0:00:00 –> 0:00:02.83 Support for Yale Cancer Answers

0:00:02.83 –> 0:00:05.094 comes from AstraZeneca, dedicated

0:00:05.094 –> 0:00:08.475 to providing innovative treatment

0:00:08.475 –> 0:00:13.025 options for people living with

0:00:13.025 –> 0:00:13.935 cancer. Learn more at astrazeneca-us.com.

0:00:13.94 –> 0:00:16.13 Welcome to Yale Cancer Answers with

0:00:16.13 –> 0:00:18.529 your host doctor Anees Chagpar.

0:00:18.53 –> 0:00:20.41 Yale Cancer Answers features the

0:00:20.41 –> 0:00:22.727 latest information on cancer care by

0:00:22.727 –> 0:00:24.211 welcoming oncologists and specialists

0:00:24.211 –> 0:00:26.696 who are on the forefront of the

0:00:26.696 –> 0:00:28.406 battle to fight cancer. This week

0:00:28.41 –> 0:00:30.175 it's a conversation about pancreatic

0:00:30.175 –> 0:00:31.94 cancer with Doctor Jeremy Kortmansky.

0:00:31.94 –> 0:00:33.056 Doctor Kortmansky

0:00:33.056 –> 0:00:34.916 is an associate professor

0:00:34.916 –> 0:00:36.729 of clinical medicine in medical

0:00:36.729 –> 0:00:38.751 oncology at the Yale School of

0:00:38.751 –> 0:00:40.838 Medicine where Doctor Chagpar is

0:00:40.838 –> 0:00:42.523 a professor of surgical oncology.

0:00:43.67 –> 0:00:45.138 So Jeremy,

0:00:45.138 –> 0:00:48.031 I think we all hear about pancreatic

0:00:48.031 –> 0:00:51.49 cancer when it affects celebrities, right?

0:00:51.49 –> 0:00:54.29 So whether it was Steve Jobs or

0:00:54.29 –> 0:00:57.85 other stars we hear

0:00:57.85 –> 0:00:59.449 about pancreatic cancer,

0:00:59.45 –> 0:01:02.684 once in a blue moon.

0:01:02.69 –> 0:01:05.938 It doesn't seem to be a terribly

0:01:05.938 –> 0:01:07.566 common cancer.

0:01:07.566 –> 0:01:10.002 Can you tell us a little bit

0:01:10.002 –> 0:01:12.292 more about how frequently

1

0:01:12.292 –> 0:01:14.76 pancreatic cancer is diagnosed?

0:01:14.76 –> 0:01:18.23 How many people get it?

0:01:18.23 –> 0:01:20.595 And who really are the

0:01:20.595 –> 0:01:22.96 people that it most affects?

0:01:22.96 –> 0:01:24.848 Yes,

0:01:24.85 –> 0:01:25.8 pancreatic cancer

0:01:25.8 –> 0:01:28.205 is actually becoming an increasingly

0:01:28.205 –> 0:01:31 more common cancer that we see.

0:01:31 –> 0:01:33.58 It's now the 5th leading cause

0:01:33.58 –> 0:01:36.679 of cancer in the United States,

0:01:36.68 –> 0:01:39.984 at about 60,000 new cases a year.

0:01:39.99 –> 0:01:43.294 So we're not only seeing increasing numbers,

0:01:43.3 –> 0:01:46.51 but also really moving up the

0:01:46.51 –> 0:01:49.91 rank of how often we see it.

0:01:49.91 –> 0:01:52.913 And you know it's interesting you brought

0:01:52.913 –> 0:01:56.347 up Steve Jobs and and other celebrities.

0:01:56.35 –> 0:02:00.03 Most recently, I think Alex Trebek is one

0:02:00.03 –> 0:02:02.52 and it's important to make distinctions

0:02:02.52 –> 0:02:06.009 when we talk about pancreatic cancer,

0:02:06.01 –> 0:02:08.31 there's two main types there

0:02:08.31 –> 0:02:09.69 is pancreatic adenocarcinoma,

0:02:09.69 –> 0:02:14.29 which is by far the more common one that is

0:02:14.29 –> 0:02:18.146 the disease that we're talking about

0:02:18.146 –> 0:02:22.356 when we think about 60,000 cases per year.

0:02:22.36 –> 0:02:24.41 And then there are pancreatic

0:02:24.41 –> 0:02:25.23 neuroendocrine tumors,

0:02:25.23 –> 0:02:27.69 which are a lot less common.

0:02:27.69 –> 0:02:30.483 They are only seen in a few

0:02:30.483 –> 0:02:32.2 thousand patients a year,

0:02:32.2 –> 0:02:34.462 and it's important

0:02:34.462 –> 0:02:36.448 to make the distinction because

0:02:36.448 –> 0:02:38.488 they behave very differently and

0:02:38.488 –> 0:02:40.81 their treatments are very different.

0:02:42.19 –> 0:02:44.095 So, let's start with

0:02:44.095 –> 0:02:44.857 pancreatic adenocarcinoma,

0:02:44.86 –> 0:02:47.158 because I think that most people,

0:02:47.16 –> 0:02:49.566 when they use the term generically

0:02:49.566 –> 0:02:51.572 pancreatic cancer that tends to

0:02:51.572 –> 0:02:53.267 be what they're referring to.

0:02:53.27 –> 0:02:55.508 Although your point is well taken

0:02:55.508 –> 0:02:57.47 with regards to neuroendocrine tumors,

0:02:57.47 –> 0:03:00.182 but tell us a little bit more

0:03:00.182 –> 0:03:02.438 about who gets these cancers.

0:03:02.44 –> 0:03:05.107 I mean, what are the risk factors?

0:03:06.08 –> 0:03:09.428 So I think like other cancers,

0:03:09.43 –> 0:03:12.79 smoking is a common risk factor.

0:03:12.79 –> 0:03:17.334 It can be related to problems that cause

0:03:17.334 –> 0:03:20.726 chronic inflammation of the pancreas so

0:03:20.726 –> 0:03:23.966 alcoholism can lead to pancreas cancer.

0:03:23.97 –> 0:03:26.57 Chronic gallstone disease can,

0:03:26.57 –> 0:03:29.82 although that's much less common.

0:03:29.82 –> 0:03:34.148 Obesity can be a risk factor as well.

0:03:34.15 –> 0:03:36.754 And then there is some question

0:03:36.754 –> 0:03:39.001 of the relationship with diabetes

0:03:39.001 –> 0:03:41.557 and whether diabetes could be a

0:03:41.557 –> 0:03:44.485 risk factor or whether the disease

0:03:44.485 –> 0:03:46.569 itself causes the diabetes.

0:03:46.57 –> 0:03:48.41 And that's something that's

0:03:48.41 –> 0:03:50.25 still being worked out.

0:03:50.25 –> 0:03:53.194 And then there is a smaller percentage

0:03:53.194 –> 0:03:56.229 of patients where it's hereditary cancer.

0:03:56.23 –> 0:03:58.555 There are some genetic abnormalities

0:03:58.555 –> 0:04:02.053 that we know of that are associated

0:04:02.053 –> 0:04:04.229 with pancreas cancer and

0:04:04.23 –> 0:04:07.002 one that is of recent importance

0:04:07.002 –> 0:04:10.208 is its relation to the BRCA gene,

0:04:10.21 –> 0:04:12.898 which is a gene that we most

0:04:12.898 –> 0:04:15.854 often think about with breast and

0:04:15.854 –> 0:04:17.567 ovarian cancer syndromes,

0:04:17.57 –> 0:04:20.33 but is also related to pancreas

0:04:20.33 –> 0:04:21.71 cancer as well,

0:04:21.71 –> 0:04:24.47 and that has had some recent

0:04:24.47 –> 0:04:25.85 implications on treatment.

0:04:27.58 –> 0:04:30.436 So when we think

0:04:30.436 –> 0:04:32.46 about these risk factors,

0:04:32.46 –> 0:04:35.428 I'm thinking about a very good friend

0:04:35.428 –> 0:04:39.141 of mine who actually was diagnosed with

0:04:39.141 –> 0:04:42.026 pancreatic cancer just over Thanksgiving.

0:04:42.03 –> 0:04:45.35 And who didn't fit any of those categories.

0:04:45.35 –> 0:04:47.43 She had no family history.

0:04:47.43 –> 0:04:49.92 She is skinny, like a rail,

0:04:49.92 –> 0:04:51.58 she doesn't have diabetes,

0:04:51.58 –> 0:04:53.652 doesn't drink, doesn't have gallstones.

0:04:53.652 –> 0:04:56.37 You know, in those people where

0:04:56.37 –> 0:04:59.112 they don't seem to have any

0:04:59.112 –> 0:05:01.814 of the common risk factors that you

0:05:01.814 –> 0:05:04.438 think about for pancreatic cancer,

0:05:04.44 –> 0:05:06.78 does that tell us anything about

0:05:06.78 –> 0:05:09.01 the biology of their disease?

0:05:09.01 –> 0:05:11.728 I mean, are there other things

0:05:11.728 –> 0:05:13.92 that we can think of

0:05:13.92 –> 0:05:16.536 in terms of their risk factors,

0:05:16.54 –> 0:05:18.108 and does that

0:05:18.108 –> 0:05:20.46 have anything to

0:05:20.549 –> 0:05:22.637 do with their prognosis?

0:05:23.99 –> 0:05:26.165 I think that those are

0:05:26.165 –> 0:05:27.905 all very good questions.

0:05:27.91 –> 0:05:30.22 There are risk

0:05:30.22 –> 0:05:32.767 factors that we can identify and

0:05:32.767 –> 0:05:35.527 then there are patients who get

0:05:35.527 –> 0:05:38.377 cancer for really no good reason.

0:05:38.38 –> 0:05:40.879 And those are people that

0:05:40.879 –> 0:05:44.006 we are still trying to maybe figure

0:05:44.006 –> 0:05:46.476 out whether there was something

0:05:46.476 –> 0:05:48.813 hereditary or environmental or some

0:05:48.813 –> 0:05:51.459 other factor that we just haven't

0:05:51.46 –> 0:05:54.736 identified yet that played a role.

0:05:54.74 –> 0:05:59.328 When it comes to pancreas cancer,

0:05:59.328 –> 0:06:05.18 the implications of how you got it,

0:06:05.18 –> 0:06:06.96 except in in certain circumstances,

0:06:06.96 –> 0:06:08.74 like the BRCA gene but,

0:06:08.74 –> 0:06:11.302 otherwise how you got it doesn't

0:06:11.302 –> 0:06:14.633 play as much of a role into how we

0:06:14.633 –> 0:06:16.791 might think about treating it or

0:06:16.791 –> 0:06:19.059 how we might expect it to behave.

0:06:20.79 –> 0:06:24.588 So the the other question is,

0:06:27.86 –> 0:06:30.724 when you talk about it

0:06:30.724 –> 0:06:33.262 being the fifth most common cancer

0:06:33.262 –> 0:06:36.45 and we think about the list right?

0:06:36.45 –> 0:06:38.086 Breast cancer, prostate cancer,

0:06:38.086 –> 0:06:40.54 colon cancer for all of these,

0:06:40.54 –> 0:06:42.636 more commonly diagnosed cancers,

0:06:42.636 –> 0:06:45.256 there's a screening test we

0:06:45.256 –> 0:06:47.907 can find these cancers early.

0:06:47.91 –> 0:06:49.42 Is there a screening test

0:06:49.42 –> 0:06:50.326 for pancreatic cancer?

0:06:51.82 –> 0:06:54.742 There isn't a good or routine

0:06:54.742 –> 0:06:57.38 screening test for pancreas cancer.

0:06:57.38 –> 0:07:00.972 I think that we know that there are

0:07:00.972 –> 0:07:04.063 some patients that have been discovered

0:07:04.063 –> 0:07:07.201 to have either a family history

0:07:07.296 –> 0:07:10.434 or patients that have been found

0:07:10.434 –> 0:07:15.11 to have pancreatic cysts on their

0:07:15.11 –> 0:07:18.26 imaging that may have been obtained

0:07:18.26 –> 0:07:21.578 for some other reason that we can

0:07:21.578 –> 0:07:24.386 follow and certainly here at Yale,

0:07:24.39 –> 0:07:26.305 we have an excellent screening

0:07:26.305 –> 0:07:28.841 program where we can refer patients

0:07:28.841 –> 0:07:31.025 to our gastroenterologists who

0:07:31.025 –> 0:07:33.209 can perform screening procedures,

0:07:33.21 –> 0:07:35.4 but that's really identifying those

0:07:35.4 –> 0:07:38.552 who are already at a heightened risk

0:07:38.552 –> 0:07:41.618 and not for the whole population like

0:07:41.618 –> 0:07:44.298 we think about with colonoscopies

0:07:44.298 –> 0:07:46.993 for colon cancer or mammograms

0:07:47 –> 0:07:48.503 for breast cancer,

0:07:48.503 –> 0:07:51.509 it's really an already pre determined

0:07:51.509 –> 0:07:53.665 population because the screening

0:07:53.665 –> 0:07:56.809 includes much more advanced or invasive

0:07:56.809 –> 0:08:00.149 testing like MRI's or endoscopic ultrasound.

0:08:00.15 –> 0:08:03.468 So it's a much more complex

0:08:03.468 –> 0:08:06.46 way to follow patients.

0:08:06.46 –> 0:08:09.09 And so without a screening test for

0:08:09.09 –> 0:08:11.194 asymptomatic people who otherwise,

0:08:11.2 –> 0:08:13.825 haven't had any

0:08:13.825 –> 0:08:15.925 abnormality that's been found

0:08:15.93 –> 0:08:17.646 incidentally, what are

0:08:17.646 –> 0:08:20.765 the ways in

0:08:20.765 –> 0:08:23.135 which they present?

0:08:23.135 –> 0:08:25.48 How is it that somebody

0:08:25.549 –> 0:08:28.198 cues into the fact that, Oh my gosh,

0:08:28.198 –> 0:08:30.214 this could be a pancreatic cancer.

0:08:30.22 –> 0:08:33.244 What are the symptoms and signs to look for?

0:08:34.6 –> 0:08:38.08 I again think this is an area

0:08:38.08 –> 0:08:40.379 that becomes challenging that

0:08:40.379 –> 0:08:43.699 the symptoms that people have,

0:08:43.7 –> 0:08:47.438 at least initially can often be vague.

0:08:47.44 –> 0:08:50.115 There can be some discomfort

0:08:50.115 –> 0:08:52.792 in the abdomen, with eating,

0:08:52.792 –> 0:08:54.4 sometimes increased belching,

0:08:54.4 –> 0:08:58.138 or increased gas may be a symptom.

0:08:58.14 –> 0:09:00.755 Things that are very easily

0:09:00.755 –> 0:09:03.37 attributable to something else until

0:09:03.461 –> 0:09:06.486 the symptoms become more significant.

0:09:06.49 –> 0:09:08.466 Sometimes people present without

0:09:08.466 –> 0:09:10.936 any symptoms but develop jaundice,

0:09:10.936 –> 0:09:13.478 they notice yellowing

0:09:13.478 –> 0:09:15.88 of their eyes or their skin,

0:09:15.88 –> 0:09:18.11 which certainly tips them off,

0:09:18.11 –> 0:09:20.2 their families that there's something

0:09:20.2 –> 0:09:23.03 going on that requires further evaluation.

0:09:23.03 –> 0:09:24.818 But because these symptoms

0:09:24.818 –> 0:09:26.606 can sometimes be vague,

0:09:26.61 –> 0:09:29.557 they can also be attributed to the

0:09:29.557 –> 0:09:32.753 much more common problems that we see,

0:09:32.753 –> 0:09:35.525 irritable bowel or reflux which can

0:09:35.614 –> 0:09:38.666 lead to delays in making a diagnosis.

0:09:40.13 –> 0:09:42.517 And so I mean that really gets

0:09:42.517 –> 0:09:45.181 to the crux of the issue, right?

0:09:45.181 –> 0:09:49.189 Is that without screening and with

0:09:49.19 –> 0:09:52.347 the symptoms that are incredibly vague,

0:09:52.35 –> 0:09:54.888 I would surmise that the vast

0:09:54.888 –> 0:09:57.153 majority of patients who present

0:09:57.153 –> 0:10:00.105 with pancreatic cancer present at a

0:10:00.11 –> 0:10:02.329 more advanced stage so talk

0:10:02.329 –> 0:10:04.814 about the stage

0:10:04.814 –> 0:10:07.47 distribution that you see in terms of

0:10:07.47 –> 0:10:09.858 the proportion of patients who present

0:10:09.858 –> 0:10:12.584 with early versus late stage disease and

0:10:12.584 –> 0:10:15.08 what the implications are in terms of

0:10:15.08 –> 0:10:17.3 prognosis.

0:10:17.3 –> 0:10:19.561 People often think

0:10:19.561 –> 0:10:21.703 about staging for cancer with the

0:10:21.703 –> 0:10:24.2 usual stage one, 2, three or four.

0:10:24.2 –> 0:10:26.39 When I think about pancreas cancer,

0:10:26.39 –> 0:10:28.7 I really try to think about

0:10:28.7 –> 0:10:30.7 it in terms of its

0:10:30.7 –> 0:10:33.004 clinical presentations and so there are

0:10:33.004 –> 0:10:35.05 patients that have resectable disease,

0:10:35.05 –> 0:10:38.938 meaning that a surgeon could go in there at

0:10:38.938 –> 0:10:42.866 the time of diagnosis and take it out.

0:10:42.87 –> 0:10:45.252 There are patients that have locally

0:10:45.252 –> 0:10:46.84 advanced but unresectable disease,

0:10:46.84 –> 0:10:48.795 meaning that it hasn't spread

0:10:48.795 –> 0:10:51.21 to other parts of the body,

0:10:51.21 –> 0:10:53.989 but it's involving the nearby blood vessels,

0:10:53.99 –> 0:10:57.364 and you can't safely take it out.

8

0:10:57.37 –> 0:10:59.775 And then patients with metastatic

0:10:59.775 –> 0:11:02.18 disease where it's spread to

0:11:02.26 –> 0:11:04.2 other places in the body.

0:11:04.2 –> 0:11:07.832 And so the the number or the percentage

0:11:07.832 –> 0:11:10.686 of patients that can have surgery

0:11:10.686 –> 0:11:13.464 at the time of their diagnosis

0:11:13.557 –> 0:11:16.315 is really only about 15 to 20%.

0:11:16.32 –> 0:11:18.56 It's a relatively low number

0:11:18.56 –> 0:11:21.668 and the other 80% sort of evenly

0:11:21.668 –> 0:11:23.412 distributed are either locally

0:11:23.412 –> 0:11:25.3 advanced or metastatic disease

0:11:25.3 –> 0:11:29.297 at the time of their diagnosis.

0:11:29.89 –> 0:11:34.066 And so it was with my my friend who

0:11:34.066 –> 0:11:38.708 was diagnosed with a locally advanced,

0:11:38.71 –> 0:11:40.052 unresectable pancreatic

0:11:40.052 –> 0:11:43.407 cancer that was encasing

0:11:43.41 –> 0:11:45.102 important blood vessels,

0:11:45.102 –> 0:11:47.358 so she certainly wasn't

0:11:47.358 –> 0:11:50.079 a candidate for surgery at

0:11:50.079 –> 0:11:52.444 the time of her presentation,

0:11:52.45 –> 0:11:56.53 so it sounds like if patients are

0:11:56.53 –> 0:11:59.284 fortunate enough to be resectable

0:11:59.284 –> 0:12:02.554 at the time of their presentation,

0:12:02.56 –> 0:12:04.688 would surgery be the

0:12:04.688 –> 0:12:06.284 primary modality upfront?

0:12:08.41 –> 0:12:12.474 That is a great question, and one that

0:12:12.474 –> 0:12:16.03 we are still trying to figure out.

0:12:16.03 –> 0:12:18.724 I think that there is clearly

0:12:18.724 –> 0:12:21.225 a standard paradigm of doing

0:12:21.225 –> 0:12:23.677 surgery followed by chemotherapy

0:12:23.677 –> 0:12:26.742 for about six months afterwards.

0:12:26.75 –> 0:12:30.646 There is a lot of interest in giving

0:12:30.646 –> 0:12:33.24 chemotherapy prior to surgery or

0:12:33.24 –> 0:12:35.785 giving part of the chemotherapy,

0:12:35.79 –> 0:12:38.796 then surgery, and then chemotherapy after.

0:12:38.8 –> 0:12:42.319 And in fact, here at Smilow we have a

0:12:42.319 –> 0:12:46.005 clinical trial which is really looking at

0:12:46.005 –> 0:12:49.34 that question of perioperative chemotherapy.

0:12:49.34 –> 0:12:53.164 How do patients do getting some of the

0:12:53.164 –> 0:12:55.36 chemotherapy treatments before surgery,

0:12:55.36 –> 0:12:57.048 and then some after?

0:12:57.048 –> 0:13:01.194 And how that might compare to those who get

0:13:01.194 –> 0:13:04.236 surgery 1st and then chemotherapy later?

0:13:05.33 –> 0:13:07.556 And so this kind of brings

0:13:07.556 –> 0:13:09.748 us to the question of, well,

0:13:09.748 –> 0:13:11.588 how effective is the chemotherapy?

0:13:11.59 –> 0:13:12.607 Because,

0:13:12.607 –> 0:13:14.98 I can imagine that many of the

0:13:15.05 –> 0:13:17.402 people who are listening to this

0:13:17.402 –> 0:13:19.292 show are thinking,

0:13:19.292 –> 0:13:22.979 if I have a cancer and you can take this

0:13:22.979 –> 0:13:27.038 cancer out and you can get it out of my body,

0:13:27.04 –> 0:13:29.378 for many people the simple

0:13:29.378 –> 0:13:32.059 logic is that might be better

0:13:32.059 –> 0:13:33.663 than having a chemotherapy,

0:13:33.67 –> 0:13:35.61 which may or may not

0:13:35.61 –> 0:13:38.928 work and they often have some

0:13:38.928 –> 0:13:41.14 trepidation about cancer spreading

0:13:41.234 –> 0:13:44.089 and then making it unresectable.

0:13:44.09 –> 0:13:46.975 So how effective is chemotherapy

0:13:46.975 –> 0:13:51.037 that we could potentially use it in

0:13:51.037 –> 0:13:53.737 a neoadjuvant fashion to potentially

0:13:53.737 –> 0:13:57.684 even shrink the cancer and get some

0:13:57.684 –> 0:14:01.032 systemic control prior to resecting it?

0:14:02.79 –> 0:14:09.48 So our newer chemotherapy regiments are

0:14:09.48 –> 0:14:11.8 good, they're not great,

0:14:11.8 –> 0:14:15.008 but they are good and they can shrink

0:14:15.008 –> 0:14:17.796 the disease for some and control

0:14:17.796 –> 0:14:20.171 the microscopic disease that might

0:14:20.171 –> 0:14:22.94 be floating around for others.

0:14:22.94 –> 0:14:25.88 I think that the challenge ultimately

0:14:25.88 –> 0:14:28.65 is that even with surgery,

0:14:28.65 –> 0:14:31.092 the risk of pancreatic cancer coming

0:14:31.092 –> 0:14:33.71 back because it has already shed

0:14:33.71 –> 0:14:36.44 these microscopic cells is very high,

0:14:36.44 –> 0:14:39.359 and so by giving chemotherapy we are

0:14:39.359 –> 0:14:41.57 hopefully attacking some of those

0:14:41.57 –> 0:14:44.234 microscopic cells that are floating around,

0:14:44.24 –> 0:14:47.234 but also making sure that putting

0:14:47.234 –> 0:14:50.22 somebody through what would be a

0:14:50.22 –> 0:14:52.47 very major operation is ultimately

0:14:52.47 –> 0:14:54.4 the right thing to do.

0:14:54.83 –> 0:14:57.518 So many complicating moving parts

0:14:57.518 –> 0:15:00.307 in the management of pancreatic cancer

0:15:00.307 –> 0:15:03.499 and we're going to learn much more

0:15:03.499 –> 0:15:06.516 about all of that right after we take

0:15:06.516 –> 0:15:09.116 a short break for a medical minute.

0:15:09.116 –> 0:15:11.42 Please stay tuned to learn more

0:15:11.498 –> 0:15:13.53 about pancreatic cancer with

0:15:13.53 –> 0:15:14.7 my guest Doctor Jeremy Kortmansky.

0:15:14.7 –> 0:15:17.04 Support for Yale

0:15:17.04 –> 0:15:19.865 Cancer Answers comes from AstraZeneca

0:15:19.865 –> 0:15:21.761 providing important treatment options

0:15:21.761 –> 0:15:24.579 for various types and stages of cancer.

0:15:24.58 –> 0:15:27.74 More information at astrazeneca-us.com.

0:15:27.74 –> 0:15:29.54 This is a medical minute

0:15:29.54 –> 0:15:31.34 about head and neck cancers,

0:15:31.34 –> 0:15:33.195 although the percentage of oral

0:15:33.195 –> 0:15:35.464 and head and neck cancer patients

0:15:35.464 –> 0:15:37.498 in the United States is only

0:15:37.498 –> 0:15:39.724 about 5% of all diagnosed cancers,

0:15:39.724 –> 0:15:41.654 there are challenging side effects

0:15:41.654 –> 0:15:43.377 associated with these types of

0:15:43.377 –> 0:15:44.653 cancer and their treatment.

0:15:44.66 –> 0:15:46.228 Clinical trials are currently

0:15:46.228 –> 0:15:48.188 underway to test innovative new

0:15:48.188 –> 0:15:50.057 treatments for head and neck cancers,

0:15:50.06 –> 0:15:52.01 and in many cases less radical

0:15:52.01 –> 0:15:54.38 surgeries are able to preserve nerves,

0:15:54.38 –> 0:15:56.666 arteries and muscles in the neck.

0:15:56.67 –> 0:15:59.19 Enabling patients to move speak,

0:15:59.19 –> 0:15:59.693 breathe,

0:15:59.693 –> 0:16:02.208 and eat normally after surgery.

0:16:02.21 –> 0:16:04.735 More information is available at

0:16:04.735 –> 0:16:05.24 yalecancercenter.org.

0:16:05.24 –> 0:16:08.258 You're listening to Connecticut Public Radio.

0:16:09.41 –> 0:16:11.768 Welcome back to Yale Cancer Answers.

0:16:11.77 –> 0:16:14.003 This is doctor Anees Chagpar

0:16:14.003 –> 0:16:16.902 and I am joined tonight by my

0:16:16.902 –> 0:16:19.232 guest doctor Jeremy Kortmansky.

0:16:19.24 –> 0:16:21.19 We're talking about pancreatic cancer

0:16:21.19 –> 0:16:23.56 and Jeremy right before the break,

0:16:23.56 –> 0:16:26.764 you had indicated to us that you really think

0:16:26.764 –> 0:16:29.846 about pancreatic cancer in terms of staging,

0:16:29.85 –> 0:16:32.419 as whether things are resectable at the

0:16:32.419 –> 0:16:34.559 time of presentation or unresectable,

0:16:34.56 –> 0:16:36.918 but not metastatic or metastatic

0:16:36.92 –> 0:16:38.496 and sadly,

0:16:38.496 –> 0:16:42.112 80% of patients or so fall into

0:16:42.112 –> 0:16:44.26 the last two buckets.

0:16:44.26 –> 0:16:45.76 And you know,

0:16:45.76 –> 0:16:47.76 that's really unfortunate,

0:16:47.76 –> 0:16:50.238 because what is the prognosis for

0:16:50.238 –> 0:16:52.624 patients who have locally advanced

0:16:52.624 –> 0:16:55.256 unresectable disease at presentation?

0:16:55.26 –> 0:16:58.34 And what is the prognosis for patients

0:16:58.34 –> 0:17:01.26 who present with metastatic disease?

0:17:03.29 –> 0:17:06.517 For those patients who have advanced disease,

0:17:06.52 –> 0:17:08.36 unfortunately we view those

0:17:08.36 –> 0:17:09.74 as incurable cancers.

0:17:09.74 –> 0:17:15.51 We can't make it go away and never come back.

0:17:15.51 –> 0:17:18.03 For patients that have locally

0:17:18.03 –> 0:17:20.55 advanced disease on occasion and

0:17:20.637 –> 0:17:22.637 it's not the expectation,

0:17:22.64 –> 0:17:25.895 but on occasion they have a

0:17:25.895 –> 0:17:28.501 great response to the chemotherapy

0:17:28.501 –> 0:17:31.849 and we can revisit that question

0:17:31.849 –> 0:17:34.919 of surgery but without surgery,

0:17:34.92 –> 0:17:37.4 ultimately, patients succumb to their

0:17:37.4 –> 0:17:41.09 disease and the goals of our treatment

0:17:41.09 –> 0:17:43.215 are to control the disease

0:17:43.215 –> 0:17:45.34 for as long as possible.

0:17:45.34 –> 0:17:48.38 Help people live as long as possible and

0:17:48.38 –> 0:17:51.598 feel as well as possible knowing that

0:17:51.598 –> 0:17:54.69 the disease can be symptomatic as well.

0:17:55.83 –> 0:18:00.648 For people who are

0:18:00.648 –> 0:18:03.688 listening to this and who may have had

0:18:03.688 –> 0:18:06.142 friends or even seen celebrities

0:18:06.142 –> 0:18:08.604 go through their own journeys

0:18:08.604 –> 0:18:12.6 with pancreatic cancer,

0:18:12.6 –> 0:18:15.192 when we say the goal is really

0:18:15.192 –> 0:18:18.243 to try to control the cancer for as

0:18:18.243 –> 0:18:21.012 long as possible and the quality

0:18:21.012 –> 0:18:23.665 of life for as long as possible,

0:18:23.67 –> 0:18:24.75 in some cancers

0:18:24.75 –> 0:18:26.55 we've discussed on this

0:18:26.55 –> 0:18:28.839 show,

0:18:28.84 –> 0:18:31.353 medical management has come a really long

0:18:31.353 –> 0:18:33.998 way such that even in those settings,

0:18:34.696 –> 0:18:37.48 people live for a long time and

0:18:37.558 –> 0:18:40.42 they talk about this being incurable,

0:18:40.42 –> 0:18:42.891 but really making it more of a

0:18:42.891 –> 0:18:44.509 chronic disease then something

0:18:44.509 –> 0:18:46.449 that is imminently fatal.

0:18:46.45 –> 0:18:49.236 Where are we in the spectrum of

0:18:49.236 –> 0:18:51.27 pancreatic cancer towards getting to

0:18:52.134 –> 0:18:55.158 oK, so I've got pancreatic cancer and

0:18:55.158 –> 0:18:58.509 I know that I can't get rid of it,

0:18:58.51 –> 0:19:00.006 but

0:19:00.006 –> 0:19:02.807 I can live with it versus this

0:19:02.807 –> 0:19:05.127 is something that

0:19:05.13 –> 0:19:08.98 is more of an imminent concern.

0:19:10.68 –> 0:19:14.852 It's still a very challenging disease and

0:19:14.852 –> 0:19:19.25 there are for a lot of other cancers,

0:19:19.25 –> 0:19:23.126 a lot of exciting new therapies and

0:19:23.126 –> 0:19:25.71 targeted therapies and immunotherapy's

14

0:19:25.8 –> 0:19:28.188 that have become available.

0:19:28.19 –> 0:19:29.986 But for pancreas cancer,

0:19:29.986 –> 0:19:33.305 the majority of patients are still treated

0:19:33.305 –> 0:19:36.593 with versions of chemotherapy and

0:19:36.593 –> 0:19:39.149 those chemotherapy drugs are modest.

0:19:39.15 –> 0:19:41.635 There are some who are

0:19:41.635 –> 0:19:42.629 exceptional responders.

0:19:42.63 –> 0:19:47.103 People who do really well for a long time,

0:19:47.11 –> 0:19:50.098 but for the majority of patients,

0:19:50.1 –> 0:19:53.06 the survival is still only

0:19:53.06 –> 0:19:56.84 measured in in months or years.

0:19:56.84 –> 0:20:00.176 And doing better and finding better

0:20:00.18 –> 0:20:02.445 therapies is of such great

0:20:02.445 –> 0:20:04.257 importance for this disease.

0:20:04.26 –> 0:20:06.834 I think we are really hoping

0:20:06.834 –> 0:20:09.584 and trying every day to find

0:20:09.584 –> 0:20:12.41 therapies that are better than what

0:20:12.41 –> 0:20:13.628 we have currently.

0:20:13.628 –> 0:20:16.47 Do we have any factors that can

0:20:16.555 –> 0:20:19.525 predict who is going to respond

0:20:19.525 –> 0:20:21.92 better to chemotherapy versus not?

0:20:24.76 –> 0:20:29.602 So we are still trying to figure that out.

0:20:29.61 –> 0:20:33.922 I had mentioned

0:20:33.922 –> 0:20:37.958 this earlier, patients that have a BRCA

0:20:37.958 –> 0:20:41.47 mutation or a similar type mutation,

0:20:41.47 –> 0:20:44.76 we find that they are more sensitive

0:20:44.76 –> 0:20:47.4 to platinum based chemotherapy.

0:20:47.4 –> 0:20:51.796 So a drug like oxaliplatin or cisplatin.

0:20:51.8 –> 0:20:54.67 And that we can see better responses

0:20:54.67 –> 0:20:57.286 there that can sometimes last longer

0:20:57.286 –> 0:21:00.915 than we might see with a patient who

0:21:00.915 –> 0:21:03.945 doesn't have one of those abnormalities.

0:21:03.95 –> 0:21:07.134 We know that there is a class of

0:21:07.134 –> 0:21:09.8 drugs called PARP inhibitors,

0:21:09.8 –> 0:21:12.29 which for this mutated population

0:21:12.29 –> 0:21:15.199 can benefit from this targeted therapy.

0:21:15.2 –> 0:21:19.25 At the end of the day, that only makes

0:21:19.25 –> 0:21:23.81 up about 7% of the patients that we see.

0:21:23.81 –> 0:21:28.57 So it's still not a not a big number and

0:21:28.694 –> 0:21:32.055 we know about 1% have another abnormality,

0:21:32.055 –> 0:21:33.51 called microsatellite instability,

0:21:33.51 –> 0:21:34.965 for which immunotherapy

0:21:34.965 –> 0:21:36.905 drugs have been helpful.

0:21:36.91 –> 0:21:40.298 And so we always test for that.

0:21:40.3 –> 0:21:45.15 But again, it's one out of 100 that we see.

0:21:45.15 –> 0:21:48.181 So the majority of the patients that

0:21:48.181 –> 0:21:51.729 we take care of are still treated

0:21:51.729 –> 0:21:54.429 similarly with these more generic

0:21:54.43 –> 0:21:57.01 chemotherapy programs with a strong

0:21:57.01 –> 0:22:00.131 emphasis in trying to encourage patients

0:22:00.131 –> 0:22:02.406 to participate in clinical trials

0:22:02.406 –> 0:22:05.539 that can help us move the field.

0:22:06.89 –> 0:22:10.234 And I want to get into

0:22:10.234 –> 0:22:13.019 the clinical trials in a minute.

0:22:13.02 –> 0:22:15.21 But before we get there,

0:22:15.21 –> 0:22:17.475 if you're treated with standard

0:22:17.475 –> 0:22:20.224 chemotherapy and all of the side

0:22:20.224 –> 0:22:22.66 effects that go along with that,

0:22:22.66 –> 0:22:24.85 knowing that you're

0:22:24.85 –> 0:22:27.04 presented with a locally advanced,

0:22:27.04 –> 0:22:28.608 unresectable or metastatic cancer,

0:22:28.608 –> 0:22:30.568 what is really the efficacy

0:22:30.568 –> 0:22:32.289 of these chemotherapies?

0:22:32.29 –> 0:22:35.562 I mean, how do patients balance the risk

0:22:35.562 –> 0:22:39.416 and the benefit of the therapy?

0:22:39.416 –> 0:22:41.881 Is this something that for

0:22:41.881 –> 0:22:45.028 some patients the therapy is

0:22:45.028 –> 0:22:47.638 worse than the disease itself?

0:22:47.64 –> 0:22:50.76 Or are these actually things that

0:22:50.76 –> 0:22:53.49 are tolerable with more modern

0:22:53.49 –> 0:22:56.27 day treatments and additional

0:22:56.27 –> 0:22:59.87 factors that you can give patients?

0:22:59.87 –> 0:23:01.622 And that has really been shown

0:23:01.622 –> 0:23:03.731 to make a difference in terms of

0:23:03.731 –> 0:23:05.489 both survival and quality of life.

0:23:07.23 –> 0:23:10.723 My job is to make

0:23:10.723 –> 0:23:12.22 the treatments tolerable.

0:23:12.22 –> 0:23:14.65 When we we pick a regimen,

0:23:14.65 –> 0:23:17.08 there are two common

0:23:17.08 –> 0:23:18.7 regiments that we use.

0:23:18.7 –> 0:23:20.725 We are already thinking about

0:23:20.725 –> 0:23:23.75 what are the side effects that are

0:23:23.75 –> 0:23:26.065 associated with those regimens and

0:23:26.065 –> 0:23:28.198 whether the patient who's about

0:23:28.198 –> 0:23:30.846 to receive it is going to be able

0:23:30.85 –> 0:23:33.685 to tolerate it based on their age and

0:23:33.69 –> 0:23:35.934 other medical problems that they may

0:23:35.934 –> 0:23:38.949 have and when we give the treatments,

0:23:38.95 –> 0:23:42.278 we do so very carefully and we pay

0:23:42.278 –> 0:23:45.487 attention to those side effects to make

0:23:45.49 –> 0:23:49.081 adjustments in the dosing or give

0:23:49.081 –> 0:23:51.103 supportive medications to really

0:23:51.103 –> 0:23:53.896 make it as tolerable as we can.

0:23:53.9 –> 0:23:57.953 It's never a desired situation that the

0:23:57.953 –> 0:24:01.49 treatment is worse than the disease.

0:24:01.49 –> 0:24:02.862 And the reality is,

0:24:02.862 –> 0:24:05.398 that for the vast majority of

0:24:05.398 –> 0:24:08.219 patients when they do start feeling poorly,

0:24:08.22 –> 0:24:10.09 it's more often the disease

0:24:10.09 –> 0:24:11.96 than it is the treatments.

0:24:11.96 –> 0:24:14.228 But we make sure we see patients

0:24:14.228 –> 0:24:16.357 every time before they get their

0:24:16.357 –> 0:24:18.535 treatments to review the side effects

0:24:18.535 –> 0:24:21.069 and give the right medications and

0:24:21.069 –> 0:24:23.174 give the supportive medications or

0:24:23.18 –> 0:24:25.798 dose adjustments that we need to do.

0:24:26.89 –> 0:24:29.398 And how do we know

0:24:29.4 –> 0:24:31.268 that the chemotherapies are working?

0:24:31.268 –> 0:24:34.07 Many patients ask about well are

0:24:34.153 –> 0:24:36.526 you going to do more blood work?

0:24:36.53 –> 0:24:39.038 Are there tumor markers?

0:24:39.04 –> 0:24:40.524 How do you know?

0:24:40.524 –> 0:24:42.75 Because you had mentioned that for

0:24:42.829 –> 0:24:45.583 some patients who present

0:24:45.583 –> 0:24:47.419 without metastatic disease,

0:24:47.42 –> 0:24:49.385 that is unresectable that

0:24:49.385 –> 0:24:52.03 potentially in some of those patients,

0:24:52.03 –> 0:24:54.125 you can reassess whether they

0:24:54.125 –> 0:24:56.22 may be candidates for resection.

0:24:57.63 –> 0:25:01.697 The best way to follow the disease is

0:25:01.697 –> 0:25:05.73 with imaging so usually a CAT scan.

0:25:05.73 –> 0:25:08.369 Sometimes an MRI or a PET scan,

0:25:08.37 –> 0:25:10.869 but usually a CAT scan gives us

0:25:10.869 –> 0:25:13.649 the level of detail that we need,

0:25:13.65 –> 0:25:15.158 including the relationship of

0:25:15.158 –> 0:25:17.42 the tumor to the vessels nearby.

0:25:17.42 –> 0:25:19.922 For those who have locally advanced

0:25:19.922 –> 0:25:22.317 disease and there is a tumor

0:25:22.317 –> 0:25:24.578 marker that we can use as well,

0:25:27.38 –> 0:25:29.2 that can be helpful,

0:25:29.2 –> 0:25:31.475 although sometimes it is not as

0:25:31.475 –> 0:25:34.362 reliable as the scans and then also

0:25:34.362 –> 0:25:36.64 really listening to the patient.

0:25:36.64 –> 0:25:39.808 Patients can have symptoms that can be a

0:25:39.808 –> 0:25:42.82 tipoff that something is getting better

0:25:42.82 –> 0:25:45.52 or getting worse even before CAT

0:25:45.52 –> 0:25:48.109 Scan tell you what's going on.

0:25:49.55 –> 0:25:52.292 And back to

0:25:52.292 –> 0:25:55.09 the story of my friend.

0:25:55.09 –> 0:25:58.12 She had chemotherapy as you suggested,

0:25:58.12 –> 0:26:01.138 and her tumor markers went down,

0:26:01.14 –> 0:26:02.472 which was great,

0:26:02.472 –> 0:26:05.58 but the imaging still showed that

0:26:05.672 –> 0:26:08.2 she had unresectable disease.

0:26:09.754 –> 0:26:14.093 She was quite happy to be done with

0:26:14.093 –> 0:26:18.223 chemo and really didn't want to

0:26:18.23 –> 0:26:20.995 do much more, but was certainly

0:26:20.995 –> 0:26:22.74 interested in clinical trials.

0:26:22.74 –> 0:26:25.61 So let's talk about clinical trials,

0:26:25.61 –> 0:26:27.086 both in that setting,

0:26:27.086 –> 0:26:29.3 after you don't respond

0:26:29.368 –> 0:26:31.483 to standard chemotherapy as well

0:26:31.483 –> 0:26:33.598 as clinical trials that might

0:26:33.673 –> 0:26:35.788 be offered to patients upfront

0:26:35.788 –> 0:26:37.903 as new therapies are developed.

0:26:37.91 –> 0:26:40.78 So what are you most excited about?

0:26:43.05 –> 0:26:45.288 I think it's interesting that you

0:26:45.288 –> 0:26:48.159 say that, I find that when I talk

0:26:48.16 –> 0:26:49.985 to a patient

0:26:49.985 –> 0:26:51.445 about a clinical trial

0:26:51.45 –> 0:26:54.365 sometimes they say to me, do you think

0:26:54.365 –> 0:26:56.92 I'm ready for a clinical trial?

0:26:56.92 –> 0:26:59.265 As if it's something that we wait

0:26:59.265 –> 0:27:01.669 until we don't have other options,

0:27:01.67 –> 0:27:03.764 and clinical trials are important at

0:27:03.764 –> 0:27:05.68 every phase of someone's disease,

0:27:05.68 –> 0:27:07.685 whether they are initially diagnosed

0:27:07.685 –> 0:27:09.69 or whether they have progressed

0:27:09.75 –> 0:27:11.52 on one or two prior therapies.

0:27:11.52 –> 0:27:14.154 We are always trying to figure

0:27:14.154 –> 0:27:17.058 out what's the best thing to do.

0:27:17.06 –> 0:27:20.148 And so the clinical trials that we are

0:27:20.148 –> 0:27:22.979 working on that we're excited about,

0:27:22.98 –> 0:27:25.977 I think we are still trying to find a

0:27:25.977 –> 0:27:29.328 role for immunotherapy in pancreas cancer,

0:27:29.33 –> 0:27:31.646 the same as in other diseases

0:27:31.646 –> 0:27:33.98 like lung cancer or Melanoma.

0:27:33.98 –> 0:27:36.1 But it's been a challenge,

0:27:36.1 –> 0:27:39.019 and so we are doing clinical trials

0:27:39.019 –> 0:27:41.349 that are looking at immunotherapy

0:27:41.349 –> 0:27:44.331 combinations as opposed to just a

0:27:44.331 –> 0:27:47.178 single drug to see if it might be

0:27:48.629 –> 0:27:52.01 better and we're looking at clinical trials that are

0:27:52.097 –> 0:27:55.673 trying to attack not just the tumor itself,

0:27:55.68 –> 0:27:58.278 but the scar tissue in the

0:27:57.278 –> 0:28:00.56 environment around the cancer cells.

20

0:28:00.56 –> 0:28:03.146 One of the challenging things about

0:28:03.146 –> 0:28:06.289 pancreas cancer is that it almost builds

0:28:06.289 –> 0:28:08.519 this protective shell around itself

0:28:08.519 –> 0:28:11.245 that can potentially make it more

0:28:11.245 –> 0:28:14.34 difficult for our treatments to get in,

0:28:14.34 –> 0:28:18.02 and so looking at drugs that can potentially

0:28:18.02 –> 0:28:21.049 eat away at that might help our

0:28:21.05 –> 0:28:23.42 more standard therapies be more

0:28:23.42 –> 0:28:25.076 effective.

0:28:25.076 –> 0:28:27.56 Doctor Jeremy Kortmansky is an associate professor of

0:28:27.622 –> 0:28:29.472 clinical medicine in medical oncology

0:28:29.472 –> 0:28:31.95 at the Yale School of Medicine.

0:28:31.95 –> 0:28:33.438 If you have questions,

0:28:33.438 –> 0:28:34.926 the address is canceranswers@yale.edu

0:28:34.926 –> 0:28:36.981 and past editions of the program

0:28:36.981 –> 0:28:38.859 are available in audio and written

0:28:38.914 –> 0:28:40.48 form at yalecancercenter.org.

0:28:40.48 –> 0:28:43.152 We hope you'll join us next week to

0:28:43.152 –> 0:28:45.758 learn more about the fight against

0:28:45.758 –> 0:28:48.548 cancer here on Connecticut Public Radio.