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POSTER

# **Incidence of unsuspected and treatable metastatic disease when performing percutaneous radiofrequency ablation of colorectal liver metastases**

D. Elias, G. Liberale, T. De Baere, C. Dromain, N. Lassau, L. Lasser.  
Gustave Roussy Institute, Surgical Oncology, Villejuif, France

**Background:** When patients with resectable colorectal liver metastases (LM) are treated with percutaneous radiofrequency (RF), some unsuspected intra and extrahepatic metastases might be ignored and not treated. This study was aimed at appreciating the incidence of preoperatively unsuspected intra and extrahepatic metastases, only discovered at laparotomy, and treatable surgically with a curative intent.

**Patients and methods:** The data of 506 patients who underwent a laparotomy and then a hepatectomy for colorectal LM were prospectively collected and retrospectively analyzed. All patients underwent at least two types of preoperative liver imaging.

**Results:** Unsuspected metastases were discovered at laparotomy in 209 patients (41.3%). There were extrahepatic metastases in 82 patients (16.2%), additional LM in 152 patients (30%), and both in 25 patients (4.9%). All of them were resected. When considering only the 124 patients presenting 1 to 3 LM measuring less than 3 cm of diameter (candidates for a percutaneous RF), the results were similar.

**Conclusion:** Laparotomy permits to discover and treat with a curative intent unsuspected intra or extrahepatic metastases in at least one third of patients with resectable colorectal LM. This does not support the use of percutaneous RF ablation instead of surgery for this population since an important survival decrease will result.

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# **Hepatic and extrahepatic colorectal metastases: when resectable, their localization does not matter, but their total number has a prognostic impact**

D. Elias, G. Liberale, D. Vernerey, J.P. Pignon, P. Lasser, M. Pocard, M. Ducreux, V. Voige, D. Malka. Gustave Roussy Institute, Surgical Oncology, Villejuif, France

**Background:** The presence of extrahepatic disease (EHD) is generally considered as contraindication to hepatectomy in patients with colorectal liver metastases (LM).

**Aim:** To demonstrate this, after resection, the prognosis is based to a greater extent on the total number of resected metastases (located inside and outside the liver), than on the site of these metastases (whether inside the liver only or not).

**Patients:** 308 colorectal patients underwent hepatectomy between 1987 and 1999, eighty four of them (27%) also undergoing the resection of miscellaneous EHD.

**Methods:** Prospective data registration and retrospective analysis. When considering the total number of resected metastases, each LM and each EHD was counted as ONE lesion. Univariate and multivariate analysis of the overall survival prognostic factors were performed.

**Results:** Mortality (until discharge from the hospital) was 3% and morbidity was 18%. It was similar for all the patients whether they underwent resection of EHD or not. Median follow-up was 99 months. The overall 5-year survival rate was 32%. In the multivariate analysis, the total number of metastases (whatever their site inside and outside the liver) had a greater prognostic value than the criteria "presence or absence of EHD". Considering the total number of resected metastases (whatever their site), 5-year survival rates were  $38 \pm 4\%$  in the group with 1-3 metastases,  $29 \pm 5\%$  in patients with 4-6 metastases and  $18 \pm 5\%$  in patients with more than 6 metastases ( $p = 0.002$ ). A very simple prognostic score based on the sex and the total number of metastases is validated and proposed for clinical use.

**Conclusion:** When resectable, the presence of EHD is no longer a contraindication to hepatectomy. More important, the total number of the metastases, whatever their location, has a stronger prognostic impact than the site of these metastases.

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# **Does rectal cancer shrinkage after neoadjuvant treatment result in an increased rate of anterior resections? A meta-analysis of randomised trials**

K. Bujko<sup>1</sup>, W. Michalski<sup>2</sup>, M.P. Nowacki<sup>3</sup>, L. Kepka<sup>1</sup>. <sup>1</sup>Maria Skłodowska-Curie Memorial Cancer Center, Department of Radiotherapy, Warsaw, Poland; <sup>2</sup>Maria Skłodowska-Curie Memorial Cancer Center, Department of Biostatistics, Warsaw, Poland; <sup>3</sup>Maria Skłodowska-Curie Memorial Cancer Center, Department of Colorectal Cancer, Warsaw, Poland

**Background:** Meta-analysis of published randomised trials was performed in order to assess an impact of rectal tumour shrinkage after radiotherapy with or without chemotherapy on anterior resections rate.

**Material and methods:** We analysed 8 randomised trials (3706 patients) in which neoadjuvant therapy resulted in a large decrease in median tumour size in experimental arm as compared to control arm. Studies in which an interval between preoperative radiotherapy and surgery in an experimental arm was less than 2 weeks were excluded from the analysis due to limited tumour shrinkage with this therapy being reported. Trials were divided in 3 groups according to whether the impact of tumour shrinkage on the incidence of anterior resection rate was: 1. a primary aim (Lyon I, Polish study); 2. a secondary aim (NSABP R-03, CAO/ARO/AIO-94); 3. Those which were not designed to address this issue (Norwegian study, MRC 2, FFCD 9203, EORTC 22921).

**Results:** Tumours' shrinkage in experimental arms had no statistically significant impact on anterior resections rate in all 3 trial groups. For group 1: the odds ratio (OR)=1.05, 95% confidence interval (CI)=0.73-1.50,  $p = 0.81$ . For group 2: OR=0.98, 95% CI=0.73-1.30,  $p = 0.88$ . For group 3: OR=1.02, 95% CI=0.87-1.20,  $p = 0.81$ . For all trials combined the overall OR=1.01, 95% CI=0.83-1.16,  $p = 0.83$ .

**Conclusion:** The meta-analysis of randomised studies does not show beneficial effect of tumour shrinkage on the incidence of anterior resections.

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# **Correct tumour staging is determining for survival after colon cancer surgery**

P. Jestin<sup>1</sup>, B. Glimelius<sup>2</sup>, L. Pahlman<sup>1</sup>, U. Gunnarsson<sup>1</sup>. <sup>1</sup>Uppsala University, Dept. of Surgical Sciences, Uppsala, Sweden; <sup>2</sup>Uppsala University, Dep. of Oncology, Radiology and Clinical Immunology, Uppsala, Sweden

**Aims:** Correct staging of colon cancer is decisive regarding further oncological treatment, surveillance and prediction of long-term survival. This study investigated the variability in accuracy of pathology reports with focus on differences between pathology departments and their compliance to regional guidelines.

**Material and method:** Data from the colon cancer register (1997-2002) of the Uppsala/Örebro health care region were analysed and the seven pathology departments in this region were compared. Included were 3735 patients who had undergone resection of a colon cancer. Cumulative 5-year survival was the main end-point.

**Results:** For 64% (n=2390) of the cases the number of lymph nodes examined was given (median 8 nodes). Survival in stage II was lower when fewer than 12 nodes were examined or when the number of nodes sampled was not given ( $p = 0.001$ , log-rank test). In stage III, N1-stage had a better survival than N2-stage ( $p < 0.001$ , log-rank test). An index of metastases (IM), derived from the number of nodes with metastases divided by the number of nodes examined, was calculated for stage III tumours. Examination of 12 nodes is necessary to assure stage III cases with the median IM (0.32) whereas 20 nodes are necessary to assure 90% of cases with the lower quartile of IM (0.16). Irrespective of the number of nodes investigated, overall survival was better among patients with IM  $< 0.33$  vs. IM  $\geq 0.33$  ( $p < 0.001$ , log-rank test). The prognostic information of the IM was higher than that of the N-stage.

**Conclusions:** Quality at a pathology department, measured by the median number of lymph nodes investigated and by the proportion of reports where the number is given, is determining for correct staging and management of the patient. An index of metastases (IM) is a possible basis for guidance in the choice of adjuvant treatments that appears superior to that of N-stage.