Disparity in Treatment for Rectosigmoid Junction Cancer: A National Cancer Database Study

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INTRODUCTION: The treatment of middle and low rectal cancer is well established, but optimal management of rectosigmoid junction (RSJ) cancer remains controversial. The varied definition may lead to misclassification, overtreatment, or undertreatment, with all associated risks. Variables other than tumor location may impact the treatment choice and subsequent outcomes. We sought to investigate the patient and provider factors that may impact the treatment approach for RSJ cancer.

METHODS: The NCDB was reviewed (2006-2017) for clinical stage II/III RSJ adenocarcinomas undergoing resection. Cases were stratified by initial treatment approach into neoadjuvant chemoradiotherapy (NACRT) or upfront surgery groups. Multivariate logistic regression evaluated factors associated with NACRT. Propensity-score matching balanced the groups across demographic, clinical, and provider factors. Kaplan-Meier curves, log-rank test, and Cox regression assessed OS. The main outcome measure was the factors associated with NACRT.

RESULTS: Of 12,206 cases, 65.1% received upfront surgery and 34.9% NACRT. Advanced age, female sex, black race, and larger comorbidity burden were associated with upfront surgery. Medicaid payer, cT3/T4, nodal disease, treatment at an academic/integrated network cancer center, and farther travel distance to the treatment facility were associated with NACRT. The PSM yielded well-balanced cohorts: 1,331/arm. In the matched survival analysis, NACRT and upfront surgery had similar 1-, 3-, and 5-year OS (p = 0.15).

CONCLUSION: In RSJ, there are disparities in patient demographics, geographic location, and treatment center type that impact who receives NACRT. However, patients receiving NACRT had similar OS to those undergoing upfront surgery. These findings demonstrate the need to standardize care for RSJ cancer in the United States.

Impact of Age and Insurance Status on Colorectal Cancer Presentation

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INTRODUCTION: Between 2013-2025, general surgery procedures in geriatric patients are predicted to increase by 18%. Inpatient geriatric colorectal surgeries are expected to increase by more than 40%. In addition to volume, the geriatric patient population is increasing in diversity, especially in New York City. This changing demographic is concerning for future disparities of care. In prior studies, impoverished elderly immigrant patients had higher stage colorectal cancer at diagnosis and were less likely to undergo colorectal cancer screening. To address any inequitable care, especially due to language barriers, we sought to identify postoperative disparities in a highly heterogeneous group of geriatric patients who underwent non-elective colectomy at this institution.

METHODS: Single-institution retrospective study on patients ≥65 years old undergoing non-elective colectomy between 2015-2020. Baseline, perioperative, and postoperative data were abstracted from a prospectively derived database used to submit data to the National Surgical Quality Improvement Program. Univariate and bivariate analysis using SAS 9.4.

RESULTS: 162 patients were identified. Mean age was 78.3 years. 40% were male. 66 patients spoke 11 non-English languages. 21 attending surgeons were proficient in 4 languages. Attending surgeon spoke the primary language of 110 patients and required translation for 52 patients. Translator use was not associated with preoperative demographics or postoperative discharge disposition (p = 0.27), 30-day readmission (p = 0.14), septic shock (p = 0.59), 30-day reoperation (p = 0.31), and 30-day mortality (p = 0.62).

CONCLUSION: Elderly patients with language barriers experience comparable outcomes in non-elective colectomy. Data may not capture inoperable cases or out-of-hospital mortality.