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 pancreatic cancer with Doctor Jeremy Kortmansky.

Doctor Kortmansky is an associate professor of clinical medicine in medical oncology at the Yale School of Medicine where Doctor Chagpar is a professor of surgical oncology.

So Jeremy, I think we all hear about pancreatic cancer when it affects celebrities, right? So whether it was Steve Jobs or other stars we hear about pancreatic cancer, once in a blue moon. It doesn’t seem to be a terribly common cancer.

Can you tell us a little bit more about how frequently
pancreatic cancer is diagnosed?
How many people get it?
And who really are the people that it most affects?
Yes, pancreatic cancer is actually becoming an increasingly more common cancer that we see. It’s now the 5th leading cause of cancer in the United States, at about 60,000 new cases a year. So we’re not only seeing increasing numbers, but also really moving up the rank of how often we see it.

And you know it’s interesting you brought up Steve Jobs and other celebrities. Most recently, I think Alex Trebek is one and it’s important to make distinctions when we talk about pancreatic cancer, there’s two main types there pancreatic adenocarcinoma, which is by far the more common one that is the disease that we’re talking about when we think about 60,000 cases per year. And then there are pancreatic neuroendocrine tumors, which are a lot less common. They are only seen in a few thousand patients a year, and it’s important to make the distinction because
they behave very differently and their treatments are very different. So, let’s start with pancreatic adenocarcinoma, because I think that most people, when they use the term generically pancreatic cancer that tends to be what they’re referring to. Although your point is well taken with regards to neuroendocrine tumors, but tell us a little bit more about who gets these cancers. I mean, what are the risk factors? So I think like other cancers, smoking is a common risk factor. But tell us a little bit more about who gets these cancers. I mean, what are the risk factors? Smoking is a common risk factor. It can be related to problems that cause chronic inflammation of the pancreas so alcoholism can lead to pancreas cancer. Chronic gallstone disease can, although that’s much less common. Obesity can be a risk factor as well. And then there is some question of the relationship with diabetes and whether diabetes could be a risk factor or whether the disease itself causes the diabetes. And that’s something that’s still being worked out. And then there is a smaller percentage of patients where it’s hereditary cancer. There are some genetic abnormalities.
that we know of that are associated with pancreas cancer and one that is of recent importance is its relation to the BRCA gene, which is a gene that we most often think about with breast and ovarian cancer syndromes, but is also related to pancreas cancer as well, and that has had some recent implications on treatment. So when we think about these risk factors, I’m thinking about a very good friend of mine who actually was diagnosed with pancreatic cancer just over Thanksgiving. And who didn’t fit any of those categories. She had no family history. She is skinny, like a rail, she doesn’t have diabetes, doesn’t drink, doesn’t have gallstones. You know, in those people where they don’t seem to have any of the common risk factors that you think about for pancreatic cancer, does that tell us anything about the biology of their disease? I mean, are there other things that we can think of in terms of their risk factors, and does that
0:05:18.108 –> 0:05:20.46 have anything to
do with their prognosis?
0:05:20.549 –> 0:05:22.637 I think that those are
all very good questions.
0:05:23.99 –> 0:05:26.165 There are risk
factors that we can identify and
0:05:26.165 –> 0:05:27.905 then there are patients who get
cancer for really no good reason.
0:05:27.91 –> 0:05:30.22 And those are people that
0:05:30.22 –> 0:05:32.767 we are still trying to maybe figure
out whether there was something
hereditary or environmental or some
other factor that we just haven’t
identified yet that played a role.
0:05:35.527 –> 0:05:38.377 When it comes to pancreas cancer,
0:05:38.38 –> 0:06:05.18 otherwise how you got it,
0:06:05.18 –> 0:06:06.96 except in in certain circumstances,
0:06:06.96 –> 0:06:08.74 like the BRCA gene but,
0:06:08.74 –> 0:06:11.302 otherwise how you got it doesn’t
play as much of a role into how we
might think about treating it or
0:06:11.302 –> 0:06:14.633 how we might expect it to behave.
0:06:14.633 –> 0:06:16.791 So the the other question is,
0:06:16.791 –> 0:06:19.059 being the fifth most common cancer
0:06:19.059 –> 0:06:24.588 Breast cancer, prostate cancer,
0:06:24.588 –> 0:06:33.262 colon cancer for all of these,
0:06:33.262 –> 0:06:36.45 and we think about the list right?
0:06:36.45 –> 0:06:40.54 more commonly diagnosed cancers,
0:06:40.54 –> 0:06:42.636 there’s a screening test we
0:06:42.636 –> 0:06:45.256 can find these cancers early.
Is there a screening test for pancreatic cancer?

There isn’t a good or routine screening test for pancreas cancer.

I think that we know that there are some patients that have been discovered to have either a family history or patients that have been found to have pancreatic cysts on their imaging that may have been obtained for some other reason that we can follow and certainly here at Yale, we have an excellent screening program where we can refer patients to our gastroenterologists who can perform screening procedures, but that’s really identifying those who are already at a heightened risk and not for the whole population like we think about with colonoscopies for colon cancer or mammograms for breast cancer, it’s really an already pre determined population because the screening includes much more advanced or invasive testing like MRI's or endoscopic ultrasound. So it’s a much more complex way to follow patients. And so without a screening test for asymptomatic people who otherwise, haven’t had any
abnormality that’s been found

incidentally, what are the ways in which they present?

How is it that somebody cues into the fact that, Oh my gosh, this could be a pancreatic cancer. What are the symptoms and signs to look for?

I again think this is an area that becomes challenging that the symptoms that people have, at least initially can often be vague. There can be some discomfort in the abdomen, with eating, sometimes increased belching, or increased gas may be a symptom.

Things that are very easily attributable to something else until the symptoms become more significant. Sometimes people present without any symptoms but develop jaundice, they notice yellowing of their eyes or their skin, which certainly tips them off, their families that there’s something going on that requires further evaluation.

But because these symptoms can sometimes be vague, they can also be attributed to the much more common problems that we see, irritable bowel or reflux which can
lead to delays in making a diagnosis.
And so I mean that really gets to the crux of the issue, right?
Is that without screening and with the symptoms that are incredibly vague, I would surmise that the vast majority of patients who present with pancreatic cancer present at a more advanced stage so talk about the stage distribution that you see in terms of the proportion of patients who present with early versus late stage disease and what the implications are in terms of prognosis.
People often think about staging for cancer with the usual stage one, two, three or four. When I think about pancreas cancer, I really try to think about it in terms of its clinical presentations and so there are patients that have resectable disease, meaning that a surgeon could go in there at the time of diagnosis and take it out. There are patients that have locally advanced but unresectable disease, meaning that it hasn’t spread to other parts of the body, but it’s involving the nearby blood vessels, and you can’t safely take it out.
And then patients with metastatic disease where it’s spread to other places in the body. So the number or the percentage of patients that can have surgery at the time of their diagnosis is really only about 15 to 20%. It’s a relatively low number and the other 80% sort of evenly distributed are either locally advanced or metastatic disease at the time of their diagnosis. And so it was with my friend who was diagnosed with a locally advanced, unresectable pancreatic cancer that was encasing important blood vessels, so she certainly wasn’t a candidate for surgery at the time of her presentation, so it sounds like if patients are fortunate enough to be resectable at the time of their presentation, would surgery be the primary modality upfront? That is a great question, and one that we are still trying to figure out. I think that there is clearly a standard paradigm of doing surgery followed by chemotherapy for about six months afterwards.
There is a lot of interest in giving chemotherapy prior to surgery or giving part of the chemotherapy, then surgery, and then chemotherapy after. And in fact, here at Smilow we have a clinical trial which is really looking at that question of perioperative chemotherapy. How do patients do getting some of the chemotherapy treatments before surgery, and then some after? And how that might compare to those who get surgery 1st and then chemotherapy later? And so this kind of brings us to the question of, well, how effective is the chemotherapy? Because, I can imagine that many of the people who are listening to this show are thinking, if I have a cancer and you can take this cancer out and you can get it out of my body, for many people the simple logic is that might be better than having a chemotherapy, which may or may not work and they often have some trepidation about cancer spreading and then making it unresectable. So how effective is chemotherapy that we could potentially use it in a neoadjuvant fashion to potentially
even shrink the cancer and get some systemic control prior to resecting it? So our newer chemotherapy regiments are good, they’re not great, but they are good and they can shrink the disease for some and control the microscopic disease that might be floating around for others. I think that the challenge ultimately is that even with surgery, the risk of pancreatic cancer coming back because it has already shed these microscopic cells is very high, and so by giving chemotherapy we are hopefully attacking some of those microscopic cells that are floating around, but also making sure that putting somebody through what would be a very major operation is ultimately the right thing to do. So many complicating moving parts in the management of pancreatic cancer and we’re going to learn much more about all of that right after we take a short break for a medical minute. Please stay tuned to learn more about pancreatic cancer with my guest Doctor Jeremy Kortmansky. Support for Yale Cancer Answers comes from AstraZeneca providing important treatment options
This is a medical minute about head and neck cancers, although the percentage of oral and head and neck cancer patients in the United States is only about 5% of all diagnosed cancers. There are challenging side effects associated with these types of cancer and their treatment. Clinical trials are currently underway to test innovative new treatments for head and neck cancers, and in many cases less radical surgeries are able to preserve nerves, arteries and muscles in the neck, enabling patients to move, speak, breathe, and eat normally after surgery. 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 am joined tonight by my guest doctor Jeremy Kortmansky. We're talking about pancreatic cancer and Jeremy right before the break, you had indicated to us that you really think...
as whether things are resectable at the time of presentation or unresectable, but not metastatic or metastatic and sadly, 80% of patients or so fall into the last two buckets. And you know, that’s really unfortunate, because what is the prognosis for patients who have locally advanced unresectable disease at presentation? And what is the prognosis for patients who present with metastatic disease? For those patients who have advanced disease, unfortunately we view those as incurable cancers. We can’t make it go away and never come back. For patients that have locally advanced disease on occasion and it’s not the expectation, but on occasion they have a great response to the chemotherapy and we can revisit that question of surgery but without surgery, ultimately, patients succumb to their disease and the goals of our treatment are to control the disease for as long as possible. Help people live as long as possible and feel as well as possible knowing that the disease can be symptomatic as well.
For people who are listening to this and who may have had friends or even seen celebrities go through their own journeys with pancreatic cancer, when we say the goal is really to try to control the cancer for as long as possible and the quality of life for as long as possible, in some cancers we've discussed on this show, medical management has come a really long way such that even in those settings, people live for a long time and they talk about this being incurable, but really making it more of a chronic disease then something that is imminently fatal. Where are we in the spectrum of pancreatic cancer towards getting to oK, so I've got pancreatic cancer and I know that I can't get rid of it, but I can live with it versus this is something that is more of an imminent concern.
It’s still a very challenging disease and there are for a lot of other cancers, a lot of exciting new therapies and immunotherapy’s
that have become available.

But for pancreas cancer, the majority of patients are still treated with versions of chemotherapy and those chemotherapy drugs are modest. There are some who are exceptional responders. People who do really well for a long time, but for the majority of patients, the survival is still only measured in in months or years. And doing better and finding better therapies is of such great importance for this disease. I think we are really hoping and trying every day to find therapies that are better than what we have currently. Do we have any factors that can predict who is going to respond better to chemotherapy versus not? So we are still trying to figure that out. I had mentioned earlier, patients that have a BRCA mutation or a similar type mutation, we find that they are more sensitive to platinum based chemotherapy. A drug like oxaliplatin or cisplatin. And that we can see better responses there that can sometimes last longer than we might see with a patient who
doesn’t have one of those abnormalities.

We know that there is a class of drugs called PARP inhibitors, which for this mutated population can benefit from this targeted therapy. At the end of the day, that only makes up about 7% of the patients that we see. So it’s still not a not a big number and we know about 1% have another abnormality, called microsatellite instability, for which immunotherapy drugs have been helpful.

And so we always test for that. But again, it’s one out of 100 that we see. So the majority of the patients that we take care of are still treated similarly with these more generic chemotherapy programs with a strong emphasis in trying to encourage patients to participate in clinical trials that can help us move the field. And I want to get into the clinical trials in a minute. But before we get there, if you’re treated with standard chemotherapy and all of the side effects that go along with that, knowing that you’re presented with a locally advanced, unresectable or metastatic cancer, what is really the efficacy
0:22:30.568 → 0:22:32.89 of these chemotherapies?
0:22:32.29 → 0:22:35.562 I mean, how do patients balance the risk
0:22:35.562 → 0:22:39.416 and the benefit of the therapy?
0:22:39.416 → 0:22:41.881 Is this something that for
0:22:41.881 → 0:22:45.028 some patients the therapy is
0:22:45.028 → 0:22:47.638 worse than the disease itself?
0:22:47.64 → 0:22:50.76 Or are these actually things that
0:22:50.76 → 0:22:53.49 are tolerable with more modern
0:22:53.49 → 0:22:56.27 day treatments and additional
0:22:56.27 → 0:22:59.87 factors that you can give patients?
0:22:59.87 → 0:23:01.622 And that has really been shown
0:23:01.622 → 0:23:03.731 to make a difference in terms of
0:23:03.731 → 0:23:05.489 both survival and quality of life.
0:23:07.23 → 0:23:10.723 My job is to make
0:23:10.723 → 0:23:12.22 the treatments tolerable.
0:23:12.22 → 0:23:14.65 When we we pick a regimen,
0:23:14.65 → 0:23:17.08 there are two common
0:23:17.08 → 0:23:18.7 regiments that we use.
0:23:18.7 → 0:23:20.75 We are already thinking about
0:23:20.75 → 0:23:23.75 what are the side effects that are
0:23:23.75 → 0:23:26.065 associated with those regimens and
0:23:26.065 → 0:23:28.198 whether the patient who’s about
0:23:28.198 → 0:23:30.846 to receive it is going to be able
0:23:30.85 → 0:23:33.685 to tolerate it based on their age and
0:23:33.69 → 0:23:35.934 other medical problems that they may
0:23:35.934 → 0:23:38.949 have and when we give the treatments,
0:23:38.95 → 0:23:42.278 we do so very carefully and we pay
0:23:42.278 → 0:23:45.487 attention to those side effects to make
0:23:45.49 → 0:23:49.081 adjustments in the dosing or give
0:23:49.081 → 0:23:51.103 supportive medications to really
0:23:51.103 → 0:23:53.896 make it as tolerable as we can.
It’s never a desired situation that the treatment is worse than the disease.

And the reality is, that for the vast majority of patients when they do start feeling poorly, it’s more often the disease than it is the treatments.

But we make sure we see patients every time before they get their treatments to review the side effects and give the right medications and give the supportive medications or dose adjustments that we need to do.

And how do we know that the chemotherapies are working?

Many patients ask about well are you going to do more blood work? Are there tumor markers? Because you had mentioned that for some patients who present without metastatic disease, that is unresectable that potentially in some of those patients, you can reassess whether they may be candidates for resection.

The best way to follow the disease is with imaging so usually a CAT scan. Sometimes an MRI or a PET scan, but usually a CAT scan gives us the level of detail that we need,
including the relationship of the tumor to the vessels nearby. For those who have locally advanced disease and there is a tumor marker that we can use as well, that can be helpful, although sometimes it is not as reliable as the scans and then also really listening to the patient. Patients can have symptoms that can be a tipoff that something is getting better or getting worse even before CAT Scan tell you what’s going on. And back to the story of my friend. She had chemotherapy as you suggested, and her tumor markers went down, which was great, but the imaging still showed that she had unresectable disease. She was quite happy to be done with chemo and really didn’t want to do much more, but was certainly interested in clinical trials. So let’s talk about clinical trials, both in that setting, after you don’t respond to standard chemotherapy as well as clinical trials that might be offered to patients upfront as new therapies are developed.
So what are you most excited about?

I think it’s interesting that you say that, I find that when I talk to a patient about a clinical trial sometimes they say to me, do you think I’m ready for a clinical trial? As if it’s something that we wait until we don’t have other options, and clinical trials are important at every phase of someone’s disease, whether they are initially diagnosed or whether they have progressed on one or two prior therapies. We are always trying to figure out what’s the best thing to do.

And so the clinical trials that we are working on that we’re excited about, I think we are still trying to find a role for immunotherapy in pancreas cancer, the same as in other diseases like lung cancer or Melanoma. But it’s been a challenge, so we are doing clinical trials that are looking at combinations as opposed to just a single drug to see if it might be better and we’re looking at clinical trials that are trying to attack not just the tumor itself, but the scar tissue in the environment around the cancer cells.
One of the challenging things about pancreas cancer is that it almost builds this protective shell around itself that can potentially make it more difficult for our treatments to get in, and so looking at drugs that can potentially eat away at that might help our more standard therapies be more effective.

Doctor Jeremy Kortmansky is an associate professor of clinical medicine in medical oncology 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 yalecancercenter.org.

We hope you’ll join us next week to learn more about the fight against cancer here on Connecticut Public Radio.