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Editorial

Time to Rethink Transanal Endoscopic Microsurgery for Rectal Cancer After Neoadjuvant Chemoradiation for Highly Selected Patients[☆]



Es tiempo de reconsiderar la microcirugía endoscópica transanal tras quimio-radioterapia neoadyuvante para el cáncer rectal en pacientes altamente seleccionados

Transanal endoscopic microsurgery is an attractive alternative to radical surgery in patients with rectal cancer. The minimal associated postoperative morbidity, need for temporary or definitive stomas and excellent functional outcomes have been considered the main advantages for this approach.¹ Unfortunately, oncological outcomes have been somewhat disappointing and paralleled the risk of lymph node metastases not being resected during local excision.^{2,3}

Widespread implementation of multimodality treatment with neoadjuvant chemoradiation could set the ideal scenario for a local excision among select patients with rectal cancer. The development of significant tumor regression (in size and depth of invasion) and potential sterilization of perirectal (metastatic) lymph nodes would allow safe resection of the primary residual tumor obviating the need for total mesorectal excision and proctectomy.⁴ In the present issue of the journal, an interesting study provides additional light into this controversial issue during management of these patients. Several reported findings are worth noticing including the excellent low local recurrence rates and the little or minimal postoperative associated morbidity.

However, caution should be considered before widespread implementation of this strategy into clinical practice. Besides the considerable limited sample size and inherent selection bias of the included patients, a few aspects should be considered.

First, a significant amount of these patients ultimately had complete pathological response. Despite the fact that clinical response did not precisely correlate to pCR in their study, there was still more than a third of patients that would eventually did not require any resection (not even local excision). In fact,

non-operative management of patients with cCR have been shown to result in superior functional outcomes to local excision and similar oncological outcomes.^{5,6} As a matter of fact, none of the patients with pCR developed local recurrences as one would expect. One could argue that local excision was able to detect a few false cCRs. However, assessment of tumor response at 8 weeks may have been too early among these patients as there is data to suggest that longer intervals are associated with increased pCR rates.^{7,8}

Second, the unique local recurrence was observed in a non-complete responder (ypT1). Perhaps the 4% reported local recurrence should have been considered exclusively among the non-responders (excluding pCR patients) and therefore, significantly higher than 4%. Local recurrence after local excision where no cancer has been resected will probably attest effectiveness of nCRT instead of the effectiveness of local excision. Local recurrence after local excision of residual cancers (exclusively non-responders) will definitely attest the effectiveness of local excision in this setting. With this in mind, we are ultimately attesting the effectiveness of highly selected 12 patients here (ypT1 or ypT2).

Third, local excision used to be an attractive alternative for most distal rectal cancers (<6–7 cm from the anal verge). Distal rectal cancers usually require temporary if not definitive stomas, functional outcomes are significantly worse and postoperative morbidity is also higher. Instead, the present study reports on patients that refused radical surgery harboring tumors between 6 and 7 cm.⁹ Considering the results of the MERCURY study where patients with T3a/b MR-staged and managed by TME had 1.7% local recurrence, one could argue that T3a/b (an definitely T2s) would not require any

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neoadjuvant CRT, particularly for tumors at the level of 6–7 from the anal verge.¹⁰ In fact, the considerably high location of these tumors may have contributed to the significantly low postoperative morbidity rate. Clearly, resection of lesions closer to the anal verge are more prone to postoperative pain and difficulties in healing with the limited elasticity (and consequently tension) of the anal canal previously irradiated.¹¹ Still, caution should be taken as previous studies suggests that in the event of completion TME in patients with unfavorable pathological features, there is an increased poor quality of the specimen and the risk of abdominal perineal excision (clearly among patients primarily fit for a sphincter-saving procedure).^{12,13} In fact, several studies suggest that ypT2 cancers are probably best suited for completion TME than local excision alone after CRT due to the increased risk for local recurrences.^{14,15} Finally, in the event of a local recurrence, salvage TME appears to be associated with high rates of CRM+.¹⁶

The present study suggests that nCRT followed by local excision using endoscopic platforms may result in very good outcomes in highly selected patients. Selection here included a significant amount of patients that probably did not require any surgery (complete pathological responses) or did not require any CRT (T2/early T3 higher than 6–7 cm).

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