Early and curable cancer of the distal sigmoid colon and rectum is asymptomatic at some stage of its development. Yet, it can be easily detected by inspection of the perianal and anal region, digital rectal examination and proctosigmoidoscopy.

Examination of the colon and rectum is essential to rule out cancer if the patient presents with:

- Rectal bleeding: Bleeding is the most common symptom of colon and rectal cancer. Bright red blood may signal a lesion in the rectum; dark red stools, a tumor in the right colon. However, blood of any description needs thorough investigation.

- Change in bowel habits: Diarrhea, increasing constipation, constipation alternating with diarrhea, decreased caliber of stools, sensation of incomplete evacuation or increasing flatus are signals of possible cancer and each requires complete examination.

- Pain: Early cancer of the rectum and colon is painless except for cancer involving the anus which is often painful even at an early stage. However, partially obstructing neoplasms of the colon may as their earliest manifestation give rise to ill-defined abdominal discomfort or mild cramps.

Other signs and symptoms of cancer include anemia which is often the first manifestation of right colon neoplasms. Weight loss is usually a late symptom.

Because many rectal and sigmoid cancers are within reach of the examining finger, Dr. Maus W. Stearns, Chief of the Colon and Rectal Service, Memorial Hospital for Cancer and Allied Diseases, New York City, outlines the technique of digital examination and describes the classic "cancer feel."

In the upcoming May/June issue of Ca—A Cancer Journal for Clinicians, Dr. Stearns will review the fundamentals of performing an endoscopic examination of the colon and rectum. This component of a routine colon and rectum examination can detect almost 70 percent of cancers in the large bowel.
Positioning the patient: If an ordinary examining table is used, place the patient in either a knee-shoulder or Sims’ position; if a proctoscopic table is available, use the inverted position.

Knee-shoulder: Have the patient assume a knee-shoulder position with knees apart, thighs perpendicular to the surface, ankles and feet extending beyond the table. The patient’s left arm should be crossed under him so his shoulder bears the weight. Allow the back to sag in “sway-back” fashion. (Fig. 1.)

Sims’: This is preferred by many examiners and is especially valuable in aged patients or those too ill to assume an inverted position. The patient should be placed on his left side with his left leg partially flexed and the right leg more acutely flexed. The left arm should be crossed under his chest with his right arm hanging over the side of the table. (Fig. 2.) Although less commonly employed, the patient may be positioned on his right side, if necessary.

Inverted: Instruct the patient to kneel on the knee board of the proctoscopic table. Then, have him bend over so that his elbows and forearms rest against the headboard and his head is supported by his hands. Gradually, tilt the table until the patient is in an inverted position. Further adjust the table to raise the pelvis and allow the abdomen to hang freely. (Fig. 3.)
**Inspection:** The patient’s confidence and full cooperation are essential: be reassuring, gentle, and always tell him what to expect as the examination proceeds.

Gently spread the buttocks and observe the perianal skin for discoloration, scars, sinuses or fistulae. Note the contour of the anal orifice. Next, retract the anal margins and examine the anal canal for evidence of prolapsed internal hemorrhoids, fistulae, or a reddish-gray nodular elevation which may indicate squamous cell carcinoma. (Fig. 4.) Although rare, look for basal cell carcinomas, darkly pigmented nevi and melanomas. Also inspect the sacrococcygeal area, the vulva and the thighs.

**Monodigital examination:** Palpate the perianal, perineal and sacrococcygeal areas for tenderness or a subcutaneous mass. Then, separate the buttocks and gently insert a gloved, well-lubricated index finger into the rectum. In order to advance the examining finger as high as possible, introduce it with the hand between the buttocks. (Fig. 5.) Note the tone of the anal sphincter muscles. Palpate for tenderness or a mass in the rectum or adjacent organs. Have the patient strain mildly so that high lesions descend with the bowel wall and come in contact with the examining finger. Palpate with particular care the posterior rectal wall immediately above the sphincter. This is the so-called “blind spot” which is poorly visualized by sigmoidoscopy. Soft lesions such as papillary adenomas are often missed by the casual examiner both by palpation and visualization.
**Bidigital examination**:

With the index finger still in the rectum, place the thumb of the same hand on the perianal skin and the tip of the coccyx. Gently palpate the tissues between index finger and thumb in a circular motion either clockwise or counterclockwise until the entire ano-perineal surface is examined. (Fig. 6.)

A sessile adenoma is small and movable. Although it is usually firm it may be very soft and not easily felt. A pedunculated adenoma is more mobile than a sessile lesion and may be confused with feces. However, it is tethered to the bowel wall and its movement is limited. Villous papillomata are usually larger than adenomata, feel granular, soft and have ill-defined edges.

The feel of a typical infiltrating cancer is unmistakable: it is nodular, hard, irregular with elevated edges. The base is broad and fixed and, in the ulcerative stage, the center is "crater-like." The cancer may vary in size from a small malignant ulcer to a tumor completely encircling the lumen. Following examination, the glove may be covered with brick-red, mucopurulent matter and blood. A fetid odor is not uncommon.

Note the exact position and extent of growth in relation to the anorectal ring, the rectovaginal septum and the prostate and seminal vesicles.

**Extrarectal/rectoabdominal palpation**:

With the finger still in the rectum, insert the middle finger into the vagina and palpate the rectovaginal septum between the two fingers. Note the position of the uterus. In men, palpate the prostate and seminal vesicles for enlargement and nodules.

Next place the patient in a lithotomy or supine position with the knees slightly flexed on the abdomen. With a well-lubricated finger in the rectum, gently push downward on the pelvic organs with the other hand to look for intraabdominal or pelvic masses. (Fig. 7.)