Disclosure

Speaker Bureau – Myriad Genetics
Relatively Common Hereditary Cancer Syndromes

- Hereditary Breast/Ovary Syndrome (BRCA genes)
  - Breast, ovary, others

- Lynch Syndrome (Mismatch Repair genes)
  - Colon, uterus, ovary, stomach, others

- Colon polyposis syndromes (APC, MUTYH genes)
  - Colon, upper GI, others
Hallmarks of Hereditary Cancer

• **Family clustering** of specific types of cancer among siblings or across multiple generations
• **Younger age** at diagnosis compared to non-hereditary cases of the same cancer
• **Multiple cancers** in the same person
• **Typical phenotypes** in some cancers
“FAMP” and Hereditary Cancer

Family

Age

Multiplicity

Phenotype
Take-Home Messages For Today

• Hereditary CRC is much more common than previously realized

• Historically, doctors do a rather poor job of recognizing these patients/families before it is too late

• Many of the resulting cancers could have been prevented, or at least found in an earlier, more curable stage

• The syndromes involve high risk for cancers other than CRC, and providers must be familiar with this spectrum of cancers
Why should we care?
Hereditary Cancer Syndromes
The Prevention Strategy

• These are relatively common cancers
• Many patients have cancer because of an inherited genetic defect, and are at risk to develop a future second cancer
• It is possible to identify these patients, as well as their family members who have the same defect but no cancer yet
• Once identified, we can actually **prevent** many of the cancers that were destined to occur
• Opportunity to identify the non-carriers within a cancer family, and to modify their risk management accordingly
## Preventable Hereditary Cancers

<table>
<thead>
<tr>
<th>Type of Cancer</th>
<th>Percent Hereditary</th>
<th>Percent Preventable</th>
<th>Effective Surveillance?*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast</td>
<td>5-10%</td>
<td>Nearly 100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Ovary</td>
<td>13-16%</td>
<td>&gt;95%</td>
<td>No</td>
</tr>
<tr>
<td>Uterus</td>
<td>3-5%</td>
<td>100%</td>
<td>+/-</td>
</tr>
<tr>
<td>Colorectal</td>
<td>5%</td>
<td>70-90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Melanoma</td>
<td>5-10%</td>
<td>Unknown</td>
<td>Yes</td>
</tr>
<tr>
<td>Pancreas</td>
<td>5-10%?</td>
<td>Unproved</td>
<td>Evolving</td>
</tr>
</tbody>
</table>

* “Effective surveillance” implies that there is a high-risk surveillance strategy available that reliably leads to earlier diagnosis of the cancer at a more curable stage.
Some hereditary cancers may be biologically distinct from their sporadic counterparts, and this may have a significant effect on:

- Overall prognosis
- Surgical decision-making
- Chemotherapy alternatives
Hereditary Colorectal Cancer Management Implications

- Lynch CRC has a better prognosis than sporadic
- Consideration of total colectomy in Lynch or FAP pts
- Consideration of prophylactic hysterectomy in Lynch patients undergoing colon resection for CRC
- 5FU not effective as the dominant drug in Lynch CRC
Epidemiology of Colorectal Cancer

145,000 new U.S. cases/year

Sporadic (70%)

Familial (30%)
Epidemiology of Colorectal Cancer

- Sporadic (70%)
- Hereditary (≈5%)
- Familial (30%)
Epidemiology of Colorectal Cancer

- Sporadic (70%)
- Hereditary (≈5%)
- Familial (30%)
- Lynch (3%)
- FAP (≤ 1%)
- MAP (≤ 1%)
- Others (?? %)
Epidemiology of Colorectal Cancer

Sporadic (70%)

Hereditary (≈5%)

Familial (30%)

Lynch (3%)
FAP (≤ 1%)
MAP (≤ 1%)
Others (?)

≈8000 New Cases/Year
Hereditary Colorectal Cancer: Common Syndromes

POLYPOSION (many colon polyps):
Familial Adenomatous Polyposis (Classic FAP)
Attenuated FAP (AFAP)
MUTYH-Associated Polyposis (MAP)
Serrated, juvenile, Peutz-Jeghers, Cowden, other rare non-adenomatous syndromes

NON-POLYPOSION (relatively few polyps):
Lynch Syndrome (formerly “HNPCC”)

Familial Adenomatous Polyposis (Classic FAP)

- Hundreds to thousands of polyps
- Early age of onset, frequently in teen years
- Mutation in the **APC** gene
- Autosomal dominant

- 30% of affected individuals represent de novo rather than inherited mutations, and therefore may have no family history of polyps or cancer
Familial Adenomatous Polyposis (Classic FAP)

- Virtually 100% chance of developing colorectal cancer unless preventive total colectomy is performed.
- Average age for colon cancer approximately 35-40 yrs
  - 7% occur by age 21, 90% by age 50
- Gastric cancer in 2-5% (may be higher in Asians)
- Duodenal, periampullary cancer 4-12%
- Thyroid cancer 4-6%
- Variety of other extraintestinal manifestations:
  - Osteomas, desmoid tumors (Gardner syndrome)
  - CNS medulloblastoma (Turcot syndrome)
  - CHRPE
Congenital Hypertrophy of the Retinal Pigment Epithelium
Attenuated FAP (AFAP)

• “FAP Lite”
  • Typically less severe but highly variable degree of polyposis
  • Often involves the right side of the colon more than the left
  • Later age of onset, often 30’s or older

• Lower penetrance for colorectal cancer, estimated 80%
• Patients with relatively low polyp density can be managed with annual surveillance colonoscopy
• Some will still eventually require preventive surgery
Attenuated FAP (AFAP)

- Same gene as classic FAP, with same rate of de novo mutations
- **The upper GI cancer risks are not attenuated**
- Extracolonic manifestations similar to classic FAP, although CHRPE and desmoid tumors are not seen as commonly

- These patients are much harder to diagnose than classic FAP
- **Critically important to track the cumulative number of adenomatous polyps removed over time**
- **Ten** is the consensus number to trigger genetic evaluation
- Desmoid tumors should also lead to genetic testing
Case Study FM

- 52 y/o male who has been under high-risk surveillance for colon cancer since age 42
- At 42 he was found to have 2 sigmoid adenomas on his first screening colonoscopy
- Repeat scope q 2-3 yrs, with 1-3 polyps each time
- Scope at 52 shows 8 adenomas, mostly ascending and transverse. One is a villous adenoma with dysplasia.
- Mother died from colon cancer at 49
- No other history of CRC or polyps known in the family
Case Study FM

50
No Polyps

52
Polyps 42

49
Colon

70

72

66

43
Never scoped
Case Study FM

- What is the key question to be asked for this patient?
Case Study FM

- What is the key question to be asked for this patient?

- Cumulative number of adenomas is now 23 (two years earlier the number had been 15)
Case Study FM

• What is the key question to be asked for this patient?

• Cumulative number of adenomas is now 23 (two years earlier the number had been 15)

• Genetic consultation leads to germline testing, and he is found to carry a mutation in the APC gene
Case Study FM

- 50 No Polyps
- 49 Colon
- 70
- 72
- 66
- 52 Polyps 42
- 43 Never scoped
Case Study FM

- 49 Colon
- 70
- 72
- 66
- 50 No Polyps
- 52 Polyps 42
- 43 Never scoped
- 30
- 27
- NEG
- NEG
- NEG
Case Study FM

First scope reveals 7 adenomas, one with dysplasia.
MUTYH-Associated Polyposis (MAP)

- MUTYH gene aka MYH
- **Recessive** trait rather than dominant
- 1-2% of Americans carry an MYH mutation, esp Europeans

- Patients who are doubly heterozygous typically have a **phenotype similar to attenuated FAP**, with highly variable degree of polyposis and age of onset, and increased incidence of duodenal polyps

- Other potential cancers include thyroid, ovary, breast, uterus, bladder, and skin – risks are not yet well characterized
MUTYH-Associated Polyposis (MAP)

- “Average” patient has onset of polyps in 40’s, and cumulative number of ten by age 50
- Some patients never reach ten polyps, but start earlier in life
- Some have developed CRC, including at young age, without ever demonstrating “polyposis” per se
- The spectrum of MAP remains poorly defined, and the syndrome is likely to be highly underdiagnosed
“Gee. I had hoped to make it to the adult table at Thanksgiving before you recommended I have my first colonoscopy.”
Cumulative incidence of colorectal cancer by age in subjects with genetic syndromes compared with the general public.

Lynch Syndrome

Lifetime Risk of Cancers (vs Normal)

- Colorectal 80% (5-6)
- Endometrial 40-60% (2.5)
- Ovary 8-12% (1.5)
- Stomach 8-10% (<1)
- Urothelial 4-5% (<1)
- Biliary/Pancreas 2-4% (<1)
- Small intestine 1-2% (<1)
- CNS (GBM) 1-3% (<1)
- Breast? Prostate?
Prevalence of Hereditary Cancer: BRCA vs Lynch Syndrome

Which ratio most closely approximates the number of U.S. patients affected with BRCA mutations compared to the number affected by Lynch syndrome?

A) 20 to 1
B) 10 to 1
C) 5 to 1
D) 1 to 1
Prevalence of Hereditary Cancer: 
BRCA vs Lynch Syndrome

Which ratio most closely approximates the number of U.S. patients affected with BRCA mutations compared to the number affected by Lynch syndrome?

A) 20 to 1
B) 10 to 1
C) 5 to 1
D) 1 to 1
Prevalence of Hereditary Cancer: BRCA vs Lynch Syndrome

- Prevalence of BRCA mutations in U.S. ≈ 1 in 400
  - Prevalence of BRCA in American Jews ≈ 1 in 40
- Prevalence of Lynch syndrome in U.S. ≈ 1 in 450
Prevalence of Hereditary Cancer: BRCA vs Lynch Syndrome

- Prevalence of BRCA mutations in U.S. ≈ 1 in 400
  - Prevalence of BRCA in American Jews ≈ 1 in 40

- Prevalence of Lynch syndrome in U.S. ≈ 1 in 450

- Fewer than 10% of all BRCA carriers in U.S. have been identified, and fewer than 2% of Lynch patients have been found
## Colorectal Cancer Phenotype

<table>
<thead>
<tr>
<th>Sporadic</th>
<th>Lynch</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avg age 60-65</td>
<td>Avg age 45-55</td>
</tr>
<tr>
<td>2/3 left-sided</td>
<td>2/3 right-sided</td>
</tr>
<tr>
<td>Variable histology</td>
<td>Mucinous, signet ring</td>
</tr>
<tr>
<td>Slow evolution from polyp to cancer</td>
<td>Rapid evolution from polyp to cancer</td>
</tr>
<tr>
<td>MSI 10-15%</td>
<td>MSI 90%</td>
</tr>
</tbody>
</table>
Genetics of Lynch Syndrome

- Caused by an inherited defect in any one of several “mismatch repair” genes (MMR). Five genes are currently available for clinical testing:
  - MLH1 (most common gene involved)
  - MSH2 (second most common, freq assoc with MTS)
  - MSH6 (excess of uterine cancers)
  - PMS2 (new, prevalence and features are uncertain)
  - EPCAM (not MMR, but adjacent to MSH2)

- Prior to 2011, clinical testing of the last two genes was not available, ie, suspicious patients who were previously “negative” may need to be retested.
Genetics of Lynch Syndrome

- These mismatch repair genes normally function as part of the “spell-check” system to correct DNA mismatch mutations that occur naturally during the DNA replication phase of cell division.

- Failure of the system leads to more rapid accumulation of these mutations – “Genomic Instability.”

- Cancer occurs when a sufficient number of these mutations occur in critical genes – it’s just a matter of time.
Lynch Syndrome
Accelerated Timeline For CRC

• Genomic instability in Lynch syndrome greatly accelerates the timeline from colon polyp to CRC
• Instead of the usual 7-10 years, it may be only 1-3 years

• Beware of the colon cancer that seemed to come out of nowhere, within 2-3 years of a normal colonoscopy

• This is not only the basis for the annual colonoscopy recommendation, but also an important clue to underlying Lynch syndrome
How do we find the people with Lynch syndrome?

- Traditional clinical criteria:
  - Amsterdam criteria
  - Bethesda criteria
- Rigorous application of “red flags” to newly diagnosed patients with colon or endometrial cancer
- Systematic review of cancer survivors
- Universal pathology screening of CRC and endometrial cancer
- Computer prediction models (PREMM, MMPro, etc)
Traditional Clinical Criteria For Lynch Syndrome

- **Amsterdam (1994)** – “3-2-1” analysis of family
  - 3 members with CRC, 2 of whom are 1st degree relatives of the 3rd, and 1 had to be under 50 at dx
  - Only colorectal cancer taken into account
  - Only 30% of Lynch families meet these criteria

- **Amsterdam II (2001)** – Included all Lynch cancers
  - Sensitivity improved to 50%

  - Age, location, histology
  - Simplified family history criteria
  - Still only captures 60-70% of Lynch families
“Red Flags” For Lynch Syndrome

• ANY pt diagnosed with CRC or uterine cancer by age 50
• ANY pt with multiple Lynch cancers, regardless of age
• Any patient with a Lynch cancer and a suspicious family history of other Lynch cancers (3 cancers within 3 degrees)

• Any colon or uterine cancer with typical Lynch phenotype:
  • Right-sided CRC (proximal to splenic flexure)
  • Lynch histology features (any one)
  • Loss of expression of a mismatch repair protein by IHC
“Pink Flags” For Lynch Syndrome

• Cancer of the ureter or renal pelvis
• Cancer of the small intestine
• Development of colorectal cancer less than three years out from a clean colonoscopy
• Sebaceous tumors (adenomas, carcinomas)
  • Muir-Torre syndrome (MTS)
Computer Models For Assessing Likelihood of Lynch Syndrome

- Several different models to determine the statistical likelihood that a given patient has Lynch syndrome
- Variables taken into account include:
  - Type and age of cancer in the patient
  - Multiplicity of cancers
  - Weighted family pattern for cancers in first and second degree relatives
- PREMM, MMRPro, others
- NCCN 2014: Patients with > 5% likelihood are appropriate for DNA testing
Diagnostic Tools For Lynch Syndrome

Tumor Testing:
• Microsatellite Instability (MSI)
• Immunohistochemistry (IHC) for MMR proteins
  • Useful for automatic screening of all CRC patients at the pathology level

Germline DNA Testing:
• Direct DNA analysis of one or more of the five genes
• This is the only way to diagnose LS, and the only way to track the mutation through the family
Microsatellite Instability (MSI)

• PCR-based test performed on the actual cancer, as well as normal tissue from the same patient
• **Detects the failure of mismatch repair** in the malignant clone compared to the normal tissue
• Confusing nomenclature: abnl test reported as “MSI-High”
• 12-15% of all CRC is MSI-high
• This test is NOT DIAGNOSTIC of Lynch syndrome, and is only 20% specific (ie, 80% have a different underlying cause which is somatic, not hereditary)
• 90% sensitive for LS
Immunohistochemistry (IHC)

- Performed on the cancer tissue, looking for the presence or absence of the four mismatch repair proteins in the tumor
- Theoretically, the defective gene will not produce the corresponding MMR protein
- **An abnormal test is NOT DIAGNOSTIC of Lynch syndrome, particularly if the missing protein is MLH1**
- Similar to MSI, IHC is 20% specific and 90% sensitive for LS, but the 10% it misses is not the same 10% that MSI misses—*together the tests are about 98% sensitive*
- Useful for screening population groups with colon and endometrial cancer
Germline DNA Testing

• Performed on blood or saliva

• Testing for mutations in any of the five Lynch genes that would render that gene defective, and therefore unable to produce the corresponding MMR protein

• This is the **only** way to confirm the diagnosis of LS, and the **only** way to track a mutation through the family
How Many CRC Patients Should Be Tested For Lynch Syndrome?

- NCCN guidelines and other consensus recommendations are set to trigger testing when the likelihood of being positive is approximately 10% or higher.

- When guidelines are applied to large groups of patients, at least 20-25% of patients with breast cancer or colorectal cancer appear to be appropriate for testing.
Traditional Lynch Syndrome Algorithm

- **Genetic Evaluation**
  - Meets Amsterdam II Criteria
  - Meets Single Revised Bethesda Criteria
  - Meets None
  - MSI and IHC on Tumor
    - Normal
    - Abnormal
      - DNA Testing
        - Likely to have Lynch Syndrome
      - Unlikely to be Lynch Syndrome (Beware the limited family structure)

Case Study AC

- 50 y/o female who was diagnosed with ascending colon cancer at 42 (2000), at the time of her first screening colonoscopy

- Right hemicolecctionomy, adjuvant chemotherapy

- Father had colon cancer at 52, died at 54
- Paternal uncle had colon cancer at 54
- Paternal grandmother had uterine cancer at 46, then colon cancer at 73
Case Study AC – “Red Flags”

• 50 y/o female who was diagnosed with ascending colon cancer at 42, at the time of her first screening colonoscopy

• Right hemicolecctomy, adjuvant chemotherapy

• Father had colon cancer at 52, died at 54
• Paternal uncle had colon cancer at 54
• Paternal grandmother had uterine cancer at 46, then colon cancer at 73
Case Study AC - FAMP

- Uterus 46
  - Colon 73

- Colon 54
  - 49 MI

- Colon 52
  - 50 Colon 42
  - 28

- No Cancers
  - 49

Age:
- 49
- 44
- 56
- 28
- 49
Case Study AC

• This patient and her family were missed at the time of her diagnosis at 42, and at every follow-up visit with multiple physicians over the next 7 years

• She was identified by systematically applying the “red flags” to our CRC survivor population

• She was found to carry a mutation in the MSH2 gene
Case Study AC

Uterus 46 Colon 73

Colon 54

Colon 52

No Cancers

50 Colon 42

49

49 MI
Case Study AC

No Cancers

Uterus 46
Colon 73

Colon 54

75

 Colon 54

49 MI

Colon 52

50
Colon 42

NEG

49

44

NEG

49

56

28

NEG

49

?
Lifetime Risk of Lynch-Related Cancers (vs Normal)

- Colorectal 80% (5-6)
- Endometrial 40-60% (2.5)
- Ovary 8-12% (1.5)
- Stomach 8-10% (<1)
- Urothelial 4-5% (<1)
- Biliary/Pancreas 2-4% (<1)
- Small intestine 1-2% (<1)
- CNS (GBM) 1-3% (<1)
- Breast?, Bladder?
Case Study AC

• She was found to carry a mutation in the **MSH2** gene

• She went on to have a prophylactic complete hysterectomy/oophorectomy

• This procedure could have been done as part of her hemicolecotomy if her Lynch diagnosis had been timely
How do we actually manage cancer risk in patients with Lynch syndrome?
Lynch-Related Cancers With Effective Risk-Reducing Strategies

• Colorectal 80% (5-6)
• Endometrial 40-60% (2.5)
• Ovary 8-12% (1.5)
• Stomach 8-10% (<1)
• Urothelial 4-5% (<1)
• Biliary/Pancreas 2-4% (<1)
• Small intestine 1-2% (<1)
• CNS (GBM) 1-3% (<1)
• Breast?, Bladder?
Cancer Risk Management In Lynch Syndrome

- Screening colonoscopy starting at 25*, annual after age 30
- Transvaginal sono and CA-125 starting at 30*, then annually
- Complete hysterectomy after child-bearing is complete (35-40)
- EGD starting at 30, then q 3 yrs unless gastric cancer in the family, or gastric polyps identified
- Annual U/A +/- urine cytology starting at 30
- ? Evolving role for EUS in screening for pancreas

*Age to start screening may need to be modified in families with cancers occurring at very young age
Case Study ME

- 39-year-old moderately obese female with menorrhagia
- Endometrial bx shows carcinoma
- Hysterectomy reveals Stage IA endometrioid carcinoma
- Family history reveals no other GYN malignancies
- Father had colon cancer at 55
- Paternal grandmother had pancreas cancer at 51
Case Study ME - FAMP

- Uterus [39]
- Pancreas [51]
- Colon [55]
- [43]
- [45]
Case Study ME

- 39-year-old moderately obese female with Stage IA endometrial carcinoma

- At 44 she underwent her first screening colonoscopy (10-year rule), and was found to have a tubulovillous adenoma in the ascending colon
Case Study ME

- 39-year-old moderately obese female with Stage IA endometrial carcinoma

- At 44 she underwent her first screening colonoscopy (10-year rule), and was found to have a tubulovillous adenoma in the ascending colon

- Repeat colonoscopy one year later was normal

- When would you scope her again?
Case Study ME

• 39-year-old moderately obese female with Stage IA endometrial carcinoma

• At 44 she underwent her first screening colonoscopy (10-year rule), and was found to have a tubulovillous adenoma in the ascending colon

• She was advised to return for follow-up colonoscopy in 3 yrs
Case Study ME

• 39-year-old moderately obese female with Stage IA endometrial carcinoma

• At 44 she underwent her first screening colonoscopy (10-year rule), and was found to have a tubulovillous adenoma in the ascending colon

• She was advised to return for follow-up colonoscopy in 3 yrs

• At 48, she was found to have adenocarcinoma in the cecum

• Right hemicolecctionomy for Stage III-A cancer
Case Study ME - FAMP

Pancreas 51

Colon 55 74

Uterus 39
Colon 48

51

49 74 72 74

53
Case Study ME – “Red Flags”

- 39-year-old moderately obese female with Stage IA endometrial carcinoma
- Right hemicolecotomy at 48 for Stage II cecal cancer
- Father had colon cancer at 55
- Paternal grandmother had pancreas cancer at 51
Case Study ME – “Red Flags”

• 39-year-old moderately obese female with Stage IA endometrial carcinoma

• Right hemicolecotomy at 48 for Stage II cecal cancer

• Father had colon cancer at 55

• Paternal grandmother had pancreas cancer at 51

• DNA testing revealed a mutation in MSH6
Case Study ME

Pancreas 51

Colon 55

48

Uterus 39
Colo 48

51

74

49

74

72

74

53

74
Case Study ME

- Colon 55
  - Pancreas 51
    - Uterus 39
      - Colon 48
        - NEG
  - 49
  - 74
  - 72
  - 74
  -유산소
  - 유산소
  - 유산소

- NEG
- NEG
- NEG
- NEG
- NEG

- 30
- 27
- 28
- 26
- 34
- 53

- NEG
- NEG

Case Study ME – The Sister

• Sister had normal colonoscopy and EGD

• Transvaginal sonogram showed a left adnexal mass, and CA-125 level was 580

• Mucinous cystadenocarcinoma of the ovary, Stage IIIC
Case Study ME Time-Line

Father’s Colon Ca
Age 55

Patient’s Uterine Ca
Age 39

Patient’s Ascending TVA
Age 44

Patient’s Cecal Ca
Age 48

Sister’s Ovarian Ca
Age 51
Case Study ME Time-Line

Father’s Colon Ca Age 55
1995

Patient’s Uterine Ca Age 39
2000

Patient’s Ascending TVA Age 44
2005

Patient’s Cecal Ca Age 48
2009

Sister’s Ovarian Ca Age 51
2011

When should this family have been diagnosed?
Case Study ME Time-Line

Father’s Colon Ca  
Age 55

1995

2000

Patient’s Uterine Ca  
Age 39

Patient’s Ascending TVA  
Age 44

2005

2009

Patient’s Cecal Ca  
Age 48

2011

Sister’s Ovarian Ca  
Age 51

At least 2 of these cancers could have been prevented
At least 2 of these cancers could have been prevented ........and 1 death
Case Study RT

- 51 y/o woman with Stage II-B cancer of the cecum
- Presented with abdominal cramping only 18 months out from a normal screening colonoscopy

- First colonoscopy at age 25, and q 3 yrs since then
- Brother diagnosed with Stage IV colon ca at age 23

- Right hemicolecctomy performed
Case Study RT

- Brother died of colon cancer at 23
- No colon polyps in either sister with q3yr surveillance

- Father had ureteral ca at 45, then prostate ca at 70
- Paternal aunt died of pancreas ca at 46
- Paternal GM had uterine ca at 44
Case Study RT – “Red Flags”

- 51 y/o woman with Stage II-B cancer of the cecum, diagnosed only 18 months after a normal colonoscopy
- Brother diagnosed with Stage IV colon ca at age 23
- Father had ureteral ca at 45, then prostate ca at 70
- Paternal aunt died of pancreas ca at 46
- Paternal GM had uterine ca at 44
Case Study RT - FAMP

- Uterine 44
- Stroke 51
- MI 55
- Pancreas 46
- Colon Ca 23
- Cecal Ca 51
- Ureter 45
- Prostate 70
- Unknown
- 79
- 55
- 46
- 76
- 70
- 74
- 54
- 23
- 26
- 28
- 18
- 19
- 22
- 14
- 18

Total:
- 232
Case Study RT

- Genetic evaluation revealed a mutation in **MLH1**
Case Study RT

MI 55 Pancreas 46 Colon Ca 23 Uterine 44 Stroke 51 Ureter 45 Prostate 70 Cecal Ca 51 Unknown

79 MI 55 Pancreas 46 Colon Ca 23 Uterine 44 Stroke 51 Ureter 45 Prostate 70 Cecal Ca 51 Unknown

54 Colon Ca 23

26 28 18 19 22 14 18
Case Study RT

• Genetic evaluation revealed mutation in **MLH1**

• Patient needed a second operation to remove her uterus and ovaries
Case Study RT – The Nieces

- MI 55
- Pancreas 46
- Uterine 44 Stroke 51
- Colon Ca 23
- Cecal Ca 51
- Ureter 45 Prostate 70
- Unknown

- 79
- 54
- 74
- 46
- 26
- 28
- 18
- 19
- 22
- 14
- 18
Case Study RT – The Nieces

MI 55 Pancreas 46
Uterine 44
Stroke 51

Colon Ca 23
Cecal Ca 51

Unknown

79
MI 55
Pancreas 46

76
Ureter 45
Prostate 70

74

46

NEG

54

26
28
18
19
22
14
18
Lynch Syndrome: How Are We Doing?

- Fewer than 2% of all patients affected with Lynch syndrome have yet been identified.

- Approximately 20-25% of all colorectal and endometrial cancer patients are suitable for focused genetic evaluation.
Screening For Lynch Syndrome: The Traditional Approach

- Traditional dependence on providers to identify these patients has been largely ineffective:
  - Wide spectrum of cancers and physicians
  - Providers underestimate the prevalence of these syndromes, and the associated cancer risks
  - Too much reliance on the “slam dunk” family history
  - Too little attention to the phenotype that is typical for Lynch colon cancer

- Families get missed, cancers continue to occur
Screening For Lynch Syndrome: The Pathology Approach

- **Automatic screening** of colon or endometrial cancers at the pathology level using MSI or IHC testing

- 15% of all colon cancers will exhibit MSI or abnormal IHC, and 90% of the Lynch colon cancers will be within this group

- Finding the 3% that are Lynch syndrome within this 15% is much easier than finding the 3% within the 100%
Screening For Lynch Syndrome: The Pathology Approach

- If MSI or IHC is abnormal, a genetic evaluation and appropriate DNA testing is triggered.

- Most labs favor IHC over MSI screening:
  - Faster, cheaper, more readily available
  - Can be performed on biopsy material
  - May provide insight as to which of the MMR genes is defective
Lynch Syndrome Algorithm: The CRC Pathology Approach

Suspicious Phenotype
- Mucinous, Right-sided OR < 70

Automatic Pathology Screening: IHC
- Absent MLH1 (80% sporadic)
- Absent MSH2, MSH6, or PMS2
- Normal

BRAF Testing
- Positive
- Negative

Genetic Evaluation
- Negative
- DNA Testing

Family Cancer History Analysis
- Suspicious
- OK
- Unlikely to be Lynch Syndrome
Lynch Syndrome Algorithm: The Universal Pathology Approach

Automatic Pathology Screening: IHC

- Absent MLH1 (80% sporadic)
- Absent MSH2, MSH6, or PMS2
- Normal

BRAF Testing

- Positive
- Negative

Genetic Evaluation

- Suspicious
- OK

DNA Testing

- Positive
- Negative

Family Cancer History Analysis

- OK
- Unlikely to be Lynch Syndrome

ALL CRC And Endometrial Cancer Patients
Case Study PS

• 64 y/o woman found to have cancer in the descending colon on routine colonoscopy
• Left hemicolectomy, Stage II-A
• Previous TAH at 49 for fibroids

• Paternal grandmother had ovarian cancer at 61
Case Study PS

No cancers on mother’s side
Case Study PS - No Red Flags

• 64 y/o woman found to have cancer in the descending colon on routine colonoscopy
• Left hemicolectomy, Stage II-A
• Previous TAH at 49 for fibroids

• Paternal grandmother had ovarian cancer at 61
Case Study PS

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- Left hemicolecction, Stage II-A
- Previous TAH at 49 for fibroids

- **Automatic pathology screening with IHC shows that the MSH6 protein is not expressed in the cancer**

- DNA testing confirms a mutation in the **MSH6** gene
Case Study PS

No cancers on mother’s side

64 Colon

44 MVA

61 Ovary

66

44

41

60

85

87
Case Study PS

No cancers on mother’s side

NEG 85

44 MVA

NEG 61 Ovary

NEG 66

64 Colon

44

41

60
Screening For Lynch Syndrome: Limitations of The Pathology Approach

• It will still miss the 10% of Lynch CRC and endometrial cancer who have normal tumor testing with IHC

• Still need proper attention to the family history, requiring providers to know the spectrum of Lynch cancers

• This strategy will not help to identify the many Lynch patients who are among the cancer survivors, or the carriers who have not yet had cancer
Summary and Call To Action

• These syndromes are more common than you may realize, and they are easily missed

• The potential impact on both cancer prevention and cancer management can be huge

• The cumulative number of colon adenomas needs to be systematically tracked in all patients with polyps
Summary and Call To Action

• Pay attention to family history of cancers other than CRC
  • Uterus, ovary, gastric, pancreas, urothelial
  • Update every time patient returns

• Universal IHC screening for MMR proteins should be performed on all CRC and endometrial cancer patients
• Consider doing it on biopsy material so that genetic results can be known before definitive surgery
Summary and Call To Action

• Rigorous application of the “red flags” will capture the majority of families in newly diagnosed patients

• Testing should be considered soon after diagnosis in appropriate patients

• A systematic process is required for providers to find the affected patients among their survivor populations
Summary and Call To Action

• Cancer genetics is now a critical element in providing high quality comprehensive cancer care

• Every physician and nurse has a role to play in identifying these patients and their families

• We can prevent many cancers that were destined to occur