Royal United Hospital Bath NHS
NHS Trust

RUH

Information for Patients

Treatments for Bowel Cancer

Healthcare you can Trust

Contents

The Colorectal Team

These are the people in the Colorectal team who you may meet when you come in for treatment or an appointment at the hospital:

Colorectal Nursing Department	01225 825836

Colorectal Nurse Specialists:
Siobhan John
Allison Rossiter
Lorraine Young

Co-ordinator:
Lucinda Knight

Colorectal Surgeons:	
Mr Stephen Dalton	01225 824922
Mr Anthony Holbrook	01225 824545
Mr Jeremy Tate	01225 824543
Mr Michael Williamson	01225 824922

Oncologists:	
Dr Emma De Winton	01225 824797
Dr Louise Medley	01225 824797
Dr Gareth Rees	01225 824321
Chemotherapy Suite	01225 824852
Radiotherapy Reception	01225 825910

Stoma Care Nurse Specialists:	01225 824056
Hazel Brooks	
Louise Jeffery	
Bart Tappe	

Introduction

This booklet is intended to support any information you have been given by your doctor or colorectal nurse specialist (CNS) regarding your forthcoming treatment and/or operation and your recovery and ongoing care.

More detailed information on all aspects of your cancer can be obtained from Macmillan (contact details are given at the back of this booklet).

Within the Royal United Hospital Bath (RUH) there is also a Cancer Information and Support Centre. This centre can provide you with information and advice regarding financial help, benefits and counselling support.

Medical words and terms can be found with an explanation in the glossary on page 27.

Your planned operation is:

……

Your surgical consultant is:

……

Your colorectal nurse specialists (CNS) are:

- Siobhan John
- Lorraine Young
- Allison Rossiter

The CNS will co-ordinate all your tests and results and support you in your on-going care.

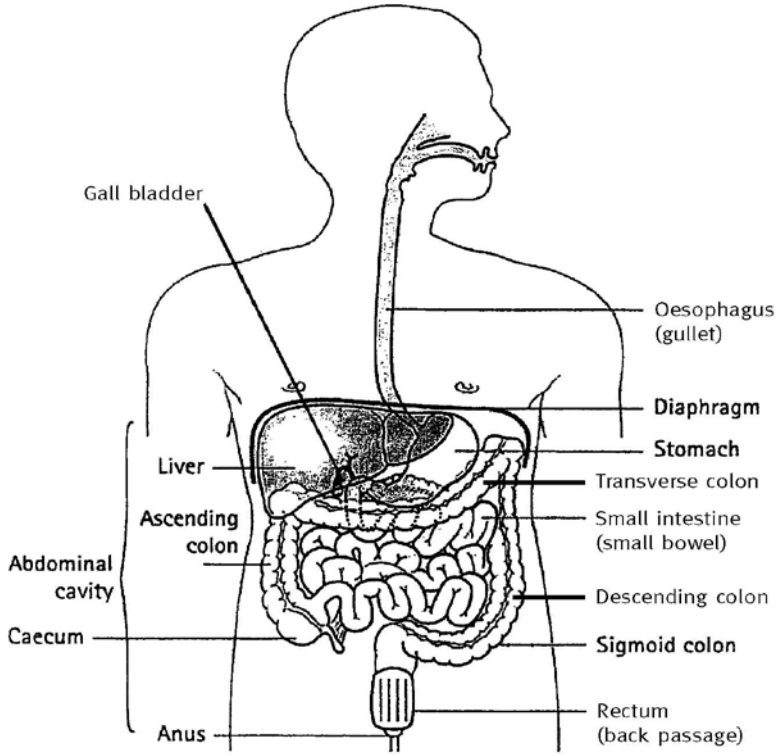
If you have any questions please contact the Colorectal Nursing Department between 9am and 5pm on week days.

If you need to leave a message, they will aim to return your call within 24 hours.

Alternatively you can ring the hospital switchboard on 01225 428331 and ask for them to be contacted via their bleep:

Lorraine Young/Siobhan John	- bleep number 7972
Allison Rossiter	- bleep number 7844

What is the Large Bowel?



The digestive system – which is also known as the gastro intestinal tract – breaks down, digests and absorbs food, and removes solid waste from the body.

The digestive system is a continuous muscular tube which extends from the mouth to the anus. Food is put into the mouth and chewed and then passes down the gullet (oesophagus) to the stomach and into the small bowel.

As food passes through the small bowel it is digested and essential nutrients are absorbed by the body. From here food passes into the large bowel (colon).

The colon is 1 metre in length and is divided into four segments: ascending colon, transverse colon, descending colon and sigmoid colon.

The main functions of the colon are the absorption of water, bile salts and electrolytes from food, and the storage of waste matter.

The waste (stool or faeces) moves along all four segments of the colon and passes out of the rectum (back passage) via the anus as a bowel movement. The rectum is about 20cm long and acts as an internal reservoir to hold the stool.

Diagnostic Tests

It may be necessary for you to have one or more of the following investigations:

Blood tests

Blood tests are taken to check your general health.

Colonoscopy

This test allows the doctor to look directly at the lining of the large bowel (colon). In order to do the test a long flexible tube which has a camera and a bright light at the end is passed through the anus to the large bowel.
If anything abnormal is found the doctor can take a small sample of tissue (a biopsy) for analysis. To allow a clear view of the bowel the colon must be completely empty of waste material.
To ensure that the bowel is empty when you come in for this test, you will be sent dietary advice and a laxative to take at home prior to admission.

Flexible Sigmoidoscopy

This test also allows the doctor to look directly at the lining of the large bowel (colon), but only the lower third of the bowel is examined.

Computerised Tomography (CT scan)

A CT scan is a special type of X-ray examination in which an X-ray machine is connected to a computer which produces cross-sectional images of the body.
For the scan we will ask you to lie on a table and be passed through the scanner which is a ring-like structure. A CT scan generally takes about 10-20 minutes and is completely painless.

You may be advised to arrive in the CT department an hour and a half before the CT is scheduled to take place as some patients will need to have a special drink which contains some X-ray dye to improve the quality of the scan pictures.

CT Colonogram (Virtual Colonoscopy)

In order to prepare for this type of scan, you will be asked to follow some instructions regarding diet for several days beforehand and take a laxative the day before the scan.

Once at the RUH, a small tube is placed just inside the rectum through which some air will be passed to inflate the bowel. You may also be given a small injection into your arm which has the effect of relaxing the bowel muscle.

Some harmless carbon dioxide gas is introduced into the rectum in order to inflate the bowel. No sedative is given. Two scans are then taken, one with you lying on your tummy and one with you lying on your back.

Each CT scan takes about 20 seconds and you will be asked to hold your breath during this. The whole examination takes about 20 minutes.

MRI – Magnetic Resonance Imaging Scan

MRI uses a strong magnetic field to produce detailed images of the rectum and sometimes the liver. The scanner uses a large cylindrical magnet which surrounds the patient in the form of a large tunnel. This is painless and takes 30-40 minutes.

Multi-disciplinary team meeting

Once you have had all of your tests, your case will be discussed at a multi-disciplinary team meeting (MDM). This meeting takes place on a Thursday morning and involves a group of specialist doctors: surgeons, oncologists, gastroenterologists, radiologists, pathologists and the colorectal nurses.

All the relevant treatment options will be considered and an individual treatment plan will be developed which will be discussed with you at your outpatient appointment.

Outpatient appointment

At your first outpatient appointment with a consultant colorectal surgeon you will also meet a colorectal nurse specialist (CNS) who specialises in bowel cancer.

Prior to your outpatient appointment you may already have had some investigations. The consultant will explain the results of your investigations and discuss your options and treatment plan with you.

Within 1-2 weeks of your appointment your GP will receive a letter summarising this consultation. You may also request a copy of this letter for your own records.

Treatment options

Radiotherapy for Rectal Cancer

Radiotherapy treats cancer by using high-energy rays to destroy cancer cells while doing as little harm as possible to normal cells. Radiotherapy isn't painful but you do have to be still for a few minutes during treatment. Radiotherapy doesn't make you radioactive and it is perfectly safe for you to be with other people including children throughout your treatment.

Radiotherapy may be given before your surgery to shrink a cancer and make it easier to remove. It may also reduce the chance of the cancer coming back. Your doctor will discuss with you whether a short course or long course of radiotherapy is recommended.

A short course of radiotherapy consists of five daily treatments given over a week just before your surgery.

A long course of radiotherapy is given every weekday for five weeks. This is usually given with chemotherapy, which can help make the radiotherapy more effective.

If radiotherapy treatment is recommended for you an outpatient appointment with an oncology consultant will be arranged to discuss this treatment in more detail. Please ask any questions that you have at any stage of your treatment.

Chemotherapy

Chemotherapy is the use of special anti-cancer drugs designed to kill cancer cells. The decision to use chemotherapy depends on the extent (stage) of the cancer and can be used on its own, alongside radiotherapy or after surgery.

Chemotherapy is usually given as a series of sessions of treatment, each session being followed by a rest period – this is known as a 'cycle' of treatment. Chemotherapy used to treat bowel cancer can be given by mouth (in the form of capsules or tablets) or by injection into the vein (as an injection or infusion).

An oncology consultant and chemotherapy nurse will discuss this treatment in detail if it is recommended for you.

Colonic Stent Insertion

If your bowel is partially or completely obstructed and surgery is not recommended then your doctor may suggest that you have a colonic stent inserted. A colonic stent is a small flexible, hollow tube that is inserted into your rectum. Once in place the stent expands to re-open the blocked section of bowel.

Your doctor will discuss this procedure with you in detail and you will be asked to sign a consent form. The procedure takes place in the X-Ray department and takes approximately 60-90 minutes depending on your individual circumstances.
For more detailed written information about this procedure please contact the Colorectal Nurses.

Surgery

Pre-operative Assessment (POA) Clinic

Prior to your surgery you will receive a letter confirming an appointment in the POA clinic and a letter to confirm the date of your operation. The POA clinic is located on the first floor of zone B (B39) and the contact number is 01225 821604.

This appointment usually lasts 2 to 3 hours and we advise that you bring along a relative or close friend who can support you in planning your care and recovery. You will meet an Enhanced Recovery Nurse during this appointment. You will have a blood test and you will be asked some questions about your general state of health. You may meet an anaesthetist and be given written information about anaesthesia and types of pain relief including epidurals.

This is a good time to discuss any further questions that you may have about your operation.

If your Consultant has explained that you might need to have a stoma formed as part of your operation, you will also be seen by the Stoma Care Nurse Specialists who will talk to you and give you written and practical information.

Bowel preparation

You will be advised about the need for bowel preparation when you have your POA appointment. In a few cases your Surgeon may want you to have a laxative to empty your bowels. If you are asked to take this laxative you will experience some abdominal cramps and have your bowels opened several times very urgently. Your Surgeon may decide that your bowel does not need preparing in this way but you may be required to have an enema

on the morning of your operation in order to empty the last part of the bowel.

Your admission

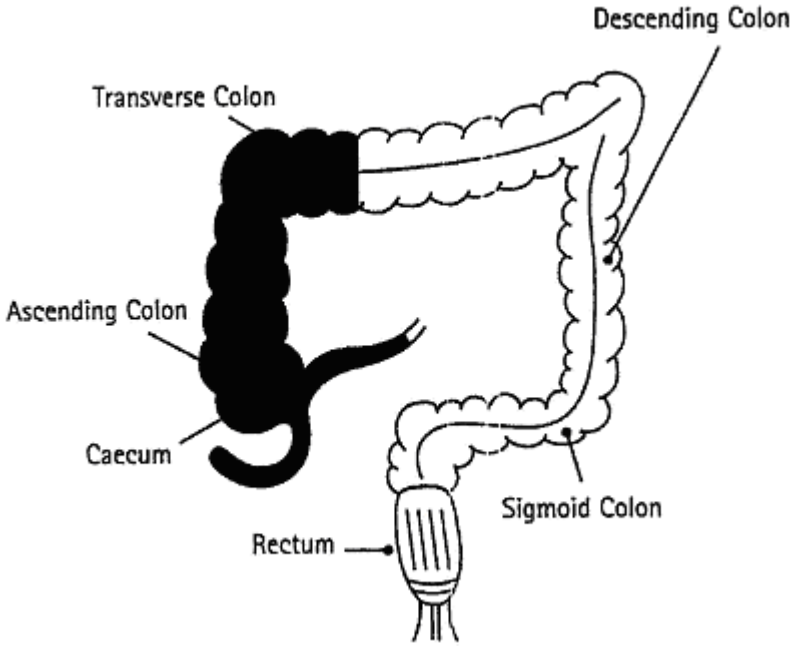
Prior to your operation you will be sent a letter to confirm the date and time of your admission to hospital. Most patients are admitted on the morning of their surgery to the Admissions Suite (B32) which is located next to Robin Smith Ward on Level 1 of zone B - their contact number is 01225 825710. If the possibility of having a stoma formed as part of your operation has been mentioned to you, a Stoma Care Nurse Specialist will see you and put a mark on your tummy unless this has already been done.

The nursing staff on the Admissions Suite will help get you ready for your operation. You will be taken to Theatre directly from the Admissions Suite. Following your operation you will return to a surgical ward.

Operations

For most patients, surgery is the mainstay of treatment for colorectal cancer. Other treatments may be used in addition. The type of surgery depends on the exact nature of each cancer.

Right Hemicolectomy

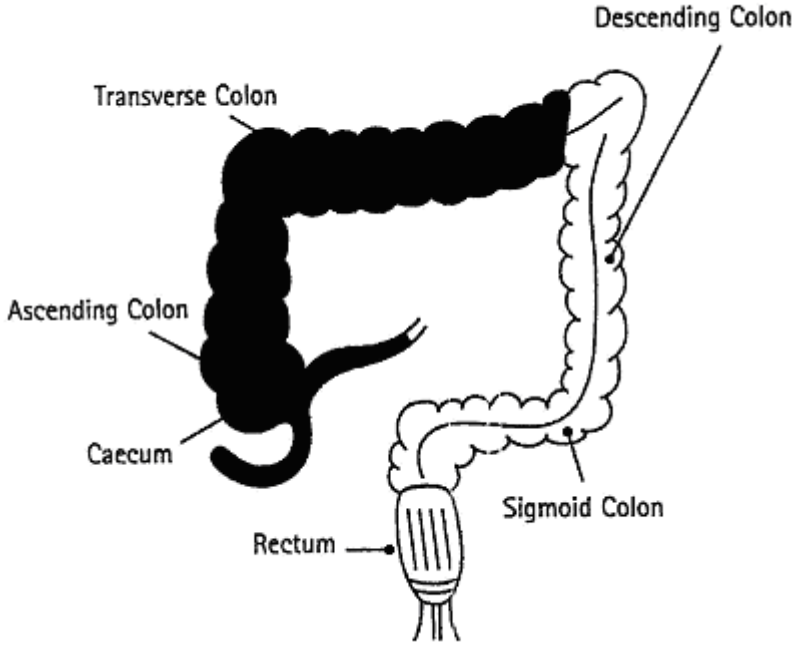


Your operation may be performed partially or completely using a laparoscopic technique (key hole surgery) and this will result in several small incisions on your abdomen.

The abdomen is also opened with a either a vertical or horizontal incision. The caecum, appendix and ascending colon and right side of transverse colon are removed together with a few centimetres of small bowel.

Continuity is restored by joining the two ends of bowel back together. The shaded area is the part of the bowel that will be removed.

Extended Right Hemicolectomy

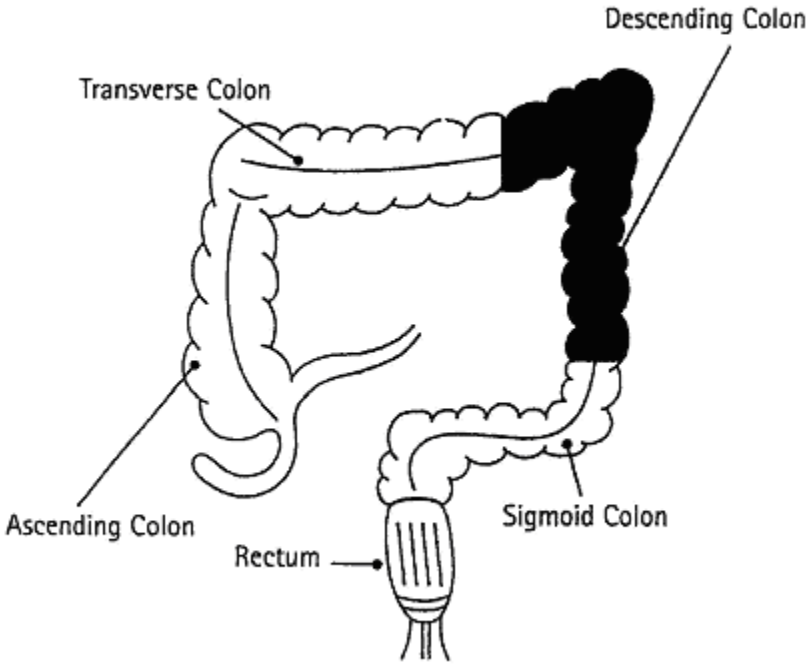


Your operation may be performed partially or completely using a laparoscopic technique (key hole surgery) and this will result in several small incisions on your abdomen.

The abdomen is also opened with a vertical incision which goes around the umbilicus (tummy button). The caecum, appendix, ascending colon and transverse colon are removed together with a few centimetres of small bowel.

Continuity is restored by joining the two ends of bowel back together. The shaded area is the part of the bowel that will be removed.

Left Hemicolectomy

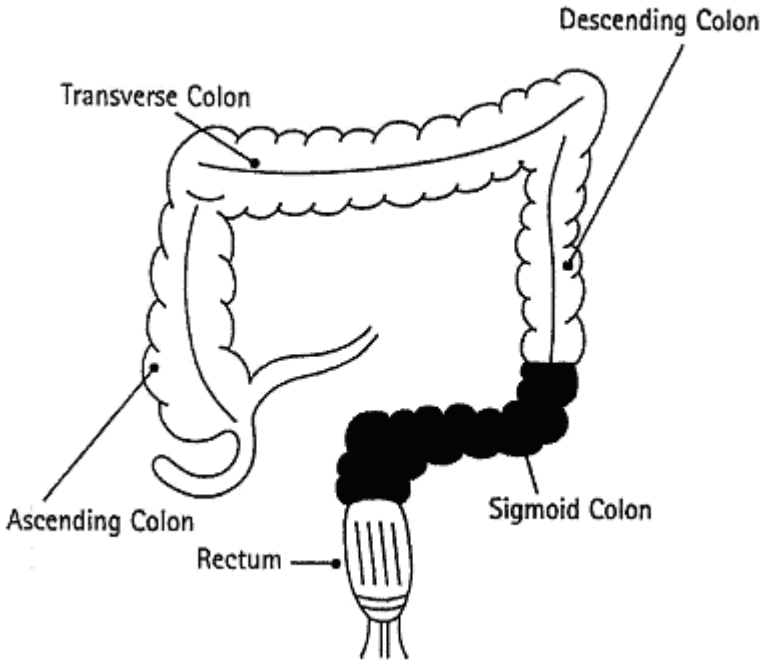


Your operation may be performed partially or completely using a laparoscopic technique (key hole surgery) and this will result in several small incisions on your abdomen.

The abdomen is also opened with a vertical incision which goes around the umbilicus (tummy button). Part of the transverse colon or descending colon is removed.

Continuity is restored by joining the two ends of bowel back together. The shaded area is the part of the bowel that will be removed.

Sigmoid Colectomy

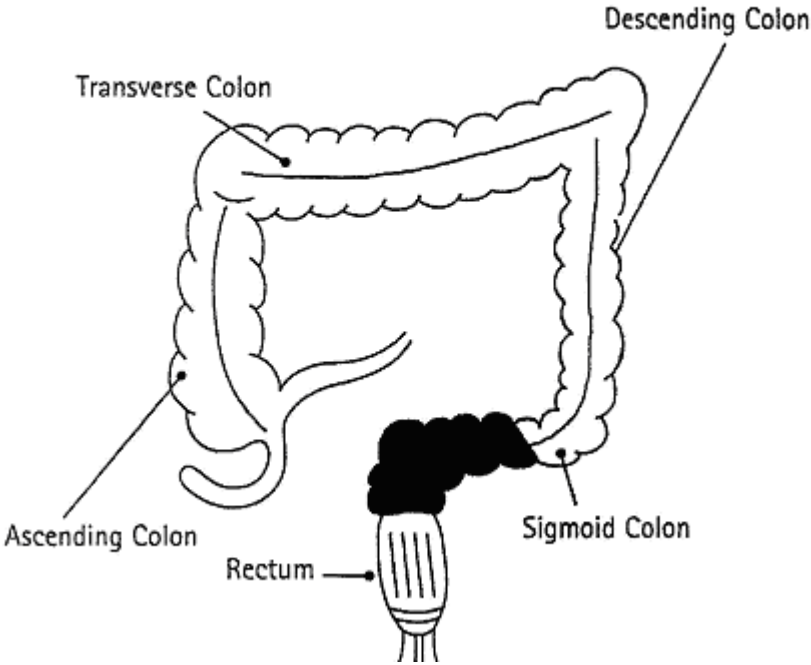


Your operation may be performed partially or completely using a laparoscopic technique (key hole surgery) and this will result in several small incisions on your abdomen.

The abdomen is also opened with a vertical incision which goes around the umbilicus (tummy button).

The sigmoid colon is removed and continuity is restored by joining the two ends – the descending colon and rectum back together. The shaded area is the part of the bowel that will be removed.

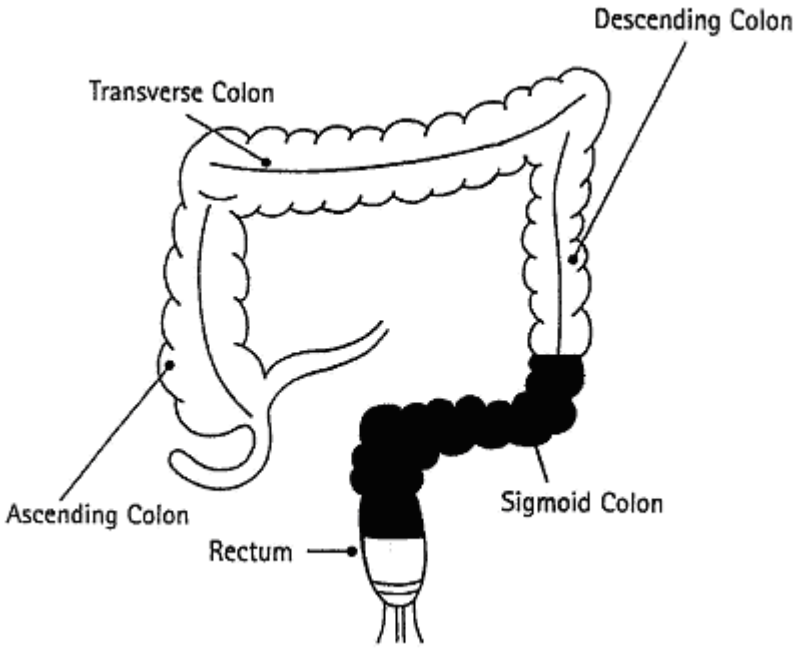
Hartmann's Procedure



The abdomen is opened with a vertical incision and the diseased section of bowel removed.

A colostomy is made out of the sigmoid colon and the rectum is over sewn so it finishes in a blind end. The shaded area is the part of the bowel that will be removed.

Anterior Resection



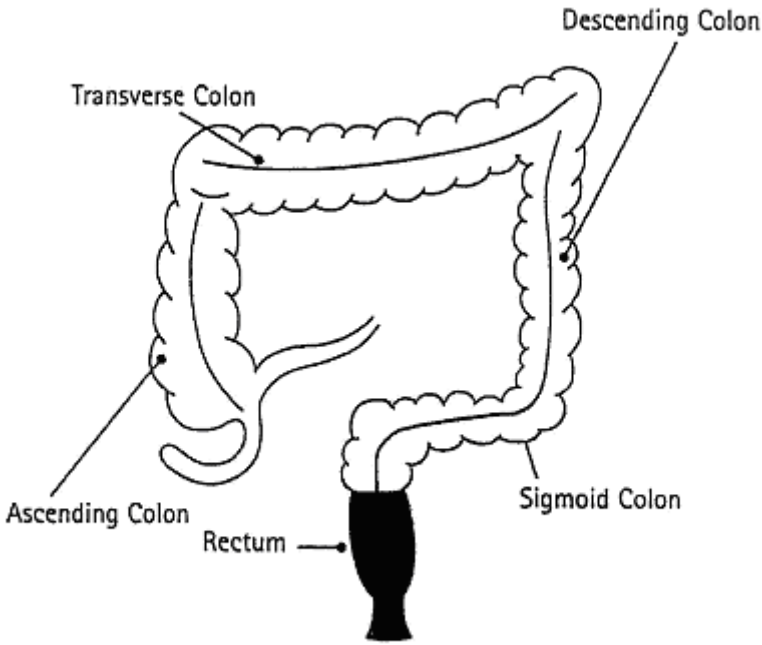
Your operation may be performed partially or completely using a laparoscopic technique (key hole sugery) and this will result in several small incisions on your abdomen.

The abdomen is also opened with a vertical incision which goes around the umbilicus (tummy button). The low part of the sigmoid colon or the high part of the rectum are removed.

Continuity is restored by joining the two ends together. The shaded area is the part of the bowel that will be removed.

Sometimes it is necessary to rest the ‘join’ in the rectum and form a temporary stoma called an ileostomy (or very occasionally a colostomy). The purpose of the stoma is to keep the bowel motions away from the join whilst it heals. If you require a temporary stoma it is usual for you to meet a Stoma Care Nurse before the operation to discuss this in more detail.

Abdomino — Perineal Excision of Rectum (APER)



This operation removes the entire rectum and anal canal. This will mean the formation of a permanent colostomy (stoma). The operation may be performed with an open vertical incision or by using a laparoscopic technique (key hole sugery) which will result in several small incisions on your abdomen.

The rectum and anus are removed through a second incision in the perineum (bottom). After the operation you will have a wound

and a stoma on your abdomen and a wound between your buttocks where the anus has been closed.

A permanent colostomy (stoma) is formed out of the sigmoid colon. The shaded area is the part of the bowel that will be removed.

Endoluminal Surgery

Polyps or some small cancers can be curatively excised by Transanal Endoscopic Microsurgery (TEMS). TEMS is a minimally invasive technique for the local resection of rectal polyps and tumours.

This procedure is carried out using specially designed microsurgical instruments that make it possible to excise lesions inside the rectum that otherwise would be accessible only by major abdominal surgery.

If TEMS is recommended for you, your Consultant will discuss this in more detail.

After your operation

Enhanced Recovery Programme

When you are admitted to hospital for your bowel operation you will take part in the Enhanced Recovery Programme. We aim to get you back to full health as soon as possible after your operation.

The usual length of stay in hospital for this type of surgery is between 3 and 7 days. Research indicates that the earlier you get out of bed after surgery and start eating, drinking and mobilising the better. This will speed up your recovery making it less likely that complications will develop. You will be encouraged to take an active role in your recovery.

During your hospital stay there will be daily goals which you will be encouraged to achieve. A team of doctors, nurses and other health care professionals will be monitoring your progress and will support you in reaching your goals.

Your recovery

Immediately after your operation you will go into a room called the post-anaesthetic care unit (Recovery) so that nurses can monitor and observe you closely until it is safe for you to return to the ward.

When you start to come round after your operation you may find you have a little tube in your mouth, this is to help you breathe. Try not to worry, you will automatically spit this out and that is perfectly normal.

When you arrive on the ward you may still feel quite sleepy, the nurses will help to make you comfortable and regularly check your blood pressure, pulse, breathing rate and temperature.

How soon will I get out of bed?

On the day of your operation you may be encouraged to get up and sit out of bed for a couple of hours. This is to reduce the risk of any complications and to help speed up your recovery.

You will be encouraged to walk around the ward and to the dining room several times each day.

Research has shown that it is important to be mobile as soon as possible after an operation to reduce the risk of blood clots, chest infections and pressure sores.

To further reduce the risk of developing blood clots you will be given a small daily injection of a blood thinning drug.

Will I have any pain?

We will aim for you to be as pain free as possible. Some discomfort is to be expected especially when getting in and out of the bed or chair. Painkillers will usually be given through a continuous infusion (Epidural) or given as tablets once you start eating and drinking. It is very important that you tell the nurse looking after you if you have any pain after your operation.

If you have had laparoscopic (keyhole) surgery you may suffer with referred pain which may be felt between your shoulder blades.

When will my bowels start working?

After your operation your bowels will slow down or may stop working as a reaction to being handled. The doctors will feel and sometimes listen to your abdomen to see if your bowel is starting to work again.

In most cases you will be encouraged to drink on the day of your operation and start eating that evening or the next morning. It may take a few days for your appetite to recover so it is best to eat little and often rather than a large meal. It is important to drink well and you may also be offered high calorie drinks.

While you are not eating and drinking, fluid will be administered to you through a drip in your arm or hand.

If you have had a stoma formed, initially blood stained fluid will be in the bag. Within a few days the bag will start filling with wind and stool. The stoma care nurse will teach you how to look after your stoma.

Will I be sick after the operation?

After having an operation some people feel sick. If you experience any nausea or sickness after your operation please tell a nurse who will be able to give you some anti-sickness drugs.

You should stop feeling sick once you start to have your bowels opened or once your stoma starts to work.

Passing urine

A catheter (tube) will be placed into your bladder to enable your kidneys to drain away urine. This tube will be removed within a few days.

Wound drains

After any operation it is normal for blood and fluid to be produced, sometimes you may require a tube from your abdomen to drain any excess fluid.

The amount will be measured and as it becomes less the drain will be removed. Ask the nurse for some pain relief before the drain is removed if you are in any way concerned.

Stitches

Your wounds may be closed with dissolvable sutures which are under the skin surface; these do not need to be removed. However if your wounds have sutures or clips that require removal, arrangements for this to happen will be made for you 8-10 days after your operation. The ward staff will discuss these arrangements with you when you go home.

Questions

If you have any questions at any time ask the ward nurses, doctors or your CNS. They will be only too pleased to explain anything that concerns you or your family.

Good tip: Write your thoughts and questions down so that you do not forget to ask!

Going home

Hospital stays can vary depending on the complexity of your operation and whether you have participated in the Enhanced Recovery Programme. The usual length of stay in hospital is between 3 and 7 days depending on your type of surgery.

Day to day activities

Illness unsettles your lifestyle. However the best indicator is you!

There is no reason why you should not resume or continue with your work or social activities when you feel well enough.

After the operation you are advised not to lift heavy objects for about six weeks. If you participate in any sports or exercise, introduce it back into your lifestyle gradually.

It is important that you rest adequately. Always accept offers of help with shopping, housework or jobs around the house until you feel well enough to resume your normal activities.

There is no reason why you should not go on holiday but discuss this with your colorectal nurse or doctor.

Driving your car

It is advisable not to drive for at least 2 weeks after your operation. You will need to check with your insurance company and be able to do an emergency stop comfortably before starting to drive again.

Diet

Once you have returned home there are no dietary restrictions on what you can eat and drink. Try to have protein enriched food (meat, fish, eggs) as these foods are good for healing. It is advisable to have a well balanced diet of fruit, vegetables, and whole wheat cereals and bread.

However, in the first few weeks after the operation it may be wise to peel away fruit skins and avoid green vegetables and sweet corn.

Bowel function

Problems may include diarrhoea, constipation or alternating bouts of constipation and diarrhoea.

Constipation: It is important to eat a high fibre diet, mobilise gently and to drink at least 2 litres of fluid each day. This can be made up of soup, tea, coffee, juice and squash, although it is advisable to avoid drinking a lot of tea and coffee because it contains caffeine and can cause dehydration and constipation.

Diarrhoea: It is not unusual, after an operation on your bowels, to have slightly looser stools and some urgency. Therefore if you feel you want to open your bowels do not try to hold on, but go to the toilet immediately.

Generally, the large bowel (colon) adapts with time and control and consistency of stools improves.

Please do not hesitate to contact your CNS who can give advice and support either over the telephone or when you have a follow-up appointment in clinic. There is a lot that can be done to help improve bowel function.

If you experience diarrhoea it is important to keep drinking to keep your body hydrated.

It may help to avoid food and dairy products for 24 hours and once the diarrhoea stops try eating dry, bland food, toast, crackers etc, and slowly return to a full diet. Some people believe live yoghurt preparations help.

If either of these symptoms persist it is important to contact your GP or Colorectal Nurse who may be able to advise on suitable medication.

Although this can be upsetting do remember that your bowel function should continue to improve over the next two years.

Sexual activities

Many people are able to continue their usual sexual activity once they have physically recovered from the effects of the surgery. However, libido (sex drive) often decreases after surgery and during chemotherapy, although this is most likely to be temporary. If you have had an operation to remove your rectum (back passage) there is a risk that you may suffer from impotence.

If you have concerns about particular aspects of your sexual activity please do not hesitate to contact your CNS who may advise you or may ensure you are referred to a relevant specialist.

Pathology

After your operation, the piece of bowel containing the cancer will be sent for examination to a pathologist (a doctor who has been trained to examine tissue cells under a microscope). The results of this examination are called ‘histology’ results.

Multi-disciplinary meeting

The decision as to whether you may benefit from chemotherapy is made at the multi-disciplinary meeting (MDM) which involves the surgeons, oncologists, radiologists, pathologists and the colorectal nurses.

A few weeks after your operation a colorectal nurse specialist is likely to contact you by phone to find out how you are recovering after your operation. Your histology results can be explained to you over the telephone. Depending on your histology results, chemotherapy may be recommended for you. If chemotherapy treatment is recommended an appointment will be made for you to

see an oncology consultant a few weeks after your operation to discuss this in more detail.

Chemotherapy

Chemotherapy may be offered to you after your surgery. Chemotherapy is a treatment given to the whole body. The medication can be given in the form of an injection into a vein in your arm or in tablet form.

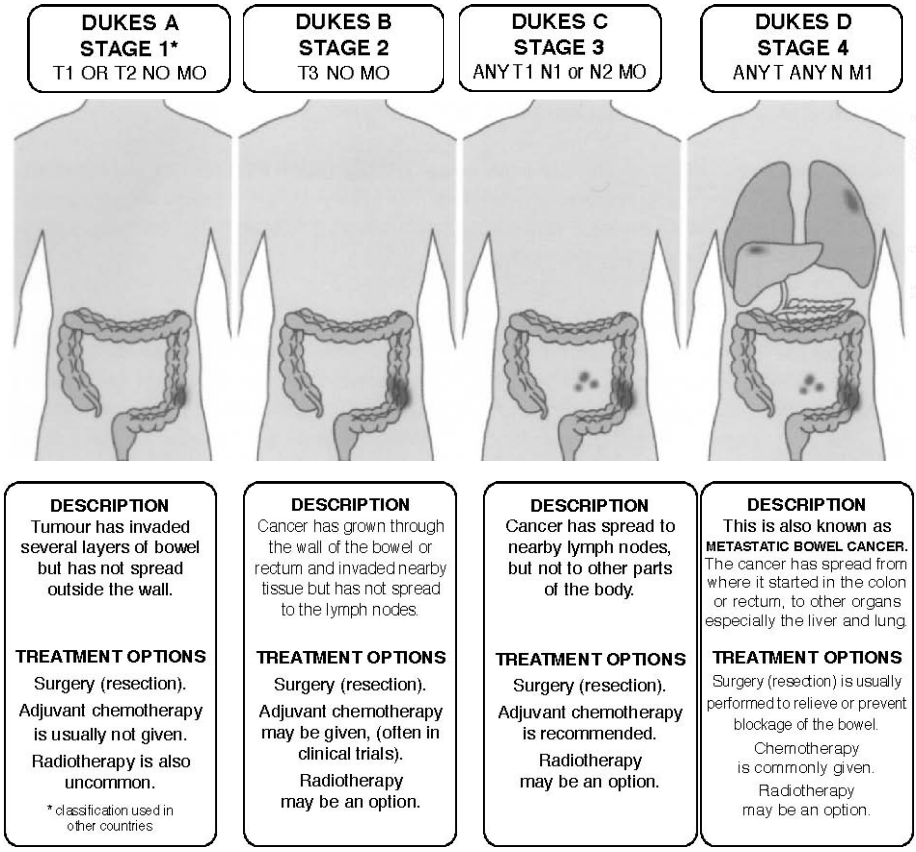
Sometimes a small plastic tube can be inserted into your chest or arm. This will stay there for the duration of the chemotherapy and be used each time you have chemotherapy to avoid using different veins in your arm each time.

Before each treatment you will have a blood test. One of the reasons for this is to check the state of your immune system, as while you are undergoing chemotherapy you are less able to fight infections. The blood test checks that you have enough healthy blood cells to protect you from infection before your treatment.

Side effects

Most of the drugs commonly offered to treat bowel cancer do not have severe side effects. Hair loss and vomiting are NOT routinely expected, unlike some other types of chemotherapy.

Bowel Cancer Staging System



You may hear your doctor talking about 'Dukes' or 'TNM' stages.

Dukes

Dukes is a simplified sort of classification for staging tumours according to their degree of invasion and spread (Dukes A, B, C, D)

TNM
TNM is a more detailed type of staging classification, describing:

1. The degree of Tumour invasion (T1 to T4)
2. Node involvement (from N0 which is that no lymph nodes are affected, to N2 where there are 4 or more lymph nodes are affected).
3. Whether distant Metastases are present or not (also called secondaries). MX means cancer spread has not been identified. M1 means that it has.

Your Treatment Plan

Pre-operatively

CT scan Y / N Date……....

MRI scan Y / N Date……....

Radiotherapy Y/ N Date……....

Surgical Outpatient appointment date:……..

Pre-admission Clinic Date: ……....

Operation Details

Operation date: ……

Operation:...……...

Post Operative Plan

Surgical appointment date: ……

Chemotherapy needed post operatively Y / N

Oncology appointment date:……...

Follow up liver scan needed after 1 and 2 years Y / N

Extra scans needed Y / N

Colonoscopy needed Y / N

Follow up

Around 4-6 weeks after your operation a surgical follow up appointment will be made for you. If you have not been informed of your histology results by phone it may be necessary for you to have an earlier appointment. The Doctor will check that you are making a good recovery and discuss with you any further tests that you may need.

Recent studies have shown that it is not always necessary for you to have regular follow up appointments with a Specialist Doctor. However you may be offered appointments with a Colorectal Nurse Specialist who can discuss any problems or concerns that you have and organise any relevant tests.

Your GP will be sent a letter following any appointments that you have and will be sent the results of any follow up scans arranged for you. You will also be informed of the results of follow up scans.

Signs and Symptoms

It is important that you are aware of the signs and symptoms that could indicate a further abnormality.

If you experience one or more of the following for more than 6 weeks you should contact your GP or your Colorectal Nurse:

1. Loose stools and diarrhoea.
2. Increasing bouts of constipation.
3. Change of normal bowel action (how often you open your bowels).
4. Blood and / or mucus with your stool.
5. Decreased appetite / weight loss.
6. Lethargy (lack of energy) – this may be due to anaemia, caused by blood loss from the bowel.

7. Sometimes people experience a feeling of not being able to completely empty their bowels (this is known as tenesmus).
8. Some people experience abdominal (tummy) pain or discomfort.

Glossary

Abdomen	The part of the body that contains the stomach, bowel and other digestive organs, also known as the tummy
Analgesics	Pain relievers / killers
Adjuvant Chemotherapy	Chemotherapy given after the main tumour has been removed
Anaesthetist	A doctor whose role is to put you to sleep so that you feel no pain during your operation
Anus	The outlet of the back passage
Barium Enema	A white solution introduced via the anus, enabling visualization of the colon and rectum
Benign	A growth which is not cancer or malignant and does not have the ability to spread to other organs
Catheter	A flexible tube that allows urine to pass out of the bladder
Chemotherapy	Treatment using drugs
Colon	The large bowel or intestine

Colorectal Nurse (Specialist)	A senior nurse who is an expert at looking after people with large bowel cancer.
Diagnosis	Determination of the cause of the disease
Faeces	Motions, stools, waste products
Immune System	Blood cells and vessels in your body which fight infection
Large Intestine	Large bowel
Lymph Node	A gland like mass of tissue that can filter cancer cells from the lymph fluid
Malignancy	A growth which is cancerous and so has the ability to spread to other organs
Metastases	The spread of cancer cells to other distant parts of the body by way of the blood or lymph fluid
Oncologist	A doctor who specialises in cancer care and prescribes chemotherapy and radiotherapy
Palliative Care	Improving quality of life, by providing support and controlling unpleasant symptoms

Pathologist	A doctor who specialises in making a diagnosis by examining tissue (cells) under a microscope
Radiologist	A doctor who uses scans and X-rays to diagnose and treat disease
Radiotherapy	Treatment using X-rays to shrink a cancer
Small Intestine	Small bowel, part of which is called the ileum
Stoma	An artificial opening in the tummy wall through which stool is passed into a bag
Stoma Care Nurse (Specialist)	A senior nurse who is an expert at caring for stomas
Tenesmus	A persistent urge to empty the bowel
Tumour	Growth, swelling

Useful Contacts

The following websites and telephone helplines may be useful for further information.

Bowel Cancer UK:	0800 8403540 www.bowelcanceruk.org.uk
Beating Bowel Cancer:	08450 719301 www.bowelcancer.org
Penny Brohn Cancer Care: Formerly the Bristol Cancer Help Centre	0845 123 2310 www.pennybrohncancercare.org
Colostomy Association	0800 3284257 www.colostomyassociation.org.uk
Macmillan	0808 8080000 www.macmillan.org.uk
Cancer Research UK	0808 8004040 www.cancerhelp.org.uk
Macmillan Cancer Information and Support Centre	01225 824049
Positive Action on Cancer (PAC) Free professional counselling	01373 455255 info@positiveactiononcancer.co.uk

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