CHAPTER 8
Importance of the IDT

It is clear enough that oncological outcomes in rectal cancer have improved r markedly in recent years and that this is not just a consequence of the widespread application of the TME technique. This report is proof of this and it is more than evident that this advance must also be attributed to a large extent, in addition to colorectal surgery, to multiple specialties such as radiology, oncology and pathology, among the most influential. Interdisciplinary management is of key importance to provide efficient, timely and appropriate care.[109] So much so, that presenting and discussing rectal cancers within an IDT has become a requirement of the National Accreditation Program of Rectal Cancer, administered by the Commission on Cancer.[247] Numerous studies published to date demonstrate the beneficial effect of the IDT on the management of these patients.

- In 2006, Burton et al.[23] compared the proportion of TME specimens with CRM + in a population of patients with and without discussion in the IDT, finding a significant reduction in the former: 1% (1/116) vs. 26% (16/62), respectively. The relationship between the positivity of this margin and the number of pelvic relapses was widely demonstrated, which is reason enough to understand the importance of the interaction among all the specialists involved in the care of patients with this complex pathology, who must be particularly specialized and dedicated to it.
- On the other hand, MacDermid et al. reported a statistically significant increase in 3-year survival for patients with stage III colorectal cancer who had undergone an IDT evaluation compared with those who had not, although no similar benefit was identified in stages II. Furthermore, Richardson et al.[187] reported a considerable improvement in the quality of the surgical specimen of TEM associated with the implementation of the IDT.
- Snelgrove et al.[209] reported that after discussion of the HR-MRI in the IDT, the treatment plan was modified in 29% of patients. Furthermore, 28 of 36 (77%) patients included in this study had a complete or almost complete mesorectum.
- Wu and et al.,[252] based on the results of their retrospective study of 687 cases, concluded that 25% of patients with recurrent rectal malignancies could receive curative treatment through the implementation of the IDT
- Holliday et al.[98] mention the benefits of IDT in the management of patients with metastatic rectal cancer, with benefits in OS and DFS.
- Lan et al.[127] also reported that after the establishment of the IDT, patients with lung and liver metastases demonstrated a statistically significant increase in 3-year survival.
- In 2014, Vaughan-Shaw et al.[240] retrospectively compared 19 patients with pT1 tumors treated in 2006 with another 24 patients treated in 2011. In 2011, all cases were discussed in an IDT specialized in early cancer and there were more patients who underwent appropriate preoperative imaging compared to 2006 (HR-MRI 18 vs. 12, ERUS 20 vs. 4 and CT 22 vs. 15, respectively). The authors concluded that there was an improvement in staging accuracy, a reduction in CRM positivity after TME, and an increase in the use of TAE.
- In 2018, Karagkounis et al.[109] evaluated 408 rectal cancer cases discussed at the IDT meeting. All presenting surgeons were required to report any changes to their treatment plan as a result of the discussion. Management modifications were reported in 112 patients.

In conclusion, there is a growing number of studies supporting the positive impact of EID meetings on the oncologic outcome of rectal cancer patients. The available evidence demonstrates a change in the treatment plan in a significant proportion of patients. However, more studies are required to assess the exact impact on OS.

Operational requirements:

- The IDT should exclusively treat patients with rectal cancer, since this disease is of sufficient entity and complexity to require this level of specialization.
- All patients must be discussed in each of the decision-making instances.
- In the light of current knowledge, the implementation of any pre-established protocol for the management of this pathology is not recommended. The therapeutic strategy must be adapted to each patient and to the infinity of variables related to the tumor and all its variants, the personal history and comorbidities, and

patient's own will when accepting therapies that may affect the quality of life. In rectal cancer, the order and timing of treatments is as important as the treatment itself, as well as the quality of its application.

- Must be led by a colorectal surgeon, clinical oncologist, or both.
- It should be made up of all the specialties involved in the management of these tumors, most of them on a permanent basis: gastroenterologists, colorectal surgeons, clinical oncologists, radiotherapists, imaging specialists, pathologists and palliatologists.
- Other specialists who should be part of the team may attend the meetings in specific situations or cases, such as geneticists, urologists, gynecologists, nutritionists, and hepatobiliary, thoracic and plastic surgeons.
- It should also be permanently integrated by other health professionals such as nurses, stoma therapists, psychologists, physical therapists, and non-medical nutritionists.
- There must be a record of all patients and each of the discussion instances.