Late Complications

International workshop on

Management of Peritoneal Surface Malignancy

9-11 August 2017, Irkutsk, Sibiria

Verena Müller
Charité - Universitätsmedizin Berlin
Chirurgische Klinik
Campus Charité Mitte I Campus Virchow-Klinikum
Head: Univ.-Prof. Dr. med. J. Pratschke

CHARITÉ

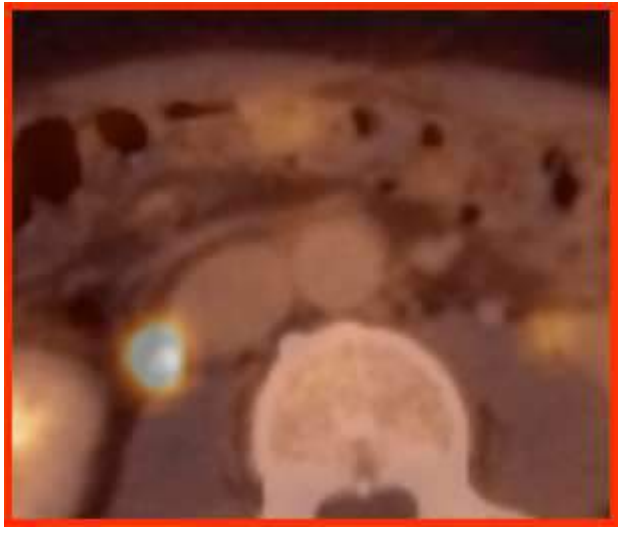
Interactive Case discussion

1. Case Male 47 years

History

- 10/2005 Laparoscopic appendectomy // hemicolectomy
  - FD Appendix carcinoma pT4 pN1 (1/71) M0 L1 V0 G2 R0
- Until 6/2006 12 cycl. FOLFOX
- 7/2012 CEA elevation to 4,2 µg/l (7/2010: CEA 2,3 µg/l)
- 9/2012 PET-CT suspect lesion
  - in the mesentery near abdominal wall
  - Small pelvis iliacal

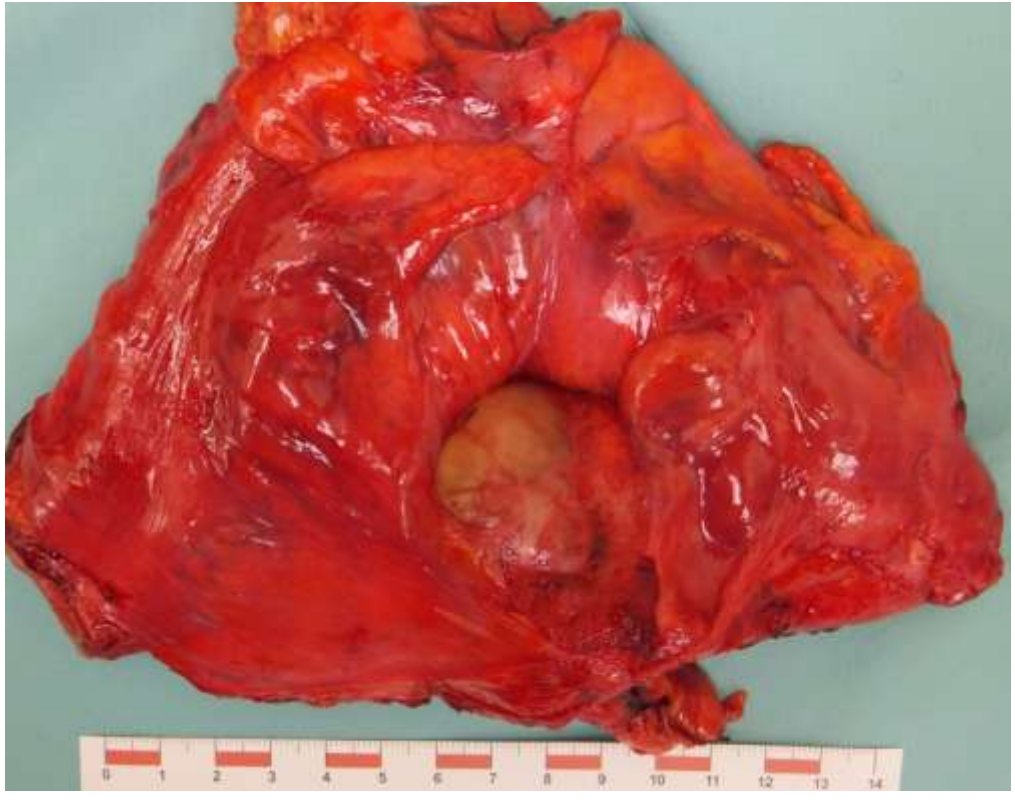
PET CT 18.09.2012



Treatment

- 11/2012 laparoscopy PCI 9
- 11/2012 gastric wedge resection, colectomy and ileorectostomy CCR 0
- Bidirectional HIPEC; 60 minutes; 42 °C
  - Oxaliplatin 598mg i.p.
  - 5-FU 797mg i.v. and LV 40mg i.v.

Lesion in the mesenteric route



CHARITÉ

Preoperative preparations and nutrition

Follow up

Uneventful stay

2 days ICU

Discharge after 19 days alltogether

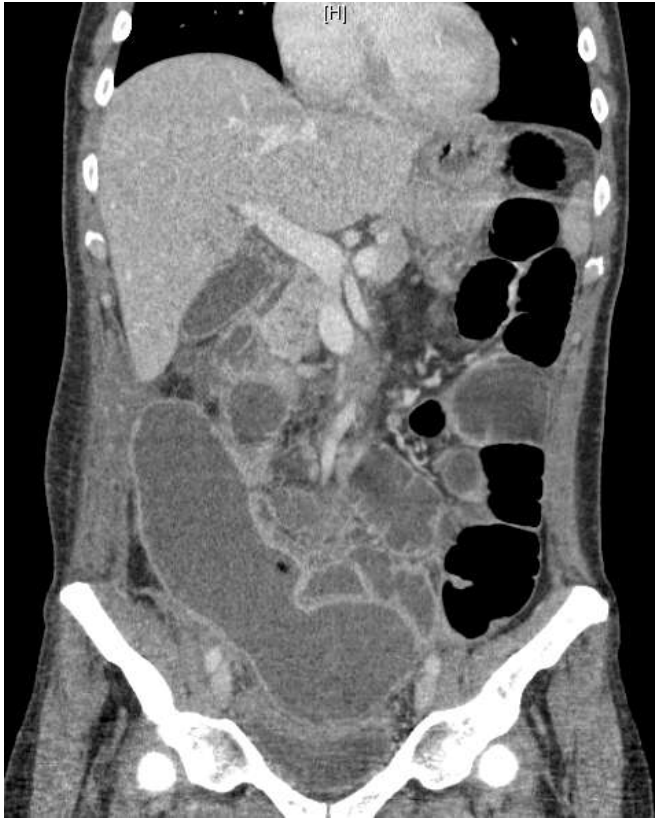
Follow up

Readmission 3 weeks later (5 weeks postoperatively)

Reduction of general condition

Weight loss

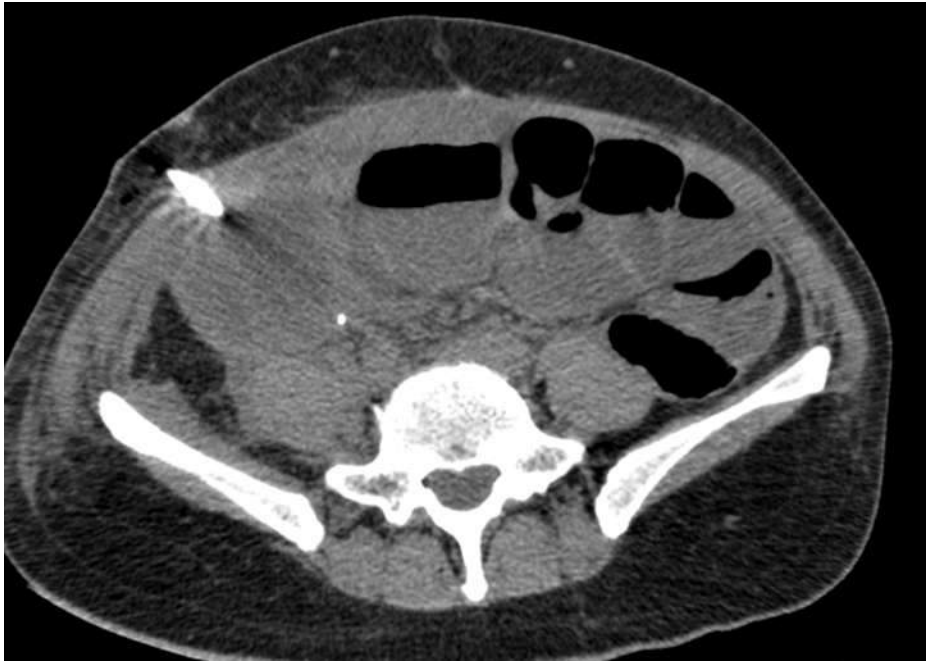
Follow up



Any ideas?

Intraabdominal abscess

Therapy?



CT guided drainage

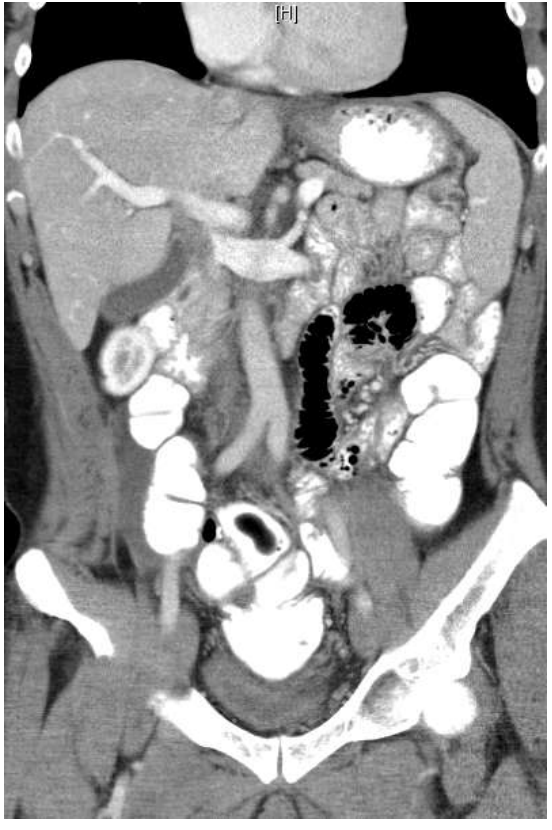
Preoperative preparations and nutrition

Через 2 года

хорошее состояние

На КТ нет опухоли

уровень CEA 1,7 мкг/л



2. Case Female 53 years

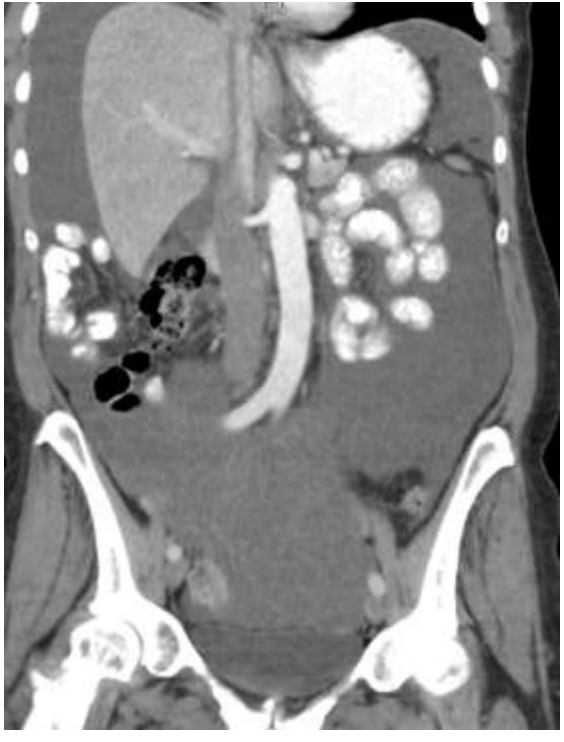
History

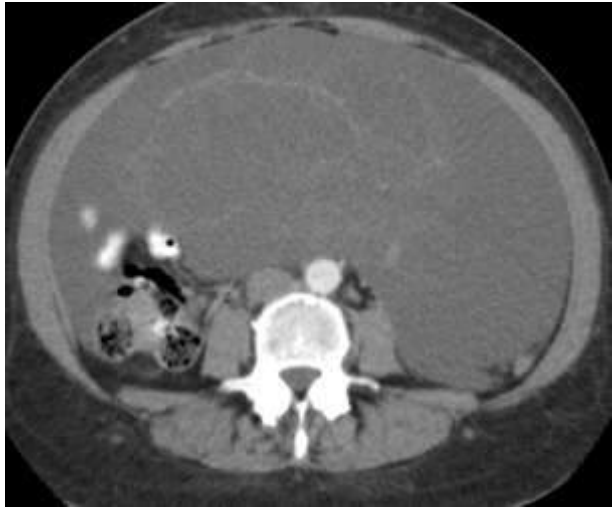
Since 3 months abdominal pressure

9/2012 Sonography and CT

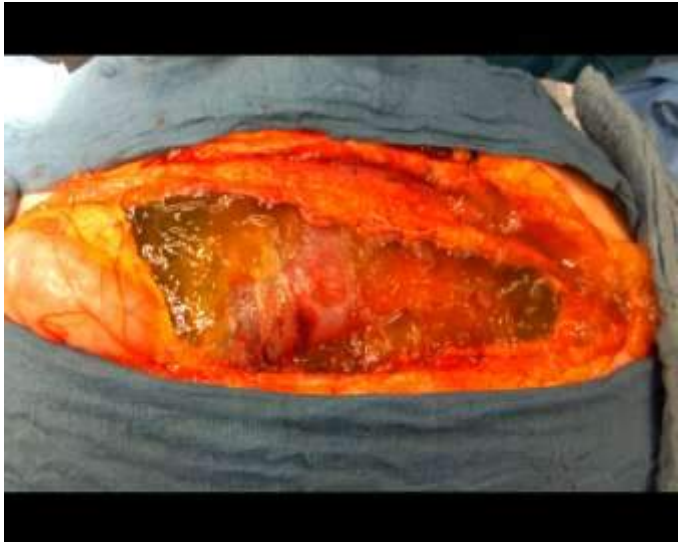
Big tumour mass

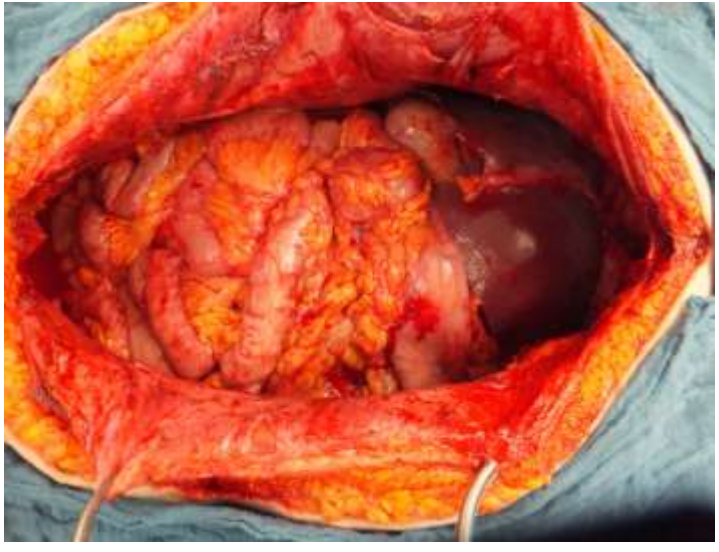
CT Scan





Treatment





-> Coecum resection, infragastric omentectomy, extraperitoneal AR plus hysterectomy and salpingoovarectomy en bloc (17 l Mucus)

-> HIPEC: CDDP and MMC

-> pT4b pM1b G1 Appendixcarcinoma

Preoperative preparations and nutrition

Neutropenia

There are three general guidelines used to classify the severity of neutropenia based on the absolute neutrophil count (ANC) measured in cells per microliter of blood:

- **Risk of infection:**
- **Minimal or Mild:** neutropenia 1000 <= ANC < 1500
- **Moderate:** neutropenia 500 <= ANC < 1000
- **Severe:** neutropenia ANC < 500

Французский анализ 2010 года

study included 1290 patients from 25 institutions who underwent 1344 procedures between February 1989 and December 2007. HIPEC was performed in 1154 procedures. The principal origins of PC were colorectal adenocarcinoma (N = 523), pseudomyxoma peritonei (N = 301), gastric adenocarcinoma (N = 159), peritoneal mesothelioma (N = 88), and appendiceal adenocarcinoma (N = 50). The overall morbidity and mortality rates were 33.6% and 4.1%, respectively. In

Table 4. Details of Major Complications (Grade 3/4 According to the National Cancer Institute Common Toxicity Criteria)

Type of Complication	No. of Patients	%
Grade 3-4 complications	422	33.6
Reoperations	178	14
Neutropenia	161	13.3
Digestive fistula	123	9.7
Pneumonia	115	9.1
Postoperative bleeding	95	7.7
Intra-abdominal abscess	90	7
Systemic sepsis	32	2.3
Bowel obstruction	20	1.5
Renal insufficiency	14	1

One of the most important issues arising from our analysis is the strong influence of the institution not only on survival but also on morbidity and morbidity rates.

The institution in which the procedure was performed was an independent prognostic indicator of postoperative complications. When comparing centers that performed

Glehen et al., Cancer 2010

CHARITÉ

Первые выводы

Заболеваемость и смертность не выше, чем после других „правильных“ процедур в онкохирургии

НО

[12]. Thus, fear of a severe post-operative course is no longer an acceptable reason for not using CCRS and HIPEC.

*Elias et al., EJC 2014

CHARITÉ

Подумайте о кривой обучения…

Так как мы можем бороться с осложнениями?

First of all, try to prevent them:

•Select your patient careful!

•Establish a rigorous preoperative work-up! SOP!

•Be aware of your learning curve

Second, detect and report them:

- Train your assistants!
- See your patient daily by your own!
- Always remember: they can come along with a severe complication even 10 days after surgery!

And third, manage them:

•Look at your hospital! You´ll need

•an excellent anesthetist

•an experienced intensivist
•a brave endoscopist

•an uncomplaining interventional radiologist

Conclusions

•Generally: manage your complications the earlier, the more aggressive.
•WE do not perform protective stoma in rectal resections.
•Whenever in doubt, you should do re-laparotomy…

So the bottom line is: manage your HIPEC-complications like you manage your complications in other cases.

Do it that way you are most familiar with.