

2017 CANCER CARE REPORT TO THE COMMUNITY

COLON CANCER SITE SPECIFIC STUDY

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INTRODUCTION:

In 2017, the American Cancer Society estimates there will be 1,688,780 new cancer cases and 600,920 cancer deaths in the United States. Colorectal cancer is the 4th most common cancer diagnosed and 2nd in cancer deaths. Previously until 2014 it was the 4th most common cause of cancer death behind lung, breast, and prostate cancer. Screening colonoscopy has been shown to effectively reduce deaths. Development of colon cancer is a stepwise process starting with the development of polyps and associated genetic changes at each stage resulting in dysplastic tissue and eventually the cancer phenotype. The most common kind of colon cancer type is adenocarcinoma which comprises 95% of cases. Other less common subtypes include carcinoid tumors, gastrointestinal stromal tumors (GIST), lymphomas, and sarcomas.

EPIDEMIOLOGY:

2017 estimates in the US by the American Cancer Society include 135,430 new cases and 50,260 deaths from colorectal cancer. The state of California has the largest number of new cases and deaths from colorectal cancer followed by Florida, Texas, and New York. Massachusetts is at 13. Wyoming has the least number of new cases and deaths followed by District of Columbia, Alaska, and Vermont. The death rate from colorectal cancer has been declining since the 1940s resulting from better detection, understanding of the biology, screening

and treatment. Overall 5 year expected survival is 65%. Modifiable risk factors that increase the risk for colorectal cancer include obesity, inactivity, smoking, heavy alcohol use and diets high in red meats and processed meats. Diets high in fruits, vegetables and whole grains have been shown to lower risk. Risk factors that cannot be modified include a history of polyps, colon cancer, inflammatory bowel disease and other familial cancer syndromes such as familial adenoma status adenomatous polyposis (FAP) and Lynch Syndrome.

AJCC STAGING AND WORK-UP:

When colon cancer is diagnosed the workup per NCCN (National Comprehensive Cancer Network) would include a colonoscopy, blood work (CBC, chemistry profile and CEA tumor marker), and CT scan of the chest/abdomen/pelvis. Other modalities for more advanced or metastatic cancer would include brain imaging with an MRI as well as PET scanning. Important histopathologic features include pathologic subtype, depth of invasion, number of lymph nodes involved, perineural invasion, lymphovascular invasion as well as genetic markers such as KRAS, and NRAS, and BRAF mutational status.



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TREATMENT:

Treatment for colorectal cancer depends upon stage as well as other clinical factors such as age, comorbidities and patient preference. Surgical resection is the mainstay of treatment for non-metastatic cancers and chemotherapy is the preferred modality for advanced or metastatic cancers. Colon cancer with radiographic evidence of metastatic disease on presentation is often diagnosed by a needle biopsy at an appropriate site which is useful for diagnostic staging purposes. Appropriate evaluation of the surgical specimen including the T (tumor) and N (node) stage with at least 12 lymph nodes evaluated is critical for prognostic and therapeutic purposes. Generally surgical resection alone is appropriate for stage I and stage II cancers without high risk features. For stage II cancers with high risk features such as poorly differentiated histology, lymphovascular invasion, bowel obstruction, perineural invasion, less than 12 lymph nodes examined, and close or positive margins adjuvant chemotherapy may provide a small benefit as far as reducing the risk of recurrence. For stage III cancers which display lymph node involvement adjuvant chemotherapy has been shown to reduce the risk of recurrence and is the standard of care in appropriate chemotherapy candidates. For stage IV cancers chemotherapy is a standard modality of treatment which has been shown to prolong survival and also is of palliative benefit.

NORWOOD HOSPITAL PATIENT DATA REVIEW:

Norwood Hospital Cancer Center data for colon cancers diagnosed and treated in 2015 and 2016 were reviewed. In 2015 there were 27 cases with 5 of 27 (18.5%) stage 0, 6 of 27 (22.2%) stage I, 10 of 27 (37%) stage II, 2 of 27 (7.4%) stage III and 4 of 27 (14.8%) stage IV. In 2016 there were 21 cases with 2 of 21 (9.5%) stage 0, 6 of 21 (28.6%) stage I, 9 of 21 (42.9%) stage II, 2 of 21 (9.5%) stage III and 2 of 21 (9.5%) stage IV. All cases were staged and treated in accordance with national guidelines including the American Joint Committee on Cancer (AJCC) and the National Comprehensive Cancer Network (NCCN). Early diagnosis and screening play a crucial role in the management and outcome of colon cancer. Future directions in our cancer center include detection of cancer susceptibility genes in high risk patients such as those with a strong family history of cancer. This may provide opportunity for early intervention such as earlier screening and prophylactic treatments.

Norwood Hospital Cancer Care Services

Norwood Hospital offers community-based care for most cancers. Services are conveniently located at the hospital and it's Cancer Center in Foxboro. Our goal is to provide local access to current treatment to achieve the best possible outcomes. We offer:

- Leading-edge radiology
- Medical oncology
- Surgical services
- Outpatient chemotherapy clinic
- Intensity-Modulated Radiation Therapy
- Seed implants
- National cancer research trials
- Community health screenings and education, including American Cancer Society programs.
- Pain management
- Rehabilitation

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