Lessons learned from the “good” cancer

Thyroid cancer has the fastest growing incidence rate of any cancer in the U.S. in the past 30 years, but it also has the highest survival rate (98 percent of patients are alive after 10 years). While it is not clear if patients or physicians – or both – started it, thyroid cancer has earned the designation “the good cancer.”

And yet, a cancer diagnosis is still cancer, and like any cancer, its treatment comes with side effects. Recently, the thyroid cancer team at the UW Carbone Cancer Center (UWCCC) developed a surgery-focused clinical trial from which they expect to help patients make informed decisions between more extensive surgery with lower risk of recurrence and less surgery with a greater recurrence risk.

In addition to performing physical tests to measure changes to voice or swallow function after surgery, the clinicians are generating a wealth of qualitative data through interviews with each patient for one hour pre-operatively and at several times post-surgery. They are still addressing the surgical questions in the study, but it is the interviews that are changing the way the team works with their patients.

“For example, we do a swallow study on a patient and it looks good, then we do a swallow questionnaire and they do pretty well, but when we talk to the patient, they talk about their swallowing challenges for 30 minutes,” said Rebecca Sippel, MD, chief of endocrine surgery at UW and a member of the Cancer Center. “It’s showing us that some of our best tests are not capturing everything patients are experiencing from a quality of life standpoint, and we’d like to understand what they are going through so we can figure out how to better support them.”

While the study, which is still being conducted, includes only thyroid cancer patients, Sippel expects it will inform clinicians who treat any patient with a better-prognosis cancer, such as early-stage breast or prostate cancers that have high survival rates.

“I think we’ve learned that this concept of the good cancer is a real struggle for these patients because it downplays their diagnosis and invalidates their experience,” Sippel said, noting that 94 percent of study participants independently mentioned they had the ‘good’ cancer in interviews. “This study is helping us understand how to better support patients, to help them with their decisions and to help them develop the appropriate social support networks, and it should translate to many other cancer types.”
Personalizing care for older adults with cancer

Older adults are often affected by a cancer diagnosis. As people age, their risk of developing cancer increases. Because of the aging baby boomer population, the incidence of cancer is expected to rise by 67 percent in older adults by 2030. There has never been a more urgent time to better understand the unique needs of older adults with cancer. The overall health of older adults with cancer varies widely, independent of age, and standard assessments used by oncologists typically do not provide a good measure of an older patient’s functional age. Determining an older patient’s functional age is vital to personalizing care plans, a strategy to avoid both under-treatment and overtreatment. For example, you may have a chronological age of 75, but because of a healthy and active lifestyle, your functional age may be more similar to someone who is younger.

For older patients, the success of cancer treatment can hinge upon factors such as how drugs are metabolized by the body, pre-existing medical conditions, physical function and mobility, frailty status and caregiver and social support. In addition, the Cancer and Aging Research Group has developed a calculator, which incorporates elements of the geriatric assessment, to help predict a patient’s risk for significant side effects from chemotherapy.

Geriatric Assessment
The geriatric assessment is a tool that oncologists can use to estimate a patient’s functional age. As it adds a substantial amount of information to the routine oncology evaluation. A geriatric assessment is a multi-dimensional, multidisciplinary evaluation of an older adult’s physical function and health, cognition, mental health, nutritional status and social support. In addition, the Cancer and Aging Research Group has developed a calculator, which incorporates elements of the geriatric assessment, to help predict a patient’s risk for significant side effects from chemotherapy.

UW Health Cancer and Aging Clinic

To assist clinicians, patients and families, a new resource, the UW Health Cancer and Aging Clinic, has been established at UW Health East Clinic, 5249 East Terrace Dr. in Madison. This clinic accepts referrals from all sources including primary care providers, geriatricians, hematologists, medical oncologists, radiation oncologists, surgical oncologists and self-referrals from patients and families. The primary goal of the clinic is to use evidence-based medicine and the multi-dimensional geriatric assessment to personalize treatment for older adults with cancer that is aligned with each patient’s goals, preferences and values.

To schedule a visit in the UW Health Cancer and Aging clinic, please call (608) 265-1210.

MARK YOUR CALENDARS

Bowlin’ for Colon
Several locations
uwhealth.org/bowling

Cross Check Cancer
Madison
madcapshockey.com

Free Head and Neck Cancer Screening
Madison
Contact Heathre Geye, (608) 265-6260

Feature Invitation at PGA West
La Quinta, CA
Contact trb@earthlink.net

Bulldog Stomp 5K Cancer Run/Walk
Pardeeville
phsrunwalk.com

Navigating Brain Tumor Care Workshop
Madison
uwhealth.org/braintumorcare

Carbone’s Pedaling for Pancreas
Verona
uwhealth.org/pedaling

Aly’s Honky Tonk Hustle
McFarland
alyshonkytonkhustle.com

Pinko De Mayo Car Wash
Madison
anwashescheck@madison.k12.wi.us

Andy North and Friends
Madison
andynorthandfriends.com

One woman’s legacy: a lesson in living benefits

Everyone’s cancer story is different, and there is no right or wrong way to deal with a diagnosis. Cathy Wingert has terminal colon cancer, and that is about as much as she will let the disease define her. “When I share my story, I rarely go into the medical part anymore,” Wingert said. “Now it’s: I need to find the good in my cancer.” This is Wingert’s cancer story now. It is the story of a woman who found the good in her cancer by becoming an advocate for patients and research. And it is the story of a woman whose family selflessly supports her as she fights for these things.

“The story I really want out there is about living benefits, because I had never heard of them before my diagnosis and I want other people to check with their life insurance to see if they have that rider,” Wingert said. “I also want to remind people to check their beneficiaries, because in many cases they are outdated.”

Living benefits are an option on many life insurance policies that allows someone with a terminal diagnosis to immediately receive the monetary benefit and use it while they are still living. The money received is tax-free, and there are very few restrictions on its use. For example, it can be used to cover medical expenses, pay for long-term care or take a vacation. [Each policy is different, so check with your life insurance for details.]

For Wingert, her living benefit is going toward a cause in which she never expected to become so involved: cancer research. She has become an avid supporter of colon cancer research conducted in the lab of her physician, Dr. Dusty Deming. She has also been involved with Fight CRC, a colon cancer research advocacy group. “This work is purposeful, meaningful and it keeps me energized,” Wingert said. “Hopefully that can be considered part of my legacy.” To learn more about Cathy’s story, please visit uwhealth.org/wingert

Emily Guerard, MD is an assistant professor of hematology and oncology within the UW School of Medicine and Public Health’s Department of Medicine. In addition to her clinical duties in Madison, Dr. Guerard also provides oncology outreach services at Southwest Health in Platteville. To learn more, visit uwhealth.org/uniqueneeds

Dusty Deming, MD is an assistant professor of medicine within the UW School of Medicine and Public Health’s Department of Medicine. In addition to his clinical duties in Madison, Dr. Deming also provides oncology outreach services at Three Lakes Health and Outreach Services at Southwest Health in Platteville. To learn more, visit uwhealth.org/uniqueneeds
A divide and conquer strategy to fighting cancer

For more than three decades, Taxol has been the most widely used chemotherapy drug to treat a variety of cancers. Still, it only benefits half of patients treated with it, and no one really knows why.

“We knew in a dish in the lab that cancer cells treated with Taxol were getting stuck in mitosis, or when they were trying to divide, and preventing cells from dividing is one way to stop cancer,” said Beth Weaver, PhD, a faculty member at the UW Carbone Cancer Center (UWCCC) who studies how DNA-containing chromosomes separate during cell division. “We assumed it was working in patients the way it was working in the lab.”

Through a collaboration with UWCCC medical oncologist and researcher Mark Burkard, MD, PhD, Weaver obtained samples from breast cancer patients who had been treated with Taxol. She found that the idea of the past 30 years was incorrect: the concentration of the drug tested in the lab was much greater than the amount that entered a patient’s cells. She needed to study lower, clinically relevant concentrations to understand how it benefits cancer patients.

Though she expected the cancer cells were getting stuck and unable to divide into two, Weaver instead found the Taxol-treated cells are dividing at lower concentrations of the drug but that their DNA is incorrectly going in more than two directions. When the cell divides, the new cells have incorrect copies of DNA, causing cells to die.

“Because we don’t know how to predict if Taxol will work, we treat each patient who is eligible, but there are side effects,” Weaver said. “We can now start to look for specific differences in tumors whose cells are prone to dividing incorrectly, and that will allow us to better identify those patients who will benefit from Taxol treatment.”

Stay Connected With Us
Sign up to receive regular e-mail updates from the UW Carbone Cancer Center about cancer prevention, read inspiring patient stories and learn more about innovations in patient care.

Subscribe to our monthly e-newsletter by visiting uwhealth.org/cancernews
Improving treatments for cancer patients?
We’re banking on it.

Patients receiving cancer treatment at University Hospital will often ask their doctor if there is anything they can do to help so future patients can be spared treatments or have better odds of beating their cancer. There is one thing patients can do that allows them to go on with their treatment plan without changes, and is as simple as signing their name: they can donate left over cancer tissue to the UW Carbone Cancer Center’s BioBank.

When a patient with any type of cancer chooses to donate tissue, a pathologist first assesses it, then any remaining tissue is collected by BioBank staff, who process, analyze and store donated tissue samples. Tissue is made available to cancer researchers, who use it in studies that can lead to earlier cancer detection, more targeted therapies and/or improved patient outcomes.

“The BioBank is really an invaluable resource for researchers, because we can ask questions using cancer tissue directly from patients,” said David Jarrard, MD, a urologist at UWCCC who studies how prostate cancer arises and ways to target it.

The donation process

The tissue donation process requires no additional treatment or procedures, and it does not change the patient’s care plan. When a patient is having a tumor removed, the sample first goes to surgical pathology, where a pathologist reviews the tissue. “When a tumor is removed, surgical pathologists sample and examine the tumor in such a way to accurately make the diagnosis, stage the disease and enable the clinical team to determine the next steps of the patient’s care plan,” said Everlyne Nkadori, a researcher at the BioBank.

“The remainder of the specimen would be discarded and is what we call remnant tissue, and our staff collects, preserves and writes notes on this tissue for future research.”

Each sample is de-identified, meaning information such as the patient’s name, date of treatment and treating physician is removed. However, information that may be important when the sample is used for research, including the patient’s age, smoking history, prior treatment or therapies and clinical outcomes, would be included.

Improving treatment outcomes through research

Jarrard, a prostate cancer physician-researcher, is one of several UWCCC investigators who rely on the BioBank to conduct his research. Prostate cancer is the second-leading cause of cancer deaths in men in the U.S., and understandably there is a need for more aggressive and targeted therapies in high-risk patients.

However, for some men diagnosed with prostate cancer, their cancer is low-grade and unlikely to spread, and those cases can be monitored by carefully watching to reduce the risks associated with treatment and prostate removal.

The problem, then, is that there is currently no approved way to distinguish high-risk from low-risk cancers. Jarrard and his colleagues had evidence suggesting that a protein, GLB1, may be a useful classification marker in prostate biopsies.

“We used a prostate cancer tissue microarray, or a microscope slide on which over 100 patients’ samples were placed, and that allowed us to quickly measure GLB1 levels in each sample,” Jarrard said. “Because patient outcomes were linked to the sample, we could conclude that higher GLB1 levels are associated with less active cancers and higher survival rates.”

As Jarrard continues to identify more proteins like GLB1 that are associated with prostate cancer risk, he expects that low-risk patients can be accurately identified and treated with active surveillance, reducing the side effects from overtreatment.

 Patients who want their tissue donated should speak to their clinician

The BioBank is legally allowed to collect any remaining tissue, but the relevant medical history is only included if a patient provides their consent to additional information.

“In this era of personalized medicine, linked clinical data become increasingly important as you want to be able to correlate clinical information with tumor type, tumor mutation profile, response to treatment and patient outcomes/survival. Our investigators are only able to get this type of valuable information when the patient consents to donating their tissue,” said Kristina A. Matkowski, MD, PhD, a pathologist at UWCCC and co-director of the BioBank.

“Ultimately, our goal is to improve patient care and survival rates and the best way to accomplish this is by having the health data linked to the tissue sample.”

Because BioBank staff do not work directly with patients, they rely on clinicians to talk to their patients about donating remnant tissue. Patients can also call the BioBank directly to discuss a possible donation. Currently, only patients being treated at University Hospital are able to donate.

“In our experience, we know that many patients would want to donate their tumor tissue to aid cancer researchers if they knew it were an option,” Matkowski said. “We strongly encourage our UWCCC patients to ask their doctor about donating their tissue to the UWCCC BioBank.”
RACE FOR RESEARCH

Robin Kvalo wanted to help her husband Michael fight lymphoma. So the week Dr. Walter Longo performed Michael’s bone marrow transplant, Robin led the top UW Carbone Race for Research team: “The race was a great outlet for me... it was something I could do for him.”

READ THEIR STORY:
UWHEALTH.ORG/KVALO