

Transcript Details

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ReachMD

www.reachmd.com
info@reachmd.com
(866) 423-7849

Understanding the Growing Burden of Early-Onset CRC

ReachMD Announcer:

You're listening to *On the Frontlines of Colorectal Cancer* on ReachMD. And now, here's your host, Ryan Quigley.

Ryan Quigley:

This is *On the Frontlines of Colorectal Cancer* on ReachMD. I'm Ryan Quigley, and joining me to discuss our approach to managing colorectal cancer in young adults is Dr. Christopher Cann. He's an Assistant Professor in the Department of Hematology and Oncology and Director of the Young Adult Cancer Program at Fox Chase Cancer Center at Temple Health in Philadelphia.

Dr. Cann, welcome to the program. Thanks so much for doing this.

Dr. Cann:

Thanks for having me. I appreciate it.

Ryan Quigley:

Absolutely. So, Dr. Cann, to start us off, what can you tell us about the rising incidence of colorectal cancer in younger patients?

Dr. Cann:

So, these are findings that are really part of an unfortunate trend over the past, I'd say, about two to three decades. These findings are consistent with an unfortunate trend in young adult and early-onset cancers. Within the colorectal space, the ages between 18 to 49 years of age are where we're seeing a drastic rise in the incidence of colorectal cancer.

To put that in perspective, by 2030, it's estimated that rectal cancer will rise by 124 percent and 46 percent within the age groups of 20 to 34 and then 35 to 49 years of age, and then early-onset cases will contribute to one quarter of all the rectal cancer diagnoses that we see. So, to put it another way, those born in the 1990s have about a four times increased risk of developing rectal cancer and a two times increased risk of developing colon cancer relative to those born in the 1950s, or their parents' age. This really is a drastic shift in incidence.

What we're finding is that for patients who are diagnosed in this early-onset timeframe, we're seeing delayed diagnosis, and they often are at more advanced stages and are often found to have more aggressive disease. Obviously, during this time in these patients' lives, it's very different from what we consider the average age onset patient in the sense of what psychosocial issues, financial issues, and those types of things they are undergoing at this timeframe. So, we're talking about patients that are in the midst of their career, their education, and starting a family all these external stressors that, when combined with a new diagnosis of an aggressive form of cancer, really is absolutely life changing.

Ryan Quigley:

In terms of colorectal cancer in younger adults, how does it differ compared with older adults?

Dr. Cann:

It's a great question. I'll speak to the genetic side first. There's this assumption that because someone presents at a younger age, there must be some inherent genetic or germline contribution to this. And it's actually the opposite. What we're finding is that 80 percent of these cases are sporadic; no identifiable inherited disorder or germline mutation is contributing to this cancer diagnosis. Granted, obviously, there are certain syndromes like Lynch syndrome that can present, but that makes up a minority of the cases.

Now, when we think of the somatic mutations, or those mutations that are presenting within the tumor itself, there are some differences. Right now, they're mostly subtle, but they're not really mutations that we can necessarily intervene upon. We see there's more TP53

mutations. There's more APC mutations. But on average, there really is not much of a drastic difference, which makes it even harder to understand why this change is happening.

From a presentation standpoint, the most common presenting symptoms are very similar to those of older-age onset, so blood in the stool, followed by fatigue and abdominal pain. But I think one of the key differences here that I always like to highlight is when patients are seeking care and when their presentation is. So, there was a large survey of over a thousand patients, and what they found was 41 percent of these patients then young adults who were diagnosed waited over six months before seeking medical attention, and two-thirds saw two or more physicians prior to them being diagnosed.

So, what that tells us is that, from both a patient perspective and from a provider perspective, there needs to be increased awareness that potentially subtle symptoms or symptoms that we would attribute to something more benign, such as blood in the stool that we're assuming would be related to hemorrhoids we can't necessarily assume that. We need to be more judicious about saying "advocate for yourselves" with young adult patients, and also, from the provider standpoint, saying, "We need to have a lower threshold to investigate symptoms that may be concerning for colorectal cancer in this age group."

Ryan Quigley:

Now, Dr. Cann, once a young adult has been diagnosed, what key considerations guide your initial workup? I imagine at that point, time really is of the essence.

Dr. Cann:

I would say so. Much of what we do when it comes to a diagnosis of a patient who's early onset versus late onset many of the pathways are the same. We ensure we have a definitive diagnosis before we ever start a treatment process, obviously, but we try to expedite any molecular testing, so next generation sequencing of the blood and of the tissue, to find out if there are any actionable mutations that we can act upon.

The key caveat is that we have every patient that fits within that early-onset timeframe getting germline testing. As I was alluding to before, although only 20 percent have a germline mutation that contributes to this, it could be very important, such as for someone who has Lynch syndrome not only for their treatment, but also for screening for other malignancies in themselves and potentially if there's any relation for their family members.

One thing I always do like to bring up is that, from a treatment perspective, is right now, unfortunately, there really isn't any division in how we treat early-onset cancers versus those of average age onset. And often we're finding, at least anecdotally, and there is some evidence of this within the oncology community at large, that we inherently try to treat young adults more aggressively so more treatments and more aggressive chemotherapy agents.

So, for example, with the standard of care chemotherapy treatments for metastatic colon cancer being FOLFOX, some people will go right to FOLFOX and add that additional irinotecan, so a triplet regimen versus a doublet. But there may not actually be necessarily a difference in survival for those patients by adding that much upfront chemotherapy relative to what you would do for an average age-onset patient. Instead, we may be just exposing young adults in early onset colorectal cancer patients to more toxicity without necessarily more benefit.

So, there's ongoing research to determine what potentially is the best avenue. But I would say that, in general, we have to be very judicious about finding out, is there targeted mutation that we can go for? And confirming the diagnosis and acting rapidly so that we can provide the best treatment possible in a most tailored way possible.

Ryan Quigley:

For those just tuning in, you're listening to *On the Frontlines of Colorectal Cancer* on ReachMD. I'm Ryan Quigley, and I'm speaking with Dr. Christopher Cann about colorectal cancer management in young adults.

So, Dr. Cann, when you're making treatment decisions, how does your approach shift when you're treating a younger patient?

Dr. Cann:

When we think about the aggressive nature of treatment, we are often inclined to say, if we potentially can get to someone who presents with a stage four diagnosis a liver metastasis or lung metastasis but is potentially resectable with treatment upfront, before neoadjuvant treatment and before we try to go for resection, we will try to push a little bit harder to have that objective response to get them to that point. But, as I was mentioning before, we just have to be very careful that we don't provide significantly more toxicity without necessarily a survival benefit in providing so much upfront chemotherapy if we do not think we can get to a curative intent position.

Other things to consider when thinking about treatment for a young adult are the other components to their care, which, to them, may be

just as important. One more important thing we always think about is the fertility aspect. The average-onset patient is in their sixties, so often out of that timeline of having or thinking about children or a family. But for early-onset, young adult patients, this is the most pivotal time in their lives to potentially consider having a child if they want that. So, it's absolutely of significant importance to have that upfront discussion with the patient before you start chemotherapy for both male and female patients so that they're potentially given the opportunity to seek fertility preservation before they start chemotherapy.

Now, there's a lot of limitations to this in the sense that with some patients, if they're too ill and they need to start therapy soon, we sometimes don't have that grace period to allow them to pursue that. But for those who do, it's paramount for them to have access to oncofertility subspecialists or fertility preservation centers that can give them the options of what's available.

For men, it's often easier because a sperm sample is easy to collect in general. However, for a female, cryo-preservation of eggs is a procedure under anesthesia that costs a lot of money, and in general, preservation of either sperm or eggs and long-term preservation can cost thousands of dollars. This, many times, is cost prohibitive and, in many states, is not covered by insurance. In that first visit or that second visit before starting chemotherapy, this needs to be discussed so that chemotherapy, radiation, et cetera do not impact the potential fertility options for patients moving forward and their ability to have children.

Ryan Quigley:

With fertility, sexual health and long-term survivorship concerns being especially relevant in this population, how do you approach those conversations with these patients?

Dr. Cann:

It's difficult because when people walk in the door, this is something they would never expect at their age. It often takes several visits to be able to really get through all the different aspects of this type of care. So, providing the most optimal care for a young adult requires a multidisciplinary team, such as social work, fertility specialists, sexual health specialists, and financial aid specialists, to come together to try to help provide the supportive aspects of care that would allow patients to focus on their cancer treatment and try to help minimize the amount of external stressors that are there.

Speaking of specific survivorship issues, sexual health is often a concern that we don't necessarily think about when we're starting chemotherapy or radiation therapy. Many, long-term, especially with radiation to the rectum, can have sexual dysfunction-related issues moving forward throughout their life. It's very important for that to be discussed upfront so that moving forward, medications can be provided if there's any issues down the line. Also, referrals to urology or to gynecology can provide that extra level of support for them as time goes forward.

We do a needs assessment at our program for each patient to ask, "What are your biggest needs as you move forward through your cancer diagnosis?" Many of them describe loss of relationships and loss of their self-image that they once had. And so offering psychological support through psychologists, therapy, social work, et cetera is paramount to have available if a patient wants that. Also, offering support groups through those who are of similar age who have gone through the same process is utmost importance as well building that sense of community to help navigate this journey that they had never intended to be on in the first place. And so we have a support group that we offer quarterly and social events to try to help patients get together to build that sense of community.

Ryan Quigley:

Dr. Cann, before we wrap up, what practical steps can clinicians take today to improve outcomes for young adults with colorectal cancer?

Dr. Cann:

I think one of the biggest things that we can do as providers at large is to ensure that we are spreading awareness that this phenomenon is occurring by ensuring that, at the patient level, they feel that they can advocate for themselves and understand that if they feel that something is just not quite right with their body chronic fatigue, constipation that's lasting longer than it should, or any symptom that they feel is not quite right they should feel empowered to reach out to their providers or have a provider help them navigate and understand why that's happening.

And at the same time, at the provider level, having a lower threshold to consider colorectal cancer as a potential cause of symptoms is so important. So many times, I have had patients come in where there's been an attribution that their hematochezia is related to hemorrhoids or that their constipation is just a chronic functional issue, when in reality, it was a cancer that was there. Just that lower threshold to say, "Hey, maybe a colonoscopy is needed. Hey, an imaging study may be needed," just to ensure that we're catching these cancers at an earlier stage. Because the earlier we can intervene, the more of a chance we have to cure patients of their disease.

Ryan Quigley:

That's a great way for us to round out our discussion. And I want to thank my guest, Dr. Christopher Cann, for joining me to discuss how we can better care for young adults with colorectal cancer.

Dr. Cann, thank you so much for doing this. It was really great having you on the program.

Dr. Cann:

Thanks for having me.

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