The impact of type 2 diabetes on long-term gastrointestinal sequelae after colorectal cancer surgery: national population-based study

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Abstract

Background: Long-term gastrointestinal sequelae are common after colorectal cancer surgery, but the impact of type 2 diabetes (T2D) is unknown.

Methods: In a cross-sectional design, questionnaires regarding bowel function and quality of life (QoL) were sent to all Danish colorectal cancer survivors, who had undergone surgery between 2001 and 2014 and had more than 2 years follow-up without relapse. The prevalence of long-term gastrointestinal sequelae among colorectal cancer survivors with and without T2D were compared while stratifying for type of surgical resection and adjusting for age, sex, and time since surgery.

Results: A total of 8747 out of 14488 colorectal cancer survivors answered the questionnaire (response rate 60 per cent), consisting of 3116 right-sided colonic, 2861 sigmoid, and 2770 rectal resections. Of these, 690 (7.9 per cent) had a diagnosis of T2D before surgery. Survivors with T2D following rectal resection had a 15 per cent (95 per cent c.i. 7.8 to 22) higher absolute risk of major low anterior resection syndrome, whereas survivors with T2D following right-sided and sigmoid resection had an 8 per cent higher risk of constipation (P < 0.001) but otherwise nearly the same long-term risk of bowel symptoms as those without T2D. For all types of colorectal cancer resections, T2D was associated with a 6–10 per cent higher risk of severe pain (P < 0.035) and a 4–8 per cent higher risk of impaired QoL.

Conclusion: T2D at time of surgery was associated with a higher risk of long-term bowel dysfunction after rectal resection, but not after colon resection excluding a higher risk of constipation. T2D was associated with a slightly higher frequency of severe pain and inferior QoL after both rectal and colonic cancer resection.

Introduction

Colorectal cancer and type 2 diabetes (T2D) are common diseases, both with increasing incidence worldwide1,2. colorectal cancer is the third most common type of cancer3. T2D affects 247 million people world-wide4, increases the risk of developing colorectal cancer5,6, and approximately 10 per cent of newly diagnosed patients with colorectal cancer have T2D6. T2D has been shown to worsen the prognosis of colorectal cancer4,5.

Due to advances in early detection, diagnostic precision, and improved treatment regimens, approximately 80 per cent of patients with colorectal cancer are now diagnosed at an early stage without detectable metastasis with more than two-thirds of non-metastatic patients alive after 5 years7,8. It is well established that late sequelae to cancer treatment are common9–11 and are an important healthcare issue.

The most frequent sequela after colorectal cancer resection is bowel dysfunction characterized by constipation, diarrhea, clustering of defecation, urgency, flatus, and faecal incontinence. These symptoms in patients that have had a rectal resection can be defined low anterior resection syndrome (LARS)12–14. Another frequent symptom is chronic pain reported by 13–22 per cent of colorectal cancer survivors15,16, however, bowel dysfunction and abdominal pain are frequently observed in individuals with T2D without colorectal cancer17. The symptoms are mainly caused by diabetic autonomic neuropathy, but enteric myopathy, alterations in blood glucose, and side effects to medication also contribute18,19. Despite the common symptomatology in individuals with T2D and in colorectal cancer survivors, no studies have investigated whether bowel dysfunction and abdominal pain after colorectal cancer resection occurs more frequently among survivors with T2D.
The primary aim of this study was to assess associations between T2D and long-term bowel dysfunction, severe pain, and impaired quality of life (QoL) among colorectal cancer survivors. The hypothesis was that all colorectal cancer resections in patients with T2D was associated with an increased risk of developing long-term gastrointestinal sequelae.

Methods

Study population

The study was based on a large population-based survey regarding long-term sequelae and QoL. All Danish colorectal cancer survivors who had undergone cancer surgery between 2001 and 2014, had more than 2 years of follow-up after surgery, and no known relapse of cancer were eligible. Data were retrieved from the Danish Colorectal Cancer Group Database (DCCG), which has a high degree of completeness (more than 95 per cent) and thus represents the population of Danish colorectal cancer patients undergoing surgical resection. The data were furthermore linked to the Danish Civil Registration System ensuring that patients who emigrated, died, or had research protection were excluded.

Patients with disseminated or recurrent disease, other previous cancer (except from non-melanoma skin cancer), permanent stoma, other major surgical procedures performed (total colectomy or pelvic exenteration), radiotherapy for other cancer than rectal cancer, or dementia were excluded.

Identifying individuals with type 2 diabetes

Individuals with T2D were identified in the Danish registries using the civil registration number, which is a unique personal identification number assigned to all Danish residents. All data are recorded with reference to this number and permits accurate linkage of recorded health information at the personal level. Data from the Danish National Patient Register (comprising information on diagnoses given during all hospital contacts in Denmark), the National Prescription Registry (comprising information on all prescriptions filled at any pharmacy in Denmark), and the Danish National Health Service Register (comprising information on podiatrist services) were used to identify individuals with diabetes as previously described by Bendix et al. Individuals were classified as having type 1 diabetes if they had only prescriptions of insulin and a diagnosis of type 1 from a medical department, otherwise diabetes was classified as T2D.

Subgroups according to anatomical site of cancer

Colorectal cancer survivors were subdivided into three subgroups according to the anatomical site of the cancer and the surgical procedure. The subgroup ‘right-sided colonic cancer resection’ (Right-CC) contained all patients with caecum or ascending colonic cancer, the subgroup ‘sigmoid cancer’ (Sig-C) contained all patients with sigmoid cancer, and the subgroup ‘rectum cancer’ (Rec-C) contained all patients with rectum cancer. Short segmental resections of the transverse colon, splenic, or isolated descending resections were excluded due to a combination of low numbers and uncertainty regarding the surgical procedure.

Patient-reported outcomes

A detailed description of the survey data has been published elsewhere. In the present study, bowel function was evaluated using the same single items (constipation, diarrhoea, faecal incontinence, urgency, clustering of defecation, and flatus incontinence) and cut-offs as for assessing LARS. Constipation was defined as bowel movements less than once per day, and diarrhoea was defined as a need to open the bowel four times or more a day. Faecal incontinence was defined as leakage of liquid stool on a weekly basis. Urgency, clustering, and flatus incontinence were only considered if the symptoms occurred on a weekly basis. The total LARS score, and thus major LARS, was only computed among rectal cancer survivors as the score is only validated in this group.

Severe pain was assessed using the PAIN score, which originally examined chronic pain in the abdomen, pelvis, and lower extremities after rectal cancer surgery. Patients with major pain were classified as having severe pain and those with minor or no significant pain as having no severe pain.

The impact of bowel dysfunction on health-related QoL was examined by a single question: ‘Overall, how much does your bowel function affect your QoL?’ Those who responded ‘some’ or ‘major’ impact were categorized as having impaired QoL, whereas ‘little’ or ‘no’ were categorized as having no impaired QoL.

Statistical analysis

Descriptive statistics were used to compare baseline characteristics and symptoms between groups. Differences were tested using Pearson’s chi-squared test and Student’s t test. A binomial regression was used for estimation of risk differences adjusted for covariate effects (generalized linear model for binary outcomes with an identity link function). Model 1 adjusts for age at surgery, sex, and time from surgical treatment to answering the survey. Model 2a additionally adjusts for chemotherapy (no/yes) in the Right-CC and Sig-C subgroups, and Model 2b further adjusts for chemotherapy (no/yes), radiotherapy (no/yes), and tumour height (5 cm or smaller, 5–10 cm, more than 10 cm from anus) in the Rec-C subgroup. The OR was calculated by using logistic regression when needed for comparison with results from other papers. Results were presented with 95 per cent confidence interval (c.i.) when relevant. In sensitivity analyses, we expanded the definition of urgency, clustering, and flatus to symptoms at a daily basis instead of weekly, whereas we restricted the definition of constipation to less than once a week and diarrhoea to more than six times daily. Furthermore, the definitions of LARS, pain, and QoL were expanded to include the ‘minor/little’ category.

All analyses were conducted using Stata version 17 (StataCorp, College Station, Texas, USA).

Results

In total, 53,617 patients were identified in the DCCG database (Fig. 1) of whom 24,124 met the inclusion criteria and received a letter of invitation to participate in an electronic survey concerning long-term functional outcome after colorectal cancer surgery. The letters of invitation were sent between November 2015 and January 2016. Based on the answers additionally 5,397 patients were excluded because they met at least one of the exclusion criteria. Surgical procedure other than right-sided colectomy, sigmoid, and rectal resections were excluded (3,420 patients). Finally, individuals with a diagnosis of type 1 diabetes (52 patients) were excluded, as well as those who developed T2D after the date of surgery and until the end of follow-up (date of answering the questionnaire) (767 patients).

Baseline characteristics

A total of 14,488 colorectal cancer survivors were eligible for the study, and 8,747 (60 per cent) answered the questionnaire.
Right-sided colonic resection
n = 5117

Responders
n = 3116 (61%)

−T2D
n = 2819 (90%)

+T2D
n = 297 (10%)

Sigmoid resection
n = 4435

Responders
n = 2861 (65%)

−T2D
n = 2630 (92%)

+T2D
n = 231 (8%)

Rectum resection
n = 4936

Responders
n = 2770 (56%)

−T2D
n = 2608 (94%)

+T2D
n = 162 (6%)

Eligible survivors
n = 14 488

CRC patients registered in DCCG
(May 2001 to Dec 2014)

n = 53 617

Patients meeting exclusion criteria
n = 29 493

Exclusion based on survey information
n = 5397

Exclusion due to study criteria:
Other surgical procedure: n = 3420
Type 1 diabetes: n = 52
T2D diagnosis during follow-up: n = 767

Table 1 displays the study population divided into surgical subgroups (3116 Right-CC, 2861 Sig-C, and 2770 Rec-C). A total of 690 (7.9 per cent) had a diagnosis of T2D at the time of colorectal cancer surgery. Compared with Right-CC, the other surgical procedures were younger (P < 0.001), more often men (P < 0.001), less often classified as having an ASA score greater than II (P < 0.001), and less often had a diagnosis of T2D (P = 0.047). The differences were most pronounced when comparing Right-CC with the Rec-C subgroup. Furthermore, within each surgical subgroup, those with T2D were significantly older (P < 0.001), more often men (P = 0.005), had higher BMI (P < 0.001), and were classified in higher ASA groups than those without diabetes (P < 0.001).

The impact of T2D on bowel symptoms in all surgical subgroups

Within each subgroup of Right-CC and Sig-C, those with T2D had almost the same frequency of long-term bowel symptoms as those without diabetes (Table 2), with the exception of a higher frequency of constipation (26 per cent versus controls 17 per cent, P = 0.001) and flatus (45 per cent versus controls 37 per cent, P = 0.016) among Right-CC survivors, and a higher frequency of constipation (26 per cent versus controls 17 per cent, P = 0.001) and urgency (30 per cent versus controls 22 per cent, P = 0.008) among Sig-C survivors.

In the rectal cancer subgroup, T2D was associated with higher frequencies of symptoms related to defaecation control (clustering, urgency, and faecal incontinence), and the risk of suffering from major LARS was higher (60 versus 48 per cent, P = 0.002). The adjusted risk difference of major LARS was 15 per cent (95 per cent c.i. 7.8 to 22 per cent) higher among Rec-C survivors with T2D compared with survivors without T2D (Table 3), and the adjusted OR was 1.9 (95 per cent c.i. 1.3–2.7). In the sensitivity analyses, the results remained unchanged (data not shown).

Bowel symptoms and surgical procedure

Overall, patients in the Right-CC and Sig-C subgroups had the same prevalence of most bowel symptoms (Table 2) with the exception that those having undergone Right-CC were more likely to suffer from faecal incontinence (6.8 per cent versus Sig-C 3.5 per cent P < 0.001) and those having undergone Sig-C were more likely suffer from urgency for defaecation (37 per cent versus Right-CC 23 per cent, P < 0.001). In contrast, Rec-C had a significantly higher frequency of almost all bowel symptoms except constipation.

Severe pain

The three surgical subgroups had about the same risk of major severe pain (prevalence 13–15 per cent, data not shown). Within each surgical subgroup, the adjusted risk difference of severe
Table 1 Baseline characteristics of study cohort

| Total | Right-CC | Sig-C | Rec-C |
|-------|----------|-------|-------|
|       | −T2D     | +T2D  | −T2D  | +T2D  | −T2D  | +T2D  |
| Number| 8747 (100)| 2819 (100)| 297 (9.5) | 2630 (92)| 231 (8.1) | 2608 (94)| 162 (5.8) |
| Age (years) (s.d.)| 65.0 (10.0) | 72.2 (7.6) | 65.0 (9.6) | 69.3 (7.9) | 25.6 (4.0) | 28.9 (4.7) |
| BMI (s.d.)| 25.8 (4.4) | 28.4 (5.5) | 25.8 (4.3) | 29.0 (4.6) | 25.6 (4.0) | 28.9 (4.7) |
| Sex ratio (M:F) | 4468:4279 | 1155:134 | 155:142 | 1373:1257 | 155:76 | 1479:1129 | 110:52 |
| Smoking status | Never smoker 3061 (35) | 933 (35) | 924 (35) | 35 | 35 | 1209 (14) |
| | Smoker 1245 (14) | 46 (16) | 46 (16) | 10 | 10 | 1245 (14) |
| | Former smoker 3232 (37) | 134 (45) | 134 (45) | 10 | 10 | 3232 (37) |
| | Missing 1209 (14) | 28 (9.4) | 28 (9.4) | 10 | 10 | 1209 (14) |
| ASA score* | I 3036 (35) | 1002 (38) | 1120 (43) | 8 | 8 | 3036 (35) |
| | II 4745 (54) | 1411 (54) | 1326 (51) | 122 | 122 | 4745 (54) |
| | >II 822 (9.2) | 938 (36) | 982 (34) | 35 | 35 | 822 (9.2) |
| Stage of disease | I/II 5591 (64) | 1729 (66) | 1502 (58) | 84 | 84 | 5591 (64) |
| | III/VI 2497 (29) | 812 (31) | 677 (26) | 32 | 32 | 2497 (29) |
| | Unknown 659 (7.5) | 90 (30) | 96 (30) | 5 | 5 | 659 (7.5) |
| Treatment | Chemotherapy 3139 (36) | 969 (37) | 940 (36) | 56 | 56 | 3139 (36) |
| | Radiotherapy 397 (14) | 387 (15) | 387 (15) | 17 | 17 | 397 (14) |

Right-CC, right-sided colon cancer resection (caecum and ascending colon); Sig-C, sigmoid cancer resection. Rec-C, rectum cancer resection; + (with) or – (without) T2D (type 2 diabetes). *ASA physical scale.

Table 2 Frequency of long-term bowel symptoms based on surgical resection type with or without type 2 diabetes

| Constipation* | Clustering† | Diarrhoea‡ | Urgency† | Incontinence† | Flatus† |
|---------------|-------------|------------|----------|---------------|--------|
| Right-CC      |             |            |          |               |        |
| Reply ‘yes’/all replies | 468/3010 (16) | 684/3066 (22) | 259/3010 (8.6) | 1150/3073 (37) | 182/3079 (6.9) |
| −T2D | 405/2730 (15) § | 610/2778 (22) | 234/2730 (8.6) | 1039/2783 (37) | 162/2790 (5.8) |
| +T2D | 63/280 (23) § | 74/288 (26) | 25/280 (8.9) | 111/290 (38) | 129/289 (45) § |
| Sig-C |             |            |          |               |        |
| Reply ‘yes’/all replies | 495/2809 (18) | 606/2829 (21) | 323/2809 (12) | 654/2831 (23) | 99/2836 (3.5) |
| −T2D | 437/2582 (17) § | 549/2600 (21) | 298/2582 (12) | 586/2606 (22) § | 87/2608 (3.3) |
| +T2D | 58/227 (26) § | 74/229 (32) | 25/227 (11) | 68/225 (30) § | 109/227 (48) |
| Rec-C |             |            |          |               |        |
| Reply ‘yes’/all replies | 332/2722 (12) | 1440/2743 (53) | 1056/2722 (39) | 1212/2749 (44) | 303/2742 (11) |
| −T2D | 316/2561 (12) § | 1340/2582 (52) § | 992/2561 (39) | 1125/2587 (45) § | 274/2580 (11) |
| +T2D | 16/161 (10) | 100/161 (62) § | 64/161 (40) | 87/162 (54) § | 104/160 (65) |

Values are n (%). Right-CC, right-sided colon cancer resection (caecum and ascending colon); Sig-C, sigmoid cancer resection. Rec-C, rectum cancer resection; + (with) or – (without) T2D (type 2 diabetes). *Defaecation six or fewer times a week. †On a weekly basis. ‡Diarrhoea is defaecation more than three times a day. §P < 0.050.

Table 3 Risk differences of severe pain, impaired quality of life and major low anterior resection syndrome after different types of colorectal cancer resections in patients with and without type 2 diabetes (adjusted and unadjusted analysis)

| Right-CC | Sig-C | Rec-C |
|----------|-------|-------|
| RD unadjusted | +T2D | RD adjusted model 1 | +T2D | RD adjusted model 2a/b | +T2D |
| Severe pain | 1 (ref) | 4.6 (−0.01; 9.8) | 9.6 (3.2; 15) | 6.0 (0.72; 11) | 13 | 7.8 (2.2; 15) |
| Impaired QoL | 1 (ref) | 3.1 (−1.6; 7.9) | 6.1 (0.72; 11) | 6.0 (0.72; 11) | 13 | 7.8 (2.2; 15) |

Values are risk difference percentage (95 per cent c.i.). Right-CC, right-sided colon cancer resection (caecum and ascending colon); Sig-C, sigmoid cancer resection; Rec-C, rectum cancer resection; + (with) or – (without) T2D (type 2 diabetes); LARS, low anterior resection syndrome; QoL, quality of life. Model 1, adjusted for age at surgery, sex, and time from surgical treatment to answering the survey; *Model 2a, model 1+chemotherapy (no/yes); †Model 2b, model 1+chemotherapy (no/yes)+radiotherapy (no/yes)+tumour height (5 cm or less, 5–10 cm, and more than 10 cm from anus). ‡Indicates significant results.
pain was higher in those with T2D than in those without (Table 3). This was most pronounced in the Sig-C and Rec-C subgroups, where those with T2D had a 9.2 per cent (3.4–15 per cent) higher absolute risk of severe pain after sigmoid resection and a 10 per cent (2.9–18 per cent) higher absolute risk after rectal resection compared with those without T2D.

**Quality of life**

In the Right-CC and Sig-C subgroups, 16–17 per cent experienced impaired QoL, whereas the frequency was 34 per cent in the Rec-C subgroup (data not shown). Those with T2D had a slightly higher risk of impaired QoL (4–8 per cent) than those without T2D (Table 3).

**Discussion**

This national cross-sectional study of colorectal cancer survivors with diabetes, demonstrated right-sided and sigmoid resection was associated with almost the same risk of long-term bowel symptoms as those without diabetes, except for an 8 per cent higher risk of constipation. In contrast, patients with rectal resection and T2D had a higher risk of symptoms related to defaecation control (clustering, urgency, and faecal incontinence) and a 15 per cent (95 per cent c.i. 7.8 to 22) increased risk of major LARS. In all resection types, T2D was associated with a slightly higher risk of severe pain and impaired QoL.

Several studies have examined long-term bowel complications after rectal resection using the LARS score. In 2018, a meta-analysis based on 11 studies was published and the estimated prevalence of major LARS was 41 per cent (95 per cent c.i. 34 to 48) [12]. This is in line with our findings among Rec-C survivors without diabetes. In a randomized setting (242 non-stoma patients), Chen et al. [29] investigated the long-term bowel function (median follow-up 14.7 years) after total mesorectal excision with or without preoperative short-course radiotherapy. They reported a similar higher OR of 1.8 (99 per cent c.i. 0.6 to 5.6) associated with diabetes as observed in the present study. The non-significant result in the study by Chen et al. might be explained by an underpowered study cohort. The present study confirmed previous findings, showing that bowel symptoms and major LARS were associated with poor health-related QoL [27,30,31], and the prevalence was higher among survivors after rectal resection compared with colonic resection [30,32].

However, bowel symptoms are also commonly reported in the general population. A Danish study on a random sample of 3440 adult citizens from the general population demonstrated that 12–18 per cent of the adult female and 10–11 per cent of the adult male population suffered from symptoms corresponding to major LARS, and the symptoms were associated with unspecified physical disease [33]. A similar prevalence of 12 per cent was found in a general Dutch population, whereas the authors reported a prevalence of symptoms of major LARS at 24 per cent among individuals with diabetes [34]. Similar higher frequencies of small and large intestinal symptoms in individuals with T2D were reported in two reviews [35,36]. Both papers found a higher prevalence of diarrhoea and constipation among individuals with T2D compared with those without. Additionally, a higher frequency of faecal incontinence, severe pain, and bloating was found in one of the studies [36].

The hypothesis was that there would be a higher frequency of long-term bowel dysfunction associated with T2D among colorectal cancer survivors due to well described diabetic gastroenteropathy [37]. A major pathological driver of diabetic enteropathy is believed to be changes in the enteric motor and sensory functions, leading to manifest symptoms such as those related to motility and secretory function [37]; however, the bowel symptoms associated with diabetes among colorectal cancer survivors differed to some extent from the general diabetes population. Diarrhoea was not associated with diabetes, whereas higher frequencies of constipation were only observed in the Right-CC and Sig-C subgroups, and otherwise T2D had only minor impact on long-term bowel symptoms in these two subgroups. In contrast, rectal cancer survivors with T2D had higher frequencies of clustering, urgency, and faecal incontinence when compared with those without T2D. These symptoms can occur due to disruption of the reflexes controlling defaecation and continence. The observed higher influence of T2D on long-term bowel dysfunction in the Rec-C subgroup when compared with the Right-CC/Sig-C subgroups can all be related to impaired nerve function associated with diabetes. Colonic function mainly comprises motility and secretion, whereas rectal function is much more complex. The colon is predominantly influenced by enteric neuronal and hormonal functioning, whereas rectal function is more dependent on direct nerve innervation controlling the defaecation and continence function. During rectal resection, nerves lie near the dissection plane and risk direct surgical injury, as well as the delayed impact of scarring, fibrosis, and the side effects of neoadjuvant treatment [38,39]. In patients with existing neuropathy, it is likely that these effects could be more pronounced.

The observed higher prevalence of severe pain among colorectal cancer survivors with T2D compared with those without diabetes could also be attributable to nerve function. Overall, the prevalence of severe pain was similar in the surgical subgroups and in the same range as formerly published studies of pain after cancer surgery [15,16,40] and colorectal surgery in general [41]. It is plausible that people with diabetes had pre-existing sensory symptoms as any autonomic and sensory neuropathy associated with long-standing diabetes affects many structures of the neuroaxis involved in pain processing [17]; however, the frequency of severe pain after surgery in diabetics is higher than expected, and it is likely that the surgical trauma in addition to chemoradiotherapy increase any pre-existing neuropathy or may be responsible for its de novo development. Only one previous study investigated the impact of diabetes, and in contrast with our findings, it did not find any association between diabetes and pain after colorectal cancer surgery [15]. The difference may be explained by heterogeneous study populations and more importantly, by a different time of pain assessment (6 months after surgery versus more than 2 years after surgery in the present study).

Bowel dysfunction following treatment of pelvic cancers is treatable. Several studies from the UK show that patients benefit from algorithm-based management and a multidisciplinary treatment approach [42–44]. If cancer survivors undergo clinical evaluation and the underlying pathophysiology to their bowel dysfunction is found, they can receive targeted treatment with marked improvement in up to 38 per cent [45]. Rectal cancer survivors with LARS may be treated with conservative treatment in a nurse-led clinic with 75 per cent of patients experiencing an improvement in LARS score [46]. Larsen et al. have shown that when asked in a survey, 10 per cent of Danish colonic cancer survivors have bowel dysfunction and are interested in clinical evaluation and treatment [47]. If cancer survivors with long-term bowel
sequelae are identified, evaluated, and treated, there is a potential for helping a large patient group, including those with diabetes.

The core strengths of the present study include the population-based data with large patient numbers, the prospectively collected disease- and treatment-related data, as well as register-based identification of the diabetes population. The study is limited by a response rate of 60 per cent. Compared with respondents, the non-respondents were older, classified in higher ASA groups, and had more often a previous diagnosis of T2D and rectal cancer. This selection bias may influence the results of this study in both directions. It is possible that colorectal cancer survivors suffering from long-term sequelae are more likely to answer the survey due to personal interest in potential treatments, which could lead to an overestimation of the symptoms. Another possibility is that a lower attendance of survivors with T2D might lead to underreporting in this group; however, we do not find any reason to believe that the selection bias is different within the three surgical subgroups and therefore, we consider the observed difference between colon and rectal resected survivors to be reliable.

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**Disclosure**
The authors declare no conflict of interest.

**Supplementary material**
Supplementary material is available at BJS Open online.

**Data availability**
Due to the Danish law it is not possible to make national health registers available, but on request we would like to collaborate and discuss reasonable access to data.

**References**
1. Arnold M, Sierra MS, Laversanne M, Soerjomataram I, Jamal A, Bray F. Global patterns and trends in colorectal cancer incidence and mortality. Gut 2017;66:683–691
2. Lin X, Xu Y, Pan X, Xu J, Ding Y, Sun X et al. Global, regional, and national burden and trend of diabetes in 195 countries and territories: an analysis from 1990 to 2025. Sci Rep 2020;10:14790
3. Bray F, Ferlay J, Soerjomataram I, Siegel RL, Torre LA, Jamal A. Global cancer statistics 2018: GLOBOCAN estimates of incidence and mortality worldwide for 36 cancers in 185 countries. CA Cancer J Clin 2018;68:394–424
4. De Bruijn KM, Arends LR, Hansen BE, Leeflang S, Ruiter R, van Eijck CH. Systematic review and meta-analysis of the association between diabetes mellitus and incidence and mortality in breast and colorectal cancer. Br J Surg 2013;100:1421–1429
5. Tsilidis KK, Kasimis JC, Lopez DS, Ntzani EE, Ioannidis JP. Type 2 diabetes and cancer: umbrella review of meta-analyses of observational studies. BMJ 2015;350:g7607
6. van de Poll-Franse LV, Houterman S, Janssen-Heinjens ML, Derksena MW, Coebergh JW, Haak HR. Less aggressive treatment and worse overall survival in cancer patients with diabetes: a large population-based analysis. Int J Cancer 2007;120:1986–1992
7. NORDCAN. Kræftstatis: Nøgletal og figurer Danmark: Tyk– og endetarm. 2019. https://gco.iarc.fr/factsheets/countries/208/tyktarm-90-danmark-208.pdf (accessed 8 August 2022)
8. Kuipers EJ, Grady WM, Lieberman D, Seufferlein T, Sung JJ, Boelens PG et al. Colorectal cancer. Nat Rev Dis Primers 2015;1:15065
9. Buccafusca G, Proserpio I, Tralongo AC, Rametta Giuliano S, Traionfo P. Early colorectal cancer: diagnosis, treatment and survivorship care. Crit Rev Oncol Hematol 2019;136:20–30
10. Jansen L, Koch L, Brenner H, Arndt V. Quality of life among long-term (≥5 years) colorectal cancer survivors - systematic review. Eur J Cancer 2010;46:2879–2888
11. Harrington CB, Hansen JA, Moekowitz M, Todd BL, Feuerstein M. It’s not over when it’s over: long-term symptoms in cancer survivors—a systematic review. Int J Psychiatry Med 2010;40:163–181
12. Cooose AD, Lonie JM, Trollope AF, Vangaveti VN, Ho YH. A meta-analysis of the prevalence of low anterior resection syndrome and systematic review of risk factors. Int J Surg 2018;56:234–241
13. Buchi C, Martling A, Sjovall A. Low anterior resection syndrome after right- and left-sided resections for colonic cancer. BJS Open 2019;3:387–394
14. Emmertsen KJ, Laurberg S. Low anterior resection syndrome score: development and validation of a symptom-based scoring system for bowel dysfunction after low anterior resection for rectal cancer. Ann Surg 2012;255:922–928
15. Jin J, Chen Q, Min S, Du X, Zhang D, Qin P. Prevalence and predictors of chronic postsurgical pain after colorectal surgery: A prospective study. Colorectal Dis 2021;23:1878–1889
16. Pan Z-Y, Hu Z-H, Zhang F, Xie W-X, Tang Y-Z, Liao Q. The effect of transversus abdominis plane block on the chronic pain after colorectal surgery: a retrospective cohort study. BMC Anesthesiol 2020;20:116
17. Meldgaard T, Keller J, Olesen AE, Olesen SS, Krogh K, Borre M et al. Pathophysiology and management of diabetic gastrectropathy. Therap Adv Gastroenterol 2019;12:1756284819830247
18. Bytzer P, Talley NJ, Leemon M, Young L, Jones MP, Horowitz M. Prevalence of gastrointestinal symptoms associated with diabetes mellitus: a population-based survey of 15,000 adults. Arch Intern Med 2001;161:1989–1996
19. Talley NJ, Young L, Bytzer P, Hammer J, Leemon M, Jones M et al. Impact of chronic gastrointestinal symptoms in diabetes mellitus on health-related quality of life. Am J Gastroenterol 2001;96:71–76
20. Ho YH. Techniques for restoring bowel continuity and function after rectal cancer surgery. World J Gastroenterol 2006;12:6252–6260
21. Emmertsen KJ, Laurberg S. Bowel dysfunction after treatment for rectal cancer. Acta Oncol 2008;47:994–1003
22. Klein MF, Gogneru I, Inghelmon P, Njor SH, iversen LH, Emmertsen KJ. Validation of the Danish Colorectal Cancer Group (DCCG) database - on behalf of the Danish Colorectal Cancer Group. Colorectal Dis 2020;22:2057–2067
23. Carstensen B, Kristensen JK, Marcussen MM, Borch-Johnsen K. The national diabetes register. Scand J Public Health 2011;39:58–61
23. Mortensen AR, Thyss A, Emmertsen KJ, Laurberg S. Chronic pain after rectal cancer surgery – development and validation of a scoring system. Colorectal Dis 2019;21:90–99
24. Feddern ML, Jensen TS, Laurberg S. Chronic pain in the pelvic area or lower extremities after rectal cancer treatment and its impact on quality of life: a population-based cross-sectional study. Pain 2015;156:1765–1771
25. Larsen HM, Elfeki H, Emmertsen KJ, Laurberg S. Long-term bowel dysfunction after right-sided hemicolectomy for cancer. Acta Oncol 2020;59:1240–1245
26. Elfeki H, Larsen HM, Emmertsen KJ, Christensen P, Youssef M, Khafagy W et al. Bowel dysfunction after sigmoid resection for cancer and its impact on quality of life. Ann Surg 2014;259:728–734
27. Juul T, Ahlberg M, Biondo S, Emmertsen KJ, Espin E, Jimenez LM et al. International validation of the low anterior resection syndrome score. Ann Surg 2014;259:728–734
28. Chen TY, Wiltunk LM, Nout RA, Meershoek-Klein Kranenburg E, Laurberg S, Marijnen CA et al. Bowel function 14 years after preoperative short-course radiotherapy and total mesorectal excision for rectal cancer: report of a multicenter randomized trial. Clin Colorectal Cancer 2015;14:106–114
29. van Heinsbergen M, den Haan N, Maaskant-Braat AJ, Melenhorst J, Belgers EH, Leijtens JW et al. Functional bowel complaints and quality of life after surgery for colon cancer: prevalence and predictive factors. Colorectal Dis 2020;22:136–145
30. van Heinsbergen M, den Haan N, Maaskant-Braat AJ, Melenhorst J, Belgers EH, Leijtens JW et al. Functional bowel complaints and quality of life after surgery for colon cancer: prevalence and predictive factors. Colorectal Dis 2020;22:136–145
31. Juul T, Ahlberg M, Biondo S, Espin E, Jimenez LM, Matzel KE et al. Low anterior resection syndrome and quality of life: an international multicenter study. Dis Colon Rectum 2014;57:585–591
32. Keane C, O’Grady G, Bissett I, Woodfield J. Comparison of bowel dysfunction between colorectal cancer survivors and a non-operative non-cancer control group. Colorectal Dis 2020;22:806–813
33. Juul T, Elfeki H, Christensen P, Laurberg S, Emmertsen KJ, Bagér P. Normative data for the low anterior resection syndrome score (LARS score). Ann Surg 2019;269:1124–1128
34. Al-Saidi AMA, Verkuijl SJ, Hofker S, Trzpis M, Broens PMA. How should the low anterior resection syndrome score be interpreted? Dis Colon Rectum 2020;63:520–526
35. Du YT, Rayner CK, Jones KL, Tailey NJ, Horowitz M. Gastrointestinal symptoms in diabetes: prevalence, assessment, pathogenesis, and management. Diabetes Care 2018;41:627–637
36. Concepción Zavaleta MJ, Gonzáles Yovera JG, Moreno Marreros DM, Rafael Robles LD, Palomino Taype KR, Soto Gálvez KN et al. Diabetic gastroenteropathy: an underdiagnosed complication. World J Diabetes 2021;12:794–809
37. Meldgaard T, Olesen SS, Farmer AD, Krogh K, Wendel AA, Brock B et al. Diabetic enteropathy: from molecule to mechanism-based treatment. J Diabetes Res 2018;2018:3287301
38. Bregendahl S, Emmertsen KJ, Fassov J, Krogh K, Zhao J, Gregersen H et al. Neorectal hyposesthesia after neoadjuvant therapy for rectal cancer. Radiother Oncol 2013;108:331–336
39. Bregendahl S, Emmertsen KJ, Lous J, Laurberg S. Bowel dysfunction after low anterior resection with and without neoadjuvant therapy for rectal cancer: a population-based cross-sectional study. Colorectal Dis 2013;15:1130–1139
40. Santos LJ, Garcia JB, Paccheco JS, Vieira EB, Santos AM. Quality of life, pain, anxiety and depression in patients surgically treated with cancer of rectum. Arq Bras Cir Dig 2014;27:96–100
41. Joris JL, Georges MJ, Medjahed K, Ledoux D, Damilot G, Ramquet CC et al. Prevalence, characteristics and risk factors of chronic postsurgical pain after laparoscopic colorectal surgery: retrospective analysis. Eur J Anaesthesiol 2015;32:712–717
42. Gupta A, Muls AC, Lalji A, Thomas K, Watson L, Shaw C et al. Outcomes from treating bile acid malabsorption using a multidisciplinary approach. Support Care Cancer 2015;23:2881–2890
43. Andreyev HJ, Benton BE, Lalji A, Norton C, Mohammed K, Gage H et al. Algorithm-based management of patients with gastrointestinal symptoms in patients after pelvic radiation treatment (ORBIT): a randomised controlled trial. Lancet 2013;382:2084–2092
44. Andreyev HJ, Muls AC, Norton C, Raphael C, Watson L, Shaw C et al. Guidance: the practical management of the gastrointestinal symptoms of pelvic radiation disease. Frontline Gastroenterol 2015;6:53–72
45. Larsen HM, Borre M, Christensen P, Mohr Drewes A, Laurberg S, Krogh K et al. Clinical evaluation and treatment of chronic bowel symptoms following cancer in the colon and pelvic organs. Acta Oncol 2019;58:776–781
46. Dalgaard P, Emmertsen KJ, Mekhael M, Laurberg S, Christensen P. Nurse-led standardized intervention for low anterior resection syndrome. A population-based pilot study. Colorectal Dis 2021;23:434–443
47. Larsen HM, Mekhael M, Juul T, Borre M, Christensen P, Mohr Drewes A et al. Long-term gastrointestinal sequelae in colon cancer survivors: prospective pilot study on identification, the need for clinical evaluation and effects of treatment. Colorectal Dis 2021;23:356–366