



CIRUGIA DEL CÁNCER DE RECTO

(MÁS SELECCIÓN MENOS AGRESIÓN)

Javier Die Trill

Jefe de Sección de Coloproctología

Hospital Universitario Ramón y Cajal. Madrid



(MÁS SELECCIÓN MENOS AGRESIÓN)

NO TRATAR AL CANCER DE SIGMA COMO SI FUESE CANCER DE RECTO





DEFINICIÓN DE RECTO



VARIACIONES EN LA DEFINICIÓN DE RECTO SEGÚN GUÍAS CLÍNICAS

| | <u>Clasificación</u> | <u>Manejo</u> |
|------------------|--|---|
| ASCRS 2024 | → No especifica. Necesidad de consenso. (11-15cm?) | → Recto superior: upfront surgery |
| NCCN 2022 | → Alto por encima de la reflexion peritoneal | → NA en estadios II-III |
| ESMO 2017 | → Recto superior 10-15cm | → Upfront surgery: cT3a-b, N0-1 (sup) y CRM y EMVI- |
| Netherland 2023 | → Actualización 2024 Sigmoid take-off | → Upfront surgery: cT3a-b, N1 (sup) y CRM- |
| UK 2017 | → No especificado | → Upfront surgery: cT3a-b, N0 y CRM- |
| GRECCAR 2016 | → No especificado | → NA si \geq T3/N+ |
| SEOM/GEMCAD 2022 | → Recto superior 10-15cm | → NA si \geq T3/N+ |



Definition of the Rectum

An International, Expert-based Delphi Consensus

Nigel D'Souza, MBBS, MRCS,†‡ Michael P. M. de Neree tot Babberich, MD,§ Andre d'Hoore, MD, PhD,¶
Emmanuel Tiret, MD,|| Evaghelos Xynos, MD, PhD,** Regina G. H. Beets-Tan, MD, PhD,††
Iris D. Nagtegaal, MD, PhD,‡‡ Lennart Blomqvist, MD, PhD,§§ Torbjorn Holm, MD, PhD,§§
Bengt Glimelius, MD, PhD,¶¶ Antonio Lacy, MD, PhD,||| Andres Cervantes, MD, PhD,***
Robert Glynne-Jones, MBBS, FRCR,††† Nicholas P. West, PhD, FRCPath,†††† Rodrigo O. Perez, MD, PhD,§§§
Claudio Quadros, MD, PhD,¶¶¶ Kil Yeon Lee, MD, PhD,|||| Thandinkosi E. Madiba, MBChB, PhD,****
Steven D. Wexner, MD, PhD,†††† Julio Garcia-Aguilar, MD, PhD,††††† Dushyant Sahani, MBBS, MD,§§§§
Brendan Moran, MCh, FRCSI,¶¶¶¶ Paris Tekkis, MD, FRCS,†† Harm J. Rutten, MD, PhD,|||||*****
Pieter J. Tanis, MD, PhD,§ Theo Wiggers, MD, PhD,†††††
and Gina Brown, MD, FRCR†‡*

Ann Surg 2019;270:955–959)

SIGMOID TAKE-OFF



BJO Open, 2023, zrad018

<https://doi.org/10.1093/bjopen/zrad018>

Original Article

Implications of the new MRI-based rectum definition according to the sigmoid take-off: multicentre cohort study

Thijs A. Burghraef^{1,2,*}, Jeroen C. Hol^{1,4}, Marieke L. Rutgers⁵, Gina Brown^{6,7}, Roel Hompes⁵, Colin Sietses⁵, Esther C. J. Consten^{1,2} and the MIRECA Study Group



MRI to guide clinical management of rectal cancer: updated consensus recommendations from the European Society of Gastrointestinal and Abdominal Radiology (ESGAR)—PART I primary staging

ESGAR Rectal Imaging Guideline Group*

Abstract

Objectives To provide up-to-date consensus recommendations on the acquisition, interpretation and reporting of MRI for the primary staging of rectal cancer.

Materials and methods A panel of twenty-six abdominal imaging experts from the European Society of Gastrointestinal and Abdominal Radiology (ESGAR) engaged in an online consensus process, led by three non-voting chairs. The process adhered to an adapted version of the RAND-UCLA appropriateness method. A total of 126 items were scored (22 general, 55 on primary staging, 49 on restaging after neoadjuvant treatment) and classified using a 80% as the cut-off to establish consensus.

Results Consensus was reached for 121 items (96%). The current manuscript addresses the resulting general recommendations and those focused on baseline staging. Key updates compared to the previous guideline editions include more detailed recommendations for image acquisition, adoption of the sigmoid take-off as a landmark to discern rectal from sigmoid cancer, updated definition of mesorectal fascia involvement by a distance of ≤ 1 mm, including involvement by irregular nodes and extramural vascular invasion; a transition to a patient-level approach for cT₄-category assessment with updated criteria for lateral nodes including a ≥ 7 mm size threshold; and recommendations on the limited use of DMN for primary staging.

Conclusions These updated expert consensus recommendations serve as clinical guidelines for the primary staging of rectal cancer using MRI. Recommendations for restaging and response evaluation after neoadjuvant treatment are addressed in a separate publication.

Key Points

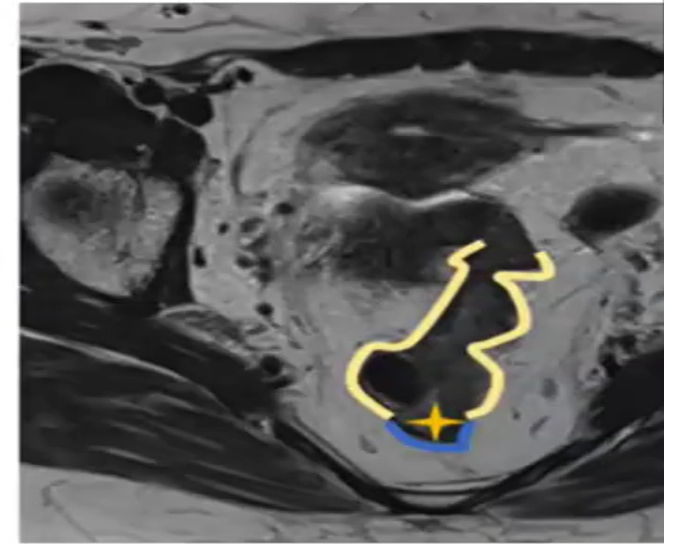
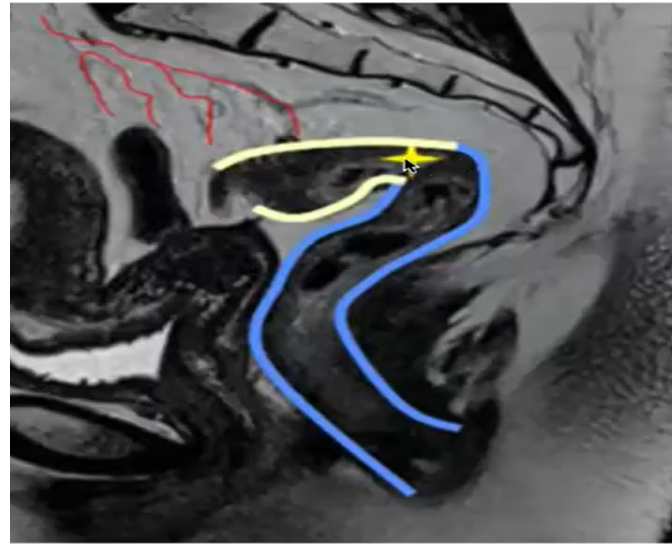
Question Since the last ESGAR rectal imaging guideline update, the rectal cancer treatment landscape has further evolved, necessitating updates to the existing guidelines.

Findings An online consensus process involving 26 panellists led to 96% consensus across 121 items discussed, including 22 general items and 55 related to primary staging.

Clinical relevance Key updates related to primary staging include more detailed recommendations for image acquisition, adoption of the sigmoid take-off, refined criteria for MRF involvement, a new patient-level approach for cT₄-assessment, and recommendations on the limited use of DMN.

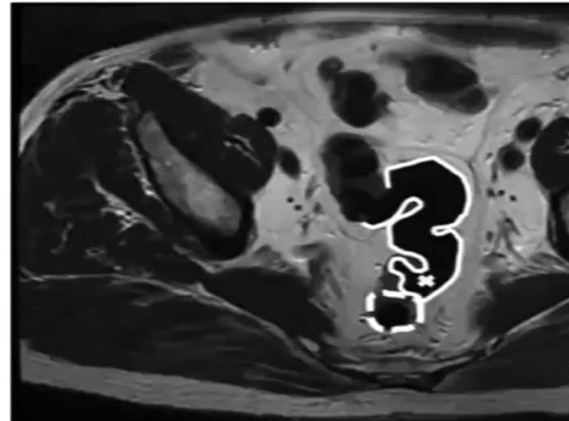
- 1300 pacientes
- 13% cambio de localización
- 50% de esos, otro tto
- Diferente morbilidad

SIGMOID TAKE-OFF



SAGITAL

Se aleja del sacro
Disposición horizontal

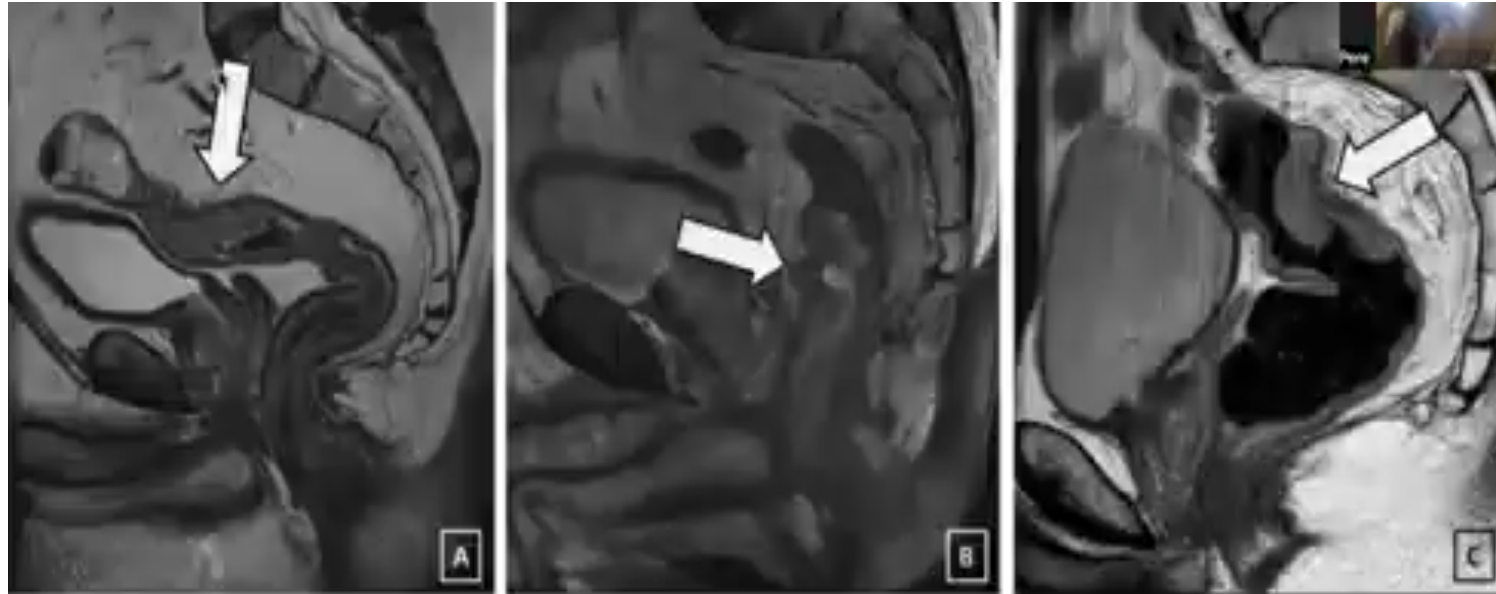


AXIAL

Disposición en vertical



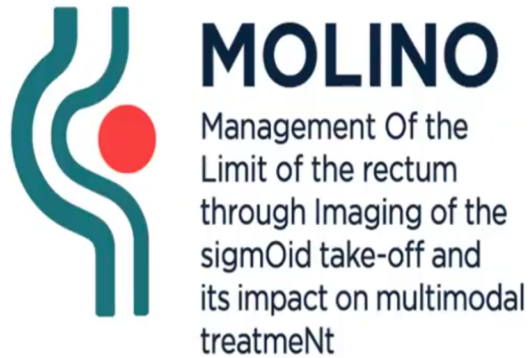
SIGMOID TAKE-OFF





SELECCIÓN: EMPIEZA EN EL DIAGNÓSTICO

Management Of the Limit of the rectum through
Imaging of the sigmoid take-off and its impact on
multimodal treatment



MOLINO Study

Intervenidos del 2017-2023

Centros:

Ramón y Cajal

La Paz

Vall d' Hebron

Marqués de Valdecilla

Virgen del Rocío

La Fe

Son Espases

Josep Trueta

Vigo

Reina Sofía (Córdoba)

Clínica Navarra

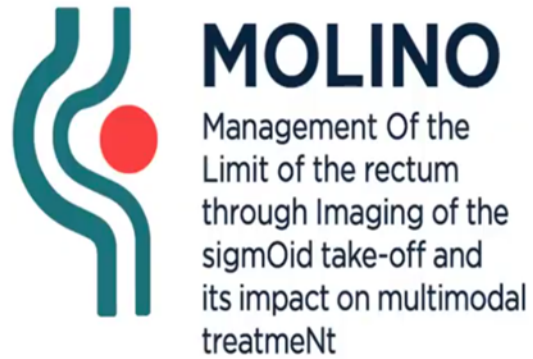
Gregorio Marañón

Clinic (Barcelona)

Objetivo Primario

Evaluar la utilidad y el impacto de establecer el punto de sigmoid take-off como una referencia anatómica estandarizada para la localización del tumor en el cáncer colorrectal, con el fin de **reducir la variabilidad en la clasificación** de los tumores de la unión colorrectal y rectosigmoideos y **guiar las decisiones clínicas**.

Management Of the Limit of the rectum through
Imaging of the sigMOid take-off and its impact on
multimodal treatmeNt



N=1411 pacientes

MOLINO Study

CAMBIO DE RECTO ALTO A SIGMA: 22.7%

**45% (138 PACIENTES) HUBIERA HABIDO UN CAMBIO EN EL
TRATAMIENTO REALIZADO**



GUIAS / CONSENSOS / PROTOCOLOS
NO SOBRETARAR TUMORES DE SIGMA
(MÁS SELECCIÓN MENOS AGRESIÓN)



TRATAMIENTOS CARCINOMA DE RECTO

RADIOTERAPIA

CIRUGIA

QUIMIOTERAPIA

(MÁS SELECCIÓN MENOS AGRESIÓN)

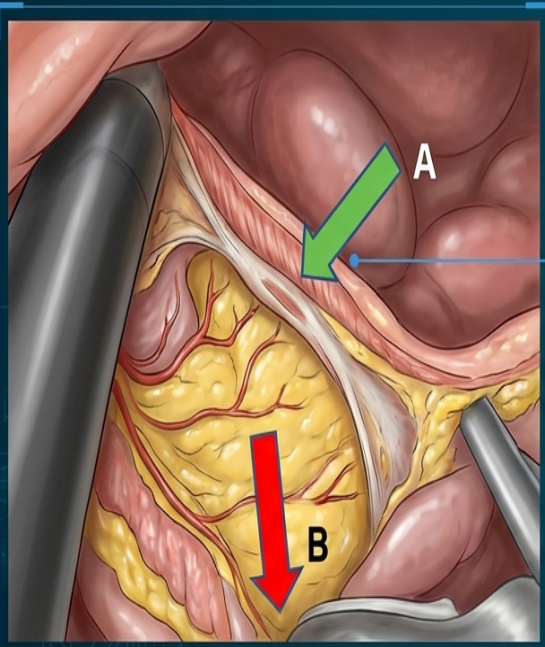


MENOS AGRESION – MAS SELECCION

- **RESECCION LOCAL EN EL CANCER DE RECTO PRECOZ**
- WATCH AND WAIT
- CANCER DE RECTO ALTO



RESECCIÓN LOCAL EN EL CÁNCER DE RECTO



Regla Quirúrgica Fundamental: La resección debe limitarse estrictamente a la pared rectal completa (flecha A), sin entrar en la grasa perirrectal (flecha B).

El Motivo: Evitar la cicatrización y alteración anatómica de la fascia mesorrectal. Si el paciente requiere posteriormente una ETM (Cirugía de Finalización), un mesorrecto virgen e intacto es crucial para evitar morbilidad severa y asegurar una escisión de calidad.

Nota: Las perforaciones a la cavidad peritoneal durante la RL pueden repararse por la misma vía transanal as por la misma vía transanal sin necesidad de convertir a laparoscopia.



TEM / TEO
(Microcirugía Endoscópica Transanal)



• **Diseño:** Dispositivo metálico rígido (7.5 - 20 cm) con visión estática fijada.



• **Ventaja:** Permite la resección de lesiones a mayor distancia del margen anal utilizando instrumental propio angulado.



• **Inconveniente:** Alto costo (especialmente TEM) y requiere equipo altamente específico.



TAMIS
(Cirugía Mínimamente Invasiva Transanal)



• **Diseño:** Utiliza un puerto flexible (ej. GelPOINT) de 4-5 cm y torres de laparoscopia convencionales.



• **Ventaja:** Reduce drásticamente los costes y ofrece mejor maniobrabilidad dentro del recto.







• **Inconveniente:** La menor longitud del puerto limita el alcance en lesiones muy proximales.

RESECCIÓN LOCAL EN EL CÁNCER DE RECTO

Candidato Ideal para RL Exclusiva

- ✓ **Perfil:** T1N0 sin factores de riesgo desfavorables.
- ✓ **Resultados:** Supervivencia cáncer-específica a 5 años equivalente a la ETM, con menor mortalidad perioperatoria (RR 0.31) y menor necesidad de estoma (RR 0.17).


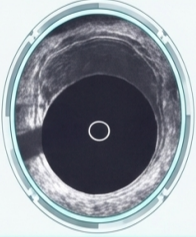
Factores de Riesgo / Requiere ETM

- | | |
|--|--|
|  Invasión: Kikuchi sm3 (Invasión submucosa profunda). |  Diferenciación: Tumores de alto grado / pobremente diferenciados. |
|  Microambiente: Presencia de "Tumour Budding" de alto grado. |  Vascular: Presencia de invasión linfovascular. |



RESECCIÓN LOCAL EN EL CÁNCER DE RECTO

La Tríada Diagnóstica (Evaluación Preoperatoria)

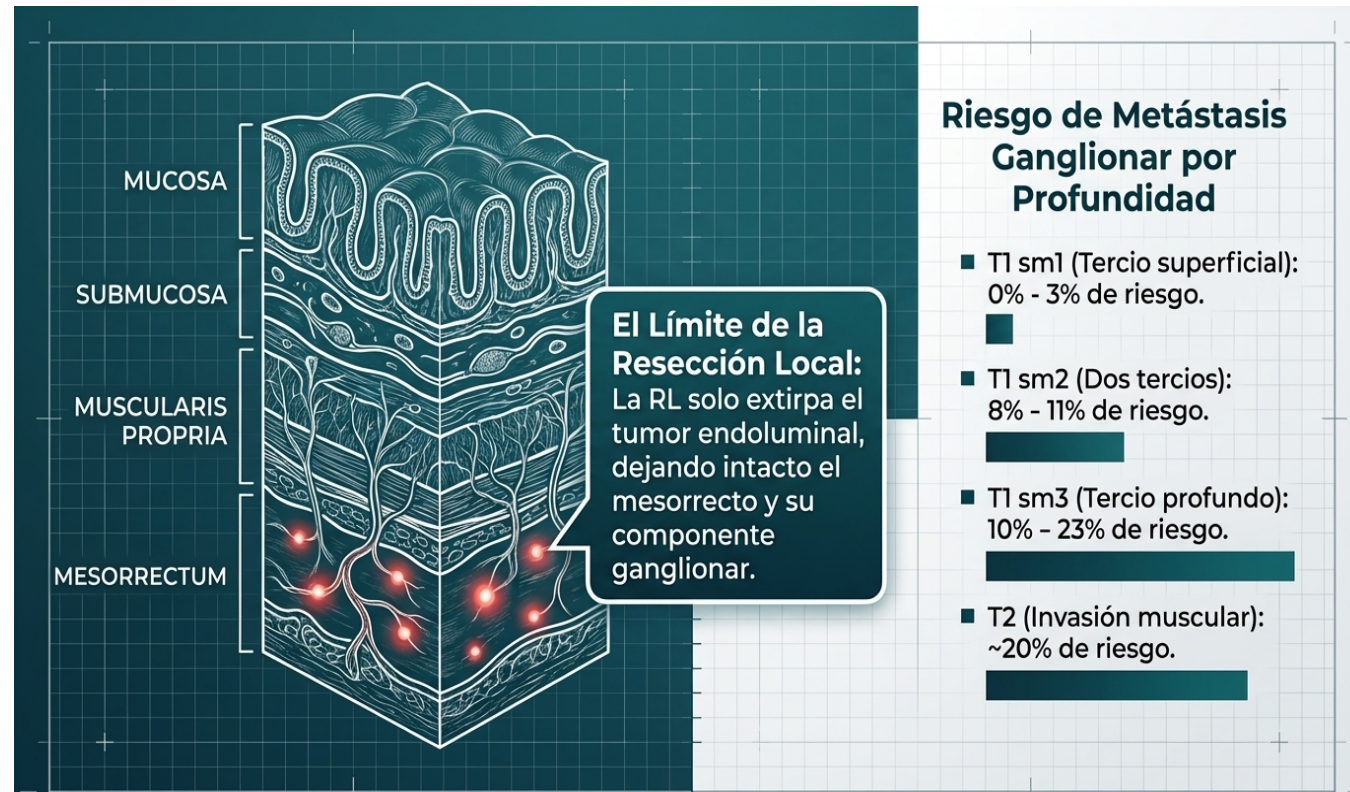
| Endoscopia | Resonancia Magnética (RM) | Ecoendoscopia (ERUS) |
|---|---|---|
|  |  |  |
| <p>Rol: Excluir lesiones sincrónicas (3% de los casos).</p> <p>Valor Predictivo: Clasificaciones de París y Kudo predicen la invasión submucosa para evitar tratamientos inadecuados.</p> | <p>Rol: Método de elección para estadificación local.</p> <p>Valor Predictivo: Secuencias de difusión evalúan todos los compartimentos ganglionares pélvicos y la invasión vascular extramural.</p> | <p>Rol: Máxima resolución espacial.</p> <p>Valor Predictivo: Superior para evaluar la profundidad exacta de invasión en la pared rectal, aunque requiere una alta curva de aprendizaje.</p> |



DISTINCIÓN ENTRE T0 Y T1



RESECCIÓN LOCAL EN EL CÁNCER DE RECTO





RESECCIÓN LOCAL EN EL CÁNCER DE RECTO

RESECCIÓN LOCAL + QRT ADYUVANTE: RESULTADOS POBRES EN T1 DE ALTO RIESGO Y T2

Review > [Br J Surg.](#) 2016 Aug;103(9):1105-16. doi: 10.1002/bjs.10163. Epub 2016 Jun 15.

Meta-analysis of oncological outcomes after local excision of pT1-2 rectal cancer requiring adjuvant (chemo)radiotherapy or completion surgery

[W A A Borstlap](#)¹, [T J Coeymans](#)¹, [P J Tanis](#)¹, [C A M Marijnen](#)², [C Cunningham](#)³,
[W A Bemelman](#)¹, [J B Tuynman](#)⁴

Affiliations + expand

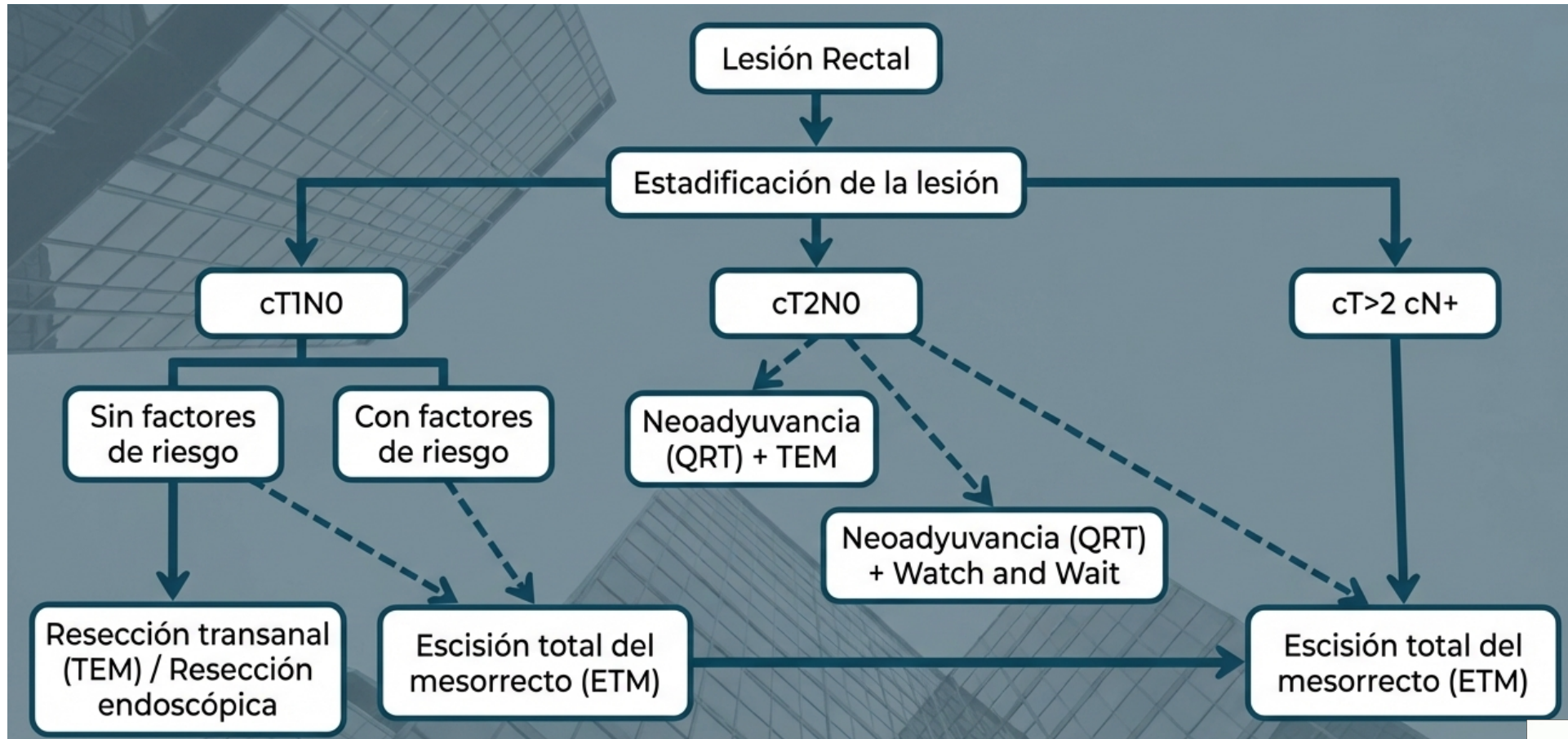
PMID: 27302385 DOI: [10.1002/bjs.10163](#)

RECIDIVA LOCAL 14 % VS 7% del TME

REC. DISTANCIA 9% en ambos.



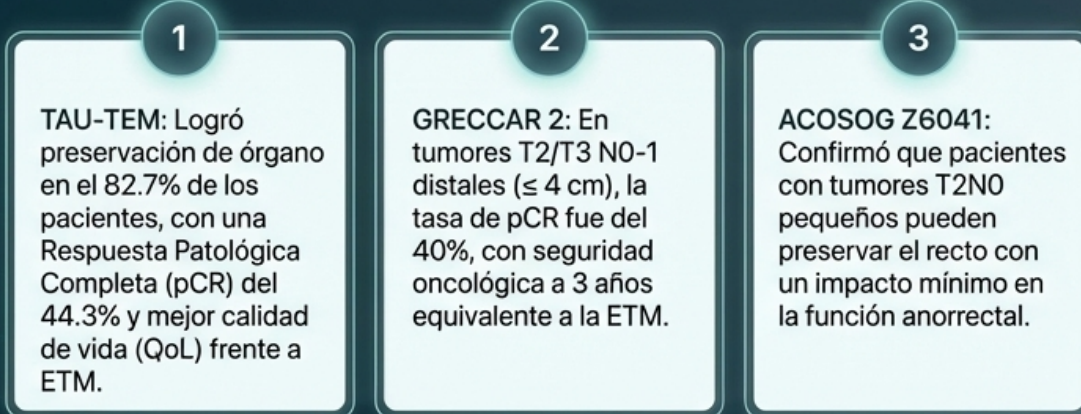
RESECCIÓN LOCAL EN EL CÁNCER DE RECTO





NEOADYUVANCIA + EXTIRPACIÓN LOCAL

Contexto: Para tumores cT2N0 o cT1 con factores de riesgo, la combinación de QRT neoadyuvante seguida de RL busca evitar la ETM tras reducir el tumor.





TUMORES MENORES DE 4 CMS

Research

JAMA Surgery | **Original Investigation**

Chemoradiotherapy and Local Excision vs Total Mesorectal Excision in T2-T3ab, NO, MO Rectal Cancer The TAUTEM Randomized Clinical Trial

Xavier Serra-Aracil, PhD; Carles Pericay, PhD; Ariadna Cidoncha, MD; Jesus Badia-Closa, PhD; Thomas Golda, PhD;
Esther Kreisler, PhD; Pilar Hernández, PhD; Eduardo Targarona, PhD; Nerea Borda-Arrizabalaga, PhD;
Angel Reina, PhD; Salvadora Delgado, PhD; Eloy Espín-Bassany, PhD; Aleidis Caro-Tarrago, PhD;
Javier Gallego-Plazas, PhD; Marta Pascual, PhD; Carlos Álvarez-Laso, PhD; Hector Guadalajara-Labajo, PhD;
Ana Otero, PhD; Sebastiano Biondo, PhD; for the TAUTEM Collaborative Group

Clinical Trial > Lancet Oncol. 2015 Nov;16(15):1537-1546.

doi: 10.1016/S1470-2045(15)00215-6. Epub 2015 Oct 22.

Organ preservation for clinical T2No distal rectal cancer using neoadjuvant chemoradiotherapy and local excision (ACOSOG Z6041): results of an open- label, single-arm, multi-institutional, phase 2 trial

Julio Garcia-Aguilar¹, Lindsay A Renfro², Oliver S Chow³, Qian Shi², Xiomara W Carrero²,
Patricio B Lynn³, Charles R Thomas Jr⁴, Emily Chan⁵, Peter A Cataldo⁶, Jorge E Marcet⁷,
David S Medich⁸, Craig S Johnson⁹, Samuel C Oommen¹⁰, Bruce G Wolff², Alessio Pigazzi¹¹,
Shane M McNevin¹², Roger K Pons¹³, Ronald Bleday¹⁴

Affiliations + expand

PMID: 26474521 PMCID: PMC4984260 DOI: 10.1016/S1470-2045(15)00215-6

TUMORES MENORES DE 4 CMS

Research

JAMA Surgery | Original Investigation

Chemoradiotherapy and Local Excision vs Total Mesorectal Excision in T2-T3ab, N0, M0 Rectal Cancer: The TAUTEM Randomized Clinical Trial

Xavier Serra-Aracil, PhD; Carles Pericay, PhD; Ariadna Cidoncha, MD; Jesus Badia-Closa, PhD; Thomas Golda, PhD; Esther Kreisler, PhD; Pilar Hernández, PhD; Eduardo Targarona, PhD; Nerea Borda-Arrizabalaga, PhD; Angel Reina, PhD; Salvadora Delgado, PhD; Eloy Espín-Bassany, PhD; Aleidis Caro-Tarrago, PhD; Javier Gallego-Plazas, PhD; Marta Pascual, PhD; Carlos Álvarez-Laso, PhD; Hector Guadalajara-Labajo, PhD; Ana Otero, PhD; Sebastiano Biondo, PhD; for the TAUTEM Collaborative Group

N: 173.

Capec+50,4 Gys + EL vs ETM

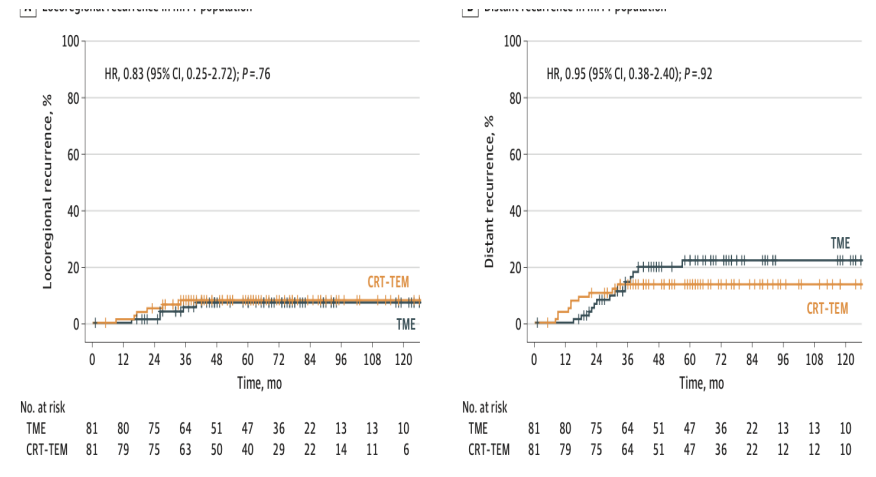
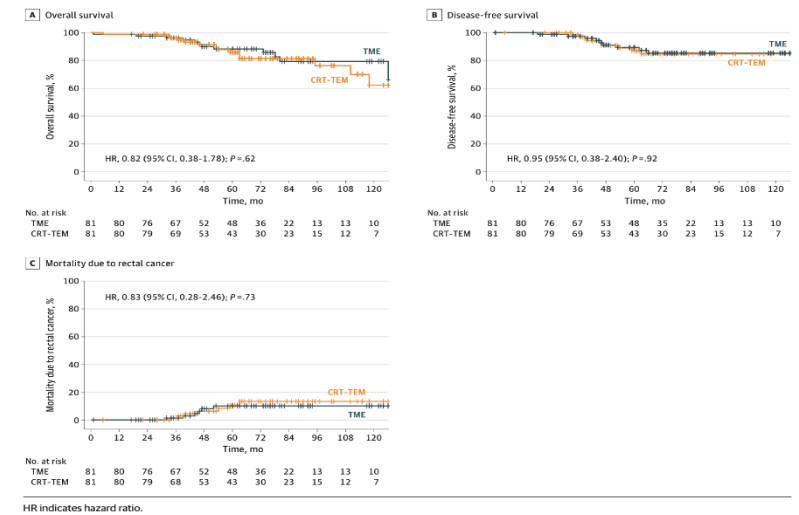


Figure 3. Overall Survival (3A), Disease-Free Survival (3B), and Rectal Cancer Mortality (3C), Among Patients Randomly Assigned to Total Mesorectal Excision (TME) vs Chemoradiotherapy and Transanal Endoscopic Microsurgery (CRT-TEM) According to Modified Intention-to-Treat Analyses





MÁS SELECCIÓN MENOS AGRESIÓN

TUMORES PEQUEÑOS < 4CMS . T1-T2



El Futuro: Las estrategias combinadas (Neoadyuvancia + RL o “Watch and Wait”) representan la evolución natural hacia la preservación de órganos, mitigando la morbilidad de la ETM en pacientes seleccionados con respuesta clínica completa.



MENOS AGRESION – MAS SELECCION

- RESECCION LOCAL EN EL CANCER DE RECTO PRECOZ
- **WATCH AND WAIT**
- CANCER DE RECTO ALTO



WATCH AND WAIT

MENOS AGRESION – MAS SELECCION

- Problemas en la selección. **NO** identificados a los respondedores

Published in final edited form as:
Dis Colon Rectum. 2025 March 01; 68(3): 300–307. doi:10.1097/DCR.0000000000003538.

Correlation Between Grade of Clinical Response to Neoadjuvant Therapy for Rectal Cancer and Oncologic Outcomes in the Era of Watch-and-Wait

Roni Rosen, M.D.¹, Aron Bercz, M.D.¹, Dana Omer, M.D.¹, Floris S. Verheij, M.D., Ph.D.¹, Hannah Williams, M.D.¹, Parisa Malekzadeh, M.D.¹, Danielle Kong, B.S.¹, Felipe F. Quezada-Diaz, M.D.¹, Iris Wei, M.D.¹, Maria Widmar, M.D., M.P.H.¹, Georgios Karagkounis, M.D.¹, Diana Roth O'Brien, M.D.², Carla Hajj, M.D.², Christopher Crane, M.D.², Ping Gu, M.D., Ph.D.³, Neil H. Segal, M.D., Ph.D.³, Marina Shcherba, D.O.³, Karuna Ganesh, M.D., Ph.D.³, Rona Yaeger, M.D.³, Emmanouil Pappou, M.D., Ph.D.¹, Paul B. Romesser, M.D.², Garrett M. Nash, M.D., M.P.H.¹, Leonard B. Saltz, M.D.³, Andrea Cercek, M.D.³, Martin R. Weiser, M.D.¹, Mithat Gonen, Ph.D.⁴, Philip B. Paty, M.D.¹, Julio Garcia-Aguilarm, M.D., Ph.D.¹, J. Joshua Smith, M.D., Ph.D.¹

¹Department of Colon and Rectal Surgery, Memorial Sloan Kettering Cancer Center, New York

²Department Radiation Oncology, Memorial Sloan Kettering Cancer Center, New York

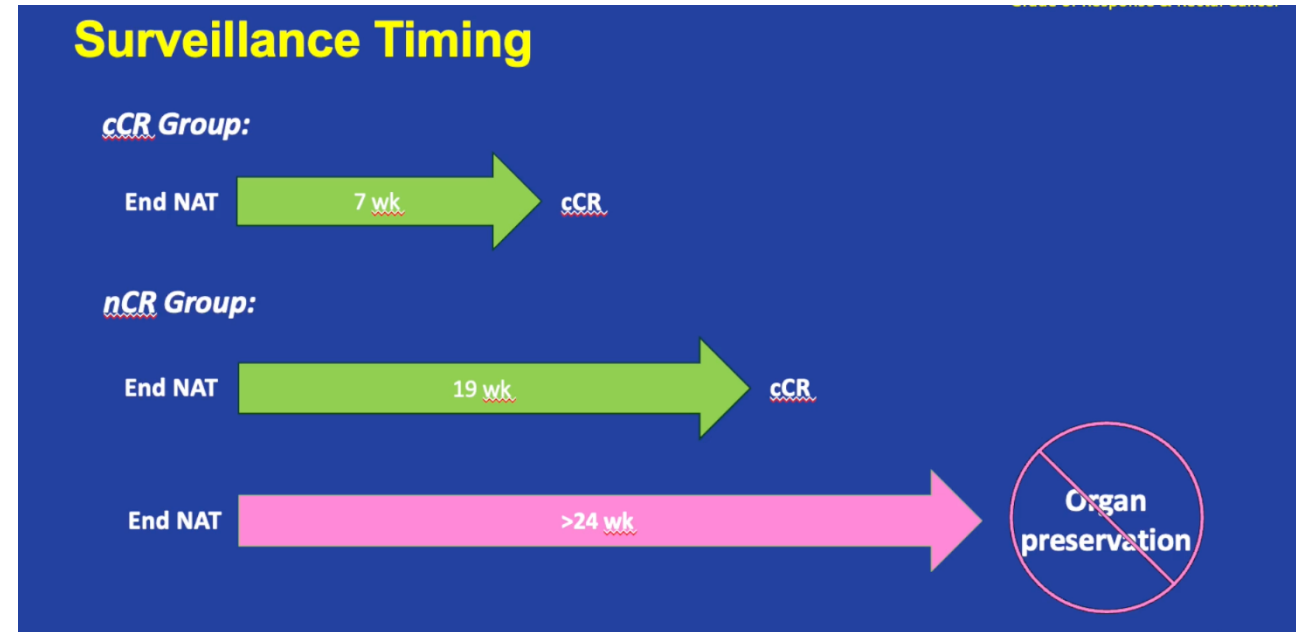
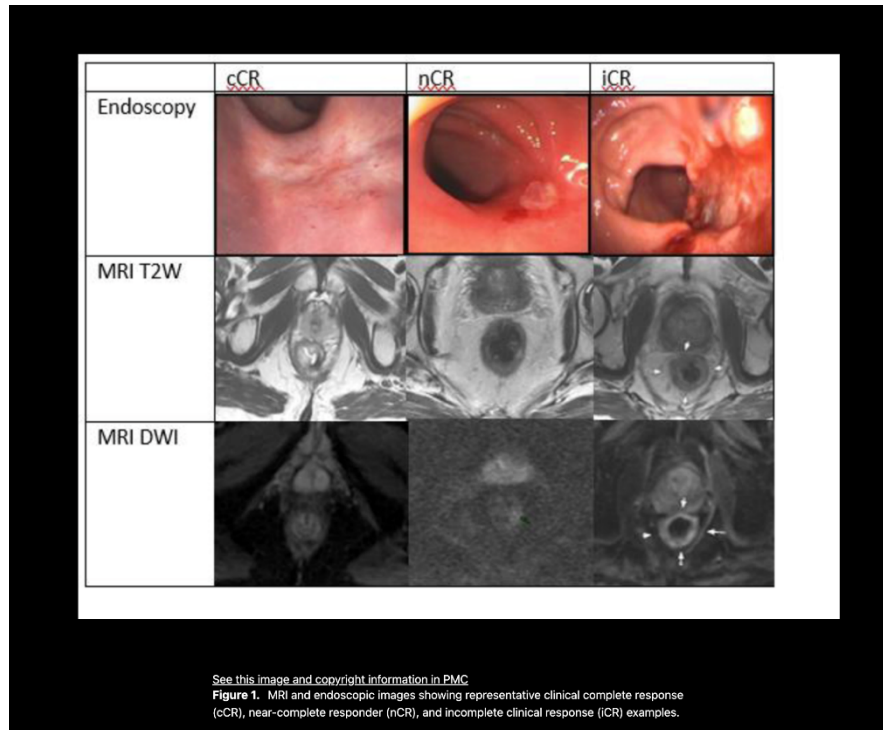
³Department of Medical Oncology, Memorial Sloan Kettering Cancer Center, New York

⁴Department of Epidemiology and Biostatistics, Memorial Sloan Kettering Cancer Center, New York



WATCH AND WAIT

MENOS AGRESION – MAS SELECCION



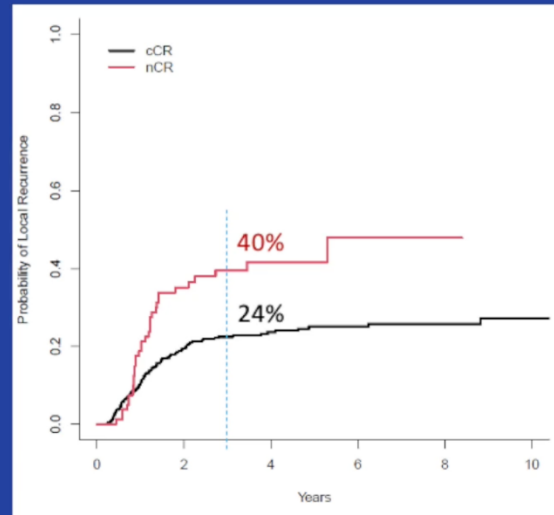


WATCH AND WAIT

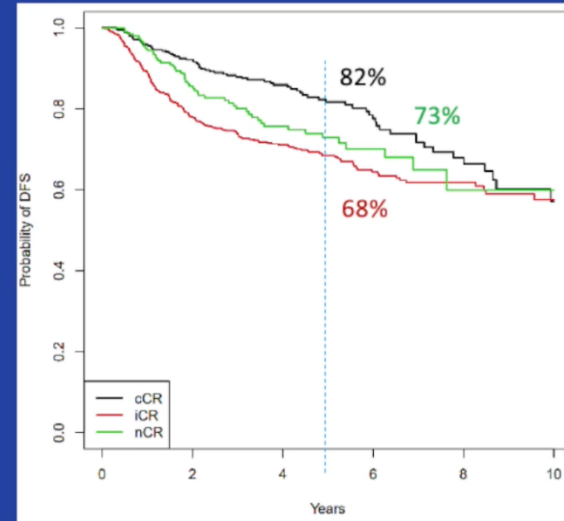
MENOS AGRESION – MAS SELECCION

Local Regrowth and Disease-Free Survival

Local Regrowth



Disease-Free Survival

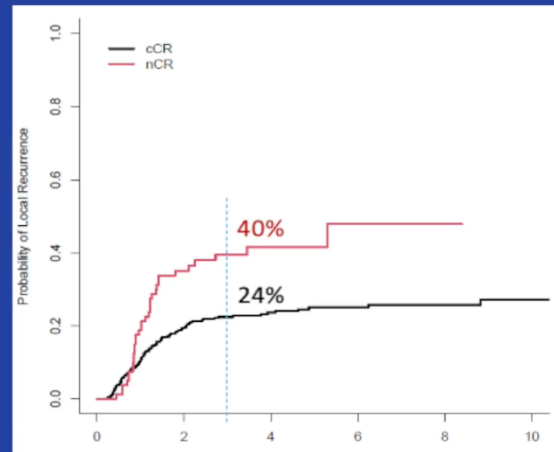




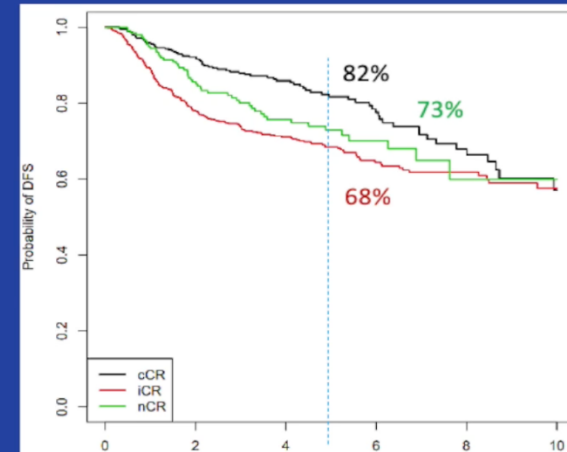
WATCH AND WAIT

Local Regrowth and Disease-Free Survival

Local Regrowth



Disease-Free Survival



5-Year TME-Free Survival (OP) Rate

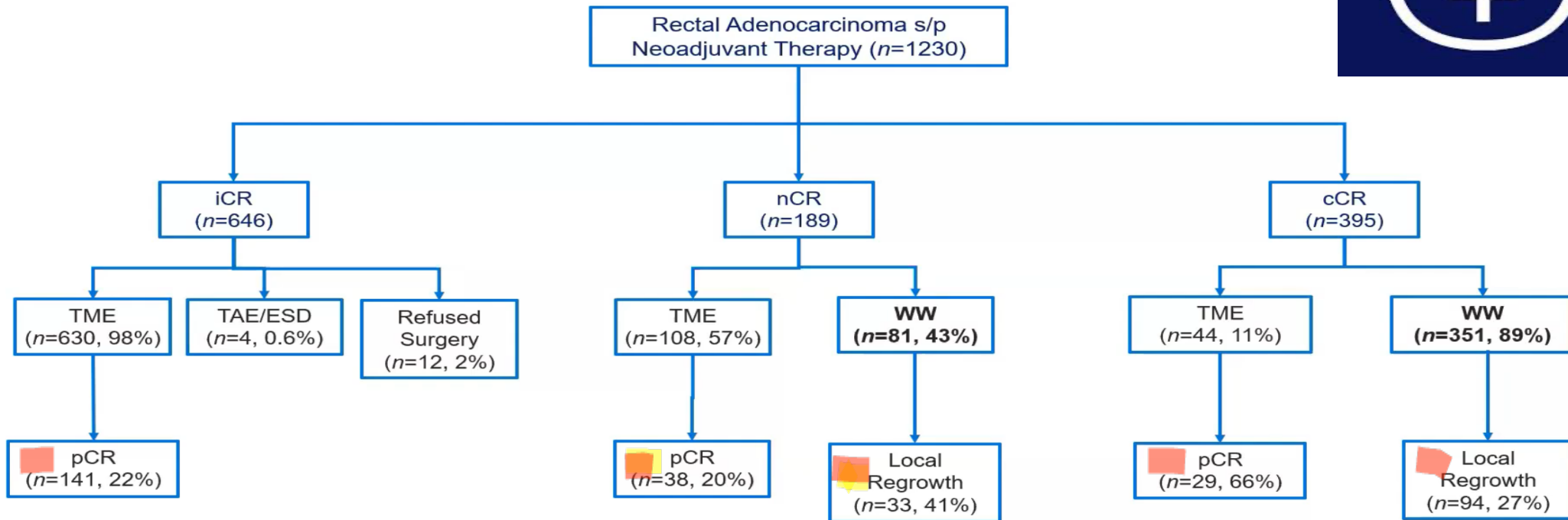
- **cCR:** 73% (IQR, 68-79%)
- **nCR:** 53% (IQR, 39-71%)

Risk of Distant Metastasis

- **cCR:** 27% with regrowth vs. 7% without regrowth (OR 4.81; 95% CI, 2.48–9.33; $p < 0.001$)
- **nCR:** 48% with regrowth vs. 17% without regrowth (OR 4.59; 95% CI, 1.65–12.75; $p = 0.004$)

WATCH AND WAIT

MENOS AGRESION – MAS SELECCION MSK Off-Protocol Cohort

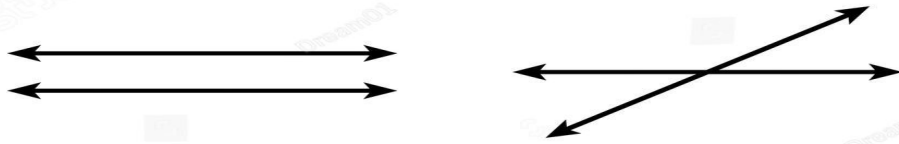


Rosen et al., *Dis Colon Rectum* 2025. (PMID: 39808079)

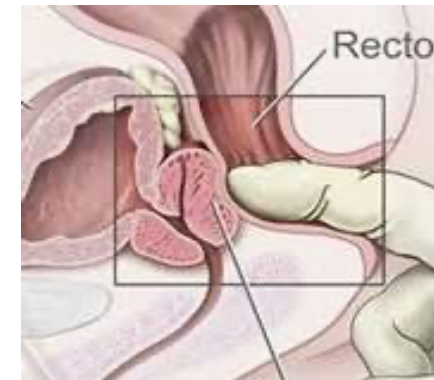


WATCH AND WAIT

MENOS AGRESION – MAS SELECCION



- Patrones no lineales
- Pacientes más jóvenes
- Decisión bien explicada
- Asumir riesgos en w&w
- Rectos más distales





MENOS AGRESION – MAS SELECCION

- RESECCION LOCAL EN EL CANCER DE RECTO PRECOZ
- WATCH AND WAIT
- **CANCER DE RECTO ALTO**



TRATAMIENTOS CARCINOMA DE RECTO

RADIOTERAPIA

CIRUGIA

QUIMIOTERAPIA

(MÁS SELECCIÓN MENOS AGRESIÓN)



CA DE RECTO ALTO MENOS AGRESION – MAS SELECCION

Clinical and Translational Oncology (2026) 28:451–462
<https://doi.org/10.1007/s12094-025-04140-4>

CLINICAL GUIDES IN ONCOLOGY



SEOM-GEMCAD-TTD clinical guidelines for localized rectal cancer (2025)

Maria José Safont Aguilera¹ · Ferran Losa Gaspá² · Encarna González-Flores³ · María Luisa Limón Mirón⁴ · José Luis Manzano Mozo⁵ · María del Carmen Riesco Martínez⁶ · Rosario Vidal-Tocino⁷ · Vicente Alonso Orduña⁸ · Elena Asensio Martínez⁹ · Ruth Vera García¹⁰

Received: 12 November 2025 / Accepted: 12 November 2025 / Published online: 3 December 2025
 © The Author(s) 2025, modified publication 2025

Abstract

This guideline provides a comprehensive overview of the management of localized rectal cancer, highlighting recent major advances in therapeutic strategies. Accurate staging remains essential, as it informs treatment decisions and facilitates risk assessment. A pivotal development in rectal cancer treatment is the adoption of total neoadjuvant therapy (TNT), which has demonstrated improved tumor response, reduced risk of systemic recurrence, and enhanced survival outcomes. This approach enables a “watch-and-wait” strategy and conservative management that may render surgery unnecessary and preserves rectal function in patients who achieve a complete clinical response. By emphasizing a structured approach to staging, multidisciplinary evaluation, and innovative treatment pathways, this guideline aims to improve outcomes while minimizing the morbidity associated with rectal cancer treatment.

Keywords Rectal cancer · Total neoadjuvant treatment · Watch and wait

Clinical and Translational Oncology (2026) 28:451–462

455

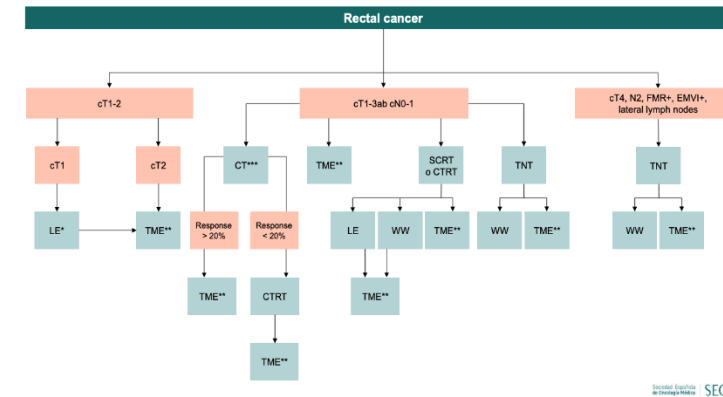


Fig. 1 Rectal cancer treatment algorithm. LE, local excision; TME, total mesorectal excision; CT, chemotherapy; CRT, concomitant chemoradiotherapy; SCRT, short-course radiotherapy; WW, watch and wait; TNT, total neoadjuvant therapy; MRF, mesorectal fascia; EMVI, extramesorectal venous invasion. *If high-risk features, proceed to TME. **Consider adjuvant QT if high-risk stage II or stage III after surgery. ***If tumors are located in the upper and middle rectum

Options without preoperative radiotherapy

In cT3a-b, N0-1, and RC located in upper or middle rectum, the risk of local and systemic recurrence is low; therefore, neoadjuvant RT may be omitted and TME surgery should be proposed.

Recently, the PROSPECT trial has proven the non-inferiority of preoperative FOLFOX to preoperative CRT with respect to DFS with similar OS and LR rates in RC staged as T2N+, T3N0, or T3N+ in subjects eligible for sphincter-sparing surgery [40]. This strategy spares patients with low

CA DE RECTO ALTO

MENOS AGRESION – MAS SELECCION



SPECIAL ARTICLE

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

R.-D. Hofheinz¹, E. Fokas², L. Benhaim³, T. J. Price⁴, D. Arnold⁵, R. Beets-Tan⁶, M. G. Guren⁷, G. A. P. Hospers⁸, S. Lonardi⁹, I. D. Nagtegaal¹⁰, R. O. Perez¹¹, A. Cervantes^{12,13} & E. Martinelli¹⁴, on behalf of the ESMO Guidelines Committee^{*}

¹TagesTherapiezentrum, Mannheim Cancer Center, University of Heidelberg, Mannheim; ²Department of Radiation Oncology, Cyberknife and Radiotherapy, Center for Integrated Oncology Aachen Bonn Cologne Düsseldorf, Faculty of Medicine Cologne, University Hospital Cologne, Cologne, Germany; ³Department of Surgical Oncology, Gustave Roussy, Villejuif, France; ⁴Medical Oncology Unit, The Queen Elizabeth Hospital and University of Adelaide, Woodville, Australia; ⁵Asklepios Tumorzentrum Hamburg, AK Altona, Hamburg, Germany; ⁶The Netherlands Cancer Institute, Amsterdam, The Netherlands; ⁷Department of Oncology, Oslo University Hospital and Institute of Clinical Medicine, University of Oslo, Oslo, Norway; ⁸Department of Medical Oncology, University Medical Center Groningen, University of Groningen, Groningen, The Netherlands; ⁹Oncology 3 Unit, Veneto Institute of Oncology (IOV) – IRCCS, Padua, Italy; ¹⁰Department of Pathology, Radboud University Medical Center, Nijmegen, The Netherlands; ¹¹Department of Colorectal Surgery, Hospital Alemão Oswaldo Cruz, São Paulo, Brazil; ¹²Department of Medical Oncology, INCLIVA Biomedical Research Institute, Hospital Clínico Universitario de Valencia, University of Valencia, Valencia; ¹³CIBERONC, Instituto de Salud Carlos III, Madrid, Spain; ¹⁴Department of Precision Medicine, Oncology Unit, Università degli Studi della Campania Luigi Vanvitelli, Naples, Italy



Available online 22 May 2025

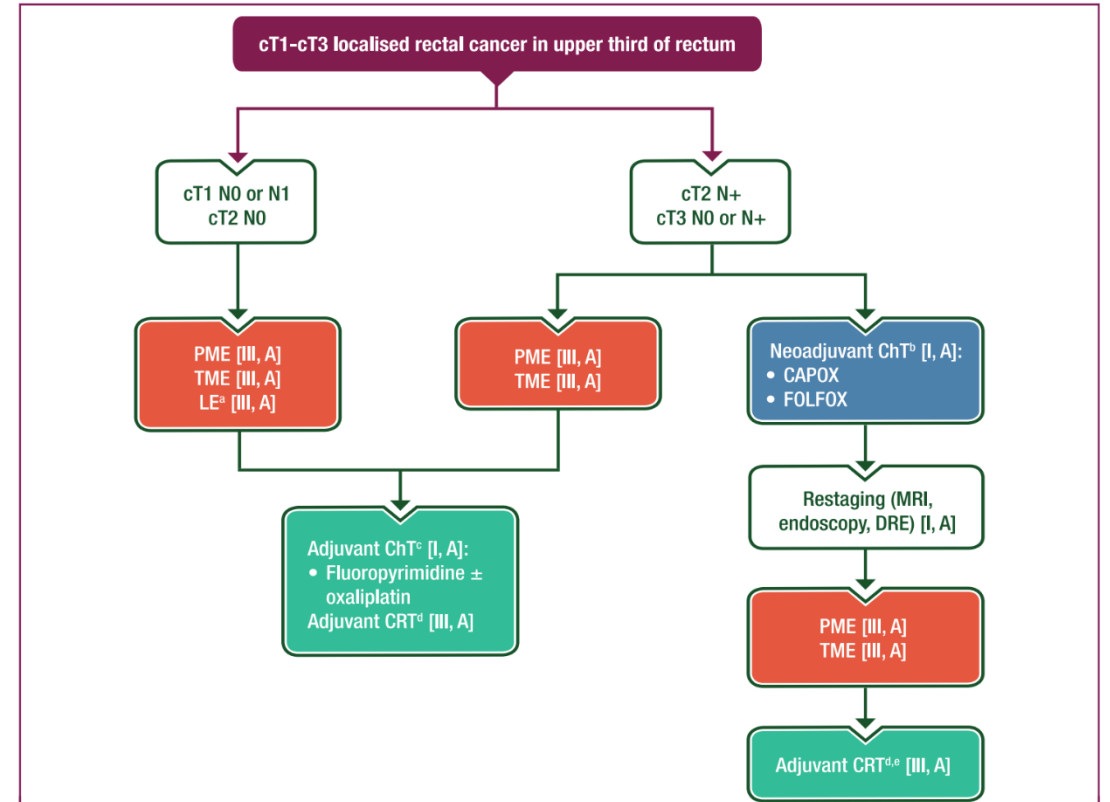


Figure 1. Management of cT1-cT3 localised rectal cancer located in the upper third of the rectum.

Purple: algorithm title; orange: surgery; blue: systemic anticancer therapy or their combination; turquoise: nonsystemic anticancer therapies or a combination of treatment modalities; white: other aspects of management and nontreatment aspects.

c, clinical; CAPOX, capecitabine–oxaliplatin; ChT, chemotherapy; CRM, circumferential resection margin; CRT, chemoradiotherapy; DRE, digital rectal examination; FOLFOX, leucovorin–5-fluorouracil–oxaliplatin; LE, local excision; MRF, mesorectal fascia; MRI, magnetic resonance imaging; N+, node positive; p, pathological; PME, partial mesorectal excision; RT, radiotherapy; TME, total mesorectal excision.

^aFor low-risk tumours (pT1 without unfavourable pathological features).

^bSalvage RT is recommended in case of intolerance to, or progression on, neoadjuvant ChT [I, A].

^cOnly following PME or TME alone, according to clinical risk assessment.

^dOnly in case of CRM positivity, pT4b, pN2 with extracapsular spread close to the MRF or poor-quality TME in patients who did not receive preoperative RT.

^eAdjuvant ChT may be considered, but its clinical value is not proven [V, C].

CA DE RECTO ALTO

MENOS AGRESION – MAS SELECCION



SPECIAL ARTICLE

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

R.-D. Hofheinz¹, E. Fokas², L. Benhaim³, T. J. Price⁴, D. Arnold⁵, R. Beets-Tan⁶, M. G. Guren⁷, G. A. P. Hospers⁸, S. Lonardi⁹, I. D. Nagtegaal¹⁰, R. O. Perez¹¹, A. Cervantes^{12,13} & E. Martinelli¹⁴, on behalf of the ESMO Guidelines Committee^{*}

¹TagessTherapieZentrum, Mannheim Cancer Center, University of Heidelberg, Mannheim; ²Department of Radiation Oncology, Cyberknife and Radiotherapy, Center for Integrated Oncology Aachen Bonn Cologne Düsseldorf, Faculty of Medicine Cologne, University Hospital Cologne, Cologne, Germany; ³Department of Surgical Oncology, Gustave Roussy, Villejuif, France; ⁴Medical Oncology Unit, The Queen Elizabeth Hospital and University of Adelaide, Woodville, Australia; ⁵Asklepios Tumorzentrum Hamburg, AK Altona, Hamburg, Germany; ⁶The Netherlands Cancer Institute, Amsterdam, The Netherlands; ⁷Department of Oncology, Oslo University Hospital and Institute of Clinical Medicine, University of Oslo, Oslo, Norway; ⁸Department of Medical Oncology, University Medical Center Groningen, University of Groningen, Groningen, The Netherlands; ⁹Oncology 3 Unit, Veneto Institute of Oncology (IOV) – IRCCS, Padua, Italy; ¹⁰Department of Pathology, Radboud University Medical Center, Nijmegen, The Netherlands; ¹¹Department of Colorectal Surgery, Hospital Alemão Oswaldo Cruz, São Paulo, Brazil; ¹²Department of Medical Oncology, INCLIVA Biomedical Research Institute, Hospital Clínico Universitario de Valencia, University of Valencia, Valencia; ¹³CIBERONC, Instituto de Salud Carlos III, Madrid, Spain; ¹⁴Department of Precision Medicine, Oncology Unit, Università degli Studi della Campania Luigi Vanvitelli, Naples, Italy



Available online 22 May 2025

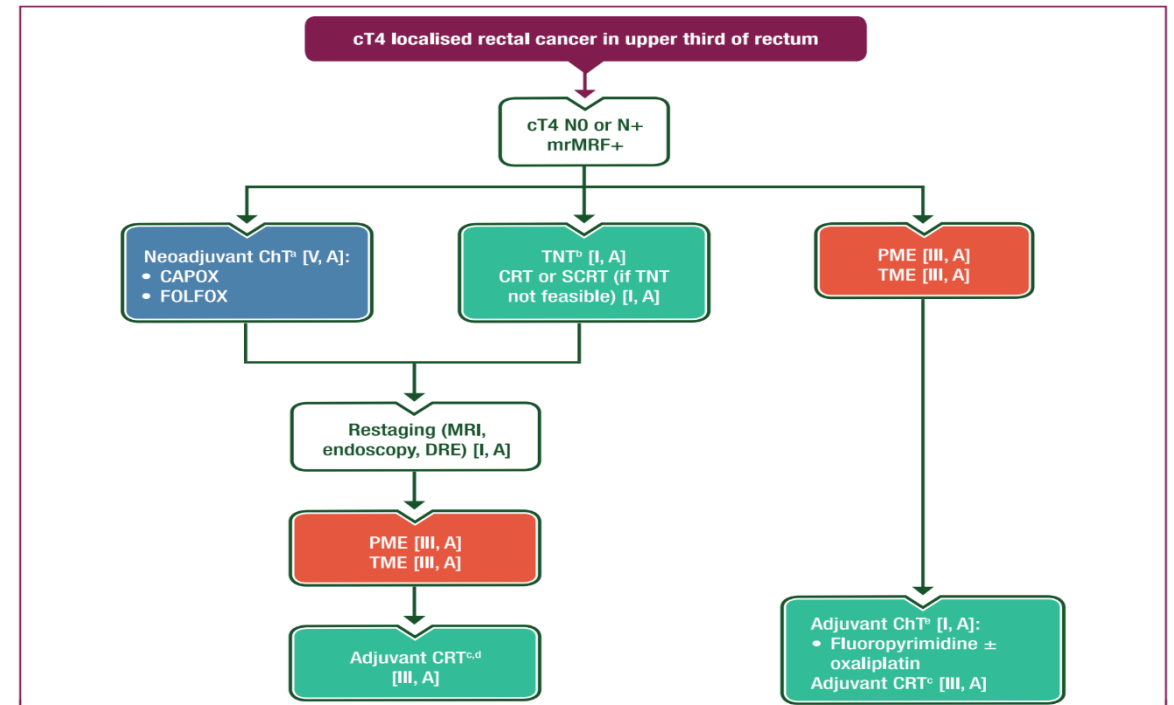


Figure 2. Management of cT4 localised rectal cancer located in the upper third of the rectum.

Purple: algorithm title; orange: surgery; blue: systemic anticancer therapy or their combination; turquoise: nonsystemic anticancer therapies or a combination of treatment modalities; white: other aspects of management and nontreatment aspects.

c, clinical; CAPOX, capecitabine–oxaliplatin; ChT, chemotherapy; CRM, circumferential resection margin; CRT, chemoradiotherapy; DRE, digital rectal examination; EMVI+, extramural venous invasion; FOLFOX, leucovorin–5-fluorouracil–oxaliplatin; LN+, involved lymph nodes; MRF, mesorectal fascia; MRI, magnetic resonance imaging; mrMRF+, involved or threatened mesorectal fascia; N+, node positive; p, pathological; PME, partial mesorectal excision; RT, radiotherapy; SCRT, short-course radiotherapy; TME, total mesorectal excision; TNT, total neoadjuvant therapy.

^aSalvage RT is recommended in case of intolerance to, or progression on, neoadjuvant ChT [I, A].

^bIn case of high-risk criteria (cT4, cN2, mrMRF+, EMVI+, lateral LN+).

^cOnly in case of CRM positivity, pT4b, pN2 with extracapsular spread close to the MRF or poor-quality TME in patients who did not receive preoperative RT.

^dAdjuvant ChT may be considered, but its clinical value is not proven [V, C].

^eOnly following PME or TME alone, according to clinical risk assessment.

CA DE RECTO ALTO

MENOS AGRESION – MAS SELECCION



SPECIAL ARTICLE

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

R.-D. Hofheinz¹, E. Fokas², L. Benhaim³, T. J. Price⁴, D. Arnold⁵, R. Beets-Tan⁶, M. G. Guren⁷, G. A. P. Hospers⁸, S. Lonardi⁹, I. D. Nagtegaal¹⁰, R. O. Perez¹¹, A. Cervantes^{12,13} & E. Martinelli¹⁴, on behalf of the ESMO Guidelines Committee^{*}

¹TagessTherapiezentrum, Mannheim Cancer Center, University of Heidelberg, Mannheim; ²Department of Radiation Oncology, Cyberknife and Radiotherapy, Center for Integrated Oncology Aachen Bonn Cologne Düsseldorf, Faculty of Medicine Cologne, University Hospital Cologne, Cologne, Germany; ³Department of Surgical Oncology, Gustave Roussy, Villejuif, France; ⁴Medical Oncology Unit, The Queen Elizabeth Hospital and University of Adelaide, Woodville, Australia; ⁵Asklepios Tumorzentrum Hamburg, AK Altona, Hamburg, Germany; ⁶The Netherlands Cancer Institute, Amsterdam, The Netherlands; ⁷Department of Oncology, Oslo University Hospital and Institute of Clinical Medicine, University of Oslo, Oslo, Norway; ⁸Department of Medical Oncology, University Medical Center Groningen, University of Groningen, Groningen, The Netherlands; ⁹Oncology 3 Unit, Veneto Institute of Oncology (IOV) – IRCCS, Padua, Italy; ¹⁰Department of Pathology, Radboud University Medical Center, Nijmegen, The Netherlands; ¹¹Department of Colorectal Surgery, Hospital Alemão Oswaldo Cruz, São Paulo, Brazil; ¹²Department of Medical Oncology, INCLIVA Biomedical Research Institute, Hospital Clínico Universitario de Valencia, University of Valencia, Valencia; ¹³CIBERONC, Instituto de Salud Carlos III, Madrid, Spain; ¹⁴Department of Precision Medicine, Oncology Unit, Università degli Studi della Campania Luigi Vanvitelli, Naples, Italy

Available online 22 May 2025

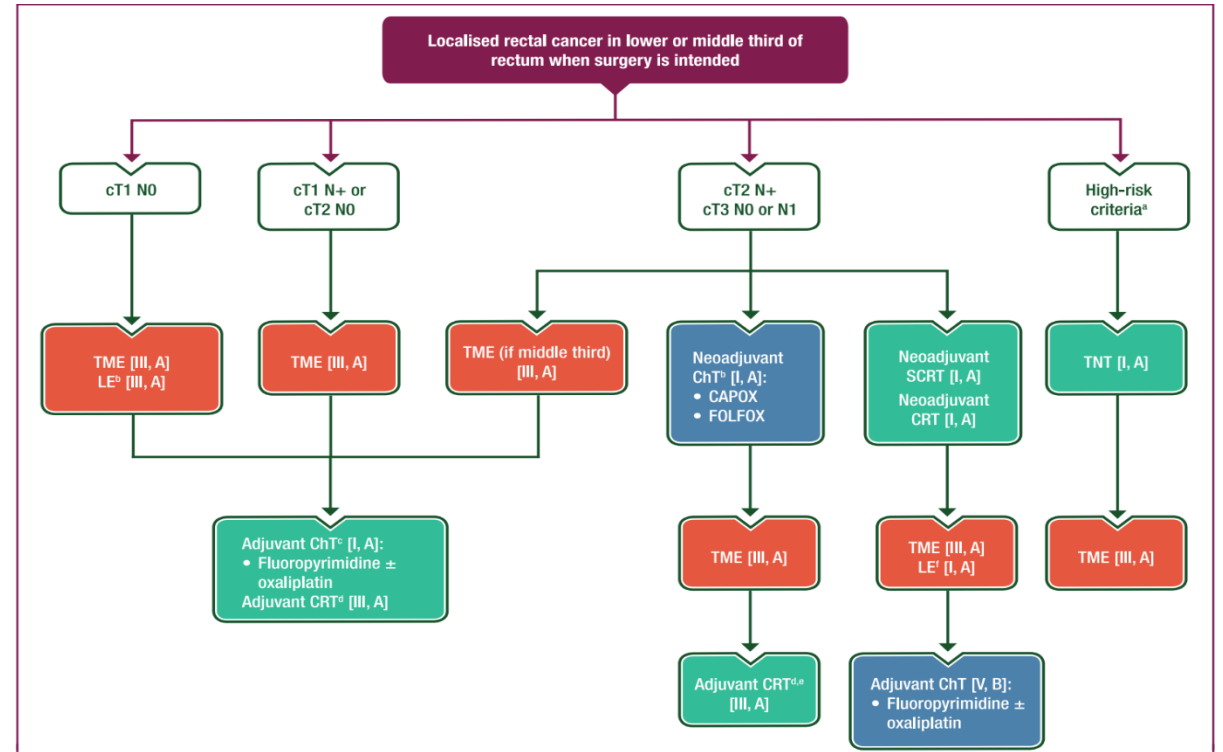


Figure 3. Management of localised rectal cancer located in the lower or middle third of the rectum when surgery is intended.

Purple: algorithm title; orange: surgery; blue: systemic anticancer therapy or their combination; turquoise: nonsystemic anticancer therapies or a combination of treatment modalities; white: other aspects of management and nontreatment aspects.

c, clinical; CAPOX, capecitabine–oxaliplatin; ChT, chemotherapy; CRM, circumferential resection margin; CRT, chemoradiotherapy; EMVI+, extramural venous invasion; FOLFOX, leucovorin–5-fluorouracil–oxaliplatin; LE, local excision; LN+, involved lymph nodes; MRF, mesorectal fascia; mrMRF+, involved or threatened mesorectal fascia; N+, node positive; p, pathological; RT, radiotherapy; SCRT, short-course radiotherapy; TME, total mesorectal excision; TNT, total neoadjuvant therapy.

^acT4, cN2, mrMRF+, EMVI+, lateral LN+.

^bSalvage RT is recommended in case of intolerance to, or progression on, neoadjuvant ChT [I, A].

^cFollowing TME alone, according to clinical risk assessment.

^dOnly in case of CRM positivity, pT4b, pN2 with extracapsular spread close to the MRF or poor-quality TME in patients who did not receive preoperative RT.

^eAdjuvant ChT may be considered, but its clinical value is not proven [V, C].

^fPatients with baseline cT2 or cT3a N0 tumours.



MENOS AGRESION – MAS SELECCION

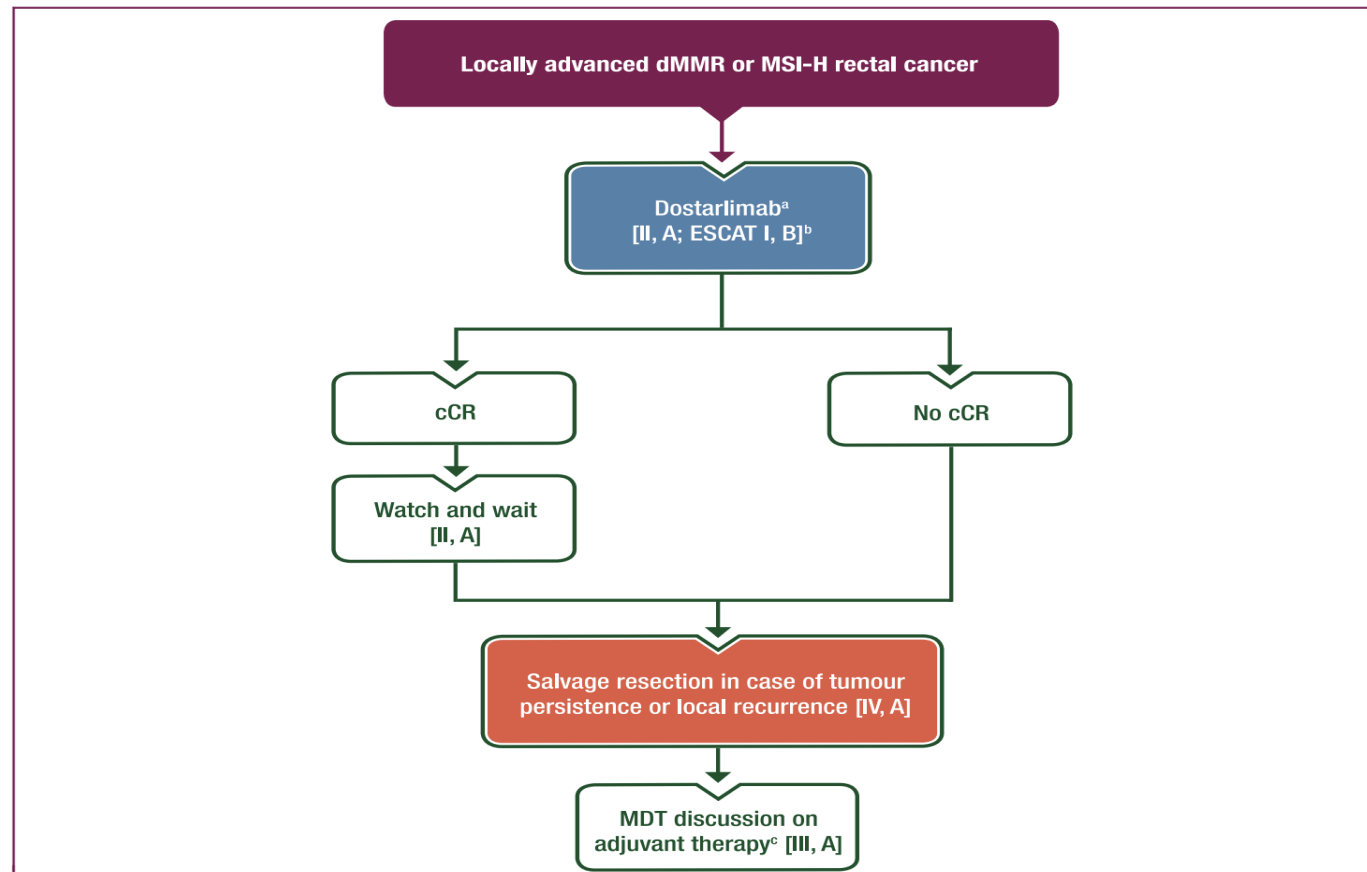


Figure 5. Management of locally advanced dMMR or MSI-H rectal cancer.

Purple: algorithm title; orange: surgery; blue: systemic anticancer therapy or their combination; white: other aspects of management and nontreatment aspects. cCR, clinical complete response; ChT, chemotherapy; CRT, chemoradiotherapy; dMMR, mismatch repair deficient; EMA, European Medicines Agency; ESCAT, ESMO Scale for Clinical Actionability of molecular Targets; FDA, Food and Drug Administration; MDT, multidisciplinary team; MSI-H, microsatellite instability-high.

^aNot EMA or FDA approved in this setting.

^bESCAT scores apply to alterations from genomic-driven analyses only. These scores have been defined by the authors and validated by the ESMO Translational Research and Precision Medicine Working Group.¹⁰⁵

^cChT or CRT considered, according to clinical risk assessment.



CONCLUSIONES

MENOS AGRESION – MAS SELECCION

- Las posibilidades terapéuticas son variadas.
- Eso dificultará la selección del tratamiento adecuado para cada paciente.
- El paciente será parte activa de las decisiones terapéuticas.
- Las opciones menos agresivas no están exentas de posibles complicaciones o vuelta atrás.



MUCHAS GRACIAS
