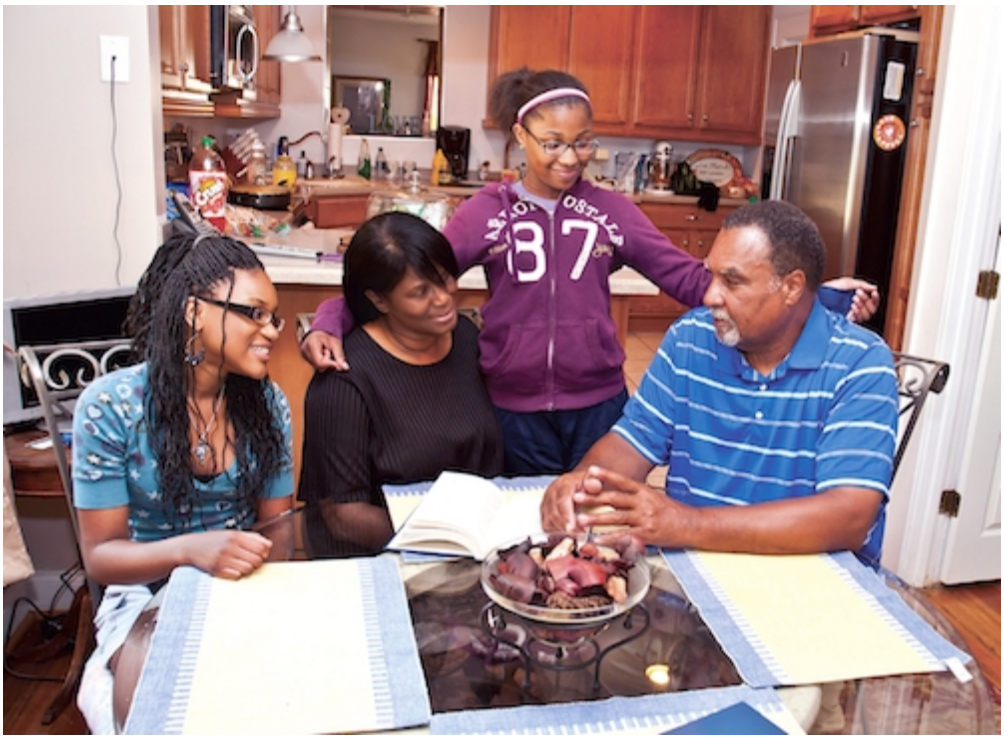
Health Hurdles: A Lesson Learned

Once opposed to life-saving medical tests, a Virginia Beach resident now stops strangers to sing their praises and, hopefully, stop the spread of colon cancer.

BY KRISTEN DE DEYN KIRK 0



Darnell Thoroughgood' s wife, Jean, told him he should have his colon checked when he turned 50. And he told her "no way." He pictured the doctor putting on rubber gloves, asking him to get on all fours on the exam table and grinning as a rectal exam started. "Oh no," says Darnell as he remembers his reaction. "Uh, uh!" He shakes his head.

"There was no way anyone was going to do that to me."

He trusted that Jean was smart and particularly knowledgeable about medicine. She worked for

Sentara Healthcare and heard about medical tests all the time. But he didn' t have the same exposure or understanding. He thought a digital rectal exam was used primarily to screen for colon cancer, not prostate cancer. While a doctor might notice something of concern during a rectal exam that could later lead to a colon cancer diagnosis, a colonoscopy is a better test.

And a colonoscopy might have been slightly more "doable" for Darnell back when he was 50– if he had thought about the fact that he could take a sedative to relax him as a small device filmed his insides.

Finally, five years later, in 2003, Darnell didn' t have much choice. For several weeks he had been bleeding during bowel movements. The amount of blood and the frequency in which it appeared increased. He and Jean tried to dismiss the symptoms as nothing serious. Probably hemorrhoids, they said. But just in case, Darnell talked with his primary care physician and was ordered to have a colonoscopy.

Jean sat in Dr. Jan Janson' s waiting room during the procedure and overheard someone on the gastroenterologist' s staff saying "Thoroughgood" and "schedule a CT." "I knew something was wrong right then," she says. Darnell heard the news a little later. "The doctor came in and said, 'Mr. Thoroughgood, you have colon cancer, and there' s a 50-50 chance of it going to your kidney and liver.' " Jean remembers staring straight ahead so her worry wouldn' t show, and Darnell tried to be stoic. The news was too much, though–he broke down in the car, crying as Jean drove to their Birdneck area home. "I started to beat myself up," he says. "Why had I played Russian Roulette?"

Catch it Early

Colon cancer, also called colorectal cancer, is the fourth most diagnosed cancer in the United States and the second leading cause of cancer death. It is also one of the most treatable forms of cancer.

That sentence seems like a non sequitur until you learn more about the disease– colorectal cancer starts as benign polyps in the digestive tract. Over time, the polyps turn into cancerous tumors, destroy tissue and spread to other parts of the body.

Fortunately, the "over time" period can be long, possibly up to 10 years. If people follow the medical guideline of having their first colonoscopy at age 50 (or younger in some cases), the chances of stopping the disease are good. They should not wait for a sign–people do not always experience the symptoms (change in bowel habits, blood, mucus, tarry stools, a feeling of

incomplete defecation) that might send them running to a doctor like Darnell. Overall, Virginians are doing an OK job of getting the proper screening for colorectal cancer, but they' re far from perfect. According to a health behavior survey by the Virginia Department of Health in 2008, 70 percent of Virginians over age 50 reported having had either a colonoscopy or sigmoidoscopy (see "Get Tested" on page 75). The average for the United States population was 62 percent. However, Chesapeake, Suffolk, Portsmouth and Isle of Wight residents reported screening rates ranging from 54 to 65 percent, significantly lower than the Virginia average. The Virginia Department of Health notes that colorectal screening rates were lower among adults who were less educated, earned less and uninsured, but the rates did not differ significantly between African-Americans and Caucasians.

Unfortunately, race differences show in other devastating ways: The average rates of colorectal cancer in Virginia between 2004 and 2008 were higher in men compared to women and in African-Americans compared to Caucasians. African-American men were diagnosed with colorectal cancer at a high rate: For every 100,000 people, 66.4 African-American men were diagnosed, 52.1 Caucasian men, 50.7 African- American women, and 39.0 Caucasian women. The average diagnosis rate was 46.8 cases per 100,000 people in Virginia. The rate in the United States was 47.9 cases.

Virginia mortality rates were also higher in men and African-Americans. African-American men died from colorectal cancer at an especially high rate of 29.3 per 100,000 people per year. African-American women were at 20.8, Caucasian men 19.2, and Caucasian women 13.3. Sadly, Portsmouth reported the highest colorectal death rate in the state from 2001 to 2006, at an average of 26.4 deaths per 100,000 people per year. The overall rate was 17 in Virginia, 17.2 in the United States.

National research reflects findings in Virginia. A 2008 study conducted by Thomas Jefferson University in Philadelphia found that African- American patients had worse "pathological features" when they were diagnosed with colorectal cancer and a lower five-year survival rate compared to Caucasian patients. Yet, researchers could not attribute the difference to a specific cause or point to a lack of screening. A 2010 study conducted by Dartmouth' s Norris Cotton Cancer Center and

published in the American Journal of Public Health was publicized in a press release entitled "Hazard of Death from Colorectal Cancer for African-Americans Growing." The researchers concluded that while overall mortality rates due to colorectal cancer declined from 1960 to 2005, the disparity due to racial differences increased. The press release read in part: "African-American patients have consistently worse stage-specific colorectal cancer survival rates than Caucasian patients, and the gap in survival rates has widened over time."

Lead Dartmouth researcher Samir Soneji notes that this was not always the case. Before 1970, Caucasian men and women experienced higher colorectal cancer mortality rates than did African-American men and women, he says. The mortality rate for African-American women started to exceed the rate for Caucasian women beginning in 1970 and for African-American men over Caucasian men beginning in 1979. The study did not explore why this change came about or how to solve it, but the lead researcher took a stab at it: "Racial disparity seems most likely to be a product of differences in access to care or the quality of that care," said Soneji in the press release. "... We want to encourage the most appropriate screening for groups that would benefit the most, bearing in mind that the historical data show that racial disparities must be considered as policy and screening programs are developed ... Racial disparities are likely to be a product of a broad set of social, biological and environmental factors."

Or in other words–the solution could be complicated.

In April, the President' s Cancer Panel announced that the number of minorities with cancer of any type will likely increase by 100 percent by 2030, while whites will experience a 31 percent increase. (The report also noted that African-Americans are now nearly twice as likely as Caucasians to be diagnosed with colorectal cancer before age 50.) The Panel encouraged leaders in the fight against cancer to adjust their approach to prevention, detection and treatment accordingly.

"Both cultural and socioeconomic factors contribute to cancer outcomes," said Cancer Panel member Margaret Kripke in an article released by the American Cancer Society, "and I think we' re only beginning to recognize how significant those factors are in terms of the cancer disparity issues." According to the President' s Cancer Panel report, much of what we know about cancer comes from studies conducted on Caucasians, and "the risk factors, screening guidelines and treatment regimens identified through research are often not appropriate for individuals of non-European descent."

However, the panel noted that lifestyle, poverty and education may have more to do with cancer

disparities than race and ethnicity. ‘‘It’ s understanding the point of view of the individual you are communicating with or treating in terms of their different ideas and beliefs and background,’’ Kripke said. ‘‘It’ s critically important that the medical profession be able to understand some of those cultural overtones and deal with them in a very sensitive way.’’

The American Cancer Society explained that it wants to help with that understanding. It is currently enrolling adults from all backgrounds for its Cancer Prevention Study-3. The goal is to study 500,000 people from ages 30 to 65 for 20 to 30 years and identify genetic, behavioral, environmental, and lifestyle factors that cause or prevent cancer. (See www.cancer.org/cps3 for details.)

Spread The Word

Darnell Thoroughgood thinks he can help lessen the divide when it comes to fighting colorectal cancer, whether it’ s racial or socioeconomical in nature. He had all the advantages that should have led him to have a colonoscopy long before he developed symptoms– his wife encouraged him; he had insurance; he had access to good doctors and hospitals. But he didn’ t have someone like him– someone mature, African-American and proud–telling him to get it done.

‘‘Now I tell everyone to get checked,’’ says the 63-year-old while sitting in his den on an overstuffed recliner. As he talked, it was noisy outside with jets flying overhead and busses whizzing by. He lives in a busy part of
town, a perfect location, really, he says. He could reach a lot of people just like him around here. He pictures his face on the side of those buses. With his image would be some sort of message like ‘‘Get a colonoscopy. I had it done. It saved my life.’’

‘‘You have all these bus signs for tax companies and other silly things,’’ he says. ‘‘Something important should be up there.’’ Although it’ s been eight years since his diagnosis, Darnell still seems to feel the fear. He doesn’ t smile once while talking about his experience, and he keeps looking toward his front window, like he’ d rather be outside instead of inside reliving those days. He doesn’ t remember a lot of details–he and Jean aren’ t sure what stage his cancer was or exactly where it was located. They were just grateful that Jean’ s connections at Sentara led them to Dr. Thomas Clifford. Darnell trusted him to do a good job and respect his wishes.

‘‘I said ‘if I have to wear a bag, just leave it,’ ’’ he recalls Darnell was referring to the possibility that a colostomy bag might be needed temporarily or permanently. This can happen if the surgeon removes part of the colon and is not able to reconnect the two ends. He would then make an

opening called a stoma on the outside of the body so waste can pass through and be collected in a colostomy bag. The thought of that was too much for Darnell to deal with.

He was pleased when he woke up after the surgery and found that not only was the bag unnecessary, he was completely done treating the cancer. He had thought chemotherapy or radiation would follow, but Dr. Clifford told him, "We got it all!"

Darnell says his wife saved his life "by being in the right place at the right time," meaning that her job with Sentara gave her the chance to know top-notch doctors. He's so grateful for a second chance that he's even given up his beloved fried chicken. Well, not the whole chicken, but he does remove the skin. He's taken charge of most of the couple's cooking, and he focuses on vegetables and lean protein. Preparing breakfast in the morning for his two granddaughters, ages 12 and 14, presents temptation–they want bacon and eggs. Darnell says he resists. Staying on a healthy track is never easy, and it's more of a challenge for Darnell in some ways. Four years ago, Jean left her job and with it the couple's health insurance. Darnell has been on disability since 1994 after a back surgery, and while he has worked some jobs since then, he hasn't secured health insurance. He takes eight pills a day for diabetes and high blood pressure, and he visits his primary care doctor about once a month. He's also had three colonoscopies since his surgery, the first a year after the surgery and two others about three years apart. The money for the medicine, doctor visits and tests comes out of his pocket.

"The colonoscopy I had just last month costs about $500," he says. "And then they found a polyp, and I had to pay more than $200 to get that removed." Jean has been calling around trying to get health insurance for the couple. No one will offer them an affordable policy. "One place told me I was the 'problem,' too," she says in disbelief. "I had a polyp recently, and it worried them. I had to explain that lots of people have them, and it's not that big of a deal if you get it removed. I know more than they do with what we've been through." The lack of insurance and his health concerns get to Darnell at times. That's when he pulls out the guitar that he stores in the corner of his den and plays a little music to cheer himself up. Two plants in the room remind him of his overall good fortune as well–both were given to him in the hospital after his surgery. One is a lush green cactus that is thriving on a stand near the front window. The other is in a pot on the floor along the back wall. Darnell tied the stem so the plant would grow straight up. It reaches nearly 6 feet high, touching a painting of a small house that reminds him of the original houses that lined his street when he was a boy. Darnell also tries to stay positive about the future by avoiding what he calls the "non-believers."

"I actually have people tell me 'once you have cancer, you never get rid of it,' " he says. "I' m careful to not talk to those people again. If I dwell on it, I won' t stay well."

Seeking the treatment best for you

Like most diseases, colorectal cancer can be treated in a number of ways. For the best results, patients should consider consulting with a doctor with specialized training. "Two things I tell people to look for are fellowship training and volume (of surgeries)," says Dr. William Rudolph, a colorectal surgeon with Sentara Surgery Specialists. The patient-doctor team can review the location of the cancer and its stage, or degree to which it has developed, and make a decision on the best course of action. Options include a low anterior resection (the surgery performed on Darnell Thoroughgood), a Total Mesorectal Excision (TME) or Transanal Endoscopic Microsurgery (TEM).

Again, the best option will depend on the cancer' s location and stage, but a minimally invasive procedure such as the TEM might be possible. Dr. Gregory FitzHarris of Sentara Surgery Specialists has performed the procedure on patients with early-stage cancerous polyps and patients with non-cancerous polyps that were too large to remove with a colonoscope. Instead of cutting into the abdomen, Dr. FitzHarris inserts a two-inch wide tube called a proctoscope through the anus and positions it over the polyps. He fills the rectum with carbon dioxide gas so that there is room to work and then uses a special microscope to look at the area directly and with a video camera. He removes the polyps and surrounding tissue with long instruments.

Dr. Rudolph describes Total Mesorectal Excision as the laparoscopic removal of the mesorectum, the fatty tissue next to the rectum. He also removes lymph nodes in which the cancer may have spread. He finds the surgery particularly effective because it gets a "wider margin," a larger area of tissue around the cancer, which can result in a lower rate of cancer reoccurrence. And because it is performed
laparoscopically, surgeons make an incision that is much smaller than they would in a traditional surgery. The smaller incision means a faster recovery with less pain and fewer painkillers.

Get Tested!

The American Cancer Society recommends that men and women follow one of these testing schedules beginning at age 50. Some doctors, including Dr. William Rudolph with Sentara Surgery

Specialists, recommend that African-Americans start the screening process at age 45. The tests that are designed to find early cancer and polyps are preferred if available. The American Cancer Society recommends that some people be screened using a different schedule because of their personal history or family history. Talk with your doctor about what is best for you:

Tests that find polyps and cancer

Flexible sigmoidoscopy every five years* or
Colonoscopy every 10 years or
Double-contrast barium enema every five years* or
CT colonography (virtual colonoscopy) every five years*

Tests that primarily find cancer

Yearly fecal occult blood test (gFOBT)** or
Yearly fecal immunochemical test (FIT) every year** or
Stool DNA test (sDNA), interval uncertain**

Flexible sigmoidoscopy

The doctor inserts a sigmoidoscope, a flexible tube with a video camera on the end, into the rectum and the lower part of the colon and reviews images displayed on the monitor. The sigmoidoscope is only about two feet long, so the doctor can' t see the entire colon.

Colonoscopy

The doctor looks at the entire length of the colon and rectum with a colonoscope, which is similar to the sigmoidoscope but longer. He or she can also use instruments to remove any polyps that are found.

Double-contrast barium enema

This test is known by other names: an air-contrast barium enema, a barium enema with air contrast and a lower GI series. A chalky liquid called barium sulfate and air are used to outline the colon and rectum on an X-ray to help with spotting abnormalities.

CT colonography (virtual colonoscopy)

This test is an advanced type of computed tomography scan– known by most people as a CT or CAT–of the colon and rectum. A CT scan is an X-ray test that produces detailed cross-sectional images. For a CT colonography, special computer programs create two-dimensional X-ray pictures and a three-dimensional view of the inside of the colon and rectum.

Fecal occult blood test

The fecal occult blood test (FOBT) is used to find occult blood (invisible blood) in feces. However, it cannot tell whether the blood is from the colon or from other parts of the digestive tract, so a colonoscopy is needed if the results are positive. The American Cancer Society emphasizes that an FOBT done during a digital rectal exam in the doctor' s office is not sufficient for screening.
More than one sample is needed.

Fecal immunochemical test

The fecal immunochemical test (FIT), also called an immunochemical fecal occult blood test (iFOBT), is a newer test that detects hidden blood in the stool. Some people prefer it because there are no food, vitamin or drug restrictions before taking it, and it is less likely to detect blood from other parts of the digestive tract, which can mean fewer false positives.

Stool DNA tests

Colorectal cancer cells can contain DNA mutations. Cells from colorectal cancers or polyps with these mutations are often in the stool. Because this test is newer, doctors have not yet established its best frequency.

* If the test is positive, a colonoscopy should be done.
** The multiple stool take-home test should be used. One test done by the doctor in the office is not adequate for testing. A colonoscopy should be done if the test is positive.
Source: American Cancer Society' s Cancer.org.

Add your comment:

Characters remaining: 2000

Please enter the letters from the image below:

Audio version (mp3)

Log in and Post Comment

Popular Articles

1. **ForKids Helps Homeless Families in Coastal Virginia**
2. **The Garage Brewery Opens in Chesapeake**
3. **Try Craft Coffee Flights at Pourfavor**
4. **Pungo Board House: Local Surf Shop in Virginia Beach**
5. **CoVa Best Of Party 2019**
6. **Outdoor Entertaining with IKEA**
7. **William & Mary Alums Make Memories with Football Field Wedding**
8. **Riptide Burgers & Tiki Bar Offers Beach Bites and Cocktails**
9. **Run for Your Life: Fitness Enthusiast Crystal Harper Shares Running Tips**
10. **Meet Alana Springsteen: From Sandbridge Singer to Country Superstar**

Sections

Medical Directory
Things to Do

Restaurants & Food
2019 Best Of Party
Weddings
Health & Beauty
Getaways
At Home

About Us

Contact Us
Advertise
Archives
My Account
Store
Subscribe
Welcome Guide
Distribution Points
Facebook
Twitter
Instagram
Pinterest