**ELIGIBILITY**

Rectal cancer, 5 years post-treatment and NED

**CONCURRENT COMPONENTS OF VISIT**

- Years 6 and up:
  - History and physical exam annually
  - Digital rectal exam, only for patients with distal palpable anastomosis annually
  - CEA annually\(^1\) if previously elevated
  - Colonoscopy every 5 years or as clinically indicated\(^2\)
  - For patients with watch/wait strategy, annual follow-up with primary surgical oncology or radiation oncology team is recommended

**SURVEILLANCE**

Category 1\(^1\)

Category 2\(^1\)

**MONITORING FOR LATE EFFECTS**

For patients who have undergone curative resection of metastatic disease, the use of surveillance imaging beyond 5 years following curative resection should be individualized

**RISK REDUCTION/EARLY DETECTION**

**PSYCHOSOCIAL FUNCTIONING**

**DISPOSITION**

Positive findings?

Yes → Return to primary treating physician

No → Continue survivorship monitoring

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\(^1\) Category 1: Localized, Stages I – III

\(^2\) Category 2: Metastatic, Stage IV

\(^3\) The recommended screening intervals for individuals with adenomatous polyps on most recent colonoscopy, genetic predisposition to colon cancer, or a history of inflammatory bowel disease can be found in the Colorectal Cancer Screening algorithm

**Note:** Clinical risk is based on preoperative staging (clinical stage) vs. pathologic staging, which is based on the post-operative tumor specimen (for patients that were unable to receive neoadjuvant therapy)
Survivorship – Rectal Cancer

Disclaimer: This algorithm has been developed for MD Anderson using a multidisciplinary approach considering circumstances particular to MD Anderson’s specific patient population, services and structure, and clinical information. This is not intended to replace the independent medical or professional judgment of physicians or other health care providers in the context of individual clinical circumstances to determine a patient’s care. This algorithm should not be used to treat pregnant women.

ELIGIBILITY

CONCURRENT COMPONENTS OF VISIT

MONITORING FOR LATE EFFECTS

Assess for:
- Pain
- Fatigue
- Bowel problems
- Sexual health
- Bladder function
- Neuropathy

RISK REDUCTION/EARLY DETECTION

Patient education, counseling, and screening:
- Lifestyle risk assessment\(^1\)
- Cancer screening\(^2\)
- HPV vaccination as clinically indicated (see HPV Vaccination algorithm)
- Screening for Hepatitis B and C as clinically indicated (see Hepatitis Screening and Management – HBV and HCV algorithm)
- Consider cardiovascular risk reduction\(^3\)
- Genetic screening (see Genetic Counseling algorithm)
- Vaccinations\(^4\) as appropriate

PSYCHOSOCIAL FUNCTIONING

Assess for:
- Distress management (see Distress Screening and Psychosocial Management algorithm)
- Body image
- Financial stressors
- Social support

DISPOSITION

Refer or consult as indicated

Rectal cancer, 5 years post-treatment and NED (continued from previous page)

NED = no evidence of disease
\(^1\) See Physical Activity, Nutrition, and Tobacco Cessation algorithms; ongoing reassessment of lifestyle risks should be a part of routine clinical practice
\(^2\) Includes breast, cervical (if appropriate), liver, lung, pancreatic, prostate, and skin cancer screening
\(^3\) Consider use of Vanderbilt’s ABCDE’s approach to cardiovascular health
\(^4\) Based on Centers for Disease Control and Prevention (CDC) guidelines

NED = no evidence of disease

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SUGGESTED READINGS


Continued on next page
SUGGESTED READINGS - continued


DEVELOPMENT CREDITS

This survivorship algorithm is based on majority expert opinion of the Colorectal Survivorship work group at the University of Texas MD Anderson Cancer Center. It was developed using a multidisciplinary approach that included input from the following:

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