Support for Yale Cancer Answers comes from AstraZeneca providing important treatment options for women living with advanced ovarian cancer. Learn more at astrazeneca-us.com.

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 it 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 02:13:189 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
0:04:35.634 –> 0:04:37.72 news about the BRCA gene mutation over
0:04:37.72 –> 0:04:40.06 the past five years or so,
0:04:40.06 –> 0:04:41.23 as you remember,
0:04:41.23 –> 0:04:42.01 Angelina Jolie,
0:04:42.01 –> 0:04:44.086 who has one of these mutations
0:04:44.086 –> 0:04:46.446 and a number of different
0:04:46.446 –> 0:04:48.246 New York Times Editorials,
0:04:48.25 –> 0:04:49.81 talking about her experience
0:04:49.81 –> 0:04:50.98 with the Mutation.
0:04:50.98 –> 0:04:53.71 So it’s called the Angelina Jolie effect.
0:04:53.71 –> 0:04:56.286 And now there’s much more known about
0:04:56.286 –> 0:04:58.886 this mutation and about how women with
0:04:58.886 –> 0:05:01.538 this mutation have a higher risk of
0:05:01.538 –> 0:05:04.238 developing ovarian cancer and breast cancer,
0:05:04.24 –> 0:05:04.956 for example.
0:05:04.956 –> 0:05:06.746 But there’s a mutation is
0:05:06.746 –> 0:05:09.04 just one of those mutations.
0:05:09.04 –> 0:05:11.025 There’s many other mutations that
0:05:11.025 –> 0:05:13.57 predispose you to getting these cancers.
0:05:13.57 –> 0:05:16.286 That’s why nowadays it is so important
0:05:16.286 –> 0:05:19.435 to know your family history and to
0:05:19.435 –> 0:05:22.771 know where you come from and to know
0:05:22.771 –> 0:05:25.021 what possible genetic mutations you
0:05:25.021 –> 0:05:27.578 might have that might predispose you
0:05:27.578 –> 0:05:30.05 to having higher risk of different
0:05:30.05 –> 0:05:32.11 cancers. In particular, ovarian cancer.
0:05:32.11 –> 0:05:34.17 So that’s important.
0:05:34.17 –> 0:05:36.564 But you know, for women who may
0:05:36.564 –> 0:05:39.175 not have a BRCA gene mutation
0:05:39.175 –> 0:05:41.511 running in their family, or
0:05:41.511 –> 0:05:44.159 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 there are 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.
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.

All great information.

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 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. 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, 89% of women with stage one and two cancers will also have 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 are 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.

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. 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 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 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. I want to take a step back though,
so at the point where you’ve gone to the gynecologist, they felt something they’ve done an ultrasound. In many of the cancers we talk about on this show, the next step is a biopsy, but it sounds like that might not always be the case in ovarian cancer. Is that right? Do we always get a biopsy before surgery? Or do we kind of sometimes just say, well you’re at a certain age. You can have a hysterectomy instead and that will accomplish two goals with one stone. How does that work? That’s an excellent question because in many other cancers we would not proceed to surgery directly. We usually will try to get a biopsy. Ovarian cancer is the exception to that because of where the ovaries are and how they are. We never biopsy ovaries because you can rupture an ovary and potentially you can make that worse if cancer cells are present, so most of the time if something looks suspicious on the ultrasound and pelvic examination,
0:25:43.66 --> 0:25:47.575 or if women get a cat scan and MRI,  
0:25:47.58 --> 0:25:50.13 or there’s some sort of imaging  
0:25:50.13 --> 0:25:52.75 that shows us especially suspicious  
0:25:52.75 --> 0:25:54.736 we would just remove it.  
0:25:54.74 --> 0:25:56.896 We would just take out the ovary  
0:25:56.896 --> 0:25:59.295 and then be able to look at  
0:25:59.295 --> 0:26:01.045 it at the microscope directly  
0:26:01.05 --> 0:26:02.046 without the biopsy.  
0:26:02.046 --> 0:26:03.706 And so when that’s done,  
0:26:03.71 --> 0:26:05.034 is a hysterectomy always  
0:26:05.034 --> 0:26:06.689 done at the same time?  
0:26:06.69 --> 0:26:08.556 Or does it matter where the  
0:26:08.556 --> 0:26:10.68 woman is in her life cycle?  
0:26:10.68 --> 0:26:12.335 So young woman versus an  
0:26:12.335 --> 0:26:13.672 older woman, for example?  
0:26:13.672 --> 0:26:16.65 Or is that just part and parcel of the  
0:26:16.65 --> 0:26:17.568 same surgery?  
0:26:17.568 --> 0:26:20.639 Exactly the same as what we talked before,  
0:26:20.64 --> 0:26:22.08 everything is truly individualized.  
0:26:22.08 --> 0:26:24.632 I have a lot of women in their  
0:26:24.632 --> 0:26:26.618 30s who have had this diagnosis  
0:26:26.62 --> 0:26:28.86 and I would never remove the ovaries  
0:26:28.86 --> 0:26:31.42 I always allow them to continue  
0:26:31.42 --> 0:26:33.66 how it was meant to be,  
0:26:33.66 --> 0:26:36.27 and we certainly can do a lot of these  
0:26:36.27 --> 0:26:38.351 surgeries and  
0:26:38.351 --> 0:26:40.448 remove that normal ovary  
0:26:40.448 --> 0:26:42.618 other things that we have to remove,  
0:26:42.62 --> 0:26:44.396 but allow them to continue their  
0:26:44.396 --> 0:26:46.321 normal lives and have normal fertility  
0:26:46.321 --> 0:26:48.373 and be able to carry pregnancies.
There’s times where that’s not possible, but most times with the young women we find a way to make it happen. If the woman is older then yes, of course we would remove the uterus as well and do a total hysterectomy but not the younger women. And so when you do that surgery, you had mentioned that many of these cancers are not caught early unfortunately and that’s one of the things that leads to the high mortality rate associated with ovarian cancer. How many of these cancers have spread outside the ovary when their first diagnosed? What impact does that have in terms of treatment and prognosis? So at this point a lot of them, the great majority of them 75% or so spread to outside of the ovary at the time of diagnosis and because of that once we complete their surgery women need some sort of additional treatment which is usually chemotherapy or some sort of targeted therapy but myself among with many other experts who now spend so much of our time just doing surgery and not
just doing chemotherapy, but really providing education to women. The future will be that more and more of these cancers will be found earlier and localized and surgery will be able to cure them. The key again, is just knowing your body and listening to your body and then seeing the physicians and seeing the providers and getting the care that you deserve, not turning away.

And with that more and more of these cancers will be found early and the nature of this disease will change.

Doctor Elena Ratner is an associate professor in the Department of obstetrics, gynecology, and Reproductive Sciences at the Yale School of Medicine. If you have questions, the address is canceranswers@yale.edu and past editions of the program are available in audio and written form at Yaleyalecancercenter.org. We hope you’ll join us next week to learn more about the fight against cancer. Here on Connecticut public radio.