OUR WEBINAR WILL BEGIN SHORTLY

Research Highlights from ASCO GI 2026

FIGHT COLORECTAL CANCER™

Research Highlights from ASCO GI 2026

Today's Webinar

01 **QUESTIONS**

Ask a question in the panel on the right side of your screen.

02 **WEBINAR ARCHIVE**

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03 **TWEET ALONG!**

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Resources

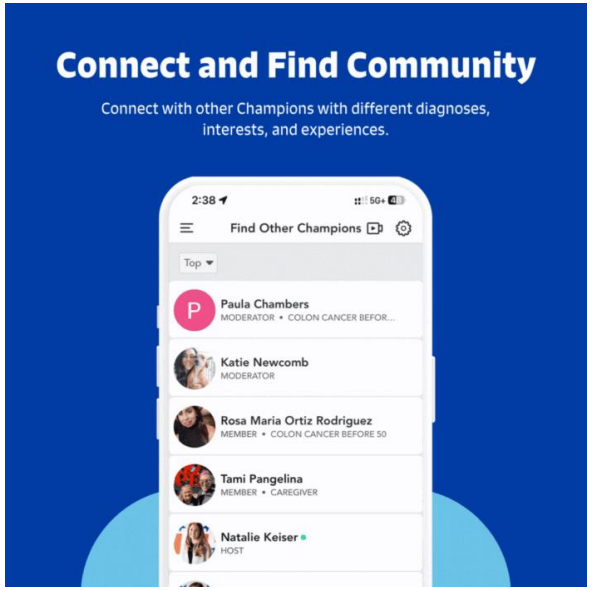
Fight CRC offers a wide variety of resources for those touched by colorectal cancer.

Visit **FightCRC.org** to view, download, and order the latest resources.

ONLINE TOOLS

CHATCRC

FREE RESOURCES



COMMUNITY OF CHAMPIONS APP

The information and services provided by Fight Colorectal Cancer are for general informational purposes only. The information and services are not intended to be substitutes for professional medical advice, diagnoses or treatment.

If you are ill, or suspect that you are ill, 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.

Today's Panelists

Shruti Patel, MD
Clinical Assistant Professor
of Medicine in Gastrointestinal Medical Oncology
Stanford Cancer Center

Daad Abighanem
Stage IV Rectal Cancer Survivor
Fight CRC Research Advocate

Megan Davies
Former Caregiver (EOCRC)
Fight CRC Research Advocate

Shruti Patel, MD

Clinical Assistant Professor
of Medicine in Gastrointestinal Medical Oncology
Stanford Cancer Center

Stanford MEDICINE | School of Medicine

What Actually Changes Practice in Colorectal Cancer

Shruti R. Patel, MD
Stanford Cancer Center

Why these six studies?

- Patients are already asking about them
- They change how we interpret data
- They impact real-world decisions in the clinic

- GLP-1 vs aspirin for primary prevention of CRC
- SCOT trial: 3 vs 6 months of CAPEOX
- BREAKWATER: BRAF V600E with targeted + FOLFIRI OR FOLFOX
- COMMIT study
- Exercise as a prescription for fatigue

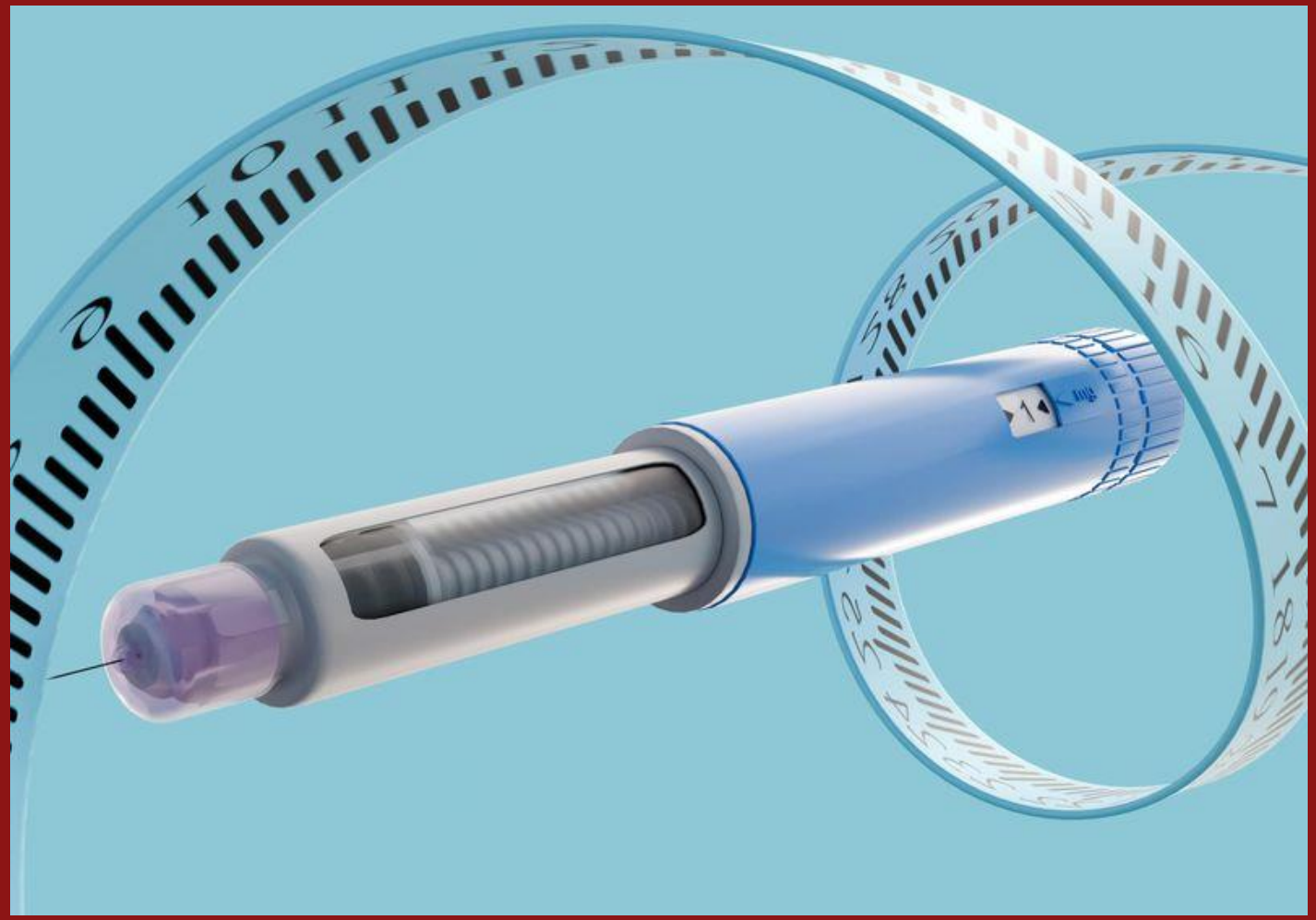
Chemoprevention Revisited in the GLP-1 Era

The Question Patients Are Asking

"Ozempic lowers colon cancer risk. Should I take it?"

"Is aspirin enough?"

"What about exercise?"



GLP-1 vs Aspirin Study

- Aspirin has been investigated for CRC prevention for decades
  - Where do GLP1s fit?
- Large real-world cohort
  - ~280,000 matched patients

ASCO Gastrointestinal Cancers Symposium

Glucagon-Like Peptide-1 Receptor Agonist vs Aspirin For Primary Prevention Of Colorectal Cancer: Evidence From A Real-World Head-to-Head Comparison

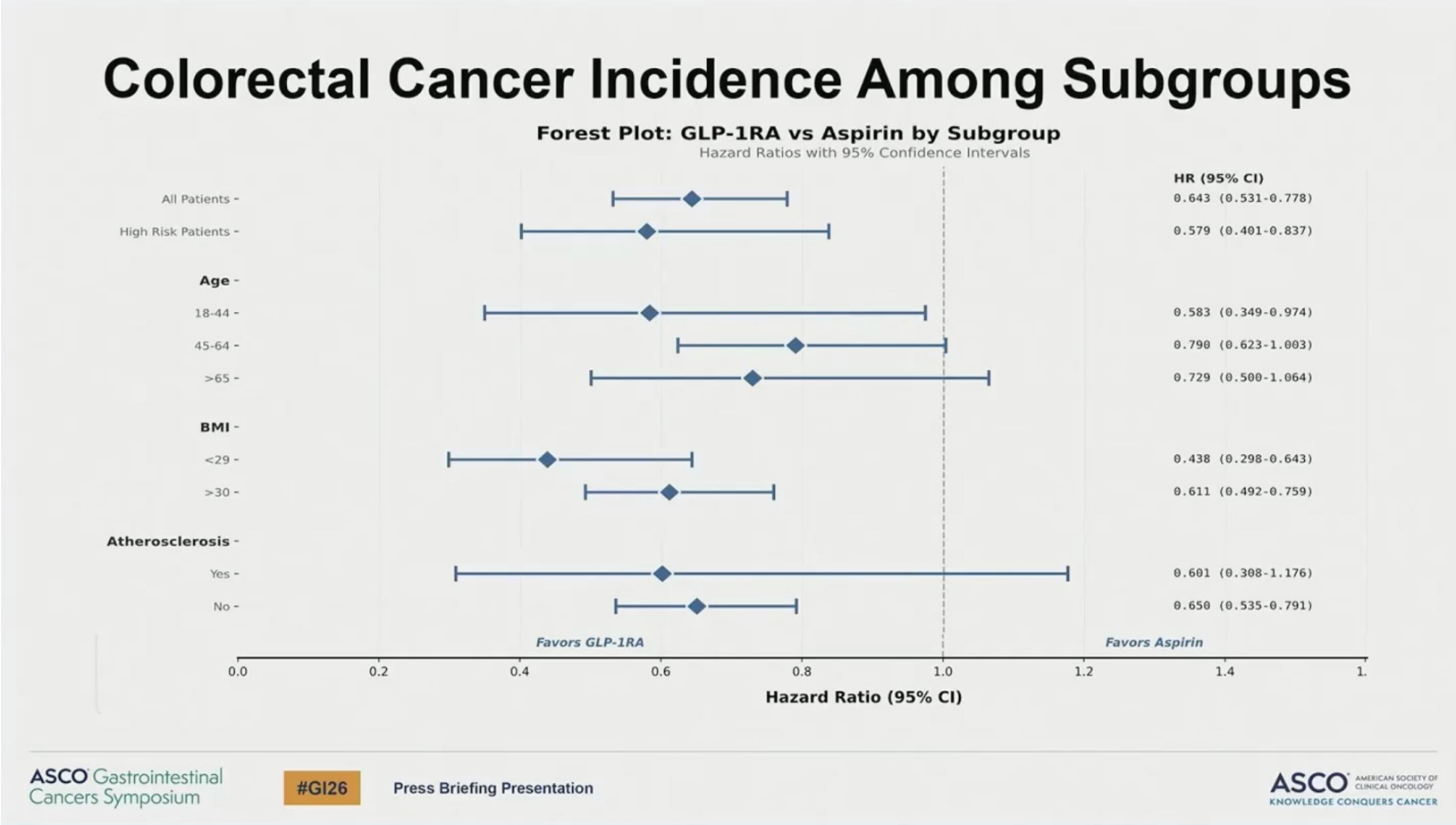
Colton Frisco Jones, MD; Elvis Obomanu MD, Arianna Neely, MD, Karecia Byfield, MD, Chidiebube Ugwu, MD, Muluken Megiso, MD, Tarfa Verinumbe, MD, Danielle Lewis, MD, Fnu Deepali, MD, Damion Persad, MD, Akil Olliverrie, MD, and Sukeshi Patel Arora, MD.

1University of Texas Health Science Center, San Antonio, San Antonio, Texas; 2Jefferson Einstein Philadelphia Hospital, Department of Internal Medicine, Philadelphia, Pennsylvania; 3 South Brooklyn Health Hospital, Brooklyn, New York; 4 Mays Cancer Center, UT Health San Antonio, MD Anderson Cancer Center, San Antonio, Texas

ASCO Gastrointestinal Cancers Symposium #GI26 Press Briefing Presentation ASCO KNOWLEDGE CONQUERS CANCER

GLP-1 vs Aspirin Study Snapshot

- GLP-1 RA users had ~36% lower CRC incidence vs aspirin users
  - Association, not causation.



What this does this mean:

- Not proof of prevention
- Absolute risk reduction is small
- Screening remains primary prevention
- Exercise?

Strengths:

- Large real-world dataset
- Propensity matching

Limitations:

- Observational design
- Residual confounding
- Obesity and diabetes interplay
- Absolute risk reduction modest

SCOT trial

Clinical Trial Updates

Check for update

Three Versus 6 Months of Adjuvant Oxaliplatin-Fluoropyrimidine Chemotherapy for Colorectal Cancer: Final Results of SCOT—An International, Randomized, Phase III, Noninferiority Trial

Timothy Iveson, MD, FRCP[1]; Mark P. Saunders, FRCR[2]; Caroline Kelly, MSc[3]; Rachel S. Kerr, FRCP[4]; Jim Cassidy, MD[3]; Niels Henrik Hollander, MD[5]; Josep Tabernero, MD[6]; Andrew Haydon, MBBS[7]; Bengt Glimelius, MD[8]; Andrea Harkin, BA[3]; Karen Allan, BSc[3]; John McQueen, BSc[3]; Sarah Pearson, BSc[9]; Kathleen A. Boyd, PhD[10]; Andrew H. Briggs, DPhil[10]; Ashita Waterston, PhD[11]; Louise Medley, FRCP[12]; Richard Ellis, FRCR[13]; Amandeep S. Dhadda, MBChB[14]; Mark Harrison, PhD[15]; Stephen Falk, MD[16]; Charlotte Rees, FRCP[17]; Rene K. Olesen, MD[18]; David Propper, MD[19]; John Bridgewater, MD[20]; Ashraf Azzabi, MD[21]; David Cunningham, MD[22]; Tamas Hickish, MD[23]; Simon Gollins, DPhil[24]; Harpreet S. Wasan, FRCP[25]; David Church, MBChB, FRCP, DPhil[4]; and Enric Domingo, PhD[4]

DOI https://doi.org/10.1200/JCO-25-00621

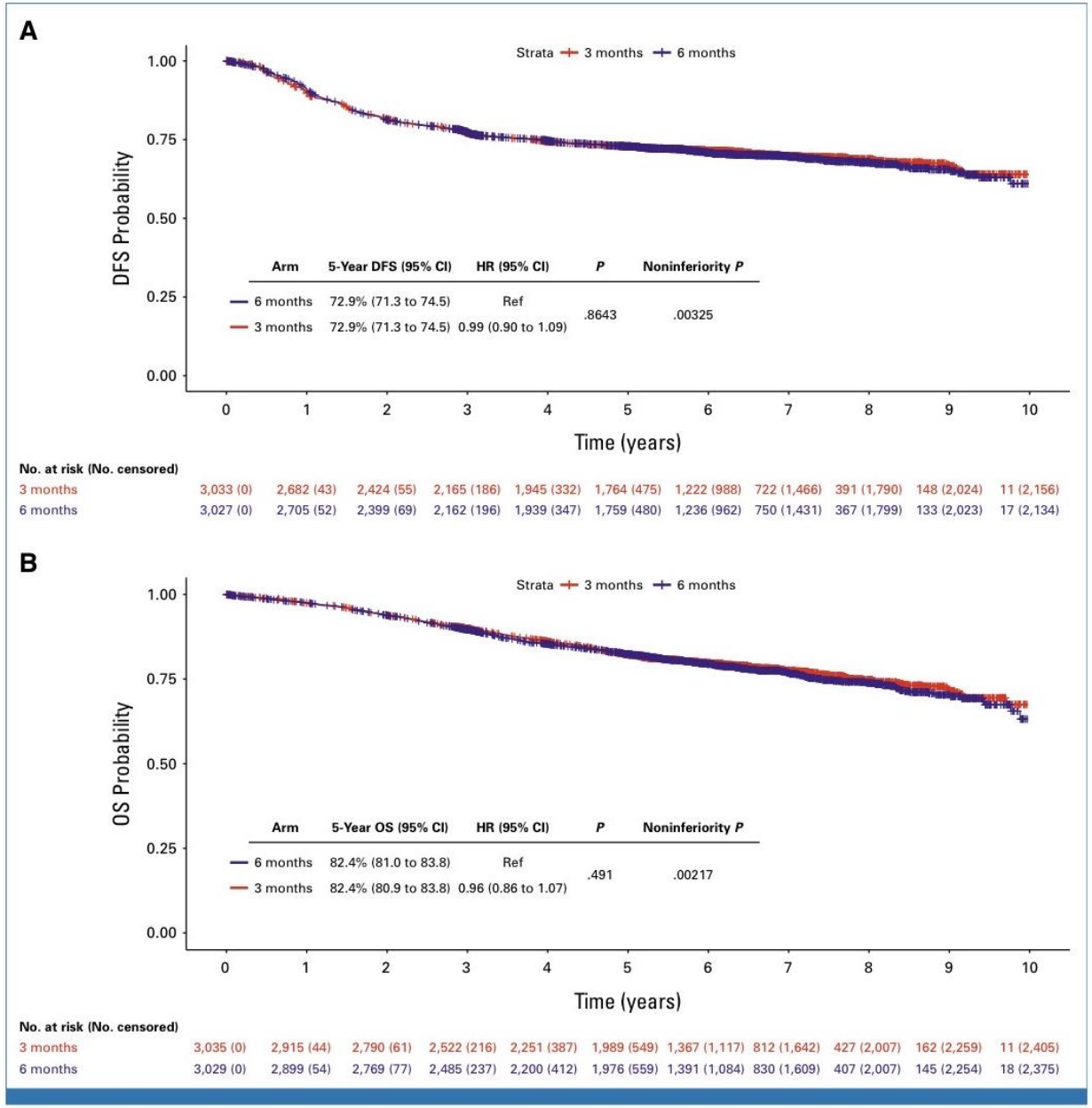


FIG 2. (A) DFS and (B) OS by duration of chemotherapy in the total study population. Kaplan-Meier curves showing probability of DFS according to chemotherapy duration. HR was calculated by Cox proportional hazards model using study minimization factors as covariables (see Methods for details). Noninferiority *P* was calculated by z-test. DFS, disease-free survival; HR, hazard ratio; OS, overall survival.

Variable	Subgroup	Events/N (3 months)	Events/N (6 months)	HR (95% CI)	*P* interaction
Treatment					
	CAPOX	417 / 2,051	457 / 2,042	0.90 (0.79 to 1.03)	.104
	FOLFOX	202 / 984	179 / 987	1.10 (0.90 to 1.34)	
Site					
	Colon	542 / 2,484	535 / 2,482	1.00 (0.89 to 1.13)	.074
	Rectum	77 / 551	101 / 547	0.74 (0.55 to 1.00)	
Sidedness					
	Right	404 / 1,765	399 / 1,747	0.91 (0.73 to 1.13)	.925
	Left	460 / 2,406	470 / 2,422	0.92 (0.77 to 1.11)	
Sex					
	Male	387 / 1,836	379 / 1,835	1.03 (0.89 to 1.19)	.132
	Female	232 / 1,199	257 / 1,194	0.86 (0.72 to 1.03)	
N stage					
	N0	76 / 552	81 / 542	0.91 (0.67 to 1.25)	.925
	N1	287 / 1,732	291 / 1,728	0.98 (0.83 to 1.16)	
	N2	256 / 751	264 / 759	0.96 (0.80 to 1.14)	
T stage					
	T1/2	30 / 373	41 / 375	0.75 (0.47 to 1.21)	.702
	T3	298 / 1,743	311 / 1,742	0.94 (0.80 to 1.10)	
	T4	291 / 918	284 / 911	1.01 (0.86 to 1.19)	
Stage/risk					
	Stage II	76 / 552	81 / 542	0.91 (0.67 to 1.25)	.467
	Low-risk stage III	163 / 1,338	185 / 1,342	0.87 (0.70 to 1.07)	
	High-risk stage III	380 / 1,145	370 / 1,145	1.02 (0.88 to 1.17)	
Overall		619 / 3,035	636 / 3,029	0.96 (0.86 to 1.07)	

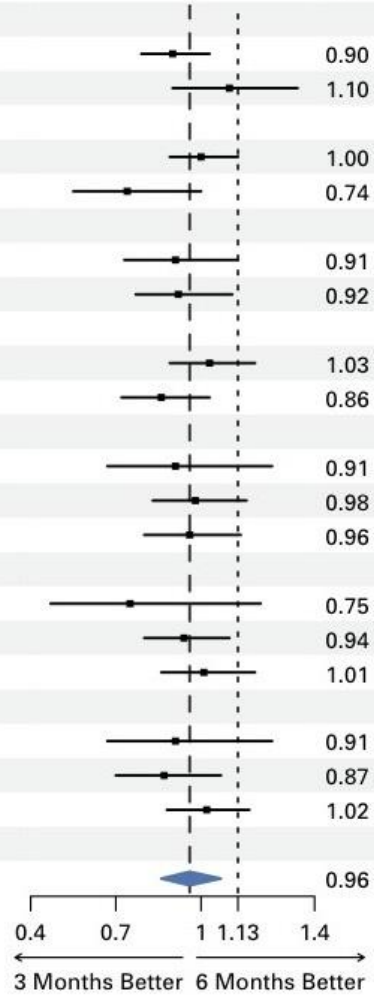


FIG 3. Overall survival by duration of chemotherapy within patient subgroups. Forest plot shows HR for overall survival with 3 months of chemotherapy relative to referent of 6 months of treatment. Proportionality of hazards between groups was not met for analysis of rectal cancers; corresponding analysis by restricted mean survival time is provided in Appendix Table A2. CAPOX, capecitabine and oxaliplatin; FOLFOX, infusional fluorouracil, leucovorin, and oxaliplatin; HR, hazard ratio.

BREAKWATER

BREAKWATER Cohort 3: Study Design

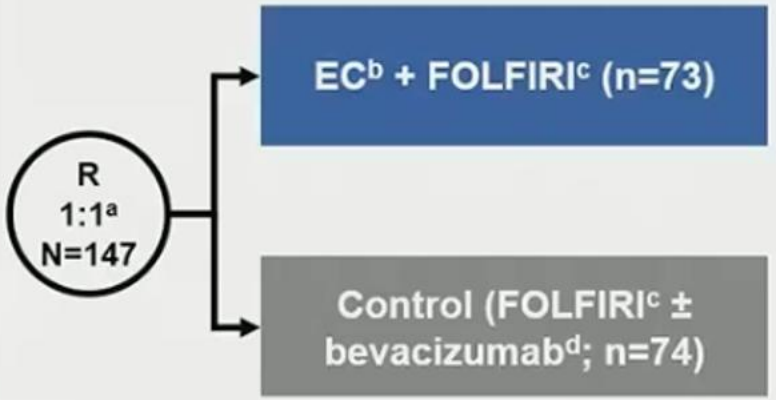
- BREAKWATER (NCT04607421) is an open-label, multicenter, phase 3 study in first line BRAF V600E-mutant mCRC

Inclusion criteria

- Age ≥16 years (or ≥18 years based on country)
- No prior systemic treatment for metastatic disease
- Measurable disease (RECIST 1.1)
- BRAF V600E-mutant mCRC by local or central laboratory testing
- ECOG PS 0 or 1
- Adequate bone marrow, hepatic, and renal function

Exclusion criteria

- Prior BRAF or EGFR inhibitors
- Symptomatic brain metastases
- MSI-H/dMMR tumors (unless patients were ineligible to receive immune checkpoint inhibitors due to a preexisting medical condition)
- Presence of a *RAS* mutation



Stratified by ECOG PS

Primary endpoint:
ORR by BICR[e]

Key secondary endpoint:
PFS by BICR

Other secondary endpoints:
OS, DOR, TTR, safety

Here we present the primary analysis of ORR by BICR (the primary endpoint), an analysis of OS, and safety in the EC + FOLFIRI and control arms

[a]Patients were enrolled between December 28, 2023, and July 1, 2024; enrollment to Cohort 3 started after enrollment to Phase 3 was complete. The planned sample size was approximately 136 patients (68 in each arm). [b]Encorafenib 300 mg orally QD; cetuximab 500 mg/m² IV Q2W. [c]Irinotecan 180 mg/m² IV Q2W; leucovorin 400 mg/m² IV Q2W; and 5-FU 400 mg/m² IV bolus, then 5-FU 2400 mg/m² continuous IV infusion over 46-48 hours Q2W. [d]Per prescribing information. [e]Using a one-sided chi-square test at a significance level of 0.025.

BICR, blinded independent central review; dMMR, deficient mismatch repair; DOR, duration of response; EC, encorafenib plus cetuximab; ECOG PS, Eastern Cooperative Oncology Group performance status; EGFR, epidermal growth factor receptor; FOLFIRI, fluorouracil/leucovorin/irinotecan; IV, intravenously; mCRC, metastatic colorectal cancer; MSI-H, microsatellite instability–high; Q2W, once every 2 weeks; QD, once daily; RECIST, Response Evaluation Criteria in Solid Tumors; TTR, time to response.

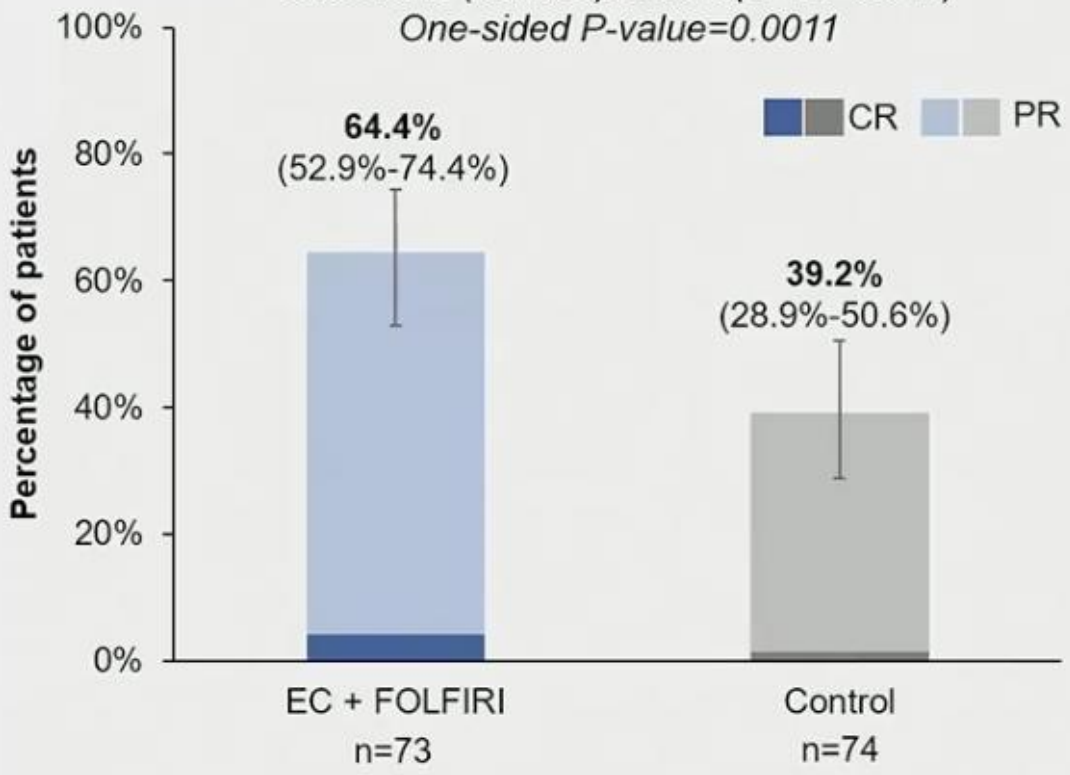
PRESENTED BY: Scott Kopetz, MD, PhD

Overview of Response by BICR

EC + FOLFIRI demonstrated statistically significant and clinically meaningful benefit in ORR by BICR, meeting the primary endpoint

Confirmed ORR by BICR

Odds ratio (95% CI): 2.756 (1.420-5.348)
One-sided P-value=0.0011



Confirmed Best Overall Response, TTR, and DOR by BICR

	EC + FOLFIRI n=73	Control[a] n=74
Confirmed best overall response, n (%)		
CR	3 (4.1)	1 (1.4)
PR	44 (60.3)	28 (37.8)
SD	15 (20.5)	25 (33.8)
Non-CR/non-PD[b]	1 (1.4)	0
PD	1 (1.4)	8 (10.8)
Not evaluable	9 (12.3)	12 (16.2)
TTR, median (range), weeks	6.9 (5.4-36.1)	7.1 (5.9-25.3)
Estimated DOR, median (range), months	NE (NE-NE)	NE (7.0-NE)
Patients with a DOR of ≥6 months, n (%)	27 (57.4)	10 (34.5)
Patients with a DOR of ≥12 months, n (%)	2 (4.3)	0

[a]FOLFIRI ± bevacizumab. [b]Patients with only non-target lesions at baseline by BICR.

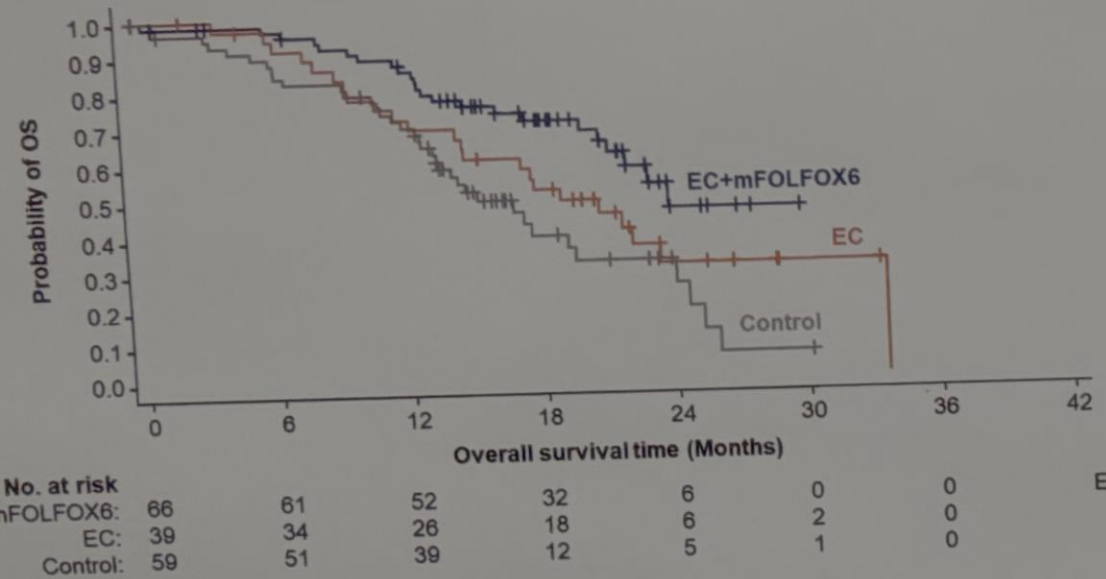
BICR, blinded independent central review; CR, complete response; DOR, duration of response; EC, encorafenib plus cetuximab; FOLFIRI, fluorouracil/leucovorin/irinotecan; NE, not estimable; PD, progressive disease; PR, partial response; SD, stable disease; TTR, time to response.

PRESENTED BY: Scott Kopetz, MD, PhD

Figure 4. OS by BICR in (A) EOCRC and (B) AOCRC

(A)

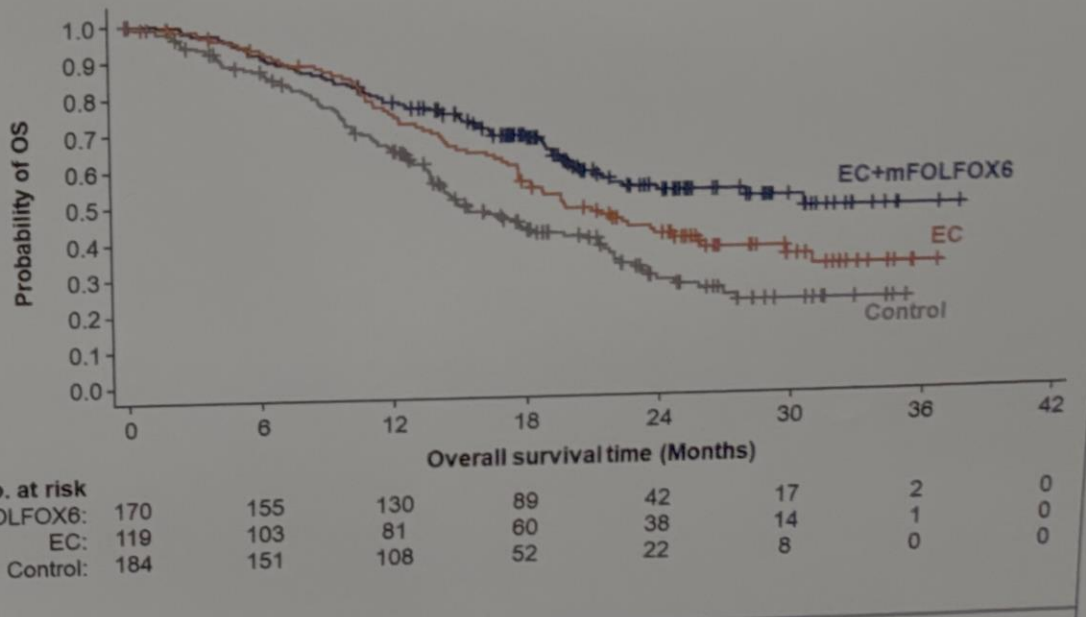
	EC+mFOLFOX6 n=66	EC n=39	Control n=59
No. of events, n (%)	23 (34.8)	23 (59.0)	36 (61.0)
Median OS, mo (95% CI)[a]	23.8 (21.1, NE)	18.9 (14.6, 23.4)	15.1 (13.2, 19.5)
OS HR vs control (95% CI)[b]	0.42 (0.25, 0.71)	0.68 (0.40, 1.16)	–



No. at risk							
EC+mFOLFOX6:	66	61	52	32	6	0	0
EC:	39	34	26	18	6	2	0
Control:	59	51	39	12	5	1	0

(B)

	EC+mFOLFOX6 n=170	EC n=119	Control n=184
No. of events, n (%)	71 (41.8)	69 (58.0)	112 (60.9)
Median OS, mo (95% CI)[a]	30.3 (21.0, NE)	19.5 (17.6, 24.5)	14.9 (13.7, 18.2)
OS HR vs control (95% CI)[b]	0.51 (0.38, 0.68)	0.70 (0.52, 0.95)	–



No. at risk							
EC+mFOLFOX6:	170	155	130	89	42	17	2	0
EC:	119	103	81	60	38	14	1	0
Control:	184	151	108	52	22	8	0	0

[a]Based on the Brookmeyer and Crowley method. [b]Unstratified based on Cox proportional hazards model.

- In patients treated with EC+mFOLFOX6, median PFS by BICR and median OS appeared numerically shorter in the EOCRC group vs the AOCRC group (10.9 vs 14.0 mo and 23.8 vs 30.3 mo, respectively)
- In patients treated with EC, ORR by BICR and median OS were improved vs control in both the EOCRC and AOCRC groups

COMMIT

Study Design

NRG ONCOLOGY
Advancing Research. Improving Lives.™

dMMR/MSI-H mCRC without prior systemic treatment for metastatic disease*

R

- **FFX/Bevacizumab**
- **FFX/bevacizumab + Atezolizumab†**
- **Atezolizumab‡**

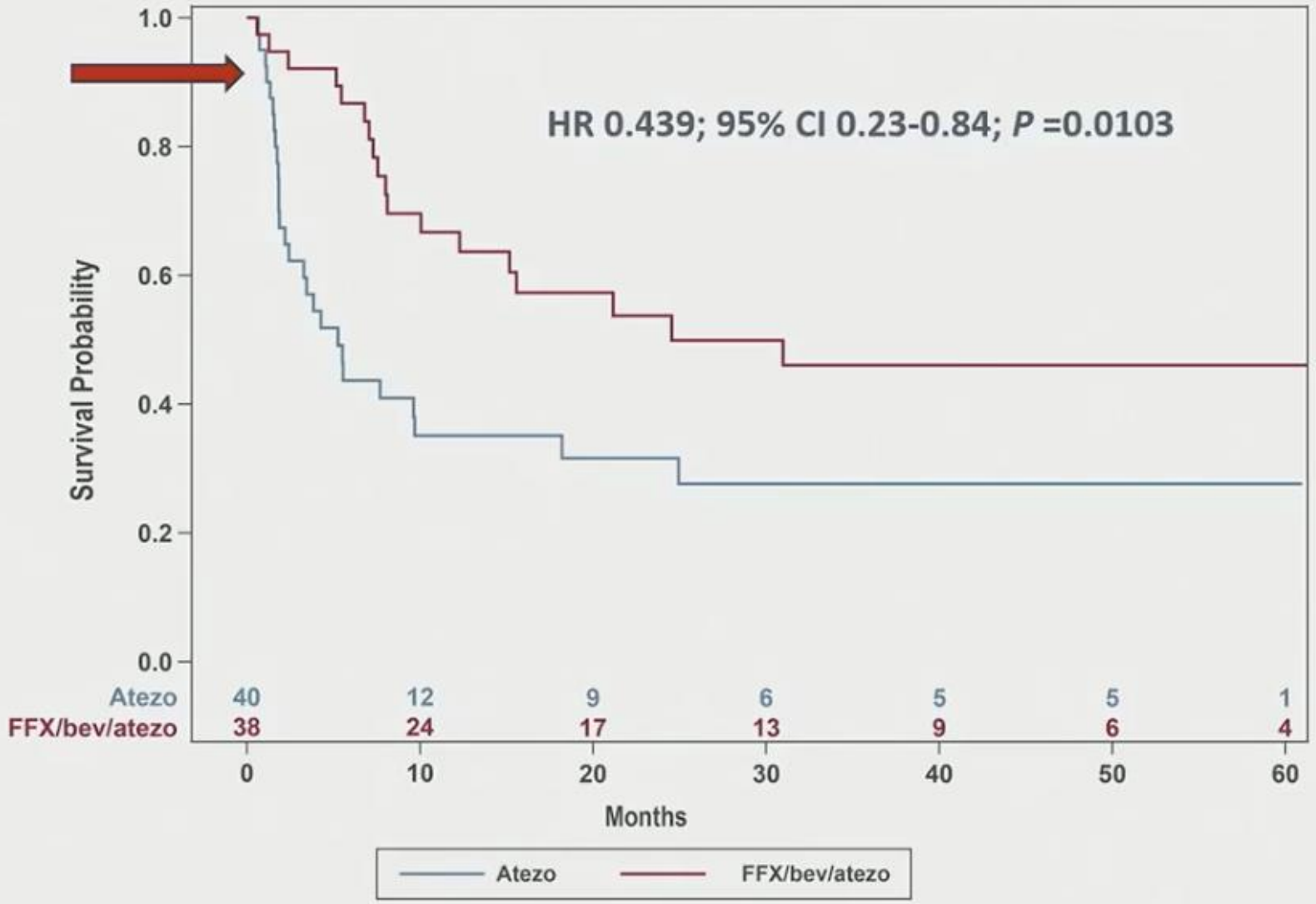
- Randomization 1:1:1 (then 1:1)
- Stratified according to:
  - ***BRAF* mutation** (V600E; non-V600E, WT, or Unknown)
  - **Metastatic disease:** (liver-only; extra-hepatic)
  - **Prior adjuvant therapy for CRC**

* One cycle of FOLFOX or CAPOX with or without bev (or biosimilar) allowed prior to enrollment

† **FFX/bev/atezo:** oxaliplatin 85 mg/m2 IV + leucovorin 400 mg/m2 IV + bevacizumab 5 mg/kg IV+ 5-FU 400 mg/m2 IV bolus on Day 1 followed by 5-FU 2400 mg/m2 IV over 46 hours plus atezo (840mg IV q2wks)

‡ **Atezo monotherapy:** 840mg IV q2wks

Progression-free Survival



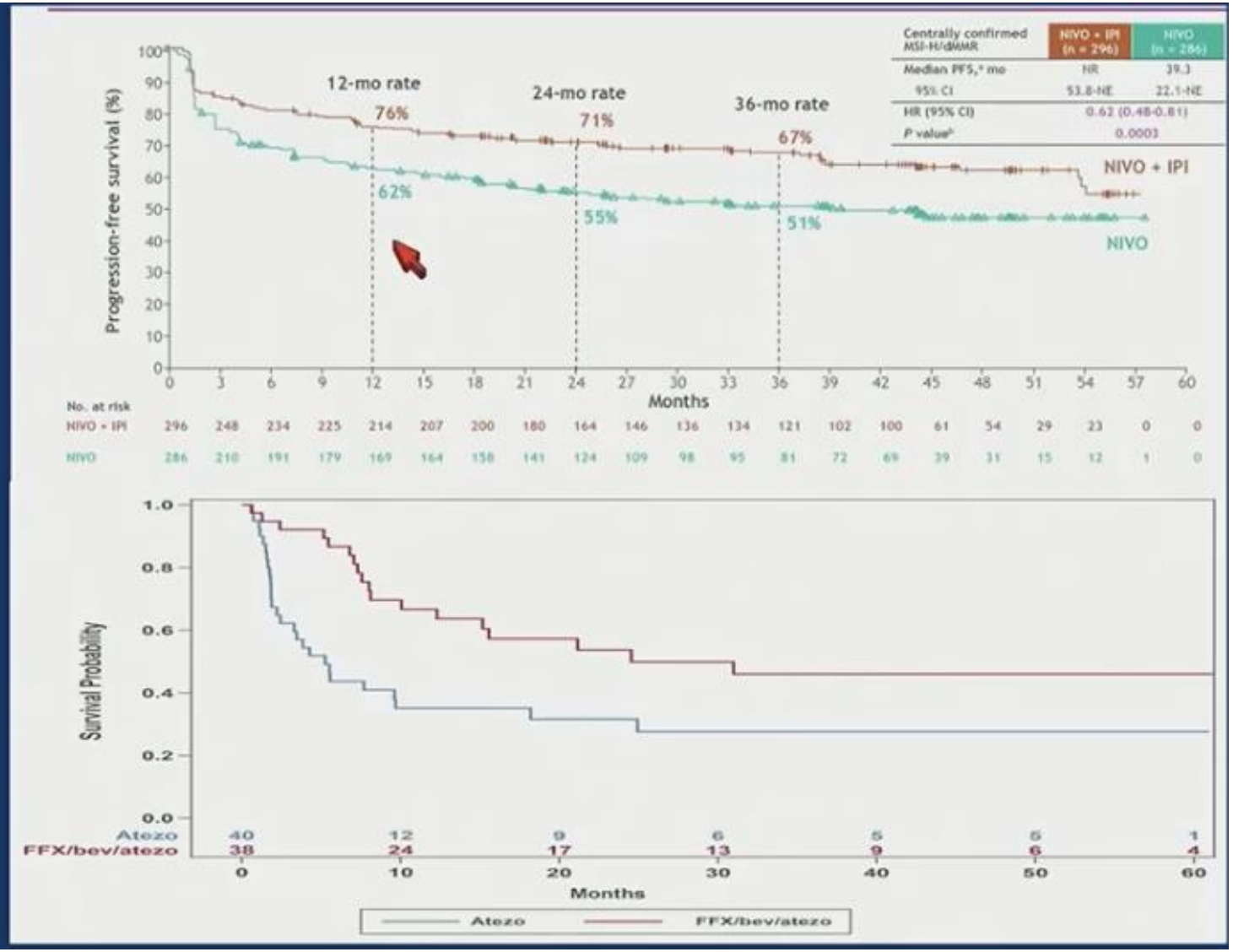
Median PFS (months)

24.5 (95% CI, 10.1–not estimable)

5.3 (95% CI, 2.2–18.2)

Comparing PFS benefits with Checkmate 8HW and COMMIT

Checkmate 8HW



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Exercise for the treatment of fatigue: ColoCare Study

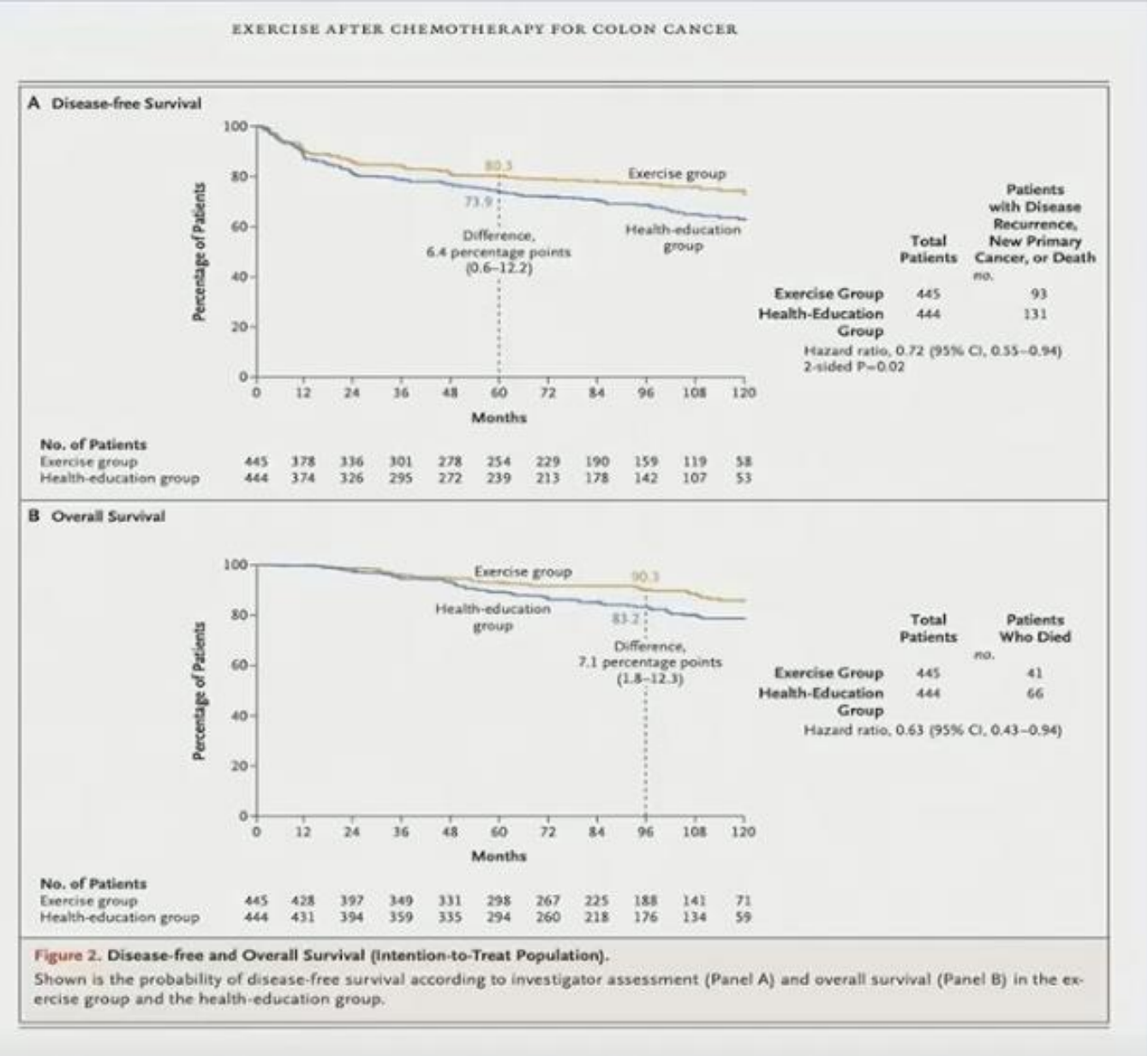
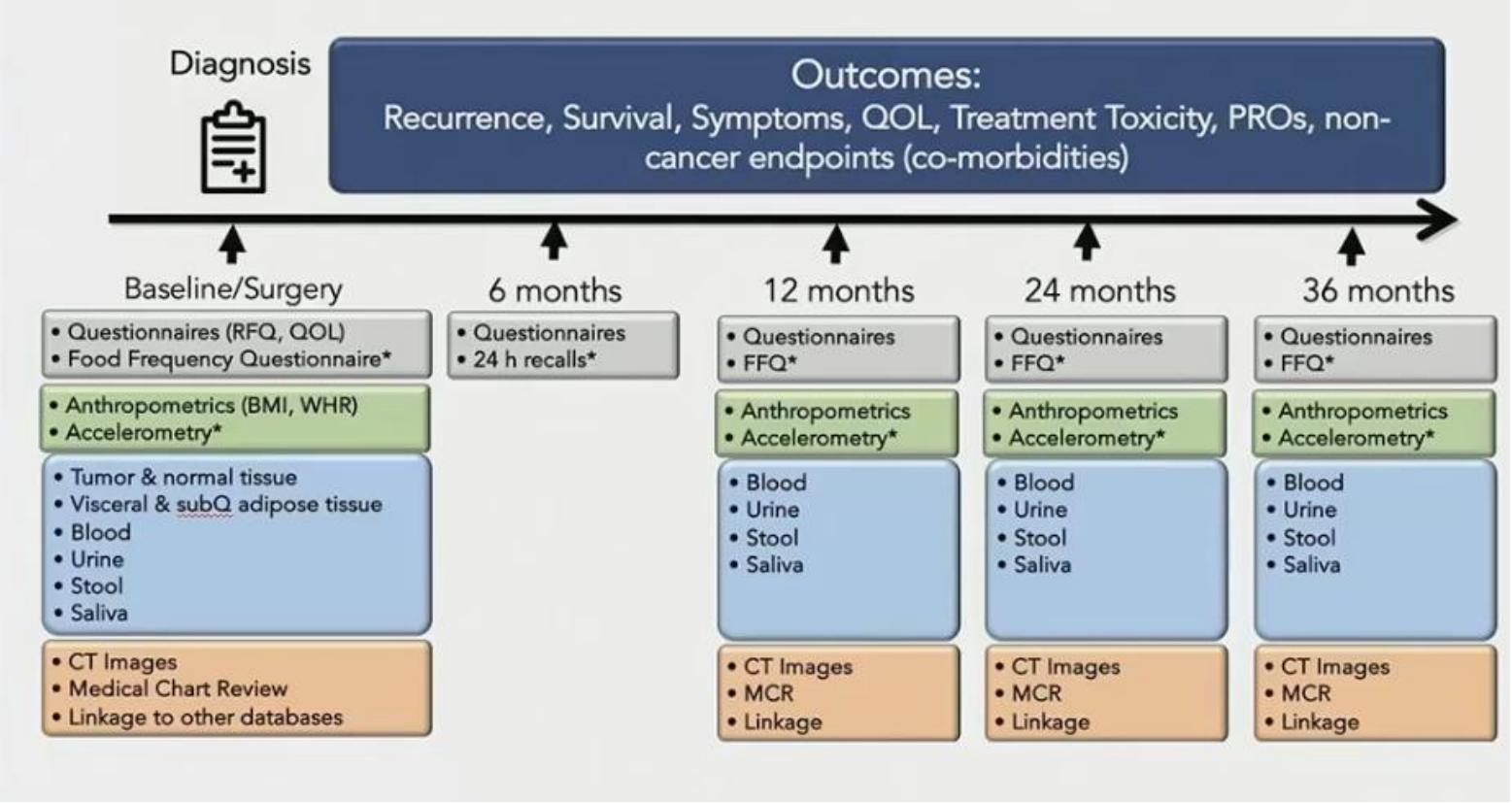


Figure 2. **Disease-free and Overall Survival (Intention-to-Treat Population).**
Shown is the probability of disease-free survival according to investigator assessment (Panel A) and overall survival (Panel B) in the exercise group and the health-education group.

CHALLENGE Study:

- Exercise intervention led to a disease-free and overall survival improvement
- It should be noted that these benefits exceed many drug trials
- Stage II and III patients who received adjuvant chemotherapy only

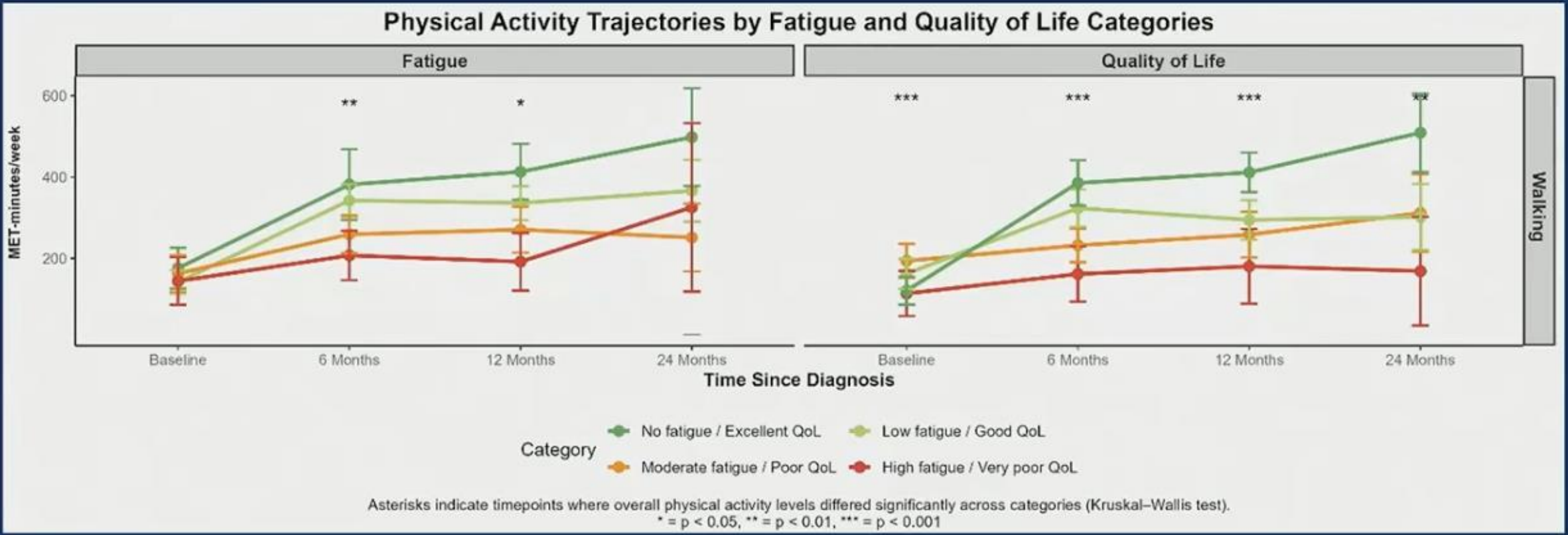
Survivorship: Fatigue Is Persistent



ColoCare Study

- 1,700+ CRC patients
  Followed for 2 years
- Higher physical activity →
  less fatigue & better QOL

Results: Walking



- Greater physical activity was associated with lower fatigue and higher QoL across all timepoints
- Strongest and most consistent signal came from walking

What did ASCO GI 2026 Change?

No big, dramatic, overnight practice-changing announcements.

- But that's not a disappointment.
- Because progress in colorectal cancer usually doesn't happen in one splashy moment.

It happens in the details.

- Refining how long we give chemotherapy
- Understanding when immunotherapy alone is enough
- Improving options for specific mutations like BRAF
- Learning where ctDNA fits and where it doesn't yet
- Recognizing exercise as real medicine

Daad Abighanem, Ph.D.

Stage IV Rectal Cancer Survivor

Fight CRC Research Advocate

Optimizing Colorectal Cancer Treatment through ctDNA

Optimizing Colorectal Cancer Treatment through ctDNA

- What are the current state and areas of investigation in ctDNA assay development? **(Dr. Yuxuan Wang)**

- In CRC care, where does ctDNA fit in monitoring disease and informing treatment decisions? **(Dr. Christine Veenstra and Dr. Dustin Deming)**

- What are the implications of ctDNA testing for CRC clinical trial enrollment? **(Dr. Hideaki Bando)**

What is ctDNA?

Circulating Tumor DNA (ctDNA)

- Consists of fragments of tumor cell DNA that are shed into the bloodstream when tumor cells die.
- Contains cancer-specific alterations (mutations, methylation patterns)

Molecular Residual Disease = MRD

- Microscopic traces of cancer that remain after surgery/treatment
- For solid tumors, MRD is often detected by ctDNA testing

Utility of ctDNA/MRD Testing

1. Check for residual cancer after surgery or treatment

- Monitor for recurrence: Detect MR earlier than imaging.

2. Monitor treatment effectiveness

3. Provide peace of mind, reduce “scanxiety”

4. *Inform treatment decisions: Escalate/De-escalate treatment?*

Advancements in Circulating Tumor DNA (ctDNA) Detection for Colorectal Cancers

Yuxuan Wang, MD PhD
Assistant Professor of Oncology
Johns Hopkins School of Medicine

The majority of DNA in bloodstream comes from non-cancer WBC

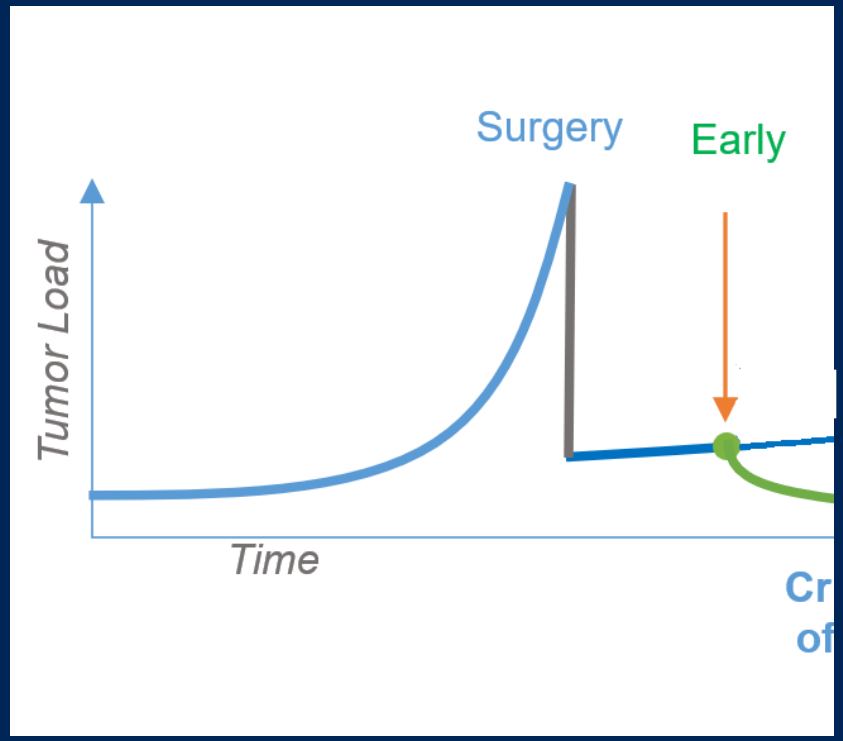
ctDNA detection and quantification greatly improved with Ultrasensitive assays:

- Track a high number of mutations
- Use highly accurate sequencing technologies
- Achieve a very low Limit of Detection

Development of a highly-sensitive assay

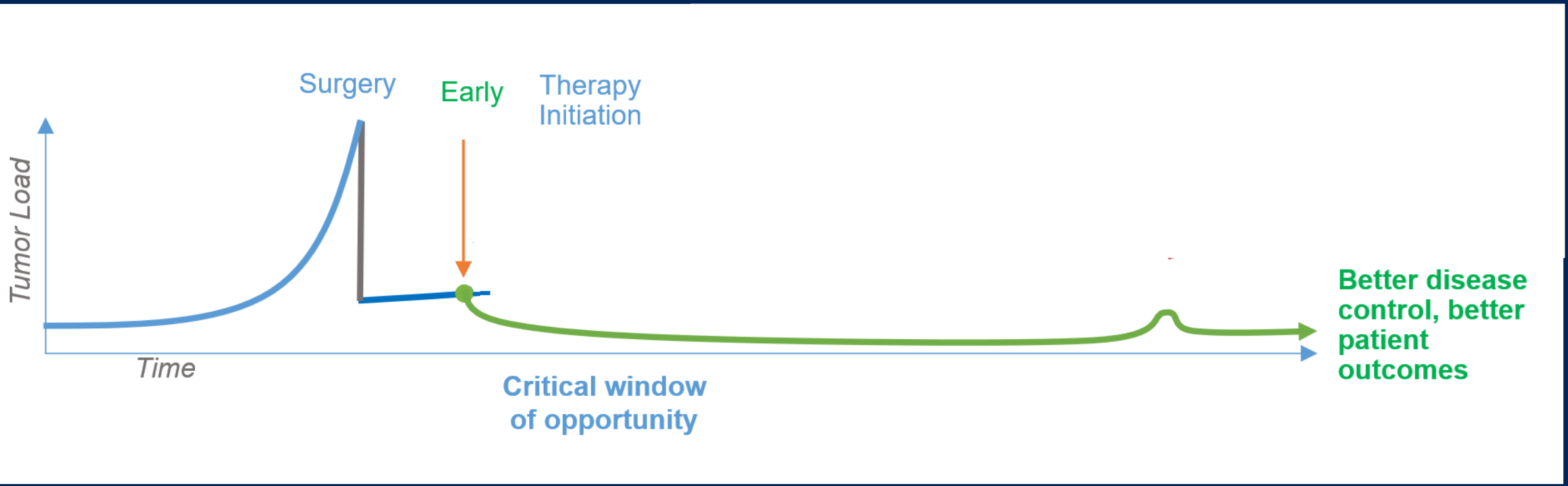
- Can detect ctDNA in blood ***~3 years*** prior to clinical diagnosis.
- ***~50-fold higher sensitivity*** than assays detecting cancers months prior to clinical diagnosis.

Earlier detection of MRD leads to better clinical outcome



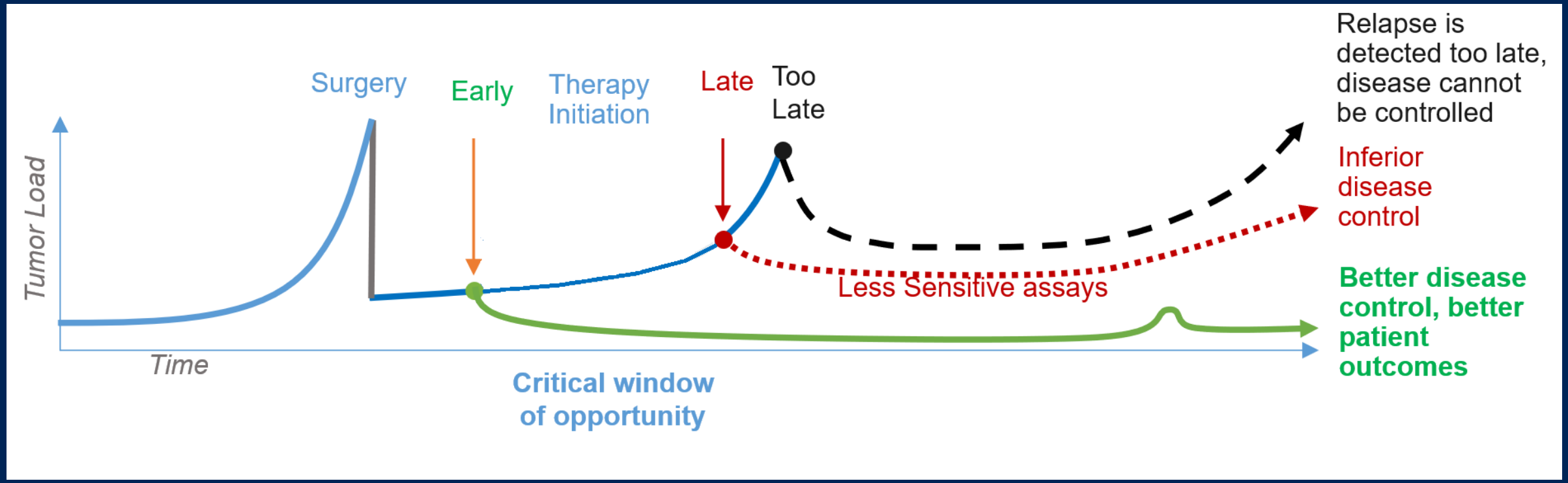
PRESENTED BY: Yuxuan Wang, MD PhD

Earlier detection of MRD leads to better clinical outcome



PRESENTED BY: Yuxuan Wang, MD PhD

Earlier detection of MRD leads to better clinical outcome



PRESENTED BY: Yuxuan Wang, MD PhD

The Role of (Total) Neoadjuvant Therapy in Colorectal Cancer: Above and Beyond the Rectum

Christine M. Veenstra, MD, MSHP

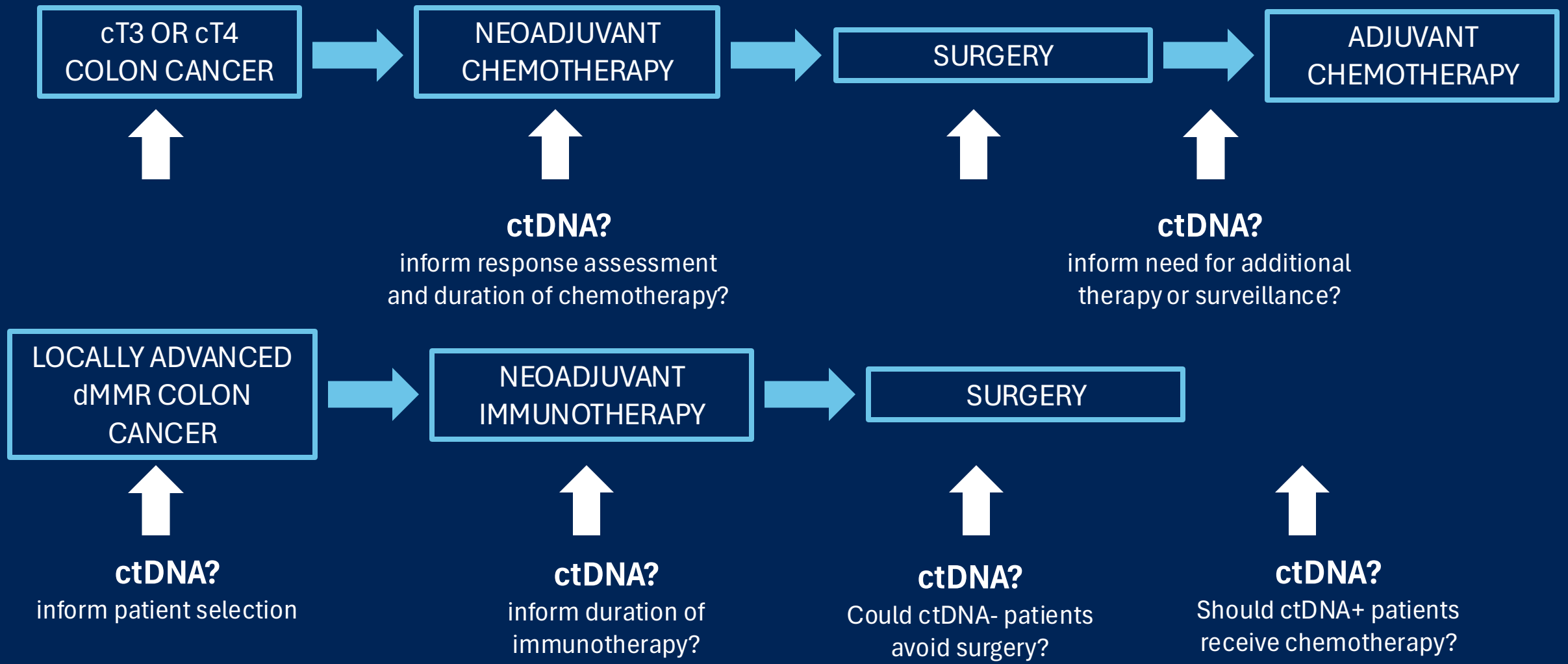
Associate Professor
Program Leader, Cancer Control and Population Sciences
Rogel Cancer Center
University of Michigan

ctDNA-Guided Adjuvant Treatment in Colorectal Cancer

Dustin Deming, MD

ACI/Schwenn Family Professor
Director, JD Fluno Colorectal Cancer Precision Medicine Program
University of Wisconsin Carbone Cancer Center

Can ctDNA inform chemo/immunotherapy?



PRESENTED BY: Christine M. Veenstra, MD, MSHP

ctDNA-Guided Neoadjuvant Treatment in Colorectal Cancer

NCCN Guidelines for Non-Metastatic Colon Cancer

- For resectable tumors, upfront surgery is recommended.
- Consider neoadjuvant chemotherapy (pMMR/MSS) or immunotherapy (dMMR/MSI-H) only for patients with:
  - T4b or bulky nodal disease
  - Locally unresectable or medically inoperable disease
- Surgery is still recommended for all patients after the neoadjuvant approach

ctDNA-Guided Neoadjuvant Treatment in Colorectal Cancer

Numerous studies showed the prognostic utility of post-surgical ctDNA testing

- MRD- patients do very well
- MRD+ patients have a highly significant risk of recurrence

Vast majority of studies are observational and retrospective

- Limited ability to use the studies to determine the utility of ctDNA testing in clinical practice

NCCN Guidelines Related to MRD Testing

"Circulating tumor (ctDNA) is a prognostic marker; however, there is currently insufficient evidence to recommend routine use of ctDNA assays outside of a clinical trial. De-escalation of care and treatment decision-making are not recommended based on ctDNA results. Participation in clinical trials is encouraged."

NCCN National Comprehensive Cancer Network®

(NCCN Guidelines Colon Cancer, Version 5 10/30/2025)

DYNAMIC-III: Stage III CRC Patients

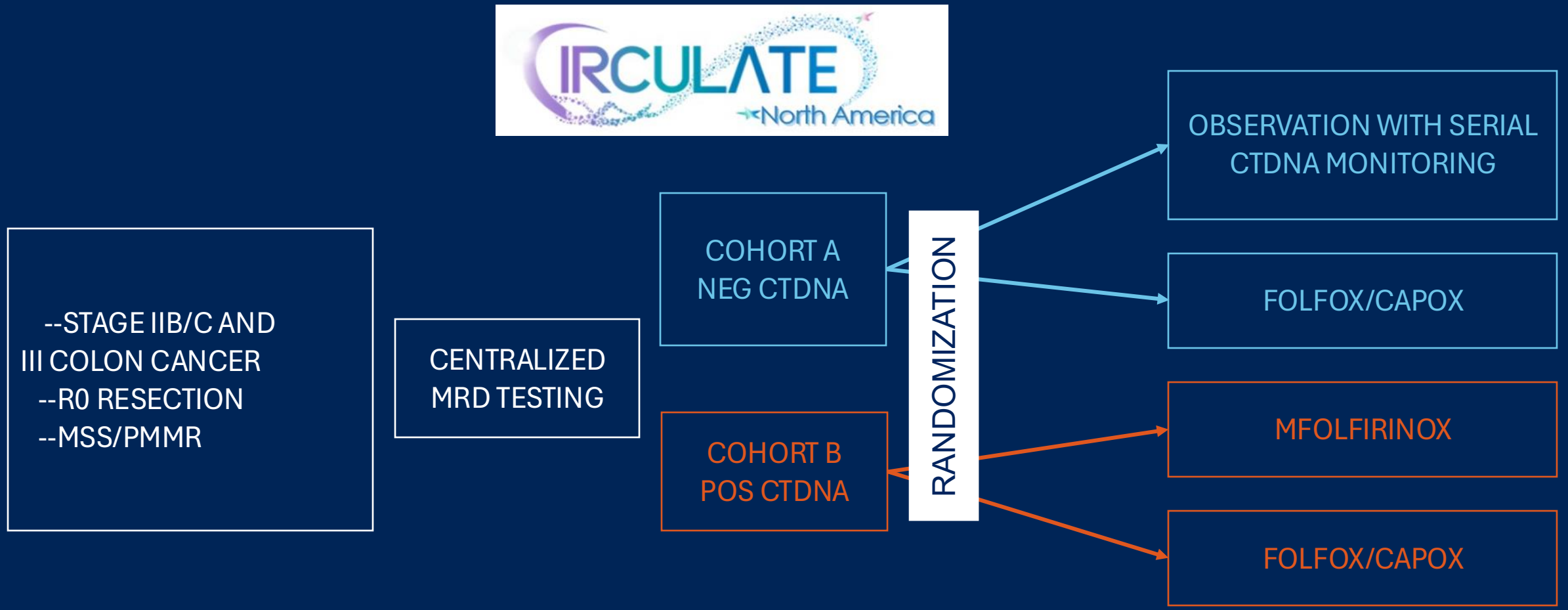
1. If ctDNA is positive and imaging is negative, should therapy be escalated?

- No evidence that escalation improves patient outcomes

2. If ctDNA test is negative, can therapy be de-escalated to reduce toxicity?

- Results slightly favored the standard treatment over the ctDNA-guided approach.
- In ***clinically low-risk*** stage III patients (T1-3N1), ctDNA-guided de-escalation ***appeared to perform similarly to standard care (3-yr RFS >90%)***

Clinical Trial Enrollment: CIRCULATE NA



(NCT05174169)

Impact of Postoperative ctDNA Dynamics on Eligibility for ALTAIR Randomized Trial in Patients with Colorectal Cancer: Implications for Clinical Trial Enrollment

Hideaki Bando, on behalf of Yoshiaki Nakamura and the CIRCULATE-Japan investigators
National Cancer Center Hospital East, Kashiwa, Japan

Impact of Postoperative ctDNA Dynamics on Eligibility for ALTAIR

ALTAIR :

- Patients who are MRD+ after surgery, randomized to Lonsurf treatment vs. placebo.
- If ctDNA detects molecular relapse before imaging does, should treatment be escalated to prevent recurrence?

How do ctDNA levels change after surgery?

Do these changes affect eligibility for ALTAIR?

Impact of Postoperative ctDNA Dynamics on Eligibility for ALTAIR

- Patients with advanced CRC stages were more likely to be ctDNA+ after surgery and get enrolled in ALTAIR.
- Higher ctDNA levels may signal fast recurrence: Clinical relapse within 3 months of ctDNA positivity.
- Serial ctDNA testing during ACT and surveillance is crucial: Some patients were ctDNA-negative after surgery or ACT but then turned ctDNA-positive during surveillance and became eligible for ALTAIR.

Key Takeaway Points

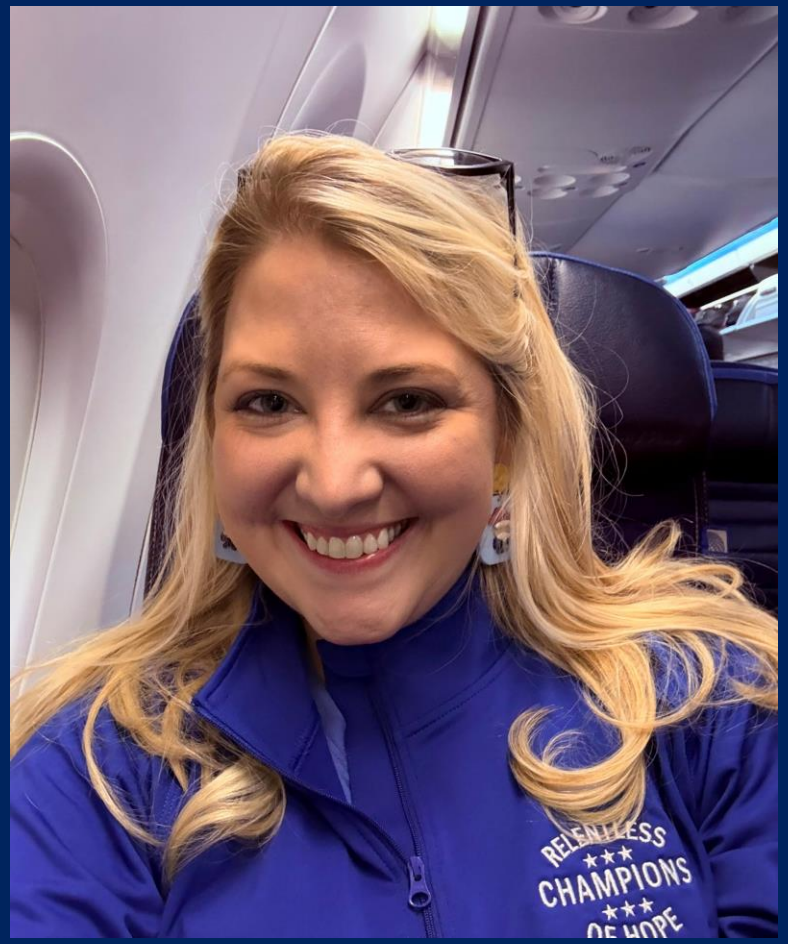
- ctDNA is a ***quantitative and sensitive*** marker for MRD detection in patients with colorectal cancer.
- The short half-life of ctDNA (16min-2.5hours) and quick turnaround time of ctDNA tests allow for early intervention, better disease control, and better patient outcomes.
- Post-surgical ctDNA positivity is one of the strongest predictors of recurrence, outperforms CEA and imaging.

Key Takeaway Points Cont.

- Using ctDNA to guide treatment is promising, but not standard of care.
- Future prospective clinical trials using ***ultrasensitive ctDNA technologies*** are required to definitively demonstrate clinical utility.
  - Patients with lowest detectable ctDNA are probably the ones who will benefit from treatment escalation
- Improved clinical risk stratification.

Megan Davies

Former Caregiver (EOCRC)
Fight CRC Research Advocate



Understanding the Caregiver Experience: Supporting Patients with Early-Onset Colorectal Cancer (EOCRC)

Megan Davies, MBA, RD, LD
Former Caregiver (EOCRC)
Fight CRC Research Advocate

EOCRC Quotes

"I would have never imagined sickness and in health would be so profound in our marriage early on. Four years into it my wife was diagnosed with stage 4 EOCRC. Our roles reversed DRASTICALLY. She was always the go-getter, never stopping but cancer halted that. I had to step up to be the encourager and take on more responsibility with our family and two young children. The biggest things I have learned through these last 2.5 years as she continues to battle is to create daily joys because we are not promised tomorrow. It doesn't have to be big gestures, but rather enjoying each day to the fullest and trying to stay present. If you look too much into the future, it becomes very overwhelming. You can do more than you can ever imagine."

-- *Robert Ray,* *caregiver to wife Darah who is fighting EOCRC*

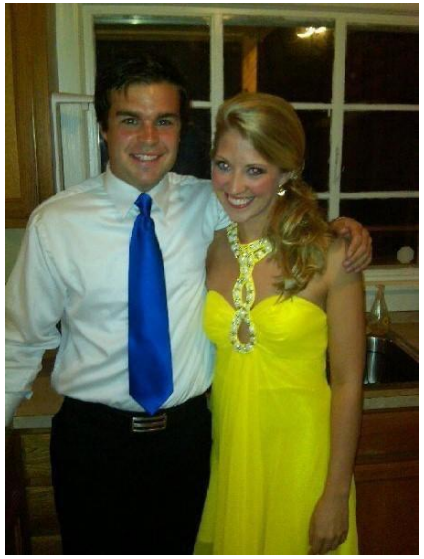
"Widening the circle. Caregiving is heavy, and allowing others to lift a corner of the load is an act of wisdom, not surrender. I wish I had known that part of me was already grieving, even while we were still fighting-and that that was normal."

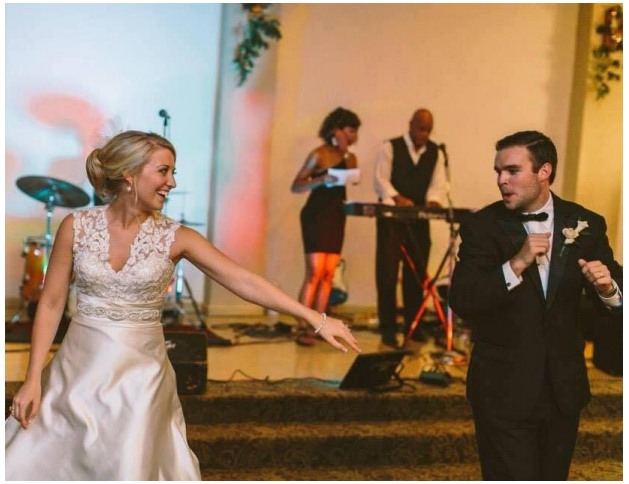
– *Kati Hook,* former caregiver to husband Brad who fought EOCRC

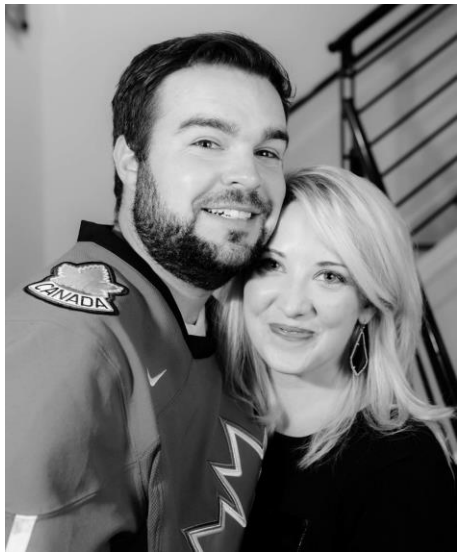
"You must figure out what you need in order to sustain the household and relentlessly prioritize it. Sleep, physical activity, and well-balanced meals have kept me feeling good. I know I can't look after everyone else if one of these areas are lacking."

– *Kate Belany,* caregiver to husband Ron who is fighting EOCRC

Story Time: Life Before Cancer







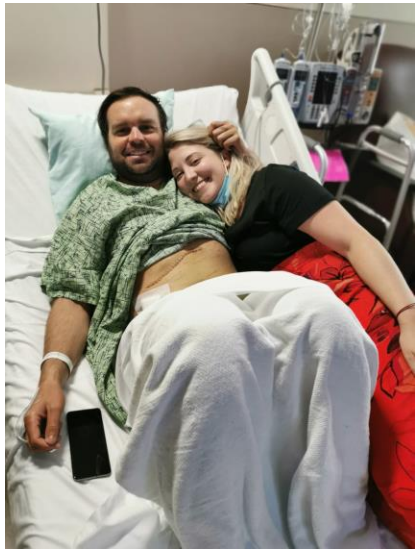
Story Continues: Life With EO Cancer

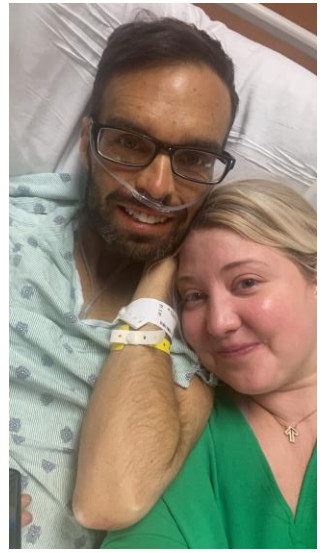










The Seen and the Unseen

- Inner World vs. Outer World
- Physical Support (i.e. Transportation, Appointments, Note Taking, Navigating medical system)
- Emotional Support (i.e. Comfort, Sounding Board, Problem Solving)
- Managing Others (i.e. family members, friends, community, jobs)
- Challenges about the future and unknown (i.e. fertility planning, sexual health, financial burden, navigating insurance, resources, end of life questions/hard conversations)
- Unexpected events (i.e. global pandemic, natural disasters, caregiver physical/mental health issues)

“Caregivers have unique challenges. We have lived experience that statistics alone do not.”

Megan Davies

Caregivers Wear Many Hats...

Partner
Companion/Friend
Nurse
Medication Manager
Patient Advocate
Living Will/POA
Mom AND Dad
Household Manager
Insurance Navigator
Boundary Keeper
Grief Holder
Working Professional
Therapist
Chef/Nutrition Manager
Researcher/Note Taker
Cheerleader
Symptom Observer
Organizer
Protector
Problem Solver
Financial Navigator
Transportation Provider
Communicator
Sounding Board
Respite Planner
Hope Sustainer

“Vulnerability is a superpower. By sharing, we make others and ourselves feel less alone.”

– Sydney Towle

Know, Talk, Awareness, Screen, Destigmatize
Thank YOU! ***#fightcrc***

How To Get Involved With Fight CRC

- Join our Resource Champions program
- Join us for in person events (Call on Congress, Climb for a Cure, others!)
- Apply to be a RATS Advocate
- Apply to our Ambassador Program
- Request resources to distribute for awareness, health fairs, or other events
- Reach out for volunteer opportunities

Thank You To Our Collaborators

Fight Colorectal Cancer Mission

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.

F!GHT CRC

THANK YOU!

F!GHT COLORECTAL CANCER™