Ruth Adewuya, MD (host):

Welcome to Stanford MedCast, the podcast from Stanford CME that brings you the latest insights from the world's leading physicians and scientists. If you're joining us for the first time, be sure to subscribe on Apple Podcasts, Amazon Music, Spotify, or YouTube to stay updated with our newest episodes. I am your host, Dr. Ruth Adewuya. Joining me today is Dr. Fauzia Riaz. Dr. Riaz is a board-certified medical oncologist and a Clinical Assistant Professor of Oncology at Stanford University School of Medicine. She earned her degree from the University of South Florida Morsani College of Medicine, followed by a residency at Georgetown University Medical Center where she served as chief resident. She then went on to complete a fellowship at Yale Cancer Center where she also completed the Advanced Health Sciences Research Program, simultaneously earning a Master of Health Sciences in Biostatistics and Research Methodologies. In addition to seeing patients, Dr. Riaz is an active member of the Stanford Breast Oncology Clinical Research Group focusing on novel therapeutics and approaches for the treatment of breast cancer. Dr. Riaz, thank you so much for chatting with me today.

Fauzia Riaz, MD (guest speaker):

Thank you for the invitation. My pleasure to be here.

Ruth Adewuya, MD (host):

I am so excited to chat with you today and to talk to you specifically about your perspective in medical oncology. To get us started, can you talk to us about what motivated you to pursue this specialty and how do you see your role evolving with the advancements in oncology?

Fauzia Riaz, MD (guest speaker):

That's a great question. There's so many reasons that drove me towards breast oncology, but I think primarily it's the people that we take care of. We can see people as young as teenagers all the way to people in their nineties. These are people who haven't done anything to develop this disease. It's a disease that does not know race, ethnicity, socioeconomic status. We see people from all walks of life. The science of it also just so interesting. We can see people who have cancers that are incredibly aggressive and clinically complex, and then on the other hand, there are people who have very well-behaving cancers who prognostically will do incredibly well. Since the field is evolving as you alluded to, and I think that as this field moves forward, we will be able to give very personalized treatment options for people who have breast cancer.

Ruth Adewuya, MD (host):

Thank you for sharing that. It sounds like there's so many innovations that are happening in this field and that keeps that field exciting and something to look forward to. My next question for you really has to dive into more of the clinical aspect of things and to talk about misconceptions about breast cancer care because I think there's a lot of information out there. From your perspective, what are some of the most prevalent misconceptions about breast cancer that you have encountered in clinical practice?

Fauzia Riaz, MD (guest speaker):

One of the biggest misconceptions that I have consistently come across is people saying, "Hey, I have no family history of breast cancer." The reality is that anyone can get breast cancer. It doesn't matter whether you have a family history or not. In fact, most people who do get breast cancer have no identifiable risk factor, meaning there isn't a first degree family member who has breast cancer. More than 70% of women who have breast cancer had no family history. Get your mammograms even if you have no family history. Early identification through screening is really the key to helping in management and preventing people from developing advanced disease.

Ruth Adewuya, MD (host):

I think the key takeaway here is encouraging patients to continue those screenings. I got that message from the provider, and I hate to say this in front of you, but I put it off for maybe nine months.

Fauzia Riaz, MD (guest speaker):

I do think that happens sometimes and what you experienced is actually not uncommon. We all live incredibly busy lives. There's so many factors that affect whether or not someone is going to go in to get their mammogram or when they had their last mammogram, but what you experienced when you got that notification about mammogram, I would say is common, is very much the norm and I know it is something else on the to-do list, but again, it's just so important because screening through mammograms actually saves lives and helps reduce mortality from breast cancer.

Ruth Adewuya, MD (host):

We move from this idea of screening and we go into the diagnosis process. From a med on perspective, how do you approach that initial diagnosis of breast cancer?

Fauzia Riaz, MD (guest speaker):

Yeah, from the medical oncology perspective, there are several factors that go into the approach. First and foremost, the question that we ask, is this local regional disease or are we dealing with breast cancer that more systemically are we dealing with metastatic cancer? That actually will drive a lot of around treatment. That'll also drive whether or not surgery gets involved. Sometimes radiation gets involved, radiation oncology gets involved. Then we think about the subtype of breast cancer. Is this hormone receptor positive, HER-II negative? Is this HER-II positive breast cancer? Is this triple negative breast cancer? We're also then thinking about the stage of the breast cancer, how advanced is it? If it's local regional disease, do we need to give treatment before surgery or after surgery? We not only work with our surgeons there, but we go over all of this with the patient. We explain why the treatment approach is, taking into account the age of the patient, whether they're pre or post menopausal, where they are in their stage of life. Those are factors that we think about how we approach the treatment of breast cancer, the initial diagnosis.

Ruth Adewuya, MD (host):

One of the innovations in the medical space is this idea of personalized medicine, and I'm curious from the med on perspective, is that something that is part of the diagnostic toolkit for clinicians when it comes to breast cancer?

Fauzia Riaz, MD (guest speaker):

When we're thinking about molecular profiling of a tumor, it's a method that helps us detect presence of different biomarkers, whether they're genes, proteins, other molecules in either tumor tissue or blood samples. This has become an important part of treatment of breast cancer. It gives us information about the behavior of the breast cancer, but also potential targets for treatments. This field is ever evolving. These molecular targets can help drive treatment forward. In the early stage setting, we do genomic profiling of hormone receptor positive tumors. Sometimes that can give us information about prognosis and decisions around the benefit of chemotherapy. In some patients, we're even able to avoid chemotherapy because of the testing we do on the tumors. And yes, it is an important part of our treatment approach and it does definitely play a role in treatment decision.

Ruth Adewuya, MD (host):

Since we're talking about treatment, we should continue on that path and talk about the many options that are now available when it comes to management of breast cancer, and you noted that there's been a lot of progress in how we understand the disease and how you manage the disease. How do you determine the appropriateness of these treatments in early stage or metastatic cancer?

Fauzia Riaz, MD (guest speaker):

This is a very broad question because it is so specific to every patient, but there are general approaches that we have. If there is a clinical trial, that is definitely a part of the discussion of management of breast cancer and really I imagine any cancer. That's the first question when we're making a decision around treatment, newly diagnosed metastatic disease, based off of data we have, we know that using a certain treatment first followed by another treatment, there is a certain sequence that we follow, but of course, nothing is cookbook, right? We do tailor to patients and then that's where molecular profiling comes into play. That's where patients like co-medical conditions come into play. That's where the extent of the disease comes into play. What symptoms are they having? We may choose a drug or a treatment that doesn't require someone to come to the infusion center or to clinic as frequently as maybe another treatment. There's treatments that can be weekly, there's treatments that can be given once a month. So there is some flexibility that takes into account not only the cancer, the person, but also just logistics of treatment.

Ruth Adewuya, MD (host):

I think it's helpful to understand these general factors, but at the same time understand that it's very much dependent on the patient. They're trying to make things fit, depending on the patient, is not all going to look the same at every time.

Fauzia Riaz, MD (guest speaker):

But it will look similar. There are certain treatments that we know, okay, this is first-line treatment for this type of breast cancer. For people who have stage two or three HER-II positive or triple negative breast cancer, they should get this chemotherapy or this chemoimmunotherapy or chemo targeted therapy. So there are some set standard of care treatment, but of course with every person you may be tweaking treatments a bit. I just don't want it to sound so broad. There's very clear this is first-line of treatment, this should be second-line. If you don't have this mutation, then do this. If you can't tolerate this, then do this.

Ruth Adewuya, MD (host):

What I'm hearing from you, there are clinical guidelines that guide the management of breast cancer. These remain the foundation for how patients are treated. However, if there are unique instances and things that come up, then the clinician has the opportunity to dig into and bring in other diagnostic methods, other management options, other treatment options into and personalize it for the patient, depending on what is available.

Fauzia Riaz, MD (guest speaker):

There are clinical guidelines and of course those clinical guidelines are data-driven and we try to ensure that patients are getting what is considered standard of care, but of course not every patient will be able to tolerate it. There's some flexibility. That's where personalization comes in. Clinical trials are just such an important part of the advancement of this field and truly our goal with clinical trials is to optimize the treatments that we're giving to our patients.

Ruth Adewuya, MD (host):

One of the questions that come up when looking at breast cancer and breast cancer management is the use of endocrine therapy, especially in hormone receptor-positive breast cancer. Why do we give this to breast cancer patients?

Fauzia Riaz, MD (guest speaker):

Of course, there are several subtypes of breast cancer. A particular subtype of breast cancer has the expression of estrogen receptors and progesterone receptors, and those are drivers of cancer. The way I word it to patients is, these cancer cells like to use your body's estrogen and progesterone as a food supply, and what we do is we block that food supply from getting to those cancer cells and starve out the disease that way. When we're blocking the access of estrogen progesterone to cancer cells where effectively the patient's also feeling those symptoms, I describe it as menopause symptoms. It'll be as if they're postmenopausal or perimenopausal, experiencing things like hot flashes, joint stiffness and aches and vaginal dryness, decreased libido, hair thinning, loss of bone density. And so all of those things, those are all symptoms and side effects of the drug, the treatment that we discuss with patients.

Ruth Adewuya, MD (host):

How do you approach the use of this, especially when you're talking about patient adherence, management of side effects?

Fauzia Riaz, MD (guest speaker):

When I'm thinking about endocrine therapy for my patients, I think the important thing is to be very candid with patients about what to expect with regards to symptoms. Initially, I'm setting up frequent visits with them to make sure that they're tolerating their treatment or tolerating it the best they can. We always try to encourage lifestyle modifications to manage side effects of endocrine therapy, but if we need to give some medications to treat the side effects of an incredibly important part of their treatment, we'll do that. I have women tell me they all of a sudden feel like they're 80 years old, and that's hard, especially when you're trying to get back to normal life. One thing to say, okay, you're going to go through chemo for this period of time and you're going to then have surgery and recovery from surgery will look like this, but those are all very finite periods of time.

Typically, the last part of treatment is going to be endocrine therapy where we're looking at trying to help patients get back to whatever normal life looks like and these medications are going to be on them for at least five years, a lot of times longer than that. That can be incredibly daunting for people. This is where we can also see a lot of challenges with adjustment disorders, depression, anxiety around surveillance and their diagnosis and trying to get back to normal life, and that can also further exacerbate I think the symptoms that they're feeling from their endocrine therapy. So I'm always very candid with patients about what potential side effects look like, and then initially we are connecting with them very frequently to make sure that they're tolerating treatment.

Ruth Adewuya, MD (host):

Endocrine therapy is part of the treatment protocol for managing the breast cancer that they have, so I imagine that these patients are aware maybe at the beginning that it's part of what they will receive, but when they're coming to you, there's a lot more on their mind than that final piece. We should talk about navigating those conversations with breast cancer patients who are talking about fertility preservation especially and women who are still wanting to have children down the line. What are some of the strategies that you use or can be utilized to address some of those challenges?

Fauzia Riaz, MD (guest speaker):

I do think this continues to be a challenge. I think it can be very expensive for some people, whether your insurance covers it or not. I think we're fortunate in the Bay Area that we have access for timely fertility preservation to happen. Our colleagues in reproductive endocrinology are so receptive and helpful when we need our patients to have their fertility preservation, but cost is definitely a major factor and access is another major factor, so people who live further out, it can be a lot more challenging for them to be able to have access to fertility preservation. I think the other challenge is patient perspective. Let's say there's someone who needs to get systemic treatment before surgery. They want to start their systemic treatment as soon as possible, and then the idea of waiting a few weeks to go through fertility preservation can sometimes be scary to them.

Our job as the physician or the clinician helping them through this diagnosis and through the treatment of breast cancer, if they do want to pursue fertility preservation, I am always supportive of that, even if it means we have to delay treatment by a few weeks. From a medical oncology standpoint, because the concern with chemotherapy and fertility preservation is due to the ovarian ablative effect of systemic chemotherapy, can give medications that suppress ovarian function through chemo while they're getting chemotherapy, and that can help protect the ovaries, so that's something we can do on our end. We want to protect their ovaries.

Ruth Adewuya, MD (host):

I think that's very encouraging to hear that there are avenues in which patients can hear around fertility preservation, and I think you're spot on in saying that we are quite fortunate in terms of access to departments like you mentioned, the opportunity to even consider that as an option. I feel like we should recognize that probably not every institution and not every organization has the same access, and I think that's probably part of where there's opportunities for growth in the field and when you start talking about equity across patients to ensure that there is access to these types of supportive strategies in different organizations and healthcare systems. Your last comment around the side effects of systemic therapies is a great segue to managing these adverse effects because it is a critical component and as you see the patient and you see the need for aggressive care or aggressive treatment in order to make sure that they're well, but then also you want to maintain the quality of life of your patient. How do you balance that need on a day-to-day basis?

Fauzia Riaz, MD (guest speaker):

I think that there have been lots of advances with supportive care. I'll split this into two big categories. So early stage breast cancer where we're treating very aggressively trying to get them to surgery, the goal of treatment is curative intent. We have very excellent supportive care treatments when it comes to the side effects of the different chemotherapy drugs, and we can categorize different regimens as being, for example, highly hematogenic, moderately or low hematogenic potential. For example, we have our nursing staff and we'll do one-on-one sessions with patients going over the medications that they get at home to help manage side effects, and oftentimes we're saying, "Okay, maybe the first three days after chemotherapy just take this anti-emetic around the clock and then change it to as needed." So a lot of it is trying to prevent some of the side effects that we know will happen or that we predict will happen.

But then the other part of it is, and I tell patients with every cycle of chemotherapy we can predict, and so we initially try to manage side effects with supportive therapies. If that's not adequate, we adjust the dosing of the drug. It's monitoring the patient and making sure that they're tolerating and adjusting the treatment to make it as tolerable to them as possible. And so that's when I'm thinking early stage breast cancer and there's this finite period of time where you're like, okay, it's going to be tough for the next 10 weeks or next 16 weeks, and we're going to get you through this.

When we're thinking about metastatic breast cancer, when it comes to metastatic breast cancer, we're not looking at a finite period of time. We're looking at people being on treatment indefinitely, so targeting those hormone receptors. That's where molecular profiling and looking for mutations that we can target is

so incredibly important because again, that helps put off chemotherapy for as long as we can. And then eventually when someone does need to have chemotherapy or does get to a point where the only treatment options available are chemotherapy, what we have found is that combination chemotherapy did not improve overall survival compared to just doing sequential single agent therapies. All it did was increase toxicity, and typically when someone is getting to a point where they're needing chemotherapy, we are only doing single agent at a time, one agent at a time, and adjusting pretty aggressively to help manage their side effects. Because again, treatment is indefinite. We want them to have good quality of life with whatever time they have.

Ruth Adewuya, MD (host):

It sounds like there's this constant balancing act and tightrope walking to support the patient in a way that gives them optimum quality of life. One of the things that I've been reflecting on, the fact that you take care of really sick patients, day in, day out, and part of me is curious about what the impact of that is on you as a physician.

Fauzia Riaz, MD (guest speaker):

There are days that you get home and you're like, wow, that was a tough day, right? There's definitely the wins, and so that also motivates and keeps us going, but I think it's about perspective. And I think the perspective that I take is that I am so grateful for my health. When I'm taking care of my patients, I'm so grateful for the opportunity to be able to provide care. Then I also self-reflect of it makes me grateful for everything in my life. I think it's all about perspective, and it's about honoring and recognizing that you are able to hopefully make a meaningful impact in that person's life, not only for that person, but for their loved ones as well, and I think that's incredibly special.

Ruth Adewuya, MD (host):

That's a really great point and a great way to frame it. As you look into the future and what's happening in the space of breast cancer, what are you most excited about in terms of emerging therapies or treatment?

Fauzia Riaz, MD (guest speaker):

There's so many things. This field is just evolving so quickly, but I think some of the things that I am incredibly excited about is the potential of circulating tumor DNA as a pivotal biomarker in not only helping making treatment decisions, but assessing treatment response, monitoring, surveillance of disease. There's just endless possibilities there, and from my end, I know Dr. Thompson, Dr. Telly and I are collaborating with colleagues at Stanford who have developed just an incredibly ultra sensitive method of detecting circulating tumor DNA, and I think that's really the direction that this field is going in.

I think other things, there's just so many things happening from a systemic therapy standpoint, but I think one of the things that I think about is traditionally breast cancer has not been a very immunogenically active disease, maybe triple negative breast cancer more than the other subtypes, but compared to other cancers in general, breast cancer has not necessarily been one that's more immunogenically active. And so this of course has affected our ability to use medications or drugs like immune therapies, and so we're really working to help make these treatments effective by changing that tumor microenvironment and making these tumors more immunogenically active and opening up potential treatment avenues for patients.

And then the last thing I'll say is, I alluded to this earlier, when I moved out to California, I think one of the most striking things I noted was I had patients traveling in three hours, four hours, just these amazing travel times to get access to care. And so I think it's important, and it is a passion of mine to understand how distance, how rurality all affect how we treat breast cancer, and then ultimately whether it affects

how well patients do. And so of course, we can have the best treatments available, but if patients can't get to them, it defeats the purpose of having this treatment.

Ruth Adewuya, MD (host):

That's really exciting. My final question, what message do you have for the next generation of oncologists who are looking to specialize in breast cancer care?

Fauzia Riaz, MD (guest speaker):

I would say be curious and follow what you're passionate about, because ultimately, if you follow what you truly care about, what you're truly interested in, then I think that's where real progress happens.

Ruth Adewuya, MD (host):

That's a really important message because I think that curiosity and following your passion is actually what will set the foundation for some of those hard days, right? That is such a powerful way to end this conversation. Dr. Riaz, thank you so much. This has been an incredibly enlightening conversation on breast cancer care from the oncology perspective.

Fauzia Riaz, MD (guest speaker):

Thank you so much for the invitation.

Ruth Adewuya, MD (host):

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