Pan Birmingham NHS
Cancer Network

Guideline for the Referral and Management of Early Rectal Cancers and Sessile Rectal Adenoma

Version History

Version	Summary of change	Date Issued
Version 1	Endorsed by Pan Birmingham Cancer Network Clinical Governance Committee	24.09.07
1.1	Prepared for review and circulated to the colorectal NSSG	20.04.10
1.2	With comments from the NSSG – for comment by Mark Chapman (MC)	11.05.10
1.3	With comments from MC	26.05.10
1.4	With further comments from Simon Bache (SB), Lara Barnish and MC. For final review by the NSSG 06 September 2010	08.06.10
1.4	Following discussion at the November NSSG, for review by MC	16.11.10
1.5	With comments from Stephan Korsgen and SB	24.02.11
1.6	With comments from MC. Circulated to the NSSG for final agreement	24.06.11
1.7	Comments received and incorporated	13.07.11
1.8	Presented at the clinical governance sub-group	03.08.11
2.0	With approval from Mark Chapman to minor amendments	31.08.11

Date Approved by Network Governance	**August 2011**

Date for Review	**August 2014**

Summary of Changes between version 1 and version 2

- Greater clarity over the inclusion of pT2.
- Assessment now also carried out at University Hospital Birmingham NHS Foundation Trust.
- All pT1 and pT2 now should be considered for radiotherapy.

1. Scope of the Guideline

This guideline makes recommendations for the referral and management of early rectal cancers and sessile rectal adenoma. That is, those with high grade dysplasia, T1 and T2 lesions.

2. Guideline Background

2.1 Early rectal cancers can be treated effectively by local excision alone with transanal endoscopic microsurgery (TEM), provided there are no adverse histological features[1, 2]. TEM alone has had good success rates[3,4], and avoids complex major surgery with its inherent risks.

2.2 Within Pan Birmingham Cancer Network patients suitable for TEM are assessed and managed by the colorectal TEM group at Good Hope Hospital (GHH) (part of Heart of England NHS Foundation Trust), or can be referred to University Hospital Birmingham NHS Foundation Trust for a diagnostic endorectal ultrasound (ERUS). The early rectal cancer multidisciplinary team (MDT) at GHH consists of surgeons, an ERUS ultrasonographer, histopathologists, a dedicated colorectal lead radiologist and coloproctology support nurses.

Guideline Statements

3. Patients selection

3.1 For local excision by TEM to be effective and safe, careful case selection is important. Preoperative staging of the lesion is of paramount importance, and ERUS is the best method to distinguish between a T1 and T2 lesion[6]. In contrast, MRI scanning is better at assessing the relationship between the tumour and the mesorectal fascia as well as perhaps nodal spread[1, 3].

3.2 Lesions suitable for TEM excision must be T1 lesions and located in the rectum up to 18 cm from the anal verge. Treatment intent should be curative. In practice, only lesions accessible with a rigid sigmoidoscope will be amenable to the TEM technique.

3.3 T1 cancers with a diameter less than 3 cm are suitable.

3.4 For benign lesions there is no limitation in size, except height of the lesion (see 3.2).

3.5 The decision regarding treatment will be made at the early rectal cancer MDT meeting and fed back to referring consultant by letter.

4. Criteria and mechanism for referral

4.1 For early rectal cancers:

This includes all sm1-3, i.e. all T1 tumours should be considered for TEMS and referred.

4.1.1 The referring hospital should carry out:

a) History and examination.
b) Rigid sigmoidoscopy and biopsy.
c) CT of the thorax, abdomen and pelvis to exclude distant metastatic disease.
d) Colonoscopy to document any co-existing lesions in the colon.
e) MRI of the Pelvis.

4.1.2 On review of the results of these investigations, the local MDT should decide whether the patient is suitable for referral for curative treatment, for second opinion, or to palliate.

4.1.3 Referral to Good Hope Hospital should be by fax (see appendix 1), and should be clearly marked as 'early rectal cancer'. This will ensure an appointment for endorectal ultrasound is generated.

4.1.4 Histology slides should be forwarded by courier at the time of referral to the lead colorectal pathologist (see appendix 2), for review prior to discussion by the MDT.

4.1.5 The fax will generate an appointment for ERUS performed by a consultant surgeon within a week of referral. A rectal examination and rigid sigmoidoscopy will be performed to assess suitability of the lesion for TEMS.

4.1.6 For both T1 and T2-lesions, the patient will be offered entry into the TREC-trial, after discussion with the referring clinician.

4.1.7 All patients will be formally discussed at the next early rectal cancer MDT at Good Hope Hospital. This group meets weekly, on Friday mornings. Treatment options will be one of the following:
a. Suitable for TEMS: treated at Good Hope Hospital.
b. Unsuitable for TEMS: back to referring clinician.
c. Suitable for TREC-trial: treated at Good Hope Hospital.

4.2 For benign rectal adenoma

4.2.1 If biopsy of the lesion reveals a benign rectal adenoma and the referring surgeon/ gastroenterologist decides it cannot be removed by polypectomy, referral can be made for consideration of ERUS and

TEMS resection. This referral should be made directly to the colorectal TEM group at Good Hope (see appendices 1 and 2).

5. Patient Information and Counselling

5.1 All patients, and with their consent, their partners will be given access to appropriate written information during their investigation and treatment, and on diagnosis will be given the opportunity to discuss their management with a clinical nurse specialist who is a member of the relevant MDT. The patient should have a method of access to the colorectal team at all times.

5.2 Access to psychological support will be available if required. All patients should undergo an holistic needs assessment and onward referral as required.

6. Palliative Care

Palliative care services will be made available to all patients as deemed appropriate by the referring multi disciplinary team.

7. Clinical Trials

7.1 Wherever possible, patients who are eligible should be offered the opportunity to participate in National Institute for Health Research portfolio clinical trials and other well designed studies. A European trial is planned looking at combining TEM with a short course of radiotherapy in the hope of increasing its therapeutic potential[5].

7.2 Where a study is only open at one Trust in the Network, patients should be referred for trial entry. A list of studies available at each Trust is available from Pan Birmingham Cancer Research Network. Email: PBCRN@westmidlands.nhs.uk.

7.3 Patients who have been recruited into a clinical trial will be followed up as defined in the protocol.

Monitoring of the Guideline

Implementation of the guidance will be considered as a topic for audit by the NSSG in 2013.

Authors of Version 2

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Stephan Korsgan	Consultant Colorectal Surgeon Heart of England NHS Foundation Trust
Lara Barnish	Deputy Director of Nursing Pan Birmingham Cancer Network

References

1. Winde G, Nottberg H, Keller R, Schmid KW, Bunte H 1996 Surgical cure for early rectal carcinomas (T1). Transanal Endoscopic Microsurgery vs. anterior resection. Dis Colon Rectum 39:969-976
2. Mentges B, Buess G, Effinger G, Manncke K, Becker HD 1997 Indications and results of local treatment of rectal cancer. Br J Surg 84:348-351
3. Kikuchi R, Takano M, Koichi T et al. 1995 Management of early invasive colorectal rectal cancer. Dis Col Rectum 38 :1286-1295
4. Bach S, Lane L, Merrie A, Mortensen NJ Stage 1 rectal cancer: Transanal Endoscopic Microsurgery or Radical Resection? 2006 Colorectal Disease 8.19 abstract O54 Gateshead 2006.
5. TEM user group meeting: Royal College of Surgeons, 24 November 2006. (personal communication.)

Approval Signatures

Pan Birmingham Cancer Network Clinical Governance Committee Chair

Name: Doug Wulff

Signature Date September 2010

Pan Birmingham Cancer Network Manager

Name: Karen Metcalf

Signature Date September 2010

Network Site Specific Group Clinical Chair

Name: Rob Church

Signature Date September 2010

ENDORSED BY THE GOVERNANCE COMMITTEE

MDT ALERT TO INCOMING PATIENT

TERTIARY REFERRAL TRACKING

To be sent to: Good Hope Hospital

Central Tertiary Cancer Alert Fax No: 0121 424 7814

From: (name of person sending this fax)	Trust: _____ Tel:

Patient Details					
Forename		Surname		DOB	/ /
NHS Number			Hospital Number (Referring Trust)		
Address					
Is the patient aware of the diagnosis?	Yes/ No/ Not known		Patient Tel. No.		

Referral Details					
Trust First Seen					
Urgent GP Suspected Cancer Referral	Yes / No	GP Decision to Refer Date (if Urgent GP Referral)		/ /	
GP name (Referring)			GP Phone		
GP Practice name					
Date First Seen	/ /	Date Discussed at MDT meeting		/ /	
Decision to Treat Date (Date discussed and agreed with patient)				/ /	
Clinician (Referring)			Speciality		
Clinician Referred to at Insert Trust			Speciality		
Has a referral letter together with imaging/histology reports been sent to clinician at Insert Trust ? If No please arrange.				Yes / No	
Referred for Treatment	Yes / No	Planned Treatment Type	Surgery/ Chemotherapy/ Radiotherapy/ Palliative Care/ Brachytherapy		
Referred for Diagnosis	Yes / No				
Diagnosis Confirmed	Yes / No	Tumour Type (Diagnosis)			
Date of Clinical intervention which confirmed cancer:			/ /		
Reasons for Delay in meeting target(s) (if applicable)					
Adjustments made (Total no. of days)		Adjustment Reasons			
Target Treatment Date					
This document is not intended to replace the clinical referral letter.					
Date Received	/ /	Date OPA	/ /	Clinic Code	/ /

ENDORSED BY THE GOVERNANCE COMMITTEE

Histology should be forwarded to:

Dr Rajul Singh
Department of Histopathology
Heart of England NHS Foundation Trust
Good Hope Hospital
Rectory Road
Sutton Coldfield
B75 7 RR