

## Endosonographic Follow-Up After Local Excision of a pT1 Rectal Carcinoma

An invasive adenocarcinoma that does not penetrate beyond the submucosa is classified as pT1. The main problem after local excision of this type of lesion is the risk of metastatic lymph nodes. It is generally accepted that histological criteria in the surgical specimen can help to predict the risk of lymph-node metastasis (1). In case of poor prognostic features, surgical resection is usually recommended. However, the management of such a situation is more difficult when the tumor is located in the part of the low rectum that would require an abdominal-perineal resection. In this case, transrectal endoscopic ultrasonography (EUS) may be helpful in minimizing the risk of overtreatment. We report here on a case of pT1 cancer of the low rectum treated by transanal resection and then followed up by endoscopic ultrasonography. This led to the diagnosis of an isolated lymph-node metastasis, resulting in an abdominal-perineal resection.

In June 1994, a 66-year-old man with ischemic heart disease underwent complete transanal resection of a villous adenoma that was shown to be benign on biopsies and which was located at the lower third of the rectum. The histology revealed a focus of carcinoma invading the submucosa, with lymphatic involvement. The patient was then referred to us for endosonographic follow-up. The first endosonographic examination, using an Olympus EUM3 endoscope (Tokyo, Japan) was normal in September. A follow-up at three months was then planned. The following December, endoscopic ultrasonography revealed a small lymph node adjacent to the rectal wall. The patient was symptom-free, the CEA was not elevated, and there was no residual rectal tumor. Six weeks later, the lymph node was slightly larger, reaching 8 mm in diameter, and more rounded, with a hypoechoic, sharply demarcated echo pattern (Figure 1). The CT scan was normal. A fine-needle biopsy guided by a transrectal ultrasonographic linear rigid probe (Toshiba PVL 725 RT) was carried out. The histology confirmed malignant disease, and the patient underwent an abdominoperineal resection after radiotherapy. The histopathological examination of the resection specimen only revealed an isolated lymph node metastasis with a diameter of 9 mm.

The patient's tumor carried a high risk of lymph-node metastasis. Although there are conflicting data regarding the incidence of lymph-node metastasis, the risk does not exceed 10% in most series. The risk of death from metastatic cancer had to be weighed up in this case against the relative risk of abdominoperineal resection in a 66-year-old patient with ischemic heart disease (2). It is now generally accepted that transrectal endoscopic ultrasonography is the most reliable technique for assessing lymph-node involvement from rectal tumors (3). The present report indicates the potential benefit of EUS for the surgical selection of patients



**Figure 1:** Endosonographic image of a rounded, homogeneous hypoechoic lymph node adjacent to the rectal wall.

similar to ours, and underlines the usefulness of fine-needle biopsy guided by an endosonographic system, providing the sagittal scan section for histological confirmation of malignancy that is required to reach a treatment decision.

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