The following colorectal cancer treatment and research updates extend from September 15th, 2022, to October 13th, 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 (Oct.10/22)**

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%2C+Open-label+Phase+2+Study+of+Lenvatinib+%28E7080%29+Plus+Pembrolizumab&show_loc=Y#locn

2. **TRK Fusion Cancer and How to Test for It (Oct.13/22)**

![Image of a child with a magnifying glass]

**What is TRK fusion cancer?**
- TRK (pronounced track) fusion cancer is a term used to describe cancers that are caused by a change to the neurotrophic tyrosine receptor kinase (TRK) gene called a fusion.
- During this fusion, an NTRK (pronounced etrak) gene joins together, or fuses, with a different gene.
- This joining causes the body to make TRK fusion proteins, which can cause cancer cells to multiply and form a tumour.
- The presence of TRK fusion proteins may be associated with more aggressive cancer.

Having TRK fusion cancer doesn’t change your original diagnosis, it just means that your tumour is driven by an NTRK gene fusion.

**Testing is the only way to find out if NTRK gene fusion is driving your cancer**

**Who should be tested for NTRK gene fusions?**
- Your doctor may consider testing in people:
  - with solid tumours that are metastatic, and
  - who are likely to experience severe complications from surgical resection, and
  - when there are no satisfactory treatments options available.

It’s important to know what’s driving your cancer to help your doctor take action.

**FastTRK** is a clinical testing program for diagnosing NTRK gene fusions.

Sponsored by Bayer, TRK is a complimentary service for healthcare professionals to find out if their patients’ cancer has an NTRK gene fusion.

Talk to your doctor about which tests are recommended for you.
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.

1. Patients undergo a biopsy to obtain a sample for testing.
2. Tissue is sent to lab to test for genomic changes.
3. Results sent to clinician to help decide on treatment.

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.

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https://www.bayer.ca/en/media/news/?fidi=TmpBPQ==&st=1
3. A Phase II, Open-label, Multicenter, Study of an Immunotherapeutic Treatment for the MSI High CRC Metastatic Population (Oct.13/22)

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 (Oct.12/22)

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.

https://sunnybrook.ca/trials/item/?i=293&paged=49335 and https://clinicaltrials.gov/ct2/show/NCT03750786
https://isofolmedical.com/arfolitixorin/

5. Updated Results From the KRYS TAL-1 Study of Adagrasib in Advanced KRAS G12C–Mutated CRC (Sept.12/22)

Updated results from KRYS TAL-1, a multi-cohort phase I/II study, evaluating adagrasib with or without cetuximab in patients with advanced colorectal cancer (CRC) harboring a KRAS G12C mutation were presented at the European Society for Medical Oncology (ESMO) 2022 Congress. In this analysis, 44 patients received adagrasib monotherapy (600 mg twice daily) and 32 patients received the combination of adagrasib (600 mg twice daily) with full-dose cetuximab, with a follow-up of 20.1 months and 17.5 months, respectively.

Among the evaluable patients in the adagrasib monotherapy cohort (n = 43), the investigator-assessed confirmed objective response rate (ORR) was 19% and the disease control rate was 86%. The median duration of response was 4.3 months, and the median progression-free survival (PFS) was 5.6 months. Of the evaluable patients in the adagrasib-plus-cetuximab combination cohort (n = 28), the investigator-assessed confirmed ORR was 46% and the disease control rate was 100%. The median duration of response was 7.6 months and median PFS was 6.9 months. In the overall subset of patients with KRAS G12C–mutated CRC evaluated in this study, adagrasib was found to be well tolerated as a monotherapy and in combination with cetuximab. The majority of observed treatment-related adverse events were grade 1 or 2 (59%); no grade 5 treatment-related adverse events were observed.

This data illustrates the importance of durable KRAS inhibition in CRC and the added benefit that dual EGFR/KRAS blockade may provide for some patients in their regimen, as evidenced by the more sustained responses from the adagrasib and cetuximab combination.
6. Fruquintinib Potentially Practice- Changing in Refractory mCRC (Sept.12/22)

According to phase 3 results presented at ESMO Congress 2022, fruquintinib can improve survival outcomes when added to best supportive care in patients with refractory metastatic colorectal cancer (mCRC). FRESCO-2 enrolled patients with refractory mCRC who had received prior treatment with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy, anti-VEGF therapy, and anti-EGFR therapy (if RAS wild-type). The patients were randomly assigned to receive placebo plus best supportive care (n=229) or fruquintinib plus best supportive care (n=458). Fruquintinib was given at 5 mg daily, dosed in a 3 weeks on, 1 week off schedule. The median follow-up was 11.3 months in the fruquintinib arm and 11.2 months in the placebo arm. The median overall survival (OS) was 7.4 months in the fruquintinib arm and 4.8 months in the placebo arm. The median progression-free survival (PFS) was 3.7 months and 1.8 months, respectively. The confirmed overall response rate was 1.5% in the fruquintinib arm and 0% in the placebo arm. The disease control rate was 55.5% and 16.1%, respectively. These results support a new, potentially practice-changing, global oral treatment option for patients with mCRC, enriching the treatment continuum for these patients.


7. Study of Onvansertib Plus SOC in mCRC Enters Phase 2 (Sept.19/22)

Plans for the phase 2 ONSEMBLE study were announced in a press release by Cardiff Oncology. ONSEMBLE is a sequential assignment study that will include roughly 100 patients with mCRC in the second-line setting. The study’s primary end point of the phase 2 study is the objective response rate, and the key secondary end points include disease control rate, the number of patients with adverse events (AEs), progression-free survival, duration of response, overall survival, the number of patients with reduction in KRAS allelic burden on liquid biopsies. The study will follow reports that onvansertib plus FOLFIRI/bevacizumab achieved a median duration of response of 11.7 months in a phase 1 trial. Preclinical data around onvansertib and irinotecan showed that the combination can overcome resistance to irinotecan. These results show patients with different KRAS mutations experiencing durable responses to treatment with onvansertib plus standard-of-care, with an objective response rate and median progression-free survival that are well above historical benchmarks. The ONSEMBLE trial will also seek to confirm the optimal dose of onvansertib in mCRC. Achieving these objectives could position onvansertib for a possible accelerated approval opportunity, though this would ultimately depend on the strength of the ONSEMBLE trial results. Chief among the study’s objectives is to generate a randomized dataset to demonstrate the contribution of onvansertib over standard-of-care alone, validating the phase 1b/2 trial results.


8. Seagen Announces TUKYSA® (tucatinib) in Combination with Trastuzumab Granted Priority Review by FDA for Previously Treated HER2-Positive mCRC (Sept.19/22)

Seagen Inc. today announced that the U.S. Food and Drug Administration (FDA) has accepted for Priority Review the supplemental New Drug Application (sNDA) seeking accelerated approval for TUKYSA® (tucatinib) in combination with trastuzumab for adult patients with HER2-positive colorectal cancer (CRC) who have received at least one prior treatment regimen for unresectable or metastatic disease. The sNDA submission is based on the results of the pivotal phase 2 MOUNTAINEER trial, which included 117 patients with HER2-positive unresectable or mCRC. All study participants had received prior standard therapies but had not received prior anti-HER2 therapy. Patients received tucatinib with trastuzumab or as monotherapy. 84 patients received tucatinib with trastuzumab. After median follow-up of 20.7 months, researchers reported a confirmed objective response rate of 38.1%. Researchers reported median progression-free survival (PFS) of 8.2 months and median overall survival (OS) of 24.1 months. There are currently no FDA-approved therapies for mCRC that specifically target HER2. Thus, the FDA’s prioritization of the application for tucatinib in combination with trastuzumab supports researchers’ belief in its significant potential to benefit people with previously treated HER2-positive mCRC.

9. Hepatic Artery Infusion Pump (HAIP) Chemotherapy Program – Sunnybrook Odette Cancer Centre (Oct.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

10. Living Donor Liver Transplantation for Unresectable CRC Liver Metastases (Oct.2/22)

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

11. Extended Right-Sided Colon Resection Does Not Reduce the Risk of Colon Cancer Local-Regional Recurrence (Sept.19/22)

It is controversial whether extensive resection of right-sided colon cancer confer oncological benefits. Researchers set out to examine short- and long-term outcomes of extended surgical removal of mesocolon compared to conventional approach using a large population-based data with local recurrence and postoperative complications as endpoints.
Radiation Therapies / Interventional Radiation

12. Study Offered at the Odette Cancer Centre to Treat Recurrent Rectal Cancer (Oct.9/22)

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

Screening

13. Trends in the Incidence of Young-Onset CRC with a Focus on Years Approaching Screening Age (Oct.10/22)

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 APC1’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.

https://academic.oup.com/jnci/advance-article/doi/10.1093/jnci/dja0220/6119347?guestAccessKey=af490637-e51e-44d0-81b9-d17d7b60e9

14. Why CRC Screening Is Crucial for Younger Adults and Black People (Sept.19/22)

NBC News’ Today Show anchor and co-host Craig Melvin led a discussion at Memorial Sloan Kettering Cancer Center (MSK) in March 2022 with a few colorectal oncologists. The topics included the impact of age and race on colorectal cancer. 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 APC1’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.

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cancer (CRC) risk and what people need to know about CRC screening and prevention, diagnosis, and treatment. During the talk, MSK experts emphasized the importance of becoming familiar with whether your family has a history of CRC. Having a close relative diagnosed with CRC might mean you need to start screening for the disease before the recommended age of 45. The Black community often faces disparities in terms of colorectal diagnoses and deaths, most of which are due to environmental factors, not biology or genetics. Some racial and ethnic groups have decreased access to high-quality cancer care, newer treatments, and specialized hospitals, along with lower screening rates, more chronic health conditions, and differences in socioeconomic status. Environmental factors also include less access to fresh foods, grocery stores, or green spaces where people can exercise. MSK recommends that people at higher risk for CRC talk with their healthcare provider about when to start screening.


15. Study Shows Many Patients Prefer Stool Test to Colonoscopy for CRC Screening (Sept.23/22)

Researchers at Cedars Sinai Medical Center surveyed 1,000 people aged 40 years or older who had not already been screened for colorectal cancer (CRC). Participants considered the top two tests recommended by a multisociety task force made up of representatives from the nation’s leading gastroenterology medical societies: yearly FITs, or colonoscopies every 10 years. When choosing between the two tests, about three-quarters of people preferred the yearly FIT over a colonoscopy every 10 years for their CRC screening. With the FIT test, there’s no change of diet, no anesthesia, and it can be done at home. If it’s negative, then you repeat it a year later. If it’s positive, you do need to get a colonoscopy so the cancer can be found, and any precancerous polyps can be removed. Understanding that there are more options like the shorter and less-invasive FIT could persuade more people to get lifesaving screenings. Which means fewer people will develop this preventable cancer.


16. Young Adult CRC Clinic Available at Sunnybrook (Oct.5/22)

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

17. CCRAN’s Partnership with “Count Me In” (Oct.1/22)

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.

Through the project, patients are asked to complete surveys to share information about their experience with CRC, to share biological sample(s), and to allow for the research team to request copies of their medical records. The project team then de-identifies and shares data from these with the entire research community.

Every patient’s story holds a piece of the puzzle that can help us better understand CRC. By discovering more about what drives cancer and sharing this data, CCRAN and the Colorectal Cancer Project believe insights can be gained to develop more effective therapies. One of the aims of the project is to reach populations that have been understudied, including individuals who are diagnosed with CRC at a young age, individuals from marginalized communities who have historically been excluded from research, and patients with metastatic CRC. Together, we can accelerate our understanding of CRC. To learn more or sign up to participate, visit JoinCountMeIn.org/Colorectal.

“Count Me In”, a nonprofit cancer research initiative, is inviting all patients across the United States and Canada who have ever been diagnosed with colorectal cancer (CRC) to participate in research and help drive new discoveries related to this disease. The Colorectal Cancer Project will enable patients to easily share their samples, health information and personal lived experiences directly with researchers in order to accelerate the pace of research.

Patients who have been diagnosed with CRC at any point in their lives can join the project by visiting JoinCountMeIn.org/colorectal. From there, patients will be invited to share information about their experience through surveys and to provide access to medical records as well as saliva samples and optional blood, stool, and/or stored tissue samples for study and analysis. Researchers from the Broad Institute of MIT and Harvard and Dana-Farber Cancer Institute use this information to generate databases of clinical, genomic, molecular, and patient-reported data that is then de-identified and shared with researchers everywhere. To date, more than 9,000 patients with different cancers have joined Count Me In and shared their data. “We still do not know why there is an alarming rise in CRC in young adults”, said Andrea Cercek, MD Co-Director, Center for Young Onset Colorectal and Gastrointestinal Cancers Memorial Sloan Kettering Cancer Center and co-scientific leader of the Colorectal Cancer...
Project. "What we do know is that this is a global phenomenon that affects otherwise healthy individuals with no known risk factors. The Colorectal Cancer Project will provide researchers important information that will lead to a better understanding of this disease."

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.
Anyone in the United States and Canada who has ever been diagnosed with CRC has the power to advance cancer research in a way that no one else can. Count Me In’s Colorectal Cancer Project enables the #crc community to complete surveys and share their biological samples & medical information with researchers to help gain insights and develop more effective therapies.

Learn more at JoinCountMeIn.org/colorectal

https://www.medicalnewstoday.com/articles/1819599
https://www.medicalnewstoday.com/articles/1819599#Recent-News-On-SSIs

18. Patients and Caregivers Needed to Help Shape Early Research for a CRC Therapy (Oct.10/22)

The Project:
Site specific immunomodulators (SSIs) are a new class of therapy, made from dead bacteria. This therapy is designed to help the body’s own defense system (‘immune cells’) fight cancer. SSIs may be a potential new treatment for colorectal cancer and have already been shown to be safe in cancer patients. Our team of scientists and clinicians are planning a clinical trial to determine if SSIs can increase the number of patients who survive colorectal cancer metastatic to the liver. The trial will start this Fall and is being led by Dr. Rebecca Auer (Ottawa) and Dr. Paul Karanicolas (Sunnybrook).

Why do we need your help?
We want patients and family members to help us shape our research, which aims to improve the experience of trial participants.

We are currently looking for patients, caregivers, or family members to join our team. As a part of our team, you will:

- Participate in group meetings (online and/or in person) with the research team from May 2022 to March 2024
- Help brainstorm and draft resources and documents for future trial participants
- Provide input on research to evaluate the usefulness of the developed resources

Who can apply?
We are looking for individuals with any of the following:

- A patient, family member, or a caregiver, with lived experience of colorectal cancer, liver metastases, and/or liver surgery
- Interested in helping shape research to assess a new therapy for colorectal cancer

No previous experience with SSIs or research is necessary. An orientation session will provide more information about the research project, and we encourage you to ask any questions you have at any time.

In appreciation for your time, partners will receive compensation for attendance at meetings and activities.

If you are interested in joining our team or would like more information:
Please contact Meredith Conboy, Research Assistant, The Ottawa Hospital Research Institute
Email: mconboy@ohri.ca

19. Under 50 National Colorectal Cancer Information/Support Group Now Available at CCRAN! (Sept.2/22)

ARE YOU AN EARLY AGE ONSET (<50 YEARS) COLORECTAL CANCER PATIENT OR CAREGIVER LOOKING FOR INFORMATION OR SUPPORT?

Meet Hayley Painter R.N. and proud survivor of metastatic colorectal cancer!
Hayley will be assuming the lead on CCRAN’s Monthly National Under 50 Colorectal Cancer Information/Support Group Meetings!

**When:** Every third Sunday of the month  
**Time:** 7:00 – 9:00 p.m.  
**Where:** Via Zoom  
**To Register:** Hayley.p@ccran.org

Please join Hayley as she will deliver important treatment updates and provide optimal support to each patient in their colorectal cancer journey at these support group meetings. To register for the meeting, please contact Hayley at hayley.p@ccran.org.

20. Launching CTO’s Decentralized Clinical Trials Survey (Sept.27/22)

Decentralized clinical trials (abbreviated as DCTs and also sometimes called remote or virtual clinical trials) are clinical trials that occur with participants that are not required to come to a study site. Participants may use videoconferencing or other technology to talk to study staff, be visited at home by study staff, use internet-based tools for collecting data and reporting, and use mobile technology (e.g., a wearable technology). The COVID-19 pandemic has led to some clinical trials being done differently from how they were originally planned. Health Canada, Canada’s regulatory agency that oversees clinical trials done in Canada, has allowed these changes to happen during the pandemic and is also looking at how some of these temporary changes might be allowed to continue in the future. This survey is being hosted by Clinical Trials Ontario (CTO), a not-for-profit organization dedicated to making Ontario a better place to do clinical trials. CTO works with the clinical trials community in Ontario and beyond and that includes working with patients and the public. The survey was co-developed with patients, health charities, patient organizations, and individuals who are involved in facilitating and doing clinical trials.

Learn more about the survey and participation here: [https://queensu.qualtrics.com/jfe/form/SV_064sQQGSzyFoIbE](https://queensu.qualtrics.com/jfe/form/SV_064sQQGSzyFoIbE)

21. Impact of Microsatellite Status in Early-Onset Colonic Cancer (Sept.19/22)

This retrospective international multicentre observational study was performed to assess the clinicopathological features, molecular characteristics, and disease-specific outcomes of patients diagnosed with early-onset colonic cancer. Criteria for inclusion were patients younger than 50 years diagnosed with stage I–III colonic cancer that was surgically resected. Clinicopathological features, microsatellite status, and disease-specific outcomes were evaluated.

A total of 650 patients fulfilled the criteria for inclusion. Microsatellite instability (MSI) was identified in 170 (26.2%), whereas 480 had microsatellite-stable (MSS) tumours (relative risk of MSI 2.5 compared with older patients). MSI was associated with a family history of colorectal cancer (CRC) and lesions in the proximal colon. The proportions with pathological node-positive disease (45.9% versus 45.6%) and tumour budding (20.3% versus 20.5%) were similar in the two groups. Patients with MSI tumours were more likely to have BRAF (22.5% versus 6.9%) and KRAS (40.0% versus 24.2%) mutations, and a hereditary cancer syndrome (30.0% versus 5.0%). Five-year disease-free survival rates in the MSI group were 95.0, 92.0, and 80.0% for patients with stage I, II, and III tumours, compared with 88.0, 88.0, and 65.0% in the MSS group.
Patients with early-onset colonic cancer have a high risk of MSI and defined genetic conditions. Those with MSI tumours have more adverse pathology (budding, KRAS/BRAF mutations, and nodal metastases) than older patients with MSI cancers. Increased understanding of the biological spectrum of MSI will guide oncotherapeutic decision-making and optimize survivorship.

Impact of microsatellite status in EAOCRC. El-Hussuna. 2022.pdf

22. EXercise for Cancer to Enhance Living Well (EXCEL) Study (Oct.11/22)

Exercise for Cancer to Enhance Living Well (EXCEL) is a 5-year Canada-wide project, which offers free, 12-week exercise classes designed specifically for individuals undergoing or recovering from cancer treatment. Classes are online through a secure video-conferencing platform, and where possible, in-person (post-COVID). Physical activity can help overcome treatment-related side effects such as fatigue and pain, improve mental health by reducing anxiety and depression, and improve overall quality of life for individuals living with and beyond cancer. Studies show that physical activity may even reduce the risk of recurrence for some cancers. Many urban centres in Canada offer cancer-specific exercise programs, however, rural and remote areas tend to lack exercise resources to support cancer survivors, resulting in lower activity levels, poorer health, and diminished quality of life. Thus, EXCEL targets cancer survivors living in rural and remote regions across Canada, empowering them to move more and providing opportunities to benefit from physical activity.

To learn more about the EXCEL study: https://kinesiology.ucalgary.ca/labs/health-and-wellness/research/research-studies/exercise-cancer-enhance-living-well-excel

To hear about participant experiences: https://www.youtube.com/watch?v=c01oo4Yd3oA

23. The Avocado-Cancer Link: Is This Fruit Cancer-Protective? (Oct.1/22)

Lately, everyone seems to have jumped on the avocado bandwagon, and for good reason. Researchers have shown that avocados are good for many body systems—cardiovascular, ocular, bone, and gastrointestinal. It has been discovered only recently that avocados may also protect against certain cancers and have the potential to inhibit cancer cell growth.

Avocados contain almost 20 vitamins and minerals and is full of healthy monounsaturated fatty acids (MUFSAs). Some studies have shown that a high-MUFA diet can protect against the risk of certain cancers, including prostate, colon, stomach, pancreatic, and cervical cancers. Not only are avocados beneficial in preventing cancers, they may also have a role in cancer treatment one day. In fact, some researchers have shown that the phytochemicals in avocados may selectively inhibit cancer cell and pre-cancerous cell growth, as well as induce apoptosis in cancer cells (cell death). Phytochemicals also encourage lymphocyte proliferation to help kill tumor cells.

Avocados are also high in fiber: one-half of an avocado contains 6-7g of fiber. This high content can help maintain a healthy digestive tract and even lower your risk of colon cancer. Fiber also affords your body natural detoxification by promoting regular bowel movements and can benefit the immune system (and overall health) by promoting a healthy gut microbiome.

https://www.mdlinx.com/article/the-avocado-cancer-link-is-this-fruit-cancer-protective/8Pflyzz2qe6g0uHHiG5fN4Ihd

Image source: https://nutritionfacts.org/2021/05/06/are-avocados-associated-with-greater-risk-or-reduced-risk-of-cancer/
24. Could you be at high risk of severe COVID-19? (Oct.1/22)

There are many factors that can put you at high risk of developing severe COVID-19 if you get infected. You may be at high risk if any of the factors below describe you. If you have a risk factor listed below, you are more likely than someone with no risk factors to have worsening symptoms that could lead to hospitalization, or even death.

With that it is important to be ready to ACT fast:
1. Assess yourself for COVID-19 symptom
2. Confirm through COVID-19 testing as soon as possible
3. Talk to your healthcare provider to seek treatment

https://www.talkcovidtreatment.ca
25. Frequently Asked Questions for COVID-19

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

A: Coronaviruses 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 fatigue, fever, 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 nose, mouth, 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-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.

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

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.

Q. 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 @govnlsoical
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