Anastomotic recurrence of colorectal cancer

Sir,—The review of Keighley and Hall (Gut 1987; 28: 786–91) is a timely reminder that this important complication of restorative resection is still incompletely understood, but one must question their conclusion that “the term ‘anastomotic recurrence’ is misleading”. Many local recurrences after an anterior resection certainly occur in the pararectal tissues, and many reports lump all local recurrences together, but recurrence which commences within the suture line is still a serious entity.

It was very much a reality to the pioneers of anterior resection in the 1930’s and 1940’s and they were dismayed to find some suture line recurrences occurring in patients who had been placed in Dukes’ grades A and B. They knew that these patients had had a radical resection, so it was natural to suspect that implantation of exfoliated cancer cells was the source of the recurrences. At the end of 1947 Lloyd-Davies and Naunton Morgan decided to counteract this hazard by thorough irrigation of the colon and rectal stump with perchloride of mercury solution. Their trial was not controlled but a rate of anastomotic recurrence of over 14% was succeeded by one of 2% after the introduction of irrigation, without other changes in technique having been made. 3 4 Later figures from St Mark’s confirmed a recurrence rate of 1–2% in over 400 radical restorative resections. 5

Those of us trained by these pioneers were certainly convinced by these results, and continued to use their techniques, including cytotoxic irrigation. In 177 radical restorative resections, 6 122 of which were followed for more than five years, we directed attention particularly to any sign of anastomotic recurrence by carrying out regular sigmoidoscopies, with biopsy of any suspicious nodule: only one positive biopsy was obtained, although 14 other pelvic recurrences could be felt in the vagina or pararectal tissues. When the operative specimen shows good distal clearance of the carcinoma, recurrence commencing within the suture line is likely to be the result of either a local change in the biology of the mucosa, or implantation. Nothing can be done at present about a field change, but there is a strong suggestion that omission of rectal washout results in more suture line recurrences. In one carefully analysed series 7 there were 16 such recurrences among 150 patients, in seven of whom the specimen was placed in Dukes’ grade A or B, with a mean margin of resection of 4.5 cm. In another report 8 11 of 34 patients suffered an anastomotic recurrence between three and 22 months after resection.

These results are not proof that all these recurrences are caused by implantation but they, and others showing suture material adjacent to recurrent tumour, do suggest that the concept of prophylactic irrigation is soundly based, especially in the light of recent evidence favouring the existence of free viable cancer cells in the rectal lumen. 9 10 It may well be that it is the mechanical effect of cleansing achieved by irrigation which is the most important effect because Heald reports no suture line recurrences after 115 resections in which water alone was the irrigant. 11

Irrigation of the rectal stump and the end of the colon before restorative anastomosis is harmless, desirable from a hygienic point of view, and easily done with the patient in lithotomy-Trendelenburg position. In the light of present knowledge it is surely right also to regard irrigation as an essential prophylactic before performing a restorative anastomosis after anterior resection for cancer.

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References


10 Skipper D, Cooper AJ, Marston JE, Taylor I. Ex-

Books


If there is a niche for the lavish ‘coffee table’ book in gastroenterology, it is more than filled by this book. The editor has disarmed criticism by pointing out that ‘This text and these illustrations were not intended to form the textbook of gastrointestinal disease and should not be used, or judged, as such.’ Instead, it is suggested that the book is ‘... a convenient aide memoire ...’ and ‘... a useful revision course for those active in gastroenterology.’ The perceptive reader will note that it is somewhat arbitrarily divided into 20 chapters of approximately equal length, each with up to 50 illustrations; both the text and illustrations may be familiar to the more fortunate. This is, in fact, an opportunistic publication, consisting of the text material from the Slide Atlas of Gastroenterology produced for Glaxo Laboratories. As the text, figures and layout of the slide atlas are completely unaltered, it is presumably one way in which the publishers and sponsors can recoup some of their financial outlay on the earlier work. For those who possess the slide atlas, it is useful to have a catalogue of all 20 parts collected in one volume. For everyone else, it would be easy to dismiss this volume as an expensive luxury. That would be wrong: medicine is visual as well as verbal, and this profuse array of colour photographs, x-rays, diagrams and line drawings serve their purpose well. In contrast, the text is cursory, and is really no more than extended captions that have been joined into a continuous narrative. Because it is tempting to browse among the pages, it is a painless form of learning; I think it serves its purpose very well. Unfortunately, the format is not likely to appeal to librarians, while the price will probably act as a deterrent to most of those who could benefit from this book.

DAVID WINGATE

News

International Society of University Colon and Rectal Surgeons
The 12th Biennial Congress will be held in Glasgow, Scotland, from 10–14 July, 1988. Further information may be obtained from CEP Consultants Ltd, 26–28 Albany Street, Edinburgh EH1 3QH.

11th International Convocation on Immunology
To be held in Buffalo, New York, from 12–16 June, 1988, on immunology and immunopathology of the alimentary canal. Further details may be obtained from Dr James F Mohn, Director, The Ernest Witebsky Center for Immunology, 240 Sherman Hall, State University of New York at Buffalo, New York 14214, USA.

Reduced subscription for trainees
Gut is available at a reduced rate of £48 per annum to bona fide trainees in gastroenterology in the areas of basic science, medicine, surgery, pathology or radiology. The reduced subscription rate will be available for one year in the first instance and a fresh application will be needed for any subsequent year, up to a total of three years. The offer does not apply to members of the BSG. Trainees should be of registrar or senior registrar status, or equivalent. Application forms are available from The Subscription Dept, BMA House, Tavistock Square, London WC1H 9JR. (Please enclose a selfaddressed, stamped envelope.)

BSG Research Award 1988
A three page summary of personal research work is invited by the Education Committee of the British Society of Gastroenterology who will recommend to Council the recipient of the 1988 Award. A bibliography may also be submitted if desired. The Award consists of a medal and £100 prize. Entrants must be 40 years or less on 31 December 1988 but need not be a member of the BSG. All (or a substantial part) of the work must have been done in the UK or Eire. The recipient will be required to deliver a 40 minute lecture at the Plenary Session of the Spring meeting in 1988. Applications (18 COPIES) should be made to: The Honorary Secretary, BSG, 3 St Andrew’s Place, Regent’s Park, London NW1 4LB, by 1 December 1987.