

Welcome to Yale Cancer Center Answers with Dr. Ed Chu and Dr. Ken Miller. I am Bruce Barber. Dr. Chu is Deputy Director and Chief of Medical Oncology at Yale Cancer Center and Dr. Miller is a medical oncologist specializing in supportive care and he is the author of the recently published book "Choices in Breast Cancer Treatment." If you would like to join the discussion you can contact the doctors directly at canceranswers@yale.edu or 1-888-234-4YCC. This evening, Dr. Ed Chu is joined by his friend Dr. Otis Brawley who is Chief Medical Officer of the American Cancer Society.

- Chu Let us start off by having you tell the listeners a little bit about your background and what got you interested in the whole field of oncology and cancer care.
- Brawley I grew up in Detroit and in high school I was very interested in science as well as politics and policy. I went to the University of Chicago, and originally was a chemistry major, met some people in the medical center and ultimately got corrupted into going into medical school. I went on to train in oncology because there were a lot of political and policy issues there. I became a practicing physician and went on to work at the National Cancer Institute for some time, and became both an administrator and a researcher there. I was recruited to Emory University as Deputy Director for Cancer Control. I spent 7 years in academia, and liked it a great deal. The American Cancer Society, for 20 years, had their home office on the Emory University Campus, and I became very friendly with folks from the American Cancer Society, especially my predecessor as Chief Medical Officer, Dr. Harmon Eyre. When he retired they asked me to replace him, and this has been a wonderful job for me because I get to do medicine and science as well as policy, and think about how we can change things in the United States so that the fruits of scientific research in medicine can positively affect people.
- Chu When you were at Emory, would you spend any time interacting with the folks at the American Cancer Society?
- Brawley Yeah, many of the epidemiologists, and we have some of the finest epidemiologists in the world at the ACS and it is my privilege to work with them, are also on the faculty of Emory. So there were a number of studies that we had in common and so I have had interactions with ACS folks ever since I got to Atlanta in 2000.
- Chu So, it was kind of an easy transition for you to go from the academic ivory tower of Emory, to the American Cancer Society?
- Brawley In many respects I just switched a little bit because I am still on the faculty at Emory; I still have a research group there and I still see patients at Emory. I get to work with these folks who I have worked with for 7 years, but now I get to work with them more intensively.

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Chu Can you tell us a little bit about some of the specific goals of the American Cancer Society?

Brawley The American Cancer Society is 96 years old. It was established with the lofty goal of controlling and ultimately abolishing cancer. Today, what we do is a lot of service to cancer patients and cancer patient families, anything from providing information about the disease and treatment, to providing information about clinical trials. We even organize volunteers who give people rides to the doctor; that is one side of it. On the other side is our research effort. We are the second largest funder of cancer research in the United States, second only to the US Government, and we also have an intermural cancer research group that does a great deal of epidemiology, cohort studies. One of the first studies to ever show that cigarette smoking causes cancer was an American Cancer Society cohort study.

Chu It really is remarkable, all of the different services that the American Cancer Society provides.

Brawley Yes, thank you. Service to patients and families is foremost, as well as giving information to the public, and then comes our research efforts. We all take those experiences and we have an advocacy arm, it is a C4, called the American Cancer Society Cancer Action Network, and they lobby state and Federal Governments for things like having smoke free laws, as well as trying to change things to make financing of healthcare more affordable to Americans.

Chu Before we forget, and obviously we will do this again at the end of the show, but for those who would like to gain additional information, either by calling the ACS or going on the internet, can you give those key details for our listeners?

Brawley Our website is www.cancer.org and we have a 24-hour, 7-day-a-week, phone line that provides cancer information. That number is 1-800-ACS-2345.

Chu And for those who want to know the specific number, it is 1-800-227-2345. I checked before the show so that we would all have that. I was also looking on the website, which I have to say I use a great deal, and it is very easy to maneuver.

Brawley Thank you.

Chu Both for physicians and in particular for patients. There also is a hotline, as I understand it, for patients and loved ones who are interested in accessing information about clinical trials.

Brawley That is correct.

Chu Do you know that number off hand?

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- Brawley I do not, but they can get it through the 1-800-ACS-2345.
- Chu Actually I happen to have it right here. For those who are interested in accessing additional information on clinical trials, the number is 1-800-303-5691. That is an invaluable service that your group offers to patients.
- Brawley Thank you, I know a number of people have found it quite useful. One of the greatest problems in cancer today is that only 3% of adults go on clinical trials, and I am preaching to the choir when I tell you that we are going to improve outcomes in cancer by having more and more people go on clinical trials. It was noted on a show I did earlier this week, that 70% to 75% of pediatric cancers are cured nowadays, and about 70% of kids with cancer go on clinical trials; the two are somewhat related. The problem is that less than 4%, closer to 3%, of adults go on the clinical trials. If you have a disease like cancer and you can get on a clinical trial, we definitely encourage you to consider participating.
- Chu That is a very-very important message. I know that here at Yale Cancer Center our goal is to try to put at least 15% to 20% of all eligible patients onto a clinical trial; it is widely important.
- Brawley We have some of the research that I did perhaps 10 to 12 years ago when I was at the National Cancer Institute in Bethesda, and it has shown that the doctors who offer a small portion of their patients the opportunity to go on clinical trials, give all their patients a better quality of care. It is actually a marker for patients if they have a good doctor, if they participate in cancer clinical trials.
- Chu That is interesting, why do you think that is?
- Brawley This is a cart and horse analogy. Is it that doctors participate in clinical trials because they are better doctors and they know that is how we improve clinical care, or is it that the clinical trials are a form of continuing medical education that allows the doctors to stay up to date? Both are probably true.
- Chu Yeah, I think you are right on that point. Let us focus a little bit on your own areas of research interest. We have focused on this issue of cancer racial disparities. Could you start off by telling us what that means and then tell us about your research?
- Brawley Sure, I was asked to look at the prostate cancer problem by Sam Broder when he was Director of the National Cancer Institute in the early 1990s. There are higher incidences in the mortality rates among blacks with cancer versus whites, and that work spread to look at a number of other

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different diseases and we began to realize that many of the disparities, for example, in colorectal as well as breast cancer, did not exist prior to about 1980. Black and white death rates were the same until 1980-1982 or so, and it was as we learned how to treat these diseases better that a higher proportion of people who were white got adequate treatment compared to the people who were black. This is important because there are some whites and some blacks who get good treatment, and some whites and some blacks who do not get good treatment. We found that poverty and disenfranchisement were the two largest factors driving whether someone got less than optimal care. This led to a series of studies looking at how people get care, do they get good care or do they get bad care? And many of these disparities and outcomes, simply meaning higher risk of death, is due to a late diagnosis, not getting good care before a diagnosis, or a combination of that as well as not having optimal therapy once diagnosed.

Chu I know that a major focus for the NCI designated Cancer Centers, and certainly from the American Cancer Society point of view, is trying to enhance access to early detection screening. Are there differences between whites and African Americans and other minority underserved populations?

Brawley There are only differences in the proportion of people who get the types of preventive services that they need. Lower proportion of blacks, for example, get colorectal cancer screen than whites; that is also true of breast cancer or cervical cancer screening. I have mentioned those three because those three screenings have clearly saved lives. I can tell you that from 1990 to 2005, about 140,000 people did not die from cancer because of breast and colorectal cancer screening. We prevented that many deaths, and it is only about 30% to 40% of Americans who are of the age where they should be getting these screening tests. I give talks about how many lives would have been saved if we had 80% to 100% of the American population that should be getting colorectal, breast, and cervical cancer screening, get screened. It is a huge problem. The uninsured are more likely not to get those tests, but even amongst insured people we have 60 plus % of insured people over the age of 50 getting colorectal cancer screening, yet we know colorectal cancer screening lowers ones chance of death by a third.

Chu As you know, my own area of interest is colorectal cancer, and it is always amazing to me that well educated individuals, who know that screening for colorectal cancer can perhaps save lives, still do not want to get the screening or early detection methodologies.

Brawley Some people are concerned about the invasiveness of the colonoscopy, which is recommended that it be done once every 10 years, and I understand that, but for those people, stool blood testing once a year has been shown to be highly effective, yet they do not get that. Stool blood testing is very inexpensive and it is not that hard to get.

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Chu In fact there is now a recent report that has just come out showing that virtual colonoscopy is probably equivalent to the gold standard invasive colonoscopy.

Brawley That is right, and for people who do not like the prep for colonoscopy, right now you do have to use some type of a prep, be it phosphate soda or GoLYTELY for the virtual colonoscopy with the CT scanner, but in the very near future, the computers are going to be able to digitally subtract the stools, so you will be able to have a virtual colonoscopy without having to get a bowel prep.

Chu I hope so because certainly that GoLYTELY, which yours truly has had at least a couple of times, is a bit of a misnomer. Getting back to the cancer disparity issue, have we made progress, and if we have not, what are some of the hurdles and obstacles that we need to overcome?

Brawley We have made some progress in cancer disparities in that we have realized that it is a huge issue, and death rates for breast cancer, colorectal cancer, and several other cancers are starting to come back towards not being the disparity, but they are still a disparity. The death rate for black versus white in colorectal, breast, cervical, lung, and a couple other cancers, was wider in 2005 than it was in 2000, but we do see the death rate for blacks starting to come down. Ultimately, if we continue the current trend, in another 15 to 20 years they will all normalize, but we have got to continue current trends by stressing the fact that there are disparities, and stressing the fact that we desperately need to make sure we get Americans adequate health care; be it preventive services before they are diagnosed, or treatment services after diagnosis.

Chu You are listening to Yale Cancer Center Answers. I am discussing the latest in cancer research education and hearing all about the great services and roles that the American Cancer Society has with my good friend, Dr. Otis Brawley who is Chief Medical Officer of the ACS.

Medical Minute

There are over 10 million cancer survivors in the US and the number keeps growing. Completing cancer treatment is very exciting, but cancer and its treatment can be a life changing experience. After treatment, the return to normal activities and relationships can be difficult and cancers survivors may face other long-term side effects including heart problems, osteoporosis, fertility issues, and an increased risk of second cancers. Resources for cancer survivors are available at Federally Designated Comprehensive Cancer Centers such as Yale Cancer Center to keep cancer survivors well focused on healthy living. This has been a medical minute and you will find more information at www.yalecancercenter.org. You are listening to the WNPR health forum from Connecticut Public Radio.

Chu Welcome back to Yale Cancer Center Answers. This is Dr. Ed Chu and I am here in the studio with Dr. Otis Brawley, Chief Medical Officer at the American Cancer Society. Before the break

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we were talking about this issue of racial disparity and I am just curious, what programs has the ACS initiated to try and help address this issue of improving access to care?

Brawley The biggest program that the American Cancer Society has launched is a discussion about access to care. We have documented a substantial number of Americans, white, black, and other, especially employed and insured Americans, once diagnosed with cancer find that their insurance is inadequate. I have gotten letters, for example, saying a 25% co-pay on a \$100,000 bill for my son's cancer is really a hard bill to swallow, we have a \$40,000 year income as a carpenter and what have you. So we have been spending a lot of time in Washington, we have had advertisements on TV talking about access to care, a lot of people talk about the 47 to 50 million Americans who have no insurance. We need to talk about that, but there is another group of Americans who have insurance and when they find out that they are underinsured is when someone in their family is diagnosed with a devastating disease like cancer. So we have spent a lot of time looking at that. Our epidemiologists have shown that the underinsured and the uninsured do not get as good treatment for disease in this country as the insured. We have shown that the 5-year survival rates are inferior with the same amount of our cancer, or same stage of cancer, among the uninsured versus the insured. We are trying to document what the problems are in getting adequate care to all people.

Chu Does the ACS have programs that might be able to help these disadvantaged patients be able to find resources and help them go for their treatments?

Brawley With our 800 number we spend a great deal of time working with people and in some instances, arguing with their insurance companies to expand coverage. We also have navigator programs, people who are ACS employees that are jointly employed by hospitals to try to find all the services that a cancer patient, or cancer patients' family, might be able to use in that community. They are somewhat like social workers, but they are actually in a charge of doing even more than a social worker would normally do. Many of those navigators are themselves survivors who have gone through the system, so they feel the kindred spirit for the folks who are going through cancer at the time. Through our 800 number, we have the ability to get access to local ACS chapters for people who need rides to the doctor. One of the things that our epidemiologists have shown us is that a third of women in this country who are supposed to get 8 weeks of radiation therapy after a lumpectomy drop out of their radiation therapy. That is one in three. It is not one in three black women; it is one in three women who should be getting radiation drop out of therapy. The biggest reason is transportation, so we are trying to get people optimal therapy by looking at logistical issues like child care and transportation, while trying to provide as many services as possible. Ultimately, the most important thing we can do for the cancer patient and their family is provide them information about cancer and provide them information about how it should be treated so they can have a good conversation, or series of conversations, with their

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health care providers because people talk to their doctors to get better service.

Chu What is really remarkable to me is that all of these tremendous services are offered free of charge.

Brawley That is absolutely correct. If anyone wants to give us a donation, we will happily accept it, but we do not sell our services, we give our services away. We think it is inappropriate to ask someone who we are trying to provide a service for, for money.

Chu I think that is tremendous. As you mentioned earlier in the first part of the show, the ACS spends a great deal of time trying to track the statistics of each of the different cancers. How are we doing with respect to the death rates and incidence of cancer over the last few years?

Brawley I am very proud of our epidemiologists; the American Cancer Society statistics for cancer are the most quoted in the world. Since 1991, we have had a decline in the death rate for cancer, led primarily by people not smoking or stopping smoking in the 1960s and 1970s, but also caused by breast cancer screening, colorectal cancer screening, and cervical cancer screening, the three screenings that we know for sure save lives. So we have had a decline that has been significant. The decline is greater amongst whites than amongst blacks, but we have seen a decline amongst Hispanics as well. In order to continue that decline, we need to start talking about people eating fruits and vegetables, people getting exercise, people not smoking, and people getting the types of preventive care measures that they need.

Chu Once patients are diagnosed with say, breast cancer or colorectal cancer, it is really remarkable the advances that we have seen in terms of the different types of treatments now available. When we were fellows and trainees at the NCI many moons ago, we did not have a lot of choices for breast cancer or colon cancer.

Brawley You and I came into science at exactly the right time, because we have gotten to see so many drugs that actually do benefit people. When you and I first met, our treatments for colorectal cancer other than surgery for early stage cancer were very rudimentary. I did not even dream back then that we would have drugs that could actually cause complete remission. We have gotten very good in our treatment of breast cancer. I am hopeful that we are going to improve our treatments for prostate cancer soon, but we have got drugs that actually work and benefit people and all of that has happened over the last 25 years.

Chu It really is a remarkable story, and again, the ACS should be commended for helping in pushing the frontiers of cancer research and therapy forward.

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- Brawley Some of the folks who have been here a little longer than me are very proud of the fact that the ACS gave out some of the first grants for 5-fluorouracil, which has been around now for 49 years. They gave out some of the first grants for Gleevec, which has been wonderful in treating some of the leukemias as well as gastrointestinal stromal tumors. We have now funded 42 people who have ultimately won a noble prize in medicine.
- Chu One of the things, maybe not as well appreciated, but when people think of the ACS they think of its screening, detection and prevention, but as you have said, there is a very strong research component in terms of ACS funding and critical groundbreaking research.
- Brawley Yeah, and the National Institutes of Health, a Federal Government arm for funding research, has decreased some of the areas in which they emphasize, for example, they are not funding as many young investigators in science, or people with PhDs or MDs who are just starting out in our medical schools to do cancer research. Nowadays, the American Cancer Society funds one third of the early investigators in science.
- Chu That is important because clearly it is the young investigators who would represent the next generation.
- Brawley Our next great advancements in the era of 2015-2020 are going to come from people who are coming out of training right now, and those are the people that the American Cancer Society are funding and trying to keep in the science, keep from just going into the practice, or the industry, keep them in the Universities, keep them doing research and developing the new drugs and new treatments.
- Chu It is amazing how quickly the time has gone. We are coming to a finish, but I was wondering if you had any key take-home messages that you would like to leave our listeners with.
- Brawley If anyone has questions about cancer, or needs any kind of information, they can always call 1-800-ACS-2345, or look on our website www.cancer.org. I always like to ask people to try to take control of their own lives when they go to the doctor, try to have a good conversation with that doctor, try to learn something and challenge the doctor with questions. You get better service that way.
- Chu That is a great message to end on, thank you for being our guest this evening.
- Brawley Thank you for having me.
- Chu You have been listening to Yale Cancer Center Answers and I would like to thank my special

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guest and good friend, Dr. Otis Brawley for joining me today. Until next time, I am Ed Chu from the Yale Cancer Center wishing you a safe and healthy week.

If you have questions for the doctors or would like to share your comments, go to www.yalecancercenter.org where you can also subscribe to our podcast or find written transcripts to past programs. Next week, you will meet Dr. Joachim Baehring who joins Ken Miller to talk about the treatment of brain tumors. I am Bruce Barber, and you are listening to the WNPR Health Forum from Connecticut Public Radio.