

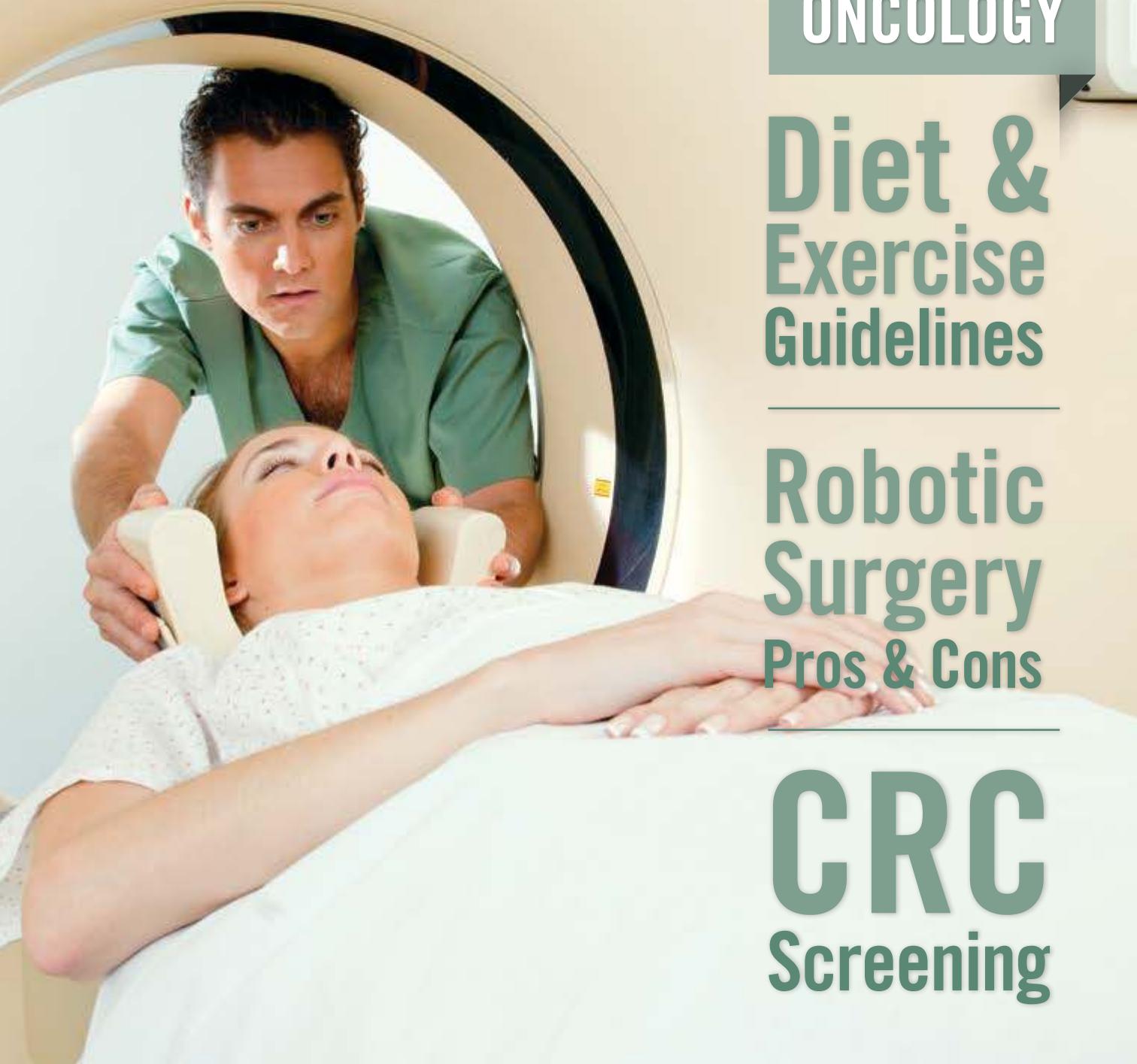
PHYSICIAN'S WEEKLY UPDATES

ONCOLOGY

Diet &
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Guidelines

Robotic
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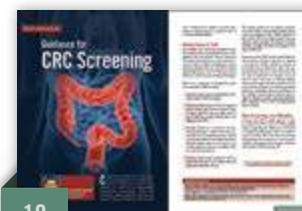
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A Message From the Editor

At *Physician's Weekly*, we are proud to present this monograph featuring several features that are applicable to oncologists. Created with the assistance of key opinion leaders and experts in the field, these articles discuss challenges and opportunities in oncology and strategies to positively change current practices. In the upcoming months, *Physician's Weekly* will continue to feature topics that affect oncologists and other cancer care providers. Your feedback and opinions are welcome; email keithd@physweekly.com. Thanks for reading!

Sincerely,

Keith D'Oria
Editorial Director, Physician's Weekly

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The Pros & Cons of Robotic Bladder Cancer Surgery



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Robotic-assisted surgical removal of the bladder is becoming increasingly popular for treating bladder cancer, despite being more expensive than traditional surgery. Benefits of the robotic approach include smaller incisions and less blood loss for patients. In addition, surgeons have a better three-dimensional view and more freedom of wrist movement when compared with conventional laparoscopy. The procedure eliminates hand tremors, making tasks like suturing easier. However, robotic surgery for this patient group is fairly new. We're only now beginning to gather larger, more comprehensive studies comparing outcomes of traditional open surgeries with robot-assisted procedures.

A New Analysis

In an issue of *European Urology*, my colleagues and I had a study published that compared perioperative

outcomes and costs of open robot-assisted laparoscopic radical cystectomy. Previous comparisons have been limited to reports from high-volume referral centers and have not made direct comparisons with regard to inpatient morbidity and mortality, lengths of stay, and costs.

Using a national database of in-patient information from 1,050 hospitals in 44 states, our research team examined 1,444 traditional open surgeries and 224 robotic-assisted laparoscopic procedures in 2009. Robotic surgery for bladder cancer resulted in fewer deaths during hospitalization (0% vs 2.5%) and fewer in-patient complications (49.1% vs 63.8%) when compared with open surgery. It also reduced the need for intravenous nutrition after the procedure (6.4% vs 13.3%). Patients who underwent both types of surgery spent about 8 days in the hospital.

Important Caveats

The costs for robot-assisted laparoscopic radical cystectomy were significantly higher, amounting to nearly \$3,800 more than traditional open surgery. This may be due to longer operation times and more use of disposable instruments that are necessary with

robotics. In addition, women were less likely to undergo a robotic procedure. This may be the result of gender-based differences in anatomy that make robotic procedures more difficult. Plus, men are three times more likely to be diagnosed with the disease.

Looking Forward

Overall, we expected to see greater expenses associated with the robotic procedure for bladder cancer, but we were surprised that there was such a significant reduction in deaths and complications, particularly this early in the adoption of robotic-assisted laparoscopic procedures. There are still opportunities for even better outcomes with the robotic procedure since many patients in our analysis didn't undergo lymph node removal.

While robotic surgery has certain advantages over the traditional open approach, it should be noted that surgeons play the most important role in bladder cancer surgery outcomes. Future investigations should follow patients beyond their hospitalization and look more closely at the severity of surgical complications, tumor characteristics, and other factors that may also play a role in outcomes. 

For more information on this article, including the contributor's financial disclosure information and reference, [click here](#).

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Guidelines for Nutrition & Exercise in Cancer Survivors



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In 2001, the American Cancer Society (ACS) first published an article summarizing the relatively small amount of scientific evidence regarding the impact of nutrition and physical activity among cancer survivors. Since that time, new studies have emerged, demonstrating the benefits of maintaining a healthy weight, getting adequate physical activity, and eating a healthy diet. The key benefits include reducing the chance of recurrence and increasing the likelihood of disease-free survival after a diagnosis.

Based on this new and accumulating evidence, an expert panel convened by the ACS issued formal guidelines for cancer survivors for the first time in the July 2012 *CA: A Cancer Journal for Clinicians*.

Encourage Regular Exercise

The ACS update recommends that clinicians encourage survivors to participate in regular physical

activity. Patients should aim to exercise at moderate intensity at least 150 minutes per week and perform strength training exercises at least 2 days per week. Clinicians need to encourage patients to avoid inactivity and return to normal daily activities as soon as possible following a diagnosis.

However, in some cases, particular issues affect the ability of patients who are recovering from cancer treatment to exercise. The guidelines provide information on many of these issues and how these circumstances should be factored into the equation when recommending activities.

Weight Management & Diet

Many patients are overweight or obese when they are diagnosed with cancer, and there's increasing evidence that obesity increases risks for cancer recurrence and reduces survival. Achieving and maintaining a healthy weight is another key recommendation in the 2012 guidelines. If cancer survivors are overweight or obese, they should be encouraged to limit consumption of high-calorie foods and beverages and increase physical activity to promote weight loss.

The guidelines also stress the importance of achieving a diet rich in fruit, vegetables, and whole

grains. When informing cancer survivors about diet, clinicians should refer to the ACS guidelines on nutrition and physical activity for cancer prevention. These guidelines, as well as the recommendations for cancer survivors, are available for free online at www.cancer.org.

It should be noted that standard vitamin and mineral supplements were recommended during and after cancer treatment in the past. Recent studies, however, suggest that many of these agents are either ineffective or may actually increase mortality risk. More data are needed on dietary supplements and multivitamins in cancer survivors. In addition, future research should further explore the benefits of exercise, weight management, and diet in cancers other than breast, prostate, and colorectal cancer.

A Unique Opportunity

Clinicians should realize that they have a unique opportunity to guide cancer survivors toward healthy lifestyle choices. We can favorably influence the cancer survivorship trajectory by fostering healthy nutrition and regular physical activity. The power of our advice and encouragement to patients cannot be underestimated. 

For more information on this article, including the contributor's financial disclosure information and reference, [click here](#).

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Staging Melanoma With SLNB



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One of the most important prognostic factors in patients with early-stage melanoma is the presence of metastasis to regional nodes. Determining which patients have nodal metastases and who may benefit from resection of involved regional lymph nodes is of key importance. Sentinel lymph node biopsy (SLNB) is a minimally invasive surgical technique that involves removal of the node(s) most likely to demonstrate metastases (the “sentinel” node) from melanoma. When cancer is found, the remaining nodes in that area are also at risk for metastases. In most cases, no cancer is detected in the sentinel node, allowing patients to avoid the pain, discomfort, expense, and side effects of unnecessary procedures or therapies.

In an effort to clarify which patients should undergo SLNB, the American Society of Clinical Oncology and the Society for Surgical Oncology published clinical practice guidelines in the *Journal of Clinical Oncology*.

Key Recommendations

Recommendations were made based on the three main stages of melanoma:

- 1. Intermediate-thickness melanomas:** SLNB is recommended for patients with cutaneous melanomas with Breslow thickness of 1 to 4 mm at any anatomic site.
- 2. Thick melanomas:** SLNB may be used for staging purposes and to facilitate regional disease control in patients with melanomas greater than 4 mm in Breslow thickness.
- 3. Thin melanomas:** There is insufficient evidence to support routine SLNB for patients with melanomas that are less than 1 mm in Breslow thickness, although it may be considered in selected high-risk patients.

It’s recommended that complete lymph node dissection be performed for all patients with a positive SLNB. If sentinel nodes are positive, additional nodes should be removed for complete staging of the disease and prevention of further metastases. Use of this procedure in thin melanomas is controversial because benefits have been unproven in clinical trials and clinical practice. Studies show that the rate of positive sentinel node detection in this group is quite low. Clinicians must determine if putting patients with thin melanomas through an additional procedure will have a positive impact for them when the benefits are unclear.

Important Implications

It’s possible that payers will review these guidelines and determine that they will only support using SLNB based on guideline-recommended indications. Clinicians who treat patients with melanoma should be aware of the recommendations and adapt their practice accordingly. The guidelines also offer assistance in deciding whether or not patients should be referred to surgical oncologists for consideration of the procedure.

Considering that the guideline was strictly evidence-based, it may differ slightly from other guideline recommendations based solely on consensus or expert opinion. Physicians should think about the standard of care; if standards aren’t being adhered to, patients may benefit from entering a clinical trial. 

For more information on this article, including the contributor’s financial disclosure information, [click here](#).

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Guidance for CRC Screening



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Colorectal cancer (CRC) has been the subject of screening guidelines from multiple organizations, creating some confusion among caregivers over which has the highest-quality, evidence-based recommendations. Rather than developing an additional guideline on the topic, the American College of Physicians recently decided

that it would be more valuable to provide information to clinicians based on a rigorous review of currently available guidelines.

Making Sense of It All

My colleagues and I developed this guidance statement using current recommendations from a joint guideline from the American Cancer Society, the U.S. Multi-Society Task Force on Colorectal Cancer, and the American College of Radiology, as well as individual guidelines from the Institute for Clinical Systems Improvement, the U.S. Preventive Services Task Force, and the American College of Radiology.

Based on our evaluations, we developed four guidance statements for CRC screening:

1. Clinicians should perform individualized assessment of risk for CRC in all adults.
2. Clinicians should screen for CRC in average-risk adults starting at age 50 and in high-risk adults starting at age 40 or 10 years younger than the age at which the youngest affected relative was diagnosed with CRC.
3. Clinicians should use a stool-based test, flexible sigmoidoscopy, or optical colonoscopy as a screening test in average-risk patients. Optical colonoscopy should be used in high-risk patients. Clinicians should select the test based on the benefits and harms of the test, availability of the test, and patient preferences.
4. Clinicians should stop screening for CRC in adults older than age 75 or in adults with a life expectancy of less than 10 years.

The evidence reviewed in our guidance statement showed that CRC screening helps identify undiagnosed, pre-malignant lesions. Earlier diagnosis of these lesions allows for timely treatment and can therefore reduce mortality. The benefit of reduced mortality outweighs the harms of screening at the ages specified above.

Because the various CRC tests have similar efficacies, shared decision making is important in selecting a screening test. Patients should be educated on the benefits, harms, effectiveness, safety, and costs associated with each test, as well as how often the test must be performed. For example, stool tests must be done every year to maintain efficacy, whereas colonoscopies should be repeated every 10 years. However, the harms of colonoscopy include perforation and bleeding, whereas a stool-based test has virtually no harm except for false positives or negatives. Therefore, patients' individual preferences play a significant role in CRC screening methods that are selected.

More Screening, Less Mortality

Currently, only 60% of adults aged 50 or older are screened for CRC in the U.S. With available evidence supporting the effectiveness of screening in reducing mortality, greater efforts are needed to screen more adults. Those who choose colonoscopy will only need to be screened two or three times in a lifetime. Ultimately, patients should be informed of the benefits of CRC screening. 

For more information on this article, including the contributor's financial disclosure information and reference, [click here](#).

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Extending Survival After Inoperable Pancreatic Cancer



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Surgical resection of adenocarcinoma can significantly improve survival, but only 20% of patients are candidates to undergo this treatment. Typically, patients with unresectable pancreatic adenocarcinoma receive palliative, non-curative therapy. Recent research, however, suggests that accurate radiographic restaging, multimodality treatment, and advanced surgical technique can offer patients who have been previously deemed unresectable the possibility for curative salvage pancreatectomy.

A New Approach

In the *Journal of the American College of Surgeons*, my colleagues and I at MD Anderson reported results from a study cohort of 88 high-risk patients who had been informed that their tumors were inoperable after an initial surgical attempt at removal. Of these patients, 66 completed a multidisciplinary treatment protocol with successful tumor removal. Risk for metastatic disease was stratified based on tumor involvement with local blood vessels, biopsy results and the nature of the tumor, and overall health status aside from pancreatic cancer. Patients who met these criteria underwent the MD Anderson protocol, which involved the following:

- A collaborative interpretation of pancreas-specific CT scans by surgeons and radiologists.
- Carefully administered preoperative chemotherapy and radiation treatment with multidisciplinary restaging prior to surgery.
- Use of advanced surgical techniques with planned removal and vascular reconstruction of involved blood vessels near the tumor.

Using this protocol, we achieved survival numbers that are comparable to those of patients receiving surgery for clearly operable tumors. On average, patients undergoing the MD Anderson protocol lived about 30 months after tumor removal, which is almost three times longer than the average survival of 11 months for patients who do not undergo tumor resection.

Key Caveats

Our findings are encouraging, but it should be noted that the protocol developed at MD Anderson is one that has been explored and refined at our institution over the last 20 years. Several considerations are important to note. Patient selection is critical and was likely reflected in this retrospective report. Radiographic imaging is the key component necessary for selection, and the interpretation of CT scans needs to be performed by both radiologists and surgeons. With good imaging and interpretation, surgeons can get a clear idea of tumor location and usually predict involvement of the vessels and the need for vascular resection and reconstruction.

Hospital type and surgeon skill are not necessarily indicators of the setting in which the MD Anderson protocol can be effective. The protocol can be utilized at other institutions, but requires a high level of technical surgical skill as well as a focused team of specialists. Although our study was a small series that involved high-risk patients, it's one of the largest to include patients who had a previous unsuccessful attempt at tumor removal and provides a strong foundation for future analyses. ^{RW}

For more information on this article, including the contributor's financial disclosure information and reference, [click here](#).

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