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<td>FOLLOW-UP AFTER INITIAL DIAGNOSIS AND TREATMENT OF COLORECTAL CANCER</td>
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| Organizations Providing Recommendation | American Cancer Society and the US Multi-Society Task Force on Colorectal Cancer  
The American Society of Clinical Oncology (ASCO)  
The National Comprehensive Cancer Network (NCCN) |
| Clinical Intent | To ensure that all eligible members who have been newly diagnosed with colorectal cancer receive follow up screening tests within a clinically appropriate frequency. |
| Physician Specialties (suggested) | Refer to PQSR 2009 Clinical Measures by Specialty. |
| Disease Burden |  
- Colorectal cancer is the third most common cancer in the United States and the second leading cause of cancer death. A person at age 50 has about a 5 percent lifetime risk of being diagnosed with colorectal cancer and a 2.5 percent chance of dying from it.[1-3]
- People with a previous diagnosis of colorectal cancer experience a higher incidence of subsequent colorectal cancer than the general population. The cumulative incidence of new cancers is about 1.5 percent at five years in this group.[4]
- Approximately 35-40% of patients with stage II or III colorectal cancer at initial diagnosis will have recurrent or metastatic disease.[5] |
| Reason for Indicated Intervention or Treatment |  
- Surveillance for second primary colorectal cancer assists in removal of pre-malignant polyps and early detection of malignancy.[4]
- Patients with locally recurrent or anastomotic disease, a limited number of metastases involving liver or lung, or metachronous (second primary) malignancies or polyps are potentially curable with further surgery. |
| Evidence Supporting Intervention or Treatment |  
- No prospective randomized trials have investigated whether early diagnosis of recurrent disease results in more favorable outcome. |
• In a retrospective cohort study of 1247 patients with colorectal cancer, of whom 548 had recurrent disease, those whose recurrences were discovered by routine surveillance testing were three times more likely to be disease-free at five years compared to those diagnosed because of new symptoms (18.6 versus 5.6 percent, respectively).[6]

• Another retrospective cohort study of 179 patients with recurrent colorectal cancer, including 137 who underwent re-operation, found that the likelihood of a complete resection was significantly higher among those whose recurrences were detected because of an asymptomatic elevation in the serum tumor marker carcinoembryonic antigen (CEA) as compared to those diagnosed with new symptoms (52.7 versus 34.5 percent, respectively).[7]

• In a meta-analysis of 5 reviews documenting 1,342 patients after treatment for colorectal cancer, those who received intensive surveillance (defined as CT scans of the liver, CEA measurements, chest x-rays, and endoscopies) were 21% less likely to have a recurrent cancer after 5 years than those who received less intensive surveillance.[4, 8]

• One prospective randomized controlled trial evaluating the efficacy of simple vs. intensive surveillance strategies after the curative resection of colorectal cancer found that intensive strategies had a higher overall survival rate in patients with stage II tumors (HR = 0.34; 95% CI, 0.12 to 0.98; P = .045) and in those with rectal lesions (HR = 0.09; 95% CI, 0.01 to 0.81; P = .03), mainly due to higher rate of resectability for recurrent tumors.[9]

• A review of evidence found an incidence rate of 0.7% two years following cancer resection. Surveillance colonoscopy allowed for 87% of cancers found to be operated for a cure.[10]

Clinical Recommendations

• The American Society of Clinical Oncology (ASCO) recommends the following[11]:
  o Annual computed tomography (CT) of the chest and abdomen for 3 years after primary therapy for patients who are at higher risk of recurrence (stage II or stage III with multiple poor risk features) and who could be candidates for curative-intent surgery.
  o Pelvic CT scan for rectal cancer surveillance, especially for patients with several poor prognostic factors
  o All patients with colorectal cancer should have a full colonoscopy in the preoperative or perioperative setting. Those who do have cancer should have a colonoscopy within 6 months after surgery. Colonoscopy should be repeated at 3 years after operative treatment, and, if results are normal, every 5 years thereafter.
  o Flexible proctosigmoidoscopy every 6 months for 5 years
for rectal cancer patients who have not been treated with pelvic radiation.

- History and physical examination every 3 to 6 months for the first 3 years, every 6 months during years 4 and 5, and subsequently at the discretion of the physician.
- Carcinembryonic antigen (CEA) every 3 months postoperatively for at least 3 years after diagnosis for patients with stage II or III colon or rectal cancer if the patient is a candidate for surgery or systemic therapy.

- The National Comprehensive Cancer Network (NCCN) recommends that all patients should have a colonoscopy one year after their initial resection and then if normal every 3 to 5 years or if abnormal after 1 year. The NCCN also recommends that all patients with at least T2 lesions should have CEA testing done every 3 months for 2 years and then every 6 months for a total of 5 years of surveillance.[12]

- A consensus guideline between the American Cancer Society and the US Multi-Society Task Force on Colorectal Cancer recommended that patients with endoscopically resected Stage I cancer, surgically resected Stage II or III cancers, and Stage IV cancer resected for cure receive a colonoscopy within 1 year to look for metachronous lesions. It makes no recommendations regarding CEA testing.[10]
References

12. NCCN. Clinical Practice Guidelines in Oncology: Colon Cancer.