MD Anderson Cancer Center Cooper
Making Cancer History®

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Clinical Update
For Medical Professionals

MD ANDERSON CANCER CENTER AT COOPER SECOND OPINION PROGRAM: Advanced expertise for optimal clinical outcomes and peace of mind

The value of a second opinion for most cancer patients cannot be overstated. While many newly diagnosed patients often feel a sense of urgency to start treatment as soon as possible, for most, taking some time to confirm that their diagnosis is correct and the recommended treatment plan is appropriate can deliver far-reaching clinical and emotional benefits.

To help these patients and their physicians realize these benefits, MD Anderson Cancer Center at Cooper offers a comprehensive Second Opinion Program that provides fast access to a multidisciplinary team of oncology experts who review the patient's medical reports and test results and collaborate to render an opinion about the diagnosis, and suggest (or confirm) recommended treatment.

Access to other treatment modalities, clinical trials

"A second opinion, particularly at an academic medical center, opens up the horizon for other available treatment modalities that an individual may not be aware of or that may not exist in their community," says gynecologic oncologist James K. Aikins, Jr., MD, FACOG, FACS, Director of Research, Division of Gynecologic Oncology, and Program Director, Gynecologic Oncology Fellowship. "For example, there might be an opening for a research protocol that we have as part of the National Cancer Institute and the Gynecologic Oncology Group—something that simply isn't available at their local hospital."

Medical oncologist Pallav K. Mehta, MD, Director of Integrative Oncology and Director of Practice Development in MD Anderson at Cooper's Division of Hematology and Medical Oncology, sees the value of second opinions from two points of view.

> "There's a comfort for both the patient and the community-based physician when the patient is seen by a second set of eyes..."

"I was in community practice for nine years before joining MD Anderson at Cooper," he relates. "While I considered myself a breast cancer specialist at the time, I've since found that you become more familiar with the nuances of a particular cancer when your primary focus is treating that type of cancer, which is the approach at an academic medical center. There's a comfort for both the patient and the community-based physician when the patient is seen by a second set of eyes—especially when they're subspecialized."

"I really recommend a second opinion," he continues. "Sometimes it simply confirms the plan the patient's doctor outlined, or maybe it points to a slightly different plan, or sometimes a very different plan. But if a patient has questions about anything or feels unsure, a second opinion is essential."

James K. Aikins, MD, Program Director, Gynecologic Oncology Fellowship

Pallav K. Mehta, MD, Director of Integrative Oncology.

Advanced tumor testing, genomic profiling

MD Anderson at Cooper's Second Opinion Program also offers access to the cancer center's advanced expertise in tumor testing and genomic profiling, which helps inform immunotherapy decisions tailored to the individual patient, including whether patients will benefit from such therapies in the first place. Tests called companion diagnostics (CDx) provide information about the safe and effective use of a targeted drug or biologic, helping oncologists determine whether a particular drug's benefits will outweigh any risks or potentially serious side effects to the patient.

Fast access for anxious patients

What about patients who are anxious to get their treatment underway and don't want to take the time to obtain a second opinion?

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To refer a patient to MD Anderson at Cooper's Second Opinion Service, call: 855.MDA.COOPER (855.632.2667). Appointments are usually available within 48 hours.

"Most solid tumors are not fast-growing," says Dr. Aikins. "Having said that, our second opinion service can usually schedule a consultation with one of our specialists within 24 to 48 hours."

"The key is helping the patient understand the difference between a medical emergency and an emotional emergency," says Dr. Mehta. "With cancer, it's not always the former, but it's always the latter.

"I've seen many patients who could wait a few weeks, even months, before starting treatment," he continues. "But there are some cases that are not amenable to waiting—a young patient with aggressive breast cancer, for example. With breast cancer, we have seven to eight medical oncologists, so we're able to see patients quickly."

Both Drs. Mehta and Aikins want to reassure community physicians about the goals of the Second Opinion Program.

"Two heads are better than one"

"We're here to work with and support community physicians and their patients," Dr. Aikins says, "and we always keep the community physician in the loop.

"Even if a patient is comfortable with her original doctor's assessment and treatment plan, I think it's still a good idea to get a second opinion because two heads are better than one," he continues.

"That includes when it's my patient going for a second opinion," he adds. "It's not about me; it's about the patient's health and peace of mind."

To schedule a second opinion evaluation appointment at MD Anderson Cancer Center at Cooper, please call 855.MDA.COOPER (855.632.2667).

MD ANDERSON AT COOPER LUNG NODULE PROGRAM: A Smart Adjunct to Lung Cancer Screening

When the National Cancer Institute's landmark National Lung Screening Trial (NLST) found that screening with low-dose CT reduced lung cancer mortality in high-risk individuals by 20 percent compared to chest x-rays, it changed the landscape of lung cancer screening, with hospitals across the nation launching programs to help current and former smokers improve their chances of surviving this deadliest form of cancer through early detection.

As a result of these screening programs, however—along with incidental findings on chest X-ray or CT scans obtained for other purposes—an estimated one million pulmonary nodules are being detected in the U.S. each year. The challenge now is to distinguish between benign and malignant nodules, expediting diagnosis for malignant nodules while minimizing testing of those that are benign.

"It's simply not feasible or appropriate to take everyone with a lung nodule to the OR and do invasive tests," says thoracic surgeon David Shersher, MD. "You need a strategy to identify who needs more of a workup, who needs to be followed, and who doesn't.

At MD Anderson at Cooper, that strategy entailed creation of a dedicated multidisciplinary Lung Nodule Program, spearheaded by Dr. Shersher and medical oncologist Polina Khrizman, MD. In addition to their respective specialties, the disciplines that comprise the program include pulmonologists, interventional pulmonologists, radiologists, an imaging navigator, a nurse navigator, and other pulmonary and cancer experts.

> "There is a certain appearance to nodules that are concerning, which our lung-specialist radiologists recognize."

David Shersher, MD, Thoracic Surgeon

Polina Khrizman, MD, Hematologist/Medical Oncologist

So how do you distinguish between a benign and malignant nodule without invasive testing?

"There is a certain appearance to nodules that are concerning, which our lung-specialist radiologists recognize," explains Dr. Khrizman. "It has to do with size and shape—if it's well-circumscribed, ragged or invasive—and its growth pattern over time.

"We also look at the patient's age, smoking history and environmental exposure to things like asbestos," she continues. "All these components help us identify those nodules that are more or less likely to be concerning. Patient

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To refer a patient to MD Anderson at Cooper's Lung Nodule Clinic, or for more information, call the Lung Imaging Navigator at **856.735.6235**

A may have a lung nodule that looks suspicious, and we may recommend biopsy right away. Patient B's nodule, by its size and shape, isn't as concerning, so we may recommend a CT in six months and follow-up in clinic.

"It's very individualized, based on different risk stratification and what we see on imaging," she adds.

"Surgery is indicated when concern is very high from a clinical standpoint and there's tremendous risk, such as when a nodule is growing in size and PET shows it's active," Dr. Shersher says, noting that MD Anderson at Cooper offers a range of non-invasive testing, including biopsy performed through the airway by the interventional pulmonary team.

A unique aspect of MD Anderson at Cooper's Lung Nodule Program is its emphasis on smoking cessation.

"We've built in a robust, evidence-based smoking cessation program that's been shown to work over the long term," Dr. Shersher says. "We know it takes up to nine attempts to quit smoking, and we have strategies that help people succeed."

Drs. Shersher and Khrizman urge community physicians to get their at-risk patients screened for lung cancer—those between the ages of 55 and 74 who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years.

"For decades, we struggled to find a test to identify lung cancer early," Dr. Khrizman says. "Now we do, and it's improving survivorship."

"Our program is designed to guide and manage patients through this complex condition, while keeping referring physicians informed throughout the care process," Dr. Shersher adds.

For a direct physician-to-physician consultation about a patient, call Dr. Shersher at 609.947.3658 or Dr. Khrizman at 215.422.2484.

For all new patient appointments, our schedulers can be reached at 855.MDA.COOPER (855.632.2667).

TREATMENT ADVANCES IMPROVE SURVIVAL AND QUALITY OF LIFE for growing number of patients with metastatic disease

"While there is no good time to have metastatic disease, there are many more options for patients in this situation than there were even five or ten years ago," says Faith (Fay) Young, MD, a MD Anderson at Cooper hematologist/medical oncologist who is board-certified in medical oncology and palliative care.

"The outlook depends on so many things—the type of cancer, its underlying biology, the patient's health, when the disease was discovered or evolved," she continues. "But compared to how it once was for someone with metastatic disease—an anticipated downward shift in prognosis and survival—that's no longer automatically the case for a growing number of types of cancer today. In fact, some patients who have metastatic disease that is limited in scope can sometimes be approached with a goal of cure."

Oligometastatic colon cancer is a case in point.

"Colon cancer was once thought to be incurable if found in any place outside of the colon—the liver and lymph nodes being the most common distant sites," Dr. Young explains. "Now we've found that with aggressive therapy sequenced appropriately, some patients with low volume metastatic disease have a chance of cure, or have much longer periods of disease control."

Aggressive therapy includes removing or sterilizing lesions amenable to surgery or radiation, or that respond completely to chemotherapy.

More favorable outcomes, better quality of life

"Fifteen years ago this was just a dream," she says. "But with appropriately designed clinical trials, and doctors and scientists partnering to identify lesions appropriate for chemo, radiation and/or surgery, the dream has become more achievable."

This approach is also being applied to cancers of the lung, testis, sarcomas, melanomas and renal cell carcinoma, as well as breast cancers, among others.

Faith Young, MD, Hematologist/Medical Oncologist

"Appropriate combinations and sequences of therapy allow for both meaningful control of the cancer and preservation of quality of life," Dr. Young notes. "We have to be able to give therapies that are adapted for the patient, and which are both efficacious and tolerable.

"If there's a patient who has a lot of physiologic reserve and whose cancer is technically curable, we'll follow a curative pathway," she continues.

Turning metastatic cancer into a chronic disease

"Even in those cases in which a curative option is extremely unlikely,

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our aim is to turn that diagnosis, if possible, into more of a chronic disease, compatible with a reasonable—or even better—quality of life," she notes.

"Many protocols are well-known and validated for treating specific tumor types," she adds. "Because some patients tolerate chemo better than others, within those protocols we can make adjustments that still allow for meaningful doses without under- or over-treating the patient.

Incorporating radiation therapy

"Stereotactic radiosurgery is a form of radiation therapy that focuses on high-power energy on a small area of the body, minimizing damage to surrounding healthy tissue. These types of treatment, as well as non-stereotactic radiation approaches, constitute another formidable weapon in the armamentarium for treating metastatic disease," Dr. Young says.

Targeted therapy has "revolutionized" cancer care

Another game-changer in treating cancer—including metastatic disease—has been targeted therapy.

"Targeted therapy has absolutely revolutionized the way we approach both primary cancer and metastatic cancer care," Dr. Young says. "And it has become mainstream versus investigational."

Targeted therapy encompasses immunotherapy, which can use either modified proteins or cells, and a class of drugs called small-molecule inhibitors, each of which is deployed differently.

"But they all work in defined situations where the targets of these drugs are recognized," she explains. "This requires genomic analysis of the tumor cells in order to identify the types of mutations or genomic changes that confer either vulnerability or resistance to these manipulations.

> "...some patients who have metastatic disease that is limited in scope can sometimes be approached with a goal of a cure."

"For example, about 40 percent of colon cancers have a mutation in the KRAS gene that makes those tumors unresponsive to EGFR inhibitors, whereas patients without that mutation gain significant tumor control if EGFR inhibitors are added to their chemotherapy," she continues. "So for the greatest safety and efficacy, we would add EGFR inhibitors only for that subset of patients without the KRAS mutation."

Similarly, in patients with esophageal cancer or breast cancer who overexpress the HER2/neu protein, drugs that specifically interrupt that signaling pathway can improve disease control.

MD Anderson at Cooper's Second Opinion Program (see related article in this issue of *Clinical Update*) also plays a key role in helping to optimize outcomes for patients with metastatic disease.

Preserving quality of life, offering hope

"These patients benefit greatly from multidisciplinary review and discussion of the options available to them," Dr. Young says, referring to the work of MD Anderson at Cooper's tumor boards. "Not only does it give them and their referring physician access to a think tank of physicians reaching consensus about the best approach for complex or previously unrecognized curative situations, but we also talk about the patient's quality of life before and after the intended treatment."

She adds, "In my work, I think often of a favorite quote from a Robert Frost poem: 'Hope is not found in a way out but a way through.' For our patients with metastatic disease, this really sums up what we try to do as clinicians, interdisciplinary care teams, and as a patient-centered cancer center."

If you have questions about a patient with metastatic disease, please contact Fay Young, MD, at **585.729.5271.**

MD ANDERSON AT COOPER RARE CANCERS PROGRAM

MD Anderson at Cooper has launched a new program to care for individuals with rare cancers. Through our Rare Cancers Program, clinical experts from our disease-site specific teams take a multidisciplinary approach to the diagnosis and treatment of rare and complex cancers providing personalized treatment plans and dedicated nurse navigation services. To learn more about this program or to refer a patient, contact program director, Tae Won Kim, MD, Division Head, Orthopaedic Surgery, at 215.516.9660.
Look for more information about this program in our next issue of Clinical Update.