

An update on colorectal cancer

By Thomas P. O'Connor Jr., M.D., Commonwealth Atrius Cancer Center
May 13, 2008



Thomas P. O'Connor
Jr., M.D.

The news about colorectal cancer (CRC) one of the most prevalent kinds of cancer in the country is both promising and concerning.

The good news: CRC incidence and deaths have been declining steadily in the United States. Five-year survival rates have increased from about half of patients in the mid-1970s to about two-thirds of patients in 2002.

The not-so-good news: Centers for Disease Control estimates that nearly 54,000 die annually from the disease and says that two out of five eligible Americans have not been screened for CRC.

Aging is the greatest risk factor for CRC. Ninety percent of cases occur after age 50, so screening should begin at that age or earlier. Other risk factors are family history and lifestyle, including diet.

Studies show a striking association between a low-fat, high-fiber diet and protection against CRC. Patients treated for CRC had a significantly higher risk of cancer recurrence and death when they ate a diet higher in red meats, refined grains and desserts versus one high in fruits, vegetables, poultry and fish. Other studies have found that cholesterol-lowering drugs (statins) may reduce CRC risk. But statins can cause side effects, and more research is needed.

Most people have no symptoms of CRC. If symptoms occur, the cancer is usually advanced. Symptoms include weakness, iron-deficiency anemia, a change in bowel habits (constipation, diarrhea) and abdominal pain all of which can signal other illnesses. That's why screening is vital and a powerful weapon in preventing the disease. Some experts estimate that if all Americans followed screening guidelines, 50 to 60 percent of CRC deaths could be prevented.

Patients have four types of screening available to them: Colonoscopy examines the inside of the colon (large intestine) and the bottom part of the small intestine, and is the best way to screen for CRC, according to the American College of Gastroenterology. Regular colonoscopies can prevent 76 to 90 percent of colorectal cancers. During colonoscopy, commonly done as an outpatient procedure, the physician passes a tube, attached to a

camera, through the anus and into the colon. Most people are sedated and feel little discomfort. Patients can choose from a larger variety of bowel-cleansing preparations, including pills. Any polyps should be removed during traditional colonoscopy.

CT Colonography ("virtual colonoscopy") scans the colon and is less invasive. Some studies have found CTC to be as accurate as traditional colonoscopy, but it may not detect small polyps.

Capsule Endoscopy is the newest procedure. The patient swallows a "camera in a capsule," which takes photos as it passes through the gastrointestinal tract. This method is used primarily to view the small intestine.

Fecal Blood Testing examines stool for blood and can be performed easily in a doctor's office. But it's not a good test for polyps, which don't usually bleed. Studies have shown that new types of stool tests DNA and immunochemical are much more accurate.

CRC screening guidelines suggest that people with average risk and no symptoms, starting at age 50, should have either a sigmoidoscopy every five years, a colonoscopy every 10 years, double-contrast barium enema every five years, or CT Colonography every five years. People at increased risk should have more frequent screenings starting at an earlier age. Physicians will recommend a schedule based on the patient's personal and family medical history.

Since CRC usually develops from precancerous polyps that become malignant over time, polyp removal may be sufficient. Advanced cases a large or highly cancerous polyp, or the spread of cancer beyond the polyp are usually treated by removing part of the colon. (A permanent colostomy bag, to collect waste outside the body, is only necessary with a total colectomy or rectum removal.)

For rectal polyps, microsurgery combined with radiation is a new, less-invasive treatment. For CRC that has spread to the liver, new chemotherapies and medical therapies are significantly improving survival rates.

Patients should talk to their primary care physician about personal and family risk factors, preventive measures, and appropriate screenings. The earlier CRC is caught, the less invasive the treatment, and the higher the survival rate. For more information on CRC and other cancers, visit the National Cancer Institute at www.cancer.gov.

Thomas P. O'Connor Jr., M.D. is an oncologist with Commonwealth Hematology-Oncology and the Commonwealth Atrius Cancer Center in Weymouth, Mass., a collaboration between CHO and Atrius Health. Physician Focus is a public service of the Massachusetts Medical Society. Readers should use their own judgment when seeking medical care and consult with their physician for treatment. For more information, visit www.commonwealthatrius.com.