

Zac Getty (00:04):

Hi. Good afternoon everyone, or good morning for those of you on the Pacific Coast or in Mountain Time. Thank you all for joining us today for our Newly Diagnosed Webinar, intended to provide guidance on understanding your diagnosis, understanding your rights as a patient, and finding trustworthy information. My name is Zac Getty and I'm the patient education program manager here at Fight CRC. Fight Colorectal Cancer is the leading patient empowerment and advocacy organization in the United States. We provide balanced and objective information on colorectal cancer research, treatment, and policy. We are relentless champions of hope, focused on funding promising high impact research endeavors while equipping advocates to influence legislation and policy for the collective good. So thank you all for coming. Before we get started with the actual webinar, let me go through a few of my housekeeping items. If you've ever attended a webinar, you know I always do this at the beginning. So we will have some time at the end of the webinar for general questions, questions about the presentation, questions for us.

(01:03):

But please feel free to use the Q&A panel on the right side of the screen to ask any questions that come up along the way. We will do our absolute best to address them at the end of the webinar and any questions that we do not get to, I will do my best to address them via email after the actual webinar has ended. We will have a recording of this webinar available on our website within the next few days. You will also receive a direct link via email as soon as it's available if you've registered for this webinar and we've started a new program, we will also provide a transcript of this webinar on our site for those of you that would prefer to read the information that's given as opposed to watching again. Also, feel free to tweet along with us. You can use the hashtag #CRCWebinar.

(01:48):

Please remember to stop by our website at FightCRC.org to check out all of our patient and caregiver resources. This includes your guide in the Fight meetups, which are an online space to meet with other patients and caregivers. They're held three times a month. They touch on a variety of topics but are also just a great place to find a sense of community. We have our free Community of Champions app where you can connect with other people in the colorectal cancer space, keep in touch with Fight CRC and know what we're up to, and an assortment of print and digital educational resources that are free to request from our website. We're happy to send you anything that we discuss today. If you have any questions, feel free to reach out to me directly. Like I said, my name is Zach and my email address is Zach@FightCRC.org.

(02:29):

I have a quick disclaimer. The information and services provided by Fight Colorectal Cancer are for general informational purposes only. The information and services are not intended to be a substitute for professional medical advice, diagnosis, or treatment. If you are ill or suspect that you are ill please see a doctor immediately. In an emergency call 911 or go to the nearest emergency room. Fight Colorectal Cancer never recommends or endorses any specific physicians, products or treatments for any condition. So, with all of that out of the way, I would like to briefly introduce our participants and we have had a slight change to our presenters today. Unfortunately, Danielle is sick and not able to attend us, but we still do have Jenny Cataldo, RN, BSN, OCN, oncology nurse navigator at UnityPoint Health at John Stoddard Cancer Center in Des Moines, Iowa.

(03:19):

Jenny, thank you so much for taking the time out of your busy schedule, in which I'm sure is busy as a nurse, my mom's a nurse, her schedule's insane and I'm sure yours is as well. So thank you so much for

taking time out of your schedule. I'm going to allow you to kind of introduce yourself real quick, go into a little bit of your background and we can kind of get started in the actual webinar.

Jenny Cataldo ([03:38](#)):

Wonderful. Yes, thank you everyone for joining and thank you for having me. I'm sorry Danielle can't be here today too. I know she would've given an amazing perspective as a survivor, and so we will definitely miss her and wish her well today. So I will do my best to answer your questions and just be here to help guide you in any way I can. A little bit about me, I've been an oncology nurse for twenty-seven years and worked in an inpatient unit in oncology for about 15, and then I've been serving in this oncology nurse navigator role since that time for the rest of my career. I mainly work with patients diagnosed with colorectal cancers. I also work with some other GI cancers like esophageal and gastric as well. But I always tell people when I meet them for the first time to consider me one of your helpers.

([04:39](#)):

And so I always say I'm a person you can go to if you have questions. I also connect patients to resources. As we know, when you get first diagnosed everything is really overwhelming and you're kind of trying to figure out what those next steps are. But then I also continue to follow patients throughout their journey. And as you know as you're going through this it's not just about the treatment and what those decisions are, but also life happens around this diagnosis. And so my role is really to help take care of all of you as you're going through this. And so hopefully today you will find some little bits of information that might help you, encourage you, and just let you know you're not alone in this fight and hopefully connect you to some resources. So with that, I guess we'll get started.

Zac Getty ([05:33](#)):

Yeah, thanks so much. And I don't want to immediately jump off script here, but as a nurse navigator do you feel that your role is well utilized by patients or do they know that you are an option to search out information and that you're there to help and guide them through this process or is it something that they discover halfway through the treatment and go, "I wish I would've had this the first day I got diagnosed"?

Jenny Cataldo ([05:56](#)):

Great question. Well, at our cancer center actually I get referrals from, I may get them from colorectal surgeons, I get them from the oncologists, I get them from... we actually have a whole support team here so we have social workers and dieticians and financial navigators. We kind of have this whole team of people. And we also may get connected to patients through what we would call distress screenings that sometimes patients fill out when you go to the doctor's office and they ask a bunch of questions on things that you might be worried about. And that also can trigger a referral if somebody says, "Gosh, on a scale of one to 10, my stress level right now is a four." We call anybody who is four or above, or if they have specific things noted, like maybe I'm concerned about financial concerns or insurance questions so that also may trigger referrals to us. So our hope is that usually actually we do see the majority of them from the beginning.

Zac Getty ([07:03](#)):

Well, that's amazing. Awesome. Historically I think it's been an underutilized discipline. So again, thanks for joining us. Thanks for providing that perspective. And we can kind of go ahead with what we've talked about so let me go ahead and move on. The first question we have here, and this maybe seems

pretty straightforward, but what is colon cancer versus rectal cancer and why are they kind of lumped together as colorectal cancer?

Jenny Cataldo ([07:28](#)):

Yeah, that is a great question. I think if you kind of go to that next slide and you look at the colon, really a colon cancer or colorectal cancer or rectal cancer is a cancer that forms in the large intestine. And you can kind of see that picture there on the left. That is your large intestine. And if you were to look at those cells under a microscope, colorectal cancers are usually an adenocarcinoma, which might have been shown on a biopsy, but they do look the same under a microscope and there's different stains that pathologists do that can tell them it's a colorectal cancer.

([08:14](#)):

And when you think of colon versus rectal cancer, that truly is just location. So your rectum is down there, kind of where Zac is pointing, those last six inches right there at the bottom, that's your rectum. So if a cancer forms in that space, then we will call it a rectal cancer. If a cancer forms over here, you have your ascending colon and then it goes across to the transverse colon up there at the top and down is your descending colon, and then that little curve is the sigmoid. And so any cancer that's formed in that area, we would call a colon cancer, but sometimes it does get kind of lumped together. The same way that someone does a liver biopsy and they're able to tell that that's a colorectal cancer that has spread to someone's liver, that is truly by looking at it under a microscope and those same stains you can figure out where that primary came from and that it's a colorectal.

Zac Getty ([09:25](#)):

Thank you. All right, we have a couple other additional slides here. Can you kind of explain what we're looking at with these?

Jenny Cataldo ([09:32](#)):

Yeah, I just threw these in there for you. I'm not sure how many of you are newly diagnosed and maybe you've been seen by a colorectal surgeon that is recommending that you need to have surgery. And this is just a picture. I have this little booklet that I usually give to patients and it's this Krames booklet and that first page is in the booklet and then they give pictures of the different types of colorectal cancer surgeries. And I'm kind of a picture gal and I think a lot of patients are. I feel like if I can see it just makes more sense to me. And when you look at these pictures, the first one is a right hemicolectomy. So if the doctor says we're going to take out the right side of your colon and people are like, "Well, what is that?"

([10:25](#)):

So that right side, if you can think about your small intestine attaches down there at the bottom by the cecum, and then if your colon cancer is found in this area, they may take out that entire right side of the colon. And what they do, you can see in the picture right next to it, then they attach your small intestine right there on the end, so they remove that section. And then that's kind of a before and after shot of a right hemicolectomy. Same thing if they have to take out the left side of your colon, that darkened area is usually... and this is generalized but that's the area that they remove and then they attach one end to the other and reconnect things for you. So that's basically your right and your left hemicolectomy.

([11:15](#)):

And then the next ones show a sigmoidectomy. That lower part there that's darkened, that is your sigmoid. And so if they're just removing that portion of the colon, they again kind of detach one side and connect it to the other. And that connection that they form, if you ever hear the word anastomosis,

which is not something that we say in regular language, but that anastomosis is where they sew things together. The picture to the right of that, that low anterior resection, these are surgeries that they use for rectal cancers. So the first ones were for a colon cancer, and then for rectal cancers they can do a low anterior resection, which again they're still taking part of that sigmoid there, you can kind of see that, and then that top half of the rectum, and they often will connect one to the other.

[\(12:17\)](#):

A lot of times, I will tell you, in this type of surgery, they do this surgery and often will give people a diverting ileostomy and that just allows that time for that to heal and then they kind of divert the stool so just that section can kind of heal and then they're able to reverse it. So for rectal cancer patients, not always, I will say, but often you will see a diverting ileostomy with this. I'll show you the next one, the other surgery that they can do for rectal cancers. I will tell you for rectal cancer patients in general, which surgery has to be done is truly all about location of where that tumor is in the rectum. If you have a rectal cancer that sits kind of higher or middle in the rectum, you've just got to think about you have to have enough to attach at the bottom so that all those muscles are intact and you have control of your bowel function.

[\(13:34\)](#):

If someone has a rectal tumor that sits really, really... if it's really low and it's invading those sphincter muscles or those muscles that give us control of our bowels, at that point it's impossible to save the rectum and so they do have to remove the entire rectum. And that's when someone would have a permanent colostomy. If you noticed, I kind of said colostomy and I said ileostomy. So a colostomy comes out of the large intestine, like in this case you can see that picture, and an ileostomy, which I mentioned, was one for the diverting ileostomy when someone has a low anterior resection that comes out of the small intestine. So that's the difference between those two.

Zac Getty [\(14:25\)](#):

Interesting. So I know that surgery can kind of carry its own set of challenges when people are facing that and specifically these different types of surgery.

Jenny Cataldo [\(14:34\)](#):

Absolutely.

Zac Getty [\(14:34\)](#):

I know specifically with low anterior resection, a part of LAR syndrome, one would like to mention that we at Fight CRC actually had a webinar late last summer with a physical therapist that focused entirely on pelvic floor health and how that can be kind advantageous to somebody facing a low anterior resection. But are there any other challenges that you're familiar with that go along with that specifically or the surgery in general that you'd like to mention or just case-by-case basis unfortunately?

Jenny Cataldo [\(15:07\)](#):

Yeah, it is, but I love that you guys did that because I would say in rectal cancer surgery specifically, like the low anterior resection, I always think of, and sometimes even they're able to get, I don't have in there where they did a colo-anal connection, which there isn't a picture of that but basically you just need enough to attach and have control. But if you think about your rectum, your rectum serves as a reservoir. So your stool gets down there and it sits in your rectum and that's what tells you you have to use the bathroom. But if you think about a surgery that shortens that rectum, you just don't have as

much space there to hold before you have to go. And so a common thing that people will talk about is how your bowels change after a low anterior resection or removing part of that rectum, is you have to go more frequently.

[\(16:09\)](#):

At times it could be more urgently. And so I would say pelvic floor therapy can definitely be a wonderful resource for patients. But also I think connecting with a dietician is also really important because there are definitely some foods and different things that you can do to kind of thicken up your bowels and slow things down. And sometimes just like adding fiber tablets, there's a lot of different things that you can do to try and kind of slow or thicken that stool so maybe it's not as frequent. I always say knowledge is power and kind of incorporating some of those other things to help. And you kind of get to know yourself, if there's foods that you ate before your surgery that gave you diarrhea that's probably not the food that I'm going to eat right before I'm going to go to a fun function.

[\(17:09\)](#):

Also, I think you have to get to know yourself really well and sometimes keeping a diary of your diet and writing, "Gosh, this was a great day, my bowels did really well, what did I eat today?" Or, "Oh, this wasn't a good day, what happened?" So I think incorporating a lot of information like that and pelvic floor therapy is amazing in a lot of respects, not only for bowel function but sexual function, urinary issues. I don't think people really realize that pelvic floor therapy is a thing until you're faced with where you need to get to know them. But they do a lot of wonderful things.

Zac Getty [\(17:51\)](#):

Thank you so much. Okay, next question we have here is what is cancer staging? When do I find out my stage and why is that important?

Jenny Cataldo [\(18:03\)](#):

Especially colorectal cancer staging is actually extremely important and makes a big difference on your treatment decisions that need to be made. It's actually a really, really important piece. And the cancer staging kind of depends on a number of things. I would say as far as finding out your cancer staging, a lot of times, most of you who are here probably have had a colonoscopy, you did your biopsy and you've been told you have a colon cancer or a rectal cancer. That biopsy doesn't necessarily give you your staging, it just tells you that you have cancer. But in that biopsy, if it was something, there's so many different scenarios, but if it was something say really tiny, really small, maybe like a stage one or maybe they just found some cancer cells, they may have just been able to remove that and pathology tells you you've got clear margins, there's nothing else you need to do and they're just going to continue to watch you. That'd be a really early stage.

[\(19:21\)](#):

But in general, I would say when we do staging, honestly for most cancers, we do what's called TNM staging, and T stands for tumor. How big was it? N stands for nodes, meaning lymph nodes, were there any lymph nodes involved? And M stands for metastasis, meaning has that cancer spread to other organs or somewhere else in the body from where it originated? Oftentimes for colon cancer patients, they get their pathologic staging after surgery, but most times they will also have done a CAT scan of their chest, abdomen, and pelvis that has looked to make sure that cancer has not spread to any other like your lungs, your liver, or any place else in the body. So you might know prior to surgery everything else looks good, but we probably won't know how big the tumor was for certain and if there was lymph node involvement just based on that. We kind of need to do the surgery.

[\(20:35\)](#):

If you can go to that next slide, this is something that I try to explain to my patients after you've had your surgery and they're waiting for your pathology to come back from surgery. If you look at the very first picture on your left, that's kind of a picture of a normal healthy colon. Everything's kind of smooth and looks very clean and normal, and oftentimes that cancer will form as a polyp on that innermost lining. And what they are looking for, in colon cancers we're going to get that pathology report, but also when you think rectal cancer patients we can get a pelvic MRI or an ultrasound that also is looking at these things, and that's called clinical, like your clinical staging if you're doing it by a pelvic MRI or a rectal ultrasound for rectal cancer patients. And then we have your pathology from a colon surgery.

[\(21:46\)](#):

So both things are looking at this. So for T kind of going back to that TNM staging, so T, first we're going to look at how big was it? So you'll get, if you can see, there's three layers to the colon. If you're a T1 that cancer was just in that very first layer. A T2 means your tumor kind of invaded that second musculature layer. If you're a T3, it touches that third layer and a T4 means it kind of broke through the wall of the colon and it might be invading other organs or structures. The next thing they look at is the N, meaning nodes. They look to see if there is any lymph nodes involved that have cancer in them. Again, if a pathologist is looking at this after surgery they are truly opening that section of the colon, they're looking at how far that tumor invaded through those walls. And then they also will look at all those surrounding lymph nodes that the surgeon took out and they look to see if there's any cancer cells in them.

[\(23:05\)](#):

If you're doing a pelvic MRI or that ultrasound I was talking about for rectal cancers, because treatment for them is initially not surgery always, you're kind of figuring out staging that way, they too will look how far did the tumor invade into these walls of the rectum? And then are there any nodes that look enlarged or potentially look like they have cancer in them? And then the M, again, was the metastasis, meaning they did that CAT scan, does it look like there's cancer anywhere else in the body? So when you get a pathologic report or you get a clinical staging for rectal cancer, they're going to give you, you might be a T2 and you can be an N0, meaning all the nodes looked good, they were all negative, there's no cancer in those. Or the MRI looks like all the nodes look like there's no cancer in those.

[\(24:01\)](#):

So you could be a T2 N0. If they said they can see that tumor invading into that third layer, you might be a T3 and then maybe they saw one or two lymph nodes that had cancer in them, you would be an N1. You can be an N1 or N2. N1 is kind of zero to three lymph nodes looked involved. N2 means four or greater lymph nodes looked involved. When you do a colorectal or colon surgery, they kind of shoot to at least try and get 12 lymph nodes out in that surgery. And when you go back to that staging graph that you had, that really breaks down the stages of colorectal cancer. And when you look on the right, that's where you can kind of see stage one is a T1 or T2, meaning they just went into the first or second layer, N0, no lymph nodes. M0 meaning no metastasis. Does that help? If people have questions feel free to throw them in the chat. That's a lot of information, but hopefully that kind of helps explain it a little bit.

Zac Getty [\(25:23\)](#):

Absolutely. It's very helpful. And I think most people, you've got one, two, three, or four and I think it's not that simple apparently, is it? You've got different spectrums within stages and more structures involved than I think people might realize. So is it unusual that colorectal cancer can only really be

staged after surgery if that's the option that [inaudible 00:25:49] with or is that common to other types of cancer as well?

Jenny Cataldo ([25:53](#)):

I think you have a good idea going into surgery. They have done CAT scans before surgery so you're going to have an idea and based on what they saw in colonoscopy they're going to be able to... they've looked at it so they know how big it is. The only thing that I would say that's a little bit hard for patients is, let's say you found that colon cancer, we know we need to go to surgery, but they aren't going to know for certain with 100% certainty if those lymph nodes are involved until they cut it out. Unless it's just obviously visible in a CAT scan that there's enlarged lymph nodes. But sometimes you don't always 100% know that until they do that, take it out, look at it under a microscope and then they can tell you.

([26:48](#)):

Because sometimes you can come in and this looks like really early stage, it looks like stage one, stage two, and then they go in, they remove it, and then if they find one positive lymph node, you wouldn't have known that until after. So that's the only part that's a little hard. And so sometimes all the decisions that you make, you can't always know every answer right before. And I think that this waiting period for patients figuring out what that ultimate plan is going to be is kind of a hard waiting game I think.

Zac Getty ([27:28](#)):

Of course, yeah, waiting to know answers is terribly difficult. If anyone has any questions about staging, please feel free to put them in the Q&A panel. Otherwise we'll just continue to move forward, and we can also come back to this if somebody decides they have a question later as well.

Jenny Cataldo ([27:42](#)):

Okay. And one thing I will tell you too, at least for colon cancer too, just to kind of understand the meaning and what it means to have some positive lymph nodes. Most often if you find an early stage, stage one or stage two colon cancer, in most cases we can just do surgery and then that person goes on surveillance. Sometimes there are reasons to give a stage two colon cancer patient chemotherapy, but if you've got some positive lymph nodes in that stage three picture, that is when we are almost always going to offer chemotherapy to that patient, because when you think about lymph nodes, we have lymph nodes all over our body and they're all connected. And so if you've got some positive lymph nodes the chance that a teeny cell could have possibly escaped and is kind of floating somewhere in the body is a possibility.

([28:51](#)):

That's not something that we're going to pick up on a CAT scan, a teeny cell that's floating somewhere. So the thought is if you have positive lymph nodes, they do want to give you chemotherapy because that chemotherapy is going to go everywhere and kill any of those cancer cells that might be floating around so they don't go somewhere and set up camp. So that's kind of that division between stage one, stage two, stage three, and then stage four, just meaning when it spreads elsewhere then there's a lot of other things that go into that plan.

Zac Getty ([29:29](#)):



Thank you. Next up, and I think this is probably the top question on a lot of people's minds when they find out and they see the cancer diagnosis, is what does survival statistics look like and is there a hope for me in my situation?

Jenny Cataldo ([29:44](#)):

There absolutely is always hope for you, definitely yes, and the survival statistics are actually really good and improving all the time. I would say that's why it's such an important thing to catch colorectal cancers early and why we push screening and why we want people to do that. Because when you think about when you catch a colorectal cancer early, we can cut it out or we find that polyp up that's maybe got some abnormal cells and we get rid of it so it doesn't turn into a cancer. And when they look at overall survival rates for colorectal cancers they often, like in this side, they will often do it five years. So it's kind of how many people with the same type of cancer diagnosis, same stage, what is their survival rate over a period of time? And they usually look at it for five years.

([30:46](#)):

And this one I think was from American Cancer Society and it was done from 2013 I think to 2019. And so these are probably even better now. I feel like they're always improving and we're always making changes. But how they look at it, instead of doing it by stage they kind of divide it into localized, meaning there's no sign that the cancer has spread outside the colon or rectum. We find it's very localized inside the colon. And when you find a colorectal cancer that early, when you look at survival rates, that's 91%. So there are millions of cancer survivors and I think people forget how there's just millions of them. And so people can do really well when you catch that cancer early.

([31:37](#)):

And even when you think about in the regional, so regional are people who find their cancer and it's maybe spread outside of the colon or rectum just to nearby structures or to lymph nodes, but it's all regional right there in that same area but maybe you have some lymph nodes but it hasn't spread to the liver, spread to the lung or anything outside of that kind of regional area and those lymph nodes. Even in that case, those people might even have to do some chemotherapy, but you've got 73% survival statistics after five years, which is really good.

([32:16](#)):

And then in stage four they have that which is the distance met, meaning cancer has spread to distant parts of the body, those at five years are 13%. And I have to believe that that's probably even higher by the next time they do that just because they're always making advancements and they're always finding out new ways to treat. And it's becoming so specialized too with using different molecular studies and targeted therapies and immunotherapies and different things that they are really honing in on how to best treat patients. And so I think people do extremely, extremely well.

Zac Getty ([33:07](#)):

The first thing you said is that there's always hope, and I just really want to emphasize that, that there is always hope. And as an organization, Fight Colorectal Cancer, we work with people who are success stories that heard one way or another like this is it, and 15, 20 years later they're still kicking.

Jenny Cataldo ([33:23](#)):

Absolutely.

Zac Getty ([33:24](#)):



And it's just survival story after survival story in situations where they were told they wouldn't be. So there's always hope. And then as a community Fight CRC really tries to stress that you are not alone in this fight and that we are here to help you through this as well. And from the moment you're diagnosed with cancer you're a cancer survivor.

Jenny Cataldo ([33:42](#)):

100%.

Zac Getty ([33:43](#)):

So there's hope and don't give up, don't quit. And like you said, statistics are always improving to be more and more specialized and it's really an amazing field of research. So thank you.

Jenny Cataldo ([33:56](#)):

And I always tell people too, these right here, these are all numbers. They're all numbers, they're statistics, which you are not. It is your story to write. No statistics can tell you what your personal story is going to be with cancer because I think all of us knows someone, my uncle had that and he lived to be 95. I mean you hear all of these stories and it's so encouraging, but it's also true. I mean, it's true, there are so many people that do really well. And so I think my best advice to you is kind of dive in, get all the information that you can and connect with support, talking to other people or whatever's in your community. And like Zac said, just this website in general has amazing support and connections. And so I think it's just pretty amazing what people are able to do.

Zac Getty ([35:05](#)):

So what doctors do patients need to see and will they be reached out to you by those physicians or do they need to hunt them down themselves?

Jenny Cataldo ([35:12](#)):

Another great question. Okay, so for colorectal cancers it can be very multidisciplinary. So maybe you went to your primary care doctor to start with and you've maybe got some symptoms, whether it's constipation, diarrhea, or maybe you had some blood in your stool, and they sent you for a colonoscopy. It could have also just been your screening colonoscopy and they found it. So you usually at some point probably, maybe primary care started then you had your GI specialist who did your colonoscopy. From that point, once you find your out that you have a colorectal cancer, I would say your next step would be you would be referred to a colorectal surgeon. And that's something that I would always ask specifically for. If they say, "Well, we have a general surgeon and a colorectal surgeon, who do you want to see?" I would always ask for a colorectal specific surgeon just because that is all that they do, that is their specialty and they are going to pull in the other people that they need.

([36:26](#)):

If it's an early stage cancer, it may not be an automatic referral to an oncologist, honestly. And some people are kind of like, "Well, aren't I going to see a cancer doctor right away?" And that's kind of those wheels get spinning. But actually if you've got a really early stage, you might just be going to surgery and if you caught it you may actually never need to see an oncologist, which is great and they'll put you into surveillance. But if you have rectal cancer, there are some other players that need to be involved and so you're going to be seen by the colorectal cancer surgeon, you should be seen by an oncologist, and often you will be referred to a radiation oncologist. Going back to the colon cancers too after surgery or

based on CAT scans, if what they see they want to pull an oncologist on board ahead of time or otherwise they would refer you to an oncologist after they get that pathology report back from your colon surgery.

Zac Getty ([37:33](#)):

I actually did have a question come through from one of the audience members and is there any time the doctors would do surgery for stage four was the question?

Jenny Cataldo ([37:42](#)):

Well, absolutely, because when you think about... First, with stage four there's a lot of things that have to come into play. So maybe you've found you have a mass in your colon, let's just say this for an example. And when they did your CAT scan they also see a couple spots on your liver and they don't know what those are yet, but they look like there's a possibility that there's some spread to the liver. So for example, with this then they're going to refer you to oncology. They're more than likely going to need a biopsy of that liver to prove that it is a spread from the colorectal or from the colon cancer. And then from that, they're always also going to want to know is this surgically resectable?

([38:33](#)):

Because sometimes you might have spread to a liver or a spread to your lung, but man, that looks like that could be resectable. So in those cases there's a lot of you might get referred to another surgeon to look. Here at our cancer center we have an oncologic surgeon who does a lot of our... we have a liver specialist who does liver resections and some of your pancreatic cancer resections, so they're always going to want to know if that is a resectable metastasis.

Zac Getty ([39:14](#)):

If they detect spots on the liver or lung, is the time to ask for a consult for a liver or lung specialist then or are they going to want to do more tests, narrow some things down?

Jenny Cataldo ([39:26](#)):

The first step, if they're thinking you have stage four, is they're going to get you to an oncologist and that oncologist will make referrals for you. So your first step is to see that cancer physician because there is a lot of moving parts and information that we need. You need a biopsy to prove it. You need CAT scans sometimes in that case, if they may also add a PET scan, if they're trying to look is that a resectable thing or is that truly a cancer? A PET scan shows up differently than a CAT scan. So sometimes in that case they will add the PET scan to look at that. There are also liver procedures that can be done by interventional radiology. So here at our cancer center we have a hepatobiliary tumor board and we also have a colorectal tumor board so some of those cases might get brought to a tumor board.

([40:26](#)):

And if you have that at your cancer center, that's a great question to ask because then I always say you get all your players there, you bring a case and they look at those CAT scans up on the screen and your pathologist is talking about that. And then you have interventional radiology looking, is there a liver procedure that we could do? Or our first shot if we can resect it, then what's the plan there? And often it is this collaboration that happens between the oncologists, the surgeons, the colorectal surgeons, the radiation, all of those people really need to come together and kind of find out what that best plan is. Often they will actually start with chemotherapy first and maybe let's see if we can shrink it and do some of that before we go to surgery.

[\(41:13\)](#):

Sometimes maybe someone has an obstructing colon cancer that spread to the liver, so we actually do have to do something to open up those bowels so they are going to have that colon surgery. So there really is so many moving parts, but I would say your first step is to have that colorectal surgeon or whoever did your colonoscopy and has reviewed those CAT scans, they will make a referral for you to the oncologist, and then the oncologist makes the referrals from there. So you don't necessarily have to start calling radiology, calling all these people. They will bring it all together for you and make it all happen.

Zac Getty [\(41:54\)](#):

Thank you so much. Yeah, you don't necessarily start with the phone book, so thank you.

Jenny Cataldo [\(41:58\)](#):

Yes.

Zac Getty [\(42:01\)](#):

Do I have to do what my physician or care team recommends or do I have a choice in the matter? What are my rights when it comes to treatment?

Jenny Cataldo [\(42:07\)](#):

Yes, you always have choice in the matter. Always, always, it's your body, it's your life. I think that you definitely want to take in all the information that you can, and obviously you're seeking out professional help and you're going to these specialists, but you can always also take in all the information and if there's something that is important to you that they've not included or maybe they're talking about something that you're like, "Gosh, I don't know if the risks," you kind of weigh the risks and benefits, because there are some, yes, we can do this but you might have some of these side effects. And so you kind of have to take in all of this information if you're ever interested in a second opinion. I think oncologists and everyone, they welcome that too. I think people sometimes are like, "Oh, will they be upset if I go for a second opinion?"

[\(43:11\)](#):

And I'm like, "No, absolutely not." I mean, I'm sure a physician would go for a second opinion himself. So if you are interested in that, you can always look to do that too. But I think there are a lot of different scenarios with colorectal cancer, even the staging and what those plans and recommendations are for you. And there are, when you look at NCCN guidelines, I guess I kind of wanted you to be aware of that, and I think we have some links to that too, but NCCN guidelines in general are guidelines that oncologists follow and that's based on research done all over the globe to find out what is the best treatment option for this patient in this scenario. But often you will see you can have this, this, or this, and that's still all considered okay in those guidelines based on research.

[\(44:19\)](#):

And so kind of understanding what those treatment options are is always a really good thing to do and know that oncologists and everyone follow those guidelines. But there are also sometimes research trials going on sometimes, so there are so many moving parts that I think you have every right to ask questions and seek second opinions, but also trust that those physicians are following those NCCN guidelines and those are also based on a ton of research that gives you your best chance at fighting the disease.

Zac Getty ([45:00](#)):

Yeah, that's a great answer. I would like to put out there that Fight Colorectal Cancer has an online tool called the patient provider finder. If you're interested in looking for a second opinion or needing to find a physician in a specific area, it's a great tool. I put the link in the chat. It's curated by us for physicians that deal specifically with colorectal cancer. You can look for surgeons, oncologists, all that kind of stuff in your area and it's a good place to start if you're searching for a second opinion. And then speaking of NCCN guidelines, so a lot of people Google their diagnosis, is the information I found online reliable or are there any sources that are reliable for medical information online?

Jenny Cataldo ([45:45](#)):

Yes, I know, Google can take us to some wonderful things but also can take us on a wild goose chase. So I think it is very important to kind of hone in on some of those definitely reliable online sources. And Zac has got those all listed right there and there is a number of them, but these are usually my go-tos that I will tell patients. These are all researched-based, evidence-based, and truly give you a lot of really good, really, really good recommendations. And they often will have, like when you go to these sites, they'll have one that's for patients and one that's for providers.

([46:33](#)):

So maybe some of the things that I'm going to look up on that website aren't necessarily stuff that you need to know every single detail of all those different things and they really help break it down and put it in patient layman's terms so that you can understand and help you formulate some questions too when you see your oncologist. I think that when you go to those sites, they also have a lot of online support as well, so I would definitely recommend all of those.

Zac Getty ([47:07](#)):

Great, thank you. Those are all in the chat as well. And again, feel free to reach out to me via email if you need specific recommendations, anything like that. I do actually have some questions coming in. Thankfully we have one slide left, so should we knock that out and then I can get to a couple of these questions and try to get you out of here on time. I respect your time here. So we see a lot of people coming to us that they find information about complementary and alternative medicine online. Do you have an opinion on that and do you think there's a place for it in a patient's treatment plan?

Jenny Cataldo ([47:38](#)):

Yes, I would say that that is one thing that is, so many different opinions about it and there's so much information and sometimes it can get overwhelming. Just even sometimes people you know, well, my uncle did this or my aunt did this or my sister did this and cured her cancer. And you have all these different things and you kind of feel like, well, gosh, I don't want to miss the boat or what am I doing? And so I would say, here at our cancer center, we have an integrative oncology team and this team we kind of focus on evidence-based and really kind of taking care of that entire person. And if it were me going through a cancer or me as a survivor of cancer, and often my patients, they're looking for something that they can control. I think when you get diagnosed with a cancer, everything kind of feels like it's spinning and it feels like it's out of control. And so they're like, well, what can I do? What can I do to help me as I'm going through this?

([48:52](#)):

And probably your most common things that you hear is different supplements or what can I change in my diet that can help me? But I would also challenge people to not just think of those things, but also to

think of exercise. There is so much research behind staying active and exercising and how that helps reduce risks of recurrence and cancer in general. Think about your sleep, are you sleeping okay? Think about the stress in your life and how you manage those stress levels and really your social connections. I think you have to think about taking care of all of yourself and if you have integrative oncology or integrative medicine in your community, it is really nice to talk to someone. And I provided these websites, these are websites that our integrative team will give to patients that offers information, because maybe you hear of this one supplement and this is going to cure my cancer, but they also are asking for thousands and thousands of dollars and how much evidence is really behind that versus maybe there are some supplements or some things that might enhance my treatment.

[\(50:22\)](#):

So I would say I think integrative medicine almost has to be a part of your treatment plan because it can't just be I'm going to do this surgery and do this chemo, but it's also going to be what are maybe some lifestyle changes that are going to help me in general? And we often can't do all of them at once. Maybe it's just a simple thing as is I recognize that my stress level is really, really high all the time and how can I help manage that a little bit? Because when you think about stress and what that does to your body, I feel like I would say think of your body as I want to create an environment in my body that is the least conducive to cancer growth and cancer cells and I'm going to avoid as many toxins as I can.

[\(51:11\)](#):

I'm going to put good things into my body. For colorectal specifically they do talk about reducing red meats and reducing processed meats and diets higher in fruits and vegetables and being active and reducing your stress levels. And so there is definitely a place for it. And I would encourage you, absolutely encourage you, to incorporate overall wellness for yourself.

Zac Getty [\(51:44\)](#):

I appreciate that viewpoint because I think so often you hear alternative medicine or complementary medicine and I think people's minds might immediately go to eschewing Western medicine for an alternative when it's not necessarily what am I taking or what drugs am I using to fight my cancer, it's how am I living my lifestyle and how can I best set my body up to help fight this cancer in addition to the treatments that I'm already undergoing? So thank you very much.

Jenny Cataldo [\(52:11\)](#):

It becomes a big collaboration.

Zac Getty [\(52:13\)](#):

Absolutely, absolutely. So we do have a couple of questions that have come in through this. First of all, thank you so much for answering all the questions we had lined out, but I would love to get to a couple of these while we still have a minute or two. The first one I have is the gastro doctor says that my tumor is in the cecum, the radiologist said the tumor is in the sigmoid. Is it common to get different diagnoses with colon cancer?

Jenny Cataldo [\(52:39\)](#):

Gosh, the cecum and the sigmoid are pretty far away from each other, so I can understand some frustration there. I would think from your colonoscopy they should be able to tell you. I mean, they have to be able to figure out if it's in the cecum. When you go back to even, Zac, you can even pull up the picture of the whole colon. Yeah, well your cecum... go to the bigger one, the APR, maybe that's... well,

the cecum is down there on that left side, you can see your little appendix sticks out. That little tiny thing is your appendix, that's your cecum right there. And your sigmoid is that last part of the colon before you get to the rectum. So if they do a colonoscopy they're going to know. They're going to know if they run into the mass right there in the sigmoid or they're going to know if it's further down in the cecum. So I would kind of just go back to your GI or whoever did your colonoscopy to find that answer out for sure.

Zac Getty ([53:51](#)):

Thank you. Can you speak on the difference between a general oncologist and a colorectal cancer oncologist and why it's important to have a colorectal cancer specialist for treatment?

Jenny Cataldo ([54:07](#)):

Well, I guess I would say in most cancer centers or community cancer centers, you are probably going to have just general oncologists who serve all the different cancers. But there probably are some cancer centers like for instance you went to a Mayo Clinic they probably are going to have maybe some oncologists that only do mainly work with colorectal cancers. They might have that. But I think honestly that you are completely safe going to a general oncologist just because they deal with all of the cancers. And so I wouldn't feel like you have to seek out a specific colorectal oncologist. When I was talking about finding a colorectal surgeon versus a general surgeon, I would definitely seek out a specific colorectal surgeon for a surgery.

Zac Getty ([55:16](#)):

Thank you. I've got one more open right now. What if you don't have access or resources to a hospital facility that has an interdisciplinary team in place? What would your recommendations be in that situation?

Jenny Cataldo ([55:30](#)):

That's a really good question. So for instance in Iowa, obviously we have a ton of really small towns and farm towns, and at least our oncologists here in Des Moines they spend time in those satellite clinics. And so maybe you go to your smaller town where you are and you go see an oncologist at that hospital, but gosh, they find you know what, you are going to need radiation, you are going to need some of these other disciplines that we don't have at our facility. They're going to need to probably refer you on your closest facility that does. Or at least that's what we would do if we have somebody in a smaller town in Iowa and maybe they need to drive to Des Moines for their radiation. And that does happen. And so I would just be talking to your initial oncologist and when they go over that treatment plan asking the question is this something that I can do here at this cancer center or do I need to seek out or need referrals to other facilities to get the additional people on board?

Zac Getty ([56:50](#)):

Thank you so much. And I have a couple thank-yous coming in to the Q&A for such an informative webinar. Thank you so much for joining us. We are at the end of our time here. Thank you very, very much for taking the time out of your busy schedule to join us for this. The information, the expertise you provided, it's a unique viewpoint that we don't often get. And I know that a voice outside of in your immediate sphere when you're going through cancer diagnosis is something to really value. So thank you so, so very much Jenny. We really, really appreciate it.

Jenny Cataldo ([57:23](#)):

Thank you. Thank you for having me and for everyone watching, I wish you well and just keep leaning on all the people that love you and keep reaching out for support and getting connected to all the people on your team that are going to create a great plan for you. I always say your best advice is be a great communicator. And if you're having issues or questions about something, your doctors want to hear from you and they want to hear what questions you have or what concerns you have. And if you need extra support, connecting to this website, obviously, and also asking in your cancer centers do they have a social worker, do they have a nurse navigator? Do they have other people on the team that are going to help look at all those other things that you often worry about, whether it's work or insurance or all the other things just to kind of make sure you're totally taken care of.

Zac Getty ([58:20](#)):

Thank you so much. Amazing advice. Thank you. I'd like to end the webinar with our mission statement. We are Fight Colorectal Cancer, we fight to cure colorectal cancer and serve as relentless champions of hope for all affected by this disease through informed patient support, impactful policy change and breakthrough research endeavors. Thank you everyone that joined us today and thank you again, Jenny, we really appreciate it.

Jenny Cataldo ([58:42](#)):

Bye-bye, take care everybody.

Zac Getty ([58:44](#)):

Take care.

Jenny Cataldo ([58:44](#)):

Bye.