10è CONGRÉS
CATALÀ DE CIRURGIA

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Barcelona, Auditori de l'Acadèmia

Societat Catalana de Cirurgia

L'Acadèmia

OCLUSIÓ DE COLON: CIRURGIA PRIMÀRIA VS STENT

Sebastiano Biondo

EBSQ-Coloproctology

Servei de Cirurgia General y Digestiva

Hospital Universitari de Bellvitge

Barcelona

Excerpta Medica

The American Journal of Surgery

The American Journal of Surgery 189 (2005) 377–383
Scientific paper

A prospective study of outcomes of emergency and elective surgeries for complicated colonic cancer

Sebastiano Biondo, M.D.[a,*], Joan Martí-Ragué, M.D.[a], Esther Kreisler, M.D.[a], David Parés, M.D.[a], Adan Martín, M.D.[a], Matilde Navarro, M.D.[b], Laura Pareja, M.S.[c], Eduardo Jaurrieta, M.D.[a]

361 patients colonic cancers

86 **(23.8%)** complicated

45 **(76.3%)** obstruction

27 **(31.4%)** palliative surgery

Cancer related survival and recurrence in patients with complicated colonic cancers may improve, moving towards that of elective surgery, if a surgical treatment with radical oncological criteria is performed.

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OCLUSIÓ DE COLON: CIRURGIA PRIMÀRIA VS STENT

Cirugía urgente vs cirugía electiva

Altos índices de morbilidad, mortalidad, estomas

Breitenstein S, et al. Br J Surg 2007
Tan CJ, et al. Br J Surg 2012
Huang X, et al. J Gastroint Surg 2014

Colocación de Stent

Cirugía urgente en electiva
Tratamiento definitivo o puente a la cirugía

Tan CJ, et al. Br J Surg 2012

Varios estudios no han podido demostrar mejores resultados en el Tto con prótesis

Sagar J. Cochrane Syst rev 2011
Van Hooft JE, et al Lancet Onco 2011

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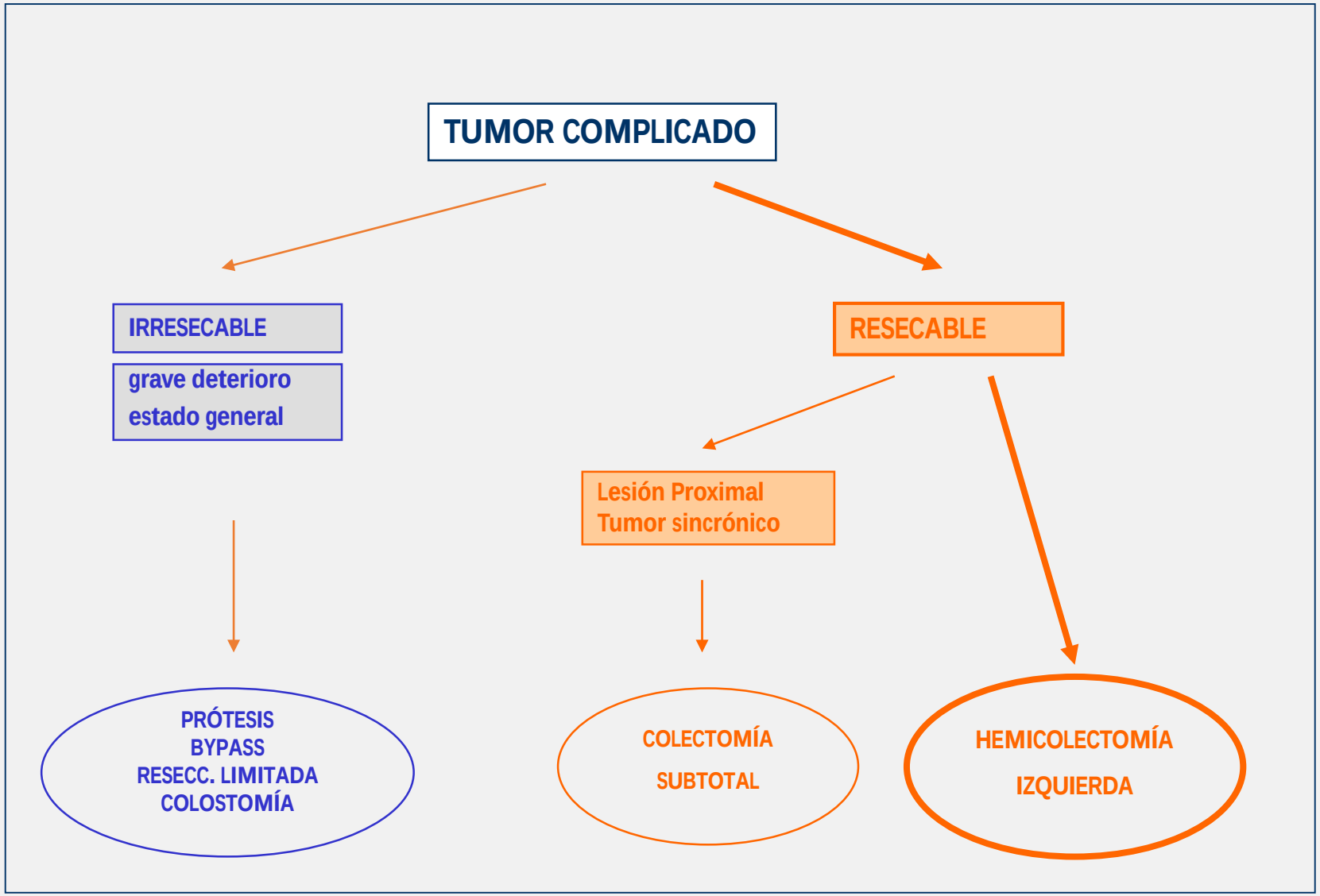
ALGORITMO TERAPÉUTICO



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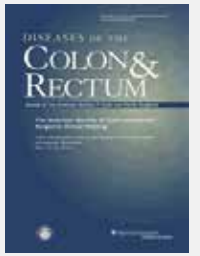
Large Bowel Obstruction: Predictive Factors for Postoperative Mortality

Sebastiano Biondo, M.D., David Parés, M.D., Ricardo Frago, M.D., Joan Martí-Ragué, M.D., Esther Kreisler, M.D., Javier De Oca, M.D., Eduardo Jaurrieta, M.D.

Department of Surgery, Hospital Universitario de Bellvitge, University of Barcelona, Barcelona, Spain



Dis Colon Rectum 2004;47:1889–97

Reason for Obstruction According to Location

	Proximal Colon n (%)	Distal Colon n (%)	*P* Value	Total n (%)
Malignant lesions				
Colorectal cancer	77 (81.0)	115 (82.7)		192 (82.0)
Extracolonic cancer	3 (3.1)	8 (5.7)		11 (4.7)
Benign lesions				
Diverticular disease	—	4 (2.8)	0.09	4 (1.7)
Hernia[a]	4 (4.1)	2 (1.4)		6 (2.5)
Volvulus	6 (6.2)	5 (3.6)		11 (4.7)
Ischemic colitis	—	3 (2.1)		3 (1.2)
Others[b]	5 (5.2)	2 (1.4)		7 (3.0)
Total	95 (40.6)	139 (59.4)		234

[a]Including groin hernia or incisional hernia.

[b]Including appendiceal inflammatory mass (4 patients), colonic tuberculosis (1 patient), ileocecal invagination by polyp (1 patient), and Ogilvie's syndrome (1 patient).

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Diseases of the Colon & Rectum

Large Bowel Obstruction: Predictive Factors for Postoperative Mortality

Sebastiano Biondo, M.D., David Parés, M.D., Ricardo Frago, M.D., Joan Martí-Ragué, M.D., Esther Kreisler, M.D., Javier De Oca, M.D., Eduardo Jaurrieta, M.D.

Dis Colon Rectum 2004;47:1889–97

	Multivariate Analysis	
	OR (95% CI)	*P* Value[a]
Age >70 years *vs.* ≤70 years	2.05 (0.92–4.60)	0.0788
ASA III–IV (*vs.* I–II)	2.86 (1.15–7.11)	0.0237
Damage of proximal colon and/or associated peritonitis (yes *vs.* no)	2.90 (1.19–7.04)	0.0184
Preoperative renal failure (creatinine >120 µmol/l *vs.* ≤120 µmol/l)	3.33 (1.36–8.14)	0.0083

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Diseases of the Colon & Rectum

Anastomotic Dehiscence After Resection and Primary Anastomosis in Left-Sided Colonic Emergencies

Sebastiano Biondo, M.D., David Parés, M.D., Esther Kreisler, M.D., Juan Martí Ragué, M.D., Domenico Fraccalvieri, M.D., Amador Garcia Ruiz, M.D., Eduardo Jaurrieta, M.D.

Department of Surgery, Hospital Universitario de Bellvitge, University of Barcelona, Barcelona, Spain

Dis Colon Rectum 2005; 48: 2272–2280

No se observaron diferencias entre pacientes con oclusión y perforación

Multivariate Logistic Regression Analysis for Leak as Outcome

Independent Predictors	OR	95 Percent CI	*P* Value
Obesity (yes/no)	9	1.5–53.7	0.016
Preoperative transfusion (yes/no)	4.09	0.77–21.61	0.097

OR = odds ratio; CI = confidence interval.

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Department of Surgery, Hospital Universitario de Bellvitge, University of Barcelona, Barcelona, Spain

Dis Colon Rectum 2005; 48: 2272–2280

The overall mortality was 6.2 % (13 patients)

Mortality and Their Cause According to Indication of Surgery

	Peritonitis (n = 106)	Obstruction (n = 98)	Hemorrhage (n = 4)	*P* Value[a]
Cardiac arrest	—	2	—	
Respiratory failure	—	5	1	
Sepsis	2	1	—	
Upper gastrointestinal hemorrhage	1	—	—	
Mesenteric ischemia	1	—	—	
Total	4 (3.7)	8 (8.1)	1 (25)	0.103

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Survival at 3 years stratified by TNM tumor stage among patients after radical surgery

	Group 1	Group 2	Hazard rate (95% confidence interval)*	P†
Overall survival				
Stage I	100%	76.23%	-	‡
Stage II	66.21%	82.26%	.501 (.232–1.082)	.0728
Stage III	52.50%	79.75%	.307 (.150–.632)	.0007
Cancer-related survival				
Stage I	100%	100%	-	‡
Stage II	78.79%	97.08%	.186 (.054–.643)	.0029
Stage III	78.95%	87.83%	.428 (.148–1.239)	.1071
Probability of being free from recurrence				
Stage I	100%	100%	-	‡
Stage II	55.68%	86.00%	.272 (.118–.630)	.0011
Stage III	52.41	75.54%	.488 (.213–1.117)	.0827

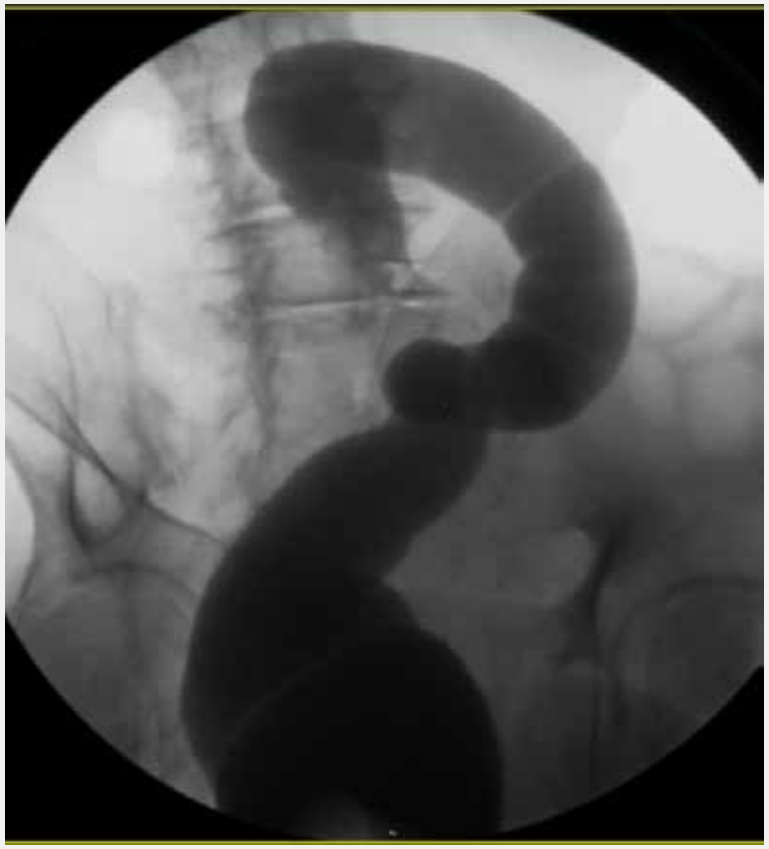
Original article doi:10.1111/j.1463-1318.2010.02549.x

Differences between proximal and distal obstructing colonic cancer after curative surgery

R. Frago, S. Biondo, M. Millan, E. Kreisler, T. Golda, D. Fraccalvieri, B. Miguel and E. Jaurrieta
Department of Surgery, Colorectal Unit, Bellvitge University Hospital, University of Barcelona and IDIBELL, Barcelona, Spain

Colorectal Dis. 2011;13:e116-22

	Proximal (%) 173	Distal (%) 204	*P*
Incisional surgical site complications			
Abscess (superficial and deep)	16 (9.2%)	28 (13.7%)	0.177
Incisional hernia	4 (2.3%)	5 (2.5%)	1*
Organ-space surgical site complications			
Abscess	10 (5.8%)	11 (5.4%)	0.870
Generalized peritonitis	4 (2.3%)	11 (5.4%)	0.127
Reoperations	30 (17.3%)	22 (10.8%)	0.066
Anastomotic leakage	28 (16.4%)	13 (7.7%)	0.014
Extra-surgical site complications			
Respiratory failure and pneumonia	13 (7.5%)	17 (8.3%)	0.770
Cardiac failure, arrhythmia	4 (2.4%)	8 (4%)	0.502*
Upper digestive bleeding	2 (1.2%)	4 (2%)	0.691*
Prolonged ileus	9 (9.2%)	15 (7.4%)	0.394
Mean hospital stay (range)	20.4 days (7–191)	19.3 days (5–90)	0.575
Mortality	25 (14.5%)	30 (14.7%)	0.944



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Original article

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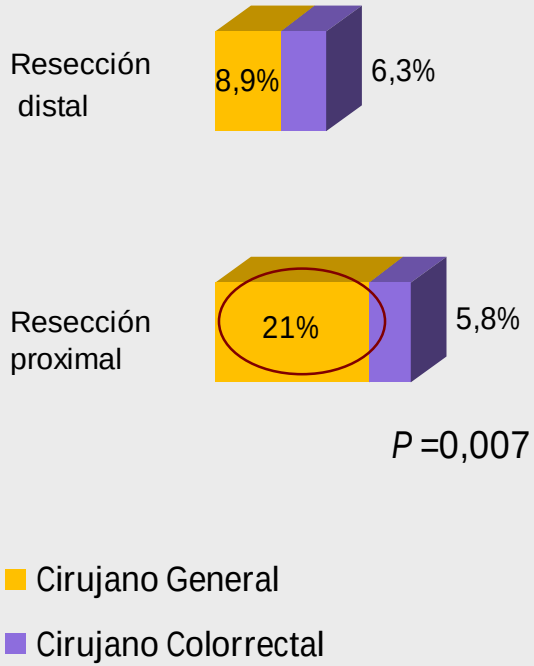
Department of Surgery, Colorectal Unit, Bellvitge University Hospital, University of Barcelona and IDIBELL, Barcelona, Spain

	Proximal (%) 173 patients	Distal (%) 204 patients	*P*
Gender			
Female	63 (36.4)	91 (44.6)	0.107
Male	110 (63.6)	113 (55.4)	
ASA			
I	14 (8.1)	28 (13.7)	0.317
II	87 (50.3)	102 (50.0)	
III	49 (28.3)	48 (23.5)	
IV	23 (13.3)	26 (12.7)	
Anastomosis			
No	2 (1.2)	35 (17.2)	< 0.001
Yes	171 (98.8)	169 (82.8)	
Comorbidity			
No	48 (27.7)	71 (34.8)	0.142
Yes	125 (72.3)	133 (65.2)	
Stage			
I	3 (1.7)	6 (3.0)	0.739
II	63 (36.4)	66 (32.3)	
III	66 (38.2)	77 (37.7)	
IV	41 (23.7)	55 (27.0)	

Colorectal Dis. 2011;13:e116-22

Dehiscencia anastomótica



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Urgencias colorrectales

Prótesis colónica. Colocación

- Ventajas

- Procedimiento “no quirúrgico”
- Conversión cirugía urgente ® cirugía electiva

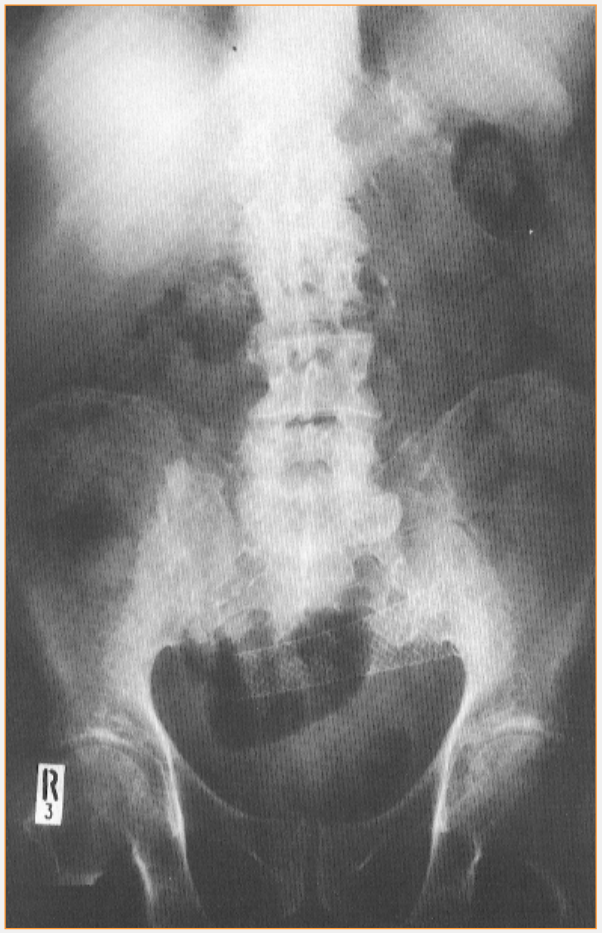
- Menor mortalidad
- “Evita” el porcentaje de estomas

Itabashi M. Dis Colon Rectum 1993
Tejero E. Dis Colon Rectum 1994

- Inconvenientes

- **Posibilidad de perforación**

- **¿”Seguridad oncológica” ?**



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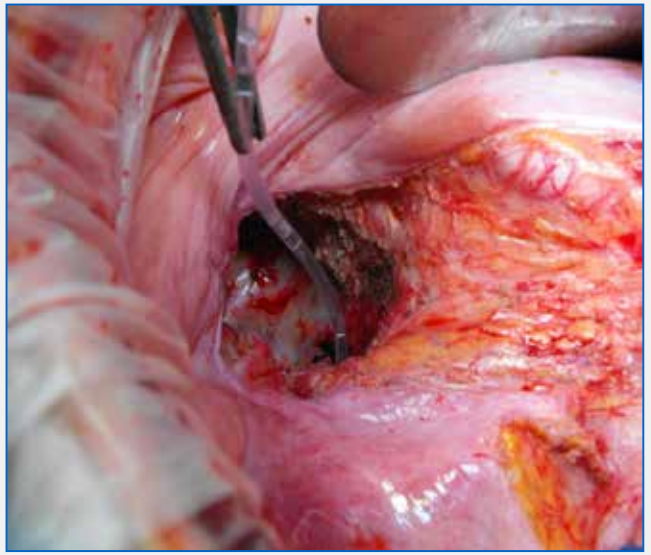
Complicaciones

- Hemorragia
- Dolor y tenesmo: inferior a 5 cm
- Impactación fecal
- Incontinencia
- Bacteriemia y fiebre
- Otras



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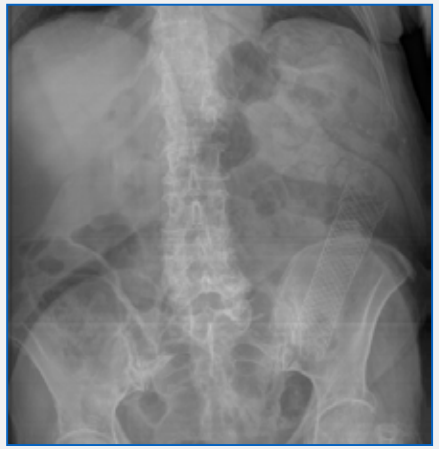
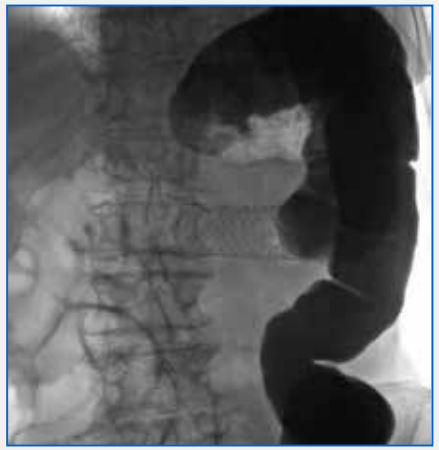
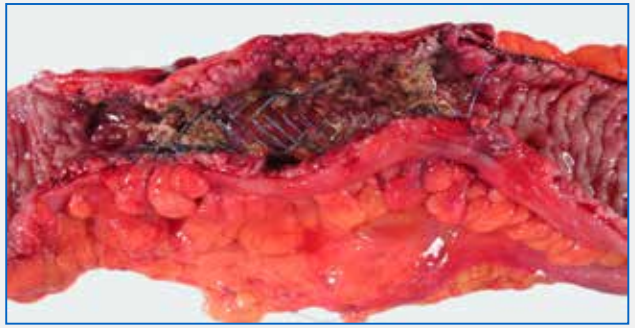
Cirugía colorrectal urgente



Migración: 3%-12%



Re-oclusión: 1%-92%
(media 12%)



Perforación: 5%-16%

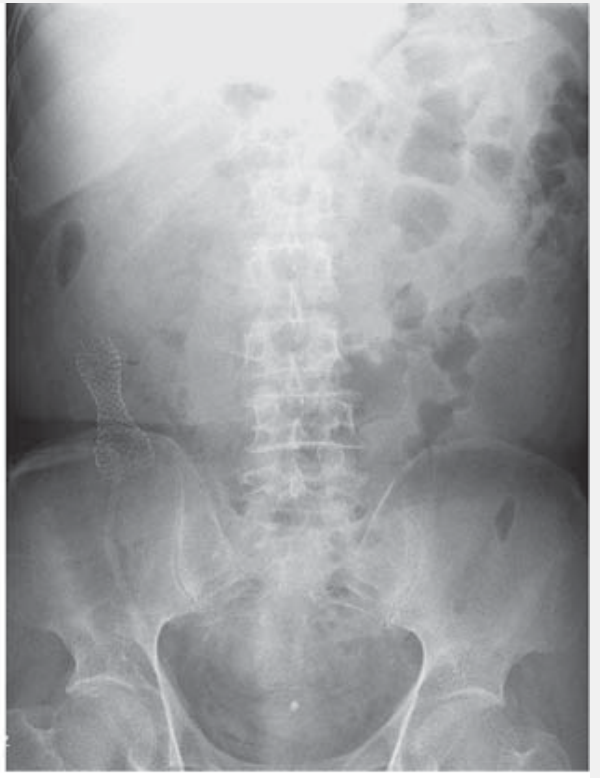
OCLUSIÓN PROXIMAL

Nivel de evidencia bajo

Grado de recomendación débil

Grading of recommendations Assessment, Development and Evaluation system (GRADE)

Efficacy of Self-expanding Metallic Stent for Right-sided Colonic Obstruction Due to Carcinoma Before 1-Stage Laparoscopic Surgery



Takuma A. et al. Surg Laparosc Endosc Percutan Tech 2014

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Available online at www.sciencedirect.com
ScienceDirect
EJSO
the Journal of Cancer Surgery
ELSEVIER
EJSO 36 (2010) 1187–1194
www.ejso.com

Outcomes in the management of obstructive unresectable stage IV colorectal cancer

R. Frago [a], E. Kreisler [a], S. Biondo [a,*], R. Salazar [b], J. Dominguez [c], E. Escalante [c]

49 pts stent: Éxito en 35 pts (71.4%) (9 re-stent) + 11 pts (22%) op.

6 pts peritonitis IQ directa

Mortalidad in 2 pts (6.1%) (stent)

It may be wise to considered stenting as part of the therapeutic armamentarium available to treat some patients and some phases of disease after an individualized evaluation.

We have observed how morbidity and failure of a less aggressive treatment, as stent has been claimed to be, is not negligible.

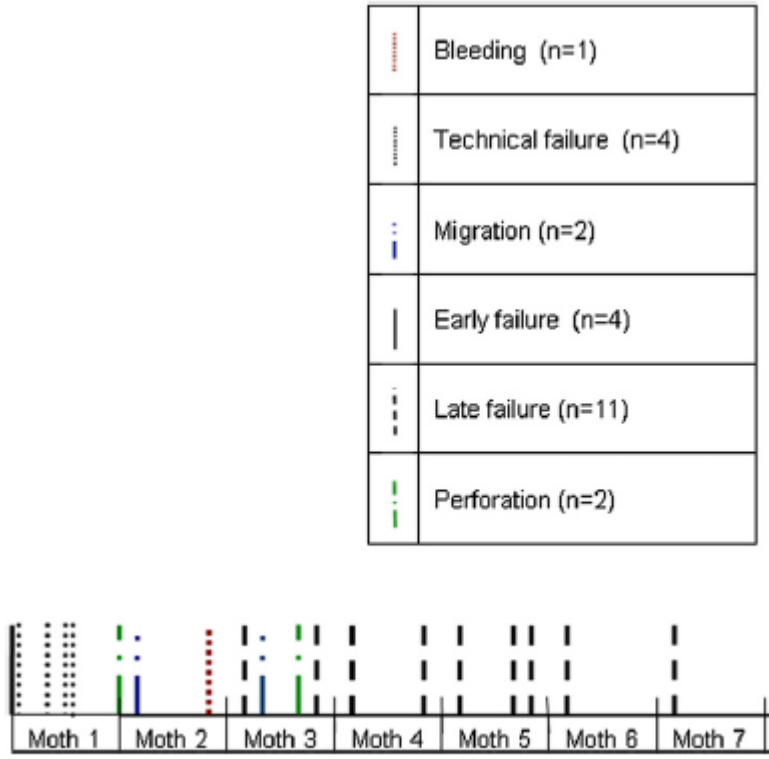

Figure 2. Chronology of stenting morbidity and failure.

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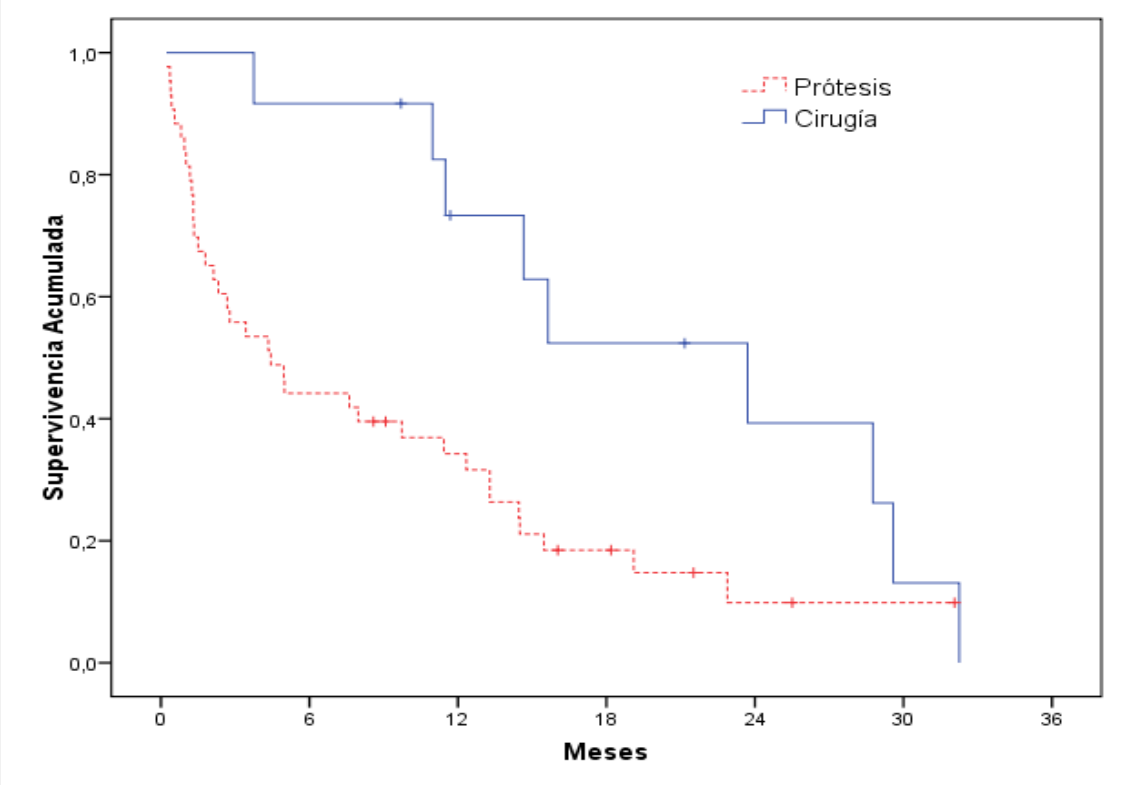

Stent : 4.4 (3.7-32.2) meses

Cirugía: 23.7 (0.2-32.0) meses

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Early closure of a multicenter randomized clinical trial of endoscopic stenting versus surgery for stage IV left-sided colorectal cancer

Authors

J. E. van Hooft[1], P. Fockens[1], A. W. Marinelli[2], R. Timmer[3], A. M. van Berkel[4], P. M. Bossuyt[5], W. A. Bemelman[6] on behalf of the Dutch Colorectal Stent Group[1]

Patient no.	Sex, age	Complications < 30 days after stent placement		Complications ≥ 30 days after stent placement	
		Mild adverse events	Severe adverse events	Mild adverse events	Severe adverse events
1	M, 64				Stent obstruction, perforation
3	F, 66				Migration
4	M, 53	Diarrhea			
5	F, 42				Stent obstruction, perforation
9	F, 88		Perforation		
16	F, 56	Pain			Perforation
17	F, 56				Perforation
18	F, 57				
20	F, 50		Perforation		

van Hooft et al, Endoscopy 2008

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Resection of Obstructive Left-Sided Colon Cancer at a National Level: A Prospective Analysis of Short-Term Outcomes in 1,816 Patients

Pieter J. Tanis[a] Nuno R. Paulino Pereira[a] Jeanin E. van Hooft[b]
Esther C.J. Consten[c] Willem A. Bemelman[a] on behalf of the Dutch Surgical Colorectal Audit

Digestive Surgery
Dig Surg 2015;32:317–324
DOI: 10.1159/000433561

1,816 pts:

1,485 pts (81.8%) acute resection

196 pts (10.8%) endoscopic stent followed by resection

135 pts (7.4%) decompressing stoma followed by resection

Use of endoscopic stenting: 18% (2009) - 6% (2012)

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Digestive Surgery

Dig Surg 2015;32:317–324
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30-day or in-hospital mortality rate:

Resection 6.9%; **Stent** 5.6%; **Stoma** 3.7%

Mortality rate after acute resection was **2.9%** in patients >70 years, but mortality rates up to **32.2%** were observed in high-risk elderly patients.

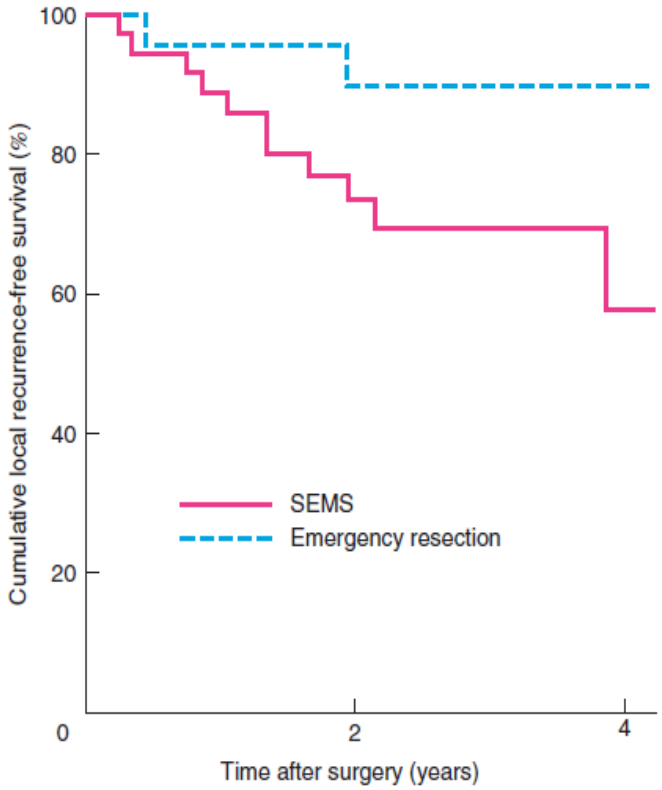
Acute resection as first choice treatment seems justified for patients >70 years of age given a mortality rate of 3%. For the elderly frail patients, mortality rates over 30% after acute resection stress the need for alternative treatment strategies.

Local recurrence after stenting for obstructing left-sided colonic cancer

K. J. Gorissen[1], J. B. Tuynman[1], E. Fryer[2], L. Wang[2], R. Uberoi[3], O. M. Jones[1], C. Cunningham[1] and I. Lindsey[1]

British Journal of Surgery 2013; 100: 1805–1809

	SEMS	Emergency resection	*P*†
Pathological tumour stage	(*n* = 62)	(*n* = 41)	0·214‡
T2	0	2	
T3	33	21	
T4	29	18	
Node stage	(*n* = 62)	(*n* = 41)	0·959‡
N0	32	20	
N1	16	11	
N2	14	10	
Adjuvant chemotherapy	25 of 60	10 of 39	0·133
Local recurrence	14 of 60	6 of 39	0·443
Distant metastasis	16 of 60	10 of 39	1·000
Overall recurrence	19 of 60	11 of 39	0·824
Overall mortality*	18 of 62	19 of 43	0·215
Cancer-specific mortality	15 of 62	16 of 43	0·180
Overall median follow-up (years)	2·7	2·8	0·294§



LOCAL RECURRENCE	SEMS "bridge to surgery"	Emergency surgery
Total	23 %	15 %
≤ 75 years	32 %	8 %

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Is Stenting as "a Bridge to Surgery" an Oncologically Safe Strategy for the Management of Acute, Left-Sided, Malignant, Colonic Obstruction?

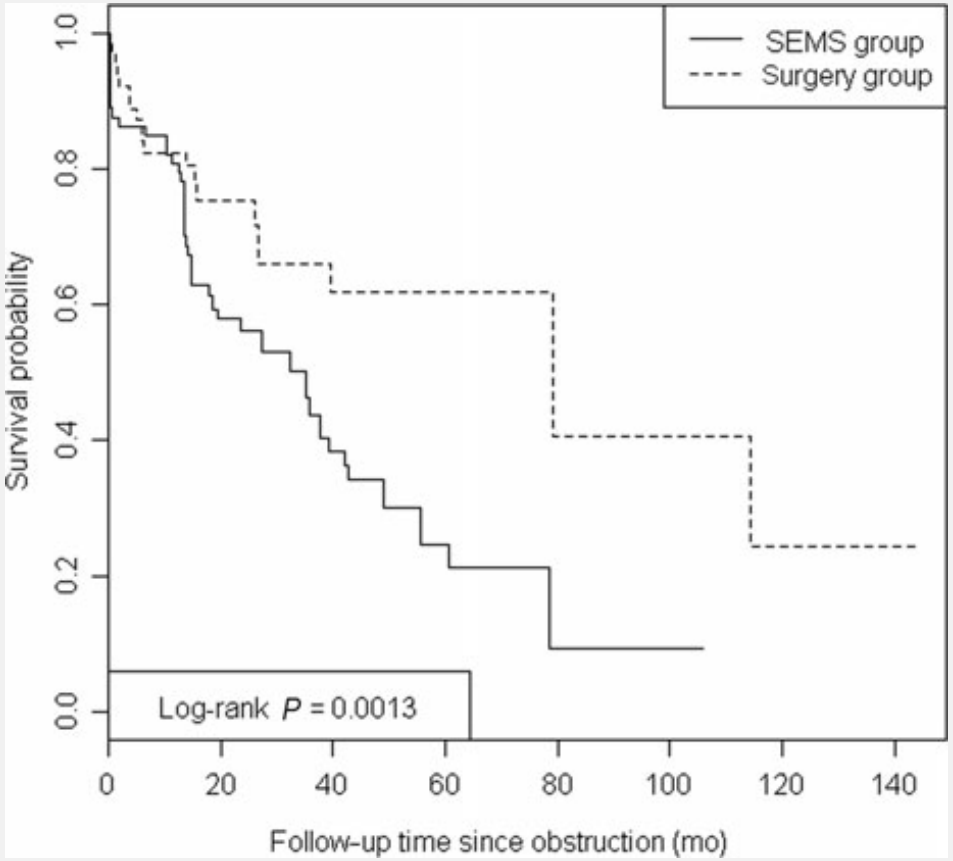
A Comparative Study With a Propensity Score Analysis

Charles Sabbagh, MD,|| François Browet, MD,* Momar Diouf, PhD,† Cyril Cosse, MD,*|| Olivier Brehant, MD,* Eric Bartoli, MD,‡ François Mauvais, MD,§ Bruno Chauffert, MD, PhD,¶ Jean-Louis Dupas, MD,‡ Eric Nguyen-Khac, MD, PhD,‡ and Jean-Marc Regimbeau, MD, PhD**

(*Ann Surg* 2013;258: 107–115)

48 pts Stent

39 pts Surgery



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(*Ann Surg* 2013;258: 107–115)

TABLE 3. Oncological Outcomes for the Study Population

Data for Overall Population	SEMS Group (Intention to Treat With SEMS) (N = 48)	Surgery Group (N = 39)	*P*
Overall survival (%) (Propensity score analysis)			
At 1 y	81 ± 4	82 ± 5	0.810
At 3 y	44 ± 6	66 ± 6	0.015
At 5 y	25 ± 6	62 ± 7	0.0003*
Cancer-specific mortality (%)			
At 1 y	6 ± 4	0	0.13
At 3 y	35 ± 7	15 ± 7	0.43
At 5 y	48 ± 8	21 ± 9	0.02*
Disease-free survival (%)			
At 1 y	67 ± 5	66 ± 6	0.90
At 3 y	40 ± 5	49 ± 6	0.25
At 5 y	22 ± 5	32 ± 7	0.24
Recurrence rate (%)	33	20	0.18
Mean time to recurrence (mo)	15.5 ± 12.2	26.2 ± 17.5	0.92

Bellvitge Hospital

Does use of a metallic colon stent as a bridge to surgery modify the pathology data in patients with colonic obstruction? A case-matched study

Charles Sabbagh · Denis Chatelain · Nathalie Trouillet · François Mauvais · Sif Bendjaballah · François Browet · Jean-Marc Regimbeau

Surg Endosc (2013) 27:3622–3631
DOI 10.1007/s00464-013-2934-3

	CS group ($n = 25$)	Surgery-only group ($n = 25$)	p
Tumor perforation [n (%)]	6 (24)	3 (12)	0.4
Peritumoral perforation [n (%)]	0 (0)	12 (48)	0.2
Tumor ulceration [n (%)]	24 (96)	15 (60)	**<0.0001**
Peritumoral ulceration [n (%)]	17 (68)	0 (0)	**<0.0001**
Abscess [n (%)]	16 (64)	16 (64)	1
Stromal inflammation [n (%)]	7 (28)	15 (60)	0.5
Vascular embolism [n (%)]	8 (32)	4 (16)	0.3
Perineural invasion [n (%)]	15 (60)	5 (20)	**0.008**
Lymph node invasion [n (%)]	13 (52)	3 (12)	**0.005**

Sabbagh C. et al. Surg Endosc 2013

Bellvitge Hospital

Colonic perforation either during or after stent insertion as a bridge to surgery for malignant colorectal obstruction increases the risk of peritoneal seeding

Su Jin Kim · Hyung Wook Kim · Su Bum Park · Dae Hwan Kang · Cheol Woong Choi · Byeong Jun Song · Joung Boom Hong · Dong Jun Kim · Byung Soo Park · Gyung Mo Son

Surg Endosc
DOI 10.1007/s00464-015-4100-6

Published online: 13 February 2015

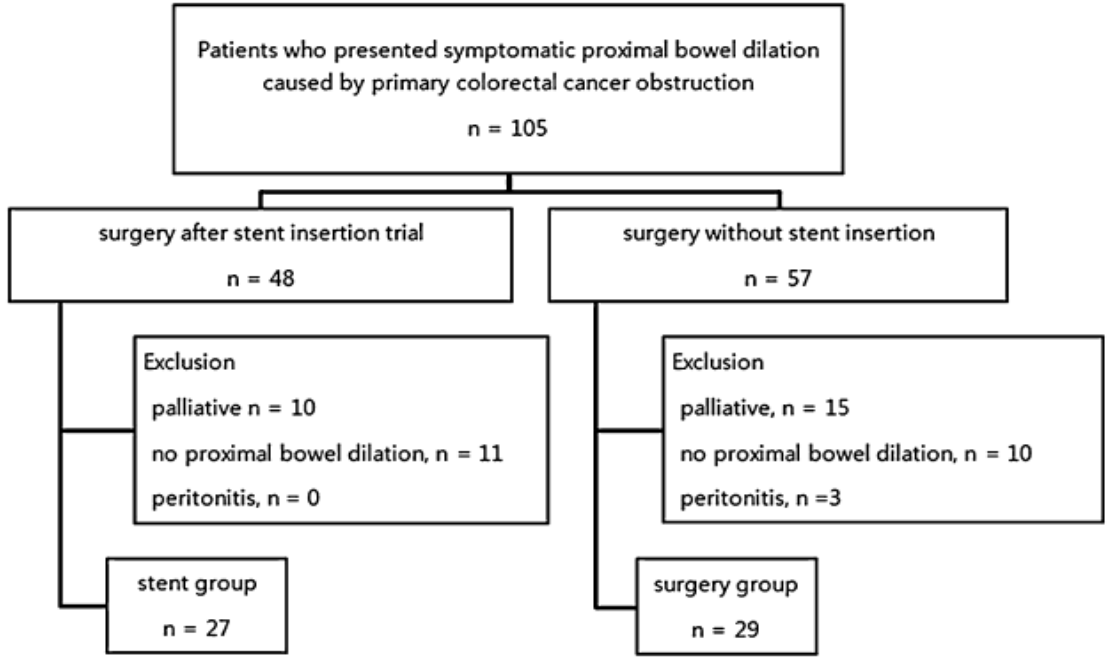

Fig. 1 Flowchart for retrospective chart review and case selection

	Stent group ($n = 27$)	Surgery only group ($n = 29$)	P value
Age, year, mean (SD)	64.6 (57.8–71.5)	70.7 (65.8–75.6)	0.244
Male sex, n (%)	18 (66.7)	16 (55.2)	0.379
Obstruction length, cm	4.6 (1.8, 3.9–5.3)	4.2 (1.4, 3.7–4.8)	0.761
Chemotherapy, n (%)	15 (55.6)	16 (55.2)	0.977
Median follow up, month (IQR)	30.0 (22.5–34.4)	26.0 (19.4–29.6)	0.329
Lt. side obstruction, n (%)	17 (63.0)	16 (55.2)	0.554
Stage			0.617
II	15 (55.6)	14 (48.3)	
III	10 (37.0)	14 (48.3)	
IVa	2 (7.4)	1 (3.4)	
Lymphovascular invasion, n (%)	4 (14.8)	5 (17.2)	1.000
Perineural invasion, n (%)	12 (44.4)	9 (31.0)	0.300

Colonic perforation either during or after stent insertion as a bridge to surgery for malignant colorectal obstruction increases the risk of peritoneal seeding

Su Jin Kim · Hyung Wook Kim · Su Bum Park · Dae Hwan Kang · Cheol Woong Choi · Byeong Jun Song · Joung Boom Hong · Dong Jun Kim · Byung Soo Park · Gyung Mo Son

Surg Endosc
DOI 10.1007/s00464-015-4100-6

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CONCLUSIONS:

Colorectal stenting *as a bridge to surgery showed no significant short- or long-term benefits compared with surgery only, and* **was associated with peritoneal seeding after perforation**. *Stenting before surgery should therefore only be considered* ***in patients with a high risk of complications associated with emergency surgery.***

Bellvitge Hospital

Emergency preoperative stenting versus surgery for acute left-sided malignant colonic obstruction: a multicenter randomized controlled trial

Isabelle A. Pirlet · Karem Slim · Fabrice Kwiatkowski · Francis Michot · Bertrand L. Millat

Surg Endosc (2011) 25:1814–1821
DOI 10.1007/s00464-010-1471-6

CONCLUSION:

This randomized trial **failed to demonstrate** *that emergency preoperative SEMS for patients presenting with acute left-sided malignant colonic obstruction could significantly* **decrease the need for stoma placement**.

Bellvitge Hospital

Colonic stenting versus emergency surgery for acute left-sided malignant colonic obstruction: a multicentre randomised trial

*Jeanin E van Hooft, Willem A Bemelman, Bas Oldenburg, Andreas W Marinelli, Martijn F Lutke Holzik, Marina J Grubben, Mirjam A Sprangers, Marcel G Dijkgraaf, Paul Fockens, for the collaborative Dutch Stent-In study group**

Lancet Oncol 2011; 12: 344–52

INTERPRETATION:

Colonic stenting ***has no decisive clinical advantages*** *to emergency surgery.*

It could be used as an alternative treatment in as yet undefined ***subsets of patients****, although with caution because of concerns about tumour spread caused by perforations.*

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Predictive Factors for Successful Colonic Stenting in Acute Large-Bowel Obstruction: A 15-Year Cohort Analysis

Derek J. Boyle, F.R.C.S.[1] • Christopher Thorn, F.R.C.S.[1] • Ashish Saini, F.R.C.R.[2]
Colin Elton, F.R.C.S.[1] • Gary K. Atkin, F.R.C.S.[1] • Ian C. Mitchell, F.R.C.S.[1]
Kevin Lotzof, F.R.C.R.[2] • Adrian Marcus, F.R.C.R.[2] • Pawan Mathur, F.R.C.S.[1]

Dis Colon Rectum. *2015;58:358-62*

126 consecutive pts: stent for colonic obstruction

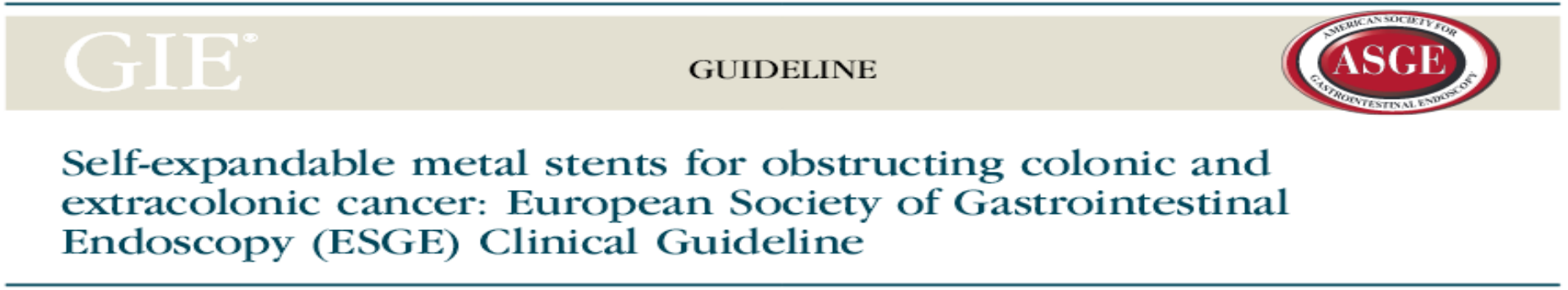
108 pts (86%) technical success

89 pts (70%) decompression

Successful deployment and clinical decompression:
colorectal cancer (p = 0.03)
shorter strictures (p = 0.01)
wider angulation distal to the obstruction (p = 0.049)

Perforation was associated with longer strictures (p = 0.03)

RECOMENDACIONES STENTS



Surgical resection is suggested as the preferred treatment for malignant obstruction of the proximal colon in patients with potentially curable disease (**weak recommendation, low quality evidence**). In a palliative setting, SEMS can be an alternative to emergency surgery (**weak recom- mendation, low quality evidence).**

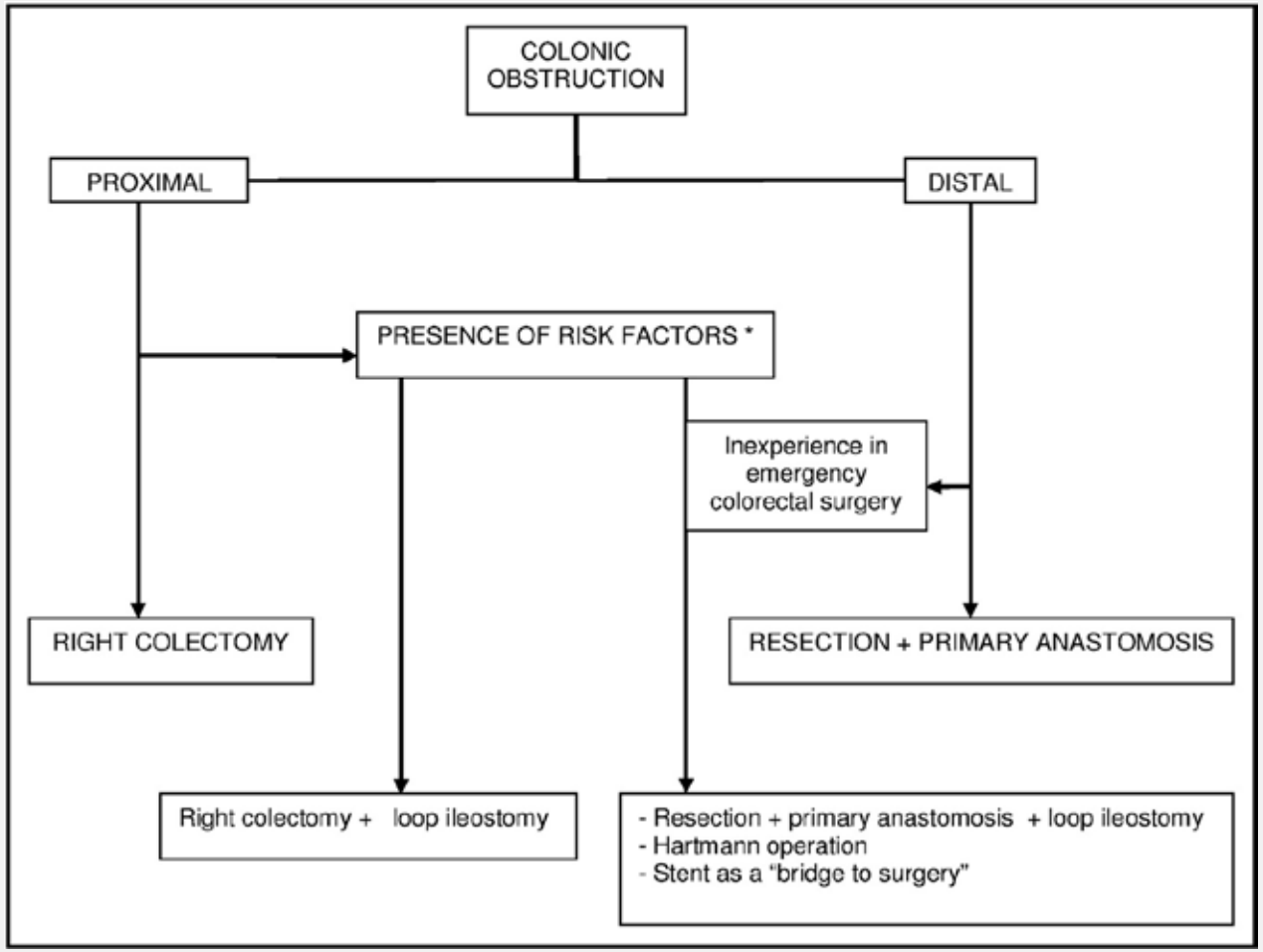
Colonic SEMS placement as a bridge to elective surgery is not recommended as a standard treatment of symptomatic left-sided malignant colonic obstruction (**strong recommendation, high quality evi-dence**). For patients with potentially curable left-sided obstructing colonic cancer, stent placement may be considered as an alternative to emergency surgery in those who have an increased risk of postop-erative mortality.
i.e. ASA ≥ III and/or age ≥ 70 years (**weak recommendation, low quality evidence**)

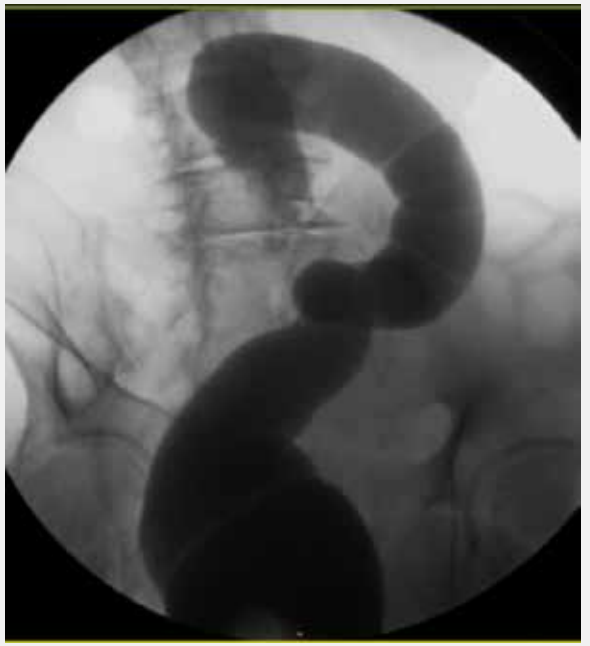
ESGE Clinical Guideline. Gastrointestinal Endoscopy 2014;80(5):747-75
doi:10.1016/j.gie.2014.09.018

Current management of acute malignant large bowel obstruction: a systematic review

Ricardo Frago, M.D., Ph.D.[a], Elena Ramirez, M.D.[a], Monica Millan, M.D., Ph.D.[a], Esther Kreisler, M.D., Ph.D.[a], Emilio del Valle, M.D., Ph.D.[b], Sebastiano Biondo, M.D., Ph.D.[a,*]

The American Journal of Surgery (2014) 207, 127-138





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CONCLUSIONES

- La cirugía urgente por neoplasia complicada de colon se asocia a elevada morbi-mortalidad. La resección con anastomosis primaria (± ileostomía) debería ser el objetivo principal en pacientes seleccionados y realizada por cirujanos con especial dedicación a la cirugía colorrectal y urgente.

- En nuestra experiencia, la especialización en cirugía colorrectal influye en los resultados postoperatorios. Especial incidencia en el tratamiento del cáncer oclusivo del colon proximal.

- La colocación de un stent como parte del arsenal terapéutico disponible para el tratamiento de pacientes con CCR ocluido y en algunas fases de la enfermedad, es una alternativa válida tras una evaluación individualizada de los pacientes.

- Los pacientes paliativos con buen estado general y sin enfermedad neoplásica localmente avanzada, quizás podrían beneficiarse de una resección paliativa de urgencia del tumor primario obstructivo.