

RUTGERS

Cancer Institute
of New Jersey

RUTGERS HEALTH

Expectant management of mesenteric nodal metastases

Amanda M. Laird, MD
Associate Professor of Surgery
Chief, Section of Endocrine Surgery
Rutgers Cancer Institute of New Jersey



A Cancer Center Designated by the
National Cancer Institute

Force or stratagem?

Steven K. Libutti, MD, FACS,^a and William B. Inabnet III, MD, FACS,^b *Bronx and New York, NY*

From the Department of Surgery Montefiore Medical Center,^a Albert Einstein College of Medicine, Bronx; and the Department of Surgery,^b Mount Sinai Hospital, New York, NY

THE 18TH CENTURY SURGEON John Hunter once wrote, “Surgery is like an armed savage who attempts to get back by force what a civilized man would get by stratagem.” In this month’s issue of

Prophylactic vs expectant management

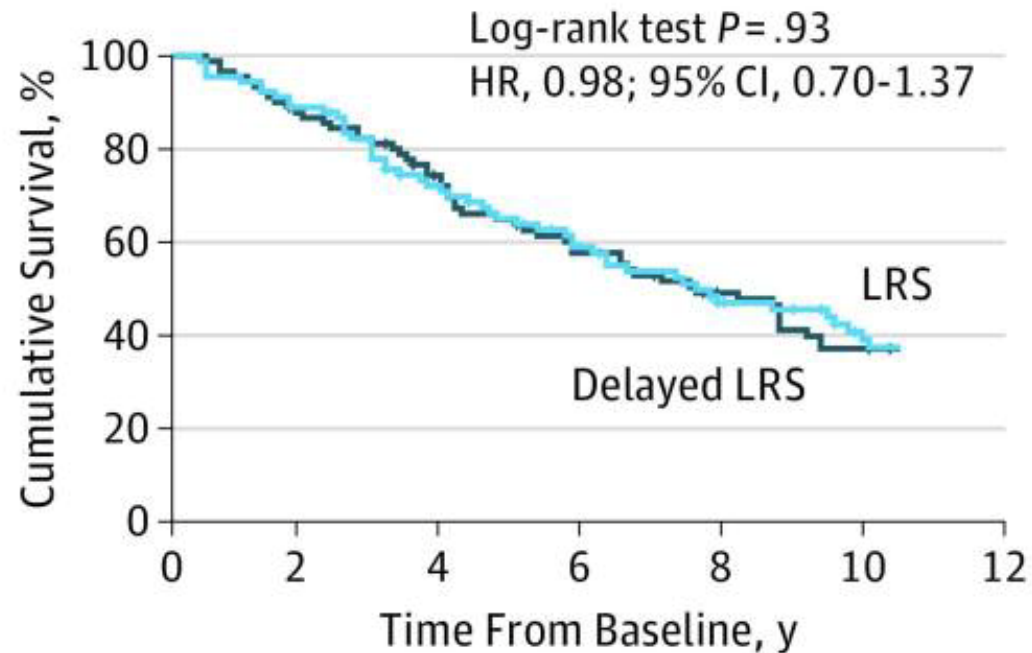
- Prophylactic:
 - Nodes identified at time of surgery or with imaging
 - Removed for staging
 - Removed to improve OS or DFS
- Expectant management:
 - Palliative surgery/symptomatic relief
 - Emergency surgery: bowel obstruction, pain
- Questions:
 - Is there an oncologic benefit (OS, DFS)
 - Does surgery increase morbidity
 - ?oncologic benefit
- Bias in presented data

Prophylactic vs delayed management

- 363 patients from a prospectively collected database
- Propensity score matched, 91 pts per group
- >90% Stage IV disease
- Grade 1 and 2 (3 excluded)
- Outcomes

- Similar 30-day outcomes (immediate vs delayed)
- Morbidity 2.2% vs 1.1%
- No Mortality

B Propensity score-matched groups



No. at risk							
LRS	91	81	61	46	33	24	
Delayed LRS	91	78	61	48	37	28	

Elective vs emergent management

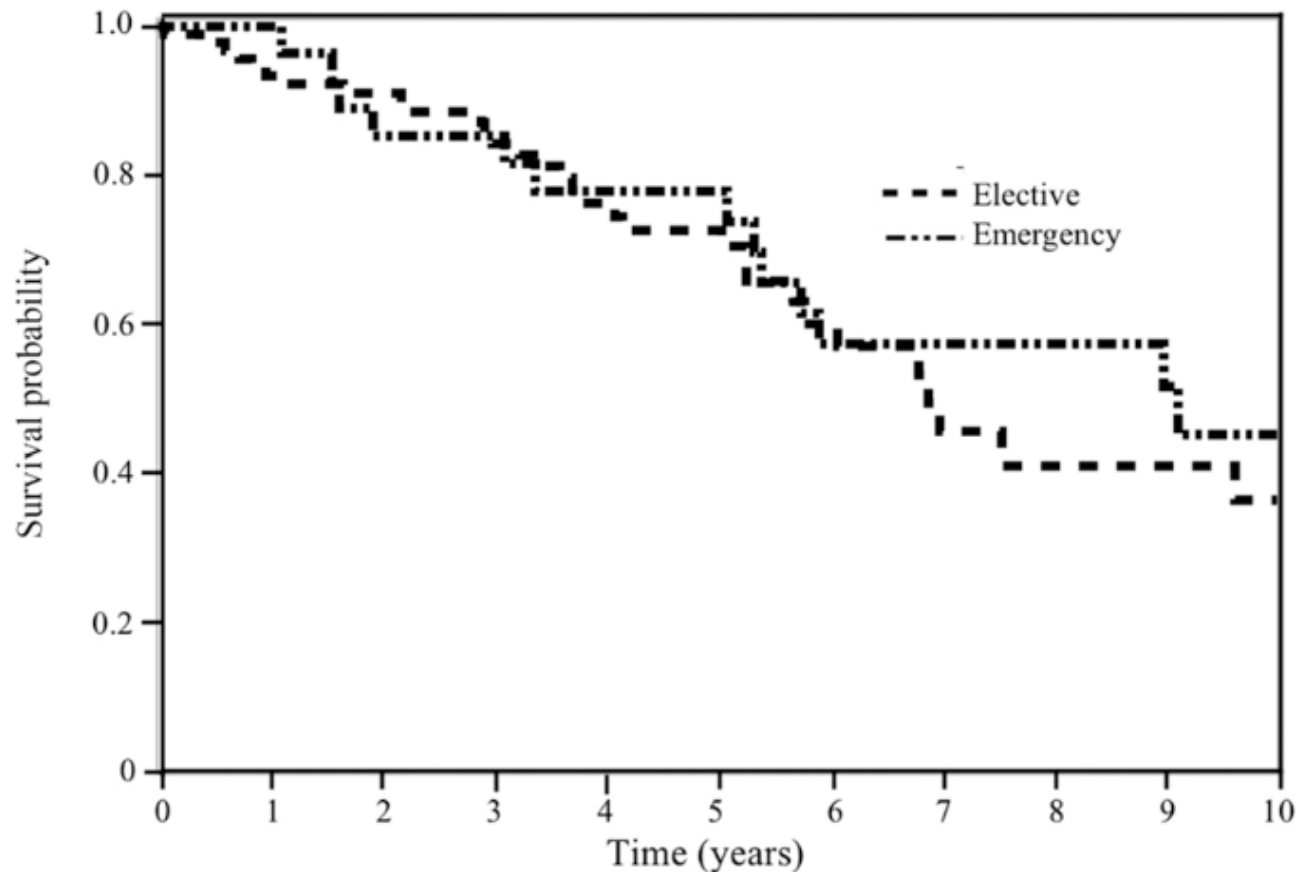
- 134 patients, institutional database
- 25% underwent emergency operation
- Retrospective, nonrandomized
- Indications for ER:
 - SBO (80%)
 - Intussusception
 - Pain (9%)
 - Mesenteric ischemia

TABLE 1. *Patient Demographics and Treatment*

	Total (N = 134)	Emergency (N = 34)	Elective (N = 100)	P Value
Age, median (range)	59 (21–91)	61.5 (41–91)	58 (21–88)	0.20
Female, n (%)	68 (50.7)	18 (52.9)	50 (50.0)	0.84
Preoperative diagnosis, n (%)	88 (65.7)	1 (2.9)	87 (87.0)	<0.001
Operation, n (%)				
Laparoscopic	36 (26.9)	4 (11.8)	32 (32.0)	0.03
Open	86 (64.2)	30 (88.2)	68 (68.0)	

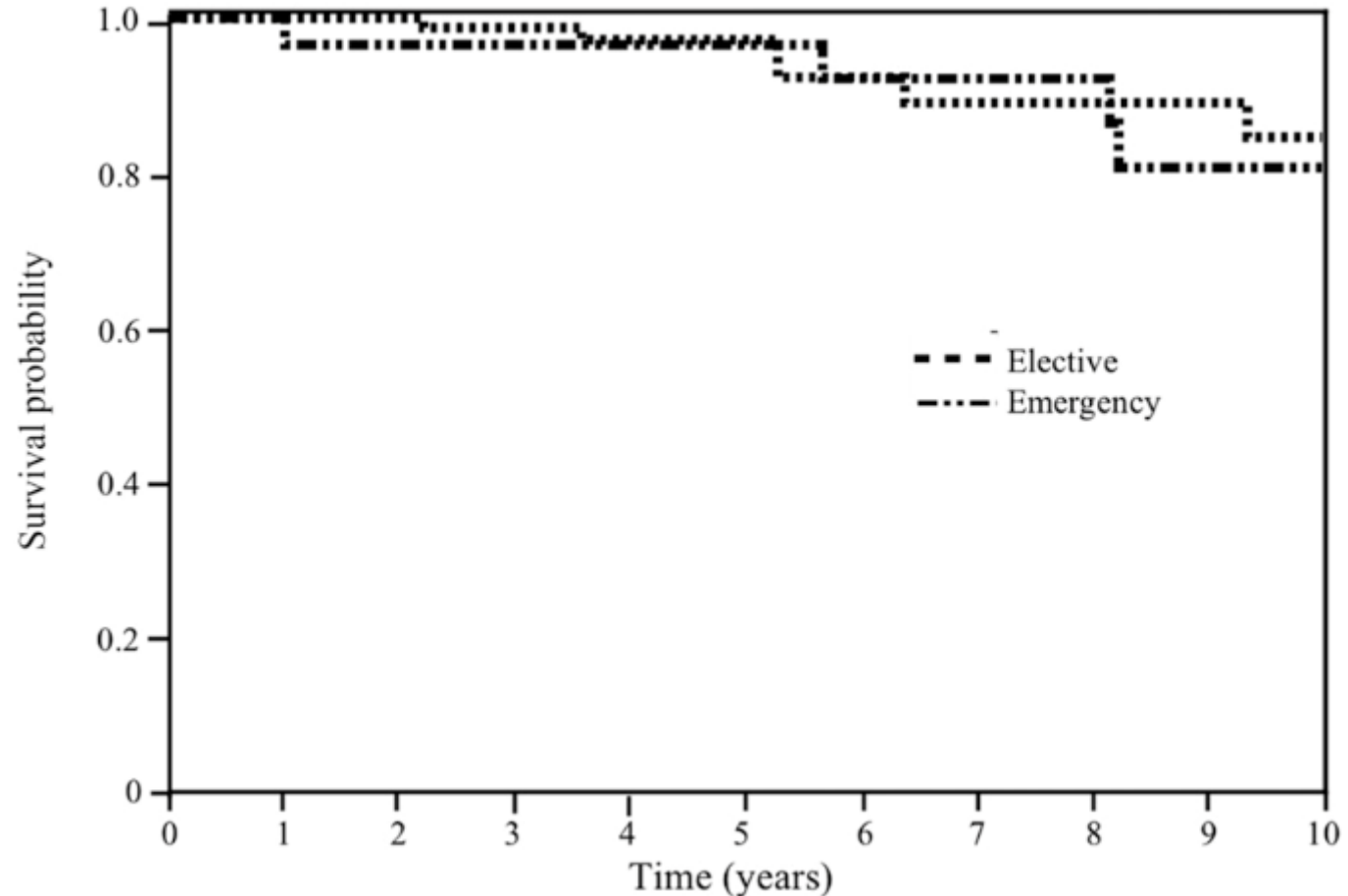
Elective vs emergent management

- DFS, ER vs ELR
- 77.9 vs 72.6%
- $p=0.71$



Elective vs emergent management

- 5-year OS, ER vs ELR
- 96.6% vs 97.2%
- $p=0.58$



Nonsurgical treatment

- Palliation/symptomatic relief
 - Goals: improvement, limit morbidity
- SBO
- Mesenteric ischemia
 - Arterial insufficiency
 - Venous congestion

Stenting of the Superior Mesenteric Vein in Midgut Carcinoid Disease with Large Mesenteric Masses

**Per Hellman · Ola Hessman · Göran Åkerström ·
Peter Stålberg · Joakim Hennings · Martin Björck ·
L.-G. Eriksson**

- 7 patients, 2005-2008
- Pain, weight loss, ascites
- Surgery not feasible due to extent of tumor or poor surgical candidacy

- 4 patients, 80% improvement in symptoms
 - Correlation to improvement in blood flow

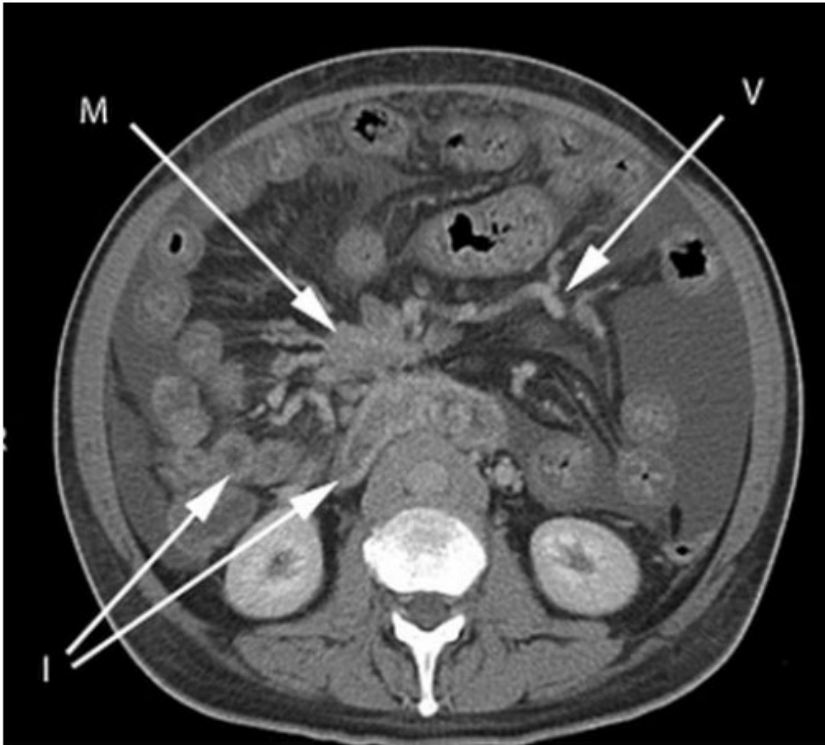


Fig. 1 Computed tomography (CT) scan performed before stenting of the superior mesenteric vein in case 1. The large mesenteric mass is shown (*arrow; M*), as are dilated collateral veins (*arrow; V*) and loops of small intestine with thick wall (*arrows; I*)

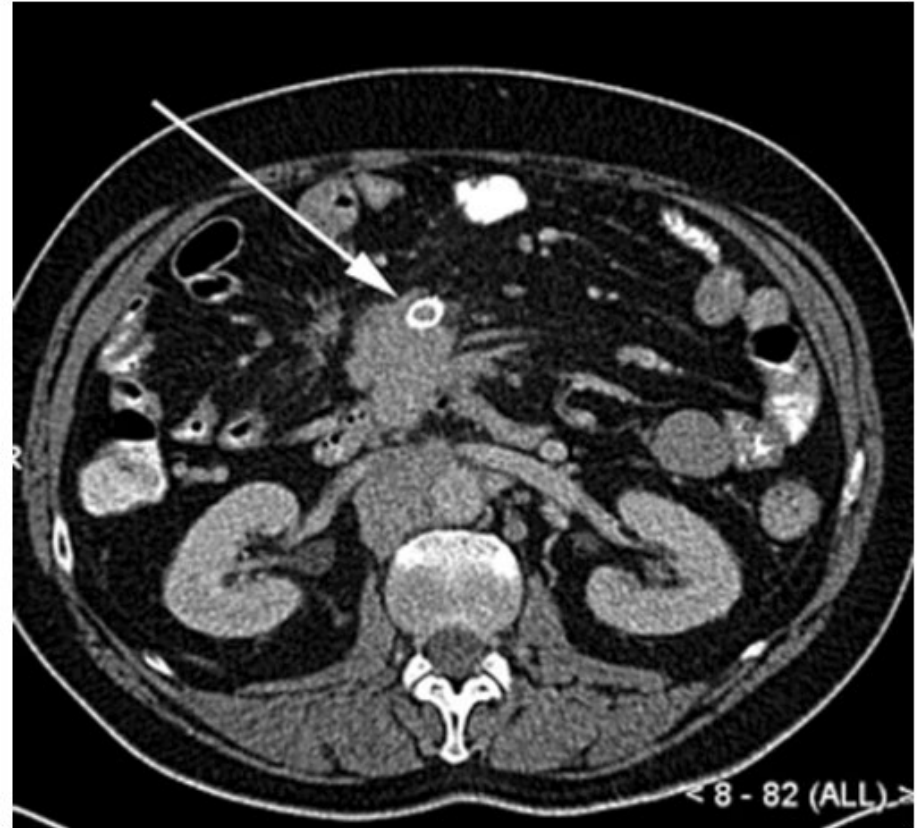


Fig. 3 Case 1: A CT scan performed 6 weeks after stenting demonstrates the stent in place (*arrow*), absence of ascites, and normalization of the thickness of the small intestine wall

Conclusions

- Expectant management = prophylactic nodal dissection
- Bias in patient selection
- No randomized data
- Potential alternatives to surgery