disease who had not received formal liver surgical review. Imaging for these patients was assesed by 4 specialist liver surgeons working at 2 different units. Disease was classified as resectable, potentially resectable after neoadjuvant chemotherapy, irresectable and unlikely ever to become resectable, or unable to assess based on current imaging. A majority decision on an appropriate management was then taken.
Results: Between Jan-Dec 2009, 110 patients were treated with palliative chemotherapy at a regional oncology unit for metastatic colorectal disease. 37 patients had been discussed at the supraregional hepatobiliary MDT prior to commencing chemotherapy, and were excluded.
CT reports for the initial staging scan were reviewed in the remaining 73 patients. 20 had widespread metastatic disease, and were excluded. The initial imaging for the remaining 53 patients with liver-only metastatic colorectal cancer was reviewed. 14 patients (25%) had resectable disease at presentation, 26 patients (47%) had borderline resectable disease and it was felt would benefit from downstaging chemotherapy and reassessment, whilst 13 patients (24%) were irresectable at presentation.
Conclusions: Non-expert decisions on resectability are leading to inappropriate patient management, with potentially curable patients being referred for palliative treatment. Specialist liver surgery review is essential for all patients with liver only metastatic disease.

6037 POSTER

Preoperative Chemoradiotherapy Improves Local Recurrence Free Survival in Locally Advanced Rectal Cancer

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Background: Preoperative chemoradiotherapy (preCRT) followed by total mesorectal excision (TME) is the recommended therapy for patients with locally advanced rectal cancer (LARC). The aim of this study was to compare the rates of local and distant recurrence and overall survival rates of patients who received preCRT versus postCRT.
Methods: Data of patients with clinical stage T3/4 N0/+ rectal cancer who received either preCRT or postCRT, and followed up at our center between 2000–2009 were retrospectively analyzed. Preoperative staging were performed with computed tomographic (CT) scanning of thorax and CT or magnetic resonance imaging (MRI) of the abdomen and pelvis, and in some cases endorectal ultrasonography. PreCRT regimen was administered as continuous infusion of 5-FU during the 6-week radiotherapy (RT) course PostCRT regimen was administered as six cycles of bolus FU five times weekly and concomitantly with RT at the 3rd and 4th cycles Patient characteristics, type of surgery, time to surgery after completion of preCRT, distance of tumour from the anal verge, clinical (c) T and N stages, pathological (p) T and N stages, presence of pathological complete response (pCR), time to adjuvant treatment after completion of surgery, disease recurrences (local or distant), and deaths with any cause were determined. Categorical and continuous variables were compared with chi-square and Mann-Whitney U tests, respectively. Local recurrence free survival (LRFS) and distant recurrence free survival (DRFS) were defined as the time from the diagnosis to the detection of any local or distant recurrence, respectively. Overall survival (OS) was defined as the time of diagnosis to death of any cause. LRFS, DRFS, and OS were estimated by using the Kaplan–Meier method. Log-rank test was used to evaluate any difference between groups.
Results: PreCRT group had more cT4 or node positive disease. The median distance of tumour from the anal verge was 8 cm. Overall, 35% of tumours were within $\leqslant$5 cm distance from the anal verge (preCRT group; 50%, postCRT group; 28%). Final surgery type was not influenced by the administration of preCRT in tumours $\leqslant$5 cm distant from the anal verge ($p = 0.3$). A pCR was achieved in 20% of the patients in preCRT group. LRFS at 5-yrs was 83.2% in preCRT and 67.8% in postCRT groups ($p = 0.04$). DRFS at 5-yrs was 71% in preCRT and 59% in postCRT groups ($p = 0.1$). 5-yr OS rates were 70% for preCRT & 62.6% for postCRT group ($p = 0.9$).

Table 1.

	preCRT	postCRT	*p* value
cT3, n (%)	40 (80)	75 (80)	0.6
cT4, n (%)	9 (18)	6 (6)	0.02
unknown, n (%)	1 (2)	13 (14)	0.01
cNpositive, n (%)	27 (54)	26 (28)	0.01
Low anterior resection, n (%)	31 (62)	69 (73)	0.1
Abdominoperineal resection, n (%)	19 (38)	25 (27)	0.1

Table 2.

	preCCRT	postCCRT	*p* value
pT2, n (%)	6 (12)	6 (6)	0.2
pT3, n (%)	27 (54)	79 (84)	0.01
pT4, n (%)	7 (14)	9 (10)	0.6
pCR, n (%)	10 (20)	NA	–
pN positive, n (%)	17 (34)	60 (64)	0.01

Conclusion: Treatment of LARC with preCRT followed by TME as compared with TME followed by postCRT improved LRFS but did not improve DRFS or OS in our patient cohort.

6038 POSTER

Transanal Endoscopic Microsurgery (TEM) After (Chemo)Radiation Therapy for Distal Rectal Cancer

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Background: Standard treatment of distal rectal cancer is chemoradiation therapy (CRT) or short course radiotherapy (SRT, 5 $\times$ 5 Gy) followed by total mesorectal excision (TME). Multimodal treatment using CRT followed by local excision (LE) is increasingly used in patients with distal rectal cancer because of the postoperative risks and problems after TME. Clinical randomised trials are lacking, but several authors describe good oncological and functional results. The aim of the study was to evaluate the multicenter results of CRT and SRT followed by LE using transanal endoscopic microsurgery (TEM) in the Netherlands.
Patients and Methods: All patients treated with CRT and SRT and LE in 3 specialised TEM centres in the Netherlands were evaluated. All patient, tumour and therapy related factors were identified from the prospective databases and medical records at the three centers.
Results: Thirty-eight patients, 18 male and 20 female, were eligible for analysis. Eight patients had a clinical T1, 16 a T2, 9 a T3, 3 a T4 tumour, clinical T stage was unknown in 2 patients. SRT was given to 23 patients and in 10 of these patients (group 1) the interval between SRT and LE was 1 week maximum (range 2−6 days). In 13 patients (group 2) the interval was more than 6 weeks (range 42–120 days). CRT (43.2–50.4 Gy + 5-FU) was performed in 13 patients (group 3) and 2 patients (group 4) underwent a different radiotherapy schedule (13 x 3 Gy). ypT-stadia were ypT0 (n = 11), ypTis (n = 1), ypT1 (n = 7), ypT2 (n = 10) and ypT3 (n = 9). Pathological complete responses (pCR) were identified in the groups treated by CRT (n = 6) and SRT followed by an interval of at least 6 weeks (n = 5).
Six patients underwent additional TME because of ypT2 (n = 1) or ypT3 (n = 5) stage in the resection specimen after LE. Postoperative wound dehiscence occurred in 13 patients (34%). There was no statistically significant difference in the 4 groups (i.e. 23, 30, 46 and 50%). In one patient the wound dehiscence was treated with a temporary ileostomy and all others did not need surgical intervention. Two local recurrences were observed in patients with ypT3 and ypT2 tumours in the excision specimen, both patients refused proposed immediate additional TME after LE.
Conclusions: Our study confirms that postoperative outcome in patients with a (near) pCR after CRT and SRT seems to be good, but complication rates are high. Prospective trials are needed to determine response rate, morbidity and long-term outcome after this promising multimodality strategy.

6039 POSTER

Pulmonary Metastatectomy for Colorectal Cancer − a Retrospective Review

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Background: Colorectal cancer is the third most common cancer in the UK. 20% of patients will develop lung metastases. The role of pulmonary metastatectomy in these patients remains controversial. Without treatment survival is estimated to be 8 months, but even with advances in chemotherapy 5 year survival in the context of metastatic disease remains only 5%.