As an epidemiologist, I knew that I had none of the main risk factors for colorectal carcinoma. As a GP, I always had an irrational horror of per rectum investigation, colonoscopy being the one I prayed I would never need.

Therefore, when my only symptom was intermittent, painless rectal bleeding, I made the standard response of a clinical academic meeting a concept outwith his or her paradigm. I ignored it. Well, it was probably just haemorrhoids, or something; I was otherwise fit and healthy, and I was far too busy and important to spend all that time attending clinics and being investigated. I was probably also reluctant to expose myself to the indignity and vulnerability of intimate examination by my professional colleagues.

It was only after several months (or probably more) that I had an actual conversation with myself, in which part of me was a layman seeking informal advice from my medical self. Not until I heard my response — ‘For goodness sake, go and see your GP immediately!’ — did I take action. I swallowed my pride, made an appointment for a week on Wednesday, and an inevitable series of events was triggered. Despite my procrastination and self-induced postponement of the necessary, the NHS took over, and everything ran smoothly, promptly, and humanely.

As the day of my colonoscopy approached, and my trepidation grew, it never once occurred to me that the outcome would be anything other than, Thank goodness that’s over! It was, in my mind, little more than a rather unpleasant box-ticking exercise. In the end (if you will pardon the expression), the investigation was perfectly tolerable, if not actually to be proposed as a preferred approach to my own diagnosis, I now find the latter finding, I therefore owe my surgeon a debt of gratitude for her skill that prevented my need of further surgery. However, for the former, I probably have myself to blame for the debilitating effects of my current chemotherapy, the above delay presumably having allowed the tumour to spread before excision.

Having learned the lesson of my passive approach to my own diagnosis, I now found two important areas in which I could be actively preventative. I was in a state of reasonable physical fitness at the time of diagnosis, and enjoyed regular running. In the time between diagnosis and surgery, I increased the frequency, intensity, and duration of my runs. My relatively healthy body mass index was probably instrumental (along with the meticulous skill of the surgical team) in allowing my operation to be completed laparoscopically, despite the tumour being even deeper in my pelvis than suspected. This and my corresponding level of cardiovascular fitness undoubtedly helped speed up an uncomplicated post-surgical recovery. In previously advising my patients to exercise and eat healthily, I had mainly been thinking about their risk of cardiovascular disease and diabetes or other chronic illnesses such as persistent pain. It is now clear to me that improving surgical risk is also important, and that we can proactively influence our own surgical prognosis.

REFERENCES


