I'm Elena Ratner. I'm the division director. She went to college, EPL, and we're so thrilled to be with you tonight. I'm joined by the most excellent providers, Mitchell Clark, who is Joanne ecologist who is practicing currently at Water Ford at Lawrence Memorial and join the Dario who is the director and who runs multiple programs within our practice. Most notably so that for early cancer detection.
Call discovery to cure. And then intimacy and menopause program, which is a survivorship program that we offer for patients with cancer that has to do specifically with menopause and with.

So we are so excited to be with you today to share with you the updates and Joanna Kalaji. So much has changed in the field of Joanna Kalaji over the past decade. You know we no longer treat the cancer is the same. You know we no longer treat the women.
the same way just because they have a certain kind of cancer. We truly now offer a personalized approach every woman. Tomorrow get studied and understood. Not only cancer, but to every patient. We believe wholeheartedly in preventative medicine. Joanna will talk today about the role of genetics and the role of Previvor ship. You know, we have struggled over generations for to find cure for bearing cancer. Few of ovarian cancer is very complex. There’s a lot of chemotherapy resistance.
There's a lot of reasons why. Unfortunately, these cancers recur and hands with concentrated. Work for generations on early detection and so much work and research is being done in early detection, but the future of ovarian cancer is probably not even early detection. The future, maybe with the present is just prevention. Finding the women who are at higher risk for these cancers and then preventing cancers in them in the 1st place so that early detection.
or cancer cure is not even an entity that this cancers can be prevented before they even happen. So that’s the Clark today will share with us updates, enjoy mycology again. Kind of concentrating with this kind of personalized approach that we offer very much within Lawrence Memorial and within here within the Yale Health System. And then join, I will talk to you about Providership and how important it is to find these women record high risk for these cancers and how important is to
really have comprehensive approach.

You know, it is so important to remember that this genetic mutations do not just affect. The ovary or the breast that all of them are intertwined and this is not just something that affects women. This is something that affects women and man for generations and it is so important that we are offering this kind of care to our patients and their families.

So again, thank you and welcome and we’re so thrilled to be with you on this Webex.
But really even more so.

We’re so thrilled to be part of your community and to be providing Joanna Kalaji care.

At Lawrence Memorial Dr Clark.

Yes thank you so much. I’m just gonna switch over and share my screen with everyone.

All race. Alright, so thank you so much Doctor Ratner for the excellent introduction and thanks everyone.

For joining us tonight on this sort of rainy Wednesday evening.

For those who, I haven’t had a chance to meet you.

My name is Doctor Mitchell Clark.
I'm within the division of dynamic at Yale and my clinical practice is focused here at Lawrence and Memorial and at the Water for Care Center. And we're going to start tonight session by talking about updates and ovarian cancer which Doctor Ratner has alluded to is very exciting right now. I don’t have any disclosures, either financial or use of any off label medication in this talk. So just some objectives for what I hope to cover in a quick discussion on these highlights is talk a little bit how the proposed origins ovarian cancer.
cancer have changed and how this impacts early prevention and early diagnosis.

Review some of the data on opportunistic salpingectomy and then risk reducing surgery for women who are identified it being a particularly high risk and then in those women who do go on to develop a cancer.

How we’ve increased our use of new management, chemotherapy and special interval surgical techniques for these women to help manage their advanced disease.

And then probably most exciting of all, is to discuss some of the emerging data on maintenance,
00:05:08.640 --> 00:05:08.965 treatment, and so how we can extend the survival of our survivors of ovarian cancer for years down the road.

00:05:11.240 --> 00:05:13.390 So my practice is primarily focused here in the water for Care Center. Like I mentioned before, we feel full range of gynecological malignancy’s as well. If complex joint surgical care as well as patients who are either thought to have or known to have a hereditary cancer syndrome which. Joanna will expand a little bit on later on this evening.
This data is and is not new for many of you. Most of you are aware that this is the second most common gynecological malignancy that we see in the US, but it certainly accounts for far more death and unfortunately in 2020 / 21,000 women were diagnosed with this disease and 13,000 of them succumb to their illness, has been that most of these women presented a very advanced stage, and as we would expect from with all cancers or survival outcomes. Certainly decrease as stage increases, but we know now through advances in
molecular testing and things that will talk about further on that. These are not just all the same ovarian cancer and the site is very busy and there’s no quiz at the end, but just to highlight the real heterogeneous grouping of histologic subtypes and how important it is that we expand our knowledge of how each of these relate to diagnosis into treatment and to survivorship. This is a picture taken out of a book that you know many of us have probably seen in our training, highlighting the survivorship.
and lifetime experience of women with ovarian cancer that really shows a sort of antiquated experience that many of us have been dealing with for years, which is survival measured in many months and not many years. And I hope we can circle back to this figure at the end of the talk and show how these advances in ovarian cancer have really led us to believe that we're going to pull this graph. From side to side and really expand the survivorship time and disease free time that our patients are able to experience. So what came first? The chicken or the egg?
And you know where did this cancer come from?

Some of you may be aware of the data that is emerging to suggest that maybe the most common types of ovarian cancer actually started in the tube for years. We thought that it was this obligatory rupture on the surface of the ring that was causing these mutations, and cancer would go on to develop. But now there’s some really exciting research and special pathology techniques were identifying these lesions at a very early stage or what is called the stick lesion or the precursor lesion, and through this work and
some very exciting science,

we actually think that the most likely mechanism is that these cancers probably start in the tube and then migrate into the peritoneal cavity and spread in the way that we know ovarian cancer to behave,

and so that brings up the opportunity of a salpingectomy for our women who are average. Age, risk and what is an opportunistic salpingectomy? When are these opportunities? If you’re telling me the cancer is starting in the tube, well, let’s take them out so this can
be at times when women are having hysterectomy for benign indications. Women who are undergoing cesarean section, desire surgical sterilization or perhaps women who are searching, searching for surgical sterilization. Outside of pregnancy. You know, I hear a lot of providers said to me, I've been doing one technique for years. I do the Pomeroy or the modified Pomeroy very happy with it. I'm very comfortable. Is the data strong and what is the benefit?
And this just highlights some of the exciting research that’s come out of some of the cancer registry showing a 35% risk reduction for death from ovarian cancer in women who underwent an opportunistic self inject to me.

I hear a lot of people say. Also, you know, I’m a little worried. At the time of C-section. Those tubes are really engorged or I’m worried about blood loss, but Jessica McAlpine, who was a fellow here at Yale a number of years ago and have gone on to Vancouver and done amazing research and work out there.
Show that in her series there was no increase, blood transfusion, hospital, length of admission was the same and no re-emission rates. Being higher for those who underwent this procedure and really only added to 10 to 15 minutes of additional surgical time, so you know that’s our average age risk women, but I’ve Joanne is going to talk about later. What do we do for patients who are known to harbor a mutation in one of these genes that significantly increases their risk? And we’ve traditionally been doing
risk reducing bilateral salpingo-oophorectomy when women have made that decision after information is shared, decision making with their provider. But there are complications related to quality of life from surgical menopause. These are important decisions that women make, balancing their quality of life against the risk of cancer and so. Two separate research groups have now collaborated to explore the idea of well, if this is in the tube, why not just take out the two? And so I want to caution you. This is still an ongoing clinical trial,
but something I wanted to highlight as emerging evidence that’s hopefully coming down the pipeline. The Tubo whiffed study, which is a combination of an American and European initiative that looks at doing just the tube and delaying new for ectomy for delaying that time again. We don’t have the data yet. For this, and we’re hoping to see what emerges from this trial, but just to highlight the fact that we’re really are focused on trying to prevent this ovarian
cancer before it even happens,
NOTE Confidence: 0.842747
and finding ways that we can do that,
NOTE Confidence: 0.842747
that balance of quality of life and
NOTE Confidence: 0.842747
individual choices for women when they’re
trying to decide what to do for themselves.
NOTE Confidence: 0.842747
Unfortunately,
a number of women will go on to
develop an advanced ovarian cancer,
and I'm sure like many of you and your
guy knock rotation as resident you
were involved in these long complex
operations with lots of disease and we
are really complex surgical debulking
because for decades our knowledge
was that you know a big operation.
Removing all the visible cancer as
possible gives the best outcome to women,

but I’m sure you also saw a lot of

patients experience more bitteti summer.

Fortunately,

mortality and high complication

rates for those.

Who are universally treated with the

same approach so universally taken

to the OR without consideration

of individual life factors.

And so there have been a number of

trials exploring the use of how

we give some chemotherapy.

First, let’s shrink this cancer down.

Let’s try to have an operation that
maybe is a little less radical, but can still provide the same Uncle logic outcome for women. And this is just one of those trials that I wanted to highlight which is the chorus trial. These folks randomized advanced age ovarian cancer to undergo either upfront surgery followed by chemotherapy or some chemotherapy first followed by surgery followed by more chemotherapy and therewith show essentially the same thing that both arms of this study showed equal survival, both overall and progression free. survival and we’ve now gone on to
further analyze and try to identify for each individual woman who’s best served by a primary surgery, who’s best served by neoadjuvant chemotherapy and really trying to make sure that we’re picking the right thing for the right patient. And not treating this as just one lump category of disease and with that has come the adoption of minimally invasive surgery. For ovarian cancer, you know, ten years ago, this is something we would really have not even considered or thought about. But as we’re treating more and more
women with neoadjuvant chemotherapy,
we're seeing more and more women who may be good candidates to undergo a minimally invasive approach. So what is the role of robotic surgery? Minimally invasive surgery? In this disease, you know? For women who are not able to undergo that primary debulking surgery did individually factors, there may be an opportunity to offer them a surgery with all the benefits of laparoscopy while still maintaining the same oncologic outcomes. And so we're very excited to see the development of randomized control trials.
that are going to answer this question.

These are ongoing, but until then we continue to look for patients who are excellent candidates who may be able to benefit from a minimally invasive approach when carefully.

One additional exciting advance in the way we do these interval surgeries is the incorporation of what is called heated or hyperthermic intraperitoneal chemotherapy.

For those of you who’ve taken care of patients with appendix cancer with some of the other
GI cancers you may be aware of. This technique for those diseases, but we’ve seen randomized evidence to show that in women who are carefully selected and offered this as part of their treatment, they actually experienced an improvement in their survival as well again. All about making the right selection for the right patient, taking into account all those individual life factors. This is not a one or one solution for every woman type of disease anymore. And just to finish off of what I think is probably some of the more exciting
evidence and will sort of lupus
into Joann’s discussion very nicely
is really the role of maintenance
therapy and how our understanding of
the biology of the tumor is critical
in assessing individualized treatment.
Patients complete their chemotherapy.
We know that.
Unfortunately,
most of our patients with advanced stage
disease will experience a recurrence
at some point in their cancer journey.
So how can we extend that time between
recurrences while maintaining excellent?
Quality of life.
I’m not going to get too much into the field of molecular biology here, but there are some very exciting studies showing that almost half of ovarian cancers are deficient in mechanisms that allow for DNA repair and without taking us all back to our undergraduate molecular biology course. Really.

To just summarize that we’re really exploiting the inherent problems with these cancer cells and turning them off themselves, and so through some very exciting preclinical and Clinical trials we seen that...
these class of medications, called PARP inhibitors, which are an oral drug taken for two to three years after chemotherapy. I’ve had excellent results in allowing patients to experience a prolonged survival solo, one which was just published a couple of years ago with probably the most exciting of these trials. These were women exclusively with the bracket one and bracket two mutation either in their tumor or in their all of their country, or all their cells, or both.
The germ line and when given for two years after they completed their treatment, they had significantly longer progression free survival than those women who went on to take placebo. And this is hot off the press from the Fgo meeting about 10 days ago. Really thrilling results to see the five year updates of this trial, and these are just numbers we never dreamed of seeing an ovarian cancer with patients randomized to elaborate, having a median progression free survival of almost. Five years and you know, if we just think about the women,
we’ve carefully over the years with ovarian cancer, to imagine telling someone after their initial treatment to expect a five year progression free survival. Let’s just, you know, really, thrilling stuff that we could have never imagined in the past. There’s still a role for these types of medications and women who are not bracket carriers. Which is why we are very diligent about testing tumors and understanding the unique characteristics of
every woman’s of varying cancer.

Earth data to support the use of these drugs in all comers with ovarian cancer,

but the strength of those recommendations in the data is certainly less for those women who don’t have these inherent mutations or changes in their tumor DNA.

So we take the time to really explore that so we can offer women as much education and data so they can make a decision about how they want to, how they want to manage their care.

This circle back to that figure that we talked about in the beginning and we just highlight some of the things
we’ve talked about tonight and how we’re trying to pull this graph from side to side and extend the survival. We hope through perhaps one day being able to do self inject to me or to continue doing BS. So now we’re able to prevent ovarian cancer from developing, were able to improve the treatment of women when they are diagnosed with their disease. Anthru PARP inhibition. We hope to extend that survival for women for many many years to come. And so there’s still a lot of exciting work going on,
and I hope we can go back to you next year with an update that just shows that we’re measuring the survival. And many many many, many years. So with that I thank you so much for listening and will hand things over to Joanna. Any questions. Right now we can take them. Otherwise we’re going to have a great Q&A session at the end.
00:18:19.550 --> 00:18:21.584 you guys tonight and Doctor Ratner.

00:18:21.590 --> 00:18:23.606 Thank you for the nice opening.

00:18:23.610 --> 00:18:25.584 Welcome, and so I will certainly

00:18:25.584 --> 00:18:28.309 try to keep my talk to 15 minutes.

00:18:28.310 --> 00:18:30.026 But if there are any questions

00:18:30.026 --> 00:18:32.010 at all during the presentation,

00:18:32.010 --> 00:18:34.430 there is a Q&A.

00:18:34.430 --> 00:18:36.425 Section at the bottom of your screen

00:18:36.425 --> 00:18:38.288 and you can type in a question

00:18:38.288 --> 00:18:40.170 and we will get to it either

00:18:40.170 --> 00:18:42.145 during the presentation or after.

00:18:42.150 --> 00:18:44.190 So I wanted to talk a little bit

00:18:44.190 --> 00:18:45.778 more about genetics and Joanne

00:18:45.778 --> 00:18:47.800 Oncology and my name is Joanna.

00:18:47.800 --> 00:18:49.280 I am a physician assistant
I graduated in 2008 and I've been part of the practice at Yale for about three years now, so I'm thrilled to share some information with you. I have no disclosures tonight. So we’re learning more and more about the genetics of gynaecologic cancers and so. Of course, for the for probably about 20 to 25 years now. We’ve known about the bracket one and bracket two genes, but we’re finding out about the additional genes that are implicated.
in gynaecologic cancers, paL B2,
brip one, the RAD 51 jeans,
and some other ones.
So these mostly lead to increased
risk of breast, ovarian,
fallopian tube, and peritoneal cancer,
as well as possibly pancreatic.
And prostate cancer.
And in bracket two specifically.
A risk of Melanoma.
You may know about the Lynch syndrome
genes or the DNA mismatch repair genes
that can lead to multiple cancers.
We often think about the GI cancers
like bowel or colorectal cancers,
but also endometrial Arian cancers.

Some of the less common genetic syndromes that we learn about our leaf from many syndrome or TP5. The three mutations Cowden syndrome or PTN and Pronunciator syndrome, which is the STK 11 or LKB one jeans. So these can have multiple different types of cancer and even benign tumors that affect women with put Seager syndrome. When we think about the inherited breast and ovarian cancer syndromes, we think about about 15 to 20% of ovarian cancers being caused by a BRCA or or similar mutation and about the same for breast cancer.
One of the differences is that breast cancer also can have more familial clustering where you can see these families with multiple cases of breast cancer but may not have a specific gene identified, and we can also see that in ovarian cancer as well, we do see women who have a couple different family members with ovarian cancer. But no gene identified yet. So there’s probably still more down the road that we will learn about with the time. The risks this is probably a little outdated now.
Now this is from 2018, but we are, you know, learning more each year. The risk with BRCA one and BRCA two in regards to ovarian cancers is about 40 to 50% risk but lots of different numbers that we see for Braca one anfar bracket two a little bit lower risk and also a little bit later in life than the Bracco one risk for ovarian cancer. I’m actually going to skip this slide so it’s a really important to test for test for the BRCA mutations in are any woman with an ovarian cancers, especially high grade serous ovarian cancer.
But really now the recommendation is any ovarian cancer type should have genetic counseling and offer genetic testing not only because it can help the patients in regards to knowing their prognosis. Knowing their decisions, for example as Doctor Clark mentioned the Carpet hitters and also being able to put the patient into long term remission and at that point we sometimes now are preventing other cancers that we do have ovarian cancer survivors who are doing well from their disease and are now having a risk reducing mastectomy to prevent breast cancer as well.
Of course, it’s important for the relatives to know as well so that if there is a mutation in the patient’s DNA then they can have cascade testing in the rest of the family members and who can also have risk reducing or prevention strategies. So again, the most common thing that we like to talk about is hereditary breast, ovarian and pancreatic cancer. Specifically the BRCA one and two genetic mutations. More common than we used to think, so depending on the source, we’re now learning that there...
00:22:42.630 --> 00:22:44.858 is a bracket mutation present in
NOTE Confidence: 0.8505517
00:22:44.858 --> 00:22:46.860 about 1 in 200 people in general,
NOTE Confidence: 0.8505517
00:22:46.860 --> 00:22:48.560 and in the Ashkenazi Jewish
NOTE Confidence: 0.8505517
00:22:48.560 --> 00:22:50.659 population about one in 20 people
NOTE Confidence: 0.8505517
00:22:50.659 --> 00:22:52.663 may carry a mutation in bracket
NOTE Confidence: 0.8505517
00:22:52.663 --> 00:22:54.620 one or bracket two, so really,
NOTE Confidence: 0.8505517
00:22:54.620 --> 00:22:57.710 really not as rare as we used to think.
NOTE Confidence: 0.8505517
00:22:57.710 --> 00:23:01.500 Recommendation again from the
NOTE Confidence: 0.8505517
00:23:01.565 --> 00:23:03.550 Cancer Network and this Society of
NOTE Confidence: 0.8505517
00:23:03.550 --> 00:23:05.138 Joanne Oncology is for universal
NOTE Confidence: 0.8505517
00:23:05.138 --> 00:23:07.199 genetic counseling and testing
NOTE Confidence: 0.8505517
00:23:07.200 --> 00:23:08.575 Another important thing to remember
NOTE Confidence: 0.8505517
00:23:08.575 --> 00:23:10.449 is that they are not the same,
NOTE Confidence: 0.8505517
00:23:10.450 --> 00:23:12.249 so Braca one is not treated or
NOTE Confidence: 0.8505517
or prevention is not the same as the bracket two patients. So we have to take that into consideration. Lynch syndrome is the same. There are different genes, and they’re not all the same, so we need to make sure that we’re not treating each Lynch syndrome patient equally. And I’ll show you a nice sample of that. On the next slide, genetic testing is recommended for women with endometrial cancer or colorectal cancer as well, men and remote colorectal cancer who have evidence of what’s called
NOTE Confidence: 0.82584774
00:23:42.796 --> 00:23:43.888 microsatellite instability or
NOTE Confidence: 0.82584774
00:23:43.888 --> 00:23:46.072 a loss of DNA mismatch repair
NOTE Confidence: 0.82584774
00:23:46.136 --> 00:23:47.960 proteins on immunohistochemistry.
NOTE Confidence: 0.82584774
00:23:47.960 --> 00:23:51.048 So this is where now every colon cancer,
NOTE Confidence: 0.82584774
00:23:51.050 --> 00:23:53.378 an every endometrial cancer is getting.
NOTE Confidence: 0.82584774
00:23:53.380 --> 00:23:57.644 This special testing the microsatellite,
NOTE Confidence: 0.82584774
00:23:57.644 --> 00:23:59.950 testing the IHC an if it’s
NOTE Confidence: 0.82584774
00:23:59.950 --> 00:24:02.446 identified that they have an issue.
NOTE Confidence: 0.82584774
00:24:02.446 --> 00:24:04.904 They will then go for genetic
NOTE Confidence: 0.82584774
00:24:04.904 --> 00:24:07.058 testing and counseling to see if
NOTE Confidence: 0.82584774
00:24:07.060 --> 00:24:09.920 they carry a germ line lynched.
NOTE Confidence: 0.82584774
00:24:09.920 --> 00:24:10.620 Premutation so the the National
NOTE Confidence: 0.82584774
00:24:10.620 --> 00:24:12.160 Comprehensive Cancer Network has
NOTE Confidence: 0.82584774
00:24:12.160 --> 00:24:14.038 really nice tables and guidelines
NOTE Confidence: 0.82584774
00:24:14.038 --> 00:24:16.132 for the prevention of cancer and
NOTE Confidence: 0.82584774
the risks of cancer in both the BRCA
mutations and the other mutations
as well for HBO See syndrome,
but also for Lynch syndrome.
So I’m just giving you one example
of the MLH, one which is the one of the more
common Lynch syndrome genes and it
gives you a specific cancer risks,
or at least ranges of risk compared
to general population for each
and what’s really important to know
is that MLH one has a higher risk
of many cancers than for example,
So it’s not just Lynch syndrome is 1 size fits all.

So what are the guidelines for identifying who should be screened for genetic cancer syndromes?

Well, I’m just going to go over briefly in the next 10 minutes or so. The guidelines from ACOG, the National Comprehensive Cancer Network, the USPS TF, and Society of Duane Oncology.

In a committee opinion piece from 2011, there were just very general guidelines that women should have family history evaluation as a screening.
tool should be reviewed and updated regularly and when appropriate, further evaluation should be considered and referral to genetics as needed.

That was updated with a lot more information in 2019. So this is kind of talking about you know every patient in your practice. In general, Obi Wan should have a hereditary risk assessment. Taking a good family history and if there’s suggested that there’s an increased risk of a hereditary syndrome referring to a specialist, or if you have the expertise in genetics, then or someone in your practice.
For example, a practice nurse can give that counseling and make an educated decision about genetic testing for the patient or the appropriate family member. We are now doing more multigene testing, so this is panel testing as opposed to just the Braca one and bracket two test. It’s much more affordable than it used to be and the tests are better than they used to be, so we also recommend that people who had genetic testing before be offered updated panel testing to make sure that we
00:26:30.844 --> 00:26:32.239 didn’t miss anything back then.
NOTE Confidence: 0.8818833

00:26:34.720 --> 00:26:36.586 Another guideline talks about the importance
NOTE Confidence: 0.8818833

00:26:36.586 --> 00:26:38.968 of pre test and post test counseling,
NOTE Confidence: 0.8818833

00:26:38.970 --> 00:26:41.259 so I know these are busy slides,
NOTE Confidence: 0.8818833

00:26:41.260 --> 00:26:43.290 but talking about you know what it
NOTE Confidence: 0.8818833

00:26:43.290 --> 00:26:45.169 means to have genetic testing what
NOTE Confidence: 0.8818833

00:26:45.169 --> 00:26:47.800 the result might be and what it might
NOTE Confidence: 0.8818833

00:26:47.800 --> 00:26:49.978 mean for their family for themselves
NOTE Confidence: 0.8818833

00:26:49.978 --> 00:26:52.147 for their medical insurance and life
NOTE Confidence: 0.8818833

00:26:52.147 --> 00:26:54.301 insurance and how to communicate those
NOTE Confidence: 0.8818833

00:26:54.301 --> 00:26:56.210 results to the patient and counsel
NOTE Confidence: 0.8818833

00:26:56.210 --> 00:26:58.260 them after the test results are back.
NOTE Confidence: 0.86296254

00:27:01.940 --> 00:27:03.626 If there is a clinically significant
NOTE Confidence: 0.86296254

00:27:03.626 --> 00:27:05.102 mutation, patients should really be
NOTE Confidence: 0.86296254

00:27:05.102 --> 00:27:06.890 encouraged to share the results with
NOTE Confidence: 0.86296254

00:27:06.945 --> 00:27:08.460 their family members and recommend
that the family members also be tested and that can be really hard to manage. The question is, am I then as the provider responsible for the family members? And that’s sometimes where a genetic counselor can really help by drafting a letter, the patient can give the letter to their family members and they can help share the information for how everybody in the family can get tested. The USPS TF recommendations were updated about a year and a half ago, this was in 2019 and one of the biggest changes to this was
when collecting a family history

to also collect information about any Ashkenazi Jewish ancestry.

So really, that should be one of your questions on the screening for family history.

Do you have any family history of cancer?

What types of cancer, what relatives? And?

Is there any Jewish ancestry in your family?

So that's one of the biggest.

Updates in the guidelines.

Again, the is talking about integrating services, individualizing your questions, and plan for genetic testing for your patients to optimize the
benefit and minimize the harm.

So that the USPS TF report was published in JAMA about a year and a half ago.

Again, talking about identifying appropriate candidates for genetic testing and then what type of tests to order. So there’s lots of different steps in the process about what are the harms of asking? What are the harms of testing? What are the harms of intervention after we test?

I do see a question in the Q&A that will try to get to shortly. So the USPSTF recommendation does give
00:28:53.776 --> 00:28:56.199 a B recommendation that primary care.
NOTE Confidence: 0.87570345
00:28:56.200 --> 00:28:57.764 Clinicians, including Obi Wans,
NOTE Confidence: 0.87570345
00:28:57.764 --> 00:29:00.110 assess women with a personal or
NOTE Confidence: 0.87570345
00:29:00.177 --> 00:29:02.126 family history of breast, ovarian,
NOTE Confidence: 0.87570345
00:29:02.126 --> 00:29:03.710 tubal or peritoneal cancers,
NOTE Confidence: 0.87570345
00:29:03.710 --> 00:29:06.188 who have any ancestry associated with
NOTE Confidence: 0.87570345
00:29:06.188 --> 00:29:08.669 BRCA mutations with an appropriate risk
NOTE Confidence: 0.87570345
00:29:08.669 --> 00:29:11.315 tool and they do give some options
NOTE Confidence: 0.87570345
00:29:11.315 --> 00:29:14.039 for different tools to use and if
NOTE Confidence: 0.87570345
00:29:14.039 --> 00:29:16.970 there’s a positive result on the tool,
NOTE Confidence: 0.87570345
00:29:16.970 --> 00:29:18.850 they should receive genetic
NOTE Confidence: 0.87570345
00:29:18.850 --> 00:29:20.866 counseling and potentially genetic
NOTE Confidence: 0.87570345
00:29:20.866 --> 00:29:22.998 testing if they’re interested.
NOTE Confidence: 0.87570345
00:29:23.000 --> 00:29:26.248 They do not recommend.
NOTE Confidence: 0.87570345
00:29:26.250 --> 00:29:28.464 Counseling for women whose ancestry is
NOTE Confidence: 0.87570345
We're not sending everybody every woman for genetic testing. One of the examples is a seven-question family history screening, others included Ontario Family History Assessment, Manchester Scoring System, the referral screening tool, a pedigree assessment tool and the tire acoustic model, which is good for breast cancer risk. These are just short screening models that can be used in your practice for regular annual visits.
SGO again recommends genetic counseling and testing for women who are at risk of having a hereditary breast and ovarian cancer syndrome. They are recommending more and more now to again, have somebody help you with that, or as a primary provider to have the expertise to provide genetic counseling for our patients. It is always important to have experts available after tests to help you know, interpret the tests and recommend the treatment plan.
Important to have an interdisciplinary team and I'll show you who the team members might be for somebody who has a hereditary cancer risk.

This talks about their women’s personal cancer history and the family cancer history and who should be offered genetic counseling and testing. So there's anybody with a high grade ovarian cancer of breast cancer early in life, cancer of breast cancer early in life, pre menopausal women who have a limit that family history or family history is unknown. Women who have a pancreatic cancer, Women who have a triple
negative breast cancer.

Women who have breast cancer with Ashkenazi Jewish ancestry, etc.

And then there may also be situations where you’d want to refer for genetic counseling even if you don’t know the family history.

So for example, if someone has very few female relatives, many relatives had hysterectomy at a young age for unknown reasons, or there’s adoption in the lineages and you may not know also for Lynch syndrome.

Again, mutations anyone with an endometrial or colorectal cancer has the mismatch repair genes.
or microsatellite instability.

Or again, depending on the family history of colorectal.

Are gynecological cancers?

If you don’t have access to the NCC and guidelines,

I would certainly encourage you to sign up.

It’s a free membership for NCC N.

To access the guidelines for prevention and cancer risk reduction an A couple years ago.

Now, this was changed from breast

and ovarian cancer, now to breast,

ovarian and pancreatic cancer syndrome,

so pancreatic cancer is becoming more recognized as part of this cancer history
syndrome and pancreatic cancer. Is now an indication for genetic counseling and testing as well as any first degree relative of a pancreatic cancer patient. Should have genetic testing if that person is no longer living. So, NCCN recommends that pretest counseling be done prior to testing. Consideration of the most appropriate test to order and then post test counseling when the results are disclosed. So then anybody who again has that experience and expertise in cancer genetics should be involved at each stage. And so there’s some good algorithms to help with how we do this,
how we help the family and what the outcomes might mean for our patients. The NCCN also has some really nice tables about what the cancer risks are and what the recommendations are, so this is just one page of the guidelines, but there are actually 3 pages that include each of the different mutations that your patient might carry. And of course, they’re not all treated the same. So for example, we’ve seen patients in our office who understood or heard that he or she carries a mutation in the bracket.
00:33:32.265 --> 00:33:34.340 gene and they come to us saying,
NOTE Confidence: 0.84908926
00:33:34.340 --> 00:33:36.200 I have the Angelina Jolie gene,
NOTE Confidence: 0.84908926
00:33:36.200 --> 00:33:38.480 and then we find out that on their
NOTE Confidence: 0.84908926
00:33:38.480 --> 00:33:40.540 genetic testing they actually carry brip,
NOTE Confidence: 0.84908926
00:33:40.540 --> 00:33:42.898 one which has a much lower risk and is
NOTE Confidence: 0.84908926
00:33:42.898 --> 00:33:44.880 managed very differently than brocco,
NOTE Confidence: 0.84908926
00:33:44.880 --> 00:33:46.430 so it’s important for us.
NOTE Confidence: 0.84908926
00:33:46.430 --> 00:33:48.614 We like to see the patients genetic
NOTE Confidence: 0.84908926
00:33:48.614 --> 00:33:50.195 testing results with our very
NOTE Confidence: 0.84908926
00:33:50.195 --> 00:33:52.225 own eyes before we start to make
NOTE Confidence: 0.84908926
00:33:52.225 --> 00:33:53.470 management recommendations.
NOTE Confidence: 0.84908926
00:33:53.470 --> 00:33:55.990 So just to kind of move on here,
NOTE Confidence: 0.84908926
00:33:55.990 --> 00:33:57.250 this is what’s really
NOTE Confidence: 0.84908926
00:33:57.250 --> 00:33:58.510 important for our patients.
NOTE Confidence: 0.84908926
00:33:58.510 --> 00:34:00.090 It is a long process.
NOTE Confidence: 0.84908926
00:34:00.090 --> 00:34:02.288 We need to 1st identify the risk,
give some counseling,
identify who the best person in the family would be for genetic testing.
Have that person tested.
Do the post test counseling.
If it’s a positive or negative test result, offer testing for the rest.
That’s called cascade testing.
Provide emotional support and that really is part of the entire process.
not just a single step in the process.
We have to emotionally support our patients with this complex disc.
Asian making referrer as appropriate for breast surveillance, on gynecological surveillance, pancreatic surveillance skin exams, all the different referrals that are necessary. Support them in fertility decisions about their children if they are young. And then provide the cancer surveillance and cancer prevention if we can. So it is a lot of work. There are a lot of questions that we can ask ourselves. Do I have time to collect a full family pedigree? Do I remember how to do that?
Does the patient know their family history or do we need to go back and gather more information from other family members?

Do I? How do I know what test to order? Does my patient, you know, have the emotional readiness for the testing? Will they be OK with the result? Do they want to be tested or do they want not to know their genetics? Should I recommend or? If my patient asks about things like 23 andme or the direct to consumer testing, do I know how to help him or her interpret that test? Who is the right person to be test tested?
00:35:37.120 --> 00:35:38.866 Am I ordering the right test?
NOTE Confidence: 0.8596407
00:35:38.870 --> 00:35:40.900 Am I ordering from the right company?
NOTE Confidence: 0.8596407
00:35:40.900 --> 00:35:42.360 What is the test mean?
NOTE Confidence: 0.8596407
00:35:42.360 --> 00:35:44.106 You know this is not just
NOTE Confidence: 0.8596407
00:35:44.106 --> 00:35:45.270 positive or negative anymore.
NOTE Confidence: 0.8596407
00:35:45.270 --> 00:35:46.430 It’s now likely pathogenic,
NOTE Confidence: 0.8596407
00:35:46.430 --> 00:35:47.920 pathogenic, likely benign or benign,
NOTE Confidence: 0.8596407
00:35:47.920 --> 00:35:49.720 and then in the middle there’s
NOTE Confidence: 0.8596407
00:35:49.775 --> 00:35:51.135 this variant where we know
NOTE Confidence: 0.8596407
00:35:51.135 --> 00:35:52.830 there’s a change in the gene,
NOTE Confidence: 0.8596407
00:35:52.830 --> 00:35:55.422 but we don’t know if it’s
NOTE Confidence: 0.8596407
00:35:55.422 --> 00:35:56.718 necessarily cancer causing.
NOTE Confidence: 0.8596407
00:35:56.720 --> 00:35:59.056 How do we proceed with the family members?
NOTE Confidence: 0.8596407
00:35:59.060 --> 00:36:01.316 Do I have to follow up all the
NOTE Confidence: 0.8596407
00:36:01.316 --> 00:36:03.174 family members testing and how well
NOTE Confidence: 0.8596407
00:36:03.174 --> 00:36:05.490 does it affect my patient as far
as insurability and general health?

So there’s a lot of things that we may not know how to help our patient with,

and we need to know where to refer them to if needed.

This is what I was talking about with a different test results that can occur on testing.

And if you’ve ever come into, you know, finding a test result or coming into a conundrum where you didn’t know the answer.

You’re not alone, and there’s actually a series of articles from some of our Yale genetic counseling colleagues.

Karina Byerly, who’s one
Danielle Bonadies, Danielle Campfield was her maiden name, who is one of our genetic counselors who’s no longer at Yale but has done some great work and talking about the errors that can happen. The wrong test is ordered. The test result is misinterpreted, or there’s not enough patients. Follow up so it happens. It’s not common. It’s not uncommon for the test to be interpreted incorrectly, and that’s where our genetic counseling colleagues can really help us.
It certainly takes a village to support these patients, so whether your patient has a mutation or has a family history. First of all, she’s probably seen cancer, and she’s probably experienced a loved one who’s been diagnosed and treated for cancer, and there’s trauma involved in that. The patient probably has a lot of questions and concerns about her family, her children, what it means for her health, and so it takes a lot of people to really help support this patient.
making sure she gets the best care.

A smile has some great resources.

The cancer genetics and Prevention program, which is available also by telemedicine.

These days there’s a lot of resources from ACOG that are available online.

Jackson laboratory up at UConn has some modules that I’ll show you shortly.

SGO has some information and there is a fee if you’re really interested.

A certificate program that’s online in clinical genetics and genomics and this program is actually for physicians or nurses, or PSA PRNS who are interested in learning more about genetics and want to, you know, help advance their care, and it’s all.
It's a one year online program. The Jackson Laboratory genetics modules are great because they're 15 minutes case based and they do give you CME credits so those are available at Jackson Lab which is part of UConn and there are 11 cases in that in those modules and the Society of Joanna Kalaji also has a genetics tool kit that has seven case based modules that’s available for providers on line. Yale’s cancer Genetics and Prevention program is at the Saint Rayfield campus in New Haven. It’s Co.
Your who managed Breast and GI Oncology.

Doctor Bale is the genetic scientific director and there are many great genetic counselors available to answer any questions that we have. And of course, Dr Ratner and myself are there to support women. Doctor Ferrell helps with pancreatic cancer surveillance.

Genetics can be referred through epic or by calling 201 DNA. And with that I will stop and take questions or we can move on to the next presentation. Please feel free to contact us anytime you can email.
Call me and we’re happy to help see patients or help with answering any questions or getting you to the right people. So thank you so much I will hand it back over to Doctor Clark and we can take questions if we need to. Thanks Joanna. I think you know, I think this is a great question by Kim. Thanks Kim for for sharing your personal experience with the meeting and maybe I’ll just read out Kim’s comments, slash question and maybe you can give us a little bit of guidance from your perspective.
Joanna so Kim writes just to say that it was recommended to me. When I received a breast cancer diagnosis in prior to genetic testing, it can make it difficult and or impossible to get coverage. I thought this was a great idea and share that with my patients now. So what’s your experience or or is this a question that you get from patients who come through the Genics program? We absolutely do, and so if you haven’t learned about it, there’s something called the genetic
Information Nondiscrimination Act or Gina prevents people with a genetic predisposition to cancer from being denied a job or health insurance. Unfortunately Gina does not protect people from being denied life insurance coverage, so life insurance certainly is something to consider before people undergo genetic testing. If that’s important to you and the genetic counselors are pretty good at talking about that as well. But for health insurance and for employment, there is some legal protection for people who have.
A predisposition to cancer

We're going to switch gears a little bit away from ovarian cancer and genetics and how that relates to gynecological cancers and talk a little bit about cervical cancer, both prevention and detection.

I think we have a great group tonight that ranges from gynecologist to those who do a lot more primary care, so I thought this would be a relevant discussion to talk a little bit of the updates from the SCCP will talk about HPV vaccination.
and understanding the role of HPV, and so I’m just going to switch over my slides here. OK. Great. We’re just going to shuffle over to physical cancer prevention. So we’re going to review a little bit The Who global strategy to eliminate cervical cancer, which has been recently put forward and discussed heavily at the recent fgo meeting. As this is a priority for The Who, but then loop that back to how does that affect us here at home in Connecticut?
In the United States, will talk quite extensively about the data on HPV vaccination as well as the indications and how that has evolved overtime and then learn to apply technique for how we can improve our vaccination rates here at home. Specifically related to what? We’re kind of coining the catch up cohort, and then we’ll segue into a little bit of a discussion on the updated 2019 AFC CP guidelines and how the newly developed app that can be downloaded from the Android or iTunes Store. It can really help you guide your decision making and provide women the
most individualized risk assessment when trying to decide how to manage abnormal cytology or biopsy results.

I don’t have any financial disclosures were not talking about anything off label, but I do want to just acknowledge and thank Merck for providing some of the infographics and informatics on HPV data as it relates to the cervical and head and neck cancer.

We’re going to talk extensively about today. So again, I think this is all very familiar information, but worthwhile to remember that cervical...
cancer is really a global burden.
It’s the fourth most common cause of cancer in women worldwide, and in 2018, /1/2 A million women were diagnosed with this disease and over 300,000 of women died. Almost all cervical cancers are related to an HPV infection, and what we see here on the top is a figure that highlights the incidence of cervical cancer worldwide, where we see a disproportionate burden. African countries as well as certain South American countries. And then when we juxtapose that against the bottom image,
showing the implementation of publicly funded HPV vaccine programs, we really see how HPV vaccination and prevention through primary prevention methods have been effective. And it’s just unfortunately not available in the region of the world where this disease is prevalent, as it is here, the devil would show is really taking a multi prong public health approach to try to reduce the burden of physical cancer worldwide. And the best way to do that is through prevention.
vaccination efforts, and I'm not going to all of the details of their plan. But what I do want to highlight is that you know as much as we talk about this as a global problem. We really have an opportunity for improvement closer to home and this is the CDC data on vaccination rates as of 2018 for HPV vaccine, and we see that for girls age 13 to 17 and boys age 13 to 17 are rates of vaccination were approximately 50%. That's pretty low when we compare to other vaccines given in the same age category.
So we think McNinja cockle, which has a 90 to 95% vaccination uptake.

Great, there really is an opportunity to improve here and I hope at the end of this will have highlighted some techniques in ways that you can improve that in your own practice.

Just want to go through sort of the impact of HPV and again I want to thank Mark for providing some of this information or these graphics which really depict the burden that HPV has on the lower genital tract and head and neck disease.
They are over 14 million new HPV infections, nearly an almost half of these are in people aged 15 to 24. These HPV infections will go on to account for genital diseases, including cervical, vulvar, and vaginal cancer, but also a high number of cancers as well that will affect both men and women, especially for our audience who may have a practice where they see both men and women. But if their efficacy in
this vaccine and how?

What is the data show in terms of the prevention of these cancers?

And we see that in people aged 16 to 23 in multiple studies,

Specifically, there were significant efficacy in reducing the burden of HPV related malignancies as well in student awards, which are significant burden on our patients but also in our health care system and millions of dollars expense annually on managing these diseases that are really
00:46:45.052 --> 00:46:46.830 preventable through primary prevention.
NOTE Confidence: 0.85195917
00:46:46.830 --> 00:46:49.680 So what are the indications according
NOTE Confidence: 0.85195917
00:46:49.680 --> 00:46:53.052 to the FDA and half of right now it
NOTE Confidence: 0.85195917
00:46:53.052 --> 00:46:55.182 is indicated for girls and women
NOTE Confidence: 0.85195917
00:46:55.182 --> 00:46:57.625 9 through 45 and talk about the
NOTE Confidence: 0.85195917
00:46:57.630 --> 00:46:59.868 expansion to 45 for the prevention
NOTE Confidence: 0.85195917
00:46:59.868 --> 00:47:01.360 of the following diseases.
NOTE Confidence: 0.85195917
00:47:01.360 --> 00:47:03.230 So this is cervical, vulvar,
NOTE Confidence: 0.85195917
00:47:03.230 --> 00:47:04.346 vaginal, **** oropharyngeal,
NOTE Confidence: 0.85195917
00:47:04.346 --> 00:47:05.834 another head and neck,
NOTE Confidence: 0.85195917
00:47:05.840 --> 00:47:07.184 cancers related to HPV,
NOTE Confidence: 0.85195917
00:47:07.184 --> 00:47:09.684 as well as the benign but bothersome
NOTE Confidence: 0.85195917
00:47:09.684 --> 00:47:12.561 genital warts that are caused by the
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00:47:12.561 --> 00:47:14.888 6:11 subtype as well as prevention
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00:47:14.888 --> 00:47:17.030 of the pre invasive disease of
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00:47:17.030 --> 00:47:18.500 the lower channel.
Tract is a very similar recommendation for boys. However, obviously know CI Nbin vein, but otherwise I’m very similar.

Recommendation indication there?

So where does the data come that helps us guide our decision making regarding the expansion of the vaccine towards people who are 24 to 45 and so in this study and this is a sort of end of study. Follow up paper looking at this age group specifically in women and they use the quadrivalent vaccine and we have no reason to believe that the efficacy will not be as good in the nano valent vaccine Gardasil Nine.
They looked at a number of outcomes related to HPV. Section and here in the per protocol name. Besides that, because the intention to treat is a little bit different, we look at the observed efficacy of the vaccine in preventing a number of different outcomes. When we look at overall persistent infection or CNN or other disease of lower genital tract, the efficacy was about 88% a little better in those who are younger and a little less, in those who are older. However, the impact CIN two or three or worse. Although listed as 83.
Unfortunately those confident interval do cross one and so the the impact there may not be as strong. However you know. I’ve had many patients who come into my office. Not a lot of questions about this and they fit in that age category and we’ll talk about how to address that on a very individualized individual risk assessment so that we can help women make informed decisions with the data that we have. So currently the CDC recommends that as of 2019,
harmonization of catch up vaccination
for appropriate persons through age 26 should be undertaken and the group from 27 on 245 is really shared clinical decision making.
So I saw a young woman recently in my practice who have been in a monogamist relationship since their first ***** encounter. She’s now 28 years old. Unfortunately, she.
Gone through into 4th and it’s reentering the dating and had questions about the efficacy of this and so we talked about that and
through shared clinical decision making she decided to proceed with getting the vaccination. Now that’s not to say that that is going to provide her the same efficacy of someone at the younger age category of the FDA recommendations, but she still falls within the CDC and the FDA recommendations and. I would encourage you to have those. Conversations with patients on a very individualized level. So there are a number of women nationwide still could benefit from updating their vaccination.
status through this catch up cohort

and even more importantly,

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So what can we do to increase vaccination rates here in Connecticut to try to prevent all of these HPV related infections? And more importantly, is HPV related building that sees and we want to assess the immunization status and for patients at each clinical encounter and then what I think is probably the most important think is probably the most important recommendation of the provider and patients very much rely on your opinion in your and value your input into their decision making and so by educating yourself about this data in these recommendations.
You’ll be able to provide a strong recommendation is appropriate for that patient. We want to either administer within our own practices or refer onto a pharmacy or clinic that can provide vaccination and to ensure that our vaccination status is updated and documented for all of our patients. These measures are supported by ACOG and encouraged and there are a number of opportunities that you could look at in the evolution of their relationship with your patients. Beginning is when they transition from care from the pediatricians.
office into gynecological care, and so perhaps they did not or did not accept vaccination in that earlier cohort than nine years and up. And so this transition into care interview I am practice is an opportunity to readdress the data and discuss that opportunity with patients when we’re giving other vaccines brings up another opportunity to discuss. The increased use of HPV vaccination and we talked before a little bit about how Mcninja cockle vaccine
given at a very similar age have very high rates of uptake. But we do not see that same experience with HPV and so by including HPV vaccination in the discussion at the same time will provide an opportunity hopefully to see increased rates of vaccination. As people are heading off to college, this provides another opportunity for counseling, either in combination with other counseling efforts regarding perhaps birth control, or pap smears, but this is another opportunity where you may be able to provide an
NOTE Confidence: 0.84948033
00:52:53.462 --> 00:52:56.352 opportunity for man or woman to become
NOTE Confidence: 0.84948033
00:52:56.352 --> 00:52:59.495 vaccinated prior to heading off to college.
NOTE Confidence: 0.84948033
00:52:59.500 --> 00:53:01.010 And like I said before,
NOTE Confidence: 0.84948033
00:53:01.010 --> 00:53:02.395 the greatest predictor in this
NOTE Confidence: 0.84948033
00:53:02.395 --> 00:53:04.153 affectionate and a lot of studies
NOTE Confidence: 0.84948033
00:53:04.153 --> 00:53:05.437 is really the recommendation
NOTE Confidence: 0.84948033
00:53:05.437 --> 00:53:07.042 of the health care provider,
NOTE Confidence: 0.84948033
00:53:07.050 --> 00:53:09.826 and so take that to heart and and
NOTE Confidence: 0.84948033
00:53:09.826 --> 00:53:12.008 patience really value that we’re trying
NOTE Confidence: 0.84948033
00:53:12.008 --> 00:53:14.629 to make a decision on what to do.
NOTE Confidence: 0.84948033
00:53:14.630 --> 00:53:15.982 I’m definitely gonna laryngologist
NOTE Confidence: 0.84948033
00:53:15.982 --> 00:53:17.672 or any anti through my.
NOTE Confidence: 0.84948033
00:53:17.680 --> 00:53:19.822 I want to highlight how we’re really
NOTE Confidence: 0.84948033
00:53:19.822 --> 00:53:21.473 trying to expand the messaging
NOTE Confidence: 0.84948033
00:53:21.473 --> 00:53:23.148 around vaccination to not just
NOTE Confidence: 0.84948033
be related to cervical cancer,

but the word in the HPV has on

the number of other head and neck

Our discussions,

more around HPV vaccination as a way

to hopefully prevent a malignancy

and less around the HPV infection

itself and the stigma that may be associated

with that for one reason or another.

We see that there is a relationship between.

HPV and cancers of the head and neck.

And we see that the prevalence of different

HPV types is very similar to what we

see in our cervical cancer patients.

Very interesting Lee.
We’ve seen a decline of cervical cancer over the years, but are beginning to see an increased rate of oral, pharyngeal cancer, especially among men, and there are significantly more or fragile cancers diagnosed annually, which just brings even more importance to why we need to include that as part of our counseling. And when we’re discussing the benefits that we can expect from HPV vaccination, males are affected 5 times more than females when it comes to these types of cancers. And so it really is behooves us to discuss.
these benefits at every clinical encounter.

So if you’re carrying for a mother who has a male child who is perhaps of the age that he could benefit from HPV vaccination, that’s an important discussion that you can have as the primary care provider of the mother of the grandmother, whoever it is, and the more that we move this conversation towards HBF and infection. And HPV vaccination as a cancer prevention strategy. We hope to see increased rates of vaccination.

And again, I think again, you know, I can’t phrase it out any other
way than just we have to try to, you know, provide our patients with all of the data in all of the information on the potential benefits of this cancer prevention strategy and hope that through that we can remove some of the stigma associated with HPV vaccination. And it highlights the importance for both men and for women, So with that in mind, and having you know, talked on and on about the importance of HPV and how it relates to cervical cancer, I do want to talk a little bit of both.
The updated ASEP management guidelines and how they are really well summarized in what I think is a pretty easy to use app that you may consider incorporating into your practice and as a way to help stratify and provide patients with the most up-to-date information on the risk of cervical cancer. And so this app reflects the 2019.Updated guidelines and once in the greatest shift is it really highlights the incorporation in the important of test history into calculating risk. So you’ll see and will provide an example tonight of how it looks,
but it’s not just about that one. Single smears a snapshot in time. The data is really supporting the use of understanding a woman’s history of dysplasia in history of HPV infection. In order to really understand what is her individualized risk assessment. And so we’ve known for a number of years now. The HPV based testing strategies are certainly superior to cytology alone. This is really a Sentinel paper that highlighted that showing that on the bottom here we can see HPV and HPV Co testing in the incidence of Cinc predicted.
The incidence of CI and three or more above in the pop history is well really matters. This is a paper currently impressing highlighted at the recent FGO meeting. Just highlighting the real importance in understanding the multiple prior screening events that a woman has undergone and trying to assess her individual life risk. So they can make appropriate decisions for themselves and so we see here on the left that a woman with three negative code tests really have a near
00:57:21.012 --> 00:57:23.920 negligible risk of a CIN 3 or above.

00:57:23.920 --> 00:57:26.266 Whereas someone who is HPV positive

00:57:26.266 --> 00:57:28.200 or persistently HPV positive or

00:57:28.200 --> 00:57:29.725 have had treatment for sin.

00:57:29.730 --> 00:57:31.490 Three or above lesion,

00:57:31.490 --> 00:57:34.723 certainly at higher risk than her well

00:57:34.723 --> 00:57:37.759 tested and Co test negative counterpart.

00:57:37.760 --> 00:57:40.104 And so this is reflected in the app

00:57:40.104 --> 00:57:42.753 and those who do have use dinner or

00:57:42.753 --> 00:57:45.040 review the guidelines can appreciate the

00:57:45.040 --> 00:57:47.698 differences in the recommendations and how

00:57:47.698 --> 00:57:49.966 things are looking compared to before,

00:57:49.966 --> 00:57:52.521 but it's really all about risk assessment

00:57:52.521 --> 00:57:54.631 as opposed to direct indications

00:57:54.631 --> 00:57:56.959 and recommendations on what to do
next for treatment or or testing.

So this is just a little example of how the app looks so on the left hand panel we’ve selected perhaps a woman who is 25 to 29. Although not a great example, 'cause we should probably be focused on 30 to 65 if we’re looking at the importance of HPV and then we select that and then we go down to indicate that we’re interested in the management of routine screening results, and then we are able to select all of these different. All these different variables that will go into helping predict risk.
and what’s new and important is the question of whether or not patient has previous screening results that could be. Input it into this algorithm to help us understand what to do next, and so our patient. Yes, she has been compliant with their screening and so we have entered her previous screening history. And so we go on now to include those prior test results in our recommendation. Based on what we’ve entered. If for one year follow-up, what’s nice,
and I think it’s really helpful for patients in ourselves to understand the overall risk, Which is the risk of CIN 3 or above, and with that we’re able to appropriately treat her to next steps. So, just to summarize, I you know we’ve covered a lot, but I think really it’s important to consider education and counseling on the benefits of vaccination. At each clinical encounter, as well as to stress the importance of a strong recommendation for those who are eligible really to emphasize
the importance of this intervention as a cancer prevention strategy and to identify someone within your practice or your Community practice who can really champion this effort and then routinely reassess your strategies. And look for areas to improve effectiveness and I would encourage you to consider this app as one tool that you use in helping manage physical cancer screening your practice. So with that you know. Thank you so much.
or anything that we’ve covered. Otherwise, this evening and hope we can clarify any points or answer any questions. I don’t see anything in the chat right now, but will give it a couple more minutes again. If you have any questions I didn’t put my email address out there, but please feel free to reach out to me directly. It’s my name mitchell.clark@yale.edu and I’d be happy to help answer any questions or help you navigate referral process if you’re seeking tour for your patient to smile Center. For evaluation.
China you have anything to add. Or yeah, doctor Clark. Thank you. I just wanted to give a shout out to a couple of our patients. I recognize some of our patients that are on tonight as well. And thank you for just being women who have been champions in our program and just getting the word out there that we can detect cancer earlier we can, we want you to be part of our family. So for the women who are out there that are patients, thank you for joining in.
For people who don’t know yet,
we have something called discovery to cure,
which is one of our programs that focuses on prevention and we do have a website.
We have a something called the teal times,
which is one of our newsletters that can go out to providers or or women and patients.
So if you have any interest in getting connected with us,
I’m happy to help connect you.
Great yeah, I agree I I you know, really thank our patients for advocating for themselves and for others in the Community who aren’t aware of the resources that are out there.
And I think all of us are probably

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going to speak with John, but it’s really our patients who motivate us and in their journey and their strength that is so motivating for us to do what we do. And it’s such an honor to take care of these strong women who really are paving the way for future treatments or participation in. Trials and things like that. We have one question here from someone in the audience asking about any known connection between vulvar cancer and patients over 75. Typically,
the older women with with bolvar
cancer is typically related to the
lichenoid diseases less related
to HPV infections and join,
and I don’t think any strong
Association known between predatory
breast ovarian cancer genes.
Are the HR jeans and involve our cancer?
Now there’s as far as we know,
there’s no Association with vulvar or
vaginal cancers with genetics that only
the only thing that may cause cervical
the only gene mutations.
But when we think about hereditary
breast and ovarian cancer syndrome,
or Lynch syndrome were thinking ovarian,
fallopian tube, and uterine cancers.

That’s great, great question.

Thank you for bringing it to our attention where you know we’re learning more and more about these and we look forward to seeing expanded results from years of experience in genetic testing.

And so this may involve overtime for sure.

Another great question from one of our best practice nurses regarding HPV vaccine and age.

Any studies showing benefit to vaccine earlier at age 9 rather than 11?

You know I don’t have the the sort of original paper up in front of me,
whether or not they broke those groups down like they did in the trial here, showing benefit to 26 to 35 at the post of 35 to 45. I think really the overall thinking is to try to get this. In its earliest possible, before any exposure to HPV. And as soon as we can do that, the better so that we do know that those people who are enrolled in the trials and HPV naive certainly had a better response at clearing that infection. And so while I don’t have any data to think 9 birth 11 off the top of my head,
I think as early as possible within the recommendations of the FDA and CDC.

We have another great question from someone asking about the role of heated chemotherapy during surgery.

That’s a great question and evolving topic.

This was one of the first RCT’s that we presented here tonight from one of the European groups and we are excited to offer this on selected patients through Smilow who are meet good criteria and who meet certain eligibility criteria?

will have good performance status.

And who meet certain eligibility criteria?
is certainly something that should be brought up with your treating oncologist in order to determine if you might be a good candidate for that type of approach, because there is early data that signals there may be benefit for those patients who are deemed eligible for that technique.

Any recommendations on improving patient tolerance? That’s a great question. So in terms of carbon hitters,
what I tell most of my patients is those first four to six weeks can be very challenging and it’s really the fatigue. I find the most part that patients struggle with a bit of the nausea as well because of the fact this is an oral medication. Most patients do. Seem to get through the first four to six weeks with either, you know, watching the anemia to ensure that the fatigue is not true. I mean, for watching the moment to make sure that the fatigue is not anemia related.
but for those who don’t make it through that sort of introductory first couple of months and still continue to struggle, there has been some exploration of perhaps switching from one partner to another. We think overall the side effects are somewhat of a class effect, but there are some very small. Series and experiences, and perhaps going a lap criptana wrapper it, or vice versa if you can get that approved based on whatever genetic profile you’re dealing with in that patient. But you know for some reason or another, some patients just seem to tolerate one better than the other, and so you know.
I tell my patients to hold, hold out if they can, and we try to support them through the first four to six weeks. But if there’s persistent grade three Grade 4 toxicity, you could consider switching to a different formulation, perhaps depending on what molecular characteristics you’re working with.

The great questions from everyone. I really appreciate the discussion.
01:07:45.910 --> 01:07:47.828 so again, please feel free to reach out if you have any questions regarding the material we covered tonight or you have a question in general, we will try to get that answer for you and we really appreciate you joining us tonight.
01:07:57.052 --> 01:07:59.596 I could have never imagined even you know when I decide to be human oncologist that we will be talking about these advances so quickly and we really hope that we evolve things at a pace. That keeps women alive longer and joining back quality of life. And until we can treat this like a
chronic disease like anything else.
Alright, so thank you so much for everyone and we hope to see you soon.