Outcome of primary tumor in patients with synchronous stage IV colon or rectal cancer: So much the same yet so different

Prise en charge de la tumeur primitive chez les patients atteints de cancer colique ou rectal avec métastases synchrones : si proches mais si différents

Following a careful reading of Poultsides et al.'s [1] “Outcome of primary tumor in patients with synchronous stage IV colorectal cancer receiving combination chemotherapy without surgery as initial treatment” in the Journal of Clinical Oncology, supporting the use of chemotherapy without routine prophylactic resection of primary tumors for patients with metastatic colorectal cancer, we would like to make some remarks and clarifications.

Two hundred and thirty-three patients with asymptomatic stage IV colorectal cancer were retrospectively analyzed. Eleven percent of patients developed primary tumor-related symptoms that were managed non-operatively or operatively. These results are in accordance with other studies and with a recent meta-analysis [2-4]. Nevertheless, we do not know how many patients were excluded due to prophylactic resection of primary tumors or symptomatic primary tumors. This data is important because the majority of stage IV colorectal in the United States undergo up-front surgical resection of their primary tumors [5] and this initial choice could introduce selection bias.

Seventy-eight patients (34%) with stage IV rectal cancer were evaluated. Poultsides et al. found no influence of the primary tumor location on emergent intervention. Nevertheless, the authors did not evaluate the presence of pelvic symptoms that deteriorate quality of life in patients with stage IV rectal cancer [6]. We do not know if patients with rectal cancer had pelvic symptoms or if they were excluded. Probably patients with stage IV rectal and pelvic symptoms benefited from treatment by radiotherapy or surgery and then were not included in the study. Among patients with asymptomatic stage IV rectal cancer, only 6% required surgery and the additional 9% required non-operative intervention (stent or radiotherapy) to palliate primary tumor symptoms. Surprisingly, only three patients with rectal metastatic cancer required external-beam radiation therapy to palliate perineal pain.

In a retrospective study, we evaluated the control of pelvic symptoms in 96 patients with rectal cancer and synchronous metastases [7]. At the time of diagnosis, 70.8% patients had pelvic symptoms. The role of surgical resection in asymptomatic patients remains debatable, however, in our study 53.3% (n = 8/15) of patients managed without surgery, developed pelvic symptoms versus 5.9% (n = 1/13) among patients treated with surgery. Moreover, patients treated by chemotherapy alone frequently (n = 5/10) developed pelvic symptoms. Our results support that surgery, after selection of patients who were able to tolerate this treatment and with prolonged survival (evaluated with Köhne score [8]), could be considered the optimal treatment as regards to pelvic symptoms. In our clinical practice, we start chemotherapy or radiochemotherapy first and at three months, if there is a good control of the metastatic disease and a good prognosis, with discussions at multidisciplinary meeting, rectal primary tumor resection is performed to ensure a good quality of life [9].

In our opinion, Poultsides et al. should reconsider their conclusion for stage IV rectal cancer that “The low incidence of late, symptom-directed intervention does not justify routine use of prophylactic surgery or radiotherapy in this setting.” Pelvic symptoms frequently occur in patients treated with chemotherapy alone and contribute to an important deterioration of patient’s quality of life [6,7,9]. Moreover, palliative colostomy rarely allows a resolution of pelvic symptoms [10,11]. For this reason, rectal cancer with synchronous metastasis needs to be analyzed independently of colon cancer, considering the importance...
of pelvic symptoms. A large prospective trial to evaluate incidence, consequence and treatment of pelvic symptoms on quality of life for patient with stage IV rectal cancer is mandatory [12].

In conclusion, there is no doubt regarding the value of non-surgical management of asymptomatic metastatic colon cancer [1—4], however, concerning asymptomatic metastatic rectal cancer, further prospective evaluation is needed [12].

Conflicts of interest statement

No potential conflicts of interest.

References


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Available online 10 March 2010