Advances in the Treatment of Uterine Cancer

Webcast
January 20, 2009
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Georgia Thornton

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Introduction

Andrew Schorr:
Uterine cancer is the most commonly diagnosed cancer of the female reproductive organs, and obesity and hormone replacement therapy may increase your risk. You'll hear more about the symptoms and diagnosis from a top expert next on Patient Power sponsored by M. D. Anderson Cancer Center.

Hello and thank you for joining us once again. I'm Andrew Schorr. Some people may be with us live even though this Inauguration Day. We have a new president, President Obama, and so there is a lot of news going on there, but if you are living with cancer that may be the predominant thought in your mind. And if you are diagnosed with uterine cancer, which is the fourth most common cancer among women, you're wondering what do you do, where do you go, what are the symptoms that you're dealing with, is it in fact uterine cancer, how advanced is it, what are the treatments, what's the prognosis after that. We're going to learn that from a leading expert from M. D. Anderson who actually was just getting out of surgery just a few minutes ago helping a woman, and she's here to help you tonight.

Georgia's Story

But before we meet her let's meet someone, an M. D. Anderson patient who has dealt with uterine cancer, and that's Georgia Thornton. Georgia is 70 years old. She lived in Lufkin, Texas, and as I learn my Texas geography that's midway, as you may know, between Houston and Tyler. And she is retired from an interesting job. She used to collect delinquent taxes for the State of Texas. She did that for 30 years, but she's retired now, so we can be buddy-buddy with her now. We might have avoided that before, but she could tell us tax stories another time. But she was always in good health. But then, Georgia, if I've got it right, in 2005 you were up in Rhode Island with your husband, and you were at a mandolin camp because you had taken up mandolin I guess as you retired. And what was your symptoms? What was going awry up there in Rhode Island?

Georgia:
Well, I just started spotting. I noticed a little pink when I would go to the bathroom and on the paper. It progressively got worse. But while I was at camp my roommate, I mentioned it to her, and she's a retired school teacher from

Providence, Rhode Island, and she said, well, Georgia, you know, you look swollen to me. And as I look back at the photographs we took at that camp I looked real puffy. I don't know if that had anything to do with it or not, but I just appeared to be swollen, and she noticed it because she had met me the year before at the same camp. So she made me promise that when I got home from the trip that I would see the doctor. And I was really hesitant to go to doctors, you know. I thought the more you stay away from them maybe you won't have a problem, which is the very wrong thing to do.

Andrew Schorr:
You had never been in a hospital, I understand.

Georgia:
Right.

Andrew Schorr:
You'd never been in the hospital until all this came up.

Georgia:
Right.

Andrew Schorr:
So I'll tell a little bit of this story in the interest of time. So you did see a general practitioner.

Georgia:
Yes, when we got home, which was about two months later. We finished our vacation and we got home, and I called first thing for an appointment and went in to see my local GP here in town.

Andrew Schorr:
Now, wait. How long did you go from when you were at the mandolin camp to when you went to the doctor?

Georgia:
About two months.

Andrew Schorr:
Whoa. Well, we're going to find out about that from our expert tonight. So you finally get to the doctor. Then there was a recommendation that you see a gynecologist.

Georgia:
Right.

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Andrew Schorr:
I understand because of insurance changes you had not gone to a gynecologist for like 13 years.

Georgia:
That's correct.

Andrew Schorr:
Oh, my. Okay. Well, we're going to talk about that tonight too. Anyway you asked, could this be a cancer? And you were told, well, probably not.

Georgia:
Right.

Andrew Schorr:
But that got your husband to thinking. He said, let's go down the road to Houston. You go to Houston and you have a biopsy, and what did the phone call from the doctor say?

Georgia:
The doctor, she said that I had cancer, and it was stage III, and that I would need to see a gynecology oncologist as soon as she could get me in with one. And she said, I have two in mind that are very, very good here, and I'm just trying to decide which one I think would be the best doctor for you. And she called me back the next day and gave me Dr. Ramondetta's name and said that she was the doctor that she had fixed me up an appointment with, and she gave me the date and the time. And then I saw Dr. Ramondetta, and she informed me that we would do surgery as soon as we could do it, which was on September the 28th.

Andrew Schorr:
All right. We're going to pick up the story a little bit there. That's my birthday, actually. So September 28, 2005, so you were like 67 years old, I guess.

Georgia:
Right.

Andrew Schorr:
So you had the surgery with Dr. Lois Ramondetta, who is our guest tonight, and we're going to meet her in just a second, Georgia's doctor. And it turned out that it wasn't stage III, right? It was stage I.

Georgia:
Stage 1, yes.

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Andrew Schorr:
And so instead of the idea of needing chemo and radiation that we'll hear about tonight you had a total hysterectomy, so uterus was removed and your ovaries were removed.

Georgia:
Right.

Andrew Schorr:
And then how long did it take to recover, Georgia?

Georgia:
Well, it took quite a while for me to get back to full strength. In fact when I asked Dr. Ramondetta on one visit how long it was going to be before I could run the vacuum she said two years, and I thought she was teasing. But as it turned out it just really took a long time for me to get my strength back. I was not even able to get up and walk in the hospital, and she couldn't figure that out either because normally patients do, but I was not able to get up and walk.

Andrew Schorr:
All right. Georgia, now, here we're, though. We're more than three years later now. How are you doing now?

Georgia:
Oh, I'm doing wonderful now. I take care of my yard. I have two acres, and it's all landscaped and I do all the work there. And of course I'm doing all the work around the house now. I've been painting.

Andrew Schorr:
Right. I know your husband passed on.

Georgia:
Right.

Andrew Schorr:
Here's the question, the key question. You didn't go to the gynecologist for three years. How about now? Do you go in for checkups?

Georgia:
I go to Dr. Ramondetta now, yes. I'm still under her care at M. D. Anderson.

Signs and Symptoms

Andrew Schorr:
All right. Let's meet her. So Dr. Lois Ramondetta is associate professor of gynecologic oncology at MD Anderson Cancer Center as well as director of

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gynecologic oncology at Lyndon Baines Johnson Hospital in Houston which is an integral part of M. D. Anderson's Outreach Program. She has a lot of positions. She's chairperson of the Harris County Hospital District cancer committee as well, and this is her particular area of interest.

Dr. Ramondetta, I know you've had a busy day in surgery. Thank you so much for joining us to help us better understand uterine cancer.

Dr. Ramondetta:
No problem. I'm happy to be here.

Andrew Schorr:
Dr. Ramondetta, so let's go back to Georgia's situation. She wasn't going for checkups, and she's obviously postmenopausal, in her late 60s, and she starts having this sort of bloating and bleeding. Is that the typical way that this cancer shows up, and is it typically in older women?

Dr. Ramondetta:
Definitely the bleeding is key, and actually that's a fortunate thing because many of the cancers we deal with don't have early warning signs and uterine cancer does. And so any bleeding after menopause should be ruled out for cancer. Most likely it's not, but that is definitely the warning sign.

Andrew Schorr:
What about the puffiness that she felt?

Dr. Ramondetta:
That's a little unusual. People respond definitely depending on whether the cancer has spread or not you might have some puffiness. That actually is more a symptom of a different kind of gynecologic cancer. Usually people present only a spotting, even asymptomatic, meaning they don't even notice it. They just see a little bit of blood on their underwear.

Andrew Schorr:
What about any trouble urinating or pelvic pain or pain during intercourse? Could that happen?

Dr. Ramondetta:
Again, with endometrial cancer, we are very fortunate. In contrast to many other GYN cancers, most of the time people present with bleeding, and even if they've been bleeding for a couple of weeks or so it's still usually stage I. In most cases you're going to have a curable cancer as long as you didn't let it go too long.

Andrew Schorr:
Well, we heard your patient say she continued to vacation for two months, and I would think with cancer that's worrisome, but it seems like it worked out okay.

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Dr. Ramondetta:
Two months is not too long. I would never recommend that to anyone, but knowing that she was away from home and that she was trying to fish up what she was doing and she didn't know what was going on, I certainly don't think it was totally unreasonable. But obviously if you had a symptom of irregular bleeding premenopausally or postmenopausal bleeding, any bleeding after menopause, then you need to see a doctor right away.

Andrew Schorr:
All right. And then one other question just related to Georgia's situation. She had a biopsy, and the first physician based on whatever information they had first said, well, this is stage III, which doesn't have as good a prognosis. That's scary. And then when you did the surgery you saw it was stage I. How does that happen?

Dr. Ramondetta:
You know, I wonder if there was some miscommunication. What she may have been saying, and I wasn't there at the time, but what she may have been talking about was actually the grade of the tumor. An endometrial biopsy takes a sample of the tumor from the inside of the uterus, and then usually there are three grades. There's a low grade, a medium or moderately differentiated grade and a high grade. There can also be some rare tumor types that might be picked up on that biopsy. We usually also call them instead of low, moderate and high we call them grade 1, 2 and 3. And what they may have been referring to is a grade 3, meaning that they're very irregular cells under the microscope and that she needed to be operated on as soon as possible. However, you cannot tell the stage of someone until you've operated on them, taken out their lymph nodes, looked around their abdomen, and this as I said is a surgically staged tumor. So until she has had surgery it would be hard to predict that someone was at advanced stage.

Andrew Schorr:
All right. And Georgia had surgery, and from that you were able to remove organs. Tell us what you would typically do and then how you would decide whether someone needs chemo and/or radiation afterwards.

Dr. Ramondetta:
Well, that might be too long of a discussion, but I will explain to you why that's difficult.

Andrew Schorr:
Okay.

Dr. Ramondetta:
The typical surgery is to take out the uterus and the ovaries. Again, these are mostly postmenopausal women. Most of the time women get this after menopause, however many perimenopausal women as well as premenopausal women can get

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uterine cancer, and in those circumstances we need to talk about whether fertility is an option. But let's take the typical over-50-year-old woman who has uterine cancer. You would remove the uterus, the ovaries and the tubes. You would take a small biopsy of the omentum, which is a fat pad hanging down in the pelvis, and we would do in most cases a lymph node evaluation. Lymph nodes filter the blood but also can collect cancer cells which are located in the pelvis and along the big vessels along your back. We evaluate lymph nodes by taking them out and then look at them under the microscope to see if cancer has spread to them.

The reason I said this is a difficult subject is because there is not a universal consensus on how many lymph nodes to take out and even exactly where they should be taken from. There is kind of a basic pattern that we follow, and I would say the trend now is to do a more extensive dissection. One of the reasons for this is that the more you take out these lymph nodes and the more you potentially prove the person has no spread--this is kind of a little bit complicated, but the more you can prove it hasn't spread then the less likely you would be to give them a treatment after you're done, for instance radiation, which has its own side effects. So the trend at this point is to do the uterus, the ovaries, the fallopian tubes, a portion of the omentum and an extensive lymph node dissection on anyone who appears to have invasion. Is that clear?

Andrew Schorr:
Okay. It is. We have time for go over it and I know we may have questions.

We'll be right back with much more of our live webcast, Advances in the Treatment of Uterine Cancer, sponsored by M. D. Anderson Cancer Center.

<u>Recovery</u>

Andrew Schorr:
Welcome back to our live webcast discussing advances in the treatment of uterine cancer, and we have a leading expert with us, Dr. Lois Ramondetta, who is associate professor of gynecologic oncology at M. D. Anderson. And also we have with us from Lufkin, Texas, Georgia Thornton who had surgery for uterine cancer three years ago, and she's doing well.

Now, you were talking about the surgery a minute ago, Dr. Ramondetta, and Georgia shared that it took her a while to recover. So tell us, when you do this maybe fairly extensive dissection you were talking about to really make sure you've got all the cancer, I know the recovery varies but what would somebody expect as far as the recovery time?

Dr. Ramondetta:
I heard what Georgia said, and I don't remember the exact statement, but I was probably trying to encourage her husband to do the vacuuming for her. Usually it's about a six- to eight-week recovery, but that brings up a very important point.

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More and more oncologists are learning how to do these kind of surgeries through minimally invasive techniques, which means trying to do these either using laparoscopes or robotic surgery techniques, and that may significantly cut down on the recovery time as well as the incision. At the time that Georgia had her surgery it was relatively new in oncology, and although we had been using laparoscopic techniques in benign surgeries, as for our abilities to do lymph nodes dissections, we were still early in our training at that point. But presently, somebody like Georgia would be a great candidate for laparoscopic surgery in which she may even go home the day after the surgery or two days after, and she would have a lot less time getting back to the things she likes to do.

Andrew Schorr:
But not vacuuming, okay. Unless you really enjoy that. Okay. Well, so, Georgia, you had this recovery, but as we said now you are not limited in your activities at all, right, Georgia?

Georgia:
Not at all, not at all.

Treatment Decisions

Andrew Schorr:
Okay, and you're feeling good. Now, Dr. Ramondetta, so some people, though, it is advanced further, and then you mentioned about radiation, and I don't know whether chemotherapy comes into it. Tell us how that decision gets made as to is other therapy needed.

Georgia:
Well, I'll mention a book that also described an unusual patient. I don't know if you're aware of that *Cancer Schmancer* book by…

Andrew Schorr:
Fran Drescher.

Dr. Ramondetta:
Yes. So she was a premenopausal patient who had irregular bleeding and saw multiple doctors which is why she wrote the book, talking about how she never got the biopsy that would have told her she had cancer because most people--most of her doctors kind of wrote it off as being irregular menstrual periods. It turned out, though, that she did have uterine cancer that sat long enough for it to become a stage II, so it involved her cervix. And in those cases the treatment can vary. Let me clarify.

Treatment of endometrial cancer is very complicated. There are multiple discussions at the treatment level about what the right treatment is, and this is really at the national level. So one of the things we often try to do is put people on

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trials that evaluate the standard treatments. But in her case she ended up with what was called a radical hysterectomy where they took more tissue around the cervix because usually the cervix isn't involved in uterine cancer. If you find somebody who has cervix involvement or pelvic lymph node involvement, there are still many people who would treat this with radiation treatment. And one of the things that will be looked at over the next few years kind of following the trend of cervix cancer is the combination of radiation and chemotherapy. Although we do this often with cervix cancer patients we don't do it as frequently in endometrial.

And the main reason--and I just want to say this real quickly--is we actually do know what one of the main causes for uterine cancer is. It was not the case in Georgia's case, let me specify, but essentially obesity is one of the main risk factors for uterine cancer. The heavier you are the higher your risk and especially postmenopausally. So that can also make surgery difficult. One of the problems we have in looking at patients who have uterine cancer is that because of the obesity they also have many other problems like diabetes and hypertension and hypothyroidism, and all those things make, one, the surgery more difficult, but also the treatment more difficult. You can imagine that taking a woman who is in her 60s and has these other what we call co-morbidities like diabetes and hypertension and combining their radiation with chemotherapy may have many more side effects than a younger patient without problems.

Now, when we use chemotherapy by itself, honestly it has to be a discussion between you and your physician. There are still so many questions about when the right time to use chemotherapy is, and I don't even think we could begin to get into here. But some of the rarer types of uterine cancer, for instance uterine papillary serous carcinoma or carcinosarcoma of the uterus, which are rarer types, often respond to chemotherapy better than anything else. And there are many people who are evaluating for anyone who has advanced disease chemotherapy over radiation alone. So at this point I don't think I could give you a simple answer.

<u>Screening and Prevention</u>

Andrew Schorr:
Sure. Sure. Well, let me ask you this, though. I just want to help women understand. When you go to the gynecologist--which, Georgia, I'm not going to berate you but I know you had insurance issues and you weren't for quite a while--but when you go or you see your doctor or a woman and you have a pap smear, does that have anything to do with uterine cancer checking or is that for cervical cancer? Are they related at all?

Dr. Ramondetta:
Great question, especially because it is January and it is Cervical Cancer Awareness Month and for those women who are listening who still have a cervix, please make sure you've gotten a pap smear every year because that is another preventable cancer.

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Now, I get that question all the time. The patients who have gotten their pap smears will come to me and say, but I had my pap smear and it was normal. Well, pap smears check for cervical cancer. They do not check for uterine cancer. Very rarely you can pick up a uterine cancer on a pap smear by finding some abnormal uterine cells on a pap smear, but that is just sheer luck. Essentially paps test for cervical cancer. Again, the lucky warning sign is irregular bleeding or spotting after menopause.

Andrew Schorr:
All right. We've talked about how it's most often in women who are postmenopausal, but you were talking about Fran Drescher, who is the Nanny on TV, and how she was premenopausal and how most doctors said, didn't even think that's what it is, but it can be. So help us understand how it might show up in premenopausal women because they're having periods, and how would the symptoms be there. And then you also mentioned along the way about fertility issues, so let's get into that for a few minutes.

Dr. Ramondetta:
Okay. Well, just for some numbers, it's about 20 percent of the women with uterine cancer get diagnosed before menopause, and about five percent of the women will actually get diagnosed before age 40. Again, obesity is the major risk factor. And although genetics play a small role, the role is 10 percent or less. So let me clarify. Of all uterine cancers only about 10 percent are related to genetics, and the syndrome that we've become more and more aware of is the hereditary nonpolyposis colon cancer syndrome, or Lynch syndrome which used to be known as specifically for colon cancer risk, but what we have learned is that the risk in women is just as high for uterine cancer as it is for colon cancer. So again only a small portion of those patients.

Now, in the younger women one of the major risk factors again is obesity, and along with obesity often coming fertility problems. You may have heard the term polycystic ovarian disease, PCO for short. Oftentimes these women have irregular menses where they sometimes bleed and sometimes don't bleed, and sometimes they'll go for half a year or even a year without a menses. What is happening inside their uterus at that time is that the lining of their uterus is building up and building up and building up because we store--this is simplified, but we essentially store estrogen in our fat. So we're getting constant exposure, and it is not getting sloughed off because you are not ovulating, and you get this what we call hyperplasia, precancer of the uterus.

The best thing for those women, first of all for their long-term health is to lose some weight. The second thing is they must have their menses regulated. Women should not be going--you possibly could go two to three months, but really the best

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thing for those women as long as they're not trying to get pregnant at the time is probably to be placed on a birth control pill or to be essentially regulated using a different hormone once a month.

Another option for these women and one that we are looking into and cannot at this point stand behind but definitely looking into is what do we do with a 30-year-old or 35-year-old woman who has newly diagnosed precancer of the uterus or potentially even a very early stage uterine cancer and wants to have children. One of the things that we're looking at is--what has been liked at in the past is using oral progesterone. One of the things that we're looking at in the future is a progesterone embedded IUD, hopefully getting a much higher dose of progesterone to the uterus.

Now, again, just to clarify, the treatment for uterine cancer is to remove the uterus. However, there are times that you can talk with your physician and certainly case reports and case series that have been published where young women have been able to avoid treatment, hysterectomy. And I can think of one patient off the top of my head who had essentially this. She had polycystic ovarian disease, she had irregular menses, wanted to have children. We were trying to manage her on oral--this was years ago so using oral progesterones, unfortunately which has the side effect of moodiness and increased weight. But we treated her and were taking her back to the OR for another sampling of her uterus and fortunately checked the pregnancy test before we went back, and she was pregnant. And she had her baby and we are still following her now and she's on a weight loss technique, only has some precancer of the uterus at this point and hopefully we'll get a handle on that too.

Andrew Schorr:
Wow. Well, I have lots of questions. And we're going to come back. We're going to take a little break. Lots more questions for Dr. Lois Ramondetta, who is an expert in uterine cancer at M. D. Anderson. We'll visit with Georgia Thornton as well about her experience and what she would say to inspire other women who may have a diagnosis of uterine cancer.

And we invite your questions. Just give us a call. 877-711-5611. That's the number to call to our studio. You can also send an e-mail to patientpower@mdanderson.org. We'll be right back with our live discussion right after this.

Andrew Schorr:
Welcome back to our discussion about uterine cancer. We have Dr. Lois Ramondetta with us and also her patient Georgia Thornton, and we invite your questions.

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Dr. Ramondetta, so I know doctors who are associated with M. D. Anderson one way or the other go far and wide around Houston. Now, where do patients typically see you? What medical centers are you at?

Dr. Ramondetta:
Actually I work for M. D. Anderson, and M. D. Anderson has gone out into the community. Actually a very special program that M. D. Anderson runs is at the county hospital. I spend half of my time operating and seeing patient at M. D. Anderson and the other half of my time on behalf of M. D. Anderson I work at a county hospital for patients who don't have insurance. This is an M. D. Anderson program. There are medical oncologists from M. D. Anderson here as well as myself, and the program is also part of the training program for the M. D. Anderson fellows. We see patients. If we are unable to provide the treatment the patient needs at the county facility then we bring them over to M. D. Anderson.

Types of Uterine Cancer

Andrew Schorr:
I see. All right. Now, I have a question. I've heard the term endometrial cancer pretty frequently. Less so uterine cancer. So how do you differentiate between the two or are they always one and the same?

Dr. Ramondetta:
They're not one and the same. It's easier to say uterine cancer or cancer of the womb, however that's a relatively general term. The uterus is made up of kind of the lining of the uterus, the muscle of the uterus and the inner lining. The endometrium is the inner lining, and it is the part that builds up every month and sloughs off every month. But inside the uterus is a muscle, the muscle that contracts to deliver a baby but is also the one that has fibroids, which are benign tumors in the uterus, and you can have a tumor, you can have a cancer that is essentially formed inside that muscle also. So when we're talking about the cancer that we're talking about and the most common type of uterine cancer it is the endometrial cancer.

Andrew Schorr:
All right. Now, some younger women develop endometriosis. Does that have any connection or risk for them developing endometrial or uterine cancer?

Dr. Ramondetta:
No, it's an unrelated issue. There are many theories about how endometriosis forms. One of the theories is that some of the cyclical tissue from the inside of the uterus somehow ends up in the abdomen, and this is why women have cyclical pain because the tissue is building and bleeding throughout the month but in the wrong place. It is not related to uterine cancer.

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Andrew Schorr:
One other area I wanted to ask you about is related to hormones. So for a long time most women were being put on hormone replacement therapy as they got older, and then there was the concern that it raised the risk of certain cancers. And you mentioned progesterone along the way. Many women are familiar with estrogen. So tell us about estrogen, progesterone, hormone replacement therapy and any increased risk of uterine cancer.

Dr. Ramondetta:
Well, the good news is that--the hormones actually cause the lining to stay thin. So birth control pills and hormone replacement therapy do not in fact decrease the risk of uterine cancer. The concern came from a kind of an unblocked exposure of estrogen to the uterus. So women who were just getting estrogen replacement without the second hormone, progesterone, with time were having uterine cancer. And this was done years ago where estrogen was given alone. It is very unusual to see a patient who has had that happen to them now. And let me clarify. If your uterus is out you can take estrogen alone, but if your uterus is still in place you should be on a combination essentially mimicking what happens in your body. Birth control pills or your hormone replacement should involve both estrogen and progesterone.

Now, the Women's Health Initiative study from a few years ago had suggested that a certain dose of estrogen and progesterone in Prempro could increase your risk of breast cancer by a small amount as well as your increased risk of blood clots. There was not a significant influence on endometrial cancer.

Listener Questions

Andrew Schorr:
Okay. Now I've got some e-mail questions for you. And I should mention that if you want to send an e-mail, if you're listening to us live you can and ask a question of Dr. Ramondetta. Here's the e-mail address again. It's patientpower@mdanderson.org. Patientpower@mdanderson.org. Or you can call the studio, and that is 877-711-5611. All right.

Here's a question we got from Jeanette from Schulenburg, Texas. I'm not exactly sure where that is, but Jeanette in Schulenburg. She wrote in, "My diagnosis is invasive endometrioid adenocarcinoma arising in the back of complex hyperplasia." So that's confusing me. And she's asking, Doctor, what does that mean, endometrioid adenocarcinoma arising in the background of complexion hyperplasia.

Dr. Ramondetta:
That's got a lot of complicated terms. I'll ask you one more question. Does it say well differentiated?

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Andrew Schorr:
It doesn't.

Dr. Ramondetta:
It doesn't say.

Andrew Schorr:
Yeah, it doesn't say.

Dr. Ramondetta:
Okay. So let me back up again. What I had said is most uterine cancer is related to estrogen exposure which comes from your weight, and one of the precursors to most uterine cancers is hyperplasia. And hyperplasia can be just mild hyperplasia, or it can be simple, as we call it, or complex. In addition there can be what we call atypical cells. So complex hyperplasia is a precursor to endometrial cancer, and in fact even for women who just have a biopsy of complex hyperplasia with atypia there may be endometrial cancer there.

Now, there are a lot of words in there that you could really sum it up as she probably--probably has an early endometrial cancer arising in hyperplasia, and again this probably is something that is still contained in the uterus. They won't know that until they do the surgery, but surgery would be the recommended treatment. And you said endometrioid adenocarcinoma. Endometrioid is the most common histology, the most common thing you see under the microscope in a uterine cancer.

Andrew Schorr:
All right. Now, we want to mention of course, as we always do, that Dr. Ramondetta, none of our M. D. Anderson experts can practice medicine over the internet. That wouldn't be fair to the patient, it's not fair to them. So we'll try to just give a more general answer and help you wherever you're listening get some guidance from that.

So here's a question from Carrie in Houston. She says, "I have stage III A endometrial cancer and currently undergoing chemotherapy. After I have completed chemo I will be doing external radiation and a vaginal cuff." Maybe you can explain what that is, Doctor. And then she says, "Do you know if there are long-term effects from the radiation treatment?"

So what's a vaginal cuff and what about, worried about side effects of radiation?

Dr. Ramondetta:
So when you take out the uterus you take out the cervix also, and you close the top of the vaginal canal, usually with sutures. That area is called the cuff. What she means is that she will have radiation both from the outside as well as the cuff,

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which means just like a tampon almost they will put radiation for a short period of time to the vaginal cuff because that is one of the very high likelihood places for cancer to recur, right next to where the uterus was.

Are there long-term effects to radiation? Yes, there can be. This is certainly you want to talk to your radiation oncologist about. There don't always have to be, but there can be. The most common side effects can be diarrhea, which usually can resolve but may leave a sensitivity to certain types of food that you might need to pay attention to. There can also be more serious complications to radiation, and again I would recommend talking to your radiation oncologist about this. But there can be more serious complications.

Andrew Schorr:
Okay. Georgia, I got a question for you. Georgia, now, how often do you go see Dr. Ramondetta now three years post surgery?

Georgia:
Once every six months.

Andrew Schorr:
Okay. And of course what we're always concerned about and hope we never hear of it is recurrence, and that leads to our question from Julie in Beaumont, Texas, for you, Dr. Ramondetta. She writes in, "I have successfully been treated for endometrial cancer, and now I worry about recurrence and want to understand follow up. What are the symptoms of recurrence? How often should I be getting checkups, and what checks are vital to detecting a recurrence?" Dr. Ramondetta?

Dr. Ramondetta:
Well, again, every patient is a little bit different. We usually stick to the standard of seeing patients posttreatment every three months for the first year, every four months for the second year and every six months until you hit five years. Most recurrences are going to occur within two to three years. Again, though, most uterine cancers are detected early because of that bleeding symptom, and so the chance of recurrence is very low.

Now, somebody who presents with a more advanced disease has a higher likelihood of recurrence. Symptoms can depend on where the recurrence would show up. If there was a recurrence at the vaginal cuff the doctor may notice it if they are doing the speculum exam. If there was perhaps something more serious like a mass you might notice symptoms, changes in your bowels, but again the likelihood is small. We do often pay attention to--don't standardly get a chest x-ray on every patient, but if they're complaining of a cough I would look there. But what I usually tell patients is that everybody has aches and pains all the time throughout their life. If you have a new ache or pain that lasts for, I usually give the number two weeks, and it's new and it's not going away, it doesn't come and go, it's more escalating over that two-week time, then it's time to get it evaluated.

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Andrew Schorr:
Now, what is the risk of someone who has been treated for uterine cancer of another cancer? Are they at any increased risk? And you mentioned--just along the way we mentioned the term ovarian cancer which many women worry about and is seen late and often is a very deadly disease. We mentioned cervical. What about these other gynecologic areas?

Dr. Ramondetta:
Well, fortunately we've usually removed--because most of the women are postmenopausal we've usually removed the cervix and the ovaries at the time of the hysterectomy. So not usually a concern. What is a bigger concern, and I can't emphasize it enough, is that weight and fat intake are more and more being associated with many different cancers including breast and ovarian, prostate for men, potentially colon, and that what we'd like to remind people and a term I'm going to borrow from another GYN oncologist is that this is a teachable moment. This is a moment where we can tell uterine cancer patients, you know, fortunately most uterine cancer patients do not die of their uterine cancer. Unfortunately, many of them have complications related to their weight.

So again not all uterine cancer patients are heavy, and I'm going to clarify right now, Georgia is an active woman and not overweight in the least, but there are many of my patients who are, and I try to tell each one of them you have a stage I, you're essentially cured. We'll follow you closely for the next five years, but now it's time to get things under control.

Andrew Schorr:
All right. We have a lot more to talk about. I also want to tell you about Dr. Ramondetta's book and we'll talk about that and also her feelings about doctor-patient communication.

But I also want to mention that we do this every two weeks. February 3rd we're going to do a. Program and we're going to discuss something that can go with obesity too. We're going to discuss cancer and heart disease. So that's on February 3rd. We'll be right back with much more of our discussion with Georgia Thornton, some words of wisdom from her, and Dr. Lois Ramondetta from M. D. Anderson. Stay with us.

<u>Partnering with Your Physician</u>

Andrew Schorr:
Welcome back to our live webcast as we go into our final segment with still some important things to discuss. Now, people who know me know I had my leukemia treatment at M. D. Anderson. I was in a phase II clinical trial for chronic lymphocytic leukemia, and it's worked out. And now that's what's done around the world after phase III trials around the world validated what I got eight years ago,

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and I have no other therapy, and I'm delighted. Knock on wood. And of course when I went to M. D. Anderson--I'm from Seattle, I'd never been to Houston before, and I just found it, as scared as I was, to be a very welcoming place.

Now, it used to be that you could go--and I'm not saying M. D. Anderson, but let's face, it we'll all had this situation where you went to the doctor and the attitude was kind of I'm the doctor and you're not and here's what we're going to do. Well, that's not the view of Dr. Lois Ramondetta, and actually she wrote a book with one of her patients, *The Light Within*. And it talks about the friendship between a doctor and a patient. Dr. Ramondetta, you're kind of like the new breed of doctor, and of course the many women who are in gynecology and gynecologic oncology, and you kind of work together. Let's talk about for women who are concerned about uterine cancer, how they can work with their doctor together to get the best care.

Dr. Ramondetta:
Well, actually I think that my entire department consists of physicians that I admire, and certainly many of my mentors came from my own department. What I was trying to say in that book which I wrote with Dr. Deborah Sills, an ovarian cancer patient and just a wonderful friend and wonderful lady who was a world religions professor as well as a mother and a wife and unfortunately had an eight-year struggle with ovarian cancer was that there are a couple of aspects to the physician-patient relationship that are, one, important for patient knowledge, and, two, important for satisfaction of care.

The first thing is to remember, all the patients to remember is although your doctor may care about you, nobody cares as much about your health as you do. And if you have a question then ask it, and if you're not getting answers then find somebody who will answer them. Sometimes the physician may not be able to provide the time to give many, many answers. I think as long as that doctor has a good team, which I happen to think I have an excellent team of nurses who work with me, as long as somebody in that team can provide you with the answers that you need, then you're okay. But if you have a question it needs to be answered. Going back to one of the questions you asked before, certainly someone who is about to get radiation needs to fully understand all the side effects of radiation before they go forward. And again remember nobody cares about your health as much as you do.

Now, the second thing I would say is that the diagnosis of cancer is life changing. It's life changing for anybody, even the possibility of having cancer is life changing. Cancer really makes you think about how you've lived your life and about how you want to live the rest of your life. And I think that the opportunities for recognizing the importance of these life-changing events as two human beings aside from the doctor patient relationship are beneficial not just to the patient but also to the physician as well. Many of us go into this field because of the relationships that we have with the patients and the ability to help them, and sometimes the best help

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even in a curative situation is knowing that all questions have been answered, and what I usually say is the best thing anyone can get at the end is peace of mind. So I'll stop there and see if you want to ask me any other specific questions.

Andrew Schorr:
I want to let our listeners know again. The book is called *The Light Within*, and it was written by Dr. Ramondetta and also her patient who became her friend, Deborah Rose Sills.

Now, when we talk about uterine cancer again, so Georgia is going to have a relationship over time, she has. Coming to see you, being diligent about that. You mention that if anything comes up, questions, if something changes, these are all things you need to speak up about. And even as you told the Fran Drescher story where she went doctor to doctor, she was premenopausal, many people did not think it was a uterine cancer. If you're not comfortable it sounds like you really have to press on.

Dr. Ramondetta:
Very, very important point. And I tried to mention, both Deb and I used to struggle with what defines spirituality, and everyone has their own definition of what spirituality between themselves and a higher power is, but what Deb and I specifically were talking about is really what we described as a spiritual relationship between a patient and a physician. And sometimes that just means really knowing what gives meaning to a person's life. And I feel like I know what that is for Georgia. I feel like I see her kind of picking up the pieces after her cancer and other events that have happened in her life and--actually not just picking up the pieces, moving forward with a strong force, and I like to see that, and I hope to know those kinds of things about most of my patients.

Andrew Schorr:
Georgia, your husband died after your surgery. He was diagnosed with lung cancer about a year later, but he gave you a gift, didn't he, when it came up in conversation with the general practitioner that cancer was an unlikely possibility but still a possibility that he wanted to make sure that you got the best care. It sounds like you did. He really gave you a gift, didn't he?

Georgia:
That's correct. That's correct.

Advice for Women

Andrew Schorr:
Yeah. Well, that really was something. What's your words of wisdom for a woman who might be listening who is finding, gee, I'm postmenopausal, I'm having this

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bleeding, and I don't really feel quite right, and I don't really like going to the doctor. What would you say to them now if they're listening and wondering what's up?

Georgia:
I would say to not be afraid to go to the doctor. I think most doctors are concerned and they do care, but if by some chance a particular doctor does not seem to be that interested or maybe have that kind of time for you, then maybe seek another one where you could feel comfortable to express every ache and pain and every thought you have at that doctor's visit. I have a wonderful doctor. I love Dr. Ramondetta I have to tell, and I'm not only one that feels that way of course. I have heard other ladies say so in the lobby. And there is a spiritual bond there in between us because she sees me not only as a patient but as a person, a creation by almighty God. I was created for a purpose, and I'm trying to live my life to accomplish the purpose that I'm here for. And Dr. Ramondetta is helping me to do that.

Andrew Schorr:
Oh, that's so neat. Well, I wish you--sounds like you want to say thank you to her.

Georgia:
I do. She knows I love her. I told her the last time we visited, and it's just one of those things. There's a special feeling there, and I appreciate all that she's done and she knows that. I give her credit and credit to my god for saving me, really.

Dr. Ramondetta:
And I'm very lucky to know Georgia, and she really does have a neat life.

Andrew Schorr:
It sounds like. Well, if I get to Lufkin, Georgia, I'm going to give you a call.

Georgia:
I hope you will.

Andrew Schorr:
And you can put me to work in your yard, okay?

Dr. Ramondetta:
She might really do that. I'm not sure you'll be able to keep up.

Andrew Schorr:
Okay. So I just want to recap a couple of things. So uterine cancer, if it's discovered early and there may be those signs of bleeding, particularly in postmenopausal women, it would be a great clue, get it worked up. Women can lower their risk if they avoid obesity. That's good for their overall health and

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certainly makes a difference here. There's a smaller percentage of women who might have this colorectal condition, and they need to be followed for uterine cancer as well. Did I get it right?

Dr. Ramondetta:
Yes, you did. Just mentioning again, postmenopausal women are at the highest risk. If you bleed in between your periods and you're a young woman you should still see a physician to discuss it. And if you're one of those women who periods have never been regular and you miss months at a time, again you should be regulated, so you should see your physician.

Andrew Schorr:
Okay. We've covered a lot of ground.

Now, somebody listening tonight is going to say, gee, I wish my sister heard it or mom heard it or even my adult children, and of course all the replays are on mdanderson.org/patientpower. Put the replay up. It should be usually a day after the live webcast, and then as soon as we can we add the transcript so it's all there for you.

Dr. Lois Ramondetta, thank you so much for helping us better understand uterine cancer and also thank you for your book, *The Light Within*, with Deborah Rose Sills, your friend who had lived with ovarian cancer and give us a gift as well. Thanks for all you do and thanks for your long day knowing you just got out of surgery and came straight to the webcast. Thank you.

Dr. Ramondetta:
You're welcome. I'm very happy to be here, and I just want to quickly mention that if somebody did want to contact me via that there is a website. It's www.thelightwithinbook.com. More pictures and things like that.

Andrew Schorr:
Okay, thelightwithinbook.com. And, Georgia, all the best to you.

Georgia:
Thank you so much.

Andrew Schorr:
Okay, I'm coming to do yard work. That's a promise.

Georgia:
Okay. I'm going to expect that.

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Andrew Schorr:
I'm going to find my way up the road there on my way to Tyler. Thank you so much to our audience. This has been a special program. We really appreciate it. I've learned a lot. I hope women take some action points from this about being checked and if anything unusual comes up follow up on it.

Now, remember, on February 3rd, 2009 we will have a program on cancer and heart disease. I'm Andrew Schorr. Remember, knowledge can be the best medicine of all. Good night.

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