

# New Multidisciplinary Clinic Strikes at Gastric, Esophageal Disease

By Tyler Smith

On a morning in early August, radiologist Phillip Koo, MD, stood before a crowded conference room in the University of Colorado Cancer Pavilion, using a computer to flash images on a screen.



*Specialists gathered Aug. 8 for a multidisciplinary conference to discuss and plan treatments for four patients with gastric/esophageal problems. They emerged with tailored treatment plans for each patient. Back row, left to right: Dr. Norio Fukami; Dr. Phillip Koo; Dr. Martin McCarter; Dr. Robert Meguid; Dr. Stephen Leong; Dr. Logan McKenna; Cheryl Meguid, DNP. Front row, left to right: Dr. Richard Schulick; Dr. Sachin Wani; Dr. Paul Menard-Katcher; Dr. Michael Weyant; Kalene Anundson, RN; Megan Boniface, PA-C; Dr. Martine Mcmanus; Tammy Bosch, RN.*

Koo's colleagues – medical, radiation and surgical oncologists; cardiothoracic surgeons; therapeutic endoscopists; pathologists, and nurses – looked on intently as he showed images depicting the extent of the tumors while pathologist Jeffery Kaplan, MD, showed slides of abnormal and cancerous tissue from the esophagus and the stomach. They listened as Physician Assistant Megan Boniface, PA-C, read histories that sketched the human suffering behind the images.

The participants threw out comments and questions. How advanced was the disease? What was the best course of treatment? What

were the risks? In an hour, the group had reviewed four cases and agreed on a treatment approach for each one.

**Many hands, lighter work.** The Aug. 8 gathering was just the second meeting of a conference bringing together clinicians from many disciplines to discuss gastric and esophageal cancer cases. Providers later would bring their recommendations to patients in the recently launched Esophagus and Gastric Multidisciplinary Clinic at University of Colorado Hospital. The goal: give patients a thorough assessment of their disease and the best options for treating it, with input from multiple specialists.

The joint discussions and unified treatment plans save untold time that had been spent on phone calls between specialists and multiple appointments for patients, said Norio Fukami, MD, an associate professor of Medicine in the Division of Gastroenterology and Hepatology at the University of Colorado School of Medicine.

The group discussions not only decrease the time to initiate treatment; they relieve emotional pressure on patients, Fukami said. Patients with gastric and esophageal tumors often suffer swallowing problems, loss of appetite, weight loss and other problems.

“Our patients are anxious for something to be done,” he said. “When they hear our recommendations for the best thing to do to treat their disease, the relief in their voices is unbelievable.”

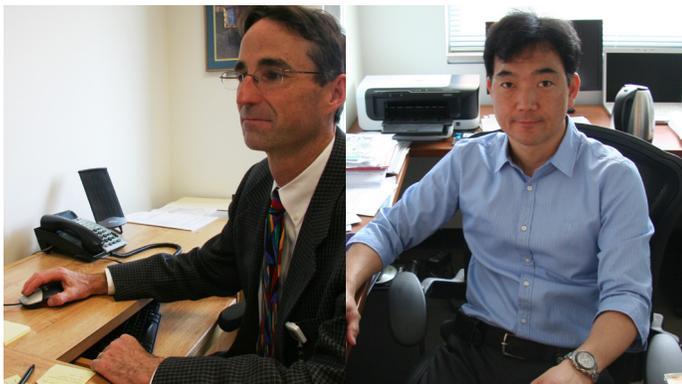
**From many angles.** The approach also broadens the viewpoints of the clinicians involved, said Martin McCarter, MD, surgical director of the Esophagus and Gastric Multidisciplinary Clinic, who participated in the conference and practices in the clinic.

“As specialist clinicians, we can certainly provide opinions about

*Continued*

cases, but we each have our own set of biases," he said. "This approach allows us to reach a more uniform decision from a variety of perspectives tailored to meet the patient's own desires."

The multidisciplinary clinic idea is well established at UCH and the Cancer Center. The new clinic evolved from the [Multidisciplinary Gastrointestinal Clinic](#), launched more than a decade ago. Others have followed suit, including the [Multidisciplinary Pancreas and Biliary Clinic](#), which debuted last October.



*Surgeon Martin McCarter, MD (left), and interventional endoscopic specialist Norio Fukami, MD, bring different perspectives to UCH's recently launched Multidisciplinary Esophagus and Gastric Clinic.*

**Worrisome trend.** The number of referrals for treatment of esophageal and gastric cancer cases is growing, making the time right for a new clinic. Fukami, an interventional endoscopic specialist, said his caseload of esophageal tumor resection procedures has increased 20 percent per year over the last five years.

A culprit in that spike, he believes, is physicians' and patients' growing awareness of Barrett's esophagus, or severe injury to the lining of the muscular tube that carries food from the throat to the stomach. That condition, in turn, is associated with gastroesophageal reflux disease (GERD), a condition in which stomach acid flows back from the stomach and damages the tissue of the esophagus.

The incidences of Barrett's esophagus and GERD are on the rise. That increase is reflected in UCH's new program for the treatment of Barrett's esophagus, led by Fukami's colleague, Sachin Wani, MD, co-medical director of the Esophageal and Gastric Center at UCH.

The increase in the prevalence of these conditions probably has contributed to the number of esophageal cancer surgical cases at UCH, said McCarter. Between 2009 and 2012, the number of such

cases rose from 17 to 40. Most of the cases are referrals, he said, probably because of the complexity of the surgeries, the general risk of complications, and the long recovery times.

**Tough spot.** The cancers usually occur at the juncture of the stomach and the esophagus, McCarter said. It is a difficult spot to reach and requires that surgeons open both the chest and the abdominal cavities. The aorta, heart, lungs, and the diaphragm, lying nearby, are vulnerable to harm.

"It's challenging to remove the tumor while preserving the adjacent structures," McCarter said. The post-surgical risks are significant, including leaks and pneumonia. Swallowing difficulties can lead to malnutrition and complicate recovery, he added.

At UCH, the standard is a two-person surgical team working in the belly and the chest – McCarter works most often with General Thoracic Surgery Chief John Mitchell, MD – but the surgeons also use minimally invasive techniques to remove tumors.

McCarter and Mitchell, for example, use a combination of laparoscopy in the belly and video-assisted thoracic surgery (VATS), which involves making small incisions for a scope with a camera and instruments to cut out the section of diseased tissue. The two have adapted VATS, most often used in lung surgeries, to esophageal procedures.

**Tailored plan.** But surgery isn't the only answer for patients, and the August 8 multidisciplinary conference illustrated the complexity of medical decision making. Specialists in chemotherapy, radiation and surgery joined McCarter and Fukami in discussing the cases.

In one, the group looked at images of a patient with a thickened esophagus that caused swallowing difficulties. There was no evidence of Barrett's esophagus, Fukami said. But an aggressive tumor had invaded the patient's stomach, suggesting the possibility of a total gastrectomy (removal of the entire stomach). The group finally settled on a combination of chemotherapy and radiation with a brief recovery period prior to surgery.

Even decisions for surgery may not be clear cut. A patient with a history of GERD and Barrett's esophagus with dysplasia or early-stage cancer, for example, may be a good candidate for minimally invasive [endoscopic mucosal resection](#) or ablation by radiofrequency (burning) or cryotherapy (freezing), all of which

Fukami, Wani and their colleagues perform. But the choice of procedure depends on the size of the tumor and how deeply it is embedded in the tissue. Additional questions may arise after he removes a tumor, Fukami said.

“Often the diagnosis is not apparent until we remove it,” he said. “Staging the tumor enables us to decide if the patient needs additional surgery or we watch it.”

Fukami has no doubt that the number of patients will increase as the multidisciplinary clinic establishes itself.

“We already are seeing more patients for complex, borderline disease,” he said. “They need help from the most experienced surgeons and from other specialists.”