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Proprietary Data: Should Researchers Share?

IMPACT OF MULTIDISCIPLINARY TEAMS AND CANCER RESEARCH.

Our Presidential Election is only days away, 48 million people in America are uninsured and health care costs are rising 2 to 3 times faster than our nation's GDP. Wherever America's health care system be in 5 years. Welcome to ReachMD's monthly series focus on public health policy. This month we explore the many questions facing health care today.

Cancer researcher used to work exclusively in Zylos. Now sometimes they worked at multidisciplinary teams. Does then health treatments get the patient faster? Welcome to "The Clinicians Roundtable" on ReachMD XM 157. I am your host, Dr. Bruce Bloom and joining us to discuss the impact of multidisciplinary teams in cancer research, is Dr. Jordan Berlin, Associate Professor and Clinical Director of Gastrointestinal Oncology at the Vanderbilt University Medical Center in Nashville, Tennessee.

DR. BRUCE BROOM:

Dr. Berlin, welcome to ReachMD.

DR. JORDAN BERLIN:

Thank you.

DR. BRUCE BROOM:

Tell us about our own medical oncology specialty, what you do at Vanderbilt?

DR. JORDAN BERLIN:

I am considered a gastrointestinal oncologist. I, along with my team, treat the patients with tumors of the GI tract. So anything that once the food passes the mouth and gets into the esophagus, anywhere the food goes or its involved in digestion, we take care of that, includes the liver, the pancreas, as well as the entire intestinal tract, the stomach, and we have by virtue of the fact that the GI tract is the most common site for, a disease called carcinoid, included.

DR. BRUCE BROOM:

You say you treat the patient, do you also do research?

DR. JORDAN BERLIN:

I also do clinical research or translational research helping to bring the laboratory research from our GI program or elsewhere into the clinic to try and learn more as we do in clinical trials.

DR. BRUCE BROOM:

So, how would you say you are week or your month is split up?

DR. JORDAN BERLIN:

Well, I also run a clinical trials office, so my week is split up between administrative, working on the clinical trials office that is supposed to be 50% of my time, then 50% of my time is spent in the clinic and then I have got about 20% of my time going to research trying to develop programs and then I have got time mentoring and of course meetings, special multidisciplinary meeting. So, I actually am considered more than 100% committed.

DR. BRUCE BROOM:

Is there a common theme to either the treatments that are used in these gastrointestinal cancers or the way they develop and the kinds of things that they cause?

DR. JORDAN BERLIN:

There are many commonalities between the cancers, but not a true common theme like there used to be. There used to be really have one drugs for these diseases, 5FU. So everything got 5FU. So, a GI oncologist was known for just using 5FU. But nowadays, we have got a lot more options and the diseases are becoming more and more differentiated. The mention of carcinoid earlier, is the one that is most significantly different, though primary liver cancers are very different; however, the intestinal cancers seemed to have some commonality and the gastric and esophageal cancers seemed to have some commonality. So, we can somehow lump them together, having said that as we are learning more and more about molecular basis of cancer, were splitting them up more.

DR. BRUCE BROOM:

Have you seen as you do these kind of researching get to know these cancers more than either within a single patient; there is a wide variety of cancers within that person?

DR. JORDAN BERLIN:

Not so much within an individual person, though there are family syndromes where the patients are particularly prone to having cancer. They will have one or two or three different cancers during the course of their time working with us.

DR. BRUCE BROOM:

And when you do a biopsy on a particular cancer in a patient, do you find different areas of the body that the cancer actually looks different even within one patient?

DR. JORDAN BERLIN:

Yes, in fact at our multidisciplinary team report this morning, we have two cancers where one was the sarcoma which is a cancer that is not the part of the GI tract per say, but can grow anywhere and in this case, it has grown inside the abdomen and in the course of the sarcoma, there appeared to 4 different sarcomas in one pathology specimen and then we had colon cancer specimen removed from the liver where part of it was poorly differentiated or looked very unlikely primary colon cells and then the other part was actually fairly well-differentiated and mucin-producing and you cannot see that where there was variability. If we looked at them by microbiology, we will

probably find even more differences across the cancer.

DR. BRUCE BROOM:

And is that one of the reason why it is so difficult for us to eradicate cancer because even within a single patient, it seems to be multiple diseases?

DR. JORDAN BERLIN:

We believe that that is the case. That as the cancers are being studied more and more we are learning the complexity of cancer. So, for example pancreas cancer where over 90% of the patient will have the K-ras mutation and a Codon 12, the fact is that there are cells within the tumor that have that mutation and the cells within it that do not have the mutation, but again it seems to be a fairly uniform mutation in pancreas cancer; however, it is still not a 100%. So, we are finding more and more variability and that may be playing a role because when you kill off percentage of the cancer cells that are sensitive to the chemotherapy or other therapy that we are using, there may be a small percentage that have inherent resistance and those are going to survive and there are going to repopulate your cancer over time.

DR. BRUCE BROOM:

So, cancer itself seems to be a little multidisciplinary? I know that you are sort of attacking at the Vanderbilt with a multidisciplinary approach. Can you talk to us a little bit about that?

DR. JORDAN BERLIN:

Both in the laboratory, the laboratory to clinical approach and the clinical approach, we are really approaching cancer with a variety of people. The most common thing is in the clinic where we have multidisciplinary clinics that involves surgeon, radiation oncologist, and medical oncologist all working together. Most of the collaboration is accomplished through the conferences or tumor boards where we have radiologist and pathologist helping us to evaluate the data that we have and we can come together to develop a plan rather than treating it in a silo and doing as you please all by yourself to work together to come up with a plan one that the radiation oncologists, the surgeons, the medical oncologists all agree upon, even if all are not involved in the treatment of that individual patient. So, we work together as teams of physicians. In addition, frankly that allows multiple medical oncologist to give their opinions, multiple surgeons, etc. to place the size of Vanderbilt that has a number of people that do the same things.

DR. BRUCE BROOM:

So, are not these multidisciplinary teams, besides their physicians, are there support personnel and other people that are involved?

DR. JORDAN BERLIN:

So, I will use the best example for me as the tumor boards that I am involved with, we have tumor boards other diseases other than GI and the tumor board this morning was attended by radiologist, pathologist, to help use to review the pathology and the x-rays. We also had, as always, one of the nurses involved in genetic counseling in case we find the patients with the family syndrome and we had a couple of the other nurses who come in addition to the usual physicians, residents, surgeons, medical oncologist, gastroenterologist will attend at times, and so a variety of different specialties come in and of all whom provide some support one way or another.

Dr. Bruce Broom:

Tell us about the signal transduction and self proliferation research program that you are involved in?

Dr. Jordan Berlin:

I am actually in the GI program here at Vanderbilt, but we collaborate with the signal transduction and the other program here at Vanderbilt in terms of doing clinical trials and I think that that example is very good because when I got my last grants, he was to do a clinical trial and liver cancer based on some data that we had obtained in the laboratories by couple of our surgeons as well as little bit of data conducted one of our signal transduction laboratories and the person who actually ended out conducting the laboratory portion of our clinical trial primarily he has been doing research in melanoma, but really focusses on signaling transduction. So, we have really worked together as a group to develop the grounds, the clinical trial, and actually we collaborate with other institutions on that clinical trial to get it done.

DR. BRUCE BROOM:

So, how was this program team formed, were people chosen or did they sort of select down to be part of the team?

DR. JORDAN BERLIN:

So, the people usually choose to be the part of the team. In the cancer center, we have three clinical programs and three basic science programs and within those programs, people are selected to be in their program based on what their research primarily involve, but when it comes to developing an individual protocol especially at our institution, we try to work between programs, so that signal transduction may work with GI one week and they may work with the breast group the next week, it is developing as a group, but your researchers what drives where you go in terms of which program within the cancer center that you are part of.

DR. BRUCE BROOM:

So, this signal transduction program has two broad ends, so let's talk about the first one, which is increasing the awareness of the research that is going on within each member's laboratory to encourage collaboration. Tell us how that works for you and the kinds of breakthroughs that you might have seen because of this kind of interdisciplinary work?

DR. JORDAN BERLIN:

There are few ways we collaborate to learn a little bit more about each other. The most obvious is just through ordinary lectures. We will have the members of the laboratory give a talk about what they are doing and what there work is and of course anybody at the cancer center wise it is invited or actually at institution wise you do not have to be a cancer center member these are posted, but in addition we actually tend to have a research retreats. These research retreats have been very helpful in that we will not have just one program present, but multiple programs present at the same time, so that the people who attend from all the program, they will see what other research is going on and that will hopefully increase the collaboration between the groups and it really works well. In addition, the leadership actually often discusses what their program is up to in separate meetings, but the larger way of doing it is through the research retreats and the common regular multiple times a week lectures that go on.

DR. BRUCE BROOM:

So, do you think this kind of open this on all medical center campuses or do you think this is kind of unique to what goes on at Vanderbilt?

DR. JORDAN BERLIN:

We like to believe that we have achieved it through a greater degree than most other campuses to some degree this probably exist at every campus, but I think it is to a greater or lesser degree, at each institution. Depending on the leadership, I think the leadership at Vanderbilt has been one that has fostered collaboration and that is an important of what happens in science. If the leadership does not foster collaboration, the people who are following, would not be encourage to do so, and therefore would not do it on their own.

DR. BRUCE BROOM:

Do you believe in enrolling patients where possible clinical trials to learn more about what the best and safest way is to treat gastrointestinal cancers?

DR. JORDAN BERLIN:

Yes, I think clinical trials are the future for every disease still. We have very few diseases where it really succeeded to a great extent such as testicular cancer or where we cure the majority of patients and we have no disease where we cure everybody. So, until we are curing everybody or nearly everybody with the disease, clinical trials are the way to go to improve upon what we are doing. Most of the time, clinical trials went unsuccessful just do not improve upon care. It is very rare that the clinical trial will have an experimental arm that will actually be worse than the original treatments, but that does rarely happen; however, most of the time, either it is going to improve the care or will be the same. Again, if our care was so great, we would not need to do the clinical trials.

DR. BRUCE BROOM:

When you are working with the patient, how do you help them decide which clinical trail to participate in?

DR. JORDAN BERLIN:

We generally have a limited number of clinical trails per setting. In other words, if a person has stage III colon cancer, we usually have only one stage III cancer trail. If we have multiple trails as we do with stage IV colon cancer, there are usually some parameters or some requirements that may make it different, but we often have for our some prioritization. We needed a group as multidisciplinary team and decide what the priority is. So that we have a trail that for example that is an MCI sponsored grant fund trail that will often be the priority trail over almost anything else here at our institution.

DR. BRUCE BROOM:

I would like to thank our guest, Dr. Jordan Berlin, Associate Professor and Clinical Director of GI Oncology at the Vanderbilt University Medical Center in Nashville Tennessee. We have been discussing the impact of multidisciplinary teams and cancer research.

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