Funding for Yale Cancer Answers is provided by Smilow Cancer Hospital.

Welcome to Yale Cancer Answers with Doctor Anees Chagpar.

Yale Cancer Answers features the latest information on cancer care by welcoming oncologists and specialists who are on the forefront of the battle to fight cancer.

This week it’s a conversation about head and neck cancers with Doctor Ansley Roche. Doctor Roche is an assistant professor of surgery and otolaryngology at the Yale School of Medicine.
00:00:30.522 --> 00:00:32.979 a professor of surgical oncology.
NOTE Confidence: 0.937051502727273
00:00:34.420 --> 00:00:36.412 Ansley, maybe we can start off by you
NOTE Confidence: 0.937051502727273
00:00:36.412 --> 00:00:38.184 telling us a little bit more about
NOTE Confidence: 0.937051502727273
00:00:38.184 --> 00:00:40.260 yourself and what it is you do.
NOTE Confidence: 0.941930716666667
00:00:40.460 --> 00:00:43.376 I'm a head and neck cancer surgeon.
NOTE Confidence: 0.941930716666667
00:00:43.380 --> 00:00:45.900 I did my training and after medical school,
NOTE Confidence: 0.941930716666667
00:00:45.900 --> 00:00:47.820 I did my residency
NOTE Confidence: 0.941930716666667
00:00:47.820 --> 00:00:49.260 training in otolaryngology,
NOTE Confidence: 0.941930716666667
00:00:49.260 --> 00:00:50.700 which is ear, nose and throat.
NOTE Confidence: 0.941930716666667
00:00:50.700 --> 00:00:53.094 And then within the field of otolaryngology,
NOTE Confidence: 0.941930716666667
00:00:53.100 --> 00:00:55.036 there are numerous subspecialties.
NOTE Confidence: 0.941930716666667
00:00:55.036 --> 00:00:58.520 I subspecialize in head and neck cancer.
NOTE Confidence: 0.941930716666667
00:00:58.520 --> 00:01:01.360 So I went on to obtain additional training,
NOTE Confidence: 0.941930716666667
00:01:01.360 --> 00:01:03.880 a fellowship in head and neck cancer,
NOTE Confidence: 0.941930716666667
00:01:03.880 --> 00:01:06.040 both in the management of
NOTE Confidence: 0.941930716666667
00:01:06.040 --> 00:01:07.420 resecting these cancers
as well as reconstructing them.

Now that we are celebrating head and neck cancer awareness Month, maybe you can tell us a little bit more about head and neck cancers. I mean it sounds like it’s a rather large bucket, kind of like saying cancers of the abdomen or cancers of the chest, it sounds like every time we say head and neck cancers I think that’s a pretty large area with a lot of things in it. Tell us a bit more about what goes into head and neck cancer and why it is that those are all kind of clumped together as opposed
00:01:43.049 --> 00:01:44.735 to specific organs like we have

00:01:44.735 --> 00:01:46.609 in other parts of the anatomy.

00:01:47.500 --> 00:01:48.796 Yeah, that’s an excellent

00:01:48.796 --> 00:01:50.416 point and you’re exactly right.

00:01:50.420 --> 00:01:53.976 It is a heterogeneous group of cancers

00:01:53.976 --> 00:01:56.900 that are clumped together essentially

00:01:56.900 --> 00:01:59.700 because of their anatomic location.

00:02:01.740 --> 00:02:04.442 Within this region, there are many different

00:02:04.442 --> 00:02:07.257 types of cancers that can arise,

00:02:07.260 --> 00:02:08.770 mostly because there are many

00:02:08.770 --> 00:02:10.630 different types of cell types

00:02:10.630 --> 00:02:12.255 within the head and neck,

00:02:12.260 --> 00:02:14.868 there’s the digestive tract, which

00:02:14.868 --> 00:02:17.570 you can think of it sort of as skin

00:02:17.570 --> 00:02:19.034 but on the inside, it’s the

00:02:19.034 --> 00:02:20.850 lining of the mouth, the nose,
the sinuses, the throat.
There’s also skin
So there are cutaneous cancers,
Squamous cell carcinoma as we know,
Basal cell Melanoma,
just to go back to the oral cavity,
the digestive tract that also most
commonly is squamous cell carcinoma,
but there are others that arise there.
And then there’s also things
like salivary gland tumors.
So growths that arise
within the saliva glands,
we have some within our cheeks,
some under our chin and under our jaw and

And so cancers can arise in any of those.

I would say the most common head

and where most of the research

efforts go is within addressing

squamous cell carcinoma of the

upper digestive tract.

And so how common the

head and neck cancers are,

depending on the year,

anywhere from the 6th to the 8th most

common type of cancer worldwide.
So not the most common, but we see quite a bit of it.

And can you tell us a bit more about risk factors? I mean who gets these cancers and why?

How do we prevent these? How can we minimize our risk?

For a long time, we attributed the majority of head and neck cancers, again specifically squamous cell carcinoma of the air digestive tract, to things like smoking and drinking,
things that we know are risk factors for other types of cancers and those remain risk factors for squamous cell carcinoma of certain sites within the head and neck, within the oral cavity, larynx, the voice box. What we’re also seeing now though is a rise in HPV associated head and neck cancer. Specifically of the oropharynx and the oropharynx, that’s the tonsils and the back of the tongue. So the area kind of at the back of the mouth, back of the throat, back of the tongue,
00:04:26.570 --> 00:04:28.670 that’s the oropharynx and that’s where
00:04:28.670 --> 00:04:31.158 we’re seeing HPV associated squamous
00:04:31.158 --> 00:04:35.330 cell carcinoma that is on the rise
00:04:35.330 --> 00:04:37.745 and accounts for at this point about
00:04:37.745 --> 00:04:41.230 70% of oropharynx cancers and it’s
00:04:41.230 --> 00:04:44.370 anticipated that by about 2030
00:04:44.370 --> 00:04:47.242 that the head and neck cancers
00:04:47.242 --> 00:04:49.540 associated with a with HPV will be
00:04:49.540 --> 00:04:51.190 higher than those not associated
00:04:51.190 --> 00:04:53.434 with HPV which will be
00:04:53.434 --> 00:04:55.450 a reverse of what it is currently.
00:04:55.450 --> 00:04:58.050 So as people kind of smoke less,
00:04:58.050 --> 00:05:00.648 those sorts of non HPV related cancers,
00:05:00.650 --> 00:05:02.534 the incidence of those are going
00:05:02.534 --> 00:05:04.500 down but HPV associated
ones are increasing.

It’s interesting that you say that the HPV cancers will overtake smoking and alcohol.

While it’s understood that people are smoking less and perhaps drinking a little bit less too, you know, when we think about HPV, we have vaccines for HPV to prevent HPV associated cancers. So why is it that we still think that HPV cancers are going to be rising to the extent that they are? There’s a bit of a lag in the age of patients that have been vaccinated and
when patients are getting this diagnosis. So the vaccine Gardasil was FDA approved in early 2000, maybe around 2010, 2012. Actually it was a little bit before that, but there are generations of people that have already acquired the HPV virus and sort of have fallen out of the window of vaccination. So the hope is that over time as more people get vaccinated that the rates will eventually go back down. But again we’re accounting for this.
window where people are not vaccinated but they're at an age where they may be diagnosed with this which is typically anywhere from 40s to 60s that they're getting diagnosed with this. So tell us more about why it is that people get HPV associated oropharyngeal cancers. When we think about HPV, many of our listeners may be thinking about it as, you know, a sexually transmitted virus that causes cervical cancers. So is it systemic spread of that virus or is that more, you know, a direct inoculation of the virus?
in the mouth due to sexual activity?

I mean how does that work?

Great question.

We do know that the risk factor for getting HPV associated head neck cancer is having numerous oral sex partners, so that does speak to your question which is it a direct inoculation perhaps it could also be you know just dormant within the body. So the jury is still out on exactly how it’s transmitted there. But we do know that the risk goes up the more oral
sex partners that you’ve had

and so getting back to the vaccine

and the fact that some

people have kind of already been exposed

to the virus, my understanding is

that now the age criterion for people

to get the vaccine has increased.

So it used to be that you had to be,

you know, in your preteen years

in order to get vaccinated.

But my understanding is

that has now increased.

So two questions.

First question is A is that true?

And B, if it is true,

if you’ve already been exposed to the virus,
NOTE Confidence: 0.93723458
00:08:24.920 --> 00:08:26.600 does the vaccine still work?
NOTE Confidence: 0.937234531
00:08:27.840 --> 00:08:30.000 Yes, it is true that they
NOTE Confidence: 0.937234531
00:08:30.000 --> 00:08:31.440 have expanded the age.
NOTE Confidence: 0.937234531
00:08:31.440 --> 00:08:33.960 I believe it’s up to 45 now.
NOTE Confidence: 0.937234531
00:08:33.960 --> 00:08:35.980 There are many different strains
NOTE Confidence: 0.937234531
00:08:35.980 --> 00:08:39.232 of the virus and so the thought
NOTE Confidence: 0.937234531
00:08:39.232 --> 00:08:40.957 with getting vaccination,
NOTE Confidence: 0.937234531
00:08:40.960 --> 00:08:43.736 even if you’ve already been exposed is that
NOTE Confidence: 0.937234531
00:08:43.740 --> 00:08:45.280 the vaccination covers many
NOTE Confidence: 0.937234531
00:08:45.280 --> 00:08:46.820 different strains and so perhaps
NOTE Confidence: 0.937234531
00:08:46.871 --> 00:08:48.586 it’s going to protect you against a
NOTE Confidence: 0.937234531
00:08:48.586 --> 00:08:50.340 strain that you have yet to acquire.
NOTE Confidence: 0.94276945
00:08:51.820 --> 00:08:56.620 So are those really the only risk factors?
NOTE Confidence: 0.94276945
00:08:56.620 --> 00:09:00.388 So smoking, drinking, and HPV
NOTE Confidence: 0.94276945
00:09:00.390 --> 00:09:05.268 it sounds like it’s the the trifecta of sin,
NOTE Confidence: 0.94276945
but do some people get oropharyngeal cancers just due to bum, bad luck, or due to genetic factors? Are there other things that could predispose people to oropharyngeal cancers? As far as the oropharynx, those are the main risk factors, but there are other risk factors for oral cavity cancer. I mean tobacco is sort of a catchall, you know for many different types of products, so chewing tobacco but also one called beetle nut which is used in parts of Asia, in Southeast Asia that it can also be associated as a risk factor.
for acquiring oral cavity cancer.

And then we think of others that are not quite as common that affect the nasal area and can be associated with things like woodworking, exposures secondary to occupation. Some metalworking can be associated with some head and neck cancers those are pretty rare.

So when it comes to risk factors that affect a good amount of people, those are pretty much the main ones that we’ve talked about, smoking, drinking and increased number of oral sex partners.
So when we think about smoking, one of the other questions that often comes up is whether it is the actual vapors or whether it is the nicotine content. So to get to the whole point of are e-cigarettes safe, is vaping safe? Does this reduce your risk of cancer versus traditional smoking or is there a risk associated with these as well? You know those products I don’t think have been around long enough for us to really know if they have the same impact on cancer predisposition as the smoked tobacco.
So we're just not at that point yet.

The kind of general recommendation though is that it very well could be associated with it, one of the concerns about smokeless tobacco is that it's getting people exposed early and there's a concern that it's so much easier to do, you could do it indoors, you could do a little bit here, a little bit there throughout the day. There's a concern that the exposure over time is higher because it's so easy and relatively discreet.

So in terms of head and neck cancer, I don’t think enough time has passed
to be able to say it is as associated or as dangerous in terms of a risk factor as smoked tobacco. So the jury is still out, but we anticipate it’s probably going to be about the same. What about for people who already have had a history of smoking, have had a history of alcohol, may have had exposure to HPV over time? You quit smoking, you quit drinking, don’t have oral sex, does that reduce your risk or is it more that if you’ve had a single exposure, that single exposure is kind
00:12:45.045 --> 00:12:47.230 of like a mark on your record
00:12:47.230 --> 00:12:49.050 that still increases your risk?
00:12:51.198 --> 00:12:55.240 We talked about it mostly with smoking.
00:12:55.240 --> 00:12:58.163 And it has to do with sort of
00:12:58.163 --> 00:13:03.600 cumulative exposure over time
00:13:03.600 --> 00:13:07.719 and typically we use the
00:13:07.720 --> 00:13:12.998 So below which your risk is lower
00:13:13.000 --> 00:13:15.346 than it is if you’ve smoked
00:13:15.346 --> 00:13:17.450 more than 10 packs per year.
00:13:17.450 --> 00:13:19.310 Pack year just refers to
00:13:19.310 --> 00:13:21.485 on average how many packs of
00:13:24.900 --> 00:13:27.612 So there’s hope for
00:13:27.612 --> 00:13:30.619 people who want to quit smoking
00:13:30.620 --> 00:13:34.400 and reduce their risk of
getting oropharyngeal cancer.

When we come back after taking a short break for a medical minute, we’ll dive into a little bit more about oropharyngeal cancers and other cancers of the head and neck, how they present, how they’re treated and what’s new on the horizon.

Please stay tuned to learn more about the care of patients with head and neck cancers in honor of Head and Neck Cancer Awareness Month with my guest, Dr. Ansley Roche.
Funding for Yale Cancer Answers comes from Smilow Cancer Hospital, where their Prostate and Urologic Cancers program comprises a multispecialty team dedicated to managing the diagnosis, evaluation, and treatment of urologic cancer.

Breast cancer is one of the most common cancers in women. In Connecticut alone, approximately 3500 women will be diagnosed with breast cancer this year. But there is hope thanks to earlier detection, non invasive treatments,
and the development of novel therapies to fight breast cancer, women should schedule a baseline mammogram beginning at age 40 or earlier if they have risk factors associated with the disease. With screening, early detection, and a healthy lifestyle, breast cancer can be defeated. Clinical trials are currently underway at federally designated comprehensive cancer centers such as Yale Cancer Center and Smilow Cancer Hospital to make innovative new treatments available to patients.
Digital breast tomosynthesis or 3D mammography is also transforming breast cancer screening by significantly reducing unnecessary procedures while picking up more cancers. More information is available at yalecancercenter.org.

You’re listening to Connecticut Public Radio.

Welcome back to Yale Cancer Answers.

This is Dr. Anees Chagpar and I’m joined tonight by my guest, Dr. Ansley Roche.

We’re discussing the care of patients with head and neck cancers in honor of Head and Neck Cancer Awareness Month.

Now, before the break,
we were talking about risk factors and things that people can do to reduce their risk of getting head and neck cancers, particularly those of the oropharyngeal tract.

So Ansley, let’s suppose that somebody does get an oropharyngeal cancer, tell us a little bit more about how those are found. Are these routinely things that are screened for that are asymptomatic or do patients present with symptoms and if so what are those? It’s highly variable how these present, we often see patients...
and this depends on the location,
we often are referred patients that have been evaluated by their dentist who notices a lesion within the mouth, a spot, something that doesn’t look quite right.
So they get a biopsy and they would get the diagnosis of cancer.
Again typically this would be squamous cell carcinoma.
So that can occur just by getting seen by a dentist regularly.
So we do strongly encourage regular dental visits every six months.
That’s one way these are diagnosed.
You can imagine that
NOTE Confidence: 0.9553487
00:16:46.035 --> 00:16:47.207 cancer within the upper digestive tract
NOTE Confidence: 0.9553487
00:16:47.210 --> 00:16:49.890 you know can be associated with things like difficulty eating,
NOTE Confidence: 0.9553487
00:16:49.890 --> 00:16:52.074 painful eating, painful chewing,
NOTE Confidence: 0.9553487
00:16:52.074 --> 00:16:53.530 painful swallowing, difficulty swallowing.
NOTE Confidence: 0.9553487
00:16:53.530 --> 00:16:56.434 So those are some also things like ear pain.
NOTE Confidence: 0.9553487
00:16:58.908 --> 00:17:03.490 Even if it’s not an ear cancer,
NOTE Confidence: 0.9553487
00:17:03.490 --> 00:17:06.248 there are some nerves in the back of the mouth, back of the throat,
NOTE Confidence: 0.9553487
00:17:10.306 --> 00:17:12.882 that if those nerves are irritated, they can actually cause what is called referred pain,
NOTE Confidence: 0.9553487
00:17:14.390 --> 00:17:18.970 So if some patients have ear pain
NOTE Confidence: 0.9553487
even though they have a cancer within their throat or their voice box,
their larynx, another symptom would be a neck mass and that implies that the cancer has spread to a lymph node within the head and neck. So cancers that arise within the oral cavity or even the skin, the back of the mouth, the oral pharynx or the voice box, once they arise there, they have a tendency or the potential to spread to surrounding lymph nodes within the neck.
So at times people don’t really notice that anything’s going on except they might feel a mass or a lump on the side of their neck.

A neck mass in an adult, without being an alarmist, is concerning until proven otherwise. Neck masses in children typically are infectious and so it’s not uncommon for them to get a course of antibiotics and then the neck mass goes away. Adults that have a neck mass,
again, it’s more concerning than it is in the pediatric population and it really should be evaluated seriously. And so let’s say you find a neck mass or you have some ear pain, or a dentist finds a spot in your mouth and refers you to your family doctor or a specialist, what happens then? So if you’ve gotten the biopsy and you’ve gotten the diagnosis then the next place to go is a specialist that is trained to take care of these sorts of
problems day in and day out.
And there are some general ENT's
that are comfortable and very
careful and proficient with taking care
of head and neck cancer patients.
But typically head and neck cancer patients
are managed by a cancer specialist,
surgical oncologist of the head and neck,
just like if you have colon cancer,
you would want a surgical oncologist to be managing that.
That also helps with facilitating
other sorts of treatment.
Let's say surgery is not the best option for you.
Chemotherapy or radiation may be better
00:19:37.974 --> 00:19:40.500 options and being involved with the head and neck cancer specialist you automatically are involved with all of these other specialists.

00:19:48.340 --> 00:19:50.398 We deliver all of our care within the context of a multidisciplinary team and we make decisions about the best way to treat patients as a team. We have weekly meetings and I think this is pretty universal within the head and neck cancer field, tumor boards or tumor discussions where we talk about new patients or any patient really, where we're trying to figure out the
best way to manage where we meet and discuss the best treatment plan taking into account that individual person looking at their scans, looking at their pathology, talking about their symptoms and then coming up with the best treatment plan for them. So it’s very patient specific, patient centered, tailored towards each patient taking into account a variety of things about that person. Even before the biopsy though, when you just go to
00:20:41.238 --> 00:20:43.361 your doctor and you have some ear
NOTE Confidence: 0.950317106
00:20:43.361 --> 00:20:47.280 pain or a neck mass or something,
NOTE Confidence: 0.950317106
00:20:47.280 --> 00:20:48.570 should patients anticipate
NOTE Confidence: 0.950317106
00:20:48.570 --> 00:20:50.720 that there are scans done?
NOTE Confidence: 0.950317106
00:20:50.720 --> 00:20:53.240 I mean, because especially in the cases
NOTE Confidence: 0.950317106
00:20:53.240 --> 00:20:55.959 like you were mentioning of ear pain,
NOTE Confidence: 0.950317106
00:20:55.960 --> 00:20:57.600 it may be that you have an earache,
NOTE Confidence: 0.950317106
00:20:57.600 --> 00:20:59.172 but it may be referred pain
NOTE Confidence: 0.950317106
00:20:59.172 --> 00:20:59.958 from somewhere else.
NOTE Confidence: 0.950317106
00:20:59.960 --> 00:21:03.600 So how do people know what to biopsy and how?
NOTE Confidence: 0.941863744
00:21:04.280 --> 00:21:05.078 Yes, great question.
NOTE Confidence: 0.941863744
00:21:05.078 --> 00:21:07.291 I mean the vast majority of the time
NOTE Confidence: 0.941863744
00:21:07.291 --> 00:21:09.335 ear pain would will probably be related
NOTE Confidence: 0.941863744
00:21:09.335 --> 00:21:10.999 to something going on in the ear.
NOTE Confidence: 0.941863744
00:21:11.000 --> 00:21:12.480 Ear infections are much more
NOTE Confidence: 0.941863744
00:21:12.480 --> 00:21:14.400 common than head and neck cancer.
So the odds are if you have ear pain you probably don’t have cancer, but it’s probably a good idea to see somebody especially if it doesn’t go away after a couple of weeks, a month or two. In terms of what to biopsy, maybe a better question is when do you start scanning? I would say if there’s a bump that you can feel, a sort of all of a sudden. If your voice has changed, sort of all of a sudden, it’s persistent over weeks.
that’s something to bring to the attention of your primary care doctor. And honestly, if your primary care doctor reassures you that everything looks great, if you’re still concerned about your symptoms, you could certainly make another appointment or honestly get a second opinion. And when you talk about multidisciplinary team in the management of head and neck cancers, in that context is there kind of an algorithm for which patients need chemotherapy,
which patients need radiation, which patients need surgery, which patients need a combination of the above? Yes, it has mostly to do with the anatomic location and also the type of tumor. So within the oral cavity, that’s the mouth, the gums, the lips, the tongue, those are managed with surgery up front, unless in very extenuating circumstances, if it’s a very advanced tumor that’s involving multiple sites, if it’s involving the jaw, the tongue, the skin, if it’s a very advanced tumor,
we may try other things first like chemotherapy,
but in general oral cavity is managed with surgery upfront and then based on what things look like under the microscope. So the final pathology that will determine whether somebody also needs radiation or chemotherapy. And then you know, if you talk about areas like the oropharynx that we were talking about before many, many years ago, it was treated with a very invasive,
somewhat highly morbid surgery to
if you can imagine,

to try to access the back of the throat,
It's kind of operating around the
corner and you'd have to do some
pretty invasive surgery to get
access back there.
So the trend was to actually
begin treating these patients with
chemotherapy and radiation and
they've responded very well and
cure rates have been very high with
that over the past 20 or so years
with the advent of literally a robot
which helps us access the back of the mouth,
the back of the throat,
NOTE Confidence: 0.911515941818182
it’s actually used quite a bit in
NOTE Confidence: 0.911515941818182
gynecologic surgeries,
NOTE Confidence: 0.911515941818182
urologic surgeries, abdominal surgeries.
NOTE Confidence: 0.911515941818182
We’ve actually been able to fashion
NOTE Confidence: 0.911515941818182
it and get FDA approval, not we,
NOTE Confidence: 0.911515941818182
but some very smart people have
NOTE Confidence: 0.911515941818182
been able to get FDA approval for
NOTE Confidence: 0.911515941818182
to operate in the oropharynx.
NOTE Confidence: 0.911515941818182
So surgery has become another way
NOTE Confidence: 0.911515941818182
that we treat oropharynx cancers
NOTE Confidence: 0.911515941818182
again with also excellent cure rates.
NOTE Confidence: 0.911515941818182
And so now we’re just trying to
NOTE Confidence: 0.911515941818182
figure out well is surgery better
NOTE Confidence: 0.911515941818182
than chemo and radiation and we
NOTE Confidence: 0.911515941818182
often do surgery plus radiation
can we get rid of the chemotherapy.

So all along the way it’s a constant struggle or a constant ambition to treat without overtreating, but treat such that we cure the cancer but without causing significant functional deficits or significant side effects from that treatment.

Things like salivary gland tumors, those are primarily treated surgically, followed again by radiation or possibly chemotherapy, and then cancers of
the voice box or the larynx, it depends on how advanced the disease is. If it’s a small tumor, we would love to be able to preserve somebody’s voice box. And so if there are nonsurgical options for larynx cancer, then that’s what we typically try to do. If the cancer has already rendered that patient to the point where they can’t really eat, they cannot breathe without a tracheostomy tube and they can’t eat without a feeding tube, then we have to ask well is this organ, and
the larynx is an organ,

is this organ worth preserving if

it’s not working that well and if

if it’s already not working well,

then the highest chance for

cure in those cases is surgery.

So again it depends really on

the location of the cancer as well

as how advanced the cancer is.

On this

show we talk about a variety of

cancers and our listeners are

very familiar with this concept of

treating patients with chemotherapy

sometimes and some cancers having

extraordinarily high rates of what we
NOTE: Call a pathologic complete response where essentially there’s no cancer left when the surgeon goes in and in some cases there are clinical trials and various other tumor types not necessarily in the head and neck, looking at non-operative approaches, when we think about the head and neck. I can only imagine that as you kind of mentioned operating in the head and neck can be very morbid. There are important structures in there that are important for function and so on. Has that neo-adjuvant approach been tried in the head and neck?
For example, in oral cancers you mentioned that the mainstay is treating with surgery upfront. Have people tried using chemotherapy as the primary modality and has that not worked?

We have done it for a handful of patients here. We know that in general oral cavity cancers will, not all of them, but some of them, will respond to chemotherapy or induction chemotherapy. But in general it’s not a durable, curable way of treating this cancer. It’s just something about the oral cavity that it’s just not as durable.
chemosensitive in that regards for it
to completely eliminate the tumor.
That’s why surgery is,
for the vast majority of cases,
the initial treatment modality.
We have been using the new adjuvant
model for very advanced tumors
where surgery would be highly,
where surgery would be highly,
the surgery the same and a
where surgery would be highly,
the surgery the same and a
lot of the cases it ends up being the same,
but honestly the control
of the cancer is,
it seems, to be better if they’ve
received the neoadjuvant treatment.
It’s actually an active area
NOTE Confidence: 0.85458055
00:28:11.565 --> 00:28:12.593 of research for us,
NOTE Confidence: 0.85458055
00:28:12.600 --> 00:28:15.685 this neoadjuvant concept and there
NOTE Confidence: 0.85458055
00:28:15.685 --> 00:28:19.060 are some trials within the head
NOTE Confidence: 0.85458055
00:28:19.060 --> 00:28:21.968 and neck section here at Yale
NOTE Confidence: 0.85458055
00:28:21.968 --> 00:28:23.976 looking at neoadjuvant treatments
NOTE Confidence: 0.85458055
00:28:23.976 --> 00:28:26.599 for oropharynx cancers.
NOTE Confidence: 0.85458055
00:28:26.600 --> 00:28:27.659 So it’s very,
NOTE Confidence: 0.85458055
00:28:27.659 --> 00:28:29.424 very exciting area of research
NOTE Confidence: 0.85458055
00:28:29.424 --> 00:28:31.800 and does have a lot of potential.
NOTE Confidence: 0.938597261764706
00:28:32.610 --> 00:28:34.692 Doctor Ansley Roche is an assistant
NOTE Confidence: 0.938597261764706
00:28:34.692 --> 00:28:38.805 professor of surgery and otolaryngology
NOTE Confidence: 0.938597261764706
00:28:38.810 --> 00:28:40.928 If you have questions, the address
NOTE Confidence: 0.938597261764706
00:28:40.928 --> 00:28:43.250 is Cancer Answers at Yale dot Edu,
NOTE Confidence: 0.938597261764706
00:28:43.250 --> 00:28:45.554 and past editions of the program
NOTE Confidence: 0.938597261764706
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.

Funding for Yale Cancer Answers is provided by Smilow Cancer Hospital.