



Surgeons' choice for rectal cancer treatment if they were a patient

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Dear Editor

Rectal cancer management is discussed within multidisciplinary team meetings with treatment options stratified based on staging, patient choice and local expertise. These include surgical options such as local excision techniques or radical surgery^{1,2}. Patients with early rectal cancer without poor prognostic features may be offered local excision with or without adjuvant chemoradiotherapy³.

With the improvement of oncological outcomes and survival, quality of life is an essential component of rectal cancer care. Preoperative treatment (mainly radiotherapy) and surgery have a negative impact on pelvic organ function, including urinary, sexual and bowel dysfunction. A study demonstrated that

75 per cent of rectal cancer patients will eventually develop long-term bowel dysfunction, which affects quality of life significantly^{4,5}. As there are complex and multimodal treatment options for rectal cancer, it can be challenging for patients to decide on their treatment and also for healthcare professionals to counsel them.

The authors performed a survey to assess a surgeon's preference regarding rectal cancer management putting themselves in the position that they were the patient. The online questionnaire presented different clinical scenarios and was widely distributed via the International Society of University Colon and Rectal Surgeons (ISUCRS) database (300 international colorectal surgeons) and was advertised on ISUCRS social media platforms from 16–28 April 2020.

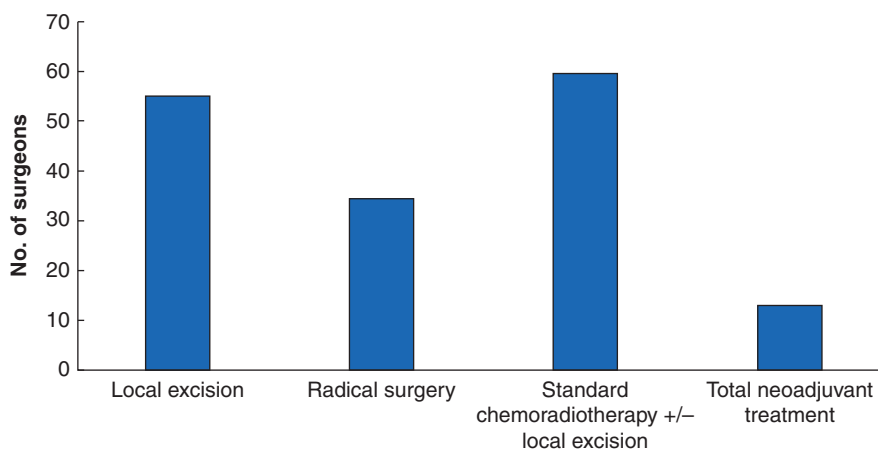


Fig. 1 Surgeons' choice for early low-rectal cancer treatment

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The survey was completed by 163 specialists (15 female), of whom 66.9 per cent were colorectal surgeons. Some 40 per cent of surgeons would choose minimally invasive surgery for their personal treatment of rectal cancer. For low rectal cancer (T1 and T2) the treatment choice would be chemoradiation and local excision (60 responders (36.8 per cent)) followed by local excision with or without chemoradiotherapy if needed (55 responders (33.7 per cent)). For locally advanced low rectal cancer T3 or greater, the preference of the responders was for laparoscopic surgery (65 responders (39.9 per cent)). The authors found a statistically significant relationship between increasing surgeon's age and their preference for an open approach. Only 21.5 per cent (35) of specialists adhered to the international guidelines regarding early rectal cancer treatment (Fig. 1). For T1 or T2 rectal cancer, surgeons more often chose local excision with standard chemoradiotherapy, standard chemoradiotherapy alone or total neoadjuvant therapy.

Research using surveys has limitations and was based on surgeons being hypothetically being placed in the position of being a patient with rectal cancer. First, the low response rate (54.3 per cent) might not reflect the true experience locally or internationally. Second, the authors did not assess the validity and consistency of the survey. Theoretically, the survey results might be different if the respondents actually had rectal cancer.

This snapshot survey demonstrates that in a cohort of colorectal surgeons there is wide variability in the treatments that they would choose themselves for their rectal cancer treatment.

In spite of the limitations, it details how managing rectal cancer is complex and requires specialist counselling of patients and a multidisciplinary approach. As a colorectal community it is essential to measure patient-reported outcome measures and ensure a holistic approach towards survivorship.

Declaration. The authors declare no conflict of interest.

References

1. Glynne-Jones R, Wyrwicz L, Tiret E, Brown G, Rödel C, Cervantes A, et al. Rectal cancer: ESMO clinical practice guidelines for diagnosis, treatment and follow-up. *Ann Oncol* 2017;**28**:iv22–iv40
2. Benson AB, Venook AP, Al-Hawary MM, Arain MA, Chen YJ, Ciombor KK, et al. NCCN guidelines insights: rectal cancer, version 6.2020. *J Natl Compr Canc Netw* 2020;**18**(7):806–815
3. Pacevicius J, Petrauskas V, Pilipavicius L, Dulskas A. Local excision ± chemoradiotherapy vs. total mesorectal excision for early rectal cancer: case-matched analysis of long-term results. *Front Surg* 2021;**8**:746784
4. Samalavicius NE, Dulskas A, Lasinskas M, Smailyte G. Validity and reliability of a Lithuanian version of low anterior resection syndrome score. *Tech Coloproctol* 2016;**20**(4):215–220
5. Dulskas A, Kavaliauskas P, Pilipavicius L, Jodinskas M, Mikalonis M, Samalavicius NE. Long-term bowel dysfunction following low anterior resection. *Sci Rep* 2020;**10**:11882