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

1. Metastatic colorectal cancer management:

   a. Is there sufficient evidence to support sequential combination chemotherapy for metastatic colorectal cancer?

   The evidence available supports sequential use of infusional combination chemotherapy regimens for the palliative treatment of metastatic colorectal cancer to achieve the best outcomes for patients in whom combination chemotherapy is appropriate.\(^1,2,3,4\) [Please see section 1.b. regarding recommended regimens.]

   It is recognized that level I evidence does not exist to allow determination of the extent of survival benefit from sequential infusional combination chemotherapy compared to one infusional combination regimen followed by best supportive care. However, such a study would now be unethical to pursue. Therefore, it is unlikely that such level I evidence will become available.

   b. If sequential therapy is recommended, which regimens should be offered in what order?

   The evidence available supports the use of an infusional 5-FU/Folinic acid/Irinotecan combination regimen first (e.g. FOLFIRI\(^2,3\), Douillard\(^5\)) followed at progression by an infusional 5-FU/Folinic acid/Oxaliplatin combination regimen (FOLFOX\(^2,3\)), in appropriate patients.

   Overall survival and first-line response rates are equivalent regardless of the ordering of these sequential regimens. However, the recommended order
avoids overlapping toxicity, in particular with regards to the prolonged neurotoxicity often seen with the Oxaliplatin regimen. Response rates to second-line therapy are also better with the recommended order.\textsuperscript{2,3}

2. Lymph node status:

   a. \textit{What is considered an adequate lymph node sampling in the staging of colorectal cancer?}

   The College of American Pathologists Consensus Statement, 2000, should be adopted.\textsuperscript{6} This recommends evaluation of 12 regional lymph nodes be considered a minimum for adequate staging of colorectal cancer. Grossly negative nodes should be submitted in toto for histologic examination. If less than 12 nodes are initially detected in the pathologic specimen, and they are all negative for metastatic deposits, the pathologist should use visual enhancement techniques to try to detect more nodes within the submitted specimen. Adequate nodal staging of colorectal cancer guides appropriate use of adjuvant therapy and improves patient survival.\textsuperscript{7,8}

   b. \textit{Is this being done currently?}

   Unfortunately, the impression is that in current practice often less than 12 regional lymph nodes are detected and evaluated.

   c. \textit{What, if anything, needs to be done to effectively improve current practice in this regard?}

   The WCCCCC Consensus Statements 2002, The College of American Pathologists Consensus Statement, 2000, and their rationale need to be disseminated at a provincial level to surgeons and pathologists involved in the care of colorectal cancer patients throughout the Western provinces. Collection and reporting to pathologists and surgeons of local data on the number of lymph nodes evaluated in colorectal cancer specimens along with the dissemination of guidelines may help to impact current local practices. Collection and reporting of local data on the number of lymph nodes evaluated in colorectal cancer specimens following dissemination of this information can help to evaluate the impact of this intervention.
3. Care of the elderly colorectal cancer patient:

   a. *Should initial adjuvant therapy for elderly colon cancer patients be tailored? If so, how?*

   In patients for whom adjuvant chemotherapy is appropriate for colon cancer, the initial dose and regimen should not be adjusted for patient's age. Performance status, co-morbidities, organ function, and patient preference, rather than age, should be the key factors evaluated with the patient in the decision whether to proceed with adjuvant chemotherapy for colon cancer.

   b. *Should initial adjuvant therapy for elderly rectal cancer patients be tailored? If so, how?*

   In patients for whom adjuvant chemo-radiation therapy is appropriate for rectal cancer, the initial dose and regimen should not be adjusted for patient's age. Performance status, co-morbidities, organ function, and patient preference, rather than age, should be the key factors evaluated with the patient in the decision whether to proceed with adjuvant chemo-radiation therapy for rectal cancer.

   c. *Should initial palliative chemotherapy for elderly metastatic colorectal cancer patients be tailored? If so, how?*

   In patients for whom palliative chemotherapy is appropriate for metastatic colorectal cancer, a mono-chemotherapy regimen (e.g. Capecitabine, Infusional 5-FU/Folinic acid, Raltitrexed) is often favoured over a combination chemotherapy regimen. However, this needs to be an individualized decision, in discussion with the patient. The initial dose of first-line palliative chemotherapy should not be adjusted for patient's age. Performance status, co-morbidities, organ function, and patient preference, rather than age, should be the key factors evaluated with the patient in the decision whether to proceed with palliative chemotherapy for metastatic colorectal cancer.
References


