CRC diagnosis as starting point of therapy. Trajectory of a patient in the health care system must be standardized.

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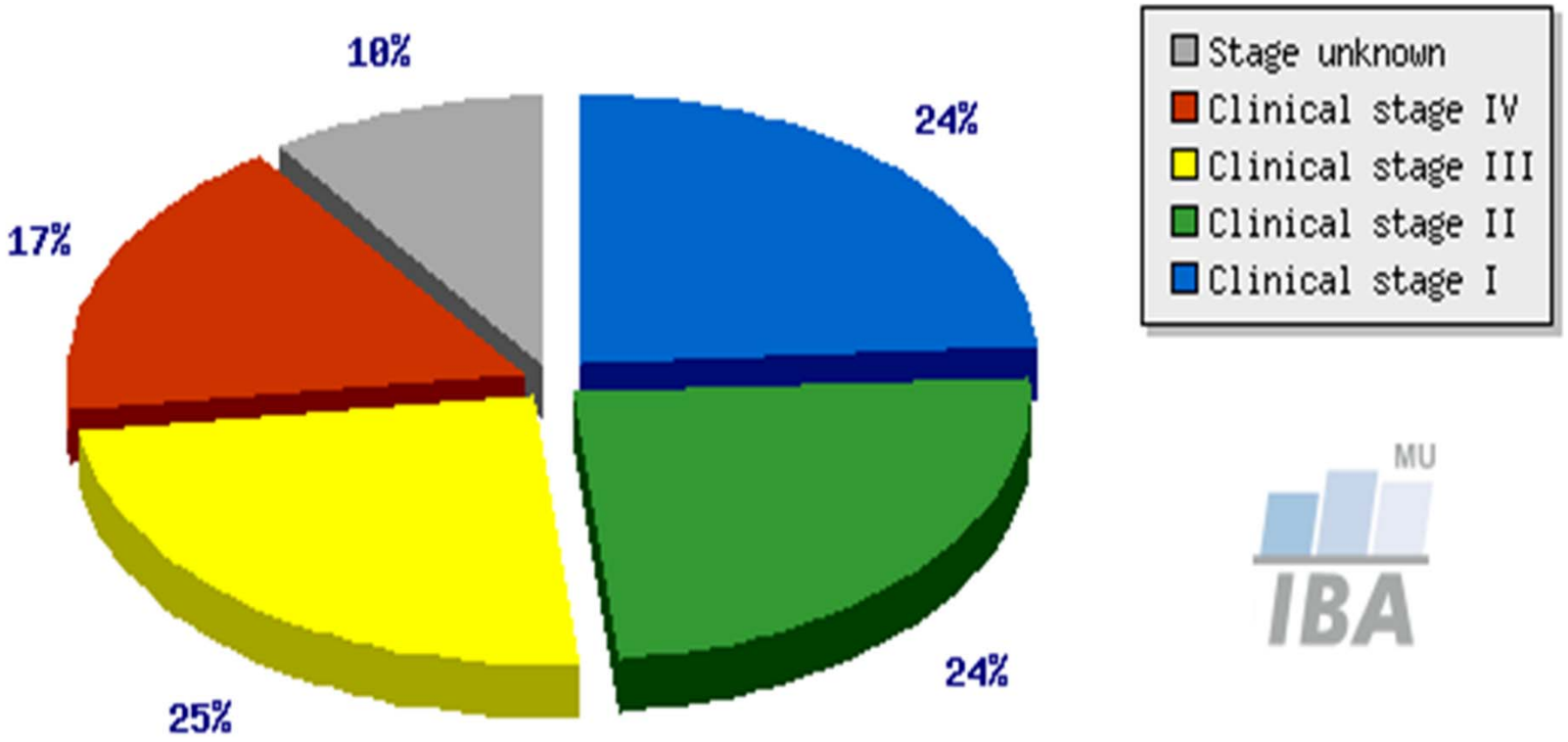
What should follow after the detection of CRC

- **Diagnostic procedures**
  - **Total colonoscopy** is the main procedure for diagnosis.
    - Determination of the exact localisation and biopsy of the lesion,
    - Detection of synchronous precancerous or cancerous lesions
  - **Preoperative examination for clinical stage (TNM)**
    - CT (chest, abdomen and pelvis)
    - Tumor markers: CEA, Ca 19-9

C18-C21 - Malignant neoplasm of colon and...

distribution of clinical stages in percents, 2012-2012



Analysed data: N=7940

Source of data: ÚZIS ČR

http://www.svod.cz

Treatmen by stage

- **Stage 0 (Tis N0 M0)**
  - Local excision or simple polypectomy.
  - Segmentary en-bloc resection for larger lesions not amenable to local excision.

- **Stage I (T1-2 N0 M0) -** Dukes' A or modified Astler–Coller A and B1).
  - Wide surgical resection and anastomosis. No adjuvant chemotherapy.

- **Stage II A, B, C (T3 N0 M0, T4 a-b N0 M0)**
  - Wide surgical resection and anastomosis.
  - Following surgery, adjuvant therapy should not be routinely recommended for unselected patients.
    - Adjuvant treatment is recomennded only for high risk disease.
      - lymph nodes sampling <12; poorly differentiated tumour; vascular or lymphatic or perineural invasion; tumour presentation with obstruction or tumour perforation and pT4 stage

Treatmen by stage

- **Stage III (any T, N1-N2, M0)**
  - Wide surgical resection and anastomosis.
  - Following surgery, the standard treatment is a doublet schedule with oxaliplatin and a fluoropyrimidine.

The decreases risk of death by		The 5-year survival after surgical resection alone is
Stadium I	-	85-95%
Stadium II	3-5%	60-80%
Stadium III	10-15%	30-60%
	+ 4-5% oxali	

Labiance R. et al. Annals of Oncology 2013

Metastatic colorectal cancer

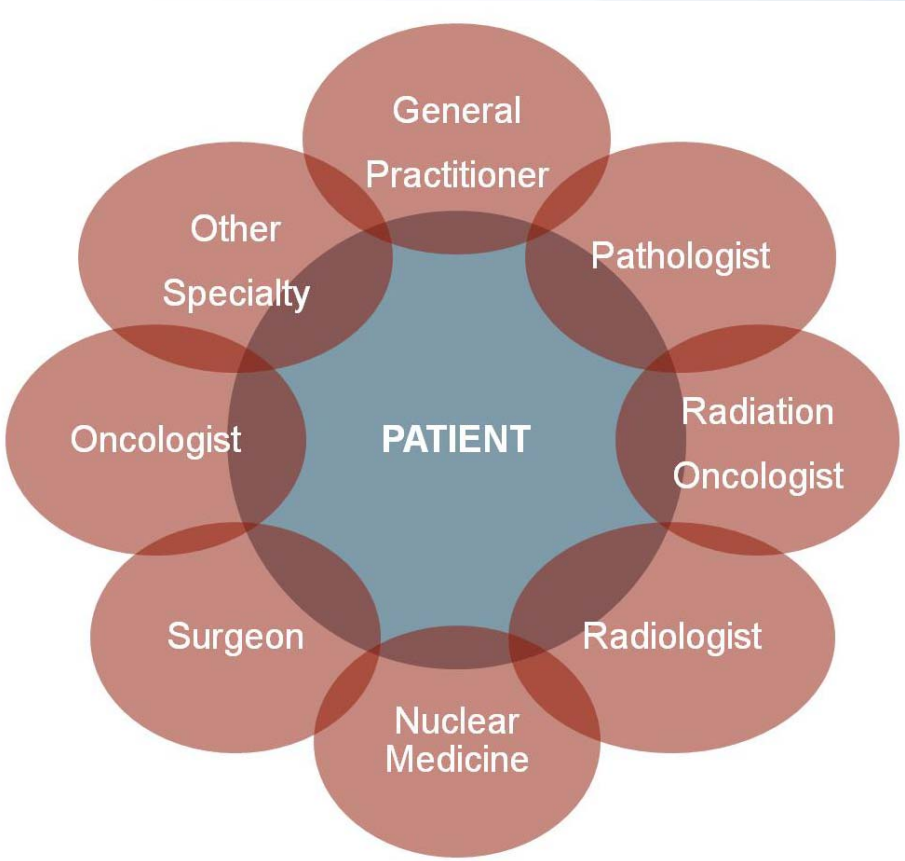
- The majority of patients (80-85%) have metastatic disease that initially is not suitable for potentially curative resection.

- It is, however, important to select patients in :
  - **whom the metastases are suitable for resection**
  - initially unresectable disease in whom the metastases can become suitable for resection after a major response has been achieved with combination chemotherapy. The aim of the treatment in the last group of patients may therefore be to convert initially unresectable mCRC to resectable disease – **potentialy resectable** .

Patient-centric approach

Tumour characteristics	Patient characteristics	Patient preference
Clinical presentation	Age	Quality of life
Tumour biology	Performance status	Expectations
RAS mutation status	Prior adjuvant treatment	Toxicity profile
BRAF mutation status	Comorbidities	Flexibility

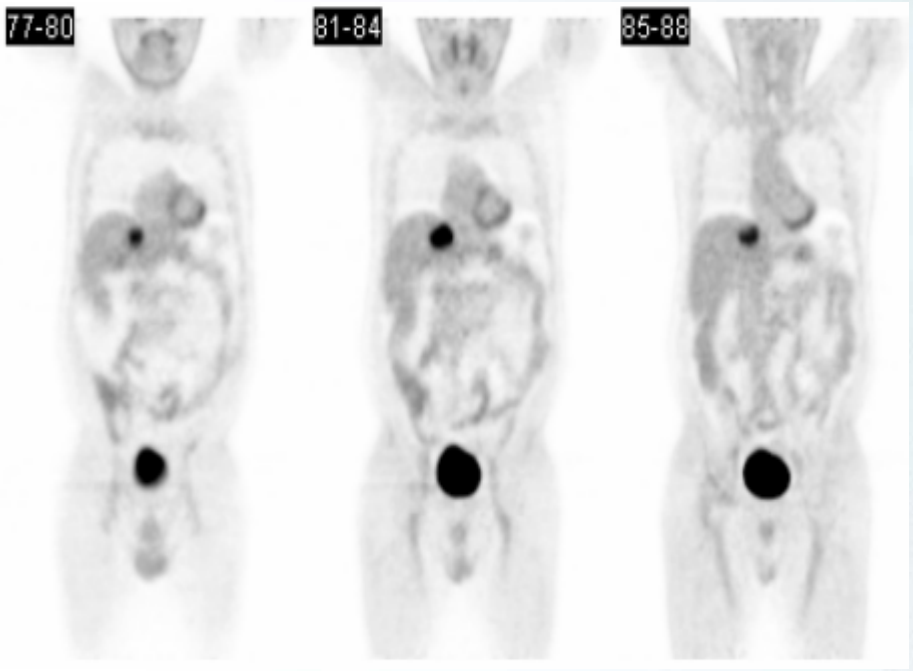
Multidisciplinary approach for selecting the best treatment strategy

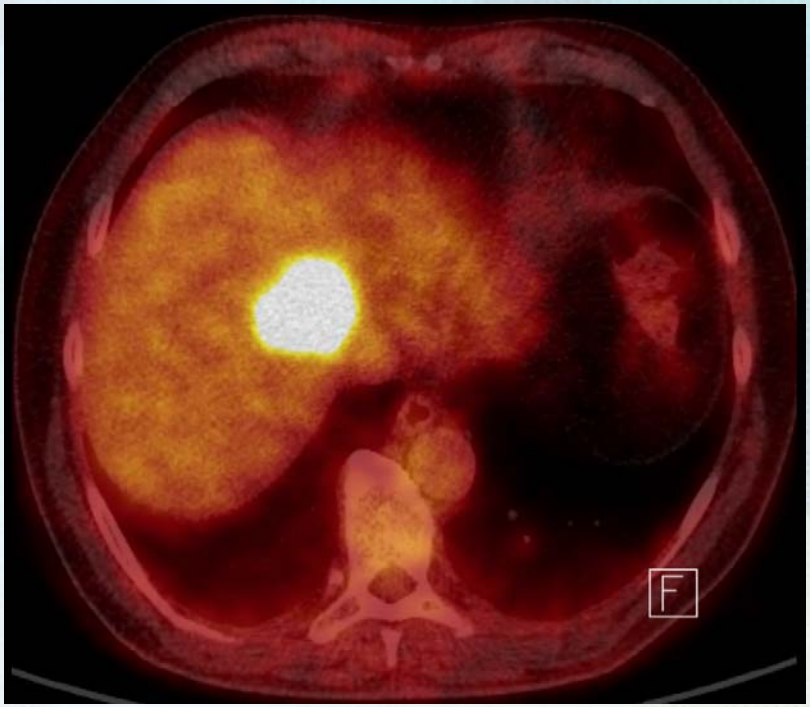


The greatest chance for cure metastatic CRC is in Comprehensive Cancer Centres (CCCs)

Patient case

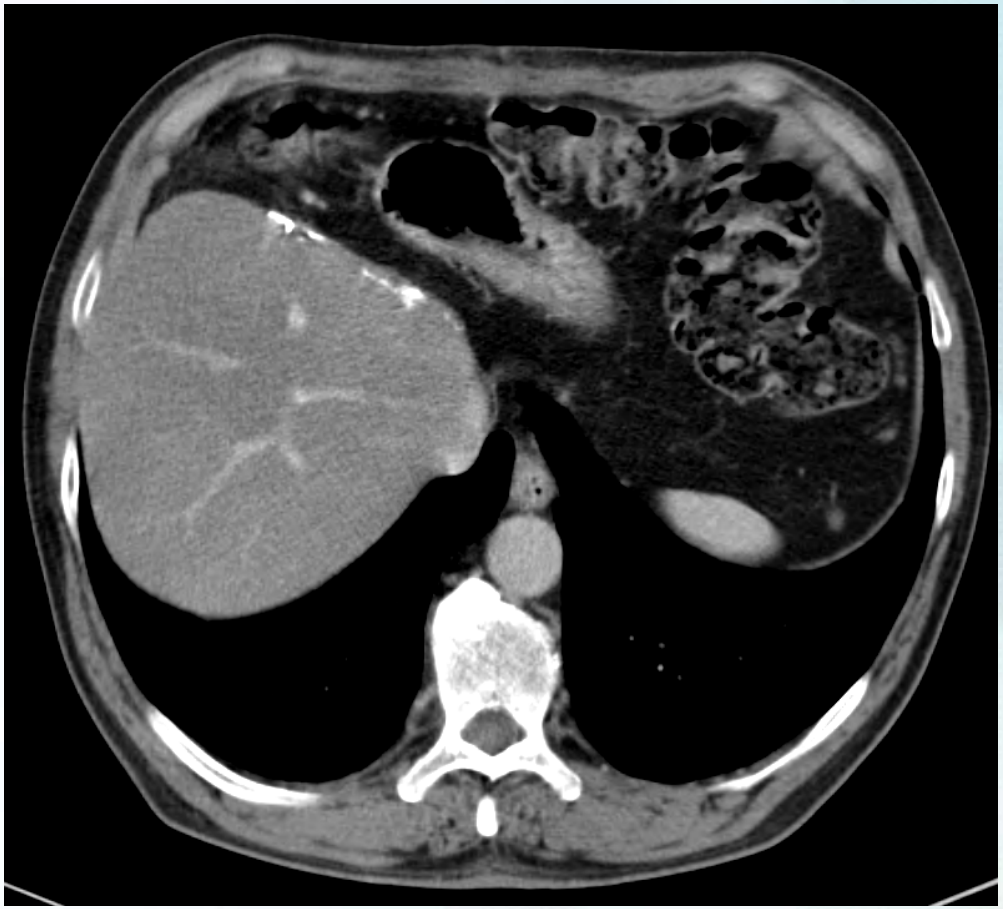
- **64-year-old university teacher**
- Adenocarcinoma colon 2007, G2, pT3 pN1 M0, k-RAS wild type,
- Resection followed adjuvant chemoherapy FU based (kapecitabine)
- Follow up started 3/2008
- **7/2009 – 1st relaps - solitary metastasis in the liver S4 by: PET/CT - 1,5 years after finished primary treatment**
- Chemobiotherapy: 4 cykly XELOX+/bevacizumab





Patient case

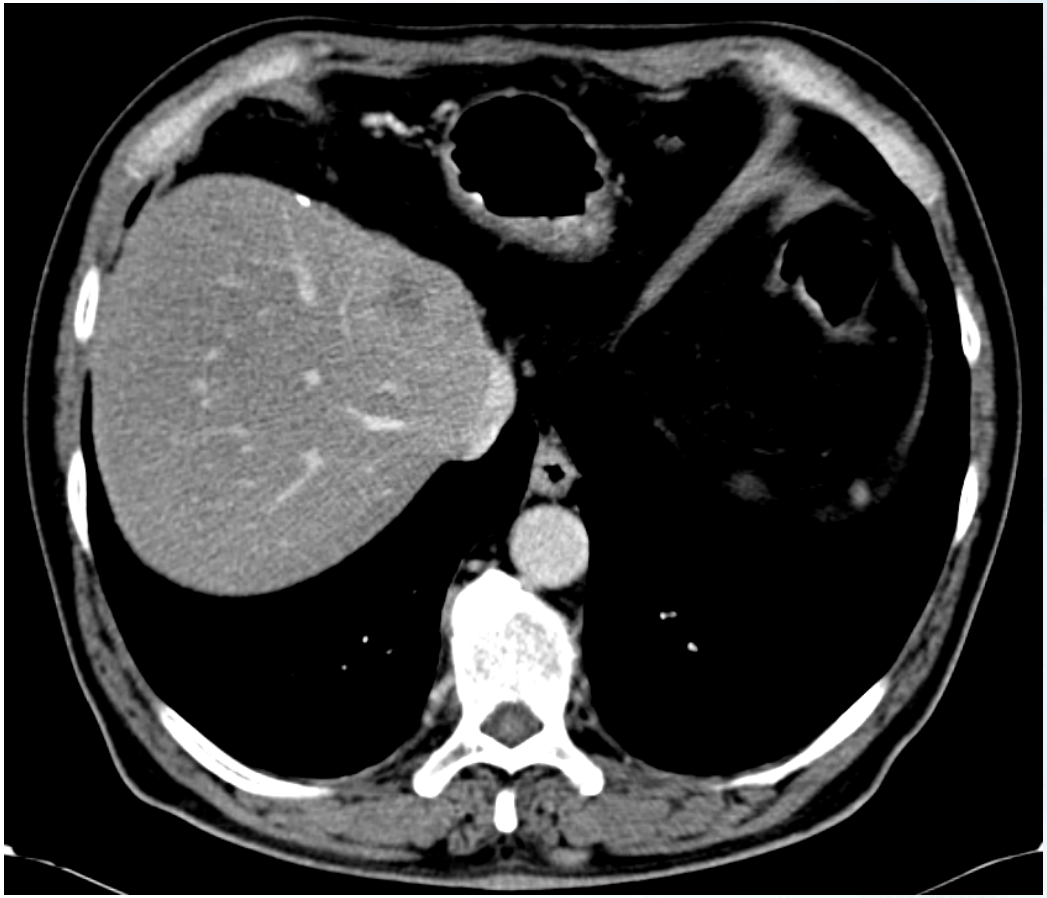
- 11/2009 –the right liver lobe resection , followed by 5 cycles of adjuvant XELOX/bevacizumab

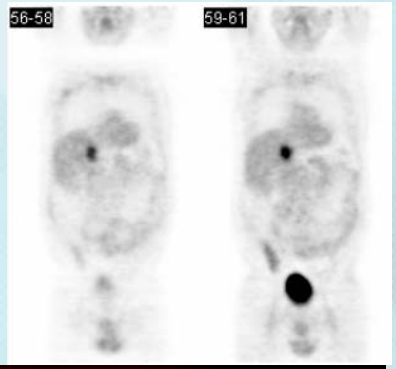


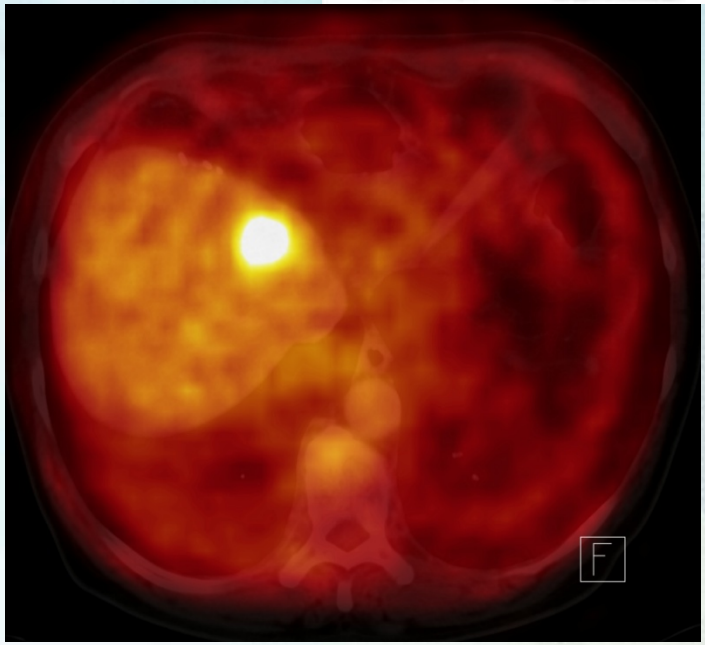
Patient case

- 2nd relaps 1,5 years after finished previous treatment

- 3/2011 PET CT- relaps in the liver S8

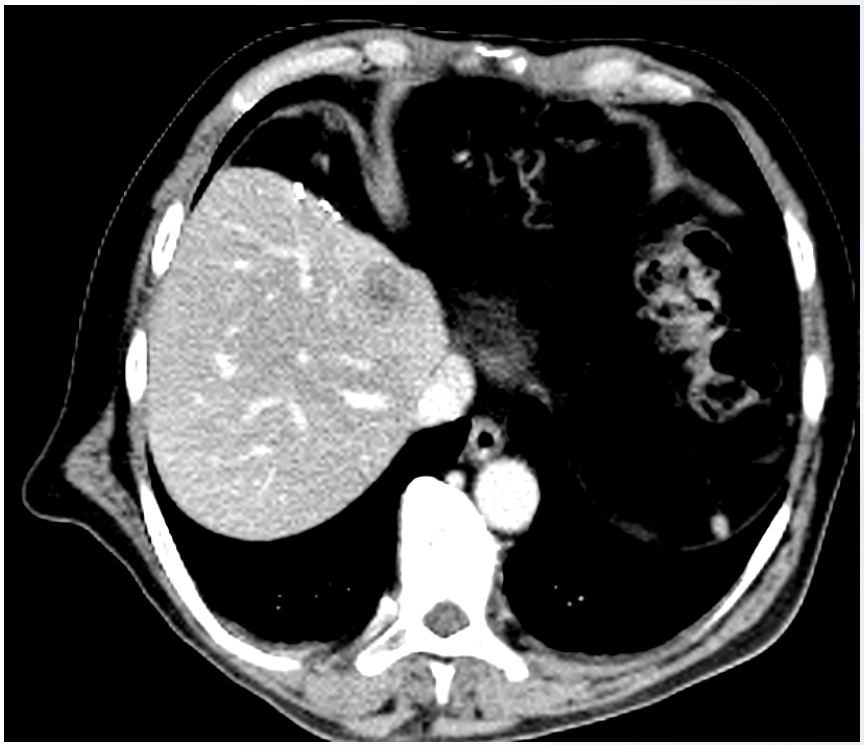


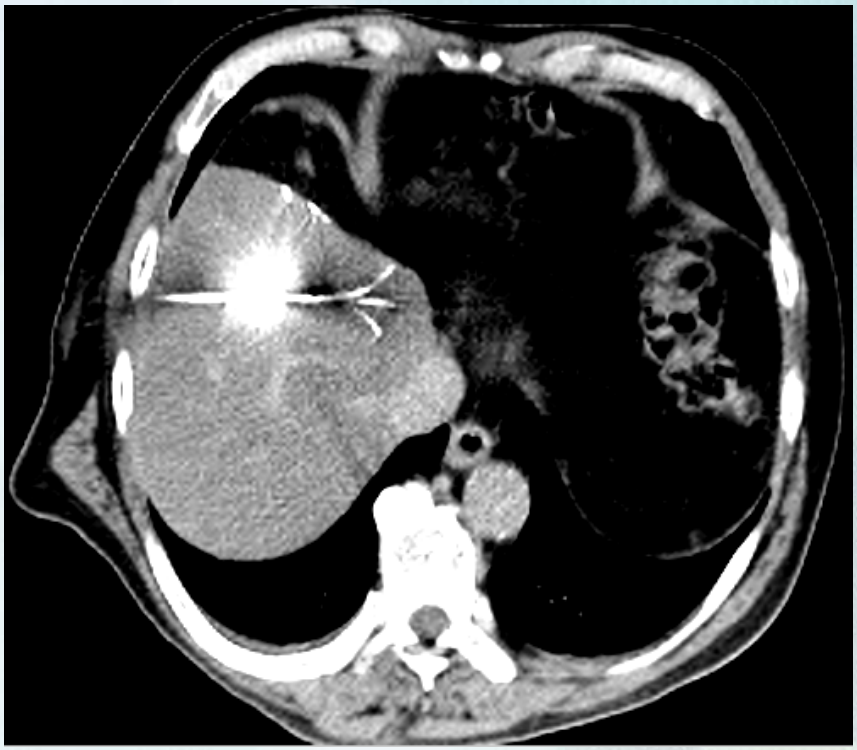




Patient case

- Radiofrequency ablation (RFA) 5/11
- Adjuvant irinothecan based chemoterapy (XELIRI) utill 9/2011

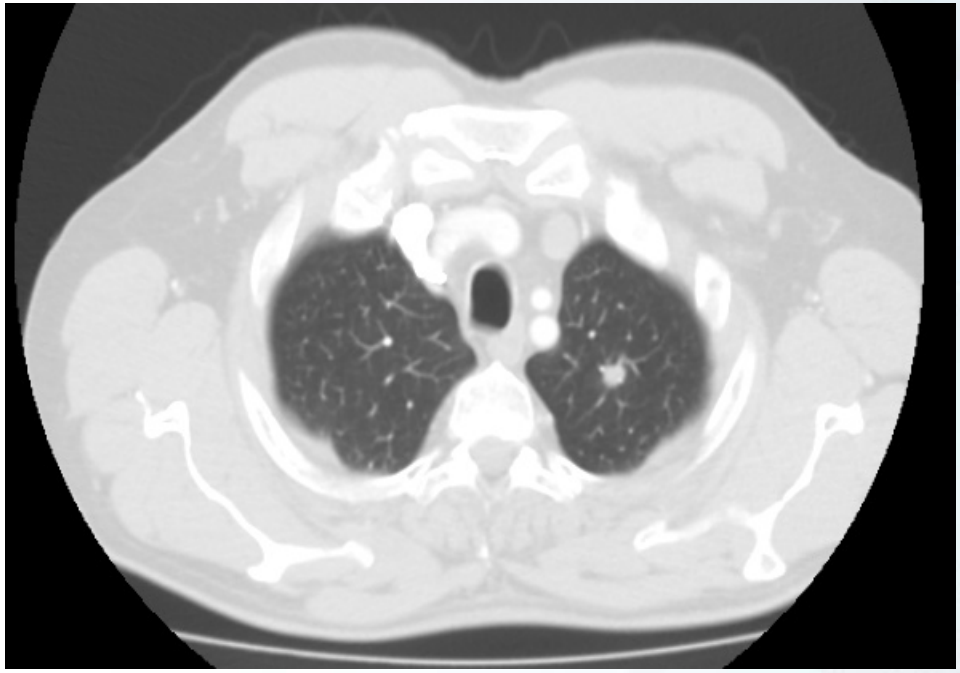


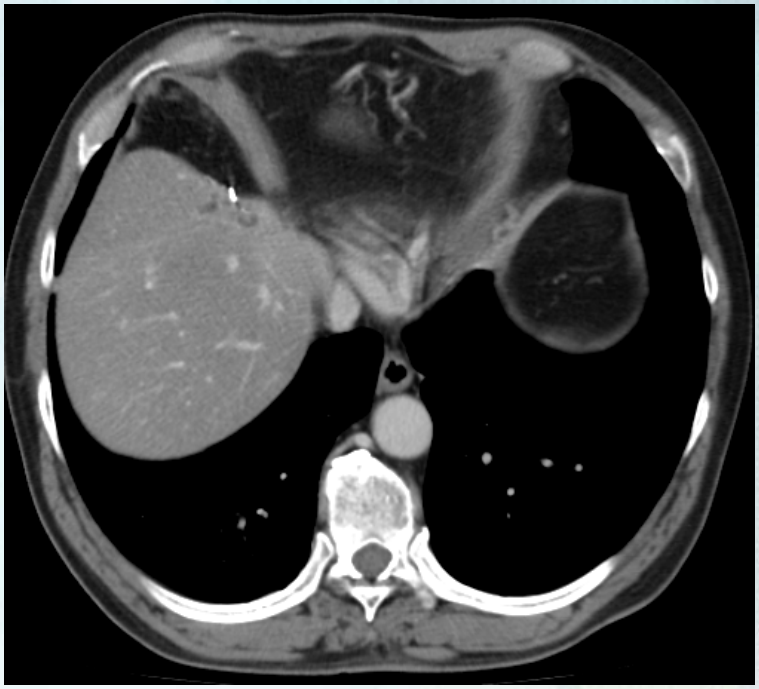


Current solutions: radiofrequency ablation, microwave ablation, stereotactic radiosurgery, Surgical resection

Patient case
- 3rd relaps of disease

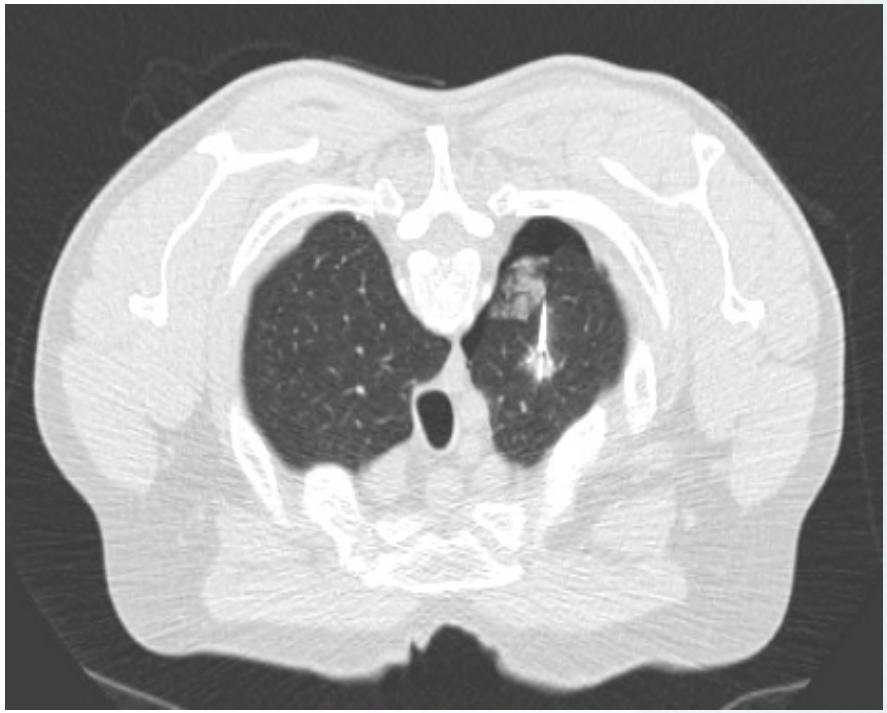
- 12/2012 relaps in lung by CT and PET
- 1 year after finished previous treatment for 2nd relaps

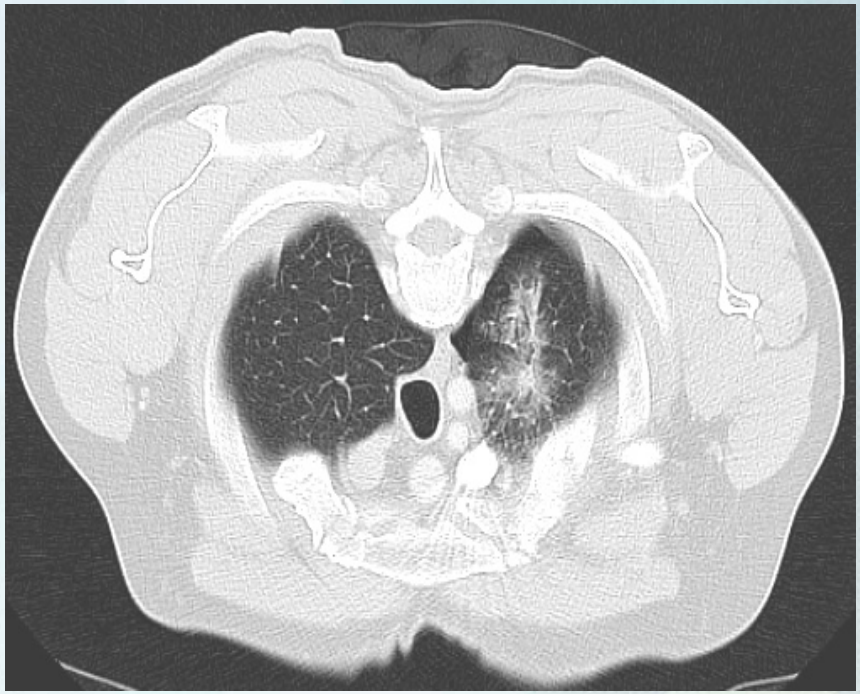




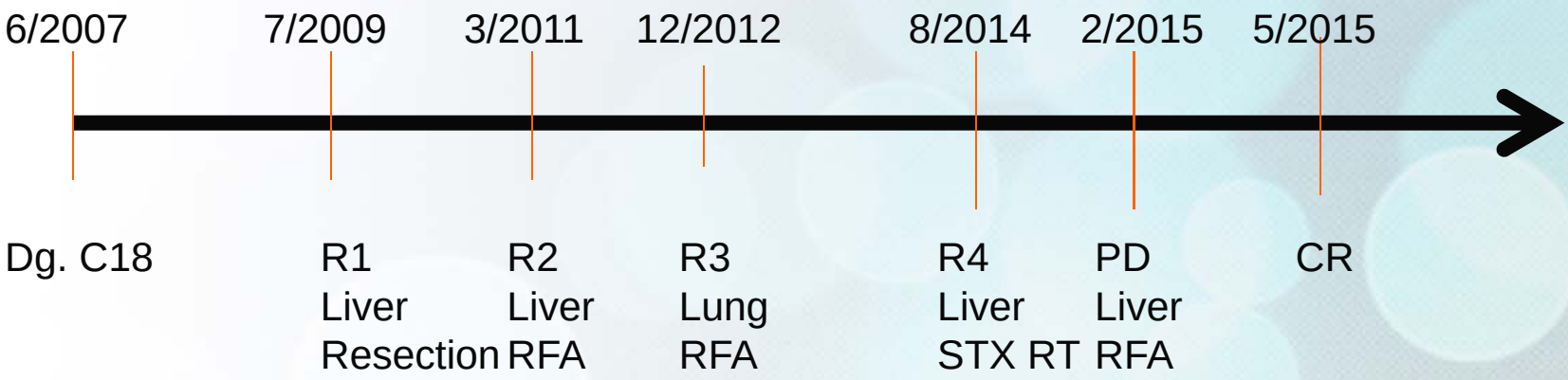
Patient case

- Radiofrequency ablation (RFA) 12/2012



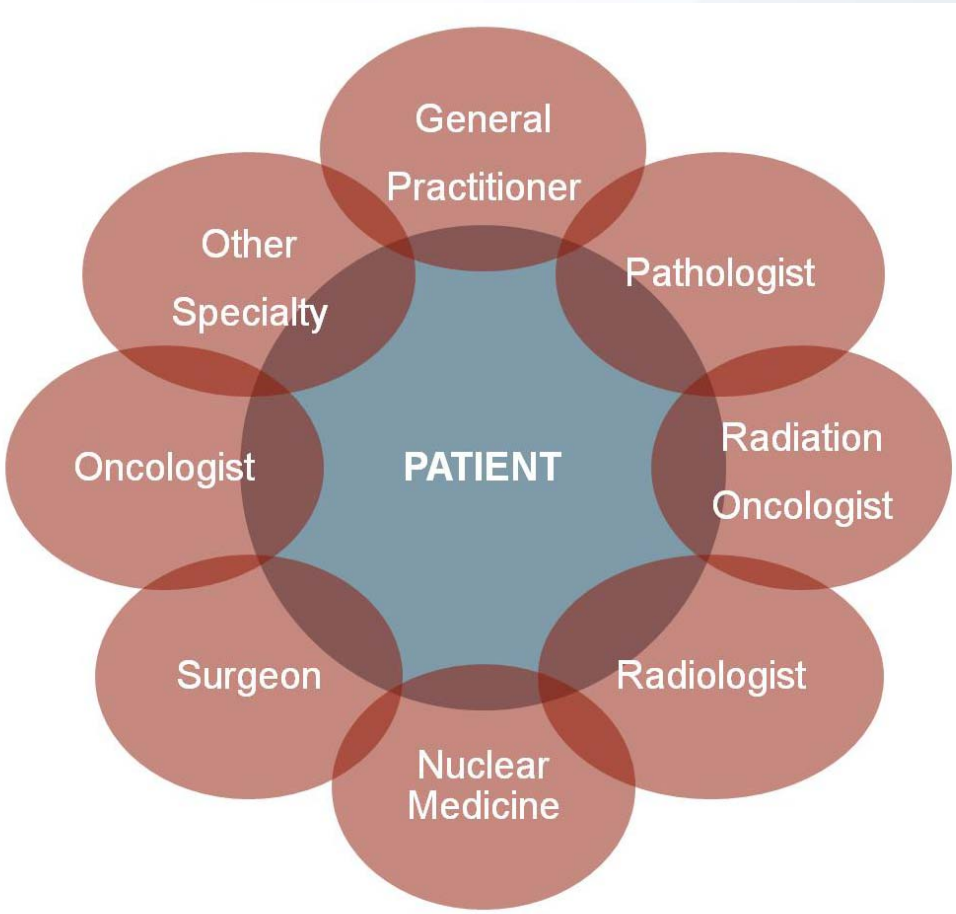


Timeline of the treatment in our patient



Patient lives 8 years from diagnosis colon cancer
Patient lives 6 years from diagnosis of metastatic colon cancer
Currently no signs of active disease

Multidisciplinary approach for selecting the best treatment strategy



- The greatest chance for cure metastatic CRC is in Comprehensive Cancer Centres (CCCs)

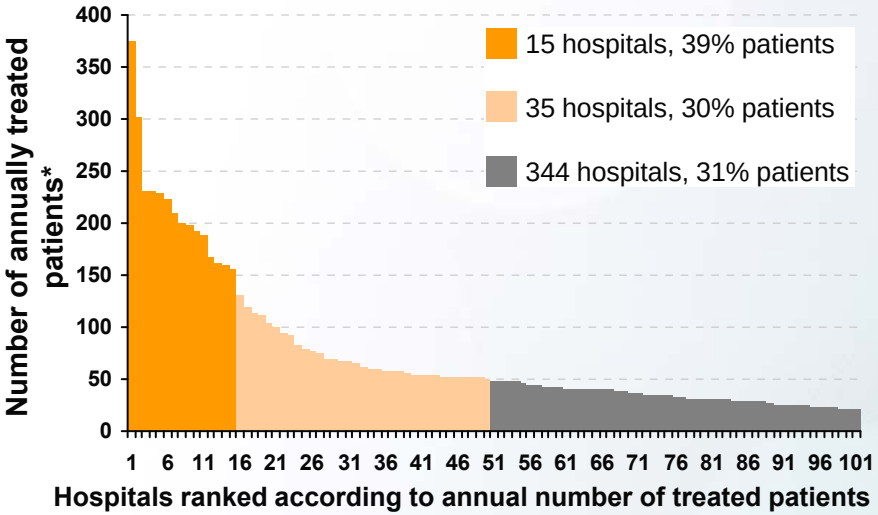
Actually survival in mCRC

- Inoperable mOS 25-30m
- Resectable mCRC (liver)
  - 5 years OS 50%
  - 7 years OS 30%
  - 10 years OS 25%

Distribution of primary colorectal cancer care*(2008-2012)

Source: NCR

All patients with CRC (N = 35,025)



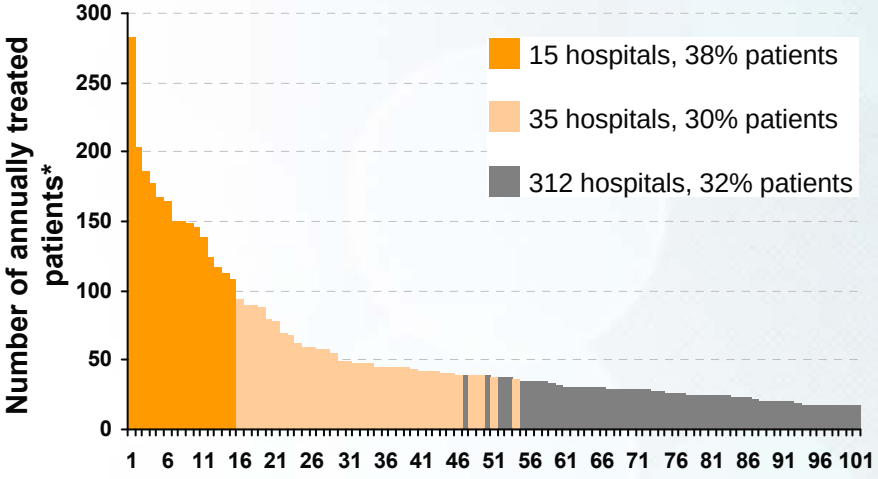
*** Patients with primary treatment in the hospital = patients who were treated in the hospital by one or more of these modalities (according to information in CNCR on primary anticancer therapy):**

- **surgery**
- **chemotherapy**
- **radiotherapy**
- **other anticancer treatment**

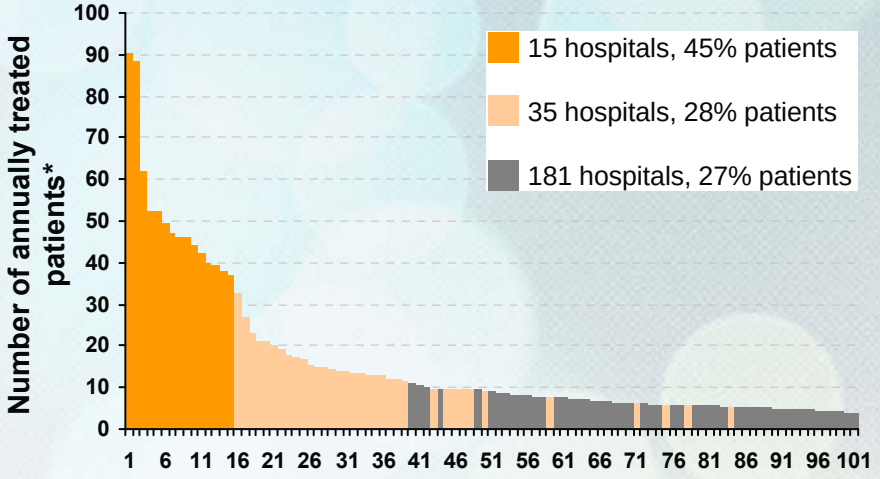
Hospitals according to annual total number of CRC patients with primary treatment:

- **≥ 150 CRC patients**
- **50 to 149 CRC patients**
- **< 50 CRC patients**

Patients with CRC stage 1-3 (N = 26,669)



Patients with CRC stage 4 (N = 7,148)



Thank you for your attention