Best Practices Checklist for Rectal Cancer

The following checklist is intended to be complementary to the WHO checklist for patient safety in the immediate pre-operative, peri-operative, and post-operative periods. This checklist can be used to (1) raise awareness of rectal cancer guidelines; (2) enhance pre-operative, intra-operative, and post-operative documentation; and (3) facilitate integration of best practices into pre-operative cancer conferences. **Similarities** to the WHO checklist include evidence-based actions consistent with best outcomes, ease of use, checklist rather than algorithm format (what to do—not how to do it). **Differences** include an emphasis specifically on elective rectal cancer surgery and cancer outcomes rather than 30-day safety outcomes.

PREOPERATIVE EVALUATION CHECKLIST

Yes No

- □ □ **Formal pathology review was performed to identify the presence of invasive carcinoma.**
- □ □ In the unobstructed patient, a complete colonic evaluation was performed.
- □ □ The tumor location within the rectum (e.g. distance from anal verge, tumor length, anterior/posterior/left/right) as well as relationship to the levators and anorectal ring was documented.
- □ □ An assessment of family history, preoperative stool continence and sexual function was documented.
- □ □ Clinical staging of the primary tumor (ERUS or MRI) was performed.
- □ □ Clinical staging for distant metastases (Chest/Abdomen/Pelvis) was performed.
- □ □ Preoperative or peri-operative CEA level was measured.
- □ □ Consideration of neoadjuvant treatment for > T2 or node positive disease has been documented. Among those who received neoadjuvant treatment, the tumor was re-staged and location was re-confirmed just prior to operation.
- □ □ A multi-disciplinary discussion of care, preferably during a formal Tumor Board conference, was documented.
- □ □ If a stoma is considered, the site was preoperatively marked.

INTRA-OPERATIVE CHECKLIST

Yes No

- □ □ A thorough exploration and assessment for extra-pelvic disease was performed and is noted.
- □ □ A sharp **total or tumor-specific mesorectal dissection** with *en bloc* radical lymphadenectomy was performed.
- □ □ The distal resection margin and its relationship to the tumor was considered prior to rectal transection and should include a distance > 1cm grossly.
- □ □ Involved adjacent organs were resected *en bloc*.
- □ □ The integrity of the pelvic nerves was assessed.
- □ □ The completeness of resection (including whether the operation was considered curative) was assessed and noted.
- □ □ The rationale for reconstruction of intestinal continuity (sphincter preservation) versus permanent stoma was documented.

In cases of reconstruction,

Yes No

- ☐ ☐ The type of reconstruction was noted including handsewn versus stapled anastomosis.
- ☐ ☐ The rationale for a pouch or end-to-side anastomosis vs. straight anastomosis was documented.
- ☐ ☐ The location of final anastomosis was noted.
- ☐ ☐ The anastomotic integrity was evaluated (e.g. leak test).
- ☐ ☐ A diverting loop ileostomy was considered for cases including pre-operative radiation or intra-operative TME.

POST-OPERATIVE CHECKLIST

Yes No

- ☐ ☐ For patients in whom a stoma was necessary as a part of their surgical treatment, the postoperative care included stoma care teaching.
- ☐ ☐ For patients with Stage II or Stage III cancer, a post-operative consultation with a medical oncologist was recommended.
- ☐ ☐ Radial and distal margins were documented on the pathology report.