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Is a "watch and wait" policy after complete response to radio chemotherapy for rectal cancer safe?

For a number of years it has been recognised that a proportion of patients with rectal cancer treated by neoadjuvant chemoradiotherapy will experience a sustained complete response and as a result a deliberate policy of watch and wait after such a response has gradually gained popularity, championed particularly by Habr-Gama and her colleagues in Brazil. However, there still remains a degree of concern around the safety of this approach and there are no randomised trials comparing watch and wait with radical surgery after complete response. It is therefore, interesting to see a matched cohort analysis from Renehan and his colleagues published in Lancet Oncology on December 16 last year, which addresses these concerns. 129 patients were managed by watch and wait in Manchester and neighbouring regional cancer centres between March 2005 and January 2015 and, of these, 109 were compared with patients undergoing surgery after neoadjuvant radiochemotherapy using a technique called propensity score matching (including T-stage, age and performance status) where each patient managed by watch and wait was compared with a similar patient undergoing surgery. Of the 129 patients managed by watch and wait, 44 (34%) had local recurrence and 36 (88%) of 41 patients with non-metastatic local recurrence underwent successful salvage surgery. In the matched groups, there were no differences in 3 year non-regrowth disease free survival or 3 year overall survival. On the other hand, those managed by watch and wait had a significantly better 3 year colostomy free survival than those who had undergone surgical resection. This study is useful in that it goes some way to providing a much needed evidence base to inform decision making for both surgeons and patients

after a complete response. There are some caveats however. Firstly, the median follow up period of 33 months is relatively short and it is conceivable that the final local recurrence rate will be greater than that which has been reported. Secondly, it must be appreciated that this is not a comparison between watch and wait and surgery in patients who have had a complete response, and it could be argued that although patients do well after a complete clinical response and no surgery, the overall outcome may be even better with additional surgery. The only way to answer this question with certainty would be by conducting a randomised controlled trial, but obtaining informed consent and sufficient numbers for such a trial would be exceptionally challenging.

This study may affect practice in terms of the approach to the patient who has completely responded to neoadjuvant therapy. However, it also begs the question as to whether we should be seriously considering non-surgical treatment as standard first line therapy for rectal cancer, much as we do for anal cancer. Although this sounds like a potentially attractive option, only 12% of the Manchester patients in this study experienced a complete response. However, the majority of these patients had T3 tumours and there were no T1 tumours. It is becoming increasingly clear that early rectal cancers respond to radiotherapy more frequently than more advanced cancers and with increasing numbers of rectal cancers being diagnosed early this is perhaps an option that should be taken seriously. We shall, of course, have information from the StarTrec trial that will help us with this issue, but perhaps it is now time to seriously consider investigating different radiotherapy regimes and different radio-sensitizers in an attempt to provide our patients with optimal treatment, avoiding surgical intervention wherever possible.

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