

# C3: COLORECTAL CANCER COALITION Momentum

News from C3: Colorectal Cancer Coalition

Volume 3, Issue 2

Winter 2008

## I'm Done With Treatment: Now What?

For Ray Beckler, 53, the day he was “cut loose” from cancer treatment after surgery and chemotherapy for stage II colon cancer was a day he will never forget.

“I practically floated home, thrilled to be finished with chemo,” he said. “I know a lot of people don’t like to get cut loose because they worry about no longer being so closely monitored, but I thought it was a major milestone. I was free and clear and I was pretty happy about it.”

But not everyone finishing cancer treatment reacts as Ray did. For some, the long-awaited

conclusion to cancer treatment leaves them glad to be done but unexpectedly sad, at loose ends, and frightened of what lies ahead.

Their fears may be well-founded but can be somewhat alleviated by better planning and communication before they leave their cancer treatment team.

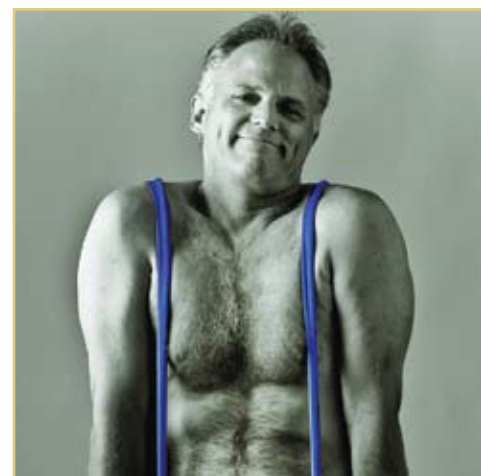
The Institute of Medicine reports that the US health care system is failing to deliver “the comprehensive and coordinated follow-up care cancer survivors deserve.”

Translation: Too often there is no system to put cancer survivors on the right track. Cancer survivors should learn what care and monitoring is recommended and then make sure that they know how to access it. Without this information, patients are more likely to feel like they’ve been cut loose with no support system at all.

It’s true that finishing treatment leaves many cancer survivors on an emotional roller-coaster, making it tough to stay focused. It’s very common for cancer survivors to initially bounce back and forth between feeling invincible and seeing cancer lurking behind every ache, pain or bout with the flu. “The challenge is to reach a point where things even out and you find a perspective you can live with,” Ray said.

For Ray, that perspective came into focus when he realized he was fully determined to “do whatever it takes” to increase his odds of remaining in that coveted “survivor” mode.

He makes sure he has copies of all his tests and treatment records. He stays on top of his follow-up program and appointments. He



RAY BECKLER AS HE APPEARS IN THE COLON CLUB'S 2008 COLONDAR.

REPRINTED WITH PERMISSION FROM THE COLON CLUB.

continues his long-standing commitment to exercising and eating a healthy diet—both proven to help prevent recurrences.

“Gradually, over time, that big scary word CANCER becomes simply cancer,” he said. “It’s still frightening and it can still make your heart race but it changes from being the primary focus in your life to being just a fact of your life.”

But it’s a fact that few can forget or escape – and nor should they. “I don’t think you’re ever done with cancer,” says Ray who not only survived stage II colon cancer but several bouts of skin cancer as well. Cancer survivors need to learn about their own risks, their inherited risks and, with their doctors, come up with a screening and check-up plan that provides a customized balance: the optimum amount of monitoring and the most peace of mind. ♦

For more on survivorship, turn to page 5

### IN THIS ISSUE:

*I'm Done With Treatment: Now What?* 1

*A Time for Reflection and Promise* 2

*New Warning for Patients with Chemo-Induced Anemia* 3

*Highlights from AACR Frontiers in Cancer Prevention Research Conference* 3

*Editorial: A Runaway Veto Pen* 4

*Dusty's Recipe for Action* 4

*Spotlight on Survivorship* 5

*Call-on Congress 2008* 6

*Why Research Advocacy Matters* 7

*C3 Remembers Janet Turcotte* 7

1225 King Street, 2nd Floor  
Alexandria, VA 22314  
703.548.1225

[www.FightColorectalCancer.org](http://www.FightColorectalCancer.org)



## Board of Directors

Nancy Roach  
Board Chair

Alan Balch, PhD  
Vice Chair

Greg Crafts  
Treasurer

Robert Erwin  
Board Secretary

Steven Depp

Carlea Bauman  
President

## Medical Review Network

Mace Rothenberg, MD (Chair)  
Vanderbilt University Medical Center

Nancy Baxter, MD, FRCSC  
University of Toronto

Al B. Benson III, MD, FACP  
Northwestern University

Richard Goldberg, MD  
University of North Carolina

Axel Grothey, MD  
Mayo Clinic College of Medicine

Heinz-Joseph Lenz, MD, FACP  
University of Southern California

John Marshall, MD  
Georgetown University Medical Center

Howard McLeod, PharmD  
University of North Carolina

Neal Meropol, MD  
Fox Chase Cancer Center

Edith Mitchell, MD  
Thomas Jefferson University

Daniel Sargent, PhD  
Mayo Clinic College of Medicine

Joel Tepper, MD  
University of North Carolina



## A Time for Reflection and Promise



CARLEA BAUMAN  
PRESIDENT

While it is typical in January to look forward to the coming year, it can also be helpful to look back to see how far we have come.

As a faithful reader of C3's *Momentum* newsletter, you no doubt know how busy we have been, but I would like to take this opportunity to tell you exactly what we were able to accomplish these last 365 days.

### Pushing research

- » Working with the American Association for Cancer Research (AACR), in 2008 C3 will directly fund a young researcher exploring cutting edge treatment for late stage colorectal cancer. The grant review process is underway and the grant, made possible by donations made to the C3 Lisa Fund (which was named after one of C3's founders, Lisa Dubow, who died in July 2007 after her nine year battle), will be awarded this spring.
- » C3-trained research advocates now sit on the Gastrointestinal Cancers Steering Committee (GISC), three of the five Specialized Programs of Research Excellence (SPORE) that focus on GI cancers and all of the NCI Cooperative Groups with GI committees in the United States. Andy Giusti, Ph.D., C3's Research Program Manager, has written an excellent piece on what research advocacy means to colorectal cancer patients on page 7. This January, C3's third annual Research Advocate Training will be held in Orlando, FL, and more research advocates will be added to the C3 army.

### Changing policy

- » For the first time in history, three bills sit in the US Congress that, if passed, will

guarantee coverage of every American butt that needs it. C3's Cover Your Butt Campaign is working to make sure that when an individual needs colorectal cancer screening or treatment – regardless of income or insurance status – he or she can get it. Log on to [www.CoverYourButt.org](http://www.CoverYourButt.org) to learn how you can help.

- » Colorectal cancer advocates are making quite a ruckus on Capitol Hill. In 2007, 2,000 colorectal cancer advocates sent almost 5,000 letters to their Members of Congress. This March 9 – 12, colorectal cancer advocates will travel to Washington, DC, to participate in C3's Call-on Congress where they will learn how to lobby their Members of Congress to support colorectal cancer legislation. Won't you join us? See page 6 for information on how to register.

### Raising Awareness

- » C3's web site traffic tripled in 2007. As a result, more people were able to receive honest, unbiased, medically-reviewed information to help them navigate their cancer diagnoses.
- » Our *Momentum* newsletter was sent each quarter of 2007 free-of-charge to 10,000 people across the US with information about how to live and thrive with colorectal cancer.
- » To date, C3 has distributed 1,000,000 colorectal cancer Blue Stars of Hope to those who are living with or affected by this disease. Thinking of all those folks out there wearing their Blue Stars of Hope makes me think of that inspiring quote by Margaret Mead: Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it's the only thing that ever has.

**Finally, as we begin 2008, the staff of C3 wishes you a year full of hope, advocacy, and refusal to accept the status quo.** ✦

## NEW WARNING FOR PATIENTS WITH CHEMO-INDUCED ANEMIA

On November 8, 2007, the US Food and Drug Administration announced changes in boxed warnings on the labels of Erythropoiesis Stimulating Agents (ESAs) better known under their brand names of Aranesp®, Procrit®, and Epogen®. ESAs are prescribed for cancer patients who have anemia due to chemotherapy.

Given potential risk for tumor growth, poorer survival, heart problems, and blood clots when ESAs are used to manage anemia in cancer patients, the FDA urges doctors to use the lowest dose necessary to avoid red blood cell transfusions.

The FDA has also published a list of Questions and Answers for ESAs Labeling Changes, available at [www.FDA.gov](http://www.FDA.gov), search term "ESA Labeling Changes."

### WHAT THIS MEANS FOR PATIENTS:

There are serious questions about the safety of ESAs.

In some clinical studies where researchers tried to raise hemoglobin to or above 12 grams per deciliter (g/dl), patients receiving ESAs had poorer survival and faster tumor growth than those not getting an ESA. There is not yet good information about whether or not something similar might occur when the targeted hemoglobin is below 12 g/dl.

To use them as safely as possible, the FDA urges patients who develop anemia while on chemotherapy to work closely with their doctors to determine the best way to manage their anemia. FDA information and recommendations include:

- » You may have an increased chance of dying sooner or your tumor (cancer) may grow faster if you take this drug.
- » Your doctor should use the lowest dose of ESA needed to help you avoid red blood cell transfusions.
- » Once you have completed your chemotherapy course, ESA treatment should be stopped.

» ESA treatment increases your chance of a blood clot. If you are scheduled for surgery, your doctor may prescribe a blood thinner to prevent blood clots.

» Blood clots can form in blood vessels (veins) in your leg (venous thrombosis). Blood clots may move from the legs to the lungs and block the blood circulation in the lungs (pulmonary embolus).

» Call your doctor right away if you experience any of the following symptoms of a blood clot while taking an ESA:

- » chest pain
- » shortness of breath
- » pain in the legs with or without swelling

The FDA clarified that ESAs are only for anemia from chemotherapy. They should not be prescribed for other cancer-related anemia.

**C3 will continue to work with the FDA and the manufacturers of ESAs on this issue. The complete FDA patient label is available at: [www.fda.gov/cder/foi/label/2007/103234s5158ppi.pdf](http://www.fda.gov/cder/foi/label/2007/103234s5158ppi.pdf)** ✦

## Highlights from AACR Frontiers in Cancer Prevention Research Conference

The American Association for Cancer Research (AACR) conference *Frontiers in Cancer Prevention Research* in Philadelphia on December 5-8 focused on studies of cancer risk and strategies to reduce that risk. Kate Murphy, C3 Director of Research Communication and colon cancer survivor, attended the meeting as part of the AACR Scientist-Survivor Program.

Some issues of prevention of colorectal cancer discussed at the conference included:

- » **A report from the World Cancer Research Fund's "Food, Nutrition, Physical Activity, and the Prevention of Cancer."** An expert panel systematically reviewed all the study evidence for how eating and exercise impact cancer risk – both positively and negatively. For colon and rectal cancer the panel found convincing evidence that physical activity decreases risk and that red meat, processed meat, alcoholic drinks, body fatness, abdominal fatness, and

greater adult height increase risk. They also found it probable that dietary fiber, garlic, milk and calcium decrease risk.

- » **Chemoprevention of colorectal cancer was a complex issue.** Folate appeared to reduce the risk of the early mutations that lead to colon cancer, but once cancerous changes had occurred it increased cancer growth. NSAIDs reduce risk for precancerous colon polyps but have dangerous side effects of their own, including gastrointestinal bleeding for aspirin and heart attacks and stroke for Celebrex. For some patients, colorectal cancer risk outweighs bleeding or cardiovascular risk, for others it does not. Finding the right chemopreventive for the right person at the right time was an important theme.

- » **Polyp risks.** Follow-up colonoscopies and analysis from the National Polyp Study helped identify risk factors for another

precancerous polyp or adenoma. High risk groups included people with three or more polyps or those who were 60 or older with a positive family colorectal cancer history. Lower risk groups had one or two polyps or had a negative family history. High risk patients should have a follow-up colonoscopy three years after their initial exam. Low risk patients can safely wait five years for another test. People who have no polyps found during their first colonoscopy should be screened again in ten years.

Discussing screening tests available to detect polyps and prevent colorectal cancer, Dr. Sidney Winawer from Memorial Sloan Kettering Cancer Center in New York said, "...it is clear that any test will reduce the risk of dying from colon cancer. Any test is better than none. **The best test is the one that gets done.**" ✦

## Editorial: A Runaway Veto Pen

Despite the fact that the war on cancer continues to rage, President George W. Bush vetoed the Labor, Health and Human Services, and Education Appropriations bill (LHHS). The LHHS bill contains funding for the National Institutes of Health (NIH) and the National Cancer Institute (NCI).

This year Congress worked hard to develop a spending package that would increase funding to the NIH by \$899 million or 3.1 percent – which, while higher than the President's budget, was still far below the 6.7 percent increase for which cancer groups like C3: Colorectal Cancer Coalition were asking. Of the \$899 million, \$128 million would be allocated to NCI.

Still, on November 13, 2007 President Bush vetoed the LHHS bill. Why? "Irresponsible and excessive spending," he stated in a radio address, declaring that he would "use my veto to stop...runaway spending."

Many in the cancer community have questioned whether the President's action was a cry for fiscal responsibility or just another way to flex his muscle against a Democratic-held Congress. Based on a study performed by the Center on Budget and Policy Priorities, the latter seems more realistic.

Key findings from this study have shown that the 2008 appropriations bills, on average, will cost less than they did from 2002 to 2006 after adjustments for inflation and population growth.

From 2002 to 2006 the President signed every appropriations bill given to him by Congress. The biggest difference between 2008 and the previous years of the administration? Congress was controlled by Republicans.

"The President's veto is political pretense, pure and simple—which is demonstrated by the

fact that the funding in this Conference Report represents a smaller share of our GDP than the Conference Reports passed by Republican Majorities in Congress in FY02, FY03, FY04, FY05, and FY06," said House Majority Leader, Steny Hoyer (D-MD).

"Yet, President Bush signed every one of those conference reports."

Fiscal responsibility is no doubt needed, but the fact of the matter is that of the President's cuts to domestic spending, the greatest cut was to medical research. At C3, we believe that an investment toward curing cancer is worth the cost. ✦



**JOE ARITE**  
POLICY &  
GRASSROOTS  
MANAGER



### DUSTY'S RECIPE FOR ACTION: MOVING FROM BEING A PATIENT TO AN ADVOCATE

**DUSTY WEAVER**  
GRASSROOTS  
COORDINATOR

When you hold a pencil very close to your eyes it blocks what you can see. As you move the pencil away you begin to see how it relates to the desk, the room, the building, the world. This is one reason why with hundreds of thousands of people affected by colon and rectal cancer there seem to be so few involved in advocacy activities — they are so focused on their personal battle with cancer, as I was when I was diagnosed, that they can't see how they can make a difference in the cancer fight.

It may take considerable time to get to where you see cancer as part of your life instead of consuming your life. But I have found my cancer advocacy to be an incredible gift. It has made me a stronger person by getting involved and fighting back against it.

These are some of the steps I took:

- » I looked at what I could do instead of what I couldn't.
- » I was realistic about what I could accomplish.
- » I started out small (cancer support groups and talking with others locally) and worked up to larger activities (like traveling to Washington, DC, to lobby my Members of Congress for increased cancer funding).

- » I used my connections to bring others into the fight.
- » I honestly critiqued what I did to see what I should keep and what I should change.
- » I was willing to think outside the box.
- » I drew on the experiences of others.
- » I gave others the opportunity to contribute by asking for their assistance.

**Colon and rectal cancer is the type of experience which can block your vision. But getting involved in the larger fight against it can be one of the most rewarding things you can do for yourself.** ✦

## SPOTLIGHT ON SURVIVORSHIP continued from page 1

### What You Need Before You Leave Treatment

Before you finish active treatment, make sure you have two things in writing: a comprehensive care summary and a plan for follow up monitoring.

#### Comprehensive Care Summary

What exactly was your diagnosis? What treatments were initiated, which were completed and when? What surgeries, chemotherapy, and radiotherapy did you receive, including dates, dosages and reactions? What clinical trials were you part of? An organized, comprehensive care summary from your treatment team is essential and could improve your health, be useful if you have to change doctors, and possibly affect your quality of life after cancer.

#### Get a Follow-Up Plan – and Follow It

What follow-up care will you need? Who will you call to schedule it? What's the timing of the tests and procedures? What longer term side effects should you expect from your treatments and when might you expect to experience them? What healthy behaviors might help prevent recurrence? What symptoms merit a call to the doctor? These and many other questions should be answered by the written follow-up plan provided to you and your primary health care provider. ✦

A care summary and follow-up plan for patients with stage II or stage III colon cancer has been created by the American Society of Clinical Oncology (ASCO) and can be found at: <http://tinyurl.com/ynlrkh>

#### KNOW WHAT COMES NEXT

Guidelines from ASCO recommend:

**Regular visits with your doctor.** Most colorectal cancer recurrences develop within five years after surgery. Doctor visits are recommended every three to six months for the first three years, every six months during years four and five, and as often as you and your doctor decide after five years. With your doctor, look at web-based prediction tools that might help better estimate the risk of recurrence.

**Carcinoembryonic antigen (CEA) test.** Patients with stage II or III colorectal cancer should get a CEA blood test every three months for at least three years after diagnosis once adjuvant therapy (chemotherapy given after surgery) is finished.

**Computerized tomography (CT) scan.** For patients who have a higher risk of recurrence and may be good candidates for surgical removal of a metastatic tumor, a CT scan of the chest and abdomen annually for the first three years is recommended. A CT scan of the pelvis is recommended for patients who are at high risk for

rectal cancer recurrence, especially those who have not had radiation therapy. Talk with your doctor to develop a plan based on your individual risk of recurrence.

**Colonoscopy.** Following surgery, a colonoscopy is recommended at one year. If normal, the next colonoscopy is at three years, followed up every five years. Some patients, however, such as those with high-risk hereditary colorectal cancer syndromes, may require more frequent colonoscopy screening. Talk with your doctor about an appropriate schedule. In Ray's case a routinely scheduled colonoscopy 18 months after surgery discovered a cancerous polyp that was dealt with swiftly and effectively at an early stage. "It's a clear case where post treatment surveillance removed another primary tumor," Ray said.

**Flexible proctosigmoidoscopy.** Patients with stage II or III rectal cancer who did not have radiation treatment of the pelvic area should have a proctosigmoidoscopy every six months for five years. ✦

## Maintaining Health and Well-Being: Taking Charge

There's a lot about cancer that is beyond the control of individuals, be they doctors or patients. But some of the lifestyle habits recommended for the general public are especially important for cancer survivors.

» **Choose the right diet:** Stage III colon cancer patients who followed a "Western diet" with emphasis on red meat, fat, refined grains and dessert were significantly more likely to have their cancer return than those who reported they ate mostly fruit and vegetables, poultry and fish, the American Society for Clinical Oncology (ASCO) reported. Risk of dying or having cancer return was 3.91 times higher for Western pattern eaters.

» **Get active physically:** Patients with stage III colon cancer who walked one mile at an average pace six days a week or had equivalent exercise had a 51% reduced risk of having their cancer return compared to those who were less active.

» **Get active personally and politically:** Ray found that becoming involved as an advocate, offering support to other cancer patients and supporting legislation that will increase research or funding were powerful and empowering ways to feel vital. C3 makes it easy to get involved by visiting its Online Action Center at [www.FightColorectalCancer.org](http://www.FightColorectalCancer.org). Ray also finds it rewarding to regularly chat with cancer patients online. He was also featured as Mr. November in the Colon Club's 2008 Colondar. For information on how to order a Colondar, visit [www.ColonClub.com](http://www.ColonClub.com).

» Visit the C3 website frequently at [www.FightColorectalCancer.org](http://www.FightColorectalCancer.org) and read *Momentum* to stay current on new research and recommendations that might pertain to your situation. ✦

Survivorship articles reviewed by Axel Grothey, MD, Mayo Clinic



# CALL-ON CONGRESS

There comes a time when you must take your fight against colorectal cancer out of your doctor's office and into the halls of Congress.

**This is that time.**

## Join C3: Colorectal Cancer Coalition at the second annual Call-on Congress

**March 9 – March 12, 2008**  
Washington, DC

*Join your fellow colorectal cancer advocates and  
make your voice heard on Capitol Hill.*

**Schedule of Events:**

**Sunday, March 9th**

Meet your fellow advocates at our Welcome Dinner

**Monday, March 10th**

Receive training in grassroots lobbying from the professionals

**Tuesday, March 11th**

Meet with your elected officials on Capitol Hill during the day  
and celebrate your newfound inner-lobbyist at our  
Advocate Awards Dinner that evening!

**Register today at**  
**[www.FightColorectalCancer.org/ConC2008](http://www.FightColorectalCancer.org/ConC2008)**

### C3 Advocates Remember Janet Turcotte

It is with sadness that C3 says goodbye to one of its most active advocates.

Janet Turcotte, 53, passed away on September 20, 2007. For over two decades, Janet embroidered the saddlecloths for the Preakness Stakes. In 2006, she began adding the colorectal cancer "Blue Star of Hope" to the saddlecloths of the 11 contenders. Her efforts brought an awareness of colorectal cancer to over 17,000 viewers of the race and she appeared on CNN to talk about it. She repeated the honor again in 2007, while undergoing treatment and battling hard against colorectal cancer.

Her tireless advocacy won the praise of her own Maryland Senator, Ben Cardin, who spoke on the floor of the US Senate to honor her: "Mr. President, today I wish to recognize Janet Turcotte, of Bowie, MD, for her courageous efforts to raise awareness of colon cancer and promote screening. I met Janet in March when she came to my office on behalf of C3: Colorectal Cancer Coalition. Janet has joined the coalition in its push for 'more research to improve screening, diagnosis, and treatment of colorectal cancer; for policy decisions that make the most effective colorectal cancer prevention and treatment available for all; and for increased awareness that colorectal cancer is preventable, treatable, and beatable.'"

Janet's smile brought instant light to any room and her passion for life lit the world. Her absence leaves a huge hole in the heart and soul of the C3 family.

*Suzanne Lindley, Canton, TX*

## Research Advocacy – Key to Winning the Fight Against Colorectal Cancer *by Andy Giusti, Ph.D.*

Winning the fight against colorectal cancer is a multi-pronged battle that involves research, policy and awareness. One critical piece of the fight is C3's work in research advocacy. Our annual training, being held this month in Orlando, FL, supports patient advocates who sit on research committees, to help them represent patients during the development of clinical trials.

But research advocacy is a much bigger hat. In the long term, C3 pushes for:

- » Strategic research to provide better treatments and screening;
- » Surveillance to ensure that approved treatments are effective and safe; and
- » Access to care for all those touched by colorectal cancer.

To accomplish this, C3 works to ensure that patient interests are represented when these decisions are made. In 2007, C3 research advocacy efforts helped on three fronts.

#### Surveillance:

- » Last year saw a major change in the way chemotherapy-induced anemia (low red blood cell levels) is treated. Erythropoiesis Stimulating Agents (ESAs), drugs that stimulate red blood cell production, have been widely used since 1993 to treat and prevent anemia in cancer patients. Both the use of, and reimbursement for, ESAs have been under scrutiny.

C3 took the lead for colorectal cancer patients, by working with both the Centers for Medicare and Medicaid Services (CMS) and the Food and Drug Administration (FDA). With CMS, C3

worked to ensure that patients with rectal cancer who needed radiation would not be denied access to ESAs. With FDA, C3 is working to ensure that appropriate research will be performed to ensure that ESAs are both safe and effective (see page 3).

#### Strategic Research:

- » The National Cancer Institute (NCI) is assessing its colorectal cancer research efforts: the state of the science, emerging needs and progress evaluation. The completion of this update will result in a coordinated colorectal cancer research effort that is focused on the needs of patients. C3 pressed NCI to undertake this assessment, and is poised to help implement the results.

### C3 took the lead for colorectal cancer patients, by working with both the Centers for Medicare and Medicaid Services (CMS) and the Food and Drug Administration (FDA).

- » The Lisa Fund, established by one of C3's founders, Lisa Dubow, is dedicated to research that will help beat colorectal cancer. C3 will collaborate with the American Association for Cancer Research (AACR) to select the first Lisa Fund recipient this year. This marks the first step in C3's direct funding of critical research.

#### C3's efforts:

- » Keep colorectal cancer research a high priority at NCI;
- » Ensure patients receive quality supportive care; and
- » Fund research into new treatment options for late stage colorectal cancer patients.

Your support will continue to promote a research advocacy agenda that will win the fight against colorectal cancer. ✦



1225 King Street  
2nd Floor  
Alexandria, VA 22314

Register to receive  
future issues of **Momentum** at  
[www.FightColorectalCancer.org/momentum](http://www.FightColorectalCancer.org/momentum)

To make corrections to your contact information  
or remove your name from our mailing list,  
please send an email to  
[info@FightColorectalCancer.org](mailto:info@FightColorectalCancer.org)  
or call our office at 703-548-1225.

# www.FightColorectalCancer.org

## Current Colorectal Cancer News and Events

[www.FightColorectalCancer.org/news](http://www.FightColorectalCancer.org/news) Stay up-to-date with what's happening in the colorectal cancer field: media reports, new clinical trials, current research results, conferences and other events, and advocacy action opportunities. Reported by Kate Murphy. Also available via RSS feed to your desktop at [feeds.feedburner.com/c3news](http://feeds.feedburner.com/c3news)

## Personalized Clinical Trials Search

[www.FightColorectalCancer.org/patients/clinicaltrials](http://www.FightColorectalCancer.org/patients/clinicaltrials) Use the C3 interactive interview to find clinical trials that meet your individual needs and get telephone assistance in choosing and enrolling in a trial.

## Information for Patients

[www.FightColorectalCancer.org/patients](http://www.FightColorectalCancer.org/patients) Learn all you can about colorectal cancer diagnosis and treatment, how to manage side effects, and how to cope with life with CRC. Discover resources for support and strength on the internet and in your community.

## Grassroots Communities of Engagement

[www.FightColorectalCancer.org/advocacy](http://www.FightColorectalCancer.org/advocacy) Policy & Grassroots Manager Joe Arite and Grassroots Coordinator Dusty Weaver provide advocates with clear, effective messaging that helps us produce the results we need for colorectal cancer research and screening. Become a One Minute Advocate at [www.FightColorectalCancer.org/advocacy/oneminuteadvocate](http://www.FightColorectalCancer.org/advocacy/oneminuteadvocate).



C3: Colorectal Cancer Coalition  
1225 King Street, 2nd Floor  
Alexandria, VA 22314  
703-548-1225  
[info@FightColorectalCancer.org](mailto:info@FightColorectalCancer.org)

