Like to welcome you to smile shares with primary care. And we are going to be talking about gynecologic issues tonight. And let’s see. Let’s advance to the next slide. Great. So this is a program that SMILE has developed with an EMG and in Doctor Karen Brown is my partner in crime here. It’s a monthly lecture series that really focuses on primary care, perspectives on cancer and hematology for primary care clinicians.
There are lots of other formats and venues to learn about cancer, but the aim here was really to develop a panel that would address questions. That primary care has around cancer on different topics and also to focus on. Teams working together in a specific region. It's a monthly lecture series, first Tuesdays of the month from 5 to 6 and we have programs all the way through until June and I'll show you at the end.
I'm gonna hand it over to Karen any other words and to get started with our first introductions. I would just echo your excitement at this series. Welcome to everybody who's watching and gratitude to everybody who has put together this program. You know, in primary care, we do a lot of work and we also rely on specialists around us. When our patients get very sick, we take pride in recognizing when they get very sick and being able to expedite their care in a way.
00:02:02.600 --> 00:02:05.936 That meets their needs both medically
NOTE Confidence: 0.88244939666667
00:02:05.936 --> 00:02:08.596 and also psychologically and and
NOTE Confidence: 0.88244939666667
00:02:08.596 --> 00:02:11.364 new cancer is a high time of need
NOTE Confidence: 0.88244939666667
00:02:11.370 --> 00:02:14.022 and and so this series represents
NOTE Confidence: 0.88244939666667
00:02:14.022 --> 00:02:16.673 not just education around new cancer
NOTE Confidence: 0.88244939666667
00:02:16.673 --> 00:02:19.501 but it also recognizes that we are
NOTE Confidence: 0.88244939666667
00:02:19.501 --> 00:02:22.022 actively working to build bridges
NOTE Confidence: 0.88244939666667
00:02:22.022 --> 00:02:24.567 between primary care both through
NOTE Confidence: 0.88244939666667
00:02:24.567 --> 00:02:27.655 education through some of our care
NOTE Confidence: 0.88244939666667
00:02:27.655 --> 00:02:29.998 signature pathways and and and
NOTE Confidence: 0.88244939666667
00:02:29.998 --> 00:02:32.614 regionally as well because we know.
NOTE Confidence: 0.88244939666667
00:02:32.620 --> 00:02:34.356 Curious relationship based and
NOTE Confidence: 0.88244939666667
00:02:34.356 --> 00:02:37.614 we hope that this will be part
NOTE Confidence: 0.88244939666667
00:02:37.614 --> 00:02:39.906 of building those relationships.
NOTE Confidence: 0.88244939666667
00:02:39.910 --> 00:02:44.242 So I am pleased to introduce Jeff Joseph.
NOTE Confidence: 0.88244939666667
00:02:44.242 --> 00:02:49.350 Doctor Joseph is now a gynecologist in
in the westerly region. He graduated.

From Block Island High School.

Fun fact. And it’s really true.

His graduating class had eight people in it.

So talk about practicing medicine in a community and being from the community.

His undergrad degree was in chemical Engineering,

His undergrad degree was in chemical Engineering,

Masters degree in Georgetown and then New York Medical College.

He did a residency at Bay State Medical Center,

and then he worked at South County Hospital in Wakefield,

RI for many years until he’s
00:03:24.472 --> 00:03:25.406 joined northeast.
NOTE Confidence: 0.882449396666667
00:03:25.410 --> 00:03:28.630 Medical Group in 2021 and
NOTE Confidence: 0.882449396666667
00:03:28.630 --> 00:03:31.291 now his practice is GYN only,
NOTE Confidence: 0.882449396666667
00:03:31.291 --> 00:03:34.693 although he can say he’s probably
NOTE Confidence: 0.882449396666667
00:03:34.693 --> 00:03:37.591 delivered over 3000 babies in
NOTE Confidence: 0.882449396666667
00:03:37.591 --> 00:03:39.819 his OBGYN years earlier.
NOTE Confidence: 0.882449396666667
00:03:39.820 --> 00:03:41.997 We are happy to have him present
NOTE Confidence: 0.882449396666667
00:03:41.997 --> 00:03:44.620 some cases on to kind of kick off
NOTE Confidence: 0.882449396666667
00:03:44.620 --> 00:03:47.185 discussions and I’ll turn it over to
NOTE Confidence: 0.882449396666667
00:03:47.185 --> 00:03:49.360 you and for additional introductions.
NOTE Confidence: 0.751751764
00:03:50.140 --> 00:03:52.800 Great, thanks and welcome Doctor.
NOTE Confidence: 0.751751764
00:03:52.800 --> 00:03:54.580 Joseph, you’re, you’re a specialist,
NOTE Confidence: 0.751751764
00:03:54.580 --> 00:03:56.860 but tonight you’re also primary care
NOTE Confidence: 0.751751764
00:03:56.860 --> 00:03:59.780 in terms of the gynecologic piece.
NOTE Confidence: 0.751751764
00:03:59.780 --> 00:04:03.000 So I’d like to introduce Johanna D’addario,
NOTE Confidence: 0.751751764
00:04:03.000 --> 00:04:08.380 MHS, PA She’s a 2008 graduate of Quinnipiac
University Physicians assistant program.
She’s got clinical experience in hospital medicine, primary care and gynecologic oncology and also experience in patient safety and PA education.
Um, she’s very interested in genetics, health and wellness, disease prevention, and she joined us at Yale New Haven Health and she joined us at Yale New Haven Health in 2018 as the coordinator of the Sexuality, Intimacy and Menopause Clinic.
She enjoys helping women with cancer maintain healthy relationships and manage treatment side effects. And she’s a member of the
Society of Gynecologic Oncology, the North American Menopause Society and the Scientific Network on female Sexual health and cancer.

Like to then turn to Doctor Mitchell Clark, who is an assistant professor and OBGYN at the division of Kynance at Yale School of Medicine. He did his residency at Yale New Haven Health and completed his fellowship training at the internationally renowned Princess Margaret Cancer Center at the University of Toronto, where he gained clinical and surgical expertise in all aspects of gynecological cancer.
Cancer care.

He also was very much engaged in a rigorous research program furthering on understanding the role of surgery and high risk ovarian cancer and also during his fellowship completed a Master of Public Health degree and continues to actively research cervical cancer prevention at a population level using administrative databases. He’s received numerous National International awards for his research, teaching and surgical skills. Including this,
00:05:52.820 --> 00:05:55.015 the Society of Gynecologic Oncology
NOTE Confidence: 0.84380274125
00:05:55.015 --> 00:05:57.809 of Canada Research Award Award of
NOTE Confidence: 0.84380274125
00:05:57.809 --> 00:06:00.469 Excellence and minimally invasive gynecology,
NOTE Confidence: 0.84380274125
00:06:00.470 --> 00:06:02.382 gynecology and Yale School
NOTE Confidence: 0.84380274125
00:06:02.382 --> 00:06:04.294 of Medicine Teaching award.
NOTE Confidence: 0.84380274125
00:06:04.300 --> 00:06:05.779 Thank you, Mitchell.
NOTE Confidence: 0.84380274125
00:06:05.779 --> 00:06:09.096 And then finally, Doctor Christy Kim,
NOTE Confidence: 0.84380274125
00:06:09.096 --> 00:06:10.320 MD, FACP,
NOTE Confidence: 0.84380274125
00:06:10.320 --> 00:06:12.215 She's an assistant professor in
NOTE Confidence: 0.84380274125
00:06:12.215 --> 00:06:14.110 clinical medicine and a General
NOTE Confidence: 0.84380274125
00:06:14.176 --> 00:06:15.884 Medical oncologist with special
NOTE Confidence: 0.84380274125
00:06:15.884 --> 00:06:18.019 interest and passion in gynecologic
NOTE Confidence: 0.84380274125
00:06:18.019 --> 00:06:20.197 and breast cancers and lymphoma.
NOTE Confidence: 0.84380274125
00:06:20.200 --> 00:06:21.684 She works at she,
NOTE Confidence: 0.84380274125
00:06:21.684 --> 00:06:23.910 she’s at the Our Smile Cancer
NOTE Confidence: 0.84380274125
00:06:23.997 --> 00:06:26.447 Hospital Care Center in Waterford
and has also participated in gynecologic oncology group clinical trials as a primary investigator. And as a member of the Society of Gynecologic Oncology Clinical Practice Committee, she co-authored neuroendocrine tumors of the gynecologic tract update and she’s also an active member of the International Gynecologic Cancer Society and European Society of Gynecologic Oncology. She was appointed as an adjunct assistant professor at Icahn School of Medicine at Mount Sinai.
She’s committed to improve the lives of those who are impacted by cancer and she feels really passionate about providing the best evidence based therapy options personalized to each patient. So great faculty tonight I will ask you to remember that we do have time reserved at the end for questions and that’s been some of the most interactive and really interesting session. So keep your questions. You can put them in the chat later or along the way we’ll keep track of them. Umm one more comment, Doctor Brown, before we start, before we begin, I just need to
recognize the fact that the New Haven.

Primary care community lost one of its

own last month and I want to dedicate

this session to Laura Whitman and

and also say a few words about her.

After spending time at Duke,

UNC Upenn and Case Western

Laura completed her residency in

internal medicine here at Yale in

1996 and it was specifically in

what we called an ambulatory care.

Back she was also a chief resident

in the primary care center,
and it was there that she and I worked together most intensively. She was recruited as a faculty member based on her excellent clinical and also educational skills. She demonstrated patient centeredness, and her kind manner was obvious to all of us who worked with her, whether we worked with her as a patient, in an exam room, in a clinic, conference room or lecture hall. She was a leader in the primary care medical education. And which relocated to the Cornell Scott Hill Health Center several years ago. She also was an author of the Yale
Office based Medicine curriculum, which is a case based study that’s used in medical residency clinics all over the country.

She was a fierce advocate for vulnerable populations as well as a fierce advocate for primary care.

Those of us who practice medicine, we learned very quickly that there’s no US versus them. I know we use it in this practice. I suspect it’s universal, that there’s a clear lack of justice in most cancer diagnosis.
Laura’s illness and death is no exception. The primary care community in the Yale Medicine community has lost someone whose impact will be felt for years to come in the lives of those who she trained in our memories and in our hearts. So with that, we will kick off with the first slide Doctor Joseph. Our first patient is a 56 year old gravida 2 para, 22 vaginal deliveries. She’s postmenopausal and she presented to the emergency department with a 2 day history of abdominal discomfort. Workup including CAT scan of the abdomen and
pelvis was consistent with gastroenteritis. She was treated with Ivy fluids and she was deemed stable for discharge. A 6 centimeter left ovarian cyst was seen incidentally on the CAT scan in the emergency room arranged to follow up with gynecology. I think right there is where we see a little bit of the power of epic because I was paged. I think the emergency room physician was a little the patient wouldn’t have follow up. She didn’t have a GYN. So I was able to review the record and request that they drew tumor markers and asked that she have a pelvic
00:10:51.829 --> 00:10:53.814 ultrasound before she was discharged.
NOTE Confidence: 0.703181013333333
00:10:53.820 --> 00:10:55.346 She wasn’t able to get the ultrasound.
NOTE Confidence: 0.703181013333333
00:10:55.350 --> 00:10:57.470 For discharge, but did get back in the
NOTE Confidence: 0.703181013333333
00:10:57.470 --> 00:10:59.799 morning so by the time I saw her telephone,
NOTE Confidence: 0.703181013333333
00:10:59.800 --> 00:11:03.020 ultrasound was already completed.
NOTE Confidence: 0.703181013333333
00:11:03.020 --> 00:11:05.435 So by the time she sees gynecology,
NOTE Confidence: 0.703181013333333
00:11:05.440 --> 00:11:08.480 the abdominal discomfort had improved.
NOTE Confidence: 0.703181013333333
00:11:08.480 --> 00:11:10.615 But she did note some abdominal bloating,
NOTE Confidence: 0.703181013333333
00:11:10.620 --> 00:11:13.077 which she attributed to her new plant
NOTE Confidence: 0.703181013333333
00:11:13.077 --> 00:11:14.998 based diet. Past medical history?
NOTE Confidence: 0.703181013333333
00:11:14.998 --> 00:11:16.876 Not too significant. Hyperlipidemia.
NOTE Confidence: 0.703181013333333
00:11:16.876 --> 00:11:19.500 She’d had an appendectomy.
NOTE Confidence: 0.703181013333333
00:11:19.500 --> 00:11:21.666 Her family history a little more
NOTE Confidence: 0.703181013333333
00:11:21.666 --> 00:11:23.110 interesting from maternal cousin
NOTE Confidence: 0.703181013333333
00:11:23.175 --> 00:11:24.789 with breast cancer at age 45.
NOTE Confidence: 0.703181013333333
00:11:24.790 --> 00:11:26.542 Maternal uncle with pancreatic
cancer at age 60.

Her parents, siblings and children are all healthy, and she was not Ashkenazi Jewish ancestry.

Pelvic exam was normal.

External genitalia, normal speculum exam.

The abdomen was certainly not acute, but there was a palpable left adnexal cyst.

The transvaginal ultrasound that was ordered did show that it was a complex ovarian cyst, and thankfully the right ovary and uterus are normal.

Again, I think that’s where the ultrasound is a little bit more
accurate test for gynecology.

Remember with the CAT scan you need IV or oral contrast.

and with uterus tubes and ovaries those those can be sort of.

Exaggerated on the CAT scan, so we kind of live and die with the ultrasound.

I had asked you tumor markers to be drawn that was the CA 125 and the H4.
The CA 125 came back elevated.

The H4 unfortunately takes about a week and that was pending at the time of the evaluation.

CEA and CA. 19 nine for normal.
With the elevated C125I referred the patient to GYN Oncology.

Thank you, Doctor Joseph.

So I had the pleasure of meeting with this lady and reviewed the workup that had been completed by Jeff thus far.

And I completely agree the ultrasound is really such a more sensitive and specific tool for us and given the complex features that we saw.

So some solid components, some abnormal vascularity within that cyst, this patient was counseled that she should really undergo a laparoscopic evaluation and at
00:13:12.635 --> 00:13:14.668 minimum removal of that tube and ovary.
NOTE Confidence: 0.841013177777778

00:13:14.670 --> 00:13:16.980 With Frozen section and plans
NOTE Confidence: 0.841013177777778

00:13:16.980 --> 00:13:18.366 for surgical staging,
NOTE Confidence: 0.841013177777778

00:13:18.370 --> 00:13:20.708 if that was to reveal a malignancy,
NOTE Confidence: 0.841013177777778

00:13:20.710 --> 00:13:22.480 most of these cases can be
NOTE Confidence: 0.841013177777778

00:13:22.480 --> 00:13:23.365 done laparoscopically now.
NOTE Confidence: 0.841013177777778

00:13:23.370 --> 00:13:24.482 But for this patient,
NOTE Confidence: 0.841013177777778

00:13:24.482 --> 00:13:26.573 we put the camera inside and what
NOTE Confidence: 0.841013177777778

00:13:26.573 --> 00:13:28.021 was immediately apparent was
NOTE Confidence: 0.841013177777778

00:13:28.021 --> 00:13:29.831 that there was already evidence
NOTE Confidence: 0.841013177777778

00:13:29.887 --> 00:13:31.669 of disease outside of the ovary.
NOTE Confidence: 0.841013177777778

00:13:31.670 --> 00:13:34.766 This can certainly be missed on CT scan,
NOTE Confidence: 0.841013177777778

00:13:34.770 --> 00:13:37.248 especially when we see very small
NOTE Confidence: 0.841013177777778

00:13:37.248 --> 00:13:38.900 peritoneal based disease and
NOTE Confidence: 0.841013177777778

00:13:38.967 --> 00:13:41.445 fortunately it’s not often that those
NOTE Confidence: 0.841013177777778

00:13:41.445 --> 00:13:43.830 things are overlooked by a CT scan,
but we do know that. Most women with an ovarian cancer will present at a more advanced stage just due to really our lack of good screening and early diagnosis right now. And so because of this, this patient’s procedure was converted to an open approach. That’s really still the standard of care when we find disease outside of the ovary, but it never hurts to put a camera inside and just sees going on 1st. And so we proceeded with more of a sudden reduction or what we used to call the debulking and now.
The goal is really shifted towards removing all of the visible disease that we see at the time of surgery and that confers really the best survival for these women. So we completed that surgery without any complications and she was discharged home three or four days after her laparotomy and we referred her on to meet with our medical oncologist. And they’re really an incredible part of what we do for these women because it’s a real combination of surgery and chemotherapy. And so she met with their medical oncologist. Discuss chemotherapy as she was found to be a case of ovarian cancer.
have a stage 3C ovarian high grade serous, which is the most common type of ovarian cancer we see. And we’ll talk a little bit about the importance of genetics and why every woman with serous ovarian cancer is referred to meet with our wonderful genetics team. And this patient was actually found to harbor a mutation in the BRCH 2 gene. This is a really great figure to show sort of how exciting things have become over just even the last 10 years in this disease.
For the last you know if we look back here 2025 years really it was it was toying with which chemotherapy combination is going to give us the best outcomes and those outcomes were still very disappointing for this disease. What we’re very excited by are the advances in maintenance therapy and our understanding of the underlying biology of most of these cancers and how that would impact what our medical oncologist and author recommending for patients to go on after they’ve completed their chemotherapy. So next slide.
This is probably one of the more important papers and one of the figures that gets put onto every talk and it really highlights that this is no longer just A1 fit all cancer that we really go ahead and look at the underlying genetics. And why that matters is that it has been found that about 50% of women with serious ovarian cancer, hybrid, serious ovarian cancer will have an underlying deficiency in homologous recombination and that means. That about half of women are eligible.
for these new types of oral medications that are taken after chemotherapy and have really revolutionized the outcomes and the survival for women for with the disease that many years ago had a survival that was measured in a few years. And we continue to look forward to seeing the excellent outcomes of the data from these trials.

I'm going to hand things over to Doctor Kim to talk a little bit more about some of the nuances in these oral meds.
00:17:00.052 --> 00:17:02.963 story polymerase inhibitors enzyme
00:17:02.963 --> 00:17:05.854 that involves in the DNA repair through
00:17:05.854 --> 00:17:09.840 the another pathway called place.
00:17:09.840 --> 00:17:13.194 Or uh. Accessing goals strand DNA
00:17:13.194 --> 00:17:16.091 breaks and partly vision blocks
00:17:16.091 --> 00:17:19.445 the ability to park inhibitor to
00:17:19.445 --> 00:17:22.958 participate in the DNA damage repair.
00:17:22.960 --> 00:17:27.265 So it’s what’s called synthetic lethality.
00:17:27.265 --> 00:17:29.920 So where the.
00:17:29.920 --> 00:17:32.237 To Mark cannot really repair its own
00:17:32.237 --> 00:17:35.374 and kind of comes to a cell bed so it’s
00:17:35.374 --> 00:17:37.636 most effective in the BRACA mutations
00:17:37.636 --> 00:17:39.939 as Doctor Clark had deluded about
00:17:39.939 --> 00:17:43.345 50% of the serious ovarian cancer
00:17:43.345 --> 00:17:47.392 harbors so HR along with becoming
00:17:47.392 --> 00:17:50.741
BRACA mutations and there are four main part manipulator including elaborate. And that was that for the first three years are at the approved for Dorian cancers, the last one is for the breast cancer.

Next slide. So this was a big trial that kind of led to the. The 2018. As a maintenance, so currently in the US the apartment numbers are indicated as a maintenance therapy. So this is a breakthrough in you know this kind of demonstrated we are. Curing some of the you know high, patients and I draw your attention to the five year mark overall survival.
There are 73% of patients that are alive compared to those 63% percent of the patients at 5 year Mark. At 7 year Mark and there are still strong separation of the curve, 67% are still alive in about 46% are alive and. Just mind you that about 50% of the placebo arm across. Crossed over to the elaborate plan and which can impact the overall survival. So this is really impactful and it's changing. Next slide. But this is just the kind of give you like what's new in ovarian cancer.
I think what we call antibody drug conjugate or ADC. This was just recently approved it's against the fully receptor alpha Mervin tuxmath. So just kind of have a diagram, it's a little bit busy picture but they're so Morehead, it's kind of like a smart bomb as antibody that targets the cell surface receptor and then. You linked to the lot of phototoxic drugs what we call payload and the ratio can be high. So the potencies are quite remarkable.
If you were to give the patients those same dose, it can be quite lethal to their patients. But the way that you designed the antibodies or conjugate you can deliver the drug in a safe manner and targets the cancer cell directly. Then the second pictured on the diagram is called the tumor treating field. This is already the technique that was approved for the neoplasma multifamily highly aggressive glioma and also for mesothelioma. And there are ongoing studies phase three as to electric field.
that pulses through the skin and interrupts the cancer cell that’s impacting the ability to divide.

Next. Slides at least two. Join us.

Regarding genetic testing.

She did have a family history, not a first degree relative.

She had a cousin with cancer and an uncle with cancer.
and we think about genetic testing. There's a couple of things I wanted to point out about some of the recent guideline updates for cancer genetics. Um, the first is really important in the primary Care World is that the preventative Services Task Force does recommend that clinicians at least assess women with a family history of breast, ovarian, tubal or peritoneal cancer, or who have an ancestry associated with the BRACA mutation. So this is specifically for BRCA one and two thinking about family history. Of ovarian cancer, which she did not have.
But in the primary care setting, it's important to take a good family history at your annual physicals and identify. First degree relatives of a patient with ovarian cancer or of course if there are multiple family, or somebody, for example, who's had a bilateral breast cancer or multiple cancers in one family member. So in this patient...
it may have been interesting to ask, you know had your uncle had any genetic testing, had your cousin had any genetic testing because that may inform this patient’s genetic testing. Unfortunately for people who are referred for genetic counseling and testing without a cancer diagnosis but a family history, the wait time is a few months to have genetic consultation and and genetic testing. But in this case because our patient is now diagnosed with ovarian cancer. And it may inform her treatment options, including PARP inhibitor therapy.
She is of course, expedited and has an urgent genetics referral for her. Umm, BRC 2 testing, which came back positive. I'm a firm believer in genetic counseling. You know, there are people who feel informed enough to order genetic tests in the community. Gynecologists are well informed to do that based on their level of experience with genetics up at UConn. There are some really nice. Um, educational programs to kind of educate you on how to do genetic screening. But really the most important thing is that patients need to have pre test counseling and post test counseling.
And the pre-test counseling really needs to be thorough enough to be able to take a good family history, know which test to order, determine if there should be panel testing which company to order from, and then making sure the patient understands the possible outcomes and possible consequences of their test results. So again. And you know, there is a high demand for our genetic counselor colleagues, but I do rely on them a lot to help me with patients when I’m...
thinking about genetic testing.
And my last few updates before we move on is that there is a very new guideline updates from the National Cancer Comprehensive Network that we no longer formally recommends ovarian cancer surveillance even in our very high risk populations, the BRC A1 and B RC2 carriers. You know for many, many years we’ve done transvaginal ultrasounds routinely, we’ve done CA 125. This is the first year that the NCCN has removed that from the guidelines.
Apologizing.

And last but not least, the most important thing I want to share with you as well is knowing the terminology for cancer genetics in regards to mutation no longer being as often used as a term that we use BRACA mutation we use variant. So there are there's a spectrum now, pathogenic variant meaning cancer causing likely pathogenic benign or this Gray area called a variant of likely benign variants meaning the. The gene is altered but not necessarily cancer causing and then this Gray area called a variant of.
uncertain significance that we do not necessarily clinically act upon. So if you have a patient who has a VUS or a variant of uncertain significance in a gene, it does not necessarily mean that he or she needs to have any prevention surgery or any surveillance for that specific type of cancer related to that gene. So I hope that helps. This is my last slide before we move on. Very important brand new in the New York Times. It was a joint statement from the Society of GYN Oncology and the National Ovarian Cancer Research.
Alliance just came out earlier this week saying that again, we don’t have great surveillance for ovarian cancer. And if there is a genetic risk or even in women without a genetic risk and there’s an opportunity to remove the fallopian tubes, that should certainly be considered. With any other surgical procedure under certain circumstances to prevent these high grade serious ovarian cancers that we believe may be starting originating in the fallopian tubes so hot off the press.
Let’s start our second case.

Our second patient is a 65 year old female referred to gynecology by her primary care provider for vaginal spotting. She reports spotting on and off for the past two weeks. This patient came from primary care, but we also see this patient from urgent or walking care. Often seeing if you can’t see your primary care or from the emergency room. Past medical history is significant. She suffers from obesity, type 2 diabetes and hypertension. She takes 2 medications for her
hypertension as well as metformin.

Her BMI is 40, so now Class 3 obesity.

Her last period was at age 53 and she did not take any hormone therapy after menopause.

Family history notable for diabetes and multiple family members, and coronary artery disease and her father.

On exam, she is in fact obese.

Family history notable for diabetes and multiple family members,

and coronary artery disease and her father.

On exam, she is in fact obese.

GYN exam is limited by her body.

Habitus Speculum exam reveals dark menstrual appearing blood in the vaginal vault and the uterus and adnexa are not able to be palpated.

So kind of following the algorithm
of postmenopausal bleeding,
STOP the bleeding, make a diagnosis,
and then make treatment.
I thought the bleeding was a little too
brisk to attempt the endometrial biopsy.
Danger is put the patient through
the biopsy but only receive blood.
Umm, and sometimes a little
uncomfortable biopsying the uterus.
I can’t palpate or see that well,
so I elected to start Provera 10 milligrams
and order transvaginal ultrasound.
The ultrasound revealed the 60
millimeter heterogeneous endometrium,
which is abnormal.
00:28:01.881 --> 00:28:03.866 Uterine length is 10 centimeters,

00:28:03.870 --> 00:28:07.510 which is generous and no

00:28:07.510 --> 00:28:08.966 myometrial abnormality.

00:28:08.970 --> 00:28:11.076 I then performed an endometrial biopsy

00:28:11.076 --> 00:28:14.594 in the office and it was returned as


00:28:16.130 --> 00:28:19.340 That's somewhat the new technology


00:28:22.550 --> 00:28:23.166 That diagnosis,

00:28:23.166 --> 00:28:23.782 I thought,

00:28:23.782 --> 00:28:25.014 should see Joanne Oncology.

00:28:28.660 --> 00:28:31.476 Thanks Jeff. And yes, we did have the,

00:28:31.480 --> 00:28:33.872 the chance to see this lady and what

00:28:33.872 --> 00:28:36.444 we spoke with her about is is sort

00:28:36.444 --> 00:28:38.130 of left untreated this condition

00:28:38.130 --> 00:28:40.014
can progress into a cancer in about 40 to 50% of women that some of the data from the older term of complex atypical hyperplasia. And so there are a lot of you know different options for treatment depending on the patient’s age, they’re surgical risk factors and what it is that they like to do. Just to sort of trail off from this patient for a second, this woman was young. Maybe she was in her early 30s and she had not had an opportunity to have children and that was part of her family planning long term.
We do actually now have some exciting data to show that using things like the progestin releasing IUD’s that we know very well from contraception can actually cause this to regress in about 80 to even maybe 90% of women. The downside is there that that’s not a definitive approach. Um, and if the underlying risk factor so the diabetes, the hypertension, haven’t been corrected, the morbid obesity haven’t been corrected, the patient is likely to. Rebound into a refractory hyperplasia at some point if and when the IUD is removed. The other population that we consider...
using either the IUD or an oral progestin in a long-term fashion are those women who we meet who have really high surgical risk factors sort of inherent in this population with the diabetes, the hypertension, the obesity, some of the cardiac disease that really put patients at risk of going to the OR. Sometimes we will choose to do a non-surgical approach in those women. However, in this lady we sat down, she was seen by her primary care provider. Who helped with risk stratification and optimization for her comorbidities.
before going to the OR and we considered her and butcher for a robotic assisted hysterectomy, removal of both tubes and ovaries and frozen section. You know you might ask, you know Doctor Joseph has taken the time to do an endometrial biopsy and we have a diagnosis of a precancerous process. But if you look at some of the historical data, the risk of there being a concurrent already invasive endometrial cancer can be as high as about 40 to 45.
And so because of that risk and the potential of a sampling error with an office based biopsy, we do recommend that women have a frozen section of the uterus at the time of the procedure. If that does relevant cancer then we do proceed with the appropriate staging which typically involves some assessment of the pelvic lymph nodes. The standard of care for these surgeries really is now moving on with an MRI. Approach or laparoscopic, you may have some patients who ask,
you know they’ve read the New York Times that robotic surgery is associated with worse outcomes that’s in cervical cancer and we are very interested to see where that goes. But for endometrial processes really the standard of care has been a MIS and and we continue to see good outcomes with that approach. So this city was found to have an early stage SO1A Grade 2 endometrioid endometrial adenocarcinoma and this is probably one of the more Common, you know final pathology that we see what we do for all of
our endometrial cancer patients is
we screen them for mismatch repair
deficiency or microsatellite instability
through both the combination of the
immunohistochemistry and the PCR.
And that is both just screened
for Lynch syndrome,
but also to look for inherent somatic
changes in the tumor that may not be related
to anything in the family or the DNA.
And I have to say this is one of the most
common questions I hear from women is they.
They get a cancer diagnosis and
the first thing they’re saying
is what do I tell my daughter?
is what do I tell my sisters?
If you know, what do I tell my sisters?
00:32:20.140 --> 00:32:21.898 How can I inform my family
00:32:21.898 --> 00:32:23.819 on on their risk of cancer.
00:32:23.820 --> 00:32:25.950 This patients results did show
00:32:25.950 --> 00:32:28.800 loss of staining in the MLH one.
00:32:28.800 --> 00:32:31.327 However that reflexes a test to look
00:32:31.327 --> 00:32:33.406 for an epigenetic phenomenon called
00:32:33.406 --> 00:32:35.716 hypermethylation in the promoter region
00:32:35.716 --> 00:32:38.909 and that is not when that is positive.
00:32:38.910 --> 00:32:40.218 That’s not indicative typically
00:32:40.218 --> 00:32:42.180 of a lynch syndrome and therefore
00:32:42.231 --> 00:32:43.936 those patients don’t often or
00:32:43.936 --> 00:32:45.300 don’t necessarily meet outward.
00:32:45.300 --> 00:32:47.358 Criteria to go on to meet with
00:32:47.358 --> 00:32:49.188 genetics just based on that result.
00:32:49.190 --> 00:32:49.555 However,
they would then qualify down the road for any treatments or medications like immunotherapy that have shown promise in this subgroup of women because of the final results of her pathology showing some high risk factors. So the Grade 2 disease, the lymphovascular space invasion, we did ask Miss T to meet with our radiation oncology team to discuss vaginal brachytherapy and that is really the most common. Type of radiation women are now receiving for these endometrial cancers, it’s typically three sessions, very well tolerated with very minimal
long term toxicity and really has shown to decrease the risk of recurrence quite significantly.

The next slide.

I just wanted to highlight some of the sort of newer exciting technology that we have in the field of endometrial cancer. I’m sure many of you who have been seeing women with breast cancer or are other cancers have been familiar with Sentinel node technology and those disease sites. But really over the last five to 10 years, we’ve seen a huge influx of data in and around the youth of a Sentinel node technology in almost
All of our gynecologic cancers, which is very exciting. Pelvic node dissection is very important in endometrial cancer. For stratifying risk and assigning adjuvant either chemotherapy, radiation therapy or both. And for years that included a pretty extensive pelvic node dissection over a fair bit of space in the pelvis there. And so this trial or more of an observational study tried to quantify how many of these women were going on to develop lymphedema of the lower legs. And just like the difficulties in treating that in the upper arms.
and the breast cancers, we have had a real challenge in managing that. Edema long-term women who develop it in the lower extremities and it’s not a negligible number and it depends on which of the gynecologic cancers it is associated with. And so we’ve got really robust data now showing that across all the different subtypes of endometrial cancer that in women whose disease appears to be fine to their uterus at diagnosis that central no technology is safe, effective and almost eliminates the risk.
of lower extremity long term symptomatic.

NOTE Confidence: 0.900094153181818

Of the team up offline.

NOTE Confidence: 0.900094153181818

Next slide.

NOTE Confidence: 0.903767166666667

So I’m going to pass it back over to

NOTE Confidence: 0.903767166666667

Doctor Kim to talk a little bit about

NOTE Confidence: 0.903767166666667

where we’re moving and endometrial cancer

NOTE Confidence: 0.903767166666667

and excitement coming down the road.

NOTE Confidence: 0.708029968333333

Thank you doctor card. So this

NOTE Confidence: 0.67867748

is a trial. Cancer

NOTE Confidence: 0.842164233529412

is the most common gynecologic cancer

NOTE Confidence: 0.842164233529412

in United States and incidents

NOTE Confidence: 0.842164233529412

are rising as you are aware.

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So five year over survival for the

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localized early stage disease is

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quite good 95% or some for advanced

NOTE Confidence: 0.842164233529412

stage that’s not the case about
higher overall survival is about 18% and you know ultimately women die from succumb to their disease. So the our trend is more and more toward successful outcome and trying to kind of figure out what are the you know targeted approach. So based on the TCG a data the individual cancers are classified based on the molecular subtopics. So I draw your attention to the left column. So there are four subtypes one the two on the left is called Poly or polymerase X1 or alternated tumors. These are instance are quite small.
About 2.6% but their outcomes. They’re quite excellent compared to the microsatellite instability or hyper mutated tumors or these are considered hot tumors in the instance about 30% close to 40%. I mean these are the type of tumor that respond really well to the immunotherapy, the 1/2 on the right, the copy number level or endometrioid subtype in the one that’s the worst prognosis is the one called Sarah slate. With P53 mutated tumor there outcome is quite poor. So based on the what does the
classifications or treatments going to be changing and especially the pathologist going to classify and mental cancer differently than what we used to.

These are just to kind of giving you perspective of people.

Isn’t that was the proof for the as a second line?

Melissa that’s tumor type for the MSI micros.

Stability of the MSI or mismatch repair deficiency tumors but with the junction with the multi oral tyrosine kinase inhibitor then that.
and this was a this changing that

they were seeing patients with advanced cancer settings are living longer regardless of double marker.

So next slide, what to expect or for the new direction? Adverse events are basically can affect any organ systems and most common organ that can be affected. So thyroid and people to come on the hypothyroid and also we need some replacement therapy. But these are early recognition and interventions and you know have your subspecialist, your pulmonologist, gastroenterologist,
dermatologist, endocrinologist you know have a referral. You have early interventions because these are quite impactful therapy and you want the patients to be on really effective therapy for long. Next. It’s just kind of giving you like a. You got the. And tougher to therapies not just for the breast cancer nowadays at the lab in combination nowadays at the lab in combination with the chemo and her to express. Advanced urine service. Serious cancer can improve the overall outcome and so overall survival,
and this was based on the doctor Elizondo sentence work.

Next that. Thanks.

So this kind of brings everybody through that kind of over the purple pearls.

Alright, so let’s review the clinical pearls, a transvaginal ultrasound is often helpful prior to gynecology or GYN oncology consultation.

The ultrasound evaluates the ovaries more accurately than a CT scan and can measure the endometrium. And I I think that if there's ever a question and you have to refer the patient on to gynecology or do you in oncology get the pelvic ultrasound.
ahead of time it it’ll make that consultation pump that much more thorough any person with ovarian cancer or.
Course to be relative with ovarian cancer would benefit from genetic testing and how to kind of get in line before the genetic testing, ovarian cancer can be a chronic disease, one of our slides showed. That with the the new treatment, the life expectancy is much longer than we we had years ago. All postmenopausal bleeding
must be evaluated.

Even spotting and remember the algorithm stopped the bleeding,

make a diagnosis and then treatment options.

Order an FSH level if there’s any question that a patient is menopausal or not menopausal.

Again, 52 year old woman has had a few periods in a year.

Is that postmenopausal bleeding or or perimenopausal?

So an FSH ahead of time is very helpful.

And many gynecologic cancer survivors are candidates for hormone replacement therapy if needed.
That’s an important point as well. If it’s not an estrogen sensitive cancer, then hormone therapy can certainly be investigated.

So and I can guide some questions if you’d like. The folks who are on the line to complete the survey when you’re done to get your credit and you can always e-mail us with questions and these are the upcoming ones. There is one question in the chat from Beth Allard,
maybe we can start there.

And and and Beth if you noticed his actually on the panel for next month’s session,

so she’s getting a little warm up here.

No, I think Jeff, this is probably for you.

Is there a place for endometrial biopsy in a pre menopausal woman versus post menopausal?

So I think an endometrial biopsy, it’s it’s I, I do it more often when there’s a question.

So remember men, Araja has an endometrial biopsy and and perimenopausal bleeding would as well because remember
tonight’s topic was GYN oncology. But most of the abnormal bleeding I see is not going to be oncology, right, even postmenopausal bleeding, it’s probably 8020 benign. So fibroids, polyps, endometritis. There’s a lot of other reasons, which is why I do the biopsy and it doesn’t go right to Doctor Clark. So I have a couple of questions that had come to me through colleagues before the session that I’ll ask. And I would also encourage all of anybody who’s attending to please send in questions. This is a pretty great opportunity.
to have a panel of people who can answer them at an intense level.

So one question that I have is about this fallopian tube study.

So in the past you know, we also recommended prophylactic oophorectomy for many women having hysterectomy.

And at this point at least in my practice, there are a lot of women having hysterectomies, hysterectomies as part of pelvic reconstruction.

So they’re not in the cancer world at all and as a primary care clinician I may offer some advice and it comes back with mixed perception.
Is that outdated?

Is it just the fallopian tube?

Now tell me the how did this all evolve?

That’s a great question, Karen.

And we’re still actually sort of going back and forth that pendulum continues to swing.

A few years ago, there was a really nice paper that came out to suggest that there may actually be some underlying estrogen still produced by the ovaries even if it’s not high enough to trigger the menstrual cycle.

And so the pendulum swing to keeping ovaries in place for women in the the age seemed to be about 65 is what that
study showed now since then there’s been a few sort of large scale.
Paper saying, you know, that benefits gained their weight against the potential of an ovarian cancer left undetected.
And so there is a bit of sort of equipoise within the scientific community. I sit down with my patients. We try to do a more individual risk assessment.
You know, is there a high risk of osteoporosis, heart disease, dementia, where those ladies might benefit
even if there’s still a little estrogen being produced there to maybe prevent some of those conditions that we know are associated with low. Estrogen early in menopause and and the other thing is where women come from in their own life experience. You know if someone they saw go through an ovarian cancer. I have to say those leaders are typically asking us to remove the ovaries at the same time, but we do. We do think the majority of at least the high grade serious does come from the two.
And of course, family history plays into that quite a bit, right? Yeah, OK. Very helpful.

Wait, I have a comment about that. So this is something that I learned a long time ago, but which maybe, but it’s because the developmentally that lines the peritoneum is, is originating from the same tissue that develops into the ovary, you guys get better.
when we look at all the sort of epidemiologic data over the last 50 years, essentially any risk, anything that reduces the number of lifetime ovulation, so pregnancy, continuous hormonal contraceptives, breastfeeding, all of those things seem to reduce your risk. And so people thought every time the egg comes out of the ovary, that rupture, that repair of the surface of the ovary, that’s eventually going to lead to your first hit and your second hit in that sort of reconstruction of the ovary. But now we’ve learned that’s actually...
probably the content of the ovum.

So the sort of pro inflammatory fluid that’s in the egg that’s coming out,

that’s bathing the fallopian tubes on their fimbriated end and they live in very close proximity and that’s that repeated pro inflammatory exposure.

That’s at least the tubal hypothesis that most of us are sort of going with right now and it’s that’s probably why all those epidemiologic factors hold.

But it’s less has to do with what’s happening on the surface of the ovary. The ovary and what that ovulation is doing to the fimbriated end of the fallopian tube and and the data on
00:46:53.067 --> 00:46:55.118 this is really quite impressive in in
00:46:55.118 --> 00:46:56.630 countries and centers that have been
00:46:56.630 --> 00:47:00.271 we have have seen a nice decline in
00:47:00.318 --> 00:47:02.260 their population rates of ovarian cancer.
00:47:05.900 --> 00:47:08.213 So I want to just add that the patients
00:47:08.213 --> 00:47:10.350 with the BRACA mutations that by
00:47:10.350 --> 00:47:12.165 the time they undergo prophylactic
00:47:12.225 --> 00:47:13.933 southernmost reckoning they already
00:47:13.933 --> 00:47:16.495 find existing tumors that are already
00:47:16.500 --> 00:47:18.636 formed like we call stick regions.
00:47:18.640 --> 00:47:20.542 So kind of give you like
00:47:20.542 --> 00:47:22.390 how the cancers are rising,
00:47:23.110 --> 00:47:24.018 that’s a great point.
00:47:24.018 --> 00:47:25.958 And and last thing I’ll talk about the
00:47:25.958 --> 00:47:27.869
tubes because I'm obsessed with the tubes.  
If you can't tell, we actually have now open at Yale we believe so strongly and they said a scientific level that women with. Bracket 2 mutations can enroll in the clinical trial that will remove just the fallopian tube and delay the removal of the ovary until menopause and they'll be followed for quality of life measures as well as development of an ovarian cancer. But because ovarian cancers occur a little later in the bracket two women, this trial has been designed to evaluate if removal of just the two would be
sufficient risk reduction for that population and we are now enrolling patients. At both the Waterford and our New Haven Care Center. That is fascinating. And honestly, as a primary care physician, I didn’t know that. I think it’s really helpful to bring out here where people may be, you know, counseling people as to whether to participate in a trial like that, that it’s a strong theory, Jeff. It looked like you were about to say something.
sterilization now has gone to salpingectomy. So you know back in the day clips, rings, tubal ligation using single port laparoscopy, that’s all kind of gone by the wayside. I bet it’s been 10 years now that voluntary sterilization is now a laparoscopic bilateral salpingectomy. And we started the fimbriated end because we think it’s the most important. They kind of tease the the fallopian tube off the ovary through the broad ligament and and get very close to the uterus so that you know. The whole fallopian tube is effectively removed. It’s kind of changed the surgery
just a little bit, but it’s still 35 millimeter ports. Still a rather simple surgery.

Back at, you know, when I was doing C sections, if we had a tubal at C-section, the same thing, no longer were we just sort of interrupting the tube but removing the whole fallopian tube. And that’s been quite a while now.

And I think for any reduction in ovarian cancer with that or is it hard to tell because of? There are other factors at play.
I think that’s where the studies are going right now, Doctor Brown.

Yeah. OK. Is there risk reduction in the high risk population?

It’ll take many, many years to know if this brings the risk down of an ovarian cancer subsequently.

But you know we’ve seen patients who do have these stick precursor lesions who then unfortunately have to have full usually hysterectomy and then we followed them along to make sure that they’re doing well afterwards, but but. A lot of young women, I think,
who are interested in permanent sterilization but also feel like this is maybe something that they can really do to reduce their risk. If they have a family history, even if the genetics are negative, they really are inclined to do something that’s in their control to reduce their risk, and this is one thing they can do. Great. So I just I’m John I’m glad you were talking because I’ll come back were talking because I’ll come back to you and then I still don’t see any other questions from our audience. I would encourage people to ask but I love your wording you blew
over it a little it was actually
you know sometimes when you hear things twice in one week it they stick and so a week ago in. Internal medicine. We had a grand rounds from a faculty member named Anna Deforest who had written a book and her point was words matter. And and she specifically said what you said, which is we don’t call things mutants and mutations. They’re called variations and that wording is important. In addition to hearing that from you and her this week, I also got back a lab report.
00:51:27.830 --> 00:51:29.170 on a patient with.
00:51:29.170 --> 00:51:31.498 I don’t know hemochromatosis or something.
00:51:31.498 --> 00:51:34.008 and it said mutant detected and you
00:51:34.008 --> 00:51:36.451 know I had never been so kind of
00:51:36.451 --> 00:51:38.803 sensitized to that as I was with that.
00:51:38.810 --> 00:51:41.316 So I I think it’s helpful to
00:51:41.316 --> 00:51:43.639 remember that that words matter and
00:51:43.639 --> 00:51:46.362 and and the other thing that’s
00:51:46.440 --> 00:51:48.500 helpful is this concept of.
00:51:48.500 --> 00:51:50.080 I guess it’s futility,
00:51:50.080 --> 00:51:52.680 but advice now against surveillance,
00:51:52.680 --> 00:51:55.911 these regular ultrasounds and markers
00:51:55.911 --> 00:51:58.299 has not proven to be effective.
00:51:58.300 --> 00:52:00.946 And so knowing that that’s now also
within the gynecologic community

in addition to our, you know, kind of preventive health focused on internal medicine communities

is very helpful.

And I think the background.

Oh, go ahead, Doctor Clark.

No, no, sorry, go ahead. I was going to say something more of an aside.

Real quick, I'll just point out that all the more importance now on family history and identification of genetics is really the key as far as prevention of ovarian cancer.

Yeah, and testing the mutation, OK. What I was gonna say I just about
one of the reasons probably that the NCCN has now dropped. This is just the really poor performance of C125. You know we order it but there are so many things that can cause it to be elevated whether that’s diverticulitis Crohn’s disease you know you see any sort of inflammatory condition. Recent COVID I had a patient who is on surveillance for ovarian cancer who didn’t tell me she had COVID recently chapter 25. It was mildly elevated obviously very anxiety provoking.
For that woman.

And so you know in ordering that it's always good to just sort of I try to really tell patients, you know, if it's a little elevated and you have one of these other conditions, please don't interpret that as a test for ovarian cancer.

And so you have 125 has really helped us with so many ways, but has really caused a lot of anxiety for for healthy women and so sort of being cognizant of sort of how to interpret those results in other ways and so sort of
the context of each patient.

Um, to try to reduce some of that anxiety until they get a chance to meet with one of us at the Cancer Center.

Thank you. This was just wonderful. I am so appreciative and I know my primary care colleagues who are listening and who will listen later. We’ll feel the same. And do you want to? Wrap up, you, you had a question, if you have a question we wrap it up from the New York Times. It seems like there’s some new
studies coming out around estrogen
replace hormone replacement therapy
and I think that always comes up.
You’ve had a you know if you’re if you’ve
had cancer or you are at high risk of cancer because of a family member,
what’s the bottom line about is it safe to take estrogen replacement therapy?
In 3 minutes I’ll take this one. In 30 seconds.
It’s it’s an individualized decision,
depends on the tumor,
depends on the patient,
depends on her all other risk factors.
Smiło does have a sexuality menopause
for cancer survivors program.
We love to see women and talk about risks and benefits for the most part. Vaginal vulvar, cervical cancer. Yes, it’s safe. Endometrial and ovarian depends on the tumor type. Doctor, you agree with that? Absolutely. And Joanna is underselling her role in Sims Clinic. This is an incredible resource at Yale, one of the first in the country to comprehensively evaluate and support women who have been previously told that they are, you know, not eligible or candidates for something.
00:55:14.348 --> 00:55:16.959 that can really improve quality of life,
NOTE Confidence: 0.791784465
00:55:16.960 --> 00:55:18.997 especially in our young women who who
NOTE Confidence: 0.791784465
NOTE Confidence: 0.791784465
00:55:21.780 --> 00:55:24.060 And so it’s very individual.
NOTE Confidence: 0.791784465
00:55:24.060 --> 00:55:27.000 I have patients who you know.
NOTE Confidence: 0.791784465
00:55:27.000 --> 00:55:28.560 Or on hormone replacement therapy ,
NOTE Confidence: 0.791784465
00:55:28.560 --> 00:55:30.996 who came off because of their cancer
NOTE Confidence: 0.791784465
00:55:30.996 --> 00:55:33.330 and their quality of life was so poor
NOTE Confidence: 0.791784465
00:55:33.330 --> 00:55:35.633 and we really don’t actually have
NOTE Confidence: 0.791784465
00:55:35.633 --> 00:55:37.391 prospective randomized data to say that
NOTE Confidence: 0.791784465
00:55:37.391 --> 00:55:39.057 it will cause your cancer to recur. 
NOTE Confidence: 0.791784465
00:55:39.060 --> 00:55:41.228 And so it is important that you actually
NOTE Confidence: 0.791784465
00:55:41.228 --> 00:55:43.467 sit down with someone like Joanna or
NOTE Confidence: 0.791784465
00:55:43.467 --> 00:55:45.414 someone who has experience with this
NOTE Confidence: 0.791784465
00:55:45.414 --> 00:55:47.454 and hear the actual data so that you
NOTE Confidence: 0.791784465
00:55:47.454 --> 00:55:50.216 know your patients can make an A truly
informed decision and not just based on you know what their friends have told them or to do or not to do. Because quality of life is just as important as survivorship. I think that’s a great place to end. Thanks to all of our faculty for the great discussion the cases. Thanks to our participants for attending and please again tell your colleagues to to attend or listen these are recording so they’re available and we look forward to seeing you in the future at our next smilo chairs which is Renee
can you put that back up for the.  
For the. For folks.  
OK. Well, that’s all right.  
We’ll, we’ll, we’ll send it around.  
It’s always the the same Tuesday at  
the same time, same time, same time,  
same place, March 7th, GI cancers. Yes.  
Thank you so much and again please  
make sure to complete the survey.  
We really appreciate that and  
have a good night everyone.  
Thank you again.  
Goodnight. Thank you. Thank you  
guys. Thank you.