
screen
colons
canada
If you
have one
of these...
take a
peek!

You get a mammogram to screen for breast cancer.

You get a regular PAP smear to detect cervical cancer.

You get a PSA done to check for prostate cancer.

You watch your blood pressure and cholesterol for the health of your heart.

DOESN'T YOUR COLON DESERVE THE SAME ATTENTION?

Colon cancer is often silent but deadly.

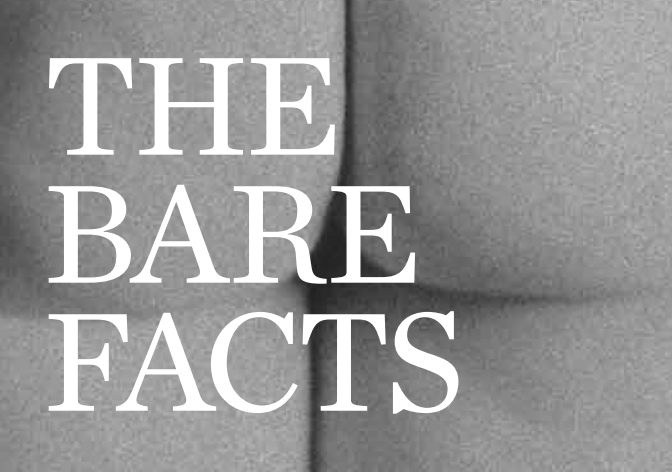
By the time symptoms show up, the cancer can be advanced and more difficult to treat.

But colorectal cancer is not inevitable. It's preventable—up to 95 per cent preventable! You just have to get off your butt and let the doctor take a peek.

This brochure will help you understand why it's so important to be screened for colorectal cancer.

BOTTOMS UP!

Your bottom should be at the top of your priority list.



THE BARE FACTS

1. Colorectal cancer **(CRC)** begins with a malignant tumour that first appears in your colon or rectum.

2. You **may not know it's there** because it starts as a polyp, hidden in that long dark tunnel. Many of us develop polyps as we age. Fortunately, they usually take years to become malignant. The trick is to find them before they become a problem.

3. There are **often no clear symptoms** of colon cancer. It is only after the tumours have penetrated the bowel wall or the cancer has metastasized that CRC is noticed by the patient. By then, it's often considerably more difficult to treat.

4. Colorectal cancer is the **second deadliest** form of cancer in Canada, second only to lung cancer. But the good news is that it's one of the most preventable cancers, with timely and thorough screening.

5. **Colorectal cancer hits men and women almost equally**. The old stereotype of colon cancer being a disease of sedentary old men is just that: a stereotype!

Colorectal cancer is not a disease of **Old Farts**. It's a disease of men and women, over 50 and under 50. You need to figure out your risk factors and talk to your doctor about getting screened.

Average Risk

- **You are 50 years old or older.**

Increased Risk

- **You have a family history of colon/rectal/bowel cancer.**
- **You have had ulcerative colitis or Crohn's disease.**
- **You have had colorectal polyps.**
- **You have had uterine, ovarian or inherited breast cancer.**
- **You eat a lot of red meat and/or processed meat.**
- **You are overweight and/or sedentary.**
- **You are a heavy drinker or a smoker.**

Lifetime Risk of Getting CRC*

No family history of CRC**	**6.5%**
One first-degree relative with colorectal polyps (parent, sibling, child)	**10–17%**
One first-degree relative with CRC	**13–16%**
One first-degree relative diagnosed with CRC before age 45	**16–40%**
More than one first-degree relative with CRC	**20–40%**

*Note: This chart represents your lifetime risk of developing CRC before you celebrate your 80th birthday. Your risk may be higher or lower depending on other factors, including your medical history, diet and lifestyle. Your doctor can help you determine your risk more specifically.
****Please also note: 75 per cent of cases of CRC show no known family history of the disease. Everyone should get screened.**

Johns, LE, and Houlston, RS: A Systematic Review and Meta-Analysis of Familial Colorectal Cancer Risk, *Am J Gastroenterol* 2001 Oct; 96(10): 2992-3003; and National Cancer Institute of Canada: Canadian Cancer Statistics 2007.

The **silent but deadly** disease

HOW DO I KNOW IF I HAVE COLON CANCER?

Colorectal cancer is **often silent**. However, sometimes there are early warning signs.

Primary Symptoms

- **Bleeding from the rectum** (don't assume you have hemorrhoids)
- **Blood in or on your stools** (it may be dark red or black in colour)
- **Diarrhea, constipation, or a combination of both, sometimes with mucus in the stool, that lasts for more than two weeks**
- **Stools narrower than usual or a feeling that the bowel is not emptying completely**
- **Change in your bowel patterns**
- **Weight loss for no apparent reason**

You may also notice

- **Bloating, abdominal fullness, general stomach discomfort that comes and goes or persists**
- **Unusual and prolonged fatigue**
- **Vomiting**

If you are suffering from some of the primary symptoms, talk to your doctor.

And remember, **colon cancer doesn't always toot its own horn!**

THE BOTTOM LINE

Guidelines for Screening for Colorectal Cancer

One **first-degree*** **relative** with CRC at age <60 or 2 or more first-degree relatives affected with colon cancer at any age	>	Colonoscopy given every 5 years beginning at age 40, or 10 years earlier than the youngest diagnosis of CRC in the family, whichever comes first
One **first-degree relative** with CRC at age >60 or 2 or more **second-degree** relatives affected with CRC	>	Average-risk screening, but beginning at age 40; could include FOBT, colonoscopy or flexible sigmoidoscopy
One **second-degree** or **third-degree relative** affected with CRC	>	Average-risk screening beginning at age 50; could include FOBT, colonoscopy or flexible sigmoidoscopy

***First-degree** = parent, child, sibling
Second-degree = grandparent, aunt, uncle, nephew, niece
Third-degree = cousin, great-grandparent, great-grandchild

The key to preventing CRC is to get screened at the right time, with the right test. We call that timely and thorough testing. Don't assume you're fine just because you don't have any symptoms.

A sobering story to get you off your butt

In 1999, Mariellen Black was diagnosed with advanced colon cancer. She was 54. She'd always enjoyed excellent health. She was strong, beautiful, full of life, and ready to spread her wings after raising four children. She went to a hospital emergency room with severe abdominal pain. Two weeks later, Mariellen had her diagnosis: Stage 4 colon cancer.

The five-year survival rate: approximately 3 per cent.

Mariellen was furious. If she had been screened for colon cancer at age 50, chances are she would be alive today. After her first round of chemotherapy, she threw a party. She gave friends and family an ultimatum: get screened if you want to be invited back! Everyone followed her good advice; a few discovered they had colorectal polyps. They were removed and today her friends and family sing the praises of getting tested. Mariellen literally saved lives because she was not shy to talk about her experience. For her, screening became the bottom line.

As she was fond of saying, "Getting a colonoscopy isn't the MOST fun you'll ever have, but it sure beats the alternative."

Mariellen called her organization CCSIF — the Colorectal Cancer Screening Initiative Foundation. In 2011, it was christened Screen Colons Canada. It's an easier name to remember and the message remains the same. Get screened for CRC.

Don't die of embarrassment.

We'd like to hear your stories of screening.
Visit our website at **www.screencolons.ca**

SCREENING FOR COLORECTAL CANCER

Screening guidelines and the availability of the tests vary across the country, but doctors advise anyone at "average" risk for CRC to get screened at age 50.

If you are at an "increased" risk, with a family history of colon cancer, you should have a colonoscopy 10 years earlier than the age at which your relative was first diagnosed. For instance, if your father was diagnosed at 55, doctors recommend you get your first colonoscopy at 45.

Talk to your doctor about which tests you need, and when, based on your family history and your individual risk factors.

Remember: In most cases, colorectal cancer that is caught at an early stage is curable. Get tested in a timely and thorough manner.

There are three standard tests for CRC

1 FOBT

The Fecal Occult Blood Test checks for blood in your feces. You must take samples of your stools over three days, smearing the stool samples on a chemically treated card, and sending it to the lab for analysis. If blood is found in your stools, you will be told to have a colonoscopy.

Pros and Cons: This is an inexpensive, widely available, do-it-yourself test, with no complicated prep. However, the FOBT is not fail-proof. Not all cancers bleed. It can detect some cancers but miss others. And some people find handling stool samples off-putting, so they put off doing the test.

2 Flex Sig

The flexible sigmoidoscopy is a finger-thin, flexible, lighted tube (the sigmoidoscope) with a tiny camera at its tip. The scope is inserted into your rectum, and up the bottom half of your colon—about 2 feet up (60 cm)—to check for polyps in the lower bowel: your rectum, sigmoid colon and your descending colon.

Pros and Cons: The flex sig is a sensitive test for detecting polyps and cancer in the lower part of your colon. It rarely requires sedation and medical people other than doctors can be trained to administer it. The prep involves taking a mild laxative to empty your lower colon and you may be given an enema. This is a good test, but not perfect, because it misses about 35–40 per cent of polyps, the ones that are higher up in your colon.

Note: Many doctors believe that a yearly FOBT combined with a flex sig every five years is more effective in reducing colon cancer deaths than if you rely on just one of the tests.

3 Colonoscopy

A colonoscopy gives a whole new meaning to the phrase “Up Yours!” But it saves lives and allows the doctor to immediately remove any suspicious looking polyps that are found along the lining of your colon and rectum.

The colonoscope is a thin, flexible tube with a camera at its tip, much like the flex sig, but longer. It lets the doctor examine the lining of your entire bowel and remove any polyps. If any are found, they will be sent to a lab and tested for cancerous cells. Frequently, the polyps are benign and with the colonoscopy "behind" you, those pesky polyps don't get a chance to develop into cancer.

Pros and Cons: The colonoscopy is the only test that screens the entire colon AND allows immediate removal of suspicious polyps while you're being examined. For those reasons, it's often called the gold standard. But it's not available everywhere, a highly trained physician must administer it, the prep is somewhat daunting, and there is a very small risk—about 1 in 1,000 cases—of perforating the wall of the colon.

Newer tests you may have heard about

The FIT: A variation on the FOBT, the fecal immunochemical test uses a more advanced laboratory method to detect the presence of blood in your stools.

The Virtual Colonoscopy: This test allows a radiologist to look for colorectal polyps without having to insert a long colonoscope into your colon. Advanced X-ray equipment is used to produce pictures of the colon and rectum. A computer then assembles the pictures into detailed images that can reveal the presence of polyps and other abnormalities. Because it is less invasive than standard colonoscopy and sedation is not required, a virtual colonoscopy may cause less discomfort and can take less time to perform. The prep is the same—and if a polyp is found, you will then have to undergo a standard colonoscopy for polyp removal.

A CRC Blood test: There are blood tests available that try to assess your current risk of having colorectal cancer, but they are not widely accepted by the medical community. The information the blood test offers can sometimes help determine whether you should have a colonoscopy. It does not diagnose the disease.

What to **REALLY** expect before, during and after a colonoscopy

Prep: This is, if you'll excuse the expression, the shitty part of the procedure. You will be told to fast for a day or two, and empty your bowel completely. You'll have to drink a few litres of water mixed with a laxative. The mixture is easier to drink if you chill it; some people add a flavouring. Plan to stay home, close to a toilet, while this process is underway. By the time you show up for the colonoscopy, your bowel will be sparkling clean. Note: Do not eat any seeds (this includes the tiny ones on raspberries and strawberries) in the week leading up to your colonoscopy. They can masquerade as polyps and cause all sorts of needless worry.

The colonoscopy itself: This test should be painless. It's performed in a doctor's office or hospital clinic. You will be offered sedation. Go for it! It takes the edge off and helps you relax.

The doctor will insert the scope up your anus, into your rectum and then carefully thread it through your entire colon. If you're curious, you can watch it all on a video screen. The doctor will examine your colon for polyps and snip off any that look suspicious. The entire scope usually takes less than half an hour. Some clinics encourage you to nap for a short time after the procedure. Arrange to have someone pick you up after the test. You shouldn't drive after the sedation.

After the test: If the doctor finds and removes any polyps, there may be a bit of bleeding. Let your doctor know if it persists. In the meantime, the polyps will be sent to a lab for review. Many are benign. If they turn out to be malignant, a specialist will "stage" the cancer and your physician will discuss treatment options with you.

Will you love this test? No. But if the colonoscopy shows you are in good form, you will probably not need another one for 5–10 years. And if polyps are found, they can be removed during the procedure. How easy and sensible is that?

A **Bottoms Up** glossary

Biopsy
The removal of a sample of tissue for purposes of diagnosis. A physical exam, imaging, a flex sig, a colonoscopy and lab tests may indicate that something is abnormal, but a biopsy of the polyp may be the only sure way to know whether the problem is, in fact, cancer.

Colonoscopy
Think telescope. Think of a long, thin, flexible telescope with a tiny camera on the tip that goes up your anus, into your rectum and takes a tour through your entire colon. The doctor who performs the colonoscopy is highly trained and the screening process usually takes less than half an hour. During the colonoscopy, the doctor removes suspicious-looking growths, or polyps, and sends them to be tested for any sign of cancerous cells.

Colostomy
A surgically created opening that allows bowel contents to empty from the colon into a bag or pouch that is outside your body.

Familial Adenomatous Polyposis (FAP)
FAP is an inherited disease that causes the growth of numerous polyps in the colon and rectum, with a very high chance of developing colorectal cancer. Genetic counselling and special screening is recommended. Fortunately, this is a relatively rare cause of CRC.

Flexible Sigmoidoscopy
A procedure in which a flexible tube is inserted into the rectum and lower colon. There is a small camera at the tip of the scope, which allows the doctor to examine the lining of the lower bowel.

Metastasis
A secondary cancer that grows when cells from the primary cancer detach themselves and move elsewhere in the body.

Occult Blood
Blood that is not visible to the naked eye. A Fecal Occult Blood Test looks for blood in the stools, blood that a patient might not notice.

Polyp

A growth found within the lining of the colon. Polyps usually start as benign, non-cancerous growths but they can become malignant/ cancerous.

Staging colorectal cancer

A determination of how deeply a cancer has invaded tissues in the colon and/or rectum, and whether it has spread to lymph nodes or distant organs. Stage 0 is the least worrisome; Stage 4 is the most deadly.

Stage 0: The tumour is localized in a polyp and can be removed during a colonoscopy.

Stage 1/Dukes' Stage A: The cancer is present only in the inner bowel wall. Ninety per cent of patients are cured by surgical removal of the cancerous bowel segment.

Stage 2/Dukes' Stage B: The cancer has grown through the muscle layers of the bowel wall. The five-year survival rate is 80 per cent after surgery.

Stage 3/Dukes' Stage C: The cancer has spread to nearby lymph nodes. When the cancer has spread to only one to three nodes, the prognosis is better than when four or more nodes are involved. The five-year survival rate after surgery alone is 35 to 60 per cent.

Stage 4/Dukes' Stage D: The cancer has spread to distant organs, for instance, your liver, lungs, ovaries or bladder. The chance of cure is small. The five-year survival rate hovers around 3 per cent. Chemotherapy, radiation and surgery may be prescribed.

WHAT ELSE CAN I DO TO PREVENT CRC?

Forget eating bran muffins—this type of fibre has proven useless in reducing the incidence of colon cancer. But a healthy diet and lifestyle are key.

- **Mother was right: eat your veggies—and your fruit!** Both have valuable anti-cancer properties and the kind of fibre that DOES help prevent colorectal cancer. Aim for five to ten half-cup servings a day.
- **Limit your consumption of fat, especially animal fat.**
- **Limit your consumption of red meat**—beef, lamb and pork—and avoid processed meats.
- **Talk to your doctor about whether you should take a low-dose, daily aspirin**. Studies show aspirin can reduce the incidence of polyps by 25 per cent.
- **Consider taking supplements.** Preliminary research suggests that calcium carbonate (combined with magnesium, for better absorption), Vitamin D, Vitamin B-Complex and folic acid tablets may help prevent colorectal cancer.
- **Get plenty of exercise.** Sedentary life is linked to an increased incidence of colorectal cancer
- **Maintain a healthy weight throughout your life.**
- **Do not use tobacco and limit your alcohol consumption.**
- **Learn your family's health history.** Share it with your relatives.
- **Get regular, appropriate screening.**
- **Spread the word, save a life.** Tell your friends and family to get screened for CRC.

Please help us promote screening for colorectal cancer. Go ahead—take some of these pamphlets home with you! Shove a few in your back pocket and tell all the people you love to get off their butts and get screened for CRC. **We're behind you all the way.**

Colon cancer is preventable, not inevitable. For more information or to make a donation, check out our website at **www.screencolons.ca.**

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Colon Cancer Canada
Cancer du colon Canada

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1 in 14 Canadians will be diagnosed with colorectal cancer

But 8 in 10 are not being tested for it. Some people say they haven't noticed any symptoms. Others say they're too shy to ask their doctor about it.

DON'T DIE OF EMBARRASSMENT.

www.screencolons.ca