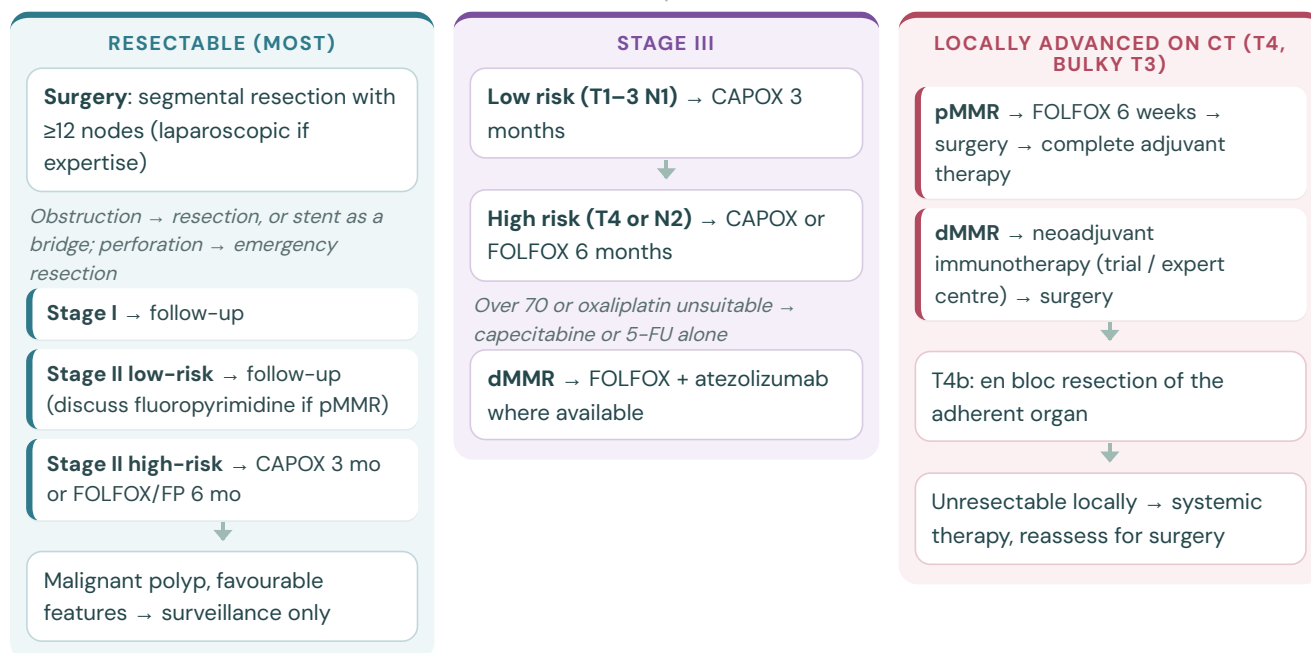


Colorectal Cancer: Non-metastatic colon cancer algorithm

Dr. Haritha Chiramana

MD, DM · Senior Medical Oncologist & Hemato-Oncologist

Colon cancer on biopsy: complete colonoscopy · CT chest-abdomen-pelvis · CEA · MMR immunohistochemistry · fitness and nutrition · tumour board



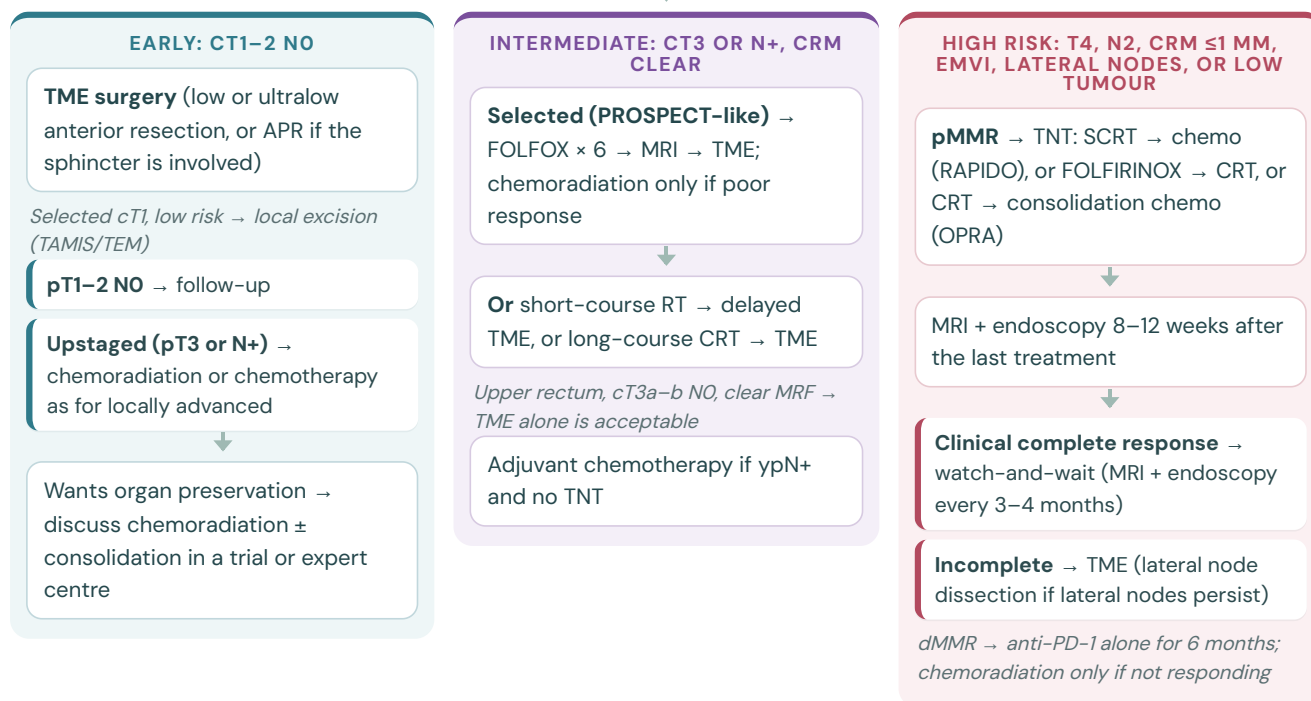
All patients: Lynch work-up if dMMR without BRAF V600E or MLH1 methylation (Lynch: consider total colectomy with ileorectal anastomosis) · start adjuvant therapy within about 8 weeks · DPYD testing where available · PI3K-pathway alteration on NGS → low-dose aspirin for 3 years · replace vitamin D if below 20 ng/mL · colonoscopy at 1 year · exercise and weight advice from the first visit.

Colorectal Cancer: Non-metastatic rectal cancer algorithm

Dr. Haritha Chiramana

MD, DM · Senior Medical Oncologist & Hemato-Oncologist

Rectal cancer on biopsy: MRI pelvis (T, CRM, EMVI, nodes, height) · CT chest-abdomen-pelvis · colonoscopy · CEA · **MMR status before any treatment** · fertility counselling · tumour board



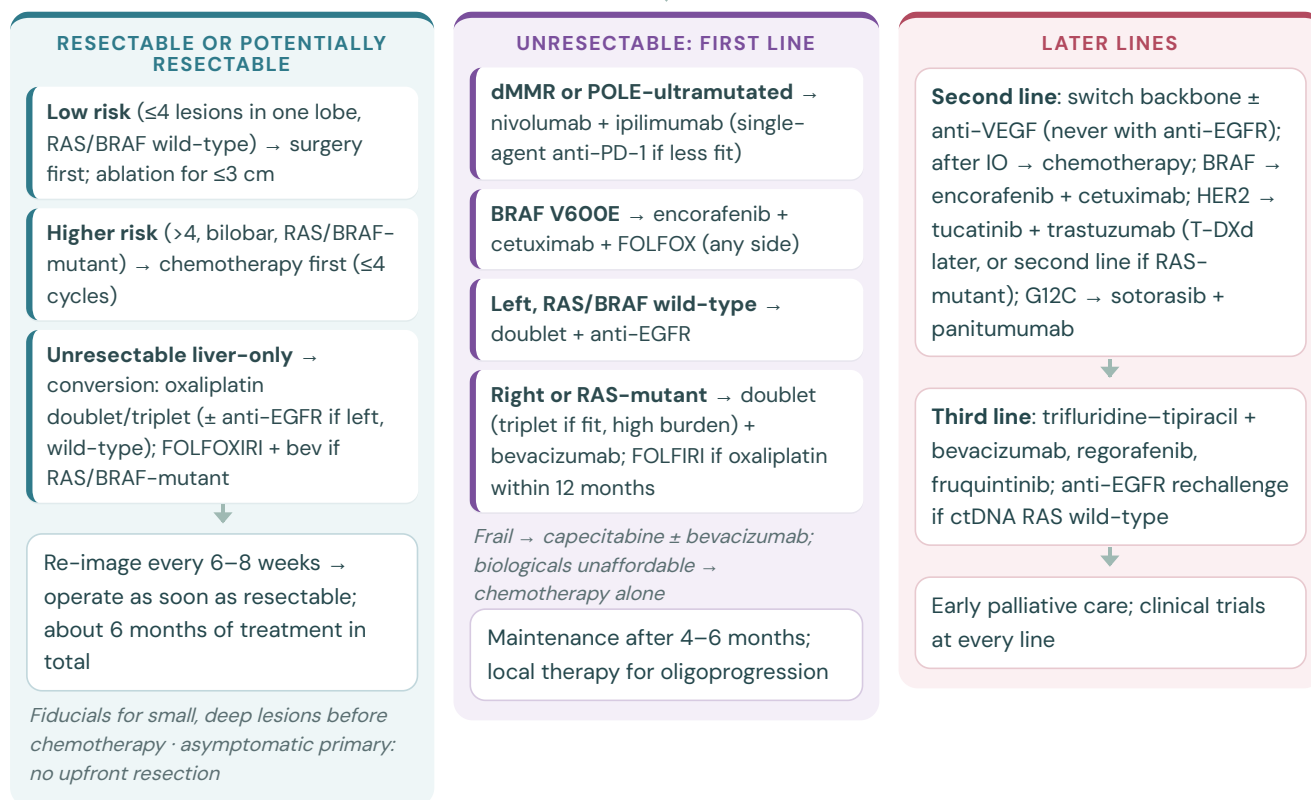
All patients: confirm MMR status before chemoradiation · TME by an experienced rectal surgeon · temporary ileostomy after low anastomosis, reverse at about 3 months · counsel about LARS, sexual and urinary function · regrowth after watch-and-wait is usually salvageable if found early.

Colorectal Cancer: Metastatic colorectal cancer algorithm

Dr. Haritha Chiramana

MD, DM · Senior Medical Oncologist & Hemato-Oncologist

New stage IV: CT ± MRI liver (PET only before metastasectomy) · **MMR, RAS, BRAF, HER2** (NGS) · DPYD · sidedness · fitness and goals · hepatobiliary/thoracic surgeon at the first MDT

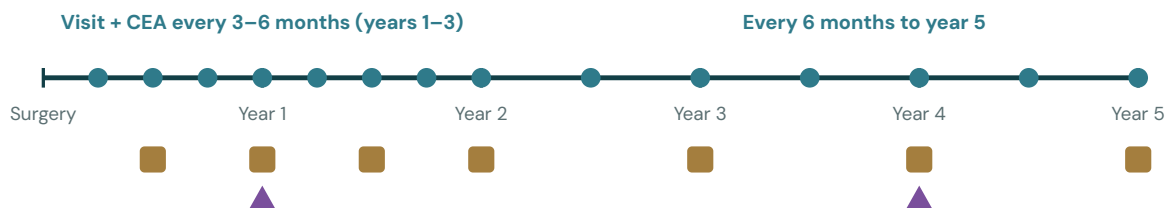


All patients: discuss goals early · obstruction → stent or diversion (avoid stents with bevacizumab) · peritoneal disease → expert-centre opinion on cytoreduction · selected unresectable liver-only disease → transplant evaluation in specialised programmes.

Colorectal Cancer: Follow-up and survivorship plan

Dr. Haritha Chiramana

MD, DM · Senior Medical Oncologist & Hemato-Oncologist



● Clinic visit + CEA: symptoms, weight, bowel and bladder function, neuropathy, stoma and LARS, mood

■ CT chest and abdomen (± pelvis) every 6–12 months to 5 years, or at least yearly for 3 years (stage II–III)

▲ Colonoscopy at 1 year; again at 1 year if advanced adenoma, otherwise every 3–5 years

Rectum: watch-and-wait/local excision → MRI + endoscopy 3–4-monthly (2 years); LAR without RT → endoscopy + EUS/MRI 6-monthly
Not routine when well: PET-CT, other tumour markers. A rising CEA needs CT (± PET) and an MDT review for a curable relapse.

A simple follow-up rhythm (NCCN, ESMO, ASCO). More intensive testing than this did not improve survival in the FACS and COLOFOL trials, but surveillance still finds resectable relapses.

Reduce recurrence

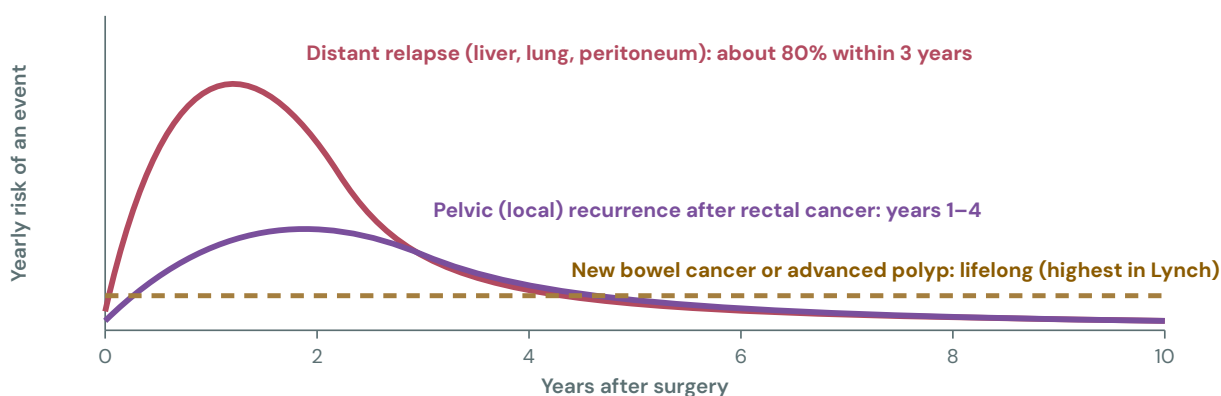
- Complete planned adjuvant or neoadjuvant therapy
- Structured exercise ~150 min/week (CHALLENGE trial)
- Healthy weight; no tobacco; little or no alcohol
- Less red and processed meat; more fibre
- Low-dose aspirin for 3 years if PI3K-altered (ALASCCA); aspirin in Lynch carriers

Red flags to report

- Rectal bleeding, new change in bowel habit
- Abdominal pain, distension, vomiting (obstruction)
- Jaundice, right upper abdominal pain
- Cough or breathlessness; bone pain
- Pelvic or perineal pain after rectal cancer

Do not forget

- Colonoscopy at 1 year, then every 3–5 years
- Colonoscopy from 40 for first-degree relatives
- Cascade testing in Lynch families
- Check neuropathy, stoma, bowel, bladder and sexual function
- Vitamin D check; fertility and menopause care after pelvic RT



When relapses happen (illustrative shape, not to scale). Intensive CEA and CT surveillance is concentrated in the first 3 years because that is when a resectable relapse can still be found; colonoscopy continues for new polyps and cancers.