

# COLONOSCOPY!



**A**re you at least 50 years old? Has your physician been after you to get a colonoscopy? Feeling squeamish? What are your alternatives? DO you REALLY need a colonoscopy?

**Fact:** Colorectal cancer (CRC) is the second leading cause of cancer deaths in the US, with more than 50,000 deaths per year.

This means that CRC is a threat that should be taken seriously. Screening to detect pre-cancerous lesions or very early stages of cancer can decrease the threat of detecting disease too late. It's estimated that screening, leading to early detection and optimal treatment, could save over 18,000 lives each year in the US.

Colorectal cancer strikes about 50 in 100,000 (5 per 10,000) thousand Americans each year. The lifetime risk of developing CRC is about 1 in 20. Who is at greatest risk?

**Fact:** Risk factors for developing colorectal cancer include:

- A previous diagnosis of colon cancer or adenomas (pre-cancerous lesions)
- A family history of early colorectal cancer (diagnosed before age 55) or multiple siblings/parents with CRC
- Familial adenomatous intestinal polyposis or Lynch syndrome

- Inflammatory bowel disease such as Crohn's disease or ulcerative colitis
- Being male, African American, or Alaskan Native
- Eating red meat; smoking; obesity

## Reduce your risk

You cannot do much about your genes, but you can decide what and how much you eat, and whether you smoke. You can lower your risk by reducing or eliminating red meat, maintaining a normal weight, and quitting smoking. If you do not have any risk for GI bleeding (e.g., ulcers, inflammatory disease, clotting disorders or taking blood thinners), talk with your health professional about the benefits of taking one aspirin or ibuprofen

daily. These anti-inflammatory medicines are associated with decreased incidence and regression of colonic adenomas.

**Fact:** Colorectal cancer is usually preceded by adenomas (non-cancerous growths). Some adenomas go away, while others progress to early stage cancer. Typically, it takes about 10 -15 years for an adenoma to become a cancer. Adenomas and cancer bleed a little intermittently. The slow progression makes screening feasible. Finding adenomas early before they become cancerous is one way to prevent CRC.

## Not your average risk

If you are at high risk of CRC because

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you've already had a CRC or polyposis diagnosis; you have a close family member (parent or sibling) diagnosed early with CRC; or you have a family history of familial adenomatous polyposis, listen to your doctor. You are not at average risk; you are a high risk. Population-based screening guidelines do not apply to you.

**Fact:** Recommendations for population-based screening for CRC are not the same in other countries. Most countries recommend screening every year (or two years), starting at age 50 (60) with a high sensitivity fecal occult blood test (FOBT) or immunochemical test (see FAQ below). In most countries, colonoscopy is recom-

mended to investigate positive screening tests, not as an initial screen. This is because a) colonoscopy is expensive; b) colonoscopy has a risk of serious side effects; and c) it's hard to convince a lot of people to get one.

Recommendations for CRC population screening for different countries			
Country	Screening Tool	Age	Frequency
US - USPSTF	FOBT, or Sigmoidoscopy, or Colonoscopy	50-75	FOBT – annual; or Sigmoidoscopy – q 5 yrs; or Colonoscopy q 10 years
Australia	FOBT	55 yrs	They are evaluating screening for 55 and 65 year olds.
Britain	FOBT	60 yrs	q 2 years
Canada	FOBT	50 yrs	Annual or q 2 years
France	FOBT	50-75	q 2 years
Germany	FOBT annually for 50-54; and starting at 55 years FOBT or Colonoscopy	55 yrs	FOBT every other year or Colonoscopy at 55 and 65 years
Israel	Hemoccult Sensa	50-74	Annually
Japan	iFOBT	40 yrs	Annually
Norway	FOBT	60 yrs	
Spain	FOBT	60 yrs	q 2 years
Sweden	FOBT	60 yrs	q 2 years

*All countries that rely on FOBT for screening recommend follow-up evaluation of positive tests with colonoscopy.*

**Fact:** The US Preventive Services Task Force (USPSTF) recommends a population-based strategy for adults ages 50 -75 any of three strategies:

- Fecal occult blood testing every year; or
- Sigmoidoscopy every five years; or
- Colonoscopy every 10 years

The USPSTF does not recommend routine screening for adults over 75

years and recommends against screening for adults 85 years who have previously had normal screens. Please notice that colonoscopy is just one of three options for population-based screening. The USPSTF does not give any of the three strategies preference over another for people at average risk of CRC.

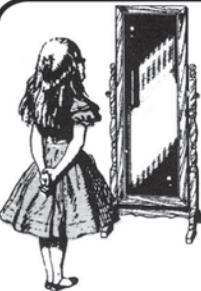
**Fact:** Screening adults between the ages of 50 and 75 with any of three rec-

ommended screening tests in the US reduces CRC deaths by about 16%. The USPSTF gives an A grade to the evidence for this recommendation.

**Remember:** No test is perfect. For any test, there will be a few people with real disease who are missed (false negative results) and a few people who don't have any disease who have a positive test (false positives). Most of the studies evaluating false positive and false negative rates have assessed the quality of very experienced testers who perform a lot of tests. Test results, particularly for sigmoidoscopy and colonoscopy, may not be as accurate if they are done by those with less experience.

**Frequently Asked Questions (FAQs)**

**What is FOBT? An iFOBT? Hemoccult Sensa?** FOBT stands for fecal occult blood test. In this test, a small amount of fecal matter is placed on a card. A chemical reagent is added to test for tiny amounts



## Through The Looking Glass

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of blood. Since polyps and tumors tend to shed blood while normal bowel doesn't, having a positive test shows a risk of CRC that needs to be evaluated (usually with colonoscopy).

An iFOBT is an immunochemical FOBT. For practical purposes, it is very similar to the FOBT.

Hemoccult Sensa is a specific brand of FOBT with very good sensitivity for detecting CRC.

**What is fecal DNA testing?** Preliminary studies have shown that testing fecal matter for DNA associated with cancer may be a useful screening strategy. Studies are ongoing to assess the benefits, costs, and risks of this strategy compared with other approaches to screening. Like FOBT, it does not require a scope.

**What about CT colonography?** CT colonography finds polyps and early adenomas using a CT scan rather than a scope; the usual bowel clean-out is still required for imaging. Like an X-ray or CT scan, this process involves some radiation. The USPSTF concluded that the current evidence is insufficient to recommend CT colonography. At this point, Medicare does not reimburse for it, and since many insurance companies follow Medicare standards, your insurance may not pay for it either. Stay tuned. Studies are underway.

**What is flexible sigmoidoscopy?** Flexible sigmoidoscopy involves putting a thin tube (scope) into the rectum and lower third of the colon (sigmoid colon). Air is pumped into the rectum to improve visualization with the scope. A sigmoidoscope does not see the upper two thirds

of the colon. The bowel preparation for a sigmoidoscopy can be similar to that for a colonoscopy or it can be less intensive.

**What is bowel preparation?** In order to visualize the bowel, it must be free of all fecal matter. Most preparation involves

- Avoid taking iron for several days before the procedure
- Clear liquids for 12 – 24 hours prior to the procedure (no red or purple liquids)
- Laxatives and/or enemas about 12 hours before the procedure

**What are the risks of flexible sigmoidoscopy?** Serious complications (death or complications requiring hospitalization) occur in about 3.4 per 10,000 procedures.

**What are the risks and costs of colonoscopy?** Risks and costs include the costs of the preparation and procedure, time off of work, risks associated with the preparation (bowel clean-out or bowel prep), risks of sedation for the procedure, and the procedure itself. Because of the sedation used for the procedure, patients are advised not to drive or operate heavy machinery for 6 – 8 hours afterward. Risks tend to be lower in settings where lots of procedures are done by clinicians who perform many procedures. The risks of the procedure itself when performed in studies by those with lots of experience are:

- Perforation of the colon in about 3.8 per 10,000 procedures
- Serious bleeding in 12.3 per 10,000 procedures
- Death or other problems requiring hospitalization occur in about 25 per

10,000 procedures

### What's the Bottom Line?

The best prevention is to lead a healthy life, free of tobacco smoke, minimizing intake of red meat (especially processed meats), and maintaining a normal (non-obese) weight. For those adults 50 - 75 years at average risk of CRC, the USPSTF recommends any of three screening strategies: annual high sensitivity FOBT; flexible sigmoidoscopy every 5 years; or colonoscopy every 10 years. If you're at higher risk, talk with your health professional about colonoscopy screening.

For more information, look on-line for information from:

US Preventive Services Task Force (USPSTF):  
[www.uspreventiveservicestaskforce.org/uspstf/uspcolo.htm](http://www.uspreventiveservicestaskforce.org/uspstf/uspcolo.htm),

US Agency for Healthcare Research and Quality (AHRQ):  
[www.ahrq.gov/clinic/uspstf08/colocancer/colosum.htm](http://www.ahrq.gov/clinic/uspstf08/colocancer/colosum.htm),

International Colorectal Screening Research Network (ICSRN)  
<http://icrsn.ceu.ox.ac.uk/>

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