Rectal cancer with synchronous liver mets: A challenging clinical case

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Servier, Roche, Genentech, Bayer, Janssen, Merck Serono, Medimmune
62 year old male
No previous diseases or comorbidities
Constipation and rectal bleeding
False diarrhea and tenesmus
No weight loss
PS 1
Physical examination

- No peripheral lymph nodes
- No hepatomegaly
- No ascites
- No pleural effusion
- DRE: Fixed tumor at 3 cm from the anal verge involving 3/4 of the circumference
• Rigid rectoscopy: a fixed tumor at 3 cm from the anal verge obstructing $\frac{3}{4}$ of the circumference
• Biopsy: poorly differentiated invasive adenocarcinoma of the rectum
• Colonoscopy: Tumor at 5 cm. Flexible colonoscopy able to surpass the rectal mass reaching the cecum. No synchronous polyps.
Diagnostic tests-2

- CBC: no anemia
- Biochemistry: within normal range. No liver alterations.
- CEA: 12.9 ng/ml
- Thorax CT scan: No lung mets
- Abdomino-pelvic CT-scan: 9 liver metastatic nodes involving both liver lobes
Abdominal CT-scan
Current approach to localized rectal cancer

• MRI Staging
• MDT discussion
• Preoperative chemoradiation if indicated
• TME Surgical resection
• Pathology assessment and estimation of risk
• Postoperative chemotherapy if indicated
Magnetic resonance imaging
Magnetic resonance imaging
Magnetic resonance imaging report

- Bulky rectal tumor below the levators and located at 1 cm from the anal verge
- Several nodes with suspected neoplastic involvement and tumor involving the mesorectal fascia
- Invasion by tumor of mesorectal fascia at the anterior and lateral left side
- Left puborectal muscle involved
- No prostatic involvement, but very close to Denonvilliers fascia
- No extramural vascular invasion
- No lateral pelvic nodes (extramesorectal)
• Symptomatic locally advanced rectal cancer
• 62-year old male
• Extensive and unresectable liver only metastatic disease
• All RAS and BRAF wild-type
• Fit patient without comorbidities
• Do not miss any opportunities
Your treatment plan:

1. Chemoradiation followed by CT
2. Chemotherapy + anti-EGFRs only
3. 5x5 Radiation followed by Chemo
4. TME up front plus Chemo
5. Liver resection plus chemoradiation
Your treatment plan:

- Chemoradiation followed by CT
- Chemotherapy + anti-EGFRs only
- 5x5 Radiation followed by Chemo
- TME up front plus Chemo
- Liver resection plus chemoradiation
Current approach to localized rectal cancer

- MRI Staging
- MDT discussion
- Preoperative chemoradiation or 5x5 radiation if indicated
- TME Surgical resection
- Pathology assessment and estimation of risk
- Postoperative chemotherapy if indicated
Treatment plan

- Radiation 5x5 Gy was given for symptomatic purposes
- Chemotherapy was started two weeks later within a randomized phase II trial with FOLFOX-Bev +/- experimental agent
- Assessment of response was considered 8 weeks after starting FOLFOX-Bev
Assessment of primary tumor by Magnetic Resonance Imaging
Assessment of primary tumor

- Asymptomatic
- Disappearance of all previous symptoms
- DRE: no mucosal damage
- Rigid rectoscopy: Normal appearance with no residual ulcer or scar
- Endoscopic ultrasonography: no disruption of bowel layers
Assessment of liver mets by CT-scan
Your treatment plan:

1. Liver surgery followed by TME
2. TME followed by liver surgery
3. Liver surgery and surveillance for the primary rectal tumor
4. No further therapy and reintroduce treatment upon progression
Your treatment plan:

- Liver surgery followed by TME
- TME followed by liver surgery
- Liver surgery and surveillance for the primary rectal tumor
- No further therapy and reintroduce treatment upon progression
Treatment plan

- Liver surgery was planned after 8 courses of FOLFOX-Bev plus 4 courses FULV-Bev
- A right hepatectomy after right hepatic artery embolization was performed 6 weeks after the last dose of Bevacizumab
- Surveillance and follow up for the primary rectal tumor
- No postoperative ChT was considered
Assessment of liver surgery

- Hospitalized for 7 days
- No liver damage: steatosis, steatonecrosis or sinusoidal occlusive disease
- A pCR was defined in the pathology report
- Multiple scar areas with no rest of malignant cells
Follow up plan

• Rectal exam plus proctoscopy plus MRI every 4 months
• CT-scan every three months
• No evidence of progression 20 months after diagnosis
CONCLUSIONS

• Locally advanced rectal cancer with synchronous multiple liver only metastatic disease
• Multidisciplinary discussion essential for all rectal cancer cases: at start and during treatment or follow up
• Do not miss any opportunities for your patients
• 5x5 Radiation plus CT may induce clinical CRs
• After chemotherapy, liver resection recommended if mets become resectable
• Surveillance of the primary tumor as an emerging option
• So far successful multimodality treatment
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