

Colorectal Cancer Management: Evolving Recommendations

The October 2007 issue of *JNCCN* focuses primarily on colorectal cancer (CRC), with the updated guidelines for CRC diagnosis and management leading the issue. These guidelines emphasize the now multidisciplinary nature of therapy for a disease that was once believed to be surgical: if the surgeon did not remove all of the cancer with adequate margins, patients were destined to develop recurrence. Chemotherapy and radiotherapy were considered salvage or palliative treatment at best.

Fortunately, the days of unacceptable recurrence rates and ineffective chemotherapy are past. The NCCN CRC Guidelines Panel reflects this modern approach. Not only does the panel include colorectal surgeons who practice in the busiest academic cancer centers in the country, but radiotherapists, medical oncologists, gastroenterologists, and pathologists who are also highly focused on CRC are included as well. This panel should be commended for producing a critical document that is also understandable for the practicing community. The NCCN staff have done yeomen work to faithfully present the panel's recommendations in a readable format, and they also deserve credit for transforming the guidelines discussion into a scholarly narrative article that documents the rationale behind the guideline recommendations with the appropriate citations. The guidelines algorithms and manuscripts are the most current "textbook" any clinician could desire for education and as a reference for managing CRC patients in his or her practice.

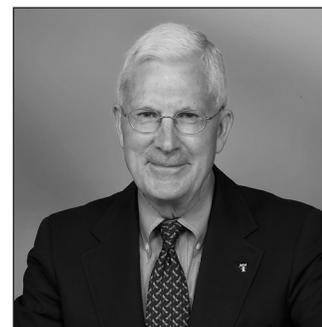
This issue also includes authored manuscripts—focused commentaries on 4 of the most controversial and important issues to the clinical management of CRC today. First, Cooper summarizes current literature on the staging and grading of malignant colorectal polyps. Based on my experience as an observer and discussant at Fox Chase Cancer Center Partner institutions tumor boards, I recommend that community hospital pathologists, gastroenterologists, and colorectal surgeons read and follow the recommendations in this article to ensure that patients with endoscopically removed polyps are managed effectively.

The NCCN CRC guidelines emphasize that a medical oncologist should meet with the patient who has a resected stage II colon cancer to discuss the possible benefits and potential side effects of adjuvant chemotherapy, and Vicuna and Benson present a reasoned discussion of adjuvant therapy for patients with stage II colon cancer. They also distinguish between the available prognostic markers (those that identify patients with aggressive forms of disease such as loss of heterozygosity of chromosome 18q) and predictive markers (those that correlate with response to treatment such as microsatellite instability or MSI). The current generation of adjuvant trials for stage II colon cancer are also reviewed.

Reidy and Saltz present a sobering but balanced discussion of targeted strategies in the management of metastatic colon cancer. This approach to CRC treatment became more controversial as the optimism generated from the original phase II trials gave way to the reality of lower responses seen in randomized phase III trials. Clinical trial results are also tempered by the cost of the targeted strategies and the side effects of the agents. The authors emphasize that more research is necessary before clinicians who treat patients with CRC can determine which are most likely to benefit from targeted strategies.

The fourth article points to the need to measure compliance with guidelines and the resulting medical outcome in clinical practice. O'Grady et al. at Fox Chase Cancer Center Partners developed and implemented an audit tool based on the NCCN Clinical Practice Guidelines in Oncology. In practices that use an electronic medical record, it is feasible and cost effective to ascertain from the oncologists' medical reports whether information surrounding crucial decision points is adequate to critique the medical care that has been delivered. With major payers interested in pay for performance and most oncologists willing to undergo repeated quality assessment, the methodology described in this article provides a way to meet the growing call for quality assessment in community practice.

I am convinced that the oncologist who treats colorectal cancers will benefit from a careful study of the articles in this issue of *JNCCN*.



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