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)

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

11-15% have altered Tx plan

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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

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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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