

EFFECTIVE BOWEL CANCER SCREENING

Minimally invasive techniques, in particular colonoscopy, is the gold standard for investigating colonic concerns



Mr Romi Navaratnam trained at 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 2002. He is also based at The Hospital of St John & St Elizabeth and The Wellington Hospital. Romi's 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 (keyhole, minimally invasive) surgery for conditions of the gall bladder, groin and abdominal herniae, appendectomy and colorectal cancer.

Colorectal cancer remains a very common cancer with poor outcomes, if identified at an established stage. These concerns were the driving influence towards the introduction of a national screening programme, the aim of which is to identify asymptomatic patients with early cancers or pre-cancerous polyps and successfully remove them.

Faecal occult blood (FOB) stool testing

This is the least accurate investigation. If test results are positive, colonoscopy and endoscopy are mandatory.

Flexible sigmoidoscopy

Is a lesser examination than colonoscopy. Flexible sigmoidoscopy trial data suggests some cancers can be missed, as only 50% of the colon is examined. A proportion of individuals require colonoscopy at a later date.

Colonoscopy

A telescope is gently introduced into the colon under sedation after bowel preparation. A diagnosis can be established immediately, which if normal, is a strong means of reassurance. Therapeutic procedures, such as painless injection of haemorrhoids, poly



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removal or haemorrhoidal band application can be done simultaneously. The risk of complication is very low (1:1100) and is even less in experienced hands.

Virtual colonoscopy (VC)

Involves identical pre-operative laxative preparation as conventional colonoscopy and the introduction of a tube into the anus. It is useful in the establishment of coincidental pathology outside of the colon, especially in frail patients.

The major disadvantage of VC is, it's less accurate than colonoscopy, with an increased incidence of missed pathology. Any lesion established on VC, eg polyps, requires subsequent colonoscopy and there are concerns with regards to radiation exposure.

Benefits of screening

Screening has a proven history in the USA and Europe, where the incidence of colorectal cancer is falling. The most accurate diagnostic

tool remains colonoscopy, with VC reserved primarily for elderly patients. On direct comparison, patients stated colonoscopy was better tolerated than VC.

Identification of early disease improves long-term prognosis. This is relevant in patients with a family history of colonic problems. Where indicated, laparoscopic surgery is routinely undertaken, which leads to enhanced recovery with minimal lifestyle disruption and a rapid return to normal activity.

FOR MORE INFORMATION

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