The Otto J. Ruesch Center for the Cure of Gastrointestinal Cancers seeks to focus national efforts on curing all cancers that affect the digestive tract, including mouth, esophageal, stomach, pancreatic, liver, bile duct, colorectal, and anal cancers. Combining expertise in molecular medicine, translational research and a patient-centered philosophy, the Ruesch Center will realize the dream of individualized curative therapies through research, care and advocacy. The Ruesch Center is part of Georgetown Lombardi Comprehensive Cancer Center and MedStar Georgetown University Hospital.

Guest Director’s Corner: Surgical Advances in Pancreatic Cancer
Lynt Johnson, MD || February 24, 2017

Pancreatic cancer is one of the most devastating cancers to patients. Each year 30,000 patients in the U.S. will confront pancreatic cancer. The most common cancer of the pancreas starts in the ducts of the pancreas and is called adenocarcinoma. Adenocarcinoma spreads within the pancreas in an insidious and silent manner until most often it compresses the bile duct leading to jaundice. Unfortunately, by this time the cancer has often infiltrated into the nerves, lymph nodes and often the abdominal blood vessels that course through the pancreas on their way to the liver from the intestines.

In the past, if the cancer involved either the artery or vein coursing through the pancreas, surgery was often considered too risky to perform to remove the cancer. Recently, experienced surgeons have developed techniques to remove cancers and segments of the involved blood vessels and reconstruct the vessels with good results. This option when combined with upfront chemotherapy and sometimes radiation have proved to achieve results the same as when removal of the tumor is done for less advanced cancers.

In some situations when the main artery to the intestines is involved a total pancreatectomy (removal of the entire pancreas) is required to allow for vascular reconstruction. When the entire pancreas is removed this results in the patient becoming diabetic and without pancreatic enzymes but both of these conditions can be managed through medical intervention. Trading removal of locally advanced pancreatic cancer for resulting diabetes favors removal of the cancer when this option is available with experienced surgeons.

As advances in chemotherapeutic and precision medicine options become available many more patients will be able to have the option for complete removal of their pancreatic cancer and survival results will improve. There continues to be active clinical trials exploring new modalities to improve outcomes in patients battling cancer of the pancreas and we look forward to changing the outlook for patients now and in the coming years.
I am a patient with advanced stage pancreatic cancer who is currently being treated at the Ruesch Center for the Cure of Gastrointestinal Cancers at MedStar Georgetown Lombardi Comprehensive Cancer Center.

In 2016, at the age of 52 years, I received a diagnosis of Stage IV Pancreatic Adenocarcinoma at my local community hospital, presenting with a 5 cm tumor on the head of my pancreas along with multiple liver metastases. I had no real risk factors for pancreatic cancer. I ate a healthy, primarily organic, diet and had a high activity level: I was an avid year-round squash player, worked out in the gym several times a week, played golf and hockey, and tried to keep up with my wife occasionally when she went running.

My first course of treatment was at my local cancer center, in London, Ontario, Canada, where I was enrolled onto a non-targeted clinical trial that combined an investigational therapy with two approved drugs. The trial yielded a very good response in the first 3 months: many of my smaller liver lesions disappeared and a partial response of my primary pancreatic tumor occurred. However, following this promising initial response, a subsequent scan showed disease progression. As I prepared to move onto standard treatment for pancreatic cancer, my wife insisted that her research seemed to show that pancreatic cancer patients were having more success by seeking alternatives to the standard treatments. Our continued research pointed us to liver-directed therapy. This type of therapy didn’t appear to be readily available in Canada and/or the USA. I opted to begin a series of treatments at The University of Frankfurt, Germany, combining liver-directed and standard pancreatic cancer therapies; a regimen that does take its toll on the body.

We continued to read about how pancreatic cancers can be quite different in each patient; what seemed to provide a response in one patient may not provide a response in a similarly diagnosed patient. So it was a simple decision when I became aware of an organization that could find characteristics specific to my cancer and identify a more individualized treatment. This company, Perthera—through their Perthera Precision Cancer Analysis (PCA) program—would perform molecular and proteomics profiling of my tumor for the purpose of identifying a “targeted” treatment. Notably, soon after we engaged Perthera, the Pancreatic Cancer Action Network (PanCAN) announced the "Know Your Tumor" program, providing a similar service.

The molecular analyses showed several interesting mutations or rearrangements in the tumor cells within my body. My cancer showed BRCA2, CDKN2A and PI3KCA mutations, a ROS1 fusion, an ERBB2 amplification, and the absence of the common KRAS mutation seen in most Pancreatic Cancers. I wasn’t sure whether any of these were good or bad but Perthera produced a report describing several treatment options based on the individual characteristics of my tumors. I began to realize that the discovered mutations in my tumor DNA may be the key to finding a more successful treatment. It was during the review of Perthera’s recommended treatments that I

STARTRK-2 Clinical Trial

Entrectinib is a oral drug that targets NTRK1, NTRK2, NTRK3, ROS1 and ALK. Some cancers are the result of specific changes (called fusions) in these genes. These fusions can be found in many different types of cancers including lung cancer, sarcoma, thyroid cancer, salivary gland cancers, melanoma, pancreatic cancer and colorectal cancer. If a fusion is detected, a targeted agent like entrectinib can be very effective, though entrectinib is currently only available through a clinical trial.

The phase I trial, which included patients at Georgetown, was recently published in Cancer Discovery. Entrectinib was well tolerated and patients with the appropriate fusions achieved rapid and durable responses.

A larger phase II trial is now underway. To qualify, a patient’s tumor must have one of the specific fusions and testing for these fusions can be arranged by any of the Lombardi oncologists.
first spoke with Dr. Michael Pishvaian from the Ruesch Center, who also serves as Perthera’s Chief Medical Officer.

Discussions with my local oncologist and Dr. Pishvaian led me to choose two of the recommended investigational targeted therapies. One option was a multiagent trial combining a PARP inhibitor (effectively targeting the BRCA2 mutation) with modified FOLFOX6 chemotherapy. The second option was a single agent trial, named STARTTRK-II, targeting the rare ROS1 rearrangement within my tumors. Treatment with the experimental drug in this trial, Entrectinib, had shown some promising results in patients with a range of cancers in earlier phase trials.

I chose the STARTTRK-II trial. Dr. Pishvaian’s knowledge and excitement about what had occurred in previous phases of this trial definitely played a key role in my decision-making. It made complete sense to take advantage of, and target one of the rather rare mutations in my tumor DNA. He explained to me that it was his view that my cancer seemed to currently have an element of control and this was the time to target the ROS1 rearrangement with the single agent and see if I could get a similar response to that seen in previous phases of this trial. His view that Pancreatic Cancer treatment potentially required looking at novel therapies to achieve better success really resonated with me and seemed very consistent with our ongoing research findings that many patients are having better results when they choose individualized treatments. Also, the thought of not subjecting my body to further, possibly aimless, blasts of toxic chemotherapy was appealing.

I could have chosen a hospital offering the STARTTRK-II trial closer to my home but after consulting with Dr. Pishvaian I believed I would receive the best care at the Ruesch Center for the Cure of Gastrointestinal Cancers at MedStar Georgetown Lombardi Comprehensive Cancer Center. To date, the medical professionals at this facility have been first class, providing my with any information I need with respect to the trial itself, and organizing my bi-weekly visits to the Ruesch Center. At this time, while it is still early, I am approaching the end of the third 28 day cycle in this trial. Imaging after the first cycle showed that I was getting a response and more imaging will be done at the end of the third cycle. I have been feeling well and, after a whole year of battling this disease, I am again working; travelling; playing squash, golf, and hockey; and have gained 20lbs. I write this article from the coast of New Zealand as my wife and I see a part of the world that, a year ago, we thought I would never see.

As we hope and pray that this treatment is durable, our research continues into what is giving pancreatic cancer patients success in their treatments so we can be prepared to take advantage of future novel therapies, if necessary. It seems evident that this targeted approach to treatment that the Ruesch Center and others are focusing on is providing successful therapy and a good quality of life to patients with the most difficult of all cancers to treat.

**Active Clinical Trials**

Clinical trials are research studies that test new drugs, treatments, or medical procedures to determine their effectiveness and safety. Clinical cancer trials are conducted only after meeting the approval of the National Institutes of Health (NIH).

There are currently 13 active clinical trials open within the GI Cancer Network for gastrointestinal cancers. Please contact the Ruesch Center (rueschcenter@georgetown.edu) for more information about the trials.

Visit: [https://ruesch.georgetown.edu/rueschclinic_trials](https://ruesch.georgetown.edu/rueschclinic_trials) at any time to stay up-to-date.

**Spotlight on NTSR**

The Nontherapeutic Subject Registry (NTSR), under the direction of Claudine Isaacs, MD and Beth Peshkin, MS, CGC, provides centralized patient recruitment services for nontherapeutic human trials at GUMC. The NTSR implements a universal protocol and consent which includes collection of core data elements from patients at GUMC with and without cancer. Patients are also consented for collection of biospecimens and tissue, and for future contact for enrollment into specific studies and follow-up. The NTSR also encompasses the Familial Cancer Registry (FCR), which is an integrated and comprehensive resource of individuals at high genetic risk for cancer. The NTSR not only is a great tool to enhance the potential to do tumor tissue specific research, it’s existence and enrollment also have resulted in the establishment of different disease specific outcome databases, which both help increase our knowledge of treatments and help the development of new treatment options for our patients.

For more information and a list of NTSR services please visit: [https://lombardi.georgetown.edu/research/sharedresources/ntsr](https://lombardi.georgetown.edu/research/sharedresources/ntsr)
Differences between rectal cancers, left-sided colon cancers, and right-sided colon cancers
Marion L. Hartley, PhD || February 21, 2017 || The Ruesch Center

It has always been assumed that colorectal cancer is one disease and, thus, management of patients with metastatic colon and rectal cancers has always been similar. However, tumor sidedness has now emerged as an important prognostic and predictive factor in the treatment of colorectal cancer. Alan Venook was the first to provide evidence that the anatomic location of a colorectal tumor (right vs. left side) had significant impact on response to therapy and patient survival. His presentation was the highlight of the 2016 annual ASCO meeting; his research team’s findings were practice-changing.

Recent work carried out by Dr. Mohamed Salem and his collaborators

Venook’s data obviously galvanized interest in right- vs. left-sided colon cancer differences. However, Dr. Mohamed Salem of the Ruesch Center and his collaborators at Caris Life Sciences (http://www.carislifesciences.com) and ARCAD (Aide et Recherche en Cancérologie Digestive; Ann Oncol 2012; 23 (1): 281-282) were marginally ahead of the game. Dr. Salem et al presented some important findings regarding differences between colon and rectal cancers at the Gastrointestinal Cancers Symposium (ASCO GI) in January 2017 (see box below for article links).

In the Caris study, 1,891 colorectal tumors that were pathologically and histologically identified as arising from the left colon, right colon, or rectum were profiled using next-generation sequencing and immunohistochemistry protein expression analyses. More frequent abnormal activation of certain gene/protein pathways (including EGFR and BRAF), as well as higher microsatellite instability and increased mutational burden were found to occur in right-sided colon cancers compared to left-sided colon or rectal cancers. An especially novel finding was that rectal cancers had different molecular profiles to colon cancers. For example, rectal cancers had significantly higher rates of TOPO1 and Her2 expression/amplification compared to colon cancers from either side.

In the ARCAD study, differences between rectal cancers and left-sided colon cancers were assessed using ARCAD’s Advanced Colorectal Cancer Database. Although, it was found that overall survival, progression-free survival, and disease response were comparable between patients with left-sided colon and rectal cancers, it was also found that KRAS mutations were more frequent in rectal cancers than in left colon cancers. Dr. Salem concluded that further investigations are warranted to determine whether rectal cancer patients should be treated with the same chemotherapy backbone and biological therapy as left-sided colon cancers.

Thus, colorectal cancers are heterogeneous and biologically diverse; they carry a continuum of molecular alterations from right to left, rather than having a sharp, clear-cut distinction (see diagram above). Personalized treatment plans must therefore be developed for patients based on their tumor’s stage and location, as well as genetic subtype. Colonic and rectal origin should undoubtedly be considered when selecting treatment regimens and stratifying patients for future clinical trials.

A number of research teams collaborated in the interpretation and presentation of these data. Ruesch team input came from GI Oncologists as well as multitalented research administrative members who continually work hard at presentation, publication, and promotion of all research work.
Ruesch Center to Host Inaugural Golf Tournament

The first annual Ruesch Center golf tournament on April 24, 2017, will bring together local business leaders and philanthropists to tee up for a cure of gastrointestinal cancers. The tournament will be hosted at TPC Potomac at Avenel Farm. Located on 220 acres of rolling wooded countryside in Montgomery County, MD., TPC Potomac is located less than 20 miles from the nation’s capital.

The Ruesch Center Classic
Drive Out GI Cancers

This championship par 70 PGA course features bent grass greens, tees and fairways with subtle elevation changes and distinctive Mid-Atlantic and Scottish-style bunkering.

Features include breakfast, bloody-mary bar, grill style lunch, silent auction, and a cocktail reception.

Visit: www.rueschgc.golfgenius.com for more information.

Scope It Out 5K Run/Walk

Sunday, March 19, 2017
Freedom Plaza, Washington, DC

The 12th Annual Scope It Out 5K Run/Walk for Colon Cancer Awareness will be held Sunday, March 19, 2017 in the heart of Washington, D.C.

Funds raised through Scope It Out 5K Run/Walk support national prevention, research and patient & family support initiatives at the Colon Cancer Alliance. Additionally, The Chris4Life Research Fund locally partners with the Ruesch Center at Georgetown Lombardi Comprehensive Cancer Center. Through this strategic partnership, this Research Fund is supporting efforts that are improving patient outcomes and saving lives.

Join our “MedStar Georgetown – The Ruesch Center” team online: http://support.ccalliance.org/goto/medstargeorgetown17

GI Cancers Alliance

The GI Cancers Alliance (GICA) was founded by The Ruesch Center for the Cure of Gastrointestinal Cancers in 2015. The Alliance is a coalition of organizations working together to address the needs of patients with GI cancers.

The mission of GICA is to raise awareness, provide education and advocate to prevent, treat and cure GI cancers through a collaboration between advocacy groups, industry and institutional partners.

Since the group’s founding, progress has already been made by aligning purposes, as the group works to create resources and tools to help fill the gaps for patients seeking help.

For more visit: http://gicancersalliance.org

Special Discount!* Use code $17EM by February 28, 2017 to receive $25 off registration! *Discount applies for physicians only
“It affects young people and old people, men and women and we need to speak with one voice,” said John Marshall, M.D., director of the Ruesch Center for the Cure of Gastrointestinal Cancers, Georgetown Lombardi Comprehensive Cancer Center. “Part of our mission here at the Ruesch Center is to convene and to bring people together, to speak with that one voice.”

Identifying the Unmet Needs of Gastrointestinal Cancer Patients
Kat Zambon || GUMC Communications

More than 11 years ago, a report from the Institute of Medicine recommended that every cancer survivor should have a comprehensive care summary and follow-up plan, or a survivorship care plan. However, a recent survey found that more than half of the 500 gastrointestinal cancer patient participants didn’t know what a survivorship care plan was.

Martha Raymond, MA, CPN, executive director of Michael’s Mission and founder of The Raymond Foundation, conducted the anonymous online survey to explore the unmet needs of patients with gastrointestinal cancer. “We met our goal and it was just a great response,” Raymond said. “We really did get some very rich data.”

More than half of the patients surveyed reported feelings of anxiety, fear, depression and sadness during their diagnosis, treatment or survivorship. “A lot of those responses were from individuals who felt isolated,” Raymond said. “It makes you very sad to hear these things.”

Read more here.

Patients with Cancer and Their Providers Share Stories of Hope
Katie Kosko || CURE Magazine

Two years ago, Emily Pomeranz went into hospice care, nearing the end of her life, after her cancer had spread to her pancreas, liver and two spots on her lung. It was her third battle with the disease, and also her worst.

But in a turn of events, instead of losing her battle she recovered, came off of hospice and is alive to share her inspirational story today. She did just that at a live broadcast of CURE Connections held during the Seventh Annual Ruesch Center Symposium: Fighting a Smarter War on Cancer on Dec. 3 in Washington, D.C.

She told an audience of patients, survivors, caregivers and physicians how she fought and won her battle against Hodgkin’s lymphoma when she was 20 years old thanks to aggressive radiation treatments – only to discover 20 years later that she had cancer again, this time in her breast.

“Radiation was like a weird double-edged sword,” she told the crowd. “I had viewed it as my saving grace because it cured me of the Hodgkin’s disease initially, so it never crossed my mind that it could actually cause harm to me.” She underwent a mastectomy, but seven years later, at age 47, she was diagnosed with stage 4 pancreatic cancer. After only five rounds of treatment, she stopped and entered hospice.

Continue the story here.
Here’s Why the Cancer Death Rate Has Plummeted
Mandy Oaklander || Jan 05, 2017 || TIME.com

Death rates from cancer, the second-biggest killer in the United States, have dropped 25% since 1991, according to a new report from the American Cancer Society. That statistic translates into a lot of lives saved; had the cancer death rate remained steady from its peak in 1991, about two million more people would have died from cancer in the years until 2014, the report finds.

The drop is fueled by decreasing death rates from the four largest types of cancer: lung, breast, prostate and colorectal. “It’s pretty exciting for us that the cancer death rate continues to decline,” says Rebecca Siegel, strategic director of surveillance information services at the American Cancer Society and lead author of the annual report, which was published in CA: A Cancer Journal for Clinicians. “We’re making a lot of progress.”

Continue the article here.

Not on Anyone’s Radar: Colorectal Cancer in Young Adults
A 3 part mini-series from Medscape TV

Why are young adults getting colorectal cancer? This three-part series examines what is known about the growing incidence of early-onset colorectal cancer, what factors may be driving it, and the heroic efforts to arrest this devastating and frequently deadly form of the disease. Dr. John Marshall, a leading oncologist, explores this phenomenon by taking us into the exam rooms and labs of a major cancer research center, and into the lives of two patients in their 30s who have metastatic colorectal cancer.

Click here to view the episodes.
Loss of Loved One is Not the End
W. Patrick Ayers || February 17, 2017

Georgetown University and its Medical Center have been central players in the lives of my family -- for me, my parents, and my six siblings. Many of us were born and cared for there, most of us attended undergraduate and/or graduate school there, and my father worked and taught there. Among us we hold thirteen Georgetown degrees. But our love and affinity for all that is Georgetown was strengthened most when we lost one of our own to cancer.

For a large family our lives were blessed and thankfully devoid of significant life or health crises. That changed when Nicole Flanagan Ayers, wife of my brother John, gave birth to their third child. During the last trimester of that pregnancy, Nicole experienced abdominal pain and the hope was that it was somehow related to the pregnancy and nothing more. Those hopes proved false when more complete tests after she delivered her baby revealed that she had intrahepatic bile duct cancer. This was a devastating blow to all of us, but most especially Nicole and my brother John.

When she was diagnosed with her cancer, Nicole was a 32 year old mother of three young children -- a three and a half year old daughter, an almost two year old son, and a newborn girl. Nicole was beautiful and sweet, and like my own mother, a dedicated woman who relished all that it means to be a mother and wanted nothing more than to raise a family. She was bright and accomplished. After success in business, she and my brother had been married nearly five years. They were in the nascent stages of their own family, eager and excited to realize the dreams and plans that they had for their life together.

Like most families confronting cancer, Nicole and John were committed to defeating it. They read up on it and consulted with experts at Sloan-Kettering in New York, Johns Hopkins in Baltimore, and Georgetown seeking the best care and considering all forms of treatment. Ultimately this lead them to the Lombardi Comprehensive Cancer Center at Georgetown and John Marshall, M.D. and his team. All the institutions consulted are outstanding in terms of facilities, people, research, and therapy. But at Georgetown the caring and compassion, exhibited in the concept and practice of *cura personalis*, the care of the whole person, were determinative. That principle is foundational in the everyday functioning of the Medical Center. It is an extension of a set of practices Ignatius of Loyola, the founder of the Jesuits, devised for the individualized attention and care of his own priests. Its extrapolation to patient care at Georgetown reflects the origin and guidance of the University operations by the founding Jesuits.

Immediately after her diagnosis and the commencement of her treatment by Dr. Marshall, Nicole was able to continue living her life as a wife and a mother to my brother and their three children. Nicole and John made the most of their time left in the year following her cancer diagnosis but after fighting the good fight Nicole succumbed to her disease in July 2006, 11 months after she gave birth. While Nicole was only a part of our family for a short period of time, she touched each one of us and we, as a family, were determined not to forget her or our deep love for her. Nicole battled hard in her young life and we used her death as a reason to continue, not give up, her fight because that is who she was and what she would have wanted us to do.

Our challenge was to develop a means to sustain Nicole in our lives. The answer was simple. At Christmas, it was a custom in our family for each adult to draw a name of a family member out of a hat and to share a gift with that person. Beginning in 2006, the year Nicole died, we committed to making a family donation at Christmas to Dr. Marshall and The Ruesch Center in loving memory of Nicole in lieu of exchanging gifts between adult family members. Participation in the family gift was voluntary and the amount each family member contributed was left entirely up to them. This past Christmas marked the eleventh consecutive year that we have made a family contribution to The Ruesch Center and, while the amounts that each of us donates varies from year to year, every one of us has participated in all of those years and we have seen our collective gift increase nearly every year.

For us, this is a story that ends not with sadness but hope. Everyone loves the stories about someone who survived cancer but the reality is, as we know, that many do not. Finding the grace through a terminal diagnosis and its aftermath is also important for people going through these situations. Nicole’s life, though far too short, lives on each year as we remember and honor her every Christmas when we make our family contribution to The Ruesch Center. Through our annual gift we continue Nicole’s fight and support the combined efforts of Dr. Marshall and the scientists and staff at the Center to combat cancer and to offer others afflicted with this terrible disease (and their loved ones) the care and comfort they need to endure their own battle. We intend to continue this fight and our gift for years to come. We can see no better way to honor Nicole and to sustain our love for her.
John L. Marshall, MD: I want to focus on the incidence of colorectal cancer in young people. I did not sign up to be a doctor for young people. I wanted old people with cancer. All of a sudden, I have a bunch of young people, young adults in my clinic with colon cancer, many of them with metastatic colon cancer. I am so lucky to have as a friend and partner Dr Thomas Weber, who is an academic professor of surgery at the State University of New York Downstate Medical Center in Brooklyn, New York. For the second year in a row, Tom has been a part of our symposium and an expert in the realm of young people with colorectal cancer. This is not on many people’s radars. Give us the big picture of where this is. Thank you for joining us, but go right to work. Give us the big picture.

Thomas Weber, MD: Thank you, Dr Marshall. Yes, it is a bit of a surprise because, when you take a 30,000-foot view, colorectal cancer incidence in the United States is actually decreasing quite dramatically for people older than 50 years of age as a result of our successful population-based screening programs. However, for people younger than 50 years, over the past two to three decades there has been a very dramatic increase in incidence: 2%-3% increases per year, largely driven by left-sided cancers and especially rectal cancer. What we see is that the result is often delayed and there is late-stage diagnosis because both the patients and providers are not anticipating a cancer diagnosis.

Dr Marshall: They’re literally sitting on it.

Dr Weber: Tragically, yes. That is a major issue. This is a major focus for us.

Dr Marshall: Do you think we are just picking it up more, or is this really an increased number of young people getting this disease?

Dr Weber: Sometimes people offer that hypothesis, but this is based on SEER data and our best cancer center data information. There is no question that the incidence is increasing dramatically. Sometimes people will say that when you look at the actual numbers, it is an order of magnitude less than what we see for people older than 50. The reality is that it is 10%-12% of all cases in the United States. We have approximately 140,000 cases in the US. That 10%-12% is 14,000 individuals, 14,000 cases per year. That exceeds the total number of acute lymphocytic leukemia, Hodgkin's, and even cervical cancer. Of course, if you are the person diagnosed, it is not a trivial number.

There is no question that the incidence is increasing dramatically.

Dr Marshall: Washington, DC, is a very young town with a lot of young people. I can go through a full day of clinic and make it until 11:00 PM without seeing somebody over the age of 50. In my world, it's getting to feel like almost half of my patient population is middle-aged and younger instead of middle-aged and older. It’s really a big deal.

Dr Weber: It’s a situation that is really screaming for some action. The way we have tried to approach the problem is to look at presymptomatic or prediagnosis strategies and then try to improve the timeline for diagnosis when people are symptomatic, because that is a big deal. How do you identify people who are at risk? You have spoken to experts about the hereditary colorectal cancer components. Interestingly, less than 20% of these cases of people younger than 50 are associated with a known hereditary syndrome.

Dr Marshall: You would expect it to be a higher proportion, but it isn’t.

Dr Weber: However, there is risk stratification. Going back to Medical School 101, take that family history and see if there are people who have been affected. That is very important, as well as other potential risk factors such as diet, weight, and diabetes. These are all potential risk factors. Risk stratification is #1, but #2 is responding and reacting in a timely manner to people who are symptomatic. For people who have had prolonged rectal bleeding with any other abdominal complaints, if you link that to any physical sign such as anemia, the probability that there is a cancer goes up dramatically. It deserves action.

Dr Marshall: If you are a 60-year-old with some bleeding, you get your scope. If you are a 35-year-old woman with some bleeding who has had two babies, it might take 6 months for somebody to be willing to do a colonoscopy on you.

Read the rest of the story here or watch the interview.
Save the Date: GI Cancer Patient Summit

For the second year The Ruesch Center and Hope Connections for Cancer Support will co-host a GI Cancer Patient Summit in Bethesda, Maryland. The date will be Saturday, July 15th. Content will be for patients and caregivers with breakouts for specific diseases.

Details to be posted as they become available: https://ruesch.georgetown.edu/gicancerpatientsummit

The Ruesch 2016 Annual Report

The 2016 Ruesch annual report gives a comprehensive report on our activities throughout the preceding year.

Download a copy here.

Ruesch Center 2017 Request for Grant Applications

Through generous donations from our patients and partners, we are fortunate to have research funding to support several pilot projects each year. This request for applications is not for all members of our cancer community, but specifically for members of Georgetown University and MedStar health. Extramural collaborations can be considered in special circumstances.

Applications are due on or before March 31, 2017. Peer review will be completed and awards announced in June 2017. The funding period runs from July 1, 2017 through to June 30, 2018.

For more information: https://ruesch.georgetown.edu/LOI

A Cure for GI Cancers

According to CA: A Cancer Journal for Clinicians, in the year 2016, 304,930 people in the United States will be diagnosed with a gastrointestinal cancer and an estimated 153,030 people will die from this disease group.

Here at The Ruesch Center we keep an open portfolio of at least 30 clinical trials at any given time. We produce approximately 40 research publications and provide over 10 educational opportunities each year. We see an average of 700 new patients annually and have a team of 30+ clinicians to see you through every stage of your cancer journey.

BUT, we can always do more. With your continued support we can move closer to a cure for GI cancer.

Visit ruesch.georgetown.edu/about/gift to make a contribution.

Ruesch Summer Student Program - 2017

The Ruesch Summer Internship Program offers undergraduate and medical students, regionally and nationally, the opportunity to engage in medical research, patient care and patient education provided at Georgetown Lombardi Comprehensive Cancer Center and MedStar Georgetown University Hospital.

The program includes assignments shadowing physicians in the oncology clinic, working alongside oncology researchers in various projects, development of a patient education project and exposure to molecular genomics, proteomics, oncologic surgery, radiation oncology and many other areas.

The application process for the Ruesch 2017 Summer program is open and will run till March 17, 2017.

Click here for more information.