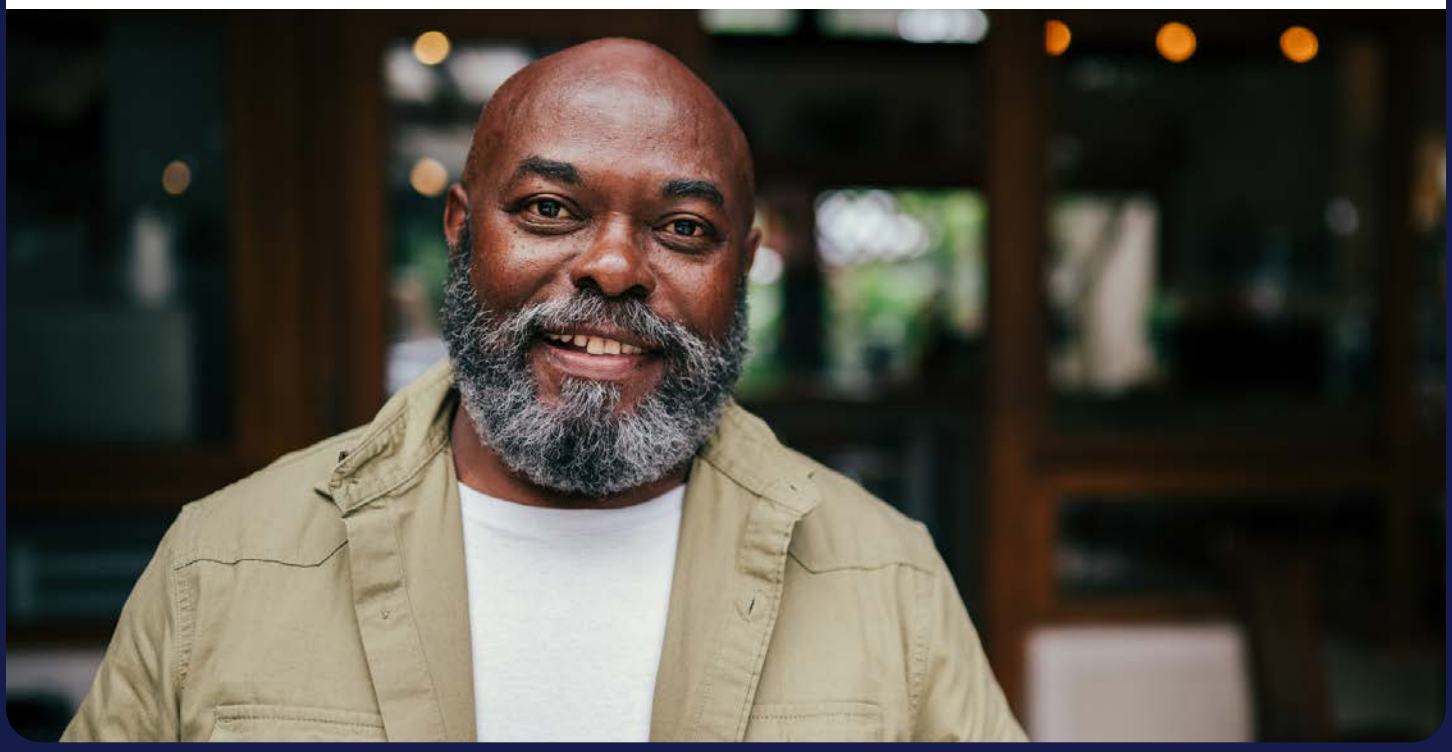
National Comprehensive Cancer Network®

2026

NCCN Guidelines for Patients®

Cancer care recommendations from leading experts at the National Comprehensive Cancer Network® (NCCN®)

Small Bowel Adenocarcinoma



Made possible by

National Comprehensive Cancer Network® Foundation

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NCCN Guidelines for Patients®

The essential guide for people facing cancer.

Based on care recommendations from leading cancer experts.

Explains high-quality cancer care provided at state-of-the-art cancer centers.

Reviewed and revised every year.

Did you know that top cancer centers across the United States work together to improve cancer care? This alliance of leading cancer centers is called the National Comprehensive Cancer Network® (NCCN®).

Because cancer care is always evolving, NCCN develops and frequently updates evidence-based cancer care recommendations used by health care providers worldwide. These recommendations are known as the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®).

The NCCN Guidelines for Patients plainly explain these expert recommendations, so you can talk with your care team about the best care for you.

These NCCN Guidelines for Patients are based on the NCCN Guidelines® for Small Bowel Adenocarcinoma, Version 2.2026 — April 7, 2026.

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About small bowel adenocarcinoma

5 What is small bowel adenocarcinoma?

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Many cancers that start in the small bowel (also called the small intestine) are adenocarcinomas. Small bowel adenocarcinomas are usually found because they cause problems and symptoms as they grow, including abdominal pain, nausea and vomiting, and changes in bowel movements.

What is small bowel adenocarcinoma?

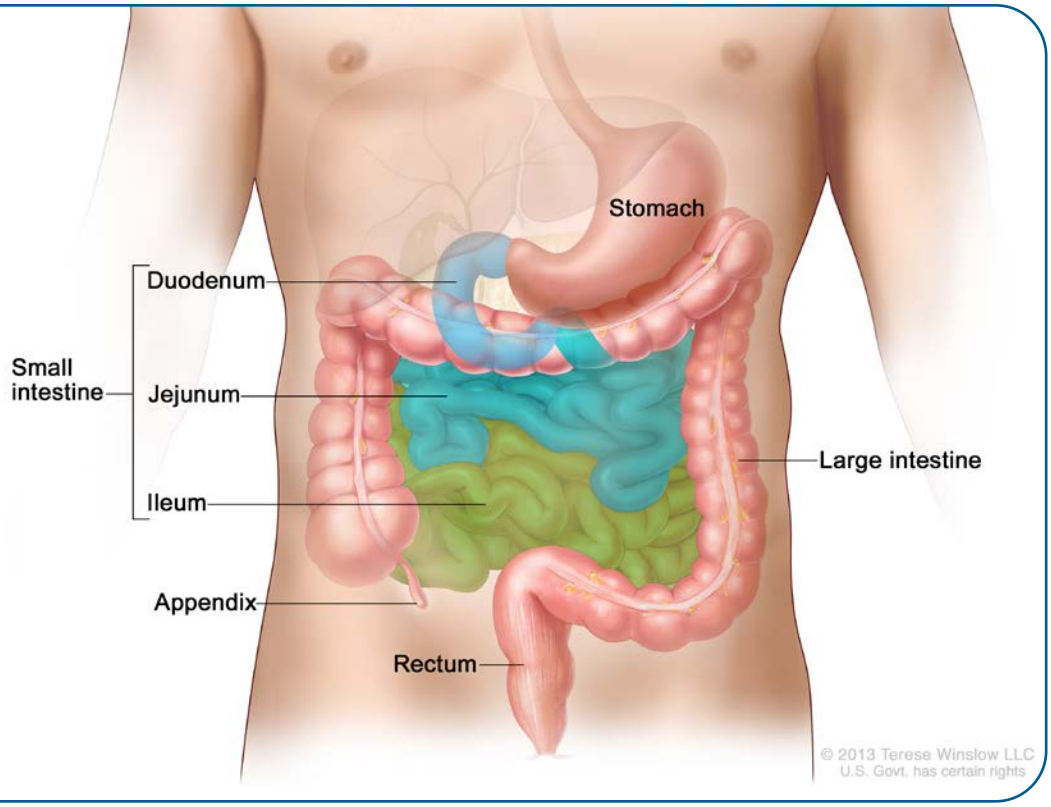
Small bowel adenocarcinoma is a disease that forms in the small intestine, an organ in your digestive system. After food leaves the stomach, the small intestine breaks it down and extracts the nutrients your body needs.

This cancer starts when microscopic cells on the inner lining of your small intestine undergo a change. The (now abnormal) cells start constantly making copies of themselves. Over time, there are so many abnormal cells that a lump called a tumor develops.

If not found and treated early, the cancer will grow through all the layers of the bowel wall and into organs and tissues in the abdomen. Cancer cells can also break off from the tumor

The small bowel

Most small bowel adenocarcinomas start in the duodenum. The rest start in the jejunum, or less often, in the ileum.



and spread in your blood or lymphatic fluid to nearby lymph nodes or to more distant organs.

Does small bowel adenocarcinoma cause symptoms?

Yes. Tumors that start in the first section of the small bowel (the duodenum) can block food from passing between the stomach and the rest of the small bowel. This causes vomiting because the food doesn't have anywhere to go.

Tumors that form in the lower sections of the small bowel can cause nausea, vomiting, constipation, cramping, and abdominal pain.

Gastrointestinal (GI) bleeding is also common in people with a small bowel adenocarcinoma. The loss of blood causes fatigue, weakness, pale skin, and other symptoms. This is called iron deficiency anemia.

Who gets small bowel adenocarcinoma?

A risk factor is something that increases your risk of developing a health problem. Risk factors for small bowel adenocarcinoma are explained next.

Inflammatory bowel disease and celiac disease

Inflammatory bowel disease (IBD) is a group of health problems that cause long-term swelling and damage in the digestive tract. Ulcerative colitis and Crohn's disease are types of IBD.

There is a known link between IBD and large bowel (colorectal) cancer. Research suggests that IBD also increases the risk of cancer in the lower sections of the small bowel, especially the ileum.

People with celiac disease may also be at increased risk of small bowel adenocarcinoma.

Inflammatory bowel diseases, such as ulcerative colitis and Crohn's disease, may raise the risk of cancer in the lower sections of the small bowel. People with celiac disease may also be at higher risk of small bowel adenocarcinoma.



In people with this condition, eating gluten (a protein in certain grains) causes an immune reaction. Symptoms can include diarrhea, bloating, and gas.

Hereditary cancer syndromes

Some rare conditions that affect families increase the risk of small bowel cancer. These hereditary conditions include Lynch syndrome, Peutz-Jeghers syndrome, and familial adenomatous polyposis. These rare conditions are discussed more in the next chapter.

Lifestyle factors

There isn't much data on lifestyle factors that increase the risk of developing small bowel adenocarcinoma. As is the case for many cancers, drinking alcohol, using tobacco, and certain eating habits may increase your risk.

Food and diet-related risk factors include not getting enough fiber, eating a lot of red or processed meats, and drinking sugary drinks.

What is the treatment for small bowel adenocarcinoma?

When it can be done safely, resection (surgery) is the recommended treatment to remove a small bowel adenocarcinoma that hasn't grown beyond the small bowel. Depending on the cancer stage (determined during surgery) and other factors, treatment with systemic therapy (anti-cancer medicines) may follow surgery.

If the cancer has already spread to the liver, lungs, or abdominal lining at diagnosis, it's stage 4 (metastatic). Surgery is rarely an option, and most people start systemic therapy. Testing the tumor for biomarkers (targetable features) helps determine which systemic therapies may work best.

What's in this guide?



Testing the tumor for an important feature called mismatch repair deficiency (dMMR) or microsatellite instability (MSI-H)



Developing a care plan based on whether the cancer is dMMR or MSI-H, and other testing results



Treatment for all stages of small bowel adenocarcinoma



Survivorship

How can I get the best care?

Advocate for yourself. You have an important role to play in your care. Many people feel more satisfied when they actively take part in planning their cancer care.

The NCCN Guidelines for Patients will help you play a larger role in your care. Discuss the recommendations in this guide with your care team. Ask questions about your options and share your goals and concerns.

Don't know what to ask? You're not alone. That's why we include suggested questions to ask at the end of chapters.

Keep reading to find the best care for you.

How this guide can help you

Making decisions about cancer care is stressful. There's a lot to learn, and you don't know what the future holds.

Use this guide to get the information and support you need.

Patients, doctors, and other health care professionals trust the NCCN Guidelines for Patients. This guide uses clear, everyday language to explain current cancer care recommendations made by respected experts in the field. Their recommendations are based on the latest research and practices at leading cancer centers.

Your health is unique to you, so your cancer care should be, too. As you read this guide, you'll learn which treatments are likely to provide the best results for you. And you'll be better prepared to talk with your care team.

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2 Testing for small bowel adenocarcinoma

This chapter discusses the tests used to diagnose small bowel adenocarcinoma and to design your treatment plan after diagnosis. All small bowel adenocarcinomas should be tested for mismatch repair deficiency (dMMR) or microsatellite instability (MSI-H). Cancers with either of these features have a high number of mutated (changed) genes and respond differently to bowel cancer treatments.

If you have symptoms of small bowel adenocarcinoma (vomiting, nausea, constipation, cramping, abdominal pain, fatigue), the tests described in this chapter are recommended. Also see **Guide 1.**

Guide 1
Tests to diagnose small bowel adenocarcinoma and make your treatment plan

Tests for diagnosis and planning your care

- CT of your chest, abdomen, and pelvis
- Esophagogastroduodenoscopy (EGD), if your doctor suspects the tumor is in the first part of the small bowel (the duodenum)
- Testing the tumor to determine mismatch repair (MMR) or microsatellite instability (MSI) status
- Determining your risk of hereditary cancers and syndromes, and possibly genetic testing
- Blood tests: Complete blood count (CBC), comprehensive metabolic panel (CMP), tumor markers (CA 19-9 and CEA)
- A check of your mental wellness and distress level

Other tests or care you may receive, if needed

- MRI of your abdomen and pelvis (if CT images are unclear)
- Balloon enteroscopy (if there is scar tissue blocking areas of the bowel your doctor needs to see)
- Capsule endoscopy, if a problem is suspected but can't be seen using other methods
- Testing for DPD deficiency, if your treatment plan includes chemotherapy
- Help to quit smoking
- Family planning and options for preserving fertility

Imaging

Imaging tests can show areas of cancer inside your body. A radiologist interprets the images and conveys the results to your oncologist. Your care team will tell you how to prepare for your scans.

CT

CT is the main imaging test used to learn the extent of small bowel cancer in the body. CT scans of your chest, abdomen, and pelvis are recommended. This is roughly the area from your shoulders to your groin.

A substance called contrast is usually used to make the pictures clearer. It may be injected into your vein, mixed with a liquid to drink, or both. If you've had an allergic reaction to contrast in the past, you may be given or asked to take a steroid and an antihistamine medication (like Benadryl) before the scan.

During the scan, you'll lie face-up on a table that moves through a short, tunnel-like machine. You will be able to hear and talk to the technician at all times.

MRI

MRI isn't often used to plan treatment for small bowel cancer. Your doctor may order an MRI of your abdomen and pelvis if the CT images are unclear or if you can't have the contrast used for CT.

Compared to a CT scan, MRI takes longer and the tunnel is narrower. Tell your team if you get nervous in small spaces. They can give you a sedative (medicine) to help you relax.

CT is the main imaging test used to see a small bowel tumor and check for cancer in major organs. Your doctor will order CT scanning of your chest, abdomen, and pelvis. This is roughly the area from your shoulders to your groin.

CT is the main imaging test used to see a small bowel tumor and check for cancer in major organs. Your doctor will order CT scanning of your chest, abdomen, and pelvis. This is roughly the area from your shoulders to your groin.



Endoscopy procedures

Endoscopy is an important tool in the diagnosis of small bowel adenocarcinoma. It allows your provider to see inside the small bowel and remove tissue samples for testing (a biopsy).

Endoscopy involves inserting a thin, tube-shaped tool called a scope into the body. The scope is guided through a natural opening, usually the mouth. One end of the scope has a small light and camera lens.

Types of endoscopy that may be used for small bowel adenocarcinoma are described next. Your care team will explain if and how you need to prepare for these procedures.

EGD

An esophagogastroduodenoscopy (EGD) is recommended for suspected tumors in the first part of the small bowel, the duodenum. EGD allows your provider to look for signs of cancer or other issues, such as enlarged blood vessels or ulcers. While you're sedated, an endoscope is guided down your throat, through your esophagus and stomach, and into your duodenum.

If it's unclear whether the tumor is in the small bowel or in a connecting organ (such as the head of the pancreas), endoscopic ultrasound (EUS) may be used during EGD. It can also be used if the extent of the cancer is unclear based on other imaging, or to biopsy areas outside the bowel (like nearby lymph nodes).

EGD usually takes less than an hour. You can go home the same day. Your throat may feel sore or swollen afterward. Ask your doctor about ways to relieve throat pain after endoscopy.

Balloon enteroscopy

Over time, inflammatory bowel disease (IBD) can cause scar tissue to form in the lining of the bowel. This causes the bowel to narrow in certain areas. This narrowing is called a stricture. Balloon enteroscopy can be helpful when there are strictures.

Balloon enteroscopy is performed while you are sedated. Using a long, thin tube (enteroscope) with a high-resolution camera at the tip, your gastroenterologist guides the scope either down your throat or up your anus to reach the small bowel.

Small balloons attached to the scope inflate and deflate. This allows the gastroenterologist to see and biopsy areas that would otherwise be blocked.

Capsule endoscopy

When a problem in the small bowel is suspected but can't be seen using imaging or other types of endoscopy, capsule endoscopy may be helpful.

This procedure involves swallowing a capsule with a tiny camera inside. While the capsule travels through your digestive tract, the camera takes thousands of pictures and transmits them to a device. The device turns the pictures into a video that your provider can view.

Biopsy and tissue testing

The tissue samples and lymph nodes removed during endoscopy are sent to a lab for testing. An expert called a pathologist examines the samples to see if there are cancer cells. If there are, the pathologist determines the cancer type and other details about the cancer.

Mismatch repair testing

All small bowel adenocarcinomas should be tested for mutations (changes) in genes that normally find and fix damaged DNA, called mismatch repair genes. Testing involves analyzing a piece of the tumor (removed during a biopsy or surgery) in a lab.

Depending on the testing method used, an abnormal result is called either mismatch repair deficiency (dMMR) or microsatellite instability (MSI-H). These cancers have a high number of mutated (changed) genes and respond differently to standard treatments.

If the cancer is dMMR or MSI-H, you will be tested for an inherited condition called Lynch syndrome.

Most small bowel cancers don't have either of these features and are described as mismatch repair proficient (pMMR) or microsatellite stable (MSS).

Family health history

Most small bowel adenocarcinomas occur for unknown reasons. But some people are born with a gene difference that makes them more likely to develop bowel and other cancers. These are called inherited cancer syndromes.

People born with Lynch syndrome, for example, are at high risk of developing colorectal, endometrial, and ovarian cancers. Lynch syndrome is caused by inherited differences in the MMR genes. For cancers

"I learned that getting a second opinion had nothing to do with trusting my doctor. It was the process of getting all the information I needed to make the best decisions for my treatment."



found to have the dMMR or MSI-H biomarker, testing for Lynch syndrome is recommended.

Peutz-Jeghers syndrome is a condition that causes polyps to form in the middle and lower sections of the small bowel (the jejunum and ileum). Small bowel adenocarcinoma can start in these polyps, putting people with this syndrome at risk.

Familial adenomatous polyposis (FAP) is a rare inherited cancer syndrome that causes many polyps to form in the colon and rectum, and rarely in the small bowel. The polyps start as benign growths, but over time can become invasive cancers.

Genetic testing for hereditary cancer risk

If your provider thinks you may have an inherited cancer syndrome, they will order a blood or saliva test. A pathologist tests the sample for **germline** (hereditary) gene differences that cause these syndromes.

Speaking with a genetic counselor is recommended for any positive genetic testing result. This expert can talk with you and your family about what the result means for you.

Blood tests

Blood tests alone can't confirm small bowel adenocarcinoma, but abnormal results may suggest a problem.

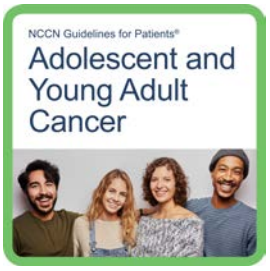
General health

A complete blood count (CBC) measures the number of white blood cells, red blood cells, and platelets in a blood sample. White blood cells help you fight infection. Red blood cells carry oxygen throughout the body. Platelets help wounds heal by forming blood clots.

A chemistry profile, also known as a comprehensive metabolic panel (CMP), is a group of tests that shows how well your kidneys, liver, and other organs are working.

Tumor markers

Cancer antigen 19-9 (CA 19-9) and carcinoembryonic antigen (CEA) are proteins normally made by digestive organs. They can be detected and measured in blood. People with small bowel adenocarcinoma tend to have more of these proteins than normal.



Fertility and family planning

If you want the option of having children after treatment, talk to your care team about any fertility-related risks of your treatment plan. They can also refer you to an expert to learn about your fertility preservation options.

See *NCCN Guidelines for Patients: Adolescent and Young Adult Cancer* at NCCN.org/patientguidelines and on the NCCN Patient Guides for Cancer app for more information.

When caused by cancer, high levels of these tumor markers at diagnosis often mean a higher cancer stage. Your care team will take these levels into account when planning treatment. Levels may be checked to see if they are changing.

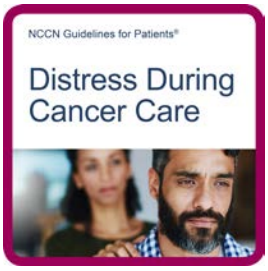
Tumor marker levels can't be used alone to diagnose small bowel adenocarcinoma, for a few reasons. High levels can be caused by other health conditions. Some people with small bowel cancer have normal levels. And, some people don't make CA 19-9 naturally.

Testing for DPD deficiency

Capecitabine and fluorouracil (5-FU) are chemotherapy medicines called fluoropyrimidines. They are often used to treat small bowel adenocarcinoma. Your body uses a special enzyme (protein) called DPD to break down these medicines so they can work properly and leave your body safely and efficiently.

Around 1 in 15 people inherit a difference in the gene that makes DPD, the *DPYD* gene. This leads to less DPD protein being made, called DPD deficiency. In these people, fluoropyrimidines can build up to the point of causing severe and sometimes life-threatening side effects, referred to as fluoropyrimidine toxicity.

Signs and symptoms often start within several days of the first fluoropyrimidine treatment. Symptoms include mouth sores, abdominal pain, blood in the stool, nausea, vomiting, and diarrhea. The skin on the palms of your hands and soles of your feet may start peeling and become red, swollen, and painful. Other



It's okay to ask for help

Ask for help if you are feeling sad, scared, helpless, angry, anxious, or any emotions that can come with a cancer diagnosis. Your care team should ask about these symptoms of emotional distress and others. It’s a recommended part of cancer care. If they don’t, speak up.

For more information about cancer and distress, see *NCCN Guidelines for Patients: Distress and Cancer Care* at NCCN.org/patientguidelines and on the NCCN Patient Guides for Cancer app.



possible side effects include shortness of breath and hair loss.

If you develop any of these symptoms in the days after receiving capecitabine or 5-FU, contact your care team right away. There is a U.S. FDA-approved treatment for this uncommon side effect of fluoropyrimidines.

If treatment with a fluoropyrimidine is planned, talk to your provider about fluoropyrimidine toxicity. After understanding your risk, you may choose to have genetic testing to learn if you have a gene variant that causes DPD deficiency.

Key points

- CT is used to see the extent of small bowel cancer in the body. If you can't have the contrast agent for CT or if the images are unclear, MRI may be used to view your abdomen and pelvis.
- Endoscopy allows your provider to see and biopsy the small bowel. Esophagogastroduodenoscopy (EGD) is recommended for suspected cancers in the duodenum. Endoscopic ultrasound (EUS) may be used to confirm the location or extent of a duodenal tumor, or to guide biopsies of areas outside the bowel.
- Balloon enteroscopy may be used when the bowel is too narrow to access with a scope. Capsule endoscopy may be helpful if other imaging and endoscopy procedures can't find the problem.
- Biopsies or other tumor tissue tests are needed to diagnose small bowel adenocarcinoma.
- All small bowel adenocarcinomas should be tested for mismatch repair deficiency (dMMR) or microsatellite instability (MSI-H). If the tumor has either of these biomarkers, genetic testing of your blood or saliva for Lynch syndrome is recommended.
- Small bowel adenocarcinoma is linked with other rare hereditary cancer syndromes. Depending on your family health history, your provider may refer you to a genetic counselor for guidance and possibly genetic testing.

Questions to ask

- Does the cancer have the dMMR or the MSI-H biomarker?
- What if I am pregnant now, or hope to be in the future?
- Is it worth it to go through treatment?
- My doctor said I need fluoropyrimidine chemotherapy. Is it safe, and should I be tested for DPD deficiency?

3
Treatment for all stages

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When possible, surgery is recommended for small bowel adenocarcinoma that hasn't spread to the liver, lungs, or abdominal lining. Systemic therapy may follow surgery. Metastatic cancer is usually treated with systemic therapy. Consider receiving treatment for this uncommon cancer as part of a clinical trial, if available.

Non-metastatic cancer

Treatment with resection (surgery) is recommended if the cancer can be safely and completely removed. For tumors in the duodenum, a Whipple procedure is typically recommended. Tumors in the lower sections of the small bowel are removed using segmentectomy. These procedures are discussed below.

For a large tumor with mismatch repair deficiency (dMMR) or microsatellite instability (MSI-H), your doctor will consider immunotherapy to try to shrink the tumor before surgery. Immunotherapy is a type of systemic therapy that activates your immune system to fight the cancer. Recommended checkpoint inhibitors are listed on page 25 in Guide 5.

If you aren't a candidate for surgery, you'll begin treatment with systemic therapy (anti-cancer medicines). See the next page for details.

Whipple procedure

Most small bowel adenocarcinomas start in the duodenum. A Whipple procedure (pancreaticoduodenectomy) is usually recommended for cancers in the duodenum, especially if the tumor has grown into any part of the pancreas or common bile duct.

During a Whipple procedure, the surgeon removes the following:

- Part of the small bowel, part of the pancreas, and part of the common bile duct
- Gallbladder
- All nearby lymph nodes
- Sometimes part of the stomach and parts of blood vessels

Reconstruction starts with attaching the pancreas and bile duct to the middle part of the small bowel (the jejunum). Then, either the stomach or duodenum is attached farther down on the jejunum. Blood vessels may need to be reconstructed.

Segmentectomy

This type of surgery is recommended for cancers in the middle or last section of the small bowel. It is also used for cancers in the duodenum that don't require a Whipple procedure.

Your surgeon will remove the tumor and 5 to 10 centimeters (about 2 to 4 inches) of normal-looking tissue on either side of it. The normal-looking tissue is called the surgical margin. They will also remove the lymph nodes closest to the tumor and any others nearby that look suspicious.

Staging

The tissue and lymph nodes removed during surgery are sent to a lab for testing. A pathologist assesses how far the cancer has grown within the bowel wall and assigns the cancer a stage of I (1), II (2), or III (3). This process is called surgical staging.

The stage is used to determine whether chemotherapy is needed.

- **Stage 1** cancer has grown into the second or third (muscle) layer of the intestine wall.
- **Stage 2** cancer has grown through the muscle layer of the intestine wall and possibly into nearby tissues or organs.
- **Stage 3** cancer has spread to nearby lymph nodes.

Systemic therapy after surgery

Treatment with systemic therapy (anti-cancer medicines) may be recommended after surgery. This is called **adjuvant therapy.** The goal is to kill microscopic cancer cells remaining in the body.

Adjuvant therapy isn't helpful for all small bowel adenocarcinomas after surgery. Whether it's recommended depends on the cancer stage (determined by surgery) and the cancer's mismatch repair (MMR) status.

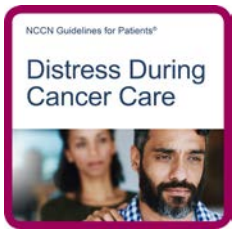
The following treatment information applies to adenocarcinomas located in any section of the small bowel.

Chemotherapy side effects

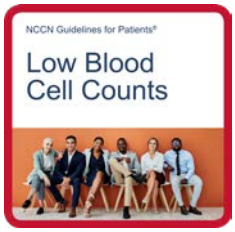
Common side effects of chemotherapy include hair loss, mouth sores, nerve damage, nausea, vomiting, low blood cell counts, and others.

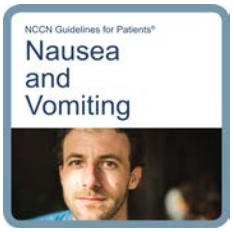
Ask your care team about ways to prevent or relieve side effects. For example, wearing frozen gloves and booties during chemotherapy infusions may lessen nerve damage in the hands and feet. Similarly, wearing a cooling cap on your scalp during infusions may prevent or lessen hair loss.

More information on supportive care is available at NCCN.org/patientguidelines and on the NCCN Patient Guides for Cancer app.









pMMR or MSS cancers

Observation is recommended for all **stage 1** mismatch repair proficient (pMMR) or microsatellite stable (MSS) cancers.

Chemotherapy may (or may not) be recommended for a **stage 2** pMMR or MSS cancer. Your doctor will consider the sub-stage (2A or 2B) and whether the tumor has features that often lead to recurrence. Discuss your options with your care team and make an informed decision together.

Adjuvant chemotherapy is recommended for all **stage 3** pMMR or MSS cancers. You'll receive one of the regimens in **Guide 2.**

For some stage 2B and 3 cancers, radiation therapy may be given before or after chemotherapy with either capecitabine or

Guide 2
Chemotherapy you may receive for small bowel adenocarcinoma

FOLFOX (Leucovorin, Fluorouracil, Oxaliplatin)
CAPEOX (Capecitabine, Oxaliplatin)
FOLFIRINOX (Leucovorin, Fluorouracil, Irinotecan, Oxaliplatin)
Fluorouracil (5-FU), Leucovorin
Capecitabine

- Most of the above regimens may be given before or after surgery (if needed). FOLFIRINOX may be given before, but not after, surgery.
- Chemotherapy is given in cycles of treatment days followed by rest days. Cycles vary in length depending on which drugs are used.
- Any regimen that has OX in the name includes the drug oxaliplatin. Oxaliplatin can cause potentially permanent nerve damage (called neuropathy) in the fingers and toes. Symptoms include numbness, cramping, tingling, or pain in these areas.
- Any regimen that has IRI in the name contains the drug irinotecan. Irinotecan tends to cause abdominal cramping, nausea, diarrhea, and hair loss.
- If regimens containing oxaliplatin are expected to be too harsh, your doctor may recommend fluorouracil/leucovorin or capecitabine alone. While they are milder, these regimens also have side effects. Capecitabine can cause hand-foot syndrome. Symptoms include redness, swelling, and pain on the palms of the hands, bottoms of the feet, or both. Sometimes blisters appear.

fluorouracil. Your doctor will consider radiation if cancer cells were found in the normal tissue surrounding the tumor (the surgical margin).

dMMR or MSI-H cancers

Observation is recommended for stage 1 and stage 2A mismatch repair deficient (dMMR) or microsatellite instable (MSI-H) cancers.

Adjuvant therapy is often recommended for stage 2B dMMR or MSI-H cancers, but observation is also an option. If adjuvant therapy is planned, oxaliplatin-based chemotherapy (either FOLFOX or CAPEOX) is recommended. The immunotherapy drug atezolizumab (Tecentriq) may be added to your chemotherapy.

Adjuvant chemotherapy with FOLFOX or CAPEOX is recommended for all stage 3 dMMR or MSI-H cancers. The immunotherapy drug atezolizumab (Tecentriq) may be added to your chemotherapy.

What if I can't have surgery?

If you aren't a candidate for surgery, you'll begin treatment with systemic therapy (anti-cancer medicines). Your options for systemic therapy depend on the MMR status of the cancer.

If the tumor is blocking the flow of stool, the bowel needs to be unblocked (usually with surgery) before systemic therapy is started. For a tumor in the duodenum, a mesh metal tube called a stent may be placed to allow stool to pass.

pMMR or MSS cancers

If the cancer is pMMR or MSS, you'll receive one of the chemotherapy regimens in **Guide 2.**

If chemotherapy works well, surgery may become an option. If the cancer stays unresectable, you will continue the same systemic therapy or switch to a different one.

dMMR or MSI-H cancers

If the cancer is dMMR or MSI-H, both immunotherapy and platinum chemotherapy are options for non-surgical treatment.

If you are eligible and immunotherapy is planned, recommended checkpoint inhibitors are listed on page 25 in **Guide 5**.

If chemotherapy is planned, platinum chemotherapy regimens for dMMR or MSI-H cancers include FOLFOX, CAPEOX, and FOLFIRINOX.

If the cancer stays unresectable, your doctor may recommend chemoradiation next. Otherwise you will continue the same systemic therapy or switch to a different one.

Surveillance

After surgery (and systemic therapy, if received), surveillance testing is done to check for:

- Late side effects of treatment
- Cancer recurrence
- New areas of cancer growth

Surveillance after treatment for small bowel adenocarcinoma includes physical exams, blood tests, and CT scans. The recommended schedule is shown in **Guide 3.**

People who have inflammatory bowel disease (IBD) or a familial cancer syndrome (like Lynch syndrome) are at high risk of forming more small bowel adenocarcinomas. More intensive surveillance may be needed and might include endoscopy of the small bowel.

In addition to surveillance testing, a range of other care is important for cancer survivors. For more information, see *Chapter 4: Survivorship.*

Guide 3
Surveillance after surgery

Physical exam and blood tests (CA 19-9 and carcinoembryonic antigen)	**Years 1 and 2 after surgery:** Every 3 to 6 months **Years 3, 4, and 5 after surgery:** Every 6 months
CT scanning of your chest, abdomen, and pelvis	**Years 1 and 2 after surgery:** Every 6 to 12 months **Years 3, 4, and 5 after surgery:** Once a year

Metastatic (stage 4) cancer

Metastasis is the spread of cancer cells through lymph or blood to other organs in the body. About 1 in 3 people diagnosed with small bowel adenocarcinoma has stage 4 cancer. This means that the cancer has already spread to the liver, abdominal lining, lungs, or other organs by the time it was found.

Surgery is rarely an option for treating metastatic small bowel adenocarcinoma. Most people receive treatment with systemic therapy. The regimen you receive first is called first-line therapy. Biomarker testing, described next, helps guide the choice of systemic therapy.

Biomarker testing

Small bowel adenocarcinomas are not all the same. Testing the tumor for biomarkers (unique features) helps identify treatments that may work better for your specific cancer and helps avoid treatments that are less likely to help.

When possible, biomarker testing is performed on a piece of tumor tissue removed during a biopsy or surgery. If this isn't an option, a sample of your blood can be tested instead.

All metastatic small bowel adenocarcinomas should be tested for the following biomarkers:

- *RAS (KRAS* and *NRAS*) mutations
- *BRAF* V600E mutations
- HER2 overexpression/amplification
- Mismatch repair deficiency (dMMR) or microsatellite instability (MSI-H)

Testing for many biomarkers at one time is called multigene panel testing (MGPT). This method can find other rare biomarkers for which targeted treatments may be available, including:

- *POLE/POLD1* mutations
- *RET* gene fusions
- *NTRK* gene fusions
- Tumor mutational burden (TMB)

Systemic therapy for pMMR or MSS cancer

Most small bowel adenocarcinomas are mismatch repair proficient (pMMR) or microsatellite stable (MSS). The first type of systemic therapy recommended for metastatic pMMR or MSS cancer is usually chemotherapy.

Most people receive an intensive (strong) combination of chemotherapy medicines. Depending on your age, overall health, and other factors, your doctor may recommend an effective but less harsh regimen. See **Guide 4.**

If you had chemotherapy with FOLFOX or CAPEOX in the past year or so, you shouldn't have more oxaliplatin. It can cause serious nerve damage.

In this case, your options will depend (in part) on whether the cancer has any biomarkers.

Guide 4
First-line systemic therapy options for metastatic pMMR or MSS cancers

Intensive regimens (bevacizumab may be added to any of these)	• CAPEOX includes Capecitabine and Oxaliplatin • FOLFIRI includes Leucovorin, Fluorouracil, and Irinotecan • FOLFIRINOX includes Leucovorin, Fluorouracil, Irinotecan, and Oxaliplatin • FOLFOX includes Leucovorin, Fluorouracil, and Oxaliplatin
Intensive regimen for cancers with a *BRAF* V600E mutation	• FOLFOX and Encorafenib (Braftovi) plus an EGFR inhibitor
Less harsh regimens (bevacizumab may be added to either of these)	• Capecitabine • Fluorouracil and Leucovorin
Options if you had FOLFOX or CAPEOX after surgery in the past year	• FOLFIRI with or without Bevacizumab (Avastin) • Taxane chemotherapy • Targeted therapy, for cancers with *BRAF* V600E mutation or a high number of mutations (TMB-H)

What is bevacizumab (Avastin)?

Bevacizumab is a type of anti-cancer medicine called an angiogenesis inhibitor. It blocks the tumor from forming the new blood vessels it needs to grow.

What is an EGFR inhibitor?

EGFR inhibitors are targeted therapies that block the activity of a specific protein involved in cell growth. They work best in cancers that form in the left side of the colon. Cetuximab (Erbitux) and panitumumab (Vectibix) are recommended EGFR inhibitors.

Systemic therapy for dMMR or MSI-H cancer

For cancers with the dMMR/MSI-H or POLE/POLD1 biomarkers, checkpoint inhibitor immunotherapy is recommended as first-line therapy.

Immunotherapy increases the activity of parts of your immune system. This helps your body find and destroy cancer cells.

Recommended checkpoint inhibitors for people who haven't received immunotherapy are listed in **Guide 5.**

Immune checkpoint inhibitors have unique side effects. Unlike other cancer treatments, the side effects of immunotherapy occur because the immune system is attacking healthy cells. Learning about possible side effects can help you notice reactions early and report them to your care team.

More information on the side effects of immune checkpoint inhibitors is available at NCCN.org/patientguidelines and on the NCCN Patient Guides for Cancer app.



Guide 5
Immune checkpoint inhibitors

Generic name	Brand name
Atezolizumab	Tecentriq
Avelumab	Bavencio
Cemiplimab-rwlc	Libtayo
Cosibelimab-ipdl	Unloxcyt
Dostarlimab-gxly	Jemperli
Durvalumab	Imfinzi
Ipilimumab plus Nivolumab	Opdivo plus Yervoy
Nivolumab	Opdivo
Pembrolizumab	Keytruda
Penpulimab-kcqx	Anikora
Retifanlimab-dlwr	Zynyz
Tislelizumab-jsgr	Tevimbra
Toripalimab-tpzi	Loqtorzi

Supportive care

Supportive care is an important part of cancer care. The goal is to improve your quality of life during and after cancer treatment. Supportive care is for everyone with cancer and their families, not just for those at the end of life.

Supportive care includes a wide range of services. Supportive care prevents or manages the symptoms of cancer and the side effects of cancer treatment, like pain and cancer-related fatigue. It also addresses the mental, social, emotional, and spiritual concerns faced by people with cancer. Supportive care provides help with additional needs, such as:

- Making treatment decisions
- Coordinating your care
- Paying for care
- Planning for advanced care and end of life

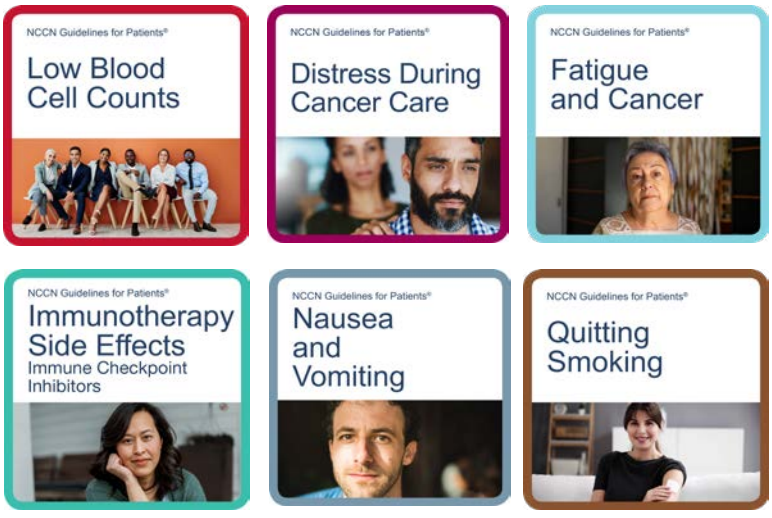
Some health care professionals refer to palliative care as supportive care. They think these types of care are alike or overlap. Others think there are important differences, but both help people with cancer to live as well as they can. Your cancer center may have palliative care specialists, who can give you additional support and help coordinate your supportive care needs.

Read more about the types of support you may receive in *NCCN Guidelines for Patients: Palliative Care,* available at NCCN.org/patientguidelines and on the NCCN Patient Guides for Cancer app.



Supportive care resources

More information on supportive care is available at NCCN.org/patientguidelines and on the NCCN Patient Guides for Cancer app.



Clinical trials

A clinical trial is a type of medical research study. After being developed and tested in a lab, potential new ways of fighting cancer need to be studied in people.

If found to be safe and effective in a clinical trial, a drug, device, or treatment approach may be approved by the U.S. FDA.

Everyone with cancer should carefully consider all of the treatment options available for their cancer type, including standard treatments and clinical trials. Talk to your doctor about whether a clinical trial may make sense for you.

Phases

Most cancer clinical trials focus on treatment and are done in phases.

- **Phase 1** trials study the safety and side effects of an investigational drug or treatment approach.
- **Phase 2** trials study how well the drug or approach works against a specific type of cancer.
- **Phase 3** trials test the drug or approach against a standard treatment. If the results are good, it may be approved by the FDA.
- **Phase 4** trials study the safety and benefit of an FDA-approved treatment.

Who can enroll?

It depends on the clinical trial's rules, called eligibility criteria. The rules may be about age, cancer type and stage, treatment history, or general health. They ensure that participants are alike in specific ways and that the trial is as safe as possible for the participants.



Finding a clinical trial

In the United States

NCCN Cancer Centers
NCCN.org/cancercenters

The National Cancer Institute (NCI)
cancer.gov/about-cancer/treatment/clinical-trials/search

Worldwide

The U.S. National Library of Medicine (NLM)
clinicaltrials.gov

Need help finding a clinical trial?

NCI's Cancer Information Service (CIS)
1.800.4.CANCER (1.800.422.6237)
cancer.gov/contact

Informed consent

Clinical trials are managed by a research team. This group of experts will review the study with you in detail, including its purpose and the risks and benefits of joining. All of this information is also provided in an informed consent form. Read the form carefully and ask questions before signing it. Take time to

discuss it with people you trust. Keep in mind that you can leave and seek treatment outside of the clinical trial at any time.

Will I get a placebo?

Placebos (inactive versions of real medicines) are almost never used alone in cancer clinical trials. It is common to receive either a placebo with a standard treatment, or a new drug with a standard treatment. You will be informed, verbally and in writing, if a placebo is part of a clinical trial before you enroll.

Are clinical trials free?

There is no fee to enroll in a clinical trial. The study sponsor pays for research-related costs, including the study drug. But you may need to pay for other services, like transportation or childcare, due to extra appointments. During the trial, you will continue to receive standard cancer care. This care is often covered by insurance.



We want your feedback!

Our goal is to provide helpful and easy-to-understand information on cancer. Take our survey to let us know what we got right and what we could do better.
NCCN.org/patients/feedback

Key points

- When possible, resection (surgery) is recommended for non-metastatic small bowel adenocarcinoma. Chemotherapy may follow. A Whipple procedure is often used for tumors in the duodenum. Segmentectomy is often used for tumors in the jejunum or ileum.
- After surgery to remove a mismatch repair proficient (pMMR) or microsatellite stable (MSS) tumor, observation is recommended for all stage 1 cancers. Stage 2 pMMR or MSS cancers may be observed or treated with chemotherapy. Chemotherapy is recommended for all stage 3 cancers.
- After surgery to remove a mismatch repair deficient (dMMR) or microsatellite instable (MSI-H) tumor, observation is recommended for stage 1 and stage 2A cancers. Chemotherapy is often recommended for a stage 2B cancer, but observation is also an option. Chemotherapy is recommended for all stage 3 dMMR or MSI-H cancers. An immunotherapy drug may be included.
- All metastatic small bowel adenocarcinomas should be tested for RAS and BRAF gene mutations, HER2 overexpression/amplification, and dMMR/MSI-H. Testing for these biomarkers (features) helps identify treatments that may work better for your unique cancer and helps avoid treatments that are less likely to help.
- Surgery is rarely an option for treating metastatic small bowel adenocarcinoma. Most people start systemic therapy. For cancers with the dMMR or MSI-H biomarker, immunotherapy is recommended as first-line therapy.
- Supportive care is available to help with your symptoms, make you more comfortable, and improve your quality of life.
- Clinical trials provide access to investigational treatments that may, in time, be approved by the FDA. If an investigational treatment proves to be effective, it may become the standard of care.

Questions to ask

- Am I a candidate for surgery? If not, is it possible that I'll become a candidate?
- How likely is recurrence after treatment with surgery?
- Am I a candidate for a clinical trial? Do you know of one I can join?
- Does my cancer have any biomarkers? How does this affect my options for systemic therapy?
- I need chemotherapy. Do you recommend cold therapy during infusions to prevent nerve damage and hair loss?
- Should I make changes to my diet or lifestyle during chemotherapy?

4
Survivorship

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Survivorship focuses on the physical, emotional, and financial issues faced by cancer survivors. Managing the long-term side effects of cancer and its treatment, staying connected with your primary care provider, and living a healthy lifestyle are important parts of survivorship.

Cancer survivors may experience both short- and long-term health effects of cancer and its treatment. The effects depend in part on the treatment(s) received. Surgery, anti-cancer medicines, and radiation therapy all have unique potential side effects.

Your primary care provider

After you finish cancer treatment, your oncologist and primary care provider should work together to make sure you get the follow-up care you need. Ask your oncologist for a written survivorship care plan. Ideally, the plan should include:

- A summary of your cancer treatment history
- A description of possible late- and long-term side effects
- Recommendations for testing for recurrence
- Clear roles and responsibilities for your providers
- Recommendations on your overall health and well-being

Paying for care

Cancer survivors face a unique financial burden. Paying for doctor visits, tests, and treatments can become unmanageable, especially for those with little or no health insurance. You may also have costs not directly related to treatment, such as travel expenses and the cost of childcare or missed work.

The term financial toxicity is used to describe the problems patients face related to the cost of medical care. Financial toxicity can affect your quality of life and access to needed health care. If you need help paying for your cancer care, financial assistance may be available. Talk with a patient navigator, your treatment team's social worker, and your hospital's financial services department.

Nerve damage

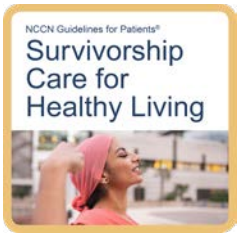
Some chemotherapy drugs, especially oxaliplatin, can damage nerves in your fingers and toes. Called neuropathy, symptoms include numbness, cramping, tingling, and pain in these areas.

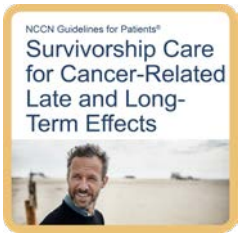
If you have painful nerve damage, duloxetine (Cymbalta) or a gabapentinoid (gabapentin or pregabalin) may help. If the pain is persistent, talk to your doctor about seeing a pain management specialist.

Methods that may help with numbness, cramping, and tingling include acupuncture, heat, ice, and balanced physical activity.

For more information on cancer survivorship, the following are available at NCCN.org/patientguidelines and on the NCCN Patient Guides for Cancer app:

- *Survivorship Care for Healthy Living*
- *Survivorship Care for Cancer-Related Late and Long-Term Effects*





Nerve damage

Nerve damage caused by chemotherapy often starts in the hands or feet. If you have shooting or burning pain, a prescription medicine called duloxetine (Cymbalta) can help.



Healthy habits for cancer survivors



Follow your primary care provider's recommendations for screening for other cancers based on your age and risk level.



Get other recommended health care such as blood pressure checks, hepatitis C screening, and immunizations (like the flu shot).



Eat a diet rich in plant-based foods. Limit red meat and processed foods. A cancer nutritionist can help you optimize your diet **during and after** treatment.



Alcohol can increase the risk of some cancers. Drink little to no alcohol.



Move more, rest less. Try to exercise at a moderate intensity for at least 150 minutes per week.



Maintain a healthy weight. Tracking your weight, diet, calories, and activity levels may help you meet your goals.



Stop using tobacco. Ask your care team about options to help you quit. Counseling and medication are often options.

Key points

- Survivorship describes the physical, emotional, and financial issues unique to cancer survivors. It starts at diagnosis and continues through your lifetime.
- A survivorship care plan is helpful in transitioning your care to your primary care doctor.
- Ideally, your oncologist and primary care provider will work together to provide recommended follow-up care. Nurse navigators can also be a helpful resource.
- If you have concerns about paying for your cancer care, financial help may be available.
- Healthy habits, including exercising and eating right, play an important role in helping to prevent other diseases and second cancers.

Questions to ask

- Can you give me a survivorship care plan? How will you provide it?
- Does this treatment center have a survivorship care program?
- What can I expect during a survivorship care visit?

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Other resources

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36 What else to do

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Want to learn more? Here's how you can get additional help.

What else to know

This guide helps you know your options so you can make informed decisions and improve your cancer care. But it's not the only resource that you have.

Ask for as much information and help as you need. Many people are interested in learning more about:

- Managing side effects
- Genetic testing
- Building a support system
- Lifestyle changes after cancer
- Coping with other health problems

What else to do

Your health care center can help you with next steps. It often has on-site resources to help meet your needs and find answers to your questions. Health care centers can also inform you of resources in your community.

In addition to help from your providers, the resources listed in the next section provide support for many people like yourself.

Where to get help

Look through the list below and visit the provided websites to learn more about these organizations.

Cancer*Care*
cancercare.org

Cancer Hope Network
cancerhopenetwork.org

Colorectal Cancer Alliance
ccalliance.org

GRACE
cancergrace.org

Imerman Angels
imermanangels.org

Love Your Buns
loveyourbuns.org

Triage Cancer
triagecancer.org

U.S. National Library of Medicine Clinical Trials Database
clinicaltrials.gov

Questions to ask

- Who can I talk to about help with housing, food, and other basic needs?
- What help is available for transportation, childcare, and home care?
- Are there other services available to me and my caregivers?



Let us know what you think!

Please take a moment to complete an online survey about the NCCN Guidelines for Patients.
NCCN.org/patients/response



Words to know

adenocarcinoma
A common type of small bowel cancer. Starts in mucus-making cells that line the small bowel.

biomarker
A targetable feature of a cancer that can help guide treatment.

carcinoembryonic antigen (CEA)
A protein that gets released by some tumors and can be detected in blood.

duodenum
The first part of the small bowel. Most small bowel cancers start in the duodenum.

familial adenomatous polyposis (FAP)
An inherited medical condition that increases the risk of bowel cancer.

gene
A sequence of DNA that provides a set of instructions for how your body works and functions.

inflammatory bowel disease (IBD)
A group of health conditions that cause long-term swelling in the digestive tract.

jejunum
The middle part of the small bowel.

large intestine (bowel)
A long tube-shaped organ that forms the last part of the digestive system. Includes the colon, rectum, and anus.

lymph node
Small groups of special disease-fighting cells located throughout the body.

metastasis
The spread of cancer cells from the first (primary) tumor to a distant site.

mismatch repair deficiency (dMMR)/ microsatellite instability-high (MSI-H)
A biomarker (feature) of some bowel cancers used to guide treatment. All small bowel adenocarcinomas should be tested for this biomarker.

mismatch repair proficient (pMMR)/ microsatellite stable (MSS)
Describes cancers without the mismatch repair deficiency (dMMR)/microsatellite instability-high (MSI-H) biomarker.

pathologist
A doctor who specializes in testing cells and tissue to find disease.

polyp
An overgrowth of cells on the inner lining of the bowel wall.

recurrence
The return of cancer after a cancer-free period.

resectable
Describes a cancer that can be safely removed using surgery.

supportive care
Treatment for the symptoms or health conditions caused by cancer or cancer treatment.

surgical margin
The normal tissue around the edge of a tumor removed during surgery.

systemic therapy
The use of medicines that enter the bloodstream. Chemotherapy, targeted therapy, and immunotherapy are examples.

unresectable
Describes a cancer that cannot be safely removed using surgery.

Whipple procedure
Surgery to remove the head of the pancreas and parts of other nearby organs. Also called pancreaticoduodenectomy.



Take our survey and help make the NCCN Guidelines for Patients better for everyone!

NCCN.org/patients/comments

NCCN Contributors

This patient guide is based on the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for Small Bowel Adenocarcinoma, Version 2.2026. It was adapted, reviewed, and published with help from the following people:

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Stanford Cancer Institute
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University of Colorado Cancer Center
Aurora, Colorado

University of Michigan Rogel Cancer Center
Ann Arbor, Michigan

University of Wisconsin Carbone Cancer Center
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NCCN Guidelines for Patients®

Cancer care recommendations from leading experts at the
National Comprehensive Cancer Network® (NCCN®)

Small Bowel Adenocarcinoma



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