



16th Annual WCGCC Conference

September 5 – 6, 2014

Saskatoon, SK

Consensus Statements

JOINT EC5-WC5 TOPIC: Use of EGFR1 in First-Line Metastatic Colorectal Cancer

(S. Berry)

- 1) What, if any, are the indications for first-line EGFR1 therapy in RAS wild-type metastatic colorectal cancer?
 - First-line anti-EGFR therapy represents an option to consider, especially in patients with relative contraindications to bevacizumab. The evidence is evolving. Decisions should be made in discussion with the patient with consideration given to quality of life and patient preference.
 - Expanded RAS testing provides optimal selection of these patients and should be considered standard of care for EGFR1 treatment.

LOCATION, LOCATION, LOCATION: What is The Best Way to Determine Rectal Tumor Location?

(F. Rashidi, D. Buie, E. Jones)

- 2) What is the best way to define the rectum and determine the location of a rectal tumor in clinical practice?
 - A multimodality assessment is recommended, incorporating both endoscopic and radiographic findings if there is any question regarding the location of the tumour in rectum versus sigmoid colon.
 - A standardized pre-operative MRI in combination with clinical & endoscopic examination by a surgeon who treats rectal cancer is recommended to determine location of a rectal cancer for staging and treatment purposes.
 - A standardized synoptic reporting of the MRI findings is recommended describing tumor location, depth, lymph node status, extramural vascular invasion, and distance of tumor or lymph nodes to the mesorectal fascia (circumferential resection margin) for treatment decision.

RADIATION THERAPY FOR RECTAL CANCER

(C. Doll, C. Lund, H. Kennecke)

- 3) What are the current indications for radiotherapy for early-stage rectal cancer?
 - For clinically T3/T4 or node positive rectal cancer, preoperative radiation is recommended.
 - If downstaging is required, chemoradiation therapy is the preferred option.
 - Chemoradiation therapy is recommended following upfront resection for patients with T3 or T4 tumors, positive circumferential margin, or lymph node involvement.
 - Low risk stage 2 rectal cancer such as T3 with a wide CRM, as defined by high resolution MRI, should be discussed at a multidisciplinary team meeting for optimal management.

CASE-BASED PANEL DISCUSSION: Multidisciplinary Management of Colorectal Cancer

(C. Doll, H. Kennecke, J. Tan, J. Park, Y. Luo)

- 4) What is the preferred adjuvant treatment in rectal cancer post neoadjuvant chemoradiation?
 - This decision is largely guided by the evidence extrapolated from the colon cancer literature and would be based upon the pre-operative staging.
 - For patients who received chemotherapy as part of long-course pre-operative chemoradiotherapy, fluoropyrimidine based chemotherapy with or without oxaliplatin for a total of 4 months is recommended.

- 5) What is the best sequence of local and systemic treatment in patients with resectable or borderline resectable advanced rectal cancer and synchronous liver metastases?
 - The best sequence of systemic and local therapies including sequencing of surgery is not well defined in patients with resectable or borderline resectable advanced rectal cancer and synchronous liver metastases.
 - For borderline resectable disease upfront systemic therapy is an option.
 - Treatment should be individualized based on the extent of primary and liver disease, patients' characteristics and local expertise after discussion in a multidisciplinary team meeting.

- 6) What is the role of liver directed therapy in patients with stage IV CRC with unresectable liver only disease?
 - The role of liver directed therapy in patients with stage IV CRC with unresectable liver only disease is currently not well defined.
 - It can be considered in selected patients after discussion in a multidisciplinary team meeting.