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Local Excision after neoadjuvant treatment for rectal cancer - Indications and Limits

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Currently, with good pre-operative staging (MRI), neoadjuvant (chemo)radiation (ChRT), and good quality surgery (Total Mesorectal Excision), local recurrence rates in rectal cancer are as low as 5%. However, this excellent oncological outcome comes with the cost of substantial peri-operative morbidity and mortality, as well as considerable long-term anorectal and urogenital dysfunction. Ultra-low anastomoses and intersphincteric resections, especially after neoadjuvant RT often leave the patient with a dubious degree of continence.

The possibility of organ preservation, either by entering in a intensive follow-up schedule in a "watch-and-wait" approach (W&W), or by proceeding to a "full-thickness local excision" can be offered. These strategies are not yet commonly accepted as standard practice. The scientific community is eagerly waiting for enough clinical evidence about the risks of local recurrence and distant dissemination. Involving the patient's wishes in a shared-decision making, especially when they are stoma-averse, could include this therapeutic option.

Intrinsic problems of this treatment option will be discussed, regarding local failure rates, procedure-specific morbidity and follow-up difficulties.

With the current paradigm of rectal cancer management being questioned, organ preservation has an important role in the armamentarium of an Oncologic Multidisciplinary Team.

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