Up to date: evidenze della letteratura internazionale riguardo indicazioni e risultati della chirurgia laparoscopica del retto

Matteo Franceschi M.D.
Chirurgia laparoscopica del retto stato dell’arte su risultati a breve e lungo termine

• SHORT-TERM OUTCOME
• LONG-TERM OUTCOME
• RAPPORTO OUTCOME/CASE LOAD
• TEAM MULTIDISCIPLINARE
Short-term outcomes

METANALISI:

- AZIZ ET AL. 2006
  Laparoscopic Versus Open Surgery for Rectal Cancer: A Meta-Analysis

- OHTANI ET AL. 2011
  A Meta-analysis of the Short- and Long-Term Results of Randomized Controlled Trials That Compared Laparoscopy-Assisted and Conventional Open Surgery for Rectal Cancer

ACS NSQIP 2011:

RCT:

Laparoscopic versus open surgery for rectal cancer (COLOR II): short-term outcomes of a randomised, phase 3 trial

Randomized Trial of Laparoscopic-Assisted Resection of Colorectal Carcinoma: 3-Year Results of the UK MRC CLASICC Trial Group

JOURNAL OF CLINICAL ONCOLOGY
Short-term outcomes

Caratteristiche degli studi

Laparoscopic Versus Open Surgery for Rectal Cancer: A Meta-Analysis

Omer Aziz, MRCS, BSc, Vasilis Constantinides, MBBS, Paris P. Tekkis, MD, FRCS, Thanos Athanasiou, PhD, FECTS, Sanjay Purkayastha, MRCS, BSc, Paraskevas Paraskeva, PhD, FRCS, Ara W. Darzi, FRCS, KBE, and Alexander G. Heriot, MD, FRCS

Endpoints: operative outcomes, postoperative recovery, and early and late adverse events.

in this analysis. Twenty studies published between 1993 and 2004 that matched the selection criteria and compared laparoscopic rectal cancer surgery with open rectal cancer surgery for rectal cancer were therefore included in this meta-analysis. These included a combined total of 2071 subjects, of which 909 (44%) underwent laparoscopic rectal cancer surgery and 1162 (56%) underwent open rectal cancer surgery. In this analysis, CLASICC reported conversion rate: 34%!

Major weaknesses:

• Patients not matched for tumour grade, stage and adjuvant treatment, all factors affecting outcomes
• Only 3 prospective randomized trials
• Only 1 trial focused on rectum (CLASICC)
A Meta-analysis of the Short- and Long-Term Results of Randomized Controlled Trials That Compared Laparoscopy-Assisted and Conventional Open Surgery for Rectal Cancer

Hiroshi Ohtani · Yutaka Tamamori · Takashi Azuma · Yoshihiro Mori · Yukio Nishiguchi · Kiyoshi Maeda · Kosei Hirakawa

A significant heterogeneity between studies was observed only for short-term outcomes, including operative time, duration of hospital stay, time to oral diet, and cost of surgery. In the long-term period, we found no significant

-Only studies in English were included, which may have increased the risk of language bias.
-A basic assessment of trial quality was made. Half of included studies were of low quality. It appeared that the authors did not take into account study quality when they interpreted the results of the meta-analyses.
-Statistical heterogeneity was assessed and appropriate methods were used to pool the results.
Short-term outcomes
Caratteristiche degli studi

Short-Term Outcomes after Laparoscopic-Assisted Proctectomy for Rectal Cancer: Results from the ACS NSQIP

David Yu Greenblatt, MD, MSPH, Victoria Rajamanickam, MS, Andrew J Pugely, MD, Charles P Heise, MD, FACS, Eugene F Foley, MD, FACS, Gregory D Kennedy, MD, PhD, FACS

We identified 5,420 patients who underwent proctectomy for rectal cancer from 2005 to 2009 and otherwise met inclusion criteria for the study. LAP was used in 1,040 (19.2%) and 4,380 patients had open resection. Table 1

Major limitations:

• Voluntary program (not a valid sample)
• No stratification for stage
• No volume/outcome
• NON RANDOM ASSIGNMENT OF PATIENTS TO TREATMENT
Short-term outcomes

Caratteristiche degli studi

COLOR II

Methods A non-inferiority phase 3 trial was undertaken at 30 centres and hospitals in eight countries. Patients (aged ≥18 years) with rectal cancer within 15 cm from the anal verge without evidence of distant metastases were randomly assigned to either laparoscopic or open surgery in a 2:1 ratio, stratified by centre, location of tumour, and preoperative radiotherapy. The study was not masked. Secondary (short-term) outcomes—including operative findings, exclusion of patients with T3 rectal cancer within 2 mm from the endopelvic fascia or T4 cancers. Therefore, the findings in this study are not applicable to all patients with rectal cancer.

Lancet Oncol 2013; 14: 210–18

1103 pts
699 lap operations

Laparoscopic and open procedures weren’t necessarily performed by the same surgeon

COREAN trial

Methods Between April 4, 2006, and Aug 26, 2009, patients with cT3N0-2 mid or low rectal cancer without distant metastasis after preoperative chemoradiotherapy were enrolled at three tertiary-referral hospitals. Patients were randomised 1:1 to receive either open surgery (n=170) or laparoscopic surgery (n=170), stratified according to sex and preoperative chemotherapy regimen. Short-term outcomes assessed were involvement of the circumferential

Lancet Oncol 2010; 11: 637–45

340 pts
50% lap operations
Short-term outcomes
Caratteristiche degli studi

Performed early on the learning curve:

• high conversion rate (33% -> 18%)

• CRM + (12% vs 5%) -> DFS and OS = a 7 anni
# Short-term outcomes

<table>
<thead>
<tr>
<th>1. PERIOPERATORI</th>
<th>2. ESITI</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Tempi chirurgici</td>
<td>• Mortalità periperatoria</td>
</tr>
<tr>
<td>• Numero di linfonodi</td>
<td>• Durata degenza</td>
</tr>
<tr>
<td>• Perdite ematiche stimate</td>
<td>• Deiscenza anastomotica</td>
</tr>
<tr>
<td>• Positività margine circonferenziale (CRM)</td>
<td>• Canalizzazione</td>
</tr>
<tr>
<td>• Tasso di conversione</td>
<td>• Ripresa dell’alimentazione</td>
</tr>
</tbody>
</table>
### Short-term outcomes

#### 1. PERIOPERATORI

<table>
<thead>
<tr>
<th>Study</th>
<th>operative time</th>
<th>Number of LN harvested</th>
<th>blood transfusion/estimated blood loss</th>
<th>Positive CRM</th>
<th>Conversion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>lap</td>
<td>open</td>
<td>lap</td>
<td>open</td>
<td>lap</td>
</tr>
<tr>
<td>Aziz et al.</td>
<td>Lap &gt; 40,18 min</td>
<td>no significative difference</td>
<td>no significative difference</td>
<td>9,5%</td>
<td>10,8%</td>
</tr>
<tr>
<td>Ohtani et al.</td>
<td>Lap &gt; 40,96 min</td>
<td>no significative difference</td>
<td>Favours laparoscopy &lt; 123mL</td>
<td>no sign diff</td>
<td>NA</td>
</tr>
<tr>
<td>ACS NSQIP</td>
<td>242 min</td>
<td>219 min</td>
<td>NA</td>
<td>NA</td>
<td>no significative difference</td>
</tr>
<tr>
<td>CLASICC</td>
<td>180 min</td>
<td>135 min</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>COREAN</td>
<td>245 min</td>
<td>197 min</td>
<td>18</td>
<td>17</td>
<td>200 mL</td>
</tr>
<tr>
<td>COLOR II</td>
<td>240 min</td>
<td>188 min</td>
<td>13</td>
<td>14</td>
<td>200 mL</td>
</tr>
</tbody>
</table>
## Short-term outcomes

### Study

<table>
<thead>
<tr>
<th>Study</th>
<th>Perioperative mortality</th>
<th>Time to stoma functioning</th>
<th>Feeding solids</th>
<th>LOS (days) Length osp stay</th>
<th>Anastomotic leak rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>lap</td>
<td>open</td>
<td>lap</td>
<td>open</td>
<td>lap</td>
</tr>
<tr>
<td>Aziz et al.</td>
<td>3,1%</td>
<td>3,2%</td>
<td>&lt; 1,72 days</td>
<td>&lt; 1,52 days</td>
<td>Lap &lt; 4,74</td>
</tr>
<tr>
<td>Ohtani et al.</td>
<td>no significative difference</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>ACS NSQIP</td>
<td>0,6%</td>
<td>1,1%</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>CLASICC</td>
<td>4%</td>
<td>5%</td>
<td>NA</td>
<td>NA</td>
<td>6 days</td>
</tr>
<tr>
<td>COREAN</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>85h</td>
</tr>
<tr>
<td>COLOR II</td>
<td>1%</td>
<td>2%</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>
Objectives

To evaluate whether there are any relevant differences in safety and efficacy after elective LTME, for the resection of rectal cancer, compared with OTME.

80 studies were identified of which 48 studies, representing 4224 patients, met the inclusion criteria. Methodological quality of most of the included studies was poor; three studies were grade 1b (individual randomised trial), 12 grade 2b (individual cohort study), 5 grade 3b (individual case-control study) and 28 grade 4 (case-series). As only one RCT described primary outcome, 3-year and 5-year disease-free survival rates, no meta-analyses could be performed. No significant differences in terms of disease-free survival rate, local recurrence rate, mortality, morbidity, anastomotic leakage, resection margins, or recovered lymph nodes were found. There is evidence that LTME results in less blood loss, quicker return to normal diet, less pain, less narcotic use and less immune response. It seems likely that LTME is associated with longer operative time and higher costs. No results of quality of life were reported.
Long-term outcome

Scarse evidenze tuttavia...

Cochrane 2012: laparoscopic surgery for cancer of the upper rectum is feasible.

*Long term results of COLORECTAL cancer resection*

**Metanalisi: Ohtani et al.**

<table>
<thead>
<tr>
<th>Study</th>
<th>number of cases</th>
<th>Overall Survival</th>
<th>DFS (70 months)</th>
<th>Local Recurrence (10 years)</th>
<th>Distant Metastasis (10 years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLASICC</td>
<td>189</td>
<td>lap</td>
<td>no sign diff</td>
<td>no sign diff</td>
<td>no sign diff</td>
</tr>
<tr>
<td></td>
<td>87</td>
<td>open</td>
<td>no sign diff</td>
<td>no sign diff</td>
<td>no sign diff</td>
</tr>
</tbody>
</table>
Long-term outcome

Long-Term Morbidity and Oncologic Outcomes of Laparoscopic-Assisted Anterior Resection for Upper Rectal Cancer: Ten-Year Results of a Prospective, Randomized Trial

Simon S. M. Ng, F.R.C.S.Ed.(Gen.) • Ka Lau Leung, M.D., F.R.C.S.(Edinb.)
Jimmy C. M. Li, F.R.A.C.S. • Sophie S. F. Hon, F.R.C.S.Ed.(Gen.)


METHODS: From September 1993 to October 2002, 153 patients with upper rectal cancer were randomly assigned to receive either laparoscopic-assisted (n = 76) or open (n = 77) anterior resection. Patients were last followed up in December 2007. Long-term morbidity, survival, and disease-free interval were prospectively recorded. Data were analyzed by intention-to-treat principle.
Long-term outcome

TABLE 4. Crude incidence of long-term morbidity

<table>
<thead>
<tr>
<th>Condition</th>
<th>Lap group (n = 74)</th>
<th>Open group (n = 74)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adhesion-related bowel obstruction</td>
<td>2 (0)</td>
<td>14 (5)</td>
</tr>
<tr>
<td>Incisional hernia</td>
<td>4 (4)</td>
<td>5 (2)</td>
</tr>
<tr>
<td>Parastomal hernia</td>
<td>1 (1)</td>
<td>0</td>
</tr>
<tr>
<td>Rectovaginal fistula</td>
<td>1 (1)</td>
<td>0</td>
</tr>
<tr>
<td>Total number of patients with long-term morbidity (%)</td>
<td>8 (10.8%)</td>
<td>19 (25.7%)</td>
</tr>
<tr>
<td>Total number of patients requiring operation for long-term morbidity (%)</td>
<td>6 (8.1%)</td>
<td>7 (9.5%)</td>
</tr>
</tbody>
</table>

Patients with operative mortality (2 in the Lap group and 3 in the Open group) were excluded from analysis. Data in parentheses are number of patients requiring reoperation unless otherwise indicated.

FIGURE 3. Cumulative probability of adhesion-related bowel obstruction ($P = 0.001$, log-rank test).

FIGURE 4. Cumulative probability of incisional hernia ($P = 0.520$, log-rank test).

FIGURE 5. Overall survival after curative resection ($P = 0.303$, log-rank test).
Figure 5. Temporal summary of expert opinion in the literature pertaining to laparoscopic surgery for rectal cancer.
doi:10.1371/journal.pone.0035292.g005
Recommendations

- Laparoscopic (including laparoscopically assisted) resection is **recommended as an alternative to open resection** for individuals with colorectal cancer in whom **both laparoscopic and open surgery are considered suitable**.

- Laparoscopic colorectal surgery should be performed only by surgeons who have completed **appropriate training in the technique and who perform this procedure often enough to maintain competence**. The exact criteria to be used should be determined by the relevant national professional bodies. Cancer networks and constituent trusts should ensure that any local laparoscopic colorectal surgical practice meets these criteria as part of their clinical governance arrangements.

- The decision about which of the procedures (open or laparoscopic) is undertaken should be made after informed discussion between the patient and the surgeon. In particular, they should consider:
  - the suitability of the lesion for laparoscopic resection
  - the risks and benefits of the two procedures
  - the experience of the surgeon in both procedures.
Laparoscopic extraperitoneal rectal cancer surgery: the clinical practice guidelines of the European Association for Endoscopic Surgery (EAES)

Laparoscopic surgery for middle and low rectal cancer can be recommended under optimal conditions (expert surgeons, expert centres, selected patients, excluding T4). (85.7% [Consensus]; GoR B: 85.7% [Consensus])

The vast majority of the panel would recommend the laparoscopic approach for rectal cancer surgery. Still, upcoming results from large randomised trials are awaited to strengthen the evidence for improved short-term results and equal long-term results in comparison with open surgery.
Laparoscopic Proctectomy for Curable Cancer

The American Society of Colon and Rectal Surgeons (ASCRS) and the Society of Gastrointestinal and Endoscopic Surgeons (SAGES) recognize that laparoscopic proctectomy may be an alternative to traditional resection of benign disease involving the rectum. The absence of five-year survival data makes it premature to endorse laparoscopic proctectomy for curable cancer.

Laparoscopic proctectomy must follow traditional surgical principles and standards including adequate mesorectal excision and the achievement of appropriate clear margins.

It is only appropriate to perform laparoscopic proctectomy for curable cancer in an environment where the outcomes can be meaningfully evaluated until laparoscopic approaches have been shown to be as efficacious as open approaches. The ASCRS and SAGES encourage the development of properly designed studies to evaluate the safety, efficacy, and benefits of this approach.

The ASCRS and SAGES consider laparoscopic proctectomy to be within the expertise of trained surgeons who focus on the treatment of rectal cancer. Development of this expertise should include observation of procedures, laboratory experience and graduated clinical responsibility as mentioned in published guidelines1,2.

1. Guidelines for Laparoscopic Resection of Curable Colon and Rectal Cancer. SAGES publication #32
The best is yet to come...

- COLOR II Trial: long term outcome

- Randomized Controlled Trial to Evaluate Laparoscopic Surgery for Colorectal Cancer: Japan Clinical Oncology Group Study JCOG 0404 (2005)

- Prospective randomized non inferiority trial – laparoscopic vs open surgery for rectal cancer ACOSOG-Z6051 American College of Surgeons Oncology Group (2008)
Results for rectal cancer

- significant association between high volume hosp and better 5 years DFS
- significant association between high volume hosp and lower rates of permanent stomas
- no difference in operative

Overall quality of the evidence was low as all included studies were observational by design. In addition there were discrepancies in the definitions of caseload and colorectal specialist. However ethical challenges associated with the conception of randomised controlled
No difference between lowest and highest volume hospitals in outcome after colorectal cancer surgery in the southern Netherlands

F.N. van Erning a,*, L.N. van Steenbergen a, W.T. van den Broek b, H.J.T. Rutten c,d, V.E.P.P. Lemmens a,c

Eindhoven Cancer Registry, Comprehensive Cancer Centre South, P.O. Box 231, 5600 AE Eindhoven, The Netherlands
b Department of Surgery, St. Anna Hospital, Bogaarde 2, 5664 EH Geldrop, The Netherlands
c,d Department of Surgery, Catharina Hospital, P.O. Box 1350, 5602 ZA Eindhoven, The Netherlands
d Department of Surgery, Maastricht University Medical Centre, P.O. Box 5800, 6202 AZ Maastricht, The Netherlands
e Department of Public Health, Erasmus MC University Medical Centre, P.O. Box 2040, 3000 CA Rotterdam, The Netherlands

Accepted 14 August 2013

Dubbi

• High volume hospitals (>=130) less T1 and more T4
• High volume hospitals more comorbidities
• High volume hospitals more preop CRT and less postop RT
• 23% of patients with locally advanced rectal cancer (LARC) diagnosed in a low volume centre was referred to a high volume centre
Laparoscopic versus open surgery for the treatment of colorectal cancer: a literature review and recommendations from the Comité de l’évolution des pratiques en oncologie

Mélanie Morneau, MSc,* Jim Boulanger, PhD,† Patrick Charlebois, MD,‡ Jean-François Latulippe, MD,§ Rasmy Lougnarath, MD,¶ Claude Thibault, MD,** and Normand Gervais, MD††, For the Comité de l’évolution des pratiques en oncologie


One prospective and 3 retrospective trials evaluated the impact of surgeon experience on oncologic outcomes following rectal cancer resection.

operative duration decreased significantly with the number of interventions performed.

Park and colleagues observed a plateau after 90 interventions followed by a decrease in operative duration...

Ito and colleagues reported that operative duration decreased from 228 to 179 minutes after more than 40 interventions...........

All 4 trials also showed a significant decrease in postoperative morbidity as the surgeon gained more experience (after 30–60 interventions had been performed..)
Dati AOUP (base dati SDO 2011-7/2013)

Diagnosi principale Like "154*"
Codice procedura Like "486*" Or Like "485*" Or Like "484*" Or Like "4835" and like"5421" or like "003*"

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2011-13</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>tot</td>
<td>lap</td>
<td>rob</td>
<td>APR</td>
</tr>
<tr>
<td>chirurgia Buccianti</td>
<td>64</td>
<td>44</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>chirurgia A</td>
<td>22</td>
<td>4</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>chirurgia B</td>
<td>11</td>
<td>7</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>chirurgia C</td>
<td>13</td>
<td>6</td>
<td>0</td>
<td>5</td>
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<tr>
<td>chirurgia D</td>
<td>18</td>
<td>8</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>chirurgia E</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>AOUP</td>
<td>132</td>
<td>69</td>
<td>8</td>
<td>25</td>
</tr>
</tbody>
</table>
Ruolo del team multidisciplinare

Survey involving 123 international experienced colorectal surgeons
**Table 1** Guideline recommendations for radiologic T staging and neoadjuvant treatment of rectal cancer [2, 6–8, 10, 11]

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>T1–2, N0</td>
<td>No neoadjuvant treatment</td>
<td>MDTs significantly influence preoperative decision-making (Table 6). Interestingly, regular MDT meetings significantly influence decisions on choice of staging modality, neoadjuvant treatment, and several other critical factors in the preoperative planning of rectal cancer treatment. We believe that regular MDT meetings will improve guideline adherence and quality of rectal cancer care, as</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>T3, N0 or T any, N1–2 (stage II or III)</td>
<td>RCT</td>
<td>No neoadjuvant treatment</td>
<td>RCT midrectal T3 with CRM &lt; 5 mm. All low rectal T3</td>
<td>RCT to mid and low T4 See T3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>T4</td>
<td>RCT</td>
<td>Radiation or RCT when CRM &lt; 3 mm</td>
<td>NA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CRM</td>
<td>NA</td>
<td>NA</td>
<td>CRM &lt;1 mm</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*NCCN National Comprehensive Cancer Network, ERUS endoscopic rectal ultrasound, CRM circumferential margin, NA no information, RCT chemoradiotherapy*
Esame eseguito con tecnica 2D e 3D previa introduzione rettale di soluzione idrica. Si evidenzia neoformazione rettale di cui si descrivono i seguenti reperti:

- **Sede** (retto alto, medio, basso): retto alto
- **Estensione longitudinale**: 68mm
- **Coinvolgimento parietale (ore 1-12)**: circonferenziale
- **Spessore massimo**: 12mm
- **Stenosi del lume (<50%; >50%)**: >50%
- **Distanza tra margine distale della lesione e muscolo pubo-rettale**: 67mm
- **Estensione dell'invasione extramurale**: 5mm
- **Morfologia infiltrativa (nodulare/infiltrante)**: infiltrante alle ore 3-4
- **Distanza minima tra margini extramurali della lesione e fascia mesorettale**: 14mm alle ore 4 con adesione alla fascia mesorettale.
- **Rapporti con muscoli elevatori (nessun contatto/contatto/infiltrazione)**: nessun contatto
- **Rapporti con i vasi extramurali (nessun contatto/contatto/infiltrazione)**: infiltrazione
- **N. Linfonodi mesorettali / distanza dalla fascia mesorettale**: almeno 3 linfonodi di 1-4mm in sede presacrale
REFERTO ECOGRAFICO STRUTTURATATO

Pisa DATA

Sig. COGNOME NOME data di nascita

ECOGRAFIA TRANS RETTALE 3D

Eco rettale eseguito con sonda rotante 360° 2050 ed ecografo Pro Focus BK Medical.

Esame eseguito in decubito laterale sinistro per restadiazione di lesione del retto recentemente sottoposta a trattamento chemio-radioterapico.

A circa 100 mm dal margine anale, a circa 60 mm dal margine superiore del muscolo puborettale, si reperta la neoformazione nota, che si estende cranialmente per circa 30 mm da ore 12 a ore 2. La lesione appare interessare la parete del viscere a tutto spessore, con interessamento del tessuto perirettale per circa 3 mm. Si apprezzano multipli linfonodi perilesionali il cui diametro massimo misura 9 mm.

uT3bN+

Dr. Riccardo Balestri
REFERTO ISTOLOGICO

Data accettazione: Esame:

PAZIENTE: 

Data di Nascita: 

Provenienza: U.O. CHIRURGIA GENERALE - AZIENDA OSPEDALIERO UNIVERSITARIA PISANA 

Medico richiedente: DR. BUCCIANTI 

MATERIALE PERVENUTO: 
1) Retto-sigma
2) Trancia di sezione prossimale
3) Trancia di sezione distale

ESAME MACROSCOPICO: 
1) Retto-sigma di 19 cm con neoplasia a placca della parete laterale sinistra e posteriore del retto di 2,2x2 cm a 1,5 cm di distanza dal margine di resezione rettale (TD1-3; TS1-3: macrosezioni). Linfonodi rettali (NR1-2). Linfonodi sigmoidei (NS1-3).
2) Trancia prossimale di 1 cm (A1-2).
3) Trancia distale di 0,6 cm (B1-2).

DIAGNOSI: 
Tipo istologico: adenocarcinoma (TD1-3; TS1-3).
Grado istologico: moderatamente differenziato (G2).
Estensione dell'invasione tumorale: infiltrante il tessuto adiposo periviscerale.
Pattern di crescita tumorale: infiltrativo.
Invasione vascolare: assente.
Invasione perineurale: assente.
Tumor budding: presente.
Infiltrato linfocitario peritumorale: presente.
Infiltrato linfocitario intratumorale: presente.
Margini di resezione chirurgica prossimale (A1-2) e distale (B1-2) indenni da infiltrazione neoplastica.
Margine radiale non raggiunto dalla neoplasia (distanza minima 1,1 cm)
Stato dei linfonodi: dodici linfonodi perirettali (TD1; TD3; TS3; NR1-2) e quindic linfonodi perisigmoidei coniperplasia reattiva (NS1-3).
yT3(G2)N0Mx

Grado di Quirke II (escissione mesorettale moderata)
Margine radiale indenne (distanza minima 1,1 cm)
TRG2 (sec. Dworack)
La nostra casistica

242 casi di tumori del retto asportati con tecnica TME (da Marzo 2008 a Aprile 2014)

158 maschi    84 femmine

età media: 66 anni

205 Quirke 3  (84.7%)
31 Quirke 2  (12.8%)
6 Quirke 1  (2.5%)

13 pz con margine circonferenziale raggiunto
Conclusioni

- IL TRATTAMENTO DEL CANCRO DEL RETTO È COMPLESSO E DEVE ESSERE AFFRONTATO SOLO NELL’AMBITO DEI GRUPPI ONCOLOGICI MULTIDISCIPLINARI

- LA CHIRURGIA DEL RETTO È COMPLESSA E DEVE ESSERE VALUTATA NEI RISULTATI INDIPENDENTEMENTE DALLA METODICA USATA

- LA LAPAROSCOPIA NON È INFERIORE ALL’OPEN NEI RISULTATI A BREVE TERMINE
Grazie per l’attenzione