Tumor Scatter After Neoadjuvant Therapy for Rectal Cancer: Are We Dealing with an Invisible Margin?

1. How should the findings in this study change the recommendations for standard distal margin assessment at surgery, given a small number of patients had tumor scatter up to 3cm from the residual ulcer after neoadjuvant therapy?
2. Did the authors reconcile the findings / pattern of pathologic tumor scatter compared to initial (clinical) assessment of the original tumor location (before neoadjuvant therapy)? (e.g. tumor scatter was present within vs. outside the extent of oringal tumor location?)
3. Is this technique and terminology generalizable to all pathologic resections for rectal cancer such that we should change typical reporting of pathologic findings?
4. The authors use the center of a residual ulcer as a reference point for tumor scatter. Is the study generalizable to patients who may have other types of residual disease after neoadjuvant therapy?

Development of The American Society of Colon and Rectal Surgeons' Rectal Cancer Surgery Checklist.

1. What are the problems with consensus-driven (via Delphi process) statements?
2. Are there important aspects of rectal cancer care that were left out of these checklists due to controversy or mixed evidence?
3. The initial feedback for these guidelines was sought at the 2011 annual meeting, with final guidelines being published in 2016. Has anything changed or been updated in rectal cancer care since this publication? (specifically related to quality programs now that the American College of Surgeons Commission on Cancer has an accreditation standards program).
4. How frequently do you think these recommendations are known / used by community general surgeons?

Comparisons of Rigid Proctoscopy, Flexible Colonoscopy and Digital Rectal Examination for Determining the Localization of Rectal Cancer

1. Do you think it matters that "a team of highly specialized surgeons performed the measurements using DRE, rigid proctoscopy, and flexible colonoscopy"?
2. Is this data generalizable to gastroenterology medicine providers performing colonoscopy?
3. Why include cancers within the reach of an examining digit? These are distal cancers that do not require endoscopy to localize, and that are less amenable to "front viewing" scopes whether flexible or rigid?

4. Was there a standardized approach used for colonoscopy in this study? For example, did surgeons ensure that their flexible scopes were straight during measurement?

Pathologic Complete Response in Rectal Cancer; Can We Detect it?

1. Does your data allow you to select a time point following nCRT where MRI or endoscopy are maximally sensitive to detecting cCR?
2. Given the sensitivity for predicting a ypT0N0 response being only 18.2%, does this effect whether you would enroll a patient into a watch and wait protocol on the basis of clinical features, or would you require a biopsy?
3. How many of your patients had a “cardinal sign” of an incomplete response, who did not have residual cancer?
4. Was there a difference between node positive and node negative cancers, based on clinical staging, in terms of the sensitivity of post-therapy CRT?