Outcome Improvement Strategies for Rectal Cancer Surgery in BC

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The Problem

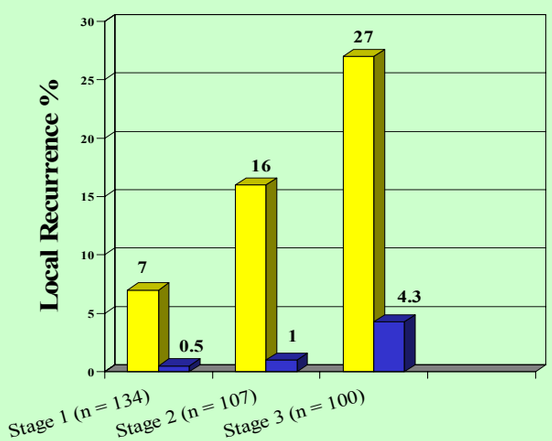
High recurrence from rectal cancer management

The Solution

All BC surgeons are encouraged to participate in:

- Education
- Prospective data form submission
- Annual feedback

1996 BC Rectal Cancer Outcomes

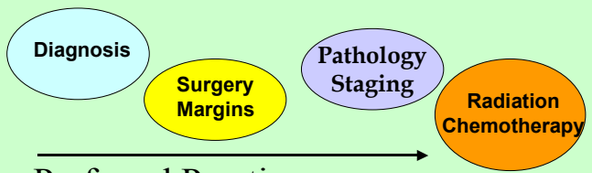


BC 4 yr postop chemorad Dutch 2 yr TME preop rad

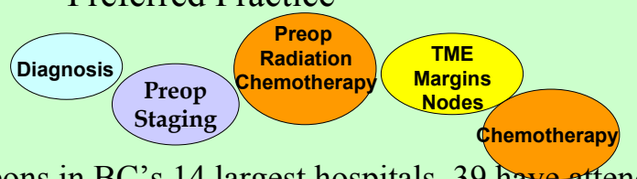
Kapiteijn E et al, N Engl J Med 2001;345:638-46

Education

Old Practice (1996)



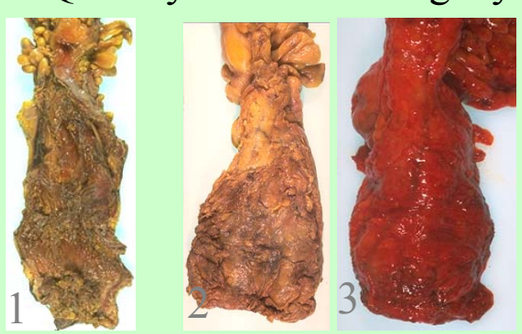
Preferred Practice



Of 80 surgeons in BC's 14 largest hospitals, 39 have attended a TME (total mesorectal excision) course and 40 will be taking the course

The course is taught using lectures, a computer-assisted learning model, OR demo, cadaver dissection and small group discussions

Quality of TME surgery



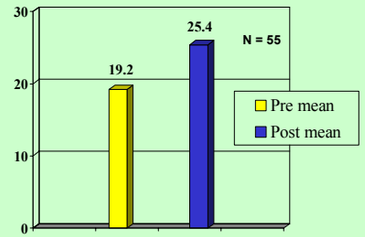
1 Poor surgery little mesorectum

2 Average surgery with incomplete removal of mesorectum

3 Excellent surgery with complete mesorectal excision

Participant CME Improvement

- Participants were tested on rectal cancer before and after instruction and were shown to improve their knowledge of management



- Pathologists are correcting their reporting on the resected TME rectal cancer specimen to include assessment of mesorectal fascial quality, radial margin and > 12 lymph nodes

Prospective Data Collection

- Surgeons are asked to submit data form: preop imaging, preop rad, surgery, pathology, chemo, recurrence, death
- Surgeon representatives will review hospital rectal cancer surgery list for completeness of patient data submission

Annual Feedback

- Quality improvement initiative:
  - Feedback to surgeons
  - Annual meeting to review outcomes

Acknowledgment: Janet Alred, Surgical Oncology Network