



Prevention

National Colon Cancer Prevention Month March 2018

COLON CANCER AWARENESS MONTH

COLON CANCER SCREENING OPTIONS

Over a fourth of Americans have never been screened for colorectal cancer.

Screening tests, which have not been directly compared in trials, are assumed to be equally efficacious.

Therefore, the Strategy is to get Patients to Undergo Any Kind of Screening

Available modalities include fecal testing, including guaiac-based fecal occult blood testing (gFOBT), immunochemical-based fecal occult testing (FIT) and stool DNA (sDNA) testing, endoscopy with colonoscopy and, increasingly rarely, sigmoidoscopy, and imaging, with both computed tomographic colonoscopy (CTC) and rarely used double-contrast barium enema.

The serum assay for Methylated *Septin 9* (mSEPT9) has not been approved for screening. Results so far indicate that mSEPT9 is less sensitive for early vs. advanced colorectal cases.

It may be more useful to monitor the cancer's treatment response than early detection.

STOOL DNA TESTING FOR COLON CANCER SCREENING (Cologuard)

Endoscopy is unique because it both screens for cancer and excises premalignant polyps, and CTC, which appears to be equally sensitive, is noninvasive.

However, the oral osmotic bowel preparation required for either approach likely deters many patients from colorectal cancer screening.

Fecal testing is a noninvasive alternative that identifies a high-risk population. Positive results provide a stronger argument for patients to accept subsequent invasive screening.

The Cologuard DNA stool test is FDA approved and covered by the Centers for Medicare & Medicaid Services (CMS).

It appears to be more sensitive but less specific than gFOBT and FIT. It is also about 20-fold more expensive.

AGE SELECTION

FOR COLON CANCER SCREENING

Age to Start Screening

Patients without a family history of colon cancer should begin screening at age 50. Screening through age 74 is recommended. (Grade A Recommendation)

Shared Decision Making (75-84 years)

Net benefits of screening decline after age 75. A life expectancy of 10 years is generally required to benefit from screening.

Patients with above-average health more likely benefit, while serious comorbid disease alters the balance against screening. The benefit is likely greater for previously un-screened patients. (Grade C recommendation)

Endoscopic complications are believed to increase, and benefits decline. Reliable age-specific endoscopy complication rates are unavailable, but perforations are estimated at 4 per 10,000 and major bleeding about 8 per 10,000. Complications of sigmoidoscopy are estimated about 4-fold less.

Potential CTC harms include radiation, about equal to annual background radiation, and extracolonic findings. The impact of radiation repeated at 5-year intervals is likely worse for patients who start using CTC younger.

The impact of extracolonic findings is not established. False-positive findings could lead to unnecessary testing and anxiety, but early detection of treatable conditions may be beneficial

Harms Outweigh Benefits (85 or older)

Because of shorter life expectancy, few patients 85 or older will likely benefit from screening.

Further, they are likely more likely to experience endoscopic complications and less resilient when they occur.

Therefore, the US Preventive Services Task Force believes screening is likely to cause net harm (Grade D recommendation).

COLORECTAL CANCER PREVENTION

Heritable risk factors, including both specific genetic defects, such as mutated mismatch-repair (MMR), and phenotypic markers of high risk such as a family history of colorectal cancer before age 50 or ulcerative colitis (UC), can be addressed directly.

Earlier screening may be helpful, and preventive colectomy for UC is common. However, other interventions, including exercise, dietary changes and medications, may be beneficial. Rapidly growing evidence identifies the gut bacterial microbiome as modifiable, both as an indicator and an agent of cancer prevention.

Aspirin 81 mg daily is recommended to prevent cardiovascular disease (CVD) and colorectal cancer for patients age 50-59 with at least a 10% chance of CVD and no risk factors for serious bleeding.

Obesity and consumption of red meats appear to increase the risk of colorectal cancer, while increased consumption of fruits, vegetables and whole grains appear to reduce the risk. Increased physical activity appears to reduce colorectal cancer risk in part by beneficial changes to the colonic microbiome.

Cigarette smoking and heavy ethanol consumption appear to increase the risk of colorectal cancer.

rectal cancer.

THE STRANG CANCER SCREENING TRIAL

Strang Cancer Prevention Institute is completing a randomized trial of interventions to improve compliance with cancer screening guidelines, including overuse, particularly in older patients. The trial closely examined the interactions between primary care doctors at the Mount Sinai West and Downtown Hospitals.

We asked doctors and patients to complete questionnaires immediately after their encounter. The preliminary results, presented in cancer conferences in the US and Europe, identify communication obstacles, especially in patients over 70, and the potential benefits of shared decision making.

The educational interventions tested were color-coded guidelines and academic detailing (educational outreach to physicians). We plan to report the final results in the next year.

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For further information please visit www.strang.org

The Strang Cancer Prevention Cookbook

Walnut-Raisin Bread

Reduce your Risk for Cancer by Eating a Healthy Diet!

2 Loaves

3 cups warm water
1 1/4-ounce envelope active dry yeast
4 cups whole wheat flour
1 tablespoon plus 1 teaspoon salt
1/4 cup honey
1/4 cup walnut oil
2 tablespoons olive oil
1 cup crushed walnuts
3/4 cup raisins
2 1/2 cups all-purpose flour



In a small bowl combine 1/2 cup of the water with the yeast. Stir lightly to combine and let sit for 5 minutes.

In a mixer or mixing bowl combine the whole wheat flour and salt. Make a small well in the center by pushing the flour to the sides. Pour the yeast, remaining water, honey and walnuts and olive oils into the center; mix. Add the walnuts, raisins and 1 cup of the all- purpose flour and mix. Add the remaining all-purpose flour 1/3 cup at a time, working the dough together; it should be moist and lightly sticky.

Place the dough on a work surface dusted lightly with flour and knead for 8 minutes until the dough is soft and elastic (add more flour only if the dough is very sticky).

Place the dough in a large, lightly greased bowl, cover tightly with plastic wrap, and let rise in a warm (but not hot) place until doubled in size, about 1 1/2 hours.

Punch down the dough and shape into 2 oval loaves. Line a baking sheet with parchment paper sprayed lightly with cooking spray. Place the loaves on the baking sheet and let it rise until almost doubled in size, about 40 minutes.

Preheat the oven to 375 F. Bake the loaves on the middle oven rack for 40 to 45 minutes, rotating the pan midway through baking; the bread should be browned lightly. Lift off the baking sheet; the loaves should sound hollow when tapped on the bottom.

Calories 161, Protein 5g, Carbohydrates 25g, Fat 5g, Cholesterol 0 mg, Dietary fiber 3g, Saturated fat 1g

Phytochemicals: phytic acids, plant polyphenols (phenolic acids), plant sterols, protease inhibitors

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Recipe by Laura Pensiero, R.D., Owner, Gigi Trattoria, Rhinebeck, New York



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