The following colorectal cancer treatment and research updates extend from July 13th, 2023, to August 17th, 2023, 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. TRK Fusion Cancer and How to Test for It (Aug.13/23)

**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 (NTRK) gene called a fusion.
- During this fusion, an NTRK (pronounced on-track) 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.

**FastTRK**

FastTRK is a clinical testing program for diagnosing NTRK gene fusions. Sponsored by Bayer, this 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.**
INTRODUCING
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 which 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
2. Immunotherapy Combined with Targeted Therapy in Patients with BRAF V600E–Mutated CRC (Jul.15/23)

In one of the first clinical trials combining immunotherapy and targeted therapy for patients with BRAF V600E–mutated colorectal cancer (CRC), researchers discovered that a combination regimen of dabrafenib, trametinib, and spartalizumab resulted in long-lasting responses. The study successfully met its primary endpoint and achieved a confirmed response rate of 24.3%, compared with a response rate of 7% in a prior trial where patients were treated with each of the same targeted therapies individually. The researchers also reported improved outcomes in one of the trial’s secondary endpoints: durability. Previously, patients with BRAF V600E–mutated CRC have seen only a short-lived clinical benefit after treatment with BRAF or MEK inhibitors. But the combination therapy resulted in an increased durability of response, with a median progression-free survival of 5 months compared with 3.5 months with BRAF or MEK inhibitors alone. The researchers noted that 57% of the patients continued with the treatment for more than 6 months and 18% continued for more than 1 year.

The findings suggested how targeted therapies in combination with immunotherapies may drive a greater immune response and improve treatment overall. This merits further clinical investigation and preclinical experiments to determine the best targeted approach to increase immune reactivity against [BRAF-mutated] CRC. The researchers acknowledged that the implications of their research may go well beyond CRC.


3. VITRAKVI (Larotrectinib) is Now Covered in Ontario, Quebec, Saskatchewan, Manitoba and New Brunswick (Jul.15/23)

Please find information below regarding public funding for VITRAKVI (Larotrectinib) in Ontario, Quebec, Saskatchewan, Manitoba and New Brunswick.

4. European Medicines Agency Validates MAA for Fruquintinib in Pretreated mCRC (Jun.16/23)

The European Medicines Agency (EMA) has validated and accepted a marketing authorization application (MAA) for priority review for fruquintinib for the treatment of adult patients with pretreated metastatic colorectal cancer (mCRC).

Fruquintinib is a highly selective and potent VEGF1/2/3 inhibitor, which if approved, will be the first and only highly selective inhibitor of all 3 VEGF receptors approved for use in this population in the European Union.

The MAA is based on findings from the phase 3 FRESCO-2 trial conducted in the United States, Europe, Japan, and Australia, in addition to results from the phase 3 FRESCO trial conducted in China. In FRESCO-2, the addition of fruquintinib to best supportive care (BSC) led to a statistically significant and clinically meaningful improvement in overall survival (OS) and progression-free survival (PFS) vs placebo plus BSC in patients with previously treated mCRC. Median PFS and OS were 3.7 months and 7.4 months with fruquintinib vs 1.8 months and 4.8 months with placebo.

European patients with mCRC have not benefitted from a treatment advancement in over a decade. Submitting the marketing authorization application to the EMA brings physicians one step closer to potentially offering this innovative therapy to patients with advanced disease. Researchers believe fruquintinib has the potential to address the longstanding unmet need for patients with previously treated mCRC regardless of their biomarker status.


5. DESTINY-CRC02 Trial Continues to Support the Use of T-DXd in HER2+ Metastatic CRC (Jun.19/23)

Treatment with fam-trastuzumab deruxtecan-nxki (T-DXd) at a low intravenous dose showed encouraging antitumor activity and a positive benefit-risk profile for patients with HER2-positive metastatic colorectal cancer (mCRC). This indicates that T-DXd may be an optimal therapeutic strategy for patients with RAS/BRAF wild-type disease, who often develop resistance to standard anti-EGFR drugs.
T-DXd was previously evaluated in HER2-positive mCRC in the phase 2 DESTINY-CRC01 trial. Results demonstrated strong and durable antitumor activity at a dose level of 6.4 mg/kg. In cohort A, which enrolled patients with HER2 immunohistochemistry (IHC) 3+ or IHC 2+/in situ hybridization positivity, the agent produced an objective response rate (ORR) of 45.3% and a median duration of response (DOR) of 7 months. Although interstitial lung disease (ILD) remains an important drug-related toxicity associated with T-DXd, events were predominantly low grade.

Primary findings from the phase 2 DESTINY-CRC02 trial presented at the 2023 ASCO Annual Meeting showed that patients who received the lower 5.4-mg/kg dose of T-DXd experienced numerically higher responses than those with the higher 6.4-mg/kg dose. Confirmed ORR was 37.8% at the lower dose vs 27.5% at the higher dose. Median DOR was 5.5 months at both dose levels, and the disease control rate was 86.6% with the low dose and 85.0% with the higher dose. Notably, the study was not powered to determine statistical significance between the 2 dose cohorts.

Preliminary efficacy was observed regardless of RAS mutational status and was also seen in patients previously exposed to HER2-targeted agents. The safety profile of T-DXd was consistent with prior data, although the lower dose level was deemed more tolerable.


6. FDA Approval Insights: Tucatinib and Trastuzumab in HER2+ mCRC (Feb.6/23)

The OncLive® podcast, OncLive On Air®, discussed the FDA approval of tucatinib plus trastuzumab in metastatic colorectal cancer (mCRC) with John H. Strickler, MD, an associate professor of medicine in the Department of Medical Oncology at Duke Cancer Institute in Durham, North Carolina.

On January 19, 2023, the FDA approved the combination of tucatinib and trastuzumab in adult patients with pretreated, RAS wild-type, HER2-positive unresectable or mCRC. This approval was supported by findings from the phase 2 MOUNTAINEER trial, in which, at a median follow-up of 20.7 months, patients who received the regimen had a confirmed objective response rate of 38.1% and a median duration of response of 12.4 months. In the interview, Dr Strickler discussed the significance of this approval, key efficacy and safety findings from MOUNTAINEER, and how ongoing research is seeking to address remaining unmet needs for patients with HER2-positive mCRC with resistance mutations.

To listen to the podcast follow see the link below:

7. Aspirin Use Tied to Lower Risk for Early CRC (Jun.1/23)

The regular use of aspirin or other nonsteroidal anti-inflammatory drugs was found to be associated with a lower risk of early-onset conventional and advanced adenomas. Researchers say that aspirin could prove to be an effective strategy in preventing early-onset colorectal cancer (CRC) cases.

The study confirms evidence from 30 years of research that suggests regular aspirin use reduces cancer risk. While emerging data have suggested that aspirin use may reduce later-onset CRC, it was not known if regular aspirin and NSAID use are associated with diminished risk of early-onset conventional adenomas, and especially the high-risk adenomas conferring greater malignant potential known to be the major precursor of early-onset CRC. The objective of the new study was to assess the association between regular aspirin or NSAID use at least twice weekly, with the risk of developing early-onset adenoma. High-risk adenomas included those that were at least 1 cm with tubulovillous/villous histology or high-grade dysplasia, or the presence of at least three adenomas.

There were 1,247 early-onset adenomas, among which 290 were considered high risk. The risk of adenomas among patients who took aspirin or NSAIDs regularly for cardiovascular protection or for inflammatory conditions, was lower than in those who did not take aspirin and/or NSAIDs regularly. While the association was similar for high-risk vs. low-risk adenomas, the benefit was more pronounced for adenomas of tubulovillous/villous histology or with high-grade dysplasia, a 33% reduction, compared with tubular adenomas. With later-onset adenomas, risk reduction was confined primarily to large or multiple adenomas, but not adenomas of advanced histology.

With CRC rates increasing, there still aren’t any preventative strategies beyond screening. With this 15% reduction with aspirin/NSAIDS in early-onset adenoma – and particularly for the quite substantial 33% benefit in advanced adenoma with advanced histology, researchers believe it is necessary to think about a precision-based chemoprevention strategy for early-onset precursors of CRC.

Image Source: https://www.aspirin.ca/en/products/aspirin-81mg-enteric-coated/
8. FDA Approves Combination Lonsurf (Trifluridine + Tipiracil) + Bevacizumab for mCRC (Aug.3/23)

The FDA approved trifluridine and tipiracil with bevacizumab for patients with previously treated metastatic colorectal cancer (mCRC). The approval applies to use of the combination by patients who received prior fluoropyrimidine-, oxaliplatin- and irinotecan-based chemotherapy, an anti-VEGF biological therapy and — if RAS wild-type — an anti-EGFR therapy.

Trifluridine and tipiracil is an oral agent that utilizes a dual mechanism of action to maintain clinical activity. Trifluridine, an antineoplastic nucleoside analogue, interferes with DNA function. The blood concentration of trifluridine is maintained via tipiracil, an inhibitor of the trifluridine-degrading enzyme thymidine phosphorylase.

The agency based the new indication on results of the randomized SUNLIGHT trial, which assessed trifluridine and tipiracil with or without bevacizumab for patients with mCRC who received a maximum two prior chemotherapy regimens and either experienced disease progression on or were intolerant to their last regimen. The results showed statistically significant improvements in progression-free survival (PFS) (median, 5.6 months vs. 2.4 months) and overall survival (OS) (median, 10.8 months vs. 7.5 months) among patients treated with trifluridine and tipiracil with bevacizumab. A video embedded in the following link shows John L. Marshall M.D., sharing insights on health-related quality of life (HRQoL) findings from SUNLIGHT study presented at ESMO World Congress on Gastrointestinal Cancer (ESMO GI) 2023. There plenty of ways in which the disease, the treatment, and the consequences of all sorts of things impact the quality of life for patients.


A few years ago, this beyond-second-line treatment felt like the last chance for patients. Now, there is a robust third-line standard with Lonsurf (TAS-102) plus bevacizumab. This combination can be used in more than 90% of patients because the only patients not eligible for this regimen are those with bone marrow dysfunctions, which are rare.

This combination also moves other drugs to the fourth or fifth lines. Now, the third line seems as good as the first and second lines because we have a good OS of 10 months for these patients and a good treatment that is well tolerated and may become a new standard. Probably after this trial with TAS-102 and bevacizumab, the global survival of patients with CRC will be changed in forthcoming trials that will be seen in 4 to 5 years from now.


Immune checkpoint inhibitors (ICI) have shown great promise in treating advanced or metastatic colorectal cancer (mCRC), especially for CRC patients with deficient mismatch repair (dMMR) and high microsatellite instability (MSI-H). For the remainder of CRC patients presenting with proficient mismatch repair (pMMR) and microsatellite stable (MSS) or low microsatellite instability (MSI-L), ICI showed a low-level response.

This study follows a 57-year-old Chinese man diagnosed with pMMR MSS IVb CRC with liver metastasis who was primarily administered two consecutive treatments, one composed of an anti-EGFR and modified FOLFOX6 and the other composed of an anti-VEGF and FOLFOXIRI. Due to severe chemotherapy side effects, the patient discontinued treatment and decided to take a third investigational treatment, where an anti-PD-1 and an anti-VEGF were given in combination with fecal microbiota transplantation (FMT) capsules.

The patient achieved a partial response (PR), and the tumor size decreased to the extent amenable to surgical resection. After surgery, the patient achieved a pathological complete response (pCR). Patients with pMMR MSS or MSI-L hardly benefit from anti-PD-1 immunotherapy. This study indicated that FMT has great potential in immunotherapy for patients with pMMR MSS CRC to improve response to ICI and patients’ survival.

gut-microbiota-transplantation-a-case-report/!


The majority of patients with CRC have microsatellite stable (MSS) disease, which does not respond to immunotherapy. New research however suggests that treatment with a novel immunotherapy combination of botensilimab plus balstilimab has significant anti-cancer activity. Results from an early phase clinical trial evaluating this approach were presented at the 2022 ESMO World Congress on Gastrointestinal Cancer in Barcelona, Spain.
Researchers evaluated the combination of botensilimab plus balstilimab in 41 patients with MSS advanced colon cancer who were heavily pretreated. More than 50% of patients had received 4 or more previous lines of chemotherapy treatment. The combination of botensilimab and balstilimab produced a 19% response rate and provided overall survival benefits in patients with microsatellite stable metastatic colorectal cancer (CRC) that is resistant to chemotherapy and/or immunotherapy. The doublet resulted in a median survival duration of 20.9 months in patients without active liver metastases (n = 69). In those with active liver metastases, the 12-month survival rate in refractory patients was 62%, for those without active liver metastases, the survival rate at 1 year was 74%. Overall, 76% of patients had treatment related side effects, but the majority of these were mild. A randomized phase 2 study in MSS colorectal cancer patients will launch later this year.


11. Overview of Metastatic CRC: Presentation and Molecular Testing (Jul.14/23)

While colorectal cancer (CRC) is one of the most common types of cancer, it should be noted that most patients with CRC will present metastatic disease at some point during their diagnosis. The video found within the link below includes Tanios S. Bekaii-Saab, MD, providing an overview of the presentation trends and molecular testing practices for metastatic CRC.


12. Future Perspectives on HER2+ Metastatic CRC (Jul.28/23)

In another video interview with Tanios S. Bekaii-Saab, MD, closing thoughts are shared regarding the unmet needs and future of HER2+ metastatic colorectal cancer (mCRC) treatment. To watch the video, please follow the link below.


13. Hepatic Artery Infusion Pump (HAIP) Chemotherapy Program – Sunnybrook Odette Cancer Centre (Aug.1/23)

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
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.

A new study is investigating a technique called In Vivo Lung Perfusion (IVLP) for delivering chemotherapy directly into the lungs at the time of surgery. Delivering chemotherapy directly to the lungs could potentially kill any microscopic cancer cells that are present in the lungs at the time of surgery, while sparing other major organs in the body from the side effects of chemotherapy.

At the University Health Network, this IVLP technique has been used recently in a Phase I study in patients with sarcoma, and they are now expanding on that experience to include patients with colorectal metastases. The purpose of this study is to test the safety of the IVLP technique and find the dose that seems right in humans. Participants are given oxaliplatin into one lung via IVLP and are watched very closely to see what side effects they have and to make sure the side effects are not severe. If the side effects are not severe, then more participants are asked to join the study and are given a higher dose of oxaliplatin. Participants joining the study later on will get higher doses of oxaliplatin than participants who join earlier. This will continue until a dose is found that causes severe but temporary side effects. The other lung will not be infused with anything, so that researchers can limit unforeseen toxicity to a single lung and see if one lung does better than the other.

The estimated enrolment is 10 participants, each with a diagnosis of colorectal carcinoma. The primary outcome is safety as measured by acute lung injury findings and the estimated primary completion date is January 1, 2027.
16. Transplant Improves Survival for Certain Patients with CRC Liver Metastases (Jul.26/23)

Liver transplant conferred a 10-year OS rate of more than 80% in selected patients with colorectal cancer (CRC) and nonresectable liver metastases, study results showed.

The liver is the most common site for metastatic disease among individuals with CRC. Liver transplantation for patients with colorectal cancer with liver metastases was abandoned in the 1990s due to poor survival. Researchers wanted to reexamine if liver transplantation could result in longer overall survival in selected patients with CRC and liver-only metastases. Thus, a nonrandomized controlled trial was conducted to determine predictive factors for long-term survival or cure after liver transplantation among individuals with CRC and liver-only metastases.

Investigators reported median disease free survival (DFS) of 11.8 months, median overall survival (OS) of 60.3 months and median RFS of 37.1 months. Individuals with an Oslo risk score of 0 had a 10-year OS rate of 88.9%. Similarly, those with a Fong Clinical Risk Score of 1 had a 10-year OS rate of 80%. Negative predictors factors for OS included largest tumor size greater than 5.5 cm, progressive disease while receiving chemotherapy, plasma carcinoembryonic antigen values greater than 80 g/L, liver metabolic tumor volume on PET of greater than 70 cm³, primary tumor in the ascending colon, tumor burden score of 9 or higher, and nine or more liver lesions.

The results suggest that — based on several clinical predictive factors — a 10-year OS of 80% or higher can be achieved after liver transplant for CRC metastases in highly selected cases. Establishing living donor programs may expand the number of donor liver grafts available for liver transplantation in patients with CRC.

17. Study Offered at the Odette Cancer Centre to Treat Recurrent Rectal Cancer (Aug.9/23)

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 affect 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

18. Trends in the Incidence of Young-Onset CRC with a Focus on Years Approaching Screening Age (Aug.10/23)

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 APCi'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.


For more information, please visit the OncoHelix website.

20. LifeLabs Launches Signatera, Offering Canadians an Innovative and Personalized Approach to Managing Cancer (Aug.1/23)

LifeLabs is pleased to share the launch of Signatera, a highly sensitive, personalized molecular residual disease assay (MRD) test developed by Natera for treatment monitoring and molecular residual disease (MRD) assessment in patients previously diagnosed with cancer. This innovative test uses circulating tumor DNA (ctDNA) and is personalized for each patient to help assess recurrence risk and identify relapse up to two years earlier than the current standard of care tools. The clinical utility of Signatera across cancer types has been validated by multiple studies. In those trials, Signatera demonstrated predictive values such as:

Signatera testing involves two phases with pre-supplied collection kits. The first phase is an initial test that analyzes both a tumor tissue and blood sample, and the second phase involves subsequent blood tests on an as-needed
basis. It is a safe, non-invasive way to monitor ctDNA levels to help physicians understand treatment efficacy and detect relapse without the inconvenience of repeated tissue biopsies and/or imaging.


21. Natera Announces Publication of Prospective, Multi-Site CIRCULATE Study in Nature Medicine Demonstrating Signatera’s Ability to Predict Chemotherapy Benefit in CRC (Aug.1/23)

Natera, Inc., a global leader in cell-free DNA testing, announced the publication of a new study in Nature Medicine, which demonstrates the ability of the Signatera molecular residual disease (MRD) test to identify patients with stage II-IV colorectal cancer (CRC) who are at an increased risk of recurrence and predict who is likely to benefit from adjuvant chemotherapy (ACT).

The paper describes results from the GALAXY arm of the ongoing CIRCULATE-Japan trial, which is one of the largest and most comprehensive prospective studies of MRD testing in resectable CRC. The data builds on results previously presented at the 2022 ASCO Gastrointestinal Cancers Symposium (ASCO GI), now with median clinical follow-up extended to 16.74 months and DFS assessment at 18 months.

In the study, 1,039 patients with stage II-IV resectable CRC were monitored prospectively using the Signatera MRD test. Key takeaways include:

- Post-surgical MRD status was predictive of chemotherapy benefit
- Post-surgical MRD status was the most significant prognostic risk factor for recurrence, in a multivariate analysis that accounted for all clinicopathological risk factors currently used for prognostication (HR 10.82, p-value <0.001).
- Pre-surgical detection rate of 95.9% in patients with pathologic stage II-III disease and 93.1% in patients with stage II-IV disease.
- Signatera dynamics are indicative of treatment response

This study provides strong evidence that Signatera MRD-positive patients will benefit significantly from adjuvant therapy, while MRD-negative patients may be safely observed, regardless of clinical or pathological stage.


22. Association of Reducing the Recommended CRC Screening Age with Cancer Incidence, Mortality, and Costs in Canada Using OncoSim (Jul.20/23)

Recent US guideline updates have advocated for colorectal cancer (CRC) screening to begin at age 45 years in average-risk adults, whereas Canadian screening programs continue to begin screening at age 50 years. Similarities in early-onset CRC rates in Canada and the US warrant discussion of earlier screening in Canada, but there is a lack of Canadian-specific modeling data to inform this.

Researchers examined the association of a lowered initiation age for CRC screening by biennial fecal immunochemical test (FIT) with CRC incidence, mortality, and health care system costs in Canada.

Using the OncoSim-CRC model, the analysis included 4 birth cohorts (1973-1977, 1978-1982, 1983-1987, and 1988-1992) representative of the Canadian population accounting for previously documented effects of increasing CRC incidence in younger birth cohorts. Screening initiation at age 45 years resulted in a net 12,188 fewer CRC cases, 5,261 fewer CRC deaths, and an added 92,112 quality-adjusted life-years (QALYs) to the cohort population over a 40-year period relative to screening from age 50 years. Screening initiation at age 40 years yielded 18,135 fewer CRC cases, 7,988 fewer CRC deaths, and 150,373 QALYs. The cost per QALY decreased with younger birth cohorts to a cost of $762 per QALY when Canadians born in 1988 to 1992 began screening at age 45 years or $2,622 per QALY with screening initiation at age 40 years. Although costs associated with screening and resulting therapeutic interventions increased with earlier screening, the overall health care system cost of managing CRC decreased.

Overall, the study found that earlier screening may reduce CRC disease burden and add life-years to the Canadian population at a modest cost. Guideline changes suggesting earlier CRC screening in Canada may be justified.

https://jamanetwork.com/journals/jamaoncology/fullarticle/2807477
23. ACP Sticks with Age 50 for CRC Screening (Aug.1/23)

The American College of Physicians (ACP) updated guidance reaffirming its stance that colorectal cancer (CRC) screening should wait until age 50 for average-risk, asymptomatic adults.

ACP acknowledged that the incidence of CRC has slightly increased in persons younger than 50, while it has decreased in those ages 50 to 64, and even more sharply decreased in persons ages 65 and older. However, considering the potential harms that can occur with CRC screening -- including cardiovascular and gastrointestinal events (serious bleeding, perforation, myocardial infarction, and angina), unnecessary follow-ups, and costs for findings deemed clinically unimportant -- the net benefit of screening “is much less favourable in average-risk adults between ages 45 and 49 years than in those aged 50 to 75 years” the authors wrote.

According to the ACP, individuals 50 and over should -- in consultation with their clinicians -- undergo an appropriate screening test based on discussion of benefits, harms, costs, availability, frequency, and patient values and preferences.

Recommended screening tests include:

- Fecal immunochemical or high-sensitivity guaiac fecal occult blood testing every 2 years
- Colonoscopy every 10 years
- Flexible sigmoidoscopy every 10 years plus a fecal immunochemical test every 2 years

The new recommendations, surprising as they may be for some, may turn the tide toward more dispassionate, evidence-based assessment of absolute benefits and harms of CRC screening. As might be expected, the guidance came with some pushback from medical societies. The Prevent Cancer Foundation said it “strongly opposes” the updated guidance, as it conflicts with the latest evidence-based screening recommendations from “organizations working in the cancer screening space every day.” The American College of Radiology also weighed in, calling ACP’s recommendation against the use of CT colonography screening “a step backward,” particularly when it comes to underserved areas with lower screening rates and higher CRC mortality rates.

https://www.medpagetoday.com/hematologyoncology/coloncancer/105724

24. Independence Blue Cross and The Colorectal Cancer Alliance Launch 45+ Reasons Campaign to Support CRC Prevention (Aug.8/23)

Independence Blue Cross (Independence) and the Colorectal Cancer Alliance (the Alliance) announced the launch of 45+ Reasons, a campaign to get more than 5,000 Black Philadelphians ages 45-75 screened for colorectal cancer (CRC) to reduce the significantly higher incidence and mortality rates of Black Americans. The campaign leverages authentic voices and stories to encourage Black individuals to seek information and screening options for CRC while breaking the stigma associated with the disease. The campaign name, 45+ Reasons, highlights the new minimum screening age and invites people to identify their own personal reasons to get screened – from being able to watch a child grow up to achieving a lifelong career goal – and emphasizes the lifesaving nature of CRC screening. The community engagement, social media, and advertising campaign aims to instill much-needed trust in the healthcare system with fact-based support for CRC as a preventable cancer.

The support of Independence Blue Cross, which is funding the campaign and overall Cycles of Impact initiative, jump-started progress to address this urgent public health issue among the Black population. Recent data from the American Cancer Society show that Black Americans are 20% more likely to be diagnosed with CRC and 35% more likely to die from the disease.

CRC screening events are being held throughout Philadelphia communities, including at Vine Memorial Baptist Church, Omega Psi Phi Men’s Wellness Day, Independence Blue Cross Member Expos in October and November and Community Alliance for Development’s Wellness Day on October 28. The Alliance is also working with Philadelphia medical centers, health systems and physician groups to help ensure that people who need colonoscopies receive access to prevention and care. Unlike most cancers, CRC has a 91% survival rate with treatment when caught early through preventive screenings.

25. Young Adult CRC Clinic Available at Sunnybrook (Aug.5/23)

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), along with Dr. Petra Wildgoose (Hepatobiliary and Colorectal Oncology Surgical Assistant), and their team at the Sunnybrook Health Sciences Centre understand the needs of this patient population.

Dr. Shady Ashamalla, Head
Young Adult Colorectal Cancer Program

Dr. Petra Wildgoose, Lead
Young Adult Colorectal Cancer Program

Both belong to a multidisciplinary team of experts in the Young Adult Colorectal Cancer Clinic who work with young CRC patients, regardless of disease stage, to create an individualized treatment plan to support each patient through their cancer journey. Patients’ 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

26. CCRAN’s Partnership with “Count Me In” (Aug.1/23)

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.
Every colorectal cancer patient’s story holds a piece of the puzzle that can help us better understand how to treat this disease. Join our partners at @joincountmein to help generate more data for CRC by sharing your medical records, samples, and unique experiences with researchers everywhere.

Learn more at JoinCountMeIn.org/colorectal

27. Patients and Caregivers Needed to Help Shape Early Research for a CRC Therapy (Aug.10/23)

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

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.

29. CaringVirtually: A Virtual Care Oncology Patient Study (Jul.27/23)

Majd Ghadban and Julia Stoneman are co-leading a study to understand cancer patient experiences with using virtual care as a method of healthcare delivery during the COVID-19 pandemic. The study is being undertaken by a network of national oncology patient organizations in Canada known as CONECTed: Collective Oncology Network for Exchange, Cancer care innovation, Treatment access and Education.

More information about CONECTed can be found on its website: https://conected.io/

In addition to Majd Ghadban and Julia Stoneman, the study team includes Jessica Finucane, Ed.S., Dr. Ambreen Sayani, Postdoctoral Fellow – CIHR Patient-Oriented Research, Leadership Stream at the Women’s College Research Institute, Women’s College Hospital, Louise Binder, Health Policy Consultant, Save Your Skin Foundation and member of CONECTed’s Steering Committee, and Dr. Tim Ramsay, Scientific Director, Ottawa Methods Centre.

Study Purpose
The purpose of this study is to understand cancer patient experiences using virtual care during the COVID-19 pandemic, and to develop recommendations that will help to ensure adoption and adaptation of equitable, equal, consistent, and comprehensive virtual care best practices across Canada. To achieve the objectives of this project, one-on-one interviews will be conducted with cancer patients who have used virtual care during the COVID-19 pandemic as part of their cancer care. These interviews are offered in both English and French, for which an honourarium will be provided. Study findings will be used to develop reports, which will be made public. The findings will also be used to inform future studies in the area of virtual care and oncology.

For more information, please click on the PDFs below.

Virtual Care in Oncology Study - Info
Virtual Care in Oncology Study - Info
30. Genetic “On/Off” Switches May Contribute to CRC Subtypes (Jul.28/23)

Investigators at the Johns Hopkins Kimmel Cancer Center suggest that expression of transcription factors — proteins that help turn specific genes on or off by binding to nearby DNA — may play a central role in the degree of DNA methylation across the genome, contributing to the development of different subtypes of these cancers.

Methylation is a process in which certain chemical groups attach to areas of DNA that guide genes’ on/off switches. Studying the expression of these transcription factors in patients with colorectal cancer (CRC) could reveal biomarkers to help determine overall survival in people with a subgroup of CRCs who generally have better survival rates and, importantly, respond better to immune checkpoint therapy — a type of immunotherapy that releases restraints that cancer cells place on the immune response.

In a series of laboratory studies of genetic material taken from tubular adenomas (precancerous polyps in the colon) and colon tumors, the researchers linked cancer-specific transcription factor expression alterations to methylation alterations in CRCs and their premalignant precursor lesions, which provided insights into the origins and evolution of different molecular subtypes of CRCs. Specifically, researchers observed that some regions of the genome undergoing increased methylation tend to have binding sites for transcription factors that are downregulated or have low expression. In some types of colon cancer, based on the types of genetic alterations associated with the cancer, transcription factors are upregulated or have higher expression.

The findings suggest that cancer-specific methylation differences potentially evolve due to perturbation in the activity or expression of transcription factors. Similar changes in DNA methylation patterns were observed in precancerous polyps. These studies highlight that the transcription factor expression changes and corresponding DNA methylation changes are early events during tumor development. The specific set of transcription factors identified in the study may help in stratifying CRC prognosis.


31. Early-Onset/Young-Onset Colorectal Carcinoma: A Comparative Analysis of Morphological Features and Biomarker Profile (Jul.23/23)

A retrospective study conducted at the Department of Histopathology, Liaquat National Hospital, Karachi, Pakistan evaluated the clinicopathological parameters and biomarker profile of early-onset colorectal cancer (EO-CRC) and compared them with those of late-onset colorectal cancer (LO-CRC). A total of 254 biopsy-proven cases of CRC, reported over a period of nine years, were enrolled in the study.

The mean age at diagnosis was 46.27±17.75 years, with female predominance (59.8%). A significant difference between the two groups (EO-CRC and LO-CRC) was noted with respect to laterality, tumor site, tumor grade, tumor type, presence of pre-existing polyps, perineural invasion (PNI), lymphovascular invasion (LVI), and IHC markers. EO-CRC (as opposed to LO-CRC) significantly affected the left colon (92.6% vs. 72.9%), with the rectosigmoid being the most common site in the majority of cases (72.1% in EO-CRC vs. 61% in LO-CRC). EO-CRC showed a higher frequency of PNI and LVI than LO-CRC (42.6% vs. 23.7%, respectively).

A significantly higher proportion of EO-CRCs were mucinous (42.6%) and medullary carcinoma (11.8%). Although the majority (54.4%) of cases of EO-CRC were grade 2 tumors at the time of diagnosis, a significantly higher proportion of them were grade 3 (44.1%) compared with LO-CRC. IHC comparisons between the two age groups showed that a significantly higher proportion of cases of EO-CRC showed positive HER2/neu expression (27.1%) compared with LO-CRC (13.2%). Conversely, the loss of expression of microsatellite instability (MSI) markers was more commonly seen in LO-CRC compared with EO-CRC.


32. Second Primary CRC in Adults: a SEER Analysis of Incidence and Outcomes (Jul.26/23)

Prior to this study, there was no large epidemiological study exploring the actual incidence and survival of second primary colorectal cancer (spCRC). The different characteristics and survival of patients with spCRC and initial primary colorectal cancer (ipCRC) still need to be explained. In addition, the factors leading to different survival status of spCRC and ipCRC were still unclear. Thus, this study planned to explore the annual incidence trend of spCRC as well as the factors influencing the occurrence and survival outcome of spCRC.
This cohort study analyzed the data of 4680 spCRC patients and 330,937 ipCRC patients. Whether patients had spCRC and whether spCRC patients survived or died were regarded as outcomes. The annual incidence of spCRC from 2004 to 2016 was analyzed.

Findings showed the incidence of spCRC was decreased except in people with initial primary tumor grade IV and those aged 15–39 years. The overall survival of spCRC patients was lower than ipCRC patients. Cancer patients with older age, high tumor grade, TNM stage, and AJCC stage should be caution to the occurrence of spCRC and timely interventions should be provided for spCRC patients to improve their outcomes. The findings might also inform future targeted screening strategies among cancer survivors and suggested the need for long-term follow-up surveillance for cancer patients.


33. Functional Recovery and Quality of Life in Older Patients Undergoing CRC Surgery (Jul.13/23)

Results from the GOSAFE study reveal that most patients aged ≥ 70 years undergoing colorectal cancer (CRC) surgery showed maintained or improved quality of life and achieved functional recovery during follow-up. The study involved prospective data, collected between February 2017 and April 2019, for 625 patients, 435 had colon cancer and 190 had rectal cancer. Surgery was minimally invasive in 73% of all patients, including 74% of those with colon cancer and 71% of those with rectal cancer; palliative surgery was performed in only 5.5% of patients.

Equal or better quality of life was reported in 69.0% of patients (including 72.8% of those with colon cancer and 60.2% of those with rectal cancer) at 3 months after surgery, and in 70.3% of patients (including 72.9% of those with colon cancer and 63.9% with rectal cancer) at 6 months after surgery. Postoperative complications were associated with poorer quality of life at 3 months and 6 months.

Functional recovery was reported for 254 (78.6%) of 323 evaluable patients with colon cancer and 94 (70.6%) of 133 with rectal cancer. Factors associated with not achieving functional recovery included: age adjusted Charlson Comorbidity Index of ≥ 7; ECOG performance score of ≥ 2; severe postoperative complications; fTRST score of ≥ 2; and palliative surgery.

The investigators concluded that the majority of older patients experience good quality of life and [experience functional recovery] after CRC surgery. Predictors for failing to achieve these essential outcomes are now defined to guide patients’ and families’ preoperative counselling.


34. Are Inflammatory Bowel Disease Patients More at Risk of CRC? (Aug.9/23)

In a recent study published in the journal Frontiers in Medicine, researchers analyzed data from a large cohort of inflammatory bowel disease (IBD) patients and compared the risk and frequency of colorectal cancer (CRC) among these patients to that of the general population.

The investigation reaffirmed that individuals with ulcerative colitis (UC) and Crohn’s disease have a higher incidence of CRC than the general population. Additionally, individuals with CRC tend to be older, exhibit a higher incidence of associated health conditions, and experience a heightened mortality risk. While individuals with UC and diabetes mellitus (DM) were found to be more prone to developing CRC, this association was not observed in patients with Crohn’s disease. The CRC incidence rate in UC patients in the present study was 2.1%, which was lower than that in the Canadian study; however, inflammatory bowel disease patients still show higher CRC rates compared to the general population, which warrants more focused surveillance.

In terms of all-cause mortality, CRC considerably increased the death rate of inflammatory bowel disease patients, which was 44-50% compared to 9-12% in inflammatory bowel disease patients without CRC. The authors also found that individuals with CRC exhibit a higher prevalence of comorbid conditions compared to prior investigations.

Primary sclerosing cholangitis (PSC) was identified as a significant risk factor for CRC in patients with inflammatory bowel disease. A significant correlation was also found between the administration of glucocorticoid steroids, the presence of DM, and the development of CRC.
Glucocorticoids have been found to influence CRC through their ability to suppress the host immune system and affect the behavior of T cells. Notably, univariate analysis revealed a significant correlation between anti-TNF treatment and decreased risk of CRC among individuals with inflammatory bowel disease.

In conclusion, the authors identified several factors that could increase the risk of CRC development in patients with inflammatory bowel disease. Age at diagnosis, primary sclerosing cholangitis, use of glucocorticoids, and DM in patients with UC were the key risk factors for CRC in UC patients compared to the general population.

Image Source: https://www.ibdrelief.com/learn/what-is-ibd

35. EXercise for Cancer to Enhance Living Well (EXCEL) Study (Jul.11/23)

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

36. Skincare Tips while on Cetuximab or Panitumumab Treatment for CRC (Jul.28/23)

Amgen has collaborated with FUSE Health and Dr. Nathan Lamond (Medical Oncologist, Dalhousie University) to produce a 5-minute video on the importance of good skin hygiene for patients on EGFRi therapy. During this talk, Dr. Lamond discusses the importance of good skin care to help prevent or lessen skin side effects caused by certain cancer treatments such as cetuximab and panitumumab used to treat colorectal cancer (CRC). Dr. Lamond provides tips for protecting the skin and using appropriate soaps, cleansers, moisturizers, sunscreens, and lip balms.

To download and view the video:
https://fusehealth.sharefile.com/d-s2d0a0747b8154e368ed5219e5654421c

37. Seven Factors That Raise Your Risk of CRC if You're Under 50 (Aug.7/23)

Scientists have revealed the seven factors that put young men at a higher risk of colon cancer - as experts scramble to find what's causing a surge in the disease. Researchers from Indiana University analyzed electronic medical records of 3,000 men aged 35 to 49 years old — a fifth of whom were diagnosed with colon cancer. To determine who was most at risk for early onset colon cancer — when the cancer occurs before the age of 50 — researchers examined the medical records against 67 factors - including diet, smoking status, and whether the men took over-the-counter medications.
Among all of the factors, scientists found seven that significantly raised men’s risk. They were: being an older age (35 to 49 years old); alcohol use; a high insurance copay; having a first- or second-degree relative, such as a parent, sibling or aunt, with colon cancer; having a high disease burden, such as being a smoker; and not regularly using statins or non-steroidal anti-inflammatory drugs (NSAIDs), such as aspirin or ibuprofen.

Dr Thomas Imperiale, a gastroenterologist at the university and lead author on the study said the findings do not suggest all young men start to take NSAIDs or statins regularly because there is a risk of side effects, such as kidney damage. He suggested that most men should instead look at the other five factors to see which might increase their risk.

This study is important because it puts whether, and possibly how, to screen people who are younger than 45 years old on the table for consideration of screening. We know that colon cancer at younger ages is on the rise, although the absolute risk is still much lower even in the 45- to 54-year-old age group. Nonetheless, that doesn’t mean that we shouldn’t be trying to identify younger people at higher risk to screen them.


COV1D-19 Updates

38. The Impact of COVID-19 on CRC Screening and Outcomes (Jul.24/23)

Scientists looked at screening programs for colorectal cancer (CRC) from 29 countries worldwide and examined participation rates and changes in screening practices in 2020 because of the COVID-19 pandemic.

In countries with participation data for 2020, the model results showed reduced CRC screening. The reduction ranged from just above 1% to 40%. There were over seven million fewer fecal screening tests for CRC in 2020 globally. About 40% of the deficit occurred in countries with organized screening vs. the rest in countries where screening data was unavailable. The decreased participation in screening would result in over 10,500 CRC diagnoses in 2020. These would be caught possibly in more advanced stages of the disease or during later screening rounds.

If catch-up screening were not carried out in 2021, this would mean 13,000 more cases of CRC and almost 8,000 more deaths than expected between 2020 and 2050. On the other hand, these figures would be lowered by nearly 80% and 85%, respectively, by such compensatory screening programs. Conversely, the scientists found that catch-up screening would reduce cases and mortality by 73–88% and 81–94%, respectively.

Despite the administrative difficulties of catch-up screening, it is important to prioritize it in view of the loss of human health and lives. For instance, the scientists found that mass media campaigns could be expensive and cost-effective in bringing more people into the screening net, thus avoiding unnecessary deaths from CRC. Overall, such modelling studies could help improve policies to reduce the impact of large-scale disruptions such as those caused by the COVID-19 pandemic.


39. 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 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 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-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.

https://www.who.int/news-room/q-a-detail/q-a-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 @CDCofBC
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 @govnlsocial
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