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So no one faces cancer alone

understanding Colorectal Cancer

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Established in 1987, the Hong Kong Cancer Fund ("Cancer Fund") is the city's largest cancer support organisation, providing FREE professional support and information to anyone touched by cancer to ensure that no one faces cancer alone.

This publication is part of the Cancer Fund's "Understanding Cancer" series, providing detailed information on cancer diagnosis and treatment options, along with practical tips to help cancer patients and their families cope with side effects and emotional distress caused by cancer and its treatment. A digital copy of the booklet is also available on our website for free download.

Our services span from the hospital to the community and the home with a network of 4 Cancer Support Centres in Central, North Point, Kwai Chung and Wong Tai Sin.

Our professional team includes oncology nurses, social workers, art therapists, dietitian and clinical psychologist. They help clients manage the physical, emotional, psychological and social challenges brought about by a cancer diagnosis.

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Introduction

This booklet has been prepared to help you understand more about colorectal cancer.

Many people feel understandably shocked and upset when told they have cancer. We hope this booklet will help you to understand the diagnosis and treatment of the disease. We also include information about support services.

Before commencing any health treatment, always consult your doctor. This booklet is intended as a general introduction and should not be seen as a substitute for your own doctor's or health professional's advice. All care is taken to ensure that the information contained is accurate at the time of publication.

We hope this booklet will answer some of your questions and help you think about the questions you want to ask your doctors.

You do not need to read it from cover to cover, just read the parts which are useful to you. You may like to pass this booklet to your family and friends for their information. They, too, may want to be informed so that they can help you cope with any problems you may have.

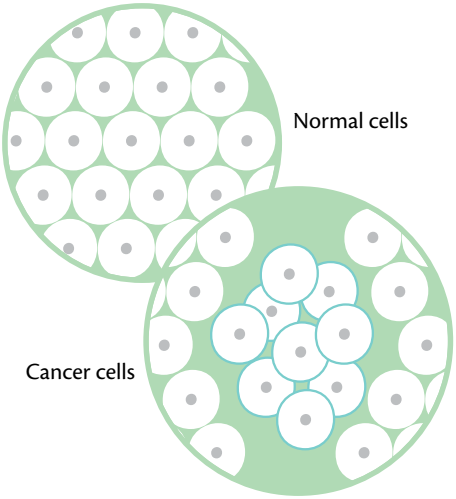
Contents

What is cancer?

Our body is made up of billions of cells, and their shape and function vary in different parts of the body. Normally, cells grow, divide (multiply), and eventually die in an orderly manner. However, when the division process goes out of control, cells continue to proliferate and accumulate in the body, forming a lump called a tumour.

Benign vs. Malignant

Tumours can be benign (non-cancerous) or malignant (cancerous). Benign tumours generally do not cause symptoms or spread to other parts of the body. They are usually not life-threatening and only need to be monitored regularly unless they grow and compress adjacent tissues, requiring treatment. A malignant tumour, also known as cancer, not only grows at the original site but can also spread. If not treated in time, they can destroy surrounding tissues and invade other organs via the bloodstream or lymphatic system, forming metastases or secondary cancer.



Primary vs. Metastatic (Secondary)

Cancer is divided into primary and metastatic types. Primary cancer refers to cancer that originates in the original site. For example, if liver cells become cancerous and form a tumour, it is referred to as primary liver cancer. Metastatic cancer refers to cancer cells spreading to other parts of the body. For example, if lung cancer cells spread to the liver and form a tumour, it is considered metastatic lung cancer and referred to as "lung cancer spreading to the liver".

The bowel

When eating, food travels down the oesophagus to the stomach and then enters the small intestine, where the main digestive process takes place and essential nutrients for the body are absorbed. The digested food then enters the large intestine (the colon and rectum - the green part in the diagram below), and water is absorbed by the colon (including the caecum, ascending colon, transverse colon, descending colon, and sigmoid colon). The remaining waste is faeces, which is stored in the rectum. Through the movement of the bowel, the faeces are expelled from the body. Keeping your bowels healthy helps to reduce the risk of cancer.

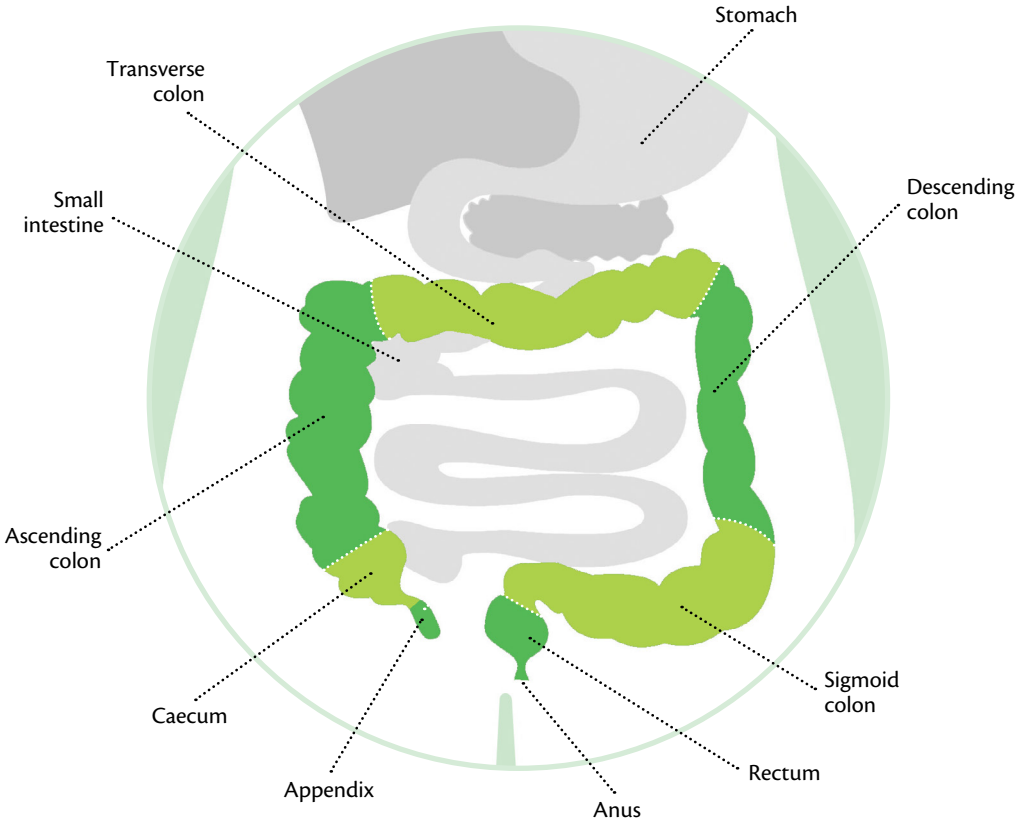


Diagram of the colon and rectum

Risk factors for colorectal cancer

The following factors increase the risk of developing colorectal cancer. Even without high-risk factors, this does not mean that you will not develop colorectal cancer.

- **Poor dietary habits:** consuming too much animal fat, red meat, and processed meats. Or insufficient fibre intake, eating too few fruits and vegetables.
- **Obesity, lack of exercise, smoking, and alcohol consumption.**
- **Family history of colorectal cancer:** If someone in the family has had colorectal cancer, blood-related family members have a higher risk of developing the disease. If a family member is diagnosed with colorectal cancer before the age of 45, or if more than one person in the family has had the disease, the risk for other members increases accordingly.
- **Having colorectal cancer gene mutations:** Familial Adenomatous Polyposis syndrome (FAP) and Hereditary Non-Polyposis Colorectal Cancer (also known as Lynch syndrome, HNPCC) are both caused by having a mutated gene associated with colorectal cancer. Without early treatment, patients with the FAP gene have an almost 100% chance of developing colorectal cancer before the age of 60. Meanwhile, patients with the HNPCC gene have up to an 80% chance of developing colorectal cancer before the age of 70. Individuals with gene mutations should undergo regular check-ups and seek early treatment.

Colorectal cancer refers to cancer that develops from polyps growing on the mucosa (lining) of the colon or rectum. Most colorectal cancers develop from adenomatous polyps in the intestine over a period of about 10 to 15 years. Therefore, timely check-ups to find and remove polyps can effectively prevent colorectal cancer.

Symptoms of colorectal cancer

- Blood (bright red or very dark) or mucus in the faeces
- Changes in bowel habits lasting for more than two weeks (e.g., intermittent constipation or diarrhoea, stools as thin as a pencil, a feeling that the bowel does not empty completely after a bowel movement.)
- Persistent abdominal discomfort (abdominal distension and colic)
- Unexplained weight loss

If these symptoms occur, it may indicate a problem with the large intestine, and early-stage colorectal cancer can often have no obvious symptoms. In addition, a tumour in the bowel can also cause a bowel obstruction, leading to constipation, intestinal colic, and abdominal distension. If you experience any of these symptoms, you should consult a physician promptly. However, other medical conditions can present with similar symptoms, which are not definitive for cancer.

How to diagnose?

If symptoms of colorectal cancer are present, you will typically first consult the general practitioner. If the general practitioner deems further examinations necessary, they will refer you to a specialist.

Digital rectal examination

Generally, a digital rectal examination (DRE) is the initial method for examining the rectum: the doctor will wear a glove and insert a finger into your rectum to check for any hard lumps or swelling. The procedure may cause mild discomfort but should not be painful.

Faecal occult blood test (FOBT)

This test detects the presence of human blood in a single stool sample. If the sample contains occult blood, indicating the presence of hemoglobin in the feces, a colonoscopy should be arranged for further investigation.

Colonoscopy

The endoscope allows for direct observation of the large intestine's interior for any abnormalities. A low-fibre diet is required for several days prior to the examination. The day before the procedure, bowel preparation involves taking a laxative and drinking large quantities of clear fluids. During the procedure, the patient lies on their side, and the doctor inserts the endoscope through the anus into the large intestine. If polyps are found during the procedure, they can be removed at the same time, reducing the chance of them developing into cancer. If necessary, a tissue sample can be taken for a biopsy. Some discomfort may be experienced during the procedure. Patients can typically go home the same day. However, as a sedative may be administered before the examination, it is advisable for a friend or relative to accompany the patient home.

Multi-target stool DNA test (FIT-DNA)

The FIT-DNA test is to analyse a stool sample for the presence of blood and genetic mutations to assess the risk of colorectal cancer. The FIT-DNA test has a detection rate of approximately 90% for colorectal cancer, but its sensitivity for significant polyps (those with the potential to become cancerous) is relatively lower. If the result is positive, a colonoscopy is required for further investigation.

Cancer marker

A cancer marker, also known as a tumour marker, is a substance found in the blood. When the concentration of certain proteins in the blood is elevated, it is often associated with a specific cancer. Changes in these levels can therefore be used to assess the presence or progression of certain cancers. There are many types of tumour markers, while carcinoembryonic antigen (CEA) is the tumour marker used in screening for colorectal cancer, with the normal value of <5 ng/ml.

The CEA level can be measured via a blood test and may be checked during a routine medical examination. However, CEA testing alone is not sufficient to diagnose colorectal cancer. An elevated level can be caused by numerous other factors, such as long-term smoking, inflammatory bowel disease, cirrhosis, or hypothyroidism. CEA is typically used to monitor for disease recurrence and therapeutic effect in patients with colorectal cancer.

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Further examination

Before surgical removal of the tumour, the doctor will typically order further examinations to determine if the cancer is metastasized, particularly to the lungs and liver, which are the most common sites. This includes:

Liver function tests

A blood test is performed to measure the levels of certain liver enzymes and proteins. Abnormal results may indicate that the cancer has spread to the liver.

Chest X-ray

This is used to check if the cancer has spread to the lungs.

Computed tomography (CT) scan

A CT scan uses X-rays to create a detailed three-dimensional (3D) image of the body, providing much more information than a standard X-ray. The procedure takes 10 to 40 minutes and is painless. The radiation from a CT scan poses no risk to others, including children.

Fasting is required for four hours prior to the scan. A contrast agent will be administered either orally or by injection. It is crucial to inform the doctor beforehand of any history of asthma, urticaria, eczema, allergic rhinitis, or allergies to certain foods, medications, or X-ray contrast agents. During the scan, the patient must lie still on the examination table, as movement will cause the image to become blurry. A CT scan has no lingering after-effects, and patients can typically return home once the examination is complete.

Ultrasound scan

This technique uses sound waves to visualise the abdominal cavity and the liver. A thin layer of gel is applied to the abdomen, and a small probe is moved across the

skin. The sound waves emitted from the probe are analysed by a computer and converted into an image. The entire procedure takes only a few minutes, is painless, and has no lingering after-effects.

Magnetic resonance imaging (MRI)

It is primarily used to visualise the body's internal tissues. The imaging principle is similar to a CT scan, but it uses magnetic fields instead of X-rays to create cross-sectional images of the body.

Due to the powerful magnetic field, all metallic objects must be removed before undergoing an MRI. Patients with certain medical implants, such as cardiac pacemakers, heart monitors, or metallic stents, may not be suitable for an MRI. It is crucial to inform medical staff of any such implants beforehand.

During an MRI scan, the patient lies still inside a large, cylindrical machine that is open at both ends. The entire procedure takes approximately 30 minutes. The machine produces loud noises during the scan, and earplugs are typically provided. Patients who feel anxious in enclosed spaces should inform the medical staff beforehand.

The results for the above examinations may take several days to become available. It is common for patients to feel anxious during this waiting period. Talking with friends or family may help to alleviate this anxiety.

Staging and treatment of colorectal cancer

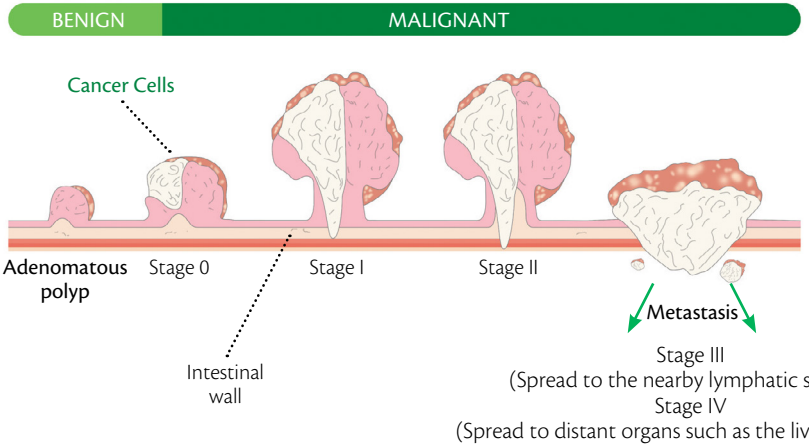
The most common treatment for colorectal cancer is surgical removal of the tumour. However, it may be combined with chemotherapy or radiotherapy to enhance treatment efficacy.

The specific treatment depends on the patient's general health, examination results, the cancer stage, and surgical findings. Some patients require other treatments before and after surgery.

Staging of colorectal cancer:

- Stage I: The cancer is confined to the wall of the large intestine and has not spread.
- Stage II: The cancer has invaded through the wall of the large intestine and may have invaded into adjacent soft tissues or organs but has not spread to the lymph nodes or distant organs.
- Stage III: The cancer has spread to nearby lymphatic system
- Stage IV: The cancer has spread (metastasized) to distant organs, such as the liver and lungs

Progression of colorectal cancer



How to plan treatment?

Factors considered when selecting a treatment regimen include the patient's age, general health, and the tumour's type, size, location and stage.

Early-stage colorectal cancer general requires surgery alone, without the need for adjunctive therapy. It is now possible for some colorectal cancers to be removed using minimally invasive surgery, which reduces complications and accelerates recovery. For more advanced colorectal cancers without signs of metastasis, other treatments such as chemotherapy or radiotherapy may also be used to reduce the risk of recurrence.

For colorectal cancer that has metastasized, treatment relies primarily on chemotherapy to control the disease, stabilise the condition, and palliate symptoms. If appropriate, targeted agents or immunotherapy may be added to enhance treatment efficacy. The decision to perform surgery depends on the individual clinical situation.

Each patient's case is unique, and doctors may hold varying views on treatment. Consequently, even for the same type of cancer, treatment regimens may vary considerably in detail. Should you have any questions regarding the treatment, be sure to discuss with your doctor.

(I) Surgery

The doctor will select the most appropriate surgical method based on the tumour's morphology, size, and the extent of its spread. Colorectal cancer surgery can be performed via traditional open surgery or minimally invasive surgery (laparoscopic colorectal surgery). Minimally invasive surgery is generally the preferred option. However, in certain circumstances, such as if the tumour is too large, traditional open surgery will be employed. Minimally invasive surgery results in smaller incisions and a quicker recovery.

Colectomy/Proctectomy

The most common treatment for colorectal cancer is the resection of the diseased segment and its associated lymph nodes, followed by rejoining the two ends of the intestine.

Sometimes, after the tumour is removed, it is not possible to reconnect the two ends of the bowel. In such cases, one end of the intestine is brought to the outside of the abdomen to form a stoma, serving as an opening for passing faeces.

The stoma is covered by a small pouch on the outside of the body to collect faecal matter. This pouch is usually temporary. A further operation is performed a few months later to rejoin the bowel. However, for a minority of patients, rejoining the bowel is not feasible, and they must use the stoma for excretion permanently.

Besides, an ileostomy is another procedure where an opening from the ileum is brought to the outside of the abdomen. Faeces are collected in a pouch covering the stoma, and this is also typically a temporary measure.

To ensure the bowel is clean, it is necessary to follow a specific dietary plan and take a mild laxative before the operation. If the tumour is causing a bowel obstruction that makes passing faeces difficult, immediate surgery may be required.

Treatment/removal of a metastasis

In certain cases, such as when cancer has spread to the liver or lungs, resection of the tumour in that area may be considered to achieve better therapeutic outcomes. The management of partial liver metastases with other methods may also be considered. These methods are as follows:

Radiofrequency ablation (RFA)

A needle-like electrode is inserted into the liver tumour, emitting an electrical current (radiofrequency) to generate high temperatures that destroy the cancer cells.

Microwave ablation (MWA)

This treatment uses microwaves to heat and destroy the cancer cells.

Cryotherapy

Alternatively, low temperature can also be used to destroy cancer cells. The procedure is analogous to RFA, where a probe is inserted into the tumour to lower the local temperature and destroy the cancer cells.

Selective internal radiotherapy (SIRT)

Microscopic radioactive beads are delivered into the blood vessels supplying the tumour area. The radiation destroys cancer cells but will also damage some healthy liver tissue. The patient's body will also be temporarily radioactive.

Stereotactic body radiotherapy (SBRT)

This treatment uses high dose of external beam radiation in each session to kill the cancer cells. The treatment course is shorter, generally requiring only a few sessions.

Not every oncology centre will offer these therapies, nor are they suitable for every patient. It is advisable for patients to listen to their doctor's explanation and advice.

Enhanced recovery after surgery (ERAS) programme

To shorten hospital stays and reduce the risk of complications, hospitals have introduced the ERAS programme. This approach focuses on improving a patient's physical condition prior to surgery, enabling them to recover more quickly after surgery. A multidisciplinary team, comprising surgeons, anaesthetists, physiotherapists, and specialist nurses, will utilise the surgical waiting period to develop a suitable rehabilitation plan for the patient to enhance their physical function for the surgery. With ERAS, a significant reduction has been observed in the length of hospital stays, alongside reduced transfusion rates and a lower risk of complications.

Recovering after surgery

The sooner mobilisation begins after surgery, the more it aids recovery. Should it not be possible to get out of bed, it is advisable to move the legs frequently while in bed and perform deep breathing exercises.

A urinary catheter is required for the first few days after surgery. In some cases, a surgical drain is placed in the wound to remove excess fluid.

To prevent infection, antibiotics are administered both before and after the operation. Wearing compression stockings after surgery helps to prevent deep vein thrombosis.

Bowl motility typically slows down as the effects of the anaesthetic wears off. Never drink anything until normal bowel function resumes. Usually, small sips of water may be taken two or three days after the surgery, with the amount gradually increased. After four to five days, a light diet can be gradually introduced. The instruction of the medical staff must be followed.

Mild pain is common for the first few days after the surgery. This can generally be managed with painkillers. Should the pain persist, the doctor should be notified for adjustment. Additionally, discomfort may be experienced at the incision site

when sitting for prolonged periods. This discomfort will gradually subside as the wound heals.

The sutures can generally be removed seven days after surgery. It is essential to inform the doctor of any discomfort experienced before discharge from hospital.

It is normal for patients to be concerned about their conditions, but they may find it difficult to talk about with those close to them. If you would like to speak with someone other than friends or family for professional advice, the professional team at our Cancer Support Centres, including social workers, clinical psychologist, and peer supporters, are on hand to provide assistance.

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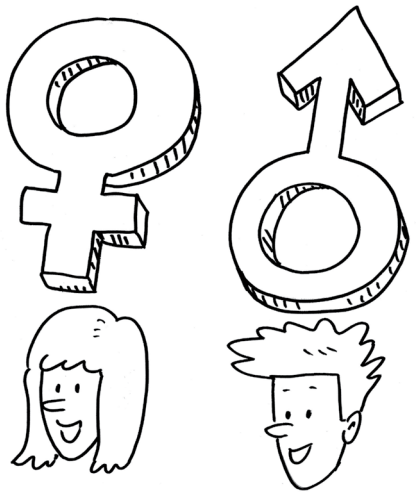
Will the surgery affect my sex life?



Most patients can resume a normal sex life after they have recovered from the surgery. Some patient may feel self-conscious about their body changes, particularly with a stoma, and may be reluctant to engage in sexual activity.

Partners should be understanding at this time, share in their feelings, and help to alleviate the patient's anxiety. It may also be worth discussing this with a doctor to see if a referral to a specialist in this area is necessary. Your doctor has likely treated patients with similar concerns, so there is no need for embarrassment.

Rectal surgery may affect the nerves connected to the sexual organs, leading to an inability for male patients to get an erection or ejaculate. However, such instances are uncommon and may be temporary.

For any queries, discuss with the doctor for a detailed explanation prior to the operation.

Eating well after surgery helps with recovery

Following the tumour removal, certain foods may affect bowel habits or stoma function.

Bowel habits will stabilise anywhere from a few weeks to a few months after surgery. Initially, however, the following changes may occur and require patience to adapt to: frequent bowel movements, urgency (the need to rush to the lavatory), diarrhoea, constipation, abdominal distension, flatulence, and soreness around the anus. These symptoms will usually lessen over time. Should these symptoms persist or if bowel

movements remain unstable, a doctor should be consulted to determine whether medication is required or if assistance from a specialist nurse or dietitian is required.

Eating at regular times helps to regulate bowel movements. If the appetite is poor, it may be helpful to try eating smaller, more frequent meals. At least one to two litres of fluids should be consumed daily. Eating more protein-rich foods such as fish, meat, and eggs will aide recovery. It is advisable to consume a wide variety of foods to ensure a balanced diet. It is recommended to keep a daily record of the types and quantities of food eaten and the body's reaction to determine the most beneficial diet for recovery. In the event of diarrhoea, it is best to eat more low-fibre foods like white bread and pasta, and to avoid high-fibre foods such as wholemeal products. Eat few leafy green vegetables; vegetables should be cooked until soft, and fruits should be peeled.

As bowel movements become more stable, foods that were not well-tolerated initially can be reintroduced to see if they no longer affect bowel function. Should the problems persist, a dietitian should be consulted.

Should flatulence or abdominal distension occur after surgery, the following measures may help to alleviate the symptoms: eating slowly and chewing thoroughly; reducing intake of beans, beer, chewing gum, fuzzing drinks, and onions; and trying peppermint oil capsules, fennel tea, or peppermint tea.

For further information on diet and cancer, please refer to our booklet **Cancer and Diet**, which is available for free download.

Cancer and Diet Booklet

Colostomy

After tumour resection, only a minority of patients will require a colostomy. Prior to the operation, the doctor will carefully select the stoma site to ensure that the stoma pouch is not easily dislodged, whether the patient is sitting, standing, or moving. The stoma site will be somewhat swollen initially; it may take several weeks to return to its normal size.

In the first few days after surgery, the nurse will manage the stoma care, ensuring that the pouch is kept clean. As recovery progresses, the nurse will teach the patient how to clean the stoma and change the pouch. It is important not to rush the learning process; proficiency will come with practice. A friend or relative may be present during the learning session to provide assistance initially.

Various brands are available on the market; the nurse can assist with selecting the most suitable stoma pouch. An adequate supply should be kept at home in a designated, private location to ensure that they are readily available.

Some patients prefer to irrigate their stoma daily rather than wearing a pouch. However, this method is not suitable for all stoma patients. It is advisable to consult a doctor or nurse first.

Sharing experience with peers can be very helpful. The Hong Kong Stoma Association is a support organisation in this field (**Tel: 2834 6096**).

Early detection saves lives

The earlier colorectal cancer is detected, the higher the treatment efficacy and survival rate. For example, the five-year survival rate for Stage I colorectal cancer patients exceeds ninety-five percent[#].

[#] Hong Kong Cancer Registry 2024 (2022 statistics)

(II) Chemotherapy

The principle of chemotherapy is to capitalise on the fact that cancer cells divide more rapidly than normal cells, using cytotoxic drugs to kill them. Chemotherapy drugs are typically administered into the bloodstream, where they circulate through the body to find and destroy cancer cells.

Commonly used chemotherapy drugs for colorectal cancer include: Fluorouracil (5-FU), Oxaliplatin, Irinotecan, and Capecitabine.

Among the drugs listed, Fluorouracil is preferred. This drug can be used in combination with other anti-cancer drugs, such as Leucovorin, to enhance its efficacy. Patients may consult their doctor to compare the effectiveness and side effects of different combination therapies.

Chemotherapy is usually administered by intravenous injection into a vein in the arm or via a catheter implanted in the chest. The chest catheter can be connected to a portable pump that delivers a measured dose of the drug into the bloodstream at regular intervals, allowing for administration at home. In addition to injections, some chemotherapy drugs are available in oral form. Depending on the drug used, some treatment sessions allow for same-day discharge, while others may require a hospital stay of several days. Each course of treatment is typically spaced 2 to 3 weeks to allow the body to recover from side effects. The number of treatment course required depends on the disease status and patient's response to the medication.

Chemotherapy before surgery

Patients with locally advanced rectal cancer may also undergo combination chemotherapy (the use of two or more chemotherapy drugs) prior to surgery to improve overall survival and reduce the chance of recurrence. Combination chemotherapy is then continued after surgery.

Chemotherapy after surgery

Chemotherapy after surgery, also known as adjuvant chemotherapy, is used to reduce the risk of cancer recurrence.

Generally, if cancer cells are found in nearby lymph nodes after tumour resection, or if the risk of recurrence is assessed to be high, chemotherapy will be considered.

Treatment for metastatic colorectal cancer

Traditional chemotherapy

While most patients with early-stage colorectal cancer recover after treatment, in some patients, the cancer cells metastasize, most commonly to the lungs and liver.

In most cases, metastatic (secondary) colorectal cancer is not curable, but chemotherapy can be used to palliate symptoms and stabilise the disease. Once administered, chemotherapy drugs travel through the bloodstream to all parts of the body, killing cancer cells. The doctor will determine the most suitable therapy based on the patient's general health, past treatment history, and response.

In a minority of cases of metastatic colorectal cancer, curative resection may be considered. Subject to the patient's physical condition, chemotherapy is also frequently used before and after surgery.

Side effects

Reduced immunity

Chemotherapeutic drugs temporarily lower the number of normal cells in the blood, which can cause fatigue and increased susceptibility to infection. During chemotherapy, blood tests will be conducted regularly, and antibiotics may be prescribed if necessary to combat infection.

Fatigue

Fatigue and a lack of energy may be experienced during chemotherapy; adequate rest is important.

Nausea

Some chemotherapy drugs can cause nausea and vomiting. Anti-emetic medication can usually alleviate this discomfort. However, different patients react differently to different drugs. If the prescribed medication does not control the vomiting, it is important to inform the doctor, as a different drug may be required.

Diarrhoea

Anti-diarrhoeal medication can slow down bowel motility and reduce diarrhoea. Eating more low-fibre foods may also be of help. It is crucial to drink plenty of fluids to replace water and electrolytes lost through diarrhoea.

Sore mouth

Chemotherapy can cause a sore mouth and, in some cases, mild ulceration. Using a prescribed mouthwash, or rinsing the mouth with plain water or a saline solution (one level teaspoon of salt dissolved in 500ml of boiled water), can alleviate the symptoms. If a sore mouth affects eating, nutritional drinks can be used as a substitute for regular meals. For more details, please refer to our booklet **Cancer and Diet**.

Hair loss

Prior to chemotherapy, it is advisable to ask the doctor if the selected drugs are likely to cause hair loss. Hair loss is usually temporary. Hair will grow back after the course of treatment is completed. For more details, refer to our booklet **Hair Loss**.

Hand-foot syndrome

Prolonged use of Fluorouracil may cause redness, swelling, and pain on the palms of the hands and soles of the feet. The pain can sometimes be severe, but it generally disappears quickly after the treatment course is completed.

Although modern chemotherapy drugs have significantly improved and have milder side effects, they remain powerful medications that many believe should be avoided if possible. In fact, different anti-cancer drugs have different side effects, and each patient's experience is unique. If a drug is indicated, it should be used. It is important to be psychologically prepared by asking about potential side effects before starting the medication. For further information on chemotherapy, please refer to our booklet **Chemotherapy**, which is available for free download.

Cancer booklet

(III) Radiotherapy

Radiotherapy is a treatment modality that uses high-energy X-rays to precisely destroy cancer cells, and its advantages lie in its ability to localise radiation to the tumour, with less chance of harming normal cells. In contrast to the chemotherapy, radiotherapy is a local treatment, affecting only the specific targeted area, while untouched areas remain unaffected. Radiotherapy for colorectal cancer is primarily applicable to the rectum (for the specific location of the rectum, please refer to the "Diagram of the colon and rectum" on Page 5). Due to the peristaltic movement of the colon, it is difficult for radiotherapy to accurately target a tumour there. The rectum, however, is situated at the anal opening and fixed within the pelvic cavity, making it more stable and thus more amenable to radiotherapy.

The doctor will determine the most suitable radiotherapy regimen based on the patient's general health, examination findings, cancer stage, recurrence risk, and the tumour's size and location.

External beam radiation therapy (EBRT)

This is commonly used for rectal cancer and less so for colon cancer. If a rectal tumour is assessed by a surgeon as being difficult to operate on, pre-operative radiotherapy may be used to shrink the tumour to facilitate resection. Radiotherapy may also be considered for rectal cancer after surgery.

Subject to the disease status and the patient's physical condition, chemotherapy and radiotherapy may be used concurrently to enhance treatment efficacy. In the event of cancer recurrence, radiotherapy is sometimes used to shrink the tumour or control the disease. It can also alleviate pain when cancer cells have metastasized to the bone.

External radiotherapy may employ the following techniques to improve treatment precision and reduce the impact on surrounding normal tissues and organs. Sometimes, real-time imaging is also incorporated to allow for real-time adjustments.

- 3D conformal radiation therapy (3D CRT): The radiation field is shaped to conform to the three-dimensional, irregular shape of the tumour. The doctor uses CT scan images to design the treatment. Computerised software allows the doctor to clearly visualise the tumour's shape in three-dimensional space, enabling accurate assessment of the radiation field. However, should the tumour shape be excessively irregular or too close to normal organs, it may not be suitable. The doctor may then arrange for the patient to undergo other radiotherapy techniques.
- Intensity modulated radiation therapy (IMRT): The principle is to deliver radiation rays of varying intensity and shape from multiple fixed angles, which intersect at the target tumour area to achieve optimal efficacy. IMRT is particularly advantageous when the tumour is deep-seated within normal tissue or adjacent to critical organs. It can improve tumour dose coverage and reduce side effects.
- Volumetric modulated arc therapy (VMAT): This is a form of IMRT technology. VMAT is an advanced version of IMRT. It can more effectively conform the radiation dose distribution to the tumour shape from multiple non-fixed angles (a 360-degree rotation). During treatment, the radiotherapy machine rotates around the patient in one or more arcs. As the tumour position changes, the radiation rays are modulated, which not only provides a uniform dose to the treatment area but also allows the dose to conform more closely to the tumour's shape, reducing the impact on surrounding normal tissues and organs. Compared with 3D CRT technology, both IMRT and VMAT offer better protection for normal tissues.
- Proton therapy: Different from traditional radiotherapy, which uses X-rays, proton therapy uses protons as the radiation source. Protons do not release energy immediately upon entering the body; they release their energy only upon reaching the tumour, similar to a "depth charge", to attack the tumour with precision. This reduces the impact on surrounding normal tissues and organs.

Side effect

With technological advancements, side effects are now milder, fewer, and more short-lived than in the past. Potential side effects include: nausea, diarrhoea, fatigue, frequent or painful urination, redness and soreness of the skin in the treatment area, and impaired bone marrow function (if the radiotherapy involves a large area of bone marrow, it may lead to a decrease in white blood cells, platelets, and red blood cells, making the patient more susceptible to infection, bleeding, or anaemia).

The severity of side effects depends on the radiation dose and the duration of the treatment course, but most discomfort can be alleviated with medication. The side effects will gradually subside after the treatment course is completed. Should the condition persist, it is imperative to inform the doctor.

Radiotherapy does not make the patient's body radioactive. Contact with others, including children, is safe both during and after treatment.

Brachytherapy

Brachytherapy is a form of internal radiotherapy suitable for patients with rectal cancer who are not candidates for surgery. However, this treatment may not be an option if the tumour is too large or located too far from the anus.

The doctor inserts a catheter through the anus into the rectum, allowing radiation to be delivered directly to the tumour at close range. As it does not need to pass through other normal organs, a higher radiation dose can be delivered to improve efficacy, while also reducing damage to nearby healthy organs. The procedure does

not require anaesthesia and creates no incision. The doctor will simultaneously use CT and MRI scans for guidance to ensure the accuracy of the radiation delivery.

Side effect

Potential side effects include mild distension or pain during bowel movements, increased bowel movement frequency, and rectal inflammation, which will gradually subside after the treatment course is completed. Should the condition persist, it is imperative to inform the doctor. Some patients may also experience long-term effects of chronic rectal injury, which can manifest as intermittent, mild rectal bleeding.

Total neoadjuvant therapy (TNT)

Total neoadjuvant therapy (TNT) is a recent approach in the treatment of low rectal cancer. It involves administering the combination chemotherapy before the surgery, which was traditionally given after surgery. The advantages are that patients are generally in better physical condition before surgery and thus have a higher tolerance for chemotherapy. Furthermore, the chemotherapy schedule is not affected by the recovery period after surgery. Depending on the individual patient's situation, TNT may involve short-course or long-course radiotherapy (see table below for details), with or without chemotherapy, and the sequence of treatment may vary.

Previously, traditional surgery for low rectal cancer often required complete removal of the anus and the creation of a permanent stoma. With TNT, however, short-course or long-course radiotherapy is administered before surgery to shrink the tumour, thereby increasing the chance of organ preservation (i.e., the anal sphincter) and reducing the likelihood of needing a permanent stoma. The full response to TNT may not be apparent for 2 to 3 months. Some patients may achieve a pathological complete or near-complete response, meaning that the tumour disappears completely or almost completely. In this situation, patients may opt for "Non-operative Management (NOM)", which relies on "active surveillance" instead of surgery. For more details, you are encouraged to discuss with your attending physician.

	Radiotherapy dose	Treatment course	Characteristics	Applicable to
Short-course radiotherapy (SC-RT)	Lower	Shorter (approx. 5 days in 5 fractions)	• Fewer side effects • Surgical resection of the tumour can proceed immediately following treatment	Patient with low-to -moderate risk rectal cancer who are candidates for local excision^
Long-course chemoradiation (LC-CRT)	Higher (with the possibility of chemotherapy)	Longer (approx. 5 weeks, in 25-31 fractions)	• The bowel in the radiotherapy area may become swollen, and there may be a stinging sensation at the anal opening. Side effects generally alleviate about one month after treatment • If a total mesorectal excision is required, it is generally recommended that the surgery be performed after an interval of 6 to 11 weeks	Patients with Stage III rectal cancer at a higher risk of local recurrence or those with Stage IV rectal cancer#

^Low-to-moderate risk: Refer to tumours with a clinical stage of T1 to T3 (T1: tumour within the bowel wall; T2: tumour has spread to the muscle layer; T3: tumour has penetrated the fat layer outside the bowel wall but has not spread to other organs) and N0 to N1 (i.e., minimal lymph node metastasis).

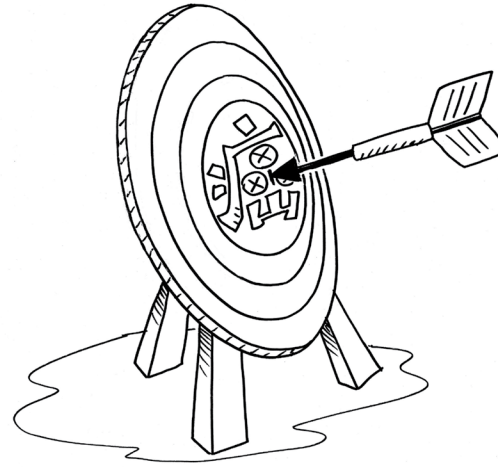
#High-risk: Refer to a low tumour (less than 5 cm from the anus); a clinical stage of T3 to T4 (T3: tumour has penetrated the fat layer outside the bowel wall but not invaded other organs; T4: tumour has spread to adjacent organs or the peritoneum); MRI findings showing the tumour is less than 2mm from the mesorectal fascia (mrCRM) and has spread to extramural vessels (mrEMVI). All these indicate a higher risk of local recurrence and metastasis.

(IV) Targeted therapy

The side effects of targeted drugs are generally milder than those of conventional chemotherapy, but they can still affect normal cells and have an impact on the body. Targeted drugs cannot cure metastatic colorectal cancer, but when used in combination with chemotherapy or alone, they may enhance treatment efficacy or prolong patient survival.

Common targeted drugs for colorectal cancer include: 1. Cetuximab, 2. Panitumumab, 3. Bevacizumab, 4. Aflibercept, 5. Regorafenib.

The mechanism of action for 1 and 2 is to block cancer cells from receiving growth-directing signals, leading to their elimination. This is known medically as anti-epidermal growth factor receptor (Anti-EGFR) therapy. Before using these drugs, the cancer cells must be tested for mutations in two genes called KRAS and NRAS to determine if the drug is appropriate.



Drugs 3, 4, and 5 are anti-angiogenesis agents (Anti-VEGF). They prevent cancer cells from forming new blood vessels, causing them to die from a lack of nutrients.

Side effects

Anti-Epidermal Growth Factor Receptor (Anti-EGFR) therapy

When the targeted drug is infused, an allergic reaction may occur. Preventative medication is generally prescribed to the patient prior to infusion, and the patient is closely monitored during the infusion. Targeted therapy may also cause side effects, including fever, muscle pain, chills, dry skin, itching, rash, and diarrhoea. In severe cases, breathing difficulties may occur.

Anti-Vascular Endothelial Growth Factor (Anti-VEGF) therapy

Common side effects include high blood pressure and proteinuria. More serious, though uncommon, side effects include blood clots or bleeding, and intestinal fistula or perforation.

How to perform the treatment?

Targeted drugs are usually administered by intravenous injection into a vein in the arm or via a catheter implanted in the chest. The chest catheter can be connected to a portable pump that delivers a measured dose of the drug into the bloodstream at regular intervals, allowing for administration at home. In addition to injections, some targeted drugs are available in oral form.

Depending on the drug used, some treatment sessions allow for same-day discharge, while others may require a hospital stay of several days. Each course of treatment is typically spaced 2 to 3 weeks apart to allow the body to recover from side effects. The number of treatment course required depends on the disease status and patient's response to the medication.

(V) Immunotherapy

The immune system is normally able to recognise and eliminate abnormal cells, but cancer cells are able to evade immune cell attack, causing the immune system to "fail". Immunotherapy works by activating the body's own immune ability to recognise cancer cells and thereby eliminating them. The most commonly used immunotherapy is the immune checkpoint inhibitor.

Immune checkpoint inhibitor

T cells are a type of lymphocyte and play an important role in the immune response. Programmed cell death protein 1 (PD-1) is an immune checkpoint on T cells. Cancer cells may express programmed cell death protein ligand-1 (PD-L1) on their surface. When PD-1 binds with PD-L1, it hinders T cells from recognising cancer cells, thus effectively causing the immune system to "fail", rendering it unable to attack cancer cells and promoting cancer cell growth.

Commonly used clinical immune checkpoint inhibitors, such as pembrolizumab, durvalumab, and nivolumab, target the PD-1/PD-L1 pathway, allowing the T-cells of the immune system to resume their normal attack function and thereby destroying the cancer cells.

Some colorectal cancer patients are suitable candidates for immunotherapy as a first-line treatment, as PD-1 immunotherapy has a more significant response in tumours with high microsatellite instability (MSI). MSI-H (high MSI) patients account for approximately 5-10% of all colorectal cancer cases.

How to choose a treatment method?

Each therapy has its pros and cons. Coupled with the fact that each person's condition and constitution differs, deciding on which therapy to use can sometimes be difficult. If a doctor recommends only one therapy, you should ask for clarification before signing the consent form: "Is this the only option? Why are other therapies not applicable?" Conversely, if several therapies are available, their respective merits and demerits must be carefully weighed to see which is relatively the most suitable.

Before deciding on a therapy, it is crucial to first understand the benefits and potential side effects of different treatments, and then to weigh the benefits of undergoing treatment against the potential impact of the side effects. It is your body, and only you can make the final decision for yourself.

Prior to deciding on a therapy with the doctor, discuss matters with friends and family; prepare a list of questions, and it may be helpful to have a friend or relative accompany you to the consultation to assist with asking questions and taking notes.

Seeking an additional professional opinion

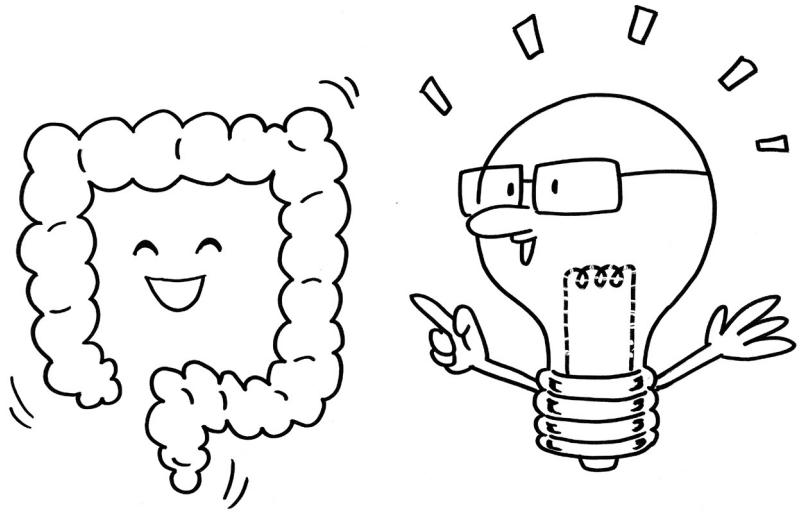
The diagnosis and treatment of cancer is complex. Before settling on a therapy, some patients wish to seek an additional professional opinion, known as a "Second Opinion", to view the problem from another perspective. Previously, finding another doctor relied mostly on recommendations from trusted doctors, friends, family, or other patients. Nowadays, some people may also search online. Relevant websites include those of medical specialists and professional bodies, hospitals, university medical schools/research institutes, and patient forums. However, determining which website's information is most applicable requires some effort.

After choosing another doctor, you can ask your attending doctor to provide a copy of your medical records for the other doctor to review. If both you and the second doctor participate in the electronic health record sharing system, you can also authorise the doctor to access your electronic medical records using your personal password. For details, please call the sharing system hotline at **3467 6300**. At the same time, ask the second doctor to provide their assessment as soon as possible. If the treatment is delayed, even the best second opinion will become in vain.

One may still seek a second opinion after the attending physician has commenced treatment. After obtaining a second opinion, it is still possible to continue treatment with the first doctor.

Post-treatment follow up

After completing the course of treatment, regular follow-up appointments and examinations are required, including X-rays, colonoscopies, and blood tests to monitor Carcinoembryonic Antigen (CEA) levels. Follow-up after treatment may continue for several years, but the frequency will decrease as the condition stabilises. During this period, any unusual changes or new symptoms should be reported to the doctor. You can also contact support organisations for patients with colorectal cancer to build a mutual support network with peers.



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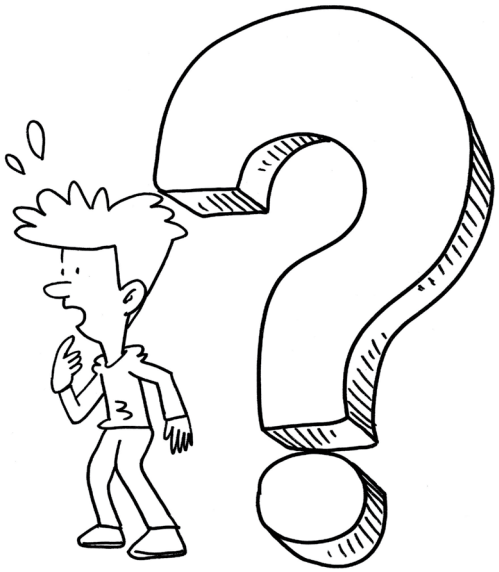
What to ask your doctors?

Before seeing the doctor to hear the diagnosis report and treatment recommendations, make a list all of your questions. You can ask a family member or friend to accompany you, take notes, remind you of the questions you want to ask, or even ask them for you. If you don't understand, be sure to ask the doctor to explain. Some patients may wish to record or video the consultation content. However, this must be done with the doctor's prior consent, and the doctor also has the right to refuse such requests. In government hospitals, prior approval must also be obtained from the Hospital Authority. Here are some common questions cancer patients have:

1. Is my tumour malignant? By what examination was this confirmed? What type is it?
2. How large is the tumour? Has it spread? Which areas are affected? What is the stage?
3. What is the best course of treatment? What are the chances of success? What are the risks involved?



4. I have heard that cancer treatment includes surgery, radiotherapy, and chemotherapy. Will I only need to undergo one type of therapy? Or, after completing one therapy, will I need to undergo further treatment?
5. How long is the entire treatment course? Is hospitalization required? What will the impact be on my daily life? Will I need to stop working?
6. Will I require a stoma? Will it affect my sex life and fertility?
7. Are the side effects severe? How can they be alleviated? Will there be any long-term after-effects?
8. How much does the entire treatment course cost? Is my insurance coverage sufficient?
9. After the course of treatment is completed, how will we determine if the treatment has been successful?
10. How often are follow-up appointments required after the treatment is completed? What regular tests/examinations are needed?
11. Why is the therapy you recommend the best option? Are there any alternative options? How much difference is there in their effectiveness?
12. If I don't have treatment now, will it be too late to consider it later?
13. After completing treatment, will my physical condition deteriorate? Will I have to make significant lifestyle adjustments and be unable to care for my children?
14. Is this type of cancer likely to recur?
15. Is the type of cancer I have hereditary? How high is the risk of my children developing the same type of cancer?
16. During treatment, is it helpful to also consult with a Chinese medicine practitioner? Will there be any conflicts?

Your feelings

Most people feel overwhelmed when they are told they have cancer. During diagnosis and treatment, your emotions may fluctuate due to physical reactions. You may experience some of the following emotions, although the order may differ. This is normal and does not mean that you are not strong enough to cope with cancer.

Navigating emotional changes is part of the patient's journey in coping with the disease. Everyone's reactions can vary, and there is no right or wrong way to feel. Your family and friends may also have similar feelings and need emotional support and guidance.

Shock and disbelief

"I can't believe it!" "It can't be true!"

Upon first learning of a cancer diagnosis, the immediate reaction may be shock, numbness, and disbelief. After the initial shock, one may refuse to accept the reality: not listening to others, only remembering one's own suffering, or repeatedly asking the doctor the same questions without truly absorbing the information.

In fact, many cancers can be treated, and even if they cannot be cured, they can usually be controlled. Therefore, patients should allow themselves time to come to terms with their emotions before discussing it with those around them. This may help in accepting the diagnosis.

Anger

"Why me?" "Why did this happen to me?"

Some patients use anger to hide their fear and sadness. They may direct their anger toward family members, colleagues, their environment, or even question their faith: "Why are you being so harsh on me?"

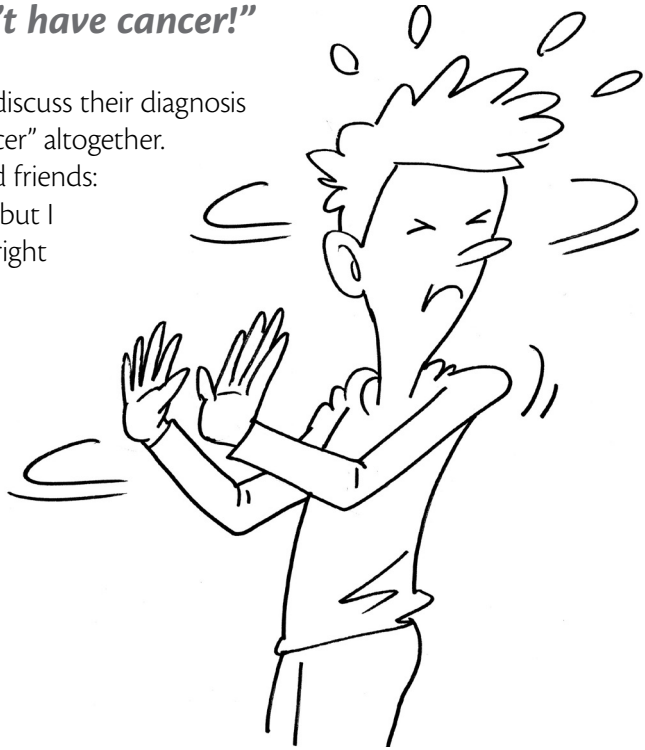
Any illness is difficult to bear, but cancer can feel especially overwhelming. Anger is a normal emotion, and you should not feel guilty about it. Sometimes, your family and friends may not fully understand that your anger is linked to concerns about your condition.

After your emotions have settled, try to express your feelings to them in an appropriate setting. If it's hard to do so face-to-face, consider using email, text messages, or even sharing this booklet with them. If you'd like to speak with a social worker or counsellor, our **free services hotline** is available: **3656 0800**.

Denial

"I'm fine!" "I didn't have cancer!"

Some patients may refuse to discuss their diagnosis and may avoid the word "cancer" altogether. It's okay to tell your family and friends: "Thank you for your concern, but I don't want to talk about this right now. I hope we can revisit it later!"



However, sometimes your family and friends may avoid the topic out of fear of upsetting you. If this makes you feel uncomfortable or isolated, don't hesitate to express that you understand your condition, want to face it positively, and need their support.

Fear

"Will I die?" "Will it hurt very much?"

Upon learning of a cancer diagnosis, "death" is often the first fear that comes to mind, followed by concerns about pain.

Recent advances in cancer treatment have led to higher success rates and lower mortality rates for most cancers. If detected early, many cancers can be cured, and for some patients, cancer has become a manageable chronic condition. If you experience pain, there are medications and other methods available to manage it, so there is no need to be overly anxious.

Another common worry is whether the benefits of treatment will outweigh its side effects. This concern is understandable, but each case is unique. You can prepare a list of all your questions and ask your doctor to explain them in simple terms until you fully understand and feel comfortable proceeding with treatment.

Some patients find that doctors' answers about expected treatment outcomes can seem vague. This is because doctors can only provide information on treatment effects and reactions based on clinical experience and data. However, each patient's

situation is different, and the true effects of the treatment can only be confirmed through follow-up examinations. However, with advancements in medical science, doctors are now better equipped to understand disease progression and offer a wider range of medications to provide appropriate follow-up and treatment options for patients.

The fear of recurrence after treatment is a common concern. The uncertainty of the future can indeed be unsettling, but reality is often less frightening than imagined. Talking to family and friends can help reduce unnecessary anxiety caused by stress. There are also many reliable resources with authoritative medical information and shared patient experiences that can help ease your concerns and allow you to approach treatment with peace of mind. However, be cautious about the sources of information you trust. Unreliable sources can lead to unnecessary worries and cause detours in your cancer journey. The Cancer Fund has produced over 40 booklets (14 in English) on topics like "**Understanding Cancer**" and "**How to Cope**", which are available at our Support Centres or can be accessed electronically on the Cancer Fund's website.

Cancer booklet

Complaint and guilt

"If I hadn't... I wouldn't have gotten cancer."

When diagnosed with cancer, some people may blame themselves or others, searching for a cause of their illness. While understanding the cause can provide psychological relief, even doctors may not always know the exact reason for a specific case of cancer. Therefore, patients should not blame themselves or dwell on unanswerable questions.

Resentment

"You haven't tried radiotherapy, so you don't understand my pain!"

During the course of an illness, feelings of resentment and frustration are common. Your family members might feel burdened by the disruption to their lives and may express frustration. It is helpful to find a moment to have open and honest conversations about your feelings. Working together to understand each other and find solutions will ease the strain. Holding on to resentment can increase stress for everyone involved.

Withdrawal and self-isolation

"Leave me alone!"

While you may desire some alone time to process your emotions during your illness, your family and friends may also want to support you during this difficult time. If you need space, try to communicate this to them. Let them know that you need quiet time to think, but that you will reach out for their support once you feel ready. This will help them understand your needs and give them the reassurance that you still value their presence.

Cancer can lead to depression and a desire to withdraw from others, which is understandable. However, if feelings of sadness persist for an extended period and start affecting your daily life, you can contact our social workers or clinical psychologists, or ask your doctor for a referral to a psychiatrist for counselling and support.

Learning to "get along" with cancer

After being diagnosed, it may take time to adjust to the changes in your life and the side effects of treatment.

You may need frequent hospital visits and feel fatigued afterward. Some patients may need extended rest at home to recover after completing treatment. During this period, focus on resting and avoid overexerting yourself, whether in daily activities or work.

Many of today's treatments have fewer side effects than in the past, allowing patients to maintain a relatively normal life during treatment.

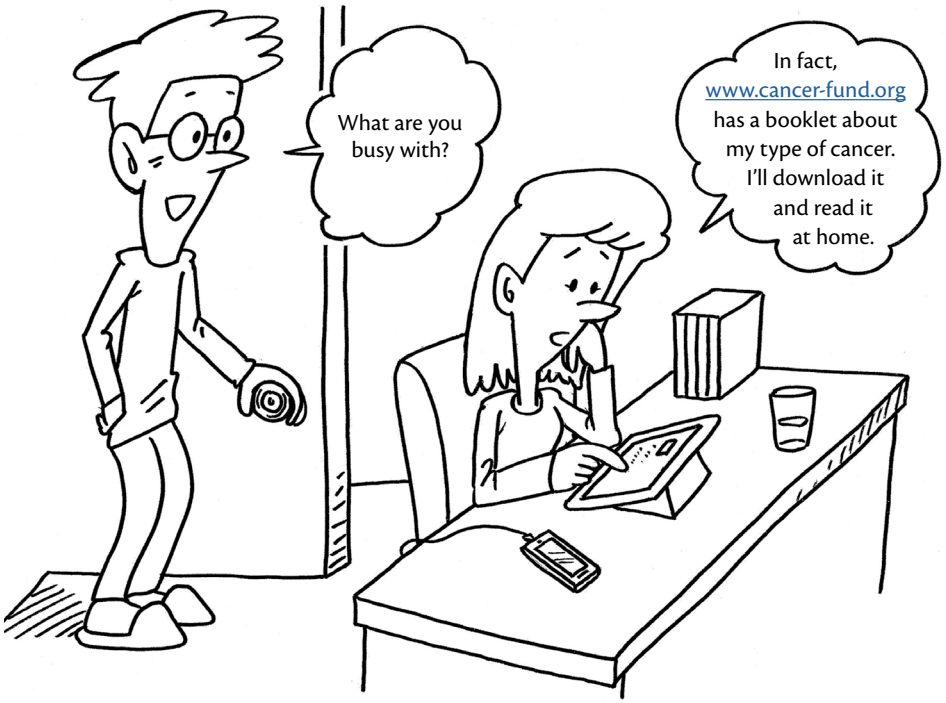
Even if cancer can be overwhelming, try not to feel defeated. Don't hesitate to share your experience with your friends and family. They will likely want to support you through this journey.

What can you do?

Upon learning of a cancer diagnosis, beyond the initial shock, some people may feel that they can only rely on doctors and wait passively. However, with the readily available information and the increasing number of social services organisations today, there are actually many things you and your family can do while waiting for diagnosis and treatment. Seeking information independently can help you understand your diagnosis better, giving you more confidence when making decisions about your treatment.

Understanding your cancer and its treatment

The more you learn about your cancer and treatment options, the easier it will be to make choices, cope with the treatment process, and adjust to life after treatment. However, sometimes information sources may not be reliable, and each patient's experience is unique. It is best to consult your doctor to ensure that the information you receive is accurate.



Patient recovery after treatment

After treatment, some patients may find it difficult to handle tasks that they previously took for granted, such as household chores. As your body gradually recovers, you can try setting small, achievable goals to slowly rebuild your confidence.

To start, focus on optimizing your diet and sleep patterns, both of which play a crucial role in supporting your recovery. You can create a healthy meal plan on your own or with the help of your family, and consult a nutritionist if needed. Relaxation is also important. There are many online resources available to help you master this skill, though it requires practice. You can access online resources at home or even attend classes, aiming for consistency and making it a part of your daily routine.

Additionally, you can incorporate regular exercise into your routine to strengthen your body. The type and frequency of exercise should be based on your physical condition, and you can set personalized goals and progress step-by-step.

Even if you find it challenging to adhere to a strict diet or exercise routine, you can explore new hobbies to support your well-being, such as walking, hiking, traveling, dancing, playing music and gardening, etc.

Financial burden

In addition to affecting your physical health, and mental well-being, cancer can also bring significant medical expenses. Apart from seeking treatment at public hospitals, you can apply for the government's "Comprehensive Social Security Assistance (CSSA) Scheme", various drug subsidy programs provided by the government and different organisations or the relief fund offered by the Cancer Fund when facing financial difficulties.

For more details, you contact our **service hotline** at **3656 0800** or speak to one of our professional team at our Cancer Support Centres.

Who can help?

Remember that many people are willing to help you and your family. Sometimes, it might be easier to talk to someone who is not directly connected to your condition. You may find it helpful to talk to a counsellor who is specially trained to offer support and advice. Our team are always willing to discuss any concerns that you might have and can arrange for one-on-one counselling or connect you with a relevant peer support group. For more information, please call the Cancer Fund's **free services hotline** at **3656 0800**.

Cancer Fund's peer support

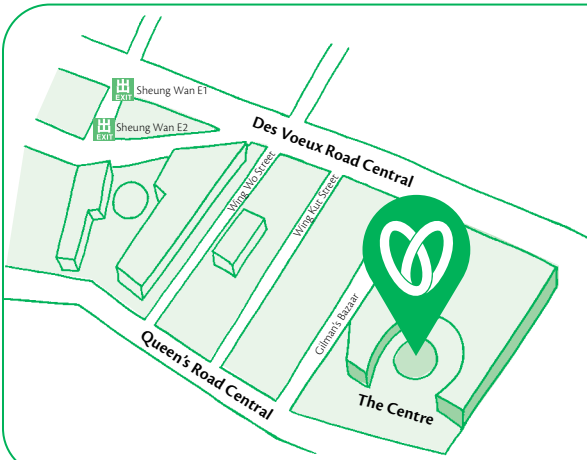
We have four Cancer Fund Support Centres located in Central, North Point, Wong Tai Sin and Kwai Chung. We are here to provide free information and counselling services for cancer patients and their families.

We have a network of 22 peer support groups under our umbrella, "Friends of CancerFund", with a strong membership of over 16,000 people that includes cancer patients and survivors. This one-of-a-kind volunteer-based network is cancer specific covering all types of cancer such as throat, prostate, colorectal, nasopharyngeal, gynaecological, breast and many more. We manage this large network through our Support Centres, providing mutual support services and organising various activities in the community.

FREE Services

3656 0800

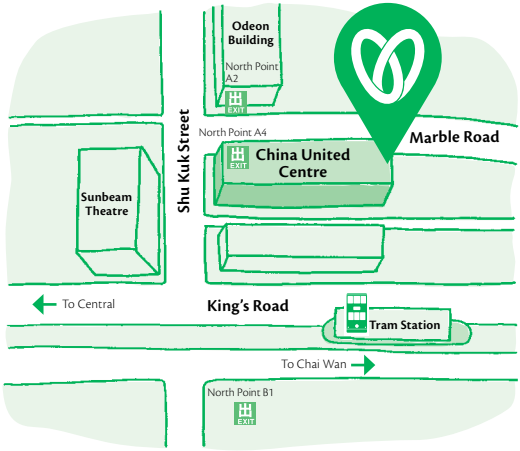
Location maps of Hong Kong Cancer Fund Support Centres



Hong Kong Cancer Fund Women Support Centre

Unit 5, Ground Floor, The Centre, 99 Queen's Road Central, Hong Kong (MTR Sheung Wan Station Exit E1/E2)

Email: canfund-hki@hkcf.org



Hong Kong Cancer Fund Support Centre (North Point)

Room 2201-03, 22/F, China United Centre, 28 Marble Road, North Point, Hong Kong (MTR North Point Station Exit A4)

Email: canfund-hki@hkcf.org

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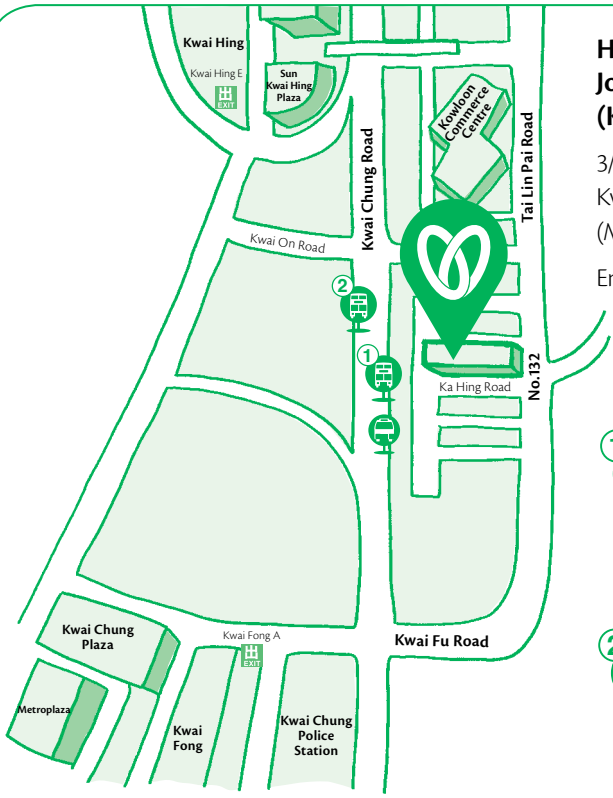

Hong Kong Cancer Fund Jockey Club Support Centre (Kwai Chung)

3/F, TLP132, 132-134 Tai Lin Pai Road,
Kwai Chung, New Territories
(MTR Kwai Fong Station Exit A)

Email: canfund-kcc@hkcf.org

Green Minibus Station
(Kwai Chung Road)
94, 302, 313

Kwai Fong Estate Bus Station
(Kwai Chung Road, Opposite to Kwai Fong Estate / Outside Yee Lim Factory Building)
237A, 265M, 269A, 269M, 290, 290A, 33A, 36A, 38A, 40, 46P, 46X, 57M, 59A, 61M, 935

Kwai Fong Estate Bus Station
(Kwai Chung Road, near Kwai Yik Road)
240X, 260C, 265M, 269M, 46P, 46X, 47X, 57M, 58M, 58P, 59A, 67M, 269P

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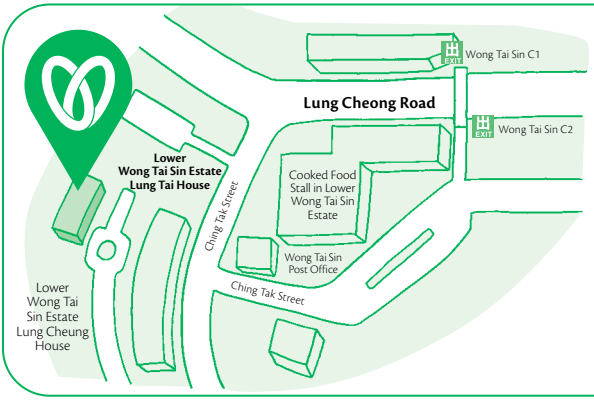

Hong Kong Cancer Fund Support Centre (Wong Tai Sin)

Unit 2-8, Wing C, G/F,
Lung Cheung House,
Lower Wong Tai Sin (II) Estate,
Kowloon
(MTR Wong Tai Sin Station Exit C2)

Email: canfund-wts@hkcf.org

"Hong Kong Cancer Fund's holistic approach to cancer care ensures people with cancer and their families have free access to life-changing information and professional support as they navigate through their diagnosis, treatment and into survivorship."

So no one should face cancer alone.

This booklet is published by Hong Kong Cancer Fund in 2025

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Hong Kong Cancer Fund

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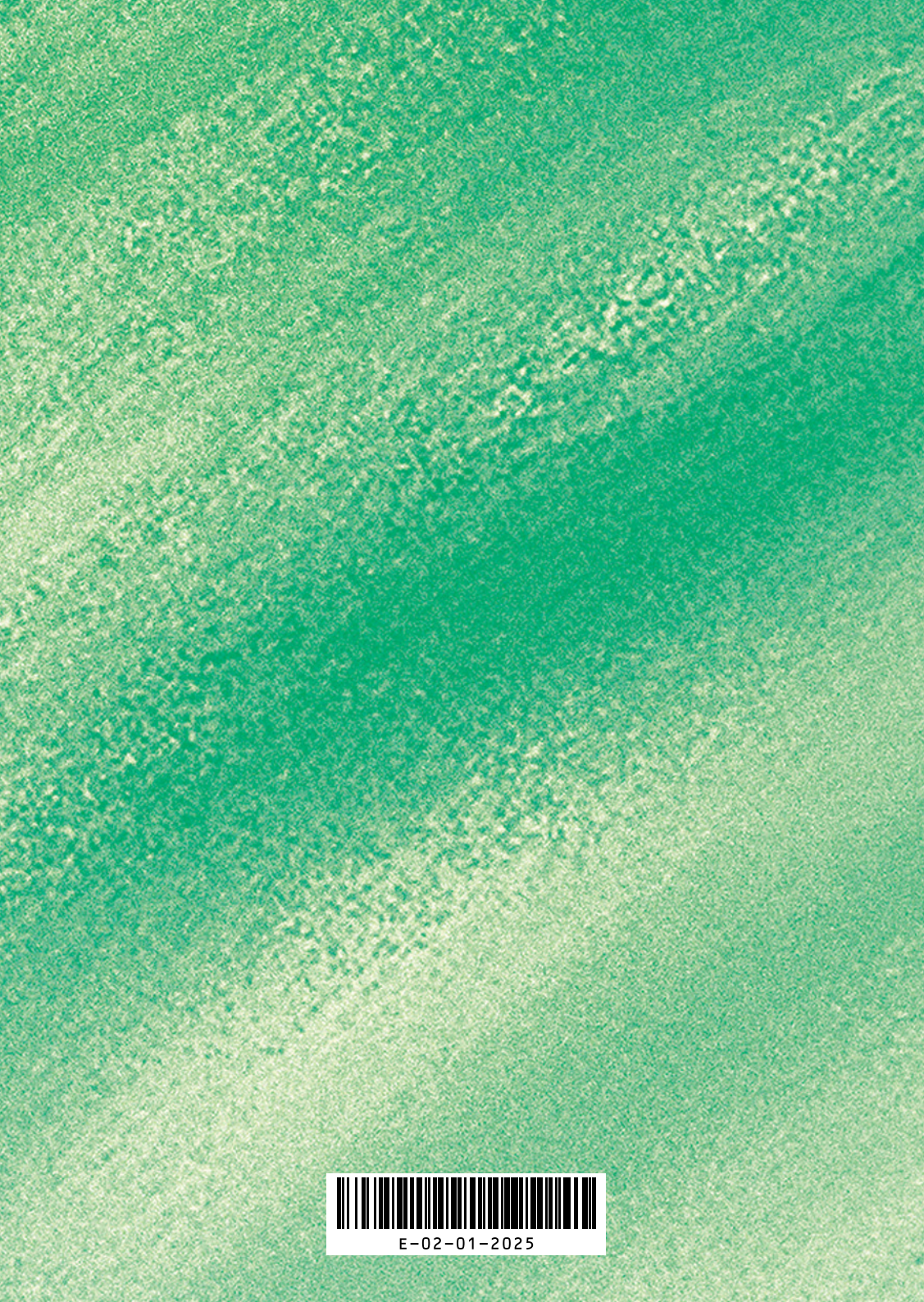
Donation Hotline: 3667 6333
Website: www.cancer-fund.org

Cancer booklets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