After a review of best current evidence and subsequent breakout discussions, consensus was achieved on all of the items discussed, as outlined below.

1. **Adjuvant stage II colon cancer management:**

   a. **Should we be treating all stage II colon cancer patients with adjuvant therapy?**

   The available evidence does not support the use of adjuvant chemotherapy in all Stage II patients.

   b. **If not are there sub-groups with Stage II colon cancer who should receive therapy?**

   Dr. Gill presented an analysis of pooled data from 7 randomized trials aimed at better understanding the benefits from adjuvant therapy. This analysis confirms that some patients with Stage II disease may have a higher risk of recurrence.

   These patients should have a dialogue with their oncologist about the risks and benefits of adjuvant therapy. This discussion should take into account the risk of recurrence, the potential benefit of the chemotherapy, risks of therapy and any co-morbidities the patient may have. The Mayo clinic is working on an Internet tool, which might be helpful for estimating risks and benefits. Patients should be encouraged to make an “educated” and individualized decision.

   The evidence supports the use of the following risk factors as prompts for a discussion about adjuvant therapy in Stage II patients:

   - T4 status and or perforation
   - High grade
   - If less than 8 nodes (ideally we should have ≥ 12 or more nodes)

   No consensus was reached on the following factors:

   - LVI
   - Ploidy
   - Obstruction
2. Adjuvant chemotherapy for bowel cancer
   a. What adjuvant therapy should we be using in colon cancer?

   DeGramont presented results from the MOSAIC trial\(^5\) at ASCO, which randomized stage II and III colon cancer patients to either an infusional 5FU/LV regimen (LV5FU2) vs. FOLFOX4. The overall disease free survival at 3yrs is 77.8% vs. 72.9% (p<0.01) for FOLFOX and LV5FU2 respectively. As yet there is no statistically significant survival difference.

   Although this data was thought to be interesting, the standard for adjuvant therapy remains 5FU modulated with leucovorin.

3. Regional therapies in the management of liver metastases from colorectal cancer.
   a. Surgical resection

   Surgical resection was considered to be the gold standard for the management of resectable liver metastases from colorectal cancer. Although no randomized trials have been done, multiple series have reported 5-year survival rates of 20-40%\(^6,7,8,9\).

   It was also felt that a hepatobiliary surgeon should be a member of the multidisciplinary team and involved in decision making of the management of all patients with liver metastases.

   b. Radiofrequency ablation (RFA)

   Radiofrequency ablation has been used for the management of liver metastases from colorectal cancer, but there seems to be a paucity of long-term results. Nevertheless the group thought there was a role for this modality in unresectable liver metastases. In the absence of a randomized comparison, the group did not feel that RFA should be used to replace surgical resection.

   c. Other therapies

   No role was seen for hepatic artery infusion or chemo-embolization outside of clinical trials.

4. Surveillance of colorectal cancer:
   a. Is there a role for serial imaging in the surveillance of colorectal patients who have received curative therapy?

   The group reviewed the recent data from the meta-analysis\(^10\) and the ASCO review\(^11\). Although there was some indication from the meta-analysis that serial imaging (SI) may be helpful, this modality was not separated from CEA and it
was impossible to see the contribution of each investigation. The ASCO panel
did not recommend serial imaging.
It was felt that this evidence was not strong enough to make a recommendation
for serial imaging.

Serial imaging should be performed in those with a pre-existing abnormality for
follow-up purposes. Serial imaging could be considered in those with a previous
curative resection of either lung or liver metastases.
References:


3 Swanson et al. The prognosis of T3N0 colon cancer is dependent on the number of lymph nodes examined. Ann Surg Oncol. 10:655-71; 2003.


