

OPTIONS

News on Cancer Research and Therapy

Colon Cancer: Issue 2

Communication and Connection Is the Key To Maintaining Control In Colon Cancer

Colon cancer is an insidious disease. It usually advances without warning signs or symptoms. Its victims can be anyone, perhaps a 61-year-old grandmother, someone in great health, with no risk factors for the disease. A jogger, a cyclist, an athlete. Someone you know. Someone like Gail Imig.

It is an understatement to say that her diagnosis of colon cancer came as a great surprise. There was no history of the malignancy in her family, and she ate all of the right foods and kept herself in great shape. But when her sister developed pancreatic cancer, Imig's physician thought she should undergo a complete gastrointestinal work-up. She got the bad news following the colonoscopy. She was now a colon cancer patient.

"I didn't know very much about colon cancer when I was told they found a tumor," Imig remembered. "So I tried to learn as much as I could as quickly as possible."

That's the best way new cancer patients can begin to take control of their disease: gather as much accurate

information as possible. "I started reading right away," said the Michigan resident, a program director for the Kellogg Foundation. "I looked at books and web sites, I asked around town to find out who were the best doctors and surgeons." The growing

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New Combination Therapy Improves Survival as Second-Line Treatment for Metastatic Colon Cancer

The combination of the novel biological drug bevacizumab (Avastin) and FOLFOX (5-fluorouracil [Adrucil]/leucovorin [Wellcovorin]/oxaliplatin [Eloxatin]) were paired in a key clinical trial (E3200) conducted by the Eastern Cooperative Oncology Group. Final results, which were presented in January at a gastrointestinal cancers symposium, show that the combination improved survival in colorectal cancer patients whose disease had progressed following first-line (initial) chemotherapy. Adding bevacizumab to combination chemotherapy significantly increased the length of survival, compared with those who receive only chemotherapy. More good news was that the combination was well-tolerated, according to researcher Bruce J. Giantonio, MD, of the University of Pennsylvania Medical School. While some patients experienced high blood pressure, bleeding, and numbness and pain in their extremities, these side effects were expected by the researchers and were treatable. Thus, in addition to its role as a valuable supplement to initial chemotherapy combinations using 5-fluorouracil, bevacizumab appears to be effective as part of a second-line (chemotherapy given after first-line or initial chemotherapy is no longer working) combination with FOLFOX.

As a biological drug, bevacizumab works by interrupting the action of a protein that is critical to the process of building new blood vessels. Without a source of blood, cancer cells cannot survive. Bevacizumab also alters the structure of blood vessels, allowing chemotherapy to be more effective. For these reasons, physicians have great hope for the drug in a number of different cancers.

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Research Advocacy Network

Advancing Patient-Focused Research

Communication and Connection Is the Key To Maintaining Control In Colon Cancer

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pile of information, which included details about different treatments and side effects, as well as the availability of potential clinical trials, helped her get a handle on the disease. Getting in touch with colon cancer survivors through support groups and personal contact gave her strength by reminding her that she wasn't alone, that a cancer diagnosis didn't mean she was about to die.

"One of the things I found out was that surgeons should be as aggressive as possible," Imig pointed out. It is only by removing the affected portion of the colon and a sufficient number of lymph nodes that physicians can be certain that a patient has been surgically "cured." The bad news is that Imig discovered this important step following her surgery. The good news is that her surgeons knew what they were doing, and the operation was a success. "We never discussed the need for aggressive surgery beforehand," she said, "and we should have."

As any coach will tell you, the ball club that is best prepared is going to win 95 percent of the time. That old sports cliché is also true in the fight against cancer. Put together the best team you can find with as many experts as you can identify. "Seek out the best doctors, go to the best hospitals, find the best advice you can," Imig said. There are a number of excellent support and advocacy groups for colon cancer that can provide of wealth of information and contacts (see "Organizations that offer information and resources for colon cancer patients, their families, and caregivers," page 7). "Don't be afraid to get a second opinion," she added. "Not all doctors agree. There are pros and cons to the different chemotherapies."

Ask The Right Questions

So, too, not all doctors rank at the head of their class when it comes to bedside communication. Some physicians, Imig stressed, are excellent at talking to patients, sitting down with them to work through all of their concerns and fears. "The best can give you a sense of confidence," she added. "When I first went to see my doctor I was terrified. But by asking the right questions, I was able to move forward with some optimism."

What are some of those questions? The most important ones revolve around the patient's diagnosis and treatment options, said Michael J. O'Connell, MD, associate chairman of the National Surgical Adjuvant Breast and Bowel Project. "Patients should seek a careful explanation of exactly what their diagnosis is and how it was made," he said. "They should ask if the physician is truly certain it is cancer, and if so, is it localized or has it spread. Is it amenable to curative surgery or if not, how can the disease best be controlled?" Patients also should learn about treatment options. If they do have surgery, O'Connell said, they will be happy to learn that very few colon cancer patients will require a colostomy (an artificial opening from the colon to aid in bowel movements).

Patients also should ask themselves an important question, he added. Are they comfortable with their medical team and institution? If not, they may want to seek a second opinion. And when looking into support groups, patients should ask for their own "navigator," O'Connell said, someone who already has made the colon cancer journey and can help steer a new patient through the system. Such an

individual can serve as an educational consultant, a source of information, and even as an inspirational role model.

"Patients need to keep open the channels of communication," O'Connell stressed. Even though this advice is true for patients with a wide range of disease conditions, it is especially true for those with colon cancer. Patients need to inform their doctors of any problems or side effects of chemotherapy, particularly diarrhea or other changes in bowel habits (see "Patients should recognize and report diarrhea early while on chemotherapy," page 6) and signs of infection, because these problems can lead to serious, even life-threatening complications. In colon cancer as in so much else in life, maintaining a dialogue is often the secret to establishing control.

Although Imig stresses that she has been lucky so far, she also knows her disease could possibly have been prevented if she had observed a regular screening schedule. "Today, I tell everyone I know, and even some that I don't know so well, to get a colonoscopy now," she stressed. "It does not matter if you think you are at low risk. I did, and here I am."

Through it all, Imig remains upbeat. She knows that cancer can appear terribly frightening and can bring despair to even the hardiest of souls. "When people hear the 'C' word, they think that they've been given a death sentence," she said. "That's simply not true. Cancer can be managed. You can live a long healthy life. Help is available; you've only got to seek it out. Accept the support of others. You'd be amazed at how friends and family will help you connect." ■

What the Studies Mean: New Findings Show Biologics Offer Added Treatment Options

The recent introduction of 2 biological drugs, bevacizumab (Avastin) and cetuximab (Erbix), gives physicians and patients new options to treat colorectal cancer. (Biologics are designed to attack a specific target in the cell.) At present, bevacizumab is approved for use in combination with the first course of chemotherapy for metastatic (cancer that has spread to other parts of the body) disease and with cetuximab for the second or third round of drug treatment.

The Role of Bevacizumab

Bevacizumab is a new treatment that blocks a protein known as vascular endothelial growth factor (VEGF). This protein is necessary for the creation of new blood vessels, a process known as angiogenesis. Tumors need a blood supply in order to continue to grow; cutting off their ability to make new blood vessels can cause tumor cells to die. Bevacizumab also changes the structure of blood

vessels within tumors, and this action may increase the amount of chemotherapy that reaches cancer cells. These actions may contribute to the findings of a major study with 5FU (Adrucil) or 5FU and irinotecan (Camptosar), which showed that the addition of bevacizumab to chemotherapy produces a significant improvement in length of survival in patients with metastatic colorectal cancer who had not received prior drug treatment.

In the study, patients were given irinotecan, 5-FU, and leucovorin (Wellcovorin), a drug regimen known as IFL, plus bevacizumab or IFL plus placebo. Patients who received bevacizumab along with chemotherapy lived longer than those who received only chemotherapy. Some patients who received bevacizumab developed high blood pressure, but physicians said this problem was treatable. A small percentage of patients developed perforations (holes) in their intestinal tract, others had bleeding or

difficulty with wound healing. Recently, the makers of bevacizumab (Avastin) have warned doctors and patients that there is an increased risk of blood clots in the arteries, heart attacks, strokes, and chest pain. These problems were more common in patients over 65. It is important to remember that all drugs can cause side effects. Talk with your doctor about the potential benefits and risks of treatment before taking a drug.

“The improvements afforded by the addition of bevacizumab to IFL suggest that blocking VEGF may be broadly applicable to the treatment of colorectal cancer,” said Herbert Hurwitz, MD, Duke University Medical Center, Durham, NC who headed the study. “These results indicate that bevacizumab plus fluorouracil-based chemotherapy should be considered a new option for the treatment of metastatic colorectal cancer.”

It must be pointed out that this trial used IFL as the chemotherapy combination of choice - at that time, it was the standard treatment for metastatic disease. However, the FDA has approved bevacizumab in any chemotherapy combination using 5FU. This includes FOLFOX (5FU, leucovorin, oxaliplatin) and FOLFIRI (5FU, leucovorin, irinotecan). Both FOLFOX and FOLFIRI use a continuous infusion of 5FU, given over 1 or 2 days rather than the bolus (shot) injection that is used with the IFL regimen. Continuous infusion 5FU has fewer side effects and has replaced IFL as the preferred chemotherapy method. In some special cases, patients will also receive bevacizumab with 5FU and leucovorin alone. Each regimen has its own set of

Avastin (Bevacizumab) Improves Survival When Added to FOLFOX as Second-Line Treatment for Metastatic Colon Cancer

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One disappointing finding of the E3200 trial was that the use of bevacizumab alone was not as beneficial as FOLFOX alone or FOLFOX with bevacizumab. The scientists monitoring the trial stopped testing that particular regimen because the initial results indicated that patients who were given bevacizumab without FOLFOX were likely to have poorer rates of survival. The full

results of studies of bevacizumab will be available soon. Still, the E3200 trial confirms that “a biological agent that targets a tumor’s blood supply can prolong survival when combined with chemotherapy, even for patients who have previously received treatment for advanced disease,” said Andrew C. Eschenbach, MD, director of the National Cancer Institute. ■

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What the Studies Mean: New Findings Show Biologics Offer Added Treatment Options

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side effects. When deciding on the first-line treatment plan for metastatic colorectal cancer, patients and doctors should discuss which chemotherapy regimen is best for them and whether adding bevacizumab is a good choice.

Cetuximab a Potential First-Line Therapy?

There also is emerging evidence that the addition of cetuximab to FOLFIRI may be safe and active as treatment for metastatic colorectal cancer. Cetuximab is a type of genetically-engineered therapy known as a monoclonal antibody. It works by specifically targeting a cellular receptor for epidermal growth factor, a protein that plays a role in regulating cell growth. Although the new study was small, the combination of cetuximab with 2 different FOLFIRI regimens (low-dose or high-dose 5FU) did not cause any of the low-dose patients to terminate treatment because they were not able to

tolerate the drugs. Only a small number of patients receiving a higher dose of 5FU were forced to stop their chemotherapy because of excessive side effects. The early results also suggest the combination may be effective in slowing down the progression of the disease. As of now the combination of cetuximab with either oxaliplatin or irinotecan has not been fully studied so physicians do not have complete safety and efficacy data as they do for 5FU infusion schedules. Larger studies are planned for the future to gather more comprehensive data and determine if there is an increase in the length of time patients live by adding cetuximab. At present time cetuximab for initial therapy is not recommended outside of a clinical trial.

Current Chemotherapy Options for Colorectal Cancer

FOLFOX and FOLFIRI continue to be the mainstays of treatment. There

are studies that are trying to determine if FOLFOX is better than FOLFIRI. The multinational MOSAIC trial, which evaluated the benefit of adjuvant FOLFOX in patients with surgically resected stage II or III colon cancer found that after 3 years of follow-up, FOLFOX patients survived longer, compared with patients treated with 5FU and leucovorin. FOLFOX also was well tolerated overall and did not cause an increase in deaths. Some critics of the trial have countered that even though disease-free survival improved after 3 years, a more important indicator of cancer drug success, overall survival (OS), did not. Additional trials investigating the use of FOLFOX, with and without bevacizumab, and comparing FOLFOX and FOLFIRI in various combinations with cetuximab, bevacizumab, or both, will also help reveal the future course of chemotherapy in adjuvant treatment for early stages of colon cancer. ■

High-Risk Stage II Colon Cancer Patients Might Want to Consider Adjuvant Chemotherapy: Panel

If you are a patient with stage II colon cancer, should you receive adjuvant chemotherapy following surgery? For patients with stage III disease, the decision is simpler; for more than ten years, experts have recommended chemotherapy after surgery for stage III patients who have no other serious health problem. Clinical trial results have shown that they are more likely to survive more than 5 years and less likely to have their cancer return. However, the evidence is far less clear

for stage II patients, largely because too few people with stage II cancer were included in the important clinical trials to know for certain whether adjuvant therapy is helpful. As a consequence, the question has been mired in controversy for many years.

In 2004, a panel of international experts was convened to help physicians and patients answer this key clinical question. Under the direction of co-chairs Al B. Benson III, MD, Northwestern University Feinberg

School of Medicine and The Robert H. Lurie Comprehensive Cancer Center, Chicago, IL, and Daniel G. Haller, MD, University of Pennsylvania Cancer Center, Philadelphia, PA, the panel attempted to determine (1) whether all medically-fit patients who have received successful surgery for stage II colon cancer should be offered adjuvant chemotherapy as part of routine practice, and (2) if adjuvant treatment makes sense for high-risk patients with a poor prognosis. After a thorough review of all

of the relevant studies, the panel decided that:

- The routine use of adjuvant chemotherapy for medically-fit stage II colon cancer patients is not recommended.
- For stage II patients at high risk, with a poor prognosis, or an inadequate sampling of nodes, there is no clear evidence from clinical studies that chemotherapy treatment enhances survival for stage II patients. Nevertheless, patients and physicians should discuss the treatment option before ruling it out.

Routine Use Unnecessary

Even though the benefits of adjuvant chemotherapy are clear for patients with stage III colon cancer, there is still no firm consensus among physicians that treatment enhances survival in stage II colon cancer.

This lack of consensus is largely due to the relatively good prognosis for stage II patients after surgery alone. As a result, it is difficult to conduct clinical trials with several thousand patients to show a small improvement in survival. Although the panel pointed out there was a small improvement in disease-free

survival with adjuvant chemotherapy, this improvement was not statistically significant. For healthy patients whose cancer has been surgically removed and who are not at high risk of recurrence, the risks of serious side effects may outweigh the potential benefits.

Patients at high risk present a different picture, however. Those who had fewer than 13 lymph nodes removed and tested may still have tiny, undetected tumors and could possibly be helped by adjuvant therapy. In general, the greater the number of

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The Clinical Trials Option...And You

Ever wonder how your doctor knows a particular drug will work for you? Clinical trials are the answer. Before any new drug or drug combination, imaging system, surgical technique, or vaccine is available in your doctor's office or cancer center, it must undergo a rigorous process of testing to meet the highest scientific standards of effectiveness and safety. Both the government and the pharmaceutical companies developing the new product oversee the process, which typically requires 3 stages of testing in humans, known as "phases," before a panel of experts meets to analyze the data and make a recommendation to the Food and Drug Administration (FDA). Only after all of this work is done—and the entire process can last a decade or more and cost upwards of \$800 million—will the FDA make its final decision to grant or deny approval.

While all clinical trials are valuable, they are particularly important in cancer. In Phase III trials new drugs and new combinations are compared with a standard therapy—for example IFL plus bevacizumab versus IFL alone. Comparing treatments in well-controlled research settings enables doctors and patients to know which drugs or regimens work better for the average patient. Unfortunately, clinical trials for cancer are difficult to complete because many patients are unaware of this option for care.

Of course, no clinical trial is free of risk. But participants receive many benefits as well. Participants may receive new treatments that are otherwise unavailable. Patients who volunteer for clinical trial also contribute to finding new treatments that may help future patients.

Before you begin treatment, talk to your physician to see if any current clinical trials are right for you. A few current adjuvant trials for early stages of colon cancer include:

- Fluorouracil, Leucovorin, and Oxaliplatin With or Without Bevacizumab in Treating Patients Who Have Undergone Surgery for Stage II or Stage III Colon Cancer
- Comparison of Adjuvant Combination Chemotherapy Regimens With or Without Cetuximab in Treating Patients With Resected Stage III Colon Cancer
- Adjuvant Oxaliplatin and Capecitabine Compared With Fluorouracil and Leucovorin in Treating Chemotherapy-Naïve (Not Previously Treated) Patients Who Have Undergone Resection for Stage III Colon Cancer

You can find information about the above trials at <http://cancer.gov>. You will also find information about many other trials, including studies for metastatic disease, prevention and symptom control. If you do not have access to a computer, you can call 1-800-4-CANCER to discuss possible trials that meet your needs. ■

High-Risk Stage II Colon Cancer Patients Might Want to Consider Adjuvant Chemotherapy: Panel

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analyzed lymph nodes, the more confident physicians and patients can be that the patient has been staged correctly. (The stage – I, II, III, and IV – of colon cancer plays an important role in determining the best treatment.) The number of removed nodes also is prognostic (an indicator of the future course of disease).

There are other features that also predict whether a patient will have a poor prognosis. These include the presence of T4 lesions (those that adhere to or invade local organs or whose lesions extend through the wall of the colon into the body cavity), tearing of the colon at the tumor site, involvement of the nearby lymph

system or blood vessels, or tumors that seem likely to metastasize. Patients who have these risk factors also should give consideration to receiving adjuvant chemotherapy.

Based on what is known about the effectiveness of treatment in stage III colon cancer, the possibility that adjuvant chemotherapy would not provide a similar benefit in stage II disease seems difficult to believe from a biological perspective, Benson and Haller said. Even though evidence of a benefit was lacking, high-risk patients and oncologists prepared to act on the other findings—the results of stage III trials—are justified in considering treatment, if they recog-

nize that the survival benefit is not large, they added. (Note: the QUASAR study has since provided evidence that survival was improved with adjuvant chemotherapy in stage II colon cancer. Patients should ask for a complete discussion of currently available information that would inform them on the risks and benefits of adjuvant chemotherapy for stage II colon cancer)

In making this choice, the panel stressed, patients must be included in the decision-making process. Physicians must provide all of the information necessary for cancer patients to decide whether to begin chemotherapy treatment or not. ■

Patients Should Recognize and Report Diarrhea Early While on Chemotherapy

Diarrhea is one of the most serious complications of colon cancer chemotherapy. Between 50 to 80 % of all patients will experience some form of diarrhea, especially when they are taking irinotecan (Camp-*tosar*), alone or in combination. As many as 33% of patients may have more serious forms of diarrhea, which can result in severe dehydration. Even more troubling, is the risk of death due to the loss of fluids and electrolytes, and the kidney and heart problems that follow.

In 2003–4, a panel of experts led by Al B. Benson III, MD, Northwestern University Feinberg School of Medicine and The Robert H. Lurie Comprehensive Cancer Center, Chicago, IL, updated the current standards to include all of latest developments in colon cancer research. These experts recommend that patients

should be monitored vigilantly and treated aggressively, especially when they have early warning signs of severe complications. Patients can help

themselves by contacting their physicians immediately at the first signs of a problem. In so doing, both physicians and patients can help reduce the risk

About the Research Advocacy Network

The patient advocacy movement has changed the face of research. Patient advocates have provided invaluable input into medical research. The mission of the Research Advocacy Network (RAN) is to develop a network of advocates and researchers who can influence medical research from concept to patient care through education, support, and collaborations. One of the most important aspects of the research process is moving research results into clinical practice. RAN works to accomplish this goal in several ways: Fact Sheets were created to explain the results of clinical research to patients making treatment decisions, Network News, an e-newsletter, is published monthly and covers a variety of topics, including describing research results and tools for advocates; and this newsletter and its companion for health care providers, *UpDate*.

For more information, visit the RAN Web site at www.researchadvocacy.org or call 1-877-276-2187.

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of serious illness or death due to diarrhea stemming from cancer therapy.

What are the most significant new research findings related to this debilitating side effect? The panel pointed to 4 main issues:

- **The risk of death associated with IFL.** Several patients in 2 recent government-sponsored clinical

trials died because of gastrointestinal side effects related to treatment with IFL. An independent panel of reviewers recommended more vigilance in monitoring symptoms, especially diarrhea, in patients receiving this chemotherapy regimen or any regimen that carries a potential significant risk of diarrhea. Physicians should monitor

gastrointestinal side effects every week, particularly in older patients.

- **The best dose of octreotide.** Loperamide (Imodium) is a standard treatment to control diarrhea. However, some patients do not respond well to the drug. For those patients, there is evidence that a high dose of

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Drug Names

Newly diagnosed colon cancer patients are faced with what can seem like an overwhelming amount of information, including the names of the drugs used to treat the disease. All drugs have more than one name, which can cause confusion. The generic name is the name given the drug before it has Food and Drug Administration (FDA) approval. Some drugs are referred to by a type of shorthand (eg, fluorouracil–5FU). Once the drug is approved, the developer and manufacturer select a brand name.

Researchers have found that using a combination (or cocktail) of drugs, has better results than using only one drug. These combinations are called regimens and are usually referred to by letters that indicate the drugs that are used (example: FOLFOX).

Drugs for treating colon cancer

Generic Name	Brand Name
Fluorouracil (5FU)	Adrucil
Leucovorin	Wellcovorin
Irinotecan (CPT-11)	Camptosar
Capecitabine	Xeloda
Oxaliplatin	Eloxatin
Cetuximab (C225)	Eribux
Bevacizumab	Avastin

Combinations of drugs to treat colon cancer

Regimen Name	Drugs in Regimen
FOLFIRI	Infusional 5FU, Leucovorin, Irinotecan
FOLFOX	5FU, Leucovorin, Oxaliplatin
IFL	Irinotecan, bolus 5FU, Leucovorin
XELIRI/CAPEIRI	Xeloda, Irinotecan/Capecitabine, Irinotecan
XELOX/ CAPEOX	Xeloda, Oxaliplatin/Capecitabine, Oxaliplatin

Drugs for treating diarrhea

Loperamide	Imodium
Octreotide	Sandostatin

*Bolus—a dose of the drug given all at once in the vein (shot)

**Infusion—drug given over a period of time in the vein (or IV)

Organizations that offer information and resources for colon cancer patients, their families and caregivers:

	Phone	Website
American Cancer Society	1.800.ACS.2345	www.cancer.org
Colon Cancer Coalition	1.202.244.2906	www.c-three.org
Colon Cancer Alliance	1.877.422.2030	www.ccalliance.org
Colorectal Cancer Network	1.301.897.1500	www.colorectal-cancer.net
Cancer Care	1.800.813.HOPE	www.cancercare.org
Cancer Research and Prevention Foundation	1.800.227.2732	www.preventcancer.org
Hereditary Colon Cancer Association	1.800.264.6783	www.hereditarycc.org
National Colorectal Cancer Research Alliance	1.818.760.7722	www.nccra.org
STOP Colon/Rectal Cancer Foundation	1.312.782.4828	www.coloncancerprevention.org
The Wellness Community	1.888.793.WELL	www.thewellnesscommunity.org

Chemotherapy Patients Should Recognize and Report Diarrhea Early

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an alternative drug, octreotide (Sandostatin) given 3 times a day may be more effective than the more common low-dose drug regimen.

- **The role of preventive therapy in patients receiving irinotecan.** To date, the results of studies to find an effective medicine to prevent the onset of diarrhea have been mixed, although a long-acting formulation of octreotide shows early promise. Further research will be necessary to fully evaluate whether it will be possible to use drug therapy as a diarrhea preventative.
- **Diarrhea induced by radiation therapy.** Some patients develop diarrhea after receiving radiation therapy. Unfortunately, at present there does not appear to be an effective way to prevent this com-

plication. Current studies using octreotide are now underway to see if this drug will be effective.

Based upon this new information, the expert panel made the following recommendations:

- Physicians, with input from patients, should rigorously assess all of their patients for symptoms and classify them as either “uncomplicated” or “complicated.”
- Complicated diarrhea includes any of the following problems:
 - 7 or more stools a day, incontinence, or a severe increase in loose, watery output in those with colostomies.
 - nausea and vomiting accompanying loose stools
 - abdominal cramping
 - severe loss of appetite
 - bleeding
 - fever
- Complicated cases should be managed aggressively. Among the treatments your doctor may prescribe are intravenous fluids for dehydration, octreotide until the diarrhea is gone, and oral antibiotics to prevent infection.
- For those who have uncomplicated, mild to moderate diarrhea (an increase of 4 to 6 stools a day or mild to moderate increase in colostomy output), dietary modifications (e.g., eliminating all milk products; eating small meals and foods such as bananas, applesauce, toast, or plain pasta; and drinking at least 8 to 10 large glasses of clear fluid such as Gatorade or broth) may be suggested. Loperamide (Imodium) also may be helpful.
- If you have diarrhea, you should keep track of the number and consistency of stools and call the doctor if you experience these “early warning signs:” diarrhea does not get better with diet changes and Imodium after 24 to 48 hours, you feel dizzy when you stand up, or you have a fever.
 - If symptoms disappear, patients should continue with their modified diet, adding solid foods gradually. Patients who have not had loose stool for at least 12 hours may be able to stop taking Imodium.
 - If patients continue to have diarrhea after 24 to 48 hours despite these precautions, the doctor should recommend an increased dose of Imodium and add oral antibiotics to prevent infection. If the problem persists after 48 hours, they may need to stop Imodium and switch to octreotide or another comparable drug.

Again, the panel stressed that patients should inform their physicians as soon as they notice any warning signs or symptoms of diarrhea. ■

OPTIONS

News on Cancer Research and Therapy

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