

AUGUST 6, 2026

INSIDE OUT

A Practical Guide to
Colon Cancer
Prevention & Gut
Wellness

MHWCAUSTIN.ORG



We will get started here
shortly! Welcome in!

ANNOUNCEMENTS

Moderators for today's meeting:



Susan Thompson
ABGOH Co-Chair



Cloe Butler
ABGOH Co-Chair

- Thanks for joining us today!
We're HYBRID
- Thank you to everyone who applied for the MHWC Worksite Certification and Awards!
- Virtual participants, please remain muted during the presentation
- Questions will be answered at the end of the presentation

1

ANNOUNCEMENTS & INTROS

2

SPEAKER

3

QUESTIONS & ANSWERS

4

RESOURCES & CLOSING
REMARKS

AGENDA

AUSTIN BUSINESS
GROUP ON HEALTH



WELCOME OUR SPEAKER



Dr. Pradeep Kumar

AUGUST 6, 2026

Gut Microbiome & Early-Onset Colon Cancer

Austin Business Group on Health

Pradeep Kumar MD



Qualifications

EDUCATION & TRAINING

Rice University — B.A., Biology

UT Southwestern — M.D.

UT Southwestern — Internal Medicine

UC San Diego — Gastroenterology

COMMUNITY & MEDIA

Past President, Travis County Medical Society (2015)

Past President, Texas Society of Gastroenterology & Endoscopy (2024)

FOX 7 Medical News (2005–present)

TCMS Physician of the Year (2024)

THE GUT MICROBIOME

Science, hype and what helps

A practical guide for everyday health



Your gut is an ecosystem—not a broken appliance

There is no single “perfect” microbiome.

A healthy community is defined less by one magic microbe and more by what the whole system does: digesting, producing useful chemicals, resisting invaders and interacting with us.



The microbiome is a crowded community

Bacteria

The best studied members
—many help process food
and make metabolites.

Most research focuses here

Viruses

Many infect bacteria and
can reshape the
community.

Still understudied

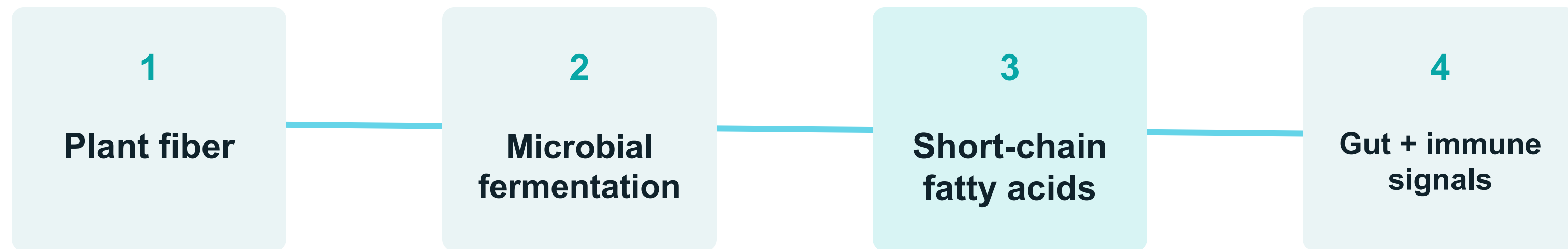
Fungi + others

Smaller in number, but still
part of the ecosystem.

Still understudied

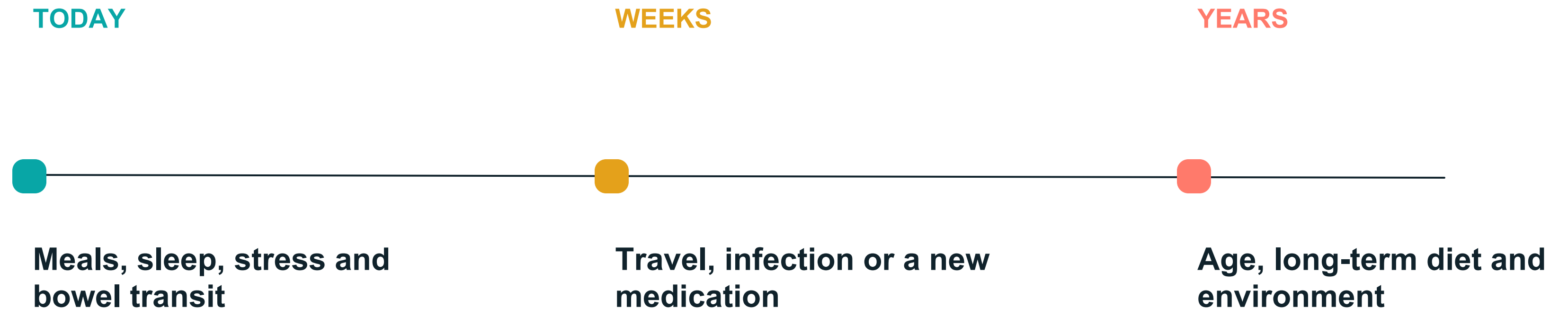
Most live in the large intestine, where food residues and mucus create a rich habitat.

Microbes turn leftovers into useful signals



One important product: short-chain fatty acids that help nourish colon cells and influence inflammation.

Your microbiome changes with context



A stool sample is a snapshot—not a permanent identity card.

Association is not the same as cause

WHAT A STUDY MAY FIND

People with condition X have a different mix of microbes.

WHAT IT DOESN'T PROVE

Those microbes caused the condition—or that changing them will cure it.

Disease, diet and medication can all change the microbiome too.

Home microbiome tests rarely change medical care

Can the lab identify organisms?

Often, yes

Is there one accepted healthy range?

No

Does the result diagnose most symptoms?

Usually not

Does it reliably choose your diet or supplements?

Not yet

Useful clinical tests target a specific question—not a vague score for “gut health.”

“Probiotic” is a category—not a treatment

Benefit depends on...

The exact strain

Different strains can behave differently.

The exact condition

Evidence for one problem does not transfer to another.

The dose + product

Viability and formulation matter.

**A label that says
“50 billion CFU”
does not prove
benefit.**

Ask: Which strain? For what outcome?

The strongest proof: recurrent C. difficile

Antibiotics can clear the infection...

...but recurrence may follow when the ecosystem stays disrupted.



This success does not mean microbiota therapy treats every condition.

Feed the ecosystem with variety

Aim for more kinds of plant foods over the week—not a perfect daily score.

- ✓ **Vegetables + fruit**
- ✓ Beans + whole grains
- ✓ Nuts + seeds
- ✓ Fermented foods, if tolerated

Protect your microbiome without fearing medicine

USE ANTIBIOTICS WISELY

Take them when they are indicated.

Do not pressure clinicians for antibiotics for viral illnesses.

Do not stop a prescribed course on your own.

KEEP PERSPECTIVE

Medicines can alter the microbiome—and still be the right treatment.

Avoiding necessary care is not “protecting your gut.”

Use five questions to spot microbiome hype

- 1** What outcome was actually improved?

- 2** Was this tested in people—or only in mice?

- 3** Is the evidence about this exact strain or product?

- 4** Is the claim based on association or an intervention?

- 5** Would the result change what I do?

Reliable resources on the gut microbiome

NPR Gut microbiome: what we know—and what remains uncertain

CCF Cleveland Clinic overview: what the microbiome does

NIH Office of Dietary Supplements: probiotics fact sheet

FDA Approved microbiota therapies for recurrent *C. difficile*

AGA Evidence-based guidance on probiotics in GI disorders

Additional Resources

WEB US Probiotic Guide — www.usprobioticguide.com

FILM Hack Your Health: The Secrets of Your Gut (2024)

Care for the ecosystem. Don't chase a perfect score.

- 01 Eat a varied, plant-rich diet you tolerate.
- 02 Use probiotics for specific reasons—not vague wellness.
- 03 Treat commercial microbiome scores as interesting, not diagnostic.
- 04 Remember: promising science is not the same as proven treatment.

EARLY-ONSET COLORECTAL CANCER

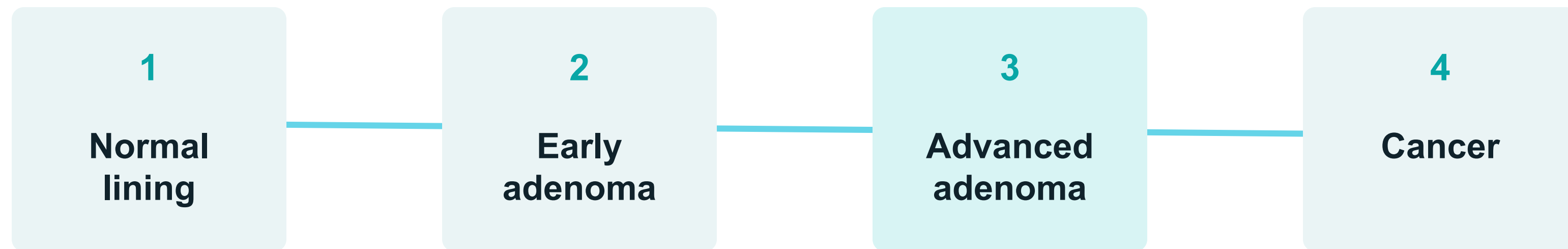
Colon cancer before age 50

What is changing—and what to do

Based on a 2025 JAMA review of early-onset gastrointestinal cancers

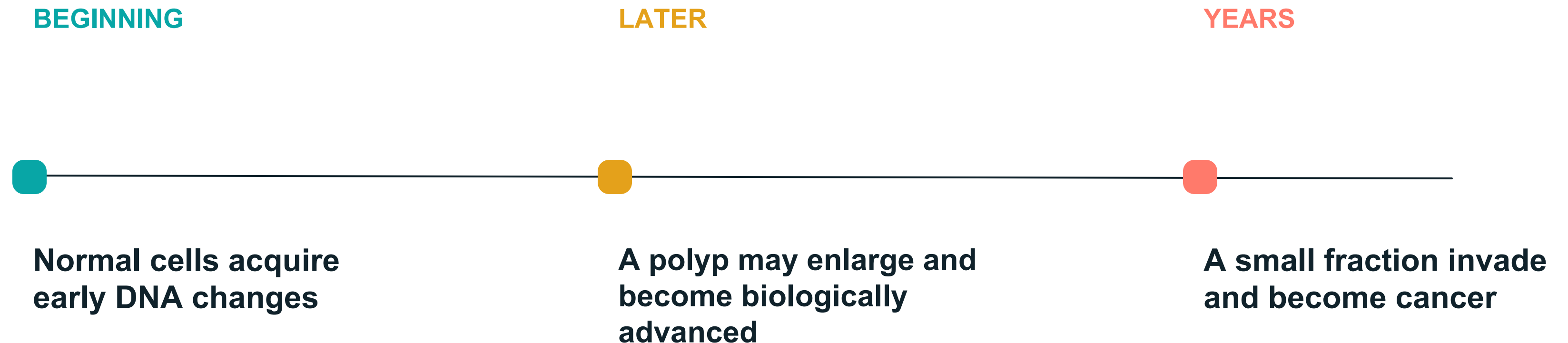


Most colorectal cancers follow a stepwise path



DNA changes accumulate over time. A minority of polyps acquire enough changes to become invasive cancer.

The adenoma-to-cancer sequence usually takes years



This long window creates an opportunity: find and remove the precursor before cancer develops.

Screening can interrupt the sequence

WITHOUT SCREENING

A precursor can remain hidden as it grows and accumulates additional changes.

WITH SCREENING

Stool testing can detect a signal. Colonoscopy can find and remove precancerous polyps.

Colorectal screening is unusual: it can prevent cancer, not merely detect it earlier.

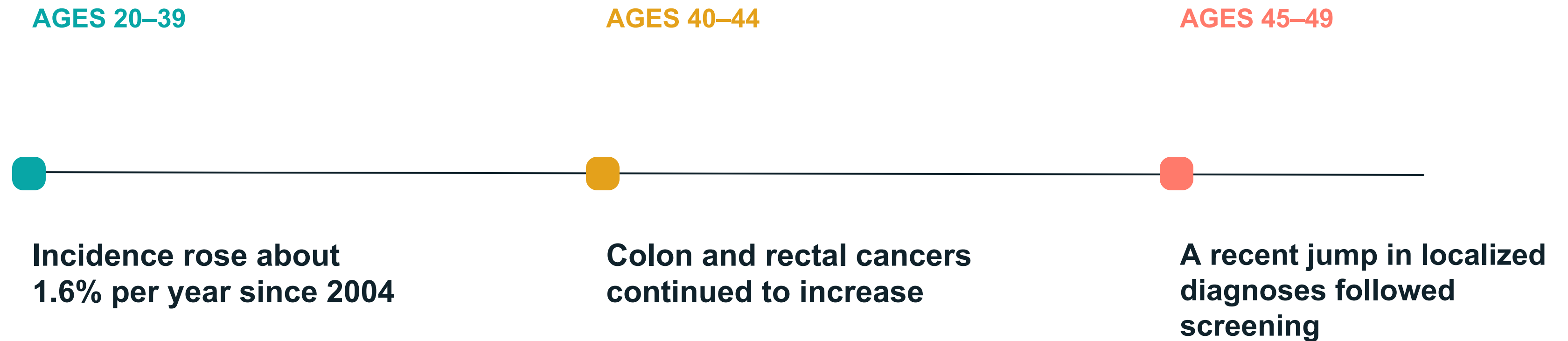
How effective is Cologuard?

Among 10,000 people in the cited clinical study, the test found:

- ✓ **92% of colorectal cancers**
- ✓ 42% of high-risk precancers
- ✓ False positives can occur
- ✓ False negatives can occur



Colorectal cancer before 50 is rising



The long-term rise began before screening at 45; the newest localized rise may partly reflect earlier detection.

The trend is important—but perspective matters

20,805

U.S. early-onset colorectal cancers reported in 2022

A substantial clinical burden

< 50

The usual definition of early-onset disease

Not a biologic cliff

STILL UNCOMMON

Most young adults will not develop colorectal cancer

Awareness—not panic

A rising relative trend can coexist with a low absolute risk for any one young person.

Why the rise? There is no single proven cause

METABOLIC

Obesity, inactivity and metabolic health

Associations—not destiny

DIET + EXPOSURES

Processed meat, alcohol, tobacco and dietary patterns

Many studies are observational

BIOLOGY

Genes, inflammation, birth cohort and microbiome clues

The causal mix remains uncertain

Risk factors overlap with later-onset cancer, but they do not fully explain the birth-cohort trend.

Most early-onset cases are not explained by one inherited syndrome

SOME ARE HEREDITARY

Lynch syndrome and other germline variants can cause cancer at young ages.

MANY ARE SPORADIC

A young patient may have no obvious family history or recognized syndrome.

Young age at diagnosis is itself a reason to consider genetic evaluation—and it can protect relatives.

Symptoms—not age—should trigger evaluation

Rectal bleeding or blood in stool

CHECK

Persistent change in bowel habits

CHECK

Unexplained iron-deficiency anemia

CHECK

Ongoing abdominal pain or weight loss

CHECK

Most symptoms have benign explanations—but persistence, recurrence or anemia deserves a medical explanation.

Rectal bleeding deserves an explanation

COMMON ASSUMPTION

**“I am too young for cancer,
so it must be
hemorrhoids.”**

SAFER RESPONSE

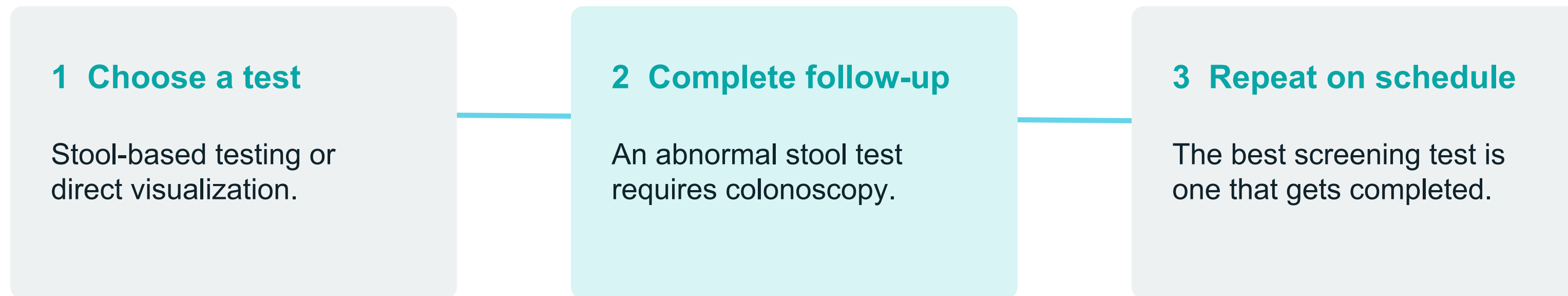
**Hemorrhoids are common—but
persistent or recurrent bleeding
should be assessed.**

A benign explanation should be established, not assumed from age.

Average-risk screening now begins at 45

You do not need symptoms to begin screening...

...because precancerous lesions and early cancers may be silent.



Colonoscopy is one option—not the only acceptable screening strategy. But it is the most effective.

Some people should start before 45

FAMILY + GENETIC RISK

A first-degree relative with colorectal cancer or an advanced polyp may move screening earlier.

Lynch syndrome and polyposis syndromes require specialized schedules.

INFLAMMATION + HISTORY

Long-standing ulcerative colitis or Crohn colitis changes surveillance.

Prior advanced polyps or colorectal cancer also change the plan.

TAKE-HOME MESSAGE

Don't panic. Don't dismiss. Act.

- 01 **Average-risk screening begins at age 45.**
- 02 Know whether family history moves your date earlier.
- 03 Persistent bleeding, anemia or bowel change deserves evaluation.
- 04 Healthy habits help—but no single habit makes risk zero.

Questions?

QUESTIONS & ANSWERS

What questions do you have for our speakers?

If you are joining virtually, put your questions in the chat!

A moderator will read questions as they are submitted.



HEALTHY GUTS IN THE WORKPLACE

NUTRITION POLICY

Develop a nutrition policy for your organization (meetings, vending machines, events, etc) with gut healthy options



Nutrition Policy Example

PROVIDE RESOURCES

Share healthy gut tips & cancer screening information in wellness email blasts, meetings, etc



American Cancer Society Colorectal
Cancer Employer Toolkit

CLOSING ANNOUNCEMENTS

SESSION EVALUATION



EMPLOYER COMMITMENT
FORM



EXAMPLE NUTRITION
WORKPLACE POLICY



SEE YOU AT OUR NEXT MEETING OCTOBER 7TH!