

## **Podcast: Understanding the Needs of Different Patient Populations in CRC**

### **Brought to you by:**

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### **Transcript**

#### **Tonke de Jong (COR2ED)**

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#### **Rahul Gosain**

Hello and welcome back to another episode of the Oncology Brothers as we continue with our GI series. I am Rahul Gosain and along with my brother and co-host Rohit Gosain, today we're going to explore the needs of different patient populations in colorectal cancer. This episode is going to be very special.

#### **Rohit Gosain**

In our clinic, every single patient and family member in that room is seeking hope. With all the data, new treatment options, and potential side effects, we need to tailor our discussion to the patient in front of us, as their needs, pathology, expectations, and what matters to them is different. A lot of this unfortunately gets lost, especially for our patients of colour or other minority backgrounds. Different socio-economic backgrounds also play a major role independently in patient's outcome at large. To focus on these disparities, we are joined by Dr. Tanius Bekaii-Saab, a medical oncologist who is the leader of gastrointestinal program at the Mayo Clinic, and Ms. Deneen Richmond, a patient, a patient advocate, and a nurse by training, and she's also the president of a large community hospital in Maryland. Tony and Deneen, thank you so much for joining us.

#### **Tanius Bekaii-Saab**

Thank you.

**Deneen Richmond**

Glad to be here.

**Rohit Gosain**

Deneen, you wear so many hats, but given our focus today on different patient populations and colorectal cancer, would you be okay to share your recent journey as a patient?

**Deneen Richmond**

Yes, and it is definitely recent, so I can easily talk about it. So there's a date that will be forever etched in my brain, and that is February 15, 2023, when I woke up from a colonoscopy and heard that I had rectal cancer. And the rest of that day was a blur, but you face your humanity, your mortality, and wonder what it's going to be like. So what was it like over the last year? I had chemotherapy, I had radiation therapy, I had surgery, I had more chemotherapy, and then just had my last surgery a little over a month ago to finally put everything back together and make me whole again. And so I'm very pleased to share that at this time, I have no evidence of disease and have moved into that next phase of surveillance, but it has really been a year.

**Rahul Gosain**

Deneen, thank you so much for sharing your personal experience. We're thrilled to hear that you are recovering well. As an oncologist, we have to be mindful of a few factors at play with any cancer diagnoses, including race, ethnicity, age, gender, Rohit brought up socioeconomic status, and studies continue to show poor outcomes in African-Americans, Black Americans, Hispanics, or patients with low socioeconomic status when it comes to colorectal cancer. So it is important for us, and it is important to be cognisant of these outcomes so that we can adapt our approach to these different patients. Tony, from your perspective, what disparities exist in access to colorectal cancer screening and treatments?

**Tanios Bekaii-Saab**

Yeah, and I'm glad to be on the discussion today. And again, the most important aspect of cancer care is preventing it. We can prevent it, that would be best. And I think with colon cancer, colorectal cancer, at least early screening, perhaps some level of prevention, but early screening we know is key to get patients to a potential cure, early cure, or even prevention. And so it's very important to focus on that discussion. As you alluded to, the burden of colorectal cancer varies quite a bit across socioeconomically disadvantaged groups, and it happens that many of these groups are in those racial ethnic groups. So the under, what we call the underrepresented minorities, I mean, it's astounding to see the differences between Blacks and Whites. It's well documented. African-Americans have a higher incidence of colorectal cancer. They tend to have it at a younger age, and they have a higher mortality rate. And a lot of it has to do with the fact that they present later in their diagnosis. They don't have the same access, for many reasons, and we'll go through these reasons, to screening. I think screening overall is problematic across the U.S. and the rest of the world, where only half of the patients actually, or half the population eligible would get their screening. But it's further accentuated when we start looking at underrepresented minorities. I mean, one example is if we look at Asian-Americans, you know, this is the second most common cancer in Asian-Americans. And when you look at the colorectal screening rate in Asian-Americans in the U.S., it's actually the lowest of all groups. So some of this is down to, we think, I mean, when we look at racial disparities, perhaps genetic predisposition, some lifestyle, but I think mostly access to high-quality care for these patients. So, you know, when starting to think about the causes, I mean, let's take, for example, African-Americans, so Black patients. There's definitely a level of distrust in

the system, and that is based on, you know, a historic perspective. And so they present later, and I think this is where it's important for us as healthcare providers to rebuild that trust with our patients, with our African-American Black patients, with all patients, but specifically that group of patients. So they're not coming forward early, they're not getting, for the most, they're not getting, you know, essentially their colonoscopies. Now, there are other factors also in the U.S., you know, insurance coverage can be a barrier, especially, again, for socioeconomically disadvantaged groups. You know, think about it, even, so if you go to someone whose livelihood depends on the hourly work schedule, to ask them to actually lose a whole day of work can mean, you know, bringing bread to the table for their families versus not. If we look at a country such as Canada with universal healthcare, the rate of colonoscopies, actually, or screening is no better than the United States. So I don't like to simplify the discussion and say, well, you know what, we'll just make it, we'll make it just available to everyone. That by itself does not solve the issue. We have to think about everything else, trust, cultural sensitivities. We also have to understand access.

### **Rohit Gosain**

Thank you so much for covering all that. It is extremely important for the points that you raised about socioeconomic status, racial disparities, especially when you gave the example of these young people missing out their work, especially when they are the sole earners of family. So those are important things that we as physicians, as a healthcare system, need to understand and listen to the patients and their needs. Deneen, that was from Tony or from physician or medical standpoint. You're from patient perspective. What do you think some of the challenges around screening for colorectal cancer that we face from patient or patient advocate or even a president from a community practice standpoint?

### **Deneen Richmond**

Sure. So I think that it's a topic, you know, when we think about what people are comfortable talking about, not everyone, if you don't have that relationship with a provider, you're not going to necessarily be comfortable going into an appointment and talking about changes in your bowel habits or seeing blood in your stool or, you know, all of those other symptoms that we know people may experience, but there's stigma. We just don't go around talking about our bowel habits. I think that that is a barrier. I also think, and I've talked to many other folks who will say, you know, there's a lot of mystery, I would put it, around colonoscopies and people just not understanding, you know, they think it's going to be painful or, you know, just not understanding what's involved in having that type of procedure. And, you know, as I say to people, look, the most uncomfortable thing is going to be the prep the day before that you're going to have to get through, but, you know, you're not going to have pain during the procedure. You won't even be aware that you've had the procedure and afterwards there's no pain, but that's not widely understood by people. So I think that is another barrier that stops people from moving forward. And then I think it's just trust and being heard. I mean, I think particularly in communities of colour, that is a big barrier around not just screening for colorectal cancer, but around accessing and getting good quality health, you know, culturally sensitive healthcare as a whole. So if your voice isn't heard, you know, in my situation, you know, I had had my screening colonoscopy and everything was fine. And then I had some symptoms years following that, several years following that. And I was originally, I think appropriately so, being treated for haemorrhoids, but it got to a point where I knew that something else was going on in my body.

### **Rahul Gosain**

Deneen, thank you so much for bringing all that. A few things to dissect. One, educating patients around the procedure, I think is so important. As a physician, Tony, Rohit and I can talk about it, but I

would think that patients want to hear from patients. That's why these conversations are so important. Otherwise, it's a biased opinion saying, oh, go get your screening colonoscopy when it's coming from your medical oncologist. And again, the other thing that you brought up is at times patients bringing up something and that's not taken seriously, that ends up being more profound, again, in patients of colour or with low socioeconomic status. There are data out there supporting that. So taking a step back as a medical oncologist, we need to be more mindful of addressing each and every patient concern and making sure we're mindful of what the long-term outcomes can be.

### **Deneen Richmond**

It's so important when we talk about building that trusting relationship, that we don't discount what someone is sharing. It may be totally irrational, but to them it's real. And if it's discounted or not acknowledged and addressed, if it's a myth or misperception, address it in plain English, not with a lot of medical jargon, but allow that person to be able to be heard and get answers to the questions that they may have.

### **Rahul Gosain**

Oh, absolutely. Educating around that is important. One thing that we get pushback is around the time that we have to spend either through EMRs or face-to-face with patients, but all this is very important. Tony, hearing all these concerns, a million-dollar question ends up being, we're seeing an alarming trend of colorectal cancer in young patient population. Again, you brought up some stats for African-American or Black Americans having a high-risk disease or greater mortality. What are some effective strategies we can consider to educate or raise awareness about colorectal cancer within these different communities?

### **Tanios Bekaii-Saab**

Yeah. One other dimension that I think we need to add, we are a multi-ethnic country, a melting pot, and language can be a barrier for many of our communities. I think about the Hispanics, Hispanic non-whites specifically, but Hispanics overall, that certainly to reach them, in addition to be culturally sensitive, language can be a significant barrier, but also to bring the issues of trust and others. Overall, I think bringing awareness is a very complex and multiple issues, but we have to hit all these points to bring awareness. But, as you brought up, one of the biggest concerns we have today is what we call an epidemic of younger patients with cancer, and specifically with colorectal cancer. Many reasons for that, we think, although none of that at this point of time has been documented clearly. There are hypotheses, is it the microbiome, lifestyle changes, but it does seem to hit even at a higher rate Blacks, African-Americans. And so, although at this point of time, the age for your first colonoscopy for normal, for average risk is 45 [in the US], many times we advocate for African-Americans actually a lower age, screening perhaps 40. So, I think education is important, and again, keeping in mind the cultural sensitivities, the trust issues, access issues, meeting patients where they're at, and raising awareness about colorectal cancer within all, and I say all, our communities. You know, we have to remove that stigma, that myth that the screening procedures is invasive. There are alternative options as well, but I still think colonoscopy is the gold standard. Now, that said, you know, there's data that supports FlexSig and FOBT stool tests. So, we have to make sure to emphasize, you know, the points that for all patients, that colorectal cancer is preventable, and if caught early, not only it's treatable, but curable. Our best chance at a cure is for it to be caught early. It's also very important to, you know, focus on families. So, with African-Americans and with others going to churches, going to places of worship, I mean, this is where you can talk actually more openly, and we have, again, to be culturally sensitive. Like you said, I don't want the oncologist to go talk to people about screening. I want to make sure that I'm one of many voices, but the voice that's closest to the community, that's closest to understanding the disease, is probably the best motivator,

including touching their families, right? I mean, we all know that the spouse, a loved one, is going to say, “you better go get that colonoscopy”. So, we want to talk to everyone, not just to the person. You know, being healthy is great. You want to continue being healthy and live a long life. So, being healthy and feeling relatively good does not replace the need for screening. I do think also that we need to educate, that's on us, you know, many of our colleagues.

### **Rohit Gosain**

Thank you so much to talk about the awareness and education aspect of it. Rahul and I very well know that because it took us forever to sort of tell our parents and get that across and have their colonoscopy done because, again, that education is certainly lacking. So, Deneen, from your perspective as a president of a community hospital and also a patient advocate, your thoughts on how we can raise awareness and also build trust with different patient groups?

### **Deneen Richmond**

So, I think that we have to use multiple different strategies and voices to raise awareness and build trust. And it makes me think about some strategies that we used just a few short years ago when we were all trying to convince everyone of the benefits of getting vaccinated against COVID. And we all know that there was lots of mistrust in communities, particularly communities of colour, yet those were the very communities, at least in my geographic area, where we were seeing the highest number of rates, hospitalisations, and deaths. So, part of our strategy, and we've leveraged this in other ways since then, and I talked to other community groups about this, is, you know, using trusted voices. So, educating people, you know, sometimes we talk about people who have lived experience in the community, but using people who are trusted already in that community. So, it was already brought up about churches and the faith-based communities. So, we had one of the, you know, prominent pastors in our community come to our hospital, get his vaccine, videotape it, talk about it. You know, he was all over social media. And so, I think that that strategy of trusted voices, you know, we went into barbershops and beauty salons, you know, gave them basic education and training, and then use them to talk to their clients that are sitting in their chairs getting their hair done. So, I think that that is a strategy, you know, that I think we really need to think about. I think that we also have to, you know, starting very young, educate people about different aspects of health, including, you know, what things to be, to watch out for, what things to make sure you talk to your doctor about. Don't be embarrassed about it. Don't be worried about what they're going to think about you if you go in and say, I have blood in my stool or whatever symptom you might be having. So, having those conversations, and then I love the thought of, you know, leveraging families. You know, that's why I share my experience of what it's like to get a colonoscopy. So, I think we just got to think about all of those ways that we really think about our health care extenders. And these are folks who, you know, haven't gone through formal training, but really can be some of our biggest health advocates with their circle, their network, their circle of friends and family, and even beyond that out in our communities.

### **Rahul Gosain**

Deneen, thank you so much for sharing those ideas. Okay, so far we've focused on screening and getting the diagnoses. So, let's say we have made the diagnoses. Tony, does age play a role in selecting a treatment option here?

### **Tanios Bekaii-Saab**

The short answer is in the absolute sense, no. Overall, colorectal cancer isn't just a disease of the elderly. But overall, in terms of treatment options, in terms of the genomic genetic composition of the cancer, for most patients, it is not dependent on a gender or age. And treatments are more

tailored to the drivers of the cancer. Now, that said, you know, it is often a misconception that because someone has an inherited risk for cancer, they will present at a younger age. The reality is, actually, most patients with an inherited risk present at a later age. Now, when we think about younger patients, we tend to be a little bit more aggressive. And when I say younger patients, that's younger than 70 or 75. A healthy 75 can withstand, again, in measured ways, aggressive treatment when indicated and if indicated and if the patient is able to. So, again, using age is with caution. Now, someone older than 75, we have to be very careful about, you know, more aggressive chemotherapy. I'm thinking about triplets, perhaps, or even EGFR inhibitors and others. I mean, we have data consistently now suggesting that, you know, someone older than 75 may not benefit, and perhaps we'll see more toxicities from a doublet versus a single agent chemotherapy. So, in some ways, you know, age may play a role, especially when it comes to the chemotherapy. When it comes to biologic and biologic targets, not as much. These are tailored, and hopefully, as we move away more and more from chemotherapy, although it's not going away, we move away from extended periods of chemotherapy, you know, then we'll have actually more and more access to better targeted or immunotherapeutic agents. But, again, age, in that sense, does not alter the composition of the tumour as much.

**Rohit Gosain**

Well, we are nearing the end. Tony, any last thought for our listeners on understanding the needs of different patients in colorectal cancer?

**Tanios Bekaii-Saab**

Yeah, no, I think we really have to keep on hammering the notion that it's not just colorectal cancer, all cancer, but specifically colorectal cancer, is not just a disease of the elderly. And I think, you know, we have to bring this awareness and the importance of appreciating, you know, what symptoms to look for. So, we need to remember that also that patients overall are working, juggling family commitments. So, for the younger patients, when they get diagnosed, when they go through their surgery, when they go through their treatment, there's a lot of gaps in their employment, there's a lot of gaps in supporting their families. And oftentimes, frankly, a lot of younger patients are reluctant, especially, again, from underrepresented minorities, are reluctant to get a colonoscopy because I'd rather not know about it. So, I think overall, education, improving access to screening programs, and part of education is essentially, you know, removing some of the stereotypes around the risks of colonoscopy. So, we have to find different allies from the community, from our own community of physicians, but mostly from the community that represent all these patients. Culturally sensitive, language sensitive, and be able to rely on bringing this information closer to home.

**Rohit Gosain**

Thanks so much for covering all the points there, Tony. Deneen, your thoughts as a patient, patient advocate, and a healthcare executive on how we can continue to do better?

**Deneen Richmond**

So, I would say from a patient perspective, starting there, you know, listen to your body, recognise that you know your body, your symptoms, what feels right and what doesn't better than anyone else. Speak up. Don't be afraid. There's nothing that you're going to tell a doctor or any other healthcare provider that's going to be, that they're going to look at you a certain way or that's embarrassing. They need to know exactly what's going on so that they can diagnose and treat you appropriately. And then, I think that on the, you know, on the provider side, whether it's on the direct clinician side or even on the administrative side, you know, we all have to commit to, one, acknowledging that these disparities that we've talked about today exist and be willing to be part of the solution. And

sometimes the solutions aren't easy and sometimes the solutions aren't totally in our own control, but we can collaborate and partner with others. We can collaborate and partner with our patients and really make a difference because, you know, I hope that a year from now, five years from now, ten years from now, that we aren't having these same conversations around, you know, differences and outcomes because we're talking about someone's human life. That's really what it all comes down to at the end of the day.

**Rohit Gosain**

Thank you, Deneen and Tony. Thank you so much for joining us today and raising awareness and education about this very important topic. Deneen, we all wish you the best with ongoing surveillance and your journey ahead. Thank you for our listeners to tuning in. Thank you.

**Tonke de Jong**

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