Best Practices Checklist for Rectal Cancer

The following checklist is intended to be complementary to the WHO checklist for patient safety in the immediate pre-operative, peri-operative, and post-operative periods. This checklist can be used to (1) raise awareness of rectal cancer guidelines; (2) enhance pre-operative, intra-operative, and post-operative documentation; and (3) facilitate integration of best practices into pre-operative cancer conferences. **Similarities** to the WHO checklist include evidence-based actions consistent with best outcomes, ease of use, checklist rather than algorithm format (what to do—not how to do it). **Differences** include an emphasis specifically on elective rectal cancer surgery and cancer outcomes rather than 30-day safety outcomes.

**PREOPERATIVE EVALUATION CHECKLIST**

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| ☐   | ☐  | **Formal pathology review was performed to identify the presence of invasive carcinoma.**
| ☐   | ☐  | ☐ In the unobstructed patient, a complete colonic evaluation was performed.
| ☐   | ☐  | ☐ The tumor location within the rectum (e.g. distance from anal verge, tumor length, anterior/posterior/left/right) as well as relationship to the levators and anorectal ring was documented.
| ☐   | ☐  | ☐ An assessment of family history, preoperative stool continence and sexual function was documented.
| ☐   | ☐  | ☐ Clinical staging of the primary tumor (ERUS or MRI) was performed.
| ☐   | ☐  | ☐ Clinical staging for distant metastases (Chest/Abdomen/Pelvis) was performed.
| ☐   | ☐  | ☐ Preoperative or peri-operative CEA level was measured.
| ☐   | ☐  | ☐ Consideration of neoadjuvant treatment for > T2 or node positive disease has been documented. Among those who received neoadjuvant treatment, the tumor was re-staged and location was re-confirmed just prior to operation.
| ☐   | ☐  | ☐ A multi-disciplinary discussion of care, preferably during a formal Tumor Board conference, was documented.
| ☐   | ☐  | ☐ If a stoma is considered, the site was preoperatively marked.

**INTRA-OPERATIVE CHECKLIST**

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| ☐   | ☐  | ☐ A thorough exploration and assessment for extra-pelvic disease was performed and is noted.
| ☐   | ☐  | ☐ A sharp **total or tumor-specific mesorectal dissection** with *en bloc* radical lymphadenectomy was performed.
| ☐   | ☐  | ☐ The distal resection margin and its relationship to the tumor was considered prior to rectal transection and should include a distance > 1cm grossly.
| ☐   | ☐  | ☐ Involved adjacent organs were resected *en bloc*.
| ☐   | ☐  | ☐ The integrity of the pelvic nerves was assessed.
| ☐   | ☐  | ☐ The completeness of resection (including whether the operation was considered curative) was assessed and noted.
| ☐   | ☐  | ☐ The rationale for reconstruction of intestinal continuity (sphincter preservation) versus permanent stoma was documented.
In cases of reconstruction,

Yes  No

☐ ☐ The type of reconstruction was noted including handsewn versus stapled anastomosis.

☐ ☐ The rationale for a pouch or end-to-side anastomosis vs. straight anastomosis was documented.

☐ ☐ The location of final anastomosis was noted.

☐ ☐ The anastomotic integrity was evaluated (e.g. leak test).

☐ ☐ A diverting loop ileostomy was considered for cases including pre-operative radiation or intra-operative TME.

POST-OPERATIVE CHECKLIST

Yes  No

☐ ☐ For patients in whom a stoma was necessary as a part of their surgical treatment, the postoperative care included stoma care teaching.

☐ ☐ For patients with Stage II or Stage III cancer, a post-operative consultation with a medical oncologist was recommended.

☐ ☐ Radial and distal margins were documented on the pathology report.