key points

SELECTED BY
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Colorectal cancer is the third most common cancer in the UK with an annual incidence of 36,100 in England and Wales. It is also the second leading cause of death from cancer in the UK. Guidelines published by NICE have set down criteria for the urgent referral of patients with clinical features suggestive of colorectal cancer. Around 80% of colorectal cancer is sporadic caused by the interaction of genetic and environmental factors via the adenoma-carcinoma sequence. Adenomas are more common with age and one in four of the population aged over 50 will develop one or more polyps.

Risk factors for colorectal cancer include: age over 60; K-ras and p53 mutations; a diet high in saturated animal fat, low in fibre and vegetables; lack of exercise; obesity and excessive alcohol intake. Inflammatory bowel disease is a risk factor for development of colorectal cancer through the association of chronic inflammation and development of malignancy. Around 20% of colorectal cancer cases are familial and in a primary care setting taking a family history may determine those with a higher than average risk who may need onward referral.

A large proportion of patients with rectal or sigmoid cancers present with a combination of rectal bleeding and a change in bowel habit (usually an increased frequency of defecation and/or looser stools). Rectal bleeding in the absence of anal symptoms occurs in over 60% of those with cancer, and a palpable rectal mass with or without tenesmus is present in 40-80% of those with rectal cancer. The majority of those patients with a suspicion of colorectal cancer will undergo full colorectal visualisation, most commonly with colonoscopy. If a tumour is diagnosed on flexible sigmoidoscopy complete full large bowel investigation will be undertaken.

Preoperative staging is essential to determine both the local and distant status of the disease. All patients with colorectal cancer should be managed by a specialist multidisciplinary team. Resection, either laparoscopic or open, should be performed by specialist surgeons. Certain patients with rectal cancer may be selected for neo-adjuvant (preoperative) radiotherapy. This form of treatment has been shown to reduce local recurrence rates, although no survival benefit has been demonstrated. Advances in chemotherapy have resulted in improved survival for colorectal cancer over the past few years. Postoperative radiotherapy is used but not commonly and also reduces local recurrence but to a lesser degree and also with no survival benefit. Patients with liver or lung metastases may be considered for resection irrespective of age.