



Professor Alan Venook: my experiences and opinions on colon cancer

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Expert's introduction

Dr. Alan Venook (*Figure 1*) is the Madden Family's Distinguished Professor of Medical Oncology and Translational Research at the University of California, San Francisco (UCSF), and the Shorenstein Associate Director for Program Development in the Helen Diller Family Comprehensive Cancer Center. He graduated from Rutgers University and received his MD from UCSF. Dr. Venook completed his residency at the Internal Medicine department of the University of California, Davis, and his Hematology/Oncology Fellowship at UCSF, joining the faculty in 1988.

Dr. Venook has most recently been associated with the findings of CALGB/SWOG80405, a study about patients with metastatic colorectal cancer that he led. He is also well known for his clinical research on the new modalities used to treat both primary and metastatic tumors of the liver. He has also served as the founding Chair of the National Cancer Institute's Hepatobiliary Task Force from 2006–2010. Dr. Venook leads the Gastrointestinal Oncology Program at UCSF, and was the Chair of the GI Committee of the Alliance for Clinical Trials in Oncology (formerly CALGB) from 2010 to 2015. He was also an Associate Editor for the *Journal of Clinical Oncology* from 2009–2015.

Interview

HBSN: *You had an excellent speech just now about colorectal liver metastases (CLM), do you mind giving a brief summary of your speech for the readers who could not be there?*

Prof. Venook: What I talked about is called colorectal cancer that spreads to the liver and metastasize, and the fact that you can cure patients with metastatic disease. It's an unusual thing when a solid tumor can be cured even after it metastasizes. The challenge is to figure out how to treat patients, and who has the best chance to be cured.



Figure 1 Dr. Alan Venook.

We would like to have more precise information about the patients, like a biomarker or some clear set of parameters to decide who can be surgically cured, and the problem is that we do not have that. So, what I talked about is more about the challenges we can overcome, and the way we can close in on some of the biomarkers. The reality now is that diagnosis is based on the clinical experience of the doctors, rather than some easier method of who is curable or who isn't.

HBSN: *I know that you specialize in colon cancer and you have been in this field for many years. What developments in the diagnosis or treatment of colon cancer have made you impressed in recent years?*

Prof. Venook: Well I have been in the business for a while so the most important improvement has been shown that if you can look and do a surveillance, and follow people without colon cancer, and look regularly enough, you can prevent many cases of colon cancer, because most of the pull ups lead to cancer. We have developed a few new treatments

that will be good for this, and we have figured out how to do fewer treatments than we used to do. So before, the initial treatments we did typically went overboard, and now we can do even less treatments than before to get the same results. But mostly the problem is that we haven't made the advancements that we would've liked to. The reason is that this is a complex disease, and we would be much better off trying to prevent it instead of trying to treat it, so we should make progress in this in field. We have made progress for sure, but it is now more difficult than before trying to make progress because we just haven't figured out the full scope of the cause of this cancer yet.

HBSN: *Is there any multi-center study on colon cancer that we could expect?*

Prof. Venook: There are, although in the multi center studies, tend to be industry driven, so like big pharma based or sponsored, or there some generic studies that are looking at big questions about colon cancer. But overall, there is only a small population of patients who will benefit from this. Right now, there are no big studies, driven by biomarker indication, which we can really rely on, or we can hope to make a big difference. Hopefully in the next year or two or three, we will have more leads, and figured out how to go forward. The last slide I showed, I think was the most hopeful thing we were doing was that we are using artificial intelligence, to take a study that I had done with 2,300 patients, to aggregate the thousands of data elements, molecular biology information, like RNA or DNA, and we are putting all of that data into an AI platform to see if we can understand what drives colon cancer. Something like that may help or not, but I think we need to do something like that to make a big difference.

HBSN: *The incidence of malignant tumors has increased every year, could you please give us some suggestions on preventing colon cancer or some methods for the early detection of colon cancer?*

Prof. Venook: The incidence of colon cancer, at least the incidence in the United States, is going down, that is because of screening, like doing a colonoscopy. But in general, I think a lot of cancers are caused by our bad habits. Cigarette smoking is the obvious one. Too much

fatty food, too much garbage, like the US exporting KFC to China, those are the kinds of bad things that I think have led to bad habits which complicate things. For example, liver cancer which is worldwide and a huge problem, while HEP C will all be eliminated in this generation, because of the anti-viral drugs, liver cancer will continue to increase in incidence because of metabolic syndrome, because they are having bad eating habits. So, we are trading one problem for another. I think lifestyle will make a big difference.

HBSN: *I learned that you served as the deputy editor-in-chief of the Journal of Clinical Oncology (JCO). How did you initially get into this role? What did you get from this role?*

Prof. Venook: Well believe it or not, I was a sports writer before I went into medical school. So I wrote about sports, I was always interested in writing. I think that in the field, what happens is I have written a bunch of journals and papers, and served as a reviewer, and people knew I was a pretty good writer. I was chosen somehow, and a lot of people applied, and I was made the associate editor for JCO. I thoroughly enjoyed it, but it was a lot of work in those 5 years. After the 5 years, I had another job, I was very busy. I think there are other very talented people who could do the job, so I stopped then, and I thought other people needed the chance. It was very time consuming, but very interesting. It is especially interesting because I didn't have to go out and look for info, all the good papers came to me, because the journal was very good, and all the good papers in my field just came to me, I was able to keep up to date with the field because of my job.

HBSN: *Being a doctor and an editor, which one you prefer more? What are the differences between these two jobs in your opinion?*

Prof. Venook: I am lucky, I am a doctor and I take aware of patients, which is very challenging. I am lucky because I get to do both. My career has allowed me to be an editor and a doctor. To do translational research, chair meetings, or chair programs. As my wife says, every day I do something different. So my job is always interesting. That is just good fortunate. I am not always good at everything and something is not as good as other, but I have been lucky to have many opportunities.

HBSN: Do you have any suggestions on running a journal?

Prof. Venook: Well, I understand your IF is 3.45 which is very impressive for a new journal. I think you just have to select the very best papers and I think you can't compromise on that. Maybe do some kind of reviews, some people might not want to do that, but of course if you want to increase your IF you want to do more reviews, and they are referenced, so IF will naturally increase based on that. You must get the best material, and send out a copy of your journal to authors, and let them know about the journal so they might want to send something in. Of course, if you think you found a good article, solicit them, and invite them to send their papers in. A good journal speaks for itself; an IF 3.45 is already quite good for a journal that is only 6 years old. So keep doing what you're doing.

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Footnote

Conflicts of Interest: The author has no conflicts of interest to declare.

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