Give Yourself the All Clear

Colorectal Cancer Prevention and Screening: What YOU Need to Know

EuropaColon

United against digestive cancers

Colorectal cancer kills through embarrassment

We know that colorectal cancer can still be a bit of a taboo subject. Embarrassment and a lack of good, clear information both play a big role in people not discussing prevention and screening options with their doctor. This leads to many people being diagnosed at a late stage, which makes the disease much more difficult to treat. People are dying unnecessarily as a result.

It doesn't have to be like this!

Colorectal cancer is generally preventable.

There are many steps you can take to help prevent colorectal cancer. It is also one of the very few cancers that can be prevented through screening.

In its early stages, it is also highly treatable.

If the disease is detected early enough, treatment is often able to cure it completely.

If you or someone close to you is over the age of 50, or you have a personal or family history of colorectal cancer, or if you are experiencing the signs and symptoms of the disease, it is important that you read this booklet about colorectal cancer prevention and screening.

Remember, taboos and stigmas gain strength from silence. The best way to overcome taboos is to talk about them. We will give you the information about this cancer and we encourage you to talk to others about it, including your family, friends and perhaps your doctor.

This booklet has been written by those who have been there and done it – colorectal cancer patients and healthcare professionals. We know through our own experiences just how important colorectal cancer prevention and screening are, and we urge you to become informed, ignore the stigma, and take action.

Introduction: The essential questions

What is colorectal cancer?

Colorectal cancer, also known as bowel cancer, is cancer of the colon or the rectum (the large bowel or the large intestine).

The colon and rectum are part of the gastrointestinal (GI) or digestive system. They help to form solid waste (stool) that leaves the body.

Why does it happen?

Most colorectal cancers start as growths, called polyps, on the wall of the colon.

Although polyps are very common as we get older, most will not develop into cancer. About 1 in 10 polyps do form a tumour in the colon, causing pain, bleeding and other symptoms. Polyps can often be removed simply and without surgery before they have a chance to develop into cancer.

There are certain risk factors for colorectal cancer which include age, family history and diet and lifestyle.

Can it be prevented?

YES. This booklet will give lots of advice on steps you can take to help prevent colorectal cancer. One of the most important steps is screening, and this booklet describes the various types of screening available (different types of screening are used and recommended in different countries). Many countries recommend regular colorectal cancer screening after the age of 50. Screening can detect and remove polyps which then prevents them developing into cancer.

Can it be treated?

YES. If it detected early enough, colorectal cancer is often curable with surgery. This is another reason why screening is so important.

So what should I do?

Read through this booklet to familiarise yourself with:

- Proven tips to help prevent colorectal cancer
- Methods of screening and diagnosis for colorectal cancer
- The highlights of the latest European guidelines for quality assurance in colorectal screening and prevention – so you know what you are entitled to
- Treatment approaches if diagnosed

Risks and prevention

While the exact cause of each individual's colorectal cancer is difficult to determine, there are certain know factors that can put people at risk. These are listed below, along with advice to help you reduce the risk, or to take appropriate steps towards regular screening.

1. Age – 50 and over	
What are the risk factors?	The risk of colorectal cancer increases as you get older. The latest European guidelines recommend that men and women should be screened for colorectal cancer from the age of 50.
So what should I do?	If you are 50 or over and your doctor has not already discussed colorectal screening with you, raise it with him or her next time you see them. Also, remember that one screening test is not enough. Regular colorectal cancer screening is recommended because many people do not have symptoms for several years.

2. Disease history	
What are the risk factors?	The following people may be at an increased risk of colorectal cancer: • Those who have had previous polyps removed or who have had cancer in the large intestine • Women who have had cancer of the ovary, uterus or breast • People with a long history of Crohn's disease or ulcerative colitis.
So what should I do?	Screening is usually recommended for people 50 and over. However, anyone with one of the disease histories above should begin screening earlier. Ask your doctor if you should be routinely screened for colorectal cancer.

3. Family history	
What are the risk factors?	A family history of colorectal cancer can increase risk. A strong family history of the disease means that you have several relatives on the same side of your family diagnosed with colorectal cancer, or one or more diagnosed at a particularly young age (e.g. under 45). The more relatives you have with colorectal cancer, or the younger the diagnosed relatives are, the higher the chance that there is a cancer gene in your family.
So what should I do?	If there is any history of colorectal cancer in your family it is very important that you discuss this with your doctor. Anyone who does have a family history should begin screening earlier than the standard age of 50. Ask your doctor if you should be routinely screened for colorectal cancer.

4. Diet and lifestyle

What are the risk factors?

A sedentary lifestyle increases the risk of colorectal cancer, as does a diet high in red meat, processed meat and fat but low in fresh fruit, vegetables, poultry and fish.

Clinical evidence has proven that obesity is directly linked to colorectal cancer.

So what should I do?

Try and eat a balanced diet and stay physically active. Specifically try to:

- Eat plenty of fibre (cereal fibre and whole grains in particular can reduce the risk of colorectal cancer)
- Limit the amount of saturated fat and trans fat in your diet
- Drink plenty of water (this will aid digestion and help prevent constipation)
- Reduce the amount of red meat and processed meat that you eat each week
- Introduce more fruit and vegetables into your diet (five portions a day)
- Maintain a healthy weight

Exercise regularly if you can - it does not have to be about working out in a gym. You can simply take the stairs, walk to the shops, do the housework, walk the dog or get off the bus a few stops earlier.

5. Smoking and alcohol	
What are the risk factors?	Although not as strong a risk factor as for other cancers, smoking may also increase the risk of colorectal cancer. Alcohol consumption also increases risk.
So what should I do?	Consider giving up smoking and try to reduce your alcohol intake.

Screening and diagnosis

Regular colorectal cancer screening increases the chance of diagnosing cancer early, or even preventing it by finding and removing polyps. Colorectal cancer is generally much more treatable and even curable when it is diagnosed early, making regular screening absolutely critical.

The latest European guidelines recommend that men and women from 50 years of age should participate in colorectal screening.

There are different screening options available – the main ones are described below. To decide which screening option is right for you, please talk to your doctor.

Screening Method	FOBT (Faecal Occult Blood Test) or FIT (Faecal Immunochemical Test) or Combined Faecal FIT and DNA marker test
What is it?	The FOBT is the main screening method recommended in the EU. There are two types – the standard guaiac FOBT (or gFOBT) and the newer FIT - Faecal Immunochemical Test (or iFOBT). The tests check for tiny amounts of blood in faeces (stool) that cannot be seen with the eye. Both are widely used and both are proven to reduce deaths from colorectal cancer. However gFOBT is gradually being replaced by FIT as recommended in the EU guidelines. The FIT is the more accurate of the two and unlike the FOBT, can also detect bleeding polyps. A recent development of FIT is to combine it with other DNA markers in faeces. This new test multi-targeted test is both expensive and requires a full stool sample but is detects more polyps than gFOBT or FIT.
Where do I take the test?	At home - stool samples are collected by the patient using a kit, and the samples are returned to the doctor.
How often should I have one?	Once every one or two years.

Screening Method	Flexible sigmoidoscopy
What is it?	In this test, the rectum and part of the colon are examined using a flexible lighted instrument called a sigmoidoscope, which is inserted into the rectum and colon as air is pumped in so the doctor can see the colon lining more clearly. During a sigmoidoscopy, abnormal growths in the rectum and sigmoid colon can be removed for analysis (biopsied).
Where do I take the test?	In a doctor's office or in a hospital. People are usually not sedated for this test. The lower colon must be cleared through enema preparation before the test.
How often should I have one?	Once every 5 years.

Screening Method	Colonoscopy
What is it?	If other screening tests are positive, the patient must usually return to the doctor for a colonoscopy to check for cancers and remove any polyps. In this test, the rectum and entire colon are examined using a flexible lighted instrument called a colonoscope, which is inserted into the rectum and the colon as air is pumped in so the doctor can see the colon lining more clearly. During colonoscopy, any abnormal polyps in the colon and the rectum can be removed.
Where do I take the test?	Usually in hospital or the doctor's office. Most patients receive some form of sedation during the test. It will take around 20-45minutes. It typically requires one day of clear liquids and laxative preparation.
How often should I have one?	Once every 10 years.

Screening Method	CT (computed tomography) scan
What is it?	A CT scan is an X-ray test that takes many pictures as it rotates around you while you lie on a table. A computer then combines these pictures into images of parts of your body being studied (e.g. the colon / rectum).
Where do I take the test?	In hospital. CT scans take longer than regular X-rays. You need to lie still on a table while they are being done. During the test, the table slides in and out of a ring-shaped scanner.
How often should I have one?	Once every 5 years.

Please note: Other screening methods exist, but are not always widely used or reimbursed and may not be as effective. These include:

- **Double-contrast barium enema**
  Air and barium are pumped into the rectum. The solution may show any polyps or tumours on X-rays. The barium enema test is used much less often than in

the past because it is less effective than other methods (e.g. colonoscopy) for detecting small polyps and cancers.

- **Digital rectal exam (DRE)**
  The doctor examines the inside of the rectum with a gloved finger.
- **Stool DNA test**
  A test which looks for certain abnormal sections of DNA (genetic material) in a stool sample.
- **Capsule endoscopy**
  A new less-invasive alternative to colonoscopy, where a digital video camera the size and shape of a pill is swallowed to visualise the gastrointestinal tract. It is later passed in a stool. Using this minimally invasive procedure can avoid potential risks associated with sedation, radiation and bleeding whilst also helping to reduce anxiety and fear.

Diagnosis

If colorectal cancer is suspected following screening or a diagnostic test, a biopsy is usually taken. The doctor removes a small piece of tissue with a special instrument and the samples are sent to the lab where a pathologist (a doctor trained to diagnose cancer and other diseases), looks at them under a microscope. The only way to give a clear diagnosis is to look at the samples under a microscope.

European screening and diagnosis guidelines – a brief summary

In 2011, the European Commission published the first ever edition of the European Guidelines for Quality Assurance in Colorectal Cancer Screening and Diagnosis. The guidelines represent an important landmark because they help to set a benchmark for best practice in colorectal cancer screening to be followed by all countries across the EU.

The guidelines consist of 10 chapters and over 250 recommendations in total. These help general populations and patients to know what they can expect from colorectal cancer screening. The guidelines state that every European citizen should be able to gain access to the recommended standards and procedures.

Examples of key recommendations:

- **Age for screening:** Men and women from 50 years of age should participate in colorectal screening.
- **Access to information:** It is important to ensure that as many of the target population as possible receive the relevant information to be able to make informed decisions about whether or not they wish to attend for colorectal cancer screening.

- **Clear information:** Use of a leaflet for the general population is advised. Information about colorectal cancer screening risks and benefits, colorectal cancer risks (incidence and risks factor), meaning of test results, potential diagnostic tests and potential treatment options should be included.
- **Screening locations:** Screening services should be in convenient locations for participants and in proximity to clinical services.
- **Personal preferences:** The provision of the service must account for the values and preferences of individuals as well as the perspectives of public health.
- **Access to screening services:** Access to screening and any follow-up assessment for people with abnormal test results should not be limited by financial barriers. In principle, screening should be free of charge for the participant.
- **Removal of lesions:** Pre-malignant lesions detected at screening endoscopy should be removed. Patients with large pre-malignant lesions not suitable for endoscopic resection should be referred for surgical resection.
- **Clear communication post-screening:** Before leaving the endoscopy unit, patients should be given a verbal explanation of the results of their procedure; they should also be given written information to support the verbal explanation.
- **Receiving test results:** The time in days, between completion of a screening test and receipt of results by the participant should be as short as possible: acceptable standard >90% within 15 days.
- **Follow-up:** Follow-up colonoscopy after positive screening (any modality) should be scheduled within 31 days of referral (acceptable >90%, desirable >95%).
- **Starting management of colorectal cancer:** The time interval between positive FS or colonoscopy and definitive management should be minimised and in 95% of cases should be no more than 31 days (acceptable standard).

After diagnosis – looking to the future

If a positive diagnosis for colorectal cancer is made, treatment is often very effective particularly if the cancer has been diagnosed at an early stage.

Since the mid-1980s the colorectal cancer survival rate has been increasing due in part to increased awareness and screening. By finding more polyps and cancer in the earlier (local and regional) stages, it is easier to treat the disease. Improved treatment options have also contributed to a rise in survival rates.

The five-year survival rate for colorectal cancer found at the early stage is better than 90%. The five-year survival rate for colorectal cancer found at the later stage currently can be up to 20%.

Which treatments will be offered to you and what your outcome will be will depend on several things, the most important of which is the stage at which the cancer is at the time of diagnosis. Your doctor will let you know the stage of your colorectal cancer, using either numbers (stage 0 to stage 4) or letters (called TNM staging, which stands for Tumour Node Metastases).

Treatment

If the cancer is diagnosed at an early stage, then surgery can be successful in removing colorectal cancer completely. The type of operation you have will depend on where the cancer is, the type and size of the cancer and whether the cancer has spread.

Many hospitals are now offering minimally invasive surgery with huge benefits for patients. The incisions are much smaller than those used in traditional surgery and there is usually less discomfort. This results in a shorter hospital stay, less need for prescription pain medications, an earlier return to normal activities with less visible scarring. It is important to note that long-term outcomes are similar between open and minimally invasive procedures, but minimally invasive surgery offers potential recovery benefits in the early period after surgery.

Radiotherapy (treatment of cancer by deep X-rays) is often used in rectal cancer but very rarely in colon cancer. It is used either before surgery (neo-adjuvant) to reduce the size of the tumour, or after surgery (adjuvant) to make sure all the cancer cells are destroyed.

If surgery is not sufficient to remove the cancer, chemotherapy (anti-cancer drugs) can be used to destroy cancer cells. Chemotherapy drugs can stop cancer cells dividing and reproducing, however, because the treatment attacks normal cells too, it does have several side effects.

There are other, newer types of treatments, including biological therapies, which target cancer cells directly and have less impact on normal cells.

A colorectal cancer tumour may be tested for relevant biomarkers before medicines are prescribed. Biomarkers can indicate whether a specific treatment is likely to work for you, allowing your doctor to tailor your treatment accordingly; this is known as personalised medicine.

In colorectal cancer, the RAS family of genes (genes that make proteins involved in cell communication pathways, cell growth, and cell death) are important biomarkers for helping doctors determine the right medicine. There are two different types of RAS gene that doctors test for. Normal RAS genes are called 'wild-type' and occur in approximately 50% of colorectal tumours. The remaining 50% of tumours have mutated RAS genes and are called RAS mutant. Treatment decisions are made based on whether the tumour harbours a wild-type or mutated RAS gene.

Testing is performed on cancer cells that are removed either during a biopsy or during surgery.

Further information and support

More information on staging, treatment, screening, diagnosis and all the other issues raised in this booklet, can be found on our website www.europacolon.com or our Facebook page at www.facebook.com/europacolonhq

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