INTRODUCTION

Rectal cancer is one of the most common cancers all over the world, more than two thirds of these cases occur in economically developed countries, rectal cancer is considered the third in frequency after non melanocytic skin cancers and lung cancer in male and non melanocytic skin cancers and breast cancer in females, rectal cancer is the fourth leading cause of cancer mortality because it has a better prognosis than more common cancers **(Parkin et al, 1997).**

Seventy percent of the patients with rectal cancer present with apparently localized disease, in these patients surgery can be curative, but relapse after complete resection are frequent. Many trials including adjuvant chemotherapy, neo-adjuvant chemotherapy, preoperative radiotherapy and immunotherapy have rapidly developed with the aim of decreasing the recurrence rate and increase the survival of the patient **(Van Custem et al, 2001).**

Minimizing post operative immunosuppression, avoiding immunosuppressive anesthetic approaches and use of immunostimulation may limit the recurrence of cancer rectum **(Kapiteijn et al, 2000).**

Genomic profiling may help to identify patient who are at high risk for developing tumor recurrence and those who are more likely to benefit from chemoradiation therapy **(Temple 2000).**

The incidence of recurrent rectal cancer varying from 2% to 25% and seems to occur with equal frequency after sphincter saving resection and abdominoperineal resection. The most common cause of recurrence is inadequate resection of all the tumor at the initial operation due to presence of microscopic tumor deposition in the tissue surrounding the rectum. Other possible causes of recurrence include implantation of viable cells on the suture line and the devolpment of a new primary

tumor **(Compton et al, 2000).**

The patient with recurrent rectal cancer presents with persistant pelvic pain which radiate to the legs if sacral roots have been involved, bladder problems may occur if recurrence devolep after abdominoperineal excision, a swelling or indurations may be present in the perineum, abscess or discharging sinus may devolep occasionally. The presence of large recurrence in the pelvis may lead to bilateral leg oedema. After sphincter saving resection the local recurrence may produce change in the bowel habit or the passage of blood per rectum **(Saltz, 2002).**

Sigmoidoscopic examination after sphincter saving resection may show friable tissue at the anastemosis which when biopsied confirm the diagnosis. However usually the recurrence is situated extrarectally and is either detected as induration on digital examination or by ultrasonography or computed tomography. This investigation can detect recurrence before it cause symptoms. The best method for treatment of recurrent rectal cancer is surgical resection and it can be also treated by radiotherapy which produce necrosis of the center of the tumor and ring of oedema around it **(Longo, 2002).**

Early diagnosis, management, and use of chemoradiation have a role in decreasing the rate of recurrence of rectal cancer **(Kanellos, 2003)**.

Aim of the Essay

The aim of this essay is to throw some lights on the recent trends in the management of residual and recurrent cancer rectum, hoping to conclude the best therapeutic management of such patient.