VIII CURSO MULTIDISCIPLINAR **NACIONAL** E **INTERNACIONAL** DE
CÁNCER COLORRECTAL
del Hospital General Universitario Gregorio Marañón
17 de **abril 2026**

CÁNCER DE RECTO: REDEFINIENDO EL TRATAMIENTO SISTÉMICO

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COI DISCLOSURE

- Employment: Sanofi (mother).
- Consultant or Advisory Role: Takeda.
- Research Funding: Pierre Fabre, Amgen.
- Speaking: Servier, LEO Pharma, MSD, BMS, Roche, Merck, Pfizer, Adventia, Recordati, AstraZeneca.

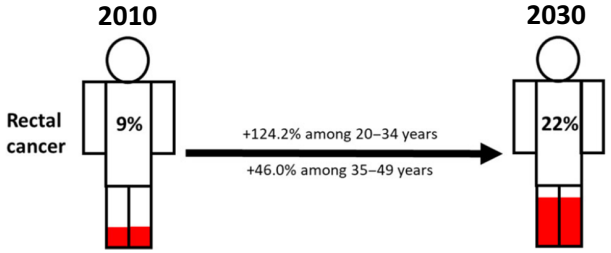
INTRODUCCIÓN

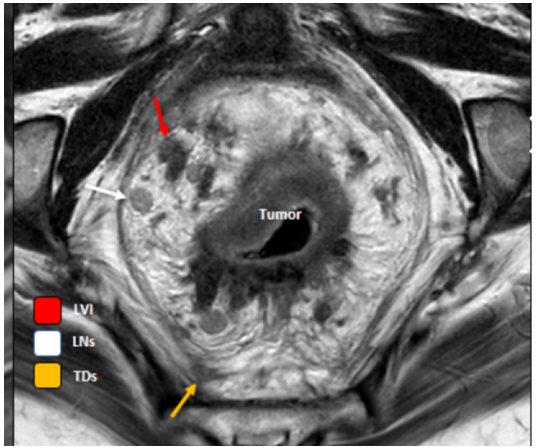
- 8º tumor en incidencia y 10º en mortalidad a nivel global.
  - Aumento en incidencia un 66% y en mortalidad un 79% para 2045.
  - Aumento muy significativo de la incidencia en población <50 años.

- Aproximadamente el 50% de los pacientes son diagnosticados en estadio localmente avanzado (LARC).

- Factores clave a la hora de la toma de decisiones:
  - Correcta estadificación (RMN)
  - Valoración multidisciplinar.
  - Individualización del tratamiento en función del riesgo.

- Factores de alto riesgo:
  - Tumores cT4 o cN2
  - Afectación de la fascia mesorrectal (MRF) o del margen circunferencial de resección (CRM)
  - Invasión venosa extramural (EMVI+)
  - Ganglios laterales +





Sung H et al. CA Cancer J Clin. 2021; Mauri G et al. Molecular Oncology. 2019

QTRT NA como SOC

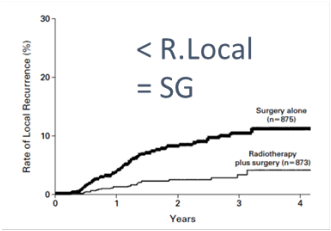
NUEVO ESTÁNDAR!

80' RT

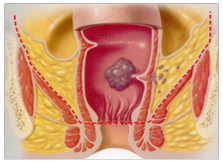
90' TME

QT-RT ady

04' QT-RT neoadyuvante



< R.Local
= SG



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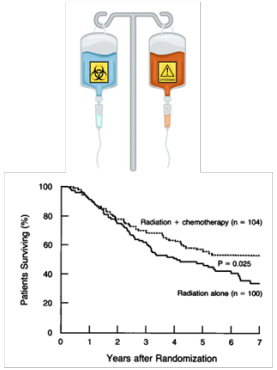

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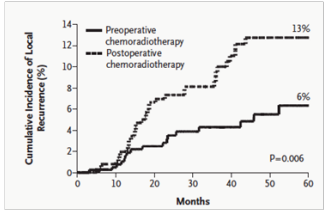


< R.Local
< Toxicidad

Racional para administrar el tratamiento sistémico antes de la cirugía:

- Aumentar tasa de respuestas y control de la enfermedad.
- Tratar la enfermedad micrometastásica.
- Mejorar el cumplimiento terapéutico.

Fisher B, JNCI 1988, Krook, NEJM 1991; Enker EW, 1995; Sauer, NEJM 2004. Imagen creada por la Dra. MC Riesco.

TNT vs RTNA + QTA

RAPIDO

High-risk rectal cancer* N=912

R

- CRT → Surgery → Optional CAPOX x8 or FOLFOX x12
- SCRT → CAPOX x6 or FOLFOX x9 → Surgery

cT4 31%
cN2 68%
EMVI+ 30%
MRF+ 61%

Outcomes	RAPIDO	PRODIGE
Median Follow-up	4.6 years	3.8 years
Primary Endpoint	3-yrs DrTF	3-yrs DFS
	23.7% vs. 30.4% (Δ 6.7%)	75.7% vs. 68.5% (Δ 7.2%)
	HR 0.75 (0.60-0.96) P=0.019	HR 0.69 (0.49-0-97) P=0.034

cT4 17%
cN2 NR
EMVI+ NR
MRF+ 27%

Outcomes	RAPIDO	PRODIGE
Local Primary Endpoints		
Intended Curative Resection	92% vs. 89% (14 patients W&W)	92 % vs. 95 % (11 patients W&W)
R0 Resections Rate	90 % vs. 90 %	95 % vs. 94 %

PRODIGE 23

Stage II-III rectal cancer N=461

R

- CRT → Surgery → mFOLFOX x12 or Cape x8
- mFOLFIRINOX x6 → CRT → Surgery → mFOLFOX x6 or Cape x4

pCR
- RAPIDO: 28.4% vs 14.3%
- PRODIGE: 27.5% vs 11.7%

3y MFS
- RAPIDO: 80% vs 73.2%
- PRODIGE: 78.8% vs 71.7%

3y LR
- RAPIDO: 8.7% vs 5.4%
- PRODIGE: 4.8% vs 5.7%

ORIGINAL ARTICLE

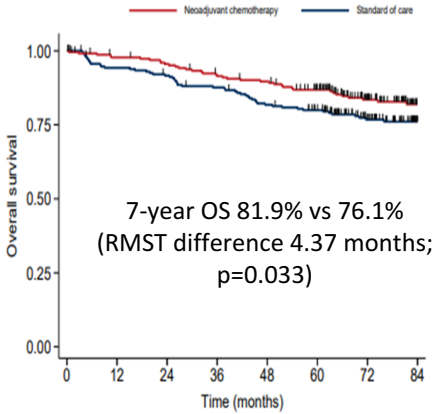
OPEN

Locoregional Failure During and After Short-course Radiotherapy Followed by Chemotherapy and Surgery Compared With Long-course Chemoradiotherapy and Surgery

A 5-Year Follow-up of the RAPIDO Trial

Seguimiento a 5 años	SCRT - FOLFOX	QTRT	p
Recidiva Local (tras cirugía R0 o R1)	10 %	6 %	0.027
Recidiva Local tras cirugía R0	7%	4%	0.049
Metástasis a distancia	23%	30%	0.011
DrTF a 5 años	27%	34%	0.048
Supervivencia global a 5 años	81.7%	80.2%	0.50

Total neoadjuvant therapy with mFOLFIRINOX versus preoperative chemoradiation in patients with locally advanced rectal cancer: 7-year results of PRODIGE 23 phase III trial, a UNICANCER GI trial.



7-year OS 81.9% vs 76.1%
(RMST difference 4.37 months; p=0.033)

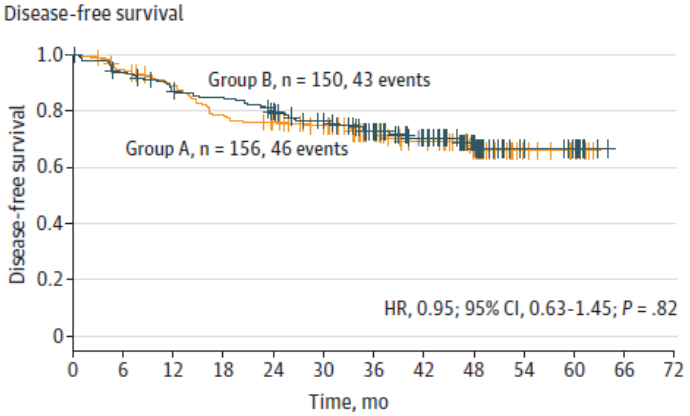
Bahadoer RR, et al. Lancet Oncol 2021; Conroy T, et al. Lancet Oncol. 2021; Jin J, et al. J Clin Oncol. 2022; Dijkstra EA, et al. Ann Surg. 2023; Conroy T, et al. Annals of Oncology. 2024

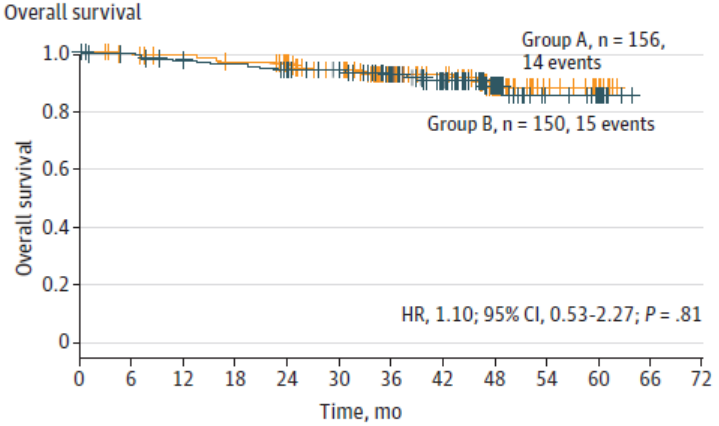
SECUENCIA TNT: INCT vs CNCT

German CAO/ARO/AIO-12 trial

Objetivo primario: pCR

	pCR
CRTx – Chemo	38/142 (27%)
Chemo - CRTx	27/142 (19%)





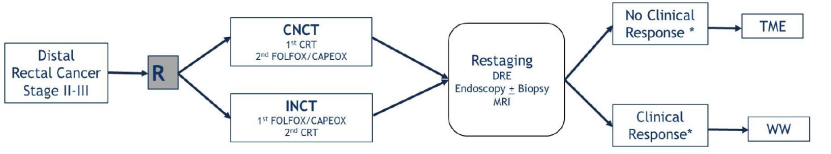
Fokas E et al. JAMA Oncology 2022

PRESERVACIÓN DE ÓRGANO: W&W

Clinical Trial > J Clin Oncol. 2024 Feb 10;42(5):500-506. doi: 10.1200/JCO.23.01208. Epub 2023 Oct 26.

Long-Term Results of Organ Preservation in Patients With Rectal Adenocarcinoma Treated With Total Neoadjuvant Therapy: The Randomized Phase II OPRA Trial

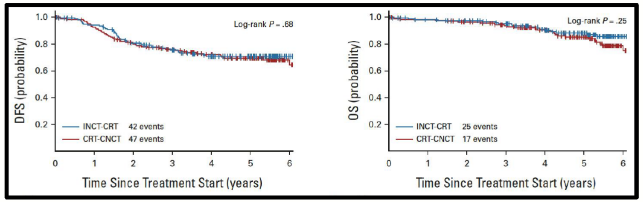
Investigational Arm



(*) Smith J et al, BMC Cancer 2015;15:767.

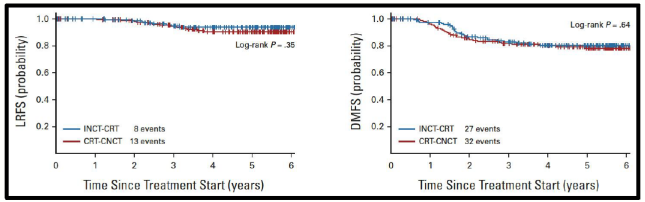
Control Arm (Historical Controls)

DFS

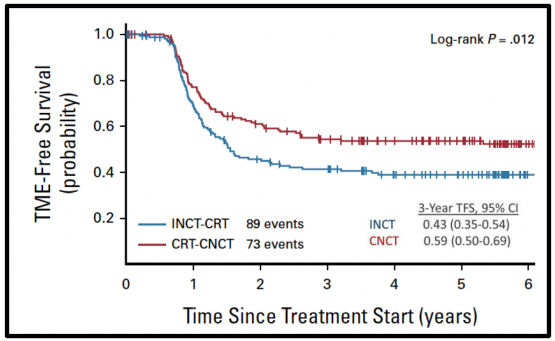


OS

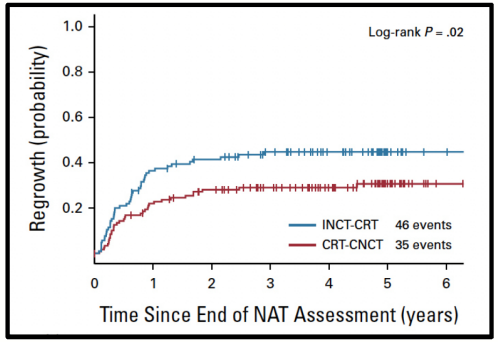
LRFS



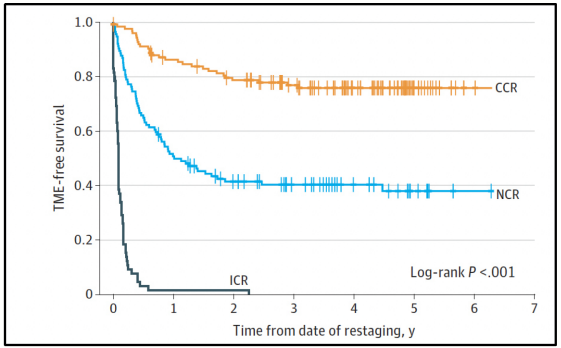
DMFS



CNCT: long-course chemoradiation (LCRT) then FOLFOX x 8
INCT: FOLFOX x 8 then LCRT



94% occurred within 2 years and 99% within 3 years after restaging



Garcia-Aguilar J, et al. J Clin Oncol. 2022; Verheij FS, et al. J Clin Oncol. 2024

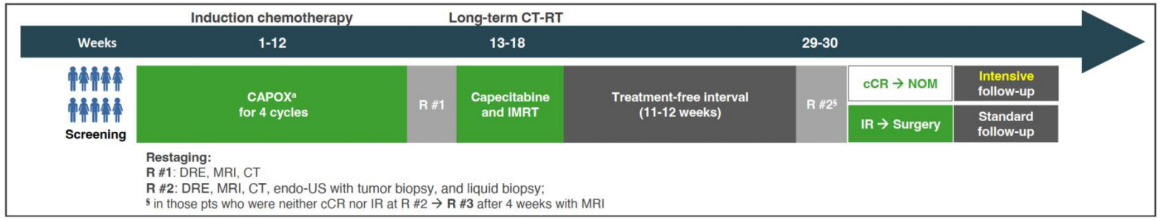
PRESERVACIÓN DE ÓRGANO: W&W

BARCELONA 2024 ESMO congress

Total Neoadjuvant Treatment (TNT) including Non-Operative Management (NOM) for Proficient Mismatch Repair Locally Advanced Rectal Cancer (pMMR LARC): First Results of NO-CUT Trial

Amatu A.[1], Zampino M. G.[2], Bergamo F.[3], Mosconi S.[4], Sibio D.[1], Gerardi M. A.[2], Prete A. A.[3], Filippone F. R.[4], Ferrari G.[1], Borin S.[2], Galuppo S.[3], Mariano S.[1], Tosi F.[1], Bonazzina E.[1], Patelli G.[1,5,6], Ghezzi S.[1], Lazzari L.[6], Bencardino K.[1], Sartore-Bianchi A.[1,5], and Siena S.[1,5]
on behalf of the NO-CUT Trial Cooperative Group

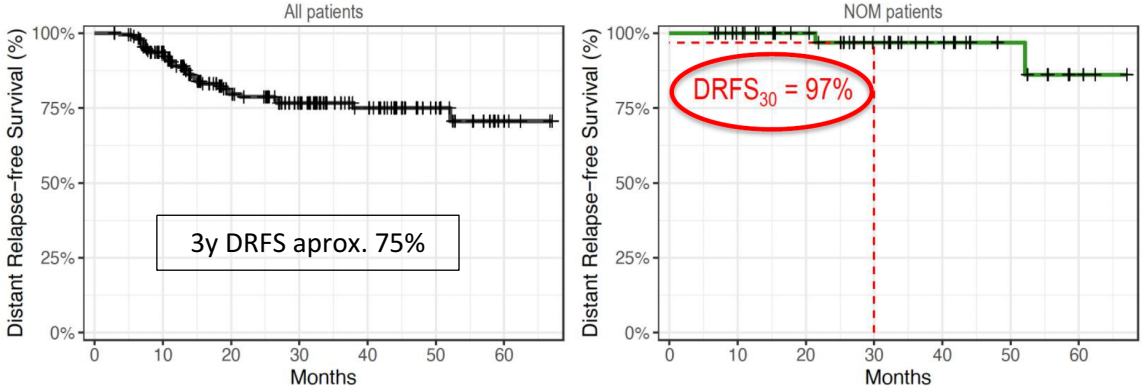
180 patients with mid/low cT3-4 and/or cN1-2, cM0, pMMR/MSS, rectal adenocarcinoma; ECOG PS 0-1, fit for surgery



- 26% patients achieved cCR and proceeded with NOM
- **Organ preservation rate was 85% (39/46)**

		cCR (%)	IR (%)	p-value
Number of patients		46 (26)	134 (74)	-
Tumor location	Low	26 (36)	47 (64)	0.017
	Medium	20 (19)	87 (81)	
Clinical T stage	T1	2 (100)	0 (0)	0.004
	T2	5 (39)	8 (61)	
	T3	37 (28)	96 (72)	
	T4	2 (6)	30 (94)	
Clinical TNM stage	II	9 (45)	11 (55)	0.065
	III	37 (23)	123 (77)	

Primary Objective: Distant Relapse-Free Survival in NOM patients

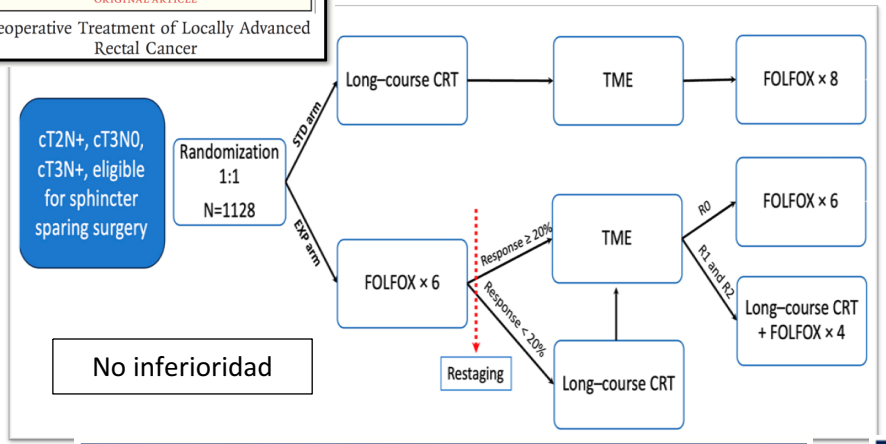


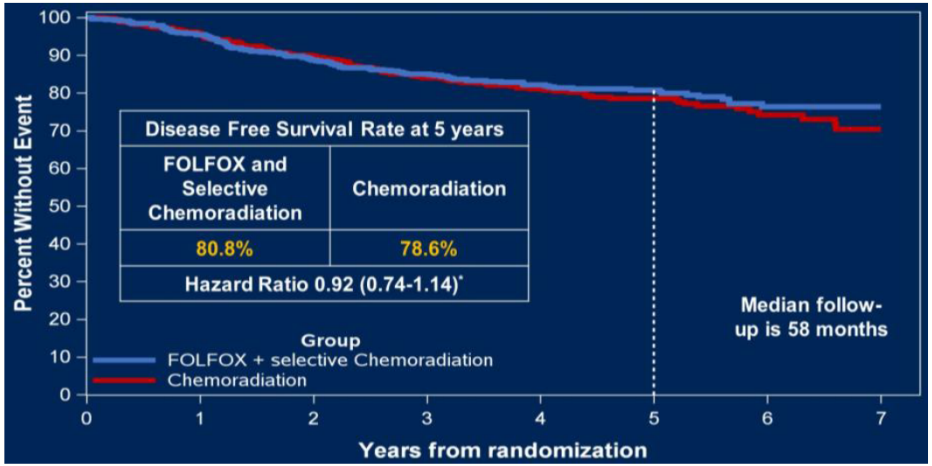
Amatu A, et al. Ann Oncol. 2024

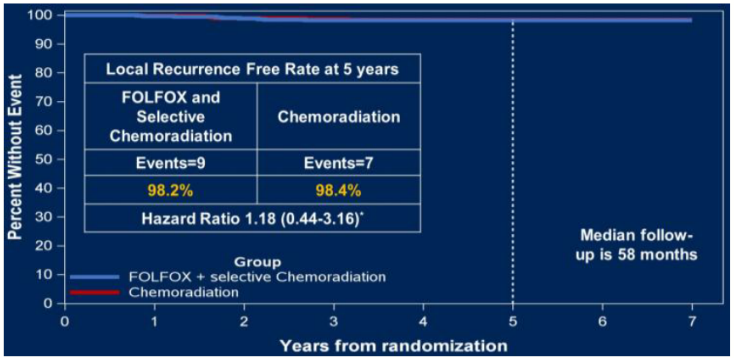
USO SELECTIVO DE RT

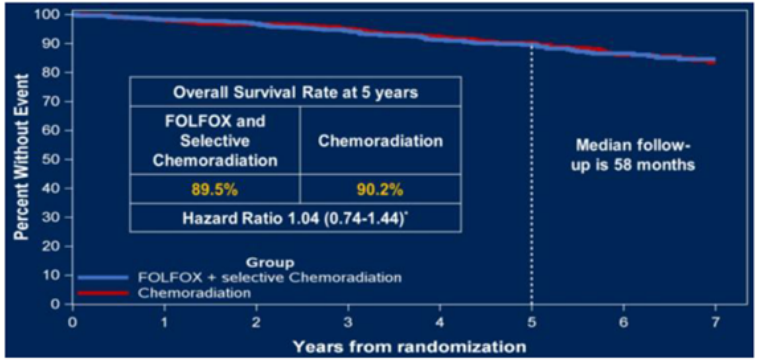
The NEW ENGLAND JOURNAL of MEDICINE
ORIGINAL ARTICLE

Preoperative Treatment of Locally Advanced Rectal Cancer







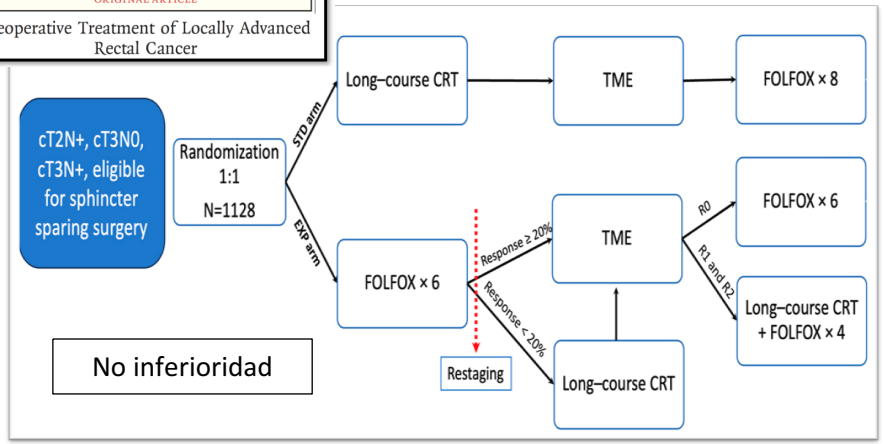


Schrag D, et al. N Engl J Med. 2023

USO SELECTIVO DE RT

The NEW ENGLAND JOURNAL of MEDICINE
ORIGINAL ARTICLE

Preoperative Treatment of Locally Advanced Rectal Cancer



Secondary endpoints in participants who completed Surgery	FOLFOX and Selective Pelvic Chemoradiation N=535	Pelvic Chemoradiation N=510
Complete (R0) Rectal Resection	99%	97%
Low Anterior Resection Rate	98%	98%
Pathologic Complete Response	22%	24%

Most severe toxicity during observation period based on CTCAE v. 4.0	FOLFOX and Selective Chemoradiation 12 weeks* 535 patients	Chemoradiation 6 weeks 510 patients
Neoadjuvant grade ≥3 adverse events	41%	23%
Adjuvant grade ≥3 adverse events	25%	39%

Quality of Life: Trend, but no significant difference between groups

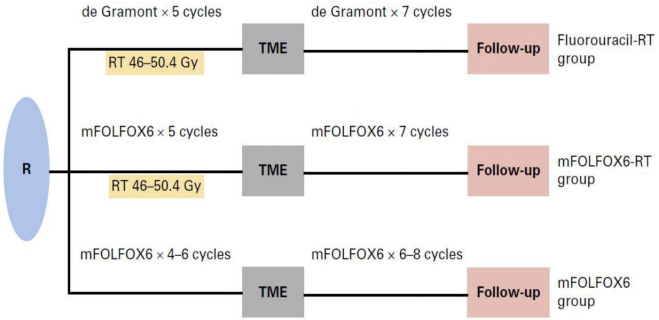
Bowel function and sexual function favor FOLFOX group

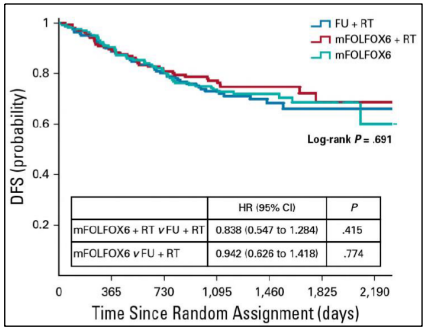
Schrag D, et al. N Engl J Med. 2023

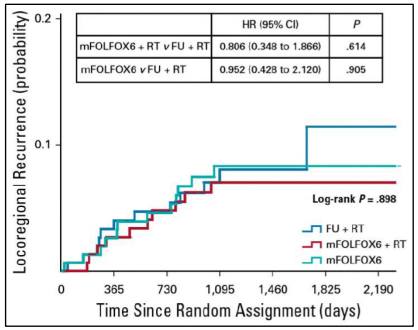
QTNA SIN RT

FORWARC

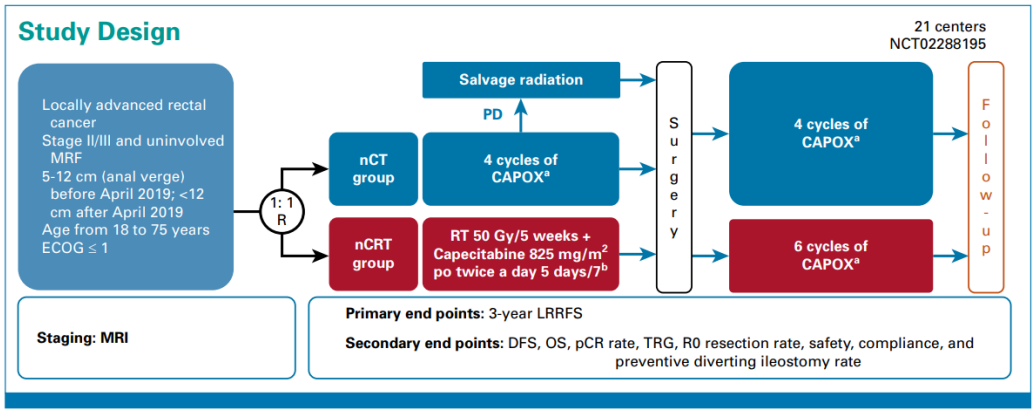
Estadio II/III
CRM-



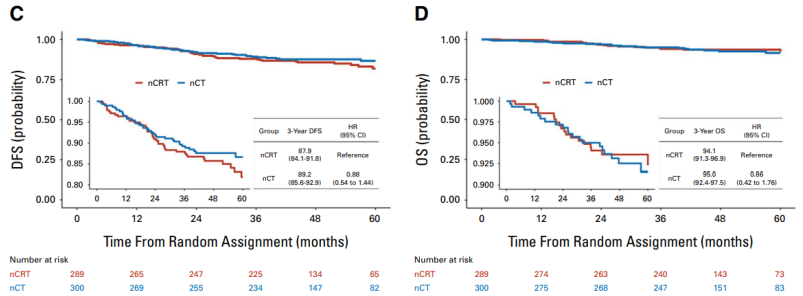




CONVERT



3y LRRFS: no se demuestra la no inferioridad



Relevance ***(A.H. Ko)***
As treatment paradigms for LARC continue to evolve, this trial offers further evidence that nCT alone represents a viable strategy for selected patients and can result in good long-term efficacy while avoiding radiation-associated toxicities.*

Deng Y et al, JCO. 2019; Mei WJ et al. JCO. 2026

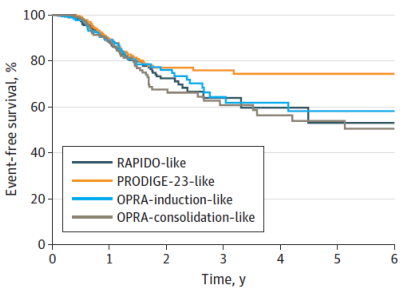
TNT - RWD

JAMA Oncology | Original Investigation

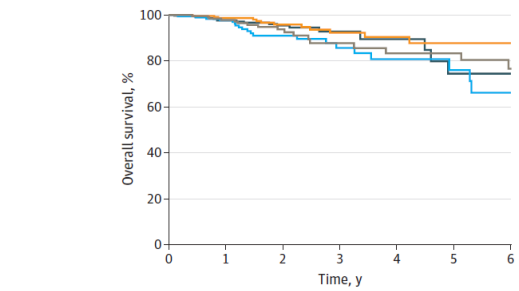
Total Neoadjuvant Therapy for Locally Advanced Rectal Cancer

- 61 centros de 21 países
- 1585 pacientes con LARC.
- 79.5% con al menos un factor de riesgo (cT4, cN2, EMVI+, MRF+, gg laterales+)
- Esquema más empleado: RAPIDO (33.4%)

Figure 3. Event-Free Survival (EFS) and Overall Survival (OS) by Total Neoadjuvant Therapy (TNT) Regimen in the Matched Population[3,9]



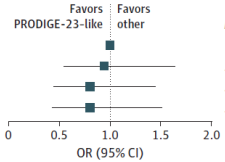
No. at risk							
RAPIDO-like	312	205	70	18	12	8	8
PRODIGE-23-like	232	178	83	54	29	20	10
OPRA-induction-like	178	121	59	26	19	12	6
OPRA-consolidation-like	206	129	50	32	23	16	9



No. at risk							
RAPIDO-like	312	245	128	36	21	14	12
PRODIGE-23-like	232	200	105	64	40	26	15
OPRA-induction-like	178	149	74	39	26	16	10
OPRA-consolidation-like	206	156	77	43	35	29	20

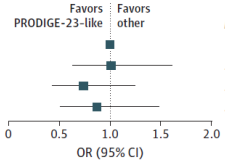
A pCR

Regimen	pCR rate, %	OR (95% CI)	P value
PRODIGE-23-like	21.9	1 [Reference]	
RAPIDO-like	21.9	0.94 (0.54-1.64)	.83
OPRA-induction-like	18.7	0.8 (0.44-1.45)	.46
OPRA-consolidation-like	19.9	0.8 (0.43-1.51)	.50



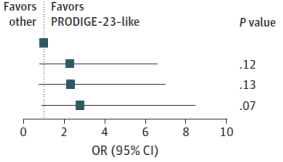
B CR

Regimen	CR rate, %	OR (95% CI)	P value
PRODIGE-23-like	24.0	1 [Reference]	
RAPIDO-like	24.9	1.01 (0.63-1.61)	.98
OPRA-induction-like	19.4	0.74 (0.43-1.25)	.26
OPRA-consolidation-like	22.3	0.87 (0.51-1.48)	.60



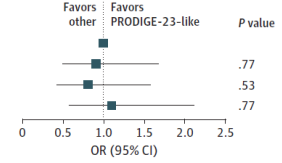
C LP

Regimen	LP rate, %	OR (95% CI)	P value
PRODIGE-23-like	3.6	1 [Reference]	
RAPIDO-like	8.5	2.29 (0.8-6.58)	.12
OPRA-induction-like	11.3	2.34 (0.78-6.99)	.13
OPRA-consolidation-like	10.6	2.8 (0.93-8.45)	.07



D DP

Regimen	DP rate, %	OR (95% CI)	P value
PRODIGE-23-like	15.7	1 [Reference]	
RAPIDO-like	14.8	0.91 (0.50-1.67)	.77
OPRA-induction-like	13.7	0.81 (0.42-1.58)	.53
OPRA-consolidation-like	18.7	1.10 (0.58-2.11)	.77



In the matched population (928 patients [58.5%]), no differences in survival outcomes were observed between the TNT regimens.

Audisio A et al. JAMA Oncology. 2025

IO en LARC pMMR

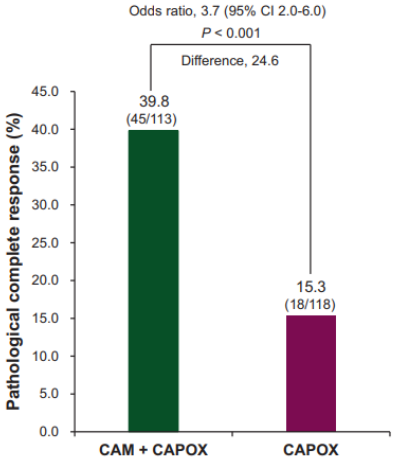
ORIGINAL ARTICLE

Neoadjuvant short-course radiotherapy followed by camrelizumab and chemotherapy in locally advanced rectal cancer (UNION): early outcomes of a multicenter randomized phase III trial

113 pacientes. LARC pMMR T3-4/N+

- **Control**: LCRT → CAPOX x2 → TME → CAPOX x6
- **Exp**: SCRT → CAPOX-camrelizumab x2 → TME → CAPOX-camrelizumab x6 → camrelizumab x17

Objetivo primario: pCR



Total neoadjuvant treatment with short-course radiotherapy followed by sintilimab plus capecitabine–oxaliplatin versus short-course radiotherapy followed by capecitabine–oxaliplatin in patients with locally advanced rectal cancer (SPRING-01): a single-centre, open-label, phase 2, randomised controlled trial

116 pacientes. LARC pMMR de alto riesgo.

SCRT → CAPOX x6 +/- sintilimab → TME

Objetivo primario: pCR

	Sintilimab plus capecitabine–oxaliplatin (n=49)	Capecitabine–oxaliplatin (n=49)	Odds ratio (95% CI)	p value
Intention-to-treat population				
Pathological complete response (ypT0N0)	29 (59·2%; 95% CI 45·4–72·9)	16 (32·7%; 95% CI 19·5–45·8)	3·0 (1·3–6·8)	0·015*
Complete response†	30 (61·2%; 95% CI 48·2–72·9)	16 (32·7%; 95% CI 21·3–46·2)	3·2 (1·4–7·5)	0·0085*
Major pathological response	36 (73·5%; 95% CI 60·3–83·5)	23 (46·9%; 95% CI 34·0–60·2)	3·1 (1·3–7·3)	0·013*
Surgical population‡				
Tumor regression grading	..	..	..	0·035*
0	29 (64%)	16 (36%)	..	..
1	7 (16%)	7 (16%)	..	..
2	5 (11%)	13 (30%)	..	..
3	4 (9%)	8 (18%)	..	..
Pathological tumour stage	..	..	..	0·11*
ypT0	29 (64%)	16 (36%)	..	..
ypT1	2 (4%)	3 (7%)	..	..
ypT2	4 (9%)	9 (20%)	..	..
ypT3	8 (18%)	14 (32%)	..	..
ypT4	2 (4%)	2 (5%)	..	..
Pathological nodal stage	..	..	..	0·32*
ypN0	41 (91%)	37 (84%)	..	..
ypN1	4 (9%)	5 (11%)	..	..
ypN2	0	2 (5%)	..	..
Neoadjuvant rectal score	..	..	..	0·077*
Low	32 (71%)	21 (48%)	..	..
Intermediate	9 (20%)	17 (39%)	..	..
High	4 (9%)	6 (14%)	..	..
Time from the end of short-course radiotherapy to chemotherapy, days	7 (7–8)	7 (7–8)	..	0·27§
Time from the end of neoadjuvant therapy to surgery, days	18 (17–19)	18 (17–19)	..	0·54§
Time from the end of short-course radiotherapy to surgery, days	157 (155–160)	158 (155–163)	..	0·23§

Data are n (%; 95% CI), n (%), or median (IQR). Proportions might not equal 100% due to rounding. yp=pathological staging assessed after neoadjuvant preoperative therapy. *p value calculated using χ^2 test. †Pathological complete response plus clinical complete response. ‡Sintilimab plus capecitabine–oxaliplatin n=45, sintilimab plus capecitabine–oxaliplatin n=44. §p value calculated using Mann-Whitney U test.

Table 2: **The efficacy of neoadjuvant treatment and pathological results**

ypT0N0: 29% vs 16% (p=0.015)

Lin ZY et al. Annals of Oncology. 2024; Tian F et al. Lancet Oncol. 2025

IO + terapia dirigida en LARC pMMR

Abstract 128: Short-course radiotherapy (SCRT) followed by immunochemotherapy plus fruquintinib as the total neoadjuvant therapy (TNT) for locally advanced rectal cancer (LARC): a multicenter, single-arm, open-label, phase II study (UNION TNT)

Zhenyu Lin[1], Peng Zhang[1], Zheng Wang, [1] Ximing Xu[2], Zhen Zhang[3], Dandan Lin[2], Ruidong Li[1], Junli Liu[1], Ke Liu[4], Jun Liu[1], Hongli Liu[1], Min Jin[1], Yan Niu[1], Dianshi Wang[1], Rong Lin[1], Huiying Shi[1], Lei Zhao[1], Linfang Wang[1], Hong Ma[1], Xiaoming Shuai[1], Mengjiao Wu[1], Kailin Cai[1], Jianli Hu[1], Qiuyue Zhang[1], Ke Wu[1], Yuping Yin[1], Tao Liu[1], Ming Cai[1], Kaixiong Tao[1]*, Tao Zhang[1]*

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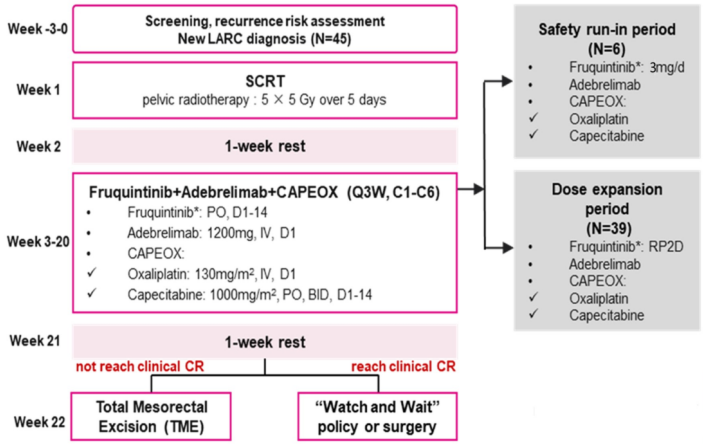
Methods

- This is a prospective, open-label, multi-centers, single-arm phase 2 study (NCT06234007).



- **Primary:** CR rate (including cCR & pCR)
- **Secondary:** 3-year EFS rate, OS, R0 resection rate, AEs
- **Exploratory:** To evaluate the correlation between potential biomarkers and efficacy

Table 1. Baseline characteristics of the pts

Characteristics, n (%)		N=45
Age, Median (range)		59 (24-75)
Gender	Male	26 (57.78)
	Female	19 (42.22)
ECOG PS	0	10 (22.22)
	1	35 (77.78)
Clinical T Stage	T3	22 (48.89)
	T4	23 (51.11)
Clinical N Stage	N0	3 (6.67)
	N1	22 (48.89)
	N2	20 (44.44)
EMVI Status	Positive	37 (82.22)
	Negative	8 (17.78)
MRF Status	Positive	32 (71.11)
	Negative	13 (28.89)
Distance from anal verge, cm	≤5	22 (48.89)
	5-10	23 (51.11)

Table 2. Compliance with treatment in surgical pts

Characteristics		N=41	
Compliance with SCRT		41	100%
Compliance with combined treatment	Completed 2 cycles	40	97.56%
	Completed 4 cycles	34	82.93%
	Completed 6 cycles	26	63.41%
Compliance with Surgery		33	80.49%

Table 3. Overall efficacy of treatment

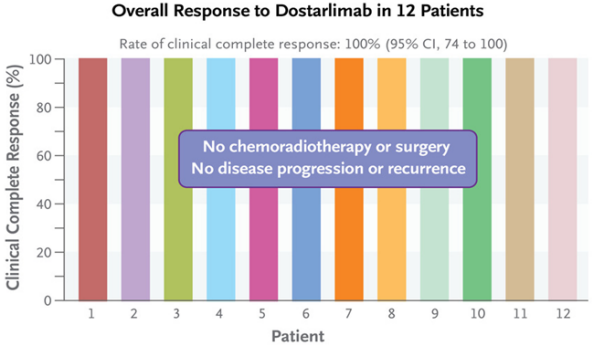
Overall efficacy	N	%
CR rate	26	63.4
cCR	7	17.1
pCR	19	57.6
R0 rate	33	100

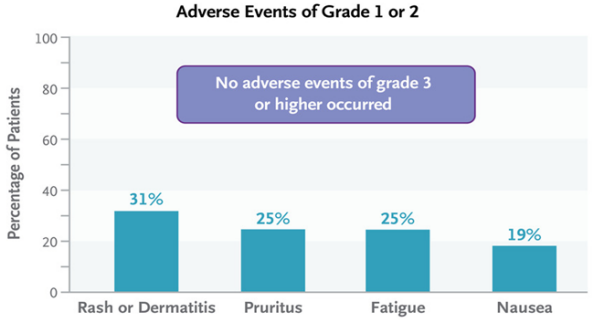
Zhang T et al. ASCO GI 2026

dMMR/MSI-H LARC

The NEW ENGLAND JOURNAL of MEDICINE
ESTABLISHED IN 1812 JUNE 23, 2022 VOL. 386 NO. 25

PD-1 Blockade in Mismatch Repair–Deficient, Locally Advanced Rectal Cancer

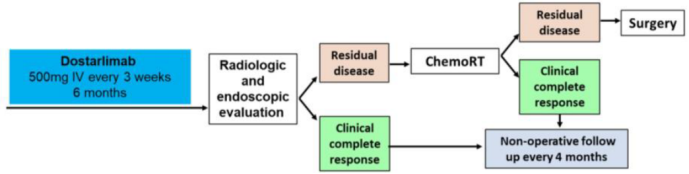


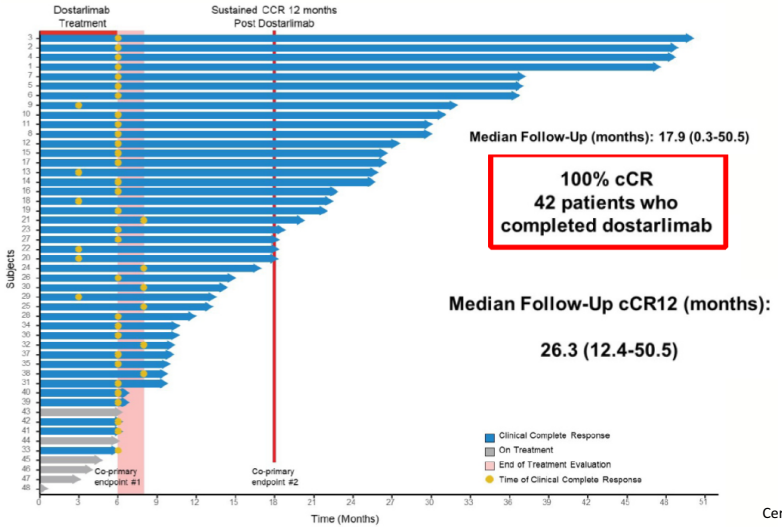


The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Nonoperative Management of Mismatch Repair–Deficient Tumors





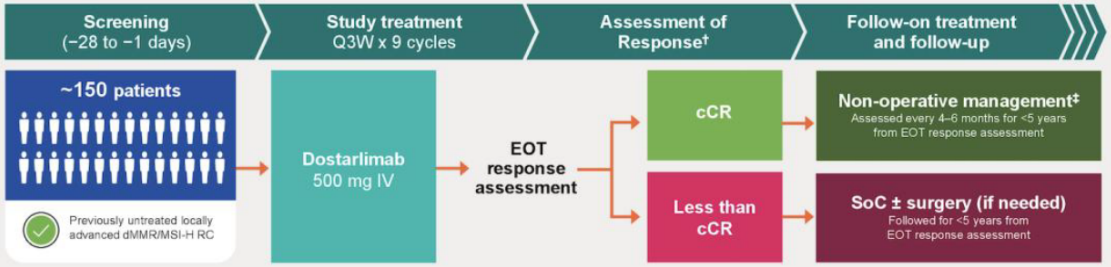
Cercek A, et al. NEJM. 2022 & 2025

dMMR/MSI-H LARC

Trial design | AZUR-1 (NCT05723562) will evaluate the efficacy and safety of dostarlimab in patients with previously untreated locally advanced dMMR/MSI-H rectal cancer

Global | Multicenter | Phase II | Single-arm | Open-label study

Participating countries:
Canada | France | Germany | Italy | Japan | Netherlands | South Korea | Spain | UK | USA



Primary Endpoint

Efficacy: cCR by ICR at 12 months

Defined as achieving and maintaining cCR for 12 months (12-month period starts from the first disease assessment after last dose of dostarlimab that demonstrates cCR by ICR)

ACTIVE, NOT RECRUITING

ClinicalTrials.gov ID NCT05723562

Sponsor GlaxoSmithKline

Information provided by GlaxoSmithKline

Last Update Posted 2024-09-23

BIOPSIA LÍQUIDA -ctDNA

NOMINATE trial (64 patients)

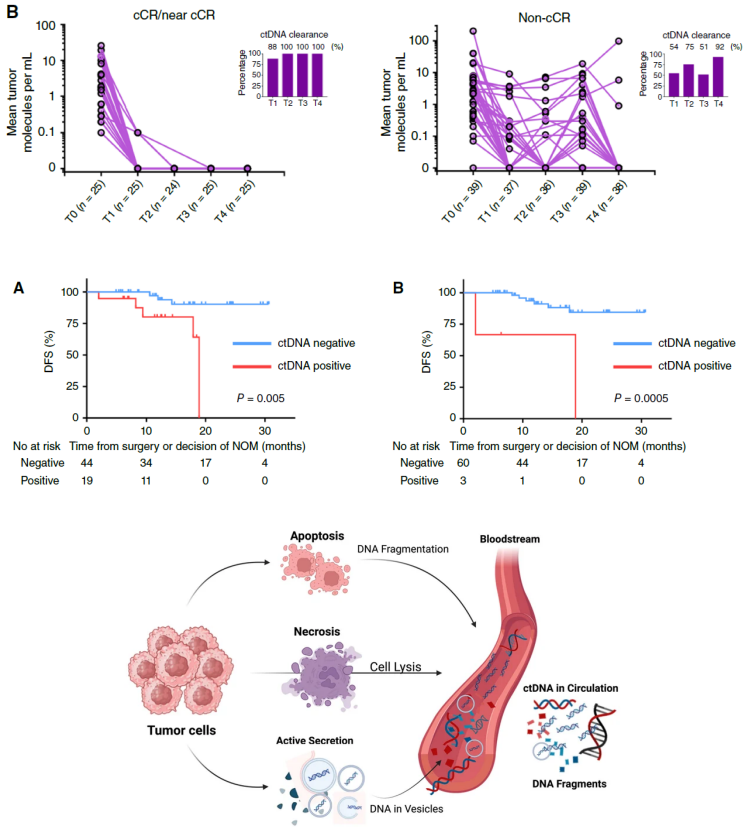
- Baseline ctDNA detection was 98.4%, decreasing to 32% at interim and 5% post-treatment.
- Among patients achieving cCR/near-cCR who entered NOM, ctDNA clearance was 100% at all post-treatment time points, whereas non-cCR patients showed significantly lower clearance rates (51% at final restaging).
- Detectable ctDNA at restaging had 100% specificity and positive predictive value for pathological residual disease and was associated with shorter DFS (HR 6.7; p=0.005).

ENSEMBLE-1 trial (Japan)

- ctDNA status after short-course RT and after 4 cycles of CAPOX was significantly associated with clinical complete response (p=0.007 for both time points),
- Post-TNT ctDNA status predicted pCR (p=0.029).

COPEC trial (153 patients)

- Poor response rate was 59.4% in the high-risk ctDNA group versus 12.4% in the low-risk group (p<0.001).
- High-risk dynamic status being a strong independent predictor of poor response (OR 11.69; p<0.001).



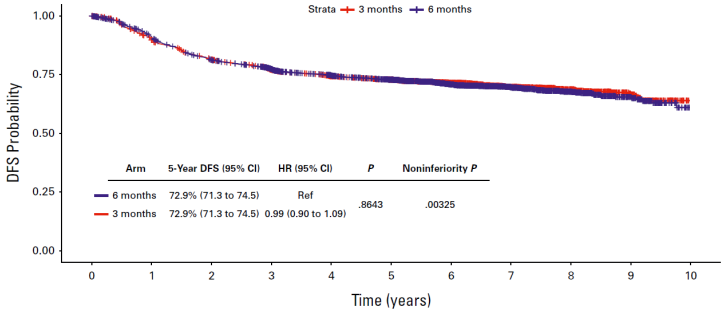
Akiyosi T et al. Clin Cancer Res. 2025; KgawaY et al. Ann Gastroenterol Surg. 2023; Shen Y et al. Trials. 2023

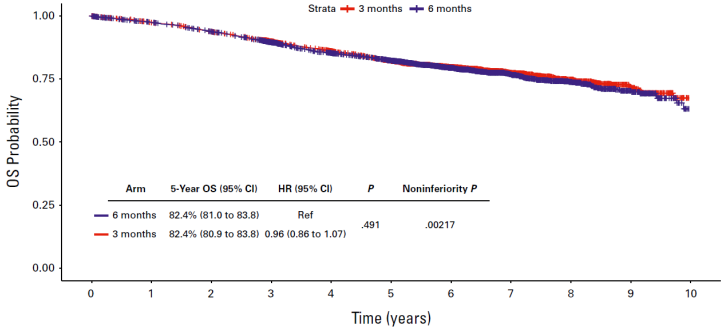
ADYUVANCIA

Three Versus 6 Months of Adjuvant Oxaliplatin-Fluoropyrimidine Chemotherapy for Colorectal Cancer: Final Results of SCOT—An International, Randomized, Phase III, Noninferiority Trial

Timothy Iveson, MD, FRCP[1]; Mark P. Saunders, FRCR[2]; Caroline Kelly, MSc[3]; Rachel S. Kerr, FRCP[4]; Jim Cassidy, MD[5]; Niels Henrik Hollander, MD[6]; Josep Tabernero, MD[6]; Andrew Haydon, MBBS[7]; Bengt Glimelius, MD[8]; Andrea Harkin, BA[3]; Karen Allan, BSc[3]; John McQueen, BSc[3]; Sarah Pearson, BSc[3]; Kathleen A. Boyd, PhD[10]; Andrew H. Briggs, DPhil[10]; Ashita Waterston, PhD[11]; Louise Medley, FRCP[12]; Richard Ellis, FRCR[13]; Amandeep S. Dhadda, MBChB[14]; Mark Harrison, PhD[15]; Stephen Falk, MD[16]; Charlotte Rees, FRCP[17]; Rene K. Olesen, MD[18]; David Propper, MD[19]; John Bridgewater, MD[20]; Ashraf Azzabi, MD[21]; David Cunningham, MD[22]; Tamas Hickish, MD[23]; Simon Gollins, DPhil[24]; Harpreet S. Wasan, FRCP[25]; David Church, MBChB, FRCP, DPhil[4]; and Enric Domingo, PhD[4]

- 1101 (18%) pacientes con LARC
- CRT permitida





5-Year OS Rate (%) and HR by Regimen and Risk Group		Regimen						CAPOX/FOLFOX Combined		
		CAPOX			FOLFOX					
		5-Year OS, % (95% CI)		HR[a] (95% CI)	5-Year OS, % (95% CI)		HR[a] (95% CI)	5-Year OS, % (95% CI)		HR[a] (95% CI)
		3 Months	6 Months		3 Months	6 Months		3 Months	6 Months	
Risk group	Low-risk (T1-3 N1)	91.7 (89.8 to 93.6)	87.8 (85.5 to 90.1)	0.73 (0.56 to 0.94)	89.7 (86.8 to 92.7)	91.9 (89.2 to 94.7)	1.30 (0.88 to 1.92)	91.0 (89.4 to 92.6)	89.1 (87.3 to 90.9)	0.87 (0.70 to 1.07)
	High-risk (T4 and/or N2)	68.5 (65.1 to 72)	70.9 (67.6 to 74.4)	1.01 (0.85 to 1.20)	71.7 (67.2 to 76.6)	73.1 (68.6 to 77.9)	1.03 (0.80 to 1.33)	69.5 (66.8 to 72.4)	71.7 (69 to 74.4)	1.02 (0.88 to 1.17)
	Risk groups combined	80.8 (78.8 to 82.8)	80.0 (78 to 82.1)	0.92 (0.79 to 1.06)	81.4 (78.7 to 84.2)	83.0 (80.3 to 85.7)	1.09 (0.88 to 1.35)			

Noninferior | Not proven | Inferior

Variable	Subgroup	Events/N (3 months)	Events/N (6 months)	HR (95% CI)	P interaction
Treatment					
	CAPOX	417 / 2,051	457 / 2,042	0.90 (0.79 to 1.03)	.104
	FOLFOX	202 / 984	179 / 987	1.10 (0.90 to 1.34)	
Site					
	Colon	542 / 2,484	535 / 2,482	1.00 (0.89 to 1.13)	.074
	Rectum	77 / 551	101 / 547	0.74 (0.55 to 1.00)	
Sidedness					
	Right	404 / 1,765	399 / 1,747	0.91 (0.73 to 1.13)	.925
	Left	460 / 2,406	470 / 2,422	0.92 (0.77 to 1.11)	
Sex					
	Male	387 / 1,836	379 / 1,835	1.03 (0.89 to 1.19)	.132
	Female	232 / 1,199	257 / 1,194	0.86 (0.72 to 1.03)	
N stage					
	N0	76 / 552	81 / 542	0.91 (0.67 to 1.25)	.925
	N1	287 / 1,732	291 / 1,728	0.98 (0.83 to 1.16)	
	N2	256 / 751	264 / 759	0.96 (0.80 to 1.14)	
T stage					
	T1/2	30 / 373	41 / 375	0.75 (0.47 to 1.21)	.702
	T3	298 / 1,743	311 / 1,742	0.94 (0.80 to 1.10)	
	T4	291 / 918	284 / 911	1.01 (0.86 to 1.19)	
Stage/risk					
	Stage II	76 / 552	81 / 542	0.91 (0.67 to 1.25)	.467
	Low-risk stage III	163 / 1,338	185 / 1,342	0.87 (0.70 to 1.07)	
	High-risk stage III	380 / 1,145	370 / 1,145	1.02 (0.88 to 1.17)	
Overall		619 / 3,035	636 / 3,029	0.96 (0.86 to 1.07)	

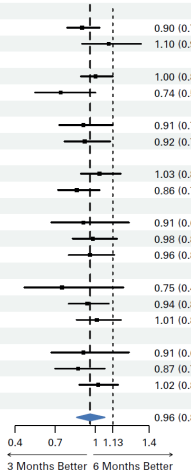
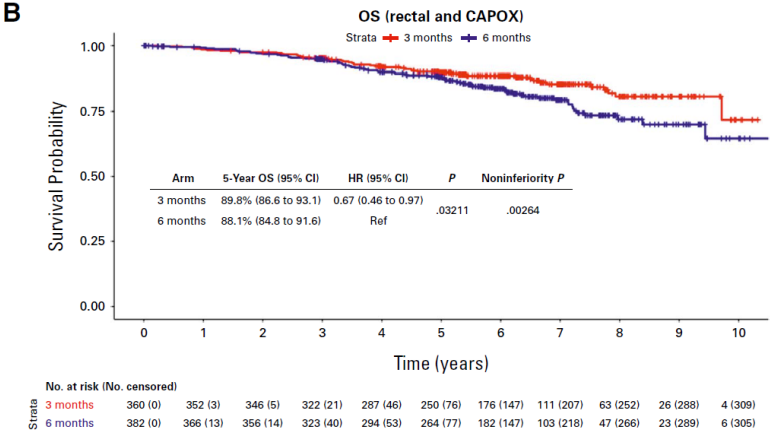


FIG 3. Overall survival by duration of chemotherapy within patient subgroups. Forest plot shows HR for overall survival with 3 months of chemotherapy relative to referent of 6 months of treatment. Proportionality of hazards between groups was not met for analysis of rectal cancers; corresponding analysis by restricted mean survival time is provided in Appendix Table A2. CAPOX, capecitabine and oxaliplatin; FOLFOX, infusional fluorouracil, leucovorin, and oxaliplatin; HR, hazard ratio.

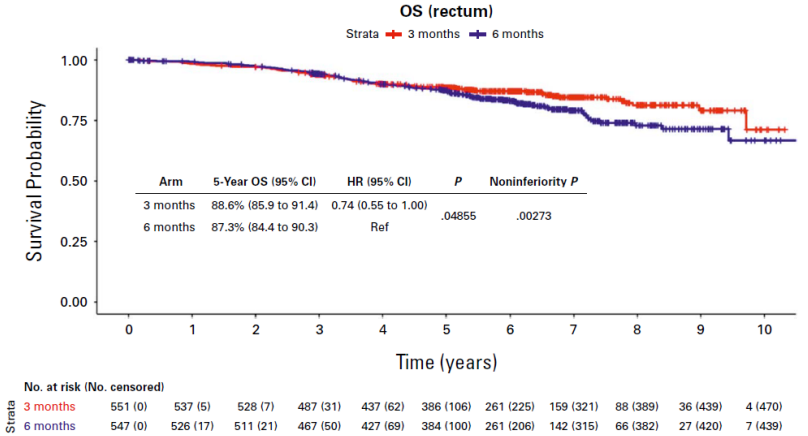
Iveson T et al. JCO. 2026

ADYUVANCIA

B



A



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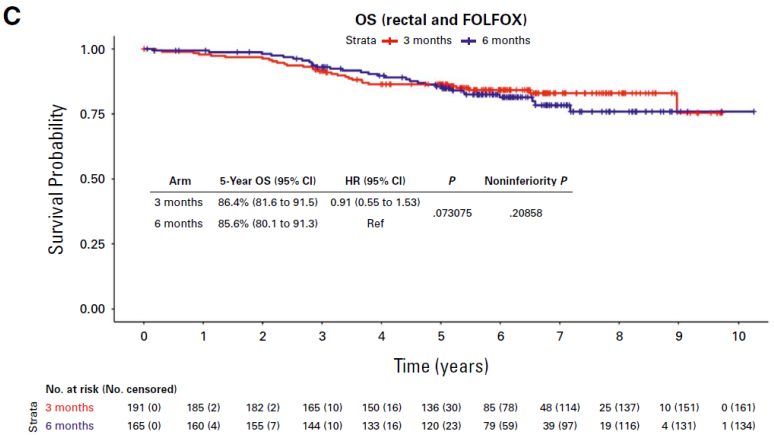


The demonstration of noninferiority for OS for 3 months of treatment is clinically relevant, as rectal cancers are increasingly treated with 3 months of preoperative chemotherapy as part of total neoadjuvant treatment. These results suggest that ***when such neoadjuvant chemotherapy is given, and particularly if CAPOX is used, further postoperative adjuvant treatment should be the exception rather than the rule.***

Iveson T et al. JCO. 2026

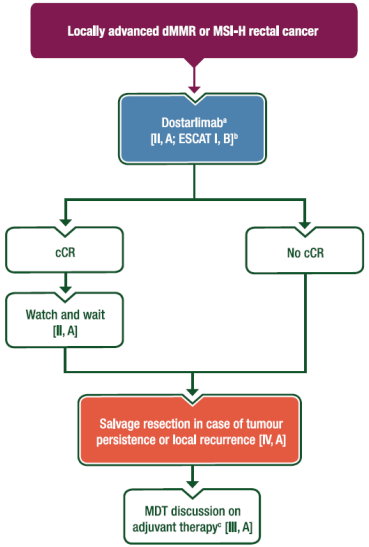
GUÍAS ESMO 2025

SPECIAL ARTICLE

Localised rectal cancer: ESMO Clinical Practice Guideline for diagnosis, treatment and follow-up☆

R.-D. Hofheinz[1], E. Fokas[2], L. Benhaim[3], T. J. Price[4], D. Arnold[5], R. Beets-Tan[6], M. G. Guren[7], G. A. P. Hospers[8], S. Lonardi[9], I. D. Nagtegaal[10], R. O. Perez[11], A. Cervantes[12,13] & E. Martinelli[14], on behalf of the ESMO Guidelines Committee*

1. **TNT**
   - Duración 3-4.5 meses. CAPOX/FOLFOX ó FOLFIRINOX.
   - Siempre si el objetivo es preservación de órgano (salvo dMMR). CNCT mejor que INCT.
   - Tumores recto superior: cT4 y/o afectación de la fascia mesorrectal.
   - Tumores recto medio/inferior: criterios de alto riesgo (cT4, cN2, MRF+, EMVI+, gg laterales +).
2. **QT neoadyuvante**
   - CAPOX/FOLFOX x3 meses.
   - cT2N1 o cT3N0/1.
   - En tumores de recto superior, cT4 con posibilidad de rescate con RT.
   - No se puede recomendar W&W si RCc.
3. **Inmunoterapia**
   - Dostarlimab neoadyuvante x9 ciclos.
   - Tumores dMMR/MSI-H.
   - Estrategia W&W.
4. **QT adyuvante**
   - Tras QTRT o TME de entrada: CAPOX/FOLFOX. FP monoterapia en pacientes frágiles.
   - Duración: 3m CAPOX, no demostrada no inferioridad 3vs6m FOLFOX.
   - Tras TNT: no de rutina, valoración individual del riesgo.



Hofheinz RD et al. Annals of Oncology. 2025

MUCHAS GRACIAS POR SU ATENCIÓN