Clinical complete response in locally advanced rectal cancer: can we offer a wait-and-see policy?

After neoadjuvant treatment in locally advanced rectal cancer, and based on the current evidence, patients undergo surgery, which includes total mesorectal excision [1], sometimes with a definitive ostomy, regardless of achieving a clinical complete response (cCR), due to the lack of correlation between clinical and pathological responses [2].

A recent publication has raised a debate whether in some cases patients who get a cCR could go into a wait-and-see policy in order to avoid a mutilating surgery [3], although it is true that the criteria of cCR, with or without the excision of the residual scar, has not been validated yet.

The recent publication in this journal of the ESMO Consensus Guidelines for Management of Patients with Colon and Rectal Cancer [4] offers, beyond the standard approach, the possibility of a conservative management in selected patients in this scenario (e.g. young patients who need a definitive ostomy), including the recommendation of the use of a nomogram to establish the risk of locoregional relapse [5].

Until now, current nomograms for predicting the risk of local recurrence after achieving a cCR include pathological response of the primary tumor and node involvement, data that could not be known without going for a surgery. This is why we do not have information a priori of the risk of relapse in our patients. However, in our opinion, the wait-and-see approach in selected patients with rectal cancer who have achieved a cCR after neoadjuvant treatment might be offered taking into account present data and after a discussion on risk benefits with the patient.

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