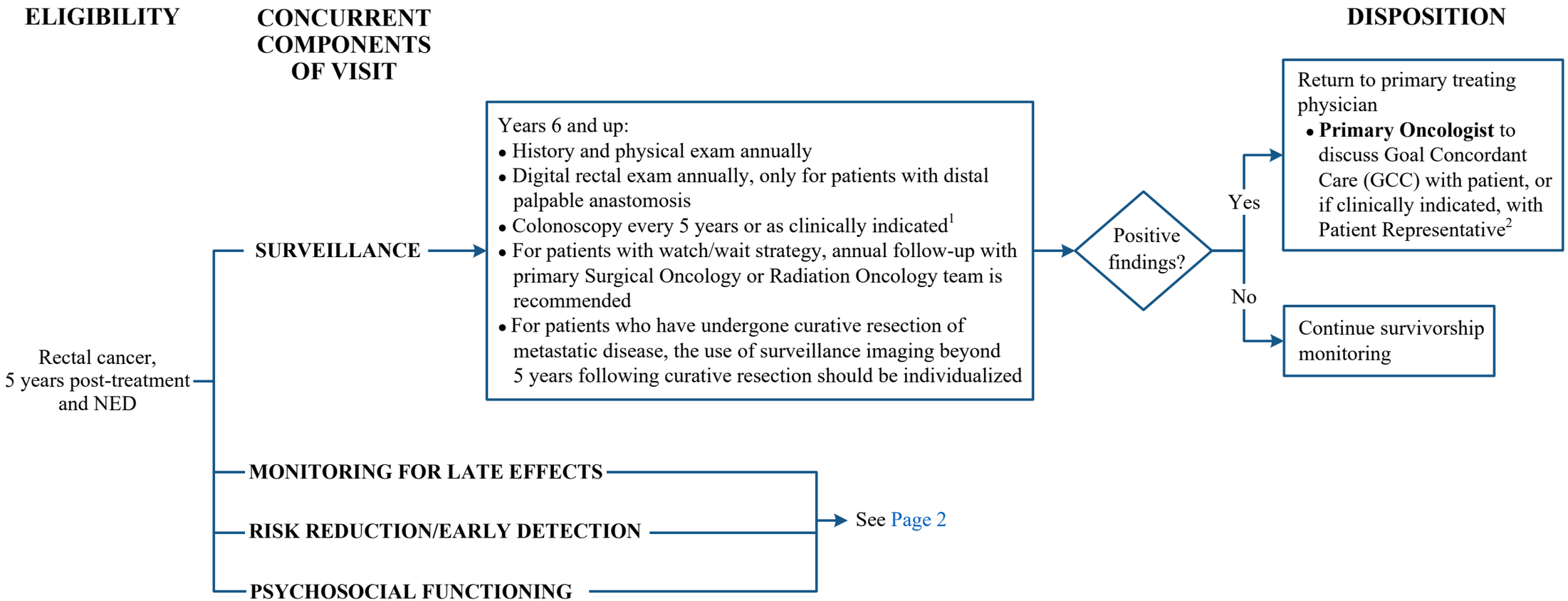
Survivorship – Rectal Cancer



NED = no evidence of disease

Note: Clinical risk is based on preoperative staging (clinical stage) vs. pathologic staging, which is based on the post-operative tumor specimen (for patients that were unable to receive neoadjuvant therapy)

[1] The recommended screening intervals for individuals with adenomatous polyps on most recent colonoscopy, genetic predisposition to colon cancer, or a history of inflammatory bowel disease can be found in the Colorectal Cancer Screening algorithm

[2] GCC should be initiated by the **Primary Oncologist**. If Primary Oncologist is unavailable, Primary Team/Attending Physician to initiate GCC discussion and notify Primary Oncologist. Patients, or if clinically indicated, the Patient Representative should be informed of therapeutic and/or palliative options. GCC discussion should be consistent, timely, and re-evaluated as clinically indicated. The Advance Care Planning (ACP) note should be used to document GCC discussion. Refer to GCC home page (for internal use only).

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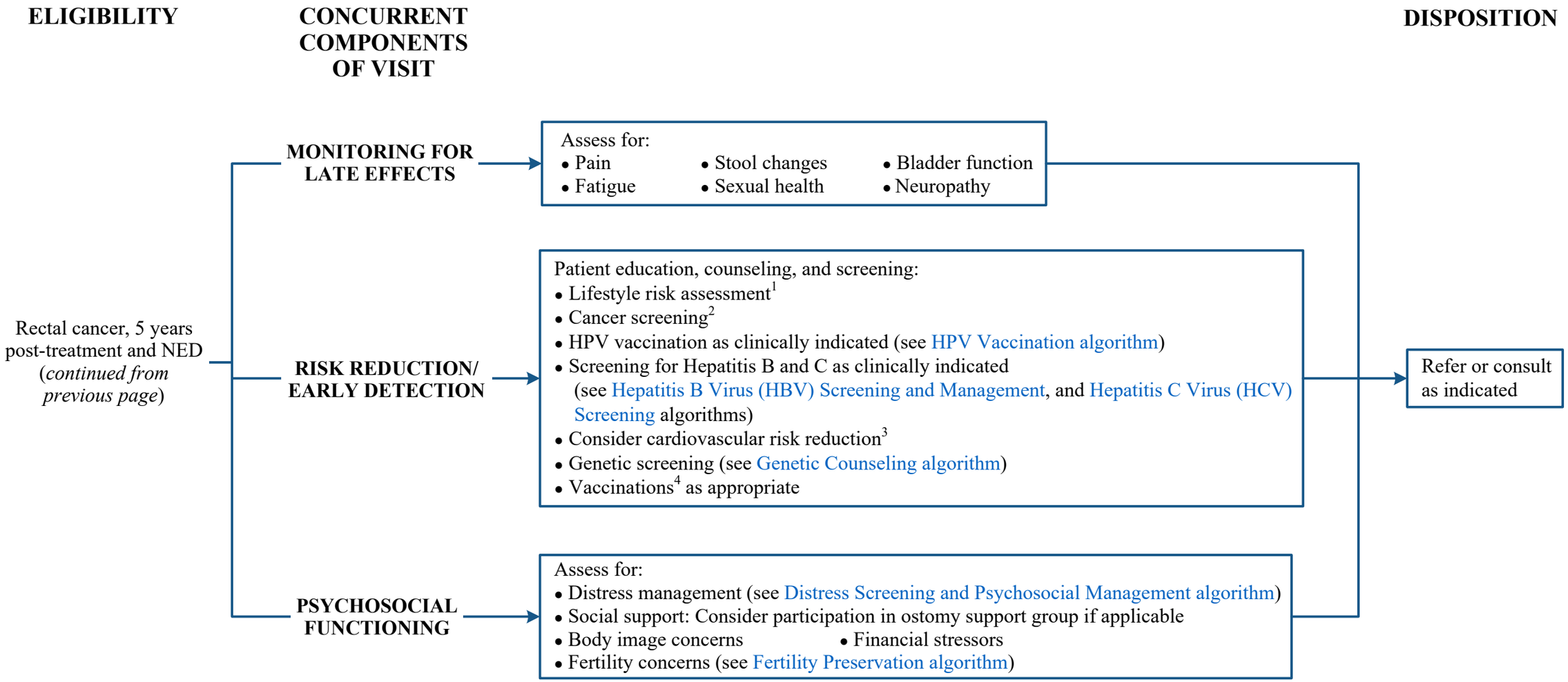

[1] See Physical Activity, Nutrition, and Tobacco Cessation Treatment algorithms; ongoing reassessment of lifestyle risks and counseling about maintaining a healthy body weight, avoiding obesity, and alcohol use assessment and counseling should be a part of routine clinical practice

[2] Includes breast, cervical (if appropriate), liver, lung, pancreatic, prostate, and skin cancer screening

[3] Consider use of Vanderbilt's ABCDE's approach to cardiovascular health

[4] Based on Centers for Disease Control and Prevention (CDC) guidelines

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