Clinical Practice Guidelines: Colon Cancer 1/3

Preop:

+ Include **CEA** (1B)

+ Evaluate proximal colon (when possible) (1C)
30-50% with synchronous adenomas

+ Get **histologic confirmation** of invasive adenocarcinoma before colectomy (1C)

+ Get **CT chest/abd/pelvis** (1B) (no routine PET) (1B)

Intraop:

+ **Document**: workup, metastases, lymphovascular drainage basins, extent /completeness of resection, anastomotic technique, other findings (1C)

+ **Synoptic operative reporting** improves documentation (1C)

+ **Extent of resection** should correspond to individualized lymphovascular drainage sites (1B)

+ Routine *extended* lymphadenectomy is **not** recommended (2B)

+ **MIS approach** preferred (1A)

Vogel JD et al. *Dis Colon Rectum* 2022;65(2):148-77

DISEASES OF THE COLON & RECTUM
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Clinical Practice Guidelines: Colon Cancer 2/3

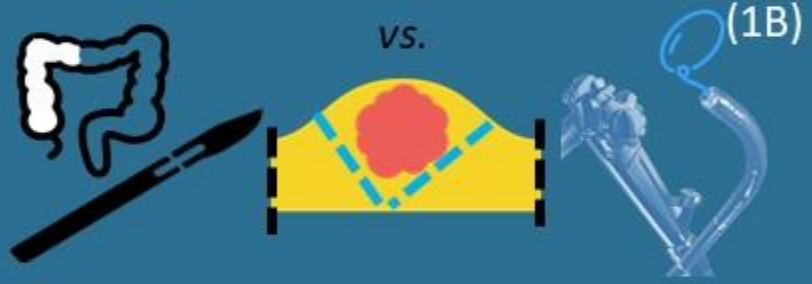
+ Synchronous lesions: Two resections or subtotal are OK (1B)

+ Resect involved adjacent organs en bloc with negative margins (1B)

Do not routinely resect:

- Ovary for prophylaxis (1C)
- Asymptomatic 1° with mets (do systemic chemo first) (1B)

+ For **"Malignant polyps"**, **endoscopic excision** or **oncologic surgery** appropriate, *depending on histologic features and completeness of resection*



Obstructing Lesions:

+ Stent first or surgery ok (1B left, 1C right)

Neoadjuvant chemo can result in tumor regression in locally advanced / borderline unresectable tumors (2B)

+ Cytoreduction (with or without HIPEC) should be considered in resectable **peritoneal metastases** (1B)

+ Staged or Combined liver resections ok (2B)

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Clinical Practice Guidelines: Colon Cancer 3/3

Postop:

+ Chemo for High Risk Stage II: obstruction, perforation, <12 nodes, poor diff, LVI, PNI, high tumor budding (2B)

+ 3-6 months Adjuvant Chemo for Stage III (1A)
(FOLFOX / CAPOX. Consider immunotherapy if MSI-H)

+ Start adjuvant chemo within 8 weeks of resection (1B)

+ Multigene assays, CDX2 expression analysis and ctDNA may be used to compliment MDT decision making (1B)

+ Locoregional Recurrence should be evaluated in multidisciplinary setting (1B)
Consider re-operation if R0 resection can be performed

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