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

<table>
<thead>
<tr>
<th>Stage</th>
<th>Local Recurrence %</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>2</td>
<td>0.5</td>
</tr>
<tr>
<td>3</td>
<td>4.3</td>
</tr>
</tbody>
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Old Practice (1996)

Diagnosis
Surgery
Pathology
Radiation
Chemotherapy
Margins
Staging

Preferred Practice

Diagnosis
Preop Staging
Preop Radiation
Chemotherapy
TME
Margins
Nodes
Chemotherapy

Education

- 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

Quality of TME surgery

1. Poor surgery: little mesorectum
2. Average surgery: incompleteness of mesorectum
3. Excellent surgery: complete mesorectal excision
