Management of Colorectal Cancer

COLON CANCER (Adenocarcinoma)

Workup: Complete colonoscopy with multiple (8 or more) biopsies
Serum CEA
CECT scan abdomen and pelvis; CECT chest or Chest X-ray[a]
PET-CT is not routinely adviced[b]
Nutritional support for severely malnourished

Non-metastatic (any T, any N, M0)

Metastatic disease (DISCUSS IN MULTIDISCIPLINARY MEETING, EARLY INTEGRATION OF PALLIATIVE CARE, Check for RAS, BRAF and MSI status)

Resectable, fit for surgery: Appropriate colectomy with complete mesocolic excision[c]

Unresectable/ unfit for surgery/ refuses surgery: Palliative Chemotherapy
Refer to palliative services
Stenting or Colostomy if indicated

Limited metastatic disease Fit and willing for aggressive treatment (some potential for cure)

Disseminated metastasis/ unfit or unwilling for aggressive treatment(no potential for cure)

Adjuvant therapy

Stage I (pT1-2,N0): no adjuvant therapy

Stage II (pT3-4,N0): MSI testing indicated
-High risk[d] or MSS/MSI-L:
3 months CAPOX or 6 months FOLFOX chemotherapy
- Low risk or MSI-H: only surveillance

Stage III (any pT,N1-N2)[e]:
-Low risk (pT1-T3,N1): 3 months CAPOX chemotherapy
-High risk (pT4,N1 or pT1-T4,N2): 6 months CAPOX or 6 months FOLFOX chemotherapy

Appropriate sequencing of systemic therapy and surgery (see flow chart below)

(see Appendix A for details of systemic therapy)

-Supportive care as appropriate

-Palliative systemic therapy (see Appendix B for details)

-Maintain continuum of care
-Encourage enrolment in clinical trials

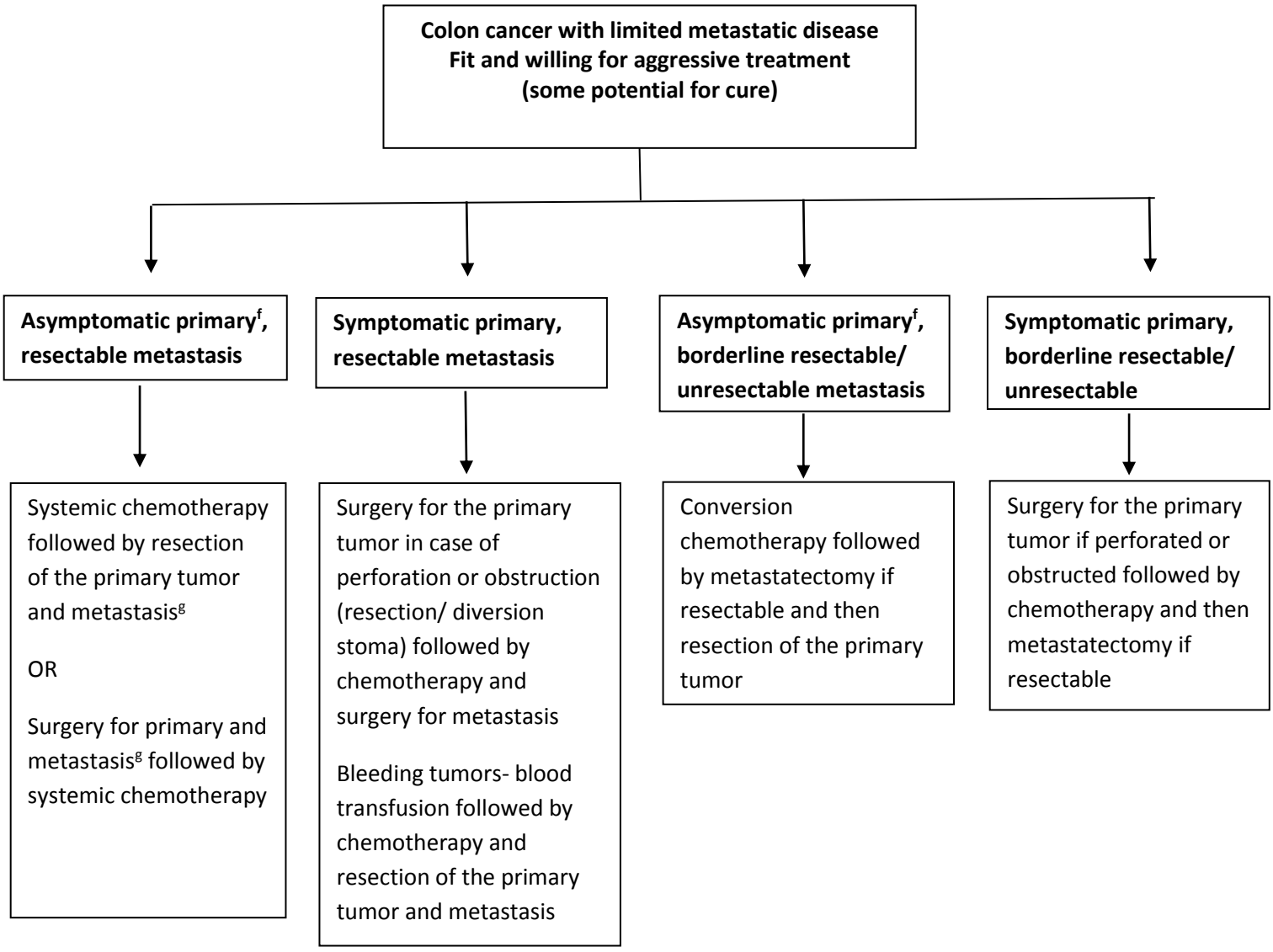
[a]A chest X-ray is an acceptable alternative to CT chest since there is no clear evidence to favour the latter. Optional- MRI can be problem solving for hepatic metastases if CT is equivocal; adding DWI improves accuracy (evidence from meta-analysis); for restaging after therapy in advanced disease, CT Abdomen and Pelvis with/ without CT Angiography may be used.

[b]PET-CT may be ordered ina)those with limited metastatic disease in liver and being planned for potentially curative treatment b)Patients with rising CEA levels and non diagnostic conventional imagingand c) To confirm metastases suspected on CT scan based on equivocal results

[c]In locally advanced tumors, 4 cycles of neoadjuvant FOLFOX chemotherapy may be given if downstaging is required (FOxTRTOT trial)

[d]High risk includes inadequate nodal sampling(< 12 nodes), pT4 stage, perforation - (major); poorly differentiated tumors, LVI/PNI, obstruction.

[e]Ref:Duration of Adjuvant Chemotherapy for Stage III Colon Cancer. Grothey A et al. N Engl J Med 2018; 378:1177-1188



[f]This scenario applies for both asymptomatic primary with synchronous metastasis or a treated primary with metachronous metastasis
[g]Single stage surgery only if metastatectomy is uncomplicated and primary tumor is easy to resect

Surveillance

Clinical examination and Serum CEAevery 3-6 months for first 5 years and then annually/ at the discretion of the physician; CECT abdomen/pelvis and Chest X-ray/CT Thorax annually for 3 years and thereafter only if clinically indicated; Colonoscopy to be performed 1 year after surgery if complete colonoscopy done upfront (if not done, then colonoscopy to be done within 6 months of surgery) and thereafter once in 5 years or when indicated clinically

Appendix A:
The systemic therapy delivered in these patients with some potential for cure consists of chemotherapy +/- targeted therapy. They should undergo evaluation for resection every 2 months while on systemic therapy.

Systemic chemotherapy choices in these patients can be
• CAPOX/FOLFOX/FOLFIRI/FOLFIRINOX

Targeted therapy/Biological agents may be added to the systemic chemotherapy backbone based on KRAS/NRAS/BRAF mutation status

Appendix B:
The systemic therapy in these patients is delivered with aim of controlling symptoms, improving survival with reasonably maintained QOL.
Determine the MSI status, mutation status in KRAS/NRAS/BRAF and HER2 amplification

Systemic chemotherapy backbone choices in these patients depend on PS, co morbidity status and prior exposure to oxaliplatin in adjuvant setting

- Capecitabine
- 5FU + Leucovorin
- CAPOX/FOLFOX
- FOLFIRI
- FOLFIRINOX (exceptional circumstances)

Targeted therapy/Biological agents may be added to the systemic chemotherapy backbone based on KRAS/NRAS/BRAF mutation status
• Cetuximab/Panitumumab (if RAS/RAF wild type)
• Bevacizumab

If MSI H or dMMR, immunotherapy with Pembrolizumab would be the best available option based on recent trial data