GUEST EDITORIAL

Rectal Cancer—
To Burn or Not To Burn

Increasingly, during the past year, physicians have asked my opinion on fulguration for cancer of the rectum. I have answered that such treatment may provide effective palliation for poor risk patients, or for senile, elderly patients who are unable to cope with a colostomy. Because these doctors usually tell me that they are electively treating good risk, operable patients with this method, I have the most uncomfortable feeling that fulguration of operable rectal cancer is becoming more common, particularly among those who do not do major surgery, and long before any solid data indicate that fulguration is as effective as abdominal-perineal resection.

In the past twenty years, the five-year survival rates for patients undergoing abdominal-perineal resections have not improved very much. However, during this same period, improved survival rates for patients with cancer of the rectum did parallel an increase in the number of resections performed. As the rates of resection leveled off, so did the increase in survival. Substitution of fulguration for resection at this time would seem to nullify the only demonstrated improvement in the survival of patients with rectal cancer.

The main arguments used to justify fulguration as a substitute for resection appear to be the following: (1) it avoids a colostomy; (2) the method can control the local tumor without a major operation and its complications; (3) fulguration of cancer produces an immune response that allows the body to handle the cancer more effectively; (4) if nodal metastases are present the results of resection are so poor that resection is not justified. I would answer these arguments with the following points:

1) There is no question that fulguration will avoid colostomy in the vast majority of patients, at least temporarily. For some patients, a colostomy is a catastrophe with which they cannot cope, although, in my experience, these patients represent a very small minority of those who have a permanent colostomy. Most patients adapt to their new situation when properly taught and encouraged and resume their normal activities.

2) When the tumor is relatively small and superficial, considerable evidence indicates that it can be destroyed locally by fulguration, but does not assure that lymph node metastases are not present. We have seen and treated sufficient numbers of patients who have previously had fulguration to know that it is not universally effective in controlling the local tumor. It is indeed true that complications of abdominal-perineal resection, such as impotence and urinary dysfunction, are avoided, although, as Dr. Madden has described them, fulguration has its own complications. It is not an ambulatory outpatient procedure by any means.

3) The statement that fulguration of rectal cancer in man produces an immune reaction which controls the cancer is pure speculation. To date, I know of no direct evidence to support this hypothesis.

4) It has been stated that the results of surgery for cancer of the distal rectum, when lymph node metastases are present, are so poor that radical resection with a colostomy is not justified. At Memorial Hospital from 1957–1964, 193 patients with cancer of the rectum...
located in the terminal 7 cms. were treated by resection. The result was an overall five-year survival rate of 57 percent and a determinate survival rate of 66 percent. Lymph node metastases were present in 68 patients and in this group there was an overall survival rate of 34 percent and a determinate survival rate of 40 percent. During this time operative mortality ran between two and three percent.

References to data which substantiate good results from fulguration of cancer of the rectum invariably cite the works of Strauss and Jackman.24 Strauss, in his initial paper, listed a number of case reports. Since then each subsequent article contains a one or two sentence statement that he has now treated a given number of patients with a 75 percent five-year survival. To my knowledge, he has never published his clinical data. Jackman’s article concerned the treatment of cancer in polyps. In his article he specifically stated that flat crater-like lesions with puckering or distortion were candidates for radical resection; that protuberant lesions were considered for fulguration. He also implied that lack of mobility, puckering or rolling of edges and areas of firmness were indications for radical resection. Jackman’s results have no relevance to the problem under discussion, clinically infiltrating adenocarcinoma of the rectum.

While it may be scientifically impossible to condemn the procedure until it has been given an adequate, well-supervised trial, it is also impossible and morally unjustified to discard abdominal-perineal resection when fulguration is still in its trial run. It is distressing that our nationally respected, elder statesmen of surgery have been unwilling to urge caution in this matter.

References
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