Where is Rectal Cancer Treatment Going?

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Surgical Oncology Network Fall Update
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CAUTION
YOU’RE DOING IT WRONG
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
  - Radiation
  - Chemo
- Multi-disciplinary approach
  - Surgeons
  - Med Onc
  - Rad Onc
  - Radiologists
  - Pathologists
  - PATIENT
Rectal Cancer Management

Landmark papers in 1980s-2000s

- TME
- Preop RT
- Adj 5FU
Results

SEER Data - DFS

Survival Distribution Function

Months
Standard of Care

Compare all other options to this standard

Best Oncologic Outcomes
Problems with Standard of Care

• TME Surgery, Radiation and Chemo can have **negative** consequences
  – Mortality
  – Complications & adverse effects
  – Function
    • GI, GU, general
  – Cosmesis
Options...quandaries...quagmires

- 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?
# Collaborative Rectal Cancer Care

## Chapter 1: Program Management

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## Chapter 3: Quality Improvement

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<td>Accountability and Quality Improvement Measures*</td>
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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
COLOR III Trial – MIS vs TaTME

Patients with rectal cancer
cT1-3N0-2
mri-CRM >1mm
Intent for curative surgery

Eligibility Check

Randomisation

Centralised MRI review

Transanal TME

Laparoscopic TME

Primary Outcome; pCRM

Secondary Outcomes;
quality of specimen, morbidity & mortality, LR, DFS, OS,
sphincter saving procedures, functional outcome, HrQoL
PROSPECT Trial

“Standard Arm”
- RANDOMIZE 1:1
- FOLFOX x 6
- Response ≥20%
- 5FUCMT* → TME → Chemo per primary MD

“Selective Arm”
- Response <20%
- 5FUCMT* → TME → Chemo per primary MD

*5FUCMT = infusional or oral 5FU + radiation therapy
Chemotherapy and Chemoradiation Followed by Surgery or Non-Operative Management (MSKCC)

Distal Rectal Cancer
MRI Staging

Randomization

Induction
FOLFOX/CapeOX
(16-18 weeks)

Interval Evaluation
DRE – Endoscopy – MRI

Chemoradiation
(5.5 weeks)

Consolidation
Chemoradiation
(5.5 weeks)

Interval Evaluation
DRE – Endoscopy – MRI

FOLFOX/CapeOX
(16-18 weeks)

Restaging
DRE – Endoscopy – MRI

Surgery
No Clinical Response

Non-Operative Management
Complete or Near Complete Clinical Response
NeoTEMS

**cT1-3^{ab} N0**

- FOLFOX or CAPOX x 3 months
  - Sigmoidoscopy to ensure TEMS feasible
    - Yes: TEMS/TAMIS
      - Yes: ypT0/T1^{good}
        - Surveillance
      - No: ypT1^{bad*} or higher
        - TME Surgery
    - No: TME Surgery
  - y^{pT1^{bad*}} LVI, R1, high grade

1^{o} Endpoint=
Organ Preservation

- cT3a,b N0
  - ≤5 mm into the subserosa
  - Clear CRM
  - No radiographic evidence of mesorectal nodal metastasis, tumour deposits or lymphovascular invasion.
Low rectal carcinoma T2T3Nx
≤ 8 cm from the anal verge and size ≤ 4 cm

Radiochemotherapy
50 Gy in 5 weeks
Concomitant Capecitabine and Oxaliplatin

Good response
(scar ≤ 2 cm)

Inclusion Randomisation

Arm A
Local excision

Arm B
TME

Bad response
(scar > 2 cm)

TME

Follow-up every 4 months
The Future of Rectal Cancer Care
EXCISION OF RECTUM.

This takes place a week to ten days later.