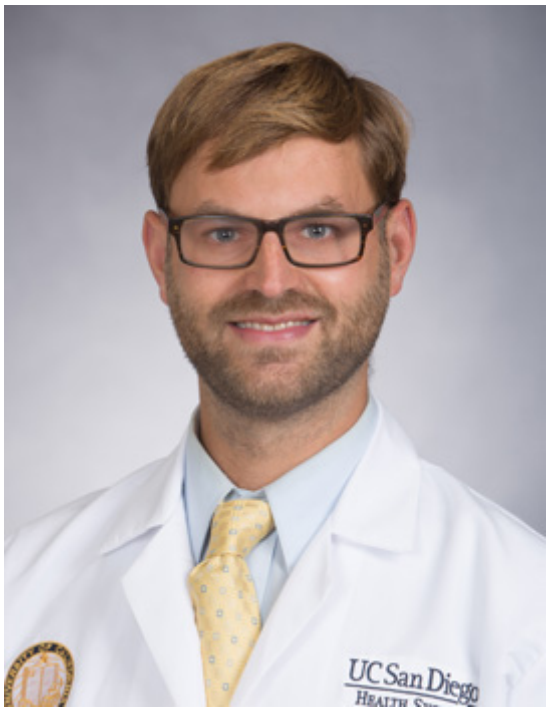
Conquering Colorectal Cancer: a Q&A with Samuel Eisenstein, MD

By Bonnie Ward | February 23, 2016

Colorectal cancer is among the most deadly cancers in the United States, second only to lung cancer in mortality rate. It is also one of the more commonly diagnosed cancers. Overall, approximately 1 in 21 people in the U.S. will get colorectal cancer at some point in their lives. While these statistics are distressing, advances in early detection and treatment are enabling many sufferers to win their cancer battles. More than 1 million Americans now count themselves as colorectal cancer survivors.



Samuel Eisenstein, MD, an assistant professor of surgery at UC San Diego School of Medicine who specializes in colorectal cancer treatment at Moores Cancer Center at UC San Diego Health, talks about symptoms, the latest treatment options and the life-saving importance of screening.

Question: Is colorectal cancer really two types of cancer?

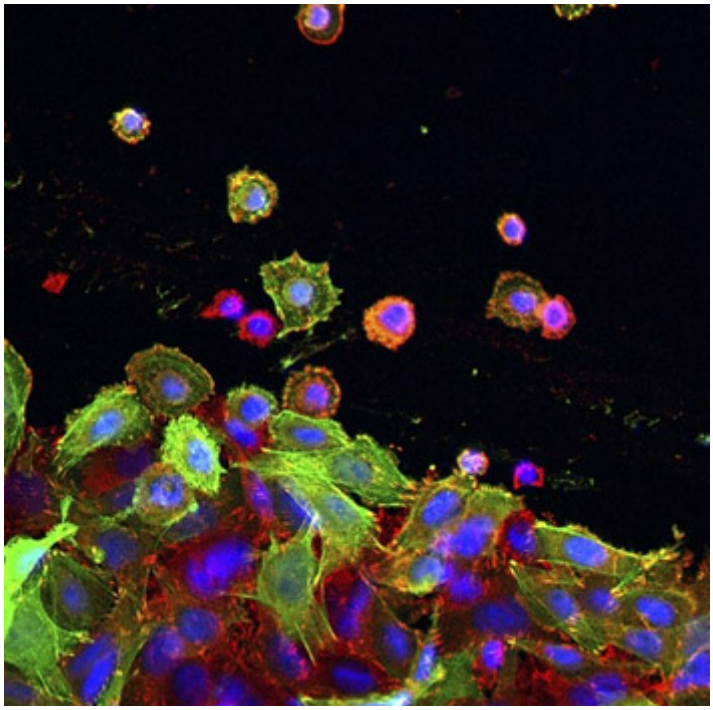
Answer: The colon or large intestine is the final section of the body's digestive tract and handles important functions, like absorbing water and converting digested food into feces, which is excreted through the rectum. People can get colon cancer or rectal cancer or both. They are biologically pretty much the same disease and both occur in the last few feet of the digestive tract. Consequently, they are known collectively as colorectal cancer. Like other cancers, they occur when cells become abnormal and grow out of control.

Q: What are its causes?

A: We don't know for sure. We believe there is a genetic predisposition that interacts with the environment to cause this cancer. Large population studies have shown that a diet high in red and processed meats contributes to the development of colorectal cancer. The low-fiber diet of many Americans also plays a role. Obesity and smoking are additional risk factors.

Q: What are its symptoms and how is it diagnosed?

A: Many of its symptoms are vague: abdominal pain, weight loss, feeling tired, a change in bowel movements, such as differences in consistency or frequency. Many people are diagnosed after having blood in the stool. But I'd say the most common way people are found to have colorectal cancer is during a routine screening.



Q: Why is screening so important and when should it begin?

A: An average person should get their first colonoscopy, which is the standard screening test, at age 50. However, if you have a family history of this cancer, we recommend getting your first screening 10 years prior to your family member's age of diagnosis. For instance, if diagnosis was at 55, then begin screenings at 45.

The reason screening is so important is that it saves lives. Polyps are fleshy growths that occur in the lining of the colon or rectum. They can be benign, but can also turn cancerous. We know that it takes about 15 years for the average polyp to go from no cancer to cancer. So if we can remove those polys during that 15-year window, we can avoid the danger of it turning cancerous. Polyps can be identified and removed during a routine colonoscopy.

Q: Approximately 60 percent of Americans get their recommended screening. Why do you think more people don't get this important procedure?

A: I think people worry that having a colonoscopy will be unpleasant. But several changes have been made in recent years to make the procedure more comfortable. For instance, we now use smaller scopes to view the colon's lining, which is less intrusive for the patient. Also, most colonoscopies are done under anesthesia, so the patient feels little or no discomfort. If 100 percent of Americans got their recommended screening, we'd have a lot fewer cases of colorectal cancer.

Q: How is it treated?

A: Treatment can involve surgery, chemotherapy or radiation or a combination of these. But before treatment begins, we need to determine the cancer's stage, which we assess using CT scans, ultrasounds and other tests. Stages run from one, indicating the cancer is small and locally contained, to stage four, meaning the cancer has spread outside the colon, most likely to the liver

or lungs. If the patient is in the earlier stages, we remove the cancer tissue surgically and follow up with chemotherapy and possibly radiation. In the case of stage 4, most patients start with chemotherapy before being considered for surgery.

Q: What are some of the latest advances in colorectal treatment?

A: Many of the colorectal tumor removal surgeries are now done laparoscopically. This involves very small incisions and reduces the patient's recovery period. These surgeries are also becoming more precise, particularly through the use of robotic instruments, a technique that was pioneered at Moores Cancer Center.

Another major focus is on using chemotherapy agents tailored to the individual. Not everyone has the same genetic defects in their tumor cells and we know that certain chemotherapies do better against certain genetic defects. If you know the genome of the cancer cell, then you can use the most effective chemotherapy agent available for destroying that type of cancer cell. At Moores Cancer Center, we are already using this practice and regularly analyze tumor tissue genomes. The challenge remains finding actionable genes – meaning tumor genes for which we have specific chemotherapies. This technique is still in its infancy but it will expand as new chemotherapies become available. It holds great promise for improving cancer treatment.

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