

Colorectal Cancer

A plain-English guide for you and your family

WHAT IS HAPPENING

Your colon and rectum are covered on the inside by a layer of cells that replace themselves constantly — millions of new cells every day. Most of the time, your immune system spots any odd cell and destroys it before it becomes a problem. But sometimes a cell picks up a broken gene (like APC, the first domino to fall), keeps dividing, and picks up more broken genes over ten to twenty years (KRAS, TP53, and others). Each broken gene takes away one more brake until the cell ignores all stop signals and becomes cancer. Some people inherit broken genes (Lynch syndrome or FAP) that make cancer much more likely and happen much younger. For most people, colorectal cancer grows silently for years with no warning at all. When it finally causes trouble, you might see blood in your stool (because the tumor breaks through blood vessels), a change in how often you go or the shape of your stool (because the tumor is blocking the path), belly pain, weight loss you did not try for, or low iron that makes you tired (because slow bleeding steals iron over time). These signs are not the cancer itself — they are what happens when a tumor gets big enough to interfere with the colon's job of moving waste and absorbing the last bits of water and nutrients. Screening (starting at age 45 for most people, earlier if your family has a history) catches polyps before they turn into cancer or catches cancer early when surgery alone can cure it. Treatment depends on the stage: surgery to remove the tumor and nearby lymph nodes, chemotherapy to kill any cells that might have escaped, and sometimes targeted drugs or immunotherapy if the tumor has certain gene patterns. The key is that this cancer is preventable and beatable if caught early, which is why screening saves lives.

What you might feel

- Blood in the stool (bright red or very dark, tar-like)
- Change in bowel habit lasting more than a few weeks (new diarrhea, new constipation, or feeling like you can't empty your bowel completely)
- Belly pain or cramping that doesn't go away
- Unexplained weight loss
- Feeling very tired or weak (fatigue)

- Anemia (low red blood cell count) with no clear reason
- Narrow or ribbon-like stools
- A lump or mass you can feel in your belly or rectum

Call the doctor right away if...

- Blood in the stool (visible or found on testing)
- Unexplained weight loss of more than 10 pounds without trying
- New constipation or diarrhea lasting more than a few weeks
- Severe belly pain or a hard lump you can feel in your abdomen
- Anemia (low red blood cells or low iron) that doctors cannot explain by diet or other causes

What the care team will do

- Monitor for signs of bowel obstruction every shift: measure abdominal girth, listen for bowel sounds, ask about passage of stool and flatus, and watch for vomiting.
- Check hemoglobin and hematocrit daily and watch for signs of acute bleeding like black tarry stools, bright red blood per rectum, low blood pressure, or fast heart rate.
- Assess pain level every 4 hours using a 0-to-10 scale, ask where the pain is located, and give prescribed pain medicine on schedule before pain becomes severe.
- Encourage the patient to get out of bed and walk in the hallway at least 3 times per day starting the day after surgery.
- Monitor the surgical incision or ostomy site every shift for redness, swelling, warmth, drainage, or bad odor, and teach the patient proper ostomy care if a colostomy or ileostomy is placed.
- Track intake and output every shift, ensure intravenous fluids run at the prescribed rate, and watch for signs of dehydration like dry mouth, low urine output, or dizziness when standing.
- Teach the patient and family about chemotherapy side effects—especially hand-foot syndrome, diarrhea, mouth sores, and low white blood cell count—and when to call the doctor.
- Screen for anxiety and depression using a simple tool, offer emotional support, and connect the patient with a cancer support group or counselor.

Medicines you may be given — and why

FOLFOX (5-FU + leucovorin + oxaliplatin)

Stops cancer cells from copying their DNA and dividing. 5-FU blocks a key enzyme that builds DNA building blocks; leucovorin makes 5-FU work better; oxaliplatin damages the DNA strands so the cancer cell can't copy them correctly and dies.

CAPOX (capecitabine + oxaliplatin)

Stops cancer cells from dividing by blocking DNA building and damaging DNA strands. Capecitabine is a pill that the body turns into 5-FU (same drug as in FOLFOX) inside the cancer cell; oxaliplatin is given by IV and damages DNA so the cell can't copy it.

Bevacizumab (Avastin)

Blocks VEGF, a signal that tumors send out to grow new blood vessels. Without new blood vessels, the tumor can't get enough oxygen and nutrients to grow and spread.

Cetuximab (Erbix) or Panitumumab (Vectibix)

Blocks EGFR, a receptor on the cancer cell surface that tells the cell to grow and divide. Only works if the tumor's KRAS, NRAS, and BRAF genes are normal (wild-type); if those genes are mutated, the grow signal is jammed 'on' inside the cell and blocking EGFR on the outside won't help.

Encorafenib + Cetuximab (or Binimetinib)

Used only if the tumor has a BRAF V600E mutation (a broken gene that keeps the grow signal jammed 'on'). Encorafenib blocks the mutant BRAF protein inside the cell; cetuximab (or binimetinib) blocks signals just upstream or downstream so the cancer can't find a workaround. Together they shut down the grow signal more completely.

Pembrolizumab (Keytruda) or Nivolumab (Opdivo)

Takes the 'brakes' off the immune system so T cells (the body's cancer killers) can recognize and attack colorectal cancer cells. Only works if the tumor is MSI-high or dMMR (mismatch repair deficient), meaning it has many DNA mistakes that make it visible to the immune system.

Regorafenib (Stivarga) or Trifluridine/Tipiracil (Lonsurf)

Used after multiple prior chemo regimens have stopped working. Regorafenib blocks many enzymes (kinases) that cancer cells use to grow, divide, and build blood vessels. Trifluridine/tipiracil is a pill chemo combo: trifluridine gets incorporated into cancer DNA and stops it from copying; tipiracil protects trifluridine from being broken down too fast in the body.

Where this information comes from

- NCCN Clinical Practice Guidelines in Oncology: Colon Cancer 2024
- NCCN Clinical Practice Guidelines in Oncology: Rectal Cancer 2024
- U.S. Preventive Services Task Force (USPSTF) Colorectal Cancer Screening 2021
- American Cancer Society Colorectal Cancer Facts & Figures 2024

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