ESMO Minimum Clinical Recommendations for diagnosis, treatment and follow-up of advanced colorectal cancer

Incidence

- The crude incidence of colorectal cancer in the European Union is 58/100,000 per year, the mortality is 30/100,000 per year.

Diagnosis

- Diagnosis of advanced colorectal cancer should always be confirmed by biopsy at first presentation or at late relapse. It may be confirmed by fine needle aspiration or by imaging at early relapse.

Staging and risk assessment

- In order to identify patients with potentially curative surgical options the staging shall include clinical examination, blood counts, liver and renal function tests, carcinoembryonic antigen (CEA), chest X-ray, liver ultrasound, and/or a CT-scan of the abdomen [D].
- A CT-scan of the chest and additional examinations as clinically needed are recommended prior to major abdominal surgery with potentially curative intent [D].

Treatment plan

- Surgery should be considered for solitary or confined liver or pulmonary metastases.
- First line palliative chemotherapy should be considered early and consists of 5-fluorouracil (5-FU) in various combinations and schedules. Infused regimens of 5-FU/leucovorin (LV) are generally less toxic than bolus regimens. The oral fluoropyrimidine capecitabine is an alternative to infusional 5-FU/LV [I, B].
- Combination chemotherapy with 5-FU/LV/oxaliplatin or 5-FU/LV/irinotecan provides better survival than 5-FU/LV. [II, A].
- Novel targeted agents, i.e. monoclonal antibodies against vascular endothelial growth factor (VEGF) and epidermal growth factor receptor (EGFR) in combination with chemotherapy may be considered in carefully selected patients.
- Second line chemotherapy should be considered for selected patients with maintained good performance status [I, A].

Response evaluation

- History, physical examination, CEA if initially elevated, liver ultrasound, and/or a CT-scan of the involved region are recommended after 2–3 months of palliative chemotherapy [V, D].

Follow-up

- There is no proof that regular follow-up after successful palliative treatment improves the outcome of patients with metastatic colorectal cancer [V, D]. Symptom-driven visits are recommended.
- Laboratory and radiographic examinations shall be restricted to patients with symptoms suspicious of relapse if needed to guide further palliative care [V, D].

Note

Levels of Evidence [I–V] and Grades of Recommendation [A–D] as used by the American Society of Clinical Oncology are given in square brackets. Statements without grading were considered justified standard clinical practice by the expert authors and the ESMO faculty.

Literature


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