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Consensus statement

Experts reviews of the multidisciplinary consensus conference colon and rectal cancer 2012: Science, opinions and experiences from the experts of surgery

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Abstract

The first multidisciplinary consensus conference on colon *and* rectal cancer was held in December 2012, achieving a majority of consensus for diagnostic and treatment decisions using the Delphi Method. This article will give a critical appraisal of the topics discussed during the meeting and in the consensus document by well-known leaders in surgery that were involved in this multidisciplinary consensus process.

Scientific evidence, experience and opinions are collected to support multidisciplinary teams (MDT) with arguments for medical decision-making in diagnosis, staging and treatment strategies for patients with colon or rectal cancer.

Surgery is the cornerstone curative treatment for colon and rectal cancer. Standardizing treatment is an effective instrument to improve outcome of multidisciplinary cancer care for patients with colon and rectal cancer. In this article, a review of the following focuses; Peri-operative care, age and colorectal surgery, obstructive colorectal cancer, stenting, surgical anatomical considerations, total mesorectal excision (TME) surgery and training, surgical considerations for locally advanced rectal cancer (LARC) and local recurrent rectal cancer

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(LRRC), surgery in stage IV colorectal cancer, definitions of quality of surgery, transanal endoscopic microsurgery (TEM), laparoscopic colon and rectal surgery, preoperative radiotherapy and chemoradiotherapy, and how about functional outcome after surgery?

Keywords: Colon; rectal cancer; Minimal invasive; Laparoscopy; TEM; TME; MRF

Introduction

Surgery is the key curative treatment for colon and rectal cancer. Additionally, palliative surgery offers valuable options to increase a patient's quality of life. Currently, surgical outcome and quality of cancer care are at the top of the list of 'improvement of care' projects. From large observational research, we know that wide variations in patterns of care and outcome exist in the field of surgical oncology.[1–3] The lack of standardization in colorectal cancer treatment was one of the most important driving forces behind the EURECCA initiative some years ago.[4] EURECCA, short for European REgistry of Cancer CAre, aims to standardize and register cancer care to reduce variance between European countries.[4] After three meetings a framework takes shape, which can be used for the implementation of guidelines and subsequent standard approach for patients with colorectal cancer. Theoretically, patients should no longer be at risk of misdiagnosing, under- or over staging, or receiving inappropriate treatment. EURECCA organized its first multidisciplinary consensus meeting held in December 2012 on colon *and* rectal cancer management. This article is one of a series of communications on the consensus meeting. The first article is the Mission statement.[4] The second article is the 'General consensus document'; it describes the epidemiology backgrounds of colorectal cancer, and lists all the actual consensus statements, describes the methodology of the performed Delphi process, and reports the results of the voting (van de Velde et al. Eur J Cancer, 2013 Oct 31, pii: S0959-8049(13)00780-6. http://dx.doi.org/10.1016/j.ejca.2013.06.048). This article presents the views of the surgeons involved in this consensus process. Other expert reviews have been written and will also be published in pubmed and linked as addenda to the general consensus document (van de Velde et al. Eur J Cancer, 2013 Oct 31, pii: S0959-8049(13)00780-6. http://dx.doi.org/10.1016/j.ejca.2013.06.048). The purpose of this article is to support the multidisciplinary teams (MDT) in their choices on colon and rectal cancer management from a surgical perspective.

Colorectal cancer surgery – general considerations

Perioperative circumstances

Fast track protocols in surgery were designed to minimize surgical complications by providing a multimodal approach implementing "as good as possible" evidence based tools to achieve early recovery after major surgery.[5] This was first done for patients undergoing colectomy and later was also implemented to the care for patients undergoing TME or liver surgery. ERAS which is short for enhanced recovery after surgery, focusses on the following standardized protocol elements, improving patient education, reducing pain, reducing nausea and vomiting, stimulating normal diet and get the patient out of bed as soon as possible.[6] Implementation projects resulted in large reduction in length of hospital stay.[6] http://www.erassociety.org/.

The main challenge to optimize perioperative care remains a continuous team effort from patient, surgeon, anaesthesiologists, general practitioner and nurses.

Laparoscopic surgery for colorectal cancer

Introduction

Laparoscopic colorectal surgery has become part of routine daily practice, although implementation varies hugely between and within different European countries.[7,8] Despite increasing level of expertise, not every patient with colorectal cancer will be a good candidate for minimally invasive surgery, mostly because of previous abdominal surgery or locally advanced tumours.

Initial implementation of laparoscopic techniques was associated to several concerns such as oncological safety with respect to radicality, adequacy of lymph node dissection and occurrence of port site recurrences. With emphasis we state that laparoscopic resection of colorectal cancer is technically challenging and requires a defined level of expertise. Nowadays, laparoscopic surgery for colorectal cancer is rendered safe in experienced hands.

Laparoscopic surgery and short-term results

The first randomized studies demonstrated classical short-term advantages of the laparoscopic approach, such as less postoperative pain, less blood loss, faster recovery of bowel function and shorter hospital stay.[9–11] These results were confirmed in a systematic review in 2006 by Reza et al.[12] Complication rate and postoperative mortality did not significantly differ among the two techniques.

A Cochrane review on laparoscopic rectal cancer surgery included 48 studies with a total number of 4224 patients.[13] Laparoscopic total mesorectal excision (TME) resulted in less blood loss ($p < 0.05$; 2 studies), quicker return to normal diet, less pain, less narcotic use and less immune response. No differences in postoperative morbidity, anastomotic leakage or mortality were found. A recently