

Differential diagnosis

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Many colorectal lesions can give rise to diagnostic difficulty. For example, it may be difficult to distinguish an inflammatory stricture or amoebic granuloma on macroscopic appearance. Similarly, endometriomas, carcinoid tumours and solitary rectal ulcers can be mistaken for adenocarcinoma. Benign adenomas can be distinguished from malignant lesions based on the appearance of their mucosal 'pit patterns', as highlighted with the 'dye spray' colonoscopy technique (see Chapter 9). Biopsy - and histological analysis remain the mainstay of diagnosis, accepting that there may be diagnostic limitations caused by sampling errors owing to small biopsy samples being unrepresentative of the larger lesion. Summary box 79.9 Diagnosis and assessment of rectal cancer

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All patients with suspected rectal cancer should undergo: Digital rectal examination Full colorectal visualisation, preferably by colonoscopy with biopsy or CT colonography or barium enema All patients with proven rectal cancer require staging by: Imaging of the chest, abdomen and pelvis, preferably by CT Local pelvic imaging by magnetic resonance imaging (MRI) and/or endoluminal ultrasonography

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