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Welcomes...

Vishnupriya G.  
Krishna, M.D.



Dr. Krishna received her medical degree from Gandhi Medical College, University Health Sciences in India. Both her Internal Medicine residency and Gastroenterology fellowship were completed at the State University of New York (SUNY). Dr. Krishna is board certified in Gastroenterology and Internal Medicine. Before coming to Annapolis, Dr. Krishna practiced Gastroenterology in Colorado. Dr. Krishna resides in Annapolis with her husband and daughter. Her primary interests are GI motility, reflux, and research of new treatments of GI diseases. Dr. Krishna is accepting patients in the Annapolis and Odenton office.

Please call to schedule a  
Consultation:

**410-224-4887**

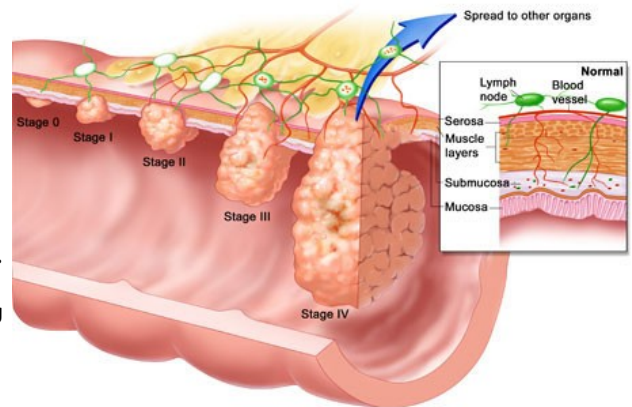
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## Colon Cancer Awareness Month—March 2010

Colorectal cancer (CRC) remains a common and lethal disease. It is the second leading cause of cancer death, and accounts for approximately 9 percent of cancer deaths overall. Approximately one in three people who develop CRC die of this disease. CRC is infrequent before age 40; the incidence rises progressively thereafter to 3.7/1000 per year by age 80. The lifetime incidence for patients at average risk is 5 percent, with 90 percent of cases occurring after age 50. However, it has favorable outcomes if found early.

The ACG recommends colonoscopy as the preferred screening/prevention test starting at age 50, and fecal immunochemical test (FIT or FOBT) annually. For patients who are unable to undergo optical colonoscopy, preferred prevention diagnostics include virtual colonoscopy, flexible sigmoidoscopy, and double contrast barium enema. Additionally, for African Americans the ACG now recommends initiating screening at age 45.

Although stool based DNA tests are available, endoscopic or radiologic tests that visualize the bowel mucosa have the potential to prevent cancer by detecting polyps that can be removed prior to malignant transformation. Most colorectal cancers arise from adenomatous polyps that progress from small to large (>1.0 cm) polyps, and then to dysplasia and cancer. These cannot be distinguished reliably by DNA tests or gross appearance; biopsy is required for diagnosis. The finding of one adenomatous polyp suggests a propensity to form polyps, and number and type of lesions found will determine the interval for subsequent surveillance colonoscopies.



Questions that will help determine if the patient may be at increased risk for colorectal cancer:

1. Have you ever had colorectal cancer or an adenomatous polyp?
2. Have you had inflammatory bowel disease (ulcerative colitis or Crohn's disease)?
3. Have any family members had colorectal cancer or an adenomatous polyp? - If so, how many, were they first-degree relatives (parent, sibling, or child), and at what age was the cancer or polyp first diagnosed?

The patient is considered at average risk if all answers to the three initial questions are "no". Patients answering "yes" to any of these questions may be at increased risk and need to be evaluated further. We suggest asking these questions by age 20.

Removal of premalignant adenomas via traditional colonoscopy can prevent cancer, and removal of a localized cancer may prevent CRC-related death.

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