DoctorsRoundTable20140130

Tanya: Good morning everyone! Thank you for listening. I hope that you're home and warm and safe after the past couple of days. We've had out in the Atlanta weather. It's amazing how 1 inch can just wreck havoc on the city that's not used to snow. But we're thankful that you're here today and our topic is demystifying colonoscopies. Excluding skin cancer, colorectal cancer is the third most common cancer in the United States and one of the leading causes of cancer related deaths. In general, the CDC reported in my research that in November of 2013, 20 million Americans still have not completed a colon cancer screening test. I have with me an expert today that's going to talk about this screening test and other things that colonoscopies are used for. Let me introduce you to Dr. Max Shapiro. Welcome, Dr. Shapiro!

Dr. Shapiro: Thank you. I'm happy to be here.

Tanya: Let me tell you a little bit about him. We've been chatting about the snow in Boston. He's originally from Boston. He got his medical degree from Tufts University, and then made his way south here to Atlanta to complete his residency in Internal Medicine from Emory University. He went on to do a fellowship in Gastroenterology and Hepatology at Georgetown University and ended back up here in Atlanta. He has special interest in colon cancer screening and right now he's in private practice at Metro Atlanta Gastroenterology at Saint Joseph. So welcome!

Dr. Shapiro: Thank you.

Tanya: Tell me how you ended up in Gastroenterology because you actually took the time and probably 2-3 years extra to train in that specialty. So, what was kind of your journey there?

Dr. Shapiro: I started out in medical school. I did a rotation in Gastroenterology as part of my internal medicine rotation. I pretty much like it right away. Mostly, there was a variety in the way that I could help people or the doctors that I was with, or helping people both including infectious diseases like hepatitis C and B, intestinal infections with chronic inflammatory diseases like Crohn's and Colitis, upper GI, lower GI diseases, liver disease and pancreas and biliary tract as well as colon and other GI cancers, including cancer prevention which we're talking about today in the form of screening.

Tanya: It's way easy to not deal about all that and take care of yourself upfront, but people are still pretty resistant. Would you agree with the CDC finding that still not enough people are getting screened?

Dr. Shapiro: Yes. Obviously, I'm biased by the people that are seeing me to be screened. All those people that are out there not being screened or not coming my way. But I'm sure that's the case that there are a lot of people that are reluctant for a variety of reasons. Hopefully, today we'll change a few minds.

Tanya: That's hopefully so. Let's just jump right in there. What are some of the main reasons? Fear of probably the procedure? I know technology has changed quite a bit. We're actually going to talk a little bit about the specifics of the procedure. What are some of the other things? Do you think it's them not knowing the baseline? Do you think it's people just not being familiar with the procedure? What do you think are some of the barriers to screening?

Dr. Shapiro: I think it's kind of all of the above. Just to think about the procedure, it is an invasive procedure. It does involve an area of the body that a lot of people are not comfortable with doctors being around. People do have issues mostly from stories that they've heard from friends and family members. A lot of times involving the preparation, in other words getting the colon cleared out to get the best test. I think less of the procedure itself, but occasionally people will hear that a friend of a friend had a major complication and they don't want that to happen to them. Sort of this horror stories they get circulated around. I think those are the primary reasons. It sums it up.

Tanya: I know that with the Affordable Care Act, we saw the president on TV, it was State of the Union the other night, we're talking a lot more on health care about prevention these days instead of just dealing with the disease once you have it. I know a lot more screening, not just for colonoscopy, but for breast health and Pap smear and all kinds of things are being included with these baseline packages. Do you think that the screening will go up or down? What's your opinion on that?

Dr. Shapiro: Well, you know likely it will go up. As you mentioned, screening, including colon cancer screening and colonoscopy, is considered in the preventive health services under the affordable care act. Most people either with traditional private insurance plan or one of the new exchange plans will have coverage of the procedure or other colon cancer screening test. Usually they cover that at a hundred percent. Usually there's no co-pay or co-insurance unless they're grandfathered into an older plan.

Tanya: It should be a pretty good coverage.

Dr. Shapiro: Including the benefits and lower barriers. I guess cost could have been a barrier, the one that we didn't talk about before. With that barrier essentially gone, hopefully more people will get on the band wagon.

Tanya: In general, even with screening lagging behind what I guess is recommended for the population and the recommendations which we'll get into. Is colon cancer itself going up or down in terms of its prevalence and incidence in the U.S.?

Dr. Shapiro: It actually is going down.

Tanya: That's what I heard.

Dr. Shapiro: In large part due to ramped up screening programs.

Tanya: So, catching it earlier.

Dr. Shapiro: Yes. One of the unique things about colon cancer, actually, is not catching it earlier but catching it when it's still not cancer, when it's a polyp which is a growth in colon that is benign but if left alone does have the potential to grow large, transform and turn into cancer. That's one place that colon cancer screening is unique. Not only are you catching cancer potentially at a very early stage like you would with the breast cancer and a mammogram, but you're actually catching before it is cancer. In that way, truly preventing the disease, not just catching it early, which would lead to a better outcome.

Tanya: We're talking right up front in the show about colon cancer screening, but I know colonoscopy is the main way that we test them. We'll talk about that procedure. What are the other indications for a colonoscopy besides colon cancer screening?

Dr. Shapiro: We divide colonoscopy into screening which we've touched on and the other part of it is diagnostic, in other words, to look for a specific cause of a problem. Certainly, one of the most common is blood in the stool. Often it is blood that is visualized but also it can be detected in microscopic form in what we call a cold blood testing with the stool card. Iron deficiency anemia and other kinds of anemia do come up. The colon is one of the most common places in colon cancer, specifically, that can lead to severe iron deficiency from chronic slow blood loss. If someone is detected to have anemia and iron deficiency, colonoscopy is recommended to at least rule out colon cancer as the source. Other types of change in bowel habits, slower bowel movements, in other words more constipation or diarrhea, change in stool form, where people see small caliber stool. There's a variety of reasons for those changes. It's usually not colon cancer but other kinds of diseases can be detected on colonoscopy, depending on the condition. Certain forms of abdominal pain can be a sign of more serious colon condition that could be found in colonoscopy. The final one we see is sometimes people have a CAT scan or x-ray or other kind of imaging test that may detect a possible polyp or other abnormality in the colon. The colonoscopy can be used to visualize the colon. Was that a real finding? Was there really a polyp or a mass there? Or was it some sort of artifact from the imaging test?

Tanya: So, to verify in diagnostic, rule in or rule out.

Dr. Shapiro: Exactly.

Tanya: Sounds good. Let's get into some screening recommendations. What are the standards at which we should get colon cancer colonoscopy screening done?

Dr. Shapiro: For the general average risk population, it starts for men and women age 50. That's when we start to see a rise in the general population of colon polyps, mostly in the few early colon cancers. It's a relatively arbitrary number, so we're really trying to get people in the early 50's.

Tanya: Is that because it's slowly growing? Are those polyps slowly growing?

Dr. Shapiro: They are. It usually takes over 10 years for early polyp to develop, grow, transform and turn into cancer. If a person is 53 or 54, they haven't missed the boat. That's another perfect time to get in and get screened. There are other risk factors mainly family history that would prompt an earlier colonoscopy, especially if the person has a first degree family member diagnosed with colon cancer at any age really, but specially if they've been diagnosed under the age of 60. Usually, we start those patients at age 40 or 10 years before their family member was diagnosed.

Tanya: Is there any kind of genetic link? We're learning about the genes for breast cancer, just like the Angelina Jolie preventatively. Is there any like that with the colon cancer?

Dr. Shapiro: Yes. There are several colon cancer genetic syndromes. That's the minority of colon cancer that we see. But even the family history that I mentioned that a first degree member would double or possibly triple the person's risk. Going from about a 5% lifetime risk for the average person, possibly up to a 10% or 15% risk.

Tanya: What would the recommendation be? Instead of 50, if you have that kind of a history, when would they start doing screening?

Dr. Shapiro: Usually at age 40, or if the family was diagnosed in their 40's, it would be starting 10 years before they were diagnosed. If a family member is diagnosed at the age of 45, you start the patient age 35.

Tanya: Do you see gender or ethnicity differences, as far as when they should get their baseline?

Dr. Shapiro: Right now for gender, even though men do have a slightly higher risk of colon cancer and polyps than women, there are no differences in the recommendations. There has been some data over the past several years that suggest African American patients may develop colon cancer earlier or may have more rapidly progressing forms. Some societies recommend starting at the age of 45 for African Americans. Not all the insurance plans have adapted to that. In order to be covered for that as a routine screening test, an individual has to check with their particular insurance plan to see if it would be covered. I encourage my African American patients to start at age 45.

Tanya: Once we get our screening done, what percent of the people that you screen do you actually find something?

Dr. Shapiro: The national data suggested about 15% of women and 25% of men at age 50 will have a benign polyp. The numbers maybe a little bit higher because as the technology and colon preparation improves over the years. Those numbers may actually go up. But right now those are sort of a benchmark of what we expect and what we tell patients to anticipate.

Tanya: Okay. And then once we have that baseline colonoscopy, how often do you recommend we come back?

Dr. Shapiro: That depends on the finding. The standard average of person that comes in at age 50 has a completely normal colonoscopy meeting. Some of the benchmark standards that we look at would not necessarily need to have another one for up to 10 years. That's the low risk group. Like I mentioned, even if they developed a small polyp the next day after the colonoscopy, it would take over 10 years for that to become a large polyp and turn to cancer. So the 10 years should be a safe window. Of course, if they develop symptoms or other things in the meantime…

Tanya: Then there would be an indication to speed it up.

Dr. Shapiro: Correct. Patients that do have polyps identified usually have a 5 year follow up, sometimes 3 years if they have large polyps or certain high risk features or many polyps. The higher risk people based on family history may need every 5 years even with a normal colonoscopy at baseline.

Tanya: Okay that sounds great. Now let's actually demystify this procedure that people are afraid of and start with the prep. You mentioned there's the old things or people may have heard stories and bring us up to date on what is the typical prep. A lot of people say that the prep is worse than the procedure.

Dr. Shapiro: Almost everyone says that the prep is worse than the procedure and it's usually true. The prep, anyway you slice it, the goal is to clean out the colon wall stool. No matter what you do, it's going to produce large volume bowel movement. The standard, like you mentioned, used to be about a gallon jug of liquid laxative the night before. That jug is still available. It's 4 liters. The way that it's being given more commonly because of a better result is actually in split dosing. Instead of drinking the whole thing the night before, it will be split some on the night before and some the morning of, which make it a little bit easier to tolerate at high volume. But also there's several newer smaller volume preps that are now in the market that are a lot easier to drink. A lot less volume and also given in a split dose format.

Tanya: So you get the same result but you don't have the massive of drinking.

Dr. Shapiro: Correct. You won't be drinking as much of the disgusting taste in laxative.

Tanya: Can they make that taste better that is disgusting? I've had my colonoscopy and that stuff is bad.

Dr. Shapiro: Some of the newer ones are more palatable. I don't think any of them are pleasant but the newer ones are definitely easier to tolerate.

Tanya: What about diet prep?

Dr. Shapiro: Again, I would encourage anyone to talk, specifically, about their own prep and their diet recommendation, etc., with their own physician. Generally speaking, at least part of the day before the test would involve a clear liquid diet so that you wouldn't be forming new solids. That would need to be then cleaned out.

Tanya: So you start the morning before you wake up probably with clear liquids and then you'd start your prep depending on what your doctor orders, some the day before and maybe carrying over to the next day.

Dr. Shapiro: Correct.

Tanya: Okay. Are most of these procedures done in an outpatient setting or in the hospital these days?

Dr. Shapiro: Most of them are on the outpatient setting. There's several of what they call Ambulatory Surgery Centers or Endoscopy Suites, where it can be done more efficiently and with less cost than in a hospital setting. Some patients that have other medical conditions would require to be done…

Tanya: Closely monitored, just in case.

Dr. Shapiro: But most people can be safely have a procedure done in an outpatient setting.

Tanya: That sounds good. That makes it way easier both in terms of cost and probably recovery and the whole experience on having to go through admission and everything in a hospital. Let's talk about what happens for the procedure themselves. The patients come in the Endoscopy center or the hospital. And then, what can they expect? What will happen to them?

Dr. Shapiro: At this point, there's probably going to be a fork in the road, depending on what kind of sedation is chosen. The two main kinds that we use these days are: One with anesthesia that delivers a medicine usually propofol, where the patient is completely sedated and is completely asleep, and really is not aware of what's going on. That does require an anesthesia provider to administer that. And the other way is what we call conscious sedation or twilight sedation, where the patient is very sleepy, relaed, and comfortable. They may be aware of some things that are going on but they don't care as much and any pain or discomfort really has the edges taken off by those medicines. So that would be up to the individual provider what they recommend for the individual patient and their practice standards.

Tanya: So, the patient checks in. They're going to have either a conscious sedation or be totally out. And then they start an IV?

Dr. Shapiro: Yes, the IV, they start it first. Both of those kinds of medication are delivered through the IV. Once the medicine is on board and the procedure is clear to start, a small flexible

camera tube is inserted into the rectum and advance all the way around the colon until it meets the appendix and the connection to the small intestine. Those are the 2 landmarks most commonly used to identify complete colonoscopy.

Tanya: And then you just start looking and taking pictures looking for polyps.

Dr. Shapiro: Exactly. The main goal on the way pushing the camera in is to get to those landmarks. Most of the careful exam is done, actually, on what's called the withdrawal, bringing the camera out. The idea is to look closely at all the walls of the colon, clear away residual stools that still maybe there. That way, small and flat polyps can be detected. Perhaps your next question is if the polyp is found.

Tanya: Exactly. Can you do anything while you're there?

Dr. Shapiro: The vast majority of the polyps can be removed at the time of the colonoscopy. If there's a very large or high risk polyp, it may need to be removed with a surgery at a separate time. The vast majority will be taken out by the person performing the colonoscopy at the time of the colonoscopy using a couple of different instruments.

Tanya: What would be large? How would you measure that? What's the break point?

Dr. Shapiro: Most polyps that are identified are going to be less than a centimeter. The ones that are larger than a centimeter are somewhat more high risk and probably would require the patient to come back for a closer follow up. Those usually can be safely removed as well. The large ones, once we start talking about 2 and 3 centimeters, especially if they're flat and covering a lot of surface area, have much higher risk of complications if they're removed at the time of colonoscopy and they may need a separate evaluation.

Tanya: Can you tell by looking at the kind and the measurements of the polyp pre-cancerous? You have to send it out for pathology, of course, anyway, but can you get a pretty good visual?

Dr. Shapiro: We can pretty well tell for the vast majority of polyps if they're really small benign appearing polyps or they start to be larger and potentially could have early cancers detected inside the polyp. Usually, if it's a cancer that has already spread into the rest of the wall of the colon, we can tell that.

Tanya: Those could be invasive in the colon wall.

Dr. Shapiro: Those have certain features where they would not be removed at the time of the colonoscopy. Some of the small benign polyps are what's called hyper plastic polyps which do not generally have pre-cancerous potential. Although there are certain features that may recommend a closer follow up. And then, the other kind is called adenomas, which are still benign, but these are thought to have a potential to turn into cancer. Not all will and certainly the one that was found will not because it was taken out. If those are present that

does increase the risk. That's why we recommend 3-5 year follow up if one of those are identified.

Tanya: Alright. So, the follow up would determine by what you actually find and how extensive it is.

Dr. Shapiro: It may have to wait until that final pathology comes back from the separate pathology report.

Tanya: How long does this procedure take?

Dr. Shapiro: The procedure itself usually takes about 20 or 30 minutes. The rest of the time spent in the office maybe up to an hour and a half to two hours, or possibly longer depending on the practice standards. There's a pre-procedure check in and evaluation, getting the IV and all that set up. Then there's the procedure and there's also the recovery. At least 20-30 minutes of recovery time.

Tanya: What is the post recovery course? Can they go back to work? They can't drive. What are some of the discharge instructions you have?

Dr. Shapiro: It definitely requires taking it easy the rest of the day if the sedation is used. I actually didn't mention that the procedure can be done without any sedation. Mostly a patient may preference that they do want to work that day or they do want to drive that day. If they have a mindset that they may feel discomfort, that's going to be temporary, kind of a gas type pain or cramping and that they're going to get through it. They really can be done without sedation. In other countries have done much more commonly without sedation. But for the vast majority of the people, there'll be no driving, no working, no major life decisions, no alcohol, and that sort of thing the rest of the day. Generally speaking, if everything went smoothly, they should be able to eat right away. Most people are hungry after the procedure because they've been fasting, either with the clear liquid diet the day before and nothing to eat that day up until the procedure. There's no specific restrictions. I just tell patients to eat whatever they feel up to. They may not want to eat a big steak dinner.

Tanya: Don't go to Krystal's. Take it easy on yourself.

Dr. Shapiro: Most people feel pretty normal within the next couple of hours, but they still have restrictions about not being able to drive, etc., because the medicine is still going to be in their system. The following day, after they go to sleep that night, wake up the next morning, they should be back to normal. They can resume all their normal activities, go back to work, and all that stuff.

Tanya: One procedural question I have is: Do you introduce gas? Are people going to have those sharp pains when they get up, like a laparoscopies or something like that, when you do the procedure? Or not really?

Dr. Shapiro: It depends. It's just actually air introduced through the colonoscope to expand the colon in order to get the best look.

Tanya: So you can see better.

Dr. Shapiro: If it's collapsed, there's a lot of fold. It's very difficult to see, so air is introduced. Generally, we do try to take it out as we take the camera back. Almost everyone will have to pass some gas during the recovery time, but usually by end of that 20 or 30 minute recovery period, if they pass enough gas, they shouldn't feel too much gas or bloating. Occasionally, people do for the next couple of hours until they pass out all of the rest of the gas.

Tanya: Can you talk a little bit about risks? Are there risks with the procedure?

Dr. Shapiro: There are risks with any procedure. This particular procedure has some more common risk that we've discussed. One is the risk of the sedation itself and that generally effects the vital signs, either the patient's ability to breathe and get enough oxygen, or it can affect the pulse or blood pressure. Those things are all monitored during the test. Those all can be reversed with additional agents to stop the medication. The other main risk that we talk about are injuring the lining of the colon during the time of the procedure, either just with introducing the camera itself, or with the instruments that we use to remove the polyps, specially with large polyps I talked about. Those generally include bleeding from the polyp's side, especially if the patient was on aspirin or blood thinners beforehand. That would need to be addressed.

Tanya: Do you stitch up there or cauterized up there? If you take the polyps out, how do you close that wound in there?

Dr. Shapiro: If it's a large polyp, cautery can be used at the time when the polyp is removed. That does a good job at preventing bleeding, though there's a small chance of delayed bleeding in those cases. Small polyps usually are removed without any cautery or other intervention, just like pulling off a hang nail. You may see a drop or two of blood. That will clot normally and not have any problems for the most part.

Tanya: Do you have to do any pre-procedure blood work?

Dr. Shapiro: Generally, most patients, no, but they do have to review with their doctor what kind of medicines they're on, specially if they're on blood thinners.

Tanya: Like Coumadin.

Dr. Shapiro: Like Coumadin, Clavex or even Aspirin, or other anti-flammatories can affect the body's ability to clot.

Tanya: So, they have to stop their medicine so many days before the procedure?

Dr. Shapiro: Again, it's individualized. It's all balancing the risks of stopping those medicines if they're required because of heart conditions, etc. They may need to be continued and just accept the slight additional risk of bleeding during the procedure. If the medicines are used for lower risk condition, they can be safely stopped. Generally, they're stopped a week or so before the test, depending on the findings, and how many polyps or large polyps are removed. They can be resumed shortly after the test is complete.

Tanya: What about perforation? Is that another risk?

Dr. Shapiro: Yes, that's another risk that we talk about. Like I mentioned at the beginning, one of the barriers that people have heard stories. Usually that's the stories that they've heard. Perforation means poking or tearing a hole in the colon that would introduce air through the abdomen. In almost all cases, it needs to be fixed by an additional surgery going to the operating room with a general or colorectal surgeon. Either fixing the injured part of the colon or removing the injured part of the colon. Definitely that's a feared concern.

Tanya: How much of a risk is that in terms of percentage?

Dr. Shapiro: It's very small. Overall, nationwide, the risk recorded are about one in a thousand, so it is very small but it does happen even in the best hands it can still happen, maybe why someone has heard of a friend of a friend happens. We think it is a very small risk and would need to be discussed impacting the decision about whether to have a colonoscopy or not, especially someone that does have other medical conditions, or they started to get it at an advance age, where the risk of the procedure may actually outweigh the benefits. But for the general 50 year old that we're talking about, that may have about a 5% lifetime risk of developing colon cancer without screening. That's about a one in twenty risk versus potentially one in a thousand risk of having a complication.

Tanya: It far outweighs the risks. Let's talk about virtual colonoscopy. We talked to the very top of the show about a lot of people may not get it done because it's more invasive. And so, with new imaging techniques, I know a lot of patients out there Googling and trying to see what can be done. We see this heart and lung scans. We see this virtual colonoscopy. Tell us about that and what your opinion is about that.

Dr. Shapiro: Colon cancer screening as a phenomenon does actually have options including colonoscopy which we would be talking more about, but there are other approved methods including testing the stool for blood yearly, limited exam called the sigmoidoscopy, or barium enema, which is an x-ray test that can look at the colon that can find large polyps. If one of those tests is positive and colonoscopy would be required to actually remove the polyps or further investigated. In the last several years, virtual colonoscopy, which is also known as CT colonography, is a type of CAT scan using special software that can format the images that the radiologist looks at to actually make it look like a colonoscopy and see polyps. Those would need to be removed with the actual optical colonoscopy. As the technology improves, those tests are getting very accurate, the virtual

colonoscopies. It maybe the right test for a particular patient. Generally, as gastroenterologists, we just encourage patients to get screened in some form or another. The virtual colonoscopy though does have its limitations. One is that, at this time most insurance companies do not cover it as the primary screening test.

Tanya: Do you think that would change in the future with more experience with the imaging?

Dr. Shapiro: It may. It still remains to be seen. But again, we just encourage patients to get screened and if a polyp is found, we remove it. As long as a well studied accurate screening test is being done, that's really the primary goal, as far as the virtual colonoscopy right now, it still requires the preparation, cleaning the colon out of stool, for most people actually is the worst part of the whole process. It does not involve what we may call the invasive part inserting the colonoscope, with the camera, into the rectum. It actually does involved inserting a tube into the rectum to inflate the colon.

Tanya: So the camera can get a clear picture.

Dr. Shapiro: So that the CAT scanner can get a clear picture of what's going on. It does involve some radiation exposure which is relatively low but can theoretically add up and have its own risk over the years. Since the CAT scanner virtual colonoscopy can detect small and flat polyps as well, we generally recommend a 5 year follow up for a normal virtual colonoscopy. Theoretically, starting at the age of 50, going to next 20 or 30 years, there may be several scans done and radiation exposure at that time. The other part of it is finding something on the CAT scan part of it that's not expected, in another part of the abdomen beside the colon. That maybe a good thing if an incidental cancer or some other organ is identified, also may be the negative if an artifactual abnormality shows up that requires more testing and other biopsies for something that turned out to be benign.

Tanya: You may end up with double test.

Dr. Shapiro: Correct. That's just another individual decision, especially if a patient is on blood thinners like we've talked about. They really would be a high risk.

Tanya: They might be a candidate, or sensitive to anesthesia, or some other indication.

Dr. Shapiro: Correct. With the caveat in mind that, again, if a polyp is found, they would be a candidate of some additional testing to remove the polyp, or a surgery for cancer if something like that is found. An individual discussion with your doctor, theoretically, among the options for colon screening.

Tanya: A new possibility that might be appropriate for some patients.

Dr. Shapiro: Or maybe living in areas in the country where there may not be access to standard traditional colonoscopy that there are in metropolitan areas, like we live in Atlanta.

Tanya: I see. Believe it or not, we're coming to the end of the show. I think we've covered most of why we take the tests, what the standards are, the follow up, and the risks and how it goes, but I know that the patients will remember stories. And so, I always ask the guests. Are there any patients that come to mind that you thought of that are reluctant to have it or you were able to get a clear picture? Or just are memorable?

Dr. Shapiro: I think the patienst that stands out to me are ones that come in for the average routine test. Most of the time they would still have no cancer but sometimes we do find a large polyp that certainly if were left alone almost definitely would have turn into a cancer that would have probably resulted in, at the very least, additional chemotherapy, surgery and potentially result in a death of this person. By coming in and removing that polyp…

Tanya: It saved their life.

Dr. Shapiro: Yes. Occasionally, we have found even large polyps that have very early forms of cancer in them and having those removed even if there's clear margins on polyps stock which we sometimes see that may be all the treatment that they need for that very early cancer.

Tanya: You know that brings up a question we didn't talked about was if you do have to send something out, how long does it take to get results back? Or on most of these tests, can you give the result to the patients when they wake up?

Dr. Shapiro: We can give the result of what we found and then we could say you have 3 small to large polyps. The pathology report is the final answer to that. That may take a week or two, depending on the infrastructure of where the polyp needs to be sent and looked up by the pathologist. Sometimes it's even shorter. It really depends on the process that's in place and what the strategy is for getting back to the patient after the polyp result is available.

Tanya: We always think it's not us. That's the message that you're telling me. You go ahead and have the screening. You hope it's not you but every now and then, you know it is.

Dr. Shapiro: Correct.

Tanya: It may have saved your life.

Dr. Shapiro: Exactly.

Tanya: Very good. I do want to hear a little bit about your practice and where you are and how patients can reach you. Tell us a little bit about Metro Atlanta Gastro.

Dr. Shapiro: We're a small group of Gastroenterologists. There's five outpatient Gastroenterologists like myself and one hospital-based physician. We're on the campus of St. Joseph Hospital. It's called Emory St. Joseph now, right across the street in the Doctor Center. We're easily available to be reached through our office number at 404-255-4333 or our website at metroatlantagastro.com.

Tanya: Do you have an endoscopy center?

Dr. Shapiro: We do.

Tanya: Do you practice so they don't have to go to the hospital? You're all operating in there and do procedures.

Dr. Shapiro: We do a vast majority of procedures in our endoscopy center.

Tanya: I've been there and it's beautiful. You even think that you're in a hospital to all you listeners out there, so there's nothing to be afraid of. It's a very convenient thing when you have your doctor and their facility right next to each other. I think that we're at the end of the show. Anything else you want to comment on about demystifying colonoscopy?

Dr. Shapiro: I think that's about it. We did talk about the lifetime risk for any individual about getting diagnosed with colon cancer in their lifetime and if you add up the population of the United States, in 2013 it was estimated that 143,000 people were diagnosed with colorectal cancer which we kind of lumped together. Because of increased advances in treatment, there's about estimated over a million people living with colon cancer in the United States. Like you said, it's the third most common cancer in men and women and actually the 2nd leading cause of cancer deaths.

Tanya: And one of the big messages today is because it is typically slower growing it is a lot of times preventable if you have your screening. So, if you get nothing out about what we talked today, please get in. You heard the baselines. If there's indication or high risk factors, 45 should be your starting point. For most Americans, you probably get your baseline at 50.

Dr. Shapiro: Correct.

Tanya: Please get in, check yourself out, and stay safe. Thanks for joining us today. Please log on to our sponsor's website at www.healthgate.com to see what savings there are that might be for you. And I think, actually, you'll be putting up some offers on healthgate yourself.

Dr. Shapiro: Hopefully by mid February.

Tanya: Yes, for colonoscopy. There's no excuse not to get in. Have a great day, Atlanta! Warm up. Thanks for joining us.

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