Supplemental online content for:

**Locally Advanced Colon Cancer: Evaluation of Current Clinical Practice and Treatment Outcomes at the Population Level**

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eAppendix 1: Translation of the Relevant Parts of the Dutch Guideline Considering Locally Advanced Colon Cancer
Guideline 2.0 (until June 2014)

Radiotherapy for T4 Colon Cancer

An irradical resection of the primary tumor should be avoided. In case of preoperative suspected irresectability based on CT imaging, preoperative (chemo)radiotherapy must be considered. In case of intraoperative suspicion of performing an irradical procedure, the tumor should be left in situ. Preoperative (chemo)radiotherapy needs to be considered and placement of clips (as a mark for radiotherapy) is advised, together with a diverting ostomy and “spacer” placement.

In the case of intraoperative notification of an irradical performed resection, the operative field should be marked with clips and postoperative (chemo)radiotherapy needs to be considered. In case preoperative (chemo)radiotherapy was applied, intraoperative radiotherapy can be considered.

Adjuvant Therapy

Adjuvant chemotherapy (FOLFOX) is routinely advised for stage III colon carcinoma. 5-FU might be replaced by capecitabine. In the case of older age and/or comorbidity monotherapy consisting of capecitabine or oral uracil-tegafur plus leucovorin can be considered. For patients with high-risk stage II colon cancer adjuvant chemotherapy needs to be considered. The choice of chemotherapeutic agent is similar as for stage III colon cancer.

Guideline 3.0 (from June 2014)

Multimodal Treatment of T4

In the case of T4 colon cancer, surgery should aim for an R0 resection according to oncologic principles (en bloc resection). Preoperative imaging and multidisciplinary team discussion are essential, and decision-making should include referral to an expert centre, neoadjuvant therapy, and the surgical procedure planning. If relevant, a gynecologist, urologist or an intraoperative radiotherapy team needs to be consulted.

Neoadjuvant chemotherapy or (chemo)radiotherapy should be considered in case a radical resection seems initially impossible, based on CT imaging. The multidisciplinary team should decide on the type of neoadjuvant therapy. In the case of intraoperative suspicion of performing an irradical procedure, the tumor should be left in situ. In case preoperative (chemo)radiotherapy was applied, intraoperative radiotherapy can be considered.

Because distinction between true tumor invasion and reactive benign adhesions is difficult, a multivisceral resection is the recommended procedure in case of uncertainty.