



FALL 2010

Healthcare Reform Is Here and the Results Are...

Steven J. Morris, M.D., FACP, PCC Board Chair, President, Atlanta Gastroenterology Associates

After a year of wrangling in Washington D.C. and around the nation, healthcare reform was enacted in two parts—the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act. The term Affordable Care Act refers to the amended, final version of the law. It was on September 23, six months later, that the first parts of the law actually went into effect.



Steven J. Morris, M.D., FACP

Much of the over 2,300-page law remains in ‘outline’ form, with many parts to be filled in later and legal challenges on constitutionality to be overcome. This is an excellent time to take a first look at some of the provisions and see what there is to like or dislike, and where the jury is out. Of course, some of this will depend on your perspective as a patient, physician, insurer, or other healthcare-affiliated worker.

See Healthcare Reform, page 5

The Lack of Propofol *What does it mean to you?*

Stanford Plavin, M.D., PCC Vice Chair, President and Managing Partner, Ambulatory Anesthesia of Atlanta

As anesthesiologists, our focus is always to make sure our patients have the best and safest experience that is available to them for their surgical and therapeutic procedures. In the past six to eight months, this goal—as well as providing a comprehensive level of high-quality services—has been increasingly difficult to accomplish due to different forces besieging our profession.



Stanford Plavin, M.D.

In recent months, the sedative-hypnotic propofol, a mainstay for practicing anesthesia personnel, has been nearly impossible to obtain. Numerous production interruptions and decisions by manufacturers to leave the market have severely hampered our clinical options. The American Society of Anesthesiologists has been keeping the anesthesia community apprised of developments and continues to work closely with the FDA (Food & Drug Administration) to overcome these severe propofol shortages. Just recently Teva announced it would no longer produce

See Lack of Propofol, page 6

In this issue...

Case Study: One patient takes all the right steps 2

Raising Awareness One 5K at a Time 3

In the News 4

Perspective: Don't Take Your Gastroenterologist for Granted 5

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CASE STUDY

One Patient Takes All the Right Steps

If anyone understands how taking proper precautions and following procedures can save your life, it would be Dennis P., a former government physicist who made many perilous trips to the South Pole as part of the Antarctica research project. So Dennis obviously was surprised when he was diagnosed with colon cancer in 2006 since he had taken preventive measures following a positive hemocult test in 1999. Once diagnosed, swift treatment and a dedicated team of medical providers resulted in a full recovery.

After the first positive hemocult, a sigmoidoscopy found no signs of cancer or polyps.

Two years later, another hemocult test indicated blood in the stool and a colonoscopy was conducted, as well as a lower and upper GI barium test. Again, no sign of cancer. A 2003 hemocult was negative, bringing Dennis relief as he figured the “problem” was gone. In 2006, as part of a general physical, Dennis had another colonoscopy that actually located the tumor.

He surmises the tumor had grown to a more visible state, and the second colonoscopy was key to locating the cancerous polyp festering in a fold of his colon.

It is also suspicious that the use of the sedative propofol during this particular procedure may have contributed to the finding. Research has shown that more pre-cancerous polyps are found in colonoscopies performed with deep sedation primarily using propofol than with milder sedation in which patients remained conscious. This was the finding of a study conducted by Katherine Hoda, M.D., of Oregon Health and Science University. The review of nearly 105,000 procedures showed doctors found polyps larger than 9mm or suspected

colorectal tumors at a 25% higher rate in patients under deep sedation.

This research further bolsters the near identical findings of two studies completed by the University of Pennsylvania and State University of New York. Those studies tracked facilities that switched from having the GI doctor perform the colonoscopy and also deliver the sedatives, to having an anesthesiologist administer propofol. The findings revealed the number and percentage of patients who had a polyp detected improved up to 43%.

His advice to others?

GET SCREENED.

The theory is that the use of propofol causes unconsciousness and immobility, permitting colonoscopists to perform the procedure with greater precision since they are not trying to hit a “moving target.”

Dennis’ tumor was found just in time—he was in stage III of the cancer and three of ten lymph nodes had been invaded. Swift surgery resulted in clean removal of the tumor and the affected nodes. Relief was followed by a painful recovery following surgery, and it was a month before he regained his strength before starting chemotherapy.

According to Dennis’ wife, Ro, he handled the chemotherapy better than most. “Some patients don’t tolerate the treatment as well as he did, especially women. We noticed that he seemed to endure the drugs more easily when the nurses hydrated him intravenously after each treatment,” Ro notes.

Overall, Dennis found the quality of the staff to be professional, but he would have enjoyed them having a more thorough knowledge of his illness and treatment—the “what’s” and “why’s” about the process.

Four years after the conclusion of his treatment, Dennis remains cancer-free. In addition to the wide use of propofol (unfortunately the industry shortage remains strong), modern technology has brought some notable improvements in the detection process—flexible scopes and pills rather than liquid prep (Dennis had to force down the famous chalky drinks).

Dennis continues to receive annual colonoscopies, and polyps have been found, but he remains cancer free. His advice to others? Get screened. •



Raising Awareness One 5K at a Time

In an exclusive interview, Kristin Tabor, founder and president of the Colon Cancer Coalition, talks to PCC.org about her organization's *Get Your Rear in Gear* 5K races and the challenges in bringing colon cancer awareness to local communities.

PCC: Why did you found the Colon Cancer Coalition and how did *Get Your Rear in Gear* races get their name?

KT: My sister passed away from colon cancer in 2002 at the age of 46. Prior to her diagnosis, our family knew very little about colon cancer. We accepted the typical stereotypes that colon cancer is a disease that only affects older men. It was my sister's dying wish that we get people's rears in gear. That was her phrase: "*Get Your Rear in Gear.*" She wanted everyone to know the real facts about colon cancer and to understand the importance of early detection. Our first *Get Your Rear in Gear* 5K took place in 2005. I founded the non-profit Colon Cancer Coalition to oversee the success of these events. Currently, we have over 40 races scheduled throughout the country for 2011, and we expect to schedule more.

PCC: You've said that one of your goals is to make colon cancer a topic that Americans can comfortably discuss. Can you explain more about that and why you feel these conversations are important?

KT: At the Colon Cancer Coalition, we want to do for colon cancer what has been done for breast cancer. Twenty-five years ago, the topic of breast cancer was considered taboo. But with increased awareness came increased screening and increased survival rates for that disease. My goal is to do the same thing for colon cancer in a shorter period of time. In some

circles, words like "colonoscopy" and "colorectal" make people uncomfortable, and this often becomes a barrier to proper screening. I'd like to make these words dinner conversation.

PCC: What are some of the challenges you've encountered as you've brought *Get Your Rear in Gear* events into communities?

KT: We've had great support in the communities, but there is always some reluctance in certain settings to be blunt about colorectal cancer. In one situation, we had a major sponsor who was thrilled about supporting our efforts but didn't want the word "colon" on any of the signage within his establishment. With some finesse and a little education, he changed his decision, but these are the challenges we've become accustomed to.

PCC: Are you seeing any changes in the willingness of local media outlets to cover *Get Your Rear in Gear* or any other colon cancer awareness events?

KT: Yes, the press continues to evolve. We've had great media coverage this year. In Philadelphia, the event was covered by NBC. In Charlotte and the Twin Cities, our events gained multiple television station coverage. Of course, I believe that more coverage would have a significant impact on our core mission, which is to raise awareness.

PCC: This year's Twin Cities *Get Your Rear in Gear* broke yet another record with close to 5,000 in attendance. You've said before that you were stunned by the number of people who came out to the very first *Get Your Rear in Gear* race. Do you continue to be surprised that these events are so well attended?

KT: I guess the best way to describe my reaction is "awe." People who are touched by this disease continue to search desperately for a way to make a difference and honor the people they love. •



*Kristin Tabor, founder and president,
Colon Cancer Coalition*

IN THE NEWS

Study Links Low Vitamin D Levels with Increased Risk of Colorectal Cancer

In a European study posted on cancerconsultants.com and published in the *British Medical Journal*, researchers found individuals with lower-than-average levels of vitamin D were at much greater risk of developing colorectal cancer. The study, helmed by France's EPCI department, studied 520,000 people and discovered that those with a vitamin D deficiency face a 32% risk of developing colorectal cancer.

Various other studies have also confirmed the reverse is true as well; those with increased levels of vitamin D were found to have a much lower risk of developing colorectal cancer. In a British study, the One National Cancer Institute surveyed 17,000 individuals, and found that people with higher vitamin D levels had a 75% less chance of developing the cancer, which is the third most common cancer in the United States.

To view the article, check out http://professional.cancerconsultants.com/oncology_rectal_cancer_news.aspx?id=44625. •

New UF Study Delves into Colorectal Cancer Patient Decision-Making

A new study commissioned by the University of Florida aims to document decision-making by individuals with colorectal cancer in regard to treatment. The study, funded by a \$1.2 million grant by the Bankhead-Coley Florida Cancer Research Program and administered through the Florida Department of Health, will examine treatment decisions based on patients who have been newly diagnosed with colorectal cancer. Treatment options often include a combination of chemotherapy and surgery.

The researchers believe verbal and non-verbal communication with healthcare providers, friends and family have an enormous impact on decisions made by the patient. The study aims to examine how this communication influences those decisions.

Researchers will first interview healthcare providers and investigate how they present information to patients, then study 4,300 patients to learn their expectations of treatment, and finally, follow a subset of 137 patients as they undergo treatment. For the full story, visit <http://www.medicalnewstoday.com/articles/202286.php>. •

JOIN PCC.ORG

What the members of PreventingColorectal Cancer.Org are doing:

- Bringing awareness to insurance companies about cost-savings associated with early diagnoses;
- Contributing to grass-root advocacy efforts on behalf of patients and doctors by taking their concerns to Capitol Hill;
- Representing patient safety and doctor concerns to the FDA and other regulatory agencies when questions need to be asked and answered; and
- Accurately representing the concerns of physicians and facility managers on issues such as sedation, reimbursements, and ambulatory surgical centers.

The benefits of becoming an organizational member include receiving the newsletter via email and printed format, invitation to participate in Coalition committees and advocacy activities, policy briefings, and prominently positioning your logo in the newsletter and on the PCC website. For more information, please call the office at (866) 333-6815. •

PERSPECTIVE

Don't Take Your Gastroenterologist for Granted

Randall H.H. Madry, PCC executive director

In this country, gastroenterologists serve as a patient's first line of defense against colorectal cancer in large part by offering colonoscopies. The colonoscopy remains the gold standard for colorectal cancer screening.

Reducing the incidence of colorectal cancer, which is the second leading cause of U.S. cancer deaths, remains a central health policy goal. A key element of this strategy is to ensure there are sufficient gastroenterologists in active practice who can administer colonoscopies. Unfortunately, experts now are predicting a shortage.

Why, you ask? The number of gastroenterologists who are planning to retire in the next decade will likely outpace the number of residency positions that will be available to medical school graduates who want to pursue the practice of gastroenterology. This trend could be further exacerbated if more patients receive colonoscopies due to public awareness campaigns and additional funding for the procedure is made available from health plans and government-funded programs.

The 71% screening rate figure is an achievable number, if we have sufficient gastroenterologists available to provide the colonoscopies.

A study conducted last year by Lewin and Associates for Olympus predicts this potentially-hazardous trend. The Lewin research reports an estimated 10,390 gastroenterologists in active practice in 2008, but the study authors note that in just 10 years, a shortage of approximately 1,050 gastroenterologists is likely.

Given the passage of the Patient Protection and Affordable Care Act, a significant number of persons

who are uninsured or under-insured will be eligible for coverage or receive new benefits, which will include colorectal cancer screenings. This could lead to 15 million or more requesting a colonoscopy. The 71% screening rate figure is an achievable number, if we have sufficient gastroenterologists available to provide the colonoscopies. The Lewin study found that training approximately 130 additional GIs per

See Perspective, page 6

HEALTHCARE REFORM

from page 1

Some of the provisions that have taken immediate effect are universally needed and positively accepted by both patients and physicians. This includes: allowing young adults to be covered under their parents' insurance until age 26; doing away with lifetime limits on insurance benefits; prohibiting the cancellation of policies without proving fraud; using the nearest emergency room without penalty; and ceasing insurance coverage denial for children with pre-existing conditions.

Some of the early negative effects of these changes were dramatic increases in premiums over the last six months as insurers awaited the new laws. Meanwhile, there have been benefits enacted already such as inclusion in Medicare and new healthcare plans of preventive services without deductibles and co-pays (to be phased in for all health plans by 2018). This includes vaccinations, mammograms, pap smears and, particularly relevant for gastroenterologists, colonoscopies.

As a physician and citizen/taxpayer, it strikes me that there really are no true provisions to decrease healthcare costs and insurance premiums. There are actually some perverse incentives that can have the paradoxical effect of raising costs. For example, if the patient/consumer incurs no cost at all for preventive services, what will motivate them to seek out the lower cost provider? Why go to an Ambulatory Surgical Center or outpatient imaging facility if the local hospital can provide the service; even at a much higher cost, since now the consumer has been removed from the equation?

Reform is clearly needed and is off to a reasonable start. The question is whether we can implement the other major provisions without hurting quality, access or making an already unaffordable system out of reach. •

LACK OF PROPOFOL

from page 1

propofol, and Hospira has recalled numerous lots of its propofol. APP, which markets and produces generic propofol/Diprivan and Fresenius Propoven, is really the only viable option at this point. What was a very affordable and readily available drug is now quite the opposite.

We are resourceful clinicians and have been challenged to provide the best and safest pharmaceutical options to our patients.

With these drugs being hard to obtain and universally displaced by the overwhelming use of propofol, one option is Lusedra (fospropofol), introduced by Eisai in 2009 and approved as a sedative-hypnotic for use as MAC sedation in diagnostic and therapeutic procedures. A prodrug form of propofol with different pharmacodynamics and pharmacokinetics, Lusedra provides a consistent level of propofol-like sedation with a single bolus injection. •

PERSPECTIVE

from page 5

year (a 33 percent increase from current planned levels) starting in 2011 would increase supply by 1,550 gastroenterologists by 2020 and would meet that anticipated demand.

A significant roadblock to achieving that goal is that there are a finite number of residencies funded by CMS. It will take a groundswell of people sharing their concerns about CMS limitations and the impending shortage with their congressional representatives to alter the current trajectory. Our website has a page that will allow you to identify your representatives and provide you with an email address (see <http://www.preventingcolorectalcancer.org/stateresources>). Contact them and share your concerns about this impending shortage. •

¹ The Impact of Improved Colorectal Cancer Screening Rates on Adequacy of Future Supply of Gastroenterologists by Lewin and Associates 2009

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