

## Advances in the Treatment of Stomach Cancer

Webcast

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Linus Ho, M.D.

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### **A Patient's Story**

#### **Andrew Schorr:**

Hello. Welcome once again to Patient Power, sponsored by M. D. Anderson. I'm Andrew Schorr. Today we're going to talk about advances in the treatment of stomach cancer. Now, happily the rates of stomach cancer have gone down, but still in the United States we're looking at 22,000 Americans will be diagnosed with stomach cancer this year and over 11,000 people will die of it. Pretty scary, and unfortunately it's often not discovered early, and so then you say, well, what can be done. Well, the good news is M. D. Anderson is doing a lot, advancing research and new approaches and a very specialized team, and we're going to talk about that in just a minute. But first I'd like you to meet someone who very recently, just really two weeks ago now as we are recording this, was treated at M.D. Anderson, came home from M. D. Anderson after treatment there for stomach cancer, but he lives in Crestview Hills, Kentucky, which is really just south of Cincinnati, Ohio, and that's Victor Hauser, who is 66 years old. He has two grown daughters, and he has five grandchildren and was diagnosed with stomach cancer I believe in September of 2007. Right, Victor?

#### **Victor:**

Yes, sir, that's correct.

#### **Andrew Schorr:**

And you're a retired businessman. Tell us about this diagnosis. What was going on for you that suddenly you were sick? What happened?

#### **Victor:**

Well, I just wasn't eating right, and I was having problems swallowing and I got sick one evening. And so the next day I went to my doctor at home and he sent me for endoscopy, and the results of that came out negative--well, bad for me with the esophageal and stomach cancer is what they diagnosed.

#### **Andrew Schorr:**

Right. And I understand when you got sick, all of us sometimes will get nauseous or even vomit, but it was unusual, wasn't it?

**Victor:**

Yes, it was. It was black. I mean, I knew something was wrong when I saw it. Normally I'm not one that goes to the doctor very often, but when I saw that I knew there was something wrong so we went to the doctor the next day.

**Andrew Schorr:**

Oh, my. So let's talk about the treatment you had. So first of all you went to the doctor. You had to then think about, well, where do you have treatment and what is the treatment. You're from Kentucky. How did you wind up in Houston at M. D. Anderson?

**Victor:**

We went to a radiologist here, a fellow that we knew, and we were talking to him. And I had heard about that day someone had mentioned M. D. Anderson or I heard--I don't know where I heard it, so of course talking to him I mentioned it. My wife had heard about M. D. Anderson that day, and my daughter had heard about M. D. Anderson. So I asked this doctor about M. D. Anderson, and he said that as far as he knows they're tops in the country. So I said, well, if it's you or your family what would you do, and he said, I'd go there, and that's what I did.

**Andrew Schorr:**

Wow. Good for you. And I have to say with my leukemia treatment starting in 1996, that's what I did too, and I live far away in Seattle, Washington. So I certainly can understand that, and being a 12-year leukemia survivor I'm really glad I did.

So you go to M. D. Anderson. There were a little complications I know there in your home area, but you went there, and you were connected with a fellow we're going to meet in just a minute, Dr. Linus Ho, who is a specialist in GI medical oncology and stomach cancer treatment as part of that. You went there and then you had chemotherapy, right?

**Victor:**

Correct.

**Andrew Schorr:**

And radiation.

**Victor:**

Correct.

**Andrew Schorr:**

Then had surgery.

**Victor:**  
Correct.

**Andrew Schorr:**  
And then needed sort of a revision surgery as well.

**Victor:**  
Yes. There was a little infection they needed to take care of.

**Andrew Schorr:**  
And then just got home. So as I understood it, now, your stomach was removed, and as we'll learn more, it goes straight to your small intestine where the digestion happens, right?

**Victor:**  
Yes.

**Andrew Schorr:**  
So you're kind of adjusting to what can you eat and how much and how often, right?

**Victor:**  
That's the problem now, yes, to figure out exactly how much I can eat and how often.

**Andrew Schorr:**  
Okay. But your hope is, I know your hobby is golf, is that you're going to be getting back to playing 18 holes or more and enjoying your grandchildren, right?

**Victor:**  
Exactly what I'm looking forward to.

### **Diagnosis**

**Andrew Schorr:**  
Okay. Sounds like a very good goal and I'm sure very achievable. Let's meet your doctor, who of course is a specialist. People come from all over to see him, and that's Dr. Linus Ho. He is assistant professor in GI medical oncology at M. D. Anderson. Dr. Ho, thanks so much for being with us.

**Dr. Ho:**  
Oh, you're very welcome.

**Andrew Schorr:**

So here's Victor Hauser, a very new patient treated very recently, and it came out of nowhere it seems for him. How does this happen that someone finds out they have pretty significant cancer in their stomach but it wasn't caught earlier?

**Dr. Ho:**

I think it derives from the fact that the symptoms are very nonspecific early on. As Mr. Hauser suggested, initially he just didn't feel right. If you're lucky enough, for example, to have a tumor that's located in the esophagus, the esophagus is a narrow organ so a relatively small tumor can begin to compromise the hole in the esophagus and make swallowing difficult. However, the stomach, being a larger organ that's designed to hold up to two liters of food and fluid, it doesn't compromise that much. You may just have vague abdominal discomfort. People may present to their doctor and be given something for ulcers or reflux, and then after a few months of treatment things are no better but in fact worse, and so it's not unusual for people to have symptoms for several months before they finally get a CT or an endoscopy that finally makes the diagnosis.

**Evaluation and Treatment**

**Andrew Schorr:**

Okay. Now, when that happens, though, and of course we always learn that in most cases earlier treatment it better. So then you discover the stomach cancer. Mr. Hauser decided, I think wisely, to come from Kentucky to M. D. Anderson. What sort of further evaluation do you do to see what are you dealing with?

**Dr. Ho:**

Well, at M. D. Anderson we have a very standardized approach towards stomach cancer keeping in mind how it often tends to spread. We do the usual things such as CT scans, lab tests. The endoscopy however we carry a step further. We do what we call an endoscopic ultrasound. And what that is is basically an ultrasound from within the stomach, and the power of that technique is that it can actually look at the walls of the stomach. And the stomach is exposed of several layers of tissue, and the deeper the tumor erodes into those layers the greater of risk of spread. So this is part of what we do for staging. So this endoscopy lets you look under the surface and see how deeply the tumor involves the stomach.

The other power of that ultrasound technique is that it can actually see lymph nodes around the stomach, and it can sometimes allow you to biopsy those and conclude whether or not there's tumor in those lymph nodes. And if there is tumor in the lymph nodes that further increases the stage and the risk of spread. So all of that is part of the staging that we do.

And then finally because the stomach cancers often spread within the abdomen that disease often is not detectable by any other means, and so we often do what we

call a staging laparoscopy. This is basically one of those mini operations that for example people often use for having their gallbladder taken out where they have two or three small holes placed in their stomach and in their abdomen and they take a look. And in that way they can see visually are there tumors that have spread within the abdomen. And also they can do what we call washings where they put in some fluids and see whether there might be some tumor cells floating around within the abdomen. So all of those procedures entail what we do for staging of stomach cancer.

**Andrew Schorr:**

So then it comes to treatment. Now, M. D. Anderson being recognized once again in the *U.S. News and World Report* as the number one cancer center, so I'm very excited about that as well I know everybody is there. But at any rate, as you advance the treatment of stomach cancer I know that you have helped lead the way in saying maybe chemotherapy and radiation or one or the other should be done first prior to surgery, which has been the standard approach. Where are we with that? Because as we heard with Victor, that's what happened with him.

**Dr. Ho:**

Right. Now, Victor's case is certainly not typical because he downplays things a little bit but when he first came here he was very ill. He was in the ICU for two weeks plus and on and on, and so his treatment was delayed. Typically, as you allude to, we do prefer trying to do chemo and radiation prior to surgery, and this is for several reasons. One, very simply, it's a much better tolerated procedure done before surgery. If Mr. Hauser could imagine, now he's had surgery, he's weakened and now you want to go through six months of chemo and radiation, it's very difficult.

Number two, you can actually get an idea of what your tumor is doing in response so therapy. For example if you have surgery first you've presumably taken out all of the tumor that you can see, and then the treatment afterwards is only in the hope of mopping up. But the only criteria for that success is whether or not the disease comes back one, two or three years afterwards. If you transfer that treatment to before surgery you have oftentimes something that you can measure on a CT scan or an endoscopy, then you treat and so you know is this chemo working or not. And after a period of time if it's not working you can switch gears. You can find another combination that might work better or maybe you decide just to go straight to surgery. So it gives you that flexibility. So those are some of the reasons that we prefer doing treatment before.

**Andrew Schorr:**

And you continue to study which drugs are right for which patient as you use chemo, right?

**Dr. Ho:**  
Right.

### **Causes and Frequency**

**Andrew Schorr:**

And then that comes to clinical trials. Are clinical trials very active in the area of stomach cancer?

**Dr. Ho:**

To some extent. I think that in the United States stomach cancer is not as frequent for example as in the Far East, so there are actually a number of trials being done in the far east, but certainly M. D. Anderson and other centers in the United States are conducting trials in stomach cancer. But we've seen actually a lot of the classic stomach cancers going down in incidence. Instead we've seen the increase in cancer centered at the junction between the stomach and the esophagus increase in frequency.

**Andrew Schorr:**

Who do you think is going on there?

**Dr. Ho:**

Well, we think that in large part reflux may play a role in the causation of those types of tumors, and this is different from the stomach cancers that arise at the end of the stomach, and those have been more historically due to diet, and that's the type of cancer we see in the Far East. And we think that things in the diet such as pickled things or salts or nitrates maybe play a role in those types of cancers. But as far as the tumors that are around the junction between the esophagus and the stomach, the greatest risk factor there appears to be reflux.

**Andrew Schorr:**

Are you thinking then that if somebody gets heartburn or eats a lot of spicy foods and then is popping pills to try to limit the acid in their stomach that that could raise their risk for this sort of cancer?

**Dr. Ho:**

Yes. Certainly I think if one has chronic reflux that's very significant it may not be a bad idea to consider an endoscopy because those situations could lead to changes that predispose to cancer. We think that the reflux causes chronic irritation. This in turn causes changes in the lining and these changes gradually can lead to cancer.

**Andrew Schorr:**

Wow. Well, we have a lot more to talk about. We're going to take a short break, and when we come back we're going to learn more about how they're advancing

the treatment of stomach cancer at M. D. Anderson. We'll hear more from Victor Hauser about his experience there. And we will take some questions that have been sent to us as well from people seeking information. You're listening to Patient Power sponsored by M. D. Anderson Cancer Center.

**Andrew Schorr:**

Welcome back as we continue our Patient Power discussion on the advances in the treatment of stomach cancer. And we have with us Dr. Linus Ho, who is assistant professor in GI medical oncology and a stomach cancer specialist at M. D. Anderson. And also one of his patients joining us from near Cincinnati, Ohio, across the border in Kentucky, Victor Hauser, who was treated just very, very recently at M. D. Anderson. Was a pretty sick guy with stomach cancer that last fall came out of the blue for him, and then he had surgeries and chemotherapy and radiation. He had a lot of treatment and hopefully will do well.

Let's go back to Dr. Ho as we understand this better. Dr. Ho, so we talked about now the approach of chemo and radiation first, and then surgery. So do you end up then where you need to continue with medical management I guess you call it afterwards? Or how does that work after the surgery?

**Dr. Ho:**

Well, people have taken varies approaches. For example in Europe they have taken the approach of using chemotherapy before and after surgery. Here we've taken the approach of loading everything up front. We do chemotherapy and radiation up front, and after surgery we simply watch. And in Mr. Hauser's case he actually had an extremely good response, better than I would have imagined. When the pathologist looked at his removed cancer under the microscope, they could not see any living tumor cells left. And so we call this a pathologic complete response, which is an excellent prognostic factor. So I think I'm very optimistic in Mr. Hauser's, you know, chances, but we will follow him very closely in the months and years to come.

**Recovering from Stomach Surgery**

**Andrew Schorr:**

Mr. Hauser was mentioning he's adjusting, you know, very recently coming back from M. D. Anderson about what he can eat and when and how often. So when you with a surgical approach remove part or all of the stomach, help us understand how somebody then can eat. How do you do it then and get the nutrition you need and just go on with your routine?

**Dr. Ho:**

So the three main functions of the normal stomach are, one, as a storage facility for the meals you eat; number two, to begin the digestive process; and number three, to control the release of that food into the intestine. Intestines are not a

high volume facility, so it's not used to handling large amounts of food. So the stomach's role is to gradually release that partially digested food so that the intestines can further the digestive process.

In Mr. Hauser's and other patients' cases, when the entire stomach has been removed then you lose those functions. Now, obviously the digestive part is not a tremendous one because you can certainly live without your stomach. However, you do lose the storage capacity and you lose the valve function of the stomach. So what that means is that, one, you can no longer eat the large volumes of food that you were able to eat before the operation. And, two, without that valve food that is normally retained until the body is ready so no longer retained and it just spills directly into the intestines. What happens then is that the digestive process can't keep up with that flow, and the result of that of course is you can have abdominal discomfort, diarrhea and other things that we kind of lump together as called dumping syndrome. So those are all things that people have to learn to adjust.

We recommend smaller, more frequent meals. And the fact of the matter is that most people reach a new equilibrium. They never get back to the weight that they were before surgery, but in many of our cases that often isn't such a bad thing.

**Andrew Schorr:**

Now, I've done some programs on weight loss surgery and I know there's a lot of training that people have to go through there, and even that dumping syndrome can come up there too if people eat too much after surgery. So is there training that M. D. Anderson does with the patients to help you understand kind of your new life?

**Dr. Ho:**

Yeah, our dieticians work very closely with our patients, one, because the vast majority of them have a feeding tube to supplement their nutrition after surgery because we know that they are not able to eat enough by mouth alone. So the feeding tube goes directly into the jejunum, which is part of the small intestine, and that supplements what the patients eat by mouth. And that's carefully controlled, and they keep tabs on how many calories and protein you get in addition to what you get by mouth. So it's a learning process. For example foods that are very sugary or high in glucose often tend to exacerbate the dumping syndrome, so patients will learn to sometimes avoid those sugary foods or whatever other foods might cause them to have problems.

**Andrew Schorr:**

And, Victor, this is the adjustment you're going through right now?

**Victor:**

Yes, it's obviously still new to me so I'm still learning what I can eat and what I can't, and have experienced some of the symptoms that Dr. Ho talked about.

**Andrew Schorr:**

Okay. Well, here's a question that we got in for you, Dr. Ho. This is from Sherry from Tulsa Oklahoma. "I'm 32 years old and was diagnosed with stomach cancer a year ago. I had surgery at the end of November of 2007 to remove 80 percent of my stomach. I had the obvious nausea, fatigue, etc., after surgery which subsided after three months. I recently started feeling the nausea again. Could this be an indication that the cancer has returned?"

**Dr. Ho:**

Certainly it could. She didn't indicate whether she got additional therapy before or after. Unless it was a very early stage tumor we typically recommend that, however at this point there's no evidence that starting treatment this late necessarily would decrease the risk of it coming back. But certainly I would recommend surveillance after surgery as we would do with Mr. Hauser to make sure that there's no disease coming back. In certain cases if it's caught early enough the current disease can be addressed.

**Andrew Schorr:**

And typically what is surveillance? Let's say for Mr. Hauser or somebody, how often do you see them or what sort of exams are done?

**Dr. Ho:**

Here we would often see patients about every three months for the first year, and that would often entail lab work and CT scans and maybe every six months or so for the first year doing endoscopy. And then gradually as time passes after treatment has been completed one can begin to gradually space out those visits.

**Treatment Advances**

**Andrew Schorr:**

Now, we talk about, our title is "Advances in the Treatment." Where do you think we've made advances? I know you've worked hard at M. D. Anderson to have sort of a very unified team, you're a medical oncologist. I know you have a lot of different surgeons, and you have pathologists and radiologists. Is it getting everybody to work together that is helping make advances? Is it the new drugs? Doing it ahead of surgery? What are you excited about that you think is really helping make a difference?

**Dr. Ho:**

Well, I think certainly it's what we call a multi modality treatment plan. I think that's really a very important thing. In Mr. Hauser's case there are at least three or

four surgeons that have been involved in his case along with myself and radiation oncologists. So it is a team effort, and we certainly get together and arrive at a consensus as to how we want to approach our patients so once someone presents we're all on the same page. We have a definite pathway that people follow. Of course sometimes things have to be amended. Again, Mr. Hauser's case was quite unusual and was not necessarily the norm, with him having surgery before he had any treatment to address an abscess and a blood clot in his abdomen, but that's been our general approach.

And I think certainly in medical oncology we're looking at finding more effective drugs because I think the major cause of failure of cure is that the disease spreads beyond surgery. And what I try to tell patients is that radiation and surgery are local therapies. So they only address the particular area immediately around the stomach. However, if there's been any spread further beyond those borders, then those modalities will not take care of those cells and they will, given enough time, eventually grow back and kill the patient. So in my mind chemotherapy is a very important part of cure by eliminating at an early stage those floaters, if you will, that will come back to bite you if they're not addressed. So our challenge is to find more effective chemotherapy to kill those floaters.

**Andrew Schorr:**

Now, you have lots of labs at M. D. Anderson, and you've talked to all the drug companies. Are you optimistic that those better therapies are in development?

**Dr. Ho:**

Oh, I think so. The large trial study in the United States several years ago, what we called the Intergroup 116 trial, for example, used 5 fluorouracil and leucovorin, and those drugs have been around for many, many years. Now the Europeans have introduced some new drugs, and the typical flow of drug development has been from treating patients with incurable metastatic disease and then bringing those effective drugs into the curative treatment, the idea being that when you have someone who could be cured you don't want to mess around too much, you want to stay more conservative. When you have incurable metastatic disease it's a better testing ground for new therapies. And so there have been improvements shown in the treatment of metastatic disease that we're now starting to try to bring into the treatment of potentially curable stomach cancer.

**Seeking Specialized Care**

**Andrew Schorr:**

One last area I want to discuss with both of you is, now, Dr. Ho, so when someone is diagnosed with stomach cancer it's not at all a common cancer, and it seems like a team approach of experienced team members with stomach cancer makes a

difference. Now, not to be self-serving about M. D. Anderson, there are other major centers too, but as far as somebody getting to one of these centers, why do you think it's important in stomach cancer?

**Dr. Ho:**

Well, I think it's important in many ways. Looking at each modality, for example in surgery surgical oncology is a field unto itself, and in various types of cancers, for example colon cancer or esophageal cancer, we're finding for example that taking more lymph nodes out is important. So the diligence in doing a good lymph nodes dissection, the attention to margins, I mean there's a technique to doing a proper cancer operation that is not the same as doing an operation for an ulcer because you've got spread. You've got to know where the tumor might go. So it's a very specialized field. And I think it's been repeatedly shown in different types of operations, not necessary cancer operations, but for example open heart surgery, lung surgery, things like that, that places with high volumes tend to have better outcomes than places that don't do as many operations. It's a technical field.

Turning to radiation, for example going back to that large trial that I referred to a little while ago, the 0116 trial, in that trial they had a central review where they reviewed the radiation plans in that trial. And this was a large study over many, many different centers across the country, some community centers, some academic centers. And they showed that about a third of the radiation plans did not follow the plan that was desired by the trial. Of course we don't know exactly which centers they were, but I think it would behoove one to go to a place where you see more gastric cancers because how one treats gastric cancer from a radiation viewpoint is also very specific. And at a place like M. D. Anderson we have radiation oncologists dedicated for example to the treatment of thoracic cancer or treatment of GI cancers as opposed to maybe again someone who has to treat all of different cancers but doesn't specialize in one particular type.

And then finally the medical oncologists, they're more likely to be up to date on cutting edge advances and maybe have a trial for chemotherapy or whatever. So I think each modality that we use in treating stomach cancer is enhanced by focusing on that cancer type, and that's typically done more often in larger academic centers.

**Andrew Schorr:**

Right. Well, it makes sense to me. And, Victor, as you listened to it, you just kept hearing this name, M. D. Anderson, M. D. Anderson. Now we've both been better educated about really why they're saying that. But I know the future is uncertain and you've been through a lot, but what's your outlook? And how good do you feel about the decisions you made so far and the team you asked to take care of you?

**Victor:**

Oh, I'm totally satisfied with the decision I made to go there. I mean, just the whole atmosphere of the place, all the doctors, the nurses, just professional and the nurses especially were just wonderful people.

**Andrew Schorr:**

Right.

**Victor:**

And, I don't know, I think they have something like close to 2000 volunteers of people who were patients of one reason or another and come back and volunteer. I just think if I hadn't gone there when I had the first problem, when I had that hematoma, I don't think I would have made it to the operation or, you know, would be alive today. But there are just such specialty people available there.

And when I went to have my stomach--actually stomach and esophagus were both supposed to be removed. That's what we thought because the tumors were in both places. There was a team of like five different types of doctors available, renal, thoracic, general doctors, heart surgeons, plastic surgeons. And as it turns out the tumor in the esophagus I guess from the treatment and whatever reason it was gone when they went in so they did not have to take out my esophagus.

**Andrew Schorr:**

Wow.

**Victor:**

So I credit Dr. Ho I'm sure immensely for that with the chemo and the radiation prescribed.

**Andrew Schorr:**

Well, Victor, I know on behalf of Dr. Ho as well and the whole team there we wish you all the best. We want you to be able to enjoy those grandchildren, watch them on the athletic field. Get some of them to play golf with you, okay?

**Victor:**

Absolutely.

**Andrew Schorr:**

Okay. And so that's Victor Hauser, who's been with us from Kentucky who has very recently been treated at M. D. Anderson and of course will continue to be followed. And Dr. Linus Ho, assistant professor in GI medical oncology at M. D. Anderson, we wish you and your multidisciplinary team there all the best. We hope we can do a future program where you say, you know, Andrew, that mortality rate has gone way down, and we've made tremendous problem further still. All the best to you, sir.



**Dr. Ho:**

Right. Thank you very much.

**Andrew Schorr:**

Well, thank you. This is what we do on Patient Power. We like to say that knowledge can be the best medicine of all. Certainly in the case of Victor and myself, we got knowledge. We went to M. D. Anderson. It's made a huge difference for both of us, so it's something for all of you to consider. And it's encouraging as we better understand now the work that's going on in stomach cancer and help people have their best shot at beating it.

I'm Andrew Schorr. Remember, we'll have our next program coming up just in two weeks, and that program is going to be on advances in the treatment of bladder cancer. So if that applies to you or someone you know please let them know and hope you can join us. Thank you. You've been listening to Patient Power brought to you by M. D. Anderson Cancer Center.

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