



In What Way Does Being Female Increase Your Cancer Risk? A Look At Gynecologic Cancers

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Introduction

Andrew Schorr:

We're live on KVI Talk Radio 570. Patient Power is coming up next where we will hear the story of a 59-year-old woman from Bellevue who thought she was seeing the early signs of menopause, and it turned out to be cancer. Are there lessons here for the women you know? There are, including your opportunity to ask questions of leading experts in the field. It's all next for you live on Patient Power on KVI Talk Radio 570.

Andrew Schorr:

Good morning around Seattle, Western Washington, listening on KVI and wherever you may be around the world on the internet, I'm Andrew Schorr. This is Patient Power, the only live program on commercial radio anywhere where week after week we cover new topics, important chronic illnesses and cancers and connect you with leading experts who can help you or someone you care about get the very best medical guidance and make smart decisions and also empower you as a patient.

Our program is sustained with wonderful financial funding to help us continue week after week. We've been doing it almost two years. I want to thank the University of Washington Medical Center, Harborview Medical Center, now the Seattle Cancer Care Alliance as well and the Virginia Mason Medical Center. They care so much about you they want this program to be on the air, on their websites as well and on my website patientpower.info that about 10,000 people are using monthly now so that you can get the best.

I want you to meet somebody who became a powerful patient advocate. For me it happened because I had leukemia and then sought out the best care, and I'm here today because of it. Gina Milano is 59. She is a mom and a grandmom, and she is from Bellevue. And a couple years ago she at her age, you know, thought she was going through menopause, ladies, had spotting, you know what that is. And she went to her doctor, and the thought was maybe that's what was going on. It was all associated with menopause, made sense, right?

But, Gina, that's not the way it turned out, was it? You relaxed for a while, but you also wondered, right?

Gina:

Yes.

Andrew Schorr:

What ended up happening?

Getting A Correct Diagnosis

Gina:

Well, a year went by and I pretty much had the same symptoms after the doctor told me not to worry, it was just menopause. He had done an ultrasound, and he also did an estrogen test, and the estrogen test showed that I certainly didn't have any dip in the estrogen so it wasn't menopause yet. But there was a build-up of the endometrial lining, which he didn't tell me about. So about a year later and I was still having the symptoms, I went back and he did another ultrasound and another estrogen test. And it was actually the lab and the people who were reading my ultrasound who told me that the size of my endometrial lining was, as he put it, alarming. It hadn't changed in about a year.

Andrew Schorr:

So you went on about a year with this spotting.

Gina:

Right.

Andrew Schorr:

But the estrogen test didn't seem to indicate it was menopause.

Gina:

Right.

Andrew Schorr:

So but you just sort of said well--

Gina:

It must be menopause. I believed the doctor. So after the "alarming" word came back, they sent me over to have a biopsy of my uterus, which is not a terribly painful procedure. It's done right there in the doctor's office. And it came back atypia cells, which are not necessarily cancerous but are a warning cell. The doctors who are here today could probably tell you more about those. And I did some research on the internet because all this was new to me. The internet can be a wonderful resource. It can also be kind of scary. Not all the information you get is correct, but one of the things that I read said even though the chance of it being cancer are small with atypia cells to take it seriously and assume that it's cancer unless it's proved otherwise. And that to me was a real turning point. Because my doctor told me to go get an orthoscopic hysterectomy, which goes through the vaginal walls, and they kind of remove everything that way, and that is very attractive because it only has a two-week recovery and you're back to work.

Andrew Schorr:

And that would get rid of the spotting.

Gina:

Well, it would get rid of the uterus and everything. But it wouldn't give the doctor the opportunity to look further and take the lymph nodes and things like that. So when I told my GP that I was considering going to Seattle Cancer Care Alliance he actually told me I was overreacting.

Andrew Schorr:

Right. And ladies, let's face it, there are instances, it could be headaches you're having, it could be fatigue, it could be spotting where sometimes you're just told, well, it's probably this, don't worry, when it could be something more serious. You need to know your own body and sometimes do your own research to push to what will allay your fears and get an accurate diagnosis if there is one to be had.

Gina:

Or ask your doctor to prove to you that it's not something.

Andrew Schorr:

Right. And of course in this case a worry would be about a scary cancer, and so you definitely want to rule that out. So what happened, Gina, was, eventually it wasn't ruled out, was it?

Gina:

After the surgery or in the surgery room they did another biopsy, and it still came up atypia cells. So I thought I was home free. I was quite happy. And then about a week or two later all the biopsy reports came back, and indeed in one of the lymph nodes there was cancer cells and in a wash that they did of my pelvic area there were cancer cells. So I was very grateful that I had gone the full route of a complete hysterectomy.

Andrew Schorr:

Right, and I just want to make that clear. The initial doctor said, well, you can have a hysterectomy, we can do it vaginally, no big deal, quick recovery. Sounds good. But it wouldn't have given the surgeon the opportunity to really look around for cancer.

Gina:

Correct.

Andrew Schorr:

You chose to go that extra way. Any woman who has had an abdominal hysterectomy knows that it's a bigger deal. It's abdominal surgery. You made that choice, and then it ended up that in fact your doctor did and the pathologist did find cancer. Now, the woman sitting next to you is your doctor, the one you chose, and that is Dr. Heidi Gray. She's a gynecologic oncologist. She did the surgery at the Seattle Cancer Care Alliance.

So, Dr. Gray, this extra detective work that Gina pushed for paid off in identifying a cancer earlier than maybe would have been known otherwise, correct?

Dr. Gray:

Yeah. I first of all just want to thank Gina for being on this show.

Andrew Schorr:

Absolutely.

Dr. Gray:

I think it's really excellent to have a patient advocate.

So in Gina's case, as she was describing, there was a couple of red flags when she came to see me. Certainly someone at the age of 59--the average age of menopause is usually around 50, early 50s, and so for someone to continue having bleeding of course always kind of raises a little bit of a red flag that symptoms have been going on for a while. And, yes, she did have a biopsy that only showed this hyperplasia with atypia, which we think of as kind of a precancerous condition, but again the length of the symptoms she was having was a little bit alarming to me.

So we did discuss about different routes of hysterectomy, but in patients with a diagnosis of this precancerous or atypia, about 25 to 30 percent will actually have cancer in her hysterectomy specimen. So it isn't, as Gina said, it's not necessarily a get out of jail free card. There is a high percentage of patients that will have cancer. And in Gina's case, again, although initially it didn't--it looked like the cancer was confined I did do a could complete surgical staging, and in her case she did have spread.

Andrew Schorr:

Okay. We're going to take a break. You're going to meet another expert, somebody who has been at the University of Washington in gynecologic oncology for a long time, actually helped train Dr. Gray too. And you're going to have an opportunity to ask questions about gynecologic cancers, endometrial, uterine cancers in general and ovarian. I know we're in Breast Cancer Awareness Month now, ladies, but this is important to be on your radar too. We'll be back with more Patient Power right after this.

Gynecologic Cancers

Andrew Schorr:

Welcome back live to Patient Power. Andrew Schorr here on what I had hoped would be a sunny day. We're getting a kind of gray blanket here in Seattle, but no rain, so I'm going to do something outdoors and enjoy the day. Hopefully you have a great weekend and you are having a great weekend.

For the ladies in your family, though, as they get older certainly we worry about breast cancer, but there are others to think about as well. Gynecologic cancers,

uterine cancers, endometrial cancer is part of that that Gina Milano from Bellevue is being treated with. He she's gone through chemotherapy and then radiation and then chemotherapy again just since January, so quite a lot but hoping to cure it.

We've also met Dr. Heidi Gray, who is a gynecologic oncologist with the UW and Seattle Cancer Care Alliance. But I mentioned there is also a senior gynecologic oncologist here as well who really has trained many and is also one of the leaders in setting the standards for the treatment of these cancers around the country, and that's Dr. Ben Greer.

Dr. Greer, thank you for being with us. Help us understand, when we talk about these cancers, we know there are 200 some-odd thousand new breast cancer case cases a year, but when we put together ovarian cancer and the uterine cancers how common are those?

Dr. Greer:

Well, I appreciate the opportunity to be on the show. You know, I think it's a very good question, and I always try when I educate for continuing medical education to point out to obstetrician-gynecologists especially that they're more likely to make a breast cancer diagnosis than a gynecologic cancer. As you mentioned, there are 250,000 breast cancers per year. There is only a total of all gyn cancers about 80,000 cases. Endometrial cancer makes up about half of that, so around 40,000 cases a year. And as Gina has shared her story, it's very important to listen to your body and your symptoms, and that's the most likely way to be diagnosed early and have a good outcome.

Andrew Schorr:

And being diagnosed early is really the name of the game in cancer generally and certainly in these. Isn't that true?

Dr. Greer:

That's true. Vaginal bleeding or spotting, as Gina had, is the way to lead to either an endometrial biopsy or an ultrasound of the lining of the endometrium to determine if it's abnormal, and then that kind of drives the decision-making for proper surgery.

Andrew Schorr:

Is there any connection between a woman who has had endometriosis and then later endometrial cancer?

Dr. Greer:

There is really not much of a connection between endometriosis and endometrial cancer. Occasionally there is some confusion if when we get the pathology back, what we call adenomyosis, which is really endometrial cells that have grown into the muscle wall of the uterus, and some people interpret that as being an invasive process when indeed it's not. And it's kind of important that when those questions arise that someone who is a specialist in gynecologic oncology and pathology reevaluate those slides to make a determination.

Signs and Symptoms

Andrew Schorr:

Dr. Gray, so we heard Gina had spotting. Dr. Greer has mentioned about spotting. So that's an early sign. Certainly there are women listening who have had that. Now, I don't mean to make them worry unnecessarily, but maybe you can give us some further guidance on when this needs to be investigated further, what you would recommend.

Dr. Gray:

Well, certainly women that have gone through menopause, so they've had complete cessation or stopping of their menstrual periods for six months to a year, who then beyond that develop any spotting really need to go to their either general practitioner or internal medicine or gynecologist to tell them about the symptoms. The work-up from there, as Dr. Greer had mentioned, is usually of course doing an exam at the time as well as an ultrasound to look at the lining of the uterus as well as potentially a biopsy or a biopsy at the time that you're in the office. As Gina mentioned, doing the biopsy is a fairly straightforward procedure that can be done in the office with minimal discomfort.

Andrew Schorr:

Okay. Now, Dr. Greer, Gina mentioned about listening to her own body, doing her own investigation. Dr. Greer endorsed that. What would you say to women listening to women who maybe just don't feel right. They're worried, and maybe the physician, first physician they visited said, Oh, it's nothing, don't worry, and, no, we don't need to look further. Or We got this test result back and it's not a big deal. I mean at some point you have to say, Well, am I overreacting, but at another point you say, Well, I'm still really worried and it could be something life threatening.

Dr. Gray:

Well, I think absolutely getting a second opinion is critical. If you feel like there's something going on but you're not getting an adequate answer to from your first practitioner, find someone else or speak to someone else. I have numerous patients who have had the story that Gina has had where someone just told them it's all, you know, okay, don't worry about it, when really it's not all okay. I don't want to frighten anyone. Many times spotting after menopause isn't cancer, however it's important to really make sure that it isn't by doing additional studies and tests.

Preventative Measures

Andrew Schorr:

Prove otherwise is what Gina was saying. We're going to come back to Gina in a minute. Want to mention about ovarian cancer too. I want to ask you about that. I always think--you know, I was watching Saturday Night Live last night, I always think of Gilda Radner, who died of that. And of course Gilda's Club is a great friend of Patient Power. Typically it's found late, and most often it is fatal. You want to catch it

early. You don't really have a test for that now. What could a woman do to try to limit her risk or have earlier detection? We've got pap smears for cervical cancer, but what do we have for ovarian, or where are you headed?

Dr. Gray:

It's a difficult area. Ovarian cancer, as you mentioned, does traditionally get diagnosed late because we have no good screening method and patients traditionally present late. However, another colleague of ours, Dr. Barbara Goff, did an excellent study several years ago looking at patient's symptoms where they took patients who were presenting to just a general clinic for a variety of--female patients, a variety of symptoms and then patients who were presenting with a pelvic mass or kind of a preoperative condition and found that patients who ultimately ended up having ovarian cancer their symptoms of abdominal pain, pelvic pain, urinary frequency and what we call bloating were much more frequent than those who presented and didn't have ovarian cancer, and they were much more severe. So it wasn't just that if you have a pain here and there, but if you have pain every day or bloating every day for a period of several weeks, then that should be something that you should really investigate and bring to your practitioner's attention.

Andrew Schorr:

So, Dr. Greer, what could come out of Barbara Goff's research--and she was on the show a couple weeks ago talking about the HPV vaccine, so folks you should listen to that--could be ultimately maybe guidelines that say if a patient is complaining of this or that you need--you, the grassroots physician out there in heartland America, need to consider early signs of ovarian cancer, right?

Dr. Greer:

That's correct. I think that the symptom complex that Dr. Goff has described is an important part of listening to your body and then making proactive action to try and have it evaluated, which would include an examination, a pelvic exam and possibly a blood test for CA-125 and also maybe even a computerized tomography of the abdomen to see if there's anything wrong.

There's been a lot of interest in doing screening with CA-125. It's probably--it has not been a useful tool for screening because one percent of the population have elevated CA-125, and some ovarian cancers don't express CA-125. But it's one of the few noninvasive tests that we have that can possibly identify somebody as at risk.

One other cautionary note about CA-125 is that women that are premenopausal that have conditions like endometriosis that we talked about or uterine fibroids or leiomyomata and other gyn conditions can also elevate CA-125, so it's somewhat of a nonspecific test.

Andrew Schorr:

Okay. We're going to take a break. I want you to think about what's going on here because I've often said that we're blessed in Seattle with some excellent, excellent physicians. We have two University of Washington, Seattle Care Alliance not just physicians but researchers. Gina said, I'm going there because I want to get the

benefit of the latest thinking, and then something as serious as endometrial cancer or ovarian cancer, I think you'd do well to do that. We're going to talk about that as we continue on Patient Power.

The Importance of Education

Andrew Schorr:

Let's get back to the issues at hand. First of all, we invite your calls. If you or someone in your family is concerned about gynecologic cancers, that's uterine cancers and also of course ovarian cancer, the number to call is 206-421-5757. 421-5757 or 1-888-312-5757. 888-312-5757. Don't be shy. It's a big deal to have two gynecologic oncologists in the studio for an hour. One of them is on call, but he's got his chief resident helping out so he can be here with you. And then we have a woman who, Gina Milano from Bellevue, who was being told maybe she was going through menopause, but it wasn't. It turned out to be cancer, and it was discovered by her really pushing to get the best. Okay.

And now I have one other point I want to make. Twenty years ago I started something called HealthTalk that became healthtalk.com. Friday was my last day. They're doing fine, but I wanted really to work hard on Patient Power, these radio shows, and what we're doing on patientpower.info. And also be a patient advocate. So I'm offering myself to the FDA to be on advisory committees as a patient and consumer representative. And it's sort of a critical time. We are in an election year. And imagine at the same time as all of us are getting older and cancer, what we're talking about today, also increases with age. It's sort of a disease with aging for the most part. The funding for cancer research, and the UW is one of the leading institutions, is flat or going down. So just as all of us when we were younger would say to the cable TV company, I want my MTV, and we got it, we need to say I want my government money for cancer research.

And, Gina, it's really important isn't it? Wouldn't you say? We're talking about ovarian cancer. We wish we had earlier tests for it, we don't. And maybe even education for doctors like the one you went to first to say, hey, what Gina could be really complaining about could be cancer, and it got overlooked, right?

Gina:

Yes. And I was feeling very healthy. I'm a bicycle rider and I never imagined that it was cancer. So the spotting is for me one of the key things, and I wished that I had known about it sooner. In fact I wish that the mini pad boxes would have a little warning label, like some of the medicines do, to say if you are using this product on a regular basis and it persists maybe you should consider following up with some medical advice.

Andrew Schorr:

You and I were talking on the phone, and it was some of the cold medicines or headache medicines. If symptoms persist for more than so many days ask your doctor. So we certainly--maybe, Dr. Greer, you can push for that. I'll do it as an advocate, but I think what a wonderful idea. On the mini pads or whatever, if these symptoms persist it may be something that needs to be looked into further.

Dr. Gray, that could be a real service because some of those women that get to you later, maybe that could have triggered them coming earlier, right?

Dr. Gray:

Well, yes. Or triggered their primary physician to work up someone a little bit sooner than waiting months and months or even years again, as in Gina's case, to come to me.

Assessing Your Treatment Options

Andrew Schorr:

One question about hysterectomy, because doesn't it remain still the most common surgery or was for so long the most common surgery, and there are new techniques. Gina mentioned about doing it through the vagina, right? But she chose not to do that to give you, her surgeon, the opportunity to really take a look at her abdomen to see was there a worry of cancer, any cancer spreading. In the end, there was. So putting it into perspective, if it's recommended that a woman have hysterectomy how do you determine when you should go the full boat route and when not?

Dr. Gray:

That's a great question and does require of course a lot of clinical judgment. There are several routes, as you mentioned, to performing a hysterectomy, and actually recently we've looked at doing kind of the more--what we call minimally invasive hysterectomy in patients with what we consider early endometrial cancer. A large study is coming out, some preliminary results have been released from that. But the key is really if you're concerned that this is an early versus more advanced cancer, I think that in cases where you're concerned that maybe there is spread outside the uterus doing an open or abdominal procedure in which you can evaluate the entire abdominal cavity thoroughly for any kinds of spread is really critical.

Andrew Schorr:

Okay. But certainly for most women who have no sign or there is not a suspicion of cancer can they just go ahead and have the vaginal? Or when do you wave a flag and say, well, maybe this isn't the best approach?

Dr. Gray:

Well, certainly if they're having a surgery for other causes that are benign, such as uterine fibroids or pelvic pain or something along those lines, once cancer has been ruled out, for example, if they were having spotting due to fibroids not cancer, but as

long as they have had the appropriate workup and negative biopsies the route of the hysterectomy really depends on the skill of the gynecologist. But certainly it's safe in those cases to perform them in a minimally invasive surgery.

Andrew Schorr:

Okay. You mentioned second opinions earlier. So if the woman has some unusual symptoms hysterectomy might be indicated and suggested that this could sort of take care of the symptoms or what you think is the cause. But there are different approaches to doing it. Is that a case before a woman rushes into or proceeds with surgery to get a second opinion? Because it seems like the more I have doctors on here I think of the art or the expert experience, and it varies by doctor, and we as patients have no way of knowing what's happened in your history that lights up different suspicions for you, well, maybe I ought to look further. So what do you say about second opinions when the patient has these sorts of situations?

Dr. Gray:

I'm always an advocate for second opinions. Even people who are coming to me for an opinion if they feel like they haven't had their questions adequately answered or have other concerns I really think that in our community--especially in the gyn oncology community we're very small and we don't look at it as a bad thing to go and poll our other colleagues. I have the benefit of working with five other gyn oncologists. Dr. Greer is one of them who are, again, as you mentioned, experts in this field, and so I use them as resources as well too. But certainly I think that at any time second opinions are worth while for patients.

Andrew Schorr:

And I know it benefitted me with my leukemia. So, Gina, what would you say to the ladies listening to have some symptoms they're kind of worried about but maybe were told relax about it. And certainly sometimes that's true, sometimes you can relax. But what would you say as far as a philosophy that women should have now, now that you've been through it, so that they rule out the really bad things or if there could be something, like the C word, as we've talked about, that it gets handled earlier, or really the treatment you need and deserve is brought to bear earlier.

Medical Records

Gina:

Education, your own research. Even if you don't necessarily get the best information on the internet, it often gives you the gives you questions to ask, because I was completely unaware of what the possibilities were and the implications and the words. The whole lingo of medical terminology was all new, so I could easily access that information on the internet and ask questions. And do ask questions. And in fact ask for copies of your medical records.

Andrew Schorr:

Which you own, folks. They're your records.

Gina:

I was surprised getting the ones from the general practitioner, which I needed to take to future doctor appointments for second opinions, I was surprised at some of the inaccuracies and things that were written on those that I wasn't aware of, like the lining of the uterus that the doctor didn't tell me about the first time.

Andrew Schorr:

Kind of like checking your credit report.

Gina:

Probably more important. Because it's your health.

Dr. Gray:

I was just going to say I would really recommend--when I see patients, especially when I've done a surgery, and Dr. Greer probably does this as well, too, copies of their pathology report and even if they want copies of their operative report and things like that, I really believe patients should keep that and read those so they know what's been going on.

Andrew Schorr:

So let me tell you who we're--if you're just tuning in who we're visiting with. That was Dr. Heidi Gray, who is a gynecologic oncologist, so trained as a gynecologist but spends a lot of time, years, working in gynecologic cancers. So she's a surgeon but she also deals with all the chemotherapies and other approaches, and we'll talk more about what the approaches are now to these various cancers and where research is headed.

And then we also have with us Dr. Ben Greer, and he is the director of gynecologic oncology at the Seattle Cancer Care Alliance. And he's more my age, and he has a wealth of experience as a professor at the UW in this area.

And then Gina Milano, who we introduced at the beginning of the show, Gina, 59 years old from Bellevue, who was told maybe she was going through menopause when she was having spotting, and it turned out to be endometrial cancer, which she has spent most of this year going through treatment for.

We'll take a break. We invite your calls. It's not often you get a chance to ask questions, and this does affect about 80,000 women a year, new cases. The number is again 206-421-5757, and 888-312-5757. We'll be back with more Patient Power right after this.

Listener Questions

Andrew Schorr:

We're back live on KVI, Andrew Schorr on Patient Power. So somebody out there is listening saying, whoa, Sally is still in bed. She should have heard this. Well, you can. Tomorrow afternoon the replay will be on patientpower.info. And about 10,000 people a month, this month, which is a 50 percent increase over last month, which is

a 50 percent increase over the month before, are going to our website and listening. You can download it on your iPod, or if you work for Microsoft your new Zune, and listen to it as an MP3 file. Okay.

We have a question from Sheila in Maple Valley. Sheila, welcome to Patient Power. Thanks for listening.

Caller:

Hi, good morning. Thank you. I was wondering if you could address uterine fibroid tumors that appear to be benign and have been tested and everything, if there's any relation in any way to uterine cancers at all.

Andrew Schorr:

Okay. I'm going to let you listen on the air, and we're going to talk to the professor, Dr. Greer. Go ahead, Dr. Greer.

Dr. Greer:

That's an excellent question. The uterine fibroids are extremely common. Probably 60 percent of women over the age of 65 have uterine myomas, leiomyomas that are--can be very small or they can be very large. There is a subset of uterine leiomyomas that actually turn out to be sarcomas of the muscle and can be very complicated.

Andrew Schorr:

And that is a malignancy, sarcoma.

Dr. Greer:

Yeah. Sarcoma is a cancer. And there is really no noninvasive way to determine whether leiomyomas are benign or malignant without removing them. There is new technology like computerized--excuse me, like PET scans which is a way of determining the metabolic activity within a tumor that may be helpful. I don't know the answer, if that has been investigated, but it is one possibility that we could possibly use.

Andrew Schorr:

Okay. So if a woman has fibroids--and I know a number who have had it--should they just worry that there's--just generally, should they worry that there's another shoe that's going to drop?

Dr. Greer:

I think that's somewhat age dependent. The younger individuals that have myomas and they are still menstruating, they are responsive to estrogen, and we are most, as clinicians, like Heidi and myself, if someone who has a myoma that happens to begin to grow rapidly, that's something that is a sign that something may be awry. Or if you have someone that is post menopausal they should shrink because they don't have the estrogen support, and if there's any change or increase in those myomas then that should be further investigated.

Andrew Schorr:

Okay. You heard it from the professor who trained a lot of the other gynecologic oncologists around here too.

Now, is this right? We have a second caller whose name is also Sheila, is that right, from Lynnwood? You're on the air. Am I right?

Caller:

Yes. Good morning.

Andrew Schorr:

Wow. It's a combination--this is the Sheila show. Okay. Go right ahead, Sheila.

Caller:

Yes. I recently received my test results back, and I have numerous cysts in my uterus. I also have some fibroid tumors. And I have cysts in each of my tubes and in my kidney. So I was advised that it looked like I could go to a gynecologist and they may suggest a hysterectomy and that I may just deal with the pain or discomfort for as long as I can deal with it and decide what to do. I've been advised to come back in another month or two to do an ultrasound.

Andrew Schorr:

So you're worried sick right now.

Caller:

Well, what worries me is that my breast exam didn't come back very well either, that there's a shadow. So I'm kind of trying to set my priorities here.

Andrew Schorr:

Okay. We're going to go to Dr. Gray for this. We're not practicing medicine over the air, a lot of disclaimers, and you obviously need to see the providers who are right for you.

I did a breast cancer program actually at the Seattle Cancer Care Alliance with Julie Galow, some people know, and Michael Hunter, who has been on our show as well, from Evergreen. And certainly I know with mammograms and various, there's a lot of stuff that comes back that isn't breast cancer, so all of this may be unrelated. But I know you've got all these cysts and things and you listen to this program, and you say, Oh, my goodness.

So, Dr. Gray, put it in perspective because Sheila and other women listening are worried, get these test results, say come back in a month, and they're losing sleep in the meantime.

Dr. Gray:

Right. Good morning, Sheila.

Caller:

Good morning.

Dr. Gray:

It sounds like there's several things that could be going on, and I agree you do have to kind of prioritize to a certain extent, but certainly all of these need to be followed up on is what I would like to emphasize. Certainly an abnormal mammogram absolutely needs to be followed up on, either to referral to the appropriate either breast cancer surgeon or a breast cancer clinic or something if you need further imaging, ultrasound, possibly a biopsy. And I would, since this is Breast Cancer Awareness Month and as we've spoken about breast cancer is the most common cancer amongst women that should--I would definitely make sure you're getting follow up for that.

The other issues, it's a little unclear what is going on. You've got some issues going on with the uterus, possibly some cysts, and then potentially something going on with the kidneys, although many times we find benign cysts when we do CT scans--I presume that's what you had--that are inconsequential of the kidney. But I think if you haven't seen a gynecologist yet I would definitely go in to see a gynecologist to at least have them look over your records and determine if you need some additional testing, such as an ultrasound.

Caller:

Okay.

Andrew Schorr:

Okay. Sheila, we wish you well. Hopefully that gives you a bit of a plan. But I know for me, I'm one, and my dad, he lived to be 92, and I'll tell you, when he had a concern he tried to figure out who was the right doctor to go to with experience and with a specialty related to what he thought his concern was. Obviously your primary care doctor can guide you, and you can say to your primary care doctor, you know, I really would feel most comfortable if I saw a gynecologist to just look at this further. And I think it's going to be the rare doctor that will say, Well, no, you know, throw cold water on that. You do what makes you feel comfortable. Thank you for listening, Sheila.

Caller:

Thank you for the program today. Appreciate it.

Andrew Schorr:

Thank you, ma'am.

Caller:

Okay. Bye-bye.

Ovarian Cysts

Andrew Schorr:

So, Dr. Greer, can somebody--there are no shortage of women with cysts, whether cystic breasts or cysts otherwise and gynecology-wise. So just put that in perspective. Is that worrisome related to cancer, or is it just another condition that happens that's nonmalignant and usually not a big deal?

Dr. Greer:

Well, in premenopausal women, cysts, and when I say "cysts" I mean cysts of the ovary, are common because when women ovulate on a usually monthly basis the corpus luteum develops, and then the potential ovum, or egg, comes out, and whether they get pregnant or not, and then the cycle begins. But some of these cysts persist, and they can be what we call physiologic cysts. And in general if we identify one that's, say, four to six centimeters in size then we would recommend that they be followed for six to eight weeks to let another cycle of menstruation happen and then re-examined to see if they've gone away. And if they've gone away then they're kind of physiologic cysts.

Persistent cysts then look into size and then also what the character of the description is, whether there is any substance inside the cyst that may then drive a decision to get other blood tests like CA-125 or to potentially recommend removal. There are benign neoplasms, cysts that are noncancerous that develop, the most common being teratomas, benign teratoma of the ovary, but they often have characteristic findings on ultrasound that kind of help guide the clinician of what the next step is.

Andrew Schorr:

I love this show. I feel like I'm going to medical school and here we've got the professor. I'm learning a lot. Again, you want to listen to some of this stuff again and you can on patientpower.info. And sometimes since Dr. Greer and Heidi are experts at a big teaching hospital and medical center, you know, refer your provider to them too. They can learn a lot as well.

We're going to take a break, get some final thoughts from our physicians and also Gina Milano, who has been through this and a lot of treatment this year, to really empower you to get the best for you. We'll be right back with Patient Power.

Closing Thoughts

Andrew Schorr:

Just a few minutes left with Patient Power and I want to get some final comments as we conclude our program on gynecologic cancers, so ovarian, all the uterine ones, endometrial. Remember, the replay will be on patientpower.info.

So Heidi Gray, so you are Gina's doctor. I always ask, are you encouraged? Do you think where we're headed can help treat these cancers better and hopefully earlier? I know it's a long road.

Dr. Gray:

Absolutely. I think that we're really at an exciting time in cancer research where the technology that has come about really in the a last ten, 15 years has been really breakthrough. And in the area, we haven't spoken about it too much, but in ovarian cancer research and a lot of the other solid tumors really trying to figure out what it is about these cancers that will enable us to detect them sooner and therefore make them much more curable, the time is now. And I'm very encouraged that the next ten to 15 years is going to be a very exciting time in cancer research.

Andrew Schorr:

Okay. And the University of Washington and Seattle Cancer Care Alliance plays a key role in that, so keep your eye on clinical trials there if these are cancers that affect you.

Dr. Greer, a quick comment from you. So for women who have spotting, sound like if it continues and certainly if they're later, 59, like Gina, to investigate it further.

Dr. Greer:

That's correct. I think that Gina's story is a powerful story to alert women of what they need to do and what kind of action, especially if they don't appear to be getting the right information from their primary care physician.

Andrew Schorr:

Okay, Dr. Ben Greer from Seattle Cancer Care Alliance. Thank you.

And, Gina Milano, you've gone through months and months of treatment. What do you want to leave women with, because you found you needed to be a proactive patient. What would you say if they're concerned?

Gina:

Take control of your health. Listen to your body. Go to the appropriate physician, preferably a specialist. That's a regret that I had is that I didn't go to a specialist earlier. If you don't get the answers that you like go get a second opinion. You're in charge. No one takes care of you or should take care of you better than yourself.

Andrew Schorr:

Well, I wish you well. I know you've been through a lot. You've got the great support, a partner who is helping you and some great friends.

Gina:

And Seattle Cancer Care Alliance has been wonderful. They've been very supportive and encouraging and never made me feel like I was rushed like you do at some doctor's offices.

Andrew Schorr:

And thanks to your doctor, Dr. Gray, for coming in with you. Thanks to Seattle Cancer Care Alliance for being one of our loyal sponsors. University of Washington Medical Center, Harborview Medical Center and Virginia Mason, thank you all.

Next week we're going to have Dr. Peter Roy-Byrne, who is from Harborview Medical Center. He's a psychiatrist. We're going to talk about something we think about more as the gray blanket comes on, but it affects people year around of course, and that's anxiety and depression. Certainly you may know somebody where this is something that affects them. What's the latest thinking about treatment? When did you need treatment? Who did you see? How do you help go on and have a high quality of life and live the life that you should, feeling good about things?

As always, remember, knowledge can be the best medicine of all. Check out our website, patientpower.info, and this is me, Andrew Schorr, wishing you and your family the best of health. See you next week.

Please remember the opinions expressed on Patient Power are not necessarily the views of the Seattle Cancer Care Alliance, our sponsors, partners or Patient Power. Our discussions are not a substitute for seeking medical advice or care from your own doctor. Please have this discussion you're your own doctor, that's how you'll get care that's most appropriate for you.