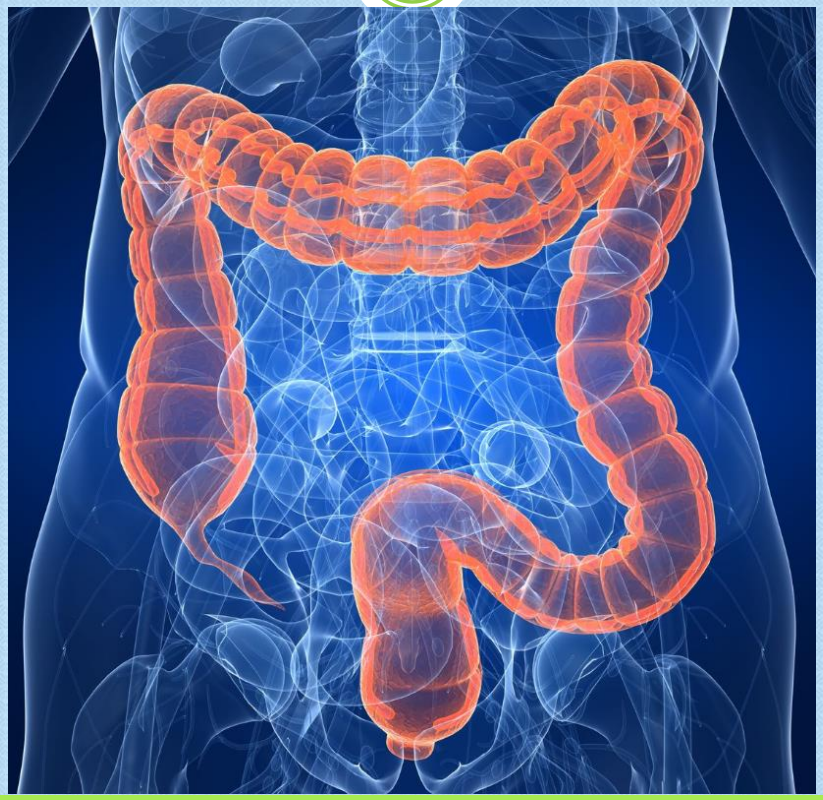
A Snapshot of Colorectal Cancer
Judy Warren CNS Colorectal Cancer
Waikato DHB



The Numbers

- Bowel Cancer affects people of all ages
- • Bowel cancer is the second highest cause of cancer-related death in NZ, 2nd to Lung cancer
- • The incidence of bowel cancer in New Zealand is amongst the highest in the world
- • 3000 + New Zealanders are diagnosed with bowel cancer every year
- • 1200 + will die from bowel cancer every year
- • 300 + under 50 will be diagnosed with bowel cancer each year

More Numbers, Cancer Registry 2009-2013

- 14,394 people living in DHB areas were registered as having bowel cancer.
- 23% localised disease
- 21% distant disease (18% not recorded)
- Māori and Pacific peoples had a higher proportion of distant disease at diagnosis
- On average, 27 % of people ED presentation
- Māori (39 %) and Pacific peoples (41 %) ED presentation

Route to Diagnosis

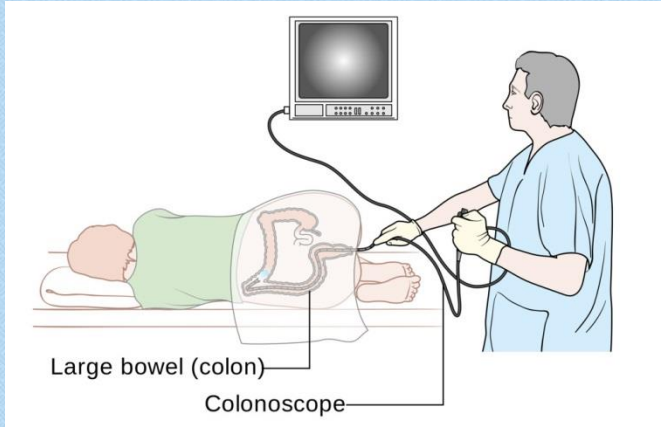
- GP referral
- Emergency department
- Other specialty
- Bowel screening

Symptoms of Bowel Cancer

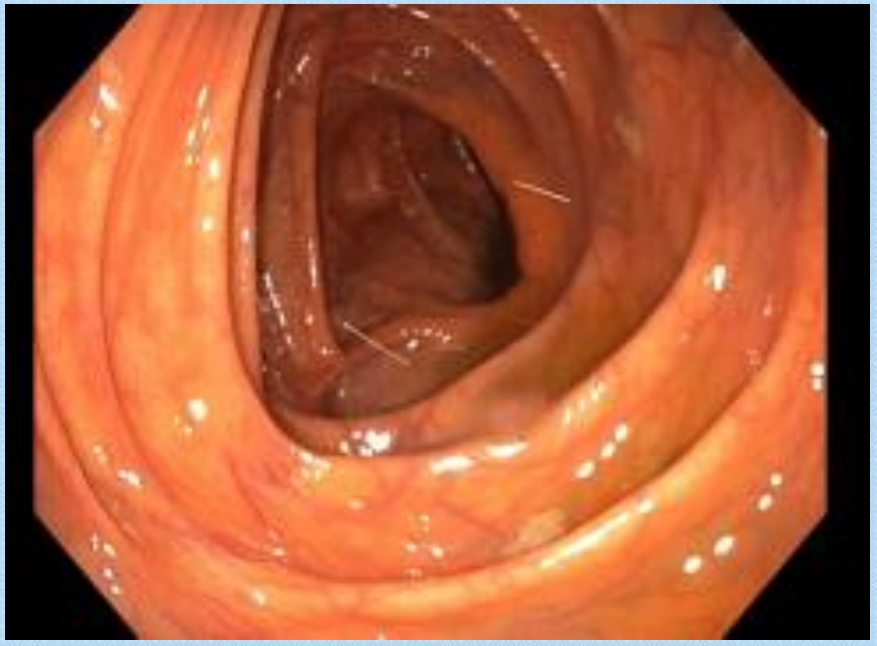
- COBH
- PR Bleeding
- Abdominal or anal pain
- Weight loss
- Feeling tired
- Sense of something not quite right
- Or nothing
- Family risk- one first degree < 50 or two first degree on same side at any age. Scope 10years younger

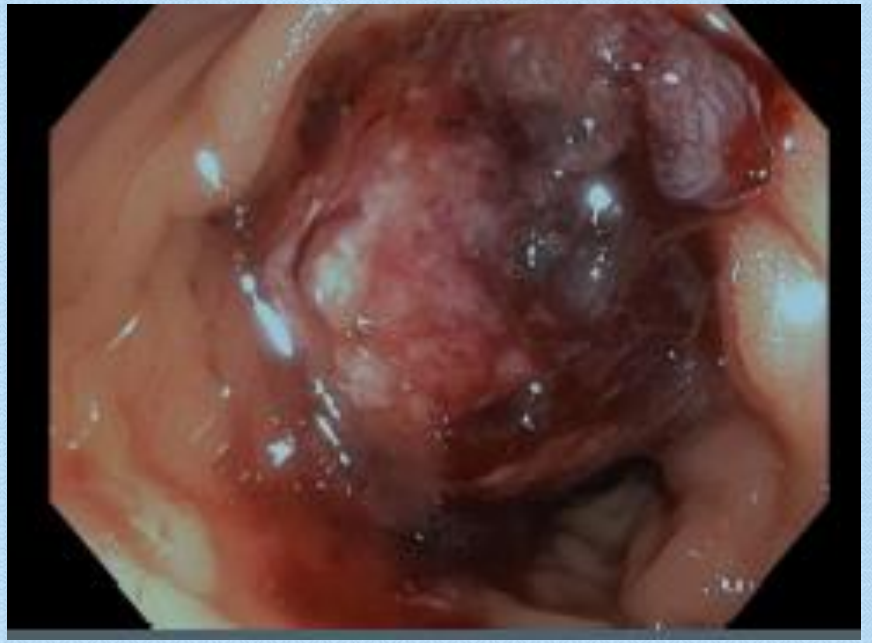
Diagnosis

- Colonoscopy



- CTC
  - a small tube is inserted a short distance into the rectum to allow for inflation with gas while CT images of the colon and the rectum are taken.





Reactions

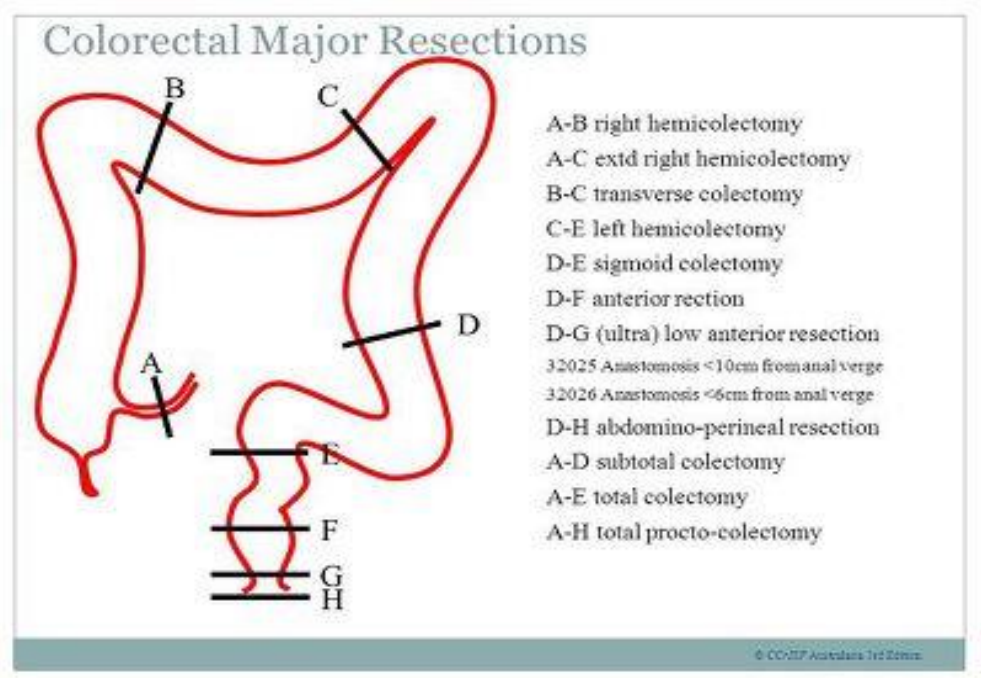
- Gold fish
- Stunned Mullet
- Pragmatic “ I knew… I could feel it”
- Tears
- Distress screening and support

Further investigations

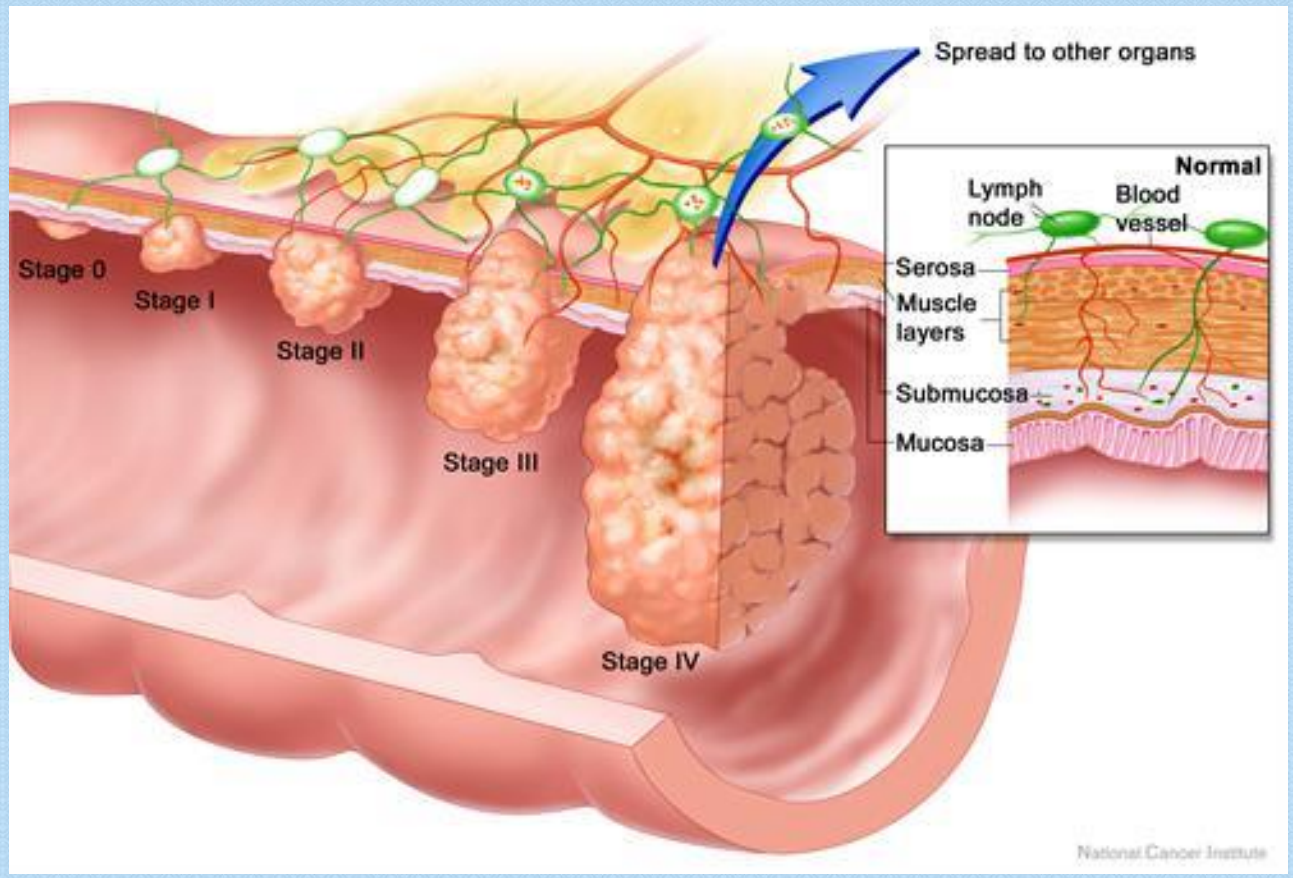
- Bloods
  CEA
  ferritin, CBC
- CT C/A/P-looking for spread of cancer
- MRI rectal
- PET CT
- MDM

Treatment

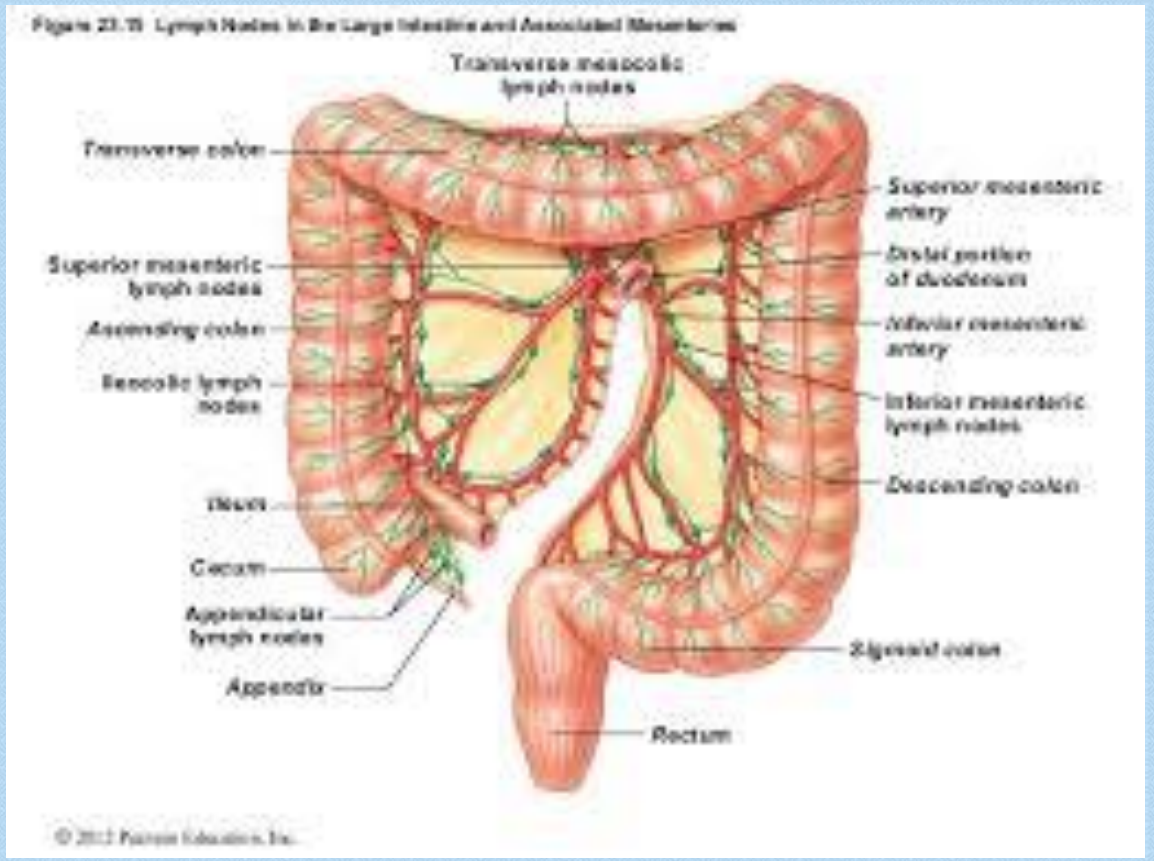
- Depends upon location of disease and spread.
- May be curative or palliative.
- Surgery , primary or for metastatic disease



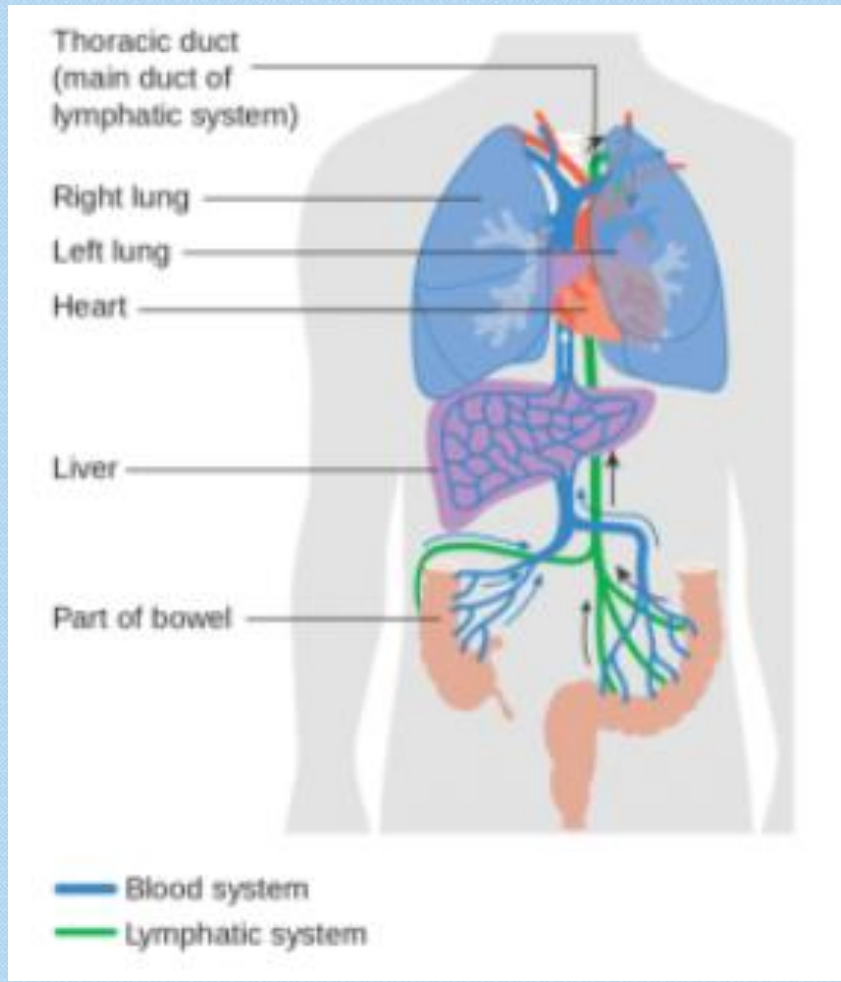
Staging


Spread to other organs
Normal
Lymph node
Blood vessel
Serosa
Muscle layers
Submucosa
Mucosa
Stage 0
Stage I
Stage II
Stage III
Stage IV
National Cancer Institute

Lymph nodes


Transverse mesocolic lymph nodes
Transverse colon
Superior mesenteric lymph nodes
Ascending colon
Ileocolic lymph nodes
Ileum
Cecum
Appendicular lymph nodes
Appendix
Superior mesenteric artery
Distal portion of duodenum
Inferior mesenteric artery
Inferior mesenteric lymph nodes
Descending colon
Sigmoid colon
Rectum

Metastatic bowel cancer



Radiation Therapy

- Curative intent or pallative.
- For rectal – pre surgery Can be short course (to prevent recurrence) 5 days or long course (5 days X 6 weeks) in conjunction with chemo (prevents recurrence and kills lymph nodes)
- Palliative symptom management
- Can be used to ablate cancer deposits in liver and lungs

Chemotherapy

- Infusion. Pump, tablets
- Curative-
  - Intra surgery HIPEC (chemo drugs added to a heated solution and pumped into the patient's abdomen,performed immediately after cytoreductive surgery
  - To "mop up" cells when nodal disease at resection
- Palliative- used to control disease spread
- Used to down size pre surgery in liver
- Side effects- usually well managed
- Used with careful consideration in elderly and comorbid

Outcomes

- Depends upon staging. (Staged 1-4)
  - Range from 90-95% for stage one to 10% stage 4 disease

- Survival rates are only estimates – they can't predict what will happen to any individual person. They estimate how likely it is that a person will *not* die from colon or rectal cancer within 5 years of being diagnosed.

Survival rates (2009-2013)

- For most people, survival and cure remain their primary concern
- Maori (38 % , non Maori 17-32 %) have higher mortality rates 2 years after diagnosis
- People over 80 (48% , <80 22-29) have higher mortality rates 2 years after diagnosis
- 69% were alive 2 years after diagnosis

Screening

- Bowel cancer is the second highest cause of cancer death in New Zealand, but it can be treated successfully if it is detected and treated early.
- Waitemata Pilot
  - 39% cancers stage 1 compared to 13% in unscreened population
  - 8 % cancers stage 4 in pilot vs approx 20-25% in unscreened.
  - Age 60-74
  - Bowel Kit

Genetic Mutations

- **account for an estimated 5–10% of cases of bowel cancer**
- 70% of people with bowel cancer have no family history

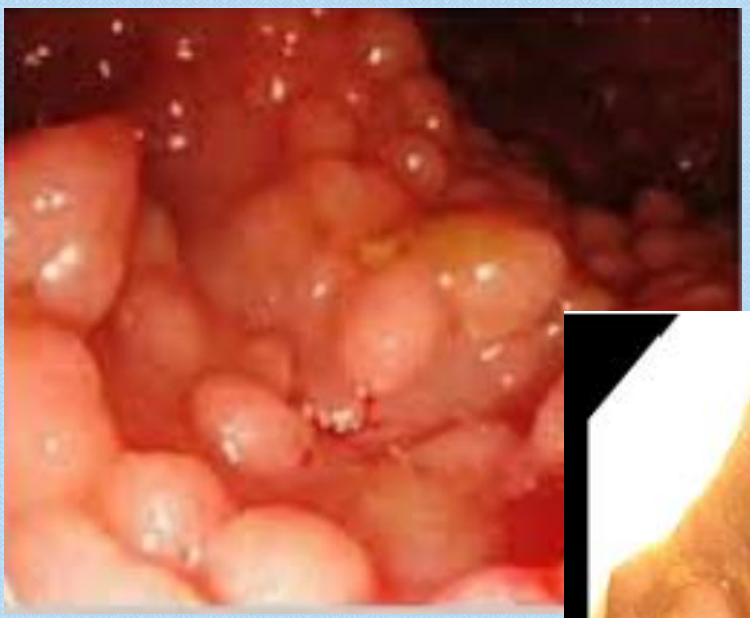
Lynch Syndrome (Hereditary Non-polyposis Colorectal Cancer)

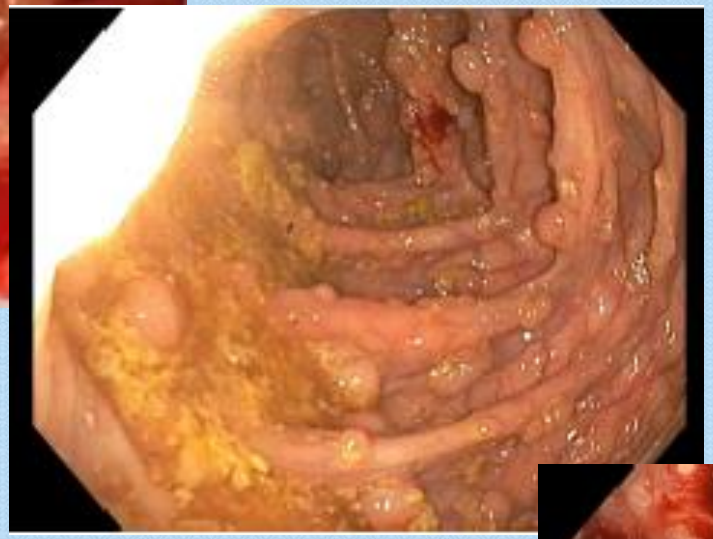
- A fault in a gene associated with DNA repair, day-to-day damage to DNA may not be adequately repaired
- MLH1, MSH2, MSH6 and PMS2.
- Autosomal dominant gene = 50/50 chance
- This increased risk of DNA damage means approximately 50% of people with Lynch syndrome will develop bowel cancer (6% general popn), endometrial, ovarian or stomach before the age of 70 years
- Screening is vital

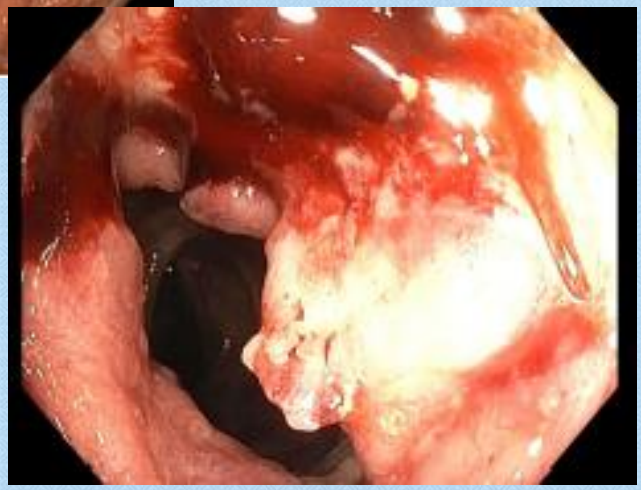
Familial Adenomatous Polyposis (FAP)

- presence of hundreds to thousands of adenomatous polyps, start in adolescence
- almost 100% lifetime risk of developing bowel cancer
- mutation in the *APC* gene
- 50% chance inheritance
- colonoscopy generally commences around age 12–15 years

FAP







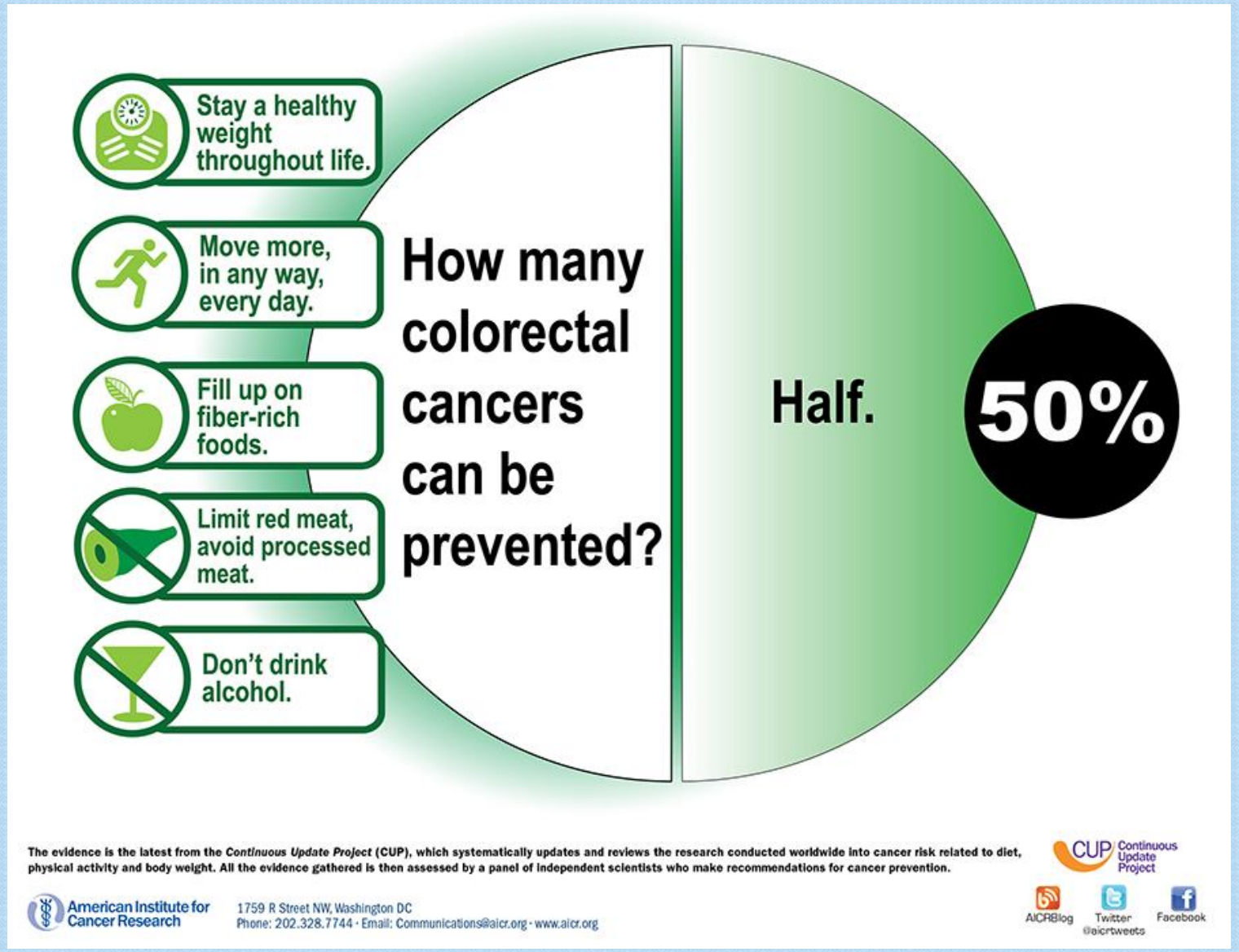
Survivorship

- Cancer survivorship is a day-to-day, on-going process that is constantly changing. It begins at diagnosis for the individual and family/whanau.
- Is living well with, through and beyond cancer
- Nationally, development of generic standards of care for people affected by cancer and for survivorship

Follow Up and Surveillance

- 3/12 CEA
- CT 18/12
- Colonoscopy

- Managing Long-term Side Effects and Late Effects
  - Peripheral neuropathy
  - Bowel function
  - Stoma/social isolation
  - Sexual dysfunction
  - Fear of disease recurrence
  -


Stay a healthy weight throughout life.
Move more, in any way, every day.
Fill up on fiber-rich foods.
Limit red meat, avoid processed meat.
Don't drink alcohol.
How many colorectal cancers can be prevented?
Half.
50%
The evidence is the latest from the Continuous Update Project (CUP), which systematically updates and reviews the research conducted worldwide into cancer risk related to diet, physical activity and body weight. All the evidence gathered is then assessed by a panel of independent scientists who make recommendations for cancer prevention.
CUP Continuous Update Project
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