

COLORECTAL CLINICAL SUBGROUP

Network Agreed Onward Referral Policy Measure 11-1C-109d

Referral Guidelines

Not infrequently certain aspects of a specific case will need discussion at either a speciality MDT within the local trust or tertiary centre MDT. A mechanism must exist to allow referral of patients for the opinion of other MDT's and for the receipt of the decision or results. If no guidelines exist specialist.

The named surgeon/investigational consultant is responsible for the onward referral to the MDT.

Where a patient is referred directly from a diagnostic service from primary care, the consultant performing the diagnostic investigation is responsible for onward referral to the MDT.

Enclosed are guidelines for possible referral/opinion to other units that have been formally agreed by the members of the Colorectal Clinical Subgroup within the Greater Manchester and Cheshire Cancer Network. These are listed below.

- Management of anal cancer following failure of chemoradiation
- Guidelines for referral of patients with colorectal cancer and hepatic Metastases
- Pre vs Post Op radiotherapy for rectal cancer

Suggestions for the surgical management of anal cancer following failure of chemoradiation.

Include trial protocol

Multidisciplinary team

In order to manage patients with anal cancer following failed chemoradiation, the multidisciplinary team should include; two colorectal surgeons, a plastic surgeon, urologist, oncologist, GI radiologist, colorectal cancer nurse specialist and stoma therapist. High dependency and ICU care should be available post operatively where required. Patients developing further recurrence should have access to a palliative care team.

Assessment

Standard investigations to determine fitness for surgery

Local disease

Examination under anaesthetic, Biopsy (recurrence must be confirmed histologically), MRI Scan, Trans anal ultrasound scanning.

Metastatic disease

Lymph node fine needle aspiration or biopsy for clinically suspicious groin nodes, CT scan abdomen and chest.

Treatment

This should be based on the extent of disease. In the absence of metastatic disease anorectal excision is the standard procedure. The operative technique should include wide excision of the anal canal and circumrectal tissue also ensuring the widest pelvic floor clearance. As both the abdominal and perineal part of the operation may be technically difficult, two colorectal surgeons working synchronously would be advantageous. Where pre-operative investigations have shown evidence of invasion of adjacent organ/s and surgical care still possible, anorectal excision with en bloc excision of the involved structures should be performed with the assistance of appropriate surgical specialists.

Reconstruction

In view of the high rates of perineal wound breakdown and the long time to perineal wound healing in many patients, a rectus abdominis flap is generally necessary unless the tissues are very favourable at the examination under anaesthetic.

Histopathological reporting

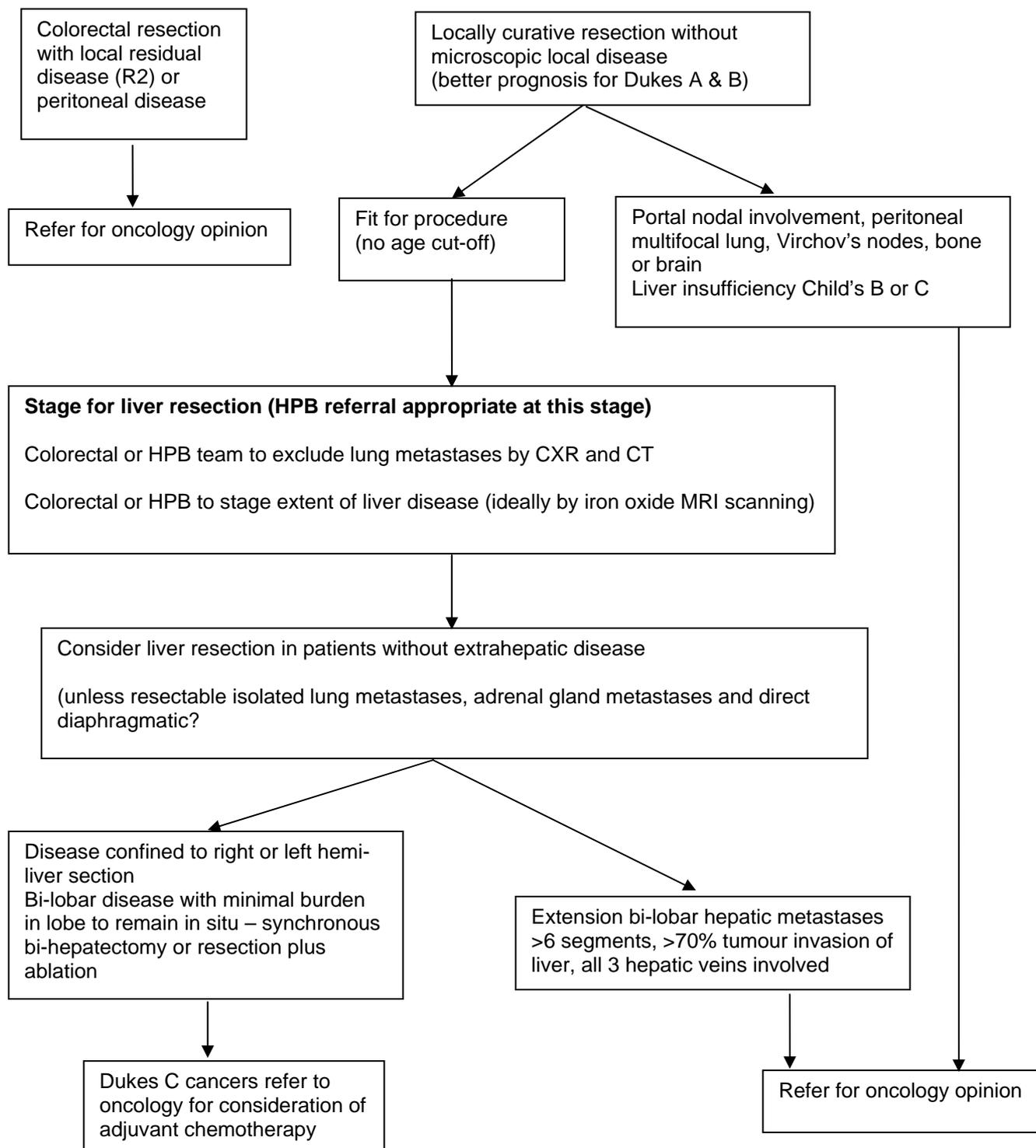
Following histopathological review all cases should be discussed at a multidisciplinary meeting to consider further adjuvant therapies.

It is suggested that colorectal cancer networks agree who the regional surgeons should be.

It was agreed that the Manchester Royal Infirmary & The Christie Hospital will be the units for salvage surgery.

The local multi-disciplinary teams would be expected to use this guideline.

**Network Agreed Referral Guidelines for Liver Metastases
(Measure 11-1A-207D)**



Pre vs Post op radiotherapy for rectal cancer

The standard North West protocol has been for pre op short course radiotherapy for rectal cancer unless it is inoperable.

This may be altered by the advent of MR scanning and the long term follow up from the Dutch and Swedish studies. The recent Mercury study strongly suggests accurate staging by MR scanning can now be performed provided that radiologists are appropriately trained, and the patients can be more readily selected for short or long course pre op radiotherapy or post operative treatment.

Important trial data still awaited include the T3/T4 operable study run in France by Bosset and the CRO7 study. Information from both of these trials should be available over the next couple of years.

In the present state of knowledge pre-operative staging, particularly by MR scanning is essential, but for now I would suggest the following.

For operable rectal cancer short course radiotherapy should be considered for T2 and T3 cancers unless the patient is in a trial, especially if the rectal cancer is in the lower third of the rectum or a T3 cancer not threatening the circumferential margin. Potentially involved lymph nodes should also not threaten the circumferential margin. The standard pre-operative short course dose is 20 cGy in 4 fractions in the North West, although this differs from the 25Gy in 5 fraction regime used elsewhere, there is published data showing that the local recurrence rate in North West compares favourably with us than the rest of the UK. (BJS submitted 2005)

There is less proven value for short course radiotherapy for T2 and for upper Rectal cancers. Nevertheless, I should stress that studies still demonstrate a benefit for all stages of rectal cancer throughout the rectum. It is therefore recommended that radiotherapy continues to be considered for all T2, T3 and T4 malignancies and discussed at the MDTs.

Locally advanced cancers ie, T3 tumours or nodes less than 2 millimetres from the circumferential margin or T4 tumours should be considered for long course radiotherapy. Evidence suggests that chemo radiotherapy is better than radiotherapy alone. The standard treatment regime is 5FU or Capecitabine and 4 to 5 weeks of radiotherapy with a total dose of 42.5 to 45cGy. There is a north west study, RICE study adding in Irinotecan to this regime.

If patients are obstructed, bleeding etc and require urgent surgery, then post op radiotherapy should be considered if the tumour or involved nodes are 2 millimetres or less from the circumferential margin. T4 tumours should also be considered depending on the width of the excision margin. The number of involved nodes possibly does not affect the decision to give post op radiotherapy, although of course could affect the decision to give chemotherapy.

Because of the downstaging following a long course of chemo radiotherapy the Chronicle study has been launched by the NCRI randomising patients who have received long course chemo radiotherapy with 5FU to Oxaliplatin and Capecitabine vs follow up alone.

Department of Health guidelines adopted by the North West Colorectal Cancer Network, state that 'all cases of rectal cancer should be discussed at the Colorectal MDT. For the MDT to give a valid opinion a clinical oncologist with a specialist interest in treatment of colorectal cancer must be involved, or a medical oncologist with a colorectal interest who must follow clinical oncology guidelines'. The guidelines submitted here are therefore to be distributed with this in mind. I would point out that in section 5 there are 3 particular areas of controversy where a clinical oncologist has to be involved in the MDT decision because of the complexity of the subject and the constant state of flux for treatment patterns in this area.

The distance from tumour to circumferential margin which needs to exist for short course radiotherapy to be safely given, has been described as 1mm in the Mercury Study. In this study radiologists, were particularly highly trained and it is quite possible that a 1mm margin should not be relied upon when considering patients who are scanned outside of this trial. My personal view is that since the risk of a local recurrence falls dramatically once tumours are beyond 2mm from the circumferential margin, a margin of at least 2mm should be considered between tumour and circumferential margin before the patient is accepted for a short course radiotherapy.

Many centres in the UK no longer give short course radiotherapy for T2 cancers or even some T3 tumours. However, there is clear evidence of an improvement in local control and possibly survival for all stages of malignancy. So it is recommended all T2 and T3 cancers are discussed at the MDT. If in doubt, I and my clinical oncology colleagues at the Christie with GI specialist interest are happy to advise.

The final major point of controversy, is whether all patients with T3 cancers of the lower third of the rectum require long course chemo-radiotherapy. There is no firm evidence one way or the other, provided that there is at least a 2mm circumferential resection margin, but again all T3 malignancies of the lower third of the rectum should be discussed for radiotherapy, either short or long course. If they are within 2mm of the circumferential margin they should automatically have long course radiotherapy. If not, then the decision can be made depending on the patient's fitness and the MDT view is the likelihood of complete surgical excision with clear margin. If the patient is sufficiently fit, then in the present state of knowledge, it would not be unreasonable to offer long course radiotherapy if in doubt.

These recommendations are less precise than the initial recommendations of March, but it was felt that although in principle firm guidance can be given in practice, it is wise to be cautious in discussing cases especially with narrow circumferential margin or where there is a low rectal cancer until the results of the Mercury Study have been validated throughout the country.