Gastrointestinal side effects of cancer treatment: are we making any progress?

Authors: Anum Faisal, Waqaar Baber, Zain Rana and Jervoise Andreyev

Introduction

In 2012, the British Society of Gastroenterology, the Association of Coloproctology of Great Britain and Ireland, the Association of Upper Gastrointestinal Surgeons, the College of Radiologists and Macmillan Cancer Support published guidance on the optimal management of acute and chronic gastrointestinal (GI) toxicities of cancer treatments.[1] The ORBIT trial,[2] hailed as a landmark study,[3] showed that targeted interventions, based on the principles in the published guidance delivered by a nurse or a gastroenterologist, can make a significant difference to those with chronic toxicity.

The largest single group of people at risk of moderate/severe long-term side effects are those treated for colorectal cancer. Follow-up after colorectal cancer treatment is increasingly devolved to junior or paramedical staff and historically has largely focused on possible recurrence. This study investigated how toxicity after colorectal cancer is assessed and managed in a large district hospital.

Methods

Outpatient clinic letters and inpatient discharge letters of a random selection of patients diagnosed with a new primary colorectal cancer over 1 year, treated with curative intent and with at least one follow-up appointment were audited retrospectively.

Results

A total of 462 patients were discussed at the colorectal MDT in 2017. Notes of252 patients, 54% men (n=136) were scrutinised. Of these, 54% (n=145 age range 26–98 years) were treated with curative intent. The site of the primary cancer was anus 1% (n=2), rectum 34% (n=49), sigmoid 16% (n=23), left colon 5% (n=7), transverse 8% (n=11), right colon 35% (n=51) and appendix 1% (n=2). 79% (n=114) had a 1-year follow-up.

65% (n=94) were treated with surgery alone. 26% (n=37) underwent surgery and adjuvant therapy (chemotherapy and/or radiotherapy). 5% (n=8) had surgery and neoadjuvant therapy (chemotherapy and/or radiotherapy). 3% had chemotherapy and radiotherapy but no surgery (n=5) and 1% (n=1) were treated with polypectomy alone.

19% were readmitted with complications of surgery (n=28) – mean length of stay, 10 days. Only 50% (n=73) of follow-up letters documented a conversation about side effects; GI 39% (n=56) psychological 6%(n=8); sexual 1% (n=1); tiredness 12% (n=17); quality of life 8% (n=11); urinary incontinence 8% (n=12).

GI problems included frequency, urgency, loss of appetite, abdominal pain, weight loss, diarrhoea, rectal bleeding, faecal incontinence and nocturnal defecation. Only 22% of patients (n=16) were offered investigations other than to rule out recurrent cancer, 41% (n=30) were offered advice and only 22% (n=16) were offered follow up to see if this advice helped.

Conclusions

Survival after colorectal cancer is improving rapidly. However, it is associated with frequent and predictable side effects. In our busy hospital trust, there is little evidence of systematic enquiry about side effects of cancer treatment or appropriate investigation and effective treatments being offered at follow-up. The lessons learnt during the UK's National Cancer Survivorship Initiative launched in 2007 and jointly run by the Department of Health and Macmillan Cancer Support,[4] have not impacted clinical practice. ■

References

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Authors: Lincoln County Hospital