ARGANZ Rectal Focus Group Update
Comment on ESGAR Rectal Guidelines v2026

We are pleased to share the recent publication of the ESGAR Rectal Imaging Guidelines Group, updated consensus recommendations for Primary staging and Restaging.[1-2]
The group consisted of ESGAR members, predominantly from Europe, but also international representation from USA, Brazil, Korea, India and Australia.

In general, the updates provide clear guidance on reporting rectal cancer MRI which are in line with ANZ practice. There are a few subtle differences which are addressed here.

Key Points for current practice in Australia & New Zealand:

- **Include Tumour Deposits as a separate entry in staging reports**
- **Assess LN in conjunction with risk factors to report as cN0 or cN+**
- **Continue to use mrTRG reporting for post treatment assessment in ANZ**

Key Changes to ESGAR guidelines and & ARGANZ Rectal Focus Group comments:

ESGAR Primary Staging:

- Tumour – lower border of tumour above 'sigmoid take off' (STO) = sigmoid tumour
- LN
    - Risk Adaptive nodal assessment: following assessment of size and morphology of LNs, the second step is to assess clinical context and risk factors for N+ disease (higher cT category, EMVI, higher number of suspicious nodes)
    - Report N0 or N+ & include level of confidence of nodal disease (definitely N0, possibly N+, definitely N+)
    - List tumour deposits (TD) separately
    - Nodes and TDs are summated for N category (i.e add together if using N1 & N2)
    - Use ≥7mm for pelvic sidewall (PSW) - obturator and internal iliac LN
    - Morphology considered in PSW LN 5-7mm

- ➔ Use of STO is optional, but can be helpful
- ➔ Include distance from ano-rectal junction (puborectalis) in reports
- ➔ Use N0/N+, or N0/N1/N2 as per local preference (no need to use subcategories e.g N2b etc)
- ➔ Don't use 'Possibly N+' in final report, as we are never 100% certain. Should decide based on available criteria (including risk factors) if cN0 or cN+ as this is more clinically helpful than 'possibly'
- ➔ Clearly report TD separately. If only TD, can report N1c.

ESGAR Restaging:

- Response defined as (near) clinical Complete Response (cCR), minor residual tumour and major residual tumour
- Combine HRT2 with DWI for assessment
- Residual tumour has intermediate T2 signal and DWI
- Use same criteria for neoadjuvant treatment CRT and TNT
- Mucinous degeneration in a primarily non-mucinous tumour should not be considered 'non response'

- 5mm size cut off for LN post treatment, aware of limitations. Correlate with primary tumour response and consider 'test of time' for an equivocal LN when otherwise clinically eligible for organ preservation. No agreed threshold for PSW LN
- In major residual tumour, provide ymr staging, including all areas of fibrosis

➔ **Continue to report using mrTRG in post treatment imaging in ANZ**
➔ DWI can be be used to assist, but HRT2 remains the primary sequence and DWI findings should match site of primary tumour and have a T2 abnormality to be considered positive

ESGAR Technique:

- Rectal gel is NOT recommended
- DWI mandatory for restaging, preferably reduced FOV.
- DWI should be acquired in the same plane as the axial oblique HRT2 sequence
- Preparatory microenema is optional, but recommended for restaging

➔ Note Australian Medicare requirements for HRT2 sequence to meet national standards
➔ This requires a voxel <1.3mm^3. [3]

ARGANZ Rectal Focus Group

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More information including ESGAR paper links, reporting templates and post treatment recommendations available at https://www.arganz.org/about/arganz-focus-groups/rectal-focus-group/

REFERENCES

1. ESGAR Rectal Imaging Guideline Group. MRI to guide clinical management of rectal cancer: updated consensus recommendations from the European Society of Gastrointestinal and Abdominal Radiology (ESGAR)-**PART I primary staging**. *Eur Radiol*. online January 29, 2026. https://link.springer.com/article/10.1007/s00330-025-12274-w
2. ESGAR Rectal Imaging Guideline Group. MRI to guide clinical management of rectal cancer: updated consensus recommendations from the European Society of Gastrointestinal and Abdominal Radiology (ESGAR): **PART II-Restaging and response evaluation**. *Eur Radiol*. online January 29, 2026. https://link.springer.com/article/10.1007/s00330-025-12275-9
3. Cancer Council Australia. Clinical practice guidelines for the prevention, early detection and management of colorectal cancer 10.2.3.1.1 https://app.magicapp.org/#/guideline/noPKwE

Abbreviations:
ANZ – Australia & New Zealand
cN – clinical N category
CRT – chemo-radiotherapy
DWI – diffusion imaging
FOV – Field of View
HRT2 – High resolution T2 weighted image
LN – lymph node
TNT – total neoadjuvant treatment