

About Health TV with Jeanne Blake
Colon Cancer
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JEANNE BLAKE: Welcome to *About Health TV*. I'm Jeanne Blake. The third most common form of cancer in men and women is called colorectal cancer, and it's highly curable when found early. On this edition of *About Health TV* we'll talk about colon cancer, how to prevent it, and how to find out if you have it. We're joined for the discussion about colorectal cancer by Dr. Tom Lamont, who is the chief of the division of gastroenterology from Boston's Beth Israel Deaconess Hospital, and Judy Geary, who is a cancer survivor. Thanks to both of you for coming in to talk about this subject. I love talking about colorectal cancer, because it can do so much good, because when it's found early, Dr. Lamont, it is so highly curable.

DR. LAMONT: Yes, with most kinds of cancer, if you get it at a point where you can take it out surgically, it's curable. If it's already spread to other organs, it's usually not or not easily curable. So our whole effort is to try to diagnose it early.

JEANNE BLAKE: Let's talk just a little bit ... I always like to start out with a little biology lesson. Why is it called colorectal cancer and not colon cancer? Actually, maybe I called it colon cancer. But it's called colorectal cancer. Explain why.

DR. LAMONT: The colon and rectum together make up the large intestine, and the rectum is the bottom part right near the outlet, and that's about 10 to 12 inches long. Then above that is the colon proper, so we just combine the two in the term colorectal cancer. Rectal cancer is a little bit different than colon cancer. For most patients and for most purposes we lump them together.

JEANNE BLAKE: Who's at the greatest risk? It's the third most common cancer for men and women, but who are those individuals who are greatest at risk for this kind of cancer?

DR. LAMONT: Aside from some unusual diseases, the greatest risk factor is age. So before age 50 it's pretty rare, not unheard of, but it's rare. After age 50, incidence starts to go up, so we consider it a disease of aging. So we're all at risk.

JEANNE BLAKE: Are the folks who do get colon cancer before age 50, like Katie Couric's husband – everyone knows that he died from colon cancer – is it always genetic, is there always a genetic

predisposition?

DR. LAMONT: Usually for younger patients, it's definitely part of the genetics syndrome. There's a couple of them. There's a group of illnesses referred to as familial polyposis, and these are patients who even as teenagers start to develop polyps of the colon and the rectum and they're at very high risk for cancer. Luckily they're only comprised of a small amount of the whole number of patients in the United States who have colorectal cancer. So there are some genetic syndromes. Any patient that has a first-degree relative with colon cancer is at ... increased risk. A first-degree relative is a parent, child, or sibling, brother or sister. So if anybody has a first-degree relative with this condition, they should get screened. And what we recommend there is they should get screened five or ten years before the age of onset in the family member. So if you have a family member who got cancer at 45, you should be getting screened earlier, say at 35.

JEANNE BLAKE: And the reason for that is the development of polyps?

DR. LAMONT: Right. You think all cancers of the colon, or nearly all, come from a polyp. So polyps of the colon are really common at age 60 or 70. A third of healthy people have a colon polyp. About 1 in 100 of those turn into a cancer, so our goal when we do the screening that we'll talk about in a minute is to get rid of those polyps, take them out. That prevents colon cancer.

JEANNE BLAKE: What is a polyp? I mean, is a simple answer tissue?

DR. LAMONT: Yes. It comes from a Latin word for foot, but it's something that sticks into the inside of the colon, and it's a tiny little bit of flesh, part of the lining of the colon, that starts to form a tumor. A polyp is a benign tumor, that is, it's not malignant. But as I mentioned, about 1 or 2 percent become malignant, so they undergo genetic changes and things happen that we're not really sure about, and over time polyps grow, become larger, then become malignant and then start to invade, that is, to spread away from the colon.

JEANNE BLAKE: I think that you mentioned this. Does every colon cancer start with a polyp?

DR. LAMONT: Not every, but there are some colon cancers that start as flat lesions that are hard to find.

JEANNE BLAKE: Oh, no kidding.

DR. LAMONT: Yeah, so those are really hard to find.

JEANNE BLAKE: So the reason that a family member, for example, or really any of us want to get the regular screening once it's time for us to do that, whether we have a genetic history or not – I mean, I'm about to have my first colonoscopy because I'm almost of the age where I need to begin those screenings – so the reason that we want to do that is because the polyps grow slowly.

DR. LAMONT: That's correct.

JEANNE BLAKE: Therefore, the early possibility of detection.

DR. LAMONT: Right. There's about a 10 or maybe 12-year lag phase between the start of a polyp and the onset of cancer. So by the time we find cancers, if we look inside and find a cancer, that's been there a while. It didn't just pop up.

JEANNE BLAKE: Right. Before we talk with Judy about how she found out she had colon cancer, let's talk about what the symptoms are.

DR. LAMONT: The symptoms of the cancer relate to the fact that it blocks the inside of the bowel, we call that the lumen, that is the tube inside where stool passes through. So if you have something that's constricting the lumen or narrowing the inside of the bowel, then feces get stuck behind it and cause cramps. Tumors also bleed. They change bowel habits. A person might go from being extremely regular to being irregular. They might see mucus or blood in their stool. So these are some of the symptoms. They also might be feeling weak, losing weight, and then have anemia. So these are some of the symptoms.

JEANNE BLAKE: I think that one of the things that we all know about colorectal cancer is that by the time you see symptoms, you've had it a while, right?

DR. LAMONT: That's correct.

JEANNE BLAKE: Because, by your very good description of the importance of finding polyps, and by the time it turns into cancer and it's shedding blood and blocking the passage of stool, it's been there for a long, long time.

DR. LAMONT: That's correct. By the time it's symptomatic it's already cancer. Occasionally polyps get big enough to block the opening too. We see that once in a while.

JEANNE BLAKE: Benign polyps.

DR. LAMONT: Benign polyps can also produce similar symptoms. The closer they are to the bottom, it's the anus, the outside, the more likely they are to cause symptoms. Higher up in the colon they're usually really silent.

JEANNE BLAKE: How come?

DR. LAMONT: Well, because the colon is pretty capacious, it can expand quite a bit, and there's one part of it called the cecum that's really quite expandable, like your stomach in the way it can expand.

JEANNE BLAKE: I see. It's just more narrow as it get closer.

DR. LAMONT: It's less narrow, but when it gets down to the bottom it starts to narrow right down, and that's when the stool passes right over it and then comes right out, so if there's any blood on it, it's fresh blood.

JEANNE BLAKE: I never knew all that. I did a lot of reports on colon cancer and I did not have anyone ever explain that to me. Thank you, Doctor. Judy, tell us how old you were when you were diagnosed with colon cancer?

JUDY: I was 48.

JEANNE BLAKE: I'm at the age of 50. Doctor, you're going "uh-huh." What does that mean?

DR. LAMONT: Why? Because you mentioned Katie Couric's husband. I don't know much about him, I'm not even sure of his age, but he would definitely be a person that we wouldn't screen nowadays, and most insurance companies wouldn't pay for screening for somebody in their forties. So I'm shaking my head, because now we see another case of somebody who could have been screened earlier, perhaps to avoid what happened.

JEANNE BLAKE: Well, tell us what happened.

JUDY: In November of 1992 I went for my annual gynecologic exam and he was the physician who ordered my annual mammogram, and at that time I was having irritable bowel symptoms. I had just gotten out of a very stressful job and I had been seeing him for 19 years, and he actually went back to the front of my chart and he said, "I see where your father had rectal cancer." I said yes, he had carcinoma in situ in a polyp, and actually had a colostomy. And he told me that I probably should by now be having a colonoscopy. I said, "Fine, I'll schedule that."

JEANNE BLAKE: And we're going to show, actually discuss what a colonoscopy is, but Doctor, can you just interject here what a colonoscopy is so that folks will know, for those who don't.

DR. LAMONT: This is an examination where you can put a scope, it's fiberoptic so it's bendable, inside the colon, look directly in there and see if there are polyps, and if we find them take them out.

JEANNE BLAKE: Terrific. Okay. And we'll go back to that. Go ahead, Judy.

JUDY: So my intention was to schedule a colonoscopy. However, the mammogram three weeks later found a breast cancer, and so I spent the next three and a half, almost four months being treated, because I also had an early cancer in the other breast, so I had four surgeries.

JEANNE BLAKE: You had already had an early cancer in the other breast?

JUDY: I didn't even know about it. Once they found the cancer on this side and I had calcifications on the other side, they became suspicious, and when they had them biopsied it showed. So I was quite busy.

JEANNE BLAKE: I guess you were.

JUDY: I was also quite stressed.

JEANNE BLAKE: So did you just forget about the colon symptoms?

JUDY: No. The first thing I did when I got diagnosed with the cancer was to go see my primary care physician, because I wanted somebody to just sort of be the quarterback of what was going to be taking place.

JEANNE BLAKE: Diagnosed with your breast cancer?

JUDY: Right. Because you deal with a lot of specialists. I told him the same thing about my symptoms, and as time progressed and I started radiation therapy, we agreed that I should try Metamucil, which bulks up the stool, because I was having symptoms of constipation and I was having mucus in my stool. A lot of gas pains. That actually helped, and I also was on an anti-anxiety medication that he thought might be contributing to my symptoms, so I went off of that.

JEANNE BLAKE: And what did you think with all that going on?

JUDY: Yeah. And they got a little bit better. I finished radiation treatments and went away on vacation and my symptoms got worse.

JEANNE BLAKE: I'm wondering, Dr. Lamont, when you hear this today, with mucus in the stool wouldn't you think that a patient would just get a colonoscopy at that point? I mean, we're not naming any names here and we're not naming any hospitals here, but

DR. LAMONT: Well, it turns out those symptoms that I mentioned before and the ones that were just mentioned here, that is mucus and gas and diarrhea, are not specific for colon cancer at all. In fact, they're very typical for something called irritable bowel syndrome, which is apparently what Judy's doctor diagnosed.

JUDY: Which happened, actually, 10 years prior.

DR. LAMONT: So this is an example where the symptom of one illness, a benign condition, can be easily confused with something more serious.

JEANNE BLAKE: I understand that. But you, Judy, also had a family history of it. And you also knew a lot about it, because, why don't you tell everybody what you were doing for your work at the time.

JUDY: I was actually working with the euphemistically called high-risk group at the Dana Farber Cancer Center on studies of both breast and colon cancer. But you have to understand, having four surgeries in five weeks and seven weeks of radiation daily, I was barely holding my head above water. I wasn't ignoring it. I was talking to my primary care physician, going to see him, changing my diet, I mean, doing all of the logical things that you would do in that situation.

JEANNE BLAKE: So seven months later did you find out?

JUDY: No. Five months to the day.

JEANNE BLAKE: You must have thought, "What is happening to my body?"

JUDY: Yes. I was a pretty unhappy camper, to say the least.

JEANNE BLAKE: What was your treatment for the colon cancer?

JUDY: I had a sigmoid resection. My colon cancer was about 14 inches up into the sigmoid colon, not down in the rectal area. So they went in and they removed a ninth of the colon, and it was a very, very large cancer. I was awake and watched the whole colonoscopy, and it was almost 5cm and it covered about two-thirds of the circumference of the bowel. So that certainly accounted for my symptoms, because stool was just having trouble going through.

JEANNE BLAKE: And because it had spread into the colon, you got chemotherapy?

JUDY: I had to have chemotherapy, because they removed the lymph nodes both above and below the section of colon, and I had cancer in four out of seven lymph nodes.

JEANNE BLAKE: Wow. You are a lucky woman to be here today.

JUDY: I sure am. And I don't take it for granted. I did once-a-week chemotherapy at the Beth Israel for 48 weeks, and I am very, very fortunate. I have had seven colonoscopies since and only once have I been polyp-free. To me, it's very consoling to know that two of them were the type that he was referring to that they know can tend more than others to become malignant. At the time of my original diagnosis, I had five other polyps, two were malignant. And then for the next five years, every year I have polyps. I only had two villous adenomas. Last year I had gone almost three years without

a colonoscopy, and they find polyps again, and this time one was abnormal, which also tends to become malignant.

JEANNE BLAKE: Okay, that's a fascinating story and I'm happy to see you looking so healthy considering everything that you've dealt with, and feeling so good and to be cancer-free today. That's great. Dr. Lamont, let's bring out the contraption. In light of the fact that I'm facing this in the next couple of weeks, I guess I'll get a peek at what's about to happen to me.

DR. LAMONT: All right. Well, this is called a colonoscope that we use to do colonoscopy, and as you can see, it's pretty flexible.

JEANNE BLAKE: That's a good thing.

DR. LAMONT: Yes, that's a good thing. We used to do a procedure called rigid sigmoidoscopy up until about 25 years ago with a long, rigid pipe that when you put in there was very uncomfortable and dangerous. And this technology was invented, actually, by the military for looking around corners. They had the idea this would be a useful spy tool, and then a gastroenterologist in the States had the idea that we could use this for looking into the body. It was first developed as a gastroscope that went down into the stomach, and then subsequently into this. So this is a recent model.

JEANNE BLAKE: I want you to share with the viewers what one patient said.

DR. LAMONT: One patient said, How are you going to get this part in?

JEANNE BLAKE: No wonder they say it's so painful. But give us just a little bit of an idea. You can't eat the day before. Is it actually two days before? Do I have to go on clear liquids the day before?

DR. LAMONT: Yes. The day before, starting around lunchtime, you can have a liquid lunch and you can have Jell-O.

JEANNE BLAKE: That is worse than this procedure.

DR. LAMONT: The part that is possibly worse than the procedure itself is, obviously, you have to clean out the bowel or we don't see anything. So it has to be pretty clean in there. And we have, you would be surprised how much stuff is in there.

JEANNE: I can't wait. I know that people don't like to get this procedure, and at least 50 percent of Americans in some states that qualify for it haven't had it. Higher than that. I think that's just the blood and the stool test.

DR. LAMONT: The screening rate is really low.

JEANNE BLAKE: Really, really low, and I think people are afraid of it. But I have to say, I'm looking forward to it. I don't know. Maybe I'm crazy. Go on.

DR. LAMONT: It gives you peace of mind. That's what most people want that ultimately do it. They want to know, and it's like anything else, once you finish your taxes, you feel good, or once you've gone to the dentist and had whatever you have done, you're glad it's over. So the same for this. You have to get cleaned out, and it is rather a vigorous flush.

JEANNE BLAKE: I think you refer to it as an explosion.

DR. LAMONT: It can be an explosion.

JEANNE BLAKE: I was surprised after you and I talked about this interview and you told me what was coming up I didn't say maybe I'll wait a year.

DR. LAMONT: No, I want you to do it. You're doing the right thing.

JEANNE BLAKE: I will do it.

DR. LAMONT: A main thing to understand is that we use sedation. We start an intravenous in a vein in the arm before the doctor even begins, and we give a big jolt of sedative so you're very sleepy. Lately we've been using sedatives that give you a little bit of amnesia just for that period of time.

JEANNE BLAKE: Great, because I already can't remember anything anyway.

DR. LAMONT: This will help. And a lot of people will wake up, and when we nudge them awake they'll ask, "Well, when are you going to start?"

JEANNE BLAKE: I don't want to miss it, though.

DR. LAMONT: And you can watch. If you're awake or you're still awake, you can look at a screen. We have to look through this. We used to have an eye concern you'd actually look under the rectum, but now we work off of a monitor similar to your TV set, and they're usually all around the endoscopy suite, so the patient can usually look at one too. And then this is inserted through the anus up into the colon, and we just steady that there. We can turn the gadget with these wheels and get around very well. We can get around corners. This is why it was derived to look around corners. And then if we see something in there, as Judy said she had some polyps, then we put this thing through this porthole here – this is a snare – and what this is just ...

JEANNE BLAKE: And so you put it over the polyp?

DR. LAMONT: Yes. Then the operator, the gastroenterologist, puts it over the polyp, and I'll be real careful not to amputate the top of your finger.

JEANNE BLAKE: Could you cut my finger off with this?

DR. LAMONT: No, no, I don't think so, but it's a very sharp wire. So then we also have cautery that we hook up.

JEANNE BLAKE: And then it cauterizes the polyp?

DR. LAMONT: Yes, it goes to a polyp that has electricity that goes through. The cautery is to make sure it doesn't bleed. So that's the procedure. If we see a tumor, we see a cancer ...

JEANNE BLAKE: Do you say that out loud?

DR. LAMONT: Well, the patient is awake and some of them are watching, so ...

JUDY: I knew.

DR. LAMONT: Yes, we have to say it. It's hard to conceal this.

JEANNE BLAKE: I'm a little gun shy – actually I'm fine – but had a mammogram.

JUDY: It's so scary.

JEANNE BLAKE: Let's talk about the fear factor around this that keeps people from going. Judy, I mean, you're just living testimony for early detection. You've already mentioned how important it is and that twice they've found polyps that could be cancerous, but what would you say to somebody who is saying, "Forget it," and they just put it off day after day after day and it turns into weeks and months?

JUDY: I would say that there are much worse procedures. I've had a few of them and the peace of mind is so worth it. Of course I was very unpopular, because everybody in my family had to have a colonoscopy, but it's very interesting. They really accommodate the patient. I want to be awake. I don't find it to be a terrible procedure, so that works for me. My sister knows nothing about either of the ones that she has had. And that was her request and they honored the request. I think it's true, the prep is worse than the procedure itself. And the other thing is that once you've had any kind of medical procedures, you'll realize people do this all day every day and they're living. Although it's a big deal to you, it's not as big a deal to them, and yet they're very understanding. I just can't recommend enough that if somebody's physician tells them they should have a colonoscopy, they should do it, because it's much easier than having colon cancer.

JEANNE BLAKE: I'm sure.

JUDY: My chance for cure after weekly chemo is still only 60 to 80 percent. I am very lucky to be here. I really am.

JEANNE BLAKE: Dr. Lamont, there are ways that we can increase our chances of not getting colon cancer, is that not getting polyps as well?

DR. LAMONT: Yes.

JEANNE BLAKE: Okay. Let's talk about what some of those are.

DR. LAMONT: Right. Well, in doing big epidemiologic studies in which we look at tens or hundreds of thousands of people to find out who gets cancer and who doesn't and then ask them questions about what they do or don't do, the following things have been identified as increasing the risk factors. High-fat diet seems to increase the risk factor. An example of that is after World War II, a number of Japanese moved from the Japanese mainland, where colon cancer is pretty rare, to Hawaii, where it's sort of intermediate. And then to Southern California, Los Angeles and so forth, where it's pretty high. And as they did that they changed their diet. They started eating an American diet and getting away from fish and soybean products and so forth. So we think that fat in the diet is definitely correlated with colon cancer.

JEANNE BLAKE: And one more reason to not eat a lot of fat in your diet.

DR. LAMONT: It turns out that heavy drinking is associated, especially beer drinking seems to be a factor. Although it should be said that alcohol consumption also protects from cardiovascular disease, so there's a plus and minus there.

JEANNE BLAKE: I wonder what's in the beer.

DR. LAMONT: It's not clear if it's the beer or the alcohol, but all alcohol seems to have a protective effect on cardiovascular disease, that's heart attacks and atherosclerosis. But it seems that beer drinking, perhaps alcohol consumption of any kind, increases the risk of colon cancer. It's not clear why, but it might be through the fact that alcohol inhibits folate absorption, so folic acid is a substance in green leafy vegetables.

JEANNE BLAKE: Is it in broccoli?

DR. LAMONT: Oh, yes.

JEANNE BLAKE: Oh, great. I eat broccoli every day. I'm the only person I know that craves broccoli.

DR. LAMONT: Broccoli and lettuce and spinach and all those things contain folic acid. So it's been shown that a small amount of folic acid every day protects, and conversely, if you don't get enough folic acid, it seems to raise your risk of getting colorectal cancer.

JEANNE BLAKE: So do you recommend a supplement for people who probably don't ... I mean, I don't know how much is in broccoli but probably not enough.

DR. LAMONT: Well, that's the problem. I mean, you're unusual in that you probably do get enough, but a lot of people don't, especially with the modern American diet and people on the run. We think it's simply easier to take a multivitamin pill every day.

JEANNE BLAKE: A multi-vitamin has folic acid?

DR. LAMONT: Yes, I think it has 400 micrograms, which has already been shown in these studies to be a solid protector against colorectal cancer. Calcium seems to protect as well, so people that use dairy products or even take supplements are going to be protected. A lot of women are already taking calcium supplements and vitamin D for bone protection, so that also seems to protect against colon cancer. Another curious thing that's not explained at all is that exercise seems to protect, and it's kind of hard to think how exercise would protect your lower intestines, but there is a connection, and maybe through diet, but it's been controlled and corrected for diets. Exercise alone, by itself, is

JEANNE: Does it keep one more regular, do you think?

DR. LAMONT: Possibly. So there would be a lot of theories. Although it's not clear that lifelong constipation is or isn't a risk. It's not clear.

JEANNE BLAKE: Well, maybe it kicks off the creation of some wonderful thing inside of us that we don't know of.

DR. LAMONT: It probably does. It's probably hormonal in some way that is just not clear. So those are a couple of things that people can do. And aspirin and drugs that are used for arthritis, like ibuprofen and other arthritis medications, definitely seem to protect against polyps and cancer, so if you're taking aspirin for cardiovascular protection, as a lot of people are taking aspirin every day, or if you happen to have arthritis and you're taking ibuprofen and other drugs like that, that seems to protect as well.

JEANNE BLAKE: Well, with that and a lot of good information here today and the peek at the colonoscopy machine, which is called what?

DR. LAMONT: Colonoscopy.

JEANNE BLAKE: Colonoscopy, okay. A sneak preview of things to come for hopefully a lot of people. Judy, we wish you continued good health, and thanks so much for coming in to tell us your story.

JUDY: You're quite welcome.

JEANNE BLAKE: In hearing your story, we can tell people that early detection saves lives a thousand times, but they would never get it as much as seeing you sit here and talk about it.

JUDY: Well, thanks. I think the other important point is to let people know that having a hereditary disposition is not the usual case.

JEANNE BLAKE: That's right. That's such a good point. We're going to end on that point because we are out of time. But that's right. The very, very few cases, Doctor, are related to genetics and the family.

DR. LAMONT: Right.

JEANNE BLAKE: Thank you so much for bringing that up, because we might have misled you. So if you're 50 or older, you should be getting a colonoscopy every two to three years or five years?

DR. LAMONT: Well, it depends on what's found at the first one, but every five years.

JEANNE BLAKE: We want to thank you for joining us on this edition of *About Health TV*, and we thank our guests. We'll see you next time.

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