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PUBLICATION

CA 15-3 TUMOR MARKERS IN DETECTION OF METASTASES IN BREAST CANCER PATIENTS

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The results indicate that there is no significant difference in maximal value that follows the metastases before they are manifested and after

they are manifested. Serum concentrations of CA 15-3 were examined at 500 patients surgically treated for breast cancer.

For the period of 12-55 months they were examined every 3 months with border value of 19.30 U/ml.

The sensitivity of Ca 15-3 in detection of distant is 86% with positive predictive value of 77% and 14 months as a mean (S.D.) time of raised marker level value. According to localisation of metastases the highest sensitivity was in hepatic, bone and multiple metastases, and lowest with locoregional recurrences.

Colorectal cancer

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ORAL

TRANSANAL ENDOSCOPIC MICROSURGERY IN EARLY RECTAL CANCER

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In the period from 8/89 to 1/94, 355 rectal tumours were locally excised by TEM, 236 of them have been adenomas and 98 carcinomas. In the group of carcinomas, 53% preoperatively have been judged as adenomas (rectoscopy, histology, endosonography).

In carcinomas, a full wall dissection or a segmental resection is always performed.

The final histology showed the following tumour stages (number of reoperated patients): 54 (8) pT1, low risk and 2 (0) pT1 high risk; 25 (16) pT2, low risk and 2 (2) pT2 high risk; 13 (8) pT3 low risk and 2 (0) pT3 high risk.

Patients with pT1 low risk carcinomas, resected *in toto*, patients treated with palliative intent, high risk patients and those who refused an open operation, were not reoperated. The more advanced tumour stages (pT1 high risk, pT2 and pT3) required another open intervention. Of the 34 reoperated, 3 showed a residual primary tumour (two in pT2 and one in pT3 carcinoma). In 15 reoperated patients, we could see lymph node metastases (only in pT2 and pT3 carcinomas). After a follow up period of 17 months, 2 of 46 patients with pT1 low risk carcinoma, 0 of 2 patients with pT1 high risk carcinoma, 0 of 9 patients with only locally excised pT2 carcinomas and 1 of 7 patients with only locally excised pT3 tumour had developed a recurrence. The two patients with recurrence of pT1 low risk tumour, underwent a second procedure for cure.

The zero mortality, the low morbidity rate and the oncological reliability of the TEM makes it the method of choice in the treatment of pT1 low risk rectal carcinoma.

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LOCAL RECURRENCE AFTER TOTAL RECTAL RESECTION, MESORECTUM EXCISION AND COLOENDOANAL ANASTOMOSIS FOR TREATMENT OF LOW RECTAL CANCER

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Globally at the NCI of Milano from March 1990 to March 1995, 112 coloendoanal anastomoses (CEAA) associated with a colic reservoir after total rectal resection (TRR) were done. The present abstract concerns 90 CEAA performed in 87 consecutive patients affected with primary rectal carcinoma (18 pts Dukes A; 20 pts Dukes B; 42 pts Dukes C and 7 pts Dukes D). All lesions were located in the lower third of the rectum with a distance from the anal verge ranging from 4 to 7 cm. The follow up period ranged from 1 to 53 months (median 22). The distance of the distal tumor margin from the resection edge of the rectum ranged from 1 to 6 cm. All Dukes A and B patients did not show local relapse while only 8 Dukes C patients presented pelvic relapses after TRR and CEAA from 7 to 14 months. Only one case showed this recurrence at the para-anastomotic site. Post-operative morbidity due to procedure was low. A perfect continence was documented in 66% of cases after colostomy closure and many patients (63%) referred one or two bowel movements a day. Presently 70 patients of this series are alive, 57 of whom without actual evidence of disease. At present it is unanimously accepted that minimum distance edge from the neoplasm must not be more than 2 cm. However some literature data and our personal experience show that free distal margin from neoplasm is less important than thought in the past, with regard to local relapse and survival time, but a careful total mesorectum excision seems to be the most important factor in reducing incidence of local and pelvic recurrence. We conclude that a conservative surgical approach such TRR and CEAA can be considered a feasible option to the traditional abdomino perineal resection for primary cancers in the low rectum.

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THE EFFICACY OF RIGS (RADIOIMMUNOGUIDED SURGERY) FOR COLORECTAL CANCER SURGERY

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Radioimmunoguided surgery (RIGS) is an intraoperative diagnostic method based on monoclonal antibodies (MoAb) labeled with a radioactive isotope (¹²⁵I). Twenty colorectal cancer pts (12 recurrent, 8 primary) were injected with an anti-TAG (tumor-associated glycoprotein) MoAb, CC49 ¹²⁵I. Workup included colonoscopy, abdominal and chest CTs. Intraoperative traditional surgeon's exploration, including liver US, was followed by a gamma-detecting probe (Neoprobe 1000) survey. The MoAb localized on the tumor in 100% of pts. In addition to the primary lesions, CT identified 6 tumor sites, the surgeon 21 sites, RIGS 48 sites—36 confirmed by Pathology (H&E). In 9/20 pts (45%) RIGS detected occult findings (H&E-confirmed). These included lymph nodes, anastomosis, pelvis, uterus and peritoneum in 8/12 (66.6%) recurrent pts, and 1/8 (12.5%) primary pts, and changed the surgical plan in 10/20 (50%) pts. Thus, RIGS surgery can lead to a non-randomized more rational approach when selecting radical or non-radical surgery for colorectal cancer.

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CAUSES AND RISK FACTORS FOR POSTOPERATIVE MORTALITY IN SURGERY FOR RECTAL CANCER, WITH OR WITHOUT PREOPERATIVE RADIOTHERAPY

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The Stockholm Rectal Cancer Study Group has conducted two prospective, randomised trials on preoperative radiotherapy in rectal cancer. The studies have shown a reduced local recurrence rate after radiotherapy but also an increased postoperative mortality in irradiated patients compared to non irradiated. This study analysed causes of death and risk factors in patients dying in the postoperative period.

Patients and methods: In all, 1406 patients were included in the two trials and 1399 of these were operated. All cases of postoperative death within 30 days of surgery were identified (51 patients), and causes of death analysed. To identify patient related risk factors for postoperative mortality a case-control study was performed, with a detailed review of clinical records.

Results: Forty-one of the 692 irradiated patients died postoperatively compared to ten of the non irradiated. The postoperative mortality in irradiated patients was significantly increased only in those irradiated