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# Letters to the Editor: Comments on *Palliative Endoscopic Therapy of Rectal Carcinoma*, Dohmoto *et al.*, *European Journal of Cancer*, 32A, No. 1, pp. 25–29, 1996

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THE REVIEW "Palliative Endoscopic Therapy of Rectal Carcinoma" [1] suggests that radiotherapy is of little value in advanced recurrent or inoperable rectal carcinoma. The references quoted are some 10 years old and do not reflect current practice. At Mount Vernon Hospital, we have treated patients with synchronous chemoradiotherapy using high-dose irradiation incorporated with external beam and intraluminal high-dose rate afterloading treatment. This is based on the Bosset [2] regimen combining 5-FU 350 mg/m$^2$ and folinic acid 20 mg/m$^2$ daily for 5 days on the first and fifth week of a radiation schedule delivering 4500 cGy in 25 daily fractions over 5 weeks. This is followed by two intraluminal brachytherapy insertions delivering 600 cGy at 1 cm on the surface of a 2 cm diameter applicator placed within the anal canal and rectum.

7 consecutive patients who have received this schedule are evaluable with a minimum follow-up time of 6 months. These patients were all elderly (median age 83 years, range 54–87) with only one patient being under 75 years of age. 3 patients had adenocarcinoma of the rectum and 4 adenocarcinoma of the upper anal canal. Complete remission was achieved in all but 1 patient following treatment. The other patient remains in partial remission, but has progressive liver metastases. The median time to achieve complete remission was 12 weeks (range 10–24 weeks). Toxicity from this treatment is predominantly severe diarrhoea occurring in 5 patients with a median duration of 3 weeks (range 3–6 weeks), and moist desquamation seen in 2 patients, all of which have resolved spontaneously.

We conclude that this approach in advanced inoperable rectal carcinoma offers good long-term local control and may in some patients have achieved cure on longer follow-up. Whilst we concede that this involves some investment of time and acute toxicity, the morbidity in this elderly age group has been acceptable.

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1. Dohmoto M, Hünerbein M, Schlag PM. Palliative endoscopic therapy of rectal carcinoma. *Eur J Cancer* 1996, **32A**, 25–29.
2. Bosset JF, Pavy JJ, Hamers HP, *et al.* Determination of the optimal dose of 5-fluorouracil when combined with low dose D, L-leucovorin and irradiation in rectal cancer: results of three consecutive phase II studies. *Eur J Cancer* 1993, **29A**, 1406–1419.

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IN THEIR review "Palliative Endoscopic Therapy of Rectal Carcinoma", Dohmoto and associates [1] suggest that patients with rectal cancer should be divided into those who are fit for curative treatment with primary surgery and those who are not because of various reasons, including extensive local tumour infiltration, for which palliative procedures are only discussed. In this latter situation, there are indisputably some non-metastatic operable patients whose tumour which seems unresectable might be amenable to secondary curative resection after irradiation with or without chemotherapy.

The EORTC Radiotherapy Group conducted three consecutive phase II studies in order to determine the optimal dose of 5-fluorouracil (5-FU) in a radiochemotherapy-based treatment in locally rectal cancer [2]. Among the patients entered into the studies, 18 had a locally recurrent disease (LR) and 39 primarily locally advanced disease (PLA) without distant metastasis; all these patients were judged by surgeons to have extensive local infiltration that precluded curative resection. They received pelvic irradiation (45 Gy) combined with 5 FU/LV (leucovorin) chemotherapy delivered during week 1 and 5 of irradiation. In the LR group, 10 patients received an additional boost dose ranging from 9 to 30 Gy (mean 18 Gy) and 5 patients, in the PLA

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group, a dose from 7 to 18 Gy (mean 13 Gy). After treatment, patients were evaluated in collaboration with the surgeon and those who were judged resectable were operated on.

In the LR group, 6 patients were operated on: 1 remained unresectable and 5 had a macroscopically complete surgical resection. At pathological examination, two tumours were sterilised and one infiltrated mucosa/submucosa only. One patient died in the post-operative period, 1 has no evidence of disease (NED) at 2 years, and 4 were NED at 4 years.

In the PLA group, 34 were operated on. For 2 patients, the tumour could not be resected. Of the 32 specimens, 6 were sterilised, 2 involved the mucosa/submucosa only, and 9 extended into but not through the muscle. After a mean follow-up of 2 years, 60% of the patients are still alive in this group.

Other approaches are possible as described by Drs R. Glynne-Jones and P.J. Hoskin who treated patients with radiochemotherapy plus an additional boost dose delivered by brachytherapy, without surgery for locally advanced disease in elderly patients [3]. Nevertheless, it must be emphasised, and our results confirm this point, that some patients are at the interface between curative and palliative aims and their treatment must be discussed by a multidisciplinary team, including radiation oncologists. Although extensive local tumour extension is related to a very heterogeneous situation, medically operable patients should be given a chance to be curatively treated by a pre-operative approach.

1. Dohmoto M, Hünerbein M, Schlag PM. Palliative endoscopic therapy of rectal carcinoma. *Eur J Cancer* 1996, **32A**, 25–29.
2. Bosset JF, Pavy JJ, Hamers HP, *et al.* Determination of the optimal dose of 5-fluorouracil when combined with low dose D,L-leucovorin and irradiation in rectal cancer: results of three consecutive phase II studies. *Eur J Cancer* 1993, **29A**, 1406–1419.
3. Glynne-Jones R, Hoskin PJ. Letter to the Editor: Comments on *Palliative Endoscopic Therapy of Rectal Carcinoma,* Dohmoto *et al., European Journal of Cancer,* 32A, No. 1, pp. 25–29, 1996. *Eur J Cancer,* 32A, 2031.