NHS
East Kent Hospitals University NHS Foundation Trust

Rectal cancer

Information for patients from the Association of Coloproctology of Great Britain and Ireland (ACPGBI)

Rectal cancer is the third most common cancer in men and the second most common cancer in women in the UK, with 40,000 new diagnoses being made each year. The cells that line the rectum may become damaged and begin to divide in an uncontrolled way. This may lead to the formation of a polyp or eventually a cancer.

What are the symptoms?

Common symptoms include:

- Bleeding from the back passage
- A change in the frequency of bowel activity
- The passage of mucous or slime
- Weight loss and poor appetite.

However, these symptoms are very common and are usually not due to rectal cancer.

How is the diagnosis made?

To make a diagnosis of rectal cancer it is essential to examine the colon and rectum either with a flexible telescope (flexible sigmoidoscope or colonoscope) or a special test called a CT colonography.

During a colonoscopy a tiny portion of tissue (biopsy) is taken from the cancer for laboratory examination. In addition to a colonoscopy, a CT scan will be arranged to examine the lungs and liver to check that the cancer has not spread. A MRI scan will also be needed to help plan the most appropriate course of treatment.

We care

How can it be treated?

The best chance of curing rectal cancer is with an operation, which aims to remove the segment of rectum with the cancer in it, along with the blood supply and lymph nodes (glands) that supply it.

These operations can be done with a single large incision (open surgery) or multiple small incisions (keyhole or laparoscopic surgery). The exact type of operation will depend on the location of the cancer.

- **Anterior resection** involves removing the upper rectum and some of the colon on the left of the body, then joining the colon back up to the rectum so that the bowel works normally.

- **Abdominoperineal resection (APR)**. If the cancer is very low in the rectum then it is not possible to remove the cancer without damaging the muscles which control the bowel (sphincters). This would lead to faecal incontinence (you are not able to control your bowel movements). In these cases it is better to remove the rectum and anus and form a colostomy, or artificial opening of the colon on to the abdominal wall.

- **Transanal Endoscopic MicroSurgery (TEMS)** is an operation that uses a specially designed microscope and instruments, to allow surgery to be performed through the anus (back passage) inside the rectum. It needs no cuts on the outside of the anus or abdomen (tummy). Sometimes TEMS is used to remove small early cancers from the rectum, avoiding major surgery, or when TEMS is considered safer than major surgery. Where necessary, your surgeon will explain these choices to you.

These are the most common types of operations, but there are others which may be discussed and can be fully explained by your surgeon.

Is a stoma necessary?

A stoma (colostomy, ileostomy) or artificial opening of the colon / small bowel on to the abdominal wall is **not** always necessary in these operations. Sometimes it is necessary to have a temporary stoma (for three months or so) to allow the bowel join to heal. The possibility of needing a stoma will be discussed with you, and if it is needed you will get all the support that you need.

Are there any other forms of treatment?

- **Radiotherapy**. Some rectal cancers respond to a course of radiotherapy before surgery. This may make surgery easier and possibly prevent the cancer coming back at the same place. If radiotherapy is recommended then you will be able to discuss it further with a specialist in this field (oncologist).

- **Chemotherapy** can be given together with radiotherapy before surgery or on its own. Once you have recovered from your surgery and the cancer has been thoroughly examined by the pathologist, it may be appropriate to recommend a course of chemotherapy. This will depend upon your general state of health and the stage of the disease. The stage of disease gives an indication as to whether the cancer has spread to other organs (usually the glands close to the bowel, the liver, or the lungs). The stage of disease is assessed by a combination of the tests that you had before your operation (CT, MRI) and the pathologist's opinion when the cancer is examined under the microscope. If chemotherapy is recommended then you will be able to discuss it further with a specialist in this field (oncologist).

- **Liver surgery**. If the cancer has spread to your liver, it may still be possible to try to cure the cancer by removing a segment of your liver with an operation. If this is recommended then you will be able to discuss it further with a specialist in this field (hepatobiliary surgeon).

Before any decisions are made all treatment options will be discussed fully with you and the people important to you (with your permission).

What are the chances of a cure?

Appropriate surgery offers the best chance of a cure, possibly combined with chemotherapy and radiotherapy. The earlier the cancer is detected and treated then the more likely the cure. In early cancers the cure rate is greater then 90%, in cancers at a more advanced stage then the chances of cure are less than 50%.

Will I need to be seen again?

You will be checked regularly following your treatment. How often will depend on the stage of your cancer and tailored to your own particular needs. This will usually include visits to the clinic, CT scans, and colonoscopy.

Produced with grateful acknowledgement to The Association of Coloproctology of Great Britain and Ireland (ACPGBI) www.acpgbi.org.uk/

This leaflet has been produced with and for patients

If you would like this information in **another language, audio, Braille, Easy Read, or large print** please ask a member of staff. You can ask someone to contact us on your behalf.

Any complaints, comments, concerns, or compliments please speak to your doctor or nurse, or contact the Patient Advice and Liaison Service (PALS) on 01227 78 31 45, or email ekh-tr.pals@nhs.net

Patients should not bring in large sums of money or valuables into hospital. Please note that East Kent Hospitals accepts no responsibility for the loss or damage to personal property, unless the property had been handed in to Trust staff for safe-keeping.

Further patient leaflets are available via the East Kent Hospitals web site www.ekhuft.nhs.uk/patientinformation

Information produced by The Association of Coloprotology of Great Britain and Ireland (ACPGBI)
Date reviewed: December 2022 Next review date: April 2026 Web 167