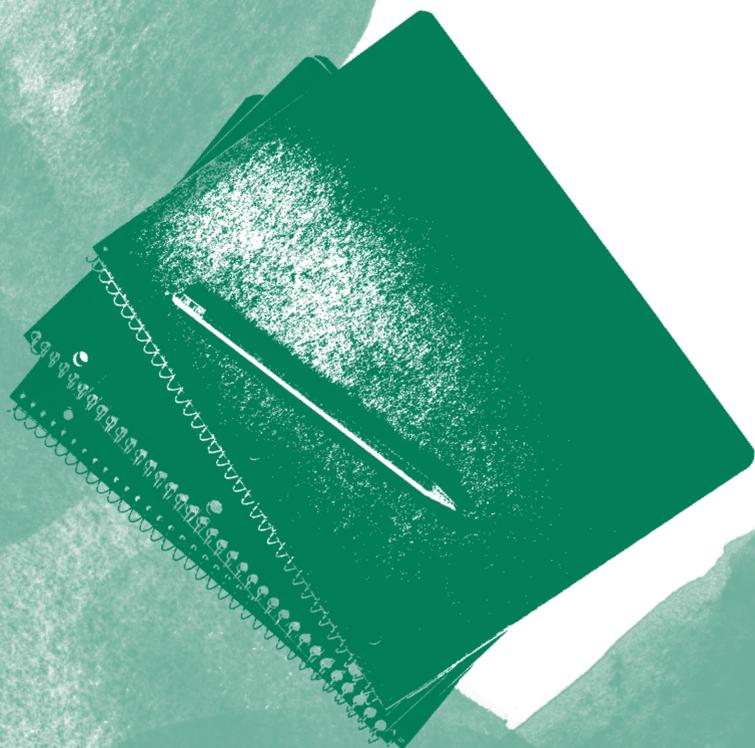


WE ARE
MACMILLAN.
CANCER SUPPORT

A practical guide to understanding cancer

UNDERSTANDING RECTAL CANCER



Contents

About this booklet	4
What is cancer?	6
The lymphatic system	8
The bowel	10
Risk factors and causes	12
Symptoms	16
How rectal cancer is diagnosed	18
Staging and grading	27
Treatment overview	32
Surgery	39
Bowel function after surgery	59
If you have a stoma	67
Radiotherapy	71
Chemotherapy	83
Chemoradiation	92
Targeted therapies	93

Research – clinical trials	96
After treatment	98
Sex life after rectal cancer	101
Your feelings	103
Who can help?	107
Relationships	108
If you are a relative or friend	110
Talking to children	111
Financial help and benefits	112
Work	115
About our information	116
Other ways we can help you	118
Other useful organisations	121
Your notes and questions	128



About this booklet

This booklet is about rectal cancer. We have separate information about small bowel cancer, colon cancer and anal cancer.

We hope this booklet answers some of your questions and helps you deal with some of the feelings you may have.



There are several videos about bowel cancer on our website. They feature people affected by cancer talking about their experiences, and health professionals explaining treatments. Visit macmillan.org.uk/cancerinformationvideos

We've included quotes in this booklet from people who've had bowel cancer. They are from healthtalkonline.org, videos on our website and people who've chosen to share their experiences with us at macmillan.org.uk/cancervoices (some names have been changed).

We can't advise you about the best treatment for you. This information can only come from your doctor, who knows your full medical history.

If you'd like to discuss this information, call the Macmillan Support Line free on **0808 808 00 00**, Monday–Friday, 9am–8pm. If you're hard of hearing, you can use textphone **0808 808 0121** or Text Relay. For non-English speakers, interpreters are available. Alternatively, visit macmillan.org.uk

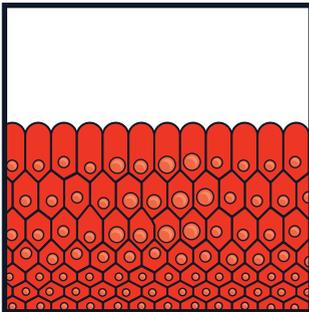
On pages 116–127, we've listed some useful contact details and other organisations that can help. On pages 128–129, there is space to write down any notes or questions you have.

If you find this booklet helpful, you could give it to your family and friends. They may also want information to help them support you.

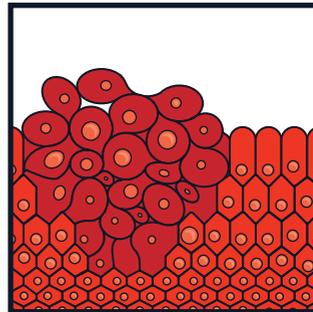
What is cancer?

Cancer starts in cells in our body. Cells are tiny building blocks that make up the organs and tissues of our bodies. They divide to make new cells in a controlled way. This is how our bodies grow, heal and repair. Cells receive signals from the body telling them when to divide and grow and when to stop growing. When a cell is no longer needed or can't be repaired, it gets a signal to stop working and die.

Cancer develops when the normal workings of a cell go wrong and the cell becomes abnormal. The abnormal cell keeps dividing making more and more abnormal cells. These eventually form a lump (**tumour**). Not all lumps are cancerous. Doctors can tell if a lump is cancerous by removing a small sample of tissue or cells from it. This is called a **biopsy**. The doctors examine the sample under a microscope to look for cancer cells.



Normal cells



Cells forming a tumour

A lump that is not cancerous (**benign**) may grow but cannot spread to anywhere else in the body. It usually only causes problems if it puts pressure on nearby organs.

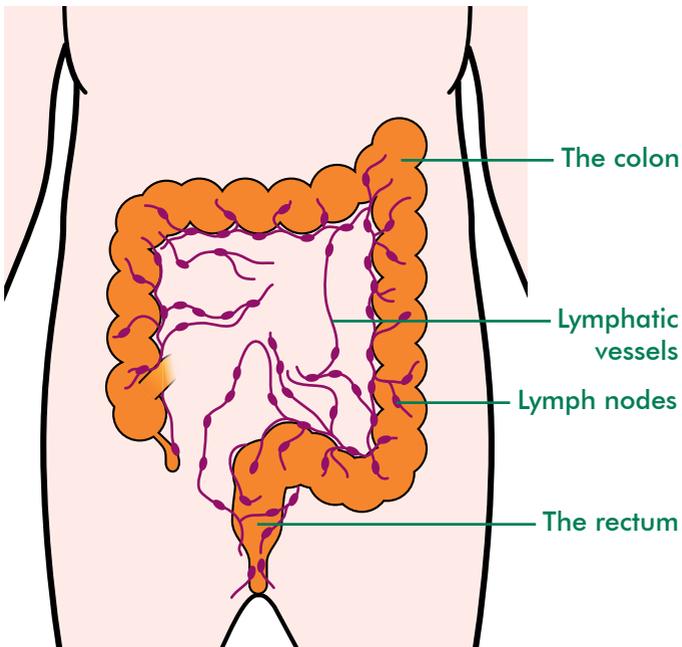
A lump that is cancerous (**malignant**) can grow into nearby tissue. Sometimes, cancer cells spread from where the cancer first started (the primary site) to other parts of the body. They can travel through the blood or lymphatic system (see next page). When the cells reach another part of the body, they may begin to grow and form another tumour. This is called a **secondary cancer** or a **metastasis**.

The lymphatic system

The lymphatic system helps to protect us from infection and disease. It also drains lymph fluid from the tissues of the body before returning it to the blood. The lymphatic system is made up of fine tubes called lymphatic vessels that connect to groups of lymph nodes throughout the body.

Lymph nodes (sometimes called lymph glands) are small and bean-shaped. They filter bacteria (germs) and disease from the lymph fluid. When you have an infection, lymph nodes often swell as they fight the infection.

If bowel cancer spreads, it is most likely to go to lymph nodes close to the bowel.

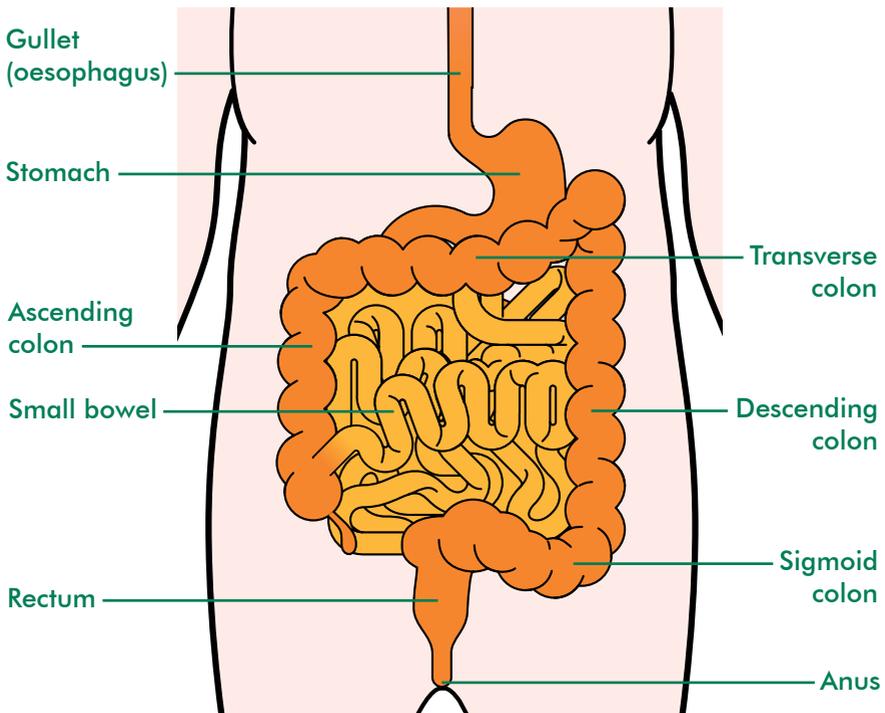


There are many lymph nodes close to the bowel



The bowel

The bowel is part of the digestive system. It's divided into two parts: the small bowel and the large bowel. The large bowel is made up of the colon, rectum and anus.



The digestive system

When food has been swallowed, it passes down the gullet (oesophagus) to the stomach, where digestion begins.

From here, it enters the small bowel, where essential nutrients are taken into the body. The digested food then moves into the colon, where water is absorbed. The remaining waste matter (stool or faeces) is held in the rectum (back passage). Nerves and muscles in the rectum help you to hold onto stools until you're ready to pass them through the anus as a bowel motion.

The anus is the opening at the very end of the large bowel. It contains a ring of muscle called the sphincter. This opens and closes giving you control over when you pass bowel movements.

The rectum

The rectum links the colon to the anus. It is about 15cm (6 inches) long.

To help describe where a cancer is, doctors divide the rectum into thirds: upper, middle and lower. The upper third is the section directly after the sigmoid colon (see diagram on opposite page). The lower third is where the large bowel joins the anus. The middle third is in between.

Most rectal cancers start in the inner lining of the bowel and develop from small growths called polyps.

Risk factors and causes

In the UK, about 14,000 people develop rectal cancer each year.

Like most types of cancer, rectal cancer is more common in older people. More than 80% of rectal cancers (8 in 10) are diagnosed in people over 60.

The exact cause of rectal cancer is unknown. But certain things called risk factors can increase the chances of developing it. Having one or more risk factors doesn't mean you will definitely get cancer. Equally, if you don't have any risk factors, it doesn't mean you won't get rectal cancer.

Diet

A diet containing a lot of red and processed meat increases the risk of bowel cancer. Red meat includes beef, lamb and pork. Processed meat includes smoked meat, ham, bacon, sausages, pâté and tinned meat. Eating fried or grilled meat may also increase the risk.

Eating two or more portions of red or processed meat a day seems to increase the risk the most. People who eat less than two portions a week have the lowest risk.

No link has been found between bowel cancer and eating poultry (such as turkey and chicken).

Not eating enough fruit and fresh vegetables may also increase risk.

Physical inactivity

People who aren't physically active are more likely to develop bowel cancer.

Body weight

Being overweight can increase the risk of developing bowel cancer, especially in men.

Smoking

Bowel cancer is more common in people who have smoked cigarettes for many years.

Inflammatory bowel conditions

Having an inflammatory bowel condition such as ulcerative colitis or Crohn's disease can increase the risk of bowel cancer. People with these conditions may be offered regular bowel screening with colonoscopies (see page 19).

Irritable bowel syndrome is not an inflammatory bowel condition and does not increase the risk of developing bowel cancer.

Family history

Most people who get bowel cancer don't have a family history of it. Having one relative who developed bowel cancer at an older age doesn't significantly affect your risk. But, if several close family members on the same side of your family have had bowel cancer, or if a close family member developed bowel cancer before the age of 50, this may mean you have a higher risk. Close family members are parents, brothers and sisters.

People who have a history of bowel cancer in their family can be referred to a specialist clinic to have their risk assessed. People at high risk of bowel cancer are offered bowel screening. This involves regular tests to look at the inside of the large bowel (colonoscopy). For more information, contact your GP or our cancer support specialists on **0808 808 00 00**.

Familial conditions

About 5% of bowel cancers (5 in every 100) are caused by an inherited faulty gene.

There are two rare conditions that can run in families: familial adenomatous polyposis (FAP) and Lynch syndrome (also called hereditary non-polyposis colorectal cancer or HNPCC). People with either condition have a very high risk of developing bowel cancer.

Familial adenomatous polyposis (FAP)

People with FAP have many hundreds of thousands of benign tumours (polyps) in the lining of their colon. They may also have polyps in their rectum. They are regularly screened using colonoscopies (see page 19) to look for signs of cancer. Usually, it's recommended that people with FAP have an operation to remove their colon and sometimes rectum. Unless the colon is removed, nearly everyone with FAP will develop bowel cancer.

FAP causes about 1% of bowel cancers (1 in every 100).

Lynch syndrome (HNPCC)

People with Lynch syndrome have an increased risk of developing bowel cancer at a young age. If you have Lynch syndrome, you will usually have regular screening using colonoscopies (see page 19). Screening usually starts from the age of 25, or five years before the age at which your youngest relative developed bowel cancer.

Lynch syndrome causes about 3% of bowel cancers (3 in every 100).

Rectal cancer is not infectious and can't be passed on to other people.



If you're concerned about your family history of bowel cancer, we can send you our leaflet *Are you worried about bowel cancer?* We also have a more detailed booklet about cancer genetics, and a booklet about bowel screening. Call 0808 808 00 00 to order any of these or visit be.macmillan.org.uk

Symptoms

The symptoms of rectal cancer may include:

- blood in, or on, your stools (bowel motions) – the blood may be bright red or dark
- a change in your normal bowel habit, such as diarrhoea or constipation, that happens for no obvious reason and lasts longer than three weeks
- unexplained weight loss
- pain in the tummy (abdomen) or back passage
- feeling that you haven't emptied your bowel properly after a bowel motion
- unexplained tiredness.

Sometimes the cancer can cause a blockage (obstruction) in the bowel. You may feel constipated and bloated, be sick (vomit) and have tummy pain.

Although these symptoms can be caused by conditions other than rectal cancer, you should always have them checked by your doctor.

If you have symptoms that don't improve within a few weeks, or if your symptoms get worse, it's important that you're referred to a specialist for tests to find out what the problem is.



How rectal cancer is diagnosed

Most people are diagnosed after going to see their GP about symptoms. If your GP suspects you may have cancer, you should be seen at the hospital within 14 days.

Some people are diagnosed after taking a test as part of the NHS Bowel Screening Programme. Bowel screening is a way of finding bowel cancer at an early stage before it causes symptoms.

Sometimes, people are diagnosed with rectal cancer after being admitted to hospital with a problem, such as bowel obstruction (see pages 53–54).

At the hospital

The specialist will ask you about your general health and any previous medical problems you've had. They'll ask whether you have a family history of bowel cancer.

They will examine you, and may carry out a rectal examination. This involves the doctor placing a gloved finger into your back passage to feel for any lumps or swelling. It may feel uncomfortable, but not painful.

You will usually have a blood test to check your level of red blood cells. If you have a low number of red blood cells, this is called anaemia. You will also have blood tests to check whether your liver and kidneys are working normally.

The main test used to look for bowel cancer is a colonoscopy.

Other tests that are sometimes used to diagnose bowel cancer include:

- virtual colonoscopy (see page 20)
- sigmoidoscopy (see pages 20–21).

Colonoscopy

A colonoscopy looks at the inside of the whole length of the large bowel. You can usually have this test as an outpatient. It takes about an hour.

Your bowel has to be completely empty for a colonoscopy. You will be given instructions on what you can eat and drink the day before the test. You'll also be given a medicine (laxative) to take to empty your bowel.

Just before the test, you may be given a sedative into a vein (intravenously) to help you feel more relaxed during the colonoscopy.

Once you're lying comfortably on your side, the doctor or nurse will gently pass a flexible tube (a **colonoscope**) into your back passage. There is a tiny light and camera on the end of the colonoscope. During the test, the doctor or nurse will use this to photograph any areas of the bowel that look abnormal. They may also take samples (biopsies) from these areas. The biopsies will be sent to the laboratory to be checked for cancer cells.

Most people are ready to go home a couple of hours after having a colonoscopy. You'll need someone to collect you from the hospital, as you should not drive for 24 hours after a sedative.

Virtual colonoscopy (CT colonography, CT enema, CT pneumocolon)

In this test, a CT scanner (see page 23) takes a series of x-ray pictures of your bowel. A computer then puts these together to make a three-dimensional picture of your bowel. This test may be done instead of a colonoscopy, or it may be done if the colonoscopy didn't give a clear enough picture.

A virtual colonoscopy is done in the hospital CT department. You can usually have it as an outpatient.

Your bowel has to be completely empty for the scan. You'll need to follow a special diet for a few days and take a laxative before the test. Your hospital will give you instructions about what to do.

Your doctor may give you an injection of a medicine to help the muscles in your bowel relax. You may also have an injection of a dye (contrast medium) at the same time. Your doctor will tell you if you're going to have this.

Just before the CT scan, the doctor will pass a tube into your back passage (rectum) and pump in some air and gas (carbon dioxide). This expands the bowel and helps to give a clearer picture. You will have two CT scans – one while lying on your back and one while lying on your front.

Sigmoidoscopy

This test looks at the inside of the rectum and the part of the colon closest to the rectum (the sigmoid colon). You can usually have it done as an outpatient.

A sigmoidoscope is a tube with a light and camera on the end. You lie curled on your left side and a doctor or nurse passes the tube into your back passage.

A small amount of air is pumped into the bowel to make it easier to see inside it. This will make you feel like you need the toilet, but the feeling will gradually go away once the test is over.

During the test, the doctor or nurse will take samples of tissue (biopsies) from any areas of the rectum that look abnormal. This is painless.

You should be able to go home as soon as the test is over.

Further tests

If any of your biopsies show that there is cancer in the rectum, you will have more tests. These are to find out the size and position of the cancer and whether it has spread. This is called staging. The results will help you and your doctor decide on the best treatment for you. Some tests may be repeated during and after treatment to check your progress. Your doctor or specialist nurse will explain this to you.

You will usually have blood tests and a CT (computerised tomography) scan. Some people also have an MRI scan or a PET/CT scan.

Blood tests

You will have blood tests to assess your general health.

Your blood may be tested for a protein called carcinoembryonic antigen (CEA). Some people with bowel cancer have higher levels of this protein. If your level of CEA is high, your doctors may check it regularly to see how well your treatment is working.



CT (computerised tomography) scan

This test checks for any signs that the cancer has spread outside the rectum. There is a photograph of someone having a CT scan on the opposite page.

A CT scan takes a series of x-rays, which build up a three-dimensional picture of the inside of the body. The scan takes 10–30 minutes and is painless. It uses a small amount of radiation, which is very unlikely to harm you and will not harm anyone you come into contact with.

You will be asked not to eat or drink for at least four hours before the scan.

You may be given a drink or injection of a dye, which allows particular areas to be seen more clearly. This may make you feel hot all over for a few minutes. It's important to let your doctor know if you are allergic to iodine or have asthma, because you could have a more serious reaction to the injection. You'll probably be able to go home as soon as the scan is over.

MRI (magnetic resonance imaging) scan

An MRI scan is used to help stage the cancer (see pages 27–31) and plan treatment.

The test uses magnetism to build up a detailed picture of areas of your body. The scanner is a powerful magnet, so you may be asked to complete and sign a checklist to make sure it's safe for you. The checklist asks about any metal implants you may have, such as a pacemaker, surgical clips or bone pins. You should also tell your doctor if you've ever worked with metal or in the metal industry, as very tiny fragments of metal can sometimes lodge in the body. If you do have any metal in your body, it's likely that you won't be able to have an MRI scan. In this situation, another type of scan can be used.

Before the scan, you'll be asked to remove any metal belongings including jewellery. Some people are given an injection of dye into a vein in the arm, which doesn't usually cause discomfort. This is called a contrast medium and can help the images from the scan to show up more clearly.

During the test, you'll lie very still on a couch inside a long cylinder (tube) for about 30 minutes. It's painless but can be slightly uncomfortable, and some people feel a bit claustrophobic. It's also noisy, but you'll be given earplugs or headphones. You can hear, and speak to, the person operating the scanner.

Other tests

The following tests are sometimes used. You can discuss with your doctor whether they are appropriate for you.

Endorectal ultrasound scan (ERUS)

This test may be used to help plan your operation. Ultrasound scans use sound waves to build up a picture of body tissues. An endorectal ultrasound scan can show the size and location of a cancer in the rectum.

For the test, you lie on your left side with your knees bent up. A nurse or doctor gently passes a small, lubricated probe into the back passage. This produces an image of the rectum on a screen.

The scan takes about 10 minutes and you can usually go home as soon as it's over.

PET/CT scan

This is a combination of a CT scan (see page 23) and a positron emission tomography (PET) scan. A PET scan uses low-dose radiation to measure the activity of cells in different parts of the body.

A PET/CT scan may occasionally be done if more detailed information is needed after a CT scan. It may also be used to help the doctors plan treatment if there is cancer in the liver or lungs.

You won't be able to eat for six hours before the scan, although you may be able to drink. A technician injects a small amount of mildly radioactive glucose (sugar) into a vein in your hand or arm. The radiation dose is very small. You then wait for the glucose to be absorbed by your body. After an hour or so you have the scan, which takes 30–90 minutes. The scan will show areas where the glucose has been absorbed. Cancers absorb more glucose than other parts of the body. This helps the doctors identify any areas of cancer. You can usually go home after the scan.

Waiting for test results

Waiting for test results can be a difficult time. It may take from a few days to a couple of weeks for the results of your tests to be ready. You may find it helpful to talk with your partner, family or a close friend. Your specialist nurse or one of the organisations listed on pages 121–127 can also provide support. You can also talk things over with one of our cancer support specialists on **0808 808 00 00**.



Staging and grading

Staging

The stage of a cancer describes its size and whether it has spread. Knowing the stage of your cancer helps doctors decide on the best treatment for you. The most commonly used staging system is the TNM system.

TNM staging system

T describes how far the **t**umour has grown into the wall of the bowel, and whether it has grown into nearby tissues or organs.

N describes whether the cancer has spread to the lymph **n**odes.

M describes whether the cancer has spread to another part of the body such as the liver or lungs (secondary or **m**etastatic cancer).

T – Tumour

The bowel wall is made up of layers of different tissues (see diagram opposite).

Tis means the cancer is at its earliest stage (in situ). It is growing into the mucosa but no further.

T1 means the tumour is only in the inner layer of the bowel (submucosa).

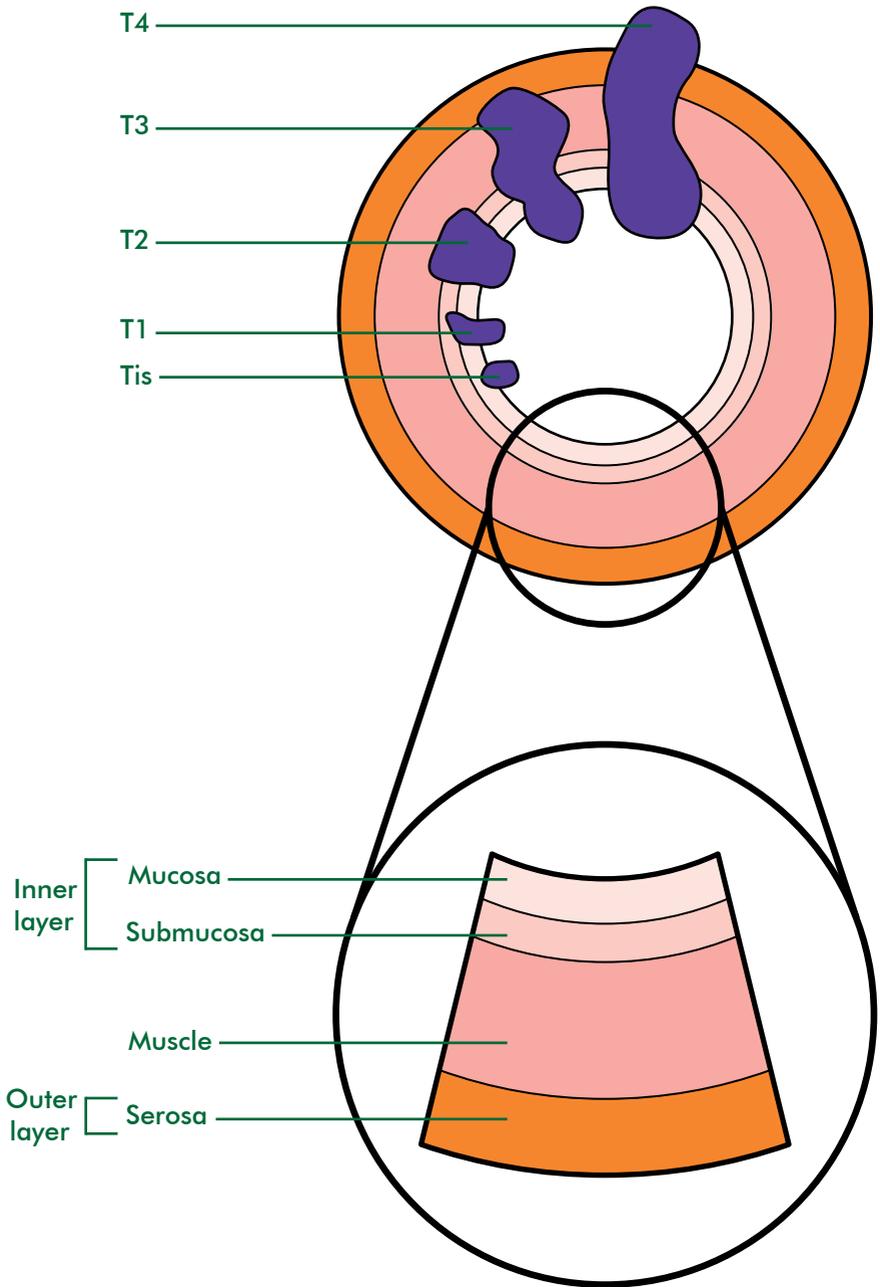
T2 means the tumour has grown into the muscle layer of the bowel wall but no further.

T3 means the tumour has grown into the outer lining of the bowel wall (serosa) but no further.

T4 means the tumour has grown through the outer layer of the bowel wall (serosa) and through the membrane covering the outside of the bowel wall (peritoneum).

T4a means it has grown into other nearby structures, such as other parts of the bowel or other organs or body structures.

T4b means the tumour has caused a hole in the bowel wall (perforation) and cancer cells have spread outside the bowel.



Cross-section showing the different layers of the bowel and the different T stages of cancer (in purple)

N – Nodes

N0 means no lymph nodes contain cancer cells.

N1 means there are cancer cells in up to three nearby lymph nodes.

N2 means there are cancer cells in four or more nearby lymph nodes.

M – Metastases

M0 means the cancer hasn't spread to distant organs.

M1 means the cancer has spread to distant organs such as the liver or lungs.

Number staging system

Information from the TNM system can be used to give a number stage from 0 to 4.

Stage 0 – The cancer is at its earliest stage and is only in the mucosa (Tis N0 M0).

Stage 1 – The cancer has grown into the submucosa or muscle but has not spread to the lymph nodes or elsewhere (T1 N0 M0 or T2 N0 M0).

Stage 2 – The cancer has grown through the muscle wall or through the outer layer of the bowel, and may be growing into tissues nearby. The cancer has not spread to the lymph nodes or elsewhere (T3 N0 M0 or T4 N0 M0).

Stage 3 – The tumour is any size and has spread to lymph nodes nearby, but has not spread anywhere else in the body (Any T N1 or N2 M0).

Stage 4 – The tumour is any size. It may have spread to nearby lymph nodes. The cancer has spread to other parts of the body such as the liver or lungs (Any T Any N M1).

Grading

The grade of a cancer gives doctors an idea of how quickly it may develop. Doctors will look at a sample of the cancer cells under a microscope to find the grade of your cancer.

Grade 1 (low-grade) – The cancer cells tend to grow slowly and look quite similar to normal cells (they are ‘well differentiated’). These cancers are less likely to spread than higher grade cancers.

Grade 2 (moderate-grade) – The cancer cells look more abnormal.

Grade 3 (high-grade) – The cancer cells tend to grow more quickly and look very abnormal (they are ‘poorly differentiated’). These cancers are more likely to spread than low-grade cancers.

Treatment overview

Treatments used for rectal cancer include surgery, radiotherapy, chemotherapy and sometimes targeted therapy. Often, a combination of treatments is used. When chemotherapy and radiotherapy are given together, it's called chemoradiation.

Treatment depends on the stage of the cancer and where it is in the rectum. It also depends on your general health and personal preferences.

It's important you have the chance to discuss treatments with your doctor. This will help you understand why a particular plan of treatment has been suggested, and how the treatment may affect you.

Surgery to remove the cancer is one of the main treatments for rectal cancer. The operation usually involves removing part or all of the rectum, as well as nearby lymph nodes (see pages 39–49). If the cancer has grown into nearby tissue or organs, the surgeon may remove parts of these too.

Sometimes, surgery is used to relieve symptoms rather than cure the cancer. This may be if the cancer is causing a blockage in the bowel (see pages 53–54).

Occasionally, surgery may be used to remove cancer that has spread to a distant part of the body, such as the liver or lungs (see pages 50–52).

Radiotherapy (see pages 71–81) or **chemoradiation** (see page 92) may be given before or after rectal surgery. These treatments help to reduce the risk of the cancer coming back in, or close to, the rectum.

Radiotherapy is also sometimes used to relieve symptoms such as pain or bleeding. This is called palliative radiotherapy.

Sometimes, **chemotherapy** (see pages 83–91) is given after surgery to reduce the risk of the cancer coming back.

If cancer has spread to the liver or lungs (secondary cancer), chemotherapy may be the main treatment. It is given to shrink the cancer and to control it for as long as possible. Some people with secondary cancer have chemotherapy to shrink the cancer before having an operation to remove it.

Targeted therapies (see pages 93–95) are sometimes used on their own or in combination with chemotherapy to control secondary cancer.

Your cancer specialist may invite you to take part in a clinical trial. You can read more about this on pages 96–97.



How treatment is planned

A team of specialists will meet to plan your treatment. This multidisciplinary team (MDT) will include a:

- surgeon who specialises in bowel cancers
- medical oncologist (chemotherapy specialist)
- clinical oncologist (radiotherapy and chemotherapy specialist)
- nurse specialist
- radiologist (specialist in x-rays and scans)
- pathologist (specialist in studying tissue samples to detect diseases)
- stoma care nurse.

It may also include other healthcare professionals, such as a gastroenterologist (doctor who specialises in bowel problems), dietitian, physiotherapist, occupational therapist, psychologist or counsellor.

If the cancer has spread to your liver, you may also be referred to an MDT that specialises in surgery for secondary cancer in the liver. In this situation, the two MDTs will work together to plan your treatment.

Talking about your treatment plan

After the MDT meeting, your cancer specialist or nurse will talk to you about your treatment options.

They will explain the main aims of treatment. These may be to try to cure the cancer, to help you live longer or to relieve symptoms. They will also tell you the possible short-term and long-term side effects of the treatments.

Deciding on which treatments are right for you is usually a joint decision between you and your cancer team. Cancer specialists have expert knowledge of the treatments, but you know your individual situation and your beliefs and preferences.

Usually, if there is one treatment that has been shown to work best, most people are happy to be guided by their cancer doctor. But there can be times when the choice of treatment will depend on your individual preferences. For example, if there are two or more treatments that may work equally well but cause different side effects. Or, if having an additional treatment may increase the chance of a cure by a small amount, but at the cost of unpleasant side effects.

Some treatments, such as radiotherapy or chemoradiation, can reduce the chance of cancer coming back. But they may cause new side effects to develop months or years later. Your doctor will talk to you about the possible advantages and disadvantages of these treatments with you.

If a cure is not possible and the aim of treatment is to control the cancer for some time, it may be more difficult to decide what to do. You may need to discuss this in detail with your doctor. If you choose not to have the treatment, you can still be given supportive (palliative) care to control any symptoms.

When making treatment decisions, it's important to talk things over carefully with your cancer team. It can help to make a list of the questions you want to ask them. You can take this to your next appointment. It's also helpful to have a relative or close friend with you at appointments. You may choose to keep notes about what has been said. You can use pages 128–129 to write down any questions or notes.



You can order our free booklet *Making treatment decisions* from be.macmillan.org.uk or by calling us. It explains how you can find out about treatment options and what things may help you make your decision.

Giving your consent

Before you have any treatment, your doctor will explain its aims. They will usually ask you to sign a form saying that you give permission (consent) for the hospital staff to give you the treatment. No medical treatment can be given without your consent, and before you are asked to sign the form you should be given full information about:

- the type and extent of the treatment
- its advantages and disadvantages
- any significant risks or side effects
- any other treatments that may be available.

If you don't understand what you've been told, let the staff know straight away, so they can explain again. Some cancer treatments are complex, so it's not unusual to need repeated explanations.

You can always ask for more time if you feel that you can't make a decision when your treatment is first explained to you.

You are free to choose not to have the treatment. The staff can explain what may happen if you don't have it. It's essential to tell a doctor or the nurse in charge, so they can record your decision in your medical notes. You don't have to give a reason for not wanting treatment, but it can help to let the staff know your concerns so they can give you the best advice.

Second opinion

Your multidisciplinary team (MDT) uses national treatment guidelines to decide the most suitable treatment for you. Even so, you may want another medical opinion. If you feel it will be helpful, you can ask either your specialist or GP to refer you to another specialist for a second opinion. Getting a second opinion may delay the start of your treatment, so you and your doctor need to be confident that it will give you useful information.

'I read everything I could find on bowel cancer. So by the time I came to see my consultant, I had got a notebook with 15 questions written down. I wanted to know how long I'd be in hospital, how long before I could drive, how I'd be affected, all these things. And I got straight answers from my consultant.'

Gordon

Surgery

Surgery is the most common treatment for rectal cancer.

You may have radiotherapy or chemoradiation before surgery. This can make it easier to remove the cancer. It also lowers the risk of the cancer coming back in the rectum or in the tissues close to it.

Surgery to remove rectal cancer

There are different techniques and types of operation that can be used. The type your surgeon recommends will depend on the stage of the cancer, where it is in the rectum and your general health.

After the operation, all the tissue that the surgeon has removed will be sent to a pathologist (see page 35). They will check the tissue carefully for any cancer cells close to the cut ends (the margins). If they find cancer cells in the margins, it is possible that not all of the cancer was removed during the operation. This is not common, but if it happens you may be offered a second operation or radiotherapy.

Local resection

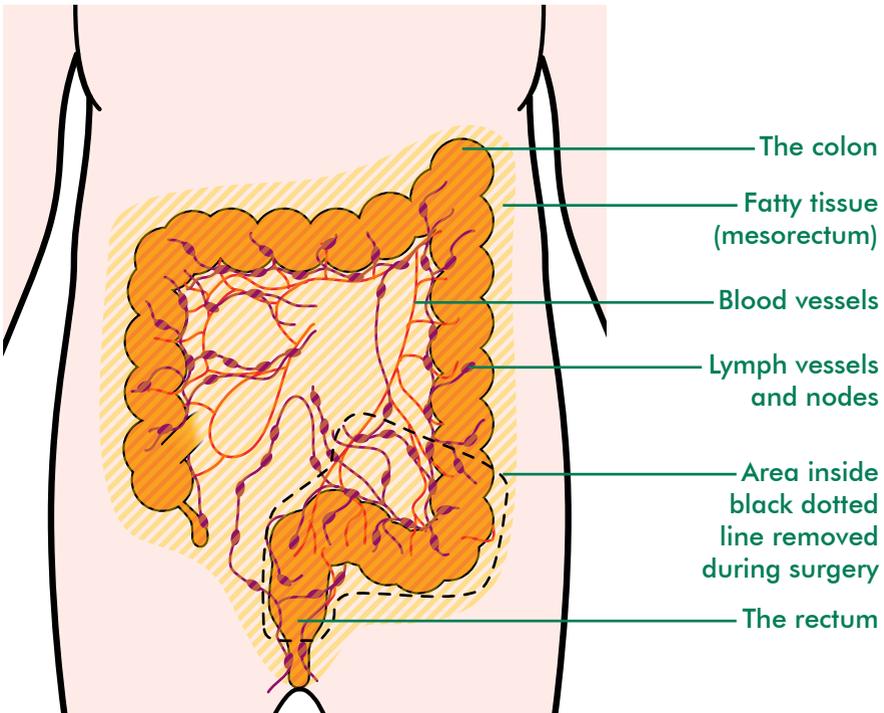
Very small, stage 1 rectal cancers can sometimes be removed using a local resection. This is a small operation to remove the cancer and some healthy tissue surrounding it.

The surgeon inserts an endoscope up the rectum to remove the cancer. An endoscope is a long, flexible tube with a tiny camera at the end. This surgery is called **transanal endoscopic micro surgery (TEMS)**.

If the cancer is very low in the rectum, close to the anus, the surgeon may not need an endoscope. They may be able to remove the cancer by passing surgical instruments up the anus. This is called a **transanal rectal resection**.

Total mesorectal excision (TME)

This is the most commonly used operation to remove rectal cancer. The surgeon removes the part of the rectum that contains cancer, as well as some healthy bowel on either side. They also remove the fatty tissue (mesorectum) around the rectum, which contains blood vessels and lymph nodes. Removing the mesorectum reduces the risk of any cancer being left behind. In the illustration below, the black dotted line shows an example of the tissue that may be removed during a TME operation.



The large bowel and mesorectum

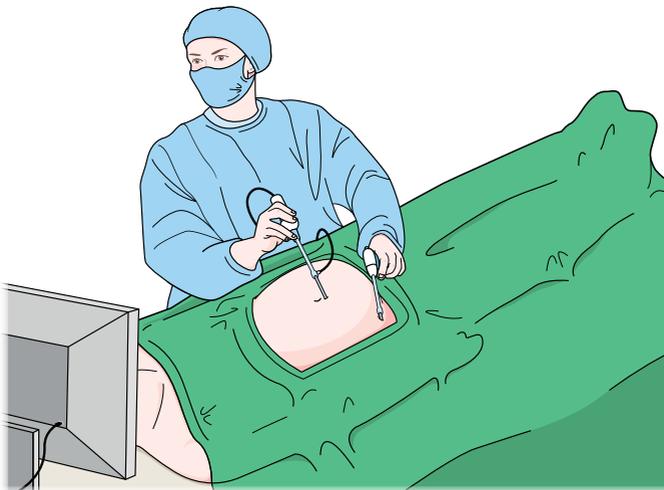
Open or laparoscopic surgery

A TME may be carried out as open surgery or as laparoscopic (keyhole) surgery.

Open surgery means the surgeon makes one large cut (incision). Afterwards, you have a wound that goes down in a line from just below your breastbone (sternum) to just below the level of your tummy button (navel). Some people have a wound that goes across their tummy instead.

In laparoscopic (keyhole) surgery, the surgeon makes four or five small cuts in the abdomen rather than one big cut. They pass a laparoscope into the abdomen through one of the cuts. A laparoscope is a thin tube containing a light and camera. Then they pass specially designed surgical tools through the other cuts to remove the cancer.

Recovery from laparoscopic surgery is usually quicker than recovery from open surgery. Your surgeon will talk to you about which type of surgery is appropriate.



Laparoscopic surgery

Stomas (colostomy/ileostomy)

After an operation to remove rectal cancer, some people will go to the toilet in a different way. They will have an opening on their tummy wall through which they pass bowel motions. This is called a stoma. A bag is worn over the stoma to collect bowel motions.

The stoma is made from an opening in part of the bowel. If the stoma is made from an opening in the colon, it is called a colostomy. If it's made from an opening in the small bowel (ileum), it is called an ileostomy.

Stomas can be temporary or permanent. A surgeon may make a temporary stoma to allow the bowel to rest after rectal cancer surgery.

There are two kinds of stoma: a **loop stoma** and an **end stoma**. To make a loop stoma, the surgeon pulls a small loop of bowel out through a cut in the tummy (abdomen). They then make an opening in the loop of bowel and stitch the loop to the skin. This forms the stoma.

To make an end stoma, the surgeon cuts the bowel and brings the active end out onto the skin and stitches it into place. This forms a stoma.

If you have a temporary stoma, you will usually have a second smaller operation a few months later to close the stoma and rejoin the bowel. This operation is called a stoma reversal (see page 69).

If the cancer is very low in your rectum, close to the anus, you are more likely to need a permanent stoma (see pages 48–49).

Your surgeon will tell you whether you are likely to have a stoma after your operation, and whether it will be temporary or permanent.



There is a video on our website of a stoma nurse explaining the different types of stoma and what happens after your operation. Visit [macmillan.org.uk/havingastoma](https://www.macmillan.org.uk/havingastoma)

Types of TME operation

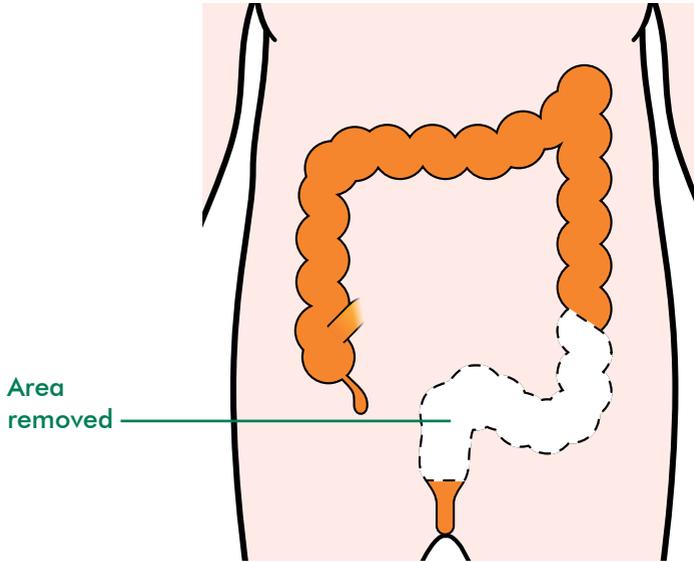
There are different types of TME operation. The type your surgeon recommends will depend on where the cancer is in your rectum, the size of the tumour and how far it is from the anus.

Anterior resection

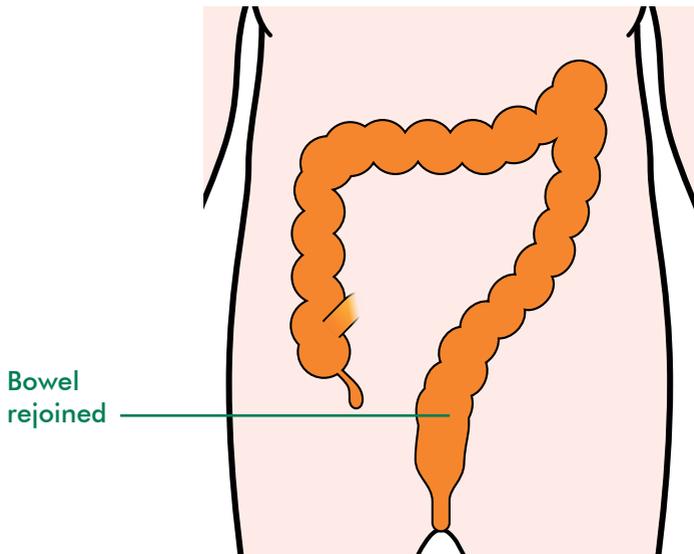
An anterior resection is usually used for cancers in the upper and middle parts of the rectum (close to the colon).

After the piece of bowel that contains the cancer is removed, the surgeon rejoins the two open ends of bowel. The illustrations opposite show the part of the bowel that is removed, and how the two ends are joined together.

Some people may have a temporary stoma (usually an ileostomy) after this operation (see pages 42–43). A stoma reversal operation (see page 69) can usually be done a few months later.



Anterior resection – area to be removed

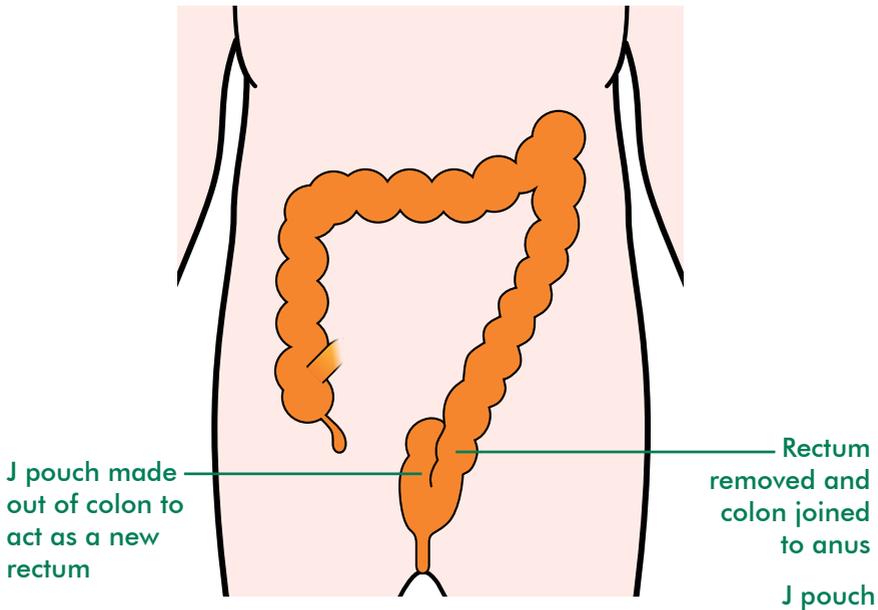


Anterior resection – bowel has been rejoined

Colo-anal and 'J pouch' surgery

This operation may be used for tumours low in the rectum. The surgeon removes all of the rectum and attaches the colon to the anus. Sometimes, the surgeon makes a pouch (called a J pouch) from part of the colon, before joining it to the anus. The pouch acts like a new rectum and stores bowel motions until it is convenient to pass them. The illustration below shows a J pouch.

You may have a temporary stoma (usually an ileostomy) after this operation (see pages 42–43). This allows the bowel to heal. A stoma reversal (see page 69) can usually be done a few months later.

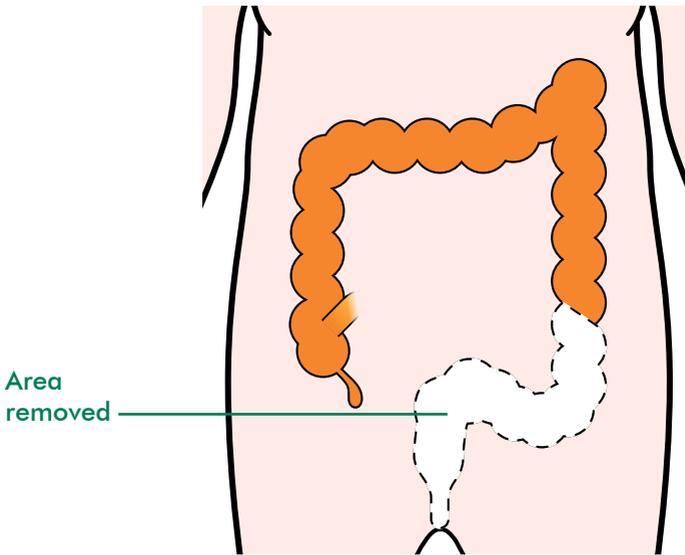




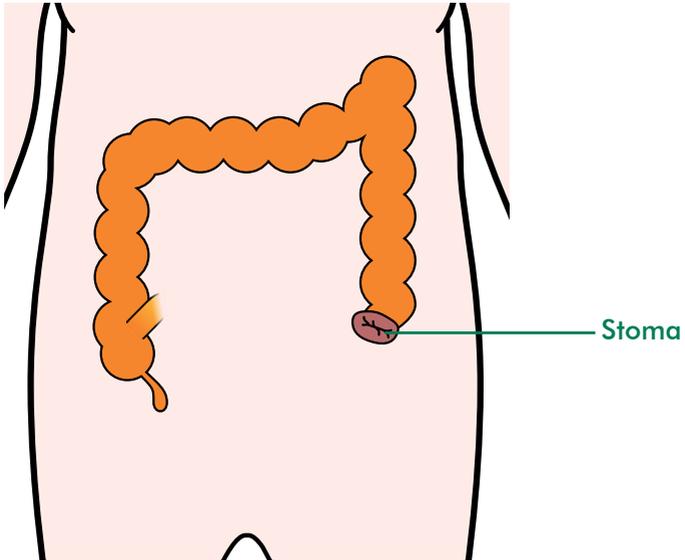
Abdomino-perineal resection (APR)

This operation is usually used for cancers that are very low in the rectum, near to the anus. In order to remove all of the cancer, the surgeon needs to remove the rectum and anus. You will have a permanent stoma (usually a colostomy) after this operation (see pages 42–43).

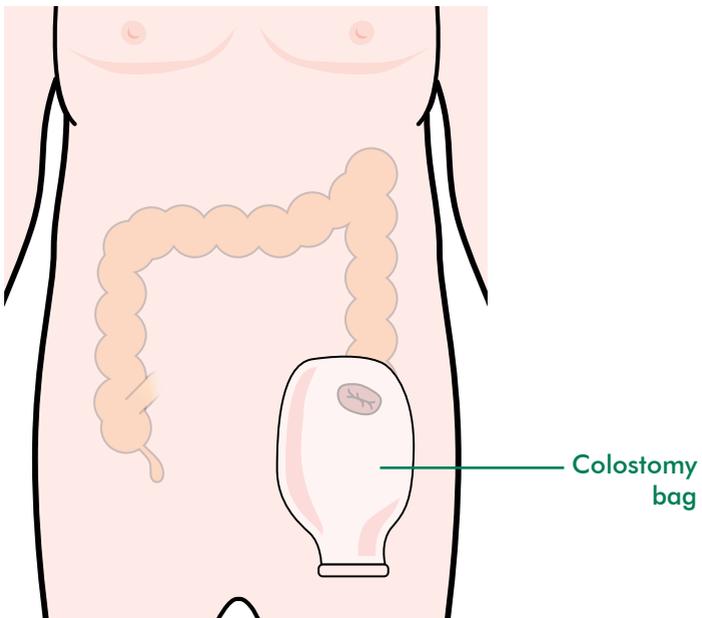
As well as the wound(s) on your tummy, you will have a wound on your bottom, where the anus has been closed.



Abdomino-perineal resection – area to be removed



Permanent stoma formed after abdomino-perineal resection



Colostomy bag outside the body

Surgery for advanced rectal cancer

Pelvic exenteration

If the cancer has grown into other organs nearby, some people need a bigger operation to try to remove it. This is called a pelvic exenteration. Your doctor will explain more about this operation if it is appropriate for you.



We have more information on pelvic exenteration that we can send you.

Lung resection

The main treatment for cancer that has spread to the lungs is chemotherapy. But occasionally, people may be offered surgery to remove the affected part of the lung. This is only if the cancer is in just one area of the lung and nowhere else in the body.

Liver resection

If rectal cancer has spread to the liver, the most common treatment is chemotherapy. The aim is to shrink the cancer and to control it for as long as possible.

Some people may be able to have surgery to remove the part of the liver affected by cancer. This operation is called a liver resection. It can sometimes lead to a cure.

Liver resection is a major operation that takes 3–7 hours. It is done by surgeons experienced in liver surgery (hepatobiliary surgeons) in specialist hospitals. This treatment is only suitable for a few people with secondary liver cancer.

An operation to remove the cancer in the rectum may be done at the same time or as a separate operation.

If you have secondary liver cancer, you can talk to your doctor about whether this surgery may be helpful for you. A course of chemotherapy is usually given before liver resection.

Other treatments for rectal cancer that has spread to the liver

If the cancer has spread to the liver and can't be removed with surgery, the main treatment is usually chemotherapy (see pages 83–91). Other treatments that target the liver may also be used. The aim of these treatments is to relieve symptoms by shrinking the cancer and controlling it for as long as possible.

Radiofrequency ablation (RFA) uses heat to destroy cancer cells. An electrode (like a needle) sends an electrical current (radiofrequency) to the tumour. The electrical current heats the cancer cells to high temperatures and destroys (ablates) them. As the cancer cells die, the area that's been treated gradually shrinks and becomes scar tissue.

RFA doesn't always destroy all the cancer cells. Some people may need to be treated more than once. RFA can be repeated if the tumour starts to grow again.

The most common way to give RFA involves a doctor placing one or more electrodes through the skin into the tumour. A CT scanner shows the position of the liver and tumours on a screen. This guides the doctor as they put each electrode into place.

Sometimes, a similar treatment called microwave ablation (MWA) is used.



We have more information about radiofrequency ablation that we can send you.

Cryotherapy means using very low temperatures to destroy cancer cells. Like with RFA, the doctor inserts an instrument into the body towards the tumour to deliver the treatment.

Secondary cancer in the liver can also be treated with radiotherapy – see pages 71–81 for more information.



We have a booklet called *Understanding secondary cancer in the liver*, which has information about treatments you may have. Order it from be.macmillan.org.uk or call us.

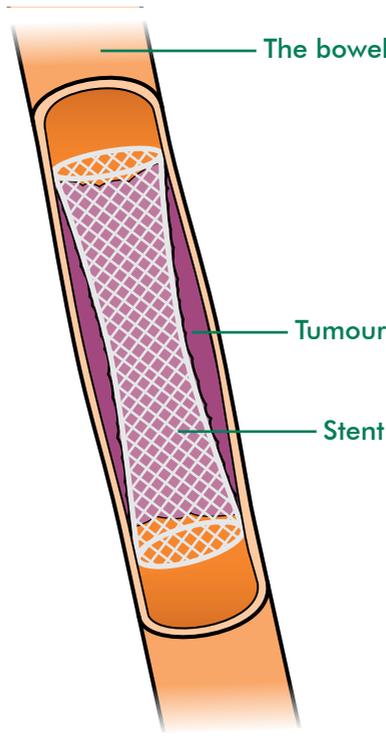
Treating a blocked bowel (bowel obstruction)

Sometimes, rectal cancer can narrow the bowel, stopping bowel motions from passing through. This can cause symptoms such as tummy pain and vomiting. It usually needs to be treated urgently. It can be treated in one of two ways.

Stenting to relieve a blocked bowel

The surgeon uses a colonoscope (see page 19) to insert an expandable metal tube (stent) into the blockage. The tube then expands to hold the bowel open.

The cancer causing the blockage can usually be removed with an operation at a later date.



Cross-section of a part of the bowel, with a stent inside

Surgery to relieve a blocked bowel

Sometimes, a bowel obstruction is treated with an operation to remove the blocked section of bowel. Most people will have a temporary or permanent stoma after this operation (see pages 42–43). The surgeon may remove the cancer at the same time or do this later in another operation.

Before your operation

If you smoke, try to give up or cut down before your operation. This will help reduce your risk of chest problems, such as a chest infection. It will also help your wound to heal after the operation. Your GP can give you advice and support to help you give up smoking. You may find it helpful to read our booklet *Giving up smoking*.

You will go to a pre-assessment clinic for tests to check you're fit for the operation. These may include blood tests, a blood pressure check and a recording of your heart (ECG).

You'll meet a member of the surgical team to discuss the operation. If you are going to have a stoma after the operation, you will also meet a stoma care nurse who will explain what's involved. This is a good time to share any questions or concerns you have about the operation. If you think you may need help when you go home after surgery, for example because you live alone or care for someone else, tell your nurse as soon as possible. It will help them to make arrangements in plenty of time.

Some hospitals follow an enhanced recovery programme, which aims to reduce the time you spend in hospital and speed up your recovery. It also involves you more in your own care. For example, you'll be given information about diet and exercise before surgery. You may be given supplement drinks to take.

Any arrangements needed for you to go home will also be organised for you. Your doctor will tell you if an enhanced recovery programme is suitable for you and if it's available.

You'll usually be admitted to hospital on the morning of the operation. You'll be given elastic stockings (TED stockings) to wear. This is to prevent blood clots in your legs.

After your operation

You'll be encouraged to start moving around as soon as possible. This helps prevent complications, such as chest infections and blood clots. The nurses will encourage you to do regular leg movements and deep breathing exercises. A physiotherapist or nurse can explain these to you.

On the evening of the operation or on the following day, you will usually be helped to get out of bed or to sit up for a short time. After this, you will be encouraged to be up for longer periods and to begin walking around the ward.

Pain

You will have some pain and discomfort after your operation. This can be controlled with painkillers. If you feel sick or are in pain, tell the nurses. They can give you medicines to relieve sickness. You may need to have your dose or type of painkiller changed.

You may be given a spinal block during the operation. This is an injection of long-lasting painkiller into the fluid around the spinal cord. It gives pain relief for up to 24 hours. Alternatively, you may have a continuous dose of painkiller into the spinal fluid through a fine tube and a pump. This is called an epidural.

Painkillers can also be given through a tube into a vein in your hand or arm (cannula). The tube is connected to a pump. This is called a PCA (patient-controlled analgesia). You can give yourself an extra dose of painkiller when you need it by pressing a button. The machine is set so you get a safe dose and can't have too much.

Before you go home, your pain will be controlled by tablets. You'll be given a prescription for painkillers you can take at home as needed.

Drips and drains

At first, you'll be given fluids into a vein in your hand or arm. This is called a drip or intravenous infusion. Once you're eating and drinking normally again, it can be removed.

You'll usually have a tube put in during the operation to drain urine from your bladder (a catheter). This will be taken out once you're eating and drinking normally and are able to walk to the toilet.

Some people may have a nasogastric tube. This is a tube that goes up the nose and down into the stomach. It's used to remove fluid from the stomach until the bowel starts working again.

You may have a tube (drain) close to the operation wound to drain fluid away. A nurse will remove it after a few days, when the fluid stops draining.

Eating and drinking

You will usually be able to eat and drink again soon after surgery. You may be given supplement drinks for a few days after surgery to help your recovery.

Stoma

If you have a stoma, it will be swollen at first but will shrink to its final size within a few weeks.

If you have a 'loop' stoma (see page 42) there may be a rod underneath the loop to support it. A nurse will usually take the rod out after a few days.

You will usually see a stoma care nurse on the first day after your operation. They will begin to teach you how to look after the stoma. Most people are able to manage by themselves within about 3–4 days. You may want to have your partner or a close relative with you while you're taught how to care for your stoma. Then they will know how to help, if needed, when you are home. You will continue to have support from a stoma care nurse after you go home.

'When I'd had the operation, a stoma nurse came in just to advise what the procedure was for changing the bag. There are stoma nurses there all the time so if you want any help, you've only got to phone. It's a simple job of changing a bag, you know. If I'm out somewhere at a hotel or somewhere, and I have lunch, I can nip out and change the bag in five minutes.'

Seamus

Going home

Depending on the type of operation you've had, you'll probably be ready to go home 3–7 days after surgery.

You'll be given an appointment to attend an outpatient clinic for your post-operative check-up. At the appointment, your doctor will talk to you about whether you need to have any further treatment, such as radiotherapy or chemotherapy.

If you have stitches, clips or staples in your wound, these are usually taken out 7–10 days after the operation. Your practice nurse can do this. If you can't leave home, a district nurse can visit you.

If you have a stoma, the hospital will give you stoma supplies to go home with. After this, you will need to order supplies from your chemist or direct from a specialist supply company. Your stoma care nurse can tell you about these. The Ileostomy and Internal Pouch Support Group and the Colostomy Association also have details of companies (see page 122). You'll need a prescription from your GP to get stoma supplies. If you're aged between 16 and 60, make sure that your doctor signs the form saying that you're entitled to free prescriptions.

Bowel function after surgery

Most people have changes in how their bowel works after rectal surgery.

If you had a local resection (see pages 39–40), your bowel will usually recover quite quickly.

After TME surgery (see page 40), it will take longer. It could take several months for your bowel function to get into a regular pattern. It may never be the same as it was before the cancer. But in time, it should settle into a routine that you recognize as normal for you.

If you had radiotherapy or chemoradiation before or after rectal surgery, this will also affect your bowel. This could mean it takes longer to get back to a regular bowel habit.

After rectal surgery, you may experience one or more of the following changes:

- needing to open your bowels several times a day (frequency)
- feeling you can't wait when you feel the need to open your bowels (urgency)
- diarrhoea or constipation
- losing control over when your bowels open (incontinence)
- difficulty telling the difference between wind or stools
- feeling bloated or passing a lot of wind
- having a sore bottom.

These effects usually improve over time. Tell your surgeon or specialist nurse if you are having problems, or if your bowel isn't settling into a routine. They can give you advice, prescribe medicines or refer you to a continence specialist nurse or dietitian.

Diet after bowel surgery

Eating at regular times helps to encourage a regular pattern for your bowel function. If your appetite isn't good, it may be easier to eat several small meals a day, rather than one or two large meals. Drink at least 1–2 litres of fluid a day, especially if you have loose stools or diarrhoea.

Including high-protein foods such as fish, meat and eggs in your diet will help your body to heal after surgery.

It's important to eat a wide range of different food types for a healthy, well-balanced diet. But, some foods may cause problems. Keeping a daily diary of what you eat and how this affects you can help.

If you have diarrhoea, choose low-fibre foods such as white bread and pasta instead of wholemeal. Eat fewer leafy green vegetables, cook vegetables well and peel fruit.

As your bowel settles, try to gradually reintroduce foods that caused you problems. You may find they no longer affect your bowel. If you continue to be limited in what you can eat, it's definitely worth getting advice from a dietitian.

Treatment such as anti-diarrhoeal medicine may help you to manage your bowel symptoms better, which may allow you to eat a wider range of foods.

Wind

Some people have problems with excess wind or bloating after bowel surgery. Here are some tips:

- Eat slowly and chew food well.
- Be aware that beans, beer, chewing gum, fizzy drinks and onions can cause wind.
- Peppermint capsules or oil, fennel and mint tea may help.

'I went through some funny times getting my body to accept foods. There were days when I was back on the loo more frequently than I'd want to be. And there'd be other periods of time when I was constipated. But if I've got to put up with the inconvenience of having to go two or three times one morning because of something I've eaten the day before, so be it. It doesn't stop me going out that day, it doesn't stop me getting on with my business and enjoying my life.'

Anita

Medicines

Your doctor or specialist nurse may recommend you take anti-diarrhoeal drugs. The most commonly used drug is loperamide (also called Imodium[®] or Diareze[®]). It slows down your bowel, making the stools more solid and less frequent.

Taking loperamide regularly, half an hour before meals, works well for some people. Loperamide is also available as a syrup, so you can adjust the dose as needed. It may take time to find the dose that works best for you. Your doctor may recommend you start with a low dose and increase this until it works for you.

It's safe to take loperamide for as long as you need it, but you should discuss this with your doctor.

Managing stress

Your emotions can also affect your bowel. Anxiety and stressful situations can make bowel movements looser and more frequent. If you don't feel in control of your bowel, this in itself can be stressful.

Learning how to relax may help your bowel to settle and will be good for your general health. Your doctor or specialist nurse can tell you about relaxation classes in your area. Some support groups also offer relaxation classes.



You may want to order our booklet *Eating problems and cancer*. It covers common eating difficulties after cancer, explains why they happen and offers some practical tips for managing them.

Pelvic floor exercises

There are exercises you can do to strengthen the muscles used for bowel control. There are two main groups of muscles that are important for bowel control: the sphincter muscles in the back passage (anus) and the pelvic floor muscles (also important for bladder control and sexual function).

Pelvic floor exercises may help if you have problems with leakage of wind or stool from your back passage. A colorectal or continence specialist can tell you if these exercises are likely to help you. They can teach you how to do them.

It can take at least 12 weeks of doing pelvic floor exercises three times a day to rebuild strength in these muscles. As your muscles improve, try doing the exercises while doing everyday jobs.

Keeping to a healthy weight

Being overweight puts pressure on your pelvic floor muscles. It's especially important to keep to a healthy weight if you have bowel control problems. Your GP can advise you on what is a healthy weight for you.



Our booklets *Managing your weight after cancer treatment* and *Healthy eating and cancer* have more information. We can send you this information for free.

Coping with bowel changes

It may take time for your bowel function to settle. In the meantime, there are things that can help you feel more confident and in control.

Protect your skin

If your bowel motions are frequent or loose after surgery, the skin around your bottom may become sore. Here are some tips:

- Keep the skin around your back passage clean and dry.
- Unperfumed wet wipes are softer on your skin than toilet paper.
- Absorbent pads and barrier creams (such as Cavilon® or Sudocrem®) help to protect your skin.
- Cotton underwear allows your skin to breathe.

Going out

If your bowel habit isn't predictable, you may feel worried about going out, especially to somewhere new. Planning ahead so that you're prepared can help you feel more confident.

Carrying a 'Just Can't Wait' card may help you to get access to a toilet more quickly when you're out. It states that the card holder has a medical condition that requires urgent access to a toilet. You can get a 'Just Can't Wait' card from the Bladder and Bowel Foundation or Disability Rights UK (see pages 121 and 126).

You can use disabled toilets too. These often offer more privacy, have a wash basin and more space if you need to change.

The National Key Scheme offers people with a disability access to about 9,000 locked public toilets across the UK. You can buy a key from Disability Rights UK (see page 126). They can also send you details of where the toilets are.

Carry a bag with supplies

Pack a bag of things you may need when you go out. This will help you feel more confident and help you to cope if an accident occurs.

You may want to include:

- wet wipes
- barrier cream such as Cavilon® or Sudocrem®
- loperamide (if you have bowel control problems)
- pads and pants (or stoma supplies if you have a stoma)
- a change of clothing
- a sealable bag.



If you have a stoma

Having a stoma, whether it's temporary or permanent, is a big change to your body. It can take time to adjust to. You may find it helpful to talk to someone who is used to living with a stoma. Your stoma nurse may be able to arrange this for you. You can also contact the Colostomy Association or the Ileostomy and Internal Pouch Support Group (see page 122).



Visit macmillan.org.uk/havingastoma to watch a video of a stoma nurse talking about looking after a stoma and showing the supplies you might use.

You can also contact our cancer support specialists on **0808 808 00 00** if you want to talk about any concerns you have. There are details of other helpful organisations on pages 121–127.

Learning to look after a stoma takes time and patience, and no one expects you to be able to cope perfectly straight away. Like anything new, it will get easier with time and practice. Your stoma nurse can help you cope with any problems.

If you have an ileostomy, you'll wear a stoma bag that opens at the bottom so you can empty it. An ileostomy produces semi-liquid waste continuously, so you'll need to empty the bag several times a day.

A colostomy may be active two or three times a day, but this will vary from person to person. It will also be affected by what you eat. It will usually settle into a pattern after a few weeks, so you can predict when it is likely to be active. You will usually need to change your stoma bag about 1–3 times a day.

Some people with a colostomy are taught how to flush out (irrigate) their colostomy once a day. This helps them to control when it is active. If you want to try this, your stoma care nurse can discuss it with you in more detail.

Before you change or empty your bag, make sure that you have plenty of bags and cleaning materials with you. It's a good idea to keep everything you need in one place, so that you don't have to search for things at the last minute. Give yourself plenty of time, so that you can work at your own pace without any interruptions.

'Life does go on. It doesn't go on the same way as it was before, but it's a different path I'm treading now. It's just as wonderful, just as rewarding, but it does take a little bit of time to get used to it, and it takes confidence to get out there in the real world. Nobody's going to know. You don't have to go into places where there's going to be a lot of people straight away. Just do things in little bite-size chunks again and see how it goes.'

Pat



The quote above is from a video on our website of Pat talking about her experience of having a stoma. Watch it at [macmillan.org.uk/livingwithastoma](https://www.macmillan.org.uk/livingwithastoma)

Stoma reversal

If you have a temporary stoma, when your treatment is over you can usually have an operation to reverse the stoma. This means you will pass stools from your bottom again.

The timing of a stoma reversal operation varies from person to person. It can range from a few months after the stoma was made, to one or two years later.

How stoma reversal is done depends on whether you have a loop ileostomy/colostomy or an end ileostomy/colostomy (see page 42).

To reverse a loop ileostomy/colostomy, the surgeon closes the opening in the loop of bowel that was used. They then remove the stitches holding the loop of bowel in place on the skin. The bowel goes back inside the tummy (abdomen).

To reverse an end ileostomy/colostomy, the surgeon removes the stitches that are holding the piece of bowel up to the skin. The piece of bowel is rejoined to the rest of the bowel inside the tummy.

After a stoma reversal, it may take some time for your bowel habit to get back to normal. You may find the advice on pages 60–65 helpful.



Radiotherapy

Radiotherapy treats cancer by using high-energy rays to destroy the cancer cells, while doing as little harm as possible to normal cells. Radiotherapy only treats the area of the body that the rays are aimed at. It is often given in combination with chemotherapy. This is called chemoradiation (see page 92). Chemotherapy makes cancer cells more sensitive to radiotherapy.

Radiotherapy doesn't make you radioactive. It's perfectly safe for you to be with other people, including children, throughout your treatment.



Our booklet *Understanding radiotherapy* has more information about this treatment, how it's given and the possible side effects.

How radiotherapy is given

There are two ways of giving radiotherapy: externally and internally.

External radiotherapy

This is normally given in the hospital radiotherapy department as a series of short, daily sessions. It uses equipment similar to a large x-ray machine. Each treatment takes 10–15 minutes. They are usually given Monday– Friday, with a rest at the weekend. Your doctor will discuss the treatment and possible side effects with you.

Internal radiotherapy

This involves having a radioactive material (the source) placed close to or inside the tumour for a limited period of time.

This is called high dose rate (HDR) brachytherapy. As with external radiotherapy, high-energy rays are used to kill the cancer cells.

Before the treatment, the rectum needs to be emptied.

This involves having a mini enema (liquid is put into the back passage to empty it). Brachytherapy is usually given under a general anaesthetic and the procedure takes about an hour.

A small number of people with early-stage rectal cancers may be treated with a type of brachytherapy called Papillon treatment.

This can be given as an outpatient and doesn't need a general anaesthetic. It is only available in a few hospitals, so you may need to travel some distance to have it. There is a website dedicated to Papillon radiotherapy where you can read more about what it is – visit contactpapillon.com

When radiotherapy is given

Radiotherapy before surgery

Radiotherapy is sometimes given before an operation. The aims are to:

- shrink the cancer so that it is easier to remove
- reduce the chance of the cancer coming back.

You may have a short course of external radiotherapy.

Treatment is given once a day, Monday–Friday, the week before surgery.

If the cancer is large, you may have a longer course of radiotherapy that lasts up to six weeks. This is usually given with

chemotherapy, which can help make the radiotherapy more effective (chemoradiation).

After a longer course of radiotherapy, you wait for at least six weeks before you have surgery. During this time, the radiotherapy or chemoradiation will continue to work, shrinking the cancer.

Some people with cancer in the middle or lower third of the rectum are offered internal radiotherapy (HDR brachytherapy) before surgery. The aim is to shrink the tumour and reduce the need to remove the anus during surgery.

HDR brachytherapy is a new treatment, so not all the potential risks and benefits are known. Before you decide to have this treatment, your doctor will explain what is involved and discuss the possible benefits and risks with you. They will also give you written information to help you make your decision.

Brachytherapy may be given in combination with external radiotherapy or on its own. Your doctor will discuss with you whether this treatment may be suitable for you.

Radiotherapy after surgery

If radiotherapy wasn't given before surgery, you may have it afterwards if:

- the cancer was difficult to remove
- some cancer cells may be left behind
- the cancer had spread through the bowel wall or into nearby lymph nodes.

External radiotherapy is usually given every weekday for 4–5 weeks.

Radiotherapy for advanced cancer

External radiotherapy may be used to treat rectal cancer that has spread or come back after treatment. It's most likely to be used to treat cancer in the pelvis (the area between the hip bones). The aim is to shrink the cancer and relieve symptoms such as bleeding or pain.

Radiotherapy can usually only be given once to any particular area of the body, because of the effects it has on healthy tissues close by.

Radiotherapy for cancer in the liver

Specialised radiotherapy techniques such as stereotactic radiotherapy and selective internal radiotherapy (SIRT) are sometimes used to treat bowel cancer that has spread to the liver. The way these are done is different from the other types of radiotherapy discussed in this booklet. The side effects are also different.

Stereotactic radiotherapy

Stereotactic radiotherapy is given using a specially adapted radiotherapy machine. It is sometimes called CyberKnife™. The machine delivers beams of radiotherapy from many different angles. This allows the doctor to give a very high dose to the tumour, but a very low dose to surrounding tissues.

This treatment is only available in a few large radiotherapy centres. If it is suitable for you, your team will discuss it with you.

Selective internal radiotherapy (SIRT)

SIRT is a type of internal radiotherapy. It may be used when cancer has spread to the liver and surgery is not possible. It can be given on its own or with chemotherapy. It is carried out under a local anaesthetic.

A doctor injects tiny radioactive beads into a blood vessel close to the tumours. The radiation destroys the blood vessels and stops blood flow to the tumours. Without a blood supply, the tumours shrink and may die. The radiation only travels a few millimeters, so other parts of the liver aren't affected and it doesn't make you radioactive.

SIRT is only suitable for some secondary liver cancers. Your doctor or specialist nurse can talk to you about whether it's suitable for you.



We can send you more information about SIRT.

Planning your treatment

To make sure radiotherapy is as effective as possible, it is carefully planned by a clinical oncologist (a doctor who specialises in radiotherapy for cancer). Your treatment will be planned on your first visit to the radiotherapy department.

Usually, you'll have a CT scan of the area that will be treated. The radiographer may draw tiny marks on your skin. These marks must stay visible throughout your treatment, and permanent marks (like tiny tattoos) may be used. These are extremely small and will only be done with your permission. It may be a little uncomfortable while they are done.

Treatment sessions

At the beginning of each session of external radiotherapy, the radiographer will position you carefully on the couch and make sure you are comfortable. During your treatment, you'll be alone in the room, but you can talk to the radiographer who will watch you from the next room. Radiotherapy is not painful, but you will have to lie still for a few minutes during the treatment. The photograph on the opposite page shows an external radiotherapy machine.

Side effects of radiotherapy

Side effects depend on things such as the dose of radiotherapy, whether it's external or internal, and whether you have chemotherapy as well (chemoradiation).

Side effects usually start a week or two after starting treatment. They may continue to get worse for a couple of weeks after treatment, before beginning to get better. Side effects usually improve gradually over the next few weeks or more.

Smoking can make side effects worse. If you smoke, try to give up or cut down. Drink at least 2–3 litres of fluid a day. Water is best. Drinks containing caffeine and alcohol can make bowel and bladder symptoms worse.

It's important to tell your radiographer, cancer specialist or specialist nurse if you have side effects. They can give you advice on how to manage them and prescribe treatments that can help.

It may take some time to recover, particularly after longer courses of radiotherapy or chemoradiation. Look after yourself by getting enough rest and gradually increasing your physical activity. This will help with your recovery.



Occasionally, some side effects don't completely go away. Sometimes, side effects develop months or years later. These are called long-term or late effects. If side effects don't get better or you notice new side effects developing, tell your cancer nurse or doctor. There are many things that can be done to help.

Tiredness

Radiotherapy often makes people feel tired, especially towards the end of treatment. Tiredness may last for a few months. Your energy levels will then gradually improve.

Effects on the skin and pubic hair

Sometimes, radiotherapy can cause a skin reaction in the area being treated. The skin may redden or get darker, and become dry, flaky and itchy. Towards the end of treatment, the skin sometimes becomes moist and sore. There may be breaks in the skin, especially around the scrotum (men), vagina (women), back passage and groin.

Your radiographer or specialist nurse will tell you how to look after your skin. They will check your skin regularly. Tell them if it is sore or if you notice any other changes. They may prescribe a cream, dressings and painkillers to help.

Your pubic hair (hair around your genital area) may fall out. It should start to grow back again a few weeks after radiotherapy finishes, but it may be thinner. Occasionally, hair loss can be permanent.

Bowel side effects

You may have loose stools or constipation, or need to open your bowels urgently. Some people have cramping pains in their tummy or back passage, or have more wind than usual.

Diarrhoea usually starts during or after the second week of radiotherapy. If you have diarrhoea, your specialist will prescribe anti-diarrhoeal tablets, such as loperamide, to help.

If you have tummy cramps, let your cancer specialist or nurse know. They can prescribe anti-spasmodic or muscle relaxant drugs to help. If you're constipated, your doctor will usually prescribe a laxative and you'll be given advice on diet.

Let your nurse or radiographer know if you have any soiling or leakage. They will give you advice on coping with this and looking after the skin in the area.

You may be advised to make changes to your diet during radiotherapy. Bowel side effects usually start to improve about two weeks after radiotherapy has finished. Sometimes, it may take a few months.

Bladder irritation

Radiotherapy can cause irritation and inflammation of the bladder lining. You may need to pass urine more often (frequency) and have a burning sensation when you do. You may also feel that you can't wait when you need to pass urine (urgency). There may be blood in your urine (haematuria).

Additional side effects in women

Changes to the vagina

Radiotherapy can make the lining of the vagina sore and inflamed. You may be advised not to have sex during and for a few weeks after treatment. This is to allow any inflammation or side effects to settle. Ask your doctor or nurse for advice. If you do have sex during treatment and could become pregnant, it's very important to use effective contraception to prevent this. Radiation may cause damage to a baby conceived during or shortly after radiotherapy.

After radiotherapy, the vagina may be narrower, less stretchy and drier than before. This may make sex uncomfortable.

Your specialist nurse may recommend you use vaginal dilators to try to prevent the vagina from narrowing. Dilators are tampon-shaped, plastic tubes of different sizes that you use with a lubricant.

Vaginal dryness can be relieved with vaginal lubricants or creams. Hormone creams can also help with dryness and vaginal narrowing. These are available on prescription from your doctor.

Early menopause and infertility

If you are still having menstrual periods, radiotherapy to the pelvic area will cause the menopause. The menopause means your ovaries are no longer producing eggs, so you will no longer be able to get pregnant.

Hormone replacement therapy (HRT) replaces the hormones your ovaries can no longer produce. This can improve menopausal symptoms, but it can't prevent infertility.

Additional side effects in men

Sex

It's fine to have sex during radiotherapy if you want to.

Sperm produced during and for some time after treatment may be damaged but still fertile. This could cause abnormalities in a child conceived soon after pelvic radiotherapy. To prevent this, your doctors may recommend that you use contraception during treatment and for six months or more after it.

Some men may have a sharp pain when they ejaculate. This is because radiotherapy can irritate the tube that runs through the penis (the urethra). The pain should get better a few weeks after treatment finishes.

Infertility

Pelvic radiotherapy may make you unable to father children (infertile). Your doctor or specialist nurse can talk to you about this.

For some men, it may be possible to have sperm stored before the treatment starts (sperm banking). The sperm can then be used in the future. It's important to talk to your doctor or nurse before your treatment starts. They can advise you about sperm storage.



We have more information about these side effects, including booklets on tiredness, fertility, sexuality and managing the side effects of pelvic radiotherapy. Visit be.macmillan.org.uk or call us on 0808 808 00 00 and we can send you the information you need.



Chemotherapy

Chemotherapy is the use of anti-cancer (cytotoxic) drugs to destroy cancer cells. It's often given in combination with radiotherapy (chemoradiation – see page 92).

The photograph opposite shows someone having chemotherapy.

Chemotherapy may be given:

- After surgery, to reduce the risk of cancer coming back.
- Before surgery, if you're having cancer removed from the liver or lungs. This is to shrink the cancer and reduce the risk of it coming back.
- As the main treatment for cancer that has spread to parts of the body such as the liver or lungs, to try to control it for as long as possible.

The drugs most commonly used to treat bowel cancer are:

- fluorouracil (5FU) often given with folinic acid (leucovorin)
- capecitabine (Xeloda®)
- oxaliplatin (Eloxatin®)
- irinotecan (Campto®)
- tegafur with uracil.

Often, two or more chemotherapy drugs are given in combination. The three most commonly used combinations are:

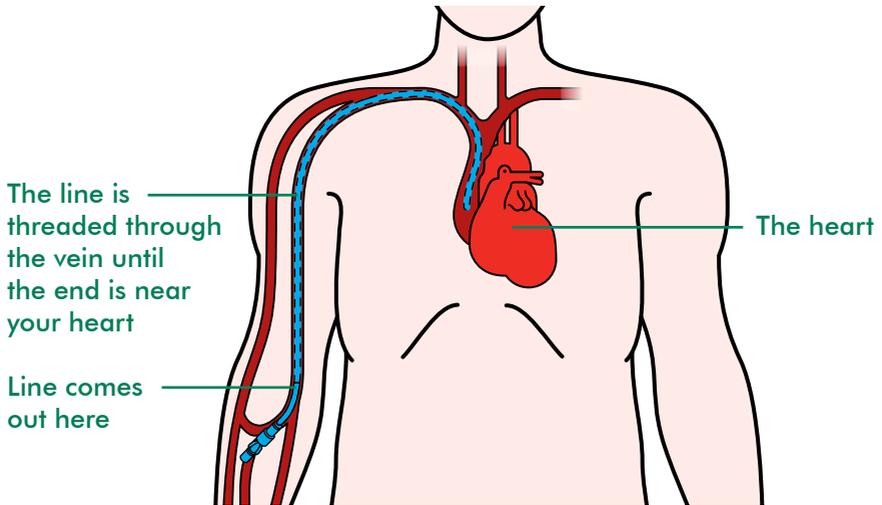
- FOLFOX (folinic acid, fluorouracil and oxaliplatin)
- FOLFIRI (folinic acid, fluorouracil and irinotecan)
- CAPOX (XELOX) (capecitabine and oxaliplatin).

How chemotherapy is given

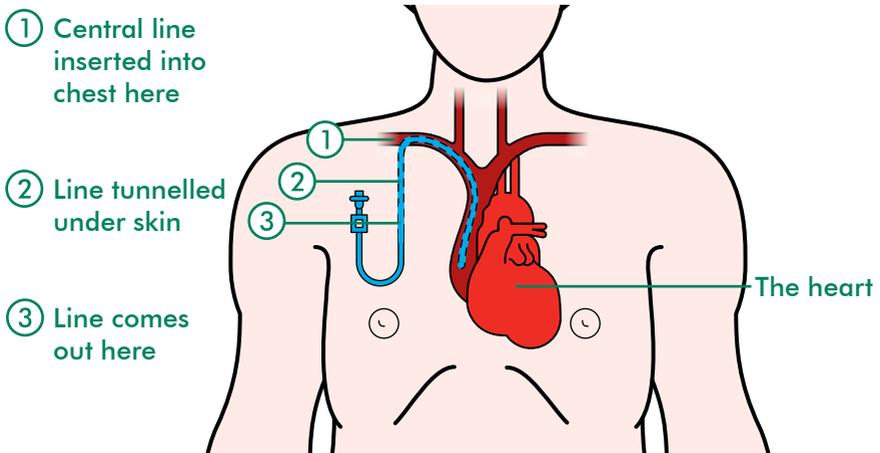
You usually have chemotherapy as an outpatient. Most drugs are given into a vein (intravenously). Some drugs, such as capecitabine, are taken as capsules or tablets.

You may be given drugs into your vein through one of the following:

- A cannula – a short, plastic tube put into a vein in the back of your hand or arm. It's taken out before you go home.
- A PICC line – a long, thin, flexible tube inserted into a vein in the crook of your arm. It stays in until your whole course of chemotherapy is completed.
- A central line – a long, thin, flexible tube inserted into a vein in your chest. It stays in until your whole course of chemotherapy is completed.
- An implantable port (sometimes called a portacath) – a thin, soft, plastic tube, put into a vein in your chest or arm. It has an opening (port) just under the skin.



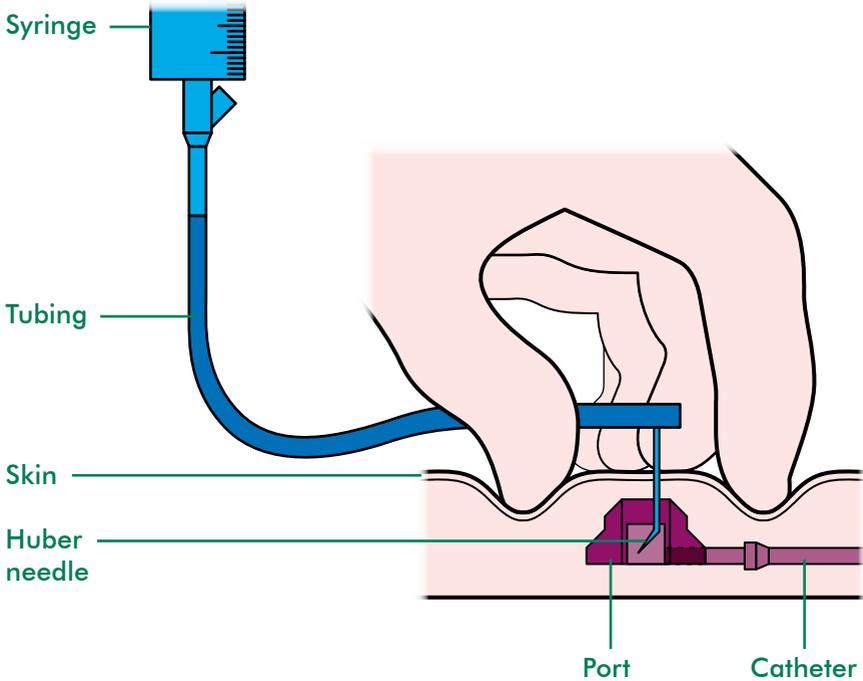
A PICC line



A central line



On our website there are two animations that show how PICC lines and central lines are put in the body. Visit macmillan.org.uk/havingaPICCline and macmillan.org.uk/havingacentralline



An implantable port

Sometimes, chemotherapy is given through a small, portable pump, attached to your PICC or central line. A controlled amount of the drug is given continuously into the bloodstream over a set period of time.

Intravenous chemotherapy is given as a session of treatment over several hours or days. This is followed by a rest period of a few weeks, to allow your body to recover from side effects. Treatment and the rest period make up a cycle of treatment. Your cancer specialist will tell you how many cycles of treatment you'll have.



Visit macmillan.org.uk/chemotherapyvideos to watch videos about chemotherapy.



Our booklet *Understanding chemotherapy* explains this treatment in more detail. We can also send you information about all of the drugs and side effects mentioned here – call us on 0808 808 00 00.

Side effects

Chemotherapy can cause side effects. These can usually be well controlled with medicines. We've described some of the more common ones here and ways of reducing them. They will gradually disappear once your treatment is over.

Risk of infection

Chemotherapy can reduce the number of white blood cells, which help fight infection. If the number of your white blood cells is low, you'll be more prone to infections. A low white blood cell count is called neutropenia.

Always contact the hospital immediately on the 24-hour contact number you've been given and speak to a nurse or doctor if:

- you develop a high temperature – this may be over 37.5°C (99.5°F) or over 38°C (100.4°F) depending on the hospital's policy – follow the advice that you have been given by your chemotherapy team
- you suddenly feel unwell, even with a normal temperature
- you feel shivery and shaky
- you have any symptoms of an infection such as a cold, a sore throat, a cough, passing urine frequently (urine infection) or diarrhoea.

If necessary, you'll be given antibiotics to treat any infection. You'll have a blood test before each cycle of chemotherapy to make sure your white blood cells have recovered. Occasionally, your treatment may need to be delayed if the number of your white blood cells is still low.

Bruising and bleeding

Chemotherapy can also reduce the number of platelets in your blood. These cells help blood to clot. Tell your doctor if you have any bruising or bleeding you can't explain. This includes nosebleeds, bleeding gums, blood spots or rashes on the skin.

Anaemia (reduced number of red blood cells)

If chemotherapy reduces the number of red blood cells in your blood, you may become very tired and feel you have no energy. You may also become breathless and feel dizzy and light-headed. These symptoms happen because the red blood cells contain haemoglobin, which carries oxygen around the body.

If your haemoglobin is low, you may be offered a blood transfusion. You'll feel more energetic and any breathlessness will be eased.

Diarrhoea

Some chemotherapy drugs can cause diarrhoea. This can start a day or several days after the treatment.

If you're taking chemotherapy tablets or capsules at home, tell your doctor or nurse if you have diarrhoea. Your treatment may need to be stopped until the diarrhoea is better.

Drink plenty of fluids if you have diarrhoea. It may also help to eat a low-fibre diet. If you have a stoma, your stoma care nurse can give you advice and support.

Some people need to make sure they are close to a toilet throughout their treatment and for a while afterwards. This can be frustrating, but it usually improves gradually a few weeks after treatment has ended. If the diarrhoea continues, it's important to talk to your cancer specialist or stoma nurse. They can help you find ways of managing it.

Nausea and vomiting

Your doctor can prescribe anti-sickness drugs to prevent, or greatly reduce, nausea or vomiting. If the sickness isn't controlled, or if it continues, tell your doctor – they can prescribe other anti-sickness drugs that may work better for you.

Sore mouth

Your mouth may become sore or dry, or you may develop ulcers during treatment. Drink plenty of fluids, and clean your teeth regularly with a soft toothbrush, to help reduce the risk of infections in your mouth. Tell your nurse or doctor if your mouth is sore. They can prescribe mouthwashes and medicine to prevent or clear mouth infections.

Tiredness (fatigue)

You're likely to become tired and have to take things slowly. Try to pace yourself and save your energy for things that you want to do or that need doing. Balance rest with some physical activity – even going for short walks will help increase your energy levels.

Laryngeal spasm

The drug oxaliplatin can sometimes cause a spasm (tightening) in the voice box (larynx). This may happen during treatment or within the few hours after it. It can temporarily affect breathing and swallowing but will settle on its own. Cold temperatures may cause the spasm. Avoid cold drinks, ice cream or ice cubes during and for a few days after treatment. In cold weather, wrap up warmly and cover your nose and mouth when going out.

Hair loss

Most drugs used to treat bowel cancer do not cause total hair loss, but your hair may thin. Hair grows back once the treatment has finished. Your nurse can give you advice about coping with hair loss.

Sore hands and feet

This is sometimes called palmar-plantar, or hand-foot, syndrome. It can be caused by capecitabine or 5FU and will improve when the treatment is finished. Using non-perfumed moisturising creams can help to relieve symptoms. Your doctor can prescribe creams if necessary.

Changes in the way the heart works

Fluorouracil (5FU) and capecitabine can affect the way the heart works. If you are having one of these drugs, you may have tests to see how well your heart is working. You may have these before, during and sometimes after treatment.

If you have pain or tightness in your chest, feel breathless or notice changes to your heartbeat at any time, tell a doctor straight away. These symptoms can be caused by other conditions but it's important to get them checked by a doctor.

Numbness or tingling in the hands or feet

Oxaliplatin can cause this. You may also notice that you have difficulty doing up buttons or similar fiddly tasks. This is called peripheral neuropathy. It is due to effects of the drug on nerve endings.

These symptoms may be triggered by cold temperatures. If you notice that your symptoms are related to the cold, avoid cold drinks and wrap up warmly in the cold weather.

It is important to tell your doctor about any symptoms you have, as they may be helped by slightly lowering the dose of the drug.

Numbness and tingling can last for several months. In some people, it may be permanent.

Contraception

It's not advisable to become pregnant or father a child while having chemotherapy, as it may harm the developing baby. It's important to use effective contraception during your treatment and for at least a few months afterwards. You can discuss this with your doctor or nurse.

Protecting your partner

It's not known whether chemotherapy drugs can be present in semen or vaginal fluids. To protect your partner, it's safest to use a condom if you have sex within 48 hours after chemotherapy.

Chemoradiation

Chemoradiation is a combination of chemotherapy and radiotherapy. It is also sometimes called chemoradiotherapy.

Chemoradiation may be given:

- before surgery to help shrink the cancer and reduce the risk of cancer coming back in or around the rectum
- after surgery to reduce the risk of cancer coming back in or around the rectum

Chemotherapy drugs make cancer cells more sensitive to radiotherapy. The chemotherapy drugs most commonly used are fluorouracil (5FU) and capecitabine.

Fluorouracil (5FU) may be given into a vein as an injection with folinic acid, or as an infusion (drip). It's usually given shortly before the radiotherapy. Your cancer doctor or nurse will tell you which days you'll have fluorouracil.

Capecitabine is taken as tablets. You usually take them every day throughout the course of your radiotherapy.

Having chemotherapy and radiotherapy together can make the side effects of each treatment worse (see pages 87–91 and 76–81). Your doctor or specialist nurse can give you more information about chemoradiation and the possible side effects of this treatment.

Targeted therapies

Targeted therapies are anti-cancer medicines that work by affecting processes that happen within cancer cells. They interfere with the cells' ability to grow. They are sometimes called biological therapies.

Targeted therapies are sometimes used to treat bowel cancers that have spread to other parts of the body. They may be given on their own or in combination with chemotherapy.

Targeted therapies that may be used include:

- cetuximab (Erbix[®])
- panitumumab (Vectibix[®])
- bevacizumab (Avastin[®])
- aflibercept (Zaltrap[®])
- regorafenib (Stivarga[®]).

All of these drugs are given into a vein as an infusion (intravenously) except for regorafenib, which is taken as tablets.

Cetuximab (Erbix[®]) and panitumumab (Vectibix[®]) are a type of targeted therapy called EGFR inhibitors. They stop cancer cells from receiving messages that tell them to grow. Not all bowel cancers respond to cetuximab or panitumumab. Your doctors will test the cancer cells for genes called KRAS and NRAS. Knowing if these genes are normal or changed (mutated) can help the doctors decide whether cetuximab or panitumumab will be appropriate for you.

Cetuximab and panitumumab are often given in combination with chemotherapy.

Bevacizumab (Avastin®), aflibercept (Zaltrap®) and regorafenib (Stivarga®) work by preventing the cancer from developing a blood supply. This deprives the cancer of oxygen and nutrients. Drugs that interfere with blood vessel growth are called angiogenesis inhibitors or anti-angiogenics.

If your cancer specialist thinks that a targeted therapy may be helpful, they will discuss this with you. However, these drugs are not widely available through the NHS. Your cancer specialist can apply for a drug to be funded if they believe it would benefit you. In England, this can be done through the Cancer Drugs Fund. In the other countries of the UK, your cancer specialist can apply to the Health Board (Health and Social Care Board in Northern Ireland) asking for the drug to be made available as an exception to the usual rules.



We can send you information about targeted therapy drugs, the Cancer Drugs Fund and what you can do if a treatment isn't available – call 0808 808 00 00.

Side effects

Some targeted therapies can cause an allergic reaction. This may happen when the drug is being given or shortly after. Signs of an allergic reaction can include flu-like symptoms, a drop in blood pressure or feeling sick (nausea). An allergic reaction is most common with the first dose of the drug. To reduce this risk, the first dose is given slowly over a number of hours. You may also be given drugs to make an allergic reaction less likely.

The most common side effect of cetuximab and panitumumab is a skin rash. Other possible effects include diarrhoea, hair changes and sore eyes.

The most common side effect of bevacizumab, aflibercept and regorafenib is high blood pressure. There is also a small risk they may cause a hole in the bowel (perforation), but this is rare.

You should always tell your cancer specialist if you have any side effects during treatment.

Research – clinical trials

Cancer research trials are done to try to find new and better treatments for cancer. Trials that are carried out on patients are known as clinical trials. These may be carried out to:

- test new treatments, such as new chemotherapy drugs or targeted therapies
- look at new combinations of existing treatments, or change the way they are given to make them more effective or reduce side effects
- compare the effectiveness of drugs used to control symptoms
- find out how cancer treatments work
- find out which treatments are the most cost-effective.

Trials are the only reliable way to find out if a different type of surgery, chemotherapy, targeted therapy, radiotherapy or other treatment is better than what is already available.

Taking part in a trial

You may be asked to take part in a treatment research trial. There can be many benefits in doing this. Trials help to improve knowledge about cancer and develop new treatments. You will be carefully monitored during and after the study.

Usually, several hospitals around the country take part in these trials. It's important to bear in mind that some treatments that look promising at first are often later found not to be as good as existing treatments or to have side effects that outweigh the benefits.

If you decide not to take part in a trial, your decision will be respected and you don't have to give a reason. However, it can help to let the staff know your concerns so that they can give you the best advice. There will be no change in the way that you're treated by the hospital staff, and you'll be offered the standard treatment for your situation.



Our booklet *Understanding cancer research trials (clinical trials)* describes clinical trials in more detail. Call us on 0808 808 00 00 and we'll send you a copy.

Blood and tumour samples

Blood and tumour samples may be taken to help make the right diagnosis. You may be asked for your permission to use some of your samples for research into cancer. If you take part in a trial you may also give other samples, which may be frozen and stored for future use when new research techniques become available. Your name will be removed from the samples so you can't be identified.

The research may be carried out at the hospital where you are treated, or at another one. This type of research takes a long time, and results may not be available for many years. The samples will be used to increase knowledge about the causes of cancer and its treatment, which will hopefully improve the outlook for future patients.

After treatment

After your treatment has finished, you'll have regular check-ups. These will usually continue for several years. You may also have scans or x-rays, and sometimes colonoscopies. If you have any problems, or notice any new symptoms in between check-ups, tell your doctor as soon as possible.

Many people feel anxious before their appointments. This is natural. It may help to get support from family, friends or one of the organisations listed on pages 121–127.

Beginning to recover

It may be some time before you feel fit and well again. Living a healthy lifestyle can help your body recover more quickly and may help reduce the risk of cancer returning. A healthy lifestyle also reduces the risk of other illnesses, such as heart disease and stroke.

Adopting a healthy lifestyle is about making small, achievable changes to the way you live, which will improve your health and well-being. It includes having a well-balanced diet, keeping active, keeping to a healthy weight, reducing stress and not smoking.

If you are a smoker, giving up is the single most important thing you can do for your health. Our booklet *Giving up smoking* can give you information and tips on how to do this.



Keeping active

You can increase the amount of physical activity you do slowly. Whatever your age or physical health, there will be something you can try, such as walking, hiking, cycling or swimming. Activities such as gardening, dancing and sport are also good to try.

Reducing stress

Having cancer can be a stressful experience. But there are things that can help. Make time to relax and do things you enjoy or that make you laugh. You may want to start a new hobby or evening class. Writing a journal or online blog may help. You may want to learn new ways of relaxing such as yoga or meditation. Some people find praying or thinking about spirituality helps.

Our booklet *Life after cancer treatment* may help. We also have booklets on diet, exercise, giving up smoking and emotions.

'Throughout my treatment I just tried to walk whenever I could, even if it was only a little. Even after my operations, I did what I could, with the help of my wife. I just felt the need to try and get moving. It felt like I was doing something active rather than being passive. After I left hospital, I carried on walking, building up slowly. At first I could only walk 100 yards and would have to stop to sit down, but each day you can do a little more. Gradually I started to feel better.'

Simon

Sex life after rectal cancer

Treatments for rectal cancer can affect your sex life and how you see yourself (self-image). You may feel too exhausted to have sex during treatment and for a while afterwards. Most people find that this gradually improves, but occasionally it can last for months or even longer.

Sometimes, surgery can damage the nerves of sexual organs. If this happens, a man may not be able to have or maintain an erection. There can also be problems with orgasm and ejaculation. Women may also find that their sexual function or response is affected. Orgasm may be less intense than before and it may take longer to reach orgasm. This may be because of changes to blood flow and nerves in the pelvic and genital area. These changes may improve over time, but are sometimes permanent.

Sildenafil (Viagra®) may help a man to get erections. If you are having erection difficulties, talk to your doctor as soon as possible. Treatment is often more effective if started sooner.



We have booklets about sexuality and cancer for men and women. They explain the effects that cancer and its treatments can have on sexuality. They also offer ways of coping and solutions to sexual problems. To order a booklet, visit be.macmillan.org.uk or call us.

After your operation, you may have a scar or stoma. If you feel self-conscious about changes to your body, it can affect your sexual desire. Talking about your feelings may help reduce your anxiety.

If you are having any sexual difficulties, talk to your doctor or nurse. There are often things that can be done to help. Some people find it difficult to talk about sexual issues because they feel embarrassed or self-conscious. Your doctor, stoma care nurse or specialist nurse will be used to talking about these issues. They can give you advice and refer you for specialist help and support if necessary.

'My husband was very good about it. He didn't find it difficult to cuddle me and we did have intercourse during the time that I had the stoma. He saw it as something that was aiding me to get better, as opposed to it being an invasion on my body that he found unpleasant.'

Anita

Your feelings

It's common to feel overwhelmed by different feelings when you're told that you have cancer. We talk about some of these here. Partners, family and friends may also have some of the same feelings.

You might have different reactions to the ones we describe here. There is no right or wrong way to feel. You'll cope with things in your own way. Talking to people close to you or other people affected by cancer can often help.

Shock and disbelief

You may find it hard to believe it when your doctor tells you that you have cancer. It's common to feel shocked and numb. You may not be able to take in much information and find that you keep asking the same questions again and again. At first, you might find it hard to talk to family and friends about the cancer. This usually gets easier as the shock wears off and it becomes more real to you. You may find you can't think or talk about anything but the cancer. This is because your mind is trying to process what you're going through.

Fear and anxiety

People can be very anxious or frightened about whether treatment will work and what will happen in the future. This uncertainty can be one of the hardest things to cope with. It can help to try to focus on what you can control. You may want to find out more about the cancer, its treatment and how to manage side effects. It can also help to talk about your feelings and to take time to do things that are important to you and that you enjoy.

Doctors often know roughly how many people can benefit from a type of treatment. But they can't be sure what will happen to an individual person. Although they may not be able to answer your questions fully, they can usually talk through any problems with you and give you some guidance.

Avoidance

Some people cope by not wanting to know very much about the cancer and by not talking about it. If you feel like this, let your family and friends know that you don't want to talk about it right now. You can also tell your doctor if there are things you don't want to know or talk about yet.

Occasionally, this avoidance can be extreme. Some people may not believe that they have cancer. This is sometimes called being in denial. It may stop them making decisions about treatment. If this happens, it's very important for them to get help from their doctor.

Sometimes, avoidance is the other way around. Family and friends may seem to avoid you and the fact that you have cancer. They may not want to talk about it or they might change the subject. This is usually because they are also finding the cancer difficult to cope with, and they may need support too. Try to let them know how this makes you feel and that talking openly with them about your illness will help you.

Anger

You may feel angry about your illness and sometimes resent other people for being well. These are normal reactions, especially when you feel frightened, stressed, out of control or unwell. You may get angry with the people close to you. Let them know that you are angry at your illness and not at them.

Finding ways to help you relax and reduce stress can help with anger. This can include talking about or writing down how you feel, gentle exercise, breathing or relaxation therapy, yoga or meditation.

Guilt and blame

Some people feel guilty or blame themselves or others for the cancer. You may try to find reasons for why it has happened to you. Most of the time, it's impossible to know exactly what has caused a person's cancer. Over time, several different factors may act together to cause a cancer. Doctors don't fully understand all of these factors yet. Instead, try to focus on looking after yourself and getting the help and support you need.

Feeling alone

Some people feel alone because they don't have enough support. Family and friends may live far away, have other commitments or feel uncomfortable because of their own fears about cancer. Try to let your family and friends know how you feel and how they could support you more.

If you need more support, you can call the Macmillan Support Line free on **0808 808 00 00** and talk to one of our cancer support specialists. Our website can help you find out about local support groups – visit **[macmillan.org.uk/supportgroups](https://www.macmillan.org.uk/supportgroups)** You can also talk to other people going through the same thing on our Online Community at **[macmillan.org.uk/community](https://www.macmillan.org.uk/community)**

It's normal to have times when you want to be left alone to sort out your feelings. But if you find you're avoiding people a lot of the time, then try to talk to your doctor or nurse.

If you need more help

These feelings can be very difficult to cope with and sometimes people need more help. This happens to lots of people and doesn't mean you're not coping.

If you feel anxious, panicky or sad a lot of the time, or think you may be depressed, talk to your doctor or nurse. They can refer you to a doctor or counsellor who can help. They may also prescribe medicine to help with anxiety or an antidepressant drug.



Our booklet *How are you feeling? The emotional effects of cancer* discusses the feelings you may have in more detail, and has suggestions for coping with them.

Who can help?

Many people are available to help you and your family.

District nurses work closely with GPs and make regular visits to patients and their families at home if needed.

The **hospital social worker** can give you information about social services, such as meals on wheels, a home helper or hospital fares. The social worker may also be able to arrange childcare for you during and after treatment.

In many areas of the country, there are also specialist nurses called **palliative care nurses**. They are experienced in assessing and treating symptoms of advanced cancer. Palliative care nurses are sometimes known as **Macmillan nurses**. However, many Macmillan professionals are nurses who have specialist knowledge in a particular type of cancer. You may meet them when you're at a clinic or in hospital.

Marie Curie nurses help care for people approaching the end of their lives in their own homes. Your GP or hospital specialist nurse can usually arrange a visit by a palliative care or Marie Curie nurse.

There's also specialist help available to help you cope with the emotional impact of cancer and its treatment. You can ask your hospital doctor or GP to refer you to a doctor or counsellor who specialises in supporting people with cancer and their families. Our cancer support specialists on **0808 808 00 00** can tell you more about counselling and can let you know about services in your area.

Relationships

Your experience of cancer may have improved and strengthened your relationships with people close to you. You may feel that you wouldn't have been able to cope so well without the support you've had from family and friends.

However, cancer is stressful and this sometimes affects your relationships. Any problems usually improve over time, especially if you can talk openly with each other. Here, we've listed some of the issues that can arise and ways of coping with them.

If you have a partner

Some couples become closer as a result of sharing the experience of cancer. However, cancer can put a lot of strain on a relationship. Problems sometimes develop, even between close and loving couples who've been together for a long time. If a relationship was already difficult, the stress of a major illness may make problems worse.

Couples that are close may assume that they know what each other is thinking, but they may not always be right. Talking openly about your feelings and listening to each other can help you understand each other's point of view.

Family and friends

You may sometimes feel that your family and friends aren't very understanding when you aren't feeling positive. You may feel they don't realise how much the treatment is affecting your life. Talking openly about how you're feeling will help them to understand you better and give you the support you need.



Our booklet *Talking about your cancer* has useful tips on how to talk to family and friends. You might also find it useful to visit our web page macmillan.org.uk/relationshipscommunication

If you are a relative or friend

Some people find it hard to talk about cancer or share their feelings. You might think it's best to pretend everything is fine, and carry on as normal. You might not want to worry the person with cancer, or you might feel you're letting them down if you admit to being afraid. Unfortunately, denying strong emotions can make it even harder to talk, and may lead to the person with cancer feeling very isolated.

Partners, relatives and friends can help by listening carefully to what the person with cancer wants to say. It may be best not to rush into talking about the illness. Often it's enough just to listen and let the person with cancer talk when they are ready.

You may find some of the courses on our Learn Zone website helpful. There are courses to help with listening and talking, to help family and friends support their loved ones affected by cancer. Visit [macmillan.org.uk/learnzone](https://www.macmillan.org.uk/learnzone) to find out more.

Our booklet *Lost for words – how to talk to someone with cancer* has more suggestions if you have a relative or friend with cancer.

If you're looking after a family member or friend with cancer, you may find our booklet *Hello, and how are you?* helpful. It's based on carers' experiences and has lots of practical tips and information.

We have more information about supporting someone with cancer at [macmillan.org.uk/carers](https://www.macmillan.org.uk/carers)

Talking to children

Deciding what to tell your children or grandchildren about your cancer is difficult. An open, honest approach is usually best. Even very young children can sense when something is wrong, and their fears can sometimes be worse than the reality.

How much you tell your children will depend on their age and how mature they are. It may be best to start by giving only small amounts of information and gradually tell them more to build up a picture of your illness.

Teenagers

Teenagers can have an especially hard time. At a stage when they want more freedom, they may be asked to take on new responsibilities and they may feel over-burdened. It's important that they can go on with their normal lives as much as possible and still get the support they need.

If they find it hard to talk to you, you could encourage them to talk to someone close who can support and listen to them, such as a grandparent, family friend, teacher or counsellor. They may also find it useful to look at the website rirap.org.uk which has been developed especially for teenagers who have a parent with cancer.



Our booklet *Talking to children and teenagers when an adult has cancer* includes discussion about sensitive topics. There's also a video on our website that may help, at macmillan.org.uk/talkingtochildren

Financial help and benefits

If you are struggling to cope with the financial effects of cancer, help is available.

If you cannot work because you are ill, you may be able to get **Statutory Sick Pay**. Your employer will pay this for up to 28 weeks of sickness. If you qualify for it, they cannot pay you less.

Before your Statutory Sick Pay ends, or if you do not qualify for it, check whether you can get **Employment and Support Allowance (ESA)**. This benefit is for people who cannot work because they are ill or disabled.

There are two different types of ESA:

- contributory – you can get this if you have made enough national insurance contributions
- income-related – you can get this if your income and savings are below a certain level.

Since October 2013, a new benefit called **Universal Credit** has started replacing income-related ESA in England, Scotland and Wales. This benefit is for people who are looking for work or on a low income.

Personal Independence Payment (PIP) is a new benefit for people under 65 who find it difficult to walk or look after themselves (or both). You must have had these difficulties for at least three months, and they should be expected to last for the next nine months. Since April 2013, PIP has started to replace a similar older benefit called **Disability Living Allowance (DLA)** in England, Scotland and Wales.

Attendance Allowance (AA) is for people aged 65 or over who find it difficult to look after themselves. You may qualify if you need help with things like getting out of bed, having a bath or dressing yourself. You don't need to have a carer, but you must have needed care for at least six months.

If you are terminally ill, you can apply for PIP, DLA or AA under the 'special rules'. This means your claim will be dealt with quickly and you will get the benefit you applied for at the highest rate.

Help for carers

Carer's Allowance is a weekly benefit that helps people who look after someone with a lot of care needs. If you don't qualify for it, you can apply for **Carer's Credit**. This helps you to build up qualifying years for a State Pension.

More information

The benefits system can be hard to understand, so it's a good idea to talk to an experienced welfare rights adviser. You can speak to one by calling the Macmillan Support Line on **0808 808 00 00**. We've just listed some benefits here, but there may be others you can get.

You can find out about state benefits and apply for them online at **gov.uk** (England, Wales and Scotland) and **nidirect.gov.uk** (Northern Ireland). These websites have information about financial support, your rights, employment and independent living. You can also get information about these issues from the relevant Department for Work and Pensions helplines or Citizens Advice (see page 125). In Northern Ireland, you can call the Benefit Enquiry Line Northern Ireland on **0800 220 674**.

Insurance

People who have, or have had, cancer may find it hard to get certain types of insurance, including life and travel insurance. A financial adviser can help you look at your needs and find the best deal for you. You can find a financial adviser by contacting one of the organisations on pages 125–126.



Our booklet *Help with the cost of cancer* has more information. Our booklets *Insurance* and *Getting travel insurance* may also be helpful. You might find our video at macmillan.org.uk/gettingfinancialhelp useful.

Work

You may need to take time off work during your treatment and for a while afterwards. It can be hard to judge the best time to go back to work, and this will depend mainly on the type of work you do and how much your income is affected. It's important to do what's right for you.

Getting back into your normal routine can be very helpful, and you may want to go back to work as soon as possible. It can be helpful to talk to your employer about the situation – it may be possible for you to work part-time or job share.

On the other hand, it can take a long time to recover fully from cancer treatment, and it may be many months before you feel ready to return to work. It's important not to take on too much, too soon. Your consultant, GP or specialist nurse can help you decide when and if you should go back to work.

Employment rights

The Equality Act 2010 protects anyone who has, or has had, cancer. Even if a person who had cancer in the past has been successfully treated and is now cured, they are still covered by the act. This means their employer must not discriminate against them for any reason, including their past cancer. The Disability Discrimination Act protects people in Northern Ireland.



Our booklets *Work and cancer*, *Working while caring for someone with cancer* and *Self-employment and cancer* have more information that may be helpful.

There's also more information at macmillan.org.uk/work

About our information

We provide expert, up-to-date information about cancer. And all our information is free for everyone.

Order what you need

You may want to order more leaflets or booklets like this one. Visit **be.macmillan.org.uk** or call us on **0808 808 00 00**.

We have booklets on different cancer types, treatments and side effects. We also have information about work, financial issues, diet, life after cancer and information for carers, family and friends.

All of our information is also available online at **macmillan.org.uk/cancerinformation**

There you'll also find videos featuring real-life stories from people affected by cancer, and information from health and social care professionals.

Other formats

We also provide information in different languages and formats, including:

- audiobooks
- Braille
- British Sign Language
- Easy Read booklets
- large print
- translations.

Find out more at **macmillan.org.uk/otherformats**

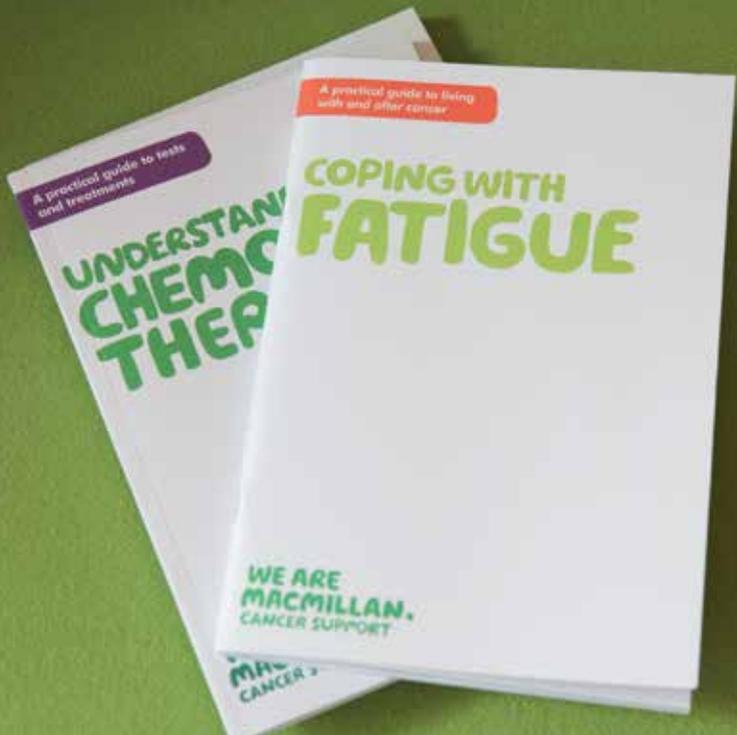
If you'd like us to produce information in a different format for you, email us at **cancerinformationteam@macmillan.org.uk** or call us on **0808 808 00 00**.

Help us improve our information

We know that the people who use our information are the real experts. That's why we always involve them in our work. If you've been affected by cancer, you can help us improve our information.

We give you the chance to comment on a variety of information including booklets, leaflets and fact sheets.

If you'd like to hear more about becoming a reviewer, email reviewing@macmillan.org.uk You can get involved from home whenever you like, and we don't ask for any special skills – just an interest in our cancer information.



Other ways we can help you

At Macmillan, we know how a cancer diagnosis can affect everything, and we're here to support you. No one should face cancer alone.

Talk to us

If you or someone you know is affected by cancer, talking about how you feel and sharing your concerns can really help.

Macmillan Support Line

Our free, confidential phone line is open Monday–Friday, 9am–8pm. Our cancer support specialists can:

- help with any medical questions you have about your cancer or treatment
- help you access benefits and give you financial advice
- be there to listen if you need someone to talk to
- tell you about services that can help you in your area.

Call us on **0808 808 00 00** or email us via our website, **macmillan.org.uk/talktous**

Information centres

Our information and support centres are based in hospitals, libraries and mobile centres. There, you can speak with someone face to face.

Visit one to get the information you need, or if you'd like a private chat, most centres have a room where you can speak with someone alone and in confidence.

Find your nearest centre at **macmillan.org.uk/informationcentres** or call us on **0808 808 00 00**.

Talk to others

No one knows more about the impact cancer can have on your life than those who have been through it themselves. That's why we help to bring people together in their communities and online.

Support groups

Whether you are someone living with cancer or a carer, we can help you find support in your local area, so you can speak face to face with people who understand. Find out about support groups in your area by calling us or by visiting [macmillan.org.uk/selfhelpandsupport](https://www.macmillan.org.uk/selfhelpandsupport)

Online community

Thousands of people use our online community to make friends, blog about their experiences and join groups to meet other people going through the same things. You can access it any time of day or night. Share your experiences, ask questions, or just read through people's posts at [macmillan.org.uk/community](https://www.macmillan.org.uk/community)

The Macmillan healthcare team

Our nurses, doctors and other health and social care professionals give expert care and support to individuals and their families. Call us or ask your GP, consultant, district nurse or hospital ward sister if there are any Macmillan professionals near you.

'Everyone is so supportive on the online community, they know exactly what you're going through. It can be fun too. It's not all just chats about cancer.'

Mal

Help with money worries

Having cancer can bring extra costs such as hospital parking, travel fares and higher heating bills. If you've been affected in this way, we can help.

Financial advice

Our financial guidance team can give you advice on mortgages, pensions, insurance, borrowing and savings.

Help accessing benefits

Our benefits advisers can offer advice and information on benefits, tax credits, grants and loans. They can help you work out what financial help you could be entitled to. They can also help you complete your forms and apply for benefits.

Macmillan Grants

Macmillan offers one-off payments to people with cancer. A grant can be for anything from heating bills or extra clothing to a much-needed break.

Call us on **0808 808 00 00** to speak to a financial guide or benefits adviser, or to find out more about Macmillan Grants. We can also tell you about benefits advisers in your area.

Visit [macmillan.org.uk/financialsupport](https://www.macmillan.org.uk/financialsupport) to find out more about how we can help you with your finances.

Help with work and cancer

Whether you're an employee, a carer, an employer or are self-employed, we can provide support and information to help you manage cancer at work.

Visit [macmillan.org.uk/work](https://www.macmillan.org.uk/work)

Other useful organisations

There are lots of other organisations that can give you information or support.

Bowel cancer support

Beating Bowel Cancer

Harlequin House,
7 High Street,
Teddington TW11 8EE
Tel 08450 719301
(Mon–Thu, 9am–5.30pm)

Email nurse@beating
bowelcancer.org

www.bowelcancer.org

Gives information and support to people affected by bowel cancer.

Bladder and Bowel Foundation

SATRA Innovation Park,
Rockingham Road,
Kettering NN16 9JH

Tel 0845 345 0165

Email info@bladderand
bowelfoundation.org

**www.bladderand
bowelfoundation.org**

Provides information and advice on bladder and bowel symptoms.

The Bobby Moore Fund

c/o Cancer Research UK,
PO Box 123,
London WC2A 3PX

Tel 020 7009 8881

Email bmf@cancer.org.uk

www.cancerresearchuk.org/bobbymoorefund

Raises money for research into bowel cancer.

Bowel Cancer UK

www.bowelcanceruk.org.uk

Gives information and support to people affected by bowel cancer.

Bowel Cancer UK in England and Wales

Willcox House,
140–148 Borough High Street,
London SE1 1LB

Tel 020 7940 1760

Email admin@bowel
canceruk.org.uk

Bowel Cancer UK in Scotland

20 Queen Street,
Edinburgh EH2 1JX
Tel 0131 225 5333

Email scotadmin@
bowelcanceruk.org.uk

Bowel Cancer UK in Northern Ireland

Email karen.donaghey@
bowelcanceruk.org.uk

Colostomy Association

Enterprise House,
95 London Street
Reading RG1 4QA

Tel 0800 328 4257
Email cass@colostomy
association.org.uk

**www.colostomy
association.org.uk**

Assist and support people
who have or are about to
have a colostomy.

IA – the Ileostomy and Internal Pouch Support Group

Peeverill House,
1–5 Mill Road, Ballyclare,
Co. Antrim BT39 9DR

Tel 0800 0184 724
Email info@iasupport.org

www.iasupport.org

Aims to help anyone who has
had, or is about to have, their
colon removed and has an
ileostomy or internal pouch.

Papillon radiotherapy website

www.contactpapillon.com

Website dedicated to Papillon
radiotherapy. It is run by people
with cancer and carers. It gives
information about what
Papillon radiotherapy is and
has a forum where you can
share your feelings, questions
or tips with others.

Cancer information and support

Cancer Black Care

79 Acton Lane,
London NW10 8UT

Tel 020 8961 4151

Email

info@cancerblackcare.org.uk

www.cancerblackcare.org.uk

Offers information and support
for people with cancer from
ethnic communities, their
friends, carers and families.

Cancer Focus Northern Ireland

40–44 Eglantine Avenue,
Belfast BT9 6DX

Tel 0800 783 3339

(Mon–Fri, 9am–1pm)

Email hello@cancerfocusni.org

www.cancerfocusni.org

Offers a variety of services to people affected by cancer, including a free helpline, counselling and links to local support groups.

Cancer Support Scotland

Calman Cancer Support
Centre, 75 Shelley Road,
Glasgow G12 0ZE

Tel 0800 652 4531

Email [info@](mailto:info@cancersupportscotland.org)

cancersupportscotland.org

**www.cancersupport
scotland.org**

Runs cancer support groups throughout Scotland. Also offers free complementary therapies and counselling to anyone affected by cancer.

Maggie's Centres

1st Floor, One Waterloo Street,
Glasgow G2 6AY

Tel 0300 123 1801

Email [enquiries@](mailto:enquiries@maggiescentres.org)
maggiescentres.org

www.maggiescentres.org

Provide information about cancer, benefits advice, and emotional or psychological support.

Penny Brohn

Cancer Care

Chapel Pill Lane,
Pill, Bristol BS20 0HH

Tel 0845 123 2310

(Mon–Fri, 9.30am–5pm)

Email

helpline@pennybrohn.org

**www.pennybrohn
cancercare.org**

Offers a combination of physical, emotional and spiritual support, using complementary therapies and self-help techniques.

Riprap

www.riprap.org.uk

Developed especially for teenagers who have a parent with cancer.

Tenovus

Head Office,
Gleider House,
Ty Glas Road,
Cardiff CF14 5BD

Tel 0808 808 1010

(Mon–Sun, 8am–8pm)

www.tenovus.org.uk

Aims to help everyone get equal access to cancer treatment and support. Provides mobile cancer support units, a free helpline, an 'Ask the nurse' service on the website and benefits advice.

General health information

Health and Social Care in Northern Ireland

www.hscni.net

Provides information about health and social care services in Northern Ireland.

NHS Choices

www.nhs.uk

The UK's biggest health information website. Also has service information for England.

NHS Direct Wales

www.nhsdirect.wales.nhs.uk

NHS health information site for Wales.

NHS Inform

www.nhsinform.co.uk

NHS health information site for Scotland.

Counselling and emotional support

British Association for Counselling and Psychotherapy (BACP)

BACP House,
15 St John's Business Park,
Lutterworth LE17 4HB

Tel 01455 883 300

Email bacp@bacp.co.uk

www.bacp.co.uk

Has a register of psychological therapists. You can search for a qualified counsellor at **itsgoodtotalk.org.uk**

Samaritans

Freepost RSRB-KKBY-CYJK,
Chris, PO Box 9090,
Stirling FK8 2SA

Tel 08457 90 90 90

Email jo@samaritans.org

www.samaritans.org

Provides confidential and non-judgemental emotional support, 24 hours a day, 365 days a year, for people experiencing feelings of distress or despair.

Financial or legal information

Benefit Enquiry Line

Northern Ireland

Tel 0800 220 674

(Mon–Wed and Fri, 9am–5pm,
Thu, 10am–5pm)

Textphone 0800 243 787

**www.nidirect.gov.uk/
money-tax-and-benefits**

Provides information and advice about disability benefits and carers' benefits.

Citizens Advice

Provides advice on financial, legal, housing and employment issues. Find details for your local office in the phone book or on one of the following websites:

England and Wales

www.citizensadvice.org.uk

Scotland

www.cas.org.uk

Northern Ireland

www.citizensadvice.co.uk

You can also find advice online in a range of languages at **adviceguide.org.uk**

Department for Work and Pensions (DWP) Disability Benefits Helpline

08457 123 456

Textphone 0845 722 4433

Personal Independence Payment Helpline

0845 850 3322

Textphone 0845 601 6677

Carer's Allowance Unit

0845 608 4321

Textphone 0845 604 5312

www.gov.uk/browse/benefits

Manages state benefits in England, Scotland and Wales. You can apply for benefits and find information online or through its helplines.

GOV.UK

www.gov.uk

Has comprehensive information about social security benefits and public services.

The Money Advice Service

Tel 0300 500 5000

(Mon–Fri, 8am–8pm,
Sat, 9am–1pm)

Typetalk

18001 0300 500 5000

www.moneyadvice service.org.uk

Offers free financial health checks and gives advice about all types of financial matters. Has an online chat service for instant money advice.

Money Advice Scotland Tel 0141 572 0237 www.moneyadvicescotland. org.uk

National Debtline (England, Wales and Scotland)

Tricorn House,
51–53 Hagley Road,
Edgbaston,

Birmingham B16 8TP

Tel 0808 808 4000
(Mon–Fri, 9am–9pm,
Sat, 9.30am–1pm)

www.nationaldebtline.co.uk

A national helpline for people with debt problems. It is free, confidential and independent.

Unbiased.co.uk

Email contact@unbiased.co.uk

www.unbiased.co.uk

On the website, you can search for qualified advisers who specialise in giving financial, mortgage, accounting or legal advice.

Equipment and advice on living with a disability

Assist UK

Redbank House,
4 St Chad's Street,
Manchester M8 8QA

Tel 0161 832 9757

Email

general.info@assist-uk.org

www.assist-uk.org

A UK-wide network of Disabled Living Centres. Staff can give advice about the products, which are designed to make life easier for people who have difficulty with daily activities.

Disability Rights UK

12 City Forum,
250 City Road,
London EC1V 8AF

Tel 020 7250 3222

Email [enquiries@
disabilityrightsuk.org](mailto:enquiries@disabilityrightsuk.org)

www.disabilityrightsuk.org

Provides information on social security benefits and disability rights. Has a number of helplines for specific support, including information on returning to work, direct payments, human rights issues, and advice for disabled students.

Scope

6 Market Road,
London N7 9PW

Tel 0808 800 3333

(Mon–Fri, 9am–5pm)

Email response@scope.org.uk

www.scope.org.uk

Offers confidential advice and information on living with disability. Also supports an independent, UK-wide network of local Disability Information and Advice Line services (DIALs) run by and for disabled people.

Support for older people

Age UK

Tavis House,
1–6 Tavistock Square,
London WC1H 9NA

Tel (England and Wales)

0800 169 6565

Tel (Scotland)

0845 125 9732

Tel (Northern Ireland)

0808 808 7575

(Mon–Sun, 8am–7pm)

www.ageuk.org.uk

Provides information and advice for older people across the UK via the website and advice line. Also publishes fact sheets and advice guides.

Support for carers

Carers Trust (Princess Royal Trust for Carers in Scotland)

Carers Trust

32–36 Loman Street,
London SE1 0EH

Tel (England) 0844 800 4361

Tel (Scotland) 0300 123 2008

Tel (Wales) 0292 009 0087

Email info@carers.org

www.carers.org and

www.youngcarers.net

Provides support, information, advice and services for people caring at home for a family member or friend. You can find details for UK offices and search for local support on the website.

Carers UK

Tel (England, Scotland,

Wales) 0808 808 7777

Tel (Northern Ireland)

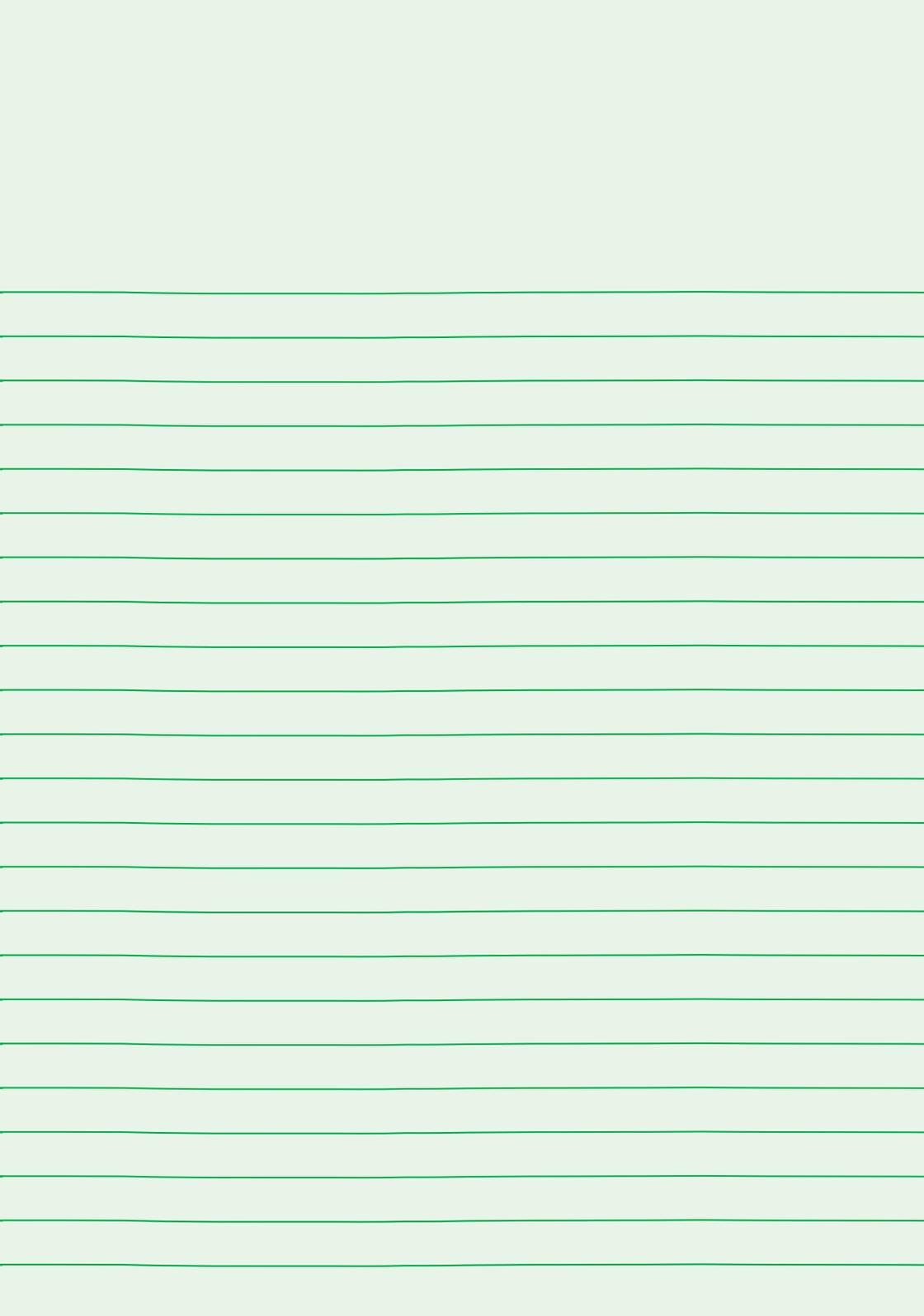
028 9043 9843

(Wed–Thu, 10am–12pm
and 2–4pm)

Email advice@carersuk.org

www.carersuk.org

Offers information and support to carers across the UK. Puts people in contact with support groups for carers in their area.



Disclaimer

We make every effort to ensure that the information we provide is accurate and up-to-date, but it should not be relied upon as a substitute for specialist professional advice tailored to your situation. So far as is permitted by law, Macmillan does not accept liability in relation to the use of any information contained in this publication, or third-party information or websites included or referred to in it. Some photographs are of models.

Thanks

This booklet has been written, revised and edited by Macmillan Cancer Support's Cancer Information Development team. It has been approved by our Chief Medical Editor, Dr Tim Iveson, Macmillan Consultant Medical Oncologist.

With thanks to: Mr Mark George, Consultant in Colorectal Surgery; Dr Mark Saunders, Consultant Clinical Oncologist; Ms Val Weston, Clinical Nurse Specialist Colorectal Cancer; and the people affected by cancer who reviewed this edition.

Sources

We've listed a sample of the sources used in this publication below. If you'd like further information about the sources we use, please contact us at bookletfeedback@macmillan.org.uk

Andreyev, Davidson, et al. Practice guidance on the management of acute and chronic gastrointestinal problems arising as a result of treatment for cancer. *Gut*. 2011. 61:179–192. DOI: 10.1136/gutjnl-2011-300563.

Health and Social Care Information Centre. *National Bowel Cancer Audit Annual Report 2013*. 2013.

Health and Social Care Information Centre. *National Bowel Cancer Audit Annual Report 2012*. 2012.

National Institute of Health and Care Excellence (NICE). Full guideline.

Colorectal cancer: the diagnosis and management of colorectal cancer. 2011.

Can you do something to help?

We hope this booklet has been useful to you. It's just one of our many publications that are available free to anyone affected by cancer. They're produced by our cancer information specialists who, along with our nurses, benefits advisers, campaigners and volunteers, are part of the Macmillan team. When people are facing the toughest fight of their lives, we're there to support them every step of the way.

We want to make sure no one has to go through cancer alone, so we need more people to help us. When the time is right for you, here are some ways in which you can become a part of our team.



Share your cancer experience

Support people living with cancer by telling your story, online, in the media or face to face.

Campaign for change

We need your help to make sure everyone gets the right support. Take an action, big or small, for better cancer care.

Help someone in your community

A lift to an appointment. Help with the shopping. Or just a cup of tea and a chat. Could you lend a hand?

Raise money

Whatever you like doing you can raise money to help. Take part in one of our events or create your own.

Give money

Big or small, every penny helps. To make a one-off donation see over.

Call us to find out more

0300 1000 200

macmillan.org.uk/getinvolved

Please fill in your personal details

Mr/Mrs/Miss/Other

Name

Surname

Address

Postcode

Phone

Email

Please accept my gift of £

(Please delete as appropriate)

I enclose a cheque / postal order /
Charity Voucher made payable to
Macmillan Cancer Support

OR debit my:

Visa / MasterCard / CAF Charity
Card / Switch / Maestro

Card number

□□□□	□□□□□□	□□□□□□	□□□□□□
------	--------	--------	--------

Valid from

□□	□□
----	----

Expiry date

□□	□□
----	----

Issue no

□□□

Security number

□□□□

Signature

Date / /

Don't let the taxman keep your money

Do you pay tax? If so, your gift will be worth 25% more to us – at no extra cost to you. All you have to do is tick the box below, and the tax office will give 25p for every pound you give.

- I am a UK taxpayer and I would like Macmillan Cancer Support to treat all donations I have made for the four years prior to this year, and all donations I make in the future, as Gift Aid donations, until I notify you otherwise.

I confirm I have paid or will pay an amount of Income Tax and/or Capital Gains Tax in each tax year, that is at least equal to the tax that Charities & CASCs I donate to will reclaim on my gifts. I understand that other taxes such as VAT and Council Tax do not qualify and that Macmillan Cancer Support will reclaim 25p of tax on every £1 that I give.

Macmillan Cancer Support and our trading companies would like to hold your details in order to contact you about our fundraising, campaigning and services for people affected by cancer. If you would prefer us not to use your details in this way please tick this box.

In order to carry out our work we may need to pass your details to agents or partners who act on our behalf.



If you'd rather donate online go to macmillan.org.uk/donate

Please cut out this form and return it in an envelope (no stamp required) to:
Supporter Donations, Macmillan Cancer Support, FREEPOST LON15851,
89 Albert Embankment, London SE1 7UQ

More than one in three of us will get cancer. For most of us it will be the toughest fight we ever face. And the feelings of isolation and loneliness that so many people experience make it even harder. But you don't have to go through it alone. The Macmillan team is with you every step of the way.

We are the nurses and therapists helping you through treatment. The experts on the end of the phone. The advisers telling you which benefits you're entitled to. The volunteers giving you a hand with the everyday things. The campaigners improving cancer care. The community there for you online, any time. The supporters who make it all possible.

Together, we are all Macmillan Cancer Support.

For cancer support every step of the way, call Macmillan on 0808 808 00 00 (Mon–Fri, 9am–8pm) or visit macmillan.org.uk

Hard of hearing? Use textphone 0808 808 0121, or Text Relay.
Non-English speaker? Interpreters available.
Braille and large print versions on request.

© Macmillan Cancer Support, June 2014. 3rd edition. MAC12475. Next planned review 2016. Macmillan Cancer Support, registered charity in England and Wales (261017), Scotland (SC039907) and the Isle of Man (604). Printed using sustainable material. Please recycle.



**WE ARE
MACMILLAN.
CANCER SUPPORT**