Volume 8 • Issue 4, 12.16

ONCOLOGY

FELLOWS

A specialty journal of
OncologyLive®

Those *Women* Who *Changed My Life*

Lessons Learned During a Surgical Oncology Fellowship

+

Patients Are a Virtue

Do We Still Need Physical Exams in the Era of Advanced Imaging Technologies?

An Update on US Cancer Statistics in 2016

OncLive® PRESENTS

Giants® of Cancer Care

NOMINATIONS FOR THE CLASS OF 2017 GIANTS OF CANCER CARE®

are now being accepted online

giantsofcancercare.com/nominate

The *Giants of Cancer Care®* Awards celebrate those individuals who have achieved landmark success within the field of oncology.

Help us identify oncology specialists whose dedication has helped save, prolong, or improve the lives of patients who have received a diagnosis of cancer.

PROGRAM OVERVIEW

- Nominations are open through March 20, 2017.
- Domestic and international nominations will be accepted. Self-nominations are permitted and encouraged.
- The *Giants of Cancer Care®* Advisory Board will vet all nominations to determine finalists in each category.
- A selection committee of 90+ oncologists will vote to determine the 2017 winners.
- The 2017 *Giants of Cancer Care®* class of inductees will be announced in Chicago on June 1, 2017.

Recognize Greatness. Recognize a Giant of Cancer Care.

Intellisphere®
Oncology Specialty Group

ONCOLOGY FELLOWS

Scan with a QR code reader to visit OncLive .com, the online home of *Oncology Fellows*.

MJH Michael J. Hennessy Associates, Inc.

Office Center at Princeton Meadows
Bldg. 300 • Plainsboro, NJ 08536
(609) 716-7777

Table of Contents

Volume 8 • Issue 4, 12.16

Interested in contributing to *Oncology Fellows*? If you'd like to submit an article for consideration in an upcoming issue, please e-mail Jeanne Linke at jlinke@clinicalcomm.com.

For more articles, go to
www.OncLive.com/publications/oncology-fellows

Those Women Who Changed My Life

Lessons Learned During a Surgical Oncology Fellowship

Dominique LeBlanc, MD

There is no such thing as a typical day for a breast surgical oncologist. Every day is different because each patient is unique—with her own disease, beliefs, fears, and hopes. Each patient has her own story.

It's easy for us to become overwhelmed by the complexities of caring for our patients. Working every day with women who have cancer can be a challenge, but also a non-negligible privilege. Since I began my breast surgical oncology fellowship, many of my friends and relatives have questioned my abilities to handle the various associated roles and responsibilities. Many of them told me that they would never have the strength and would be too affected to pursue this type of medical practice. It is true that surgical oncology is not an easy profession. It is a tremendously demanding job that often makes one feel as though they are on an emotional roller coaster; but on the other hand, it is a job that is life-changing and abundantly rewarding.

How do we cope with the pressures we face daily at work? How do we help our patients through this journey they have been thrown into unwillingly?

Throughout residency and thus far in fellowship, I've had opportunities to learn how to manage so many different roles from incredible staff members and my patients.

Lessons From My Patients

Courage. Determination. Perseverance.

Courage is defined as the choice and willingness to confront fear, pain, danger, or uncertainty. Courage sits in your clinic every day. It resides in the lovely lady you are faced with telling that she will have to receive chemotherapy and thus lose all of her hair. It lives in the young mother, who, while you are explaining to her the uncertainties of her future, smiles back and tells you she will do everything possible to achieve cure. Or in this sweet lady with hair white as snow who is learning that she will have to be put to sleep and have her left breast removed. Our patients are great examples of courage, determination, and perseverance. They are strong fighters, ready to give all they have in the battle against their cancer. Yes, it is sometimes really hard to see your patients suffering or not doing well, but we also use

treatments that help lead to cure in many patients.

Lessons From My Staff

During residency, I had the opportunity to pursue elective rotations at some of the best cancer centers in Canada. I met one of the most inspiring surgeons I have encountered thus far at one of these centers. On top of all of the medical knowledge he provided, he taught me some of the most powerful life lessons so far in my career.

ABOUT THE AUTHOR

Dominique LeBlanc, MD, is a breast surgical oncology fellow at University of Toronto, Canada.

Be Passionate

Oncology is always evolving, with new concepts and new data frequently emerging. For this reason, patient care has to be adaptable to the new information. Our job necessitates a constant learning process, where we must incorporate the most recent studies and developments into the day-to-day care we provide. It requires passion and the ability to think outside the box, always in the best interest of our patients.

Give Hope

I will never forget the discussion we had on day 1 in the ward after leaving the room of a patient with a peritoneal carcinomatosis. "Give them hope." Despite the stress and demands of our job, I have learned an important key to success: "Always put your heart to the patients you are taking care of." And always instill hope in them. Facing cancer brings misunderstandings and can lead patients to feel helpless. Remind them that there are better days coming. If we lose hope, they lose hope, and then we all lose the battle.

We are very lucky to play our parts in our patients' treatments. Let us not underestimate this. When you have a 53-year-old patient entering the operating room for her mastectomy and you realize she is frightened by the unknown, hold her hand silently because she needs comfort. Give her hope. When your 43-year-old metastatic patient, who has 3 young children at home, comes to you with disease progression, be courageous and transparent to her because that is what she wants and needs. Give her hope and remind her that you and the team are there to take care of her. She needs support, and this is where your multidisciplinary team comes in. Always remind your patient that she is not alone and yourself that you are not alone in taking care of her. Help your patient and her family to face the illness. Relieve their suffering, and listen to them. And when your lovely 65-year-old patient comes into your office for her follow-up 5 years after the completion of her surgery and chemotherapy, celebrate with her that she is disease-free. She has hope.

Remain Hopeful Ourselves

Unfortunately, doctors and medicine have limits. When those limits are reached, we feel like we have failed. We feel powerless and useless. Discussing those feelings of failure is often taboo in the medical profession. If we experience these feelings, we have to remind ourselves to seek help and advice, however. Talking to a colleague or our family is important.

Embrace Life

Being a breast surgical oncology fellow offers me the privilege to help so many women. Treating patients every day has helped me realize how fragile and precious life is. One out of every 9 women will have breast cancer; breast cancer affects all women, young and old, rich and poor. Our physical health cannot be taken for granted, so let's embrace life!

I may be helping women to change the course of their disease daily, but at the end of the day, the one who has changed the most is me. ■

Do you know an extraordinary oncology nurse?

We want to hear from you!

CURE® is now accepting essay nominations for the *2017 Extraordinary Healer® Award for Oncology Nursing*. We invite you to take this opportunity to describe the compassion, expertise and helpfulness a special oncology nurse has exhibited in caring for patients. Nominations can come from a current or former patient, caregiver, or peer.

Win *a* trip!

Three essay finalists, along with the nurses they nominated, will be honored at a special reception during the *Oncology Nursing Society's 42nd Annual Congress*, **May 4-7, 2017**, in **Denver, Colorado**.

Deadline Extended!

Nominations must be received by **January 15, 2017**, so start writing today!

cure® 2017

Extraordinary Healer® AWARD

FOR ONCOLOGY NURSING

Visit **curetoday.com/healeraward** to read the contest rules and submit your essay online.

Patients Are a Virtue

By Andrea Merrill, MD

It is 4:45 AM on a Saturday in June. My alarm has just gone off. Additional sleep threatens to pull me under again as I grope for the snooze button. "Just 5 more minutes," I beg. Ten minutes and 2 alarms later, I finally pull myself from my bed. I throw on a pair of scrubs, down a cup of coffee, and rush to the hospital to start my morning rounds.

I only have 3 short teams to round on this morning and, I am ashamed to admit this, I am eager to "get them over with." It is a feeling I regret, but it is also, unfortunately, shared among many of my colleagues.

Many recent articles and forums have described the unhappiness and feelings of burnout among current physicians. The never-ending paperwork, increasing regulation, and enforcement of ill-advised quality-assessment measures detract from actual patient care. The practice of medicine now resembles something very different from what we initially envisioned it to be when we were bright-eyed, eager medical students.

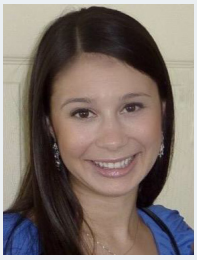
Complicating my feelings even further is the fact that patience has never been my strong suit. Rather, I'd consider patience as my eternal weakness. I often explain this challenge to others during self-evaluations and interviews. I walk fast, I talk fast, and I even eat fast. As a general surgery resident, I have little time for inefficiency.

My plan on this Saturday morning is to proceed quickly—move in, move out—so that I can return home quickly to enjoy my Saturday … and maybe take a nap. However, my plans are soon thwarted by a late and unprepared intern. It is clear

that he has not read up on our patients, which creates more work for me. My mood immediately turns sour.

I rush through visits with my first 2 patients in the Intensive Care Unit as the intern trails behind. Things are running smoothly, and as we head upstairs to see our floor patients, I feel as though everything is back on track. Then, we reach our next patient. She is in her 40s and has just undergone a bilateral mastectomy with reconstruction, having recently been diagnosed with early-stage breast cancer. She is visibly anxious and upset this morning. Despite my attempts to reassure her that everything is going well, she bursts into tears. I hold her hand and reassure her that it is okay to cry and momentarily feel fear, and even pity. I stop and instantly forget about the other 20 patients on my list. I forget my desire to round quickly. Instead, I take the time to focus and listen to this woman as she opens up to me about her concerns and fears. It takes a little while, but she eventually relaxes a bit, her tears dry up, and I am able to move on.

ABOUT THE AUTHOR



Andrea Merrill, MD, is a research resident in surgical oncology at Massachusetts General Hospital. Dr Merrill plans to apply for a surgical oncology fellowship after residency.

> **"How can I feel tired and rushed when these patients are so positive and thoughtful in the face of such adversity?"**

My next patient, who has metastatic colon cancer, is an amazing woman. She is in her mid-40s and has the support of a husband and 2 children. She is about to undergo her fifth operation in less than 3 years. I enter this patient's room and note that although it is just 6:30 AM, somehow she is perky and full of energy as she relaxes in her green, plaid pajamas. She immediately asks me how I am doing and tells me that she feels bad that I have to work this weekend. She is amazing. Again, I instantly stop rushing around and forget about my list of patients and the passing time. We talk about the milkshake her brother may bring for her from the ice cream shop down the street. We talk about her son's cello recital scheduled for later this afternoon that she likely won't attend. And we talk about the 2 miles in laps around the hospital floor she'll walk by the end of the day. I tell you—she's amazing! I don't want to leave this patient, but when I do, I leave with a smile on my face and tears in my eyes, in awe of her resilience.

I quickly continue on to visit with my next patient who is a similar ball of energy. He has been doing barre exercises in the hallways using the side railing for support, although he has 5 liters of stoma output every day after extensive surgery for metastatic colorectal cancer. He has even been teaching the nurses how to do the exercises! As I enter his room, he beats me to the punch and asks me about my day. We begin to talk and once again, I relax a bit. This trend of rushing to the next patient, then relaxing, continues until my rounds are finished. Then it is time to run down the list with the attending and go home.

As I finish on this Saturday morning, I reflect back and realize that I've gained more from my interactions than my patients have. My experiences this morning have helped to teach me to slow down and listen. For me, this is part of overcoming burnout and exhaustion. Connecting to patients is one of the things that initially attracted me to medicine and, specifically, surgical oncology.

Every patient has a story and a journey, which often get lost in the mundane ritual of charting and checking off boxes on my to-do list. My patients and these visits have given me a different perspective. "How can I feel tired and rushed when these patients are so positive and thoughtful in the face of such adversity?" I try and hold on to this memory so that I'll continue to stop and listen. Maybe I'll finally learn some patience after all. ■

There Can Only Be One Best.

We're proud to announce that

cure Connections®

has been selected as the
2016 min Magazine Media Awards'

Best Video Series

Real people expressing their feelings, fears and hopes.

An opportunity to hear cancer patients, along with their families and loved ones, speaking openly about their experiences is a click away. These discussions will address many of your patients' questions, helping them prepare for the journey ahead.

curetoday.com

A patient video series brought to you by cure® magazine, the premiere BPA-audited, direct-to-patient oncology publication.

BPA WORLDWIDE CONSUMER

Visit **curetoday.com** and subscribe to receive the latest video updates.

Do We Still Need Physical Exams in the Era of Advanced Imaging Technologies?

By Faisal Musa, MD

Throughout fellowship, my experiences working with patients in clinic have taught me many lessons. In particular, I've learned the true value of a physical exam. While working in a continuity clinic alongside my program director, who has a special interest in breast cancer, I've had a special opportunity to observe and learn from him the proper way to conduct a breast exam. Working with this program director has also taught me to be mindful of certain important considerations in patients with metastatic disease.

In this article, I present the case of a woman with widespread disease in the bone, lung, and colon. Initially, she was thought to have colon cancer based on imaging results. However, a simple physical breast exam revealed something very different.

ABOUT THE AUTHOR

Faisal Musa, MD, is an oncology and hematology fellow at the University of Florida Health Cancer Center – Orlando Health.

Patient Case Explored

Our patient is a 66-year-old woman with an unremarkable past medical history. In fact, this patient reported no history of ever being seen by any healthcare provider. She presented to the emergency department with worsening neck pain and right-sided chest pain, which had been bothering her for weeks. She denied symptoms of weakness, tingling, numbness, and urinary or fecal incontinence. When she was seen by our team, her initial physical exam was normal.

Upon meeting with this patient, our team ordered a CT scan of her neck. Results revealed multiple lytic lesions, with C5 cord compression. Because these findings raised suspicion of malignancy, a CT scan of the patient's chest and abdomen was conducted as well. Results of the second scan revealed diffuse osseous metastatic disease. Extraosseous soft-tissue components were noted at numerous levels in the cervical, thoracic, and lumbar areas of her back. The scan further revealed several bilateral pulmonary nodules with mediastinal adenopathy and indeterminate mural-based soft tissue that involved a short segment of the ascending colon. An MRI scan of the woman's spine also revealed diffuse osseous metastatic disease throughout her spine, with cord compression at C5 and epidural disease at L1 and L2.

In light of this information, an oncology service at an outside hospital was consulted. The patient's physical examination, which included a neurological exam, was normal. It was after this that she received a recommendation to be transferred to our facility for a neurosurgical and radiation oncology evaluation, as metastatic colon cancer had been suggested as a diagnosis based on imaging results.

She was transferred to our hospital and examined by the neurosurgery service, who (since she had no neurological deficit), preferred to wait to make a treatment decision until receiving an actual tissue diagnosis. However, she was started on high-dose steroids and our service was consulted.

When I reviewed her chart, I really did not feel that this patient had metastatic colon cancer. I considered her amount of bone disease and her intact liver. I also considered the basic principles of medicine and noticed that despite being seen by several doctors, not one had performed a simple breast exam.

After getting up to speed on this patient's medical history, I asked her if she had noticed any changes

in her breasts or other symptoms, such as discharge. She said she had felt something in her right breast 8 months earlier that she thought was a painless cyst and showed no concern about it.

I conducted my own physical exam and, as it turned out, she had a 5-cm mass in the middle of her right breast. The mass was firm and nontender to palpation. The patient had nipple inversion, but no signs of rash or erythema. Her axillary exam was normal. This right-breast mass was not previously detected during any of this woman's imaging scans.

The results of an ultrasound-guided biopsy of her right breast were consistent with estrogen-receptor/progesterone-receptor–positive and human epidermal growth factor receptor 2–negative invasive ductal carcinoma. Neurosurgery deferred surgery, and radiation oncology started treating her C5 disease since there was no neurological defect.

I communicated these findings to the initial oncologist who had seen this woman, and he was very appreciative of my attentiveness and willingness to dig deeper into this patient's case. He explained to me that, "We, as oncologists, sometimes forget to do a breast physical exam because of all of the imaging technology available. But this patient serves as an excellent example of why it is important to conduct a complete physical exam, especially during an initial patient encounter."

Takeaway

Cases such as this one highlight an important principle in oncology. We frequently talk about pathology and imaging results, but we rarely talk about physical exam findings, even in tumor boards. This case clearly demonstrates the importance of the physical examination in oncology, as it can play a huge role in a patient's diagnosis and treatment. ■

For more articles, go to
www.OncLive.com/publications/oncology-fellows

An Update on US Cancer Statistics in 2016

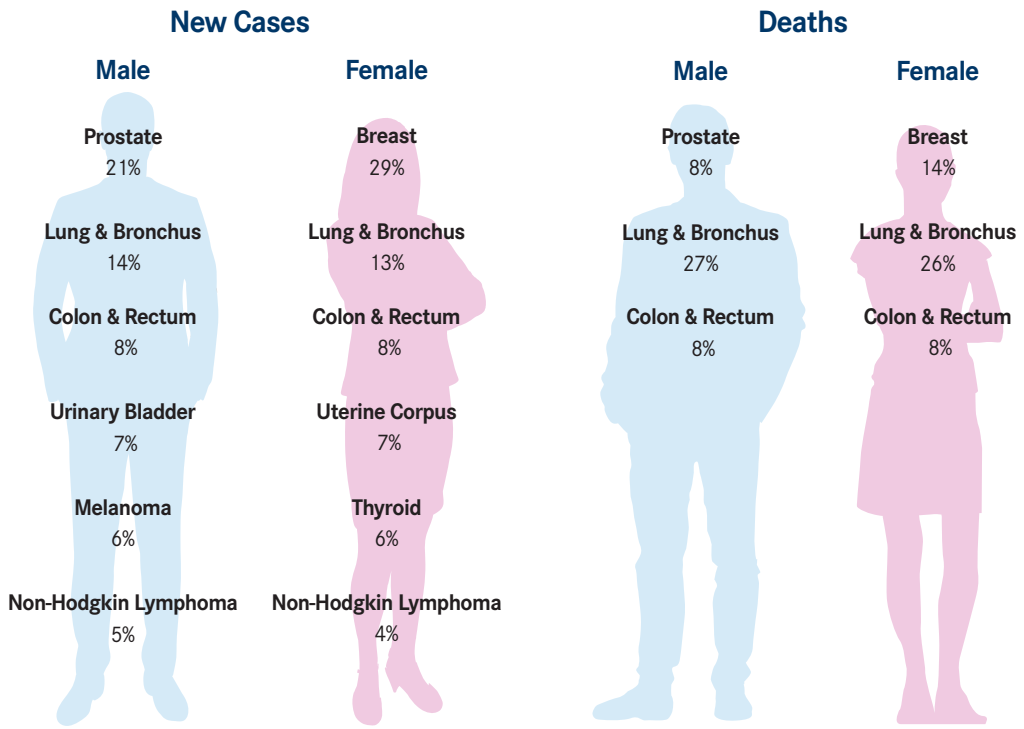
According to the American Cancer Society's latest report on cancer statistics, Cancer Facts & Figures 2016, improvements in early detection and treatment, as well as increased public awareness regarding cancer risk factors, have had positive effects on combatting the overall cancer epidemic.

As reported, more than 1.7 million cancer deaths have been avoided to date. Additionally, the 5-year relative survival rate for all cancers diagnosed between 2005 and 2011 was 69%, up from 49% during 1975 to 1977.

The American Cancer Society report also includes statistics about the estimated number of new cancer cases and the leading types of cancers affecting both males and females in 2016, and reported on the leading cancers that result in mortality **(Figure)**[1]

In males, prostate cancer is the most common type of cancer diagnosed, and is the second most common type of cancer to cause death. In females, breast cancer is the leading type of cancer diagnosed and is the second ranked cause of cancer death. Cancers of the lung and bronchus and colon and rectum also top the list of new cancer cases and deaths in both geners.[1] ■

Figure: Leading Sites of New Cancer Cases and Deaths[1]



Adapted from ACS website. American Cancer Society. Cancer facts & figures 2016. ACS website. http://www.cancer.org/acs/groups/content/@research/documents/document/acspc-047079.pdf. Published 2016. Accessed November 28, 2016.

REFERENCE

American Cancer Society. Cancer facts & figures 2016. ACS website. http://www.cancer.org/acs/groups/content/@research/documents/document/acspc-047079.pdf. Published 2016. Accessed November 28, 2016.

MOBILE MEDICINE: APPS FOR THE HEALTHCARE PROFESSIONAL

HemCIS Hematology Calculator

PRICE: Free

PLATFORMS: Android

The HemCIS Hematology Calculator mobile app provides hematology specialists with tools that are useful when diagnosing and managing patients. Professionals can reference information on lymphoid disorders, plasma cell disorders, stem cell transplantation, and more. Information on ECOG/WHO performance score and the Karnofsky performance status scale is also available.

http://bit.ly/2eUh5Zm

GuidelineCentral – Medical Guidelines Reference

PRICE: Free

PLATFORMS: Android, iPhone, iPad, and iPod touch

The GuidelineCentral medical guidelines reference app offers access to more than 2600 medical guideline summaries representing all of the main clinical specialties and most well-known medical associations. Also included are algorithms, charts, medical tables, and search tools to enable professionals to access comprehensive information on clinical trials and treatment while on the go. The app is functional even when there is no Internet connection.

http://bit.ly/2eUl1JC

MeVis Lung-RADS

PRICE: Free

PLATFORMS: Android, iPhone, iPad, and iPod touch

The MeVis Lung-RADS mobile app is designed to help radiologists, oncologists, pulmonologists, and medical students develop and practice routine use of the Lung CT Screening Reporting and Data System (ACR Lung-RADS, Version 1.0), which is used as a quality assurance tool to structure and standardize lung cancer screening, CT interpretation, and reporting of assessment categories.

http://bit.ly/2eeNKaK

MedAbbreviations: Medical Abbreviations Reference

PRICE: $0.99

PLATFORMS: iPhone, iPad, and iPod touch

The MedAbbreviations mobile app provides users with instant access to over 14,000 medical abbreviations, including medical terms, common shorthand, and names of professional associations and organizations. There is a search tool, or users can look for abbreviations in the app's alphabetical index. All information can be bookmarked for future reference or added to a Favorites list, which users can organize based on their preferences.

http://apple.co/2fHBdkB

2017 Oncology & Hematology Meetings

January 13-16, 2017
15th Annual Oncology Update: Advances and Controversies
Steamboat Springs, CO
http://bit.ly/2ePHHhG

January 19-21, 2017
2017 Gastrointestinal Cancers Symposium
San Francisco, CA
http://bit.ly/1tYJsJv

January 27-28, 2017
Cancer Survivorship Symposium: Advancing Care and Research
San Diego, CA
http://bit.ly/1Kimr8C

February 11, 2017
13th Annual International Symposium on Melanoma and Other Cutaneous Malignancies®
Sunny Isles Beach, FL
http://bit.ly/2bBR2sB

February 16-18, 2017
2017 Genitourinary Cancers Symposium
Orlando, FL
http://bit.ly/1a9KmFf

March 9-12, 2017
34th Annual Miami Breast Cancer Conference®
Miami Beach, FL
http://bit.ly/2erQan0

March 12-15, 2017
Society of Gynecologic Oncology (SGO) Annual Meeting on Women's Cancer
National Harbor, MD
http://bit.ly/1MadmSl

March 23-25, 2017
National Comprehensive Cancer Network (NCCN) 22nd Annual Conference: Improving the Quality, Effectiveness, and Efficiency of Cancer Care™
Orlando, FL
http://bit.ly/2gVV27t

April 1-5, 2017
American Association for Cancer Research (AACR) Annual Meeting 2017
Washington, DC
http://bit.ly/2dvPvPO

April 26-29, 2017
The American Society of Pediatric Hematology/Oncology's (ASPHO's) 30th Annual Meeting
Montréal, Quebec, Canada
http://bit.ly/2h7k44c

April 29, 2017
2nd Annual School of Gastrointestinal Oncology™
New York, NY
http://bit.ly/2gc3fAy

ONCOLOGY FELLOWS

CALL *for* PAPERS

We welcome submissions to ***Oncology Fellows***, a publication that speaks directly to the issues that matter most to hematology/oncology fellows at all stages of training. ***Oncology Fellows*** aims to provide timely and practical information that is geared toward fellows from a professional and lifestyle standpoint—from opportunities that await them after the conclusion of their fellowship training to information on what their colleagues and peers are doing and thinking right now.

Oncology Fellows features articles written by practicing physicians, clinical instructors, researchers, and current fellows who share their knowledge, advice, and insights on a range of issues.

We invite current fellows and oncology professionals to submit articles on a variety of topics, including, but not limited to:

- **Lifestyle and general interest** articles pertaining to fellows at all stages of training.
- **A Word From Your Fellows:** articles written by current fellows describing their thoughts and opinions on various topics.
- **Transitions:** articles written by oncology professionals that provide career-related insight and advice to fellows on life, post training.
- **A Day in the Life:** articles describing a typical workday for a fellow or an oncology professional, post training.

The list above is not comprehensive; suggestions for future topics are welcome. Please note that we have the ability to edit and proofread submitted articles and that all manuscripts will be sent to the author for final approval prior to publication.

Learn more about ***Oncology Fellows*** at:
www.onclive.com/publications/oncology-fellows

If you are interested in contributing an article to ***Oncology Fellows*** or would like more information, please e-mail Jeanne Linke at **jlinke@clinicalcomm.com**.

OncLive®.com