

Yale Cancer Center

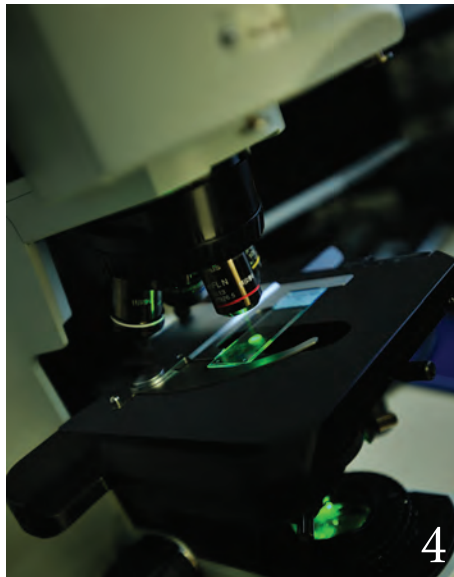
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MAGAZINE



Amending a Bias in Cancer Care

spring | summer 2012



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yale cancer center

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YALE CANCER CENTER AND SMILOW CANCER HOSPITAL AT YALE-NEW HAVEN continue to gain momentum as we integrate new faculty members and staff and expand our scientific and patient care endeavors to meet our research goals and the needs of cancer patients throughout the region.

On January 1, Yale Cancer Center welcomed 18 new clinicians to our faculty, along with 121 staff members with the transition of the former Medical Oncology & Hematology, PC (MOH) to six Smilow Cancer Care Centers in Connecticut. This integration is a new model for cancer care in our state, providing patients access to the resources and quality principles standard at Smilow Cancer Hospital at Yale-New Haven, while maintaining six local cancer care locations. Our goal is to ensure patients and families throughout Connecticut have access to Smilow quality cancer care and treatment within 35 minutes of their home.

I am pleased that our patient satisfaction scores at Smilow Cancer Hospital are strong throughout the inpatient and outpatient care centers. The outpatient oncology patient satisfaction scores remain at greater than 90%, with nearly 7,000 patient visits to our hospital per month. Our patients' experience is one of the key areas of focus of the leadership of Smilow Cancer Hospital and we will continue to focus on improved patient and family experiences in 2012.

One year ago, Yale University and Gilead Sciences, Inc. signed a 10-year, \$10 million per year, funding agreement to support cancer research in Yale's Cancer Biology Institute. Through the research efforts of our SPORE in Skin Cancer, the team is working on identifying therapeutic targets for the treatment of melanoma with the support of the Gilead project and will transition into the next phase of testing. I am confident that we will have more successful research outcomes to report on from the Gilead project in the second year of our funding agreement.

The next six months at Yale Cancer Center will be focused on our CCSG renewal application to the National Cancer Institute, which is due on September 25. The CCSG grant is the funding and award mechanism that establishes Yale Cancer Center as one of only 41 National Cancer Institute Comprehensive Cancer Centers (NCI CCC). One of the initial institutions, Yale Cancer Center has been an NCI CCC for 37 years.

I look forward to updating you on our progress in the next issue of *Centerpoint Magazine*, and hope you enjoy the warm summer months.

Sincerely,

Thomas J. Lynch, Jr., MD
Director, Yale Cancer Center
Physician-in-Chief, Smilow Cancer Hospital



Robotic Surgery Gives Renewed Life to Patients with Head and Neck Cancer

Emily Fenton **writer** Peter Baker **photographer**

When Wendy McCabe's dentist recommended that she have a biopsy done on a growth spotted at the base of her tongue during a routine cleaning, she didn't think anything of it. However, when the results came back as cancer, she was shocked. Her first reaction was to ask, "Am I going to die?" Her second reaction was to assemble her support network and take action.

Her support network consisted of her husband and her sister. They went right to work and had her scheduled for appointments at both Smilow Cancer Hospital and Memorial Sloan-Kettering Cancer Center. For Wendy, it was easier to leave everything in their hands and focus all her energy on staying positive. Her first appointment was at Smilow with Dr. Benjamin Judson, Assistant Professor of Surgery (Otolaryngology). After weighing all of her options, she decided Smilow was the right place for her. She immediately felt comfortable with Dr. Judson, and enjoyed the ease with which she could get to Smilow and preferred the calming environment.

After viewing the tumor with an endoscope, Dr. Judson commented that he was surprised her dental hygienist had spotted anything at all; Wendy had no symptoms. The tumor was very small, and thankfully was caught early. "I had smoked in the past and am sure that's most likely what caused the cancer to develop. I focused on doing everything the doctor told me, and stayed off the internet. Dr. Judson made me feel very confident that everything was going to be alright, and that was enough for me," said Wendy.

It was decided that Wendy would undergo transoral robotic surgery, a minimally invasive approach to treating cancers of the head and neck. Robotic surgery allows the surgeon to see and reach the tumor and remove it with minimal side effects. This procedure is not available at any other cancer center in Connecticut, and at only a few centers in the country. Dr. Judson has been performing transoral robotic surgery at Smilow Cancer

Hospital for a year and a half, and has treated 16 patients using the technique.

"The side effects are generally much less than the alternative treatments. Patients usually spend 2-5 days in the hospital following the treatment due to a sore throat and difficulty swallowing," commented Dr. Judson. "The surgery is done under general anesthesia and a retractor is used to retract open the mouth and the robot arms and endoscope are passed through the mouth in order to visualize and access parts of the throat not otherwise reachable without the robot."

Wendy also had to have lymph nodes removed from her neck to make sure the cancer had not spread. When asked if she would be okay with having a scar, she replied that she didn't care as long as they made sure everything cancerous was removed from her body. Wendy has experienced no long term side effects from the treatment. At first she experienced numbness and loss of taste, but those went away. "Cooking is my passion and my greatest fear was that my sense of taste would not return, but everything has gone back to normal, and I am back to cooking. This was as positive an experience as I could have expected. Everyone from the nurses to the reception staff were amazing and I never had to wait for my tests or appointments, which made things a lot easier on me," Wendy commented.

Every four months Wendy sees Dr. Judson for a follow-up and she just had her one year chest x-ray, which showed no signs of cancer. Wendy commented that she is more nervous now going for her annual mammograms and appointments, but is diligent about it. "I could not have gotten through this experience without the support of my husband and sister. They took care of everything for me so that I could focus on getting better," said Wendy. "It's amazing the advances that have been made in the treatment of cancer. My first complaint when I woke up from my surgery was that my back hurt from lying still for so long, and that was amazing to me. I cannot thank Dr. Judson and his team enough." 🌱



Harriet Kluger, MD, Associate Professor of Medicine (Medical Oncology) and her research assistant, Saadia Aziz.

For years, patients with brain metastases have been excluded from clinical trials of new cancer therapies. A recent paper by Harriet Kluger, MD, Associate Professor of Medicine (Medical Oncology) at Yale Cancer Center and Smilow Cancer Hospital at Yale-New Haven, asks the question, “Melanoma Brain Metastases: Is It Time To Reassess The Bias?” Dr. Kluger’s answer is an emphatic yes.

Her determination to amend this bias began about three years ago when a man in his early 50s, still a robust soccer player with teenage children, came to her with melanoma and two small brain lesions. She tried to get him into studies that were testing effective new drugs against melanoma, but he was rejected because of the treatable brain lesions. He died of liver metastasis. “It was heartbreaking,” she said. “It really got me thinking.”

First she wanted to understand the origins of the bias. Twenty years ago, brain imaging was primarily done on older generation CT scanners, which couldn’t detect brain lesions until they were fairly large. The only available treatments were whole-brain radiation or surgery. Consequently the prognosis for people with brain metastases was dire—survival of four months or less—so including them in trials made little sense.

AMENDING A BIAS IN CANCER CARE

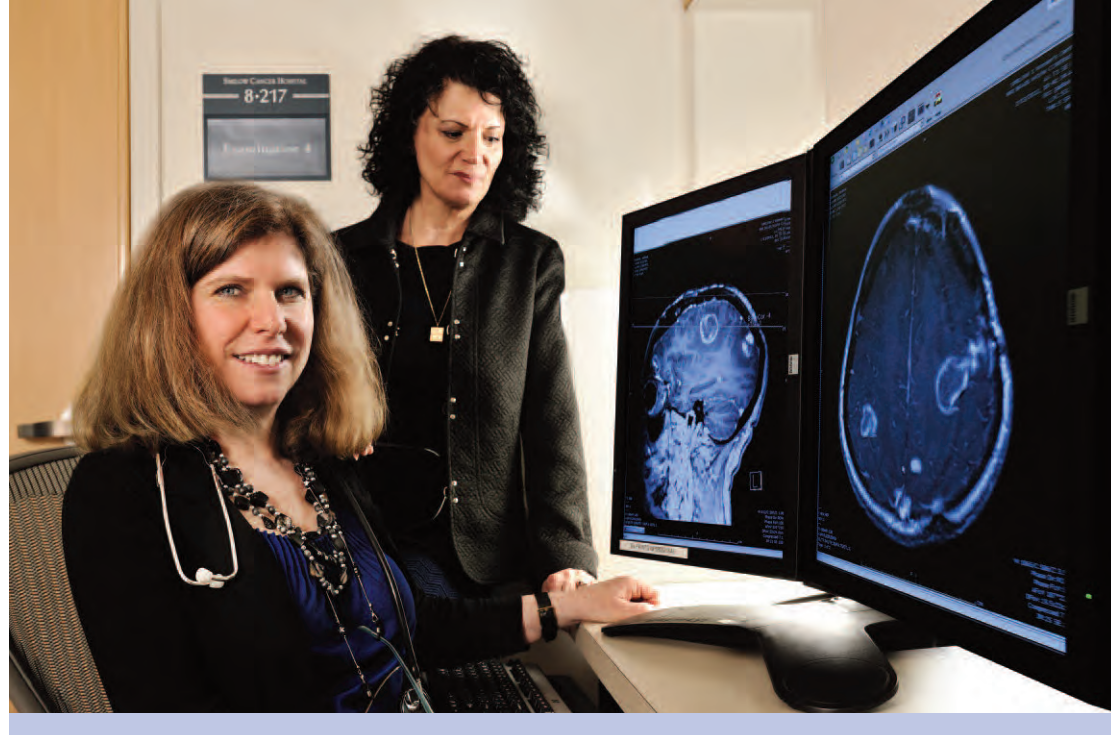
Steve Kemper **writer** Peter Baker **photographer**

Much has changed because of improved imaging and local therapies. Oncologists now order MRI scans of the brain early in the course of metastatic disease. “And when we find lesions,” explained Dr. Kluger, “we can treat them with gamma-knife therapy, with minimal complications and really good control.” These improvements have doubled the survival time of patients with brain metastases.

Yet the bias against including such patients in clinical trials remains in place, said Dr. Kluger, even though brain metastasis patients are not homogenous. Patients with a couple of small brain lesions whose clinical course is defined by large tumors in other sites, and who could benefit immensely from access to experimental therapies, are shunted into the same category as patients with overwhelming brain metastases.

“Experimental therapies are often better than the FDA-approved therapies,” said Dr. Kluger, “but many studies still exclude patients who have had any brain metastases at all. The bias is crumbling a little bit in that some newer trials are allowing us to treat patients who have had brain metastases that have been stable for a few weeks—a standard not required of any other organ—but at least it’s better than completely disallowing them.”

The early phases of new drug trials are typically initiated and driven by pharmaceutical companies, who usually don’t have brain metastases patients in mind when testing or developing a new drug. When such patients are included, it’s usually much later, when the drug is far along. Dr. Kluger understands the concerns that drug companies and researchers have about allowing patients with brain metastases into their trials. Patients with poor prog-



“WE MIGHT THROW OUT GOOD DRUGS”

noses who die during a trial can falsely skew the results and impede or even stop a drug’s development. “We might throw out good drugs,” said Dr. Kluger, who suggests that patients with brain lesions be included earlier in the process of drug development. The only time this has happened is a recent first-in-man clinical trial run by GlaxoSmithKline, which allowed inclusion of ten patients with untreated brain metastases.

Meanwhile she is in discussions with a drug company to conduct Yale’s first investigator-initiated trial aimed specifically at untreated brain metastases. She hopes to establish a multidisciplinary brain metastasis focus group within Smilow Cancer Hospital to run trials that give these patients access to new therapies.

Her lab and collaborators are also working on new initiatives, with pilot funding from the Cancer Center. “We are profiling tumors to identify molecules associated with brain metastases,” she said, “so that down the line we can target them with drugs.” A collaborator, Lieping Chen, MD, PhD, Professor of Immunobiology and Co-Director of the Cancer Immunology Program at Yale Cancer Center, is working on immunotherapy that would manipulate the immune system to reject brain metastases. Another collaborator, Peter Glazer, MD, PhD, Professor and Chairman of the Department of Therapeutic Radiology, is looking for ways to sensitize brain metastases to radiation therapy. And Marcus Bosenberg, MD, PhD, Associate Professor of Dermatology and Pathology, is developing new mouse models to allow testing of drug passage across the blood-brain barrier.

All of these activities have a similar goal: to change the bias that keeps brain metastases patients like that soccer-playing father from getting the cutting edge treatments that could prolong their lives. ↻



Tanning Linked to Skin Cancer in Young People

J Am Acad Dermatol. 2011 Dec 8.

The first rigorous study of an increasingly common form of skin cancer in young people has linked indoor tanning with risk. This new study, by Yale Cancer Center researchers, finds that people who used indoor tanning beds are at a significantly higher risk of developing basal cell carcinoma (BCC) before the age of 40 than people who never used indoor tanning beds. BCC is an extremely common type of skin cancer, more frequent than all other cancers combined.

The research team determined that young people who had tanned indoors had a 69 percent increased risk of early-onset BCC. The association was strongest among women and the risk increased with years of indoor tanning use.

Anti-smoking Campaigns Have Saved Over 800,000 Lives

J Natl Cancer Inst. 2012 Mar 14.

More than 800,000 lives were saved in the United States between 1975 and 2000 thanks to anti-smoking measures, according to a new study that used a Yale mathematical model to quantify for the first time the impact of anti-smoking measures on lung cancer. The authors also note that 2.5 million people who died from smoking-related lung cancer in this same period might have survived if stricter tobacco control measures had been in effect.

Researchers from the Yale School of Public Health, Yale Cancer Center, and more than a dozen other universities and institutes formed the Cancer Intervention and Surveillance Modeling Network (CISNET) consortium and used various mathematical models to analyze trends in cigarette smoking and quantify the impact of various tobacco control measures. Using Yale's mathematical model to calculate smoking rates, the researchers found that this gradual reduction in smoking over a 25-year period beginning in 1975 resulted in approximately 824,000 fewer lung cancer deaths, 603,000 of which were among men.

Tiny Genetic Variation Can Predict Ovarian Cancer Outcome

Oncogene. 2011 Dec 5.

Yale Cancer Center researchers have shown that a tiny genetic variation predicts chances of survival and response to treatment for patients with ovarian cancer. The findings provide new insights into the biology of a new class of cancer marker and suggest a genetic test may help guide the treatment of women with ovarian cancer.

Women who possess the biomarker identified by the Yale team – a variant of the well-known KRAS oncogene – are three times more resistant to standard platinum chemotherapy than women without the variant. Also, post-menopausal women with the variant are significantly more likely to die from ovarian cancer. About 12-15 percent of Caucasians and 6 percent of African-Americans are born with the variant of the gene, which helps regulate destruction of damaged cells. This variant is found in up to 25% of newly diagnosed ovarian cancer patients.

Prostate Cancer Treatment Overused in Some Older Patients

Arch Intern Med. 2012 Feb 27.

Treatment is not always warranted for older men with prostate cancer and a short life expectancy, Yale School of Medicine researchers found. The research team analyzed nine

years of Medicare data and determined that over the past decade, there has been a trend towards higher use of curative treatment for prostate cancer among men with certain types of tumors and a short life expectancy. The study included 39,270 patients between the ages of 67 and older.

These results suggest that cancer treatment was increasingly aggressive in patients who had the lowest likelihood of seeing clinical benefits. The researchers noted that while not treating potentially fatal cancer can reflect poor-quality care, aggressively managing disease that is unlikely to progress puts patients at risk for complications and increases costs without medical benefits.

Immune System Turning on Itself May Trigger Melanoma Growth

Sci. Transl. Med. 2012 March 28.

A new study by researchers from Yale and Johns Hopkins reveals the molecular pathway by which the body's inflammatory immune response may trigger its own inhibition, protecting tumor cells from destruction and allowing the growth of melanoma – the deadliest form of skin cancer. The study appeared in Science Translational Medicine.

Although it occurs less often than other skin cancers, melanoma causes the majority of skin cancer deaths. It is often curable in its early stages, but once it has spread invasively, it is very difficult to treat.

The researchers focused on a specific immune-inhibiting molecule in melanoma tumors known as B7-H1. They found that in patients whose tumors expressed B7-H1, suppression of the inflammatory immune response promoted the growth and aggressiveness of their melanoma tumors.

Further, they uncovered the mechanism by which this happens: Tumor cells somehow utilize an active component of the immune response itself, interferon gamma, to turn on B7-H1 and protect themselves by suppressing the immune system.



The Unhealthy Glow of a Golden Tan

“Go get a tan,” urged an ad from the Indoor Tanning Association. “Your body will thank you.”

More likely, your body will develop skin cancer, according to new research from Yale Cancer Center about indoor tanning. Published in late 2011, the study is the first to link basal cell carcinoma under age 40 with the use of ultraviolet (UV) emitting tanning devices. The researchers found that young indoor tanners, when compared to peers who never visited tanning salons, increased their risk of early-onset basal cell carcinoma by 69 percent. And the younger someone began indoor tanning, the greater the risk, which also increased with frequency of use. There was an elevated risk for basal cell carcinoma even in indoor tanners who never burned when using tanning beds. The group at greatest risk was young women, who are also the most frequent users of indoor tanning beds. The researchers concluded that 27 percent of early-onset basal cell carcinomas—43 percent among the women—could be prevented if tanning devices had never been used.

The Yale study adds more evidence to several recent indictments of indoor tanning. In July 2009 the World Health Organization classified UV-emitting tanning devices as

Group 1 carcinogens, like tobacco and asbestos. In 2010 scientists from the University of Minnesota reported that people under age 60 who had ever tanned indoors were at 74% increased risk of developing melanoma, the most lethal form of skin cancer, compared to those who never tanned indoors. In February investigators from a U.S. House of Representatives subcommittee reported that the tanning industry continues to tout the health benefits of indoor tanning, lies to potential customers about the risks, disregards FDA recommendations on frequency of indoor tanning, and tar-

In July 2009 the World Health Organization classified UV-emitting tanning devices as Group 1 carcinogens, like tobacco and asbestos.

gets teenage girls in its advertising.

“When people talk about cancer prevention, they mention tobacco, diet, physical activity, and obesity,” said senior author, Susan T. Mayne, PhD, the C.-E.A. Winslow Professor of Epidemiology at the Yale School of Public Health and Associate Director of Population Sciences for Yale Cancer Center. “I have not seen indoor tanning on the radar the way it needs to be. This is an obvious missed opportunity—skin cancer is mostly a completely preventable cancer.”

The Yale study’s lead author, Leah Ferrucci, PhD, a postdoctoral fellow in Chronic Disease Epidemiology, said the clear link between cancer and indoor tanning is especially important because most of the people who currently use tanning salons are young. “Consequently we have people developing skin cancer at a much younger age,” she said, “and they still have 50 or 60 years of risk where they can continue to develop these cancers. If we can stop indoor tanning among this young age group, we can prevent many of these skin cancers, and we can also prevent the high costs of treatment and morbidity down the line.”

Skin cancers increase with age, said Dr.

Mayne, yet 37 percent of the people under age 40 in the study had already had more than one basal cell carcinoma. “With the high prevalence of exposure among young people to indoor tanning,” she added, “what could be coming down the pike is terrifying.”

In March Dr. Ferrucci submitted testimony to the Connecticut legislature in support of a bill that would ban minors under 18 from using indoor tanning booths. On January 1, 2012, California became the first state to ban indoor tanning for anyone under 18, West Virginia joined soon after. Other states are considering similar prohibitions in their 2012 legislative sessions. Many states restrict minors from using tanning salons in some way, usually by requiring parental consent under the age of 14 or 16. But Drs. Ferrucci and Mayne pointed out that parents probably aren’t aware of the risks and that local health agencies rarely have the time or resources to monitor teenagers in tanning salons. As with cigarettes, a ban would provide greater clarity.

The other key to prevention is to convince people to change their risky behavior, a difficult task. “Our culture teaches that tan skin is desirable,” said Dr. Mayne,

“and young women are particularly image-conscious.”

Drs. Ferrucci and Mayne and other members of the research team, Drs. Brenda Cartmel, Joel Gelernter, and Allen Bale, have been recently funded to explore the hypothesis that indoor tanning may be addictive. They are re-contacting 600 people from the original study to measure tanning addiction, and trying to link measures of tanning addiction with genes that have been linked to other addictive disorders. The data suggesting that tanning may become addictive are preliminary, said Dr. Mayne, “but they are provocative.”

If addiction to indoor tanning is genetically mediated like other addictive behaviors, she continued—for instance, like alcoholism—then banning young people from doing it likely becomes even more important, since generally the earlier someone begins an addictive behavior, the more likely addiction becomes.

Other authors in the recently completed study include Drs. David Leffell and Annette Molinaro. The work was part of the Yale Specialized Program of Research Excellence in Skin Cancer, which is led by Dr. Ruth Halaban. ☺



PETER BAKER

The Smilow Cancer Care Center in Derby, Connecticut.

A New Hybrid Model for Cancer Care

In January 2012, Smilow Cancer Hospital at Yale-New Haven dramatically extended its ability to serve cancer patients throughout Connecticut by launching a network of Smilow Cancer Care Centers. The new network adds 18 physicians, 121 staff members, and six pharmacists in six community cancer care centers (Derby, Guilford, Hamden, New Haven, Orange, and Waterbury). Merging the state's largest private cancer practice, Medical Oncology & Hematology, PC, into Smilow Cancer Hospital created the largest cancer care delivery system in CT.

"We're bringing together Yale's academic cancer care model and the community care

model," said Arthur Lemay, the network's Executive Director. Combining the models, he added, strengthens both, and creates a new paradigm for cancer care in Connecticut. Patients in the network benefit from the comforts and convenience of seeing their doctor in a location close to home and avoid the hassles of travel.

"Yet they can also take advantage of all the things Smilow Cancer Hospital has to offer," said Anne Chiang, MD, PhD, Chief Medical Officer for the network and Assistant Professor of Medicine (Medical Oncology). "They will have access to clinical trials and cutting edge therapies that aren't always available in community cancer centers. Their doctors will be able to freely consult experts with subspecialty expertise."

gist at the Smilow Cancer Care Center in Waterbury within the Harold Leever Regional Cancer Center, agreed. "I feel like an equal colleague with world class people, not an appendage at all." The integration with Smilow, he added, is "a win all around. It brings the resources of Smilow to my patients, and it gives me easy access to tremendous resources in terms of research, clinical trials, and thought leaders. It lets me practice at the level of a first-class uni-

tertiary treatment. All of this, added Mr. Lemay, will make Yale more attractive to partnering with therapeutic drug development companies. The expansion will also help Yale maintain its National Cancer Institute designation as one of the country's 41 "comprehensive cancer centers."

"This is a hybrid of community care and academic medicine that really hasn't been done on this scale before," said Johanna LaSala, MD, a clinician at the Smilow

"This is a hybrid of community care and academic medicine that really hasn't been done on this scale before. We're taking the best practices from two somewhat different cultures and melding them into something with a synergy for cancer care that gives patients a tremendous advantage. It's an exciting time for all of us."

Johanna LaSala, MD

The cancer care centers will also be able to import specialty services from Smilow that will enhance the practices: for instance, social workers, clinical dietitians, and genetic counselors.

"Unlike the usual affiliation relationship," said Dr. Chiang, "this is a true partnership. The physicians who practice in the community are Yale faculty, not affiliated faculty, and the employees in the care centers are also Smilow Cancer Hospital at Yale-New Haven employees."

Kert D. Sabbath, MD, a medical oncologist

at the Smilow Cancer Care Center in Orange. "We're taking the best practices from two somewhat different cultures and melding them into something with a synergy for cancer care that gives patients a tremendous advantage. It's an exciting time for all of us."

The new network also brings new patients to Smilow. The cancer care centers significantly increase the number of Smilow's patients. The average number of daily visits to medical oncologists in Smilow in January was 148, compared to 226 in the cancer care centers.

"We now have access to a broader pool of patients for clinical trials," said Dr. Chiang. The cancer care centers also will help keep patients in-state who might otherwise be sent to New York or Boston for

Mr. Lemay expects the Smilow network to continue to expand. "We are in active discussions with other practices and hospitals," he said. The goal: to make Smilow-quality cancer care available within 30 minutes of every cancer patient and their family in Connecticut. ↻



PETER BAKER

Debbie Santangelo and her three children.

Parenting at a Challenging Time

When Debbie Santangelo’s husband Eric was diagnosed with stage IV lung cancer at the age of 42 it came as a shock to everyone, including their three young children. Eric was healthy up until his diagnosis, when he had a blemish removed from his face that came back as cancerous. Three months later, Eric passed from his disease.

“Eric was determined to stay alive for his family, and he kept this positive attitude throughout his diagnosis and treatment,” Debbie explained. “However, the disease proved too big for him, and had spread too far, too fast.” Eric spent his last 6 weeks at Smilow Cancer Hospital surrounded by his loved ones.

When Eric was first diagnosed with cancer, he and Debbie were faced with the difficult

task of explaining the scenario to their three children, then ages 12, 10, and 7. As his disease progressed and his prognosis became worse, they had to talk about the fact that he may not survive. Debbie and Eric questioned for awhile how they were going to tell them. They were worried about the long-term effects it could have on their personalities. When the concerns

came to the attention of their social worker, she referred them to the Parenting at a Challenging Time (PACT) service at Smilow Cancer Hospital.

The purpose of PACT is to guide parents with cancer and teach them what terminology to use, what knowledge is age appropriate, and the skills to handle certain situations that may arise. Andres Martin, MD, MPH, the Riva Ariella Ritvo Professor in Pediatric Oncology Psychosocial Services at the Yale Child Study Center, is the psychiatrist involved with the program and he, as well as a team of social workers, provide consultation to parents to give them a better idea of how to talk with their children after a diagnosis.

Even though Debbie has extensive background in child development as a special education teacher, she was unsure how to approach each of her children in the most supportive, appropriate way. “PACT taught us to be honest and up front with our children, because that would help them the most in the long run. We are so much closer as a family because of PACT. I was made aware of what my children were going through and how it was affecting them, and they also saw how hard it was for me. This mutual respect and understanding would never have occurred without PACT. It opened a dialogue between us that I didn’t think was possible.”

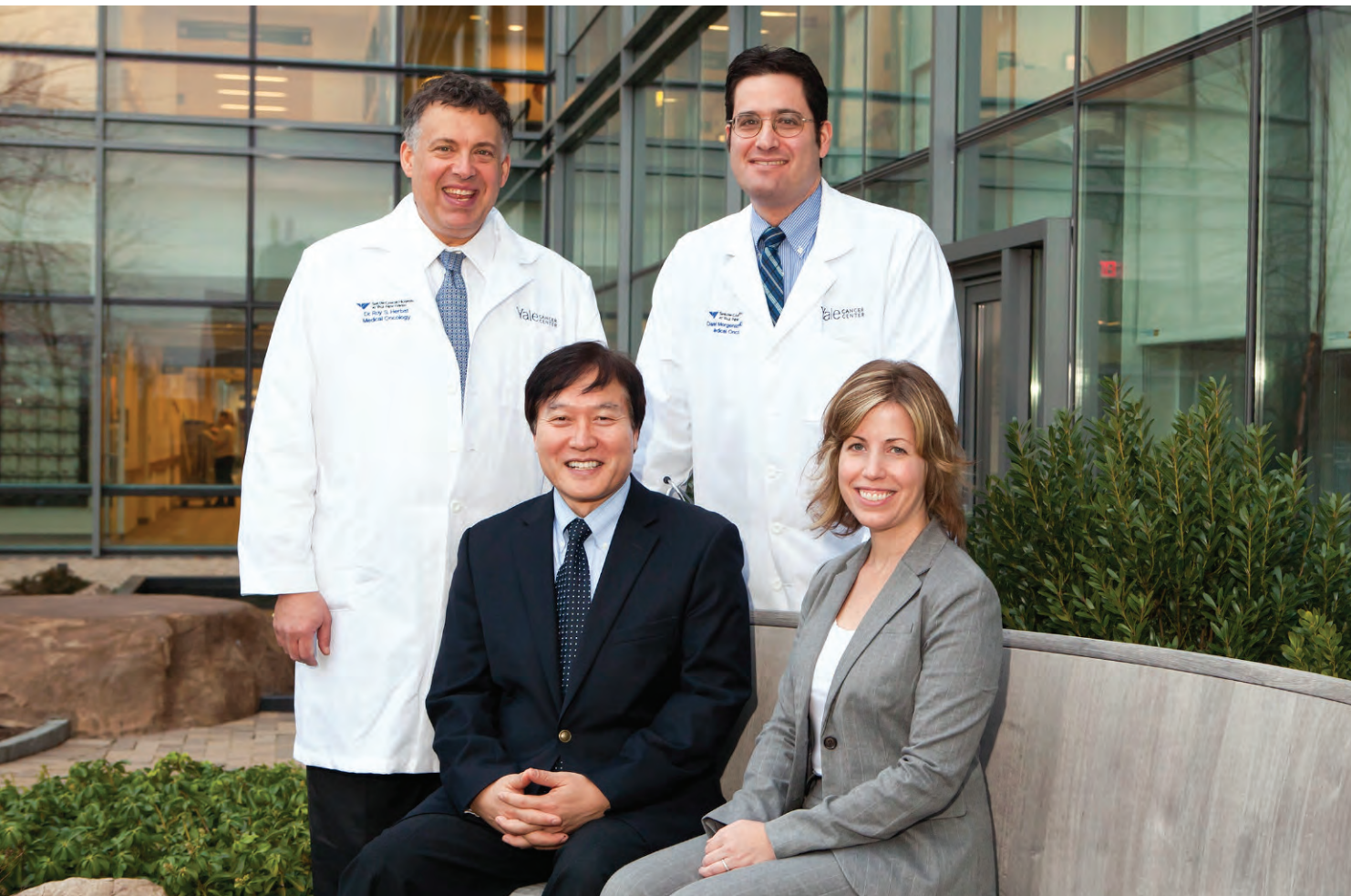
Dr. Martin explained that PACT gives parents the tools to talk to their children in a manner that is beneficial for both of them. The idea is to intervene and prevent issues from happening down the road. “When a parent is diagnosed with cancer, it doesn’t mean they stop being a parent. It’s just parenting under very stressful circumstances,” explained Dr. Martin. “The focus is on helping the parents and working with them to decide what’s best for their family. We serve as parenting coaches for the family unit.”

Bonnie Indeck, LCSW, Manager of Oncology Social Work at Smilow Cancer Hospital, co-manages the PACT program and is one of nine social workers involved. Since implementing the program over a year ago, there have been over 140 consultations. The goal is to eventually grow the program to address the needs of all parents undergoing cancer care.

“The idea of the program is to offer support and guidance to parents, including how to frame discussions with children, whether about a new diagnosis, the need for treatment, or approaching end-of-life,” Ms. Indeck said. “One of our long-term goals is to help the children remain emotionally healthy so they are able to adjust to their parent’s illness and its impact. We want the parent to focus on getting well without unnecessary worry about their children.”

After Debbie’s husband Eric passed, she was left with the questions and the grief. PACT gave her the advice and support she needed to guide her family through this time. As a way to keep his memory alive, she built a Zen garden featuring bamboo plants Eric had planted that had long been forgotten in the backyard. The garden serves as a reminder to the family of their wonderful husband and father. Debbie also recently participated in Yale Cancer Center Schwartz Rounds, a forum to help physicians, nurses, and caretakers become more aware of the importance of family involvement in care. She shared her story, and experience with PACT, to promote the service and help families who might otherwise not know about the program, or seek it out on their own. Debbie commented that it was a very positive experience, which she hopes can make a difference for another family going through a similar experience.

“I can’t imagine having gone through this without the help we received from PACT. I feel so much better knowing they are there for my family and me and can provide us with resources that will help us along the way, because this is a long-term process. Before Eric left us, he knew that his children would be okay, and that was very important for us.”



TERRY DAGRADI

Translational research efforts at Yale Cancer Center are led by Roy S. Herbst, MD, PhD, Peter (Ja Seok) Koo, PhD, Daniel Morgensztern, MD, and Julie Boyer, PhD.

Gift Brings Personalized Cancer Therapy a Step Closer to Reality

When Roy S. Herbst, MD, PhD, joined Yale as Professor of Medicine (Medical Oncology), Associate Director for Translational Research, and Chief of Medical Oncology at Smilow Cancer Hospital at Yale-New Haven last March, his arrival was seen as an important step toward the vision Yale Cancer Center Director Thomas J. Lynch, MD, had begun articulating in 2009. That vision centers on “personalized” cancer treatment—therapy regimens tailored to an individual patient’s tumor based on DNA sequencing of tissue biopsies. That vision is now closer to becoming a reality thanks to the generosity of David B. Heller, a grateful former patient of Dr. Herbst’s.

Through the Diane and David B. Heller Charitable Foundation, Mr. Heller and his wife, Diane, made a \$1 million gift to support Dr. Herbst’s efforts to advance translational research and cancer treatment at Yale Cancer Center. The gift will support efforts that Dr. Herbst, an expert in lung cancer research and clinical care, has been

leading for some time. Over the last several years, Dr. Herbst has spearheaded clinical studies of many anticancer drugs. His work using erlotinib in combination with bevacizumab was among the first to combine multiple targeted agents for non-small cell lung cancer (NSCLC). As co-principal investigator of the multifaceted Biomarker-Based Approaches of Targeted Therapy for Lung Cancer Elimination (BATTLE-1) trial, Dr. Herbst and his colleagues made significant advances in personalized therapy of NSCLC by using molecular analysis of tissue biopsies to determine the most appropriate targeted treatment available for each patient.

The Heller Foundation’s new gift supports Dr. Herbst’s vision for building translational research at Yale, including an expansive National Cancer Institute (NCI)-funded BATTLE-2 trial, which he designed. The trial’s objective is to further improve the efficacy of targeted therapies by identifying the NSCLC patients most likely to benefit from them. Dr. Herbst is committed to promoting similar studies initiated by Yale investigators, and has recently supported translational research collaborations among groups of three or more faculty members—including basic and clinical scientists, and junior and senior investigators—through an internal award mechanism called T-TARE (Translational-Targeted Area of Research

“By facilitating the expansion of our molecular profiling capacity, this gift allows us to develop an innovative translational medicine program under Dr. Herbst’s leadership. Ultimately, we want to use molecular profiling to help guide every patient’s treatment.”

Thomas J. Lynch, MD

Excellence). Out of seven applications received, four were awarded funds to strengthen the collaboration and facilitate the submission of new multi-investigator grant applications to the NCI.

New translational research initiatives at Yale will be highly collaborative, drawing on Yale’s strengths in anticancer drug design and genome analysis and integrating resources at the Yale Center for Genome Analysis and the new Cancer Biology Institute on Yale’s West Campus. In addition to launching BATTLE-2 and other similar translational research programs, the Hellers’ gift will enable Dr. Herbst and colleagues to build an infrastructure that will benefit similar studies of other forms of cancer.

The BATTLE-2 trial and other future translational research initiatives will be conducted under the auspices of Yale Cancer Center’s new Translational Research Program, which launched last fall under the leadership of Dr. Herbst

and Julie L. Boyer, PhD, Associate Director for Translational Research Administration at YCC. Peter (Ja Seok) Koo, PhD, Associate Professor of Medicine (Medical Oncology), was also recruited to this effort at Yale from MD Anderson in October.

“By facilitating the expansion of our molecular profiling capacity, this gift allows us to develop an innovative translational medicine program under Dr. Herbst’s leadership,” Dr. Lynch explained. “Ultimately, we want to use molecular profiling to help guide every patient’s treatment.”

“This is a truly special gift from a man for whom I have enormous respect. I am thankful for the Hellers’ investment in our plans, and I am especially grateful for their astute appreciation of the importance of flexible support in building translational research programs like this at Yale,” Dr. Herbst commented. ↻



Q+A

meet the physician

Peter G. Schulam, MD, PhD

Chairman and Professor of Urology, Director of the Prostate and Urologic Cancers Program

Urology was recently elevated to a department at Yale with your recruitment, what are your goals for the department over the next 12 months?

The goal for the department over the next 12 months is to focus on faculty and staff recruitment. We are actively recruiting faculty to care for patients at the West Haven VA and at Yale-New Haven Hospital. The department's vision includes programmatic development in genitourinary oncology focusing on both translational and health services research. In addition, we are embarking on a joint clinical program in pelvic reconstruction and incontinence with gynecology and colorectal surgery.

Central to the department's vision is a continual focus on patient and referring physician satisfaction. Our mission of patient and family-centric care is being developed in partnership with the mission and leadership focus at Smilow Cancer Hospital.

How has robotic surgery improved the recovery for your patients? Is robotic surgery standard of care?

The biggest advance in prostate cancer treatment in the last 5 years has been the adoption of robotic surgery. Robotic surgery now accounts for more than 80% of all prostatectomies performed for prostate cancer in the United States. I believe there are several advantages to this technique including minimal blood loss, reduced postoperative pain, and decreased convalescence.

There also may be an advantage to this technology with regard to transferability. That is, it may be easier to teach a radical prostatectomy to surgeons in training using the robotic system versus open surgery. The reason may be due to the visual guidance afforded by the magnified, high-resolution endoscopic image.

Enthusiasm, however, needs to be tempered by the fact that the robot alone is not the sole source for surgical outcome. The surgical technique used is not as important as the surgeon's experience. With respect to the primary outcomes (cancer control, urinary control, and sexual function), there is little difference between a robotic and an open prostatectomy when performed by a skilled surgeon.

PSA testing is often a controversy in the media. Is it a useful tool? How do you explain variations to your patients?

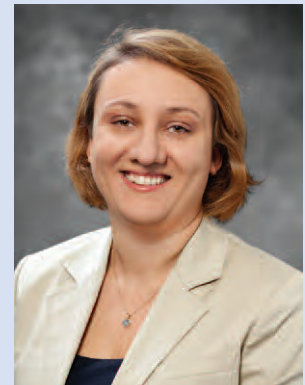
Currently, the prostate-specific antigen (PSA) test is a useful tool. There was quite a bit of media attention generated about PSA testing back in November of last year when the U.S. Preventive Services Task Force released a draft recommendation against prostate cancer screening for men of all ages. However, prostate cancer screening has decreased prostate cancer-specific mortality in the United States since its widespread adoption in the mid 1990s. The draft recommendation was supported by the fact that prostate cancer treatment can be associated with significant morbidity that can have an adverse effect on quality of life and that prostate cancer is over-treated in the United States. Overtreatment leads to patients with non-life threatening, low-risk disease being subjected to the significant potential harms of radiation and surgery.

The real question that needs to be addressed is how to identify those patients with high-risk disease, realizing that not every patient with prostate cancer needs treatment. This area will be a focus for the Department of Urology at Yale. The department will study methods to improve screening for prostate cancer, to identify those patients whom would most benefit from intervention, and explore alternative treatments that reduce the adverse effects on quality of life. This program will be a multidisciplinary effort linking engineering, diagnostic radiology, and urology.

Iris Isufi, MD

Iris Isufi, MD was recently appointed to the faculty at Yale Cancer Center and Smilow Cancer Hospital as an Assistant Professor of Hematology. Dr. Isufi completed her fellowship in Medical Oncology and Hematology at Yale Cancer Center. She received her medical degree from Stony Brook University Medical Center and completed her internship and residency at Albert Einstein College of Medicine/Montefiore Medical Center in NY.

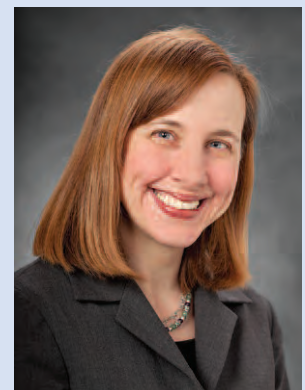
Dr. Isufi is actively involved in the clinical care of patients with hematologic malignancies in need of allogeneic or autologous stem cell transplants. Dr. Isufi also assists with clinical research efforts to find new ways to minimize organ toxicity from stem cell transplantation conditioning regimens and limit graft versus host disease.



Jennifer Kapo, MD

Jennifer Kapo, MD has joined Yale Cancer Center and Smilow Cancer Hospital at Yale-New Haven as Chief of Palliative Medicine. Dr. Kapo is an Associate Professor of Medicine (Geriatrics). Most recently, Dr. Kapo was at the University of Pennsylvania where she was the medical director of the palliative care services at the Philadelphia Veterans Administration Medical Center. Dr. Kapo will expand our capacity to provide clinical palliative medicine to our patients. In addition, she will focus on developing a research mission in palliative medicine and expanding teaching opportunities for existing Yale faculty, staff, fellows, residents, and medical students.

Dr. Kapo received her medical degree at the University of Pennsylvania. She completed her residency at the University of Colorado and a fellowship in geriatric medicine and palliative care medicine at the University of Pennsylvania.



John Roberts, MD

Dr. John Roberts has accepted a position to lead a comprehensive Adult Sickle Cell Program at Smilow Cancer Hospital. Dr. Roberts will be a member of the medical oncology faculty and will also care for patients in the Prostate and Urologic Cancers Program.

Dr. Roberts joins Yale Cancer Center from Virginia Commonwealth University (VCU), where he was past interim chair of the division of hematology, oncology, and palliative care and past co-director of the VCU Adult Sickle Cell Program. At VCU Massey Cancer Center, Dr. Roberts was Associate Director for Clinical Research and Director of the Clinical Protocol and Data Management Shared Resource. He received his undergraduate degree from Harvard University and his medical degree from the University of Pennsylvania.



Fatma Shebl, MD, PhD

Fatma Shebl, MD, PhD has joined the Yale School of Public Health as an Assistant Professor in the Division of Chronic Disease Epidemiology. Dr. Shebl was the successful candidate following a joint search process between the Yale School of Public Health and Yale Cancer Center that was targeted at the recruitment of a scholar conducting epidemiologic or population sciences research on infectious agents and cancer.

Prior to joining Yale, Dr. Shebl was a research fellow at the National Institutes of Health in the division of cancer epidemiology and genetics in the infections and immunoepidemiology branch. She received her medical degree at Alexandria University in Egypt and her PhD from the University of Maryland in Baltimore.



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