The following colorectal cancer treatment and research updates extend from April 14th, 2022, to May 12th, 2022, inclusive and are intended for informational purposes only.

This content is not intended to be a substitute for professional medical advice. Always consult your treating physician or guidance of a qualified health professional with any questions you may have regarding your health or a medical condition. Never disregard the advice of a medical professional or delay in seeking it because of something you have read on this website.

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1. Phase II LEAP Clinical Trial For mCRC (May 15/22)
   The purpose of this study is to determine the safety and efficacy of combination therapy with pembrolizumab (MK-3475) and Levantine (E7080/MK-7902) in patients with triple-negative breast cancer (TNBC), ovarian cancer, gastric cancer, colorectal cancer (CRC), glioblastoma (GBM), or biliary tract cancers (BTC). Participants will be enrolled in initial tumor-specific cohorts, which will be expanded if adequate efficacy is determined. The trial is available at the
Odette Cancer Centre and at the Princess Margaret Cancer Centre in Toronto as well as the following Centres throughout Canada: Abbotsford, BC; Winnipeg, MB; CHU de Quebec. For information, visit the link below.

https://clinicaltrials.gov/ct2/show/study/NCT03797326?term=A+Multicenter%3CA+Open-label+Phase+2%3>+Study+of+Lenvatinib+%28E7080%29+Plus+Pembrolizumab&show_locs=Y#locn

2. TRK Fusion Cancer and How to Test for It (May 15/22)
Tumour-Agnostic Therapies
Advances in precision medicine have brought therapies that specifically target what is driving a patient's cancer.

Treatment with more traditional cancer therapies is based on where the tumour is located in the body.

Tumour agnostic therapies target a specific genomic change in the cancer cells regardless of where the tumour is located in the body.

Genomic changes in cancer cells are identified through diagnostic testing of the cancer cells. The results help clinicians decide on a treatment for each patient.

Advantages of tumour agnostic therapies:
- Targets the genomic change that is the root cause of the cancer to suppress tumour growth
- Harnesses our growing understanding of cancer biology
- Offers an innovative, new and effective approach to treating cancer

Change required to adopt tumour agnostic therapies in Canada:
- A shift in mindset: this is a new concept that differs from the traditional approach of treating cancer based on tumour location
- Access to genomic testing: identifying patients who would benefit from treatments requires a robust testing infrastructure
- An evolved, more adaptive assessment of treatments for public coverage is required that includes recognition of smaller patient populations, new clinical trial methods, and ability to examine new data over time

https://www.bayer.ca/en/media/news/?dt=TmpBPQ==&st=1
3. A Phase II, Open-label, Multicenter, Study of an Immunotherapeutic Treatment for the MSI High CRC Metastatic Population (May 12/22)

The purpose of this study is to look at the effectiveness of the vaccine DPX-Survivac in combination with the drugs cyclophosphamide and the immunotherapy Pembrolizumab in patients with solid cancers who are identified to be MSI-High. All patients will receive combination therapy of DPX-Survivac, cyclophosphamide, and pembrolizumab. Patients participating will know which treatment they are receiving. The trial is currently hosted at the Odette Cancer Centre, and a new site is opening at Mt. Sinai Hospital.

4. Phase III Study at the Odette Cancer Centre Comparing Arfolitixorin vs. Leucovorin in Combination with 5FU, Oxaliplatin and Bevacizumab in Patients with Advanced CRC (May 1/22)

The purpose of this study is to look at the effectiveness of the drug Arfolitixorin in combination with 5-fluorouracil (5FU), oxaliplatin, and bevacizumab in patients with colorectal cancer (CRC). Patients with advanced/metastatic CRC who meet certain criteria may be able to participate. There will be two groups of patients participating in this study;
- one group will receive Arfolitixorin in combination with 5FU, oxaliplatin, and bevacizumab,
- while the other group will receive the drug Leucovorin in combination with 5FU, oxaliplatin, and bevacizumab (standard of care).

The doctor and study staff will not know which group a patient is in. Patients will be randomized to receive one treatment or the other.

About Arfolitixorin:

Arfolitixorin is Isofol’s proprietary drug candidate being developed to increase the efficacy of standard of care chemotherapy for advanced CRC. The drug candidate is currently being studied in a global Phase 3 clinical trial. As the key active metabolite of the widely used folate-based drugs, arfolitixorin can potentially benefit all patients with advanced CRC, as it does not require complicated metabolic activation to become effective. Treating cancer patients with arfolitixorin – The goals:

- When treating CRC, for example, arfolitixorin is administered in combination with 5-FU to increase cell mortality in circulating cancer cells and in cancerous tumours.
- Arfolitixorin is administered in conjunction with rescue therapy after high-dose treatment with the cytotoxic agent, methotrexate, in order to suppress the cytotoxic effect in surrounding healthy tissue. The treatment is used for certain types of cancer, such as osteosarcoma, a type of bone cancer. This involves administering arfolitixorin separately, 24 hours after the chemotherapy.

5. Novartis Enters KRAS G12C Space with Positive Phase I/II Data in CRC (Apr.15/22)

Novartis researchers presented data from the Phase I/II KontRASt-01 trial at the American Association for Cancer Research's annual meeting in New Orleans. The Phase I portion of the study evaluated Novartis' JDQ443 in patients with advanced KRAS G12C-mutated solid tumors, and the Phase II portion of the study focused on advanced KRAS G12C-mutant colorectal and non-small cell lung cancer. Patients needed to have received prior standard-of-care therapy, be intolerant of or ineligible for approved therapies, and no prior KRAS inhibitor treatment.

Of 39 evaluable patients in the study, 11 patients (28.2%) had a confirmed or unconfirmed response with all of the responses in patients with non-small cell lung cancer (NSCLC) and colorectal cancer (CRC). Based on this data, Novartis is expanding its JDQ443 monotherapy NSCLC and CRC cohorts in the KontRASt-01 trial. The company is also beginning to enroll patients with KRAS G12C-mutant solid tumors in combination arms of the trial. One arm will evaluate JDQ443 plus Novartis' SHP2 inhibitor TNO115 in solid tumors, and another arm will enroll solid tumor patients for treatment with JDQ443 and Novartis' anti-PD1 drug tislelizumab. Finally, Novartis is also planning a randomized Phase III trial, KontRASt-02, of JDQ443 versus docetaxel in previously treated patients with advanced or metastatic KRAS G12C-mutant NSCLC. That trial has not opened yet, but the company expects to begin enrolling patients by mid-2022.

6. Hepatic Artery Infusion Pump (HAIP) Chemotherapy Program – Sunnybrook Odette Cancer Centre (May 1/22)
The HAIP program is a first-in-Canada for individuals where colon or rectal cancer (colorectal cancer) has spread to the liver and cannot be removed with surgery. The program involves a coordinated, multidisciplinary team approach to care, with close collaboration across surgical oncology, medical oncology (chemotherapy), interventional radiology, nuclear medicine, and oncology nursing. The Hepatic Artery Infusion Pump (HAIP) is a small, disc-shaped device that is surgically implanted just below the skin of the patient and is connected via a catheter to the hepatic (main) artery of the liver. About 95 percent of the chemotherapy that is directed through this pump stays in the liver, sparing the rest of the body from side effects. Patients receive HAIP-directed chemotherapy in addition to regular intravenous (IV) chemotherapy (systemic chemotherapy), to reduce the number and size of tumours. Drs. Paul Karanicolas and Michael Raphael are the program leads and happy to see patients who may be eligible for the therapy.

Presently at Sunnybrook Odette Cancer Centre, HAIP is being used in patients with colorectal cancer that has spread to the liver that cannot be removed surgically and has not spread to anywhere else in the body. Patients who have few (1-5) and very small tumors in the lungs may be considered if the lung disease is deemed treatable prior to HAIP. If you believe you may benefit from this therapy and/or would like to learn more about the clinical trial, your medical oncologist or surgeon may fax a referral to 416-480-6179. For more information on the HAIP clinical trial, please click on the link provided below.

http://sunnybrook.ca/content/?page=colorectal-colon-bowel-haip-chemotherapy

7. Living Donor Liver Transplantation for Unresectable CRC Liver Metastases (May1/22)

Approximately half of all colorectal cancer (CRC) patients develop metastases, commonly to the liver and lung. Surgical removal of liver metastases (LM) is the only treatment option, though only 20-40% of patients are candidates for surgical therapy. Surgical therapy adds a significant survival benefit, with 5-year survival after liver resection for LM of 40-50%, compared to 10-20% 5-year survival for chemotherapy alone. Liver transplantation (LT) would remove all evident disease in cases where the colorectal metastases are isolated to the liver but considered unresectable.

While CRC LM is considered a contraindication for LT at most cancer centers, a single center in Oslo, Norway demonstrated a 5-year survival of 56%. A clinical trial sponsored by the University Health Network in Toronto will offer live donor liver transplantation (LDLT) to select patients with unresectable metastases limited to the liver and are non-progressing on standard chemotherapy. Patients will be screened for liver transplant suitability and must also have a healthy living donor come forward for evaluation. Patients who undergo LDLT will be followed for survival, disease-free survival, and quality of life for 5 years and compared to a control group who discontinue the study before transplantation due to reasons other than cancer progression.

https://clinicaltrials.gov/ct2/show/NCT02864485

RADIATION THERAPIES/INTERVENTIONAL RADIOLOGY

8. Study Offered at the Odette Cancer Centre to Treat Recurrent Rectal Cancer (May 1/22)

Magnetic resonance-guided focused ultrasound (MRg-FU) is a less invasive; outpatient modality being investigated for the thermal treatment of cancer. In MRg-FU, a specially designed transducer is used to focus a beam of low-intensity ultrasound energy into a small volume at a specific target site in the body. MR is used to identify and delineate the tumour, focus the ultrasound beam on the target, and provide a real-time thermal mapping to ensure
accurate heating of the designated target with minimal effect to the adjacent healthy tissue. The focused ultrasound beam produces therapeutic hyperthermia (40-42°C) in the target field, causing protein denaturation and cell damage. Currently, there is no prospective clinical data reported on the use of MRg-FU in the setting of recurrent rectal cancer. Recurrent rectal cancer is a vexing clinical problem. Current retreatment protocols have limited efficacy. The addition of hyperthermia to radiation and chemotherapy may enhance the therapeutic response. With recent advances in technology, the investigators hypothesize that MRg-FU is technically feasible and can be safely used in combination with concurrent re-irradiation and chemotherapy for the treatment of recurrent rectal cancer without increased side-effects. The study is being offered at the Odette Cancer Centre. Here is the link to the study protocol:

https://clinicaltrials.gov/ct2/show/NCT02528175?term=magnetic+resonance+guided+focused+ultrasound&recr=Open&rank=1

9. Trends in the Incidence of Young-Onset CRC with a Focus on Years Approaching Screening Age (May 1/22)

With recent evidence for the increasing risk of young-onset colorectal cancer (yCRC), the objective of this population-based longitudinal study was to evaluate the incidence of yCRC in one-year age increments, particularly focusing on the screening age of 50 years. The study was conducted using linked administrative health databases in British Columbia, Canada including a provincial cancer registry, inpatient/outpatient visits, and vital statistics from January 1, 1986 to December 31, 2016. Researchers calculated the incidence rates per 100,000 at every age from 20 to 60 years and estimated annual percent change in incidence (APCI) of yCRC using joinpoint regression analysis. 3,614 individuals were identified with yCRC (49.9% women). The incidence of CRC steadily rose from 20 to 60 years, with a marked increase from 49 to 50 years. Furthermore, there was a trend of increased incidence of yCRC among women. Analyses stratified by age yielded APC's of 2.49% and 0.12% for women aged 30-39 years and 40-49 years, respectively and 2.97% and 1.86% for men. These findings indicate a steady increase over one-year age increments in the risk of yCRC during the years approaching and beyond screening age. These findings highlight the need to raise awareness as well as continue discussions regarding considerations of lowering the screening age.


10. Guardant Debuts its First Cancer Screening Blood Test for Catching Colorectal Tumors (May 2/22)

The blood-testing company Guardant Health aims to offer a simpler option to people who may have missed their recommended appointments to be checked out for colorectal cancer (CRC)—such as a colonoscopy—with the launch of its first cancer screening test. Guardant estimates that one in three adults have not completed the recommended set of screening tests for CRC, which include colonoscopies every 10 years and annual stool-based tests starting at age 45 (in the U.S.) and 50 in Canada. The test searches for early signs of CRC from pieces of tumor DNA found floating in the bloodstream. In a clinical study of about 300 samples, the assay showed 91% sensitivity in detecting positive cases, including 90% for people with early, stage I cancers, 97% for stage II and 86% for stage III. Shield also demonstrated a low rate of false positives, at 8%, but the company said that a negative result does not fully rule out the presence of cancer. People who have a signal detected by the test should be referred to a colonoscopy for confirmation, and Guardant said its blood test is intended to complement, not replace, current screening methods.


11. Empirical Evidence Points to Benefit of Earlier Colon Cancer Screening (May.5/22)

According to an analysis of the Nurses’ Health Study II, screening for colorectal cancer (CRC) in women before the age of 50 can significantly reduce the risk of CRC compared to those who have no endoscopic screening or decide to initiate testing at age 50. Researchers found a 50-60% lower risk of CRC among women who started endoscopy screening at age 45 compared to those who had not undergone screening at all. In addition, they learned that starting screening at ages 45 to 49 resulted in a significant reduction in the population’s actual cases of CRC.
diagnosed through age 60, compared to a strategy in which women began screening at ages 50 to 54. While the study was focused on women, Andrew Chan, a gastroenterologist and epidemiologist at MGH, and senior author of the study, suggests the same benefits likely accrue to men, though he adds further studies are needed. The findings support guidelines from the past 4 years that recommend screening for CRC at 45 years of age and provide empirical evidence for patients, physicians, and policy makers to consider when making decisions about CRC screening in a younger population.

https://news.harvard.edu/gazette/story/2022/05/women-who-screen-for-colorectal-cancer-at-45-reduce-risk-by-60/
https://www.medpagetoday.com/gastroenterology/coloncancer/98565

**OTHER**

12. Young Adult CRC Clinic Available at Sunnybrook (May 2/22)

A recent study led by the University of Toronto doctors has observed a rise in colorectal cancer (CRC) rates in patients under the age of 50. The study mirrors findings from the U.S., Australia and Europe. The growing CRC rates in young people come after decades of declining rates in people over 50, which have occurred most likely due to increased use of CRC screening (through population-based screening programs) which can identify and remove precancerous polyps. Patients diagnosed under the age of 50 have a unique set of needs, challenges and worries. They are unlike those diagnosed over the age of 50. Dr. Shady Ashamalla (colorectal cancer surgical oncologist), and his team at the Sunnybrook Health Sciences Centre understand the needs of this patient population.

Dr. Ashamalla belongs to a multidisciplinary team of experts in the **Young Adult Colorectal Cancer Clinic** who will work with young CRC patients, regardless of disease stage, to create an individualized treatment plan to support each patient through their cancer journey. Their needs and concerns will be addressed as they relate to:

- Fertility concerns and issues
- Young children at home
- Dating/intimacy issues
- Challenges at work
- Concerns about hereditary cancer
- Relationships with family and friends
- Psychological stress due to any or all of the above

The team of experts consists of:
- Oncologists (medical, surgical, radiation)
- Social workers
- Psychologists
- Geneticists
- Nurse navigator

Should a patient wish to be referred to Sunnybrook, they may have their primary care physician, or their specialist refer them to Sunnybrook via the e-referral form, which can be accessed through the link appearing below. Once the referral is received, the **Young Adult Colorectal Cancer Clinic** will be notified if the patient is under the age of 50. An appointment will then be issued wherein the patient will meet with various members of the team to address their specific set of concerns.

http://sunnybrook.ca/content/?page=young-adult-colorectal-cancer-clinic

13. Updates from The Colorectal Cancer Project (Apr.20/22)

CCRAN is proud to partner with Count Me In, a nonprofit research initiative, on The Colorectal Cancer Project. This new project is open to anyone in the United States or Canada who has ever been diagnosed with colorectal cancer (CRC). Patients can find out more and join at JoinCountMeIn.org/Colorectal.
Over 250 patients have joined the Colorectal Cancer Project since the launch in fall 2021. Every patient that joins the Colorectal Cancer Project enables us to learn more about colorectal cancer. Pts diagnosed at any age, whether newly diagnosed or years from their diagnosis, can enroll. If you have ever been diagnosed with colorectal cancer, you can visit JoinCountMeIn.org/Colorectal to enroll and have a direct impact on research and future treatment strategies.


In light of the rapidly rising rates of early-age-onset colorectal cancer (EAO-CRC) among Canadians under the age of 50 and the impactful outcomes associated with this disease, CCRAN convened the inaugural Early-Age-Onset Colorectal Cancer Symposium in June 2021. Bringing together a cross-section of patients, clinicians and researchers, the virtual symposium discussed the implications of the current evidence on EAO-CRC and to offer directions for research and clinical practice. A total of 170 people registered for the symposium. Of the participants, 42% identified
as patients or belonged to a patient group, and 33% were healthcare professionals or researchers. The table below summarizes key actions of the symposium, identified as being important for improving outcomes in EAO-CRC.

<table>
<thead>
<tr>
<th>Action</th>
<th>Outcomes</th>
<th>Who</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase awareness of EAO-CRC</td>
<td>General public and primary care practitioners know the risk factors and symptoms of CRC in people &gt; 50</td>
<td>Primary care practitioners, Oncologists, Patient support groups, Health educators</td>
</tr>
<tr>
<td>Promote earlier detection in younger populations</td>
<td>CRC screening programs include ages 45+</td>
<td>Provincial health ministries</td>
</tr>
<tr>
<td>Increase number of family physicians in Canada</td>
<td>All Canadians can see a family physician at least once per year</td>
<td>Provincial and federal governments, Medical associations and colleges</td>
</tr>
<tr>
<td>Support research to identify unique risk factor profiles, tumour characteristics and treatment models</td>
<td>Risk-stratified approaches to managing EAO-CRC</td>
<td>Medical researchers, Government and non-government funders</td>
</tr>
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Much more can be found about CCRAN’s first EAOCRC Symposium by visiting the publication found in Current Oncology: [https://www.mdpi.com/1718-7729/29/5/256/pdf](https://www.mdpi.com/1718-7729/29/5/256/pdf)

Stay tuned as CCRAN hosts its second EAOCRC Symposium on October 27-28th, 2022, whose first scheduled day will target patients and caregivers and the second day will target clinicians, policy makers and other experts across the continuum of colorectal cancer care.

15. Colon Cancer Survivors Suffer Less Recurrence and Live Longer with Healthy Lifestyle (Apr.18/22)

A new paper that focuses on predicting survival outcomes for stage 3 colon cancer patients found that colon cancer patients who have a healthier diet and lifestyle are predicted to live longer and have a lower risk of recurrence compared to patients with unhealthier habits, regardless of tumor characteristics. After a median follow up of slightly more than 7 years from approximately 1,000 colon cancer patients’ data, 311 people had died and 350 had experienced recurrences. The researchers first used the standard prediction model based on clinical and other medical characteristics, such as tumor location. Then they repeated the analysis with patients’ diet and lifestyle factors incorporated into the model.

The paper found that when incorporating lifestyle into the model, patients who maintained a healthy diet and lifestyle were predicted to live longer and have reduced risk of cancer recurrence. By adding healthy lifestyle habits to the established model, researchers were able to improve the accuracy of the prediction models. Then the authors devised hypothetical scenarios that would separate patients into high, average and poor risk categories depending upon their risk for five-year survival after treatment. Incorporating diet and lifestyle factors into the model made a difference in health outcomes among all groups, with those having the worse prognosis seeing the strongest effects. Among patients at poor risk for survival, those having the most favourable diet and lifestyle habits had a 45% reduced risk of predicted death and recurrence over 5 years compared to a 2% reduced risk based on clinical factors alone. Conversely, having the unhealthiest diet and other lifestyle factors increased predicted death and recurrence at each risk level. A patient at average risk with the least healthy habits would increase their 5-year risk of death and recurrence over 50% compared to those with the healthiest habits, according to the model. Both patients and providers could utilize these models for diet and lifestyle modifications that could meaningfully improve patient outcomes.


16. Increasing Incidence of Early-Onset CRC (Apr.21/22)

An alarming increase in cases of early-onset colorectal cancer (CRC), defined as diagnosis in patients younger than 50 years of age, has occurred in the United States and other high-income countries over the past few decades. Early-onset CRC now accounts for approximately 10% of all new diagnoses of this cancer, and an accompanying increase in CRC–related mortality during the past decade has also been observed among younger patients.
Although patients with early-onset CRC are more likely to have a hereditary syndrome than those who have later-onset disease, most cases are sporadic, with no identifiable cause. A lot of the symptoms of CRCs can be vague—like stomach pain or cramping. It’s important to be aware of what to look out for, and consult a doctor if you notice any of these symptoms:

1. Change in bowel habits (like diarrhea, constipation, narrowing of stools) that is persistent.
2. Rectal bleeding.
3. Anemia (low red blood cell counts).
4. Cramping or abdominal pain.
5. Weakness or fatigue.
6. Unintentional weight loss.

People with a family history of cancer should speak to their physician about being screened earlier. If you have a first-degree relative with a history of CRC, it is best to start screening 10 years before the age they were diagnosed. For example, if a family member was diagnosed at 45, that would mean you may want to consider screening at 35. At the latest, those with a family history of colon cancer should start screening at age 40. People who have other risk factors like inflammatory bowel disease or hereditary syndromes (like Lynch syndrome), should discuss what age to begin screening with their doctor.


17. Wireless Device to Provide New Options for CRC Treatment (Apr.25/22)

For those diagnosed with colorectal cancer (CRC), surgery has been the only option that offers a solution. Unfortunately, surgery is frequently complicated by disease recurrence at the site of the original cancer when microscopic cancer cells are left behind at the time of surgery. Chemotherapy is a treatment option that is often given in conjunction with surgery, although it can lead to toxic side effects. Researchers at Texas A&M University are working to develop a low cost, minimally invasive wireless device that offers precise, safe treatment options for cancers. They will utilize photodynamic therapy (PDT) during surgery by using a photosensitizer—a drug activated by light—to kill the cancer cells. During this process, surgeons will be able to remove the bulk of the tumor, then fully irradiate the tumor bed when the photosensitizer is activated by the light. This combination would result in a complete treatment in a safe and effective way with no toxic side effects.

In the long term, the work will result in a platform that has the potential to provide clinical-quality health monitoring capabilities for continuous use beyond the confines of traditional hospital or laboratory facilities. It will also allow for treatment options to prevent the development of additional malignancy and therefore significantly improve the quality of life for people with cancer.

https://www.sciencedaily.com/releases/2022/04/220425144205.htm

18. Payer Targets Health Equity in CRC Prevention (May.5/22)

Independence Blue Cross (Independence) is partnering with a nonprofit dedicated to colorectal cancer (CRC) awareness and research in order to improve preventive care and health equity for CRC. Along with Colorectal Cancer Alliance (the Alliance), Independence will work toward bringing CRC screenings to more Philadelphians, specifically more Black residents, through a program called Cycles of Impact. This is a pilot program that aims to screen at least 2,400 people in Philadelphia. The goal is to prevent 60 or more cancer diagnoses, particularly among Black Philadelphians, who are known to be disproportionately impacted by CRC.

A third of all adults who should receive a CRC screening do not get screened, thus lowering the screening age could expand the number of individuals who receive the screening. Screening is an important way to prevent colorectal cancer, but it is not the only step that payers can take in order to support members who are at risk for CRC. Payers can educate members on colorectal cancer, identify and close gaps in care, and offer telehealth and home healthcare methods of support. Home testing kits have become a popular way to overcome barriers to screenings.


19. “Keto” Molecule May Be Useful in Preventing and Treating CRC (Apr.27/22)
A study conducted at Perelman School of Medicine at the University of Pennsylvania found that beta-hydroxybutyrate (BHB), a natural molecule produced in the liver in response to keto diets or starvation, strongly suppresses the growth of colorectal tumors and could potentially be used as a preventive measure and treatment against colorectal cancer (CRC).

The study examined whether different types of diet could hinder CRC development and growth. Six groups of mice were put on diets with varying fat-to-carb ratios and were given a chemical technique that normally induces colorectal tumors. They found that the 2 diets with 90% fat-to-carb ratios one using lard (pig fat) and the other Crisco (mostly soybean oil) prevented colorectal tumor development in most of the animals on those diets. Conversely those on low-fat, high-carb diets developed tumors. Even in the case where mice started the diet after colorectal tumors started growing, the diets showed a “treatment effect” by significantly slowing further tumor growth and spread.

In later experiments, scientists concluded that tumor suppression is linked to a slower production, by stem cells, of new epithelial cells lining the colon. This slowdown of gut-cell growth was traced to BHB – normally produced by the liver as a “starvation response” triggered in this case by low-carb keto diets. BHB is an alternate fuel source for key organs in low-carb conditions as well as a powerful growth-slowing signal for gut-lining cells. Scientists were able to reproduce the tumor-suppressing effects of the diet by giving the mice BHB, either in their water or via an infusion copying the liver’s natural secretion of the molecule. They showed that BHB applies its gut-cell growth effect by activating a surface receptor called Hcar2 which in turn stimulates the expression of a growth-slowing gene, Hopx. BHB had the same growth-slowing effects on human gut lining cells via the human versions of Hcar2 and Hopx. Clinical trials of BHB supplementation are needed before any recommendation can be made about its use in prevention or treatment of CRC.


20. Mixed Messaging on Red Wine (Apr.19/22)

While many choices you make to lower the risk of cancer also lowers the risk of heart disease, trying to make a smart choice about alcohol can be confusing. Alcohol – especially wine – has an image as a heart-healthy choice, and fewer than 4 in 10 people are aware that alcohol poses a cancer risk.

The evidence is stronger than ever linking alcohol to increased risk of breast cancer. Just 10 grams of pure alcohol consumed daily raises the risk of premenopausal breast cancer 5%, and the risk of postmenopausal breast cancer 9%. While the risk of breast and esophageal cancers increases at even low levels of consumption, alcohol beyond moderation also raises the risk of cancers of the colorectum, stomach, liver, mouth, pharynx, and larynx. DNA damage can occur from the free radicals formed as alcohol is metabolized, forming acetaldehyde, a recognized carcinogen. Alcohol may also act as a solvent, increasing other carcinogens’ ability to damage cells. At the same time observational studies following large groups of people for many years, found that those who drink moderate amounts of alcohol have a lower risk of heart disease compared to people who drink large amounts and compared to those who don’t drink alcohol. However, in studies like these, which can’t establish cause-and-effect, some of the people with little or no alcohol consumption are people who have health problems that led them to avoid alcohol. A closer look shows that alcohol stands on a thin line when it comes to heart health: Blood triglyceride levels can rise with too much alcohol and in turn raise heart disease risk.

Despite some differences in how alcohol affects the risk of heart disease and cancer, there is agreement about a commonsense approach. Recommendations agree that for those who choose to drink, it is best if women limit alcohol – especially wine – as a heart healthy choice, and fewer than 4 in 10 people are aware that alcohol poses a cancer risk.

https://www.aicr.org/resources/blog/mixed-messaging-on-red-wine-separating-myth-from-fact/?utm_medium=email&utm_source=cancer_focus&utm_campaign=4_2022&sl_tcid=84eType=EmailBlastContent&cid=3a2492ac-6351-4e8c-abba-2b0b76e10654

Moderna has put forward a request to the Food and Drug Administration (FDA) for emergency authorization of its mRNA COVID-19 vaccine for children 6 months to 5 years of age. The vaccine is a two-dose regimen, given at one-quarter the strength of the adult vaccine. No COVID_19 vaccines have been approved in the U.S. for children under 5.

While cases are currently low in many parts of the US, Dr. Diego Hijano, an infectious disease specialist at St. Jude Children’s Research Hospital in Memphis, Tenn stated it makes sense to have a vaccine available to younger children before the next surge. “It takes time for children to be fully protected,” he said, “because it’s two doses separated by several weeks, in the case of this vaccine, and then you have to wait two weeks after the second dose for full protection.” In addition, he said there is a need to have vaccines available to protect younger children from coronavirus infection. “We know they can get severe disease and they can be hospitalized, even if they don’t have a co-morbidity,” he said. “We also have very few options to treat [this age group] because most of the treatment options are for adults or children over 12 years of age.” Dr. Hijano recommends that parents of young children continue to take steps to protect them by avoiding large indoor gatherings and those two years or older wearing masks in indoor public settings. Tentative dates of June 8, 21 and 22 have been scheduled by the FDA to review applications.


Image Source: https://www.istockphoto.com/illustrations/covid-19-vaccine-kids

22. People with Long COVID Benefit from Rehab Therapy (Apr.29/22)

It is estimated that up to 30% of people who contracted COVID-19 will experience some type of long-term health problems with fatigue as the most common symptom. A study conducted in Ireland found that occupational therapy can improve the overall wellbeing and quality of life among people with long-haul COVID who are living with chronic fatigue. Researchers found that an occupational therapy fatigue management program resulted in positive changes to those with post-COVID symptoms who said their tiredness was affecting their work, leisure activities, and self-care. Occupational therapy helps people get back to their everyday activities by teaching them techniques to manage their fatigue. The program spanned a four-week period with three 1.5 hours of group therapy covering self-management techniques to address fatigue, brain fog, sleep hygiene, energy conservation and pacing of activities by taking breaks before reaching the point of exhaustion.

https://www.healthline.com/health-news/how-people-with-long-covid-can-benefit-from-occupational-therapy-programs?slot_pos=article_5&utm_source=Sailthru%20Email&utm_medium=Email&utm_campaign=daily&utm_content=2022-05-03&apid=35071678&repid=9077a6d0cbff335009cb5ae79f93eb9292ac3a379e364c111d37c7b

The following COVID-19 guidelines are specific to Ontario. To view guidelines for the other provinces, visit the link below.

https://mcusercontent.com/cd2e2c87bb7cfd6ca8070a603/files/d8fe927df7b6-8b37-eb97-ff8ec5c9b02d/National_COVID_19_Guidelines_Tracker_MAY112022.pdf?mc_cid=d0d1b07e43&mc_eid=5c784ad19e

24. Frequently Asked Questions for COVID-19

Q: What is COVID-19 (or novel Coronavirus Disease - 19)?

A: Coronavirus are a large family of viruses that can cause illnesses in humans and animals. Coronaviruses can cause illnesses that range in severity from the common cold to more severe diseases such as Severe Acute Respiratory Syndrome (SARS) and most recently, COVID-19. COVID-19 or novel coronavirus originated from an outbreak in Wuhan, China in December 2019. The most common symptoms associated with COVID-19 can include fever, fatigue, and a dry cough. Though additional symptoms have now been linked with the disease, which may include aches and pains, nasal congestion, runny nose, sore throat, diarrhea, skin rash and vomiting. It is also possible to become infected with COVID-19 and not experience any symptoms or feeling ill. The spread of COVID-19 is mainly through the transmission of droplets from the nose or mouth when a person coughs, exhales or sneezes. These droplets land on surfaces around a nearby person. COVID-19 can be transmitted to that nearby person who may end up touching the surface contaminated with COVID-19 and then end up touching their mouth, nose, or eyes. A person can also contract COVID-19 through inhaling these droplets from someone with COVID-19. Although research is still ongoing, it is important to note that older populations (over the age of 65), those with a compromised immune system and those with pre-existing conditions including heart disease, high blood pressure, lung disease, diabetes or cancer may be at a higher risk of severe illness due to COVID-19.

https://www.who.int/news-room/q-a-detail/q-a-coronaviruses

Q: What can I do to avoid getting Coronavirus?

A: There are various ways in which we can reduce our risk of contracting COVID-19. Below are some measures suggested by the World Health Organization:

1. Keep at least 2 metres (or 6 feet) between yourself and other people. This will reduce the risk of inhaling droplets from those infected with COVID-19.
2. Regularly clean your hands for at least 20 seconds with warm water and soap, or an alcohol-based hand rub. This will kill any viruses on your hands.
3. Avoid touching your eyes, nose and mouth. If the virus is on your hands, it can enter the body through these areas.
4. Follow good respiratory hygiene by covering your mouth and nose with a tissue or elbow when you cough and sneeze. This prevents the droplets from settling on surfaces or being released into the air around you.
5. Stay home as much as possible, especially if you are feeling unwell. If you think you may have the Coronavirus, please see “What should I do if I think I have Coronavirus?” section.
6. Please wear a face covering or mask in public when physical distancing is not possible.
Q: Are there special precautions that people with cancer can take?

A: People with cancer (and other chronic ailments such as heart disease, diabetes, high blood pressure and lung disease) are at a higher risk of severe illness due to COVID-19 as cancer is considered a pre-existing health issue. Some cancer treatments including chemotherapy, radiation and surgery can weaken the immune system, making it harder for the body to fight infections and viruses, such as Coronavirus. It is important to diligently follow the World Health Organization’s recommendations above to reduce the risk of contracting COVID-19. If you have any concerns about your risk, it is best to contact your doctor or healthcare team. Will anything change with regards to my cancer related medical visits? As each patient and treatment plan is unique, it is always best to contact your health care provider for updated information about your treatment plan. In some cases, it is safe to delay cancer treatment until after the pandemic risk has decreased. In other cases, it may be safe to attend a clinic that is separate from where COVID-19 patients are being treated. Oral treatment options could be prescribed by your care provider virtually, without the need to attend the clinic. Finally, some follow-up appointments or discussions could be held virtually (via skype or zoom for example) or over the phone to minimize your risk. As we know, conditions and protocols are changing daily due to the nature of the COVID-19 outbreak, and vary based on location, therefore, the best first step is to reach out to your care provider for guidance.

https://www.cancer.gov/contact/emergencypreparedness/coronavirus

Should you wish to contact your local public health agency, please see below.
Alberta
COVID-19 info for Albertans
Social media: Instagram @albertahealthservices, Facebook @albertahealthservices, Twitter @GoAHealth
Phone number: 811

British Columbia
British Columbia COVID-19
Social media: Facebook @ImmunizeBC, Twitter @CDCoBc
Phone number: 811

Manitoba
Manitoba COVID-19
Social media: Facebook @manitobagovernment, Twitter @mbgov
Phone number: 1-888-315-9257

New Brunswick
New Brunswick Coronavirus
Social media: Facebook @GovNB, Twitter @Gov_NB, Instagram @gnbca
Phone number: 811

Newfoundland and Labrador
Newfoundland and Labrador COVID-19 information
Social media: Facebook @GovNL, Twitter @GovNL, Instagram @govnsocial
Phone number: 811 or 1-888-709-2929

Northwest Territories
Northwest Territories coronavirus disease (COVID-19)
Social media: Facebook @NTHSSA
Phone number: 811

Nova Scotia
Nova Scotia novel coronavirus (COVID-19)
Social media: Facebook @NovaScotiaHealthAuthority, Twitter @healthns, Instagram @novascotiahealthauthority
Phone number: 811

Nunavut
Nunavut COVID-19 (novel coronavirus)
Social media: Facebook @GovofNunavut, Twitter @GovofNunavut, Instagram @governmentofnunavut
Phone number: 1-888-975-8601

Ontario
Ontario: The 2019 Novel Coronavirus (COVID-19)
Social media: Facebook @ONTHealth, Twitter @ONTHealth, Instagram @ongov
Phone number: 1-866-797-0000

Prince Edward Island
Prince Edward Island COVID-19
Social media: Facebook @GovPe, Twitter @InfoPEI,
Quebec
Coronavirus disease (COVID-19) in Québec
Social media: Facebook @GouvQc, Twitter @sante_qc
Phone number: 1-877-644-4545

Saskatchewan
Saskatchewan COVID-19
Social media: Facebook @SKGov, Twitter @SKGov
Phone number: 811

Yukon
Yukon: Find information about coronavirus (COVID-19)
Social media: Facebook @yukonhss, Twitter @hssyukon
Phone number: 811