

## Living Beyond Cancer

### The Short and Long Term Effects of Colorectal Cancer

**Guest: Dr. Emily Groves and Dr. Carl Schmidt**

**Lauren Hixenbaugh:** Welcome to Living Beyond Cancer. I am Lauren Hixenbaugh, the coalition manager for Mountains of Hope. Living Beyond Cancer is a series of podcasts created for cancer patients, survivors and their caregivers. This series is sponsored by the West Virginia Cancer Coalition, Mountains of Hope, and is produced by the West Virginia University Cancer Institute's Cancer Prevention and Control. Today's topic is the short and long-term effects of colon cancer. Today's guests are Dr. Carl Schmidt, Director and Chief of the Division of Surgical Oncology, and Dr. Emily Groves, a colorectal surgeon in the Department of Oncology at West Virginia University's Cancer Institute. So we will just like to start the day with both of you, kind of telling us what your role is at the Cancer Institute.

**Dr. Emily Groves:** Hey Lauren, thanks for having us. Dr. Groves here. I grew up here in West Virginia. I am one of the colorectal surgeons here at WVU. Just started about just over a year ago, and I am really happy to be back. It is been a long time since I've been in West Virginia. I am traveling the country, learning my trade, and now we are here and what I see is a lot of colon cancer, rectal cancer primarily as well as anal cancer and I see benign conditions as well.

**Lauren Hixenbaugh:** Okay, great. We are so glad to have you back in West Virginia.

**Dr. Carl Schmidt:** I am Carl Schmitt. I work for Dr. Groves. Actually, I hope that's true. I am the Director of our division but I see that role as hopefully helping recruit and retain very talented surgeons like Dr. Groves and then helping her expand her programs for the people in the state. I am fortunate as well to help lead our quality initiatives for the Cancer Institute such that we can make sure we are doing best care in the entire healthcare network for all cancer patients. And one of our biggest areas of focus is colon and rectal cancers, since that's one of the largest cancers by incidence in the country. My clinical practice focuses on tumors in the liver and pancreas; that's a good compliment to Dr. Groves because colon cancers frequently metastasize to the liver.

**Lauren Hixenbaugh:** All right. Thanks for letting us know what you do. Like I said, I am glad you both are here. It is exciting to have two guests today.

**Dr. Emily Groves:** Do you usually only have one?

**Lauren Hixenbaugh:** Yeah, we usually have one. So it was interesting when you asked; we'll see how it goes. I like a challenge. This podcast is primarily for survivors, patients, and their caregivers. So a big term, and it sort of means something different to everybody, is survivorship. So what does survivorship mean to you?

**Dr. Emily Groves:** So I would say survivorship means a lot of things. Like you said, it means something

different to everyone, but for me It is kind of two fold. Once you hear the word cancer, especially pertaining to yourself, everything changes. So from that moment forward, at first, the diagnosis hits you hard but then after that you realize that you have to keep living. You got to go to work. You have to take the kids to school or take care of your parents or whatever it is that's going on in your life. So how do we integrate your cancer treatment and then hopefully subsequent your cancer cure and surveillance afterward into your day-to-day life.

**Lauren Hixenbaugh:** Yes, absolutely. In a lot of these podcasts we have talked about the psychosocial, we will later on talk about the physical effects. But we certainly have talked about what you're kind of bringing up right now, that psychological effect that survivors go through. So do you want to talk a little bit more about that? What are some psychosocial effects that folks that receive colon cancer treatment?

**Dr. Emily Groves:** Well, sure. I mean anyone that receives a cancer diagnosis, there's going to be psychosocial effects, especially with colon cancer specifically, what stage is my cancer? Am I going to do other modalities of treatment. Maybe you have to go see an oncologist beforehand or maybe you're cured with surgery up front and then maybe you find out later you have to do a chemotherapy. Or with rectal cancer, are you going to have to go do radiation five days a week for several weeks. And that can be really impactful in your life right then. And then how will this change, moving forward. I always get the question for psychosocial impact, am I going to have a bag? And I am referring to a colostomy bag. And so I get that question a lot from people can I work with this, can I workout with this and am I going to have this or not? And It is a big hindrance for people sometimes seeking care. They're worried that this may be too impactful on their life. So I get a lot of questions about that.

**Lauren Hixenbaugh:** Yeah, certainly.

**Dr. Carl Schmidt:** I think with colon cancer or any cancer, a lot of the psychosocial effects are centered around fear and loss of control. It is critical for us to understand those feelings and emotions and work that all into how we provide a plan that on our end is evidence-based and hopefully effective but also for the person in their family, one that they have confidence in where they establish trust. And then that gets back to the survivorship question you asked in my opinion also because we have a gap in medicine, but especially in cancer care, that is the sort of scientific viewpoint that we have is do our therapies work and to what level. And then even to the point of when we can make our goals simple for colon cancer, it can be cured. We can cure early stage colon cancer with very high, 90 plus percentile rates, even sort of middle stage colon cancer has a high rate of cure. Now I'd say certainly over 80% and that would depend on certain features. But the middle stage colon cancers though do require a surgical removal of the cancer and chemotherapy and for rectal cancers, radiation as well. So it is putting the person through a lot. And so of course our goal can still be cure with a high rate, but what are the goals of the person and their family and how much are they willing to go through or what can they go through with the financial challenges and travel challenges and in a rural state like ours, those are magnified compared to what most other people have to balance. We don't do the greatest job of putting all of that together and making sure we understand what our goals and priorities are on the treatment team end of it and what the person's goals and priorities are and survivorship programs, especially with the concept that survivorship starts at the diagnosis and not when you complete therapy. A big part of it to

me is bridging that gap of understanding and goals and priorities so that we work together on shared goals that make sense to both. And even the late stage colon cancers have a small chance for cure. But certainly then our goal might be cancer control if we cannot cure, which is can you live with a reasonable quality or good quality for many months to many years. And some can with stage four colon and rectal cancers. But again, what's the cost to the person? So you think about that a lot when you've been doing this for over a decade and Dr. Groves will more and more, as you go through the years.

**Lauren Hixenbaugh:** So you talked a little bit about the long-term effects. Do you want to touch a little bit more on the short and long-term effects that survivors may experience? I know that kind of differs depending on the treatment.

**Dr. Emily Groves:** Sure it can be pretty variable depending upon like we've talked about your cancer and how far along it is, what stage it is. A short term effects can be anything from, if we do a operation to remove a portion of your colon, the short term effects would be recovery from an abdominal operation and depending upon how we do it, that recovery can go more quickly or more slowly and then regaining somewhat normal bowel function afterward. For some folks that happens on the second day after the operation, they're back to having normal bowel movements and things like that. But for other folks it takes a little while. If your colon cancer is further down the line so to speak, closer to the end of your colon, sometimes that can mean changes to your bowel habits for quite some time. So everyone's a little bit different in terms of their postoperative recovery. Now some of the more long-term effects and certainly in a psychosocial manner is more frequent colonoscopies, things like that working around more frequent office visits and things like that. But as you get further away from your cancer and longer into your survivorship, often those types of visits slow down and things return back to normal.

**Lauren Hixenbaugh:** Okay.

**Dr. Carl Schmidt:** I'll jump in and say I think It is important to emphasize that cancer care is complex. There are for instance rectal cancers or particularly low rectal cancers where the use of radiation and the consideration of whether someone will need a permanent or a temporary ostomy or colostomy, and short and long-term side effects from both, from the complicated operation and radiation all come into play and would doubly emphasize the need to be taken care of by specialists. There's just a preponderance of evidence that for those type of situations where again, complications of the cancer itself or the therapies are at higher levels than more simpler cases. The best way to minimize the risk of that for the legitimate hope of getting back to as normal a quality of life as someone can have requires expert care. The surgeon, the medical oncologist, the radiation oncologist and so, and that's a bit of a plug for that particular diagnosis, rectal cancer, since this is going out to patients and families and those interested in the state. That's specialty care at larger hospitals with again, for the surgical part, surgeons who like Dr. Groves have specialty training, use minimally invasive surgical approaches like robotic surgery and who do this every week, several times a month versus people who frankly don't do it as much. Conversely, for many people with colon cancer, the risks are less and there can be much more of a higher expectation that return to normal quality of life without long lasting physical effects should be the norm and that can be accomplished by most qualified surgeons certainly in our state and anywhere. Again, depending on certain patient factors and their overall health and whether the operation is more

complex or not. But that's a good breakdown of in this particular disease, for most colon cancers, I'd say you can expect if we do our job that you'll return to pretty normal quality of life and you may need some medications for this or that. Rectal cancer is different, you need specialty care or your risks of permanent decrease in quality of life are higher than they need to be.

**Dr. Emily Groves:** I think along with that too is if you ask us these questions, we are going to give you a very surgically based answer. So I think if you're a patient going through this kind of multidisciplinary cancer treatment program, ask each of your providers these questions because you're going to get a slightly different answer from each. And then if you ask friends or look for other cancer survivors, they may give you a totally different answer because I think, just like cancer, everybody's different and everyone's going to react differently in terms of long-term effect. Some folks sail right through it and never want to look back and some folks have to have to deal with it on a day-to-day basis. So I think it is just important to remember that everyone's a little different and no one can predict exactly what long-term effects you're going to have. But certainly get opinions from lots of different specialties and specialists and certainly friends that have undergone it. But ultimately everyone is going to react differently.

**Lauren Hixenbaugh:** So what are some of those post-treatment needs? A lot of the physicians that have been on the podcast have talked about like PT and OT. Are those typical needs?

**Dr. Emily Groves:** Certainly, I tell people, if you get your surgery robotically, generally you recover pretty quickly. But oftentimes people get open surgery and that's fine too. The most important thing is getting the cancer out. And then we will get the consequences of whatever type of surgery you have later. So if you are debilitated before surgery, you are going to be debilitated after surgery. So if you were teetering on the edge of needing physical therapy in the first place, you're definitely getting it afterward and certainly everyone gets an assessment from physical therapy.

And some folks, the physical therapists will say, yep, you are checked out, you are good to go. And for some people that's all they need to hear and then they're off to the races, going to the grocery store and doing the things that they need to do. And some folks need a little help. So in terms of barriers, there's physical therapy that we can provide in the inpatient setting as well as occupational therapy. But if you need that kind of continuing physical therapy, we can arrange for someone to come to your house if you qualify for that. Or you can go to a facility close by your home to continue to get physical therapy and other therapies. There's enterostomal therapists who are folks that help if you end up needing a temporary or permanent ostomy. They can help with the adhesion of the appliance and things like that. So there's a lot of different people that help out postoperatively with regaining that quality of life as quickly as possible.

**Lauren Hixenbaugh:** It is important to have that team of people behind you. So one of the things I think you actually, both of you hadn't mentioned it, is kind of communicating what your needs are with your whole team. And so there's been some concern about the lack of linkage between their oncologist and the primary care provider. What would your recommendation be for patients? How do they kind of solve that, patients and their caregivers?

**Dr. Carl Schmidt:** I think that's a great question. It is interesting that communication in medicine I think

has often been rightly criticized for being inadequate. Both communication to people and communication to our partners in primary care, who need to know when their patients have had a critical illness or otherwise a hospitalization requiring care. You would think that the electronic medical record would have fixed all of that.

**Lauren Hixenbaugh:** Yeah, that was a conversation with my last session, yeah.

**Dr. Carl Schmidt:** It really hasn't. And I am not an IT specialist, and so, I am not sure what the barriers are. But I would say I certainly endeavor, as I am sure Dr. Groves does, to send a letter through Epic to the primary care doctor after every visit that outlines what's the current status of our part of care for the patient and then what we think. But so it may be, fax machines don't work or we have wrong numbers or one would hope in 2020 we are not using fax machines I guess.

**Dr. Emily Groves:** Every day. It is going off constantly. It is right by my office.

**Dr. Carl Schmidt:** Right. I wish that could be more personal, but at the same time, in an ideal world you'd have maybe in the least a text message or a personal phone call. But again, the HIPAA law from the feds, interrupts our ability to effectively communicate. And I think Congress would be the first to tell you that they really didn't intend for that consequence of that law. But now I cannot text a primary care doctor. Your patient, Mrs. Smith is doing well after her right liver removal because then I've broken a federal law. So it is all a bit silly. But those are, excuses are like elbows, everyone has one. So we must endeavor to do better.

**Dr. Emily Groves:** Carl, you are surgeon, you know there are two elbows.

**Dr. Carl Schmidt:** That's true. It is because the actual phrase is a different body part. But anyway, so things I think are encouraging though, is the electronic medical record does have the MyChart function. So I think our center is seeing more and more people sign up for MyChart, especially as its capabilities are enhanced for what they can do with it. And as it is available on more devices, phone, tablet, computer, those things are nice. One of our partners, Dr. Hannah Hazard, who leads our breast program and is the Interim Director for the Cancer Center. She has brought this program from one of the cancer hospitals in Boston to us that's enhancing the electronic forms of communication between our postoperative patients and us and our care teams. So the more that we can use technology to effectively communicate with the patient, then they have the information. And again, I do not like to put the burden on them to share things with their PCP. We should do that. But it is one avenue and I've for years given people a physical copy of their pathology report from a cancer operation. And I always say, your PCP should have access to this, but if you happen to be in their office and they say, I do not have any records, at least this is a start, because that often tells a lot, the pathology report. And then sometimes it is just on my own, kind of remembering, oh this PCP is not in the network, they don't have Epic. And I'll instruct my team, please send the pertinent information, which is usually just my latest note. Maybe this imaging report, pathology report to the PCP. So the effort should still be largely on our part to make sure that communication happens. But, still, it is a challenge.

**Dr. Emily Groves:** Yeah. I think we are working on documentation, like Dr. Schmidt said, where we can hand the patients something that kind of summarizes your cancer care mostly for you, but also sending that document to your primary care doctor or your primary care provider. We know not everyone has a primary care doctor and so that document can be really helpful, not necessarily to tell providers what to do, but just to warn them, hey, every three to six months, this patient is going to need a small bit of blood work and perhaps a scan. Certainly I would like to see them. So it just kind of gives the primary care provider a schedule of what's going to happen. Like Dr. Schmidt said, I hate putting that on the patient when I give them that piece of paper. But at least this one document exists that can be passed around. I obviously try to send the primary care folks a summary of care as well.

**Lauren Hixenbaugh:** That's helpful, especially when the care provider, is often a family member or something, not a health care provider. The caregiver is a family member and something like that is helpful for them. They may not understand some of the terms but they can say here's what I received from their doctor and give it to them. I think that's really helpful.

**Dr. Emily Groves:** But I think it is always important to be persistent and for some reason you haven't heard from another doctor or doctors haven't been in communication with one another. Certainly I would say all providers throughout the state are willing to talk to each other and it is mostly about getting hold of one another if the electronic medical record is not there, like we discussed. So certainly everybody's approachable and can be contacted. It is just about making it happen.

**Lauren Hixenbaugh:** Yeah.

**Dr. Carl Schmidt:** We have had some exciting meetings with the cancer prevention and control teams and leadership here that the actual physical document of a cancer treatment summary was an idea that the Commission on Cancer (CoC) from the American College of Surgeons proposed several years ago. And hospitals have struggled with this because although the idea of it, which is just a short summary primarily for the patient and the primary care doctor to be completed in the medical record at the completion of initial cancer care is a great idea. However, the problem for most hospitals I think is who does it, because we do typically, we do notes in the chart and other things. And so adding another one for that express purpose was again, just like who does it? However, what we are working on here is to say that's a great idea and we can go way beyond the basic requirement from the CoC to do that and we can do it better. So what the group's idea has been is one to have for maybe our 15 or 20 major cancers, to have that document be very specific to that cancer. So it asks specific questions for a survivorship assessment to determine what other needs, like you asked about earlier, besides PT, OT, can it be psychosocial needs, financial needs, all kinds of things can be assessed. Again, not just at the end, but ongoing. So this can be a living document in the record that's specific to the cancer for the unique needs in that group, where again, all of that can be done in real time. And then I think it won't be kind of who works on that document. It'll be that multiple people work on it because it is again, an integral part of their care throughout treatment and afterwards. So that's been an exciting thing. We have actually worked on colon cancer as one of the early pilots for that goal to make the cancer treatment summary unique to the cancer. And again, a document that helps us all. But then as Dr. Groves said, when it is all wrapped up, that should still be a succinct enough overall document that is very useful to the person and the PCP because it'll say this is the cancer you had, this is the stage, this was the treatments you

had, this is the team members that are your team. And then this was the assessment as you were going through it, what we thought we could help with besides just treatment and again, what were the resources for that. So that's an exciting thing that hopefully WVU can be an example of how you can take a basic requirement from a national leader and make it even better.

**Lauren Hixenbaugh:** That's an exciting development for sure. So one of the things you are sort of talking about here is resources for patients. So what are some resources that you recommend?

**Dr. Emily Groves:** So I think if you are a listener who's found this podcast, you're probably relatively technically savvy. There are tons of forums out there in terms of cancer survivorship that you can find. You can do that through the American Cancer Society website, in other places. And you can probably speak Lauren to more about the Mountains of Hope initiative.

**Lauren Hixenbaugh:** Yeah. So Mountains of Hope is the cancer coalition, West Virginia State's cancer coalition. And we do have a website and it is [moh.wv.gov](http://moh.wv.gov) and you can find out all sorts of different information, but mainly we are the author of the West Virginia cancer plan. So there's a lot of information there. And then there's a tab on our website for resources and then you can always shoot us an email, give us a call and we can help answer some questions too. So my last question for you guys is always my favorite and because I think it is a sort of a loaded question and you guys get to answer how you want, which is what are common questions that you get from your patients?

**Dr. Emily Groves:** Oh, since I kind of deal with a pretty sensitive subject area of the body, I get a lot of kind of funny questions or a lot of, I'll say marital arguments happen in my office. Like somebody forced somebody else to get a colonoscopy and aren't they glad that they did. And I told you. And so the actual office visits can get kind of entertaining despite the sour subject of cancer. So those are always fun, just listening to people bicker, tells me they have got a good relationship. But I get a lot of questions. Probably my number one question when someone finds out that they have to have surgery for colon cancer is am I going to have to have a bag? And I would say the answer for a lot of people is no. I think more people think that they are going to have to have one then actually end up with one. And I think it is a big barrier. It makes folks not want to come in and it makes folks kind of hesitant to deal with the diagnosis. So I will say that relatively few of my cancer patients end up with permanent colostomies. But that seems to be a kind of high level topic of discussion. And then I get a lot of, is my hair going to fall out with chemo? I mean, I am a surgeon, but I know that with the chemo that we give, it is not that type of chemo generally for colon cancer.

**Lauren Hixenbaugh:** And I think that's good for people to know, that there's different types of chemo.

**Dr. Emily Groves:** Oh sure. Yeah. I mean there's so many different types.

**Lauren Hixenbaugh:** Sometimes, It is all kind of all lumped into one thing.

**Dr. Emily Groves:** Probably the primary complaint I get, and maybe you'll talk to oncologists as well, but one of the chemotherapy agents that if you happen to have node positive disease and you need chemotherapy, gives you kind of numbness and tingling it at your fingertips. That's probably the one

complaint I get the most from folks. But yeah, a lot of the questions are kind of centered around colostomy bags. Continence is also a huge question. So it is, you can put me together, but is that going to be something that I am going to want? So some people, if you are incontinent all of the time, then maybe you want that colostomy bag. That may be a better quality of life for you than what you have right now.

**Lauren Hixenbaugh:** What does the quality of life look like? I have a very limited knowledge of a colostomy bag.

**Dr. Emily Groves:** So there are folks that have colostomy bags that I guarantee you know, but you don't know they have a bag. So it is not something that's obvious in day-to-day interactions necessarily. And once you learn how to change the appliance effectively, the appliances can stay on for several days at a time. So that becomes less cumbersome because I think people are worried that it is always going to leak or they are always going to have troubles with it. So I think that you will find that you probably know a lot more people with bags than you think you do just because it can be so discreet, but it can be frustrating.

**Lauren Hixenbaugh:** Yeah.

**Dr. Emily Groves:** Certainly right off the bat, it is a learning process. It is learning a new limb essentially. But everyone gets the hang of it eventually. Very few people just cannot do it.

**Lauren Hixenbaugh:** The quality of life is relatively positive?

**Dr. Emily Groves:** Oh yeah, yeah. You can do the things you like to do, walk, workout, whatever it is that you like to do before the colostomy, we can get you to doing those things afterward.

**Lauren Hixenbaugh:** Yeah, I think that probably eases some people's fear. That's great.

**Dr. Emily Groves:** Right. Absolutely.

**Dr. Carl Schmidt:** I was thinking about your question too, what are common questions that I get. And I will be honest, some of the most common questions I don't know the answer to. One of those is, well what caused this? And it is actually true for most cancers that we cannot sit with you and explain that we know of a definitive cause. Some exceptions would be for many people with lung cancer, but not all. But for many it is smoking that we can probably point to as the major cause. For a certain type of liver cancer that I take care of, we can say cirrhosis of the liver is the cause, but the cirrhosis of the liver may have been caused by multiple possibilities. For colon cancer for sure, for most people we meet, there will not be one single thing we can point to that's the reason that someone has a colon cancer. There are certainly colon cancers that run in some families, but again, for the majority of people it is likely multiple factors. And I don't think that's very reassuring to people when we tell them that. Maybe I try to just emphasize in the answer to that question that most likely it is not something you did or did not do. That's the reason it just is. But that's a tough one. The other one is how long has it been there? So we do know for colon cancer, the usual timeline from the earliest polyp or abnormality in the colon



lining that starts to kind of head towards being a cancer to a fully invasive cancer is on the order of years. It is a 10 year or so timeline from the earliest changes to full cancer. But I don't know if that's reassuring for people. Sometimes not because then they wonder what could I have done to have caught it earlier? Especially if you didn't get your first colonoscopy like you were supposed to do when you were 50, or you ignored that little bit of bleeding for a while. All of these things might not be reassuring to someone if you tell them something was around for years. But sometimes it is if you're telling them that we are going to do your operation in two weeks and they worry that it is going to change a lot in two weeks, we can usually reassure someone it has been there for months to years. And so that timeline is so, it is just interesting, some of these very common questions we really do not have definitive answers to. And I think that's hard for people. And again, gets back to, knowledge is control and now the cancer patient has lost control of so many things. And so again, seeking knowledge is a way to get some of that back. But the truth is we know less than we want to know about any cancer. And then the other common questions, of course, am I going to be able to handle the chemotherapy or am I going to be able to handle the surgery? Is it going to make me sick? And the truth is, the answers to those questions are yes, we just hope temporarily. And we have to emphasize that we know we are asking you to make sacrifices for us to be able to do the things that can hopefully help, but also the honest that to what level we are going to help is always an unknown. But at least in colon cancer, we can give a lot more positive answers than negative, even to a lot of people with stage four metastases where it is a good time to be a colon cancer specialist because there is legitimate hope and very effective treatments.

**Lauren Hixenbaugh:** That's wonderful.

**Dr. Carl Schmidt:** Contrasting some other cancers where we are behind this one.

**Lauren Hixenbaugh:** Yeah. So as we begin to wrap up today, let's kind of go back and revisit a couple of things. One thing I really like to do and you can each do it if you want to. If there was one thing that people remembered from today's podcast, what would you want it to be?

**Dr. Emily Groves:** So I'd want people to, as Dr. Schmidt touched on, remember that colon cancer isn't a sentence or anything like that. When you're told that you have colon cancer, there is a lot of hope. Cure rates are really high for early stage disease. And as he stated, even metastatic disease that spread to other sites, there are a lot of treatments for, to give you the quality of life that you are looking for, for months to hopefully years after that serious diagnosis. So the outcomes are good and be proactive and come see us to get it done.

**Dr. Carl Schmidt:** Yeah, I'll jump on that too. That's the thing that I would say is if you have a colon cancer and you're initially given a message that doesn't seem like there's much hope, then make sure you've talked to more than whoever that person is because the rules keep changing. And again, I am a liver surgeon, so in that world that used to be that we did not do surgery on the liver if there was more than four liver tumors. But the rules change because we have more effective chemotherapies. We have these other liver therapies that are not even surgical removal, that are very effective type of regional therapies. So as all these things change, again, why you need to hear from a specialist about what the options are for you. So just don't take the first answer to your questions about your colon cancer as the

definitive answer, especially if it doesn't seem like someone knows what the options are for you or that they're not giving much hope. We can give more hope to some than others. But I sometimes worry about the people that could have had options that we never get to see because someone sort of wrongly assumed that they couldn't help them. But maybe a little bit even contracting to that. The other thing I would say is just remember that you are in control. Our job is to tell you what options there are and what we can do and what those risks and downsides are and what the upsides are. But how much of any chemotherapy you do, if any, how much of a big surgery we do or not, is ultimately hopefully an informed choice that you make with our help. And that's something that we just tell you, you "have to do". West Virginians are, I've lived here a year and a half and it is been great. I so appreciate the chance to work with people from this State. But they are very respectful of us and certainly trusting of us, but then also deferential to us. And so Dr. Groves and I can tell someone usually like, well, we are just going to do this big operation on you. And they say whatever you got to do doc. And I like that a lot of times. But at the same time I really want them to know that I would want to know any hesitancy or concern and that we talked through it and sometimes even change the plan because sometimes my plan is the wrong plan based on what someone really wants. And they got to remember they are in control.

**Lauren Hixenbaugh:** They need to advocate for themselves a little bit. Sometimes that's difficult for people. Well that's wonderful. I am glad that you guys are here today to kind of give us that information and kind of spread the word about some positivity really surrounding colorectal cancer. So you can find out more information about living beyond cancer and you can visit, like I said earlier, the [moh.wv.gov](http://moh.wv.gov) or you can visit us on the cancer institute page at [wvucancer.org](http://wvucancer.org). We also have a Facebook page that I was talking with you guys about earlier, so that is for caregivers, survivors and patients to kind of get that support that they need to talk to one another, share resources. So all you have to do is go to Facebook, search, Living Beyond Cancer, ask to join the group, and we would really love to have you. But Living Beyond Cancer would really like to thank both of you, Dr. Carl Schmidt, and Dr. Emily Groves for joining us today, as well as our listeners. We hope that you will continue to join us.

**Dr. Emily Groves:** Thanks so much for having us.

**Lauren Hixenbaugh:** Yeah.

**Dr. Carl Schmidt:** Thank you.