Living with Ovarian Cancer and COVID-19: Updates with Dr. Brian Slomovitz

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Elana Silber:
My name is Elana Silber and I am the CEO here at Sharsheret, the national Jewish breast and ovarian cancer organization. And we're really glad to see all of you here tonight, we know these are very challenging and uncertain times for many of you. And even the timing of this call could be difficult so we will be recording this call for people to access it on Sharsheret's website, sharsheret.org, after the webinar is finished and will be saved there. We are mindful of your privacy so if you would like to participate anonymously, feel free to turn off your video and to change the name on your screen. The only faces that will appear on our website will be those of the speakers. And just making sure, there's a lot of zoom conferences out there, just making sure you're in the right place. Tonight's webinar is focusing on living with ovarian cancer and COVID-19 presented to you by Sharsheret.

Elana Silber:
Sharsheret has actually been an organization that's been providing virtual support since our inception back in 2001 providing emotional support, mental health counseling, financial subsidies, and up to date health information for the last 19 years. And so when this pandemic started to hit, Sharsheret's team of mental health professionals were quick to respond to the urgent concerns of women like you, women who are living with ovarian cancer, and women who are living and facing breast cancer. So, tonight is a part of a series of webinars that we've been presenting with up to date information from experts in the field. So I really thank you all for being with us today. Today's webinar was made possible with support for some of our sponsors that I'd like to share their names, the Seigman and Edith Blumenthal Memorial Fund, Daiichi Sankyo, Eisai, GSK, and Seattle Genetics.

Elana Silber:
We're very privileged to have two incredible speakers with us tonight. Our first speaker will be Kimberly Tronick, who is a Sharsheret peer supporter in our ovarian cancer program and will share her story with us today. And we have Dr. Brian Slomovitz who is a gynecologic oncologist at Broward Health Medical Center in Fort Lauderdale. In addition, he is a professor of obstetrics and gynecology at the Wertheim College of Medicine which is part of Florida International University. Dr. Slomovitz has published hundreds of papers and abstracts in the field of gynecologic oncology. Currently, his particular interests are in early detection of ovarian cancer, PARP inhibition for ovarian cancer, robotic surgery, and immunotherapy for endometrial and cervical cancers. So I think that we have our experts on the call tonight.

Elana Silber:
This is meant to be interactive in the way that you can share your questions and comments in the chat on the side. And I will be facilitating a Q&A at the end. Some of you have some questions in advance but if questions come up along the way, feel free to put them in the chat and we will address them on the call. So now it is my pleasure to introduce you to Kimberly and we'd love to hear your story.

Kimberly Tronick:
Thank you so much. And thank you for having me, I'm so grateful to be able to share this experience. As advertised, my name is Kimberly Tronick. I'm a freelance writer in Los Angeles and I'm also a two-time stage three ovarian cancer survivor. And I think one key point to my journey that I really am passionate about sharing is the reason my diagnosis was such a shock. And the reason for that is I had no known family history of cancer and I also had no known family history of the BRCA gene mutation. So my father is of Ashkenazi Jewish descent, my mother is Swedish. And back in the early 2,000s when my mom first heard of BRCA, she

actually approached a geneticist in Boston and said, "Should we get testing for my daughter?" So again, this is about 20 years ago.

Kimberly Tronick:
And the geneticists told my mom since we had no family history of cancer or the BRCA gene mutation, that I wasn't considered high risk and that we didn't need to get me tested, which we now know, big mistake, we should have insisted on getting tested, but we didn't. We took the geneticist's word for it. So in 2017, I started getting some off and on pains in my upper right abdomen and I went to urgent care, I got checked out, they said nothing was wrong. So a couple of months go by and I'm still getting that pain but all of a sudden I noticed I had a very swollen abdomen, I started feeling queasy, I couldn't keep food down, I had difficulty eating. So my father, bless his heart, he's a pathologist, he immediately knew that I had ovarian cancer but he didn't want to scare me. And obviously, we couldn't know for sure without a biopsy, but he said, "Go to the ER, get checked out."

Kimberly Tronick:
So I did, I went to the emergency room, they kept me overnight. And, excuse me, after several tests, they woke me up the next morning and gave me the news. And they said "We're going to do a biopsy, but it looks like it could be stage three cancer." There was tumors on my ovaries, my uterus, my spleen, my liver, and all around my stomach. But the doctor said, "You don't make sense to me. You're young, you're healthy, you're 36, you have no other issues, you have no family history of cancer, you have no family history of BRCA, you just don't make sense to me." So he said, "We're going to do some genetic testing on the first day of chemo." Which we did and surprise it came back positive for the BRCA 1 mutation. So then my whole family went and got tested as well. And lo and behold, all of the men on my father's side of our lineage tested positive for BRCA 1 as well.

Kimberly Tronick:
So since that genetic mutation causes breast and ovarian cancer primarily, all of those men were just silent carriers and I'm the first woman that cancer actually manifested in. So that's why it was very frustrating to know that I should have been tested all those years ago when my mom asked the question, but we didn't. So we quickly jumped into treatment, which was chemotherapy, and then a hysterectomy where they also removed my spleen. We finished off with more chemo. And then the following year, I actually got a small recurrence where we found a liver tumor. So I jumped back into chemo, got liver surgery, and then I got a preventative double mastectomy just to be on the safe side because of the BRCA gene mutation. And now I'm happy to report I'm finally healthy, thank you. And I really just want to use my story to help inspire or just help anyone that either is facing it, or will have to face it, or is a caretaker, I just want to use my story to help people.

Kimberly Tronick:
That's why I'm very honored and happy to be able to blog with Sharsheret, to be a peer supporter with Sharsheret, to share my story with Sharsheret because I really think that community and support are everything when you're going through this kind of journey. So I will always be grateful to Sharsheret for that reason. And I'm just happy to share this information with anybody that could find use of it. So that's the story.

Elana Silber:
Thank you, Kimberly. It's good to hear good news at this time and all of us are here for you and so appreciate you giving back. And we know that we learned so much from the women who share their experiences. So thank you for sharing so openly and so warmly and really continued

good health. As we turn from the personal to the professional, I'm glad to turn the floor over to the doctor. So here we go.

Brian Slomovitz:
Great. Thank you very much and thank you for allowing me... I hope everyone can hear me okay. Thank you for allowing me to present to your group. I guess as we're waiting for the professional, I guess I'll speak for a couple of words. That was a joke. First of all, I'm a gynecologic oncologist, I'm a researcher, I'm a clinical trialist, right now my academic appointment, FIU. For full disclosure, I'm going to talk about different things that go on in ovarian cancer, nice things like drug approvals and things that are better for patients. And for full disclosure part of my work is to work with these drug companies so it's important that we say that whenever we're speaking to a group. But all the opinions are my own and my goals for being here is to work with groups like yours and Sharsheret and other patient advocacy groups to better relay information, to really offer support, to let people who are out there, who are scratching their heads, help them get some answers they're looking for.

Brian Slomovitz:
And I like this call because I'm going to speak for about 10 minutes now, and then we'll have a lot of time for question-answer and things like that. If you put your pointer over my name, my email address is there so I'm happy to answer any emails, I have no problem with that at all. So what I figured, we're talking about ovarian cancer and COVID, and COVID is really taken over our lives. I figured the way I'd go through this is really run through ovarian cancer and Kim, thank you very much for your story. I think whenever you hear stories like that and have a smiling face up on the other side of the room, or I guess now the other side of the webinar, it's always nice to hear, so thank you for sharing. I know it takes a lot of energy to do that. So, thank you for that.

Brian Slomovitz:
So I want to give you from our perspective, what goes on medically with ovarian cancer, and then along this journey that we're going to go on, I'll talk about how COVID has changed that a little bit for us. So first of all, similar to Kim's symptoms, ovarian cancer does present oftentimes with abdominal symptoms, abdominal swelling, abdominal pain, bloating, sometimes it could be a cough, sometimes pelvic pain, sometimes vaginal bleeding. It's still the most lethal of all gynecologic or women's cancers and the reason for that really is because we don't have an early detection tool for it. Most women are diagnosed with stage three or four disease. So we need to do better at that.

Brian Slomovitz:
So for the typical patient, some of the risk factors, Kim mentioned a big one, hereditary BRCA mutations. The 10 minutes I have, can't even touch the surface of talc, so I'm not going to go there, but as you all know, there's a lot of talk about baby powder and ovarian cancer in the news. We need to do better identifying symptoms and then patients ultimately, they get to see a gynecologist or gynecologic oncologist. Typically, they have as I mentioned, stage three or four disease. That means there's spread of disease in the upper abdomen. How does ovarian cancer spread? Imagine taking a fist full of sand and throwing it on the inside of a wet balloon or the inner abdominal cavity. And it spreads like seeding, and then that's exactly what we call it medically, seeding. So it goes into different areas.

Brian Slomovitz:
Now, here's the first-line of treatment is chemotherapy with surgery. In Kim's case, she got chemotherapy first. Here's the first point about COVID. With COVID and with keeping patients

out of the hospital, usually in the past, we did have to choose between new surgery first or chemotherapy. With COVID, we've really been giving more of chemotherapy first in the hopes of ending this pandemic. And I think it worked as we saw the curve flattened, we kept the "healthy patients" who have ovarian cancer out of the hospitals where we're loaded with patients who were intubated and unfortunately suffering from that disease. So while the first-line is usually a combination of chemotherapy and surgery, it still is, but instead of having the doctor choose, we go for chemo first to keep patients out of the hospital.

Brian Slomovitz:
Now, the good news with ovarian cancer, the first drugs we give are something called carboplatin. And I know a lot of people here know about these, some of you may not. Carboplatin and paclitaxel, it's the paclitaxel that causes of the hair loss. Unlike me, your hair will grow back mine won't so... And patients do pretty well with it, patients go through six cycles of therapy and about 90% of the time, the cancer goes away. So it's usually three cycles of chemo, surgery. With COVID surgery could have been pushed out a little bit later, but then they'll finish surgery in six cycles. And for about 90% of the people, the cancer's gone. In the past, we'd say, go live your life, enjoy, do the best you can.

Brian Slomovitz:
We've really changed that recently and even with COVID, the FDA has really pushed some major, major, major drug approvals, which I want to talk to you about. And one of the drugs we've had is an IV drug called bevacizumab, it's an anti-vascular drug. Imagine if a tree grows, it needs roots, if a tumor grows, it needs blood vessels. Avastin will prevent that blood vessel formation. Some of the approvals though that we've seen are something called PARP inhibitors and PARP inhibitors used to be a class of drugs that in 2018, that really only, if you had a BRCA mutation, you would know about in the first-line setting, but in the European meeting, that happened last October before all of this went on, they were major presentations showing that PARP inhibitor actually work for all women. Not only those with a BRCA mutation.

Brian Slomovitz:
And here comes to the second of caveat about COVID. So up until this pandemic, we had a choice. Should we give maintenance therapy, Avastin or PARP inhibitors? Which ones should we give to patients or nothing? I'm a big believer that maintenance therapy works, giving patients a drug to suppress the disease helps keep it away. We've been doing more and more of PARP inhibitors. The key reason why it's an oral drug, you don't need to come in to get the infusion. So because of the pandemic and keeping patients out of the hospitals so they don't get infected, we've been using more oral drugs. The key two points for patients, one they're still effective. So don't think that just because you're taking a pill it doesn't work, it actually does work pretty well.

Brian Slomovitz:
The other point, and the negative point, they still have side effects. So even though it's an oral pill and it's not something that's going in your arm, they're still side effects associated with the PARP inhibitors that we need to monitor. And with COVID, sometimes patients will get blood drawn at home or go to a doctor's office instead of the hospital to get tested. Now again, I promise I'm going to stay on time. So that's the good news of ovarian cancer in the first-line, 90% go away. We put patients on a maintenance therapy. Unfortunately about 60 to 75% of the time it comes back. We have better drugs now and better combinations of drugs to get rid of it again. And in particular, same as in the first-line, PARP inhibitors work in the second-line for a maintenance therapy.

Brian Slomovitz:
So we give chemotherapy again, when God forbid it comes back, but then we have these PARP inhibitors, oral therapies that we're choosing to keep patients out of the hospital to keep the disease away longer. There again it's important to monitor symptoms and to make sure that the blood counts are okay and things like that, but it's giving us an option. Now, unfortunately in some patients, the cancer is going to keep coming back. What I like to say, ovarian cancer is becoming more and more of a chronic disease, not like diabetes or hypertension, but more like breast cancer. It goes it comes, it goes to comes. When we move later in the lines of therapy, not only are we looking for drugs that have efficacy and are effective, we're also focusing on quality of life.

Brian Slomovitz:
Now, one of the big factors of quality of life and one of the things that we're really losing out within this pandemic are the supportive services that many cancer centers, whether they be academic or community centers have for our patients. By locking the doors and only letting the sickest patients in, we're losing out on some of the support groups that are hospital-based some of the massage therapy, the pet therapy, all the different things that we did for our patients. That's why events like this are so important it's a new norm we're communicating in. A year ago we would be doing this in the waiting room of our office talking to 10 or 15 patients or at a hotel, in a ballroom talking about this in a nice setting. It's important that we do the support type of groups because this is part of our therapy. It's not only the treatment for recurrent disease, but it's also maintaining our quality of life, knowing that you're not alone, knowing that there's other people in this, and that it's a good support for not only patients, but their families and loved ones as well.

Brian Slomovitz:
So in the second-line setting, we want to work on support groups obviously and actually using different drugs. And that's where, again, the PARP inhibitors and there's some other oral therapies. We're using oral biologic therapies, hormonal therapies that could help keep the disease away longer but also keep patients out of the hospital. So the good news is and to summarize, the immediate ramifications of the pandemic in relation to COVID is that we're not seeing higher rates of recurrence, we're not seeing higher rates of death due to the disease. We're seeing numbers that are staying the course but we actually need to work on patient support things, support groups, we need to work on maximizing our use of the oral therapies.

Brian Slomovitz:
And as we reopen, I'm in Florida and we're going to have a disaster in this state. But as we reopen, we really have to be careful to do it slowly and carefully, not show up in your doctor's office without a mask and to sit in a crowded waiting room, but to make sure that we're maintaining our social distancing, we're doing our face mask, and things like that. I know I covered a lot in a short period of time but I know I also want to make sure that we have a lot of time for questions and things like that. So I'll leave it at that and I'll open up the floor for questions.

Elana Silber:
Okay, so thank you so much. And I'm happy that you touched on a lot of things which will trigger questions for people as we go forward. And thank you for your focus on support. Sharsheret is all about quality of life and we love to partner with the medical community to compliment the incredible work that you're doing. So thank you for that. We had some questions that came in online, there's a question in the chat, and I have some in my email, so we're just going to run through them. And we'll start with the first one that came in on the chat and asked if you have

any statistics regarding immunotherapy drug trials, such as tecentriq? Have you seen any improvement in recurrences with immunotherapy drugs?

Brian Slomovitz:
That's a great question. So immunotherapy is one of the key therapies now we're using for all of cancer. In gynecologic cancers, we're seeing that diseases like cervical cancer and endometrial cancer actually have pretty high response rates to immunotherapy. Unfortunately, to date, there's not a lot of high responses to immunotherapy in ovarian cancer. It doesn't mean it's not going to work, it means we haven't figured out the right combination yet that will work. It's important to study if you're on a clinical trial right now, I don't want you to get upset thinking I'm telling you bad news, it's important to these trials and I have about three or four different trials now, looking at immunotherapy in ovarian cancer, that we're investigating this.

Brian Slomovitz:
Real quick on immunotherapy, if you could imagine the immunotherapy, the whole purpose is for your body to identify something that shouldn't be there. Unfortunately, ovarian cancer is a little bit sneaky and the body does not recognize it as something that shouldn't be there. So we're working on ways, we're injecting patients with viruses that stick to the cancer to hopefully stimulate the immune system to work. But we're not there yet, but I would encourage you to think about this clinical trials.

Elana Silber:
Thank you. We talked a little bit about BRCA positive and so the questions come in is PARP therapy effective if you are BRCA negative and the carboplatin wasn't that effective?

Brian Slomovitz:
Yeah, that's a great question. And so for PARP therapy, the best predictor of response to PARP therapy is not BRCA status. BRCA status is important, but the best predictor to respond to PARP therapy is platinum sensitivity. So in this example of where someone is BRCA negative and was platinum resistant, personally, I'm not overly excited about PARPs. I will use it at some point, hopefully we get a response to some other agents but it won't be my first choice. In that situation, I would look for other markers, I would do next-generation sequencing, sequences the whole tumor to see if there's other targeted mutations that may be there, and there's also other chemotherapeutic agents like Doxil, gemcitabine, topotecan which may have an effect. But for a patient if they're BRCA negative, I'd like them to be something called HRD or homologous repair deficient and that's a scientific term. But it's also just another way of saying I'd like the tumor to show signs of PARP sensitivity.

Elana Silber:
So while we're talking about genetics, first of all, I want to just put it out there, a little self-promotion but also to be helpful, that we have a genetic counselor on staff so a lot of the language that may seem foreign to you, Peggy is amazing and you can call her and speak directly and she can help explain a lot of what your doctors are sharing with you and talk to you a lot about the genetics aspect so you are prepared for your appointments with the doctors. Also on the subject of genetics, I know that Kim talked a little bit about her genetic mutation, is there a difference for the risk for ovarian cancer if you have a BRCA 1 or a BRCA 2 mutation? And for men who have a mutation, what cancers do they have to be worried about? So it's a two part question.

Brian Slomovitz:

No, that's a great question. So number one with the BRCA 1 mutation, yes, there's a higher risk it's about a 40% chance of ovarian cancer, 20% to 30% chance of ovarian cancer with BRCA 1 and it's about half of that with BRCA 2, so it's more common with BRCA 1. There's other obviously breast cancer, 80% of the time, you can get breast cancer with BRCA mutation, either one. For BRCA 1 mutation there's also a risk for uterine cancers as well. In men, we're worried now with BRCA mutations, we're worried about some prostate cancers, some pancreatic cancers. So we're learning more and more and it's great that you guys have a genetic counselor there working with you. I do think it's important, I'll say this clearly, all women with ovarian cancer should get genetic testing.

Brian Slomovitz:
In the past, we had to choose who would get genetic testing but even if you have zero risk factors, you're not Ashkenazi Jewish, you don't have a family history, you're older, all women with ovarian cancer should get genetic testing because we do find cases of BRCA mutations in these groups of patients. And now it's not only for your own personal health, but there could be familial implications and not only for your personal risk of other cancers, but for treatment as well with the PARP inhibitors.

Elana Silber:
So there's a lot of conversation about genetics, but we have a question from a young woman who is diagnosed at age 22 with triple negative breast cancer. And at 25 with germ cell ovarian cancer. She had genetic testing done, nothing was found. She's now 26, she's had two surgeries and chemotherapy. She wants to know your feelings on what you would say would be another reason for ovarian cancer if nothing is found in her genetics.

Brian Slomovitz:
So first of all, Shonda, thank you for sharing your story I know it's difficult and it's difficult to open up to a room full of 50 strangers. So based on what you're sharing, there is no relationship, there is no genetic hereditary relationship between triple negative breast cancers and germ cell tumors of the ovary. They're both cancers, obviously, they're both devastating diagnosis. The good news about the germ cell tumor is there's a very, very, very high treatment rate. So unlike the typical ovarian cancers, high-grade Cirrus, BRCA associated occur later in life, patients with germ cell tumors have a much higher chance of doing very, very, very well. So I hope that you're in that group.

Brian Slomovitz:
The interesting thing about genetics, we know what we know now but we're still going to learn more. Science is progressing, now we can get a full genome sequencing back in a short period of time and it's not prohibitively expensive. 10 years ago, we weren't even considering that. But that being said, there are still some genes and some hereditary syndromes that we haven't identified yet and as we continue to do genetic testing we may. But in your particular case, and if you're BRCA negative, I would say, and patients don't like this sometimes but they do, your reason for getting cancer may be more bad luck than anything else. It doesn't mean we shouldn't continue to investigate.

Elana Silber:
And that helps us with our answer to one question of how hereditary is ovarian cancer if everyone is BRCA negative? So I know that at Sharsheret, we have many families where breast cancer and ovarian cancer is on many of the female members, but there's still no known gene. So it goes back to what you said that maybe there's still much more to discover, but does that help answer the question how hereditary is ovarian cancer if everyone is BRCA negative?

Brian Slomovitz:
No. I think one of the big risk factors as we're saying, one of the big risk factors for ovarian cancer is hereditary factors. There are other genes that are homologous repair deficiency genes that are not BRCA 1, BRCA 2. There's RAD50 there's really CHEK2, there's a whole list that can be associated with ovarian cancers. HNPCC or hereditary nonpolyposis colorectal cancer syndrome can actually cause ovarian cancer as well. So hereditary ovarian cancers don't have to be limited to BRCA. But hereditary cancers really is only still will make up 15% to 20% of the cancers. Again, and the scientific word is sporadic, I like to say bad luck, most of the cancers are not hereditary in nature, unfortunately.

Elana Silber:
We have a very specific question so if it's not something that you can answer on this call, let us know. But someone is asking a question about doing surgery for a third recurrence, she has a two centimeter tumor in her abdomen and her oncologist says that if they do surgery, it'll just grow back since it's after the first recurrence. Now, I know we don't make any diagnosis on these calls or anything, this is supposed to be general information. Is there a general way you can answer this question?

Brian Slomovitz:
Yeah, I would say and that's a great question and I appreciate the sensitivity to personal issues. I would say more recently studies have shown that we don't re-operate for recurrent disease. There was this study done by my friend, Rob Coleman, out of MD Anderson who showed that giving chemotherapy is just as good as surgery and chemotherapy. And recently there was a European study which said patients had to be very, very highly selective. That being said, I recommend that you see a seasoned gynecologic oncologic surgeon who it's not their first or second year in practice, they see a lot of cases and everyone should be treated as an individual. So have I operated on patients for a third or fourth recurrence? Of course, I have, even with the studies there. But everyone should be treated differently and you deserve an opinion from an expert in the field who can give you your best chance of living, to be honest.

Elana Silber:
There's a question, is it easier to have access to PARP now? There was a thought that it was not freely prescribed to anyone, how does that change recurrence rates?

Brian Slomovitz:
So real quickly, the answer is yes for patients with high grade serous ovarian cancer in the maintenance setting. The FDA recently approved the drug Niraparib, which is made by GSK, that's ZEJULA for first-line maintenance in all patients with ovarian cancer. That means if they respond to first-line therapy, they can get a PARP inhibitor. There's another FDA approval recently based on something called the payola study of a drug called Olaparib with bevacizumab, so it's a combination, in first-line maintenance. That's for patients who have HRD marker. And in the second-line, there's a pan approval for all ovarian cancer patients. So ultimately it's doctor's practice based on FDA approvals. And with these FDA approvals, insurance companies are more readily willing to pay. I will say, and as I mentioned earlier, I do work for all the PARP companies. They all have patient access programs which are pretty reasonable. And again it's not up to me to say what's reasonable or not for someone else's finances, but they are pretty reasonable. I know a lot of patients who are originally given the no from the insurance company, get at a pretty reasonable cost.

Elana Silber:

Okay. So we've talked a lot about diagnosis of ovarian cancer but the question is coming in, what is happening in developing a diagnostic? I know what you're sharing, everyone knows there is no mammogram for ovarian cancer. What's the developments in that area?

Brian Slomovitz:
So one of the areas that we're looking at, and it's interesting, and I've been doing some research with Bob Bast and Robert Knapp. And if you don't know those two, those are the two that invented the CA-125 tests. Bob Bast is still at MD Anderson, and Robert Knapp is retired down here in Florida. They're looking at CA-125 a different way, not just to say is it normal or abnormal, but they're looking at it to see compared to one's own baseline, to see its rate of increase. So they're seeing that if the CA-125 value goes up, even if it stays below that 30 or 35 level, but if it goes up compared to the baseline, in some of those patients they should be sent to gynecologic oncologists, or at least have an ultrasound.

Brian Slomovitz:
So some of that preliminary work is being done, it's actually published from the MD Anderson group with Karen Lu that I've worked with them on. But it's not really ready for non-investigational yet, but I think it may be sometime in the future. Right now I would not recommend that you go to your doctor and say, draw a CA-125 because what that does, if it's not being looked at in a special way, it leads to too many unnecessary surgeries. And unnecessary surgery can have its own morbidity and mortality, so I'd be very careful about that. But yes, in summary, we need to do better at early identifying ovarian cancer.

Elana Silber:
And when you talk about the CA-125, they want to know if... You say to go for a scan, see what's going on, if it goes up. But what else could cause it to go up if there's nothing suspicious found on a PET or CT scan?

Brian Slomovitz:
COVID And really anything. And I'm saying it half-jokingly, anything could cause a CA-125 to go up. Gastroenteritis, a bad cold, you're stressed out a little bit, a urinary tract infection. What I tell patients all the time it's if a CA-125 goes up, the only thing that tells us to do is to get a CT scan or a PET scan, some sort of imaging. An elevated CA-125 by itself is not recurrent disease, it raises red flags and it's something that we need to look for, but it's not recurrent disease. But that being said, in all seriousness, it is a good marker. So when it does go up we take it seriously and we look to make sure there's no cancer.

Elana Silber:
We have a question that came in. This woman said she was told that after treatment, it's common for doctors to continue monitoring ovarian cancer survivors through blood work, CA-125, and CT scans beginning every three to six months and then every year. Her question is with the recurrence rates so high, and she's heard it high as 85%, why do they continue monitoring with more time in between scans? Wouldn't it make more sense to test and scan more often as we get further away from treatment rather than testing less often?

Brian Slomovitz:
That's a great question and that's a question that we consider all the time. If we had a great treatment that works as soon as we diagnose a recurrence, then we would do that because we want to diagnose the recurrence as soon as possible and give that great treatment and prevent the cancer from growing anymore. Unfortunately, we have good treatments for recurrence, but they're not great. So if a patient's asymptomatic, they're doing well, there's maybe a little bit of

disease going on. I'm not saying it's not something we shouldn't take seriously, but allowing them to live their life and waiting for another scan in three months isn't causing them to live or isn't decreasing their survival at all. If anything, it's giving them three months of a high quality of life without a cytotoxic therapy that can cause some side effects. So identifying it earlier makes sense only if we could actually do something that's highly effective. While our treatment for occurrences are good, we're not really missing out if we waited three months, if anything, we're giving patients more time that's symptom-free without therapy.

Elana Silber:
Thank you. If the cancer is in their peritoneal lining, is that different than ovarian cancer or no?

Brian Slomovitz:
That's a great question. So there is a subtype of ovarian cancer called primary peritoneal cancer and we know it looks like, it acts like, and it plays out like ovarian cancer. Under a microscope it looks the same, oftentimes even if it doesn't originate from the ovaries it affects the ovaries, and we know it's ovarian cancer because men don't get it, it's only found in females. Those primary peritoneal cancers actually we treat just like ovarian cancers. We give the same therapies, we put them on the same clinical trials and things like that, and the prognosis and treatment is about the same. So, yes.

Elana Silber:
And then there's just a question about fertility and ovarian cancer. There was discussion about just removing fallopian tubes, leaving ovaries mostly for prophylactic purposes, for those who have BRCA mutations. Is there new information about what should be removed? Is there a risk by leaving in your ovaries? What are your thoughts on that?

Brian Slomovitz:
No, that's a great point. And more recently we're learning that the fallopian tube may be the site of origin for ovarian cancers. So particularly in our younger patients who are BRCA positive, there are some who speculate by just removing the tubes, leaving the ovaries in that could decrease the risk of cancer and help maintain premenopausal state. And if patients want to do IVF or become pregnant, they could still do that. I still think that's experimental. In general, the recommendation for patients with BRCA is to do an oophorectomy and removal of tubes at the age of 35 or when childbearing is complete.

Brian Slomovitz:
But there's always exceptions and I do think that there are some cases that we can maintain fertility a little bit longer, but in those patients, I would do more active surveillance with CA-125s and ultrasounds to make sure that we're not missing something that we could catch pretty early. The problem is, and in summary what I'm saying is early stage ovarian cancer has a 95% survival. It's when it becomes late stage, that it's more deadly so we really don't want it. If possible, we want to remove the ovaries before it becomes advanced stage disease.

Elana Silber:
Okay. And then there's a question about, they just want a clarification for something you said earlier regarding monitoring. Do you mean it does not change morbidity rate if it's caught at three months, versus six months, versus a year?

Brian Slomovitz:
So it doesn't. So basically when you catch the recurrence, it... So I'll give you an example in the United States, we use CA-125 as a marker to see when it recurs. The CA-125 goes up, we go

out, we get a CT scan and we diagnose if there's recurrence or not. There was a study done comparing what we do here to the United Kingdom. In England, they don't do that, they want to treat recurrences based on symptoms. What they found was the survival in both groups were exactly the same. So even though we caught recurrences early, the overall outcome if given the best therapies, are about the same. So in my practice, year one every three months, year two every four months, years three to five, every six months, and then yearly thereafter. Which I think is a reasonable approach, I wouldn't do it any sooner, but no, if you miss a recurrence at three months and you get it at six months, for the most part, the outcomes will be about the same.

Elana Silber:
Okay, I think we're good. I think you answered a lot of questions in a short amount of time. I'm really glad that this is going to be taped. And people are accessing Sharsheret's website where we have a whole suite of virtual programs and services to help women at all stages of cancer before, during, and after diagnosis, even into survivorship. And I think the information that you're sharing, ovarian cancer is critical. So thank you for your time and your expertise. Thank you, Kim, for sharing. We do have a peer support network with thousands of women and we can match women one-on-one based on their diagnosis based on their issues and concerns. So if this is something that you want to benefit from, everything is confidential, everything is private, everything is made to be convenient for you, we know you are busy, we know you have a lot going on and you don't have a lot of time for this so let us take care of that for you.

Elana Silber:
I just wanted to let you know that if you or anyone you know is going through something and they want to reach Sharsheret, we are here open all the time, www.sharsheret.org, (866) 474-2774, you can find us on Facebook, you find us Instagram, LinkedIn, wherever you are, we are. We can speak with you, we can help you, we are there for you so feel free to refer friends, family, or even yourself, everything is free. We have upcoming webinars, we have a really exciting paint with me night, an opportunity for cancer survivors, no matter what stage you are, to join us for an evening with a feel-good night, paint night together with a wonderful leader who can help us all paint the same painting at the same time and it's really a fun feel-good evening, that's happening on July 8th.

Elana Silber:
And we have updates with the latest cancer information from ASCO on Thursday, July 16th, so I hope you all join us. And thank you, Dr. Slomovitz and thank you, Kim, for your time and thank you all for sharing your questions, everything that happens stays here, and we're a happy group to stay together and share experiences. And we wish everyone continued good health through this pandemic into a brighter future where we can all be together in person. Thank you.

Brian Slomovitz:
Great. Thanks, everyone.

About Sharsheret

Sharsheret, Hebrew for “chain”, is a national non-profit organization, improves the lives of Jewish women and families living with or at increased genetic risk for breast or ovarian cancer through personalized support and saves lives through educational outreach.
With four offices (California, Florida, Illinois, and New Jersey), Sharsheret serves 150,000 women, families, health care professionals, community leaders, and students, in all 50 states.

Sharsheret creates a safe community for women facing breast cancer and ovarian cancer and their families at every stage of life and at every stage of cancer - from before diagnosis, during treatment and into the survivorship years. While our expertise is focused on young women and Jewish families, more than 15% of those we serve are not Jewish. All Sharsheret programs serve all women and men.

As a premier organization for psychosocial support, Sharsheret’s Executive Director chairs the Federal Advisory Committee on Breast Cancer in Young Women, Sharsheret works closely with the Centers for Disease Control and Prevention (CDC), and participates in psychosocial research studies and evaluations with major cancer centers, including Georgetown University Lombardi Comprehensive Cancer Center. Sharsheret is accredited by the Better Business Bureau and has earned a 4-star rating from Charity Navigator for four consecutive years.

Sharsheret offers the following national programs:
The Link Program

- Peer Support Network, connecting women newly diagnosed or at high risk of developing breast cancer one-on-one with others who share similar diagnoses and experiences
- Embrace™, supporting women living with advanced breast cancer • Genetics for Life®, addressing hereditary breast and ovarian cancer
- Thriving Again®, providing individualized support, education, and survivorship plans for young breast cancer survivors • Busy Box®, for young parents facing breast cancer
- Best Face Forward®, addressing the cosmetic side effects of treatment
- Family Focus®, providing resources and support for caregivers and family members
- Ovarian Cancer Program, tailored resources and support for young Jewish women and families facing ovarian cancer • Sharsheret Supports™, developing local support groups and programs

Education and Outreach Programs

- Health Care Symposia, on issues unique to younger women facing breast cancer
- Sharsheret on Campus, outreach and education to students on campus
- Sharsheret Educational Resource Booklet Series, culturally-relevant publications for Jewish women and their families and healthcare Professionals

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