



**PROPOSED REVIEW OF SIGN GUIDELINE
CONSULTATION FORM**

Title of guideline	SIGN 67:Management of Colorectal Cancer
Date of publication	2003
SIGN scoping search – sources	<p>MeSH headings for the condition specified and any common variations as free text, plus terms for the interventions and care processes discussed in the guideline</p> <p>Sources: Guidelines: NICE; National Library for Health guidelines finder; National Guidelines Clearinghouse; GIN Web site. Technology appraisals: NICE; UK HTA database (Southampton); INAHTA database. Cochrane reviews: Cochrane Library. Other good quality systematic reviews: UK HTA database (Southampton); DARE.</p>
SIGN scoping search - summary	<p>Guidelines – 28 HTAs – 1 Cochrane reviews – 14 Other good quality systematic reviews – 22</p>
Other guidelines/HTAs	<ul style="list-style-type: none"> ▪ NICE: Improving outcomes in colorectal cancer. June 2004 ▪ New Zealand Guidelines Group (NZGG). Surveillance and management of groups at increased risk of colorectal cancer. Wellington (NZ): New Zealand Guidelines Group (NZGG); 2004 May. 84 p. [222 references] ▪ American Gastroenterological Association medical position statement: hereditary colorectal cancer and genetic testing. Gastroenterology 2001 Jul;121(1):195-7. ▪ Finnish Medical Society Duodecim. Prevention and screening of colorectal cancer. In: EBM Guidelines. Evidence-Based Medicine [CD-ROM]. Helsinki, Finland: Duodecim Medical Publications Ltd.; 2005 Feb 23 [Various]. ▪ U.S. Preventive Services Task Force. Screening for colorectal cancer: recommendations and rationale. Ann Intern Med 2002 Jul 16;137(2):129-31. PubMed ▪ Singapore Ministry of Health. Colorectal cancer. Singapore: Singapore Ministry of Health; 2004 Feb. 85 p. [245 references] ▪ Figueredo A, Rumble RB, Maroun J, Earle CC, Cummings B, McLeod R, Zuraw L, Zwaal C. Follow-up of patients with curatively resected colorectal cancer: a practice guideline. BMC Cancer 2003 Oct 6;3(1):26. [62 references] PubMed ▪ Desch CE, Benson AB 3rd, Somerfield MR, Flynn PJ, Krause C, Loprinzi CL, Minsky BD, Pfister DG, Virgo KS, Petrelli NJ. Colorectal cancer surveillance: 2005 update of an American Society of Clinical Oncology practice guideline. J Clin Oncol 2005 Nov 20;23(33):8512-9. [35 references] PubMed ▪ Gastrointestinal Cancer Disease Site Group. Kocha W, Maroun J, Jonker D, Rumble RB, Zuraw L. Oral capecitabine (Xeloda) in the first-line treatment of metastatic colorectal cancer [full report]. Toronto (ON): Cancer Care Ontario (CCO); 2003 Dec 5. 19 p. (Practice guideline report; no. 2-15). [26 references] ▪ Smith RA, Cokkinides V, Eyre HJ. American Cancer Society guidelines for the early detection of cancer, 2003. CA Cancer J Clin 2003 Jan-Feb;53(1):27-43. [57 references] PubMed ▪ Anthony T, Simmang C, Hyman N, Buie D, Kim D, Cataldo P, Orsay C, Church J, Otchy D, Cohen J, Perry WB, Dunn G, Rafferty J, Ellis CN, Rakinic J, Fleshner P, Stahl T, Gregorcyk S, Ternent C, Kilkenny JW 3rd, Whiteford M. Practice parameters for the surveillance and follow-up of patients with colon and rectal cancer. Dis Colon Rectum 2004 Jun;47(6):807-17. [54 references] PubMed

- Gastrointestinal Cancer Disease Site Group. Figueredo A, Moore M, Germond C, Kocha W, Maroun J, Zwaal C. Use of irinotecan in the second-line treatment of metastatic colorectal carcinoma. Toronto (ON): **Cancer Care Ontario (CCO)**; 2004 Jul. 21 p. (Practice guideline report; no. 2-16). [40 references]
- Gastrointestinal Disease Site Group. Germond C, Maroun J, Zwaal C, Wong S. Use of raltitrexed (Tomudex) in the management of metastatic colorectal cancer. Toronto (ON): **Cancer Care Ontario (CCO)**; 2005 Feb 10. 13 p. (Practice guideline report; no. 2-17). [22 references]
- Gastrointestinal Cancer Disease Site Group. Use of irinotecan (camptosar, CPT-11) combined with 5-fluorouracil and leucovorin (5FU/LV) as first-line therapy for metastatic colorectal cancer [full report]. Toronto (ON): **Cancer Care Ontario (CCO)**; 2003 Feb [online update]. 20 p. (Practice guideline; no. 2-16b). [17 references]
- **Association of Coloproctology of Great Britain and Ireland**. Referral guidelines for bowel cancer. London (UK): Association of Coloproctology of Great Britain and Ireland; 2002 Apr 25. Various p. [356 references]
- **Otchy D, Hyman NH, Simmang C, Anthony T, Buie WD, Cataldo P, Church J, Cohen J, Dentsman F, Ellis CN, Kilkenny JW 3rd, Ko C, Moore R, Orsay C, Place R, Rafferty J, Rakinic J, Savoca P, Tjandra J, Whiteford M**. Practice parameters for colon cancer. Dis Colon Rectum 2004 Aug;47(8):1269-84. [152 references] [PubMed](#)
- **Institute for Clinical Systems Improvement (ICSI)**. Colorectal cancer screening. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2006 Jun. 50 p. [71 references]
- Welch S, Kocha W, Rumble RB, Spithoff K, Maroun J, Gastrointestinal Cancer Disease Site Group. The role of bevacizumab (Avastin) combined with chemotherapy in the treatment of patients with advanced colorectal cancer. Toronto (ON): **Cancer Care Ontario (CCO)**; 2005 Dec 12. 23 p. (Evidence-based series; no. 2-25). [18 references]
- Winawer S, Fletcher R, Rex D, Bond J, Burt R, Ferrucci J, Ganiats T, Levin T, Woolf S, Johnson D, Kirk L, Litin S, Simmang C, **Gastrointestinal Consortium Panel**. Colorectal cancer screening and surveillance: clinical guidelines and rationale. Update based on new evidence. Gastroenterology 2003 Feb;124(2):544-60. [102 references] [PubMed](#)
- Davila RE, Rajan E, Adler D, Hirota WK, Jacobson BC, Leighton JA, Qureshi W, Zuckerman MJ, Fanelli R, Hambrick D, Baron TH, Faigel DO. **ASGE guideline**: the role of endoscopy in the diagnosis, staging, and management of colorectal cancer. Gastrointest Endosc 2005 Jan;61(1):1-7. [72 references] [PubMed](#)
- **Figueredo A, Zuraw L, Wong RK, Agboola O, Rumble RB, Tandan V**. The use of preoperative radiotherapy in the management of patients with clinically resectable rectal cancer: a practice guideline. 2003 Nov 24;1(1):1. [PubMed](#)
- Benson AB 3rd, Schrag D, Somerfield MR, Cohen AM, Figueredo AT, Flynn PJ, Krzyzanowska MK, Maroun J, McAllister P, Van Cutsem E, Brouwers M, Charette M, Haller DG. **American Society of Clinical Oncology** recommendations on adjuvant chemotherapy for stage II colon cancer. J Clin Oncol 2004 Aug 15;22(16):3408-19. [45 references] [PubMed](#)
- Smith A, Rumble RB, Langer B, Stern H, Schwartz F, Brouwers M, Laparoscopic Colon Cancer Surgery Expert Panel and Program in Evidence-based Care. Laparoscopic surgery for cancer of the colon. Toronto (ON): **Cancer Care Ontario (CCO)**; 2005 Sep. Various p. (Evidence-based series; no. 2-20-2). [13 references]
- **American College of Radiology (ACR), Expert Panel on Radiation Oncology-Rectal/Anal Work Group**. Locally unresectable rectal cancer. Reston (VA): American College of Radiology (ACR); 2002. 10 p. (ACR appropriateness criteria). [30 references]
- **Place R, Hyman N, Simmang C, Cataldo P, Church J, Cohen J, Denstman F, Kilkenny J, Nogueras J, Orsay C, Otchy D, Rakinic J, Tjandra J**. Practice parameters for ambulatory anorectal surgery. Dis Colon Rectum 2003 May;46(5):573-6. [47 references] [PubMed](#)
- **Tjandra JJ, Kilkenny JW, Buie WD, Hyman N, Simmang C, Anthony T, Orsay C,**

	<p>Church J, Otchy D, Cohen J, Place R, Denstman F, Rakinic J, Moore R, Whiteford M. Practice parameters for the management of rectal cancer (revised). <i>Dis Colon Rectum</i> 2005 Mar;48(3):411-23. [143 references] PubMed</p> <ul style="list-style-type: none"> ▪ Colorectal Cancer Screening : guidance on large bowel surveillance for people with two first degree relatives with colorectal cancer or one first degree relative diagnosed with colorectal cancer under 45 years. British Society of Gastroenterology. Oct 2002 ▪ Colorectal Cancer Screening : guidelines for follow up after resection of colorectal cancer. British Society of Gastroenterology. Oct 2002 <p>NICE. The clinical effectiveness and cost effectiveness of capecitabine and tegafur uracil for colorectal cancer. May 2003.</p>
Main conclusions from new evidence	<ul style="list-style-type: none"> ▪ Capecitabine or tegafur with uracil (and folinic acid), to be taken by mouth, should be among the first options considered for a person with metastatic colorectal cancer. <i>Guideline recommends that outside a clinical trial, the choice of an appropriate regimen includes continuous infusional fluorouracil (Lokich), FUFA infusion (de Gramont) or capecitabine (A). Evidence on tegafur/uracil was awaited.</i> ▪ Two reviews found that there is no conclusive evidence that surveillance colonoscopy prolongs survival in patients with extensive colitis. <i>The guideline recommends that patients with left-sided colitis or pancolitis of 10 years duration should undergo three yearly colonoscopy with mucosal biopsies and biopsy of any suspicious lesions and that the frequency of examination should increase to yearly when the disease has been present for 20 years, or when indeterminate dysplasia has been diagnosed (D).</i> ▪ One review suggests that if the long-term oncological results of laparoscopic and conventional resection of colonic carcinoma show equivalent results, the laparoscopic approach should be preferred in patients suitable for this approach to colectomy. Another shows that laparoscopic colectomy appears to be more expensive and to take longer than traditional open surgery. <i>There is a good practice point that says laparoscopic surgery can be considered for colorectal cancer.</i> ▪ No apparent differences in quality of life are found in rectal cancer patients with a permanent stoma when compared to non-stoma patients. <i>Guideline says that patients who require stoma formation generally experience more problems than those who do not, without citing evidence. There are no recommendations about stoma and QoL.</i> ▪ There was evidence from three pooled RCTs that ASA significantly reduces the recurrence of sporadic adenomatous polyps after one to three years. There is evidence from short-term studies to support regression, but not elimination or prevention of CRAs in FAP. <i>No recommendations made whilst waiting for long term toxicity data.</i> ▪ There is an overall survival benefit for intensifying the follow-up of patients after curative surgery for colorectal cancer. It is not possible to infer from the data the best combination and frequency of clinic (or family practice) visits, blood tests, endoscopic procedures and radiological investigations. <i>There is a good practice points that says colonoscopic follow up after curative resection for colorectal cancer should be carried out as for adenomatous polyps (ie 3-5 years depending on presence of adenomas).</i> ▪ There is no convincing evidence that mechanical bowel preparation is associated with reduced rates of anastomotic leakage after elective colorectal surgery. There is evidence that this intervention may be associated with an increased rate of anastomotic leakage and wound complications. The dogma that mechanical bowel preparation is necessary before elective colorectal surgery should be reconsidered. Mechanical bowel preparation before colorectal surgery cannot be recommended as routine. <i>The guideline acknowledges that there is no evidence that bowel preparation confers benefit, but finds that the quality of evidence suggesting no effect is too weak to make a definitive statement that it is not necessary. There is a good practice point suggesting that the decision to use bowel preparation must be individualised according to the patient's need and the surgeon's experience.</i> ▪ The optimal VTE prophylaxis in colorectal surgery is the combination of graduated compression stockings and low-dose unfractionated heparin. The unfractionated heparin can be replaced with low molecular weight heparin. <i>The guideline recommends that patients undergoing surgery for colorectal cancer should have venous thromboembolism prophylaxis (A), but refers readers to the SIGN VTE guideline for details on how.</i>

	<ul style="list-style-type: none"> CT colonography should only be used in research protocols, or when other accepted screening methods are not appropriate, until heterogeneity is more clearly explained and CT colonography is found to be sensitive. <i>Guideline recommends a CT pneumocolon as a sensitive test for colorectal cancer, where the radiological expertise and equipment exist (D).</i>
New areas that could be added to the guideline	<ul style="list-style-type: none"> Capecitabine or tegafur with uracil (and folinic acid) in metastatic colorectal cancer Stoma and quality of life The optimal VTE prophylaxis in colorectal surgery
Summary of the recommendations that could be updated	<ul style="list-style-type: none"> Effect of surveillance colonoscopy on survival Role of laparoscopic surgery Role of NSAIDs and aspirin follow-up of patients after curative surgery for colorectal cancer mechanical bowel preparation

Please answer the following questions as fully as possible:

Name, designation, organisation:	Other: 2 Academics: 2 Consultant: 4
1(a) Is there still a requirement for an evidence-based guideline on this topic?	
	Yes = 8
1(b) If no, should the guideline be withdrawn?	
2(a) Do you agree with the assessment of the impact of the new evidence and its likely effect on recommendations?	
	<ul style="list-style-type: none"> No = 1 Yes = 7 I think there is much more evidence that require review in the field of non-surgical approaches. There have been a number of pivotal phase III trials published which have altered clinical management and they are not listed in the current revision summary With regard to laparoscopic surgery facts have shown no detriment. NICE have said laparoscopic colonic surgery should be offered where appropriate While I agree with the assessment of the impact of the new evidence and its likely effect on the recommendations as far as it goes I believe that there is a substantial body of evidence in both surgical and non-surgical approaches to colorectal cancer. In particular there have been a number of important phase III trials which have altered clinical management and which are not mentioned in this document.
2(b) Based on the information given above, and your own clinical judgement, does the guideline require revision in the light of new evidence? <i>Please give details.</i>	
	<ul style="list-style-type: none"> Yes = 7 No = 1 New agents, such as monoclonal antibodies merit review, the role of adjuvant chemotherapy for node negative patients, the role of peri-operative chemotherapy for patients with respectable liver metastases, the use of combination chemotherapy as first line therapy The chapter on chemotherapy and radiotherapy requires total revision as significant sections don't reflect current evidence and practice. Data from the Mosaic study and NSABP-07 establish the role of oxaliplatin based combination chemo in adjuvant setting. There role of combination chemotherapy in advanced disease is now considerably broader than in the guideline. There are data from multiple sources including the MRC Focus study results. There requires to be a section on the role or otherwise of the newer biological agents such as cetuximab and bevacizumab (irrespective of NICE/SMC advice). MRC trial CR07 on short course preop radiotherapy has been presented and is likely to be published within the time frame of any review of the guideline as well as further data which have been published from the Dutch TME radiotherapy study. Section 7.1 on preop staging doesn't reflect current practice and any revision needs to include data from the MERCURY study and probably broadened to include an assessment of the data on PET scanning. As mentioned in SIGN conclusions the section on follow up merits review. Clinically a very high profile and important area. The guideline must be seen to be contemporary and relevant even if there are only relatively modest changes Need to review laparoscopic colorectal surgery practice point in light of above I believe that the guideline does require revision in the light of new evidence, particularly related to radiotherapy for rectal cancer, adjuvant chemotherapy for colorectal cancer, perioperative chemotherapy for patients with liver metastases, the use of new biological agents, new evidence in terms of lifestyle factors and chemoprevention and finally I believe account needs to be taken of the National Screening Programme and more robust guidance is needed in this area.

3 Please list any additions to the remit of the guideline that you think would be beneficial	
<ul style="list-style-type: none"> ▪ See above ▪ As mentioned above I believe that the guideline should be extended to include detailed recommendations on population screening. ▪ Data on newer regimens is available e.g XELOX. These data were presented at ASCO 2007 (J Cassidy et al. Journal of Clinical Oncology, 2007 ASCO Annual Meeting Proceedings Part 1. Vol 25, No. 18S (June 20 Supplement), 2007: 4030). This is likely to be published soon and will be submitted to SMC in Q1 2008. Consideration should be given to including reference to such newer regimens in the guideline. 	
4 Please tick your preferred option for reviewing this guideline	
a. there is no new evidence that will affect existing recommendations and the guideline should not be reviewed at this time	1
b. some recommendations will change in the light of the new evidence and selected elements of the guideline should be reviewed	5
c. the entire guideline should be reviewed	2
d. the guideline should be withdrawn	

Thank you very much for taking part in this consultation.

Please return to: Safia Qureshi, SIGN Executive, 28 Thistle Street, Edinburgh EH2 1EN, safia.qureshi@nhs.net