

Women and Colorectal Cancer

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Each year more than 26,000 American women die of colorectal cancer (CRC). CRC takes as many lives as ovarian and cervical/uterine cancers combined. A common misconception is that CRC is “a man’s disease.” In fact it is an “equal opportunity killer.”

ARE YOUR FEMALE PATIENTS AT INCREASED RISK?

Age and Menopause: Are the most important risk factors for developing CRC. As women grow older, their risk doubles every five years.

Colorectal polyps: If you or your family has a history of polyps there is a higher risk.

Cancer history: Women with breast or uterine cancers and/or a family history of CRC are at higher risk than others.

Crohn’s disease and/or colitis: These chronic inflammatory conditions increase your CRC risk tenfold.

HOW CAN PATIENTS REDUCE THE RISK OF CRC?

Healthy weight: Exercising regularly, a diet low in animal fats and high in fiber can reduce your risk. Overweight women (body mass index of >30) are at increased risk.

Hormone replacement therapy (HRT): Decreases the risk of developing CRC in postmenopausal women by 20-45%.

Calcium: Taking supplemental calcium decreases the development of polyps and reduces the risk of CRC by 30-50%.

GET CHECKED! Participation in CRC screening exams and tests works to prevent CRC

HOW DOES CRC DEVELOP?

CRC typically develops from precancerous polyps (abnormal growths). Over time some become CRC.

WHAT ARE SOME WARNING SIGNS?

Alarming symptoms are bleeding from the rectum, change in bowel habits, such as new constipation or persistent diarrhea. Abdominal or rectal pain and unexplained weight loss may be symptoms of larger cancers. Blood from the rectum, with stool or on the toilet paper is NEVER okay.

*“If CRC
is diagnosed early
the cure rate can be
as high as 90%.”*

WHEN SHOULD PATIENTS BE CHECKED FOR CRC OR COLON POLYPS?

Screening for CRC should start at age 50. An earlier evaluation is essential for symptoms like bleeding, anemia, abdominal pain, weight loss, change in of bowel habits or fatigue.

CRC can be caused by a genetic defect that leads to a familial predisposition to get CRC. Patients with a genetic defect (e.g. familial polyp syndrome) that is linked to CRC should be screened in their late teens. Screening in people with Crohn’s disease and ulcerative colitis is also mandated.

WHAT SCREENING TESTS ARE AVAILABLE?

Digital rectal examination and stool occult blood testing, flexible sigmoidoscopy and colonoscopy are available. The latter use a narrow flexible camera "scope" that visualizes polyps and allows their removal.

Stool testing for hidden (occult) blood should be carried out yearly; flexible sigmoidoscopy should be performed every 5 years. A colonoscopy should be carried out every 10 years.

X-ray tests like "virtual colonoscopy" and lower GI studies can be used for screening. However, polyp removal is not possible with x-ray tests.

IS CRC CURABLE?

If CRC is diagnosed early the cure rate can be as high as 90%. Sadly, less than half of colorectal cancers are detected at an early stage. Many individuals ignore colorectal symptoms. Currently only about 50% of women undergo the recommended screening for CRC.

HOW IS CRC TREATED?

An operation to remove CRC is necessary if not confined to a polyp. Minimally invasive surgery (laparoscopy and robotic surgery) has made surgery more precise. Incisions are smaller than with open surgery; healing is usually faster and less painful. With specialized technique, very rarely this requires a permanent colostomy which is a surgically created abdominal opening for passage of stool ("a bag".)

If the cancer has spread, proper treatment may include chemotherapy and/or radiation.

CRC is preventable. Early detection and prevention by undergoing regular screening is the best approach. Hence, do not overlook any changes in bowel habit, bleeding or pain; rather, discuss your CRC concerns with your doctor, a gastroenterologist or a colorectal surgeon.

WHAT IS A COLORECTAL SURGEON?

Colorectal surgeons have completed advanced training in the treatment of colon and rectal cancer and other problems (after five years training in general surgery.) Colon and Rectal Surgeons are experts in the treatment of benign and malignant colorectal conditions, perform routine screening examinations and perform operations when necessary.

Dr. Raub grew up in Cincinnati, Ohio where he attended college and medical school. He completed his surgical residency at the University of Rochester, and trained in colon and rectal surgery at the Lahey Clinic Medical Center in Boston. Dr. Raub joined RCRS in 1988 and lives in Webster.

Dr. Hriesik was born and raised in Germany where she attended medical school. She completed her Surgical Residency at Drexel University of Medicine in Philadelphia. She graduated from two fellowships; the first in Surgical Oncology at the University of Pittsburgh and then in Colon and Rectal Surgery at the Cleveland Clinic in Ohio. Dr. Hriesik joined the practice in 2008.



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