GUIDELINES FOR CASE SELECTION FOR LAPAROSCOPIC COLORECTAL RESECTION

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Laparoscopic resection of colorectal cancer is now well established. It has been shown in a large randomised controlled trail to be of benefit over open resection in terms of shorter post operative recovery, and also reduced analgesic requirement.(COST trial Clinical Outcomes of Surgical Therapy Study Group. A Comparison of laparoscopic assisted and open colectomy for colon cancer.*(N Engl J Med,* 2004: 350:2050-2059). In addition this trial also reported equivalence between the open and laparoscopic approach in terms of cancer recurrence and survival, and this has been confirmed by the results from subsequent trials. In addition, the five year follow up of the CLASSIC trial has recently been published *(BJS 2010:97:1638-1645)*. This has confirmed the oncological safety of laparoscopic surgery for both colonic and rectal cancer, there being no difference in the 5 year local recurrence rate for either anterior resection or abdominoperineal resection.

The first NICE guidelines published regarding laparoscopic colorectal cancer resection stated that patients should be offered a laparoscopic resection only within a randomised controlled trial. The guidelines were then revised to state that all patients should be offered laparoscopic resection if they and their condition were suitable, and if their surgeon had been trained in laparoscopic surgery for colorectal cancer, and performs the operation often enough to keep their skills up to date (www.nice.org.uk/TA105). This guidance was subsequently waived due to a lack of trained laparoscopic surgeons. In response to this training need the national training programme for laparoscopic surgery (Lapco) was developed. There are now over 150 trainees at Consultant level registered with Lapco and the first trainees are exiting the programme.

In October 2010 the waiver was lifted on the NICE guidelines. This means that from October all patients that are suitable for laparoscopic colorectal cancer resection should be offered the opportunity to be treated in this way in line with the guidelines above.

The peer review measures for Colorectal Cancer Network Site Specific Groups (NSSG) have stated that there should be a list of surgeons authorised to perform laparoscopic colorectal cancer surgery, and there should be a policy for the network, whereby laparoscopic colorectal surgery should only be performed by surgeons in the network who are on the list as specified. Entry on the list requires that the surgeon has been trained in the Lapco national training programme, or have performed more than 20 laparoscopic colorectal resections before December 2009. With the first trainees being signed off from the programme many Trust will be in a position to implement the guidelines in October; however there will be a small number of Trusts who will not be in a position to implement the guidelines and offer laparoscopic resection (http://www.lapco.nhs.uk/peer-review.php)

A recent survey of Association of Coloproctology members in England has shown that as of October 2010 80% of respondents to the survey offer laparoscopic colorectal surgery. Of those who not offer the laparoscopic option, 55% have set arrangements for referral within their MDT, however if there is no laparoscopic surgeon available, only 22% have onward referral arrangements outside their MDT.

Appropriate case selection of patients for laparoscopic colorectal cancer resections is of paramount important as inappropriate selection may result in an increase in conversion rate and complications.

The National cancer peer review programme manual for cancer services: colorectal measures state the network site specific group should, in consultation with the MDTs, agree and produce the minimum network criteria for a patient to be offered laparoscopic colorectal cancer surgery.

The criteria should include the following:

- Patient with a BMI of less than 30
- Patient has had no previous major abdominal surgery
- Obvious T4 cancers on pre-operative staging should be avoided
- Tumours not requiring TME (Total Mesorectal Excision);
- No clinical or radiological signs of obstruction

There criteria are by no means absolute, and are not contraindications to laparoscopic surgery. The experience of both the surgeon and the unit will affect these referral criteria for each individual MDT, and more experienced surgeons will be able to offer both laparoscopic TME, and laparoscopic surgery to patients with a BMI of over 30. Ultimately the decision for each patient will depend on both patient and surgeon factors.

A separate patient information leaflet has been produced to support discussions with the patient about the suitability of laparoscopic surgery (available on www.lapco.nhs.uk/patient-information.php)

In order to aid the implementation of the NICE guidelines in October there should be a policy developed by all MDTs whereby all patients who fulfil the agreed criteria developed by that network should be offered the option of laparoscopic surgery as an alternative to open surgery for the surgical treatment of cancer.

Multidisciplinary Team Meetings

All Colorectal cancer patients should be discussed preoperatively after all relevant (histology, imaging, EUA) investigations have been performed. Using the peer review guidelines on case selection outlined above, and taking into account the local experience available in the MDT, both open and laparoscopic options should always be discussed taking into

account patient and tumour factors. Part of the MDT decision should therefore be whether the patient is suitable for a laparoscopic resection.

Outpatients

The patient should then be seen in outpatients, by the most appropriate surgeon, who may not be the surgeon they originally presented to. The decision as to which surgeon (laparoscopic vs. open) will see the patient will be decided as part of the MDT discussion. The results of the discussion can then be included in the patient's pre - operative consultation, which should include the option of laparoscopic or open surgery. The benefits and disadvantages of both should be discussed with the patient.

Onward referral

Irrespective of which surgeon the patient was originally referred to or seen by, MDT members should always be willing to refer patients on within MDTs if the surgeon does not have the capacity or skill to perform a procedure. Surgeons who do not offer laparoscopic resections should be willing to refer on the patients who are suitable to those that do. If the outcome of the subsequent outpatient discussion is that the patient wishes to opt for an open operation the patient can be treated by the original surgeon.

MDTs and NSSGs should devise guidelines and timely mechanisms for onward referral between MDTs within a network. If a particular MDT does not have a trained laparoscopic surgeon then there needs to be set criteria in place for transfer of suitable patients to an MDT where laparoscopic surgery is offered. This should normally be within the same network. There should be a system whereby patients can be offered a timely clinic appointment for a discussion about whether to have a laparoscopic resection. The referral should be straight from the MDT so as to not duplicate outpatient appointments and induce delay. The patients should be fully staged and referred ready for an operation, so as to reduce the time delay which may result from transfer, and prevent breaching.