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# Gastrointestinal Disorders: Nursing Perspectives on Diagnosis, Treatment, and Care- An Updated Review of Colorectal Cancer

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**Abstract:**

**Background**: Colorectal cancer (CRC) is the third most commonly diagnosed cancer globally, and the third leading cause of cancer-related mortality. Its prevalence is rising among individuals under 50 years of age, despite declines in older populations. Nurses play a critical role in recognizing early symptoms and promoting screening for early diagnosis and intervention.

**Aim**: This review aims to explore the nursing perspectives on diagnosing, treating, and caring for patients with colorectal cancer, with a particular focus on the updated screening guidelines, risk factors, and diagnostic methods.

**Methods**: A comprehensive literature review was conducted, focusing on CRC etiology, patient presentation, risk factors, and the impact of early detection and screening. Sources were drawn from recent studies, screening guidelines, diagnostic tests, and pharmacological treatments relevant to CRC.

**Results**: CRC is largely preventable through early detection, with screening starting at age 45. Key risk factors include family history, diet, obesity, and inflammatory bowel diseases. Diagnosis is confirmed through colonoscopy, biopsy, and imaging techniques. Treatment includes chemotherapy, radiation, and surgical interventions, with the survival rate varying by stage at diagnosis.

**Conclusion**: The rise in early-onset CRC necessitates improved awareness and earlier screening, particularly among individuals with a family history or lifestyle-related risk factors. Nurses play a vital role

in educating patients and facilitating early interventions, which can lead to better outcomes. The implementation of updated screening guidelines and personalized treatment plans will be crucial in addressing this growing health issue.

**Key Words**: Colorectal cancer, early-onset, nursing perspectives, screening, diagnostic methods, chemotherapy, treatment, risk factors

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**Introduction:**

Colorectal cancer (CRC) represents the most prevalent malignancy within the gastrointestinal (GI) tract, ranking as the third most commonly diagnosed cancer and the third leading cause of cancer-related mortality globally [1]. In the United States, it is the second leading cause of cancer death, with approximately 150,000 new diagnoses annually [1]. Although mortality rates have steadily declined among individuals aged 50 and older, there has been an alarming rise in early-onset CRC (EOCRC) among those under 50 years of age [1]. Projections suggest that by 2030, 1 in 10 cases of colon cancer and 1 in 4 cases of rectal cancer will occur in patients younger than 50 [2]. Nurses play a pivotal role in improving patient outcomes by recognizing early signs and symptoms and promoting early screening.

**Etiology:**

CRC is largely a preventable disease, with early detection and appropriate treatment significantly improving cure rates [3]. The majority of CRC cases originate as adenocarcinomas, tumors that develop in the epithelial layer of the colon (see *Adenocarcinoma of the Colon*). Initially, adenocarcinomas manifest as benign polyps, but as these polyps grow, the likelihood of malignancy escalates. Metastasis typically occurs via the blood or lymphatic system, with the liver being the most common site of spread, followed by the lungs, brain, and bones. Early detection through screening is critical in preventing the progression of premalignant lesions, such as adenomas or polyps, into invasive adenocarcinomas. Genetic factors, environmental influences such as diet, and inflammatory conditions of the GI tract are central to the development of CRC. Genetic mutations, particularly those affecting the adenomatous polyposis coli gene, are often responsible for the malignant transformation. Familial adenomatous polyposis, resulting from mutations in this gene, confers an almost inevitable risk of CRC by age 40. Other established risk factors include:

- **Nutritional factors**: Diets high in red meat and animal fats, coupled with low intake of fiber, fruits, and vegetables, are linked to an increased risk of CRC [1].
- **Obesity**.
- **Modifiable risk factors**: Smoking, alcohol consumption, and physical inactivity.
- **Dietary influences**: Excessive consumption of beverages containing high-fructose corn syrup, which may foster tumor growth.
- **Inflammatory bowel diseases**: The risk of CRC increases with the extent and duration of these diseases [5].

The five-year survival rate for CRC patients in the U.S. is approximately 65%. This survival rate inversely correlates with the cancer's stage at diagnosis, ranging from 14.3% for metastatic CRC to 90.2% for localized cases [5].

**Patient History and Physical**

The increasing incidence of CRC in individuals under 50 years is concerning, particularly as the rate among older adults declines [1, 2]. Prior to diagnosing EOCRC, a comprehensive patient history and physical examination are essential, with particular emphasis on the signs and symptoms presented. Four key symptoms have been strongly associated with EOCRC: rectal bleeding, abdominal pain, diarrhea, and iron-deficiency anemia [7]. Other common symptoms include nausea, vomiting, diarrhea, constipation, and

weight loss [8]. Advanced CRC may present with signs such as hepatomegaly, ascites, or a palpable abdominal mass [9]. Patients may also exhibit nonspecific symptoms such as dizziness, weakness, or fatigue. Women should be questioned regarding their menstrual history and any abnormal bleeding patterns.

**Patient Presentation**

Patients with CRC may present with a broad spectrum of symptoms or may exhibit no symptoms at all. Early-stage CRC is often asymptomatic and is frequently detected during routine screening colonoscopies before any clinical symptoms arise. In more advanced cases, patients may report symptoms such as rectal bleeding, unexplained abdominal pain, iron-deficiency anemia, changes in bowel habits, intestinal obstruction, or even perforation. Suspicious symptoms include hematochezia (passage of fresh blood in or with stools) and/or melena (dark, tarry stools). For patients with advanced metastatic CRC, the median survival with treatment ranges from 24 to 30 months, but without treatment, it is typically reduced to 6 to 9 months. Numerous factors can influence survival outcomes [10].

In patients under the age of 50, abdominal pain is the most commonly reported symptom of CRC [1, 2]. Younger individuals tend to present with fewer classic red-flag symptoms and may present primary care providers with vague or nonspecific complaints. The family history of CRC is the most significant risk factor for EOCRC. Genetic counseling should be considered for individuals with a family history of the disease. The risk of CRC is two to four times higher in individuals with a first-degree relative diagnosed with the disease, and this risk increases with earlier age at diagnosis [2]. A thorough nursing interview can help identify high-risk individuals, enabling the initiation of early screening and timely interventions. Some studies attribute the rise in CRC among younger patients to a cohort effect, where age-specific incidence rates are influenced by changes in exposures such as behavioral, cultural, lifestyle, or environmental factors [2]. A diet high in protein, fat, and low in fiber, common among young adults, may contribute to this increase, likely due to the resultant gut inflammation. However, a definitive cause for the rise in EOCRC has not yet been conclusively identified.

**Risk Factors**

Family history plays a pivotal role in assessing the risk of colorectal cancer (CRC). It is essential for healthcare providers to inquire about any familial history of genetic syndromes associated with colorectal malignancies. Such syndromes include familial adenomatous polyposis, Gardner syndrome, Turcot syndrome, MYH-associated polyposis, and Lynch syndrome, all of which predispose individuals to early-onset colorectal cancer (EOCRC) [11]. For patients with a relevant family history, genetic testing may be recommended, provided it is deemed appropriate. Additionally, individuals with inflammatory bowel diseases, such as ulcerative colitis or Crohn's disease, face an elevated risk of developing CRC. The risk is influenced by the age of onset and the duration of the illness, although recent advances in medical treatment and surveillance practices have contributed to a decline in the overall risk among these patients [12]. One of the most significant risk factors for CRC is a first-degree family member's history of the disease. A study conducted in 2021 highlighted that nearly 45% of familial EOCRC cases could have been potentially prevented through timely screening, such as performing a colonoscopy at least five years prior to the age at which the first-degree relative was diagnosed [14, 15].

**Screening Guidelines**

Recent updates to CRC screening guidelines now recommend initiation at age 45, continuing through age 75, with personalized adjustments based on individual patient needs. No further screening is advised after the age of 85. The approved screening modalities include fecal occult blood testing, fecal immunochemical testing (FIT), multitargeted stool DNA tests, flexible sigmoidoscopy, and colonoscopy, with colonoscopy maintaining its status as the gold standard. The frequency of screenings depends on the chosen method and prior findings [14]. The most common signs and symptoms associated with CRC at different stages are outlined as follows:

- **Early-stage symptoms** may include diarrhea, constipation, and weight loss, along with changes in bowel habits and rectal bleeding.
- **Early-onset CRC (EOCRC)** often presents with abdominal pain and iron-deficiency anemia, alongside the gastrointestinal symptoms observed in early-stage CRC.
- **Advanced CRC** may manifest with more severe signs such as hepatomegaly, ascites, and the presence of an abdominal mass, indicating metastatic progression.

**Available Screening Tests**

A variety of screening tests are available for CRC detection, each with distinct intervals for testing:

- **Fecal tests** include the occult blood test, FIT, and multitargeted stool DNA test. The recommended frequency for these tests is annually for occult blood and FIT, and every 1-3 years for multitargeted stool DNA.
- **Endoscopic tests** such as flexible sigmoidoscopy are suggested every 5 years, or every 10 years when coupled with annual FIT testing. Colonoscopy should be performed every 10 years.
- **Radiological exams**, like colonography, are typically performed every 5 years, although the timing should be discussed with the healthcare provider based on the patient's specific risk factors.

**Diagnostic Findings**

In patients presenting with symptoms indicative of CRC, laboratory tests are vital to support the diagnosis. A complete blood count may reveal iron-deficiency anemia, with decreased hematocrit and hemoglobin levels, and a low mean corpuscular volume. To ascertain the cause of anemia, further tests for serum iron and ferritin levels should be performed. If iron-deficiency anemia is confirmed, additional investigations, including evaluation of menstrual patterns and stool tests (for occult blood, FIT, or DNA markers), are warranted. Positive results necessitate further procedures such as esophagogastroduodenoscopy and colonoscopy. The complete metabolic panel provides crucial information on the patient's kidney function, electrolyte balance, and nutritional status. Elevated liver function tests may suggest liver metastasis, necessitating further examination. Carcinoembryonic antigen (CEA) levels are significant for both diagnosing and monitoring CRC, as they typically increase in the presence of the disease and may decrease following surgical resection. However, it is essential to recognize that CEA can also be elevated due to other conditions, such as pancreatic or hepatobiliary diseases [15]. Radiological imaging, including chest X-rays and contrast-enhanced CT scans of the chest, abdomen, pelvis, and liver, is instrumental in assessing disease progression and determining the appropriate surgical approach. For patients with dyed allergies or when evaluating ambiguous lesions, MRI and PET scans may be utilized.

**TNM Classification System**

The TNM classification system provides a standardized method for describing the extent and spread of colorectal cancer (CRC). The system is divided into three main categories: primary tumor (T), regional lymph nodes (N), and distant metastases (M).

- **Primary Tumor (T)**: The size and extent of the primary tumor are classified as follows: T0 indicates no evidence of a primary tumor; Tis refers to carcinoma in situ, where cancer cells are confined to the mucosal lining without invasion into surrounding tissues; T1-4 represents increasing degrees of tumor size and involvement in surrounding tissues; and Tx indicates that the tumor cannot be measured or located.
- **Regional Lymph Nodes (N)**: The degree of regional lymph node involvement is classified from N0, which indicates no evidence of disease in the lymph nodes, to N1-4, which represents progressively increasing degrees of nodal involvement. Nx indicates that the regional lymph nodes cannot be assessed clinically.

- **Distant Metastases (M)**: The presence or absence of distant metastases is categorized as M0 for no evidence of distant spread, M1-4 for ascending levels of metastatic involvement, including distant lymph nodes, and Mx for when the presence of metastases cannot be determined.

**Diagnosis**

Colorectal tumors often progress without noticeable symptoms, making early detection challenging. The diagnosis of CRC typically involves procedures such as colonoscopy, tissue biopsy, and lymph node biopsy. During a colonoscopy, a flexible tube equipped with a video camera is inserted into the colon to visualize the entire colon and rectum. Tissue samples may be collected, and polyps can be exercising during the procedure for further examination in a laboratory biopsy. Although blood tests are not definitive for CRC, they may help rule out other conditions and can provide insights into associated symptoms like bleeding or infection [16]. In the context of early-onset colorectal cancer (EOCRC), differential diagnoses to consider include diverticulitis, peptic ulcer disease, Crohn's disease, ulcerative colitis, hemorrhoids, adenomatous polyps, ischemic colitis, infectious colitis, irritable bowel syndrome, and iron-deficiency anemia of alternative causes [8]. Less commonly, diagnoses such as arteriovenous malformations, carcinoid tumors, and gastrointestinal lymphoma should also be considered [5].

**Staging**

Colorectal cancer staging follows the tumor-node-metastasis (TNM) system established by the American Joint Committee on Cancer. This system incorporates biopsies from the primary tumor and other body sites to stage the cancer. The staging process evaluates three key components: the tumor size and its local extension (T), the involvement of regional lymph nodes (N), and the presence of distant metastases (M). The stages of CRC range from Stage 0, where cancer cells are confined to the polyp and have not invaded surrounding tissue (in situ), to Stage 4B, where metastasis has occurred to distant organs or lymph nodes. The staging process is crucial for determining the appropriate surgical approach and subsequent treatment plan [4].

**Pharmacologic Therapy**

Chemotherapy is a treatment modality that utilizes either systemic or localized cytotoxic agents to damage cellular DNA or target rapidly proliferating cells. Although various classes of cytotoxic drugs employ distinct mechanisms of action, a common outcome is bone marrow suppression. Many of these agents are also classified as vesicants, which may cause significant tissue damage, including blistering and necrosis, if extravasation occurs [17]. The adverse effects of chemotherapy are widespread and can include bone marrow suppression leading to leukopenia (with white blood cell counts falling below 1,000 $mm^3$), anemia (hemoglobin levels below 10 g/dL), thrombocytopenia, alopecia (hair loss typically occurring 2 weeks post-treatment), anorexia, gastrointestinal disturbances such as nausea and vomiting, urinary stone formation, mucositis, and cognitive impairments. Effective nursing assessments and interventions are critical in mitigating these adverse reactions. Common nursing interventions involve limiting patient exposure to visitors to reduce the risk of infection, administering analgesics for pain management, monitoring for signs of bleeding, providing comfort measures such as hats and scarves to address alopecia, and offering small, bland meals along with cool drinks to ease gastrointestinal symptoms. Regular mouth care is emphasized, involving gentle oral hygiene to prevent mucosal trauma, using soft-bristled toothbrushes or swabs for cleaning, and frequent rinsing of the oral cavity. Additionally, nurses should provide emotional and cognitive support for patients experiencing difficulties with concentration and memory [17].

**Pharmacological Considerations for Specific Chemotherapeutic Agents**

Nursing assessment and education are essential for patients receiving chemotherapy. Specific drugs require particular attention:

- **Pyrimidine analogs** such as capecitabine and fluorouracil necessitate careful monitoring for adverse effects, including hematuria or melena, signs of infection, jaundice, edema, persistent diarrhea, and

cholinergic symptoms like increased salivation, diaphoresis, and abdominal cramps. Patients should be advised to avoid alcohol and NSAIDs due to their potential to exacerbate bleeding risks.

- **Topoisomerase inhibitors** such as irinotecan require regular monitoring of laboratory values for organ function, bleeding risks, and potential pulmonary toxicity. Patients should be educated to report symptoms of cholinergic reactions and avoid alcohol and NSAIDs to minimize bleeding risk.
- **Folic acid analogs** like leucovorin necessitate observation for signs of allergic reactions such as itching, rash, or facial flushing. The patient should be instructed to immediately report symptoms of severe allergic reactions, including difficulty breathing, wheezing, hives, or swelling of the face or throat.
- **Alkylating agents** such as oxaliplatin require monitoring of renal and hepatic function, as well as signs of pulmonary fibrosis or peripheral neuropathy. Patients should be informed to avoid cold exposure, including ice packs, and immediately notify the provider if symptoms of reversible leukoencephalopathy syndrome (e.g., headache, altered mental state, or seizure), infections, respiratory distress, painful urination, or allergic reactions occur.

**Immunotherapy**

Immunotherapy, initially studied by Dr. William Coley, has evolved from his observation that some cancer patients entered remission following bacterial infections. This insight led to the concept of harnessing the body's immune system to fight cancer. The National Institutes of Health defines immunotherapy as a treatment designed to stimulate or suppress the immune system to combat cancer, infections, and other diseases [19]. Essentially, immunotherapy allows for the modulation of the immune response, either by activating or suppressing it, based on the disease state of the patient. The objectives of immunotherapy include downstaging the cancer, extending progression-free survival, and improving overall survival [14, 20]. Common adverse effects of immunotherapy include localized reactions such as pain, swelling, redness, and itching, as well as systemic flu-like symptoms. More severe reactions can include weight gain, edema, heart palpitations, sinus congestion, gastrointestinal disturbances, infections, or organ inflammation [21]. Comprehensive nursing assessments, along with appropriate interventions and patient education, are vital in managing these side effects and ensuring patient comfort throughout the treatment process.

**Surgical Treatment**

Surgical resection remains the cornerstone of colorectal cancer (CRC) treatment, with the specific approach depending on the stage of the cancer and the region of the colon involved. Endoscopic resection is the least invasive method, utilizing a flexible tube to remove polyps or tumors from the lower colon. Laparoscopic surgery is minimally invasive, performed through small incisions in the abdominal wall, offering shorter recovery times and fewer complications compared to traditional open abdominal surgery. The quicker recovery allows for the timely initiation of adjunctive chemotherapy. Robotic surgery, similar to laparoscopic surgery, utilizes computer-assisted controls to enhance the precision of the surgical procedure.

In contrast, open abdominal surgery is preferred for more complex cases where optimal visualization is required. During surgery, lymph nodes are examined for metastatic involvement, and the cancer stage is determined by evaluating the extent of spread into the mucosal wall, adjacent tissues, regional lymph nodes, and distant organs. Depending on the extent of the tumor, surgical resection may involve removal of a section of the colon or, in more advanced cases, a total colectomy, necessitating a colostomy for waste elimination. Colostomies may be temporary, allowing for reversal once the patient has recovered from chemotherapy and surgery, or permanent, depending on the individual's condition. Patients should be informed about different types of colostomy options, including external colostomies, which require the use of a plastic pouch to collect waste, or internal pouches that are surgically constructed and connected to the rectum. Prior to surgery, patients should discuss these options with their surgeon. Referral

to a certified ostomy nurse is crucial for providing wound care, education on ostomy care, and emotional support for patients adjusting to life with a new ostomy appliance [24].

**Adverse Reactions and Nursing Implications**

The nursing care plan must address both the physical alterations and the psychosocial challenges that patients undergo during colorectal cancer (CRC) treatment. Long-term effects from CRC surgery may encompass persistent pain, scarring, body image concerns, diarrhea, or fecal incontinence, with the potential need for either a temporary or permanent ostomy [22]. Adverse reactions from radiation therapy are influenced by the treatment dose and site and typically include fatigue, skin alterations, strictures, and lymphedema. Chemotherapy side effects are associated with specific drugs but generally manifest as fatigue, neuropathy, diarrhea, fertility and sexual dysfunction, and cognitive impairments. Psychosocial consequences for patients may include emotional distress, anxiety, depression, fear of cancer recurrence, financial strains, spiritual challenges, and significant changes in personal roles [20]. Reassurance and educational support are essential for helping patients navigate their individual treatment experiences, with nurses playing a pivotal role in providing consistent care and assistance.

**Patient Education**

In addition to demonstrating a high level of expertise in cancer care, nurses must offer compassionate, patient-centered care that builds trust and fosters confidence. Tailoring nursing interventions and educational content to the individual needs of each patient is essential, particularly for those undergoing cancer treatment [23]. Common educational needs for CRC patients receiving chemotherapy, radiation, or surgery include:

- **Management of Adverse Reactions**: Nurses should support patients in managing both the physiological and psychological effects of cancer treatments. It is critical to address not only physical challenges but also emotional and psychological concerns that may arise during treatment.
- **Medication Education**: Nurses should provide detailed explanations of all prescribed medications, covering their purpose, mechanisms of action, proper dosage, and potential side effects.
- **Wound Care Instructions**: Patients must be educated on proper care for abdominal incisions and perineal wounds, including signs of complications such as wound dehiscence, excessive redness, bleeding, purulent drainage, or unusual odors. They should be informed about the appropriate steps to take if these symptoms occur.
- **Post-Surgical Restrictions**: Advise patients to refrain from heavy lifting, pushing, or pulling for six weeks after surgery to allow sufficient time for wound healing.
- **Perineal Incision Care**: For those with a perineal incision, patients should be instructed to avoid prolonged sitting and utilize a soft, "waffle" pillow instead of a rubber or plastic donut ring while seated.
- **Colostomy Care**: Patients who require a colostomy should receive comprehensive education on how to care for the stoma and perform colostomy irrigation if indicated.

In the case of skin damage due to external radiation, nursing education should include the following guidelines:

- Advise gentle cleansing of the affected skin with mild soap and warm water, followed by patting dry.
- Instruct the patient to avoid removing any dark ink markings that demarcate the radiation field.
- Refrain from using lotions, perfumes, deodorants, or powders on the irradiated skin.
- Encourage the use of non-restrictive, soft cotton clothing over the treatment area, and advise protection from excessive sunlight, heat, or cold.

**Discharge Teaching**

Nurses should emphasize the importance of adhering to follow-up visit schedules as recommended by the healthcare provider. Patients should be encouraged to modify their diet by increasing the consumption of fruits, vegetables, poultry, fish, and whole grains while reducing the intake of red meat, refined grains, and concentrated sweets. Such dietary adjustments have been shown to improve cancer outcomes, particularly in terms of reducing recurrence or mortality [24]. Additionally, participation in early CRC detection procedures, particularly colonoscopy, should be encouraged as a preventive measure. Nurses should also recommend connecting with community resources such as the United Ostomy Association and the American Cancer Society for further support and education (see Patient Resources).

**Focus on Prevention**

Colorectal cancer is preventable, and early screening and diagnosis are essential components of effective prevention strategies. Nurses must be proactive in dispelling the misconception that CRC is primarily a disease of older adults. Raising awareness of the early warning signs of CRC, particularly in younger adults, is crucial, as rates of morbidity and mortality in this demographic are rising. Primary care providers should advocate for earlier screening and lifestyle modifications for individuals at higher risk of CRC. Through timely and effective patient education, nurses can significantly impact the prevention and early detection of colorectal cancer.

**Conclusion:**

Colorectal cancer (CRC) remains one of the most significant health concerns worldwide, with rising rates of early-onset CRC, particularly among individuals under 50 years of age. Early detection through screening has proven to be a key factor in improving survival rates and reducing the burden of the disease. This updated review highlights the importance of early diagnosis, identification of risk factors, and the critical role of nurses in improving patient outcomes. Genetic predisposition, lifestyle choices, and environmental factors such as diet and obesity are established contributors to the development of CRC. Early-onset CRC, in particular, has become a rising concern, with younger individuals presenting with non-specific symptoms such as abdominal pain and iron-deficiency anemia. Genetic counseling and early screening are essential for individuals with a family history of CRC or genetic syndromes like familial adenomatous polyposis. Nurses can play an integral role by conducting thorough assessments, identifying high-risk individuals, and promoting awareness of screening guidelines, which recommend starting at age 45 for average-risk individuals. The diagnostic process for CRC involves several steps, including colonoscopy, biopsy, and imaging techniques such as CT scans and MRI. The accurate staging of CRC is essential to determine the appropriate treatment approach, which may include surgery, chemotherapy, and radiation therapy. The pharmacological management, particularly with chemotherapy, remains the cornerstone of treatment for advanced stages of CRC, although it comes with significant side effects that require careful monitoring. The increasing incidence of early-onset CRC underscores the need for healthcare providers to adapt screening protocols and focus on high-risk groups. Nurses, through early detection, education, and patient advocacy, can help ensure that individuals receive timely interventions that can greatly improve their prognosis. Implementing updated CRC screening guidelines and offering personalized treatment plans will be vital in managing the growing prevalence of CRC and reducing its impact on public health.

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**اضطرابات الجهاز الهضمي: وجهات نظر التمريض حول التشخيص والعلاج والرعاية - مراجعة محدثة لسرطان القولون والمستقيم**

**الملخص:**

**الخلفية :**يعتبر سرطان القولون والمستقيم (CRC) ثالث أكثر أنواع السرطان تشخيصًا عالميًا، وثالث سبب رئيسي للوفاة المرتبطة بالسرطان. يتزايد انتشاره بين الأفراد الذين تقل أعمارهم عن 50 عامًا، رغم انخفاض معدلاته في الفئات العمرية الأكبر. يلعب الممرضون دورًا حاسمًا في التعرف على الأعراض المبكرة وتعزيز الفحوصات للكشف المبكر والتدخل العلاجي .

**الهدف :**تهدف هذه المراجعة إلى استكشاف وجهات نظر التمريض حول تشخيص وعلاج ورعاية مرضى سرطان القولون والمستقيم، مع التركيز بشكل خاص على الإرشادات المحدثة للكشف المبكر، والعوامل المسببة، وطرق التشخيص.

**المنهجية :**تم إجراء مراجعة شاملة للأدبيات، مع التركيز على مسببات سرطان القولون والمستقيم، وتقديم المرضى، والعوامل المسببة، وتأثير الكشف المبكر والفحص. تم الاستناد إلى دراسات حديثة، وإرشادات الفحص، والاختبارات التشخيصية، والعلاجات الدوائية المتعلقة بسرطان القولون والمستقيم.

**النتائج :**يمكن الوقاية من سرطان القولون والمستقيم إلى حد كبير من خلال الكشف المبكر، ويبدأ الفحص عند سن 45. تشمل العوامل المسببة الرئيسية التاريخ العائلي، والنظام الغذائي، والسمنة، وأمراض الأمعاء الالتهابية. يتم تأكيد التشخيص من خلال التنظير القولون، والخزعة، وتقنيات التصوير. يشمل العلاج الكيميائي، والإشعاع، والتدخلات الجراحية، مع اختلاف معدل البقاء على قيد الحياة حسب مرحلة التشخيص.

**الخاتمة :**يتطلب ارتفاع معدلات الإصابة المبكرة بسرطان القولون والمستقيم زيادة الوعي وإجراء الفحوصات في وقت مبكر، خاصة بين الأفراد الذين لديهم تاريخ عائلي أو عوامل خطر متعلقة بأسلوب الحياة. يلعب الممرضون دورًا حيويًا في توعية المرضى وتسهيل التدخلات المبكرة، مما يؤدي إلى نتائج أفضل. سيكون تنفيذ الإرشادات المحدثة للفحص وخطط العلاج الشخصية أمرًا بالغ الأهمية في معالجة هذه المشكلة الصحية المتزايدة.

**الكلمات المفتاحية :**سرطان القولون والمستقيم، الإصابة المبكرة، وجهات نظر التمريض، الفحص، طرق التشخيص، العلاج الكيميائي، العلاج، العوامل المسببة.