Transcript: The Importance of Lung Cancer Screening for Veterans

Mitch Jelniker:

Veterans who have bravely served our nation face a new battle, a heightened risk for lung cancer.

Diane Mulligan:

During their service, they may have been exposed to asbestos, burn pits, and other occupational hazards. Each year, nearly 8,000 veterans are diagnosed with lung cancer, but one and a half million are eligible for low-dose CT scans that can help spot lung cancer earlier. Hi there. I'm Diane Mulligan.

Mitch Jelniker:

And Mitch Jelniker. Our colleague and co-host of this podcast, Jordan Sherman is on vacation. We should tell you though that the high rates of lung cancer among veterans are exactly why Lung Cancer Foundation of America has launched Breath of Honor: Lung Cancer Screening for Veterans campaign.

Diane Mulligan:

And so today, on this Lung Cancer Foundation of America's Hope With Answers: Living With Lung Cancer podcast, we'll learn more about veterans' lung cancer options and the need for more lung cancer screening from both a leading lung cancer specialist and a Navy veteran who is a lung cancer patient.

Jim Pantelas:

What I would tell vets is that if you're breathing, you can get lung cancer. Getting screened is a no-brainer.

Dr. Drew Moghanaki:

Lung screening in many ways is a win-win for all. The patient wins because their cancer is smaller, it's more curable, the treatments are much less toxic.

Jim Pantelas:

Lung cancer screening is a piece of cake.

Diane Mulligan:

Lung cancer is a tough topic. It's a disease that affects patients, families, friends, coworkers, but first, it's a disease that affects people. The Hope With Answers: Living With Lung Cancer podcast brings you stories about people living, truly living with lung cancer, the researchers dedicated to finding new breakthrough treatments, and others who are working to bring hope

into the lung cancer experience. Dr. Drew Moghanaki and Jim Pantelas, thank you so much for joining us today. We're thrilled to be having this conversation with you. Dr. Moghanaki, let's start with you. So you are the chief of thoracic oncology at the UCLA Department of Radiation Oncology and the co-director of the VA Lung Precision Oncology Program at the Greater Los Angeles VA Healthcare System. What would you say to our nation's brave veterans who may be hesitant to get screened for lung cancer?

Dr. Drew Moghanaki:

It's a no-brainer to get screened for lung cancer. Get screened because guess what? You've got treatments that can save your life. No one needs to die of lung cancer if we catch it early enough.

Mitch Jelniker:

Dr. Moghanaki, as we mentioned, you work with the VA where there's an estimated, I think, one and a half million veterans enrolled in VA Healthcare that do meet that lung cancer screening criteria. That's a positive. That's a lot of people though. Is the VA able to reach all those veterans?

Dr. Drew Moghanaki:

Yeah. So of the nine million veterans who do receive VA Healthcare, we do estimate about 1.5 million of them meet the criteria, and we are trying our best to screen them. It used to be difficult for VA to provide timely care to all of the veterans for a variety of reasons, not just volume, but also a lot of our veterans live really in far away places and there's scheduling challenges. But today, you can go online and see this. Congress has authorized appropriations for VA to purchase care in the community whenever it can't meet its needs. So at this point, I don't see any reason why the VA under its congressional authorizations can't screen all of these veterans. We just got to reach them and find them and get them screened.

Diane Mulligan:

Jim, you're a Navy veteran and a 17-year, no, 18-year now, right? Lung cancer survivor.

Dr. Drew Moghanaki:

Yes.

Diane Mulligan:

I'm interested in your story and what kind of message you have to the veterans out there about finding out whether or not they're eligible to be screened and finding out whether or not it's worth it them to have this screening. What do you think?

Jim Pantelas:

I was diagnosed with a non-small cell lung cancer, and I was a heavy smoker for many years, but had quit before I was diagnosed. I had quit a couple of years before I was diagnosed. But the reality is, is that I was also exposed to asbestos while I was in the service. I live in a part of the country that has higher than average rates of radon. What I would tell vets is that if you're

breathing, you can get lung cancer. If you increase the odds of getting lung cancer, which smoking does, then you should be screened. But because you were in the service, you were exposed to toxins, because you were in the service, you were exposed to living in different parts of the country or the world that may have had toxins that you're not aware of. Getting screened is a no-brainer.

Mitch Jelniker:

That's the bottom line. Is there any hesitancy when you talk to fellow vets, Jim, about getting screened? Are they aware that that's available to them?

Jim Pantelas:

There's huge hesitancy. The hesitancy is, is they know that they're at higher risk because they have a smoking history. They don't know anybody that's survived. So if you find lung cancer, "I'm just going to die," why should I want to go find it? That's why a unicorn like me is helpful because I've survived it 18 years. And there's that hesitancy because it's just another kind of nail in the coffin that, "Oh, I'm going to go. They're going to find something. It's going to be another one of those conversations with my doc where he's just telling me I got to quit again," because they've had all of those conversations. So yeah, there's hesitancy. There's a lot of hesitancy.

Diane Mulligan:

Dr. Moghanaki, I'm interested on your perspective on that. Sometimes we call it nihilism where it's just like, "It's not worth going to get screened. It's not worth finding out. I don't even want to deal with it." What's your perspective, especially with the veterans that you work with?

Dr. Drew Moghanaki:

Over time, I've been able to get a more honest narrative from a lot of these veterans, and a lot of them tell me they already feel like they're living on borrowed time as it is. I mean, they saw people get blown up, even if they came back from even these Middle East fields of battle. A lot of people in their squad died from Gulf War syndrome and other ailments that we're still trying to figure out. So this idea that they're just grateful to be alive. And so it's a little bit, the bar is a little bit higher to convince them to say, "Look, you're not going anywhere, and I just don't want you to die of lung cancer prematurely." I'm a treating physician. I'm a lung cancer specialist. So I take care of people with all stages of disease. And lung screening in many ways is a win-win for all. The patient wins because their cancer is smaller, it's more curable, the treatments are much less toxic.

Sometimes they're simple. For example, if you catch lung cancer when it just pops up, you can go to the operating room. If things go well, you're at home the next day. That's amazing. Cured. No more treatment. Things don't go well? There's other treatments and keep people alive for much longer than ever before. I win because the treatments that I've been trained to deliver are effective and are curing people. But that hesitancy is there for really three main reasons. And the reasons are stigma, nihilism, and fatalism. And the stigma comes from, look, there was a time where smoking was glamorous. If it was not for the surgeon general and the American Society and other groups trying to tell kids to stop smoking, today, it would still be glamorous

and you just get your lungs screened. No problem. But society has told all smokers, "You're a bad person. You need to stop. Smoking is bad. You're bad. Smoking causes lung cancer."

So then you feel like, "Uh-oh, if I get lung cancer, I must be a bad person because I didn't quit." And society also doesn't understand what addiction is when it comes to smoking. I mean, smoking is more than just a bad habit. And as a good friend of mine says, "Picking your nose is a bad habit. Smoking is an addiction." It requires medications, therapy. And the quit rate, the success rate is not as high as we want it to be. But nonetheless, any veteran who I'm trying to talk to or any American or anyone in the world who I'm trying to convince to get screened, that stigma really creates that hesitancy. And then that is then compounded by the nihilism, which is, "Well, if I get lung cancer, I'm going to die anyway," as Jim just said.

So there will be a day where... And we're getting there. We're making step-by-step progress more so than ever before since about 2015. That's when we broke through a glass ceiling and a whole bunch of new drugs started getting approved. But that nihilism persists and that nihilism feeds fatalism, which is, "Look, I'm just going to die anyway. Every time I lit that cigarette, I knew it, and I deserve to die." It's really, really bad. So there's a big psychology component of this to helping people, empower people and say, "You know what? You don't have to die. It's going to be fine. And we've got this amazing simple scan. You lay on a scanner, it slides you into the CT. Two minutes, you're up and out of there. Can save your life. It's amazing."

Diane Mulligan:

Amazing. Yeah.

Mitch Jelniker:

That is. It is really good news. So Doctor, I'm curious, once a veteran is diagnosed with lung cancer, and you and Jim alluded to, maybe that's not a shock necessarily, but still heavy news, and you might get in the car and start to drive home and think of about 21 things you should have asked. If someone is diagnosed with lung cancer, what should they be asking? What do they need to know?

Dr. Drew Moghanaki:

Well, so if you go through the whole process of a scan and then biopsy and eventually says, "Yep, we found it. You really have lung cancer," I think it's, "Can this be treated? Should it be treated? And how would it be treated?" You can talk about all the details, all that, but really it's one main question, "What is the goal of that treatment?" So that a person who has lung cancer can know, "Do I really have a chance for cure?" There's only two answers, yes or no. "Yes, there's a chance, can't promise you, but there's a chance," or, "You know what? We currently don't have a cure for your type of lung cancer because it's too far advanced." And then you can add those questions about, "Should I get it treated or not?" I'm curious what Jim thinks a veteran should ask when they're first diagnosed.

Jim Pantelas:

The vast majority of people that are diagnosed with lung cancer get treated in the community setting, maybe get treated by a general oncologist that treats one or two lung cancer patients a year. And I think the question needs to be, "Who treats my kind of lung cancer? What kind of lung cancer do I have?" Because every lung cancer is kind of different. There are different

mutations. Are they getting genetic testing? Are they in a facility that'll understand what that means? Are they getting treated by a doc that'll understand all of that? Lung cancer treatments are changing so rapidly that you need somebody that's involved, if not at the research level, then at least reading the research results. As veterans, we need to be asking questions about, "Where's the best place I should be treated for this? Who's the best doc within our system to treat this? And can I get a referral? And can I get a second opinion?"

Dr. Drew Moghanaki:

I would add one more thing on top of this to sandwich it collectively. Lung cancer requires a multi-team effort. You've got to have all the team members. You can't just go to one doctor because that doctor relies... So if it's a surgeon, they rely on the medical oncologist who relies on the radiation oncologist. And sometimes we don't even know what we're looking in a scan. We need a really good radiologist who understands lung cancer. We also get PET scans and we also get pulmonologists. And so if you can, if you've got lung cancer, go find a world-class team. And the good news is there are good teams in the community. You don't always have to go to an academic center, but you got to make sure it's a team that focuses on lung cancer. And one way to know that is they'll have a conference once a week where all they do for an hour is they talk about lung cancer. Most community hospitals don't. They're going in eight different directions at the same time. But if you can find a lung cancer team, probably optimizes your chances to have a good outcome.

Diane Mulligan:

Dr. Moghanaki, when people find out, when veterans find out, when anyone finds out that they have lung cancer, how important is it for them to ask their doctor, "What is my biomarker?" And to also find out whether or not they have small cell lung cancer or non-small cell lung cancer?

Dr. Drew Moghanaki:

Yeah, really glad you asked that question. So for the longest time, we always needed to know if it's non-small cell or small cell because that would define the different types of treatment pathways we would recommend. However, today, it doesn't matter what type of lung cancer you got, we've got to get biomarker testing because it divides up these two cancers into dozens of other smaller subtypes of cancers. And once you know what type of subtype of lung cancer you have, then we can pick the best drug for that type of cancer. And the only way to know that is to get biomarker testing so we know which biomarker to apply our treatment management strategy to.

Diane Mulligan:

Isn't it true that sometimes that means that you don't have to have chemo and radiation? It could be just taking pills during the day to handle your cancer.

Dr. Drew Moghanaki:

That's one of many benefits of knowing that biomarker. Sometimes we'll know that some drugs aren't going to work. So we won't waste our time with this possible side effects of that drug. Or as you mentioned, we'll discover, "Oh wow, you don't even need chemotherapy. There is literally a pill, much less side effects, that you'll take instead. And guess what? You'll also live longer."

But I'll tell you this, if you don't get biomarker testing, you'll never know. You might just get chemotherapy, and I just don't want to think about how tragic it is when that happens.

Diane Mulligan:

Dr. Moghanaki, you're a radiation oncologist. Explain how that's a little bit different. And also, I know that there've been some amazing advances in radiation oncology. Can you talk just a little bit about that for us?

Dr. Drew Moghanaki:

Yeah, sure. So there's three cornerstones for treating cancers. There's two local therapies, that's either to cut it or to zap it with radiation. So either surgery or radiation. And then the other is drug therapies, which are medical oncologists deliver. So when it comes to local therapies, surgery's getting better and better every year. Smaller incisions, people going home day after surgery. And that's great. Radiation, same thing. We used to treat large areas just to be safe. Now, we can really pinpoint the tumor. And even a lung tumor, you think about it, every time you take a breath, that tumor is moving. We can now get video reconstructions of that tumor and we can zap these things incredibly high doses safely.

Diane Mulligan:

Yeah. I'm also interested in adjuvant IO. Those are big words. What the heck does that mean to the general public out there? And is this something that a lung cancer patient should consider?

Dr. Drew Moghanaki:

IO stands for immuno-oncology, or basically the discipline that delivers immunotherapy. First, so surgery has been around since ether was discovered around the Civil War. Radiation has been around since 1890s. And we didn't have any drugs that could help cancer until about 1950s. And we've been doing a lot of research to find more innovative ways to treat cancers, and the latest has been to modulate the immune system. So you wonder, "Why do you need to do that?" Well, for a long time, no one thought the immune system can clear cancer, but some people did and they continue to believe, and one of them won a Nobel Prize in medicine for discovering that immunotherapy does actually eradicate cancers. And I just want to quickly give a quick lesson about the lung and how it is such an immune-sensitive organ.

Think of all the junk that you breathe in every day; dust particles, bacteria, viruses. And the lungs have this incredible immune system to clear stuff out of there, including tumors. We might get little tumors every day, but the lungs just clear it out. However, sometimes these tumors will start to grow, and they can grow really, really big, few inches in size, and the immune system doesn't see it at all. And what scientists did is they figured out a way to get the immune system to actually see that tumor. And once it does, next thing you know, your immune system just goes in and gobble, gobble, gobble, eats up the tumor. So today, immuno-oncology or immunotherapy basically is a treatment that is no longer a poison directed to the tumor, but instead, truly modulating your immune system to go clean up the cancer. Jim, did I simplify it enough?

Jim Pantelas:

I think you did. I do. As someone that's been through surgery and radiation and chemotherapy, the only thing that I would add is that until 1990, we didn't even have a standard of care for lung cancer, early stage lung cancer. Catching a lung cancer through screening is still the best option that we have, the most effective option that we have. Yeah, we're able to deal with some tumors and some cancers after the fact and when somebody's diagnosed at a later stage, but it's nowhere near as effective as the cancers that we catch in early screening.

Mitch Jelniker:

Screening is so important. And so Jim, if you have fellow veterans watching and they think, "Okay, what am I in for?" I mean, your cancer has been in remission for a number of years, which is wonderful, but you still need to get scanned every year. What is it like?

Jim Pantelas:

It's a whole lot easier than an endoscopy or colon cancer screening. It takes less than two minutes, and you're done. It's probably the least invasive of the screenings that I'm aware of. I've never had a mammogram, but I've been told they're not really comfortable. I certainly have been screened for colon cancer, and that's not been fun. Lung cancer screening is a piece of cake. And it's nothing like an MRI. Drew mentioned, it draws you into the machine and takes you out. An MRI, they draw you in. They keep you in. It feels like you're in a coffin sometimes. For somebody that's claustrophobic like me, I can't do an MRI without active sedation. But a CAT scan's nothing like that. It really is easy.

Diane Mulligan:

I also wanted to bring up the idea of clinical trials. Jim, would you consider entering a clinical trial if your cancer flared up again?

Jim Pantelas:

I certainly would. There's some tremendous stuff going on in lung cancer research. And as Jamie Stutz would say, "We're the cool kids on the block now." I want us to be more than that. I want us to be the leaders of the block. But yeah, I would participate, and I have participated in studies when I was actively being treated. I was treated on a study because we had to create a way that I could get chemotherapy and radiation therapy ongoing at the same time because my cancer turned out to be more aggressive than we had anticipated. But yeah, I would.

Mitch Jelniker:

You would do it. And Dr. Moghanaki, I'm curious, if just to dovetail with that, would you explain why a lung cancer patient might want to consider a clinical trial?

Dr. Drew Moghanaki:

Yeah. It's really an amazing opportunity to be a part of getting us to a day where no one dies of lung cancer, which I think will happen. It's not right for everyone, but I'll tell you why it is right for many. So clinical studies are trying to break through glass ceilings. We're trying to identify the next drug that will get us to people living even longer than they are today. There is so much oversight. There are so many layers of protection. And what this does is, is creates, especially in

this country because I believe there's criminal statutes if you ever were to conduct an unethical trial, it allows the comfort and peace that you are going to be taken care of by not just the person in front of you telling you about the study, but the institutional review board and the regulatory agencies and the auditing bodies.

And so you can be reassured that you're truly getting... Whether you get, let's say, treatment A or treatment B, both treatments really are as promising as each other. And your doctors and your scientists just don't know if one is better than the other. We recruit veterans all the time to clinical studies, and what I hear is they just love the opportunity to help someone behind them. And that's what clinical research is about. That person who says, "Yes, I'll participate and I'll either get A or B," the patient doesn't know, the doctor doesn't know, but the scientists do know, and that's the best way to figure out if one is better than the other. But at least hey know that the next person behind them will know which of these treatments are better. Jim, does that resonate? And what would you add to that?

Jim Pantelas:

It does. And we're service driven. Don't give us a bunch of BS. Don't tell us that this experimental drug is the answer to everything. Don't tell us that this is going to cure my cancer. Tell me what you're going to learn. Tell me what you hope to learn and give me a mission because we are mission driven, we are service driven. And it is about the next guy. I mean, you don't get people functioning in a war zone because they want to be there. You get them functioning in the war zone because they want to make sure somebody else doesn't have to.

Dr. Drew Moghanaki:

Why are we doing this study? Because we don't like what we have. We don't know this is better. It's promising. That's why we're spending millions of dollars doing this study. And that's the why. And then it's an invitation of, "Would you be willing to help us and mankind figure this out?" Thank you, Jim.

Diane Mulligan:

That's fantastic. That's fantastic.

Mitch Jelniker:

That's great.

Diane Mulligan:

Well, Jim and Dr. Moghanaki, I want to thank you both for joining us. That was a great conversation. What a great conversation with Dr. Drew Moghanaki and Navy veteran Jim Pantelas, both who provided great insight into the world of someone living with lung cancer and why veterans must safeguard their future and get lung cancer screenings.

Mitch Jelniker:

Now, to find out more about the Breath of Honor campaign and lung cancer screening, visit our website, lcfamerica.org, or you can visit screenavet.org. They will be able to learn more there

about all the aspects of lung cancer, from screening to treatment, and you can take our lung cancer screening quiz to see if you should talk to your doctor about getting screened.

Diane Mulligan:

Make sure to subscribe to the Hope With Answers: Living With Lung Cancer podcast. You'll be notified every time a new episode is available. So visit us online at lcfamerica.org where you can find more information about the latest in lung cancer research, new treatments, and more. You can also join the conversation with LCFA on Facebook, Twitter, and Instagram.