

Advances in Treatment of Throat Cancer
Webcast
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Introduction

Andrew Schorr:

Thank you for joining us on Patient Power on mdanderson.org. I'm Andrew Schorr broadcasting live from Seattle, Washington. I made a long trip to M. D. Anderson for my leukemia care, but I think it made a huge difference to me. So wherever you are around the world, listen carefully because we're going to connect you tonight with the latest information on the advances and treatment of throat cancer. So whether you live around Texas or you live around the world this will be important information for you. If you're listening to us live, if you're listening to our replay, reading the transcript, we're delighted to connect you every two weeks with Patient Power with leading experts from M. D. Anderson, and as the lady said inspiring patients, and I am just bowled over by who I meet.

And I want you to meet one of those people. I'll put them in the Patient Power hall of fame, if you will. My contemporary, I'm 57, Diana is about that, just a few months older, 58. Diana Kerrigan joins us from Wimberley, Texas, and if you don't know Texas geography, it's halfway between Austin and San Antonio.

Diana, let's see if I get this right. You and your husband, Bob, retired. You'd been 30 years at an electric co-op, right?

Diana:

That's exactly right.

Andrew Schorr:

So you retired, and then last July you had a tooth problem so you go to the dentist and you thought you'd get that fixed, and the dentist does not like what they see in your mouth and sends you to an ear, nose and throat specialist because you had what seemed like a little growth or something at the top of your mouth in the back, right?

Symptoms of Throat Cancer

Diana:

That's right. Dr. Posten, my dentist in New Braunfels, saw what he called a suspicious looking place, and I had told him that it had been bleeding, and he sent me to Dr. Charles Llano, an ear, nose and throat specialist in New Braunfels, said he wanted me to go sooner versus later.

Andrew Schorr:

Right. So you go to the ENT, as we call them, and he says, oh, well, it's probably no big deal. Come back in three months. So you and Bob go on vacation and you come up my way to the Pacific Northwest because I know you have a 40-year-old son here, and you go to Vancouver Island, the neat Canadian city of Victoria. You have your vacation, but something is going on in the top of your mouth. What did it feel like?

Diana:

It felt like cauliflower, Andrew. It was sore and if I would eat anything a little bit spicy or peppery or have an adult beverage the alcohol would burn, and so I really had to watch what I ate until I got home.

Andrew Schorr:

All right. So you go home and you say do not pass go, I'm going back to the ear nose and throat doctor. You did and so the doctor does biopsies and he says, well, we'll get the tests, we'll call you in a week or so, but then the phone rang much sooner, didn't it?

Diana:

It did. It rang the next day and his nurse said that she would like to have my husband and I come in the following morning, which happened to be Dr. Llano's day off so I knew that was not a good sign. They wanted to give us the results of the biopsy. So we had all night to think about it.

Andrew Schorr:

Oh, I hate that. I hate that. So you go in and right away it was clear you were dealing with something pretty serious. What did he say?

Diana:

He was so, so thoughtful in his approach. He said that I wish I had good news for you, Mrs. Kerrigan, but I don't. You have squamous cell carcinoma, either a stage I or II, and you need to be seen immediately by a surgeon and a radiation oncologist.

Andrew Schorr:

Well, that journey eventually took you to M. D. Anderson in Houston, three, three and a half hours up the highway, and you connected with the team there and a wonderful surgeon who will be our guest in a second, became your doctor, Dr. Chris Holsinger. What happened? You get to M. D. Anderson, they do a lot of tests and what happens then?

Diana:

They did. I actually started some tests in San Marcos and New Braunfels before I got to M. D. Anderson, and it just so happened that Dr. Llano had gone to school with Dr. Holsinger. So I was very blessed in the beginning. He called Dr. Holsinger immediately and asked if he would accept me as a patient, and he did. I went to see Dr. Holsinger about two weeks later, met with him, met with all of his staff, his fellows and began the journey of how we were going to treat my cancer.

Diagnosing Throat Cancer

Andrew Schorr:

Well, let's meet Dr. Holsinger. Dr. Holsinger, let's hear it from your side. So Diana comes to you and she's saying the decision is to see what you're dealing with. So what are these tests you do to try to understand, what is the exact throat cancer that you're dealing with and then begin to come up with a plan?

Dr. Holsinger:

Well, the first thing that we do, and I just wanted to thank you all for having me on as a guest and for highlighting throat cancer. It's not as rare as people think and all of us here at the department of head and neck surgery are very grateful for this time.

Andrew Schorr:

Our pleasure.

Dr. Holsinger:

But one of the things that we do, I'm an ear, nose and throat specialist, an otolaryngologist and head neck surgeon, and one of the things that we do - if you recall those old head mirrors that you would see in the Norman Rockwell paintings, we have very good equipment and special lighting and endoscopes to look into areas of the mouth and into the throat that you can't normally see. And we do a very thorough exam with these special instruments that let us look around corners and see things with special light that gives us the kind of detail that we can to distinguish normal from precancer or from cancer.

And then based on that initial exam we'll usually order an imaging study to look at the areas of the throat and correlate what we see on the surface with what's underneath and also to examine the lymph nodes of both sides of the neck and other structures. So we start there with the clinical exam and go to usually a CT scan or MRI.

Andrew Schorr:

So, Diana, the doctor was describing all the exams and tests they do to see what they're dealing with. So then you go into the discussion about, well, what do you do about it? We'll find out what happened to you then. So you had a discussion about radiation, surgery. What were the different things that were discussed and how did you feel about it?

Diana:

One of the first people that I saw when we discussed my options was a radiation oncologist, and I immediately got very scared and knew that that was not something that I really wanted to do. He was very nice. I liked him and trusted him immediately, but his name was William Morrison and his description of what my long-term effects would be were very frightening. No dental work, affect my salivary glands which with throat cancer was not something that would be conducive to me not having cancer again. And so I knew that it would be a much longer process to get rid of the cancer and being somewhat of a person that wants immediate results and wanted more control, I really didn't want to go that route. Fortunately, Dr. Holsinger and his staff took that into account and I guess it helped the decision to be made, Dr. Holsinger.

Dr. Holsinger:

Well, yes, exactly. One of the things that is great about practicing here and I think really plays into the advantage of the patient here is that you see a true multidisciplinary team here. And not only did Dr. Morrison see you but you also saw a speech language pathologist, you saw a dentist and a whole array of specialists. And then we get together on Thursday nights at 5 p.m. and talk about every single new patient who comes in, and we go over your physical exam findings, we review the imaging with our neuroradiologists, and we all come to a consensus of what the best options for each individual patient would be and so that you don't have a diagnosis and it's just this cookie cutter type of, Here's a diagnosis and there's the treatment. We really try to personalize the care based on your health, your disease and what's best for you.

Diana:

And my personality type came into play somewhere along the line, which was the first time I was ever glad to be obsessive-compulsive.

Dr. Holsinger:

I hadn't noticed that about you.

Minimally Invasive Surgery

Andrew Schorr:

Yeah, right, right. Let's carry on the story just for a minute so people know what happened in your case and that is that you chose to have minimally invasive surgery, robotic surgery that Dr. Holsinger was able to do in your case and you know, surgery is a big deal no matter what, even if it's called minimally invasive surgery, but here you were. You had the surgery in November, I think November 16, two days in the hospital. The multidisciplinary team kicks in with all sorts of people trying to help you rehabilitate, swallow and begin to be able to open your jaws more.

Diana:

Talk.

Andrew Schorr:

So here comes Thanksgiving. Let's help people see that in perspective. And so you really couldn't open your jaw very much then, and so Thanksgiving dinner my understanding is what you did is you put your favorite Thanksgiving foods in a blender and ate them through a straw, right?

Diana:

That's what I did. I have wonderful neighbors. They invited us over, the typical Thanksgiving dinner, and I put everything on the table that was my favorite into the blender and I drank it through a straw.

Dr. Holsinger:

You had a turkey shake?

Diana:

I had a turkey shake.

Andrew Schorr:

Turkey and stuffing and everything. And then Christmas dinner comes, and you'd made a lot of progress by then. And you actually had the family over to dinner which you could make. Now, it's certainly one of the staples was mashed potatoes, but you were able to eat. And now you've been working with the rehab people to work on opening your jaw more and more, and it's pretty normal now, isn't it?

Diana:

It's getting there. It is definitely getting there. It's not where I need it to be. I can't for instance get my dental work done yet, but it is definitely much improved. To give you an example I started doing the, TheraBite is the name of the appliance I use. I started that around November the 26th or -8th and I could open my mouth

18 millimeters. I started at 42. Today I am at 36 millimeters in the evening, so I still have a few more to go because I have to be able to maintain that for a certain amount of time. When you use your TheraBite the way I understand it, to keep you from getting lockjaw because you get fibrosis in your jaw during the healing process and everything they do inside your mouth during the surgery, so in order to get your mouth open enough to get food in you've got to be able to use this appliance and faithfully do this rehabilitation on a daily basis, ten times a day for one hundred repetitions.

Andrew Schorr:

Wow. It's like going to the gym for your mouth. But you've made tremendous progress. Let's put this in perspective. So, Dr. Holsinger, so first of all in Diana's case you were able to do surgery only, minimally invasive robotic surgery that we want to hear more about. She's not had radiation or chemo, and the hope is you got the cancer and she can return to a full life. And as far as movement of her jaw and eating and recovery she's doing her part working hard on that.

I know we talk about head and neck cancers broadly, 45,000 new cases is year, and a most of them, I think you told me earlier three quarters are throat cancers. When we talk about throat cancer what are we talking about? What type did she have, and what other types are there?

Dr. Holsinger:

For purposes of discussion we divide head and neck cancer into several different types. And the American Cancer Society has a nice website on this as well. But we think about the disease in these four categories. There's oral cavity and lip. There's the oropharynx, which is the throat as it begins in the mouth. Then there's also the hypopharynx, which is the deeper structures of the throat as you move toward the esophagus. And then within the throat is the larynx. So oral cavity, oropharynx, hypopharynx and larynx comprise what we think of as head and neck cancer and what we have lumped together.

Post-Surgery Treatment

Andrew Schorr:

And the approaches may vary. Now, it so happened that you were able to do robotic surgery where she had the cancer, and I know we'll talk after the break more about the whole group of minimally invasive approaches. But although Diana didn't want radiation there may be times when radiation or chemotherapy do come into play, right?

Dr. Holsinger:

Is very appropriate. And Ms. Kerrigan had a stage I. It was a T1 N0 M0 oropharyngeal carcinoma that touched on the soft pallet, which is part of the oropharynx, and also the beginning toward the back of the oral cavity. And with a

stage I cancer both surgery and radiation have excellent control rates, and radiation in particular is what we have relied on for years. But there are some side effects from every type of treatment, chemotherapy, radiation, and certainly surgery has its side effects but one of the reasons that this transoral robotic approach was helpful for Mrs. Kerrigan was that she had had some dental issues and the impact on routine dental care with radiation can sometimes be difficult to manage down the road. So we're able to at a single setting to treat her and in the operating room with frozen section margins guarantee that we'd gotten this tumor with a wide margin, whereas radiation would take six to seven weeks and then there's a recovery time.

We try to consider all these factors. When we think about this, surgery versus radiation, oftentimes we're not just thinking about the single, primary tumor, in this case in the oropharynx, we're also thinking globally about the patient. Is there metastasis to the lymph nodes of the neck? Are there metastases to the lung?

Andrew Schorr:
Right.

Dr. Holsinger:
And when the nodes are involved radiation is oftentimes better to use up front because a single modality of treatment can take care of that throat cancer and the nodes.

Andrew Schorr:
Chris, we'll go through that in greater detail. We have lots of questions from people as we continue our live webcast discussing advances in the treatment of throat cancer. It's all on Patient Power live as we continue our discussion sponsored by M. D. Anderson Cancer Center. Stay with us.

When is Robotic Surgery Appropriate?

Andrew Schorr:
Welcome back to our live webcast as we're discussing advances in the treatment of throat cancer. I'm Andrew Schorr. We do this every two weeks. I'm honored to have with me Diana Kerrigan, who joins us from Wimberley, Texas. Just last fall and then around Thanksgiving time Diana was diagnosed and then treated with robotic surgery for her throat cancer, and she's making a really good recovery as you heard about. We're going to hear more from Diana as we talk about what does she say to other people with this diagnosis and to their family members as well, how has her family coped.

And then we have with us one of the leading experts in the treatment of this with some of the latest approaches. That's Dr. Chris Holsinger. He's an assistant professor and attending surgeon at M. D. Anderson Cancer Center.

Dr. Holsinger, so we understood you can use robots now, this robotic approach like we've heard about for prostate cancer, and I know they're doing it for gynecologic cancers now. So you're applying this right in the head. When is the robotic surgery appropriate? And what are other minimally invasive surgical approaches?

Dr. Holsinger:

One of the reasons we're excited about transoral robotic surgery is that this area has been very difficult sometimes to treat without having to do transcervical or through the neck incisions and sometimes needing even to divide the jaw and to do other types of open procedures that can require longer rehabilitation and have a substantial impact on swallowing and speech. Part of that is the complexity, the three-dimensional complexity to head and neck, and what you may be able to see you can't necessarily operate on.

And surgical robotics, there's a system called the da Vinci that allows us to expose an area in the throat that we could see but not operate on with our two hands because the throat is a narrow area. And with three-dimensional vision, with two high-resolution cameras and surgical robotic arms we can turn corners, we can use lasers and electrocautery to resect tumors and only resect a margin and not have to take lots of normal tissue to get that safety margin. And by minimizing the amount of tissue that's removed functional outcomes we believe are better.

And Dr. Greg Weinstein at the University of Pennsylvania and others have really led the charge with this. And I was lucky enough to study with him and we brought this down to Texas, and I think it's worked out very well for our patients.

Andrew Schorr:

Let's make the point that this approach now for head and neck cancer and throat cancer, this is not at every hospital or on every corner, nor are there doctors who are expert in using it. So it has a lot of advantages. People need to seek it out, and we're fortunate that it's at M. D. Anderson. How long have you been doing it and how do you feel it's going?

Dr. Holsinger:

Well, transoral minimally invasive approaches have been around, believe it or not, for 30 years. And we started using lasers to resect through the mouth cancers of the throat and also of the larynx. Geza Jako and Dr. Strong at Boston University started doing this in 1972, and a series of technological innovations have allowed us to continue to develop this approach and really push the envelope to where now we can take out half of the larynx and preserve someone's ability to speak and swallow.

We've got an IRB, a protocol, a clinical trial to study this, as do several other institutions around the country, and we've been doing this now for about two years.

And we're hoping to look at what the functional advantages are to this approach compared to other treatment options, whether that's traditional surgery, going through the neck, or radiation or radiation with chemotherapy. And for a patient like Diana it was just perfect. It's a small tumor. It was readily visualized with the robotics, and we got a great margin and we had her back to essentially a normal diet in a month, which is really great.

Symptoms of Throat Cancer

Andrew Schorr:

Let's talk about the symptoms, Dr. Holsinger. So Diana felt something in her mouth, and it would bleed. What are the different symptoms that someone might have for throat cancer?

Dr. Holsinger:

A couple of cardinal head and neck symptoms, and I'm going to list them off in a second, but before I list them off I don't want to alarm anyone listening because a lot of these symptoms that I'm going to say are indicative of head and neck cancer are symptoms that we have with a common cold or with allergies. So it's really something that you need to discuss with your doctor, and any of these symptoms that I'm going to list that last for two weeks are what really concern us.

But those symptoms are severe trouble swallowing or painful swallowing that lasts over two weeks. Obviously any kind of hoarseness that doesn't come and go, that's persistent, is something that needs to be evaluated by an otolaryngologist or someone who can visualize the throat with those endoscopes that I mentioned at the start of the show. Any patient with a neck mass, again, that doesn't resolve, or with ear pain, especially in an adult that lasts for over two weeks is someone that may have an indication to have a very careful laryngoscopy or pharyngoscopy exam.

Throat Cancer Risk

Andrew Schorr:

Who's at risk for throat cancer? I think of smokers, of course, but could there be other risk factors as well? And what age does it usually develop at?

Dr. Holsinger:

Exactly. Traditionally this is a disease that develops in patients who smoke, who've smoked more than 25, 30 or 40 pack-years. But we're seeing a change in the etiology of this disease. There has been recent work out of Johns Hopkins and Eric Sturgis is working here at M. D. Anderson on this as well that has implicated the human papillomavirus as a major cause for especially oropharyngeal carcinoma in younger women. And so that's a change in the etiology of this disease.

And you asked about the age at presentation. This was a disease that we saw in patients predominantly in their 60s and 70s, and now we're seeing more and more patients in their 40s and 50s and some patients even in their 20s and 30s. What's the cause precisely of all that is that all HPV we don't know for certain, but we are seeing a change in the epidemiology of this cancer.

Andrew Schorr:

Diana, I think you told me you had one sort of an irritation that you would get in your mouth, right, Diana, and you can tell me what it's called, Doctor, but a connection between any kind of chronic mouth condition where someone might be at high risk.

Diana, what is that called.

Diana:

Mine was oral lichen planus, it's l-i-c-h-e-n and then p-l-a-n-u-s. And it's basically an inflammatory condition that affects the lining of the mouth. It most often occurs on the inside of your cheeks. It can be on your gums, your tongue, lips, other parts of the mouth. Sometimes it can involve the throat or the esophagus, which of course in my case it involved my throat.

Andrew Schorr:

And you've had that for how long?

Diana:

I probably had it for about three years, although my dentist as well as the dental oncologist at MDA and Dr. Holsinger agreed that my case was very minor, but it could be a contributing factor.

Andrew Schorr:

Let's find out. One second, Diana, I just want to ask the doctor to put it into perspective for us. What about that, what is it and is there a connection?

Dr. Holsinger:

Well, oral lichen planus is indeed a chronic inflammatory condition, and oftentimes cancer will develop out of the body's repair mechanisms when you're constantly in a state of inflammation. And that concept you'll see in a variety of different disease types. But in Diana's case this really related to the gums immediately around the teeth and some of the mucosa of the oral cavity as it transitioned into the oropharynx. And fortunately the transition of oral lichen planus into cancer is not common, and with good dental care and watching this carefully most cancers that develop from that can either be prevented or caught at a very early stage.

Diana:

Which mine was.

Life After Throat Cancer Surgery and Treatment

Andrew Schorr:

Right. I just want to make a couple of comments. I've had two friends, neither was a smoker, who died of head and neck cancer. And you're right when you talked about the surgical approaches earlier. One of them just had very disfiguring jaw surgery, so if there are newer approaches, welcome, because it certainly affected his speech and his ability to eat. So the progress you're talking about is a really big deal. And then of course having a further understanding of what the causes could be, and then in the case of Diana I guess moving on it pretty quickly.

So, Diana, how do you feel about the future now? So Dr. Holsinger goes in with robotics that gets to places his hands couldn't. How do you feel about the future as far as just going on with your life?

Diana:

Well, obviously I'm very optimistic because he has assured me he has removed my cancer to this point, and obviously he's my new best friend. I will continue to be seeing him monthly for ultrasounds of my head and neck. We'll be watching my lymph nodes very closely for a while. And then after that I'll be seeing Dr. Llano, my ENT, one month and then Dr. Holsinger the next month for a couple of years to make sure that this doesn't come back, because it's my understanding it has a tendency to do that.

Dr. Holsinger:

Right. And one thing just to connect your own personal experience, Andrew, with someone who it sounds like presented at a very late stage...

Andrew Schorr:

Yes.

Dr. Holsinger:

With Diana's case as stage I, a very early case...

Andrew Schorr:

Right.

Dr. Holsinger:

...is really promoting public awareness about this disease, because I think when you talk about head and neck cancer it is somehow more frightening sometimes than other cancers because at every moment of every day we're speaking, we're swallowing, we're breathing, and to think about a cancer affecting those absolutely vital structures, especially speech that constitute so much of our personality, it's very scary, and I think people tend to shy away from it. And shows like this are

really helpful so that if someone does have symptoms this can help get them to a physician sooner so that we can catch more disease in the stage I and II category and hopefully prevent those later stages, patients who present with later stage disease.

Andrew Schorr:

Right. And we're going to talk about the surveillance that people like Diana might have over time. Obviously, you don't want a recurrence or if there is to be one to catch it as early as possible. Lots more to talk about.

Also, we have lots of questions we've gotten in from folks and we have room for more. Here's the phone number to call if you want to call the studio. We're going to take your questions now as we continue.

We'll be right back with much more of our discussion on the advances in the treatment of throat cancer on Patient Power, sponsored by M. D. Anderson Cancer Center.

Andrew Schorr:

Let's dive into your questions for Dr. Holsinger. All right, Dr. Holsinger, are you ready?

Dr. Holsinger:

Yes, sir.

Throat Tumors

Andrew Schorr:

Okay. So first of all here's a question that we talked about what to look for, and you talked about certain things that might persist for two weeks, so first we want to put it into perspective for people. Gina from Katy, Texas wrote in. "I found a small lump which feels like cartilage on my throat. It is sore. It's not part of any symmetrical pattern of my pharynx. I don't smoke and I don't drink heavily. Does it sound like a possible tumor or am I just being paranoid?"

Dr. Holsinger:

Well, obviously it's difficult to give a diagnosis over the web or phone or the radio.

Andrew Schorr:

Right.

Dr. Holsinger:

And so I would recommend that she be evaluated by a head and neck specialist to really see exactly what this corresponds to, because the anatomy is so complex that sometimes if you've accidentally bitten your tongue or had some spicy foods or whatever something can become irritated that you just never noticed before.

But, typically smooth, even, mucosa or the lining of these areas usually is not indicative of cancer. And pain that waxes and wanes or is sometimes not there at all, these are signs that indicate that there's probably not a cancer there, but, again, have someone who is familiar with this area take a look at that.

Andrew Schorr:

I would vote for that, for sure. Because, you know, you know your body best and also you know what's worrying you. And with cancer, for sure, as we heard with Diana, you were concerned. Even though somebody said come back in three months, you go off on vacation, you were worried it did not feel right, you go straight back to the doctor. So I'm sure you would tell people, like I would, if you're concerned about it go get it checked, right?

Diana:

Oh, absolutely. Early detection literally saved my life. Finding it soon changed my quality of life as well as possibly my life. Because had I just let it go obviously the tumor was going to grow and spread. Nothing good can come out of waiting. It's better to know. It's better to sleep at night. Living in Katy, Texas I pass through there every time I go see Dr. Holsinger, all I can say is I would try to get in there just as quickly as possible. It's better to know.

Dr. Holsinger:

Yeah. And there are some great ear, nose and throat specialists out there in Katy, and we're happy to see you here as well. But if you're concerned if it's a new finding then have someone take a look at that.

Andrew Schorr:

Okay. So that comes to a question from Valerie from San Antonio who wonders, "How often should you be checked for throat cancer?"

And I know, Dr. Holsinger, you're the lead author on a big article that's about to come out. Give us just a little clue what the recommendation should be like when somebody has a physical at what age should this be sort of the check?

Dr. Holsinger:

We're lucky that this area is oftentimes seen by our colleagues of a variety of disciplines, not only internists and family practice physicians but also dentists well.

And so I think a yearly dental exam is a great way to start with this, and, you know, I think after the age of 40, if you are going to develop head and neck cancer, that's when a real risk begins, certainly after 50 and after 60.

But I think with head and neck cancer, again to come back to this point, many of the symptoms, hoarseness, a little trouble swallowing, a lump in the throat, ear pain, a lump in the neck, these are all symptoms and signs that we face with a common cold and so if any of those symptoms persist for longer than two weeks, two or three weeks especially, it's worth having a specialist checking that out. So we in the United States don't have the guidelines for routine screening for head and neck cancer, but certainly if there are any of those symptoms it's good to have them checked out right away.

Treatment without Surgery

Andrew Schorr:

Now, Phil in Dallas sent us an e-mail and he says, "I have just found out that I have nasopharynx cancer and I'm scheduled to get a CAT scan to see if it's spread. What are my options if I do not want surgery." Diana chose surgery. He said, "I do not want surgery. Do you have to have surgery, or can you get treatment without all of that?"

Dr. Holsinger:

So head and neck cancer in the United States is interesting. Nasopharyngeal cancer is a distinct subsite that's just about the areas that I described. If you were to draw a line back from the nose and then draw another line extending up from where the throat is, where those two lines meet, sort of between your ears, as it were, is the area called the nasopharynx. And nasopharyngeal cancer is obviously very difficult to access surgically and radiation therapy plays a very important role in this disease. I'm sure your physicians in Dallas, by ordering the CT scan and with other tests, are assessing not only the lymph nodes but also to look in the lungs and other areas to rule out any potential metastasis.

The mainstay of treatment for nasopharyngeal cancer is radiation therapy with or without chemo. And because this tumor arises in the area where there's a lot of lymphoidal tissue there's the sense that it's exquisitely responsive to radiation therapy. And we see a fair amount of these patients and are encouraged with some good results, especially for the earlier stages.

Andrew Schorr:

Let's mention a word about radiation. I know you're a surgeon, but M. D. Anderson, I've done programs with your colleagues in the radiation oncology area, they've made a lot of progress in new approaches to putting the radiation where it needs to be and avoiding the healthy tissue. So it's become a much more attractive approach in sort of your armamentarium, hasn't it?

Dr. Holsinger:

Exactly. There have been tremendous improvements in radiation in the last 20 years, and radiotherapists like Dell Morrison and Kian Ang and Adam Garden and all the folks we have are real craftsmen. And these folks literally only treat head and neck cancers with few exceptions. And the expertise and sheer experience of our group is really amazing. What they have helped to develop, and Dr. Cliff Chao especially has brought to our department, is a technique called intensity modulated radiotherapy. And using a three-dimensional CT scan of the tumor they can take the imaging study and use that to create the radiation fields that minimize radiation does in areas where we don't want it, to keep it off the parotid glands, which are the salivary glands, and the upper portion of the face to prevent radiation, delayed radiation effects in the skin and the submandibular glands and other salivary glands as well as to minimize toxicity to the surrounding spinal cord.

Not only is IMRT being used more commonly we also have the Proton Center, which uses very precise fields that are allowable with using proton as your energy source. And it's really remarkable how precise especially for the skull base these proton fields can be. So it's exciting to see all of this come together. Both minimally invasive surgical techniques, improvements in radiation therapy to minimize side effects and some of the new targeted chemotherapy agents and induction chemotherapy agents.

So I think you know we haven't cured this disease yet but it's an exciting time to bring new options for patients and not just say, You have this, well, you've got to have the most radical thing possible. I think we can step back now and say, What is your disease, what is your health, what is your wishes let's tailor a program to treat you to optimize your oncological outcome and cure you first of all and then do our best to maintain high quality of function and quality of life.

Targeted Drug Therapies

Andrew Schorr:

Right. And at M. D. Anderson you have all those tools as well as some brilliant minds.

I should mention to our audience that we did a program specifically on proton therapy, this new radiation oncology approach you heard about. So that's in our archives, just the replays of previous programs. I'd urge you to listen to that to understand that. M. D. Anderson made a tremendous investment in that, and it's been paying off for people just tremendously.

You mentioned along the way targeted drug therapies. Sometimes that's going to be needed. Do you feel that your colleagues in the medical oncology world that they have new tools as well?

Dr. Holsinger:

Yeah, it's very exciting. We for years have used chemotherapies that rely on an ability to kill cancer cells, which divide more rapidly than any normal cell in the body. And we administer that chemotherapy, and again I'm obviously a surgeon not a medical oncologist, so I'm stepping out of my comfort zone here, but chemotherapy that targets fast-growing cells not only takes out cancer cells but also normal cells. And a variety of techniques have been developed now using monoclonal antibodies, using special molecules called tyrosine kinase inhibitors, that attack a unique gene or molecular defect that's present in that individual patient's cancer and so that the drug that's being given doesn't affect all cells, it only affects cells that have a particular genetic abnormality. And that's called targeted therapy.

And we are doing lots of studies using targeted therapy like directed toward the epidermal growth factor receptor plus more effective but less toxic chemotherapy agents with docetaxel and cisplatin to put all those together, to reduce these tumors so that the radiation therapist's job is easier or the surgeon's job is easier.

Andrew Schorr:

So that's part of the discussion then, Chris, isn't it? Let's say if you're going to maybe use this tri-modal approach or maybe radiation or surgery, then sometimes the drug therapy might be used first to shrink the tumors and then you have a more focused area to work on.

Dr. Holsinger:

Exactly. And that's an area that we're exploring with a variety of compounds for patients with laryngeal cancer. My good friends and colleagues have put together a study that actually took patients with larynx cancer, who a standard of care is radiation and surgery, and we've done a study that showed that certain patients with laryngeal cancer might actually respond to chemotherapy alone. It's very experimental approach, and it needs to be derivative by a better, larger study across different institutions, but sometimes we can use this induction or neoadjuvant approach to reduce the tumors not only to make the radiation therapy less potentially toxic but also to take a patient from needing a large surgery to a much less invasive surgery. And that's certainly something we're going to be studying here in the next year in particular.

Homeopathic Medicine

Andrew Schorr:

Okay. Here's a little Patient Power moment when I get on my soapbox. So I came from Seattle to M. D. Anderson because they have the world's largest leukemia clinic and they have doctors who specialize in the leukemia that I was diagnosed with. And I didn't know anything about the clinical trials, but that became part of

the discussion. Might there be research going on at M. D. Anderson either just there or as M. D. Anderson is one of the centers around the world where maybe tomorrow's medicine might be offered to me today, still experimentally, but that should be part of your discussion. And I think that's one of the advantages of going to M. D. Anderson is what's been the standard approach and might in your case, you have an educated discussion with your doctor there to see is there something that's being investigated that might show promise for you. So that's my little commercial for clinical trials, but I really believe it.

Also we did an earlier program with Dr. Maurie Markman who's the head of the clinical research area at M. D. Anderson and he explains that in depth, and I would urge you to listen to that.

Dr. Holsinger, here's another question. Talk about treatments, and so we talk about these high-powered approaches, but Drew from Houston wrote in, "My father's 71 years old and has throat cancer, stage I. Can this be treated by homeopathic medicine?"

What's your thought?

Dr. Holsinger:

Well, certainly I never want to say to anyone that any kind of a treatment is not going to work, but certainly you want to use alternative medicine therapies, homeopathic therapies very carefully. You want to make sure that there's good evidence for any type of treatment. And I think with the advent of clinical trials there's much better evidence for using what we would consider standard therapy more and more often there's not as much evidence for using homeopathic regimens. I think what may drive that is fear of some of the treatment consequences. I know Diana was very concerned about the impact of radiation therapy on her dental care, and in her case that may be true, with lichen planus. But in other patients many, many have radiotherapy with very few if any side effects down the road, and the same could be said with chemotherapy.

And so I think before homeopathic treatments or tried I think it's good to really think about why a more standard approach isn't being used and what might underlie anxiety about those standard approaches.

Diana:

Andrew, can I just add one little thing on that?

Andrew Schorr:

Yes, ma'am.

Diana:

I have had acupuncture treatments for many years for various reasons, and I discussed that with Dr. Holsinger in the very beginning. I have a son who is an Oriental medical doctor, and so homeopathic and alternative medicines were an issue that I had. And I would like to just say that I went with the surgical approach because it has more proven history for cancer of the throat and again because it affects so many functions of daily life, but a week after my surgery I was having acupuncture for inflammation and swelling. I went every week. My face went back to normal quicker than most people. I healed quicker than more people. I had treatments of acupuncture for the teeth pain that I had, the exposed roots. So I used it in conjunction with Western medicine but at the appropriate time.

Dr. Holsinger:

I think that's a great way to think about it. I never say no to these sorts of things but it needs to be really incorporated into our multidisciplinary approach.

Andrew Schorr:

Right. I want to make a couple points because I get to do these shows all the time and I hear people tell these stories. So first I would say M. D. Anderson practices evidence-based medicine. So that means there are studies that you rely on, Dr. Holsinger, and you often are the authors of the studies but really seeing how things work and studying it and documenting it and really being very scientific about it. That's what I want as a patient. I want to know that you've studied it and really can talk turkey with me about what you believe a difference this will make for me. Not just a story I saw on the internet or a neighbor said this worked for Uncle Charlie or something like that.

Now, that said, there may be additional approaches that have very little downside. Certainly acupuncture has very little downside and may be helpful, and you can explore that, I think. Don't you usually say, Dr. Holsinger, just be careful, do no harm?

Dr. Holsinger:

Exactly. First do no harm. Hippocrates, a physician to us all. But in fact I want to say actually Joe Chiang, an anesthesiologist, and Mark Chambers have actually studied acupuncture in the setting of the management of dry mouth or xerostomia for patients who had radiation therapy and found it to be very, very effective in a prospective trial that I think they're writing up. So, exactly, it's nice to blend all these approaches together and not rule out one over the other but try to put them together in a way that makes the most sense. It gives you the best chance for cure and recovery.

Andrew Schorr:

Right. And there are two other aspects to that. Again, we've done almost a year's worth of programs, Patient Power programs with M. D. Anderson, and so one of

them is on complementary and alternative medicine integrated into cancer care. So there's a whole department at M. D. Anderson that deals with that, and so please look at the replay on that and so much is there.

And that goes back to where we were before, Dr. Holsinger. You look at the whole person and so really there's a lot that your department has to offer in understanding that people have these needs.

Dr. Holsinger:

Yeah, exactly. And not just having a cookie-cutter approach where you have this stage and this age and you get that treatment but really to tailor this, a personalized medicine approach. And hopefully not only are we going to do that by using cutting-edge laser surgery techniques and robotic techniques and IMRT and targeted therapy but also to take the tumor itself and to profile it using genomics or proteomics and to study not only the disease itself but how you might respond to radiation therapy or how you might respond to surgery and to put that using a scientific basis all together and really making this a truly personalized medical program for your treatment. And that's where I hope we'll be in ten years. And certainly that's part of the fun about being here is that we've got great scientists and great clinicians who are working together on clinical trials to try and provide the next generation of evidence-based data.

Hope for the Future

Andrew Schorr:

Diana what would you say? Somebody may be listening to this who's just terrified. It was very scary day for you when you saw your ear, nose and throat doctor and he comes in on his day off and he tells you have cancer and you know throat cancer is very serious. So somebody may be listening or a family member. What you would you say to them, what would you say to a family member so that they can see that, you know, the sun can shine again?

Diana:

Well, I have always been a glass is half full type of person but I believe very firmly that not only was it the early detection but the peace of mind that I was given when I was an able to go to M. D. Anderson. Sitting here for this hour listening to Dr. Holsinger has just reiterated to me that I didn't have to know all of that. I know that he knew it and that he was going to take good care of me and that I was going to have the best care possible. I could focus on the fear that I had, the fear that my husband had as a caretaker, the trauma we were going through, our family and friends. I actually have a cousin in Nebraska who's just e-mailed me while I'm on the phone with you telling me she's listening in.

And so for my family to know that I'm doing well to be able to hear my voice and that I'm speaking the way I always did after only two months. It's been a lot of work, it's been a long journey but you can definitely, definitely make it.

Andrew Schorr:

What's your cousin's name, by the way?

Diana:

Sharon.

Andrew Schorr:

Well, Sharon thank you for listening. You know I spoke to Diane on the phone for the first time last night and thought, wow, this lady I'm going to talk to has had cancer in cancer in the back of her mouth and all that and she'll have difficulty talking and she'll be tired, and this was just a couple of months ago. Wow. You are remarkable, Diana, so I'm really just amazed.

Dr. Holsinger:

She's a model patient for rehabilitation following minimally invasive surgery too. I have to say that.

Diana:

Well, thank you. But you know it falls back on quality of life and it goes back to the speech therapist that worked with me in those first few weeks and I would swallow and water would go up my nose or food would go up my nose. I'm not trying to paint a rosy picture that the robotic surgery was just peaches and cream. Obviously there were many tough moments, but the team at M. D. Anderson, the nutritionist who helped me when I was losing weight so dramatically, Dr. Holsinger's fellows, everyone was so caring and helpful that it helps you to get down that journey not knowing what you're going to find at the end. And every day I think, okay, when do I go back to MDA so that I get that reassurance again? And I'm going monthly, and I can tell you when that appointment is because I see that as an optimistic part of the rest of my life.

Andrew Schorr:

We're going to take a quick break then we'll be back with some final comments as we continue our fascinating broadcast on advances in throat cancer sponsored by M. D. Anderson Cancer Center.

Andrew Schorr:

We're going to give you a bonus and just go a few minutes longer than our normal hour because I love Dr. Holsinger and he's really paved the way with the team there in head and neck cancer, and we want to give them their due. Also, Diana, you are such a patient advocate given what you've been through, and I know your family is listening around the country and just inspired by you.

Dr. Holsinger, so just to pull all this together. So you're a relatively young, handsome guy, I've seen your picture on the web.

Dr. Holsinger:

Well, no, I don't know about that.

Progress in Research

Andrew Schorr:

And I know Diana just loves you. So you're watching where this has been in the treatment of head and neck cancer and where it's going and there are people listening to every word who want hope. What would you tell them about the progress that you and your colleagues are making at M. D. Anderson?

Dr. Holsinger:

Well, I think we've got a great team here. We've got a great head and neck surgery department. Randy Weber, our chairman, has really pulled together people from lots of different backgrounds, and we're bringing together minimally invasive surgery with our colleagues in radiation oncology, are using IMRT and protons and working with our medical oncologists to hopefully craft a truly personalized medicine approach to how we treat this disease. Because it's an important disease. It's a disease, not that other diseases are easier or harder to deal with, but when you're afflicted with head and neck cancer it affects every time you swallow, every time you breathe, and that's what you need. You need three different disciplines coming together providing the latest technology, whether it's the fiber optic laser or surgical robotics, to just look at the whole person and tailor a treatment plan that makes sense.

Andrew Schorr:

Right. And I think it's important and you mentioned it earlier on that you have audiologists and nutritionists and social workers. And, Diana, you really embrace that. I mean I know you don't like driving up the highway time and again. You told me Bob's not a big fan of the Houston traffic going up there coming from your smaller town, but when you get there you feel it's well worth it.

Diana:

Oh, absolutely. On one of our first visits I told you in our pre-interview I stepped off the elevator, I looked left, I looked right and within seconds three people were asking me if they could help me. It's just so heartwarming. You can sit in the lobby and have a cup of coffee and before you know it you've got several people sitting around sharing their stories, and they're all hopeful, and every one of them say, Yes, I have cancer but I'm at M. D. Anderson. It's the good news, bad news.

Dr. Holsinger:

That's what's exciting to work here is that oftentimes many of us who work here have been afflicted by family members who themselves have had to deal with cancer, and it's a special place.

Andrew Schorr:

Well, I will say that. When I flew down from Seattle I had never been to Houston before, and it was quite scary. When you're diagnosed with cancer and that's your worst fear and then you go to this huge medical center area of Houston and then a really big part of it is the M. D. Anderson Cancer Center and maybe you don't know anybody. Well, you don't know anybody for about a nanosecond. And I'm always amazed when I go there and the leukemia department, if you've ever been there, you probably have a really neat, modern area, Dr. Holsinger, but leukemia guys are still in an older part of the medical center, and the waiting room is kind of cozy with a lot of people in it unfortunately who come from all over the world, but very quickly people are chatting and making connections.

And I know it used to be where I'd go on the internet and tell a group of leukemia patients I was going to M. D. Anderson and going to see my doctor, Dr. Keating, at 1:30 on Friday and somebody would say, well, I'm the 12:30 appointment and I'm the 2:00 p.m. appointment and then we said, Well, let's go to lunch. So really it's people coming together. We're delighted to do this on the internet.

I want to mention and you mentioned along the way progress being made in different cancers. Our next broadcast we're going to cover skull based surgery, and so that will be fascinating too. But for people concerned about throat cancer listen back to this program. We'll be posting the replay. A transcript will be there. It will be on the M. D. Anderson website. It will also be pushed out there as I mentioned earlier on the new Microsoft health search engine.

Dr. Holsinger, I wish you all the best with the progress you're making, and it sounds really hopeful.

Dr. Holsinger:

Thank you very much, Andrew. It's really been a pleasure to participate in Patient Power. And Diana, thank you too.

Diana:

Sure. I'm just glad to help. It takes a village literally, and M. D. Anderson is the best I know. I'll see you on the 5th, Dr. Holsinger.

Dr. Holsinger:

See you on the 5th.

Andrew Schorr:

There they are. Your new best friend. And, Diana, you're one of my new best friends too. I am so pleased to meet you, and I know your family far and wide, your son up here in Seattle, whoever is listening, is just delighted to hear you speak and your energy and know that we're going to have a reunion next year, okay? And can I come to a Christmas dinner sometime?

Diana:

Oh, you certainly can, Andrew. And I hopefully will have something a little more chewable next year that everyone can enjoy. It won't all be mashed.

Andrew Schorr:

Right. More of the mashed potatoes, and we're not going to put it in the blender, okay?

Dr. Holsinger:

No turkey shakes.

Diana:

That's right. That's right.

Andrew Schorr:

No turkey shakes. Thank you so much for being with us, both of you. This is what we do on Patient Power. I'm just so honored that M. D. Anderson makes all this possible. Their commitment wherever you get treatment is to be an informed, empowered patient, family member so that you get the best, and if it makes sense then come to M. D. Anderson where I know they offer you the best.

As always, knowledge can be the best medicine of all. In Seattle, I'm Andrew Schorr. You've been listening to Patient Power brought to you by M. D. Anderson Cancer Center.

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