CHAPTER 18
Survey

To know the state of the knowledge about the neoadjuvant treatment of rectal cancer, we developed a short survey, only 12 questions with 4 options shown below. It is a simple survey, which could be answered in a maximum of 4 minutes, with eminently practical questions about the most common decisions.

This survey was disseminated through the email of our society and also through the social networks (Linkedin, Twitter and Instagram) of our dissemination organ, the Revista Argentina de Coloproctología, which has a strong presence and more than a thousand followers. The questions and answers obtained are shown below, along with the analysis of the results:

1. In your usual practice, what cases of rectal cancer are presented in the interdisciplinary team? (Fig. 15)
   a. Only advanced cases.
   b. I don't have an interdisciplinary team.
   c. At the request of the treating surgeon or oncologist.
   d. All cases.

2. In your opinion, what is the minimum number of annual rectal cancer surgeries required to be considered a high-volume surgeon? (Fig. 16)
   a. More than 10.
   b. More than 20.
   c. More than 30.
   d. More than 40.

3. In your opinion, what is the aim of indicating neoadjuvant therapy in rectal cancer? (Fig. 17)
   a. Local control of disease and organ preservation.
   b. Local control of disease, organ preservation and extend survival.
   c. Extend survival and organ preservation.
   d. Local and distant disease control.

4. In which cases from your usual practice do you indicate a short-course radiotherapy regimen? (Fig. 18)
   a. Always.
   b. Only in stage IV.
   c. In patients with occlusive symptoms.
   d. Never.

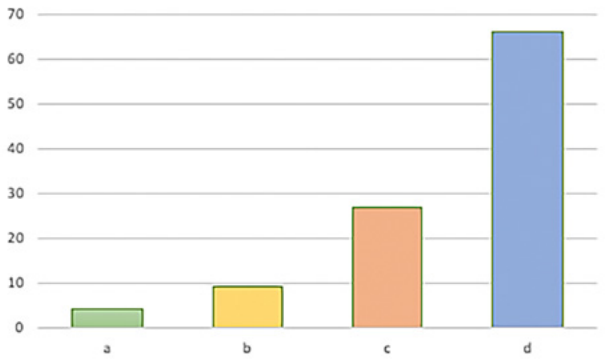

Figure 15: More than 60% discuss all their cases in the IDT, 25% do so selectively and slightly more than 12% still report that they practically do not participate in these meetings and make their decisions individually.

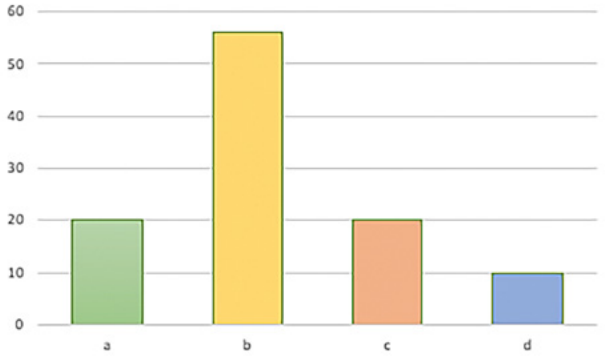

Figure 16: Fifty-three percent consider that an expert surgeon should perform no less than 20 radical operations for rectal cancer per year, only 10% believe that it should be 40 and 36% divides equally between 10 and 30 operations per year.

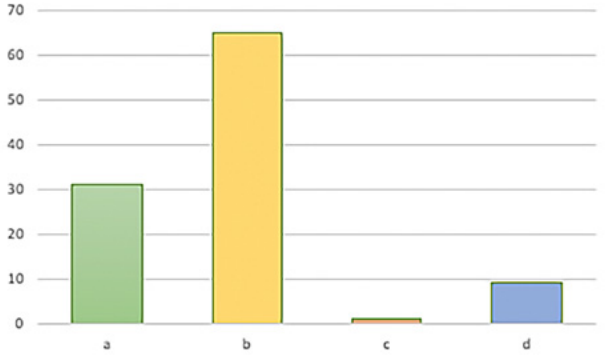

Figure 17: Sixty percent believe that the goals of neoadjuvant therapy are to control the disease locally, preserve the rectum and prolong survival, while 30% still do not believe that neoadjuvant therapy aims to prolong survival.

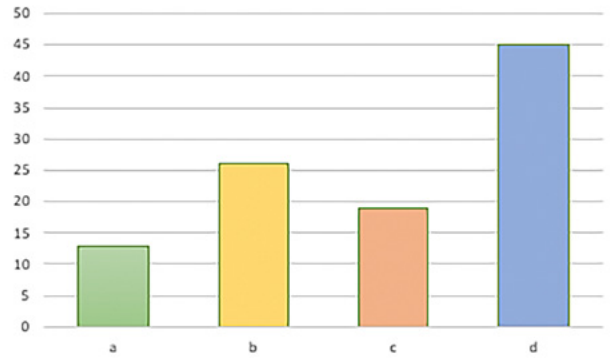

Figure 18: Regarding short-course RT regimen, around 45% do not indicate it in any case, while 25% do so in stage IV. It is surprising that 18% answered that they indicate it in the presence of occlusive symptoms and 12% that they always indicate it.

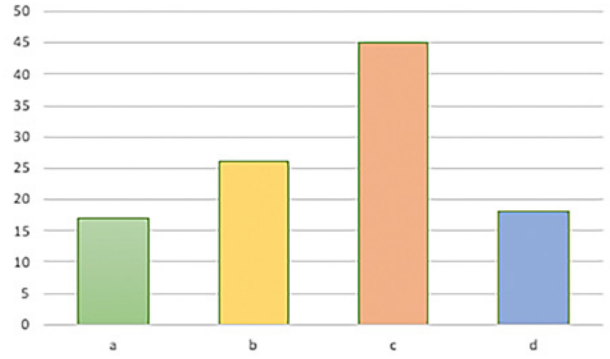

Figure 19: The waiting time for the first response evaluation after neoadjuvant therapy was divided into almost identical parts between 4 and 10 weeks with 17%. Coinciding with the majority of recommendations, 25% do so at 6 weeks and 42% at 8 weeks.

5. In your practice, how long does it take from the end of the neoadjuvant treatment to the first control to evaluate the response? (Fig. 19)
   a. 4 weeks.
   b. 6 weeks.
   c. 8 weeks.
   d. 10 weeks.

6. Do you consider the indication of the W&W strategy in your practice? (Fig. 20)
   a. Yes.
   b. Never.
   c. Only if the patient requests it.
   d. Only in patients with high surgical risk.

7. When planning surgery after neoadjuvant treatment is completed, do you rely on initial staging or on tumor response? (Fig. 21)
   a. Initial staging.
   b. Post-neoadjuvant staging.

8. In patients with non-metastatic rectal cancer, but at high risk of distant disease, would you or your interdisciplinary team indicate a regimen of TNT (total neoadjuvant therapy)? (Fig. 22)
   a. Yes.
   b. No.

9. What evaluation method should not be lacking in the follow-up of a patient within the W&W protocol? (Fig. 23)

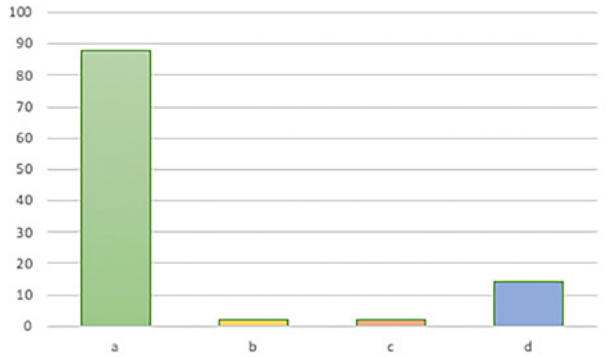

Figure 20: Eigthy-three percent of those surveyed already consider NOT in their practice, 13% do so only in high-risk cases for surgery. Less than 2% do it only at the request of the patient and another 2% do not consider it in their practice.

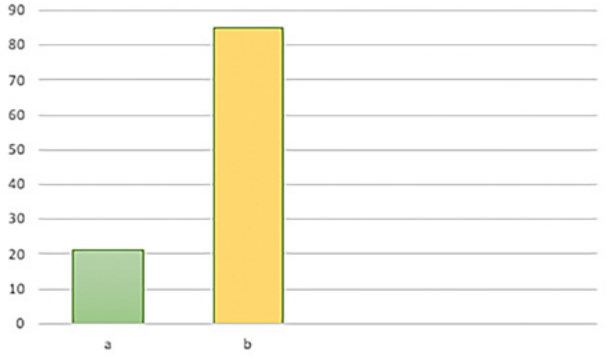

Figure 21: Eigthy percent make their surgical decisions based on post-neoadjuvant staging and 20% on initial staging.

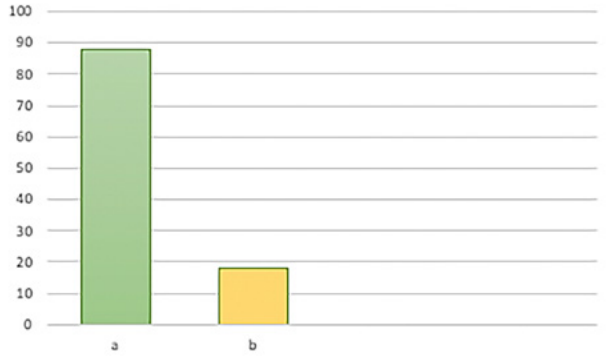

Figure 22: Regarding the new TNT strategies, 83% responded that they are considered by them or by their IDT when defining the treatment strategy for patients.

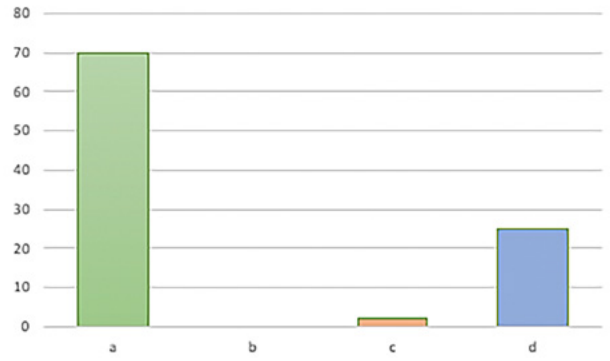

Figure 23: Seventy-five percent follow the patients included in a W&W protocol with proctological examination, colonoscopy and HR-MRI. Only 25% add PET-CT.

a. Proctological examination, HR-MRI and colonoscopy.
a. Proctological examination, colonoscopy, PET-CT.
b. Colonoscopy, HR-MRI and PET-CT.
c. Proctological examination, HR-MRI, colonoscopy and PET-CT.

10. In a 50-year-old male with a rectal tumor 6 cm from the anal margin, with initial cT4N2a staging and complete clinical and imaging response, you would indicate: (Fig. 24)
a. W&W.
b. Low anterior resection.
c. APR.
d. TEM/TEO /TAMIS.

11. In a 40-year-old male patient with a cT2N0 stage tumor 4 cm from the anal margin, would you consider neoadjuvant therapy in order to preserve the rectum? (Fig. 25)
a. No.
b. Only long-course CRT, since my patient may never need ChT.
c. I would consider induction TNT.
d. I would consider consolidation TNT according to response.

12. In which cases do you or your interdisciplinary team consider adjuvant treatment after neoadjuvant therapy? (Fig. 26)
a. Whenever neoadjuvant treatment was indicated.
b. Always, except in cases with a pCR.
c. Only in stage ypN +.
d. Only in stage ypN2.

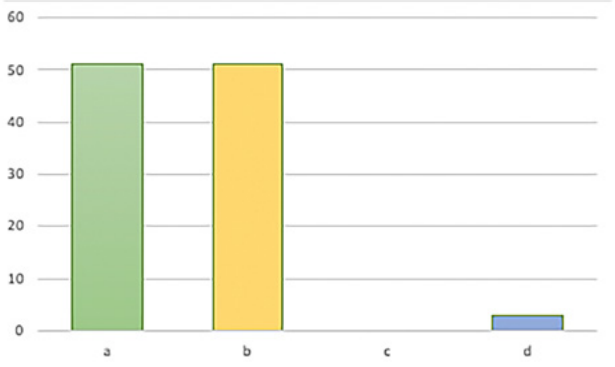

Figure 24: When faced with cCR in a cT4N2a tumor 6 cm from the anal margin in a male patient, 48.5% prefer radical surgery and 48.5% W&W, despite the high risk of regrowth observed in these cases. No one would indicate an APR and only 3% would do an excisional biopsy of the scar by TEM, TEO or TAMIS.

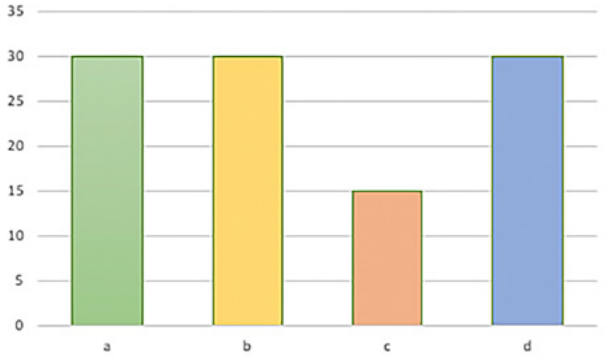

Figure 25: In a cT2N0 tumor located 4 cm from the anal margin, 15% would indicate induction TNT, while the rest are equally distributed in identical percentages, close to 28%, among long-course CRT, consolidation TNT or direct surgery without any previous treatment. In this situation, in which opting for neoadjuvant treatment would have the objective of preserving the organ, a CRT regimen sounds reasonable and, depending on the response, proceed to consolidation ChT.

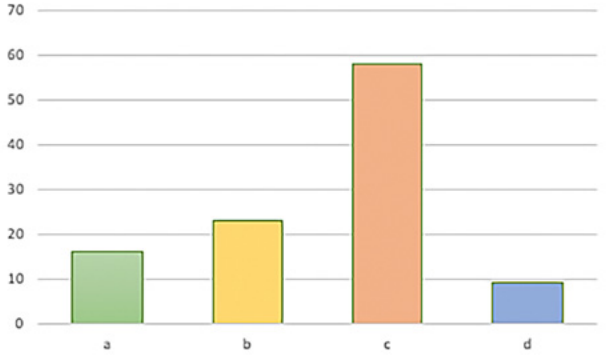

Figure 26: Finally, the indication of adjuvant ChT after neoadjuvant therapy was also a question in which there were no great coincidences, which is reasonable given the scarce evidence. However, 55% would do so in ypN + tumors, 21% always, except in cases with pCR (ypT0N0), 15% whenever neoadjuvant therapy was indicated, and 8.5% only in stage ypN2.