1 man in 7
...will have prostate cancer in his lifetime.

What are his options?
Who’s on the cover: The day this photo was taken, Hugh Smith (right) was celebrating the second anniversary of his prostatectomy via robotic surgery at Emory Saint Joseph’s Hospital. Prostate cancer had already hit members of Smith’s immediate family, so he wanted an aggressive treatment strategy. He says it’s paid off: no side effects and no recurrent cancer.

Jack Stein (left) has had 15 years of prostate cancer treatments, including chemo, brachytherapy, and immunotherapy. Stein says he’s counting on his doctors to discover the next “silver bullet” that will keep his cancer in check.

These are just two of the more than 220,000 American men who are diagnosed with prostate cancer every year.
5 Questions for Walter J. Curran, Jr.

In his sixth year as executive director of Winship Cancer Institute, Wally Curran provides more than just leadership. He continues to see patients, has his hand in critical radiation oncology research, and has even signed up to be an advisor to NASA.

Q:1 What three words describe the work being done at Winship?

Depth, breadth, and compassion.

Q:2 How is Winship making a difference in advancing new discoveries in the treatment of cancer? As the only National Cancer Institute–designated cancer center in the state of Georgia, Winship’s involvement in clinical trials sets us apart from other medical centers. We give cancer patients access to cutting-edge care that is often not available elsewhere. Last year we enrolled over 800 patients onto clinical trials that evaluate new therapies.

Q:3 How will the oncology field evolve over the next decade? I expect that formative changes will require attentive stewardship by physician leaders.

Q:4 What advice do you give to new residents who are training in oncology?

Take the time to listen to your patients and learn from them. Be sure to give thanks every day for having such extraordinary expertise and skill to serve people in need.

Q:5 This issue of the Winship magazine focuses on an important topic in men’s health. What do you do to stay in shape?

I am a life-long runner and I try to clock 20 miles a week. My love of running led to the creation of the Winship Win the Fight 5K. We’ll mark our fifth anniversary with this year’s event scheduled for October 3rd. I hope to see a good turnout at the starting line!

Reclassifying Brain Tumors with Precision

Winship cancer researcher and neuropathologist Dan Brat is the first author of a groundbreaking study that will change the way patients with diffuse gliomas, a form of brain tumor, will be diagnosed and treated in the future.

Brat and 306 other researchers from 44 institutions studied a group of six related brain tumors that has been surrounded by diagnostic confusion for decades. They used a large number of advanced molecular platforms capable of examining the genetic make-up of brain tumors (e.g., mutations, gene deletions, and other genetic changes) and were able to determine that there are three well-defined types of tumors based on this analysis, rather than six as previously thought.

“...The use of the biomarkers in the diagnosis of these forms of brain tumors will lead to a much more consistent manner of diagnosis and patient management. It will also allow us to investigate these tumors as unified groups in a way that should advance our understanding.”

Brat will join an international group of neuropathologists in Heidelberg, Germany, meeting this summer to revise the World Health Organization classification of brain tumors based on new molecular findings. This is a major step in starting to classify and treat brain tumors more precisely based on their genetic makeup.

WINSHIP EXPANDS HOSPITAL ACCESS

Winship Cancer Institute has expanded access to its high quality cancer care in alignment with its broad clinical research program at both Emory Saint Joseph’s Hospital (ESJH) and Emory Johns Creek Hospital (EJCH). In addition, Winship has established the Winship Cancer Network as a means to improve access to such vital services throughout Georgia and the Southeast.

Longstanding and continued support from the Robert W. Woodruff Foundation has enabled Winship to advance cancer care and access to services like these for tens of thousands of patients throughout Georgia and beyond.

In addition to expanding services at ESJH and EJCH, the Woodruff Foundation’s most recent grant will be used to expand and improve Winship’s Shared Resource portfolio with special emphasis on its Cancer Prevention and Control Research Program. Researchers in this program are continually evaluating the best methods to reduce and eliminate the development of cancer among high-risk individuals across Georgia and the Southeast.

Khuri Named AUB President

Fadlo R. Khuri, deputy director of Winship Cancer Institute, chair of the Department of Hematology and Medical Oncology, and executive associate dean for research at Emory University School of Medicine, was named president of American University of Beirut (AUB) in Beirut, Lebanon. He will begin his tenure there on September 1, 2015.

Khuri, who is also the Roberto C. Goizueta Distinguished Chair for Cancer Research, is considered one of the leading translational clinical investigators and physicians in lung and aerodigestive medical oncology in the world. In his 13 years at Emory, Khuri has been instrumental in leading the development of some of the most important cancer-related programs in Georgia and throughout the nation.

Khuri Named AUB President
GAME CHANGING APL CLINICAL TRIAL

Winship oncologist Anand Jillela is spearheading a clinical trial for patients with Acute Promyelocytic Leukemia (APL) that could change the mortality rate for this disease on a major scale. Often called the heart attack of leukemias, APL is a highly aggressive disease that is curable if treated early. A third of patients, however, do not survive the first month of treatment. By observing and analyzing the problem, Jillela and his team of physicians, nurses, and research staff came up with a collaborative approach that decreases mortality from 30 percent to about five percent. This new trial is open to patients all across the country.

Jillela has found that some physicians who treat patients with APL may not be familiar with the potential complications that can develop during treatment. He took a very detailed treatment algorithm and boiled it down to a three-step process that can be easily shared. “As soon as we get a call from a community physician, we send the simplified algorithm via smart phone,” says Jillela. “We come up with a treatment plan based on what the patient is experiencing and follow up with them regularly to get them through that difficult first month.”

Winship researchers will receive a $3.5 million Informatics Technology for Cancer Research (ITCR) U24 award from the National Cancer Institute. David Gutman and Lee Cooper, assistant professors in the Departments of Neurology, Biomedical Informatics, and Biomedical Engineering, will use the five-year award to develop software tools to help researchers gain new insights from cancer imaging data. The award will set the stage for novel applications in human cancer research, both at Winship as well as for the cancer research community as a whole.

Their work is focused on digital microscopy images of tissue slides that have traditionally been used by pathologists for diagnostic purposes. Advances in technology allow these slides to be stored as digital images, producing massive databases that can be explored using data analytics algorithms. “Our goal is to build tools to identify visual patterns in these images that can help us better understand cancer biology, or to improve accuracy of cancer prognosis,” says Gutman. “This award is unique because it lets us take the tools we have developed beyond our labs to create an open-source resource for the cancer research community at large.”

ITCR awards are intended to build tools to address the growing number of “big data” problems imped ing cancer research. “All areas of medicine are experiencing an explosion of data, but this is especially true in cancer,” says Cooper. “Transforming cancer data into knowledge that can benefit patients is one of the major challenges facing cancer researchers today.”

Researchers Receive NCI Informatics Award

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Improving Pediatric Care in Low- and Middle-Income Countries

Winship’s Nattia Esiasihvili will travel to Slovenia in June to provide training to other pediatric radiation oncologists. Esiasihvili specializes in the treatment of complex pediatric cancers and hematological malignancies in adults. She is an international expert in her field and is the only pediatric radiation oncologist in the state of Georgia.

NEW WINSHIP LEADERSHIP APPOINTMENTS

Winship Cancer Institute named Sagar Lonial as the chief medical officer (CMO) and Charles A. Staley as chief quality officer (CQO) effective February 2015. Both physicians join Winship’s senior leadership team and will advance Winship’s clinical programs and services within all of its clinical facilities. Lonial, professor and executive vice chair of Emory’s Department of Hematology and Medical Oncology, is an internationally recognized authority in the management and research related to B cell malignancies, including multiple myeloma. As Winship CMO, he will oversee all clinical care initiatives impacting both clinicians and patients.

Staley, a professor and director of Emory’s Division of Surgical Oncology, specializes in the management of patients with gastrointestinal cancers. He previously served as Winship’s CMO and now assumes responsibility for the institute’s quality improvement processes across all disciplines and campuses.

Lonial and Staley will collaborate on tracking and improving patient services and satisfaction as well as focusing on cancer outcomes at Winship.

Carla J. Berg was named Winship’s associate director for population sciences. Berg, an associate professor in the Department of Behavioral Sciences and Health Education at Emory’s Rollins School of Public Health, will be responsible for the strategic growth of population science activities at Winship. Population science studies in cancer examine patterns and behaviors relating to cancer prevention, detection, and treatment.

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A central challenge in diagnosing and treating prostate cancer is distinguishing fast from slow, aggressive from indolent. Consider the experience of Gerald Alexander.

A former Air Force surgical service specialist who completed several tours of duty in Iraq and Afghanistan, Alexander was preparing to retire from the military and make a transition to teaching high school in Warner Robins, Georgia. As part of a routine pre-retirement physical exam, his doctors performed a PSA (prostate specific antigen) test, and the PSA level was high. A biopsy in early 2013 revealed the clear presence of cancerous cells. The Gleason score (see glossary page 9), a measure of how aggressive tumor biopsy samples look to a pathologist, was 9 out of 10.

By Quinn Eastman • Illustration by Laura Coyle
Alexander was having frequent back pain, which he thought was from arthritis. Based on his back pain and some suggestive bone scans, a radiation oncologist in Warner Robins suspected that the cancer had already metastasized. He was told to “get his affairs in order.” However, another of his local doctors didn’t agree and to resolve the uncertainty, he came to Winship Cancer Institute.

He met with a team of Winship doctors and they determined that the cancer, while potentially serious, was not a big hurdle for him. “My background as a surgical tech made me not fear the surgery,” he says. “Some men I met decided to have seeds, but I had the attitude: okay, let’s fix it. What do you recommend?”

First, his prostate gland was removed with a laparoscopic procedure. Positive margins—meaning that some cancer cells may have been left behind—indicated that he should plan for radiation and a limited course of treatment with leuprolide, a testosterone-lowering drug. The radiation treatments were grueling, but in the spring of 2015, Alexander was back at work, instructing his junior ROTC students and planning for summer camp.

Alexander’s journey with prostate cancer has been an example of fast. Most men’s initial encounters with prostate cancer don’t play out as quickly.

Most of the time when an elevated PSA level spurs a man to have a biopsy, no cancer is detected. Health care experts have criticized the PSA test for driving many men to seek definitive treatment for cancers that might not pose a danger, even years down the line. And on the other side of the coin, an initial biopsy sometimes doesn’t detect a cancer whose presence is suggested by rectal examination.

This uncertainty leaves men like David McGehee of Atlanta stumped. McGehee had two elevated PSA readings and a urologist he had been consulting assumed he would proceed to a biopsy. He wasn’t so sure. Having recently started a new relationship at 69, he was concerned about the risks, however small, of infection or nerve damage that come with a biopsy. He started looking for other testing options.

“I’ve been trying to learn all about sensitivity and specificity,” he says. “I’ve been doing my homework, and it’s still confusing as hell.”

Winship is at the forefront of research aimed at helping men at all stages of their journeys with prostate cancer. Men like McGehee, who may or may not be in the early stages, will want to know more about whether a biopsy or prompt treatment is really necessary.

Some may need basic information and help making a decision about different forms of treatment and their possible side effects such as impotence or incontinence (see sidebar on page 10). Some men will have the option of active surveillance, sometimes called watchful waiting, instead of immediate definitive treatment such as radiation or surgery. Those at more advanced stages could benefit from information about a cancer’s recurrence or spread, and effective treatments that could stop a recurrent cancer’s growth for years.

Peter J. Rossi, a Winship radiation oncologist who treats men with prostate cancer at Emory Saint Joseph’s Hospital, says he helps patients evaluate their fears and quality of life issues, but the ultimate decision is up to each individual man.

“You can help by sorting through their values,” Rossi says. “Are they afraid of disability in the future, what’s the effect on their lifestyle today? Do they want to have kids? We talk about all the risks, we summarize all the worst-case and best-case scenarios, and leave it to them to make a decision.”

This article will tell you about 1) new biomarkers for detecting and diagnosing prostate cancer, 2) an imaging probe for detecting recurrent prostate cancer, and 3) newer treatments, including a therapeutic vaccine approach.

**Diagnosing: is it an aggressive cancer?**

At Winship, urologists and cancer biologists are part of a nationwide effort to develop new blood and urine tests that could substantially improve detection and diagnosis of prostate cancer. “Overall, the effect of PSA testing over the last few decades has been to drive down mortality from prostate cancer,” says Martin G. Sanda, director of Winship’s prostate cancer program and chairman of the Department of Urology at the Emory University School of Medicine. “The cost is that for every cancer detected where we save a man’s life, we are detecting another, or two, that may not need to be treated.”

A third to half of men who have a biopsy based on the PSA blood test are found to have prostate cancer, but only one in five of them has a cancer that is
sufficiently aggressive to warrant treatment (those with a Gleason score of 7 or higher).

"Only a minority of cancers with a Gleason score of 6 will ever require treatment and that treatment can be deferred until the cancer becomes more aggressive," Sanda says.

Sanda and colleagues at other medical centers in the National Cancer Institute's (NCI) Early Detection Research Network have been examining whether two RNA markers from urine could predict whether a subsequent biopsy will display a Gleason score of 7 or higher.

A test for one of these markers, PCA3, a gene that is hyperactivated in prostate cancer, is already FDA-approved for men who are considering a repeat biopsy after an initial negative result. The other marker, called TMRPSS2-ERG or T2-ERG for short, is a DNA alteration that is present in about half of all prostate cancers.

In a study led by Sanda, a test looking for both PCA3 and T2-ERG was validated with more than 500 patients and confirmed in a separate group of 500 more across the country. Sanda says those two markers could reduce by one half the number of unnecessary biopsies that are done based on abnormal PSA results. While that's better than PSA alone, "there's still room for improvement," Sanda says.

Improvement could come from research being done by Carlos Moreno, John Petros, Kathryn Pellegrini and colleagues at Winship. They began with samples of tissue obtained after prostatectomy from 100 men treated at three medical centers, including the Atlanta Veterans Affairs Medical Center, and followed the patients' progress.

In a 2014 Cancer Research paper, Moreno's team was able to define a 24-gene signature for the cancers that are most likely to recur. This signature, which is more accurate than a commercially available panel at predicting recurrence, could be useful in guiding doctors in selecting treatment and imaging options, he says.

Working back to earlier stages of disease, the researchers are now looking for the same gene signature in biopsy and urine samples. In a pilot study with urine samples, the pattern of RNA markers could separate aggressive from slow-moving cancers, as indicated by later biopsy. The team is now planning larger studies.

"The signature could be useful at several points," Moreno says. "Eventually, we want to be able to provide prognostic information before surgery, or even tell a patient before a biopsy whether he really needs one."

Recurrent cancer: where is it?

If after surgery or radiation, a prostate cancer seems to come back, based on PSA testing, a big question a patient and his doctors may have is: where is it?

A Need to Know

By Viraj Master, Director of Clinical Research, Department of Urology, and Ashesh B. Jani, Professor, Department of Radiation Oncology

We have been studying health literacy for over a decade and our research has helped identify a critical need for improving patients' understanding of the terminology doctors use when discussing prostate cancer treatment. If patients don't understand these terms, it severely limits their ability to have meaningful discussions about treatment options. Perhaps the most troubling aspect of this is that it can lead to "decisional regret."

Our initial study showed that patient comprehension is not good at all. Only 15 percent of the patients understood the meaning of "incontinence (urine leakage)"; less than a third understood "urinary function" and "bowel habits"; fewer than 50 percent understood the word "impotence (inability to achieve erection)."

Other studies suggest the problem is a widespread phenomenon. As we defined the scope of the problem we were seeing, we also felt compelled to seek solutions to it. Our next step was to develop a video-based tool that uses narrated animations to explain 26 terms that doctors and medical staff routinely use in talking with prostate cancer patients. Our second study showed that after viewing the video, patients' understanding of key terms significantly improved.

We believe video tools can help patients understand critical prostate health terms in a meaningful way. The ultimate goal is to give patients a vocabulary toolkit to enable them to make shared and informed decisions about their treatment options. Our next goal is to improve the tool further, and study its use at different centers.
“It’s a lot easier to plan the attack, if we know where the enemy is,” says Winship urologist Peter Niech. “If a cancer is still localized, we may want to try salvage therapy, either radiation or surgery, before advancing to something systemic.”

Depending on how primary treatment took place, a prostate cancer often comes back in the prostate bed (where the prostate gland was), and may appear in nearby lymph nodes. In advanced cases, the cancer may spread to the bones.

Emory radiologist and Winship member David Schuster and radiochemist and Winship member Mark Goodman have been developing a PET (positron emission tomography) imaging probe that shows prostate cancer detection efforts since the prostate is so close to the bladder. In contrast, the probe 18F-FACBC, based on amino acids, is taken up by prostate cancer cells but doesn’t appear as much in urine. FACBC has its limitations. It also may be taken up in benign prostate hyperplasia or inflammation. This means it probably won’t be as useful by itself for evaluating primary prostate cancers, but it has a lengthening track record in recurrent cancer.

In a 2011 publication, Schuster and his colleagues compared FACBC to ProstaScint, a commercially available probe. FACBC showed superior sensitivity and specificity in detecting tumors outside the prostate bed. Schuster is now collaborating with Winship radiation oncologist Ashesh Jani to study FACBC’s benefits in designing radiation treatments for patients with recurrent prostate cancer after prostatectomy.

In Jani’s study, which lasts until 2017, one group of patients is examined using FACBC, while another gets conventional imaging. The question is whether using information gleaned from FACBC to direct the radiation results in a longer lasting remission than with the control group.

Marble countertop salesman Paul Reckamp, who was a participant in Jani’s study, keeps a file on his phone noting his PSA levels for the last several years. Reckamp had a radical prostatectomy in July 2010 at Emory Saint Joseph’s Hospital, but the cancer appeared to come back a year and a half later. FACBC imaging confirmed that the cancer had appeared in nearby lymph nodes but not elsewhere, and doctors could then plan radiation treatment that drove his PSA levels back down again.

“I couldn’t have been more pleased with the study,” he says. “It told me and the doctors what we wanted to know.”

Later in the game: new treatments
If a prostate cancer recurs after definitive treatment, a standard approach is to provide drugs such as leuprolide. The drugs trick the testicles, the main source of testosterone, into halting testosterone production. This helps to curb the growth of prostate cancer cells, which generally depend on testosterone to grow. However, prostate cancers can eventually figure out a way around this obstacle. In describing this phenomenon, doctors use the term “castration resistance,” even though hormone therapy is now more common than surgical removal of the testicles.

“The basic problem is that other cells start making testosterone, such as fat cells, adrenal cells, or the cancer cells themselves,” says Bradley Carthon, a Winship medical oncologist specializing in genitourinary cancers. “This leads to castration resistance.”

Carthon and his patients have participated in studies testing newer agents, such as abiraterone, enzalutamide and other hormone-based therapies, against castration-resistant prostate cancer. These drugs suppress testosterone production both within and outside the testes. A current trial at Winship looks to combine abiraterone with a new radium-based drug, a way of delivering radiation to bone metastatic prostate cancer. This combination could have an even greater effect on a man’s disease than treatment with single agents alone, Carthon says.

With patients who do have aggressive, metastatic disease, when to give chemotherapy depends on the type of hormone therapy being used and the cancer’s response. This is especially true for patients who have received prior chemotherapy. “This is sequencing the genomes from prostate cancers, and compiling for each one a list of ‘epitopes’: potential handles that the immune system could grab onto. Kissick says Provenge is a good “proof of principle,” but there may be better targets than PAP for the immune system to hunt. Working with Sands and Emory Vaccine Center director Rafi Ahmed, Kissick is sequencing the genomes from prostate cancers, and compiling for each one a list of “epitopes”: potential handles that the immune system could grasp onto. Kissick envision.

For his part, Sanda thinks that research he and Kissick published in 2013 could be developed into an “off the shelf” prostate cancer immunotherapy. They identified an epitope corresponding to the T2-ERG mutation, present in the majority of prostate cancers, and found that immune cells that recognize that epitope are present in prostate cancer patients, although inactive.

“The problem is how to make it active again, to turn on the immune system,” he says. “This may eventually become the groundwork for not just a therapeutic vaccine, but one that could be preventive,” Sands says.

No matter where a man is on the path of dealing with prostate cancer, Winship research aims to expand the options at every stage. 

Martin Sands, John Petros and Viraj Master are three of the physicians on Winship’s prostate cancer team.
From Bench to Bedside

The unique layout of the Winship building, with three floors of patient clinics and three floors of research labs, brings scientists face to face with those who benefit from their research: cancer patients.

Patients on clinical trials know their treatments come from scientific discoveries, but they usually don’t get a chance to meet the researchers who make those discoveries. So we set out to bring them together in this photo essay.

*The patients in these photos are on clinical trials that can be found on the Winship website at winshipcancer.emory.edu/clinical-trials

By Catherine Williams • Photo essay by Ann Borden
Denis Brosnan, a businessman and educator, believes in the power of academic research to unlock the mysteries of cancer. Diagnosed with colorectal cancer in 2014, Brosnan did his own research to find an alternative to the standard of care offered to him at another cancer center. He found it with a Phase I clinical trial designed by Bassel El-Rayes.

The cutting edge therapy started in a Winship lab with the discovery that blocking a specific protein in colorectal cancer cells can make them sensitive to the effects of standard treatments, like radiation and chemotherapy. That led to successful animal model experiments and then to a clinical trial. Brosnan was one of the first patients to enroll.

As both physician and researcher, El-Rayes has been connecting the dots, from lab research to clinical trials and a treatment that has led to Brosnan's remission.

For Deana Chiusano, a discovery in Larry Boise's multiple myeloma lab led to enrollment on a trial that has transformed her battle with the disease. A drug known as ABT-199 has been effective against certain types of leukemia and lymphoma. Boise hypothesized that ABT-199 also could work for myeloma patients with a specific chromosomal translocation (the transfer of one part of a chromosome to another).

Researcher Shannon Matulis tested the hypothesis when Chiusano donated her bone marrow cells for research. Although Matulis didn’t know whose cells she was testing, she clearly saw they were sensitive to the drug. Chiusano lives in Pittsburgh but travels to Atlanta every three weeks for a Phase I trial. After years of treatments elsewhere with minimal response, Chiusano has seen dramatic improvement with this tailored therapy.

Alan Massey, a head and neck cancer patient who calls himself a misplaced cowboy, says he should have been born on a ranch. Nabil Saba sees patients and leads several clinical trials, so a walk in Lullwater Preserve with Massey is a welcome break.

Massey and Saba share a love of nature. They also share an appreciation for the cancer-fighting potential of immunotherapy. Massey's metastasized cancer demanded a comprehensive approach, so he started a trial that combines standard chemotherapy and a monoclonal antibody with a new drug that acts on a protein to stimulate certain parts of the immune system.

That was over a year ago, and Massey has been treated at Winship nearly every Friday since then.

Georgia Chen grew up hearing "drink more tea!" So she was thrilled when green tea showed potential as a preventive agent.
Why are some individuals more likely to develop cancer or to develop a more aggressive form of cancer? Why do some people not get the care they need, when they need it? Winship clinicians and researchers confront such disparities daily – and are working to understand and change them.
Risk disparity

Genetic research is a key to understanding how either race or ethnicity affect the incidence of different cancers and how these factors may contribute to different responses to the same treatments.

Multiple myeloma, a blood cancer of the immune system's plasma cells, occurs two to three times more often in African Americans than in Caucasians. Finding out why could lead to better therapies for all. Winship researchers couldn’t do it without people like Veronica Reynolds.

In her mid-50s, the busy realtor developed severe pain. She asked herself if she had strained her back, driving back and forth showing houses or picking up grandchildren? She told herself it would go away. It got worse. One doctor told her she looked too well to hurt as much as she claimed. Another believed her but his pills barely helped. After two years, she feared her heart would stop from pain. At Grady Memorial Hospital, imaging revealed fractured bones, due to bone destruction. Other tests provided the multiple myeloma diagnosis – and led Reynolds to Leon Bernal-Mizrachi, a Winship hematologist/oncologist who sees patients at Grady.

Reynolds credits God for sending her to Bernal-Mizrachi and to Jonathan Kaufman, director of Winship's ambulatory infusion center, who oversaw her stem cell transplant following high dose chemotherapy. She credits herself for following the complex treatment regimens. And she's "ecstatic," she adds, about being part of her doctors' research. "I hope I have enough fight in me to live to see it help many people like me.”

Reynolds – and her genes – are part of a massive multi-institutional study to sequence the entire genome (more than three billion DNA base pairs) of 1,049 African Americans with multiple myeloma and another 7,084 without the disease. The Winship component, headed by Sagar Lo- nial, Bernal-Mizrachi, and Ajay Nooka, has gathered almost a third of the study’s participants, thanks to the researchers’ commitment and Georgia’s high African-American population. Although still in process, the study is already producing valuable insights. Winship physicians routinely take tissue cells from multiple myeloma patients, looking for genetic variants that indicate who is at higher risk of relapse. They hope this new study will help identify why this disease occurs more frequently among African Americans and determine if there are treatments that may be specific to these patients.

Winship researchers also are looking at genetic differences in another blood cancer, diffuse large B-cell lymphoma (DLBCL), the most common form of non-Hodgkin lymphoma. Compared to Caucasians, African Americans have a lower incidence of DLBCL – but are more often younger, with more advanced disease, and a lower chance of surviving. A multi-institutional study headed by Winship hematologist/oncologist Christopher R. Flowers, director of the Emory Lymphoma Program, is finding subtle genetic differences, depending on race, in DLBCL subtypes. This builds on earlier work by Bernal-Mizrachi’s team, which demonstrated that different subtypes have different signaling pathways (cells that activate cell division and other functions). Abnormal activation can lead to cancer and cancer cell growth. The long-term goal is to develop new drugs to block different pathways. But the Bernal-Mizrachi team already has demonstrated that using different existing drugs, depending on patients' subtypes, itself positively changes outcomes.

In fact, Bernal-Mizrachi says new drugs are changing how clinicians view racial disparities. For years, African-American multiple myeloma patients were believed to have poorer outcomes after autologous stem cell transplants (transplants using the patient’s own stem cells), like that given Reynolds. But a recent Emory study of transplants from 2006 to 2012 showed newer maintenance drugs had improved outcomes for both blacks and whites. In fact, preliminary results indicate Afri-
Care disparity

“At Winship, we use fundamental science to get at the root causes of cancer, including cancer disparities. We then go to the next step, looking at disparities in why some groups get care sooner or later than others.” says Walter J. Curran, Jr., executive director of Winship. “Our faculty are dedicated to reducing the burden of cancer for all Georgians, and our work exploring the cause of disparities in patient outcomes will improve the lives of all cancer survivors.”

Winship clinicians working with patients from different populations and Winship researchers working with population-based studies in cancer prevention and control are finding that race and ethnicity have less to do with disparities in health care than do economics and knowledge gaps or misconceptions. Change these, they say, and you can do a lot to erase some of the worst disparities.

Take, for example, cervical cancer, where disparities in incidence and outcome abound, nationwide and among the patients seen by Winship gynecologist Lisa Flowers, who is based at Grady. Those disparities are all the more troubling, says Flowers, because cervical cancer is completely preventable and is highly curable when detected early.

As with many diseases, minorities and other underserved populations suffer most. Nationally, new cases of cervical cancer are 65 percent higher among Latinos and 45 percent higher among African Americans than among white women (except those in Appalachia and some other rural areas). But mortality is markedly higher for African Americans.

Higher rates of new cases for Latinos occur in part, says Flowers, because many Latinos are newcomers to the U.S. and are less likely to have had access to screening. African Americans are screened at a higher rate, surpassing both Latinos and white women. They more often die, she says, in large part due to less follow-up after abnormal test results.

Follow-up care can be challenging. A woman has to find a doctor and pay for colposcopy (examination of the cervix) to see if the abnormal cells found by a Pap test (the standard screening for cervical cancer) are pre-cancerous. She can receive aid from the state for treatment only if she has a diagnosis of high grade precancerous cells or cancer. If, that is, she is a legal resident or citizen of the U.S.

If Latinos can surmount problems such as money, transportation, and citizenship, they usually take the next step, says Flowers. For some, however, and for many low-income African Americans she sees at Grady, myths create another barrier to screening or follow-up. Myths like “I don’t need screening because women who get cervical cancer are promiscuous and I’m not.” Most people unknowingly have the sexually-transmitted human papilloma virus (HPV) at some time in life, but in most cases it goes away on its own without leading to cervical cancer.

I once had a test so I know I’m not at risk.

Most abnormal Pap tests turn out not to be cancer, but they paralyze some women with fear. They refuse to think about follow-up or leave it in God’s hands.

Lisa Flowers says no one should die from cervical cancer, one of the most preventable and curable of cancers. But women do—especially African Americans.

A Clinical Study to Help Treat Recurrent Prostate Cancer

For more information about the trial, visit winshipccr.cancer.emory.edu/ACCInfo

Ashish Jani, MD
Phone: 404-778-3827
Email: ajani@emory.edu
Meet Kimberly Curseen

As the primary physician for the Supportive Oncology Clinic at Winship Cancer Institute, Kimberly Curseen helps patients take a big step in their cancer journey.

How does supportive care differ from hospice?
While hospice care is typically provided to patients during the end of their lives, supportive care is appropriate at any stage in a serious illness and can be provided along with curative treatment. Supportive care teams work closely with individual oncologists to develop personalized symptom management plans that help patients accomplish their treatment goals.

Is there any scientific evidence showing that it makes a difference?
Several recent studies have shown that supportive care improved patient quality of life, lessened their symptoms, and reduced the time they spent in intensive care. One study also showed that certain lung cancer patients who had outpatient supportive care also lived longer than patients without supportive care intervention.

Who provides supportive care and where is it given?
Supportive care is provided by a team of doctors, nurses, and other specialists who work together with a patient’s other physicians to provide an extra layer of support. Supportive care teams can provide this in the hospital, through clinics, and in some programs in the home.

Does insurance cover the costs of supportive care services?
As with other hospital and medical services, most insurance plans will cover all or part of supportive care services. Prior authorization may be required. Medicaid and Medicare will also cover the costs.

For more information about the Winship Supportive Care Clinic call 404-778-6448.

What is supportive care?
Supportive care, also known as palliative care, provides relief from the symptoms and stress of a serious illness—whatever the diagnosis. The goal is to improve quality of life for both the patient and the patient’s family. Supportive care can help with emotional and spiritual issues as well.

The threat of winter weather didn’t keep almost 300 supporters from attending the fourth annual Friends of Winship “Fashion A Cure” fashion show and luncheon. Cancer survivors, caregivers, and others modeled clothes from 18 local boutiques. The fundraising event brought in more than $160,000, a bump of $41,000 over last year’s show. The donations will benefit Winship’s cancer research programs.