Northern Cancer Alliance Colorectal Stratified Follow Up Clinical Review and Surveillance Guidelines

Developed and endorsed by the Northern Cancer Alliance Colorectal Tumour Board 2020

Title:	NCA Colorectal Stratified Follow Up Clinical Review and Surveillance Guidelines				
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INTRODUCTION

Following the production of the Clinical Advice to Cancer Alliances for the Commissioning of the Whole Bowel Cancer Pathway in November 2017 this section has been updated to reflect the Cancer Alliances responsibility to promote the use of stratified follow up pathways and remote or self-care follow-up along the lines of the National Cancer Survivorship Initiative [NCSI].

Follow-up policy after an apparently curative resection for colorectal cancer remains controversial and there is no consensus among clinicians about the optimum practicable regimen. Furthermore, there is no evidence that even the most intensive forms of follow-up influence overall survival. Patients with good social support and minimal long-term effects of their treatment should be suitable for self-managed follow-up.

Patients who have not had adjuvant treatment will be followed up by the surgeons. As possible attendances will alternate between surgery and oncology. The frequency of visits will vary up to every 3-6 months for the first 2 years and every 6-12 months between years 2 and 5 postoperatively. If possible combined Surgery-Oncology clinics will be established where patients would be reviewed jointly and systematic computer-based records will be created.

INCLUSION CRITERIA

Tumour type	Adenocarcinoma
Site	Colon
Stage	T1/2/3
Nodal Stage	N0
EMVI	Negative
Resection status	R0
Metastatic disease	No
Age	>50 years
Performance Status	0/1/2
Neo-adjuvant treatment	None
Clinician decision	Suitable

Patients who will be followed for the detection of recurrent disease

- are fit for surgery or chemo / radiotherapy;
- should be seen within three months of surgery to assess any late complications;
- should be offered this if they specifically request it for psychological reassurance;
- should be reassured that the risk of recurrence declines rapidly after the first two years after treatment so that by year 5, recurrence is very unlikely.

STRATIFIED FOLLOW-UP

Stratified follow-up involves reduction of routine appointments from the pathway. Routine surveillance tests will still be completed as outlined below. The following suggestions are made:

CEA

- CEA to be measured on every patient pre-operatively and on every follow- up visit until end of year 2 and then yearly thereafter in-line with the shared care agreement until discharge at end of year 5. If the value of CEA doubles or rises continually a CT scan of the abdomen and chest or a CT scan of the abdomen plus a chest x-ray will be performed.

FBC

- To be measured on every patient pre-operatively and on every follow up visit until the end of year 2 and then yearly thereafter in-line with the shared care agreement until discharge at end of year 5. If the value is abnormal, results should be flagged to the trust key worker.

Colonoscopy

- Patients will receive a Colonoscopy request at 1 and 4 years post-operatively
- Further colonoscopy after this may be required depending on age, genetic profile, and risk
- Patients should also be encouraged to enter the national bowel cancer screening program

Liver imaging

- A CT scan of the liver is the preferred investigation of choice for liver screening. There should be a minimum of 2 CT scans of the chest, abdomen and pelvis in the first 3 years of follow-up. These should be done at end of year 1 and end of year 2.
- All patients who have had a Total Mesorectal Excision as a potentially curative resection should be followed up for the purpose of auditing the surgeon's performance of the technique.
- Audit of the outcome of treatment requires accurate and complete collection of data which may be difficult to obtain by postal questionnaire or through the general practitioner. Follow-up may be justified for this reason alone.

The results will be reviewed by appropriately qualified or trained staff and the patient and GP informed of the results. This information may trigger a recall of the patient back to specialist services as required.

Patients should be offered a 1:1 appointment with the CNS at the end of primary treatment to explain how stratified follow up works and to ensure the patient knows how to contact the service if there are any concerns or symptoms in between surveillance testing. [This could be done in the same session as the end of treatment HNA].

Patients with stomas, bowel function, and other late effects of treatment [surgical or chemotherapy] may initially need planned hospital follow-up or in the community by trained staff. The frequency of follow up investigations delivered either remotely or in secondary care

will depend upon the risk of recurrence and should be intended to pick up recurrence before symptoms develop.

A system must be developed for rapid re-entry of patients to the specialist cancer service as required.

There should be a policy for follow-up of HPCC and FAP. The frequency of surveillance colonoscopy for these groups of patients should be in line with British Society of Gastroenterology surveillance guidelines. Ideally there should be a single clinical lead to oversee service delivery for the surveillance of these patients and ensure referral pathways are followed.

MINIMUM FOLLOW-UP SCHEDULE

Colorectal cancer follow-up is the shared responsibility of the specialist team, primary care and the patient. A minimum follow-up schedule should be agreed. It should include at least 2 CT scans of the chest, abdomen and pelvis and a colonoscopy within the first three years after surgery. A completion colonoscopy should be performed as soon as practicably possible in those patients who had an incomplete examination before surgery. Teams may choose to supplement this with regular CEA tests, which may continue for five years post-treatment.

After 5 years, patients may have further surveillance colonoscopies and if not, should be encouraged to join the national screening program. Tests should be delivered irrespective of whether a patient is seen in the clinic. The follow-up schedule may be conducted in the form of telephone clinics or virtual clinics in place of conventional clinical visits for patients.

Test/Year	0 – 1	1 – 2	2 -3	3 – 4	4 - 5
Clinical review	3 monthly nurse led after 1st	6 monthly	Shared care at year 3	Shared care	Shared care
CEA	3 monthly	6 monthly	Annually	Annually	Annually
FBC	3 monthly	6 monthly	Annually	Annually	Annually
Endoscopy	If not had completion pre-operative done as baseline	Colonoscopy or CTC [may be combined with CT i.e. CTC instead]		Colonoscopy or CTC [may be combined with CT i.e. CTC instead]	
CT C/A/P	Pre-operative [completed if not e.g. emergency]	End Year 1	End Year 2		

*Some trusts may require urea and electrolytes (U+E) checking to help when requesting CTs

SURVEILLANCE

Patients who contact any member of the colorectal specialist team with worrying symptoms will be seen by the appropriate team within two weeks and if necessary, the case will be discussed at the MDT meeting.

All patients following initial treatment for colorectal cancer, will be given information about self-care and surveillance. A list of symptoms that could be a cause for concern and a contact number for the Colorectal CNS will be given as part of the information pack developed by Trusts.

GPs and patients should also be given information on symptoms which may indicate recurrence.

Shared care follow up should follow local policies devised by the Trusts and CCGs.

A treatment summary should be sent to the GP and patient within 6 weeks following primary treatment - surgery, chemotherapy or radiotherapy. The National Cancer Survivorship Initiative treatment summary template should be utilised. This template is available on Somerset and Infoflex systems. Follow up after surgery should focus on post-operative issues, promoting and sustaining recovery (including early detection and management of late effects), future planning, and stoma management.

Patients' emotional and practical needs should be assessed, using an HNA undertaken by a CNS to identify specific needs, and appropriate care has or needs to be provided.

The above strategy for stratified follow up may only result in a minority of patients being placed on the shared care follow up pathway. As such further redesign and a pilot of more remote monitoring on a more extensive basis is being developed for Newcastle/Gateshead hospitals and CCG and will report to the tumour board at the end of 2020. If successful it is expected other trusts and CCGs would widen the stratified follow up criteria.