

GUIDELINES & PROTOCOLS

ADVISORY COMMITTEE

Follow-up of Patients after Curative Resection of Colorectal Cancer

Revised 2004

Scope

This guideline provides follow-up recommendations for asymptomatic patients after curative resection of colorectal cancer. These recommendations are intended to rationalize follow-up of the initial cancer and to prevent the development of additional colorectal cancer. They do not apply to patients with familial adenomatous polyposis (FAP), hereditary non-polyposis colon cancer (HNPCC) or inflammatory bowel disease. Recommendations for the detection of colorectal neoplasms in asymptomatic patients are found in the guideline, *Detection of Colorectal Neoplasms in Asymptomatic Patients*.

RECOMMENDATION 1: Clearing colonoscopy

Ideally, colonoscopy should be performed pre-operatively. If this is not feasible, then it may be done three to six months post-operatively if no metastases were found. Air-contrast barium enema combined with sigmoidoscopy is an acceptable alternative where colonoscopy is not readily available.

RECOMMENDATION 2: Post-operative follow-up

After recovery from surgery, visits should only be scheduled as needed. The routine use of liver enzyme tests and abdominal ultrasound is not recommended in the absence of symptoms.

RECOMMENDATION 3: Tumour markers

The value of carcinoembryonic antigen (CEA) testing in the post-operative period is controversial and its usefulness is therefore limited. However, in individuals who would be candidates for resection of isolated hepatic or pulmonary metastases, serial measurement of CEA levels post-operatively (every three months for two years) may be of value in detecting recurrence that is treatable in up to 25 per cent of patients.

RECOMMENDATION 4: Prevention of new cancers

Repeat colonoscopy once every three years until no new adenomas are discovered. Thereafter, repeat colonoscopy every five years until the detection of new tumours is unlikely to influence the patient's lifespan. Air-contrast barium enema combined with sigmoidoscopy is an acceptable alternative where colonoscopy is not readily available.

RECOMMENDATION 5: Low rectal cancer

For patients who have undergone low anterior resection of rectal cancers, digital rectal examinations and proctoscopy or sigmoidoscopy should be undertaken at three months, six months, one year and two years to look for anastomotic recurrence. Thereafter, Recommendation 4 should be followed.

Rationale

Colorectal cancer (CRC) is the second leading cause of cancer-related deaths in North America. A number of circumstances increase the likelihood of developing CRC, including:

- previous history of CRC
- family history of CRC (first degree relative)
- history of colorectal adenomas
- chronic inflammatory bowel disease

The vast majority of CRCs develop from adenomas. In long-standing inflammatory bowel disease cancers usually develop from non-polypoid dysplasia which is not detected on barium enema.

Detection and removal of adenomas has been clearly demonstrated to reduce CRC mortality, and identification of cancer at an early stage markedly increases survival rates. Therefore, periodic surveillance of high-risk individuals is useful to reduce CRC mortality.

The typical growth rates of adenomas suggest that annual colonoscopy is no longer justified. The usual progression from normal mucosa to cancer is five to ten years. "Routine" clinical and laboratory follow-up to detect metastatic disease is seldom beneficial. In some cases, the detection of isolated liver metastases with subsequent treatment may improve survival.

Patients with low rectal cancer have higher rates of local recurrence and need closer surveillance of the anastomotic site. Resection margins for tumours above the rectum are generally wider and therefore colonoscopy need not be performed more frequently than every three to five years to detect anastomotic recurrence.

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Sponsors

This guideline, revised by the Guidelines and Protocols Advisory Committee, supersedes the guideline: *Follow-up of Patients after Curative Resection of Colorectal Cancer* developed in 1998 and revised in 2001. This revision has been approved by the British Columbia Medical Association and adopted by the Medical Services Commission.

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This guideline is based on scientific evidence current as of the effective date.

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- to encourage appropriate responses to common medical situations
- to recommend actions that are sufficient and efficient, neither excessive nor deficient
- to permit exceptions when justified by clinical circumstances.