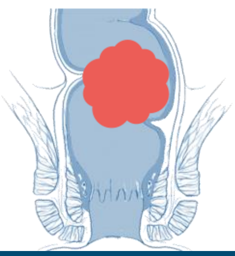
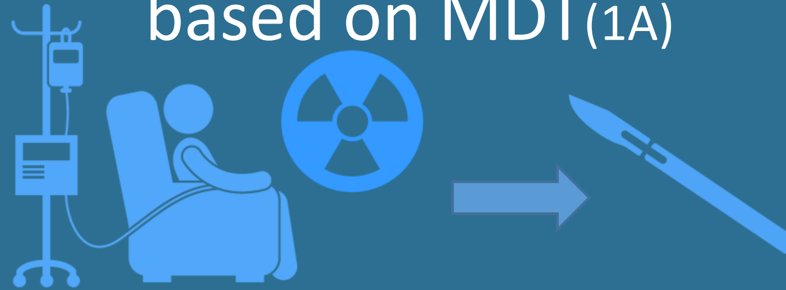


Clinical Practice Guidelines: #RectalCancer (1/3)

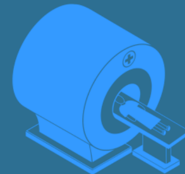
Protocolized **MRI** is **preferred staging** method *(ERUS ok for T1/2 or if MRI contraindicated)* 1B

Treatment Plan should be discussed at multidisciplinary tumor (MDT) board (1C)

Neoadjuvant ChemoXRT for T3 or N+ patients based on MDT(1A)

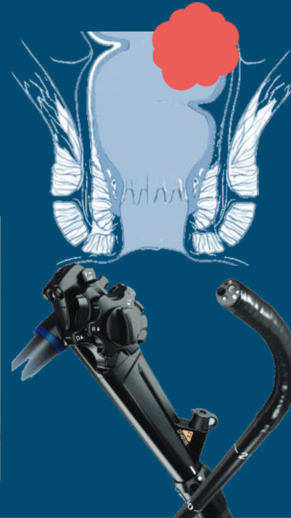


Restaging should be **considered after neoadjuvant** CXRT with locally advanced tumors (1C)



11-15% have altered Tx plan

Distance of the tumor edge to the anal verge and relationship to sphincter **should be measured** 1C



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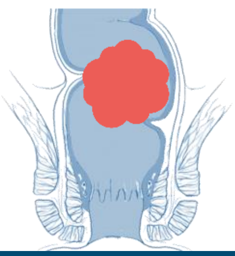


ASCRS American Society of Colon & Rectal Surgeons

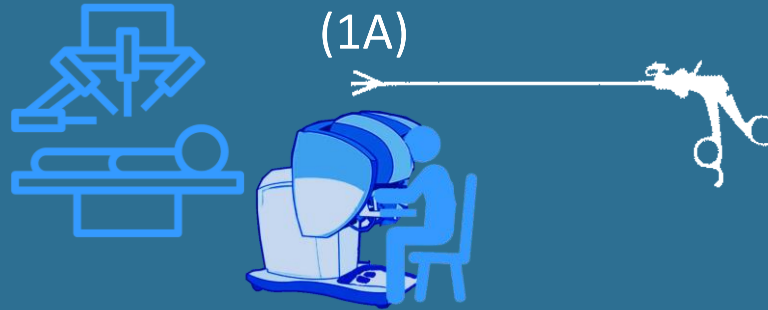
Clinical Practice Guidelines: #RectalCancer (2/3)

For **mid & low tumors, TME** should be performed (with 1-2cm distal margin if anastomosis planned) 1A

For **upper 1/3 tumors, tumor-specific partial mesorectal excision** is ok if at least 5cm margin (1A)

Minimally invasive TME is safe in experienced hands

(1A)



Local Excision is appropriate in ***carefully selected* T1N0** pts without high risk features **1B**

7-21% local recurrence rate

<3cm, full thickness excision

TaTME remains controversial 1B

Learning curve ~40 cases, limited long term oncologic data

Operative report should contain staging, findings, and details of procedure (synoptic checklist) 1C

D C&R

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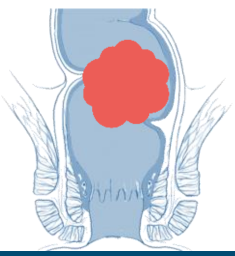


Clinical Practice Guidelines: #RectalCancer (3/3)

Patients with complete clinical response should be **offered radical resection.**

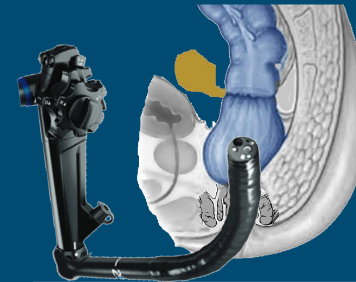
"Watch & Wait" can be considered for ***highly select patients*** in **protocolized** setting 1B

Routine **lateral lymph node dissection** is not required (in absence of clinically positive nodes) 1C

Adjuvant chemo is recommended for Stage II/III within 8 weeks of resection

During surgery: Rectal washout (2C) & Colonic J-pouch (2B) may be used.

If a stoma is planned, preop marking should be performed (1B) and any anastomosis should be air-leak tested (1B)



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