key points

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Colorectal cancer is the second most common cause of death from cancer in the UK. In 2009, there were 41,142 new cases registered. The UK has one of the lowest survival rates for colorectal cancer in Europe. Common alarm symptoms include rectal bleeding, change in bowel habit and iron deficiency anaemia. Abdominal mass, weight loss, nausea and vomiting, anorexia and abdominal swelling are less common presenting symptoms. Patients meeting the NICE criteria for urgent referral should be referred via the two week wait pathway to the local colorectal department for prompt assessment to exclude colorectal cancer.

Colorectal cancer has a male predominance and is strongly associated with age, 80% of new cases occur in patients aged over 60. Obesity and limited exercise are strong risk factors. Diets low in fruit and vegetables and fibre and high in red meat have also been associated with an increased risk. Patients with one first-degree relative under 45 or two first-degree relatives of any age have an approximate lifetime risk of developing colorectal cancer of 16-25% in men and 10-15% in women. Having one first-degree relative who developed the disease after the age of 65 barely increases lifetime risk. Patients with ulcerative colitis and Crohn's colitis also have an increased lifetime risk of colorectal cancer.

In the NHS Bowel Cancer Screening Programme, patients are screened with a faecal occult blood test (FOBT) which they complete at home and return by post. Patients with positive tests are then offered further investigation, typically colonoscopy. The sensitivity of colonoscopy for detecting abnormalities is > 90% and hence it is the gold standard test for evaluating the large bowel. Once a diagnosis of colorectal cancer has been confirmed, the extent of disease is evaluated by a CT scan of the chest, abdomen and pelvis.

The treatment of colorectal cancer depends on the site and stage of the disease. The stage of the tumour reflects the depth of tumour invasion and is closely linked to survival. Currently it is recommended in stage I disease that if the histology reveals that the tumour involves, or is within 1 mm of, the resection margin, further treatment should be considered. This could be surgical resection or endoscopic surveillance with or without further polypectomy. With stage II and III disease patients should be offered surgical resection of their tumour. If the staging CT reveals metastatic disease the priority of treatment should be to control patient symptoms.

After curative resection patients should be followed up in a colorectal clinic initially every four to six weeks. They should be offered regular surveillance for recurrence and metastatic disease with a minimum of two CT scans of their chest, abdomen, and pelvis in the first three years and regular CEA tests. Prompt reinvestigation of the patient should be commenced if there is any clinical, radiological or biochemical suspicion of recurrent disease.