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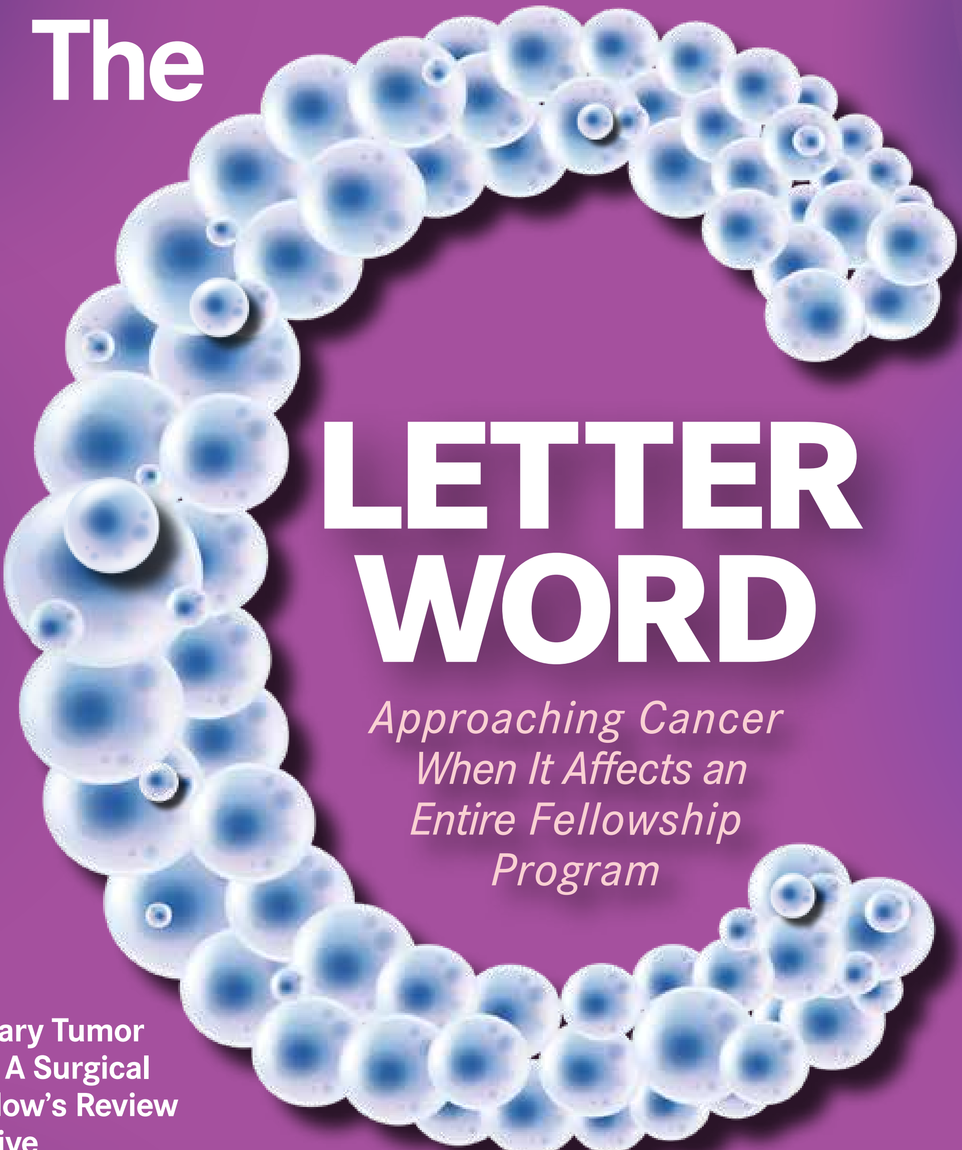

The C LETTER WORD

Approaching Cancer When It Affects an Entire Fellowship Program

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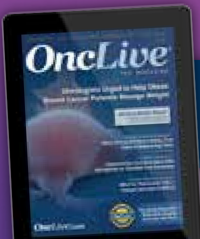
Interdisciplinary Tumor Conferences: A Surgical Oncology Fellow's Review and Perspective

Does Physician–Physician Communication Matter?



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The C Letter Word

Approaching Cancer When It Affects an Entire Fellowship Program

By Theresa Marcus

The “C” letter word—a 6-letter word that has the ability to render one terrified, uncertain, and seeking assurance of cure. Cancer is something I never feared. In fact, when I initially accepted the position as Education Program Coordinator for the Hematology-Oncology Fellowship Program at Beaumont Health System, I felt like I was finally doing something to fight the very disease that took 2 of my grandmothers, as well as other relatives, from me way too early. I enjoyed being a part of a team that would educate future physicians who sought to cure others’ grandmothers as well as conduct research in the hopes that one day a cure could be found. This position was a “big picture” calling for me, and one that I embraced wholeheartedly. Little did I know that soon I would be hearing that 6-letter word as a patient, not just as a program coordinator.

For 13 years, I have seen fellows come and go through our program. I enjoy seeing them learn the essentials of what it takes to become a compassionate and successful hematologist-oncologist. Even though most days I feel like a paper pusher or the annoying coordinator whom fellows love to avoid because I am always after them for paperwork, I never forget my small role in the big picture. However, that perspective changed abruptly the day I woke up from a procedure and a doctor looked at me and said, “We found a tumor and we think it is cancer. You need to have a scan right away to see if it has spread anywhere else, and you need to see a surgeon as soon as possible!” My first thought as I struggled to come out of the anesthesia and make sense of what I was hearing was, “Put me back out. Give me more anesthetic because this must be a nightmare!” I had no idea, then, what the coming months would bring.

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Besides the personal fears and struggles I faced due to being diagnosed at age 36 with colon cancer, I wondered how I was going to relay this news to my program director. We have worked very closely together for 13 years, and we make a great team. I knew he would be just as devastated as I was when he heard the news. Despite this internal struggle, my ultimate desire was to run to him as fast as I could for help. After all, we are in the cancer business. He and all the faculty members, fellows, and staff are the best at what they do. Our team is involved in cutting-edge research and treatment; for example, team members discuss recent publications at journal club and present on the latest research at our conferences. I could not think of going anywhere else.

> This is a journey that I did not want to keep private. I wanted the very best people on my team. The 6 fellows in my program rose to the challenge.

The faculty that I respect so dearly conferred and decided who would be in charge of my care. To this day I tell my wonderful oncologist that I feel bad that she drew the short end of the straw in being chosen to follow my case. Fortunately for me, she sees it differently, and treats me like family. With my permission, the program director and I immediately met with the fellows to share the news with them. This is a journey that I did not want to keep private. I wanted the very best people on my team. The 6 fellows in my program rose to the challenge and began to offer words of support and encouragement. They also shared research knowledge, connections they had to data and other physicians around the country, and biblical scriptures. Additionally, they were there to answer any questions I had about my cancer, treatment, and side effects.

After surgery to remove the cancer, I was treated for 6 months with chemotherapy. All the fellows would periodically check on me to make sure I had not passed out at my desk from fatigue. They also took up a collection and gave my family a gift card to assist with meals. Our fellowship clinical navigator with whom I work so closely offered me rides to and from home for times I did not feel up to driving and would come and sit with me during my chemotherapy treatments. She and the chief fellow really stepped up and assisted with several of my job duties while I was incapacitated or not at work due to surgery and treatment. Even though it was stressful for them to do extra work, they never spoke a word of complaint to me.

One day, during the course of my treatment, my program director sat down on the floor in my exam room, as there were no chairs left. He looked up at my husband and told him not to worry. He gave my husband his personal cell phone number and encouraged him to call anytime with questions or concerns. He told us not to listen to advice or any of the "cancer gone bad" stories that survivors or their families love to relate. He reminded us that the team I had in place was composed of experts in the field. Traveling this cancer treatment path is something they do every day, and they have the knowledge to answer any and all questions. My dear faculty member, who became my oncologist, sat with my parents and spent a lot of time answering their questions and calming their fears.

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I remember the fellow who came to my office and comforted me by saying that no matter what the cancer type or stage, we can always try something, and advised me not to become disheartened or give up. Then, there was the rest of the faculty, fellows, and our Graduate Medical Education director and staff who were so busy, but still took the time to swing by during my chemotherapy treatments to share a story, a joke, or a word of encouragement. When my final treatment was finished, like me, they all rejoiced. I remember walking into our June fellowship graduation dinner, which was shortly after my last chemotherapy treatment, and the entire room of fellows, faculty, and staff stopped to clap and cheer for me because it was a victory we all shared together. The future was suddenly looking a lot brighter.

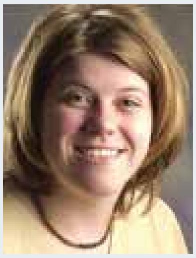
A month later, I had a follow-up scan to make sure the chemotherapy had done its job. To my dismay, the cancer had recurred in the same location where it was initially discovered! This was devastating because it meant yet another cancer surgery. Another surgery was not on my personal radar!

I wanted to get back to my full-time job assisting faculty and fellows by fighting cancer as a coordinator, not return to being a cancer patient. Unfortunately, I became the rare statistic. I was the 36-year-old cancer coordinator who got a cancer diagnosis and a recurrence less than a year from my initial diagnosis. Now, I found myself in patient mode again and an interesting case study to boot!

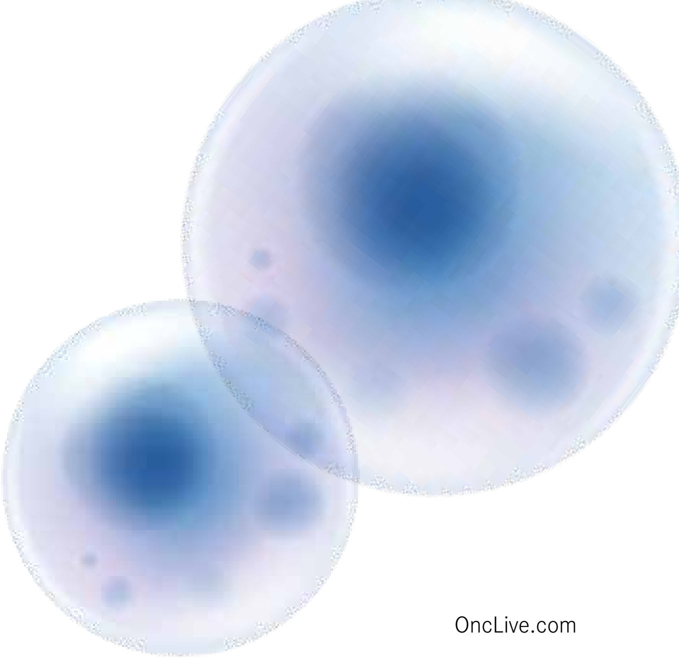
I volunteered to have my case presented at the tumor boards. There was a big debate on whether to administer more chemotherapy or just monitor me closely. Naturally, I was thankful to hear that after many scans, exams, and tumor board discussions, my team decided that close monitoring was the winner.

Now, almost a year later, I am happy to report that I am cancer-free. I believe it is because of the ongoing relentless support from my medical team, as well as that of my family, my church, my friends, and my co-workers. The only way I felt I could ever repay each of them was to get back to work and do a great job as program coordinator for a group of individuals I admire and have grown to love. I will never forget all of the amazing things they did to help me on my cancer journey. I now serve in my role as a coordinator with a greater passion, seeing that these oncologists and fellows do not just “talk the talk” but that they also “walk the walk.” They are compassionate and knowledgeable, and they proved it through the care I received when I needed it most. They walked with me through the gloomiest season of my life, and they renewed my passion for the big picture of why we do what we do every day in the Hematology-Oncology Fellowship Program. In this program, we are changing lives—we are holding the hands of those traveling through the darkest valleys they have ever known, and no matter how big or small our role may be along the journey, we are giving hope to those who have recently heard that 6-letter word themselves. ●

ABOUT THE AUTHOR



Theresa Marcus is the hematology/oncology fellowship coordinator at Beaumont Health System in Royal Oak, MI. During the development of this article, she received editorial support from Judy Whitfield, a medical services manager at Cancer Care Associates, PC, in Royal Oak, MI.



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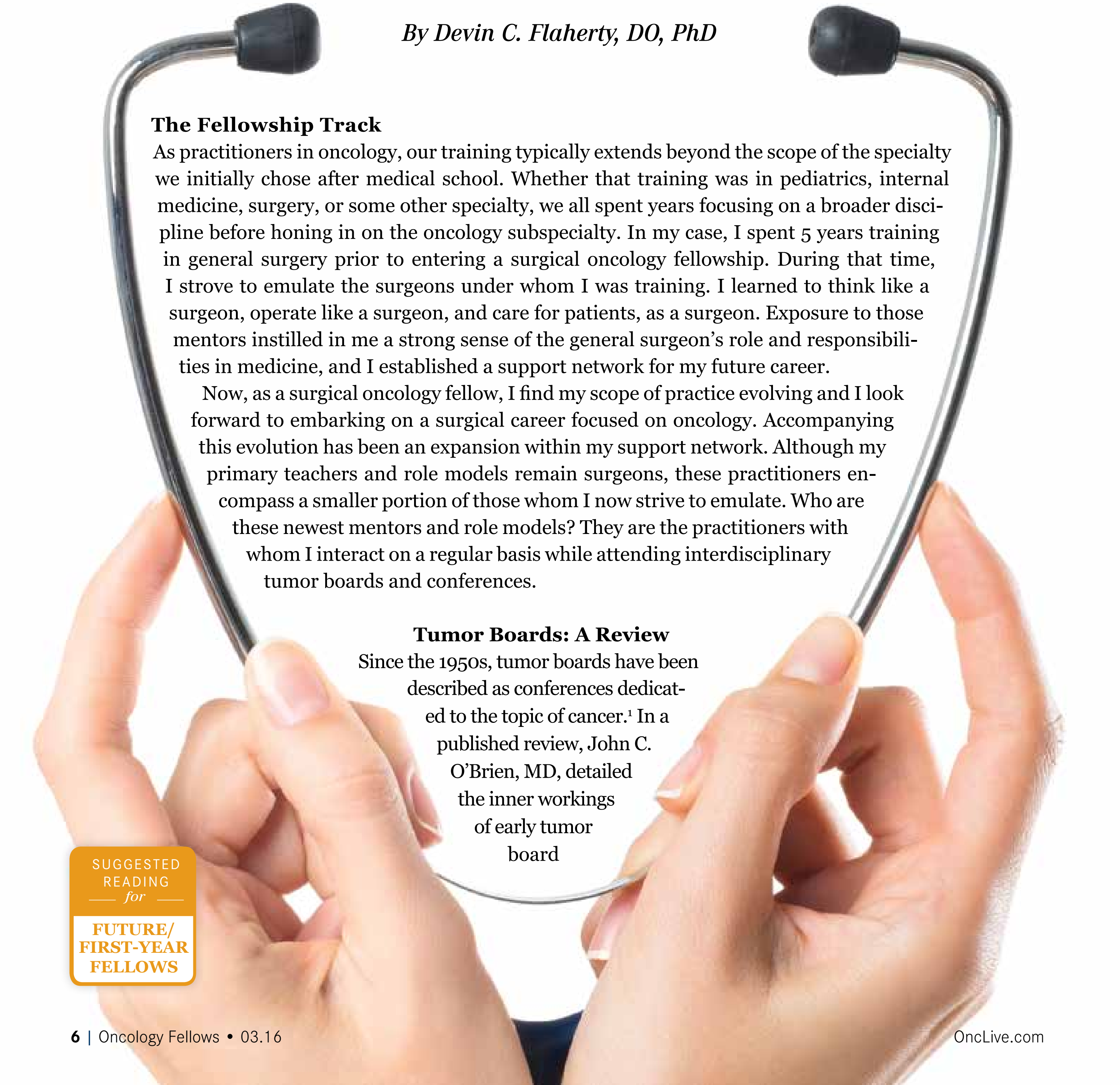
Interdisciplinary Tumor Conferences: A Surgical Oncology Fellow's Review and Perspective

By Devin C. Flaherty, DO, PhD



The Fellowship Track

As practitioners in oncology, our training typically extends beyond the scope of the specialty we initially chose after medical school. Whether that training was in pediatrics, internal medicine, surgery, or some other specialty, we all spent years focusing on a broader discipline before honing in on the oncology subspecialty. In my case, I spent 5 years training in general surgery prior to entering a surgical oncology fellowship. During that time, I strove to emulate the surgeons under whom I was training. I learned to think like a surgeon, operate like a surgeon, and care for patients, as a surgeon. Exposure to those mentors instilled in me a strong sense of the general surgeon's role and responsibilities in medicine, and I established a support network for my future career.

Now, as a surgical oncology fellow, I find my scope of practice evolving and I look forward to embarking on a surgical career focused on oncology. Accompanying this evolution has been an expansion within my support network. Although my primary teachers and role models remain surgeons, these practitioners encompass a smaller portion of those whom I now strive to emulate. Who are these newest mentors and role models? They are the practitioners with whom I interact on a regular basis while attending interdisciplinary tumor boards and conferences.

Tumor Boards: A Review

Since the 1950s, tumor boards have been described as conferences dedicated to the topic of cancer.[1] In a published review, John C. O'Brien, MD, detailed the inner workings of early tumor board

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meetings at Baylor Hospital in the late 1960s and regular breast tumor conferences at MD Anderson Hospital and Tumor Institute in the 1970s. Attendees included medical, radiation, and surgical oncologists, along with other subspecialized surgeons.[2] Multidisciplinary tumor boards have slowly evolved from general case meetings into weekly focused gatherings on cancers affecting specific organs, "mini-tumor boards," and even molecular tumor boards.[3,4]

It is no surprise that multidisciplinary meetings started at large hospital systems that could easily support the required subspecialty attendance. Today, with technologic advances, quality multi-disciplinary meetings can be offered to hospitals and practitioners located in geographically remote settings.[3] A pilot study in Germany set out to evaluate the feasibility of long-distance, multicenter tumor board meetings, using the Internet as a platform. A total of 39 tumor board conferences were conducted between December 2004 and August 2006, and the results of the pilot were published in 2007. The authors concluded that online collaboration was indeed possible.[5]

Through a literature search, I discovered that efforts have been made by practitioners to investigate the role and efficacy of tumor boards in medical systems. The endpoints evaluated in these studies have included patient satisfaction, clinical outcomes, team dynamics, and communication.[3]

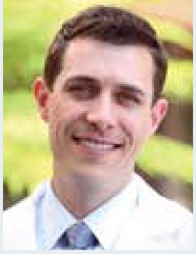
Results from a study conducted in the United Kingdom and published in Lancet Oncology demonstrated a greater than 60% increase in the percentage of patients with cancer managed by interdisciplinary teams over a 10-year period from the late 1990s to the mid-2000s.[6] Despite this increase in coordinated case management, the tumor board conference, as an entity, has recently come under fire. A 2013 survey study reported in the Journal of the National Cancer Institute investigated Veterans Administration (VA) hospitals with established tumor boards. Investigators concluded that the VA hospitals' multidisciplinary tumor boards had little effect on use, quality, and survival measures. Keating et al did note, however, that measuring the efficacy of a tumor board is complex and multifactorial, making it difficult to objectively quantify endpoints.[7] This article fanned the flames of a question already being asked, "Are tumor boards a waste of time?"[8]

In a 2015 follow-up study from the same group, Kehl and colleagues published outcome results from patients with lung and colorectal cancer whose cases were discussed at multidisciplinary meetings. Despite concluding that the impact of tumor boards on survival, quality of care, and communication was not obvious, the authors did report an overall higher rate of clinical trial participation in those subjects whose cases were reviewed in a multidisciplinary setting. In addition, surgery was more often performed with curative intent on patients with stage 1 or 2 non-small cell lung cancer after tumor board review, and lower mortality rates were reported in cases of stage IV non-small cell lung cancer and extensive-stage small cell lung cancer reviewed in a multidisciplinary setting that discussed solely challenging cases. Kehl et al concluded that more focused investigations need to be undertaken with regard to the features of tumor boards most beneficial to patient care.[9]

A Surgical Oncology Fellow's Perspective on Multidisciplinary Conferences

I lean forward, toward the edge of my seat; what I am witnessing has me captivated. The room is hushed and all eyes are directed toward the unassuming, soft-spoken medical oncologist seated at the end of a large conference table. She is speaking quickly and has been, by rote, for the last 3 minutes. Her diction moves fluidly from the results of one randomized trial to another as her encyclopedic knowledge of the literature effortlessly rationalizes various treatment approaches associated with a complicated cancer case. I audibly exhale and realize I've been holding my breath.

ABOUT THE AUTHOR



Devin C. Flaherty, DO, PhD, is a surgical oncology fellow at the John Wayne Cancer Institute at Providence Saint John's Health Center in Santa Monica, CA.

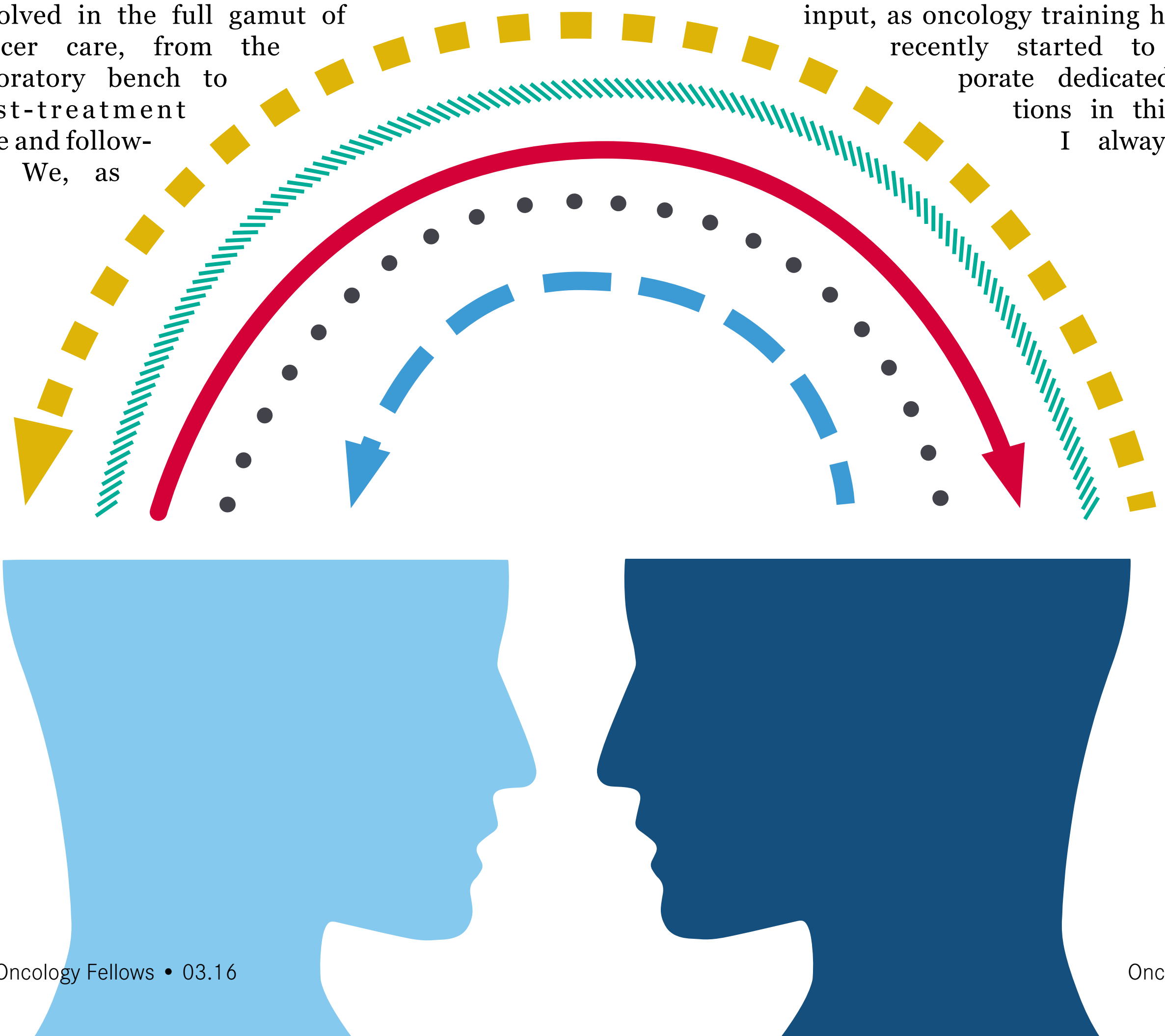
I remember the fascination I had as a medical student when first presented with the Whipple procedure. Surgery involving the head of the pancreas is analogous to doing roadwork on the East Los Angeles Interchange—that is to say, it is a complicated endeavor. Fast forward 7 years, and now as a second-year surgical oncology fellow who is well acquainted with the nuances of this procedure, my focus has globally broadened to include considerations regarding the treatment of these patients before and after operative intervention in order to obtain the best long-term outcome. Where can a practitioner obtain subspecialty guidance regarding ongoing care from multiple disciplines? The simple answer is a tumor board.

Cancer is a dynamic entity both in the literature and within the human body. It can take years for a clinician to truly have command of the literature, and new information is constantly becoming available. Tumor boards offer an environment that not only fosters careful rationalization of cancer treatments, but also serves to educate the practitioners in attendance. Thus, a tumor board is a kind of melting pot for subspecialty fact sharing. Personally, I have enjoyed my increased exposure to tumor board conferences during fellowship, and through regular attendance, I have found inspiration from a new group of role models in this interactive environment.

Who are these new role models? They are the medical oncologists systemically attacking cancer, the radiation oncologists utilizing focused beams to treat the unseen and dampen recurrence, the radiologists scrutinizing with surgeons and endoscopists the resectability of a tumor, and the nurse navigators directing the board's attention away from the raw facts and advocating for the patient's emotional well-being. Important contributors to interdisciplinary conferences also include pathologists, other surgical and medical specialists, nurses, social workers, researchers, and in-training practitioners who are involved in the full gamut of cancer care, from the laboratory bench to post-treatment care and follow-up. We, as oncologists, can develop the perfect care plan, but it is the patient who needs toembrace this plan. The patient's mental, emotional, and spiritual issues can easily be overlooked by a busy practitioner who is buried in the details of the case. All of these facets of care can be addressed by the tumor board.

The influence of these newest mentors will undoubtedly remain with me when I begin my practice of surgical oncology. I am certain that upon performing my first case that requires an intraoperative frozen section I will keenly remember the passion our director of pathology brought to conferences when discussing the importance of the handling and orientation of a pathologic specimen. "Pathology is low-hanging fruit to oncologists, Dr Flaherty. Take every opportunity to learn from it." It is this kind of knowledge, knowledge obtained from and reinforced through multidisciplinary conferences, which will guide my practice patterns and make me a better oncologist.

As new oncology practitioners, we will also find that as medicine and standards of care evolve, so will tumor boards. For example, cancer genetics is a rapidly evolving field that requires specialist input, as oncology training has only recently started to incorporate dedicated rotations in this area. I always look



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forward to the comments our geneticist typically reserves for the end of a discussion. With a growing focus on personalized cancer care, these practitioners offer a new layer to the prospective treatment of our oncology patients.

Finally, what about those cases that we just cannot win?

In a recent issue of *Oncology Fellows*, Dr Bollin offered timely and thoughtful insights into the importance of palliative care training during fellowship.[10] Despite its importance, a publication in the *Annals of Surgical Oncology* highlighted the lack of palliative care training that fellows receive during surgical oncology fellowship. Program directors of surgical oncology and hepatobiliary fellowships were surveyed; the results revealed that only 60% of responding programs offered formal training in palliative care.[11] As a future surgical oncologist, I appreciate the importance of this training because I recognize the nature of the foe we are battling. Inevitably, all oncologists will be placed in situations where palliative care training will allow them to appropriately and compassionately assist a patient and their family in accepting this new direction in care.

Granted, not all cases presented at tumor boards require palliative measures. There remains, however, a role for education regarding palliative care. Perhaps efforts should be made at those institutions without palliative care representation to reach out to these practitioners and encourage their participation in regular multidisciplinary conferences. Perhaps, as fellows, we can spur this initiative along by being advocates for the patients we present at tumor boards and personally extend an invitation to a palliative care practitioner when appropriate.

As a surgical oncology fellow, I have defined my new heroes. The interdisciplinary setting is a welcoming and comfortable environment that promotes a team approach to conquering cancer. There is so much knowledge and experience in one room, and everyone brings a different dish to the table that helps to create a full-course meal for all of us to share. And when the hour is up and the tumor board comes to a close, we all rise, sated and ready to continue the fight. Now, during fellowship, when we are sitting less on the periphery and are more involved in presentation and discussion, we should relish the opportunity to settle in and learn. Every week, I leave the tumor board inspired and count my blessings to be involved in this branch of medical care.

Beyond Fellowship

Recently, I contacted a friend who had just graduated from the complex general surgical oncology training program at my institution. Our conversation touched upon his move, the new city he was living in, and, finally, the manner in which he was preparing for his first day on the job. Expecting to hear about a planned busy clinic day or hours of electronic medical record training, I was surprised at his answer: "I am preparing for tumor board." As new oncology practitioners, the tumor board setting will likely be one of our first opportunities to make an impact on patient care. We should all look forward to this opportunity and prepare for our role in this effective and necessary pillar of oncologic care.

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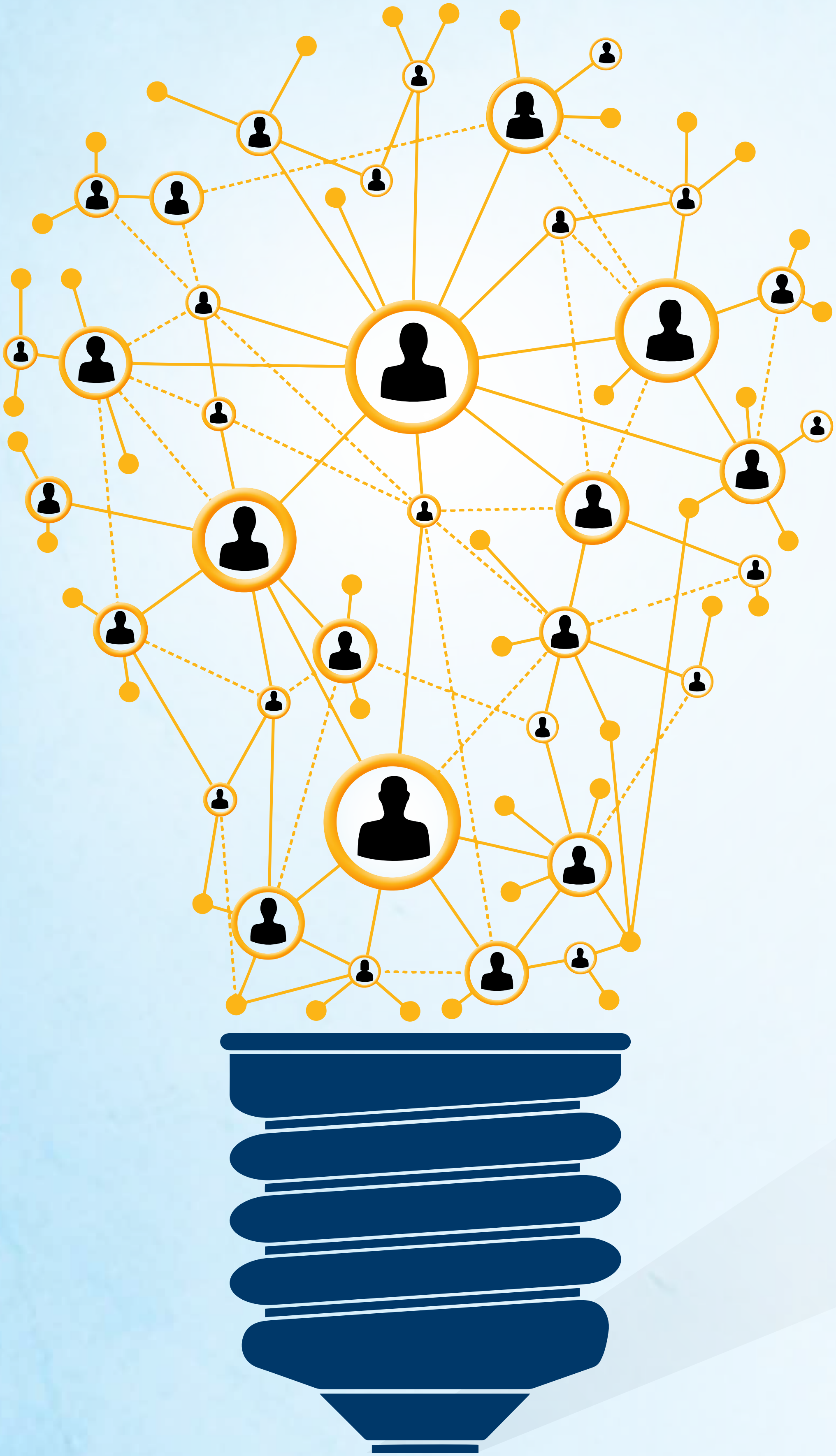

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Does Physician–Physician Communication Matter?

By Faisal Musa, MD

I've learned many lessons throughout fellowship. One of the most valuable has been recognizing the importance of regular collaboration among the members of a patient's care team. No matter how engrossed we become in our own work, teaming up with other healthcare professionals can help ensure an accurate diagnosis and improve quality of care.

In this article, I present the case of a woman with chronic pancytopenia and a "normal bone marrow biopsy" felt to be related to rheumatoid arthritis (RA) and immunosuppression. However, a visit to the pathology department two years after the initial diagnosis revealed something quite different. Cases such as this one serve as a reminder to us all about the importance of working together with others as part of a team-based approach.

Patient Case Explored

Our patient is a 62-year-old woman with a past medical history of RA, hypertension, and hypothyroidism. This patient was initially seen in August of 2013 by one of our oncologists. During the initial evaluation, it was noted that she was being treated for chronic immunosuppression for active RA with prednisone (10 mg daily) and etanercept. Her complete blood count showed leukopenia 1200/mcL, neutropenia with an absolute neutrophil count of 300/mcL, and thrombocytopenia 55,000/mcL.

The patient's physical examination revealed mild to moderate splenomegaly; a computed tomography scan of her chest, abdomen, and pelvis came back negative; and a bone marrow biopsy looked fairly normal except for increased cellularity relative to her age. Her hematologist assumed that she did not have a bone marrow disorder and attributed her pancytopenia to her autoimmune disease and immunosuppression. Based on his assessment, the hematologist began treating her with growth factors and transfused blood products on an as-needed basis.

SUGGESTED READING
for
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In November of 2015, she presented to the hospital with a gangrenous finger attributed to vasculitis. At this visit, she was found to have worsening pancytopenia with a white blood cell count of 600/mcL, hemoglobin of 10.7 g/dL, and platelets of 61,000/mcL.

My team and I began putting all of the pieces to this puzzle together. Based on her previous diagnosis of RA, splenomegaly, and pancytopenia, we began to strongly consider that she may have large granulocytic leukemia (LGL). LGL is a chronic type of leukemia that is more common in the western world and is characterized by pancytopenia and splenomegaly, and sometimes fever or weight loss. Notably, LGL is usually associated with autoimmune disease.

Based on my suspicion, I performed another bone marrow biopsy and specified an order to evaluate for LGL. To make sure that the pathologist was aware of my patient's health history, I went to the department and reviewed the case further. Sure enough, the pathology report revealed CD57$^+$CD8$^+$CD4$^-$ T cells consistent with LGL. The pathologist was very grateful that I had pursued the case so diligently, as she explained to me that LGL is commonly missed if there is no suspicion for it.

I notified the patient's oncologist right away and together we discussed this new diagnosis and the treatment options that would be most appropriate. We decided on a treatment plan that involved a long-term, slow tapering of the patient's steroid along with weekly methotrexate and growth factors, as needed.

Take-away

Cases such as this one highlight an important principle in oncology. We frequently talk about physician communication and tumor boards; yet often, we merely read the reports and notes when making clinical decisions. This case clearly demonstrates the importance of communication and working as a team to reach the right diagnosis.

Always remember that "If it looks like a duck and walks like a duck, it is a duck." Do not hesitate to discuss your thoughts with other providers. Our case was a slam dunk after finally detecting our patient's LGL. Initially, the diagnosis was missed because the potential for LGL was not considered and discussed with a pathologist. ●

ABOUT THE AUTHOR

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The Multidisciplinary Approach in Cancer Care

According to an analysis of 2012 data by the CDC, the proportion of patients who survive at least 5 years following a diagnosis of cancer is up to 66%.[1,2] Five-year survival rates for patients diagnosed with prostate, breast, lung, or colorectal cancers are shown in the **Figure**[1].

These improvements in cancer survival rates reflect advances in diagnosis and treatment (ie, drug therapies and surgical techniques).[3] Improvements may also reflect increases in patient knowledge and improvements in communication among all persons involved in patient care. Because patients with cancer interact with many healthcare professionals in several different settings during various stages of their care,[4] it is important that the insights of each healthcare professional be considered and understood by other care providers as well as by the patient.

Vaartio-Rajalin et al assessed the patient education process in oncology and suggested that collaboration and communication among healthcare teams in various settings regarding patient education can benefit the patient tremendously. The authors highlighted the benefits of educating the patient about their condition and options for treatment, and explained that patient knowledge can empower participation in the decision-making process and increase self-care ability.[4]

SUGGESTED READING *for*
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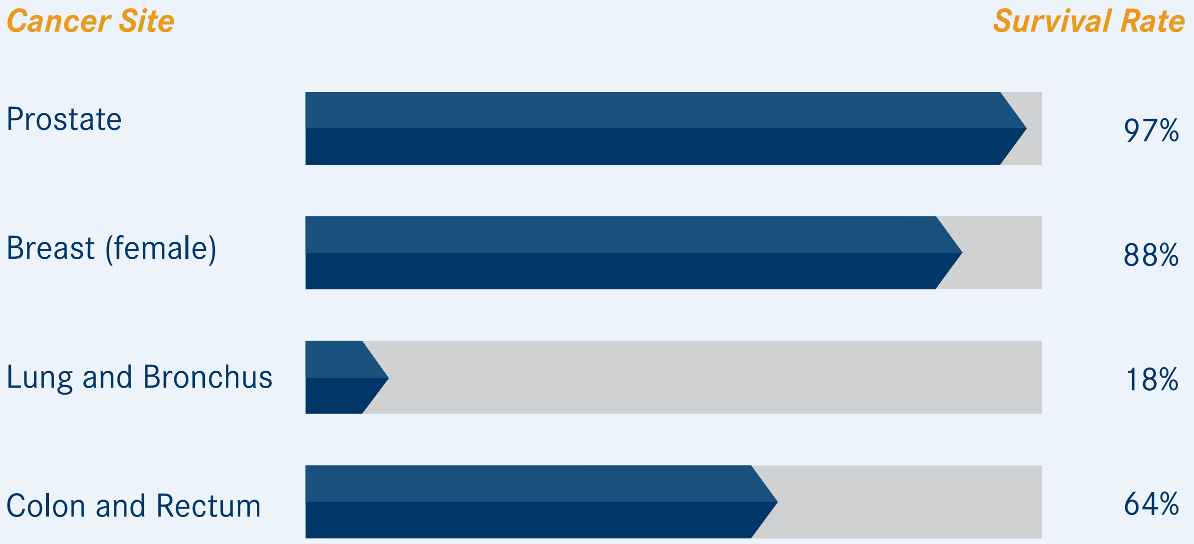
Figure. Five-Year Relative Survival Rates for Patients Diagnosed With Select Common Cancers[1]



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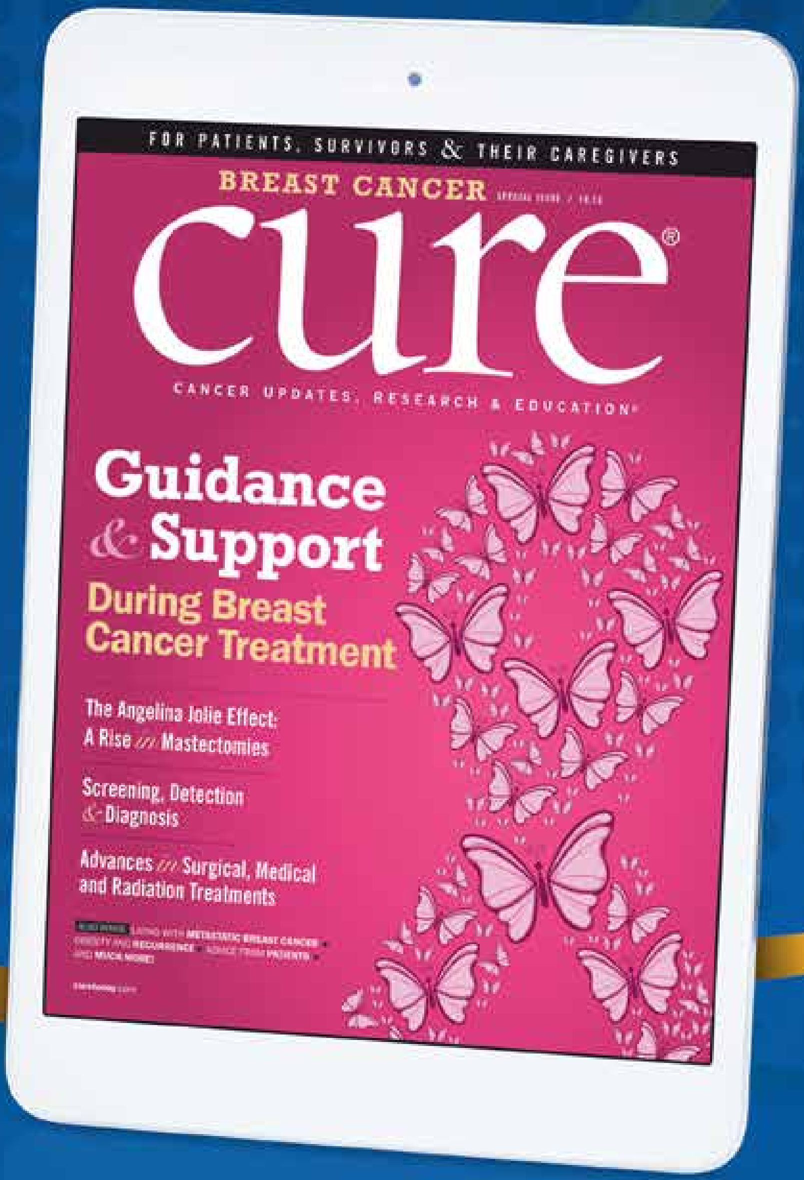

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We invite current fellows and oncology professionals to submit articles on a variety of topics, including, but not limited to:

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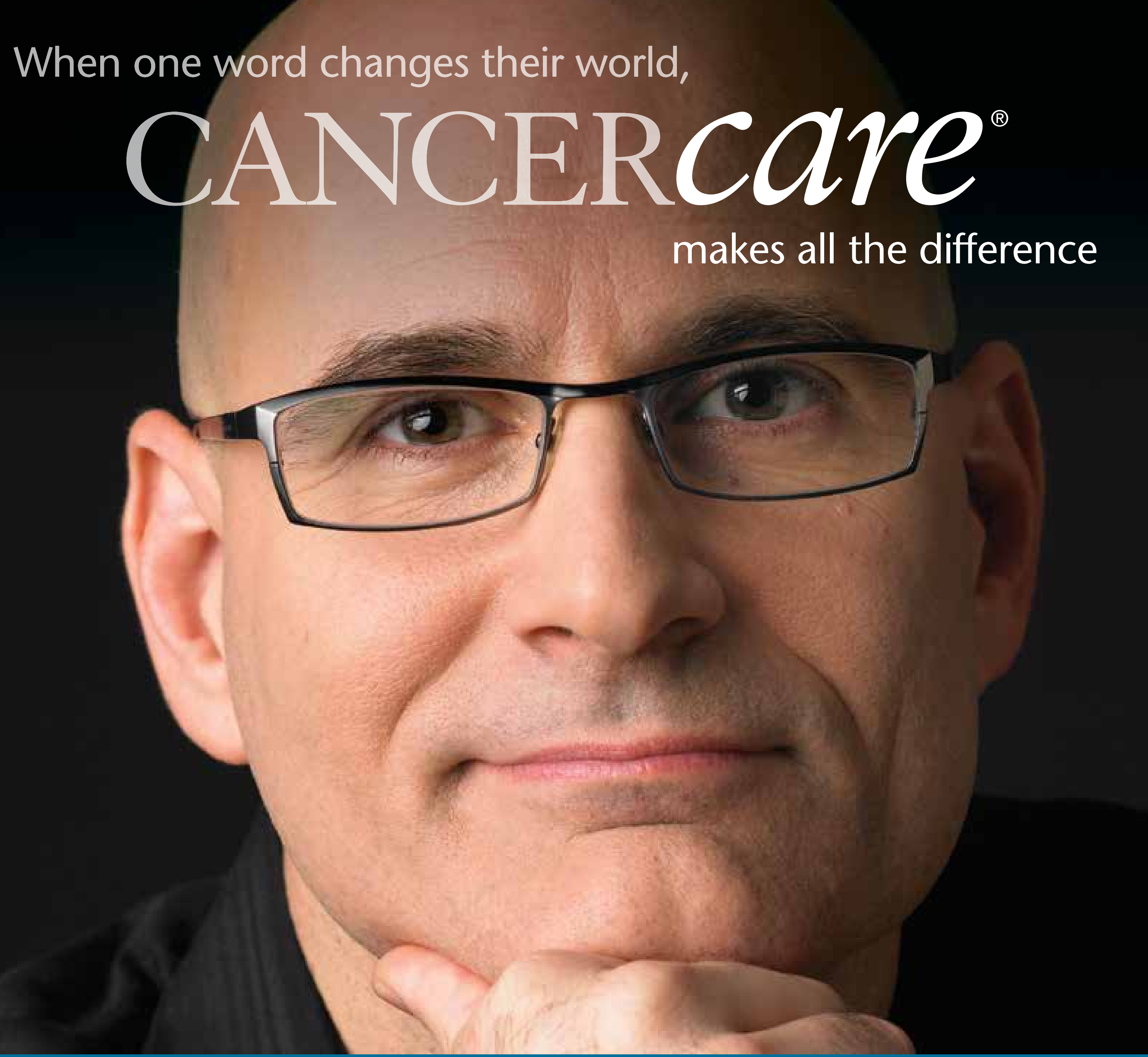
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