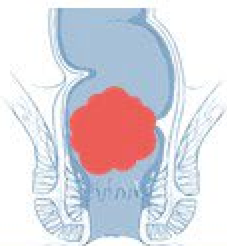
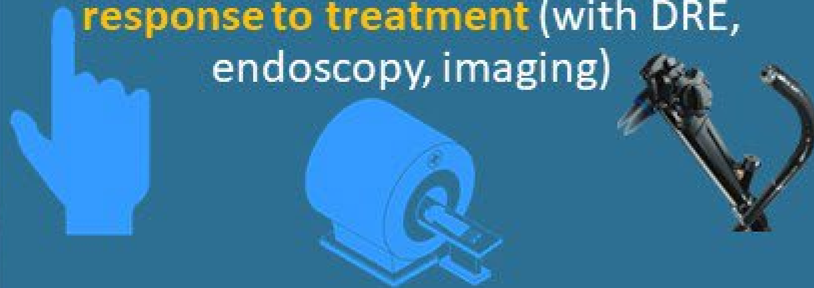


Clinical Practice Guidelines: #RectalCancer (1/2)

Tumors of the **upper rectum** ***usually*** do **not** benefit from neoadjuvant chemoradiotherapy, and should typically undergo **surgical resection**

Total neoadjuvant therapy (TNT) is typically recommended for T3 or N1 mid or low rectal CA

After TNT for rectal cancer, patients should be **assessed to determine the response to treatment** (with DRE, endoscopy, imaging)



Endoscopic biopsy for the presence of residual disease **is limited** by high false negative rates

Acceptable to use: "**induction TNT**" (systemic chemotherapy followed by radiation therapy

Chemo | XRT (Short or Long) → 8-12w

or "**consolidation TNT**" (upfront radiation therapy followed by chemotherapy

XRT (Short or Long) | Chemo → 8-12w

**W&W not well studied with SHORT course XRT*

Langenfeld SJ et al. *Dis Colon Rectum* 2024;68(1):18-31

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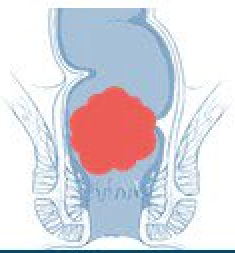
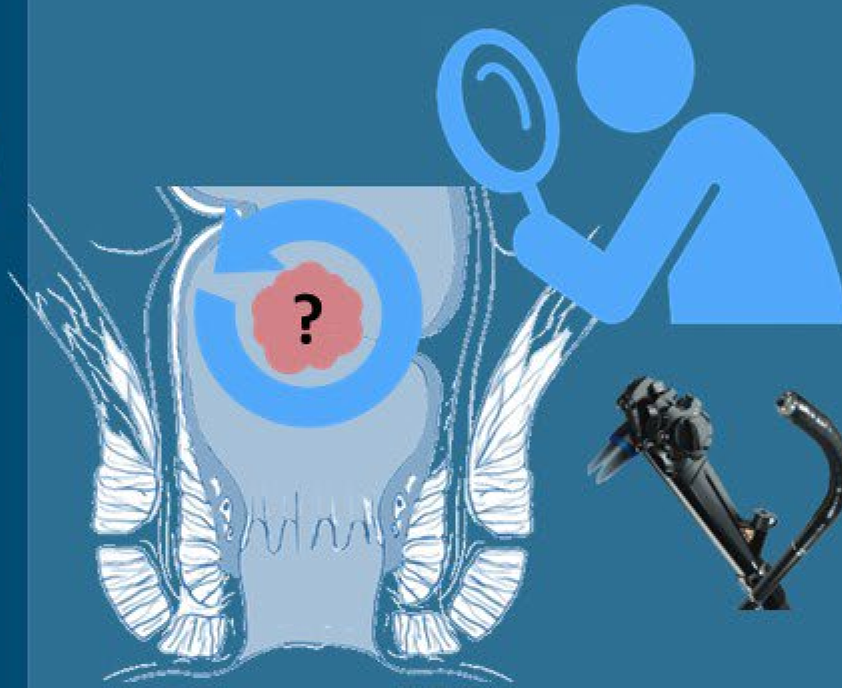


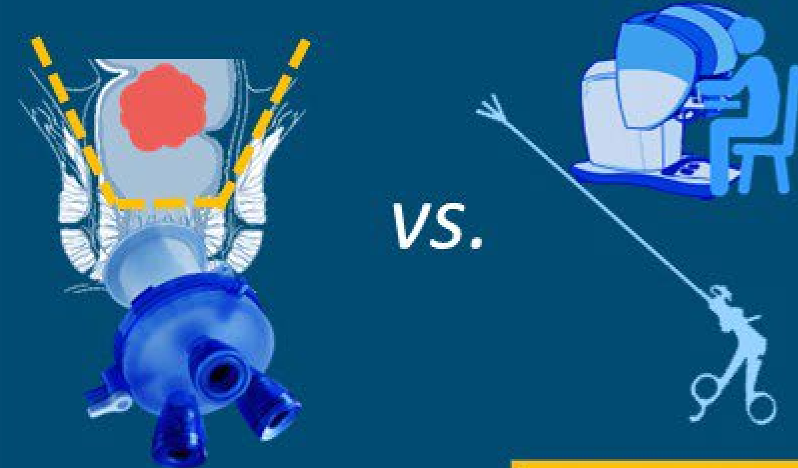
Clinical Practice Guidelines: #RectalCancer (2/2)

Watch-and-wait can be offered to select patients with clinical complete response in experienced centers **with established protocols** (with DRE, endoscopy, imaging - highest risk in first 2-3 years)

Watch-and-wait patients should undergo **surveillance to assess for local tumor** regrowth *(occurs in 20-30%)*



Compared to lap/robotic LAR/TME, **transanal TaTME** for mid and low rectal cancer has **similar overall complication rates and functional outcomes**



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DISEASES OF THE COLON & RECTUM
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