

Treatment of Colon Cancer and Pancreatic Cancer: Are We Making Progress?

Webcast

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Eric's Story

Andrew Schorr:

Hello and thank you for joining us once again. I'm Andrew Schorr, happy to bring you Patient Power sponsored by Northwestern Memorial Hospital. We do this every two weeks talking about pretty significant health topics and connecting you with leading experts from Northwestern and, just about always, inspiring patients. Tonight you are going to meet two. We are going to discuss two really scary diagnoses, but are we making progress? And I think the answer is yes, and you are going to hear that from a leading expert from Northwestern Memorial and also the Robert H. Lurie Comprehensive Cancer Center at Northwestern.

We are going to talk about the treatment of colon cancer and pancreatic cancer. Now, I have had dear friends who have been diagnosed with colon cancer and also my mother really diagnosed too late when it had spread. And unfortunately in several of those cases they didn't live a full life at all. My mother died after about four and a half years. Now, this was 20 years ago, and a lot has changed, but it had spread to her liver, as it does sometimes and too often unfortunately. We have made progress. You are going to hear just an incredible story in just a minute.

And then there is pancreatic cancer, and I think as most people will know if you are diagnosed with pancreatic cancer the statistics, just the broad numbers, are not good, but I increasingly I have to say meet people who defy the statistics, who got expert care and are going on with longer lives, full lives. And you are going to meet someone like that in a minute.

Now, let's meet the man who has had advanced colon cancer and I like to say has been putting it in the rearview mirror after a lot of treatment and going about and living his life, and that's Eric Lentz. Eric is from Skokie, Illinois. He is 52 years old. He is married with two kids who are probably listening on the computer right now. Hi, kids. And Eric is in the sales business for swimming pools and hot tubs and all those sorts of things, and he does that around Chicago.

When he was 48, which is often before people start getting colonoscopy, he had some bleeding, went to his doctor, doctor says must be your diet, change your diet, don't worry about it. Then it continues, and he has some pain, goes to a doctor again, same story. Finally the third doctor when he goes says, well, we better

check. They attempted colonoscopy. And, Eric, if I have got this right, when they tried the colonoscopy, there was a tumor that made it too large I guess to do the colonoscopy. Is that right?

Eric:

Yes, it is.

Andrew Schorr:

Oh, my goodness. So you knew you had continuing symptoms. We love it when the doctor says, oh, it's probably nothing. You found out not only was it not nothing, it was something, well, quite frankly I think what many people would find terrifying. So what happened next?

Eric:

Well, when we heard that it was advanced, at first when we went to the colonoscopy they couldn't even perform the test because the tumor was so large that they couldn't even get into my colon. And then we had, next we had a CT scan, which revealed that we had numerous lesions on my liver, well over 20 lesions on both sides, on the left and right sides of my liver.

Andrew Schorr:

Wow. Now, my mother had had it spread to her liver. It had just started to spread, and she actually lived about four and a half years with that, you know, 20-some-odd years ago when the treatments weren't anything like what they are now. You are talking about 20 lesions on your liver. So what do they do when that happens? I have this image of you need surgery at some point, but there is also drug therapy and maybe even radiation that needs to come into play.

Eric:

Right. Well, first thing was that we went into a trial study at another hospital, and we were on a cocktail of drugs, five different drugs, and the key drug being the Avastin, which has only been out for approximately five to six years. We were in the trial study, and after the very first eight weeks we had very significant reduction of the lesions on my liver, which was a very good sign. When we had first gone in and spoke with an oncologist, they told us I probably had 12 to 19 months, and then just after eight weeks we were told that it was very likely that I had gone from terminal to chronic, which was just incredible news for us.

Andrew Schorr:

Yeah. If you can't cure the cancer, living with it chronically, and I know you were able to go back to your business. Now, eventually you continued your care at Northwestern Memorial. So what treatment resumed there?

Eric:

Okay. After about six months we took a break for a while. We had reduced the lesions to where they weren't growing, and the CA count in my blood was at normal, zero to three, and then after a few months the lesions started coming back. So we went to Northwestern and again we did the cocktail of drugs. It was it was oxaliplatin, leucovorin, Avastin, and 5-FU. And then just after eight weeks, the lesions had shrunk so small that we met with Dr. Sato, and we ended up going in for surgery. We had two different procedures done. We had radio frequency ablation done on one day, and then the following day we had chemoembolization done. And then of course there was recovery.

And then we had about four to five months where everything looked good, and then the lesions started coming back again. So then we started our third round of chemo at that time. And then that was a year ago just this month. We decided we had shrunk them down enough to where we went in for a third surgery, and we had the right side of my liver removed. And while they were in there, they burned the small lesions that were on the left side.

Andrew Schorr:

Wow. So, Eric, you have been through a lot, but I spoke to you earlier today, and you were out there selling swimming pools. How are you doing today?

Eric:

Oh, I do great. I just, physically I would never know that I actually have the cancer. This round of chemo, which is our fourth round, we are actually just taking the chemo pills, so my life is pretty much normal. I don't even have any real side effects from the Xeloda that I take now. I am just going about life as normal and enjoying it more than ever.

Andrew Schorr:

Wow. We are all glad to hear that. And, you know, the kids listening on the computer, or if we have people around Chicago listening on the radio out there in Aurora and in Naperville, and I know everybody is delighted with this result.

I want to introduce our leading medical expert who is with us tonight, and that is Dr. David Mahvi. Dr. Mahvi is new to Northwestern, been there three months. He is Chief of GI/Oncologic surgery there at Northwestern Memorial Hospital, and he is a professor of surgery at Northwestern University's Feinberg School of Medicine. He is also a member of the Robert H. Lurie Comprehensive Cancer Center.

So, Dr. Mahvi, what I hear in Eric's story first of all is one of great hope for people, but also there are a variety of modalities coming together. Now, I heard about various drug cocktails, so combination therapy including these newer medicines like Avastin. I heard about a couple of different surgeries, not just to the colon, but to where the cancer had also spread. Heard about radiofrequency ablation. So a lot

of stuff coming together that allows a gentleman like this to go back and work and be with his family. Is that the name of the game now with advanced colon cancer?

Dr. Mahvi:

Well, I think colon cancer has changed a lot. We, you know, years ago would really just take out people's colons, and that would be it. And I think what Eric said is exactly right, that we have tried to take colon cancer and instead of making it this kind of terminal diagnosis that metastatic colon cancer, we are trying to make it into a chronic disease. Not a chronic disease maybe like hypertension, but a chronic disease like HIV infection, where we keep trying new and newer and newer things. New drugs keep coming down the pike, and we keep trying them.

The interesting thing about colon cancer is that you don't just have chemotherapy to deal with it. You have surgery, chemotherapy, radiotherapy, which we haven't really talked about a lot which isn't relevant to the liver, and the trick to it is figuring out when to utilize these, when to stop, when they are making someone so miserable that, you know, you need to try something different. We talked about a lot of different types of therapy, but I think it's one of those things you just get all these people in the same room, and you sit down and say, well, this is where we are, and we all put our heads together and kind of decide where we want to go next.

Linda's Pancreatic Cancer Diagnosis

Andrew Schorr:

We are going to take a lot more about what Northwestern offers as far as these specialists being in the same room to talk about Eric's situation or other people and seeing how all these modalities and the expertise can come together, and we are going to learn about that in a minute.

I wanted to introduce someone else. So we are going all around the country. You are actually joining us from San Francisco tonight where you are at a conference. I am actually based in Seattle, and Eric is in Skokie. We have our audience all around the world really, but around Chicago. And then we have Linda Milenkovic. Now, Eric is 52, and his colon cancer was discovered at 48. Linda is 62, and about three years ago, imagine this, she was just settling the affairs of a dear friend who had died within two and a half weeks after a diagnosis of pancreatic cancer, and then--and cancer is not catching, if you will, but listen to this. Linda was feeling tired, really tired to the point where eventually she asked her husband, Heinz, to take her to the emergency room.

And then, Linda, you got the same diagnosis, pancreatic cancer. It must have been just so shocking.

Linda:

It was not to be believed to have two people that close, and the time span was so tight. No. Totally unbelievable.

Andrew Schorr:

Now, Linda, I want to just give you the glimmer of the happy story here because often as one might think in pancreatic cancer it has not been that way, and actually my mother died of colon cancer, my father remarried, and the woman he married in his seventies, she died of pancreatic cancer. So unfortunately I have had experience with both of these illnesses with unhappy endings.

So I am delighted to say, though, Linda and Heinz are now retired, and this is three years post diagnosis of pancreatic cancer, and they live way up on the coast of Maine now, right? I mean, we have cold weather I know in Chicago, but it's got to get cold up there in Maine, Linda, and that's retirement?

Linda:

It's not bad on an island, really.

Andrew Schorr:

Okay. You celebrate every day, I know. I want to just go through your pancreatic cancer a little bit, and then we are going to get much more into the details of the treatment approaches now for both colon cancer and pancreatic. So let's understand this. So you go to the emergency room, they say you have pancreatic cancer, and you start getting jaundiced, I know, which is typical. And they are trying to help your pancreas. You were then referred from a suburban hospital I think in Joliet to Northwestern. What happened next?

Linda:

It turned into probably the wildest race of my life, more testing than I had ever conceived of. I was put almost immediately into trials of both radiation and chemotherapy because when you are dealing with a cancer with a 98 percent mortality rate, what have you got to lose by doing a trial? If you can't do something for yourself, maybe you can for someone else. My reaction to the chemo was rather drastic. I didn't hold food for months. In the course of ten months, I dropped a hundred pounds. I had it to lose, and unfortunately that's part of the contributing factor to this particular cancer.

But we saw the surgeon within a matter of two weeks after diagnosis, and it was very nice, very small, and very inoperable. It was wrapped around the mesenteric artery, which basically feeds the gut. And he said that he was very sorry, and we went on to massive chemo and radiation for six weeks, and no great results. We continued with CAT scans every eight weeks. ERCPs literally down the throat with a TV camera and rebiopsying. Blood marker numbers started to drop a little.

Andrew Schorr:

I want to skip ahead just a little in the interest of time. You went through a lot, but the point is eventually there were treatments that showed a decrease in size of the tumor, and I think as you described to me on the phone earlier today the surgeon who kept monitoring this saw a little window of opportunity to do a surgical procedure. And I want to skip over to Dr. Mahvi just for a second, and we are going to take a break in a minute.

Dr. Mahvi, there is this procedure, and I know I had an in-law who had it, the Whipple procedure, which I would imagine has got to be one of the most complicated abdominal surgeries, but it can be lifesaving or life extending in pancreatic cancer, and that's what Linda had. But you have to I guess feel confident that the surgery is worth it, if you will, that you can cut out these tumors.

Dr. Mahvi:

Well, it is a big operation, but you are in a situation like Linda was in where the only way to effect any kind of cure or survival is to remove the tumor. If you can't remove the tumor, you can control it, but you really don't have that long-term shot, so we have to weigh the risks and the benefits. It's a big operation, but it's one that's effective in this tumor. You have to select your patients very carefully, and I think certainly that was what was going on there. They were watching this and watching this. And typically you will get this window where you have a chance to go in and try to remove these things. And we take the operation very seriously, but we also think that in the right patient they tolerate the operation well, and sometimes we are able to take the tumors out and fix them. It's a tough tumor to deal with, but I think that operation, despite its, you know, kind of physiology of really affecting someone's body is a very effective cancer operation.

Andrew Schorr:

Well, we are going to talk a lot about more about it and hear more from Linda and Eric along the way and a lot of information on the latest from Dr. Mahvi. I would mention also that this in-law of mine who is in Los Angeles maybe listening tonight, she too had the Whipple procedure, and it's worked out well for her, and so we are so grateful.

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Deciding on Treatment

Andrew Schorr:

Thank you for joining us for our live broadcast sponsored by Northwestern Memorial Hospital. Andrew Schorr here with Patient Power. Thanks for joining us on the radio if you are in the Chicago area or on the internet all around the world as we connect with the leading surgical expert in GI/Oncology or what we would call cancer of the colon or sometimes the liver, but also the pancreas. And we have

with us two survivors of more advanced colon cancer and also pancreatic cancer. And we are delighted, and they are both doing well, and we will hear more from them as we go along.

If you want to give us a call and ask a question or make a comment, 877-711-5611, or send an e-mail to nmh@patientpower.info. And if you are listening to this program, and you say, oh, I wish Aunt Susie had heard this or another relative or a friend, then remember we will post a replay tomorrow on the ihealth area of nmh.org. So it's www.ihealth.nmh.org. And then we will add a transcript in a couple of weeks, and share it with your doctor or other people who may want to know more of this expert information we will share tonight.

Dr. Mahvi, so let's dig into it little bit more, first about colon cancer. So fortunately with colonoscopy, if people have it, you know, these precancerous polyps may be discovered and snipped out. Sometimes when that's not discovered I know it can start to spread into the wall of the colon, and when it advances can break through that and go to other organs like it did for Eric or for my mother. So then it's a tougher game, and it sounds like beyond surgery then you need the systemic approaches, and these other radiation approaches, etc. So at Northwestern, as you said earlier, you can get together in a room of specialists and discuss that. It used to be that surgery would happen, but not all these others, and/or the other treatments would come later. If I heard right with Eric sometimes now some of these other therapies come first to try to shrink the tumor. Do I have that right?

Dr. Mahvi:

You do. And there is kind of two issues there, one is the primary colon cancer and one is the metastatic disease, and surgery is going to be most effective for dealing with the primary tumor, especially when it's localized, which is why we spend so much time pushing people to have colonoscopies and find these tumors early because we cure most of these surgically. But sometimes they present in relatively advanced stages, and surgery alone is not going to be effective because we know that there is going to be disease outside of the colon, and we know that we have to treat it with some other kind of therapy, and those tend to be systemic therapies. And by systemic therapies I typically mean chemotherapy or some of the new drugs like Eric got, such as Avastin, bevacizumab, which are a completely different class of drugs than we are used to using for cancers.

Andrew Schorr:

Now, we are hearing about these drug cocktails, and myself as a leukemia survivor, I got that. I got three drugs together. One was a brand new one actually in a clinical trial as well. So is this combination therapy showing success? Not everybody. Not everybody responds, but here was Eric who responded greatly, and I have this image of the drug therapies kind of hitting the cancer cell, you know,

one hits it in the knees and one in the abdomen, and one, pow, right to the jaw trying to knock it out. Is that the idea of these different modalities in sort of a synergistic power?

Dr. Mahvi:

Yeah, I think so. I think I would use another, a little bit slightly different analogy and say that you would go up to a big, huge guy, and the first time you would hit him in the stomach with your fist. And if that didn't work, you know, you would try to kick him in the knees, and if that didn't work you would pick up a huge baseball bat and hit him over the head, and you just keep trying things until you knock it down. And Eric's case is relatively typical. You try a drug or a drug combination, and if that doesn't work, it doesn't completely do what you want it to, we have other drugs in our toolbox that we can pull out and try to get things to shrink.

And we know if the drugs aren't effective, if they are not causing any impact on the tumor, that we are much less likely to cure these tumors surgically, so it matters a lot to us. We watch these very closely to see how the drugs are working, and if they are not working we switch to something different.

Andrew Schorr:

Now, tell me about radiation. Where does that come into play, both external radiation and also actually implanted radiation?

Dr. Mahvi:

Well, external radiation is really critical in rectal cancer, and the reason it's critical is because it's an anatomic thing. The rectum is in a relatively small space, the pelvis, and if it just gets a little bit outside of the colon, you are very close to the side of the pelvis, and there is just not much there. And we tended to have tumors recur in the pelvis, and radiation will lower the incidence of that and prevent it in most people. So we tend to use radiation in rectal cancers.

If it's in the colon, meaning it's higher up before it gets down to the sort of lower colon and the rectum, there is not as many structures around there and there is not much that it can grow into, so it's not as effective. But for rectal cancers almost all of those patients at some point in their therapy would get radiation. Sometimes we use it before we do the tumor resection as a way to shrink a tumor that we think is too big to take out, or because we want to make the operation technically easier, but sometimes we use it after the surgical procedure also.

Andrew Schorr:

Now, what about implanted radiation because I know Eric's cancer had these lesions, 20 I think he said on his liver, and I know there are these approaches where you can implant little spheres, I think?

Dr. Mahvi:

Well, you don't really, you inject them, and you use the blood supply of the liver to try to deliver them. And what you do is you inject them into one of vessels that leads to the liver, and it pushes it out to the liver, the blood stream, and they attach themselves to these tumors preferentially and the radiation then kills the tumors from sort of inside out rather than outside in, so. They are probably a little more effective against primary liver tumors like hepatocellular cancer, which is a primary liver tumor. And we are sort of, I mean, Northwestern has always been at sort of the forefront of that particular process, and we keep trying different things and trying to treat different tumors. So we don't quite know where that, or the holy grail of that would be to find a radiation source attached to something that would just attach to the tumor cells, and we could just kill the tumor cells without any other toxicity of the liver, and we are working to that, but we are not quite there yet.

Radiofrequency Ablation

Andrew Schorr:

Now, radiofrequency ablation, so my understanding is that's something done in the OR to try to kind of zap lesions you see when cancer has spread in the abdomen?

Dr. Mahvi:

Well, it's most effective in the liver. And you can either use it in the OR, which is how we typically use it, or you can use it through the skin, just putting a needle directly into the liver by one of our radiologists. It's a way to just kill tumor cells without losing a lot of liver. We typically use it in a setting where someone has more than one liver lesion, and we are taking out one of them, and the other one is in a place where it would be difficult to remove. So what it does is it heats the tumor cells up to the point where the protein kind of coagulates meaning that the tumor cells then die. And we try not to treat much of the normal liver around it so that it's a way to kind of just kill the tumor cells.

It's not quite as effective as resection, so we would always default to resection, but a lot of patients have not just one lesion that's easy to take out, but they will have one in one side of the liver and one in the other side of the liver, or multiple lesions in both sides, and this is a way to kind of extend the benefits of surgery to a bigger patient population.

Andrew Schorr:

Now, Eric, you mentioned along the way that you did have liver resection, right? You had part of your liver removed, correct?

Eric:

Yes. That was my last surgery. That was just about a year ago.

Andrew Schorr:

Okay. So tell us about that, Doctor. So you mentioned resection. Eric had it. So the cancer had spread. He had had these other modalities to the lesions on his liver, but then he had it removed. So how do you get along with part of a liver?

Dr. Mahvi:

Well, the liver is really kind of a cool organ. I guess I shouldn't say that. That sounds kind of self-serving. But it regenerates. So you can remove in a completely healthy liver, you can probably remove 75 percent of it or 80 percent, and it will regenerate. And if you look at the liver a year later, it's the same size that it was before. So it's why we can kind of do this. There is a lot of redundancy to the body. There is two kidneys. The liver is huge. And if you take out that much of the liver, your liver function tests still are normal, and it regenerates, and it allows you to do bigger and bigger and bigger operations.

We are a little bit constrained by the chemotherapy, which makes the liver not regenerate quite as well, but we still are able to do pretty aggressive surgical procedures because of that ability of the liver to very quickly regenerate. It's a very interesting phenomenon. Certainly most of the organs in the abdomen, most of the organs in the body don't regenerate. The liver is kind of an unusual organ.

Andrew Schorr:

Well, we have so much more to talk about, and we are going to discuss pancreatic cancer and the unique things there, also understand this surgery, the Whipple procedure, and in both cases how--well, what does Dr. Mahvi say about his outlook as we try to give hope to people affected by these serious conditions and make those rates of survival go up yet higher, long-term survival.

You are listening to Patient Power sponsored by Northwestern Memorial Hospital. We will be right back as we continue our discussion with Dr. David Mahvi and also long-term survivors now, Eric Lentz and Linda Milenkovic. Stay with us.

Whipple Procedure

Andrew Schorr:

Welcome back to our live broadcast as we are about to dig into a deeper discussion about pancreatic cancer where as Linda Milenkovic, formerly of Joliet but now from Eastport, Maine, and some of your fans are listening by the way, Linda, as she mentioned earlier the statistics as anyone knows when they are diagnosed with it are not good, but I tell people all the time on this program you are not a statistic. When I was first diagnosed with leukemia, you know, I opened the book, "always fatal condition." Well, there was research going on that was changing that, and hopefully Linda is an example of where there is change going on in pancreatic cancer and Eric in advanced colon cancer.

So, Linda, you had a whole range of treatment at Northwestern, and now you and Heinz get to live in Eastport, Maine by the fireplace now watching the moon out there over the Atlantic. How do you feel about the care that you received?

Linda:

It was nothing short of phenomenal because we had seen the statistics, and suddenly I had oncologists who wanted to throw the book at this beast who decided to occupy me, and they started making a difference. It took ten months to get to surgery, but without the team I had, I don't think I would be talking to any of you right now. They were incredible.

Andrew Schorr:

Yeah. I think that says it all.

Now, Dr. Mahvi, help us understand, when you do surgery, and that's what my relative had and she is a survivor, and I have had another woman on from Houston, Mary, she had the surgery, and now Linda. So it can be life extending or life saving. What do you have to do when you do this Whipple procedure, which I know in Youna's case it was about over nine hours, and, Linda, yours was something like ten and a half hours? Is that right?

Linda:

That's what my husband tells me. I missed the fun.

Andrew Schorr:

Okay. So, Dr. Mahvi, very intricate, and certainly if you are a candidate for this surgery you want to go to a place like Northwestern where you are well familiar with it. It's not an everyday thing. What do you have to do in kind of laymen's terms to help people, you know, help their life be saved?

Dr. Mahvi:

Well, it is a complicated operation, but what you are trying to do is achieve a margin around the tumor in the pancreas that has normal tissue in it. Because we know if we cut right next to a tumor we are not very good just looking at tumors as to where they stop, and they tend to come back because you have left a few cells there. And what you try to do in all cancer surgeries is get a normal margin of tissue around the tumor.

The problem with the pancreas is that there is a lot of stuff around it that you can't really easily take out. And the only way to get a normal rim of tissue around it is to take out the things around it, which means the pancreas, part of the pancreas, part of the bowel, because the stomach kind of drapes itself over the pancreas, and that's how the digestive juices from the liver get to the bowel is they go right

through the pancreas. So you have to take out a piece of the bowel, part of bile duct, which is how the bile gets from the liver to the GI tract, and that goes right through the pancreas. So you have to then take out of a piece of the pancreas.

And you are left with all of these things to kind of replumb, and that's why the surgery takes so long is that you have to, after going through a relatively complicated operation you then have to turn around and then hook everything back together. And it does take a long time. Sometimes you have to take out part of blood vessels that are going next to the tumor, which makes it even a longer surgical procedure. And it's not something that most people do much of. It's just, it's a relatively rare surgical procedure, and I think most surgeons don't have enough experience with the operation to do it, and they tend to defer to people like us who do lots and lots of this kind of surgery.

Andrew Schorr:

Well, I think that was implied also in what Linda was saying is, Linda, you said had you not gotten the care you did at Northwestern that you wouldn't be with us tonight, and I think that's so true that when somebody has a diagnosis like pancreatic cancer, you want to get with a team where this is what they do. And certainly that's what Dr. Mahvi does and his colleagues at Northwestern. I could not recommend that enough.

So I want to ask a question, and it goes to you too, Linda. We have an e-mail question that came in from Megan in Chicago, and Megan asks, well, what is the effect of the Whipple procedure, the surgery for pancreatic cancer we were discussing, on long-term health and quality of life?

So first to you, Linda, how about it now? How are you doing in your quality of life and your outlook for long-term health? And I know there were some steps along the way.

Linda:

There were. The two things that we didn't run headlong into, I have no problem with diabetes or sugar consumption or anything like that, and I am on no pancreatic enzymes, both real pluses. So given the basic year post-Whipple getting back on your feet, learning how to eat, what you can tolerate, learning to digest fats again, basically there isn't much that I can't handle, that I can't eat. It has taken the better part of the two years to get everything going through and utilizing all food sources, but it's back to normal. Activity levels are good. The only thing I find is that I tire a little bit, and beyond that, oh, there isn't anything that can't be dealt with.

Andrew Schorr:

But it beats the alternative, doesn't it?

Linda:

Oh, yeah.

Andrew Schorr:

I'll say. Now, I will just make a comment, and, Dr. Mahvi, I would love yours too. So my relative, Youna, after the Whipple procedure she was in intensive care for quite a long while, and she did have to get over some complications of this intricate surgery. Linda, you were not in the hospital a long time, were you?

Linda:

I had one day in intensive care and 11 days total in the hospital post op.

Andrew Schorr:

Wow. Wow. So, Dr. Mahvi, does the experience vary with the recovery from this surgery for pancreatic cancer?

Dr. Mahvi:

Well, it does, and it's really dependent on whether you do or don't have a complication of the operation, and the complication rate of this operation is probably about one in five. So if you do have a complication, which is not unusual, and it doesn't have anything to do with anything. It just is something that happens with the surgery, it does keep you in the hospital for quite a while. It keeps you in the ICU longer. It takes longer to recover, but even in a perfect scenario like Linda's, it still is a tough operation to overcome.

And I guess the one thing I would emphasize that she said earlier is the team part of it, and we talked about teams as being, you know, surgeons and medical oncologists, but I think the thing that kind of holds our little team together is really our nursing staff. Linda Feldman is our nurse that really deals with a lot of patients with pancreatic cancer, and they are unbelievably dedicated to these patients. And I think that helps people get through the system because even after you have had your surgical procedure it takes a long time to get over this, and these are people that are very versed with dealing with the complications of this and the recovery. And sometimes all you need is someone to say, oh, that's normal, and I think people then feel better. And I would kind of be interested in Linda's thought on that.

The Patient Experience at Northwestern Memorial Hospital

Linda:

You were mentioning Linda Feldman. She was my guardian angel. She held our hand from literally diagnosis through two turn-downs, finally into surgery when I was ready to quit chemo and just throw in the towel. Without the backup from her

and both my radiation and my regular oncologist, I don't know where I would have run. Support groups are wonderful, but I was too sick to be using them, so I was totally dependent on the medical staff, and they held it together.

Andrew Schorr:

Yes. I want to maybe put in another comment about teams, particularly at a wonderful academic medical center like Northwestern is. You know, there are other people behind the scenes who play a role, the pathologists who specialize in these specific diseases, and the radiologists who are very well trained, and we talked about how the radiologist and then the radiation oncologist gets involved. There are a lot of people involved in helping you get well.

And, Eric, I am sure you had that kind of experience too at Northwestern.

Eric:

Absolutely. The doctors and the oncologists, there was just a great team. It was such a difference going to Northwestern than where we were previously. It made all the difference in the world.

Listener Questions

Andrew Schorr:

Wow. I am glad to hear that.

Let's go on with some other e-mail questions, and here's one from Gary in Indianapolis. And Gary says, "I have colon cancer apparently at the beginning of my colon, and I will soon be having surgery. How long will this surgery keep me out of work, and what questions should I be asking the doctor?"

Now, that's all we know about his story, and I would mention that we always have this disclaimers. We can't do medicine, personal medicine over our broadcast. But typically and that may be a primary colon cancer it sounds like, Doctor. What would be the recovery from that?

Dr. Mahvi:

Well, it is hard to practice surgery over the phone specifically, but it sounds like a primary colon cancer, which is great. It means that it likely can be fixed surgically.

And the questions that I would ask is can this be done laparoscopically, meaning that you would do the surgery without a big incision. Sometimes it can, and sometimes it can't, but the recovery typically is a little bit faster with laparoscopy.

It depends, as far as when you can go back to work, it really depends on what kind of work you do. If you are at sort of a desk job, you can probably get back a little bit sooner. I don't think most people feel great after a colon operation for three or

four weeks, but at that point I think they could. If you are lifting transmissions or something, it's probably a little bit longer. It's probably closer to six weeks. And we have had people, their range of that is very broad. I have had people go back to computer kind of work within, you know, a few days. I am not sure they were very effective, but they really wanted to. But I would say typically somewhere between three and six weeks would be a typical recovery from a colon operation.

Andrew Schorr:

Okay. Here's a question we just got in, and I want to just get the name. Let's see. Monica from Augusta, Maine, so not on the coast like you, Linda, in the state capital there. Linda is listening. And she writes this. "Doctor, I am listening to your webcast, and there has been a lot of reference to having surgery as a primary course of action for liver metastases. What about a patient who is a poor candidate for surgery?" And she wanted to know if you could speak a little bit about, I think she means the, TheraSpheres as a radiation procedure for the liver, not radiation frequency ablation. And she also asked about CyberKnife for abdominal metastases. So we talked a little bit about those injected TheraSpheres I thought, but she also asks about the CyberKnife.

Dr. Mahvi:

Well, the TheraSpheres are really something you would use if you couldn't do surgery technically, if it was just a technical impossibility. If a patient is really not a candidate for surgery because of their medical condition, they are just too sick to have an operation--the TheraSpheres can make you pretty sick, so it sometimes is not a very good treatment for that either. And if the metastases in the liver are small enough, sometimes what you could do is do it percutaneously, meaning that you would sedate somebody, and you could put a small probe into the tumor and then heat the tumor up and use radiofrequency ablation or something. But it's a tough situation if you really can't tolerate surgery, which usually means you can't tolerate chemotherapy either, so you are kind of in a little bit of a bind. But I think there is always options. You shouldn't assume there aren't any options, and just keep pushing the envelope a little bit to see what's out there. But if someone really can't tolerate an open surgical procedure, there are other alternatives I think.

Andrew Schorr:

And what is CyberKnife? And does this come into play with cancer that has spread?

Dr. Mahvi:

It typically doesn't in the liver. And it's really a technical thing. It's going to sound very technical, but when the--something has to really be still for that to work, and the liver obviously moves when you breathe. So it's very difficult to target it with a CyberKnife, which is radiation therapy, because you just can't quite figure out where it is. I think eventually it will probably work, but it has to do gating,

meaning that every time you breathe it would shoot some radiation at it, and when you, you know, exhaled it would stop, but the technology is really not there yet to at least deal with the liver.

For the colon, which is relatively fixed, and the rectum, we are still again not there, but I think we are closer for that than we are for metastatic tumors, so it's something that's coming along. And our ultimate goal is not to do surgery because it really does knock people down. But right now there is really no more effective therapy for these primary tumors than to surgically remove them.

Andrew Schorr:

Okay. We are going to take another break. When we come back we invite more of your questions, and you can give us a call right to the studio if you want, 877-711-5611. If we have some questions, hopefully we have got Dr. Mahvi locked in his hotel room at a conference in San Francisco, we will go a couple of minutes over, and I do have several more e-mail questions, both about pancreatic and colon cancer, to cover. Stay with us for our live broadcast as it continues helping you hear the latest on the treatment of colon cancer and pancreatic cancer, sponsored by Northwestern Memorial Hospital.

Andrew Schorr:

Welcome back to our final segment of our live broadcast which folks are listening to in suburban Chicago. Thank you for joining us, and also on the web around the world as we hear more from Dr. David Mahvi, who is chief of the GI/oncologic Surgery at Northwestern Memorial Hospital. He is also a professor at Northwestern University's Feinberg School of Medicine and a member of the Robert H. Lurie Comprehensive Cancer Center at Northwestern University. And then also with us is Eric Lentz, who has gone through lots of treatments for advanced colon cancer, doing well, selling swimming pools to every new condo building they put up in Chicago, I hope, Eric. And then Linda Milenkovic, who is joining us from Eastport, Maine, but she used to live in Joliet, and she has got those retirement years ahead of us hopefully as a long-term pancreatic cancer survivor.

A couple more e-mail questions I would like to get to Dr. Mahvi. So here's one from Randy in Addison, Illinois. Randy said, "I had read somewhere about oxygen therapy and its benefits, and I was surprised because I didn't know that oxygen therapy could successfully treat cancer." He says, "My friend has colon cancer, and I want to tell him about this therapy, but I am not sure if it's true. So," he says, "can oxygen therapy be used in cancer treatment?"

Dr. Mahvi:

That's a complicated question. You use oxygen for certain parts of therapy. I think using oxygen therapy as a stand-alone treatment rather than what we have as sort of standard systemic therapy is not proven. I am not saying it doesn't work, but it's just not something that we have any idea if it works. Having said that, you

need oxygen in tissues for other therapies to be effective. Radiation is not particularly effective if you don't have oxygen around. If the tissue is not really well oxygenated, it doesn't work. Chemotherapy, the same way. You just can't deliver the drug. So you certainly do need oxygen for all these therapies to work, and if you have tissue that does not have enough in it, they are not very effective. So it does make some sense intellectually, but really nobody has ever proven it.

And I always worry of things like that that aren't proven, that there are people out there that might take advantage of somebody who really wants something, and there is not much else available, and that's kind of what I worry about with a lot of these sort of alternative, in quotes, therapies.

Andrew Schorr:

Right. And I just want to underscore that from the patient advocate point of view. So there are doctors and clinics and hospitals who, you know, invest in a certain approach. When you are talking about pancreatic cancer, advanced colon cancer, you want the full range of treatments available to you in clinical trials as well, the kind of thing you would find at a large, well respected academic medical center like Northwestern. And then you want the expertise to go with it. And so I urge you if you have one of these diagnoses to please consult if you are near Northwestern, and get on a plane and go there, see Dr. Mahvi and his team where they are talking about this all together, as he said, in a room, or another leading center if you live way at a distance. But it's so important to give it your best shot at a cure or making cancer chronic, as we have heard in Eric's case.

One other question I want to get to, and forgive us if we just go a couple of minutes long, Carrie, who is listening in Atlanta, Georgia, has a concern about her family history, Doctor. She says, "These types of cancer seem to be common in our family. Both of my grandfathers had colon cancer, and my aunt had pancreatic cancer. Is there a connection? And what can I do to lower my risk?"

Dr. Mahvi:

Well, you worry there is a connection. I mean, you don't know. There is some genetic cancer syndromes that do have both of those in them. We know the way to screen for colon cancer is colonoscopy, and it's unusual for someone to have a normal colonoscopy and develop colon cancer in the five years after the colonoscopy. So that's clearly the most effective screening tool.

Screening for pancreatic cancer is a little trickier, and we don't have great screening tests. We have blood tests for it, but they typically don't detect early tumors, so that's a trickier one to screen for. And I don't think we are quite sure who to screen. Patients like her who have that obvious family history are people that we would think about screening, but the only real way to screen for pancreatic cancer is probably with imaging, like CAT scans or MRI s, and there is some down sides to that because at least with CAT scans you are exposing people to radiation.

So there is really not a good pancreatic screening test. The colon cancer screening test I think is very well established, and I would certainly encourage her if she hasn't had a colonoscopy to talk to her physician about getting a colonoscopy.

Proper Screening

Andrew Schorr:

Now, I want to make a point. Eric, I am sure you would underscore it. There you were, 48, a couple of years before the recommendation typically of starting colonoscopy, and the doctors you saw first said, oh, it couldn't be colon cancer, it couldn't be colon cancer, but it was. And I have a friend who died of it who was in his earlier 40s. So I think people really need to be vigilant. You have got to advocate for yourself, wouldn't you say, Eric? If you have bleeding, and it's not going away, or you have pain, you have got to get to the bottom of it, wouldn't you say?

Eric:

Absolutely. And every doctor that I saw said you are not 50 yet, as if for some reason that magical number of 50. They said, oh, you are not 50 yet. You really don't need a colonoscopy. Well, since I was diagnosed I have heard so many people that have heard the same thing. You are not 50 yet, don't worry about it. And then by the time of the test it's too late. So you have to be very, very aggressive with the doctors getting that test done.

Andrew Schorr:

Right. Because if they are wrong, you're the loser. So I would say please folks, if you have any of those symptoms, and you can look up on the web, we didn't tick them all off here, but we have done a number of other programs, please get checked. If there is a family history, talk to your doctor about does this apply to you.

The other thing that I have heard, Dr. Mahvi, is what you all are increasingly doing, both in research and in standard therapy, is not only a cohesive approach that brings together several modalities perhaps but also very individualized care. So one person may respond to certain drugs or be a candidate at a certain time for surgery or certain radiation approach or these spheres we heard about, and another person might benefit from a different approach. That's what you all talk about all the time now, isn't it?

Dr. Mahvi:

Well, you really do have to individualize therapy, and a lot of these new therapies are targeted at very select patient populations. We certainly have seen that in breast cancer where the drugs, there is a large armamentarium of drugs, but they only work for certain set subclasses of patients. We are starting to see the same thing in colon cancer, and I expect we will see the same thing in pancreatic cancer.

But we hope to get to a point where we are not using a drug like a big hammer over someone's head but something that we know the tumor is curing, something that the drug will attack, and that we are not treating large populations where the drug is not going to be effective. So I think it becomes very individualized.

You really just can't say, well, you have this disease, and this is how we treat it, and we are going to start treating it, and we are going to be done in six months. We are not really going to think about it until we are done. You really can't do that anymore. You have to treat someone for a while and sort of see what's happening and see what the effect is, and if that doesn't work, try something different. If it's working, keep going with it or consider some other kind of therapy to augment them. So it's much more difficult I think to treat these cancers than it was 10 or 12 years ago, and we really didn't at that point have any effective therapy to treat tumor outside of a primary organ.

Outlook for the Future

Andrew Schorr:

It may be difficult, but you are saving some lives too, and what I find so wonderful to hear in Eric's case and in Linda's, and I am sure this happens routinely in a major center like yours is, you didn't give up on people. Because Linda was not for a long time a candidate for surgery, and then there was that window. Eric was told initially you got maybe less than two years to live, and here he is, and he is selling swimming pools. So people, the providers kept with them, and I think that's just the way it should be.

I want to get a final comment from you, Dr. Mahvi, and then I want to hear from Eric and Linda for the people listening with these diagnoses. And thanks for all sticking with us just a couple of extra minutes until we round this out. Dr. Mahvi, so you have been at this for a while. You have moved all the way to be the chief of GI/oncologic surgery. Are you hopeful that we are doing better and that we can do better still?

Dr. Mahvi:

Well, yes. Absolutely. Well, the answer to that is a hundred percent absolutely, and that's one the reasons I came to Northwestern is because I think we are really poised to do something that's unique in this field. And the way to do that is to do innovative surgical techniques and to do innovative chemotherapy clinical trials, and just keep attacking this from all different angles. And I am very excited about this. And I have watched just in my career, I'm not that old, I have watched a lot of these diseases turn from something that's really hopeless into something where we go, well, you know, we will keep treating that, and we think we will be, you know, even if we can't cure it, we will make someone's life better. So I'm very hopeful about this.

It's just oncology right now is a very exciting place to be from a career standpoint because you can walk up to someone where before you really couldn't say that. You could say, well, we will try, but we don't think this will work. And now you say, you know, we have got a lot of different ways to treat this, and we are going to keep hitting at it until, you know, we get rid of it.

Andrew Schorr:

Well, we wish you and your colleagues at Northwestern Memorial and the people, you know, you communicate with in your field around the world all the best, and thank you so much for your dedication to patients with these serious conditions and their families. Thank you, Dr. David Mahvi, chief of GI/oncologic surgery at Northwestern Memorial. Thanks for being with us, sir.

Dr. Mahvi:

It's a pleasure.

Andrew Schorr:

Eric Lentz, there you are in Skokie. So as I said you are getting to sell swimming pools, and your kids have been listening to our broadcast on the computer, and you are feeling pretty good. What would you say to somebody where they are 48 and they haven't even had a colonoscopy and then they find they are diagnosed with this that is supposed to affect older people, if at all, to give them some hope that they can go on with their life?

Eric:

Well, the main thing I think is a positive attitude. Just absolutely 100 percent say to yourself you are not going to let this win. You are going to win the battle. And then as well as seek out the best medical staff that you can possibly find, and that's what we found at Northwestern. My oncologist, Dr. Mary Mulcahy, my surgeons, Dr. Bentrem and Dr. Sato have been tremendous. Linda as well, we have dealt with Linda. The whole team has just been tremendous.

And then just, mainly just keep a positive attitude, and question everything. Don't just leave everything up to the doctors. Between visits you are going to have probably 15 to 20 questions. Write them down so that when you see your doctor you can get all these questions answered. If you just--you know, doctors are very busy, and you go in there and sure enough you've left and you have forgot to ask three or four questions. And then the other thing is just be very proactive with your treatment. Constantly ask questions, and be a part of the decision-making as far as the drugs you're going to be taking, the surgeries you're going to be getting. Just stay right on top of it. And then again the most important thing is to keep faith and to have a positive attitude and so absolutely enjoy every day, because if you have a positive attitude it's going to go a long ways.

Andrew Schorr:

Well, kiss those kids when you get off this broadcast and say daddy did a great job. Give them a big hug.

Eric:

Okay.

Andrew Schorr:

Eric Lentz from Skokie, thank you so much for joining us. All the best to you.

We're going to give the final word to Linda Milenkovic, who used to be the queen of Joliet and now she's out there in Eastport, Maine getting ready for the winter and cozying up to Heinz there in your retirement. Linda, what would you say? People get diagnosed with pancreatic cancer and they think frankly it's all over. You're an example where it's not.

Linda:

I agree with what was just said. Proactivity, attitude accounts for so much of it. And believing in that team that you're working with, looking for the best, working with them. Go for the trials, you have nothing to lose. But a lot of it is don't forget that family and friends. It's so easy to shut them off, you don't feel good, and they need to be needed too. You aren't the only one being treated. Everyone around you is too. You need to work together. And please remember to laugh because if you haven't laughed at something every single day you've lost a little.

Andrew Schorr:

Well, I know you're celebrating life there. All the best to you and a long life, Linda, with Heinz. All the best. If I get out there to Maine, where I used to live, I'll come see you.

Linda:

Any time.

Andrew Schorr:

Thank you for joining us. Thank you. We're going to cozy up by the fireplace.

Well, this is what we do on Patient Power every two weeks. I hope this program has been helpful. Please share it with others. In about two weeks we're going to have another one of our programs. That's going to discuss the most common thyroid cancer which is really very treatable, papillary thyroid cancer. We're going to have with us Dr. Dina Elaraj, who like everyone at Northwestern is really a specialist in that, and that's what she does.

Thank you so much for joining us. Let us know how we did. You can always send us an e-mail to Patient Power or nmh@patientpower.info. Thank you. And as always I like to say knowledge can be the best medicine of all. I'm Andrew Schorr. Good night.

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