

## Appendix 1

## MCN Colorectal Cancer Follow-up Guidelines

Follow -up Pathway	Patient Group	Risk Stratification	Follow-up Year 1			Follow-up Year 2		Follow-up Year 3	Follow-up Year 4	Follow up Year 5
			6w	6m	1yr	18 m	2 yr			
<b>Patient Directed</b>	<b>Significant comorbidities</b>	Not fit for adjuvant therapy or further surgery in the event of recurrence	Clinic review	Patient discharged from follow up <sup>(3)</sup>						
<b>Post-Surgical Active Follow up</b>	<b>Stage 1</b> <b>Stage 2</b>	<b>Low risk</b> (no nodal involvement & no EMVI)	Surgical Clinic review	Surgical Clinic review <sup>(4)</sup> CEA	Surgical Clinic review <sup>(4)</sup> CEA CT CAP Colonoscopy <sup>(7)</sup>	Surgical Clinic review <sup>(4)</sup> CEA	Surgical Clinic review <sup>(4)</sup> CEA CT CAP	Surgical Clinic review <sup>(4)</sup> CEA, CT CAP <b>End of Follow up</b>	<b>Colonoscopy<sup>(7)</sup></b> Patients encouraged to continue participating in Bowel screening.	
<b>Intensive Post Adjuvant Treatment <sup>(5)</sup></b>	<b>Stage 2</b> <b>Stage 3</b>	<b>High Risk</b>	Surgical Clinic review	Clinic review <sup>(4)</sup> CEA	Clinic review <sup>(4)</sup> CEA CT CAP Colonoscopy <sup>(7)</sup>	Surgical Clinic review <sup>(4)</sup> CEA	Surgical Clinic review <sup>(4)</sup> CEA CT CAP	Surgical Clinic review <sup>(4)</sup> CEA, CT CAP <b>End of Follow up</b>	<b>Colonoscopy<sup>(7)</sup></b> Patients encouraged to continue participating in Bowel screening.	
<b>Radically treated Metastatic Disease (Surgeon and Oncologist discretion) <sup>(6)</sup></b>	<b>Stage 4</b>		Surgical Clinic review	Clinic review <sup>(4)</sup> CEA CT CAP	Clinic review <sup>(4)</sup> CEA CT CAP Colonoscopy <sup>(7)</sup>	Clinic review <sup>(4)</sup> CEA CT CAP	Clinic review <sup>(4)</sup> CEA CT CAP	Clinic review <sup>(4)</sup> CEA, CT CAP CEA, CT CAP Colonoscopy <sup>(7)</sup>	Clinic review <sup>(4)</sup> CEA,CT CAP	

Notes: 1) Patients who have been identified as requiring regular colonoscopic surveillance e.g. for Lynch Syndrome, should continue to receive this.

2) All patients should have their CEA checked at time of diagnosis.

3) Patients & GP should have access to easy referral back to the service via the colorectal CNS in the event of any colorectal concerns.

4) Although Specialist nurse led follow up is the preferred option, the WOS MCN acknowledges that this might not be possible in every Health Board.

Therefore, Clinic Follow up could be Specialist nurse or doctor delivered, and either face to face (F2F) or telephone consultation.

5) High Risk patients will be discharged from Oncology follow up upon completion of their adjuvant treatment and will be followed up in the surgical clinic thereafter.

6) 5 year Follow up is only considered for stage 4 patients with radically treated metastatic disease.

7) Year 1 and year 4 follow up colonoscopy are the gold standard, The MCN recognises that if there is no local capacity then the fall-back position is a year 3 colonoscopy.

**In the case of an incomplete preoperative Colonoscopy, a completion post op Colonoscopy should be done within the first 6 months.**

**Patients with Polyps should be followed up as per the agreed polyp follow up guidelines.**

**Patient that are complete pathological responders following neoadjuvant CRT will follow the active surveillance (Watch & Wait) pathway.**

**More frequent imaging may be required following MDT discussion.**

**Given that there is no firm evidence base to support any single follow up strategy, these guidelines should not supersede clinical judgement in the management of individual patients.**