Cancer
Council

Understanding Bowel Cancer

A guide for people with cancer, their families and friends

Cancer information

Cancer Council Helpline
13 11 20

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Understanding Bowel Cancer is reviewed approximately every two years. Check the publication date above to ensure this copy of the booklet is up to date. To obtain a more recent copy, phone Cancer Council Helpline 13 11 20.

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Note to reader

Always consult your doctor about matters that affect your health. This booklet is intended as a general introduction to the topic and should not be seen as a substitute for your doctor's or other health professional's advice. However, you may wish to discuss issues raised in this booklet with them. All care is taken to ensure that the information in this booklet is accurate at the time of publication.

Cancer Council Australia

Cancer Council Australia is the nation's peak non-government cancer control organisation. Together with the eight state and territory Cancer Councils, it coordinates a network of cancer support groups, services and programs to help improve the quality of life of people living with cancer, their families and carers. This booklet is funded through the generosity of the people of Australia. To make a donation and help us beat cancer, visit Cancer Council's website at www.cancer.org.au or call your local Cancer Council.

Cancer
Council

Cancer Council Australia
Level 14, 477 Pitt Street, Sydney NSW 2000
Telephone 02 8063 4100 **Facsimile** 02 8063 4101
Email info@cancer.org.au **Website** www.cancer.org.au
ABN 91 130 793 725

Introduction

This booklet has been prepared to help you understand more about bowel cancer.

Many people feel understandably shocked and upset when told they have bowel cancer. We hope this booklet will help you understand how bowel cancer is diagnosed and treated. We also include information about support services.

We cannot give advice about the best treatment for you. You need to discuss this with your doctors. However, we hope this information will answer some of your questions and help you think about other questions to ask your treatment team.

This booklet does not need to be read from cover to cover – just read the parts that are useful to you. Some medical terms that may be unfamiliar are explained in the glossary. You may also like to pass this booklet to your family and friends for their information.

How this booklet was developed

This information was developed with help from a range of health professionals and people affected by bowel cancer. It is based on the National Health and Medical Research Council's clinical practice guidelines for bowel cancer.

Cancer Council Helpline **13 11 20** can arrange telephone support in different languages for non-English speakers. You can also call the Translating and Interpreting Service (TIS) direct on **13 14 50**.

Contents

What is cancer?

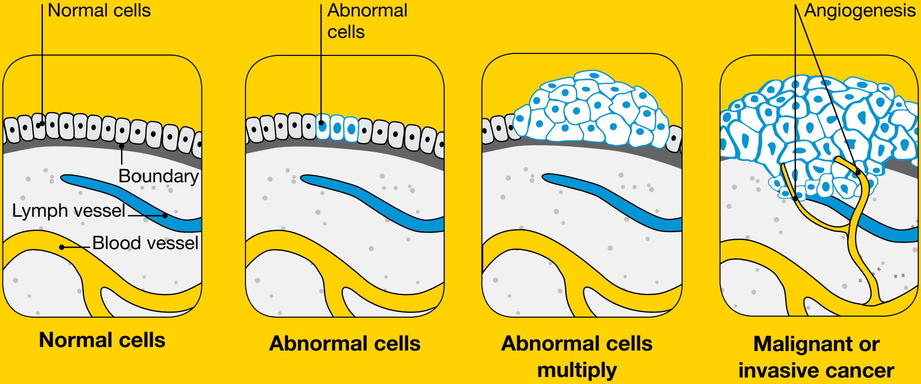
Cancer is a disease of the cells, which are the body's basic building blocks. The body constantly makes new cells to help us grow, replace worn-out tissue and heal injuries. Normally, cells multiply and die in an orderly way.

Sometimes cells don't grow, divide and die in the usual way. This may cause blood or lymph fluid in the body to become abnormal, or form a lump called a tumour. A tumour can be benign or malignant:

Benign tumour – Cells are confined to one area and are not able to spread to other parts of the body. This is not cancer.

Malignant tumour – This is made up of cancerous cells, which have the ability to spread by travelling through the bloodstream or lymphatic system (lymph fluid).

How cancer starts

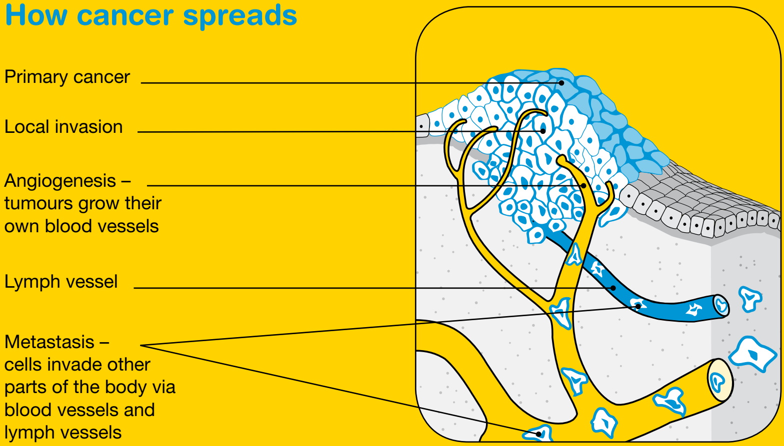


The cancer that first develops in a tissue or organ is called the primary cancer. A malignant tumour is usually named after the organ or type of cell affected.

A malignant tumour that has not spread to other parts of the body is called localised cancer. A tumour may invade deeper into surrounding tissue and can grow its own blood vessels (angiogenesis).

If cancerous cells grow and form another tumour at a new site, it is called a secondary cancer or metastasis. A metastasis keeps the name of the original cancer. For example, bowel cancer that has spread to the liver is called metastatic bowel cancer, even though the person may be experiencing symptoms caused by problems in the liver.

How cancer spreads



The digestive system

The bowel is part of the digestive system, which is sometimes called the gastrointestinal (GI) or digestive tract. The digestive system starts at the mouth and ends at the anus. It helps the body to break down food and turn it into energy. It also gets rid of the parts of food that the body does not use. This solid waste matter is called stools or faeces.

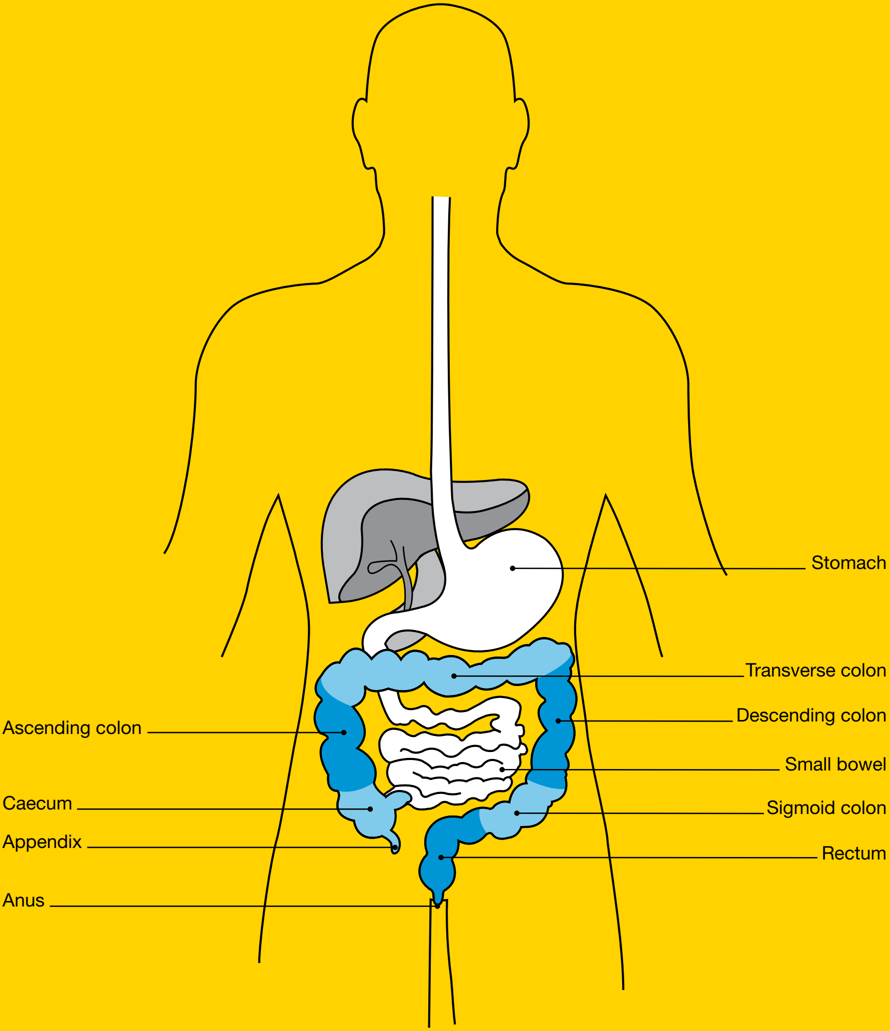
There are two main parts of the bowel:

- **Small bowel –** a 4–6m long tube that takes food from the stomach and absorbs nutrients. Also called the small intestine.
- **Large bowel –** absorbs water and salts and turns what is left over into waste (stools or faeces). Also called the large intestine. The large bowel has several sections.

Parts of the large bowel

Caecum	A pouch at the beginning of the large bowel that receives waste from the small bowel. The appendix is a small tube hanging off the end of the caecum.
Colon	The main working area of the large bowel. The colon is divided into four parts (ascending colon, transverse colon, descending colon and sigmoid colon) and stretches from the caecum to the rectum. It is about 1.5m long.
Rectum	The last 15–20cm of the large bowel.
Anus	The opening at the end of the digestive tract. The anus has strong muscles that keep it closed. During a bowel motion, these muscles relax to release stools from the rectum.

The digestive system



Key questions

Q: What is bowel cancer?

A: Bowel cancer is cancer in any part of the large bowel (colon or rectum). It is sometimes also known as colorectal cancer.

Bowel cancer grows from the inner lining of the bowel (mucosa). It may develop from growths on the bowel wall called polyps. Polyps are usually harmless (benign), but they may become cancerous (malignant) over time. Malignant polyps may be small or large, flat or mushroom-shaped.

If untreated, bowel cancer can grow locally into the deeper layers of the bowel wall. It can spread from there to the lymph nodes (glands). These small, bean-shaped masses are part of the body's lymphatic system. If the cancer advances further, it can spread to other organs, such as the liver or lungs (metastasis).

In most cases, it develops fairly slowly and stays in the bowel for months or years before spreading.

Q: How common is it?

A: Bowel cancer is the second most common cancer affecting people in Australia. About 14,000 people are diagnosed with bowel cancer every year.

About one in 17 men and one in 25 women will develop bowel cancer before the age of 75. It is most common in people over 50, but it can occur at any age.

Q: What are the symptoms?

A: In its early stages, bowel cancer often has no symptoms. However, some people may experience the following:

- a change in bowel habits, such as diarrhoea, constipation, or smaller, more frequent bowel movements
- a change in appearance of bowel movements (e.g. narrower stools or mucus in stools)
- a feeling of fullness or bloating in the bowel or rectum
- a feeling that the bowel hasn't emptied completely after a bowel movement
- blood in the stools or on the toilet paper
- unexplained weight loss
- weakness or fatigue
- rectal or anal pain
- a lump in the rectum or anus
- abdominal pain or swelling
- a low red blood cell count (anaemia), which can cause tiredness and weakness.

Not everyone who has these symptoms has bowel cancer. Other medical conditions, such as haemorrhoids or tears in anal tissue, and some foods or medications, can also cause these changes. If you have any of the above symptoms for more than two weeks, see your doctor for a check-up.

> “I started to have some bleeding when I went to the toilet. There were no other warning signs – it just happened out of the blue, so I went to see my GP.” *Andrew*

Q: What are the risk factors?

A: The exact cause of bowel cancer is not known. However, some factors increase the chance of developing it:

Risk factors include:

- **getting older –** bowel cancer most commonly affects people over the age of 50
- **bowel diseases –** people who have an inflammatory bowel disease, such as Crohn's disease or ulcerative colitis, have a significantly increased risk, particularly if they have had it for more than 8–10 years
- **lifestyle factors –** being overweight, doing little physical activity, a diet high in fat or animal products, high alcohol consumption and smoking can play a part
- **other diseases –** people who have had colorectal cancer are more likely to develop another bowel cancer; some people who have had ovary, endometrium or breast cancer may also be more likely to develop it
- **Ashkenazi Jewish heritage –** people from this background are more likely to develop bowel cancer
- **inheriting a rare genetic disorder –** see opposite for more information about familial adenomatous polyposis and Lynch syndrome
- **strong family history –** see opposite.

Polyps in the bowel are a risk factor for bowel cancer. If polyps are removed, the risk of bowel cancer is reduced but it can still occur.

Inherited genetic conditions

There are two rare conditions running in families that cause a small number (5–6%) of bowel cancers:

- **Familial adenomatous polyposis (FAP) –** This condition causes many polyps to form in the bowel. If polyps caused by FAP are not removed, they become cancerous.

- **Lynch syndrome –** This increases the risk of developing bowel cancer and other cancers. It was previously known as hereditary non-polyposis colorectal cancer (HNPCC).

Family history of cancer

If one or more of your family members (such as a parent, sibling or grandparent) have been diagnosed with bowel cancer, it may run in your family. This is a possibility if two relatives on the same side of your family have cancer, or if they were diagnosed before the age of 55.

Other cancers, such as breast cancer, can also run in the family, and this may increase your risk of developing bowel cancer.

If you are concerned about your family history, see your general practitioner (GP) for regular check-ups and discuss whether you should have a further assessment.

Doing regular physical activity, maintaining a healthy weight and eating a diet high in fruit, vegetables and fibre may help protect against bowel cancer.

Diagnosis

Your GP will examine you and refer you to a specialist for further tests. The tests you have depend on your specific situation and may include:
- general tests to check your overall health and body function
- tests to find cancer
- tests to see if the cancer has spread (metastasised).

Some tests may be repeated during or after treatment to check how well the treatment is working.

Waiting for the test results can be a stressful time. It may help to talk to a friend or family member, a healthcare professional, or call Cancer Council Helpline 13 11 20.

Cancer screening tests

Bowel cancer is a common cancer, so you may have a screening test. Screening is the process of looking for cancer in people who don't have any symptoms.

Faecal occult blood test

This screening test looks for blood in your stools (faeces), which may be a sign of cancer or another bowel condition. The faecal occult blood test (FOBT) can find traces of blood in the faeces that are invisible to the naked eye but can be seen with a microscope.

An FOBT can be done at home, using a kit that costs $30–$40. You will usually need to take samples from two separate bowel motions and send them in the envelope provided to a laboratory. The samples are examined under a microscope.

If the test is positive (you have blood in your stool), contact your doctor, who will be able to advise you about the next steps. Your doctor will check for haemorrhoids and other non-cancerous conditions, and do further tests to check for bowel cancer.

The FOBT is recommended to people aged 50 and older, every two years, because ageing is one of the risk factors for bowel cancer.

National Bowel Cancer Screening program

The Australian Government offers free FOBT kits to people turning 50, 55 or 65. From 2013, people turning 60 will also be offered the test.

An FOBT does not diagnose bowel cancer. It is a simple, non-invasive method of showing whether further tests such as a colonoscopy (see page 16) may be required.

Research shows that 90% of bowel cancers are curable if found early.

To be eligible for a free test, you need to have a Medicare card or a Veterans Affairs card. You will automatically be sent an invitation to participate within six months of your birthday. You do not have to participate in the screening program but it is highly recommended.

For more information, see **www.cancerscreening.gov.au/bowel** or phone **1800 118 868** (free call from fixed phone line).

General tests

Physical examination

Your doctor will examine your body, feeling your abdomen for any swelling.

To check for problems in the anus and rectum, your doctor will insert a gloved finger into your anus to feel inside for any lumps or swelling. This is called a digital rectal examination (DRE), and it helps the doctor detect problems in the lowest part of the bowel.

The DRE may be uncomfortable, but it shouldn't be painful. It might make you feel like you are going to open your bowels, but it is very unlikely that this will happen. Because the rectum is a muscle, it can help to try to relax during the test.

Sometimes the doctor will insert a small, rigid telescope (sigmoidoscope or proctoscope) into the anus to see the lining of the lower part of the bowel. You do not need to empty your bowel or have an anaesthetic for this test.

Blood test

You may have a blood test to assess your general health and to look for signs that you are losing blood in your stools.

Some doctors also measure the levels of carcinoembryonic antigen (CEA), which is a protein produced by some cancer cells. If your blood tests show that you have a high CEA level, your doctor may organise more tests. This is because other conditions, such as smoking or pregnancy, may also increase CEA levels.

The blood test may also measure chemicals that are found or made in your liver, and check your red blood cell count. Low red blood cell levels (anaemia) is common in people with bowel cancer, but may also be caused by other conditions.

Tests to find cancer

Flexible sigmoidoscopy

This test allows the doctor to see the rectum and the left side of the lower part of the colon. To have a flexible sigmoidoscopy, you will need to have an empty bowel (see *Bowel preparation* on page 18).

Before the test, your doctor may give you a light anaesthetic. You will lie on your left side on an examination table, and the instrument will be gently inserted into your anus and through the bowel.

The sigmoidoscope blows air into the bowel. This inflates the bowel slightly and allows the doctor to see the bowel wall more clearly. Any unusual areas can be seen with the camera and light at the end of the tube. The doctor can also use the sigmoidoscope to remove a piece of tissue for examination. This is called a biopsy.

A sigmoidoscopy takes about 10–20 minutes. Though it may feel uncomfortable, it should not be painful. Cramping and pressure in your lower abdomen will ease when the air leaves your colon after the test is over (by passing gas).

Colonoscopy

A colonoscopy examines the whole length of the large bowel. This is the best, most accurate test to examine the large bowel for cancer in most people.

- Before a colonoscopy, you will have a bowel preparation to clean your bowel – see page 18. On the day of the procedure, you will probably be given an anaesthetic so you don't feel any discomfort or pain. This will also make you drowsy and may put you to sleep during the examination.

- The doctor will insert a flexible tube with a camera on the end, called an endoscope, into your anus and up into your rectum and colon.

- Air will be pumped into your colon, and your doctor will look for abnormal tissue (such as polyps), which will be removed for further examination (biopsy).

The main side effect of a colonoscopy is temporary flatulence and wind pain, which is due to air pumped into the large bowel during the test. More serious but rare complications include damage to the bowel or bleeding. Your doctor will talk to you about the risks. Overall, the test is safe and the benefits far outweigh the risks for most people.

A colonoscopy usually takes about 20–30 minutes. You will need to have someone take you home after the colonoscopy, as you may feel drowsy or weak.

Screening colonoscopies

If one of your family members has had bowel cancer at a young age (less than 55 years), or more than one member of your extended family has had bowel cancer, your doctor may recommend that other family members have a screening colonoscopy as a precaution. Screening colonoscopies are recommended at 50 years of age, or 10 years before the age of the youngest person with cancer, whichever comes first.

Virtual colonoscopy

A virtual colonoscopy uses a CT or MRI scanner (see page 20) to create images of the colon and rectum and display them on a screen instead of putting an endoscope into your bowel.

Your bowel needs to be empty for the colonoscopy, so you will have a bowel preparation (see page 18). You will probably lie on your back or stomach and a thin tube will be inserted into your rectum to pump air into your colon. This may feel uncomfortable.

After your colon is inflated, you will be moved into the scanner. The scanner will create 3D images of your colon while you hold your breath for short intervals.

Although a virtual colonoscopy is less invasive than a colonoscopy and your bowel can be seen in detail, your doctor may not be able to see small abnormalities or take tissue samples. If the doctor suspects any abnormalities, or if the scan results are unclear, you will also be advised to have a standard colonoscopy.

Bowel preparation

Before some diagnostic tests, you will have to clean out your bowel. This will help the doctor see inside the bowel clearly.

The cleaning process varies between hospitals and for different people, so ask if there are any instructions for you to follow. It's important to follow the instructions so you don't have to repeat the test.

Consider using soft toilet paper, wet wipes or barrier cream so your skin does not get irritated during preparation. Preparation may involve:

Having an enema – One common way to clear the bowel is using an enema. This is liquid that is inserted directly into the rectum. The enema solution washes out the bowel, and is usually passed into the toilet along with any faeces.

Taking laxatives – Another type of bowel preparation is an oral laxative (in tablet or liquid form), which will cause you to have watery diarrhoea.

Making diet changes – For a few days before the diagnostic test, you may be told to avoid high-fibre foods, such as vegetables, fruit, wholegrain pasta, brown rice, bran, cereals, nuts and seeds. Instead, choose low-fibre options, such as white bread, white rice, meat, fish, chicken, cheese, yoghurt, pumpkin and potato.

Drinking clear fluids – Your doctor might advise you to drink only fluids, such as broth, water, black tea and coffee, and clear fruit juice without pulp for 12–24 hours before the test.

It is important to drink plenty of fluid during the preparation to prevent dehydration.

Talk to your doctor if you are concerned about anything during the bowel preparation.

Barium enema

A barium enema is a type of bowel x-ray procedure. Barium is a white contrast liquid that shows up on x-rays. Before having this procedure, you will have a bowel preparation.

During the procedure, you will lie on an x-ray table while a barium-filled tube is inserted into your rectum and released into your colon. The doctor may also pump air into your colon to force the enema fluid into creases in the bowel wall.

The barium will show up any lumps or swellings, and x-rays of your inflated colon will then be taken. This 30-minute test can be uncomfortable, but it is not painful.

For a couple of days afterwards, your stools may be white. This is the barium being removed from the body. It can also cause constipation, however taking a mild laxative for a couple of days may help.

If an abnormal area is found, you will probably need to have a colonoscopy or other type of test.

Further tests

If the tests described on the previous pages show you have bowel cancer, you will have one or more scans to see if the cancer has spread to other parts of your body. A scan is painless and is usually done as an outpatient. Most people are able to go home as soon as the test is over.

CT scan

A CT (computerised tomography) scan uses x-ray beams to create a detailed picture of the inside of the body.

Before the scan, dye is injected into a vein to make the pictures clearer. This may make you feel hot all over for a few minutes and leave a strange taste in your mouth.

The CT scanner is large and round like a doughnut. You will lie on a table that moves in and out of the scanner. It takes about 30 minutes to set up the machine, however, the scan itself takes 5–10 minutes.

The dye used for a CT or MRI scan is called a contrast solution and may contain iodine. If you are allergic to iodine, shellfish, fish or dyes, let the person performing the scan know in advance.

MRI scan

An MRI (magnetic resonance imaging) scan uses radio waves and magnetism to create cross-sectional pictures of the body. Dye may be injected into a vein before the scan to help make the pictures clearer.

You will lie on a table that slides into a metal cylinder that is open at both ends. Some people feel anxious lying in the narrow metal cylinder. You may be given a mild sedative to help you relax.

Before arranging the test, your doctor will ask you questions about your medical history to check you can have the test. People who have a pacemaker or other metallic objects in their body cannot have an MRI due to the effect of the magnet.

PET scan

During a PET (positron emission tomography) scan you will be injected with a small amount of radioactive glucose solution. It takes 30–90 minutes for the solution to circulate around your body. You will be asked to sit quietly during this time.

Your body is then scanned for high levels of radioactive glucose. Cancer cells show up brighter on the scan because they are more active and take up more of the glucose solution than normal cells.

Though it may take several hours to prepare for and have a PET scan, it is usually done on an outpatient basis.

Ultrasound

An ultrasound is a test that uses soundwaves to build up a picture of your body. A device (transducer or probe) is placed on or in your body. This sends out soundwaves that echo when they meet something dense, like a tumour, and images are projected onto a computer screen. There are two types of ultrasounds depending on the type of cancer you have:

- **Abdominal ultrasound –** This may be done to see whether bowel cancer has spread to the liver. A gel is spread over your abdomen to conduct the soundwaves and the transducer is passed over the abdominal area to create the image. The test takes 15–20 minutes.

- **Endorectal ultrasound (ERUS) –** A probe is inserted through the anus into your rectum. This can be uncomfortable, and there may be some light bleeding from the rectum. However, it takes about 10 minutes.

  An ERUS is usually done if other tests show there is cancer in the rectum or anus. It helps your doctor determine the size of the cancer and if it has spread into the bowel wall. It may also help the doctor plan surgery or decide if other treatments are needed.

A chest x-ray may be taken to check if the cancer has spread to the lungs or lymph nodes in your chest.

Staging bowel cancer

The tests described on pages 14–22 help show whether you have bowel cancer. Some tests, such as the MRI, CT and ERUS scans, may also show how far the cancer has spread. This is called staging and it helps the doctor decide the best treatment for you.

- **Clinical stage –** This type of staging gives your doctor's estimate of the extent of the disease, based on the test results.
- **Pathologic stage –** This is based on diagnostic tests plus tests on the cancer and lymph nodes removed during surgery. Test results are usually available about a week after the operation.

In Australia, the most common bowel cancer staging systems are Australian Clinico-Pathological Staging (ACPS) and TNM.

ACPS staging system

Stage A	Cancer is found only in the bowel wall.
Stage B	Cancer has spread to the outer surface of the bowel wall.
Stage C	Cancer has spread to the lymph nodes near the bowel.
Stage D	Cancer has spread beyond the lymph nodes to other areas of the body, such as the liver or lungs.

TNM staging system

Gives information about the tumour, nodes and metastasis. Each letter is assigned a number that shows how advanced the cancer is. If the letter X is used instead of a number, it means that it can't be determined.

T (Tumour) 1–4	Indicates how far the tumour has grown into the bowel wall and nearby areas. T1 is a smaller tumour; T4 is a larger tumour.
N (Nodes) 0–2	Shows if the cancer has spread to nearby lymph nodes. N0 means that the cancer has not spread to the lymph nodes; N1 means there is cancer in 1–3 lymph nodes; N2 means cancer is in four or more lymph nodes.
M (Metastasis) 0–1	Shows if the cancer has spread to other, distant parts of the body. M0 means the cancer has not spread; M1 means the cancer has spread.

Paul's story

When I was in my late 30s, I had a little bit of bleeding when I went to the toilet. I thought it might be polyps, but when it became more frequent and heavy, I decided to go to the GP.

My GP put me onto a specialist who used a little camera to have a look inside. I went to have a colonoscopy a week later. Right away, my doctor showed me a picture of a large 15cm tumour in my lower bowel.

The cancer was aggressive so my medical team wanted to treat it right away. I had the option of having surgery first, then chemotherapy and radiotherapy, or radiotherapy followed by an operation. The team recommended the second option.

I had a week of intense radiotherapy. I had some nausea, so I'd have to have something about an hour afterwards. It caused some stomach upset.

Before the operation, I saw a stoma nurse who talked to me about what to expect. The surgeon planned to make a temporary stoma but halfway through, he saw that the tumour was all the way down the bowel and he had to make a permanent one.

I'm used to the colostomy now but I have my up and down days. I feel self-conscious sometimes because I think the bag is noticeable under most fitted mens clothing. Other people say it's not noticeable but I don't wear the same things I used to.

I learned to live with the stoma. The stoma hasn't stopped me travelling, I've been able to holiday in Bali a couple of times.

Prognosis

Prognosis means the expected outcome of a disease. You may wish to discuss your prognosis and treatment options with your doctor, but it is not possible for any doctor to predict the exact course of your disease.

Test results, the type of cancer you have, the rate and depth of tumour growth, how well you respond to treatment, and other factors such as age, fitness and medical history are all important in assessing your prognosis.

In most cases, the earlier bowel cancer is diagnosed and treated, the better the outcome.

Which health professionals will I see?

Your GP plays an important role in your ongoing care. They will arrange the first tests to assess your symptoms, or further tests if you have had a positive faecal occult blood test. If these tests do not rule out cancer, you will usually be referred to a surgeon or a physician who specialises in the digestive system (a gastroenterologist). They will arrange more tests and advise you about treatment.

You will be cared for by a range of health professionals who specialise in different areas of your treatment. These health professionals will take a team-based approach to your care (multidisciplinary team or MDT). See the next page for a list of health professionals you may see.

Health professional	Role
colorectal surgeon	diagnoses bowel cancer and operates on cancer in the large bowel and rectum
gastroenterologist	diagnoses bowel cancer and specialises in the digestive system and its disorders
medical oncologist	prescribes and coordinates the course of chemotherapy
radiation oncologist	prescribes and coordinates the course of radiotherapy
cancer care coordinator or clinical nurse consultant (CNC)	supports patients and families throughout treatment and liaises with other staff
nurses	care for you during and after surgery; help administer drugs; and provide care, information and support throughout the course of your treatment
stomal therapy nurse (STN)	provides information about surgery and adjusting to life with a temporary or permanent stoma
operating room staff (such as anaesthetists, technicians and nurses)	prepare you for surgery and care for your during the operation and recovery
dietitian	recommends an eating plan to follow while you're in treatment and recovery
social worker, counsellor, physiotherapist and occupational therapist	link you to support services and help with emotional, physical or practical issues

Key points

- There are many types of tests used to diagnose bowel cancer, but you will only have the tests you need.

- A faecal occult blood test (FOBT) is when a stool sample is examined for traces of blood. This can be used to screen healthy people for bowel cancer and assist with diagnosis. It is often done as part of a national screening program.

- If blood is found during the FOBT, you will probably have a colonoscopy. A colonoscopy can be used to look for cancer in the entire large bowel.

- A flexible sigmoidoscopy is used to view the last 50cm of the colon. A rigid sigmoidoscopy looks at the rectum only.

- A bowel preparation may be needed before some tests. This cleans out the bowels so the doctor can see clearly.

- X-rays, CT scans and MRI scans are painless and take pictures of the inside of your body. They may show the location of the cancer and whether it has spread.

- The doctor will assign the cancer a stage based on diagnostic tests. This describes the size and spread of the cancer. You may be told the stage of the cancer after bowel surgery, when enough tissue and lymph nodes have been examined.

- Your prognosis is the expected outcome of the disease. The earlier bowel cancer is diagnosed and treated, the better the likely outcome.

- You will probably see many health care professionals who will work together as a multidisciplinary team to diagnose and treat you.

Treatment

Your medical team will recommend a treatment based on what you want, your general health, the location of the cancer in the bowel and if the cancer has spread.

The most common treatment is surgery, but you may also have chemotherapy and radiotherapy. Treatments may be combined.

Surgery

There are different types of surgery for bowel cancer. The aim of surgery is to remove all the cancer and nearby lymph nodes.

Minimally invasive surgery

Minimally invasive surgery, also called keyhole or laparoscopic surgery, means the operation involves several small cuts (incisions) instead of one large cut (open technique). This may include robotic surgery.

The surgeon passes a thin, flexible tube (laparoscope) through one of the incisions in the abdomen. The laparoscope has a light and camera. The cancer is removed using other long, thin instruments that are inserted through the incisions.

The minimally invasive technique usually means less pain and scarring and a faster recovery with less time spent in hospital.

There are advantages to both types of surgery – your surgeon will advise you on what is suitable for you. Whether or not minimally invasive surgery is recommended depends on the size and location of the cancer, and if surgery is available at your hospital or treatment centre.

Surgery for cancer in the colon

The most common type of surgery is called a colectomy. There are different types of colectomies depending on where the cancer is located and how much bowel is removed (see page 30).

The surgeon may use an open technique or a minimally invasive technique. You will be given a general anaesthetic, then the surgeon will make a cut in the abdomen to find the part of the colon containing the cancer and remove it. Lymph nodes near the colon and some normal bowel around the cancer will also be removed.

The surgeon usually joins the two ends of the bowel back together with stitches or staples. Sometimes the bowel isn't joined together but one end is brought through an opening made in your abdomen. This procedure is called a colostomy. The opening – called a stoma – allows faecal waste to be removed from the body.

The surgeon may later be able to do another operation to rejoin the bowel. In some cases, this isn't possible and the stoma will be permanent. For information about stomas, see pages 45–50.

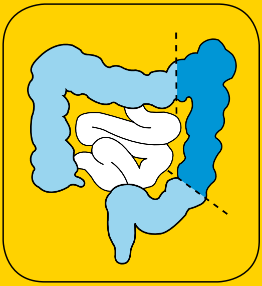
After surgery, you will have a scar. Its appearance will depend on the surgical technique used to do the operation. Most people who have open surgery have a scar from their navel to their pubic area.

See page 36 for information about recovering from surgery, and page 44 for dealing with dietary changes.

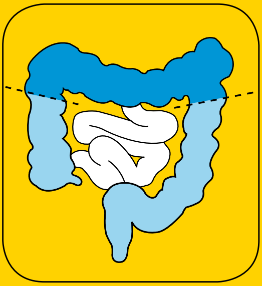
Types of colectomies

The area shaded dark blue will be removed by the surgeon.

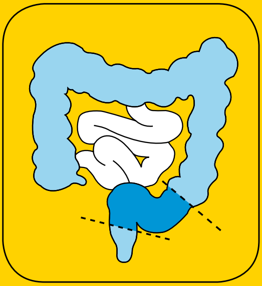
Right hemicolectomy
The right side of the colon is removed.*



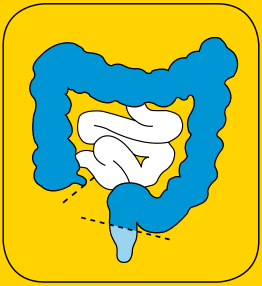
Left hemicolectomy
The left side of the colon is removed.*



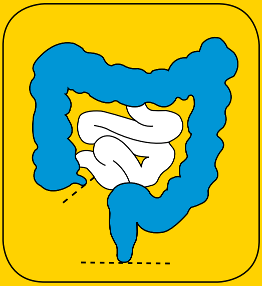
Transverse colectomy
The middle part of the colon is removed.



Sigmoid colectomy
The sigmoid colon is removed.



Subtotal or total colectomy
Most or all of the bowel is removed.



Proctocolectomy
All of the colon and rectum are removed.

**If the transverse colon is also removed, it is an extended right or left hemicolectomy. For information about anterior resections, see page 32.*

If the cancer is attached to another organ, the surgeon may also remove that organ during surgery to get rid of all of the cancer. This is called an en-bloc resection.

If there are two cancers

In a small number of people, two separate cancers may be found in the large bowel at the same time. The cancers may be discovered through diagnostic tests or during surgery. In this case, there are three options for surgery:

1. Remove two sections of the bowel.
2. Remove one larger section of the bowel, containing both areas with the cancer.
3. Remove the entire colon and rectum (proctocolectomy) to prevent any chance of another cancer forming.

The type of surgery you have depends on your doctors' recommendations and what you want.

Local excision

People who have early stage tumours or are not fit for a major operation may have a local excision. During this operation, the surgeon removes the cancer through an instrument inserted into the rectum or colon. This is done instead of cutting into the abdomen.

The different types of local excision include transanal excision, transanal endoscopic microsurgery (TEMS) and, less commonly, a colonoscopic excision. The type of surgery you have will depend on the location of the cancer.

Surgery for cancer in the rectum or anus

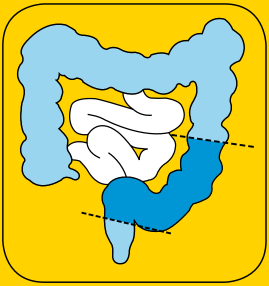
If you have rectal or anal cancer, you may be advised to have an abdominoperineal resection/excision or anterior resection.

The type of operation you have depends on where the cancer is located. This will also determine whether the bowel can be rejoined, and where in the rectum the join can be made.

Resections in the rectum or anus*

Abdominoperineal resection or excision (APR or APE)

The sigmoid colon and entire rectum and anus are removed. Your doctor will use the descending colon to create a permanent stoma, and waste will be removed through this opening. After the operation, you will have two wounds: one on your abdomen and one where your anus was removed.

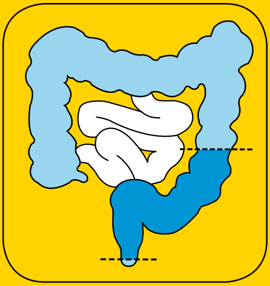


High anterior resection

The surgeon removes the lower left part of the colon and upper part of the rectum. Nearby lymph nodes and surrounding fatty tissue are also removed. The end of your bowel is rejoined to the top of the rectum.

Your surgeon will talk to you about the technique that will be used to do the operation: open style with a larger cut or minimally invasive (see page 28).

Some surgeries lower in the bowel can cause nerve injury, leading to conditions such as erectile dysfunction. If you are concerned about this, discuss it with your surgeon.



Ultra-low anterior resection

The lower left part of the colon and the entire rectum are removed, along with nearby lymph nodes and surrounding fatty tissue. The end of the bowel is joined to the lowest part of the rectum, just above the top of the anal canal. In some cases, the surgeon may also create an internal pouch (called a colonic J-pouch) using the lining of the large bowel. The J-pouch will be connected to the anus and will work as a rectum. You may have a temporary stoma made from the part of the small bowel (ileostomy), which will be reversed once your J-pouch heals.

**The area shaded dark blue will be removed by the surgeon.*

Surgery for cancer that has spread

If the cancer has spread to other parts of the body, you may still be offered surgery. This can help control or slow the growth of the cancer. The surgeon may remove:

- small secondary cancers (e.g. in the liver or lungs)
- a blockage in the bowel (see opposite)
- cancerous parts of the bowel that are attached to another organ, such as the uterus or bladder, which can be caused by inflammation or cancer spreading.

The operation may involve the removal of parts of the bowel along with all or part of other organs.

In rare cases, a woman may need to have her uterus removed (hysterectomy). This means she can no longer have children naturally. Your doctor will discuss your fertility with you before the surgery and can refer you to a counsellor or fertility specialist if you wish.

Your medical team will discuss what kind of follow-up and treatment is recommended after sugery. Most people have regular check-ups for the rest of their life because the chance of developing another primary cancer is higher than average.

The type of operation you have for advanced bowel cancer will depend on your individual situation, so talk to your surgeon about what to expect. You can also call the Helpline for more information.

Bowel obstruction

Some people with bowel cancer can get a blocked bowel as the cancer grows. This is called a bowel obstruction. It causes uncomfortable symptoms, such as pain, nausea, vomiting and constipation.

Surgery to remove the cancer may help unblock the bowel. In some cases, this may mean you will need a stoma (see pages 45–46).

Not everyone with a blockage will want an operation or be fit enough to have it. Your surgeon will discuss the options with you.

If you cannot have surgery or choose not to have it, your surgeon may be able to put in a small tube (stent) to help keep the bowel open. In this procedure, the surgeon inserts the stent through the rectum using an endoscope.

You will stay in hospital for one or two nights after having a stent inserted so you can be monitored. Your symptoms will usually clear up quickly once the stent is in place.

If you are unable to have surgery or a stent, you may be given some hormone medication to help control the symptoms of a bowel obstruction. You may also be given medication to help with feelings of discomfort.

For more information about bowel obstruction and stenting, call Cancer Council Helpline **13 11 20** or talk to your medical team.

Recovery after bowel surgery

The recovery time after bowel surgery varies, depending on the type of surgery. You will probably be in hospital for 5–7 days, but it can take 2–3 months to fully recover.

At first, you will need some pain relief. This may be given by an injection into your spine (epidural anaesthetic), which dulls the feeling below your waist. Some people have morphine by a slow injection into a vein (infusion). Other people will have patient-controlled anaesthesia (PCA). The PCA system allows you to control the dose of pain relief yourself.

You will receive fluids through a drip (intravenous infusion) until you are able to start eating and drinking again. You may need fluids for a few days.

While in hospital, and when you return home, you may have some of the following side effects:

- **Blood clots –** People who have abdominal surgery are at risk of developing blood clots in their legs, which can be life threatening. During surgery, your surgeon may apply pressure to your calves using compression stockings. Afterwards, you may be given regular injections of a blood-thinning substance. It is important to get out of bed and walk around as soon as you are able, and to move your legs if you are bedridden.

- **Chest infection –** You may be instructed to do deep breathing exercises to prevent getting a chest infection.

- **Changes in bowel function –** Many people find they have softer and more frequent bowel movements. You may find that you need to go to the toilet as soon as you feel the urge. Bowel function usually improves within a few months, but for some people, it can take longer. It may help to talk to your surgeon, a continence nurse or dietitian. See page 44 for more details.

- **Fatigue –** Try to get plenty of rest and only do what is comfortable. You may have to remind your family and friends that you are still recovering, even several months after surgery.

- **Changes in your diet –** See the *Diet after treatment* section (page 50) for information about your diet after an operation for bowel cancer.

> “I was in hospital seven days after surgery. At first, I was on a drip, and then I was on a liquid diet until I had a bowel motion. This meant soup, soup and more soup, followed by jelly, juices and hot beverages.” *Fiona*

Chemotherapy

Chemotherapy is the treatment of cancer with anti-cancer (cytotoxic) drugs. The aim of chemotherapy is to kill cancer cells while doing the least possible damage to healthy cells.

If the cancer is contained inside the bowel, surgery is usually the only treatment needed and chemotherapy is not used.

Chemotherapy may be used for the following reasons:

- **Neo-adjuvant therapy –** Some people who have surgery have chemotherapy (and/or radiotherapy, see page 40) beforehand to shrink the tumour and make it easier to remove during surgery.

- **Adjuvant chemotherapy –** Chemotherapy is often recommended for people after surgery if the cancer hasn't been completely removed or if it has spread into the lymph nodes. Chemotherapy may be given if there is a chance the cancer could come back, or as treatment if the cancer does come back.

- **Palliative treatment –** If the cancer has spread to other organs, such as the liver or bones, chemotherapy may be used to reduce your symptoms and make you more comfortable (see page 42).

If you have chemotherapy after surgery, you will probably have 6–8 weeks to recover. You will start chemotherapy when your wounds are healed and you are strong enough.

Chemotherapy drugs are usually injected into a vein (given intravenously) or supplied in tablet form. Some people have a small medical appliance called a port-a-cath or catheter placed beneath their skin through which they receive chemotherapy. You will probably have sessions of chemotherapy over several weeks or months. Your medical team will work out your treatment schedule.

Your doctor may advise you to use contraception during chemotherapy, due to the effects of the drugs. See page 63.

Side effects

Some chemotherapy drugs can cause side effects. The side effects depend on the drugs used and the dosage levels. The most common side effects include:

- tiredness
- feeling sick (nausea)
- diarrhoea
- mouth sores and ulcers
- loss of appetite
- sore hands or feet
- a drop in levels of blood cells
- skin peeling and increased sensitivity to sunlight, particularly for people who are given a type of chemotherapy called fluorouracil (or 5FU).

People react to treatment differently – some people may have few side effects while others have many. Most side effects are temporary, and there are ways to prevent or reduce them. Your doctor may prescribe medication to manage the side effects, arrange a break in your treatment, or change your treatment.

For more information about chemotherapy and its side effects, call the Helpline for a free copy of *Understanding Chemotherapy*.

During chemotherapy, you will have a higher risk of getting an infection and bleeding. Tell your doctor if you feel more tired than usual, or if you bruise or bleed easily. If you have a temperature over 38°C, contact your doctor or go to the emergency department.

Radiotherapy

Radiotherapy uses high-energy x-rays or electron beams (radiation) to kill or damage cancer cells. The radiation is targeted to cancer sites in your body, and treatment is carefully planned to do as little harm as possible to your normal body tissue around the cancer.

Radiotherapy is often part of the treatment for rectal cancer. It can also be given:

- before or after surgery, to reduce the chance of the cancer coming back
- instead of surgery
- at the same time as chemotherapy (chemoradiation)
- as a palliative treatment (see page 42).

During treatment, you will lie under a machine that delivers x-ray beams to the treatment area. Each treatment only takes a few minutes once it has started, but setting up the machine and seeing the radiation oncologist may take more time.

If radiotherapy is given along with chemotherapy for rectal cancer, you will probably have it once a day, Monday to Friday, for about 5–7 weeks. You may have a shorter course of radiotherapy if it is given by itself. The number of treatments you have depends on your radiation oncologist's recommendation.

For more free information about radiotherapy and its side effects, call **13 11 20** or visit your local Cancer Council website.

Side effects

Radiotherapy can cause temporary and permanent side effects. Side effects of radiotherapy may include:

- bleeding
- diarrhoea
- nausea
- tiredness or fatigue
- mild headaches
- urinary or faecal incontinence (see page 44)
- redness and soreness in the treatment area
- reduced fertility (see below).

People react to treatment differently, so some people may have few side effects while others have many. Tell your treatment team about the side effects you have so they can give you advice about how to manage them.

Effects on ability to have children (fertility)

Radiotherapy to the pelvis and rectum can affect your fertility.

For men, radiotherapy can damage sperm or reduce its production. This may be temporary or permanent. Some doctors suggest that men avoid trying to make a baby (conceiving) naturally for six months after radiotherapy treatments have finished. If you want to have children or are unsure what your plans are, you may be able to store sperm before treatment starts for future use.

Some men have erection problems because the radiotherapy damages the surrounding blood vessels and not enough blood is able to fill the penis. Your doctor may prescribe medication to reduce this problem.

For women, radiotherapy may lead to damage and shrinking of the vagina, making sexual intercourse difficult. It can also cause early menopause and infertility if the ovaries receive some of the radiation.

If you go through menopause and are no longer able to have children naturally, you may feel very upset and worry about the impact on your relationship. Even if your family is complete, you may have mixed emotions. Talking to your partner, a counsellor or a fertility specialist about your options can help.

Palliative treatment

Palliative treatment helps to reduce symptoms of cancer without trying to cure the disease. It is particularly important for people with advanced cancer. However, it is not just for people who are about to die and it can be used at different stages of cancer to improve your quality of life.

Treatment may help with pain relief and stopping the spread of cancer, but it can also involve the management of other physical and emotional symptoms. Treatment may include radiotherapy, chemotherapy or other medication.

For more information, call the Helpline for free copies of resources about palliative care and living with advanced cancer.

Key points

- Surgery is the most common treatment for bowel cancer. You may also have chemotherapy or radiotherapy.

- The type of surgery you have depends on where the cancer is in the bowel, the type and size of the cancer, and whether it has spread. Your surgeon will explain the procedure and any possible complications.

- The most common type of colon surgery is a colectomy. There are different types of colectomies depending on the tumour's location. People with rectal or anal cancer may have a type of surgery known as an anterior resection.

- The surgeon makes a cut in the abdomen, removes the section of the bowel affected by cancer and where possible joins the two ends of the bowel back together.

- If it is not possible to join the bowel ends, one end will be brought out onto an opening to the outside of the body (stoma). Waste (faeces) will pass through this stoma into a bag.

- Sometimes a temporary stoma may be created to allow the bowel time to heal. It is usually reversed in a later operation.

- In some cases, you may be able to have minimally invasive surgery (keyhole surgery) or a local excision.

- Chemotherapy is treatment with drugs. It may be used before or after surgery, if the cancer has spread or if there is a chance the cancer will come back.

- Radiotherapy is treatment with x-rays. It is often part of the treatment for rectal cancer.

Coping with dietary and bowel changes

After treatment for bowel cancer, many people find that they need to adjust to changes to their digestion or the way their bowel functions.

While you don't have to follow a strict diet after treatment, many people find that certain foods cause them discomfort and could make bowel problems worse.

Incontinence

The movement of waste through the large bowel can become faster after surgery or radiotherapy. This can mean you need to go to the toilet more urgently and more often. It may also result in a loss of control over bowel motions (faecal incontinence).

An operation or radiotherapy may weaken the anus, making it difficult to hold on when you feel the need to empty your bowels.

It is common to have difficulty controlling when you pass urine (urinary incontinence), urinating more often or not emptying the bladder fully. For example, radiotherapy to the pelvis can irritate the lining of your bladder, which is near your large bowel. This can cause temporary urinary incontinence.

If you experience bladder or bowel changes, you may feel embarrassed. However, both faecal and urinary incontinence usually improve with time and there are ways to manage your symptoms. Talk to your health care team about whether the changes to your bowel or bladder habits are likely to be permanent.

tips

- Go to the toilet frequently, to empty your bladder or bowels.
- Carry an extra pair of underwear and some non-alcohol cleansing wipes in case you soil yourself.
- Consider wearing a continence pad or disposable undergarment.
- Ask your doctor for any medications to treat continence problems.
- If the skin around the anus or bottom is sore, itchy or broken, ask your doctor or pharmacist for advice on using a suitable cream to soothe and heal it.
- Talk to a dietitian about changes to your diet that may help reduce incontinence.
- Visit **www.toiletmap.gov.au** to locate public toilets.
- Contact the Continence Foundation of Australia for support and additional information, such as advice on strengthening exercises. Visit the website **www.continence.org.au** or call **1800 33 00 66**.

Having a stoma

A stoma is a surgically created opening in the abdomen through which part of the bowel is attached. Some people need a stoma after bowel surgery, which may be temporary or permanent, so that waste can be removed from the body.

A temporary stoma is only needed until the newly joined bowel has healed. The surgeon will determine the safest time to close your stoma. Less than 10% of people with bowel cancer need a permanent stoma.

The two types of stoma are:

- **colostomy –** the most common type of stoma, created from an opening in the large bowel
- **ileostomy –** a stoma created from an opening in the small bowel.

A stoma is soft, moist and red or pink in colour as it is formed from the same type of tissue as the inside of the mouth. It may be level with your skin or slightly raised. The stoma itself doesn't have any feeling, but the skin around it does.

Stomas vary in size and can change shape in the first six months following surgery. A stomal therapy nurse can give you advice about any changes to your stoma or the skin surrounding it. See page 50 for information about nurses.

How the stoma works

When the bowel moves, wind and waste material (faeces) come out through the stoma. A small, disposable, flat plastic bag is worn on the outside of the body to collect this waste. This is called a stoma bag or an appliance.

Stoma bags have adhesive on the back, so they should stick firmly to the skin and provide a leak-proof, odour-proof system. They are usually not visible under clothing.

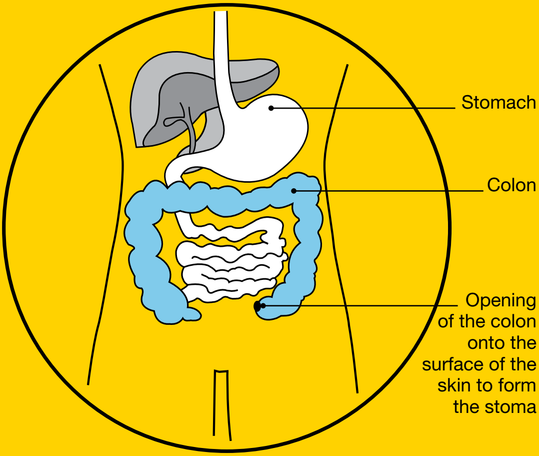
Attaching the bag – Your stomal therapy nurse will help you choose an appliance suitable to your lifestyle. For example, in humid weather or during vigorous physical activity, you may need to use extra stoma paste or powder to secure the bag.

Emptying the bag – When the bag is about one-third full, you will empty the contents down the toilet. Some bags are drainable, while others need to be changed each time there is a bowel movement. Discard stoma bags in the rubbish bin instead of the toilet.

Some people don't like to wear bags. If you have a colostomy in your descending colon, you may be able to learn how to give yourself a type of enema (colostomy irrigation) to remove the waste once a day. Talk to your doctor and stomal therapy nurse about this option.

Colostomy

The most common type of stoma is a colostomy, which is a stoma from an opening in the colon.



Coping with a stoma

Having a stoma, even temporarily, is a big change in a person's life and takes some adjustment. However, thousands of Australians have a stoma and most lead a relatively normal life.

The stoma may sometimes impact on your travel plans, social life and sexual relationships, but these issues can be managed, especially with some forward planning. Unless your job or hobbies involve very strenuous labour, the stoma should not stop you from participating in your usual activities.

You may worry about how you will look and how other people will react to your appearance. Although the stoma bag may seem very obvious to you, most people won't notice anything is different unless you tell them. The stoma's location may make some clothes less comfortable (e.g. tight waistbands or belts) but you will generally be able to continue wearing your normal clothes.

You can discuss changes to aspects of your everyday life with a stomal therapy nurse (see page 50). Your family may also need information and support, and can be included in discussions with the stomal therapy nurse if you wish.

> “My colostomy bag came adrift a few times. I quickly learned to carry a stoma bag replacement kit with me, in case of emergency.” *Steve*

Stoma Appliance Scheme

The Australian Government has a Stoma Appliance Scheme, which provides free stoma supplies, such as bags and accessories, to Medicare cardholders with a temporary or permanent stoma who belong to a stoma association.

Visit the Department of Health and Ageing website at **www.health.gov.au** and type 'Stoma Appliance Scheme' into the search box for more information.

Support for people with a stoma

You will be signed up to a stoma association so you can obtain free appliances and related products, and also get ongoing support. There may be a small joining fee.

Stoma associations offer a variety of different services to members. This includes:

- information on all aspects of stoma care
- stoma-related products
- support groups for people of all ages
- a way to connect you to other people who have a stoma, which may help you adapt to the changes.

To find a stoma association in your state or territory, see the Australian Council of Stoma Associations website, www.australianstoma.com.au, or contact Cancer Council Helpline 13 11 20.

Stomal therapy nurses

If there is a chance you could need a stoma, the surgeon will probably refer you to a stomal therapy nurse before surgery. You can ask to see a stomal therapy nurse if you aren't referred.

Stomal therapy nurses are specially trained in stoma care. They can:

- talk to you about the best place for the stoma to be located
- answer questions about your surgery and recovery
- provide you with printed and audiovisual resources
- give you information about adjusting to life with a stoma, including how you will need to look after your stoma when you are out of hospital.

For more information, contact the Australian Association of Stomal Therapy Nurses on www.stomaltherapy.com, talk to an ostomy association (see page 49) or call the Helpline.

Diet after treatment

After treatment – particularly surgery – you won't have to follow a particular diet. However, you may find that some foods cause discomfort or diarrhoea (see opposite).

Your medical team may tell you about some foods to avoid, but foods can sometimes affect people differently, so you may be told to experiment to work out which foods cause problems for you. It is best to limit – not eliminate – these foods from your diet, as you may find that your tolerance improves over time.

The Australian Government's booklet, *Improving Bowel Function After Bowel Surgery*, provides some helpful tips. Visit the website **www.bladderbowel.gov.au** to download a copy.

Diarrhoea

Having loose or frequent bowel motions (diarrhoea) for long periods can be distressing. The fast movement of food through your bowel before your body can absorb the water and nutrients can make you dehydrated. If left untreated, this can be dangerous. Having diarrhoea that is hard to control can also make you feel tired.

Diarrhoea may be caused by different types of treatment:

- **Surgery –** If you have had part of your colon taken out, your bowel motions may be looser than you were used to. This is because the colon absorbs water to form your stools. With a shorter colon, the stools do not form as solidly as before. This may be an ongoing problem.

- **Radiotherapy –** Radiotherapy often causes diarrhoea. It can take several weeks to settle down after treatment has finished.

- **Chemotherapy –** This treatment can cause diarrhoea and nausea. These side effects will go away after treatment and you can gradually resume a normal diet.

Some people find it embarrassing to talk about having diarrhoea. You may worry that the diarrhoea means the cancer is still there or has come back. This is not usually the case after treatment for bowel cancer.

It is important to talk to your doctor and nurses about diarrhoea. They will discuss ways to help control it, such as using medication, changing your diet and replacing fluids. You may also be referred to a physiotherapist who specialises in bowel function.

Foods that make bowel motions too soft and more frequent

fruit (fresh or dried)	grapes, stone fruit, such as apricots, peaches and plums, and most berries
vegetables and legumes	capsicum, cabbage, onions, beans, peas, corn, broccoli, lentils, dried beans, baked beans, peas and Brussels sprouts
alcohol	beer, wine and spirits (can also cause dehydration)
bran, nuts, seeds and fibre	multigrain, wholemeal and high-fibre breads and some breakfast cereals, such as muesli
spicy foods	chilli and curry
caffeine	coffee, tea, chocolate and cola-type soft drinks and energy drinks
sugar-free foods and drinks	the sweetener sorbitol has a laxative effect

tips

- Avoid high-fibre foods, such as the foods listed on page 52.
- Reduce caffeinated drinks, such as tea, coffee, cola and chocolate milk.
- Avoid full-fat dairy foods, such as milk, butter, yoghurt and cream, and fried foods.
- Eat foods with less fibre, such as white rice, pasta, white bread, oats, rice-based cereal, potatoes, bananas, fish, eggs and lean meat.
- Well-cooked vegetables without seeds, husks or skin, such as carrots, potato and pumpkin, are good choices.
- Try to eat three small meals, rather than three large meals, and snack frequently. Eat and drink at regular intervals throughout the day.
- Drink plenty of water so that you don't become dehydrated.
- Treat or prevent dehydration with a rehydration drink, such as Gastrolyte®.
- Try to maintain a balanced diet so your body is nourished. If you have trouble eating a certain type of food, talk to a dietitian who can help you find the best diet.
- If your anus is sore, use a cream or ointment to soothe it.
- If you suspect that a certain food causes diarrhoea, avoid it for 2–3 weeks. Reintroduce one type of food at a time. If the diarrhoea flares up again, you may want to avoid that food.
- Having diarrhoea can be exhausting, so rest as much as possible and ask family or friends to help out with any chores you need to do.

Wind (flatulence)

Many people who have treatment for bowel cancer find that it makes them gassy. This can particularly be a problem after bowel surgery. Reducing the foods that produce wind may be helpful.

Foods that produce wind/gas

eggs	prepared any way
vegetables	broccoli, cabbage, onions, cauliflower, corn, asparagus and Brussels sprouts
legumes	lentils and beans
dairy products	strong cheeses and large serves of dairy products, such as milk and cream
fizzy (carbonated) drinks	some soft drinks and beer
raw and dried fruit	pears, dates, raisins, figs, prunes, grapes, pineapple, apples and bananas

tips

- Cut food into small, bite-sized pieces.
- Chew food slowly and thoroughly.
- When you have a drink, take small sips.
- Try charcoal tablets, natural yoghurt and/or peppermint tea to reduce wind and odour.
- Ask your doctor about doing light exercise, which can relieve bloating and gas.

Blockages

For people with a stoma, some foods can cause blockages. This means solids, fluids and gas can't move through as they normally would. This can be uncomfortable.

Foods that can cause blockages

high-fibre foods	oranges, strawberries and apples
raw vegetables	coleslaw, celery, carrot and tomatoes
cooked vegetables	spinach, green beans, broccoli and cauliflower
seeds or kernels	popcorn, nuts, coconut and corn
spicy foods	chilli and curry
fruit and vegetable skins	apples, grapes and tomatoes
meat casing	sausages

tips

- Eat regular meals.
- Try to maintain a balanced diet so your body is nourished.
- Chew food slowly and thoroughly.
- Cut food into small pieces.
- Drink up to eight glasses of fluid a day to stay hydrated.
- If you have trouble eating a certain food, talk to a dietitian about your diet.

Key points

- After treatment for bowel cancer most people find their bowel functions change.
- You may need to go to the toilet more urgently or lose control over bowel motions (faecal incontinence).
- There are many ways to manage incontinence. For support and information contact the Continence Foundation of Australia at **www.continence.org.au**.
- Some people will need to have a stoma, which is a surgically created opening in the abdomen. Waste (faeces) passes out of the body through this opening. The two types of stoma are a colostomy, which takes part of the large bowel out to the abdomen, and an ileostomy, which creates a stoma from the small bowel.
- A stoma may be temporary or permanent.
- A stomal therapy nurse will answer any questions you have and help you adjust to life with a stoma.
- Membership to an ostomy association entitles you to free stoma supplies through the Australian Government's Stoma Appliance Scheme.
- Diarrhoea and wind are common problems following treatment for bowel cancer. You may need to change some foods in your diet, especially if the diarrhoea or wind is ongoing, or if you have a blockage.
- It is important to drink plenty of fluid throughout the day so you don't get dehydrated and to reduce constipation and blockages.
- A dietitian can give you advice on removing certain foods from your diet and tell you if and when to reintroduce them.

Making treatment decisions

Sometimes it is difficult to decide on the right treatment. You may feel that everything is happening so fast you don't have time to think things through. If you are feeling unsure about your options, check with your doctor how soon your treatment should start, and take as much time as you can before making a decision.

Understanding details about the disease, the available treatments and their possible side effects will help you make a well-informed decision. This decision will also take into account your personal values and the things that are important to you and your family. It is common to feel overwhelmed by information so it may help if you read and talk about the cancer gradually.

- Weigh up the advantages and disadvantages of different treatments, including the impact of any side effects.
- If only one type of treatment is recommended, ask your doctor why other choices have not been offered.
- If you have a partner, you may want to discuss the treatment options together. You can also talk to friends and family.

You have the right to accept or refuse any treatment offered by your doctors and other health care professionals. Some people with advanced cancer choose treatment even if it only offers a small benefit for a short period of time. Others want to make sure the benefits outweigh the side effects so that they have the best possible quality of life. Some people choose options that focus on reducing symptoms and make them feel as well as possible.

Talking with doctors

When your doctor first tells you that you have cancer you may not remember all the details about what you are told. You may want to see the doctor again before deciding on treatment. Ask for the time and support to make your decision.

If you have questions, it may help to write them down before you see the doctor. You can also check the list of suggested questions on page 73. Taking notes or recording the discussion can help too. Many people like to have a family member or friend go with them to take part in the discussion, take notes or simply listen.

If your doctor uses medical terms you don't understand, ask for an explanation in everyday language. You can also check a word's meaning in the glossary (see page 74).

tip

If you have several questions for your doctor, ask if it is possible to book a longer appointment.

A second opinion

Getting a second opinion from another specialist may be a valuable part of your decision-making process. It can confirm or clarify your doctor's recommendations and reassure you that you have explored all of your options.

Some people feel uncomfortable asking their doctor for a second opinion, but specialists are used to people doing this.

Your doctor can refer you to another specialist and send your initial results to that person. You can get a second opinion even if you have started treatment or still want to be treated by your first doctor. Alternatively, you may decide you would prefer to be treated by the doctor who provided the second opinion.

Taking part in a clinical trial

Your doctor may suggest you consider taking part in a clinical trial. Doctors run clinical trials to test new or modified treatments and ways of diagnosing disease to see if they are better than current methods. Over the years, trials have improved treatments and led to better outcomes for people diagnosed with cancer.

If you join what is called a randomised trial for a new treatment, you will be chosen at random to receive either the best existing treatment or the promising new treatment.

To help you decide whether or not to participate, you can talk to your specialist or the clinical trials nurse. If you're still unsure, you can also ask for a second opinion from an independent specialist. If you do decide to take part, you have the right to withdraw from the trial at any time; doing so will not jeopardise your ongoing treatment for cancer.

For more information about clinical trials and other research, including questions to ask your doctor and how to find a suitable study, call Cancer Council Helpline 13 11 20. You can also find trials on the website www.australiancancertrials.gov.au.

Looking after yourself

Cancer can cause physical and emotional strain. It can also impact on your body image, relationships and outlook for the future. It's important to take time to look after yourself by eating well, exercising, reducing stress and improving your wellbeing.

Healthy eating

Eating nutritious food will help you keep as well as possible and cope with cancer and treatment side effects. Depending on your treatment, you may have special dietary needs. See pages 50–55 for some tips for changing your diet to help with digestion. A dietitian can help you manage any eating difficulties, and choose the best foods and meals for your situation. Cancer Council Helpline can send you free information about nutrition and cancer.

Staying active

Research shows it is helpful to stay active and exercise regularly if you can. Physical activity, even if gentle or for a short duration, helps to improve circulation and digestion, reduce tiredness and elevate mood. The amount and type of exercise you do will depend on what you are used to, how well you feel and what your doctor advises.

If you aren't used to exercise or haven't exercised for a while, make small changes to your daily activities. You could walk to the shops, take the stairs, do some gardening or join a gentle exercise class. If you want to do more vigorous or weight-bearing exercise, ask your medical team what is best for you.

Complementary therapies

Complementary therapies are treatments that may help you cope better with side effects such as pain. They may also increase your sense of control over what is happening to you, decrease your stress and anxiety, and improve your mood.

There are many types of complementary therapies, such as herbal medicine, acupuncture, massage, relaxation and meditation. Some cancer treatment centres offer these therapies as part of their services, but you may have to go to a private practitioner. Self-help CDs or DVDs can also guide you through different techniques.

Let your doctor know about any complementary therapies you are using or thinking about trying. Some therapies may not be appropriate, depending on your medical treatment. For example, herbs and nutritional supplements may interact with your medication or surgery, resulting in harmful side effects. Massage, acupuncture and exercise therapies should also be modified if you have lowered immunity, low platelets or fragile bones.

Call Cancer Council Helpline for more information about complementary therapies and alternative therapies.

Alternative therapies are often defined as those used instead of conventional medical treatments. These therapies may be harmful if people with cancer delay or stop using medical treatment in favour of them. Examples are coffee enemas and magnet therapy.

Relationships with others

For many people, the experience of having cancer and any ongoing challenges causes them to make some changes in their life. You may also have a new outlook on your values, priorities, or life in general. Some people find that these changes can affect their relationships. However, sharing your thoughts and feelings with family, friends and colleagues may help to strengthen your relationships with them.

If you feel uncomfortable talking about your feelings, take your time and approach others when you are ready. People usually appreciate insight into how you are feeling and guidance on providing support during and after treatment. Calling Cancer Council Helpline may help you build your confidence to discuss your feelings with others.

Give yourself time to adjust to your cancer diagnosis, and do the same for friends and family. People often react in different ways, for example being overly positive, playing down fears, or keeping a distance. They are also dealing with the diagnosis and the changes. If someone's behaviour upsets you, it might help to discuss how you both feel about the situation.

Sexuality, intimacy and cancer

Having cancer can affect your sexuality in both physical and emotional ways. The impact of these changes depends on many factors, such as treatment and side effects, the way you and your partner communicate, the way you see your changed body, and your self-confidence. Knowing the potential challenges and addressing them will help you adjust to these changes.

Some people with cancer have the support of a partner, while others do not. If you meet a new partner during or after treatment, it can be difficult to talk about your experiences, particularly if the cancer has had an impact on your sexuality.

While sexual intercourse may not always be possible during and immediately after treatment, closeness and sharing can still be part of your relationship.

Many people with a stoma worry that the stoma will affect their ability to give or receive sexual pleasure or that the changes to their body are unattractive. In women, if the rectum is removed, there may be a different feeling in the vagina during intercourse. It may be uncomfortable, as the rectum no longer cushions the vagina. In men, creating a stoma usually involves removing part or all of at least one organ in the pelvic area. This may affect the nerves controlling erections.

Contraception

Your doctors may advise you to use certain types of contraception, such as condoms, for some time during and after treatment. This is to protect your partner and to avoid pregnancy, as some types of treatment, such as chemotherapy and radiotherapy, can be toxic to your partner or harm a developing baby. Ask your doctors what precautions to take.

Changing body image

Cancer treatment can change the way you feel about yourself (your self-esteem). You may feel less confident about who you are and what you can do. This is common whether your body has changed physically or not. You may feel self-conscious if you have a stoma or need to use incontinence pads, and you may wonder if people will notice. However, it is unlikely that people will be aware of this unless you tell them.

You may not feel like socialising, especially when you are getting used to any changes. Give yourself time to adapt and try to see yourself as a whole person (body, mind and personality) instead of focusing only on the parts of you that are different.

For practical suggestions about hair loss, weight changes and other physical changes, call Cancer Council Helpline.

Look Good...Feel Better program

Cancer treatments, such as chemotherapy and radiotherapy, can sometimes cause side effects such as hair loss and skin irritation. These changes can make you feel self-conscious.

Look Good...Feel Better is a free two-hour program for both men and women to teach them techniques using skin care, hats and wigs to help restore appearance and self-esteem during and after treatment.

Call **1800 650 960** or visit **www.lgfb.org.au** for more information and to book into a workshop.

Life after treatment

Life after cancer treatment can present its own challenges. You may need to take some time to adjust to any physical and emotional changes.

You may have mixed emotions. Beforehand, you may have been busy with appointments and focused on treatment, but afterwards you may feel anxious or vulnerable. You might worry about every ache and pain and wonder if the cancer is coming back.

Some people say that after cancer they have changed priorities and see life in a new way. For example, you may decide to travel, spend more time with family, or do volunteer work.

Although you might feel pressure to return to normal life, you may find that you don't want your life to return to how it was before cancer.

You might find it helpful to:

- take time to adjust to physical and emotional changes
- re-establish a new daily routine at your own pace
- spend time on a leisure activity you enjoy
- maintain a healthy diet and lifestyle
- schedule regular check-ups with your doctor
- share your concerns with family and friends and tell them how they can support you
- call Cancer Council Helpline 13 11 20 to connect with other people who have had cancer, or to request a free booklet about life after cancer.

If you have continued feelings of sadness, have trouble getting up in the morning or have lost motivation to do things that previously gave you pleasure, you may be experiencing depression. This is quite common among people who have had cancer.

Talk to your GP, as counselling or medication – even for a short time – may help. Some people are able to get a Medicare rebate for sessions with a psychologist. Ask your doctor if you are eligible. Your local Cancer Council may also run a counselling program.

The organisation beyondblue has information about coping with depression and anxiety. Go to www.beyondblue.org.au or call 1300 224 636 to order a fact sheet.

After treatment: follow-up

After your treatment, you will need regular check-ups to monitor your health and confirm that the cancer hasn't come back and there are no new cancers. You may have a physical examination, blood tests including checking CEA levels (see page 14), a scan or a colonoscopy.

Check-ups will become less frequent if you have no further problems. Between follow-up appointments, let your doctor know immediately of any health problems.

What if bowel cancer returns?

For some people bowel cancer does come back after treatment, which is known as a relapse or recurrence. This is why it is important to have regular check-ups.

If the cancer is confined to the bowel, it may be possible to surgically remove it. Removing the tumour can help relieve symptoms and, in some cases, may cure it.

If bowel cancer has spread beyond the bowel, you may be offered treatment, such as surgery or chemotherapy, to help control or slow the growth of the cancer. Sometimes small secondary cancers are removed from the liver or lungs.

If you have advanced bowel cancer, you may get a blocked bowel (bowel obstruction). For more information, see page 35.

Tumour ablation may also be used for secondary cancer in the liver. For more information, see Cancer Council's booklet *Understanding Cancer in the Liver*.

Seeking support

When you are first diagnosed with cancer, and during different stages of treatment and recovery, you may experience a range of emotions, such as fear, sadness, anxiety, anger or frustration. If sadness or anxiety is ongoing or severe, talk to your doctor.

It may help to talk about your feelings. Your partner, family members and friends can be a good source of support, or you might prefer to talk to:

- your treatment team
- a counsellor, social worker or psychologist
- your religious or spiritual adviser
- a support group or someone who has had a similar experience to you – see page 70
- Cancer Council Helpline.

If you need practical assistance, such as help around the house, it may be hard to tell people what would be useful. You might prefer to ask a family member or friend to coordinate offers of help.

You may find that while some people you know are supportive, others struggle to know what to say to you. If you have children, the prospect of telling them you have cancer can be unsettling. Cancer Council has a range of free resources to help people talk about cancer and deal with the emotions that cancer may bring up. Publications are available for people with cancer, partners, carers, children, friends and colleagues.

Call 13 11 20 for resources and support. You can also download booklets from the Cancer Council website.

Practical and financial help

A serious illness can cause practical and financial difficulties. Many services are available so you don't have to face these problems alone:

- Financial or legal assistance – through benefits, pensions and programs – may help pay for prescription medicines, transport costs to medical appointments, utility bills or basic legal advice.
- Meals on Wheels, home care services, aids and appliances can be arranged to help make life easier at home.
- Subsidised travel and accommodation may be available if you need to travel long distances for treatment.
- Home nursing care may be available through community nursing services or local palliative care services.

Ask Cancer Council Helpline or your hospital social worker, occupational therapist or physiotherapist which services are available in your area and if you are eligible to receive them.

Cancer Council library*

Following a cancer diagnosis many people look for information about new types of treatment, the latest research findings and stories about how other people have coped. Cancer Council has a range of books, CDs, DVDs and medical journals that may be helpful for you. Call the Helpline for more information.

** Not available in Victoria and Queensland*

Talk to someone who's been there

Coming into contact with other people who have had similar experiences to you can be beneficial. You may feel supported and relieved to know that others understand what you are going through and that you are not alone. There are many ways for you and your family members to connect with others for mutual support and to share information.

In these support settings, people often feel they can speak openly and share tips with others. You may find that you are comfortable talking about your diagnosis and treatment, your relationships with friends and family, and your hopes and fears for the future.

Ask your nurse, social worker or Cancer Council Helpline about suitable support groups and peer support programs in your area.

Types of support services*

Face-to-face support groups – often held in community centres or hospitals

Online discussion forums – where people can connect with each other at any time – see **www.cancerconnections.com.au**

Telephone support groups – for certain situations or types of cancer, which trained counsellors facilitate

Peer support programs – match you with a trained volunteer who has had a similar cancer experience, e.g. Cancer Connect.

** Not available in all areas*

Caring for someone with cancer

You may be reading this booklet because you are caring for someone with cancer. Being a carer can be stressful and cause you much anxiety. Try to look after yourself – give yourself some time out and share your worries and concerns with somebody neutral, such as a counsellor or your doctor.

Many cancer support groups and cancer education programs are open to carers, as well as people with cancer. Support groups and some types of programs can offer valuable opportunities to share experiences and ways of coping.

Support services such as Home Help, Meals on Wheels or visiting nurses can help you in your caring role. There are also many groups and organisations that can provide you with information and support, such as Carers Australia, the national body representing carers in Australia. Carers Australia works with the Carers Associations in each of the states and territories. Phone 1800 242 636 or visit www.carersaustralia.com.au for more information and resources.

You can also call the Helpline to find out more about different services and to request free information for carers and families looking after someone with cancer.

> “Caring for my mum was deeply emotional. It was difficult, but it gave me a tremendous sense of caring and giving.” *Sharyn*

Useful websites

The internet has many useful resources, although not all websites are reliable. The websites below are good sources of information.

Australian

Cancer Council Australia	**www.cancer.org.au**
Australian Association of Stomal Therapy Nurses	**www.stomaltherapy.com**
Australian Council of Stoma Associations	**www.australianstoma.com.au**
Bowel Cancer Australia	**www.bowelcanceraustralia.org**
Cancer Australia	**http://canceraustralia.gov.au**
Carers Australia	**www.carersaustralia.com.au**
Continence Foundation of Australia	**www.continence.org.au**
Department of Health and Ageing	**www.health.gov.au**
Department of Human Services	**http://humanservices.gov.au**
Dietitians Association of Australia	**www.daa.asn.au**
HealthInsite	**www.healthinsite.gov.au**
National Cancer Screening Programs	**www.cancerscreening.gov.au**
National Public Toilet Map	**www.toiletmap.gov.au**

International

American Cancer Society	**www.cancer.org**
Macmillan Cancer Support	**www.macmillan.org.uk**
National Cancer Institute	**www.cancer.gov**

Question checklist

You may find this checklist helpful when thinking about the questions you want to ask your doctor about your disease and treatment. If your doctor gives you answers that you don't understand, ask them to say it again using different words.

- What type of bowel cancer do I have?
- Where in the bowel is the cancer?
- Has the cancer spread? How fast is it growing?
- What treatment do you recommend and why?
- Are there other treatment choices for me? If not, why not?
- What are the risks and possible side effects of each treatment?
- Will I need a stoma? If so, will it be temporary or permanent?
- How long will treatment take? Will I have to stay in hospital?
- How much will treatment cost? How can the cost be reduced?
- Will I have a lot of pain with the treatment? What will be done about this?
- Are the latest tests and treatments for this type of cancer available in this hospital?
- Are there any clinical trials or research studies I could join?
- How frequently will I need check-ups after treatment?
- Are there any complementary therapies that might help me?
- Should I change my diet during or after treatment?
- If the cancer comes back, how will I know?

Glossary

You may come across new terms when reading this booklet or talking to health professionals. You can check the meaning of other health-related words at www.cancercouncil.com.au/words or www.cancervic.org.au/glossary.

abdomen
The part of the body between the chest and hips, which contains the stomach, liver, bowel, bladder and kidneys.

abdominoperineal (AP) resection
An operation for rectal cancer, which involves removing the rectum and anus and creating a permanent colostomy.

adjuvant therapy
A treatment given with or shortly after another treatment to enhance its effectiveness.

advanced cancer
Cancer that has spread into the surrounding tissues or away from the original site (metastasised).

anaemia
Deficiency in the number or quality of red blood cells.

anal sphincter
See sphincter.

anterior resection
A surgical procedure to remove cancer in the rectum.

anus
The opening at the end of the bowel where solid waste matter normally leaves the body.

appliance
See stoma bag.

ascending colon
The right side of the bowel.

barium enema
An examination of the bowel area using a white contrast liquid. It is inserted into the rectum and x-rays are taken.

benign
Not cancerous or malignant.

biopsy
The removal of a small sample of tissue from the body, for examination under a microscope, to help diagnose a disease.

bowel

In this booklet, the term bowel refers to the large bowel, which is also known as the colon.

bowel movement

Defecation. Evacuating waste matter from the bowels.

bowel obstruction

When the bowel is blocked so that waste matter is unable to pass through easily.

bowel preparation

The process of cleaning out the bowel (removing stools) before a test or scan to allow the doctor to see the bowel more clearly.

caecum

The pouch at the beginning of the large bowel that receives waste from the small bowel.

carcinoembryonic antigen (CEA)

A protein that may be in the blood of a person with bowel cancer.

catheter

A hollow, flexible tube through which fluids can be passed into the body or drained from it.

chemotherapy

The use of cytotoxic drugs to treat cancer by killing cancer cells or slowing their growth.

colectomy

A surgical procedure in which cancerous areas of the colon are cut out and the healthy parts are sewn back together. Types of colectomies are named depending on the part of the colon removed. They include: right and left hemicolectomies, and transverse, sigmoid, subtotal and total colectomies.

colon

The main working area of the large bowel, where water is removed from solid waste. Its four parts are the ascending colon, transverse colon, descending colon and sigmoid colon.

colonic J-pouch

An internal pouch surgically created using the lining of the large bowel. It may be formed during an ultra-low anterior resection.

colonoscopy
An examination of the large bowel with a camera on a flexible tube (endoscope), which is passed through the anus.

colostomy
An operation in which the colon is connected through an opening in the abdomen (a stoma) to the surface of the skin.

Crohn's disease
A benign type of inflammatory bowel disease that may increase a person's risk of developing bowel cancer.

CT scan
A computerised tomography scan. This scan uses x-rays to build a picture of the inside of the body.

descending colon
The left side of the colon.

digital rectal examination
When a doctor inserts a gloved finger into the rectum to feel for any abnormalities.

endorectal ultrasound
A soundwave-generating device called a probe is inserted into the rectum, and a picture of the rectum appears on a screen.

endoscope
A flexible tube used to examine the bowel during a colonoscopy.

enema
A liquid solution that washes out the bowel.

faecal occult blood test (FOBT)
A test that checks stools for microscopic traces of blood.

faeces
See stools.

familial adenomatous polyposis (FAP)
A benign condition that causes polyps to form in the large bowel. The polyps will become cancerous if untreated.

fertility
The ability to conceive a child.

flatulence
Wind or gas.

gastrointestinal (GI) tract
The passage from the mouth to

the anus that allows a person to digest food and eliminate waste. The lower GI tract includes the colon and rectum.

incontinence
The accidental or involuntary loss of urine or faeces.

inflammatory bowel disease
A benign condition that causes inflammation of the bowel.

large bowel
Part of the lower GI tract. The large bowel stores waste until it is ready to be passed out of the body as a bowel movement. Its four main parts are the caecum, colon, rectum and anus.

local excision
A type of surgery for colon cancer. The surgeon inserts a tube (endoscope) through the rectum and into the colon, to cut out the cancer without cutting through the abdominal wall.

lymph nodes
Also called lymph glands. Small, bean-shaped structures that form part of the lymphatic system. They collect and destroy bacteria and viruses.

Lynch syndrome
A disease that increases the risk of developing bowel cancer. Previously called hereditary non-polyposis colorectal cancer (HNPCC).

malignant
Cancerous.

menopause
When a woman stops having periods (menstruating) and can't become pregnant anymore.

metastasis
A cancer that has spread from another part of the body. Also known as secondary cancer.

minimally invasive surgery
A surgical technique that involves several small cuts instead of one large cut on the abdomen. Also called laparoscopic or keyhole surgery.

MRI scan
A magnetic resonance imaging scan. It uses magnetism and

radio waves to take cross-sectional pictures of the body.

ostomy
See stoma.

palliative treatment
Medical treatment for people with cancer to help them manage pain and other physical and emotional symptoms.

polyp
A projecting growth from a surface in the body, such as the large bowel. Most polyps are benign, but they can become malignant.

primary cancer
The original cancer. Cells from the primary cancer may break away and be carried to other parts of the body, where secondary cancers may form.

proctocolectomy
The surgical removal of the entire colon and rectum.

prognosis
The expected outcome of a person's disease.

radiotherapy
The use of radiation, usually x-rays or gamma rays, to kill cancer cells or injure them so they cannot grow and multiply.

rectum
The last 15–20cm of the large bowel, which stores stools until a bowel movement occurs.

recurrent cancer
Cancer that has returned after treatment of the primary cancer. A recurrence may be local (in the same place as the primary) or distant (in another part of the body).

relapse
The return of a disease after a period of improvement.

remission
When the symptoms of the cancer reduce or disappear. A partial remission is when there has been a significant improvement in the cancer. A complete remission is when there is no evidence of active cancer.

screening
Testing members of the general public for signs of a disease.

sigmoid colon
The section of the colon after the descending colon and before the rectum and anus.

sigmoidoscope
The rigid or flexible tube used during a sigmoidoscopy.

sigmoidoscopy
An examination of the rectum and lower colon. In this procedure, a doctor inserts a sigmoidoscope into the anus.

small bowel
The middle part of the GI tract, which takes food from the stomach and absorbs nutrients.

sphincter
Strong muscles that form a valve. The anal sphincter muscles relax when a bowel movement occurs.

staging
The process of determining if the cancer is early or advanced.

stent
A tube placed into a blocked organ to create a passage for substances to pass through.

stoma (ostomy)
A surgically created opening to the outside of the body.

stoma bag
A pouch that collects waste from a colostomy or ileostomy. Also called an appliance.

stools (faeces)
Waste matter that normally leaves the body through the anus.

transverse colon
The section of the colon between the ascending and descending colon.

ulcerative colitis
A benign bowel disease that may increase a person’s risk of developing bowel cancer.

ultrasound
A non-invasive scan that uses soundwaves to create pictures.

virtual colonoscopy
A medical imaging procedure that uses a CT or MRI scanner to create and display images.

How you can help

At Cancer Council we're dedicated to improving cancer control. As well as funding millions of dollars in cancer research every year, we advocate for the highest quality care for cancer patients and their families. We create cancer-smart communities by educating people about cancer, its prevention and early detection. We offer many free practical and support services for people and families affected by cancer. All these programs would not be possible without community support, great and small.

Join a Cancer Council event: Join one of our community fundraising events, such as Daffodil Day, Australia's Biggest Morning Tea, Relay For Life, Girls Night In and Pink Ribbon Day, or hold your own fundraiser or become a volunteer.

Make a donation: Any gift, large or small, makes a meaningful contribution to our work in supporting people with cancer and their families now and in the future.

Buy Cancer Council sun protection products: Every purchase helps you prevent cancer and contribute financially to our goals.

Help us speak out for a cancer-smart community: We are a leading advocate for cancer prevention and improved patient services. You can help us speak out on important cancer issues and help us improve cancer awareness by living and promoting a cancer-smart lifestyle.

Join a research study: Cancer Council funds and carries out research investigating the causes, management, outcomes and impacts of different cancers. You may be able to join a study.

To find out more about how you, your family and friends can help, please call your local Cancer Council.

Cancer Council Helpline 13 11 20

Cancer Council Helpline is a telephone information service provided throughout Australia for people affected by cancer.

For the cost of a local call (except from mobiles), you, your family, carers or friends can talk confidentially with oncology health professionals about any concerns you may have. Helpline consultants can send you information and put you in touch with services in your area. They can also assist with practical and emotional support.

You can call Cancer Council Helpline 13 11 20 from anywhere in Australia, Monday to Friday. If calling outside business hours, you can leave a message and your call will be returned the next business day.

Visit your state or territory Cancer Council website

Cancer Council ACT
www.actcancer.org

Cancer Council Northern Territory
www.cancercouncilnt.com.au

Cancer Council NSW
www.cancercouncil.com.au

Cancer Council Queensland
www.cancerqld.org.au

Cancer Council SA
www.cancersa.org.au

Cancer Council Tasmania
www.cancertas.org.au

Cancer Council Victoria
www.cancervic.org.au

Cancer Council Western Australia
www.cancerwa.asn.au

UNDERSTANDING BOWEL CANCER

JAN 2013

For support and information on cancer and cancer-related issues, call Cancer Council Helpline. This is a confidential service.

Cancer Council
Helpline
13 11 20