The Coalition with Dr. Shani Belgrave: A Conversation about Ovarian Cancer Michelle Glasgow MD Transcript

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Introduction and Guest Welcome

Welcome to The Coalition. This is a talk show dedicated to discussing health, wellness, and inspiration. I'm your host, Dr. Shani Belgrave. Hello, everyone.

Welcome to The Coalition. I'm your host, Dr. Shani Belgrave. I am a bariatric and minimally invasive surgeon in Atlanta, Georgia. You can get connected with me at www.drshanibelgrave.com.

I am elated to welcome back to the show today, Dr. Michelle Glasgow. Dr. Michelle Glasgow is a renowned gynecologic oncologist who joins the show to share her expertise on ovarian cancer right on time for ovarian cancer awareness month.

Dr. Michelle Glasgow, welcome back to the coalition. Thank you so much, Dr. Bella Grave. I'm so excited to be here to speak with you yet again, third time this time.

Yes, the third time's a charm. And of course, shout out to Brown University. I've had the privilege of knowing Dr. Michelle Glasgow. We both did our undergraduate and medical studies at Brown University.

So we are experiencing another full circle moment from Providence to Atlanta. So Dr. Glasgow, can you please get us started by telling us about the magnitude of the problem?

How common and how significant is ovarian cancer? So ovarian cancer is one of the most common gynecologic malignancies in the US. I would say about 22,000 women are diagnosed every year.

And it is known to be a very lethal gynecologic cancer in that Perhaps about 14,000 women may die each year. I always counsel women when they're first diagnosed, however, that this is a treatable cancer and that we are seeing improved survival because there have been a lot of advances in treatment over the last few years.

Okay. And so what are the signs and symptoms of ovarian cancer? So first I'll just say, and I can talk about this a little bit more as we discuss further, is that there are several different types of ovarian cancers.

Not all ovarian cancers are the same. One type differs from another type according to the cells that the pathologist sees under the microscope. The most common type of ovarian cancer falls under the category of the epithelial type of ovarian cancer, and that cancer arises from the cells which are on the surface of the ovary.

Ovarian Cancer Overview and Symptoms

And then the other types, which are a little bit less common, fall under the category of germ cell tumors, which tend to be seen in younger women and then sex cord stromal tumors.

which can be seen in women, I'll say across ages. But when most people hear ovarian cancer, they think of the epithelial type of ovarian cancer, typically the high-grade serous type, which is the most common.

In terms of the symptoms of ovarian cancer, and I'll speak more to the epithelial type of ovarian cancer, the symptoms are very easy to confuse with other symptoms, which you may find with other benign conditions.

So for instance, some women may experience bloating, constipation. They may experience changes in weight. They may feel that it's harder to close their pants or to pull their pants up.

They may experience some pain or discomfort or some urinary frequency. And unfortunately for many women, because these symptoms can be confused with other conditions that are not cancerous, They may undergo evaluation with many other physicians prior to seeing a GY oncologist, prior to undergoing imaging that shows a mass on their ovary.

So then how is it diagnosed? So that's a really important question. Ovarian cancer, I will say, has a bad reputation. And again, I'm going to refer right now more to the more common epithelial type of ovarian cancer.

It has a bad reputation because when it is found in many cases, it's found at stage three or stage four. The staging refers to where the cancer has spread to.

So a stage one ovarian cancer is a cancer that's just limited to the ovary. Stage two is when it is extending outside the ovary and the pelvis, and then generally stage three involves spread to lymph nodes or the upper abdomen, and stage four is more distant disease.

Partially because it can take a longer time to diagnose, most women are found to have stage three or stage four disease at diagnosis. What that means is they may have a mass on their ovary, but then they may also have smaller tumors in their upper abdomen.

There is a finding called carcinomatosis, which is often seen with ovarian cancer. That refers to the spread of multiple small tumors in the upper abdomen.

You can have small tumors on the surfaces of the bowel, the intestine, the liver, the spleen, and then with more advanced stages you can have involvement of fluid with cancer cells around the lung or in the lung itself.

So then most times when it's found how is it picked up then on a CT scan? Yes, yes. I will say that up to perhaps 15 to 20 percent of cases of ovarian cancer can be found at stage one.

They're not always found at stage three or four but In the majority of cases, they can be found. And the reason for that again is because it can take a while for patients to actually undergo evaluation.

Sometimes they'll have symptoms that they don't seek out evaluation for because they think it's normal. So some women think, especially as they get older, it's normal to have some more constipation or to gain some weight.

And women sometimes ignore those symptoms when they may be actual symptoms of ovarian cancer. Or they may see other providers prior to seeing a gynecologist or a GYN oncologist who will order other types of tests, but not a CT scan.

So then what are the risk factors and kind of when is it most commonly found and what age group of women? So it generally is found more in women who are considered perimenopausal or premenopausal women.

So I would say women above the age of 50 more, but unfortunately we are seeing more and more cases which are diagnosed in women who are younger. in their 30s, 40s, even 20s in some cases.

I will say for the other types of ovarian cancer, the germ cell tumors especially, that's another type of ovarian cancer, which typically is diagnosed in younger women.

Diagnosis, Staging, and Disease Spread

When they say younger, maybe like 18, 19 years old, they're early 20s. And one thing I didn't add before is unfortunately, there is no good screening test for ovarian cancer.

So there isn't a test like a mammogram or colonoscopy, which you can undergo to find the cancer or find this condition in a precancerous phase before it develops.

So it's generally found when women are symptomatic or have some symptom and then undergo imaging, which shows a mass on their ovary. Or in the cases of women with stage three or more advanced disease, where they'll find the mass on the ovary and other masses on the abdomen and pelvis.

So is there a difference in prognosis? Because you mentioned that the epithelial type is more common, and then that was more prevalent in older women, but that there's a difference, the germ cell, that is more common in younger women.

Is there a difference in the prognosis between those two types? Yeah, that's a very good question. I will say that for, I'll speak for the germ cell tumors first.

For most, for I'd say all ovarian cancers really, surgery at some point is central to the treatment. And for germ cell tumors, fertility sparing surgery can be performed safely.

And I just mentioned that because a lot of the women with germ cell tumors are younger women. in their teens or early 20s who haven't had children. And they can often undergo surgery to remove the affected ovary, potentially lymph nodes as well.

And in some cases, they do need chemotherapy as well. And they can still go on to have children in the future. So I just want to emphasize that because I think it's very important.

For germ cell tumors, they can be cured of their disease and where they can go on to live years and decades into their adulthood. For the other types of ovarian cancers, so the epithelial type as well as the sex cord stromal type, Surgery, again, is a mainstay of the treatment.

In terms of the prognosis, it really depends on their stage of diagnosis, whether it's a stage one or stage three. as well as the cell type. So it's a bit of a complicated answer in terms of the prognosis, but I will, I always tell patients who are newly diagnosed, especially with the more common like epithelial high-grade serous type, that it is a treatable cancer, but it really does become a chronic disease because for instance, for a patient with a stage 3C high-grade serous ovarian cancer, for instance, where a patient presents with an ovarian mass plus a lot of ascites, which refers to a lot of fluid in the abdomen and pelvis, which just shouldn't be there, it's because of the cancer, plus small tumors on the bowel, even the liver.

Those patients, they generally would be treated with a combination of chemotherapy and surgery. In terms of the order, the goal of surgery when there's obvious spread of the cancer is to get out all the visible disease.

So when a patient is seen by a G1 oncologist, they will undergo imaging, which will usually either include a CT of the chest, abdomen, and pelvis or a PET scan, and then they'll make an assessment If the patient can undergo what we call or we refer to as optimal cytoreductive surgery, which means they undergo surgery and there's no visible cancer left, they also make the assessment of whether the patient is well enough to undergo such an extensive surgery.

And if it's felt that those patients can undergo such a surgery, they'll generally undergo surgery first and then receive six chemotherapy treatments thereafter, and then go on a pill to prevent the cancer from returning.

Risk Factors and Protective Factors

But for patients who it's deemed that surgery is not the best option for them first, they'll then receive what we call neoadjuvant chemotherapy, which refers to receiving three cycles, generally sometimes four, of chemotherapy first, and then they undergo repeat imaging.

And once we see that they're having an adequate response, then they undergo surgery. And then they usually receive three cycles of chemotherapy after that.

I will say that for both groups of patients, whether they undergo surgery first and then chemotherapy or

chemotherapy, surgery, and then more chemotherapy, the chances of entering a remission, and I always describe to patients having a clear scan, are very high.

About 80%, but about at least 60% of those patients will develop recurrence, usually within two to three years. There's a small percentage of patients.

less than 25% who will recur within six months of completing chemotherapy. And those patients do have a poor prognosis. Those patients are what we describe as platinum resistant or platinum refractory if the cancer were to grow while they were receiving chemotherapy.

But for those patients who develop a recurrence two to three years after or even some women may develop a recurrence five years after completion of treatment.

We often treat with chemotherapy again. And some patients can be on, it can be a bit of a roller coaster, but where they're on and off treatment for years.

So I really describe the treatment and the prognosis for those patients with a high, especially a high grade serosilverin cancer when they recur as truly chronic because it is a cancer that they can live with, but live with on and off treatment.

And I also mentioned to patients when I meet with them, especially when they recur, I just emphasize the importance of quality of life because I think that's really important to consider on these treatments, especially chemotherapy, that they can live with the cancer on and off treatment with a decent quality of life.

As the side effects can be tolerable for most, but the chemotherapy does have side effects and I always counsel patients on what those side effects may be.

Each chemotherapy is different. Each chemotherapy has different side effects, and some patients are able to tolerate treatments better than others. And it's always an important discussion to have.

Well, thank you so much, Dr. Glasgow, for being so thorough. I wanted to go back a little bit, especially since this is not a cancer that can be screened for, for us to talk about risk factors.

Yeah. So one of the strongest risk factors is a genetic mutation. So the genetic mutations which are known the best to the public are the BRCA mutations.

So BRCA1, BRCA1, BRCA2, they can increase the risk of ovarian cancer up to 40% and they are associated with breast cancer. For the epithelial type of ovarian cancers, I just want to mention, I'm sorry I did not mention this earlier, is that there's ovarian cancer, but then there's also fallopian tube cancer.

And you can develop a cancer in the fallopian tube and essentially it presents the same way as ovarian cancer. It's treated the same way as ovarian cancer.

And then there's also another cancer called primary peritoneal cancer, which is a cancer of the peritoneum, which is the lining of the abdomen and the pelvis.

And again, it presents and is treated the same way. But going back to risk factors, I just thought about that. Going back to risk factors, I always tell new patients who told me that they've undergone genetic testing and they were told they don't have a BRCA mutation.

It's not just the BRCA mutation, which increases the risk of ovarian cancer. There are other mutations. And now when we perform genetic testing for ovarian cancer, usually patients will undergo a multi-gene panel.

because there are other mutations, for example, Paul B2, RAD51C, and D, Brip. The mutations are associated with Lynch syndrome, which is also associated with endometrial cancer, can increase the risk of ovarian cancer.

So you can have genetic mutations, but then I also mentioned family history, because patients can have a strong family history of ovarian cancer, but they may not have a genetic mutation.

and their family history cannot be ignored. For those women who have a strong family history of ovarian cancer especially and have a negative genetic mutation or don't have a mutation, I'll tell them that it's possible that they have a mutation but it just hasn't been identified yet according to the tests that we have available for genetic testing.

In terms of other risk factors, I think it's also important to comment on those factors which are protective. But before that, I will say that endometriosis can increase the risk of ovarian cancer as well as using assisted reproductive technologies, meaning using IVF to conceive.

Sometimes that can increase the risk. of ovarian cancer. But then there are protective factors. So for instance, breastfeeding, pregnancy, these are protective factors.

And then also tubal ligation, but specifically removal of the fallopian tubes. And the reason for that is that there has been some research which has shown that ovarian cancers actually start in the edge, what we call the fimbria or the fingers of the fallopian tubes.

So in the past, for instance, when women expressed that they wanted to tie their tubes to prevent as a form of contraception and to prevent future pregnancy, their tubes were actually tied.

or they were burned surgically. But now for those women who are expressing they would like a tubal ligation, many gynecologists are actually removing the whole fallopian tube because of the link with ovarian cancer.

The other risk factor or protective factor I'll mention which can reduce the risk of ovarian cancer is also the use of oral contraceptive or birth control pills.

I was just gonna add another risk factor, obesity. Um, I will say that is a risk factor, but it's not as consistent as the others. Yeah. But, um, unfortunately I'm finding that obesity I think increases the risk for so many different cancers, but it is a risk factor too.

The thing that I wanted to touch on is when you talked about family history and that someone may have a strong family history of ovarian cancer, but test negative on the panels, and that just means that it's maybe a mutation that hasn't been discovered yet.

How would you counsel those women? Do you recommend prophylactic salpingectomy? I mean, not salpingectomy, oophorectomy? So that's a really good question.

Depending on their age and their family history, I would counsel them on that option. For women who have a known mutation, there are guidelines, actually, according to which suggests that women should have, for instance, a woman with a BRCA1 mutation.

It's suggested that she have her ovaries and fallopian tubes removed between the ages of 35 and 40, or when she has completed childbearing. For a BRCA2 or a PALB2 mutation, that recommendation is for after the age of 40. You did mention salpingectomy.

So a salpingo-ufrectomy is removal of the ovaries and the fallopian tubes, and a salpingectomy is removal of just the fallopian tubes. In answer to your question, for a patient who has negative testing but a strong family history, I would definitely discuss removal of the ovaries and the fallopian tubes.

prophylactically, the question is always the timing, because a lot of these women who I'm seeing with either mutations or a family history tend to be premenopausal.

And with removal of these organs, they go into premature surgical menopause.

Prevention, Surgery, and Hormone Therapy

And then that's a discussion of how to handle the symptoms of menopause, and then whether to pursue hormone replacement therapy or not, and then For those women who have a mutation, which would also increase their risk for breast cancer, then that is also a discussion with their breast specialists and or medical oncologists on hormone replacement therapy.

There is quite a bit of research looking into the benefits of prophylactic salp injectomy. So just removing the fallopian tubes to try to reduce the risk of these ovarian and fallopian tube cancers prior to removing the ovaries, especially for those women who are younger and have completed childbearing, but they are not yet ready to remove their ovaries and then go into menopause.

But that's not yet standard of care. But that is an area of research. I'm so happy you brought up the hormone replacement, because that is a hot topic right now.

almost an explosion of perimenopause and menopause care. Oh, yeah. That is a hot topic. It's a controversial topic. Yes, yes, yes. Because as I'm listening to different talks and seeing what's going on, I just want to see what your thoughts are on this.

What do you think? Do you think that people that are using hormones topically, to control some of the symptoms that it might be an option in people who have had a cancer risk as opposed to systemic hormones or is that still unclear?

So I will say that topical hormones do have a risk of systemic absorption. I'll just say that that is something important to consider in terms of cancer risk.

But the other thing I'll mention is that I think a lot of topical hormones may fall under the realm of being compounded. our society, when I say our society, like ACOG, the American College of Obstetricians and Gynecologists, as well as SGO, the Society of Gynecologic Oncologists, they recommend when hormones are used that they be prescribed in sort of the FDA format or FDA approved forms.

I am Hesitant, I don't recommend compounded hormones just because I have seen where patients have received hormones that are compounded where the doses are incorrect.

Or there's an issue with the absorption and then they develop a side effect related to that particular use of the hormones. Often I will see patients who've developed abnormal bleeding in the setting of compounded hormone use.

So that is something that I just caution patients on in terms of the compound, the use of compounded hormones. But I will say that for patients who have a gynecologic cancer, and this is just a general statement because it can get a little bit complicated, but for women who have a gynecologic cancer that is not hormonally driven, and that's an earlier stage, hormone replacement therapy is safe.

And there's a lot of research to show that. So for ovarian cancer, for my patients with ovarian cancer, I'll discuss, depending on the exact type of ovarian cancer, I will discuss hormone replacement therapy with them for those women who are premenopausal.

at their diagnosis. For those women who are post-menopausal and who've already been in menopause at their diagnosis, I generally don't just start hormone replacement therapy.

I think that the best time to start hormone replacement therapy is when you go into menopause. But for my patients who have an earlier stage and don't have a hormone hormonally driven cancer or have a cancer that has positive hormone receptors, I will talk to them about hormone replacement, depending on their symptoms.

Well, beautifully stated. I just wanted to reiterate that while the show is educational in nature, that these are very

complex topics. And so people really would need to get a one-on-one consultation with their provider as they try to make decisions related to their health.

Thank you so much. So Dr. Michelle Glasgow, what would be your takeaway message for people to know about ovarian cancer? So what I would say is to know your body.

Simply know your body and know when something is changing. And if you're concerned that something is changing, don't forget about your gynecologist. A lot of women, will go to their primary care doctor or another specialist and they never think about seeing their gynecologist.

Because unfortunately, a lot of women, especially after they finish having children, they don't go back to their gynecologist. Or if they undergo like a hysterectomy removing their uterus and cervix, but don't have their ovaries removed, they also don't go back and they forget about their gynecologist.

And I just say, just don't forget about your gynecologist, especially if you have any new symptoms and specifically the symptoms of like bloating, constipation, new pelvic pressure, changes in how you urinate or how you have bowel movements.

Takeaways, CA-125, and Contact Information

Just remember, especially if you do have your ovaries still, or even if you have had your ovaries removed, you can still reach out to your gynecologist because they may view you and order tests that your other specialists may not order.

Um, one test I just want to mention, which we haven't talked about those, the CA 125 level, um, because we've talked a bit about imaging, but I just want to mention the CA 125 level is that is a test, which is a tumor marker, which is ordered sometimes when there's concern for ovarian cancer.

And I always like to tell patients that that is not a perfect test. So it's very helpful to order when women have a mass, but unfortunately the only way to know if cancer is there, is present, is by examining tissue that's removed surgically.

But for younger women who have a CA125 level drawn, it could be elevated because of cancer, but it can also be elevated if they're menstruating, if they're having their periods.

or if they have a UTI or if they have like an appendicitis or diarrhea or something like that. And then similarly, women can have up to 15 to 20% of women can have ovarian cancer and have a normal CA125.

So I always counsel women, sometimes women will go to their primary care doctors and request the CA125 level be drawn and they may not know about all the things other conditions other than cancer that can cause it.

So just another reason to reach out to your gynecologist if you have any new symptoms or if you want to discuss the role of testing or screening. Well, thanks so much.

I thought that takeaway was brilliant because when we first started the conversation and you mentioned the symptoms, it sounded a lot like irritable bowel syndrome or, you know, something along those lines.

So I can see how someone may not even think that those symptoms would have anything at all to do with their ovaries. So that's a great takeaway. And I also love the fact that you pointed out the CA125 because it's so important in medicine to understand that if you check something and it doesn't come back positive, it doesn't necessarily mean you do not have a certain condition.

So just to make sure that you're seeing someone who knows how to synthesize everything and put it together. Dr. Michelle Glasgow, you already know you have to come back again.

I'd love to. I love talking with you and just talking about the conditions that I treat every day. Absolutely, absolutely. So Dr. Michelle Glasgow, what is the best way for people to reach out to you?

I think the best way is to just to call our office. I believe the number is 770-721-9400. One of the things that we pride our my office prides ourselves on is you call us and someone picks up right away.

So you don't have to listen to the props. So just call the raffles. Wonderful. Well, thank you so much, Dr. Michelle Glasgow. We will see you another time.

Thank you. Well, everybody, thank you so much for tuning in to a very impactful episode of The Coalition. I'm your host, Dr. Shani Belgrade. You can stay connected with me, www. DrShaniBelgrade.com.

Very special thank you to Dr. Michelle Glasgow, renowned gynecologic oncologist at Northside Hospital Cherokee. You can get connected with Dr. Michelle Glasgow by giving her office a call.

You guys make sure that you share this episode with friends and family, your neighbors to raise awareness for ovarian cancer. I'll see y'all next time.