Background

Management of rectal cancer with involved pelvic lymph node (LPLN) at the time of diagnosis—the stage we refer institutionally to as Stage 3.5—was controversial. The American Joint Committee on Cancer’s 7th edition classifies internal iliac lymph nodes (LNs) as regional (Stage III), but both external and common iliac LNs as metastatic (Stage IV). However, in many Asian countries all LPLNs are considered regional and patients are treated with curative intent, with literature supporting improved outcomes with LPLN dissection. Management patterns of these patients by U.S. radiation oncologists is unknown. Given the changes in recommendations over the years, we hypothesized real-time practice patterns would vary from national guidelines.

Methods

We invited practicing U.S. radiation oncologists to complete an IRB-approved online survey. Invitations were sent in Nov. 2016. Questions pertained to background characteristics, self-rated knowledge of key clinical trials, and management of patients with localized rectal carcinoma.

Respondents who use a particular imaging modality in < 75% of their patients for staging were defined as low utilizers of that modality. Those who use a specific imaging modality in ≥ 75% of their patients are defined as high utilizers.

Results

Survey Respondents: We received 220 responses from practicing radiation oncologists, whose background characteristics are summarized in Table 1. Biopsy: 10.5% recommend dissection at the time of TME compared to respondents from academic centers (81.5% vs 62.8%, p=0.036).

Conclusions

Surveyed US radiation oncologists almost uniformly approach rectal cancer patients with both internal (regional) and common (metastatic) LNs with curative intent, despite the current national guidelines. Based on the results of the MERCURY trial,a as many as 10% of patients diagnosed with localized rectal cancer are found to have suspicious pelvic lymph nodes on diagnostic pelvic MRI. Management of rectal cancer patients with involved LPLNs—Stage 3.5—is currently not based on robust clinical evidence, and prospective clinical studies are greatly needed to establish the most appropriate management of these patients.

Table 1. Background characteristics of radiation oncologists who completed the survey (n=220).

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References


