BCAN Patient WEBINAR SERIES

Understanding Bladder Cancer Pathology

Tuesday, January 17, 2017

Part II: Question & Answer Session

Presented by

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Question 1: The pathologist providing a second opinion indicated he did not initially received everything from the first pathologist. How could this happen?

This is whereas a pathologist or a medical professional I find some challenges. What ends up happening is that as you advertise for business, you start to get a lot of cases that come in. These patients want to see where it's easy to send, you know, where the information straightforward. It doesn't always mean it's the best place. If these places will start to get a lot of business, meaning some places will see a hundred or more cases a day. Physically, to sit there and look through every single slide is impossible. Now, the question is, should you be rendering a diagnosis without looking at every single slide?

I think it's very dangerous. We would never ever do that in basic pathology care. If I received a new case, I would be negligent if I didn't look at every slide. But for practicality, this place is dumped and I think sometimes, things can go very wrong. I think it's good that they were honest about that, but the fact is if you have a two-tray of case, they might've looked at one slide, the slide that fellows went, "Oh, I think this is a person in training. I think this might be the worst." Then, they look at it. I think part of the problem is that there's a huge financial incentive in it, which is why personally I find some disagreements myself with these practices.

The problem is the people who are so now invested in this can't see it for themselves as a conflict of

interest. I do worry it will impact patient care. From our end, this is why when we do, do complications, we don't do it in the back. We talk to the patient. We look at every slide. We invite the patient in if they're local. I think we need to get them towards a more office visit based setting honestly to do this properly. Unfortunately, it's true in a lot of places will not even put that disclaimer on.

Question 2: What is the probability that a high-grade tumor is assessed as low-grade or an invasive tumor is assessed as non-invasive?

Yeah, I think some of that could be sampling. In big tumors or upper tract tumors, sometimes they can get all of the tumors. There's a little bit left behind or they can't assess part of it. Sometimes, there's a gradation. The images I showed of the low-grade and high-grade were very clear cut. The reality is most of them don't look like that. They're kind of somewhere in between and we even used to have a category that was kind of this intermediate category to be the old grade one, two, three system. The problem is if you get pathologists a choice between low, high, and somewhere in between, 80 or 90% will say somewhere in between.

To better stratify for clinical care, which I think has been a good idea, we have gone to the low-grade versus high-grade. The problem is a lot of tumors don't fit in that. Similarly, with invasive, it depends how much. Is it towardly invasive, just a little invasive? With the new guidelines that we just recommended that that part of it should become more clear. We think that tumors that aren't very invasive are probably similar in progression to those that are not invasive but we need to more data and we need to figure out the best system to do that.

Again, it's subjective and this is why it's good to have not only more than one pathologist look at it and I would recommend that before you have a major surgery because that's the time to do it but the urologist and oncologist really need to correlate this with what they're seeing clinically. They can't just go off a pathology report. It has to make that with everything else they're seeing. As a patient, you have the right to ask those questions.

Question 3: In the last three years, [a patient has] been treated but they've never met a pathologist. "Is it something I can insist on?" They've gone through three TURBTs and they're in the middle of BCG. How would a patient have access? How do they get access to speaking to a pathologist? How do they ask for their pathology report if it's not offered to them?

I would say first of all, there are quite a lot of pathologists who do not take the time to meet with patients for financial reasons, for time reasons because they haven't been trained to do it. I and my group here have a very different thought process around this because I know what it's like to have my family members and myself be a patient and want to get information from someone who's giving me a diagnosis. Because of that, we are very proactive. If a patient calls, I will pick up the phone. I'll talk to them and look at the slides. Then, go through the whole process, talk to their urologist, et cetera.

I would say if you're at a center that doesn't do that and I'll say it, a lot of them don't, the best is to go through the urologist. You should certainly be able to get a copy of that pathology report, no question. You can ask the urologist if he or she recommends any of the pathologists there to talk to because there

may be a reason that you haven't had an opportunity to do that. The urologists are very smart when it comes to pathology reports. I know that they do a good job at explaining them but I also know that patients also have a lot of questions and sometimes, it's nice to meet the person behind who's rendering the diagnosis and be able to have a more candid conversation.

I would say, in this case, I would start with your urologist. What we do here may be a bit different than a lot of other places. I think it's a better way but like I said, until insurance and billing, and hospital operations catch up and there's more buy-in, not every place will do it.

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