Manchester Cancer Colorectal Cancer Pathway Board
Clinical Guideline for Colorectal Cancer: Laparoscopic, Robotic and TaTME surgery.

Publication Date

May 2019

Purpose

- ✓ To offer guidance to Trusts and clinicians on the appropriate selection of patients for laparoscopic, robotic and TaTME colorectal cancer resection.
- ✓ To set out the requirements for governance and supporting services to be delivered by Trusts offering laparoscopic colorectal cancer resections.

Development

This guidance set out in this document is based upon*:*

- Colorectal cancer. The diagnosis and management of colorectal cancer. NICE Clinical Guideline 131 (December 2014) guidance.nice.org.uk/cg131
- National Peer Review Programme Manual for Cancer Services Colorectal Measures Version 1.0 (Jan 2014)
- Colorectal Cancer Surgery Standards ACPGBI Advisory 2012
- Previous guidance: Greater Manchester and Cheshire Cancer Network criteria and referral guidelines on laparoscopic colorectal cancer surgery, 2012
- Effect of Robotic-Assisted vs Conventional Laparoscopic Surgery on Risk of Conversion to Open Laparotomy Among Patients Undergoing Resection for Rectal Cancer: The ROLARR Randomized Clinical Trial. JAMA. 2017 Oct 24;318(16):1569-1580
- https://www.pelicancancer.org/our-research/bowel-cancer-research/tatme
- Association of Coloproctology of Great Britain & Ireland (ACPGBI): Guidelines for the Management of Cancer of the Colon, Rectum and Anus (2017) – Surgical Management

Review Date

May 2021

Guidance

1. Indications for laparoscopic resection

1.1. Patients offered surgical resection as treatment for colorectal cancer should be offered the option of laparoscopic resection where the following criteria apply:

- ✓ BMI less than 35
- ✓ No previous multiple abdominal operations
- ✓ Avoiding T4 cancers on pre-op staging
- ✓ No signs of obstruction

1.2. Patients in whom the above criteria are not met may also be considered for laparoscopic resection but the choice of surgical approach should be considered carefully and agreed in the MDT.

1.3. All patients in whom the criteria apply should be discussed at the MDT and patients reviewed by laparoscopic surgeons to discuss the benefits of laparoscopic resection.

1.4. ACPGBI guidance states

Laparoscopic resection should be considered in all patients with colon cancer.
This should be performed by suitably trained, experienced surgeons who should audit outcomes and submit results to the NBOCA database. Recommendation grade A

Open surgery results in similar outcomes com-pared with laparoscopic surgery for cancer of the rectum.
Laparoscopic surgery may have some short term benefits. Recommendation grade B

Patients undergoing laparoscopic surgery should be made aware of the possibility to convert to an open operation as a part of informed consent. Recommendation grade D

2. Indications for Robotic resection

2.1. Services for the provision of robotic resection vary locally.

2.2. Any patient being offered robotic resection should be discussed in the MDT beforehand specifically to this approach.

2.3. Any robotic resections offered should be performed by appropriately trained surgeons with required governance and preceptorship.

3. Indications for TaTME resection

3.1. TaTME is an evolving technique and services for the provision of TaTME resection vary locally.

3.2. Any patient being offered TaTME resection should be discussed in the MDT beforehand specifically to this approach.

3.3. Any TaTME resections offered should be performed by appropriately trained surgeons with required governance and preceptorship.

3.4. All patients undergoing TaTME should be entered into the national database of outcomes

4. Supporting services & governance

4.1. Units undertaking laparoscopic colorectal cancer surgery should have the facility for preoperative endoscopic tattooing to facilitate intraoperative tumour localisation

4.2. MDTs will submit the total numbers of colorectal cancer surgical resections within the unit and the number performed laparoscopically by the unit to the Pathway Board annually.

4.3. Upon request by the pathway board, MDTs will provide further details on application of the criteria where uptake of laparoscopic surgery appears low.

4.4. MDTs will submit a list of the surgeons offering laparoscopic resections for colorectal cancer in their Trusts to the pathway board.

Appendix 1

NICE Clinical guideline 131 (December 2014)

1.2.5 Laparoscopic surgery

1.2.5.1 Laparoscopic (including laparoscopically assisted) resection is recommended as an alternative to open resection for individuals with colorectal cancer in whom both laparoscopic and open surgery are considered suitable.

1.2.5.2 Laparoscopic colorectal surgery should be performed only by surgeons who have completed appropriate training in the technique and who perform this procedure often enough to maintain competence. The exact criteria to be used should be determined by the relevant professional bodies. Cancer networks and constituent trusts should ensure that any local laparoscopic colorectal surgical practice meets these criteria as part of their clinical governance arrangements.

1.2.5.3 The decision about which of the procedures (open or laparoscopic) is undertaken should be made after informed discussion between the patient and the surgeon. In particular, they should consider:

-the suitability of the lesion for laparoscopic resection

-the risks and benefits of the two procedures

-the experience of the surgeon in both procedures

Appendix 2

ACPGBI website: From Colorectal Cancer Surgery Standards ACPGBI Advisory 2012

Laparoscopic Colorectal Cancer Surgery

The ACPGBI would expect the following of any colorectal surgeon performing laparoscopic surgery for colorectal cancer:

A. Surgeons authorised to perform laparoscopic colorectal cancer surgery must have been trained on the national laparoscopic colorectal surgery programme (LAPCO) or have been declared exempt by having performed 20 or more laparoscopic colorectal cancer surgical resections prior to 31st December 2009. This must agreed by the Lead Clinician of the MDT and their Trust's Chief Executive.

B. Surgeons who have gained CCT and carried out laparoscopic colorectal cancer surgery during their higher surgical training (or laparoscopic fellowships) and who have performed at least 20 laparoscopic colorectal cancer resections in recognised units by trainers who themselves fulfil the requirements in 'A' above will be deemed to have had sufficient experience to initiate such surgery at Consultant level.

If a change in surgical care of elective colorectal cancer patients is proposed that does not accord with these recommendations it is the duty of the Medical Director and Lead Clinician for Colorectal Cancer to raise their concerns with senior management and external professional bodies as appropriate.

ACPGBI members' attention is drawn to the GMC document Leadership and Management for All Doctors which states in paragraph 87 and 88:

87 If you have a management role or responsibility, you will often have to make judgements about competing demands on available resources. When making these decisions, you must consider your primary duty for the care and safety of patients. You must take account of any local and national policies that set out agreed criteria for access to particular treatments and allocating resources, and make sure that these policies are available to clinical staff.

88 If you are concerned about how management decisions might conflict with your primary duty to patients, you must take steps to manage or deal with any conflict; for example, by:

- A. asking for colleagues' advice
- B. declaring the conflict to your board or other decision-making body
- C. asking for advice from external professional or regulatory bodies, including defence organisations, if necessary.

Appendix 3

List of Laparoscopic Colorectal Cancer Surgical Practitioners

Trust	Clinician	ACPGBI 2012 criteria (A or B)
Bolton	P Harris	A
	D Smith	B
	G Faulkner	B
Christie	Chelliah Selvasekar	A
	Hamish Clouston	B
	Jonathan Wild	B
	Omer Aziz	B
CMFT	Rajeev Jushwaha	A
	Finlay Curran	A
	Christine Craig	A
	David Donnelly	B
East Cheshire	Usman Khan	A
	Simon Ward	B
	Mohammed Sadat	A
	Chris Smart	B
Mid Cheshire	Caroline Bruce	B
	Arif Khan	A
	Jon Hardman	B
	Claire Nockolds	B
Pennine	Mr Richards	A
	Mr Salman	A
	Mr Ali	A
	Mr Byrne	B
	Mr Huq	B
	Mr Kurrimboccus	B
	Mr Brammer	
Salford	C Mason	B
	D Watson	A
	J Epstein	A
	L Pearce	B
	N Lees	A
	D McWhirter	B
	G Carlson	B
Stockport	Sajal Rai	B
	Fergus Reid	B
	Michael Marsden	B
Tameside	Mr Mamoon H Solkar	A
	Mr Karim Muhammad	A
MFT (Wythenshawe)	Sarah Duff	B
	Aswatha Ramesh	A
	Mr Wal Baraza	B

	Miss Laura Hancock	B
	Abhiram Sharma	B
	Karen Telford	A
Wigan	Marius Paraoan	A
	Nasir Iqbal	B