



Where is Rectal Cancer Treatment Going?

Manoj J. Raval

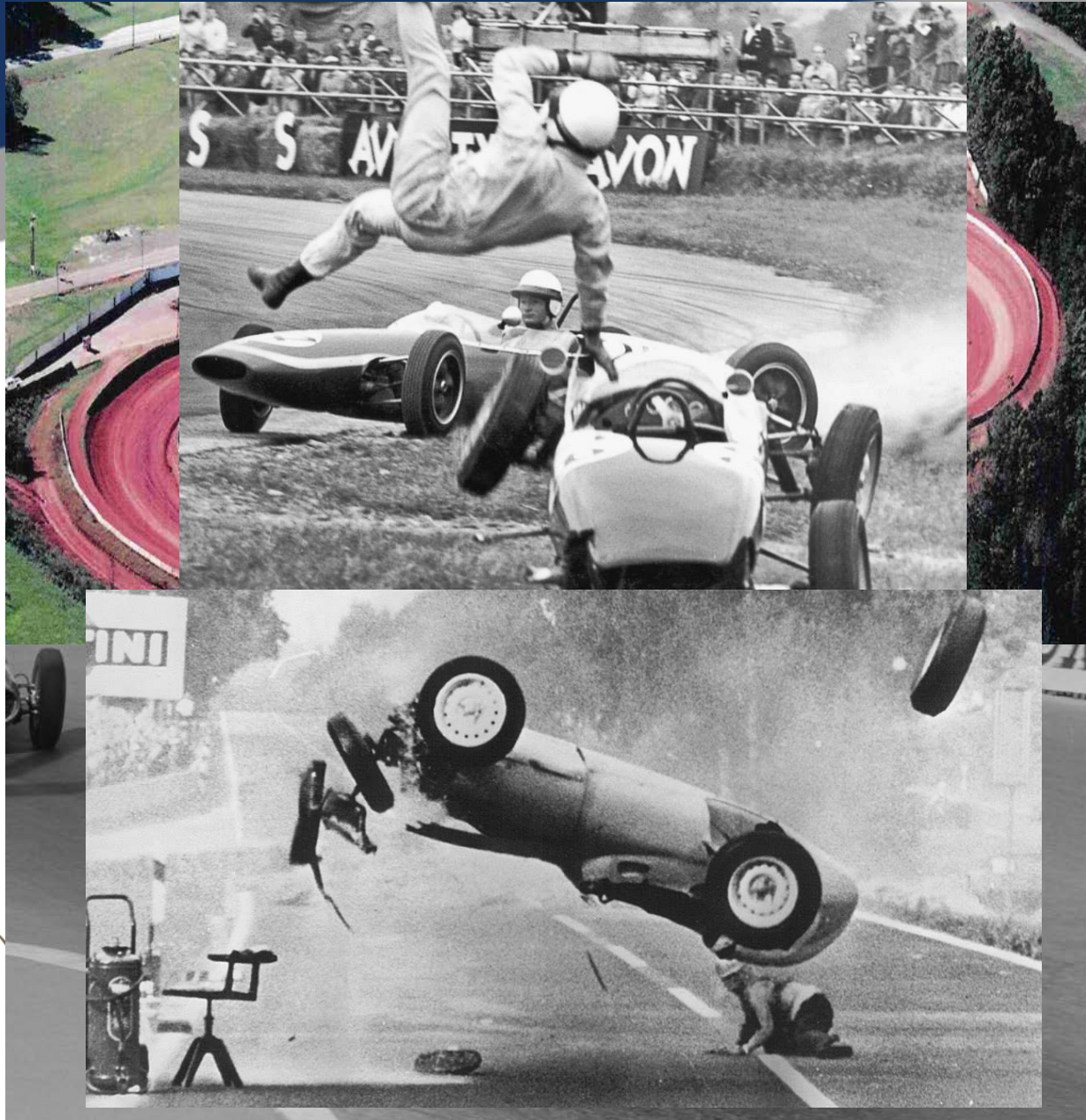
Surgical Oncology Network Fall Update

October 14, 2017





Rectal Cancer – A Brief History

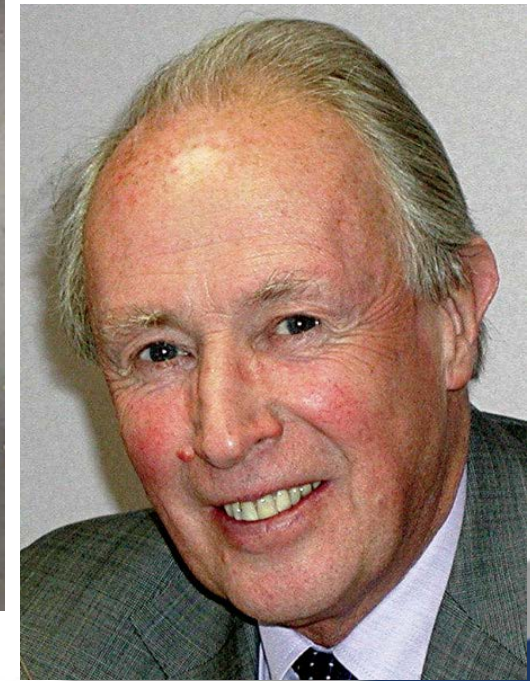


- Excise the rectum
- Pre-TME era
- Blunt dissection
- Crude surgery

- Local recurrence >50%!

Rectal Cancer – A Brief History

- Total mesorectal excision



Rectal Cancer – A Brief History



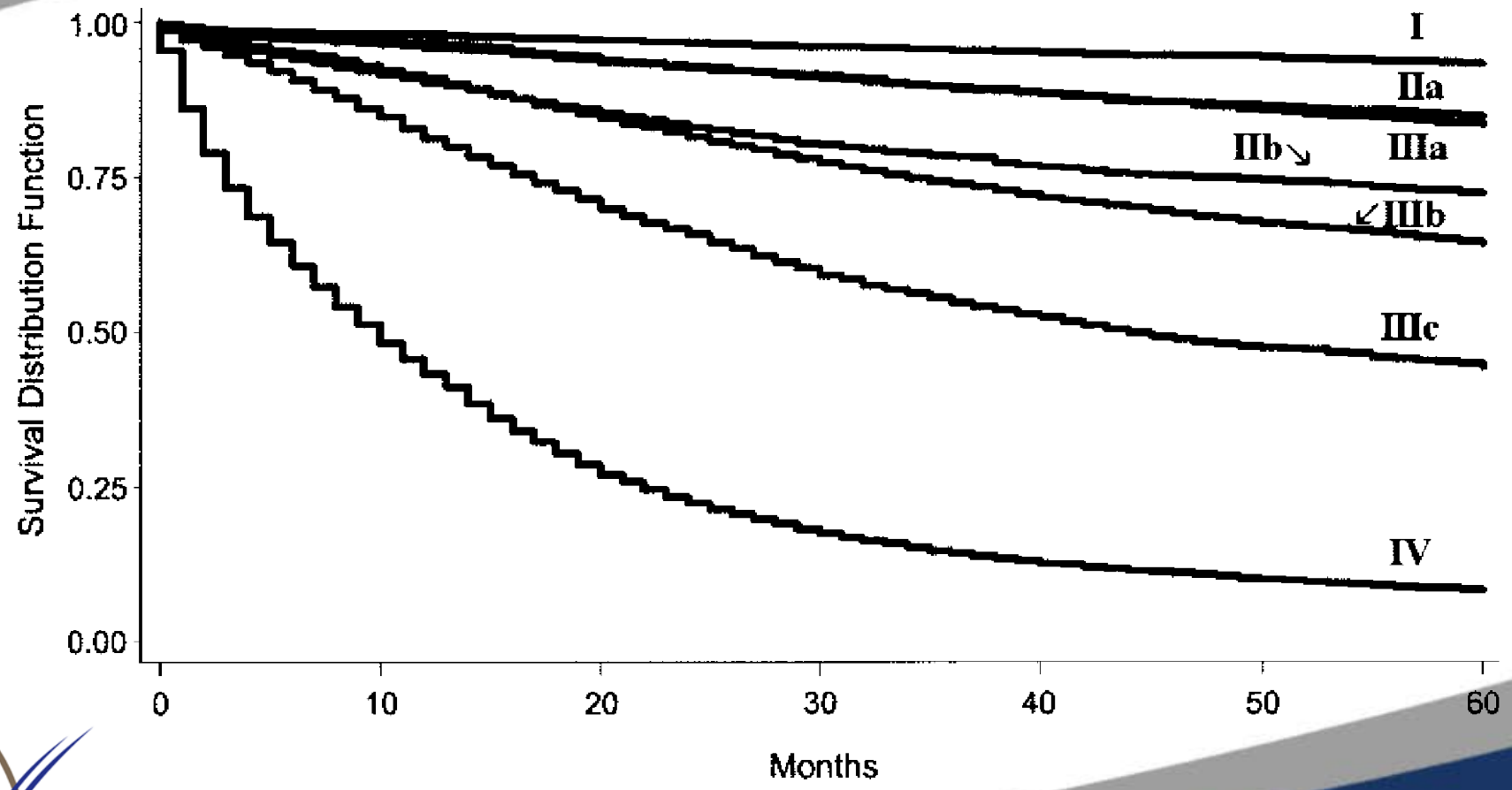
- Adjuvant Rx

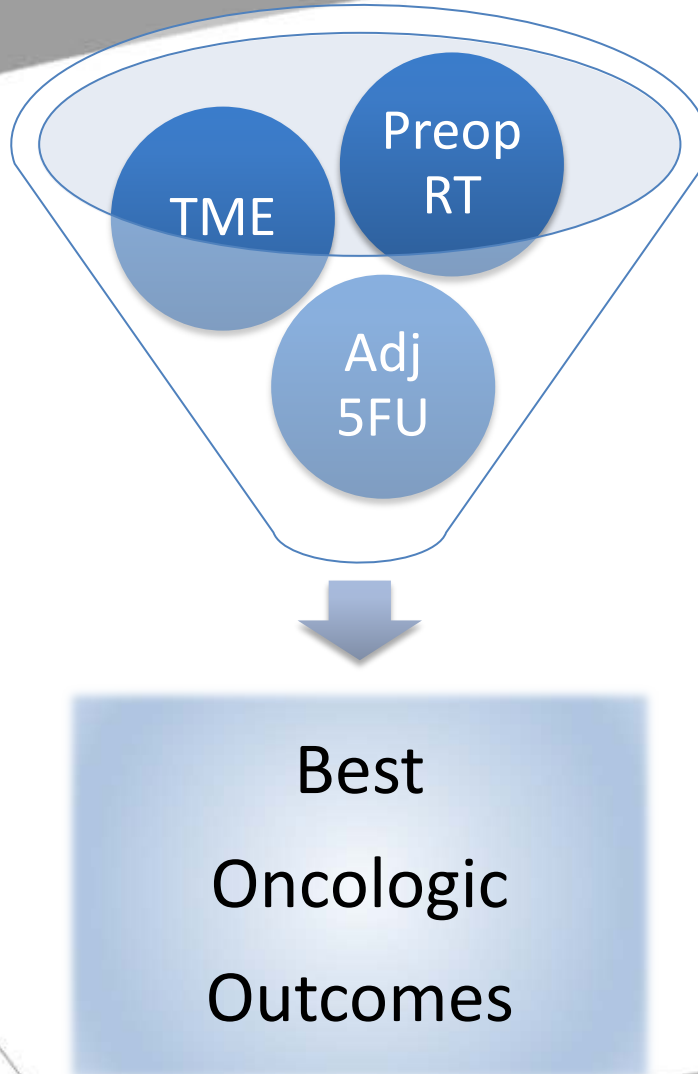
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Landmark papers in 1980s-2000s



SEER Data - DFS





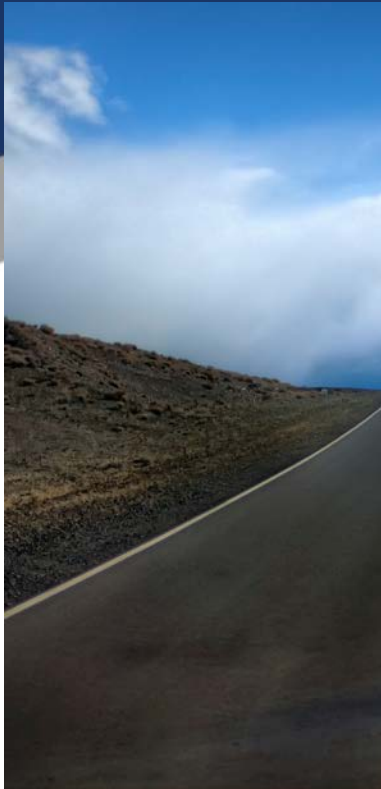
***Compare all
other options
to this standard***

- TME Surgery, Radiation and Chemo can have **negative** consequences
 - Mortality
 - Complications & adverse effects
 - Function
 - GI, GU, general
 - Cosmesis



- Eliminate RT?
- More RT?
- Different RT?
- More selective RT?
- TEM instead of TME?
- Wait longer after RT for surgery?
- No surgery at all?
- More upfront chemo?
- RT then chemo then surgery?
- Decide on surgery depending on response to RT?
- ***Compare any new options with standard of care***

So Where Do We Go From Here?





A QUALITY PROGRAM
of the AMERICAN COLLEGE
OF SURGEONS

THE NATIONAL ACCREDITATION PROGRAM FOR RECTAL CANCER STANDARDS MANUAL

2017 EDITION



Chapter 1: Program Management

- Standard 1.1:** Commission on Cancer Accreditation
- Standard 1.2:** Rectal Cancer Multidisciplinary Care
- Standard 1.3:** Rectal Cancer Multidisciplinary Team Attendance
- Standard 1.4:** Rectal Cancer Multidisciplinary Team Meetings
- Standard 1.5:** Rectal Cancer Program Director
- Standard 1.6:** Rectal Cancer Program Coordinator
- Standard 1.7:** Rectal Cancer Program Education*

Chapter 2: Clinical Services

- Standard 2.1:** Review of Diagnostic Pathology
- Standard 2.2:** Staging before Definitive Treatment
- Standard 2.3:** Standardized Staging Reporting for Magnetic Resonance Imaging Results
- Standard 2.4:** Carcinoembryonic Antigen Level
- Standard 2.5:** Rectal Cancer Multidisciplinary Team Treatment Planning Discussion
- Standard 2.6:** Treatment Evaluation and Recommendation Summary
- Standard 2.7:** Definitive Treatment Timing
- Standard 2.8:** Surgical Resection and Standardized Operative Reporting*
- Standard 2.9:** Pathology Reports after Surgical Resection
- Standard 2.10:** Photographs of Surgical Specimens
- Standard 2.11:** Multidisciplinary Team Treatment Outcome Discussion
- Standard 2.12:** Treatment Outcome Discussion Summary
- Standard 2.13:** Adjuvant Therapy after Surgical Resection

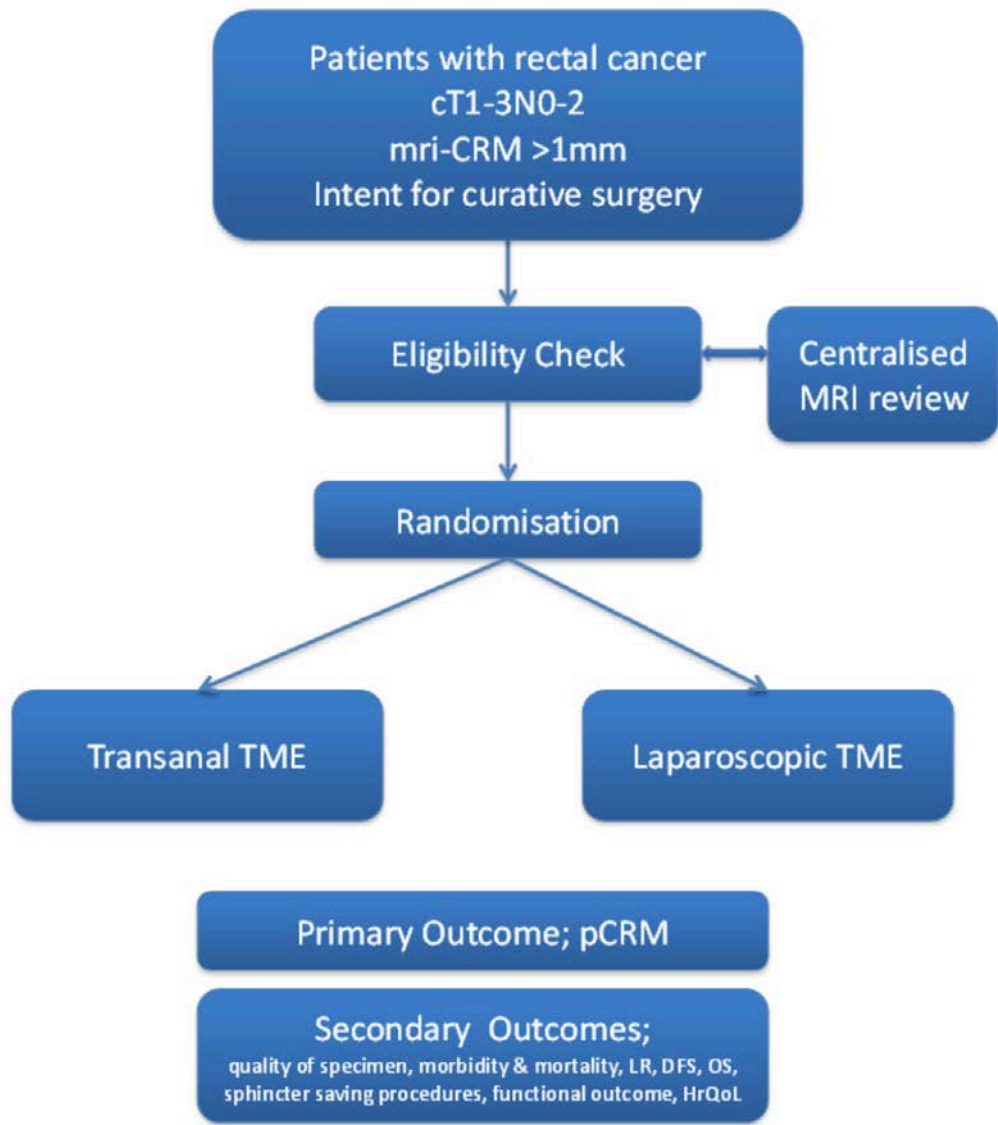
Chapter 3: Quality Improvement

- Standard 3.1:** Rapid Quality Reporting System*
- Standard 3.2:** Accountability and Quality Improvement Measures*

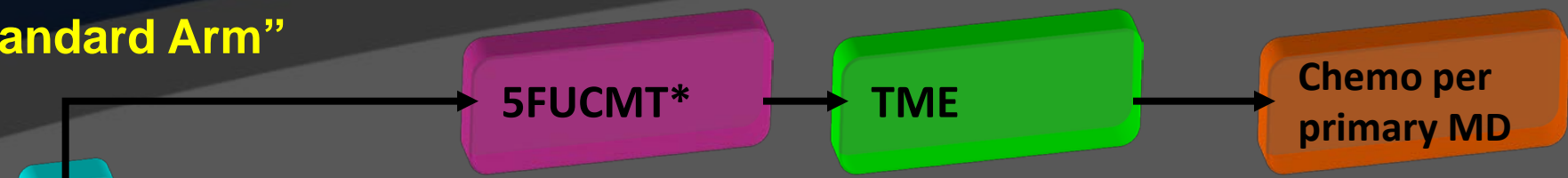
So Where Do We Go From Here?



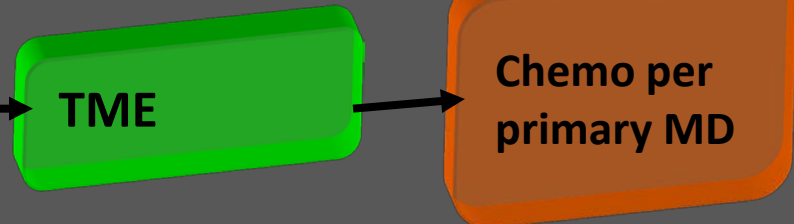
- Long term cancer remission
- Minimal morbidity
- Best QOL
- Least impact on function
- **Responsible intro of novel techniques and regimens**



“Standard Arm”



Response $\geq 20\%$



“Selective Arm”

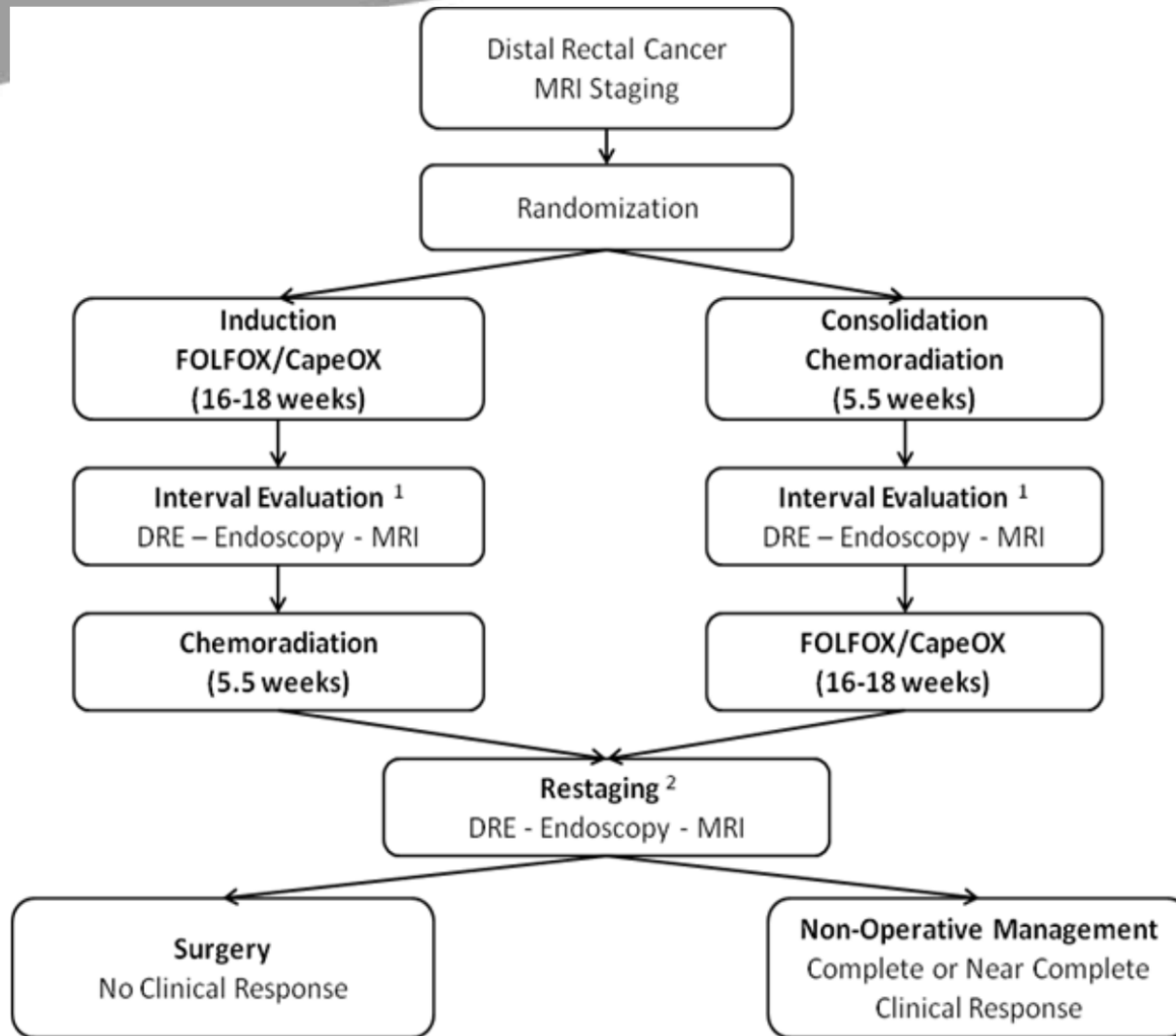


Response $< 20\%$



*5FUCMT = infusional or oral 5FU + radiation therapy

Chemotherapy and Chemoradiation Followed by Surgery or Non-Operative Management (MSKCC)



cT1-3^{ab} N0



FOLFOX or
CAPOX
x 3 months

Sigmoidoscopy to ensure
TEMS feasible

No

TME
Surgery

Yes

TEMS/TAMIS

ypT1^{bad*} or higher

TME
Surgery

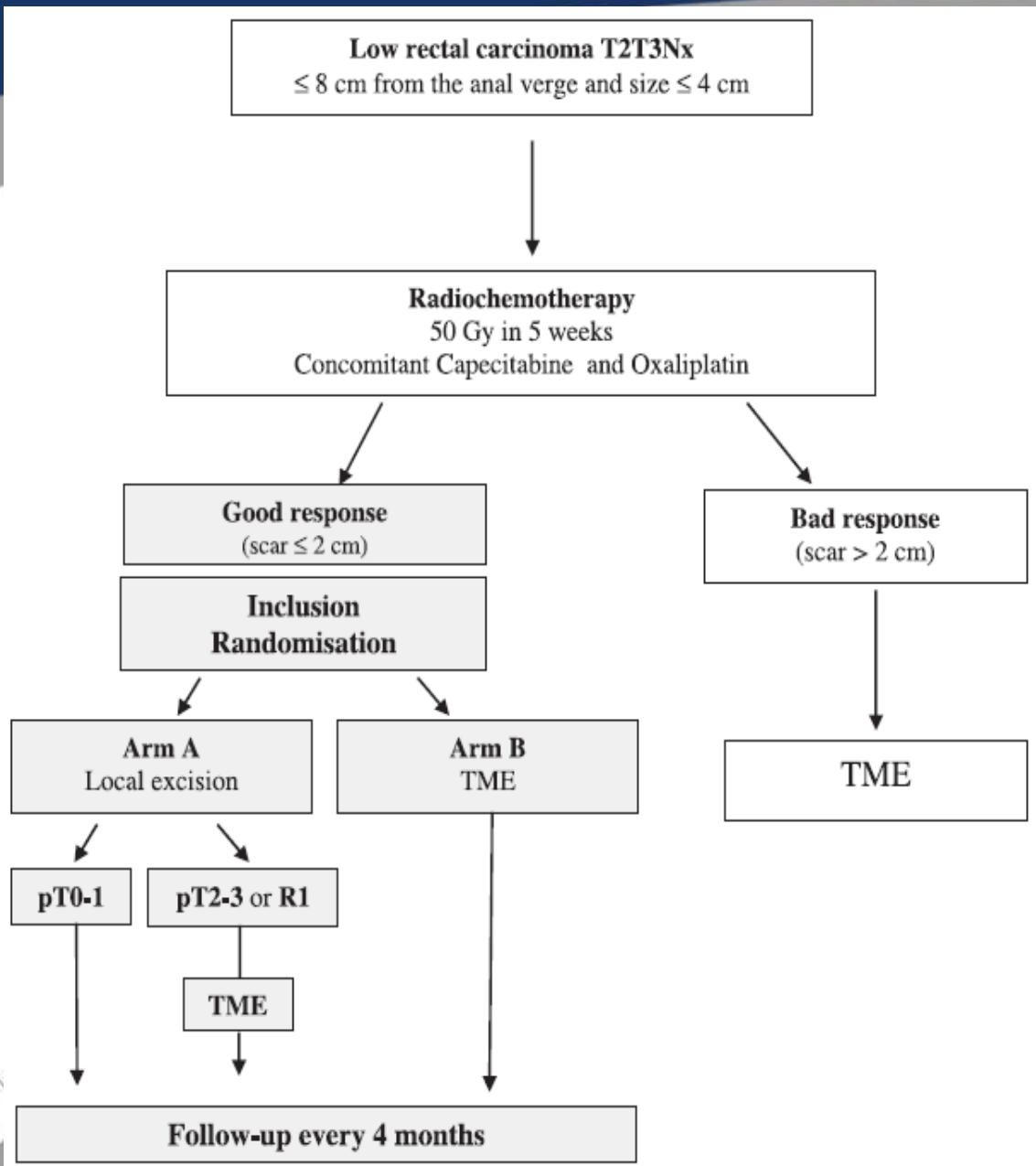
1^o Endpoint=
Organ Preservation

↓ ypT0/T1^{good}

Surveillance

cT3a,b N0
≤5 mm into the subserosa
Clear CRM
No radiographic evidence of
mesorectal nodal metastasis,
tumour deposits or
lymphovascular invasion.

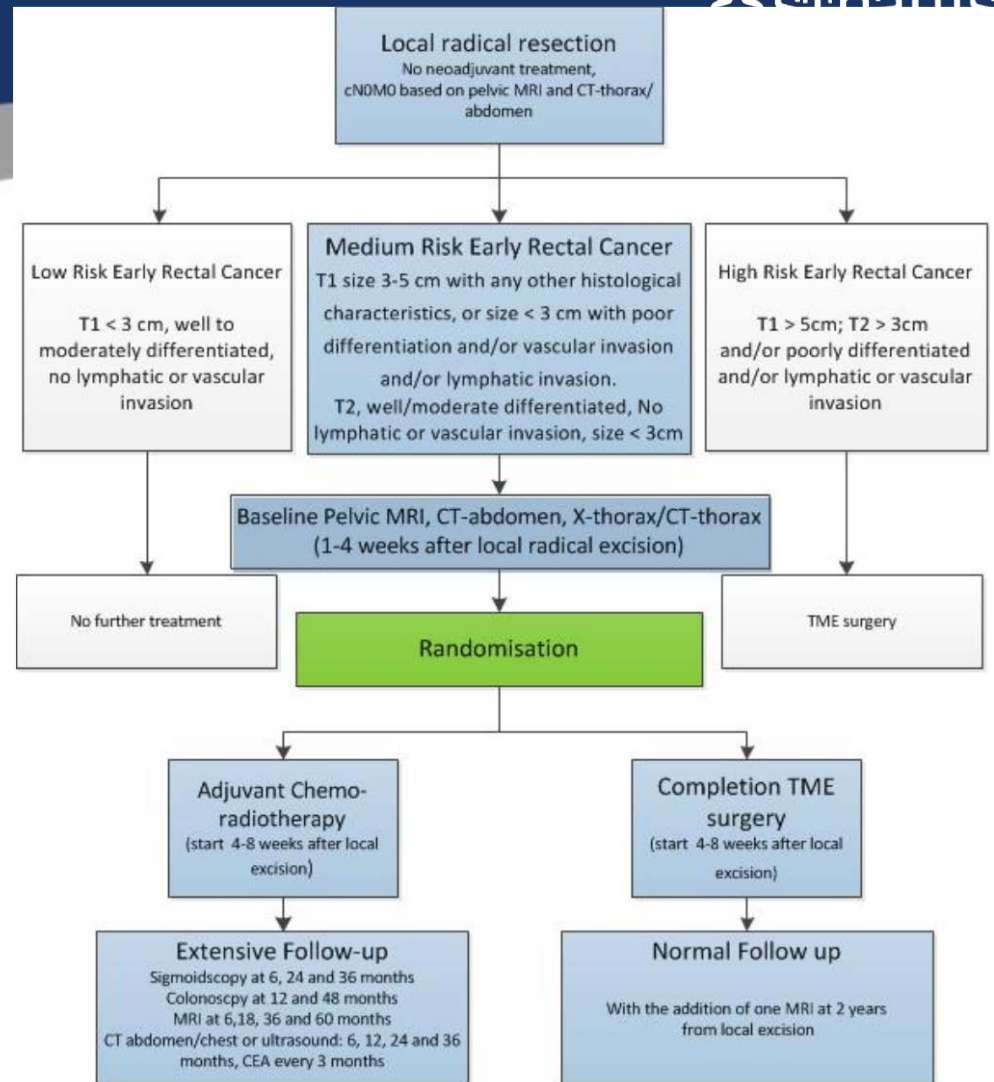
* ypT1^{bad} LVI, R1, high grade



TESAR Trial



Rectal preserving treatment for early rectal cancer. A multi-centred randomised trial of radical surgery versus adjuvant chemoradiotherapy after local excision for early rectal cancer.



Tumor Stadium	Well differentiated	Moderately differentiated	Poorly differentiated	Lymphatic invasion	Venous invasion	Size > 3cm	Size > 5cm
T1							
T2							

The Future of Rectal Cancer Care



THE GRAND UNIFIED THEORY

Randell L. Mills

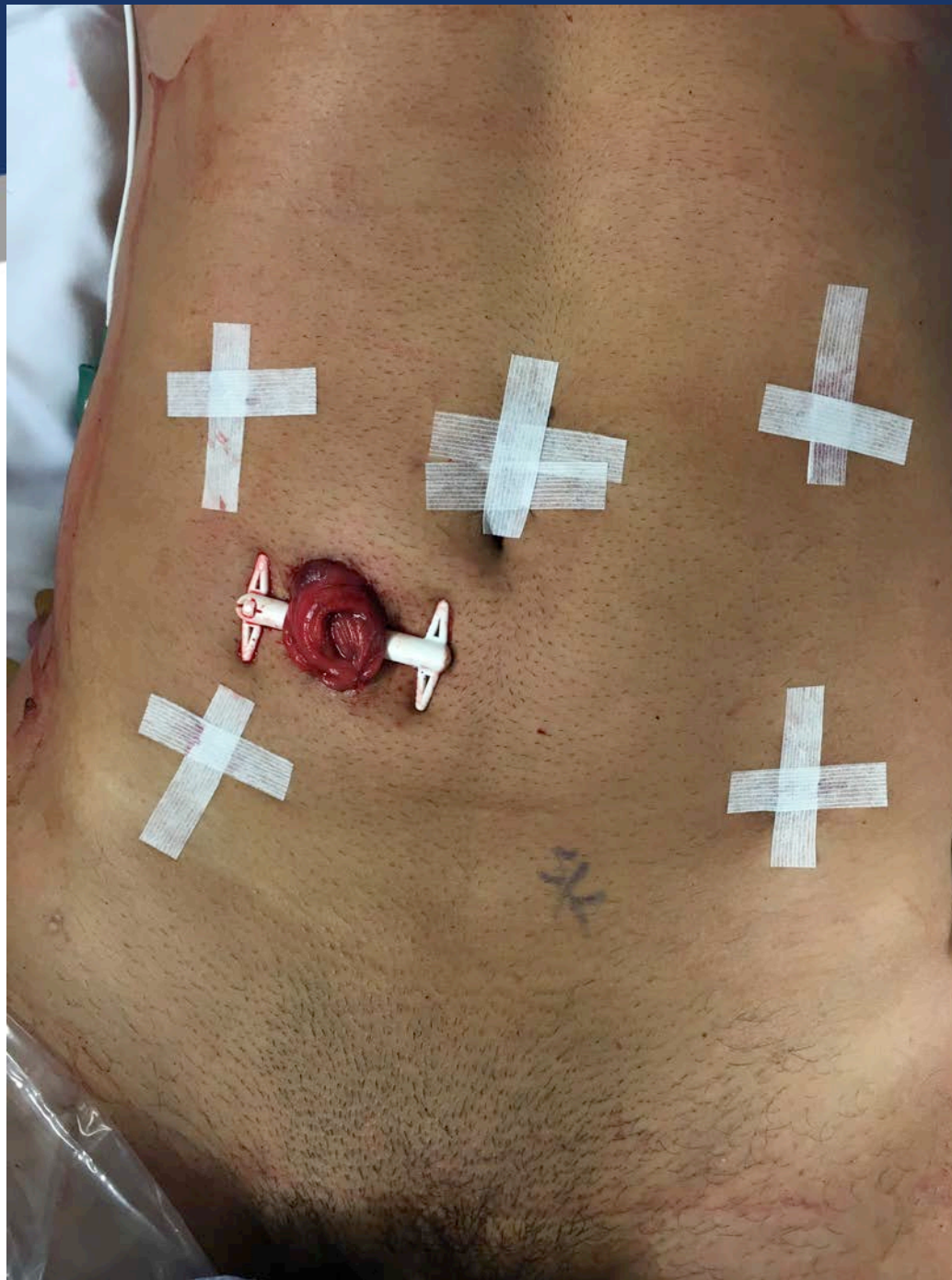
John J. Farrell





EXCISION OF RECTUM.

This takes place a week
to ten days later.





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OF BRITISH COLUMBIA

