West of Scotland Cancer Network

Colorectal Cancer
Managed Clinical Network

Colorectal Cancer

Regional Follow-up Guidelines

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Approved by	Colorectal Cancer MCN Advisory Board
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Colorectal Cancer Regional Follow-up Guidelines Review

The purpose of the Colorectal Cancer Regional Follow-up Guideline is to ensure consistency of practice across the West of Scotland and periodic review of the follow-up guidelines will continue to ensure that management of patients after initial treatment for Colorectal Cancer are:

- Patient-centred;
- Aligned to recognised current best practice;
- Equitable across the region;
- Clinically safe and effective; and
- Efficiently delivered.

The guideline is reviewed on the basis that the key aims underpinning the purpose of follow-up are to:

- Manage and treat symptoms and complications;
- Provide psychological and supportive care; and
- Detect and treat recurrent disease.

Follow-up practice should be patient-centred and, ideally, supported by empirical evidence demonstrating improved outcomes and survival. In the absence of good quality evidence, care should be tailored to the needs and preference of individual patients; construction of appropriate follow-up guidance requires balancing perceived patient needs with effective utilisation of resources.

Following review, the resultant regional MCN guideline, described in detail in Appendix 1, has been produced taking into consideration current evidence on follow-up after apparently curative resection of colorectal cancer. Given the continuing lack of evidence to support any single follow-up strategy, these guidelines represent safe, effective and efficient practice. The guideline recommends a less intense approach to follow-up for low risk patients and for those patients who, for clinical reasons, missed the window for adjuvant therapy but would likely be fit for further intervention if required.

The guidelines should not supersede clinical judgement or specific patient requests in determining management of individual patients and should be used as a minimum standard when considering local implementation. For example, patients who are proven or suspected as having an inherited predisposition to bowel cancer for whom more frequent colonoscopic surveillance has been advised (usually 2 yearly) should continue to receive this in addition to the follow up recommended herein.

The guidelines are recommended for implementation across the region and it is proposed that compliance is monitored with regular feedback to the Advisory Board from local MDT lead clinicians. The MCN does not intend to prospectively audit activity through the regional audit programme, as routine and reliable capture of follow-up data is very resource intensive. Nurse-led follow-up is encouraged by the MCN, either face to face or by telephone or virtual connection, but it is recognised that this may not always be possible in every locality. The MCN will review these guidelines periodically to ensure continued relevance and alignment to recognised good practice.

According to the MCN published Clinical Management Guidelines, rectal cancer patients who demonstrate a complete response to neo-adjuvant chemo-radiotherapy may be placed on an active surveillance follow-up pathway. The patient diary at Appendix 2 provides an overview of what a patients expected surveillance pathway would involve. After 5 years with no signs of progressive disease, these patients will be discharged.

Appendix 1

MCN Colorectal Cancer Follow-up Guidelines

Follow -up Pathway	Patient Group	Risk Stratification	Follow-up Year 1			Follow-up Year 2		Follow-up Year 3	Follow-up Year 4	Follow up Year 5
			6w	6m	1yr	18 m	2 yr			
Patient Directed	**Significant comorbidities**	Not fit for adjuvant therapy or further surgery in the event of recurrence	Clinic review	Patient discharged from follow up [3]						
Post-Surgical Active Follow up	**Stage 1** **Stage 2**	**Low risk** (no nodal involvement & no EMVI)	Surgical Clinic review	Surgical Clinic review [4] **CEA**	Surgical Clinic review[4] **CEA** **CT CAP** **Colonoscopy**[7]	Surgical Clinic review[4] **CEA**	Surgical Clinic review[4] **CEA** **CT CAP**	Surgical Clinic review[4] **CEA, CT CAP** **End of Follow up**	**Colonoscopy**[7] Patients encouraged to continue participating in Bowel screening.	
Intensive Post Adjuvant Treatment [5]	**Stage 2** **Stage 3**	**High Risk**	Surgical Clinic review	Clinic review [4] **CEA**	Clinic review [4] **CEA** **CT CAP** **Colonoscopy**[7]	Surgical Clinic review[4] **CEA**	Surgical Clinic review[4] **CEA** **CT CAP**	Surgical Clinic review[4] **CEA, CT CAP** **End of Follow up**	**Colonoscopy**[7] Patients encouraged to continue participating in Bowel screening.	
Radically treated Metastatic Disease (Surgeon and Oncologist discretion) [6]	**Stage 4**		Surgical Clinic review	Clinic review [4] **CEA** **CT CAP**	Clinic review [4] **CEA** **CT CAP** **Colonoscopy**[7]	Clinic review [4] **CEA** **CT CAP**	Clinic review [4] **CEA** **CT CAP**	Clinic review [4] **CEA, CT CAP**	Clinic review [4] **CEA**, **CT CAP** **Colonoscopy**[7]	Clinic review [4] **CEA**,**CT CAP**

Notes: 1) Patients who have been identified as requiring regular colonoscopic surveillance e.g. for Lynch Syndrome, should continue to receive this.
2) All patients should have their CEA checked at time of diagnosis.
3) Patients & GP should have access to easy referral back to the service via the colorectal CNS in the event of any colorectal concerns.
4) Although Specialist nurse led follow up is the preferred option, the WOS MCN acknowledges that this might not be possible in every Health Board. Therefore, Clinic Follow up could be Specialist nurse or doctor delivered, and either face to face (F2F) or telephone consultation.
5) High Risk patients will be discharged from Oncology follow up upon completion of their adjuvant treatment and will be followed up in the surgical clinic thereafter.
6) 5 year Follow up is only considered for stage 4 patients with radically treated metastatic disease.
7) Year 1 and year 4 follow up colonoscopy are the gold standard, The MCN recognises that if there is no local capacity then the fall-back position is a year 3 colonoscopy.

In the case of an incomplete preoperative Colonoscopy, a completion post op Colonoscopy should be done within the first 6 months.
Patients with Polyps should be followed up as per the agreed polyp follow up guidelines.
Patient that are complete pathological responders following neoadjuvant CRT will follow the active surveillance (Watch & Wait) pathway.
More frequent imaging may be required following MDT discussion.
Given that there is no firm evidence base to support any single follow up strategy, these guidelines should not supersede clinical judgement in the management of individual patients.

Appendix 2

MCN CRC Follow-up – Active Surveillance for Rectal Cancer Patient Demonstrating Complete Response to Neo-Adj Chemo-Rad

WOS MCN
Active Surveillance follow-up diary for Complete Pathological Responder Patients
(rectal Cancer patients)

Addressograph

Diagnosis .....

Date of Diagnosis .....

Surgery .....

Consultant .....

Specialist Nurse .....

Year one
Flexible sigmoidoscopy (with photographs) and rectal exam at:
- 6 weeks after the post treatment assessment
-12 weeks (3 months)
-18weeks
- 26 weeks (6 months)
- 38 weeks (9 months)
- 52 weeks (12 months)

MRI assessment at:
4months after the post treatment assessment
8 months
12 months

Year 2
Flexible sigmoidoscopy at:
4 monthly intervals
MRI at:
6 monthly intervals

Year 3-5
Flex sigmoidoscopy at:
6 monthly intervals
MRI at:
6-12 months intervals

After completing 5 years of active surveillance follow up you will be discharged back to your GP.

We would then encourage you to take part in the Bowel Screening Programme if you are 50 to 74 years of age.

The timings of surveillance investigations (eg flexible sigmoidoscopy) indicated overleaf are an approximation; if you have not received notification of your appointment for MRI scan or sigmoidoscopy within 6 weeks of the interval stated then please contact one of our specialist nurses:

Sister Loraine
Tel.: 0141-451

Sister Stephanie
Tel.:0141-451

Sister Bridget
Tel.: 0141-451

Sister Margaret
Tel.: 0141-451