

Editorial

Early Rectal Cancer

S. Myint

Clatterbridge Hospital, Wirral, UK

The local treatment of early rectal cancer with radiotherapy is controversial, but for T1N0M0 tumours it is now universally accepted as an appropriate alternative standard treatment to radical surgery. However, for more advanced tumours, this approach is still not generally regarded as an acceptable alternative treatment in the UK.

Over the past decade there has been increasing interest in local radiotherapy options for small tumours in the lower third of the rectum as an alternative to abdominoperineal resection. This treatment option is mainly offered to elderly patients or younger patients with medical comorbidity who are at higher anaesthetic risk. The local radiotherapy option is also attractive to a small percentage of patients who are totally averse to a stoma and accept the greater oncological risk to avoid permanent colostomy. In the UK, national guidelines currently do not recommend local radiotherapy as an alternative option to the gold standard of radical surgical treatment because there are no large randomised trials to support its efficacy. Such trials are difficult to organise due to the small number of patients with early rectal cancer at each centre. A multicentre international effort will be necessary for such a trial. This issue was discussed at the international local treatment group meeting in Paris in April 2007, and it was agreed to set up a high-quality observational phase II trial. In addition, the UK Transanal Endoscopic Microsurgery (TEM) Users Group is also planning a trial of short-course preoperative radiotherapy followed by TEM compared with radical surgery for early high-risk rectal cancer patients.

Most European rectal cancer trials include local resection as an option for patients who are downstaged after preoperative chemoradiotherapy. Evidence is growing that these patients will do well with avoidance of major surgery, which has significant mortality and morbidity and improved quality of life. We have seen some patients who vote with their feet when offered radical surgery. Moreover, there is now an ethos in the National Health Service that we should listen to the patients and that they have the right to choose their treatment options. Moreover, it is important that clinicians objectively balance the benefits of radical surgery, which has a lower local recurrence rate (1–2%) but significant mortality (5–10%) and morbidity rates (30–40%), compared with local radiotherapy, which has a slightly higher local recurrence rate (5–10%), but has much lower mortality (<1%) and morbidity rates (5–10%). The clinician has the

responsibility of explaining all the treatments that are available to the patient without personal bias. The advantages and disadvantages of each treatment option available should be clearly pointed out so that patients and their relatives can consider these carefully and decide on which treatment they wish to pursue. Discussions need to be carefully documented, as the patients may be prepared to accept the higher risk of local recurrence with local treatment in order to avoid a stoma.

At present, in the UK, the number of patients with early rectal tumours at presentation is relatively small (<10%). Every case should be discussed in detail at the specialist multidisciplinary team meetings. This, including the option for local radiotherapy issue, will become a greater problem when colorectal screening is introduced and about 3000 patients (>30%) per year will be diagnosed with early rectal cancer.

One of the major drawbacks of local contact radiotherapy is the lack of available machines to treat patients. The Papillon treatment facility using the Phillips 50 kV machine is now obsolete as the ageing machines are not being replaced. There is an urgent need for replacement machines, as currently there are only a few centres in the world able to treat patients using the Papillon technique. Since 2005, Professor Jean Pierre Gerard from Nice and the team from Clatterbridge, together with engineers and physicist, have been actively involved in designing a new Papillon 50 machine. The European Union (Ariane) company, which is based in the UK, has finally produced two prototype machines, one to be based at Clatterbridge and the other to be shared between Lyon and Nice. Hopefully, full production will start in 2008 and several centres around the world have expressed their intention to obtain them to treat patients with early rectal cancer in their respective countries.

The publication of this special issue is timely as we need international consensus on how best to manage patients with early rectal cancer. In this special issue, experienced clinicians from around the world have contributed their personal experience and their views on the best practice for early rectal cancer. An international consensus meeting on Papillon treatment was first held at Clatterbridge in 2005, followed by another meeting in London at the British Institute of Radiology in 2006. This year's meeting was held in Paris in April and the next international Papillon meeting

119 is planned for April 2008 in Liverpool. Hopefully, the
120 necessary evidence to support local treatment (radiotherapy/
121 TEM) as an acceptable alternative to standard surgery in the
122 UK will be provided by the collaborative international group
123 and the TEM Users Group trials.
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Author for correspondence: S. Myint, Department of Clinical
Oncology, Clatterbridge Hospital, Clatterbridge Road, Bebbington,
Wirral CH63 4JY, UK. E-mail: sun.myint@ccotrust.nhs.uk

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