Um, thanks for joining tonight. We want to welcome you to smile shares with primary care tonight. That are going to talk about issues around GI cancers and my name is Anne Chang, GI cancers and my name is Anne Chang, and my partner in establishing this is Karen Brown, and we are. Here to welcome you to this monthly lecture and many of you have been with us before this came about really.
through discussions between Karen and myself and others focusing on the primary care perspective on cancer. There are a lot of venues where you can get cancer information, but this is intended to really partner with primary care at and this cancer specialist to focus on those issues that are most interesting to you and most pertinent to you. Well, it’s as you know a case based discussion. We have three cases tonight that we’re going to try to get through and to highlight certain key clinical pearls and certainly the advances.
for you to know about. Umm, so we'll do our introductions first and then we will go into the case presentations and then we always like to have about 10 minutes available for your questions and answers. So either put them into the chat or else keep them for the end. That’s always the really interesting and important part. So we’ll definitely leave time for that. Karen, do you want to go ahead and introduce yourself and?

And. Start with the introductions. Sure. Thank you.
So for those who don’t know me, my name is Karen Brown. I’m an internist in North Haven at the Divine St. Complex and the medical director of EMG Primary Care. I am thrilled to introduce two of my colleagues who have collaborated on in making this talk, something that will be really applicable to primary care, focusing on diagnosis and the kind of intersections. Between primary care and oncology, Doctor Elizabeth Allard, who we call Beth,
is originally from Wisconsin. She received her undergrad degree from Carnegie Mellon in Biology, and then she received both a PhD in Pathobiology and an MD from Brown University. She broke the usual MD, PhD, mold and completed her residency in Family medicine at UMass Medical School in Worcester at an inner city health clinic. She’s been employed by a prior. Hospital owned family practice then spent 15 years in private practice and is now a very valued member.
00:02:59.093 --> 00:03:01.711 of our Northeast Medical Group’s
NOTE Confidence: 0.821898285
00:03:01.711 --> 00:03:05.639 primary care team and she runs an all
NOTE Confidence: 0.821898285
00:03:05.639 --> 00:03:08.969 female family practice in Waterford.
NOTE Confidence: 0.821898285
00:03:08.970 --> 00:03:11.538 She creates care with a thoughtful
NOTE Confidence: 0.821898285
00:03:11.538 --> 00:03:12.822 and scientific framework.
NOTE Confidence: 0.821898285
00:03:12.830 --> 00:03:14.552 She’s a leader in her practice
NOTE Confidence: 0.821898285
00:03:14.552 --> 00:03:16.150 on in her geographic region,
NOTE Confidence: 0.821898285
00:03:16.150 --> 00:03:17.974 and she’s a member of the
NOTE Confidence: 0.821898285
00:03:17.974 --> 00:03:19.190 primary care steering group,
NOTE Confidence: 0.821898285
00:03:19.190 --> 00:03:21.638 where her insight helps to guide all of
NOTE Confidence: 0.821898285
00:03:21.638 --> 00:03:26.297 us as we build systems of primary care.
NOTE Confidence: 0.821898285
00:03:26.300 --> 00:03:28.240 Doctor Scott Thornton attended
NOTE Confidence: 0.821898285
00:03:28.240 --> 00:03:30.665 University of Pittsburgh School of
NOTE Confidence: 0.821898285
00:03:30.665 --> 00:03:32.791 Medicine and completed his residency
NOTE Confidence: 0.821898285
00:03:32.791 --> 00:03:36.050 at UConn and in the colorectal surgery
NOTE Confidence: 0.821898285
00:03:36.050 --> 00:03:38.520 at Muhlenberg Regional Medical Center.
He is also a northeast Medical Group physician. He’s a colon and rectal surgeon in Shelton, CT, right next to our walk in, which is a convenient location and he has a Bridgeport hospital affiliation. He’s well respected by colleagues. He’s cared for patients. With um colon and rectal cancer for nearly 30 years, his professional interests include laparoscopic colorectal surgery, rectal and hemorrhoidal issues and he is an avid golfer.
When he is outside of the office, I'll turn it over to you and to introduce your Smilow colleagues. Thank you. And I should say I'm a medical oncologist and associate cancers director for clinical initiatives. So I'm going to start with Doctor Amit Khanna, who is an associate professor of surgery at Yale School of Medicine. And he's the director of colorectal region and as such he's responsible for leading the provision of colorectal surgical services across the area in collaboration with
Doctor Khanna has more than 20 years of experience as a high volume surgeon and specializes in minimally invasive treatment and management of inflammatory bowel disease colorectal malignancies. Anorectal diseases.

Doctor Pam Kunz is associate professor of medicine and director of the Center for Gastrointestinal Cancer at Yale Cancer Center and SMILo. She joined us at Yale from Stanford University,
where she was the director of the Neuroendocrine Tumor program there and leader of in endocrine Oncology research group and the director of the Neuroendocrine Tumor Fellowship, but beyond her record of accomplishment. Dr. Kunz is an international leader in the clinical care of patients with neuroendocrine tumors are called nuts. And she’s also advancing the field through clinical trials and translational science that is really defining the next generation of therapies for patients with this rare diagnosis.
And then finally, doctor Justin Persico is assistant professor of clinical medicine in the section of medical oncology, and he’s the director of Smilow Cancer Hospital care centres in Trumbull and Fairfield. He focuses his clinic on the care of patients with GI cancers, and his specific interests include research on lifestyle factors that impact pathogenesis, treatment and survivorship of colorectal cancer patients. He attended Tufts University School
of Medicine, where he also completed.

This fellowship in hemlock,

so our distinguished faculty.

I'm going to hand it over to Doctor Allard to start with our first case.

Thank you.

Thank you so much, Shannon.

So we want to begin with talking about cases.

And it's probably a great surprise that this is colon Cancer month and that a lot of people are probably going to be expecting a colon cancer case.

So I might as well just put it out there up front.

But we’re going to try to take each case this afternoon and focus on a different way.
So we’re going to focus on this one pretty thoroughly because we know colon cancer so common. So we begin our story with a 45 year old woman with a past history of arthritis and elevated cholesterol should prevent presents for a complete physical exam. She’s a non-smoker who drinks 3 glasses of wine per day and the question of the hour is does this patient need colon cancer screening? And we all know that five years ago, three years ago we would have said three years ago we would have said probably not unless there was a risk.
But now things have changed and before I go forward on this case let’s look at pathways. So if we look closely now that we have. These wonderful pathways in our system at EPIC as ambulatory care continues to advance. We have three ways to look at colon cancer screening. The first one we’ll look at in greater detail is obviously initial screening, but then there’s screening for someone who has had a previous normal evaluation and for someone who’s had an abnormal. And we all know that the GI doctors come up with these recipes of how often to screen. But I think it’s great to have access
NOTE Confidence: 0.90561518
00:07:58.146 --> 00:08:00.149 to all of this so we can look at it.
NOTE Confidence: 0.90561518
00:08:00.150 --> 00:08:02.530 Let’s move on to our next slide.
NOTE Confidence: 0.90561518
00:08:02.530 --> 00:08:04.058 So once we’re in pathways and we go
NOTE Confidence: 0.90561518
00:08:04.058 --> 00:08:05.669 to the initial screening pathway,
NOTE Confidence: 0.90561518
00:08:05.670 --> 00:08:06.666 this is what it looks like.
NOTE Confidence: 0.90561518
00:08:06.670 --> 00:08:08.080 So if you’re seeing a patient
NOTE Confidence: 0.90561518
00:08:08.080 --> 00:08:09.820 and you’re not certain what to do
NOTE Confidence: 0.90561518
00:08:09.820 --> 00:08:10.824 or whether they’re eligible,
NOTE Confidence: 0.90561518
00:08:10.824 --> 00:08:12.876 you look up this pathway through
NOTE Confidence: 0.90561518
00:08:12.876 --> 00:08:14.730 the through the pathway system.
NOTE Confidence: 0.90561518
00:08:14.730 --> 00:08:16.824 And the colon cancer initial screening
NOTE Confidence: 0.90561518
00:08:16.824 --> 00:08:19.188 at the very top has two items.
NOTE Confidence: 0.90561518
00:08:19.190 --> 00:08:21.174 The first is asking whether or not this
NOTE Confidence: 0.90561518
00:08:21.174 --> 00:08:23.008 patient is a candidate for screening.
NOTE Confidence: 0.90561518
00:08:23.010 --> 00:08:23.776 And yes,
in general, healthy patients between the ages of 45 and 75 are recommended screening or anyone with a life expectancy of greater than 10 years. On the flip side, you might be asking who isn’t a candidate? And again, details are there, but anyone obviously with any chronic or terminal illness such as cancer and stage heart failure, we’re not going to put them through a colonoscopy because we know that’s a significant risk to them. And likewise, if we’re going to treat a colon
cancer and they already have this concomitant illness, that may just be too much.

Next step on the flow diagram is you know additional details of who is high risk.

So we know people with the first degree relative with cancer of the colon or polyps of the colon is at higher risk as well as people with irritable bowel disease and people with certain genetic syndromes. 

Final step on the pathway, quick look, there are several ways we can screen. 

Before COVID we mostly focused on the colonoscopy since COVID, on the colonoscopy since COVID,
I myself and others have certainly considered more of the options that are available.

Uh, that don’t involve such an invasive procedure, particularly Cologuard.

But for the purposes of this conversation, we’re not going to go into more detail at this point.

So let’s move back to our case in the next slide.

The patient underwent her screening colonoscopy.

It took a whole year and that brings up a point for us PCP’s. If you see someone who is due

Our job is to look at that health maintenance list all the time.
00:09:52.462 --> 00:09:53.890 for something, talk to them about it,
00:09:53.890 --> 00:09:55.350 whether it’s their, you know,
00:09:55.350 --> 00:09:56.700 preventative health maintenance visit or
00:09:56.700 --> 00:09:59.247 it might even be a visit for something else.
00:09:59.250 --> 00:10:02.030 We,
00:10:02.030 --> 00:10:04.030 So she had the screening and it revealed
00:10:04.030 --> 00:10:06.235 a large tubular adenoma greater than 10
00:10:06.235 --> 00:10:08.560 millimeters and the patient was recommended.
00:10:08.560 --> 00:10:10.970 Repeat screening in three years.
00:10:10.970 --> 00:10:12.629 Going to turn to our next slide,
00:10:12.630 --> 00:10:14.727 which is going to show us in the pathways.
00:10:14.730 --> 00:10:16.760 If you’ve had an abnormal
00:10:16.760 --> 00:10:18.790 colonoscopy now what you do.
00:10:18.790 --> 00:10:20.043 So it may be hard to see
00:10:20.043 --> 00:10:21.428 this on all of your screens,
NOTE Confidence: 0.893006371666667
00:10:21.430 --> 00:10:23.677 but this basically goes through the details
NOTE Confidence: 0.893006371666667
00:10:23.677 --> 00:10:26.117 of depending on the what the findings are,
NOTE Confidence: 0.893006371666667
00:10:26.120 --> 00:10:27.972 how frequently the next
NOTE Confidence: 0.893006371666667
00:10:27.972 --> 00:10:29.824 colonoscopy needs to occur.
NOTE Confidence: 0.893006371666667
00:10:29.830 --> 00:10:31.290 And in her particular case,
NOTE Confidence: 0.893006371666667
00:10:31.290 --> 00:10:33.048 because it was a large adenoma,
NOTE Confidence: 0.893006371666667
00:10:33.050 --> 00:10:35.150 it’s recommended that she undergo
NOTE Confidence: 0.893006371666667
00:10:35.150 --> 00:10:37.870 screening again in three years.
NOTE Confidence: 0.893006371666667
00:10:37.870 --> 00:10:40.810 But another little sub point here.
NOTE Confidence: 0.893006371666667
00:10:40.810 --> 00:10:42.760 This particular patient didn’t listen to
NOTE Confidence: 0.893006371666667
00:10:42.760 --> 00:10:45.332 her PCP right away and again spent another
NOTE Confidence: 0.893006371666667
00:10:45.332 --> 00:10:47.649 year deciding whether or not to do this.
NOTE Confidence: 0.893006371666667
00:10:47.650 --> 00:10:48.300 But fortunately,
NOTE Confidence: 0.893006371666667
00:10:48.300 --> 00:10:50.250 when she saw her primary care
NOTE Confidence: 0.893006371666667
00:10:50.250 --> 00:10:51.550 physician one year later,
00:10:51.550 --> 00:10:53.510 she was willing to go forward with

00:10:53.510 --> 00:10:54.070 the procedure.

00:10:54.070 --> 00:10:55.967 So let’s turn to our next slide.

00:10:58.810 --> 00:11:01.316 So here she’s had the initial colonoscopy

00:11:01.316 --> 00:11:03.450 that reveals the tubular adenoma.

00:11:03.450 --> 00:11:04.586 It’s four years later.

00:11:04.586 --> 00:11:06.006 She’s finally going for that

00:11:06.006 --> 00:11:07.646 She feels great.

00:11:07.646 --> 00:11:08.734 She has no symptoms.

00:11:08.740 --> 00:11:10.402 She’s not concerned.

00:11:10.402 --> 00:11:12.618 She undergoes repeat colonoscopy.

00:11:12.620 --> 00:11:14.092 And unfortunately a transverse

00:11:14.092 --> 00:11:16.300 mass was found in her colon.

00:11:16.300 --> 00:11:17.524 But pathology report revealed

00:11:17.524 --> 00:11:19.760 at a no carcinoma of the colon.
And in a moment we’re going to hear more from our surgeon about what the next steps are. I do want to stop for a minute and give a personal thanks to Doctor Rachelle Andre who assisted me with coming up with this particular case which we use today. OK, Amit.

So you know this is a very common story. This is something that all of you see and and unfortunately our patients and I just want to talk a little bit about how to help with making preoperative evaluation easier.
so that you can help guide your patience through this process as it’s always a challenging one for them.

But we also want to take out any of the mystery of helping us support your patients once they are diagnosed with colon cancer.

So if we could go to the next slide. You know, if we just think about colon cancer broadly, you know, where does everyone fall? Well, about 65% of patients are going to have sporadic disease. And I think one of the most common questions I get from primary care doctors is,
00:12:23.300 --> 00:12:25.420 you know, do they need a genetics evaluation?
00:12:25.420 --> 00:12:27.196 How important is that family history?
00:12:27.200 --> 00:12:29.517 Well, most of our colon cancer patients
00:12:29.517 --> 00:12:31.979 are going to have sporadic disease,
00:12:31.980 --> 00:12:34.236 but a significant amount of them
00:12:34.236 --> 00:12:36.530 will have a familial component,
00:12:36.530 --> 00:12:37.865 which means that there isn’t
00:12:37.865 --> 00:12:38.666 an actual germline.
00:12:38.670 --> 00:12:39.678 Mutation that we see,
00:12:39.678 --> 00:12:42.001 but but we know that it’s running in a
00:12:42.001 --> 00:12:44.250 family and that they have a family history.
00:12:44.250 --> 00:12:45.720 And then the thing that we,
00:12:45.720 --> 00:12:48.447 we see you know sort of less commonly but
00:12:48.447 --> 00:12:51.498 we do find more and more frequently
00:12:51.498 --> 00:12:53.799 are actual hereditary genetic defects.
00:12:53.800 --> 00:12:56.149 And I think the other part of it from
a primary care perspective is how can we help our patients get the most efficient access to surgical care, how do we do that work up and I think it’s helpful for our primary care colleagues to understand.

Well, what is a complete workup and there’s a few questions that that often get asked me and I think the one is you know do we need to do a genetics evaluation before surgery and I think in most cases we don’t. But we will do that screening process when the patient gets referred in
00:13:27.351 --> 00:13:29.526 for their first surgical evaluation.
NOTE Confidence: 0.804863948333333
00:13:29.530 --> 00:13:32.134 And we’re very lucky that we have
NOTE Confidence: 0.804863948333333
00:13:32.134 --> 00:13:34.659 a very robust genetics program at
NOTE Confidence: 0.804863948333333
00:13:34.659 --> 00:13:37.317 SMILLO and it’s actually right
NOTE Confidence: 0.804863948333333
00:13:37.317 --> 00:13:39.810 on the campus where Doctor Persco.
NOTE Confidence: 0.804863948333333
00:13:39.810 --> 00:13:41.560 Myself certainly see patients and
NOTE Confidence: 0.804863948333333
00:13:41.560 --> 00:13:44.072 so we’re able to get patients in
NOTE Confidence: 0.804863948333333
00:13:44.072 --> 00:13:44.770 quite efficiently.
NOTE Confidence: 0.804863948333333
00:13:44.770 --> 00:13:47.535 Sometimes we don’t have the results back
NOTE Confidence: 0.804863948333333
00:13:47.535 --> 00:13:50.209 before patients need to go through surgery.
NOTE Confidence: 0.804863948333333
00:13:50.210 --> 00:13:52.898 But in most cases as you can see
NOTE Confidence: 0.804863948333333
00:13:52.898 --> 00:13:55.858 in you know talking about 95% of
NOTE Confidence: 0.804863948333333
00:13:55.858 --> 00:13:57.772 patients what we don’t need the
NOTE Confidence: 0.804863948333333
00:13:57.772 --> 00:13:59.426 information ahead of time or we
NOTE Confidence: 0.804863948333333
00:13:59.426 --> 00:14:01.364 can make a decision based on the
NOTE Confidence: 0.804863948333333
00:14:01.364 --> 00:14:02.690 patient’s previous history.
So the things that are really important to us are previous genetic syndromes, previous polyps, age at diagnosis of their. Colon cancer, obviously the CAT scans that we perform usually chest, abdomen and pelvis. Sometimes physicians will ask me, do I really need a CT of the chest? Can I just use a chest X-ray? And we’ll talk a little bit about why that’s important in a second. And then I think the last point here is that we take care of patients as teams.
And so early multidisciplinary involvement is something that we really emphasize. And care of our patients and that’s not just the surgeon, the oncologist or radiation oncology or genetics counselors that’s our primary care partners and our specialist. So we really have a lot of emphasis on making sure that we’re optimizing these patients for surgery because that can really have a big impact. And also if there’s any other interventions such as cardiac interventions or pulmonary interventions that may add value on certainly management of.
Anticoagulation around surgery is another big one. Next slide, please.

And so just these are some some pearls I think that are helpful just to think about you know as your counseling your patients and I always tell our patients when they come to see me, you’ve known me for 10 minutes, you’ve known your primary care doctor a lot longer.

So it’s really important that you reach out to your primary care physician and ask questions, you know ask about your surgeon, ask about the approach the the options
that you have and we look at that.

It's a very important partnership.

So 1/3 of colon cancer patients may have some mutation and these are in the younger than fifty group CEA,

which we will almost always do before surgery does have a significant predictive value of overall survival.

And so if you have an elevated CEA at diagnosis you know your your hazard of death compared to patients with a normal CEA is, is quite different.

In terms of the chest CT,

we still do it even though the risk of metastasis is quite low.
The yield allows us to see some indeterminate lesions that may need follow up and so that’s why we do it. And so universally we ask for chest CT’s. Sometimes I get asked about a pet CT in the preoperative setting and there are a few situations where we might do that. But for the large number of patients that present to us with colon cancer that they’re not undergoing pet CT’s as a preoperative evaluation. So I’m generally not needed.
00:17:00.708 --> 00:17:02.940 of trying to figure out what the right
NOTE Confidence: 0.861349671538462
00:17:03.002 --> 00:17:05.318 approach for any individual patient is.
NOTE Confidence: 0.861349671538462
00:17:05.320 --> 00:17:06.036 And I,
NOTE Confidence: 0.861349671538462
00:17:06.036 --> 00:17:08.542 you know I often tell patients that
NOTE Confidence: 0.861349671538462
00:17:08.542 --> 00:17:10.390 customized care is quality care.
NOTE Confidence: 0.861349671538462
00:17:10.390 --> 00:17:13.295 We have guidelines and we have data
NOTE Confidence: 0.861349671538462
00:17:13.295 --> 00:17:16.228 that really helps us a ton to figure
NOTE Confidence: 0.861349671538462
00:17:16.228 --> 00:17:23.010 out which one of those custom roles
NOTE Confidence: 0.861349671538462
00:17:23.010 --> 00:17:26.230 And apologize for the background
NOTE Confidence: 0.861349671538462
00:17:26.230 --> 00:17:28.942 and that these can be customized
NOTE Confidence: 0.861349671538462
00:17:28.942 --> 00:17:31.734 to the patient’s best interest.
NOTE Confidence: 0.861349671538462
00:17:31.734 --> 00:17:34.246 So a robotic approach,
NOTE Confidence: 0.861349671538462
00:17:34.250 --> 00:17:37.610 a laparoscopic approach or an open approach,
NOTE Confidence: 0.861349671538462
00:17:37.610 --> 00:17:40.326 all of those can be very appropriate
NOTE Confidence: 0.861349671538462
00:17:40.326 --> 00:17:42.656 and we really find that at least
for right colon cancers,

the outcomes are very similar.

So oncologic outcomes here for robotic

versus laparoscopic approaches they have.

Stop improving one to be superior

That being said, pain,

postoperative recovery,

length of stay,

you know,

those have definitely been shown

to be slightly in the advantage

of a robotic approach,

but ontologically probably very similar.

The last thing I want to talk

about.
about a little bit is just about

Lymphadenectomy and the extent that

we do not to belabor this too much,

but the the importance of doing a.

Adequate lymphadenectomy with

getting over 12 lymph nodes,

but there’s been some discussion and

you might hear this in the literature

you might hear this in the literature

or hear patients ask you about this,

the idea of a complete musicolic excision

or an extended lymphadenectomy and

or an extended lymphadenectomy and

you know that’s become more and more.

Employed in Europe and in Asia and

right now in the United States,

the American side of colorectal

surgeons has not recommended that we
00:18:54.115 --> 00:18:56.640 do a routine extended lymphadenectomy.

00:18:56.640 --> 00:18:58.236 But if we see, you know,

00:18:58.240 --> 00:19:00.020 suspicious notes outside of the

00:19:00.020 --> 00:19:01.800 normal field of our dissection,

00:19:01.800 --> 00:19:03.664 that there does seem to be data that

00:19:03.664 --> 00:19:05.497 we should go ahead and remove those.

00:19:05.500 --> 00:19:07.444 And all that means is just doing sort

00:19:07.444 --> 00:19:09.560 of a little bit more of a lymph,

00:19:09.560 --> 00:19:11.732 lymph node dissection right on top

00:19:11.732 --> 00:19:13.540 of the superior mesenteric vein.

00:19:13.540 --> 00:19:15.190 But right now we’re not,

00:19:15.190 --> 00:19:17.444 we’re not advocating or at least our

00:19:17.444 --> 00:19:19.106 our guidelines don’t advocate

00:19:19.106 --> 00:19:20.996 for us to do that routinely.

00:19:21.000 --> 00:19:22.232 And then the last thing I would

NOTE Confidence: 0.813356727368421
say is that we,
we really work hard to integrate
our eras on care signature pathways
within our preoperative planning.
So that really involves us
making sure that you know,
we’ve got our patients very well
educated in the office on what they
need to do before surgery and their
expected discharge and what they need.
To do when they get home and obviously
all of this allows us to hopefully get
our patients home and back into
your offices looking for the next steps.
Thanks again for the opportunity to be here.
So this is a Justin Persico.
I’m going to take it from here to continue the discussion and I guess I should preface the discussion that we that we are talking about colon cancer patients here. We do segregate rectal cancer patients into a different category and think about them a bit a bit differently in terms of how we approach it. But for typical colon cancer patients, the paradigm is you know typically the stage and to do surgery and then they would be referred to the medical oncologist and I wanted to use. Is this opportunity to sort of highlight a couple of points that are sort of
practice changes that have happened
maybe in about the last five years
that might be important for you to know as you send your patience for a referral to us, umm, the this, this case in particular is a patient with a stage 3 colon cancer. So the data is quite clear that those benefit those patients benefit from adjuvant chemotherapy. But how we give it as well as what we do with earlier stage patients, particularly stage two patients has changed a bit.
I’ll first discuss stage two patients,
even though that’s a little different than this particular case.
But in the past, medical oncologists have used clinical pathologic features to decide, you know, which patients within that stage would be at the highest risk because studies have failed to show consistently that all stage, stage two patients benefit from adjuvant chemotherapy. But we do know there are a subset who are at a significantly higher risk and
those patients really should get treatments.

In the past we use these factors

I've listed here whether the patient presented with an obstructive tumor or a larger a T4 tumor or bathing

whether there's a risk factor like seeing Lymphovascular invasion even though we don’t see lymph node invasion yet.

But this is largely I think going to be supplanted and this transition has already happening in oncology with what we call circulating tumor DNA testing.

So, so this is a a serum test, a blood test that we can do on
00:22:10.998 --> 00:22:12.936 patients when they are referred to us.

00:22:12.940 --> 00:22:16.209 Uh which would detect uh whether there

00:22:16.209 --> 00:22:19.084 is actually cancer tumor DNA in the

00:22:19.084 --> 00:22:21.338 bloodstream and and as you might expect

00:22:21.338 --> 00:22:23.615 this is this is a poor risk factor.

00:22:23.620 --> 00:22:27.380 I put in this recurrence free survival

00:22:27.380 --> 00:22:28.773 curve from this recent dynamic

00:22:28.773 --> 00:22:30.471 trial that was published in New


00:22:31.910 --> 00:22:35.577 There’s also other groups who have

00:22:33.722 --> 00:22:37.905 and as you can see the patients who

00:22:35.577 --> 00:22:37.905 did have detectable circulating


00:22:41.450 --> 00:22:43.946 So these are stage two patients.
And so those patients are likely the best candidates for adjuvant chemotherapy and patients who tested negative had actually very excellent disease free survivals going out four years and those patients probably don't, won't benefit from chemotherapy. So this is the emerging more and more the main data that's still lacking here is just the confirmation that if these patients do test positive for circulating tumor DNA do they benefit from. Chemotherapy, uh, but we, we know like I said there's a high risk group and and this this
actually this disease free survival curve is one of the better ones. When you look at some of the data from like what’s what’s called the circulate trial, there’s a few of those going on across the world. The outcomes are even worse in their studies compared to this. And we actually at Yale had one a clinical trial called the COBRA trial actually I think it might just be on pause, but it’s an ongoing trial. Where we’re looking at these stage two patients and then randomizing them to get treatment or not treatment depending
on the presence of circulating tumor DNA to try to answer that question. So, so this is something your patients may be coming across for stage three patients like I mentioned the data is quite clear that they benefit from chemotherapy. But what’s happened in the last five to maybe 10 years now is there’s been further work on trying to separate out. Patients that may not need the typical recommendation, which would be six months of adjuvant chemotherapy. There is this group called the ideal Trial Analysis Group.
that’s taking the data from multiple adjuvant chemotherapy studies. And I’ve come with some pretty interesting results analyzing this and the most significant here is that they found patients who had Lower earlier stage, stage three, Stage 3B with three or less lymph nodes have the same outcomes if they receive three months of adjuvant regimen where we use capacity and oxaliplatin compared to six months of traditional folfox chemotherapy, which is great because it’s shorter.
duration and it helps reduce the most feared I think long term complication of these treatments which is peripheral neuropathy, rates of peripheral neuropathy with three months of chemotherapy are only about 10%. Compared to more than 60% with six months of chemotherapy. So. So this is an example of how we’ve actually been able to to reduce the treatment in certain circumstances. Now patients with more than three lymph nodes or other high risk factors like having two separate tumor deposits from the primary tumor T4 tumors.
These types of things we still recommend you know they be treated more aggressively as a high risk patient with six months of combination chemotherapy.

So, so with that I think we can pass it back for discussion of case 2.

All right. Justin and Anna, thank you so much for expanding on what we see as primary care doctors and bringing us over to what happens when our patients leave our offices and start seeking care with the surgeons and medical oncologists that need to take care of them.
Our next discussion is going to be a little bit different because we're going to spend some time talking about a case. We're going to talk a little bit about discussion points for us as primary care physicians, a little bit about the treatment of this disease, but we're going to bring it in a little bit of a different direction which I think will be brought up in another of the smile shares programs coming up.

So case two, we have a 75 year old woman with a history of Type 2 diabetes, hypertension, spinal stenosis, peripheral arterial disease.
She's a former smoker who presented to her PCP with a 2 month history of chest pain, epigastric pain, dysphagia, and 11 pound weight loss. She's very active and walks 2 miles per day, helps care for her grandchildren on physical exam. She's thin but otherwise looks good. Her lab work shows that her kidney functions are normal, LFT's are normal, except for a bump in her Lt. to 40, and her hemoglobin is only seven. So. Every day of our lives,
people walk in our offices.

They have a big gastric pain,

We're trying to figure out what
to do with it.

We use a lot of proton pump inhibitors
and diet change and so forth.

But what we need to learn is
what are the symptoms
in this case that raise concern.

And what do we need to do when we
see these warning signs that make us
think that this isn’t just another
time to hand out the purple pill, so.

First discussion point,
what are the symptoms in this case that raised concern?

Obviously, the weight loss is kind of a standout. And secondarily, the hemoglobin of seven, we think malignancy. We think something big and bad is happening if the body is so affected as to cause weight loss and anemia. And what we need to do at that point is these are the people that we’re probably not going to be really doing the medication trials with. We may put them on a medication,
but we might say you really need to see a GI specialist at this point. You really need to have some testing done. So if we could go to the next slide, our patient did undergo testing. And her cat scan did show thickening of the GE Junction, multiple liver metastases, pulmonary embolus of the left lower lobe. Ultrasound also showed in the left lower extremity and occlusive DVT. She underwent EGD and biopsy, which showed a mass poorly differentiated adenocarcinoma. Her two negative MSSP DL1
CPS greater than five.

And this patient obviously is just a little bit more of an advanced situation that our last case,

but let’s hear from our oncologist, Dr. Pam Koons about what she would do for this patient.

Thank you, Pam.

So you know when I’m first meeting with a patient in a new patient visit, I try to go over and be really clear about what we’re defining in terms of the stage of the disease.

So this is a stage four or metastatic.
GE junction adenocarcinoma with liver metastases. Defined to the patient really what that means and what our goals of care are. So if even in that first meeting I would say the goals of care are to control the disease, we will not be able to get rid of the disease. This patient is robust enough to consider doing first line chemotherapy. And before we get into that I do want to define some of the acronyms that are used in this because I think it’s.
Just to for the you may see these in pathology reports.

So her two is and MSS are both standardly done now for most GI cancers.

So her two is in the family of epidermal growth factor receptor is about 15 to 20% of patients will be her two positive.

This is more common probably in the language of breast cancer that you may be familiar seeing this.

But we do have targeted therapies for this for patients who are her two positive including something called.

S2 is amab or her septum.

MSS refers to microsatellite stability
or microsatellite instability.

We see this commonly.

We see microsatellite instability with Lynch syndrome which was mentioned in the earlier case where again testing this now routinely in all GI cancer.

So this patient was microsatellite stable, therefore unlikely to have Lynch syndrome and we use this some to think about immunotherapies and then the third category or the third item listed in the pathology report. Is PDL one. It’s the combined positivity score of greater than or equal to five. That CPS score is actually the
number of PDL 1 staining cells.

So this is an immune marker that includes the tumor cells, the lymphocytes and the macrophages in a combined score.

And this is a little debatable as to what positive is in this case, but it really indicates there’s a specific indication for the use of nivolumab in the first line setting so that.

For a CPS score of greater than or equal to 5.

So when I so this patient a standard first line treatment would be the combination of folfox and
nivolumab full foxes,

5 FU and oxaliplatin again talked about by the way on a multiple choice test,

full foxes often the right answer for most GI cancers.

So that was already discussed in colorectal cancer and nivolumab is one of our checkpoint inhibitors, it's a PD1 antibody.

This is becoming pretty common language. Really across specialties if thinking about checkpoint inhibitors because we see a lot of immune related side effects, many of you have may have taken care of patients with some of these.
So as I start talking about treatment and goals of treatment, I also will mention sometimes patients will ask, well, what’s my prognosis? I don’t often kind of bring that up on my own. During the first visit, I will talk about again, palliative versus curative treatments. But if a patient asks me, we will sometimes talk about median overall survival. And for this audience, the median overall survival
is probably 12 to 14 months.

It was about 14 months in this clinical trial with FOLFOX and nivolumab.

But it can certainly be less and I tell patients that the first few months is really a test of biology of their cancer as we learn a little bit more about how they tolerate the treatment and how they respond.

So our patients as we just discussed a moment ago did end up receiving the palliative chemotherapy of the combination of folfox in the volume NOB.

She saw improvement of her dysphagia reduction, the size of her liver lesions.

So I’ll pass to Beth for the next slide.
She was also started on Lovenox obviously to treat the fact that she was hypercoagulable from her cancer and had the PE and DVT at diagnosis. Unfortunately, after about nine months the CAT scan showed some progression and she did develop worsening dysphagia. Her performance status deteriorated and she needed a G2 for nutrition and spent a fair amount of time in the hospital. She insisted on continuing chemotherapy until she became bed bound due to weakness and recurrent DVT. And this is one of those moments I wanted to insert into this talk.
which I think is so important for us,

this primary care doctors,

how do we talk to our oncology partners with our patients?

When do we in you know interact.

And I think it’s important for

us first to hear kind of from the oncologists how Pam do you direct

the care at end of life and then I’ll talk a little bit more after you’ve, you’ve told me how you do things. 

Sure, absolutely.

I mean I think this is a really great opportunity for something we could really do better.

Is the partnering between oncology
and primary care physicians, particularly if PCP’s have a long trusting relationship with their patients. I think that can be really valuable to have these conversations. I think that usually when someone is deteriorating or if we get a scan like this, it’s really important to talk about their goals of care. You know if this patient is robust enough, we may consider additional treatment, but this patient has really been deteriorated significantly and if they are bed bound. They would be. We use something called a performance
status or the ECOG performance status.

If they’re in bed more than half the day, they would be an ECOG performance status of three and we generally would not continue chemotherapy at that point. And so I start talking about palliative care often. We will have started palliative care in the outpatient setting even before Hospice. That’s often probably a good time, for us to be communicating with you. Umm, patients often get confused as to who they go to with questions really throughout their oncology. Journey,
but I would say especially when they’re needing, when they’re more symptomatic. And I think having open lines of communication between UNC and palliative care is important. And then I would say 1 Pearl that I have around end of life and goals of care communications is that if you can do it early and often, it’s really helpful. So that the slow drip of information around goals of care and around definitions of palliative care and Hospice and destigmatizing,
all of that is critical and it often. Takes multiple visits.

Yeah. I totally agree and appreciate your thoughts. I think that sometimes there’s an extreme stereotype that an oncologist is always going to want to treat a patient regardless of where they are at stage. And I think you’re right, the more we plant seeds of conversation and sometimes for our patients like if
they have other health problems and

you’re seeing them and then you’re like,

how is their cancer treatment?

Knowing you can kind of nicely

insert you know what’s going on.

But I think what’s great about

us and having epic,

which I didn’t have as I was in private

practice is that I can communicate

with all of these oncology staff

members either through an annoying

instant message or just a regular

message or see seeing a note to them.

And so we can really improve

our conversations that way.
And then if we need to have a real phone conversation and talk to them about like what do you think for this patient and should I try to counsel them about end of life issues or Hospice or palliation? That, you know, we’re all moving towards that obviously when everyone is on the same page and the patients hearing things from the oncologist, but you have these options and they’re hearing something similar from their primary care doctor.
It can only go better because if you’ve ever spent time in a Hospice care setting like I have as a medical student, I loved it.

The nurse said the perfect moment is when everyone is at the same decision point at an end of life situation. So when we’ve decided that treatment is no longer valuable. But we can get every person in that person’s family as well as the patient and the team all saying, yes, this is where we are. We’re in a good place.
Thank you for allowing us to have that different discussion, Pam. I really appreciate it. So our last case kind of at first I was like well is this really a case we’re going to do and of course it is because it’s still part of GI cancer and this is another case that I wanted to make everyone aware of. I have a 56 year old woman who presented to a surgeon actually. She had a few month history of increasing rectal pain and bleeding. And of course, we need to think about what those things could be. But I want to insert my thoughts,
which is that so many of us, as primary care doctors say, must be a hemorrhoid. Oh, you know, maybe it’s a fissure if it’s painful, but if it’s really a lump down there, it’s got to be a hemorrhoid. I don’t need to see it. I don’t need to look at it.

You know, let’s just talk about 6 fast and let’s talk about avoiding Constipation. But obviously this case is a GI cancer case. So that’s not where we’re going. Where we’re going is a basic concept.
that I want to emphasize to all of you.

When your patient feels a lump in their ** area,

we need to do that exam.

We need to actually take a step further.

In this situation,

the patient mentioned that her pain was worse with bowel movements.

On exam,

she had a 2 by 3 centimeter anal mass.

A biopsy of the mass did reveal squamous cell carcinoma.

Its P 16 positive.

She underwent full staging and fortunately didn’t have evidence of metastasis.

Her treatment has involved
chemotherapy as well as radiotherapy. But in a moment I’m going to see some graphic images. So, as it says here, warning graphic images on their way. Thank you so much. Hi guys. First I want to basically demystify the ***.
The **** is just a part of your body, like everybody, like everything else. And looking at and evaluating the unit should be done just like any other piece of skin. In order to look, you have to have an assistant to kind of hold the cheeks apart. And if you lay the patient on their left hand side and you kind of hold the cheeks up, you'll be able to see the entire anal area carefully. If you look at these, they're 5 pictures here, the anal cancer one, you can look and say it's almost looks like a hemorrhoid, but if you touched it, it would be firm and irregular. Anal cancer is in the anal area.
Skin cancer in the anal area are just like skin cancer is in other places. They’re generally firm, irregular, discolored doesn’t look normal. So if you just think about that and you think about anything that’s abnormal. More likely that that’s the thing they have to worry about in the send to a specialist. But look and feel. If you look and feel, you will not make mistakes frequently. If you look at the pictures of the right, these are anal warts. Warts look relatively the same in multiple different areas.
The middle one at the bottom are hemorrhoids.

Now if you touch all of these different things, they will be all different.

But the annual cancer is firm, irregular, discolored.

So I just want to talk briefly about anal squamous cell cancer. So it’s a relatively faster growing cancer especially in the immune compromised group. Now that people have been living much longer with HIV, they are now getting secondary and tertiary diseases and this is a very common one. Anal squamous cell cancer is analogous to cervical and vaginal squamous cell cancer.
It’s similar tissues involving the similar HPV source just to remind everybody if you test 20 to 30 year old. Kids the day you test them 80% body the day you test them. So it’s very common high risk groups, men who have sex with men, HIV positive patients and or people who have immune compromised, we’re getting more and more immune compromised patients with liver transplants and kidney transplants etcetera. And also anybody who has a history of HPV disease not infection but
disease which are warts both in the front and the back genital. As well as dysplasia of the cervix or the vagina. So there's a large group of people who are at high risk and I put anal pap smear as prevention here because as analogous tissue prior to the papilloma testing, cervical cancer had something like a 90% mortality rate and we've significantly dropped death rates because we're finding cancer in the pre cancer stage. Now best as I can tell there's only a couple ways to do that. That's with polyps and colorectal.
cancer you prevent.

If you find people who have dysplasia on anal or cervical pap smears, you can keep them from getting cancer. So in the back of your mind you have to remember HIV, HIV positive, low immune system. Men who have sex with men or who have previous HPV disease should have anal pap smears once a year. I'm done.
a little bit here with this slide.

But with you know with one comment I'll make about anal, anal squamous cell carcinoma is, that's because these patients are often immunocompromised, doesn't mean that they're not candidates for aggressive therapy, chemotherapy and radiation actually plenty of studies show that. They do just as well and tolerate it just as well with few exceptions and it is a disease that we can cure with chemotherapy and radiation and and avoid surgery. So.
So that’s always the goal and you know surgery is used more as a salvage technique for these patients. Should they not fully respond and go into complete remission with their chemotherapy and radiation or should they recur later on because radiation can really only be given once and at that point you’re really reliant on what the surgeon can do. And I want to use this opportunity as we’re talking about rectal bleeding to highlight something I think most primary care doctors have already.
have noticed and are aware of.

You know in both the medical literature and the literature that there has been a rise in diagnosis of colorectal cancer and specifically I’m talking about rectal cancer here in younger patients. This is part of the reason why the screening age has been reduced from 50 to 45, but.

But you know this, this slide is just to sort of highlight, this is also something you should be thinking about. You know if you’re seeing a patient who has symptoms you maybe you do a rectal exam and you don’t really see
anything on the rectal exam

that we still have to think about you know rectal cancer as a potential reason for bloody stools.

The current estimation is that there's about 18,000 new cases each year.

And people under the age of 50 and colorectal cancer has been rising in terms of the leading causes of death and cancer death I should say and patients age 20 to 50.

as you can see this data from the SEER database showing in men, it is actually the number one now and women #3 so high high up
00:45:10.984 --> 00:45:13.018 on the list for both.
NOTE Confidence: 0.830697888095238
00:45:13.020 --> 00:45:15.125 Additionally we’ve we’ve known for
NOTE Confidence: 0.830697888095238
00:45:15.125 --> 00:45:17.723 some time now that that African
NOTE Confidence: 0.830697888095238
00:45:17.723 --> 00:45:19.793 Americans black patients are are
NOTE Confidence: 0.830697888095238
00:45:19.793 --> 00:45:22.354 more at risk for rectal cancer
NOTE Confidence: 0.830697888095238
00:45:22.354 --> 00:45:24.838 but there have been recently more
NOTE Confidence: 0.830697888095238
00:45:24.838 --> 00:45:27.131 spikes in incidents in whites,
NOTE Confidence: 0.830697888095238
00:45:27.131 --> 00:45:29.566 Native Americans and Alaskan natives.
NOTE Confidence: 0.830697888095238
00:45:29.570 --> 00:45:31.370 So that gap is is closing.
NOTE Confidence: 0.830697888095238
00:45:31.370 --> 00:45:33.246 So we have to be thinking about
NOTE Confidence: 0.830697888095238
00:45:33.246 --> 00:45:35.474 it you know pretty pretty evenly
NOTE Confidence: 0.830697888095238
00:45:35.474 --> 00:45:37.290 across our patient population.
NOTE Confidence: 0.830697888095238
00:45:37.290 --> 00:45:39.040 The reason for this is still unclear
NOTE Confidence: 0.830697888095238
00:45:39.040 --> 00:45:41.066 a lot of smart people looking into
NOTE Confidence: 0.830697888095238
00:45:41.066 --> 00:45:43.180 this every conference I go to I’m.
NOTE Confidence: 0.830697888095238
00:45:43.180 --> 00:45:45.040 Always interested in what research
00:45:45.040 --> 00:45:47.922 is going on in terms of the causes

00:45:47.922 --> 00:45:50.148 for this and what they found

00:45:50.215 --> 00:45:52.380 it is really nothing definitive,

00:45:52.380 --> 00:45:56.818 this is. A very complex subject with a

00:45:56.818 --> 00:45:59.829 lot of variables involved, but but some.

00:46:01.980 --> 00:46:02.520 Up there.

00:46:10.420 --> 00:46:12.769 The other factor?

00:46:14.790 --> 00:46:17.310 Because there’s of course been

00:46:17.310 --> 00:46:19.830 a rasterized kind of physical

00:46:19.914 --> 00:46:22.349 activity that we’ve also had.

00:46:22.350 --> 00:46:24.870 Some young face young folks in particular.

00:46:27.670 --> 00:46:32.326 Diets more prosthetic, you know,

00:46:32.326 --> 00:46:34.885 being used less, less, you know,

00:46:34.885 --> 00:46:36.606 cooking and less Whole Foods

00:46:36.606 --> 00:46:39.217 are being zoomed and a lot of
interesting data in terms of the changes that are happening. Buy it. It’s very complex. That could be linked here, but not, not yet. A lot more to come over the coming years. So, so keep your eye out for that. So that concludes the formal part of our talk, but I hope that you are thinking of questions. I see one has popped up. Please enter them. Before we answer, I just want to put in a plug for another medical education opportunity called trust your gut.
We're on March 16th, Chavier lore and.

Two, Kaship will present on colon cancer screening with an update and this will involve a lot of details that Beth did not have time to cover when she covered the care signature pathway on you know, stool based screening when it's appropriate and reclassification of colon cancer screening to a two step screening when a non invasive tool is used and.

One of the most exciting developments is that that's now covered equally by insurance as screening.
if a Cologuard is positive.

So we will leave that up as well as kind of the announcement of next month where we will have palliative care and a more extensive discussion.

So I am going to move on to questions. We have one from Doctor Breyer. Beth as one of the panelists, do you have any additional questions for our SMIL0 colleagues at this time?

Yeah, I do have a few, one of them and I think it got brought up with the GYN cancer screening.
CEA is an indicator of things.

So again sometimes patients get kind of hung up on things.

I haven’t had one of these lately, but I get the sense that we’re only going to be doing tumor marker assessments after we have a positive diagnosis.

But I wanted your thoughts on patient comes to me Doctor Allard, you know my so and so has colon cancer. Can we just do this? EA level?

What’s your thinking about that? Should I say no, and if so, why?

No, I don’t want to take that one.
Take that at all but yes, no. So you're exactly correct that this is really a post you know diagnosis test that there has not been a study showing that this is a good screening test for colon cancer. So that's what I usually advise patients that with you know without a diagnosis we've never really shown that this test is going to detect if you have colon cancer or tell us if you have colon cancer or tell us if you're at a higher risk of colon cancer or any of that information. So, so that's usually you know how I advise I think in my experience you know the the CA 125.
And the gynecologic malignancies because it’s used, you know, so, so much. It’s more commonly the question but CEA may come up from time to time and everybody’s familiar with PSA which is a completely different story. And I would you tell patients that there are you know studies showing that can be an effective screening test although that is as you know it’s primary care doctor still that’s a matter of somewhat debate so. Yeah, go ahead.
in and and support Justin as well.

And I think that’s a that’s that’s a very realistic I think thing

because often even when you know

you do a screening colonoscopy you

you'll say well should I just get

the CEA as well at that time and and

the answer there obviously is no.

I mean there are very rare

circumstances well where we will do

it without a diagnosis sometimes.

And this is rare.

If we have a patient who’s sort of got,

you know, this diverticular disease
that doesn’t get better and and they may have a small Abscess at the same time.
And imaging is sort of you know, maybe concerning a little bit for more of a, you know, a thickening or a mass like lesion. We might do it in that setting, you know there are very rare circumstances where we might use it and I think the other thing that’s important to note. Is when patients come in and they have verified colon cancer by pathology and on colonoscopy amass and their CA is normal. It’s important to tell patients.
at that time as well. But not all colon cancers make CEA
and that that's an important thing because it's not always you know, it doesn't always portend a great prognosis and so you know these nuances are important and and I love that question, it's such a great question.

Well, sometime we'll bring back a group to talk about what is being referred to as liquid biopsy in the late literature. That is will be on our minds. I'm going to move to Doctor Breyer. There's question who points out that there was a wonderful lecture,
00:52:17.030 --> 00:52:18.822 this was at a general internal medicine

00:52:18.822 --> 00:52:21.405 grand rounds, about the care of patients

00:52:21.405 --> 00:52:23.057 living with developmental disorders.

00:52:23.060 --> 00:52:26.280 And as these patients are living longer,

00:52:26.280 --> 00:52:30.288 is there a recommendation about screening

00:52:30.288 --> 00:52:33.480 them or those who are conserved,

00:52:33.480 --> 00:52:36.640 for example, with mental illness?

00:52:36.640 --> 00:52:38.904 I feel like this might be as much

00:52:38.904 --> 00:52:40.580 primary care as anything else.

00:52:40.580 --> 00:52:42.012 I don’t know that.

00:52:42.012 --> 00:52:43.444 Do you have a?

00:52:43.450 --> 00:52:44.570 A thought about that.

00:52:46.720 --> 00:52:48.520 I think I kind of look at like what the

00:52:48.574 --> 00:52:50.548 guideline says and say how functioning is

00:52:50.548 --> 00:52:52.558 that individual and if we detect the cancer,
what is it we’re going to do afterward, right. So if there’s an anticipated process by which that person’s going to be supported through their cancer diagnosis and could undergo surgical procedure and so forth, then I would lean towards it versus someone that has a lot more limited functioning. So I think it’s hard. Also, the first thing that pops into my little head is Cologuard. I’m like, oh, let’s screen some of these folks that way because. It’s just so much of an easier process than preparing for the colonoscopy and that might feel...
00:53:22.414 --> 00:53:24.697 like a cheap out to some of you.
00:53:24.700 --> 00:53:26.812 But I look at the whole patient and
00:53:26.812 --> 00:53:29.548 say let’s not put them through things
00:53:29.548 --> 00:53:31.268 that aren’t unnecessarily complicated.
00:53:31.960 --> 00:53:33.136 I think that’s a great point.
00:53:33.140 --> 00:53:35.780 I mean I’ve had a lot of patients,
00:53:35.780 --> 00:53:36.928 you know, you know,
00:53:36.928 --> 00:53:39.773 I think we have a lot of patients that
00:53:39.773 --> 00:53:42.223 are autistic and you know doing a
00:53:42.297 --> 00:53:44.817 prep requires a whole family effort.
00:53:44.820 --> 00:53:47.529 It’s not an easy thing to do.
00:53:47.530 --> 00:53:49.746 Um to support a patient through that process.
00:53:49.750 --> 00:53:52.326 And so I wholly agree with you,
00:53:52.330 --> 00:53:55.156 it’s got to be a conversation
00:53:55.156 --> 00:53:58.130 between the family the caregivers,
00:53:58.130 --> 00:54:00.200 the primary care team about really
NOTE Confidence: 0.788603228333333
00:54:00.200 --> 00:54:02.561 trying to find what that you know
NOTE Confidence: 0.788603228333333
00:54:02.561 --> 00:54:04.703 I always say you know on screening
NOTE Confidence: 0.788603228333333
00:54:04.774 --> 00:54:07.222 talks you know the people ask me well
NOTE Confidence: 0.788603228333333
00:54:07.222 --> 00:54:09.228 what’s the best test the screening
NOTE Confidence: 0.788603228333333
00:54:09.228 --> 00:54:11.649 test for colon cancer and it’s the
NOTE Confidence: 0.788603228333333
00:54:11.649 --> 00:54:13.809 one that you’re able to get and so
NOTE Confidence: 0.788603228333333
00:54:13.809 --> 00:54:16.260 you know if you if you’re able to
NOTE Confidence: 0.788603228333333
00:54:16.260 --> 00:54:17.720 get multiple ones then getting.
NOTE Confidence: 0.788603228333333
00:54:17.720 --> 00:54:19.370 You know, a colonoscopy or Cologuard,
NOTE Confidence: 0.788603228333333
00:54:19.370 --> 00:54:20.984 you know those are great things
NOTE Confidence: 0.788603228333333
00:54:20.984 --> 00:54:23.329 but I don’t think we can be overly
NOTE Confidence: 0.788603228333333
00:54:23.329 --> 00:54:24.839 judgmental when we’re looking at
NOTE Confidence: 0.788603228333333
00:54:24.839 --> 00:54:26.631 these sorts of special circumstances
NOTE Confidence: 0.788603228333333
00:54:26.631 --> 00:54:29.070 because it’s a better situation to do
NOTE Confidence: 0.788603228333333
00:54:29.070 --> 00:54:31.390 a test that is practical to be able

98
00:54:31.390 --> 00:54:34.373 to get done then not do anything at all.
00:54:34.380 --> 00:54:36.096 Because we all know of patients
00:54:36.096 --> 00:54:37.497 that just say, well you know,
00:54:37.497 --> 00:54:39.059 I’m not going to do it at all
00:54:39.059 --> 00:54:40.879 because it’s just too hard for this
00:54:40.879 --> 00:54:42.298 individual patient to be able to
00:54:42.298 --> 00:54:43.150 go through that process.
00:54:43.150 --> 00:54:44.202 So they, you know,
00:54:44.202 --> 00:54:46.360 I think it’s a really great question.
00:54:46.360 --> 00:54:47.926 You know, it’s, it’s a really.
00:54:48.610 --> 00:54:49.240 Now I,
00:54:49.250 --> 00:54:51.650 I and I will just chime in one step
00:54:53.942 --> 00:54:56.470 it’s positive it leads to colonoscopy.
00:54:56.470 --> 00:54:59.417 So you did the same decision making
00:54:59.417 --> 00:55:02.319 applies to even a non invasive stool
NOTE Confidence: 0.823603508181818
00:55:02.319 --> 00:55:04.653 based test and and Doctor Breyer
NOTE Confidence: 0.823603508181818
00:55:04.653 --> 00:55:07.068 was also happy with the answer.
NOTE Confidence: 0.823603508181818
00:55:07.070 --> 00:55:08.606 Thank you for that follow up.
NOTE Confidence: 0.823603508181818
00:55:08.610 --> 00:55:12.506 So I have another one from Doctor Banatski.
NOTE Confidence: 0.823603508181818
00:55:12.510 --> 00:55:16.087 When we order an anal pap do
NOTE Confidence: 0.823603508181818
00:55:16.087 --> 00:55:18.630 we order cytology and HPV?
NOTE Confidence: 0.823603508181818
00:55:18.630 --> 00:55:21.060 Every time if the cytology is
NOTE Confidence: 0.823603508181818
00:55:21.060 --> 00:55:23.739 negative and the HPV is positive,
NOTE Confidence: 0.823603508181818
00:55:23.740 --> 00:55:25.594 can you talk about frequency of
NOTE Confidence: 0.823603508181818
00:55:25.594 --> 00:55:27.440 follow up and where to refer?
NOTE Confidence: 0.823603508181818
00:55:27.440 --> 00:55:30.000 So we have a a lot of guidelines
NOTE Confidence: 0.823603508181818
00:55:30.000 --> 00:55:33.312 for Pap smear and HPV as far as
NOTE Confidence: 0.823603508181818
00:55:33.312 --> 00:55:35.040 our recommendations to repeat,
NOTE Confidence: 0.823603508181818
00:55:35.040 --> 00:55:39.900 but I there there is less for anal PAP.
NOTE Confidence: 0.823603508181818
00:55:39.900 --> 00:55:41.588 Scott, is this you?
So first of all, there are few people who do anal pap smears. It’s not a hard thing to do, no reason to test for the virus. Either they have dysplasia or they don’t. If they do have displays, that leads to a high resolution anoscopy which is a 5 minute outpatient with anesthesia exam, kind of like a colposcopy.
after a high resolution anoscopy and treatment repeat Pap smear in a year.

Again low grade lesions tend to not be as important as high grade lesions. But this simple thing for primary care docs, just think about one thing, if you have patients who are high risk, get them as someone who can do a pap smear. A pap smear is basically a Q-tip and I can teach anybody to do it and takes 15 seconds. So again. Just get it to somebody who can do a pap smear will will follow up the patients after that. But I think we're actually at time it is 559.
And wow, do I ever want to thank each of our panelists for their preparation and their really great presentations. And I definitely thank everybody who tuned in at the end of a work day at 5:00 o’clock to listen, because I know we’ve made it worth your while. But that also definitely is something to inspire gratitude. So thank you and I want to thank you as well. And and just Renee if you can put that last slide up if folks can can answer or or. I log in. For the CME piece and if you want to have any feedback, some of you want to have any feedback, some of you
have provided really great feedback,
which we're actually looking for as we think about extending this for next year.
So if you enjoyed the program, please put your comments on several of you, put really interesting questions and have a little bit of an e-mail conversation around that as well. So thank you all for joining us and thanks to our faculty. Everybody have a great night. Thank you.