

Clinical Updates



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Hematologic malignancies: Rare cancers need doctors who treat rare stuff

Lymphomas, multiple myeloma and leukemias are rare forms of blood cancers. The estimated number of new cases of non-Hodgkin's lymphoma and leukemia are five percent and four percent for men, and four percent and three percent for women, respectively. Multiple myeloma and Hodgkin's lymphoma account for less than one percent of all newly diagnosed cancer cases. In contrast, prostate cancer, lung cancer and colon cancer comprise roughly 40 percent of all new cancer cases for men, while breast cancer, lung cancer and colon cancer make up approximately 50 percent of all new cancer diagnoses for women.

The sequencing of the human genome (The Human Genome Project) led to rapid development of our understanding of the molecular basis of cancer. The identification of molecular cancer targets used for molecular testing, genetic screening, cancer prevention, oncogenomics and pharmacogenomics ushered in the new era of personalized cancer medicine. Subsequently, the FDA continues to approve new or expanded indications for all cancer subtypes. For example, there are more than 30 drugs approved for patients with multiple myeloma. While it is exciting to have many therapeutic options for patients, it is difficult to know how to sequence such therapy and manage any subsequent toxicity without an astute understanding of the underlying disease.

Intuitively, we as clinicians know that clinical experience matters when complex treatment is required. In light of the ever-growing mass of information that is available to the oncology community, it only makes sense that a disease-specific clinician is most capable of managing a specific cancer, especially a rare cancer. For example, patients with chronic lymphocytic leukemia are more likely to live an extra two years if they are treated by a disease-specific expert

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rather than a generalist. Patients with multiple myeloma have inferior outcomes if they are not evaluated by a myeloma specialist within a year of diagnosis. Furthermore, there exist significant barriers to adherence with evidenced-based guidelines among community-based oncologists.

At Baptist MD Anderson Cancer Center, we are passionate about taking care of patients with lymphoma, leukemias, multiple myeloma and other blood malignancies and disorders. Our model represents a unique multidisciplinary and comprehensive approach to the care of the blood cancer patient. Our outpatient team encompasses providers who are hematologic malignancy-specific and includes physicians, nurse practitioners, pharmacists, nurse navigators, clinic nurses and medical assistants. Our inpatient team is comprised of a dedicated Baptist MD Anderson blood cancer physician consultant and an oncology-specific hospitalist. All of our patients are discussed at our multidisciplinary care conference, and a team-based approach to care is instilled in our culture.

Our relationship with our Houston colleagues at MD Anderson Cancer Center enables us ongoing opportunities to bring the latest developments to our blood cancer patients and our clinical trials portfolio continues to grow. In addition, our hematology physicians are on the cutting edge of blood cancer research development as active members of several National Cancer Institute steering committees and advisors for biotechnology advances.

- 1 Freeman AT, Zhou L, Trogdon J et al., Impact of NCI Comprehensive Cancer Center Designation, Provider Specialization and Patient Sharing with Community Providers on Outcomes for Patients with Multiple Myeloma. *Blood*. 2017;130:529.
- 2 Goldberg SL, Akard LP, Dugan MJ, et al., Barriers to physician adherence to evidence-based monitoring guidelines in chronic myeloid leukemia. *J Oncol Pract*. 2015;11(3): e398-404.
- 3 Shanafelt TD, Kay NE, Rabe KG et al., Hematologist/oncologist disease-specific expertise and survival: lessons from chronic lymphocytic leukemia (CLL)/small lymphocytic leukemia (SLL). *Cancer*. 2012;118(7): 1827-37.
- 4 Siegel RL, Miller, KD, Jemal A., *Cancer Statistics, 2017*. CA: Cancer J Clin 2017;67:7-30.