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Welcome to Yale Cancer Answers with your host Doctor Anees Chagpar.

Yale Cancer Answers features the latest information on cancer care by welcoming oncologists and specialists who are on the forefront of the battle to fight cancer. This week it's a conversation about ovarian cancer with doctor Elena Ratner.

Doctor Ratner is an associate professor in the Department of obstetrics, gynecology, and Reproductive Sciences at the Yale School of Medicine where doctor Chagpar is a professor of surgical oncology.

Maybe you could start off by telling us a little bit more about ovarian cancer.

I know that a lot of people have heard about it, but they may not know as much about it as they know about other cancers.

So what exactly is it?

How common is it, and who gets it?

Perfect questions to start with
and it is so wonderful to be able to discuss this with you today and with our listeners as it is ovarian cancer month and we’re trying to raise awareness for this cancer. Ovarian cancer overall is not very common, only 1.4% of lifetime risk of getting the cancer, and this cancer is more prevalent in certain groups. Genetic predisposition plays a very important role as to some other factors that I’m sure you and I will discuss today during our conversation. But the important thing about ovarian cancer is that unfortunately it still continues to be a very deadly cancer. 24,000 women get this cancer yearly in the United States and as high as 16,000 women die from this cancer and the reason for that is because, unfortunately, this is a cancer that is very difficult to diagnose early. We used to say that this is the cancer that whispers, and during our conversation today I would like to prove to you that 0:02:15.364 is not the case, but nevertheless,
these cancers, unfortunately are frequently diagnosed at a later stage. And even though most of them respond very nicely to chemotherapy upfront, this is a very, very smart cancer and unfortunately they learn how to resist the treatment that we give them. And again, during our conversation today, I would like to discuss with you as to how the treatment for this cancer is really improving, and there’s so many new treatments and new ways of management that we are using now that we didn’t have six months ago, two years ago. So the outlook for this cancer looks very bright, but this is a very important cancer to be aware of because we, as women are our best advocates and we are fighters for our own lives and our own bodies. And that’s why it’s very important to know about this cancer and to know what symptoms to look out for. A lot to cover in this show and I’m really excited to talk about this. So let’s start with risk factors.
Are all women equally at risk or are there some things that really predispose some women to getting ovarian cancer? You mentioned for example, genetics. Yes, there’s definitely factors that increase your risk of getting ovarian cancer. We now understand that genetics play such an important role in the old cancers most likely, but definitely for ovarian cancer, and it’s not just for women who have family history of ovarian cancers. We know that there’s genetic mutations that increase your risk of ovarian cancer and breast cancer and pancreatic cancer and melanoma and prostate cancer in men. When we talk about genetic predisposition and when I talk to women about their risks, I don’t just ask whether somebody in the family had ovarian cancer, even though of course that itself would be a risk factor, but it’s more what other cancers run in the family. Is there a family member who had breast cancer? Is there anybody who is a male who had breast cancer and those cancers are suspicious for BRCA gene mutation. There’s been quite a bit in the...
news about the BRCA gene mutation over
the past five years or so,
as you remember,
Angelina Jolie,
who has one of these mutations
and a number of different
New York Times Editorials,
talking about her experience
with the Mutation.
So it’s called the Angelina Jolie effect.
And now there’s much more known about
this mutation and about how women with
this mutation have a higher risk of
developing ovarian cancer and breast cancer,
for example.
But there’s a mutation is
just one of those mutations.
There’s many other mutations that
predispose you to getting these cancers.
That’s why nowadays it is so important
to know your family history and to
know where you come from and to know
what possible genetic mutations you
might have that might predispose you
to having higher risk of different
cancers. In particular, ovarian cancer.
So that’s important.
But you know, for women who may
not have a BRCA gene mutation
running in their family, or
who may not have a family history of
any cancers or for those who really don’t know their family history, maybe they were adopted or have come from families where they really haven’t gotten any of that knowledge passed on to them before people passed away, maybe they were adopted or have come from families where they really haven’t gotten any of that knowledge passed on to them before people passed away,

are there other risk factors that also play into your ovarian cancer risk?

Yes, and so much of this is truly individualized. You know there’s no formula. There’s no specific check list. It is really just talking to women and kind of understanding what are their risks. What are the protective things that they bring to the table when we look for the risks of ovarian cancer. So for example,

women who have had a lot of children, it is very protective. For anybody who has had five children, that decreases their risk to 50%.

Anybody who breastfed each one of their five children for five years cumulatively has a decreased risk of ovarian cancer by 50%.

Women who use birth control pills, those are incredibly protective for ovarian cancer. Every opportunity I get and every
girlfriend that I talk to, I always tell my listeners and my patients and my friends try to use birth control pills for five years if they can. Anybody who uses birth control pills for five years decreases their risk of ovarian cancer by 50%. Anybody who uses it for 10 years decreases it for as high as 80%. Anybody who uses for 15 years decreases it for as high as 90%. So the benefit is really quite astounding as to what we can do. Women who had their fallopian tubes removed, in the older days we used to do tubal ligations. Now, in many cases we actually would take out the fallopian tube and that significantly decreases your risk for as high as 70%. The hysterectomy, even if there is some left behind that significantly decreases their risk, so there’s a number of different protective factors that one can do to try to decrease the risk. There’s two different ways that
we now think about ovarian cancer, the traditional theory of ovarian cancer was that the more times that the woman ovulates, the more risk of developing cancer of the ovaries and that’s why anytime when you are not ovulating whether it’s pregnancy or breastfeeding or your birth control pills, that decreases your risk. The newer thought is that ovarian cancers might not actually be ovarian cancers at all. They actually might be fallopian tube cancers that then subsequently spread to the ovaries and that’s why it is so important that if you’re having hysterectomy, fallopian tubes do not have a purpose. Ovaries, of course do because they give you hormones, but fallopian tubes, the only purpose is for pregnancy so many times where women have hysterectomies their ovaries left behind. It is very very important that the fallopian tubes are removed as well. Or, if the fallopian tubes are tied, it gets
removed rather than just tying it, because we now know that a great number of these cancers originate in the fallopian tubes. So if those are removed, then the risk is significantly decreased.

Now let’s suppose you’ve tried to minimize your risk, but still, one of the things that you mentioned is that the part of ovarian cancer that causes death is because it’s caught late, and we know for many cancers that there is effective screening, right?

We’re heading into October. Breast cancer awareness. We all know that mammograms help us find breast cancer early. What do we have or do we have anything in terms of screening to help women to find ovarian cancer early? So that’s exactly the trouble with ovarian cancer, and that’s why we talk so much about ovarian cancer prevention with identifying risks and trying to do anything you can to decrease your risk, because unfortunately, we do not have as good of
a test for ovarian cancer
as we do for breast cancer with mammograms and there
is a lot of literature that shows that there’s really no benefit to doing routine ultrasounds for normal risk population because unfortunately ultrasounds even in combination with a tumor marker blood test called CA 125, there’s literature that in the normal population that does not help you detect cancer early. And on the contrary, pushes women to have more unnecessary surgery. But that’s not the case for high risk women.
For women who are at higher risk for whatever risk factors that we discussed previously, then ultrasounds combined with this blood test called CA 125 are a benefit, but unfortunately still very limited. That’s why it is so important for this ovarian cancer awareness to exist and for women to know the signs and symptoms for ovarian cancer because that is really the best screening or the best early detection and risk reduction is through awareness of the symptoms and listening to your body. And so one of the things
that you said at the outset is that for many years ovarian cancer was thought about as the cancer that whispers because so many of the signs and symptoms may be things that women may shrug off, but they may not be really aware of as being potential red flags for ovarian cancer. So tell us more about those signs and symptoms that women should be aware of to be thinking about. And when should they be going in and seeing their gynecologist? For generations we used to say, there's just nothing you can do for ovarian cancer. It's what it is. You just cannot diagnose it early because there's no early symptoms, but we know that is not the case. Multiple very good studies have been published to show that yes, the majority of women, 97% percent of women with advanced ovarian cancer, will have symptoms, but 89% of women with stage one and two cancers will also have symptoms. The trouble is exactly how you said that these are also normal symptoms that are symptoms of perimenopause. Is this a symptom of having a period?
There's hormonal changes so the majority of the women who have the symptoms are actually completely normal and the symptoms that we're talking about is bloating, some Constipation, some diarrhea, bladder symptoms, weight gain, Clothes not fitting well. Feeling like you need to get bigger clothes because they're not fitting well around the waist. The important thing again, and this is I think the most important thing of our conversation today is the great majority of the women who are listening to this today we all experience symptoms and a great majority of these symptoms are completely normal. The symptoms that we need to pay attention to are the symptoms that don’t just happen during periods or during ovulation. Those are the symptoms that happen every single day for two weeks, and also symptoms that happen together, let's say bowel and bladder symptoms, bloating and bladder symptoms. Those are the symptoms to pay attention to. We are going to dig into all of those symptoms and how we can actually make a diagnosis right after we take
a short break for a medical minute. Please stay tuned to learn more about the treatment and diagnosis of ovarian cancer with my guest doctor Elena Ratner. Support for Yale Cancer Answers comes from AstraZeneca providing important treatment options for patients with different types of lung, bladder, ovarian, breast and blood cancers. More information at astrazeneca-us.com.

This is a medical minute about breast cancer, the most common cancer in women. In Connecticut alone approximately 3000 women will be diagnosed with breast cancer this year, but thanks to earlier detection, non invasive treatments, and novel therapies, there are more options for patients to fight breast cancer than ever before. Women should schedule a baseline mammogram beginning at age 40 or earlier if they have risk factors associated with breast cancer. Digital breast tomosynthesis or 3D mammography is transforming breast screening by significantly reducing unnecessary procedures while picking up more cancers and eliminating some of the fear and anxiety.
many women experience. More information is available at yalecancercenter.org.

You’re listening to Connecticut public radio. Welcome back to Yale Cancer Answers. This is doctor Anees Chagpar and I’m joined tonight by my guest doctor Elena Ratner. We’re talking about ovarian cancer and right before the break Elena, you started to tell us some of the signs and symptoms that women should really be aware of in terms of trying to find ovarian cancer early because we simply do not have really good screening tests. So it’s really up to women to pay attention to their bodies. But one of the things that struck me was that many of the symptoms you mentioned, a little bit of bloating, a little change in bowel habits or bladder function, a little bit of weight gain, your pants not fitting. I mean those happen to all of us all the time right? You go out for a big meal and you feel a little bloated after that.
You might have a little bit of Constipation or diarrhea. Your pants don’t fit right and you think Oh my God, I’m gaining weight. But should women be going to their gynecologist every time one of those things happens? Tell us more about what are really the triggers that you would say you know what this has gone on a bit too long, you really need to get to your gynecologist, you need to advocate for yourself that this is something that needs to be looked into. Yes, that’s exactly correct. You really nailed it when we discussed before all of us experiencing it. It’s totally normal. The key is to know what is normal for you and then be aware when something happens is not within what’s norm for you. So usually what I tell women is pretty much consistent symptoms is lasts for two to three weeks.
That is the time to just get checked out. I’m a huge proponent that just talking to somebody or getting things checked out is of such benefit. The interesting thing is when I speak to women with ovarian cancer and then in their minds they go back to when everything began. It just wasn’t considered by them to be anything that they should really pay attention to. The other important thing is that a lot of women, when these things happen, actually do not go to gynecologist. Most women go to urologists because they having bladder symptoms. They go to a gastroenterologist because they’re getting bowel symptoms, interestingly a lot of women go to chiropractors because they having this discomfort and they’re trying to make that better. So we actually do education not just to women, but to providers. I actually do tons of talks in the state of Connecticut to different physicians and different providers. We have this designation that we created to certify physicians and providers who know how to...
Identify symptoms for varying cancer, because unfortunately not all of this is just women symptoms. Many times, women go to the physicians appropriately because they know that what they are experiencing is not normal, and that provider checks out this area, and clears that up. But unfortunately they don’t piece things together, and this delay in diagnosis continues, and this is actually a very persistent problem, and something that a lot of women feel so passionate about that we started this whole program where we are doing a lot of Education, not just for women, but for providers to make sure they know exactly what symptoms and how to identify it, and when to refer and when to order an ultrasound. But you know, at the end of the day this should not be yet another thing that we don’t have to worry about. You know it’s important to know your body and listen to your body. It’s important to be your advocate, but at the end of the day.
we need to assure that providers also know the symptoms and know how to piece things together and take best care. But I can imagine that many providers are thinking things are common and so really having patients say, I agree that things are common, but this isn’t common for me, so I think that while you’re quite right that it’s important that providers really know the signs and symptoms, it’s also really critical that women advocate for themselves. So Elena is the first step in diagnosis getting an ultrasound or CT? What should women expect when they go to their family doctor or their gynecologist or their GI doc or somebody with these vague symptoms and we’re trying to rule out ovarian cancer. Yeah, so the important part is to be seen by a gynecologist and to do a pelvic exam. Those are always very important and there’s a lot of information that we as providers can get out of a physical examination. Pelvic examination. Second step would
be together just an ultrasound. You know cat scans and mris are usually not necessary and actually not the best test for these at all. So we would get as a trans vaginal ultrasound. And usually we would not do tumor marker unless we have two markerS called CA 125 and it is not a great test. There’s a lot of times that is falsely positives or false negative so we won’t order it always. We order it in circumstances, but only after the ultrasound. So that’s what you would expect. Great and let’s suppose you do that. You’ve been having these vague symptoms. You go to your doctor. Your doctor says, you know, maybe we ought to send you to your gynecologist. The gynecologist does a pelvic exam and a trans vaginal ultrasound, and they think that they feel something or they see something in the ovary. Now, what happens? So women with ovarian cancer, women for whom we suspect of having cancer, are managed usually by team of doctors.
You know, the gynecologist, of course plays a very important role and then works together with other colleagues like myself, who specializes in treatment and surgeries and chemotherapy for these cancers. So the point I wanted to make is how much better things are today than they have been in the past. We now truly provide personalized care. I now can do surgeries laparoscopically or robotically where women can go home the same day whereas four years ago they will stay in the hospital for a week if not longer. So surgically if you were concerned about ovarian cancer you would have a hysterectomy and then you would get a biopsy and we would look under a microscope, to try to identify the cells and that’s how a diagnosis would be made, but everything now starts from that first step where you have surgery and again now we do everything truly in the personalized fashion where most women are now great candidates for this robotic surgery and they
go home
same day and they go back to work
within a week and then extending to chemotherapy where we no longer treat
women the same way that we used to treat.
We no longer treat somebody the
same way just because they have
the same cancer as somebody else.
We truly study
their mutations and truly understand what
is driving and causing the cancer in
particular women,
and then the treatment that we recommend
and then we provide is
based specifically on that.
So we use a lot of targeted therapies.
We use a lot of pills nowadays.
You know some chemotherapies are still through IV how they used to be.
But a lot of them now are just oral pills that you don’t even have
to come into the office to get.
You can get from home.
There’s immunotherapy.
There’s a lot of these targeted achievements,
again specifically for that patient,
and I think that’s the key to success.
And more and more of these cancers are going to be cured.
So that’s really encouraging.
0:24:39.46 –> 0:24:41.917 so at the point where you’ve gone
0:24:41.917 –> 0:24:43.814 to the gynecologist, they felt
0:24:43.814 –> 0:24:45.924 something they’ve done an ultrasound.
0:24:45.93 –> 0:24:48.1 in many of the cancers
0:24:48.1 –> 0:24:50.408 that we talk about on this show,
0:24:50.41 –> 0:24:52.33 the next step is a biopsy,
0:24:52.33 –> 0:24:54.402 but it sounds like that might not
0:24:54.402 –> 0:24:56.807 always be the case in ovarian cancer.
0:24:56.81 –> 0:24:57.695 Is that right?
0:24:57.695 –> 0:25:00.33 Do we always get a biopsy before surgery?
0:25:00.33 –> 0:25:02.89 Or do we kind of sometimes just say,
0:25:02.89 –> 0:25:05.45 well you’re at a certain age.
0:25:05.45 –> 0:25:07.12 You can have a hysterectomy
0:25:07.12 –> 0:25:08.79 instead and that will accomplish
0:25:08.855 –> 0:25:10.25 two goals with one stone.
0:25:10.25 –> 0:25:11.53 How does that work?
0:25:11.53 –> 0:25:12.49 That’s an excellent
0:25:12.49 –> 0:25:13.77 question because
0:25:13.77 –> 0:25:15.37 in many other cancers
0:25:15.37 –> 0:25:17.61 we would not proceed to surgery directly.
0:25:17.61 –> 0:25:20.546 We usually will try to get a biopsy.
0:25:20.55 –> 0:25:22.855 Ovarian cancer is the exception
0:25:22.855 –> 0:25:25.631 to that because of where the
0:25:25.631 –> 0:25:27.959 ovaries are and how they are.
0:25:27.96 –> 0:25:30.105 We never biopsy ovaries because
0:25:30.105 –> 0:25:32.25 you can rupture an ovary and
0:25:32.323 –> 0:25:34.939 potentially you can make that worse
0:25:34.94 –> 0:25:37.12 if cancer cells are present,
0:25:37.12 –> 0:25:39.731 so most of the time if something
0:25:39.731 –> 0:25:42.021 looks suspicious on the ultrasound
0:25:42.021 –> 0:25:43.659 and pelvic examination,
If women get a cat scan and MRI, or there's some sort of imaging that shows us especially suspicious, we would just remove it. We would just take out the ovary and then be able to look at it at the microscope directly without the biopsy. And so when that’s done, is a hysterectomy always done at the same time? Or does it matter where the woman is in her life cycle? So young woman versus an older woman, for example? Or is that just part and parcel of the same surgery? Exactly the same as what we talked before, everything is truly individualized. I have a lot of women in their 30s who have had this diagnosis and I would never remove the ovaries. I always allow them to continue how it was meant to be, and we certainly can do a lot of these surgeries and remove that normal ovary other things that we have to remove, but allow them to continue their normal lives and have normal fertility and be able to carry pregnancies.
0:26:48.38 –> 0:26:50.3 There’s times where that’s not possible,
0:26:50.3 –> 0:26:53.288 but most times with the young
0:26:53.288 –> 0:26:56.057 women we find a way to make it happen.
0:26:56.06 –> 0:26:58.09 If the woman is older
0:26:58.09 –> 0:27:00.785 then yes,
0:27:00.79 –> 0:27:03.233 of course we would remove the uterus
0:27:03.233 –> 0:27:05.81 as well and do a total hysterectomy
0:27:05.81 –> 0:27:07.74 but not the younger women.
0:27:07.74 –> 0:27:10.435 And so when you do that surgery,
0:27:10.44 –> 0:27:12.684 you had mentioned
0:27:12.684 –> 0:27:15.043 that many of these
0:27:15.043 –> 0:27:16.998 cancers are not caught early
0:27:17 –> 0:27:19.082 unfortunately and that’s one of the
0:27:19.082 –> 0:27:21.815 things that leads to the high mortality
0:27:23.95 –> 0:27:26.194 How many of these cancers have
0:27:26.194 –> 0:27:28.182 spread outside the ovary when
0:27:28.182 –> 0:27:29.866 their first diagnosed?
0:27:29.87 –> 0:27:32.294 What impact does that have in
0:27:32.294 –> 0:27:34.77 terms of treatment and prognosis?
0:27:36.07 –> 0:27:38.828 So at this point a lot of them,
0:27:38.83 –> 0:27:41.818 the great majority of them 75% or so
0:27:41.818 –> 0:27:44.33 spread to outside of the ovary at
0:27:44.414 –> 0:27:47.046 the time of diagnosis and because of
0:27:47.046 –> 0:27:49.676 that once we complete their surgery
0:27:49.676 –> 0:27:53.001 women need some sort of additional
0:27:53.01 –> 0:27:55.285 treatment which is usually chemotherapy
0:27:55.285 –> 0:27:58.434 or some sort of targeted therapy but
0:27:58.434 –> 0:28:00.822 myself among with many other experts
0:28:00.822 –> 0:28:03.888 who now spend so much of our
0:28:03.888 –> 0:28:06.406 time just doing surgery and not
0:28:06.406 –> 0:28:08.37 just doing chemotherapy, but really
0:28:08.37 –> 0:28:11.1 providing education to women.
0:28:14.53 –> 0:28:16.588 The future will be that more and
0:28:16.588 –> 0:28:18.747 more of these cancers will be
0:28:18.747 –> 0:28:20.355 found earlier and localized and
0:28:20.36 –> 0:28:23.104 surgery will be able to cure them.
0:28:23.11 –> 0:28:24.109 The key again,
0:28:24.109 –> 0:28:26.107 is just knowing your body and
0:28:26.107 –> 0:28:28.212 listening to your body and then
0:28:28.212 –> 0:28:30.318 seeing the physicians and seeing the
0:28:30.318 –> 0:28:32.37 providers and getting the
0:28:32.37 –> 0:28:35.184 care that you deserve, not turning away.
0:28:44.192 –> 0:28:46.53 And with that more and more of
0:28:46.604 –> 0:28:48.872 these cancers will be found early
0:28:48.872 –> 0:28:50.384 and the nature of
0:28:50.39 –> 0:28:51.738 this disease will change.
0:28:51.738 –> 0:28:53.76 Doctor Elena Ratner is an associate
0:28:53.824 –> 0:28:56.146 professor in the Department of obstetrics,
0:28:56.15 –> 0:28:57.59 gynecology, and Reproductive Sciences
0:28:57.59 –> 0:28:59.75 at the Yale School of Medicine.
0:28:59.75 –> 0:29:01.194 If you have questions,
0:29:01.194 –> 0:29:02.638 the address is canceranswers@yale.edu
0:29:02.638 –> 0:29:04.634 and past editions of the program
0:29:04.634 –> 0:29:06.458 are available in audio and written
0:29:06.51 –> 0:29:08.028 form at Yalecancercenter.org.
0:29:08.03 –> 0:29:10.946 We hope you’ll join us next week to learn
0:29:10.946 –> 0:29:13.54 more about the fight against cancer.
0:29:13.54 –> 0:29:15.864 Here on Connecticut public radio.