

Colorectal Cancer Deaths Could Be Cut by 50%

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The continued decline in new cases of colorectal cancer represents only a tantalizing peek at what could be achieved if more people took advantage of colon cancer screening, experts say.

A concentrated push to increase screening to 80%—the rate now seen with mammography—could cut by half the 52,000 colorectal cancer deaths expected this year, said Dr. Bernard Levin, vice president for cancer prevention and population science at the M.D. Anderson Cancer Center, Houston.

National surveys show that each year, about half of U.S. citizens eligible for screening undergo the test. But despite the steady decreases in new colon cancer diagnoses and mortality, a 50% screening rate just isn't good enough.

"Although it's high, it's not at the optimal level," Dr. Levin said in an interview. "What is outstandingly obvious is that we could do so much more."

Dr. Sidney Winawer, a gastroenterologist who holds the Paul Sherlock Chair at Memorial Sloan Kettering Cancer Center, New York, agreed.

"We don't have anything in colorectal cancer like the educational outreach that we see for breast cancer screening. They get their message out consistently, repeatedly, and to many different groups. That's what we need to do—not just talk about screening once a year in March [National Colorectal Cancer Awareness Month]."

The American Cancer Society's latest report on U.S. trends says about 112,000 new cases of colorectal cancer will be diagnosed in 2007. That's a 2% decrease from the 2004 report, and a continuation of the decline since 1985. But colorectal cancer is

still a killer, ranking third in both prevalence and mortality in men as well as women, the report says.

The problem of education is one that must be "attacked on multiple fronts," said Dr. Winawer, who is also the director of the World Health Organization's Collaborating Center for the Prevention of Colorectal Cancer. "Patient education is only one part of our task. We also need to educate providers—gastroenterologists, primary care physicians, nurses, and health maintenance organizations."

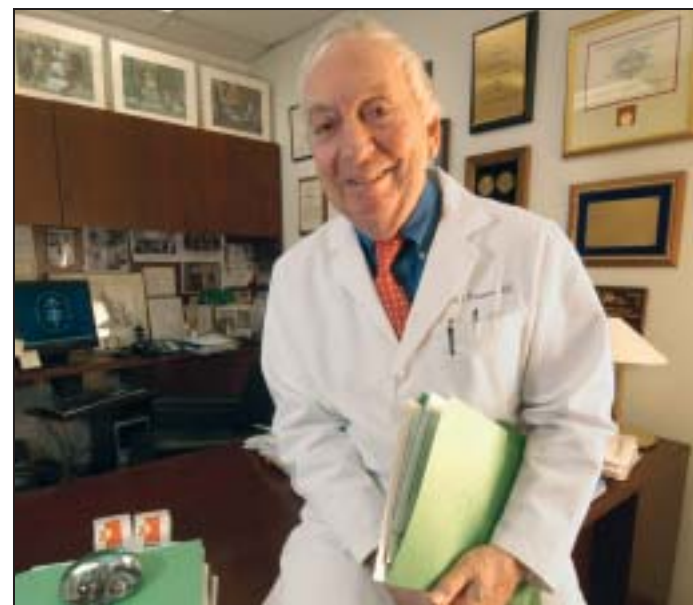
He envisions a message with three components: family history, gender equality, and minimizing fear. "We have to emphasize that the risks are equal for men and women. ... It is an equal-opportunity killer."

People with a family history of polyps or colorectal cancer are at significantly increased risk of developing the disease; they need to understand that screening is even more important for them, and should begin at a younger age.

"And we simply have to address the fear component of this," Dr. Winawer said. "People shouldn't be afraid to be screened. The tests are much more comfortable than they were, sedation is much better, we are more experienced, and the instruments are much better." In addition, he said, most patients don't need to be afraid of what the scope might see, since most colonoscopy findings are easily removed polyps or very early, highly curable cancers.

Because screening picks up these early lesions, it has also contributed to the significant decrease in colorectal cancer mortality noted in the ACS report—about 5,000 fewer deaths are expected this year than were expected according to the 2004 report.

But advances in treatment also play a



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widespread use of nonsteroidal anti-inflammatories, which are known to reduce both colon polyps and cancer."

Still, the experts agreed, screening is the area that deserves the most emphasis. Advances in the comfort and accuracy of screening will combine to make it a more acceptable option for more people, they predicted.

"We are in an exciting time with regard to developing options for screen-

ing," Dr. Winawer said. "Soon we're going to see better stool screening methods, including a DNA mutation test and an immunochemical test, both of which may be much more accurate than fecal occult blood."

In the longer term, he said, nurses and technicians will be able to use self-propelling colonoscopes; an endoscopist will only get involved if the imaging reveals polyps that need attention. And computed tomographic colonography (CTC) will make imaging studies much more acceptable to a wider pool of patients.

There are also demographic disparities to address, Dr. Levin said. "African Americans have a higher incidence and a higher mortality from colorectal cancer. It may be a mix of biology—the cancers themselves may be different—and access to medical care."

Education of patients and physicians is key, he said. It's unreasonable to expect every primary care physician to spend 5 minutes discussing screening with every eligible patient, but "it's not unreasonable to take 7 seconds and give a simple message: 'Don't die of embarrassment. Get screened.'"

Hormone therapy in postmenopausal women might also be exerting a small protective effect, Dr. Levin added. "And there may be some small effect of the very

very strong role here, said Dr. Alfred Neugut, head of cancer prevention and control at Herbert Irving Comprehensive Cancer Center, New York.

"Colorectal cancer has seen some huge advances in treatment in the last few years, some of the most dramatic treatment changes seen in any cancer. We went from having just one active drug, 5-fluorouracil, to having six or seven."

Advances in adjuvant therapy for regionally advanced colon cancer have also had a significant impact on mortality. "There has also been an improvement, although less dramatic, in treating metastatic colon cancer," Dr. Neugut said.

Screening and treatment are undoubtedly the biggest contributors to the steady decrease in colorectal cancer, the physicians said. But other factors are at work, exerting a smaller effect or one that is difficult to extrapolate. "Lifestyle changes have probably played a part," he said. "People are more health conscious with regard to diet and exercising."

GI Cancer Trends Detailed in Report

The American Cancer Society's 2007 report highlighted trends not only in colorectal cancer but also in other gastrointestinal cancers.

Gastric cancer fell slightly, continuing its dramatic 60-year decline, said Dr. Alfred Neugut. "Gastric cancer was the No. 1 cancer in the U.S. for years. Now it's almost negligible. The reasons probably are dietary, reflecting refrigeration and the increase in the consumption of fresh foods, rather than smoked and cured foods that contained cancer-causing nitrates and nitrites."

There is also some speculation that the widespread use of antibiotics in childhood has decreased the prevalence of *Helicobacter pylori*, leading to decreased rates of gastric cancer in adults.

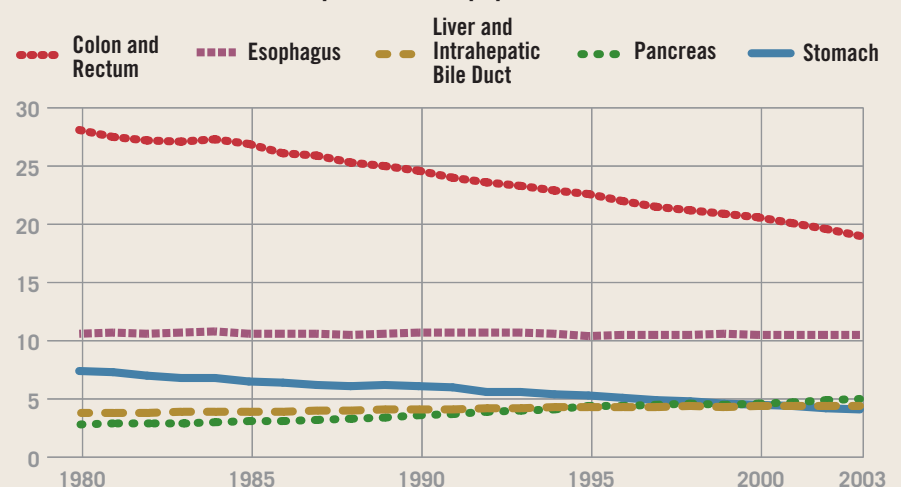
There have been no significant improvements at all in pancreatic cancer incidence or mortality, the report noted. The report predicts 33,000 deaths, equally divided between the genders, for 2007. The small declines that have occurred are probably related to a

general decrease in smoking, said Dr. Neugut.

Overall esophageal cancer rates are steady, but this trend masks changes within the disease, said Dr. Neugut. "Adenocarcinoma continues to increase, but squamous cell carcinomas are decreasing, and they are really compensating for each other in terms of the overall incidence." Increasing obesity and untreated gastroesophageal reflux disease leading to Barrett's are probably the driving forces behind the rise in esophageal adenocarcinoma. The decrease in squamous cell cancer is probably related to the decline in smoking, he said.

The ACS report estimates more than 19,000 new cases of liver cancer for 2007, the vast majority of which will occur in men. Liver cancer had been increasing up until about 1999, the report said, but now seems to be stabilizing. The incidence of the disease is directly related to the prevalence of hepatitis C infections, said Dr. Neugut.

Mortality Rates for GI Cancers (per 100,000 population)



Note: Age-adjusted total U.S. mortality, based on data from the Surveillance, Epidemiology, and End Results Program and the Centers for Disease Control and Prevention.

Source: National Cancer Institute