A Doctor's Journey: Surviving Colon Cancer (No BS Guide to Colon CA Part 2) Transcript

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Introduction to Colon Cancer Awareness

Last episode, we talked about colon cancer in the context of screening, prevention, certain treatments, general information that people need to be aware about, especially given that this month is Colon Cancer Awareness Month.

Now we're going to switch gears a little bit. I'm going bring on a person who is a colleague of mine who actually personally faced a diagnosis of colon Just like we did last time with breast cancer, you're going to hear a personal story about somebody else's journey with colon cancer for diagnosis and the steps they took to combat the disease.

And I need to stress something here. Her story is going be very personal and just like the breast-cancer survivor story that I hosted a few months back, not everybody with this disease is gonna have the same outcome, the treatment options.

This is designed not to scare you, it's designed to give you hope, but also to encourage prevention as a primary means of detecting a very fatal disease.

A disease that is rising in younger and younger people. Christina Dillon's story is mentioned in Forbes Magazine, and I'm going to link into the description of this episode so that you can read her words for yourself as well.

I am Dr. Mark Papadakis, nobody particularly special, just another frickin' ER doctor, And this is the Jaffer Gast, let's get to it. All right, I'm back and we're here with Dr.

Christina Dillon. Cristina, thanks again for joining me. How are you? Good, how's it going? Pretty good. So Dr Christina Dylan, she and I went to medical school together for at least the first two years at Toro College of Osteopathic Medicine.

And then you went, where'd you go after that? Tell us about your post. transferring to Western University in California, Southern California. So that's actually where I have my degree from.

And then after med school, I went to residency at Arrowhead Regional Medical Center, and that is in Colton, California And you did internal medicine? Is that right?

That's what you're practicing right now. Internal medicine, you are a hospitalist and you still in Cali. Yes, so I live in Southern California and I have a private practice.

It's a direct primary care practice and, um, I also work as a hospitalist, uh, as well. What's your name of your practice? Exordia Medical Group. Awesome.

So, you know, the whole focus of this topic today, it's March where it is Colon Cancer Awareness Month and you yourself are, well, guess I'm going to count you now as survivor of colon cancer.

Yes. Um, because you were diagnosed, tell us, In March 2025, so it's going to be one year shortly actually at the end of the month.

Dr. Dillonu2019s Medical Background

I was diagnosed two days after my 40th birthday. So it was not the greatest. So tell us about that, because I saw,

so you have a, how this came about is you actually have an interview in Forbes magazine, um, that you talked about your basically journey, not just with colon cancer, but also beforehand, cause you had ulcerative colitis.

Is that right? So let's kind of start, I guess, with ulcers of coli diagnosis. Cause you went through medical school with all sorts of Colitis, which is really not an easy thing to go through.

I mean, you know, That's one thing. So when did you get diagnosed with Ulcer of Collitis? I was diagnosed in I, was 25. So I actually, you know, I never really, um, it, never missed a day of school, and never miss today of residency work.

Um, It was pretty, You know you have like a flare up here and there, but it was I'd say pretty well, like. you know, controlled symptom-wise on pretty, on just oral medications.

And after eight years, you get screening colonoscopies every year because when you have IBD, You have a higher risk of colon cancer. So I started doing that and things just seemed fine.

They never really recommended escalating therapy. I had two children. So before I first had my screening colonoscopy, everything looked good. I always try to make sure with family planning that I was up to date on everything because when you're pregnant, it's a long time and difficult to get those kind of things done.

Everything looked fine before my first child and then I have him and I then had second child about two years after. So typically you get out every year after eight years with IBD, but because mine looked okay, the GI at the time said I could stretch it to two to three years.

So after my son, my first son I ended up waiting like I think two years and again, everything looked fine before I got pregnant with my second son. And then he said again he could go like two, three, years so then after son was born, My second son was born, I didn't have my next screening colonoscopy until about two years after that.

Ulcerative Colitis and Routine Screening

And then I went to a new GI because my other GI retired and she found a lot more inflammation. I did have any symptoms, so it's kind of difficult because a lotta times I know GIs sometimes will like escalate therapy, not just on like what the colon looks like or what pathology looks from the biopsies, but also your symptoms.

So I don't really have symptoms But she went in and then she's like, oh, you look really inflamed. So let's escalate the therapy. Cause at the time I was just on oral mesalamine, which is pretty basic.

And then you switched me to a medication called Stellara, a little bit stronger that calm the inflammation. Then she said, okay, I want to make sure everything looks okay.

Because you don't really have any symptoms. It's not like I can really go off of, Oh, well your symptoms are better. The drugs really working. She's, like let have you come back in like three, four months.

and see how the drugs doing. And so that's all the inflammation calmed down. She was actually better able to see certain areas that were really inflamed.

Then she was able see this lesion. It wasn't a mass, it was extremely small. she actually said it just looked like a tiny pinpoint dimple. So it could have been easy to miss, especially with all of the information she said.

I was gonna say so basically the inflammation was probably hiding this lesion the first time around and then I need to calm that down and Then subsequently here we are so it wasn't like a huge Fungiating mass or anything like that, you know, very tiny.

Yes I very lucky because so then she was trying to do it's called an endoscopic mucosal resection where they basically they inject like like a saline solution or some kind of solution between the submucosa and the muscularis,

and then they can just remove the lesion.

And so she was able to separate it, but she having a little bit difficult time with I think her loop was not able adequately grasp the tissue. So she's like, I don't want to disturb the area and cause difficulty, so I guess she ended up sending me to a specialist at a different, like an academic center, and he does ESD, the endoscopic sub-mucosal dissection.

And so she's like, let's have you go and be evaluated by him and see if he can just remove the whole thing. She's, it's probably nothing because it doesn't really look like much, but just because of your history, let's not take a chance.

And so I go and then when he evaluated it, he said that he didn't think it looked too suspicious either. He actually ended up just doing the EMR. So that's a little bit more superficial than the ESD.

Then he's like, oh, don't worry about it. It's probably going to be fine. then he calls me up on his cell phone at like 7 a.m. a couple of days later.

Surprisingly, it's actually a dental carcinoma. I was like And I, it was like, I don't even think it 7 o'clock yet. It was so early in the morning and I was just shocked.

You haven't woken up yet, too. I mean, you're getting a phone call, having waken up and all of a sudden it's like hey, by the way, we think you have colon cancer.

Yeah, I was like, totally shocked. But thankfully, you know, like the initial path, from the biopsy, it was, very low grade, there's, no tumor buds and it looked like it, was early even then, but obviously super scary.

So, they, the next step for somebody with IBD with colon, like a colorectal cancer, you have to be evaluated by a colon rectal surgeon. Because some people, if we don't have that IB D history, they have maybe not so invasive ways of treating it.

Like they could just maybe resect that portion. But for me, I had to have a total proctocollectomy where they take the entire thing out because it's, assume if you had that there, probably going to happen elsewhere.

Let's go back because you basically had the colonoscopy, your original GI doctor says, okay, there's something here, inflammation calmed down, we see something.

We kind of took a little bit of it, I don't know, but we want to disturb it. And so they woke you up. So you're now like, you know in recovery says hey, We found this thing, it's probably nothing, But you got to go now see this other doctor, you know, the more specialists.

How long did that take you? What's the timeline between that test and the specialist? Oh yeah, so I had that one I believe on March 12 and then I have the follow-up like with the the specialists for the ESD at the Academic Center.

That was exactly two weeks later. So it was like on the 24th. And then, I've had the diagnosis on 28th, a couple days later, and then I was, that was a Friday, horrible to get a diagnosis on a friday where you're festering over the weekend.

And then, um, but he, I, was able because of my, like, you know, have like wonderful colleagues at the hospital I work. I know a very good like colorectal surgeon, multiple, and, another surgical oncologist, called them like right after I got off the phone.

It was like totally freaked out. And they're like, don't worry, we're going to take care of this. It's going be okay. And, they referred me to one of their colleagues at City of Hope and he's like an authority in colorectal surgery.

He's a very good, like renowned surgeon and particularly for the type of surgery that I was going require. So, that's

I, was in his office on a Tuesday and I had a first appointment with another colerectial surgeon on Monday.

Finding the Lesion and Cancer Diagnosis

I met with two different ones, but I ended up going with this colo rectal surgeon at city of hope. Okay. All right. And then ultimately, so you had to have the total, this procedure done, how long between that meeting and basically the surgery that is done?

So I believe I saw the colorectal surgeon, I think it was like April 2nd. It was a Tuesday. And then I was scheduled to have, they have to do imaging, you have do labs.

So, had all the staging done and so initial staging, everything was kind of pointing towards like an early stage one. But the problem with the, it, was technically rectal cancer.

Those ones are a little bit. Um, difficult with even imaging because sometimes you can have like, you know, I had MRI with, um, contrast, CTs with contrast abdomen, chest, abdomen pelvis, whatever.

And, uh, even though the lymph nodes, there was nothing enlarged. Sometimes they, the cancer is so small. It can, The lymph notes can be as small as like three millimeters sometimes, and that's not going to really pop up.

So even thought the imaging looked good, You really don't know the final path until, or you don' know your, your staging until you have your final pass back.

It was like reassuring that the labs and imaging looked good, but it was still really hard because I wasn't going to have that final answer until after the surgery, which took place on April 30th.

So within about a month, everything was kind of dialed in and dealt with. Okay. And then what's the recovery look like for you? Did you have like a colostomy bag or like how did that look?

So how it worked was I had the total proctocolectomy and it's called an ilial anal pouch at the anastomosis. It's like IPAA, it is a J-pouch. So essentially they take the small, like the ilium and they create like a new rectum, if you will.

And so while that, It is big surgery, I think it was like six or seven hours. Wow. Cool. They remove the whole colon rectums, they do this reconstructive surgery.

And then it has to heal. And so I had to have a temporary ileostomy for two months while that healed. Then after two month, I was able to basically have that taken down and then everything kind of reanastomosed.

So far, so good. Things are working as they should. Yeah. I mean, it was the recovery. Interestingly, I feel like the recover from the actual, like I call it the mack-tatty surgery, the big one.

Like I recovered really fast, with the ileostomy, and I felt great after eight weeks. So the week I was scheduled for my takedown and reversal or whatever, i felt wonderful.

like i had tons of energy. i could have gone back to work. And then I had the takedown and then that was like, interestingly, even though it was a smaller surgery, because it only like maybe an hour long, I'm still recovering.

I don't know. It's been a difficult recovery in terms of a lot of pain. Like pelvic pain and stuff, but I have another colorectal surgeon who specializes in like pelvic floor dysfunction.

And so she's helped, like you can do like Botox and it helps with like relaxing all of your muscles and like the pelvic area. So that's been really helpful, but yeah, it's a slow recovery, I'd say.

I don't know. And you're still basically being treated for ulcerative colitis too? You're taking the medication and everything else on top? No. Oh, you are done?

I'm not actually. I mean, because I've had like endoscopies since I had the surgery to check on the reconstruction and they said everything looks good.

They don't really see any inflammation and the colon, there's like residual rectal tissue left, like I think two centimeters. But every time I've had, I think, three so far since the surgery, and they said it's looked good.

So I actually go again in April. We'll see if it still does. And sometimes people do. I mean, you're not wrong. Some people still need to take medication even after the surgeries, just as a case-by-case basis, So let's go back because you mentioned about your symptoms, that you had no symptoms.

We talk about rectal bleeding as a big one, but what else? What other symptoms? Cause you, you know, with ulcerative colitis, You have flare-ups, should have pain, things like that.

So that's not really a good viable something to go by really. And you may have bleeding too. so what have you looked at personally for ulcersative Colitis as, a symptom to that raises some red flags?

Surgery, J-Pouch, and Recovery

Well, kind of what I was mentioning earlier, I didn't really, it was pretty well controlled. So I don't have any bleeding. I did have pain. It didn have changes that would be even alarming.

What would be your symptoms though? So let's say if you were like having a, it's like, what would it be a red flag that, oh, you really got to get a colonoscopy.

So, yeah, I mean, like if. You have any like blood in the stool, even a drop, It's not normal. It needs to be looked into. Even people always chalk it up.

Oh, its like hemorrhoids, but maybe, But you don't know until you look and sometimes. you know, change in stool caliber, like if it's really thin or any changes in shape that's abnormal to what you're used to.

Maybe if you are having diarrhea, if its been lasting like several weeks and like, hmm, that is weird. And outside of like an illness or new constipation, even bloating or acid reflux, any kind of GI symptom that new that for you, should always be looked into.

There's, I mean, we talked about this last episode too, about the rise in rates of colon cancer in younger, younger people too. One of my colleagues, her husband unfortunately passed away of Colon cancer and he was 35. And again, he had GI like symptoms.

It was, you know, new bloating, it was nausea, was pain. There was a lot of different things. I was like, this is weird. So he went to get checked out and that's when they found.

By that time, unfortunately, it had already progressed to, you know, stage four. I mean, It was just, everywhere. And they're looking, apparently, and your Forbes article mentioned this, colon cancer rates on those under 50 are expected to rise 3% annually.

I don't know. I mean, you know, we're both physicians. And I posed the question to the GI doc I spoke to last time, but what is it about? Is it something in our lifestyle, our diet?

What is that is causing these rises? I think people are still looking into it. There's a lot of energies trying to go towards figuring out the why. A lot is environmental and I gut microbiome that I think that we still need to learn more about.

They're linking heavy processed foods at a young age, like childhood until adulthood, increased rates of IBD and colorectal cancers with that. So I think an obesity, you know, there's a lot of things that I can contribute, but I that it's probably a combination of thing.

So it is hard to really pinpoint. But I know for me, I grew up on like processed foods. Like looking back, it was all I ate actually from a young, young child, like little, little.

Until I mean, didn't really eat all that healthy until I was an adult. Yeah. By then you're diagnosed with IBD as it is. So that you almost had to force a dietary change to some degree, I would think.

Yes, but I wasn't the greatest. I still eat too much fast food and processed food. And you just, you know, your, think you are invincible. Like I'll be all right, and I think that we all kind of fall in that sometimes where you don't think, ah, it's not going to happen to me.

It'll Right. And then all of a sudden, here we are. Now, does your diagnosis guide or in some way inform how you treat your own patients, both in the hospital setting and in your primary practice?

You know, do you look a little bit closer to people with GI symptoms? But let me caveat this. For emergency physicians, when a case goes wrong with us, that sticks in our mind.

So we just have a heightened sense of awareness about a diagnosis that we tend to look for a little bit more in other people who normally you would think that, oh, well that's not really a thing in this population.

Do you think, do you look a bit closer to people coming with GI complaints or anything like that? Yes and no. And the reason why I say no is because my husband and I both, like before this all happened, we've been such sticklers about prevention and screening.

We're just so hyper about that with our patients. I always like my quote with everybody, all my patients, an ounce of prevention is worth a pound of cure.

And because there's people that they're so hesitant to do, maybe mammograms or colonoscopies. And so I spend so much time educating them on the pros, the cons, alternatives.

I've always really done that even before this. But I think now I'm a little bit more heightened with. any GI symptom, I'm like, oh, wait, we got to look into this, you know, like in my mind.

But, or as particularly family history, because I think that people tend to kind of dismiss that. I don't think patients, a lot of patients don t realize how impactful that is.

Like if you have like all sometimes have people come in and they're like multiple, Oh, my aunt, My grandma, and my cousin this have had colon cancer. And I m like okay, well, You have to get a screen colonoscopy, They may have never been told that until then, and they don't understand.

But they're so, but it's not my mom. It's my brother. If you have multiple second degree relatives, that still counts actually as a first degree. Were there any insurance hurdles that you ran into getting screening and testing?

You know, okay, that is interesting because I know that insurances with our own patients like we don't with direct primary care. We don' actually bill insurance.

It's a more of a membership based model, but we still deal with insurance For like, you know, prior authorizations, like say if somebody needs an MRI, whatever.

And I experienced zero issue. They covered everything right away, stat urgent. and I was so shocked because I hear these horror stories where people like care is delayed.

Now, and, I don't know if it's just the type of plan I had. I, had it through my employer, through the hospital, well, it was technically a hospitalist group.

I don't know if it was just a plan that I had through them. It was a PPO with Health Net. And I honestly, it a really

good experience. They did not deny a single thing and nothing was delayed.

million times easier. I'm sure. Wow. Yeah. And there were no real big surprise bills or anything. Then I just switched my employer at the hospital, the hospitals group I am employed by I should say, they switched to a different insurance, it's Blue Cross PPO, but they're already like just some simple stuff they've like denied.

And I like, hmm, this wouldn't have happened with my old insurance. Like, so that'll be interesting to see how it goes. So I'm really very fortunate that I had the insurance I when I had all that going on, like the big stuff like, you know, this massive surgery and all these scans and, different specialists.

And so I actually, I don't have anything. I have only positive things to say about my experience with that, which I know is probably a minority, but I'm very thankful that it wasn't.

And is health net its own in the like insurance company? Is it, it's not run by like UnitedHealthcare. It's on a subsidiary or anything like that, as far as you know.

You know, I never looked into it. I don't, i'm not real sure. And again, like I'm, not saying, you should have. Again, out of curiosity, because we hear the horror stories like you said about people getting denied care, delayed care.

Symptoms, Risk Factors, and Rising Cases

Right. you have, United Healthcare is kind of the big bad in a lot of this stuff. A few years ago, they tried to change the prudent, we're going against the Prudent Late Person Rule when it came to emergency room visits in Georgia.

The idea that UnitedHealthcare wanted to bill the patient based upon was it emergent or non-emergent based on the final diagnosis. You came in for chest pain, but I put a diagnosis of, you know, gastric reflux.

They were going to try and come back and say, well, that's not an emergency room care. We're not going actually pay that. And there's a lot of aiming and hawing where basically it's like, are you going against what's called the prudent layperson law?

Meaning that you have no idea your chest, pain is a heart attack or reflox. That's up to me to decide. So why are your punishing the patient for? you know, basically being a good, a prudent layperson and getting this thing checked out.

Thankfully, that was very short-lived. You know that got struck down. But again, you have these companies like UnitedHealthcare trying to save a buck or two and really it's at the expense of the patient.

And already you've somebody who has a history of colon cancer, IBD, surgery, suddenly getting the laser denied by Blue Cross. It's like, well, what do you want to do here, you know?

Yeah, it is kind of interesting. So we'll see how it goes. I just switched, I don't know, a few months ago. Luckily, like the bulk of what I needed done is done.

And now it's just healing. Um, did not require for now any chemotherapy or radiation because it was stage one. They just, they said that basically surveillance after the surgery, the resection.

Yeah, and for people who aren't aware too, you know, what you underwent was not a simple surgery. This was, they literally took out a good chunk, let's say of your colon, created like that little blind pouch, create it out, put a pouch on top of that.

And then for the other portion that was still remaining, They literally had to tie it all together. and while that portion of the colon was healing, the poop was coming out into the pouch.

They went back in, had that part reattached to the colon so that everything is now seamless on the inside. That's

basically what Dr. Dylan underwent here.

And so it's hard to fathom that there isn't some form of pain. There isn' t some long-term recovery from this. This isn t just like a simple, Oh, I had my tonsils out and you're back two weeks later.

Like this is, you know, what is the expected recovery to back to getting you to a hundred percent? Like how long did they tell you it might take? I think that I'm not the norm.

I thing most people feel like kind of back to basics by now. I think I just had like a more prolonged recovery. Like I know that the J-pouch for maturity wise, like in terms of tolerating different foods and you know, bathroom frequency, that takes, I've read anywhere from like 18 to 24 months.

And, but some people, it's sooner. Some, you know, some, people never adapt and they have to have it removed and have a bag for the, they, have, to go back to that.

So it, really, individual. But I think the majority of patients do really well with the type of surgery I have. Actually, when I was reading about it before I had it done, I mean, everywhere all the articles I, was, reading they had like 90% or more patient satisfaction with this, like what in medicine has like 90% or more satisfaction, with anything.

So I was like, of course I'm going to do it. That's right. I think that it should, you know, once everything's kind of healed and matured, I, think, that people will just go on and they'll just live their life.

Well, what's the alternative? I mean, chemotherapy and radiation, but I I don't know what the success rate of that is. Was that ever discussed? Was it ever an option?

No, because just the type I had, it was so small. I think that surgery is the standard of care for what I have going on. That really wasn't an options for where I was at.

In the history of IBD, they have to take everything because if you have it there, you're probably going to get it somewhere else. If not today, maybe five years or whatever, some arbitrary amount of time later.

And not for nothing, you know, your young and healthy enough that surgery recovery now is a lot easier than it might be in 10 years or 15 years. Yeah.

And it was done fully robotically. So I think that's why like the first surgery I healed so fast. Like, I mean, didn't really have any pain. I just was like really good.

You have like, the couple of weeks are a little rough because, it's even just having small little incisions and it a big surgery. I think the first two weeks was just standard like any other abdominal surgery was, you know, had some pain, but it was totally managed.

It wasn't anything. I that the hard part was because I had a loop ileostomy in the beginning, the temporary one. So there was a lot of like skin irritation and like where they, have the adhesions around or the adhesive from like the bags and stuff.

And so that was difficult to deal with, But that wasn' really a surgical problem. Let me ask you this question. Did you talk about this, if you talked about it with your children?

Because your, children at the time were, you had a one year old, obviously, whatever. Oh, he was actually two at that time. Okay. So he, was two, at a time and then you, had, and he and his children was five at, the times.

He was a little bit more aware of what's going on. How did you approach that conversation, If you approached that, conversation at all?

Insurance, Treatment, and Family Impact

Well, to be honest, I don't think that they understood. They just were not aware enough to understand the word and what cancer even means. So it was just, mommy has an owie.

That's all I would say. And they were very receptive to that and they're very gentle. You know, they are little boys, so they obviously have a lot of energy, but they always like really careful around me after the surgery.

Like, oh, Mommy has a owy on her stomach. We gotta be careful. It was basically just that. You know, I did not paint like a doom and gloom kind of thing.

Yeah, it was I tried to keep it light But you know they unfortunately they do see the sides of cancer that with the emotional side. It's hard to Keep things together sometime.

So I'm sure that they you, know Hopefully I didn't totally ruin that. We need to make a core memory, you Know that's We tried our best like to shield them as much as we could we definitely tried her best I know when my cousin had breast cancer, I had her on the show back in the fall.

They were much older, they were approaching middle school age, teenage years. So they are much more aware of what was going on with their mom. And there was a discussion where they had to sit down and say, hey, you know, For them, it was a lot of preparation, like, I'm going to look different, you know, i'm gonna lose some of my hair, for her it's breast cancer, so she went through a double mastectomy.

It was actually prophylactic in a way because of the type of cancer. So there's a preparation before it happened, which I think made it… It's not easy, but it made it easier for, you know, things that kind of happen at home too.

And you, I think, says in yourself in the article, which I want to pull up your article real quick here. All right. So, and you say it here, when you're a parent for your changes, it's the immediate mental health of what their lives would look like without you.

I think it was a very interesting quote because people also assume that we as physicians immediately just look to the medical side. It's very analytical, it's basic, scientific, but that's not the case.

Anytime we have these diagnoses, we feel the same weight on ourselves as much as a patient does. especially when we have families. Did your medical knowledge, your medial training reassure you about what's going to happen or were you more concerned than you think than the average patient?

Like how did that, what was your mental state at the time? I think that for me, sometimes knowing too much is like… not the greatest. I think that, you know, it's easy for your mind to travel to like worst case scenarios.

And in the beginning, like I said, I didn't know it was all signs were pointing towards stage one, but I did it know until I had the final path. So and that took time because you had to wait from basically diagnosis until it had a final pass.

It was kind of a while. six weeks or eight weeks, or something. And that's a long, it was felt like an eternity because it either going to be like stage one or stage three because if the lymph nodes came back positive, which thankfully none of them did.

So I think that where, you know, obviously if you're a higher stage you have higher rates of recurrence and things like that. You just worry like, oh, I hope that doesn't happen.

But I don't think we're immune to You know, sometimes people think, oh, well, she's a doctor, then she'll know all the stats and that that will offer reassurance.

And while maybe a little bit, but you're still human and it still is really impactful and, and scary. What, if there's anything that you can say to somebody listening to this, that's scared of getting screening, who has colon cancer or scared the treatment, is there any message you could offer them or anything you couldn't share that might, anything, you want to say them?

I feel that, you know, it's better. The sooner you can catch something, the better it is. You know it, nobody wants to get these, colonoscopies are not fun, but they're really quick.

They're not that bad. I think the prep is the worst part. not that long and you know you're sedated you don't you wake up from like a nap. It's easy to put your head in the sand but you sometimes you just have to go you have go through it no matter what whether it's going to be whatever stage it is so it better to know sooner than later.

You have better outcomes if it caught sooner. And I would say, research your condition once you have a diagnosis, because I often say your patients will know their disease better than you will.

Because now they have to live with this, so they're going to do all the research, they are going look into this.

Prevention, Screening, and Closing Advice

And, you know, I will tell other physicians who are listening to this don't be afraid of the patient who knows their condition too. If you are going to have somebody who with a life-threatening diagnosis or a chronic diagnosis, give them resources, get them information, and let them research it because oftentimes that reduces fear of the condition itself, being aware of what's going on too.

And even support groups, I think, would be great because especially for some of them more rare illnesses or unique surgeries that maybe are not done a lot, you know, like a lotta people don't know about, Like for mine, having this J-pouch is kind of unique.

A lot of people have them. I just wasn't really aware until it happened to me, but they have these forums on Facebook where it's people with the same condition.

It's very helpful to have that kind support. So I think even for different physicians that have maybe practices that unique illnesses to see if they patients that are willing to you know, like be part of a support group.

I'm sure that they probably would. Yeah. Especially in their local areas. Get together as things that you can just share stories about how you're doing.

You don't feel alone and isolated. Yeah, it doesn't have to be some like social media thing. It can just be something private like, oh, you know, there's a group of patients that have similar and, they, here's the contact and they meet up every once in a while or, or maybe they don't meet, but it's just somebody that you can talk to.

Yeah. Exactly. Well, Dr. Christina Dillon, thank you so much for coming on, telling us your story. For those interested in reading the entire story on Forbes, I am going to link it into the description.

You can find it on YouTube. or on Apple Podcasts, and all that if you go into the actual description of the episode itself. So, Christina, thank you so much for coming on.

It was great to see you. Yes, it was good to you too. We'll catch up soon. Thanks again to Dr. Christina Dillon for being on the show to discuss her personal story with combating colon cancer.

Her story of ulcerative colitis was a very unique case. She was getting screenings yearly for some time, then every two years, once her disease became a little bit more managed.

But even then, she still developed cancer, and she is at high risk for it because of her illness. As I said in the introduction, not everybody's story with colon cancer is going to be the same.

Prevention truly is the key to combating this disease. Treatments are available, but oftentimes when people develop symptoms, it's already too late. You need to have routine screenings starting at the age of 45 or younger depending on your own individual risk factors.

If you have questions or concerns about your personal risk factor, talk to your doctor, reach out to a GI specialist for further information, and they can better guide you on the treatment regimen and screening tools right for you.

As I said, I'm going to link Dr. Dillon's Forbes interview into the comment section below. Give it a read yourself. An ounce of prevention truly is worth more than a pound of cure.

Take this disease seriously and get tested, get screened, and talk to your friends and family about doing the same if you know they are overdue for their colonoscopy.

As always, be safe, make good choices, And we'll see you next time.