Advances in the Treatment of Esophageal Cancer
Webcast
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INTRODUCTION

Andrew:
Hello and welcome once again to our live webcast Patient Power on mdanderson.org. I'm Andrew Schorr broadcasting live far from Houston, Seattle, Washington, but I went to M.D. Anderson for my leukemia care, and now I'm an 11-year survivor. And I was in clinical trial and so glad I did it, what's now ranked again the number one cancer center.

So we're going to talk about what services they have when it comes today to a particular cancer, esophageal cancer. And the statistics on esophageal cancer are not the brightest. We're trying to make progress, and we will talk about what they're doing at M.D. Anderson that is making progress, but survival rates among patients with cancer of the esophagus, the roughly foot-long tube that takes the food from the mouth to the stomach. They have improved over the years but late discovery of the disease is usually what's common.

But I want you first to meet somebody who was lucky enough for it to be discovered early, almost by accident, if you will, and then he went to M.D. Anderson and got care that's helped him go on, back to work. He's a really neat guy. Phil joins us. He's my age, 57, a little bit older.

But we're young guys, right, Phil?

Phil:
We sure are.

THE FIRST SIGNS OF ESOPHAGEAL CANCER

Andrew:
And you are way up at altitude, if you will, in Black Forest, Colorado, 7500 feet. We're now after Thanksgiving in November starting to get a little snow, the big storm coming. But you had a big storm in your life just last December, January. I know that you'd been going on five years, you tell me, and you'd been having just spontaneous vomiting, if you will, that would happen first infrequently and then increasingly frequently. You kind of lived with Tums and Prilosec in your pocket, didn't you?

Phil:
I couldn't go anywhere unless I had them in my pocket, or when I went to bed at night I had to have them in my nightstand because I would wake up at night just with the burning reflux and indigestion. I had to have them all the time.

Andrew:
Now, we should mention that you are a base guitarist and really quite an accomplished guy who goes on tour and performs on stage and is a studio musician and all sorts of music, rock and blues and jazz. And we've probably heard you along the way. But even it got so bad that you were on stage and one time you just started vomiting and had to go off stage.

Phil:
I had to run right off the stage. That was the last gig I did. It was last December, and I haven't been able to play since.

Andrew:
Now, you'd been going to your primary care doctor in Colorado all along, and he thought it wasn't anything serious.

Phil:
Well, he thought it was food poisoning, the flu, just, you know, all these things. We couldn't ever pinpoint what it was and he would just send me home. I knew something was really wrong because a person doesn't vomit like I was doing and not have something seriously wrong. We just couldn't figure out what it was.

Andrew:
Well, I know you have a great girlfriend, Gina. And Gina final finally said, We need to get this checked. And you were referred to a gastroenterologist and they can do endoscopy from the top or the bottom, and they did it from the top and then did it again. What did they find?

Phil:
Well, first they found I had Barrett's.

Phil:
Barrett's esophagus, and we're going to talk about that on today's program as we learn the connection between Barrett's esophagus and esophageal cancer. So they found that and then what?

Phil:
He said he suspected something and wanted me to come back after I think it was 90 days and have another one. And I came back and had the other upper GI, and then he had an appointment with me I guess two weeks after I had the GI, and he called me a week after I had the procedure, and when he called me early I knew something was wrong. Because they don't call early if, you know…

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Andrew:
Nobody likes those calls. I didn't like the call-back from my doctor when I had what I thought was a routine blood test. And he said, I'll only call you if it's something we're worried about, something serious. And when he called the next day that led to, guess what, you've got leukemia. So we all hate those calls and probably most of the people listening have unfortunately received calls like that.

So you did see an oncologist in Colorado Springs, not far away, but again Gina said, You're going to M.D. Anderson, and I guess you're glad you did.

Phil:
Yes, I am. I really am.

Andrew:
So you connected with the actual director of the esophageal program there, and that's your doctor, Dr. Wayne Hofstetter. He's been on Patient Power before. He's an associate professor at M.D. Anderson. Dr. Hofstetter is a surgeon.

So, Dr. Hofstetter, you saw Wayne, and I understand in his case maybe he was lucky that he got down there when he did because we were talking about the statistics of all too often esophageal cancer is discovered late.

SURGERY TO TREAT ESOPHAGEAL CANCER

Dr. Hofstetter:
Hi, Andrew. That's right. We were lucky to see Philip when we did. It turns out that because of the symptoms that he had and the endoscopy that followed those symptoms they were able to find a cancer at the earliest stages while it was still curable.

Andrew:
So Phil, you had surgery, correct?

Phil:
Yes.

Andrew:
Dr. Hofstetter, what surgery did Phil have? He's told me about having part of his stomach removed and some of his esophagus and kind of connecting things up again. In a case like that, what do you do?

Dr. Hofstetter:
In a situation where you have someone with Barrett's esophagus and a cancer down in the esophagus you really need to make sure you remove the primary organ where the tumor is. And really the scary part about the esophagus is that it's got

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areas that tumors can hide. So we have to get around the tumor plus we have to take normal tissue above it and normal tissue below it.

If you will, there's a connection between the esophagus which we call the gastroesophageal junction. So we have to take out a little bit of stomach. We have to take a bit of the esophagus out, and then we have to figure out a way to put you back together. There are multiple options for that, and in a typical esophagectomy, which is what Mr. Farrell had, we reconnected his stomach up to his esophagus.

Andrew:
Now, Phil, you are a lucky guy in that this was not advanced. And you had the surgery in April, come back to Colorado after several days in the hospital. You're planning for a full future of music, and I understand you're planning to go tour in Italy this summer. So do I take it you're feeling well?

Phil:
I'm doing great. I'm amazed at how well I'm doing, as a matter of fact. We have a record out that's supposed to be released real soon from our label in Milan, Italy, and we'll be touring Europe when that's done, when it's out.

Andrew:
Well, that's great to look forward to that, and I know you're working on your music right now.

Dr. Hofstetter, so here we have it when it's discovered early. What are the signs and symptoms of esophageal cancer? Here he was having vomiting. I know typically it's often reflux. What should we be looking for?

SYMPTOMS OF ESOPHAGEAL CANCER

Dr. Hofstetter:
Really, Andrew, we want to find the patients that are presenting at an earlier stage. I think Mr. Farrell represents the penultimate in our ability to find someone who had an early-stage tumor. And really we often find people like that serendipitously. We're lucky if we find somebody who has an early cancer, and it's usually because of other symptoms, because they've had vomiting or they've had long-time reflux that's being looked into or queried.

The patients that present to us typically have symptoms of obstruction. A tumor will grow in the bottom part of the esophagus, and it starts to choke off the esophagus so that when you're eating it becomes difficult to swallow. And that may become progressive from interfering with your regular meal, say maybe steak, to interfering with soups and then liquids. And then you'll notice that you start losing weight, and it's at that point that we see patients who have pretty aggressive disease and they show up to us with this aggressive disease that is more difficult to cure.

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But the patient who shows up to us and says, Look, I've had this long-standing history of reflux disease. I have a lot of heartburn. I've got this burning. I've got this epigastric pain or I have pain in my belly or I may even feel like I'm having a heart attack after I have meals. And that's a very typical symptom. And these symptoms just don't go way. And like Mr. Farrell they just keep going on and on, and finally they say, Look, this is just not right, I'm going to have this looked at. And a gastroenterologist is astute enough to put a scope down into the esophagus and look around and see if there's a problem. Those are the patients that we find that come to us with curable disease.

Andrew:
So the lesson there is if you've persistent reflux or upper epigastric symptoms you do want to see a gastroenterologist to see is there something else going on.

Dr. Hofstetter:
By all means. We don't have a perfect screening study yet, and it's going to take a long time before we have a perfect screening study if we ever do get one. It's currently not a blood test. An endoscopy is relatively easy to do, but it does require some effort. You have to go into the hospital. You have to see your gastroenterologist. It's an outpatient procedure, and it's relatively safe and easy. And Mr. Farrell will tell you that he's had a few of them at least by now that have gone very well. But that is the only way for us at this point to really find out what's going on with the esophagus.

And doctors feel like an endoscopy is an extension of a physical exam. You wouldn't expect to go in to see your pulmonologist and not have your pulmonologist listen to your lungs. By the same aspect if you're complaining of things like upper GI symptoms you wouldn't expect someone who is interested in your esophagus not to look at your esophagus. So really the primary way to find out if there is a problem going on with the esophagus is just to look at it.

Andrew:
Just one question. I've had various GI exams over the years. What about the barium swallow and other tests? Are they as definitive as just the scoping and taking a look?

Dr. Hofstetter:
Yes. Those are good tests to find things that are initial problems, especially when they're functional problems. If you're having difficulty swallowing, etc., your doctor may start off by ordering a barium swallow, and there's absolutely nothing wrong with that. Sometimes they're so good they can even show mucosal changes, and the mucosa is like the paint on the wall. It's like that very superficial lining, like the skin that you have over your hand. That's the equivalent to the mucosa inside the esophagus.

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And the barium swallow can be sensitive enough often to show you Barrett's esophagus. It will show those changes. But often that is an indicator that, Hey, there is a real problem in the esophagus, and we're going to go ahead and do an endoscopy. Because the benefit of doing the endoscopy is if there is any abnormalities you can take a biopsy, and then the pathologist will examine the biopsy and tell you whether there is any cellular change that can lead to further problems down the road, such as esophageal cancer.

BARRETT'S ESOPHAGUS

Andrew:
Well, we've learned our lesson with colon cancer with the importance of colonoscopy, and it sounds like something similar. So let's talk about the people at risk. So Phil was told that he had Barrett's esophagus. What's Barrett's esophagus? And what's its connection with esophageal cancer?

Dr. Hofstetter:
Barrett's esophagus is a condition that you'll find out about when your gastroenterologist looks down inside your esophagus and says, "There are some changes in your esophagus that I see." And those changes are caused by years of a condition where you have inflammation or damage to your esophagus. Typically, in the United States, that damage is caused by reflux disease. You have acid in your stomach. You have bile that's produced by your liver that washes back into your stomach and then back into your esophagus. And the combination of these chemicals wash up onto the esophagus.

You can imagine over years if you were dripping acid onto your skin you would start to have a sore and then that sore could lead to genetic changes. You'd have kind of a chronic sore. What happens in the esophagus is that that chronic sore changes into a new lining, a more acid-resistant lining very similar to the lining that you have in the colon. So your colon interestingly enough has a more acid resistant lining than your esophagus does. However, the downside of that is that in the esophagus this Barrett's esophagus condition, and Barrett is the name of the original doctor that described it, the Barrett's esophagus condition is actually a premalignant or precancerous lesion.

Now, not everybody who has Barrett's esophagus will go on to get esophageal cancer, but it is an indicator that we have to be careful with these patients. Maybe anywhere from 0.5 to one percent of patients who have Barrett's esophagus will go on to contract an esophageal cancer. But we don't know who is going to get it. In other words, if I was going to take a million people with Barrett's esophagus I couldn't pick out the one percent who is at risk to go on to get adenocarcinoma. So by giving someone a diagnosis of Barrett's esophagus that tells us that, Look, we need to have some vigilance about doing surveillance to make sure that you don't progress on to something that could become esophageal cancer.

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Andrew:
I understand that there's a connection with people who have smoked for many years or smoked and were drinkers as well. Imagine, Phil, you're around that in the music world and other people. You're often in smoky situations, I think any of those situations I've seen where people are playing at concerts. So, Dr. Hofstetter, what's the connection between smoking, maybe smoking and alcohol and higher risk of esophageal cancer?

SMOKING AND ESOPHAGEAL CANCER

Dr. Hofstetter:
Smoking is not good for us in any situation. It's interesting. I recently saw a program where in other countries there's a big, you know, surgeon general warning on the pack of cigarettes that says "Smokers die young". And we're not quite at that point in the United States, but certainly cigarette smoking is associated with every major disease that we have in the United States, and cancer is one of the largest ones.

Esophageal cancer and smoking are integrally related. So those patients that have reflux disease and smoke are probably at higher risk of getting esophageal cancer than someone who just has reflux disease. There's also another type of esophageal cancer. Americans get two types of esophageal cancer. Adeoncarcinoma is related to reflux disease, and smoking contributes to the risk of contracting this illness. Another type of esophageal cancer that we get is called squamous cell esophageal cancer, not associated with reflux disease, and is more typical in life-long damage to the esophagus caused by smoking or drinking or both together.

You can imagine that years and years of caustic damage to the esophagus would not be well tolerated.

Any kind of chronic chemical damage in the esophagus can then lead to esophageal cancer, and both of the major subtypes are equally dangerous.

Andrew:
Okay. And the rates, I just want to talk about that for a second. About 14 and a half thousand Americans will be diagnosed with one of these types of esophageal cancer this year, and about over 13 and a half thousand deaths will result. So this early detection is so important.

We're going to take a break and when we come back we're going to take your calls and your questions as we continue. We're visiting with Dr. Wayne Hofstetter, who is the director of the esophageal program at M.D. Anderson Cancer Center, and also his patient, Musician Phil Farrell, who joins us from Black Forest, Colorado.

We'll be back with more of our discussion on esophageal cancer on Patient Power sponsored by M.D. Anderson Cancer Center. Stay with us.

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PROTON THERAPY AS A TREATMENT OPTION

Andrew:
Thanks for tuning in tonight to our live webcast. You can give us a call about esophageal cancer. We have an experienced patient who thinks the right treatment he got at M.D. Anderson saved his life. And we've got the leading expert, one of the leading experts for sure, but the leader of the team, the director of the esophageal surgery program, Dr. Wayne Hofstetter who is a surgeon at M.D. Anderson.

We're talking about the various approaches. We just heard a little message about proton therapy, and I know that has some positive implications for esophageal cancer. Dr. Hofstetter, what is proton therapy? What are you doing with it at M.D. Anderson as it relates to esophageal cancer?

Dr. Hofstetter:
Well, proton therapy is a method of delivering radiation that pinpoints a cancer. Older types of radiation generally would go through your tissue, and it wouldn't necessarily stop at the tumor. It would go right through it, and that radioactive beam, if you will, would go through, hit your tumor, affect the tumor, but it would also affect the tissue on the way in and on the way out of your body. These are really accelerated radioactive particles.

The beauty of this proton beam therapy is that you can direct these radioactive particles right to the tumor so it goes in and hits the tumor and stops. So basically what you're doing is you're affecting less tissue. You're affecting less normal tissue on the way in and on the way out. You don't have the same kind of tissue damage to the surrounding structures that you might have with conventional radiation.

In terms of the integration of proton therapy with esophageal cancer, we are still working with our proton therapy doctors, the radiation oncologists, and integrating them in into our protocols. We have several protocols for treating advanced esophageal cancer and locally advanced esophageal cancer where proton beam is integrated. We feel it's helping and enabling us to treat wide areas of esophageal cancer where a patient may have an esophageal cancer in the stomach but a lymph node higher up in the chest, where otherwise having given conventional radiotherapy would result in a significant amount of radiated tissue and significant amount of side effects.. Proton is really helping us to treat people more effectively.

Andrew:
Well, that's good news. Now, you're a surgeon, and so surgery is one mode, and we're going to talk about how you can do that in a less invasive, I think what you're calling minimally invasive surgery, and I want to learn about that. But also you're

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the director of the program, and you have sort of multi modality, if you will. Help us understand how this all comes together to see what treatment a patient needs and which tools might be brought to bear. Maybe just surgery, radiation, chemo, how you figure out what's right for them.

MULTI-MODALITY THERAPY

Dr. Hofstetter:
I'm the director of the esophageal surgery program at M.D. Anderson Cancer Center, and what I do is direct the multidisciplinary conference, but I also direct our surgery program at M.D. Anderson. We work as a team in collaboration with our other multidisciplinary partners who are in medical oncology, GI medical oncology, pathology, radiation oncology, gastroenterology, radiology and the other related healthcare services. And that's really what we strive to focus on and what we strive to advertise is that we're really a large team focused on esophageal cancer.

Because of our collaborations we're able to take patients with a locally advanced or advanced esophageal cancer, give them multiple types of treatments; chemotherapy, radiation, a combination of chemotherapy and radiation and surgery, if it's appropriate, to try and cure this cancer. Our ability to treat patients has gotten better and better and better. We have better detection. We have better ways of treating patients. We also have better ways of getting them through their therapy, meaning that the recovery is potentially faster.

Andrew:
Okay. Now we're starting to get more e-mail questions. Here's one that came from Carolyn. Carolyn writes in, "What are the implications of not having surgery but only chemo and radiation? And are there any statistics showing survival rates with and without surgery? Are there actually any statistics showing survival rates in a year, two years, three years, preferably comparing the treatment plans?"

Dr. Hofstetter:
That's an excellent question, and all the data is not in yet. So there is a group of patients who once they've received chemotherapy and radiation will be what we call complete responders. The tumors will have completely melted away after chemotherapy and radiation. And that's an excellent finding. We want to emphasize that our best performers after receiving therapy, are those patients that responded well to medical therapy.

However, that's only about 25 to 30 percent of the group of patients that we treat with multi-modality therapy. The real question is that we don't know exactly which patients fall into the complete response category versus the partial response category. In 2007 and ongoing into 2008 the way we've been able to tell if people have been complete responders is one of two ways. We either operate on them and we find out they've had a complete response, or we follow them. If we follow them and they've not been operated on and they show evidence of local/regional

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recurrence, meaning the tumor came back in the esophagus or in the lymph nodes in the surrounding area, and there's not evidence of tumor elsewhere making them inoperable, such as like in their liver or bone or somewhere else in the body that would render you inoperable, then we go ahead and offer esophagectomy.

The data out there is sparse. There is one trial that's going to be brought forward by the Germans where they compared chemotherapy plus surgery versus chemoradiation plus surgery versus not doing surgery at all. And the interesting finding is that those patients who are excellent responders who had a complete response may have a slight benefit from having surgical resection afterwards. And that's what we found at M.D. Anderson as well. However, most specifically those patients who have not had a complete response are really the ones that benefit from having surgical resection.

Our patient's question is, Am I complete responder or am I not a complete responder? And we don't know until we follow or operate. So we have some data that's missing. In other words did you respond completely to therapy or not. The PET scans, the EGDs, the CT scans, that part of the workup may show that you had a complete response or not, but clearly we don't know what's going on at the cellular level. So we're still looking for ways that we can figure out whether patients have responded completely and if that response is durable, meaning, as I mentioned before, about 30 percent or maybe a little less than 30 percent will have a complete response, but only in half of those cases is that response durable. Many of those patients recur.

So the question comes down to what is my overall cure rate if I get chemotherapy and radiation alone. Well, for someone who's got locally advanced disease it's probably somewhere around 12 to 15 percent. Does surgery add to that? We know that if you've had a complete response and go ahead and have surgery that our cure rates are somewhere between 55 and 60 percent at three years and that's durable out to five years, meaning that those patients are cured.

Is the added benefit 35 percent on top of the 15 percent I already told you? No, because that's selected out of a group of patients that have already done well, so I'm not really comparing apples to apples. I'm comparing apples to oranges. But what I can tell you is that there's a lasting durable effect that surgery adds. Whether or not it's appropriate for you to go on to have surgery after you've had chemotherapy and radiation is a conversation that really you should have with your surgeon and your oncologist, and that's the important determination.

Andrew:
Carolyn's question is a good one. Thank you for that very complete answer. I just want to also point out that, Phil, you've had surgery but you've had no other treatment, correct?

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Phil:
Yes.

Andrew:
All right. So in the early discovery situation. That might be very appropriate then just to stop after surgery, correct, Dr. Hofstetter?

Dr. Hofstetter:
Yeah. We were lucky enough with Mr. Farrell to have found tumor that was at its earliest stages, meaning that it had only gone into the most superficial parts of the wall of the esophagus. And with my patients I generally describe the wall of the esophagus very similar to the wall of a house. There's paint, drywall, stucco and in between that are the studs. In the studs is where all the electricity and plumbing runs. So what I talk to you about is the mucosa, and the mucosa really occupies the paint and the drywall.

And Mr. Farrell's tumor only occupied into the paint and the drywall, and we were fortunate enough not to have that tumor get into the studs. Because once it gets into the studs it's got access to the whole house. It can get in the electricity. It can get into the plumbing. So that's when we start advocating using things like chemotherapy to treat the whole body. The word we use is systemic. So we want to treat systemically for something you've got risk to have gone through the whole house. Tumors that are localized just to the esophagus can be treated just with esophagectomy. That means we're removing the tumor itself along with the esophagus, and the cure rates are very high.

Andrew:
Okay. Now, I believe we have a caller with us. Bob joins us from New Jersey. Bob, you're on the air with M.D. Anderson's Patient Power. Welcome to the program.

Caller:
Thank you.

Andrew:
Bob, what's your question.

Caller:
I'm four years out from having an esophagectomy.

Andrew:
Yay.

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DUMPING SYNDROME

Caller:
My question is I have dumping syndrome, and I was wondering if the doctor or the patient has a similar dumping syndrome and if they have anything that they can suggest to help increase your quality of life.

Andrew:
Well, let's ask the doctor. First of all, Dr. Hofstetter, what is dumping syndrome and what do you do about it?

Dr. Hofstetter:
Dumping syndrome is a very common situation. It happens frequently after surgery. And it's generally caused by the fact that your body is not used to having this new hook-up. You're hooked up now from your mouth all the way down to your intestinal tract, and you used to have a little gateway, and that gateway was your stomach. And the amount of food that was put into your stomach was monitored and was just metered out into your intestine at slow intervals. In so doing your pancreas and your liver would keep up with the metering. You would meter out enough glucose. You would meter out enough digestive enzyme to keep up with the food that was being placed into your intestine at the same time.

When you have an esophagectomy you speed up the rate that the food goes into your mouth and into your intestine, and your intestines go, Oh, my gosh, I can't keep up with all this. And it spews out a bunch of digestive enzyme. It spews out a whole bunch of hormone like insulin, which causes your glucose levels to go down. You may feel tired. You may need to go lay down. You may need to go to the restroom 30 minutes after you've eaten. And those are all symptoms of dumping syndrome.

Interestingly enough, some component of dumping syndrome initially occurs in about 85 percent of our patients. However, the shiny side of that coin is that it goes away in almost everybody, and it goes away because your body relearns how to handle those processes as it goes through the healing phase. We also deal really, really closely--and I would say that this member of our team is the most important member of our team postoperatively, with our nutritionist.

And our nutritionist here at M.D. Anderson Cancer Center is Linda Pataki, and she works with every one of our patients and Mr. Farrell knows her, and he knows that it's very important to follow at least initially a diet that limits the amount of fluid that you take with food. There are types of food that you don't want to take immediately. In other words, foods that are high in sugar, high in dairy, such as custard or pudding or somethings like that, they may be hard on your system. And you don't want to give yourself a lot of carbohydrates. So the easiest things for people to eat are proteins, meats, eggs, etc., these kinds of foods meter out slowly and don't cause that insulin surge that's going to lead to dumping later on.

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If those things have all been tried and you're working specifically with a nutritionist, you're still not getting relief, say maybe six months have gone by after your operation, maybe even longer than that, and you're still having difficulty with dumping, there are several types of medications that your doctor can prescribe to help you with dumping syndromes. I would say that it is the very, very rare patient I have that ends up having dumping syndrome that is problematic and worrisome and needs medical treatment for very long. It's got to be in the single digits. So the encouraging bit of news is that in those patients who do get dumping it resolves in almost everyone.

Andrew:
Okay. That's great information for Bob and anyone else who's listening.

Now, Bob gave us a call and I encourage you to call us. You're listening to a live webcast of Patient Power sponsored by M.D. Anderson. Much more on esophageal cancer coming up right after this.

EATING AFTER AN ESOPHAGECTOMY

Andrew:
Welcome back live to our webcast. Andrew Schorr here talking about esophageal cancer and connecting you with a leading expert from M.D. Anderson Cancer Center in Houston. As you know that's one if not the top it's certainly among the top tier cancer centers in the world. And I got my treatment there, and, Phil, you went there from Black Forest, Colorado and I know it made a big difference for you.

Here is a question we have, and this is an e-mail question, and it's from Ann Marie in Newark, New Jersey, Dr. Hofstetter. "I'm worried about the Christmas holidays after an esophagectomy. We'll be eating out, always something scary," she said. And she'll be in Ireland, "where it's a huge occasion and where you eat and drink too much. I'm lucky if I can eat a sandwich at the moment. Does it get better over time?"

Dr. Hofstetter:
That's a great question and similar to the question that we fielded earlier. There are some symptoms that come up after surgery, and fortunately most of them abate very quickly. When I have this conversation with my patients in the clinic I sit down just like we're talking right now. We spend a great amount of time in clinic, maybe 45 minutes, an hour, sometimes that happens again as a repeat in another visit, and we talk about these kinds of symptoms that will come up.

Interestingly enough, I have had the opportunity to take several of those patients to surgery, and then after surgery become friendly with my patients. I go out to dinner with them. We eat. I've eaten out with my patients socially maybe, oh, a dozen or more times. And I sit across from a patient whom I've done an

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esophagectomy on and you would look at that patient and never know they had an esophagectomy. You can't see the surgical scars, they're eating normal foods, they're eating at a normal pace. They're not getting up every five minutes to go and regurgitate. Now, of course, results may vary.

But the nice thing is that when you start to eat you may not be able to eat very much, but over time that stomach that has been pulled up into your chest and reconnected into your esophagus will condition itself. It will get to be more like an esophagus and a stomach and function better for you over time. So I tell people that when they start off eating they're going to be able to eat maybe a third or less of what they were eating as a normal meal before.

When they get to the point where everything has kind of resolved itself and they're back to normal, they do have to eat smaller meals. They can't eat the huge meals. They can't go through the holiday buffet line two and three and four times. When they're full, they're done eating. However, you will be able to eat what amounts to a normal size meal, normal being normal for maybe a European, maybe not an American, but it's about half to two-thirds of a most peoples current normal-sized meal.

I've had many patients go on to be able to eat as much as they ever ate before. However, I usually encourage patients not to overeat. If you overeat it causes symptoms like dumping. So I say just limit the amount you eat. Eat enough so that you feel full. Wait a little while, maybe a couple hours, three, four hours, you can go back and eat again and snack. And that's probably a healthier way for us to eat anyway.

Andrew:
Let's just check with Phil for a second. Phil, what's been your experience in recovering and what you can eat or how much you can eat?

Phil:
It's like the doctor says, your body tells you what it can do. And it tells you when your limit is. That's what I found. I can't eat as much as I used to, and I get to this point where I know I've got to shut it off right now. We just went through Thanksgiving, and I was able to eat a lot--not a lot, but I was able to eat like everybody else, but I just had to limit what I did. And your body tells you when you need to shut it down.

Andrew:
Okay. Good advice. Does that cover the topic pretty well, Dr. Hofstetter?

Dr. Hofstetter:
Yeah, that's great.

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Andrew:
Okay. Let's go on. Now from California, go right ahead, Jay.

Caller:
Hello, Phil, and hello, Dr. Hofstetter.

Phil:
Is this my friend Jay?

Caller:
Yeah. Right on.

Caller:
Yeah, it's great to hear you, Phil. Phil actually alerted me to the broadcast today via e-mail, which I'm awfully glad you did Phil. I've been enjoying it tremendously. Dr. Hofstetter, I've been very much enjoying your discussion of food and of eating. I had surgery in late July and now, I'm a foodaholic, you understand, but food, it's been really a chore even to enjoy eating of anything so far. And I was very encouraged with what you were saying just now that will--the enjoyment of food will come back, Doctor?

Dr. Hofstetter:
Yeah, it will. And, Jay, I appreciate your question. Not everybody has the same results. Some people it takes awhile for them to get used to their esophagectomy. I'd like to say that everybody has the exact same results, but really they've had different surgeons, as well, and I'm not trying to toot my horn at all, it's just that sometimes there's subtleties about the cancer or the way things got put together it may take you a little bit longer to heal up.

It's not uncommon for people after they've had surgery to not enjoy food. The food doesn't taste as good. It doesn't have any taste at all, or it may be difficult to get down. Or once it goes down it doesn't agree with you. But I find that after a while your body starts to turn around, and it's almost like a computer rebooting. My patients can sometimes come back and complain and say, Doc, I'm just not eating well. I'm not maintaining my weight. Nothing tastes good, etc. And I say, Just keep trying. Keep at it, just little bits at a time. Don't force yourself. Don't overeat. Don't make it a chore, but you have to eat at every meal. You have to try and eat four, five, six times a day. Eat something.

I generally tell my patients to chew on cashews. I should get stock in the cashew market. They're going to owe me big time. But everybody that has an esophagectomy goes to get cashews. Why? Because they're salty. They stimulate your appetite, and you can munch on them. They're high on protein. They're high in calories. I tell them just keep trying and things will get better. They'll improve over time.

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MINIMALLY INVASIVE SURGERY TECHNIQUES

Andrew:
Dr. Hofstetter, let's understand the more complete picture of treatment. So we talked about your work with proton therapy. We talked about surgery. We've talked about chemo and radiation. As far as surgery goes you've developed techniques there that you're using to have much less trauma to the body. Tell us a little bit about that, less invasive surgical techniques.

Dr. Hofstetter:
There are several ways to go about removing an esophagus, and we generally do that through two or three incisions in your body. And because the esophagus and the stomach occupy different cavities it means we'd have to be in the chest, we'd have to be in the belly. And if we want to remove the entire esophagus for whatever reason, because we need to based on the location of tumor or because we want to put the connection back in the neck, then that's a third incision in the neck. And we've also found that in some patients that’s overkill because it's too much surgery, such as with Mr. Farrell. In other patients we may want to preserve nerves that may decrease the instance of dumping that we heard about today. That's called a vagal-sparing esophagectomy, and that's a very novel way of treating someone who's got an early cancer who you do not feel is going to have a lymph node invasion or involvement in the glands around the esophagus and can also preserve a lot of the function of the remaining stomach and the intestine.

And then we've also developed ways, and this has been done in several places in the United States, not just at M.D. Anderson, but we do it here as well--where we do minimally invasive surgery. A technique that we're very proud of is one where we remove the esophagus using just telescopes that are placed in the chest. And the advantage to the patient is that we don't have to cut any ribs, we don't have to make an incision in the chest, and yet we're still doing a very complete operation where we're removing lymph nodes, which is different than other types of operations where the esophagus may be removed but lymph nodes aren't removed. So it's a complete operation.

It's done virtually the same way as you would do it open, however, you don't have the same amount of trauma because you're using small cameras and televisions that all fit inside the chest. Of course, the television doesn't fit in the chest, but the camera does. And the instruments fit in there. We don't have to spread the ribs apart, and that confers a lot of advantage in terms of pain and recovery.

Andrew:
Okay. Here's a question we got in from Richard in Harlingen, Texas?

Dr. Hofstetter:
You got it.

TIME FRAME FOR TREATMENT

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Andrew:
Okay. I got it. All right. Now I'm a Texan. I was down there last week, too, and the weather was great.

Now here's a question from Richard. "Is this time frame normal? I've been taking many tests since the first of November and was diagnosed with esophageal cancer two weeks later, and recently I was sent to a surgeon who set up an upper GI for the 3rd of December, and I go back for results December 10. I've also had many tests with a cardiologist and a CAT scan. All of these tests have taken time, and I don't see anything being done soon. I had stomach surgery in the mid 1970s where they already removed 40 percent of the stomach." So he says, "Seems like these complications have slowed everything up, and I'm concerned that time is of the essence and my cancer will grow in the meantime." And he says, "Thank you, and I appreciate your advice." And he said he plans to come to M.D. Anderson if he can.

So he's worried about how quickly this cancer is growing while sort of this full work-up is being done.

Dr. Hofstetter:
Yeah, thanks for your question, Richard. It's a very common question. And any time we're diagnosed with a cancer or anything that really concerns us your immediate reaction is, I just want to get this taken care of and I want to get it taken care of yesterday. And we would all have that same response, and all of us who have been in that same situation do have that same response.

So I spend a significant amount of time sitting down and telling people these kinds of situations that come up, like cancer, take a long time to get that way. In Mr. Farrell's situation he had symptoms for five years or longer before this thing came on and it came on in an early stage. But by the time we see tumors in the esophagus they've probably began there many months or even years before. It's impossible to tell exactly how long, but they've likely been growing there for quite some time. These are things that you see smoke, you see flames, but you don't see wildfires. But they do grow.

The question becomes is it appropriate to rush into things and just rush right into treatment or rush into surgery, or do you want to get a workup first. If I had the option of doing things quick or doing things right, I'd rather do things right. So if I'm in someone's shoes who has esophageal cancer and I say, Look, I'd rather just get straight to surgery my doctor would slow me down and say, Whoa, let's work things up and make sure surgery is appropriate or let's make sure that treatment X or Y is appropriate first.

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It is frustrating to have to deal with the workup, but it is appropriate. It sometimes can take a matter of weeks before you even get to the first episode of treatment, whether that be chemotherapy or radiation, and that's not inappropriate, especially for someone who like you who has had 40 percent of their stomach removed.

In that situation where you have had some complications before such as previous stomach surgery, you need to be working with a hospital or with a physician and surgeon who has been in that situation before. I'm sure Richard is in that situation, he's researched it. But if not, I would seek out that situation.

Andrew:
Okay, folks. And you know what my vote is. I chose to go to M.D. Anderson because they have specialist there who specialized in what I had been diagnosed with, and that's all they do. And of course as we talk to Dr. Hofstetter, that's what he's devoted to with the whole multidisciplinary team there. So please consider that if you're not an M.D. Anderson patient. If you are like Phil or me I know we feel we got quality care.

We'll be back with more of our live webcast on esophageal cancer sponsored by M.D. Anderson Cancer Center. Stay with us.

DIFFERENT TREATMENT APPROACHES

Andrew:
If you're a cancer patient listening, no doubt there is a caregiver there somewhere or somebody who is close to you who cares about you and who will be by your side through treatment, and that brings up the topic of the program we'll have on in two weeks on December 4th. The title is, "Caregivers: A Vital Part of the Treatment Team," and we'll have advanced practice nurse Phyddy Tacchi, who does support groups and counseling at M.D. Anderson specifically for caregivers and patients as well. And we'll have the incredible story of Barbara England, who spent almost six months over at M.D. Anderson with her husband, Sydney, who had a bone marrow transplant. They had highs and lows, but the support services available at M.D. Anderson made a huge difference for her. So that's in two weeks. So you'll want to get that on our Patient Power section of the M.D. Anderson website.

Let's go back to our discussion about esophageal cancer with Dr. Wayne Hofstetter, who is the director of the esophageal program there.

Dr. Hofstetter, I was curious to know, you have surgery, another modality is radiation, another is chemotherapy and various drugs. How do you decide which goes first? Does surgery always go first?

Dr. Hofstetter:
That's a great question, Andrew. The individualization of therapy really comes down to what's appropriate for your tumor. Typically, if someone has tumor that

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has gone through the wall, and I talked to you earlier about tumor going into the wall like where the studs are, meaning that it's gained access to the lymphatic tissue or the lymph nodes, those are patients that we treat with neoadjuvant therapy. That's a term that's specific for people who get chemotherapy before they get surgery. The word definitive chemotherapy and radiation means they get chemotherapy and radiation then they go to observation, meaning no surgery after that.

It really is dependent on how you present. Wayne Hofstetter shows up with esophageal cancer or Philip Farrell or Andrew Schorr, we may all have esophageal cancer but we all may have different stages. We have different likenesses of esophageal cancer, and our treatment could vary drastically. So surgery may be appropriate as it was with Mr. Farrell. It may be appropriate to go ahead and start with chemotherapy and radiation, and that's something that your multidisciplinary team will decide along with you in terms of a treatment paradigm for you.

Andrew:
Okay. And that's what we get at M.D. Anderson. It's not on every street corner, so you need to seek it out.

Phil, I want to give you a chance to talk, sort of a Patient Power moment, if you will. You went all the way from Colorado with guidance from Gina, who I imagine is the love of your life, especially now with the guidance she's given you, down to M.D. Anderson. Now, that's a big deal. You think, well, cancer care, down the street in Colorado Springs or maybe in Denver or wherever, it's all the same. What's your experience?

Phil:
Well, I just didn't think I could get what I needed here, and everybody we talked to said that that was the best place to go. And when I got there I found out why. And it was. I was scared to death when the GI doctor told me those words, You have cancer, you know, it was a shock. Although I knew I was sick just hearing those words, you want to find the best place you can find, and that's what I found down there. All doctors' staff is just great. They were just--they made me feel really good and secure.

THE IMPORTANCE OF PARTNERING WITH YOUR DOCTOR

Andrew:
Well, that was my experience too. There are a number of leading cancer centers in the country, and so wherever you may be, wherever you are around the world, I guess our overlying message is get care. Get a second opinion. Get care you feel comfortable with. And I know part of that was going on for you too, Phil. You went to an oncologist who you didn't feel comfortable with, and that's when you started looking, right?

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Phil:
Yeah, my primary care doctor told me to go to this guy here in Colorado, and I went there, and we went into his office and he was wearing a Donald Duck hat. And, you know, I just didn't feel that was the kind of guy I wanted to go to.

Andrew:
Yeah. I don't want to make jokes about that, but absolutely, whether it's that or something more subtle you want somebody who will listen to you.

And, Dr. Hofstetter, I want to give you a lot of credit. You mentioned several times a partnership with a patient and working on a treatment plan and discussing it together. And so I really want to commend you for that, and I think that's really part of M.D. Anderson's style, if you will.

I wanted to just get to one other area of questions. We talked about people recovering from surgery. Some people, though, may also have radiation or chemotherapy and have, you know, mouth sores or other side effects. Where are we now in supporting people, managing those side effects and recovering from them? What can people expect?

Dr. Hofstetter:
It's very common for people who undergo chemotherapy and radiation to have symptoms. In fact, it's the norm. It's unusual for you to go through radiation without having some symptoms, especially as you're going towards the end or the latter part of the radiation. You know that the radiation is affecting the tissue. It has to kill the tumor, and it affects the surrounding tissue in ways also.

However, the nice part about that, as I said before, the encouraging part is that those symptoms generally will go away. There's a lot of medications that your doctor, either your radiation oncologist or your medical oncologist, will be able to prescribe for certain symptoms. A lot of people come into my office and say I don't want to get that radiation. I've heard it does bad things. Or I don't want to get that chemotherapy. That does bad things. But I usually am able to assuage their fears and say, This is not the same chemotherapy that your mother might have gotten. This is not the same chemotherapy that you heard about 50 years ago.

I have people that come in to get therapy that keep working through their entire therapy. Some people don't have symptoms at all. But most people have symptoms, if they do have symptoms at all, they are mostly tolerable. If there are issues that come up you want to be with a team who knows what they're doing. You have to understand when you're in trouble and when you can just--just the way to say this is like, Look, we're doing fine. Just move on. Or, No, this is serious. We need to back off or we need to have you come into the hospital and take a look at this. So experience really counts.

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And you'll notice that when you have symptoms and you speak to your physician and you say, I'm having these symptoms, they'll say, yes, yes, this is expected, this is part of the normal treatment process. First of all, don't worry about this, and that assuages your fears and your worries. And second of all, this is what we're going to do to help you. And third of all, this is going to get better over time.

Andrew:
I want to ask you about one last area, and that is Where are we headed? So you've devoted yourself to this from the surgical perspective, and you work with your colleagues related to radiation. We talked about proton therapy, and certainly there's progress being made in targeted systemic therapies and chemotherapy and other drugs. For someone who's listening to this and says, Okay, I may need treatment for this or, gee, I worry about a family member sometime in the future, are we making progress? And how do you feel about the future?

Dr. Hofstetter:
I think the future for esophageal cancer is going to be no surgery. Interestingly enough, I'm a surgeon and I'm trying to make surgery an obsolete aspect of treatment for esophageal cancer. It's not a common disease so it's good that whenever someone is treated for esophageal cancer that they're in a system where there are specialists, such as M.D. Anderson, such as other institutions throughout the country who treat esophageal cancer regularly and daily, which is what we do.

If you're in a situation like that, the physicians are able to put you on clinical trials to learn something about it. And what we're trying to learn at M.D. Anderson Cancer Center is when surgery is appropriate and when it's not appropriate. Certainly in certain situations, such as Mr. Farrell's, surgery is curative. We don't need anything else. We don't need chemotherapy and radiation. We also have other protocols that are looking to eliminate surgery by doing less invasive things such as endoscopic therapies.

And we're working on ways to get earlier detection. In other words, when we're looking at Barrett's esophagus who's going to go on to get esophageal cancer, and let's intervene before the cancer comes up. So we have trials going on for Barrett's esophagus and looking for those early cancers.

For those patients that do present with more advanced disease, those patients are at higher risk for having recurrence, and we're putting patients on trial to have them treated to try and decrease the instances of recurrence. In other words, we get it to get gone and then we want it to stay gone. So we're trying to find ways and treat patients who are going to have long-term and durable cures.

Andrew:
That sound great to me, and, Phil, I know it does to you too.

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So, Phil, I want to wish you all the best with that tour coming up in Italy in the summer. Each been to Italy. You'll have a great time. And is Gina going as well?

Phil:
I'm not sure yet, I don't know.

Andrew:
I'm going to send you a plane ticket buddy, okay? She better go, because she's made a big difference for you up there at the altitude of Black Forest. Right, Gina? I'm sure she's like pounding on you right now. Well, that's a celebration of life, but be careful if you eat pizza because that's spicy stuff. And all the best. And, really, thank you for being with us.

Phil:
Thanks for having me.

Andrew:
And you know what? I'm really glad you with Gina's leadership pushed for you to get quality care, and I know you got that at M.D. Anderson.

And, Dr. Wayne Hofstetter, director of the esophageal program, I don't think you'll ever be out of business as a surgeon, but you know what? You're right. If you don't have to do esophageal surgery and the other treatments can take hold and get the job done, that's fine. And thank you for your commitment to curing this at M.D. Anderson. All the best to you, sir.

Dr. Hofstetter:
Thank you, Andrew.

Andrew:
It's always a pleasure. Dr. Hofstetter has been with us before. You'll be a regular, and we'll give you like a plaque with little medals on it for being on Patient Power.

Really, I love the folks I meet from M.D. Anderson. I was down there recently, just a week or so ago. And, like I said, the weather was great in Houston, and really it's a pleasure to work with M.D. Anderson.

Do these Patient Power programs. Please check out the replays, and December 4th we're going to have this very important program on the support that's offered for caregivers and just how caregivers recognize they have a heavy load and how they can manage that and stay healthy themselves.

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As always, knowledge can be the best medicine of all. I want to thank Phil Farrell for sharing his experience and, Gina, thank you, in the background as well.

From Seattle I'm Andrew Schorr thanking you for joining us for Patient Power sponsored by M.D. Anderson Cancer Center. Have a good night.

Please remember the opinions expressed on Patient Power are not necessarily the views of M. D. Anderson Cancer Center, 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.

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