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EDITORIAL

- 968 COVID-19 and information and communication technology in radiation oncology: A new paradigm
Fernández C, Ruiz V, Couñago F
- 976 Practice change in the management of metastatic urothelial carcinoma after ASCO 2020
Gajate P, Torres-Jiménez J, Bueno-Bravo C, Couñago F
- 983 Stereotactic body radiation therapy: A good dance partner of oligometastatic non-small cell lung cancer to the sound of SINDAS study
Mielgo-Rubio X, Garde-Noguera J, Juan O, Couñago F
- 990 New standard in locally advanced rectal cancer
Solé S, Baeza R, Gabler C, Couñago F

MINIREVIEWS

- 996 Predictive indicators of successful tyrosine kinase inhibitor discontinuation in patients with chronic myeloid leukemia
Stuckey R, López-Rodríguez JF, Sánchez-Sosa S, Segura-Díaz A, Sánchez-Farías N, Bilbao-Sieyro C, Gómez-Casares MT
- 1008 Fluoropyrimidine-induced cardiotoxicity
Deac AL, Burz CC, Bocsan IC, Buzoianu AD

ORIGINAL ARTICLE**Retrospective Study**

- 1018 Forkhead box P3 and indoleamine 2,3-dioxygenase co-expression in Pakistani triple negative breast cancer patients
Asghar K, Loya A, Rana IA, Bakar MA, Farooq A, Tahseen M, Ishaq M, Masood I, Rashid MU
- 1029 Overall and cause-specific survival for mucoepidermoid carcinoma of the major salivary glands: Analysis of 2210 patients
Taylor ZC, Kaya EA, Bunn JD, Guss ZD, Mitchell BJ, Fairbanks RK, Lamoreaux WT, Wagner AE, Peressini BJ, Lee CM

Prospective Study

- 1045 Assessment of burden and coping strategies among caregivers of cancer patients in sub-Saharan Africa
Akpan-Idiok PA, Ehiemere IO, Asuquo EF, Chabo JAU, Osuchukwu EC

CASE REPORT

- 1064 Latent brain infection with *Moraxella osloensis* as a possible cause of cerebral gliomatosis type 2: A case report
Strojnik T, Kavalar R, Gornik-Kramberger K, Rupnik M, Robnik SL, Popovic M, Velnar T

- 1070** Preoperative rectal tumor embolization as an adjunctive tool for bloodless abdominoperineal excision: A case report

Feitosa MR, de Freitas LF, Filho AB, Nakiri GS, Abud DG, Landell LM, Brunaldi MO, da Rocha JJR, Feres O, Parra RS

- 1076** Endometrial clear cell carcinoma invading the right oviduct with a cooccurring ipsilateral oviduct adenomatoid tumor: A case report

Hu ZX, Tan MH, Li QZ, Xu JL, Chen W, Xie ZH, Zhou YJ, Liang Q, An JH, Shen H

ABOUT COVER

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Preoperative rectal tumor embolization as an adjunctive tool for bloodless abdominoperineal excision: A case report

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Abstract

BACKGROUND

Abdominoperineal excision (APE)-related hemorrhage can be challenging due to difficult access to pelvic organs and the risk of massive blood loss. The objective of the present study was to demonstrate the use of preoperative embolization (PE) as a strategy for blood preservation in a patient with a large low rectal tumor with a high risk of bleeding, scheduled for APE.

CASE SUMMARY

A 56-year-old man presented to our institution with a one-year history of anal bleeding and rectal tenesmus. The patient was diagnosed with bulky adenocarcinoma limited to the rectum. As the patient refused any clinical treatment, surgery without previous neoadjuvant chemoradiation was indicated. The patient underwent a tumor embolization procedure, two days before surgery performed *via* the right common femoral artery. The tumor was successfully devascularized and no major bleeding was noted during APE. Postoperative recovery was uneventful and a one-year follow-up showed no signs of recurrence.

CONCLUSION

Therapeutic tumor embolization may play a role in bloodless surgeries and

related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

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increase surgical and oncologic prognoses. We describe a patient with a bulky low rectal tumor who successfully underwent preoperative embolization and bloodless abdominoperineal resection.

Key Words: Rectal neoplasms; Proctectomy; Bloodless medical and surgical procedures; Embolization, therapeutic; Colorectal surgery; Case report

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Core Tip: Abdominoperineal excision (APE) remains a major surgery with considerable morbidity. Half of patients undergoing APE have some type of postoperative complication, and bleeding requiring transfusion of blood products is the main morbidity of the procedure. Preoperative embolization as a strategy for blood preservation in a giant rectal hemangioma has been successfully described.

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INTRODUCTION

An abdominoperineal excision (APE) consists on a combined abdominal and perineal resection of the anorectum and may be performed in benign conditions and malignancies. In low rectal cancer, advances in chemoradiotherapy and surgical devices have warranted a decrease in APE rates. Nevertheless, in those cases with anal sphincter involvement, the operation may undoubtedly be an alternative for oncologic control^[1].

Despite the evolution of colorectal surgery, such as the development of laparoscopic access and robotic surgery, proctectomy remains a major surgery with considerable morbidity^[2]. Approximately half of patients undergoing APE have some type of postoperative complication, and bleeding requiring transfusion of blood products is the main morbidity of the procedure^[3].

APE-related hemorrhage can be challenging due to difficult access to pelvic organs and the risk of massive blood loss (> 1000 mL of blood)^[4]. Furthermore, blood loss and blood transfusions have been associated with worse oncologic and postoperative outcomes in non-metastatic colorectal cancer. This effect is not completely understood but immunomodulatory signals leading to immunosuppression may be involved in adverse events^[5].

The concept of bloodless surgery involves a series of perioperative strategies to prevent transfusion of blood products^[6]. Recent studies have shown promising results in patients who have adopted this strategy, in bloodless centers^[7]. Of note, the positive effect on surgical results depends on the adoption of adequate blood conservation methods^[6]. The objective of the present study was to demonstrate the use of preoperative embolization (PE) as a strategy for blood preservation in a patient with a large low rectal tumor with a high risk of bleeding, scheduled for APE.

CASE PRESENTATION

Chief complaints

The patient was a 56-year-old man who suffered from anal bleeding and rectal tenesmus.

History of present illness

He presented to our institution with a one-year history of anal bleeding and rectal

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tenesmus. Worsening of symptoms was progressive. The patient also reported anorectal pain and weight loss (15% of body weight in the same period).

History of past illness

No underlying diseases were reported by the patient.

Physical examination

Physical examination was normal, except for a rectal mass starting 1 cm from the anal border, circumferential and obstructive.

Laboratory examinations

Laboratory tests were normal, except for a hemoglobin level of 9.4 g/dL. Carcinoembryonic antigen level was 3.34 ng/mL.

Imaging examinations

Colonoscopy was incomplete due to the bulky rectal mass. Tumor biopsy revealed a rectal adenocarcinoma. Abdominal and thoracic contrast-enhanced computed tomography scans showed extensive parietal thickening of the rectum, with an extension of 17.5 cm without signs of locoregional and distant metastasis (Figure 1).

FINAL DIAGNOSIS

The patient was diagnosed with bulky adenocarcinoma limited to the rectum. As he refused any clinical treatment, surgery without previous neoadjuvant chemoradiation was indicated.

TREATMENT

The patient also refused blood transfusion due to religious belief. To decrease bleeding during surgery, the patient underwent a tumor embolization procedure, two days before surgery performed *via* the right common femoral artery. Devascularization was performed with regular micra tris-acryl gelatin microspheres (500 μ m) until partial reduction of vascular flow in the tumor topography. Metal coils were also released in the main trunk of the rectal arteries with subsequent administration of acrylic glue (25% n-butyl-cyanoacrylate). Angiographic control evidenced occlusion of the main branch and preservation of collateral circulation of the rectum and part of the tumor topography by small adjacent rectal branches (Figure 2). Regarding the surgical procedure, due to the absence of an adequate anal margin, we opted for an APE with total mesorectum excision and terminal colostomy in the upper left quadrant of the abdomen. A large rectal tumor occupying the entire pelvis was diagnosed, and there was no involvement of other abdominal organs (Figure 3). There was no blood transfusion during the operation. Pre- and postoperative hemoglobin levels were 9.4 and 9.1 g/dL, respectively. Analysis of the surgical specimen showed an adenocarcinoma of the rectum and anal canal, 15 cm in longitudinal length and invasion of the muscularis propria. A total of 54 disease-free lymph nodes were retrieved. There was no angiolymphatic and perineural invasion; however, extensive tumor necrosis was observed (Figure 4).

OUTCOME AND FOLLOW-UP

Surgical margins were free of neoplasia and tumor staging was classified as pT2pN0cM0. The patient was discharged on the 7th postoperative day due to a metabolic ileus clinically managed. Adjuvant chemotherapy was not performed and no synchronous colonic neoplasms were diagnosed during the colonoscopy performed three months after surgery. Clinical evaluation 12 mo after surgery, showed no evidence of cancer recurrence.

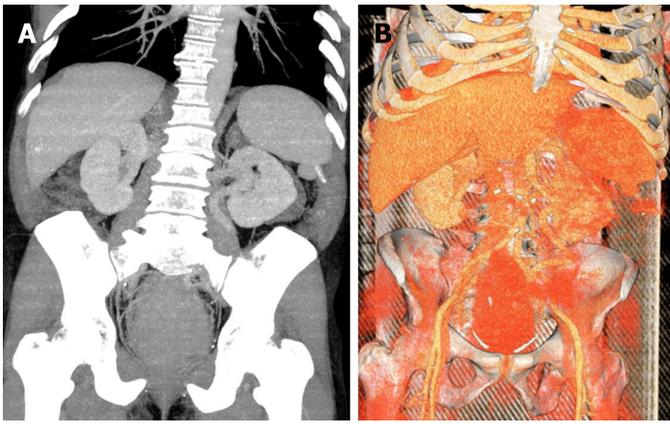


Figure 1 Computed tomography scans with vascular reconstruction. A: A bulky rectal tumor with B: Marked hypervascularization.

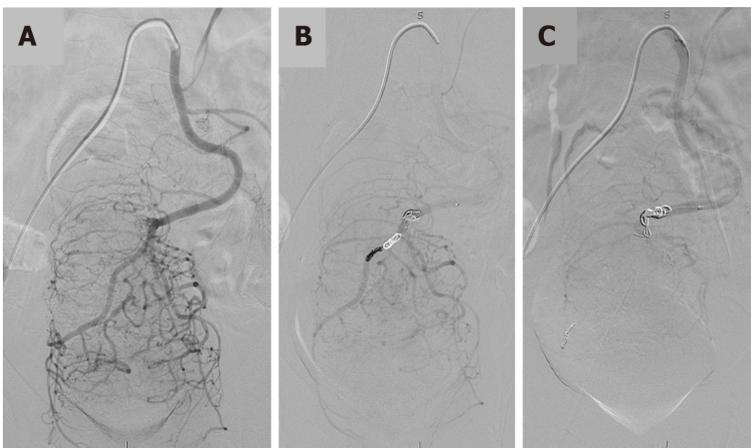


Figure 2 Preoperative embolization. A: Digital subtraction angiography (DSA) of the inferior mesenteric artery identifying the enlarged superior rectal artery with prominent branches supplying the rectal tumor; B: DSA of the inferior mesenteric artery after 300-500 micra tris-acryl gelatin microspheres distal embolization into the superior rectal artery and partial occlusion of its main branch with controlled detachable platinum coils; C: Final DSA control of the inferior mesenteric artery after injection of N-butyl-2 cyanoacrylate with ethiodol 1:4 at the bifurcation of the right and left branches of the superior rectal artery, showing a significant reduction in distal arterial supply.

DISCUSSION

Under normal conditions, the evaluation of blood supply in the distal rectum and mesorectum shows a predominance of blood vessels within the rectal wall^[6]. In rectal cancer patients contrast-enhanced endoscopic ultrasound imaging usually reveals well vascularized masses with inhomogeneous enhancement of the contrast resulting from necrotic areas^[9]. In the reported case, although atypical, a hypervascularized mass, with a predominance of blood vessels in the mesorectum was observed, as demonstrated by imaging exams. This hypervascularization is a hallmark of cancer and may be associated with the worst oncologic outcomes and with surgical complications (accidents during dissection and greater blood loss)^[10].

The most common measures of blood conservation in oncologic patients have been discussed elsewhere and can be grouped according to the period in which they are started^[6]. In APE patients, preoperative measures include treatment of anemia, suspension of substances that interfere with coagulation and careful procedure. Intraoperatively, it is important to minimize surgical trauma and to identify the proper surgical plane to perform a fine total mesorectal excision. Also, there is potential for autologous blood salvage and autologous normovolemic hemodilution. Postoperatively, lower levels of hemoglobin should be tolerated whenever possible and laboratory testing should be reduced to a minimum^[6].

PE as a strategy to reduce intraoperative blood loss is a concept that has been developed for several anatomical territories. In pelvic tumors, devascularization rates greater than 75% can be obtained^[11]. In our experience, PE was safe and successfully reduced intraoperative bleeding in a patient with a giant cavernous hemangioma of

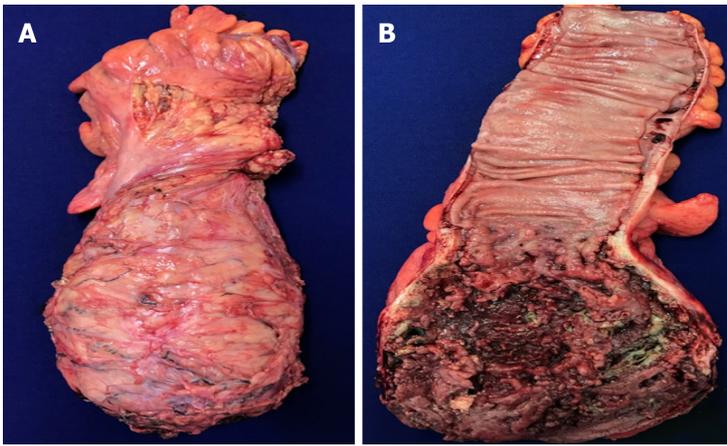


Figure 3 Surgical specimen after abdominal perineal resection. A: Total mesorectal excision; B: Extensive tumor necrosis can be observed after opening the surgical specimen.

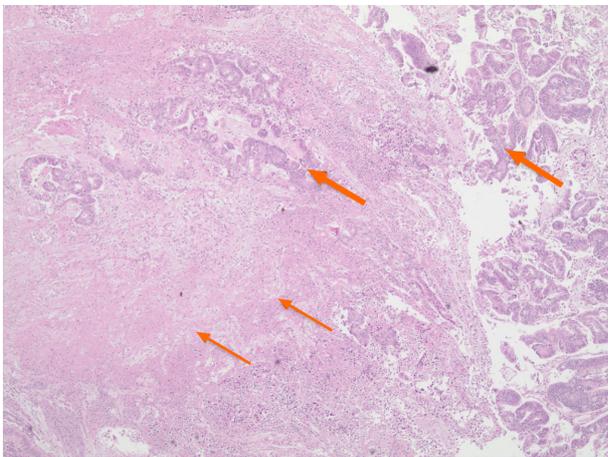


Figure 4 Rectal adenocarcinoma (thick arrows) showing extensive tumor necrosis (thin arrows). Hematoxylin and Eosin stain, × 40 magnification.

the rectum^[12]. Although relatively simple and safe, PE can lead to significant tumor necrosis and a higher risk of bleeding, therefore, surgical resection of the tumor mass must be performed early. At our institution, we perform the definitive operation within 48 h after PE.

To the best of our knowledge, PE of bulky rectal tumors with modern techniques has not been described; however the rationale sounds reasonable, since a correlation between devascularization and less blood loss has been observed in other hypervascular tumors such as in renal masses^[13]. In our experience, preoperative embolization of locally advanced rectal tumors reduces the blood content within bulky masses and can be used as an effective and safe adjunct to blood conservation. However, prospective and randomized studies are necessary to reveal the causal relationship between PE and reduced blood loss in bulky rectal masses.

CONCLUSION

Based on our experience and on a literature review we believe that preoperative embolization of rectal cancer may be an adjunctive tool in bloodless rectal surgeries.

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