

## Preoperative Rectal Cancer Management: Wide International Practice Makes Outcome Comparison Challenging: Reply

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In a letter to the editor Dr. Hottenrott provides valuable comments [1] on our survey describing international preoperative rectal cancer management [2]. In our opinion, three key messages are derived from our survey: First, most surgeons agree to neoadjuvant treatment when there is an increased risk of finding histologically positive circumferential margins. In addition, we found more than 40 other indications for neoadjuvant treatment (see our Table 4). This emphasizes the need for an international agreement, as different indications for neoadjuvant treatment will select noncomparable groups of patients in outcome studies.

Second, we have shown (see our Table 6) that multidisciplinary team (MDT) meetings significantly influence several important decisions in preoperative rectal cancer management. Interestingly, centers with regular MDT have a higher rate of using magnetic resonance imaging (MRI) (Odds Ratio [OR] = 3.62) and consider a threatened circumferential resection margin (CRM) as indication for

neoadjuvant treatment (OR = 5.67). We believe that MDT improves preoperative management of rectal cancer by increasing adherence to national guidelines. Similar discussions in international rectal cancer societies are needed aiming towards an international consensus statement.

Finally, our survey revealed sparse use (35% of all cases) of MRI. The goal for the radiologic examination in rectal cancer is to explore the tumor's relation to nearby anatomical structures. This evaluation will conclude with TNM staging, important for chemoradiotherapy, surgical treatment, and prognosis. Magnetic resonance imaging has a central role in this evaluation and should be the first choice radiologic modality [3]. Not only is MRI crucial in detection of TNM stage but also plays a central role in determination of the tumor's distance to the mesorectal fascia and the CRM. Magnetic resonance imaging has moderate sensitivity on T1 and T2 tumors, and should be supplemented with rectal ultrasound.

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In our survey,  $^{18}\text{F}$ -fluorodeoxyglucose positron emission tomography (PET) was used by 55% in selected cases and by 1% in all cases. In our opinion PET has no central role in primary management of rectal cancer [4]; however, we believe PET will gain increased importance in management of rectal cancer in the future.

Biologically targeted agents for adjuvant and neoadjuvant treatment are promising treatment options; however, patient selection and prediction of treatment effects remain problematic [5].

The wide variations in practice for preoperative management of rectal cancer should alert national and international rectal cancer experts as well as health care administrators. This will influence health care costs, side effects, quality of life, local recurrence, and cancer-specific survival.

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