Expert Commentary on Neoadjuvant Therapy for Rectal Cancer

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It is indeed a very exciting time to be treating rectal cancer. Until the last decade, there were very limited options for our patients with rectal cancer. For stage I rectal cancer, upfront surgery was the standard of care unless dealing with a very early and histologically favorable lesion amenable to local excision. Stage II to III was very poorly characterized by the American Joint Committee on Cancer staging classification where the recommendation was to receive 5-fluorouracil–based chemoradiation therapy followed by surgery at a very specific interval and, in most cases, adjuvant chemotherapy. For stage IV disease, the field was somewhat less defined. More recently we have seen a dramatic change in the way we treat rectal cancer from diagnosis to long-term follow-up. The eighth edition of the American Joint Committee on Cancer staging classification more clearly outlines the advances in our understanding of the natural history of the disease and the importance of novel prognostic markers. The quality of our imaging, specifically MRI, has dramatically improved to the point that, in Europe, MRI has become the pivotal factor in planning treatment and assessing response. With better staging comes the understanding that not all stage II to III cancers are created equal and therefore should not be treated the same way. To optimize treatment recommendations, patients with rectal cancer are better served when individually discussed using a multidisciplinary tumor board format. The National Accreditation Program for Rectal Cancer developed through a collaboration between The Optimizing the Surgical Treatment of Rectal Cancer Consortium and the Commission on Cancer, a quality program of the American College of Surgeons are providing guidelines for a uniform multidisciplinary structure. Several studies, primarily from Europe, have shown significantly improved oncologic results after implementation of a multidisciplinary team evaluation. In my practice very few patients are treated according to the old standard of care. For example, we are using induction chemotherapy for patients with locally advanced disease and threatened circumferential resection margins or bulky disease, selective use of radiation in the context of the PROSPECT randomized controlled trial, and, more recently, nonoperative management in the context of the Organ Preservation in Rectal Adenocarcinoma trial. These 3 approaches, although applicable to very different clinical scenarios, are clear examples of how we now use response to therapy as a way to tailor treatment to the specific cancer and the individual patient. This can only be done with consistent high-quality MRI imaging with the goal to achieve a margin-negative resection or to avoid surgery altogether. It is also important to mention that, in this complex equation, the timing of surgery has been recognized to be of critical importance, because it appears that response rates increase as the interval extends with implications for decreases in lo-cal recurrence and improved survival.

Although surgery remains the centerpiece of this complex puzzle, we need to understand and accept that optimal results can only be achieved in a collegial, multidisciplinary environment. What a great time to be a colon and rectal surgeon!

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