

Cancer Network Guidelines For The Referral and Management of Early Rectal Cancer

1. Introduction & Background

The management of rectal cancer has undergone a significant paradigm shift over the last two decades, moving from radical resection as the default, toward organ preservation for early-stage disease. Preserving the rectum avoids the significant morbidity associated with Total Mesorectal Excision (TME), including low anterior resection syndrome (LARS), permanent stoma requirements, and impacts on sexual and urinary function.

The Lancashire Teaching Hospitals NHS Foundation Trust (LTHTR) Early Rectal Cancer (ERC) Service has been at the forefront of this evolution for over 18 years. As a designated regional specialist centre, the early rectal cancer service provides expert multidisciplinary care for the population of Lancashire and South Cumbria. The latest addition of Robotic TAMIS (Transanal Minimally Invasive Surgery) to the ERC service, has expanded the range of options available for the management of both early rectal cancer and large rectal polyps.

2. The Specialist ERC MDT

The LTHTR ERC service is underpinned by a dedicated ERC MDT. All referrals are reviewed by a core team of ERC specialists:

- **ERC Specialist Surgeons:** Mr. Beveridge & Mr Peristerakis
- **ERC Lead Consultant Radiologist:** Dr. Thind
- **ERC Lead Consultant Pathologist:** Dr. Al-Mudafer
- **ERC Lead Oncologist:** Dr Williamson (incl collaboration with Prof. S. Myint - Specialist Contact Radiotherapy Centre, Clatterbridge)
- **ERC CNS** Yvonne McCallum

3. Surgical Modalities & Platforms

- **TEMS (Transanal Endoscopic Microsurgery):** Utilising the **Storz platform** suitable for 2 quadrant access.
- **Robotic TAMIS** Utilising the **Intuitive Da Vinci Xi platform** which allows for superior visualization and 4 quadrant access, enabling the team to push the boundaries in organ preservation for:
 - Large malignant lesions (up to 6cm) in the context of non-standard cancer treatment for highly selective group of patients, not suitable for standard treatments.
 - Complex, large benign rectal polyps (including extensive circumferential polyps)
- **Endorectal Ultrasound (ERUS):** Provided in-house for selected cases as an adjunct to MRI imaging.

4. Referral Criteria

* Regional units should refer the following cases to the LTHTR ERC MDT for consideration of TEMS / organ-sparing management:

Early Rectal Cancer	a. Confirmed or suspected cT1/T2 adenocarcinomas with a size up to 3cm. b. Polyp cancers previously treated with EMR, with positive/equivocal margins.
Large Polyps	Polyps of any size (including circumferential polyps) with or without concerning endoscopic features (e.g. induration, ulceration, "non-lifting") with benign or equivocal histology and not suitable for EMR. (Benign polyps >2cm have >18% risk of containing malignancy).
Non-standard	Up to 6cm, node negative rectal cancers (including cases of complete nodal regression following neoadjuvant therapy), in patients who have exhausted oncology options and are medically unfit for radical resection (but fit for an intermediate risk procedure) or those who have formally refused TME surgery. Highly selective cases may be considered for Robotic TAMIS.

5. ERC service referral pathway

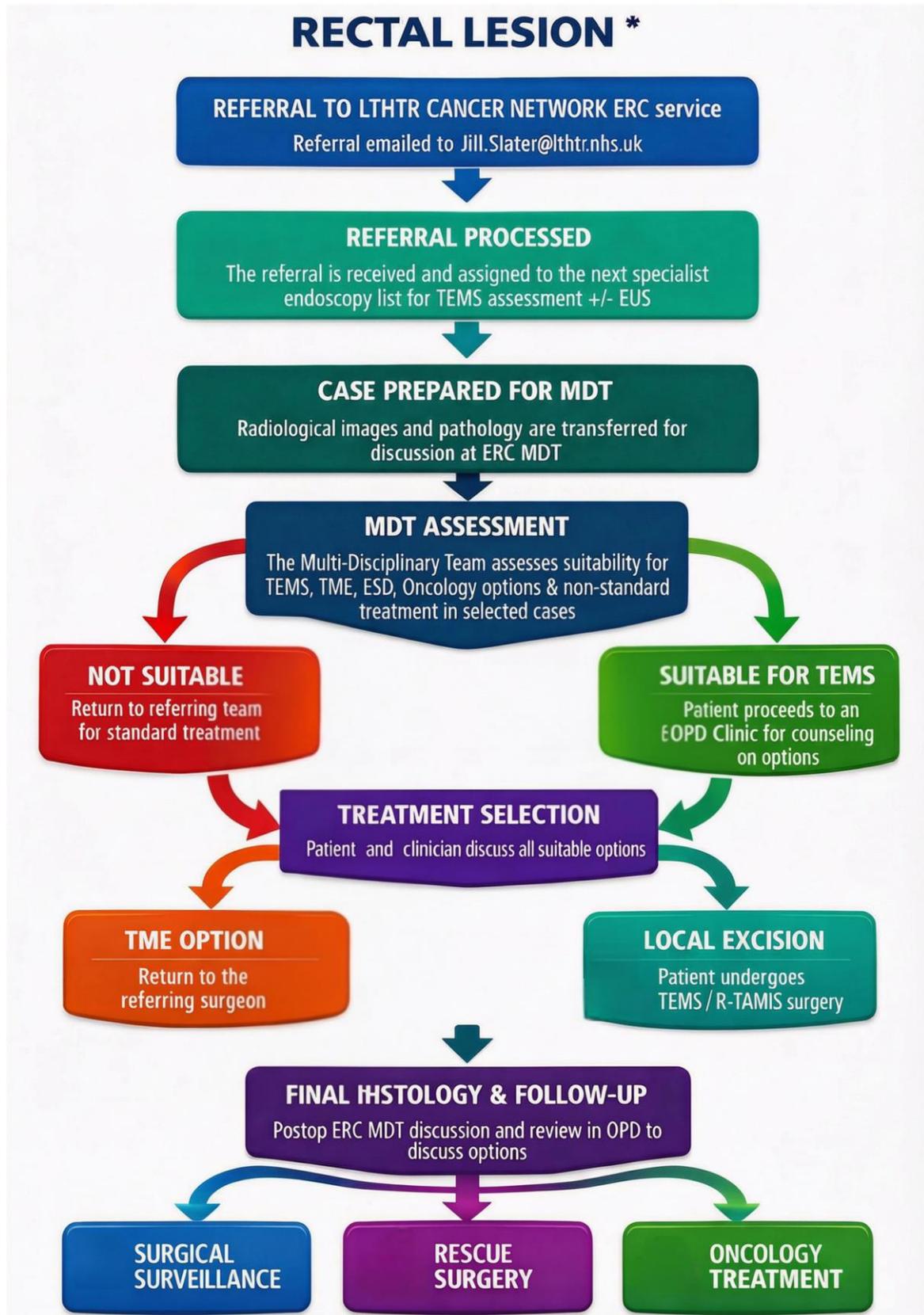
The regional units should forward referrals for cases that meet the referral criteria to the LTHTR Cancer Network ERC service via email to Jill.Slater@lthtr.nhs.uk. The referral is reviewed by an ERC surgeon and assigned to a specialist endoscopy list for TEMS assessment or directly for review at the ERC MDT. The case is then prepared for ERC MDT discussion after transferring all relevant radiological images and pathology/endoscopy reports.

At ERC MDT discussion, suitability for TEMS, TME, ESD, oncology options, or non-standard treatments is evaluated. If not suitable for TEMS and suitable for standard treatment options, the patient will be referred back to the local colorectal clinician. If suitable for TEMS, the patient will attend an OPD clinic for counselling on all suitable options as per NICE guidelines.

Treatment selection involves a comprehensive discussion between the ERC surgeon and the patient, about all suitable options (NICE QS20). If the patient opts for resectional surgery, they will be referred for treatment back to their local hospital. If the patient opts for rectal sparing surgery, they will get counselled for TEMS or R-TAMIS surgery. If the patient declines surgery, the option of contact radiotherapy will be discussed (IPG809).

Postoperative histology is discussed at the ERC MDT. An OPD follow-up is subsequently arranged to discuss the MDT outcome with the patient and plan further management including surgical surveillance, rescue surgery, or oncology treatment (including contact radiotherapy).

ERC Service Referral Pathway



6. 5-Year Surveillance Programme

Intensive patient follow-up is essential after TEMS surgery to promptly identify cancer recurrence and proceed with salvage surgery. The surveillance pathway is illustrated below

PROCEDURE	3M	6M	9M	12M	18M	24M	36M	4Y	5Y
OPD	●	●	●	●	●	●	●	●	●
CEA	-	●	-	●	●	●	●	●	●
FOS	●	●	●	-	●	●	●	-	-
MRI	●	●	●	●	●	●	●	-	-
CT	-	-	-	●	-	●	-	-	-
Colonoscopy	-	-	-	●	-	-	-	●	-

NOTE:

East Lancashire Hospitals NHS Trust (ELHT) provides the assessment and management of ERC for its local population in accordance with national guidance and standards. As previously agreed in the colorectal Clinical reference group, ELHT patients do not require referral to Lancashire Teaching Hospitals NHS FT as management is provided locally. All ERC patients are discussed in an MDT setting, with appropriate staging and imaging arranged locally

7. References

1. **National Institute for Health and Care Excellence (NICE) [NG151].** *Colorectal cancer: diagnosis and management.*
2. **Association of Coloproctology of Great Britain and Ireland (ACPGBI).** (2017/2022). *Guidelines for the Management of Cancer of the Colon, Rectum and Anus.*
3. **British Society of Gastroenterology (BSG) / ACPGBI.** (2025). *Guidelines for the management of large non-pedunculated colorectal polyps.*
4. **ESMO Clinical Practice Guidelines.** (2021). *Rectal cancer: diagnosis, treatment and follow-up.*
5. **NICE Quality Standard [QS20].** (Updated 2022). *Colorectal cancer Quality Statement 2: Discussing treatment options in early rectal cancer.*
6. **National Institute for Health and Care Excellence. (2025).** *Low-energy contact X-ray brachytherapy for rectal cancer* (Interventional Procedures Guidance [IPG809]).