

Clinical Practice Guidelines: #RectalCancer (1 / 3)



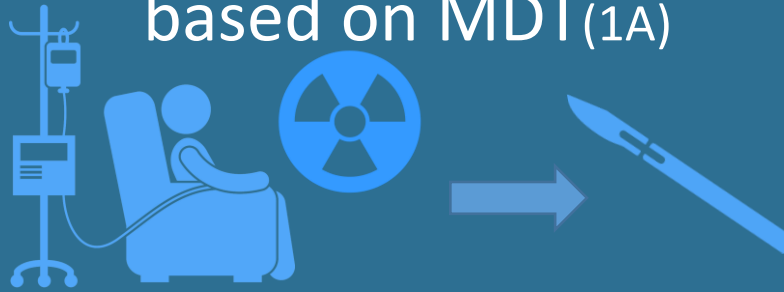
Protocolized **MRI** is **preferred staging** method
(*ERUS ok for T1/2 or if MRI contraindicated*) 1B



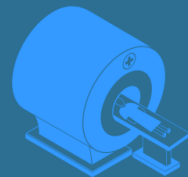
Treatment Plan should be discussed at **multidisciplinary tumor (MDT) board** (1C)



Neoadjuvant ChemoXRT for **T3 or N+** patients based on MDT(1A)



Restaging should be considered **after neoadjuvant CXRT** with locally advanced tumors (1C)



11-15% have altered Tx plan

Distance of the tumor edge to the anal verge and relationship to sphincter **should be measured** 1C

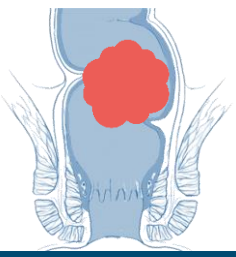


DISEASES OF THE COLON & RECTUM



You N et al. *Dis Colon Rectum* 2020;63





Clinical Practice Guidelines: #RectalCancer (2/3)

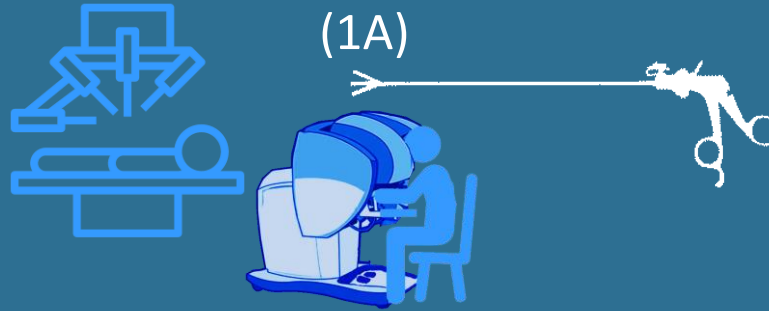


For **mid & low tumors**,
TME should be performed
(with 1-2cm distal margin
if anastomosis planned)



For **upper 1/3 tumors**,
**tumor-specific partial
mesorectal excision** is ok
if at least 5cm margin (1A)

**Minimally invasive TME is
safe in experienced hands**



Local Excision is appropriate in
carefully selected T1N0 pts
without high risk features **1B**



**TaTME remains
controversial 1B**

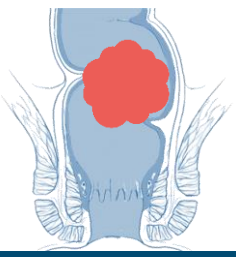
Learning curve ~40 cases, limited long term oncologic data



**Operative report should
contain staging, findings, and
details of procedure
(synoptic checklist) 1C**



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Clinical Practice Guidelines: #RectalCancer (3/3)



Patients with **complete clinical response** should be **offered radical resection**.



“**Watch & Wait**” can be considered for **highly select patients** in **protocolized** setting 1B



Routine **lateral lymph node dissection** is not required (in absence of clinically positive nodes) 1C



Adjuvant chemo is recommended for Stage II/III within 8 weeks of resection



During surgery: Rectal washout (2C) & Colonic J-pouch (2B) may be used.

If a stoma is planned, preop marking should be performed (1B) and any anastomosis should be air-leak tested (1B)

