Colonoscopy the Dreaded C Word

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The cancers this show hosted by Dr. Bill Evans and brought to you by the cancer assistance program help when you really need it.

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Welcome to the cancer assistance programs Podcast. I'm Dr. Bill Evans, professor emeritus at McMaster University in department of oncology. welcome you to this podcast. If it's your first listening, I'm glad you've joined us, I think you'll really enjoy the topic today, which focuses on colorectal cancer screening. If you've listened to us before Welcome back, become a regular listener. And because as we review various topics, you'll become better informed about the many hopeful advances in the management of cancer, from treatment to supportive care to prevention and early detection. In the last couple of months, we we talked about some of the reasons the chair of the department of oncology at McMaster University Dr. Jonathan Sussman, felt hopeful about the future and we did talk about the progress being made. And that might be an interesting podcast for some of you who are first time listeners to take a listen to and you can reach any of these podcasts on the cancer Assistance Program website, which is cancer assist.ca. Or on one of your favorite podcast sources Google Apple or Spotify. I get to interview really smart people and I'm blessed today to interview Dr. Barry Loman. I've known Barry when he was Chief of Medicine at McMaster University. He's a professor of Department of Medicine and a gastroenterologist and the regional endoscopy lead for Cancer Care Ontario, and currently leading a major initiative implementing new information technology at Hamilton Health Sciences. So welcome, Barry, I'm really delighted to see you again and to chat to chat with you about colorectal cancer screening.

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Many Thanks, Phil, it's a pleasure to be here.

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A good place to start because I've come to realize over time that although we medical people understand perfectly things like the colon and what it does, that our listeners out there may not really understand what parts of their body do even where they're located. And so maybe you could just describe a little bit about the intestinal tract, and in particular, the colon and what it does. And then we'll talk about how it goes about developing cancer.

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For sure, so I suspect most people know but the gastrointestinal tract is really a long tube that starts just below your mouth with the esophagus and extends down through the esophagus through the stomach, into the small intestine, and then eventually into the colon. And finally, through the rectum, where we all pass our poop every day, or every other day. And really the colons role in all of that is storage. After food is digested and properly absorbed by the the small intestine, the colons job is to take what's left behind, remove some fluid from it and store it until such time as it's time to evacuate the colon and pass your bowel movement.

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So That's its job. And it usually does it reasonably well. But it like many parts of the body can develop cancers. And actually, colon cancer is a pretty common cancer in Canada as looking at Canadian cancer statistics, and I think in 2020, they estimated that 26,900 Canadians would develop colorectal cancer, that's quite a phenomenal number. And it's linked to second after lung cancer overall, and responsible for about 12% of all cancer deaths. But it's also a cancer that could be found very early where results are, are quite excellent. And even prevented through testing that we call screening. And again, that term screening may not mean much to some people and perhaps that's something we need to explain very.

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Yeah, so it's, it's it's extremely important that we talk about screening because what we're trying to do is, is identify people without symptoms, who may have a small lesion in the colon with what we call a polyp. And if we can detect that polyp and prevent it from growing and eventually becoming a cancer, then we can as you said, but we can prevent colon cancer or we can find colon cancer at a much earlier stage. So the idea is given exactly what you said that this is such a common cancer. And we know that the risk of developing colon cancer starts to rise around age 50, that we ask people to be part of a screening program that says they're going to take care of their colon health by undertaking a screening for any evidence of a polyp or to find a tumor in the bowel before its advanced and therefore improve their their outlook.

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So maybe it's appropriate to comment on what some of the risk factors are for colon cancer. You mentioned we start screening in this province of 50. So average, that's sort of average risk 50 And up, but what are some of the things that increase your risk of, of having colon cancer besides getting older, which we have no control over?

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Yeah, so there's, there are a few things that are really important. And I think the first one really to address is, is whether there's a family history. And so if you are an individual who have a member of your family who had colon cancer, or is known to have major polyps in their colon, that does increased the risk. And so that puts you into a different group of, of who should be checked and how they should be checked. And somewhere around 30%, or three out of 10 colon cancers can be associated with a family history. So it's really important that if that's the case that you discuss that with your your physician, and perhaps go down a different path than the routine or as Bill calls it, the average rescreening. There's good evidence that that diet does play a role in this. And it's really important that we think about avoiding, you know, high fat diets and and, you know, focusing more on high fiber. The truth is that we all kind of know what a good diet is. And it's, it's really a matter of avoiding excess fat, adding fiber to the diet whenever possible. And, you know, reducing the amount of processed foods and in particular, processed meats, and so on, that can increase the risk of developing a polyp, or cancer.

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And I guess there's some other conditions that predispose people to develop colon cancer, that are worth noting that also placed them at a higher risk than our sort of the average group versus screening for other people who have some types of bowel inflammation, or even some genetically determined diseases that produce a lot of polyps, right?

07:56

Yeah, so you're absolutely right, there are a number of very well understood genetic conditions beyond just having a family member with colon cancer, that vastly increases the risk. And the two most common of those would would be what's called FAAP, or familial adenomatous polyposis. And in those cases, the family history is usually quite striking. And the risk comes much earlier in life. And there's a second syndrome called H NPCC, or Lynch syndrome, which also is associated with a very high risk of cancer. And again, in those individuals, when that family history is known, they really need to start having their examinations much earlier in life, sometimes even in their late teens or early 20s. People who have ulcerative colitis or chronic inflammation of the colon are also an increased risk of developing colon cancer, especially if they've had their disease for over 10 years. And if their entire colon is affected by the ulcerative colitis. In those individuals, we do recommend that they come for a colonoscopy on a fairly regular scheduled basis to try and prevent that or find that long before it has a chance to become advanced.

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And apart from those, my understanding is that there's an increase in colorectal cancer among certain populations, like our indigenous population. And is it also true in people of color that there's an increasing risk of risk and earlier age? Yeah,

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the answer to both of those is absolutely correct. Bill. There is evidence that our Aboriginal and indigenous populations are at higher risk and have poorer outcomes. Some of that might be related to to their living conditions or their access to health care, but it is absolutely true. Without our indigenous populations that are at higher risk, and there is evidence that people who have a genetic background of black or Asian have a higher incidence of of colon cancer,

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I guess we had the celebrated case of the actor, Chadwick Boseman, who died of colorectal cancer at age 43, shone a bit of a light on the fact that people of color are at higher risk and at an earlier age of contracting this disease, but for the for the average risk person doesn't have inflammatory bowel disease doesn't have a genetic predisposition doesn't fall into one of those groups. We were just mentioning. We recommend colorectal screening, but there are different types of screening procedures that can be done. And in Ontario, we we recommend a test that looks at the stool basically to find presence of blood, right. So and that even that the test that's used has changed in recent times, and maybe just describe that testing how it's done, how effective it is. And does it make a difference to the outcome for colon cancer?

11:18

Yeah, this is this is really important and has been a major change in Ontario over the last year. So for many years, we have had an old fashioned term that we call the FOBT, which is a test to look for evidence of blood in the stool. The idea is that if you can detect small amounts of blood, you can hopefully find polyps and or tumors of the colon earlier, and literally for 25 years that that FOB t test has been available. And there's absolutely no doubt, if you look at large populations that that test reduces the mortality of individuals with with colon cancer if people are compliant. The problem with that old test is is it's inconvenient. It requires you to take a sample three consecutive days of your stool and smear it on a card. You're supposed to change your diet, avoid certain medications. And so the the willingness of people and the accuracy of the test is really not been what we have wanted. And so over the last number of years, and in many jurisdictions, a new test called the fit or the FIT test has come along. And the idea is the same, we're looking for evidence of blood in the stool, it actually looks for a different component of blood. But the nice thing about this new test is it's at least twice as sensitive in detecting blood in the stool. It doesn't require the person to change their diet, they don't have to change medications or avoid medications. And the test is done on a single sample of stool. It comes in a in a really a very convenient kit, and with very clear instructions. So it can be done very easily. It's at least as I said twice as sensitive. And we really hope that the convenience of it together with conversations like we're having today will increase the number of individuals who are willing to go through these screening procedures and hopefully allow us to find you to have a polyp before it has a chance to grow up and cause real trouble down the line.

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I guess all tests have false negatives and false positives. So how does the FIT test do in that regard?

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So it it is vastly improved from the old FOBT test the to use the technical term sensitivity and specificity that sensitivity is and specificity are both in the 90% range. No test is perfect. But I can tell you that if you happen to have a positive FIT test, the there it's at least four times out of 10 that we will find a significant polyp in your colon when we follow up with a colonoscopy. And that's very significant because each one of those polyps if they're of any size, have the potential someday to have become progressed to the to becoming a cancer. So it's a big deal. And if you've got a positive test, we absolutely want to have you come for your colonoscopy and there's a very good chance that we're going to find something important.

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So we're going to take a quick break and we'll continue with our conversation after the message from the cancer Assistance Program. All

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registered today for the cancer assist programs virtual care walk on Saturday, May 29. start or join a team, set a fundraising goal and begin collecting pledges in support of free services for cancer patients and families in our community. Whether you choose to walk, hike, bike or roll five kilometers, we hope you'll help us come together virtually in honor of a friend or loved one affected by cancer. Your support will provide help when it's needed most. Who are you walking for? Visit cancer sis.ca to register.

15:41

Now do polyps routinely bleed that's always been something that's troubled me I when I think of a polyp, as opposed to a cancer because I'm cancer sort of altered of growth and with a lot of new blood vessels, and I can imagine it leading regularly. And commonly people present with anemia as a result of bleeding from a colon cancer. But do polyps regularly bleed too? Or is there a risk of missing them simply because it didn't bleed often enough? So

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it's a it's an extremely interesting and good question. Because most polyps when you look at them, you would say exactly what you said, Bill, like, why did that turn the Fit positive test the fit test positive. And so there is something going on there, especially with what we would call a larger lesion, maybe bigger than then sort of a thumbnail. And there's very good evidence that even though they don't look like they're bleeding, we tend to detect them with this new test. So there's something happening on a microscopic basis, even though we don't see it that allows us to detect these these lesions.

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Because I think it's one of the most important things that this is not just early detection of cancer before it's spread. It's it's finding it before it's actually become a cancer and preventing, wheeling it's one of the strongest messages that we need to deliver here is that this is really a preventive measure and could avoid a whole lot of grief of developing an advanced cancer. And people really shouldn't be doing this routinely, if they're over 50 years of age.

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Yeah, it's really very important. And as you said, like a polyp is not cancer, a polyp has the potential to become a cancer. So if we remove it, then we eliminate the risk that that polyp is going to grow up and cause trouble someday. But it's also really important that if if a polyp is becoming malignant, that we remove it before it has a chance to invade the wall of the colon and start to spread, because we know that their survival rate goes from 90 plus percent, from a very early cancer to only maybe one in five survival after five years if we find it too late. So it says all about early detection.

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I was gonna bring up those statistics of localized cancer has that 90% plus five year survival and distant cancers, according to the data in the US is only a 14% five year survival. So you want to find it early. And even if it's progressed to cancer, if it's found at an early stage that 90% figure still can apply. So all the more important to have the test now if the test is positive, you're going to undertake a colonoscopy. Right? And maybe describe how that's performed and what you're looking for.

18:45

Yeah, so a colon out, everybody's kind of heard a little bit about colonoscopy. So hopefully, I can tell you the truth and, and relieve some some fear. So colonoscopy is a way to examine the inside lining of the colon with a light scope along black tube with that has a very high definition camera on it. In order to do that, we do have to have people undertake a preparation which is meant to to literally wash the colon so that we can see the lining and you know, a well prepared colon. The inside of that colon looks just like the inside of your hand. It's as clean as a whistle. And, and with high definition and expert eyes we can see very small lesions as small as a couple of millimeters. The test requires it to be done, obviously in a facility that that's able to provide the necessary equipment and the nursing support and monitoring of the patient while it's done. Virtually all colonoscopy is done with some form of sedation and that can be what we call conscious sedation which is a combination of medications to make Are you a bit groggy to reduce any pain, and to allow us to get through the examination with minimal discomfort, in some circumstances that can be done with more aggressive sedation. But the general feeling is that for average colonoscopy conscious sedation is is adequate. The colon actually doesn't have any pain fibers on the inside, there's really no pain fibers on the inside, but there are stretched fibers on the outside or of the bowel. And so when people get discomfort, it occurs as we go around the corners, the colons, not a straight line, it's got lots of twists and turns. So a little bit of cramping going around the corners is quite normal. But the risk of of a major complication from a colonoscopy is is in the range of one in 2000, which means that, you know, 1999 times out of 2000. It's a straightforward procedure. If there is a polyp found, that can almost always be dealt with at the same time, very large lesions might require a second exam or the help of a more expert individual on those kinds of difficult lesions. But the vast majority of times, if a polyp is found, it will be removed at the same time as the initial examination.

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So having been on the receiving end, so to speak, up, I think the hardest part was preparation. I have I have had more than one colonoscopy. So I've had it with conscious sedation and with nothing with nothing it was because it was going to see my boss right after the procedure was done. So I, I didn't want to be groggy talking to my boss at the time, and I can attest to going around those corners is uncomfortable, to say the least. But overall, it's a pretty straightforward procedure. And I'd like people to know and recognize that. So they're not deterred from, you know, having tests because of fear of the colonoscopy being a difficult procedure. Some people would say, Well, why not just go straight to colonoscopy, you're actually looking at the inside of the bowel, you can see all these little polyps or little cancer forming and so on. Why why test with with the FIT test? And I'm sure that comes up often. And we need to respond to that.

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Yeah, it does. And, you know, there, this has evolved over the over the last decade or so there was there was a very strong push in and to some degree in the, in other jurisdictions, particularly in the United States, there's, there's a strong push that, you know, you should just go straight to colonoscopy, as you said, Bill. In many other jurisdictions, and in particular, in Ontario, we're not recommending that anymore. And it really has to do with with capacity. And this is where the arithmetic starts to become really important. Because if you if you look at the the gains by doing fit testing and scoping the people who need them, versus the people who want them, all of a sudden, if you if you screen 100,000 People in Ontario, by colonoscopy, it's going to cause a heap cost a huge amount of resources. Whereas if you screen with a poop test, and only scope, the ones who are positive, you're going to detect somewhere around 10 times more cancers by doing the FIT test than you would by just doing 100,000 colonoscopies. And so, you know, Cancer Care Ontario is is very clear now that we really should not be offering routine colonoscopy for people at age 50. And we should focus on those who have undertaken the FIT test and who are found to be positive. I'd also say that, you know, in the COVID world as it exists now, our capacity to do these kinds of procedures is impacted. And so our ability to offer average risk screening tests for people, when we're struggling to keep the, the procedures for the people who really need them is really compromised. So it's another reality of the COVID world that we're in. I

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did want to ask you about the impacts of COVID. Now in terms of the the FIT test, getting out it shouldn't be anything to impact that negatively from the pandemic perspective. So there I could understand the colonoscopy side of things, but is it interfered in any way with people actually getting their Fit Test sent out to them?

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Yeah, it did for a while, so Oh, at the end of March, we put a we've the Cancer Care Ontario and the lab, put the FIT test on hold, because we really stopped doing all but the most urgent procedures that has now been stopped. And we're back to normal offer of fit testing for anybody over age 50, who doesn't otherwise fit into a high risk group. So it did for a while, but that's gone. And we're, we're back and we're hoping to be full steam ahead.

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Well, that's good to hear. Because I, I know, there's been some estimates in the US about the impacts of holding screening programs during the pandemic, resulting in cancers emerging later on that are more advanced and actually increasing the death rates. Dr. Fauci In fact, I think in July was estimating something in the order of 20,000 increase in cancer deaths because of screening programs being put on hold. So I'm glad to hear that the FIT test is available for people and hopefully they're paying attention. And that's getting it sent in. And what about the role of flexible sigmoidoscopy? And do Is there still the program of nurse LED flex say get in Hamilton, or is that been replaced by the FIT test? Yeah,

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that's been replaced now. So what Bill's referring to is, is a kind of like a third of a colonoscopy, it looks at the left side of the colon. And was meant to be a mechanism to identify people who were at high risk of polyps and to suggest those who needed to go on to have a colonoscopy. There is a lot of literature over the years that is has shown that that's of benefit. But again, it's it's a matter of capacity. And given the increasingly positive effects of the fit screening. The province has moved away from offering flexible sigmoidoscopy.

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It's good to know. Now there are some other ways of screening the colon and I imagine the answer is going to be similar, but they're radiologic means we've computed tomography and other things, any of them. Are there special circumstances where it is useful to screen using these other types of technology?

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Yeah, so CT or CT calligraphy did get a lot of traction a number of years ago as a screening modality. And basically what that means is you have to still do a prep to have your colon as as clean as possible. But instead of coming and having a scope, you go and have a CAT scan, where they distend your colon with with either carbon dioxide or air and then do a CAT scan. And if they find a polyp, then you get to go and have a colonoscopy. And if you don't, then you're off the hook. Again, it's a matter of resources, for the most part, but also, there's a small group of people who have very twisty colons, you know, some people have straight hair, some people have curly hair, some people have very curly colons that are difficult to negotiate. And in that case, a CT is a very good second choice, but it wouldn't be our first choice. Not

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sure. All right. Now, we talked about risk factors. mostly focusing on on diet, are there any other things that people can do that might reduce their risk of developing colon cancer?

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Yeah, I think I would, I would just ask them to, to to pay attention to any new symptoms that would say, this is different for me, everybody has their own bowel habit. And there is really no fixed normal. There's no law that says you need to have a poop every day at 6am or any other specific time. But if you're noticing a significant change from what's your previous bowel habit to something new, that's worth a conversation with your with your doctor. If you're having rectal bleeding, that is very definitely something that we would want to think about and and, you know, a drop of blood every once in a while. If you're straining at the time of a bowel movement, that's one thing but if you're now seeing a change and you're seeing rectal bleeding or you're having pressure or pain in the rectum, those are symptoms now that would move you from screening to symptomatic assessment by your doctor and by your gastroenterologist or general surgeon And then a decision about whether you really needed to have a colonoscopy. So it's just paying attention to your body and things that are changing or things that are not normal for you.

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And if you had some recommendations about trying to reduce your risk, and you mentioned things like exercise, or is there a role for aspirin, we'd pick mini aspirin for trying to not have heart attack people is often on statins to lower their cholesterol, and these things are said to have some influence on colon cancer.

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Yeah. So let's talk about aspirin. Briefly, there is a there is evidence that aspirin and anti inflammatory drugs do reduce the recurrence rate or the development rate of of polyps. And there, there are a couple of trials actually that have shown people who take low dose aspirin have a lower incidence of polyps. But this is a two edged sword. And and so aspirin and anti inflammatory drugs also have the potential to cause bleeding in the intestine and the development of ulcers. So that's conversation you need to have with you with your family doctor about risk benefit. I don't expect that this group very, or your audience would have been paying much attention to this necessarily. But the more recent recommendations for aspirin, prevention of heart attacks and so on has also actually changed and is much more conservative than it used to be in terms of who should be on aspirin. And I would say the same would apply low fat diet absolutely important. The evidence that taking a cholesterol lowering drug reduces colon cancers not great if, if at all. And after that there really isn't a lot of other medication intervention that can be recommended. You know, I kind of kid people in my clinic and I from from a diet point of view, I kind of say, Listen, if it really tastes good, you need to think twice about whether you want to be eating it, because it's probably because it's probably got fat in it, and and it might not be the best choice.

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Well, that's quite an interesting comment, that might be a good comment to end on. But I don't think we should stop quite there. I wanted to give you sort of a last, you know, opportunity as we wind up just to, you know, say what you'd want to want an audience to hear about colorectal screening. What's the key message right now that they should be processing particularly in this unfortunate COVID pandemic period. So

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I guess I would say a couple of things. And you started this at the beginning bill it and like colon cancer is common. It's the second most common cancer in our society. And it's different than lots of cancers. Because if it is caught early, we can make a huge difference. So this is a real opportunity for people to be careful and to take care of themselves. And please have a conversation with your family doctor about doing the screening poop test. I think that's the first one. The second one is if you do have a positive test, please underline four times, please come and get your colonoscopy that will get you done within eight weeks of getting the result. And there's a very good chance that we're going to we're going to do something really beneficial for you. So please, if you do it, and it's positive, come and see us. everybody's worried about COVID. The hospital is safe. It is a place where you can come confident that the staff and everybody else are following all of the all of the recommendations to reduce COVID risk. And please don't delay, because there's very good evidence that the longer you wait after a positive FIT test, the more likely it is that you're going to have a more advanced tumor.

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Well, those are excellent messages for listeners to hear and to end with. And I want to thank you very much, Dr. Leung for giving your time to talk to us about colorectal screening its importance and how it can make a huge difference and preventing or preventing colorectal cancer or at least finding it early when it's best treated with the best results. So thank you so much for your time. Take care.

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Thanks, Phil. It's a pleasure. Appreciate the opportunity.

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This has been the cancers this show brought to you by the cancer Assistance Program.