key points

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Colorectal cancer is the fourth most common cancer in the UK. Approximately 42,000 new colorectal cancers are diagnosed every year, and it is the second most common cause of cancer deaths in the UK. Most cancers are thought to develop from colonic adenomas and incidence is strongly related to age.

The majority of cancers are left sided and typically present with a change in bowel habit, blood in the stool or colicky abdominal pain. Rectal cancers can present with fresh red bleeding and large tumours can cause tenesmus (the intense and frequent desire to defecate, with little or no stool passed). Right-sided cancers most often present with anaemia. As the diameter of the caecum is large and the bowel contents at this stage liquid, it is uncommon for right-sided cancers to present with obstructive symptoms. In both right- and left-sided cancers occasionally the patient may notice an abdominal mass or inexplicable weight loss.

Lynch syndrome is an autosomal dominant condition that accounts for 3% of colorectal cancers. It presents with early colorectal cancer typically diagnosed in the fifth decade and is associated with a number of other cancers including endometrial, stomach, small bowel, urothelial (renal pelvis, ureter, bladder) and ovarian cancer. Familial adenomatous polyposis is also inherited in an autosomal dominant fashion and accounts for < 1% of colorectal cancers. Lifestyle risk factors include high consumption of red or processed meat, low fibre intake, sedentary lifestyle, obesity, smoking and high alcohol consumption. Patients with IBD are also at increased risk and all colitis patients should be offered surveillance colonoscopy starting ten years after onset of symptoms.

Colonoscopy is the gold standard investigation for suspected colorectal cancer. CT colonography is used as an alternative to endoscopy in patients who cannot tolerate bowel preparation e.g. the frail and elderly. Once a diagnosis of cancer has been made the patient will undergo staging with a contrast-enhanced CT of the chest, abdomen and pelvis. This allows for assessment of local invasion, lymph node spread and distant metastasis (most commonly in the liver and lungs). For rectal cancers, the patient will also have an MRI of the pelvis to determine the necessity for preoperative radiotherapy or chemotherapy in the hope of reducing local recurrence rates.

Surgery is the only potentially curative treatment for colorectal adenocarcinoma and is offered to around two-thirds of patients. Increasingly, laparoscopic surgery is used. Defunctioning stomas are frequently created following rectal surgery as the rectum has a poor blood supply and heals more slowly compared with the rest of the colon. Patients with Dukes B and C disease should be considered for adjuvant chemotherapy to reduce the risk of recurrence. All patients who undergo resection for colorectal cancer should have formal specialist follow-up.