

COLON CANCER MANAGEMENT

Management of colon cancer in this practice is completed using the NCCN (National Comprehensive Cancer Network) guidelines. To cure a colon cancer, surgery is the main treatment, and the typical operation is called a segmental resection. During the procedure, the cancer and a length of normal tissue on either side of the cancer as well as the nearby lymph nodes, and the blood supply to the area are removed. This is based on the fact that tumors can spread through the lymphatics to the lymph nodes and through the blood vessels to other parts of the body. In the case of colon cancer, the liver and lungs are the most common organs that tumors metastasize to.

The location of the tumor, more than the size, impacts the decision making for how much colon should be removed, because of the theoretical blood supply to and drainage from the area around the tumor. A tumor of the cecum (beginning of the colon) or the ascending colon would be managed by a Right Hemi-colectomy (removing the right side of the colon). A Right Hemi-colectomy, or an extended Right Hemi-colectomy could also manage a tumor of the beginning of the Transverse colon, while a tumor of the end of the Transverse colon would be managed by a Left Hemi-colectomy (removal of the involved portion of the Transverse colon along with the entire Descending colon). A tumor of the mid portion of the Transverse colon would be managed by a sub-total colectomy, (removal of the entire Right colon, Transverse colon and Descending colon) because the blood supply to and drainage from this area can spread out in opposite directions. The remaining sections of the colon are then re-attached. A tumor of the sigmoid colon involves removing the sigmoid colon and re-attaching the descending colon to the top of the rectum. A colon resection rarely causes any major problems with digestive functions, but it usually takes several days after surgery for the bowels to start functioning again.

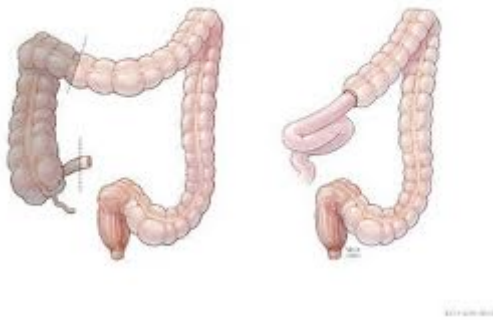
In those unusual situations where a tumor has penetrated the colon wall and spread into other organs, such as the small intestine or the abdominal wall, a wider resection with en bloc removal (removed without opening up the planes of the tumor to the attached tissue) is undertaken. This type of removal will help to keep tumor cells from spreading further.

Occasionally, a temporary colostomy may be needed. This situation may arise with an obstructing cancer, whereby the colon could not be cleaned out prior to the operative procedure so that the chances for a leak from the re-attachment are greater than normal. A colostomy is an opening in the abdominal wall for getting rid of body wastes, into a bag. More rarely, a permanent colostomy may be needed for patients in poor health who are unable to tolerate a more extensive operation.

After the surgical procedure, a pathologist, examines the removed specimen to determine the depth of penetration of the tumor into or through the bowel wall, and to determine if there is any lymph node involvement. If lymph node involvement were present, than the next step would be evaluation by an Oncologist (a cancer specialist) to discuss the need for additional treatment by chemotherapy.

In our practice, we follow all of our colon and rectal cancer patients on a regular basis. They will be typically seen every 3 months for the first 2 years (about 80% of recurrent cancer occurs during this time period), every 4 months during the third post operative year, every 6 months for the 4th and 5th years out and yearly after that. We will plan on a 3 month and 1 year CT scan, a 1 year colonoscopy, and CEA levels every visit if the CEA was elevated prior to surgery.

Right Hemicolectomy



Left Hemicolectomy



Sigmoid Colon Resection

