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General Surgery

THE MANAGEMENT OF PRIMARY COLON CANCER - A REVIEW

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KEYWORDS :

Colorectal cancer is the third most common cancer affecting both males and females in the United States; approximately 70 percent of cases arise in the colon[1] .The diagnosis of colon cancer is usually made by colonoscopy. Pre treatment clinical staging is best accomplished by physical examination and computed tomography (CT) scan of the chest, abdomen, and pelvis.Serum levels of the tumor marker carcino embryonic antigen (CEA) should be obtained preoperatively in most patients .Ideally, each patient should have a colonoscopic examination of the entire colon prior to surgery. If full colonoscopy cannot be performed because of obstruction or poor preparation, CT or magnetic resonance colonography can be done, or alternatively, the entire residual colon should be examined colonoscopically soon after resection.

A family history of colorectal and other extracolonic cancers should be sought prior to therapy, as an inherited predisposition to colon cancer may alter the surgical approach, prompting consideration of subtotal or total colectomy in high-risk individuals..Surgical resection is the only curative modality for localized colon cancer.Endoscopic resection is a reasonable alternative to radical surgery for selected early stage colon cancers arising in a polyp, as long as they meet certain criteria for favorable risk.

There is no consensus as to which patients, if any, are suitable for neo adjuvant approaches rather than upfront surgery. Patients with potentially resectable disease with negative margins should undergo resection, rather than up front chemotherapy or chemo radiotherapy, if they are surgical candidates. Patients who are appropriate for initial chemotherapy include those with locally unresectable colon cancer, those whose margins of resection are judged to be potentially compromised, or those who are medically inoperable. For patients who have undergone potentially curative resection of a colon cancer, postoperative (adjuvant) chemotherapy eradicates micrometastases,reduces the likelihood of disease recurrence, and increases cure rates. The benefits have been most clearly demonstrated in patients with stage III (node-positive) disease. In this setting, a six-month course of oxaliplatin-based chemotherapy is generally recommended.[2].The benefit of chemotherapy for resected stage II disease is controversial, and treatment decisions must be individualized.
Chemotherapy carries a risk of significant toxicities, including mucositis, emesis, diarrhea, febrile neutropenia, fatigue, hair loss, hand-foot syndrome, and cardiotoxicity. The frequency and severity of these side effects vary according to the specific drugs used and how they are administered. Fortunately, most are reversible when chemotherapy is discontinued.

Most patients who present with metastatic disease are not surgical candidates, and palliative chemotherapy is generally recommended. However surgery may provide a potentially curative option for selected patients with limited metastatic disease, predominantly in the liver and lung. An aggressive surgical approach to both the primary and the metastatic sites is warranted in such patients in conjunction with systemic chemotherapy. For patients with unresectable distant metastases, the overwhelming majority of patients without symptoms who initiate chemotherapy never require palliative surgery.

Following treatment for a stage II or III colon cancer, posttreatment surveillance usually consists of periodic history and physical examination and assay of the serum CEA, annualsurveillance CT scans, and periodic colonoscopy. Recommendations for posttreatment surveillance from a number of expert groups are compared and contrasted in the Following treatment for stage I colorectal cancer, post treatment surveillance consists only of periodic history and physical examination and colonoscopy. Regularly updating a three-generation family history pedigree from cancer survivors can be valuable to help determine the potential risk of cancer in family members, as well as the survivor's own risk of subsequent cancers that may be associated with a previously unrecognized hereditary syndrome.

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