Focus on colorectal cancer

The DMH Cancer Care Institute teams up with the American Cancer Society: Building a healthier community 80 percent by 2018. Colorectal Cancer Screening—A call for heightened awareness and screening. Working together to save lives!
Decatur Memorial Hospital has embraced the shared goal of reaching 80 percent screened for colorectal cancer by 2018.

Shared Goal: Reaching 80% Screened for Colorectal Cancer by 2018

Background

Colorectal cancer is a major public health problem. It is the second leading cause of cancer death, and a cause of considerable suffering among more than 140,000 adults diagnosed with colorectal cancer each year. However, colorectal cancer can be detected early at a curable stage, and it can be prevented through the detection and removal of precancerous polyps.

Commitment

Our organizations stand united in the belief that we can eliminate colorectal cancer as a major public health problem. We have screening technologies that work, the national capacity to apply these technologies, and effective local models for delivering the continuum of care in a more organized fashion. Equal access to care is everyone’s responsibility. We share a commitment to eliminating disparities in access to care. As such, our organizations will work to empower communities, patients, providers, community health centers and health systems to embrace these models and develop the partnerships needed to deliver coordinated, quality colorectal cancer screening and follow up care that engages the patient and empowers them to complete needed care from screening through treatment and long-term follow-up.

Pledge

[____ Decatur Memorial Hospital _______] is embracing the shared goal of reaching 80% screened for colorectal cancer by 2018.

Approved by __Timothy D. Stone Jr., President and CEO, Decatur Memorial Hospital____
Colorectal Cancer

Education and Awareness

- Colorectal cancer is the third leading cause of cancer death in men and women in the United States.
- Colon cancer often starts with no symptoms.
- Screening helps prevent colorectal cancers.
- Only 62.5 percent of eligible people in Illinois get regular colorectal cancer screenings.

Digestive System Function

- The colon is also called the large bowel or large intestine.
  - A muscular tube about 5 feet long.
  - Absorbs water and salt from food.
  - Stores waste matter.
  - Moves solid waste to the rectum where it is eliminated.
- The rectum is the last 6 inches of the digestive system.

Figure 3. Leading Sites of New Cancer Cases and Deaths – 2016 Estimates

<table>
<thead>
<tr>
<th>Male Estimated New Cases</th>
<th>Female Estimated New Cases</th>
<th>Male Estimated Deaths</th>
<th>Female Estimated Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prostate 180,890 (21%)</td>
<td>Breast 246,660 (29%)</td>
<td>Lung &amp; bronchus 85,920 (27%)</td>
<td>Lung &amp; bronchus 72,160 (26%)</td>
</tr>
<tr>
<td>Lung &amp; bronchus 117,920 (14%)</td>
<td>Lung &amp; bronchus 106,470 (13%)</td>
<td>Prostate 26,120 (8%)</td>
<td>Prostate 40,450 (14%)</td>
</tr>
<tr>
<td>Colon &amp; rectum 70,820 (8%)</td>
<td>Colon &amp; rectum 65,670 (8%)</td>
<td>Colon &amp; rectum 26,020 (8%)</td>
<td>Colon &amp; rectum 23,170 (8%)</td>
</tr>
<tr>
<td>Urinary bladder 58,950 (7%)</td>
<td>Uterine corpus 60,050 (7%)</td>
<td>Pancreas 21,450 (7%)</td>
<td>Pancreas 20,330 (7%)</td>
</tr>
<tr>
<td>Melanoma of the skin 46,870 (6%)</td>
<td>Thyroid 49,350 (6%)</td>
<td>Liver &amp; intrahepatic bile duct 18,280 (6%)</td>
<td>Liver &amp; intrahepatic bile duct 8,890 (3%)</td>
</tr>
<tr>
<td>Non-Hodgkin lymphoma 40,170 (5%)</td>
<td>Non-Hodgkin lymphoma 32,410 (4%)</td>
<td>Lung &amp; bronchus 14,300 (4%)</td>
<td>Lung &amp; bronchus 14,240 (5%)</td>
</tr>
<tr>
<td>Kidney &amp; renal pelvis 39,650 (5%)</td>
<td>Melanoma of the skin 29,510 (3%)</td>
<td>Leukemia 12,720 (4%)</td>
<td>Leukemia 10,270 (4%)</td>
</tr>
<tr>
<td>Oral cavity &amp; pharynx 34,780 (4%)</td>
<td>Leukemia 26,050 (3%)</td>
<td>Urinary bladder 11,820 (4%)</td>
<td>Urinary bladder 10,470 (4%)</td>
</tr>
<tr>
<td>Leukemia 34,090 (4%)</td>
<td>Pancreas 25,400 (3%)</td>
<td>Kidney &amp; renal pelvis 9,940 (3%)</td>
<td>Kidney &amp; renal pelvis 8,890 (3%)</td>
</tr>
<tr>
<td>Liver &amp; intrahepatic bile duct 28,410 (3%)</td>
<td>All sites 841,390 (100%)</td>
<td>Brain &amp; other nervous system 6,610 (2%)</td>
<td>Brain &amp; other nervous system 6,610 (2%)</td>
</tr>
</tbody>
</table>

Estimates are rounded to the nearest 10, and cases exclude basal cell and squamous cell skin cancers and in situ carcinoma except urinary bladder.

Colorectal Cancer

Prognosis better when caught early

The lifetime risk of developing colon and rectal cancer is five percent for general population. The risk increases with family history and inflammatory bowel disease (Ulcerative colitis and Crohn’s). The risk is even higher with genetic mutations especially Familial Adenomatous Polyposis (FAP).

Family history plays an important role in development of colon and rectal cancer.
Colorectal Cancer—KNOW YOUR FACTS:

**Colorectal Cancer Symptoms**
Colorectal cancer might not cause symptoms at first, but if it does, it may cause one or more of the following:

- Abdominal pain or discomfort
- Changes in bowel frequency/consistency
- Narrow stools
- Blood in your stool
- Feeling as if your bowels don’t empty completely
- Unexplained fatigue
- Unexplained weight loss
- Nausea or vomiting
- Anemia

**Colorectal Cancer Risk Factors**
- Being age 50 and older
- Smoking
- Overweight or obesity, especially those who carry fat around their waists
- Physical inactivity
- Excessive alcohol consumption, especially men
- Regular alcohol consumption increases risk two fold
- Diagnosis at younger age
- Diet high in red meat (such as beef, pork, lamb) processed meat (such as bacon, sausage, hot dogs, cold cuts)
- Personal or family histories of colorectal cancer or benign (not cancerous) colorectal polyps
- Personal histories of inflammatory bowel disease (such as ulcerative colitis or Crohn’s disease)
- Family histories of inherited colorectal cancer

**Colorectal Cancer Prevention**
- Be physically active for at least 30 minutes at least five days a week
- Maintain a healthy weight
- Don’t smoke; if you do smoke, quit
- If you drink alcohol, no more than one drink a day for women; two drinks for men
- Eat fruits, vegetables and whole grains to help you get and stay healthy
- Eat less red meat and cut out processed meat

**Colorectal Cancer Detection**
*The best time to get screened is before you have symptoms.*
If you’re at an average risk, start getting screened at age 50. If you’re at a higher risk, start screening earlier and more often.

**Colorectal Cancer Screening Guidelines:**
- Colonoscopy, every 10 years
- Virtual colonoscopy, every 5 years*
- Flexible sigmoidoscopy, every 5 years
- Double-contrast barium enema, every 5 years

Tests that mainly find cancer
- Stool occult blood test (FOBT) (guaiac), every year
- Stool immunochemical test (FIT), every year
- Stool DNA test (sDNA), ask your care provider; technology is evolving

*An abnormal result of a virtual colonoscopy, or a positive FOBT, FIT or sDNA test, should be followed up with a colonoscopy.*
Colorectal Surgeon Ranjodh Singh, MD, answers your questions about getting a colonoscopy, a procedure that allows doctors to look inside the rectum and colon for polyps, abnormal areas or cancer. Once you learn how truly valuable this test is, you won’t look for reasons to avoid it.

What happens during a colonoscopy? Dr. Singh: A scope (a tube-like instrument with a light and lens for viewing) is inserted through the rectum into the colon. Polyps or tissue samples can also be removed for testing under a microscope.

Why is it necessary to prep for a colonoscopy? Dr. Singh: During a routine colonoscopy, we expect to find at least one polyp in about 25 percent of men. To find these polyps, the colon wall has to be clean. The cleaner the colon, the better we can detect polyps.

What can you tell me about the anesthesia used for the procedure? Dr. Singh: We use two types of sedation with colonoscopies. The first, known as “twilight sleep,” is also known as “moderate sedation.” That’s where intravenous medicine is given during the procedure to keep patients comfortable and has a slight amnesiac affect. Throughout the procedure, we monitor the patient’s heart rate, blood pressure and oxygen saturation. The second sedation is called “deep sedation.” Patients are in a much deeper sleep and won’t remember anything.

What if a polyp is found? Dr. Singh: If a polyp is found, we remove it. Polyps come in a variety of shapes and sizes. Any polyp can transform into colorectal cancer.

Are there complications with having a colonoscopy? Dr. Singh: Serious complications are rare (three per 1,000 cases). Serious complications can include bleeding, perforation, infection and a cardio-pulmonary event. Like any other procedure, these are inherent risks. However, by completely avoiding the procedure, you lose the benefit of polyp detection and may develop colorectal cancer in the future. It’s all a matter of risk and benefit. I believe the benefits far outweigh the risks.

Is there any way to reduce the risks of complications? Dr. Singh: Patients with heart or lung diseases may be more susceptible to a cardio-pulmonary event. In any case, we do recommend that patients who have serious medical history speak with the person doing the colonoscopy prior to having the procedure.

What would you say to someone who is avoiding a colonoscopy? Dr. Singh: Colon cancer is the third leading cause of cancer death in the U.S. Colon cancer is very preventable. Unlike other cancers, we can detect and remove polyps, and by removing polyps, we can essentially prevent colorectal cancer.

How will the anesthesia affect me and how will it be administered? Dr. Singh: The anesthesia will be administered through an IV. Most people won’t remember any of the procedure.

How long will it take? Dr. Singh: The colonoscopy itself takes about 30 minutes. The prep begins at home the evening before. The morning of your colonoscopy you spend about three hours at the clinic or hospital. After the procedure, you’ll return home to rest for the remainder of the day. You can usually return to your usual activities the next day.

Will my insurance cover a screening colonoscopy? Dr. Singh: The majority of health insurance companies cover colon cancer screening, including colonoscopies.
Diana Freeman has been a DMH employee for the past 28 years. She works as a System Administrator in the DMH Cancer Institute Radiation Oncology department. Diana is a healthy 51-year old with no family history of colorectal cancer and no symptoms of this disease. This year she made the right decision to get a screening colonoscopy. She shares her experience below:

What motivated you to get a screening colonoscopy? 
Diana: Working in Radiation Oncology, I was aware of the importance of the colon screening. Anytime we can be proactive and not have to go through the struggles we see our patients go through it is worth it. I did have several physician friends give me friendly reminders as well.

The prepping is usually the most dreaded part of a colonoscopy. How did your prepping go the day before your procedure?
Diana: The prep was fairly simple, and considering how much liquid I have heard you had to drink in the past, this was considerably less. The taste although not great, was better than I had anticipated. Refrigerating it ahead of time and adding Gatorade and ice helped.

What were your results?
Diana: I had three polyps. Two of these were smaller and one was a little larger. I was a little concerned about the larger, more irregular one. However, none of them showed there were any cancer cells present.

What advice would you tell your family and friends after getting your results?
Diana: I would advise everyone to get the colonoscopy screening. There is absolutely no way to know what is going on inside without taking a peek. I had three polyps, and absolutely zero signs or issues to let me know they were there.

“Please encourage your family and friends to get their rear end checked. Colorectal Cancer Screening saves lives.”

—Diana Freeman
Introduction by Radiation Oncologist
Harold Yoon, MD

Cancer of the colon and rectum is a common and lethal disease. It is the third most commonly diagnosed cancer in the U.S., excluding skin cancer. There will be an estimated 132,700 new cases diagnosed in 2015. Of those diagnosed, approximately 35 percent will die of their disease, which makes colorectal cancer the third leading cause of cancer death. An estimated 49,700 deaths will occur this year. One in 20 or 5 percent of Americans will be diagnosed with colorectal cancer in their lifetime. (The graph below shows that DMH incidence of colorectal cancers are higher than Illinois and national overall cancer incidence.)

As has been the case with most cancers, U.S. mortality rates from colorectal cancer have steadily decreased over the last 40 years. Much of this improvement is due to the detection and removal of polyps, finding cancers at an earlier stage, and more effective treatment.

Many risk factors are associated with the disease. It is known that the incidence of colorectal cancer varies substantially throughout the world. The highest rates can be found in Europe, North America, and Australia, whereas the incidence in Asian and African countries is reduced as much as 50 percent or more. Modifiable behaviors such as unhealthy diet, physical inactivity, smoking, and obesity have been linked to increase the risk of colorectal cancer. Other risk factors include a family history of colorectal cancer or inflammatory bowel disease.

Colonoscopy is the gold standard for screening and surveillance of colorectal cancer. Most cancers begin as precancerous polyps that are often present despite the absence of symptoms. The surgeon or endoscopist will visualize any suspicious lesions and perform a biopsy or remove the lesion in entirety. At that point, the specimen is reviewed by a pathologist who will confirm the presence of malignant or premalignant cells. The most common type of colorectal cancer is adenocarcinoma.

At DMH, 92 cases of colorectal cancer were diagnosed in 2014. This is largely consistent with registry data from the past 5 years. Although all average risk Americans 50 years of age and older are recommended to have colonoscopy screening, only 40 percent of cancers are diagnosed at an early stage, likely reflecting low rates of (Continued)
screening. To that end, DMH has joined the “80 by 18” pledge, a National Colorectal Cancer Roundtable initia-
tive to increase screening rates to 80 percent by 2018 (see graph below).

Once a diagnosis of cancer is established, further test-
ing is often performed to help determine the appropriate 
management. Patients undergo blood tests including 
complete blood count, chemistry, and liver function 
assessment. They also need CT scans or a PET scan of the 
chest, abdomen and pelvis to look for the presence of 
disease spread to other organs such as lymph nodes, the 
liver, or lung. In addition, MRI and endorectal ultrasound 
(EUS) are helpful in assessing a rectal cancer’s stage and 
the need for preoperative chemotherapy and radiation in 
advanced cases. Molecular testing is currently being 
investigated to determine its utility in providing prognos-
tic information and guiding treatment.

Depending largely on the stage of cancer, treatment 
includes one or more of the following modalities: surgical 
removal, chemotherapy, and radiation. In 2014, only 
16 percent of colorectal cancers treated at DMH were 
stage I, which are treated with surgery alone. Fifty-three 
percent were stage II and III for which treatment includes 
a combination of surgery and chemotherapy; radiation is 
also indicated for advanced cancers in a rectal location. 
Finally, 11 percent are diagnosed as stage IV, meaning 
disease has spread outside the primary location and 
regional lymph nodes to other organs. Patients with stage 
IV disease are usually treated with systemic chemothera-
py, although surgery and radiation can also be used in 
selective cases. (See graph below.)

A review of colon cancer cases diagnosed and treated 
in the years 2003—2006 at Decatur Memorial Hospital 
demonstrates survival rates similar to those reported on a 
national level. The five-year survival for stage I cancers 
was 84 percent, reflecting a high cure rate. As the stage 
increases, the rate of survival diminishes: 60 percent for 
stage II, 53 percent for stage III, and 12 percent for stage 
IV. Stage IV cancers are considered non-curative, and 
treatment is directed towards both extending life and 
optimizing life quality.

In conclusion, colon cancer continues to impact the 
lives of our patients that live in Decatur and surrounding 
areas. Decatur Memorial Hospital has demonstrated 
results consistent with the national cancer data. We are 
committed to working with our oncology team of physi-
cians and primary care physicians to continuously 
improve results and the lives of the patients we service in 
central Illinois.
Colon cancer is a common medical concern for patients, and screening has become widespread for early detection, including endoscopic screening via colonoscopy. This allows your clinician to visualize abnormalities in the colon, and take biopsies (small pieces of the abnormal area) for further examination. That is when a pathologist is needed. The final specimen after surgery is also very carefully examined, and with the lymph nodes status, will help oncologists determine the need for chemotherapy and stage the cancer accurately.

A biopsy is taken, the material is sent to the lab, and the tissue is processed. The end result is a collection of glass slides stained with various dyes. These slides can be examined with a microscope. Not all lesions sampled are cancer, but it is very important to identify those that are cancerous and precancerous lesions. This is done by looking at the cells. Are they multiplying too fast? Do they have abnormal shapes and/or sizes? Are they located in the wrong place within the colon? Sometimes there are special and immunohistochemical stains that can help your pathologist with diagnosis.

Molecular studies are the newest information that can be provided by pathologists. These studies look for an abnormal protein, or abnormal genetic defect, that may be associated with some cancers. Molecular studies include testing for microsatellite instability (MSI testing), among various other markers relating to colon cancer. If cancer is diagnosed, molecular test results can allow an oncologist to tailor specific therapy and specific drugs to target a specific tumor type. The end result: better treatment.

Once colorectal cancer is detected, additional tests (X-rays, CT, MRI and PET scans) are performed to determine how far the cancer has progressed. This process is called staging. The stage of the disease greatly influences both treatment and survivability.

According to the American Cancer Society, the most commonly used staging system for colorectal cancer is that of the American Joint Committee on Cancer (AJCC) also known as the TNM system. This system describes—

The Tumor, how far it has grown and whether or not it has grown into nearby areas
Lymph Node involvement
Metastasis, the spread of the cancer to other parts of the body

Stage I: The tumor has grown into but not through the inner wall of the colon or rectum.
Stage II: The tumor extends farther into, or may have passed through the wall of the colon or rectum and may have invaded nearby tissue, but there is no involvement of the lymph nodes.
Stage III: The cancer has spread to nearby lymph nodes, but not to other parts of the body.
Stage IV: The cancer has spread to other parts of the body, such as the liver or lungs.
Recurrent: After a period of absence, the cancer has returned to the colon, rectum or other part of the body.
Colorectal Cancer

By Jon Locke, MD, Radiologist

The DMH Radiology department provides the most innovative technology to evaluate and treat patients with cancer. Imaging studies produce pictures of areas inside the body. These studies are important tools in determining stage. These diagnostic tools can show the location of the cancer, the size of the tumor, and whether the cancer has spread. Stage describes the extent of cancer in the body. For colorectal cancer, the stage is based on how far the cancer has grown into the wall of the intestine, if it has reached nearby structures, and if it has spread to the lymph nodes or distant organs. The stage of a cancer is one of the most important factors in determining prognosis and treatment options. DMH provides state-of-the-art radiologic diagnostic tools for staging colorectal cancer. Imaging testing for colon and rectal cancers includes 3T (Tesla) MRI, PET/CT, and other diagnostic x-rays. Also available is an endoscopic rectal ultrasound performed by colorectal surgeons.

Colorectal Cancer

By Ranjodh Singh, MD, Colorectal Surgeon

Surgery is the primary treatment for early colorectal cancer; the most common surgery is a colectomy. There are different types of colectomies depending on where the cancer is located and how much of the bowel is removed. The surgeon may use a traditional or minimally invasive technique to remove the part of the colon containing the cancer. Lymph nodes and some normal tissue around the site will also be removed. See diagram below. The surgeon usually joins two ends of the bowel with stitches or staples. Sometimes, however, one end of the bowel is brought through an opening made in the abdomen and stitched onto the skin. This is called a colostomy (large bowel) or ileostomy (small bowel). The opening (called a stoma) allows fecal waste to be removed from the body. In some cases, the surgeon can later rejoin the bowel; sometimes this isn’t possible and the stoma is permanent.

(Continued)
Surgery for cancer in the rectum
If you have rectal cancer, you may have an abdominoperineal resection (also known as an abdominoperineal excision) or an anterior resection. The type of operation you have depends on where the cancer is located. This will also determine whether the bowel can be rejoined. The surgery may be open style or minimally invasive.

Abdominoperineal resection or excision (APR or APE)
The sigmoid colon and entire rectum and anus are removed. Your surgeon uses the descending colon to create a permanent stoma (known as a colostomy) for feces to leave the body. The anal area will be stitched up and permanently closed.

High anterior resection
The surgeon removes the lower left part of the colon and the upper part of the rectum. Nearby lymph nodes and surrounding fatty tissue are also removed. The lower end of your bowel is rejoined to the top of the rectum.

Ultra-low anterior resection
The lower left part of the colon and the entire rectum are removed, along with nearby lymph nodes and fatty tissue. The end of the bowel is joined to the lowest part of the rectum, just above the anal canal. In some cases, the surgeon creates a colonic J-pouch (see next diagram).

Colonic J-pouch
An internal pouch is made from the lining of the large bowel. This J-pouch will be connected to the anus and work as a rectum. You may have a temporary ileostomy (a stoma from the small bowel), which will be reversed once the J-pouch heals.

Surgery that involves the lower part of the bowel can cause injury to nearby nerves, leading to conditions such as incontinence (accidental loss of urine or feces) or erectile dysfunction. Speak to your surgeon about any concerns you may have.

Local excision
People who have early stage bowel cancer or are not fit for a major operation may have a local excision. Instead of cutting into the abdomen, the surgeon inserts an instrument into the anus to remove very small tumors from the bowel. Transanal excision (TAE) and transanal endoscopic microsurgery (TEMS) are local excision techniques for rectal cancer. A less commonly used method is a colonoscopic excision, which can remove small tumors from the colon. The type of surgery you have will depend on the location of the cancer.
Colorectal Cancer
Chemotherapy, Targeted Therapy

By James L. Wade III, MD, FACP, FASCO, Medical Oncologist

Chemotherapy is cancer treatment that uses medicines to destroy cancer cells. This approach is used for some patients with colon cancer after surgery to lower the chance that the cancer could return or spread. Chemotherapy is also used in combination with radiation therapy for some patients who have rectal cancer before the patient has the cancer removed with surgery. This strategy also helps prevent the cancer from returning. Finally, chemotherapy is used to improve the survival and quality of life of patients who have had colon or rectal cancer spread to other areas.

The DMH Cancer Care Institute, in partnership with DMH surgeons and Cancer Care Specialists of Illinois, has been involved with National Cancer Institute clinical trial programs for more than 30 years. These trials have led to significant improvements in cancer therapy and outcomes. During the past 20 years, the duration of chemotherapy after surgery has been reduced from 52 weeks to 24 weeks, while seeing improvements in patient outcomes and quality of life. These treatments, known as post-operative adjuvant chemotherapy, are now tailored to a patient’s age, overall health, the specific cancer characteristics and the risk of cancer returning.

Nowadays, even patients who have stage III colon cancer (a disease that has already spread to lymph tissue) can experience a good outcome.

Patients who are found to have locally advanced rectal cancer (also known as stage 2 or stage 3) are benefitted when chemotherapy and radiation are given at the same time. This combined approach before surgery significantly lowers the odds of the cancer returning to the pelvis after surgery and to other areas as well.

After recovery from surgery, some patients who had a significant amount of cancer removed can benefit from additional chemotherapy.

Although chemotherapy cannot cure patients with stage 4 cancer, it can help the patient enjoy a significantly longer and better quality of life. Newer colon cancer medications now focus on specific sub-types of molecular changes within cancer cells to improve effectiveness against the cancer. Patients are now living with their cancer 2—3 times longer than in the past. The DMH Cancer Care Institute in partnership with Cancer Care Specialists of Illinois and several national cancer research organizations tests the newest chemotherapies and other new immunologic approaches to control colon cancer.

Colon cancer is best treated when found early. Newer drugs combined with surgery and specific tumor ablation techniques have helped more central Illinois patients overcome and survive colon cancer.

Researchers discovered 58 years ago that 5-Fluorouracil (5-FU) had anti-cancer properties. Since then, 5-FU based chemotherapy has become the mainstay in treating patients who have colon cancer. Now, 5-FU is commonly combined with other newer chemotherapy agents that can more effectively control and often cure colon and rectal cancer.

This year the Food and Drug Administration (FDA) approved two new medications: Ramicuramab is a monoclonal antibody that reduces cancer-stimulated blood flow. When used with other chemotherapeutic treatments, it was associated with better response rates and longer duration of action. Lonsurf is for patients with colon cancer that has progressed after several previous treatments. Lonsurf is taken orally twice a day for five days, and then repeated the following week, followed by a two-week rest. Its use was also associated with an improved response rate and longer survival. Continued research will help clinicians learn how to best incorporate these new medications with our current treatments to further improve patient outcomes.
Colorectal Cancer
Radiation Therapy

By Harold Yoon, MD, Radiation Oncologist

Radiation therapy is used in a variety of situations for patients with colon and rectal cancers. External beam radiation therapy is delivered by one of the two high energy linear accelerators available at the Cancer Care Center of Decatur. The latest in technology advances have resulted in highly focused and targeted treatment to the tumor cells, thereby shrinking the disease and attaining its therapeutic goal while minimizing side effects.

The most common use of radiation therapy is in locally advanced, stage II or III rectal cancers. With the use of endorectal ultrasound, MRI and PET scans, proper selection of appropriate patients and localization of tumors is more accurate than ever before. We are careful to work closely with our surgeons and medical oncologists to coordinate and integrate these complex treatments.

We remain committed to staying on the forefront of medical advances. A relatively new indication of radiation therapy is its use in stage IV disease, to other organ sites where the disease has spread, or metastasized. One example is radioembolization, where microscopic beads containing radiation are injected directly into a tumor deposit in the liver. This treatment is available in limited sites throughout the country. Decatur Memorial Hospital in partnership with the Interventional Radiology Department is proud to offer this special type of treatment. Another example is using Stereotactic Body Radiation Therapy (SBRT) for metastatic sites in the lungs. SBRT is a safe, painless and convenient modality that uses millimeter accuracy to deliver high doses of radiation in relatively few treatments. SBRT is available at the Cancer Care Center of Decatur.

Interventional Radiology
Colon Cancer Liver Metastasis

By Howard Wiarda, MD, Interventional Radiologist

DMH Interventional Radiology uses minimally-invasive image-guided procedures to diagnose and treat diseases in nearly every organ system. As an alternative to surgery, IR procedures may decrease risk, pain and recovery time. Our IR team offers advanced treatment/procedures that are liver or tumor directed, including any of the following:

- Radiofrequency Ablation (RFA)/Cryoablation—offers a nonsurgical, localized treatment that kills the tumor cells with heat or ice, while sparing the healthy surrounding tissue. Most people can resume their usual activities in a few days. This does not typically require an overnight stay.
- TheraSpheres/Y-90—is similar to chemoembolization but uses radioactive microspheres. This treatment incorporates the radioactive isotope Yttrium-90 into the embolic spheres to deliver radiation directly to the tumor. This technique allows for a higher, local dose of radiation to be used, without subjecting healthy tissue in the body to the radiation. The Yttrium-90 radiates from within and, since it is administered in the hepatic artery, it can be viewed as “internal” radiation. This procedure is usually very well tolerated and patients go home the same day.
Colorectal Cancer remains a great challenge in central Illinois. Over the last decade, an intensive community-wide screening initiative has reduced the mortality of colorectal cancer in Macon County. In addition, new treatments for patients with advanced disease have extended quality survival for many. However, much more work needs to be done.

The DMH Cancer Care Institute, in partnership with Cancer Care Specialists of Illinois, has made a major contribution in advancing our understanding of the molecular and genetic heterogeneity of colorectal cancer. We have enrolled 75 patients in the National Surgical Breast and Bowel Project Foundation (NSABP) MPR-1 study, which is an exploratory program that is looking for new genetic mutations in colorectal cancer that might lead to targeted treatments. In addition, we were the major contributors to the NSABP FC-7 Phase 1 protocol, which was a first in human exploratory treatment for a select group of patients whose colorectal cancer had a unique molecular signature. This pioneering study demonstrated that the EGFR and Her-2 receptors in a patient’s colorectal cancer could be blocked at multiple levels, thus resulting in slower cancer growth.

The challenge of colorectal cancer is far broader than the study of cell signal pathways and new drug development. Colorectal cancer is an illness that haunts families, preys on the elderly, and robs individuals of quality of life in what was supposed to be the golden years. To better understand this impact, James L. Wade III, MD, FACP, FASCO of the DMH Cancer Institute worked with the Millikin University College of Nursing’s Miranda Watson, RN, MSN, CNL and Mary Jane Linton, RN, EdD, CNE, CNL, to analyze our colorectal cancer experience over the last ten years. The result of this work is summarized in Miranda’s soon to be published manuscript: “A Nested Population Control Study for Macon County, IL: The Occurrence of Stage IV Colorectal Cancer.” Miranda found 131 patients with newly diagnosed colorectal cancer who presented with stage IV disease, the most advanced stage. This group represented about 10 percent of all new colorectal cancer patients in our area, but a group that had a very poor prognosis. Remarkably, 48 percent of these patients were living alone, as being either never married (11 percent), divorced (16 percent), or widowed (21 percent). This high percentage of living alone at this age is significantly higher than the national average. In addition, several of those who presented with stage 4 colorectal cancer remarked that they were married, but were caring for an ailing spouse.

Miranda concludes that we must, as a community, remember those persons who become isolated. We should encourage and remind them through support groups, hospice survivor programs, churches, and other media to remember their own health and undergo screening and early detection. We hope that in the future we can do a better job finding and engaging this vulnerable group in our community. This is a lesson that the DMH Cancer Care Institute will take to heart.
Colorectal Cancer
Support and Patient Testimony

By Tammara Wagoner, Colon and Rectal Cancer Survivor

I am a 44-year old full-time wife, mother and attorney. I had managed to gain a good balance between work and home. I considered myself one who “had it all,” and although my life had a tendency to be a little hectic, I was content. In September 2014, however, I received life altering news and things were going to get a lot more hectic.

I made a visit to the DMH emergency room after experiencing pain in my right side. I am no doctor, but I assumed that the pain and the location were consistent with issues involving my appendix. I underwent an abdominal CT which revealed symptoms associated with a malignancy. Things went full speed from there.

I immediately visited my family doctor, Roberto Pabalate, MD, who referred me to Gastroenterologist Richard DiLorenzo, DO. A colonoscopy confirmed what my husband and I had been unable to speak about since the original visit to the emergency room: I had colorectal cancer.

My first thoughts had me reeling at the idea of not being here to watch my kids grow up and not growing old with my husband. I decided that I would do whatever I needed to do to win this fight, but I wouldn’t, no I couldn’t, do it alone.

I made an appointment at the Cancer Care Center of Decatur to see Medical Oncologist Dolores Estrada-Garcia, MD. She confirmed that the cancer was “advanced.” I would need chemotherapy and radiation treatment before surgery and follow-up chemotherapy after surgery. Radiation Oncologist Mary Anne DePaz, MD, reviewed the radiation component of the treatment. I hadn’t seen this many physicians at one time in my life. The doctors, nurses and support staff were wonderful. They seemed to understand not only my illness but my need to keep from being overwhelmed and consumed by it.

Before beginning radiation therapy, I searched for a surgeon. I was told it was going to be a difficult surgery. I was willing to go anywhere to find the best surgeon. I was pleased to find him at Decatur Memorial Hospital. Colorectal Surgeon Ranjodh Singh, MD, explained the location of the tumors (yes, there was more than one) and what that meant in regards to organ removal. Although the news was by no means great, I was oddly at ease with what needed to be done having had ample opportunity to discuss the surgery and possible outcomes.

I was determined to maintain as much normalcy as possible. For the pre-surgery chemo-radiation, I took oral chemotherapy and scheduled my radiation treatments during my lunch hour which probably made me difficult to deal with at times, but everyone seemed to understand. In January 2015, I underwent an extensive surgery that resulted in removing portions of my colon and rectum. Post-surgery I had additional chemotherapy finishing my last treatment session the first week of September 2015.

I had never thought about being diagnosed with colon/colorectal cancer at age 43. Although I wasn’t familiar with this type of cancer, I was sure it was something that occurred in “older” people. Looking back, I don’t recall being faced with a lot of symptoms that I would have associated with anything more than those I just chalked up to childbirth and biological changes associated with it…what woman having gone through a pregnancy hasn’t experienced constipation. I had undergone a sigmoidoscopy approximately 10 years prior and there had been polyps located, but the normal follow-up after that type of finding is 10 years, so I wouldn’t have had a follow-up based upon that finding of polyps any earlier.

It was a crazy year, but with the help of an army of physicians and nurses, my husband, my children and my friends, I made it through. I am grateful to them all, I could not have done it alone.
Routine check-ups detect cancers

By Robert Flider, Colon Cancer Survivor

In July, I learned I had prostate cancer and met with Urologist Oncologist Thomas Tarter, MD, PhD, to discuss treatment options. However, Dr. Tarter was not yet ready to act due to detection of questions that arose due to a CT scan. In consultation with my primary care physician Alan Bilyeu, MD, Dr. Tarter sent me to Gastroenterologist Sudhakar Sheth, MD, for a colonoscopy, which was conducted in August.

The result: A malignancy and another diagnosis of cancer. One of the more difficult things a cancer patient must do is let family members know about the diagnosis. So, for the second time in a month, Jean and I had to let our children and family know about this second intrusion into our lives. Naturally, everyone had a lot of questions and fortunately, during the process, we were able to reassure everyone, including ourselves, that the medical professionals to whom we were entrusting our care were truly dedicated to ensuring the best possible outcome.

Dr. Sheth strongly recommended that I see Dr. Singh, a surgeon who specializes in colon disorders. Drs. Tarter and Bilyeu strongly concurred.

Jean and I met with Dr. Singh, who impressed us with his knowledge of my particular situation, including the colon cancer and the previous diagnosis of prostate cancer. His personal approach gave us an assurance that he was knowledgeable about my situation and, perhaps as importantly, had been in contact with Dr. Tarter concerning coordination of my situation.

Ultimately, both doctors concluded that it would be most critical to deal with the colon cancer first, as it was a more aggressive type of cancer that has the potential to spread outside of the colon.

On Friday, Sept. 25, I had my surgery. Dr. Singh had explained prior to the surgery the various outcomes. I had a chance to express my concerns and hopes for the best possible outcome, and he assured me that he would do his best to achieve that outcome. He explained that, until he actually performed the surgery, he could not possibly know the extent of the cancer, and that I would need to trust his judgment once the surgery began. Again, Jean and I felt reassured by his knowledge and openness and concern about my ultimate well-being. One of the major hurdles would be learning whether the cancer had spread.

The surgery was no cakewalk, and it took longer than anticipated. Immediately after the surgery, Dr. Singh was there to explain the surgery and shared his impression, pending the pathologist’s report, that it did not appear the cancer had spread. The following week, the pathologist’s report of the initial reading showed that the tissues were cancer-free.

Dr. Singh seemed as relieved as we were when the pathologist’s final report concluded that the cancer had not spread beyond the portion of the colon he had removed. Given my previous diagnoses, we felt incredibly
DMH Supportive Services

Some patients find that the emotional and physical effects of colon cancer and rectal cancer can be stressful, even isolating. To help, DMH Cancer Care Institute offers supportive services and support groups.

Nutrition Services

"Eat Right to Help the Fight" is a free program offering nutritional counseling. Patients learn how to cope with low appetite, weight loss, taste changes, nausea and other symptoms while learning how to increase protein and/or calories. For details, call 217-876-4700.

Rehabilitation Services.

Helping Oncology Patients Excel (HOPE) helps cancer patients excel in life, long after their cancer treatment is complete. Rehabilitation during and after treatment can address mobility, flexibility, chemotherapy-induced neuropathy, cancer-related fatigue, pain, lymphedema, cognitive function. To schedule a free screening, call 217-876-2646.

Facing Cancer Together.

A support group for all cancer patients and their caregivers, Facing Cancer Together offers participants an opportunity to share thoughts, feelings and information. This support group meets the second Wednesday of each month at 1:30 pm at the Cancer Care Center of Decatur.

Pastoral Services—A DMH Chaplain is available to meet with patients for spiritual support and counseling. For details, call 217-876-4320.

Resource Library—The DMH Cancer Care Institute offers internet access, books, and other free educational materials to help patients and families in their search for knowledge and understanding. For more information, call 217-876-4750 or visit www.dmhcares.org

Wound Ostomy—A certified Wound-Ostomy nurse is available to answer questions and/or help with ostomy (iliostomy, colostomy, urostomy) care and education. To make an appointment, call 217-876-2909.

Social Services

"Coping With Cancer"

A licensed social worker is available to help patients and families throughout their cancer experience. Counseling; emotional support; and help with practical concerns, such as advanced directives, community resources, financial assistance, and more. For more information, call 217-876-4735.

ART as Therapy

This program is coordinated by the Cancer Care Specialists of Illinois. Cancer patients and their families are welcome to use the art therapy room to express their feelings creatively. For more information, call 217-876-6600.

Look Good Feel Better

Coordinated by the Cancer Care Specialists of Illinois, Look Good Feel Better is a free program that teaches beauty techniques to help women cope with side effects associated with cancer treatment. The group meets every other month at 6 pm. For more information, call 217-876-6600.

Wig Bank

A Wig Bank is coordinated by Cancer Care Specialists of Illinois. Free wigs, hats and scarves are available to cancer patients. For more information, call 217-876-6600.

For more information call 217-876-4750
or visit us online at— http://www.dmhcares.org/services/cancercare/CommunityOfHope.pdf
Myths about colon cancer:

Myth #1: Colorectal cancer is a man's disease. **Truth:** The risk is almost the same for men and women. The lifetime risk in men is about 1 in 19; in women it’s 1 in 20. (Source: American Cancer Society)

Myth #2: Colorectal cancer is most common in caucasian people. **Truth:** African Americans have the highest rates of getting AND dying from colorectal cancer. Caucasians have the second highest rate, followed by Hispanic, Asian/Pacific Islander, and American Indian/Alaska Native people. (Source: Centers for Disease Control)

Myth #3: Colorectal cancer only affects people over age 50. **Truth:** While most colorectal cancers are diagnosed in people over 50, the disease can affect people of any age, especially those with a strong family history, multiple risk factors or those who carry specific genetic mutations. It is important to talk to your doctor about your personal situation. If your medical history suggests you may be at risk or if you are having symptoms, you should get screened for colorectal cancer.

Myth #4: Colorectal cancer is a rapidly spreading, deadly disease. **Truth:** Most forms of colorectal cancer are slow growing and as many as 95 percent of cases are curable if detected early.

Myth #5: I don’t have any symptoms therefore I don’t have the disease. **Truth:** During the early stages, most people with colorectal cancer have no symptoms at all. By the time symptoms—such as changes in stool, rectal bleeding, abdominal pain or unexplained weight loss—develop, the disease is often in a more advanced stage, meaning the treatment is less effective and the risk of dying from the disease is higher.

Myth #6: Having a colonoscopy is painful and embarrassing. **Truth:** Having a colonoscopy is not as unpleasant as most people expect it to be. The procedure takes 15—30 minutes during which time the patient is sedated to prevent discomfort.

Myth #7: Preparing for a colonoscopy is difficult. **Truth:** The steps necessary to clean out the colon in preparation for having a colonoscopy can be inconvenient, but there are various options your doctor can choose from to make the process more tolerable for you. A little discomfort or inconvenience is a small price to pay to possibly save your life.

Myth #8: A colonoscopy is the only way to screen for colorectal cancer. **Truth:** Colonoscopy is considered the gold standard in colorectal cancer screening. The entire colon can be examined and polyps can be removed immediately during the same procedure. However, there are alternatives such as a virtual colonoscopy, flexible sigmoidoscopy and fecal occult blood testing.

Myth #9: If I have a polyp, I have cancer. **Truth:** Polyps can be benign (not cancerous) or pre-cancerous meaning that if they are not removed they have the potential to become cancerous.

Myth #10: If I have colorectal cancer, I will have to have a colostomy bag. **Truth:** Thanks to improvements in surgical techniques and treatment options, colostomies, which are artificial openings for the collection of excrement, are rare. When they are necessary, they can be temporary.

Myth #11: I saw what someone went through with colorectal cancer and the same thing will happen to me. **Truth:** Each person's experience is different, and having colorectal cancer now is not the same as having it twenty, ten or even five years ago. Tremendous strides have been made in both the diagnosis and treatment of colorectal cancer. Most diseases that are detected early are curable. Minimally invasive surgical techniques, more targeted and effective radiation and chemotherapy treatments, laser technology and cutting edge medical research have all contributed to making cancer treatment less traumatic and more effective, even for those with advanced stages of disease.

And perhaps the biggest myth of all…

Myth #12: There is nothing I can do to reduce my risk of getting colorectal cancer. **Truth:** While some risk factors like family history are beyond your control, an estimated 50—75 percent of colorectal cancer can be prevented though lifestyle alone! Eat a plant-based diet that is high in fruits, vegetable and whole grains; reduce your intake of red and processed meats; maintain a healthy weight; don’t smoke; drink alcohol in moderation; and enjoy regular exercise to reduce your chances of developing colorectal cancer or to keep it from coming back.
HAPPY BIRTHDAY!

If you’ve recently entered your 5th decade, you know that you need to schedule your first screening colonoscopy (if you haven’t already).

To schedule a screening colonoscopy, talk to your primary care physician. (If you don’t have a primary care physician, call 217-876-2856.)

For general information about screening colonoscopies, call 217-876-6030.