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Rectal resection following neoadjuvant therapy in a midwest community hospital setting: The case for standardization over centralization as the means to optimize rectal cancer outcomes in the United States☆

DR. MICHAEL A. VALENTE (Cleveland, Ohio): You should be congratulated for this very timely and important study in the field of rectal cancer outcomes and quality. The issue of centralization over specialization is a critical topic right now, and we are in the midst of a review by the NAPRC under the auspices of the American College of Surgeons Committee on Cancer, and this was happening at our institution just a few weeks ago. The NAPRC's goal is to improve the quality of rectal cancer care by standardizing treatment, not necessarily centralizing treatment. Multiple standards do exist, but the key components which I'll review are the role of the multidisciplinary team, including pathology, radiology, colorectal surgery, radiation medical oncology, having regularly scheduled tumor boards having well performed synoptic reporting by both the radiologists and the pathologists, and, of course, intraoperative quality metrics, including circumferential resection margin and other margin status related to the TME. This paper displays what a single high volume surgeon can achieve in a relatively low volume institution in geographical areas where there may not be subspecialty care. I do have some questions. I will limit them to three.

Number one, were most of these patients or all the patients presented at a multidisciplinary tumor board consisting of what the NAPRC would recommend as the standard of treatment at this point? Number one.

Number two, in your experience being now at an academic institution and being in a small community area, what is your recommended number of rectal cancer resections that a surgeon, no matter where his or her location is, be per year to be part of this endeavor?

And then last, and number three, in your experience, how do you recommend or what is your recommendation going towards these non-specialty surgeons in the rural areas or smaller communities? How do they get this multi-disciplinary team together? How do we get radiation and pathology and medical and radiation oncology? How do we get more radiation being performed in a timely manner?

DR. CIROCCO: The first one was – the tumor board. So there are no tumor boards, but as I was saying, you can kind of construct your own. You gather what you need, and basically your oncology, your colleagues in oncology make phone calls. Patients are seen and then collaboration between radiation and medical oncology because they are going to synchronize the chemo and then the radiation therapy over that five to six weeks.

Numbers was next. So I hate to give numbers because that's a proxy for expertise, and it's a poor proxy, like colonoscopies. You do a whole lot of colonoscopies as a resident. Do you know how to do it? No. You've done a hundred, but how well have you done them? But for the sake of the literature, I will tell you that I think ten comes up for a single surgeon, ten per year over and over. For an institution, 25 to 30 comes up over and over. So what do we do?

I think so out in the communities, I think you funnel cases, and this has been done over the years. So when colonoscopy came around in the '70s, well, the young partner went off and learned it. Robotics, young partner. So I think if you funnel rectal cancer to a single member of a group of general surgeons, that's one way to crank those numbers up and get somebody doing that.

If you are going to do a case such as Whipple, and we mentioned, you want to, I think, concentrate those to a single member. That's one way to get around it. These patients don't want to travel. And there have been studies, you know, you can travel here to an expert or you can stay with your local general surgeon. They want to stay with their local general surgeon. I mean, we know that.

I think your question was, so what do we do? I think, as I mentioned, we try and increase expertise locally. The deal with NAPRC is, I fear that the bar is going to be so high, the only ones that are going to be able to pass over that bar are all the cancer centers that we all know about, including Cleveland Clinic.

So we still have an issue, what do we do west of the Mississippi, what do we do in smaller areas. And I think general surgeons are always going to take care of those patients. I think we use the Web. We can use conferences. I think it's done here in Michigan where you can call Ann Arbor and say, hey, I got this 80-year old obstructive, what do you think? Well, maybe you can divert them in a different area so you don't mess up an area, say, in the descending, which would be your reanastomosis, maybe, down the road. So maybe we can talk. We've got social media going. Why can't surgeons reach out that 300 miles and say, I've got so and so here, what do you think? Well, divert them, fix them, take care of the problem. Maybe we'll see him, and if we see him maybe locally they can have the radiation and chemo.

I think the fallacy is these patients don't travel. They travel. The folks I see out in the community, out in the farms, they travel. They travel to me. They travel to the oncologist. They're already traveling. So they are not going to go another 200 miles, and if you mandate, who's going to pay for it. So I think there are ways to get around

☆ (Presentation given by W. C. Cirocco, M.D.)

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this. I think the NAPRC, I think in some ways I think standardization is the way to go. So my pathologist when I was working in Kansas City, they didn't grade the specimen. I didn't know CRM's, et cetera.

Nodal clearance, I only got 10.5. Well, what kind of clearance techniques were they using? So I think we can standardize the load. We should, you know, kind of take this to the streets, take this locally. Even in California. I mean, most of that state is rural. So there are issues, as I come in contact with surgeons, that have issues in states that you wouldn't think, well, California has got it figured out or whatever. But there are rural communities and people out there that get impacted by this, and I think standardization, giving help, as they did in Canada, through the College. We have chapters everywhere. Why can't the College train surgeons, come together like they did in Alberta, British Columbia, and just have education. You can have Dr. Sachdeva, that spoke this morning. You can have simulation. You can have cadavers. You can teach TME. And you can radiation oncologists, you know. Radiation units are different. I think that's probably more of a barrier than surgical aspect of this, but it's very important as I've seen the numbers.