COLORECTAL CANCER

This sheet is for your information and is not a substitute for medical advice. The specifics of your condition and treatment should be discussed with your oncologist to establish the optimal treatment plan for you as an individual.

Colorectal cancer is the third most common cancer in both males and females in South Africa, occurring in people in the age group of 50 to 70 years. People may have cancer but show no symptoms and are then diagnosed at a very late stage, when the cancer may have spread. Colorectal cancer is commonly misdiagnosed as haemorrhoids or irritable bowel syndrome. Any changes in bowel habits or persistent anal bleeding warrants further investigation. It is often diagnosed only after repeated episodes of blood in the stool, bowel obstruction symptoms or unexpected anaemia.

Groups with a high risk for the development of colorectal cancer include patients with hereditary conditions such as familial polyposis, where literally hundreds of polyps (growths) with the potential for malignant transformation are found throughout the colon. Non-familial polyposis syndromes and ulcerative colitis (chronic bowel inflammation) also place individuals at risk.

More common conditions with an increased risk include a history, or first-degree family history, of colorectal cancer and a personal history of precancerous bowel lesions, as well as ovarian, endometrial or breast cancer.

Investigations for possible colorectal cancer include:

- special test on stools to detect blood in stools
- inspection of the colon using a thin, lighted tube (colonoscopy or sigmoidoscopy) with or without biopsy (removing a small piece of tissue from the growth or bowel)
- x-rays and special type of x-rays called computer tomography (CT) scans
- blood tests which assess whether you are losing blood and to assess whether the cancer may have spread to other organs.

Treatment options

Treatment will depend on the nature and extent of the condition, as well as on your general state of health.

Surgical removal of part of the affected bowel (called a resection) is the primary treatment and results in a high percentage of cures in many patients. Depending on the site and the extent of the condition, the remainder of the bowel may be directly joined. If this is impossible a stoma (temporary opening) for drainage of faeces will be brought out on the abdominal wall. This may be a temporary or permanent diversion.

Recurrence following surgery is a major problem. In some instances radiation and chemotherapy are used to reduce this risk. The role of chemotherapy to reduce the risk of the cancer spreading to other organs has been widely accepted in higher risk groups. Radiation may also be used to reduce the risk of recurrence if there is a possibility to do so. This is of special importance in rectal carcinomas – malignant cancer that arises from tissue that line the surfaces of structures throughout the body – where chemotherapy may also be used to enhance the radiation's effect.

In cases of advanced disease, chemotherapy is used to slow down its progression.

References

GVI Oncology (South Africa). Website: http://www.cancercare.co.za
Uptodate Patient Information. *Colon and rectal cancer*. Website: http://www.uptodate.com/home/index.html