Lauren Hixenbaugh (00:00):

Welcome to Living Beyond Cancer. I'm Lauren Hixenbaugh, the manager for the West Virginia University Cancer Institute's mobile cancer screening program. And I'm your host for today's podcast. For those who haven't joined us before, Living Beyond Cancer is a series of podcasts created for cancer patients, survivors, and their caregivers. This series is created at the West Virginia University's cancer institute in collaboration with Mountains of Hope, the state's cancer coalition, cancer prevention and control, and the Bridge to Survivorship program. In today's podcast, we'll be discussing colorectal cancer screening treatment and beyond. As we do, you may hear several screening options that are recommended through the United States Preventative Services Task Force guidelines. Let's just take a quick moment to explain those. The screening age begins at 45 for both men and women of average risk. People in good health should continue regular colorectal cancer screening through at least age 75. For average risk patients who do not have a family history of colorectal cancer, polyps or genetic syndromes related to colorectal cancer, there are three recommended early detection tests.

(01:19):

The first one is the fecal immunochemical test, also known as FIT, and it detects blood in the stool and it is done once a year. The second type is the FIT-DNA. This test is done every three years, and it combines the FIT test that detects altered DNA in the stool. And for this test, you collect an entire bowel movement and you do send it to a lab where it's checked for that altered DNA and for the presence of blood. And then third is a screening colonoscopy that looks inside the colon while under sedation. If the test is negative, it's conducted every 10 years. Again, these are for average risk patients. For those at high risk for colorectal cancer, you should talk with your doctor about the screening test and the schedule that is right for you. We hope this helps prepare you for our conversation with Dr. Atluri today as we delve deeper into our discussion regarding colorectal cancer. I do have the pleasure of having Dr. Atluri with me today. And I'll just start off today by asking her to tell us a little bit about herself and her role at WVU.

Dr. Atluri (02:31):

Thank you for having me. This is a great opportunity to get folks to be more aware of what they need to know regarding colorectal cancer and what they need to do about it. I'm a associate professor of hematology oncology at WVU Medicine and I've been practicing GI Oncology for about 20 years.

Lauren Hixenbaugh (02:55):

Wonderful. Well, again, we're so happy to have you with us today and hear all about your perspective and information that you have to share with us and our listeners. Again, we'll start off today very broad and just tell us a little bit about what is colorectal cancer and the signs and symptoms associated with it.

Dr. Atluri (03:12):

Colorectal cancer is a cancer that could start anywhere in the colon and rectum, and it usually starts out as a polyp and then grows to become a cancer. And what's important to realize about that is that it gives us an opportunity to change the course of how a cancer grows in someone's body by allowing us to use screening to detect polyps in patients so that we can treat the polyps and get rid of them before they even have a chance to become a cancer. And I think that makes it unique in most of the cancers that we know about because this process of growing from a polyp to a malignant cancer can take some time up to 10 years in the average risk person. It can be shorter in patients who have hereditary mutations or hereditary syndromes or a family history, but on average, one of the reasons why we tell people that

you can have a colonoscopy every 10 years is it takes about 10 years for a polyp to grow into a malignant lesion. And again, that's just for average risk patients.

Lauren Hixenbaugh (04:28):

Wonderful. And now you mentioned screening tools. Do you want to tell us a little about what that looks like? I'm sure many of our listeners that are familiar with any type of colorectal cancer have heard of some of them, but maybe not all of them, and what's beneficial about each of them?

Dr. Atluri (04:44):

Sure. Screening is important because like I said, it is a way for us to intervene and prevent a polyp from becoming a cancer. In 2020, the national screening rate in the United States for colorectal screening of any kind was around 70%, 69.7%. And in West Virginia it was 64.4%, so we're a little bit below the national average. And ideally even the national average is lower than we want it to be. We would like it to be at least 80%. And if I recall, I don't think any state in the United States comes close to 80%. I think some of the Northeastern states come close to 70, 72%. By looking inside the colon and taking a look through the whole of the rectum in the colon, a GI doctor can detect any abnormalities in the tissue and while they're there, they can do a biopsy, which is taking a piece of the tissue and detecting whether you have a polyp or a cancer. And so you're getting a definitive answer immediately whether the cancer is there or not. And if there is one, then we can act upon it and treat the patient accordingly.

(06:06):

Stool-based tests are used and they are an accepted method of screening. However, they have to be done pretty frequently and regularly. And so that is a disadvantage because a colonoscopy, like I said, in the average risk person, you only have to do it once every 10 years. The disadvantages with the colonoscopy is that you have to take time off from work to do the procedure. And I think that the actual colonoscopy itself is really not that cumbersome. You're not even aware what's happening. It's the preparation that you have to do prior to the colonoscopy, so you have to clean out your bowels. And so to do that, they give you this medicine that you have to drink that makes it happen. It is uncomfortable in terms of that, but once it's done, you don't have to do it again for 10 years. Now, with the stool-based tests, you do have to do them more frequently, and the frequency depends on which type of test you do.

(07:08):

There's the FOBT, which is just looking at the presence of blood in the stool, and that can sometimes be a false positive because if you're on iron or your diet can influence the positivity of that test. And secondly, even if that test comes back positive, you still end up having to do a colonoscopy because it just tells us that the screening test was positive. And because of this abnormality, now we have to then do the more definitive screening test for any kind of malignancy. If you do the FIT type of testing where they're looking at the stool, but instead of just looking for the presence of blood, they're actually looking for the globin protein, which is in the blood molecule, so it's actually looking for the red cell itself. And now some more advanced tests that we have are looking at stool DNA, so that it makes the test a little bit more sensitive and specific. These tests can be done once every three years instead of yearly like the FOBT.

(08:24):

And so the advantages for both of these tests are that the patient can do it in the office or at home, and the test results happen right away and you don't have to do a prep or take off time from work. The disadvantage is of course, that even if it's a negative test, it's not 100%. And if it's a positive test, you still

have to do the colonoscopy to get a definitive answer. And the second thing about a colonoscopy that I want to say in addition to the advantage of having to do it less frequently and being a more comprehensive test, is that if you have a polyp in addition to being a screening tool, it's actually treating you. And that's why we think incidence of colon cancer has declined because if we're preventing polyps from turning into cancers by the screening that we're doing, then the incidence of cancer can come down. And we do see that the incidence of colon cancer and most age groups has been declining over the years and the last few decades.

(09:33):

However, we have noticed in the last decade or so that the incidence of colon cancer is growing in a group of patients that are in the younger population between the ages of 20 and 34 to be specific, but 20 to 40 if we're looking at decades. This has changed the recommendation from getting colonoscopies starting at the age of 50 for average risk patients to starting at the age of at least 45. The recommendations have changed for screening needs to start at the age of 45 and not 50. And the screening of course can be a colonoscopy or any of the stool based testing. There's advantages and disadvantages to both like I've alluded to. And I think it comes down to because people will ask me, well, what would you do? And I think that's hard. I actually did a colonoscopy just because I am the kind of person who just wants to forget about having to do something and not having to worry about something for 10 years is a big deal.

(10:44):

Even though it's every 10 years and some people might like that better, at the end of the day, we want people to at least get some form of screening done. And I think that's what we struggle with as medical professionals and people trying to make recommendations. And the challenge in the United States has been to convince people to get colonoscopies in a timely fashion. And if you can at least do the stool based screening and be regular with that, at least that is an acceptable form of screening and you're doing something to decrease your risk of colon cancer. I think it comes down to doing something versus nothing. But yes, ideally a colonoscopy if we can.

Lauren Hixenbaugh (11:33):

Absolutely. The best test is the one that's taken, right?

Dr. Atluri (11:37):

Right. Correct. Exactly.

Lauren Hixenbaugh (11:39):

Do you want to loop back and talk about the common symptoms associated with colorectal cancer?

Dr. Atluri (11:44):

Sure. It can be difficult because sometimes symptoms can present that are not usual, and sometimes people won't have any symptoms. And I think that's difficult for patients to understand. I'll have patients saying to me, "Well, I didn't even have a problem and I just went for my screening colonoscopy and here I have a cancer." I think recognizing that cancers can present in many ways is important, but the most common symptoms that we would see is change in bowel habits. If you're pretty regular or you're not, but you notice that you may be going more than you regularly do or less frequently, seeing blood in the stool of course is definitely an important symptom to recognize.

(12:30):

Seeing maybe that you're not eating as much, that you have a decreased appetite, that you're losing weight over time when you're not actually trying to. You may have symptoms where you notice that your abdomen is swelling if there's a tumor that's kind of blocking the stool from coming out. Sometimes people will say, my pants are a little... I haven't gained weight, but I feel more bloated and my pants are a little tighter, or I have to wear them a little lower down. Those are some of the things that you could look to kind of think, oh, maybe this needs to be evaluated by a physician.

Lauren Hixenbaugh (13:12):

Great. Now we've talked through signs and symptoms and what types of screening are available. A patient does have that positive test come back, so what are we doing to treat that? And I know there's a broad spectrum of things depending on the type and stage of cancer, but maybe just give us a broad look on how we would be treating that.

Dr. Atluri (13:38):

Sure. In general, when someone is diagnosed with cancer, the first thing that we do is we try to take images or pictures of their whole body to make sure it didn't spread anywhere, so doing a CAT scan or a PET scan. And once we establish that it hasn't spread anywhere is between stages one and three, cancers are potentially curable and we try to do everything we can to decrease the risk of the cancer coming back. And definitely for colorectal cancer, it would include a team of people looking at individual patients. And for colon cancer, it usually is a combination of surgery and chemotherapy. For rectal cancer, it would be a combination of chemotherapy, radiation and surgery. Rectal cancer is treated slightly different from colon cancer in that usually there is a component of radiation involved. And without going into too much of the details, the chemotherapy is generally the same in the setting of stage one to three.

(14:51):

For patients who have metastatic cancer or stage four, there are times when surgery or radiation can be included in the plan of care to try to cure these patients with aggressive attempts at surgery, a combination of surgery, chemotherapy, and maybe radiation. We have been able... Even in the metastatic setting, we have been able to afford cure in about 30% of patients. But these are patients who have very low burden of disease and a group of doctors sits together and sees that can we try to decrease the burden of disease in these patients and get them to a place where we could potentially cure them? But it can't happen for everybody, unfortunately. Of course, we are trying to get to a place where that could happen for everybody.

Lauren Hixenbaugh (15:49):

Absolutely. That's the goal, right?

Dr. Atluri (15:51):

Exactly.

Lauren Hixenbaugh (15:53):

One of the terms that we often hear questions about is a multidisciplinary care team, and you mentioned a group of doctors, so I assume that's probably what maybe you were alluding to when you're talking about that. Do you want to talk about the benefits of that and the benefits of being treated at a facility that provides that?

Dr. Atluri (16:13):

Yes. Cancer care has become very complex with time. It does involve really good communication between the medical oncologist, the radiation oncologist, and the surgeons, all the people that are involved in the different aspects of a patient's care. And I think for a patient, the benefit is we're going to be able to maximize our ability to look through all the data, look through the CAT scans, look through the lab work, make sure nothing has been missed. Pathologists, radiologists, other doctors are also present at a multidisciplinary tumor board. And we go through every single piece of data regarding the patient's cancer, and then we come up with a plan of care. And in most cases, I would say the plan of care is already known to all of us because it is a standard. I think as I was mentioning, there are some patients in the metastatic setting that we have to look at carefully to see if these are patients that we want to do more aggressive therapies in to get them to a place where we could potentially cure them.

(17:23):

And that's when I think a multidisciplinary team becomes even more essential because unless you have that communication amongst all the doctors, the best plan of care may or may not be chosen. And I think that advances are happening so quickly in medicine and just keeping abreast of all the data and the newer drugs and the technology that's coming through that we've become more and sub-specialized in our fields and having an opportunity to learn amongst ourselves with our colleagues that, oh, you guys are doing that now. Well, if you guys are doing that, maybe I can change this aspect of what I'm doing. I think physicians who communicate amongst each other for the benefit of the patient is really the best way to understand what a multidisciplinary tumor board is.

Lauren Hixenbaugh (18:15):

Sure. And as people are going through treatment and with Living Beyond Cancer, we always try to talk about the broad spectrum of care. And so if you're outside the WVU system and you're advocating for yourself, a loved one, what should people be asking for? Is there key terms or folks like you that they could reach out to that would guide them or that they should... Tips that they should be asking for as they're going through care?

Dr. Atluri (18:43):

Sure. I don't think that it's necessary that you have to be treated in a university type setting to get quality care. I think that even larger practices, more and more people are not practicing oncology in a private practice setting and it's multi-specialty setting, and even multi-specialty groups do offer multidisciplinary care to their patients. And so I think for patients to advocate for themselves is to just make sure they understand that the surgeons and the radiation doctors or the medical oncologists, all their doctors are talking to each other and aware of each other's plan of care. And you can ask directly, but I think most of the time you'll end up knowing the physicians themselves will say, oh, I spoke to the surgeon and this is what we came up with. That implies that some form of multidisciplinary care is happening, but of course in a university setting, it is happening all the time.

Lauren Hixenbaugh (19:52):

Wonderful. And one of the topics that we haven't talked about so far is clinical trials and that relating to colorectal cancer.

Dr. Atluri (20:02):

Clinical trials are great. They're great for patients as well as for physicians and for science in general. There's various different types of clinical trials out there, and I think that's what patients need to understand. Some trials are more cutting edge where they're looking at, "Hey, can we make a really good treatment better by adding something?" And so in addition to what you would normally get, you're getting an extra drug or an extra intervention that might make your treatment even better than what the standard of care is. And those kinds of trials are easy to get patients on because there's a possibility that it could work better than what they would've gotten otherwise. But even if it doesn't, they're at least getting what they should be getting, so it's a no-brainer. You're not hurting the patient in any way. I think the other kind of trials that most patients when they come to me get confused about because they're worried about being experimented on or being practiced on, so to speak.

(21:09):

And I think that's an unfortunate perception. I think what happens is when there are patients who have gone through multiple lines of therapy and the cancer is still growing and we don't have really good options in terms of what tools in our toolbox so to speak, or we've used up all the tools. And at that point in time there are ways to get drugs that are in development or that we think have shown in different types of trials to be beneficial against cancer, but we just don't know. I can tell you it might work because it's worked in X situation, but I don't know if it works specifically for this cancer. And it's not an experimentation as much as it is a way of trying to give different options to people so that we can try to get them drugs or get them to a point where the cancer is still under control, even though we've run out of our regular options.

Lauren Hixenbaugh (22:17):

And I think it's important to people to know, I'm just going to reiterate something that you said, that there's all kinds of different clinical trials, both treatment and more advanced, that we're trying something that's completely new.

Dr. Atluri (22:31):

And sometimes trials are just observational or they're looking at quality of life. They want you to do a questionnaire while you're on treatment so they can figure out how people feel while they're getting treatment. Because if there's more people that are having sleepless nights, then maybe we should do something to help them with that and give more support, so there's all kinds of trials.

Lauren Hixenbaugh (22:50):

Finding out what additional services that might be available to them.

Dr. Atluri (22:53):

Exactly.

Lauren Hixenbaugh (22:54):

Wonderful. Moving forward, one piece that we haven't talked about is what type of lifestyle or are there any type of lifestyle choices I should say that would keep your risk of developing colorectal cancer lower?

Dr. Atluri (23:16):

I think that this analysis of what type of lifestyle would be better for patients to prevent getting a colon cancer is a question that a lot of people are looking at because of this surge of younger patients having colon cancer. And everybody's looking at why. I think in general, of course not smoking, decreased alcohol consumption are two obvious lifestyle changes that most people already know about in terms of preventing cancer risk. Specifically, it was interesting this year at GI-ASCO, they went through an analysis where they were just looking at diet and what types of diet might affect this younger population. It was trying to stick to a diet where you're eating less processed foods and trying to eat more fresh food or I think at a minimum, limiting your consumption of processed foods in eating healthier foods in general where you can identify them. And I think that's keeping it as broad and simple as possible.

Lauren Hixenbaugh (24:29):

Sure, definitely. And we hear that for lots of our different cancers, keeping alcohol consumption, tobacco use and eating healthy diet as well as exercise are all beneficial for all different types of cancer it seems like. As we begin to wrap up today, I just want to take a moment and revisit some key points that you think listeners would be good takeaways.

Dr. Atluri (24:59):

Sure. I think that trying to maintain a healthy lifestyle, exercising, doing all those things that are more difficult and make our days more busy of course, but are ultimately important for us living healthier lives with quality and not just longer lives, which of course is also a goal. I think there's been a lot of discussion recently in the news, and I just wanted to bring it up because I didn't talk about it when I discussed screening in general. And there's a test called the SHIELD Test, which is a blood-based test, and there's different companies and different brands that are coming out, but basically it's looking at blood and looking to see if you can detect colon cancer cells through the blood as a screening tool. And it's a complex test that looks at genomics and circulating tumor DNA, and it is not FDA-approved as of yet.

(26:09):

And hopefully in the future, five years from now, 10 years from now, it will become standard of care because if we can develop a test that's blood-based and not stool-based and do it on a more regular basis, the likelihood of people participating is high. The best cancer screening test is the one that people actually do. If you're never going to do a colonoscopy, at least do the stool-based testing because those can still help you. Right now, the blood-based tests are being developed and studied. They're just not being used yet. Don't get too confused. Colonoscopies and stool-based tests are the two tests that we have available to most of the population at this point in time.

Lauren Hixenbaugh (27:03):

Great. If we had one tip at the end of this that listeners were to remember, what would that be?

Dr. Atluri (27:12):

Well, colorectal cancer has risen to being the second most common cause of cancer death in the United States in both women and men. I think taking it seriously and being vigilant about lifestyle changes and really taking ourselves to task and our friends and family and saying, go get screened. And until it's determined what exactly, because right now we don't know why there's an increased incidence in the younger population, we can only speculate. And until we know better, I think that knowing what we do know, screening and better lifestyles are the two things that we can actually do to make changes.

Lauren Hixenbaugh (27:55):

Great. Well, thank you so much for being here with us today. We really appreciate you and giving some clarity to lots of questions that people have for us. We hope that our listeners will continue to join us and we'd really like to thank Dr. Atluri for joining us today. Thank you.

Dr. Atluri (28:13):

Thank you so much.