Clinical Practice Guidelines: #RectalCancer (1/2)

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

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

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

ChemoXRT (Short or Long) 8-12w

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

XRT (Short or Long) 8-12w

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

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

6 cycles


*D&W not well studied with SHORT course XRT
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