Minimally Invasive Treatment for Lung Cancer
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Hello everyone, and welcome to our discussion today. My name is Angelo Reyes I’m a doctor and I’m a surgeon. I’m chief of thoracic surgery at the Beth Israel Medical Center in Manhattan, New York City, as well as the chief of thoracic surgery in their Brooklyn division. We would like to talk to you today about our multidisciplinary approach to lung cancer, how we help to support the patients, how we help to treat them both before, during, and after their surgery. I’d like to introduce you to some members of our team and help you understand some of the things that we do to try to tackle the lung cancer as it stands in 2009.

In 2009, lung cancer is really the number one cause of cancer-related deaths in this country. It far exceeds breast cancer, colon cancer, and prostate cancer, and, in fact, if you add up the mortalities from those three cancers alone, it is still less than the total number of deaths from lung cancer in general. I hope that our discussion today will be informative to you and help us to help you understand lung cancer as it is treated in the United States today.

As an introduction too, I’d like to introduce some of my colleagues on our multidisciplinary team, and our first doctor here is Dr. Samuel Acquah. He’s the director of the medical intensive care unit and the director of the endobronchial ultrasound service on the pulmonary division of Beth Israel. Our third doctor here today is Dr. Walter Choi who is the director of the lung cancer division of the radiation oncology service. Good morning, Walter?

Good morning. How are you?

Morning Sam, thank you for coming. I really appreciate that you took time out of your day to come. As an introduction, I would like each of them to tell you some words about what they do and how they apply their expertise to our patients. Sam, why don’t you start.

Thanks, Dr. Reyes. It’s really a recognized fact that, you know, lung cancer is the leading cause of mortality. And unfortunately, it’s normally detected in a late stage, you know, and even when detected early, you know, there is a lag time between when detected, you know, and when patients get treatment. Okay. So it’s very important, you know, to work in a multidisciplinary fashion, you know, like what we have here, to expedite the diagnosis, you know, and start treatment early to try and improve outcomes for patients who have lung cancer.

Thank you. Thank you, Sam. Dr. Choi.

Thanks Angelo. Again, let me reiterate what Sam was saying about the importance of a multidisciplinary team when managing such a complicated disease as lung cancer, and we really do have a great team here to do that because we work so closely together so often. My role, after Sam assists in diagnosing cancers, is to work with Dr. Reyes and our thoracic medical oncologist, Dr. Steve Malamute [PH], who unfortunately couldn’t be here today, in order to implement the appropriate and the best treatment for our patients.

Sam, what do you think are the most important steps for a patient when they are initially diagnosed with lung cancer? What do you think are the first steps that they should take?
Okay. As a pulmonologist, you know, in the front of, you know, seeing patients you know, who develop lung can, you know, so they normally come to me from their medical doctor, you know, with an abnormal chest X-ray. As you know, the suspicion of lung cancer, you know, can be very stressful to a patient. So it’s a very important to work very fast, you know, to reach a diagnosis. Once you have abnormal X-ray, I think the next thing to do would be to get a CAT scan, you know, which is CT scan, which will give better anatomic detail of the abnormality on the X-ray, and then after the CAT scan, you know, the next thing would be to get PET scan, which is the positron emission tomography. Essentially it’s a special kind of scan, you know, where you inject glucose into the patient’s body and the cancer cells, you know, take up glucose more than the regular cells in the body, and it will give us some idea of whether the abnormality is due to cancer or do to something else. Okay.

Once we’ve done that, you know, think I the next step would be to get tissue diagnosis. Okay. That’s where the multidisciplinary approach a very helpful because we meet on a weekly basis and we review the scans, and based on where the abnormality is, you know, we make a decision as to what the best approach to making a diagnosis. From the pulmonary standpoint, we usually do what we call a “bronchoscopy,” which is a small endoscopic camera, which we go through the lungs and try and get a biopsy of the lesion. There are other ways to approach the lesion, so depending on where it is, you can also have what we call a “transthoracic needle biopsy.” Some of them, obviously as you know, are very difficult to get to, so Dr. Reyes would have to do it surgically to make a diagnosis.

But once, you know, we establish a diagnosis by doing the bronchoscopy, the next important part is to stage. And that’s very critical in determining the outcome and also the best treatment modality for the patient. With staging I think the CAT scan and the PET scan will give you what we call a “non-invasive stage” of the patients. Okay. But you will need to try and determine if the cancer has spread beyond the primary lesion itself, you know. And there are many ways in which we can do that. Okay. And that’s where at Beth Israel, you know, we have pioneered non-invasive ways of staging the mediastinum.

What Dr. Acquah said about pre-operative staging is absolutely on target. You know it’s really important to try to have an accurate a preoperative evaluation of the extent of the disease that you’re dealing with, especially when you understand that 85 percent of lung cancer cases are really not operable at the time of the diagnosis. To that end, Sam had really pioneered at Beth Israel some pretty elaborate and technically advanced diagnostic procedures for us using advanced bronchoscopy, and I’m hoping that he can show us some of this equipment and tell us a little bit more about that as well as a little bit more about staging. Sam.

Thank you, Angelo. As I was saying before, I think staging -- the stage of the cancer is trying to determine whether it’s still local where it can be treated with surgery or whether it’s way advanced and surgery will not be an option. Okay. And with most cancers, you know, they spread first by going through what we call the “mediastinum,” which is the middle of the chest. You know, that’s where using minimally invasive techniques, you know, to try look at the mediastinum, you know, to try and see if any of the lymph nodes are involved is crucial to help stage the patient. Cancer is staged in different stages. It goes through stage one through stage four. You know, one, again, is about into A and B, and these stages help determine what the best treatment should be.

One of the crucial things is to see if the cancer is localized to one part of the chest where it can be taken out or whether it’s spread to the other part of the chest, and then, you know, it’s too late. As Dr. Reyes mentioned, you know, traditionally staging has been done by surgical mean, which means doing a mediastinoscopy, which is a surgical procedure done in the OR, which has some morbidity and mortality associated with it. Currently, there are new techniques which are called “semiinvasive techniques” to help stage the mediastinum.

One of the techniques which has been used and which -- and again, you know we have been doing this for the past two years, is what we call the “endobronchial ultrasound.” And I bring this
up to show you what one of these cameras look like. It’s a very small camera. I like to show the tip. It’s the size of what I’ll say a pen. And usually this is a same-day procedure, you know, meaning you come in the same day, you go home the same day. It’s done under conscious sedation so you don’t need to go to the operating room. So it cuts out all the morbidity with going to the operating room.

And the patients are very comfortable during this procedure, Sam.

Yes. Yes. It’s much more comfortable also. And also it cuts down the cost, you know, in terms of staging. Okay. We normally use this small camera, you know, with under sedation and sleeping. We’ll go through your mouth and go through your main windpipe and go into the lungs. Okay. And with my camera, it can zoom in on this. You can see it has a small ultrasound at the tip here, you know, which is the multiplication of this bronchoscope, which is very helpful. This camera helps us to visualize, you know, around the mediastinum.

It acts like a radar almost.

Exactly. That’s what it does. And I can feed a small needle through here, you know, which you know, will help me biopsy the lymph nodes in the mediastinum, and that will help determine if those lymph nodes are involved with cancer or not, and I think it has proven to be very, very effective, and most of the data, you know, show that it’s a 90 percent, sensitive and specific for staging the mediastinum.

So, Sam, as you’re doing this, you’re really looking it at the lymph nodes on a TV right next to the procedural stage, the operating table for the procedure.

Exactly. And as you can see, this is a picture of me, you know, going through the main trachea. You can see I’m coming to the carina. It divides into the right and the left. On this next clip here, you know, you can see a lymph node and you can see me passing my needle through and puncturing the lymph node, and this is the way we are able to get samples. And once that’s done, we have a cytologist right there who tells us whether we’ve got samples or not, and then it goes to the lab to be analyzed.

What are the minimum size criteria for lymph nodes that you approach in this fashion?

Yeah. Traditionally it’s .5 CM. Okay. So we can get anything above .5 CM we can get, and we’ve gotten a few at .3, .4 CM, but normally it should be about .5 CM.

I think it’s such a great technique. The patients are extremely comfortable when they do this, and I think one of the important factors that Sam has applied to this technique is an aggressive approach to getting preoperative biopsies and tissue for us, and I think that helps us tremendously. The other aspect that I think is great is the rapid onsite evaluation so that he’s positive when the patients leave the procedural room that diagnosis is pretty much assured. Walter, how important is preoperative staging from an oncologic point of view?

Well, honestly, it’s crucial. Without knowing what stage of disease we’re dealing with at the outset, we would not be able to offer the appropriate treatment for that patient. So without the help of Sam and yourself and our radiologists in staging the patients’ lung cancer, you and I could not possibly have enough information to give patients good advice as far as what sort of treatments they need for their cancer.

I’d like to stress to everyone that what we do here at Beth Israel is really a multidisciplinary approach, both before and during any type of procedure. All of these cases are discussed between all of us as a team. I think that Dr. Acquah’s input and Dr. Choi’s input is absolutely critical to the best care for the patients. I think that we should probably talk about a little bit of what the surgeries are entailed, Walter.
Sam, before we bring a patient to surgery for any kind of lung operation, what are the important steps and considerations that both we as physicians and the patients themselves, what should they bring to the table?

So in terms like once the diagnosis is made, you know, then I think it’s very important to discuss with the patient what the different treatment options are for the particular type of cancer they have. So that’s where we discuss it also a team, you know, and offer the patient different treatment options. Part of the assessment of whether they can be surgical candidates, you know, also is trying to determine if they can be able to tolerate the surgery, you know, do they have enough lung function to tolerate the surgery, and that’s where I as a pulmonologist fit in. And part of the evaluation will be to do a full pulmonary function test, you know, to get an assessment of their lung function, and then make a determination as to whether they can tolerate surgery.

The pulmonary function tests are absolutely critical to me as a surgeon because the entire goal of surgery is to not only remove the cancer and remove the dominant lesion but also to ensure that the patients are able to resume their full and normal regular activities of daily living exactly as they wanted to do before the surgery and obviously that they want to do after the surgery as well.

Once we have the pulmonary function tests and medical clearance, and if after the preoperative evaluation shows that surgery is certainly a possibility, the best long-term outcome for any patient is really if they can be considered to be a surgical candidate. I’d like to now show you some clips of what we actually do during the surgery. But before we do that, let me just tell you that how we approach surgery these days is not through some large and mutilating thoracic incision. Very rarely now do we put a rib spreader into the chest and actually retract the chest, and that previously caused the large amount of postoperative pain.

What we like to do now is approach everything through minimally-invasive incisions, each of them about a centimeter-and-a-half long, really very tiny incisions. We go in between the ribs. We divide just the soft tissue of the thorax, the chest wall. And, you know, for the most part, we really try not to damage the chest wall in the way that historically lung cancer surgery was done. It’s really an elaborate video game, and I would like to show you some of the images from some of our operations.

Right here you’re looking at the inside of the right chest cavity. Down at about the 6:00 o’clock position is the lung, and in the smoker, you can see that oftentimes the lung is attached to the chest wall, and attached in a major way like concrete. And so before we can really do anything, we have to free up the lung. And this is exactly what we’re doing over here. And Sam and Walter, I don’t know if you’re had an opportunity to really see a lot of the work -- what we do, but this is a harmonic scalpel. It’s an ultrasonic device that both cuts and stops bleeding all at the same time, and it allows for very, very safe dissection of the lung off the chest wall. And you can see how nicely it did that with minimal smoke and minimal damage to surrounding tissue. And, in fact, it’s a cold knife, Sam. You can touch it while it’s working and it won’t burn you.

So are you able to remove a whole lobe, you know, by doing the video-assisted thorascopic surgery alone?

Absolutely. And you know I think that’s really what our thrust is here at the thoracic surgery service at the Beth Israel Medical Center. We really like to approach everything through a minimally-invasive way, and we do full oncologic resections through the thorascopes.

Right here, you know, you can see all those black spots on the lung, are really the effects of years and years of tobacco exposure and maybe a lifetime of living in the city. So probably you and I, Walter and Sam, we all have those type of things. This is the hot scissors that we use, a little bit different technique, but you can, again, see how the lung is very stuck to the chest wall.
What we like to do here is use the scissors to kind of gently tease the lung off of the chest wall and cut these adhesions and make sure that they don’t bleed all at the same time.

Before we can do any kind of surgery we really have to have the lung freely mobile within the chest cavity, and it’s important in both open and minimally-invasive surgery to have the best exposure that you can. What we like about our instruments is the about to use the instruments and get into all kind of impossible angles. And you can see us bend and manipulate the instrument here in order to allow us to get into the best possible angle to dissect and free up the lung.

So, Dr. Reyes, how long does one of these surgeries take?

It depends, Sam. If we do a wedge resection just for diagnosis and simply that, it’s a very efficient procedure and it can take about an hour, hour-and-a-half to do once we actually start working. In any kind of suspicious lesion, Walter, you know, sometimes we don’t have tissue diagnosis before we take the patient to surgery and what we like to do is what’s called a “frozen section” where we remove a portion of the lung with the lesion involved. And while the patient is asleep, we bring the specimen to the pathology lab, and in about 15 or 20 minutes, they can really tell us pretty definitively whether it’s a malignancy or not.

If the lesion is benign after the frozen section report, then all we do is just the wiper section. And in that case, Sam, the procedure takes about an hour-and-a-half or so from once we start working to when the patient leaves the room. If it turns out to be malignant, then we approach everything really with thoracoscopic surgery in mind because it’s a way to minimize postoperative pain, shorten length of stays, and minimize, really the overall mortality to some of these patients, who, don’t forget, have oftentimes many associated medical conditions and are also relatively advanced in age.

Here you can see me just trying to get the rest of this lung free now. I really like the way these instruments work, you know, Sam and Walter. You know, they really allow you to get in there into all kinds of impossible crevices, and it’s really a big advantage to have these flexible instruments versus some of the more rigid instruments that are applicable in an earlier generation of thoracic and thoracoscopic devices and definitely better than some of the rigid instruments that we used to use in more classic open thoracic surgery.

This is us getting more of that lung off the chest wall here. And this is a wedge resection. There’s a portion of the lung being acquired by the lung clamp there. And this is an endoscopic stapling device, which applies a layer of titanium staples and cuts the lung all at the same time. The diameter of that is ten millimeters so it fits into the ten millimeter port that allows us to have entry. And you can see once we cut there’s a fine layer of staples, titanium staples, that are laid down, that both cut the lung and also prevent and limit the amount of bleeding that occurs in any type of surgery.

Oftentimes you can’t get across the whole piece that you want to get across with one shot of the stapling device, so we bring in another stapling device. We reload it and open it. And here we just kind of have to wiggle it into that area. Right here, we would get that in right there, close it in and lock it and fire it. And you just work your way across the portion of the lung that you want to resect. And this is the last little bit here. Once we have that specimen out, and we’ll show you how we do that, that gets sent to the lab for analysis. You can see the blade come across there. See how nice and clean the staple line is?

Yeah.

There’s just a little pedicle left there. Once we get the specimen out there, we send that immediately to lab. And, in fact, we really apply this type of procedure, Sam, to most patients with any kind of lung notch or that we need a diagnosis on or if we’re worried it’s a malignancy.
It’s really facilitated a lot of our work because it’s pretty minimally invasive, and even in the sickest patients we can certainly get them through, and so we really apply this to pretty much all comer at this point.

How long will the patient be expected to stay in the hospital after a procedure like this?

Well let me tell you about a real story. We operated on an 80-year-old patient who had lung cancer, and we did a thoracoscopic lobectomy on her. She was very active before surgery, and she actually could have gone home on the second day after surgery, but we were a little worried about that, so after she got mad at us on the third day, we sent her home.

And here, this is the final staple coming across the wedge. And see now we just check to make sure it’s free. Once we have the specimen out we always like to check to see that the staple line is airtight. So what we do is we fill up the lung space with a little bit of saline solution and that’s what that liquid is there, after we make sure that there’s no excessive bleeding and things like that. And then we just immerse our staple line into the water and we ask anesthesia to blow up the lung. And you can see there, the remainder of the lung inflates there. And we check to see that there are no bubbles. At the end of the surgery, we like to make sure that there’s no bleeding in the chest before we leave, and this is that same kind of coagulating scissors that we use to get hemostatis at our port sites to make sure that we don’t bleed into the chest after surgery. You can see how the wrist gives you a nice angle.

That’s very nice control you have there.

Yeah, it’s a beautiful instrument really. You can see it oozing out a little bit there at the edge, so you just grab it in between the scissors. Look how nicely you can hug the contour of the chest wall. Once the surgery is complete, really the patient’s -- as we had discussed, the patients really go home between three to five days if we approach everything through the thoracoscope. And then after that, really, the most important -- and actually surgery and resecting the lesion is really just the beginning of the story. The real work begins after surgery and in the postoperative and in the long-term phase. And really, I would like Dr. Choi to talk a little bit about how the radiation oncology service and the medical oncology service both treat and support the patients through this sometimes difficult time of their course. Walter.

Thanks, Angelo, you know, at this point, oftentimes we've done the EBUS or the wedge resection or some other surgical procedure for the diagnosis and staging of the patients. If we’ve determine that either a surgical approach is not the appropriate treatment for this patient or in other cases a combined approach of radiation, with or without chemotherapy, in sequence with surgery is appropriate, then those patients come and meet myself and Dr. Malamute, the medical oncologist who works with us. And then we start to explain to the patient the treatment that’s laid out for them.

For example, in a case of a patient who requires a preoperative course of chemotherapy and radiation, for example, followed by surgery, the patient would meet Dr. Reyes, who would send them to myself and Dr. Malamute. And before any treatment begins, we all would meet with the patient, all discuss our roles in their treatment and, you know, the outcomes and side effects and expectations that the patient can have.

My role is to deliver radiation therapy in these lung cancer patients. And what radiation therapy is is the use of high-energy X-rays that preferentially kill cancer cells with minimal damage overall to the normal surrounding tissues. You know, the way we implement radiation in 2009 is very sophisticated. We have very advanced computer modeling, and we work very closely with our departmental physicists to come up with very precise and accurate treatment plans that can deliver high doses of radiation to a lung tumor and also spare all the surrounding tissues to a dose of radiation that those normal tissues can tolerate.
In general, these treatments have been found to be more effective both in terms of controlling the cancer locally and in terms of survival when it’s combined with chemotherapy. So the medical oncologists and I work very closely and collaborate to deliver the treatment together. Because we have such a close relationship, we’re able to do it in a way where we can really minimize the side effects and make sure that everything works in a very streamlined fashion.

Generally speaking, a course of radiation can take anywhere between five to seven weeks and throughout that time, the medical oncologist and myself, we see the patients on at least a weekly patient if not at least more often. We really do prefer to keep a very close eye on these patients. They’re often quite ill, and we think it’s really important to make sure that they’re able to tolerate their treatment with a minimum of symptoms, which is the usual case for these patients.

After a patient completes their radiation and chemotherapy, if they’re being considered for surgery, toward the very end or at the very end of their planned course of chemotherapy and radiation, we repeat their staging. Usually the most important staging modality to repeat is the CAT scan, and at that time, I always go over the CAT scan with you, Angelo. And the main question we have at that point is whether or not the patient is operable.

The important thing to realize is that we have to do this in a very efficient manner so that if, God forbid, the patient is not a surgical candidate, we don’t have a large gap while we’re waiting for that determination to be made, because if the surgery is not a possibility then additional radiation and chemotherapy might be offered. So when we have a team that works so closely together and talks and discusses patients on a very regular basis we can afford to have a combined modality approach because we can avoid any unnecessary delays in treatment.

Usually once, Angelo, you’ve made the determination that a patient can have surgery after chemotherapy and radiation, there’s usually some recovery period after the chemotherapy and radiation for the normal tissues to heal and the side effects to go away, and at that point, the patients will move onto surgery with you.

What type of support services are available for the patients through the oncology services they go through their radiation and chemotherapy treatment?

Well at Beth Israel and the Continuum Cancer Centers we actually pride ourselves in a comprehensive approach to patient management, and that not only includes the physicians, the nurse practitioners and the nursing staff, but we’re also very rigorous in maintaining adequate nutrition. We have complimentary therapies including meditation and acupuncture and therapeutic touch and complimentary alternative medications that might be useful in patients who feel that that’s an avenue that they would like to explore.

Again, the other thing that’s important is to always make certain that the pulmonologist, Sam, in most of our cases, and yourself are always very involved in the patients, so if they’re having a problem that’s more of a pulmonary side effect as opposed to a radiation side effect. You know, it’s not to have many people who are seeing the same patient and able to have new or novel ideas in the approach to managing them.

I think some of the support services that -- the innovative support services that Walter was talking about have been a tremendous advantage to some of my patients because I know that some of the patients that have gone through surgery and are being treated currently by Walter are very happy with the acupuncture and the therapeutic touch. And, in fact, there’s pet therapy in the hospital as well. And I’ve had some of my patients had that and they’ve been very, very happy with that. And I think some of these other alternative support mechanisms are important to patients when it comes to this particularly difficult time of their treatment course.
We always like to tell the patients that surgery and chemotherapy, the pulmonary evaluation before, these are all critical steps. But I always tell them that, you know, all of this is really just the beginning of the entire story, and the real story is surveillance and close follow up afterwards, because once you’re a cancer patient, you’re always a cancer patient really for the rest of your life.

I’d like to now maybe have you meet one of our patients, and I’d like to give, before that, just a little bit of an introduction to her. This is one of our favorite patients we treated very recently in our multidisciplinary fashion. She presented originally with an oropharyngeal cancer, the cancer of the upper airway here in the throat. And during the workup of this particular cancer, she was also found to have a very large left upper lobe lung lesion. It measured about one-and-a-half centimeters in greatest diameter, and that’s about something like this, maybe the size of a large cumquat.

Now she was presented to both Sam and Walter, and she was presented in a multidisciplinary fashion to our tumor board, and we discussed her case, as we do with most of the cases that we work together on. And it was decided that given her extensive tobacco smoking history, as well as her very, very excellent pulmonary function tests and preoperative evaluation and her young age that we would address the lung cancer — the lung mass first, and that’s essentially all the background, and we took her to surgery. We operated and presented her to the operating room and performed a thoracoscopic lobectomy because we wanted to minimize the effects of surgery, major lung surgery on her, so that she could move onto the next steps in her treatment plan as quickly as possible. And so without any further adieu, I’d like to maybe introduce you to Sister Sullivan, and let’s listen to some of her words.

Larynx cancer. PET scan and CAT was ordered. And from that PET scan and CAT scan it was discovered I also had lung cancer. I say “had” because they got all of the cancer out. Dr. Reyes was able to get all of the cancer out of the lung. When the final diagnosis came in for both cancers, my case was taken before the staff board and I was discussed at the staff meeting. And it was decided that the lung cancer would be taken care of first. So that’s what I recommended — that’s what they recommended to me, and I went along with it.

Now, Sam, she smoked about a pack-and-a-half a day for almost 30 to 40 years and really quit the week of her diagnosis. How does that affect a patient like this?

Unfortunately, smoking also causes emphysema, you know, which is destruction of the lungs, you know, and it doesn’t affect all people who smoke but the majority of people who do smoke do have emphysema, so it’s very important and that’s where your techniques are important, you know, because a lot of them have compromised lung function to start off with, and I think they cannot tolerate, you know, large incisions, you know, big lobes being removed. And using the minimally invasive techniques, you know, I think is very important to help minimize the amount of lung taken out and the recovery time from the surgery.

Now, Walter, she was also very involved with the oncology service preoperatively because there was a big discussion as to whether or not we would go ahead with radiation, chemotherapy, or even surgery. What do you tell a patient in that situation? How do you address that with them?

Well, I mean in a patient like Sister Sullivan, she really had two separate cancers, which is rather uncommon but not unheard of. But in her case the truth is that she had two very highly curable cancers if they were both approached appropriately. And to do so — the most important things in terms of her treatment is to get her treatment done as quickly as possible. And the way that we were able to do that is to decide which treatment would take the longest as far as treatment and recovery and see which treatment would be able to be done a little more quickly. In her case, a lobectomy, especially the thoracoscopic lobectomy that you performed, is a very quick procedure
and recovery time compared to a course of radiation for larynx or pharyngeal cancer, which can typically take about seven weeks.

So we were able to offer her surgery for her lung cancer and very quickly have a recovery time in the normal time it takes for a radiation oncologist to plan out their larynx cancer radiation treatment. So she was offered two curable treatments for two curable cancers in the amount of time that it would normally would treat only a single lung or larynx cancer.

I think it’s a tremendous advantage of a multidisciplinary approach. And using the minimally invasive technique she went home in four days. But let’s hear what else she had to say.

After the diagnosis, I was scared, I really was. But you have to go with the diagnosis. There’s nothing you can do to change it. The only way you can change it is to get the proper treatment. And Dr. Reyes was very honest, and if there was something -- a kind of pre-op test that he couldn’t do or there was not enough time to do it, like for one of the needle biopsy on the thyroid, I would have had to wait two months if I had had it here. They got a doctor at New York Eye and Ear to do it the day I was here to see Dr. Reyes. So that’s really what impressed me. I was also given an appointment with a cardiologist to check out the heart prior to the surgery to make sure that was all right. That doctor said come right over also. So the availability and the professionalism of the doctors really impressed me a great deal. And I felt better knowing I was in the hands of Dr. Reyes and these other doctors.

Sam, I think the medical side did a great, great service to Sister Sullivan before her operation because they were just so available to her in any every way.

Yeah. And again, as I said before, I think it is very, very important from the time of detection, you know, to making diagnosing, staging, getting the patient ready, you know, should be in as short a time as possible, and as you can see with Sister Sullivan, the outcome was great.

I think she has other things to tell us, Sam.

Okay.

The admitting office downstairs once that admitting process was done, then you had to be taken up to the eighth -- I think it was the eighth or ninth floor to change, and then be taken back downstairs. That I found a little bit difficult, you know, and then put in the holding area. But once I was in the holding area, again the professional courtesy kicked right in with the staff that was there and the operating team. And the doctors came over, introduced themselves, explained what their position was and what they would be doing, and everything was fine.

What I liked was when I pressed the button, because I was in a great deal of pain, and I had a difficulty sleeping at nighttime, when I pressed the button, someone was there right away. That has not happened to me before in other hospitals. You wait and wait. And I explained to them what had happened and the nurses, if they couldn’t administer the medicine because they needed a doctor’s order, they immediately called a doctor who was on staff at that time and got a response from him as soon as possible, which I was very impressed. You don’t get that kind of response, at least I haven’t received that kind of response, in other hospitals. If I needed something during the daytime, water or anything, ice, they were there immediately as well.

As I said, you know, she went home about four days after surgery, and what she said about the holding area, I think, is really on target. You know it’s pretty anxiety provoking for a patient to be sitting in a holder area waiting for the operating room to open up and for the procedure to begin. But I think the anesthesiologists that we work with here in the hospital are really excellent about trying to support the patient through that particular period before the surgery. And, you know, we work all the time with just a very select group of thoracic anesthesiologists and so, you know, we
have a very close association with them. They know what we want. We know how to work with them. And so I think the patients benefit by that.

Also, on the floor we have a dedicated floor just for our patients, so our nurses are specialized in taking care of this particular and very specialized category of patients, because there’s a number of specialized drains and pain medication modalities that they’re involved with in order to help to make their hospital stay as comfortable as possible. And it’s very important that the nursing staff and the support staff to these patients while they’re in the hospital have experience in that regard. So let’s see what else Sister Sullivan has to say.

I still have a little difficulty breathing. Maybe that will, you know, improve with time. I get tired. But, you know, that’s par for the course. That goes with the treatment that was done. And I’m just building myself up. That’s what I’m concentrating on right now after the surgery.

I really like her approach because, you know, she didn’t deny that she had a problem. She didn’t hide from it, and she completely addressed it in a way that’s really very, very courageous for any patient. What do you think, Walter?

Right. I mean lung cancer can be a terrifying diagnosis and a terrifying problem to live with. And honestly, somebody who has a great outlook and a great support system around them really has a great advantage. You know, it’s really important to look at this as a problem that can be solved and to recognize that treatment may not be, you know, completely without side effects, but the alternative can be devastating. So when we’re able to offer any sort of treatment to a patient, you know, I feel that that’s rewarding to myself knowing that I can help a patient in some way to be cured of their cancer, as I’m sure that you feel as well.

It’s really a pleasure when the outcome turns out to be positive for the patients, and I think everybody that’s involved in our team really, really gets a tremendous sense of wellbeing and happiness when the outcomes are good and the patients do well. Sam, what are your thoughts about what we do and how we handle our patients.

So I think it’s very important, you know, that we have this multidisciplinary team that focuses on lung cancer. And as you can see, you know, even though we are doctors and we focus more on the medical aspects, you know, as Dr. Choi just mentioned, you know, having cancer is very, very stressful and it’s important to address the other issues the patient has, you know, like the pain control, you know, just seeing that she’s supported psychologically. And as a team, especially with Sister Sullivan, we did an excellent service, you know, by providing her all that. And she turned out to be a very happy person.

Now she had two cancers, which makes her a little bit of a special case. But, in fact, really it’s all from the same root. She had a problem and she had an excellent external support staff. But what our team tried to do, as Walter and Sam both pointed out, we tried to be part of that support staff as well and to offer her the most efficient way to solve and to treat both of her issues. And we’re very happy that we did it.

I want to thank you for coming here today and listening to us. I hope that we shed some light for you on our team approach to treating lung cancer. We think that the multidisciplinary approach at the Beth Israel Medical Center is a treatment of thoracic oncologic problems is really the way to do it in the 2009 and beyond. And I’m hoping that Sister Sullivan can have some final words for us now.

Somebody else who has been diagnosed with lung cancer, I would definitely recommend Dr. Reyes, and I would tell the person, make an appointment as soon as possible, get an appointment, because he is excellent with regard to his professional care. You have to do what you have to do. You know you can’t give into the cancer. You’ve got to fight it. This was my second bout with cancer, so I’ve had experience with it, and you got to kick it.
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