Treatment and complications in Metastatic Rectal Cancer
DISCLOSURE OF INTEREST

- No disclosures.
Background

- 62 year old woman.
- Hypertension May 2018. (treatment related)
- Family history: Brother 49 Colon cancer; Daughter 21 Carcinoid lung cancer (No Lynch syndrome)

Clinical Symptoms: Rectal tenesmus. Bowel habit alteration.

Colonoscopy March 3, 2018: Neo-formation at 10cm from anal verge which occupied all the circumference with luminal stenosis. Biopsy: High grade dysplasia → Rectal Adenocarcinoma. CEA: 5,8

HR Pelvic MRI March 9, 2018: T4N2 stenosing voluminous rectal tumor with an extension of 6-7 cm depending on the posterior aspect of the rectum which infiltrated and surpassed the muscularis propria. Solid spiculated growth with an extensive infiltration of the posterior mesorectal fascia. Pathological adenopathies in left external iliac territory. (Stage IIIC 8th ed.)

Ch-A-P CT-Scan March 12, 2018: No distant metastasis.

MDT

Preoperative treatment: CAPEOX (4) followed by long-course CRT (Pelvis irradiation with integrated boost at 180 / 214cGy / fraction / day until total dose of 45750cGy. Treatment administered between 04/25/18 – 06/01/2018.)

HR MRI July, 2018: Middle third rectum tumor with moderate response to treatment, radiological stage T4aN1, mr-vTRG3 and mrTRG3. (Stage IIIB 8th ed.)

Ch-A-P CT-Scan July, 2018: No distant metastasis.

Laparotomy July 31, 2018: Middle third rectum neoplasm that infiltrated sacrum and left lateral wall (unresectable). Colostomy.
Treatment and Complications


- Due to Distant Relapse after surgery recovery (09/28/2018), (now a stage IV rectal cancer (lung metastasis)), received systemic treatment Bevacizumab 5 mg/kg+FOLFOX between October 10, 2018 and Nov 2, 2018.

- November 15, 2018 was diagnosed of an evolved thrombosis of the external iliac, common femoral, superficial femoral and left popliteal veins. LMWH anticoagulation was given, which required dose reduction due to a rectal bleeding episode.

- Continued treatment with Bevacizumab 5 mg/kg+FOLFOX between Nov 22, 2018 and March 7, 2019.

- December 19, 2018 SD.

- February 1, 2019 Port-a-Cath® withdrawal due to left subclavian thrombosis; insertion of a new one in April 2019 in contralateral subclavian vein.

- March 12, 2019 lung metastatic DP.

09/28/2018 03/12/2019
Radiotherapy or anti-angiogenic…or both?

- Initiated with FOLFIRI+Aflibercept 4mg/kg April 8, 2019.
- Hospitalized between May 15-21, 2019 due to spontaneous rectal bleeding preciseing heparin dose reduction and withdrawal of Aflibercept.
- Received last dose of FOLFIRI in May 22, 2019 after recovery.

- Between June 4th and 6th new rectal bleeding episode and also through colostomy with no hemodynamic repercussion.
- CT Scan June 7: Locally advanced rectal tumor with fistulization towards collection in the presacral space. Stable pulmonary disease.
- June 18 Hb 8.7 (previous 12.5)
- June 19 Rectoscopy/colonoscopy
Now what?

- Surgery and radiotherapy were not a viable option.
- BSC?
- 06/21/2019: An embolization was carried out with a super selective approach of the superior hemorrhoidal artery with particles of 500-700 microns. The final control shows embolization of this artery, respecting the vascularization of the sigmoid and left colic branches of the inferior mesenteric artery.

- July 10, continued FOLFIRI without Aflibercept. Received 3 more cycles and stopped due to right subclavian vein thrombosis, requiring Porth-A-Cath® withdrawal in August 30.
- August 28th: treatment strategy changed to Irinotecan+Capecitabine as another Porth-A-Cath® insertion was dismissed.
- October 17th: DP with new lung metastases.
- October 30th: Lonsurf® was requested.
- Patient maintains ECOG-PS 1.
Thank you for your attention!