Rises and Advancements in Colorectal Cancer Transcript

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Why Young Cases Rise

Leslie Schlachter: Hello, and welcome back to The Vitals, the Mount Sinai Health Systems podcast exploring the people and innovations advancing medicine today. I'm your host, Leslie Schlachter, a neurosurgery physician assistant here at the Mount Sinai Hospital. Today, we discuss the rising rates of colorectal cancer, particularly among younger adults.

It's an issue that's received increasing attention in recent news and in the medical community. Colorectal cancer was once thought as primarily a disease affecting older adults, but historic numbers of patients are finding themselves with a diagnosis in their 30s and 40s, and sometimes even younger.

Today, we'll talk about why that might be happening, what symptoms people should pay attention to, when to seek screening, and what happens if a screening test reveals something concerning. To guide us through this, we're joined by three of Mount Sinai's experts, Doctors David Greenwald and Dr. Pascal White, who are both gastroenterologists, and Dr.

Deirdre Cohen, who is a medical oncologist treating colorectal cancer. Thank you so much for joining us. Welcome.[00:01:00]

Okay, so we've been hearing lately that colorectal cancer has been affecting younger patients. Um, I mean, I've seen it in the news like Instagram and TikTok, but, like, what trends are you guys seeing in your practice? Are you also seeing it in younger patients?

Pascale White: Absolutely. I think the one thing that really struck me in the past couple of months is the new ar- JAMA article that came out that said, uh, colorectal cancer is now the number one cancer-related death in patients under 50 in the United States of America.

And this tracks with what we're seeing in our endoscopy practices, patients who are coming in with symptoms in our clinics and saying, "Hey, um, this could be a hemorrhoid." I'm saying, "It very well could be something like a hemorrhoid

that's benign, but we're seeing trends with younger people being diagnosed with this disease, and so we need to check it out."

Leslie Schlachter: Why? Why, why is this happening? What do you think is the reason?

Pascale White: Long and short, we don't know. Um, there are different, uh, things that we're thinking about at this point. Could it [00:02:00] be environmental? Could it be the microbiome? Could it be early antibiotic exposure? All these things that we're trying to look into at this point, but the long and short of it is that we're working really hard to figure out what's happening.

David Greenwald: Okay. So obesity's also been blamed- Absolutely ... um, and diet, but again, there's nothing, there's no real hard evidence to explain it, but it's definitely a trend that we've noticed, and the sort of the bottom line is that if you're under 40 or 45 and you have a symptom like rectal bleeding, it needs to be checked out, not just sort of said, "Oh, it's probably a hemorrhoid.

This is nothing," or, "It'll go away." Yeah. But definitely come seek healthcare professional guidance, um, and probably some sort of investigation to understand why it's there.

Risk Factors And Microbiome

Leslie Schlachter: We did a podcast a couple months ago on the surgeon general's update for alcohol, with colorectal cancer being one of the cancers that you're at increased risk if you drink alcohol.

Do we think that alcohol is to blame for this? Maybe has, is alcohol been on the rise?

David Greenwald: So alcohol is a risk factor for- Yeah ... colorectal cancer. Yeah. There are a lot of things that are risk factors. [00:03:00] The most important risk factor for colorectal cancer turns out to be advancing age. So although you just mentioned young people- Mm again, just, just the, um, simple fact of getting older is the most, um, impactful reason for getting colorectal cancer. Um, alcohol itself, there are other risk factors. We think a diet that's increased in red meat or processed meats, um, cigarette smoking, all of those- Mm-hmm ... are risk factors for colorectal cancer.

Leslie Schlachter: So cigarette smoking is also a risk for colorectal cancer?

David Greenwald: Yes.

Leslie Schlachter: I want you to know I know the answers to some of my questions. I do. Pretty much. And, like, I don't.

David Greenwald: There are a zillion reasons, there are a zillion reasons why cigarette smoking is bad. This is one of them.

Leslie Schlachter: Okay. And you're so... You guys are, like, seeing the patients, symptomatic, they come in.

We'll get back to, like, diagnostics and stuff, but you're treating these patients. Correct. What, what would be your guess are, if you were to, like, name your belief for the top three reasons why younger people are getting colorectal cancer?

Deirdre Cohen: I think it is probably a lot to do with diet, um, early, uh, exposure to antibiotics, and then [00:04:00] the sedentary l- you know, lifestyle that we are seeing.

So, but again, I think to a prior point, we don't really know. These are all hypotheses. Mm. But I think that they're gaining more and more ground.

Leslie Schlachter: Right. This, the, uh, early exposure to antibiotics, can you guys just, like, go into more detail? 'Cause this is the first time I'm hearing of this.

Deirdre Cohen: Well, I think it's more about changing your microbiome, right?

So we all have, um, bacteria that live and breathe, or not breathe, but live on us, with us, and they play a huge part in health and disease. And there can be, um, alterations in that, um, the communities of bacteria, um, that can lead to dysbiosis and, you know, ultimately its, uh, downstream effects in terms of immune function, um, and allowing, uh, cancers to develop.

So chronic inflammation, um, uh, is, is part of it. So really, like- But- ... a community disruptor.

David Greenwald: Yeah. Erick,

Leslie Schlachter: in your...

David Greenwald: Yeah. Yeah, it can be a community disruptor. I just [00:05:00] wanna put a little plug in for the use of antibiotics when they're necessary. Oh, yes. Right. So antibio- And I know you would, I know you would- Fair

but antibiotics are really important in, in, you know, fixing certain bacterial infections that can be very serious. So this is not to say that all antibiotics are bad, but they have to be used judiciously and properly.

Leslie Schlachter: 100%. Agreed. Do you guys have, like,

Pascale White: a

Leslie Schlachter: GI approved- Backwards ... probiotic for when you're on antibiotics?

You're not gonna catch me there. No. So, like- Negative ... do you tell people to take probiotics or just, like, have yogurt, kefir? Is that, like, a thing?

Pascale White: No. Really? Not a thing. Just in terms of prevention- Mind blown ... no.

David Greenwald: Mm-mm. Why mind blown?

Leslie Schlachter: I don't know. Yeah. 'Cause I feel like- Out there in the world- Yeah ... you're suppo- they tell you to take, they- Right

I don't know who they are right now. Yeah, yeah. Like they is, I don't know- Yeah ... Instagram and TikTok I guess.

David Greenwald: Yeah, yeah, that's

Leslie Schlachter: right. They tell you to take probiotics- Yeah ... and you think you have to. Yeah. But you are telling us no.

David Greenwald: So the evidence is very weak to nonexistent, depending on what you're looking at, for the use of probiotics for, uh, when you're taking antibiotics or for irritable [00:06:00] bowel syndrome in general.

Very, very weak. So yeah, TikTok and Instagram say that, but you gotta go back to the scientific evidence.

Leslie Schlachter: So this is why we actually have this podcast, to say exactly these things. All right, so let's- So,

David Greenwald: and the probiotics don't necessarily hurt people.

Leslie Schlachter: Just the wallet.

David Greenwald: They cost money. That's exactly right.

Your bank account. And that's exactly what I say to my patients. Yeah. Which is, "This is not gonna hurt you, but it's gonna separate you from your money." Yeah. And they understand me.

Leslie Schlachter: There's room for that. Yeah. Yeah. It's up to you. Sometimes it feels good to put probiotics in, even if you know you're throwing your money out the window.

David Greenwald: It's up to you.

Leslie Schlachter: Okay. Yeah. Um, all right.

Symptoms And Red Flags

Leslie Schlachter: So let's go back to diagnostics. You said if you have a symptom to come in and get checked. So like you said rectal bleeding, what are some other symptoms that you can look for?

Pascale White: Yeah. Abdominal pain that is, uh, prolonged, and we're not talking about the run-of-the-mill if you went out to eat something and you get a little sick and you have a couple...

You know, a bellyache for one or two days. We're talking about patients who have like chronic, for weeks or months on end, abdominal pain. Patients who have weight loss that they're not intending to lose. They're patients who, you mentioned rectal [00:07:00] bleeding. Um, they're patients who have a change in what their stool looks like, right?

We call it a change in caliber of stool. So if it looks pencil thin, if it looks smaller than usual. Or even if your, uh, bowel habits have changed. For example, if you're going too often or having looser stools, or if you're not going off more often enough, like if you're having constipation. These are all things that are off your baseline that you really want to have checked out with your physician.

Leslie Schlachter: So you had said that obesity is also a risk factor for colorectal cancer, and now there's medicines out there like all these GLP-1s, right? Down- upside of GLP-1, hopefully we see a decrease in obesity. Downside of GLP-1s, change in stool character, change in symptoms. What are you guys seeing with that? Are you guys seeing patients coming in trying to figure out what's what?

David Greenwald: Yeah, so it's a great question, actually. So we've actually talked about this a couple of times. The GLP-1 agonists and other similar drugs, yeah, are incredible for weight loss. Um, they're... The, part of the way they work is they slow down the GI tract, the stomach, and the colon as well, [00:08:00] mostly the stomach.

But so constipation and change in bowel habits is pretty frequent. And the concern now is whether people who have some of these early warns, warning signs that Dr. White was just talking about and are taking GLP-1 agonists or similar drugs are gonna confuse the two of them and delay their diagnosis. I don't know that we know that that's happening just yet, but it's certainly a possibility and something we have to be aware of.

Leslie Schlachter: Yeah. I, um, I've been on GLP-1s. I have a lot of patients on GLP-1s, and it's like, it, the constipation is real.

David Greenwald: Yep.

Leslie Schlachter: Mm. Yeah. It's, it can be actually pretty scary.

David Greenwald: Yeah.

Leslie Schlachter: Yeah. So back to the blood in the stool. So is blood in the stool like the number one sign of colorectal cancer? 'Cause I feel like that's what we hear.

Pascale White: I mean, it's a sign. There could be a number of things. Um, and patients say, "Blood in the stool, does it matter the color? Does it matter how

frequent?" I always say to my patients, "It's never normal to see blood in the stool." It could either be from a completely benign or just non-dangerous cause, like a hemorrhoid or a little fissure or a cut around the [00:09:00] anus, or it could very well be a bleeding, you know, polyp or malignancy.

Leslie Schlachter: How can you tell the difference?

Pascale White: We can't, which is why we always say, "When you have a symptom, talk to a provider. Come in-" Mm. "... have us check it out with a colonoscopy." Do you

Leslie Schlachter: need a colonoscopy to evaluate blood in the stool, or is that something that you guys can figure out on just an exam?

Deirdre Cohen: We need a colonoscopy

Pascale White: Yeah, we need a colonoscopy.

Some patients say, "Can you do a rectal exam?" I'm like, "I can do a rectal exam, but that doesn't mean whatever is bleeding is bleeding right now." And so whatever bled at that point may have stopped, but we need to check it out with a colonoscopy, with a camera study.

Screening Options Explained

Leslie Schlachter: Can you now walk us through what the options are for colorectal screening?

David Greenwald: Sure. So there are a variety of options, which is really good. Um, at, at Mount Sinai we talk about choice because there's a choice in colorectal cancer screening options. In fact, our colorectal cancer screening program is called CRC Choice. Anyway, those choices include looking for blood in the stool, typically called an FIT test or fecal immunochemical test, which is looking for blood in the [00:10:00] stool.

Um, a, um, test that looks for blood in the stool and abnormal DNA, which are little pieces of cells that might be coming off of polyps or tumors, um, that's called fit DNA. It's marketed commercially as Cologuard. Many people know about it. And then there's colonoscopy, um, which has become the gold standard over many, many years now because it allows us to both detect abnormalities

like polyps, which are little growths, and remove them at the same time to prevent cancer.

There are a couple other options. There's a CT colonography, which is a CAT scan of the abdomen, which is reconstructed into a kind of a video that looks like a colonoscopy. Um, and there's a capsule as you described- Mm ... um, which is exactly what it sounds like. It's like a little magic capsule that's got a, a CCD chip, like a, a digital camera chip in it with an antenna and a battery and some lights, and when you swallow the capsule, the battery turns on, the lights turn on, the camera turns on, it starts to take pictures.

There's also an antenna in there that [00:11:00] transmits those images wirelessly to a belt recorder or hard drive, and then eventually the capsule goes in the toilet. The hard drive comes back to us. We download the images. Do you have to fetch the capsule? You do not have to fetch the capsule- That's very good Um, and then we look at those images, and it gives us essentially a different view, just like a colonoscopy.

Leslie Schlachter: So they're like little-

David Greenwald: Lots of options ...

Leslie Schlachter: they're like little bomb robots that you- Little ... send into a bomb room

David Greenwald: to look-

Leslie Schlachter: And it would be- ... but not be there.

David Greenwald: Man ... super cool if we could put little scissors in there and then snip the polyps out, but we haven't gotten there yet.

Deirdre Cohen: That's really funny. Can I ask, what are your guys' thoughts about ctDNA in terms of screening?

David Greenwald: You're talking about blood testing?

Deirdre Cohen: Yeah.

David Greenwald: Yeah, so I was just gonna get to that. Oh, sorry. But yeah, blood- No, that's fine. Yeah, so blood testing is also now available, um, for, uh,

testing for colorectal cancer. There's one, uh, that's FDA approved. There are s- some others in the works, and there's another version of it also as well.

But, um, they are terrific right now at screening for cancer. They are not as effective by any means at screening for polyps. And since we know that in colorectal cancer there's a precursor lesion, an early [00:12:00] lesion- Right ... called a polyp that's not cancerous, and if we take it out, people don't get cancer. So that's, to me, is sort of where we're going with this.

So-

Leslie Schlachter: So if you had, like, a negative screening test, you could safely think you're okay, but you're not.

David Greenwald: If you had a negative blood test, for example- Right ... you probably don't have cancer, but you may still have a polyp. Okay. For sure. And we wanna get to those polyps. Right. It's the same thing with some of the stool-based tests, actually.

Leslie Schlachter: So- So isn't there, isn't there, like-

David Greenwald: Great question ...

Leslie Schlachter: what's, what's the blood test that you can screen for can- What is it called? GRAIL.

David Greenwald: Well, there's,

Leslie Schlachter: there are multiple- But wasn't there, like, there was, like, when I was in PA school 20 years ago, there was a blood test for screening.

David Greenwald: Yeah, that was called Septin 9.

It's- Okay ... um, it's sort of fallen out of favor. Yep. These other tests that we're talking about now are much more sensitive, um, and, and specific than those early tests. Okay. But they've still got, I think they've got a ways to go. Well,

Deirdre Cohen: no, that's- Yeah. Do you agree? I meant to ask- Yeah ... my gastroenterology friends what your thoughts are on blood-based, uh, testing, although I suspect, uh, in the next five to 10 years- Correct

that there may be far [00:13:00] fewer colonoscopies done.

David Greenwald: And that, I think that would... I mean, Dr. White can comment, but I mean, I, that would be fine with us- Yep. Yeah ... as long as the sensitivity and specificity- Sure. I know ... which are doctor words- We're not there yet ... to try, you know, are perfect or good enough- Yeah

that we're not missing anyone along the way. Interesting, yeah. So yeah, we, we'd be good. We would love- Blood

Deirdre Cohen: work can't clip the polyps, though.

David Greenwald: Well, we would love to get to a place where we could mass screen the whole population with a non-invasive test, like a stool test or a blood test, and then reserve the colonoscopies- Yeah

for the people, 30 to 40% of people right now, who have polyps who will benefit from that. So yeah, that would be terrific.

Deirdre Cohen: And I know patients much prefer to have a blood test than the stool. I'm sure you guys struggle, right, with having patients, um-

Pascale White: I, we book- Yes.

David Greenwald: Yes.

Leslie Schlachter: Yes. Yes

Pascale White: Yes. The, the idea of having, you know, an invasive procedure or being put under sedation or anesthesia to some patients-

David Greenwald: No, she's talking about the stool-based test over a blood test

oh,

Pascale White: yeah.

David Greenwald: Oh.

Pascale White: Yeah. Stool collection.

David Greenwald: Yeah. Yeah, there's a, there's an ick factor

Leslie Schlachter: to it. Yeah. There's just, just is like extra. Yeah. Sorry. Is that what you mean? Are we talking about you collect it in a container and send it to a lab? Yes, yes. Or you go in for a rectal? [00:14:00] No.

Deirdre Cohen: No.

Leslie Schlachter: You collect

Deirdre Cohen: it at home. Oh. And there's that ick factor.

Sorry, did I sidetrack your question? No, no, that's fine. I just think that it'll be a much bigger uptick. I feel like we could capture a whole lot of more patients for screening, uh, who are, you know, concerned about colonoscopy and that prep, and then even just collecting stool at home, which is obviously far easier than a colonoscopy prep.

Right. Um, so, you know.

Pascale White: But we definitely

Deirdre Cohen: have to be- But it's not ready yet.

Pascale White: Yeah, we definitely have to be careful. It can't be, um, overstated the fact that the blood tests at this point are not detecting early colorectal cancer, which when it is detected early, you have a higher survival rate, up to 90%. And so with patients who have early cancers, we want to find them and potentially have it cured, right?

Um, but these blood tests are not good at that yet.

Leslie Schlachter: So it's just one tool in the toolbox for right now. Correct. And do you use the blood test to follow patients?

Deirdre Cohen: Yes,

Leslie Schlachter: we

Deirdre Cohen: do. Move,

Leslie Schlachter: okay. Yes. So

Deirdre Cohen: once

Leslie Schlachter: they're in treatment. So close surveillance for- We're getting to treatment, I promise.

Pascale White: Oh, that's fine.

David Greenwald: It's a different blood test though, that you're following.

Different blood, or a different

Leslie Schlachter: blood test, yes. So what are the recommendations right now? [00:15:00] Let's just talk about the general healthy public, then we can talk about people that have, like, obvious risk factors, like, I don't know, ulcerative colitis or Crohn's, and then people with family history. So what's the screening recommendations?

Pascale White: So right now it's 45 for everybody. So we like to say 45 is the new 50, uh, for patients who need to know that 40, that the age went down to 45 because we're seeing a uptick in, uh, early colorectal cancer. Uh, so it's 45 for all, and these are for patients who are at average risk. So patients who have no family history of colorectal cancer, patients who have no personal history of polyps, patients who, um, have no symptoms at all, so they're not anemic, they're not lo- losing weight or having blood in the stool.

Uh, these are patients who are gonna come in and say, "I'm asymptomatic, average risk." We're gonna screen you at 45. Patients who have any other risk factors, they're gonna be screened earlier

Leslie Schlachter: So for patients who have a primary care doctor, I know how our EMR works. Something will come across their screen saying, "Ding, ding, forty-five, send them for a colonoscopy."

But, like, how do you capture patients that, like, [00:16:00] don't have their yearly PCP or follow their care? How do we make sure that they're getting it?

David Greenwald: Okay. So there has been an enormous amount of work done on outreach to the public to make sure that this message is getting to everyone, and it's getting to everyone in different languages, in different populations with

different messaging to the different populations because we know that the messaging that reaches one population won't necessarily reach the other.

So there are national organizations that we're all involved in that have put forth or put together really amazing public relations information to try to get that word out that this is a, um, preventable disease. Colorectal cancer is largely preventable if we can take polyps out. If it's not preventable, as Dr.

White was saying, it's, and detected early, it's treatable, so it's beatable. And that's the message we're getting out there. So we have to just keep getting that message out. Yeah. And having said that, the screening rate in New York City right now is about sixty-nine percent, which means that thirty-one percent of the eligible population hasn't been screened.[00:17:00]

Hmm. And around the country, it's not any different than that. And the rates are even lower in the groups that have lower insurance or less insurance, our federally qualified health centers. The screening rates are in the thirties and forty percent right now. So we've got a lot of work to

Leslie Schlachter: do. Yeah. Are these-- Is a colonoscopy, which is the gold standard, is that covered by patients who have Medicaid?

Yeah. Yes.

David Greenwald: Absolutely.

Leslie Schlachter: So there should be, you know.

David Greenwald: With no co-pays and no deductibles.

Leslie Schlachter: Okay. Well, I guess this would be a good time just to, like, pause for a second. So if you are new to The Vitals, um, please make sure that you scan the QR code below. We want to make sure that you guys follow us and get all this information moving forward.

And hopefully, if you can't stay for the whole episode, also scan the QR code below to make an appointment to see one of our gastroenterologists if you're, you know, forty-five or up and haven't had a colonoscopy. Okay, so let's, let's keep going. So you, you have a patient, they're getting their colonoscopy, polyp, whatever.

Can you tell right then and there during the colonoscopy whether that looks like something cancerous or, or not? [00:18:00]

Pascale White: You can tell if something looks malignant most of the time, but because we don't know, we have to remove them and send them off to the pathologist, right? So if we're finding a big tumor, yes, some things are pretty obvious, but these polyps that we're taking out, we send them off to the pathologist to confirm if they're pre-cancerous or not, 'cause not all polyps are pre-cancerous.

Right. There are some polyps that don't turn into cancers. Right. It's the pre-cancerous ones that we wanna find and remove.

Leslie Schlachter: And then the ones that have the pre-cancerous, like the polyps, you just follow them close- more closely with colonoscopies moving forward?

Pascale White: It depends on the type of pre-cancerous polyp.

It depends on the size. It depends on the number we find. We have guidelines that tell us, uh, you know, when to come back for these colonoscopies.

Treatment Stages And Trials

Leslie Schlachter: So now we have a patient with cancer.

David Greenwald: Yeah.

Leslie Schlachter: Like, what, what kind of cancer is colorectal cancer? Is it adenocarcinoma? What are we dealing with?

Deirdre Cohen: Yes, it is an adenocarcinoma gland-forming tumor, correct.

Leslie Schlachter: Okay, and so what are the treatments? So are there, is there surgery, radiation, chemo?

Deirdre Cohen: Yes is the answer. Um, it really depends. It's very [00:19:00] stage dependent, right? So if it's a stage one colorectal cancer, for example, um, that's treated with surgery alone. So most of those patients never see me, which is wonderful.

They have over, well over 90%, uh, survival rate. Uh, for stage two, typically it's mainly, uh, surgery again. We do look at ctDNA to help us prognosticate their risk of recurrence and whether chemotherapy would be, um, helpful to lower that risk of recurrence. But for the most part, stage two patients are not getting chemotherapy, and surgery alone is curing them.

Um, it's where we get into stage three and four where, uh, there's more multimodality therapy, uh, including surgery, chemotherapy, and, uh, radiation in the setting of rectal cancer. So that's where we really use radiation therapy. Um, and there is a distinction between, um, you know, biomarkers within colon cancer, so and certainly gastroenterologists can also, you know, chime in [00:20:00] here in terms of, uh, tumors that are mismatch repair deficient or microsatellite unstable.

Um-

Leslie Schlachter: Can you bring that down five notches for-

Deirdre Cohen: Yes ... me and our viewers? So that is a biomarker. It's basically a mutation, um, that can happen either you've inherited it from mom or dad, and then it's called Lynch syndrome, uh, or it's sporadic. Um, and basically it's a error in DNA repair. Um, but it actually allows for the tumor to produce more antigens.

And so these tumors are much, uh, better behaving, and they also respond to immunotherapy, which I know is a big hot, uh, topic.

Leslie Schlachter: So you wouldn't-- So once the pathology comes back and you can do some genetic workup on the actual tumor itself, you then can find out whether or not they're candidates for immunotherapy versus just like chemotherapy.

Deirdre Cohen: Yeah. So we do a lot of testing on the tumor to help us understand the biology of the tumor, so including whether they would be good candidates for immunotherapy and, you know, what, um, what [00:21:00] treatment they would, um, best, uh, you know, need.

David Greenwald: And this is way different than it was like 10 years ago. Yes. I mean, this didn't e- none of this even existed- Yes.

It's very- Which is so cool.

Leslie Schlachter: Like what,

Deirdre Cohen: what a, what a biggest difference- It's much more personalized medicine. Yeah. So we're really looking and understanding, um, what's driving the tumor and, you know, having more targeted approaches. And we're also, um, you know, backing off from some of our more aggressive therapies in that setting.

So for example, for a mismatch repair deficient or MSI-high rectal cancer, we're now, uh, able to treat these patients only with immunotherapy and forego surgery and radiation, which is huge in terms of quality of life and functional outcomes. Enormous.

Leslie Schlachter: I know, I know you're the oncologist, you're not the surgeon, but like you said for stage I and stage II, surgery can be curative.

Can you just tell us a little bit about what that is? Is that like a big surgery with a bag? Is it something smaller?

Deirdre Cohen: Sure. So, um, typically, you know, for, uh, colon cancer, it's they're taking out [00:22:00] part of the colon, so a hemicolectomy, whether it's on the right side or the left side. Um, and there's no bag involved, so they are, you know, put back together, if you will.

So

Leslie Schlachter: snip, snip, reconnect.

Deirdre Cohen: Correct. Um, and they have complete, um, you know, normal function. I mean, there, there's a little change, uh, early on, but generally people live a, a really full and, you know, normal life, um, following surgery.

Leslie Schlachter: Okay. And then, so is it like more of like when... 'Cause when I think colorectal cancer, I can't help it.

I worked in urology for years, so I had patients with stomas. Like, who are the patients that are getting the bags?

David Greenwald: Most of the patients with colorectal cancer are not getting bags unless they come in fully obstructed and blocked. Mm-hmm. And then the bag is actually a temporary measure while the, um, while the, um, the rest of the, uh, situation is taken care of.

Um, and then eventually it's, again- Right ... the tumor will usually be resected, taken out, and then the colon reconnected in, in the vast majority of the cases.

It's

Leslie Schlachter: like a healing mechanism.

David Greenwald: It's a healing mechanism, yeah. There are [00:23:00] lots of patients who get bags for other reasons- Right ... diverticulitis and so forth.

But in terms of colorectal cancer, it's pretty rare.

Deirdre Cohen: Yeah. Mm-hmm. I think, you know, the, the only time would be a very low-lying rectal cancer. Right. Um, and even then we're trying to avoid that with chemotherapy and radiation, um-

Leslie Schlachter: How long does treatment usually last?

Deirdre Cohen: That also kind of depends on the stage.

So certainly for metastatic it's sort of indefinite. It really depends also if there's limited metastatic disease, what we call oligometastatic disease, where we can surgically remove all of the metastases, um, versus if it's widespread and then sort of treatment continues until, um, as long as patient's tolerate it and the tumor's responding.

But for, typically for stage III where it's surgically resected and there are lymph nodes that are, are involved with cancer- Mm-hmm ... we give about six months of chemotherapy- Okay ... on average.

Leslie Schlachter: And do you have any clinical trials right now that are going on?

Deirdre Cohen: We do have several clinical trials, uh, going on.

So we have a study looking [00:24:00] at, um, basically using ctDNA, which is circulating tumor DNA, so looking at sort of fragments of cancer cells or the DNA of the cancer cells in the blood and, um, adjusting treatment based on that. So escalating, uh, treatment if the, um, the ctDNA is positive in the blood or deescalating if it's negative.

So really trying to avoid over treating patients who are gonna be cured with surgery alone and avoiding chemotherapy, 'cause certainly chemotherapy can have some long-term side effects. And then escalating, trying to cure more patients who, um, you know, may benefit for a, a more, uh, intense regimen. We also have, uh, treatments in the metastatic setting, so more, um, some studies looking at, uh, bispecific antibodies in combination with chemotherapy.

And I don't know if this is too-

Leslie Schlachter: No, no, it's g- it's good. It's good ...

Deirdre Cohen: much.

Chemo Plus Immunotherapy

Deirdre Cohen: Um, uh, and then we have a couple of, uh, bispecific antibody treatments in the [00:25:00] metastatic setting right now.

Leslie Schlachter: I would imagine the patients are looking for more of like the immunotherapy route than the standard chemo route.

Deirdre Cohen: Well, I think chemotherapy still pl- it's still the backbone for treatment of colorectal cancer.

We're not quite ready to give that up. Um, so a lot of our studies are adding immunotherapy agents in combination with chemotherapy.

Leslie Schlachter: Maybe you guys can get your little video robots to spit little

David Greenwald: Yeah. So we actually-

Leslie Schlachter: Can we antigen things, add a polyp

David Greenwald: or something ... so we, we actually have other parts of the GI tract where we put chemotherapeutic agents directly against the tumor, like in the bile duct.

So yes, and if we can get our little capsule to direct itself perfectly, that would be terrific. You can work with us on that.

Screening Pathway And Tumor Boards

Leslie Schlachter: So you guys are gastroenterologists. You're an oncologist. I guess the only person we're missing here is a colorectal surgeon. But is that, like, typically the pathway, how this, how this works?

And is there a connection back? Do you need surveillance colonoscopies? How does it work once you're kind of like in the colorectal pathway?

Deirdre Cohen: Well, I'd just [00:26:00] add that I think someone who's very important in this whole pathway is the PCP, which I think we alluded to, right? Looking for anemia, right? Which I think when I think about my patients who have been diagnosed with colon cancer, a, a lot of them present just with new, newfound iron deficiency anemia.

Like they show

Leslie Schlachter: up to their primary and, "Oh, look." "

Deirdre Cohen: Oh, there's only-- Yeah, your hemoglobin's now 10." And- Okay ... and so then they're referred to- Right ... to my colleagues,

David Greenwald: yeah. And even more important is the primary-- I mean, that's very important, but even more important is the primary care physician just saying, "You need to, uh, deal with colorectal cancer screening," because a lot of people shy away from this- Mm-hmm

because they're embarrassed about having a colonoscopy. They're embarrassed about playing around with their stool for the stool-based testing. There's all sorts of reasons why people have avoided colorectal cancer screening. But it turns out to be really beneficial. It's one of the few cancers that we can show where screening and then d- uh, eliminating polyps, we've actually decreased the rate of colorectal cancer in this country pretty dramatically over the past 30 years.

So the primary care physicians and, um, [00:27:00] other healthcare providers who are providing primary care- Right ... them telling a patient, "You need to get screened," turns out to be the single most important factor in getting that patient screened.

Leslie Schlachter: Yeah. No, I love that. I have a primary care here at Mount Sinai, and I'm not gonna say her name, but she's not, like, the most warm, fuzzy PCP.

But she is like, "This is what you have to deal with." She knows who you are. Just like gives me a bullet point list of what has to get done, and if certain things aren't done, they're-- the office is calling being like, "Why did you cancel this? Why?" And I love it. Mm. That's how they should all be.

Pascale White: It's good.

Deirdre Cohen: Th- this is the team with, uh, surgery as well as radiation, and I mean, we have what we call tumor boards, where we're presenting patients, and we're reviewing in addition to with pathology, uh, radiology, interventional radiology.

So it's a big team. Um, but I think after the completion of treatment, the core group of surgery, um, medical oncology, and gastroenterology, uh, continue.

David Greenwald: Uh, the people who come [00:28:00] in either for their colonoscopy or with a stool-based test that's positive, and that's really important that if the stool-based test is positive, those patients need a colonoscopy.

Leslie Schlachter: So the patient doesn't even need to see you for the stool-based

David Greenwald: test. No. The

Leslie Schlachter: PCP can send it- No ... and then be like...

David Greenwald: No. In fact, on the Super Bowl- Right ... the Cologuard people were advertising just I love that ... stepped in, yeah.

Leslie Schlachter: Yeah.

David Greenwald: So-

Leslie Schlachter: Just pick it up at CVS.

David Greenwald: Well, yeah, sorta. Get some- Not really. It's a mail-in thing, but yeah.

Leslie Schlachter: Instacart.

David Greenwald: Yep. But anyway, once, once those, once, you know, if any of those tests are positive, then we do work with our colleagues on staging, as Dr. Koren was saying, and then we refer them typically to our oncologist to manage along with the surgeon if that's relevant.

Leslie Schlachter: So basically- So- ... colonoscopy, positive pathology, MRI, CAT scans?

Yes. Staging.

David Greenwald: Yep.

Leslie Schlachter: You.

David Greenwald: Yep.

Leslie Schlachter: May- m- maybe, maybe not. Maybe just colorectal surgeon.

David Greenwald: Correct.

Pascale White: Depends.

Leslie Schlachter: Okay.

David Greenwald: Depends.

Leslie Schlachter: Got it. Yeah, and I think you just brought up a really good point before, and then for those of you guys listening, one of the things that can be really stress-inducing is when you go to a doctor, get diagnosed [00:29:00] with something, you wonder, like, "Should I get a second opinion?

Should I get a second opinion?" And especially in New York and major cities, it c- you can feel like you need to get multiple opinions from people. And one of the great things about a place like Mount Sinai, we are an academic institution, and we have multidisciplinary teams. So what they talked about is a tumor board, and you guys said your tumor board's probably similar to ours.

So GI, medical oncology, radiation oncology, colorectal pathology, radiology, everybody reviews Complex cases for sure, but sometimes non-complex cases

where it's like, "Should we do this? Should we do that?" Um, and then there's a group consensus that comes out of the tumor board, and by default you're getting, like, over 10 opinions in one visit.

Correct. And that's a big benefit.

Deirdre Cohen: And in fact, we, uh, for every rectal cancer patient, it's not just complicated ones, every single rectal cancer patient is presented at our multidisciplinary conference, so.

David Greenwald: Yeah.

Leslie Schlachter: That's, that's really important because, like, if you're getting an opinion out of Mount Sinai, then you know you're getting [00:30:00] multiple opinions that came together as one.

AI In Colonoscopy

Leslie Schlachter: Are you guys using artificial intelligence at all in colorectal cancer? Ooh, that's a great question. It's a little bit-

David Greenwald: We are. So we absolutely are. Yeah. So, um, there are... We're, we're in baby step mode right now- Okay ... but it's a big step where we're using it. So the, the easiest to explain example is that we're using it during our colonoscopies- Mm

to look at the screen. So in a colonoscopy we're looking at a video image of the inside of the colon, and as I said, we're looking for polyps. 30% of me- uh, women have polyps, 40% of men when we screen them have polyps. So we can use artificial intelligence to look at the TV screen, and it puts a little green circle or an arrow pointing at something and says, "Hey, look there."

And that there might be some residual stool, or it might be a polyp that I saw or it might be a polyp I didn't see. Mm. So that's the way we're mostly using artificial intelligence right now. It's terrific at increasing the yield in polyp detection, and we're still studying whether it actually affects outcomes or not,

Leslie Schlachter: so.

H- So far, just like you're... When the little arrow goes up on yours, [00:31:00] do you ever go, "Oh, I didn't see that. Thank you"?

David Greenwald: Yeah, um, so I've seen demos where... And yes, absolutely, yeah. You sort of say, "Oh," you know? That's great. And we've been doing that for years also with the other people in the room. So yep, we have technicians and nurses- Our techs

in the room, and we ask them to actively participate- So

Leslie Schlachter: OI, other intelligence ...

David Greenwald: other intelligence. Yeah. But now we're using computer artificial intelligence. It's very cool.

Leslie Schlachter: Yeah, that is really cool. That's good. Yeah, no, that's really helpful. That's a team. Thank you. Yeah. In, in neurosurgery when we order scans, um, the AI radiology reads it, and then we'll send something out.

Like, so let's say it's not in the list for the neuroradiologist to read for another couple hours, if there's something that picks up, it moves it to the top of triage, which is really helpful. Oh. Yeah. Love that. Yeah, no, it's really, really great.

David Greenwald: Love that.

Myths Trust And Hope

Leslie Schlachter: What are some of the biggest misconceptions out there about colorectal cancer that we should talk about?

Pascale White: Stressing that it's no longer a disease of older people. Um, younger people are getting colorectal cancer.

Leslie Schlachter: And let's say it again, it's the number one-

Pascale White: It's the number one cancer, uh, death in patients under the age of 50 in the United States of [00:32:00] America.

Leslie Schlachter: It's

Pascale White: a really big deal. Very big deal. And they didn't expect that to happen so soon.

It was projected that this would be the case in 2030. It is now the case now. So this is a trend that is most definitely alarming, and we want everyone to know about that.

David Greenwald: There's a myth that colorectal cancer is only a man's disease. Actually, equally affects men and women. There's a myth out there that if you don't have a family history, you don't need to be screened.

That's not true. Family history is important, but it's not the only thing, and most colorectal cancer occurs in people with no family history. And then the last big misconception, I think, is that if you have no symptoms, you're fine. But again, as we said, this is a preventable illness if-- a preventable disease if we can find it, and we're looking for people without symptoms who have polyps.

Leslie Schlachter: We gotta get the polyps out.

David Greenwald: We gotta get the polyps out. This is very much akin to cervical cancer- Yeah ... where Pap smears find, um, cancer before it's cancer, and then you can do something about it and prevent it.

Leslie Schlachter: Mm-hmm.

Pascale White: I think the other, uh, myth out there is that, uh, colorectal cancer comes in a part- a particular, [00:33:00] uh, race or particular gender.

Um, there are a lot of disparities in this disease. There are patients who are getting, uh, diagnosed with this disease at far higher rates. For example, American Native Alaskan Indian patients have now the highest incidence of colorectal cancer in the United States. Uh, second to that is for African Americans.

Uh, so a lot of disparities here in terms of, uh, screening disparities, in ca- in terms of survival disparities. Not everyone is getting screened, and we really need to make a concerted effort to reach those populations that are dying of this disease at higher rates to really get the message out there.

Leslie Schlachter: Mm-hmm. What about you for myths?

Deirdre Cohen: I would say, I mean, I think you guys covered it very well, but from my perspective I would say that it is not a death sentence. So we can still cure you if you are to be diagnosed with colon cancer. Um, so there are really,

really, um, new advanced treatments out there that are curing more and more [00:34:00] patients even in, you know, metastatic, uh, stages.

Leslie Schlachter: And it sounds like you guys aren't trying to bulldoze patients with treatments. You're trying to do, like, the least amount that you need to be- Correct ... not as aggressive.

Deirdre Cohen: That is, yes, it is all about precision medicine and really, um, focusing on the biology of the tumor and giving no more or less than what a, uh, you know, is called for.

Leslie Schlachter: I think it's always been there, but I think it kind of lifted a little bit more during COVID, was this mistrust of healthcare professionals, pharmaceutical companies, um, like some sort of conspirac- conspiracy. Do you see that with any patients when it comes to chemo, that it's poison or that there's, like there's gotta be reasons that you're pushing drugs on them?

Is that a part of your practice at all?

Deirdre Cohen: I think there is a level of questioning about, because of the side effects of chemotherapy, right? So the chemotherapy, uh, kills good, uh, kills the cancer cells, but it also, the side effects are due to, um, damaging some of our [00:35:00] normal healthy cells. And the way we give it is on a certain, um, cycle schedule so that those healthy cells can, um, get better, and this is not terribly toxic to patients.

But I essentially, you know, build trust I think is very important, as you had mentioned earlier. Um, and explain that, um, really explain the studies. You know, that after s- surgery this number of patients who get chemotherapy recur versus this number of patients, which is much higher, who don't get chemotherapy.

Mm. And there's a clear benefit. Um, and that I wouldn't be giving it if it wasn't, you know, effective. Um, and I think, you know, it's, it's a matter of showing the data and reassuring patients. I think more than, than, um, I think most patients are m- mainly concerned about the side effects more than that it's- Not like

Leslie Schlachter: mistrust

Deirdre Cohen: mistrust. Yeah. Yeah. It's more about the side effects and whether they're gonna tolerate it, and is the chemotherapy worse than the disease? And I [00:36:00] always explain to every p- one of my patients, like,

my job is to never allow the treatment I'm giving you to be worse than your disease. That's not the goal here at all.

I'm here to make you better.

Leslie Schlachter: Yeah. I mean, 'cause we, we see, I see that in my world of neurosurgery where sometimes People are just like, "Nope, I don't wanna go through that, and I just will let nature take its course." And patients can make that decision. But that's so nice to hear that from a medical oncologist, like, "My goal is for the treatment to not be worse than the disease."

Yeah. I love that.

Deirdre Cohen: And I think in colon cancer, it is a disease, even in an advanced setting, where survival is we're talking years, so it's not as nihilistic as, you know, most of my patients do not choose comfort care, although that is always part of the discussion. If we can't cure it, that is an option to have supportive palliative care only.

Um- Right ... and that's, you know,

Leslie Schlachter: it's- And by the way, like, palliative care for colon cancer does not sound fun. It sounds obstructive.

Deirdre Cohen: Well, I mean, I think palliative care is part of treatment. Yeah. So I wouldn't say that, actually. [00:37:00] I, I actually- No,

Leslie Schlachter: like meaning just choosing palliative care. That- I mean- I mean, you say you don't s- you don't get that that often.

Deirdre Cohen: No, we don't. We don't. Yeah. Not, not from without having had some treatment- Okay ... initially.

Pascale White: Yeah. And I think I, I would just wanna mention in terms of the mistrust in the medical community, we can't ignore the fact that there were some people in this country that did undergo atrocities that really mishandled their trust in the medical system.

Mm-hmm. And so to handle these communities with care, with understanding, with empathy, um, and to be able to have a discussion about side effects, to be able to have a discussion about treatment protocols, to be able to explain to this community to build their trust, is absolutely critical.

Leslie Schlachter: Yeah. Agreed.

Agreed. Would you guys be able to each stare- share a story about a patient that, um, you know, like a big save or maybe like something that was like a heartwarming story, something that the, the viewers could maybe [00:38:00] be like, "God, I real- yeah, I, I gotta go in and get screened"?

Pascale White: I have a story. Okay. It comes to top of mind, uh, and I think you heard this story, Dave, at, at our, at last conference.

Um, there was a patient, African American man. Uh, he was in his 40s, and I saw him on my clinic list, and I said, "Okay, I'm gonna go in. I have the statistics. I know..." Because a lot of the times they're very apprehensive about getting screened, especially the young men. Um, so when I went in there, uh, he looks at me, says, "Are you Dr.

White?" I said, "I am Dr. White." He said, "I'm definitely getting my colonoscopy with you." And I said, "Why?" He said, "Because you have your Jordans on." Yes. And it hit me that the connections that we make with our patients is far reaching than our degrees. It's far reaching than our training. It is the ability for the patient to connect with their physician, to build that trusting relationship, and I had no idea that my Jordans would have this- Yeah

big impact on this patient, but he felt- And I would also feel the same way ... you know? Um, but he felt as [00:39:00] though I could understand where he was coming from. Mm-hmm. That patient ended up getting screened. I found the tiniest, and I mean to this day I can't even believe I, I saw it, and it didn't look like anything, but it was a s- a, a, a precancerous a- aggressive polyp.

And if he didn't come in, th- I don't know what it would've turned out to be. If you weren't wearing your Jordans. I think about it all the time. I am wearing my Jordans every Tuesday in clinic- Mm-hmm ... for colorectal cancer awareness month, um, in honor of him. But it's one of those things where you never know how you're gonna connect with a patient.

Right. You never know how that patient's going to decide to get screened. And, um, these are the moments where you say, "This was a life-saving procedure for you, and please go out there and tell everyone that you know to get screened. Because if you didn't, this could've end, you know, had a different ending."

Leslie Schlachter: That's a good social media story right there.

Pascale White: I did ta- I did actually. Good. Good.

David Greenwald: So I have a similar story, but I'll, I'll make it a little bit different. Um, it was also, um, a [00:40:00] young man very recently, and I could do one from, like, every week actually but-

Leslie Schlachter: Right.

David Greenwald: Um, he was in his late 40s. He had postponed doing his colonoscopy for a couple of years- Mm-hmm

'cause he said that he was freaked out by the prep. So I just wanna touch briefly on the fact that the prep is not as bad as everybody thinks.

Leslie Schlachter: I think we definitely need to talk about the prep.

David Greenwald: We'll come back to that. How about that? But, um, this gentleman, um, finally came in, so in 48, so he was three years behind our recommendations.

Uh, he was perfectly prepped. Everything was good. And when I was done, um, you know, I told him that I had found six polyps. Um, and none of them were scary looking to me, but that we would send them off to the lab and so forth. And he looked very, very disappointed, like he had somehow failed, that he was supposed to have a perfect colon.

Aw. And, um, so I said to him, "No, actually, this is exactly why we're doing what we're doing, and you didn't do anything wrong. But you had these polyps, and we took them out." And much like Pascal, Dr. White was saying, like, you know, this potentially... Like, he- he's just gonna continue on, you know, in his life, and maybe we've prevented him from getting [00:41:00] colorectal cancer.

That has amazing impact on him and his family, you know, 10, 20, 30 years from now. And I actually remind the nurses and the techs that I work with when we do stuff like that what we're doing.

Leslie Schlachter: Right.

David Greenwald: Um, so that's my heartwarming story for the

Leslie Schlachter: day. That is. Yeah. He walked out with a hop in his step because he had a squeaky colon.

David Greenwald: Yeah, but he didn't even realize how good it was. I'm sorry. And, um, it was great. And let's come back to the prep, please.

Deirdre Cohen: Yeah. Uh, so I would say a little different in the sense, um, that I treated a patient with... who- 80-year-old gentleman who was diagnosed b- basically from a dermatologist because he had a fistula.

So in fact, the cancer fistulized through his skin from the cecum- Mm ... um, and was, was, uh, leaking essentially, and he had seen all these doctors. No one knew what it was. He finally got an im- imaging and had a biopsy and was found to have colon cancer, and he was about to have this huge surgery, uh, when we realized, um, appropriately that we tested, uh, [00:42:00] for the biomarker that I mentioned for this, uh, uh, marker mismatch repair, and it was deficient, which meant the tumor basically melted away with immunotherapy.

So he didn't need any surgery. He didn't need any chemotherapy, and he is thriving, doing-

Leslie Schlachter: So he's had a fistula repair?

Deirdre Cohen: What? No, he didn't have anything. He didn't need anything. That just closed up. It just closed up on its own. Yes. What a win. His own body healed it. That's great. Uh, his own immune system. So-

Leslie Schlachter: Wow

Deirdre Cohen: um, so that's why I say there's,

Leslie Schlachter: there's hope in-

Deirdre Cohen: That's a great story ... treatment.

Prep Lifestyle And Access

Leslie Schlachter: So back to the prep. I h- I've had a colonoscopy. I've had two.

David Greenwald: Good.

Leslie Schlachter: Um, I had hemorrhoids a decade ago.

David Greenwald: Okay.

Leslie Schlachter: Yeah. But my, my- They're very common ... Ari Grinspan, Ari Grinspan is my gastroenterologist. He's excellent. And he said, "I'm really sorry, but this is what we gotta do," and that's what we did.

I did not have a good experience with my prep- Okay ... if you catch my drift. Got it. Did not like it, and it scared me.

David Greenwald: Okay.

Leslie Schlachter: So, like, please tell me the prep has changed, 'cause that was not fun.

David Greenwald: So I don't know what you had, and we're not gonna talk about that right now, unless you really, really want to. I drank stuff.[00:43:00]

You... Well, everybody drinks stuff. Right. So most of the preps, um, right now taste better than the preps that the comedians like to make fun of, and have... I mean, their entire routine can be about colonoscopy preps, and it works. Um, but the preps that we're using for the most part right now are a powder that mixes with some better-tasting liquid.

So either it's a sports drink, like Gatorade or Powerade or sugar-free Powerade, Crystal Light, coconut water, or a flavored solution that comes with a commercially available preparation that also tastes better. We're also using lower volumes than we used to use. So previously, people used to drink something called GoLytely.

It was, like, four gallons, four quarts or a gallon of seawater. Yeah. Terrible. Yeah. Um, I mean, I've tried it. It's terrible. Yeah. So we've replaced that with things that are much easier to take, and because it's lower volume and easier to ta- uh, easier tasting, people tend to s- at the end of it, say, "Oh, that wasn't so bad."

So you need to try again.

Leslie Schlachter: Yeah. Yeah. I'll let you know how my next one goes. So they're just, [00:44:00] like, better tolerated.

David Greenwald: Yeah, and I've- Is really the goal here ... I've done a couple of colonoscopy preps myself also- Mm-hmm ... and they were not bad. I don't know if your experience, and your experience, or your patient's experience.

Well,

Pascale White: I had only one, and it was not that bad, and I actually prepped the, um, while I was scoping, so like- Yeah, I did

David Greenwald: too, actually.

Leslie Schlachter: Oh, you did your prep on a scope day?

Pascale White: I did my prep on a scope day. Me too. All right. Okay. Well, I guess

Leslie Schlachter: everybody-

Pascale White: Well,

Leslie Schlachter: we do. Great. Do you have to prep for the video robot?

David Greenwald: For the capsule.

Yeah. I mean, there is a prep involved in that, yes. Yeah. Yeah, 'cause

Leslie Schlachter: it needs a squeaky clean

David Greenwald: state. It needs, well, it needs the, the colon needs to be- Mm-hmm ... as clean as it can be. Got it. Yeah.

Leslie Schlachter: Okay. So as we're finishing up, um, whether you want to prevent your risk of colorectal cancer or prevent it from recurring, is there anything that patients have control of that they could do to decrease their risk?

Deirdre Cohen: Yeah. So I think what is, what I tell all my patients when they've completed their course of treatment and they're moving into surveillance is to keep moving. So exercise is really, really important to lower the risk of recurrence. So is healthy eating, so we talk about sort of low fat, [00:45:00] uh, low processed foods, red meats, high fruits and veggies, sort of what every doctor tells their patients.

Leslie Schlachter: Wait, sorry. Low red meat or high red meat?

Deirdre Cohen: Low, low. Red meat. Low, yes. '

Leslie Schlachter: Cause then you went to fruits and veggies, so I just wanted to make

Deirdre Cohen: sure it was

Leslie Schlachter: comma-

Deirdre Cohen: Oh, yes ... or semicolon. Comma, thank you. Fruits and veggies. Yes, yes. High, high greens, low meats, if any. Um, and, uh, avoid the processed foods. Uh, we also make sure that everyone's vitamin D is, um, at, at, uh, a good level.

Mm-hmm. Um, and m- avoiding alcohol, um, you know, I would say in moderation, if at all. Uh, and certainly avoiding smoking.

Leslie Schlachter: Okay. Yeah, I mean, if you think... Like, to me, I'm not in your world, but to me, common sense says decades ago people were buying real food and prepping it at home, and like eating out minimally, and processed foods were just starting to come up.

Now it's like most of the foods people eat is processed, and [00:46:00] people aren't necessarily buying whole foods and making dinner or their food every day. To me, it just seems like an obvious connection.

Deirdre Cohen: Yeah.

Leslie Schlachter: But we're just not saying it yet 'cause we can't prove it yet.

Deirdre Cohen: There's a very strong hypothesis in terms of looking, you know, when you look globally at rates of colorectal cancer.

Mm-hmm. Um, so s- I, w- we, we have a very strong, uh, correlation with, between ultra-processed foods and risk of cancer, so.

Leslie Schlachter: And then can you just define exercise for us? Because exercise to some people might be they just walk back and forth to work every day. So like what exercise are you recommending

Deirdre Cohen: for- Any exercise.

Just move your body. Um, you know, it's not so prescriptive. Um, there was a study looking at prescriptive exercise in terms of meeting with a physical therapist twice a week initially and then once a week subsequently, um, for patients with stage three colon cancer versus giving patients just information and encouragement to exercise, and there was a significantly lower [00:47:00] risk of recurrence for those patients who, you know, had to show up, um, and meet with a therapist.

But it's not the specific amount of exercise. I really think it's the consistency, um, for, for patients or for all of us.

Leslie Schlachter: Okay. What about you guys? Anything preventative that you wanna add?

David Greenwald: The thing I would talk about is barriers. I wanna break down barriers. So if we can talk about all the different barriers to people getting colorectal cancer screened, they include financial barriers, and we've tried to eliminate those financial barriers.

So colonoscopy, for example, is now again free from co-pays and deductibles, so there's no financial barrier. Um, the embarrassment factor. We really don't want people to be so embarrassed by stool-based tests or colonoscopy that they just don't come. Right. So we had a slogan that we put on taxi cabs around New York City a number of years ago that said, "Don't die of embarrassment."

There are l- real-life barriers, like getting somebody to take care [00:48:00] of your kids or your elders that you're caring for so that you take the time to get the colonoscopy. There are a zillion barriers like that. We need to break down each one of those barriers. Mm-hmm. And they're different, as I said earlier, for different communities.

And then we can sort of increase the screening rate in New York City to 70%, 80% and beyond.

Leslie Schlachter: Do you guys participate-- 'Cause I know that there, the Mount Sinai Medical School, the medical students see patients in the uninsured clinic. Mm. Um, do you guys participate in that from a GI perspective? That way, uninsured patients can at least get in the door, and then eventually get the care they need.

Pascale White: Yeah, absolutely. A lot of, uh, us see patients at 102nd Street, which a lot of our fellows are trained, um, at that location, as well as the FPA, or the faculty practice associates. And so we do see patients who come from right here in our catchment area, in our backyard, in East Harlem, where we, we can serve, uh, them to, uh, see them in the clinic, see them in [00:49:00] the office, make sure that they're, have choices for their screening, and make sure that they know that choice exists.

David Greenwald: And I'll add to that. We do provide colonoscopies for the patients from that EHOP clinic that you're talking about- Yeah. I-- Thank you. I could remember the name ... who have positive screenings.

Leslie Schlachter: Yeah.

David Greenwald: Yeah. Um, and they need a colonoscopy. We bring them absolutely in, no charge, no... Every-everything is taken care of.

Yep.

Leslie Schlachter: That's great.

David Greenwald: Appropriate. That's

Leslie Schlachter: great.

David Greenwald: The way it has to be.

Leslie Schlachter: Yeah, it should. It has to be. Thank you guys so much for being here. I really appreciate your time.

David Greenwald: Thank you.

Leslie Schlachter: Thank you. Thank you. That's all for this episode of The Vitals. I'm your host, Leslie Schlachter. Subscribe to The Vitals and the Mount Sinai Health System's other video podcast programming on YouTube, Apple Podcasts, Spotify, or wherever you get your podcasts.

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