When Should We Expect Curative Results of Neoadjuvant Treatment in Locally Advanced Rectal Cancer Patients?

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Abstract

This review on recently published literature aims to summarize published data on pathologic complete response following neoadjuvant treatment in biopsy proven locally advanced rectal cancer patients. Published articles referring to pCR rectal cancer patients...
were identified using PubMed search. Eleven relevant articles were selected, based on tumor, treatment, and patient characteristics reporting. As a conclusion, rectal cancer patients with the highest chances of complete clinical or pathological response to neoadjuvant treatment are males, who are around 60 years, diagnosed with well or moderate differentiated locally advanced rectal cancer.

Key words: rectum, neoadjuvant, chemoradiotherapy, complete response

Introduction

Colorectal cancer (CRC) is the most common diagnosed type of cancer of the digestive tract and the 3rd most frequent type of cancer worldwide for both sexes (1). Its aggressivity is confirmed by the high mortality rates, in United States of America estimates suggesting that from 147,950 individuals diagnosed with this disease, 53,200 will die as a consequence of it (2). Although official data for CRC incidence and mortality is lacking for year 2020, starting 2012 methods of projecting the total numbers of new cases and deaths of CRC are available (3,4). Considering current literature data, we can conclude that CRC is more frequent and has higher mortality rates in females compared to males (5).

After reviewing the latest published data, we consider the “colorectal cancer” category obsolete due to the fact that currently clinical, treatment and epidemiological data have been reported, and that colon cancer and rectal cancer should be discussed as separate diseases (6).

Locally and regionally advanced rectal cancer rates remain high worldwide, probably due to the low number of countries, considering the worldwide mortality rates, which implemented national screening programs for this disease. For stages II and III, rectal cancer survival rates are ranging between 80% and 50%. However, variations still exist, probably due to individual and treatment related factors (6).

Regarding rectal cancer treatment, surgery remains the main therapeutic option according to current international guidelines (7,8), even for the (oligo)metastatic stages. However, especially for low and middle rectal cancer, the rates of sphincter-preservation procedures remain low, with important decrease in patient’s quality of life (QoL).

Preoperative chemoradiotherapy for locally advanced rectal cancer has been associated with increased local control and survival rates. Moreover, neoadjuvant chemoradiotherapy increased not only negative margin tumor resection rates, but also sphincter-sparring surgery rates (9).

We reviewed current literature databases and selected studies that focused on rectal cancer patients that underwent neoadjuvant chemoradiotherapy and had pathologic complete response (pCR), coded ypT0 N0. The purpose was to identify the main characteristics of rectal cancer patients, that have the highest chances of complete response following pre-operative treatment, focusing on radiotherapy.

Materials and Methods

We conducted a systematic search of current available electronic databases, in order to identify studies that focused on pCR rectal patient’s characteristics. Published articles referring to pCR rectal cancer patients were identified by using PubMed search on MeSH headings “rectal cancer” AND “complete response”. Titles and abstracts screened for data “preoperative OR neoadjuvant AND radiotherapy OR irradiation AND chemo-therapy AND/OR chemoradiotherapy”, were collated. Reference lists from the selected articles were evaluated in order to add other
pertinent articles. Duplicate studies were excluded after this primary analysis. Conference abstracts, scientific letters, case reports, and studies not reporting patient population characteristics were excluded.

**Results**

*Figure 1* presents the study selection process. Initially, 2805 studies were identified. Studies that were duplicated or that had irrelevant content were excluded. After checking the study exclusion criteria, 30 studies remained. In order to avoid more duplicates, another 8 studies and 3 meta analyses were excluded.

Although 7 studies were not reporting all study selected data, they were still used due to the large patient population, finally resulting 19 studies, from which 11 totally fulfilled study criteria. These studies and the selected study criteria are presented in *Table 1*.

**Discussions**

We reviewed institutional and multicenter analyses to identify the rectal cancer patients that had a pCR following neoadjuvant chemoradiotherapy, so that we could find certain patient, tumor, and treatment related features associated with higher chances of responding following neoadjuvant treatment with a complete response.

**Table 1.** List of studies used in this review

| Study                        | Mean Age (years) | Majorit. Gender | Stage | Differentiation grade | Total RT dose | Concurrent CHT | Time until surgery (weeks) | Pcr (No pts.) |
|------------------------------|------------------|------------------|-------|-----------------------|---------------|-----------------|----------------------------|---------------|
| Aguilar et. al. (9)          | 57               | M                | III   | G1-2                  | 50 Gy         | Yes             | 5.7                        | 21            |
| Hughes et al. (10)           | 71               | M                | II    | NA                    | 45 Gy         | Yes             | 15                         | 23            |
| Capirici et al. (11)         | 63               | M                | II-III | NA                    | 50 Gy         | Yes             | 7.9                        | 499           |
| Yeo et al. (12)              | 56               | M                | III   | G1-2                  | 50 Gy         | Yes             | 7.5                        | 304           |
| Tulchinsky et al. (13)       | 61               | M                | II-III | NA                    | 45-50 Gy      | Yes             | 7                          | 26            |
| Habr-Gama et al. (14)        | 58               | M                | I-III | NA                    | 54 Gy         | Yes             | 37 cCr: 22 pCR: 5          |               |
| Maas et al. (15)             | 61               | M                | I-III | NA                    | 45-50.4 Gy    | Yes             | NA                         | 484           |
| Decampos-Lobato et al. (16)  | 54               | M                | II-III | NA                    | 50.4 Gy       | Yes             | 8                          | 58            |
| Zorrcolo et al. (17)         | 61               | M                | II-III | NA                    | 50.4 Gy       | Yes             | 9.5                        | 300           |
| Dossa et al. (18)            | 59.5             | M                | I-III | G2                    | 45 - 54 Gy    | Yes             | 7                          | 2455          |
| Kuan et al. (19)             | 61               | M                | II-III | G2                    | 40 – 50 Gy    | Yes             | 7                          | 259           |
However, our research focused on rectal cancer only patients, and what we identified is that although there were some studies that did not focus on this characteristic, most of the selected studies have unanimously reported that pCR rates are higher in males than in female patients.

Age was another characteristic that we considered necessary to evaluate, due to the fact that age related literature reported data suggesting that in certain countries, like United Kingdom, incidence rates were higher in male rectal cancer patients than in females, for patient population above 45 years. This incidence gap between the two genders widened proportionally with age increase, the highest ratio being reported for the 70-74 years patient population. Furthermore, it has been shown that women exhibit delayed colorectal cancer development compared to men. In our literature review, all studies reported median age for the enrolled patients, resulting in a median age of 61 years for the pCR rectal cancer patients.

One of the drawbacks of our study was the lack of data regarding patient related comorbidities. Current literature data (22) suggests that toxicity following radiation to the pelvis is more common in diabetics and increases the risk of fecal incontinence.

Tumor Related Characteristics

For oncological patients, clinical stage remains the main tumoral prognostic factor regarding survival data. In the studies selected for this metanalysis, most of the rectal cancer patients who were reported as pCR-ers to neoadjuvant chemoradiotherapy, were diagnosed with locally advanced (stage II-III) disease. This was probably due to the fact that neoadjuvant treatment is recommended by most of the treatment guidelines in these stages for rectal cancer patients. However, although 2 of the reviewed studies (9,12) focused solely on stage III rectal cancer, most studies enrolled in our literature review reported results stages II and III biopsy proven rectal cancer, 4 studies (14,15,18,23) also reviewed data of stage I rectal cancer patients for whom pCR was achieved.

Cancer cells differentiation grade is already known to be an important predictive factor when we are referring to radiotherapy response. In previously published studies (24) for patients with rectal cancer undergoing radiotherapy, the differentiation degree is one of the main factors influencing tumor downstaging and residual tumor cell density. Our literature search results found that only 4 studies (9,12,18,19) reported this characteristic of cancer cells for rectal cancer pCR patients. These studies confirmed that following neoadjuvant chemoradiotherapy, the highest pCR rates were achieved for well and moderately differentiated rectal tumors.

One of the drawbacks of this study was the lack of data regarding imunohistochemistry and pCR relationship. Current literature data focusing on pathological characteristics of rectal tumor cells report the importance of imunohistochemical tumor characteristics, such as p21, p53 and ki67 values, as important predictive factors for tumor shrinkage following neoadjuvant chemoradiotherapy (25-27).

Treatment Related Characteristics

All studies focusing on pCR in rectal cancer patients that underwent neoadjuvant chemoradiotherapy were used.

Regarding radiotherapy, it is widely recognized that its main purpose in this treatment phase is to downsize or downstage large tumors. Although, not all patients respond favorably to radiotherapy, some studies (14,15,18,23) reported its use as neoadjuvant treatment event in smaller tumors. A recent analysis of the NCD in 2017 (28) reported a pCR rate of 13% in an overall cohort of 27532 patients. In none of the reviewed literature reported data short course radiotherapy or altered fractionation radiotherapy schedules were used. A vast majority of the studies we reviewed reported the use of neoadjuvant radiotherapy up to a total dose of 45 to 50 Gy. However, in 4 studies (14,23,29,30), radiation doses above 50 Gy were used, with only one
study (23) reporting total doses of 60 Gy in the neoadjuvant treatment setting. A recent study (31) reviewed radiotherapy parameters that were most associated with pCR in rectal cancer patients and reported that total dose was the main radiation factor influencing pCR rates. Another study (32) suggested that increasing tumor radiation dose, without neoadjuvant treatment prolongation, should be a feasible way of achieving better tumor response. Therefore, preoperative long course radiotherapy associated with simultaneously integrated boost (SIB) up to doses above 50 Gy on the tumor, achieved a very high tumor response rate without increasing acute or late toxicity (33). Common limitations of the recent studies focusing on radiotherapy were the use and the timing of chemotherapy drugs, because that would induce higher variability in tumor response to neoadjuvant chemoradiotherapy (34).

Regarding chemotherapy, in most studies reporting pCR for rectal cancer patients following neoadjuvant chemoradiotherapy, infusional 5FU was used as monotherapy, 5 days/week, weeks 1 and 5 of radiotherapy. All studies from our metanalysis reported data regarding the type of chemotherapy used, and what we observed was that multi-drug chemotherapy regimens were usually used concurrently with lower doses of radiotherapy, due to the risk of cumulative toxicity, especially hematological. Few studies used high doses of radiotherapy and concurrent polichemotherapy, but unfortunately few data regarding patient characteristics was provided. As expected, most studies found that neoadjuvant polichemotherapy and radiotherapy were associated with a slight increase in pCR rates and significant increase in grade 3/4 toxicities, compared to concurrent monochemotherapy and radiotherapy (27-30). A study’s results also suggest an extremely aggressive neoadjuvant treatment comprising of polichemotherapy with 5FU and high dose radiotherapy do not increase the rates of pCR patients (31,32).

Based on other studies (35, 36) reported data, Urick et al (37) tested the enhancement of 5FU-induced in-vivo and in-vitro radio-sensitization, and found that its enhancement and cytotoxicity are increased, resulting in an increase in radiation sensitization, further resulting in an increase in mitotic catastrophe and apoptosis, a reduction in Stat-3 phosphorylation, and a reduction in Survivin expression. Considering that infusional 5FU shows encouraging results, Capecitabine is recommended to be administered 825 mg/m², twice daily for 7 days a week, ideally 1-2 hours before radiotherapy (38,39). This proves to be most effective, due to its constant citotoxic effect that prevents tumoral regrowth, without an increase in toxicity (40). Due to the good tolerability of neoadjuvant chemoradiotherapy with Capecitabine, recent studies started to emerge reevaluating the addition of other chemotheraphy drugs in the Capecitabine and radiotherapy neoadjuvant schedule, with promising results regarding pCR rates in rectal cancer patients (41). However, after literature research, case reports (42,43), and modest cohort size studies were found to reporting complete response following neoadjuvant concurrent radiotherapy and polichemotherapy.

Usually, rectal curative surgery is undergone at 6-8 weeks following neoadjuvant chemoradiotherapy. However, retrospective studies revealed that an interval prolongation beyond 8 weeks is associated with higher rates of pCR. Studies evaluating pCR rates in rectal cancer patients who underwent radical surgery following neoadjuvant chemoradiotherapy, showed that delaying surgery above 8 weeks results in an almost doubling of pCR rates, compared to those that were operated in less than 7 weeks, from approximately 15% to 27% respectively. (44-47). Some of these authors (44,45) have also suggested that delaying surgery was also associated with better local control, disease-free survival, and cause-specific survival.

Most surgeons are reluctant to this delayed surgery approach due to the risk of late radiation side effects such as fibrosis, although, studies on this are also emerging, and the reported data is encouraging, suggesting no increased rates of blood loss, blood transfusions,
operative time, post-operative complications, length of hospital stay, or overall morbidity/toxicity (45,47).

Although in most studies that we reviewed (48, 49) surgery was delayed with at least 7 weeks, in Habr-Gamma et al. study (14), the mean interval between neoadjuvant treatment completion and surgical resection was 37.7±18.4 weeks due to a watch and wait approach, radical surgery being delayed as much as possible and replaced for suspected residual disease with a conservative approach such as full-thickness local excision.

Jian-Wei Zhang et al (50) proposed in their research a nomogram for predicting pathological complete response and tumor downstaging in patients with locally advanced rectal cancer, on the basis of a randomized clinical trial. The authors concluded that tumor length, tumor circumferential extent, distances from the anal verge, clinical T category neoadjuvant treatment regimen were significantly associated with good tumor downstaging.

More research is still needed in this area. Although it is widely accepted that prior pelvic tumor irradiation and local anatomy (51,52) might lead to an increased risk of developing rectal cancer tumors, there is limited data regarding the response of these radiation induced tumors to neoadjuvant chemoradiotherapy.

Conclusions

This review’s objective was to identify a pattern of features for rectal cancer patients undergoing neoadjuvant chemoradiotherapy who have the highest pCR rates. As previously mentioned, more data like immunohistochemistry and molecular biology testing would have certainly helped us. As a conclusion, rectal cancer patients with the highest chances of complete clinical or pathological response to neoadjuvant treatment are males, aged around 60 years, diagnosed with well or moderate differentiated locally advanced rectal cancer. For these patients, the most appropriate neoadjuvant treatment in order to achieve complete response before radical surgery, should be concurrent chemoradiotherapy. Radiotherapy should be administered up to a total dose of 50 Gy, using a conventional fractionation regimen, preferably with a highly conformal technique like IMRT/VMAT. Concurrent chemotherapy should consist of 5FU administered intravenously, as a bolus, days 1 and 21 of treatment, or oral Capecitabine 825 mg/m², twice daily, on administration with 1-2 hours before radiotherapy session, 7 days/week. If Capecitabine is preferred as concurrent chemotherapy and highly conformal radiotherapy is used, other chemotherapy drugs (ex. Leucovorin, Oxaliplatin) can be used concurrently.

Postneoadjuvant treatment evaluation should be done at least 8 weeks following the end of treatment. We recommend that if clinical complete response is achieved, a tumoral bed blind biopsy should be done. Also, patients obtaining pCR should be actively monitored. Adjuvant chemotherapy following neoadjuvant treatment, in the absence of surgery should be considered, not necessarily to reduce relapse rate, but to prevent disease spreading.

Conflicts of Interest

All authors declare no conflicts of interest exist.

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