

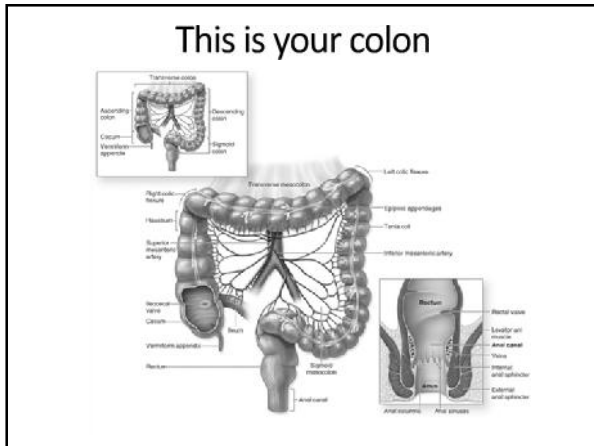
Colon and Rectal Cancer
Screening and Management
OSPA CME Update November 3, 2012

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Objectives

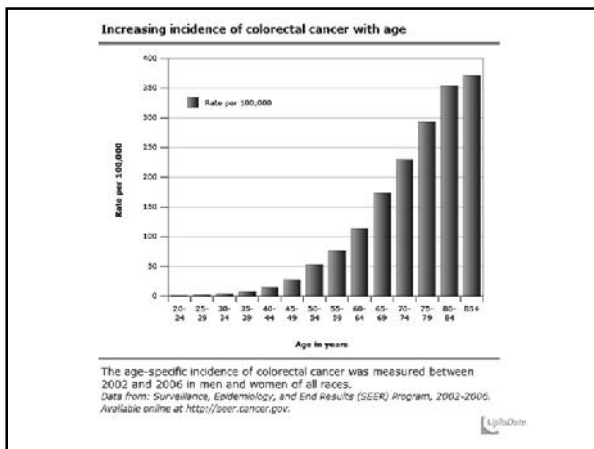
- Identify who is at risk for developing colon and rectal cancer.
- Understand Screening Guidelines for average and high risk patients.
- Recognize standard treatment and prognosis for colon and rectal cancer.

Colon and Rectal Cancer
A common disease in older patients



Cancer in the United States 2011

Men		Women	
New Cases/ Deaths		New Cases/Deaths	
Prostate	240,000/34,000	Breast	230,000/40,000
Lung	115,000/85,000	Lung	106,000/71,000
Colon/Rectal	70,000/25,000	Colon/Rectal	70,000/25,000



Screening Guidelines

Average Risk for Colon and Rectal Cancer

- Who is in the Average Risk Group?
 - No Family History of colon or rectal cancer
 - No family history of advanced colon or rectal polyps
 - No recent GI complaints (change in bowel habits, rectal bleeding, anemia, unexplained weight loss)
- Single First Degree Relative with Colon or Rectal Cancer after age 60
- Average Risk Patients begin screening at age 50 (45 for African Americans)

Screening Guidelines

Increased Risk of Colon and Rectal Cancer

- Who is in the Increased Risk Group?
 - Single First Degree Relative with Colon or Rectal Cancer (or advanced Adenoma) before age 60
 - Two or more Second Degree Relatives with Colon or Rectal Cancer (or advanced Adenoma)
- Screening should begin at age 40 or ten years before the onset of the cancer.
- Increased Risk patients are screened every 5 years.

Screening Guidelines

Special groups

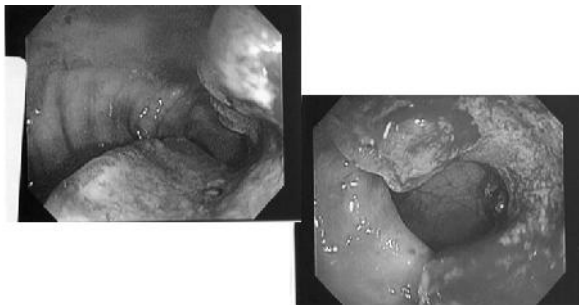
- Inflammatory Bowel Disease
- Familial Adenomatous Polyposis
- Hereditary Non-Polyposis Colon Cancer

- Refer to GI Medicine.

It's a trap!

- 43yo WF with red blood streaking her stools over the last year.
- No change in bowel habits
- No weight loss or anorexia
- No family history of colon or rectal cancer
- DNA analysis of tumor is negative for Lynch Syndrome

Stage I Cancer of the Rectosigmoid Junction



Special Groups

Red Flags!

- Colon Cancer does occur before age 60 even in those patients who have no family history of Colon or Rectal cancer
- Patients over the age of 40 with potential signs of bleeding or GI complaints should be evaluated.
 - Rectal bleeding
 - Change in bowel habits
 - Unexplained loss of weight
 - Anemia

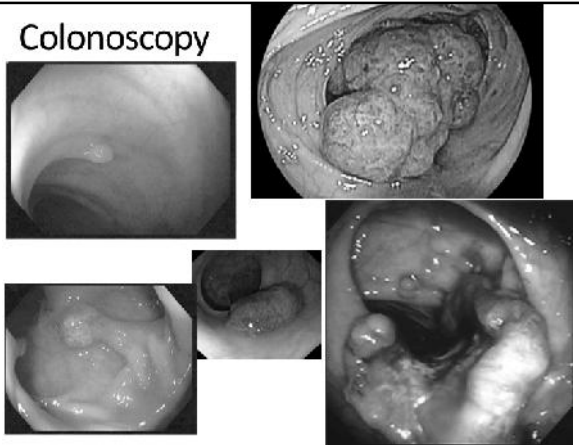
How should you Screen?

Cancer Screening vs. Prevention

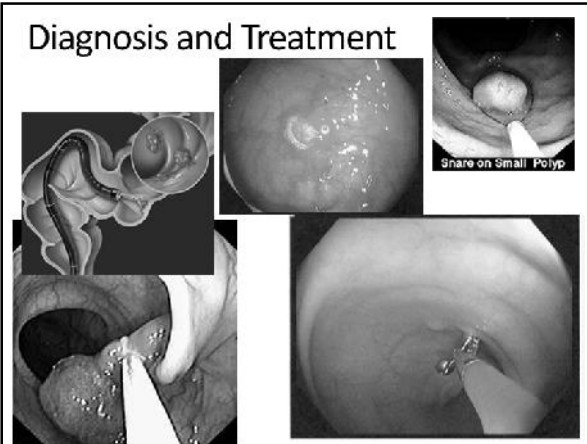
- FOBT (Guaiac, DNA, FIT)
- Flexible Sigmoidoscopy
- Colonoscopy

- CT Colonography (Virtual Colonoscopy)
- Barium Enema

Colonoscopy



Diagnosis and Treatment

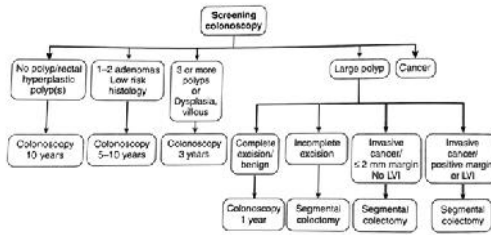


Colonoscopy

Quality Indicators

- Successful Bowel Preparation
- Complete visualization of the bowel including the base of the cecum
 - Withdrawal time of 6 minutes
- Low rate of complication
 - Bleeding
 - Perforation
- Consistent identification and removal of polyps
 - 15-25%

Screening Results and follow up



Colon Cancer

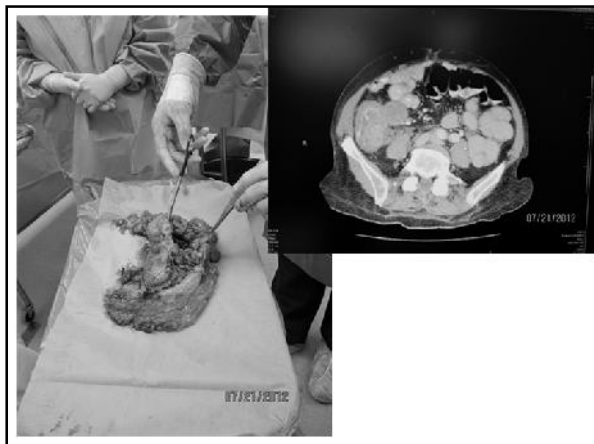


Case History

- 61yo WM, uninsured, with intermittent anemia and transfusions over the previous year.
- No gross blood with bowel movements
- Past history of colon surgery in 1993 for an indeterminate mass
- Normal EGD
- Colonoscopy shows two areas of cancer in the ascending colon

Case History

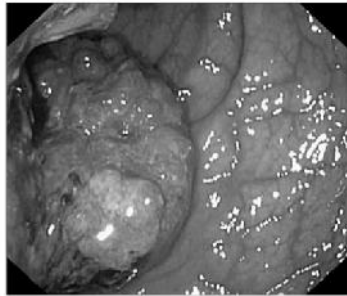
- CEA 4.5 (non-smoker)
- Hct 14.1 (yes, Hct!)
- LFTs normal
- Colonoscopy showing invasive cancer
- CXR Normal
- CT Scan showing large right colon mass
- Final Pathology showing two primary cancers
- Cecal Cancer T3N1 with 1/16 nodes involved
- Ascending Colon Cancer T1N1



Evaluation and management

- CBC, CMP,CEA
- CXR
- CT scan of the abdomen and pelvis
- Surgery: Laparotomy vs. Laparoscopy
- Chemotherapy

Rectal Cancer

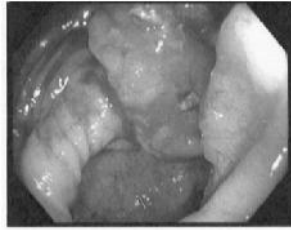


Case History

- 49yo WF with an increased frequency of stools and intermittent bright red blood per rectum
- No family history of colon or rectal cancer
- No recent weight loss
- No anemia

Case History

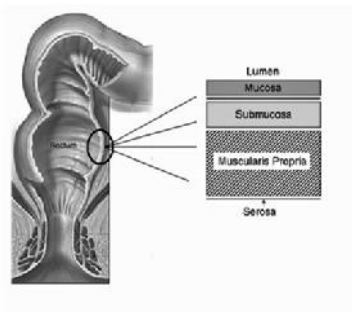
- Digital examination did not identify a mass
- Colonoscopy shows a mid-rectal tumor (10cm from the anal sphincter)
- Biopsies show invasive carcinoma

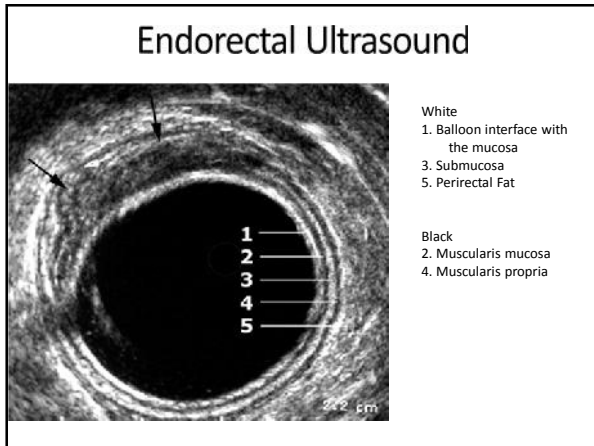


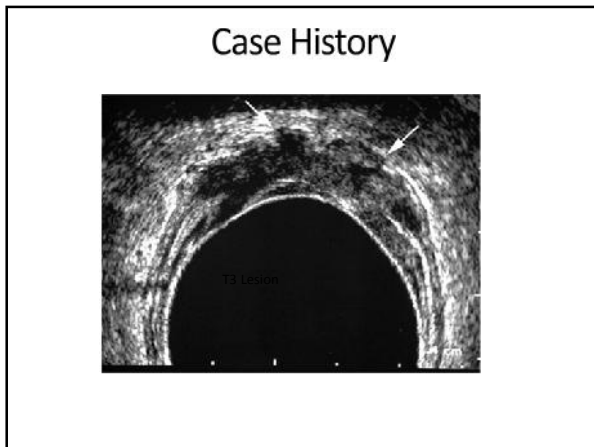
Case History

- CBC and CMP normal
- CEA 1.2
- CXR normal
- CT scan of the abdomen and Pelvis normal
- Endorectal Ultrasound suggests a T3 lesion
- No lymph nodes seen. Clinical Stage II
- DNA evaluation of tumor is negative for Lynch Syndrome

Evaluation of Rectal Cancer







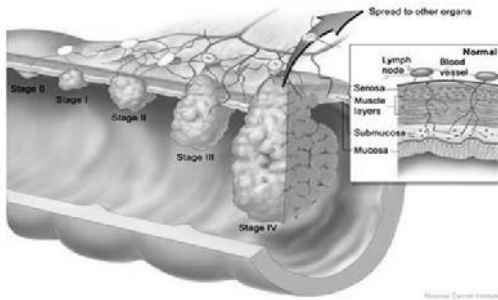
Case History

• Radiation Therapy	• Surgery 9/27/2011
• 28 treatments over 40 calendar days	• Laparoscopic assisted low anterior resection with loop ileostomy
• Treatment complete on 7/18/2011	• No residual cancer in specimen
• Concurrent Chemotherapy with 5-FU continuous infusion	• Closure of ileostomy 11/8/2011

Evaluation and management

- Labs, CXR, CT, endoscopic ultrasound
- Neoadjuvant therapy: Radiation and Chemotherapy
- Surgery: Sphincter saving vs. APR
- Surgery: Laparoscopy vs. Laparotomy
- Additional Chemotherapy

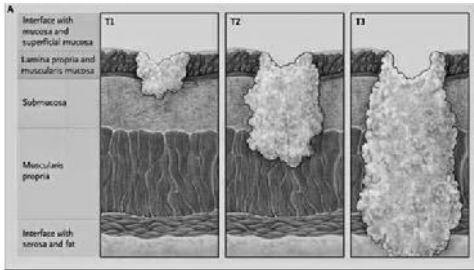
Staging and Prognosis



Staging and Prognosis

- T1 Tumor invades submucosa
- T2 Tumor invades muscularis propria
- T3 Tumor invades through muscularis propria into pericolorectal fat
- T4 Tumors invades into adjacent structures
- N0 No regional nodes
- N1 Metastasis to 1-3 nodes
- N2 Metastasis to 4 or more nodes
- M0 No distant metastasis
- M1 Metastasis to distant site (liver, lung, ovary)

Depth of Invasion



Staging and Prognosis

• Stage I	(T1-2 N0)	93%
• Stage IIA	(T3 N0)	85%
• Stage IIB	(T4 N0)	72%
• Stage IIIA	(T1-2 N1)	85%
• Stage IIIB	(T3-4 N1)	64%
• Stage IIIC	(any T N2)	44%
• Stage IV	(M1)	8%

Questions?
