C3: COLORECTAL CANCER COALITION

Momentum

News from C3: Colorectal Cancer Coalition | Volume 2, Issue 4 | Summer 2007

My Colon Cancer—Inherited?

CORINNE CAPOLINO AT THE MARCH 20, 2007 CALL-ON CONGRESS AWARDS DINNER.

FOR MORE INFORMATION ABOUT C3'S CALL-ON CONGRESS LOBBY DAY AND TRAINING, SEE PAGE 3.

IN THIS ISSUE:

My Colon Cancer—Inherited?	1
Wall Street, King Street and Pennsylvania Avenue: Where We Spent our March	2
Tennessee Waltzing on the Steps of The Capitol	3
Colorectal Cancer Advocates Storm Capitol Hill	3
Son Runs (And Runs And Runs) to Beat Mom's Cancer	4
C3's Stock is Rising	4
How to Get Yourself and Your Family Genetic Testing	5
Dusty's Recipe for Action	6
Colorectal Cancer Screening and Treatment Bill Introduced in the House of Representatives	6
Clinical Trial Spotlight	6
Rectal Cancer: Putting the Spotlight on Our Bottom Lines	7

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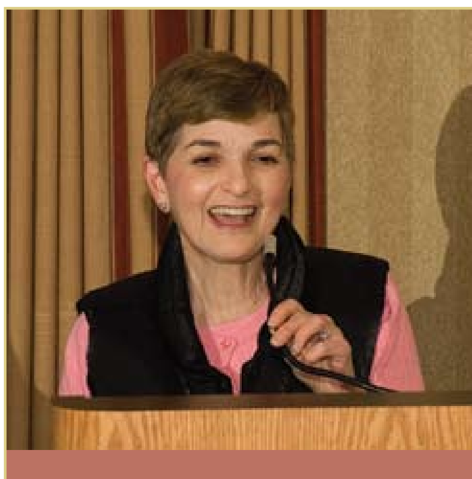

"I knew I inherited my cancer from my father. He had multiple cancers, including colon, kidney and bladder cancer," said Corinne Capolino from Brooklyn, NY. "His sisters and his mother had several cancers between them, including colorectal, endometrial, renal and brain cancer."

Corinne was diagnosed with early-stage uterine cancer in 1974 at age 35. Since then, she has been diagnosed with three separate occurrences of colon cancer.

Is colorectal cancer inherited?

Colorectal cancer is caused by a series of genetic changes *(mutations)* in cells lining the colon and rectum. The mutations result in a pre-cancerous polyp that may become cancerous over time. A polyp can take five to ten years to become cancerous for people of average risk.

Most colorectal cancers (approximately 75%) occur in people over the age of 50 who have no special risk factors, and are called sporadic colorectal cancers. People with sporadic colorectal cancer have cell mutations in only their tumors. Other cells in their body do not contain the cancer-causing mutations.

Sometimes, colorectal cancer has some relation to family genetics, but the specific genetic patterns might not yet be known. This condition, known as familial cancer, is apparent in families with many cases of colorectal cancer, especially in people younger than 50. About 25% of colorectal cancers are thought to be familial.

A subset of familial cancers involve known inherited mutations *(germline mutations)* which means that every cell in the person's body contains this mutation. These germline mutations are inherited by children from their parents. Approximately 3% - 5% of all colorectal cancers have been identified as inherited. Hereditary non-polyposis colorectal cancer (HNPCC, or Lynch Syndrome) and familial adenomatous polyposis (FAP) are examples of inherited colorectal cancer.

Genetic Counseling

"I don't have children, so at first I didn't see the point of genetic counseling or testing. But I have four brothers and 46 nieces and nephews. I realized that if my cancers were inherited, they might be at higher risk."

Genetic counselors help patients understand their genetic patterns through discussions about family history. Corinne's counselor worked with her to diagram her family pedigree, which showed several close relatives who were diagnosed with cancer at relatively young ages.

Corinne decided to have her blood tested to see if she carried a gene that increased her risk of cancer. The test indicated that Corinne's genes carried an HNPCC mutation.

Corinne's test results convinced several family members to speak with a genetic counselor and get tested. Thus far, one brother and one nephew tested positive for HNPCC, and their families are being screened appropriately.

continued on page 5

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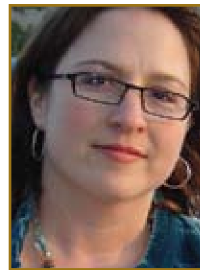
Wall Street, King Street and Pennsylvania Avenue: Where We Spent our March



CARLEA BAUMAN
EXECUTIVE DIRECTOR

March 2007, Colorectal Cancer Awareness Month, was quite a month for C3: Colorectal Cancer Coalition. We literally rang in the month at the New York Stock Exchange (page 4), welcomed new staff, cheered as our advocates stormed Capitol Hill (page 3), and, finally, at the end of the month, moved into our own office.

When it comes to our policy & grassroots efforts, C3 is saying hello to a new face, and goodbye to an old friend.

Joe Arite (pronounced "Uh-REE-tee") is C3's Policy and Grassroots Manager. He comes to us from Men's Health Network, where he worked on public policy that promoted disease prevention. He underwent trial by fire on his third week on the job, when he played a major role in our grassroots lobbying event, Call-on Congress, quickly winning the hearts of C3's most fervent advocates.

Joe replaces Jim Wetekam, C3's public policy & grassroots consultant. Jim developed C3's grassroots program, including our first training in April 2006. His efforts resulted in Rebecca Dague's work with Congressman Regula last summer, and Suzanne Lindley's work with Senator Hutchinson last fall. Thank you, Jim!

At the end of March, C3 moved out of our "incubator" office, supported by Genetic Alliance and into the first office space of our own in Virginia, right on Old Town Alexandria's famous King Street —just across the Potomac River from Washington, DC. We thank the fine folks at Genetic Alliance for taking such good care of us for our first two years of existence. And while I'm thanking folks, I would like to take a second to express my gratitude to Doug Bishop, a telecommunications consultant who spent hours developing and programming the phone system in our new office —free of charge. Anyone who has ever had to maneuver through such complicated (and costly) endeavors can truly appreciate the value of his service.

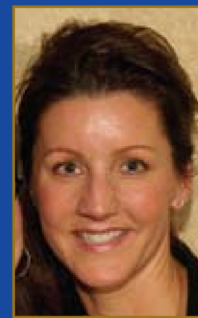
As we look forward to the second half of the year, we see that there is still much work to be done. There is a colorectal cancer screening and treatment bill that needs your help to pass (page 6). Cancer funding is still well below where it needs to be, and policies are being developed which could help—or hurt—people touched by colorectal cancer. We'll need the stamina of an endurance runner, so it's a good thing we have a role model in Vinnie Torres (page 4).

We won't rest on our laurels —and we hope you will continue to join us in the fight. If you have not done so already, please visit our newly re-designed web site at www.FightColorectalCancer.org. Sign up to be a One Minute Advocate so you can hear about all of this right when it happens.

C3 TAKES ON CAPITOL HILL. FROM LEFT: JOE ARITE, CARLEA BAUMAN, ANN WORNICK, MARGARET JOHNSTON, CHRISTINE NIEMI, CORINNE CAPOLINO, KATE MURPHY (SEATED), FLORENCE KURTILLA

TENNESSEE WALTZING ON THE STEPS OF THE CAPITOL

By Ann Wornick, Franklin, TN



I am so fortunate to have had the opportunity to "Call-on Congress" with C3. It was my first time doing this sort of grassroots lobbying.

I am a three-year stage III colon cancer survivor. When I first thought about going to Washington, DC, I felt very intimidated. But I found a kinship with other C3 advocates from the minute I got to the hotel. We were all there to push for increased awareness and funding. We hit Capitol Hill with excitement, knowledge and purpose!

I met with my two US Senators, Bob Corker (R-TN) and Lamar Alexander (R-TN) and with the health aide to my US Representative, Marsha Blackburn (R-TN-07). We discussed federal funding for colorectal cancer research and prevention, and I felt like my voice was heard.

At the end of the day, the advocates all got together at the hotel for a celebration dinner. Everyone shared their high points of the day —we all had triumphant stories to share!

Two weeks before Call-on Congress, my friend Joni Foraker lost her battle with colon cancer. She had been my inspiration to get involved in advocacy and I carried her picture with me the whole time I was in DC. I asked that colorectal cancer be made a federal priority, not just for me, but for everyone, and especially for people like Joni, whose voice and spirit continues in each of us, and pushes us forward.

Colorectal Cancer Advocates Storm Capitol Hill

C3 held its first annual "Call-on Congress" March 18 -21, 2007. Thirty advocates from around the country came to Washington, DC, to fight against colorectal cancer.

They were treated to a day of training by leaders in colorectal cancer research and public policy. By the end of that day, their heads were swimming with facts, figures and strategies on how to best get their messages across to their Members of Congress.

The next day, advocates had face-to-face meetings with their Members of Congress where they urged them to increase funding for research and prevention at the National Cancer Institute (NCI) and the Centers for Disease Control and Prevention (CDC).

While the advocates were visiting the offices of their elected officials, 1,000 colorectal cancer advocates from around the country were phoning into those same offices to demand increased cancer funding.

"We actually had advocates tell us that while they were in meetings with their Members of Congress, advocates were calling in at the very same time," said Dusty Weaver, Grassroots Coordinator for C3. "It was an incredible show of force."

One visit in particular was very special to both C3 and its advocates. Senator Ben Cardin (D-MD), who has been extremely vocal in the cancer funding fight, was honored with the "Congressional Champion" Award. He was presented with the award by one of his constituents, Janet Turcotte, and C3 Executive Director Carlea Bauman.

Additionally, Janet, a stage IV colorectal cancer survivor, gave Senator Cardin a saddle blanket she embroidered for the 2006 Preakness Stakes, a legendary horse race which takes place annually in Maryland. The saddle blanket, along with all the others worn in the race, had the Colorectal Cancer Star of Hope stitched on it.

While the advocates were visiting the offices of their elected officials, 1,000 colorectal cancer advocates from around the country were phoning into those same offices to demand increased cancer funding.

Call-on Congress participants included colorectal cancer survivors, families of patients, and those who have lost loved ones to this disease. Many had never been to Washington, DC before. They were driven to action by their need to make the world better for people fighting colorectal cancer.

Want to join us in 2008? Log on to www.FightColorectalCancer.org and sign up as a One Minute Advocate.

C3 would like to thank Amgen and PhRMA for the charitable donations that made this program possible.

C3 ADVOCATES JOIN MARYLAND RESIDENT JANET TURCOTTE IN PRESENTING BEN CARDIN (D-MD) WITH THE "CONGRESSIONAL CHAMPION" AWARD.

MARILIA SARDINHA AND SEN. MIKE MICHAUD (D-ME)

Son Runs (And Runs And Runs) to Beat Mom's Cancer

Vinnie Torres's personal web site has a poem on it by Langston Hughes called "Mother to Son":

> Well, son, I'll tell you:
> Life for me ain't been no crystal stair
> But all the time
> I'se been a-climbin' on,
> So, boy, don't you turn back.
> Don't you set down on the steps.
> For I'se still goin', honey,
> I'se still climbin'.

A child gaining strength from his mother is a familiar theme for Vinnie. In 2005, his own mom, Theresa Torres, was diagnosed with stage I colorectal cancer. "You get news like that and you realize overnight that your mom can be gone," he stated.

Vinnie, 32, had been an endurance runner for less than two years. Now, he was able to turn to his running as an outlet for his worry and a way to contribute to his mother's cancer fight. In 2006, the Pasadena, CA, resident logged over 465 race miles and summited Mount Kilimanjaro —all in the name of colorectal cancer awareness.

He used several of his races, one 50-miler and two 100-milers, as opportunities to raise money for C3: Colorectal Cancer Coalition. "It was easy to ask for money for my races," said Vinnie. Friends and co-workers pledged money based on how many miles he completed.

In his first 100-mile race, he dropped out with 32 miles to go. "I put too much pressure on myself," he said. He felt like he'd not only let himself down, but the colorectal cancer community as well.

Next up was the Javelina Jundred (the J's are pronounced as H's) two months later. His parents, grandmother and girlfriend came out to support him. "It was great," he said. "The course was a 15-mile loop, so every couple of hours, I'd run by my cheering section."

Marathoners will say that an endurance race is more mental than physical —so knowing that he'd get an emotional boost at regular intervals was a big help. Still, at mile 48, he was in serious trouble.

"It was 10 hours and 45 minutes into the race —the middle of the night —and my legs just didn't want to move anymore," he recalled. He was seriously contemplating quitting.

He'd told his family to go to sleep rather than cheer him on through the wee hours of the night. But when he arrived at mile 60, he found his girlfriend and mother waiting for him with encouraging words and hot soup. "My mother said that as long as I was out there, she would not sleep," Vinnie said, his voice choked with emotion. "Hearing that kept me going. That got me across the finish line."

He completed the 100 miles in 29 hours and 28 minutes.

Theresa, who today is living cancer-free, couldn't be prouder of her son. "He's always been this way," she said. "Everyone loves him —even his bosses!"

Vinnie plans to keep running. To date, he's raised over $2,000 to fund the fight against colorectal cancer —and changed countless lives with his determination to beat the disease that threatened his beloved mom.

VINNIE TORRES WITH HIS MOM, THERESA, AFTER HE COMPLETED THE JAVELINA JUNDRED IN NOVEMBER 2006.

C3'S STOCK IS RISING

On Monday, March 5, 2007, C3: Colorectal Cancer Coalition rang the Opening Bell of the New York Stock Exchange in honor of Colorectal Cancer Awareness Month.

The idea to approach the New York Stock Exchange was the brainchild of C3 advocate and stage IV colorectal cancer survivor Rob Michelson. Rob works at the Exchange and, like many colorectal cancer patients, is often frustrated by the lack of attention given to his disease. After five months of lobbying, the Exchange called C3 with an invitation late Friday evening, March 2nd, to ring the bell the following Monday.

For an insider's take on ringing the bell heard around the financial world, log on to www.FightColorectalCancer.org/advocacy/2007/03/.

C3 ADVOCATE ROB MICHELSON (CENTER) RINGS THE OPENING BELL OF THE NEW YORK STOCK EXCHANGE. TO HIS LEFT IS CARLEA BAUMAN, C3'S EXECUTIVE DIRECTOR AND KATE MURPHY, C3'S DIRECTOR OF RESEARCH COMMUNICATION AND 23-YEAR COLORECTAL CANCER SURVIVOR.

COMMEMORATIVE MEDALLION PRESENTED TO C3 BY THE NEW YORK STOCK EXCHANGE

My Colon Cancer — Inherited? *Continued from page 1*

The American Society of Clinical Oncology [1] (ASCO) says that genetic testing is appropriate when:

- An individual has personal or family history that suggests genetics are involved (multiple cancers, multiple generations);
- The test result can be clearly understood;
- The test result will help the individual and/or family members make decisions around treatment or appropriate screening.

ASCO also recommends that individuals talk with genetic counselors before and after testing to make sure that the test, its limitations and its results are clearly understood. Genetic counselors helped Corinne and her family understand that:

- HNPCC increases the risk of colorectal and other forms of cancer, such as uterine cancer;
- Frequent and early screening for colorectal cancer will help to find and remove polyps early, before they become cancerous;
- People who carry an HNPCC gene also need regular testing for other cancers, including uterine cancer.

Corinne and her family then worked with doctors to define appropriate medical care and screening schedules.

"I was lucky," said Corinne. "All of my cancers were diagnosed early and could be easily treated and cured. Now I make sure I get regular colonoscopies and check-ups. My nephew, who's in his 40s, can be screened regularly so that if he does get colorectal cancer, it can be caught early. And his children too."

"My point is, think about the children."

[1] *American Society of Clinical Oncology Policy Statement* Update: Genetic Testing for Cancer Susceptibility *Adopted on March 1, 2003, by the American Society of Clinical Oncology www.asco.org/asco/downloads/Genetic_Testing.pdf*

Reviewed by Axel Grothey, MD Mayo Clinic and Neal Meropol, MD Fox Chase Cancer Center

Colorectal Cancer By The Numbers

Incidence of Colon Cancer		
70-75%	Sporadic	
25 - 30%	Familial and Inherited	FAP <1% HNPCC 1%-3%

Type	Definition	Family Impact
Sporadic	Cancer diagnosed in individuals over the age of 50 who have no obvious family factors	Generally not significant
Familial	Cancer diagnosed in individuals with a family history but who do not have HNPCC or FAP	Family members may be at increased risk for colorectal cancer
HNPCC (Hereditary Non-Polyposis Colorectal Cancer)	Inherited mutation(s) which increase the risk of developing colorectal cancer	Family members may be at increased risk for colorectal, endometrial and other cancers
FAP (Familial Adenomatous Polyposis)	Inherited mutation in the APC (adenomatosis polyposis coli) gene which almost always results in colorectal cancer	Family members may have the mutation

Source: Andrew M. Kaz and Teresa A. Brentnall
"Genetic Testing For Colon Cancer," Nature Clinical Practice, Gastroenterology & Hepatology (2006) 3, 670-679
www.nature.com/ncpgasthep/journal/v3/n12/pdf/ncpgasthep0663.pdf

HOW TO GET YOURSELF AND YOUR FAMILY GENETIC TESTING

Courtesy: Collaborative Group of the Americas on Inherited Colorectal Cancer, www.cgaicc.com

The risk of developing colorectal cancer is not the same for everyone. Knowing your risk is important because it affects the age you should begin screening, the type of screening, and how often you need to be screened. You may be at risk for inherited colorectal cancer if any of the following is true:

- You or a close relative had colorectal or endometrial (lining of the uterus) cancer before age 50.
- You had colorectal cancer more than once or you had colorectal cancer AND another cancer.
- You and/or several closely-related family members had colorectal polyps, colorectal cancer, or endometrial cancer.
- You or a close relative had colorectal polyps before age 40.

People with hereditary colorectal cancer may have a high lifetime risk for colorectal and other cancers.

An individual screening plan based on your risk can help you to prevent cancer.

You may benefit from a genetic evaluation by a genetic counselor, doctor, or health-care professional with special training in hereditary cancer risk assessment.

To find a genetic counselor, visit the National Society of Genetic Counselors website at www.nsgc.org

If you live in the Philadelphia area and have a family history that could indicate hereditary colorectal cancer, you may be eligible for a research program involving live internet-based genetic counseling at Fox Chase Cancer Center.

The program is looking at ways to help individuals touched by hereditary colorectal cancer:

- *understand their risk factors; and*
- *communicate effectively with family members.*

Want to learn more? Please call Melissa Klein Cabral, Project Manager at Fox Chase Cancer Center at 215-728-7041.

DUSTY'S RECIPE FOR ACTION

Keep the heat on your elected officials this summer.

DUSTY WEAVER
GRASSROOTS COORDINATOR

You don't have to go to Washington, DC to see your Senators or Representative. You can schedule in-district meetings with them in the coming months during either the Independence Day recess (July 2-6) or the summer recess (August 6-31). Here's how:

1. Enter your zip code into the One-Minute Advocate at www.FightColorectalCancer.org to find your Senators and Representative. Click on "View Info" to get contact information for the district office.
2. At least two weeks prior to the recess, call the district office to schedule an appointment with your Senators and Representative. Be flexible. Schedules fill fast, so the earlier you call, the better.
3. Your goal of the meeting is to discuss the needs of colorectal cancer patients. Explain this to the staff when requesting your meetings so they can be prepared when they see you.
4. When you have scheduled your meeting(s), send an email to info@FightColorectalCancer.org to get a list of questions to ask, along with supporting information, materials and tips. We will assist you to make sure your meetings are very productive.
5. Call the district office several days before your meeting to confirm the appointment.
6. Follow-up your meeting with a thank you note that reviews the points covered in the meeting.
7. Tell C3 about the responses you receive from your Senators and Representative.
8. Keep in touch with your elected officials! It will help keep this issue on top of the pile. ✣

Colorectal Cancer Screening and Treatment Bill: You Can Help Get it Passed!

JOE ARITE
C3 POLICY & GRASSROOTS MANAGER

In March, Representatives Kaye Granger (R-TX-12), Albert Wynn (D-MD-04) and Patrick Kennedy (D-RI-01) introduced the Colorectal Cancer Prevention, Early Detection and Treatment Act of 2007 (HR 1738).

This legislation would authorize $50 million in funding for grants to public and nonprofit organizations. The grants would be used to carry out programs to provide vital colorectal cancer information, screenings, and follow-up care to men and women ages 50 to 64. These programs focus on those least likely to have access to care, such as poor, low-income, uninsured, underinsured and racial and ethnic minorities.

"With 52,000 Americans expected to die from colorectal cancer in 2007 alone; it is vital that we begin to properly invest in research, prevention, and treatment," said Carlea Bauman, Executive Director of C3. "We regularly hear from patients who need colonoscopies but do not have insurance and cannot afford to pay for them out of pocket. Legislation like this will save lives and reduce costs to the health care system by catching colorectal cancer before it has advanced to its most deadly, hard-to-treat, and costly stages."

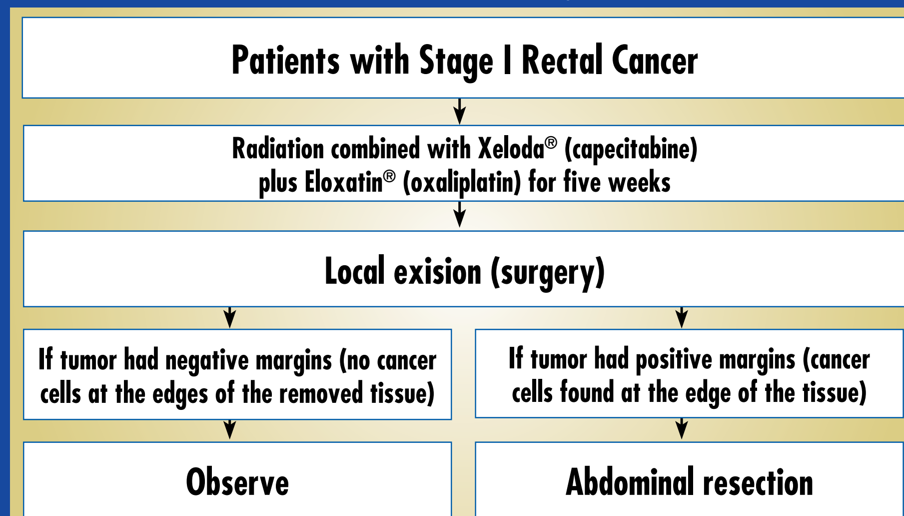
Similar legislation was passed in 1991 to provide screening for breast and cervical cancer —and that program has screened nearly 3 million women. Since colorectal cancer is the second leading cause of cancer deaths, the time is now to pass the Colorectal Cancer Prevention, Early Detection and Treatment Act.

Do you want to see this bill become reality? You can help! Please ask your US Representative to co-sponsor HR 1738. For more information, visit www.fightcolorectalcancer.org/hr1738.

CLINICAL TRIAL SPOTLIGHT! STAGE I RECTAL CANCER? CHECK OUT Z6041

Patients with suspected stage I rectal cancer typically have surgery (local excision) through the anus to scoop out the tumor and determine the extent of tumor growth. If the tumor has penetrated the rectal wall, or if the patient has indications that the cancer has spread to lymph nodes, a second surgery is completed to cut out the part of the rectum that has been affected (called an "abdominal resection"), and may be followed by chemoradiation.

A clinical trial is currently enrolling patients with stage I rectal cancer to determine if chemoradiation prior to local excision can keep the cancer from returning for three years (disease-free survival). The trial is also looking to see if the number of abdominal resections can be lowered by this pre-surgical treatment.



To find out if you are eligible for this trial, call 800-4-CANCER (800-422-6237). Z6041 is an NCI publicly-funded trial offered through the American College of Surgeons Oncology Group. *Reviewed by Heidi Nelson, MD, Mayo Clinic.*

Rectal Cancer: Putting the Spotlight on Our Bottom Lines

"Rectal cancer is tough," says Dusty Weaver, C3's Grassroot Coordinator. "When I tell people that I had rectal cancer, the word makes them flinch."

"When C3 was founded, we deliberately named ourselves the Colo*rectal* Cancer Coalition," says Carlea Bauman, C3's executive director. "Dusty's right. 'Rectal' is an uncomfortable word, just like 'breast' used to be. And the idea of a colostomy – the bag – is very scary to newly diagnosed patients."

Many people faced with a diagnosis of rectal cancer fear that they will need a permanent colostomy *(stoma)* or bag, as it is sometimes informally called. However, research is helping find new treatments and surgical techniques which decrease the odds of a colostomy, and most importantly, improve long-term survival.

Treatment for rectal cancer generally involves radiation combined with chemotherapy *(chemoradiation)*, surgery, and sometimes additional treatment with chemotherapy after surgery. Specific treatment depends on the cancer's stage and how far the tumor has spread in the rectum and beyond it. Depending on the situation, chemoradiation may be given either before surgery *(neoadjuvant treatment)* or after surgery *(adjuvant treatment)*.

Research Brings Progress

Research is helping patients with all stages of rectal cancer live longer and live better. Research advances include:

- New biologic treatment options such as Avastin® (bevacizumab), Erbitux® (cetuximab) and Vectibix® (panitumumab) may increase survival for patients with metastatic or recurrent rectal cancer;
- Chemoradiation prior to surgery can sometimes shrink tumors, reducing the risk that the cancer will return in the rectum and the possibility that a colostomy will be necessary. Recent research found that even when neoadjuvant radiation causes the tumor to disappear, surgery with good margins is necessary;
- Chemoradiation that includes Eloxatin® (oxaliplatin) or Xeloda® (capecitabine) may reduce the chance of early-stage rectal cancer returning;
- Refinement of surgical techniques such as total mesorectal excision and local excision, and the ability to focus radiation treatment more closely may keep rectal cancer from returning while limiting the long-term side effects of surgery and radiation;
- Patients who undergo surgery at hospitals where rectal cancer surgery is frequently performed tend to live longer than patients who are treated at lower-volume hospitals.

Living With Rectal Cancer Treatment

While some patients sail through treatment with very few side effects, others may have a tougher time.

"People don't always understand the impact of rectal surgery and radiation," says Kate Murphy, C3's Director of Research Communication and manager of a large online listserv for people touched by colorectal cancer. "Radiation can make your skin and rectal area tender and cause diarrhea—hard topics to talk about with your family and friends."

Patients who don't have a colostomy may experience short- or long-term problems with bowel management. "Both radiation and surgery can cause tissue damage which makes bowel control difficult," says Kate. "This condition – also known as fecal incontinence – can be emotionally devastating and limit work or normal activities."

Bottom Line: We Need More Research

"Finally, it is apparent that, in view of the multiple promising new agents for the treatment of colorectal cancer that have only recently come on the scene, it is necessary to conduct clinical trials for rectal cancer in a much more rapid manner," says Michael O'Connell, MD, in a 2005 Journal of Clinical Oncology editorial.*

"Rectal cancer research is critical, and the research needs to include quality of life issues such as bowel management," says Carlea. "And I think we need to get people saying the word 'rectal.' We believe that when people are comfortable saying that they have rectal cancer, they will be more open to seeking out the best treatment for themselves, including clinical trials." ✣

** Journal of Clinical Oncology, Vol 23, No 24, August 20, 2005: pp 5450-5451*

Reviewed by Heidi Nelson, MD, Mayo Clinic.

WILL I NEED A COLOSTOMY?

If your tumor is large or very close to the anal sphincter (the muscle that closes the rectum) and its size cannot be reduced by neoadjuvant chemoradiation, it may be necessary to remove the entire rectum and anus. In that situation, the end of the colon (stoma) is brought out through the skin to form a permanent colostomy. At other times, a colostomy may be temporary to allow tissues to heal. After healing, the colostomy is reversed and the cut ends of the colon or rectum are reconnected so that stool passes normally through the anus.

If your doctor thinks that you might need a colostomy as part of your rectal cancer treatment, ask about pre-surgical counseling from an enterostomal nurse who can help you choose the best site for the stoma for your lifestyle. After surgery, the nurse will help you learn to care for your colostomy. ✣

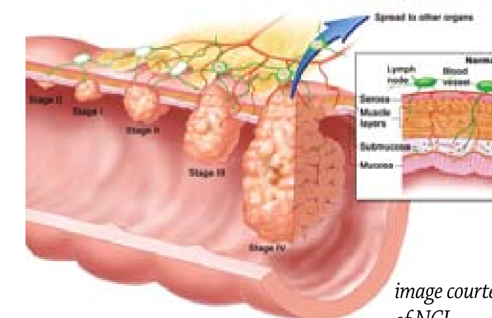


image courtesy of NCI

RESOURCES

Locate a colorectal surgical specialist
American Society of Colon and Rectal Surgeons
www.fascrs.org

Support groups for people with ostomies
United Ostomy Associations of America
www.uoaa.org 800-826-0826

Information about fecal incontinence
International Foundation for Functional Gastrointestinal Disorders
www.aboutincontinence.org 888-964-2001

1225 King Street
2nd Floor
Alexandria, VA 22314

*Register to receive future issues of **Momentum** at **www.FightColorectalCancer.org/momentum***

To make corrections to your contact information or remove your name from our mailing list, please send an email to info@FightColorectalCancer.org or call our office at 703-548-1225.

MARK YOUR CALENDAR! On August 22nd, **CancerCare,** in collaboration with C3: Colorectal Cancer Coalition, will offer a free telephone education workshop entitled, *Communicating with Your Doctor About Adjuvant Treatment for Colorectal Cancer.* The workshop will take place from 1:30 to 2:30 Eastern Time. For details, and to register for the workshop, call **w800-813-HOPE**, or visit the CancerCare website at **www.cancercare.org/tew.**

www.FightColorectalCancer.org

Current Colorectal Cancer News and Events *www.FightColorectalCancer.org/news* Stay up-to-date with what's happening in the colorectal cancer field: media reports, new clinical trials, current research results, conferences and other events, and advocacy action opportunities. Reported by Kate Murphy. Also available via RSS feed to your desktop at *feeds.feedburner.com/c3news*

Personalized Clinical Trials Search *www.FightColorectalCancer.org/patients/clinicaltrials* Use the C3 interactive interview to find clinical trials that meet your individual needs and get telephone assistance in choosing and enrolling in a trial.

Information for Patients *www.FightColorectalCancer.org/patients* Learn all you can about colorectal cancer diagnosis and treatment, how to manage side effects, and how to cope with life with CRC. Discover resources for support and strength on the internet and in your community.

Grassroots Communities of Engagement *www.FightColorectalCancer.org/advocacy* Policy & Grassroots Manager Joe Arite and Grassroots Coordinator Dusty Weaver provide advocates with clear, effective messaging that helps us produce the results we need for colorectal cancer research and screening. Become a One Minute Advocate at *www.FightColorectalCancer.org/advocacy/oneminuteadvocate*.

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