Blue NOTES

A resource guide for primary care

Evidence based guidelines for colorectal cancer patient follow-up and side effects

Definition of Stages

STAGE II

All patients with a malignancy that has invaded through the muscularis propria into pericolic fat or through the serosa with or without invasion into surrounding organs (T3 / T4) **without** involvement of metastasis to their lymph glands or distant organs.

STAGE III

All individuals, regardless of their tumour stage, with evidence of metastasis in their lymph glands without involvement of distant organs.

The program is **NOT** intended for patients who have Stage I or Stage IV disease. By definition this includes:

STAGE I

All patients who have cancer that has not invaded through the submucosa (T1) or the muscularis propria (T2) with negative lymph nodes.

STAGE IV

All patients who have cancer that has demonstrated metastasis to distant organs.

This program applies to all patients with colon or rectal cancer treated with curative intent with **STAGE II or III disease**. The guidelines are intended to be applied to cases where patients are believed to be candidates for further treatments in the event of loco-regional or distant recurrence. While surveillance may provide reassurance to patients and identify recurrent disease amenable to curative interventions, it also creates stress and anxiety for patients, and morbidity secondary to investigations required to confirm a diagnosis and earlier identification of disease that is NOT amenable to cure. It is recommended there is discussion with patients to ensure a full understanding of the benefits and risks of surveillance before submitting themselves to rigorous follow up.

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Evaluation	Recommendation	Recommended Frequency
Physical examination, history, and CEA	A medical history and physical examination along with the laboratory test of CEA should be performed	Every 6 months for 5 years
Abdominal imaging	Abdominal CT scan is preferred or US if CT is difficult to access	Annually for 3 years
Pelvic imaging	Pelvic CT scan is recommended if the primary tumour was located in the rectum or US if CT is difficult to access	Annually for 3 years
Chest imaging	Chest CT scan is recommended or CXR if CT is difficult to access	Annually for 3 years
Colonoscopy	Surveillance colonoscopy is recommended	At 1 year following surgery; the frequency of subsequent surveillance colonoscopies should be dictated by the findings of the previous one, but generally should be performed every 5 years, if the findings of the previous one are normal
*Sigmoidoscopy	Surveillance for rectal cancer treated without radiation	Every 6 months for 5 years

History and physical exam should focus on symptoms of local or distant disease. Frequent sites of metastasis include liver, lung, and bone.

The history should include asking about:

- Bowel, bladder and sexual function with rectal cancer patients
- Unexplained weight loss / GI complaints, abdominal ascites
- Fatigue
- New onset bone pain
- New headaches, or other neurological symptoms

The physical exam should include:

- Abdominal exam including palpation and scar examination
- Examine inguinal nodes for rectal cancer
- Respiratory and cardiovascular assessment
- Rectal exam annually and more frequently as needed
- Assessment for pallor and palpable lymphadenopathy
- Abdominal examination paying particular attention to scar and new onset of mass lesions or organomegaly

Any new or persistent or worsening symptoms warrant the consideration of a recurrence, especially:

- Vague constitutional symptoms such as:
    - Fatigue
    - Nausea
    - Bloating
    - Unexplained weight loss
- Headaches or other neurological symptoms
- Abdominal pain
- Dry persistent cough
- New nodules or masses

Signs and symptoms specific to rectal cancer include:

- Pelvic pain
- Sciatica
- Difficulty with urination and / or defecation
- Difficulty with sexual function may exist immediately post-operatively. Deterioration after 6-12 months may be the result of recurrence

****All signs and symptoms for colon cancer also apply to rectal cancer patient follow up.**

Fatigue is a very common side effect of cancer treatment.

Recommendations:

- The only proven intervention for benign fatigue is exercise. Fatigue improves with time; if it persists longer than 6 months post treatment, other causes such as those listed below should be ruled out

More serious cancer or cancer treatment-related causes can include:

- Thromboembolic events
- Recurrence of cancer
- Changes in heart function related to chemotherapy

Refer the patient back to the cancer program for management of these issues.

Fax number: 1-888-509-4484 or 519-685-8664

More information about cancer fatigue:
http://www.cancerview.ca/idc/groups/public/documents/webcontent/manage_cancer_fatigue.pdf

Psychosocial Concerns may include anxiety / depression, fear of recurrence, relationship concerns, body image, genetic risk, spirituality and other specific issues. Some family practitioners may wish to use a quick screening tool to identify any concerns that emerge post treatment. In some cases, multiple vague physical symptom complaints may be an indicator of poor post-treatment psychological adjustment.

Recommendations:

- Rule out underlying physical diagnosis
- Treat anxiety or depression
- Antidepressants such as citalopram and escitalopram have the potential to interact with 5HT3 antiemetics like granisetron and ondansetron and cause a prolongation of the QT interval. This is relevant for patients on chemotherapy
- Non pharmacological resources include referral to counselling or psychotherapy, relaxation training, cognitive behavioural therapy, supportive-expressive therapy, or psycho-educational interventions

Contacts:

London Regional Cancer Program – Supportive Care Program
Assessment and referral to community resources: 519 685-8622

Community counselling agencies and other resources:

Day Counselling	519 434-0077	Wellspring Support Network	519 438-7379
Family Counselling Services	519 433-0183	Canadian Cancer Society Peer Support	1-888-939-3333

More information about psychosocial support:
http://www.colorectal-cancer.ca/en/find-support/living-with-cancer/

In patients who received ostomy, a lifestyle adjustment will be required.

Peristomal Skin Complications

Complication	Cause / Description	Treatment
Radiotherapy-related skin problems	Acute dermatitis with subsequent desquamation (like sunburn). With higher levels of exposure, skin may blister leaving eroded areas. Increase in stoma output (diarrhea) as a result of radiotherapy can indirectly result in peristomal skin breakdown	Apply beclomethasone spray to peristomal skin with each appliance change
Malignancy	Patients who have had ostomy surgery for a bowel malignancy may develop secondary deposits within or around the stoma (probably more common with adenocarcinoma of the bowel). This may represent seeding of tumor to the skin	Surgical: refer to the patient's treatment surgeon An Enterostomal Therapy nurse specialist should be consulted for recommendations
* Irritant Dermatitis	Peristomal skin becomes reddened / discoloured with loss of epidermal layer. The skin is moist / macerated and may bleed	Refer to an Enterostomal Therapy nurse specialist

Peristomal Complication	Cause / Description	Treatment
* Contact (Allergic) Dermatitis	Red, irritated skin corresponding to the shape of the adhesive contact surface	Follow-up with an Enterostomal Therapy nurse specialist to ensure appropriate pouch equipment, proper technique of application and adequate care of stoma and peristomal skin is taking place Consider dermatology consult for patch testing to determine allergen. Consider topical antihistamine applied to peristomal skin with each appliance change (Flonase spray can be used in this manner and does not inhibit appliance adhesion)
Candidiasis	Caused by a leaking / poorly fitting ostomy appliance, heat / body perspiration, denuded skin	Medline Arglaes Powder contains silver which has a topical antifungal affect. Lightly sprinkle on the area brushing away loose powder. Apply with each appliance change until resolved. Powder can be purchased over-the-counter at ostomy supply retailers

*Peristomal skin is highly susceptible to developing either irritant or contact dermatitis, as a result of the skin stripping with repeated appliance changes, intermittent contact with irritating stoma effluent, and the occluded / humid environment that the appliance creates which increases the risk of sensitization.

Please note:

These are some of the more common peristomal skin complications which may present in this patient population.

AVOID creams and ointments as the ostomy appliance barrier will not adhere. If these types of topical therapies need to be used, the appropriate dressing must be applied to provide a drier surface for appliance adhesion.

Ostomy wear time should be three days or more once a routine is attained post-op. Short wear times should mandate a review with the surgeon or hospital Enterostomal Therapist. Irritation of the skin or ulceration that causes severe pain or difficulty with appliance changes should also mandate a review.

General Ostomy Related Resources for Patients and Primary Care

Canadian Association for Enterostomal Therapy: Find an ET Nurse
https://members.caet.ca/etfinder

UOAC Chapters
www.ostomycanada.ca/chapters.htm

Crohn's and Colitis Foundation of Canada
Toll Free: 1-800-387-1479
www.ccfc.ca

Canadian Society of Intestinal Research
Toll free: 1-866-600-4875
www.badgut.com
Email: info@badgut.com

ConvaTec Canada
http://www.convatec.ca

Familial Gastrointestinal Cancer Registry
Phone: 1-416-586-4800 Ext. 8334

IDEAS (Intestinal Disease Education and Awareness Society)
Phone: 604-255-9606
Email: info@IDEAS-NA.com

Coloplast Canada
http://www.coloplast.ca

Hollister Canada
http://hollister.com/canada

Argyle Medical Distributors Inc.
http://www.argylemedical.com

Financial Resources

Assistive Devices Program (ADP)

Any resident of Ontario who has a valid health card issued in their name and has a permanent ostomy can apply for funding. ADP provides $600 annually in two installments and $800 annually if receiving Ontario Works (OW), Ontario Disability Support Program (ODSP), or Assistance to Children with Severe Disabilities (ACSD). ADP will fund a maximum of two ostomies. The ADP application form can be found at:

http://www.health.gov.on.ca/en/public/programs/adp/adp_fm.aspx

Disability Tax Credit Certificate

Individuals with an ostomy may be eligible for this tax credit. The form number is T2201 and can be found online at:
http://www.cra.gc.ca/disability
The form will need to be completed by a physician. The form can be completed anytime throughout the year.

Symptoms Related to Surgery	Recommendations for Management
Frequent and / or urgent bowel movements or loose bowels	If conservative manoeuvres such as diet, fibre and Imodium are not working, refer back to the surgeon For patients with terminal ileum resection, try Cholestyramine
Gas and / or bloating	Diets high in soluble fibre can cause excessive gas and bloating These symptoms usually improve with time and changes to the diet
Incisional hernia	Refer back to surgeon Patient can use a hernia belt / binder
Increased risk of bowel obstruction	Seek medical attention if patient presents with: • Crampy abdominal pain, nausea and vomiting • Inability to pass gas or have a bowel movement

Symptoms Related to Medications	Recommendations for Management
Peripheral neuropathy (associated with treatment using oxaliplatin)	• This is a common symptom • This symptom may improve with time away from chemotherapy • If affecting quality of life, try Lyrica / Gabapentin for neuropathic symptoms
"Chemo-brain" including difficulty with short-term memory and the ability to concentrate	• This symptom is also commonly reported and usually improves with time • Reassure the patient

Symptoms Related to Radiation	Recommendations for Management
Localized skin changes (i.e., colour, texture, loss of hair)	• Skin atrophy is rare • More common: Mild hyperpigmentation — no specific treatment • Skin moisturizers for chronic dry desquamation for symptomatic relief
Rectal ulceration and / or bleeding (radiation colitis)	• Diet modifications to minimize constipation • If moderate, use fibre containing foods • Appropriate analgesics for pain from rectal ulcers • Lower G.I. endoscope to assess severity or rule out other causes of rectal bleeding • Rectal route — steroid preparations to minimize acute episodes of pain / bleeding • Surgical opinion for severe intractable symptoms
Anal dysfunction (incontinence)	• Diet modifications to avoid diarrhea and loose stools • Anti-diarrhea's (Imodium / Lomotil) • Sanitary pads for undergarments
Bowel obstruction (from unintended small bowel scarring)	• Medical evaluation with clinical exam / imaging (abdominal x-rays and CT scan) to asses for evidence, level and degree of obstruction • Urgent assessment by surgeon if bowel obstruction suspected

Symptoms Related to Radiation	Recommendations for Management
Infertility	The likelihood of fertility issues may have been discussed and acted on in the pre-treatment phase. If a patient is seeking more information, contact the Fertility Clinic at London Health Sciences Centre: 519 685-8500 ext. 55224
Sexual dysfunction (e.g., vaginal dryness, erectile dysfunction, retrograde ejaculation)	**Female:** the use of vaginal moisturizer three times per week and a thick lubricant prior to sexual activity is recommended **Male:** if there are ongoing erectile dysfunction and retrograde ejaculation issues, patients may be referred to a local Urologist
Second primary cancers in the radiation field (typically about seven years after radiotherapy)	Refer back to the patient's treating surgeon

Despite the lack of high-quality evidence on secondary prevention in colorectal cancer survivors, the following counselling goals are reasonable based on lower levels of evidence and the expert opinion of the authors:

- Maintain an ideal body weight
- Engage in a physically active lifestyle
- Eat a healthy diet

**There is insufficient data to make a firm recommendation regarding the role of acetylsalicylic acid (ASA) in the secondary prevention of colorectal cancer.

- Regular cardiovascular exercise, preferably weight bearing
- Dietary counselling (refer patients)
- Local exercise and fitness programs aimed at colorectal cancer survivors (refer patients)