



Follow-up of colorectal cancer survivors

Colorectal cancer five-year survival rates are high for people whose cancer is detected early.

Follow-up includes scheduling regular review and ensuring cancer survivors are aware of the risks and symptoms of late effects associated with their colorectal cancer treatment.

Five- and 10-year survival (Australia)

In Australia, five-year survival rates range from about 90% for people whose cancers were detected at the earliest (localised) stage, to 7% for people diagnosed with distant metastatic cancer.

In 2004, five-year survival for colorectal cancer was 61.8% and 10-year survival was 56%.

Potential issues for survivors

Survivors may experience many different issues after completing treatment: physical, emotional, psychosocial and practical.

Survivorship care ideally addresses all of these issues. The four main aims of care during the survivorship phase, as detailed by the Institute of Medicine's report (see Hewitt et al. 2006) 'From cancer patient to cancer survivor: lost in transition', are:

- surveillance for cancer spread, recurrence or second cancers

- coordination between specialists and primary care providers to ensure that all of the survivor's health needs are met (incl. health promotion, immunisation, screening for cancer and non-cancerous conditions, and the care of concurrent conditions)
- intervention for consequences of cancer and its treatment (e.g. problems such as sexual dysfunction, symptoms including pain and fatigue, psychological distress experienced by cancer survivors and their caregivers, and concerns related to employment and insurance)
- prevention and detection of new cancers and recurrent cancer.

Surveillance for cancer spread, recurrence or second primary cancers

About one in three people who have curative surgery for colorectal cancer will die as a result of recurrent disease.

Follow-up is intended to improve on this outcome by detecting recurrence when it is at an earlier stage and potentially curable. In general, this will mean detecting recurrence in an asymptomatic person with resectable suture-line recurrence, or resectable liver and lung metastases. There is evidence of benefit in terms of cure by further surgery for about 1% of such patients.

Intensive follow-up appears to improve survival by enabling earlier detection and treatment of recurrent cancer.





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US guidelines sometimes recommend stool blood test be included in follow-up. However, the role of FOBT is contentious. The optimal schedule, including duration, is not yet clear.

Which patients?

The ACN revision committee guideline recommends 'Intensive follow up for colorectal cancer should be considered for patients who have had potentially curable disease, although optimal investigation and pathways are yet to be firmly established'.

New symptoms: advice for survivors

Cancer survivors may wait to discuss some symptoms if they know a surveillance/ check-up appointment is scheduled. Cancer survivors must be advised to contact their doctor if any symptom arises that is causing them concern.

Advise the cancer survivor you are treating to contact you if:

- they experience any symptoms of bowel obstruction, hernia, abscess or any functional bowel problems

- they experience bleeding from the bowel or altered bowel habit
- they have unexplained pain or discomfort.

Coordination between specialists and primary care providers

Follow-up may be performed by the specialist or GP. A randomised controlled trial of colon cancer patients whose follow-up was led by GPs showed they experienced similar outcomes, although patterns of investigation varied.

It is important that follow-up care is coordinated. Guidelines included in the Victorian Government's patient management framework (colorectal tumour stream) recommend that follow-up should be by a multidisciplinary team, although not all disciplines need to be involved in the longer term follow-up. The guidelines recommend that the team, in consultation with the GP, decides on who will coordinate follow-up. Responsibility needs to be agreed between the designated lead clinician, GP and cancer survivor, and an agreed plan documented. The plan should identify who should be notified if the patient does not attend for follow-up. Patient-specific follow-up may require access to occupational therapy, physiotherapy, social work, dietitian and/or nurse. The GP has a key role in follow-up.

Review for cancer recurrence

Timing of review	Review type	Consider also
Early post-discharge	History Examination	Regular CEA measurement CT scan
Then three- to six-monthly for two years	<ul style="list-style-type: none"> • DRE • Sigmoidoscopy in patients who have had an anterior resection of the rectum 	
Then six-monthly to yearly thereafter		
After three to five years, and then at three to five-yearly intervals	Colonoscopy	

Source: Adapted from Australian Cancer Network Colorectal Cancer Guidelines Revision Committee (ACN Revision Committee) 2005. Guidelines for the prevention, early detection and management of colorectal cancer. Sydney: Cancer Council Australia and Australian Cancer Network.

Note: this schedule may change, due for example to the detection of recurrence or the development of other illnesses. The schedule needs to be tailored to individual situations.





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Intervention for consequences of cancer and its treatment

Late effects of colorectal cancer treatment

Note to cancer survivors: late effects from cancer treatment are generally uncommon and often rare. Do not assume that you will get a late effect if you had a treatment described here. Please speak to your doctor if you have any concerns about late effects from your cancer treatment

Late effects can occur as a consequence of surgical resection, chemotherapy and radiotherapy.

For the survivor and their partner, cancer and its treatment may create relationship problems, including changed roles and fear of recurrence. The survivor may fear being a burden.

Survivors who go through and beyond cancer treatment without partners or close family and friends may experience great loneliness.

Further information related to late effects:

- Bowel obstruction, abdominal wall hernia and abscess may be life-threatening. Ensure survivors are aware of symptoms and know to contact their doctor if any occur.
- For patients with functional problems, advise about diet and anti-motility agents and refer to specialist dietitian if needed.
- Ensure the person with the stoma is aware of potential problems and knows to make an appointment if any symptoms arise. Refer survivors with quality of life issues related to a stoma to a stomal therapist or stomal nurse who understand the physical and psychosocial issues. Consider referral to a stoma support group (accessible via the Cancer Council Helpline on 13 11 20).
- Consider referral to an infertility specialist for relevant survivors.
- Younger patients may have sought advice about sperm banking or egg harvesting before surgery and may need further counselling and advice after treatment has finished. Refer to infertility specialist.

Enquire about mood and whether the survivor feels they are coping. Assess survivor's level of distress/depression. Support groups and/or contact with a fellow survivor through a service such as Cancer Connect (contact via Cancer Council Helpline on 13 11 20) may be helpful.

Late physical effects of colorectal cancer treatment

Complication	Cause/association
Bowel obstruction	Surgery
Abdominal wall hernia	Surgery
Abscess	Radiotherapy
Functional problems (caused by reduced storage capacity of bowel, leading to more frequent and incomplete bowel movements, urgency, leakage and incontinence, also constipation, diarrhoea and flatus)	Surgical resection Nerve damage affecting anal sphincter function from surgery and radiotherapy
Ostomy issues (prolapse, skin-related problems, leakage, stenosis of stomal opening)	Ostomy
Infertility	Radiotherapy to pelvic area
Sexual dysfunction associated with treatment and changed body image <ul style="list-style-type: none"> • males: erectile dysfunction • females: dyspareunia 	Surgery (esp. ostomy) Radiotherapy to pelvic area
Urological dysfunction (incomplete emptying, urgency, overflow or stress incontinence, loss of bladder sensation, dysuria, chronic urinary tract infections)	Surgery (low rectal cancer resection)
Radiation enteritis, small bowel obstruction, rectal stricture	Radiotherapy
Peripheral neuropathy	Oxaliplatin





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Prevention and detection of new cancers and recurrent cancer

Follow-up care should include counselling about improved diet, maintaining a healthy weight, smoking cessation and increasing physical activity as these may help to prevent secondary, recurrent or a new primary colorectal cancer. They may also reduce many of the psychosocial consequences of cancer treatment.

Advise survivors (unless there are health reasons that indicate otherwise) to do at least 30 minutes of moderate-intensity physical activity on most, preferably all, days. The NHMRC has produced dietary guidelines for Australian adults, on which advice to survivors can be based.

Don't neglect other aspects of primary health care. Where indicated, monitor survivors' cholesterol, blood pressure and blood glucose. Survivors should have regular dental examinations and be counselled on routine sun protection.

Survivors need appropriate screening for other cancers at recommended time intervals. Mammography every two years is recommended for women at average risk aged between 50 and 69. Women of moderately increased risk may need screening at an earlier age and women at high risk should be offered appropriate clinical surveillance at a specialist cancer or genetic clinic. All women who have ever been sexually active should commence having Pap tests between the ages of 18 and 20 years, or 1 to 2 years after commencing sexual activity, whichever is later. In some cases screening for cervical cancer may be appropriate before 18 years of age. Women over 70 years of age who have had two normal Pap tests in the past five years do not require further Pap tests. If a woman over 70 years has never had a Pap test, or requests a Pap test, they should be screened. There is insufficient evidence for population based screening for ovarian cancer; however, women who are at potentially high risk should be referred to a familial cancer clinic for assessment and management.

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Further information

This overview was prepared with reference to:



Australian Government Department of Health and Ageing 2005. National physical activity guidelines for Australians. Canberra: Australian Government.



Australian Cancer Network Colorectal Cancer Guidelines Revision Committee (ACN Revision Committee) 2005. Guidelines for the prevention, early detection and management of colorectal cancer. Sydney: Cancer Council Australia and Australian Cancer Network.



Australian Institute of Health and Welfare, Cancer Australia & Australasian Association of Cancer Registries 2008. Cancer survival and prevalence in Australia: cancers diagnosed from 1982 to 2004. Cancer Series No. 42. Cat. No. CAN 38. Canberra: AIHW.



Hewitt M, Greenfield S, Stovall E (eds) 2006. From cancer patient to cancer survivor: lost in transition. Committee on Cancer Survivorship: Improving Care and Quality of Life. National Cancer Policy Board. Institute of Medicine (IOM) and National Research Council of the National Academies.



Ko C, Ganz P 2007. Cancer survivorship issues in colorectal cancer. In Ganz P (ed) 2007. Cancer survivorship today and tomorrow. New York: Springer Science+Business Media.



Metropolitan Health and Aged Care Services Division (MHACSD) 2006. Patient management framework. Colorectal tumour stream: colon and rectal cancer. Victorian Government Department of Human Services.



National Health and Medical Research Council 2003. Dietary guidelines for Australian adults. Canberra: NHMRC.



Wattchow D et al. 2006. General practice vs surgical-based follow-up for patients with colon cancer: randomised controlled trial. British Journal of Cancer 94: 1116–21.

Also see:



National Comprehensive Cancer Network. This US site provides consensus-based guidelines developed by expert groups, and other clinical resources.

Australian Cancer Survivorship Centre
A Richard Pratt Legacy



Australian Cancer Survivorship Centre

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