Colorectal Cancer Screening and Prevention
Community Presentation

Speaker Notes

Slide 6	**From normal to cancer** The transition from normal colon to development of a pre-cancerous polyp (adenomatous polyp) and finally to development into cancer that grows deep into the wall of the colon and spreads to lymph nodes and other organs is slow. It may take 7-12 years. This long time from the first development of polyps that can be seen during a colonoscopy or sigmoidoscope provides an excellent opportunity for cancer prevention through finding and removing polyps before they become cancers.
Slide 8	**Who gets colorectal cancer?** Suggestion: Ask audience members to raise a hand if they have a family member who has or had colon or rectal cancer. People with a family member with colorectal cancer are at higher risk of getting colorectal cancer—but the majority of people who get colorectal cancer have no family history of colorectal cancer. "Family history" includes people with one first-degree relative diagnosed with colorectal cancer or adenomatous polyps before age 60two first-degree relatives diagnosed with colorectal cancer or adenomatous polyps at any age • any of the known inherited syndromes
Slide 9	**Colorectal cancer risk factors** The reasons for these racial and ethnic differences are unclear. Some of the excess mortality in African Americans appears to be related to lower use of colorectal cancer screening and to differences in treatment. The reasons for higher incidence rates in African Americans are also unclear; however, dietary/nutritional factors, rates of physical inactivity, variability in screening rates, lower use of diagnostic testing, and increasing smoking rates have been most commonly implicated. Source: ACG press release, 2005. http://www.gi.org/media/releases/march212005.asp. Restatement of recommendations in 2008.
Slide 10	**Colorectal cancer risk factors (2)** The reasons for these racial and ethnic differences in disease incidence are unclear and may involve genetic differences, dietary differences, and differences in screening.
Slide 11	**True or false poster**

	This educational poster was produced for the Screen for Life initiative to raise awareness of the facts about colorectal cancer and encourage people to undergo regular screening for colorectal cancer. Although colorectal cancer is NOW the 2nd leading cause of deaths from cancer • it is preventable • it can be cured if diagnosed early • both prevention and cure require screening for everyone, based on your age and risk factors • don't wait for symptoms
Slide 13	**Your role: your lifestyle** Smoking: Both women and men who are heavy smokers and were still smoking or had quit less than ten years ago have twice the risk of colorectal cancer or an advanced colon polyp as people who never smoked. Heavy smoking is defined as smoking 30 pack years—for example, smoking 2 packs per day for 15 years or 1 pack per day for 30 years. However, women who smoke less than 30 pack years have the same risk as men who are heavier smokers. Women require less exposure in pack years to have an increase in risk. Source: Anderson JC et al. "Smoking and colorectal neoplasia: women require less tobacco exposure for similar increased risk as compared to men." American College of Gastroenterology Annual Scientific Meeting, October 6, 2008. Diet: Evidence is mixed about the impact of eating meat on colorectal cancer rates. Both Mormons and Seventh-day Adventists have lower than average rates of colon cancer, although Mormons eat amounts of meat, fat, and fiber similar to the general U.S. population, whereas Seventh-day Adventists in general eat meat less than once a week. [Among Adventists, vegetarians had lower rates of colon cancer than did nonvegetarians. Colon cancer incidence in Mormons was 37% below the U.S. average, and that of non-Mormons living in Utah was 18% below the U.S. average.] Sources: Lyon JL, Sorenson AW. Colon cancer in a low-risk population (Mormons). *AJCN.1978;* 31: S227–S230. Fraser GE. Associations between diet and cancer, ischemic heart disease, and all-cause mortality in non-Hispanic white California Seventh-day Adventists. *AJCN.1999;* 70(3): 532S–538S. Obesity:

	Obesity is associated with increased incidence of colon cancer. [New research suggests that this is due to association of a variant of the gene coding for adiponectin, which increases risk of obesity, diabetes, and risk of colon cancer.] Source: Kaklamani VG, Wisinski KB, Sadim M, et al. Variants of the adiponectin (ADIPOQ) and adiponectin receptor 1 (ADIPOR1) genes and colorectal cancer risk. *JAMA*. 2008; 300(13); 1523–1531. Alcohol: Compared with people who reported drinking no alcohol, people who reported drinking more than 2 average-size drinks per day had a small increase in risk for colorectal cancer. The increase in risk was highest in people who drank more than 3 average-size drinks. [The authors could not find differences in colorectal cancer risk by the type of alcoholic beverages people drank. In addition, the 8 studies showed no relationship between alcohol intake and the location of colorectal cancers within the intestine.] Source: Cho E, Smith-Warner SA, Ritz J, et al. Alcohol intake and colorectal cancer: a pooled analysis of 8 cohort studies. *Annals.* 2004; 140(8):603–613.
Slide 16	**Early diagnosis saves lives** Source: http://www.cancer.org/docroot/CRI/content/CRI_2_4_3X_How_is_colon_and_rectum_cancer_staged.asp
Slide 17	**People at higher than average risk of colorectal cancer** Sources: Screening for colorectal cancer: clinical summary of U.S. Preventive Services Task Force recommendation. *Annals.* 2008;149(8). http://www.annals.org/cgi/content/full/149/9/627 Prevalence of colon polyps detected by colonoscopy screening in asymptomatic black and white patients. Lieberman DA, Holub JL, et al. *JAMA*. 2008;300(12):1417–22.

Slide 18	**Screening: who and how** Starting screening at age 50 was more favorable in terms of benefits and risks than starting screening earlier. The gain in life-years associated with screening from age 75 to 85 was small in comparison to the risks of screening people in this age group. For individuals older than age 85, other health conditions make risks of screening greater than benefits. Evidence suggests that screening programs for people between the ages of 50 and 75 using fecal occult blood testing, sigmoidoscopy, or colonoscopy, will all be equally effective in reducing deaths from colon cancer if people follow the screening recommendations (i.e., fecal occult blood testing every year, sigmoidoscopy every 5 years with fecal occult blood testing at 3 years, and colonoscopy every 10 years). Source: Screening for colorectal cancer: clinical summary of U.S. Preventive Services Task Force recommendation. *Annals.* 2008;149(8). http://www.annals.org/cgi/content/full/149/9/627
Slide 25	**CT colonography** The accuracy of computed tomographic colonography for detection of large lesions appears to be in the 80%–-90% range, which is lower than the accuracy of colonoscopy. Current data suggest that computed tomographic colonography is an effective colon cancer screening modality in the United States. However, it is not ready for widespread implementation, largely because of lack of standards for training and reading and the fact that the number of skilled readers is limited. Source: Rockey DC. Computed tomographic colonography. *Curr Opin Gastroenterol.* 2009;25(1):55-8.
Slide 26	**Polyps and colorectal cancer in African Americans** <u>American College of Gastroenterology 2008 recommendations for CRC screening for African Americans</u> Incidence rates in African Americans as a group were 12.3% higher than those in Caucasians (9.5% higher in African American men and 17.5% higher in African American women). The reasons for higher incidence rates in African Americans are unclear; however, dietary/nutritional factors, rates of physical inactivity, variability in screening rates, lower use of diagnostic testing, and increasing smoking rates have been most commonly implicated. African Americans with colorectal cancer have decreased survival compared with Whites. From 1992–1999, the five-year survival rate for African Americans was 53%,

	compared with 63% for Whites. Part of the explanation for the lower survival rates is that a large proportion of African Americans present with Stage IV disease. This effect has been ascribed to lower screening rates, less use of diagnostic tests, and less access to health care. For African Americans and Whites with the same stage of disease (Stage II or III), survival is lower for African Americans, *except in the Veterans Administration system, where access to care is equal*. Evidence indicates that African Americans have a higher rate of right-sided colon cancers than other groups. Source: ACG press release, 2005. http://www.gi.org/media/releases/march212005.asp. Accessed February 5, 2009. Restatement of recommendations in 2008.
Slide 27	**Screening older seniors** Source: Screening for colorectal cancer: clinical summary of U.S. Preventive Services Task Force recommendation. Annals.2008;149(8). http://www.annals.org/cgi/content/full/149/9/627

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Colorectal Cancer Screening Community Education—Evaluation

Learning Objectives

The presentation on colorectal cancer (CRC) screening prepared me to do the following:	*Definitely* don't agree				*Definitely* agree
1. Explain why colorectal cancer screening is worthwhile.	1	2	3	4	5
2. Describe one colorectal cancer screening test.	1	2	3	4	5
3. Determine whether I should be screened for colorectal cancer based on my age.	1	2	3	4	5
4. Identify one lifestyle change I could make to reduce my risk of colorectal cancer.	1	2	3	4	5

Quality of Presentation

	Definitely don't agree				*Definitely* agree
1. The content of the slides was clear and informative.	1	2	3	4	5
2. The slides were easy to read and interpret.	1	2	3	4	5
3. The speaker presented the content effectively.	1	2	3	4	5

Suggestions for helping us better achieve the learning objectives:

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