Small and Early Rectal Cancer MDT

The Small and Early Rectal Cancer (SERC) MDT is held every 2 weeks on the second and fourth Tuesdays of each month at the Royal Liverpool University Hospital.

Referrals should be sent on the specific referral form to Lorraine Kitts, MDT Co-ordinator on 0151 706 3403 by at least Friday noon before the Tuesday meeting. Referral information should include: all available imaging (on disc), endoscopy reports, any endoscopic photographs, histology reports and a brief summary of the case including the patient’s performance status. The referral should also have a fax back number and email address of the local MDT making the referral. In addition the patient’s home telephone number and mobile phone number should be included.

All patients with possible T1 lesions will be referred for endosonography. This will be performed at Royal Liverpool Hospital if not available locally.

Cases that should be referred to the SERC MDT include any lesions within the rectum (i.e. below 15cm from the anal verge) that meet one of the following criteria:

- Histologically and clinically indeterminate neoplastic lesions >3cm in maximum diameter (i.e. large lateral spreading lesions of the rectum)
- Sessile rectal polyps <3cm that are suspicious for malignancy on endoscopy
- Biopsy confirmed rectal cancers <3cm in maximum diameter that are cT2cN0 or better on MR scanning and/or endoanal ultrasound
- Rectal polyps removed by local excision (endoscopic or transanal) that show unexpected pT1 malignancy on histology

The referring clinician is welcome to attend the MDT (in person or via video link) to discuss the case.

Following review of all the available clinical information, the case may be deemed unsuitable for local treatment and classical surgery recommended. This decision will be communicated to the referring clinician who will be responsible for the patient’s continued care.

Some patients may be deemed unfit for any anti-cancer treatment. The Small and Early Rectal Cancer MDT will write to the referring clinician, who will remain responsible for the patient’s care.

Review of histology may be required, in which case the slides will be obtained directly from the referring hospital by the histopathology department. The case will then be discussed again at the next meeting.

On occasions, additional imaging, endoscopy or biopsy will be recommended. Wherever possible this will be carried out at the referring hospital without the patient having to travel to the Royal.

1C-111 and 1C-117d
Where facilities or expertise for specialist investigations are not available at the local hospital, the patient’s care will be taken over temporarily by the MDT while the necessary information is obtained. The patient may be offered an appointment to enable a SERC MDT member to explain the test and the reason for this in person.

On occasions, specialist investigation may be needed quickly without time to see the patient in advance. Under these circumstances the SERC MDT Colorectal Nurse Specialist will contact the patient directly to explain why further tests are needed, what these will entail and when and where these will be carried out.

If cases are considered suitable for local excision (TEMS, transanal excision or endoscopic mucosal resection) or if contact (Papillon) radiotherapy is recommended, the patient’s care will be taken over by one of the SERC MDT clinicians for treatment. There is an agreed network policy that surgeons who perform curative local resection of suitable stage T1 rectal cancer are:

- Paul Rooney, Consultant Colorectal Surgeons, Royal Liverpool
- Paul Carter, Consultant Colorectal Surgeons, Royal Liverpool
- Paul Skaife, Consultant Colorectal Surgeon, Aintree
- Simone Slavik, Consultant Surgeon, Aintree
- S Ahmed, Consultant Colorectal Surgeon, Royal Liverpool
- Liviu Titu, Consultant Colorectal Surgeon, Wirral Hospitals

The patient will be contacted by the SERC MDT Colorectal Nurse Specialist to inform them that their case has been discussed and that they will be seen the following week (or earlier) by an appropriate member of the core team.

All cases treated by local excision will be discussed again at the SERC MDT. A decision regarding further treatment will be made based on risk stratification.

Subsequent surveillance will usually be the responsibility of the referring clinician but on occasions, a SERC MDT member may wish to undertake this him/herself for a limited period. This will be made clear to the referring clinician.

Post-treatment surveillance protocols are as follows:

- **Benign histology** – endoscopic review at 2-3 months with further treatment if residual/recurrent disease. If further treatment necessary, endoscopic review again at 2-3 months. Once disease cleared, full colonoscopy at 1 year. Surveillance thereafter according to BSG guidelines.

- **Malignant histology** - DRE and sigmoidoscopy every 4/12 for first 3 years, then DRE and sigmoidoscopy every 6/12 for next 2 years. CEA and CT liver/chest as per Network Guidelines. Full colonoscopy 5 years.

All decisions and action plans made at the SERC MDT will be communicated to the referring consultant within one working day using a standard proforma.

The proforma will also be made available to core and extended SERC MDT members, the patient’s GP and the local key worker (usually the Colorectal Nurse Specialist).
In some cases, the chair may also dictate a letter to the referring consultant with a copy to the GP and other relevant clinicians, summarising the treatment options to be recommended.

Paul O'Toole, Consultant Gastroenterologist, May 2010

Reviewed: Colorectal CNG, May 2011
To be reviewed: May 2013
Small Early Rectal Cancer – Management flow

**GP Referral**

Local Colorectal Team
Initial investigation and staging:
- Clinical Diagnosis
- Histology, Transanal U/S
- CT Abdo/Pelvis and MR Pelvis

Local MDT
Small rectal Cancer Diagnosed:
Rapid referral to Small Rectal Cancer MDT at RLUH

Small Cancer MDT
RLUH
Review pathology/imaging, validate and record data and agree treatment plan
(IF UNSUITABLE FOR LOCAL EXCISION REFER BACK TO LOCAL MDT: CLASSICAL SURGICAL RESECTION +/- RADIOTHERAPY)

Consultation

Local excision:
- Transanal excision
- TEMS
- EMR

Post excision MDT review

LOW RISK: R0, T1 sm 1-2, <3cm, mid-upper rectum, well/mod differentiated, no lymphovascular invasion, clear margins > 2mm, age > 45 yrs

INTERMEDIATE RISK: R0, T1 <3cm with at least one adverse feature
- Sm3, lymphovascular invasion, margin < 2mm, lower rectum, age < 45yrs. REFER FOR RADIOTHERAPY (Clinical Trial)

Consultation

HIGH RISK: Incomplete or piecemeal excision, completely excised but T2, poorly diff, signet or mucinous histology. CLASSICAL SURGICAL RESECTION +/- RT (Clinical Trial)

Discuss treatment plan with local MDT/patient

Surveillance
Benign polyps
Endoscopic assessment at 3-4 months. Rpt colonoscopy 1 year, further colonoscopy as per BSG guidelines

Early rectal cancer
DRE/SIG 4/12 first 3 years
DRE/SIG 6/12 next 2years
CEA, CT Liver/ Lungs as per guidelines. Colonoscopy 5yrly