Rectum Cancer

Version 1.2004
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- College of Oncology
- Belgian Society of Medical Oncology (BSMO)
- Belgian Group of Digestive Oncology (BGDO)
- College of Medical Imaging
- Belgian Society for Radiotherapy-Oncology (BVRO-ABRO)

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General algorithm

Clinical presentation
- GP or specialist

Diagnostic procedure
- Invasive cancer
  - Elective situation
  - Emergency
  - Clinical staging
  - MOC (optional)

Isolated cancerous polyp
- Psychosocial help?
  - Patient consultation
  - Locally advanced
    - Pre-operative radiotherapy and/or chemotherapy
    - Stoma nurse help?
      - Surgery
        - Histology
          - MOC: final staging

Metastases
- Unresectable Metastases
  - Resectable Metastases

Stage 4
- Adjuvant chemotherapy

Stage 3
Stage 2
Stage 1

Psychosocial help?
- Patient consultation

Follow-up
Staging

**pT** Primary Tumour

- **Tx** Primary tumour cannot be assessed
- **T0** No evidence of primary tumour
- **Tis** Carcinoma in situ: intraepithelial or invasion of lamina propria
- **T1** Tumour invades submucosa
- **T2** Tumour invades muscularis propria
- **T3** Tumour invades through the muscularis propria into the subserosa, or into nonperitonealized pericolic or perirectal tissues
- **T4** Tumour directly invades other organs or structures or perforates visceral peritoneum

**M** Distant Metastasis

- **Mx** Presence or absence of distant metastases cannot be determined
- **M0** No distant metastases detected
- **M1** Distant metastases detected

**G** Histologic grade

- **Gx** Grade cannot be assessed
- **G1** Well differentiated
- **G2** Moderately differentiated
- **G3** Poorly differentiated
- **G4** Undifferentiated

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* A tumour nodule in the pericolorectal adipose tissue of a primary carcinoma without histologic evidence of residual lymph node in the nodule is classified in the pN category as a regional lymph node metastasis if the nodule has the form and smooth contour of a lymph node. If the nodule has an irregular contour, it should be classified in the T category and also coded as V1 (microscopic venous invasion) or as V2 (if it was grossly evident), because there is a strong likelihood that it represents venous invasion.
### Staging

#### TNM Stage grouping

<table>
<thead>
<tr>
<th>Stage</th>
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<th>M0</th>
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<tr>
<td>Stage I</td>
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<td>Stage II B</td>
<td>T4</td>
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<td>M0</td>
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<tr>
<td>Stage III A</td>
<td>T1 or T2</td>
<td>N1</td>
<td>M0</td>
</tr>
<tr>
<td>Stage III B</td>
<td>T3 or T4</td>
<td>N1</td>
<td>M0</td>
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<tr>
<td>Stage III C</td>
<td>Any T</td>
<td>N2</td>
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<tr>
<td>Stage IV</td>
<td>Any T</td>
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## Various chemotherapy regimens

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<th>FOLFOX 4</th>
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<tr>
<td>Oxaliplatin 85 mg/m IV over 2 hours, day 1</td>
<td></td>
</tr>
<tr>
<td>Leucovorin* 400 mg/m IV over 2 hours, days 1 and 2</td>
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</tr>
<tr>
<td>5-FU 400 mg/m IV bolus, then 600 mg/m IV over 22 hours continuous infusion, days 1 and 2</td>
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<tr>
<td>Repeat every 2 weeks</td>
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<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Irinotecan 180 mg/m IV over 2 hours, day 1</td>
</tr>
<tr>
<td>Leucovorin* 400 mg/m IV over 2 hours prior to 5-FU, days 1 and 2</td>
</tr>
<tr>
<td>5-FU 400 mg/m IV bolus, then 600 mg/m IV over 22 hours continuous infusion, days 1 and 2</td>
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<td>Repeat every 2 weeks</td>
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<table>
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<tr>
<th>FOLFOX 6</th>
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<tbody>
<tr>
<td>Oxaliplatin 100 mg/m IV over 2 hours, day 1</td>
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<tr>
<td>Leucovorin* 400 mg/m IV over 2 hours, day 1</td>
</tr>
<tr>
<td>5-FU 400 mg/m IV bolus, then 2.4-3.0 g/m IV over 46 hours continuous infusion</td>
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<td>Repeat every 2 weeks</td>
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<td>Irinotecan 180 mg/m IV over 90 minutes, day 1</td>
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<td>Leucovorin 400 mg/m IV over 2-hour infusion during Irinotecan, day 1</td>
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<td>5-FU 400 mg/m IV bolus, then 2.4-3 g/m IV over 46 hours continuous infusion</td>
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<td>Repeat every 2 weeks</td>
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<table>
<thead>
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<tbody>
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<td>Leucovorin 350-400 mg IV over 2 hours, day 1</td>
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<tr>
<td>5-FU 400 mg/m IV bolus, then 2.4 g/m IV over 46 hours continuous infusion</td>
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<td>Repeat every 2 weeks</td>
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<table>
<thead>
<tr>
<th>mFOLFIRI (IFL)</th>
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<tr>
<td>Bevacizumab + 5-FU containing regimens:</td>
</tr>
<tr>
<td>Bevacizumab 5mg/kg IV every 2 weeks + 5-FU and Leucovorin</td>
</tr>
<tr>
<td>or IFL</td>
</tr>
<tr>
<td>or FOLFOX</td>
</tr>
<tr>
<td>or FOLFIRI</td>
</tr>
<tr>
<td>IFL In combination with bevacizumab</td>
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<table>
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<tr>
<th>FOLFOX 7</th>
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<tbody>
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<td>Leucovorin 400 mg/m IV over 2 hours, day 1</td>
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<td>5-FU 400 mg/m IV bolus, then 2.4 g/m IV over 46 hours continuous infusion</td>
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<td>Repeat every 2 weeks</td>
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<table>
<thead>
<tr>
<th>FOLFIRI</th>
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</thead>
<tbody>
<tr>
<td>Irinotecan 125 mg/m IV over 90 minutes, days 1, 8, 15, 22</td>
</tr>
<tr>
<td>Leucovorin 20 mg/m IV, days 1, 8, 15, 22</td>
</tr>
<tr>
<td>5-FU 500 mg/m IV, days 1, 8, 15, 22</td>
</tr>
<tr>
<td>Repeat every 6 weeks</td>
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</table>
## Various chemotherapy regimens

<table>
<thead>
<tr>
<th>Regimen</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capecitabine</td>
<td>2,500 mg/m /day PO in two divided doses, days 1-14, followed by 7 days rest. Repeat every 3 weeks</td>
</tr>
<tr>
<td>Protracted IV 5-FU</td>
<td>5-FU 300 mg/m /d protracted IV infusion</td>
</tr>
<tr>
<td>Bolus or infusional 5-FU/leucovorin</td>
<td>Mayo regimen&lt;br&gt;Leucovorin 20 mg/m IV bolus, days 1-5&lt;br&gt;5-FU 425 mg/m IV bolus one hour after start of Leucovorin, days 1-5&lt;br&gt;Repeat every 4 weeks</td>
</tr>
<tr>
<td>Irinotecan</td>
<td>Irinotecan 125 mg/m IV over 90 minutes, days 1, 8, 15, 22&lt;br&gt;Repeat every 6 weeks</td>
</tr>
<tr>
<td></td>
<td>Irinotecan 300-350 mg/m IV over 90 minutes, day 1&lt;br&gt;Repeat every 3 weeks</td>
</tr>
<tr>
<td>Roswell-Park regimen</td>
<td>Leucovorin 500 mg/m IV over 2 hours, days 1, 8, 15, 22, 29, and 36&lt;br&gt;5-FU 500 mg/m IV bolus 1 hour after start of Leucovorin, days 1, 8, 15, 22, 29, 36&lt;br&gt;Repeat every 6 weeks</td>
</tr>
<tr>
<td>Cetuximab ± irinotecan</td>
<td>Cetuximab 400 mg/m 1st infusion, then 250 mg/m weekly&lt;br&gt;±&lt;br&gt;Irinotecan 350 mg/m IV every 3 weeks or&lt;br&gt;180 mg/m IV every 2 weeks or&lt;br&gt;125 mg/m every week for 4 weeks&lt;br&gt;Every 6 weeks</td>
</tr>
<tr>
<td>de Gramont</td>
<td>Leucovorin* 400 mg/m IV over 2 hours, days 1 and 2&lt;br&gt;5-FU 400 mg/m IV bolus, then 600 mg/m IV over 22 hours&lt;br&gt;continuous infusion, days 1 and 2&lt;br&gt;Repeat every 2 weeks</td>
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INTRODUCTION

The guidelines presented covers diagnosis, treatment and follow up of colon cancer. It is based on the existing international guidelines which have been critically appraised (Appendix 1) and on the consensus of national societies. It's also important to mention the national, multidisciplinary project on rectal cancer PROCARE: http://www.belsurg.org/imgupload/BPSA/PROCARE%20GUIDELINES%20printversie82005.pdf

The definition of rectal tumours in this guideline is: tumours whose distal edge is seen within 16 cm from the anal verge as measured with a rigid rectosigmoidoscope (Procare guideline).

We will go through the following topics:

- Diagnosis
- Clinical Staging
- Multidisciplinary team meeting (optional)
- Treatment of non-metastatic disease
  - surgery
  - pathology
- Final staging - Multidisciplinary team meeting
  - follow up
  - adjuvant therapy
- Treatment of metastatic disease
  - resectable metastases
  - b. unresectable metastases

The grade of recommendation is stated in the text as follow:

GR A = Evidence derived from RCT or meta-analysis or systematic review of RCT
GR B = Evidence from non-randomised controlled trials or observational studies
GR C = Professional consensus, or case reports or case series

The key to evidence statements and grade of recommendations are presented in appendix 2.

SEARCH FOR EVIDENCE

First the existing guidelines were searched in October 2004 using as keywords “colon, rectum and colorectal with cancer and neoplasm”. The National Guideline Clearinghouse (114 references) and Pubmed (131 references, limit: practice guideline) were searched, without date limit or language restriction.

The websites of known agencies were systematically searched (Europe: ESMO, The Netherland: Oncoline, UK: NICE, The association of coloproctology of GB and Ireland, Scotland: SIGN, CANADA: Ontario Cancer care, USA: NCCN, NIC, ASCO, American Society of colon & rectal surgeons, France: ANAES, FNCLCC, Singapore: Ministry of Health). Two search engines were also searched (Google and Journalservice for medics) with the same keywords than mentioned earlier.

Finally a search for systematic reviews in the Cochrane database and in DARE (19 references) was performed.
DIAGNOSIS

Patient’s history
A personal history has to be taken (GR C).
The diagnostic procedure is generally indicated for patients with the following symptoms [1-3] (GR B):

- **For all ages**: rectal bleeding with change in bowel habits to looseness or increased frequency over a period of six weeks and/or palpable abdominal mass and/or iron-deficiency anaemia without overt cause.
- **Over 60 years**: rectal bleeding without any symptoms, or change in bowel habits to looseness or increased frequency.

A family history has to be taken:
In order to determine the high risk groups, a family history of at least two generations should be taken to every patient with colon cancer [1,2] (GR B).

If there are 1 or 2 family members diagnosed with colon cancer, if the patient is less than 50 years old or if the patient has concomitant or previous ovarian or endometrium cancer, a 3 generations extensive family history is required (GR C).

Patients with suspected hereditary conditions should be oriented towards a Genetic Service [1] or a Familial Cancer Clinic (GR C).

Examination
A complete clinical examination has to be done (GR C).
Colonoscopy with biopsy is recommended for every patient with suspected rectal cancer [1,2] (GR C). If not possible, an enema [4] has to be performed [1,2] (GR B).

Importance of good orientation of the specimen (quality criteria for endoscopist and pathologist). The biopsy must give answers to the following questions [1,2] (GR B):
- Malignant or benign?
- Is it a carcinoma within a polyp or an invasive cancer?
- What is the differentiation grade of the tumour?

Diagnostic conclusion
At the end of the diagnostic procedure, an answer must be given to the following questions:
- Is it an isolated cancerous polyp which has been completely resected? If the answer is yes (Tis stage), there is no other treatment except if there is histological evidence of tumour at, or within 1 mm of, the resection margin, there is lymphovascular invasion or the invasive tumour is poorly differentiated [1,5,27] (GR B). (All polyps have to be sent to the pathologist for analysis (GR C).
- Is it a recurrence of a previous colon cancer [27] (GR C)?
- Is it an invasive cancer (GR C)?

Emergency
In case of emergency (bleeding, perforation, obstruction,…) routine procedures may be neglected and immediate resection should be considered in optimal candidates [1,2,7,8] (GR B).

In that case, intraoperative liver ultrasound and postoperative imaging is necessary [1] (GR B).
CLINICAL STAGING

Following staging examinations are recommended:

- CEA level [9,27] (GR C).
- The primary choice is thoraco-abdominal contrast CT is recommended [2,9] (GR C).
- Liver [1,2]: MRI is an alternative. US can be considered when contrast CT or MRI are not possible (GR B).
- Chest [1,2]: CT scan [10] (GR B).
- Lymph nodes: CT scan [2,9] (GR B).

cTNM: pre-treatment clinical classification, based on clinical examination, imaging, endoscopy, biopsy, surgical exploration or other.

FIRST MULTIDISCIPLINARY TEAM MEETING (MOC) – OPTIONAL

The objective of this first meeting is to decide on the therapeutic strategy based on the clinical staging [2] (GR C).

If possible, the general practitioner (GP) of the patient should attend this meeting [2]. Otherwise, the staging has to be fully and clearly communicated to the GP and/or specialist of the patient (GR C).

Patients should be given clear information about the potential risks and benefits of treatment in order that they can understand adequately the therapeutic decision [1,2] (GR C). Information about local support services should be made available to both the patient and their relatives [1,2] (GR C). Healthcare professionals should respect patients' wishes to be involved in their own management [1,2] (GR B).

The need for psychosocial help must be evaluated and offered if required [2] (GR B).

PROCEDURE IF NON-METASTATIC DISEASE

Surgery

If no metastases are found, the patient is oriented to surgery which remains the only curative option [1,2,11,27,28] (GR C).

Preoperative radio/chemotherapy

Preoperative radiotherapy, planned with 3 or 4 fields (and not parallel opposed fields), should be considered in patients with operable rectal cancer [1,2,29-31] (GR A).

Chemotherapy could be given synchronously with radiotherapy [1,2,27, 28,31] (GR C). The regimens usually used are bolus FUFA or continuous fluorouracil (Procare guideline) (GR C). The patient with T1-2 rectal cancer cStage I in whom an adequate TME (Total Mesorectal Excision) procedure is performed does not need neoadjuvant therapy. Neoadjuvant therapy is recommended in all other cases, except for tumours located at less than 6 cm from the anal verge or with a Circumferential Resection Margin less than 5 mm (Procare guideline) (GR C).

YTNM: classification after induction therapy.

Preoperative preparation

A preoperative risk assessment should be performed according to the appropriate guidelines (www.kenniscentrum.fgov.be/fr/Publications.html).
Before undergoing surgery, the patient should have venous thromboembolism prophylaxis with anti-platelet therapy (GR B) and antibiotic prophylaxis (single dose of antibiotics providing both aerobic and anaerobic cover given within 30 minutes of induction of anaesthesia) [1,2,8,9,11] (GR A).

**Surgery**
The safe margin between the lower end of the tumour and the rectal stump must be greater than or equal to 2 cms [31] (GR B). An appropriate mesorectal excision, depending on the localization of the tumour, has an impact on the rate of local recurrences [1,27,28] (GR B). There is currently no indication for extensive pelvic nodal clearance [31]. Lymph nodes at the origin of feeding vessel should be identified for pathologic examination. Lymph nodes outside the field of resection considered suspicious should be biopsied or removed [9,11,27] (GR C). Tumour tissue left behind indicates an incomplete (R2) resection. The surgery report must indicate if the resection was complete (R0 - R2) [2,6,27] (GR C).

**Postoperative radiotherapy**
Postoperative radiotherapy should be considered in patients with rectal cancer who did not receive preoperative radiotherapy (e.g. case of emergency) and who are at high risk of local recurrence [1,30,31] (GR C).

**Histological procedure**
The exact procedure to examine a colon resection specimen is described in a consensus text made by the gastrointestinal pathologists [12]. The pathologist should search for lymph nodes in the resection specimen and the number found should be noted [2] (GR B). In patients with colon cancer who are treated with curative intent, 12 or more nodes should normally be examined; if the median number is consistently below 12, the surgeon and the pathologist should discuss their techniques [2] (GR B). Patients with inadequately sampled nodes could be offered adjuvant chemotherapy [13] (GR C).

All reporting of colon cancer specimens should contain gross description, histology type, differentiation by predominant area, margins (tumour involvement), metastatic spread, background abnormalities, staging [1,2] (GR B).

**FINAL STAGING**
Rectum cancers should be staged following the TNM staging system [9,27,28] (GR B): pTNM: post-surgical histopathological classification (Staging).

The final staging is done during the second multidisciplinary meeting (MOC) on the basis of all results and reports available for a given patient [2] (GR C). If possible, the general practitioner of the patient should attend this meeting. Otherwise, the staging has to be fully and clearly communicated to the GP and/or specialist of the patient [2] (GR C).

Depending on tumour stage, the further treatment options are decided [1,2,13,27,28] (GR A). A written report with staging and treatment options is mandatory for each patient [8] (GR C).
TREATMENT

A decision tree of the treatment in general is presented here.

Stage I: Follow up (GR A)
Stage II: Chemotherapy is discussed based on risk assessment (ev. Adjuvant online) (GR A)
Stage III: Absolute indication for chemotherapy (if no major objection) (GR A)
Stage IV: See treatment of metastatic disease

Adjuvant treatment

As indicated in the final staging section, stage III rectum cancer is an absolute indication for adjuvant chemotherapy (GR A). Different options, i.e. infusional 5-fluorouracil in association with folinate, oral fluoropyrimidines, infusional 5-fluorouracil in association with folinate and oxaliplatin [1,2,19,20] (GR A) are available and reimbursed in Belgium (www.cbip.be/ggr/index.cfm?ggrWelk=/GGR/MPG/MPG_J.cfm www.bcfi.be/ggr/index.cfm?ggrWelk=/GGR/MPG/MPG_J.cfm).

The choice of a regimen for a given patient is based on his/her risk profile and the toxicity of the drugs (GR C). Various regimens are presented here.

Adjuvant radiotherapy combined with chemotherapy could be an option, although there is no clear evidence that this combination improves survival [32] (GR C).

Treatment of metastatic disease

Treatment of resectable metastases

Following therapeutic strategies can be proposed [1,2,5,9,27] (GR C):

- surgery of the primary tumour and the metastasis in the same procedure
- surgery of the primary tumour followed by:
  - surgery of the metastasis, or
  - chemotherapy and then surgery of metastasis

Criteria for resectability of metastases [6,27]

Liver

- Complete resection must be feasible based on anatomic grounds and the extent of disease, maintenance of noble hepatic function is required [27] (GR C).
- There should be no unresectable extrahepatic sites of disease [27] (GR C).
- The primary tumour must be controlled [27] (GR C).
- Re-resection can be considered in selected patients [27]

Resection is the treatment of choice for resectable liver metastases. Other techniques such as radiofrequency might be optional or complementary [27] (GR C).

Note: MRI with contrast agent has significantly superior sensitivity than CT for preoperative assessment of operability of liver metastasis [21] (GR B).

Lung

- Complete resection based on the anatomic location and extent of disease with maintenance of adequate function is required [27] (GR C).
• Resectable extra-pulmonary metastases do not preclude resection [27] (GR C).
• The primary tumour must be controlled [27] (GR C).
• Re-resection can be considered in selected patients [27] (GR C).

After resection, adjuvant chemotherapy can be considered [1,2,5,22-25,27] (GR C). The decision is made on individual basis.

The patient assessment and decision about treatment options should be done during the multidisciplinary team meeting, in presence of the patient's general practitioner. The role of the pain clinic in pain management has to be discussed [1,2] (GR C).

The need for a psychosocial help must be evaluated and, if required, the help has to be started [1,2] (GR B).

The follow up procedure is the same than that for patients without metastasis.

Treatment of unresectable metastases

• If the patient presents with symptoms related to the primary tumour (bleeding, obstruction,…): resection of primary tumour followed by chemotherapy [1,2,9,11] (GR B).

• If the patient has no symptoms related to the primary tumour: chemotherapy [26] (GR A).

Each patient should receive an evaluation for first and second line chemotherapy [1,5,25,27] (GR C). Today, therapy with oral fluoropyrimidines in monotherapy or infusional 5-fluorouracil in combination with either Irinotecan or Oxaliplatin is considered as standard (GR C). The decision on which regimen for a given patient is especially based on the performance status [1,2,27] (GR A).

Reevaluation of patients under treatment for metastatic disease should include an every 2 to 3 month CT assessment, always performed with the same tools for comparison reasons (GR C). MRI can be considered in specific conditions (GR C). At every evaluation the different treatment options must be discussed (GR C).

The patient assessment and decision about treatment options should be done during the multidisciplinary team meeting, in presence of the patient's general practitioner. The role of the pain clinic in pain management has to be discussed [1,2] (GR C).

The need for a psychosocial help must be evaluated and, if required, the help has to be started [2] (GR B).

Patients with advanced colorectal cancer may benefit both from treatment of the cancer and from palliative care. These are concomitant approaches to management [1,2] (GR C).

Palliative care specialists should be members of, and integrated with, colorectal cancer multi-disciplinary teams; their role includes the provision of education and advice for other health professionals and direct patient management [2] (GR C).

A patient in good health status and progressive under standard therapy should be proposed a clinical trial protocol [2] (GR C).

FOLLOW-UP

Patients who have undergone curative resection for colorectal cancer should undergo formal follow up in order to facilitate the early detection of recurrence and/or metastatic disease [1,2,5,14-17,27] (GR A).

Although no absolute scientific prove of outcome benefit of an intensive follow up policy [16], we could recommend following strategy:

• Physician visit: every 3 to 6 months for the first 3 years after initial
treatment, every 6 months during years 4 and 5 and then yearly for 5 years [10] (GR C)

- CEA every 3 months during 3 years if patient is candidate for surgery or systemic therapy [10] (GR C)
- CT thorax and abdomen at 3 months and every year during 3 years in patients at higher risk of recurrence [10,18] (GR C)
- Colonoscopy after 3 years and every 5 years in average risk patients [10] (GR C)

PET should be performed in patients with a high clinical suspicion of recurrent disease associated with negative or equivocal work up (high pre test probability):

- Suspcion of local recurrence of a colon cancer with equivocal CT, MRI and endoscopy
- Exclusion or confirmation of metastasis in equivocal CT, MRI lesions (eg. indeterminate lymph nodes in the retroperitoneal space; a pulmonary or hepatic nodule)
- A rising CEA level.

(see KCE HTA report on PET scan:
### Appendix 1: Evidence table

<table>
<thead>
<tr>
<th>Titel</th>
<th>Country</th>
<th>Year</th>
<th>Scope</th>
<th>AGREE overall assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guidelines for the management of colorectal cancer - The association of coloproctology of GB and Ireland [8]</td>
<td>UK</td>
<td>2001</td>
<td>Colorectal</td>
<td>Recommend (with provisos or alterations)</td>
</tr>
<tr>
<td>Use of irinotecan in treatment of metastatic colorectal carcinoma - Cancer care Ontario [22]</td>
<td>Canada</td>
<td>2000</td>
<td>Colorectal</td>
<td>Strongly recommend</td>
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<tr>
<td>Use of raltitrexed in management of metastatic colorectal cancer - Cancer care Ontario [23]</td>
<td>Canada</td>
<td>2002</td>
<td>Colorectal</td>
<td>Strongly recommend</td>
</tr>
<tr>
<td>Use of irinotecan combined with 5Fluorouracil and leucovirin as first line therapy for metastatic colorectal cancer - Cancer care Ontario [24]</td>
<td>Canada</td>
<td>2003</td>
<td>Colorectal</td>
<td>Strongly recommend</td>
</tr>
<tr>
<td>Follow up of patients with curatively resected colorectal cancer – Cancer care Ontario [14]</td>
<td>Canada</td>
<td>2004</td>
<td>Colorectal</td>
<td>Strongly recommend</td>
</tr>
<tr>
<td>Postoperative adjuvant Radiotherapy and/or Chemotherapy for Resected Stage II &amp; III Rectal Cancer – Cancer care Ontario [32]</td>
<td>Canada</td>
<td>2001</td>
<td>Rectum</td>
<td>Strongly recommend</td>
</tr>
<tr>
<td>The use of Preoperative radiotherapy in the management of patients with Clinically respectable Rectal cancer - Cancer care Ontario [29]</td>
<td>Canada</td>
<td>2004</td>
<td>Rectum</td>
<td>Strongly recommend</td>
</tr>
<tr>
<td>Rectal Cancer - NCCN [27]</td>
<td>USA</td>
<td>2004</td>
<td>Rectum</td>
<td>Recommend (with provisos or alterations)</td>
</tr>
<tr>
<td>Rectal cancer treatment – NCI [28]</td>
<td>USA</td>
<td>2003</td>
<td>Rectum</td>
<td>Recommend (with provisos or alterations)</td>
</tr>
<tr>
<td>Colorectal cancer surveillance et Adjuvant chemotherapy for stage II colon cancer – American Society of clinical oncology [13]</td>
<td>USA</td>
<td>2000</td>
<td>Colorectal</td>
<td>Strongly recommend</td>
</tr>
<tr>
<td>Rectumcarcinoom - Oncoline (vereniging van Integrale kankercentra) : consensus based [33]</td>
<td>Netherlands</td>
<td>2001</td>
<td>Rectum</td>
<td>Would not recommend</td>
</tr>
</tbody>
</table>

Note: The assessment of the guidelines was made with the AGREE instrument which can be found on: [http://www.agreecollaboration.org/pdf/agreeinstrumentfinal.pdf](http://www.agreecollaboration.org/pdf/agreeinstrumentfinal.pdf)
Appendix 2: Key to evidence statements and grades of recommendations

SCOTTISH INTERCOLLEGIATE GUIDELINES NETWORK (SIGN) [1]

Levels of evidence

1++ High quality meta-analyses, systematic reviews of RCTs or RCTs with a very low risk of bias
1+ Well conducted meta-analyses, systematic reviews of RCTs, or RCTs with a low risk of bias
1- Meta-analyses, systematic reviews of RCTs, or RCTs with a high risk of bias
2++ High quality systematic reviews of case control or cohort studies
   High quality case control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal
2+ Well conducted case control or cohort studies with a low risk of confounding or bias and a moderate probability that the relationship is causal
2- Case control or cohort studies with a high risk of confounding or bias and a significant risk that the relationship is not causal
3 Non analytic studies, e.g. case reports, case series
4 Expert opinion

Grades of recommendation

A At least one meta-analysis, systematic review of RCTs, or RCT rated as 1++ and directly applicable to the target population; or body of evidence consisting principally of studies rated as 1+, directly applicable to the target population, and demonstrating overall consistency of results
B A body of evidence including studies rated as 2++, directly applicable to the target population, and demonstrating overall consistency of results; or Extrapolated evidence from studies rated as 1++ or 1+
C A body of evidence including studies rated as 2+, directly applicable to the target population and demonstrating overall consistency of results; or Extrapolated evidence from studies rated as 2++
D Evidence level 3 or 4; or Extrapolated evidence from studies rated as 2+

NATIONAL INSTITUTE FOR CLINICAL EXCELLENCE (NICE)

A Evidence derived from randomised controlled trials or systematic reviews of randomised trials
B Evidence from non-randomised controlled trials or observational studies
C professional consensus

AMERICAN SOCIETY OF CLINICAL ONCOLOGY

Level

I Meta-analysis of multiple well designed, controlled studies; randomised trials with low false-positive and low false-negative errors (high power)
II At least one well designed experimental study; randomised trials with high false-positive or high false-negative errors or both (low power)
III Well designed, quasi-experimental studies, such as nonrandomised controlled, single-group, preoperative-
postoperative comparison, cohort, time, or matched case-control series

IV Well designed, non experimental studies such as comparative and correlational descriptive and case studies

V Case reports and clinical examples

Grade

A Evidence of type I or consistent findings from multiple studies of type II, III or IV

B Evidence of type II, III or IV and generally consistent findings

C Evidence of type II, III or IV but inconsistent findings

D Little or no systematic empirical evidence

NATIONAL CANCER INSTITUTE (NCI)

Strength of study design

- Randomised controlled clinical trials
  - Double-blinded
  - Non blinded (allocation schema or treatment delivery)
- Non randomised controlled clinical trials
- Case series
  - Population-based, consecutive series
  - Consecutive cases (not population-based)
  - Non consecutive cases

NATIONAL COMPREHENSIVE CANCER NETWORK (NCCN) [6]

Category 1 There is uniform NCCN consensus, based on high level evidence, that the recommendation is appropriate

Category 2A There is uniform NCCN consensus, based on lower-level evidence including clinical experience, that the recommendation is appropriate

Category 2B There is non uniform consensus (but no major disagreement), based on lower level evidence including clinical experience, that the recommendation is appropriate

Category 3 There is major NCCN disagreement that the recommendation is appropriate

SINGAPORE MINISTRY OF HEALTH (SMOH)

Level IA Evidence obtained from meta-analysis of RCT and systematic reviews of RCT

Level IB Evidence obtained from at least one RCT

Level IIA Evidence obtained from at least one well-designed controlled study without randomisation

Level IIB Evidence obtained from at least one other type of well-designed quasiexperimental study

Level III Evidence obtained from well-designed non-experimental descriptive studies, such as comparative studies, correlation studies and case studies

Level IV Evidence obtained from expert committee or opinion and/or clinical experience of respected authorities without transparent proof.
REFERENCES

1. SIGN, management of colorectal cancer, SIGN, Editor. 2003.
2. NICE, Guidance on Cancer Services Improving Outcomes in Colorectal Cancer, NICE, Editor. 2003.

26 Best, L.S., P; Baughan, C; Buchanan, R; Davis, C; Fentiman, I; George, S; Gosney, M; Northover, J; Williams, P, *Palliative chemotherapy for advanced or metastatic colorectal cancer.*, in Cochrane Database of Systematic Reviews., C. library, Editor. 05-27-2003.


