

Bowel cancer investigation

Checking for bowel cancer doesn't have to be an intrusive experience



Mr Romi Navaratnam (left) did his training in Nottingham, Cambridge, London and Sri Lanka, prior to being appointed consultant colorectal and laparoscopic surgeon at the North Middlesex University

Hospital and honorary senior lecturer at the Royal Free Medical School in London in 2002. He is also based at The Hospital of St John & St Elizabeth and The Wellington Hospital.

His specialist interests include the investigation and management of gastrointestinal problems, such as irritable bowel syndrome (IBS), common anal conditions, including rectal bleeding, haemorrhoids (piles), fissures, fistulae and pruritus ani (itching of the anus).

He has a major interest in colonoscopy, endoscopy and undertakes laparoscopic (minimally invasive, keyhole) surgery for conditions of the gall bladder, appendix, groin and abdominal herniae and colorectal cancer, with extremely positive outcomes.

Bowel cancer awareness

This form of cancer remains a legitimate concern, with 30,000 cases diagnosed every year in the UK. It primarily affects people over the age of 50, however, a degree of caution is required when patients, irrespective of age, experience symptoms. UK cancer survival rates, despite a recent slight improvement, are decidedly worse in comparison to other European countries owing to the advanced stage of the disease at presentation. The UK colorectal cancer screening programme was introduced in an attempt to identify asymptomatic patients with early malignant lesions – and pre malignant polyps – and successfully remove them, thus improving long term prognosis.

High risk symptoms

- Rectal bleeding with loose stools which lasts for more than six weeks.



- Rectal bleeding in the absence of anal canal symptoms, eg peri anal itching.
- Increased frequency of passing stools which lasts for more than six weeks.
- Palpable abdominal or rectal mass.
- Iron deficiency anaemia.

Low risk symptoms

- Transient change in bowel habit for less than six weeks, eg constipation.
- Persistent abdominal discomfort (however, in people over the age of 50, there is a 10% association with intra-abdominal malignancy

detect flat or small lesions and the exposure to ionising radiation. Similar to flexible sigmoidoscopy a proportion of patients will require colonoscopy thereafter.

- Colonoscopy is the gold standard investigation. Removal of small polyps, haemorrhoidal injection or banding can be carried out simultaneously. As the procedure is undertaken under a light sedative, it tends to be better tolerated than flexible sigmoidoscopy or CT pneumocolon. There is a complication rate of 1:1100 (less so in experienced hands). Reassuringly, a diagnosis can be established immediately in most cases.

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and thus requires investigation). Vigilance is required in patients with established ulcerative colitis and in the presence of first degree relatives with bowel cancer, especially if diagnosed under the age of 60.

Choices after patient assessment

- Flexible sigmoidoscopy, a telescope test which, following an enema, examines 50 % of the colon. The right colon is not routinely examined and thus pathology can be missed.
- Virtual colonoscopy (VC) involves a scan and is ideal for elderly patients with vague symptoms, where the relevant pathology may not originate from the colon. Disadvantages include the need for pre-operative laxatives (similar to colonoscopy), discomfort upon introducing an insufflation tube into the anus, the inability to

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FOR MORE INFORMATION

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