Cancer Reference Information

All About This Topic

Other Information Sources

Glossary

Cancer Drug Guide

Treatment Options

Treatment Decision Tools

Detailed Guide: Colon and Rectum Cancer

Surgery

Printer-Friendly Page

Email this Page

Colon surgery: Surgery is the main treatment for colon cancer. The most commonly performed operation is called a *segmental resection*. To prepare for this surgery you will be given a bowel prep which may consist of laxatives and enemas. Just before the surgery you will be given general anesthesia, which puts you into a deep sleep. During the surgery, your surgeon will make an incision in your abdomen. Then he or she will remove the cancer and a length of normal colon on either side of your cancer, as well as the nearby lymph nodes. Usually, about one fourth to one third of your colon is removed, but more or less tissue may be removed depending on the exact size and location of your cancer. The remaining sections of your colon are then reattached. When you wake up you will have some pain and will need to be given painkillers, usually morphine, for 2 or 3 days.

For the first couple of days, you will be given intravenous fluids and not be able to eat. But a colon resection rarely causes any major problems with digestive functions and you should be able to eat in a few days. If the tumor is large and has blocked your colon, or it has punched a hole in your colon so wastes have leaked out, a temporary *colostomy* may be needed. A colostomy is made when the end of the colon is brought through an opening in the abdomen to the outside for the purpose of getting rid of body wastes. A pouch is then used to hold that waste. Rarely, if a tumor can't be removed, a permanent colostomy is needed.

It is possible to remove some very early colon cancers (stage 0 and some stage I tumors), or cancerous polyps, by surgery through a colonoscope. When this is done, the surgeon does not have to cut into the abdomen. This is called a *polypectomy*. The cancer is cut out across the base of the polyp's *stalk*, the area that resembles the stem of a mushroom. *Local excision* removes superficial cancers and a small amount of nearby tissue.

It is sometimes possible to remove segments of the colon and nearby lymph nodes through a laparoscope. This is sometimes called “laparoscopic” or “keyhole” surgery. Using a *canula* (a narrow tube-like instrument), the surgeon

Overview

Detailed Guide

What Is It?

Causes, Risk Factors and Prevention

Early Detection, Diagnosis, Staging

Treating Colon and Rectum Cancer

- How Is Colorectal Cancer Treated?
- Surgery
- Radiation Therapy
- Chemotherapy
- Clinical Trials
- Treatment by Stage of Colon Cancer
- Treatment by Stage of Rectal Cancer
- Complementary and Alternative Methods
- Coping With Advanced Cancer

Talking With Your Doctor

enters the abdomen. A *laparoscope* (a tiny telescope connected to a video camera) is inserted through the canula, giving the surgeon a magnified view of the internal organs, which is displayed on a television monitor. Several other canulas are inserted to allow the surgeon to work inside and remove part of the colon. These incisions are usually small and heal quickly. Although using laparoscopic surgery to remove colon cancers was once considered experimental, this is no longer true. A recent study has shown that laparoscopic surgery is as likely to be curative as the standard approach and patients recover faster and feel better than they do after conventional colon surgery.

Rectal surgery: Surgery is usually the main treatment for rectal cancer, although radiation and chemotherapy may also be used in addition to surgery. Several surgical methods are used for removing or destroying rectal cancers.

Polypectomy and local excision can be used to remove superficial cancers or polyps. *Local transanal resection* involves cutting through all layers of the rectum to remove invasive cancers as well as some surrounding normal rectal tissue. Polypectomy, local excision, and local transanal resection are done with instruments inserted through the anus, without making a surgical opening in the skin of the abdomen. This procedure can be used to remove some stage I rectal cancers that are relatively small and not too far from the anus.

Some stage I rectal cancers and most stage II or III rectal cancers are removed by either *low anterior resection* or *abdominoperineal resection*. Low anterior resection is used for cancers in the upper two thirds of your rectum, close to where it connects with the colon. In this procedure the tumor can be removed without affecting the anus. After low anterior resection, your colon will be attached to the anus and your waste will be eliminated in the usual way.

A low anterior resection is like most abdominal operations. You will take laxatives and enemas before surgery. Just before surgery you will be given general anesthesia, which puts you into a deep sleep. The surgeon makes the incision only in the abdomen. Then the surgeon removes the cancer along with a margin of normal tissue on either side of the cancer. In addition, the surgeon will also remove lymph nodes and a large amount of fatty and fibrous tissue around the rectum. Then the colon can be reattached to the rectum that is remaining so that a permanent colostomy is not necessary. Sometimes, when special techniques are necessary to prevent a permanent colostomy, you may need to have a temporary colostomy opening for about 8 weeks while the surgical site heals. A second operation is then performed to close the temporary colostomy opening.

If the cancer is in the distal third of the rectum (the part nearest to the anus) and especially if it is growing into the sphincter muscle (the muscle that keeps the anus closed and prevents stool leakage), the anus and sphincter muscle may also need to be removed. Then an operation called an *abdominoperineal resection* is necessary. Here, not only does the surgeon make an incision in the abdomen, he or she must also make an incision in the perineal area around the anus. This incision allows the surgeon to remove the anus and the tissues surrounding it including the sphincter muscle. Having this procedure also means you will need a permanent colostomy to eliminate your stool.

The usual hospital stay for either of these procedures is 4 to 7 days depending on your overall health. Recovery time at home may be 3 to 6 weeks. If you have had a colostomy, you will need help in learning how to manage it. Specially trained *ostomy nurses* or *enterostomal therapists* can do this. They will usually see you in the hospital before your operation to mark a site for the colostomy opening, and later can come to your house or an outpatient setting to provide you with more training.

More Information
The Cancer Experience
Related Tools & Topics
Prevention & Early Detection
Bookstore

Sign In
Not registered yet? Register now or see reasons to register.

If the rectal cancer is growing into nearby organs, a *pelvic exenteration* may be recommended. This is a very extensive operation. Not only will the surgeon remove your rectum, but also nearby organs such as the bladder, prostate, or uterus when the cancer has spread to these organs. You will need a colostomy after pelvic exenteration. If your bladder is removed, you will also need a *urostomy* (opening where urine exits the front of the abdomen and is held in a portable pouch).

Side effects of surgery: Side effects include bleeding from the surgery, blood clots in the legs, and damage to nearby organs during the operation. Rarely, the connections between the ends of the intestine may not hold together completely and leak. If an infection occurs, it is possible that the incision might open up, causing a gaping wound. Later, after the surgery, you might develop what are called adhesions that could cause the bowel to become blocked.

Sexual impact of colorectal surgery: If you are a man, an abdominal perineal resection can cause you to have "dry" orgasms by damaging the nerves that control ejaculation. Sometimes the surgery only causes retrograde ejaculation, which means the semen goes backward into your bladder. The difference between no emission at all and retrograde ejaculation becomes important if you want to father a child. Retrograde ejaculation is less serious, because infertility specialists can recover sperm cells from your urine and these cells can be used to make a woman pregnant. If sperm cells cannot be recovered from your semen or urine, infertility specialists may be able to retrieve them directly from your testicle by minor surgery, and then use them for in vitro fertilization to produce a pregnancy. In some situations, AP resection may stop your erections or ability to reach orgasm. In other cases your pleasure at orgasm may become less intense. Normal aging may cause some of these changes, but they may be enhanced by the surgery.

If you are a woman having a colostomy, you should not normally expect any loss of sexual function. No matter what your gender, more information on dealing with the sexual impact of cancer and its treatment is available in the American Cancer Society documents, Sexuality and Cancer: For the Man Who Has Cancer and His Partner and Sexuality and Cancer: For the Woman Who Has Cancer and Her Partner.

Surgical treatment of colorectal cancer metastases: Sometimes, treatment of cancer that has spread to other organs, or metastasized, can help you to live longer -- or even to be cured. If only a small number of metastases are present in the liver, lungs, or ovaries, they may be removed by surgery. If only a few liver metastases are present, completely removing them along with the colorectal tumor may even cure you. Liver metastases may also be destroyed by freezing them (cryosurgery), by heating them with microwaves, by injecting material into large blood vessels feeding the tumor to block blood flow *(embolization)*, or by injecting concentrated alcohol into the tumor. These methods do not require a surgical operation. The freezing probe, microwave probe, or needle is inserted through the skin and guided to the tumor by CT scans or ultrasound images. However, these methods are not curative.

Revised: 05/24/2005

Copyright 2005 © American Cancer Society, Inc.
All content and works posted on this website are owned and copyrighted by the American Cancer Society, Inc. All rights reserved.