ISLHD COLORECTAL CANCER MULTIDISCIPLINARY TEAM

LOWER GASTRO-INTESTINAL TRACT CANCERS

MODEL OF CARE

VERSION CONTROL

V1.0	May 2013 (Draft)
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CONTENTS

CONTEXT

INTRODUCTION

Lower gastro-intestinal cancers include anal, colon and rectal cancers. These cancers are defined as follows:

- **Anal cancer** is defined as a lesion that occurs between the dentate line and the outer limit of the perianal skin, defined to be 5 cm from the anal verge radially. Most anal cancers are squamous cell carcinomas, but lymphoma, sarcoma or melanoma can also occur.
- **Colon cancer** is defined as a malignant lesion that occurs within the large intestine. Most colon cancers are adenocarcinomas.
- **Rectal cancer** is defined as a malignant lesion located within 15cm of the anal verge. Most rectal tumours are adenocarcinomas, which means that the cancer originates in the glandular cells that line the inside layer of the wall of the rectum.

EPIDEMIOLOGY

NSW incidence data from 2009 shows[1]:

- Bowel cancer was ranked as the second most common cancer in men and women in Australia (excluding non-melanoma skin cancer), accounting for 12.6% of all new cancers.
- The average age of diagnosis was 71 years
- The risk of developing bowel cancer before the age of 85 was 1 in 10 in men and 1 in 15 in women.
- The age-standardised incidence rate of bowel cancer was 60.5 per 100,000 people; this has not changed significantly over the last 10 years.

Australia-wide mortality data from 2010 shows[2]:

- Bowel cancer was the second leading cause of cancer-related death in Australia, accounting for 15.3% of all cancer deaths.
- The age-standardised mortality rate for bowel cancer is higher for men. In 2011, there were 19.7 deaths per 100,000 men from bowel cancer, compared with 12.7 deaths per 100,000 women. This has decreased from 34.2 per 100 000 and 23.5 per 100 000, respectively in 1991.
- Five-year relative survival for bowel cancer for the period 2006-2010 in Australia was 65.3% for men and 67.1% for women.

NSW data for colon and rectal cancers can be separated as follows[3]:

- Colon cancer: age-standardised incidence rate; 39.6/100 000. Age-standardised mortality rate 14.0/100 000
- Rectal cancer: age-standardised incidence rate; 21.7/100 000. Age-standardised mortality rate 7.8/100 000

Australia-wide data for anal cancer is as follows[4];

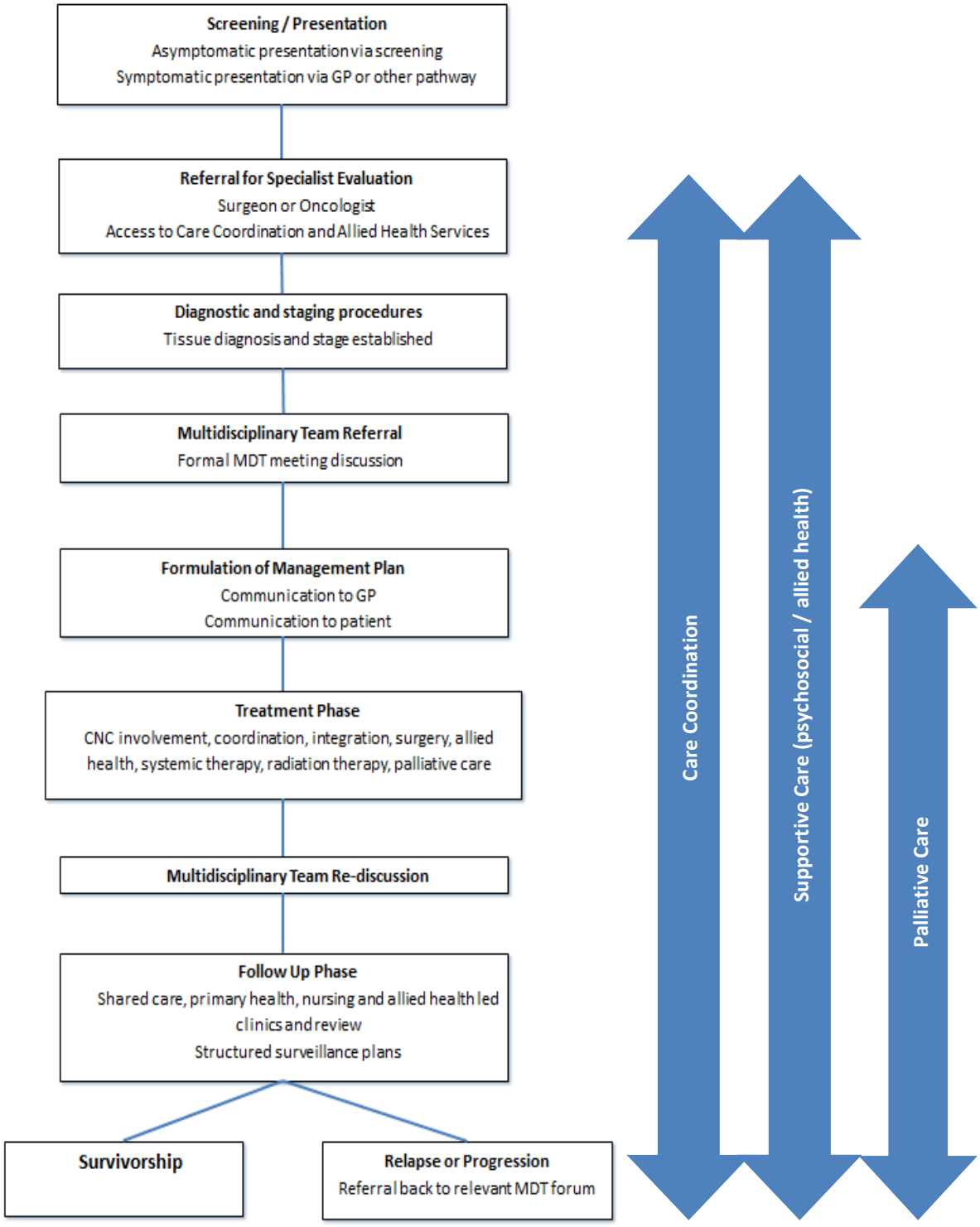
- Age-standardised incidence rate: 1.4/100 000.
- Age-standardised mortality rate: 0.4/100 000.

RISK FACTORS FOR BOWEL CANCER[5]

- The risk of bowel cancer increases with age; those aged over 50 years are at higher risk.
- Family history of bowel cancer.
- Familial adenomatous polyposis or hereditary non polyposis colon cancer
- Recognised genetic conditions predisposing person to high risk of cancer
- Colonic polyps
- Inflammatory bowel disease such as ulcerative colitis or Crohn's disease
- Obesity, a sedentary lifestyle, a diet high in animal fats and processed meats, tobacco consumption or heavy alcohol consumption may increase risk, but are not stand alone risk factors.
- Specifically, anal cancer occurrence is associated with human papilloma virus infection and immunosuppression.

[1] Currow, D. & W. Thomson. 2014. *Cancer in NSW: Incidence Report 2009. Sydney: Cancer Institute NSW*.
[2] Australian Institute of Health and Welfare & Australasian Association of Cancer Registries. 2012. *Cancer in Australia: an overview, 2012.*
[3] ibid
[4] Australian Institute of Health and Welfare. 2011. *Australian Cancer Incidence and Mortality (ACIM) Books - Anal cancer.* Canberra Australia.
[5] Tracey, E., T. Kerr, A. Dobrovic & D. Currow. 2010. *Cancer In NSW: Incidence and Mortality Report 2008*. Sydney: Cancer Institute NSW.

FIGURE 3: IDEAL MODEL OF CARE PATHWAY



THE IDEAL PATHWAY FOR THE CANCER PATIENT'S CLINICAL JOURNEY

This model of care aims to outline the ideal best practice model for the management of patients with lower GI cancers within the Illawarra Shoalhaven Local Health District.

PRESENTATION / SCREENING

Patients present to the General Practitioner (GP) for assessment and appropriate diagnostic tests in order to diagnose (or exclude) cancer. It is well reported that the early detection of lower GI cancer, especially at an asymptomatic stage, is associated with improved patient outcomes.

ASYMPTOMATIC PRESENTATION

1) The National Health and Medical Research Council (NHMRC) recommend organised screening with faecal occult blood testing (FOBT) every 2 years for all Australians over 50 years of age[6]. A person with a positive FOBT should be referred for a colonoscopy within 2 weeks by the General Practitioner.

2) Patients at higher risk, such as those with a strong family history of bowel cancer, those who have inherited an autosomal dominant genetic mutation that increases their risk of bowel cancer (e.g., Familial adenomatous polyposis and hereditary nonpolyposis colorectal cancer syndrome) should be referred to the hereditary cancer clinic. Those with long history of inflammatory bowel disease should have appropriate surveillance and management[7].

SYMPTOMATIC PRESENTATION

Some presenting symptoms for lower GI cancers include:

- Rectal bleeding
- Altered bowel habit
- Abdominal discomfort, bloating or cramping
- Iron deficiency anaemia

Patient should present to their GP with any of the above symptoms. The GP performs a digital rectal examination and organises FOBT (*not required for frank bleeding*) and blood tests including FBC and Iron studies. Referral for diagnostic colonoscopy and biopsy should be attended at time of appointment. This procedure should occur within 4 weeks if the faecal occult blood test positive is positive[8].

Some patients may present to an Emergency Department (ED) with acute bowel obstruction/acute abdomen necessitating urgent surgical intervention. In less urgent cases patients seen in the ED require a referral to an appropriate specialist for further assessment and diagnostic investigations.

Timely access to diagnostic and staging tests from the point of first presentation is vital in ensuring patients can proceed to treatment and achieve the best possible outcome

REFERRAL FOR SPECIALIST EVALUATION

Patients with a suspected diagnosis of a lower GI cancer should be referred to a physician or surgeon accredited to perform colonoscopy (FRACS, FRACP or equivalent). This should occur within 4 weeks of referral if symptoms are suggestive of cancer[9]

A patient with a confirmed diagnosis should be referred to a general or colorectal surgeon who is part of a multidisciplinary team (MDT). The patient should be seen by the surgeon within 2 weeks of referral[10].

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[6] Australian Institute of Health and Welfare. 2013. *National Bowel Cancer Screening Program: July 2011 - June 2012 monitoring report*. Cancer series. Cat. no. CAN 71. Canberra, Australia.
[7] Australian Cancer Network Colorectal Cancer Guidelines Revision Committee. 2005. *Guidelines for the Prevention, Early Detection and Management of Colorectal Cancer.* The Cancer Council Australia and Australian Cancer Network, Sydney.
[8] Victorian Government Department of Human Services. 2014. *Optimal cancer care for people with colorectal cancer: A guide to consistent care*. Melbourne, Australia. DRAFT
[9] ibid
[10] Victorian Government Department of Human Services, op cit.

Further investigations and care may occur in the public and private sectors and occur across speciality groups.

All patients with rectal cancer should be referred to a surgeon with expertise in rectal cancer, with the exception of an emergency presentation[11]. Rectal cancers which are T3 or above, and/or possibly node positive on preoperative MRI should be discussed at a colorectal MDT meeting.

Diagnostic and Staging Tests

The following investigations will be required to confirm diagnosis and staging of lower GI cancers. These tests will assist the MDT forum in confirming the optimum pathway and management plan for each patient[12,13].

- Colonoscopy is offered to patients without major comorbidity. If a suspicious lesion is found, a biopsy is performed to attain histological proof of diagnosis, unless contraindicated.
- For patients with major comorbidity, CT colonography, flexible sigmoidoscopy or barium enema could be offered. If a lesion suspicious of cancer is detected, a biopsy is performed unless contraindicated.
- Computed Tomography Scan (CT Scan) – chest abdomen and pelvis
- **For rectal or anal cancers -** Magnetic Resonance Imaging (MRI Scan) of pelvis or anorectal region
- Consider endorectal ultrasound in patients with rectal cancer to help distinguish between T2 and early T3 lesions if necessary, or if MRI is contraindicated.
- PET scan if appropriate
- Baseline tumour markers- CEA

Care coordination is vital at this point in the patient journey in ensuring that the necessary investigations, appointments and patient support are organised in a timely way.

Multi-disciplinary Team Referral

Lower GI MDT will provide a District wide structure and framework to ensure that once a tissue diagnosis has been obtained and full staging completed, suitable cases are considered through the MDT forum. Cases will be selected for discussion at MDT meetings according to the Colorectal MDT Referral Criteria (Appendix A). Uncomplicated cases not requiring discussion in the MDT meeting will be managed by MDT-member clinicians according to current guidelines. It is acknowledged that there may have been consultation between specialist practitioners prior to these meetings but the recommended care plan will be under the umbrella of the specific MDT and ensure standardisation of evidence based treatment and management of all patients. This will ensure that the delivery of quality care across the District remains evidence based and complies with the most current guidelines and practices[14].

This multi-disciplinary forum will be District wide in approach. Patients residing in the more rural and remote areas of the Local Health District (LHD) will have access to this multidisciplinary forum and their care will be co-ordinated by the lower GI cancer MDT. Referral and inclusion at the lower GI cancer MDT will be assisted via the videoconference and telemedicine links between Wollongong, Shoalhaven and Milton.

Referral Structure

The primary specialist making the original MDT referral will hold responsibility for the patient care and be the lead clinician until such time as subsequent referral to another practitioner. Preferably treatment will be planned after the completion and review of all relevant investigations.

For anal and rectal cancers, combined modality neoadjuvant therapy is often the optimal approach, and therefore it is preferable that MDT referral and patient discussion take place before surgical intervention.

[11] Department of Health, Western Australia. 2008. *Colorectal Model of Care*. Perth: WA Cancer & Palliative Care Network
[12] Victorian Government Department of Human Services, op cit.
[13] National Institute for Health and Clinical Excellence (NICE). 2011. *Colorectal cancer. The diagnosis and management of colorectal cancer.* National Institute for Health and Clinical Excellence, London, UK.
[14] National Breast Cancer Centre. 2005. *Multidisciplinary meetings for cancer care: a guide for health service providers*. National Breast Cancer Centre, Camperdown, NSW.

Patients with other lower GI cancers will be presented for MDT planning after surgery, particularly with respect to follow up chemotherapy.[15]

Patients with pre-operative T4 or metastatic disease, bowel obstruction or patients with confirmed lymph node involvement or lymphovascular space invasion post-surgery will also be tabled at the MDT with respect to consideration of chemotherapy.

The Multidisciplinary Team

The multidisciplinary team should comprise (in alphabetical order)[16]:

- Allied Health
- Colorectal Surgeon
- General Practitioner
- Hepatobiliary surgeons
- Medical Oncologist
- Clinical Nurse Consultant (CNC)
- Palliative Care Specialist/CNC
- Pathologist
- Radiation Oncologist
- Radiologist
- Stomal Therapist

The multidisciplinary team needs to be adequately resourced in order to achieve the required outcomes and responsibilities in terms of primary specialist, documentation of the agreed management plan within the oncology information system and its wider circulation to include all members of the team and the patients GP.

Formulation of Management Plan

A management plan is created for every patient discussed at an MDT, which will be recorded electronically contemporaneously. This plan will include recommendations for clinical care, supportive care and possible involvement of the Genetics Service where appropriate. Communication of these recommendations is vital. Correspondence will be generated electronically for the relevant specialists and general practitioners involved in care of the patient. The MDT recommendations will form part of the patient's electronic medical record.

Key practitioners who will be involved in delivering each modality required for care will meet with the patient and family to communicate the recommendations of the meeting. The role of these practitioners will be to educate the patient about the treatment options and reasons for the recommendations. Full disclosure of relevant information is required along with an in-depth discussion about risk benefit assessment before consent to proceed is obtained. Participation in research and/or clinical trials should be encouraged where available and appropriate.

Nurse coordinators can assist with the above process depending on the needs assessment of the individual patient, their carer and family. Education and co-ordination of care is essential to the success of efficient care. Education and practical support will also be offered by allied health practitioners.

Needs assessments should be repeated throughout a patient's treatment pathway to ascertain need for involvement of nurse coordinator, psychosocial or other support.

Treatment phase

This phase is concerned with the type of treatment that will be delivered, who will provide it and where it should be provided to ensure safe, high quality and effective care irrespective of the patient's location, background and circumstance.

[15] Victorian Government Department of Human Services, op cit.
[16] National Breast Cancer Centre, op cit.

Surgery for lower GI cancers should be performed by surgeons (FRACS or equivalent) with adequate training and experience in colon or rectal surgery that enables institutional credentialing and agreed scope of practice within this area[17]. Surgery should be performed in institutions (usually tertiary and secondary hospitals) that provide appropriate facilities including:

- Surgeon, stomal therapist and anaesthetic services
- Intensive care and/or high dependency care unit
- 24 hours medical staff availability
- 24 hours operating room access
- Diagnostic and interventional radiology
- Pathology
- Allied health

Radiation therapy should be prescribed by a Radiation Oncologist (FRANZCR or equivalent) with adequate training and experience that enables institutional credentialing and agreed scope of practice within this area. Radiation therapy treatment will be provided at each of the cancer services hub sites: Illawarra Cancer Care Centre and the Shoalhaven Cancer Care Centre. Radiation therapy should be performed in a treatment unit with the following characteristics:

- Linear accelerator and treatment planning system capable of delivering 3D conformal radiotherapy
- Trained radiotherapy therapists, physicists, nurses and allied health professionals.
- Access to Palliative Care Services

Chemotherapy should be prescribed by a Medical Oncologist (FRACP or equivalent) with adequate training and experience that enables institutional credentialing and agreed scope of practice within this area.

Chemotherapy will be provided at each of the cancer services hub sites, Illawarra Cancer Care Centre (also including the in-patient chemotherapy) and the Shoalhaven Cancer Care Centre, with additional services provided at the Milton Ulladulla Community Cancer Centre Spoke Site. Private chemotherapy facilities are also provided through Southern Medical Day Care Centre and Wollongong Private Hospital.

Chemotherapy and targeted therapy administration should be performed in a treatment unit with the following characteristics:

- Nurses with adequate training in chemotherapy administration, handling and disposal of cytotoxic waste and Central Venous Access Device care and management
- Pharmacist with adequate training in chemotherapy medication, including dosing, calculations according to treatment protocols and chemotherapy preparation
- Access to allied health
- Access to advice after-hours and emergency care
- Access to Palliative Care Services

Treatment consideration needs to include Central Venous Access Device insertion.

Genetic testing plays an important role in determining treatment pathways and follow up care including surveillance of at risk family members. Referral to a genetic counsellor should occur in the following circumstances[18];

- Histopathology demonstrates abnormal immunohistochemistry or microsatellite instability in an isolated case of colorectal cancer in an individual less than 60 years old, or in an individual of any age where there is a family history or with colorectal, endometrial, ureteric or renal cancer
- Family history includes 3 or more relatives with colorectal, endometrial, ureteric or renal cancer
- Patient is less than 50 years old

Notes on definition of measurable timeframes

"Decision to Treat" date defines the point when the patient and clinician agree to a prescribed treatment. The "Ready for Care" date is used in the field of radiation oncology as the date which, in the opinion of the treating clinician, the patient is

[17] Royal Australasian College of Surgeons. 2008. *Surgical competence and performance guide,* 1st edition. Royal Australasian College of Surgeons, Melbourne, Australia.

[18] Australian Cancer Network Colorectal Cancer Guidelines Revision Committee, op cit.

ready to commence treatment. For example, the patient has recovered from any previous procedures, all diagnostics have been completed, as well as insertion of central venous catheter should it be necessary[19].

ANAL CANCER

Surgery

For small (<2cm), well differentiated squamous cell carcinomas (T1N0), local excision is the primary treatment. Surgery is also used as salvage treatment following combined modality chemotherapy and radiotherapy for any larger squamous cell anal carcinoma[20].

Combined Modality Systemic Therapy and Radiation

Combined modality chemotherapy and radiation therapy is the definitive treatment for anal squamous cell carcinoma. It should commence within 2 weeks from the "Ready for Care" date[21].

Due to the complexity of combined modality treatment and the requirement for insertion of a Central Venous Access Device, involvement of the nurse coordinator is recommended.

COLORECTAL CANCER

Surgery

Surgery is the primary treatment in the management of colorectal cancer. The primary goal is a wide resection of the primary tumour with all loco regional lymph nodes in an intact mesocolic or mesorectal fascia. Surgery may also be considered for patients with metastatic disease in whom the metastases are suitable for resection and also those with initially unresectable disease whereby the metastases become suitable for resection after a major response has been achieved with combination chemotherapy.[22]

Note: KRAS and NRAS testing should be ordered at time of surgery. Pathologists will determine whether test to proceed if lymph node involvement confirmed.

For patients with potentially resectable liver metastases, referral to hepatobiliary surgeon should be attended prior to commencement of chemotherapy.

Radiation Therapy

Radiation therapy for treatment of colon cancer has a limited role. It may benefit patients with tumour penetration to a fixed structure, or those who may have symptomatic advanced disease, when delivered with palliative treatment intent.

Patients with liver metastases, who are not appropriate candidates for liver resection, may benefit from Selective Internal Radiation Therapy (SIR-Spheres). The role and benefit of radiation therapy will be discussed in the MDT meeting.

Systemic Therapy

Adjuvant chemotherapy is recommended for Stage III and high risk Stage II colorectal cancer (high risk Stage II includes; presentation with intestinal obstruction or perforation, Inadequate lymph nodes sampling (less than 12), poorly differentiated tumour, vascular, lymphatic or perineural invasion or pathological T4 stage [23])

Chemotherapy may benefit those with locally advanced or metastatic disease and may even convert initially unresectable metastatic disease to resectable disease[24].

[19] Royal Australian and New Zealand College of Radiologists (RANZCR): Faculty of Radiation Oncology. 2013. *Management of Waiting Lists for Radiation Oncology. "Quality in the timeliness of patient care".* Version 2.
[20] Glynne-Jones, R., J.M.A. Northover & A. Cervantes. 2010, *Anal cancer: ESMO Clinical Practice Guidelines for diagnosis, treatment and follow-up,* Annals of Oncology 21 (Supplement 5): v87-v92
[21] Royal Australian and New Zealand College of Radiologists (RANZCR): Faculty of Radiation Oncology, op cit.
[22] Van Cutsem, E., B. Nordlinger & A. Cervantes. 2010. *Advanced colorectal cancer: ESMO Clinical Practice Guidelines for treatment*. Annuals of Oncology 21, (Supplement 5), v93-v97.
[23] Labianca, R., B. Nordlinger, G.D Beretta, A. Brouquet & A. Cervantes. 2010. *Primary Colon Cancer. ESMO Clinical Recommendations for diagnosis, adjuvant treatment and follow-up.* Annals of Oncology 21 (Supplement 5): v70–v77.
[24] Labianca, R., B. Nordlinger, G.D. Beretta, A. Brouquet & A. Cervantes op cit.

Pathology will indicate genetic criteria that will influence treatment decision making, i.e. colon cancers with micro-satellite instability do not respond to fluoropyrimidine chemotherapy[25].

Chemotherapy in the adjuvant setting should commence within 8 weeks of surgery[26]. In the metastatic setting, ideally chemotherapy should commence within 4 weeks of the decision to treat.

RECTAL CANCER

Surgery

All patients with rectal cancer should be discussed pre-operatively in a MDT setting where there is expertise in rectal cancer, with the exception of an emergency presentation[27].

Patients should have their surgery performed by surgeons with adequate training and experience in the management of rectal cancer[28] [29].

For surgically favourable cases of rectal cancer, (clinical T1-2 and some early T3N0 with clear meso-rectal fascia), initial surgical excision is the primary treatment. For unfavourable, locally advanced rectal cancer (T3-4,) or rectal cancer likely to be node positive surgery is also used following combined modality chemotherapy and radiotherapy[30].

Note: KRAS and NRAS testing should be consistently ordered at time of surgery. Pathologists will determine whether test to proceed if lymph node involvement confirmed.

For patients with potentially resectable liver metastases, referral to hepatobiliary surgeon should be attended prior to commencement of chemotherapy

Radiation Therapy

For unfavourable or locally advanced or advanced (T3-4)or node positive rectal cancer, short or long course pre-operative radiation therapy is commonly indicated. Neo-adjuvant treatment should start within 2 weeks of the "Ready for Care" date[31].

Postoperative radiation therapy with combined modality chemotherapy is no longer recommended as standard of care. It may be used in patients with positive circumferential margins, node positive tumours, perforation in the tumour area or in other cases with high risk of local recurrence if preoperative radiation therapy has not been given[32]. This should occur within 4 weeks of surgery[33].

Systemic Therapy

Combined modality chemotherapy and radiation therapy is the optimum neoadjuvant treatment for rectal cancer. It should commence within 2 weeks of the "Ready for Care" date. In the post-operative setting, combined modality chemotherapy and radiation therapy should commence within 4 weeks of surgery[34].

[25] ibid
[26] Des Guetz G., P. Nicolas, G. Perret, J. Morere, B. Uzzan. 2010. *Does delaying adjuvant chemotherapy after curative surgery for colorectal cancer impair survival? A meta-analysis*. European Journal of Cancer 46(6):1049-55.
[27] Department of Health, Western Australia. *Colorectal Model of Care*. Perth: WA Cancer & Palliative Care Network
[28] Archampong, D., D.W. Borowski & H.O Dickinson. 2010, *'Impact of surgeon volume on outcomes of rectal cancer surgery: a systematic review and meta-analysis'. The Surgeon*, vol. 8, pp. 341-52.
[29] Australian Cancer Network Colorectal Cancer Guidelines Revision Committee, op cit.
[30] Glimelius B., E. Tiret, A. Cervantes & D Arnold. *Rectal Cancer: ESMO Clinical Recommendations for diagnosis, adjuvant treatment and follow-up.* Annals of Oncology 2013.
[31] Royal Australian and New Zealand College of Radiologists (RANZCR): Faculty of Radiation Oncology, op cit.
[32] Wong R., S. Berry, K. Spithoff, M. Simunovic, K. Chan, O. Agboola et al. 2008. *Preoperative or postoperative therapy for the management of patients with stage II or III rectal cancer*. Wong R, Brown J, reviewers. Toronto (ON): Cancer Care Ontario.
[33] Royal Australian and New Zealand College of Radiologists (RANZCR): Faculty of Radiation Oncology, op cit.
[34] Royal Australian and New Zealand College of Radiologists (RANZCR): Faculty of Radiation Oncology, op cit.

Adjuvant chemotherapy is recommended for all patients with Stage II or III following neoadjuvant combined modality therapy and/or surgery[35]. In the metastatic setting, chemotherapy is the optimal treatment, this should commence within 4 weeks of decision to treat.

Due to the complexity of concurrent treatment and the requirement for insertion of a Central Venous Access Device, involvement of the nurse coordinator is recommended.

FOLLOW-UP PHASE

The follow up phase includes screening for long-term treatment toxicity, monitoring for disease progression or relapse and addressing survivorship issues as it provides reassurance to patients who appear to be free of disease. This part of the journey is based on outpatient review and outpatient investigations. A plan for follow-up will be outlined to each patient after the treatment course and may involve co-ordinated follow up with different specialists, nurse led clinics and shared care follow-up with primary and ambulatory health care. This should be local follow-up and should consider a structured shared care approach between the surgical and oncology teams so as to avoid duplicate examinations and multiple visits to multiple specialists. All members of the multidisciplinary team will have access to follow-up documentation and investigative results to ensure continuity of the agreed follow-up plan, reducing duplication and avoiding unnecessary patient burden.

Patients treated for lower GI cancers will have an agreed, written follow-up care plan, which will be recorded by a named healthcare professional (or professionals), a copy sent to the GP and a personal copy given to the patient. This plan should include:

- Designated named healthcare professionals
- Dates for review of any therapy
- Details of surveillance
- Signs and symptoms to look for and seek advice on
- Contact details for support services

Patients who are medically fit should undergo regular surveillance as they are at increased risk of second primary lower GI cancers. Patients identified to be at moderate to high risk of metastatic or recurrent disease, should undergo surveillance to identify potentially resectable metastases (often hepatic).

The follow-up plan should be individualised according to the risk of recurrence and individual specific patient needs or requirements and be agreed by the patient. The coordinating MDT clinician should clearly document this plan in the patient record and / or the oncology information system. Ideally this plan should be communicated to the patient's general practitioner.

Follow-up of patients in rural areas of the LHD should be coordinated between specialists and the GP, with input from the lead clinician as required, using telemedicine facilities at the cancer sites or within GP practices.

CLINICAL EXAMINATION AND INVESTIGATIONS

The following investigations will be required to support the best practice follow care for lower GI cancer patients.

- Colonoscopy performed 1 year after initial surgery. Then at least at 3 and then 5 years, depending on scope results
- Computed Tomography Scan (CT Scan) annually for 3 years, unless high risk for recurrence
- Tumour Markers 3 – 6 monthly for 5 years
- For patient's having had low anterior resection surgery performed, an anorectal examination should be performed every 6 months for 2-5 years.

These tests should be available to patients as close to their place of residence as possible to minimise the ongoing burden of follow-up for the patient limiting the loss of patients to follow-up.

[35] National Comprehensive Cancer Network (NCCN). 2014. *NCCN Clinical Practice Guidelines in Oncology. Rectal Cancer.* Version 3.

SURVIVORSHIP

The transition from active to post treatment care is critical to long term health. Care should be planned and coordinated. Patients should have knowledge of their increased risk of second / recurrent cancers or treatment related morbidities as this encourages them to actively participate in their continuing post treatment care.

Routine follow up visits should become opportunities to promote a healthy life style, check for cancer recurrence and manage lasting effects of the cancer experience.

Survivorship support may occur through primary care, nurse-led or patient-led and should be guided to make use of the various programs and initiatives available at state and national levels through organisations such as the NSW Cancer Council, NSW Cancer Institute and Cancer Australia.

RELAPSE OR PROGRESSION

This phase concerns the diagnosis and management of patients who have recurrence of the disease (local or metastatic) and who need assessment regarding further treatment. This may occur initially at the patients GP level, and requires subsequent involvement of the specialist and the multidisciplinary team.

Patients with relapse or recurrence require expert opinion as to the best plan of management and this is best provided by the Colorectal MDT. This plan may involve further treatment, or referral to the palliative care service. The resultant outcome will be documented and communicated to the primary health care team.

The process outlined in this document should be revisited as to the best management plan for the patient with disease relapse of progression.

PALLIATIVE CARE

It is recognised that in lower GI cancer management, specialist palliative care services should be incorporated for symptom management for all patients at any stage of the treatment plan. This will depend on the assessed level of need of the patient and their requirements. Palliative care will be provided through referral to the consultative service in Wollongong hospital or the community based palliative care service in the LHD dependent upon patient circumstances and geographic location.

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APPENDIX A

Referral Criteria – ISLHD Colorectal Cancer MDT

	1: For urgent discussion at MDT meeting	2: For discussion at MDT meeting	3: Not for discussion at MDT meeting
Category A: New diagnosis	**1A**: All rectal cancer prior to treatment **1A**: All anal cancer prior to treatment **1A:** Complex stage IV colorectal cancer	**2A**: Colon cancer stage II (complex), III and IV or neuroendocrine tumour **2A**: Patient without diagnosis advice sought from MDT	**3A**: Stage I colon cancer **3A:** Uncomplicated stage II or uncomplicated stage III colon cancer
Category B: Re-discussion	**1B:** Complex stage IV colorectal cancer	**2B**: New issue for patient: previously treated on treatment	

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