RN Navigators
Their Role in patients with Cancers of the GI tract

Nurse Navigator Defined
❖ "Nurse Navigator – A clinically trained individual responsible for the identification and removal of barriers to timely and appropriate cancer treatment.
❖ They guide the patient through the cancer care continuum from diagnosis through survivorship.
❖ More Specifically, the nurse navigator acts as a central point of contact for a patient and coordinates all components involved in care including surgical, medical and radiation oncologist; social workers; patient education; community support; financial and insurance assistance; etc.
❖ This person has the clinical background and is a critical member of the multidisciplinary cancer team.
❖ (Academy of Oncology Nurse and Patient Navigators)
Principles of Navigation

❖ Patient Centered
❖ Focus on timely movement through a complex healthcare system
❖ Serves to integrate a fragmented healthcare system
❖ Eliminate barriers for patients
❖ Defined point of beginning and end
❖ Coordination

CARES Model of Navigation Care

❖ C: Coordinated, compassionate care
❖ A: Anticipatory guidance
❖ R: Referrals
❖ E: Education
❖ S: Support

Referral Pattern

❖ Varies
❖ Gastroenterologist, or primary
❖ Inpatient (per nursing)
❖ Pathology Reports
GI Cancers

- Colorectal
- Anal
- Pancreatic
- Others

Colorectal Cancers From Cecum to Anal Canal

Signs and Symptoms of Colorectal Cancer

- Change in Bowel Habits
- Bleeding
- Pain
- Weight Loss
Risk Factors for Developing Colorectal Cancers Are:

- Diets rich in Fat and Cholesterol
- Obesity
- Hx of Colorectal Cancer increases risk for second primary colon cancer
- Family History and Genetic Factors
- Prior radiation to the prostate

 Syndromes that may put people at a higher risk of developing colon cancer

- Lynch Syndrome
- Familiar Adenomatous Polyposis

Colon Cancer Stages

- **Stage 0** – Carcinoma in situ of the colon. A noninvasive cancer, and additional treatment may not be needed if all the cancer was removed with polypectomy.
- **Stage I** – Some of these tumors may not need treatment after a polypectomy, some T1 & T2 tumors may be treated with colectomy and lymphadenectomy.
- **Stage II** – Cancer has grown into the fourth layer of or outside the colon wall. Surgery is advised for stage II cancer.
- **Stage III** – Cancer has spread from the colon to nearby lymph nodes or there are tumor deposits. Surgery is advised with adjuvant chemo, however, some stage III will require neoadjuvant therapy followed by surgery then adjuvant chemo.
- **Stage IV** – The cancer has spread to distant organs. Chemo may shrink the tumor enough for surgical cure to be possible. Options are surgery with post-op chemo for 6 months or neoadjuvant for 2-3 months, surgery, and possible adjuvant chemo.
Colon Cancer Staging Studies

- Colonoscopy – with polypectomy and/or Bx
- CEA (Carcinoembryonic Antigen)
- CT with Contrast – of chest, abd, pelvis
- MRI with contrast and CT w/o contrast
- EUS for rectal cancer

Examples of Colon Resections

- AP Resection
- Hemicolecotomy

Colon Cancer Treatments

- Surgery
- Colon resection with or without ostomy
- Possible chemo; Adjuvant therapy dependent on stage
- Possible radiation dependent on stage
Rectal Cancer

- Surgery dependent on stage
  - T1-2, N0
  - Transanal or Transabdominal excision

- Neoadjuvant chemo/Radiation
  - Any T, with Lymph node involvement
  - T3-4

Surveillance

- For Stages II-III
  - Physical every 3-6 months for 2 years, then every 6 months for 5 years
  - CEA Levels every 3-6 for 2 years then every 6 months for 5 years
  - CT of chest/abdomen/pelvis every 6-12 for 5 years.
  - Colonoscopy – For stage II-III at 1 year after treatment.

Case Study

- 70 year old female presents for a screening colonoscopy following a positive cologuard test (uses advanced stool DNA technology to find elevated levels of altered DNA and/or Hgb in abnormal cells which can be associated with cancer or pre-cancer)
- Colonoscopy shows a mass located at 40cm, biopsied. Pathology shows moderately differentiated invasive adenocarcinoma.

- What would you expect for stages studies?
Results

CT of Chest/Abd/Pelvis showed tumor and lymphadenopathy.

- The patient had hemicolectomy, 14.5 cm of colon was removed. Pathology shows moderately differentiated invasive colonic adenocarcinoma with high grade dysplasia, all margins are negative for malignancy, no lymphovascular or perineural invasion is seen, adenocarcinoma invades through the muscularis propria into the subserosal tissue, 2 of 23 lymph nodes are positive with metastatic adenocarcinoma.

- What would the Pathologic TNM staging be?

- Now, that surgery is complete would you think any further intervention would be necessary and why?

Presenting Symptoms

Anal Cancer

- Rectal Bleeding – 45%
- Pain or the sensation of a rectal mass – 30%

Risk Factors for Developing Anal Cancer

- HPV
- STD’s
- Hx of cervical, vulvar or vaginal cancer
- Immunosuppression
- HIV
- Smoking
Anal Cancer Staging Studies

- DRE – Digital Rectal Exam
- Inguinal lymph node evaluation
- CT of chest/abd/pelvis
- PET/CT Scan

Anal Cancer Staging

- **Stage 0:** Abnormal cells are in the first layer of the lining of the anus only
- **Stage I:** The tumor is no larger than 2cm and has not spread to the lymph nodes or other parts of the body
- **Stage II:** The tumor is larger than 2cm but has not spread to the lymph nodes or other parts of the body
- **Stage IIIA:** The tumor may be any size and has spread to either the nearby lymph nodes or to another organ
- **Stage IIIB:** The tumor has invaded other nearby organs, but lymph nodes spread is limited to the area around the rectum, or the tumor may be on any size, lymph nodes spread can be local or distant but no spread to distant organs.
- **Stage IV:** The tumor may be any size and has spread to the lymph nodes and to distant parts of the body.

Primary Treatment for Anal Cancer

- **Local Excision**
- Or **Chemo/Radiation**
Anal Cancer Surveillance

- Digital rectal exam/anoscopic eval between 8-12 weeks after completion for chemo/radiation, then every 3-6 months for the first 5 years.
- Inguinal node palpation
- Annual chest/abd/pelvic CT for 3 years
- PET Scan possible

Case Study – Anal Cancer

- A Patient came in for a flex sig, has had a colonoscopy recently and was told she had an anal fissure, which was treated with nitro cream, rectally. However it did not resolve, and patient sought a second opinion. A flex sig was carried out and the left anal mass was biopsied.
- Biopsy confirms – Squamous Cell In Situ, HPV +.
- What are the next scan(s)/Labs/Consults that should be completed??

Studies then show.....

- An MRI of the pelvis with and without contrast showed a 3.3x2.3x2.5 cm mass anterior anal canal. Enlarged left inguinal lymph nodes; suggestive of metastatic disease, small left distal perirectal lymph nodes measure up to 5mm could also represent metastatic disease.
- PET/CT – 4.8 cm mass: 1.8cm Left inguinal node has metabolic activity
- What would you think the staging of this cancer would be???
- Mitomycin and 5FU are first line treatment
- The patient will also undergo radiation treatment regime. What are the potential side effects????
- What are some things we can suggest to minimize potential radiation side effects?
Symptoms of Pancreatic Cancer

- Weight Loss
- Jaundice
- Abd Pain and/or back pain
- Anorexia, Nausea, Vomiting
- Dark Urine
- Weakness

Pancreatic Cancer Risk Factors

- Risk Factors Include:
  - Chronic Pancreatitis
  - ETOH
  - Cirrhosis
  - Hep B
  - H. Pylori
  - Diabetes
  - Obesity and Diet
  - Smoking

Inherited Conditions

- Lynch Syndrome
- Hereditary Breast and Ovarian Cancer
- Familial Malignant melanoma dn pancreatic syndrome
- Peutz-Jeghers Syndrome
- Li-fraumeni Syndrome
- Familial adenomatous polyposis
Staging Scans and Labs
- CT Scan – Pancreas protocol
- MRCP or ERCP
- Bx versus brushings
- CA 19-9
- EUS
- MRI

Pancreatic Cancer Staging
- Stage 0 – Cancer in-situ, the cancer has not yet invaded outside the duct in which it started
- Stage I – Tumor is in the pancreas but no spread to lymph nodes or other parts of the body
- Stage II – Tumor extends beyond the pancreas but the tumor has not spread to nearby arteries, veins, but may have spread to lymph nodes
- Stage III – Tumor has spread to nearby arteries, veins, and/or lymph nodes
- Stage IV – Tumor has spread to other parts of the body

Staging is important as determining if RESECTABLE or not

Treatment Options
Surgery, Chemo, Radiation, Clinical Trial, Supportive Care
- Resectability status should be made by a surgeon
- Only about 20% of patients with pancreatic cancer are resectable.
Different Surgical Options

- Tumor at head of pancreas – Whipple
- Tumor at Tail of pancreas – Distal Pancreatectomy
- Tumor throughout the pancreas or located in many areas in the pancreas – Total Pancreatectomy
- What are potential suspected side effects from this type of surgery?

Pancreatic Cancer Surveillance

- Physical Exam every 3-6 months for 2 years then every 6-12 months for 5 years.
- Exam should include Symptom Assessment
- CA19-9
- CT scan

Pancreatic Cancer Case Study

- Patient having a workup for a different Dx, has an abd/pelvis CT. An incidental pancreatic cystic mass is identified. MRI was completed, follow up was recommendation. A follow up MRI & CT of Abd in completed 1 year later confirming pancreatic cancer in distal body and tail.
- What other Labs, consults, would be appropriate at this time?
The patient goes to surgery and undergoes resection of neck, head and tail of pancreas, partial gastrectomy, splenectomy.

- Pancreatic and stomach margin are clear on frozen section.
- Pathology reveals:
  - Moderately-poorly differentiated adenocarcinoma, margins as described above
  - Spleen negative for adenocarcinoma.
  - However the tumor invades attached gastric subserosa and involves inked pancreatic resection margin surrounding gastric tissue.
  - No involvement of pancreatic duct margin
  - Extensive perineural invasion
- What would you expect the staging of this cancer to be?

WRAP UP/QUESTIONS

- How can you help??
- Early referrals
- Communication
- ???????