The No-BS Guide to Colon Cancer (Part 1) Transcript

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Intro and Colon Cancer Awareness Month

It's March, which means it's Colon Cancer Awareness Month, the one time of year we can legally talk about your backside for 35 minutes straight. On this episode of the JafferCast, I'm joined by GI specialist Dr.

Hannah Doe to talk why the screening age dropped to 45, why your daily salad is a fiber failure, and why you're charcuterie board is essentially a carcinogen platter.

Don't at me on that one, folks. recovering the gold standard of naps and why you shouldn't let the fear of the prep stop you from preventing a literal killer.

I'm Dr. Mark Papadakis, nobody particularly special, just another freaking ER doctor. Stay tuned because if you've ever wanted to hear two doctors talk about big fluffy poops with professional sincerity, you're in the right place.

All right. I'm here with Dr. Hannah Do. Hanna, thanks for joining me. Welcome to the show. Yeah. Well, thank you so much, Mark, for having me, you know, it's a real honor and a pleasure to be here, with you all in this, uh, You know fine afternoon.

Um, Dr Do and I are actually colleagues on the Bucks County Medical Society. And Dr, Do is a GI physician associated with, um, Penn Medicine at Doylestown Health.

So, Hannah, do you want to talk a bit about yourself, like medical school, where you're at the residency, all that kind of stuff? Yeah, of course. So, you know, I grew up in our state capital in Harrisburg, Pennsylvania, and I went to school here in Philadelphia.

I was at Jefferson Medical College, which is now the Sidney Kimmel College. Wait, is it really? I didn't know that. That's news to me. Yeah. It's officially renamed. I think it was a hundred million dollar donation.

Oh my, oh my. Okay. And so, then I want on to do my internal medicine residency up at Yale New Haven. And then I wanted to look for some warmer weather and I was out in Southern California and University of Southern, California for my GI fellowship, but happy to be back in Pennsylvania.

I've been at Penn Medicine, Doylestown Health for about eight years now. You know, as I met you through the Bucks County Medical Society, being a former president, been also really passionate about advocacy and the medical service line director at my hospital and serve on the exec committee as well.

So again, very nice. you to be here and to talk about colon cancer awareness in March, which is just such a, you know, dear issue to my heart. And it's something, I'm happy to.

Talk to your viewers about as well. Yeah. You know colon, cancer is one of those diseases that has been in the news a lot over the past, even a couple of years.

We're just, there's articles and articles coming about, about this diagnosis occurring in younger people. Well, we're seeing that in our practice too, but people are also rightfully scared.

Dr. Doe's Background and GI Practice

It's like, Oh my God, what's going on? Why is this happening? I get different opinions all the time. You know, some people say, oh, it's the processed foods.

Other people, say oh it was just genetics. People say it actually hasn't really changed. We're just being more and

more aware of it or better testing or wherever the case is.

But you know March is colon cancer awareness month, hence our discussion. And the next episode, I'm going to try and push out FYI, you might get two episodes in two weeks for the first time in like history here.

Working overtime here. Working over time. Depends on how busy I decide to make my weekend. Uh, we'll see. We're recording on a Friday. I'm hoping to push this episode out, uh, next Wednesday.

So, yeah. so talk to us. You've been in obviously practice for, you know, a number of years now. Doelson Health for eight years. you've done a Number of colonoscopy screenings, You know diagnosis, things like that.

Let's talk first about risk factors. When it comes to colon cancer, what has been the number one highest risk factor for colon Cancer? Yeah, well, I think a lot of things are multifactorial, but definitely family history.

So generally, if you have a first degree relative, so that means mom, dad, brothers, or sisters, that can increase your risk. Aging, you know, there is an increased incidence that we're seeing in younger folks, But the older we, the longer we live, There is just more exposure.

And there has been a correlation increased risk of growing polyps and then developing into colon cancer. I would say the third big risk factor that I see in a lot of folks would be inflammatory bowel disease.

So conditions like ulcerative colitis and Crohn's that cause chronic irritation or inflammation to the gut that if uncontrolled will definitely increase the risk of colon cancer.

And then the last would, you know, things that people are ingesting. You know high alcohol intake or tobacco. How about highly processed sugary drinks?

Yeah, so generally what we think is protective against polyps and colon cancer would be high fiber fruits and vegetables and unprocessed foods. So I definitely would agree that if somebody is eating a lot of, you know, we describe things that are highly carcinogenic as in the burnt parts of barbecue.

And that dark, delicious, crispy part, it does increase your risk of colon polyps as well as highly saturated and processed foods. It's interesting. Do you see, is there any data, and I don't know the answer to this if you know it, about people who live in like southern states with a huge barbecue culture?

Like you would talk about Texas barbecue, things like that. Is there a higher incidence of something like a colon cancer or diseases from smoked meats and barbecue and things You know, that's fascinating.

I don't know off the top of my head, you know the distribution within the United States of the incidence of colon cancer, but I definitely do know that the World Health Organization has designated highly processed and smoked foods.

Like, all the lovely things that we enjoy in a charcuterie board, those things to be a carcinogen, a type one carcinogen. So I would imagine that there is a correlation there for sure.

Remember that, the next time you host a party with your charcuitery board people. Um, but, you know, it's also important to know that moderation is obviously key.

So when we talk about, obviously not everybody drinking alcohol or eating smoked meat is going to develop colon cancer, But it is important about risk and the idea that everything that we put into our body has consequences to some degree.

You can eat an all vegan diet and you can still be at risk for heart attack if the genetics are there. It is what it. What about the age of screening?

So it used to be, the guidelines were, all right, 50 years old, You've got to get your first colonoscopy. Now there's talk about dropping it to 45. If it hasn't been dropped already, I don't know.

It already is, Mark. So that's the really exciting part. I mean, for many, many years, the screening was traditionally at the age of 50. You know, it's that birthday gift at that turn of that.

the century, generally there was a carve out. So those with African-American ancestry, it was 45.

Colon Cancer Risk Factors and Diet

And that was thinking that due to the underserved nature of the population and or maybe the diet to screen at 45, however, the American Cancer Society several years ago decreased the screening of recommendation to 45 and ever since then, all of these subsequent societies, that American Gastro Association, as well as the United States Preventive Task Force have all lowered it to And in general, we're seeing all insurers, Medicare as well as commercial, really respecting that guideline.

And I think that is important because the new data just came out recently that pretty much all cancer deaths under the age of 50 have declined with the exception of colon cancer.

So that's really where we want to make that dent by starting to screen at 45. Because in my mind, Mark, Essentially, colon cancer is preventable, right?

Because we know it starts as a polyp. So I get in there and I remove a Polyp that basically allows that person to live longer. And it shows a mortality improvement, which not many studies can show.

Yeah. And I remember my father started getting screened at 45 because his mother, my grandmother had colon cancer. So that automatically was, all right, first degree relative, now you're down to a degree.

If you have a first-degree relative now, does that screening age get lower to now 40 or is it still at forty-five? it's generally like 45 or 10 years younger than the time of diagnosis of your index family member.

So, yeah, and my father had polyps removed, things like that. My mother has had a polyp removed. The scary part about my family history is my mother is adopted.

There's like a whole genetic tree that's missing as far as what am I at risk for, what's she at-risk for. Does the task force talk about unknown family history?

Do they talk about, oh, now you're at higher risk because we don't know your family's history for that reason? So, you know, unfortunately, we really don' have a lot of data in that sense.

But I would definitely say nowadays, the genetic testing is so good, meaning there is an Invitae assay of 86 different genes, either a blood draw or a mouth swab.

And insurance companies have started covering more as well as the costs to the patient if they don't meet all the criteria, meaning a degree relative with a proven germline mutation, et cetera, can actually have genetic testing.

And I think that's really powerful because most folks may not realize that I actually have a cohort of patients here in Bucks County that have Lynch syndrome.

And it is not actually uncommon that one of their parent or they have been adopted because with Lynch Syndrome, it's not uncommon to develop colon cancer in your 20s or 30s.

So there can be medical things that may lend somebody to being adopted. So for a lot of these folks, meeting with a good genetics counselor, running a family tree to the extent that there's awareness to it.

And some folks even adopted may have data with their biological parent, you know, in an open adoption. But if not, wanting a genetic test is a is good idea, I think.

Yeah, I agree. I know for people who are studying for infertility, for example, they go to like fertility specialists. They do genetic testing, largely to screen for, you know, inherited disease for that would affect field viability.

But they also screened for other genetic markers too. Honeydinks, Parkinson's, all of these different things. And I think I remember back in the day, there was a long discussion about who should get genetic tests.

You know should it be given to everybody? Should there be counseling with it? Like, should this be kind of like you do it yourself as a referral? Because There's a lot of data that comes with this type of testing and, you know, broad data by itself without any kind of explanation, without kind analysis can be very concerning, very dangerous, gut wrenching for a lotta people too.

If you seem to say, hey, there's the gene that's for like Huntington's, it's like, oh my God, now what? It's well, that why we need genetic counseling to go along with us here.

a hundred percent, they cannot be done apart. And that's why I really, you know, when folks come to me and say that they've maybe done 23 and me or some of those ancestry, um, You know commercial products, it's not really quite as good as, sitting down with the genetics counselor, having a referral from a physician and then having that interpreted.

So there are quite a lot of mutations that I make it. I'm the number one referral to my genetic counselor here at Doyle. Excellent. And so, you know, I come across a lot of mutations that may pop up and generally, some of them are of unknown significance.

So, we don't quite understand it now, but it's in a repository that in the future, if we were to understand that I can recontact the patient. That's number one.

The other thing for a lotta folks that mean not want to do genetic testing, because let's say they don' have children, I still say would be very helpful for themselves because one singular mutation can put, for example, BRCA2 actually can't put somebody at risk for both colon as well as breast and even a small risk of pancreatic.

So it's very powerful to know if you have it or not have independent of, you know, knowing for your children. The one caveat I will tell a lot of my patients, especially if they're on the younger side is if your thinking about embarking on genetic testing, it is a really good idea.

If you've contemplated getting life insurance or disability insurance to do that first. Yes, 100%. That's one thing that I got in residency that was drilled upon me to get life insurance when you're younger and healthy because heaven forbid something happens in five years, 10 years.

You have a diagnosis that sticks with you no matter what. Yeah. And you know, my wife and I, we did genetic testing prior to the birth of our child.

Screening Age and Genetic Testing

So yeah, if all of a sudden, again, random screening can… pop something up and now it stays with you. And suddenly your life insurance plans in health insurance plants can see all that information and suddenly you're high risk.

Your premium went from $200 a month to $800 a months. Congratulations. So let's shift gears because I want to talk a little bit about the actual process.

Like we talk about how colonoscopies are the easiest sleep you'll have. Oh, it's this and that. It's pretty simple. What somebody goes to you and says, all right, we're going to do a colonoscope.

Guide us to the process of that, what happens. It's so, so funny, Mark. I'm not one of those GI doctors. When I had my colonoscopy, I felt like I went to war a little bit and it came back.

So, you know, it's an endeavor that definitely requires dedication. And so when somebody is thinking about having a colonoscomy, we do try to make it as easy as possible.

So the first thing is if you are 45 and up and it's a screening, meaning you're not having any diarrhea, rectal bleeding, pain, et cetera, and kind of just doing it for age, in my practice, it is quite easy.

In a lot of practices, we have something called an open access forms. Penn Medicine Doylestown, there's just an electronic form which I created. You can put all of your demographics in there.

Generally folks that would not qualify for open access would be if you're extremely high risk with heart disease, dialysis on blood thinners, wearing home oxygen, that type of thing.

But generally if your healthy then my office would call in and discuss the procedure with you. And generally about a week prior to the procedure, we modified the diet.

So we generally ask folks to kind of eat less fiber or foods with seeds. And the reason being is that if you eat a lot of nuts and seeds, roughage can last in the colon, and then it can clog up our scopes.

Then generally, about day prior the date that you choose to schedule your colonoscopy, you will do a fast and a liquid diet, So generally, at first it sounds like, oh my gosh, I'm not going to be allowed to eat anything.

Well, not quite true. I encourage a lot of liquids, so things like lemonade, orange juice, liquids that are clear and see-through. We do allow you to some solid foods that aren't clear.

For example, when I did my own, gummy bears were my friend. I actually had to send my husband, my children away because, you know, My husband will be eating fried chicken while I'm trying to fast.

And so, so I have them go out of the house and, and after a period of time, actually, I think I was just more thirsty than I, was really hungry. You kind of, kind get past that.

and then generally around five o'clock, You'll be drinking a prep and we have marvelous preps now. We have things ranging from that good old four gallon go lightly, which is kind ancient.

to all the way to 100% pills. So when I had my colonoscopy, I used a pill prep called SuTab. There are 12 pills, not all together, but in the span of every five minutes.

And there's no taste, it's very palatable, and you kind of just drink it with whichever liquid you prefer. That could be water, dairy, lemonade. Really, there was no tastes.

The only downside of this pill preps is if You have trouble swallowing, obviously, wouldn't be a great agent for you. I do allow folks to chop it in half.

So cutting the pills in-half is easy. And then generally within about two to four hours after ingesting the pill, you will have an urge to go to the bathroom.

Boy, it's quick. It comes upon you, and then after several bouts of purging, at the end, when you're kind of ready, the stools come out more like liquid.

That's the toughest part. And I joke with my folks and I say, you know, that really is a pain in the butt. Yeah, unintended. But, the nice part about it is it's a good cleanse.

So, it really kind of purges out the gut, get a night's sleep, wake up the next morning. We do do a double prep, so

about four to five hours prior to the procedure, we'll do another round of the prep.

And then come to my procedural unit, you meet our entire team, our nursing staff, or anesthesia team. And it really is a great nap. Only most colonoscopies are about half an hour to 45 minutes.

I tell folks, there can be a little bit of gas. You might want to feel like you're going to fart after the procedure. and really minimal discomfort. Most folks, you know, feel pretty good and kind of go about their day.

I take a lot of photos, I'd like to say I'm a photo taker and what's funner than seeing our insides, right? And most folks I would say, um, tolerate very, very well and about four out of 10 folks grow polyps.

So again, a very powerful tool because when we remove polyp, we know that prevents those polypes from growing larger into a tumor or mass or cancer later on.

Yeah. And your agent that you use to have people go, have you go to sleep is Propofol. Is that still widely used? Yes. Propafol has a bit of an amnesiac property too.

So I have myself actually had an endoscopy at the age of 20, 24, I want to say. I had some reflux and I remember for me, there was just no prep. It was, you know, fasting the night before.

Yeah? And they had the camera go and I was prepped on the table. I gargled with like a lidocaine, swish and spit kind of deal. And I always concerned about the idea of a camera going down my throat, into my stomach, and then I'd be gagging and discomfort and this and that.

Apparently, when I'm on my side, they put this device in my mouth and the next thing I remember from one second to the other was a doctor next to me talking to be about a procedure.

Literally there was like no in-between whatsoever. And then the next thing I remember after that was walking out, then I was in the car, and then on the couch.

Colonoscopy Prep and the Procedure

Like it was a very spotty memory after. But apparently it's a similar situation where my parents have had it multiple times now and it is the same thing.

They get a little amnesiac, they don't remember what the doctor said. So one thing that I say to people when they're going for procedures is try and have somebody with you.

You know, obviously you need somebody to drive you home because you're not going to be really fit to. But somebody who's at least going be able to take notes and kind of listen to the doctor after the fact, because, you probably won't remember much of what happened either.

Yeah. Having somebody with you is great. We always provide an extra copy of the report to, take home. And generally I wait, I do the next case or two before I come back and, and speak to just allow folks to really wake up and understand what's happening.

but, but yeah, it is a great nap. I want to tangent because you mentioned something about the prep. You said no seeds or foods with seeds and things like that.

A long-standing direction for people with diverticulosis has been avoid seeds in your diet. Now, I understand the recommendation has changed a little bit.

So it's not as strict, but the seed problem here is just it can obscure the camera. It does stick around in the colon. But the thought process for those with diverticulosis, little outgoing pouches, like extra pouch in the colon, it gets stuck there and it creates divertigulitis.

Is that still, is that really still a concern for that patient population? No, that's actually completely been debunked to like 180 degrees. So divertikuloses are the presence of these pouch and kind of explain it to folks that, you know, the muscles in our body as we age sag.

right? So there's no muscle that is as taut or elastic as it was when we were 20 and 30. And so these little sags that form within the colon, we, you know, name it diverticulosis.

Nine out of 10 folks, so 90% of folks with diverticalosis will never have a complication. But 1 out of 10, unfortunately, sometimes can have either. We don't quite understand exactly what triggers it.

It can be associated with constipation or poor diet, sedentary lifestyle, obesity. Generally, something tickles these pouches like a nut or a seed or even a polyp or tumor.

and then these pouches become irritated and inflamed and they cause a lot of pain. In the past, when somebody has had an episode of diverticulitis, we generally, for two weeks after the attack, eat a really bland, low-fiber diet, which is still true.

But actually, once that period passed, we recommend a high fiber diet, a fiber rich in fruits and vegetables, which do contain nuts and seeds, such as cucumbers, tomatoes, those types of things.

So the studies that came out showed that folks with diverticulosis, the pouches, when we split them in two groups, and these studies, I don't know the number off the top of my head, but like hundreds of folks, with a nut seed-free diet versus a regular diet.

There was no difference. Interesting. Diverticulitis attacks. Now, being a pragmatist, I always tell folks, well, if you go out and you eat like a bag of popcorn, you have diverticulitus, then maybe don't eat that bag popcorn.

But the majority of folks I see, it's generally not a direct instigator to an attack. That's good to know, especially because one of my relatives who does have diverticulosis, she was told that throughout most of her life.

Oh, don't eat nuts, Don't Eat Seeds. But I noticed that the issue that most Americans specifically have is a lack of fiber in their diet. We have like a huge population that eats a lot of protein, which is great, but not a a of a fiber.

You know other countries getting protein is the problem for us is getting that fiber down. So yeah, I remember I had a general surgeon in medical school.

We had a patient who was in their service for diverticulitis and he basically was treated and was going to be discharged and we talked about diet for him.

And he talked fiber and said, yeah, you really want to pass, I quote, big fluffy poops. It's true. That's a marker of a good high fiber diet. And someone who I guess isn't constipated obviously, but then the caveat to that is people who are eating, you know, like your, your grains and your things with high fiber, those kind of vegetables, You got to supplement that with water too, because that can lead to constepation if you're not actually getting proper hydration, especially if your active, But more especially, if yours sedentary because there's nothing to help propel that down out of there.

So yeah, keep that in mind. Yeah. I mean, not to belabor the point, but my special focus is in nutrition and metabolic support. And you have no idea how little fiber we get in America.

The American Nutritional Guidelines recommend 30 to 35 grams of fiber per day. And when I speak to my patients about this, a lot of folks will tell me, oh, yeah, I have a bowl of salad a day.

I'm good, et cetera. And I said, you know what? I challenge you to do a fiber count. Maybe you're right. So I started doing it for myself. A large apple, if you Google that, that's two grams of fiber.

If you buy a traditional five ounce bag of spinach, let's say at Giants or the traditional grocery store, and you look on the back on a nutritional label, it's only five grams.

Who's eating six? bags of spinach a day, you know, even a bowl of salad for lunch and a ball of salads for dinner. It's very hard in American diet. So I am a big proponent of recommending a fiber supplement, something like Metamucil or Benofiber.

I actually personally take one myself just to keep good gut health because fiber has been shown to do so many wonderful things. And I'll tell you this, four things that it does that people don't that take it for granted.

Fiber not only lubricates and traps gas within the gut, but it has been shown to decrease risk of diverticulitis. It also decreases, so a diet high in fiber will decrease polyp and cancer rate.

it also naturally lowers cholesterol. So shockingly, my cardiology friends like it. I made the mistake of checking my cholesterol in January 2nd, So don't do that.

Yeah, I wonder what happened before that? How was that Yeah. And the last thing about fiber, which people don't realize is it gives you satiety. So when you add fiber to your diet, it helps you feel full.

It's a great way of kind of like a check and balance and a gray way to thinking about it is just like oranges. If you drink a glass of orange juice, there's very little fiber you're gonna not feel full at all.

Diverticulosis, Fiber, and Gut Health

You can drink, and that could be three or four oranges to make that orange juice, where if you take the time to peel an orange and actually eat it and ingest the fiber that comes with that, it's gonna make you feel and be more satiated with much less calories.

Yeah, I remember there's a lot of people who are into juicing, depending on, you know, the demographic where you're living. I had known somebody in medical school that was starved to get into Juicing.

And I asked the question, why? You know? Why is it? So I said, well, because you can get more nutrients per serving, per glass, whatever. And I think the problem with that mindset, because we were learning a little bit about nutrition.

Yes, we do learn about nutritional medical school for all the influencers out there, but the idea that you're not getting the fibrous portion of the vegetable that when you juice it, you grind it down and all that pulp that throw out, well, that's the fiber.

You know, yes, the vitamins and the minerals are there in your little slurry, but first of all, your body can only process a certain number of vitamins, and minerals at a time and it'll furrow out the excess.

So you're just kind of throwing away good vegetable matter that you could actually, you gut could be using too. If you want a little fruit smoothie to kind get you going through the day, fine, But also be aware that your not getting that beneficial fiber either.

so if you are doing that stuff, supplement as you can or just better off just eat that apple rather than juice it down or something. I agree. Now, as far as treatment goes with colon cancer, let's say somebody has stage one, stage two, what is the usual course of treatment for patients with?

Let's, say like, okay, they see a polyp, a mass, it hasn't spread anywhere yet versus somebody now with stage three, four. Is there surgery always indicated?

Is chemotherapy always indicate? What's that going to look like? Yeah, so this is like a really big question, right? So, I actually would say that I have a small cohort, probably within my two hands, where I've called folks up and I

said, hey, you know what?

I had good news and bad news. You know, the bad new is you have colon cancer. The good new, is I took it out completely for you, endoscopically with clear margins, and now you're cancer free.

So that's really like what I consider to be the holy grail of GI, right? So an early stage colon cancer in situ that is able to being removed endoscopically, so that has happened.

I actually pretty much remember every single one because this is like the dream. And in fact, I just saw somebody last week about that and she was shocked that I remembered her and I said, of course I remember you.

So I would say while it's rare, it is certainly possible. Can you tell if something is cancerous based upon while you're already in there or is it just you remove it and you find out after the fact?

So these early type of cancers, you know, we have special lighting we can put on it that makes us suspicious, but sometimes it is very hard. I will definitely tell you this, I recently had a gentleman with Lynch syndrome, which is a genetic hereditary condition.

He had had about nine colonoscopies with a partner and I did his 10th. So with Lynch, he gets screened very frequently. The guideline is one to two years.

And it was a small polyp. I was shocked actually that it came back as colon cancer. He was cured and actually I just did three year follow-up surveillance colonoscopy, you know, within the past two.

or so, and he remains geared. And now I actually take care of his daughter, who also has lunch, is three children, only one of whom is positive. So those cases definitely stay with you because they're really the strong winds.

The other types, the stage two that is not resectable endoscopically or stage one, then I would say generally I refer them to one my amazing colorectal surgeon partners.

We're fortunate that I work with three and then depending on the location. So generally I would tattoo it to help with the surgical, you know, planning.

We generally stage with CAT scans. A CAT scan of the chest, abdomen, pelvis, we check tumor markers, blood work. And these folks generally are resectable.

With a colonic resection, surgically, the lymph nodes will be checked to assure the proper staging. And then generally, these patients are cured. They do undergo surveillance colonoscopies a year after their resection.

Then generally if that's healthy, it then goes to three and then five years. Now, the tough stages are the stage three. A stage 3 really requires a multidisciplinary approach.

It also really depends where. So the colon cancer encompasses the rectum. but the rectal cancers are treated a little bit differently. So rectum cancers tend to get chemotherapy and radiation upfront to shrink them and then consideration of surgery afterwards.

Whereas most areas in the colon in earlier stages can be operated upon first. What is devastating, unfortunately, is the siege for colon cancers. And I will tell you, you know, if there is spread to the liver or the bones, other areas within the body, then generally it's not curable, but it is treatable with chemotherapy, radiation.

Sometimes can be offered surgery to treat symptoms, very obstructed or bleeding is predominant symptom, but that's kind of, you know, the wide array of where colon cancer can be found.

But really with good screening guidelines, we really should be catching colon, cancer early and curing a lot of folks. Yeah. So, so that really important.

What is the prognosis in terms of years, months, even about for a stage four diagnosis on average, would you say?

Treatment, Staging, and Prognosis

You know, I think for me, it is very, very hard to say that to someone. So I thing it's a variety of factors. I that the patient's comorbidities, meaning, you know is this young person that really otherwise doesn't take medication is healthy.

versus somebody that may be older with other health issues, heart failure, dialysis, emphysemas. So I think how someone does respond to treatment is highly variable based on their baseline health prior to the diagnosis.

Yeah, I think ultimately end of the day, the message is, you know, screening saves lives. We need to have people be aware that, colon cancer is not just a treatable and curable cancer, but one that doesn't have to begin in the first place.

That's the main thing. And it's so, so easy to. screen for it and then treat it while it's early that it should not be a fight. But people are scared of the procedure.

They're scared to the diagnosis that comes with it. So I get it, you know, all of us understand no one wants to diagnose this. No one want to go through a procedure that sounds horrible, but it is not.

That's the thing. It's not it people say it the best time you'll have for a very good reason, I think. Yeah, and I think that also nowadays, primary care physicians also are offering the stool-based testing, like, you know, that are picking up microscopic blood and or the Cologuard, which picks up, methylated DNA of some of the tumors.

But what I tell a lot of folks is, in life, the effort really correlates to the benefit, right? So while the stool studies are very easy to do, I don't, you know, disparage anybody from doing it because something is better than nothing.

But the Stool Studies are really there to detect cancer, When a colar guard turns positive, you know, it's detecting potentially some methylated DNA. It's not preventative.

A colonoscopy truly is the ultimate test because not only can it detect cancer, but like I mentioned, It can prevent it by taking out polyps at a small stage or even remove early stage cancer and cure cancer right there.

So a colonospey is only screening modality that allows, detection and prevention. And that that really is a big distinction. Yeah, one of the things we do in the ER and are related to this is called a D-dimer.

So a d-dimer is the test we often in an ER for a screening for pulmonary embolism. If somebody comes in, they're 27 years old. They have chest pain. The odds of you having a heart attack are low just based upon your age alone, unless there's other factors at play.

But for other demographics and women, especially who are on birth control or there is some kind of a clotting disorder, that could be at risk for blood clots in And I tell my residents say, if you did a D-dimer, like if, you sent this person home without any testing, and you didn't consider it, would you sleep at night?

Probably not. So you do a d-dimer, use screen for it. If it's positive, it doesn't mean you got it it just means now we've got to do, a CAT scan of the chest.

But now let's say somebody comes in, they're 65 years old. They've been coughing up blood. You're having really bad chest pain. Yeah, but not having a heart attack.

What are the odds of them having possible blood clot in the lung? higher, right? So I say to them, would you sleep well at night if you did a D-dimer on this patient and it came back negative?

You say, hey, your D dimer is negative, go home. It's probably not a blood clot in the lung. You probably wouldn't,

because the risk is, we talk about false positive, false negative.

All these different testing terms. At the end of the day, a cold regard, I think, in my opinion, is great for somebody who is young with no risk factors who may not be eligible to get a screening colonoscopy yet.

You know, are they concerned about it? Is there something going on? They're a little bit more constipated than usual. Sure, you know get it. I would first of all advise talking to your doctor of things, but sure, if you want to, at least kind of you're curious about if your concerned, get the call regard, try and see what happens.

If you are 65 years old, I'm sorry, call regarded if it's negative, ain't doing it, okay. You got to get that colonoscopy here. I can see a situation where insurance is probably going to be like, you know, yeah, if you're 30 years old, do you want screening?

Stool Tests vs Colonoscopy and Closing Remarks

Here's a call regard, we'll approve that. We won't approve a colonoscopy. I understand that logic. They're borrowing, other risk factors and things like that, but yeah.

The call-regard testing is good for some people. Once you hit the age where colonoscytes become a routine thing, it's not. You got to stop. All right.

Well, Dr. Hannah Doe, thank you again for joining me. I'm GI physician, fellow colleague of mine up at Doyle Sound Health, part of now Penn Medicine. If you're in the area, in Bucks County area definitely call her up, schedule your next colonoscopy, especially if you are 45 and older.

Okay. So it is the best sleep you'll ever have, as they say. Yeah, for sure. And thank you so much Mark for having me on the show. I very much appreciate it.

Um, and like I mentioned, if anybody's interested in talking about screening or any other GI digestive issues, feel free to call my office. Then I'm also happy to share my open access form link with Mark as well.

Yeah, I'll put that in the description on YouTube and as well as the podcast sites aswell. So if you're listening to this in your car, like my wife may or may not be, by all means go into the website, take a look at the link if your in area.

Obviously for living in California, probably a little bit difficult unless you want to fly out all the way over here, but either way. Thank you for coming on.

I will see you next time I'm sure. We have a lot more to discuss about other topics aswe. Yep, it's my pleasure. Take care and have a great rest of your day.

See you everybody. Alright, thanks again to Dr. Hannado for joining me here on the Jafford cast. Gastroenterologist, affiliate with Penn Medicine at Doylestown Health.

Some key items to hammer home before you head out. 45 is the new 50. If you're 45 years old, you are eligible for a colonoscopy. No excuses. It's not just gallons of sludge as far as the prep goes anymore either.

Pill preps are a game changer, and perhaps overall are less taxing compared to previous. Also, don't forget to increase your fiber intake, as chances are you probably aren't getting enough.

And remember, stool tests find cancer, but colonoscopies prevent it. Choose wisely. As usual though, don't take our advice on it, if you have any questions or concerns about your health, reach out and talk to your own doctor.

If you found this helpful, or at least mildly entertaining, do the thing, hit subscribe, leave a 5 star review on Apple or Spotify, and check the description for Dr.

Doe's open access link if your in the Philly, Bucks County area. Stay safe, keep those pipes clean, I'll see you next time.