



Clinical Practice Guidelines: #RectalCancer (1/2)



Tumors of the **upper rectum usually** do **not** benefit from neoadjuvant chemoradiotherapy, and should typically undergo **surgical resection**



Total neoadjuvant therapy (TNT) is typically recommended for T3 or N1 mid or low rectal CA



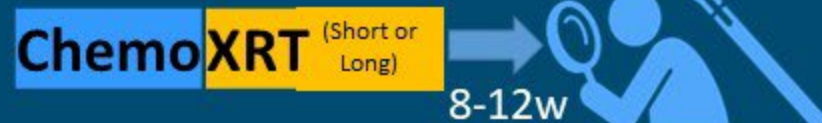
After TNT for rectal cancer, patients should be **assessed to determine the response to treatment** (with DRE, endoscopy, imaging)



Endoscopic biopsy for the presence of residual disease **is limited** by high false negative rates



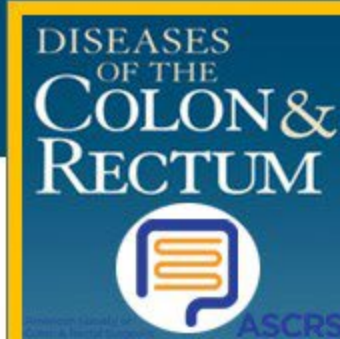
Acceptable to use: **“induction TNT”** (systemic chemotherapy followed by radiation therapy)



or **“consolidation TNT”** (upfront radiation therapy followed by chemotherapy)



**W&W not well studied with SHORT course XRT*



Langenfeld SJ et al. *Dis Colon Rectum* 2024;68(1):18-31





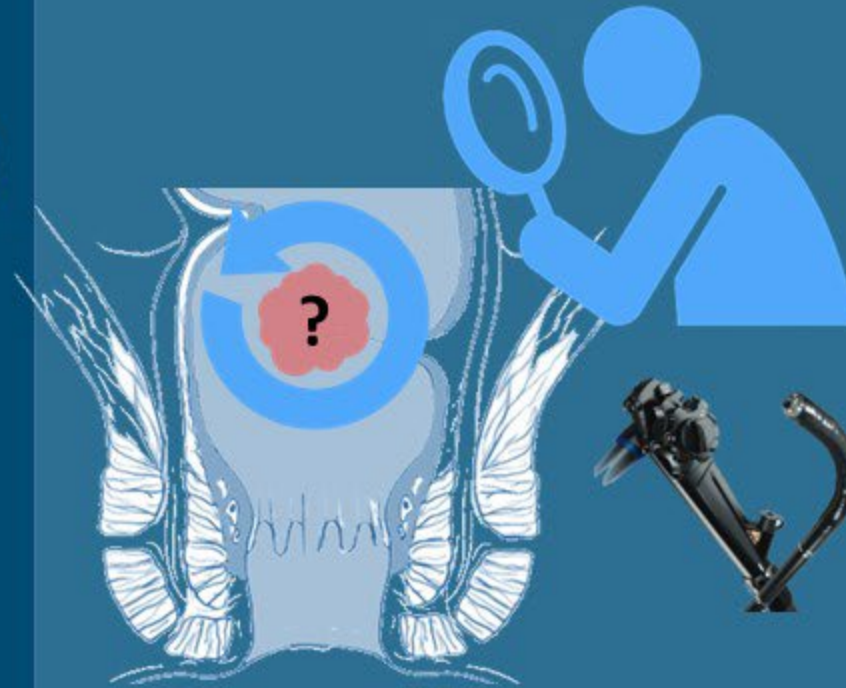
Clinical Practice Guidelines: #RectalCancer (2/2)



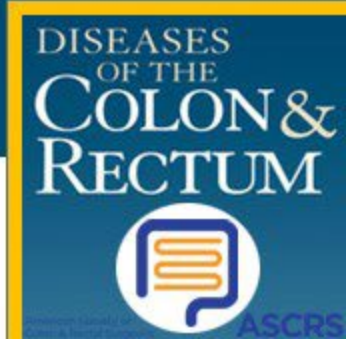
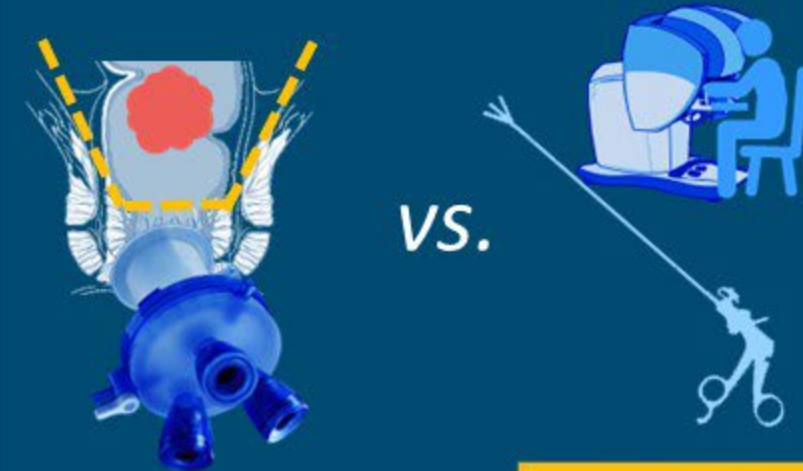
Watch-and-wait can be offered to select patients with clinical complete response in experienced centers **with established protocols** (with DRE, endoscopy, imaging - highest risk in first 2-3 years)



Watch-and-wait patients should undergo **surveillance to assess for local tumor** regrowth (occurs in 20-30%)



Compared to lap/robotic LAR/TME, **transanal TaTME** for mid and low rectal cancer has **similar overall complication rates and functional outcomes**



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