North West
Rectal Cancer Complete Response Registry
Spring 2014 Newsletter

26/02/2014 Issue 1

Registry Phase 2 launch

The four Cancer Networks taking part in the audit

Each year in the UK, there are approximately 15,000 new cases of rectal cancer. For many patients with locally advanced disease, pre-operative chemo-radiotherapy (CRT) will be offered, followed by resection surgery 10 to 15 weeks later.

By 2009, we in the North West, and others internationally, recognised that in 15% to 20% of cases, CRT may result in complete disappearance of tumour. In patients without tumour on imaging and endoscopy (clinical complete response [cCR]) a 'watch and wait' policy might be considered as an alternative to major resection.

At the time, this represented a new paradigm for treating rectal cancer. So a Registry was established from the four neighbouring cancer networks: Greater Manchester & Cheshire, Merseyside & Cheshire, North Wales, and Lancashire & South Cumbria. The data have been coordinated at the Christie through Laura Morrison.

The figures below show that phase 1 (baseline collection) has been a great success - thank you to those contributors.

In March 2014, we will launch phase 2 of this project - we will be conducting a 2 to 3 year follow-up with the aim of undertaking a case-control study to evaluate the oncological outcomes of a 'watch and wait policy 'in an 'off-trial' multi-centred setting in the North West of England.

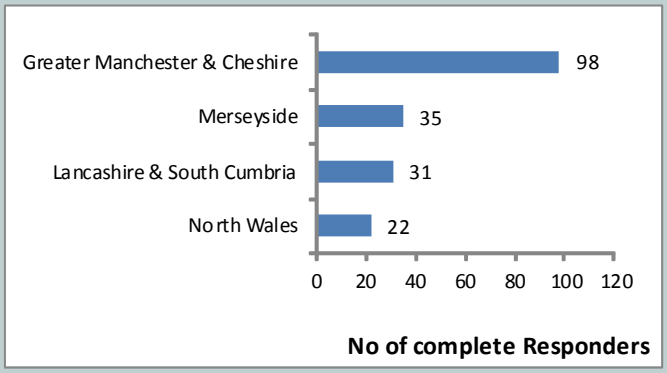
Thanks to grant support from the Bowel Disease Research Foundation, we are funding a new project-specific senior audit coordinator, Lee Malcomson, who will collect these longitudinal data, and with our statisticians at the University of Manchester, analyse the data.

The Registry 2009 to current

To date, we have had 186 cases submitted to the Rectal Cancer Complete Response Registry. The registry is open to clinical and pathological complete responses.

Of the 186 registered cases, 127 are clinical complete responders on an 'active' watch and wait policy.

It has been great that all four (former) Networks have contributed patients to the registry. But it is likely that these numbers are an underestimation.



The number of complete responders submitted by each Network

Registration is through a one-page pro forma via the contact e-mail on the following page, in patients: (i) with pathological complete response after major resection; or (ii) with clinical complete response and offer 'watch and wait', typically determined around the time of the post-CRT re-assessment.

In this issue:

Steering committee

Professor Andrew Renehan, Colorectal Surgeon, The Christie NHS Foundation Trust & University of Manchester

Dr Simon Gollins, Clinical Oncologist, North Wales Cancer, Treatment Centre

Dr Mark Saunders, Clinical Oncologist, The Christie NHS Foundation Trust

Mr Nigel Scott, Colorectal Surgeon Royal Preston Hospital

Dr Shabbir Susnerwala, Clinical Oncologist, Royal Preston Hospital

Professor Arthur Sun Myint, Clinical Oncologist, Clatterbridge Cancer Centre, Liverpool

Miss Sarah T O'Dwyer, Colorectal Surgeon, The Christie NHS Foundation Trust

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Professor Renehan's Report from the Champalimaud Foundation International Consensus Meeting

The first International Consensus Meeting on "Rectal Cancer, when not to operate" was recently hosted by the Champalimaud Foundation Lisbon, Portugal. A multidisciplinary audience of over three hundred delegates from many European and American countries participated. The faculty of speakers included world leaders in the field of complete response in rectal cancer – and included Professors Habr-Gama (Sao Paulo), Perez (Sao Paulo) and Beets (Maastricht), and Mr Philip Paty (Sloan-Lettering Memorial, NY).

In a packed programme, many clinical, radiological and pathological issues were presented and debated. Here, are a flavour of some of the key messages:

- The definition of clinical complete response (cCR) includes findings from endoscopy and MR imaging. Findings from biopsy lack specificity.
- Several speakers showed that the proportion of cCRs increases with time since end of chemo-radiotherapy, but the matter of 'when' in the definition is not clearly established.
- Presently, the main setting of cCR is after long-course chemo-radiotherapy. However, the meeting also recognized that there are ongoing trials of short-course radiotherapy with long internals to re-assessment, and that cCRs are observed in this setting.
- An active decision to 'watch and wait' rather than operate is becoming standard care in several countries, but currently, the perception is that this practice varies widely.
- The meeting recognized an additional group of patients with 'near complete' clinical response. In these patients, the potential roles of TEM and local radiotherapy techniques were discussed, though without broad agreement on exact indications and outcomes.
- Intra-luminal re-emergence of disease after watch and wait occurs. The meeting agreed that these should be termed 're-growths' to distinguish from local recurrence after conventional rectal cancer treatment – the former can be readily salvaged; the rather generally confer a poor prognosis.
- The cited re-growth rates are partly determined by the definition of the denominator group – and are likely to vary between 10% and 20%.
- The meeting emphasized the need to develop and establish patient-reported assessment tools to evaluate functional outcome to better compare different approaches to managing rectal cancer. These should inform patient decision, not just patient consent.

The Data Management Team from left to right:

Lee Malcomson, Laura Morrison and Professor Andrew Renehan