



The Association of Coloproctology of Great Britain and Ireland (ACPGBI) is a group of 1000+ surgeons, nurses, and allied health professionals who advance the knowledge and treatment of bowel diseases in Britain and Ireland.

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of Great Britain and Ireland**

Rectal cancer
Patient information

Rectal cancer is the third most common cancer in men and the second most common cancer in women in the UK with 40,000 new diagnoses being made each year. The cells that line the rectum may become damaged such that they begin to divide in an uncontrolled way. This may lead to the formation of a polyp or eventually a cancer.

What are the symptoms?

Common symptoms include:

- Bleeding from the back passage
- A change in the frequency of bowel activity
- The passage of mucous or slime
- Weight loss and poor appetite

However, these symptoms are very common and are usually not due to rectal cancer.

How is the diagnosis made?

To make a diagnosis of rectal cancer it is essential to examine the colon and rectum either with a flexible telescope (flexible sigmoidoscope or colonoscope) or a special test called a CT colonography. During colonoscopy a tiny portion of tissue (biopsy) is taken from the cancer for laboratory examination. In addition a CT scan will be arranged to examine the lungs and liver to check that the cancer has not spread. A MRI scan will also be required to help plan the most appropriate course of treatment.

How can it be treated?

The best chance of curing rectal cancer is with an operation which aims to remove the segment of rectum with the cancer in it along with the blood supply and lymph nodes (glands) that supply it. These operations can be done with single large incision (open surgery) or multiple small incisions ('key-hole' or laparoscopic surgery). The exact type of operation will depend on the location of the cancer.

- Anterior resection: Involves removing the upper rectum and some of the colon on the left of the body and joining the colon back up to the rectum so that the bowel functions normally.
- Abdominoperineal resection (APR): If the cancer is very low in the rectum then it is not possible to remove the cancer without damaging the muscles which control the bowel (sphincters). This would lead to faecal incontinence. In such circumstances it is better to remove the rectum and anus and form a colostomy, or artificial opening of the colon on to the abdominal wall.
- Transanal Endoscopic MicroSurgery (TEMS): TEMS is an operation, using a specially designed microscope and instruments, to allow surgery to be performed through the anus (back passage) inside the rectum. It requires no cuts on the outside of the anus or abdomen (tummy). Sometimes, TEMS is used to remove small early cancers from the rectum and so avoid major surgery or when the TEMS operation is considered safer than major surgery. Where necessary, your surgeon will explain these choices to you.

These are the commonest types of operations but there are others which may be discussed and can be fully explained by your surgeon.

Is a stoma necessary?

A stoma (colostomy, ileostomy), or artificial opening of the colon/small bowel on to the abdominal wall is NOT always necessary in these operations. Sometimes it is necessary to have a temporary stoma (for 3 months or so) to allow the bowel join to heal. The possibility of requiring a stoma will be discussed with you and if it is required then you will get all the support that you need.

Are there any other forms of treatment?

- Radiotherapy: Some rectal cancers respond to a course of radiotherapy before surgery. This may make surgery easier and possibly prevent the cancer coming back at the same place. If radiotherapy is recommended then you will be able to discuss it further with a specialist in this field (oncologist).
- Chemotherapy: This can be given together with radiotherapy before surgery or on its own. Once you have recovered from your surgery and the cancer has been thoroughly examined by the pathologist it may be appropriate to recommend a course of chemotherapy. This will depend upon your general state of health and the stage of the disease. The stage of disease gives an indication as to whether the cancer has spread to other organs (usually the glands close to the bowel, the liver or lungs). The stage of disease is assessed by a combination of the tests that you had before your operation (CT, MRI) and the pathologist's opinion when the cancer

is examined under the microscope. If chemotherapy is recommended then you will be able to discuss it further with a specialist in this field (oncologist).

- Liver surgery: If the cancer has spread to the liver it may still be possible to attempt to cure the cancer by removing a segment of the liver at an operation. If this is recommended then you will be able to discuss it further with a specialist in this field (hepatobiliary surgeon).

All treatment options will be discussed fully with you and, with your permission the people important to you, before any decisions are made.

What are the chances of cure?

Appropriate surgery offers the best chance of cure possibly combined with chemotherapy and radiotherapy. The earlier the cancer is detected and treated then the more likely the cure. In early cancers the cure rate is greater than 90%, in cancers at a more advanced stage then the chances of cure are less than 50%.

Will I need to be seen again?

You will be checked on a regular basis following your treatment. The frequency with which you will be seen will depend on the stage of cancer and will be tailored to your own particular circumstances. This will usually include visits to the clinic, a CT scans and colonoscopy.

Further information

<https://www.bowelcanceruk.org.uk/about-bowel-cancer/>

<https://www.cancerresearchuk.org/>

<https://www.nhs.uk/conditions/bowel-cancer/>