



Ontario Health
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**A Quality Initiative of the
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Ontario)**

**Follow-up Care, Surveillance Protocol, and Secondary
Prevention Measures for Survivors of Colorectal Cancer**

*E. Kennedy, C. Zwaal, T. Asmis, C. Cho, J. Galica, A. Ginty, A. Govindarajan and the
Colorectal Cancer Survivorship Guideline Development Group Guideline Group/Expert Panel.*

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For information about this document, please contact Erin Kennedy, the lead author, through
the PEBC at: Phone: 905-527-4322 ext. 42822 Fax: 905-526-6775
E-mail: ccopgi@mcmaster.ca

For information about the PEBC and the most current version of all reports, please visit the
OH (CCO) website at <https://www.cancercareontario.ca/en/guidelines-advice> or contact the
PEBC office at: Phone: 905-527-4322 ext. 42822 Fax: 905-526-6775
E-mail: ccopgi@mcmaster.ca

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PUBLICATIONS RELATED TO THIS REPORT

- Members of the Gastrointestinal Cancer Disease Site Group. Follow-up of patients with curatively resected colorectal cancer. 2012 Mar 20 [Education and Information 2012 Mar 20]. Program in Evidence-based Care Practice Guideline No.: 2-9 Education and Information 2012.
- Sussman J, Souter LH, Grunfeld E, Howell D, Gage C, Keller-Olaman S, et al. Models of care for cancer survivorship. Sussman J, Fletcher G, reviewers. Toronto (ON): Cancer Care Ontario; 2012 Oct 26 [ENDORSED 2017 March 28]. Program in Evidence-based Care Evidence- Based Series No.: 26-1 Version 2 ENDORSED.
- Cancer Care Ontario Person-Centred Care Guideline: Endorsement and Adaptation of CG 138: Patient experience in adult NHS services: improving the experience of care for people using adult NHS services. 2015 May 2015. Person-Centred Care Program.
- Follow-Up Model of Care for Cancer Survivors: Recommendations for the Delivery of Follow-up Care for Cancer Survivors in Ontario. 2019 March. Cancer Care Ontario Survivorship Program.

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Follow-up Care, Surveillance Protocol, and Secondary Prevention Measures for Survivors of Colorectal Cancer

Recommendations

This is a quick reference guide and provides the guideline recommendations only. For key evidence associated with each recommendation, the systematic review, and the guideline development process, see the Full Report.

GUIDELINE OBJECTIVES

This guideline is an update to a previous version (i.e., GL 26-2 Version 2). The main objectives are:

1. To determine the surveillance regimen that leads to the largest benefit for stage I-IV colorectal cancer survivors treated with curative intent.
2. To determine preferred models of follow-up care in Ontario.
3. To identify signs and symptoms of potential recurrence and determine when to investigate.
4. To evaluate patient information and support needs during the survivorship phase.

TARGET POPULATION

Adult colorectal cancer survivors defined as patients who have completed primary, curative treatment for colorectal cancer stages I to IV and are without evidence of disease.

INTENDED USERS

This guideline is targeted to:

1. Clinicians (e.g., medical oncologist, radiation oncologist, surgeon, advanced practice nurse, physician assistant, primary care provider [family physician, nurse practitioner, family practice nurse]) involved in the delivery of care for colorectal cancer survivors.
2. Healthcare organizations and system leaders responsible for offering, monitoring, or providing resources for colorectal cancer survivorship protocols.

PREAMBLE

The Supplemental Information section that follows the recommendations provides links to webpages with tools to help with communication, patient education, and decision aids; a list of signs and symptoms; and a list of psychosocial supports and informational needs of patients that may impact follow-up requirements and decisions.

RECOMMENDATIONS

Recommendation 1
For patients with stage I-III colon cancer: • A medical history and physical examination should be performed every six months for three years. • Computed tomography (CT) of the chest, abdomen and pelvis (CT CAP) should be performed at one and three years OR one CT CAP could be performed at 18 months.

• The use of carcinoembryonic antigen (CEA) is optional if CT imaging is being performed. • Surveillance colonoscopy should be performed one year after the initial surgery. The frequency of subsequent surveillance colonoscopy should be dictated by the findings of the previous one, but it generally should be performed every five years if the findings of the previous one is normal.
Qualifying Statements for Recommendation 1
• The use of CEA in combination with CT CAP does not lead to a survival advantage compared to CT CAP alone. • CEA is optional in patients with elevated CEA prior to treatment provided that CT CAP imaging is being performed. • If complete colonoscopy was not performed in the course of diagnosis and staging (e.g., due to obstruction), a complete colonoscopy should be performed within six months of completing primary therapy. • There was insufficient evidence to support these recommendations for patients with rectal cancer, patients with stage IV colon cancer, and patients over the age of 75 years. Therefore, the follow-up in those patients is at the discretion of the treating physician. • There was no evidence to support follow-up in patients with stage I-III colon cancer beyond three years. Therefore, follow-up after this time period is at the discretion of the treating physician. • These recommendations do not apply to patients with rectal cancer undergoing non-operative management or to patients with increased risk of cancer including but not limited to inflammatory bowel disease, familial adenomatous polyposis, and Lynch syndrome. • Patients should be informed of these current recommendations and the treating physician should discuss the specific risks and benefits of these recommendations with their patient.

Table 1.1 Recommended evaluation and intervals for routine surveillance of stage I-III colon cancer survivors

Intervention	Interval	
	Years 1 to 3	Years 4 and 5
Physical examination	Every 6 months	At discretion of treating physician
CEA	At discretion of treating physician	At discretion of treating physician
CT of the Chest, Abdominal and Pelvic Imaging (CT CAP)	CT CAP at Years 1 and 3 OR CT CAP at 18 months	At discretion of treating physician
Colonoscopy	At 1 year following surgery, the frequency of subsequent surveillance colonoscopies should be dictated by the findings of the previous one but generally should be performed every 5 years if the findings of the previous one are normal.	

CEA=carcinoembryonic antigen; CT=computed tomography

Recommendation 2

While there is limited evidence to support a shared care model for the follow-up of patients with colorectal cancer, this approach was supported by the Working Group and Expert Panel.

Follow-up care is complex and requires multidisciplinary, coordinated care of the patient delivered by the cancer specialist, family physician or nurse practitioner, and allied health professionals.

The roles and responsibilities of the multidisciplinary team members need to be clearly defined and the patient needs to know when and how to contact each member of the team.

Qualifying Statement for Recommendation 2

- It is expected that implementation of a shared care model will need to be region specific based on the available resources and provider models in each individual region.

Recommendation 3

The signs and symptoms of recurrence may be subtle and must be considered in the context of the patient's overall health and pre-existing conditions. There is insufficient evidence to recommend any individual sign or symptom or combination of signs and symptoms as a strong predictor of recurrence.

Patients should be educated about the potential signs and symptoms of recurrence and know which member of the multidisciplinary care team they should contact if they develop any new or concerning signs or symptoms.

A list of signs and symptoms of colorectal cancer recurrence can be found in the Supplemental Information section following the recommendations.

Recommendation 4

Psychosocial support about the risk of recurrence and provision of empathetic, effective, and coordinated communication are most highly valued by patients for post-treatment physical effects and symptom control.

Continuing professional education should emphasize the importance of communication skills and coordination of communication between the patient and family, and healthcare providers.

A list of late and long-term physical and psychosocial effects of colorectal cancer and links to communication resources and tools can be found in the Supplemental Information section following the recommendations.

Supplemental Information: Colorectal Cancer Follow-up Resources

1. Colorectal Cancer Follow-up Resources

Communication Skill Resources and Training

Physiciansapply.ca

- Communication and Cultural Competence Program, Communication Skills Module: Medical Communication skills
- Modules that focus on communication between health professionals and patients
- <https://physiciansapply.ca/commskills/introduction-to-medical-communication-skills/>

Ontario Health (CCO) Follow-up Model of Care for Cancer Survivors: Recommendations for the Delivery of Follow-up Care for Cancer Survivors in Ontario. March 2019.

- These Recommendations aim to provide guidance to healthcare providers and administrators on implementing optimal delivery of follow-up care for all cancer survivors by clarifying: the roles of primary care providers and specialist teams; settings in which this care should be provided; and processes involved in organization of follow-up care.
- <https://www.cancercareontario.ca/en/guidelines-advice/types-of-cancer/58736>

Ontario Health (CCO) Person-Centred Care Guideline

- The objective of this guideline is to establish a standardized set of recommendations for providing person-centred care in the delivery of adult oncology services in Ontario.
- This guideline provides guidance for use by all clinicians and staff within adult oncology service settings, and for use by patients (and/or family members and caregivers) and their care providers to inform the provision of person-centred care.
- <https://www.cancercareontario.ca/en/guidelines-advice/types-of-cancer/38631>

R.E.D.E. to Communicate®: Foundations of Healthcare Communication

- This course introduces clinicians to the R.E.D.E. Model of relationship-centered communication and how it applies to any clinical practice. This peer-led course is grounded in evidence-based practices, adult learning theory and experiential learning.
- <https://my.clevelandclinic.org/departments/patient-experience/depts/experience-partners/training/foundations-of-healthcare>

Decision Aids

Ottawa Hospital Research Institute

- <https://decisionaid.ohri.ca/AZlist.html>

Patient Education (How to) Materials

Canadian Association of Psychosocial Oncology (CAPO) <https://www.capo.ca/>

- Evidence-informed guidelines can be found
- <https://www.capo.ca/guidelines>

Canadian Association of Nurses in Oncology (CANO/ACIO)

- Survivorship resource based upon literature reviews of the topics in table of contents
- www.cano-acio.ca/survivorship_manual

American Society of Clinical Oncology (ASCO)

- Models of long-term follow-up care
- <https://www.asco.org/practice-policy/cancer-care-initiatives/prevention-survivorship/survivorship/survivorship-3>

Canadian Cancer Society (CCS)

- Follow-up after treatment for colorectal cancer
- <https://www.cancer.ca/en/cancer-information/cancer-type/colorectal/treatment/follow-up/?region=on>

University of Ottawa Psychosocial Oncology Laboratory: Fear of Cancer Recurrence

- <https://socialsciences.uottawa.ca/psychosocial-oncology-laboratory/resources>

CancerCare Manitoba

- Moving Forward after Colorectal Cancer
- <https://www.cancercare.mb.ca/For-Health-Professionals/follow-up-care-resources/index.html>

Discussion (related) tools

Canadian Oncology Symptom Triage and Remote Support (COSTaRS)

- <https://ktcanada.ohri.ca/costars/> (intended for nurses)

Canadian Association of Psychosocial Oncology

- [The Emotional Facts of Life with Cancer: A Guide to Counselling and Support for Patients, Families and Friends](#)

Ontario Health (CCO)

- Follow-up Model of Care for Cancer Survivors
- <https://www.cancercareontario.ca/en/guidelines-advice/types-of-cancer/58736>

CancerCare Manitoba

- Follow-up Care Plan
- <https://www.cancercare.mb.ca/For-Health-Professionals/follow-up-care-resources/index.html>

2. Signs and Symptoms of Colorectal Cancer Recurrence

Signs and symptoms of colorectal cancer are subtle and complex. Patients with local or distant recurrence may be symptomatic or asymptomatic. Symptoms of recurrence depend on the site of recurrence and may vary between patients.

Local recurrence refers to the cancer coming back in the same area of the colon or rectum where the original cancer was found and where the surgery took place. Distant recurrence refers to the cancer spreading to other areas and is most often in the liver and/or lungs. Both local and distant recurrence are most likely to occur in the first two years following treatment.

The list below represents some of the signs and symptoms of recurrence that were put together by a group of cancer specialists. If you are experiencing any of these symptoms, especially if they are new, it is important to discuss this with your healthcare provider.

Sign or Symptom	Type of Recurrence	
	Local	Distant
Abdominal pain	X	X
Dry cough		X
Rectal bleeding	X	
Changes in bowel habit	X	
Fatigue	X	X
Nausea	X	X
Unexplained weight loss	X	X
Anemia	X	X
Pain	X	
Stoma bleeding	X	
Palpable mass	X	X
Abdominal pain from hepatomegaly		X
Jaundice		X
Pleuritic chest pain or shortness of breath		X
Anorexia, cachexia, and weight loss		X
Dyspnea		X
Loss of appetite		X
Signs and/or symptoms specific to rectal cancer*		
Pelvic pain	X	
Sciatica	X	
Difficulty with urination or defecation	X	

*There are no signs or symptoms specific to colon cancer that would not also apply to rectal cancer.

3. Common and/or Substantial Long-term and Late Effects

There are many health needs and concerns and physical and psychosocial long-term and late effects of colorectal cancer that both the physician and patient need to be aware of to mitigate discomfort, effectively manage symptoms, and improve quality of life. The highest priority supportive care needs for colorectal cancer survivors are for information and education and physician communication, particularly around the risk of recurrence. Psychosocial support about the risk of recurrence and provision of empathetic, effective, and coordinated communication should be emphasized more than post-treatment physical effects and symptom control.

Physical Long-term and Late Effects	
• Issues with bowel function - o Frequent and/or urgent bowel movements - o Loose bowels - o Incontinence - o Gas and/or bloating • Postoperative issues - o Possible but low risk of incisional hernia - o Possible but low risk of bowel obstruction • Peripheral neuropathy (associated with treatment using oxaliplatin) • Chemotherapy-related cognitive side effects • Issues with fertility • Sexuality function (e.g., vaginal dryness and pain with intercourse, erectile dysfunction, retrograde ejaculation) • Stoma care and life-style adjustments for patient who have received ostomy • Possible changes in urinary function • Chronic pain • Fatigue • Nutritional and diet considerations	
Psychosocial Long-term and Late Effects	
• Psychological distress • Depression • Anxiety • Worry • Fear of recurrence • Changes in sexual function/fertility	• Body and/or self-image • Relationships • Other social role difficulties • Return to work concerns • Financial challenges • Support for family