THE CANADIAN ASSOCIATION OF GENERAL PRACTITIONERS IN ONCOLOGY
CAGPO
L'ASSOCIATION CANADIENNE DES MÉDECINS OMNIPRATICIENS EN ONCOLOGIE
ACMOO

RECTAL CANCER CASE

Case #1

Rectal Cancer Case

A 53-year-old woman presents with a two-month history of rectal bleeding. She is not having melena. Bowel movements are painless. She has a history of hemorrhoids and initially felt this was the cause of the bleeding. She has a family history of colon cancer with her father having been diagnosed at age 55 with metastatic colon cancer. She has not participated in colon cancer screening and is reluctant to consider colonoscopy. Her past medical history is otherwise non-contributory. She was about 20 pounds overweight but has lost 5 pounds unintentionally over the last 2 months. She is peri-menopausal.

Her family doctor refers her to a surgeon for assessment. On digital rectal examination he can feel a nodular mass on the right.

1. How would you investigate this patient?
2. What are her risk factors for rectal cancer?

Rigid sigmoidoscopy confirms a lesion at 7 cm. She subsequently undergoes a colonoscopy, which fails to show any other lesions. The rectal lesion is biopsied and confirms adenocarcinoma.

3. Does she warrant any additional staging investigations pre-operatively?
4. Does she require a preoperative CEA level? What is its utility?
5. What is the role of neoadjuvant (preoperative) treatment in rectal cancer? How are the chemotherapy and radiation administered?
6. What is the advantage of preoperative CMT?
7. In what scenario would the recommendation be to proceed with pre-operative radiation solely (i.e. no preoperative chemotherapy)?
8. What are the indications for short course versus long course radiation?
9. What is the role of total neoadjuvant therapy and in what scenario is it appropriate to offer it?

CT chest, abdomen and pelvis does not reveal any evidence of metastatic disease. She declined an MRI of the pelvis because of a history of claustrophobia. She is referred to her local cancer centre for consultation.

10. What surgical options would you consider for this patient?

Her surgeon recommends a TME (total mesorectal excision) procedure, which she undergoes uneventfully. Pathology confirms a 2 cm lesion with invasion into muscularis propria. The distal margin is negative at the edge of the mesorectum. Three of 12 nodes are positive.

11. What stage of disease does this patient have?
12. What is the significance of commenting on the distance that the distal margin is from the tumor?
13. What is the local failure rate following TME?
14. What are the benefits of TME versus the more traditional LAR or APR?
15. How many lymph nodes are required for an adequate evaluation of lymph node status?

16. Does the number of involved lymph nodes affect survival?
17. Is she a candidate for further therapy post-operatively? If so, what, and how is it administered?
18. What toxicities would you expect from CMT (combined modality therapy)?
19. What radiation techniques are available to minimize treatment related complications?
20. How effective is CMT in decreasing her risk of recurrence? What about total neoadjuvant therapy?
21. Once she has completed treatment, how would you follow her? (i.e. how frequently, and with what, if any, investigations)
22. How do recurrence patterns differ between rectal and colon cancers, and how does this affect follow-up recommendations?
23. For patients with rectal cancer who develop recurrence, how are systemic treatment options affected if the tumor is KRAS wildtype versus KRAS mutated? MSI-high versus MSS? How would a BRAF mutation affect treatment options?

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