Wasif Saif, MD
Battling Pancreatic Cancer and Living on Hope

Watching Dr. Wasif Saif in action in his office, the words ‘whirling dervish’ come to mind. His Blackberry rings, his computer chimes to inform him of new email, and his fax machine hums continually as he sits at his desk for an interview. But when he takes a call from Marguerite Chappa, a patient with pancreatic cancer, he is focused only on her. "How are you today? You sound better; I can hear that you’re breathing more easily, you’re not as short of breath," he says.

Dr. Saif’s passion for his "sons and daughters," as he calls his patients, is matched by their devotion to him. “I cannot say enough. He’s very caring and intelligent. And when he’s with you, he’s really with you,” said Ms. Chappa. She survived nearly three years after her diagnosis, defying the odds for a disease that kills nearly 96 percent of patients within five years.

It’s no wonder pancreatic cancer is feared as a death sentence. The 11th most common cancer in the United States, it is the fourth leading cause of cancer deaths. "Most of the treatment options we’ve tried in the last decade have failed. With pancreatic cancer, the window of opportunity for treatment is usually very short, so we don’t have time to try different drugs or shuffle things around," explained Dr. Saif, Associate Professor of Medical Oncology and Co-Director of the Yale Cancer Center Gastrointestinal Cancers Program.

Caught early enough, pancreatic cancer is sometimes cured with surgery. But early diagnosis is extremely rare. There is no generally accepted screening test for the disease. Often, it is diagnosed at a late stage because the symptoms – abdominal or back pain, nausea, fatigue, weight loss, and jaundice – mimic other, nonmalignant diagnoses. A doctor cannot feel the tumors during a physical exam because the pancreas is seated so deeply within the abdomen.

“"I don’t treat cancer, I treat a patient.”
Wasif Saif, MD

Our tradition as an NCI designated comprehensive cancer center is continually strengthened by our successes in cancer treatment, research, and education. I am extremely grateful for the dedication and support of my colleagues at Yale Cancer Center, Yale School of Medicine, and Yale-New Haven Hospital for their immense contributions to the grant submission and I’m pleased to lead such an outstanding group of cancer clinicians and scientists at Yale.
Over 60,000 women are diagnosed with cancer every year and 10% of those women are under the age of 40. Many of these women may not realize the affect that cancer treatment can have on their fertility. It is an issue that many physicians need to be educated on as well. New advances in fertility preservation are providing new options for young women who have been diagnosed with cancer and are looking forward to continuing their life after cancer.

Dr. Pasquale Patrizio, Professor of Obstetrics, Gynecology & Reproductive Sciences at Yale School of Medicine and Director of the Yale Fertility Center, says that three factors need to be considered before choosing the appropriate option for fertility preservation: age, the timeframe between diagnosis and the start of cancer treatment, and the type of cancer. Dr. Patrizio’s outlook on the future of fertility preservation is positive. “The field of fertility is growing quickly. In the last 3-4 years we have seen some major advancements,” said Dr. Patrizio.

Embryo freezing is the most established form of fertility preservation available for women that do not require immediate treatment for their cancer, and it is effective in one quarter of the embryo transfers. It involves well established and widely available standard in-vitro fertilization (IVF) techniques. The disadvantage is that a partner, or willingness to use donor sperm, is necessary. Also, the hormone stimulation used during the process may increase estrogen levels causing some cancers to grow.

Egg freezing is also becoming a very viable option for young single women that have the option of delaying the start of their cancer treatment. Mature eggs are removed, without being fertilized, and then frozen and stored for future use. The advantage of this process is that a partner is not needed; however, hormone stimulation is still used and it remains an experimental process. Another alternative is freezing ovarian tissue, which circumvents the delay in cancer treatment. This process remains highly experimental and has only resulted in two live births to date.

Embryo freezing is the most established form of fertility preservation available for women that do not require immediate treatment for their cancer, and it is effective in one quarter of the embryo transfers. It involves well established and widely available standard in-vitro fertilization (IVF) techniques. The disadvantage is that a partner, or willingness to use donor sperm, is necessary. Also, the hormone stimulation used during the process may increase estrogen levels causing some cancers to grow.

Egg freezing is also becoming a very viable option for young single women that have the option of delaying the start of their cancer treatment. Mature eggs are removed, without being fertilized, and then frozen and stored for future use. The advantage of this process is that a partner is not needed; however, hormone stimulation is still used and it remains an experimental process. Another alternative is freezing ovarian tissue, which circumvents the delay in cancer treatment. This process remains highly experimental and has only resulted in two live births to date.

Egg freezing is also becoming a very viable option for young single women that have the option of delaying the start of their cancer treatment. Mature eggs are removed, without being fertilized, and then frozen and stored for future use. The advantage of this process is that a partner is not needed; however, hormone stimulation is still used and it remains an experimental process. Another alternative is freezing ovarian tissue, which circumvents the delay in cancer treatment. This process remains highly experimental and has only resulted in two live births to date.

Embryo freezing is the most established form of fertility preservation available for women that do not require immediate treatment for their cancer, and it is effective in one quarter of the embryo transfers. It involves well established and widely available standard in-vitro fertilization (IVF) techniques. The disadvantage is that a partner, or willingness to use donor sperm, is necessary. Also, the hormone stimulation used during the process may increase estrogen levels causing some cancers to grow.

Egg freezing is also becoming a very viable option for young single women that have the option of delaying the start of their cancer treatment. Mature eggs are removed, without being fertilized, and then frozen and stored for future use. The advantage of this process is that a partner is not needed; however, hormone stimulation is still used and it remains an experimental process. Another alternative is freezing ovarian tissue, which circumvents the delay in cancer treatment. This process remains highly experimental and has only resulted in two live births to date.

Embryo freezing is the most established form of fertility preservation available for women that do not require immediate treatment for their cancer, and it is effective in one quarter of the embryo transfers. It involves well established and widely available standard in-vitro fertilization (IVF) techniques. The disadvantage is that a partner, or willingness to use donor sperm, is necessary. Also, the hormone stimulation used during the process may increase estrogen levels causing some cancers to grow.

Egg freezing is also becoming a very viable option for young single women that have the option of delaying the start of their cancer treatment. Mature eggs are removed, without being fertilized, and then frozen and stored for future use. The advantage of this process is that a partner is not needed; however, hormone stimulation is still used and it remains an experimental process. Another alternative is freezing ovarian tissue, which circumvents the delay in cancer treatment. This process remains highly experimental and has only resulted in two live births to date.

Embryo freezing is the most established form of fertility preservation available for women that do not require immediate treatment for their cancer, and it is effective in one quarter of the embryo transfers. It involves well established and widely available standard in-vitro fertilization (IVF) techniques. The disadvantage is that a partner, or willingness to use donor sperm, is necessary. Also, the hormone stimulation used during the process may increase estrogen levels causing some cancers to grow.

Egg freezing is also becoming a very viable option for young single women that have the option of delaying the start of their cancer treatment. Mature eggs are removed, without being fertilized, and then frozen and stored for future use. The advantage of this process is that a partner is not needed; however, hormone stimulation is still used and it remains an experimental process. Another alternative is freezing ovarian tissue, which circumvents the delay in cancer treatment. This process remains highly experimental and has only resulted in two live births to date.

Embryo freezing is the most established form of fertility preservation available for women that do not require immediate treatment for their cancer, and it is effective in one quarter of the embryo transfers. It involves well established and widely available standard in-vitro fertilization (IVF) techniques. The disadvantage is that a partner, or willingness to use donor sperm, is necessary. Also, the hormone stimulation used during the process may increase estrogen levels causing some cancers to grow.

Egg freezing is also becoming a very viable option for young single women that have the option of delaying the start of their cancer treatment. Mature eggs are removed, without being fertilized, and then frozen and stored for future use. The advantage of this process is that a partner is not needed; however, hormone stimulation is still used and it remains an experimental process. Another alternative is freezing ovarian tissue, which circumvents the delay in cancer treatment. This process remains highly experimental and has only resulted in two live births to date.

Embryo freezing is the most established form of fertility preservation available for women that do not require immediate treatment for their cancer, and it is effective in one quarter of the embryo transfers. It involves well established and widely available standard in-vitro fertilization (IVF) techniques. The disadvantage is that a partner, or willingness to use donor sperm, is necessary. Also, the hormone stimulation used during the process may increase estrogen levels causing some cancers to grow.

Egg freezing is also becoming a very viable option for young single women that have the option of delaying the start of their cancer treatment. Mature eggs are removed, without being fertilized, and then frozen and stored for future use. The advantage of this process is that a partner is not needed; however, hormone stimulation is still used and it remains an experimental process. Another alternative is freezing ovarian tissue, which circumvents the delay in cancer treatment. This process remains highly experimental and has only resulted in two live births to date.

Embryo freezing is the most established form of fertility preservation available for women that do not require immediate treatment for their cancer, and it is effective in one quarter of the embryo transfers. It involves well established and widely available standard in-vitro fertilization (IVF) techniques. The disadvantage is that a partner, or willingness to use donor sperm, is necessary. Also, the hormone stimulation used during the process may increase estrogen levels causing some cancers to grow.

Egg freezing is also becoming a very viable option for young single women that have the option of delaying the start of their cancer treatment. Mature eggs are removed, without being fertilized, and then frozen and stored for future use. The advantage of this process is that a partner is not needed; however, hormone stimulation is still used and it remains an experimental process. Another alternative is freezing ovarian tissue, which circumvents the delay in cancer treatment. This process remains highly experimental and has only resulted in two live births to date.
that is familiar with fertility with respect to cancer treatment.”

A roadblock arises for women who require treatment for their cancer right away, and do not have time for embryo or egg freezing. The time between diagnosis and treatment is very crucial because 6–8 weeks may be needed for fertility preservation. Dr. Patrizio is pushing forward with a very exciting and promising procedure for women who have limited time before they need to begin their cancer treatment. He has developed a procedure that freezes an entire ovary instead of just tissue from the ovary. “This is a very new idea. We are the first and only University to perform the procedure,” Dr. Patrizio said. One ovary is removed before the woman undergoes cancer treatment and is frozen. It takes three hours to freeze the entire ovary and Yale has the only freezing device, the Multi-Thermal Gradient (MTG), that will do this. The process is a HIC designated protocol and remains experimental. Dr. Patrizio hopes that after a few women have undergone this treatment it will be more widely available through a clinical trial. “We are still trying to determine the best way to restore the ovary after it has been defrosted. There are several options that we are exploring to provide the most efficient method,” Dr. Patrizio explained.

All fertility options have their downsides, but Dr. Patrizio expects that freezing an entire ovary may prove to be a more viable option than the techniques that are currently available. According to Dr. Patrizio, freezing entire ovaries has already yielded more success than other options when tested in larger animals so there is hope that it will be more successful in humans as well.

This procedure will give women more options. They will no longer have to choose between saving their own life and preserving their fertility. Dr. Seli and Dr. Patrizio continue to work together to advance the field of fertility preservation. In the near future, Dr. Patrizio will have determined whether or not whole ovary freezing is a safe and feasible option for women. Both doctors acknowledge that saving the patient is the most important part of treating cancer, but once they are cured, providing the option for fertility, can give them new hope for their future.

For more information on the Yale Fertility Center, go to yalefertilitycenter.org

Jay Epstein, another of Dr. Saif’s patients, has a typical story. “I’d gone to my doctor for routine blood work. I felt fine, but I’d lost a lot of weight.” After a CT scan and biopsies, he was told he had late-stage pancreatic cancer, and that very little could be done. Indeed, people with Stage IV pancreatic cancer survive, on average, only four to six months.

Dr. Saif, however, had a different opinion. “He decided we had to try chemotherapy anyway. I’ve been on chemotherapy since the end of 2005; the tumor has shrunk by 66% and we’re still going,” said Jay.

Still, his story is all too rare. The two standard chemotherapy drugs approved by the FDA often fail; when they do, experimental drugs are the only other option. Here lies another of Dr. Saif’s strengths. Nationally known for his research, he has several ongoing clinical trials and more in the offing.

For example, he has received a peer grant from the National Comprehensive Cancer Network for a clinical study combining two drugs: Xeloda, a drug approved for colon and breast cancer but considered experimental for pancreatic cancer, and a Chinese herb, PHY906, which was developed at Yale. “Besides offering a second line treatment, it’s convenient because both drugs are given by mouth. PHY906 not only appears to be active with the cancer cells, it also decreases the side effects of Xeloda and makes the drug more potent,” he explained.

Dr. Saif also runs clinical trials funded by several pharmaceutical companies. Some of these studies test novel therapies that decrease blood supply to the tumor; others produce antibodies that act against the growth factor in the cancer cells.

Although his patients have more access to experimental drugs, chemotherapy is only part of the treatment. “I don’t treat cancer. I treat a patient. Pancreatic cancer has a lot of complications, including major challenges to pain control, weight loss, and loss of appetite. The family is nervous, scared, and sad.” Dr. Saif works with a specialized team that includes oncologists, surgeons, and gastroenterologists as well as nurse practitioners, research nurses, social workers, and nutritionists to care for the patient and to help their family.

Besides working to improve treatment regimens, Dr. Saif and his colleagues at Yale Cancer Center are trying to understand the molecular biology of pancreatic tumors, to identify people at high risk for the disease, and to develop early screening techniques. People with a family history of pancreatic, colon, ovarian, or lung cancer are in this group, including those with genetic abnormalities such as BRCA2, known as the breast cancer gene. “We are collecting data on those at higher risk for pancreatic cancer to help us to determine how it can be detected earlier. I have patients that I watch closely, doing special lab tests, ultrasounds, or endoscopy to look at the pancreas,” he explained. Pharmacogenetics, or learning how to identify people with genetic abnormalities and tailor drug treatments for them, is another focus for the future. “We are moving in the right direction,” he added.

Meanwhile, he said, “the pleasure I get from helping the sickest people is immeasurable and unbelievable. I live on hope.” The hope he gets from people like Marguerite, who said: “I’ve gone back to work part-time and I’ve lived long enough to have a grandson.”

To learn more about clinical trials for pancreatic cancer, go to yalecancercenter.org/trials
Yale Cancer Center currently has numerous clinical trials available to cancer patients in search of novel therapies. These trials are evaluating new methods of prevention, detection, and treatment of cancer. Clinical trials give patients at Yale Cancer Center immediate access to the future of cancer care.

Clinical trials are currently available for patients in fifteen different disease areas. For more information on all of the trials currently open for accrual at Yale Cancer Center, please go to yalecancercenter.org/trials or call 1-866-YALECANCER.

A Select Listing of Protocols for GYNECOLOGICAL CANCERS:

**HIC 0507000367**

An Open-Label, Single-Arm, Phase II Study of IV Weekly (Days 1 and 8 every 21 Days) HYCAMTIN in Combination with Carboplatin (Day 1 every 21 Days) as Second Line Therapy in Subjects with Potentially Platinum-Sensitive Relapsed Ovarian Cancer

**HIC 0507000414**

A Phase II Study Of AP23573, a mTOR Inhibitor, an Female Adult Patients with Recurrent or Persistent Endometrial Cancer

**HIC 0510000730**

A Phase III Trial of Carboplatin and Paclitaxel plus Placebo versus Carboplatin and Paclitaxel plus Concurrent Bevacizumab Followed by Placebo versus Carboplatin and Paclitaxel plus Concurrent and Extended Bevacizumab in Women with Newly Diagnosed Ovarian Cancer

**HIC 0510000732**

A Phase III, Randomized Trial of Weekly Cisplatin and Radiation versus Cisplatin and Tirapazamine and Radiation in Stage IB2, IIA, IIB, and IVA Cervical Carcinoma Limited to the Pelvis

**HIC 0601000992**

A Randomized Parallel Group, Open Label Active Controlled Multicenter Phase III Trial of Patupilone versus Pegylated Liposomal Doxorubicin in Taxane/Platinum Refractory/Resistant Patients with Recurrent Epithelial Ovarian, Primary Fallopian, or Peritoneal Cancer

**HIC 0705002665**

A Randomized Phase III Trial of Maintenance Chemotherapy Comparing 12 Monthly Cycles of Single Agent Paclitaxel or Xyotax versus no Treatment until Documented Relapse in Women with Advanced Ovarian or Primary Peritoneal Cancer

For the latest schedule information and audio and written archives of all shows, please go to yalecancercenter.org/answers
Camaraderie among athletes is common as they strive together to reach goals and to attain new distances or records, but the spirit among the riders and volunteers at the Connecticut Challenge on Saturday, July 28th was unparalleled. Working together, 437 riders and 194 volunteers made the third annual CT Challenge a tremendous success. Riding in honor or memory of cancer survivors and to raise funds to support The Connecticut Challenge Survivorship Clinic at Yale Cancer Center, each cyclist left the starting line with a special commitment to succeed.

The leadership of the CT Challenge has allocated the proceeds from the annual event to support The Connecticut Challenge Survivorship Clinic at Yale Cancer Center to address the needs of cancer survivors. The clinic opened in 2006 and provides screening for long-term consequences resulting from cancer treatment and information to help survivors minimize or avoid future health concerns.

“The enthusiasm and dedication of the riders and supporters of the Connecticut Challenge is inspirational. Their support is crucial to our mission to provide care to cancer survivors throughout the state of Connecticut,” Dr. Ken Miller, Medical Director of the Clinic said.

The Connecticut Challenge Survivorship Clinic is the first dedicated, multidisciplinary resource for cancer survivors in Connecticut to provide patients and their families with vital information on cancer prevention, wellness, supportive services, and the latest health research and developments. For more information, or to schedule an appointment for a consultation, please call (203) 785-CARE.

For more information on the Connecticut Challenge, to contribute to the establishment of the Survivorship Clinic at Yale Cancer Center, or to find out how to participate in next year’s ride, please go to ctchallenge.org.

1. John Ragland and Jeff Keith, Co-founders of the CT Challenge
2. Team Yale Cancer Center
3. Team Yale Pediatrics
4. Melinda Irwin and Mark Ellis and their two sons
Cancer Center as we begin another 5 years of accomplishments with the sustained support of the National Cancer Institute,” said Richard L. Edelson, MD, Director of Yale Cancer Center.

Yale Cancer Center is one of 39 comprehensive cancer centers in the nation and the only one in Southern New England. Yale was one of the first 11 cancer centers to be designated comprehensive under the National Cancer Centers plan in 1974. The NCI designation is given to Centers who meet strict criteria for patient care, cancer research, clinical trials, and community outreach and education. Yale Cancer Center received an excellent evaluation from peer reviewers and the National Cancer Institute during its most recent grant submission.

The advantages of receiving care at a comprehensive cancer center for patients are numerous, including the large collection of oncologists specializing in specific types of cancer, many of whom are nationally known cancer physicians and leading researchers in their field. The close collaboration between research and clinical care also ensures patients receive the most innovative treatments available.

With over 230 members, Yale Cancer Center harnesses the scientific resources of Yale School of Medicine, Yale-New Haven Hospital, and Yale University and focuses on translational research, an approach through which laboratory discoveries are quickly and efficiently integrated with clinical patient care.