



# PASSAGES

COLORECTAL HEALTH NEWSLETTER

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UNIVERSITY of CALIFORNIA, SAN DIEGO | Department of Surgery

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## Welcome

Dear Friends, Patients, and Colleagues,

This is our inaugural colorectal health newsletter entitled "Passages". The newsletter is a result of our desire to continue to provide education and guidance on colorectal health issues long after you have left our offices.

Our goal is to update you with the latest information and expert advice on various digestive disease topics. Our panel of contributors are all faculty and staff of the University of California, San Diego Health System which include a nutritionist, pharmacist, colorectal nurse practitioner, licensed wound, ostomy and continence nurses, and a patient advocate who also happens to be a member of our nursing administration. These wonderful individuals have donated their time generously and are available online to answer specific questions through our email address: [passages@ucsd.edu](mailto:passages@ucsd.edu).

We invite anyone and everyone with interest to submit articles, healthy recipes, or requests for future topics to our website at <http://www.colorectal.ucsd.edu/passages> and please include the names, addresses and emails of anyone you feel might want to receive *Passages* on a regular basis.

Our first issue is dedicated to the many wonderful patients that we have had the privilege to treat with colorectal cancer. This issue focuses on screening, surveillance and prevention. Future issues will cover the entire spectrum of digestive diseases including hemorrhoids, diverticular disease, constipation, inflammatory bowel disease, hereditary cancer and irritable bowel syndrome.

Finally we would like to thank all of our generous donors for their support of our research and patient care activities. If you would like to make a contribution to the colorectal research and education fund (CREF) to support this newsletter and other activities, please contact us via our email address or call Barbara Andrews at 858-822-6517.

Please read on and send us your feedback. Best wishes for a happy and healthy 2008.

Dr. Sonia Ramamoorthy  
Dr. Bard Cosman

## Colorectal Cancer Screening and Surveillance

Colorectal cancer is the second leading cause of cancer deaths among men and women in the United States. Common risk factors include age, personal or family history of polyps or cancer, long-standing Crohn's disease or ulcerative colitis, heavy alcohol use, smoking, diet and sedentary lifestyle.

The symptoms may be nothing at all until the cancer is advanced. Common symptoms may be a change in bowel habits, stools that are tarry, bloody or with mucus and/or abdominal pain. Other symptoms may include unexplained weight

*“Common symptoms may be a change in bowel habits, stools that are tarry, bloody or with mucus and/or abdominal pain.”*

loss, anemia, and anorexia.

Some treatments include surgery, chemotherapy and radiation therapy. The treatment plan depends upon the location of the cancer, size and any metastasis (spreading to other areas of the body). Screening is for average risk individuals and begins at age 50 and surveillance is for anyone with personal or family history of cancer/polyps, or a known hereditary colorectal cancer syndrome. Depending on your history or family history, surveillance can start at any age depending on risk factors and needs to be properly assessed by a gastroenterologist or colorectal surgeon.

The key message is that colorectal cancer is largely preventable so take a moment, think about your risk factors, and initiate the conversation with your health care provider.

—Sonia Ramamoorthy, MD  
Colorectal Surgeon



Moores Cancer Center.

# Information on Colorectal Cancer and Ostomies



Many medical and surgical advances have been made in the treatment of colorectal cancer. The ability to surgically maintain intestinal continuity and preserve sphincter function for normal stool elimination is often possible.

A temporary intestinal opening or "ostomy" may be created to divert stool away from the surgical area to allow healing. A permanent ostomy may be necessary if sphincter preservation is not possible.

Sometimes no ostomy is needed at all. A colostomy is an opening in the large intestine for stool waste. An ileostomy is an opening of the small intestine. Ileostomy discharge is more liquid and frequent than colostomy stool.

A pouch is worn over the "stoma," which

is the intestinal ostomy opening. Average stoma size is 1 ¼ to 1 ½ inch once initial surgical swelling subsides. The pouch is adhesive and sticks to the body over the stoma. It collects and contains stool, and is emptied at intervals. Stool frequency depends on where the intestinal opening is created and is highly variable.

After recovering from ostomy surgery, people in good health can continue an active lifestyle with friends, sports, work, family and intimacy. Today's ostomy products are discreet, odor proof, sturdy and disposable. Most medical insurances cover part or all basic pouch and product costs. Depending on the type of ostomy, there are few to no dietary restrictions.

Most people find there is a period of mental and physical adjustment for any type of change to the body. For those facing ostomy surgery, support and information is available.

Wound, Ostomy, Continence nurses

(WOC nurses) are registered nurses with specialized training in ostomy management. Their expertise includes pre and post operative counseling and education, stoma site marking for stoma placement, teaching patients and family ostomy care, pouch fitting, and possible assistance in rehabilitation after surgery with an ostomy.

The United Ostomy Association of America (UOAA) is another excellent resource dedicated to providing education, support, improvement in life quality and advocacy for those with ostomies.

For further information, please contact Sharon Scullen or Cheryl Garnica at (619) 543-8203.

Or visit the website of the Ostomy Association of San Diego at <http://www.uoaa.org>.

—Cheryl Garnica, RN CWOCN and Sharon Scullen, RN CWOCN

# Aspirin or Nonsteroidal Anti-inflammatory Drugs for the Primary Prevention of Colorectal Cancer



The U.S. Preventive Services Task Force (USPSTF), released its recommendation in March of 2007. In summary, the USPSTF recommends **against** the routine use of aspirin and nonsteroidal anti-inflammatory drugs (NSAIDs) to prevent colorectal cancer in individuals at average risk for colorectal cancer.

The vast majority of cases of colorectal cancer arise from adenomatous polyps in average risk individuals older than 50 years of age. Studies have shown that aspirin and NSAIDs, taken in higher doses for longer periods, reduce the incidence of adenomatous polyps. There is also fair evidence that aspirin used in doses higher than those recommended for the prevention of cardiovascular disease and NSAIDs may be associated with a reduction in the incidence of colorectal

cancer.

However, there is good evidence that aspirin increases the incidence of gastrointestinal bleeding in a dose-related manner and fair evidence that aspirin increases the incidence of hemorrhagic stroke. Plus NSAIDs have been shown to increase the incidence of renal impairment, especially in the elderly.

Cyclooxygenase-2 (COX-2) inhibitors for example, Celebrex®, a class of NSAID, have been proven to increase the incidence of renal impairment as well as appearing to be associated with increased risk for cardiovascular events.

Thus, there is good evidence of at least moderate harms associated with aspirin and NSAIDs. Therefore, the USPSTF concluded that harms outweigh the benefits of aspirin and NSAID use for the prevention of colorectal cancer.

References:



1. NCCN Practice Guidelines in Oncology – v.1.2007
2. Routine Aspirin or Nonsteroidal Anti-inflammatory Drugs for the Primary Prevention of Colorectal

Cancer: U.S. Preventive Services Task Force Recommendation Statement. *Annals of Internal Medicine*. 2007; 146:361-364.

—Stephen E. Segal, PharmD  
Pharmacist

# Nutrition and Colon and Rectal Cancer Prevention



Good nutrition and a healthy lifestyle can help prevent and improve your odds of developing colorectal cancer. Screen test along with a few simple changes in your diet and lifestyle can dramatically reduce your overall risk of developing colorectal cancer.

In other circumstances, if you have been diagnosed with colon cancer or if you are a colon cancer survivor you can still help maintain your health during treatment and/or increase your chances of staying cancer-free by maintaining good nutrition and a healthy lifestyle.

In particular, certain foods can assist in helping to protect you from colon and rectal cancer as well as improve your overall health and well-being:



- Whole grain breads, pasta, cereal and brown rice
- Dried beans
- Fresh fruits and vegetables
- Low-fat dairy
- Lean cuts of meat

Most of these foods listed above are high in fiber. High-fiber foods help move waste through your digestive tract faster, so harmful substances don't have much

contact with the lining of the intestine.

High-fiber foods are also rich in phytonutrients, which appear to protect against several forms of cancer. The American Gastroenterological Association recommends that individuals take in ~30 grams of fiber a day.

Other tips for developing/maintaining a healthy lifestyle include:

- Getting regular physical activity (30-40 minutes at least 5 days a week) – walking, biking, hiking, aerobics.
- Moderate use of alcohol (1 drink for women and no more than 2 drinks for men per day)
- No smoking

—Jill Jarrett, MS, RD  
Department of Surgery

## The Nurse's Corner: Question & Answer

**Q:** *What is the colon? How does it function?*



**A:** The gastrointestinal tract contains the organs that digest food. From the mouth, food

passes through the esophagus, the stomach, the small intestine, and finally, the large intestine. Each organ has a specialized function in digestion. The stomach stores food, churns it around, and begins digesting it. The small intestine, sometimes called the small bowel, absorbs fats, proteins, and carbohydrates. The remaining waste, called feces, enters the large intestine, which is made up of both the colon and the rectum.

The colon is a tube-shaped organ inside the abdomen. It is about five feet long and 2 1/2 inches wide and stretches from the right side of the abdomen over to the left side. The colon's role is to absorb

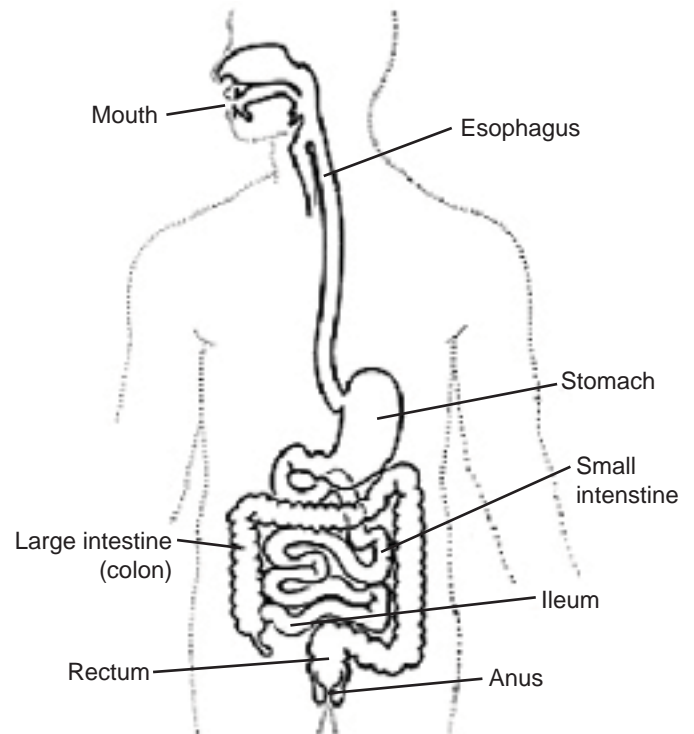
water and nutrients in to the bloodstream while pushing waste out of the body.

Contents from the small intestine move through the ascending colon, transverse colon, sigmoid colon to the rectum where the muscular bands of the colon splay out and create a pouch.

The rectum functions as a reservoir designed to expand and hold stool before defecation (having a bowel movement). It empties through the opening called the anal canal.

In the anal canal, the muscular layers of the rectum thicken into a circular band of tissue called the anal sphincter, in combination with the rectal reservoir, defecation can be put off to an appropriate time.

The colon has four layers: mucosa, the submucosa, muscularis and the serosa. The inner mucosal layer is similar to the lining of your mouth, shiny, smooth and moist. It contains glands that help with secretion of mucus



and absorption of water. The submucosal layer contains blood vessels and lymph channels. The muscularis layer pushes the contents of the colon towards the rectum. The serosa is the tough outer most layer of the colon that along with the muscularis layer protects the colon.

References:

1. Bullard, K. & Rothenberger, D. Colon, Rectum, and Anus. In: Brunicaardi C, ed.
2. Schwartz's Principles of Surgery, 8th ed. McGraw Hill Co., 2005: Chapter 28, <http://online.statref.com>.

—Barbara Andrews, APRN-BC  
Nurse Practitioner

# Meet Our Doctors

## Bard Cosman, MD



Dr. Bard Cosman is currently a Professor of Clinical Surgery at UCSD School of Medicine. He finished training in Colon and Rectal Surgery at the University of Minnesota in 1995, having done his General Surgery training at Stanford University. Originally from Tenafly, NJ, he is a graduate of the College of Physicians and Surgeons at Columbia University. He is board certified in Colon and Rectal Surgery, General Surgery, and Spinal Cord Injury Medicine.

For the last 12 years, he has been involved with clinical work and teaching at UCSD and the San Diego VA Medical Center. He teaches anatomy and surgery to UCSD medical students. His clinical research deals in HIV-related anal disease, anal dysplasia, hidradenitis suppurative and the epidemiology of pilonidal sinus and anal fistula. He has received several teaching awards from the UCSD medical students. His office is located at UCSD Owen Clinic (4168 Front St. Suite 1, San Diego, CA 92103).

In his non-working time, Dr. Cosman enjoys cycling, running, hiking and reading to his four children.

## Sonia Ramamoorthy, MD



Dr. Sonia Ramamoorthy is a Colorectal Surgeon who practices at UCSD Thornton Hospital and the Moores Cancer Center.

She completed her undergraduate degree in Genetics at UC Berkeley, completed her MD and Master's Degree in Biomedical Sciences at Boston University. Traumatized by the cold weather, Red Sox fans, and the high cost of education, she happily returned to California to complete her General Surgery training at UC San Diego Medical Center and went on to specialize in Colorectal Surgery at Barnes-Jewish Hospital/Washington University in St. Louis Missouri.

Choosing a career in academic medicine she worked at UCSF Medical Center for several years prior to coming to UCSD where she is engaged in both clinical and basic science research. Her research focus is in treating colorectal and anal cancer while her clinical practice covers all aspects of colorectal surgery with an emphasis on minimal invasive and robotic techniques.

In her free time, Dr. Ramamoorthy loves to be with her family cooking, gardening and traveling.

## Patient's Perspective



I have been a nurse at UCSD since 1995. When I was diagnosed with cancer, I wanted to go to the leaders in cancer research and a hospital where I knew the nursing staff would be attentive and

caring. UCSD was my choice.

During my thorough diagnostic workup, Dr. Plaxe discovered a second cancer in my colon. Dr. Ramamoorthy was consulted and together they coordinated their surgical teams and performed one surgery to remove both cancers. I am

now an 18 month cancer survivor! My family and I will be forever grateful for the expert and compassionate care we received from the doctors and nurses who watched over me during my surgery and recovery.

—Ellen Nyheim, RN

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