

Colorectal Cancer

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1401.11.05

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Clinical Presentation

- Right colon: occult blood loss, resulting in iron deficiency anemia
- The left and sigmoid colon: macroscopic rectal bleeding, altered bowel habits with signs of partial obstruction (increased difficulty defecating, abdominal bloating, decrease in stool caliber, and increased frequency of small-volume bowel movements).
- Rectum: rectal bleeding, obstruction, and, occasionally, alternating diarrhea and constipation.

Any patient older than 30 with a change in bowel habits, iron deficiency anemia, or rectal bleeding should undergo a complete examination of the colon and rectum by colonoscopy

Diagnosing and Screening for Colorectal Cancer

- Risk Assessment:
- High-risk patients have a family history of colon cancer in a first-degree relative, a personal history of adenomatous polyps, a history of IBD, or a known familial cancer syndrome (FAP or HNPCC).
- Patients with none of these risk factors are determined to be average risk.

Diagnosing and Screening for Colorectal Cancer (continued)

Beginning at age 50, average-risk individuals should follow one of these screening options:

- Flexible sigmoidoscopy every 5 years
- Colonoscopy every 10 years
- CT colonography (virtual colonoscopy) every 5 years

- Fecal occult blood test (FOBT) every year
- Fecal immunochemical test every year
- Stool DNA test (sDNA), interval uncertain

*Colonoscopy should be done if test results are positive.

Diagnosing and Screening for Colorectal Cancer (continued)

High-risk patients need to undergo colonoscopy.

- Patients with a first-degree relative with colon cancer will typically begin colonoscopy 10 years before the age of diagnosis of cancer for their family member or the age of 50, whichever comes first.
- Patients with a history of polyps will have colonoscopy at an interval shorter than 10 years and depending on the number of polyps and histologic type.
- Patients with IBD for 10 years or more should begin annual colonoscopic surveillance with biopsies.

Staging Workup

- CT scans of the chest (with IV contrast), abdomen and pelvis (with oral and IV contrast) to rule out distant metastatic disease.

Common sites for metastasis are the liver and lung.

- Carcinoembryonic antigen (CEA)

useful in following patients after resection to detect recurrence.

- Staging for rectal cancer includes an additional study, typically an MRI or EUS.

to assess the depth of tumor invasion in the bowel wall and the involvement of lymph nodes.

Treatment of Colon Cancer

The initial step in the treatment of colon cancer is surgery.

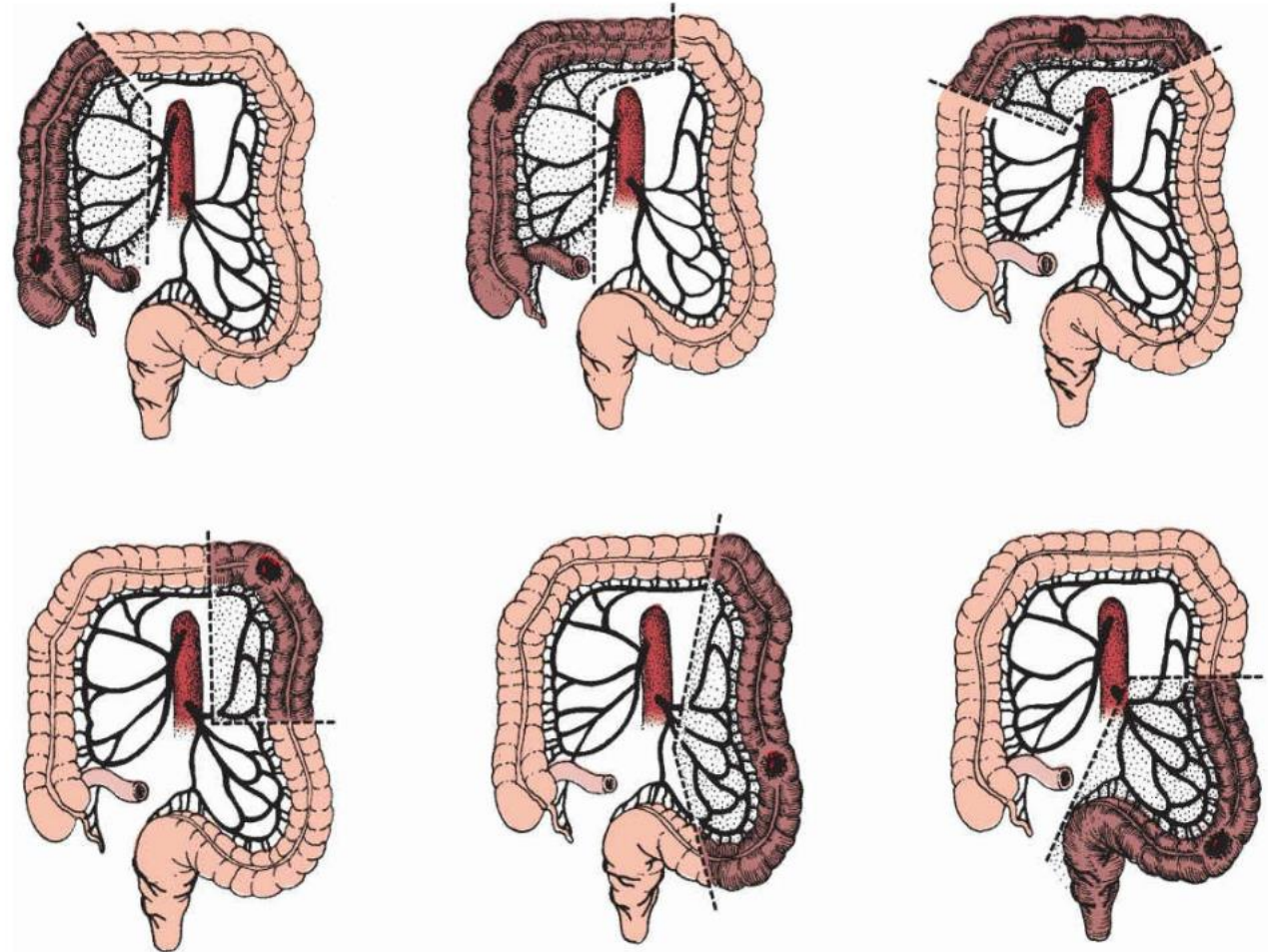


Figure 15-20 Indicated operative resection for colon cancer in different sites. The boundaries of the resection are dictated by lymphatic drainage patterns that parallel the blood supply.

Treatment of Rectal Cancer

- Neoadjuvant chemoradiotherapy:

Rectal cancers that are found on staging pelvic MRI or EUS to invade through the rectal wall (T3 or T4) or have lymph node involvement (N+) are initially treated with chemotherapy and radiation.

- Surgery for rectal cancer:

LAR with primary anastomosis + protected with a temporary proximal diverting stoma to prevent anastomosis leakage.

APR with permanent end sigmoid colostomy: when a rectal cancer invades the sphincters of the anal canal.

Adjuvant Chemotherapy

The specimen removed in the operating room for a colon or rectal cancer is sent to the pathologist for staging.

- Stages 1 and 2 of colon: surgery alone.
- Stage 3 colon cancer and stage 2 and 3 rectal cancer: Adjuvant chemotherapy.

Prognosis and Follow-up for Colorectal Cancer

Most recurrences occur in the first 18 to 24 months.

- History, physical exam, and CEA every 3 months for the first 2 years and every 6 months for the next 3 years. (A progressive rise mandates a complete evaluation of the patient, including CT of the chest, abdomen, and pelvis)
- Colonoscopy is routinely performed at 1 and 4 years postoperatively and then every 5 years thereafter.
- CT scans of the chest, abdomen, and pelvis are done annually in those patients at high risk (stage 3) for recurrence.

The most important prognostic variable is lymph node involvement.

Thank you for your attention