



March 2010

11th Annual Colon Cancer Awareness Month Be a Star... know the risks of colon cancer!

COLORECTAL CANCER (CRC) FACTS:

- CRC is the 3rd most commonly diagnosed cancer in the U.S.
- CRC is the 3rd leading cause of cancer death in men and women in the U.S.
- Colon screening can PREVENT many cases of CRC.
- CRC is curable when detected at an early stage through colonoscopy.
- More than 145,000 Americans are diagnosed with CRC each year which results in 50,000 deaths.
- Nine out of ten new cases of CRC are in patients aged 50 and over.
- CRC diagnosis and deaths are high in African-American men and women.
- Many health plans cover colon screening.
- Only 17% of Americans are screened annually.

DECREASE YOUR RISK

- Maintain a healthy weight.
- Adopt a physically active lifestyle.
- Eat a healthy diet.
- Limit alcohol consumption.

SIGNS OF COLORECTAL CANCER

In early stages, colon cancer does not have any symptoms which is why colon screening plays such an important part in detection. Polyps grow in the intestine and may cause obstruction or bleeding. Below are some of the warning signs:

- Rectal bleeding.
- Bloody stool or toilet water after a bowel movement.
- A change in the shape of your stool.
- Cramping pain in the lower stomach.
- Discomfort or an urge to have a bowel movement when there is no need to have one.
- New onset of constipation.
- Abnormal weight loss.

WHAT IS A COLONOSCOPY?

A colonoscopy lets gastroenterologists see the lining of the large intestine (rectum and colon). Using a thin flexible tube (endoscope), they can look inside the colon for problems such as swelling, tumors or growths (polyps). During a colonoscopy, a gastroenterologist can biopsy any suspicious areas, cauterize any areas of bleeding or remove polyps.

Talk to your doctor about colon screening if you have any of the above symptoms. Ask your doctor to contact the Digestive Disease Center to schedule your colonoscopy.

4th Annual Unmasking Colon Cancer Ball

On Saturday, March 6th, the 4th Annual Unmasking Colon Cancer Ball took place in Charleston at the South Carolina Aquarium to launch the Colon Cancer Alliance's national Dress in Blue campaign, raising awareness about colorectal cancer and the importance of screening. Ball participants came through with donations that netted over \$70,000. Such generosity will have a direct impact on colon cancer reduction efforts in South Carolina during what we all know are very difficult economic times. Donated funds will be used in their entirety to support activities related to colorectal cancer awareness and screening, including free colonoscopy screening programs that mainly serve the state's uninsured and medically underserved.

"Each year this ball provides a huge boost to awareness, research and local screening programs, which provide free screening opportunities for hundreds across the Palmetto state," said Dr. Frank Berger, director of the Center for Colon Cancer Research at the University of South Carolina.



Dr. Brenda Hoffman is escorted down the fashion show runway by Dr. Jay Popp, a Columbia gastroenterologist.



Dr. Peter Cotton, modeling a stylish tuxedo is escorted during the Sacks Fifth Avenue fashion show by his lovely wife, Marion.



Above, Dr. Christopher Lawrence and his wife, Sally who had some of her original artwork on display for the evening.



To the left, Dr. Larry Comerford (center) and his wife, Barbara (left), with Sydney Jones (right) of AmGen Corporation.

To the right, Drs. Brenda Hoffman and Michael Frye (right) with Dr. Kristin Wallace and her husband, David Parker (left). Dr. Wallace is a Ph.D. who performs colon cancer research at MUSC. Research rocks!



A BRIEF HISTORY OF COLONOSCOPY

by Peter B. Cotton, M.D.

Colonoscopy is now a household word, and older folks talk at the dinner table about their colonoscopy experiences almost as much as they brag about their grandchildren. But the procedure has not been around for long. The first attempts to look inside the nether regions were made with rigid metal tubes, which could not be inserted beyond the rectum. Some photographs of the upper colon were obtained in the late 1950s with a tiny camera on a long flexible shaft. However, the breakthrough came with the introduction of flexible endoscopes incorporating fiber-optic viewing and light bundles. The first "fiberscope" was developed in USA in the early 1960s by Hirschowitz and colleagues, and Overholt used one soon afterwards to examine the sigmoid colon. Passing deeper in the very tortuous colon proved challenging. One Italian group solved the problem by having the patient swallow a weighted string. When it appeared out of the anus, they attached a scope to it, and literally pulled the scope up from the mouth. The technique did not become popular! Many iterations of longer instruments followed, eventually achieving the best combination of flexibility and controlled stiffness to make deep insertion possible on a regular basis.

In the late 1980s, fiberoptic instruments were superseded by videoscopes, ie instruments with tiny TV cameras at the tip. These provide superior images, which everyone in the room can see on TV monitors. The images can be recorded, and even transmitted to other hospitals or countries. Developments continue, focusing mainly on getting more detailed views of the colon lining with magnifying scopes or viewing with different colored lights.

A big concern of the professional societies for gastroenterologists and surgeons who do colonoscopy is to ensure that the procedures are done well, and that the whole colon is examined. Studies show that substantial training and experience are required. Poor quality colonoscopy often misses lesions, even cancers. Many companies are attempting to make complete colonoscopy easier with clever advancing and even self-steering devices.

Colonoscopy is used to find the source of colonic symptoms, such as bleeding, but increasingly also in

people without symptoms. The purpose of screening colonoscopy is to find small growths (polyps) that can be removed before they grow into cancers. Removing polyps at colonoscopy was first done in New York by Shinya and Wolfe, using a home-made sere snare (lasso) device. This was a dramatic breakthrough, since, previously, removing a polyp meant major surgery, and weeks of recovery. Anyone who complains that their colonoscopy (or the laxative preparation) was unpleasant might wish to reflect on how far we have come in 30 years. The scourge of colon cancer can largely now be prevented by these means.

HAVE YOU SEEN THE BLUE STAR?



Similar to other awareness ribbons, the Blue Star symbol was developed by the National Colorectal Cancer Roundtable. The NCCRT is a nationwide coalition of more than 60 public, private and volunteer organizations committed to raising colorectal cancer awareness. In honor of National Colorectal Cancer Awareness Month, the National Colorectal Cancer Roundtable and the Society of Gastrointestinal Nurses and Associates has donated 500 Blue Star pins to be distributed to staff and patients during the month of March. We wish to thank them for their generosity.



The Blue Crew - many DDSL staff wore blue in support of the 1st Annual National Wear Blue Day on March 5, 2010 to promote awareness of colon cancer.