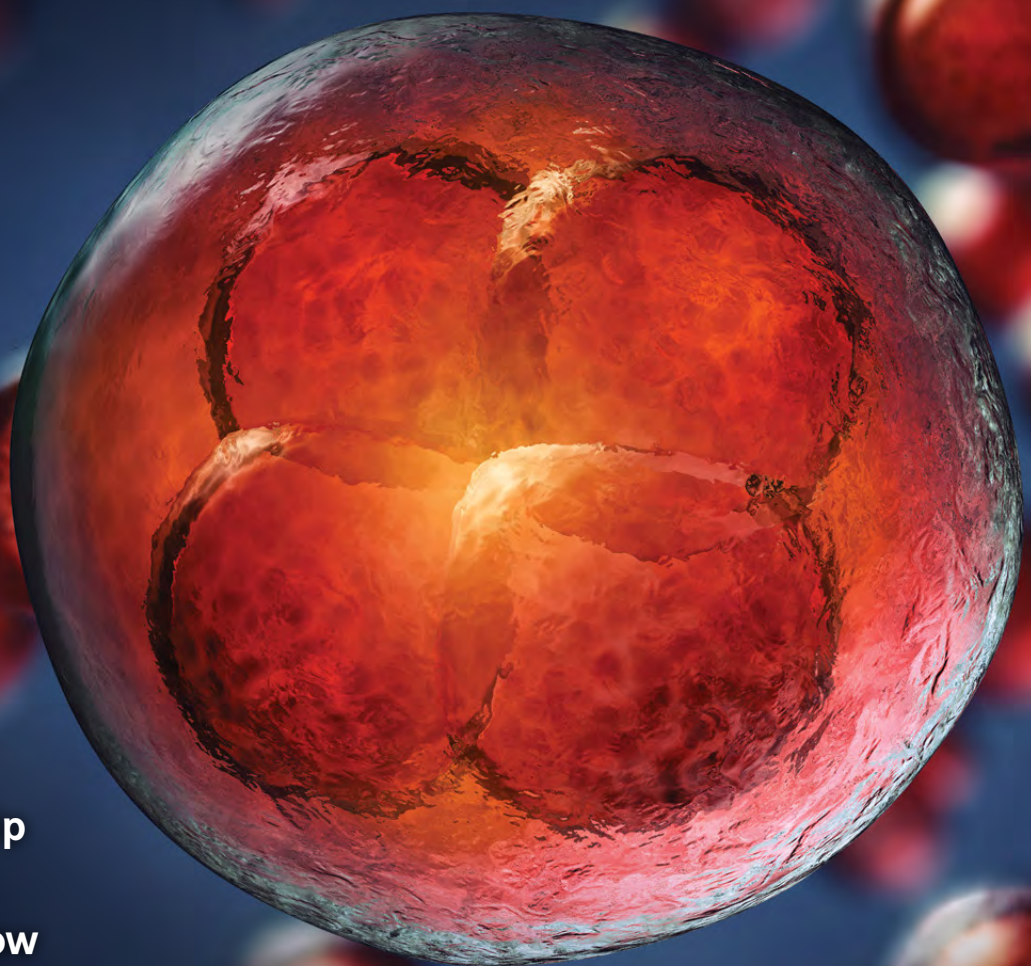
Volume 6 • Issue 1, 3.14

ONCOLOGY FELLOWS

Limited Availability of Non-Caucasian Stem Cell Donors *A Growing Problem?*



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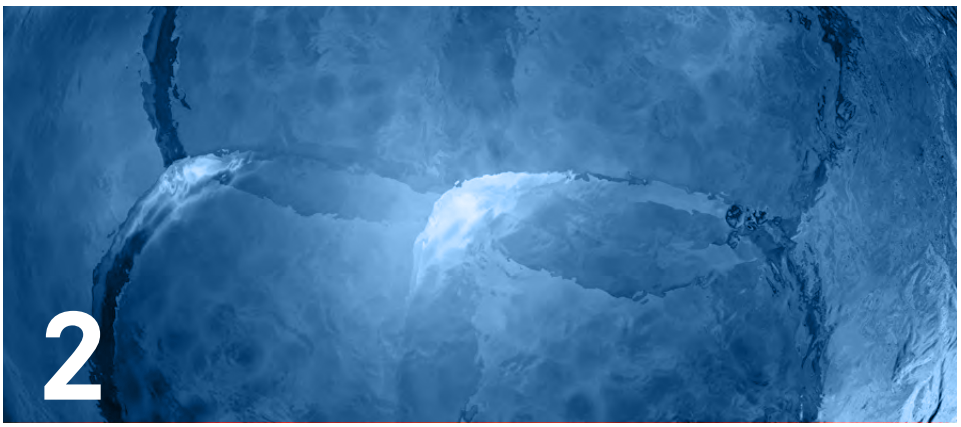

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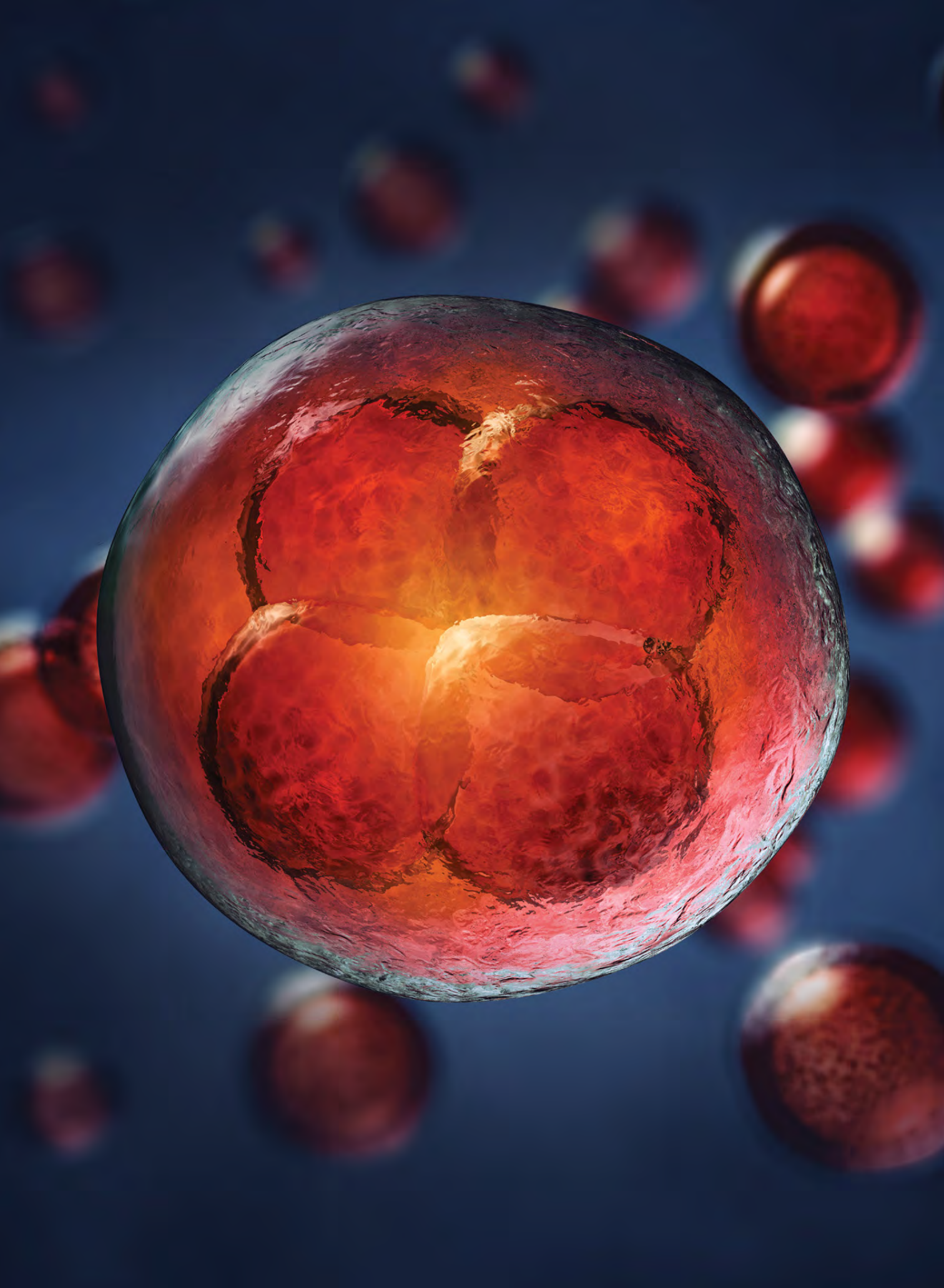

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Limited Availability of Non-Caucasian Stem Cell Donors *A Growing Problem?*

By Prerna Mewawalla, MD

- A Korean patient within my clinic was diagnosed with high-risk myelodysplastic syndrome. Stem cell transplant was the only chance for cure. Unfortunately, her sibling wasn't a match, and no matches were located in the American donor registry either. There were 2 matches found in the Asian donor registry, but both were unavailable.
- A recent media article described a woman of Indian descent with leukemia who could not find a donor for a life-saving bone marrow transplant.[1]

In the instance of the first patient, the search for a donor continues. In the instance of the second, the tragedy of this woman's death could have very well been averted.[1]

What are stem cell transplants and when are they used?

Hematopoietic stem cell transplantation (HSCT) is a procedure performed to help restore hematopoietic stem cells, cells that normally divide or mature into white or red blood cells, and platelets that have been destroyed by chemotherapy or radiation treatment. HSCT is performed most commonly for certain types of blood and bone marrow cancers. To restore the cells, the procedure includes the use of peripheral blood, bone marrow, or umbilical cord tissue.[2] For certain types of cancer, it is the only hope for cure. Unlike patients undergoing solid organ transplants, those undergoing HSCT have to be matched for DNA, specifically for human leukocyte antigen (HLA) types on chromosome 6.[3]

The relationship between ethnicity and available donor matches

Historically, it has been observed that patients are more likely to match their HLA type with another person within the same ethnic group. The number of HLA types seen among one ethnic group may vary significantly from that seen in another ethnic group. While there are no substantial studies to provide statistics, it is widely believed that Caucasians have fewer HLA types compared with other ethnicities. Therefore, Caucasians are more likely to locate a donor match than patients from other ethnicities (eg, Asians, Indians, Hispanics, African Americans). This gap is further exacerbated due to a low number of donors among non-Caucasian ethnicities.[4]

In the United States, the 2012 National Marrow Donor Program (NMDP) registry reported that 63% of adult donors were Caucasian, 27% were of a minority group, and 10% reported unknown race/ethnicity. The likelihood of finding a matched unrelated donor for a Caucasian is 93%, and a mere 66% to 82% among minorities, depending on the ethnicity. African Americans are the least likely to find a match.[5]

Prerna Mewawalla, MD, is a practicing fellow at Western Pennsylvania Allegheny Health System.

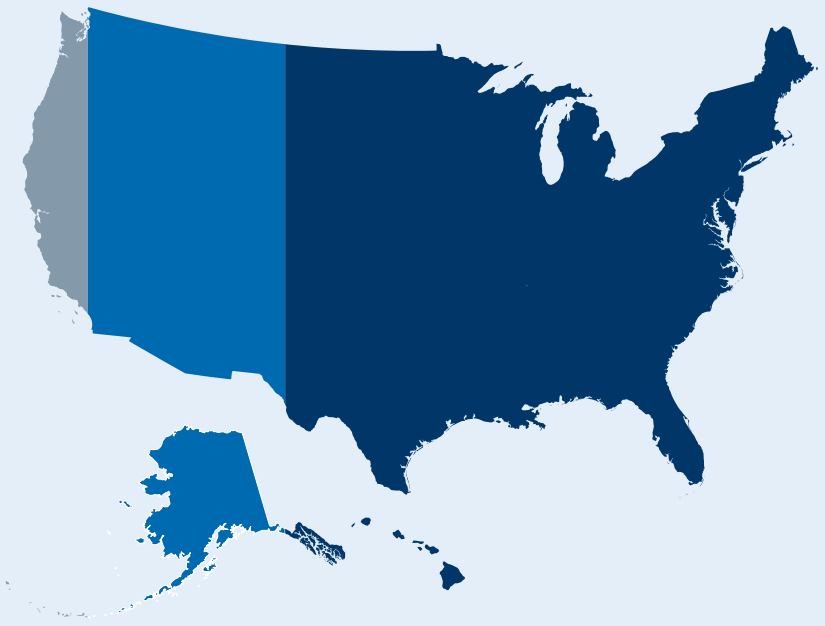
Adult Donors in the United States[5]

2012 National Marrow Donor Program Registry

63%
CAUCASIAN

27%
MINORITY GROUP

10%
UNKNOWN RACE/ETHNICITY



According to the National Cord Blood Program, African Americans make up only 12% of the US population. There would have to be 3 times more African Americans than Caucasians in a bone marrow donor registry to have the same likelihood of finding a match.[6]

Additionally, in India, where the current population is roughly 1.2 billion,[7] only about 45,000 people have signed up as bone marrow donors.[8] Comparative figures from the US NMDP indicate over 10 million donors. About 1 in 300 will be selected as a best possible donor.[9]

Other factors that limit transplants in minorities

In addition to the fact that minorities are at a disadvantage for stem cell transplants because there are fewer people to match with, other factors further limit the number of stem cell transplants in minority groups.

Religious beliefs, myths, and a lack of awareness often discourage people from donating.[10,11]

Among the many prevailing myths, there is the myth that stem cell donation is a painful procedure accompanied by several side effects. In many countries, blood donation is considered painful and/or harmful.[10,11] Based on my experience, patients do not like the idea of invasive needles being pushed into their bone for bone marrow. However, they are not aware that stem cells can also be donated by peripheral blood, just as in platelet donation.

Additionally, many cultures throughout the world do not emphasize the importance of public charity. Such acts of service are typically saved for family and friends.[10]

Cord blood transplants expand among minority groups

Although there are a limited number of stem cell transplants among minority groups, there has been an increase in the proportion of cord blood transplants. For example, the NMDP recently reported that 44% of transplants in minority groups were cord blood transplants.[5]

During a cord blood transplant procedure, a partial match is acceptable. However, cord blood transplants are more complicated, as the number of cells is much lower. A cord blood transplant also has a longer lead time for engraftment, which may result in an increased incidence of infections and complications.[12]

Addressing unmet needs

To address the challenge of the limited availability of stem cell donors in non-Caucasians, it is vital that we increase awareness through more campaigns that are

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targeted specifically to minorities. These campaigns should be publicized in areas where specific minority groups dwell.

At an international level, the myths regarding stem cell transplantation need to be addressed by informing the general public that donations can be collected through peripheral blood, just as in platelet donation, and not through the bone. An increase in the absolute number of patients who register worldwide increases the chance of minority patients in the United States finding a match. Even 1 extra life saved can make these actions, although challenging, worthwhile. ■

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How to Plan for Your Conference Trip

By Amer Zeidan, MD

I still remember my first time attending the annual American Society of Hematology (ASH) meeting in 2008. I remember feeling completely overwhelmed as I stepped into the enormous convention center, and I remember feeling embarrassingly clueless about which sessions to attend and how to find the rooms where the sessions were being held.

My prior meeting experience was limited to small, one-room conferences with 100 attendants at the most. This left me unprepared and unsuspecting of how to arrange for these larger meetings. The memories of me getting lost in the hallways during that 2008 meeting ran through my mind as I attended my 6th consecutive ASH meeting this past December in New Orleans.

I see "fellow" fellows share similar experiences while attending major conferences such as the ASH or the American Society of Clinical Oncology (ASCO) annual meetings, where tens of thousands of participants converge. For this reason, I felt that I should share what I have learned about optimizing your experience and making the best use of your time during these meetings.

Plan accommodations early and with colleagues

Once you have decided to attend a meeting, book your hotel as early as possible. Try to book your hotel as soon as the registration opens, as these hotels fill up very quickly. The longer you wait, the higher the likelihood that you will end up in a hotel that is either more expensive or further from the convention center. The same goes for booking your flight. Remember that tens of thousands of people arrive, stay, and leave from where you are traveling at the same time.

Additionally, ask your colleagues if they are attending the same conference. Sharing a room with a colleague or a friend can be a great way to save money because hotel rooms tend to be very expensive during a major event. The registration websites for the ASH and ASCO conferences tend to have rooms reserved special for conference participants. Booking through these sites can help you receive a more favorable rate; but remember that these rooms go quickly once registration opens.

Think of the sessions you want to attend before arriving at the convention center

Look for a list of the activities, lectures, seminars, and poster-viewing sessions that accompany the registration materials that are mailed to you. A calendar of events should also be listed on a conference website. There are also smartphone apps available to facilitate planning a personal itinerary.

Become familiar with the convention center and locations of presentations

During your first day at the convention center, try to orient yourself to the layout of the building. Convention centers

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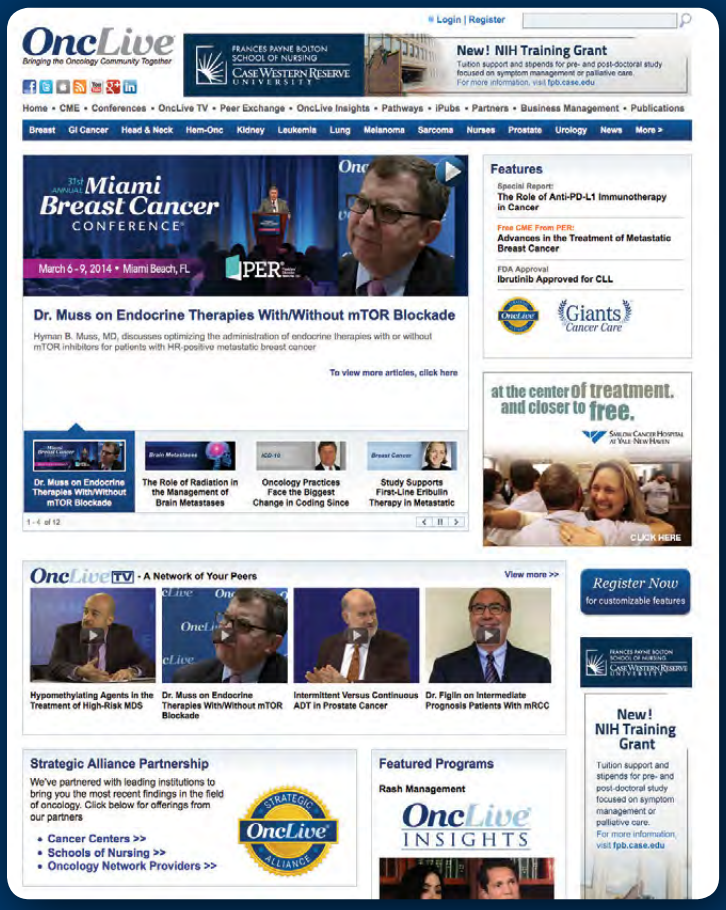

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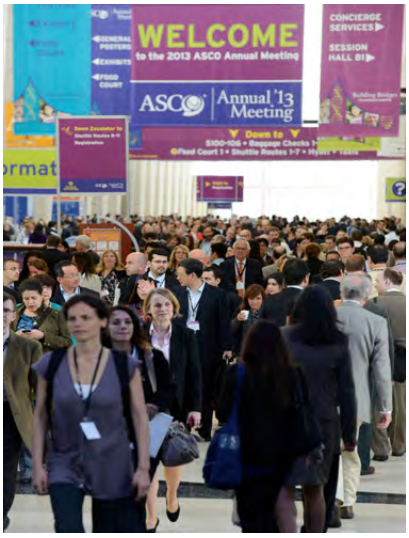
tend to be very large and you can get lost easily. Note that some presentations and lecture sessions are held in the hotels that surround a convention center. I suggest researching the location of the hotel in advance if a session of interest to you is being held there. I have missed several sessions in the past that I really wanted to attend due to not studying the map of the convention center and surrounding hotels beforehand and have gotten lost along the way.



Allow for walking time between sessions

Remember to allow time to walk to the activities that you want to attend. There are several simultaneous sessions and lectures and others that are separated by only a few minutes of time. Some are located very far from each other. I have missed the first 10 or 15 minutes of several sessions that I really wanted to attend in the past because I failed to realize how far the rooms were from my current location.

Take advantage of special conference services, particularly those dedicated to fellows

Both ASH and ASCO have conference shuttle buses that frequently travel for free between certain hotels and the conference center. Using these buses can save you the cost of a taxi ride or car rental fee, and can spare you the hassle of parking. It also allows you the chance to socialize with fellow participants while traveling. You should inquire at your hotel, or during registration, about travel routes and shuttle times.

Utilize the special services that both ASH and ASCO offer to fellows and members in training. Both conferences offer special sessions dedicated to fellows that focus on career planning (academic, community, industry, and regulatory settings), discussions of various research pathways (clinical, translational, and basic), explore available funding opportunities and mechanisms, and discuss other subjects of interest to fellows. ASH usually offers a half-day educational session during the first day of the meeting that is dedicated to fellows. This meeting is very useful, but you need to plan to arrive early if attending it.

Additionally, both conferences have a "lounge area" dedicated to fellows and members in training. These lounge areas offer snacks and tea or coffee for free, have useful flyers about fellowship opportunities, offer a quiet setting if you need to prepare for your presentation or send an e-mail, and allow for the opportunity to meet fellows from other states and countries. Remember that these fellows will be your colleagues and possibly research collaborators in the future. You are likely to run into them in the future, so you should take the chance to socialize and network with them.

Submit an abstract

Submitting an abstract to ASH or ASCO meetings is a very good idea. If your abstract is accepted it will give you the chance to present your research in a very prestigious setting, allow you the chance to meet leaders in your field of research, offer you the chance to improve your presentation skills, and allow you an opportunity to win an "abstract" or "travel" award that can fit very nicely on your CV and offset some of the costs of your trip.

Discover fun outside of the conference

Finally, it is not all about science and medicine. Make sure to leave some time in your itinerary to discover the city where the conference is held. Check out a museum or visit a unique restaurant. Because we get very busy during fellowship, going out for dinner with friends from your hospital during these conferences can be a good chance to reconnect and catch up, and can help you connect with people in your field. ■

Amer Zeidan, MD, is a hematology/oncology fellow at the Sidney Kimmel Comprehensive Cancer Center at The Johns Hopkins Hospital in Baltimore, MD.

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Life as a First-Year Fellow

Jodie Barr, DO, is currently a fellow at University of Kansas Medical Center.

Jodie Barr with family.

I can remember waiting anxiously on match day; checking the computer every few seconds to see if I matched. The results were in… I got in! Feelings of excitement and accomplishment overwhelmed me. I received hugs from my program director and faculty. After 3 years of residency, and another as chief resident, I was happy to have made everyone proud.

That night, after the excitement waned, a feeling of anxiety set in. Thoughts of moving to a new city 9 hours away from home, along with the fact that I was pregnant with my first child, were a little overwhelming.

Things became very busy and fast paced. I tried to do the best job I could as a chief while I began looking for a place to live and preparing for my first day of fellowship.

Before I knew it, all of our belongings were loaded into a truck and my new endeavor was beginning, ready or not. I felt a multitude of emotions as my husband and I pulled away from our home with a 2-month-old child, our Boston terrier, and Grandma and Grandpa, who thankfully helped us move. I felt torn as I considered leaving with the first grandchild in my family in 19 years and pursuing my dream that I had worked so hard for. Thinking, though, of the incredible opportunity that I would pursue kept me going through that long drive.

During my first day of fellowship, I thought that I was having palpitations as I walked into the cancer center. So many things were going through my mind.

"Wow this is so cool that I'm here! What will my colleagues be like? Will I be able to live up to the expectations set by the program? I already miss my little one!"

As I walked into the conference room, I was welcomed by my colleagues and program director. This eased my fears a bit. Orientation went smoothly and I thought to myself, "OK, I can do this. No problem." But then, the palpitations came back. I was told by the chief fellow that I had to go see consults on my first day, and then I had to attend my first continuity clinic. My pager started to beep! Three new consults. After a deep breath I thought, "Well, here we go!" I worked my way through the consults as best as I could and then headed to clinic.

I was told by the chief fellow that I had to go see consults on my first day, and then I had to attend my first continuity clinic. My pager started to beep! Three new consults. After a deep breath I thought, "Well, here we go!"

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My first patient in clinic was an incredible gentleman with extensive-stage small cell lung cancer. Once again, I felt those palpitations as I walked into the exam room. I thought, "Please don't ask me anything! Or maybe just ask me something internal medicine–related…I can answer those questions." After speaking with my patient and meeting with his incredible family, I felt a comfort knowing that I had made the right decision.

So, I made it through the first week. Then through the first 2 months. After this came the call for a bone marrow biopsy. I had practiced a few as a resident, but was definitely not confident in my skills. Again came those palpitations.

I was very fortunate as the gentleman that I was to do the biopsy on had had several prior. He practically talked me through the procedure. Meeting this amazing gentleman reminded me again that I was in the right field.

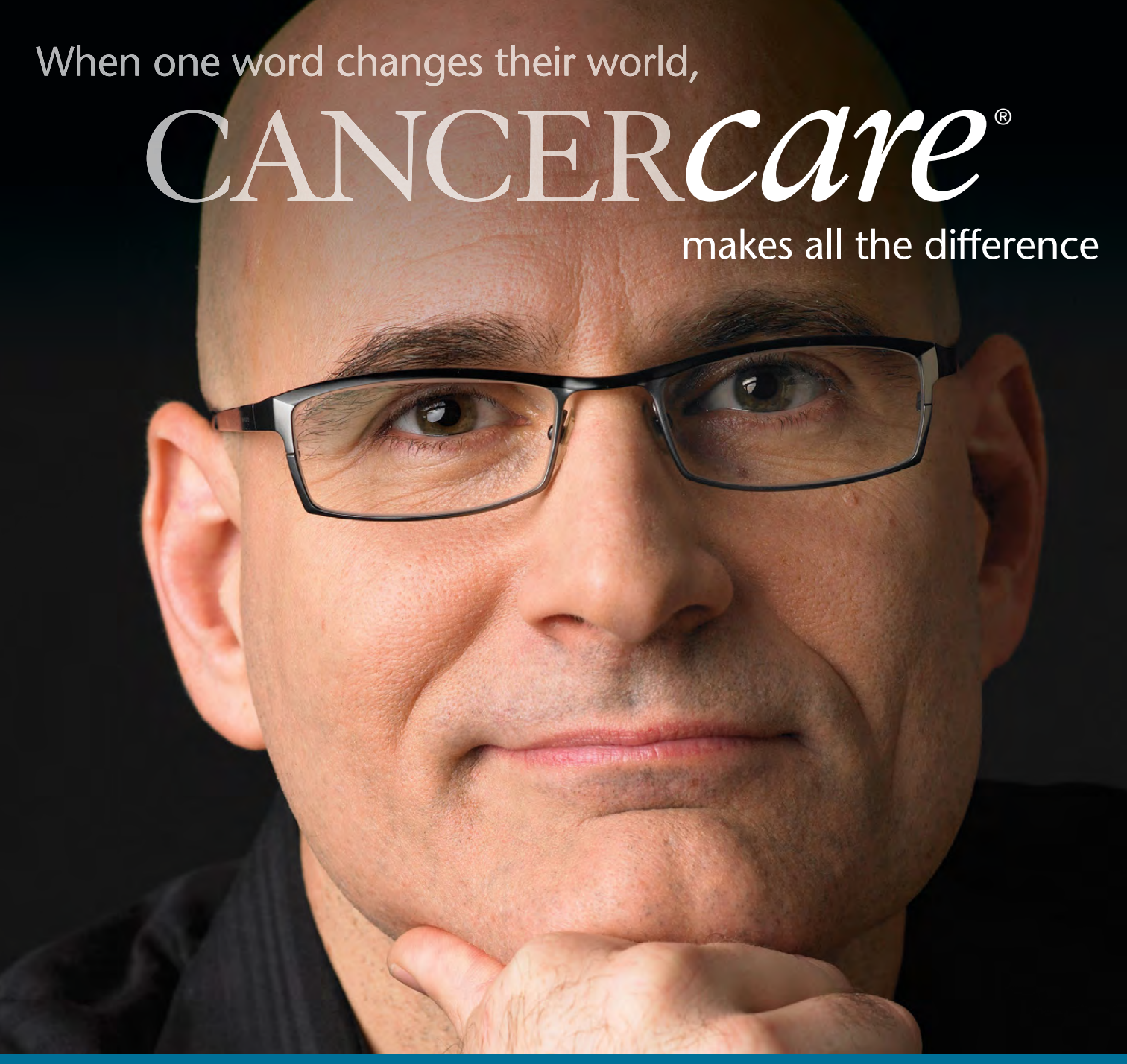
After 3 years of internal medicine residency I thought I was a pro. Well, I was wrong. Call-in fellowship was much different. Taking calls from home was a whole new ball game.

I was finally in the groove of things when my first call came along. I thought, "No problem, I can handle this." After 3 years of internal medicine residency I thought I was a pro. Well, I was wrong. Call-in fellowship was much different. Taking calls from home was a whole new ball game. I felt scared out of my wits, especially receiving calls from patients that were incredibly sick. Each time, I hoped I had made the best decision for the patient. I probably drove my fellow colleagues and attendings crazy with questions. Although I have slowly gained confidence in my decisions, I admit that I still need some help here and there.

After all of these firsts, I have learned a few things that have helped me through each situation. Here are a few tips for getting through your first 6 months of fellowship:

1. Take a deep breath before you pass out. Everything will be just fine!
2. Ask questions. No questions are stupid! It's better to ask than to have a bad patient outcome.
3. Read as much as possible, even though this is difficult as a first-year. Try to set aside at least 20 minutes a night to read about a patient you saw that day.
4. Learn the basics and the studies that led to them, and then build upon those with new studies.
5. Take time for your family. Set aside all the things that you have to do for those important moments, because you are where you are thanks to their support.
6. Embrace your patients. You will learn more from them than any books you can read.
7. Support your colleagues. They will have your back when you need them most.
8. Don't be discouraged. You will face more challenges than you have ever dealt with before. Face them head on with confidence.
9. Set time aside to decompress, especially on the day when you lose your first patient to cancer.
10. Finally, enjoy the journey. Soak up as much as you can in your 3 years and go forward in your career with a fierce passion and love.

All in all, my first 6 months of fellowship have been a whirlwind of emotions. From learning how to balance work and family, especially with a new little girl—to learning what a specific translocation for acute myeloid leukemia means for prognosis—to supporting my patients through the most difficult time they have ever faced—it has been an incredible journey thus far. I wouldn't have asked for any career path other than this! ■



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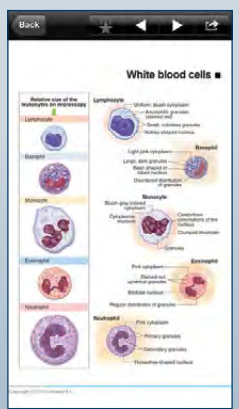

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The Cancer Drug Dictionary features over 1200 technical definitions and synonyms, as published by the National Cancer Institute, about the agents that are currently being used for the treatment of patients with cancer or cancer-related conditions. This app is suggested for physicians as a quick reference tool.
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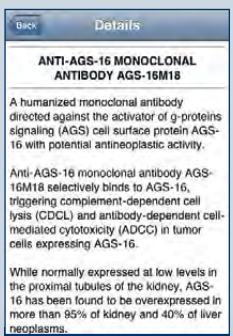


Comorbidities and Cancer

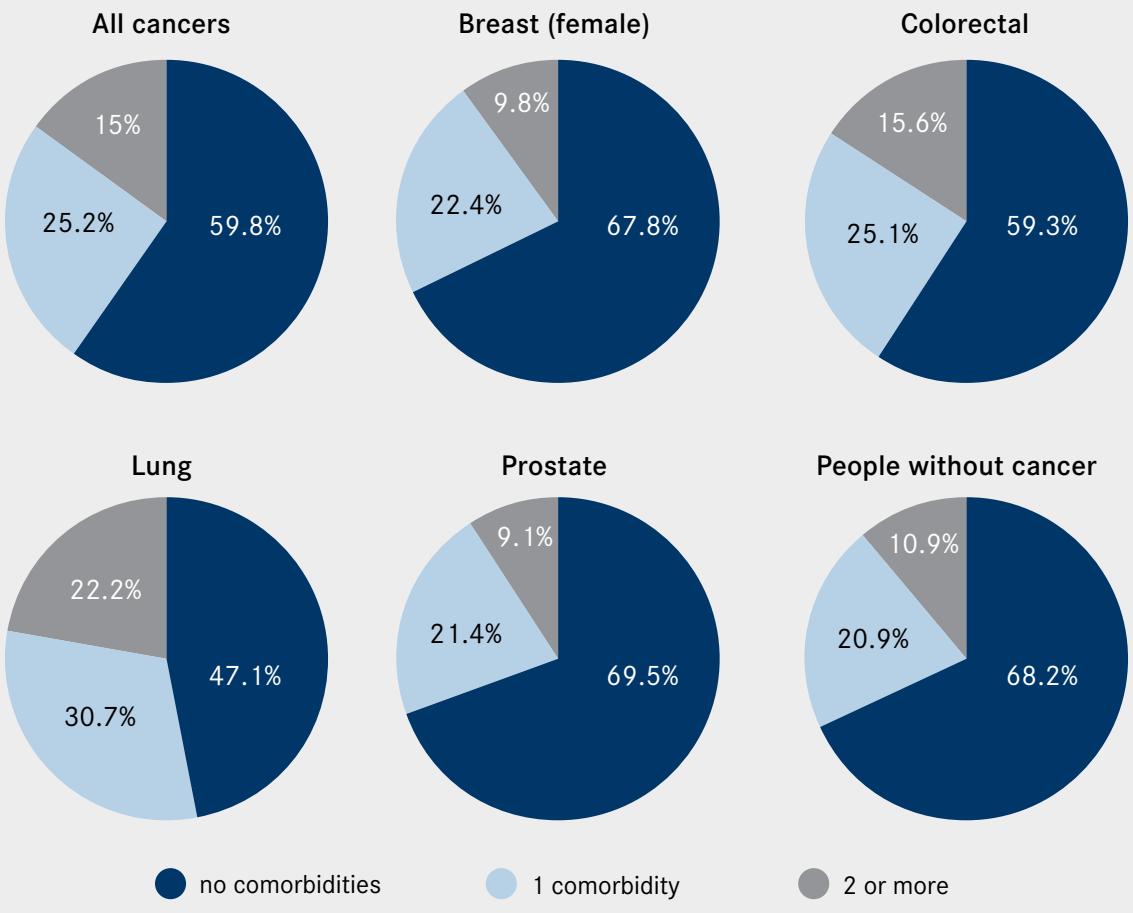
Incorporating comorbidity measures into treatment planning may lead to better decisions about the potential risks and benefits of treatment options for patients with cancer.

A recent report by Edwards et al revealed that 40% of patients with lung, colorectal, breast, or prostate cancer 66 years or older had ≥1 comorbidity. The 16 chronic conditions analyzed in this report were acute myocardial infarction, acquired immunodeficiency syndrome, cerebrovascular disease, chronic renal failure, cirrhosis/chronic hepatitis, congestive heart failure, chronic obstructive pulmonary disease, dementia, diabetes, diabetes with sequelae, history of myocardial infarction, liver disease, paralysis, rheumatologic disease, ulcer disease, and vascular disease.[1,2]

Although data demonstrate that cancer death rates are dropping in the United States, the prevalence of comorbidities greatly affects a cancer patient's chances for overall survival.[1,2]

For this reason, healthcare professionals should consider incorporating measures of comorbidity into their decision-making process. Understanding how multiple diseases work together and affect a cancer patient's outcomes is crucial during decisions about therapy.[1,2]

Prevalence of selected comorbidities for those 66 years and older, 1992 to 2005[2]



Source: National Cancer Institute

References

1. Edwards BK, Noone AM, Mariotto AB, et al. Annual Report to the Nation on the status of cancer, 1975-2010, featuring prevalence of comorbidity and impact on survival among persons with lung, colorectal, breast, or prostate cancer [published online December 16, 2013]. *Cancer*.
2. Lung cancer death rates continue to fall, helping drive decrease in overall cancer death rates; Annual Report to the Nation includes special feature highlighting the contribution of other diseases on survival of patients. National Cancer Institute website. http://www.cancer.gov/newscenter/newsfromnci/2013/ReportNationDec2013Release. Published December 16, 2013. Accessed January 22, 2014.

Conference Center

2014 Oncology & Hematology Meetings

March 6-9
31st Annual Miami Breast Cancer Conference
Miami Beach, FL
http://bit.ly/1bdXoB0

March 13-15
NCCN 19th Annual Conference: Advancing the Standard of Cancer Care
Hollywood, FL
http://bit.ly/ezsktT

March 15
7th Annual Interdisciplinary Prostate Cancer Congress
New York, NY
http://bit.ly/1iPWZcf

March 22-25
SGO 45th Annual Meeting on Women's Cancer
Tampa, FL
http://bit.ly/1dXgkJ8

April 5-9
AACR Annual Meeting 2014
San Diego, CA
http://bit.ly/1dbwtrl

May 7-9
Accelerating Anticancer Agent Development and Validation Workshop
Bethesda, MD
http://bit.ly/1er60XZ

May 30-June 3
2014 ASCO Annual Meeting
Chicago, IL
http://bit.ly/1lQaPwB

July 17-19
13th Annual International Congress on the Future of Breast Cancer
Huntington Beach, CA
http://bit.ly/Kyuky3

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Call for Papers

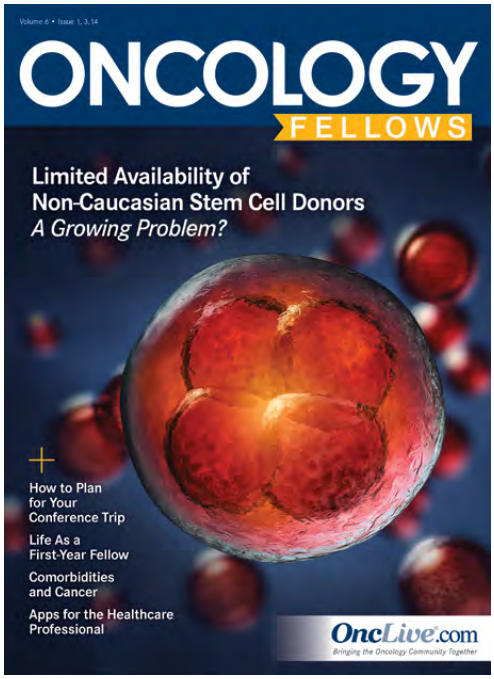
We welcome submissions to ***Oncology Fellows***, a publication that speaks directly to the issues that matter most to hematology/oncology fellows at all stages of training. ***Oncology Fellows*** aims to provide timely and practical information that is geared toward fellows from a professional and lifestyle 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 posttraining.

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



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.

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1. Overall, how would you rate the information and resources found in *Oncology Fellows*? (1 = not useful at all, 5 = very useful)

❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5

2. Which topics would you most like to see addressed in future issues?

❑ Personal finance and money management
❑ New developments in medical technology
❑ Subspecialty-specific clinical and research updates
❑ Career advice
❑ Other (please specify) _____

3. In my opinion, the number 1 topic that oncology fellows need more information on is: _____

_____

4. How important do you think it will be to effectively use information technology in your clinical career, if applicable? (1 = not important at all, 5 = very important)

❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5

5. How often do you go online to research clinical information?

❑ 5 or more times a day
❑ 2-4 times a day
❑ Once a day
❑ A few times each week
❑ Once a week
❑ Hardly ever

❑ Please contact me—I am interested in contributing an article for an upcoming issue.

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