WEBVTT
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NOTE Confidence: 0.881473302841187
00:00:00.000 --> 00:00:02.580 Agenda welcome everyone to Cancer Center grand rounds and really pleased to have three various themed colleagues presenting and I, you know, I think if there's one particular theme that I think emerges among many from today's forum is that we have what's really great is the number of talented people across multiple disciplines. Who are making progress on pivotal questions in cancer care in Cancer Research, and I think today's forum is just you know one very clear of many examples of three individuals doing great work,
00:00:42.470 --> 00:00:44.997 each coming from it from a different
discipline but working together towards really making a difference for patients
for the field and and obviously advancing our research and educational agenda.
And I would, I'll do.
I'd like to do is really.
00:00:59.190 --> 00:01:01.998 Introduce one of our speakers and ask him
and I think frankly in the past.
I guess nine months or so really
00:01:13.093 I guess nine months or so really
00:01:14.320 needs no introduction.
00:01:16.780 Kevin, as many of you know,
00:01:20.196 joined us in in or about January.
As our chief medical officer for the Yale Cancer Center and Smilow Cancer Hospital. And is also a professor in the Department of surgery. Kevin is responsible for our clinical enterprise, working with our leaders in nursing and other disciplines, and has really done an extraordinary job and certainly working. You know, arriving here and nothing less stepping into the frying pan with Kovid. And really the need to work collaboratively across so many people to execute on what was heroic.
An extraordinary response on so many parts.

Beyond his success as our chief medical officer, is an international leader in the clinical care and research of patients with a paddle, as well as gastrointestinal ligatures.

Before joining us here, Kevin was a professor at Oregon Health and Science University where he was the medical director of the Knight Cancer Institute and the chief of surgical oncology.
and Kevin is going to.
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Take over with our discussion of evolving multidisciplinary management
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evolving multidisciplinary management of colorectal liver metastases,
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and I'll let Kevin take over and introduce the other great faculty,
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introduce the other great faculty,
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Kevin, thank you. Charlie,
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thanks, thank you so much for that really gracious introduction.
NOTE Confidence: 0.85429435968399
I’m thrilled to be here.
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We’re going to do kind of A tag
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team screen sharing here and let me
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see if I can get going with that. OK, is that working for folks?
NOTE Confidence: 0.879898011684418
I only see you Kevin. OK.
There you go. Got it, how about that OK? Well, you know it’s as Charlie alluded to. I’ve had the pleasure of spending much of my career as hepatobiliary surgical oncologist. And you know, I will share that one of the most gratifying aspects of my time in surgical oncology is participating and witnessing the dramatic advances that we have had in the multidisciplinary care of patients with colorectal liver metastases and one of the things that I was most excited about is I prepared for my transition to the ill Cancer Center in Smilow.
Cancer Hospital was the fact that we truly have. Kind of. We essentially have a world class team of experts across disciplines who are contributing to the care of this unique group of patients. And we have all of the elements here and I want to with that as a jumping off point. Introduce my two partners in this multidisciplinary grand rounds. Doctor Michael Cicchini is a seasoned veteran of Yale, a graduate of the Albert Einstein School of Medicine, who came here to New Haven for residency.
stayed on for fellowship, and has just continued to rocket to prominence from there. Michael profited as many of our fellows have from the mentorship and guidance of doctor Jill Lacey, who is as most of you know, the Dean of our GI medical Oncologist. Michael has carved out a really unique spot for himself and our organization, an increasingly across the country. In a mix of traditional clinical research and GI medical oncology as well as phase one clinical trial work and drug development.
So delighted to have him with me today and as a clinical partner. Next, doctor David made off is a relatively recent addition to the Yale team. When I was preparing for my move here, he was one of the most one of the people that I was most excited to partner with. David, his essentially written the book on portal vein, embolization, and optimization of the hepatic remnant for in preparation for complex hepatobiliary surgery, he spent much there earlier part of
his career at the MD Anderson Cancer Center, then transitioned back here to the East Coast where he’s at Cornell for a number of years and then more recently we’ve been fortunate to recruit him as the vice chair for clinical research and the section chief of Interventional radiology. And I will say kind of quickly, Is this side note one of the things that I enjoy most about caring for patients with colorectal liver metastases? Is that it really is a team sport. This multidisciplinary grand rounds does highlight a number of us who are
involved from surgery, medical oncology, interventional radiology. I do feel little remiss in not having some other folks on a panel who were important contributors such as radiation oncology. And other disciplines, but I know we'll have other opportunities. We're not going to cover everything today. Our goal is a team is to kind of give you some broad brush overviews of developments and high points. I will be talking. I'll be giving an overview and talking about some surgical strategies mainly
focusing on patients with advanced disease.

Doctor made off will be talking about his real area of world class expertise. Which is various techniques to optimize the liver remnant to support complex resection.

Role of Interventional radiology and Michael will be updating us on the numerous advances and systemic chemotherapy for the disease.

Well, the idea of resecting colorectal metastases is not new. You know surgeons have been doing this for 40 plus years.

What is exciting is the developments that have been made in the safety.
of these operations.

The number and variety of technical approaches and the slow but steady increase in long-term survival that patients enjoy after these procedures.

Why would we focus on aggressive liver directed therapy for this patient with liver metastases?

Well, as many of you understand, the liver disease in metastatic colorectal cancer often serves as the main source of Morbidity and mortality and affect the driver demise for folks with this disease. And this occurs through a number of pathways.
Patients with bulky disease can experience liver failure more commonly. They suffer from progressive biliary obstruction which is understandable, untreatable, and once this occurs an they’re jaundice, it is very difficult to. Provide ongoing effective systemic chemotherapy, and it leads to kind of a downhill spiral. The good news is that from multiple currents. Case series we know that complete resection of colorectal liver metastases patients can enjoy up to and sometimes more of 50% five year survival rate.
yet, there remain significant challenges. Roughly, only 20% of patients with this disease process are resectable at the time of presentation, and even with aggressive surgical therapy recurrence remains frustratingly high. Often you know 80% at about the five year mark. I don’t want to steal doctor Cecchini’s Thunder here, and I apologize for stepping on his turf, but no self respecting surgical oncologist would talk about progress in this area without some mention of...
the groundbreaking advances that have been made in systemic chemotherapy.

I think this timeline kind of tells the story.

We’ve gone from the 5FU era, which was the case for many years is.

Really, the only chemotherapeutic option in this disease with a 12 to 14 month median survival to our current modern regimens with Folfox, Flevo and increasingly triplet chemotherapy or patients even without surgery, are enjoying survival of 29 plus months so.
As much as we have, surgeons congratulate ourselves on our technical wizardry of big piece of the progress in the background is effective chemotherapy. So this is what I am, a surgical oncologist. Love to see a patient with easily resectable disease, limited number of tumors, one maybe two tumors that are peripherally placed not in close proximity to major vascular structures, and these folks are amenable to an atomic or segmental resection. The surgical options for managing folks like this are manifold.
They can be treated well within traditional open operation. Lapre Scopic. Liver resection is now in the mainstream, and increasingly we’re used utilizing the robotic platform to address some of these tumors. Now more commonly, what we see particularly at large academic medical centers, such as we work in our patients who have such as we work in our patients who have advanced colorectal liver metastases. These are patients with multi focal disease. Often the diseases bilateral on both sides of the liver and often their bulky lesions which are in
So I’m going to share the story of a 48 year old woman who I treated in Portland about eight years ago. She presented with bulky, complex liver disease, Anna sigmoid non obstructed sigmoid primary cancer in place. So not to dwell on too many liver technicalities, but she had a high central liver lesion in close proximity to the vena cava sitting right under the confluence of the three hepatic veins. Should an additional bulky lesion.
in segment for the liver sitting in proximity to one of the pedicles in the middle hepatic vein? And then she had another bulky lesion in segment five and six on the right side of the liver. So this is a perfect segue into the need for multidisciplinary strategies to address patients like this with advanced colorectal liver metastases. And I’m going to talk today in my section about 3 strategies to approach this group of patients, all requiring the integration.
of multiple disciplines.

Probably the most common is what we described is conversion chemotherapy, which involves the upfront utilization of multiagent chemotherapy. Usually oxaliplatin based to downstage tumors within the range of respectability. Another approach that is increasingly used at high volume centers around the world is what we call staged habitectomy. This is breaking the surgical treatment up into two sessions with an intervening procedure called portal vein embolization, which leads to optimization of growth of the plant hepatic remnant.
And then the last topic I will touch on briefly is something that many of us around the world are starting to do which is complex parenchymal sparing resections, which allow simultaneous resection of multiple sites of disease. So the patient I described did go on to have eight cycles of F olfox with bevacizumab Avastin, and she was in the subset of patients who enjoyed a stunning response. As you can see, the central lesion shrunk dramatically. You can start to see some width on the Ivy,
00:14:59.620 --> 00:15:02.446 see a little more space around
NOTE Confidence: 0.835261046886444
00:15:02.446 --> 00:15:04.330 the dip attic veins.
NOTE Confidence: 0.835261046886444
00:15:04.330 --> 00:15:06.195 This lesion is now shrunk
NOTE Confidence: 0.835261046886444
00:15:06.195 --> 00:15:08.060 away from the left portal.
NOTE Confidence: 0.835261046886444
00:15:08.060 --> 00:15:10.436 Pedicle involves the caudate lobe of
NOTE Confidence: 0.835261046886444
00:15:10.436 --> 00:15:13.608 the liver which is a bit of a tricky
NOTE Confidence: 0.835261046886444
00:15:13.608 --> 00:15:16.638 place to operate but now has good clearances.
NOTE Confidence: 0.835261046886444
00:15:16.640 --> 00:15:18.525 The left pedicle segment for
NOTE Confidence: 0.835261046886444
00:15:18.525 --> 00:15:20.033 lesion significantly smaller and
NOTE Confidence: 0.835261046886444
00:15:20.033 --> 00:15:21.860 the right side liver lesion,
NOTE Confidence: 0.835261046886444
00:15:21.860 --> 00:15:22.570 also smaller.
NOTE Confidence: 0.835261046886444
00:15:22.570 --> 00:15:25.410 This allowed us to take her to the
NOTE Confidence: 0.835261046886444
00:15:25.486 --> 00:15:28.516 operating room and one operative setting.
NOTE Confidence: 0.835261046886444
00:15:28.520 --> 00:15:30.458 Treat her with a left hip.
NOTE Confidence: 0.722936868667603
00:15:30.460 --> 00:15:32.952 It ectomy a caudate lobe resection segment
NOTE Confidence: 0.722936868667603
00:15:32.952 --> 00:15:35.577 6 or section in a sigmoid colectomy.
This was her diseases that appeared in the operating room, stomach, liver, Gallbladder, and the caudate. Lesion shrunken in partially calcified. The segment 56 lesion again nice response partially calcified and what she wound up with his complex bilateral resection, but with plenty of good healthy liver remnant left and I know everyone. reports their greatest success. What happened with this lady is she had a single side of recurrent disease about two years after that we treated with a little wedge resection and she is disease free at last.
Follow up about 8 years out.

So what we’ve learned over the years in the French are really led the way in this is that patients can enjoy even after chemotherapy.

Conversion can enjoy a very high rate of long-term survival.

This is data from Renee.

A damn now presented years ago, but makes the point.

They looked at their subset of patients from their entire spectrum of liver metastases who are respected after conversion chemotherapy.

And although this group of patients who were converted to Resectable
did not enjoy the survival that the primary population did, 33% five year survival in a subset of patients extending out into the eight to 10 year mark as my patient did. I’d only just you. While I was there, my partner, Sky Mayo and I took a kind of new approach to kind of optimizing this approach. We started a hepatic arterial infusion program. As many of you know, this involves the placement of a
chemotherapy pump in a catheter

into the hepatic artery to deliver

focus chemotherapy with the

It’s a complex operation involves

dissection of the hepatic artery

placement at the pump in a subcutaneous

pocket with installation of FDR.

We did this in combination with

systemic chemotherapy with Folfox.

I’m just going to quickly report these

results we placed about 27 pumps.

At this time we analyze data.

We looked at the 1st 20.

Two of these pumps, all.

A subset for unresectable disease.
Many of these were high risk disease, 36% with the K Ras mutant. All had synchronous disease. All had multiple liver lesions. The point relate relative to this talk that I’d like to point out is that. Of the 13 patients that we were aiming to convert to respectability, a subset we were able to eventually get to the operating room with very extensive bilateral disease, so this is yet another kind of regional chemotherapy strategy to convert patients to Resectable. Another approach that is done
throughout the world that is facilitated by David’s work is a two stage HEPA tech to me. This is for patients with complex, lateral disease, they go to the operating room in one session and either have reception of the left liver disease or ablation. Then they go on to portal vein embolization, which leads to hypertrophy of the left liver and the remainder of the disease is respected in a second operation. And this is a strategy that allows us to treat what can be otherwise completely unrespectable disease.
So series from around the world to demonstrate that even for patients with advanced bilateral disease, if we can complete the two stage resection, we can provide patients with excellent long-term survival. There is always going to be a subset of patients who dropped out due to progression between the operations or in the course of therapy. And unfortunately, those folks don’t do well, but this is a great strategy to get patients to the operating room. One of the things that I
number of other surgeons that started to do in recent years, is exploit the concept of the R1 Vascular margin. This is related to the fact that there is going to be a subset of patients like this who have bulky tumors and the diseases in close proximity to a major vein or poorly pedicle. But it is possible if you can get a wide resection margin on the rest of it and get a very narrow margin that’s positive only on the vein to get excellent local Disease Control in that part of the liver and still preserve significant liver parenchyma.
My Friend Doctor Guido Tort

Caelian Milano has been kind of the primary proponent of this,

and I think that this is a strategy that is gaining traction and many

HP be centers around the world.

Guido and his team have reported their experience and one of the things that

I think his striking is that patients who have you compare their survival.

When you compare R0 resection with R1 resection from the liver parenchyma,

there’s clearly decrement in survival.

However, the group that have an R1 margin
only on a vessel have a survival. It is virtually identical to those that are R0 resection. I think that this is a great example of a theme that we see across surgical oncology and multiple diseases breast cancer. The most notable here where we overtime have gone to a multi modality approach involving chemotherapy, radiation and much more limited surgery going from radical mastectomy to breast conservation. Now moving towards even eliminating the axillary component of breast cancer surgery. Same in head and neck. Laryngeal preservation,
possibly preservation of the rectum in Rectal carcinomas.

Sarcomas off ajil cancer.

The theme is consistent throughout integration.

Multi modality therapy allows a more conservative operation,

and I think we’re getting there and liver cancer.

This was one of my cases from Portland,

not a great picture,

but a patient who I took care of.

You had multifocal disease in the upper part of the right side of the liver and left liver requiring
00:22:27.942 --> 00:22:29.745 reception down on to the hepatic veins and right point medical.
NOTE Confidence: 0.855382919311523
00:22:31.180 --> 00:22:33.835 Kind of a wedge resection on the left side,
NOTE Confidence: 0.855382919311523
00:22:33.840 --> 00:22:37.467 all able to do this in a single operation.
NOTE Confidence: 0.855382919311523
00:22:37.470 --> 00:22:39.115 The greatest thing about this
NOTE Confidence: 0.855382919311523
00:22:39.115 --> 00:22:40.760 is that all of these
NOTE Confidence: 0.871058881282806
00:22:40.833 --> 00:22:43.798 strategies do require multidisciplinary care.
NOTE Confidence: 0.871058881282806
00:22:43.800 --> 00:22:46.971 An integration, as I take off my
NOTE Confidence: 0.871058881282806
00:22:46.971 --> 00:22:50.129 surgeon hat and put on my CMO hat,
NOTE Confidence: 0.871058881282806
00:22:50.130 --> 00:22:52.470 all of these strategies come together
NOTE Confidence: 0.871058881282806
00:22:52.470 --> 00:22:55.553 in the fact that our aim at the
NOTE Confidence: 0.871058881282806
00:22:55.553 --> 00:22:57.719 Yale Cancer Center through both our
NOTE Confidence: 0.871058881282806
00:22:57.798 --> 00:23:00.792 care signature effort as well as
NOTE Confidence: 0.871058881282806
00:23:00.792 --> 00:23:02.788 our multidisciplinary disease teams,
NOTE Confidence: 0.871058881282806
00:23:02.790 --> 00:23:05.541 is to create a wrap around set
NOTE Confidence: 0.871058881282806
00:23:05.541 --> 00:23:07.920 of services for our patients.
As I mentioned, it’s not just liver surgery and medical oncology. An Interventional radiology. We need to coordinate care for many of these patients, including radiation therapy. Image Ng, including nuclear medicine. Of course, oncology, nursing, pathology, social work, our colleagues in colorectal cancer surgery need to be involved in genetics, and I think that’s the promise. An fun of what we’re doing, so I’d like to hand off now to doctor made off.
Thank you David.

I guess I need to stop my screen. Share my screen here.

And.

OK, so can you hear me. Yes, we can hear you. So what I would like to thank Charlie and Kevin, as well as my for giving me the opportunity today to speak at the El Cancer Center grand rounds. As you may recall, I didn’t discuss this topic of liver regeneration in last December, but today I will be focusing on how
these techniques relate to optimizing the anticipated future liver remnant prior to resection in patients, really with only colorectal liver metastases. Very happy to be here in terms of the fact that this is, like Kevin said, this is really in my life’s. Work and passion and having the opportunity is for me very, very nice. So. As you just heard from Kevin, there have been tremendous advances and Pat ability. Every surgical techniques, such that death is now considered rare. However,
complications such as fluid retention,
Cola stasis, an impaired synthetic function still contribute to prolong recovery times. An extended hospital stays.
This is particularly true instead of an extent, but did have a tech to me where 5 or more per node segments are removed, and in fact, as you can see, the mortality in this setting can approach 8 to 10%. This can be seen from this French study.
and the size of the liver remnant, and this is not in regards to the severity of the overall complications, but really only the complication rate. So at this time there’s really no limit to how smaller liver.

In order to reduce the morbidity of Petra section at least 20% mushrooming in patients with normal underlying liver that is. For example, patients that have colon cancer Mets to the liver without ever having touch chemotherapy 30% in injured liver such as those that have had extensive chemotherapy or Seattle hepatitis and 40% in those with underlying cirrhosis.
So there’s many preoperative strategies to prepare the liver for resection and. These include Portland Embolization, which was briefly discussed by Kevin radiation lobectomy. There’s an apps procedure that will get into briefly and also something called liberties deprivation. Support and embolization is the original strategy, first described by professional recruiters from the University of Tokyo in 1990. It’s been used to redirect portal blood to the future liver remnant or FLR, and by doing so initiate hypertrophy of the non embolized
segments and by doing this we can reduce the number of overall perioperative complications and increase the pool of potential surgical candidates who have what we call marginal anticipated future liver remnant volumes. Please note that the goal is really not to improve the overall survival after resection is compared to those that did not require PV. It’s just really to achieve similar survival rates to those patients who want to undergo surgery. It did not actually require PV an ultimate until recently.
The general consensus was the PV was the standard of care at most had ability, every centers worldwide or safe and effective generate generation or generation of the FLR.

It’s now been over a decade since the first meta analysis of usefulness of PV was published, and in this study they would do 37 publications with over 1000 patients and found a previous states with a low mortality and morbidity rate. Further, 85% of the patients were able to get their proposed surgery. However,
as you can see down here is that there was a substantial group of patients that were not respected and this was due mostly to disease progression or insufficient.

I stated previously the goal of PV in the setting of colorectal cancer is to get similar survival rates to those patients who do not require PV. Here we see two actually French studies and pretty old. There actually showed where these outcomes were born out. Now PV E not only causes the
Liberty purchase fee, but it also results in improved function of the FLR and this has been shown by nuclear medicine studies with alobar function shifted from the embolized than an embolism for after the further in patients with Hilar Cholangio Carcinoma, who had biliary drainage catheters more bile is produced in the non embolized bourbon in the embolized liver and Lastly. We can see that less alterations in liver function tests after resection occur following PV even knows in which PVE. Was not performed. So for decades CT has been the
cornerstone for surgical planning and
when assessing the FL are we do our
calculations based only on the size of
the liver. Remaining siti does directly
measure the future liver remnant and the
total liver volume is not actually measured,
but rather it’s estimated from
the Association between the
liver and patient size.
And this is based on body waiting patients,
body surface area or a larger
body would need a large deliver.
Smaller patient may need a smaller liver.
The FL R2 total estimated liver volume
can then allow for uniform comparison.
Adefa lower volume parts of resection, whether or not PVE was performed. And this is the formula which is based on a linear regression equation from over 500 Western adults. It’s critical to understand the denominator does not change on the pre and post CT scans because it is an estimate. One must realize that PV E does cause atrophy of the emboli segments that there have been cases where the total liver volume is directly measured. And went down after PV E. Therefore, even if the numerator is unchanged, the FL, our percentage may inadvertently increase,
giving once a false sense of belief that hypertrophy did occur. And unfortunately patients have died after surgery when this happens. So if we look at this patient with colorectal liver metastases here we see approximately 4 weeks later that the FLR grew from 17 to 30% or degree of hypertrophy of 13%. This patient also had. Kinetic growth rate of 3.5%, which is a good indicator and this will be discussed in much more detail in a little bit. In recent years,
there’s actually been controversy as to be appropriate limit for resection, and this may depend on the institution and the formula being used. In Europe, for example, therapies use the cut off for the need for pbe. That said, we showed during my time at MD Anderson there statistically significant differences in outcome, whether it be from liver insufficiency or death. If you have less than 20% of your FL are remaining. Once you had more than 20% of your FL are remaining. And further, we wanted to see the impact of
PV in the patient population.

We found that in those patients that had at least 20%, meaning that they already either had 20% not requiring PV or had 20%, and in those days we did it with a higher environment to see if there was any difference, and we compared them to those patients who had less than 20% and actually had 20% who did not require PV, and compared them to those also that. And we found that as long as the PV confidence is above 0.81, we can conclude that the environment with PV is better.
00:31:39.486 --> 00:31:41.670 patient after PV at least 20%
NOTE Confidence: 0.811400353908539
00:31:41.670 --> 00:31:43.440 of the future liver remnant,
NOTE Confidence: 0.811400353908539
00:31:43.440 --> 00:31:46.542 it really was no difference in
NOTE Confidence: 0.811400353908539
00:31:46.542 --> 00:31:48.610 what happened after resection.
NOTE Confidence: 0.811400353908539
00:31:48.610 --> 00:31:50.416 So we talked about the brief
NOTE Confidence: 0.811400353908539
00:31:50.416 --> 00:31:53.727 So what is the degree of purchasing?
NOTE Confidence: 0.811400353908539
00:31:53.730 --> 00:31:53.973 W ell,
NOTE Confidence: 0.811400353908539
00:31:53.973 --> 00:31:56.160 it's the post PV efl R minus the pre
NOTE Confidence: 0.811400353908539
00:31:56.219 --> 00:31:58.284 PV EOFLR which gives you a dynamic
NOTE Confidence: 0.811400353908539
00:31:58.284 --> 00:31:59.935 measure of liver regeneration and
NOTE Confidence: 0.811400353908539
00:32:01.700 --> 00:32:03.964 this is important because there
NOTE Confidence: 0.811400353908539
00:32:03.964 --> 00:32:05.168 is an amount of high purchase that
NOTE Confidence: 0.811400353908539
00:32:05.168 --> 00:32:07.221 If you have complications in our study
NOTE Confidence: 0.811400353908539
00:32:07.221 --> 00:32:09.078 published in MD Anderson in 2007,
00:32:09.080 --> 00:32:10.952 you can see that those patients
00:32:10.952 --> 00:32:13.389 that have more than 5% degree if I
00:32:13.389 --> 00:32:15.054 purchase he had significantly less
00:32:15.054 --> 00:32:17.021 complications that had more than 5% FL.
00:32:17.021 --> 00:32:20.810 So here we have a tale of two rivers,
00:32:20.810 --> 00:32:22.262 one patient with Cirrhosis,
00:32:22.262 --> 00:32:24.440 and HTC who underwent a right
00:32:24.509 --> 00:32:25.529 hip attacked me,
00:32:25.530 --> 00:32:27.345 the other with colorectal liver
00:32:27.345 --> 00:32:29.521 metastases and only had 5% steatosis
00:32:29.521 --> 00:32:31.326 who underwent an extended right.
00:32:31.330 --> 00:32:32.594 He protected me here.
00:32:32.594 --> 00:32:34.490 We see that the cirrhotic patient
00:32:34.553 --> 00:32:36.050 had excellent hypertrophy,
00:32:36.050 --> 00:32:38.953 while the other patient had only 1% growth.
Interesting Lee, the cirrhotic patient, did well after surgery, while the patient that had the normal liver or what we thought was a pretty normal liver actually. Died after their reception. Therefore, if we see that you can use these numbers to see that patients that have at least 20% FLR and at least 5% degree of hypertrophy had a zero percent, 90 day mortality. And like I said, this information can be used when trying to understand whether a patient should be indicated for...
00:33:09.332 --> 00:33:10.696 their reception after PV.

00:33:10.700 --> 00:33:13.596 So now that we know the floor cut

00:33:13.596 --> 00:33:16.370 off numbers that is 20% for normal liver,

00:33:16.370 --> 00:33:18.890 30% for injured liver from chemotherapy and.

00:33:18.890 --> 00:33:19.883 40% for Cirrhosis,

00:33:19.883 --> 00:33:22.739 and we know that if I purchased the 5%,

00:33:22.740 --> 00:33:24.987 is this enough to really be able

00:33:24.987 --> 00:33:25.950 to predict which

00:33:26.022 --> 00:33:28.447 patients should have their surgeries?

00:33:28.450 --> 00:33:30.907 So we now know that we’ve had

00:33:30.907 --> 00:33:32.899 purchase fees based on the timing

00:33:32.899 --> 00:33:35.425 of the image Ng and that a true

00:33:35.425 --> 00:33:38.089 assessment of the epilogue growth is

00:33:38.089 --> 00:33:40.196 difficult to compare among patients.

00:33:40.196 --> 00:33:42.494 Therefore, we developed a new variable

NOTE Confidence: 0.847820580005646
called the kinetic growth rate or KJR, which is the degree of hypertrophy over the time elapsed from PV E in the number of weeks. So here we see three patients with colorectal liver metastases, each with a degree of hypertrophy, well within the amount needed for successful, however, the patient on the bottom actually occurred in 70 days. However, the patient on the bottom actually died from liver failure after section, so we went back and reviewed the cases and found that the time for the first 2 patients with 35 days to get these results, while we found that the patient had died, it actually occurred in 70 days.
So when we went back and calculated the kinetic growth rate, the patient that I had only 0.3% per week, while the other two had much higher growth rates. Therefore, when assessing patients which should have surgery, we found that in order to really be safe, that we really need 2% per week. That led to know hepatic insufficiency or 90 day mortality. So, is Kevin stated earlier we can now extend the boundaries for safer section.
by using advanced surgical strategies such as the two stage protecting colon article, living metastases, patient first had systemic chemotherapy with excellent response, then had surgery to clear the left lateral liver. The FL, our volumes were calculated to be 16% of PV was performed, then FLR was then found to be 26%. So the definitive resection was then performed. So to assess the benefit of the two stage separate ectomy,
we reviewed patients who had invented the advanced strategy with extended pack resection and compared those those that did not have tumor in their FL are therefore not really needing second stage. Our results had shown that there was no difference in overall and disease free survival in those patients that required the two stage protect me as compared with those that only required the one stage. And as Kevin showed from our study from MD Anderson in a really highly selected. And she cohort who did complete
the second stage.

We were able to achieve a 60% five year survival, which is really considered amazing. Anything about a decade ago given to buy Alobar nature of the disease. However, there is some concerns regarding team be one of the major concerns is the potential drop out of up to 35% of patients due to an insufficient FL patients due to an insufficient FL are or or tumor progression within the four to six week waiting period from the TV to the definitive resection. Therefore, other approaches are needed.
So one. Issue that has been entertained has been that PV can lead to expedited tumor growth, so to that end the recent data supports that we can use chemotherapy during the waiting period and also can be used within the postoperative period which at one time was thought to maybe limit for generation. However, that has not borne out to be the case. So there are other alternative approaches that we can use. It is Interventional radiologist.
This is a case. This is a study that was performed from Korea where TV did not leave the sufficient regeneration. Anna Korean group found that later performing right, having bane embolization in addition to the PV is shown here actually result in better outcomes. We’ve also used something called radiation lobectomy. This is done by the Transarterial Bar Administration of Y-90 microparticles. She’s now an established means of providing local tumor control within the liver.
That said, there was an unintended phenomenon of contralateral liver I8 and seven in several retrospective studies. Contralateral hypertrophy? A curd from 21 to 47%, and therefore this has been suggested as an alternative to PV with the benefit of local tumor control. And the test of time. So we had talked about this earlier, but nuclear medicine is showing improved liver function after PV E in this small study of 13 patients, with some being colorectal liver.
metastases who underwent some nuclear medicine scintigraphy. They showed that using radiation lobectomy actually can cause changes in regional liver function, and this correlated with the functional liver absorbed doses from Y-90 and then in 2014 a group from France compared 141 patients who underwent right PV with third. 35 patients who underwent radiation 35 patients who underwent radiation at two centers that were matched for criterion known to influence liver regeneration after PVD. The radiation was performed if the authors found the case would be challenging.
00:38:21.260 --> 00:38:23.240 provid PB and to be honest,

00:38:23.240 --> 00:38:25.550 I'm not sure why this would be,

00:38:25.550 --> 00:38:28.078 but when they match the patients they found

00:38:28.078 --> 00:38:29.839 significantly more hypertrophy after PV.

00:38:29.840 --> 00:38:31.772 They concluded that while the hyper

00:38:31.772 --> 00:38:33.060 chicken radiation lobectomy substantial

00:38:33.111 --> 00:38:34.786 and doesn’t minimize tumor progression,

00:38:34.790 --> 00:38:36.440 PV can induce significantly greater,

00:38:36.440 --> 00:38:38.402 and I purchased the in radiation

00:38:38.402 --> 00:38:40.070 lobectomy with these therapeutic doses.

00:38:40.070 --> 00:38:42.230 So how do you decide if you should

00:38:42.230 --> 00:38:44.360 use PV or radiation lobectomy?

00:38:44.360 --> 00:38:46.010 The decision should be based

00:38:46.010 --> 00:38:47.000 on achievement intent,
Is the patient a candidate for section now and what is the plan resection if the reception should be done now you should just go ahead and perform the P PE. You also need to know what type of malignancy patient has and whether the patient has underlying liver disease. Cases where patients have bottle bar colorectal metastases that require a Tuesday check. Her protect me. There is likely really no role for radiation lobectomy, as you can see, I’m personally not in favor of the radiation lobectomy in this approach.
as you would really need to do 190 of both lobes and it seems appropriate in the setting of HTC with cirrhosis. But I don’t think it really is appropriate in the setting of colorectal liver metastasis. Another approach is Alps, which is short for associating liver partition and portal vein ligation. This approach was proposed to replace pbe with two surgeries. He performed interactive right portal vein ligation followed by completely divest arising. Segment four of the liver and
at the same session is surgeon clears the floor of tumor.
The patient is then closed with the tumor bearing liver in place, while the FLL rapidly have Portuguese and then the Sturgeon returns within 7 to 10 days for a second laparotomy to complete the definitive resection. And early reports actually showed very strong tumor growth. I mean, fellow growth and was believed to have a lower risk for tumor progression.
when comparing PV 2 apps that were the massive infest or hypertrophy in the Alps Group,
but it came at a much higher cost of major complications and death. Interestingly, while the kinetic growth rate was found to be higher, microscopy studies from Japan showed that the hepatocytes were not mature and not really able to handle the increased blood flow to the FL area. Therefore, it was shown that it is not simply regenerating the liver rapidly, but also in a way that allows the hepatocytes to mature appropriately.
Lee,

A systematic review and meta-analysis for colorectal liver metastases was performed, confirming the findings of the faster kinetic growth rate with Alps. But with the increased morbidity and mortality. So for this reason numerous modifications have been proposed, many of which negated distinct advantages of why Alps was proposed in the 1st place. And Lastly, I want to show a new procedure, one that we will now be using it Yale, while while I already showed sequential
NOTE Confidence: 0.752619624137878
00:41:10.616 --> 00:41:12.670 PV into Patty being embolization,
NOTE Confidence: 0.752619624137878
00:41:12.670 --> 00:41:14.836 Liberty is deprivation is performing PV.
NOTE Confidence: 0.752619624137878
00:41:14.840 --> 00:41:17.012 And how do you been embolization
NOTE Confidence: 0.752619624137878
00:41:17.012 --> 00:41:18.460 in a single session?
NOTE Confidence: 0.752619624137878
00:41:18.460 --> 00:41:20.658 The goal is to shorten and optimize
NOTE Confidence: 0.752619624137878
00:41:20.658 --> 00:41:22.849 the phase of liver preparation.
NOTE Confidence: 0.752619624137878
00:41:22.850 --> 00:41:24.218 Or surgery without the
NOTE Confidence: 0.752619624137878
00:41:24.218 --> 00:41:25.586 aggressive nature of Alps,
NOTE Confidence: 0.752619624137878
00:41:25.590 --> 00:41:26.962 and in this early
NOTE Confidence: 0.752619624137878
00:41:26.962 --> 00:41:28.334 feasibility study from 2016,
NOTE Confidence: 0.752619624137878
00:41:28.340 --> 00:41:30.566 the procedure was found to be safe
NOTE Confidence: 0.752619624137878
00:41:30.566 --> 00:41:32.679 and feasible in a small patient
NOTE Confidence: 0.752619624137878
00:41:32.679 --> 00:41:34.504 cohort of only seven patients,
NOTE Confidence: 0.752619624137878
00:41:34.510 --> 00:41:36.743 and then the same group then added
NOTE Confidence: 0.752619624137878
00:41:36.743 --> 00:41:39.203 embolization of the middle of having pain
NOTE Confidence: 0.752619624137878
to the right hepatic vein embolization, and they found that by doing so they can get safe and provide the most marketing rapid elevation in hypertrophy and liver function. Unprecedented for an IR procedure, and just soon Kevin and I will be the Copia eyes. Or yell prospective clinical trial. Looking at Libertines deprivation called Dragon One and Dragon 2. Dragon One is a feasibility study, and Dragon 2 actually will compare it to the standard of care which is PV. So in conclusion, liver regeneration is critical to
managing colorectal liver metastases, 
and, as I hope to have shown, 
there are numerous strategies 
that can regenerate the liver, 
either percutaneously or by surgical means. 
Currently, 
the understanding of Liberal generation 
in this area is really at its infancy. 
Any apples opportunities do 
exist for research, 
so I’m looking forward to 
working with your team and 
Kevin on this dragon study and 
thank you for your attention.
Thank you David, that was awesome.

NOTE Confidence: 0.729231476783752

Thanks bikini.

NOTE Confidence: 0.781764268875122

Kevin David, can you stop sharing? OK, stop the sharing here, yeah?

NOTE Confidence: 0.819342970848084

Alright, so I’m Michael Cicchini.

NOTE Confidence: 0.819342970848084

I’m a medical Oncologist and

NOTE Confidence: 0.819342970848084

I’m going to talk about the chemotherapy

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in the Peri operative management of these liver metastases for colorectal cancer.

NOTE Confidence: 0.819342970848084

So first I’m going to talk

NOTE Confidence: 0.819342970848084

about the molecular profiling.

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That’s important to decide.

NOTE Confidence: 0.819342970848084

Chemotherapy agents as well as sightedness,

NOTE Confidence: 0.819342970848084

which is not truly molecular

NOTE Confidence: 0.819342970848084

profiling but certainly hasn’t impacted the chemotherapy selection.
The two types of patients we encounter, the unrespectable patiently up respectable biologics and then some of the damage our agents can do that can complicate the role of complicated surgery so. Molecular profiling for colorectal cancer. What information do I really need to know to make a chemotherapy decision? Wrap the grass in the raft status are very important and they have been so for some time mismatch repair status microsatellite status, repair status microsatellite status, which is analogous to that and then the sightedness has become increasingly important for determining
determining which biologic to use.

So the origin of the primary tumor was at a left sided tumor or right sided tumors.

So to remind ourselves why Rasen rap status is so important.

We need to go back to the EGFR pathway.

So in our ask mutated cancer or at mutated cancer.

This is this pathways constitently activated below the level of the ship receptor.

We have drugs syntax Mammon,

Panitumumab two monoclonal antibodies to target EGFR receptor that we add on
NOTE Confidence: 0.819342970848084
00:44:40.426 --> 00:44:42.186 to chemotherapy, so they’re effective.
NOTE Confidence: 0.819342970848084
00:44:42.186 --> 00:44:44.790 If this pathway is not constituent active,
NOTE Confidence: 0.819342970848084
00:44:44.790 --> 00:44:45.552 blow it.
NOTE Confidence: 0.819342970848084
00:44:45.552 --> 00:44:47.457 So in a rash wild.
NOTE Confidence: 0.819342970848084
00:44:47.460 --> 00:44:52.014 I porra filetype we add on
NOTE Confidence: 0.819342970848084
00:44:52.014 --> 00:44:54.291 Panitumumab Humanized Monoclonal
NOTE Confidence: 0.819342970848084
00:44:54.291 --> 00:44:58.299 Antibody an and or so or sucks Mad A.
NOTE Confidence: 0.819342970848084
00:44:58.300 --> 00:44:59.377 A chimeric antibody,
NOTE Confidence: 0.819342970848084
00:44:59.377 --> 00:45:01.531 but for the patients that are
NOTE Confidence: 0.819342970848084
00:45:01.531 --> 00:45:02.450 mutated in rats,
NOTE Confidence: 0.819342970848084
00:45:02.450 --> 00:45:04.865 we have to take a different approach.
NOTE Confidence: 0.819342970848084
00:45:04.870 --> 00:45:06.600 So bad this is mab.
NOTE Confidence: 0.819342970848084
00:45:06.600 --> 00:45:08.574 Kevin talked about a little bit
NOTE Confidence: 0.819342970848084
00:45:08.574 --> 00:45:09.890 to monoclonal monoclonal antibody
NOTE Confidence: 0.819342970848084
00:45:09.943 --> 00:45:11.743 against veg that Jeff Vascular
NOTE Confidence: 0.819342970848084
endothelial growth factor,

and that’s also added on to chemotherapy

be Rapids become important just

in the last couple of years.

Now we have targeted agents for

that and Grafton if insta tox mad,

but for the Intents and purposes

of this stock graph is used as

a negative prognostic.

Mutation and most of those

patients are not can be included

in the consideration of surgery.

So why is the mismatch repair

status so important?

So to answer that,

we first have to remember what
mismatch repair proteins do.

So Emily age 1:00 PM S 2 Ms H2, and six.

These are the four most clinically relevant mismatch repair proteins.

Their function is to follow the DNA polymerase machine DNA polymerase machinery along as it undoubtedly makes some mistakes.

It fixed these single base mismatches, which are most prevalent in these areas, called microsatellites, which are dynamically Titan tribe.

nucleotide repeats across the genome. You can imagine this DNA machinery.

It’s really caught up on.
all this repetitive DNA.

Lots of mistakes are made so we know when these are lost.

Tumors have very high tumor mutational burden that which leads to a lot of Neoantigens.

We’ve known for some time that these are some of the most sensitive cancers to immunostimulatory therapies such as anti PD one and four therapies.

So they’ve been approved in the refractory setting for you for a few years but only recently just a few months ago.

Did we get to see their activity in the first line setting?

You can see very dramatic separation
00:46:37.030 --> 00:46:38.530 of these two curves here.
00:46:38.530 --> 00:46:40.020 Green being Pember Lizum app,
00:46:40.020 --> 00:46:42.684 purple being the chemo arm for a first line.
00:46:42.690 --> 00:46:44.170 Microsatellite instability.
00:46:44.170 --> 00:46:47.440 High collector cancer.
00:46:47.440 --> 00:46:49.216 you’re seeing 48% of patients that
00:46:49.216 --> 00:46:50.104 are microsatellite instability,
00:46:50.110 --> 00:46:51.600 higher progression, free and alive.
00:46:51.600 --> 00:46:54.272 At at two years versus only 19% with chemo.
00:46:54.272 --> 00:46:55.456 But for today’s top,
00:46:55.460 --> 00:46:56.950 what’s really important to look?
00:46:56.950 --> 00:46:58.410 Actually look at this part
00:46:58.410 --> 00:47:00.510 of the curve on the far left,
that’s going to surgery would be.

Maybe early on in their treatment journey

A bit more inferior to chemotherapy.

In this setting in a very rapid drop off,

even with Pam bro,

which obviously has a tail on this curve.

So immunotherapy in the new edge

of insteading for somebody that’s

initially resectable, for example,

is definitely not ready for prime time.

And I think future directions will
certainly be chemo immunotherapy,

and hopefully will negate some

of the early drop off.

Why is sightedness important?
So we've known for some time that high and got the left sided Colon is a different embryologic origin in the right right colon so hindgut for left and got for right. Right sided tumors generally worse prognosis, Right sided tumors generally worse prognosis, Right sided tumors generally worse prognosis,

Higher crass and left side it more than more traditional APC mutations in TP 53 mutations and we know that even if your rash wild type, it matters whether or not you respond to a EGFR antibodies such as anti tumor map or cetuximab.
So it’s really the rash wildtype left sided tumors that we’re thinking about using these drugs in the first line setting. And even if rash while typing right sided data SIM it at this is a map should still be considered. So what are the drugs that we have at our disposal to help these patients so full F ox? We’ve probably all heard full box, full fury, full F ox series. We’ve probably all heard full box, full fury, full Fox series. And when we use in pancreatic cancer here, full fear knocks, but they’re slightly different approaches. So what is folfox? So five fluoro uracil,
which is patented by Charlie Heidelberger. I think in 1957 and is still around and going strong. Is a family space inhibitor so you don’t have time to look around for rapidly dividing cells. Luca born potentiates the activity of five FU. It’s a vitamin that we give along with the chemotherapy. Oxaliplatin is the oxen in full box, and that’s in platinum agent that causes double stranded breaks and are in Attic, which is the IRI. In full fury is.
Ultimately converted into its active form. About summarize, one inhibitor, SN 38 and ultimately also end result is double stranded breaks, so these are the main agents we have. We started out again with just 5F U and this is about what we were doing back in the early 90s, so we had about a median survival of 12 year for patients with mosaic answer. When we started to have doublet chemotherapy’s in full box and full theory, we move this out about the two year mark. Now we’re really between the two and three, or mark or median overall survival. For most, for most of our active trials
00:49:40.942 --> 00:49:43.117 with colorectal cancer with folfox theory,
00:49:43.120 --> 00:49:45.479 the triple combination that’s a bit more toxic and reserved for younger patients
00:49:45.479 --> 00:49:47.534 is about a 32 month median survival,
00:49:47.534 --> 00:49:52.835 so we have to ask ourselves at tumor board, what does this patient have it with?
00:49:52.840 --> 00:49:55.178 Cash pathway to cure?
00:49:55.180 --> 00:49:56.328 So what our main goals with chemotherapy?
00:49:56.328 --> 00:50:00.545 We’ve heard a little bit about conversion therapy,
00:50:00.545 --> 00:50:01.550 converting the unrespectable patient to a respectable patient.
00:50:01.550 --> 00:50:02.886 If we have a patient that’s upfront, resectable chemotherapy can still be useful to reduce the surgical complexity.
Eradicate micrometastatic disease, which is also hopefully doing for the unrespectable patient and then also assess the biology of the aggressiveness of the disease. Is somebody actually getting a response through chemotherapy, or they just rapidly progressing? That’s not a patient you want to surgery anyway, and if we know that even in the best of circumstances the patients never going to get to a surgical option that the treatment is prolonging life, hopefully by controlling disease in improving tumor related symptoms,
so we should think about this as two groups, the unrespectable patient. And the resectable patients. So the upfront resectable patient and just there’s no right way to integrate chemotherapy into these patients. By the way, different centers take different approaches, but there’s more nuanced than just this slide. But when to consider a front reception? Generally, for fewer liver metastasis, chemotherapy response? Not really. The surgeon doesn’t really think
chemotherapy response is going to lower the complexity of the operation. But when do we do it when there's more than four suspicious knodel involvement? My Liberty disease. But again, there's more nuanced to this, so we have to take everything. Every aspect of the patient into account. Do they have a lot of other comorbidities? Where if they are not tolerating chemotherapy well, we're expecting significant increase in liver damage, which could complicate in operation? Is there reason to suspect that they have particularly aggressive
disease and you want to give him the
tincture of time on chemotherapy to
make sure they’re not just rapidly
progressing and you’re going to put
them through an unnecessary operation?
Did they recently received full Fox for?
For management of primary primary,
so could a slight response results
in maybe converting an
open reception to a laprascopic reception.
So what, what chemotherapy do
we typically use? So again,
these are patients that could be respected,
most likely, so full Fox,
a doublet chemotherapy,
perhaps with the biologic bevacizumab 
NOTE Confidence: 0.794327676296234
00:52:07.352 --> 00:52:08.200 panitumumab receptors amount,
NOTE Confidence: 0.794327676296234
00:52:08.200 --> 00:52:10.328 but the important part is to limit the 
NOTE Confidence: 0.794327676296234
00:52:10.328 --> 00:52:12.749 number of chemo cycles as much as possible. 
NOTE Confidence: 0.794327676296234
00:52:12.750 --> 00:52:14.703 These patients that can get to surgery 
NOTE Confidence: 0.794327676296234
00:52:14.703 --> 00:52:16.717 quickly and should get to surgery quickly, 
NOTE Confidence: 0.794327676296234
00:52:16.720 --> 00:52:18.484 and we want to do as little 
NOTE Confidence: 0.794327676296234
00:52:18.484 --> 00:52:20.263 damage is possible to the to 
NOTE Confidence: 0.794327676296234
00:52:20.263 --> 00:52:21.547 the liver without chemotherapy. 
NOTE Confidence: 0.794327676296234
00:52:21.550 --> 00:52:23.405 So we should image patients early and 
NOTE Confidence: 0.794327676296234
00:52:23.405 --> 00:52:25.806 as soon as thought as soon as feasible. 
NOTE Confidence: 0.794327676296234
00:52:25.810 --> 00:52:27.798 These patients should be taken into surgery. 
NOTE Confidence: 0.794327676296234
00:52:27.800 --> 00:52:29.528 We generally plan to do six 
NOTE Confidence: 0.794327676296234
00:52:29.528 --> 00:52:30.680 months total of chemotherapy. 
NOTE Confidence: 0.794327676296234
00:52:30.680 --> 00:52:32.800 But the rest would be reserved for later. 
NOTE Confidence: 0.794327676296234
00:52:32.800 --> 00:52:34.456 So what about the unresectable patient?
Now this patient can’t get this surgery without a response, so it’s a different approach, so we talked a little bit about what is undetectable. But so, how likely is this understandable patient going to be able to get an operation? Perhaps as high as a third 1/3 of the time that we will get enough cited reduction to convert this patient to respectable? But what regiment is best?
Again, if you look at guidelines, both guidelines are very so. The guidelines don’t really take much of a stand. They say Folfox Folfiri Anna tumor map. But this is a mad. They kind of leave it up to the treating oncologists asthma. On the other hand, takes a more dogmatic approach. It says full flux is the recommendation or for unresectable metastases. Considerable Fox series, so that’s that’s the approach that we would take here, predominantly in the United States
that most centers would do. But certainly here at Yale for the younger fit patients, we would do full oxaliplatin. This is a map, but for our upfront, resectable patients we would again just be doing a doublet. So I'm going to skip through this in the interest of time, especially since Kevin showed some of the slides are ready. So what about our biologics? So this is another level of nuance. Again, to do our chemotherapy here.
So we have.

We have agents such as bad.

This is a map which is a vascular

endothelial growth factor antibody

against speculative growth factor,

which is created by the tumors and

stimulates blood vessel growth.

Because the tumor needs

increased vascularity,

so we know that bevacizumab

increases response rates,

but it can potentially increase

perioperative complications.

We see vascular events such as

such as arterial thrombi, Venus,

on occasion perforations,
but the big concern is wound healing, so we generally would hold bevacizumab within six weeks prior to any server dream. There is some data that supports it up to four weeks prior to surgery, but the concern is how you when you hold it preoperatively. So this is actually been looked at. The addition of bevacizumab in systemic therapy for unresectable liver metastasis. So we have a cohort of patients here split up into two groups. These are all kras mutated patients or patients that are
perfect fit for bevacizumab.

So full blocks plus bevacizumab in arm a in Folfox alone.

In R&B you can see that the reception, the rate of R0 Resection complete resection, 22 verses about 6% without the berbasis matters so very, very big difference about getting to surgery there.

What about progression free survival 9 1/2 months median versus about 5 1/2 months favoring Bevis is maben blue here. Less less striking difference about 25 versus 20 months. Both are statistically significant.
So bad this is a map should be used in the Peri operative management with Folfox 4 correct meeting liver metastases. What about the EGFR antibody face? These are highly effective therapies for patients that are crashed while type. You think you think we see a similar a similar story here. In fact, we're. In exact opposite, so again, we have two groups here. This is a new epoch study, split into chemotherapy, perioperatively before and after surgery with cetuximab,
an without stuck some, and so without cytoxan map is here in blue. Progression free survival curve here so you can see the red group chemotherapy plastic doing inferior to the chemotherapy alone group. Same thing with overall survival. What’s really interesting? If you look at these curves, these are these are the Times of surgery, so this curve have not separated. They separate later. An obvious explanation to this oh would be an awesome app. Is creating some increase in perioperative complications?
But that’s not the case and the fact that the changes in progression free and overall survival happened later again speaks to. They did that. It’s not an actual increase in proper complications. Frankly, I haven’t seen any good explanation for why this we’re seeing these confusing results, but I think we should proceed with caution when using our bodies in the perioperative setting. I think a lot of my colleagues have not bought into this.
and I again uncertain on the
rest of the biological rationale,
but it’s a very striking overall survival difference.
It’s almost three years.
Median overall survival difference without the antibody.
So chemotherapy associated liver diseases will close on South are drugs can do damage.
That’s why the name that our approach is to limit the number of cycles when feasible,
so Oxaliplatin, cut static sinusoidal abnormalities.
You can see the dilations here in
light of these sinusoids that directly from oxide Platt and you can see nodular regenerative hyperplasia. This, like lighter pink nodule here. Crowding out the more healthy liver tissue here, which creates noncirrhotic portal hypertension, both from Oxaliplatin, where Uniti Concuss. Seattle hepatitis so fatty fatty infiltration and inflammation of the liver. Here very severe case, and the less of your case. But frankly there shouldn’t be fact. Neither of these images.
So in conclusion, we took about the importance of molecular results. Those are things that need to be sent on every patient so that the medical oncologist can know what treatment approach should be done. The role of sightedness, our approach to the unrespectable, and some of the damage our agents can do. Thank you so much. Michael, thank you for high speed yet incredibly comprehensive overview of rapidly evolving and complicated field and. David, I want to thank you as well.
Given the time, I don’t think we have much leftover for discussion, I would just.
Close by saying that this is an incredibly exciting field to work in, I think the overview that my partners have given gives the audience a sense of the enormous complexity yet opportunity involved for our patients. And I think for all of us who work together, it is yet another call. For an extraordinary level of teamwork, all of these clinical services have to be linked together by meticulous communication.
our nurses and administrative Staffs.

As we kind of navigate care throughout a very complex system.

Charlie, anything to add.

Oh, I just want to thank David, Michael and Kevin for really just a brilliant discussion.

And thank you for your leadership, your collaboration and building a team around a pivotal area of care, research and thanks everyone for joining.

us and think giving us a lot to think about and really exciting progress.