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Suggested Treatment and Follow-Up Protocols for Colon and Rectal Cancer in their Different Clinical and Molecular Stages

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Colon cancer

Introduction

Colon cancer is second in frequency in both sexes. It is alsothe second in mortality from cancer. The most important risk factorsare: diet rich in red meat and low in vegetables and fruits, obesity, lack of physical activity, smoking and family history of polypus or colon cancer. Appliedand validated tracing methods significantly reduce their mortality.

For staging it is recommended in all patients to perform a complete physical examination, request CEA, tomography of t or rax and tomographyof abdomen and pelvis or resonance of abdomen and pelvis with contrast.

‘Classification according to TNM 8th edition
Primary tumor (T)
Tx Inaccessible primary tumor
T0 No evidence of primary tumor
T1 Tumor invading submucosa
T2 Tumor invading muscle propria
T3 Tumor invading subserosa or peri-colonic or perirectal tissue, not peritonized
T4 Tumor invading or adjacent organs or structures and/or perforating the visceral peritoneum
T4a Tumor perforating the visceral peritoneum
T4b Tumor invading or adjacent organs or structures
Nodes (N)
NX Nodes not accessible
N0 Without metastasis in regional nodesN1 Met stasis in1-3 regional nodes
N1a Metastasis in 1 regional ganglion
N1b Metastasis in 2-3 regional nodes
N1c tumor site
N2 Metastasis in 4 or more regional nodes
N2a Met a stasis in 4-6 regional nodes N2b Metastasis in 7 or more regional nodes
Metastasis (M)
M0

Without metastasis
M1 With distant metastasis
M1a Metastasis confined to one or no peritoneal metastasis
M1b Metastasis in more than one or body
M1c peritoneal metastasis with or without involvement of others or bodies

STADIUM	T	N	M
0	Tis	N0	M0
I	T1, T2	N0	M0
Iia	T3	N0	M0
IIB	T4a	N0	M0
IIC	T4b	N0	M0
IIIA	T1, T2	N1/N1c	M0
	T1	N2a	M0
IIIB	T3-T4a	N1/N1c	M0
	T2, T3	N2a	M0
	T1, T2	N2b	M0
IIIC	T4a	N2a	M0
	T3, T4a	N2b	M0
	T4b	N1-2	M0
Iv	Any T	Any N	M1
VAT	Any T	Any N	M1a
Ivb	Any T	Any N	M1b
IVC	Any T	Any N	M1c

Stage 0: According to the depth of invasion and the presence of risk factors (lymphovascular invasion, historical grade3, invasion in the submucosa, moreinvolved genes or polipos ésil) polypectom i a endosc or pica complete can be performed in those without risk factors or cholectomi a in those who do have them.

Stages I, II and III: The treatment is radical surgery, the technique will depend on the experience of the surgeon. It includes the resectionof the compromised chol or nico segmentand lymphadenectomy. Distal and proximal margins must be at least 5 cm, and the nodal count at least 12.

Adjuvant is indicated in stage III and stage II high-risk (see table)

High-risk stage II definition
Insufficient nodal count <12
Poorly differentiated tumor (G3)
Vascular, lymphatic or perineural invasion
Tumor that presents or with exclusivity T4 perforation

Another factor to consider in the indication ofadjuvant is the absence of microsatellite instability.

The recommended high-risk stage II QTP regimen is based on fluoropyrimidines (5-fluorouracil + leucovorin or capecitabine). Oxaliplatin does not confer overall survival benefits. Of

According to data from the IDEA study, CAPOX x 3 months is ahigh-risk stage II option. In patients with microsat and lites instability, treatment is not recommended, as the results are detrimental.

In stage III, adjuvant with a scheme based on fluoropyrimidines and oxaliplatin, FOLFOX or CAPOX is suggested. At present in patients with stage III of low risk (T1-3N1) can be considered to perform 3 months of CAPOX scheme, in therest 6months are recommended (CAPOX OR FOLFOX).

Follow-up is extremely important, since patients withmetastasis detected in a timely manner can access treatments with curative int

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Rectal cancer

Introduction

Likecolon cancer, it is among the mostcommon tumors. Its incidence in the last years is on the rise, mainly in those under 50 years ofage. The presence of rectal symptoms or bleeding is its mostfrequent form of presentation, and diagnosis is based on the findings of digital rectal examination and endoscopy, with confirmation of biopsy.

Multidisciplinary management and correct stagingare key. It is very important that all patients have a complete study of the colon, to rule out syncrorsingle tumors. In those in which the surgery was performed without a complete study of the colon, the same shouldpreferably be performed before 6 months of surgery.

In the early stages, echo-endoscopy is usefulfor adequate local staging. Magnetic resonanceimaging of the abdomen and pelvis is essential for adequatelocoregional and distant staging, evaluationof extramural

vascularinvasion and synchronic metastasis. It helps define the preoperative treatment and extent of the surgery.

Computed tomography is the mostindicated method for remote evaluation and positron emission tomography(not standard) may be considered in patients with extensiveextramural vascular invasion, high CEA values, or suspectedCT metastasis a, to evaluate injuries from a distance.

Classification according to location
Upper rectum: Middle rectum: Inferior rectum: 10-15 cm anal margin 5-10 cm from anal margin < 5 cm from anal margin
STAGING TNM edition 8th
Primary tumor (T) Tx Inaccessible primary tumor T0 No evidence of primary tumor T1 Tumor invading submucosa T2 Tumor invading muscle propria T3 Tumor that invades subserosa or peri-col ornico or perirectal tissue, according to the Infiltration of the muscle layer propria, subclassified: T3a <1 mm T3b 1-5 mm T3c 6-15 mm T3d >15 mm T4 Tumor that invadesor is attached to adjacent organs or structures and/or perforates the peritoneum visceral T4a Tumor that perforates or adheres to the visceral peritoneum T4b Tumor that invades or is attached to adjacent bodies or structures Nodes (N) NX Nodes not accessible N0 Without metastasis in regional nodes N1 Metastasis in 1-3 regional nodes N1a Metastasis in 1 regional ganglion N1b Metastasis in 2-3 regional nodes

N1c Deport tumor site

N2 Metastasis in 4 or more regional nodes N2a Metstasis in 4-6 regional nodes

N2b Metastasis in 7 or more regional nodes

Distant metastasis (M)

M0 Without distant metastasis

M1 With metastasis

M1a Metastasis confined to one or no peritoneal metastasis

M1b Metastasis in more than one or organ

M1c Metastasis peritoneal with or without involvement of others or organs

Stadium	T	N	M
0	Tis	N0	M0
I	T1, T2	N0	M0
Iia	T3	N0	M0
IIB	T4a	N0	M0
IIC	T4b	N0	M0
IIIA	T1, T2	N1/N1c	M0
	T1	N2a	M0
IIIB	T1-T2	N2b	M0
	T2, T3	N2a	M0
	T3, T4a	N1/N1c	M0
IIIC	T4a	N2a	
	T3-T4a	N2b	
	T4b	N1-2	
VAT	Any T	Any N	M1a
Ivb	Any T	Any N	M1b
IVC	Any T	Any N	M1c

Treatment

T1 tumors are also classified according to:

Haggitt's subgroups: considers pedunculated or unstubborn conformation, historical or logical grade, presence oflymphovascular invasion and budding growth. These are all factors that predict the risk of lymph node involvement, important data to decide the type of surgeryand the methodby which it will be performed.

Kudo/Kikuchi subgroups: considers the conformation, the level of infiltration in the submucosa and the depth of invasion.

Block surgery is indicated when the resection marginsarecommitted as well as at depth. Japanese guidelinesrecommendradical surgery + lymphadenectomyin those with unfavorable risk factors (poorly differentiated tumors, withlymphovascular invasion and depth of invasion greater than 1000 μm).

In the rest of the tumors, that is, >T1 or with risk factors, the surgeryindicated in rectal tumors is the total excision of the mesorectum (MSD) associated with the resection oat least 12 nodes.

Very early tumors (T1 sm1 N0): If there are no adverse factors, endocan resection ortransanal pica is sufficient. RTP ± QTP can be an alternative. If there are adverse factors (MS 2 or more, grade 3, vascular or lymphatic invasion) the surgerythat is indicated is the total resectionof the mesorectum. For high-risk patients withtransanal resection and adverse factors, perioperative CRT is an alternative.

Early or good tumors (T1-T2, T3a/b N0 of middle or upper rectum, N0 or N1 if superior rectum), MRC (circumferential radial margin) not compromised, without vascular invasion extramural: surgery (MSD). If bad or stic factors are detectedin the surgical piece(CRM+, N2) consider QTP +/- RTP. An alternative is CRT + watch and wait in patients (complete or progressive response) who are cold, at high risk or in those who do not accept surgery.

Intermediate tumors (T3 of low rectum, with healthy elevators, radial margin circumferences not compromised, T3a/b with N1-2, without extramural vascular invasion): single surgery (MSD) only if adequate surgery is prevented, with risk of recurrence ≤5%, or short RTP / CRT followed by MSDs. Watch and wait can be considered in patients at risk if they have a complete response.

Malignant tumors (T3c/d or low, levator threatened, intact mesorectal fascia, T3c/d of the median rectum with or without N1-2, extramural vascular extension, T4aN0): Short RTP or CRT followed by MSDs. It can be considered watch and wait in which they get a complete response.

Locally advanced tumors (cT3 with mesorectal fascia involvement, T4a/b, levator involvement, or involved nodes): CRT or short RTP (can be combined with folfox and long wait for surgery). RTP short alone in cold or elderly patients with comorbidities.

There is no difference in benefits between CRT and short RTP when it comes to local recurrence. On the other hand, in tumors in which downstaging is required, CRT is recommended since it increases the chances of R0 surgery, compared to RTP alone or short.

There are 2 forms of preoperative radiation therapy
Short RTP (25 Gy total with fractions of 5 Gy for a week) followed by immediate surgery (less than 10 days after the first fraction), or with long wait for surgery. Both have equal benefits but the second is accompanied by fewer postoperative complications.
CRT: 45-50 Gy in 25-28 fractionsplusa boost until reaching 54 Gy in 3 fractions. This modality is preferred in cases of CRM+. Alsoin the case of requiring adjuvant treatment. When concurrent CRT treatment is performed, fluoropyrimidines are used.

Another treatment modality is to perform preoperative, inductionor consolidation chemotherapy. There are more modern studiesof total neoadjuvant treatment (TNT) in which it is proposed to perform QTP and RTP, both complete scheme preoperatively. The objective is to treat possible micrometasis early, improve toxicity and adherence to treatment both in time and in adequate doses. There are 2 modalities: with induction, in which treatment with QTP (FOLFOX/Capox) is started and then RTP is applied, and with consolidation, radiotherapy is administered first and then chemotherapy.

It unstandardized how the most appropriate modality is in each case, nor is it the best RTP or QTP scheme. There is a trend of greater benefit in the induction modality, due to the early treatment of micrometastasisin higher-risk tumors such as those with ENVI+ or N+. On the other hand, this trend of benefit is observed with the consolidation modalityin T4 tumors or with MRC +, in terms of the greater chance of reduction ofdisease volume and preservation of organs.

Preoperative RTP has no benefit in tumors of the rectum high (more than12 cm from the MA) and aboveperitoneal reflexion, which should be treated ascolon cancer. Once treatment is complete, assessment of response, and when it takes place, is key. The standardfor response evaluationare the same as those used at the beginning (Touch, MRI, Rectoscopy and CT).

Watch and wait: After neoadjuvant treatment, 10-40% of patients have a complete clinical response (RCC) within 12 weeks of initiation of treatment. RCC is considered to be the absence of palpable tumor or irregularities to the touch, absence of visible lesi or n on rectoscopy, and absence of residual lesi or n on MRI at the site of the primary tumor and nodes, and a negative biopsy of the site of the primary lesiorn. At present we consider that this strategyis only applicable to selected cases in the context of a committee of tumors.

After short RTP, when downstaging is not sought, immediate surgery is recommended, within7 days from the end of neoadjuvancy, and within 3 days in people over 75 years (<10 days from the first application).

The recommended wait for surgery, after CRT, is 4-12 weeks, in patients who performed short RTP, should not exceed 10 days, from the onset of rays. In selected cases, delaying surgeryallows to increase the complete response rate or optimize surgical planning.

Postoperative CRT should be considered in the face of the finding of adverse factors after surgerysuchas: ≤1cm MRM, perforated tumor, incomplete MSD, pT4b, pN2, pN1c, EMBI +, invasionorperineural near the mesorectal fascia.

Postoperative QTP may be considered after neoadjuvancy. The level of evidence of benefit is lower than incolon cancers and is limited to progression-free survival. It is not yet well established whether the stage to be taken into account for the choice of scheme is the initial clinical stage or the stage of the surgical piece. The incorporation of oxaliplatin depends on the risk of toxicity and recovery.

Local recurrence

In patients with local recurrence who have not been irradiated, preoperative CRT and eventual surgery are recommended. In selected cases, and evaluated in the tumor committee, re-irradiation may be considered to facilitate curative resection, or short RTP followed by QTP (fluoropyrimidine + oxaliplatin-based) followed by rescue surgery, or induction QTPfollowed by surgeryor CRT and eventual surgery.

Metastatic disease

QTP alone may be insufficient, and RTP of the primary tumor may be useful. Short RTP followed by QTP startingwithin 2 weeks is preferred to improvesymptoms. In oligo-metastatic patients, treatment with QTP is started seeking the most appropriate timefor surgerywith metastasectom. In the choiceof the systemic scheme, guidelines for metastatic colon cancer can be considered.

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Clinical or biochemical suspicion of metastatic diseasemust be confirmed by genes andeventually biopsy (In many cases the cleavageis the bestto obtain histology). In all patients, there should be evaluation by imagesof the rax, abdomen and pelvis. In patients with exclusive hepatic disease,an resonance should be performed. In patients with potentially curable metastatic pattern, FDG PET is suggested. Patients with systemic diseaseshould undergo molecular studies (mutation of KRAS, NRAS and BRAF). Although the study of microsatellite instability will not serve for the choice of the first line, it is useful as a predictive and predictive markerof response insubsequent lines. In some patients, amplification of Her2 can be detected, which is a known target of treatment in other pathologieswith scientific evidence of efficacy but without approval in our environment, but usefulto raise in the framework of research or compassionate use. Treatment: There are different clinical scenariosto consider: Unresectable, potentially resectable and resectable patients. Oligometastatic disease:a controversial definition. The goal of treatment is the possibility of R0 resectionor local ablative treatment. When the disease is confined to one organ or a few or a few organs, surgery is the indication and the onlyone with curative intent. Meta a stasis hepa ticas or pulmonary, technically resectable: In patients with metaa Stasis clearly resectable and of good practice, perioperative chemotherapy may not be necessary (although the current trend is to do chemotherapy in mostpatients). Hepatic metastases smaller than 2 cm and more than1 cm deep in the liverhave a higher risk of disappearing with imagesafter QTP and shouldbe resected because complete pathologicalresponseis rare. In patients with aless clear or unfavorable problem, perioperative QTP (3 months before and 3 months after surgery) should be administered with FOLFOX or CAPOX scheme. The current suggestion is 2 months of QTP and evaluation(no more than2 months for the impact of oxaliplatin and irinotecan on liver tissue). Tico healthy) and then 4 months in the postoperative period. When pronóstico or resectability cannot be defined, as occurs in patients with diagnostic metastasis, perioperative chemotherapy should also be considered.

In patients with ǁupfront surgery, chemotherapy should always be performed (the exceptionbeing the patient previously polytreated with lifesaving surgery). The adjuvant schemes used are FOLFOX or CAPOX, it is not recommended to perform adjuvant monoclonal antibodies.

In patients with potentially resectable hepatic or pulmonary disease, prior systemic treatment should be considered.

Among patients with unresectable disease, there are 2 groups: those who will never be resectable and those who will be converted, after systemic treatment.

Conversion treatment aims to make unresectable metastases resectable. Resectability should be studied between 2 and 4 months after treatment since the rate of resectioncorrelateswith the response to systemic treatment.

There is no consensus on the best conversion scheme. Consider the laterality of the primary.

In patients with wild-type RAS/BRAF and left primary the options are: QTP doublet + anti EGFR, (or FOLFOXIRI + anti EGFR there are phase 2 studies with high response rates).

In patients with wild-type RAS/BRAF and primary right the options are triplet alone or Triplet + Bevacizumab, or Doublet + Bevacizumab.

In patients with mutated RAS/BRAF and left primary the options are: FOLFOXIRI + bevacizumab, or doublet + bevacizumab.

In patients with mutated RAS/BRAF and primary right the options are: triplet alone or Triplet + bevacizumab, or doublet + bevacizumab.

Patients with mutated BRAF, considered a subgroup of malpractice, maybe treated with triplets and bevacizumab.

It should be borne in mind that very prolonged induction treatments deteriorate the reserve.

functional hepatic and can complicate the evolution or postoperative n.

In some selected patients withmetastatic diseasein unfavorable or infrequent sites and ablative treatments with or without surgery may be considered: It is recommended to start the best systemic treatmentto induce response. When the best response is obtained‖ thestrategies available for local treatment are evaluated, these may include: ablative treatment (surgery, radiofrequency ablation, microwave, cryoablation), SBRT, embolization (radius or chemoembolization).

In correctly selected patients with peritoneal disease (favorable peritoneal index),

cytoreduction surgery and HIPEC can be considered. Itshould only be considered in experienced centers.

Within the patients subject to treatment with unresectablemetastatic disease there are 3 categories:

- Group 1A: Intensive treatment to obtain cytoreductionand conversionto resectable or passible for use ablation techniques.

- Group 1B: Intensive treatment to obtaina rapidreductioninthe volume of disease due to imminent clinical threat, or organ dysfunction or severe symptoms.

- Group 2: Does not require intense treatment and the objective is disease control.

The options as first lines of treatment are the doublets: FOLFOX, CAPOX, FOLFIRI. In selected patients, triplets such as FOLFOXIRI. Treatment with fluoropyrimidines as a monodrug is an optionin asymptomatic, unresectable patients who are not candidates for drug combination.

Biological agents are indicated in most patients in the first linefor metastatic disease. The anti-VEGF antibody, bevacizumab, is used in combination with FOLFOX, CAPOX, FOLFIRI, and FOLFOXIRI in selected patients, with the aim of improving response rate for eventual cytoreduction,especially toBRAF mutation. It is alsoassociated withfluoropyrimidines in patients who do not tolerate doublets. In patients with wild type RAS, another optionis anti-EGFR antibodies that can be combined with FOLFOX or FOLFIRI. Anti-EGFR therapy with capecitabine is not recommended.

Bevacizumab is more active in primary tumors of the right colon, while anti-EGFR is more active in the left. There is stillcontroversy as to the order in which the schemes should be indicated. The truth is that all patients who are candidates for treatment should receive all available biologic and agents, a strategy known as a continuum of care‖.

After an initial induction treatment, one options maintenance.

Initial outline	Maintenance
FOLFOX + Bevacizumab	Fluoropyrimidines + Bevacizumab
CAPOX + Bevacizumab	Fluoropyrimidines + Bevacizumab
FOLFIRI + Bevacizumab	Fluoropyrimidines + Bevacizumab
FOLFOXIRI + Bevacizumab	Fluoropyrimidines + Bevacizumab

When there are symptoms or images of progression, the initial scheme can be reintroduced or rotated to the second line.

Second-line treatments recommended in patients who maintain good performance. The choice scheme depends on the one used in the initial line, the response to that scheme and the duration of the response.

Firstline	Second line options
QTP ± Anti-EGFR	Another QTP + bevacizumab scheme
QTP + Bevacizumab	Another QTP + bevacizumab or FOLFIRI + ramucirumab regimen (if baseline was FOLFOX)
QTP ± Bevacizumab	FOLFIRI or irinotecan + anti-EGFR (RAS WT)

In third-line treatment, in RAS and BRAF wild type patients, who have not received anti-EGFR (cetuximab or panitumumab), these antibodies should be considered an option. They are preferred to be used in combination chemotherapy.

In colorectal tumors with microsatellite instability (dMMR or MSI-H), pembrolizumab, or Nivolumab may be used after progressionto fluoropyrimidines, oxaliplatin, and irinotecan.

Other options are regorafenib and trifluridine-tipiracil in patients progressed to fluoropyrimidines, oxaliplatin, irinotecan, bevacizumab, and anti-EGFR. One consideration how to administer the Regorafenib, the current trend is to start the 1st cycle with low doses and increase the dose weekly (80 mg / dayiat week 1, 120 mg / d week 2 and 160 mg / d week 3 if toxicity does not appear grade 2 or more: phase 2 study REDOS).

Another therapeutic strategy is the re-exposure to previouslyused drugs, considering whether I leave it in response and the progression-free interval.

For unapproved treatments, there is preliminary evidence for the use of the combinationof encorafenib-binimetinib + cetuximab or panitumumab in tumors with BRAF V600E mutation.

When prompt response is required, by aggressive biology or in symptomatic patients, doublet + anti-EGFR or bevacizumab according to RAS is suggested, and in selected patients' triplet ± bevacizumab.

When the goal is to delay progression or n doublet + anti-EGFRor bevacizumab according to RAS is also recommended, and in selected patients another options triplet ± bevacizumab.

In patients with good response or at least disease control, maintenance treatment may be considered. If progression occurs during maintenance inthe first few months, consider rotating to another treatment line. On the other hand, if it happens later, the complete scheme of 1o line can be reintroduced. In elderly

patients with good general condition the recommended treatment is the same as in young people, since the same benefit is expected.

Chemotherapy Regimens cancer colorectal
Capecitabine 2,500 mg/m2d ia 1-14 every 21 days.
5-Fu bolo:
Roswell Park: Fluorouracil 500 mg/m2 bolus + Leucovorin 500 mg/m2 weekly x 6 every 8 weeks Mayo Clinic: Fluorouracil 425 m/m2 bolus + Leucovorin 20 mg/m2d1-5 every 28 days
5-Fu infusional*:
De Gramont: Fluorouracil 400 mg/m2 bolus + Fluorouracil 2400 mg/m2 ic 48 hs + leucovorin 400 mg/m2 (there are different variants of this scheme)
Irinotecan
Irinotecan[1] 350 mg/m2 every 21 days
Irinotecan 180 mg/m2 every 14days
irinotecan 125 mg/m2 d ia 1, 8, 15, 22 every 42 days
Schemes with doubles
CAPOX every 21days
Oxaliplatin 130 mg/m2 + Capecitabine 1000 mg/m2 every 12 hours as 1-14

FOLFIRI every 14days

Irinotecan 180 mg/m2 + Fluorouracil 400 mg/m2 bolus + Fluorouracil 2400 mg/m2 CI + Leucovorin 400 mg/m2

FOLFOX 6 amended every 14days

Oxaliplatin 85 mg/m2 + Fluorouracil 400 mg/m2 bolus + Fluorouracil 2400 mg/m2 ic 46 hs + Leucovorin 200 mg/m2days1 and 2 each (there are different accepted variants)

Chemotherapy triplets

FOLFOXIRI every 14days

Irinotecan 165 mg/m2 + Oxaliplatin 85 mg/m2 + Fluorouracil 3200 mg/m2 ic 48 hs + Leucovorin 200 mg/m2

Monoclonal antibodies

Bevacizumab

5 mg/kg every 14 days (10 mg/kg may be administered in selected patients) 7.5 mg/kg every 21 daysassociated with fluoropyrimidines +/- Oxaliplatin

Cetuximab

weekly: loading dose 400 mg/m2 and 250 mg/m2 per week Maintenance every 14days: 500 mg/m2

Panitumumab:

6 mg/kg every 14days

Ramucirumab:

8 mg/Kg EV every 2 weeks as part of a scheme.

Other:

Regorafenib 160 mg dia 1-21 every 28 days

Trifluridine/Tipiracil 35 mg/m2 every 12 hours, days1-5 and 8-12 every 28 days

Pembrolizumab 200 mg EV every 21 daysNivolumab 240 mg EV every 14 days

480 mg EV every 28days

*Infusional or capecitabine-based schemes strongly suggested for greater efficacy

1 in case of severe toxicity evaluate UGT1A1 polymorphism in allele 28

2 in case of severe toxicity measured (dihydropyrimidine dehydrogenase) deficiency

General follow-up care program

First year after treatment

- Physical exam and CEA test every three to six months
- CT scans of the abdomen and chest every year (every six to 12 months for patients at high risk of recurrence)
- For patients with rectal cancer, a pelvic CT scan every six to 12 months
- Colonoscopy one year after surgery
- Rectosigmoidoscopy every six months for patients with rectal cancer who did not receive radiation therapy to the pelvis

Second year after treatment

- Physical exam and CEA test every three to six months
- CT scans every year (every six to 12 months for patients at high risk of recurrence)
- For patients with rectal cancer, a pelvic CT scan every six to 12 months
- Recto sigmoidoscopy every six months for patients with rectal cancer who did not receive radiation therapy to the pelvis

Third year after treatment

- Physical exam and CEA test every three to six months
- CT scans every year (every six to 12 months for patients at high risk of recurrence)
- For patients with rectal cancer, a pelvic CT scan every six to 12 months
- Recto sigmoidoscopy every six months for patients with rectal cancer who did not receive radiation therapy to the pelvis

Fourth year after treatment

- Physical exam and CEA test every three to six months
- For patients with rectal cancer, a pelvic CT scan every year
- Recto sigmoidoscopy every six months for patients with rectal cancer who did not receive radiation therapy to the pelvis

Fifth year after treatment

- Physical exam and CEA test every three to six months
- For patients with rectal cancer, a pelvic CT scan every year
- Recto sigmoidoscopy every six months for patients with rectal cancer who did notreceive radiation therapy to the pelvis

What this means for patients

Regularly scheduled follow-up care helps increase the likelihood of discovering a treatable recurrence. Discussing your risk of recurrence is important as you approach the end of your cancer treatment. There are prediction tools on the Internet to help your doctor better estimate your risk of recurrence. Knowing this information helps your doctor develop an appropriate follow-up care plan. Talk to your doctor about your risk of recurrence and how it affects your follow-up care program. Many people who finished colorectal cancer treatment received follow-up care through their primary care doctor. Your oncologist can provide you and your primary care doctor with a written summary of your treatment, as well as recommendations for your follow-up care.

In addition to regular follow-up care, people recovering from colorectal cancer are advised to follow established guidelines for good health, including maintaining a healthy weight, exercising, not smoking, eating a balanced diet, and getting recommended cancer screenings. Talk to your doctor about the plan that best fits your needs.

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