



## **WHAT PCPS NEED TO KNOW:** Update on Colorectal Cancer Screening, Comprehensive Treatment Options

Initiation of colon cancer screening is recommended by age 50 for average risk individuals. Screening may be indicated at a younger age for high risk individuals, such as those with a family history of colon cancer or certain hereditary syndromes. While the American Cancer Society now suggests initiation of colon cancer screening at age 45 for all average risk individuals, MD Anderson Cancer Center and the major gastroenterology societies (American Gastroenterological Association, American College of Gastroenterology, and American Society for Gastrointestinal Endoscopy) continue to follow the existing guidelines.

The American Cancer Society's screening suggestion may be in part a response to one analysis that showed an increase in new cases of colorectal cancer among younger adults.

"The analysis showed an increase in new cases of colorectal cancer among younger adults," says Tara Lautenslager, MD, a gastroenterologist at Cooper's Digestive Health Institute. Notably, the proportion of cases diagnosed in individuals under age 50 nearly doubled between 1990 and 2013, going from 6% to 11% in that time. Most of these diagnoses (72%) were people in their forties.

"The reasons behind this upward trend aren't totally defined yet, but obesity—an independent risk factor for numerous types of cancer—probably plays a role," she says.

However, the vast majority—90%—of colorectal cancer cases still occur in older adults, so screening in this population remains imperative.

**"Colon cancer is preventable by performing colonoscopy and removing precancerous polyps."**

In addition to obesity, there are a number of lifestyle factors that contribute to polyp growth and potential development of colon cancer, including cigarette smoking, excessive alcohol consumption, and a diet high in animal fat and/or low in antioxidants. Primary care physicians have the opportunity to counsel patients on these modifiable risk factors as well as initiation of screening.

Aside from colonoscopy, there are additional screening options available—giving individuals more choices for early detection.



**Tara Lautenslager, MD**  
Gastroenterologist Cooper Digestive Health Institute

"For patients who don't want to undergo colonoscopy—they wish to avoid sedation or the prep, for example, or can't take the required time off from work—stool tests are approved options that respect individual preference," she says. These tests include an annual highly sensitive fecal immunochemical test (FIT), CT colonography, and Cologuard, the only FDA-approved test that detects colorectal neoplasia-associated DNA markers and the presence of occult hemoglobin in human stool.

If these tests detect an abnormality, prompt follow-up with colonoscopy is then indicated. When appropriate, a technique called chromoendoscopy, in which dyes or stains are used during colonoscopy to enhance tissue differentiation, may be used.

*continued on page 2*

“Colon cancer is preventable by performing colonoscopy and removing precancerous polyps,” Dr. Lautenslager continues. “And with early diagnosis, it’s also treatable.”

“But the greatest responsibility for prevention and early detection falls to primary care physicians,” says Steven McClane, MD, FACS, FASCRS, Head, Division of Colorectal Surgery and Co-Director, Gastrointestinal Cancer Program. “They’re on the front lines of patient care, and we rely on them to be aware of their patients’ family history, listen to patient complaints about abdominal pain, rectal bleeding, or changes in bowel habits, and get them referred to us for a diagnostic workup.

“And don’t dismiss these issues in younger patients,” he urges.

When colon, rectal, or anal cancer is detected, treatment obviously depends on the type and stage of the malignancy. This is where MD Anderson Cancer Center at Cooper’s multidisciplinary approach to treatment proves invaluable.

“Patients are able to see all the different providers they need

during a single visit,” Dr. McClane says. “Our team includes colorectal surgeons, radiation oncologists, medical oncologists, geneticists, social workers, dietitians, even a liver surgeon, if needed for metastatic disease.

“We all see the patient, then share our expertise to formulate a care plan before we give our recommendation to the patient,” he continues. “It’s an approach that only a major cancer center, with all these resources, can offer. And it makes a real difference in patient outcomes.”

Surgical resection is the most common treatment for colorectal cancer, and MD Anderson at Cooper offers both laparoscopic and robotically assisted options.

“Patients generally have better outcomes with these minimally invasive approaches since their hospital stays are shorter, the incisions are smaller, and there are fewer complications than with open surgery,” Dr. McClane says.

In addition, the entire colorectal surgery team adheres to enhanced recovery after surgery (ERAS) protocols. These are patient-centered, evidence-based pathways to reduce patients’



**Steven McClane, MD, FACS, FASCRS**  
Head, Division of Colorectal Surgery  
Co-Director, Gastrointestinal Cancer Program

surgical stress response, optimize their physiologic function, and speed recovery.

Other leading-edge treatment options for colorectal cancer include external beam, stereotactic and intraoperative radiation therapy; chemoradiation; and systemic therapies including chemotherapy, immunotherapies, and targeted therapies (the latter includes anti-angiogenesis treatments, epidermal growth factor receptor inhibitors, and tumor-agnostic treatment that focuses on a specific genetic change called an NTRK fusion).

“To have a patient come to our cancer center as soon as they’re diagnosed can make a real difference,” Dr. McClane says. •

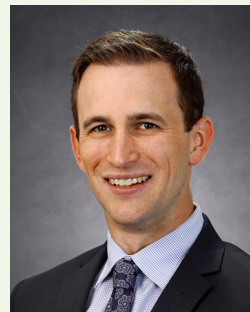
## Welcome New Physicians



**Young Ki Hong, MD, MPH**  
Surgical Oncology and  
Hepatobiliary Surgeon  
Department of Surgery



**Kinjal Kiran Dargan, MD**  
Attending Physician  
Division of Hematology/  
Medical Oncology



**Gary Eastwick, MD**  
Attending Physician  
Department of Radiation Oncology



**Danica Giugliano, MD**  
Colorectal Surgeon  
Department of Surgery



## ESOPHAGEAL AND PANCREATIC CANCERS: Advances in Screening Guidelines, Treatments

Esophageal and pancreatic cancers remain among the malignancies with the poorest survival rates, due largely to a lack of effective screening options. As a result, many of these cancers are detected at later stages, when treatment options are limited and the prognosis is grimmer. Notably, an estimated 85 percent of esophageal cancers are diagnosed at stages 3 or 4, while 45 to 55 percent of pancreatic cancers are diagnosed after the disease has metastasized.

In this article, two MD Anderson Cancer Center at Cooper experts discuss recent advances in screening and treatment aimed at improving outcomes for these malignancies.



**David Shersher, MD**  
Co-Director, MD Anderson Cancer Center  
at Cooper Aerodigestive Program

### Esophageal Cancer

“When it comes to screening for esophageal cancer, there is no consensus among the half-dozen or so relevant professional societies,” says thoracic surgeon David Shersher, MD, Co-Director of the MD Anderson at Cooper Aerodigestive Program. “All of the recommendations differ, so there really are no universal screening guidelines.

“Most groups do recommend screening based on the presence or absence of Barrett’s esophagus—potentially precancerous changes to the esophagus related to chronic reflux disease,” he continues, noting that about one-third of high-risk Barrett’s patients can progress to developing cancer.

“But for the portion of the general public that has significant reflux disease, the real question is which patients will progress to develop Barrett’s, and which of these will progress to develop esophageal malignancies,” he says. “Our program seeks to capture these cases earlier, leading to a significant improvement in survival.”

To that end, MD Anderson at Cooper has adopted these screening guidelines:

- Patients with esophagitis should undergo initial endoscopy; if there is no dysplasia, subsequent endoscopic screening every two years is recommended.
- If patients have Barrett’s esophagus, they should undergo annual endoscopy for low-grade dysplasia, or more often if there is something concerning.
- If the patient is in active treatment for high-grade dysplasia, an appropriate endoscopic screening schedule is tailored to the individual patient.

“Our program seeks to capture these cases earlier, leading to a significant improvement in survival.”

He urges community physicians to be aware of the risks of reflux disease.

“This is not a benign condition,” he says, “and patients with medically refractory gastroesophageal reflux disease (GERD) are a particularly difficult patient population to manage. We want to work with

primary care physicians to ensure not just good screening and aerodigestive health, but also identify which patients are at risk of progressing to Barrett’s or esophageal cancer.

“For these patients, lifetime proton pump inhibitors (PPIs) or antacid therapy is not enough,” Dr. Shersher says. “But surgeries such as robotically assisted fundoplication or hernia reductions can provide symptom relief and reduce the risk of disease progression.”

The newest technology for treating intractable GERD is the LINX® Reflux Management System. It consists of a small band of magnetized titanium beads wrapped around the lower esophageal sphincter (LES); this helps prevent gastric acids from refluxing from the stomach into the esophagus while also safely allowing the LES to open for swallowing. MD Anderson at Cooper is the only facility in South Jersey performing this minimally invasive procedure.

For patients with Barrett’s esophagus (either low- or high-grade dysplasia), Dr. Shersher notes that there have been significant

advances in interventional endoscopic treatments, including radiofrequency ablation and endoscopic mucosal resection.

Once a diagnosis of esophageal cancer is confirmed, treatment may include endoscopic surgery to remove small tumors, or open esophagectomy or esophagogastrectomy for more advanced malignancies, along with chemotherapy and/or radiation therapy.

“Esophageal cancer is one of the few cancers continuing to rise in the U.S., and we need to come together to treat it in a more targeted fashion,” Dr. Shersher says. “With a dedicated multidisciplinary team, we’re here to help do just that.”

#### Pancreatic Cancer

“Screening is a challenge for pancreatic cancer,” states Francis Spitz, MD, Vice Chief, Department of Surgery, and Head, Division of General Surgery. In fact, because no screening test has been shown to lower the risk of dying from this cancer, no major professional groups recommend routine screening for it in people who are at average risk.

“But at MD Anderson at Cooper we’ve developed a screening program for patients who are at high risk of developing pancreatic cancer, that evaluates family history and genetic risks,” he continues, noting that the program mirrors the one developed at MD Anderson Cancer Center in Houston.

“High risk is defined as having two first-degree relatives with

pancreatic cancer, or a single first-degree relative with a genetic abnormality,” Dr. Spitz says. Inherited gene mutations have been linked to as many as 10 percent of pancreatic cancers; these mutations include hereditary breast and ovarian cancer syndrome caused by mutations in the BRCA1 or BRCA2 genes; familial atypical multiple mole melanoma (FAMMM) syndrome; familial pancreatitis; Lynch syndrome; Peutz-Jeghers syndrome; and Von-Hippel Lindau syndrome.

“These are all complex surgeries that are best performed in a high-volume center, which we are.”

“For high-risk patients, we use MRI and endoscopic ultrasound to evaluate and screen for early pancreatic lesions,” Dr. Spitz says.

When pancreatic cancer is detected, surgical options include minimally invasive and traditional open Whipple procedure (pancreaticoduodenectomy), and partial and distal pancreatectomy.

“These are all complex surgeries that are best performed in a high-volume center, which we are,” Dr. Spitz notes. In fact, MD Anderson at Cooper is the top provider of pancreatic surgery in the state.

In addition, MD Anderson at Cooper adheres to enhanced recovery after



**Francis Spitz, MD**

Vice Chief, Department of Surgery Head, Division of General Surgery

surgery (ERAS) protocols, which are perioperative care pathways designed to hasten recovery by maintaining preoperative organ function and reducing the body’s stress response following surgery.

“This approach ensures good nutritional support in the perioperative period, utilization of non-narcotic medications, early mobilization, and early feeding,” Dr. Spitz says. “The goal is to shorten length of stay and enhance the patient’s return to a normal lifestyle. In a national database, our outcomes in this regard put us in the high-performance category.”

He also notes that preoperative chemotherapy (neoadjuvant therapy) is becoming a more standard approach—one that’s been used at MD Anderson in Houston for several years, and which has been adopted at MD Anderson at Cooper.

“Patients can often tolerate chemotherapy better before surgery than after,” he says. “In patients treated this way, we’re seeing median survival, five-year survival, and overall survival rates that are better.” •

For more information or to refer a patient to the Aerodigestive Program or Gastrointestinal Cancer Center at MD Anderson at Cooper, please call

**855.MDA.COOPER (855.632.2667)**





## NEW DEDICATED PROGRAM FOR RARE CANCERS Provides Focused Multispecialty Expertise

The National Cancer Institute defines rare cancers as those that occur in fewer than 15 out of 100,000 people each year. Due to their rarity, they are often more difficult to prevent, diagnose, and treat than more common malignancies. Furthermore, because of the few number of cases, research is challenging—and limited.

Through its newly established Rare Cancers Program, MD Anderson Cancer Center at Cooper aims to give patients an edge when it comes to dealing with these diseases, which include most cancers of the oral cavity and pharynx, as well as certain brain and central nervous system, digestive, respiratory, genitourinary, and bone and soft tissue malignancies also known as sarcomas.

Orthopaedic oncologist Tae Won B. Kim, MD, the program's director, explains its genesis: "We were seeing a significant number of rare cancers, and because these patients require specialized resources, we felt that a dedicated, highly coordinated program could offer these patients optimal care," he says.

The clinical resources offered through MD Anderson at Cooper's Rare Cancers Program are extensive, starting with a multidisciplinary team ranging from medical oncologists, surgeons, pathologists, and radiation oncologists.

"We have pathologists who specialize in the analysis of all types of tumors, and they are able

to perform molecular profiling and other special testing of the latest genetic markers," he says, noting that these sophisticated capabilities enable faster, more efficient diagnoses of cancers that, in less-experienced hands, can be notoriously difficult to diagnose—thereby delaying time to treatment.

The program also is able to give patients access to a comprehensive array of treatment options, including standard chemotherapy, radiation, and surgical oncology, as well as the latest immunotherapies and targeted drug regimens that are specific to a patient's cancer.

**"We were seeing a significant number of rare cancers, and because these patients require specialized resources, we felt that a dedicated, highly coordinated program could offer these patients optimal care."**

MD Anderson at Cooper's partnership with MD Anderson Cancer Center in Houston, Texas, also provides a distinct advantage.

"Through our partnership with one of the nation's leading cancer centers, we can call upon our colleagues in Houston, who may have considerable experience dealing with a particular types of



**Tae Won B. Kim, MD**  
Director, Rare Cancers Program

rare cancers—consulting with them to determine the best course of treatment," Dr. Kim notes. "We don't have to reinvent the wheel with a new protocol."

In addition, through its robust clinical trial offerings—including those in Houston—MD Anderson at Cooper can offer South Jersey patients novel treatments before they are widely available.

A hallmark of the Cooper Rare Cancers Program is a patient-centric care model in which patients are seen at their initial visit by all of the appropriate specialists they may require.

"The care team is assembled based on each patient's individual needs, and the various disciplines come to the patient instead of the patient having to visit different specialists on different days," Dr. Kim says. "This approach facilitates the advanced care coordination these patients need because their disease is so rare and unusual, and enables the best minds to come together to discuss the patient's care plan.

"This is important because the standard of care often isn't well defined for rare tumors," he adds. "And it helps patients walk away

*continued on page 6*

from their initial visit with a clearer understanding of their disease and what their treatment will entail, as well as the confidence in knowing that an entire team is working collectively and collaboratively on their behalf.”

Supportive-care services are also an integral component of the Rare Cancers Program. These services include nutrition counseling, complementary medicine therapies, palliative care, financial counseling, and social work.

Equally important, the program has dedicated nurse navigators to help guide patients through the diagnosis and treatment process in a “meaningful, thoughtful way,” Dr. Kim notes. “It is also designed to facilitate patients in receiving care as quickly as possible. Ideally, we would have patients come in to see specialists less than a week from the time a referral is made.”

“Rare cancers can be some of the most difficult and unusual cases a community physician may encounter,” he adds. “We’re here to help them tackle these cases by offering a multidisciplinary approach that is expeditious and gives their patients the best possible treatment based on the latest scientific knowledge.” •

## The Rare Cancers We See

While the NCI defines rare cancers as those with fewer than 15 cases per 100,000 people per year, collectively they are relatively common—with one in five cancers diagnosed in the U.S. considered a rare cancer. We see the full range of these cancers, including:

### Bone and Soft tissue

- Bone sarcomas
- Soft-tissue sarcomas
- Complex pelvic tumors including metastases

### Oral cavity & pharynx

- Lip
- Tongue
- Salivary gland
- Floor of mouth
- Gum and other mouth tissue
- Nasopharynx
- Nose, nasal cavity and middle ear
- Tonsil
- Larynx
- Oropharynx
- Hypopharynx

### Brain & central nervous system

- Meninges
- Brain
- Spinal cord, cranial nerves and other parts of CNS
- Pituitary gland
- Pineal gland

### Digestive system

- Small intestine
- Anus, anal canal and anorectum
- Gallbladder
- Retroperitoneum, peritoneum, omentum and mesentery

### Respiratory system

- Trachea, mediastinum

### Genitourinary system

- Penis
- Testis
- Ureter

### Gynecologic

- Vagina
- Vulva

### Breast

- Male breast cancer
- Inflammatory breast cancer

### Other rare cancers

- Soft tissue, including heart

For more information or to refer a patient to the Rare Cancers Program at MD Anderson at Cooper, please call

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**(855.632.2667)**

In the next issue of

# Clinical Update

MD Anderson at Cooper specialists will discuss:

- Inflammatory breast cancer
- Advances in radiation therapy
- Cancer genetics: Empowering personalized care