PERSONALIZING THE APPROACH TO CANCER TREATMENT

DAVID SIDRANSKY, MD

How You Are Your Own Best Champion

All cancer diagnoses are daunting, but every patient is unique. While cancer drugs and treatment regimens are generally prescribed based upon large swaths of the patient population, the key issue in oncology today is determining how to personalize or individualize treatment. After hearing the words “you’ve got cancer,” most patients are given a drug or combination of agents according to guidelines or standards of care. These treatments, in the oncologist’s best judgment, are considered most likely to work based on the results of clinical studies in patients with similar tumor types.

However, cancer patients often require several courses of drugs and regimens before doctors can identify the optimal therapy. In the meantime, precious time is lost; patients may suffer unpleasant side effects while tumors may continue to grow and mutate. Eventually tumors can become resistant to therapies, further reducing the future effectiveness of other anti-cancer agents. Current cancer drugs are also increasingly expensive; when patients undergo several essentially ineffective courses of therapy, costs mount unnecessarily.

Given the toxicity and side effects of certain treatments, and that only a fraction of patients may benefit from these drugs, an informed patient is his or her own best champion. In the performing arts, the saying goes that the best actors are the best listeners. In medicine, too, listening is one of the most important skills a physician can develop. Working with patients over the years—hearing them air their questions, concerns, and fears—has enabled me to identify five important steps any recently diagnosed cancer patient should take:

Step 1: Establish an Advocate

A patient advocate, who acts as a witness and recorder of events, helps the patient to recall information whenever necessary, and to identify areas where more information or clarification is needed.

Step 2: Keep Good Records

Many patients feel overwhelmed upon first hearing their diagnosis. Maintain thorough notes and records from your first diagnosis forward. It is difficult to remember everything one hears in a doctor’s office, much less to process and understand it all.

Step 3: Ask Questions

Patients should ask questions in terms of their specific diagnosis or situation and ask about alternate options. Questions should be written down ahead of time, as they might be forgotten upon meeting with the physician. In fact, patients should keep a running list of any questions they might have. Patients should also ask to consult with other physicians and gather as many opinions as they feel necessary. Some basic questions you will want your doctors to answer include:

* What are the cell type, grade, and stage of my cancer? What does that mean in my case?

* What treatment options are there? What do you recommend for me? Why?

* What is the goal of this treatment?

* Based on my cancer as you see it, what are my chances of survival? How long would you expect me to survive?

* What are the risks or side effects that I should expect? What can be done to mitigate these?

* What are the chances my cancer will return with the treatment we have discussed and what would be the next step?

* What should I do to ready myself for treatment? Should I follow a special diet? A special exercise regimen?

* How much will this treatment cost me out of pocket?

* Are there clinical trials available for my cancer?

* What cutting edge therapies are available?

* What complementary and alternative treatments would be potentially beneficial for me?

Step 4: Stay Informed and Empowered

Newly diagnosed cancer patients must remember that they are the decision maker, not the physician. There are things a doctor may not know. For example, the information required...
PERSONALIZING continued

may not be readily available to him or may not fall within the treating physician’s specialty or field of expertise. There are many treatment options to evaluate, and advances in multiple disciplines that patients and physicians will want to consider.

Step 5: Avoid “Analysis Paralysis”

In other words, try not to grow overwhelmed with the myriad details of options or recommendations. Establish and agree upon set goals with your doctors. Discuss risks and benefits with your treating physicians and those close to you. Becoming an informed patient and an empowered self-advocate is an important step for newly diagnosed patients. Patients should understand that there might be differences of opinions and conflicting information. Look to trusted physicians and advisors to guide you toward making the best decisions for treating your specific disease. However, as soon as possible, pick the physician who will supervise and manage all of your care — “the quarterback.”

The Future of Personalized Oncology

Fortunately, the future of personalized oncology medicine looks brighter every day. The rapidly developing field of genomics -- the study of genes and their function -- has expanded the playing field in cancer as well as in a number of other medical conditions. Significant development of the practice of personalized oncology is a direct outgrowth of the Human Genome Project, a thirteen-year project completed in 2003 that resulted in the precision mapping of human genetic information and deepened our understanding of how cancer grows.

The project and other medical advancements have provided doctors with knowledge about genetics and mutations, helping them specifically target therapies in a direct way. Doctors can use genetic information -- obtained from the tumor itself -- to help determine what chemotherapeutic agents will and won’t work in a specific individual. As these cancer treatments become more targeted, cancer patients will benefit from them in terms of outcome, costs, and quality of life.

Capitalizing upon this research, the promise exists that oncologists will be able to develop processes that enable us to better evaluate the effectiveness of anti-cancer agents before they are administered to patients. One such process involves the implantation of primary human tumors in immune deficient mice followed by growth and propagation of the resulting engraftments (“Tumorgrafts”), closely preserving the biological characteristics of the original human tumor. Treatment drugs are then administered to evaluate the Tumorgraft’s sensitivity or resistance to each drug.

Putting this model into practice, recently I worked with a lung cancer patient who arranged to have his tumor implanted into a mouse that was then propagated for specialized drug testing using this platform. A large number of different anticancer agents were tested against the patient’s specific tumor in the Tumorgrafts. Testing with a triple regimen of Irinotecan, sorafenib, and bevacizumab resulted in substantial tumor growth inhibition. The tumors growing in the mice responded well to this combination of anticancer drugs. Considering the Tumorgraft results, the patient’s physician chose to administer this triple therapy to the patient. The patient’s response was similarly positive, with a long tumor...

PERSONALIZING continued on page 3.
remission that demonstrated the predictive nature of this treatment approach.

This predictive model, which enables us to discover genetic markers in tumors and correlate these markers with treatment response, will help in new drug development and may also enable the development of personalized vaccines directly from the patient’s tumor. Ongoing studies in these models could bring the oncology community one giant step closer to its ultimate goal: enabling us to isolate the right treatment, for the right patient, at the right time.

Editor's Notes: Dr. David Sidransky co-founded and serves as Chairman of the Board of Directors of Champions Biotechnology, a company engaged in the development of advanced preclinical platforms and tumor specific data to provide personalized oncology services and to enhance the value of oncology drugs.

Dr. Sidransky is a renowned oncologist and research scientist named and profiled by TIME magazine in 2001 as one of the top physicians and scientists in America, recognized for his work with early detection of cancer.

Since 1994, Dr. Sidransky has been the Director of the Head and Neck Cancer Research Division at Johns Hopkins University School of Medicine and Professor of Oncology, Otolaryngology, Cellular & Molecular Medicine, Urology, Genetics, and Pathology at John Hopkins University and Hospital.

He is one of the most highly cited researchers in clinical and medical journals in the world, in the field of oncology during the past decade, with over three hundred peer-reviewed publications. He has contributed more than forty cancer reviews and chapters.

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A TIME FOR SHARING

My husband, Jeff, and I live in southern New Hampshire and discovered another reason in 2002 why we are fortunate to live so close to Boston. On Halloween 2002 after a year of misdiagnoses (gastric reflux and sinus infection) we requested an ENT consult. Jeff (never a smoker or much of a drinker) was diagnosed by an ENT with stage 2 base of tongue cancer. Since surgery would have taken enough of his tongue to affect his ability to speak and eat, he was referred to a radiation oncologist and medical oncologist and opted for 36 radiation treatments (7200 rads) and 7 chemo treatments (cysplatin) at a local community hospital where I worked. They told him “the good news is that we can cure you. The bad news is that the treatment is very difficult to go through.” He began radiation without a feeding tube but by December he couldn’t swallow. Due to his weakened condition without food, he had one inserted. He lost 20 pounds during his treatment regimen.

The radiation treatments caused fatigue and weakness. One day he didn’t think he could make it to the treatment but with help dressing and getting ready he did. On his last day of radiation staff from my department at the hospital greeted him as he rang the bell and left for good. Traveling and eating out were very difficult and remained so for several years. We researched easy to eat easy to swallow food options and sought the services of a dietitian (but found that we taught her more than she taught us). Among other complications from the radiation treatments were: xerostomia (diminished saliva), trismus (lockjaw), epiglottis malfunction, poor blood supply to bones and gums causing tooth loss.

In the years that followed Jeff had several bouts of osteoradionecrosis (dead jaw bone) which were treated by a local oral surgeon and 56 hyperbaric treatments. After the final hyperbaric “dive” my department’s staff again appeared to congratulate him dressed in deep-sea garb. During this time he contracted severe trismus where he could only open his mouth the width of ½ a finger. He had physical therapy (PT) in June 2007 to try to resolve this situation. Four days after the second PT appointment he developed severe pain and an infection that brought him to the Emergency Department in NH. He was transferred to a Boston hospital for emergency surgery. He was followed by a Boston oral surgeon but he maintained a temperature for months that didn’t resolve itself. We sought a second opinion at Boston Medical Center (BMC), liked their plan and began treatment there. They, unlike the first Boston hospital, agreed to our request for an Infection Disease consult. In October 2007 he underwent surgery to treat three infections in the tissue and bone that had probably been there for months. Five days later he had a titanium chain inserted since the jaw had fractured. He was sent home to undergo 12 weeks of intravenous antibiotics 4x/day and to get fit for the big surgery that was yet to come.

We decided to take a quick trip to South Miami Beach Florida in January and on the evening before we left Jeff came down with shingles on the same side of his head as the ORN. We made it to the doctor in the morning before our flight and got drugs for the shingles. Though it wasn’t the best trip we’ve ever taken, it was nice to get away from the New England winter for a few days.

Then in December 2008, Jeff underwent a 16-hour surgery to rebuild his jaw using six inches of fibula, tissue, artery and skin from the left lower leg. The surgeons closed the donor site with skin from his upper right thigh. Another fly in the ointment was a diagnosis of Fry’s Syndrome. The surgeons had severed the parotid nerve and it reattached to a sweat gland so when he chews he sweats on the left side of his face! When Jeff last saw his Boston oral surgeon, the doctor asked “do you want to see me anymore?” and Jeff responded, “Can we write?”

Since he wasn’t a candidate for tooth implants due to the radiation that diminished blood flow to his jawbone and tissue, he was fit for partial plates a year after the free flap surgery. This has made a big difference in his ability to chew and swallow and, concomitantly, in his comfort level eating with company.

Now 18 months after the transplant surgery he is eating (the trismus was reversed) carefully, has regained strength and is active once again. We are traveling again; first with a cruise to eastern Caribbean and another planned to the Panama Canal. He is hiking: made it 2/3 of the way up Mount Major last year and to the top this year, swimming and doing gardening and wood splitting. This coming winter’s goal is to ski again.

Some reflections on this time in our life: Best thing was our team of OMS and ENT docs and residents at BMC. We weren’t just a number in this busy medical center: we communicated by email with our doctors and their staff. At our second visit at Infectious Disease the receptionist asked how the trip down from NH was as we approached the desk!

Help from family and friends were lifesavers. They helped with trips to doctors, hospital visits, fall cleanup in our large yard and help with the generator during a winter power outage.

Many times we reflected on the meaning of our marriage vows…in sickness and in health. Like many others we found that humor helped us to get through this. One of our favorite things was to tell people that his doctor surgically inserted Jeff’s foot in his mouth. We also sang, “the leg bone connected to the neck bone…” as we thought about the marvels of the surgeries.

While going through the treatments and following the surgeries Jeff liked watching and listening to visitors rather than being the center of attention. Friends came for a sledding party so Jeff could enjoy seeing people having fun.

As the primary care giver, my spirituality became stronger during this time and has remained so. Our family has learned what is important in life and what is not.

Jeff hasn’t been sick a day since all of this began. He may have the free flap medically tattooed since the skin from his leg that is now on his neck doesn’t match the color of his skin. The scars took some getting used to but there was no need to hide though some were curious about where they came from. He is still a very handsome man and the love of my life.

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ORAL, HEAD, AND NECK CANCER NEWS
Coffee May Protect Against Head and Neck Cancer

• Caffeinated coffee protected against oral cavity, pharyngeal cancers.
• Regular coffee drinkers had a 39 percent decreased risk of cancer.

PHILADELPHIA — Data on the effects of coffee on cancer risk have been mixed. However, results of a recent study add to the brewing evidence that drinking coffee protects against cancer, this time against head and neck cancer. Full study results are published online first in Cancer Epidemiology, Biomarkers & Prevention, a journal of the American Association for Cancer Research. Using information from a pooled-analysis of nine studies collected by the International Head and Neck Cancer Epidemiology (INHANCE) consortium, participants who were regular coffee drinkers, that is, those who drank an estimated four or more cups a day, compared with those who were non-drinkers, had a 39 percent decreased risk of oral cavity and pharynx cancers combined. Data on decaffeinated coffee was too sparse for detailed analysis, but indicated no increased risk. Tea intake was not associated with head and neck cancer risk. The association is more reliable among those who are frequent, regular coffee drinkers, consuming more than four cups of coffee a day. “Since coffee is so widely used and there is a relatively high incidence and low survival rate of these forms of cancers, our results have important public health implications that need to be further addressed,” said lead researcher, Mia Hashibe, PhD, assistant professor in the department of family and preventive medicine at the University of Utah, Salt Lake City, and a Huntsman Cancer Institute investigator. “What makes our results so unique is that we had a very large sample size, and since we combined data across many studies, we had more statistical power to detect associations between cancer and coffee,” she said. At the AACR Frontiers in Cancer Prevention Research Conference last December, researchers from Harvard presented data that showed a strong inverse association between coffee consumption and the risk of lethal and advanced prostate cancers — men who drank the most coffee had a 60 percent lower risk of aggressive prostate cancer than men who did not drink any coffee. More recently, results of another study published in the January issue of Cancer Epidemiology, Biomarkers & Prevention showed a decreased risk of gliomas, or brain tumors, associated with coffee. This association was found among those who drank five or more cups of coffee or tea a day, according the researchers from the Imperial College, London. Cancer Epidemiology, Biomarkers & Prevention editorial board member Johanna W. Lampe, Ph.D, R.D believes this current analysis by Hashibe and colleagues provides strong, additional evidence for an association between caffeinated coffee drinking and cancer risk. “The fact that this was seen for oral and pharyngeal cancers, but not laryngeal cancers, provides some evidence as to a possible specificity of effect,” said Lampe, who is a full member and associate division director in the division of public health sciences at Fred Hutchinson Cancer Research Center, Seattle, Wash. “These findings provide further impetus to pursue research to understand the role of coffee in head and neck cancer prevention,” she added. Lampe is not associated with this study. Additional research is warranted to characterize the importance of timing and duration of exposure and possible mechanisms of action, according to Hashibe.

Radiation Treatment for Head and Neck Cancer May Produce Hearing Loss

Treatment for head and neck cancer that includes radiation therapy often induces hearing loss, and the damage can be substantial and permanent, Brazilian researchers have reported. Their findings were published in the November 2010 Archives of Otolaryngology—Head and Neck Surgery.

In the case-control study, which included 282 participants, case patients had head and neck cancer and had been treated with radiation therapy, either alone or in combination with chemotherapy, and the auditory system was included in the field of radiation. The control group included healthy individuals and patients with cancer who had not received therapy that affects hearing. The median age for both groups was approximately 61.

Over a median follow-up of 7 years, approximately 72 percent of case patients suffered hearing loss (as measured by standard audiologic assessment methods) compared with approximately 49 percent of the control group, reported Christiane Schultz from the Audiology Department at the A.C. Camargo Hospital in São Paulo, Brazil, and her colleagues.

The most common type of hearing loss in both groups was related to inner ear damage (sensorineural), but case patients were statistically significantly more likely than control subjects to experience severe hearing loss. Case patients were also far more likely to report (via a standardized questionnaire) that hearing loss represented a severe handicap (19.1 percent versus 2.8 percent).

Attention to this side effect is critical, the researchers wrote, because loss of hearing can promote social isolation and depression. “Concern for the quality of life of patients undergoing cancer treatment is necessarily growing,” they continued, “and determination of hearing loss should form part of such investigations to enable better rehabilitation.”
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Strong Memorial Hospital
1st. Thursday: 4:30-6:00 PM
Sandra E. Sabatka, LMSW  585-276-4529
Sandra_Sabatka@URMC.Rochester.edu

NEW YORK-STONY BROOK
Ambulatory Care Pavilion
1st. Wednesday: 7:30-9:00 PM
Dennis Staropoli  631-682-7105
den.star@hotmail.com

NEW YORK-SYOSSET
NSLIJ-Syosset Hospital
2nd. Thursday: 7:30-9:30 PM
Christine Lantier  631-757-7905
clantier@optonline.net
Mary Ann Caputo  516-759-5333
mary.ann.caputo@spohn.org

NEW YORK-WESTCHESTER
White Plains Hospital Cancer Center
2nd. Thursday: 7:00 PM
Mark Tenzer  914-328-2072
tenzer1@optonline.net

NORTH CAROLINA-ASHVILLE
Call for additional information
Kathleen Godwin  828-692-6174
kgodwin@morrisbb.net

NORTH CAROLINA-CHAPEL HILL/DURHAM
Comucopia House
3rd. Wednesday: 6:00 PM
Dave Gould  919-493-8168
dave.gould@da.org

NORTH CAROLINA-CHARLOTTE
Blumenthal Cancer Center
2nd. & 4th Thursday: 1:30-3:00 PM
Meg Turner  704-364-7119
terri.painchaud@nhc.org

N CAROLINA-HENDERSONVILLE/WNC
Pardee Health Ed. Ctr. Blue Ridge Mall
2nd. Tuesday: 5:00-6:30 PM
Kathleen Godwin  828-692-6174
kgodwin@mchsni.org

OHIO-CLEVELAND
Cleveland Clinic Fairview Hospital
2nd. Thursday: 4:00 PM
Tom Wurz 440-243-6220
roc8@hotmail.com
Gwen Paull, LISW 216-476-7241
Gwen.paull@fairviewhospital.org

OHIO-DAYTON
The Chapel Room One Elizabeth Place
Hank Deneski 937-832-2677
2nd. Monday: 6:00-8:00 PM
hdeneski@mindspring.com

OHIO-LIMA
St. Rita’s Regional Cancer Ctr.
Allison Rad/Onc. Ctr. Garden Conf Rm
3rd. Tuesday of even month: 5:00 PM
Holly Metzger, LMSW 419-996-5606
hmetsger@healthpartners.org
Linda Glorioso 419-996-5616
ldglorioso@health-partners.org

OKLAHOMA-TULSA
Hardesty Public Library
1st. Tuesday: 6:30 PM
Christine B. Griffin, RN 918-261-8858
beritgriffin@cox.net

OREGON-MEDFORD
Providence Medical Center
2nd. Friday: 12:00-1:30 PM
Richard Boucher  650-269-8323
richard.boucher@hp.com

OREGON-THE WILLAMETTE VALLEY
Samaritan Reg CA Cntr Library
2nd. Wednesday: 5:00-6:30 pm
Lisa Nielsen 541-757-9882
HNCsurvivor@comcast.net

PENNSYLVANIA-HARRISBURG
Health South Lab 3rd, Tues: 6:30 PM
Joseph F. Breitsford  717-774-8370
jbreitsford1@mmcm.edu

PENNSYLVANIA-MONROEVILLE
Inter Community Cancer Center
Last Friday of month: 3:00 - 4:00 PM
Beth Madrishin  412-856-7740
bmadrish@wpahs.org

PENNSYLVANIA-NEW CASTLE
UPMC Jameson Cancer Center
Medical Arts Bldg Suite 104
3rd Wednesday, 6:00-7:30 PM
Jeanie Williams, Patient Navigator
Becky Rainville, RN
724-656-5870

PENNSYLVANIA-PHILADELPHIA
Penn Med Perelman Ctr Advanced Med
1 W. Pavilion Pl % Fam Conf Rm
1st. Wednesday: 9:30-11:00 AM
Micki Naimoli 856-722-5574
Tracy Lautenbach 215-662-6193
lautenbach@uphs.upenn.edu
Mia Benson Smith, MS 215-662-4641
mia.benson smith@uphs.upenn.edu

PENNSYLVANIA-YORK
Apple Hill Medical Center
2nd. Wednesday: 5:00 PM
Dianne S. Hollinger, MA, CCC-SLP
717-851-2601
Dhollinger@wellspan.org
Diane McElwain, RN, OCN, M.Ed
717-741-8100
dmcelwain@wellspan.org

TENNESSEE-CHATTANOOGA
Intercommunity Cancer Center
Last Friday of month: 3:00 - 4:00 PM
Beth Madrishin  412-856-7740
bmadrish@wpahs.org

TEXAS-DALLAS
Parkland Radiology Center
Wednesday: 9:30-11:00 AM
Kerrigan Cancer Center
2nd. Saturday: 10:00 AM
Dan Stack 972-373-9599
dan.stack@parkland.com

TEXAS-FORT WORTH
Moncrief Cancer Resources
2nd. Wednesday: 3:30-5:00 PM
Marla Hathcoat, LMSW
817-838-4866
marla.hathcoat@moncrief.com

TEXAS-HOUSTON/TOMBALL
 Tomball Regional Hospital
2nd. Tuesday: 12:00 Noon-1:30 PM
Lynda Tustin, RN
281-401-5900
ltustin@tomballhospital.org

TEXAS-MCALLEN
Rio Grande Regional Hospital
3rd. Tuesday: 6:00 PM
Stephanie Leal, MA,CCC,SLP
SAL1275@aol.com
Cheryl Lopez, MS, CCC, SLP
956-632-6426

TEXAS-PLENO
Regional Medical Center at Plano
4th. Tuesday: 6:00-8:00 PM
Polly Candela, RN, MS
214-820-2608
Polly.Candela@baylorhealth.edu

TEXAS-STONY BROOK
Orthopaedics Hospital Radiology/Oncology
2nd. Monday: 5:30-7:00 PM
Corinne Cook, LCSW
703-776-2813
Corinne.cook@innova.com

TEXAS-TOMBALL
Intercommunity Cancer Center
Last Friday of month: 11:30-1:00 PM
Vikki Bravo 434-982-4091
vsb4n@virginia.edu

WASHINGTON-SEATTLE
Evergreen Hospital Medical Center
Radiation/Oncology
2nd. Tuesday: 6:30-8:00 PM
Kellie Jackson 425-788-6562
kellie.jackson@hotmail.com

WASHINGTON-SEATTLE
Swedish Medical Center
2nd. Friday: 5:00-7:00 PM
Susan (Sam) Vetto, BSN, RN, BC
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svetto@vcam.org
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206-215-1770
joanne.fenn@swedish.org

WISCONSIN-MADISON
Univ. of Wisconsin Hospital ENT Ctr.
Monday: 4:30-5:30 PM
Rachael Kammer, MS, CCC-SLP
608-263-4896
kammer@urology.wisc.edu

WISCONSIN-MILWAUKEE
Medical College of Wisconsin
Conference Rm. J, Rm. 1010
2nd. Wednesday: 4:30-5:30 PM
Tammy Wigginton, MS, CCC-SLP
414-805-5662
twigginton@mcw.edu
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