Bowel Cancer

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Bowel Cancer
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Clinical Guidelines

How common is bowel cancer?

In Australia bowel cancer is the most common internal malignancy for both sexes combined. The average Australina has a 1-in-24 lifetime risk of developing bowel cancer. The disease is increasing as the average age of the population rises. In 1999, 11,637 new cases were diagnosed in Australia. Australia is amongst the top 10 high risk countries in the world.

What is the cause of bowel cancer?

The basic cause of bowel cancer is not known. It is more common in the developed countries within which there are interesting variations. Dietary factors appear to be important as bowel cancer is less common in vegetarians. Genetic factors are also a significant issue.

Is there any difference in bowel cancer in females and males?

Bowel cancer is slightly more common in men. Rectal cancer is also more common in men, but in women colon cancer is more common than rectal cancer.

At what age does it occur?

It is unusual for bowel cancer to occur before 40 years of age, in a patient who is an average risk. The risk however increases throughout life.

If I have a realtive with bowel cancer does that increase my risk?

One close (first degree) relative such as mother, father, sister, brother or child, increases the risk of bowel cancer threefold. Two first degree relatives increases the risk by a factor of eight. Multiple second degree relatives (grandparents, aunts, uncles and cousins) undoubtedly have an influence on the development of bowel cancer in a patient but mathematical expressions of this risk are not available.

At what age should the children start investigation and how long should this continue?

In typical circumstances, tests should commence around the late 30's. If the parent's bowel cancer occurred before 45 years of age the screening investigations of the offspring should begin at an earlier age. Regular tests should continue for life.

Are there some bowel diseases which increase the risk?

Benign neoplasms of the colon (polyps) are regarded as pre-malignant. Approximately 5% of polyps removed will show a focus of cancer. This means that polyps in the colon should be removed. Patients with chronic colitis have an increased risk of bowel cancer and require regular surveillance indefinitely to observe the colon for pre-malignant changes.

What are the symptoms?

Rectal bleeding and an alteration in bowel habit are the most frequent symptoms. Abdominal pain and anaemia may be related to bowel cancer.

When should I have tests for rectal bleeding?

Although most causes of rectal bleeding are due to benign (non-malignant) diseases a small number of such patients will be found to have bowel cancer. Therefore even one episode of bleeding should be adequately investigated.

What are the tests to diagnose bowel cancer?

Medical judgement is necessary to decide which and how many tests are appropriate. The tests may be a combination of digital (glove) examination, rigid sigmoidoscopy (25cms.), flexible sigmoidoscopy (60cms.), or colonoscopy (approximately 100cms.) or barium enema x-ray.

How much bowel is removed and how will it affect me subsequently?

In the average situation 20 to 25 cms. of bowel are removed and this usually causes no long-term effect on digestive processes.

Will I have a "bag" (colostomy) when the surgery is performed?

A temporary colostomy is sometimes necessary to rest the operation area for a few weeks. A small reversal operation is then performed subsequently. A permanent colostomy is only necessary when a rectal cancer is situated near the anal sphincter muscles which must be removed to cure the cancer. 97% of all bowel cancer patients will aviod a permanent colostomy. This improved situation is due to the techniques which are practised by surgeons specially trained in this area of surgery.

If a colostomy is necessary will my work, recreation and lifestyle be restricted?

There is virtually no limitation on a person's capacity to continue with their occupation once they have recovered from the operation. Sporting and recreational activities can continue as before the operation.

Is radiotherapy necessary?

It may be used when managing cancer of the rectum before or after the operation.

Is chemotherapy part of the treatment?

Recent overseas trials have encouraged the use of chemotherapy in certain patients after operation for cancer of the colon where local spread of the tumour has invoked lymph glands. This treatment may continue for up to a year. The therapy is an inconvenience but the side effects are less severe than those seen with chemotherapy for other cancers.

What are the prospects of cure after treatment?

This depends on a number of factors such as the biology (growth characteristics) of the cancer and its spread at the time of operation. If the situation looks hopeful at operation, then two thirds of patients will be cured. Cancers treated at an early stage have a 90% chance of cure.

Are screening tests something the community should be having?

A screening test is one applied to a patient who has no symptoms. Many cancers "leak" small amounts of blood into the bowel which mixes with faeces and cannot be seen in the stool. Chemical tests which can identify the blood are known as faecal occult blood tests (FOB). Recent (1993) overseas evidence has demonstrated improved results of bowel cancer management involving the use of FOB tests. Annual screening in patients over 40 years is now recommended.

Should I go to my doctor for a regular check for bowel cancer?

FOB (faecal occult blood) tests have been distributed by some hospitals and service clubs who conduct a carefully supervised investigation programme. Personal contact with the family practitioner is recommended for patients where physical examination, FOB tests or other investigations can be discussed. The doctor may indicate that referral to a Colorectal Surgeon is necessary.

Can bowel cancer be prevented by a healthy diet?

The reduced roughage in the diet of the Western Community this century, has resulted in a population whose transit times (passage of faeces) in the colon are slower than optimal. It has been postulated that cancer producing substances (carcinogens) in the faeces will act on the bowel wall for longer periods. More roughage (fibre) in the diet is therefore recommended to increase the transit time.

The digestive reaction between bacteria, bile and animal fats remains under suspicion as a possible factor in bowel cancer. In view of these observations a precautionary policy of removing fat from red meat, and consuming less red meat is recommended.

High fibre and leafy vegetables may contain a variety of anti-cancer compounds but this is unproven at the present time. However, their inclusion in the diet is nevertheless recommended.