**TABLE OF CONTENTS**

|  |  |  |
| --- | --- | --- |
| **Chapter** | **Title** | **Authors** |
|  | Table of Contents |  |
|  | Introduction, Objective and Target Users |  |
|  | Authors |  |
|  | Instructions for Use  Proposed Training Schedule  Test Questionnaire |  |
| Topic 1 | Primary Care, Referral & Prevention | Dr. Siti Aminah |
| Topic 2 | Screening | Dr. Rosaida |
| Topic 3 | Surveillance | Prof. Dr. Najib |
| Topic 4 | Diagnostic (Radiological) | Dr. Noraini |
| Topic 5 | Diagnostic (Pathological) | Dr. Salmi |
| Topic 6 | Surgical Management | Dr. Ahmad Shanwani |
| Topic 7 | Chemoradiotherapy | Dr. Ibtisam |
| Topic 8 | Post-treatment Follow-up & Surveillance | Dr. Salahuddin |
|  | Case Scenario 1 | All CPG DG members |
|  | Case Scenario 2 |
|  | Case Scenario 3 |
|  | Case Scenario 4 |

\*The content of this Training Module is subject to changes when it is deemed necessary to do so base on the feedback from the target users.

**INTRODUCTION**

The Clinical Practice Guidelines (CPG) on Management of Colorectal Carcinoma is published in 2017. A Quick Reference (QR) and a Training Module (TM) are developed to increase the utilisation of the CPG. This TM has been developed by the members of Development Group (DG) of the CPG. The content of the TM are extracted from the main CPG. It may be reproduced and used for educational purposes, but must not be used for commercial purposes or product marketing.

**OBJECTIVES**

* To actively disseminate and train healthcare providers to practice on recommendations in the CPG. It may also be used for educational purpose in the management of colorectal carcinoma in any healthcare settings in Malaysia.
* To assist the ‘trainers’ in delivering all components related to the implementation of the CPG systematically and effectively.

**TARGET USERS**

All healthcare providers involved in the management colorectal carcinoma in primary, secondary and tertiary health care settings

|  |
| --- |
| This document contains a Training Module booklet and a CD-ROM on:   * Introduction, objectives, target users, authors and instructions for use * Proposed training programme/schedule * Test questionnaire * 8 lectures (in **PPT**) * 4 case discussions (in **PPT**) |

**AUTHORS**

|  |  |
| --- | --- |
| Dr. Nil Amri Mohamed Kamil  Consultant Colorectal Surgeon  Hospital Sultanah Bahiyah, Kedah | Dr. Hjh. Rosaida Hj. Md. Said  Consultant Gastroenterologist  Hospital Ampang, Selangor |
| Assoc. Professor Dr. Ahmad Najib Azmi  Lecturer & Gastroenterologist  Faculty of Medicine & Health Sciences  Universiti Sains Islam Malaysia  Negeri Sembilan | Dr. Noraini Abdul Rahim  Consultant Radiologist  Institut Kanser Negara, Putrajaya |
| Dr. Ahmad Shanwani Mohamed Sidek  Consultant Colorectal Surgeon  Hospital Raja Perempuan Zainab II, Kelantan | Ms. Nik Nuradlina Nik Adnan  Pharmacist  Institut Kanser Negara, Putrajaya |
| Dr. Ch’ng Gaik Siew  Consultant Clinical Geneticist & Paediatrician  Hospital Kuala Lumpur, Kuala Lumpur | Dr. Salahudin Baharom  Consultant Colorectal Surgeon  Hospital Selayang, Selangor |
| Dr. Fauziah Jaya  Consultant Gastroenterologist  Hospital Raja Permaisuri Bainun, Perak | Dr. Salmi Abdullah  Pathologist (Anatomic Pathology)  Hospital Selayang, Selangor |
| Dr. Hafizah Zaharah Ahmad  Clinical Oncologist  Institut Kanser Negara, Putrajaya | Dr. Siti Aminah Akbar Merican  Consultant Family Medicine  Klinik Kesihatan Batu Rakit, Terengganu |
| Dr. Hanin Farhana Kamaruzaman  Senior Principal Assistant Director  Health Technology Assessment Section  Ministry of Health Malaysia, Putrajaya | Dr. Tee Hoi Poh  Consultant Gastroenterologist  KPJ Pahang Specialist Hospital, Pahang |
| Dr. Ibtisam Muhamad Nor  Clinical Oncologist  Hospital Kuala Lumpur, Kuala Lumpur | Dr. Tengku Norita Tengku Yazid  Consultant Pathologist (Chemical Pathology)  Hospital Selayang, Selangor |
| Dr. Mohd. Aminuddin Mohd. Yusof  Head of CPG Unit  Health Technology Assessment Section  Ministry of Health Malaysia, Putrajaya | Dr. Zalwani Zainuddin  Consultant Gastroenterologist  Hospital Sultanah Bahiyah, Kedah |

***First published November 2017***

CPG Secretariat, Health Technology Assessment Section

Medical Development Division, Ministry of Health, Malaysia

4th Floor, Block E1 Parcel E, 62590 Putrajaya

E-mail: [**htamalaysia@moh.gov.my**](mailto:htamalaysia@moh.gov.my)

**INSTRUCTIONS FOR USE**

This Training Module consists of:

1. Lecture - eight sections
2. Case scenario - four sections
3. Training programme/schedule
4. Test questionnaire

(A booklet and a CD on this Training Module are enclosed together)

The training may be conducted in one day and consists of two parts. In part 1, didactic lectures are delivered to the whole group of training participants to inculcate the understanding on the management of colorectal carcinoma. In Part 2, participants are grouped into smaller groups to deliberate on cases of colorectal carcinoma with assigned facilitators. In both parts, there should be active participation from the training participants for effective learning.

The test questionnaire must be given to the training participants before the training session starts (pre-test) and after it ends (post-test). The pre-test is to assess the level of knowledge and understanding of training participants in the management of in colorectal carcinoma. The post-test is to ascertain the increase in the training participants’ knowledge after attending the training session.

Should the trainers have any queries, kindly forward to htamalaysia@moh.gov.my

.

**Training of Core Trainers on**

**CPG Management of Colorectal Carcinoma**

|  |  |  |
| --- | --- | --- |
| **Time** | **Lecture/case discussion** | **Lecturer/facilitator** |
| **First Day (27/09/18)** | | |
| 8.30 - 9.00 am | Registration  Pre-test | MaHTAS |
| 9.00 - 9.20 am | Introduction, Implementing the Guidelines & Ice-breaking | Dr. Nil Amri/ Dr. Mohd. Aminuddin |
| 9.20 - 9.35 am | Primary Care, Referral & Prevention | Dr. Siti Aminah |
| 9.35 - 9.55 am | Screening | Dr. Rosaida |
| 9.55 - 10.10 am | Surveillance | Prof. Najib |
| 10.10 - 10.30 am | **Morning Tea** |  |
| 10.30 - 11.15 am | Case Discussion 1 | Facilitators/Dr. Zalwani |
| 11.15 - 11.30 am | Diagnostic (Radiological) | Dr. Noraini |
| 11.30 - 11.45 am | Diagnostic (Pathological) | Dr. Salmi |
| 11.45 - 12.30 pm | Case Discussion 2 | Facilitators/  Dr. Tengku Norita |
| 12.30 - 2.00 pm | **LUNCH** |  |
| 2.00 - 2.40 pm | Surgical Management | Dr. Ahmad Shanwani |
| 2.40 - 3.30 pm | Case Discussion 3 | Facilitators/  Dr. Salahuddin |
| 3.30 - 4.00pm | **Q & A** |  |
| **Second Day (28/09/18)** | | |
| 9.00 - 9.40 am | Chemoradiotherapy | Dr. Ibtisam |
| 9.40 - 10.30 am | Case Discussion 4 | Facilitators/Dr. Hafizah |
| 10.30 - 11.00 am | **Morning Tea** |  |
| 11.00 - 11.30 am | Post-treatment Follow-up & Surveillance | Dr. Salahuddin |
| 11.30 - 12.00 pm | Post-test & Closing | Dr. Nil Amri/Dr. Mohd. Aminuddin |

**TEST QUESTIONNAIRE**

**Answer all questions by circling the right answers.**

| **No.** | **Question** | **Answer** | |
| --- | --- | --- | --- |
| **True** | **False** |
| **1.** | **Colorectal carcinoma:** | | |
| 1. Most commonly occurs in the caecum. | T | F |
| 1. Acute obstruction is the common presentation of right sided tumour. | T | F |
| 1. Patients undergoing surgery should have venous thromboembolism prophylaxis. | T | F |
| 1. Mechanical bowel preparation may be performed in colon carcinoma surgery. | T | F |
| 1. The mainstay of treatment is surgical resection. | T | F |
| **2.** | **High risk features for colorectal carcinoma:** | | |
| 1. Male | T | F |
| 1. Obstruction | T | F |
| 1. Perforation | T | F |
| 1. T4 disease | T | F |
| 1. Poorly differentiated tumour | T | F |
| **3.** | **Epidemiology:** | | |
| 1. Age adjusted incidence rate was 1.33 times lower among male. | T | F |
| 1. Left-sided carcinoma is the commonest form. | T | F |
| 1. A smoker has 16% increased risk of developing CRC. | T | F |
| 1. Diabetes is not an identified risk for CRC. | T | F |
| 1. Intake of calcium, flavonoids and increased dietary fiber are some preventives measures. | T | F |
| **4.** | **Screening modalities in colorectal carcinoma are:** | | |
| 1. IFOBT | T | F |
| 1. Colon capsule endoscopy | T | F |
| 1. Sigmoidoscopy | T | F |
| 1. Colonoscopy | T | F |
| 1. CT scan of abdomen | T | F |
| **5.** | **Genetics:** | | |
| 1. Between 40-50% of all CRCs are attributed to well-deﬁned highly penetrant hereditary colorectal cancer syndromes. | T | F |
| 1. Less than 50% of CRC are sporadic in nature. | T | F |
| 1. Familial CRC confers a life-time CRC risk that may approach 70-90% compared to general population. | T | F |
| 1. Amsterdam Criteria has high sensitivity and specificity (>95%) to find microsatellite instability in a tumour and is used as a modality to identify patients with Lynch syndrome. | T | F |
| 1. Genetic counseling and genetic risk assessment is required for all individuals whose family history is suggestive of a hereditary CRC syndrome before proceeding with genetic testing. | T | F |
| **6.** | **Radiology:** | | |
| 1. Radiation exposure from CT Colonography is higher than the typical dose for Double Contrast Barium Enema. | T | F |
| 1. CT accuracy in identifying CRC and nodal metastases depends on the stage of the tumour. | T | F |
| 1. MRI is the best modality in assessing the relation of the rectal carcinoma with the potential CRM (Circumferential Resection Margin). | T | F |
| 1. FDG-PET CT has a role in the evaluation of recurrent CRC. | T | F |
| 1. CT scan is the modality of choice in diagnosing and staging rectal carcinoma. | T | F |
| **7.** | **Regarding histopathological reporting of CRC:** | | |
| 1. 12 lymph nodes examination should be aimed for proper histopathological examination. | T | F |
| 1. Circumferential margin is considered involved by tumour if it is seen only on the inked margin. | T | F |
| 1. Perforation proximal to tumour is staged as pT4. | T | F |
| 1. Histopathology reporting proforma improves the inclusion of important key parameters for CRC resection specimen. | T | F |
| 1. Macroscopic assessment of the plane of excision of rectal cancers predicts local recurrence. | T | F |
| **8.** | **In surgical resection** | | |
| 1. A thorough surgical exploration should be performed at the time of resection. | T | F |
| 1. Number of lymph nodes resected has been associated with survival. | T | F |
| 1. Resection margins of CRC specimens must be tagged for orientation. | T | F |
| 1. The prognosis of colon perforation due to colon carcinoma is better than perforation from other causes. | T | F |
| 1. The same principles applied in both open and laparoscopic surgical resection. | T | F |
| **9.** | **Chemoradiotherapy:** | | |
| 1. Adjuvant chemotherapy in stage III colon cancer improves overall survival. | T | F |
| 1. Sensory neuropathy is a rare side effect of Oxaliplatin. | T | F |
| 1. Adjuvant chemotherapy should be given >6 months. | T | F |
| 1. In rectal cancer, pre-operative chemoradiotherapy results in lower incidence of local recurrence compared with radiotherapy alone. | T | F |
| 1. There is no role of palliative chemotherapy in stage IV rectal cancer. | T | F |
| **10.** | **Follow-up and surveillance:** | | |
| 1. History and physical examination should be performed every 3-6 months for 5 years. | T | F |
| 1. Surveillance colonoscopy at year 1 and every 3-5 years thereafter, depends on the previous colonoscopy findings. | T | F |
| 1. If a colonoscopy has not been performed before diagnosis, it should be done within a year of surgery. | T | F |
| 1. CEA level monitoring is of no value. | T | F |
| 1. CRC survivors are encouraged to maintain an ideal body weight, participate in regular physical activity and consume a well-balanced diet. | T | F |

**ANSWERS FOR TEST QUESTIONNAIRE**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Question** | | **Answers** | **Question** | | **Answers** | **Question** | | **Answers** |
| **1.** | a. | **F** | **5.** | a. | **F** | **8.** | a. | **T** |
| b. | **F** | b. | **F** | b. | **T** |
| c. | **T** | c. | **F** | c. | **T** |
| d. | **T** | d. | **F** | d. | **F** |
| e. | **T** | e. | **T** | e. | **T** |
| **2.** | a. | **F** | **6.** | a. | **F** | **9.** | a. | **T** |
| b. | **T** | b. | **T** | b. | **F** |
| c. | **T** | c. | **T** | c. | **F** |
| d. | **T** | d. | **T** | d. | **T** |
| e. | **T** | e. | **F** | e. | **F** |
| **3.** | a. | **F** | **7.** | a. | **T** | **10.** | a. | **T** |
| b. | **T** | b. | **F** | b. | **T** |
| c. | **T** | c. | **F** | c. | **T** |
| d. | **F** | d. | **T** | d. | **F** |
| e. | **F** | e. | **T** | e. | **T** |
| **4.** | a. | **T** |  |  |  |  |  |  |
| b. | **T** |  |  |  |  |  |  |
| c. | **T** |  |  |  |  |  |  |
| d. | **T** |  |  |  |  |  |  |
| e. | **F** |  |  |  |  |  |  |