



QUALITY IN ENDOSCOPY

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COLONOSCOPY &
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THE GREAT DEBATE 6

Colorectal stenting for advanced colorectal carcinoma - CONTRA

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Name: Philippe Rougier, ESDO board
Institution: L'Université Paris Descartes
Country: Paris, France





european society of digestive oncology

Colonic stents, contra

Philippe ROUGIER

ESDO board

Université de Paris V, René Descartes

Hépatogastroentérologie &

Digestive Oncology

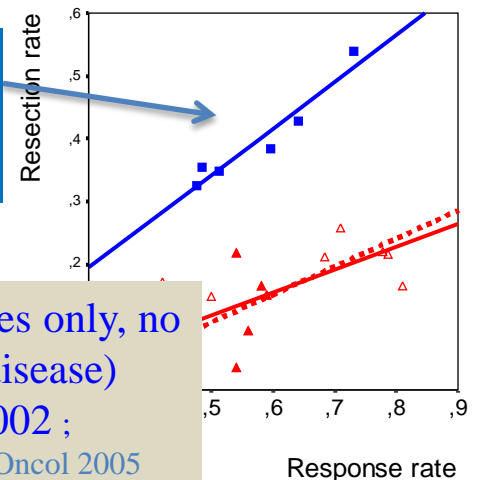
CHU HEGP, APHP, Paris, France



Introduction: CRC in occlusion

- **70% of colonic stenosis are related to cancer and # 10% of colonic cancer are revealed by an occlusion** (only clinical & radiological diagnosis must be considered +++).
- **Stent and occlusion=> 2 situations:**
 - metastatic CRC => stent for palliation ?
 - « a priori » curable CRC=> stent as « bridge to surgery » ?
- **Other therapeutic options in emergency:**
 - Immediate surgery: resection (high morbidity) vs colostomy (much less morbidity ...)
 - Medical management + early start of chemotherapy
(Response Rate $\geq 50\%$; FOLFIRINOX # 70%)

Secondary resections



liver metastases only, no extrahepatic disease)

($r=0.96$; $p=0.002$;

Folprecht G, Ann Oncol 2005

Response rate

Management of CRC in occlusion: Optimal Treatment ?

1- Synchronous metastases (Stage IV) => best Palliation ?

- Early administration of chemotherapy when possible +++.
- Preservation of chances for secondary resections after chemotherapy
- In elderly patients (> 75 year-old)
 - Chemotherapy is as efficient as in younger patients if they fit for medical treatments...
 - In elderly patients, PS 3-4, etc TT must favor quality of life

=> Importance of a multidisciplinary discussions in all cases with all concerned specialists... and patients' wishes

ESGE CLINICAL GUIDELINE: Self-expandable metal stents for obstructing colonic and extra-colic cancer (experts opinion, J Von Hoft et al.)

MAIN RECOMMENDATIONS

In METASTATIC PATIENTS

1- Prophylactic colonic stent placement is not recommended... reserved for patients with symptoms and imaging evidence of large bowel obstruction, without signs of perforation . (strong recommendation, low quality of evidence).

• ...

4- SEMS placement is recommended as the preferred treatment for palliation of malignant obstruction (strong recommendation, high quality of evidence), **except in patients treated or considered for treatment with anti-angiogenic drugs (e.g. bevacizumab)** (strong recommendation, low quality of evidence).

1- Strategy for CRC with Synchronous Metastasis (M) ?

standard rules (experts opinion & ESMO and French guidelines)

- **In absence of occlusion: no indications for colonic stent... even in symptomatic patients .**
- **Active chemotherapy: = > 2-year survival: # 50%**
 - responses > 50% on primary T and M,
 - allows secondary resection of M in # 20%.
- **Curative resection of the primary must be facilitated**
(patients in good PS and liver limited metastasis...)
- **Interest of multidisciplinary staff with gastroenterologists, surgeons and oncologists ...**

Colonic stent in palliative situation: NY experience*

168 pts in the palliative group (1999-2008)

- Immediate technical and clinical success: 96% & 99%
- **Long term outcomes: 41 complications: # 25%**
 - Perforation: 9% ; Occlusions: 9% ; Migration: 5% ; Erosion/ulcer: 2%
 - Clinical success at 6 months: 77%
- **Mean stent patency: only 4.5 months (145 days)...**
 - 108 / 122 (88.5%) free from obstruction (implantation – death)
- **Prognostic factors for complications**
 - Intraluminal lesions: 19 => **27%**
 - Bevacizumab: 23 => **35% (# risk of perforation x 3)**
 - Distal colon placement: 13 => **27%**

Colorectal stents vs Colostomy: NS

3 randomised studies (low power)

1- **N = 15 pts in each arm.** success rates : 93 % ; until death : 53 %

• OS median : 21,4 (STENT) vs 20,9 months (colostomy)

• Hospital stay : mean 28 vs 60 d

Xinopoulos, Surg Endosc 2004

3- **N= 11 and 11 in each arm.**

• OS median : 297 d (STENT) vs 280months (colostomy)

• Hospital stay : mean 2-4 d vs 8 d (7-10)

Fiori, Anticancer Res 2004

2- **N=21 pts: Dutch Stent – multicentric:** 10 stents vs 11 surgery

– Stopped for overmortality in STENT arm

– 6 perforations → 3 deaths (stent type ?)

van Hooft, Lancet 2006; van Hooft, Endoscopy 2008



Colorectal stents vs Colostomy: 2 systematic reviews (low power, not on individual data)

1- Liang (2014) : 9 studies ; 3 Random

Liang , Surg Today 2014

high success rates : 94 % ; higher late complications: 16 % vs 8%

Shorter hospitalization (-6.07 days)

2- Zhao (2013) : 13 trials ; 3 Random

Gianotti et al, Surg End 2013

Same results , same overall survival (7.6 vs 7.9 mths)

Mean time to chemotherapy: SEMS: 15.5 d vs 33.4 d

But no information on the proportion of patients who effectively received chemotherapy...

Strategy with immediat (or early) resection of the primary must be favored when feasible

- **Kaufman: 115 pts out of 185 had palliative surgery:**

=> Better survival if surgery of the primary ($p < 0.0001$)

And if surgery + chemo (30 mths vs 15) ($p < 0.0004$)

(Kaufman et al. Colorectal Dis 2008 ; 10: 498-502).

- **Karoui: 208 pts with synchronous unresectable M CRC.**

=> better survival (univariate):

- **1^{ary} colectomy*** ($p=0.031$) ; **2^{ary} curative surgery*** ($p < 0.001$)
- well differentiated tumor* ($p < 0.001$) ; exclusive liver metastases* ($p < 0.027$)
- **absence of colonic stent ($p=0.009$) ;**
- **addition of antiangiogenic*** ($p=0.001$) or anti EGFR ($p=0.013$)

* positive in multivariate analysis (Karoui M et al. Dis Colon Rectum 2011).

⇒ 3 ongoing trials test the benefit of an immediat surgery in case of synchronous, non resectable, metastases

Colorectal stent in palliative situation: to avoid colostomy or resection ?

Conclusion : CONTRA

**The need of stenting appears limited...to few
very palliative indications...**

- because other active treatments are available
- because the long term results are not good !
- because randomized trials are not well powered
- because chemoth. must be favored

Management of CRC in occlusion: Optimal Treatment ?

1- Synchronous metastases (Stage IV)

2- Locally advanced CRC => Optimal curative treatment

- Must favor chances of curative resection in 1 or 2 time.
- And administration of active neoadjuvant or adjuvant chemotherapy: *(best strategy: surgery + chemoth. +/- radio-chemoth.)*

=> Importance of a multidisciplinary approach in all cases with all concerned specialists... and patients' wishes

2-Colorectal stent in curative situation: « bridge to surgery »

- **Advantage: avoid transient colostomia**
- **Feasability established since 20 years** (*Tejero, Dis col rect 1994*)
- **Tan 2012 (Cochrane) : random T ; 234 pts.** (*Br J Surg 2012*)
 - SEMS: higher successful primary anastomosis (RR: 1.58) ;
 - lower overall stoma...
 - but 3 trials stopped prematurely... 2 for morbidity...
 - => higher morbidity than expected and silent perforation
- **De Ceglie 2013:** 14 studies ; 3 Random (405 pts)
Hetrogeneity +++ ; Increase successful primary anastomosis

2-Colorectal stent in curative situation: « bridge to surgery »

Stents may have a potential «carcinological» risk

- Risk of tumor manipulation (carcinologic surgical rule)
- Risk of silent perforation.
- Risk of tumor dissemination
 - No clear clinical data, but ...poor long term results...
 - **Increase in the number of circulating tumor cells**
(*Maruthachalam, Br J Surg 2007*)

Colonic stents: contra

- 1- The benefit/risk ratio in most of the cases is low
- 2- Many indications are deleterious
- 3- Technical conditions +++ are often not met
- 4- Medical treatments and survival are often impaired after stenting. =>SEMS restricted to very old patients ?
- 5- Trials must better evaluate the long term results of colonic stents



Endoscopy 2014; 46: 546-52. ; Acta endoscopica 2014; 44: 208-18.