RadioMD Interview Transcript: Robert Roses, MD

Melanie Cole (Host): Welcome to this podcast series with the experts at Penn Medicine. I'm Melanie Cole and today, we're discussing Penn Medicine's gastric cancer and surgery program. Joining me is Dr. Robert Roses. He's an Associate Professor of Surgery at the Hospital of the University of Pennsylvania. Dr. Roses, it's such a pleasure to have you join us today. Please start by telling us a little bit about the prevalence of gastric cancers and what are you seeing in the trends?

Robert Roses MD (Guest): A disease, that at least in the United States of intermediate prevalence. So, there are about 25,000 cases a year of gastric cancer and as points of reference, colorectal cancer is upwards of 140,000 cases per year, breast cancer more than 250,000 cases; so much less common disease in the United States. But it bear mention that worldwide gastric cancer is a major cause of cancer morbidity and mortality. So, it's the fourth most common cancer in the world and the second major cause of cancer related death in the world. So, common disease overall and in the United States a little less so, but because we have gained some momentum taking care of this disease, we see a lot of patients at Penn with this disease.

Host: Well then tell us about the Penn Medicine's Gastric Cancer and Surgery Program. Why did you see a need for this type of program and what conditions do you treat there?

Dr. Roses: in the United States this isn't a very common disease and as a downstream consequence of that I think a lot of hospitals' programs see a couple of cases per year and with that comes a lot of variation in approach. And so what is the mission? The mission is to zero in on elements of care or treatment that might have a bigger impact on outcome and take a more consistent approach and when we started seeing more patients with this disease and focusing in on some of those elements; we were able to come up with a more consistent approach that we could apply and of course there are always nuances and we deviate from that and their options but we're not reinventing the process every time. We have a couple of paradigms that we can follow for patients.

Host: Well then Dr. Roses for other providers, what types of services do you offer. Tell us a little bit about the physician services.

Dr. Roses: So, there are two big categories. As I said, there are nuances but the two big categories, there are patients who are diagnosed with a so-called early stage stomach cancer. It's a small localized tumor that doesn't penetrate too deeply into the stomach wall and for those patients in general; the mainstay of treatment is surgical. There are a lot of patients however, we present with more advanced disease either locally advanced disease, they've got a bulkier tumor or a more diffuse tumor, a tumor that penetrates more deeply into the gastric wall, has access to the lymphatics and might spread to nearby lymph nodes, might spread to more distant sites and for those patients, surgery is often not sufficient and the disease is often treated with a combination of surgery and often chemotherapy. And if a patient presents with those features; they'll see me, they'll see one of our medical oncologists. They may see a radiation oncologist, depending on the distribution of disease and we work collaboratively. We work together.

Host: Well what's exciting in your field right now Dr. Roses? Tell us about some of the latest and most exciting advances in gastric cancers today.

Dr. Roses: So, I think the biggest thing that has had the largest immediate impact on treatment is an advance in the medical treatment of stomach cancers. So, in the past, there had been evidence for a couple of different approaches for so-called locally advanced gastric cancer. One approach would be surgery first and then chemotherapy and radiation afterwards. Another approach would be chemotherapy first and then surgery. And that later approach there was some evidence behind it with a different chemotherapy regimen but over the course of the last really two years; data emerged that supported a different regimen what they call FLA chemotherapy which seems to have a bigger impact on outcome and so, that data that evidence has provided momentum for more patients getting a chemotherapy first approach and then surgery. And we, like many other programs have been encouraged by our experience with that approach.

Host: What about things like advances in radiologic imaging? Have they augmented your diagnostic and therapeutic capabilities for surgery, during surgery and before and even after?

Dr. Roses: So, maybe I can reframe the question slightly. What imaging do patients get? So, patients more often than not when patients are diagnosed with stomach cancer; they are diagnosed on the basis of an endoscopy. The GI doctor, the gastroenterologist does an endoscopy, he see a mass, does a biopsy, the biopsy shows a malignant tumor cancer of the stomach. And the frequently utilized modalities, imaging modalities are repeat endoscopy with endoscopic ultrasound which is most helpful for defining how big the tumor is and how deep it penetrates into the stomach wall.

Cross sectional imaging like the conventional CT scan which provides some information about the local tumor but might identify nearby or distant lymph nodes or other sites of disease. PET scan in some cases can provide additional information then often, particularly for patients with local advanced disease, a bigger tumor or a tumor that seems to have spread to nearby lymph nodes; I'll perform a diagnostic laparoscopy, a simple outpatient surgical procedure to rule out the presence of more distant spread of disease because stomach cancer has a proclivity to spread to the surfaces of the abdominal cavity.

If I understand your question, what you are getting at, is there anything we can do in the operating room to refine our surgical approach and we have explored that in collaboration with an intraoperative imaging program at Penn looking at the use of intraoperative infrared imaging; can it help better define what the margin of resection should be in the operating room or pick up on the presence of occult metastatic disease in the operating room. And we've explored that. It's really in its infancy as a clinical tool.

Host: Well thank you for that answer. And you mentioned before, the multidisciplinary approach and the type of providers. Who else is involved in the program? When a patient comes to you and they have seen you and other providers; who is following them? Who is helping them with diet, and all of the comorbid situations that might go along with gastric cancers?

Dr. Roses: Surgery, frequently medical oncology, sometimes our clinical nutrition group. We've also developed a patient support group and a nurse practitioner that I work closely

with Katelyn Perch has really organized this great structure and patients who either are going to undergo gastrectomy or recovering from gastrectomy, come together and teach each other. And they are really the experts on recovery from gastrectomy, the patients who have already been through this. And that's been a really productive part of the process and it's become very well entrenched, at least for my patients to get involved with that group. And so, it's a couple of clinicians with different specialties and then nurse practitioners, clinical nutritionists, also other patients.

Host: So, tell us about your care model. How is it as you are seeing it, improving the way patients receive their care and even outcomes? What makes it unique and what have you been seeing?

Dr. Roses: Yeah, I think that we've evolved toward a much more coherent unified collaborative multidisciplinary process for patients. We have an approach in terms of every element of the process from staging. What studies do we need, which studies can we disband with? Maybe we can avoid unnecessary studies. But what are the critical studies that are going to dictate what the first best step is and as I mentioned, in general, it's either going to be upfront surgery for early stage disease, frequently upfront chemotherapy for locally advanced disease; but there are some variations on that depending on how patients present. And getting people the right information early, eliminating unnecessary workup that isn't helpful; I think has made a big impact and we've seen I think very good clinical outcomes, and I think patients have had a very good experience.

And then experience begets more experience. So, because patients have done well, we're seeing more patients with this disease and we've taken a very consistent surgical approach and really tried to minimize some of the pitfalls that come with these big operations that are a challenge for patients. But we're really tried to rachet down on some of the issues that people trip up on and try to ensure a really good outcome for the greatest proportion of patients. And I've been very gratified. It think we've been able to do that.

Host: Dr. Roses, as we wrap up, when do you feel for other providers that it's very important for them to refer to the specialists at Penn Medicine and speak a little bit about the surgical expertise, any clinical trials or research you would like to mention. Wrap it up for us.

Dr. Roses: I think what I would say is this is a challenging disease. People come in frequently with symptomatic tumors or if they are not symptomatic; it's a challenging spectrum of disease and from a surgical standpoint; the operations we do for this disease have longstanding ramifications for patients, how they live day to day. I think the view of gastric cancer as a surgical disease, it's going to be a simple operation, recovery and patients are cured doesn't account for a lot of that complexity and in my view, this disease requires a committed multidisciplinary team, good preoperative education, good postoperative education and follow up from a multidisciplinary group to ensure that people do well over a long period of time. It's not nearly as favorable to take care of an occasional patient, do an operation and refer to a medical oncologist. You want a committed group of people who really care about the disease and who are going to weight the most contemporary evidence and choose the best first step and second step and third step.

And I think that's what we're trying to do and hopefully, we've been successful in doing it. My

view is that we have. And so, we're very committed to doing this and to providing really good care and that's the message I'd want to convey to other physicians and to patients.

Host: Thank you so much Dr. Roses, for joining us today and sharing your expertise and telling us about the Penn Medicine's Gastric Cancer and Surgery Program. That concludes this episode from the experts at Penn Medicine. To refer your patient to Dr. Roses, a specialist at Penn Medicine; please visit our website at www.pennmedicine.org/refer or call 877-937-PENN. Please remember to subscribe, rate and review this podcast and all the other Penn Medicine podcasts. I'm Melanie Cole.