 5/16 (31%)



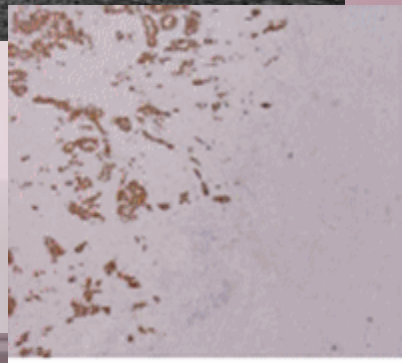
Qui opérer? Critères oncologiques



A Expanding type

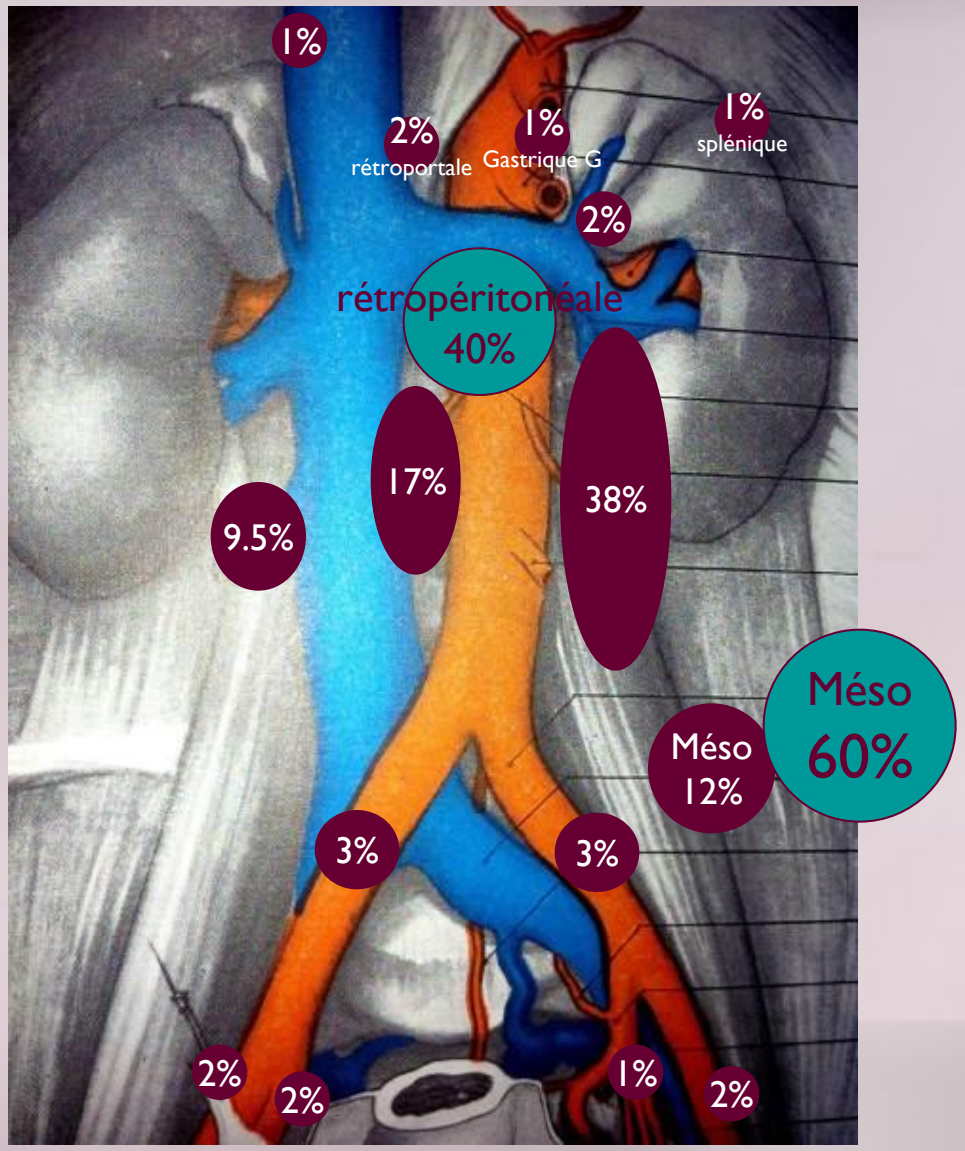
Radiology

Absence of Tumor Invasion into Pelvic Structures in Locally Recurrent Rectal Cancer:
Prediction with Preoperative MR Imaging[1]



B Infiltrating type

Comment opérer? Quel curage?

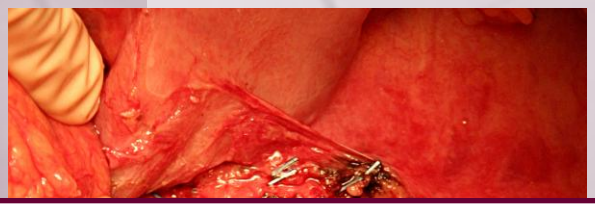


Série IGR non publié

Bowne WB, et al. Dis colon Rectum 2005

Comment opérer: Quel curage?

- Les curages diminuent les récidives en comparaison aux picking dans les cancers de l'ovaire[1]

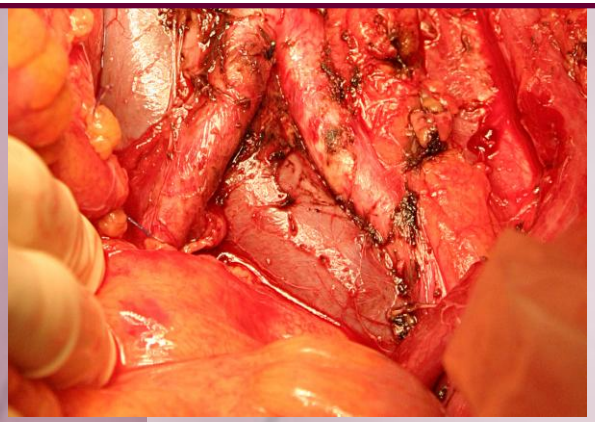


- Les récidives sont dans la moitié des cas ganglionnaires[2]

Réaliser un curage ganglionnaire extensif (IAO-C, latéro-aortique, latéro-cave) incluant les iliaques

→10% iliaque

→3% récidive locale

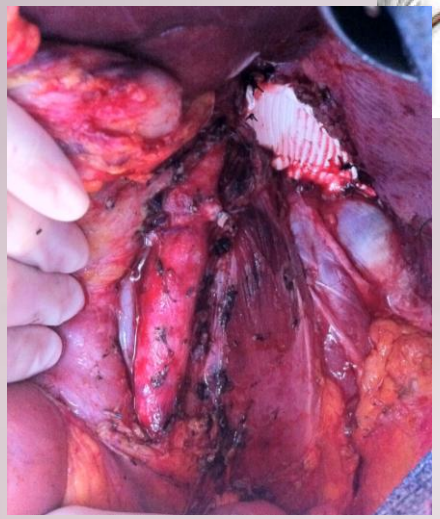


- Le nombre moyen de ganglions envahies 4-7[2,3]

1. *Panici PB et al., J Nat Cancer Inst 2005*
2. *Dumont F et al., Eur J Surg Oncol 2012*
3. *Lefevre JH et al., Ann Surg Oncol 2008*

Comment opérer
Curage Sus rénale?

Faisable[1], plus complexe.



1. Heidenreich A et al. Therap Adv Urol 2012

Comment opérer Curage Sus rénale?

Univariate prognostic factor analysis.

	n	3y-RFS	p*	3y-OS	p*
Age (yr)					
<60	15	40.0	0.509	60.0	0.848
≥60	7	28.6		75.0	
Gender					
M	11	27.3	0.945	54.6	0.642
F	11	45.5		72.7	
Histology					
Adenocarcinoma	18	31.8	0.692	68.1	0.156
Others	4	50.0		50.0	
Primary site					
Rectum	13	27.7	0.811	57.7	0.216
Colon	9	37.5		75.0	
Time to LN relapse (mo)					
≤24	15	31.1	0.617	66.7	0.442
>24	7	42.9		57.1	
Single	12	37.5	0.458	55.6	0.768
Multiple	10	30.0		80.0	
Largest LN size (cm)					
0.7–2.0	12	31.3	0.673	66.7	0.448
2.1–3.3	10	37.5		66.7	
Vertical distance of LN (cm)					
1.3–4.0	12	37.5	0.712	66.7	0.976
4.1–18.0	10	30.0		64.0	
CEA level before RT (ng/dL)					
≤5	12	66.7	0.002	91.7	0.065
>5	10	0		37.5	
RT dose (Gy)					
55.8	8	25.0	0.206	62.5	0.577
60 or 63	14	40.8		65.5	
Concurrent chemotherapy					
Fluoropyrimidine	18	31.8	0.691	63.2	0.657
Others*	4	50.0		75.0	
Adjuvant chemotherapy					
Yes	16	42.9	0.122	77.8	0.010
No	6	0		33.3	
Response					
CR	13	49.5	0.014	92.3	0.028
PR	6	16.7		50.0	
SD	3	0		0	

Réalisable mais probablement en étant encore plus hypersélectif

Phase II

Curati
colore

Seung-Gu Yeo [a,b], Dae Yong Kim [a,*], Tae Hyun Kim [a], Kyung Hae Jung [c], Yong Sang Hong [c], Sun Young Kim [a], Ji Won Park [a], Hyo Seong Choi [a], Jae Hwan Oh [a]

[a] Research Institute and Hospital, National Cancer Center, Goyang, Republic of Korea; [b] Department of Radiation Oncology, Soonchunhyang University College of Medicine, Cheonan, Republic of Korea; [c] Department of Oncology, University of Ulsan College of Medicine, Seoul, Republic of Korea

Radiochimiothérapie péri-opératoire

- Utilisée dans 16 à 60%[1-3]
- Risque de re-récidive locale rétropéritonéale 2-44%[1,3,4]

Phase II trial

Curative chemoradiotherapy for isolated retroperitoneal lymph node recurrence of colorectal cancer

Seung-Gu Yeo [a,b], Dae Yong Kim [a,*], Tae Hyun Kim [a], Kyung Hae Jung [c], Yong Sang Hong [c], Sun Young Kim [a], Ji Won Park [a], Hyo Seong Choi [a], Jae Hwan Oh [a]

[a] *Research Institute and Hospital, National Cancer Center, Goyang, Republic of Korea;* [b] *Department of Radiation Oncology, Soonchunhyang University College of Medicine, Cheonan, Republic of Korea;* [c] *Department of Oncology, University of Ulsan College of Medicine, Seoul, Republic of Korea*

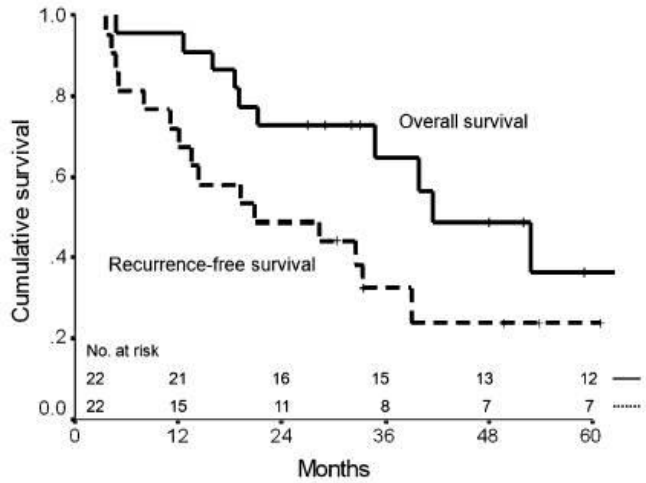


Fig. 2. The 3- and 5-year overall survival rates were 64.7% and 36.4%, respectively. The 3- and 5-year recurrence-free survival rates were 34.1% and 25.6%, respectively. The number of patients at risk for each type of survival is shown at the start of each year.

1. *Shibata D et al., Dis Colon Rectum 2002*
2. *Min BS et al., J Surg Oncol 2008*
3. *Dumont F et al., Eur J Surg Oncol 2012*
4. *Panici PB et al., J Nat Cancer Instit 2005*

Récidives ganglionnaires abdominales avec métastases viscérales associées de cancer colique

Qui opérer?

PERGAMON

European Journal of Cancer 36 (2000) 2044–2052

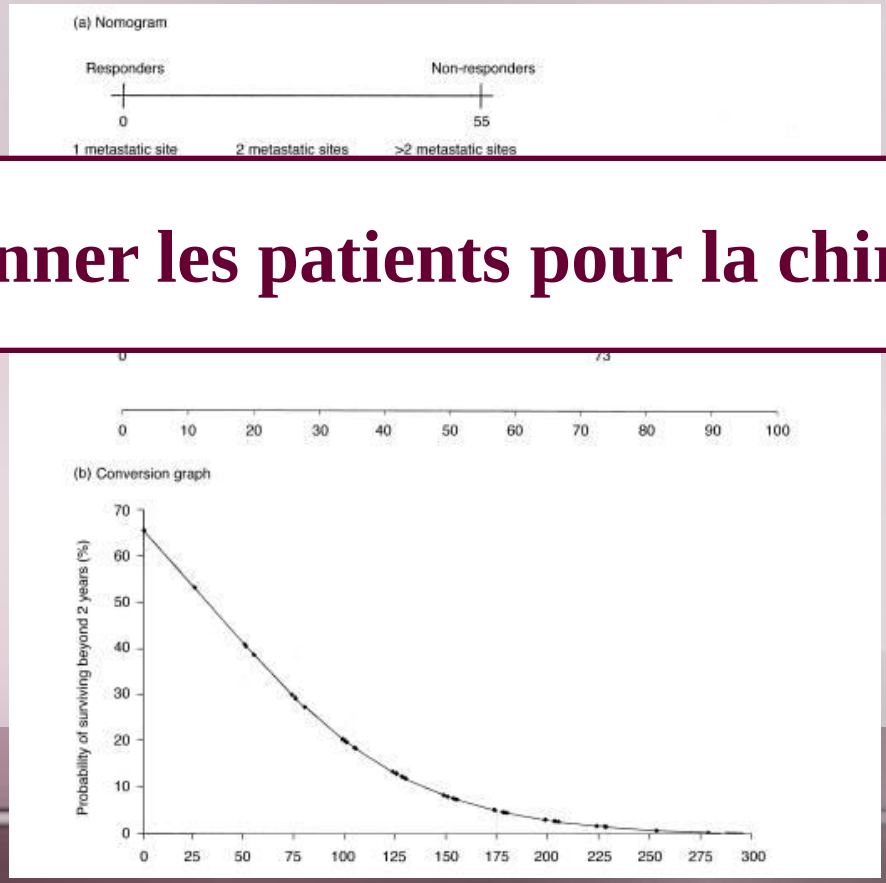
European Journal of Cancer
www.ejconline.com

A clinical nomogram for predicting long-term survival in advanced colorectal cancer

C. Massacesi, A. Norman, T. Price, M. Hill, P. Ross, D. Cunningham *

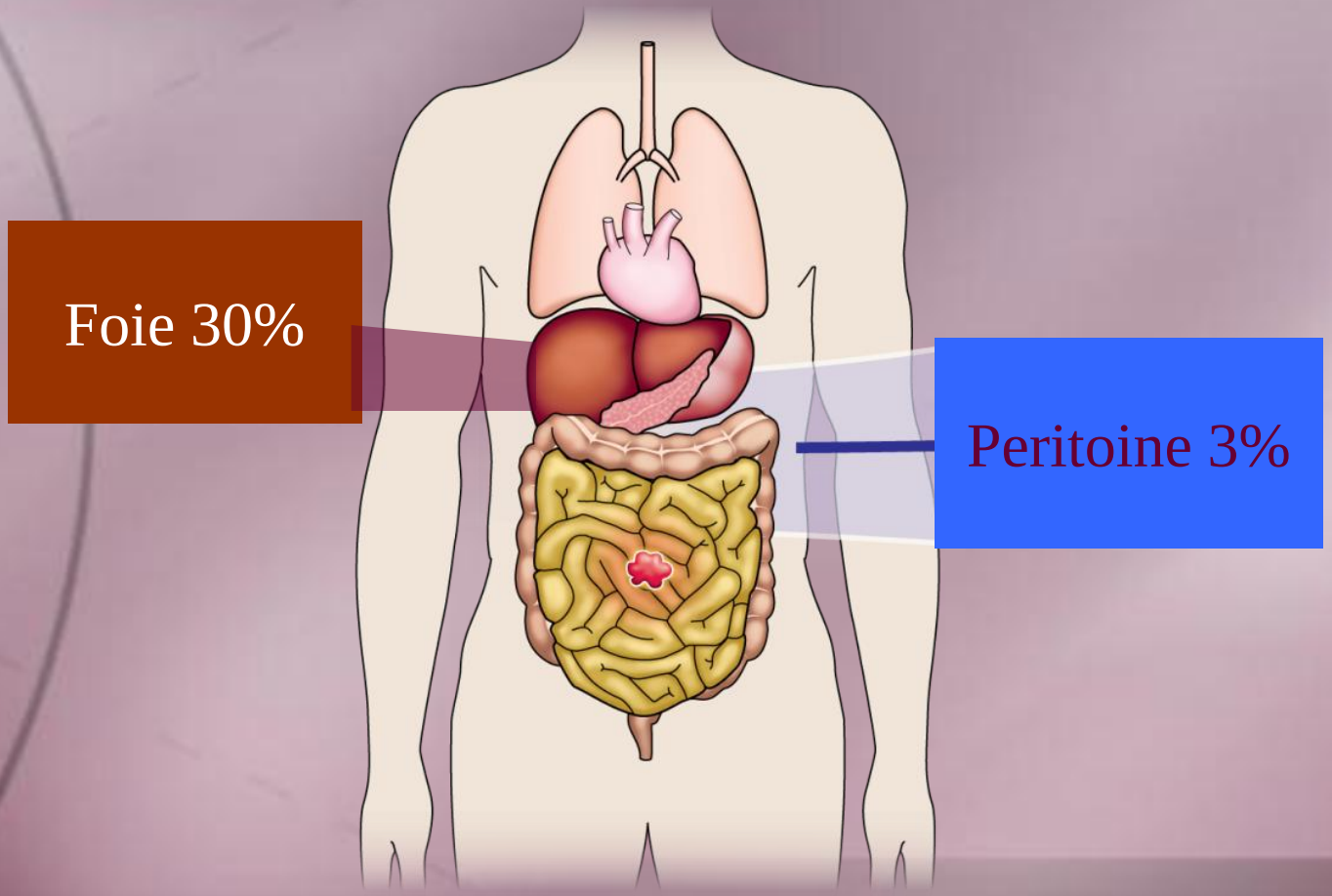
The Department of Medicine and GI Unit, The Royal Marsden NHST, London and Sutton, Surrey SM2 5PT, UK

Received 20 March 2000; received in revised form 19 June 2000; accepted 20 July 2000



Sélectionner les patients pour la chirurgie

Distribution des métastases associées



Données IGR non publiée

Hepatic and Extrahepatic Colorectal Metastases: When Resectable, Their Localization Does Not Matter, But Their Total Number Has a Prognostic Effect

Dominique Elias, MD, PhD,[1] Gabriel Liberale, MD,[1] Dewi Vernerey, MSc,[2] Marc Pocard, MD, PhD,[1] Michel Ducreux, MD, PhD,[3] Valérie Boige, MD,[3] David Malka, MD, PhD,[3] Jean-Pierre Pignon, MD, PhD,[2] and Philippe Lasser, MD[1]

308 resected patients

84 patients with EHD

			Nb of LMs		
			1-3 n=65	4-6 (n=13)	>6 (n=6)
Site and number of EHDs	Peritoneum	1-10	18	4	3
		>10	8	2	2
	Lung	1-2	4	2	0
		>2	7	0	1
	Local recurrence		16	3	0
	Distal Lymph Node	1-3	6	0	0
		>3	3	2	0
	Hepatic Lymph Node	1-2	5	1	0
		>2	5	0	0
	Ovary		4	1	1
	Miscellaneous*		18	6	1

224 patients without EHD

Nb of LMs		
1-3 n=152	4-6 n=50	>6 n= 22

* Striatus muscle= 6, adrenal= 6, small bowel or duodenum= 5, wound = 5, pancreas = 2, bladder =1

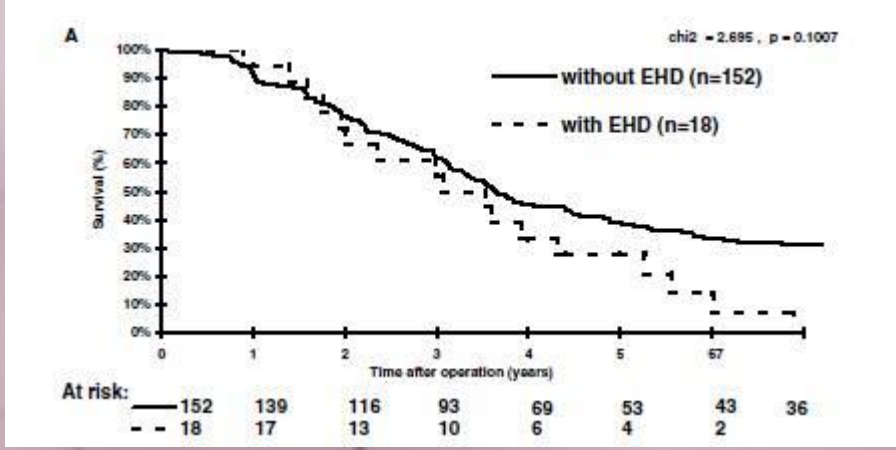
FIG. 1. Distribution of liver metastases (LMs) and extrahepatic disease (EHD) in the 308 patients. Nb, number.

Annals of Surgical Oncology, 12(11): 900–909
DOI: 10.1245/ASO.2005.01.010

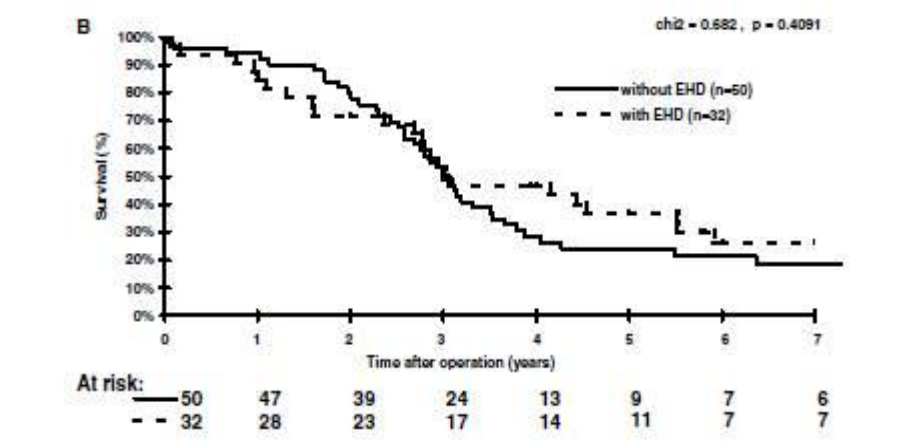
Institut de cancérolog
GUSTAVE ROUSS
VILLEJUIF - www.igr.

Hepatic and Extrahepatic Colorectal Metastases: When Resectable, Their Localization Does Not Matter, But Their Total Number Has a Prognostic Effect

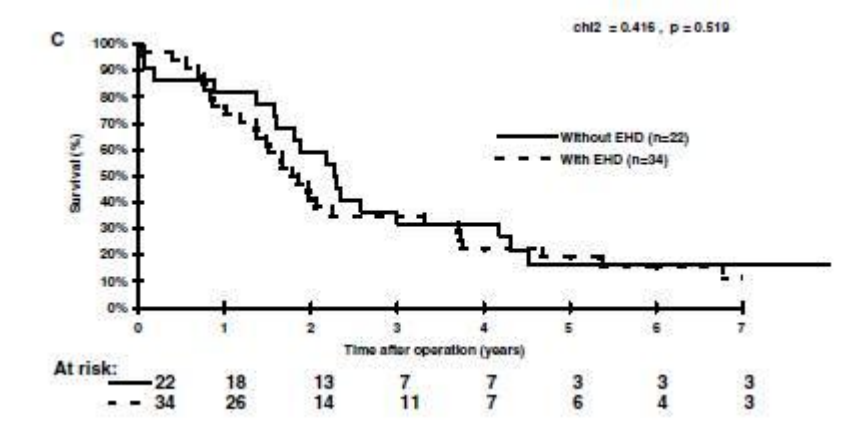
Dominique Elias, MD, PhD,[1] Gabriel Liberale, MD,[1] Dewi Vernerey, MSc,[2] Marc Pocard, MD, PhD,[1] Michel Ducreux, MD, PhD,[3] Valérie Boige, MD,[3] David Malka, MD, PhD,[3] Jean-Pierre Pignon, MD, PhD,[2] and Philippe Lasser, MD[1]



❖ 1 à 3 métastases



❖ 3 à 6 métastases



❖ > 6 métastases

Annals of Surgical Oncology, **12**(11): 900–909
DOI: 10.1245/ASO.2005.01.010

Hepatic and Extrahepatic Colorectal Metastases: When Resectable, Their Localization Does Not Matter, But Their Total Number Has a Prognostic Effect

Dominique Elias, MD, PhD,[1] Gabriel Liberale, MD,[1] Déwi Vernerey, MSc,[2] Marc Pocard, MD, PhD,[1] Michel Ducreux, MD, PhD,[3] Valérie Boige, MD,[3] David Malka, MD, PhD,[3] Jean-Pierre Pignon, MD, PhD,[2] and Philippe Lasser, MD[1]

TABLE 2. *Multivariate analysis of prognostic factors, including the completeness of resection*

Variable	n	HR	*P* value
Sex			
Male	160	1.4 (1.1–1.8)	.0112
Female	148	1	
Radicality of resection			
R0	257	1	.0002
R1	33	1.2 (.8–1.9)	
R2	18	2.9 (1.7–4.8)	
Extrahepatic metastases			
No	224	1	.999
Yes	84	1.0 (.7–1.4)	
No. of resected intrahepatic and extrahepatic metastases			
1–3	170	1	.0180
4–6	82	1.2 (.9–1.7)	
>6	56	1.7 (1.2–2.5)	

HR, hazard ratio.

Annals of Surgical Oncology, **12**(11): 900–909
DOI: 10.1245/ASO.2005.01.010

Institut de cancérolog
GUSTAVE ROUSS
VILLEJUIF - www.igr.

Hepatic and Extrahepatic Colorectal Metastases: When Resectable, Their Localization Does Not Matter, But Their Total Number Has a Prognostic Effect

Dominique Elias, MD, PhD,[1] Gabriel Liberale, MD,[1] Dewi Vernerey, MSc,[2] Marc Pocard, MD, PhD,[1] Michel Ducreux, MD, PhD,[3] Valérie Boige, MD,[3] David Malka, MD, PhD,[3] Jean-Pierre Pignon, MD, PhD,[2] and Philippe Lasser, MD[1]

TABLE 1. *Overall survival rates at 3 and 5 years according to the main prognostic factors (univariate analysis)*

Variable	n	Survival rate (%) 3 y	Survival rate (%) 5 y	*P* value
N	215	52.2 ± 3.4	28.1 ± 3.1	
Extrahepatic metastases				.0
No	224	55.9 ± 3.3	33.5 ± 3.2	
Yes	84	46.2 ± 5.5	27.6 ± 5.0	
Timing of metastases				.774
Synchronous	137	51.0 ± 4.3	29.0 ± 3.9	
Metachronous	171	55.0 ± 3.8	34.2 ± 3.7	
No. of resected liver metastases				.0170
1–3	217	57.4 ± 3.4	35.9 ± 3.3	
4–6	63	48.0 ± 6.4	24.4 ± 5.6	
>6	28	32.1 ± 8.8	16.7 ± 7.3	
No. of resected hepatic and extrahepatic metastases				.00210
1–3	170	61.0 ± 3.8	37.7 ± 3.7	
4–6	82	50.7 ± 5.6	29.2 ± 5.1	
>6	56	33.4 ± 6.4	18.1 ± 5.3	
Radicality of resection				<.0001
R0	257	56.7 ± 3.1	35.3 ± 3.0	
R1	33	43.1 ± 8.9	19.3 ± 7.3	
R2	18	22.2 ± 9.8	5.6 ± 5.4	

Ce n'est pas le siège des métastases qui compte mais leur nombre

Annals of Surgical Oncology, **12**(11): 900–909
DOI: 10.1245/ASO.2005.01.010

Enfin presque!

A Comparative Study of Complete Cytoreductive Surgery Plus Intraperitoneal Chemotherapy to Treat Peritoneal Dissemination From Colon, Rectum, Small Bowel, and Nonpseudomyxoma Appendix

Dominique Elias, MD, PhD, Olivier Glehen, MD, PhD,† Marc Pocard, MD, PhD,‡ François Quenet, MD,§ Diane Goéré, MD,* Catherine Arvieux, MD,¶ Patrick Rat, MD, PhD,‖ François Gilly, MD, PhD,† and the Association Française de Chirurgie*

TABLE 6. Multivariate Analysis of the Prognostic Factors (440 Patients Treated With Compete Cytoreductive Surgery Plus Intraperitoneal Chemotherapy)

	P	Relative Risk	95% CI
Peritoneal index*	<0.0001	1.049	1.027–1.072
Adjuvant chemotherapy†	0.002	0.599	0.434–0.828
Invaded lymph node‡	0.001	1.568	1.1.3–2.28
Origin§	0.06		
Colon		1.000	1.000
Rectum		1.147	0.592–2.224
Appendix		0.455	0.242–0.856
Small bowel		0.685	0.392–1.199

*Each increasing of 1 point increases the risk of death of 4.9%.
†To receive adjuvant chemo decreases the risk of death of 41%.
‡To present an invaded lymph node increases the risk of death of 56%.
§In comparison to a colic origin, a rectal origin increases the risk of death of 14%, the appendix origin decreases it of 55%, and a small bowel origin decreases the risk of 32%.

A Comparative Study of Complete Cytoreductive Surgery Plus Intraperitoneal Chemotherapy to Treat Peritoneal Dissemination From Colon, Rectum, Small Bowel, and Nonpseudomyxoma Appendix

Dominique Elias, MD, PhD, Olivier Glehen, MD, PhD,† Marc Pocard, MD, PhD,‡ François Quenet, MD,§ Diane Goéré, MD,* Catherine Arvieux, MD,¶ Patrick Rat, MD, PhD,‖ François Gilly, MD, PhD,† and the Association Française de Chirurgie*

Annals of Surgical Oncology **14**(1):128–133
DOI: 10.1245/s10434-006-9185-7

Cytoreductive Surgery and Hyperthermic Intraperitoneal Chemotherapy in the Management of Peritoneal Surface Malignancies of Colonic Origin: A Consensus Statement

J. Esquivel,[1] R. Sticca,[2] P. Sugarbaker,[3] E. Levine,[4] T. D. Yan,[3] R. Alexander,[5] D. Baratti,[6] D. Bartlett,[7] R. Barone,[8] P. Barrios,[9] S. Bieligk,[10] P. Bretcha-Boix,[11] C. K. Chang,[12] F. Chu,[13] Q. Chu,[14] S. Daniel,[13] E. deBree,[15] M. Deraco,[6] L. Dominguez-Parra,[16] D. Elias,[17] R. Flynn,[10] J. Foster,[18] A. Garofalo,[19] F. N. Gilly,[20] O. Glehen,[20] A. Gomez-Portilla,[21] L. Gonzalez-Bayon,[22] S. Gonzalez-Moreno,[23] M. Goodman,[24] V. Gushchin,[25] N. Hanna,[5] J. Hartmann,[26] L. Harrison,[27] R. Hoefer,[28] J. Kane,[29] D. Kecmanovic,[30] S. Kelley,[31] J. Kuhn,[32] J. LaMont,[32] J. Lange,[33] B. Li,[14] B. Loggie,[18] H. Mahteme,[34] G. Mann,[35] R. Martin,[36] R. A. Misih,[37] B. Moran,[38] D. Morris,[13] L. Onate-Ocana,[39] N. Petrelli,[37] G. Philippe,[40] J. Pingpank,[41] A. Pitroff,[1] P. Piso,[42] M. Quinones,[43] L. Riley,[44] L. Rutstein,[45] S. Saha,[46] S. Alrawi,[29] A. Sardi,[25] S. Schneebaum,[47] P. Shen,[4] D. Shibata,[31] J. Spellman,[48] A. Stojadinovic,[49] J. Stewart,[4] J. Torres-Melero,[50] T. Tuttle,[51] V. Verwaal,[52] J. Villar,[53] N. Wilkinson,[54] R. Younan,[6] H. Zeh,[7] F. Zoetmulder,[52] and G. Sebbag[55]

L'association ADP rétropéritonéale et carcinose péritonéale est une contre indication à la résection

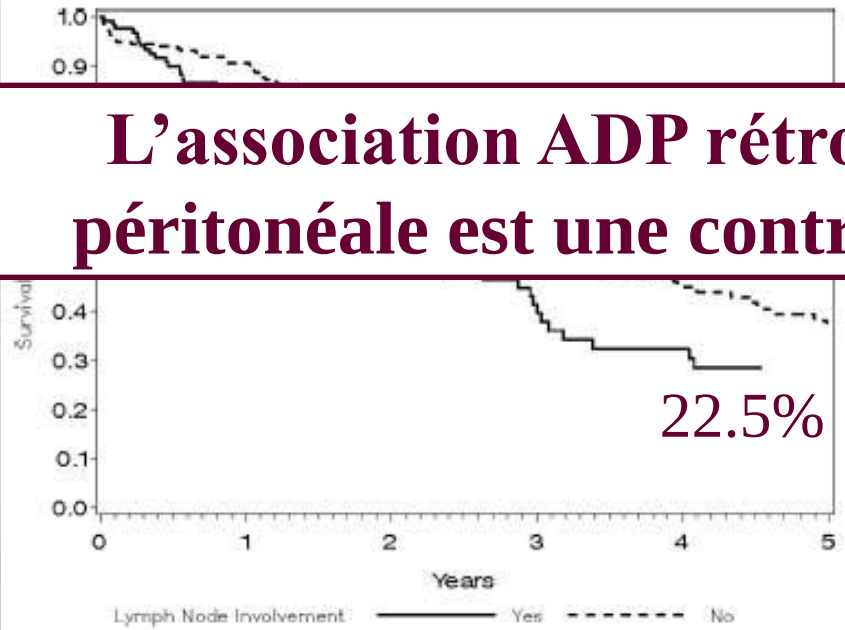
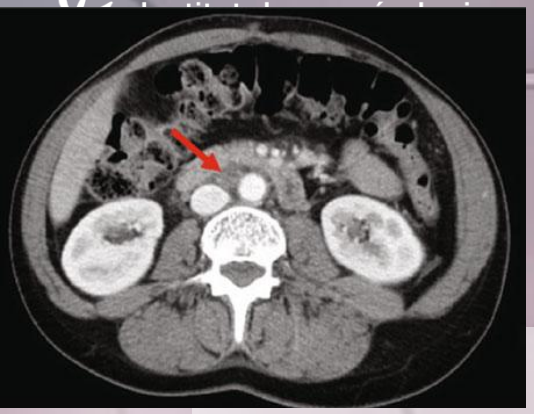


FIGURE 3. Survival rates according to lymph nodes status in patients undergoing a complete cytoreductive surgery (CC-R0) and IP chemotherapy ($P = 0.001$).

graphic variables that are usually associated with increase chances of achieving a complete removal of all tumor greater than 2.5 mm:

(1) ECOG performance status two or less;
(2) no evidence of extra-abdominal disease;
(3) up to three small, resectable parenchymal hepatic metastases;
(4) no evidence of biliary obstruction;
(5) no evidence of ureteral obstruction;
(6) no evidence of intestinal obstruction at more than one site;
(7) small bowel involvement: no evidence of gross disease in the mesentery with several segmental sites of partial obstruction;
(8) small volume disease in the gastro-hepatic ligament.

Traitement préventif?



Ann Surg Oncol
DOI 10.1245/s10434-012-2623-9

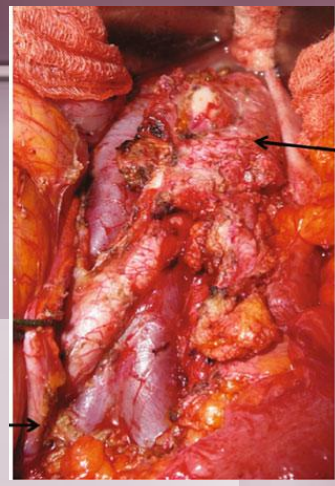
Annals of
SURGICAL ONCOLOGY
OFFICIAL JOURNAL OF THE SOCIETY OF SURGICAL ONCOLOGY

ORIGINAL ARTICLE – COLORECTAL CANCER

Ovarian Metastasis Is Associated with Retroperitoneal Lymph Node Relapses in Women Treated for Colorectal Peritoneal Carcinomatosis

Clarisse Eveno, MD[1], Diane Goéré, MD[1], Peggy Dartigues, MD[2], Charles Honoré, MD[1], Frédéric Dumont, MD[1], Dimitri Tzanis, MD[1], Léonor Benhaim, MD[1], David Malka, MD, PhD[3], and Dominique Elias, MD, PhD[1]

[1]Department of Surgical Oncology, Institut Gustave Roussy, Villejuif Cedex, France; [2]Department of Biopathology, Institut Gustave Roussy, Villejuif Cedex, France; [3]Department of Medical Oncology, Institut Gustave Roussy, Villejuif Cedex, France



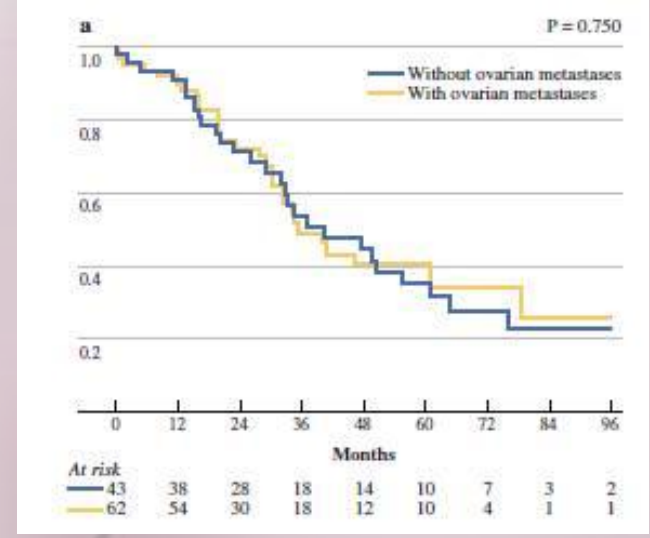


TABLE 2 Sites and rates of recurrences after a median follow-up of 74 (range 10–196) months after complete cytoreductive surgery plus intraperitoneal chemotherapy for colorectal peritoneal carcinomatosis in women with and without OM

Site	With OM, *n* (%)	Without OM, *n* (%)	*p*
All	47 (76)	35 (81)	0.66
Peritoneum	18 (35)	18 (51)	0.25
Lung	19 (37)	11 (31)	0.73
Liver	14 (27)	13 (37)	0.51
Retroperitoneal lymph nodes	18 (35)	1 (3)	0.001

OM ovarian metastases

Conclusions

- Les récidives ganglionnaires sont rares et de mauvais pronostics, sauf chez des patients sélectionnés.
- Les curages sont peu morbides.
- La chirurgie R0 améliore la survie chez des patients sélectionnés répondeurs à la chimiothérapie, faible ACE, oligométastatiques, en bon état général
- La place de la Radiochimiothérapie péri-opératoire reste à déterminer mais semble intéressante