

Yale CANCER CENTER *answers*

WNPR Connecticut Public Radio



Hosts

Anees Chagpar MD

*Associate Professor of
Surgical Oncology*

Susan Higgins MD

*Professor of Therapeutic
Radiology, Obstetrics,
Gynecology, and
Reproductive Sciences*

Steven Gore MD

*Director of Hematologic
Malignancies*

Gynecological Cancers and Fertility

Guest Expert: Elena Ratner, MD

*Assistant Professor, Obstetrics, Gynecology and
Reproductive Sciences, Yale School of Medicine*

Yale Cancer Center Answers is a
weekly broadcast on **WNPR**
Connecticut Public Radio Sunday
Evenings at 6:00PM

Listen live online at cpbn.org

Listen to archived programs at
yalecancercenter.org

Welcome to Yale Cancer Center Answers with your hosts doctors Anees Chagpar, Susan Higgins and Steven Gore. Dr. Chagpar is Associate Professor of Surgical Oncology and Director of the Breast Center at Smilow Cancer Hospital. Dr. Higgins is Professor of Therapeutic Radiology and of Obstetrics, Gynecology and Reproductive Sciences and Dr. Gore is Director of Hematological Malignancies at Smilow and an expert in Myelodysplastic Syndromes. Yale Cancer Center Answers features weekly conversations about the research diagnosis and treatment of cancer and if you would like to join the conversation, you can submit questions and comments to canceranswers@yale.edu or you can leave a voicemail message at 888-234-4YCC. This week it is a conversation with Dr. Elena Ratner. Dr. Ratner is Assistant Professor of Obstetrics, Gynecology and Reproductive Sciences at Yale School of Medicine. Here is Dr. Susan Higgins.

Higgins First I wanted to tell people what the term gynecologic oncologist means. A lot of people are really familiar with medical oncologists who give chemo, but they are not really familiar with what gynecologic oncologists do in the cancer world. Could you tell us a little bit about the role that you have in cancer care?

Ratner Gynecologic oncologist is a very special specialty, which I actually think is the best specialty there is. We get to take care of women who are diagnosed with gynecologic cancers. The reason why I think it is such a fantastic specialty is that this specialty allows me to take care of my patients from the moment they started having symptoms through the surgery and through their chemotherapy if they need it and through the rest of their treatment, so the highlight of my specialty is the relationships that I make with my patients because we are together for many, many years.

Higgins And I think it is really one of the few cancer specialties where you are doing the surgery, you do the chemotherapy and pretty much everything that comes with it throughout the course of their disease, so you have this long relationship with the patient.

Ratner Exactly correct, and a lot of my patients do not even have cancer, a lot of our patients are something we call pre-vivors. They are the women who for whatever reason we feel might be at higher risk for certain gynecologic cancers and we monitor them and surveillance them so that they do not develop these cancers, so it is a very broad population of women, I have young women, I have women who are also young but not that young and we take care of all these populations.

Higgins That is fascinating that they are a pre-vivor group who is high risk, could you talk about that and how do you identify them and what types of things do you do for them?

Ratner Cancer therapy is changing. For many years we have tried really hard to cure cancers, to find new chemotherapies, to find new ways to treat them and we have been successful with that. We then started paying attention and concentrating on diagnosing these cancers early, something called early cancer detection, but now the future is different. Now, we are looking to prevent those cancers. I do not want you to even get a stage I cancer. I want you to never get cancer, so the key is to identify the women who we worry might be at increased risk for those cancers and start

3:45 into mp3 file https://az777946.vo.msecnd.net/cancer/2015%201206%20YCC%20Answers%20-%20Dr%20Ratner_239482_5.mp3

watching them early and preventing those cancers from happening. One of the most important parameters of this risk assessment is family history, so women who have a strong family history of ovarian cancer, of breast cancer, and there are a couple of other cancers that we feel might be genetic, these are some of the women that we involve in our care and we do send them for surveillance where we try to make sure that they do not develop cancers.

Higgins How does a person get to you? They do not just show up in the GYN clinic I am sure. How do you get to see the patients that are high risk in the clinic?

Ratner That is a great question. Probably the best thing that has happened in this field has been Angelina Jolie and there is something we call the Angelina Jolie effect. After Angelina Jolie published the information about her personal genetic mutation which is the BRCA mutation and the prophylactic surgeries and different things that she has done not to develop those cancers, it made this conversation public and allowed me to be able to go and give talks and meet with young women and other women and bring this to their attention. Angelina Jolie, in the New York Times article that she published, made this conversation okay and since that time, I have done many different seminars and conversations in the library at JCC, at YMCA's, all kinds of different places where we talk to women telling them, learn your history, learn your family history, talk to your mom, talk to your grandparents, talk to your great-grand parents, find out what kind of cancers you carry in your genes and with that, women identify themselves as being considered high risk and they come to our practice.

Higgins I know that being in the Tumor Boards and talking to the genetic counselors and reading their notes, this is something that they struggle with, getting an accurate family history. A lot of people do not know their family history and it is now part of your healthcare in a way, right, to know your family history, because then you can get plugged into the proper clinics like yours where BRCA genes are identified. Maybe we could talk about what happens when you identify, for example, someone who has a BRCA mutation, how does that work once you find out that you have it, what kind of things can you do?

Ratner You are absolutely correct about what you said. The genetic counselors are a key to this. In general, we do not do a great job with pedigree's and figuring out the family history and we all know stories about our background, but the genes that we carry are more important than a lot of other things that we think are important, so yes, for those women who do carry some sort of a family history who we worry could be at high risk, they must see a genetic counselor. Genetic counselors do a fantastic job drawing out a pedigree, truly learning about their history, and very frequently genetic counselors will send the patient back to her family to get more information. Once that is done, if the woman is considered to be at high risk or we worry about her genetic risk, then we do genetic testing and it is a very easy procedure. It is either just a saliva or blood test. In older days, it used to be very expensive, but nowadays, it is not. There are many different companies that do it and it is very affordable and a great majority of insurance

companies actually cover these. If the women are found to have these mutations and there are a number of them, but

7:46 into mp3 file https://az777946.vo.msecnd.net/cancer/2015%201206%20YCC%20Answers%20-%20Dr%20Ratner_239482_5.mp3

there are a few that are truly associated with increased risks such as BRCA1 mutation and BRCA2 mutation, one of which Angelina Jolie carries, if those women have these mutations, then they do get involved with the surveillance program both for breast cancer and for ovarian cancer. For breast cancer, for example, there are a number of options for surveillance to try to find the cancers early and those include mammogram and MRIs and certain other things that they can do. For ovarian cancer, we also do a great number of different things which include ultrasounds and blood tests but we also talk about decrease in risk and what you can do, for example birth control pills are very protective for ovarian cancer. Anybody who has taken five years of birth control pills, their risk of ovarian cancer becomes 50% less.

Higgins That is fascinating, I did not know that, that is a simple measure that no one would really associate with risk reduction.

Ratner I tell all my girlfriends to at some point try to get in 5 years of birth control pills, just for ovarian cancer reduction and there are other things, for breast cancer, alcohol use, there is a lot of literature recently about how much alcohol increases your risk and we recommend less than 5 to 7 drinks a week so that your breast cancer risk is not increased and those are just some of the examples of things that you can do in your normal life to decrease your risk of developing cancer in the future. We do ultrasounds, we do blood tests, those are not perfect but we have a special center where we do those and we feel confident about those results and therefore, those women who truly have these genetic mutations which increase their risk of developing ovarian cancer, sometimes when they get close to menopause, we recommend a surgical intervention and that way they never develop ovarian cancer and they are no longer at risk.

Higgins I think a lot of people when they think about having their ovaries out, they imagine a big incision in the belly, but I think that has changed in the past several years and you are an expert with the laparoscope and this is now a relatively well tolerated and quick procedure. Maybe you could talk about how you remove the ovaries laparoscopically and also the other part that I think is interesting is you have a team of people that look closely at the ovaries to see what is really going on there and that is namely our pathologists, and they do a special sort of protocol for looking at the ovaries a little closer than we would in some other situations.

Ratner That is correct, nowadays the great majority of everything that we do is laparoscopic, so for removing of ovaries, for example, you have tiny 2 or 3 incisions which are lesser than the nail along your pinky. The surgery itself is quite quick, 30 minutes or so and you go home the same day and there is very little recovery time. Nowadays a great majority of all the surgeries that we do are laparoscopic. Things that in

the past, just like you said, where we used to do an incision and the recovery time is long, that is not the present and certainly not the future. The more time passes, the more we are going to do these things with very low invasive components and of course taking out the ovaries is not for everybody, everything has a risk and benefit, so taking out the ovaries would be for those women who are truly, truly at such increased risk for whom I feel that taking out of the ovaries significantly decreases their risk of developing those cancers because the

12:02 into mp3 file https://az777946.vo.msecnd.net/cancer/2015%201206%20YCC%20Answers%20-%20Dr%20Ratner_239482_5.mp3

surgery of removing the ovaries is not significant, but those women then go into menopause and very frequently early menopause and surgical menopause, so a lot of what we do is we meet with those women beforehand. Again, in the older days, we used to take out the ovaries and then six months later or a year later, or never, we used to talk to them about their menopausal symptoms and deal with that. That is not the present. Now, we meet with women before we take their ovaries out, we discuss with them the possible menopausal symptoms that they could have and more importantly what the interventions are that we are going to suggest and the interventions are vast. The range is from hormonal medicines for women, even for BRCA women, we have a lot of literature to say that those are very safe, there is a lot of literature that says that using estrogen in women who have had their ovaries removed even with BRCA mutation does not increase their risk of breast cancer and actually taking out your ovaries decreases the risk of breast cancer by 50% if that is done before menopause, but for those women who either cannot have hormones or who do not want to have hormones, we use herbal medicines, we use acupuncture, we use exercise classes, so we have a wide range of things that we can offer because the most important thing is that women should not live with those symptoms, we want to do a lot of things to prevent cancer, but at the same time, we do not want to subject them to the side effects because we can manage them.

Higgins That is great, I like this whole idea of the multidisciplinary approach and when we return we will talk a little bit more about the complementary therapies, but right now we are going to take a short break for a medical minute. Please stay tuned to learn more information about gynecologic cancers with Dr. Elena Ratner.

Medical Minute
The American Cancer Society estimates that there will be 75,000 new cases of melanoma in the US this year with over 1000 of these patients living in Connecticut. While melanoma accounts for only about 4% of skin cancer cases, it causes the most skin cancer deaths. Early detection is the key and when detected early, melanoma is easily treated and highly curable. Clinical trials are currently underway at federally designated comprehensive cancer centers, such as Yale Cancer Center and at Smilow Cancer Hospital at Yale-New Haven to test innovative new treatments for melanoma. The goal of the Specialized Programs of Research Excellence (SPOR) in skin cancer grant is to better understand the biology of skin cancer with the focus on discovering targets that will lead to improved diagnosis and treatment. This has been a medical minute brought to you as a public service by Yale Cancer Center and Smilow Cancer Hospital at

Yale-New Haven. More information is available at yalecancercenter.org. You are listening to WNPR, Connecticut's Public Media Source for news and ideas.

Higgins Welcome back to Yale Cancer Center Answers. This is Dr. Susan Higgins and I am here with my guest this evening, Dr. Elena Ratner and we are talking about gynecologic cancers. During the first half, one of the things we touched upon was the pathologist as part of their team as opposed to some other specialties, or more so than other specialties, and gynecologic oncology I think is one of the most multidisciplinary, team oriented specialties and the teamwork starts at the Tumor Board where we discuss our patients, and I think a lot of patients do not even know about this but

15:58 into mp3 file https://az777946.vo.msecnd.net/cancer/2015%201206%20YCC%20Answers%20-%20Dr%20Ratner_239482_5.mp3

when we are coming together to outline a management plan including specifics about the cancer care and the therapies and sequencing, we are all sitting in a room with our pathologist and radiation oncologists are there, gynecologic oncologists are there and we outline it as a group and then follow through as a group. Maybe you can touch on how important it is to have a team taking care of patients with gynecologic cancers?

Ratner I think a multidisciplinary approach is the key. It is particularly important in gynecologic cancers because these cancers are so diverse and women can benefit from so many different aspects of care, so you are absolutely correct, there is no way that anybody can do this alone. Tumor Boards are places where we meet and patients are discussed very carefully and in great detail and in that way patients get benefit from opinions from many different specialties including GYN oncologists, and again this is not one GYN oncologist, it is usually 4 or 6 GYN oncologists in the room so we hear multiple opinions. Radiation oncologists are physicians who provide radiation therapy to people. Radiologists are the physicians who read CAT scans, MRI and chest x-rays. Pathologists who look at the slides and are able to provide us with a vast amount of information regarding the tumors, and now so much is done and it's truly personalized care. The care that I provide to one patient is very different from the care that I will provide to somebody with exactly the same disease, with exactly the same cancer an hour later in the day. We look at women not as patients, not as cancers that they carry but truly as women who are now suffering with these diseases, so every single woman needs a different approach and different therapy and different chemotherapy and different radiation and different plan, but also different things for her quality of life, so a big component of this multidisciplinary approach are physicians and providers from palliative care, those are providers that help women cope with a cancer diagnosis, with chemotherapy, with radiation and with the symptoms that it brings and then later on, survivorship; those are special providers who follow women after their cancer is treated when they no longer have the cancer and they are cured but the sequela of some of the treatments of the cancer continue and those specific providers follow these women throughout the rest of their life, so this is truly a multidisciplinary approach where women benefit from all these different opinions and I think that is why Yale is so special because here at Yale we are able to provide our women and our patients with this great care that is comprehensive.

Higgins And the team effort right from the beginning, many of us have seen patients upfront where we discuss our specific plans and I think it is important because there is no replacement for the face-to-face encounters that we have. We all have an electronic medical record which has factual information but I think at the Tumor Board the art and science meet where we are basically putting together the factual information but then personalizing it and then we can carry that plan all the way through and I am glad you spoke about palliative care and the survivorship issues because in the past medicine has been focused on the cure and the cure alone but patients felt very abandoned when it came to follow up and how do you deal with all the sequelae of treatment, there are sexuality issues, there are pain issues, could you talk about some of the palliative tools that we have now that we never had before. We have a whole team for that now, right?

20:10 into mp3 file [https://az777946.vo.msecnd.net/cancer/2015%201206%20YCC%20Answers%20-%20Dr%20Ratner 239482 5.mp3](https://az777946.vo.msecnd.net/cancer/2015%201206%20YCC%20Answers%20-%20Dr%20Ratner%20239482%205.mp3)

Ratner I will briefly follow up on the point that you made in terms of sexuality and menopause, I myself, along with Dr. Mary Jane Minkin, started a special clinic at Yale Cancer Center that deals with sexuality, intimacy and menopause. This was years ago, and the reason we started this clinic was because of a patient that I came across who was a long-term cancer survivor and in all our books and in all my charts, at that time we still had paper charts, it kept saying how this patient was a pure success and miracle and yet this patient was miserable. We were all patting ourselves on our back that her cancer was cured but we were not paying attention to her. We were not paying attention to who she was and how this cure affected her, how the chemotherapy and radiation surgery, how it affected her. She was a young woman who was never able to return back to her normal life even when the cancer was cured because of the side effects that she experienced, so that is how the sexuality, intimacy, and menopause clinic was born. It was born for this one particular woman and when she was better and she got remarried and she was happy and healthy, we realized how many women need this kind of care and now this has become very much a part of our routine treatment and this is now a very successful practice. We see a lot of women with gynecologic cancers, breast cancers, with blood cancers, and so forth, so it is just one of the few examples of things that we can do to improve quality of life. Palliative care is amazing. Smilow Cancer Hospital has expanded their palliative care over the past couple of years and now we have a great team of physicians and social workers and ministry and they are able to help women as they cope with the side effects of chemotherapy and radiation and surgery. They help manage pain and depression. It is a truly comprehensive approach. A lot of my women, when we meet for their chemotherapy visits, we do not talk about chemotherapy, we talk about exercise and nutrition and the trips that they are going to take because that is the future. The future is that yes, we do have to give chemotherapy. Unfortunately, that is still the case. The case is that as much as I try and as much as I am going to learn about the tumor and I am going to try to do something called targeted therapy where I will give you something that really knocks your tumor but hopefully does not give you too many side effects, nevertheless, chemotherapy is hard, but I do not want that to be your life. I want that to be something that you come and you get and then all of us rallying around you to try to help you with the quality of life, so again whether it is

exercise, whether it is nutrition, whether it is pain management, whether it is menopausal symptoms, whether it is dealing with the children who are dealing with you having cancer diagnosis, that is what we provide.

Higgins What is really nice about that also is that patients are always asking me, what can I do, what can I do to help myself and it sounds like in that arena you are partnering with the patient and sort of empowering them get back to their normal life and maintain their health in ways that you can actually guide them and offer them services, like the sexuality clinic and it sounds like that started with Dr. Minkin from a little seed and it is a really well recognized program at the center.

Ratner Absolutely, it started from that need, it started from me coming across this patient and realizing what we as physicians or providers consider a cure and a success is not that in the eye of the patient and I think that is an important point when I give talks to residents or fellows, I always talk about that. I always say to make sure that success is her success and not your success.

24:39 into mp3 file https://az777946.vo.msecnd.net/cancer/2015%201206%20YCC%20Answers%20-%20Dr%20Ratner_239482_5.mp3

Higgins Right, because we have our own idea of what success is and I always tell residents that also when I am speaking to them because there are some people where there is a curative therapy and there are other people where it may not be curative, but helpful, but then when we go beyond that there is always something you can do for the patient and I try to get them to think outside of the realm of the very hard core Western medicine. You can give them chemo, you can give them radiation. We do not want them to stop there with their thinking. We want them to think in this more holistic way, and I actually went to the University of Rochester Medical Center where George Engel was sort of the founder of the psychosocial or psychobiological approach to the patient where we do not just treat the disease, we treat the patient in their entirety and that was a big emphasis at our medical school and I have carried that through in my practice.

Ratner Absolutely, with the sexuality and menopause clinic that is what we do, we actually do it in collaboration with psychology and Dwain Fehon and his team have always done this with us because we very quickly realized that maybe 50 if not 40% of the women's problems are physiologic and you cannot walk this alone, so we provide this multidisciplinary approach to them.

Higgins Right and again mental health has always been in the background sort of in the shadows of health in general and now we are realizing that there is tremendous fall out when people have their lives sort of swept out from under them. I have this conversation with patients over time, but now they have got this tremendous challenge to rebuild their lives, but sometimes in the shadow of depression and anxiety and a sort of PTSD because it is a trauma, getting a cancer and getting cancer treatment is traumatic, so it is great to hear you have this psychiatric help.

Ratner And the future is bright. Cancer therapy is changing and it changes not by years, not by months, but by weeks. Every week something new comes up, new research is being done, I come to my lab at night and I do experiments and I am just so thrilled about the future. The future is bright, but it is important to remember that cure and treating cancer is not the only thing. We have got to keep working and we have got to make it better, we have got to cure all these cancers or we have got to prevent all these cancers, so these women do not even have to deal with it, but we cannot forget the quality of life and we cannot forget that the key for us as it is for the patients, is to get back to their normal lives.

Higgins I sometimes say, you know a lot of us have not been ill, but when you have been ill, it gets you inside the issue, so I have a saying it is good for doctors to be sick every so often.

Ratner Absolutely.

Higgins But there is also this golden rule about how you would want to be treated. How would you want to come through this and then what would you be faced with in terms of continuing your life and I think if we really start to think hard about that there is a lot of support that our patients are going to need.

27:57 into mp3 file https://az777946.vo.msecnd.net/cancer/2015%201206%20YCC%20Answers%20-%20Dr%20Ratner_239482_5.mp3

Ratner Absolutely.

Higgins So we need to carry that through and I think one of the reasons gynecologic oncologists and radiation radiologists, we love what we do, is that we embrace that and the long-term follow up. There is nothing more rewarding than having someone come back five years later and seeing that not only were we able to cure the cancer but they were able to put all the pieces back together.

Ratner Exactly.

Higgins I think one of the highlights sort of in my career, we always have things that stick in our mind, was a patient that I treated and at that time she was pregnant. She just had a baby, she had a cancer that we cured and she was lost to follow up for eight years because she had a very busy family life, but it was a very challenging clinical situation and when I saw her, her family was shattered by this and so one day she showed up in my clinic and here she is, her daughter is 8 years old, she is working, she is working as a teacher, she has a full life and it is all behind her and I think, having that sort of outcome which is for me the more gratifying, that we were able to get her through all these things from a very devastating point. We did a very complex implant on her and my residents still talk about it because it was one of the most complex we ever did, but she came back a few times, she got back on her feet and then seeing her 8 years later in totally normal, I have done it, I am back, I am fully functional, that was one of the most gratifying times in my career I think because I saw that it all came together for this person and they had their life back and I think that is what people fear.

Ratner Yes.

Higgins And that is a huge part of what we can do for them with all of these complementary therapies, the psychiatric support and I think that is only going to grow. I think that is a big part of what is exciting in medicine.

Ratner Absolutely.

Higgins How can we put the whole picture together for our patients.

Ratner It is interesting that you said that, I try to brainwash my children to go on to medicine which I am not being successful at, but that is what I tell them, when I tell my kids what it is that drives me and why this is the best thing to do is exactly what you have just said, to give them their lives, and this crazy thing happens, they get this diagnosis and the best thing is to talk about it or to see them 10 years later and say, do you remember that day when I told you 10 years from now we would talk and you will remember this day and I will get you through this and you will get back to normal and you will get your life back.

30:27 into mp3 file https://az777946.vo.msecnd.net/cancer/2015%201206%20YCC%20Answers%20-%20Dr%20Ratner_239482_5.mp3

Higgins And it is hard for people to believe that at the time but it really is the promise of the patient-doctor relationship that no matter what happens we are going to stick by you and we are going to get through this and I always tell the residents, you can give them chemo, you can give them radiation, but that part of it, just saying we are going to be there for you no matter what happens, that is the seed of what makes that whole line of encounters successful.

Ratner Absolutely.

Higgins When patients know that you are really their champion and you are going to stick with them no matter what happens and we hope for this great outcome and we see it a lot, that is I think the key to the real healing that happens which happens in your office every day. It happens everytime you walk in the door, it is the way that you look a patient in the eye and that is part of taking ownership for everything that comes from that point onward.

Ratner I have generations of patients in my office, I now have some people who have three generations who I remember taking care of their mom and their grandmother and it is great, it is family.

Dr. Elena Ratner is Assistant Professor of Obstetrics, Gynecology and Reproductive Sciences at Yale School of Medicine. We invite you to share your questions and comments, you can send them to canceranswers@yale.edu or

you can leave a voicemail message at 888-234-4YCC and as an additional resource, archived programs are available in both audio and written form at yalecancercenter.org. I am Bruce Barber hoping you will join us again next Sunday evening at 6:00 for another edition of Yale Cancer Center Answers here on WNPR, Connecticut's Public Media Source for news and ideas.