Substituting today very happy to be here.

So we have two talks today and I think it should be a very interesting hour.

Our first talk will be by Anne Chang and Congratulations. 

And so an is associate Professor of Medicine, medical oncology and Deputy Chief medical Officer and Chief Integration Officer

Officer for Smile Cancer hospital.

As of about 3 hours ago.

She specializes in thoracic oncology with a background in translational research and metastases,
and a clinical focus has been built

00:00:35.789 --> 00:00:38.019 has been to build an amazing small cell lung cancer program here with a comprehensive portfolio of clinical trials testing novel therapeutics.

00:00:40.568 --> 00:00:44.336 Her research interests focus on development of clinical trials and translational studies to test novel agents and combinations with immune checkpoint inhibitors for both small and non small cell lung tumors.

00:00:44.476 --> 00:00:46.476 and development of clinical trials and and overseas operations quality.

00:00:46.726 --> 00:00:50.641 Over now nine years an she’s helped to build our smiling network, which I think will hear about today.

00:00:50.641 --> 00:00:54.192 checkpoint inhibitors for both small cell and non small cell lung tumors.

00:00:54.192 --> 00:00:57.908 cell and non small cell lung tumors.

00:00:57.910 --> 00:01:00.136 Over now nine years an she’s helped to build our smiling network,

00:01:00.136 --> 00:01:02.219 to build our smiling network,

00:01:04.509 --> 00:01:05.958 and overseas operations quality
efforts in clinical research,

NOTE Confidence: 0.80177414

adult care centers.

NOTE Confidence: 0.80177414

She's a particular focus in quality

NOTE Confidence: 0.80177414

measurement and improvement and

NOTE Confidence: 0.80177414

his work to achieve ASCO copy

NOTE Confidence: 0.80177414

certification for the entire smell.

NOTE Confidence: 0.80177414

Academic clinical practice

NOTE Confidence: 0.80177414

of actually received.

NOTE Confidence: 0.80177414

Actually, the Joe Simone Award,

NOTE Confidence: 0.80177414

just recently in Q just passed away

NOTE Confidence: 0.80177414

last week, but a big honor for Masco,

NOTE Confidence: 0.80177414

so an it’s a pleasure to have

NOTE Confidence: 0.80177414

you here for our first talk.

NOTE Confidence: 0.80177414

Transformation in quality building

NOTE Confidence: 0.80177414

a cancer network,

NOTE Confidence: 0.80177414

and.
NOTE Confidence: 0.8790028
00:01:35.280 --> 00:01:37.476 Thanks Roy, it’s really a pleasure
NOTE Confidence: 0.8790028
00:01:37.476 --> 00:01:40.651 to be able to talk to you today
NOTE Confidence: 0.8790028
00:01:40.651 --> 00:01:42.686 and thanks for the invitation.
NOTE Confidence: 0.8790028
00:01:42.690 --> 00:01:44.868 I was trying to decide between
NOTE Confidence: 0.8790028
00:01:44.868 --> 00:01:46.980 lung cancer and the network,
NOTE Confidence: 0.8790028
00:01:46.980 --> 00:01:49.906 but because of the timing of the
NOTE Confidence: 0.8790028
00:01:49.906 --> 00:01:51.933 announcement this morning and I
NOTE Confidence: 0.8790028
00:01:51.933 --> 00:01:54.355 thought that it would be nice to
NOTE Confidence: 0.8790028
00:01:54.355 --> 00:01:56.730 highlight the work that has gone
NOTE Confidence: 0.8790028
00:01:56.730 --> 00:01:58.680 into building a cancer network.
NOTE Confidence: 0.8790028
00:01:58.680 --> 00:02:00.630 So that’s what I’m focusing,
NOTE Confidence: 0.8790028
00:02:00.630 --> 00:02:03.290 but I did put in a couple
NOTE Confidence: 0.8790028
00:02:03.290 --> 00:02:05.758 of slides with my trials so.
NOTE Confidence: 0.8790028
00:02:05.760 --> 00:02:08.488 I suck that in.
NOTE Confidence: 0.8790028
00:02:08.490 --> 00:02:13.834 OK, so I’m sharing my screen my disclosures.
NOTE Confidence: 0.8790028
And this is for four.
If you recognize it, it’s South Ferry terminal farmers market in San Francisco and it’s amazing place because the quality of the food and the shops are really outstanding. I had the best Peach I’ve ever had in my life. The atmosphere is buzzing in the shops are full of colorful, beautiful produce as far as you can see and when I was here which seemed to me that this was more than a farmers market where. Each farmer sets up their shop.
individually next to each other, but somehow there was a transformation of the individual stands into a different collective entity, real community, and so in the same way that in the same way I want to talk about cancer or cancer network today, there really has been a trend over the past 10 years of academic institutions or other entities buying up practices or putting up their names on. Affiliated practices, but what I wanted to focus on is how I think we’ve built
a real transformative network,

a community that is better than the individual units where cancer delivery is really somehow transformed.

And so you know, this is, as a guiding principle for this work.

As it is, Carter said transformation is a process,

not an event.

And you start with a sense of urgency form a coalition and you create and share that vision.

You empower others to act on that vision. You plan, create short term wins, consolidate those advances,
and hardwire new systems.

And I think the bottom line.

Here is that quality improvement methodology is really been the basis of my job in the network and formed the foundation of building our vision over the past almost 10 years.

So the objectives for today’s talk really are two number one provider, network development, overview, describe quality concepts and metrics and network development to discuss ways to further the research mission in the network.

And then finally recognize the
benefits of expanded community.

So this is how it all began.

We started my job this was in 2011.

There was no network.

We had hired anybody but we did have

Yale Smilow state of the art disease based,

patient centered clinical operation.

We had outstanding faculty,

staff,

trainees,

cutting edge clinical research

resources and across organizational

commitment for expansion and really

a powerful coalition of folks

to carry out that vision,

which was really to provide
comprehensive care to all patients.

Close to home in Connecticut and to provide a platform for Yale Clinical Research and expand access to trials.

So this is really the result. 9 1/2 years later the this. This is our clinical footprint in Connecticut and in Rhode Island. This stars are where our care centers are and we do provide care to patients within 30 minutes of where they live. In Connecticut. We provide care to about 45% of newly diagnosed cancer patients in Connecticut and we also provide about or.
We accrue about 25% of therapeutic clinical trial enrollments as, as Roy mentioned, we have achieved ASCO quality oncology certification throughout our entire network in the main campus. This is the only way to certify ambulatory practices. Many of you are familiar with the ACOS, which certifies cancer programs. In all of the physicians are what YM? With the exception of Hartford, where the physicians are still Saint Francis employed, but do have a faculty appointments and
are a stipend from Yale and all of the staff are employed or least, and we do have cross system policies and procedures and quality initiatives. This is a timeline where I started here in 2011 and we did not have a network and then over the course of the next 9 1/2 years. We brought in practices and procedures and perfecting our onboarding process and now as I said
we have 15 locations in two states.

We have all we have almost 50 MD's, 16 aips and over 400 staff we see

over 9000 new patients 100 and

over 25,000 treatment visits yearly and

the contribution margin on an annual basis is greater than 110,000,000.

So I think that this is really been successful and I'm going to talk a little bit about the onboarding practice.

This is where we really utilized integration and transformative change strategies to engage the stakeholders.

The physicians that the staff in the practice, and we.

So I think that this is really been successful and I'm going to talk a little bit about the onboarding practice.
There's at the bottom line is that there's really no shortcut here.

It really is hard work having regular meetings on transition issues such as epic pharmacy, workflow changes, and those transitioned into practice meetings which were very useful. On an ongoing are useful on an ongoing basis. We developed a formal onboarding curriculum, and this utilized leaders and peers. is faculty and it really included the Smilow vision and structure. Faculty roles and expectations. What does it mean now to be part of
Yale and Smilow? How does quality work?

NOTE Confidence: 0.8576237

How does the research apparatus work?

NOTE Confidence: 0.8576237

Who are the dart leaders?

NOTE Confidence: 0.8576237

What is that mean?

NOTE Confidence: 0.8576237

What is what are academic mentors and and?

NOTE Confidence: 0.8576237

So going through that that curriculum also involving team building and leadership training and including our multidisciplinary members not only met Aachen Heme, but our surgical colleagues are rat out colleagues pain and palliative care so. Um? Be the next.

NOTE Confidence: 0.8165863

What is what are academic mentors and and?

NOTE Confidence: 0.8165863

So going through that that curriculum also involving team building and leadership training and including our multidisciplinary members not only met Aachen Heme, but our surgical colleagues are rat out colleagues pain and palliative care so. Um? Be the next.

NOTE Confidence: 0.8165863

Either or the next part of quality improvement is really measurement, and this is a graphic of the really PDS.
A cycle you have multiple. You know, iterations of how do you improve care, but measurement is really important, and so we started measuring at baseline because we wanted to make sure that we could measure progress and not just, you know, stick a sign on the door. That said, Yale Smilow and this paper published in 2018 really showed improvements in multiple domains of quality, including volume, clinical integration, quality metrics, and patient satisfaction. I’m going to show you. Few of those. At some of that data now.
So in annual visits for chemo you can see the main campus in blue over the years and then.

When the Kirsten's Care Center started in 2012, you could see the growth has really been significant and we do give now more chemo in our care centers than we do in the main campus.

In terms of standardization, we utilized coping. Measurement Copy is a program through ASCO called quality Oncology Practice Initiative and it consists of.

Go up to 90 metrics of oncology care.
00:10:45.110 --> 00:10:46.990 of ambulatory oncology,
00:10:49.415 --> 00:10:51.355 national iyanar consensus based
00:10:54.058 --> 00:10:59.030 so we had a measurement at baseline.
00:11:00.970 Representing the practices before they
00:11:03.743 joined and then this is four years
00:11:06.035 later we looked at the significant
00:11:08.217 differences and saw that really the
00:11:10.245 only changes were in the positive.
00:11:12.847 These are actually shown here and and
00:11:15.617 so this was really important to me
00:11:18.400 because I wanted to make sure again
00:11:22.114 it wasn’t just putting in a sign on the door,
00:11:25.978 but that we were actually using.
National consensus based metrics
to show that we were improving quality for our patients.
We also, as Roy mentioned at the beginning, did copy certification across our network and the academic campus. This is similar to the ACOs certification there.
26 standards and you really have to show in document that the process from soup to nuts of chemotherapy administration and policies and procedures are in place that show us. That are up to snuff for ASCO certification and we're certified in 2019.
Um, regarding clinical integration.

I'll just show you the.

And this represents cases

President care Center cases

presented at smilow tumor boards.

We have 13 disease specific multi

D tumor boards and we’ve asked all

of our physicians to present one

of two cases a month understanding

that we can’t present all of them.

But really, those complex cases that

need that multi D discussion needs to be

presented and so you can see in 2013.

This was difficult because the

logistics around dialing in,
which is so easy now by assume it.
But at that time was very difficult.
Getting the path reviewed, getting the.
Radiology diagnostic imaging to be available that was really hard at the time and now I think we’ve received we’ve sort of the steady state, right around 500.
That’s the case also.
Sorry, this is 2018-2019, 2020, right around the 500 mark,
which I think represents sort of the steady state.
Um, with respect to customer service.
Those of you who have.
You know,
Pay attention to press ganey know that we always cluster in this 90s area. It's very difficult to make any changes here, but if you look at again baseline press ganey scores for practices that we acquired and six years later, you can see that in all of the cases we actually stayed the same. We're actually improved with one exception here is is this the site, but in some cases really significantly improved patient satisfaction.

Um? This highlights some of the innovative projects that we've taken on in the network.
This was a pilot with Asko Asko.

NOTE Confidence: 0.783603353333334

has a quality training program that

NOTE Confidence: 0.783603353333334

is 6 months and has three didactic

NOTE Confidence: 0.783603353333334

sessions and a very aggressive

NOTE Confidence: 0.783603353333334

curriculum every two weeks around

NOTE Confidence: 0.783603353333334

process mapping and barrier analysis

NOTE Confidence: 0.783603353333334

and ultimately multiple PDS a cycles.

NOTE Confidence: 0.783603353333334

In this case, we had a team from every care center at the time in 2000.

NOTE Confidence: 0.783603353333334

17 and we did it again,

NOTE Confidence: 0.783603353333334

2018 which were interdisciplinary team.

NOTE Confidence: 0.783603353333334

So we had doctors partnering

NOTE Confidence: 0.783603353333334

with nurses or nutrition,

NOTE Confidence: 0.783603353333334

or and in one case in MA Pharmacy

NOTE Confidence: 0.783603353333334

to conduct quality improvement

NOTE Confidence: 0.783603353333334

projects and all of those groups were
able to complete at least one PDS,
a cycle over two years or each year,
each year getting through.
Ipedia say cycle and this work ultimately resulted in nine story in five national presentations,
Jane Kanowitz lead in water Ferd in 2018 is actually the care center quality goal for 2021.
I think many of the participants in these projects were really energized by the teams and the and what they learned around quality improvement.
And one question was how do we sustain that gain? You know, I think that it’s important to be able to use those tools in QI to better care and recognize opportunities to reuse them to face challenges and. And this is actually what we’re doing now in the ambulatory transformation work group we have. A number of groups that are really using the same QI tools and change tools in lockstep. Action across multiple teams to respond to the pandemic and work towards transformation of care,
whether it’s relocation of sites or rapid uptake of Tele health. Or you know, developing and disseminating best practices. I think that this is the same process as the ASCO Smiler pilot but now applied to the. Immediate. Covid pandemic. Now that we’re in, so you. The work these groups are doing over the coming months, and I think it’s been really exciting. So now I’m going to turn to clinical
research, and as I mentioned before, we have about 25% of our YCC therapeutic enrollments from the care centers. This is also a process that needed to be built and hardwired. This is back in 2012. We had three cooperative group trials open and we had to figure out how to do ESO. Peas, around drug shipment and lab processing and training the staff. The docs to do trials where they hadn’t done that before and as well as the Pisa trials to make sure that they were comfortable and had oversight of the process. Overtime we developed a monthly clinical
NOTE Confidence: 0.8512973
00:17:46.406 --> 00:17:48.931 research working group that has research
NOTE Confidence: 0.8512973
00:17:48.931 --> 00:17:51.169 champions from each site that meet
NOTE Confidence: 0.8512973
00:17:51.169 --> 00:17:53.348 monthly and vote on their portfolio.
NOTE Confidence: 0.8512973
00:17:53.350 --> 00:17:55.305 The disease team leaders come
NOTE Confidence: 0.8512973
00:17:55.305 --> 00:17:57.260 to those meetings and present
NOTE Confidence: 0.8512973
00:17:57.332 --> 00:17:59.387 their portfolio and new trials,
NOTE Confidence: 0.8512973
00:17:59.390 --> 00:18:03.358 and I think that this process is really.
NOTE Confidence: 0.8512973
00:18:03.360 --> 00:18:07.000 Grown obviously here in the next slide you
NOTE Confidence: 0.8512973
00:18:07.000 --> 00:18:10.842 can see that the accrual per the yearly
NOTE Confidence: 0.8512973
00:18:10.842 --> 00:18:14.469 accrual by sight and the highest sites.
NOTE Confidence: 0.8512973
00:18:14.470 --> 00:18:16.398 Saint Francis Northaven Trumbull,
NOTE Confidence: 0.8512973
NOTE Confidence: 0.8512973
00:18:16.880 --> 00:18:21.000 I think one of the things we’ve learned
NOTE Confidence: 0.8512973
00:18:21.000 --> 00:18:25.368 is that they need to have or they have
NOTE Confidence: 0.8512973
00:18:25.368 --> 00:18:29.827 a ACRSL lab which allows all protocols.
NOTE Confidence: 0.8512973
No, let’s which.

Means that there’s no limit on protocols that they can open due to lab processing times.

Certainly the 2020 accrual was affected by Covid Inc.

In our in 2018 we had 224 this year.

If you take out the months that we had covid and we had very good accrual prior and have really picked up now we would have certainly hit 200 between 200 and 220.

If not for the covid, so we activated a new site this year in Westerly.

They are now treating some of the patients who were started in Waterford and.
Now, in Rhode Island and you can see it actually in Waterford, which opened three years ago. There’s been really great accrual growth there as well, so I think that there’s really a lot of potential here if the next slide shows you the yearly accrual by the DART. So which kinds of trials are having the best accrual breast in GI have are certainly at the top. The long and heme are not far behind as well as T rad ngu that are increasing.
so I think again, there’s a tremendous potential here in the care centers, and as we have all. Our docs aligning with disease teams. I think this will just increase in the future. Um, this is the. Kurt Sabbath, who is one of our care center docs who helped to lead research initially. Now now hand it over to Neil Fishback. Kurt always said that he felt that clinical research is synonymous with quality care because there’s so many eyes on the patient. There’s so much emphasis on important communication,
shared decision making, and that really epitomizes quality. In our case, the vision had always been to provide research as access to our patients close at home, and I think that even more than the numbers per site, this is what really strikes me. Every year we have somewhere around 85 to 87% of our physicians who put at least one patient onto trial. So I think we really changed that culture. We’ve had a research summit every year, usually around 80 people.
That includes our care center docs or DART team members or CTO staff get prizes. We have about 13 care center physicians who served as PII on trials and right now we have 83 trials open in nine disease types. About 50% cooperative group 43% industry sponsored in 10% IIT’s. Here you see that our care center accruals form about 60% of our cooperative group trials, so that’s really important. This is one of my trials. This is a national trial that we have opened in about guess 900 sites across the US in Canada,
but in our care centers as well.

I'm National Co chair with has poor guy and it’s a first line PDL.

positive trial for non squamous non small cell and I think that this is an important trial because it either randomizes you two arms which start with immunotherapy and then if you progress you going to chemo. Or you add chemo to the pen bro Appan progression.

That’s an important question.

This is the the chemo IO control arm and this trial I think will tell us. Very important.
Give us information on sequencing of chemo.

If you can spare it upfront.

If you add it to the immunotherapy if that will help.

And ultimately because we are collecting tissue from this trial, we're going to be looking for prognostic signatures for Pember Lizum app and predictive signatures for addition of chemo to immunotherapy.

This is also an IIT of mine in small cell which with the biopsy upfront and then on treatment at week four after after treatment with EPI.

Nevo and this trial has 17 patients who started on it with 10 paired pre
and on treatment biopsies and this trial is open in our network and we’ve had 11 accruals from our network and I think that’s important because. Talking to colleagues of bars across the country who have networks and who are trying to do. Clinical trials they’ve really relied on industry sponsored the cooperative, and very few actually have have diploid Iits in in the network. So this this just shows you a number of the items that we have and you can see that here’s 12 accruals or 30% of Doctor Lacey’s modified folfirinox,
and in this case Doctor Kim Johans.

That’s 88% of her seven out of eight accruals for her and you know, for Doctor Nipper, it’s a 4040% of her accruals for her IIT as well so. I think this is really important research and support of our investigators at Yale.

So what is the future hold? Among other things, I think there are certainly opportunities for building multidisciplinary care to enhance our Smiler signature of care in the network and to build on our current Med. Onken Hemang Craddock networks to
We are developing formalized multi-D clinics and that some of the work that I’m going to carry on in my integration role and strengthen our alignment with disease teams. And certainly our disease centers to provide service excellence and positive patient outcomes. This is my favorite slide. This is what I think is the most exciting piece of all of this but really I think the faculty that have
joined his care center is one of them. Francesca is going to give a grand rounds right after me. They all master clinicians. They have devoted their really the clinical arm of a female cancer and smilow cancer hospital within the community and all have joined with the disease teams to do you know any number of really exciting things. BPI on trials do collaborative research projects, develop Qi projects, help teaching our house staff and anymore so it has really been my honor to represent these folks and
to work with them. And I can’t. I can’t emphasize enough that it’s really been a work collaborative effort of many, many, many hands to build the network, including Charlie and Lori. Kevin Billingsley, Aleesa Chomsky, Monica Fradkin, Connie Engelking, Roy Herbst, Stephanie Pauline, have invested so forth. Jeremy Court Manske will take over as the Chief Network Officer for Medical Services and head up the medication department. And I will be focused on really developing...
the service lines and integration

So thank you for the time and

Think I. I’m done so I’d love to

answer any questions if if there

were any. Thanks and that was wonderful.

And congratulations on a very well

deserved promotion and we see why.

So we have a few questions.

Please put them in the chat.

Melinda Erling comments were lucky to have

this infrastructure with the care centers.

I know a lot of non therapeutic

interventional research being done in the

care centers related to tobacco control,

nutrition, exercise and obesity,
so I will just follow up and say no.

Make it secure.

Diverse state as you go up and down the 95 corridor.

How are we trying to help increase the diversity of our patient population at our care centers to get more patients from diverse backgrounds on trials?

That’s certainly something that we can now do that we have so much integration within the state.

Great great question.

I’m just going to go back and share my screen again so you can see who’s doing a lot of this work.
You know, Melinda, that’s a planted question because we just put together a narrow one to study the lean interventions in the care centers, and I think that’s going to be really exciting groups if you look here. This is Andrea Silver and she’s done a lot of work actually devoted, one of her passions is in increasing under increasing representation of of clinical trials and addressing disparities of care, and she’s done a number of things, including that grant the initial grant called own it.
which was oncology works
with New Haven getting.
Community representatives to
weigh in on what kind of research
is done in the and building those relationships.
I think that you know our cancer Grant has been incredibly.
You know there's been a big focus on trying to increase representation of of folks in our clinical trials, and that certainly is a focus for us.
Right, that’s that wonderful one.
More question.
And then we’ll move on.
Someone comments. It’s amazing how you built these tumor boards, even before anyone knew what zoom was. So now that we have zoom in, everyone can zoom from their phone from their walk. Can we use this technology to further integrate? You know multi modality, care subspecialty care with you showed us 55 or so doctors around the state. Are we using these tools of Tele Health to do even better now to integrate our care? Yeah, I mean, I think that with covid we’ve really we toggled up
to over 50% of usage and adoption

And and I think that we have.

You know initiatives on next day

You can utilize Tele health for,

and certainly within our multi D clinics

were thinking about doing that as well.

I think there’s a lot of innovation and

you know I’ll I’ll mention you know again,

Melinda’s talked.

I didn’t talk about the non therapeutics,

but we certainly have used the care

centers as places to participate

with the smoking cessation.
Joe Biden Moon shot initiative.

As well as.

You know collect samples for Stephanie, Aliens, NDS,

registry and attempts to understand the science behind that.

to understand the science behind that.

So I think there’s just you know no end to what you can do with the resources and the team that we have.

Great well thanks Anne.

Wonderful talking again,

congratulations.

So we have a second speaker,

it’s Doctor Francisca Montinari,

Doctor Martner.

Doctor Martin Ari is an assistant.
NOTE Confidence: 0.83359927
00:30:27.740 --> 00:30:29.971 professor of clinical medicine in the
NOTE Confidence: 0.83359927
00:30:29.971 --> 00:30:32.167 hematology section and cares for patients
NOTE Confidence: 0.83359927
00:30:32.167 --> 00:30:34.179 with hematologic malignancies at our
NOTE Confidence: 0.83359927
00:30:34.179 --> 00:30:36.219 southernmost care center in Greenwich.
NOTE Confidence: 0.83359927
00:30:36.220 --> 00:30:38.120 Documentary recently joined Yell from
NOTE Confidence: 0.83359927
00:30:38.120 --> 00:30:40.020 the New York Presbyterian Hospital,
NOTE Confidence: 0.83359927
00:30:40.020 --> 00:30:41.540 Columbia University Medical Center,
NOTE Confidence: 0.83359927
00:30:41.540 --> 00:30:43.440 College of Physicians and Surgeons,
NOTE Confidence: 0.83359927
00:30:43.440 --> 00:30:45.485 which she was assistant Professor
NOTE Confidence: 0.83359927
00:30:45.485 --> 00:30:47.121 of medicine and Experimental
NOTE Confidence: 0.83359927
00:30:47.121 --> 00:30:48.884 Therapies Therapeutics in the
NOTE Confidence: 0.83359927
00:30:48.884 --> 00:30:50.610 Center for Lymphoid Malignancies.
NOTE Confidence: 0.83359927
00:30:50.610 --> 00:30:52.542 Doctor Montanari received her medical degree
NOTE Confidence: 0.83359927
00:30:52.542 --> 00:30:54.610 from the University of Pavia in Italy,
NOTE Confidence: 0.83359927
00:30:54.610 --> 00:30:56.150 which she graduated Magna ***
NOTE Confidence: 0.83359927
laude and completed both residency and Fellowship and New York University School of Medicine, but she was awarded the Fellow of the Year Teaching Award. She served on the Institutional Review Board Committee and as director of the Institutional Lymphoma Tumor Board at Columbia University, and he is part of the steering committee of the Lymphoma Research Foundation, and Lymphoma rounds were so lucky to have been able to recruit Francisca recently, and she’s going to talk to us now. About post transplant
00:31:23.364 --> 00:31:25.488 lymphoproliferative disorders franceska.
00:31:27.850 --> 00:31:30.310 Thank you for the introduction,
00:31:30.310 --> 00:31:32.770 so I’ll share my screen.

00:31:37.680 --> 00:31:40.707 OK, so good afternoon everybody.
00:31:40.707 --> 00:31:44.421 I will review today was transparently
00:31:44.421 --> 00:31:45.930 proliferative disorders.
00:31:45.930 --> 00:31:49.759 So here’s my disclosures. So we are.
00:31:49.760 --> 00:31:53.491 We will review together and how PLD
00:31:53.491 --> 00:31:56.308 are classified according to the
00:31:56.308 --> 00:31:58.560 most recent WHL classification,
00:31:58.560 --> 00:32:01.310 the Epidemiology, the risk factors
00:32:01.310 --> 00:32:04.060 at timing of onset prognosis,
00:32:04.060 --> 00:32:06.260 and therapeutic options including
00:32:06.260 --> 00:32:08.460 a current treatment paradigms,
00:32:08.460 --> 00:32:11.220 ongoing clinical trials and

50
future directions.

So let’s start with the classification under the revised 2016 W 2 classification post.

Transplant lymphoproliferative disorder are classified under the immune deficiency.

Associated lymphoproliferative disorders, along with lymphoproliferative diseases associated with primary immune disorder, HIV infection and other iatrogenic immunodeficiency.

Um, by definition they are any lymphoid or plasmacytic proliferation that develop as a consequence of immuno suppression.

In order sequence of a solid organ or stem cell allograft, it is considered officiality.
And based on the new classification, the device classification detailed include nondestructive PTL. These further subclassified into plasmacytic hyperplasia. Infectious modern closes like and Florida follicular pleasure which is a new entity under the new revision, polymorphic deity monomorphic TLD that comes into the B cell neoplasm and T cell nail Plaza and the classical Hodgkin lymphoma. So purely nondestructive, these diseases are classified based on the pathology major.
findings and undersell prevalence.

There is usually preservation of the architecture, and these are polyclonal B cell proliferation by immunophenotyping genetic studies.

There typically be positive the responsive to MENA suppression reduction in most of the cases and they are usually seen in kids. So in the pediatric population. So we do see on the bottom an example of plasmacytic hyperplasia with the preservation of the architecture of the lymph node and infiltrates of abundant plasma cells. Peter D.
NOTE Confidence: 0.7702043
00:34:04.282 --> 00:34:07.018 Polymorphic this is an entity that
NOTE Confidence: 0.7702043
00:34:07.018 --> 00:34:09.686 is characterized by either a genius
NOTE Confidence: 0.7702043
00:34:09.686 --> 00:34:11.776 mix of immunoblastic plasma cell
NOTE Confidence: 0.7702043
00:34:11.776 --> 00:34:14.334 and different size. The lymphocytes.
NOTE Confidence: 0.7702043
00:34:14.334 --> 00:34:16.619 The architectural is the architecture
NOTE Confidence: 0.7702043
00:34:16.619 --> 00:34:17.990 is usually faced.
NOTE Confidence: 0.7702043
00:34:17.990 --> 00:34:20.205 These are mostly polyclonal but
NOTE Confidence: 0.7702043
00:34:20.205 --> 00:34:22.964 presence of monoclonal B cell have
NOTE Confidence: 0.7702043
00:34:22.964 --> 00:34:25.289 been described and detected by
NOTE Confidence: 0.7702043
00:34:25.289 --> 00:34:27.590 immuno phenotype and genetic tool.
NOTE Confidence: 0.7702043
00:34:27.590 --> 00:34:32.620 There mostly EBV positive and
NOTE Confidence: 0.7702043
00:34:32.620 --> 00:34:34.129 Six somatic hypermutation.
NOTE Confidence: 0.7702043
00:34:34.129 --> 00:34:36.644 So here’s an example of
NOTE Confidence: 0.7702043
00:34:36.644 --> 00:34:38.528 architectural effacement on the left,
NOTE Confidence: 0.7702043
with the associated to a large area
NOTE Confidence: 0.7702043

of necrosis and on the right variable
NOTE Confidence: 0.7702043

size and shape lymphoid infiltrate.
NOTE Confidence: 0.80955

Monomorphic PTSD, those are the one
NOTE Confidence: 0.80955

that do fulfill the criteria for non
NOTE Confidence: 0.80955

Hodgkin lymphoma or plasma cell neoplasm,
NOTE Confidence: 0.80955

small B cell lymphoma are not considered
NOTE Confidence: 0.80955

at not the designated as PTLT,
NOTE Confidence: 0.80955

with the exception of the beaded positive
NOTE Confidence: 0.80955

extranodal marginal zone lymphoma that
NOTE Confidence: 0.80955

usually arise in the cutaneous or
NOTE Confidence: 0.80955

subcutaneous tissue and this is because
NOTE Confidence: 0.80955

their standardized incidence ratio
NOTE Confidence: 0.80955

is not different than in the regular
NOTE Confidence: 0.80955

population and they’re not started to happen.
NOTE Confidence: 0.80955

As a consequence of the immune suppression,
00:35:21.770 --> 00:35:24.826 besides those any other kind of non Hodgkin lymphoma is considered uppity ality.

NOTE Confidence: 0.80955

00:35:24.826 --> 00:35:27.330 So the architecture defacement is usually present.

NOTE Confidence: 0.80955

00:35:28.910 --> 00:35:32.095 Immuno, phenotypic and genetic features are typically recapitulating what we do see individual competent counterpart.

NOTE Confidence: 0.80955

00:35:32.025 --> 00:35:34.415 And here I included an example on the left of.

NOTE Confidence: 0.80955

00:35:39.376 --> 00:35:41.600 You should be selling for infiltrating.

NOTE Confidence: 0.80955

00:35:45.010 --> 00:35:47.480 This is a renal allograft biopsy with the showing about this planning T cell gamma,

NOTE Confidence: 0.80955

00:35:52.255 --> 00:35:56.455 Delta,
T cell lymphoma with the characteristic infiltration of the small blood vessels. Finally, classical Hodgkin lymphoma has also been associated and described in the setting of post transplant and is considered to be APTLD. It fulfills the criteria for the high school informing that we do see and immunocompetent population, but is typically mixed cellularity. It’s always EBV positive and we do see that predominantly in the renal transplant recipients. Therapies treated like the Hodgkin lymphoma and immunocompetent counterpart.
and here an example of a release time. Excel on the bottom surrounded by an inflammatory background of lymphocytes and using fields. And this is our typical greatest number Excel with the city 20 CD 30 positive ITI. So very very Inter genius group of diseases. And so how? How frequently are our diesel informers? So we do about 40,000 transplant every year in the United States and period is the second most common malignancy in this patient population behind non Melanoma skin cancer. So it accounts for 21% of all the
cancers in recipients of solid organ transplant as compared to only four to 5% of the cancers and immuno competent population. The incidence has increased over the past two decades and this is for a variety of reasons. The increased age at the older age of the Gilded Age of and owner and recipients new immunosuppressive treatment. The introduction of the haploidentical stem cell transplant and improved awareness of the disease and diagnostic schools. So after a solid organ transplant, the risk of developing a PLD varies for over 20% two point,
8% depending on the organ transplanted
multi visceral intestinal being associated with a higher risk followed by lung,
heart, liver, pancreas and kidney being the carrying the lower risk for multiple attic stem cell transplant.
The risks varies based on the HLA degree of the HLA matching. And the need for T cell depletion. So it is a highest for upload denticle without this addition 20% and it goes down to 3% in recipients of matched related dollar hematopoetic stem.
cell transplant. So what do we know

in terms of risk factors besides

the type of the transplant of the

transplanted organ or the type of

allogeneic stem cell transplant?

For recipients of solid organ transplant,

it is an established risk factor.

The degree of Mr.

EBV mismatch at the time of transplantation

with the recipients being a big

negative and the donor EBV positive.

Also, the intensity of the induction,

immunosuppression,

treatment and duration of

maintenance therapy,

including increased the need of
treatment due to graft rejection episodes.

There is a strong evidence associated with the use of certain immunosuppressive drug.

And in contact with others that are less associated and weak, evidence of risk is associated with infectious diseases and non EBV infection for instance, and other characteristics, genetic characteristics or underlying comorbidities of the host. For hematopoietic stem cell transplant recipient, age seems to be the biggest risk.
factor for development of these diseases and the conditioning.

So in terms of timing, typically PTSD arrives early in the setting of hematopoetic stem. The transplant and leader in the setting of a solid organ transplant, but it’s not really that predictable. We considered an early onset if the PTSD arise in the first year after the transplant and the late onset, if it arises a year later. Starting one year after the transplant and.
early onset to an acute EBV infection or a reactivation of the virus in the setting of a reduction of the MTV cytotoxic T cell lymphocytes, usually early PTLDREB positive, and frequently there is the allograft is involved. In the late onset there have been many hypothesis so hidden around the infection with the baby, then resolved and lymphoma keeps developing other viruses besides BV has been hypothesized as playing a role such as CMV, a persistent antigenic stimulation.
done by the allograft and lymphocyte deregulation in the setting of a chronic immuno suppressed state. These are usually. More likely, extra node with Extranodal involvement, not necessarily involving the graft and the monomorphic subtype is the most common. So what do we know about the prognosis of this disease that are regarding prognosis are mostly from single institution retrospective analysis and during my time at Columbia University I work on setting up a tumor bank for this disease with pathological
specimen link to clinical information, and this is what we have learned from the analysis of 120 patients. This is the largest series published so far on this specific disease. Interestingly, most of the clinical features that we think might predict an outcome might have an impact on the overall survival. Did not correlate with overall survival in our patient population, including the subtype of the PTSD, the decade of diagnosis prior or after the introduction of their attack.
Some organ do kind of organ transplanted
NOTE Confidence: 0.8300465
DV status, graft involvement,
NOTE Confidence: 0.8300465
and extranodal involvement
NOTE Confidence: 0.8300465
or stage of diagnosis.
NOTE Confidence: 0.8300465
So using a recursive partitioning model,
NOTE Confidence: 0.8300465
we separated patient.
NOTE Confidence: 0.8300465
Recursively,
NOTE Confidence: 0.8300465
at each step into two distinct
NOTE Confidence: 0.8300465
groups based on the variables that
NOTE Confidence: 0.8300465
provided the maximal separation based
NOTE Confidence: 0.8300465
on survival and using this model,
NOTE Confidence: 0.8300465
we were able to identify based on
NOTE Confidence: 0.8300465
age CD 20 expression and equal status
NOTE Confidence: 0.8300465
for groups that were well separated
NOTE Confidence: 0.8300465
in terms of roll survival and with
NOTE Confidence: 0.8300465
an even number of patient and in the
NOTE Confidence: 0.8300465
00:42:50.005 --> 00:42:52.513 lowest group we can see that the
NOTE Confidence: 0.8300465
00:42:52.513 --> 00:42:55.087 medium overall survival was not reached.
NOTE Confidence: 0.8300465
00:42:55.090 --> 00:42:57.045 Those were essentially mostly pediatric
NOTE Confidence: 0.8300465
00:42:57.045 --> 00:42:59.440 patients with a good performance status.
NOTE Confidence: 0.8300465
00:42:59.440 --> 00:43:01.680 What is in the very high risk group
NOTE Confidence: 0.8300465
00:43:01.680 --> 00:43:03.969 elderly with a foot Burma status and
NOTE Confidence: 0.8300465
00:43:03.969 --> 00:43:05.634 essentially all patients with the
NOTE Confidence: 0.8097424
00:43:05.695 --> 00:43:07.115 CD? Twenty negative disease,
NOTE Confidence: 0.8097424
00:43:07.115 --> 00:43:09.190 the median overall survival was
NOTE Confidence: 0.8097424
00:43:09.190 --> 00:43:11.490 as short as one point 3 months.
NOTE Confidence: 0.8097424
00:43:11.490 --> 00:43:14.190 So what else we have learned,
NOTE Confidence: 0.8097424
00:43:14.190 --> 00:43:16.702 we know very well that T cell lymphoma
NOTE Confidence: 0.8097424
00:43:16.702 --> 00:43:20.457 have a much worse prognosis than Bissell
NOTE Confidence: 0.8097424
00:43:20.457 --> 00:43:22.290 informal immunocompetent population.
NOTE Confidence: 0.8097424
00:43:22.290 --> 00:43:24.696 But what are?
NOTE Confidence: 0.8097424
What is the behavior of this LPT?

LD is not well, no, not due to the rarity of these diseases.

So we did analyze in our series of pulling over monomorphic PTSD and the differences between B cells and T cell TLD.

And we do see that they sort of recapitulate what we do see and immuno competent counterpart in terms of prognosis with the median overall survival being very low for the T cell and compared to the diesel in monomorphic PLD. Also, we did observe that the time of the median time to answer it was much longer for T cell nine years.
00:44:02.421 --> 00:44:04.899 compared to three years for the B cell type and all T cell period in our series were leaving negative.

00:44:10.690 --> 00:44:13.539 Another thing that we have also learned is that importance of more marrow of staging and the incidents of more involvement in the in PLD.

00:44:22.520 --> 00:44:26.056 It is very common in our series of patients at 23% of monomorphic PLD had bone marrow involvement compared in the T cell subtypes 50%.

00:44:35.030 --> 00:44:35.514 Also, polymorphic exhibited our very high bone marrow involvement.

00:44:39.390 --> 00:44:42.393 15.7 All the cases of polymorphic with
where bone marrow involvement was detected. This resulted in up stage of the disease. And ever involvement was associated with poorer outcome. So we did compare the incidence of the involvement of Lombardy Boomer the involvement of monomorphic PTSD compared to the normal diffuse large B cell to the normal diffuse large B cell lymphoma and HIV diffuse large B cell lymphoma patients diagnosed during the same time frame at our institution and we do see here that monomorphic, detailed involvement compared to the HIV positive diffuse large B cell involvement and this is suggest that immuno compromised.
NOTE Confidence: 0.8097424
00:45:21.610 --> 00:45:24.006 State regardless of videology
NOTE Confidence: 0.8097424
00:45:24.006 --> 00:45:27.001 vial associated or higher trajanic
NOTE Confidence: 0.8097424
00:45:27.001 --> 00:45:30.516 maybe is a major risk factor for
NOTE Confidence: 0.8097424
00:45:30.516 --> 00:45:32.400 dissemination to the marrow.
NOTE Confidence: 0.8097424
00:45:32.400 --> 00:45:33.090 Finally,
NOTE Confidence: 0.8097424
00:45:33.090 --> 00:45:35.850 this is a loser.
NOTE Confidence: 0.8097424
00:45:35.850 --> 00:45:37.957 Analyze last year actually two years ago
NOTE Confidence: 0.8097424
00:45:37.957 --> 00:45:40.346 and this was presented at ASH in 2019.
NOTE Confidence: 0.8097424
00:45:40.350 --> 00:45:42.432 We did analyze the data regarding
NOTE Confidence: 0.8097424
00:45:42.432 --> 00:45:44.954 the cell of origin and the impact
NOTE Confidence: 0.8097424
00:45:44.954 --> 00:45:47.078 of treatment on the outcome of
diffuse large B cell lymphoma.
NOTE Confidence: 0.8097424
00:45:48.970 --> 00:45:51.455 So these type and in our series
NOTE Confidence: 0.8097424
00:45:51.455 --> 00:45:53.458 non germinal center was more
NOTE Confidence: 0.8097424
00:45:53.458 --> 00:45:55.178 common than germinal center.
NOTE Confidence: 0.8097424
I just want to highlight here that as previously reported and non germinal center PTSD is usually be positive versus germinal center is usually it will be negative clinical characteristic, organ transplant, immunosuppressive, treatment time of onset was not different in these two subtypes and there is a trend suggesting a better outcome, a better PFS and OS in patients with. Germinal standard compared to non germinal center mirroring the outcome in Indiana competent population and RE broker did not improve overall survival or progression.
Free survival were compared to R chop but in not resulted also either in an increase. Toxicity in our series was extremely low and only one patient died in each treatment group. So the current challenges for PT LDR this is an uncommon disease, as we saw there is a bigot originality in the type of PTSD that is it originality in the patient population, in the allograft or multiply attic stem cell transplant, and immunosuppressive treatment they receive that is a high mortality rate.
that is associated with the chemotherapy and this is usually in length to the increased risk of infection that we do see in these patients. Population and unique to this patient population is the risk of graft failure. So currently general principle of treatment include immunosuppression reduction. I just want to mention that the only perspective trial that utilize immunosuppression reduction as part of a sequential treatment for this disease on a very large sample of you know on a very large number of patients 160 patient showed a 40% incidence of acute graft reaction.
So typical in the adult population immunosuppression reduction is utilized at the same time. Other interventions such as rituximab are or combination. Chemotherapy surgery, radiation therapy. Unlikely. What we do see in Hodgkin and an article in former is a well established the treatment for stage one disease, PTSD and in the relapsed and refractory setting. There are adoptive immunotherapy utilizing EBV specific cytotoxic T cells and high dose chemotherapy.
00:48:21.653 --> 00:48:24.845 with a toddler stem cell transplant
NOTE Confidence: 0.7767812
00:48:24.935 --> 00:48:26.907 or both being explored.
NOTE Confidence: 0.7767812
00:48:26.910 --> 00:48:30.886 So there are only few prospective trials,
NOTE Confidence: 0.7767812
00:48:30.890 --> 00:48:33.170 primarily on polymorphic and
NOTE Confidence: 0.7767812
00:48:33.170 --> 00:48:36.622 monomorphic beissel. PTSD and hold the.
NOTE Confidence: 0.7767812
00:48:36.622 --> 00:48:38.934 Stop for trials here.
NOTE Confidence: 0.7767812
00:48:38.940 --> 00:48:39.310 Um,
NOTE Confidence: 0.7767812
00:48:39.310 --> 00:48:41.900 use their attack some as a single
NOTE Confidence: 0.7767812
00:48:41.900 --> 00:48:45.082 agent with a very high with a good
NOTE Confidence: 0.7767812
00:48:45.082 --> 00:48:47.589 overall response rate under an CR rate,
NOTE Confidence: 0.7767812
00:48:47.590 --> 00:48:49.290 but not exciting overall survival
NOTE Confidence: 0.7767812
00:48:49.290 --> 00:48:51.792 due to early relapse is the best
NOTE Confidence: 0.7767812
00:48:51.792 --> 00:48:53.642 results that have been achieved
NOTE Confidence: 0.7767812
00:48:53.642 --> 00:48:55.622 that utilizing either a sequential
NOTE Confidence: 0.7767812
00:48:55.622 --> 00:48:57.647 treatment or a risk stratifies
NOTE Confidence: 0.7767812
00:48:57.647 --> 00:48:59.830 sequential treatment and this is the
PTL D1 trials that is the largest phase two trial ever conducted in this patient population and reported by the German. Study group so will review the results of the PD L D1. The risk stratified sequential treatment. This was published in JCO in 2017. Patients were with that newly diagnosis of PTSD received an induction treatment with rituximab and then based on their response they received the consolidation with rituximab alone or they were escalated to our CHOP. and 152 patients were enrolled again.
This is the largest study in this disease that has ever been conducted and we do still at 1/4 of them after the initial induction with maximum achieved a CR and these were the patient that did not receive. Um, instead of toxic treatment, the overall response rate was a dieta CR rate 70%. Army generation of response was not reached and let me down. Overall survival was 6.6 years treatment related mortality in this study was 8% which is the lowest reported in this patient population and
This is an attribute.

This has been attributed to the fact that a quarter of the patients were spared cytotoxic chemotherapy.

So, what's new in PID?

Recently over the past five years, it has been more and more recognized than PTSD tend to be.

CD30 positive. So, this is a study by vision. Others showed that out of 108 patients with PTSD diagnosed between 1994 and 2011, it was 85% of this patient expresses CD30 including 81% of the diffuse large B cell lymphoma.

This is very particular to...
00:50:52.030 --> 00:50:54.470 the query after the PTLD.
NOTE Confidence: 0.82772666
00:50:54.470 --> 00:50:55.990 Because in the immunocompetent,
NOTE Confidence: 0.82772666
00:50:55.990 --> 00:50:58.270 if you started selling for my
NOTE Confidence: 0.82772666
00:50:58.338 --> 00:51:00.243 usually city third expression is
NOTE Confidence: 0.82772666
00:51:00.243 --> 00:51:02.919 probably less than 20% and not only
NOTE Confidence: 0.82772666
00:51:02.919 --> 00:51:05.217 demonstrated a high CD 30 expression.
NOTE Confidence: 0.82772666
00:51:05.220 --> 00:51:07.776 They also demonstrated that it was
NOTE Confidence: 0.82772666
00:51:07.776 --> 00:51:10.735 associated with a better outcome. So.
NOTE Confidence: 0.82772666
00:51:10.735 --> 00:51:13.760 Twice this interesting or important,
NOTE Confidence: 0.82772666
00:51:13.760 --> 00:51:16.770 we now have a drug that targets
NOTE Confidence: 0.82772666
00:51:16.770 --> 00:51:19.220 specifically city 30 brentuximab windowed
NOTE Confidence: 0.82772666
00:51:19.220 --> 00:51:22.442 and is an antibody drug conjugate
NOTE Confidence: 0.82772666
00:51:22.442 --> 00:51:25.509 that binds to the city 30 and one.
NOTE Confidence: 0.82772666
00:51:25.510 --> 00:51:27.410 Since the internalised release,
NOTE Confidence: 0.82772666
00:51:27.410 --> 00:51:29.785 monumental restarting E which is
NOTE Confidence: 0.82772666
00:51:29.785 --> 00:51:31.573 microtubule disrupting agent which
NOTE Confidence: 0.82772666
00:51:31.573 --> 00:51:33.643 end up like causing apoptosis.
NOTE Confidence: 0.82772666
00:51:33.650 --> 00:51:35.034 As we all know,
NOTE Confidence: 0.82772666
00:51:35.034 --> 00:51:37.110 grant access method Odin is now
NOTE Confidence: 0.82772666
00:51:37.193 --> 00:51:40.063 approved with various indication in
NOTE Confidence: 0.82772666
00:51:40.063 --> 00:51:42.359 Hodgkin lymphoma anaplastic large.
NOTE Confidence: 0.82772666
00:51:42.360 --> 00:51:44.940 Calling from.
NOTE Confidence: 0.82772666
00:51:44.940 --> 00:51:46.293 So in 2019,
NOTE Confidence: 0.82772666
00:51:46.293 --> 00:51:48.097 at the ASH meeting,
NOTE Confidence: 0.82772666
00:51:48.100 --> 00:51:50.760 the results of these Phase 1 two
NOTE Confidence: 0.82772666
00:51:50.760 --> 00:51:53.372 trial of Brentuximab in Jordan plus
NOTE Confidence: 0.82772666
00:51:53.372 --> 00:51:55.702 rituximab as frontline treatment for
NOTE Confidence: 0.82772666
00:51:55.702 --> 00:51:57.700 patients with immuno suppression
NOTE Confidence: 0.82772666
00:51:57.700 --> 00:52:00.175 associated lymphoma were presented and
NOTE Confidence: 0.82772666
00:52:00.175 --> 00:52:03.920 in this was a very small study.
NOTE Confidence: 0.82772666
00:52:03.920 --> 00:52:07.360 22 patients with previously untreated
NOTE Confidence: 0.82772666
00:52:07.360 --> 00:52:08.736 immunosuppression associated.

NOTE Confidence: 0.82772666

00:52:08.740 --> 00:52:10.156 Little pretty effective disorder,

NOTE Confidence: 0.82772666

00:52:10.156 --> 00:52:11.926 including 1516 patients were PTSD

NOTE Confidence: 0.82772666

00:52:11.926 --> 00:52:13.449 post transplant clipart affective

NOTE Confidence: 0.82772666

00:52:13.449 --> 00:52:14.941 disorder patients who receive

NOTE Confidence: 0.82772666

00:52:14.941 --> 00:52:16.510 an induction were attacks.

NOTE Confidence: 0.82772666

00:52:16.510 --> 00:52:17.611 In other words,

NOTE Confidence: 0.82772666

00:52:17.611 --> 00:52:19.446 given in combination with Brent

NOTE Confidence: 0.82772666

00:52:19.446 --> 00:52:21.708 accidents and Odin and patient worry

NOTE Confidence: 0.82772666

00:52:21.708 --> 00:52:23.910 stage and according to their response,

NOTE Confidence: 0.82772666

00:52:23.910 --> 00:52:25.515 they either received more out

NOTE Confidence: 0.82772666

00:52:25.515 --> 00:52:27.639 attacks immigrant tax map in loading

NOTE Confidence: 0.82772666

00:52:27.639 --> 00:52:29.459 as consolidation and maintenance,

NOTE Confidence: 0.82772666

00:52:29.460 --> 00:52:32.064 or if they had progression of

NOTE Confidence: 0.82772666

00:52:32.064 --> 00:52:34.669 disease were removed from the study.

NOTE Confidence: 0.82772666

00:52:34.670 --> 00:52:35.906 Again, small study,
very short follow-up about encouraging result with a very high overall response rate, and see a rate of 60% so. I'm very excited to announce that we're about to open a phase two trial for this patient population here in the Yale network, and this is going to be a trial in collaboration with them. Are you clinic and with UVI so is just trial where patients with post transplant lymphoproliferative disorder CD 20 and CD 30 positive which essentially is the vast
00:53:11.530 --> 00:53:13.590 majority of PTSD will receive
NOTE Confidence: 0.82772666
00:53:13.590 --> 00:53:15.238 an induction treatment with.
NOTE Confidence: 0.82772666
00:53:15.240 --> 00:53:17.155 Maximum burn toxin overload and
NOTE Confidence: 0.82772666
00:53:17.155 --> 00:53:19.551 and then based on the response
NOTE Confidence: 0.82772666
00:53:19.551 --> 00:53:21.969 at a pet city after induction,
NOTE Confidence: 0.82772666
00:53:21.970 --> 00:53:24.469 they will receive more of the same
NOTE Confidence: 0.82772666
00:53:24.469 --> 00:53:27.126 treatment so and there will be spared
NOTE Confidence: 0.82772666
00:53:27.126 --> 00:53:29.394 of cytotoxic treatment or will be
NOTE Confidence: 0.82772666
00:53:29.468 --> 00:53:31.476 escalated to rituximab, Pentax,
NOTE Confidence: 0.82772666
00:53:31.476 --> 00:53:33.060 Melvin Gordon, and Bendamustine,
NOTE Confidence: 0.82772666
00:53:33.060 --> 00:53:35.436 for a total of 6 cycles.
NOTE Confidence: 0.82772666
00:53:35.440 --> 00:53:37.420 Primary objective of the study.
NOTE Confidence: 0.82772666
00:53:37.420 --> 00:53:39.280 Our overall response rate complete
NOTE Confidence: 0.82772666
00:53:39.280 --> 00:53:42.050 and partial at the end of the
NOTE Confidence: 0.82772666
00:53:42.050 --> 00:53:44.150 treatment and PFS secondary objective.
NOTE Confidence: 0.82772666
00:53:44.150 --> 00:53:45.419 Intend to explore.
Additional responsibilities at the end of the induction phase, which include the grant axiom of windowed in on top of rituximab, duration of response and overall survival, and we’re planning to also deep dive into the frequency of infection. Peripheral sensory neuropathy, then rate doesn’t craft of interaction and treatment related mortality. Exploratory studies. Are at the end to identify new biological and genetic markers that might be productive to response resistance.
to this therapeutic combination.

So. Um?

I'm going to leave you with this last slide, future strategies and these are. This is a list of the clinical trials that are currently about to recruit or recruiting for this for post transplant lymphoproliferative disorder.

This top line is the study is our study that I just mentioned and we're about to open here at Yale. This line is the study that follows up the PLD one trial from the German group, whether increasing where they're
integrating the IPI score and the organ transplanted to further risk stratify patients after induction with rituximab and I have substituted rituximab subcu to the regular attacks enough that they used in the PTL D1 trial. Another trial that I would keep an eye on is there tax amount plus a club routine atrial that is not yet recruiting and is going to be done in Cleveland and besides this retrial which address the untreated population in the refractory setting, there are a lot of trials with the adoptive T cell treatment.
And with this and this, is it? So thank you for your attention.

Thank you, that was a wonderful talk and it’s great to see that you have a trial and I guess it’s opening Greninger will be. So very very well linked to the first talk we heard from Ann.

Do you have any questions or comments where we’re just about a time, but we might have time for one or two?

Do you see a lot of this in your practice right now? Currently have one patient which is,
which is a lot considering that I’ve just started two months ago. So we have we typically used to have. Colombia is a big transplant center and we we tend to. We were seeing a lot of these patients, but to say a lot was about 20-30 cases per year. Just to put this in context, so this is a rare disease weapon. As we grow Greenwich as a expert site, you know for these types of diseases you’ll get you’ll draw more and more from Manhattan, and where I’m sure there are.
many post transplant patients,

Francine Flash has a question. She asks any role for checkpoint inhibitors in these EBV driven tumors.

This is a very good question and I think that due to the peculiarity of these patients population, which are recipients of hematopoietic stem cell transplant or solid organ transplant, there is a lot of. We’re very worried about causing it’d have to be action or graft versus host disease, and so I don’t.

I’m not aware of any study utilizing checkpoint inhibitors in this specific patient population.
OK, maybe I see a study in the making, maybe an investigator initiated trial. Well, our Francisco that was great. Thank you so much. Welcome to the group you've. It's great to have you and this will end grand rounds for today. I want to thank Renee and her team for helping get this set up and I hope everyone has a good rest of the day. Will see you soon. Thank you, thanks everyone.