Organ conservation is now the norm in surgical oncology. Definitive CT-RT for selected patients can obviate the need for an abdomino-perineal resection with a permanent colostomy.

From January 2011 to December 2015, a total of 38 consecutive patients with low rectal cancer were morphologically grouped as:
1. Proliferative, non-obstructive lesions (N=30)
2. Stenotic, infiltrative and obstructive lesions (N=8)
based on clinical, endoscopic and CT scan studies.

Patients with pararectal extension of the primary lesion and significant pelvic nodes were excluded. Therapy consisted of 4 cycles of chemotherapy followed by RT (45Gy). Concurrent CT-RT was avoided to prevent significant rectal and bladder symptoms. Final therapeutic response was evaluated 6-8 weeks post therapy.

Outcome of CT-RT was defined as:
- Complete response (CR): No disease on clinical, endoscopy, biopsy and imaging
- Partial response (PR): Significant but incomplete reduction in the size of the tumor
- No response (NR): No significant change in tumor

Those patients with PR, NR or recurrences were subjected to surgery. Patients were followed up for a mean of 23.8 months (8-55 months)

**Selection Criteria for Definitive Chemo-Radiotherapy in Low Rectal Cancers: A Preliminary Data from a Single Centre, India**

R Parikh, P Desai, Breach Candy Hospital, Mumbai, India

### Background

Organ conservation is now the norm in surgical oncology. Definitive CT-RT for selected patients can obviate the need for an abdomino-perineal resection with a permanent colostomy.

### Material and Methods

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### Results

<table>
<thead>
<tr>
<th>Group 1</th>
<th>Complete Response (N=16)</th>
<th>Partial Response (N=12)</th>
<th>No Response (N=2)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Complete Response (N=16)</td>
<td>75%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Partial Response (N=12)</td>
<td>40%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No Response (N=2)</td>
<td>53%</td>
<td></td>
</tr>
</tbody>
</table>

### Conclusions

Definitive CT-RT in proliferative and non-obstructive low rectal cancers should be considered as a therapy of choice. Whereas stenotic, infiltrative and obstructive lesions should be subjected to primary surgery.