So Eric, you and I have known each other for a while, but I was hoping that you could tell everybody a little bit more about yourself and how it is that you became a breast medical oncologist.

Oh gosh, it was a long time ago that I decided to be a breast cancer doctor. As a medical student, I was actually interested in cancer and did my thesis in medical school on a breast cancer subject, but I didn’t necessarily think I would become a breast cancer doctor and then for a while
I actually thought about being a psychiatrist, but decided that wasn’t probably quite what I wanted to do. And as a resident I just found cancer to be the most interesting area that I dealt with. And so I was actually here at Yale as a resident. And then I went to Duke as a fellow. And in truth I was interested in breast cancer, but it was also an opportunity because the job opened up as someone to really take care of most patients with breast cancer. At Duke in those days, it was a time when we knew much less about breast cancer, and when a very young doctor could suddenly become the breast cancer expert, the breast cancer expert, which is certainly not the way it would be today. It’s been an incredible journey. And it’s been a really perfect profession for me. So tell us a little bit more about why you say that.
think about the perfect profession
they would think about something that
is highly lucrative that does not
require a tremendous amount of effort.
And where everybody around you is
happy and doing well, but when we think
about cancer doctors in general,
these are people who work incredibly hard.
They have very long hours.
They may not be remunerated
as well as one would think,
and the people around them and
the patients that they have,
although sometimes do well, sometimes don’t.
So how do you square that?
I’ll pick that apart a little bit and
answer it in a number of ways.
So first I have to say I’ve always
been paid more than enough to meet the
needs that I have and my family has,
so that’s been fine. In terms of
wanting a job where I might not have
to work so hard that was never really
part of my vision and I’m somebody
who likes to work hard who likes to
get involved and so working hard in
an area where you really love what
you’re doing is pretty easy for me.
And I think the reason it’s been
such a perfect profession is that
it has been the perfect mix for me,
of both patient care and research and education. And in some administration or leadership. And the proportion of those various components has varied overtime. But I have to say that I’ve always loved taking care of patients. I’ve learned more than one can imagine from taking care of people. And at the same time, I’ve loved doing the research I’ve done because if all I did was take care of patients, I think it would be fine. But I wouldn’t feel like I was making the kind of improvements that I would like in the field. So you know, I think one of the things that you point out is something that a lot of people in cancer medicine feel. Which is there is a certain pride, a certain humility and a certain joy in being able to not only help patients on a 1 to 1 basis, but also to help patients writ large in the future. Doing the kind of research that can move the field forward. So can you tell us a little more about the research that you’ve been involved with over the last 30 years?
I do want to make one comment first though, which is that the place where I feel as a person most centered is when I’m in a room with a patient and the door is closed as of course it always is for privacy and I can just focus on that individual and for me time stops and I’m really doing nothing but paying attention to what’s going on in there. And that’s a feeling that I don’t often have in other aspects of my life where many people will say, you know, are you paying attention? And I may not always be, but I always am when I’m in the room with the patient.

But in terms of research, my research has really been clinical research and translational research. Translational meaning clinical research that begins to touch on what’s going on in the laboratory, but my focus has been on trying to improve treatments for women and occasionally men with breast cancer, and that’s really gone in two directions. It’s gone in the direction of identifying treatments that are truly more effective and that allow people to live longer and better lives.
when can we do less treatment and spare people side effects that they don’t need and that too has been very satisfying because of course, the best treatment for anyone is the treatment that they need. Not too much, not too little, but just the right amount. And so let’s dive a little bit more into both of those. So one of the things that we’ve kind of noticed over time is that we have gotten more effective treatments and not only have they been more effective, they’ve been more personalized. So we’ve seen this burgeoning of personalized medicine of genomics of targeted therapies, talk a little bit more about the genesis of that. And where do you think things are going in terms of breast cancer? For years we knew that not all breast cancer was the same, but a patient would ask what kind. I would be able to tell her, and this is now 25 years ago, I’d be able to say you have stage one breast cancer.
You have stage two breast cancer, which really doesn’t say what kind of breast cancer it is. It just says how much breast cancer there is because stage is essentially a measure of amount of cancer. But what we’ve learned, and we’ve learned this both through clinical trials and through laboratory research that’s been done, is that there are really multiple different subtypes of breast cancer. It’s not one disease, it’s a family of diseases and exactly how many family members there are, that’s still a little bit unclear, but there are at least four very distinct types of breast cancer, and these are all treated in a different way and in a way that is much more personalized than was the case 10 or 20 years ago. And that’s allowed us to give therapy that is effective and needed, but not a waste of time because it’s simply causing side effects without producing benefit. And so the other aspect that you had mentioned is this whole concept of deescalation. Can we get the same results or perhaps
even better results by doing less therapy?
So less of the therapies that may not be as effective or as needed?
Can we cut down on how much surgery we’re doing?
Can we cut down on how much radiation we’re doing?
Can we cut down on how much chemotherapy?
I think there may be some people who may say, who wants more therapy, but others may be a little bit apprehensive thinking that corners may be cut. Are we really getting the same results by doing less?
Sure, you know it’s interesting, there are both patients and doctors who are worried about backing off, and in some cases I think they don’t appreciate that some of our therapies have really profound consequences and side effects that one can easily do without and may last for years and years, so doing less may be doing more in some cases if the therapy itself isn’t needed. Medical oncologists, people like me, tend to take credit for this whole concept of deescalation or backing off. But in truth it’s the surgeons who really started it. And if people remember back 50 or
60 years ago, radical mastectomy was a terribly deforming operation, performed routinely, and it was through a series of experiments, of clinical trials, that people find that you actually could do much less in the way of surgery. Radical mastectomies became modified radical mastectomies, and then it was demonstrated unequivocally, absolutely, that for women who are appropriate candidates for an excision alone, or a lumpectomy plus radiation is entirely the equivalent to a mastectomy. And then more recently, over the past decade, we’ve learned that in many cases we can do far less in the way of lymph node surgery. The radiation oncologists have also looked carefully at who needs more and who needs less and have been more personalized. And again in medical oncology, now that we have identified subtypes of breast cancer and can reliably do that, we have found that there are many areas where we can or many patients for whom we don’t need to use treatments like chemotherapy,
where we can use hormonal therapy alone and in the setting of 1 subtype of breast cancer, what’s called HER2 positive breast cancer, we’ve found that oftentimes very limited courses of chemotherapy can be every bit as effective as something that’s more extreme. And so a lot of that, though is really predicated on generating the evidence that underpins that rationale. That yes, you can do less and achieve same outcomes, and that really goes to clinical trial participation. But some patients might be a little bit reticent to participate in clinical trials, so how do you talk to patients about clinical trial participation and how important it is to move the field forward. Well, ultimately a trial has to be right for a patient and in truth, there’s nothing that should ever compel or force a patient to participate in the trial. It has to be voluntary, but in general, with clinical trials, we’re actually trying to do better. So in some cases we’re doing randomized clinical trials that compare a
standard with something that we hope is better than the standard and much of the time, we're testing new treatments that actually do turn out to be better or certainly not worse. And in clinical trials that may not be randomized still there the intent, of course, is to develop a treatment or an approach that is better than the standard approach. Having said all that, there are patients who just want the standard therapy they're comfortable with what is known, and they don’t want to stray beyond that. And that’s that’s OK. I will say, however, that all of the improvements that I talked about a few minutes ago all came about as a result of clinical trials. If you’re backing off on therapy and trying to do less, that should be done as part of a clinical trial to demonstrate that it’s safe. If you’re looking at a new therapy, and I don’t want people to think for a minute that although we do is back off on therapies, we still need to develop
new and better therapies,

hopefully therapies that don’t have a great deal of toxicity.

But when we’re doing that,

that’s part of a clinical trial as well.

So local trials are really absolutely critical for moving the field forward,

and the reason we have made so much progress in breast cancer is that mostly women,

because unfortunately even the men who have breast cancer are often excluded from the clinical trials,

but women have very generously participated in trials.

We’re going to pick up this conversation right after we take a short break for a medical minute.

Please stay tuned to learn more about innovations in Breast Cancer Care with my guest doctor Eric Winer.

Funding for Yale Cancer Answers comes from Smilow Cancer Hospital,

where you can view videos from their survivorship team by searching for the smilow survivorship playlist on YouTube.

The American Cancer Society estimates that nearly 150,000 people in the US will be diagnosed with colorectal cancer this year alone.

When detected, early colorectal cancer
0:16:03.55 –> 0:16:06.18 is easily treated and highly curable,
0:16:06.18 –> 0:16:08.556 and men and women over the age of 45
0:16:08.556 –> 0:16:10.105 should have regular colonoscopies
0:16:12.14 –> 0:16:13.596 Patients with colorectal cancer
0:16:13.596 –> 0:16:15.78 have more hope than ever before,
0:16:15.78 –> 0:16:18.576 thanks to increased access to advanced
0:16:20.44 –> 0:16:22.44 Clinical trials are currently underway.
0:16:22.44 –> 0:16:23.88 Federally designated comprehensive
0:16:23.88 –> 0:16:26.76 cancer centers such as Yale Cancer
0:16:26.76 –> 0:16:29.268 Center and its Milo Cancer Hospital
0:16:29.268 –> 0:16:31.739 to test innovative new treatments for
0:16:31.739 –> 0:16:33.979 colorectal cancer tumor gene analysis
0:16:33.979 –> 0:16:36.216 has helped improve management of
0:16:36.216 –> 0:16:38.396 colorectal cancer by identifying the
0:16:38.396 –> 0:16:41.238 patients most likely to benefit from
0:16:41.238 –> 0:16:43.808 chemotherapy and newer targeted agents,
0:16:43.81 –> 0:16:46.69 resulting in more patient specific treatment.
0:16:46.69 –> 0:16:49.67 More information is available at
0:16:49.67 –> 0:16:50.954 you’re listening
0:16:53.33 –> 0:16:55.688 Welcome back to Yale Cancer answers.
0:16:55.69 –> 0:16:58.338 This is doctor Anish Chappar and I’m joined
0:16:58.338 –> 0:17:00.79 tonight by my guest doctor Eric Weiner.
0:17:00.79 –> 0:17:02.49 We’re talking about advances in
0:17:02.49 –> 0:17:04.608 the care of patients with breast
0:17:04.608 –> 0:17:06.708 cancer and right before the break,
0:17:06.71 –> 0:17:09.195 Eric, you were telling us a little
0:17:09.195 –> 0:17:11.422 bit about clinical trials and about
0:17:11.422 –> 0:17:13.594 how various advances had been made
as a result of clinical trials. But that, really, this is a very personal decision for patients. Some patients want to participate in clinical trials. That potentially could positively impact them, because as you say, we’re always trying to do better and potentially positively impact future generations of breast cancer patients. On the other hand, other patients may feel more comfortable with standard of care. The tried and true, and I think that that applies to many of the decisions that are made with patients. So can you tell us a little bit more about how patients make decisions about? Karen and a little bit about what that relationship is, what that interplay is between the doctor and the patient in terms of coming up with a plan that is individualized and right for a given patient. Decision making really varies from patient to patient and. I think that one of the one of the real keys for doctors is being able to adjust to the patient and to understand how involved she wants to be in terms of the decision.
There are patients. Who truly don’t want a great deal of information and as much as one as a doctor may may try to provide it. Really want the doctor to make the decision for them and just in, and let them know you know what the treatment is going to be. I don’t think that’s the majority of people anymore, though, and I think that most individuals with breast cancer really want to be actively involved in the decision. They want to know what the choices are. That’s certainly true when it comes to decisions about surgery and whether someone has a lumpectomy or whether they have a mastectomy. But it’s also true in terms of the decisions about about medical therapy, about hormonal therapy and chemotherapy. And so I think that.

As clinicians, really need to be able to talk to our patients, understand where they’re coming from, and understand how we’re going to get to a decision together, and so you know when you think about that, though, I mean, it certainly brings up a myriad of ethical, potentially issues,
so you know patients who may be of certain cultural backgrounds where, for example, Male members of the family may come up to you before you go into the room with the patient saying, please don’t discuss anything to do with my wife’s diagnosis with my wife. I will manage all of the decisions. So how do you? How do you manage that? Ohh, you know that’s a really hard question and it’s a really hard situation and it’s one that I have quite honestly struggled with for years and years. In general, my feeling is that as much as one has to respect someone’s culture and how they want to approach a problem, there are also ways in which we take care of people in the United States. And for me it’s not OK, not telling someone what their diagnosis is, and it’s not OK, not involving them in any way in the treatment decisions. I certainly can modify my approach and I want to listen to the family and respect the family. But I also feel like we have to be respectful of the way we feel that people need to be taken care of in this country. Humane way here in this country. You know it brings up another whole Pandora’s box of the issues in terms...
of the fact that even in this country different people are treated differently. Whether we consciously know it or not. But there are disparities in terms of care, racial disparities, ethnic disparities, disparities based on income and insurance. And a whole myriad of other issues. Can you talk a little bit about how those disparities play into the management of patients with breast cancer? And perhaps some of the things that are being done or being contemplated to reduce those disparities? So this is an absolutely huge issue for the community. It’s a huge issue for us at Yale, and in fact I will share that. Just yesterday we had a strategic planning retreat and at least 50% of it was focused on community outreach and issues related to disparities. It is very clear that anything that makes someone a little bit different, puts them at risk for getting less than adequate cancer care. That’s true in terms of race. That’s true in terms of sexual orientation, education, income. Disabilities and on and on. And if we did nothing but eliminate
all the cancer care disparities for women with breast cancer, we would probably save at least half of the lives that are lost each year. And I there’s no study that actually has come up with that figure. That’s my own guess. But I think that it’s probably quite accurate. This is really a critical issue for us. It’s going to be an even more critical issue over the course of the next decade as we develop better and better therapies, not just for breast cancer, but for all cancers. The challenge for us as cancer doctors and as cancer researchers is going to be to make sure that we get the care to everyone, and that’s not going to be simple, but it’s something that that we’re really going to have to work on with with. Really full intensity. You know, address addressing disparities is something that I think many institutions are looking at and trying to tackle, because it is such a complex issue,
that kind of underpins it is this concept of financial toxicity. We know that cancer care is incredibly expensive and that really the care that individual patients can afford varies based on their income based on their insurance status. And yet as we develop these newer therapies that come down the pike as we were talking about before the break, they tend to be pretty expensive, so what can we do to reduce financial toxicity that can really help many patients and kind of level some of the playing field? Well, you can think of financial toxicity in a couple of ways. One is of course is just the sometimes substantial out of pocket costs for copays, but also for things like parking and days off from work and childcare and everything else and we can certainly do our best to try to help patients with that by connecting them to services in the Community and using, at times philanthropic funds to cover some of those expenses. I think the bigger issue though is that the cost of cancer care in the
United States has become truly overwhelming. It’s bankrupting for virtually any individual who doesn’t have adequate insurance. New drugs cost in the range of 100 to $200,000 a year. I mean, these are numbers we can’t even fathom. And so I think this is really a policy issue and at some point we’re going to have to change our approach to the way we look at drug development and the way we look at the Pharmaceutical industry as a whole as people may be aware, many drugs are much less expensive in other countries and we really don’t do a very good job of regulating drug prices. So this is all going to have to change in the years ahead. We’re going to need a new approach. What I don’t want to see is a decision that we’re suddenly going to stop developing new drugs because they’re too expensive. Of course we still do need new drugs, not just in breast cancer, but for many many different types of cancer. Yeah, but you bring up a good point. Which is, you know, these drugs are very critical in terms of spurring on innovation to help us to conquer cancer as it were.
But the cost really can be prohibitive here in the United States, which brings up another issue which is there are many places in the world where there are many places in the world to middle income countries where people still get cancer and yet the cost of these newer therapies if it’s prohibitive here, in the United States one can only imagine how completely out of reach it is for patients in other parts of the world. So what responsibility do you think we have here in the first world to help our fellow human beings in other parts of the globe? And what do you think should be done in terms of that? Yeah, so I think we have a very significant responsibility. I do want to say that I think our very first responsibility is making sure that everyone in the United States gets the care that they deserve. But I think we also have to focus on people around the world. There are efforts that are going on with professional societies in different countries trying to make sure that drugs are available to people and this is something that is really very much a work in progress,
but the better our care gets, the more tragic it is that care isn’t delivered to everyone.
Doctor Eric Winer is a professor of medicine and medical oncology at the Yale School of Medicine.
If you have questions, the address is canceranswers@yale.edu and past editions of the program are available in audio and written form at yalecancercenter.org.
We hope you’ll join us next week to learn more about the fight against cancer here on Connecticut Public radio.
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