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

Yale Cancer Answers features the latest information on cancer care by welcoming oncologists and specialists who are on the forefront of the battle to fight cancer. This week, it's a conversation about cancer care in the community with Doctor Anamika Katoch.

Dr Katoch is assistant professor of clinical medicine and medical oncology at the Yale School of Medicine, where Doctor Chagpar is a professor of surgical oncology.

Doctor Katoch, maybe you could start off by telling us a little bit about yourself and what it is that you do.

So I’m a hematologist oncologist, and I work out of Smilow Waterbury. It’s a small community setting we work out of a regional Cancer Center called the Harold Leever Cancer Center.

The more common cancers, of course, are more common,
so I tend to see those more than the others. But breast, lung, colon, lymphoma, and also some hematology patients. And so how common is cancer in the community? I mean when we think about cancers, very often we think about people going to large centers. New York, Boston, Houston, New Haven. But you’re in a small Community Center. So how often does cancer present in those community centers? It is surprising to see that cancer is very prevalent, and especially in the Waterbury area. I would say maybe because it has been an industrial town. And we do tend to see a lot of breast cancer. A lot of bladder cancer in this area as well. And yes, the bigger centers actually have the good fortune of having many good bigger centers around us. There’s Memorial Sloan, Dana Farber. And certainly these are very useful and helpful for us when we have particularly tough situations where we need to
get another opinion or some help.

But I would say in the general Community, cancer is fairly prevalent and so many people, because cancer really doesn’t discriminate based on where you live and many people may wonder, are there advantages and disadvantages to being treated closer to home versus going into a larger center? What would you say to people who are contemplating those decisions?

It is important, especially for certain rare cancers especially for certain rare cancers to be seen at bigger centers that tend to see a lot more of those cancers. Sarcomas being one.

They require a real multi disciplinary approach. You have to have surgeons who’ve done enough of those surgeries, trained radiation oncology team, trained chemotherapy professionals who’ve dealt enough of with that cancer.

It is always patients preference to be treated close to home and nobody wants to drive 2 hours to get treatment because you know chemotherapy, treatment is not just about chemotherapy,
it’s also about supportive care that goes with it. So we don’t just see patients on day one and say OK, now we’ll see you in three weeks. It doesn’t work like that. So we see patients on day one, we’re always available by phone. We are seeing them sometimes the very next day, sometimes within a week. Sometimes they need transfusion support. Sometimes they need transfusion support. So it is a complicated and complex process, so patients preference is always to be treated in your home and I would say that we have very robust multidisciplinary teams for almost all cancers and we also recognize that some cancers do better when they are referred out to tertiary centers, one major example being acute leukemia. It is a cancer that requires a lot of resources. A lot of support, a lot of experience and people who have acute leukemias tend to do better when they’re treated at tertiary care centers, so this is also recognizing what are your limitations. And what are the patients that
you can best serve and which patients will do better if they are referred out? And so I guess the take home message there is that if a patient has a cancer that they can be seen at a Cancer Center in their community and that Community Center will have no hesitation about referring them out to a larger center if that’s in the patients best interest. That is absolutely correct and a lot of times it is driven by physicians. Sometimes it’s driven by patients, but I have to say that patients often feel uncomfortable telling their physicians that they want to get a second opinion and part of it will also depend upon your approach to the patient, and we’re sort of very open about it. We understand that this is cancer. It can be a life changing diagnosis. So we will often say to our patients, if you would like another opinion, please let me know and I will help you get one. Sometimes people do elect to get another opinion and lots of times people say no, what you’re saying makes sense if
they’ve already developed a sense of trust and confidence in you they will stay with you and be treated close to where they live and so are there particular cancers that are particularly amenable to being treated closer to home. So you mentioned that the rare cancers might be ones where you want to seek a second opinion, but are there certain cancers that you think, if you have for example, breast cancer or colon cancer that that those really can be treated closer to where you live that you don’t necessarily need to go to a larger center. That is absolutely true. It of course depends upon the strength of your surgical staff and your surgical support, because a lot of these cancers do need surgery. So if you have a trained oncological surgeon on staff who is equipped to do these surgeries, then I think these cancers can be very well handled in the community. And what questions should patients be asking of their team of doctors if they are...
seen by a Community cancer program, what questions should they be asking in order to make the best informed decision as to where they should be treated?

That’s a good question, but can be a little bit tricky. I don’t know if patients would entirely feel comfortable sometimes asking their physicians what their experiences in treating this cancer are. And I do get that question, but very occasionally, I think it is important for patients to get involved in their care and ask these questions, and I think a lot of times people don’t ask this question because they feel that they are going to offend the physician. Which sometimes may be true, but most times is not. So I think it’s fair enough to say, Doctor, do you treat a lot of these cancers and it’s sort of a ubiquitous question. How do patients generally do? Do you think I need a second opinion? So I think these are all fair questions to ask and say, do you work with the surgeon closely? Do you know if he’s done many surgeries?
Is it possible for me to speak to someone who has gone through this process? Also, just basic questions that might help keep patients well informed. And I think that that’s so important that patients really do advocate for themselves and truthfully, many Community programs actually do have the infrastructure to be able to provide good quality care for the more common cancers. So you mentioned, for example, that you have a multidisciplinary team tell us more about how that works in the Community setting? I would say that our care, even if I say so myself, We bring most of our cases to a multidisciplinary tumor conference. So if I were to pick, let’s say, the most common cancer that we see in women, which is breast cancer. So once a woman gets a mammogram, gets a biopsy, or sees a surgeon, she is presented at a multidisciplinary tumor conference. For people who don’t know what that is, it is basically a collection of many oncologists or any
oncologists in the community.
Radiation oncology, radiology, the breast surgeons themselves, social worker, nutritionists.
So we all get together as a team and discuss the presentation of each sort of person’s cancer, and then we decide to dealing with that situation. Being most of the time, it’s standard, but things are changing. You know we were used to using, for example, chemotherapy in always the post surgical setting. But now we’re moving to using treatment sometimes upfront before surgery so not everybody is a good candidate for that. We talk about the things like that.
10% of the cancers that are diagnosed, especially breast cancer I’m talking about can be genetic, so we always talk about that.
We have a genetic counselor as a part of the team who will
be there and say, OK, I think this person needs to meet with me. We need to check her or family members. If there are financial issues. Social issues. We have a social worker who is present who can help guide patients through that process. We have a licensed nutritionist who can provide support as to healthy diets. Because this really becomes a very important part of what people feel that they have some control over it and it empowers them. And of course we know that obesity and cancer have a direct link so we always want to talk about maintaining a healthy lifestyle and a healthy body mass index. Once a case is discussed at the Multidisciplinary conference, we will then make recommendations. The patient gets established with medical oncologist or radiation oncologist, and it’s really a very good collaborative approach. The other thing that we often talk about on the show is things like personalized medicine and genomics.
So are those things available in Community settings or are those really only the purview of the larger academic centers? There has been so much progress in these things that they are now easily available to us as well. Our goal is always to be able to offer standard a standard of care, which means if you were to see an oncologist here or you went to the West Coast and used an oncologist there, the therapy recommended would be similar, if not identical, so that is called standardized care and it is based now on genomics, which do play a huge role in determining treatment for cancer, it has been a significant advance. In the treatment of breast cancer, when we look back we find that we were probably over treating a lot of the breast cancer patients with chemotherapy. Now we have tests that can actually determine benefit from chemotherapy, and these are based on genomic tests allowed for a lot of the cancers including lung cancer, colon cancer we are doing molecular testing we’re
identifying targets on these cells, which we know drive the growth of cancer cells, and then we can actually pick medications that would specifically block these drivers and that is sort of the tailor made approach for treating cancer. So it sounds like you know patients can get that same kind of genomic testing in personalized therapies even staying closer to home. We’re going to take a short break for a medical minute and come back and talk more about cancer care in the community with my guest Doctor Katoch. Support for Yale Cancer Answers comes from AstraZeneca, working to eliminate cancer as a cause of death. Learn more at astrazeneca-us.com. This is a medical minute about colorectal cancer. When detected early, colorectal cancer is easily treated and highly curable and as a result it’s recommended that men and women over the age of 45 have regular colonoscopies to screen for the disease. Tumor gene analysis has helped
improve management of colorectal cancer by identifying the patients most likely to benefit from chemotherapy and newer targeted agents, resulting in more patient specific treatments. More information is available at yalecancercenter.org.

You're listening to Connecticut Public Radio. Welcome back to Yale Cancer Answers. We're discussing the care of cancer patients in the community and right before the break we were talking about some of the differences and the other thing that I was wondering about was clinical trials. So often on this show, we talk about the importance of clinical trials and how that’s one of the ways to get tomorrow’s therapies today in that patients often will get the best care by participating in clinical trials for which they are eligible and for which their Doctor thinks they would benefit from. Talk to us about whether clinical trials are available in the community setting.

You bring up a great point, and it is true that we wouldn’t be where we are today in cancer if we didn’t encourage our patients.
0:16:08.03 –> 0:16:10.76 to participate in clinical trials.
0:16:10.76 –> 0:16:13.318 As everyone knows, 2020 has
0:16:13.318 –> 0:16:15.138 been a particularly challenging year,
0:16:15.14 –> 0:16:18.344 and also for clinical trials it has been a very
0:16:18.344 –> 0:16:20.617 challenging year simply because
0:16:20.62 –> 0:16:21.715 clinical trials require
0:16:21.715 –> 0:16:22.81 very diligent follow-up,
0:16:22.81 –> 0:16:24.29 mostly for patient safety,
0:16:24.29 –> 0:16:27.19 and that we all know because of covid
0:16:27.19 –> 0:16:29.78 we’ve had to resort to
0:16:29.78 –> 0:16:31.584 virtual appointments and seeing
0:16:31.584 –> 0:16:34.08 patients may be a little bit
0:16:34.145 –> 0:16:36.677 less frequently than we normally would,
0:16:36.68 –> 0:16:39.214 so a lot of the clinical trials
0:16:39.214 –> 0:16:40.75 had to be put
0:16:40.75 –> 0:16:44.03 on hold, but usually we have a very
0:16:44.03 –> 0:16:46.418 robust collection of clinical trials
0:16:46.418 –> 0:16:48.888 for patients with breast cancer,
0:16:48.89 –> 0:16:50.694 colon, cancer, lung cancer,
0:16:50.694 –> 0:16:51.596 chronic leukemias,
0:16:51.6 –> 0:16:52.502 and myelomas.
0:16:52.502 –> 0:16:54.757 That brings up
0:16:54.76 –> 0:16:57.329 a great point. The fact that you’re
0:16:57.329 –> 0:17:00.405 part of a network and can avail
0:17:00.405 –> 0:17:02.77 yourself of clinical trials that
0:17:02.77 –> 0:17:05.61 are available at larger centers.
0:17:05.61 –> 0:17:08.316 Maybe not all of the trials,
0:17:08.32 –> 0:17:11.338 but certainly a collaboration whereby
0:17:11.34 –> 0:17:13 patients can avail themselves
0:17:13 –> 0:17:14.245 of clinical trials,
0:17:14.25 –> 0:17:17.155 oftentimes closer to home, and if not,
0:17:17.16 –> 0:17:20.445 you can always send them to to a larger
0:17:20.445 –> 0:17:22.578 center where they can participate
0:17:22.578 –> 0:17:25.9 and that brings up my next question,
0:17:25.9 –> 0:17:28.948 which is in those cases where
0:17:28.948 –> 0:17:32.225 there is a particular nuances of the care
0:17:32.225 –> 0:17:35.877 or where a second opinion might be needed,
0:17:35.88 –> 0:17:38.28 is it possible for patients to
0:17:38.28 –> 0:17:40.412 seek a second opinion somewhere
0:17:40.412 –> 0:17:42.657 and still get treated
0:17:42.66 –> 0:17:43.8 closer to home?
0:17:43.8 –> 0:17:46.46 So for example getting the
0:17:46.54 –> 0:17:49.669 advice of an oncologist closer to home
0:17:49.669 –> 0:17:52.21 about what particular regimen to use,
0:17:52.21 –> 0:17:55.53 or how a radiation plan might be structured,
0:17:55.53 –> 0:17:58.85 but then still get their care closer to home?
0:17:58.85 –> 0:18:00.99 Absolutely yes,
0:18:00.99 –> 0:18:03.13 and this happens more
0:18:03.13 –> 0:18:05.579 frequently than one would think.
0:18:05.58 –> 0:18:08.076 And you know, sometimes I’ll say to my
0:18:08.076 –> 0:18:10.5 patients when I’m torn between two options.
0:18:10.5 –> 0:18:13.443 And I’ll say I would like you to see,
0:18:15.09 –> 0:18:17.058 so and so maybe at the Dana Farber Institute,
0:18:17.06 –> 0:18:19.356 maybe closer to home at Smilow.
0:18:19.36 –> 0:18:21.53 And then I always give them the
0:18:21.53 –> 0:18:24.18 option that if this is
0:18:26.228 –> 0:18:28.538 recommended and if it’s not on a clinical
0:18:28.538 –> 0:18:31.489 trial and we are able to do it here,
0:18:31.49 –> 0:18:33.814 you are welcome to come here and
0:18:33.814 –> 0:18:36.188 we would love to treat you here
0:18:36.19 –> 0:18:37.95 if that is your preference,
0:18:37.95 –> 0:18:38.781 so this is,
you know a very sort of open discussion with patients,
and sometimes patients will finish their clinical trial and then will continue to follow with you as their primary oncologist.
Ultimately it’s about the patient. What is best for the patient, and I make sure that our patients know that and they’re not feeling pressured and not feeling that their offending us in any way. It’s important for patients and everybody listening to really understand that. You know this is a collaboration and it’s a collaboration amongst physicians who are all trying to treat you in the best possible way. And so you’re not going to offend anybody and for for the most part many of us actually do seek the opinions of our colleagues at multidisciplinary tumor conferences like you mentioned, as well as outside the institution and frequently you can get the same care then closer to home. If somebody has a better idea of how to treat something. Whereby those services are available in the community.
You can still do so.

Talk to me a little bit about kind of community support. You mentioned one of the disadvantages sometimes of going into a larger center is that you know frequently if care is required, for example with radiation therapy, five days a week for many weeks that a 2 hour drive might not be the most feasible thing one would also imagine that just being in the community where you’re at, being around loved ones and so can sometimes be a little bit more comfortable for patients. Do you find that that’s the case?

So I would say that in cancer care just having the support of the people you love is so meaningful because it’s not just a physical psychological diagnosis that affects all the people around you.

So it’s really important to have that social support not only from your family, but also from where you are being treated so where we are for example, at the Yale Cancer Center
we have a radiation oncology division, which is in the same building. So people who need radiation can come right there. If we are doing something which is a combination chemotherapy and radiation, we will try to make sure that their appointments can be coordinated so life really can be as simple as possible for them. Sometimes people don’t have transport, so we have a social worker on site who will arrange for transport for people and we will tell our patients, our elderly patients who often rely on their children but their children work, so it’s not always possible for somebody to give you a ride each day back and forth. So we have that kind of support and we want our patients to know about it. We want them to use it. We also have support groups.

We have a very robust and active breast Cancer Support group. Other support groups which are not as robust but are present. They meet once a month I think now with some of them have been meeting remotely but that women
also find a very strong sense of community and support with those centers and I would think that the other place where optimizing and kind of using that social support is at end of life. In terms of palliative care. So our palliative care resource is available in the Community both on inpatient as well as there is such a thing as home palliative care where people can really take community all the way back to your own home and have the services that keep you comfortable at the end of life at home. You bring up an excellent, excellent question, so valutative care is a very important part of cancer care, and you know it includes pain control. It includes things that can occur like loss of appetite, loss of interest in life, so we actually offer a consultative service that is available through Yale. We can do it either virtually or we can do it in the office, we actually have consultative care services available on site, so that is outpatient and inpatient.
Palliative care services are available through both hospitals. So both Waterbury Hospital and Saint Mary’s Hospital offer palliative care services is an inpatient unit. A lot of patients want to be home. They want to be surrounded with the loved ones they want to be in familiar surroundings. So we have several Hospice agencies, who can make that possible and who do really do a very fabulous job of taking care of patients at the end of life, they trained to do that. They are compassionate, their empathetic and most patients are very pleased with their services. It’s really important for cancer patients to get treated where they feel the most comfortable and being surrounded by loved ones, particularly at the end of life, is something that they may consider. You’ve mentioned a few times this whole crisis that we’ve been through with Covid, which in and of itself has restricted mobility in terms of going across state lines for certain states, travel and so on.
Talk to us a little bit about how the covid epidemic affected cancer care in the community. Well, you know a lot of the screening procedures that people would go for, I think those have been the first ones to have gone away or have been put on hold. Screening mammograms, screening colonoscopies, those have been a challenge, so people have either put them off or have just been afraid to go out. And you know, we’ve resorted to some virtual visits. Which I would say patients are thankful that they’re seeing a doctor, even if they’re not coming into the office and patients who have been able to come to the office are just so delighted to be there, and they have often said to me that this is my first outing in the last three months. I cannot tell you how happy I am to be here, so it’s sort of kind of funny to hear that. But a lot of people have delayed their care and we are beginning to see a little bit of an uptick now in patients presenting with slightly advanced cancers at this time because
of the lack of screening, you think lack of screening and self delayed patient care, obviously, for reasons that are understandable. And so are you recommending that people get back into screening now? Do you think that we have gotten over the height of the pandemic such that people should really get back into doing those screening mammograms and colonoscopies? I think in the Community people are already back to it. You know our centers, they are asking everybody to wear masks, temperature checks. Most people now have been immunized. I would say at least 90% of my patient population, who I ask has either received the vaccine or is going to receive it in the next few days so I do get a sense that at least as far as medical care is concerned, that the Community is getting back to normal. And do you think that some of the things that we’ve kind of learned about medicine and how medicine can be delivered? For example, you know virtual visits and telemedicine really opened up a whole horizon for people for
whom transportation was a big issue. Do you think that that’s here to stay? That will continue to have Tele medicine visits into the future? Excellent question and I think that it is here to stay and it has made life simpler for a lot of people. But it has also brought along many challenges. The older patients cannot get the video connection. They are so frustrated by the end of the visit. But I would say the telephone visits go much smoother, especially if you’re dealing with an older population or you know people who are just not comfortable doing it on the phone. Other than the technology challenge, I think it is here to stay. Doctor Anamika Katoch is an assistant professor of clinical medicine and 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.
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