

Association of Coloproctology of Great Britain & Ireland (ACPGBI): Guidelines for the Management of Cancer of the Colon, Rectum and Anus (2017) - Introduction

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1 Introduction

1.1 Multidisciplinary teams

1.2 Prevention and earlier diagnosis

1.3 Laparoscopic Surgery and Enhanced Recovery After Surgery (ERAS)

1.4 Low rectal cancer

1.5 Radiology and Histopathology

1.6 Chemotherapy and Radiotherapy

1.7 Outcomes and Survivorship

1.8 Person-centred care

1.9 Summary

1 Introduction

The ACPGBI has been at the forefront in developing guidelines, position statements and national training programs related to both common, and complex, colorectal pathology. These initiatives often serve as a global reference in this challenging field. The Association of Coloproctology of Great Britain and Ireland (ACPGBI) 2007 Colorectal Cancer Management Guidelines have been the basis for continuous evolution in the way these cancers are managed. The current update aims to clarify many recent developments on the multidisciplinary management of colorectal cancer and to provide links to relevant publications. The recommendations made within these guidelines have been graded according to the Oxford Centre for Evidence-based Medicine – levels of evidence (www.cebm.net/oxford-centre-evidence-based-medicine-levels-evidence-march-2009/). We hope that these guidelines will offer a framework for clinicians and MDTs to tailor treatments to suit individual patients. We also hope to direct future research and debate in a rapidly evolving field.

A substantial part of the workload of colorectal units is to not only exclude diagnosis of cancer but to manage cancer of the colon, rectum and anal canal. Access to information through technology, and particularly the internet, has changed perceptions and expectations of cancer patients, their carers and clinicians. The general public and healthcare providers continue to shift focus towards cancer prevention and early diagnosis. At the other end of the spectrum, patients with locally advanced, recurrent or metastatic cancer are increasingly

being considered for tailored multimodal therapy, based on molecular biology and pharmaceutical advances.

In the UK, through the NCRI Colorectal Cancer Clinical Trials Group and numerous other research organizations, we are proud of our record of being at the forefront of designing and completing many internationally acclaimed oncological and surgical trials. These have been instrumental in shaping our current clinical practice. We must continue to build on this foundation by developing and recruiting into new trials to further improve treatment.

1.1 Multidisciplinary teams

Over the last few decades, multidisciplinary teams (MDTs) have evolved, and consolidated, in individual units to manage colorectal cancer. At the MDT meeting, the clinical nurse specialist, with the attending surgeon, are best positioned to act as the patients' advocates and ensure crucial decisions are made with a first-hand knowledge of the patient and their wishes. It is pertinent that MDT recommendations are based on the available information and recommendations may, or may not be appropriate, or acceptable to the individual patient. Clinicians should support patients requesting second opinions and guide them with appropriate pathways. Current MDTs should look to extend their role in training junior surgeons, radiologists, histopathologists and oncologists, and mentoring new members of the core team. Personal-audits and regular feedback between core members should be an integral part of the development of the MDT.

Ongoing sub-specialization has encouraged development of specialist MDTs in a number of areas including anal cancer, early rectal cancer, 'beyond'-TME and recurrent pelvic cancers, and cytoreductive surgery.

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Teams treating colorectal disease need to recognize the spectrum of disease, diversity of treatments and develop care pathways to access specialist MDT's.

1.2 Prevention and earlier diagnosis

Public awareness campaigns and the NHS Bowel Cancer Screening Program have impacted positively on the diagnosis of early stage disease, and polyp detection and clearance are likely to reduce colorectal cancer incidence. Introduction of Faecal Immunochemical Test and Bowel Scope Screening will further improve the stage at diagnosis of colon and rectal cancer.

Bowel cancer screening has added to the challenge of treating polyp cancers and early rectal cancer; oncological adequacy of minimally invasive interventions (polypectomy and local excisions) vs morbidity and mortality risk of resection surgery. The ongoing SPECC (Significant Polyp Early Colorectal Cancer) Pelican/ACPGBI Program aims to stimulate discussion and training in these areas. Robust risk stratification tools to help MDTs and patients make informed decisions, especially in an older and frailer population, are needed. Clinical trials, such as the recently completed NCRI TREC-1 and the new NCRI STAR-TREC in early rectal cancer will add to this knowledge.

1.3 Laparoscopic Surgery and Enhanced Recovery After Surgery (ERAS)

The Laparoscopic Colorectal Surgery (LAPCO) program, which was a joint initiative between the ACPGBI and NHS England, delivered high quality accreditation training in laparoscopic surgery to NHS colorectal surgeons. This initiative, together with increasing public awareness of laparoscopic surgery, has resulted in a steady year-on-year increase in the proportion of cases treated by minimal access, whilst achieving good oncological outcomes in addition to the short-term early benefits, particularly in colon cancer but less so in rectal cancer.

Introduction of ERAS on the background of minimally invasive surgery has improved short-term outcomes including length of stay. Optimal results have been reported using a combination of ERAS and minimal access techniques. The concepts from colorectal surgical ERAS programs have been adopted by other surgical fields and have benefited a wider group of patients.

1.4 Low Rectal Cancer

The Low Rectal Cancer Development (LOREC) program is another joint initiative between the ACPGBI

and NHS England, providing training to MDTs on the overall management of cancers arising at, or below, the level of the insertion of the levator muscles, including the appropriate use of extralevator abdominoperineal excision (ELAPE). The longer-term oncological outcomes and the associated morbidity of this initiative are yet to be reported.

1.5 Radiology and Histopathology

High quality radiology and detailed histopathology reporting is crucial, as it underpins MDT decision making. This provides quality assurance to patients and clinicians on management decisions. Radiology and pathology provide valuable prognostic indicators in colon and rectal cancer, which helps to determine further management. Advances in imaging and use of biomarkers have initiated individualized treatment strategies to be developed in all stages of disease. We predict that these advances will expand exponentially in the next decade.

1.6 Chemotherapy and Radiotherapy

The use of preoperative radiotherapy, with or without chemotherapy in addition to surgery in 'operable' rectal cancer reduces local recurrence rates, but much of the published evidence predates modern imaging, making it difficult to quantify the exact benefits. Together with ongoing improvements in surgical techniques, such as ELAPE for advanced low rectal cancer, and an increasing awareness of immediate and long-term toxicity, the risk-benefit of using radiotherapy in rectal cancer, either to downstage disease or to reduce local recurrence needs careful consideration on an individual basis. There remains significant variation in the use of radiotherapy nationally, but with further refinements in imaging and expansion of knowledge, this will allow more selective utilization. However the role of optimal surgery remains crucial.

Further advances in the use of adjuvant chemotherapy, with the addition of new targeted agents have failed to materialize. The focus has shifted to earlier use of systemic therapy in the neoadjuvant setting for colon and rectal cancers, as well as reducing the duration and toxicity of adjuvant therapies.

There is increasing worldwide interest in the potential for non-operative management of rectal cancers of all stages. Ongoing trials to improve pathological complete response rates (pCR) and translational studies to develop new predictive markers, together with high-quality observational trials such as the NCRI Deferral of Surgery, may allow for safe deferral and hopefully,

complete avoidance of surgery in selected patients who have potentially achieved pCR after preoperative chemoradiotherapy (CRT).

1.7 Outcomes and Survivorship

The National Bowel Cancer Audit (NBOCA) has evolved from being a voluntary audit when first launched in 2000, to currently being a quality assurance tool for individual surgeons and NHS Trusts. Although it has provided invaluable data to drive up the standards of care delivered nationally, there remain opportunities to further improve the quality of data collected.

Through NBOCA, the publication of individual colorectal surgeons' outcomes has empowered patients, by providing online information about volumes and outcomes of individual surgeons and NHS Trusts. Individual surgeon outcome reporting is contentious and unit data may be more meaningful and is the subject of ongoing discussion.

1.8 Person-centred care

Most importantly, treatment of colorectal cancer should take into account individual preferences, and be delivered with dignity, compassion and respect. Patients need to understand that the management of their cancer is individualized and complex. They should be given an explanation for the perceived delays in commencing treatment, such as the need for further investigations or MDT discussion. Response to treatment is often

unpredictable, as are many of the acute and late toxicities. These uncertainties should be openly discussed and patients should be able to make informed choices about their care, in partnership with their healthcare professionals. These decisions should be subject to regular review at appropriate key points during treatment, to accommodate any changes in circumstances and to allow the patient the opportunity for further discussion or reconsideration.

Healthcare professionals must not underestimate the psychological and social impact of a diagnosis of colorectal cancer on the individual as well as family, carers and supporters. There is wide variation in their reactions, their ability to cope and their recall of information received, which may be subject to strong emotions and anxiety. Communication and listening skills for such patients need to be exemplary as they form a vital part of the patient journey, from undergoing treatment, to recovery and eventual readjustment to life beyond hospital.

1.9 Summary

These guidelines offer an updated framework for colorectal cancer clinicians and MDTs. They will continue to evolve and require updating in light of ongoing developments and emerging evidence.

Conflicts of interest

None of the authors have any conflicts to declare.