**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)

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

- **Restaging** should be considered after neoadjuvant CXRT with locally advanced tumors (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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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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