

0:00:00 -> 0:00:02.205 Support for Yale Cancer Answers  
0:00:02.205 -> 0:00:04.41 comes from AstraZeneca, a  
0:00:04.493 -> 0:00:06.493 biopharmaceutical business that is  
0:00:06.493 -> 0:00:08.993 pushing the boundaries of science  
0:00:08.993 -> 0:00:11.71 to deliver new cancer medicines.  
0:00:11.71 -> 0:00:15.17 More information at [astrazeneca-us.com](http://astrazeneca-us.com).  
0:00:15.17 -> 0:00:17.33 Welcome to Yale Cancer Answers with  
0:00:17.33 -> 0:00:19.769 your host doctor Anees Chagpar.  
0:00:19.77 -> 0:00:21.66 Yale Cancer Answers features the  
0:00:21.66 -> 0:00:23.98 latest information on cancer care by  
0:00:23.98 -> 0:00:25.468 welcoming oncologists and specialists  
0:00:25.468 -> 0:00:27.961 who are on the forefront of the  
0:00:27.961 -> 0:00:29.677 battle to fight cancer. This week,  
0:00:29.68 -> 0:00:31.57 it's a conversation about the role  
0:00:31.57 -> 0:00:33.699 of surgery in high risk ovarian  
0:00:33.699 -> 0:00:35.699 cancer with Doctor Mitchell Clark.  
0:00:35.7 -> 0:00:37.812 Doctor Clark is an assistant professor  
0:00:37.812 -> 0:00:39.983 of obstetrics and gynecology in the  
0:00:39.983 -> 0:00:41.743 division of Gynecological Oncology at  
0:00:41.743 -> 0:00:43.49 Yale University School of Medicine,  
0:00:43.49 -> 0:00:45.362 where Doctor Chagpar is  
0:00:45.362 -> 0:00:47.702 a professor of surgical oncology.  
0:00:48.05 -> 0:00:50.562 Dr. Clark, maybe we can start off by talking  
0:00:50.562 -> 0:00:52.867 a little bit about ovarian cancer.  
0:00:52.87 -> 0:00:55.518 Many people talk about this as  
0:00:55.518 -> 0:00:58.368 the cancer that whispers, tell us more about  
0:00:58.37 -> 0:00:59.318 that.  
0:00:59.318 -> 0:01:01.214 Although ovarian cancer is not the  
0:01:01.214 -> 0:01:02.694 most common gynecological cancer  
0:01:02.694 -> 0:01:04.908 that we encounter in our specialty,  
0:01:04.91 -> 0:01:07.034 it is unfortunately the cancer that

0:01:07.034 -> 0:01:08.876 accounts for the greatest morbidity  
0:01:08.876 -> 0:01:11.036 as well as the greatest mortality  
0:01:11.036 -> 0:01:13.169 among the diseases that we do treat.  
0:01:13.17 -> 0:01:15.132 You're absolutely right in saying that  
0:01:15.132 -> 0:01:17.758 this is the cancer that whispers because  
0:01:17.76 -> 0:01:19.524 unlike a lot of the other  
0:01:19.524 -> 0:01:21.659 cancers we see in our practice,  
0:01:21.66 -> 0:01:23.29 the symptoms of ovarian cancer are  
0:01:23.29 -> 0:01:25.24 very nonspecific and often very vague.  
0:01:25.24 -> 0:01:27.501 Tell us more about  
0:01:27.501 -> 0:01:29.139 what those symptoms might be,  
0:01:29.14 -> 0:01:31.048 because I'm sure that there are  
0:01:31.048 -> 0:01:32.71 listeners out there going great,  
0:01:32.71 -> 0:01:35.104 so there's a cancer that is  
0:01:35.104 -> 0:01:36.7 potentially lethal that has  
0:01:36.778 -> 0:01:39.028 symptoms that are really vague.  
0:01:39.03 -> 0:01:41.454 How am I gonna know if I have this?  
0:01:41.46 -> 0:01:42.98 Absolutely, for  
0:01:42.98 -> 0:01:45.556 the most part, these symptoms occur as the  
0:01:45.556 -> 0:01:47.848 ovarian tumors grow and as you can imagine,  
0:01:47.85 -> 0:01:50.306 it starts off with a very small tumor  
0:01:50.306 -> 0:01:51.82 and progresses to something that  
0:01:51.82 -> 0:01:54.23 causes a lot of pressure in the pelvis.  
0:01:54.23 -> 0:01:56.358 So I tell women anytime you feel  
0:01:56.358 -> 0:01:57.927 that there's pain or pressure  
0:01:57.927 -> 0:02:00.006 in the pelvis or in the abdomen,  
0:02:00.01 -> 0:02:01.792 that's something that's concerning and should  
0:02:01.792 -> 0:02:03.958 be brought up with your gynecologist.  
0:02:03.96 -> 0:02:06.152 Beyond that, we do tell women to be  
0:02:06.152 -> 0:02:08.516 aware of any changes in their weight,  
0:02:08.52 -> 0:02:09.495 either weight loss or

0:02:09.495 -> 0:02:11.334 weight gain, and sometimes it  
0:02:11.334 -> 0:02:13.35 can be as simple as something as  
0:02:13.41 -> 0:02:15.408 bloating or a bit of constipation  
0:02:15.41 -> 0:02:17.762 that is just out of characteristic from what  
0:02:17.762 -> 0:02:20.047 they have been experiencing in the past.  
0:02:20.05 -> 0:02:22.178 We do know that ovarian cancer tends  
0:02:22.178 -> 0:02:24.678 to occur in women as they get older,  
0:02:24.68 -> 0:02:25.912 particularly those who are  
0:02:25.912 -> 0:02:26.836 past menopause.  
0:02:26.84 -> 0:02:27.139 However,  
0:02:27.139 -> 0:02:29.232 there still can be many cases of  
0:02:29.232 -> 0:02:31.143 ovarian cancer in women that are  
0:02:31.143 -> 0:02:32.713 younger than the menopausal status,  
0:02:32.72 -> 0:02:34.568 and it's important to keep this in  
0:02:34.568 -> 0:02:36.954 mind when gynecologists as well as  
0:02:36.954 -> 0:02:38.489 primary care physicians are seeing  
0:02:38.55 -> 0:02:40.44 patients with these vague symptoms.  
0:02:51.8 -> 0:02:54.312 There are some rare  
0:02:54.312 -> 0:02:57.199 types of ovarian cancer that behave very  
0:02:57.199 -> 0:02:59.817 differently than the more common types  
0:02:59.817 -> 0:03:02.33 that we see in the older population,  
0:03:02.33 -> 0:03:04.955 and these can happen in young girls.  
0:03:04.96 -> 0:03:07.72 So it is important that mothers and young  
0:03:07.72 -> 0:03:10.188 daughters present to their pediatrician  
0:03:10.188 -> 0:03:12.756 with any of these similar complaints  
0:03:12.76 -> 0:03:14.225 related to increase in abdominal  
0:03:14.225 -> 0:03:16.29 pain or a bit of bloating,  
0:03:16.29 -> 0:03:19.258 or noticing something  
0:03:19.258 -> 0:03:21.07 uncharacteristic compared to what it has  
0:03:21.07 -> 0:03:23.301 perhaps been in the past as they were  
0:03:23.301 -> 0:03:25.6 developing as an adolescent.

0:03:25.6 -> 0:03:27.34 Doctor Clark when we  
0:03:27.34 -> 0:03:29.45 think about all of these symptoms,  
0:03:29.45 -> 0:03:31.055 especially around  
0:03:31.055 -> 0:03:32.73 the holiday time, it's pretty  
0:03:32.73 -> 0:03:35.215 common to get a little  
0:03:35.215 -> 0:03:37.651 bit of weight gain or in some  
0:03:37.651 -> 0:03:39.808 of our cases a lot of weight gain,  
0:03:39.808 -> 0:03:41.65 a little bit of bloating,  
0:03:41.65 -> 0:03:43.67 a little bit of constipation.  
0:03:43.67 -> 0:03:45.567 When is there a trigger point at  
0:03:45.567 -> 0:03:47.676 which you say, this has  
0:03:47.676 -> 0:03:49.858 been going on for X amount of time,  
0:03:49.86 -> 0:03:52.004 I need to go and see the doctor,  
0:03:52.01 -> 0:03:53.618 or is it really  
0:03:53.62 -> 0:03:55.69 kinda see how it goes and if it gets  
0:03:55.69 -> 0:03:57.926 to a point that's concerning to you,  
0:03:58.198 -> 0:04:00.074 that's when you should see a doctor.  
0:04:00.08 -> 0:04:02.77 Can you give us a little bit of a clue?  
0:04:02.77 -> 0:04:04.914 Because some of these are so non specific,  
0:04:04.92 -> 0:04:06.48 I'm sure all of our listeners  
0:04:06.48 -> 0:04:07.88 are listening to this going,  
0:04:07.88 -> 0:04:09.23 yep, I've had weight gain,  
0:04:09.23 -> 0:04:10.838 I've had Constipation, I've had bloating.  
0:04:10.84 -> 0:04:11.644 Oh my God,  
0:04:11.644 -> 0:04:13.252 do I have an ovarian tumor?  
0:04:14.09 -> 0:04:16.328 This is something that we're hearing  
0:04:16.328 -> 0:04:18.188 very commonly or especially now  
0:04:18.188 -> 0:04:20.042 during Covid with many people at  
0:04:20.042 -> 0:04:21.959 home tending not to be as active,  
0:04:21.96 -> 0:04:23.928 perhaps as they were before Covid.  
0:04:23.93 -> 0:04:26.458 Many of the gyms and fitness regimens that

0:04:26.458 -> 0:04:28.369 our listeners were probably more engaged  
0:04:28.369 -> 0:04:30.82 with pre covid are just not available,  
0:04:30.82 -> 0:04:32.46 so we are finding patients  
0:04:32.46 -> 0:04:34.1 coming in with these concerns,  
0:04:34.1 -> 0:04:35.408 especially related to the  
0:04:35.408 -> 0:04:36.716 bloating and weight gain.  
0:04:36.72 -> 0:04:39.366 I tend to tell women that if they experience  
0:04:39.366 -> 0:04:41.176 these symptoms that persist despite  
0:04:41.176 -> 0:04:43.78 changes in their diet or perhaps  
0:04:43.78 -> 0:04:45.478 their level of exercise that go  
0:04:45.478 -> 0:04:47.288 beyond a few weeks to a month,  
0:04:47.29 -> 0:04:48.605 these are things that should  
0:04:48.605 -> 0:04:50.247 be brought to the attention of  
0:04:50.247 -> 0:04:51.339 their primary care doctor,  
0:04:51.34 -> 0:04:52.548 or they're gynecologist  
0:04:52.548 -> 0:04:54.058 especially because these are very  
0:04:54.058 -> 0:04:55.596 vague symptoms and I don't want  
0:04:55.596 -> 0:04:57.352 to alarm our listeners and to say  
0:04:57.352 -> 0:04:58.652 that everyone with Constipation or  
0:04:58.652 -> 0:05:00.52 everyone with a bit of bloating is  
0:05:00.52 -> 0:05:02.14 likely to have an ovarian tumor,  
0:05:02.14 -> 0:05:04.324 but I think it is important for both  
0:05:04.324 -> 0:05:06.33 the patient and the provider to keep  
0:05:06.33 -> 0:05:08.277 these things in the back of their  
0:05:08.277 -> 0:05:10.237 head as we try to identify as many  
0:05:10.24 -> 0:05:11.836 women as possible in the early stages  
0:05:11.836 -> 0:05:13.479 of this very challenging disease.  
0:05:14.05 -> 0:05:16.57 And do you find that people with  
0:05:16.57 -> 0:05:18.829 ovarian tumors tend to present with  
0:05:18.83 -> 0:05:20.846 things that may signal  
0:05:20.846 -> 0:05:22.88 a loss of ovarian function?

0:05:22.88 -> 0:05:25.463 Often times when we have tumors  
0:05:25.463 -> 0:05:28.03 in various parts of the body,  
0:05:28.03 -> 0:05:29.502 it'll affect the actual  
0:05:29.502 -> 0:05:30.974 functioning of that organ.  
0:05:30.98 -> 0:05:33.54 So when we think about ovaries and we  
0:05:33.54 -> 0:05:35.76 think about production of estrogen,  
0:05:35.76 -> 0:05:37.962 for example, people may  
0:05:37.962 -> 0:05:40.665 have hot flashes, and so on and so  
0:05:40.665 -> 0:05:43.12 forth as they go through menopause.  
0:05:43.12 -> 0:05:45.52 But with ovarian cancer, if you  
0:05:45.52 -> 0:05:46.972 don't have those symptoms,  
0:05:46.972 -> 0:05:49.4 does that mean that that's likely OK?  
0:05:49.4 -> 0:05:51.633 Or how often would you find  
0:05:51.633 -> 0:05:53.378 people presenting with an ovarian  
0:05:53.378 -> 0:05:55.183 tumor that actually presents with  
0:05:55.183 -> 0:05:57.442 things like hot flashes and vaginal  
0:05:57.442 -> 0:05:59.287 dryness and things like that?  
0:06:02.11 -> 0:06:04 For the most part, these tumors do occur in women  
0:06:04 -> 0:06:05.709 as they have exited menopause  
0:06:05.709 -> 0:06:08.013 and so the ovarian function is  
0:06:08.013 -> 0:06:09.748 already at baseline, quite low.  
0:06:09.748 -> 0:06:12.06 But even in those women who are still  
0:06:12.122 -> 0:06:14.11 having regular menstrual periods,  
0:06:14.11 -> 0:06:16.414 who are perhaps in their late  
0:06:16.414 -> 0:06:17.95 30s or early 40s?  
0:06:17.95 -> 0:06:20.351 We haven't seen as much of a  
0:06:20.351 -> 0:06:21.831 relationship between the hormonal  
0:06:21.831 -> 0:06:23.741 status in the hormonal symptoms  
0:06:23.741 -> 0:06:26.634 and a link between that in an  
0:06:26.634 -> 0:06:27.93 underlying ovarian pathology.  
0:06:27.93 -> 0:06:30.252 So so important for people

0:06:30.252 -> 0:06:32.241 to recognize that because they  
0:06:32.241 -> 0:06:34.076 may be saying to themselves,  
0:06:34.08 -> 0:06:36.378 while I'm not having  
0:06:36.38 -> 0:06:37.916 hot flashes, I'm not  
0:06:37.916 -> 0:06:39.836 having tremendous pain,  
0:06:39.84 -> 0:06:42.353 but it really is a cancer that  
0:06:42.353 -> 0:06:44.28 whispers the other question that  
0:06:44.28 -> 0:06:46.996 our listeners may have is if you've  
0:06:46.996 -> 0:06:49.436 had a history of ovarian cysts,  
0:06:49.44 -> 0:06:51.395 often times people have gone  
0:06:51.395 -> 0:06:53.35 to the gynecologist and maybe  
0:06:53.419 -> 0:06:55.509 had an ultrasound or something,  
0:06:55.51 -> 0:06:57.49 and they've been told, oh  
0:06:57.49 -> 0:06:59.07 you've got ovarian cysts.  
0:06:59.07 -> 0:07:01.44 Does that increase their risk of  
0:07:01.44 -> 0:07:03.743 ovarian cancer?  
0:07:03.743 -> 0:07:06.232 So ovarian cysts are a very normal part of every  
woman's menstrual  
0:07:06.232 -> 0:07:08.148 history and reproductive history.  
0:07:08.15 -> 0:07:10.13 Every time the cycle occurs,  
0:07:10.13 -> 0:07:13.058 a cyst develops on the ovary and should  
0:07:13.058 -> 0:07:15.259 regress after each menstrual cycle.  
0:07:15.26 -> 0:07:17.54 What's important to remember is that  
0:07:17.54 -> 0:07:20.344 as women exit menopause and are no  
0:07:20.344 -> 0:07:22.364 longer having regular menstrual periods,  
0:07:22.37 -> 0:07:24.202 cysts should not form  
0:07:24.202 -> 0:07:26.056 regularly, and they should certainly  
0:07:26.056 -> 0:07:28.15 not progress and become larger and  
0:07:28.21 -> 0:07:29.865 more complex appearing on ultrasound  
0:07:29.865 -> 0:07:31.76 or any sort of imaging.  
0:07:31.76 -> 0:07:34.397 So just because a woman has had this in

0:07:34.397 -> 0:07:36.798 the past does not necessarily mean that  
0:07:36.798 -> 0:07:40.209 she will go on to develop an ovarian cancer,  
0:07:40.21 -> 0:07:42.506 but it is important for women who do  
0:07:42.506 -> 0:07:44.63 have cysts, that may have suspicious  
0:07:44.63 -> 0:07:46.862 findings on imaging that she follows  
0:07:46.929 -> 0:07:48.639 regularly with her gynecologist to  
0:07:48.639 -> 0:07:51.364 decide if and when it merits a referral  
0:07:51.364 -> 0:07:53.73 to an oncologist for a more specialized opinion.  
0:07:53.73 -> 0:07:56.026 Are there any women who  
0:07:56.026 -> 0:07:58.161 are particularly at risk of getting  
0:07:58.161 -> 0:08:00.226 ovarian cancer, or is this kind  
0:08:00.226 -> 0:08:02.23 of an equal opportunity killer?  
0:08:02.23 -> 0:08:04.51 There are a number of risk factors that  
0:08:04.51 -> 0:08:06.885 make a woman more likely to experience  
0:08:06.885 -> 0:08:09.25 an ovarian cancer in her lifetime.  
0:08:09.25 -> 0:08:11.574 One of the strongest is family history,  
0:08:11.58 -> 0:08:13.918 and when we think of family history,  
0:08:13.92 -> 0:08:15.852 it can be divided into those women  
0:08:15.852 -> 0:08:18.468 who have a known family history of a  
0:08:18.468 -> 0:08:20.62 genetic syndrome that may make them  
0:08:20.62 -> 0:08:23.196 more likely to experience a number of  
0:08:23.196 -> 0:08:25.44 different cancers and those who are  
0:08:25.44 -> 0:08:27.315 not necessarily related to a known  
0:08:27.315 -> 0:08:28.35 genetic syndrome,  
0:08:28.35 -> 0:08:30.714 but do have family members,  
0:08:30.714 -> 0:08:32.29 grandmothers, mothers perhaps who  
0:08:32.359 -> 0:08:34.579 did experience an ovarian cancer.  
0:08:34.58 -> 0:08:36.908 And the other category would be  
0:08:36.91 -> 0:08:39.46 those that do have a known genetic  
0:08:39.46 -> 0:08:41.612 predisposition so those who are  
0:08:41.612 -> 0:08:43.874 related to the BRCA gene and many

0:08:43.874 -> 0:08:46.129 women are familiar with that genetic  
0:08:46.129 -> 0:08:48.579 syndrome as it relates to risk of  
0:08:48.58 -> 0:08:50.53 breast cancer and ovarian cancer.  
0:08:50.53 -> 0:08:52.792 But we are also understanding that  
0:08:52.792 -> 0:08:54.82 there are other hereditary cancer  
0:08:54.82 -> 0:08:56.648 syndromes like Lynch syndrome  
0:08:56.65 -> 0:08:59.282 that can also increase a woman's risk of  
0:08:59.282 -> 0:09:01.437 developing certain types of ovarian cancers,  
0:09:01.44 -> 0:09:03.96 so it is important in those women who have  
0:09:03.96 -> 0:09:06.1 strong family histories of cancers to  
0:09:06.1 -> 0:09:08.272 speak with their primary care doctor,  
0:09:08.28 -> 0:09:10.52 or if they do have an oncologist  
0:09:10.52 -> 0:09:12.04 to consider genetic testing  
0:09:12.04 -> 0:09:14.248 if it is indicated so that we can  
0:09:14.248 -> 0:09:15.955 identify those women whom perhaps  
0:09:15.955 -> 0:09:18.133 could benefit from some type of  
0:09:18.133 -> 0:09:20.069 prophylactic procedure to reduce their  
0:09:20.069 -> 0:09:21.959 risk of developing ovarian cancer  
0:09:21.96 -> 0:09:23.778 down the road.  
0:09:23.778 -> 0:09:25.921 What about women who don't have a family  
0:09:25.921 -> 0:09:27.657 history or genetic predisposition?  
0:09:27.66 -> 0:09:29.706 How common or uncommon is ovarian  
0:09:29.706 -> 0:09:31.75 cancer in those women?  
0:09:31.75 -> 0:09:33.455 In those who don't have those  
0:09:33.455 -> 0:09:34.819 strong family risk factors,  
0:09:34.82 -> 0:09:38.272 the risk is about 1 to 3% for their lifetime.  
0:09:38.272 -> 0:09:40.396 Now that's quite small in comparison  
0:09:40.396 -> 0:09:42.394 to some of the other cancers that  
0:09:42.394 -> 0:09:44.71 we see in the gynecological tract,  
0:09:44.71 -> 0:09:47.097 but the issue is that even though  
0:09:47.097 -> 0:09:49.086 it is rare, like I mentioned,

0:09:49.086 -> 0:09:50.374 being that this disease does  
0:09:50.374 -> 0:09:52.209 account for so much morbidity,  
0:09:52.21 -> 0:09:52.946 and unfortunately,  
0:09:52.946 -> 0:09:55.89 survival rates are just not as good as  
0:09:55.961 -> 0:09:58.285 they are for the other cancers.  
0:10:02.16 -> 0:10:04.757 And when we talk about  
0:10:04.757 -> 0:10:06.48 high risk ovarian cancer,  
0:10:06.48 -> 0:10:08.052 what exactly is that?  
0:10:08.052 -> 0:10:10.017 Are there certain ovarian cancers  
0:10:10.017 -> 0:10:12.717 that are more likely to result in  
0:10:12.717 -> 0:10:14.74 morbidity and mortality than others?  
0:10:14.74 -> 0:10:16.308 So as you mentioned  
0:10:16.31 -> 0:10:18.09 regarding those cancers that do  
0:10:18.09 -> 0:10:21.201 occur in the very young women,  
0:10:21.201 -> 0:10:23.306 typically are less aggressive cancers and  
0:10:23.306 -> 0:10:25.377 those younger patients do experience  
0:10:28.1 -> 0:10:30.458 the more common type of ovarian  
0:10:30.458 -> 0:10:32.388 cancers that we see,  
0:10:32.388 -> 0:10:34.894 which we call high grade  
0:10:34.894 -> 0:10:37.488 serous and this is a subtype of ovarian  
0:10:37.488 -> 0:10:39.569 cancer that is quite bad behaving,  
0:10:39.57 -> 0:10:41.574 but unfortunately is the most common  
0:10:41.574 -> 0:10:44.58 type that we see and is the one that  
0:10:44.58 -> 0:10:46.185 does present at advanced stage.  
0:10:49.83 -> 0:10:52.486 I wanted to kind  
0:10:52.486 -> 0:10:55.129 of delve a little bit more into that,  
0:10:55.13 -> 0:10:57.405 so if women present with these kind  
0:10:57.405 -> 0:10:59.423 of vague symptoms and they've  
0:10:59.423 -> 0:11:01.698 listened to this show on Yale Cancer  
0:11:01.765 -> 0:11:03.67 Answers and they've decided to  
0:11:03.67 -> 0:11:06.054 go and talk to their primary

0:11:06.054 -> 0:11:08.079 care physician or their gynecologist,  
0:11:08.08 -> 0:11:09.77 how is that worked up?  
0:11:09.77 -> 0:11:11.708 I mean, what should women expect  
0:11:11.708 -> 0:11:13.396 as they advocate for themselves  
0:11:13.396 -> 0:11:15.741 and making sure that if they have  
0:11:15.741 -> 0:11:17.568 an ovarian cancer it's found,  
0:11:17.57 -> 0:11:19.604 or at least that it's ruled out.  
0:11:20.96 -> 0:11:23.529 The thing I want to get across, and it's very  
0:11:23.529 -> 0:11:26.056 important is that we do not have any  
0:11:26.056 -> 0:11:28.076 screening test for ovarian cancer,  
0:11:28.08 -> 0:11:30.061 and so women who've had a pap  
0:11:30.061 -> 0:11:32.26 smear and a physical exam as  
0:11:32.26 -> 0:11:34.38 part of their annual assessment.  
0:11:34.38 -> 0:11:36.186 cannot necessarily be reassured that they  
0:11:36.186 -> 0:11:38.848 do not have an underlying ovarian cancer,  
0:11:38.85 -> 0:11:41.167 so women who have these symptoms that  
0:11:41.167 -> 0:11:43.321 we've talked about should expect their  
0:11:43.321 -> 0:11:45.883 doctor to perform a very thorough physical  
0:11:45.951 -> 0:11:48.135 exam that does include a pelvic exam,  
0:11:48.14 -> 0:11:49.86 and then usually this is  
0:11:49.86 -> 0:11:51.58 followed up with some imaging,  
0:11:51.58 -> 0:11:54.002 either by ultrasound or CT scan in  
0:11:54.002 -> 0:11:55.732 conjunction with some blood tests  
0:11:55.732 -> 0:11:57.937 that may help point their doctor in  
0:11:57.937 -> 0:12:00.464 the direction that this may be an  
0:12:00.464 -> 0:12:02.244 ovarian cancer that requires evaluation  
0:12:02.244 -> 0:12:03.62 by a gynecological oncologist, and  
0:12:03.62 -> 0:12:05.156 so women who are in  
0:12:05.156 -> 0:12:07.076 the High risk group,  
0:12:07.08 -> 0:12:09.426 so those women who have a  
0:12:09.426 -> 0:12:10.99 very strong family history,

0:12:10.99 -> 0:12:13.72 the women who have a genetic predisposition,  
0:12:15.68 -> 0:12:18.41 people who are at very high risk,  
0:12:18.41 -> 0:12:20.365 there are some more advanced  
0:12:20.365 -> 0:12:21.147 screening techniques.  
0:12:21.15 -> 0:12:22.73 There's nothing for ovarian  
0:12:22.73 -> 0:12:25.1 cancer in terms of blood tests  
0:12:25.177 -> 0:12:27.017 or routine CT or ultrasound  
0:12:27.02 -> 0:12:27.8 evaluations  
0:12:27.8 -> 0:12:29.75 despite several large international trials,  
0:12:29.75 -> 0:12:32.726 we have not been able to identify a  
0:12:32.726 -> 0:12:35.527 modality of screening that has shown  
0:12:35.53 -> 0:12:38.036 to reduce the incidence of this cancer,  
0:12:38.04 -> 0:12:40.238 or to identify at a stage where  
0:12:40.238 -> 0:12:42.494 we could intervene and make a  
0:12:42.494 -> 0:12:44.15 significant difference in outcomes.  
0:12:44.15 -> 0:12:45.402 Having said that, however,  
0:12:45.402 -> 0:12:48.093 those women who do know that they harbor  
0:12:48.093 -> 0:12:49.597 an underlying genetic predisposition  
0:12:49.597 -> 0:12:52.287 to cancer like the BRCA gene,  
0:12:52.287 -> 0:12:54.167 or Lynch syndrome, should  
0:12:54.167 -> 0:12:55.937 follow regularly with a gynecologist  
0:12:55.937 -> 0:12:59.131 who can talk to them about some of the  
0:12:59.131 -> 0:13:01.375 increased surveillance that we can do,  
0:13:01.38 -> 0:13:03.25 or perhaps intervention through surgical  
0:13:03.25 -> 0:13:05.64 removal of the tubes and ovaries.  
0:13:05.64 -> 0:13:07.962 At a stage prior to the development of a  
0:13:07.962 -> 0:13:10.113 cancer that may be appropriate depending  
0:13:10.113 -> 0:13:12.49 on the person's underlying genetic mutation.  
0:13:13.84 -> 0:13:16.336 Yeah, so you're talking about  
0:13:16.336 -> 0:13:18.778 removing the ovaries and the tubes  
0:13:18.778 -> 0:13:21.228 before they get a cancer to reduce

0:13:21.228 -> 0:13:24.067 the risk that they will get a cancer.  
0:13:24.07 -> 0:13:26.73 Does it reduce the risk to zero?  
0:13:34.31 -> 0:13:35.06 Unfortunately, it  
0:13:35.06 -> 0:13:38.48 is not absolutely 0, but it is quite close.  
0:13:38.48 -> 0:13:41.52 It does bring the risk down to a  
0:13:41.52 -> 0:13:43.75 below 4%. There are some  
0:13:43.75 -> 0:13:45.97 inherent risks  
0:13:45.97 -> 0:13:47.856 related to the lining  
0:13:47.856 -> 0:13:50 of the abdomen called the peritoneum.  
0:13:50 -> 0:13:53.01 This is an area of tissue that is near to  
0:13:53.087 -> 0:13:56.095 where the ovary and tube would have been,  
0:13:56.1 -> 0:13:58.116 but after removal of tubes and ovaries  
0:13:58.116 -> 0:14:00.624 in a woman that's very high risk  
0:14:00.624 -> 0:14:02.208 given her genetic predisposition,  
0:14:02.21 -> 0:14:04.16 her risk is significantly reduced compared  
0:14:04.16 -> 0:14:07.599 to what it would have been if she had not  
0:14:07.599 -> 0:14:08.987 undergone that prophylactic procedure.  
0:14:08.99 -> 0:14:10.374 Well, that's great information  
0:14:10.374 -> 0:14:12.832 for people to know. We're going to  
0:14:12.832 -> 0:14:14.74 learn much more about the surgical  
0:14:14.74 -> 0:14:16.89 management of high risk ovarian cancer  
0:14:16.89 -> 0:14:20.607 after we take a short break for a  
0:14:20.607 -> 0:14:23.54 medical minute, please stay tuned to  
0:14:23.54 -> 0:14:25.75 learn more with my guest  
0:14:25.75 -> 0:14:27.076 Doctor Mitchell Clark.  
0:14:27.08 -> 0:14:29.035 Support for Yale Cancer Answers  
0:14:29.035 -> 0:14:30.599 comes from AstraZeneca, dedicated  
0:14:30.599 -> 0:14:32.936 to providing innovative treatment  
0:14:32.936 -> 0:14:36.081 options for people living with  
0:14:36.081 -> 0:14:36.71 cancer. Learn more at [astrazeneca-us.com](http://astrazeneca-us.com).  
0:14:36.71 -> 0:14:39.496 This is a medical minute about Melanoma.

0:14:39.5 -> 0:14:41.485 While Melanoma accounts for only  
0:14:41.485 -> 0:14:43.728 about 4% of skin cancer cases,  
0:14:43.728 -> 0:14:45.9 it causes the most skin cancer  
0:14:45.97 -> 0:14:47.85 deaths. When detected early  
0:14:47.85 -> 0:14:49.846 however, Melanoma is easily treated  
0:14:49.846 -> 0:14:51.777 and highly curable. Clinical trials  
0:14:51.777 -> 0:14:53.672 are currently underway to test  
0:14:53.672 -> 0:14:55.81 innovative new treatments for Melanoma.  
0:14:55.81 -> 0:14:57.91 The goal of the specialized  
0:14:57.91 -> 0:14:59.59 programs of research excellence  
0:14:59.59 -> 0:15:02.28 in skin cancer or SPORE grant is  
0:15:02.28 -> 0:15:04.208 to better understand the biology  
0:15:04.208 -> 0:15:06.959 of skin cancer with a focus on  
0:15:06.959 -> 0:15:09.091 discovering targets that will lead  
0:15:09.091 -> 0:15:11.326 to improved diagnosis and treatment.  
0:15:11.33 -> 0:15:13.414 More information is available  
0:15:13.414 -> 0:15:14.456 at [yalecancercenter.org](http://yalecancercenter.org).  
0:15:14.46 -> 0:15:18.516 You're listening to Connecticut Public Radio.  
0:15:18.52 -> 0:15:18.91 Welcome  
0:15:18.91 -> 0:15:20.84 back to Yale Cancer Answers.  
0:15:20.84 -> 0:15:23.185 This is doctor Anees Chagpar  
0:15:23.185 -> 0:15:25.61 and I'm joined tonight by my  
0:15:25.61 -> 0:15:27.398 guest doctor Mitchell Clark.  
0:15:27.4 -> 0:15:29.864 We're talking about the role of surgery  
0:15:29.864 -> 0:15:32.239 in high risk ovarian cancer and  
0:15:32.239 -> 0:15:34.723 right before the break Mitchell  
0:15:34.73 -> 0:15:36.858 you talked about the fact that in  
0:15:36.858 -> 0:15:39.359 women with a genetic predisposition,  
0:15:39.36 -> 0:15:41.29 even though you can remove  
0:15:41.29 -> 0:15:42.834 the tubes and ovaries,  
0:15:42.84 -> 0:15:45.928 it doesn't reduce their risk down to zero.

0:15:45.93 -> 0:15:49.01 You can still get cancer on the peritoneum.  
0:15:49.01 -> 0:15:51.386 That lining of the abdominal cavity.  
0:15:51.39 -> 0:15:53.375 Although it does reduce your  
0:15:53.375 -> 0:15:54.566 risk quite substantially,  
0:15:54.57 -> 0:15:57.756 so my next question is in women  
0:15:57.756 -> 0:16:01.34 who have been found to have ovarian cancer,  
0:16:01.34 -> 0:16:04.012 we talked a little bit about the fact  
0:16:04.012 -> 0:16:07.021 that this is a cancer that really  
0:16:07.021 -> 0:16:09.291 presents with very nonspecific symptoms.  
0:16:09.3 -> 0:16:11.29 You go to your gynecologist,  
0:16:11.29 -> 0:16:13.28 or to your family physician,  
0:16:13.28 -> 0:16:16.066 they do a thorough physical exam and  
0:16:16.066 -> 0:16:19.25 then maybe an ultrasound or a CT scan.  
0:16:19.25 -> 0:16:21.632 What happens next in terms of  
0:16:21.632 -> 0:16:22.823 making the diagnosis?  
0:16:23.68 -> 0:16:26.088 So after the results of these tests,  
0:16:26.09 -> 0:16:28.136 many patients will refer to meet  
0:16:28.136 -> 0:16:30.559 with myself or one of my colleagues  
0:16:30.559 -> 0:16:32.855 to discuss whether or not all of  
0:16:32.925 -> 0:16:35.013 the different aspects of the work  
0:16:35.013 -> 0:16:37.096 up are pointing in the direction  
0:16:37.096 -> 0:16:38.814 of an ovarian cancer. Typically,  
0:16:38.814 -> 0:16:41.566 most women will come with the CA 125,  
0:16:41.57 -> 0:16:43.705 which is a blood test that helps  
0:16:43.705 -> 0:16:45.33 us understand if the findings  
0:16:45.33 -> 0:16:47.268 on the CAT scan are consistent  
0:16:47.268 -> 0:16:49.479 with the possible ovarian cancer.  
0:16:49.48 -> 0:16:51.7 However, I do want to clarify  
0:16:51.7 -> 0:16:53.936 for our listeners that this is  
0:16:53.936 -> 0:16:55.964 not a test for ovarian cancer.  
0:16:55.97 -> 0:16:58.61 It is really just one piece of the

0:16:58.61 -> 0:17:00.328 diagnostic evaluation that we undertake  
0:17:00.328 -> 0:17:02.308 to help understand if the symptoms  
0:17:02.308 -> 0:17:04.416 are related to an ovarian cancer.  
0:17:04.42 -> 0:17:06.576 So once patients are referred to meet  
0:17:06.576 -> 0:17:08.881 with us and these results are pointing  
0:17:08.881 -> 0:17:11.86 us in the direction of an ovarian cancer,  
0:17:11.86 -> 0:17:14.857 then we have to decide whether or not this  
0:17:14.857 -> 0:17:17.595 patient is best suited by starting with us,  
0:17:17.6 -> 0:17:19.29 an operation or a surgical  
0:17:19.29 -> 0:17:20.98 removal of her ovarian cancer,  
0:17:20.98 -> 0:17:23.269 or whether or not we need to  
0:17:23.269 -> 0:17:24.83 consider starting with treatments  
0:17:24.83 -> 0:17:26.369 such as chemotherapy.  
0:17:26.37 -> 0:17:28.526 And we've really evolved over the last  
0:17:28.526 -> 0:17:31.046 five to 10 years in understanding how  
0:17:31.046 -> 0:17:33.344 to triage women to the appropriate  
0:17:33.413 -> 0:17:35.735 first step in their cancer treatment.  
0:17:35.74 -> 0:17:38.221 And how is that decision made?  
0:17:38.221 -> 0:17:40.387 So we historically would take all  
0:17:40.387 -> 0:17:42.932 women to surgery initially and there  
0:17:42.932 -> 0:17:44.788 was significant morbidity associated  
0:17:44.788 -> 0:17:47.55 with these very complex operations that  
0:17:47.55 -> 0:17:50.142 involve removing all of the different  
0:17:50.142 -> 0:17:53.022 areas of the abdomen and pelvis where  
0:17:53.022 -> 0:17:55.24 we found these cancerous tumors.  
0:17:55.24 -> 0:17:55.674 However,  
0:17:55.674 -> 0:17:57.844 now we understand through rigorous  
0:17:57.844 -> 0:17:59.58 international trials that there  
0:17:59.647 -> 0:18:01.672 are women who actually benefit  
0:18:01.672 -> 0:18:03.292 from starting with chemotherapy.  
0:18:03.723 -> 0:18:05.838 Ovarian cancer is a very

0:18:05.838 -> 0:18:08.014 chemosensitive disease, as we call it.  
0:18:08.014 -> 0:18:10 In that these cancer cells do  
0:18:10.076 -> 0:18:12.406 respond to that systemic treatment  
0:18:12.406 -> 0:18:14.736 and shrink the tumors down.  
0:18:14.74 -> 0:18:17.17 In order for surgery to be  
0:18:17.17 -> 0:18:18.79 accomplished with less morbidity  
0:18:18.859 -> 0:18:20.845 and then perhaps in the past,  
0:18:20.85 -> 0:18:23.142 just like in systemic treatment like  
0:18:23.142 -> 0:18:24.67 immunotherapy and PARP inhibition,  
0:18:24.67 -> 0:18:27.806 we're trying to do that same type of  
0:18:27.806 -> 0:18:30.017 precision medicine in surgery as well.  
0:18:30.02 -> 0:18:32.435 We want to look at each patient  
0:18:32.435 -> 0:18:34.388 very individually and assess her  
0:18:34.388 -> 0:18:36.503 underlying risk factors or underlying  
0:18:36.503 -> 0:18:38.89 health status in order to decide,  
0:18:38.89 -> 0:18:41.26 is this a patient who should  
0:18:41.26 -> 0:18:42.84 be initially operated on,  
0:18:42.84 -> 0:18:45.68 or is this a patient who for other  
0:18:45.68 -> 0:18:47.745 reasons should start with chemotherapy  
0:18:47.745 -> 0:18:50.734 and both of those options have been  
0:18:50.74 -> 0:18:52.72 found to be equally efficacious.  
0:18:52.72 -> 0:18:55.226 But oftentimes when we talk  
0:18:55.226 -> 0:18:57.46 about treating people with chemotherapy,  
0:18:57.46 -> 0:18:58.248 especially targeted  
0:18:58.248 -> 0:18:59.43 therapy and immunotherapy,  
0:18:59.43 -> 0:19:01.704 oftentimes there is a biopsy done  
0:19:01.704 -> 0:19:04.507 that'll look at the tumor and tell  
0:19:04.507 -> 0:19:06.937 us whether it has certain receptors.  
0:19:06.94 -> 0:19:08.91 For example, in breast cancer,  
0:19:08.91 -> 0:19:11.08 we talk about HER 2  
0:19:11.08 -> 0:19:13.705 which is also found in other cancers.

0:19:13.71 -> 0:19:16.032 For immunotherapy we often look at  
0:19:16.032 -> 0:19:17.83 checkpoint inhibitors PD one PDL1  
0:19:17.83 -> 0:19:21.1 and so on, but thus far in the work  
0:19:21.192 -> 0:19:24.209 up we haven't heard about a biopsy.  
0:19:24.21 -> 0:19:27.21 So how do you make that decision of,  
0:19:27.21 -> 0:19:29.262 we're going to treat  
0:19:29.262 -> 0:19:30.63 with chemotherapy versus surgery  
0:19:30.692 -> 0:19:32.46 or immunotherapy versus surgery?  
0:19:32.46 -> 0:19:35.46 And what kind of systemic therapy to use?  
0:19:35.46 -> 0:19:36.579 That's a great  
0:19:36.58 -> 0:19:39.205 point. So when patients are first considered,  
0:19:39.21 -> 0:19:40.97 whether or not they should  
0:19:40.97 -> 0:19:43.41 go down the route of surgery.  
0:19:43.41 -> 0:19:45.318 Or whether they should go down  
0:19:45.318 -> 0:19:46.59 the road of chemotherapy.  
0:19:46.59 -> 0:19:48.426 If chemotherapy is felt to be  
0:19:48.426 -> 0:19:50.409 the best option for that woman,  
0:19:50.41 -> 0:19:52 we do get a biopsy.  
0:19:52 -> 0:19:53.56 As we mentioned, most ovarian  
0:19:53.56 -> 0:19:55.49 cancers do present at advanced stage,  
0:19:55.49 -> 0:19:55.859 unfortunately,  
0:19:55.859 -> 0:19:58.442 but this does allow us to obtain  
0:19:58.442 -> 0:20:00.31 a biopsy of one of these  
0:20:00.31 -> 0:20:01.249 metastatic lesions somewhere  
0:20:01.249 -> 0:20:02.814 in the abdomen and pelvis.  
0:20:02.82 -> 0:20:04.773 In order to ensure that we do  
0:20:04.773 -> 0:20:06.28 have the correct diagnosis,  
0:20:06.28 -> 0:20:08.352 this also allows us to begin the  
0:20:08.352 -> 0:20:09.585 process of undertaking genetic  
0:20:09.585 -> 0:20:11.905 testing of the tumor so that we can  
0:20:11.905 -> 0:20:13.645 understand what types of targeted

0:20:13.645 -> 0:20:15.38 therapies may benefit this patient.  
0:20:15.38 -> 0:20:17.27 For women who go to surgery,  
0:20:17.27 -> 0:20:19.814 that tumor will be sent to our expert  
0:20:19.814 -> 0:20:21.326 pathologist during the operation so  
0:20:21.326 -> 0:20:23.645 that they can have a look under the  
0:20:23.645 -> 0:20:25.739 microscope while the patient is asleep  
0:20:25.74 -> 0:20:27.624 in order to confirm that this  
0:20:27.624 -> 0:20:28.88 is an ovarian cancer.  
0:20:28.88 -> 0:20:31.688 By the time the patient sees us in the  
0:20:31.688 -> 0:20:34.218 office with the combination of CA 125,  
0:20:34.22 -> 0:20:36.404 the CT scan images as well as  
0:20:36.404 -> 0:20:37.758 the distribution and location  
0:20:37.758 -> 0:20:39.846 of the disease on the imaging,  
0:20:39.85 -> 0:20:42.394 most times we are able to make a  
0:20:42.394 -> 0:20:44.149 presumptive diagnosis of ovarian cancer,  
0:20:44.15 -> 0:20:45.998 but you're very correct in saying  
0:20:45.998 -> 0:20:47.664 before we initiate any type  
0:20:47.664 -> 0:20:48.78 of systemic treatment,  
0:20:48.78 -> 0:20:51.097 we do ensure that we have confirmation  
0:20:51.097 -> 0:20:53.417 of the type of cancer that this is.  
0:20:55.07 -> 0:20:57.554 I want to look at both of  
0:20:57.554 -> 0:21:00.04 those arms of the tree individually.  
0:21:00.04 -> 0:21:02.357 For patients who go to surgery,  
0:21:02.36 -> 0:21:05.429 one of the things that you said was that  
0:21:05.43 -> 0:21:09.357 the surgery tends to be quite extensive.  
0:21:09.36 -> 0:21:11.754 And so walk us through what  
0:21:11.754 -> 0:21:13.57 that surgery actually looks like.  
0:21:13.57 -> 0:21:16.054 I mean, do you start by by doing a  
0:21:16.054 -> 0:21:18.569 kind of surgical biopsy of the tumor  
0:21:18.569 -> 0:21:21.29 and sending that to your pathologist?  
0:21:21.29 -> 0:21:23.397 Do you take out the whole ovary

0:21:23.397 -> 0:21:25.784 and then what are all of these  
0:21:25.784 -> 0:21:27.554 surfaces that you were talking  
0:21:27.554 -> 0:21:29.72 about that are actually removed  
0:21:29.72 -> 0:21:31.475 if the diagnosis of ovarian  
0:21:31.475 -> 0:21:32.528 cancer is confirmed?  
0:21:32.53 -> 0:21:34.98 So when women are taken to surgery,  
0:21:34.98 -> 0:21:37.708 we are trying to make the decision of  
0:21:37.708 -> 0:21:40.667 whether or not the disease can be removed  
0:21:40.67 -> 0:21:43.61 in its entirety and what I mean by that  
0:21:43.685 -> 0:21:46.557 is the goal of surgery in ovarian cancer,  
0:21:46.56 -> 0:21:48.408 whether or not that surgery happens  
0:21:48.408 -> 0:21:50.773 at the beginning of her cancer journey  
0:21:50.773 -> 0:21:52.921 or whether it happens after some  
0:21:52.921 -> 0:21:54.853 chemotherapy is to remove all of  
0:21:54.853 -> 0:21:56.363 the visible ovarian cancer tumors.  
0:21:56.37 -> 0:21:58.818 Now the ovary is open to the abdomen  
0:21:58.818 -> 0:22:00.94 and pelvis inside a woman's body,  
0:22:00.94 -> 0:22:03.103 and so these cancer cells have a  
0:22:03.103 -> 0:22:05.747 tendency to try to get out and escape  
0:22:05.747 -> 0:22:07.787 and attach to that peritoneum that  
0:22:07.787 -> 0:22:10.09 I talked about before that can land  
0:22:10.09 -> 0:22:11.995 on various surfaces  
0:22:11.995 -> 0:22:14.07 working throughout the abdomen and  
0:22:14.07 -> 0:22:16.617 pelvis and so it's important that we  
0:22:16.617 -> 0:22:18.615 review those images prior to taking  
0:22:18.615 -> 0:22:20.911 one with the surgery so that it helps  
0:22:20.911 -> 0:22:22.588 us understand how extensive an  
0:22:22.588 -> 0:22:24.671 operation might be. For some women  
0:22:24.671 -> 0:22:26.406 their surgery might include removing  
0:22:26.406 -> 0:22:28.138 the ovaries, the uterus, cervix,  
0:22:28.138 -> 0:22:29.868 as well as the omentum,

0:22:29.87 -> 0:22:32.993 which is a fat pad that lays over the bowel,  
0:22:33 -> 0:22:34.866 but for some women their  
0:22:34.866 -> 0:22:36.81 surgery may be more extensive,  
0:22:36.81 -> 0:22:38.898 including removal of perhaps the spleen,  
0:22:38.9 -> 0:22:41.436 a segment of the bowel,  
0:22:41.436 -> 0:22:43.331 every woman's cancer surgery  
0:22:43.331 -> 0:22:46.117 is very individualized to her disease.  
0:22:46.12 -> 0:22:48.95 And we take a great deal of time in ensuring  
0:22:49.019 -> 0:22:51.787 that we select patients to take to surgery  
0:22:51.79 -> 0:22:53.506 who are good candidates to have  
0:22:53.506 -> 0:22:55.569 all of the visible tumors removed.  
0:22:55.57 -> 0:22:57.574 We know from decades of research  
0:22:57.574 -> 0:22:59.94 that the only value in surgery in  
0:22:59.94 -> 0:23:02.187 ovarian cancer is when we can remove  
0:23:02.256 -> 0:23:04.188 all of the visible disease if not  
0:23:04.188 -> 0:23:05.875 down to a very tiny amount.  
0:23:05.875 -> 0:23:07.585 If we don't feel that that  
0:23:07.585 -> 0:23:09.12 can be achieved upfront,  
0:23:09.12 -> 0:23:10.98 women will be triaged to that  
0:23:10.98 -> 0:23:12.625 chemotherapy arm of the decision-making  
0:23:12.625 -> 0:23:15.04 tree so that we can shrink down  
0:23:15.04 -> 0:23:16.61 the disease at the outset.  
0:23:16.61 -> 0:23:18.938 And then perform an operation at a later  
0:23:18.938 -> 0:23:21.499 date that removes all their visible cancer.  
0:23:21.5 -> 0:23:24.108 You know when you put it that way  
0:23:24.11 -> 0:23:26.245 Doctor Clark, it sounds like the best  
0:23:26.245 -> 0:23:28.923 option for the majority of women would be  
0:23:28.923 -> 0:23:31.178 to have systemic therapy first, because  
0:23:31.178 -> 0:23:33.918 if the cancer was resectable,  
0:23:33.92 -> 0:23:36.644 having the chemotherapy first would shrink  
0:23:36.644 -> 0:23:40.059 it down and still make it resectable,

0:23:40.06 -> 0:23:41.764 if not more resectable.  
0:23:41.764 -> 0:23:45.25 And if the tumor was quite extensive,  
0:23:45.25 -> 0:23:47.99 having chemotherapy or systemic therapy  
0:23:47.99 -> 0:23:51.798 first would shrink that and make that  
0:23:51.798 -> 0:23:54.726 option of surgery more attainable so  
0:23:54.73 -> 0:23:56.858 it would seem to me that the  
0:23:56.858 -> 0:23:59.522 patients in whom surgery first was a  
0:23:59.522 -> 0:24:01.622 recommendation would be quite small.  
0:24:01.99 -> 0:24:04.902 Is that right?  
0:24:04.902 -> 0:24:07.131 Yeah, size is one of the characteristics that we look  
at in  
0:24:07.131 -> 0:24:08.921 helping decide which patients will  
0:24:08.921 -> 0:24:11.069 benefit from surgery at the outset.  
0:24:11.07 -> 0:24:13.068 For patients who have disease that  
0:24:13.068 -> 0:24:15.651 is beyond a certain size or located  
0:24:15.651 -> 0:24:17.235 in multiple different places,  
0:24:17.24 -> 0:24:19.774 we do know from research that those  
0:24:19.774 -> 0:24:21.589 patients do benefit from this  
0:24:21.59 -> 0:24:23.094 pre treatment with chemotherapy  
0:24:23.094 -> 0:24:24.974 in order to reduce  
0:24:24.98 -> 0:24:26.978 the size of their ovarian cancers,  
0:24:26.98 -> 0:24:29.66 and as we've been discussing a lot today,  
0:24:29.66 -> 0:24:31.33 most women do unfortunately present  
0:24:31.33 -> 0:24:33 with this metastatic picture,  
0:24:33 -> 0:24:35.256 and so we are finding more and more  
0:24:35.256 -> 0:24:37.67 utility in using the chemotherapy at the  
0:24:37.67 -> 0:24:40.01 outset of a patient's cancer journey.  
0:24:40.01 -> 0:24:41.907 But I just want every listener to  
0:24:41.907 -> 0:24:44.399 know if they do encounter a personal  
0:24:44.399 -> 0:24:46.019 experience with ovarian cancer,  
0:24:46.02 -> 0:24:48.03 that both options should be considered,

0:24:48.03 -> 0:24:50.473 and that's why it's so important that  
0:24:50.473 -> 0:24:51.881 gynecological oncologist is involved  
0:24:51.881 -> 0:24:54.023 in that decision making at the very  
0:24:54.023 -> 0:24:55.71 beginning of her cancer journey.  
0:24:57.13 -> 0:24:58.805 Is there a disadvantage to  
0:24:58.805 -> 0:25:00.145 pursuing systemic therapy first,  
0:25:00.15 -> 0:25:03.412 even if you have a small tumor  
0:25:03.412 -> 0:25:06.179 and it's confined to the ovary?  
0:25:06.18 -> 0:25:08.682 Would there be a disadvantage  
0:25:08.682 -> 0:25:10.86 to doing systemic therapy first,  
0:25:10.86 -> 0:25:12.985 could you avoid systemic therapy  
0:25:12.985 -> 0:25:15.53 if you had surgery first?  
0:25:15.53 -> 0:25:17.984 Ovarian cancer treatment is really a  
0:25:17.984 -> 0:25:20.21 medley of chemotherapy and surgery,  
0:25:20.21 -> 0:25:22.335 and the question is what  
0:25:22.335 -> 0:25:24.46 combination and in what order?  
0:25:24.46 -> 0:25:27.01 We do know for women that  
0:25:27.01 -> 0:25:28.71 have smaller disease burden,  
0:25:28.71 -> 0:25:31.26 that's typically confined to the ovary,  
0:25:31.26 -> 0:25:32.96 or perhaps in locations,  
0:25:32.96 -> 0:25:35.349 that would not require  
0:25:35.349 -> 0:25:36.888 multiple surgical procedures,  
0:25:36.89 -> 0:25:39.382 that they do actually have a survival  
0:25:39.382 -> 0:25:41.448 benefit to initiating their treatment  
0:25:41.448 -> 0:25:43.778 with surgery followed by chemotherapy.  
0:25:43.78 -> 0:25:45.4 On the flip side,  
0:25:45.4 -> 0:25:47.02 as we have mentioned,  
0:25:47.02 -> 0:25:48.616 those with significant amount  
0:25:48.616 -> 0:25:50.611 of disease in various locations  
0:25:50.611 -> 0:25:53.092 have been shown to benefit from  
0:25:53.092 -> 0:25:54.704 receiving the chemotherapy first.

0:25:54.71 -> 0:25:56.735 We almost never treat with  
0:25:56.735 -> 0:25:58.355 one without the other,  
0:25:58.36 -> 0:26:00.946 and this disease has been something  
0:26:00.946 -> 0:26:02.67 that has been traditionally  
0:26:02.746 -> 0:26:04.924 treated with both a combination of  
0:26:04.924 -> 0:26:07.27 those two of those two options.  
0:26:07.92 -> 0:26:09.774 And so where do you see  
0:26:09.774 -> 0:26:11.56 therapy moving in the future?  
0:26:11.56 -> 0:26:13.546 What are the exciting  
0:26:13.546 -> 0:26:14.87 developments that you've seen,  
0:26:14.87 -> 0:26:17.512 say in the last year or so?  
0:26:17.512 -> 0:26:19.122 What are the exciting things  
0:26:19.122 -> 0:26:21.11 that are coming down the pike  
0:26:21.11 -> 0:26:23.006 that women who may be facing  
0:26:23.006 -> 0:26:24.799 ovarian cancer should know about?  
0:26:25.89 -> 0:26:28.151 Well, our dream in ovarian cancer is  
0:26:28.151 -> 0:26:30.698 to see this disease detected at its  
0:26:30.698 -> 0:26:33.389 preclinical or very early stages and  
0:26:33.389 -> 0:26:35.93 the ability to detect this through a  
0:26:35.93 -> 0:26:38.268 simple blood test or screening test  
0:26:38.268 -> 0:26:39.876 would really revolutionize ovarian  
0:26:39.876 -> 0:26:41.67 cancer treatment and the experience  
0:26:41.67 -> 0:26:43.84 for patients who do face this disease.  
0:26:43.84 -> 0:26:46.367 There are many groups who are working  
0:26:46.367 -> 0:26:48.15 on developing tests like this,  
0:26:48.15 -> 0:26:50.74 but they really are in the research  
0:26:50.74 -> 0:26:53.412 setting only and until then we need to  
0:26:53.412 -> 0:26:56.119 focus on how best to manage patients  
0:26:56.12 -> 0:26:57.78 who present with advanced disease.  
0:26:57.78 -> 0:27:00.062 We've seen a number of approvals and  
0:27:00.062 -> 0:27:02.466 new drugs and new therapies in ovarian

0:27:02.466 -> 0:27:05.42 cancer just in the last one to two years.  
0:27:05.42 -> 0:27:08.399 And when we think back to 10 years ago,  
0:27:08.4 -> 0:27:09.98 the number of different treatments  
0:27:09.98 -> 0:27:12.315 that a patient would have open to  
0:27:12.315 -> 0:27:13.719 her are significantly increased,  
0:27:13.72 -> 0:27:16.401 and we're excited to be able to  
0:27:16.401 -> 0:27:18.24 offer patients treatment that can  
0:27:18.24 -> 0:27:20.704 even be taken of an oral tablet once  
0:27:20.775 -> 0:27:22.347 or twice a day at home.  
0:27:22.35 -> 0:27:24.324 That may help reduce their risk  
0:27:24.324 -> 0:27:26 of ovarian cancer coming back,  
0:27:26 -> 0:27:28.03 we even see patients who  
0:27:28.03 -> 0:27:30.21 experience ovarian cancer survival as  
0:27:30.21 -> 0:27:33.232 a chronic disease and until we can  
0:27:33.232 -> 0:27:35.147 develop a reliable screening tests  
0:27:35.147 -> 0:27:37.439 that can detect this very early,  
0:27:37.44 -> 0:27:39.822 we hope to improve outcomes and  
0:27:39.822 -> 0:27:42.35 extend survival as long as possible,  
0:27:42.35 -> 0:27:44.39 perhaps even until the next  
0:27:45.617 -> 0:27:48.48 best thing comes down the pipeline.  
0:27:48.48 -> 0:27:49.3 I mean,  
0:27:49.3 -> 0:27:50.88 it certainly sounds exciting,  
0:27:50.88 -> 0:27:52.855 especially when you think about  
0:27:52.855 -> 0:27:55.018 where we started this conversation,  
0:27:55.02 -> 0:27:58.604 which was talking about how ovarian cancer  
0:27:58.61 -> 0:28:00.515 is a disproportionate killer of  
0:28:00.515 -> 0:28:03.042 women with cancer as opposed to  
0:28:03.042 -> 0:28:04.71 other gynecologic malignancies  
0:28:04.71 -> 0:28:07.038 but the concept of finding it  
0:28:07.038 -> 0:28:09.51 early and finding new treatments,  
0:28:09.51 -> 0:28:10.818 especially oral treatments,

0:28:10.818 -> 0:28:12.126 is certainly exciting.  
0:28:12.13 -> 0:28:15.175 Which brings me to my last question,  
0:28:15.18 -> 0:28:16.936 which is,  
0:28:16.936 -> 0:28:21.13 this era of Covid has made us all think  
0:28:21.13 -> 0:28:24.052 a little bit more creatively about  
0:28:24.052 -> 0:28:27.5 how we treat patients with cancer.  
0:28:27.5 -> 0:28:29.714 Trying to avoid having them in  
0:28:29.714 -> 0:28:31.46 hospital settings and so on.  
0:28:31.46 -> 0:28:33.554 How has this affected your practice  
0:28:33.554 -> 0:28:35.354 in terms of treating patients  
0:28:35.354 -> 0:28:37.37 with ovarian cancer and what are  
0:28:37.37 -> 0:28:39.591 some of the options that women  
0:28:39.591 -> 0:28:41.496 have availed themselves of  
0:28:41.496 -> 0:28:43.34 that they may not have  
0:28:43.34 -> 0:28:46.356 previously?  
0:28:46.356 -> 0:28:48.702 I have to say, one of the saddest things to see in the  
covid  
0:28:48.702 -> 0:28:51.445 era is women who come in with delayed  
0:28:51.445 -> 0:28:54.133 diagnosis and I know that that stems  
0:28:54.14 -> 0:28:56.354 from personal concern of exposure and  
0:28:56.354 -> 0:28:58.8 going into their health care providers.  
0:28:58.8 -> 0:29:00.928 But I would encourage all women to reach  
0:29:00.928 -> 0:29:02.952 out to their practitioners in order  
0:29:02.952 -> 0:29:05.411 to establish either a telephone or a  
0:29:05.411 -> 0:29:07.451 video visit so that they can have some  
0:29:07.451 -> 0:29:09.085 time to meet with their practitioner  
0:29:09.085 -> 0:29:10.831 and discuss some of the symptoms  
0:29:10.831 -> 0:29:12.757 that we've been talking about today.  
0:29:12.76 -> 0:29:14.285 We have really revolutionized our  
0:29:14.285 -> 0:29:16.131 ability to access patients in their  
0:29:16.131 -> 0:29:17.757 home environment or in an environment

0:29:17.757 -> 0:29:19.59 that is most convenient for them,  
0:29:19.59 -> 0:29:21.732 and I hope the telephone and video  
0:29:21.732 -> 0:29:23.53 video visits will be something that  
0:29:23.53 -> 0:29:25.791 we can continue to use as we move  
0:29:25.791 -> 0:29:27.291 forward outside of the covered  
0:29:27.291 -> 0:29:29.386 area so that we can provide  
0:29:30.272 -> 0:29:32.487 really meaningful and convenient care  
0:29:32.487 -> 0:29:35.106 to people when they need it most.  
0:29:35.11 -> 0:29:35.49 Doctor  
0:29:35.49 -> 0:29:37.896 Mitchell Clark is an assistant professor  
0:29:37.896 -> 0:29:40.266 of obstetrics and gynecology in the  
0:29:40.266 -> 0:29:41.662 division of Gynecological Oncology  
0:29:41.662 -> 0:29:43.819 at the Yale School of Medicine.  
0:29:43.82 -> 0:29:45.34 If you have questions,  
0:29:45.34 -> 0:29:46.86 the address is [canceranswers@yale.edu](mailto:canceranswers@yale.edu)  
0:29:46.86 -> 0:29:48.963 and past editions of the program  
0:29:48.963 -> 0:29:50.883 are available in audio and written  
0:29:50.939 -> 0:29:52.538 form at [yalecancercenter.org](http://yalecancercenter.org).  
0:29:52.54 -> 0:29:55.308 We hope you'll join us next week to  
0:29:55.308 -> 0:29:58.013 learn more about the fight against  
0:29:58.013 -> 0:30:00.905 cancer here on Connecticut Public Radio.