Reviewed: September 2023
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Agreed Network Guideline for The Management and Referral of Early Rectal Cancer

The primary treatment of rectal cancer is through surgery and long-term outcome is related to achieving a complete resection of the tumour, with negative resection margins. This also relies upon accurate pre-operative imaging and clinical assessment. This allows for the identification of patients who may benefit from additional therapy which may improve long term prognosis. The major prognostic factors are related to the degree of penetration of the tumour through the bowel wall, histological grade of the tumour, the relationship of the tumour to the resection margin and the presence or absence of nodal involvement.

Early Rectal Cancer (ERC)

As a consequence of the localised nature of T1 tumours (i.e., carcinomas that have not invaded the muscularis propria) they have a high cure rate. A sub-group of these tumours will be suitable for complete local resection without the need for circumferential resection of the rectum and mesorectum (standard anterior resection or abdomino-perineal resection of the rectum), via Trans-anal Endoscopic Microsurgery (TEMS)

Indications for referral include:

All T1 rectal tumours lying within 18cm of the dentate line that are proven to be malignant up to 3cm in size.

Other polyps, clinically suspicious for malignancy including:

1. polyps with proven high-grade dysplasia or benign polyps with a focus of invasive cancer should also be referred irrespective of size.
2. All large polyps with benign histological findings on biopsy, where there is clinical concern of malignancy.

T2 cancers rectal cancers in patients unfit for major resectional surgery, should also be referred for consideration of TEMS.

Polyps previously removed by other means with adverse histological features should be referred for consideration of full thickness resection via TEMS. Large benign polyps (>2cm) should also be referred that cannot be removed endoscopically.

Star Trec

Patients with Stage T1-3 N0 tumours <4cm diameter in the non-peritonealised portion of the rectum may be eligible for inclusion in the STAR TREC trial of combined neoadjuvant radiotherapy and local resection.
https://www.birmingham.ac.uk/research/crctu/trials/startrec/index.aspx
Consideration should be given to referring these patients if they are interested in participating in this trial.

Mechanism for referral

Rapid referral and processing are essential to the patients' pathway.
A copy of the patient's endoscopic findings, histology and any radiology should be forwarded to either Alan Beveridge (AJB) or Ioannis Peristerakis (IXP) via their secretary.
Kelly Lawson Kelly.Lawson@lthtr.nhs.uk 01772523157 (AJB sec)
Jill Slater Jill.Slater@lthtr.nhs.uk 01772522261 (IXP sec)

The current set up at LTHTR allows for all patients to be seen and clinically assessed within a week of referral. This will be supplemented by staging investigations including endorectal ultrasound.

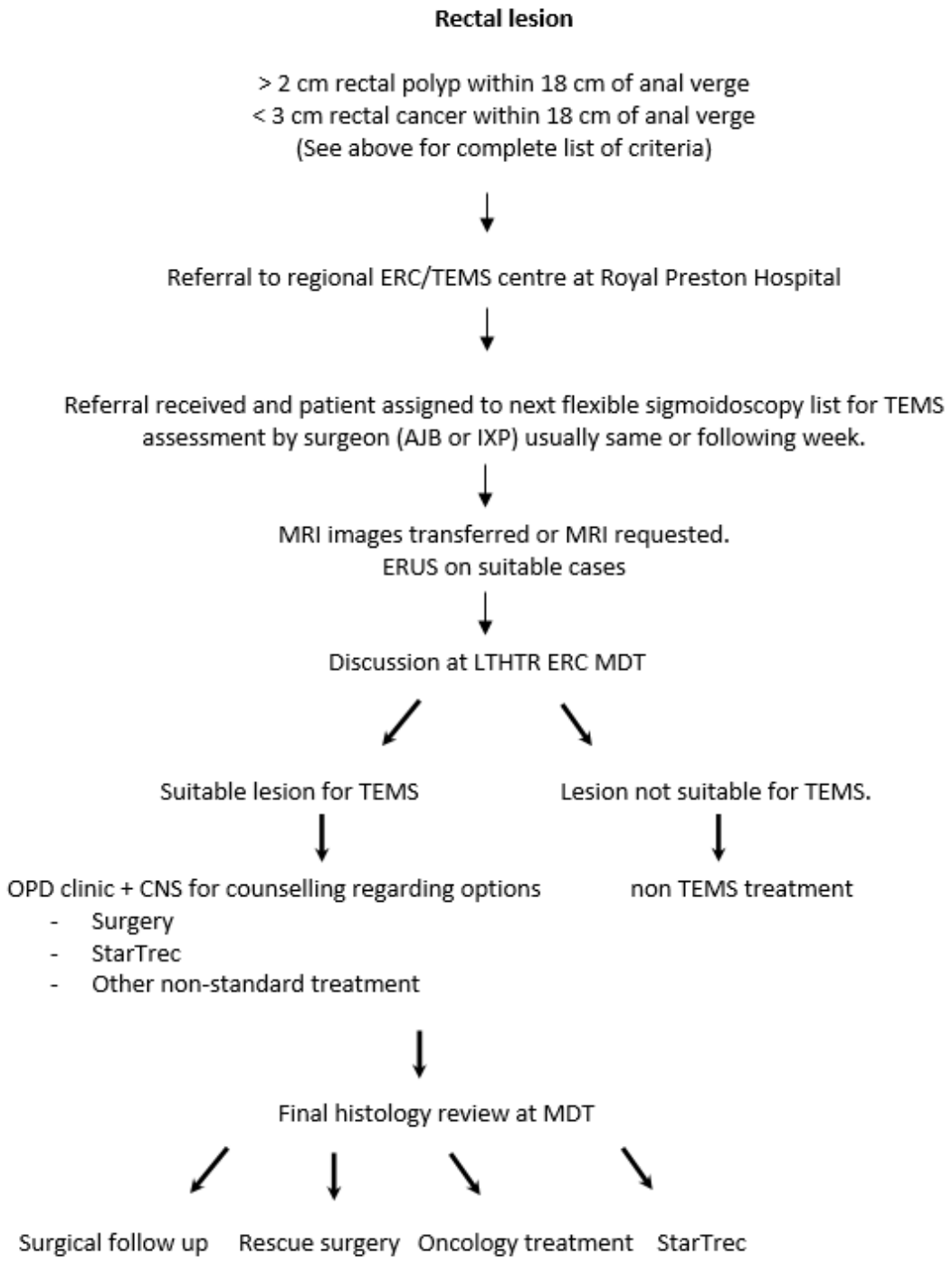
Case discussion will be undertaken at the weekly RPH Early Rectal Cancer MDT. If TEMS is deemed appropriate, surgery will be arranged by AJB or IXP. If TEMS is not appropriate the patient will be returned to the referring clinician. Patients that fulfil the inclusion/exclusion criteria will be offered the option of entering the StarTrec trial.

Follow up following TEMS

All lesions removed by TEMS undergo discussion of final histology at RPH Early Rectal Cancer MDT.

- T1 good prognosis tumours will remain under clinical review,
- Poor prognosis T1 lesions i.e., those with poor differentiation, lymphovascular invasion, or final pathological staged > T1, will need to be considered for rescue surgery. This can take place at the referring centre or LTHTR following discussion with referring consultant.
- Alternatively, contact radiotherapy or external beam radiotherapy and chemotherapy may considered.

Referral Pathway



LTHTR will continue to offer the network ERC service.

ELHT requested to offer ERC services for their local patients. Considering, that historically ELHT referred ERC patients outside the network agreement, ELHT can continue to manage ERC patients locally as long as the service complies with national standards.

LTHTR ERC MDT

TEMS Surgeons Alan Beveridge
Ioannis Peristerakis

ERC lead Radiologist Gagan Thind

ERC lead Pathologist Muammer Al-Mudaffer

ERC Oncologist Williamson (In collaboration with Sun Myint, Clatterbridge)

CNS team Yvonne McCallum

Surveillance of ERC following TEMS

	3m	6m	9m	12m	18m	24m	36m	4y	5y
OPD		X		X		X	X	X	X
CEA		X		X	X	X	X	X	X
FOS	X	X	X		X	X	X		
MRI	X	X	X	X	X	X	X		
CT				X		X			
Colonoscopy				X				X	