Neo-adjuvant Therapy and Dynamic Imaging for Breast Cancer
Webcast
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Introduction

Andrew Schorr:
Hello and thank you for joining us once again on Patient Power sponsored by the Seattle Cancer Care Alliance. Andrew Schorr broadcasting live not from Seattle where I usually am but way across the country in Vero Beach, Florida. Yes, folks, I am looking at the dark Atlantic Ocean where it's in the 70s. I hear back in Seattle it's not quite so nice, but we are going to have some important information for anyone concerned about breast cancer, so don't focus on the weather. Let's focus on important medical knowledge that can make a difference for you or a loved one.

We are going to talk tonight about breast cancer, but more specifically about something called neo-adjuvant therapy, so that's drug therapy that's used before any kind of surgery, lumpectomy or mastectomy, in an effort to try to cure the cancer or certainly shrink it way down. And we are going to hear about some new research going on at the Seattle Cancer Care Alliance to try to perfect that to help a wider group of women who have larger tumors right at the outset. We are also going to learn how they monitor this while they are doing the therapy with something called dynamic imaging. So two very exciting areas of research at the Seattle Cancer Care Alliance that we are going to talk about tonight, and you will meet a principal investigator who is a medical oncologist at the Seattle Cancer Care Alliance.

But first I would like you to meet Janell Sabol. Janell is just 33 years old. I say just because I am much older. She is from Edmonds. She is a former preschool teacher, and she has two young children. She has Nathan, who is just two and a half, and she has Anthony, who is six, and she and Gary, her husband, have been married ten years.

Just in a couple of days she is getting ready for an anniversary. But things can happen along the way, and for her just a few months after the birth of Nathan when she was nursing him she noticed that she had a lump in her right breast. Pretty scary, but typically in younger women it's not something to worry about. And so she went to her obstetrician, what about this?
Probably nothing, but she still felt it. She was concerned, and she went to her regular primary care doctor, what about this? Probably nothing, but let’s refer you to the Seattle Cancer Care Alliance where they can kind of work it up, take a closer look. Had a mammogram, and then an ultrasound and with a biopsy to poke in there and take a look at something that maybe looked a little suspicious.

Well, let’s pick up the story, Janell. What happened about a week later after the biopsy? What was the result?

**Janell’s Story**

**Janell:**
The result was that it was cancerous. It was quite a blow to us. Like you had said, we just had had a baby, and it was not what I had expected.

**Andrew Schorr:**
And you had been told along the way that any kind of scary problem like that was very unlikely.

**Janell:**
Correct, yes. I had, they just kind of thought it was most likely just a clogged milk duct since I was nursing and just had a baby. I guess it can be common to have a clogged milk duct, but the fact that it wasn't going away when I was nursing was a little bit of concern for me.

**Andrew Schorr:**
Yeah, no kidding. So you kind of go to pieces for a while I am sure when you have a diagnosis, and believe me when I had my diagnosis of leukemia I didn't going to pieces on the outside, but I did on the inside, and it was very difficult for my spouse. And I'm sure it was a shocker to Gary. And here you were just building a life together really now with a second child. So they explained your options. So what were the options they explained to you as far as treatment?

**Janell:**
Well, as far as treatment went, I had a few options. I could have a mastectomy followed by chemotherapy; or I could do a lumpectomy, chemo, and radiation; or I could do chemo, a lumpectomy, followed by radiation.

**Andrew Schorr:**
Okay. So the last two were kind of switching the order of whether the drug therapy or the chemotherapy was first or second.

**Janell:**
Correct.
Andrew Schorr:
Now, you chose option three, the drug therapy first, or what will help people understand neo-adjuvant therapy. Why did you choose that?

Janell:
The reason I chose that was I was a little bit, well, I think anybody in this situation, I was scared, and I wanted to make sure that the drug, the chemo was working. And so I thought, you know, we were going to have, we were going to monitor it fairly closely. Dr. Specht was going to, had met, you know, and had talked us through it, and so I chose to do the chemo first that we could see if it was shrinking the tumor and working.

Andrew Schorr:
Right. Well, we're going to talk a lot about that tonight, that whole idea of watching the drugs at work. And so you chose that, and you had the chemotherapy, and then you did have a lumpectomy. So you didn't need a whole mastectomy. You had a lumpectomy in your right breast, and then you had six weeks of radiation.

Janell:
Correct.

Andrew Schorr:
All right. What's the result then? Here we are, we are about what, three years, two and a half years later? What has the result been?

Janell:
So far I have been cancer free.

Andrew Schorr:
Well, that's great news. That's great news.

Janell:
Yes. And when I actually went in for surgery, the tumor was gone, so that was really exciting too.

Andrew Schorr:
Right. So let's point that out. So the result you got is the drugs actually worked, and the lumpectomy, the job of the surgeon then was really to get rid of scar tissue and check of course to see if there were any visible cancer cells, but there were not.

Janell:
Correct.
Andrew Schorr:
Wow. Well, that's terrific. So that was a wonderful result. Well, let's meet your doctor who you have mentioned, Dr. Jennifer Specht, and then understand more about what they are working on to see can they get the result that you had for more women.

And so Jennifer Specht, let me tell you about her a little bit. She is an assistant professor at the University of Washington, and she is also an assistant member at the Fred Hutchinson Cancer Research Center. As you know, the Seattle Cancer Care Alliance is a partnership between the University of Washington, the Fred Hutchinson Cancer Research Center and also Seattle Children's. So Jennifer as a hematologist and oncologist is from UW and also Fred Hutchinson.

So, Dr. Specht, help us understand, first of all, welcome to the program and thank you for your dedication to women with breast cancer and ongoing research which has made such a difference, you and your colleagues along the way, and hopefully can make more. This neo-adjuvant chemotherapy or drug therapy result that Janell had was terrific, but it doesn't help all women. So help us understand what the goal of research is and even where neo-adjuvant therapy comes in. Who is it right for in the first place?

Goals of Neo-Adjuvant Therapy

Dr. Specht:
So first off let me just say thank you very much, Andrew, and it's a privilege to be able to be involved in this program. I have the opportunity to work with a fantastic group of physicians specifically related to breast oncology at the Seattle Cancer Care Alliance. And I also want to thank Janell very much for participating in this program.

So neo-adjuvant chemotherapy which you described which means giving chemotherapy that goes throughout the whole body prior to surgery for breast cancer is an option that we discuss with women, particularly when they present with larger tumors, which we call locally advanced breast cancer or inflammatory breast cancer. And the majority of women when they develop breast cancer have very small tumors, and so the majority of women we recommend surgery first.

However, we know that some women will present with more disease in the breast or with involvement of the lymph nodes under the arm, and for those women our previous research would tell us that giving chemotherapy before surgery can actually do several things for the tumor. It can shrink the tumor and allow more women to be candidates for lumpectomy, but biologically it also makes sense because it gets drug into the body sooner, more quickly, and we can hopefully eradicate the tumor or make the tumor go away completely at the time of surgery.
Andrew Schorr: An that's what happened with Janell.

Dr. Specht: And that's exactly what happened with Janell. We call that result, it's technically called a pathologic complete response, and that refers to no residual cancer in the breast and/or in the lymph nodes under the arm where breast cancer most commonly spreads.

Andrew Schorr: And with a result like that, the hope is then Janell and women like her who get that result can go on with a long life.

Dr. Specht: Exactly. And many institutions, and we have a number of studies which tell us that those women who achieve, or the tumors that achieve that pathologic complete response, those women have an excellent prognosis meaning the likelihood of breast cancer coming back later in life to other parts of the body like the bone, the liver, and the lung is much, much less, and their prognosis is outstanding compared to women who have residual cancer in the breast after neo-adjuvant therapy.

Candidates for Neo-Adjuvant Therapy

Andrew Schorr: All right. Let's put this in perspective and what's challenging and you are addressing in research. So what percentage of the women who are candidates for neo-adjuvant therapy and receive it achieve the kind of complete response that Janell did?

Dr. Specht: Well, that's the challenging part is that with our present chemotherapy drugs it's really only a minority of women, somewhere between eight and maybe up to 30 and sometimes 40 percent of women who will achieve the pathologic complete response. And predicting who will achieve that depends a little bit on the exact type of the tumor, but clearly we are not able to get that good response in all of the women, and certainly we have a lot of room there for improvement because what we would obviously like to see is that we can achieve a pathologic complete response in a much higher percentage of patients who are treated with this type of therapy.

Andrew Schorr: So you have a research study that you are one of the main, principal investigators on, and that's the idea to adjust or add to the traditional approach for neo-adjuvant therapy for these women to see if you can have a complete response in more women.
Dr. Specht:
Correct. So a number of investigators for many years have been looking at different regimens of chemotherapy and more recently what might be the best scheduling of the same drugs that are standardly used for breast cancer. And building on the work that was done by my colleagues here in the Seattle Cancer Care Alliance particularly Dr. Georgiana Ellis, Dr. Bob Livingston, and Dr. Julie Gralow, there has been a long history of studying a type of chemotherapy called continuous or metronomic chemotherapy where we give the standard chemotherapy drugs in a slightly different schedule, where we give smaller doses of the drugs but on a more frequent basis, daily or weekly as opposed to large doses of chemotherapy every two or three weeks.

And so we have this backbone of what we call the continuous chemotherapy that involves giving two drugs, a drug called doxorubicin and a second drug called Cytoxan or cyclophosphamide then followed by a third drug called paclitaxel, and we had this backbone that we knew worked quite well, but again we only achieved, we only saw that complete response in a minority of women. So our research, our present research study is adding an additional drug that isn't chemotherapy, but it's called a biologically targeted agent. It's a drug called sunitinib, or Sutent is the brand name. And one of the things that we have learned through our studies is that blood vessels are very important to the growth of breast cancer, the vasculature, how this tumor receives its fuel. And we know from other studies that have been done at our center that certain tumors can have a distorted blood vessel growth pattern, and those tumors can be particularly resistant to chemotherapy. This metronomic or continuous type of chemotherapy seems to have effects on blood vessels as well as actually killing the tumor, and so it was a logical step to add this newer agent called sunitinib to our backbone of chemotherapy to see if we can improve the rate of that pathologic complete response which means allow more women to have no tumor left at the time of their surgery.

Andrew Schorr:
All right. We are going to get much more into the science of it and explain more about this research and how you monitor it and understand how this drug you have been mentioning, which is approved for other cancers but not yet for breast cancer, how you are investigating it to see if it can help here. And it's very exciting research, and I know if women have questions, they can give us a call. Or you can send an e-mail to us, patientpower@seattlecca.org. We will be back with much more of Patient Power right after this.

Andrew Schorr:
Welcome back to our live webcast sponsored by the Seattle Cancer Care Alliance. Andrew Schorr here as we are discussing neo-adjuvant therapy for breast cancer and how research is adding a new drug to try to get a better result for more women who are affected. And also we are going to talk in a minute about the imaging that goes along the way to see how that drug therapy is working. You don't want to receive cancer medicine, believe me, that then you find out months later didn't do
the job. You want to know. And we heard about that from Janell Sabol, and we will hear more from her doctor and researcher, Jennifer Specht, in just a minute.

Janell, I want to go back to you. So you are hearing about this science. Now, you were lucky, fortunate, whatever the right word is, you were one of the minority of women we heard who got this result where the cancer seemed to disappear. It's a whole scary process, but for women who are considering treatment, sounds like you have a lot of faith in Dr. Specht and where this research is headed.

Janell: Absolutely. Absolutely. It's just, you know, you have to trust your doctor and know that you are in good hands.

Andrew Schorr: And the Seattle Cancer Care Alliance, that's where you were diagnosed. How did the treatment go? Do you feel like you got good care?

Janell: Absolutely. I got the best care that, anywhere, I think, by going there. I mean the people, the doctors there are so helpful and the nursing staff. It's just it's an amazing place.

Andrew Schorr: I am going to ask you a real direct question, Janell. Do you feel that Dr. Specht and her colleagues saved your life?


Andrew Schorr: Dr. Specht, I know that's gratifying for you, and you are trying to help more and more women who are affected by this. When someone has this locally advanced, I think that's what you called it, breast cancer, so it's a larger tumor, so if I heard you right, if it can respond to the drugs, then they can be as well off as someone who just had a little itty-bitty tumor, not that any size tumor is good. But it sounds like though that when you can have a result like Janell you can be very encouraged.

Dr. Specht: Yes, that's true. When women or when patients present with breast tumors that are larger in the breast or when the breast cancer has already spread to the lymph nodes under the arm, in the axilla, we know that in general their prognosis for having a long-term survival is lower than for those women who present with tiny tumors that haven't spread to the lymph nodes. And so that's one of the reasons why we offer them, oftentimes offer chemotherapy before their surgery because we are concerned that the disease even if we can't see that it has spread, that it may have already spread to other parts of the body that we have no way to detect on
our normal studies like CAT scans and x-rays and things. And so the idea of giving neo-adjuvant chemotherapy is that we get chemo into the body more quickly, and the chemotherapy works everywhere in the body, in the breast, in the lymph nodes and also potentially to other places if there were one or two cancer cells that had already escaped to the breast and the lymph nodes.

**Andrew Schorr:**
Now, if someone's cancer is discovered and it's larger, does that necessarily mean the cancer is a more aggressive? And I know we will talk about inflammatory breast cancer, but apart from inflammatory breast cancer, does it just mean it was discovered later or does it mean that these cells are dividing more quickly?

**Dr. Specht:**
You know, it's a little bit complicated. As we learn more about breast cancer, we learn that there is actually probably several different diseases that we call breast cancer. So there are some, the majority of breast cancers probably grow pretty slowly, meaning that they change and grow slowly and that they might have been present in the breast for many months prior to the time that they were able to be diagnosed either by mammogram or by forming a lump that a woman might feel.

However, there are other types of breast cancer including the type that Janell had that do grow more quickly, and those are oftentimes breast cancers that are what we call estrogen receptor negative, and HER2/neu negative types of cancers. Those cancers grow more quickly, and they tend to have a more aggressive biology or again be more likely cancers to come back even after successful treatment. And so when a woman presents, depending on the type of breast cancer that she has, that can also help us in terms of guiding her on what the best therapy is as we look at these different types of breast cancer.

**Andrew Schorr:**
All right. And I just want to understand the type of breast cancer that Janell had was estrogen receptor negative, correct?

**Dr. Specht:**
Correct.

**Andrew Schorr:**
Where many older women, the more typical is estrogen receptor positive.

**Dr. Specht:**
That's correct. And what has been identified more recently in the last several years is the type of breast cancer that's now being called triple negative, and sometimes also called basaloid breast cancer. And this specific type of breast cancer is defined as one that grows more quickly. It usually is a high grade tumor, which is something that's assigned by the pathologist based on the appearance of the cells,
and then it's also defined by the fact that it is estrogen receptor negative, progesterone receptor negative, which is another hormone receptor, and HER2/neu negative.

Andrew Schorr:
Wow. And we have talked in other programs about women when they are told they have HER2/neu positive breast cancer, we have had a drug that's really been revolutionary for a while, Herceptin, to target that situation. Triple negative has been more difficult I know traditionally. So now you are doing this research with Sutent. So tell us about this drug. It's approved for what other cancers?

Dr. Specht:
So Sutent or sunitinib is a drug that's called a tyrosine kinase inhibitor, so it's an oral drug that interferes with the activity of several types of, several specific proteins. The drug has been studied in a variety of different types of cancers but has been FDA approved for the treatment of renal cell carcinoma and for the treatment of a more rare type of tumor called gastrointestinal stromal tumor, or GIST.

Andrew Schorr:
Okay. I should mention, and correct me if I am wrong, but in medical oncology you are frequently taking a drug that was effective in one type of cancer, looking at it scientifically and saying is there a chance it could help in this other cancer situation. I had that very much in leukemia where there was a non-Hodgkin's lymphoma drug, Rituxan, that was used, and it was effective for me. So that's exciting when there can be that transference.

Now, we talked a little bit about the idea of what these drugs do, anti-angiogenesis drugs. I think this one would fit in there. There are others. I know some people and other cancers and even in more advanced breast cancer have heard about Avastin. So the idea, if I get it right, is that healthy cells have one pathway for blood supply, but cancer cells almost have sort of backdoor blood supplies they develop, and therefore since they have this separate system they develop, if you can just cut that off healthy cells can go on and still receive nutrition and divide properly. Is that right? It's kind of like there is this other, these bad guys, if you will, develop their own supply, and if you have drugs that can target that you can be successful?

Dr. Specht:
Yes, that's correct. We know that tumors and breast cancers in particular can be very dependent on pathways that involve the vascular, that involve vascular endothelial growth factor receptors and that the drugs like Avastin or bevacizumab, which is now an FDA approved drug, seem to work by interfering with blood vessel growth. And we know that tumors need blood vessels to supply them with
nutrients in order for the cells to grow and divide, and so this class of targeted agents which really aren’t chemotherapy but more biologic agents that target the blood vessels are gaining increasing importance in the treatment of breast cancer.

Andrew Schorr:  
Well, let's talk more about that. So this drug Sutent then, or tell me the generic name again or the scientific name.

Dr. Specht:  
It's sunitinib.

Andrew Schorr:  
Sunitinib. I'm going to get that right. This is an oral medicine, you said, a pill. So tell us how often does someone take that? In your research study now how often would they take that? And then in a minute we are going to learn about how you monitor it.

Dr. Specht:  
Sure. So Sutent is a drug that's taken once a day every day, and the way that we are studying it in breast cancer is to combine the Sutent with one of the standard chemotherapy drugs that we use called paclitaxel or also called Taxol. And paclitaxel is generally given by vein, intravenously, once a week. And for the purposes of this research study we are giving, women are taking the Sutent once a day for a period of 12 weeks while they are receiving the paclitaxel chemotherapy drug.

Andrew Schorr:  
Okay. Let's talk a little more about that. So I want to help people understand about imaging. So Janell mentioned it about monitoring what therapy she received. So what do you do to see whether with the addition of this drug and the effect of the other drugs, the backbone you talked about, whether they are interfering with the supply of the cancer cells and then hopefully helping them die?

Types of Imaging for Breast Cancer

Dr. Specht:  
So we have several different types of imaging that we can use in the treatment of breast cancer. The most common are things like mammogram, which is also used as a screening test that we recommend for all women, but we also have other tests like ultrasound. And these really depend, these are tests that look at the size and the shape of the tumor, and they can be useful, but they don't tell us as much about the biology of the cancer itself. So we have other types of imaging that are called metabolic or functional imaging, which are studies like breast MRI and studies like PET scans which look at glucose incorporation. And these studies do tell us a little about the size of the tumor, but really they give us more information
about features of this cancer, things like the amount of blood flow that we can measure going to the tumor and particularly about the metabolic activity or how much the cancer cells are using glucose and other nutrients.

**Andrew Schorr:**
Did I get it right, Dr. Specht, that the idea that we want to help people understand here is you are developing new ways to see is the therapy working, maybe not real time, but in very short order, where it used to be that somebody might have a therapy for months, and then you would try to look at the results then?

**Dr. Specht:**
Yes, that's true. The tests that we are looking at in breast cancer are two specific tests that are already used in clinical practice, and those are breast MRI and then the FDG or glucose PET scan. Both of these tests are used in women who have breast cancer. For MRI we use this test to evaluate what the size of the cancer is in the breast and also to look at the lymph nodes under the arm. MRI and MRI done with some additional analysis by the radiologist can also give us some hints about blood flow. And that's the part that is more experimental, but it's still information that a radiologist can glean from a standard MRI that many women will have at the time that they are diagnosed with breast cancer.

**Andrew Schorr:**
All right. Well, it sounds extremely promising, and you will tell us along the way how women can participate in these studies. And we are going to hear more from Janell Sabol and her words for other women as well as we continue. We are talking about neo-adjuvant therapy for breast cancer, and then, as we just were, dynamic imaging to see how it's working. Much more to come. Or you can send us an e-mail to patientpower@seattlecca.org. We will be right back with more of Patient Power.

**Andrew Schorr:**
Welcome back to our webcast as we discuss neo-adjuvant therapy for breast cancer and also studies in dynamic imaging to see how an additional drug added to the neo-adjuvant therapy can help. We have with us Dr. Jennifer Specht, who is a medical oncologist at the Seattle Cancer Care Alliance, and also her patient Janell Sabol, who had neo-adjuvant chemotherapy, and it has worked quite well.

So, Dr. Specht, let's talk about the trials. So one is adding this drug to the backbone as you talked about in neo-adjuvant chemotherapy, and then also another that's related about imaging. If a woman wants to participate at the Seattle Cancer Care Alliance, how does that happen?
Clinical Trial Participation for Breast Cancer Patients

Dr. Specht:
Sure. So the trial that we have going on right now is for women who have locally advanced or inflammatory breast cancer, and the type of breast cancer is one that does not have, that is HER2/neu negative, so it is not over expressing the HER2-new protein. The reason that this study is for women who don't have HER2 positive disease is that we already have Herceptin and other drugs that are very effective for treating that particular type of breast cancer. So women who have more advanced disease when they initially present are a candidate to participate in this phase II clinical trial.

Women who are interested should contact the Seattle Cancer Care Alliance, the intake office, and they will be connected with a coordinator who will help make sure and negotiate so that they get in to see the right, to see one of our team either in medical oncology or in our breast cancer multidisciplinary clinic.

Andrew Schorr:
All right. So, and do you have a number you want to give out? Is there a phone number?
Dr. Specht:
The number for the intake office is, I believe that it is 288, and then the letters SCCA, I believe. But it's available also on our website.

Andrew Schorr:
Right. Certainly go on their SCCA website, and it's all there. So I have a question for Janell. So Janell, you hear about this research. Sometimes any of us might be hesitant, saying, you know, I don't know if I want to be part of a clinical study if it's experimental. I don't know if you participated in any studies or if one had been offered to you, knowing what you know now, what would you say to women about considering being in a trial?

Dr. Specht:
Well, actually I was part of a study, and I went back and forth with deciding whether or not I wanted to do it. It was a little bit overwhelming and scary first of all just to be diagnosed and then to also partake in a study. But I think that, you know, you have to look at it in two ways. One is what's going to be the best result for you, and then also potentially providing information not only to the doctors but for other women out there who later on may be diagnosed with breast cancer and allowing them different treatments.

Andrew Schorr:
Right. I will just say in my own case, now it's about 8 years ago, I was able to be in a phase II clinical trial, just like what Dr. Specht is discussing, and had it at a single center, and it was certainly investigational, and it worked for me, and it has continued to work. I am so happy, knock on wood, about that. But it's also what
many other patients with my leukemia have now worldwide. So I kind of feel good about that. I am glad that it worked for me, and I am really glad that it has helped lay the groundwork for research for them.

Now, Dr. Specht, we talked about, you know, trying to help a wider group of women, and you mentioned along the way inflammatory breast cancer. Is that situation different, or is it the same as someone who simply has a larger tumor that's discovered?

Dr. Specht:
Inflammatory breast cancer is a very rare type of breast cancer. It's one where oftentimes it's very difficult if not impossible to feel any single lump in the breast, and oftentimes it presents with skin changes which can look an awful lot like a breast infection called mastitis. Inflammatory breast cancer seems to have a more aggressive biology, meaning that the breast cancer cells are seeming to grow more quickly. And we know that in general women who present with inflammatory breast cancer again have a poorer prognosis, meaning more aggressive disease that's more likely to come back at a later time. And so it is, it's a rare type of tumor. It can be sometimes difficult to diagnose. And it's one where we have realized that giving chemotherapy prior to surgery has really become the standard of care for this particular type of tumor.

Andrew Schorr:
Okay. Now, are you encouraged with this whole, with the use of a medicine now to try to further starve the cancer cells of blood, now we are seeing that in more later stage breast cancer. We have talked about Avastin. This whole approach, are you really excited about it? How do you feel about it?

Dr. Specht:
Oh, I think this is a very exciting opportunity so that we can hopefully improve outcomes for women. As we learn more and more about the biology of breast cancer I think that our therapies become smarter. When I talk with my patients and I think maybe when I spoke with Janell initially, we talked about chemotherapy. It's very effective, and it is very effective in treating breast cancer, but it's not very elegant in that it's essentially, chemotherapy, there's poisons that we give the body that kill cells that grow fast. But the ability to add these biologic agents, like Avastin, like sunitinib, and like Herceptin that I think you spoke about with my colleagues, these agents are much more elegant, meaning that they target specific features of the cancer cells that are important for the cancer to grow.

And so I really do think that this idea of targeting our therapies specifically to the cancer and more specifically trying to find the weak spots in the cancer and use these biologic agents is an incredibly exciting opportunity for us to improve outcomes for women with breast cancer, for all patients with breast cancer.
Andrew Schorr:
Well, I want to certainly congratulate the SCCA on its work in playing a role in this. I know a lot of exciting research has been done there. You have been part of it too. And you mentioned these other interviews we have done with your colleagues, and if someone looks at the library of programs that we have done with colleagues like Dr. Gralow you mentioned, and I don’t know if I have interviewed Dr. Ellis, maybe I have, but other experts you have here, there is so much knowledge for women who are diagnosed with breast cancer to learn from these earlier programs. And they are all at sccapatientpower.org. We keep them all there. And they are also on our website, patientpower.info.

I want to go back to sort of Janelle's story a little bit. So Janell, Dr. Specht, as you well know she went first to her OB and then to her primary care doctor, and it took a while, and she was concerned along the way but maybe reassured a little bit that probably it was nothing, most likely it was nothing serious. But it was. It turned out to be something. What advice would you give to women when they are worried, or maybe they have this intuition where they just want to make absolutely sure, and they just, it's just something that's persistent. How should a woman proceed, and maybe even somebody just 30 years old where it's so unlikely?

Dr. Specht:
Well, this is always a challenging situation, and as Janell pointed out it's probably one of the most frightening things that a woman might experience. But I think it’s important for women to really to listen to themselves and to be sensitive to what their gut tells them, so to speak. Janell was very appropriate in that she sought out medical attention. Her physicians ordered the right work-up in terms of the mammogram and the ultrasound. And I think ultimately, you know, we need a biopsy to make a diagnosis, and that can certainly help us establish exactly what's going on.

And so it is challenging because again statistically speaking most women who are in their 30s who feel a lump in their breast, it will turn out to be completely benign and not cancer, but I do think that it's important for women to feel empowered to make sure that they asked their questions, that they share their concerns with their physician so that they make sure that the right work-up is being done and that they feel really comfortable with the result no matter what it shows.

Andrew Schorr:
Janell, what about you? So what would you say to women? Now, you obviously had some ongoing misgivings. Tell us about that. What propelled you to go back, want to see another doctor and really just go through the whole process to try to get an answer?

Janell:
Well, for me, I had mastitis from nursing, and so the fact that the lump wasn't going away, I thought it could have been a side effect from the mastitis. But I
think looking back on it now in my gut I knew that it was cancer, but again being only 30 I didn't think that it was possible. But I think, the key is early detection and so, you know, for the best results I think, you know, you just need to just go in there and know that you're in good hands with whatever doctor you are going with, and, you know, get the best treatment possible.

Andrew Schorr:
And we always tell people time and time again related to cancer is you want it to be diagnosed early, and it sounds like anything we can do, Dr. Specht, to encourage women. If they have misgivings, if they feel something, they need to really help, work with their healthcare team to find out what it truly is.

Dr. Specht:
Exactly. And I really, I do encourage women to just make sure that if you continue to feel uncomfortable, your doctor may not initially recommend a biopsy, but oftentimes will say, well, let's come back in three or six months and check on that again. So seeing your physician, having your mammogram and potentially an ultrasound and really just communicating well with your healthcare team are the most important.

Andrew Schorr:
Okay. Well, we are going to talk some more after the break. We have been learning about how research is trying to make the advantages of neo-adjuvant therapy, have it have effect for a wider group of women. We are going to talk to Dr. Specht in a minute about where are we now with trying to identify up front which woman is likely to benefit from these drug therapies. Can you tell right away, maybe even before anything is administered, or is that still a challenge of research. Much more coming up on Patient Power as we continue. You are listening to Patient Power sponsored by the Seattle Cancer Care Alliance. We will be right back.

Andrew Schorr:
Welcome back as we continue our live webcast discussing new research to help more women who are diagnosed with breast cancer and research that’s going on at the Seattle Cancer Care Alliance. Now, I mentioned just before the break wouldn't it be great if they could do various tests and know which women will respond to medication prior to any kind of surgery for breast cancer and what medication? Now, we really don't have that complete picture, do we, Dr. Specht? Why is that so difficult?

Predicting Response to Medication and Surgery

Dr. Specht:
Well, particularly for some of the newer agents that target blood vessel growth we don't have yet one specific marker or something that we can look at on the breast cancer cells that will definitely tell us whether or not the tumor will respond to one
of these agents. And even with chemotherapy it's very difficult to predict exactly which tumors will shrink and which ones will not. Work that has been done here at the University of Washington and Seattle Cancer Care Alliance by Dr. David Mankoff and colleagues, and I think Dr. Mankoff has been previously interviewed on Patient Power, has looked at using a test called PET scan, FDG glucose PET. And by looking at the PET scan of women who have locally advanced breast cancer they have been able to detect patterns that can be seen at the baseline, so before a patient starts on treatments. And certain patterns of glucose metabolism and patterns of blood flow are now appearing as though they are able to predict which patients will eventually respond to chemotherapy.

Andrew Schorr:
Okay. But it's still very early, right? It's not something that's in standard practice.

Dr. Specht:
Yes. Using the scans to predict which patients get chemotherapy is definitely, definitely not standard of practice. However, the type of PET scan that we use here is one that is commonly used to make sure that the cancer hasn't spread to other parts of the body, to other organs in the body. So it is a test that clinically is in widespread use for women with breast cancer, but to use it for this particular purpose is still certainly considered experimental and is something that we are hoping to perfect.

Andrew Schorr:
Okay. But for instance you can test for HER2/neu and then know that Herceptin would likely work for a given woman, but for these variety of other breast cancer subtypes, if you will, like the estrogen receptor negative where it's also negative in these other areas, we don't have a test yet?

Dr. Specht:
Exactly. That's correct.

Andrew Schorr:
Okay. I've been learning about science with all this. So, Janell, you listen to all this science. Are you encouraged? Let's face it. You and I both worry will the cancer come back? And so we listen very carefully to the march of science, and we hang on every word that researchers like Dr. Specht say. Are you hopeful? Are you encouraged? How do you look towards the future?

Janell:
I am very encouraged. I am just, even in the two years since I was diagnosed, I can see a huge growth in research and new treatments, and it's exciting, and I am hoping that, you know, we're going to find a way to help other women to have high success rates.
Andrew Schorr:
Yes. And let's have like a universal cure. I mean, the doctors say,

Janell:
Absolutely.

Andrew Schorr:
Well, if we could make cancer chronic and you could go on with your life because it's at such a low level, we would take that. But we like the C word, cure, and that's so we want to stay that way. And you and I have both had great results so far and may that continue. And that's my next question for you. So there are women out there who might well and maybe with this new research get the result you have even if their cancer has been discovered to be larger or more advanced. But they are terrified as you were, and probably in some moments you get scared again. What would you say to them to give them some hope that maybe they can get back to their full life?

Janell:
Well, my first piece of advice would be to stay strong and, you know, throughout the whole process make sure you are comfortable with where you are seeking treatment at and. You know, each day is a new day and just staying positive is key, and knowing that other women out there have gone through what they are going through, and, you know, you have your good days, you have your bad days, but in the end, you know, it's all going to be okay. You know, support is key to staying positive.

Andrew Schorr:
Now, Janell, I know you had some really bad days just emotionally, and it's very understandable. How did you get past that? Who helped you?

Janell:
I have a huge support system with my family and my friends. And, you know, for me just reflecting and just, yes, you have those days where it's like oh, my goodness, I don't want to get out of bed, but you need to. And for me I think it helped having a baby that needed me to take care of him also, which not every woman has that. But, you know, just getting up and knowing, you know, I think the stronger you are, the more positive you are, the better your outcome is.

Andrew Schorr:
All right. So you've got those two little guys who Gary is taking care of tonight so you can have a nice, quiet place to be, Anthony and Nathan. So what's your dream for your life with them?
Janell:
My dream is to continue to fight this and be healthy and strong, and just knowing that every day is a new day. And we don't sweat the small stuff. We just now kind of like go with life.

Andrew Schorr:
That's me. I definitely don't sweat the small stuff. And what about a woman taking support from other women? You spend time talking to other people with breast cancer, don't you?

Janell:
I do. You know, I want women to go out there and get their mammograms and, you know, early detection is key. And I think that for me when I was going through treatment it was really important for me to talk with other women to know what's going to happen next. Especially like with each stage of the chemo, losing your hair and that kind of stuff, and just different resources that are out there for women was key for me, and finding that with other support groups.

Andrew Schorr:
Well, I know you spend time talking to other women, and I want to thank you. And thank you for being with us tonight and talking about it because I know you can't help but kind of relive the journey, which has been a roller coaster ride and a scary one at times and a very hopeful one at times. And it was great news that you received even, you know, when the surgeon went in there and said well, it's just scar tissue, and we don't see any cancer, and that result to continue now two and a half years later. So we wish you and Gary and the two boys a long, happy, healthy life, and we thank you for being with us tonight.

Janell:
And thank you for having me. I appreciate it.

Andrew Schorr:
Oh, no, it's great. I want to go back to your doctor, Dr. Jennifer Specht at the Seattle Cancer Care Alliance, to just put all this in perspective. So we talked about the work that Dr. Mankoff is doing in imaging and trying to help maybe someday we will be able to know who should embark on which therapy and if it's likely to work and the research you are doing adding oral medicine for women who need neo-adjuvant therapy to try to have a bigger bang for more people to fight that cancer, and there have been other advances along the way in the imaging. So you take all this together, Jennifer, are you encouraged where things are headed? There has been really a lot of progress in breast cancer, and most women do well. And I know you want all women to do well, but are you encouraged?
Dr. Specht:
Absolutely. I think that we have so many new advances, so many new drugs, particularly drugs that target specific pathways that are important in breast cancer. This is an incredibly exciting time to be an oncologist and to be in breast cancer research. However, having said that, I still do see patients and unfortunately not all of my patients have the same excellent outcome that Janell has experienced. So it's very sobering on many days to realize that we still, although we are making progress, it's not nearly as quickly as what we would like, and we still do have a very long way to go.

The majority of women who will be diagnosed with breast cancer are going to be survivors, however we still lose far, far too many strong, vibrant and amazing women to this disease, and so as a researcher, we have tremendous progress yet to be made.

Andrew Schorr:
Very good point. And I know that propels you and so many of your colleagues around the country. I have to say I have gone to the sort of convention or conference that breast cancer researchers go to, in the past the San Antonio Breast Cancer Symposium, and now you have what, 10,000, 11-, 12,000 people from around the country all dedicated to moving things forward in breast cancer? And I know you have that coming up in December, and I know there will be some exciting research presented then. And I know maybe some with you, Dr. Mankoff. And so we are very, very hopeful that that can make a difference in the work you do at the Seattle Cancer Care Alliance. So I want to thank you for being with us, Jennifer, and all the work you do and your dedication to patients just like Janell.

Dr. Specht:
Well, thank you very much. Again it's been a privilege to participate in this program, and thanks again to Janell for taking time from her family to be with us.

Andrew Schorr:
Right. Thank you, Gary, too, for looking out for the kids there. I want to mention we do this every two weeks, and I always learn so much. On our next program we are going to be discussing the latest treatments in reconstructive surgery for head and neck cancer, and we are going to have Dr. Neal Futran. So that's in two weeks coming up on Patient Power sponsored by the Seattle Cancer Care Alliance.

Thank you so much for being with us. If you want to hear the replay, we will have that posted usually in about 24 hours, and then we will adding the transcript. Tell people you know about it who are very interested in breast cancer and where research is headed and even share it with healthcare providers you know, and that might help them too. So thanks so much for listening. And thank you to the Seattle Cancer Care Alliance for being our sponsor so we can do this for you every two weeks. I am Andrew Schorr. Remember, knowledge can be the best medicine of all. Good night.
Please remember the opinions expressed on Patient Power are not necessarily the views of Seattle Cancer Care Alliance, its medical staff or Patient Power. Our discussions are not a substitute for seeking medical advice or care from your own doctor. That’s how you’ll get care that’s most appropriate for you.