Welcome to Yale Cancer Answers with your host doctor Anees Chagpar. Yale Cancer Answers features the latest information on cancer care by welcoming oncologists and specialists who are on the forefront of the battle to fight cancer. This week, it’s a conversation about colon and rectal cancer with doctor Amit Khanna, who is the director of Colon and rectal surgery for the Bridgeport region and an associate professor at the Yale School of Medicine where Doctor Chagpar is a professor of surgical oncology.

Amit, maybe we can start off by you telling us a little bit about yourself and what you do. So I’m a colon and rectal surgeon and I treat diseases both benign and malignant of the colon and the rectum and also help to organize programs for our digestive health service lines. So it includes all digestive health disorders.
So let’s pick up on that and put two of those things together so you know when we talk about colorectal cancer, tell us a little bit more about it. How common is it? How lethal is it? Who gets it? Why should we care? So it’s a huge public health issue for us. We’re probably going to see, the predicted number of cases by the American Cancer Society is approaching 150,000 new cases of colon and rectal cancer in the United States. Right now, it’s the third most commonly diagnosed cancer in the United States in men and women. The good news is that we’re seeing lower incidence rates in older populations, but unfortunately, we are also seeing some trends or increases in younger adults, so we’re making progress in a lot of areas, and we’re also facing new challenges. When you say younger adults, how young is young? Classically our screening guidelines have been aimed at
the population older than 50, so the classic age of getting your first colonoscopy if you don’t have a family history or other risk factors has been 50, and that’s largely been designed because we know that the incidence of colorectal cancer rises significantly after the age of 50, and that’s been the way it’s been for many, many years. In 2018 though, a recognition of changes in our cancer statistics showed that we were seeing patients in their younger years, meaning under 50 having a rise in their incidence, and so we were very concerned about that from about 2012 to 2016 we were seeing about a 2% increase in younger populations under 50 developing colorectal cancer. And so organizations like the American Cancer Society in 2018 dropped the age of recommendation to 45. Not all of the societies have gone along with that, but there’s an increasing recognition that it’s becoming a greater issue than just those over 50. And do we know why that is? I mean, why are
young people now getting colon cancer?

So it’s a great question, and I think that we don’t know the answer, we have some data and some evidence that suggests that a significant portion of the younger population has a family history, and there’s some genetic component, but that’s not the whole story, so only about 40% of those patients have a family history and even smaller percent actually have a genetic predisposition that we’re aware of to put them at increased risk so it’s got to be something that is not related to those specific family history risks and those genetic disorders which predispose patients to get colon cancer at an earlier age. In fact, the majority of those patients don’t have those risk factors. So what we really think is that it could be related to what we call the lifestyle risk factors and environmental factors. Tell me more about what those lifestyle factors and environmental factors are.

Obviously the big one whenever we’re talking about digestive diseases is our diet, and the younger population under 50s may impact their risk for
colorectal cancer is being studied, and we don’t know exactly how that is, but we do have some surrogates for that, and one of them is obesity, which we know increases the risk of colorectal cancer. We also know that physical inactivity increases the risk of colorectal cancer. We also know that there’s data that the microbiome, meaning the bacterial flora, the balance of different bacteria that reside in the colon and in the GI tract, may play a role in the development of colorectal cancer. And there is a lot of research going on now to help us understand what those factors are, but at this time it’s not entirely clear what other factors I mean. Smoked meats, particular fats in the diet, anything like that increase your risk of colorectal cancer. Absolutely great point, yeah, I think that we know that processed meats just as those you described are associated with an increased risk of colorectal cancer. And now you know we are looking to understand. In younger populations,
how much of a factor those are playing in the development of colorectal cancer in these younger age groups and of note identifying patients earlier with early stage disease affords that patient a better survival, and so if we can catch lesions early, we have a much better chance of helping that patient through their cancer journey and having. An ultimate great outcome for that patient, but the later they present or the later we diagnose those patients and their stages more advanced it becomes increasingly harder to get those patients a good outcome, and so in the younger populations particularly it’s a challenge because it’s a paradigm shift you know within, not only the patient themselves, but also in the healthcare community to recognize that patients under the age of 50. You know, are a group of patients that are still at risk for colorectal cancer, and it’s not just 50 plus folks. What are the signs and symptoms that people should be looking for that they should go and see their doctor? Yeah,
So I think there's such an important thing. I think for patients to understand that rectal bleeding is a very common thing, but it's abnormal, it's always abnormal. And so if you're having rectal bleeding, that's something that needs to be investigated by your provider. A change in your bowel function, if your bowel function is regular, you know, once or twice a day, and now you're going 6 times today. That's something that you want to communicate to your provider. And weight loss is a really important one too. If you're not trying to lose weight and you're losing weight, or you have a significant change in your appetite. Change in bowel function may also be discomfort when you're moving your bowels or a change in the character of your stools or the color, and those are all signs that you should communicate to your physician and be aware of that. Those changes really do need to be discussed and evaluated. I think it's also really important to understand your family history.
So if you’ve got siblings or older siblings and you know you’re 35 and you’re, you know may have an older sibling or your parents or other family members that have a history of polyps, and so having a family history of polyps can also impact how you should be screened.

And so I think the paradigm of screening patients just based on their age. Is not adequate and what we really need to think about is personalized screening for each patient and then educating patients on the importance of recognition of symptoms regardless of their age.

And so I’m going to pick up on screening in a minute but but getting back to these symptoms, I mean for many of our listeners out there, they may be thinking, you know, if I have a little bit of rectal bleeding, it might just be hemorrhoids.

If you know I have a little bit of diarrhea, it might be you know, the meal that I Late last night that just didn’t agree with me.

You know, is there is there a time frame that these symptoms should be continuous for or present for before people start sounding the alarm bells?
I think it’s a great point.

I usually tell patients that if you’ve noticed a consistent if you’ve noted consistent symptoms over a period of two weeks, that’s probably enough for you to seek care. And sometimes patients are very astute in saying you know what I ate, something that was bad yesterday and I got sick and then two days later I felt fine.

I think it’s the patients that are having a sustained set of symptoms over a period of two weeks or more, and those are the patients were real concerned about period. I mean if we think about patients who have rectal pain for example, over a period of at least two to three weeks. An rectal bleeding that can be a significant issue and not every one of these patients that’s having these symptoms is going to have colorectal cancer. In fact, the majority or not, but we know you’re at increased risk when you have those symptoms, and I think that it’s also sort of the engine warning light of the body.

And I always say this to patients who may come in with a benign
anorectal disorder which may cause bleeding hemorrhoids or anal fissure, which is a tear in the anal mucosa, but that warning system we want to treat that bleeding so that that warning systems intact right so? If you do have hemorrhoids and you’re bleeding every so often if it’s happening all the time, then you really lose that as a warning signal because it’s happening every so often and you blow it off. So we really want to get those other benign diseases treated so that we still have that warning system in place. We’re going to take a short break for a medical minute when we come back. We’re going to talk more about screening with my guest doctor Amit Khanna. Support for Yale Cancer Answers comes from AstraZeneca, working to eliminate cancer as a cause of death. Learn more at astrazeneca-us.com. This is a medical minute about breast cancer, the most common cancer in women in Connecticut alone. Approximately 3000 women will be diagnosed with breast cancer this year, but thanks to earlier detection, noninvasive treatments, and novel therapies, there are more options for patients to
fight breast cancer than ever before.

Women should schedule a baseline mammogram beginning at age 40 or earlier if they have risk factors associated with breast cancer.

Digital breast Tomosynthesis or 3D mammography is transforming breast screening by significantly reducing unnecessary procedures while picking up more cancers and eliminating some of the fear and anxiety that many women experience.

More information is available at yalecancercenter.org.

You’re listening to Connecticut public radio.

Welcome back to Yale Cancer Answers. This is doctor Anees Chagpar and I’m joined tonight by my guest, doctor Amit Khanna.

We’re talking about surgical care of colorectal cancer and right before the break we were talking about this increase that we’ve seen in terms of young people getting colorectal cancer.

And we talked a little bit about the symptoms that people should be on the lookout for.

Whether that’s a change in bowel habit or whether it’s feeling full or whether it’s rectal bleeding.

But oftentimes am I mistaken, oftentimes if you’ve got symptoms and
0:14:20.046 –> 0:14:23.27 you’re presenting with colorectal cancer,
0:14:23.27 –> 0:14:25.5 you’re picking up colorectal cancers
0:14:25.5 –> 0:14:28.8 later than if you were asymptomatic?
0:14:29.3 –> 0:14:32.318 Is that right?
0:14:32.32 –> 0:14:35.338 Absolutely, depending on where the colon lesion,
0:14:35.34 –> 0:14:38.358 or polyp, which is early changes
0:14:38.358 –> 0:14:41.904 or abnormal changes, or growths in
0:14:41.904 –> 0:14:46.65 the colon that are not cancer yet.
0:14:46.65 –> 0:14:49.22 You may be completely asymptomatic,
0:14:49.22 –> 0:14:52.1 and if they are on the
0:14:52.1 –> 0:14:54.87 right side of the colon,
0:14:54.87 –> 0:14:59.496 you may not ever develop any symptoms at all,
0:14:59.5 –> 0:15:02.168 and that’s the fundamental
0:15:02.168 –> 0:15:05.503 benefit of doing screening for
0:15:05.51 –> 0:15:07.916 colorectal polyps and colorectal cancers
0:15:07.92 –> 0:15:10.416 using a variety of
0:15:10.416 –> 0:15:12.521 modalities because you can be
0:15:12.521 –> 0:15:14.346 asymptomatic and so one of
0:15:14.35 –> 0:15:16.684 the things that I always think
0:15:16.684 –> 0:15:18.693 is great about colorectal cancer
0:15:18.693 –> 0:15:20.943 screening is that you can pick
0:15:20.943 –> 0:15:23.458 up these cancers like you can
0:15:23.458 –> 0:15:25.206 with many screening modalities.
0:15:25.21 –> 0:15:27.496 You can pick up these cancers
0:15:27.496 –> 0:15:29.63 before they become a cancer,
0:15:29.63 –> 0:15:31.685 and you can potentially eliminate
0:15:31.685 –> 0:15:34.21 them right then and there during
0:15:34.21 –> 0:15:36.598 that screening test so that
0:15:36.6 –> 0:15:38.008 it’s not just screening,
0:15:38.008 –> 0:15:39.416 it’s also prevented it.
0:15:43.66 –> 0:15:46.264 When I was in medical school and I was trying
0:15:46.264 -> 0:15:48.931 to figure out what it is I wanted
0:15:48.931 -> 0:15:51.624 to do with with my life in terms
0:15:51.624 -> 0:15:53.898 of my profession and my focus,
0:15:53.9 -> 0:15:56.364 that was really very appealing to me.
0:15:56.37 -> 0:15:58.266 Was the idea that you could
0:15:58.266 -> 0:16:00.002 identify disease in its early
0:16:00.002 -> 0:16:02.017 form and intervene and change
0:16:02.02 -> 0:16:04.684 the course of someone’s life and
0:16:04.684 -> 0:16:07.639 prevent them from having to go through
0:16:07.64 -> 0:16:10.05 cancer or potentially improve their
0:16:10.05 -> 0:16:13.75 quality of life.
0:16:13.75 -> 0:16:16.57 We’re able to use a variety
0:16:16.57 -> 0:16:19.78 of different tests to
0:16:17.98 -> 0:16:19.86 identify early stages
0:16:19.86 -> 0:16:22.21 of the disease, so let’s
0:16:22.21 -> 0:16:25.03 talk about these
0:16:25.03 -> 0:16:27.386 screening modalities, and
0:16:27.386 -> 0:16:30.218 first off the indications for screening
0:16:30.218 -> 0:16:33.016 and who needs to get screening.
0:16:33.02 -> 0:16:35.37 So you mentioned that the
0:16:35.37 -> 0:16:36.78 American Cancer Society,
0:16:36.78 -> 0:16:39.17 because we’ve seen an increase
0:16:39.17 -> 0:16:40.928 in colorectal cancer,
0:16:40.928 -> 0:16:44.444 in young patients has moved their
0:16:44.444 -> 0:16:46.559 guidelines down to asymptomatic
0:16:46.559 -> 0:16:49.912 people starting at the age of 45.
0:16:49.92 -> 0:16:51.99 But you also mentioned that
0:16:51.99 -> 0:16:54.06 it shouldn’t just be age.
0:16:54.06 -> 0:16:57.364 So if you do have a family history,
0:16:57.37 -> 0:16:59.86 let’s say when should you
0:16:59.86 -> 0:17:02.135 get screened, the general thought
is that personalized screening is going to be a much more high yield approach to screening patients. So what are those things that are important with a personal history of colorectal cancer? If you’ve had a history of polyps yourself, or you personally had colorectal cancer that’s a much higher risk group. A family history of colorectal cancer, personal history of inflammatory bowel disease. Whether that’s colitis or Crohn’s disease. And then, if you’ve had a suspected history of some familial syndromes that puts you at high risk for having polyps and then also things like having a history of radiation, those are all things that put you at a higher risk, including family members that have had colorectal cancer or polyps on their colonoscopies. And if you fit into any of those criteria when should you be getting screened? So depending on your risk category, it’s not the same for every patient, but if we look at patients that have a strong family history.
0:18:13.106 –> 0:18:15.494 or have a known family member, 0:18:15.5 –> 0:18:17.63 it depends on how close that 0:18:17.63 –> 0:18:19.43 family member is to you. 0:18:19.43 –> 0:18:21.978 So a first degree relative might be 0:18:21.978 –> 0:18:24.089 different than you know a cousin, 0:18:24.09 –> 0:18:26.29 but generally what we say is if you 0:18:26.29 –> 0:18:28.647 have a first degree family member 0:18:28.647 –> 0:18:31.245 who’s developed colon or rectal cancer, 0:18:31.25 –> 0:18:34.194 we should be screening that patient at least 0:18:34.2 –> 0:18:36.825 10 years prior to when that patient’s 0:18:36.825 –> 0:18:38.71 family member was diagnosed. 0:18:38.71 –> 0:18:41.552 So 10 years prior to their 0:18:41.552 –> 0:18:44.039 diagnosis or 45 years of age. 0:18:45.68 –> 0:18:46.91 You mentioned radiation. 0:18:46.91 –> 0:18:48.14 So if you’ve 0:18:48.14 –> 0:18:50.6 had a previous history of radiation, 0:18:50.6 –> 0:18:53.06 you’re in a higher risk category. 0:18:53.06 –> 0:18:56.75 What do you mean by a history of radiation? 0:18:56.75 –> 0:19:00.03 Is that going to a tanning Salon? 0:19:00.03 –> 0:19:02.9 Is that getting a chest X ray? 0:19:02.9 –> 0:19:04.244 Is that having 0:19:04.244 –> 0:19:06.484 radiation therapy for ovarian cancer? 0:19:06.49 –> 0:19:09.55 What is that and how does that 0:19:09.55 –> 0:19:12.957 play into when you should be getting 0:19:12.957 –> 0:19:15.79 screened for colorectal cancer? 0:19:15.79 –> 0:19:18.744 We’re talking about radiation for 0:19:18.75 –> 0:19:20.438 pelvic or abdominal cancers, 0:19:22.183 –> 0:19:25.021 so radiation to treat a prior cancer 0:19:25.021 –> 0:19:28.147 in the abdomen those are the 0:19:28.147 –> 0:19:31.66 patients that we tend to want 0:19:31.66 –> 0:19:34.636 to identify and screen more frequently.
The lower dose radiation patients maybe having perhaps more frequent exposure, we don’t know enough about those patients to justify screening them at a different or more aggressive interval. It’s more for patients that have had treatment for a prior cancer with radiation to the abdomen or pelvic region. When you talk about screening it at different intervals, it really brings up this whole bugaboo of the different screening modalities so people have heard about things like stool tests that are advertised on TV all the way up to colonoscopies, and then these are all recommended at different intervals. So can you walk us through what are the recommended tests for colorectal screening? How frequently we should be getting them, and how you decide what test you should be getting? I mean, should everybody be getting colonoscopies or is it just simpler to do a stool test? How do we make these decisions? It’s a great question and it’s honestly the most frequent question I get asked by family members.
and friends,
what test should I get and the answer I always have is the same which is the test that you’re willing to get is the best test, so often patients I see are very hesitant to have a colonoscopy in the interval for an average risk patient is at age 45. And then if you have a normal exam, it’s to have a follow up colonoscopy at 10 years, but there are other options. Some patients don’t want to undergo a colonoscopy. The cost is an issue. They may not have access to a colonoscopy or it’s quite costly for them and there are other ways to approach this for average risk individuals and I emphasize average risk individuals which is the most widely advertised one that you’ll see on TV is a stool DNA test, you’re going to be recommended to have that one that is sent as a kit to your home and then you send a stool sample back and that’s generally supposed to be performed every three years. If it is positive, it’s important that patients understand that, then they are going to be recommended to have
a colonoscopy, so those two tests combined can be more expensive.

than having a colonoscopy alone. The other two tests that are stool based tests are what we call fit tests or fecal immunochemical tests, which are sensitive for detecting blood in the stool, and then something called a fecal occult blood test or an FOBFOBT test which is done annually both of those other two tests, the fit test and the FOBT tests are done annually, so those are cards you get sent home with, and then you send back to your doctor and they process for the presence of blood.

I mean the other two tests that we call structural exams include, CT COLONOGRAPHY, which is a CT scan, that creates images of your colon, and that’s sort of been termed the virtual colonoscopy. And then there’s a more limited colonoscopy, which is known as a flexible sigmoidoscopies and those other two tests the CT colonography and the flex SIG as we refer to it,
a flexible sigmoidoscopies the intervals on those are every five years, but I want to make clear that the flexible sigmoidoscopies have limitations because it’s only exposing or it’s only visualizing the rectum in the sigmoid colon and we know that lesions can grow in the middle part and on the right part of the colon, and those can be missed. So we emphasize that a colonoscopy has some significant advantages over flexible sigmoidoscopies, and then the limitation of the CT colonography is that if you do see a polyp, you can’t intervene at that time. And so the colonoscopy has the opportunity to be both diagnostic and therapeutic. If polyps are identified, they can be removed in the same setting. Many advantages and disadvantages of all of these different tests. So let’s go over them just a little bit more. So the fit test and the FOBT. These are both stool based tests, and they’re both annual. So if somebody says, well, I don’t mind doing a stool based test,
which one is better?
Well, I think that the cost of the fit tests and the FOBT tests make it very scalable. So doing an annual exam for one of these tests is actually, inexpensive.
The problems with some of these is that a lot of patients don’t send them back, and so the yield on those can be an issue, but it’s a reasonable test. It’s good for detecting blood, but it’s also a cross sectional test, so if you’re not bleeding at that instance when you do the test from, say, a polyp that’s present, or potentially an early lesion, you might miss it. The stool DNA test is a bit more sensitive because it’s looking for specific changes in stool DNA, and it’s quite good at picking up cancers above 90% sensitive,
as we would like it to be,
but it’s still a pretty reliable test and
I think we’re going to see more and more patients take advantage of
stool DNA based tests as sort of a filter before they go to colonoscopy.
And those stool DNA tests you said are only three years versus the fit test
And the FOBT which is every year, right?
And an important misconception that I often hear with patients is they’ll think the stool DNA test is equivalent to a colonoscopy, and it’s not.
The interval is very different.
The stool based DNA test is every three years and a colonoscopy every 10 years, and so it’s really up to the patient to decide well do I want to do colonoscopy and be done with this for 10 years if it’s normal or do I want to have to keep going through this every three years?
And if they are positive, any of the DNA tests, then I’m going to have to have a colonoscopy anyway.
And then if it is positive I have to have colonoscopy.
If I get a colonoscopy to start off with and it’s normal,
I could go to 10 years, but if they do find something, they would also be able to treat it at the same time in most cases. So my final question just really quickly in the 30 seconds that we have left, you mentioned that colonoscopies are really expensive, but aren’t they covered by insurance yet? They are covered by insurance and Medicare covers, colonoscopy, and most insurance plans cover colonoscopy. We also have state by state variation in colonoscopy, but most Medicaid in most states covers colonoscopy and there are actually a lot of resources to help patients access colonoscopy, but sometimes the out of pocket expenses for colonoscopy, even with insured patients, can be significant and so one of the goals I think for us as a healthcare system is to realize that the return on the investment for us increasing our screening colonoscopy rates has been borne out in the data, and that colorectal cancer in the 50 and above age group has
really been impacted by the advent of aggressive screening colonoscopy programs. Doctor Amit Khanna is director of Colon and rectal surgery for the Bridgeport region and is an associate professor at the Yale School of Medicine. If you have questions the address is cancer answers at yale.edu and past addition to the program are available in audio and written form at yalecancercenter.org. We hope you’ll join us next week to learn more about the fight against cancer here on Connecticut Public Radio.