Complete Response of Locally Advanced (stage III) Rectal Cancer to Metabolically Supported Chemoradiotherapy with Hyperthermia

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Abstract

Background: Locally advanced rectal cancer is defined as a rectal mass that cannot be resected without a high probability of leaving residual disease at the tumor site. While the standard treatment for locally advanced rectal cancer is chemoradiotherapy followed by surgery, this study reports a locally invasive rectal adenocarcinoma patient who achieved complete pathological and clinical remission after receiving a combination of metabolically supported chemotherapy (MSCT), radiotherapy (RT) and hyperthermia (HT).

Case presentation: An 81-year-old female underwent a rectosigmoidoscopy at a referring hospital following a complaint of bloody stools for a period of 20 days. The rectosigmoidoscopy revealed an ulcerated tumor beginning at the level of the anal sphincter. A pathological examination of biopsy material revealed moderately differentiated invasive adenocarcinoma and the patient received a diagnosis of stage III (T3N2M0) locally invasive rectal cancer. When further follow-up revealed colonic obstruction, the patient was recommended an abdominoperineal resection (APR) and was referred after refusing surgical treatment. The patient received a metabolically supported combination of oxaliplatin, 5-florouracil (5-FU) and calcium folinate (FOLFOX6) concomitant to RT and local HT and, ultimately, never underwent surgery. 27 months since her disease-free PET-CT scan, the patient remains with no sign of disease recurrence.

Conclusion: According to the findings of the present study, the non-surgical treatment and achievement of complete clinical and pathological remission of locally advanced rectal adenocarcinoma may be possible by means of a combination of MSCT, RT and HT.

Keywords: Pathological complete response; Locally advanced rectal cancer; Metabolically supported chemotherapy; Hyperthermia

Introduction

With nearly 1.4 million new cases diagnosed in 2012 and 607,000 deaths recorded in 2008, statistics show that colorectal cancer is the third most commonly diagnosed cancer among males and the second most commonly diagnosed cancer among females [1,2]. The management of colorectal cancer depends largely on the location of the tumor mass. Nonetheless, surgical resection is the cornerstone of curative treatment [3]. For lower rectal tumors, which are located within up to 6 cm of the anal verge, abdominoperineal resection (APR), with an ileal colostomy, has long been considered the gold standard [4]. If such tumors are also locally advanced (stages II and III), surgical treatment is preceded by preoperative 5-florouracil based concurrent CRT [5,6]. While the standard treatment for locally advanced rectal adenocarcinoma is neoadjuvant chemoradiotherapy (CRT) followed by surgery [6], its treatment by way of metabolically supported chemotherapy (MSCT), radiotherapy and hyperthermia has never been reported.

MSCT is an approach to chemotherapy administration based on Warburg's hypothesis that "cancer is a disease of metabolic dysregulation" [7] and his 1924 finding that cancer cells carry out glycolysis instead of oxidative phosphorylation for energy generation [8]. In practice, it involves an 8-10 hour fast starting the previous day, the application of pharmaceutical doses of regular insulin and the development of mild hypoglycemia prior to the administration of chemotherapeutic drugs. It is used to enhance the cytotoxic effects of chemotherapeutics and to decrease their toxicity. Hyperthermia (HT), similarly, is a form of treatment that exposes body tissue to temperatures exceeding 42°C for the purpose of improving the tumoricidal effects of both radio and chemotherapy.

Here, the case of a patient with locally advanced rectal adenocarcinoma who achieved complete pathological and clinical remission after receiving a combination MSCT, RT and HT is reported.

Case Presentation

An 81-year-old female underwent a rectosigmoidoscopy at a referring hospital following a complaint of bloody stools, severe constipation and abdominal swelling for a period of 20 days. The rectosigmoidoscopy revealed an ulcerated and vegetative tumor beginning at the level of the anal sphincter. A pathological examination of biopsy material revealed moderately differentiated invasive adenocarcinoma and the patient received a diagnosis of stage III (T3N2M0) locally invasive rectal cancer. A pathological examination of biopsy material revealed moderately differentiated invasive adenocarcinoma and the patient received a diagnosis of stage III (T3N2M0). When further follow-up revealed colonic obstruction, the patient was recommended an abdominoperineal resection (APR) and was referred after refusing surgical treatment. The patient received a metabolically supported combination of oxaliplatin, 5-florouracil (5-FU) and calcium folinate (FOLFOX6) concomitant to RT and local HT and, ultimately, never underwent surgery. 27 months since her disease-free PET-CT scan, the patient remains with no sign of disease recurrence.

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Figure 1: Histopathological examination showing moderately differentiated invasive adenocarcinoma.

Figure 2: Whole body (18F)-florodeoxyglucose (FDG)-PET-CT showing the presence of a mass, spanning a 5.5 cm segment of the rectum associated with rectal wall thickening.

Figure 3: Follow-up PET-CT showing shrinkage of the primary tumor and decrease in rectal wall thickening.

Locally advanced rectal cancer cannot be resected without a high probability of leaving microscopic or gross residual disease at the original tumor site due to tumor fixation or adherence to neighboring tissue [9]. Hence, standard treatment in the case of most patients with locally
advanced disease incorporates multiple modalities, including preoperative CRT, surgery and postoperative chemotherapy [11]. The significance of preoperative CRT has been widely researched and that preoperative CRT achieves high rates of local control and five-year overall survival rates of about 60 percent for patients with locally advanced rectal cancer has been reported in several retrospective studies [12-15]. Standard CRT consists of 5-FU-based infusional chemotherapy and concurrent fractionation RT (45 to 50 Gy administered over a period of 5.5 to 6 weeks) [16]. Surgical exploration is undertaken four to eight weeks after neoadjuvant CRT and additional chemotherapy is administered following surgery [9]. Of the treatment modalities employed in the treatment of the present case, metabolically supported chemotherapy is based on the Warburg hypothesis, a phenomenon also referred to as the “Warburg effect.” According to this hypothesis, deficiency in oxidative phosphorylation and elevated glycolysis in cancer cells are the primary causes of cancer and a dysregulation of the metabolism at a cellular level is the cause for progressive transition from normalcy to malignancy [17]. MSCT is centered on various types of metabolic interventions directed towards correcting this metabolic dysregulation at a cellular level. In practice, the metabolic modification of cancer cells is achieved through the use of insulin, which together with insulin like growth factors I and II (IGFs), is central to the mechanism of autonomous growth and malignancy in cancer cells [18]. Studies suggest that insulin enhances the cytotoxic effects of chemotherapeutic drugs, first of all, by increasing membrane fluidity and permeability for thereby allowing for increased drug penetration [16,19-21]. The adsorption of drug molecules onto insulin and the formation of drug-insulin complexes, later internalized by receptor-mediated endocytosis, have also been discussed as causes for increased intracellular drug levels and resulting increased cytotoxicity [22-25]. The metabolic modification that insulin brings about in cancer cells is, most importantly, related to the cross reaction of insulin with IGF receptors located on cancer cell membranes. This cross-reactation extends the S-phase fraction of the cell cycle [26] and ultimately renders cancer cells more susceptible to the cytotoxic effects of anticancer drugs, especially in the case of cell-cycle phase-specific agents [27]. Therefore, adding insulin to chemotherapy regimens allows for the use of lower systemic drug doses with increased efficacy – as higher intracellular doses are achieved within cancer cells – and an increased level of safety – as the lower concentration of insulin receptors on normal cells spares them from the intensity of the cytotoxic effects of chemotherapeutic drugs [28].

HT is the second form of treatment the present case received. HT is defined as a form of treatment in which body tissue is exposed to high temperatures (up to 45°C) to damage and kill cancer cells or to make cancer cells more sensitive to the effects of radiation and certain anticancer drugs [29,30]. The antimtumor effects of HT have been clearly demonstrated [31-34]. Numerous clinical trials carried out since the early 1970’s, have shown that HT significantly improves the effectiveness of both CT and RT by interfering with the repair of radiation-induced DNA damage [35] and through synergistic interaction with cytotoxic drugs [36]. When RT is administered in combination with HT, in vivo studies have demonstrated that the effect of radiotherapy can be enhanced by a factor of between 1.2 and 5 [37,38]. HT is also reported to be the most potent radiosensitizer to date. That the administration of chemotherapy agents, including plain analogues, alkylating agents and nitrosoureas, together with HT, enhances the efficacy of these drugs by a factor of between 1.2 and 10 in virtually all cell lines has also been reported [39]. General discomfort, patient anxiety and pain due to the “hot-spot phenomenon” (specific acute to subacute side effects caused by electrical interface) have been reported as common problems related to the local HT of deep-seated tumors in up to 60% of patients [40]. The patient reported in the present study experienced mild discomfort during the first 3 sessions of HT. This discomfort later resolved. The patient experienced no such late toxicity symptoms as chronic bowel dysfunction, ulceration of the bowel or bladder or obstruction/stricture of the ureters. Such signs of toxicity were not observed in any patients included in a phase II clinical trial carried out by Rau B et al. either [41].

Although there are no reports of the non-surgical treatment of locally advanced low-lying rectal adenocarcinoma using RT and HT combined with MSCT, various non-randomized and randomized trials for rectal cancer have demonstrated an improved local response with the combined use of HT and standard radiochemotherapy [42]. One randomized trial that employed endovacutary HT in addition to radiotherapy with locally advanced T4 tumors reported that radical resection rate was significantly increased in the combined treatment group (55% vs. 27.1% with radiotherapy alone) and that the patients in the combined treatment group also had significantly improved 5-year survival rates (36% vs. 7%) [43]. Using similar techniques as the previously mentioned trial, Mori et al. treated 11 patients with deep-seated rectal cancer (Dukes’ A-C) and reported benefit in 6 of 11 cases [44]. A phase III trial that treated 146 patients with rectal cancer (Dukes’ A-C) either by preoperative RT and HT or preoperative RT alone, with patients in the control arm appointed for surgery with no preoperative treatment, reported significantly increased complete response rates (22.7% vs. 5.3%) and 5-year survival rates of 66.7% versus 50% after RT alone and 40.5% in the control arm [45]. In contrast to the patients in the previously mentioned studies, however, the case reported at present received MSCT and never underwent a resection. Regardless of never having undergone surgery, the patient has maintained a disease-free status.

To our knowledge, this is the first study discussing the use of MSCT, RT and HT for the treatment of locally invasive rectal adenocarcinoma. Considering the benefit that the present case received, further research is necessary in these areas for the standardization of such treatment modalities.

**Conclusion**

This study, which is limited to one patient and discusses a 27-month follow-up period, demonstrates that the non-surgical treatment and achievement of complete clinical and pathological response may be possible by means of a combination of MSCT, RT and HT.

**References**