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Preoperative radiotherapy for locally advanced rectal cancer during and after the COVID-19 pandemic

Editor

COVID-19 represents a global emergency that has had a profound impact on all areas of healthcare provision. Considerable research efforts during this pandemic have been channelled towards the rapid development of modified clinical pathways for patients with complex acute and chronic disease[1]. For patients with a new diagnosis of cancer the implications are considerable. In the case of colorectal cancer (CRC), it is estimated that the outbreak will result in delayed diagnosis in approximately 83 000 patients[2]. Although we have to accept some delays due to limits on resources and the risk of collateral COVID-19 infection during treatment, there are points in the pathway at which we can modify current practice to mitigate these delays. In the multimodal treatment of rectal cancer, modifying radiotherapy schedules represents one such area that is gaining traction.

Current neoadjuvant treatment for locally advanced rectal cancer (LARC) in Europe is typically either long-course chemoradiotherapy (LCCR) (using 45–50·4 Gy in 25–28 fractions with concurrent fluoropyrimidine chemotherapy), followed by total mesorectal excision (TME) after 6–10 weeks, or short course radiotherapy (SCRT) with 5 × 5 Gy and immediate surgery. These differing strategies have been used in parallel in Northern Europe, and current ESMO (European Society for Medical Oncology) and NCCN (National Comprehensive Cancer Network) guidelines accept either schedule to minimize the risk of local recurrence[3]. The relative merits of each have been keenly debated for over 20 years although agreement has yet to be reached. Although LCCR has been preferred for tumour downstaging, recent data indicate that SCRT with a delay of several weeks is associated with similarly acceptable tumour regression[4].

At the Royal Free Hospital (London), we have conventionally favoured LCCR followed by radical surgery after a delay of 8–10 weeks in patients with LARC. During the COVID-19 outbreak, our CRC multidisciplinary team has shifted toward preoperative SCRT and a delay of 6–8 weeks, followed by surgery. This move was intended to minimize hospital footfall as well as avoid the need for concomitant chemotherapy with its associated risk of immunosuppression. Furthermore, by reducing the number of hospital visits, SCRT allows patients to adhere more reliably to social distancing recommendations. In terms of time gained in the treatment pathway, the 5 × 5 Gy strategy in SCRT reduces active treatment time to just 5 days compared with 5–6 weeks with LCCR, effectively allowing patient and clinician to recover over 30 days of treatment time. It is also likely that the chances of significant treatment interruption if the patient were to test positive for COVID-19 would be reduced with SCRT, compared with LCCR.

The question that naturally arises from this is what strategy to pursue moving forward, once the current COVID-19 crisis has ended. The authors are of the opinion that the improved convenience and flexibility of SCRT, coupled with its potential oncological equivalence, better patient compliance, reduced early toxicity[5] and improved cost-effectiveness, make it the schedule of choice for the majority of patients with LARC now, and beyond COVID-19.

R. Mirnezami[1], J. Knowles[1], A. Kar[2] and R. Glynne-Jones[3]
Departments of [1]Colorectal Surgery and [2]Radiation Oncology, Royal Free Hospital, London, and [3]Radiotherapy Department, Mount Vernon Centre for Cancer Treatment, Mount Vernon Hospital, Northwood, UK

reza.mirnezami@nhs.net
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