Robotic Assisted Surgery: Expanding Treatment Options
Webcast
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Eduardo Mendez, M.D.
Lydia Miner

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Lydia’s Story

Andrew Schorr:
Surgery for head and next cancers can be daunting, and in some cases it's not even an option. Fortunately with technological advances minimally invasive surgery with a robot is becoming increasingly available as a treatment option. Coming up Dr. Eduardo Mendez from UW Medicine and his patient, Lydia, will talk about how robotic assisted surgery is giving patients a better quality of care. It's all next on Patient Power.

Hello and welcome to Patient Power sponsored by UW Medicine. I'm Andrew Schorr. Well, cancer of course is a scary diagnosis. For me it was leukemia, starting with nose bleeds, but cancer can show up in a variety of ways. Imagine if it was just some sort of a fullness in your tongue or you thought that it was just a pill stuck in your throat, and you always thought maybe it was just something minor and it would go away. But what if it didn't go away and you found out it was cancer. That's what happened to Lydia Miner, and she was just 48 years old at the time, an environmental consultant from Anchorage, Alaska.

Lydia, so you're going around, what, for weeks or months with this fullness in your tongue?

Lydia:
Yeah, it probably was weeks up to possibly two months because it would come and go, this sensation that I had swallowed a pill that hadn't gone all the way down, and it was there sometimes and then it would go away. And so for quite a while I thought I was probably just imagining it.

Andrew Schorr:
Right. So you go to the doctor and eventually you get worked up further and they take a scope and they--did they go down through your mouth into your throat or where did the scope go?

Lydia:
Oh, no. It went up my nose.
Andrew Schorr:
And the person doing it, I think a physician assistant, what did he or she say.

Lydia:
He said, well, sure enough, there is something down there in your throat. And that was my first confirmation that I had not imagined something being stuck in my throat. He'd actually put his eyes on it and seen something there.

Andrew Schorr:
So is what follows then going to an ENT and then having a biopsy?

Lydia:
He tried to reassure me that it wasn't anything that I needed to worry about necessarily, that it could be something other than cancer but that I would need a biopsy and in the meantime I should have a CAT scan. So a CAT scan was scheduled for just a few days later, so that was the first thing I did, and then I saw the ENT surgeon at the practice where the PA had scoped me.

Andrew Schorr:
All right. And he said?

Lydia:
Within about five minutes of looking at the CAT scan turned around and looked at my partner, David, and me and said, I've got to tell you, I think you have cancer.

Andrew Schorr:
And then the question comes up, as devastating as that is, is what do we do about it. What did he describe as the options and how difficult they might be for you?

Lydia:
He said in cases like this after looking at the CAT scan that he would say that the tumor was inoperable but that it was highly treatable with radiation and chemotherapy, which could be done here in Anchorage.

Andrew Schorr:
But he said it would be rough, though.

Lydia:
He did. He said it would be very, very rough. And he did a little bit of description of what the surgery might be like and just sort of said it's not something we really want to consider because it's so damaging to your tissue and your quality of life will be forever impacted.

Andrew Schorr:
So that was a low point for you and David.
Lydia:  
It was, but I'm the kind of person who tries to see the silver lining so I focused hard on the success that he talked about that I would find if I had radiation and chemotherapy.

Andrew Schorr:  
But then the question comes up, and I know you're talking to your friends and maybe you have some medical people friends and family and saying, well, gee, are there other options.  Should there be anything we should check out?  So out of that came some thought should you get I guess a second opinion somewhere else, and so you're talking with a radiation oncologist in Alaska who is affiliated with the folks in Seattle at UW medicine.  What happened next?

Lydia:  
Right.  Dr. Halligan at Providence Alaska Cancer Center was the second doctor we saw after we had my biopsy surgery, and he'd agreed with the ENT surgeon that radiation and chemotherapy were the treatments that I should consider.  But I'd been speaking--I lived in Seattle for a number of years and I'd been speaking with some friends that lived down there and they told me about the Seattle Cancer Care Alliance which had not been formed when I was living there.  So I mentioned that to Dr. Halligan and said is there any way that you can have my records sent down there so that someone else could look at it.  I understand that you're the second doctor that said radiation and chemotherapy are the ways that you should go and that you have a good chance of success using these.  And that's when Dr. Halligan said, well, I went to U-Dub med school and, yeah, I know the doctors down there, and I'll be happy to make sure your records get down there.

Andrew Schorr:  
And he was going anyway so he personally took them.

Lydia:  
That's right.  Yeah, he was going to visit a daughter, he was a Husky, and dropped them off personally.

Andrew Schorr:  
Neat.  So the records reviewed by other radiation oncologists who kind of confirmed the plan that had been suggested to you in Alaska and the thought that surgery would be difficult and you probably would need radiation and chemo, but what they do of course at UW Medicine and at the Seattle Cancer Care Alliance is that they have groups of doctors who discuss cases.  So your case kind of went through that process.  What happened then?

Lydia:  
We had seen Dr. Halligan on a Monday and we were planning to start radiation and chemotherapy the following Monday.  And he called us on Friday afternoon and said, the tumor board just looked at your records.  I just got the phone call.  They think they can do surgery.  Cancel--if you want to pursue this cancel the radiation and chemotherapy and get down here.  We'll set up the appointments.  Come as soon as you can.
Andrew Schorr:
So get to Seattle, and that brings you to our guest—and we have a happy ending for this story, folks. Stick with us. That brings you to a surgeon there, an otolaryngologist, and that’s Dr. Eduardo Mendez at UW Medicine and Seattle Cancer Care Alliance. And so he starts talking to you about a brand new way of doing surgery on the head and neck with a robot. What did you think about that?

Lydia:
I thought it sounded fantastic. David was a little less interested in trying something brand new. Dr. Mendez explained that they’d been treating cancers like this transorally using lasers and that they were fairly comfortable with that and that it had been done for years and it was a successful method. And then he said, but we have a new way that I think you’re a perfect candidate for and it involves a robot. And David said, let’s just stick with the one you know, and I said, you shut up. Dr. Mendez, tell me about the robot.

Andrew Schorr:
So you did have that, and we’re going to learn about what the alternative would have been, whether with laser or more aggressive surgery. So, Lydia, now I understand this was around the time of your birthday. When was the surgery, in April now of 2010, and when was your 49th birthday?

Lydia:
I turned 49 on April 22nd, and I had my surgery on April 23rd.

Andrew Schorr:
Wow. No one would think of surgery as a birthday present, but it was minimally invasive surgery compared to what you might have had otherwise. Some people, their speech and swallowing and a whole bunch of stuff would be affected. How was the recovery?

Lydia:
It was fine. I had a very sore throat, and other than that it was almost like nothing had really happened to me.

Andrew Schorr:
Okay. And now we're back a couple months later. Trouble swallowing?

Lydia:
No.

Andrew Schorr:
Disfigurement?

Lydia:
Well, I had a second surgery that resulted in a scar.
Andrew Schorr:
You had the lymph nodes, yeah. Right. But on your jaw or on your tongue?

Lydia:
It seems it's all fine. It's the same.

Andrew Schorr:
You're talking fine, tasting things fine?

Lydia:
My taste has changed. I think I'm tasting things okay, but some of the things I used to have more desire for I'm just sort of iffy on now.

Andrew Schorr:
Okay. Well, if you gave up a lot of ice cream or cake or stuff and you keep your girlish figure maybe that's okay. But the thing is that's a small price to pay for beating cancer, right?

Lydia:
Oh, it certainly is, and things don't taste bad or awful. It's just things are a little more bland.

Andrew Schorr:
I understand. And it originally was thought you were going to need radiation and chemo. What happened?

Lydia:
Dr. Mendez had a goal for me with surgery, which would be that I would not have to have chemotherapy at all and that the radiation dosage that I would be treated with would be reduced. So after the successful robotic surgery he removed the tumor in its entirety and got to clean margins all the way around it, and that was a goal that the doctors had agreed to, if we met that goal that I would probably not have to have chemotherapy. So we knew that after the robot surgery. That was about a week after I had had the first surgery. A week after that I was back in Seattle to have the lymph nodes removed, and 25 lymph nodes were removed, and the pathology for all 25 came back as noncancerous.

Andrew Schorr:
Wow. So what did that mean about radiation?

Lydia:
Dr. Mendez had the pathology report in his hand and he told us he'd only seen it for a minute or two before he came in to talk to us. We were on our way to the airport to fly back to Anchorage a week after I had had the lymph node surgery, and he walked in the room and said, this is a game changer. He said it sort of with a smile but not entirely so we didn't really know if it was going to be good news or bad news, and he seemed fairly
stunned at the papers he was looking at in his hand and finally told us that the pathology reports indicated that none of the lymph nodes had cancer. And it was assumed by everyone that one or two would based on what the CAT scan looked like.

Andrew Schorr:
So no radiation.

Lydia:
So he said I don't think you need to have radiation. I think you're no longer stage III. This makes you stage II, and I don't think you need radiation and I'll talk to the tumor board about it.

Andrew Schorr:
And they agreed.

Lydia:
And they agreed, and then we told our radiation oncologist here, Dr. Halligan, and he said, I agree.

Andrew Schorr:
Neat. Okay. Just to sum up before we meet Dr. Mendez and hear more about an amazing approach that was used that really let you get back on with living, how do you feel this has worked out? I mean, you were on sort of the leading edge of medicine for head and neck cancer and this particular type of tumor. You know, not everybody wants to be sort of patient number one. You were really with this robotic approach for this. How do you feel about it? How do you feel it worked out, and how do you feel about Dr. Mendez and the team?

Lydia:
I feel like it worked out better than, you know, short of--after the first surgery and Doc coming back and saying, we were all wrong, you don't have cancer, it couldn't have worked out better.

Andrew Schorr:
Mm-hmm.

Lydia:
And people that are in my life here in Alaska and other places around the world are as shocked as I am, and I know...sorry. Just a minute. I know how lucky I am that it took two surgeries and I'm done. I know. I am very, very lucky.

Andrew Schorr:
Let's meet this man who helped bring skill to go with the luck and the latest technology. That is Dr. Eduardo Mendez who is assistant professor the otolaryngology, head and neck surgery at UW Medical Center and of course affiliated also with the Seattle Cancer Care Alliance. So, first of all, Dr. Mendez, it must touch you too to know how grateful Lydia is.
Dr. Mendez:
Absolutely. It's moving to me as well and...I'm sorry as well. It is very moving to me, and I'm very pleased that she's so satisfied with the outcome, and to be part of that is what medicine is all about.

Andrew Schorr:
It is. All right. Let's understand. We've alluded to the fact that if a tumor in the head and neck or where she had it, in her throat, was operable at all that while there could be this laser approach there also could be very major surgery, which I think could be splitting the jaw to get to where you need to get to try to cut out the cancer, so it sounds like the use of a robot is quite an advance.

Dr. Mendez:
That's correct. These tumors are in a location that it's hard to get to, and in the past the morbid approaches have been designed to be able to allow our hands to operate on this tumor and to excise it. While these operations were very morbid and very involved and long, and many patients were not, understandably so, apt to undergo them, and so for a long time these tumors were essentially treated with chemotherapy and radiation.

Andrew Schorr:
If someone had the surgery, though, they could be looking at a substantial hospital stay, blood loss, there's always the risk of infection of course, pain. And if you did have the surgery how would it affect your eating or swallowing?

Dr. Mendez:
Significantly so. It's a difficult process for patients. Typically if you have the surgery we work closely with our speech pathology team to essentially teach the patient how to swallow again and how to manage food and how to potentially avoid that area so that they wouldn't aspirate food into their windpipe. The recovery can be extended. Sometimes it will take patients months up to a year. And many times we get them to the point where they can have a full swallowing function, sometimes it's more what we call recreational to kind of wet their taste, but primarily all the food and nutrition is delivered through a feeding tube that goes directly into the stomach. So the treatment had been rough.

Andrew Schorr:
No kidding. So, Lydia, when you were kind of broken up there a minute ago you knew what it could have otherwise been.

Lydia:
Yeah, and I know people in my life personally who have gone through that as well as one of my own heroes here in Alaska, Lance Mackey, the four-time Iditarod winner, had throat cancer.
Risk Factors for Head & Neck Cancer

Andrew Schorr:
Right. So, Dr. Mendez, let's understand first of all, let's back up a minute, the causes. I understand one of the causes, this surprised me, and Lydia and I had spoken about it earlier, is the human papillomavirus, HPV. And somewhere back in your past, Lydia, you had been afflicted by that, right?

Lydia:
In the 80s I had a series of abnormal pap smears and eventually had to have a cone biopsy, and my doctor at the time, a doctor in Seattle, had mentioned HPV as a potential cause for cervical cancer back then. I think in the 80s, even then, that was more theoretical than actually established. But when HPV showed up in my surgical biopsy here I remembered that perhaps I had had it all those years ago.

Andrew Schorr:
Wow. So, Doctor, HPV can be one of the bad guys related to these head and neck cancers. What are other potential causes?

Dr. Mendez:
Typically smoking and drinking are the most common risk factors for developing these sort of tumors. In the oropharynx though, in the back of the throat where Lydia had it, for nonsmokers and nondrinkers HPV has been overwhelmingly more associated with this tumor.

Advances with Robotic Surgery

Andrew Schorr:
Let's go back to the robot. So we talk about access. So where otherwise you might have to do a very extensive surgery and then some reconstructive surgery going on maybe a whole day, 12 hours, with the access with the robot, how long does the surgery take, and how long is the recovery?

Dr. Mendez:
Well, Lydia's surgery from the moment that she was put to sleep to the moment that we had finished excising her tumor, removing it, was about 44 minutes.

Andrew Schorr:
Oh, my.

Dr. Mendez:
And then we had to ensure that the margins were clear and had to wait for pathology to tell us that, which was an additional 20. But the surgery had been finalized at around 44 minutes or so. And then we woke her up, which took another 15.
Andrew Schorr:
So if someone had had the more dramatic surgery that would go on all day, I would imagine they're in the hospital for quite a while.

Dr. Mendez:
Yes. Typically our patients that have the open approach, the 12-hour surgery that you had mentioned, go to the intensive care anesthetized overnight. And then they spend about two days in the intensive care unit, after which point they can be moved down to the regular floor. And they spend about an extra seven days or so in the hospital where they are having the tracheostomy management and their feeding tube management done.

Andrew Schorr:
Well, that's a long time, and of course feeding tube is a big deal. And, Lydia, how long were you in the hospital for, having had robotic surgery?

Lydia:
I had my surgery on Friday morning and I was released Monday.

Andrew Schorr:
That's incredible. So, Doctor, what adjectives, what words would you use to describe it, just descriptor words for how big a deal, how big a change this is for patients like Lydia who otherwise might need the extensive open approach if they had surgery at all?

Dr. Mendez:
This is a paradigm shift, and I only use those terms very seldomly because they only happen seldomly in the career of a physician. And I think that one of the paradigm shifts that happened was in the early turn of the century when we had knowledge that tumors that were HPV associated were responsive better, responded better to chemotherapy and radiation than tumors that were not and that the addition of chemotherapy helped with the treatment of these tumors. So there was a significant shift from the open surgical approaches to nonsurgical alternatives, which really up until the past couple years was how patients were treated.

And that's why Lydia had her advice, which was sound advice and a sound way to manage this, but we had been exploring ways of trying to change this and offer more minimally invasive approaches to these tumors. We had been successful at achieving this with tumors that were lower in the throat, but still the access issue with the tumors at the back of the throat and the base of the tongue was hard to overcome. So up until robotics came along then we still had just really one option that was tolerable to patients. And so once this is approved by the FDA at the turn of this year...

Andrew Schorr:
Wow. Some might call it revolutionary.

Dr. Mendez:
It really was a paradigm shift.
Andrew Schorr:
Lydia, nobody wants to have a serious illness--

Dr. Mendez:
Absolutely.

Andrew Schorr:
But I guess the best would be if you do to have it timed with when there's a revolutionary treatment to come along that you can benefit from, and I guess that's what you mean when you say how lucky you are.

Lydia:
Yeah, definitely. And having a doctor who is staying on top of the all the new techniques, the new technologists and has the capacity to use that tool and works at a facility that finds investment in training for that doctor to use a tool like that, it all just sort of fell together. We have felt nothing but blessed that we got to meet the Doc and be one of his first patients.

Andrew Schorr:
Right. Now, of course you're fortunate, Providence Alaska Medical Center and the doctors up there keep in close touch with UW Medical Center and UW Medicine and Seattle Cancer Care Alliance. There's actually a network partnership there. So even in an outlying state you were able to get the latest medicine, and that worked out so well for you. What would you say to other people? So somebody is given this diagnosis, the unfortunate fullness in their tongue our difficulty they might have in their throat and it turns out to be the worst, a head and neck cancer, and they're pretty devastated. I know you were. What would you say to them to give them some hope that maybe as we hear about new approaches like this that they could get back to a full life?

Lydia:
I would say, you know, that it's treatable and be sure that you understand when your options are. Ask your doctors to bring--if you live in a state or a city where you don't have access to good cancer docs ask your docs to forward your records to a place like Seattle Cancer Care Alliance or a university research hospital. They might be able to help you who might--who have doctors and technology on the cutting edge who are looking for candidates to help them with their research and what's progress in new technologists. You know, it's treatable, and if surgery isn't your option radiation and chemotherapy have come--my understanding is they've come a long way from where they used to be. You might have a rough go, but there's support out there for you.

Andrew Schorr:
And you're part it. Dr. Mendez, just to be clear, although the use of the robot at the University of Washington with Lydia was brand new that doesn't mean that the technology had not gone through a lot of review to get to that point where you were able to have Lydia as a patient, correct?
Dr. Mendez:
That is correct. The work that had been done prior and that led to FDA approval was well studied. It was well substantiated. It is important to understand that it was not a new procedure. The approach through the mouth, or what we call the transoral approach, had existed for some time, and so we had the knowledge of the anatomy from an endoscopic view, from the transoral view. We knew where the cuts needed to be made, what were the potential risks and benefits. It's just that we did not have a tool that would articulate and small enough and would allow us to get there.

And so it became a natural fit. But it was worked up and developed since 2006 when they started to really be tested. So it took a number of years of testing in patients that were essentially on protocols before it was FDA approved to bring it online, and keeping in close contact with my colleagues who were doing this led me to understand that this was going to be a paradigm shift and that I needed to move forward with training.

Andrew Schorr:
Well, I think this is a perfect example for folks, and Lydia, I'm sure you agree, first, that you've got to ask questions, second opinions, sometimes third opinions, asking, getting a lot of smart people to look at your case before you pull the trigger on a certain approach, and many of these are big gun approaches, so you really want to think about it, and it worked out well for Lydia. Lydia, we have Dr. Mendez on with us, who of course was sort of the point person for the whole team that worked with you, but because this is a public program what do you want to say to Dr. Mendez as part of that team for how things have worked out and how do you feel?

Lydia:
I feel great and the Doc inspired confidence in David and me from about 60 seconds into meeting him. It was really something to meet a young surgeon who is so dedicated to his patients as people, and I don't know that there's many doctors that we would have said, sure, I'll be your first patient and spend all the next six weeks before we come back in training so that you don't harm me when you get in there with a robot, but we always felt very, very confident with Dr. Mendez. He treated me, first of all, as a person, and it wasn't really what I was expecting from a young hot shot surgeon, to be perfectly honest.

But I can also tell you that the residents that worked with Dr. Mendez at the U-Dub are following in his footsteps in that regard extremely well. I loved every single one of them that came to my hospital room during both stays. They were nothing but warm and compassionate, and when you have confidence in your surgeons and when he had confidence in my as a patient, that I could do this too, it made all the difference. And, Doc, you know I think that.

Dr. Mendez:
Thank you, Lydia.

Andrew Schorr:
Do you want to say anything to him directly?
Lydia:
Thanks. And in August we're going to have a beer with you.

Dr. Mendez:
That sounds good. Maybe we'll play golf too.

Lydia:
Okay.

Andrew Schorr:
Dr. Mendez, so, first of all, I know this is as you said what medicine is all about. So again just recapitulating, the use of the robot in head and neck cancers opens up possibilities for patients who may not have had that before and the chance hopefully to go back to a pretty full life.

Dr. Mendez:
I agree with that, and I think that one has to--I'm very grateful to Lydia for trusting me as her doctor provider, and this is what gets me up in the morning. And I think that--I look forward to following her cancer-free for all these years.

Andrew Schorr:
Amen. And Lydia, so now you're recovered, you've got back to work. What's your hope for the future?

Lydia:
Well, I'm going to be seeing Dr. Mendez every three months for the next two years. I need to be closely monitored, and I'm hoping that we have good visits every three months and that I continue to have clean checkups. And I'm happy to spend time on programs like this, and I imagine that I will be spending more time in whatever capacity I can find in talking to people about cancer, about HPV and HPV prevention and early detection.

Andrew Schorr:
Right. Well, all the best to you and David, and I'm glad you went with your point of view. You're the patient, a powerful patient, as we like to say, and I'm glad it's worked out so well, and I'm glad that technology and skill came together for you to let you go on with a good life and hopefully just beat that cancer forever. Lydia Miner, thanks for being with us. All the best up there in Alaska. I'll have to come visit you, whether it's on a cruise or come up there, and if you play golf I'll do that with you too. Okay?

Lydia:
That sounds great.
Andrew Schorr:
All right. Thank you. Dr. Eduardo Mendez from UW Medicine and also Seattle Cancer Care Alliance, thanks for your dedication and really helping pioneer new approaches that are available to us. Hopefully we don't need them, but when we do we're glad you're there with them. Thank you so much for being with us.

Dr. Mendez:
It's a pleasure.

Andrew Schorr:
This is what we do on Patient Power is really connect you with in this case like a pioneer, Dr. Mendez, in helping with this approach for people and inspiring patients like Lydia Miner. Thanks for joining us. I'm Andrew Schorr. Remember, knowledge can be the best medicine of all.

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