بوی باران، بوی سبزه، بوی خاک
عطر نرگس، رقص باد
آمده اینک بهار
خوش به حال روزگار

هفت سین ایرانی

Panel subject:
RECTAL CANCER

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- **Case 1**

- A 56 year old man who is a retired english high school teacher has come to you with the complaint of rectal bleeding and recent bowel habit change.

- He tells that has had bleeding since 1 year ago, firstly was less, but he did not care, with passing the time it became more and pain added to it, also his defecation has worsened in recent 3-4 months.

- PMH: mild HTN since 6 years ago
- **FH: his father died of stomach cancer 7 years ago**
- HH: sometimes smokes since youth

- **What further Qs do you ask?**

- Other symptoms such as: his rectal bleeding form, WL, cough, bone pain, headache …

- **What do you do now?**

- **Ph/E?**

Alert and conscious, not pale,

no LAPs, Lung and spines: Nl

AP: Nl.

Wt: 76 Kg, Ht: 171 cm

TR: Nl

- **Lab data includes:**

CBC, BUN/Cr, LFT, FBS&Lip: Nl

ESR, LDH, Ca/P: Nl

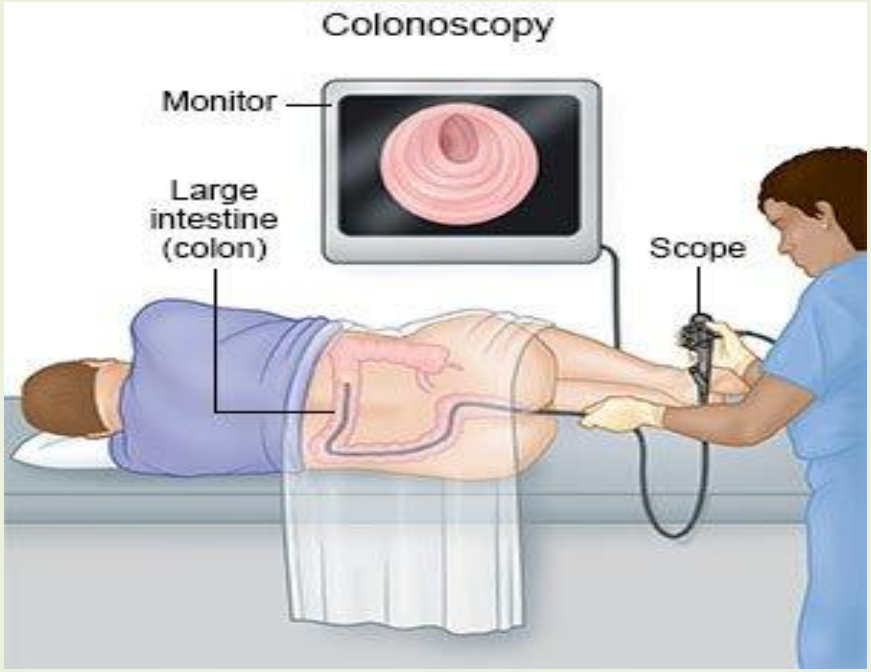
CEA: 48, CA19-9: 78

PSA: Nl

PT, PTT, BT: Nl

- **What do you do now?**

- **Total Colonoscopy**



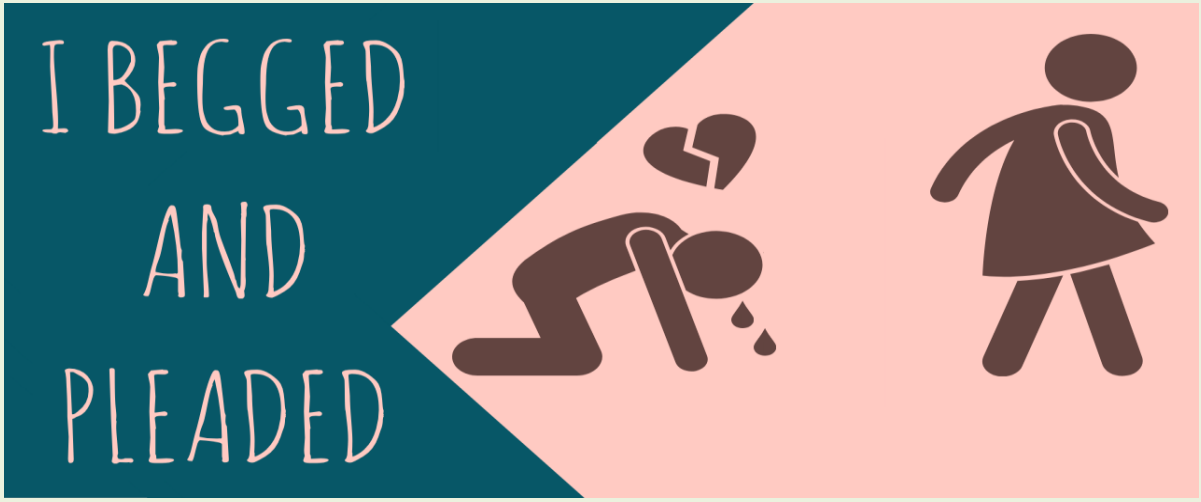
- Just an ulcerated mass in 11 cm above AV, multiple biopsies were taken, scope passed easily.

- **Path. Report: Adenocarcinoma, G2**

What do you do now?

- Can we do surgery now?
- Or further W/U needed, then make correct decision?

- I beg you please let’s go to approach like a professional and skilled physician.

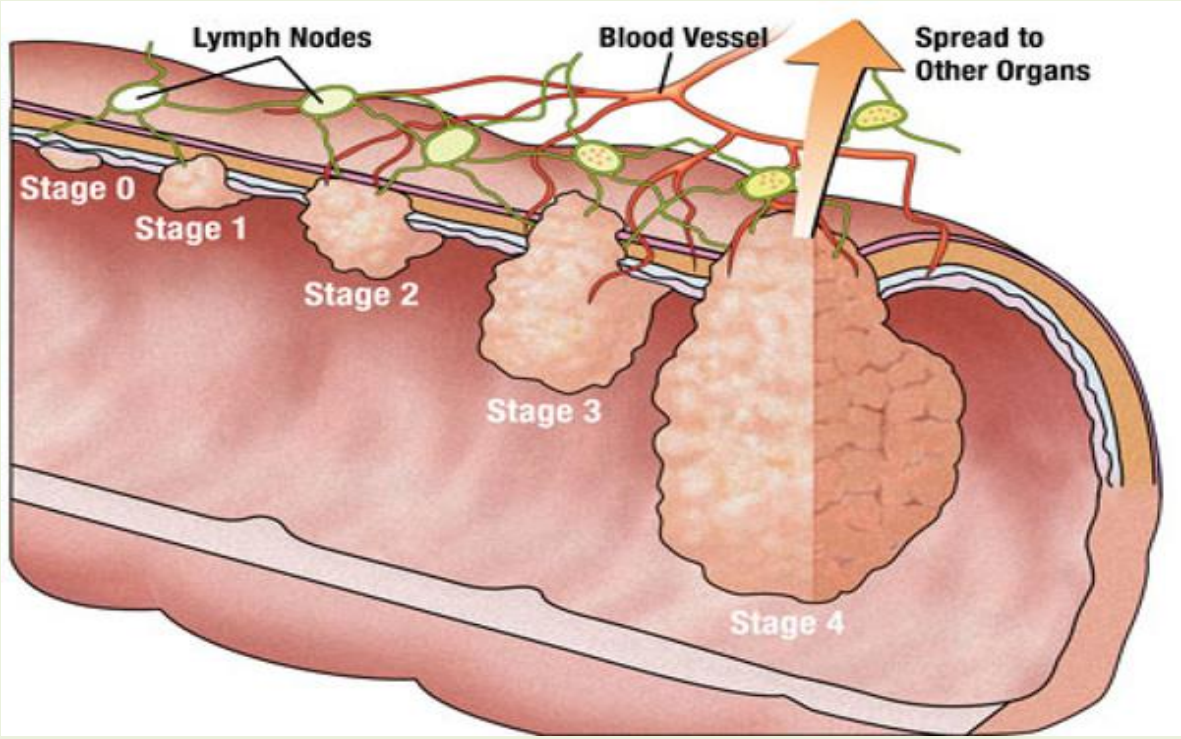


- Please at least ask 1-**CEA**, do 2-**chest & AP CT-scan with cont. and** 3-**PMRI+-GAD** **before** making decision to treat these patients.

A very important point:

Complete staging

is critical.



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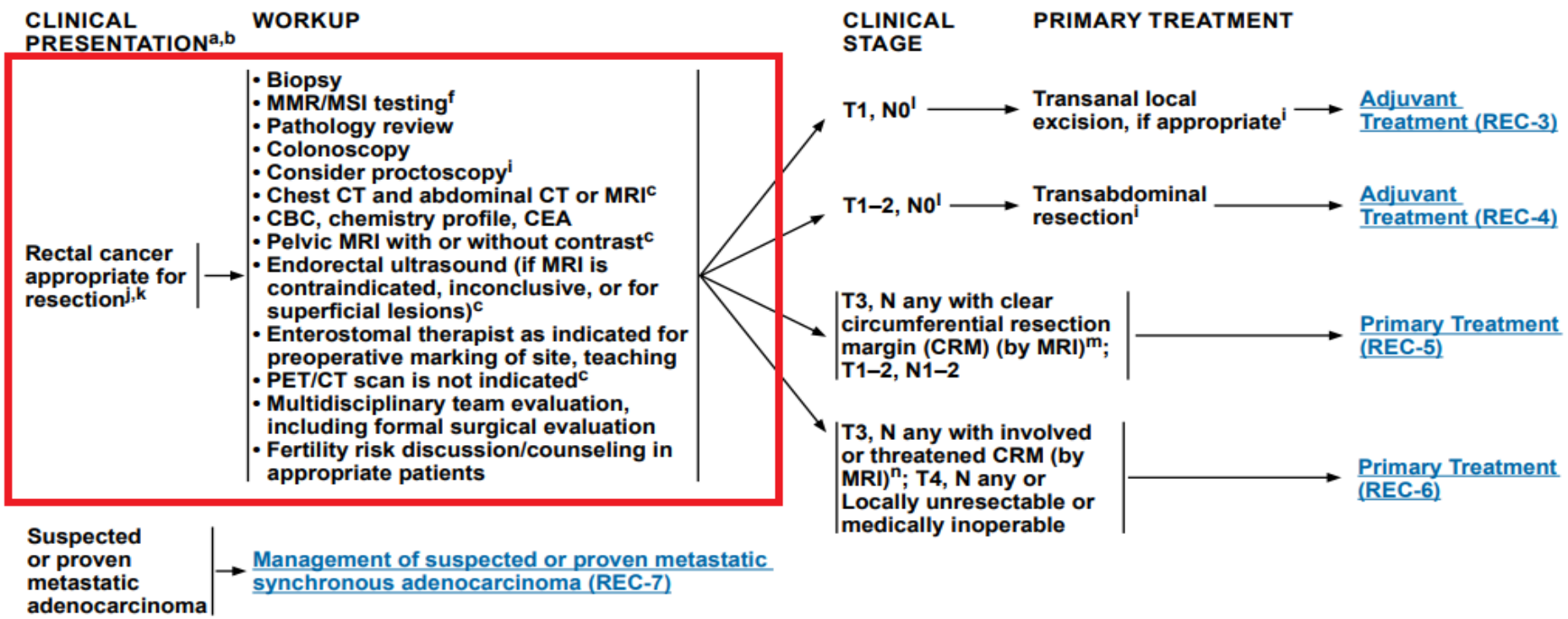

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Lynch Syndrome

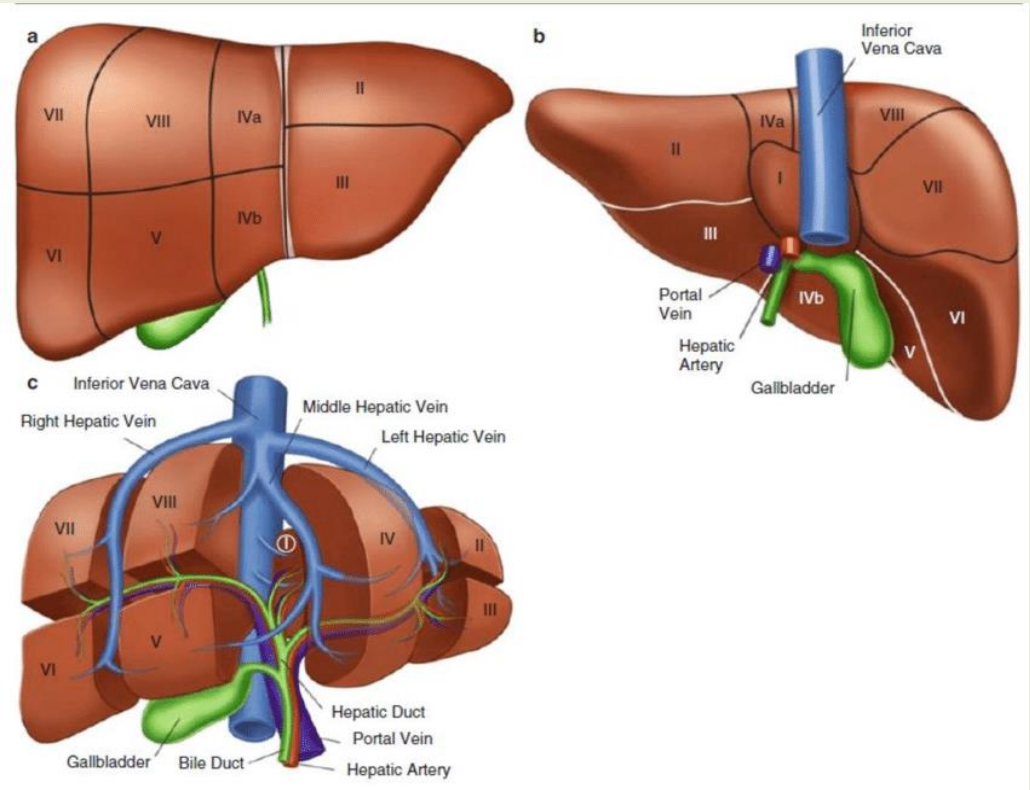
CRITERIA FOR THE EVALUATION OF LYNCH SYNDROME

- Known LS pathogenic variant in the family
- Personal history of a tumor with MMR deficiency determined by PCR, NGS, or IHC diagnosed at any age[a] (See LS-A)
- An individual with colorectal or endometrial cancer and any of the following:
  - Diagnosed <50 y
  - A synchronous or metachronous LS-related cancer[b] regardless of age
  - 1 first-degree or second-degree relative with an LS-related cancer[b] diagnosed <50 y
  - ≥2 first-degree or second-degree relatives with an LS-related cancer[b] regardless of age
- Family history[c] of any of the following:
  - ≥1 first-degree relative with a colorectal or endometrial cancer diagnosed <50 y
  - ≥1 first-degree relative with a colorectal or endometrial cancer and a synchronous or metachronous LS-related cancer[b] regardless of age
  - ≥2 first-degree or second-degree relatives with LS-related cancers,[b] including ≥1 diagnosed <50 y
  - ≥3 first-degree or second-degree relatives with LS-related cancers[b] regardless of age

- Chest CT-scan: Nl

- **Abd CT-scan: 2 lesion in liver, a 27*18 mm in seg. 3 and a 22*20 mm in seg. 2.**

- PMRI: CRM+, T3N1



- **Dynamic liver MRI+-GAD needed.**

- **Highly suggestive for liver metastases.**

- **Doing liver biopsy under guide or not?**

- **Now what should you do?**

- **Can we start treatment now?**

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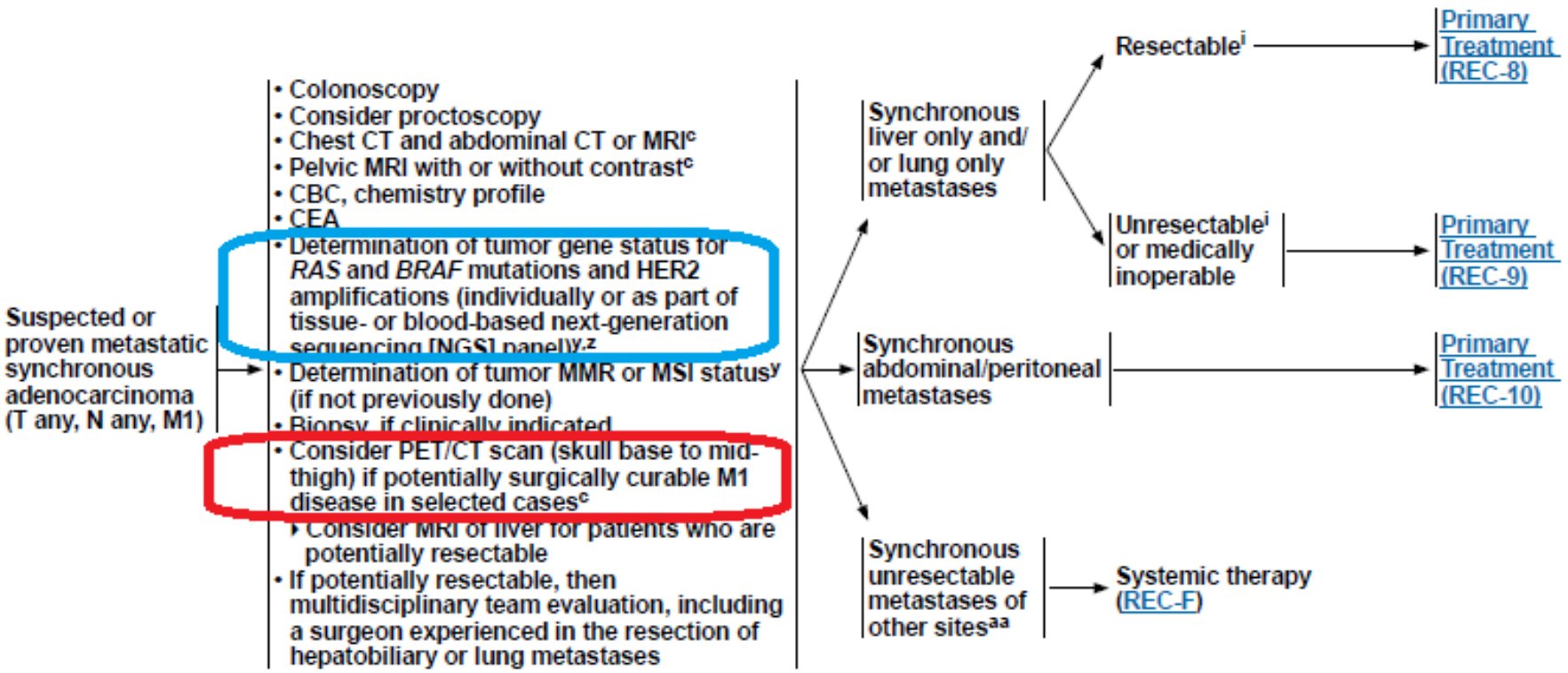

Now do surgery or nCht?

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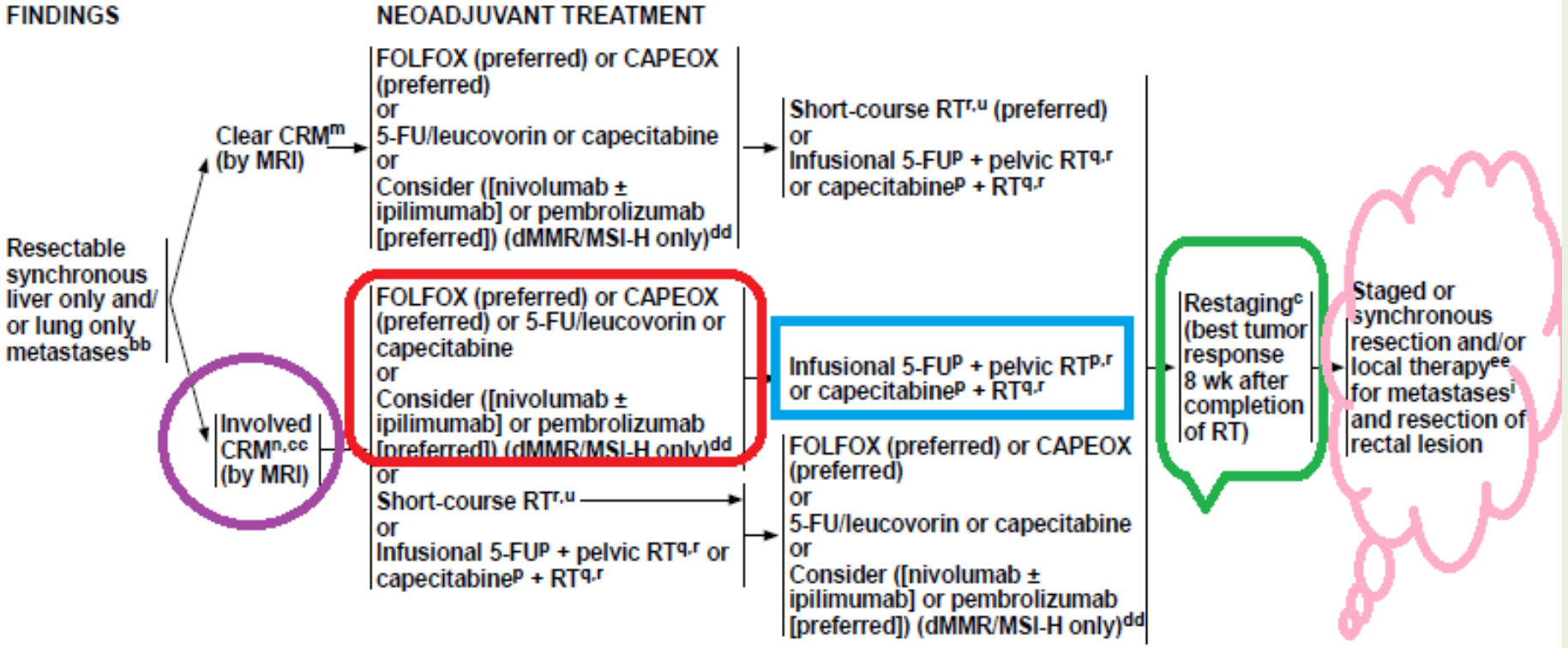


- After 4 months of XELOX, he is much Better. **Tumor markers: NI**

- XRT?

- Restaging?

- The Pt. received XELOX and then CRT, restaging done, lesions decreased in size, then synchronous surgery done successfully.

- How to F/U him?

SURVEILLANCE[c]

Transanal local excision only →
- Proctoscopy (with endoscopic ultrasound [EUS] or MRI with contrast) every 3–6 mo for the first 2 y, then every 6 mo for a total of 5 y
- Colonoscopy[a] at 1 y after surgery
  - If advanced adenoma, repeat in 1 y
  - If no advanced adenoma,[hh] repeat in 3 y, then every 5 y[ii]

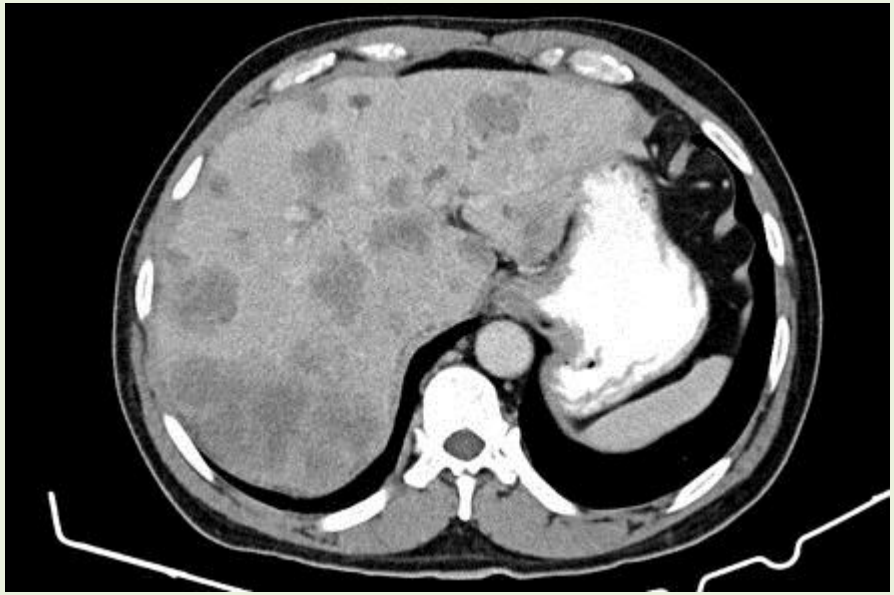
Stage I with full surgical staging →
- Colonoscopy[a] at 1 y after surgery
  - If advanced adenoma, repeat in 1 y
  - If no advanced adenoma,[hh] repeat in 3 y, then every 5 y[ii]

Stage II–IV →
- History and physical examination every 3–6 mo for 2 y, then every 6 mo for a total of 5 y
- CEA[ii] every 3–6 mo for 2 y, then every 6 mo for a total of 5 y
- Chest/abdominal/pelvic CT
  - Stage II, III: every 6–12 mo (category 2B for frequency <12 mo) for a total of 5 y
  - Stage IV: every 3–6 mo (category 2B for frequency <6 mo) x 2 y, then every 6–12 mo for a total of 5 y
- Colonoscopy[a] in 1 y after surgery except if no preoperative colonoscopy due to obstructing lesion, colonoscopy in 3–6 mo
  - If advanced adenoma, repeat in 1 y
  - If no advanced adenoma,[hh] repeat in 3 y, then every 5 y[ii]
- PET/CT scan is not recommended
- Principles of Survivorship (REC-G)

→ Serial CEA elevation or documented recurrence → Workup and Treatment (REC-12)

- After 4 yrs of Tx, he has CEA rise.

- What do you do now?



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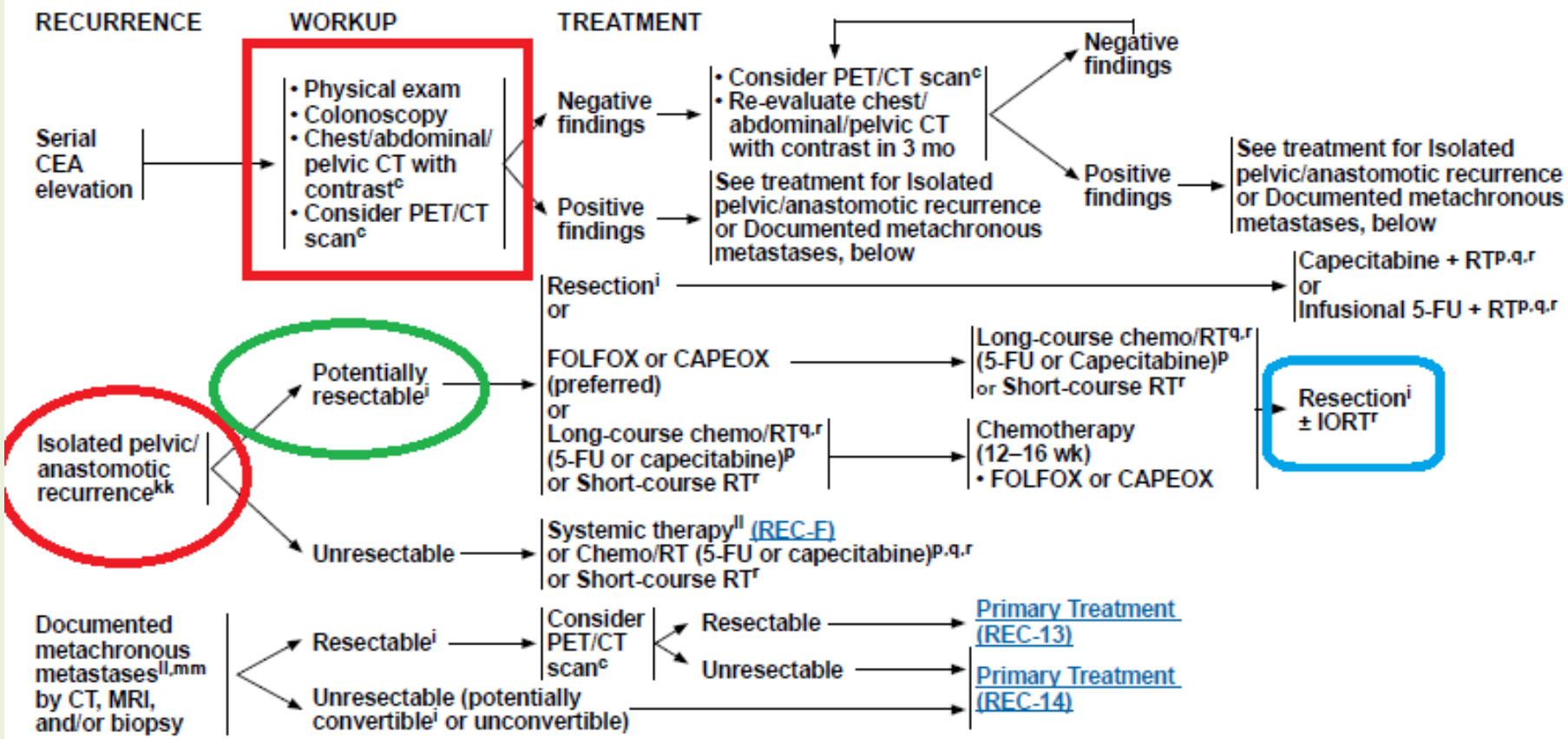

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CONTINUUM OF CARE - SYSTEMIC THERAPY FOR ADVANCED OR METASTATIC DISEASE[a,b]

INITIAL THERAPY[c]

Intensive therapy recommended

- FOLFOX[d] ± bevacizumab[e] → Progression → REC-F (2 of 13)
- or CAPEOX[d] ± bevacizumab[e] → Progression → REC-F (2 of 13)
- or FOLFOX[d] + (cetuximab or panitumumab)[f] (*KRAS/NRAS/BRAF* WT) → Progression → REC-F (2 of 13)
- or FOLFIRI[g] ± bevacizumab[e] → Progression → REC-F (3 of 13)
- or FOLFIRI[g] + (cetuximab or panitumumab)[f] (*KRAS/NRAS/BRAF* WT) → Progression → REC-F (3 of 13)
- or FOLFIRINOX[d,g,h] ± bevacizumab[e] → Progression → REC-F (4 of 13)
- or ([Nivolumab ± ipilimumab] or pembrolizumab [preferred]*)[i,j,k,l] (dMMR/MSI-H only)[f] → Progression → REC-F (5 of 13)

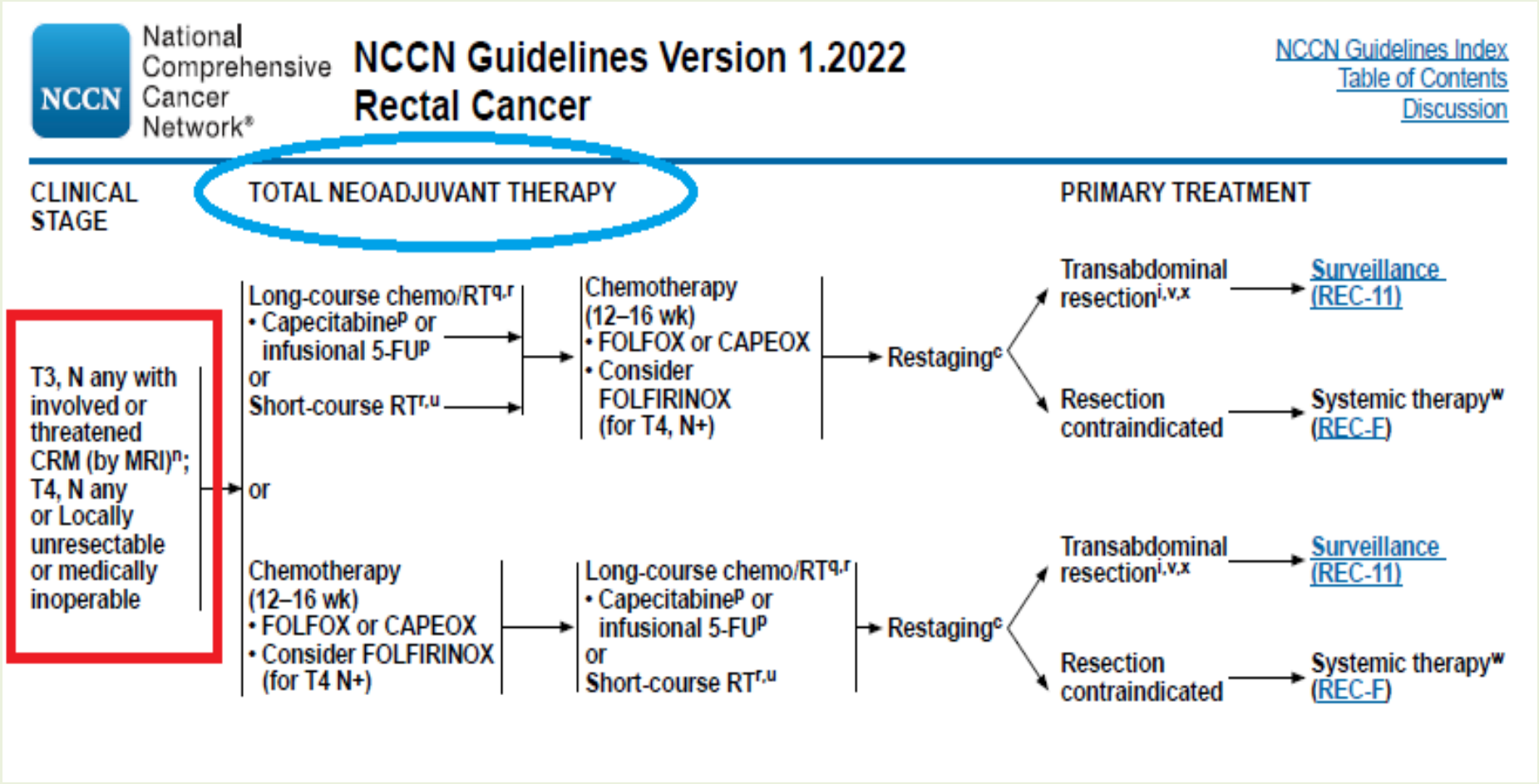
Intensive therapy NOT recommended

- 5-FU ± leucovorin ± bevacizumab[e]
- or Capecitabine ± bevacizumab[e]
- or (Cetuximab or panitumumab)[f] (category 2B) (*KRAS/NRAS/BRAF* WT)
- or (Nivolumab or pembrolizumab [preferred]*)[i,j,k,l] (dMMR/MSI-H only)[f]
- or Nivolumab + ipilimumab*[i,j,k,l] (dMMR/MSI-H only)[f] (category 2B)
- or (Trastuzumab[m] + [pertuzumab or lapatinib])[n] (HER2-amplified and *RAS and* BRAF WT)[f]

→ Progression
- Improvement in functional status → Consider initial therapy as above[o] or If previous fluoropyrimidine, REC-F (5 of 13)
- No improvement in functional status → Best supportive care See NCCN Guidelines for Palliative Care

- **Case 2**

- Chest CT-scan: Nl
- Abd CT-scan: Nl
- PMRI: CRM+, T3N1
- Tx?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CLINICAL STAGE
TOTAL NEOADJUVANT THERAPY
PRIMARY TREATMENT
T3, N any with involved or threatened CRM (by MRI)[n]; T4, N any or Locally unresectable or medically inoperable
Long-course chemo/RT[q,r]
• Capecitabine[p] or infusional 5-FU[p]
or
Short-course RT[r,u]
Chemotherapy (12–16 wk)
• FOLFOX or CAPEOX
• Consider FOLFIRINOX (for T4, N+)
Restaging[c]
Transabdominal resection[i,v,x]
Surveillance (REC-11)
Resection contraindicated
Systemic therapy[w] (REC-F)
or
Chemotherapy (12–16 wk)
• FOLFOX or CAPEOX
• Consider FOLFIRINOX (for T4 N+)
Long-course chemo/RT[q,r]
• Capecitabine[p] or infusional 5-FU[p]
or
Short-course RT[r,u]
Restaging[c]
Transabdominal resection[i,v,x]
Surveillance (REC-11)
Resection contraindicated
Systemic therapy[w] (REC-F)

In those patients who achieve a complete clinical response with no evidence of residual disease on digital rectal examination, rectal MRI, and direct endoscopic evaluation, a "watch and wait," nonoperative (chemotherapy and/or RT) management approach may be considered in centers with experienced multidisciplinary teams.

Thank you for your attention