



The Dudley Group
NHS Foundation Trust

Cancer of the rectum: investigations, diagnosis and treatment

The Colorectal Nursing Service
Patient Information Leaflet

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Your Colorectal Team

Consultant leading your care:

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Your colorectal/stoma nurse/key worker leading your nursing care:

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Other doctors that may be involved in your care:

.....

Introduction

Your hospital doctor may have explained that you have a possible cancer of the rectum that requires further investigations to stage the disease.

This booklet aims to provide information to help you understand more about cancer of the rectum, investigations that you may need and any proposed forms of treatment. We hope you find it useful and that it will help you understand the care you will receive.

At the end of this booklet, you will find a glossary of terms to help you and a list of useful organisations you may wish to contact to gain further information or support.

If you think that reading this booklet has helped you, you may want to pass it on to your family and/or friends who might find it useful. They, too, may want to be informed so that they can support you and help you cope with any problems you may have.

What is cancer?

The tissues and organs of the body are made up of tiny building blocks called cells. These cells repair and reproduce themselves continually as they age and become damaged.

Sometimes during this process, normal cells become abnormal and as they continue to reproduce (divide) they develop into a tumour. Tumours can either be cancerous (malignant) or non-cancerous (benign).

In a benign tumour, the cells do not spread to other parts of the body. However, if they continue to grow, they may cause a problem by putting pressure on the surrounding organs or causing a blockage, for example, in the bowel.

A malignant tumour consists of cancer cells that have the ability to spread away from the original site. If the tumour is left untreated, it may invade and destroy the surrounding tissue. If cells break away from the original cancer (the primary one), they can spread to other organs of the body through the bloodstream. When these cells reach a new site, they may continue to grow and form a new tumour. This is known as a secondary cancer or metastasis.

What is the large bowel?

The large bowel is made up of the colon and rectum. It is the last part of the intestines and forms part of our digestive system (see figure 1). The food we eat travels from the mouth to the stomach and then passes through the small bowel where essential nutrients are absorbed into the bloodstream. The digested food then enters the large bowel and the colon absorbs water from it.

The colon runs up the right side of the abdomen, across the abdomen and down the left side ending in a wider portion called the rectum (back passage). As the colon absorbs water from the faeces it becomes more solid, and is eventually passed from the body through the anus as a bowel motion.

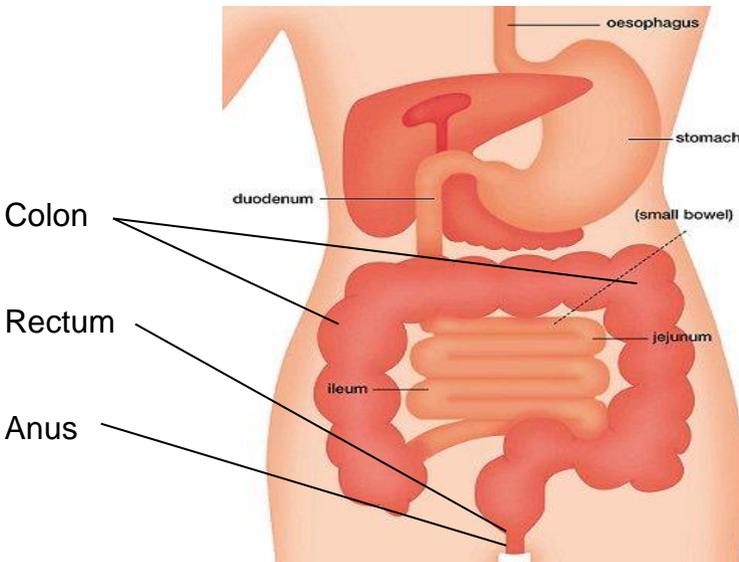


Figure 1 – the digestive system from the oesophagus (food pipe) to the anus

Colorectal cancer

Colorectal cancer is the third most common cancer in the UK after breast and lung cancer, with approximately 41,265 new cases diagnosed in 2014 in the UK (Cancer Research UK).

Occurrence of colorectal cancer is strongly related to age, with almost three-quarters of cases occurring in people aged 65 years or over. Colorectal cancer is the second most common cause of cancer death in the UK after lung cancer (Cancer Research UK, 2014).

People with a strong family history of colorectal cancer affecting people below 40 years of age have an increased risk of developing the disease.

People with some long standing inflammatory diseases of the bowel, such as Crohn's disease or ulcerative colitis, may also have an increased risk of developing colorectal cancer.

People who have a rare genetic condition known as familial adenomatous polyposis (FAP) or adenomatous polyposis coli, in which benign tumours called polyps are found in the lining of the colon, have an increased risk of developing bowel cancer.

There are many different kinds of cancer. Colorectal cancer is cancer of the colon (large bowel) and rectum (back passage). Cancer of the colon and the treatment of it will be outlined in this booklet.

What are the symptoms of rectal cancer?

Rectal cancer can cause many symptoms which may include any of the following:

A change in bowel habit – symptoms can include going to the toilet more often and looser motions, perhaps alternating with periods of constipation. You may see dark blood in the motion or pass mucus.

Bleeding – rectal bleeding that persists. The most common sign is blood in or on the stools.

Other symptoms – other signs are unexplained weight loss, tiredness or breathlessness without obvious reason (usually due to anaemia from loss of blood). Some people feel a lump in the tummy.

How do you find out if I have rectal cancer?

The following tests and investigations are all used to make a diagnosis of rectal cancer. They will allow us to determine the extent of your problem and plan your treatment.

Although we are aiming to find out if you have rectal cancer, it is also important that we also look at all of your large bowel and other organs that might be affected by this cancer. This can be achieved in a variety of different ways. The tests will be selected depending on your individual condition.

Blood tests

Your consultant will request routine blood tests such as:

- Haemoglobin (Hb) or a full blood count (FBC) to check for anaemia and any other problems.
- Urea and electrolytes (U&E) to check how well your kidneys are working.
- Carcinoembryonic antigen (CEA) which can give an indication of active bowel cancer and is used for diagnosis together with other diagnostic tests.

Barium enema

This is an examination using barium to outline the whole bowel which then shows up on X-rays. It will be carried out in the hospital X-ray department.

It is important that the bowel is empty for the test so that a clear picture can be seen. Therefore, we will give you a preparation to take the day before your test to empty your bowel. You will need to drink plenty of fluids when you take this.

On the day of your barium enema, you will not be able to eat anything until after the test has been completed. The X-ray department will send you an instruction sheet with more information about this.

For the test, a small tube is placed in the anus and liquid barium and some air are put into your bowel through this tube. It is important to keep the liquid barium and air in the bowel until all the X-rays have been taken. The barium outlines the bowel and X-rays are taken to show up any abnormal areas.

For a couple of days after the test, you may notice that your stools are white. This is the barium coming out of your body and is nothing to worry about.

Sigmoidoscopy

This test allows the doctor to look at the inside of the rectum and lower part of the large bowel. It is usually carried out in the hospital outpatient department or gastrointestinal unit (GI unit).

For the test, you will need to lie curled up on your left side and then the doctor will gently pass a tube into your back passage. A small hand pump is attached to the tube so that air can be pumped into the bowel.

A light on the inside of the tube helps the doctor to see any abnormalities. If necessary, the doctor can take a small sample of tissue (called a biopsy) for examination using a microscope to check for cancer cells. The biopsy should not hurt.

Colonoscopy

If your consultant wants to look inside the whole length of the large bowel, they may suggest you have a colonoscopy. This will usually be carried out in the GI unit.

For this test, the bowel has to be completely empty which means taking a preparation similar to that used for a barium enema. We will give you this and the instructions of how and when to take it.

Just before the test, we may give you a sedative into a vein to help you relax. We will discuss this with you.

You will need to lie on your side. The doctor will gently pass a flexible tube into your back passage which can pass around the curves of the bowel. A light on the inside of the tube helps the doctor to see any abnormal areas and allows photographs and samples (biopsies) to be taken of the inside of your large bowel.

As you may be sedated for the procedure:

- You will need to arrange for a responsible adult to take you home afterwards, either by car or taxi. You will not be able to go home on public transport.
- Someone should stay with you overnight.
- You cannot, by law, be in charge of a motor vehicle or moving machinery for 24 hours afterwards.
- The medication (Midazolam) we give some patients before a colonoscopy relaxes and makes you comfortable. However, it may affect your memory for up to 24 hours afterwards. You may not remember information given to you by the doctor but we will give you a report to take home.
- The effect of the sedation (Midazolam) may be prolonged by other medication you are taking. We will discuss this with you when you come for the procedure.

CT scan or CT colonogram

A CT scan is a type of X-ray that uses a scanner to take a series of detailed images of your body. This includes looking at the structures of your body including internal organs, blood vessels and bones. The scan gives information about tumours that helps the doctor plan your treatment.

For the CT scan, you usually need to arrive before the scan time. This is because you may need to drink some special fluid before to highlight your bowel on the scan pictures.

If you are having a CT colonogram, we will send you the fluid before the scan. You will need to drink this over several days along with some mild laxatives as your bowel will need to be clear for the scan.

When you come for a CT scan, you will usually need to have an injection of contrast dye into a vein in your arm. This highlights the blood vessels and certain organs on the pictures.

If you are having a CT colonogram, the doctor will pass a very small flexible tube into your back passage to gently pump air into your colon. The air is important as it inflates the bowel slightly, opening any folds which might hide any polyps or growths.

The scanner itself looks like a large Polo mint as it has a hole in the middle. During the scan, you will lie on a table that moves through the hole. You will be in the scanner room for several minutes and many pictures are generated. A doctor (known as a radiologist) will look at these afterwards. The interpreting of the pictures takes a while so the report will be sent to your specialist later.

MRI scan

Magnetic resonance imaging (MRI) is often used as well as CT scans when looking at rectal tumours. It uses strong magnetic fields and radio waves to see inside the body, rather than X-rays.

Due to the strong magnetic fields used, we will send you a questionnaire beforehand to make sure that there are no circumstances preventing you from having an MRI scan.

The scan takes several minutes and during the test you will need to lie very still. The scanner makes a lot of noise so we will give you headphones to wear. We usually play music through these so you can bring along your favourite CD, if you want.

Anal/rectal ultrasound

This is an examination using high frequency sound waves to create images of tissue layers beneath the surface of the anal canal or the rectum. It uses a smooth probe the size of a finger which is placed in the anus or rectum.

This procedure can be performed for patients who have rectal cancer who are unable to have a MRI scan. It allows very good visualisation of the tissue. It is a safe procedure and no radiation is used. The examination is performed by a consultant who has special training in ultrasound.

What is an anal/rectal ultrasound used for?

This test is used to map out anal fistulas before surgery (see 'Glossary of terms' for more information about anal fistulas). It is also used to look for abnormal areas or cancer, infections around the anus area and tears, scarring or injuries in the sphincter muscle in the anus. It provides additional information about rectal polyps and rectal cancer.

How do I prepare for the ultrasound?

Your bowel will need to be clear so we will send you an enema in the post with your appointment. You will need to use this at home before you come to the hospital for the procedure.

When you arrive in the GI unit, a nurse will complete your assessment documents with you, including your medical history and current medications. The consultant will explain the procedure to you, answer any questions you have and obtain your written consent. Feel free to ask questions if something is not clear to you.

What happens after an ultrasound?

We will give you instructions to follow at home. Usually there are no restrictions on activity.

What happens after I have had all my tests and investigations?

The findings of your tests and any biopsies will be discussed in a colorectal cancer multidisciplinary team (MDT) meeting by your consultant. After this, we will create a treatment plan for you (please see section on ‘What treatment options are there?’ for more information about this).

Sometimes as a result of discussions in the MDT meeting, you may need to have more investigations. If this is the case, your consultant or specialist nurse will contact you to discuss this.

The role of the colorectal cancer multidisciplinary team

NHS guidelines state that “everyone diagnosed with colorectal cancer should be under the care of a multidisciplinary team”. This is a team of health professionals who work together to discuss your case and how best to manage your treatment, the benefits of treatments available and the most appropriate types of treatment to meet your individual needs.

The colorectal cancer multidisciplinary team meetings are held on Monday lunchtimes (except for bank holidays). Your case will be discussed when all your investigations have been completed and a treatment plan will be created for you.

The consultant who will be in charge of your treatment and your specialist nurse will discuss this treatment plan with you in the outpatient department. This may be a different consultant to the person you saw in the first instance.

The consultant's secretary or your specialist nurse will contact you by telephone with the time for this appointment.

The colorectal multidisciplinary team

Consultant colorectal surgeons

Mr Kawesha, Mr Patel, Mr Oluwajobi, Mr Stonelake,
Miss MacLeod

Consultant gastroenterologists

Dr Fisher, Professor Ishaq, Dr Shetty, Dr De Silva,
Dr Mahmood, Dr Rattehalli

Consultant pathologists

Dr Shinde, Dr Nair

Consultant radiologists

Dr Hall, Dr Ajayi

Consultant Medical Oncologist

Dr Grumett

Consultant Clinical Oncologist (Chemo/radiotherapy)

Dr Habib Khan

Clinical Nurse Specialist

Colleen Fernando

Colorectal/stomacare sisters

Sam Cook, Helen Hill, Janet Whittaker, Rebekah Del Gaizo

Stomacare Support Worker

Amanda Chater

MDT Co-ordinator

Denise Weaver

Colorectal/Stomacare Secretary

Mandy Clarke

Staging the disease

Your treatment will depend on the stage of disease at time of diagnosis. In order to stage the disease, the specialists use the findings from the tests and biopsies. They look at the characteristics of the tumour, whether the cancer has spread and if so, where it has spread to.

There are two standard systems used to stage bowel disease. These are the Dukes' staging system and the Tumour, Node and Metastasis (TNM) staging system.

The Dukes' staging system

The stages of the Dukes' staging system are described in the following table:

Dukes' stage	Extent of cancer
A	Cancer is confined to the wall of the bowel
B	Cancer has spread through the wall of the bowel
C	Cancer has spread to the lymph nodes
D	Cancer has spread to other organs

The TNM staging system

This more detailed staging system describes the size of the primary tumour (T), whether any lymph nodes contain cancer cells (N), and whether the cancer has spread to another part of the body (M).

T stage	Extent of cancer
T1	Tumour is only in the inner layer of the bowel
T2	Tumour has grown into the muscle layer of the bowel wall
T3	Tumour has grown into the outer lining of the bowel wall
T4	Tumour has grown through the outer lining of the bowel wall. It may have grown into another part of the bowel, or other nearby organs or structures. Or it may have broken through the membrane covering the outside of the bowel (the peritoneum)

N stage	Extent of cancer
N0	There are no lymph nodes containing cancer cells
N1	One to three lymph nodes close to the bowel contain cancer cells
N2	There are cancer cells in four or more nearby lymph nodes

M stage	Extent of cancer
M0	Cancer has not spread to other organs
M1	Cancer has spread to other parts of the body

What treatment options are there?

Surgery is usually the first treatment for rectal cancer; however, this will depend on the stage of your disease. Your consultant will discuss your specific treatment plan with you.

Clinical trials

Depending on the outcome of the MDT meeting, we may ask you if you want to participate in a clinical trial before surgery. This will be explained firstly by your colorectal surgeon at your outpatient appointment and then in more detail by the appropriate oncologist (doctor specialising in cancer treatment).

Surgery

Your consultant will explain the surgical procedure to you with the aid of a diagram. You may be offered laparoscopic surgery, otherwise known as keyhole surgery. This type of surgery reduces discomfort after surgery, minimises scarring and reduces your hospital stay, although the risks are the same as that of open surgery.

Your specialist nurse will give you written information about it and will answer any queries or questions you may have.

After surgery

The part of the bowel containing the cancer will be examined by our Pathology Team. When the results are available, we will discuss in the next available MDT meeting whether further treatment in the form of chemotherapy is advisable.

If this is the case, we will refer you to a medical oncologist who will discuss this treatment with you in more detail at an outpatient appointment.

In addition, you will have an appointment about four weeks after your surgery where your consultant surgeon will discuss your results with you.

Radiotherapy

This uses high energy X-rays to destroy cancer cells while doing as little harm as possible to normal cells. It is given to selected patients with rectal cancer before surgery to shrink the tumour and make it easier to remove. The treatment is carefully planned and monitored for each person, to ensure that normal cells suffer little or no long term damage.

Some patients (very few) may also benefit from radiotherapy after surgery if it is thought that there may be small amounts of cancer cells left behind.

Radiotherapy is given as an outpatient at The Deansley Centre at New Cross Hospital in Wolverhampton. You will need to go there every day for between five days to six weeks depending on the nature of your rectal tumour. We will discuss this with you beforehand.

If you need radiotherapy, we will send you an appointment to go to the radiotherapy department for treatment planning to ensure that you receive carefully targeted treatment.

On this visit, you will need to lie under a large machine called a CT simulator which takes a scan of the area to be treated. A small number of pinprick tattoo marks will be put onto your skin. These are used to accurately target the radiotherapy X-rays when your treatment starts.

At the beginning of your radiotherapy, you will be advised how to look after the skin in the area to be treated. Before each session of radiotherapy, the radiographer will position you carefully and comfortably as you have to be still whilst the treatment is given.

The treatment only takes a few minutes. During this time, you will be left alone in the room but the radiographer will be watching you carefully from an adjoining room. The treatment is not painful.

Will I suffer from any side effects?

Radiotherapy to the bowel area can cause side effects such as diarrhoea, nausea and tiredness. If you do suffer from nausea, this is usually mild and anti-sickness drugs can normally control this effectively. If you do not feel like eating, you can replace meals with nutritious, high calorie drinks which are available on prescription or from most chemists.

Diarrhoea can occur if radiotherapy irritates your bowel. This can be reduced by medication which your hospital doctor or GP can prescribe.

As radiotherapy can make you feel tired, try to get as much rest as you can to help you cope with the tiredness and the daily travelling. In addition, the skin in the area being treated may become red and sore. The nurses and radiographers will advise you how to look after your skin during your course of treatment.

Finally, radiotherapy to the bowel can cause inflammation of the lining of the bladder (cystitis). This can make you feel as if you want to pass urine often and you may also feel a burning sensation when you pass urine. It will help to drink plenty of fluids to make the urine less concentrated and again, your hospital doctor or GP can prescribe medication to make you more comfortable.

These side effects usually continue while you are having treatment and then disappear slowly once the course of treatment is over.

Chemotherapy is often given as well as radiotherapy. If this is the case, your oncologist will discuss this with you.

Chemotherapy

The specialists trained extensively to use chemotherapy drugs are called medical oncologists.

Chemotherapy is the use of special anti-cancer drugs (known as cytotoxic drugs) to destroy cancer cells. They are usually given by injection into a vein in the back of the hand or into a Hickman Line. This is a tube which avoids the need for needles and goes into a vein below the collar bone.

Nearly all chemotherapy is given as a day case procedure where you only have to be at hospital for the day.

The reasons for giving chemotherapy are as follows:

- 1) to shrink the tumour and make it easier to remove during surgery (which we call neo adjuvant chemotherapy)
- 2) to increase the chance of a cure after surgery (which we call adjuvant chemotherapy)
- 3) to treat advanced disease and prolong life (which we call palliative chemotherapy)

Neo adjuvant and adjuvant chemotherapy saves many lives and if appropriate to your care, may form part of your treatment plan.

You may have just one drug or a combination of drugs. The main chemotherapy drug used to treat colorectal cancer is called 5-fluorouracil (or 5FU). It is usually given with the vitamin folic acid or with other chemotherapy drugs.

It can be given as an infusion (drip) for 48 hours, daily or at weekly intervals initially. The dosage will depend on the condition being treated and whether or not other drugs are being given to you.

Other drugs which may be used are irinotecan and oxaliplatin. Irinotecan kills the rapidly multiplying cells that make up a cancer. For patients receiving their first course of chemotherapy for colorectal cancer, it is usually given every two weeks and can also be used in conjunction with other anti-cancer drugs.

Oxaliplatin is normally given with 5FU. It is a platinum-based chemotherapy drug given to treat metastatic colorectal cancer (cancer which has spread). It has also been recommended by the National Institute for Health and Care Excellence (NICE) to shrink secondary tumours in the liver and can lead to potentially curable surgery for some people.

It can be given every two or three weeks as a course of treatment. The number of courses you have will depend on the type of cancer you have and how well it is responding to the drugs. However, the treatment is generally given for six to 24 doses over three months to a year.

You will need to have blood tests taken on the day of treatment and these, together with the state of your health, will determine whether you have the drugs on the day.

If the cancer starts to grow again, during or after the chemotherapy, you may be given a different type of chemotherapy drug. This is known as second line treatment.

Several research trials are being carried out to find the best type of chemotherapy for colorectal cancer. You may be asked if you want to take part in one of these trials using new chemotherapy drugs or new types of treatments.

Will I suffer from any side effects?

Some people experience very few side effects and even those who do suffer from them will only have these temporarily during treatment.

Some of the more common side effects include reduced resistance to infection, tiredness, hair loss, mouth ulcers, nausea and diarrhoea. However, nausea and diarrhoea can usually be well controlled with medicine. Some people also experience soreness and redness on the palms of their hands and soles of their feet.

You should talk to your medical oncologist about any side effects from the chemotherapy drugs.

What alternative treatments are there?

Self-expanding metal stents (SEMS) are metallic tubes used to hold open the bowel, if it is obstructed by a tumour, so that stools can pass through. They can provide rapid relief of distressing symptoms in people who cannot have surgery, or for those who have symptoms of bowel obstruction which need to be treated urgently.

This treatment may be suggested before any detailed investigations are carried out. It can help stabilise a patient's condition so that a longer term treatment plan can be created.

SEMS are being increasingly used for people with a bowel obstruction as they are considered to be a safe and effective way of achieving relief in patients with advanced colorectal cancer.

Although they are considered to be convenient and safe, several complications have been reported. The complications depend on where the stent is located in the bowel and include stent obstruction and movement, perforation (damage) of the colon and/or rectum, impacted stools, bleeding, abdominal pain and the constant feeling of wanting to pass stools.

However, complications are usually minor in the majority of people and if treated, usually only last about 48 hours.

Stenting carries a mortality rate (rate of deaths) of around two per cent. However, it should be remembered that this is a lower risk than the 20 per cent mortality rate associated with emergency surgery.

Complementary therapies

Complementary therapies are natural therapies which can be used with conventional medical and nursing treatments. However, they should not replace traditional care.

Complementary therapies include a number of different treatment kinds such as counselling, acupuncture, aromatherapy, homeopathy, meditation, visualisation, healing, relaxation, massage, osteopathy, reflexology, hypnosis and dietary treatments.

The aim of these therapies is to relieve physical symptoms and help emotional reactions, including stress and anxiety, and therefore enhance wellbeing. Frequent symptoms that complementary therapies aim to improve are flatulence (passing wind), sleep disorders, tiredness, worry and pain.

In every instance, it is recommended that you use a suitably qualified practitioner to give you the complementary therapies. We strongly advise you to speak to your consultant before starting a course of therapy, to ensure that it will not interfere with your other treatments.

White House Cancer Support in Dudley provides a wide range of complementary therapies for both patients and their family and carers. They have specific knowledge and expertise about cancer related issues (see section 'Where can I find out more?' for contact details). Your specialist nurse/key worker will be happy to give you their contact details.

What treatment will I have if I have advanced colorectal cancer?

Advanced colorectal cancer means the cancer has spread from where it started in the bowel or back passage to other parts of the body such as the liver or lungs. Your cancer may be advanced when it is first diagnosed, or it may come back some time after you are first treated.

Once a bowel cancer has spread to another part of the body, it is unlikely to be curable. However, treatment can often keep it under control for quite a long time.

The choice of treatment depends on the cancer type, the number of secondary cancers and where they are, and the treatment you have already had. Surgery can be used in some situations to treat advanced colorectal cancer and often results in a stoma (for example, a colostomy). Chemotherapy can sometimes be used to shrink a cancer and control symptoms.

Money and financial support

Some people may experience financial problems due to their illness or operation. If this is the case, support may be available. Advice can be provided by the Citizens Advice Bureau or Macmillan Cancer Support (see section 'Where can I find out more?' for contact details).

Alternatively, you may want to discuss this with your colorectal specialist nurse.

Prescriptions

People with cancer in England can have free prescriptions. If you live in England and need prescriptions for things that are related to cancer or its effects, you can apply for an exemption certificate by collecting form FP92A from your GP surgery or oncology clinic.

Follow up care

You will have follow up appointments for up to five years. This will often include a physical examination, blood tests including for the carcinoembryonic antigen (CEA), visualisation of the colon (colonoscopy) and CT scans. Your consultant will let you know when you need to have these tests.

Throughout the follow up period, you can contact the colorectal clinical nurse specialists on 01384 244286. If we are not in, please leave a message on our 24-hour private answering machine and we will get back to you.

What other support is available to me?

Most people feel overwhelmed when they are told that they have cancer. Many different emotions arise which can cause confusion and frequent changes in mood, and everyone experiences this differently. These emotions are part of the process that people go through in trying to come to terms with their illness.

Friends and family often experience similar emotions and need support and guidance too.

It is important to remember that there are people available to help you and your family. Your specialist nurse/key worker will be very pleased to help you. They may suggest working through your anxieties with you or if necessary, refer you to an appropriate specialist.

You may find it easier to talk to someone who is not directly involved with your illness. If this is the case, you might find it helpful to talk to a counsellor.

You may also want to get together with other people who are in or who have been in a similar position to you. The White House Cancer Support in Dudley offers information, relaxation and support when needed. Anyone who is newly diagnosed with cancer is welcome to contact them. Partners are also welcome. Their address and contact details are included in the list of useful addresses that follow, or you can ask your specialist nurse or key worker for their contact details.

Where can I find out more?

Here is a list of useful addresses and contact details:

Beating Bowel Cancer

Harlequin House

7 High Street

Teddington

TW11 8EE

020 8973 0011

www.beatingbowelcancer.org.uk

Benefit Shop

35 Churchill Shopping Centre

Dudley

West Midlands

DY2 7BL

01384 812639

White House Cancer Support

10 Ednam Road

Dudley

West Midlands

DY1 1JX

01384 231232

www.support4cancer.org.uk

Fax: 01384 459975

Email: info@support4cancer.org.uk

Cancer Research UK

PO Box 1561

Oxford

OX4 9GZ

0300 123 1022

www.cancerresearchuk.org

Citizens Advice Bureau

www.citizensadvice.org.uk

Citizens Advice Bureau – Dudley Branch

0344 411 1444

Email: dudleybureau@dudleycabx.org

Colon Cancer Concern

www.canceractive.com

Colostomy Association

Enterprise House

95 London Street

Reading

RG1 4QA

0800 328 4257

www.colostomyassociation.org.uk

Crohn's and Colitis UK

45 Grosvenor Road

St. Albans

Hertfordshire

AL1 3AW

0300 222 5700

www.crohnsandcolitis.org.uk

Ileostomy and Internal Pouch Support Group

Danehurst Court

35 - 37 West Street

Rochford

Essex

SS4 1BE

0800 0184 724

www.iasupport.org.uk

Ileostomy Association Stourbridge Branch

Contact the Secretary

01562 755630

Stourbridge.iasupport.org

Email: stourbridge@iasupport.org

Institute for Complementary and Natural Medicine

Can Mezzanine

32-36 Loman Street

London

SE1 0EH

0207 922 7980

www.icnm.org.uk

Lynn's Bowel Cancer Campaign

5 St George's Road

Twickenham

TW1 1QS

www.bowelcancer.tv

Macmillan Cancer Support

89 Albert Embankment

London

SE1 7UQ

0808 808 00 00 (Monday to Friday, 9am to 8pm)

www.macmillan.org.uk

Glossary of terms

These are some of the medical words and terms you may come across during your appointments for colorectal investigation.

Abscess

A localised collection of pus in a cavity formed by decay of diseased tissues.

Acute

Sudden onset of symptoms.

Adjuvant therapy

Chemotherapy and radiotherapy used after surgery.

Aetiology

Cause.

Anaemia

A reduction in the number of red cells or haemoglobin (iron) in the blood which means that the blood is less able to carry oxygen around the body.

Analgesia

Pain relief.

Anastomosis

The joining together of two ends of healthy bowel after diseased bowel has been cut out (resected) by the surgeon.

Anus

The opening to the back passage.

Barium enema

An X-ray of the large bowel (colon) used for diagnosis.

Benign

Non-cancerous.

Biopsy

Removal of small pieces of tissue from parts of the body (e.g. colon – colonic biopsy) for examination using a microscope for diagnosis.

Caecum

The first part of the large intestine forming a dilated pouch into which the ileum, the colon and the appendix opens.

Chemotherapy

Drug therapy used to attack cancer cells.

Chronic

Symptoms occurring over a long period of time.

Colon

The large intestine extending from the caecum to the rectum.

Colonoscopy

Inspection of the colon by an illuminated telescope called a colonoscope.

Constipation

Infrequency or difficulty in passing bowel motions.

Crohn's disease

Inflammation of the lining of the digestive system.

CT scans

A type of X-ray. A number of pictures are taken of the abdomen and fed into a computer to form a detailed picture of inside of the body.

Defaecation

The act of passing faeces/bowel motions.

Diagnosis

Determination of the nature of the disease.

Diarrhoea

Passing looser and more frequent bowel motions.

Distal

For colorectal investigations, this means the part further down the bowel towards the anus.

Diverticulum

Small bulges that develop on the lining of the intestine that can become inflamed and infected (diverticulitis).

Dysplasia

Alteration in size, shape and organisation of mature cells that indicates a possible development of cancer.

Electrolytes

Salts in the blood e.g. sodium, potassium and calcium.

Endoscopy

A collective name for all visual inspections of body cavities with an illuminated telescope e.g. colonoscopy, sigmoidoscopy.

Enema

A liquid introduced into the rectum to encourage the passing of motions.

Exacerbation

An aggravation (worsening) of symptoms.

Faeces

The waste matter eliminated from the anus (other names – stools, motions).

Fistula

An abnormal connection, usually between two organs, or leading from an internal organ to the body surface e.g. between the end of the bowel (anal canal) and the skin near the anus.

Haemorrhoids (piles)

Swollen arteries and veins in the area of the anus which bleed easily and may prolapse (protrude from the anus).

Hereditary

The transmission of characteristics from parent to child.

Histology

The examination of tissues (e.g. from a biopsy) under the microscope to assist diagnosis.

Inflammation

A natural defence mechanism of the body in which blood rushes to any site of damage or infection leading to reddening, swelling and pain.

Lesion

A term used to describe abnormalities in the tissue of the body.

Malignant

Cancerous.

Mucus

A white, slimy lubricant produced by the intestines.

Neutropenia

Reduction in the number of white cells which fight infection.

Oedema

Accumulation of excessive amounts of fluid in the tissues resulting in swelling.

Oncologist

A doctor who specialises in cancer care using drugs and radiotherapy.

Palliative care

Improving the quality of life by providing support and control of unpleasant symptoms.

Pathology

The study of the cause of the disease.

Perforation of the bowel

An abnormal opening in the bowel wall which causes the contents to spill into the normally sterile abdominal cavity.

Peritonitis

Inflammation of the peritoneum (the thin layer of tissue that lines the inside of the abdomen) often due to a perforation.

Polyp (bowel)

A small growth on the inner lining of the bowel.

Prophylaxis

Treatment to try and prevent a disease occurring before it has started.

Proximal

For colorectal investigations, this means further up the bowel towards the mouth.

Radiologist

A doctor who interprets X-ray pictures to make a diagnosis.

Radiotherapy

The use of high energy rays which attack cancer cells.

Rectum

The large intestine above the anus (the back passage).

Relapse

Return of the disease activity i.e. the cancer has come back.

Remission

A lessening of symptoms of the disease and return to good health.

Sigmoid

The part of the colon shaped like a letter 'S' or 'C' that is closest to the rectum and anus.

Sigmoidoscopy

Inspection of the sigmoid colon with an illuminated telescope called a sigmoidoscope.

Stoma

An artificial opening made by surgery of part of the intestine onto the abdominal surface which allows stool to exit the body.

Stricture

The narrowing of a portion of the bowel.

Suppository

A bullet-shaped solid medication put into the rectum.

Tenesmus

Persistent urge to empty the bowel.

Terminal Ileum

The end of the small intestine (ileum) which connects to the caecum.

Tumour

An abnormal growth which may be benign (non-cancerous) or malignant (cancerous).

Ulcerative colitis

Ulceration and inflammation of the large bowel.

Ultrasound

Use of high frequency sound waves to produce pictures of organs on a screen for diagnostic purposes A small hand held device called a transducer is passed with conducting jelly over the specific body area.

Please note that we hold all the details about your care on a computer programme in the department.

If you have any questions, or if there is anything you do not understand about this leaflet, please contact:

The colorectal clinical nurse specialists on 01384 244286
(8.30am to 5pm, Monday to Friday)

If we are not in, please leave a message on the answerphone and we will get back to you.

Russells Hall Hospital switchboard number: 01384 456111

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