Greater Manchester
Cancer Alliance

Stratified Follow up for Colorectal and Peritoneal Cancers

This document merges the

- **Greater Manchester Cancer Alliance Colorectal Personalised Stratified Follow-Up document (ratified February 2024) and**
- **Personalised Stratified Follow-Up Colorectal & Peritoneal Oncology Service The Christie NHS Foundation Trust document ratified December 2024**

Document Control

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Signed off by	**GM Cancer Colorectal Pathway Board**
Date	
Version Number	**3**
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Version number	Date	Revision Author	Status	Revision Made
2.1	25/03/2026		Review	Merged GM PSFU document with The Christie PSFU document
2.1	25/03/2026		Review	Amended to SFU to reflect that all colorectal pathways are tracked, irrespective of whether patients are on PSFU
2.1	25/03/2026	Kim Lagan-Walters, Colorectal Nurse Specialist, East Cheshire	Review	Changed eligibility criteria from Have capacity to consent to PSFU to “Have capacity to understand and engage with PSFU”
2.1	25/03/2023	Helen Ashby, Colorectal Clinical Nurse Specialist	Review	Amended wording on trials and treatment side effects to include PSFU where clinically appropriate.
2.3	01/04/2026		Review	High Risk pathways aligned with updated Christie document
2.3	02/04/2026		Review	Removed Stage 12 Dukes tumours from Intermediate Risk
2.4	02/04/2026		Review	Added Best Supportive Care Pathway
3	August 2026	Approved by Pathway Board	Final	

1. Purpose

This document provides local guidance for Stratified Follow Up (SFU) within the Greater Manchester (GM) Colorectal cancer pathway including patients remotely followed up under a Personalised Stratified Follow Up (PSFU) pathway.

This protocol applies to all Greater Manchester local units and specialist centres involved in the treatment of patients with colorectal, peritoneal, anal or NET cancer. Other units, such as East and Mid Cheshire, may also adopt this protocol; however, its use is not mandated outside Greater Manchester.
This model of care is aligned with the NHS Long Term Plan, National Cancer Plan 2026, British Society of Gastroenterologists (BSG) guidelines, the NHSE Personalised Care for Cancer Initiative, and the current NHS priorities and operational planning guidance for 2026/27.

2. Introduction

Stratified follow-up tailors review frequency to a patient's risk of recurrence, ensuring higher-risk patients receive more intensive monitoring while lower-risk patients have less frequent contact. Patients may be followed up by a Consultant, Clinical Nurse Specialist or remotely on a PSFU pathway.
The overall aim of PSFU is to improve patient experience and outcomes with tailored aftercare and supported self-management. It is intended to meet the wider needs of a cancer patient than is possible by routine clinic follow up alone. It reduces the frequency of hospital-based outpatient appointments but must be supported with rapid access to clinical review if symptoms of recurrence are reported.

3. Risk stratification

All newly diagnosed colorectal cancer patients should receive information about their diagnosis, treatment options, and subsequent follow-up pathway at the end of treatment, including an explanation of Personalised Stratified Follow-Up (PSFU). At the end of treatment, patients will be placed on the appropriate follow-up pathway as determined by the clinician (Consultant, Clinical Nurse Specialist or remotely on a PSFU pathway), with the plan clearly explained.

Patients' risk categories may be changed during follow-up, or they can be removed from a stratified pathway at any point during follow-up if clinically indicated.

4. PSFU process

PSFU pathways support patients to self-manage their condition, rather than following traditional clinic-based follow-up. To engage in self-care effectively, patients must have the knowledge, skills, and confidence to manage their condition. They should understand the re-entry process, the support and tools available to enable self-management, and the ongoing surveillance and screening that will occur during the follow-up period.

If patients are to be remotely followed up (PSFU pathway) they should be provided with specific written information about PSFU.

Patients should be reassured that they will receive the following to support them:

- Tumour specific written information (usually given at diagnosis)

- End of Treatment Summary (EOTs) should be given/sent after treatment is completed. The EOT should be sent to the patient and GP and includes details of the treatment, treatment outcome, symptoms of side effects or recurrence and contact details for the CNS.
- End of Treatment personalised care and support plan.
- PSFU information leaflet if on a PSFU pathway
- Contact details for the patient's key worker
- Reminders/ appointments for routine follow up tests, if appropriate.
- Confirmation of the outcome of those tests
- A discharge letter at the end of their follow up period.

5. Eligibility Criteria to be placed on a PSFU pathway

Suitability is determined by the treating team and at MDT and should be assessed using the following criteria.

- Completed primary treatment for a colon, rectal or anal, NET or peritoneal cancer and clinically well
- No physical, cognitive or emotional issues affecting their ability to self-manage.
- Able to communicate their concerns.
- Are willing and able to access healthcare.
- Not on active or maintenance treatment.
- No diagnosed recurrent disease that would prevent the patient from safely self-managing.
- No treatment-related side effects that would prevent the patient from safely self-managing.
- Not enrolled in a clinical trial where trial follow-up requirements conflict with PSFU
- Do not have a rare tumour.
- Not deemed inappropriate by the MDT because of oncological concerns or non-engagement

Trusts will also complete an Equalities Impact Assessment (EIA) for PSFU which will include specific cohorts of patients with protected characteristics that should be included with reasonable adjustments made or excluded. The EIA should be read alongside this protocol.

6. Risk groups and Schedules

Patients risk categories may be changed or removed from a stratified pathway at any point during follow up. This decision will be taken by the clinical team and/or MDT and the patient.

Colon and Rectal Cancers

- **Low Risk**
  Endoscopically removed T1 polyp cancers
- **Intermediate**
  Tumours with curative resections (previously referenced as Stage12, Dukes A-C)
- **High Risk.**
  Stage 4 disease at presentation with primary and metastatic sites resected (liver, lung, peritoneum)
- **Watch and Wait**

Clinical complete response after chemoradiotherapy for rectal cancer (recruit to OnCoRe)

- **Tems/Tamis**
  Transanal endoscopic microsurgery (TEMS)/ Transanal minimally invasive surgery (TAMIS)
- **Post Papillion Radiotherapy**
  Patients treated at Clatterbridge who return to GM for follow up.
- **High Risk Rectal**
  Positive resection margin

Appendix/Colorectal +/- peritoneal disease

- **Surgical Treatment**
  CRS & HIPEC/debulking/other procedure. Pseudomyxoma Peritonei (PMP), appendix adenocarcinoma, appendix Goblet Cell adenocarcinoma (GCC) and colorectal with peritoneal metastases.
- **Surgical Treatment**
  - LAMN I/HAMN I
  - LAMN II/HAMN II
- **Non-Operative**

Neuroendocrine Tumours (NET)

- **Post-Resection NET**

Anal Cancers

- **Surgical**
  Local Excision of Squamous Cell Carcinoma (SCC)
- **Surgical**
  Post-Salvage Surgery

Best Supportive Care
Patients to be followed up on an individual basis.

6.1 Schedules of follow-up

First endorsed by pathway board December 2019. Tems/Tamis endorsed 2021, Re-endorsed by pathway board December 2023, Post-Papillon added April 2026

Follow-up investigations should be scheduled as close to the defined protocol timepoints as possible. Where delays occur, subsequent testing intervals may be adjusted accordingly, with clinical judgement and patient-specific factors taking precedence over the standard schedule. The digital remote monitoring system will continue to reflect the next protocol milestones, irrespective of any previous delays.

The start date of a follow-up schedule is normally the date of the End of Treatment appointment or the operation date and will be decided locally.

Groups	**Time (months)**													
	3	**6**	**9**	**12**	**15**	**18**	**21**	**24**	**30**	**36**	**42**	**48**	**54**	**60**
1. **Low Risk** (endoscopically removed T1 polyp cancers)	Endoscopic visualisation of scar[a]	CEA		CEA CT TAP Colon*		CEA		CEA CT TAP	CEA	CEA		CEA Colon		CEA
2. **Intermediate** tumours with curative resections**		CEA		CEA CT TAP Colon*		CEA		CEA CT TAP	CEA	CEA CT Tap		CEA Colon		CEA
3. **High Risk** (stage 4 disease) at presentation with primary and metastatic sites resected (liver, lung, peritoneum)		CEA CT TAP		CEA CT TAP Colon*		CEA CT TAP		CEA CT TAP	CEA	CEA CT TAP		CEA CT TAP Colon*		CEA CT TAP
4. **Watch and Wait** for clinical complete response after chemoradiotherapy for rectal cancer (recruit to OnCoRe)	CEA MRI F Sig	CEA MRI F Sig CT TAP	CEA MRI F Sig	CEA MRI CT TAP Colon*		CEA MRI F Sig CT TAP		CEA MRI F Sig CT TAP	CEA MRI F Sig	CEA MRI F Sig CT TAP		CEA F Sig CT TAP Colon[c]		CEA CT TAP Colon [d]

5.**Tems/Tamis** Transanal endoscopic microsurgery (TEMS)/ Transanal minimally invasive surgery (TAMIS)	CEA MRI F Sig	CEA MRI F Sig	CEA MRI F Sig	CEA MRI Colon CT TAP		CEA MRI F Sig		CEA MRI F Sig CT TAP	CEA MRI F Sig	CEA MRI F Sig CT TAP		CEA MRI Colon		CEA MRI F Sig CT TAP***
6**. Post Papillon Radiotherapy.** Patients treated at Clatterbridge who return to GM for FUP	CEA DRE F Sig MRI	CEA DRE F Sig MRI CT TAP[b]	CEA DRE F Sig MRI	CEA DRE F Sig MRI CT TAP	CEA DRE F Sig MRI	CEA DRE F Sig MRI	CEA DRE F Sig MRI CT TAP	CEA DRE F Sig MRI	CEA DRE F Sig MRI	CEA DRE F Sig MRI CT TAP	CEA DRE F Sig MRI	CEA DRE F Sig MRI CT TAP	CEA DRE F Sig MRI	CEA DRE F Sig MRI CT TAP
7.**High Risk Rectal** (Positive resection margin) (rectal only)	MRI (Pelvis)	CEA MR Pelvis CTTAP	CEA MR Pelvis	CEA MR Pelvis CTTAP Colon*		CEA MR Pelvis CTTAP		CEA MR Pelvis CTTAP	CEA	CEA CT TAP		CEA MR Pelvis CTTAP		CEA CT TAP

[a] Frequency of further investigation of scar depends on findings at the 3 month flexi sig or colonoscopy

*Patients will have year 1 and 4 colonoscopy as per 2019 BSG guidelines

**High risk patients in this group may have additional scan, this will be discussed with the individual patient if clinically indicated

***CT TAP after 60 months at the discretion of individual provider

[c] Not Christie

[d] Christie only

[b] Clatterbridge as per treatment summary advocate CT A+P GM should consider annual CT TAP

Appendix/Colorectal Tumours +/- peritoneal disease

Groups	Time (months)											
	6m	12m	18m	24m	3y	4y	5y	6y	7y	8y	9y	10y
1.Surgical (CRS & HIPEC/debulking/other procedure) PMP, appendix adenocarcinoma/goblet cell adenocarcinoma colorectal peritoneal metastases.	CTTAP CEA Ca19.9 Ca125	CTTAP CEA Ca19.9 Ca125	CTTAP CEA Ca19.9 Ca125	CTTAP CEA Ca19.9 Ca125	CTTAP CEA Ca19.9 Ca125	CTTAP CEA Ca19.9 Ca125	CTTAP CEA Ca19.9 Ca125	CEA Ca19.9 Ca125	CTTAP CEA Ca19.9 Ca125	CEA Ca19.9 Ca125	CEA Ca19.9 Ca125	CTTAP CEA Ca19.9 Ca125
2. Surveillance post primary appendicectomy HAMN I			CT AP CEA CA125 CA19.9			CT AP CEA CA125 CA19.9						
3. Surveillance post primary appendicectomy LAMN II/HAMN II		CT AP CEA Ca19.9 Ca125		CT AP CEA Ca19.9 Ca125	CT AP CEA Ca19.9 Ca125	CEA Ca19.9 Ca125	CT AP CEA Ca19.9 Ca125	CEA Ca19.9 Ca125	CT AP CEA Ca19.9 Ca125	CEA Ca19.9 Ca125	CEA Ca19.9 Ca125	CT AP CEA Ca19.9 Ca125
4 Non-operative appendix adenocarcinoma/goblet cell adenocarcinoma	CTTAP CEA CA19.9 CA125	CTTAP CEA CA19.9 CA125	CTTAP CEA CA19.9 CA125	CTTAP CEA CA19.9 CA125	CTTAP CEA CA19.9 CA125	CTTAP CEA CA19.9 CA125	CTTAP CEA CA19.9 CA125	CEA CA19.9 CA125	CTTAP CEA CA19.9 CA125	CEA CA19.9 CA125	CEA CA19.9 CA125	CTTAP CEA CA19.9 CA125

NET

Groups	Time (months)											
	6m	12m	18m	24m	3y	4y	5y	6y	7y	8y	9y	10y
1. Post-Resection NET	CTTAP 5-HIAA	CTTAP 5-HIAA	CTTAP 5-HIAA	CTTAP 5-HIAA	CTTAP 5-HIAA	CTTAP 5-HIAA	CTTAP 5-HIAA	CTTAP 5-HIAA	CTTAP 5-HIAA	CTTAP 5-HIAA	CTTAP 5-HIAA	CTTAP 5-HIAA

Anal Cancers*

Groups	Time (months)											
	Baseline or Re-staging	6wks	3m	6m	9m	12m	18m	24m	30m	36m	48m	60m
1. Surgical – Local Excision of SCC	Clinical Exam Pelvic MR PET-CT CTTAP	Clinical Exam	Clinical Exam (optional)	Clinical Exam Pelvic MR	Clinical Exam (optional)	Clinical Exam Pelvic MR CTTAP	Clinical Exam Pelvic MR	Clinical Exam Pelvic MR CTTAP	Clinical Exam	Clinical Exam Pelvic MR CTTAP	Clinical Exam CTTAP	Clinical Exam CTTAP
2. Surgical – Post Salvage Abdomino-perineal Resection (APR) Surgery	EUA Pelvic MR PET-CT	Clinical Exam	Clinical Exam	Clinical Exam Pelvic MR	Clinical Exam	Clinical Exam Pelvic MR CTTAP	Clinical Exam Pelvic MR	Clinical Exam Pelvic MR CTTAP	Clinical Exam Pelvic MR	Clinical Exam Pelvic MR CTTAP	Clinical Exam	Clinical Exam

*Taken from Christie Anal Cancer MDT Follow-Up Guidelines (2024) – Table 4. Margin ASCC treated by local excision (<4cm N0), and Table 6. Post-salvage surgery for local relapse of anal cancer.

Best Supportive Care

Groups	Time (months)
	Indefinite
1. Best Supportive Care (BSC)	No set milestones

7. Recurrence

A patient with recurrence within the first 5 years (liver/lung/peritoneal metastasis) will restart the pathway (including surveillance protocols) from their operation date.

8. Re-accessing the specialist team as required

- All patients and their GPs will be aware of how to access the Colorectal Specialist Team if concerns arise within the surveillance period. Safe robust and sustainable open access systems will be in place to facilitate this.
- Patients and their GPs will have contact numbers and guidance about when and how to access further support. Access will be via the Specialist Team through an open access system.
- To deliver a robust rapid re-entry pathway, it is essential to ensure there is appointment capacity with the existing Colorectal and oncology clinics.
- A patient who contacts the specialist team with symptoms of progression must have a clinical assessment within 2 working days
- If a patient is required to have further investigations following their routine surveillance, they will be recalled for further imaging and be seen in clinic within 1 week of that imaging being discussed at MDT.

9. Responsibilities and Governance

It is the responsibility of the clinician, CNS and/or MDT to identify and offer (P)SFU to appropriate patients. Where a patient has had treatment at a number of different Trusts, follow up will be carried out by the Trust as detailed in the end of treatment responsibilities mapping document. The Trust responsible for the follow up is also responsible for the end of treatment appointment and written summary. The Christie only has responsibility for adding patients to a SFU when The Christie is overseeing the patient's follow-up for the full 5-10-year period.

If patients or GP's contact the CNS with symptoms of possible recurrence, they must be offered a clinical assessment within 2 working days. It is preferable to assess at the time of contact.

Appropriate cross cover arrangements for the CNS must be in place to ensure patient contacts are not unduly delayed due to planned/unplanned leave.

It is the responsibility of the specialist team to enrol all patients on a (P)SFU pathway onto a secure digital remote tracking system.

Updating the system, routine test requests and patient letters can be delegated to appropriately trained members of the Colorectal team.

The system must flag overdue tests/letters to ensure patients follow up is not missed.

It is the responsibility of the team to follow up patients in a timely manner and ensure the tracking system is kept uptodate.