

0:00:00 -> 0:00:02.85 Support for Yale Cancer Answers  
0:00:02.85 -> 0:00:05.13 comes from AstraZeneca, dedicated  
0:00:05.13 -> 0:00:09.192 to advancing options and providing  
0:00:09.192 -> 0:00:13.447 hope for people living with  
0:00:13.447 -> 0:00:14.298 cancer. More information at [astrazeneca-us.com](http://astrazeneca-us.com).  
0:00:14.3 -> 0:00:16.502 Welcome to Yale Cancer Answers with  
0:00:16.502 -> 0:00:18.72 your host, Doctor Anees Chagpar.  
0:00:18.72 -> 0:00:20.57 Yale Cancer Answers features the  
0:00:20.57 -> 0:00:23.115 latest information on cancer care by  
0:00:23.115 -> 0:00:24.807 welcoming oncologists and specialists  
0:00:24.807 -> 0:00:27.084 who are on the forefront of the  
0:00:27.084 -> 0:00:29.026 battle to fight cancer. This week  
0:00:29.026 -> 0:00:30.518 it's a conversation about  
0:00:30.518 -> 0:00:32.01 neuroendocrine tumors in colon  
0:00:32.072 -> 0:00:33.797 cancer with Doctor Pamela Kunz.  
0:00:33.8 -> 0:00:36.194 Doctor Kunz is director of GI Medical  
0:00:36.194 -> 0:00:38.271 Oncology at the Yale School of  
0:00:38.271 -> 0:00:40.245 Medicine where Doctor Chagpar is  
0:00:40.245 -> 0:00:42.64 a professor of surgical oncology.  
0:00:43.74 -> 0:00:46.236 Pam, maybe we can start off  
0:00:46.236 -> 0:00:47.9 by setting the context?  
0:00:47.9 -> 0:00:49.66 What exactly are neuroendocrine  
0:00:49.66 -> 0:00:52.3 tumors and what do they have  
0:00:52.378 -> 0:00:54.138 to do with colon cancer?  
0:00:55.47 -> 0:00:56.232 Great question.  
0:00:56.232 -> 0:00:57.756 So neuroendocrine tumors are  
0:00:57.756 -> 0:00:59.75 just another type of cancer.  
0:00:59.75 -> 0:01:01.67 They can originate actually in  
0:01:01.67 -> 0:01:04.03 almost any part of the body,  
0:01:04.03 -> 0:01:06.358 most commonly in the GI tract  
0:01:06.36 -> 0:01:09.248 and in the lungs and what makes them

0:01:09.248 -> 0:01:11.852 different from colon cancer is what the  
0:01:11.852 -> 0:01:14.53 cells look like under the microscope.  
0:01:14.53 -> 0:01:16.57 So it's actually a completely different  
0:01:16.57 -> 0:01:19.199 type of cancer than colon adenocarcinoma,  
0:01:19.2 -> 0:01:21.14 which is the most common  
0:01:21.14 -> 0:01:22.692 type of colon cancer.  
0:01:23.76 -> 0:01:25.324 So these neuroendocrine tumors  
0:01:25.324 -> 0:01:27.67 they can arise in the colon,  
0:01:27.67 -> 0:01:30.407 which would make them a colon cancer.  
0:01:30.41 -> 0:01:33.14 But they look different under the microscope.  
0:01:33.14 -> 0:01:35.486 So they're not exactly the same  
0:01:35.49 -> 0:01:37.054 garden variety colon cancer  
0:01:37.054 -> 0:01:39.009 that we usually think about?  
0:01:39.72 -> 0:01:42.786 That's correct, and so we would call  
0:01:42.786 -> 0:01:45.318 those a neuroendocrine tumor of the  
0:01:45.318 -> 0:01:47.592 colon and what's unique about these  
0:01:47.592 -> 0:01:50.595 is that we try our best to  
0:01:50.595 -> 0:01:52.476 identify where these cancers start,  
0:01:52.476 -> 0:01:54.048 because that has implications  
0:01:54.048 -> 0:01:56.479 on how we treat that cancer.  
0:01:56.48 -> 0:01:59.266 So they may start in the colon,  
0:01:59.27 -> 0:02:02.056 which is in fact actually quite rare.  
0:02:02.06 -> 0:02:03.736 Most commonly, they'll originate  
0:02:03.736 -> 0:02:06.25 in the small intestines in the  
0:02:06.32 -> 0:02:08.05 pancreas and in the lungs,  
0:02:08.05 -> 0:02:10.948 and they can spread to lymph nodes  
0:02:10.95 -> 0:02:12.61 or to the liver.  
0:02:12.61 -> 0:02:14.685 And so when someone says  
0:02:14.685 -> 0:02:16.998 they have a colon cancer,  
0:02:17 -> 0:02:19.155 we often just assume that  
0:02:19.155 -> 0:02:20.448 that's colon adenocarcinoma.

0:02:20.45 -> 0:02:23.048 The garden variety, as you said.  
0:02:23.05 -> 0:02:25.619 But what's very important is that we  
0:02:25.619 -> 0:02:28.753 rely on our pathologists to tell us  
0:02:28.753 -> 0:02:31.687 exactly what histologic type, that means,  
0:02:31.69 -> 0:02:34.084 what the cancer cells look like  
0:02:34.084 -> 0:02:36.227 under the microscope to determine  
0:02:36.227 -> 0:02:39.029 whether it's an adenocarcinoma or a  
0:02:39.03 -> 0:02:40.398 neuroendocrine tumor.  
0:02:40.398 -> 0:02:42.45 Let's talk a little bit more  
0:02:42.516 -> 0:02:44.116 about how that process actually  
0:02:44.116 -> 0:02:46.229 happens and what the big deal is.  
0:02:46.23 -> 0:02:47.982 I mean, for many people they  
0:02:47.982 -> 0:02:49.958 may think a cancer is a cancer,  
0:02:49.96 -> 0:02:51.969 and I don't want  
0:02:51.97 -> 0:02:53.686 neuroendocrine cancers.  
0:02:53.69 -> 0:02:55.12 I don't want this cancers,  
0:02:55.12 -> 0:02:57.129 and I don't want that cancer,  
0:02:57.13 -> 0:02:58.57 I just don't want cancer.  
0:02:58.57 -> 0:03:01.769 I'm beginning to sound like Doctor Seuss.  
0:03:01.77 -> 0:03:06.664 But how do we differentiate between an  
0:03:06.664 -> 0:03:09.46 adenocarcinoma and a neuroendocrine tumor?  
0:03:09.46 -> 0:03:12.95 And why is that important?  
0:03:14.49 -> 0:03:17.89 So when a patient first develops  
0:03:17.89 -> 0:03:20.238 symptoms that may bring them to,  
0:03:20.24 -> 0:03:22.295 for example, their primary care  
0:03:22.295 -> 0:03:23.939 doctor or a gastroenterologist,  
0:03:23.94 -> 0:03:27.132 some of the symptoms may in fact  
0:03:27.132 -> 0:03:29.607 overlap between having any sort of  
0:03:29.607 -> 0:03:32.57 cancer of the colon or the GI tract.  
0:03:32.57 -> 0:03:34.934 They may have abdominal pain or  
0:03:34.934 -> 0:03:37.1 changes in their bowel habits,

0:03:37.1 -> 0:03:39.97 and then they may undergo a biopsy.  
0:03:39.97 -> 0:03:42.847 That biopsy could be through a colonoscopy,  
0:03:42.85 -> 0:03:45.43 or, if the cancer has spread  
0:03:45.43 -> 0:03:47.5 somewhere else it may be  
0:03:47.5 -> 0:03:49.57 a biopsy of that spot,  
0:03:49.57 -> 0:03:52.433 like a biopsy of the liver and  
0:03:52.433 -> 0:03:54.539 once that biopsy is taken,  
0:03:54.54 -> 0:03:56.892 that tissue, the tumor tissue  
0:03:56.892 -> 0:03:59.803 goes to a pathologist as a  
0:03:59.803 -> 0:04:02.329 doctor that specializes in looking at  
0:04:02.329 -> 0:04:05.304 cells under the microscope to help us  
0:04:05.304 -> 0:04:08.5 determine exactly what type of cancer it is,  
0:04:08.5 -> 0:04:12.339 they will look at what the cells look like.  
0:04:12.34 -> 0:04:14.878 They will also do very special  
0:04:14.878 -> 0:04:17.46 stains to help us identify  
0:04:17.46 -> 0:04:19.51 certain characteristics of those cells,  
0:04:19.51 -> 0:04:21.56 and it matters because every  
0:04:21.56 -> 0:04:23.2 cancer is treated differently.  
0:04:23.2 -> 0:04:25.664 We now have large clinical trials that  
0:04:25.664 -> 0:04:29.421 tell us one cancer may do better with a  
0:04:29.421 -> 0:04:31.81 different chemotherapy versus another,  
0:04:31.81 -> 0:04:34.715 and so it's very critical in fact  
0:04:34.715 -> 0:04:37.04 to determine what type of cancer  
0:04:37.04 -> 0:04:39.96 that is in order for us to tailor  
0:04:39.96 -> 0:04:42.465 that treatment to the patient.  
0:04:43.75 -> 0:04:46.3 And also you know,  
0:04:46.3 -> 0:04:49.7 I think going back to what you had  
0:04:49.7 -> 0:04:52.25 said earlier, the cell of origin  
0:04:52.25 -> 0:04:54.375 for these cancers is different.  
0:04:54.38 -> 0:04:57.348 So for adenocarcinomas as you mentioned,  
0:04:57.35 -> 0:05:00.241 those are cancers that arise in the

0:05:00.241 -> 0:05:03.299 colon in the glands of the colon,  
0:05:03.3 -> 0:05:05 whereas these neuroendocrine tumors  
0:05:05 -> 0:05:07.125 they may arise somewhere else.  
0:05:07.13 -> 0:05:09.59 Now do normal endocrine tumors that  
0:05:09.59 -> 0:05:12.174 you mentioned that can arise most  
0:05:12.174 -> 0:05:14.344 commonly in the small intestine,  
0:05:14.35 -> 0:05:17.146 or the pancreas or the lung.  
0:05:17.15 -> 0:05:19.586 Do those metastasize to the colon,  
0:05:19.59 -> 0:05:22.032 or when you find a neuroendocrine  
0:05:22.032 -> 0:05:23.66 tumor of the colon,  
0:05:23.66 -> 0:05:26.096 is it generally a neuroendocrine tumor,  
0:05:26.1 -> 0:05:28.949 albiet rare that started in the colon?  
0:05:28.95 -> 0:05:31.4 Usually we label these  
0:05:31.4 -> 0:05:33.43 based on where they start,  
0:05:33.43 -> 0:05:36.279 so if we're calling it a colon,  
0:05:36.28 -> 0:05:38.315 neuroendocrine tumor or a small  
0:05:38.315 -> 0:05:39.536 intestine neuroendocrine tumor,  
0:05:39.54 -> 0:05:41.964 that's because we believe they started  
0:05:41.964 -> 0:05:44.419 in those places and they start,  
0:05:44.42 -> 0:05:46.315 you're absolutely right from cells  
0:05:46.315 -> 0:05:48.738 that are different from these glandular  
0:05:48.738 -> 0:05:50.586 cells that an adenocarcinoma  
0:05:50.59 -> 0:05:51.814 originate from neuroendocrine  
0:05:51.814 -> 0:05:53.038 cells are unique.  
0:05:53.04 -> 0:05:55.075 They happened to be scattered  
0:05:55.075 -> 0:05:56.296 throughout the body.  
0:05:56.3 -> 0:05:57.932 They share features of  
0:05:57.932 -> 0:05:59.564 some typical cancer cells,  
0:05:59.57 -> 0:06:01.748 but one thing that makes them  
0:06:01.748 -> 0:06:04.213 unique is that some of them  
0:06:04.213 -> 0:06:06.089 can actually secrete hormones.

0:06:06.09 -> 0:06:08.946 That's how they get their name endocrine.  
0:06:08.95 -> 0:06:11.17 And so these cancers that  
0:06:11.17 -> 0:06:13.44 originate in the small intestine,  
0:06:13.44 -> 0:06:14.292 for example,  
0:06:14.292 -> 0:06:16.422 sometimes can secrete a hormone  
0:06:16.422 -> 0:06:18.586 called serotonin that can cause  
0:06:18.586 -> 0:06:20.616 things like diarrhea and flushing.  
0:06:20.62 -> 0:06:23.254 And some of the pancreatic neuroendocrine  
0:06:23.254 -> 0:06:26.259 cancers can secrete other types of hormones,  
0:06:26.26 -> 0:06:27.14 for example,  
0:06:27.14 -> 0:06:27.58 insulin,  
0:06:27.58 -> 0:06:31.04 that can make your blood sugar quite low.  
0:06:31.04 -> 0:06:33.77 So it's a combination of  
0:06:33.77 -> 0:06:36.011 things that helps us eventually  
0:06:36.011 -> 0:06:37.975 lead to that diagnosis,  
0:06:37.98 -> 0:06:38.41 and  
0:06:38.41 -> 0:06:41.02 then tailor that treatment and so  
0:06:41.02 -> 0:06:44.521 if a patient were to present and they  
0:06:44.521 -> 0:06:48.167 go and they have a colonoscopy and they  
0:06:48.167 -> 0:06:51.519 have a biopsy and the biopsy shows  
0:06:51.52 -> 0:06:54.052 a neuroendocrine origin is it likely  
0:06:54.052 -> 0:06:56.32 that started in neuroendocrine  
0:06:56.32 -> 0:06:58.85 cells of the colon itself?  
0:06:58.85 -> 0:07:01.834 Or does this prompt then a little search  
0:07:01.834 -> 0:07:04.122 to see whether that neuroendocrine  
0:07:04.122 -> 0:07:07.517 tumor that was found in the colon  
0:07:07.597 -> 0:07:10.297 actually came from somewhere else,  
0:07:10.3 -> 0:07:13.018 or how common would that be  
0:07:13.018 -> 0:07:16.25 for it to migrate to the colon?  
0:07:16.25 -> 0:07:19.746 Many of our listeners may know that garden  
0:07:19.746 -> 0:07:22.658 variety colon cancer goes other places.

0:07:22.66 -> 0:07:25.69 It goes to the liver and  
0:07:25.69 -> 0:07:27.946 so on and so forth.  
0:07:27.95 -> 0:07:29.45 But do these neuroendocrine  
0:07:29.45 -> 0:07:30.95 tumors that may start,  
0:07:30.95 -> 0:07:33.206 for example, in the small bowel,  
0:07:33.21 -> 0:07:35.09 end up in the colon?  
0:07:35.97 -> 0:07:37.9 That would be very unusual.  
0:07:37.9 -> 0:07:39.81 They would more commonly spread  
0:07:39.81 -> 0:07:42.52 to lymph nodes and to the liver,  
0:07:42.52 -> 0:07:44.44 but to your original question,  
0:07:44.44 -> 0:07:46.63 we do something called a staging  
0:07:46.63 -> 0:07:49.688 work up really at the time anyone is  
0:07:49.688 -> 0:07:51.968 diagnosed with any sort of cancer  
0:07:52.043 -> 0:07:54.407 that helps us determine the extent  
0:07:54.407 -> 0:07:56.76 of the cancer where perhaps has  
0:07:56.76 -> 0:07:58.685 the cancer spread anywhere else.  
0:07:58.69 -> 0:08:02.01 We do that by using a CTE or a CAT  
0:08:02.117 -> 0:08:05.733 scan that helps us look at the chest,  
0:08:05.74 -> 0:08:07.89 the abdomen and the pelvis.  
0:08:07.89 -> 0:08:10.648 For other areas of cancer we will  
0:08:10.648 -> 0:08:13.307 also sometimes do blood work that  
0:08:13.307 -> 0:08:15.627 includes looking at blood tests,  
0:08:15.63 -> 0:08:17.338 cell counts, liver tests,  
0:08:17.338 -> 0:08:20.83 kidney tests to also see if there is  
0:08:20.83 -> 0:08:23.368 any other effect on other organs,  
0:08:23.37 -> 0:08:24.23 and so  
0:08:24.23 -> 0:08:26.065 you'll do this regardless of  
0:08:26.065 -> 0:08:27.9 whether they presented with a  
0:08:27.967 -> 0:08:30.427 neuroendocrine tumor or whether they  
0:08:30.427 -> 0:08:32.395 presented with an adenocarcinoma?  
0:08:32.4 -> 0:08:34.98 That's correct, yes

0:08:34.98 -> 0:08:38.704 and  
0:08:38.71 -> 0:08:42.262 kind of getting back to where we started  
0:08:42.262 -> 0:08:45.419 in terms of patient presentation,  
0:08:45.42 -> 0:08:48.51 you had mentioned that neuroendocrine tumors,  
0:08:48.51 -> 0:08:52.129 because they tend to secrete these hormones,  
0:08:52.13 -> 0:08:56.176 they can present with symptoms of diarrhea  
0:08:56.176 -> 0:08:59.868 and flushing and so on and so forth.  
0:08:59.87 -> 0:09:03.14 Whereas many colon cancers actually  
0:09:03.14 -> 0:09:05.756 may be completely asymptomatic  
0:09:05.76 -> 0:09:07.89 often because we have screening,  
0:09:07.89 -> 0:09:10.02 For our listeners,  
0:09:10.02 -> 0:09:12.582 there was an update to the  
0:09:12.582 -> 0:09:14.29 screening guidelines for colon  
0:09:14.367 -> 0:09:16.839 cancer that was recently put out.  
0:09:16.84 -> 0:09:19.39 Do you want to tell us  
0:09:19.39 -> 0:09:21.946 a little bit more about that?  
0:09:21.95 -> 0:09:22.754 Yes, definitely,  
0:09:22.754 -> 0:09:25.568 and I think that's also another key  
0:09:25.568 -> 0:09:27.907 between the garden variety,  
0:09:27.91 -> 0:09:29.886 colon adenocarcinoma and neuroendocrine  
0:09:29.886 -> 0:09:33.3 tumors is that there are precursors or  
0:09:33.3 -> 0:09:35.18 pre cancers to colon adenocarcinoma  
0:09:35.18 -> 0:09:37.41 that we can detect as polyps.  
0:09:37.41 -> 0:09:40.917 So small little growths within the colon,  
0:09:40.92 -> 0:09:44.077 we can detect and remove and prevent  
0:09:44.077 -> 0:09:48.233 cancer and the way we do that is through  
0:09:48.233 -> 0:09:51.301 colonoscopies and so last week the  
0:09:51.301 -> 0:09:54.805 large guidelines body called the United  
0:09:54.805 -> 0:09:57.528 States Preventive Services Task Force,  
0:09:57.528 -> 0:10:00.108 a large organization that  
0:10:00.11 -> 0:10:02.14 helps determine guidelines for screening,



0:10:02.14 -> 0:10:05.388 came out out with a new recommendation.  
0:10:05.39 -> 0:10:08.288 It's in draft format right now, to  
0:10:08.288 -> 0:10:10.397 lower the colon cancer screening  
0:10:10.397 -> 0:10:13.509 age to 45 from the age of 50,  
0:10:13.51 -> 0:10:17.155 so this is moving it earlier by five years,  
0:10:17.16 -> 0:10:19.44 and that's for people that have  
0:10:19.44 -> 0:10:22.029 an average risk of colon cancer,  
0:10:22.03 -> 0:10:24.732 so no strong family history  
0:10:24.732 -> 0:10:27.223 or personal history or other risk  
0:10:27.223 -> 0:10:29.743 factors that would increase your risk.  
0:10:29.75 -> 0:10:32.3 This is for average risk individuals.  
0:10:32.3 -> 0:10:33.548 And so why  
0:10:33.55 -> 0:10:35.63 did they do that?  
0:10:35.63 -> 0:10:37.814 Why are they now thinking that  
0:10:37.814 -> 0:10:40.62 people need to get screened earlier?  
0:10:40.62 -> 0:10:42.7 Are we finding cancers at  
0:10:42.7 -> 0:10:45.172 earlier ages?  
0:10:45.172 -> 0:10:47.27 We are in fact finding cancers at earlier ages  
0:10:47.27 -> 0:10:49.766 really, since the 1990s,  
0:10:49.77 -> 0:10:52.712 we've seen an increase of 2% per  
0:10:52.712 -> 0:10:55.364 year of the incidence of colon  
0:10:55.364 -> 0:10:58.507 cancer in people under the age of 55.  
0:10:58.51 -> 0:11:01.025 Some other organizations,  
0:11:01.025 -> 0:11:03.54 the American College of Gastroenterology  
0:11:03.54 -> 0:11:05.368 decreased their screening recommendation  
0:11:05.368 -> 0:11:08.46 age to 45 years for black men.  
0:11:08.46 -> 0:11:11.673 This was in the mid 2000s and in 2018  
0:11:11.673 -> 0:11:14.987 the American Cancer Society reduced that  
0:11:14.987 -> 0:11:18.733 colon cancer screening age to 45 for  
0:11:18.733 -> 0:11:22.224 all people and that was just two years ago,  
0:11:22.224 -> 0:11:25.41 and I think that over the last few years

0:11:25.496 -> 0:11:28.712 we've seen just stronger evidence to  
0:11:28.712 -> 0:11:31.25 support lowering this screening age,  
0:11:31.25 -> 0:11:33.47 and therefore the United States  
0:11:33.47 -> 0:11:35.69 Preventive Services Task Force came  
0:11:35.757 -> 0:11:38.007 out with this recommendation last  
0:11:38.01 -> 0:11:39.01 week and  
0:11:39.01 -> 0:11:42.685 the screening guidelines for colon  
0:11:42.685 -> 0:11:46.939 cancer may be a little bit confusing for  
0:11:46.939 -> 0:11:50.482 some of our listeners because it really  
0:11:50.482 -> 0:11:53.946 depends on the type of test.  
0:11:53.95 -> 0:11:56.932 Sometimes they say get a colonoscopy  
0:11:56.932 -> 0:12:00.915 every 10 years, but then there are other  
0:12:00.915 -> 0:12:03.906 tests like flexible sigmoidoscopy.  
0:12:03.906 -> 0:12:05.898 There are contact tests.  
0:12:05.9 -> 0:12:08.58 There are now tests like  
0:12:08.58 -> 0:12:10.92 Cologuard so stool DNA tests.  
0:12:10.92 -> 0:12:14.446 There are fecal occult blood tests, can you  
0:12:14.446 -> 0:12:17.526 help our listeners to understand  
0:12:17.526 -> 0:12:21.103 these different tests and what they  
0:12:21.103 -> 0:12:24.49 should be doing in terms of screening?  
0:12:24.49 -> 0:12:27.142 Because when they read the  
0:12:27.142 -> 0:12:30.579 guidelines it may get a little confusing.  
0:12:31.29 -> 0:12:33.81 So your team  
0:12:33.81 -> 0:12:36.09 of doctors will help guide you to  
0:12:36.09 -> 0:12:37.566 select the test that's  
0:12:37.566 -> 0:12:39.78 best for you and  
0:12:39.78 -> 0:12:41.256 full disclosure,  
0:12:41.256 -> 0:12:43.47 my husband is a gastroenterologist and  
0:12:43.47 -> 0:12:46.782 we talk about this a lot at home,  
0:12:46.79 -> 0:12:49.652 and I'll  
0:12:49.652 -> 0:12:52.767 quote something that he says which is any

0:12:52.767 -> 0:12:55.278 screening is better than no screening.  
0:12:55.28 -> 0:12:58.223 And so I think your first stop  
0:12:58.223 -> 0:13:01.3 is talking to your primary care doctor.  
0:13:01.3 -> 0:13:03.715 So these are the doctors that will  
0:13:03.715 -> 0:13:06.261 often refer you to get colon cancer  
0:13:06.261 -> 0:13:08.415 screening that is right for you.  
0:13:08.42 -> 0:13:11.356 Your next stop usually is with a gastroenterologist  
0:13:11.356 -> 0:13:13.633 and they will talk with  
0:13:13.633 -> 0:13:16.229 you about this range of screening and  
0:13:16.229 -> 0:13:18.781 you did a very nice job listing  
0:13:18.781 -> 0:13:21.182 those options and these are tests  
0:13:21.182 -> 0:13:23.73 that look for hidden blood in stools.  
0:13:23.73 -> 0:13:25.86 Those are called occult blood tests.  
0:13:25.86 -> 0:13:28.121 There is the DNA based test so  
0:13:28.121 -> 0:13:30.45 we know that colon cancers can  
0:13:30.45 -> 0:13:33.006 actually shed DNA into the stool.  
0:13:33.01 -> 0:13:35.38 And we can look for that.  
0:13:35.38 -> 0:13:38.458 A sigmoidoscopy will look just in the  
0:13:38.458 -> 0:13:41.307 bottom portion of your large intestine,  
0:13:41.31 -> 0:13:42.79 called the sigmoid colon,  
0:13:42.79 -> 0:13:45.497 so it will only detect that and it is  
0:13:45.497 -> 0:13:47.557 an actual camera that's inserted  
0:13:47.557 -> 0:13:49.205 into the sigmoid colon.  
0:13:49.21 -> 0:13:52.094 A full colonoscopy will have a camera  
0:13:52.094 -> 0:13:55.126 inserted into the entirety of your colon,  
0:13:55.13 -> 0:13:58.29 and so there's a huge range of options.  
0:13:58.29 -> 0:14:01.055 And I agree it can be confusing,  
0:14:01.06 -> 0:14:03.08 but I think that the  
0:14:03.08 -> 0:14:05.432 best thing is to really talk with  
0:14:05.432 -> 0:14:07.707 your primary care doctor and gastroenterologist  
0:14:07.707 -> 0:14:09.327 about these options.

0:14:09.33 -> 0:14:11.406 Some tests may be better for  
0:14:11.406 -> 0:14:12.444 different patients,  
0:14:12.45 -> 0:14:15.568 but let me talk a little bit about  
0:14:15.57 -> 0:14:17.784 some of the advantages of why  
0:14:17.784 -> 0:14:19.26 colonoscopy and perhaps even  
0:14:19.326 -> 0:14:21.234 sigmoidoscopy outweigh some of  
0:14:21.234 -> 0:14:23.209 the others right after we take  
0:14:25.794 -> 0:14:28.408 a short break for a medical minute.  
0:14:28.41 -> 0:14:30.666 Please stay tuned to learn more  
0:14:30.666 -> 0:14:32.17 information about colon cancer  
0:14:32.239 -> 0:14:34.34 with my guest, Doctor Pamela Kunz.  
0:14:34.34 -> 0:14:37.808 Support for Yale Cancer Answers  
0:14:37.808 -> 0:14:40.12 comes from AstraZeneca, dedicated  
0:14:40.205 -> 0:14:43.429 to providing innovative treatment  
0:14:43.429 -> 0:14:47.459 options for people living with  
0:14:47.459 -> 0:14:48.265 cancer. Learn more at [astrazeneca-us.com](http://astrazeneca-us.com).  
0:14:48.27 -> 0:14:51.196 This is a medical minute about genetic  
0:14:51.196 -> 0:14:53.738 testing which can be useful for  
0:14:53.738 -> 0:14:56.156 people with certain types of cancer  
0:14:56.156 -> 0:14:58.876 that seem to run in their families.  
0:14:58.88 -> 0:15:01.382 Patients that are considered at risk  
0:15:01.382 -> 0:15:03.854 receive genetic counseling and testing so  
0:15:03.854 -> 0:15:06.056 informed medical decisions can be based  
0:15:06.056 -> 0:15:08.67 on their own personal risk assessment.  
0:15:08.67 -> 0:15:10.48 Resources for genetic counseling and  
0:15:10.48 -> 0:15:12.29 testing are available at federally  
0:15:12.341 -> 0:15:14.377 designated comprehensive cancer centers.  
0:15:14.38 -> 0:15:16.012 Interdisciplinary teams include geneticists,  
0:15:16.012 -> 0:15:17.316 genetic counselors, physicians,  
0:15:17.316 -> 0:15:18.288 and nurses  
0:15:18.288 -> 0:15:20.718 who work together to provide

0:15:20.718 -> 0:15:22.961 risk assessment and steps to  
0:15:22.961 -> 0:15:24.956 prevent the development of cancer.  
0:15:24.96 -> 0:15:26.74 More information is available  
0:15:26.74 -> 0:15:27.63 at [yalecancercenter.org](http://yalecancercenter.org).  
0:15:27.63 -> 0:15:31.23 You're listening to Connecticut Public Radio.  
0:15:31.23 -> 0:15:31.63 Welcome  
0:15:31.63 -> 0:15:33.63 back to Yale Cancer Answers.  
0:15:33.63 -> 0:15:35.808 This is doctor in Anees Chagpar  
0:15:35.808 -> 0:15:38.221 and I'm joined tonight by  
0:15:38.221 -> 0:15:40.426 my guest doctor Pamela Kunz.  
0:15:40.43 -> 0:15:42.43 We're talking about colon cancer,  
0:15:42.43 -> 0:15:43.537 and neuroendocrine tumors,  
0:15:43.537 -> 0:15:46.12 and right before the break we were  
0:15:46.184 -> 0:15:48.149 talking about some recent updates  
0:15:48.149 -> 0:15:50.608 to the colon cancer guidelines that  
0:15:50.608 -> 0:15:52.728 recommend that everybody at  
0:15:52.728 -> 0:15:55.23 average risk start getting their colon  
0:15:55.23 -> 0:15:58.43 cancer screening done at the age of 45.  
0:15:58.43 -> 0:16:00.992 Now, for anybody who's read those  
0:16:00.992 -> 0:16:02.7 colon cancer screening guidelines,  
0:16:02.7 -> 0:16:04.41 it's a little bit confusing.  
0:16:04.41 -> 0:16:06.12 There's all kinds of tests  
0:16:06.12 -> 0:16:08.2 that are out there, and Pamela,  
0:16:08.2 -> 0:16:10.33 you were telling us right before  
0:16:10.33 -> 0:16:12.657 the break that this is a decision  
0:16:12.657 -> 0:16:14.624 that you really need to make  
0:16:14.624 -> 0:16:16.379 with your health care team.  
0:16:16.38 -> 0:16:17.744 Your primary care doctor,  
0:16:17.744 -> 0:16:18.426 your gastroenterologist.  
0:16:18.43 -> 0:16:20.59 But you are going to make a pitch  
0:16:20.59 -> 0:16:23.219 for a particular form of screening.

0:16:23.22 -> 0:16:26.298 So tell us a little bit more about that.  
0:16:27.42 -> 0:16:30.227 That's right, so there are a number  
0:16:30.227 -> 0:16:33.256 of options, but I was going to talk a  
0:16:33.256 -> 0:16:35.84 little bit more about colonoscopies.  
0:16:35.84 -> 0:16:37.905 I think that colonoscopies really  
0:16:37.905 -> 0:16:40.416 meet a number of different needs  
0:16:40.416 -> 0:16:42.66 in terms of the screening goals,  
0:16:42.66 -> 0:16:45.572 so number one, to take  
0:16:45.572 -> 0:16:49.334 a step back to describe them,  
0:16:49.334 -> 0:16:52.046 your gastroenterologist will use a  
0:16:52.046 -> 0:16:54.686 small camera on the end of a tube  
0:16:54.69 -> 0:16:57.15 and that allows them to detect  
0:16:57.15 -> 0:16:59.455 small polyps, which are these  
0:16:59.455 -> 0:17:01.76 precancerous spots and remove them,  
0:17:01.76 -> 0:17:04.476 and I think that is critical  
0:17:04.476 -> 0:17:07.289 in terms of cancer prevention.  
0:17:07.29 -> 0:17:10.321 Some of these other tools might identify  
0:17:10.321 -> 0:17:13.75 that perhaps you have a precancerous lesion,  
0:17:13.75 -> 0:17:16.51 or perhaps you have a cancer,  
0:17:16.51 -> 0:17:19.372 but don't also enable the ability  
0:17:19.372 -> 0:17:22.04 to actually remove that polyp,  
0:17:22.04 -> 0:17:24.848 so that's why I think colonoscopies  
0:17:24.848 -> 0:17:27.2 really are probably the best  
0:17:27.2 -> 0:17:29.696 tool and considered the gold standard.  
0:17:30.12 -> 0:17:34.224 So just to be honest, r  
0:17:34.224 -> 0:17:36.702 I think a lot of people when  
0:17:36.702 -> 0:17:38.879 they think about colonoscopy,  
0:17:38.88 -> 0:17:42.435 the things that kind of make people less than  
0:17:42.435 -> 0:17:45.548 enamored with the technique, is number 1,  
0:17:45.548 -> 0:17:48.048 the prep because your colon needs  
0:17:48.05 -> 0:17:50.927 to be really clean for somebody to

0:17:50.927 -> 0:17:53.932 put a camera in there and actually  
0:17:53.932 -> 0:17:56.953 be able to see anything and #2,  
0:17:56.953 -> 0:17:59.425 the whole thought of having  
0:17:59.43 -> 0:18:02.778 to put up your bottom end is not particularly  
0:18:02.778 -> 0:18:05.444 appealing to people when they can think of  
0:18:05.45 -> 0:18:07.928 instead just sending in a stool sample,  
0:18:07.93 -> 0:18:09.862 which although not appealing,  
0:18:09.862 -> 0:18:12.76 sounds a little bit nicer than  
0:18:12.841 -> 0:18:15.817 putting a tube up your bottom end so  
0:18:15.82 -> 0:18:19.735 if you were to do the other, say,  
0:18:19.735 -> 0:18:23.34 a fecal occult blood test or a  
0:18:23.34 -> 0:18:27.175 stool DNA test that now  
0:18:27.175 -> 0:18:31.01 is being marketed to patients,  
0:18:31.01 -> 0:18:32.108 if that's negative,  
0:18:32.108 -> 0:18:34.67 how confident are you in the results?  
0:18:34.67 -> 0:18:35.768 If it's positive,  
0:18:35.768 -> 0:18:38.33 you'll likely end up needing a colonoscopy.  
0:18:38.33 -> 0:18:39.428 Is that right?  
0:18:39.428 -> 0:18:40.16 That's right,  
0:18:40.16 -> 0:18:42.356 so if those tests are positive,  
0:18:42.36 -> 0:18:45.28 you will still need to do the prep.  
0:18:45.28 -> 0:18:47.32 I think that's one of the  
0:18:47.32 -> 0:18:49.152 aspects of a colonoscopy that  
0:18:49.152 -> 0:18:51.137 most people are worried about.  
0:18:51.14 -> 0:18:53.492 That's when you have to drink a  
0:18:53.492 -> 0:18:55.405 special fluid that helps clean  
0:18:55.405 -> 0:18:58.324 out your colon in order for the  
0:18:58.324 -> 0:19:00.29 gastroenterologist to really see a shiny,  
0:19:00.29 -> 0:19:03.02 clean colon and detect the polyps so  
0:19:03.02 -> 0:19:05.528 the prep is scary.  
0:19:05.53 -> 0:19:08.407 And in terms of these other options,

0:19:08.41 -> 0:19:09.577 if it's negative,  
0:19:09.577 -> 0:19:13.34 so if a fecal occult blood test is negative,  
0:19:13.34 -> 0:19:16.217 or the stool DNA test is negative,  
0:19:16.22 -> 0:19:18.68 it's reassuring, but it's not 100%.  
0:19:20.09 -> 0:19:23.338 And colonoscopy really allows the  
0:19:23.338 -> 0:19:25.496 gastroenterologist to look inside your  
0:19:25.496 -> 0:19:28.264 colon and see if there are any polyps,  
0:19:28.27 -> 0:19:29.67 and to remove them.  
0:19:29.67 -> 0:19:32.338 Now before the break we were also  
0:19:32.338 -> 0:19:34.294 talking about neuroendocrine tumors  
0:19:34.294 -> 0:19:37.559 and you had mentioned that  
0:19:37.559 -> 0:19:40.535 these are from a different cell of origin.  
0:19:40.54 -> 0:19:42.172 They often secrete hormones,  
0:19:44.22 -> 0:19:46.758 and rarely they can actually  
0:19:46.758 -> 0:19:49.13 reside inside the colon as well.  
0:19:49.13 -> 0:19:51.23 Now does a colonoscopy  
0:19:51.23 -> 0:19:52.63 find these as well,  
0:19:52.63 -> 0:19:55.157 or are these kind of hidden and  
0:19:55.157 -> 0:19:57.558 the only way that you can really  
0:19:57.558 -> 0:20:00.188 find them is when you present with  
0:20:00.19 -> 0:20:01.669 symptoms?  
0:20:01.67 -> 0:20:04.466 A colonoscopy will help us detect any  
0:20:04.466 -> 0:20:08.076 abnormalities in the colon actually, and it  
0:20:08.076 -> 0:20:11.527 will help detect other types of cancers.  
0:20:11.53 -> 0:20:14.882 It will help detect other types of conditions  
0:20:14.882 -> 0:20:17.939 such as inflammatory bowel disease,  
0:20:17.94 -> 0:20:20.47 but what's unique about neuroendocrine  
0:20:20.47 -> 0:20:24.031 tumors is that they don't have a  
0:20:24.031 -> 0:20:26.401 precursor or a precancerous spot  
0:20:26.401 -> 0:20:28.78 that develops before the cancer.  
0:20:28.78 -> 0:20:31.804 So very likely if a neuroendocrine



0:20:31.804 -> 0:20:33.316 tumor is present  
0:20:33.32 -> 0:20:36.638 in the colon, it's already a cancer,  
0:20:36.64 -> 0:20:38.79 whereas for colonoscopy the  
0:20:38.79 -> 0:20:42.061 intent is to try to catch cancers  
0:20:42.061 -> 0:20:45.163 earlier before they are even cancers.  
0:20:45.17 -> 0:20:47.07 So detect the polyps.  
0:20:48.63 -> 0:20:50.71 And the guidelines for colonoscopy,  
0:20:50.71 -> 0:20:52.334 if I remember correctly,  
0:20:52.334 -> 0:20:55.29 are for a colonoscopy every 10 years.  
0:20:55.29 -> 0:20:57.37 Some people may look at  
0:20:57.37 -> 0:20:59.45 that and say 10 years.  
0:20:59.45 -> 0:21:01.946 What happens if I develop one  
0:21:01.946 -> 0:21:03.61 of these precancerous polyps  
0:21:03.61 -> 0:21:04.855 in the interim,  
0:21:04.855 -> 0:21:07.345 is 10 years really the guideline,  
0:21:07.35 -> 0:21:09.846 and what do you say to  
0:21:09.846 -> 0:21:11.51 people who have those  
0:21:11.51 -> 0:21:14.005 concerns?  
0:21:14.005 -> 0:21:15.668 10 years is the guideline that's assuming  
0:21:15.668 -> 0:21:18.164 that you again have average risk,  
0:21:18.17 -> 0:21:19.89 and assuming that  
0:21:19.89 -> 0:21:21.908 first, colonoscopy is completely normal.  
0:21:21.908 -> 0:21:23.893 If that colonoscopy shows polyps,  
0:21:23.9 -> 0:21:27.076 very likely you're asked to come back sooner,  
0:21:27.08 -> 0:21:29.336 often within three years to see  
0:21:29.336 -> 0:21:31.86 if there are any more polyps.  
0:21:31.86 -> 0:21:34.646 But if your colonoscopy is totally clean,  
0:21:34.65 -> 0:21:38.223 you are often asked to return in 10 years,  
0:21:38.23 -> 0:21:40.726 and that's because what we've learned  
0:21:40.726 -> 0:21:43.4 about the biology of polyps is it  
0:21:43.4 -> 0:21:46.039 often can take 10 years for

0:21:46.039 -> 0:21:48.967 a polyp to turn into a cancer.  
0:21:48.97 -> 0:21:49.816 Now that's  
0:21:49.816 -> 0:21:52.777 I would say on average or typical  
0:21:52.777 -> 0:21:56.04 there are exceptions to that rule, and  
0:21:56.04 -> 0:21:59.91 so the good news for all of our listeners,  
0:21:59.91 -> 0:22:03.294 of course, is that if you do undergo  
0:22:03.294 -> 0:22:05.93 a colonoscopy as Doctor Kunz is  
0:22:05.93 -> 0:22:08.94 recommending starting at the age of 45,  
0:22:08.94 -> 0:22:10.66 if it's completely clean,  
0:22:10.66 -> 0:22:13.24 you don't have to drink that  
0:22:13.32 -> 0:22:15.39 prep for another 10 years,  
0:22:15.39 -> 0:22:19.66 which is always a nice thing to know as well.  
0:22:19.66 -> 0:22:20.92 Doctor Kunz,  
0:22:20.92 -> 0:22:23.056 you had mentioned that  
0:22:23.06 -> 0:22:25.125 for these polyps you can kind of  
0:22:25.125 -> 0:22:28.098 take them out at the time of the  
0:22:28.098 -> 0:22:29.714 colonoscopy and potentially prevent  
0:22:29.714 -> 0:22:31.599 yourself from getting a cancer.  
0:22:31.6 -> 0:22:34.085 But if you've got a neuroendocrine tumor,  
0:22:34.09 -> 0:22:36.589 that's often a cancer that's already there.  
0:22:36.59 -> 0:22:39.355 And sometimes you can find colon cancers  
0:22:39.355 -> 0:22:42.234 that are already in the form of a  
0:22:42.234 -> 0:22:44.419 colon cancer before finding it just as  
0:22:44.42 -> 0:22:46.91 a polyp. Is that right?  
0:22:46.91 -> 0:22:49.943 Yes, and so the biopsy that's done at the time  
0:22:49.943 -> 0:22:53.124 of the colonoscopy can help us to tell  
0:22:53.13 -> 0:22:55.026 what kind of cancer this is,  
0:22:55.03 -> 0:22:56.92 is this an adenocarcinoma?  
0:22:56.92 -> 0:22:58.816 Is it just a pre cancer?  
0:22:58.82 -> 0:23:00.4 Is this a neuroendocrine cancer?  
0:23:00.4 -> 0:23:02.682 So if it's a pre cancer and

0:23:02.682 -> 0:23:04.508 the polyps removed is that it?  
0:23:04.51 -> 0:23:06.4 Do you have to take anymore  
0:23:06.4 -> 0:23:08.049 medications or is removing the  
0:23:08.049 -> 0:23:10.011 polyp and getting your follow up  
0:23:10.011 -> 0:23:13.2 colonoscopy all you need to do?  
0:23:13.2 -> 0:23:15.718 If all that is detected is a  
0:23:15.718 -> 0:23:17.77 polyp and they're able to  
0:23:17.854 -> 0:23:20.139 completely remove it  
0:23:20.14 -> 0:23:22.11 then the recommendation is just  
0:23:22.11 -> 0:23:23.686 following up your gastroenterologist  
0:23:23.686 -> 0:23:25.93 says in terms of recommended intervals.  
0:23:25.93 -> 0:23:28.246 So if they find multiple polyps,  
0:23:28.25 -> 0:23:31.338 or even just one, it will certainly be,  
0:23:31.34 -> 0:23:34.562 please come back and see us before 10 years  
0:23:34.562 -> 0:23:37.51 but there is no treatment needed.  
0:23:37.51 -> 0:23:39.054 There's no chemotherapy needed,  
0:23:39.054 -> 0:23:40.984 and nothing else is needed.  
0:23:43.73 -> 0:23:47.324 Let's move on to  
0:23:47.324 -> 0:23:49.72 the other two scenarios.  
0:23:49.72 -> 0:23:53.308 Let's suppose this is an actual  
0:23:53.308 -> 0:23:55.102 garden variety adenocarcinoma.  
0:23:55.11 -> 0:23:56.91 What happens then?  
0:23:58.27 -> 0:24:01.038 So if we determine that based on the  
0:24:01.038 -> 0:24:03.828 biopsy that it's a colon adenocarcinoma,  
0:24:03.83 -> 0:24:05.8 then patients are usually  
0:24:05.8 -> 0:24:08.2 referred to see an oncology team.  
0:24:08.2 -> 0:24:09.784 That team consists of  
0:24:09.784 -> 0:24:11.368 usually a medical oncologist,  
0:24:11.37 -> 0:24:13.746 like myself, and often a surgeon,  
0:24:13.75 -> 0:24:16.99 and we will embark on this staging work up  
0:24:16.99 -> 0:24:20.11 that I'd mentioned a little bit earlier.

0:24:20.11 -> 0:24:23.183 So that includes blood work and that  
0:24:23.183 -> 0:24:26.416 will usually also include a CT scan of  
0:24:26.416 -> 0:24:29.55 the chest and the abdomen and the pelvis.  
0:24:29.55 -> 0:24:31.34 To determine extent of disease,  
0:24:31.34 -> 0:24:32.056 meaning, where  
0:24:32.056 -> 0:24:33.846 has the cancer gone?  
0:24:33.85 -> 0:24:36.349 Is it localized just in the colon?  
0:24:36.35 -> 0:24:38.569 Has it spread to nearby lymph nodes  
0:24:38.569 -> 0:24:40.649 or has it spread further,  
0:24:40.65 -> 0:24:43.506 perhaps to the liver or to the lungs?  
0:24:44.92 -> 0:24:47.02 And so, let's say it  
0:24:47.02 -> 0:24:48.7 hasn't spread anywhere then what?  
0:24:48.7 -> 0:24:51.493 Then we will often have  
0:24:51.493 -> 0:24:53.32 a multidisciplinary team meeting.  
0:24:53.32 -> 0:24:56.68 We do this for many of our cancers.  
0:24:56.68 -> 0:24:58.78 It's called a tumor board.  
0:24:58.78 -> 0:25:01.398 In fact, we have our GI cancer  
0:25:01.398 -> 0:25:03.4 tumor board this afternoon,  
0:25:03.4 -> 0:25:06.12 and the tumor board is a place where  
0:25:06.12 -> 0:25:08.44 there are multiple specialists,  
0:25:08.44 -> 0:25:09.28 medical oncologists,  
0:25:09.28 -> 0:25:10.54 surgeons, pathologists, radiologists,  
0:25:10.54 -> 0:25:13.078 a whole group of doctors that  
0:25:13.078 -> 0:25:15.25 will help determine the next  
0:25:15.25 -> 0:25:17.854 best plan for someone who has a  
0:25:17.854 -> 0:25:19.678 localized colon cancer that often  
0:25:19.678 -> 0:25:21.897 the next step is often a surgery  
0:25:21.897 -> 0:25:24.56 to remove a portion of the colon  
0:25:24.56 -> 0:25:26.46 that contains the cancer plus  
0:25:26.46 -> 0:25:28.36 some additional colon to make  
0:25:28.36 -> 0:25:30.647 sure that we've removed enough and

0:25:30.647 -> 0:25:33.076 also some lymph nodes to help us  
0:25:33.076 -> 0:25:35.202 determine if the cancer  
0:25:35.202 -> 0:25:37.27 has spread to those lymph nodes.  
0:25:38.36 -> 0:25:40.465 And then is chemotherapy or  
0:25:40.465 -> 0:25:42.57 radiation in their future as well?  
0:25:42.57 -> 0:25:44.675 That depends on  
0:25:44.675 -> 0:25:46.78 the stage of the tumor.  
0:25:46.78 -> 0:25:49.306 So now that the patient  
0:25:49.31 -> 0:25:51.03 has had their surgery,  
0:25:51.03 -> 0:25:53.61 we are able to accurately determine  
0:25:53.692 -> 0:25:56.9 what stage they have in this stage is  
0:25:56.9 -> 0:25:59.408 determined based on three key features,  
0:25:59.41 -> 0:26:01.936 and that's called the TNM staging.  
0:26:01.94 -> 0:26:04.768 which stands for tumor (T), nodes (N), and metastases (M).  
0:26:04.768 -> 0:26:07.841 And the T stage generally refers to  
0:26:07.841 -> 0:26:11.3 ia combination of the size and then  
0:26:11.3 -> 0:26:14.244 how deep in the lining of the colon  
0:26:14.244 -> 0:26:16.986 that tumor has spread, the N stage  
0:26:16.986 -> 0:26:19.793 refers to the number of lymph nodes  
0:26:19.793 -> 0:26:22.193 involved and the M stage refers  
0:26:22.193 -> 0:26:24.17 to has the cancer metastasized  
0:26:24.17 -> 0:26:26.51 or spread to a distant location,  
0:26:26.51 -> 0:26:28.85 like the liver or the lungs,  
0:26:28.85 -> 0:26:30.8 and so our pathologists help  
0:26:30.8 -> 0:26:32.36 us with that.  
0:26:32.36 -> 0:26:35.09 The CT scan itself also helps us,  
0:26:35.09 -> 0:26:37.547 and so for someone with a colon  
0:26:37.547 -> 0:26:40.16 cancer it's a little bit nuanced,  
0:26:40.16 -> 0:26:42.59 but I would say in general,  
0:26:42.59 -> 0:26:45.416 if someone has a colon cancer

0:26:45.416 -> 0:26:48.459 that is stage three or greater,  
0:26:48.46 -> 0:26:51.876 that would mean that they have  
0:26:51.88 -> 0:26:53.832 local lymph nodes involved  
0:26:53.832 -> 0:26:56.272 that usually does mean that  
0:26:56.28 -> 0:26:58.46 they need post surgical chemotherapy  
0:26:58.46 -> 0:27:01.925 and so now let's move to the  
0:27:01.925 -> 0:27:03.129 neuroendocrine situation.  
0:27:03.13 -> 0:27:05.142 How are these different?  
0:27:05.142 -> 0:27:08.16 How often do you find metastases  
0:27:08.252 -> 0:27:10.457 at the time of diagnosis?  
0:27:10.46 -> 0:27:12.528 Are these resected surgically?  
0:27:12.528 -> 0:27:15.63 Is there more often medical management?  
0:27:15.63 -> 0:27:18.6 How is your approach similar or  
0:27:18.6 -> 0:27:22.35 different to regular colon cancer?  
0:27:22.35 -> 0:27:24.318 Well, I think that  
0:27:24.32 -> 0:27:26.944 the work up for many of these GI  
0:27:26.944 -> 0:27:29.463 cancers are the same where we get a  
0:27:29.463 -> 0:27:31.757 biopsy and we do this staging work  
0:27:31.757 -> 0:27:34.487 up with blood tests and a CT scan.  
0:27:34.487 -> 0:27:36.449 And then we meet and  
0:27:36.45 -> 0:27:38.4 we have a tumor board discussion  
0:27:38.4 -> 0:27:40.719 to come up with the next plan,  
0:27:40.72 -> 0:27:42.688 so those are the common principles.  
0:27:42.69 -> 0:27:43.749 But you're right,  
0:27:43.749 -> 0:27:45.514 the treatment plan and tailoring  
0:27:45.514 -> 0:27:47.358 that treatment to the patient often  
0:27:47.358 -> 0:27:49.413 differs by cancer and so that is  
0:27:49.413 -> 0:27:50.889 true for neuroendocrine tumors.  
0:27:50.89 -> 0:27:52.039 Neuroendocrine tumors are  
0:27:52.039 -> 0:27:53.954 often much slower growing than  
0:27:53.954 -> 0:27:55.41 their adenocarcinoma counterparts,

0:27:55.41 -> 0:27:57.648 and neuroendocrine  
0:27:57.648 -> 0:27:59.788 tumors have a very different  
0:27:59.788 -> 0:28:01.51 system of classification.  
0:28:01.51 -> 0:28:05.434 I won't go into all of those details now,  
0:28:05.44 -> 0:28:08.254 but that does help us determine  
0:28:08.254 -> 0:28:11.538 what the next best step is and  
0:28:11.54 -> 0:28:15.578 we do include things like surgery.  
0:28:15.58 -> 0:28:18.064 Sometimes patients will have had the  
0:28:18.064 -> 0:28:21.108 cancer spread at the time of diagnosis,  
0:28:21.11 -> 0:28:23.23 and if that's the case,  
0:28:23.23 -> 0:28:24.58 we have medications,  
0:28:24.58 -> 0:28:25.93 including some chemotherapies  
0:28:25.93 -> 0:28:28.33 that help us slow down the  
0:28:28.33 -> 0:28:31.93 growth of that cancer, and so the  
0:28:31.93 -> 0:28:34.076 chemotherapies though are different than  
0:28:34.076 -> 0:28:37.26 what you would get for a regular colon  
0:28:37.26 -> 0:28:38.956 cancer?  
0:28:38.956 -> 0:28:41.08 This is an important  
0:28:41.08 -> 0:28:43.63 take home for every cancer type.  
0:28:43.63 -> 0:28:46.1 The chemotherapy regimen  
0:28:46.1 -> 0:28:48.788 is often different  
0:28:48.788 -> 0:28:50.819 depending on that cancer type.  
0:28:50.82 -> 0:28:52.388 There's sometimes some overlap,  
0:28:52.39 -> 0:28:54.376 but for the most part,  
0:28:54.376 -> 0:28:57.197 the way we determine if a chemotherapy  
0:28:57.197 -> 0:28:59.552 regimen works for a given cancer  
0:28:59.552 -> 0:29:01.427 is through a clinical trial.  
0:29:01.43 -> 0:29:04.02 Clinical trials are ways we test new  
0:29:04.02 -> 0:29:05.956 medicines or new combinations of  
0:29:05.956 -> 0:29:08.218 medicines and prove that it works  
0:29:08.218 -> 0:29:10.86 in a very specific cancer type.

0:29:10.86 -> 0:29:11.25 Doctor Pamela Kunz  
0:29:11.25 -> 0:29:14.482 is the director of GI Medical  
0:29:14.482 -> 0:29:17.496 Oncology at the Yale School of Medicine.  
0:29:17.5 -> 0:29:19.056 If you have questions,  
0:29:19.056 -> 0:29:20.612 the address is canceranswers@yale.edu  
0:29:20.612 -> 0:29:22.76 and past editions of the program  
0:29:22.76 -> 0:29:24.722 are available in audio and written  
0:29:24.783 -> 0:29:26.418 form at yalecancercenter.org.  
0:29:26.42 -> 0:29:29.26 We hope you'll join us next week to  
0:29:29.26 -> 0:29:32.026 learn more about the fight against  
0:29:32.026 -> 0:29:34.99 cancer here on Connecticut Public Radio.