Six Things You Must Know About Colon Cancer

1) What Tests Are Available for Diagnosing Colon Cancer?

Colonoscopy: Colonoscopy is considered the "gold standard" for colon cancer screening. It is usually performed by a gastroenterologist, a doctor who specializes in diseases of the gastrointestinal system. A colonoscopy involves the insertion of a colonoscope into the anus, rectum, and colon. A colonoscope is a long, thin tube with a light and a viewing mechanism through which the doctor is able to view the inside walls of your rectum and colon. Colonoscopy is considered the best of all available tests for detecting and removing polyps, small growths on the inside walls of the rectum and colon that can develop into colon cancer. Colonoscopy requires thorough bowel prep (i.e., the removal of all stool from the colon and rectum) before the test can be performed. Colonoscopy also requires mild sedation during the test. Because of the need for bowel prep and sedation, most people will miss some work on the day before and the day of their colonoscopy. Because colonoscopy often involves cutting polyps from the inside bowel wall, it carries the risk of bleeding and bowel perforation. Bowel perforation can lead to serious and even fatal illness if not detected and treated immediately. Another potential drawback associated with colonoscopy is that the colonoscope cannot always be extended the entire length of the colon.

Sigmoidoscopy: This test involves the insertion of a sigmoidoscope into the anus, rectum and lower colon. A sigmoidoscope is like a colonoscope except it is shorter in length and can only reach the level of the rectum and lower colon. The lower colon is called the sigmoid colon. A sigmoidoscopy requires bowel prep and sedation just like colonoscopy, but sigmoidoscopy leaves the entire upper colon unexamined. For this reason, sigmoidoscopy is considered inferior to full colonoscopy as a means of detecting colon cancer. This is especially true because studies have shown that most colon cancers arise in the upper part of the colon.

Barium Enema: Barium enema, also sometimes referred to as “double contrast barium enema”, is an older test. It is performed by a radiologist. Barium enema requires prior bowel prep just like colonoscopy and sigmoidoscopy. Once the bowel has been prepped, it is inflated and a barium-containing liquid is inserted through the anus, into the rectum and up into the colon. While this liquid travels up through the rectum and lower and upper colon, x-rays are taken of the patient’s abdomen. The radioactive barium liquid in the rectum and colon appears white in color on these x-rays. This provides an outline of the inside walls of the rectum and colon. Any large tumors growing on these walls can thus be visualized. The major disadvantage of barium enema is that it often does not show smaller growths, such as small polyps, which can contain or lead to colon cancer. For this reason, barium enema is considered inferior to colonoscopy as a screening test for colon cancer.

Virtual Colonoscopy: This is the new wave for colon cancer screening. Virtual colonoscopy involves the use of magnetic resonance imaging (MRI) or computed tomography (CT) to take a three-dimensional picture of the inside of the colon and rectum. Virtual colonoscopy does not require the insertion of long tubing into the bowel, and with the use of a special technique called “fecal tagging”, some forms of virtual colonoscopy do not require uncomfortable bowel prepping. Recent studies of virtual colonoscopy indicate that it is about as good as colonoscopy
at detecting polyps larger than .5 cm, but not as good as colonoscopy at detecting precancerous
growths that are smaller than .5 cm. Another significant disadvantage of virtual colonoscopy
compared to traditional colonoscopy is that polyps cannot be removed or biopsied during virtual
colonoscopy while they can with traditional colonoscopy.

2) **What Are the Leading Risk Factors for Colon Cancer?**

Colon cancer is the second leading cause of cancer-related death in the United States. Over
150,000 people are diagnosed with colorectal cancer each year. Over 50,000 people in the U.S.
die from colon cancer each year. Here are the leading risk factors for colon cancer:

- Age (more than 90% of all diagnosed colorectal cancers involve people over 50 years old)
- Prior history of colorectal polyps (particularly if the polyps were large or there were
many of them)
- Prior history of colon cancer (particularly if you had your first colon cancer when you
were younger than 60)
- Prior history of inflammatory bowel disease (including ulcerative colitis and Crohn's
Disease, but excluding irritable bowel syndrome)
- Family history of colon cancer (up to 20% of people who develop colon cancer have a
family history of the disease)
- Inherited genetic susceptibility to colon cancer (e.g., familial adenomatous polyposis or
hereditary non-polyposis colon cancer, a.k.a. Lynch syndrome or Peutz-Jeghers syndrome)
- Racial and ethnic background (for reasons that are not yet fully understood, African
Americans have the highest colorectal cancer incidence and mortality rate of any racial
group in the United States)
- Life style-related factors (diets high in red meats and/or processed meats; physical
inactivity; obesity; smoking; heavy alcohol usage; type 2 diabetes)

3) **What Are the Primary Symptoms of Colon Cancer?**

- Change in bowel habits lasting more than a few days (e.g., diarrhea, constipation,
constipation that turns into diarrhea, narrowing of stool)
- Feeling like you need to have a bowel movement which is not relieved by having a bowel
movement
- Rectal bleeding, dark stools, or blood in the stool
• Cramping or abdominal pain

• Weakness, fatigue, or unexplained weight loss

4) What Should You Expect at the Doctor’s Office?

If you go to your doctor with any of the symptoms associated with colon cancer, you should expect your doctor to take a careful medical history. Your doctor will also ask you about your symptoms and try to determine your level of risk by identifying your risk factors for colon cancer. Your doctor will also perform a physical examination. During your physical, your doctor will feel your abdomen to look for masses or enlarged organs. Your doctor will also perform a digital rectal examination. Your doctor will order blood tests to look for anemia, which can be a sign of tumor-related internal bleeding, as well as CEA, a colorectal tumor marker that can be found in your blood. Your doctor will also order a fecal occult blood test. This test is used to find trace amounts of blood in your stool. Finally, your doctor will refer you for a colonoscopy.

If any polyps or abnormal growths are identified during your colonoscopy, these growths will be removed and biopsied. In a biopsy, a small piece of the removed tissue is evaluated under a microscope by a pathologist. Biopsy testing is the only way to know for sure whether colon cancer is present.

5) What is the Relationship Between Colon Polyps and Colon Cancer?

While not all colorectal polyps go on to become colon cancer, almost all colon cancer starts its life as a non-cancerous colorectal polyp. The two most common types of colorectal polyps are hyperplastic polyps and adenomatous polyps. Adenomatous polyps are also called adenomas. Hyperplastic polyps almost never go on to become cancerous. Adenomas are far more likely to evolve into colon cancer if left in the colon long enough. The general rule is that the larger an adenoma grows, the greater chance it has of becoming cancerous.

Adenomas are classified into three different sub-types, depending on how they look under the microscope. These three sub-types are tubular adenomas, villous adenomas, and tubulo-villous adenomas. Roughly 70% of all removed polyps are tubular adenomas. They tend to be small and are rarely associated with colon cancer. About 15% of all removed polyps are villous adenomas. These tend to be larger and they carry a high risk of turning into colon cancer. Tubulo-villous adenomas are a mixture of tubular and villous adenoma and they carry a moderate risk of turning into colon cancer.

Because the risk of colon cancer grows as the polyp becomes larger, all polyps should be removed as soon as possible. Removal of a polyp during colonoscopy is not always possible, depending on the size, shape and location of the polyp within your colon. Many colorectal polyps grow on a narrow stock. Polyps that grow on a narrow stock are called pedunculated polyps. Other polyps are not on a stock and tend to grow flat against the colorectal wall. These are called sessile polyps. As a rule, pedunculated polyps are far easier to remove during a
colonoscopy than are sessile polyps. Therefore, if you have been diagnosed with a large adenomatous sessile polyp, you may need surgery to ensure the complete removal of the polyp.

The last thing you should know about polyps is that they are graded according to their level of “dysplasia”. The word dysplasia means “bad cell formation”. Dysplasia is halfway between non-cancerous and cancerous. When removed and biopsied, both tubular and villous adenomas may contain abnormally formed cells that are almost but not quite cancer. These abnormal cells are called dysplastic cells. Polyps that contain dysplastic cells, i.e., dysplasia, are graded from low grade dysplasia to high grade dysplasia. High grade dysplasia is considered an ominous sign that colon cancer may soon develop.

6) When Should You Get Your First Colonoscopy?

If you have no risk factors for colorectal cancer and no abnormal bowel symptoms, most experts agree that you should get your first colonoscopy at the age of 50. After this initial screening colonoscopy, you should get a repeat colonoscopy within three years if any of the following was found during your initial colonoscopy: three or more adenomas of any size; any polyp with high grade dysplasia; a villous or tubulo-villous adenoma; or any polyp 1 cm or greater in size. If only one or two small (less than 1 cm) tubular adenomas with no high grade dysplasia were found, you should get your repeat colonoscopy in five years. If no adenomas were found, a repeat colonoscopy should be performed in 10 years.

If you have risk factors for colon cancer, such as a family history, your initial colonoscopy should take place when you turn 40. If you have inflammatory bowel disease, such as ulcerative colitis, your initial screening colonoscopy should take place 20 years after the date of your inflammatory bowel disease diagnosis, or at the age of 40, whichever comes first.

If you have any symptoms associated with colon cancer, you should get a colonoscopy as soon as possible, no matter what your age.

About Berger & Lagnese

If you or a loved one has been diagnosed with colon cancer, or died from the disease, and you wonder if it could or should have been detected and treated earlier, call the colon cancer lawyers of Pittsburgh, Pennsylvania, and have your case reviewed at absolutely no cost to you. The lawyers at Berger & Lagnese will find the answers to your colon cancer questions.