

Ovarian Cancer Treatment: The Future is Bright  
Webcast  
April 24, 2007  
Dr. Julian Schink

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## **Introduction**

### **Andrew Schorr:**

Hello and welcome back to another edition of Patient Power sponsored by Northwestern Memorial Hospital, committed to you and your family being smarter about important health topics so you can make well-informed decisions.

Today we're talking about ovarian cancer, and ovarian cancer is the fourth leading cause of death in women. And with us is a true national expert on ovarian cancer, and that's Dr. Julian Schink. Dr. Schink is the chief of the division of Gynecologic Oncology at Northwestern Memorial, and also he's the medical director at the Robert H. Lurie Comprehensive Cancer Center at Northwestern University. Dr. Schink, thank you so much for being with us.

### **Dr. Schink:**

It's my pleasure. Thank you for having me.

## **Current State of Ovarian Cancer: Symptoms & Survival**

### **Andrew Schorr:**

Dr. Schink, ovarian cancer is a very scary cancer diagnosis for women in that it's often caught later when there's less to do and so the mortality is high. Are things improving in the outlook for ovarian cancer?

### **Dr. Schink:**

Well, things really are improving dramatically over the last 30 years. Our success in the treatment of cancers like this don't come from one magic bullet that suddenly wiped out that cancer but in fact come from lots of basic science and clinical research added together to make incremental improvement in how we do for patients with this very difficult cancer.

And just as evidence of the success that we've had so far, if you look back at the 1970s the median survival or the average amount of time that a woman who had ovarian cancer lived was only 14 months. In the most recent trial that was published by our research team that's called the Gynecologic Oncology Group, that's a national research group that we participate in, the median survival was 67 months. So that's fivefold.

### **Andrew Schorr:**

Big change.

**Dr. Schink:**

Yeah, that's a big change. Five times increase in how long women with this cancer live. I consider that a great success. The tragedy is, though, that still far too many women are dying from this cancer.

**Andrew Schorr:**

Now, we think of different people diagnosed with it and of course it stands out years ago the famous comedian Gilda Radner so hence we have Gilda's Clubs around the country and maybe even some overseas. So we want it to be detected earlier or prevented. First of all, the incidence, how common is ovarian cancer?

**Dr. Schink:**

Well, one in 55 women in the United States will develop ovarian cancer in their lifetime, so it is a very common cancer. In fact it was once called or has been called in the past the silent killer, because the symptoms are not thought to develop until the chance of curing this is poor. Recent studies, however, have shown that that term is untrue and that in fact there are symptoms of ovarian cancer and that these symptoms occur more commonly in women with ovarian cancer, while they're common--other people may have them.

The combination of bloating, pelvic or abdomen pain, difficulty eating or feeling full quickly or urinary symptoms tends to be persistent with women with ovarian cancer, and they represent a change from normal for those women. The frequency or number of such symptoms is really a key in diagnosing this. So women who have ovarian cancer say almost daily for two or three weeks they have had these symptoms. Those women need to see their doctor.

**Andrew Schorr:**

Now, a lot of doctors don't know about this yet, because weren't people taught in medical school years ago ovarian cancer was usually caught late and we don't have a test to spot it early.

**Dr. Schink:**

That's true. But interestingly even people with early-stage ovarian cancer have those symptoms. So it's important that the patients listen to their body, and when they have these symptoms and they persist that they be assertive with their physicians. And not be afraid to educate their physicians. Say, You know, there is data now that says these symptoms are real. This is a change for me. And I think the language, if you want to be assertive the language that someone should use is to say, This is new for me. This is a change. This is not what I'm used to.

**Andrew Schorr:**

And again could you just recap those symptoms that could go together if they persist. Because I know a lot of women want to take note of this for sure.

**Dr. Schink:**

Right. Those symptoms are bloating, pelvic or abdominal pain, difficulty eating or feeling full quickly, and urinary symptoms such as urgency or frequency.

**Andrew Schorr:**

And then typically the woman complains about that and says this is new for me, what would be the follow-up? Would it be an ultrasound?

**Dr. Schink:**

An ultrasound is a very important test that has a high likelihood of detecting ovarian cancer if it is present. So that would certainly be very appropriate. As would the blood test called CA 125. In some patients--and a physical examination, because often, usually, you can feel enlarged ovarian masses in a patient like this. And then finally a CAT scan, while it's a much more expensive and more difficult test, can be very helpful as well.

**Most At-Risk Populations to Develop Ovarian Cancer**

**Andrew Schorr:**

Who's at risk for ovarian cancer?

**Dr. Schink:**

The most obvious group of people who are at risk for ovarian cancer are women who have the gene called BRCA 1 or 2. And in fact you gave the example of Gilda Radner earlier. Gilda Radner had a very typical family history of BRCA 1. BRCA 1 is a gene that predisposes or increases a woman's risk of developing both breast cancer and ovarian cancer. And if you were look at Gilda Radner's family you would see that her mother had breast cancer and that her maternal grandmother had ovarian cancer. But they didn't know it was ovarian cancer because it had happened so many years earlier that they called it symptom cancer. Furthermore, Gilda had a cousin who had ovarian cancer. So she had a pretty typical picture of someone who has a family at increased risk.

Not every woman, of course, is quite so lucky to have a family where it's really obvious. And then for those people we really need to talk about the red flags, you know, the signs that be aware that you might have this gene abnormality or someone in your family might have this gene abnormality. And some of those red flags are two family members with breast or ovarian cancer, or worse yet, one family member who has both breast and ovarian cancer. Or breast cancer at a really young age like less than age 30. Those are real warning signs.

We have to credit Gilda Radner and her husband, Gene Wilder, with raising

awareness about both ovarian cancer and familial ovarian cancer more than any other single individual has. And that really has done a lot to raise awareness and allow women to be more conscious about both the symptoms and also inherited risk.

**Andrew Schorr:**

Absolutely. So okay. Let's say you are at risk and are there any--just as an aside, are there any ethnic groups, Ashkenazic Jews or anything that are more likely to have that gene?

**Dr. Schink:**

Well, there are. And the Ashkenazi Jews are more likely to have this gene. And in fact if you look at the general population, just take everyone the United States, about one in 800 women have this gene. So it's pretty rare. In the Ashkenazi Jewish community, it's one in a hundred.

**Andrew Schorr:**

Oh, wow.

**Dr. Schink:**

So eight times more likely.

**If Genetically At-Risk: Preventative Measures**

**Andrew Schorr:**

Okay. So if someone--if you identify that family history then somebody would have the option of having a blood test that could confirm or rule out that they in fact have that gene?

**Dr. Schink:**

That's right. And the test is very effective at looking at that. And then a woman who is told that she has this gene mutation can plan her life around what that means and how she can prevent ovarian cancer.

Unfortunately, right now we don't have a great screening test for ovarian cancer. We have strategies for monitoring women who are at increased risk, strategies like doing regular ultrasounds. Here at Northwestern we do those every six months, along with a CA 125 level. But we've never proven that those frequent tests actually save lives or prevent anyone from getting ovarian cancer. We just hope that if they develop it we catch it early. Studies have looked at that, though, and haven't yet proven that that kind of screening is effective. So for a woman who has completed her childbearing, we counsel those patients that they should have--to have their ovaries removed.

**Andrew Schorr:**

And I think you call that an oophorectomy, I think.

**Dr. Schink:**

That's right. Or, we call it a prophylactic, which means preventive, oophorectomy.

**Andrew Schorr:**

Let's say you had the gene, family history etc., you have that, is your risk gone?

**Dr. Schink:**

It's not gone but it's markedly reduced. And there is a little bit of debate about how reduced it is. Some people would say it's reduced by 80 percent. A woman's risk of ovarian cancer, if she has this gene, is somewhere between 20 and 40 percent of getting ovarian cancer in her lifetime.

**Andrew Schorr:**

That's pretty high.

**Dr. Schink:**

Yeah, that's pretty high. We lower that number down to about 4 percent. And that's because there's other tissue in the pelvis that looks and acts like ovarian tissue, and it can still develop this cancer. But that's a very dramatic reduction in risk for these women. And interestingly, so--these women, unfortunately, they have a very high risk of breast cancer as well. And in fact in some studies it's been said to be as high as 85 percent chance of getting breast cancer in their lifetime. If they have their ovaries removed, and ovaries are a source of estrogen, that risk of breast cancer goes down almost in half.

**Andrew Schorr:**

Wow. So they can be the sort of the bad actors there. Well, I can see how it can give a woman if she has the BRCA 1 or 2 gene some peace of mind in doing that, and certainly if she's finished childbearing. But of course there are cases of ovarian cancer where there's not a genetic connection identified. Is there anything that women maybe in that larger group can do to prevent, lower their risk?

**Dr. Schink:**

Absolutely. And you're right, 90 percent of the cases of ovarian cancer occur in women who don't have an inherited risk. For women in general, though, using birth control pills lowers their lifetime risk significantly. And if they use birth control pills for more than five years in their life that risk is lowered three times. So, you know, I said that one in 55 women in the United States develop ovarian cancer. In fact your risk would only be one in 150 if you use birth control pills for many years. Having said that there's still some risk. It's not complete protection, but it helps. The use of tubal ligation as a form of contraception also lowers women's risk, at least in half.

**Andrew Schorr:**

Wow.

**Dr. Schink:**

So there are certainly things that women can do. But right now the strategy that is most effective, of course, is removal of the ovaries. But we would never want to advocate that for someone who didn't have a significant increased risk going in.

**Andrew Schorr:**

Right. I have to ask you because we see articles in the paper about drink this and it lowers your risk of cancer or use these supplements or this or that. From where you sit, as head of gynecologic oncology at Northwestern, is there anything a woman could eat or avoid, supplement to take or not take that would change, from what you know in science, their risk of ovarian cancer?

**Dr. Schink:**

Not ovarian cancer. I'm a very strong proponent of a healthy diet that has an adequate amount of roughage and beta carotin for preventing cancers in general as well as an adequate intake of vitamin E or other antioxidants to really do your best to prevent cancers in general. But we haven't linked any of those interventions to preventing ovarian cancer.

**Andrew Schorr:**

Okay.

By the way, if you as a listener are just joining us we're visiting with Dr. Julian Schink, who is the medical director of the Robert H. Lurie Comprehensive Cancer Center of Northwestern, and he's also the chief of the division of Gynecologic Oncology at Northwestern Memorial Hospital. If you would like a referral to Dr. Schink or other experts there at Northwestern Memorial, the phone number to call, of course, is 1-877-926-4NMH. 1-877-926-4664. And you can arrange an appointment.

**Treatment Options**

Moving on, though, as we discussion ovarian cancer, Dr. Schink, so if someone is diagnosed hopefully earlier, and I did interview a woman once where she was in a sauna and she was kind of lying on her back in the sauna and for some reason she started feeling around her abdomen. She felt something and while it turned out to be ovarian cancer and wasn't early, maybe it wasn't as late as it would have been otherwise. She just kind of felt something. But she had surgery and she was doing okay.

What have the treatments been and how are they changing?

**Dr. Schink:**

Well, the cornerstone of treatment for ovarian cancer is surgical removal of the ovaries, the uterus and the tissues that this cancer typical spreads to, which is the omentum, that's a fatty apron in the abdomen, the appendix and often the lymph nodes in the pelvis and just above the pelvis. By successfully removing all of the visible cancer you increase the chance that the woman will be cured. And even in those women who aren't cured you markedly increase the chance of them being alive one, two, three, even five years later. So that is the most important first step.

There are several studies that show if you go to a center of excellence, a center that is committed to treating ovarian cancer like Northwestern or many of the other academic medical centers in this community or around the country, you are much more likely to have all of your cancer removed. So it's essential that someone does their best to get all of that cancer out.

Earlier at the beginning of this show I talked about the improvements that we've made in survival from ovarian cancer and how it's improved five times over the last 30 years. Much of that improvement is linked to being more aggressive at surgery and removing all of the cancer. But another component of that improvement is that our chemotherapy has evolved. It has changed. And we now follow that surgery with chemotherapy.

And it would appear the most effective chemotherapy is when we put the drugs directly into the abdominal cavity. That approach to chemotherapy, which we call intraperitoneal chemotherapy, is only used if the majority of the cancer has been removed surgically. It doesn't work if you have bulky residual cancer behind.

**Andrew Schorr:**

So surgery first and then follow up with this targeted chemotherapy, directed chemotherapy. So is there a pump that somebody has that's pumping it right into their abdomen or how is it administered?

**Dr. Schink:**

Well, we put that little port under the skin and it has a tube connecting from the port into the abdominal cavity. That port is accessed by our nurses with a needle, it goes through the skin and then that's connected to a pump and a bag of chemotherapy. And it infuses that chemotherapy drug directly into the peritoneal cavity, where it distributes evenly around the abdomen and contacts all of the surfaces where that ovarian cancer had been or where microscopic cells of that ovarian cancer might still be left behind.

We call that intraperitoneal chemotherapy. Years ago they affectionately called it a belly bath. And it has made a big difference in how women do. The study that demonstrated that this was a better way to do chemotherapy, improved the median

survival from 51 months to 66 months. That's a 15-month improvement. That's over a year of improvement in average life expectancy for these patients.

**Andrew Schorr:**

How are we with the drugs that you're using now? Chemotherapy is trying to kill the cancer cells. It can have side effects because it can affect healthy cells as well. Where are we--you know, the name of the game, we've done programs in breast cancer and other areas where the name of the game has been targeted therapies that try to recognize the cancer cell and spare the others. Where are we with that related to ovarian cancer?

**Dr. Schink:**

Well, there are certainly researchers that are working to develop some targeted therapies that look at molecular mechanisms unique to ovarian cancer, but we don't have one yet that is part of our everyday regimen. And I think it will be a little while before we do.

The most promising of the biologic agents or agents that really specifically target parts of the cancer cell, the most exciting new one is a drug called bevacizumab, or some people may have heard of it by its brand name which is called Avastin. This drug is now commonly used in the treatment of colon cancer and lung cancer and has made very dramatic improvement in outcomes of those cancers and is now being studied in the treatment of ovarian cancer. I suspect the addition of Avastin will be our next big improvement this incremental effort to do better.

**The Role & Benefit of Clinical Trials**

**Andrew Schorr:**

Well, that leads me to a question as you try drugs that were developed or approved first for other cancers often you have clinical trials going on. So is that important? A woman is diagnosed with a very serious cancer, ovarian cancer, and it wasn't caught early, so, you know, she's got a tough road to hoe there. Is it then important to connect with a leading center, Northwestern being one, where they're likely to also have trials that might give you a shot at tomorrow's medicine today or combining newer powerful agents in a new way to see if they can be more effective?

**Dr. Schink:**

Absolutely. Clinical trials are where the future treatments for cancer start, and it is a patient's opportunity to get, in a sense, cutting edge therapy. We are a member of the Gynecologic Oncology Group that is a national consortium of cancer physicians sponsored by the National Cancer Institute and studying new treatments for ovarian cancer and other gynecologic cancers. If you look at the improvements that we've seen in the last 30 years each of those can be tied to Gynecologic Oncology Group or what we call GOG study. And incrementally just every

improvement is represented by a GOG study where a new drug combination or a new treatment strategy is tested, tested first on those women who are willing to participate in a clinical trial. And they are the ones who are the first to benefit.

Interestingly, in those GOG trials, while you can't promise this to everyone going forward in clinical trials, the experimental arm has won or been better than the conventional arm in almost every one of those ovarian cancer trials that the GOG has done. So it truly does represent the next new treatment.

**Andrew Schorr:**

And just one question about trials. If a woman enters a trial will she get care that's at least as good as the standard care she would have gotten anywhere?

**Dr. Schink:**

Absolutely, yes. She'll get state-of-the-art standard care but also may have access to a newer treatment that wouldn't be available otherwise.

**Andrew Schorr:**

So, you know, one of the things I hear from one of the leading centers, they remind people and I believe it and I'd love to know what you think, is when you are diagnosed with a serious cancer your first shot is your best shot because cancer cells are wily and they can become resistant to therapy, so you want to go after it when they haven't been exposed to anything. So if I get it right leading centers such as Northwestern is going to have the broadest range of tools to attack that cancer aggressively and try to beat it back or beat it as well as you can the very first time.

**Dr. Schink:**

Absolutely. We certainly would very much like to have the first shot at putting out that fire, so to speak. When it comes back it is always harder to treat. And just to put that into perspective, I talked earlier about the importance of aggressive surgery, what some people might call radical surgery, to get rid of ovarian cancer. A nice study done by Johns Hopkins showed that if you go to an expert center 70 percent of women will have what is described as optimal surgery. And if you go to a nonexpert center that surgical removal only occurs 30 percent of the time.

Now, the difference in survival is dramatic. It's not measured in months, it's measured in years, the difference in survival whether your cancer is all removed at the first surgery or not until some later date. It's just a huge, huge difference in your chance of being cured or living a long time.

**Andrew Schorr:**

Wow. You get my vote of what I would do.

So certainly that's what Patient Power is all about is becoming smarter about these

often very serious conditions and saying, Well, if this happens to me or someone I love or if it has happened how do I approach it. Now, getting smarter is important and Northwestern Memorial has a Health Learning Center, besides these programs. It's there for you. If you want to contact the Health Learning Center it's 312-926-5465. 312-926-5465. You can schedule an appointment with a health educator or a medical librarian who can help you navigate this.

You may want to listen again to our program with Dr. Julian Schink. After all, he's the head of Gynecologic Oncology at Northwestern, and I know you have a great department behind you, Dr. Schink, and this research that goes on every day. So when you take all this together, we're making progress. Maybe now a way to look at are there signs of ovarian cancer earlier. Identify women who are high-risk. Are they in that smaller percentage but important to know percentage of people who have that breast or ovarian cancer gene and need to be either monitored or maybe some prophylactic surgery. And now you're making progress with the administration of chemotherapy as well as the surgical techniques.

So when you take all this together, are you encouraged? A woman comes to you, and obviously everybody's situation is different, but the families look to you, and you're their barometer. Are you encouraged of where things are headed?

### **Future in Diagnosis and Treatment**

#### **Dr. Schink:**

I am very encouraged, and the progress that we've made in the last 30 years has been exciting but slower than any of us would want to see. The new drugs and the new treatments and the new surgical strategies that we have looking forward are very exciting. And certainly offer even greater hope for our patients, whether it's the patients that haven't yet been diagnosed or those patients that are currently on treatment. We have really exciting treatment options going forward in the future.

Obviously, our best outcome would be to prevent this cancer. It's always easier and we would always be happier if no one ever got this. But knowing that it may happen to someone we're going to continue to aggressively seek the best treatments available.

#### **Andrew Schorr:**

And it sounds like you have sort of a multidisciplinary team. You've got surgeons. You've got medical oncology. I'm sure you have counselors and educators to support people at Northwestern. So if someone is diagnosed with this, for them and their family there's a team that can help.

**Dr. Schink:**

Absolutely. We have a wonderful supportive oncology team that can help patients with the whole range of issues, whether those be nutritional concerns, emotional challenges of this new diagnosis or the practical issues that a social worker might need to help them intervene with. We have a health educator in the cancer center right there with access for the patient.

Because one of the things that's just not lost on me at all is that a patient doesn't know, quite honestly, if she's getting the best medical treatment there is, but she certainly knows if she's getting the best emotional treatment. You know. And so not only is it my responsibility to make certain that I give her the best medical treatment but that I take care of the other side as well, because she should feel as good as she can about this intervention.

**Andrew Schorr:**

Well, it's great to hear what you're offering at Northwestern Memorial and the progress being made, both in identifying ovarian cancer early, helping women know who may be at risk and have a discussion with other women in their family if that comes up too, the positive gene, for example, and the approaches in treatment. We wish you well with your research and what you're doing with Northwestern.

We've been visiting with Dr. Julian Schink, chief of the division of Gynecologic Oncology at Northwestern Memorial Hospital, and he's medical director at the Robert H. Lurie Comprehensive Cancer Center at Northwestern. Dr. Schink, thank you so much for being with us.

**Dr. Schink:**

You're very welcome. Thank you for having me.

**Andrew Schorr:**

Thank you, sir.

And for our audience, we're going to change gears for our next program on May 8, and we're going to take a look at a very serious noncancer condition, and that is stroke. So we're going to have Dr. Mark Alberts live as we do a webcast on Tuesday, May 8, 7 p.m. central, What You Need to Know About Stroke. I hope you can join us.

And also, tell people about the replay of this program on ovarian cancer and all our programs. There are all at [healthnet.nmh.org](http://healthnet.nmh.org). If you'd like to request an appointment just go on line. If you want to find out more about Dr. Schink, his department and make an appointment, just go to [www.nmh.org](http://www.nmh.org).



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