OK, why don’t we get started?

Welcome everyone to Cancer Center grand rounds.

I’m Roy Herbst and I’m broadcasting here with Paula Pike from the North Haven Care Center, which is actually the home of the main campus.

Thoracic oncology right now and today is going to be a very special presentation.

’cause I think there will be something for everyone.

All the way from the clinic to the lab and back, and we’re going to actually have
a relatively large panel where we’re going to hear from some of the members of the thoracic center and get their thoughts. And there’s also some exciting breaking news on lung cancer for anyone who has a nap, they’ve probably seen the articles in the Times and other CNN just in the last hour, so we knew about that. So we’re going to talk about that. So welcome everyone, I’m going to introduce the panel at the end, but I’m going to show a few slides just to get us warmed up.
So I'm really excited to be here and I'm really just here. I'm in the conductor of an amazing orchestra of wonderful people that really make up the program that you're going to hear about today. That's been in existence for some time where we're just going to try to expand it out to even more places with the same expertise, caring quality that we've come to expect. So I'm going to talk about the lung, cancer, clinical care and research program, and I'm going to introduce the Thoracic Disease Center.
Something many of you have heard about in recent days. These are my disclosures.

So we're talking about lung cancer and lung cancer has an amazing burden worldwide, with over 2,000,000 cases worldwide, an 1.76 million deaths.

Still, the number one cause of cancer death, perhaps more breast cancer or prostate cancer, are diagnosed skin cancer.

For screening for lung cancer is still in the US. You can see 135 thousand plus deaths despite all the improvements you're going to hear about today,
most of lung cancer, 84 percent is non small cell. 50% of small cell. The majority of the non small cell is adenocarcinoma and more than half presents already metastatic. And that makes it even more difficult to treat. And of course, tobacco, the single largest preventable cause, leading to 30% of all cancer deaths there. About 20 cancers that you can track back to tobacco, but in those who are non smokers,
especially in lung cancer, you can see the potentially actionable mutations for which we now have drugs either in trial or for the most part as approved agents. What a change from 1520 years ago, and there are even data now for K wrasse targeted drugs will talk a little bit about that for those who have smoked. The adenocarcinoma is about 12% now have a target. Weather or twality for this disease is really improving and you can. You can see that here both
for men and for women.

This is the data from the American Cancer Society and the rate of lung cancer.

The incidence is decreasing by 2.6% a year and the mortality by 4.3% in men and women. One point, 2% incidents and three point 1% mortality. This is the result I would contest of better prevention.

Primary prevention not smoking. Secondary prevention. You know the cat scanning will talk about that, but also some of the therapies. Some of them that had their origins here with science and studies at Yale. Well, here's the history of
the Thoracic Oncology program, and I’m a relative newcomer to some of the group that’s been here.

Look in the bottom left and Lynn Tanui really had the idea for this. Working with Lynn Wilson and my friend and many of yours. The late John Urine, The late John Urine, this is actually ground ham, and so he was a great surgeon, but he was not a thoracic. Only surgery. Did cardio cardiac disease as well. So Lynn got some money and had the idea to recruit US thoracic surgery. Specialist and build a section.
of thoracic surgery.
And of course you recruited Frank.
And that happened.
Then you can.
You can see that the group here.
Then you can see the tip program
that we've come to know and love.
And John to Chomsky.
And a team that can do interventional
techniques along biorepository.
Actually Lens set that up with
And John to Chomsky.
And a team that can do interventional
techniques along biorepository.
Actually Lens set that up with
Frank Susan main.
Now one of the ranking members
of the FDA with Susan was here
working with Bonnie Gould,
Rothberg, David rhyming,
Kurt Shopper: If any of the scientists in the audience need tissue, we have it.

Then I came around 2011, about 10 years ago. Actually, exactly 10 years ago today, we work very hard to even build further, and we develop the yeast spore in lung cancer. The lung nodule screening program is a robust and going strong and here’s a recent retreat.

About two years ago that Dan Buffa organized and you can see the numbers of people that are involved. This is truly a team effort.
And here you can see a bit of the evolution and you know people have aged quite gracefully.

So here is 2004. Now at the very origin Scott I just came to know he’s done an amazing job. He came to work with John.

John passed away in his first month with Scott, took on the Heward, and he’s going to join me in a second. He’s dancing a patient and I’ll tell you about his early work in immunotherapy. Then, of course, here’s the group in 2008, already quite robust.
You know, building this doctor Decker. Then in 2012, this is the referral. First retreat that I helped organize. With Lynn and Frank and this was over there at the up on Prospect St. And then here’s our more recent group. Well, what I really want to talk to you about is multi modality care and how multi modality care makes a difference and that’s why we’re even working harder now to promote the thoracic center. So what you can see is you know there are so many aspects of multi modality care, including screening.
Pulmonologists, radiologists, surgeons, medical oncologists, social workers. Of course, the clinic administration, the wonderful nursing and support staff. It really is a village and we had it all here. I can tell you, having worked at many great hospitals over the years, it’s all here expert care at all sites. Common practice patterns will do even more of that protocols available in all disciplines at all sites, and quality and compassionate care. And we’re just going to do more of that with this new iteration of the thoracic center.
Now thoracic research and I've given grand rounds that my my team have given grand rounds. I just want to introduce that research can be basic. In the lab we have tons of that. Yeah, it’s the best in the world translation or the lab to the clinic. I think that’s the special sauce. Being able to take that back and forth. Of course to the clinic and clinical studies and not to forget outcomes in the community. You know we have proteomics. We have genomics right now. The key is community omics.
00:07:39.740 --> 00:07:41.630 We gotta get out to the community.
NOTE Confidence: 0.84947467
00:07:41.630 --> 00:07:42.980 We live in New Haven.
NOTE Confidence: 0.84947467
00:07:42.980 --> 00:07:45.196 We’ve gotta get out to the New Haven.
NOTE Confidence: 0.84947467
00:07:45.200 --> 00:07:47.750 Car door you’ve gotta get outta
NOTE Confidence: 0.84947467
00:07:47.750 --> 00:07:49.450 to Trumbull to Bridgeport.
NOTE Confidence: 0.84947467
00:07:49.450 --> 00:07:54.034 Up North we have to do all that.
NOTE Confidence: 0.84947467
00:07:54.040 --> 00:07:55.558 So what is the major accomplishments?
NOTE Confidence: 0.84947467
00:07:55.560 --> 00:07:59.054 Again, just a few.
NOTE Confidence: 0.84947467
00:07:59.054 --> 00:08:01.829 Hopefully arrive soon and tell us about this.
NOTE Confidence: 0.84947467
00:08:01.830 --> 00:08:02.574 You know,
NOTE Confidence: 0.84947467
00:08:02.574 --> 00:08:06.070 Yeah I.
NOTE Confidence: 0.84947467
00:08:06.070 --> 00:08:08.566 I heard about immunotherapy
NOTE Confidence: 0.84947467
00:08:08.566 --> 00:08:11.039 happening here with Marios Nolan and
NOTE Confidence: 0.84947467
00:08:11.039 --> 00:08:12.884 Harriet Kluger Scott taking over
the first or second patient ever treated with lung cancer on a PD, L1 and PD1 inhibitor here at yeah. This woman three times refractory to lung cancer, squamous cell disease prognosis here would have been months just saw her couple of months ago. 10 plus years amazing. This is the curve. This is from Scott’s first study, published this. It’s one of the more cited papers last year or two years ago in JCO. Look at the tail of this curve.
Now we of course want to do better,
and for anyone watching this
and you’re thinking.
Of course we have to do better,
but five year overall actual survival comma.
Sure this is 16%.
This is the tale of the curve
simply transformation ull.
We have innovation.
This is an investigator initiated trial.
Very proud of this,
this was a collaboration between
the Melanoma group.
They have a Sport 2 led by Harriet Cougar
Marcus and part of that’s more as well,
but this was a while back.
Sarah Goldberg and Veronica Chang, of course, who’s a neurosurgeon who does the Gamma knife? Here’s a patient with Brain Mets with lung cancer who was going to be candidate for immunotherapy. We could have radiated the brain here and two weeks of radiation would have probably resulted in some cognitive impairment. But instead this patient was treated with immunotherapy, and in this very first study, it was shown that patients actually respond in the brain.
and this actually was before any of the clinical trials were allowing this and anyone was doing this in clinical practice, innovative and Carla studies from this, maybe Kurt will tell us a bit about that when we call on him. Again, and quantify all these, but we’ve published it, builds the scientific literature. It helps get this to other places.
It builds our reputation.

Basic science, I’m actually.

We have amazing basic science, just one of our sport projects.

Project 2 Katie and Sarah both here working with Mark Lemon from the Cancer Biology Institute. Mechanistic approaches to counter TKI resistance and easier from lung cancer.

So here’s the team this. I think this is in the library in the brain room working to develop their methods to counter EGFR resistance. Publishing well, changing the field we’ve had.
We have a long slow retreat here a few years ago that Katie ran with Christine. Lovely from Vanderbilt, this is what we need to do more of our continuing to bring the best science to bear on this disease. And then what about translational science? This is the area where I have put most of my time, but we built a lung spore. It took us a few years, but in 2015 we became only the third lung Spore. Here we are celebrating and then we renewed it on our very first try in 2020. Why?
Because we had impact in smoking cessation in immunotherapy and targeting EGFR resistance. And we continue to go strong. This is our current spore iteration. We have projects right now and you’ll hear about this new new targets for immunotherapy. Everyone in the world is using Leaping’s first discovery. Now we’re working on one of his. Others were working on brain metastases with Don when a wonderful addition to this team, Katie and her team. As I mentioned, Sarah and Mark working on each year for a pathway resistance,
or continuing to look at prevention with smoking.

Is this trial Bentall and Lisa Fucito. And others, this trial Brenda and others is about to unveil its results. And again, publishing well in high profile journals. These drugs and this is just the list I could think of. You know, in the last night when I was making the slide with Doctor Joe who helped me with these slides, you can see all these drugs. Their first uses. How to use them, the mechanism,
the biopsy studies all really with some origins here at Yale Cancer Center. Very proud of that. People could come here. I still recall with that as Alisme AB nine years ago. Patient coming from New York because they couldn’t get immunotherapy in New York that getting in here at Yale. I’d like to see us do more of that with the next generation of either targeted therapies or immuno therapies. And with surgical techniques and with other types of treatments. We have a dark eyed disease.
00:12:45.740 -- 00:12:46.828 our last weeks meeting.
NOTE Confidence: 0.8792891
00:12:46.830 -- 00:12:48.998 Some of the leaders will be on there.
NOTE Confidence: 0.8792891
00:12:49.000 -- 00:12:51.520 I guess I must have taken a phone call in
NOTE Confidence: 0.8792891
00:12:51.585 -- 00:12:54.168 the middle of the call and they caught me.
NOTE Confidence: 0.8792891
00:12:54.170 -- 00:12:55.530 You never know when you’re
NOTE Confidence: 0.8792891
00:12:55.530 -- 00:12:56.618 on the zoom button.
NOTE Confidence: 0.8792891
00:12:56.620 -- 00:12:57.980 Amazing amazing group of people.
NOTE Confidence: 0.8792891
00:12:57.980 -- 00:13:00.148 These are the people that make it happen.
NOTE Confidence: 0.8792891
00:13:00.150 -- 00:13:02.193 I hope I know many of them are watching
NOTE Confidence: 0.8792891
00:13:02.193 -- 00:13:04.258 and I appreciate their work so much
NOTE Confidence: 0.8792891
00:13:04.258 -- 00:13:06.140 and really fantastic and our leaders.
NOTE Confidence: 0.8792891
00:13:06.140 -- 00:13:07.904 Jennifer Pope incera public.
NOTE Confidence: 0.8792891
00:13:07.904 -- 00:13:09.227 Just amazing team.
NOTE Confidence: 0.8792891
00:13:09.230 -- 00:13:11.043 Are accruals you know these are the
cruise without the phase one patients

'cause a lot of lung patients go to phase one but this has been pretty decent.

I would like to see this go higher.

How are we going to make this higher by bringing more patients here and by having more trials and being more efficient.

I’m not a skier. If I was a skier, this would be the biggest slope I’d ever want to go on.

And I gotta tell you, we gotta fix this a little bit of a downturn last year. Some of this is kovid.

Some of this is, you know,
the current environment,

but we're going to bring this up and this.

This is where our tissue samples come from.

This is our innovation.

This is how we help more patients.

But our trials are very nicely divided.

Very proud of this 40% or so of

our accruals are the care centers.

The lung team really is already

multidisciplinary and already

working between the care centers

and you can see while 37.8% are

industry were very active in the NCT.

Several of the group have

leadership committees.
Leadership position in the lung Committee that Decker has leadership myself and several others that Cappelletti and you can see investigator initiated trials. About 10% we're going to do even more of those for the future. This just opened, I think Scott’s probably downstairs putting someone on so this is an investigator initiated trial with the drug cyclic 15. What does it mean? Investigator initiated Yell holds the Ind Yell is fully responsible for this trial.
We're getting the drug from next cure.

A company that leaping has been involved with and we're getting the.

Where the phase one studies were initially run and we're getting the Pebble is a map from work, but we're pulling out altogether. We're getting the biopsy. The biopsies will be picked up in the clinic by one of our team to go to David's lab. Will go to Kurt Slab. Only pings lab. This is how science has to be done. The best treatments and then understanding the mechanism. All that happening through the system.
Just to finish up, we have a wonderful program in small cell lung cancer. This is led by and Chang, you know, small cell is a community type disease. I think it’s one of the reasons why Anna smoking related to these two. Why we have so much care? Center accrual because some of her innovation with the care centers in this small cell program. And then lung cancer screening. I’m going to Clint Ocus in a bit but this is just been a phenomenal labor of love from Lynn and the team to get screening at multiple sites.
And again it couldn’t be more timely
Cousins going to tell us a little bit about how screening is not only being done but it’s being expanded. Community outreach and engagement. I mentioned that you know our lung map trial. Here I am with Doctor Joe talking to the Cultural Ambassadors the way you get trials out to the community as you go to the community, you talk on the radio programs. You go to. The churches were doing that. You were donating masks were creating. Navigators were going to do more of this. Now we have a network no, I mentioned. I’m here 10 years ago.
Little bit more than nine years ago we brought in the first group Mo H 21 doctors. Now we have 15 sites where care can be delivered. I believe this is Westerly RI. Be nice to have a boat so look at all these sites that we have and we need to now expand and deliver multi modality care innovative care, protocol driven care or at least the best standard of care at all these sites. We're doing that, but we're going to do it even better as we expand. So Kevin Vest,
who I’ve known since I got here, who’s done so much for this endeavor,
has spoken to this group before about the disease centers,
pulling together things into a clinical research and education component,
and inclusivity, cons of the wheel or working together.
I’m not going to go into this into much detail except to say thank you,
because you gave us the resources and the stimulus to take lung cancer to this level.
So now we have our cabinet and by the way, this is no way to mean that if
you’re not listed on the cabinet, you’re not critical. They’re going to work. Streams are going to be subgroups, but this is just the start. As we launch this, I’ve agreed. I have plenty else to do, but I’m passionate about this. I think as you all know, and I can work all the different areas. I’m going to be the coordinator for now, and I’m starting out as a coordinator, but Dan Boffa remains the clinical director. He’s doing amazing job with this Scott. Get challengers,
our Chief of Thoracic Medical oncology.
NOTE Confidence: 0.8006987

Sarah Goldberg will be the research director.
NOTE Confidence: 0.8006987

And Katie Poletti, the scientific director.
NOTE Confidence: 0.8006987

They only speak working very closely with
NOTE Confidence: 0.8006987

Kevin and with administrative staff,
NOTE Confidence: 0.8006987

and this cabinet is meant to
NOTE Confidence: 0.8006987

represent different disciplines,
NOTE Confidence: 0.8006987

but also different centers.
NOTE Confidence: 0.8006987

Suggestions at Greenwich,
NOTE Confidence: 0.8006987

Vinny is at Bridgeport and I’m going to
NOTE Confidence: 0.8006987

introduce them all in just one moment.
NOTE Confidence: 0.8006987

So here’s our panel.
NOTE Confidence: 0.8006987

I did what I wanted to do.
NOTE Confidence: 0.8006987

20 minutes.
NOTE Confidence: 0.8006987

I’ve invited all this group to be here today.
It’s a new way to doing to do grand rounds, but having been on most of the grand rounds the last year I missed the interactive format. I think it would be interesting to. I want to see plenty of questions. I’m going to ask each of these panelists to be careful with their time. Ask them one to introduce himself. To tell them to tell us what they do and then tell us a little bit of something that’s really exciting in your area and perhaps how you think we can bring that to the disease center.
00:18:35.170 --> 00:18:36.030 throughout Connecticut.
NOTE Confidence: 0.8006987
00:18:36.030 --> 00:18:38.046 So with that, I think I'll stop.
NOTE Confidence: 0.8006987
00:18:38.050 --> 00:18:39.490 I just went over knowledge.
NOTE Confidence: 0.8006987
00:18:39.490 --> 00:18:42.073 We have so much support from from the team,
NOTE Confidence: 0.8006987
00:18:42.080 --> 00:18:42.932 but also philanthropy.
NOTE Confidence: 0.8006987
00:18:44.352 --> 00:18:45.529 This is all philanthropy that
NOTE Confidence: 0.8006987
00:18:44.352 --> 00:18:45.529 comes to lung cancer.
NOTE Confidence: 0.8006987
00:18:45.530 --> 00:18:47.258 More on the way I hope.
NOTE Confidence: 0.8006987
00:18:47.260 --> 00:18:50.668 And we have peer reviewed funding as well.
NOTE Confidence: 0.8006987
00:18:50.670 --> 00:18:54.180 So I don’t let me see if Lynn is on the line.
NOTE Confidence: 0.8006987
00:18:54.180 --> 00:18:56.710 Lynn’s not here yet, so.
NOTE Confidence: 0.8006987
00:18:56.710 --> 00:18:59.006 After sort of do a Bayesian approach here.
NOTE Confidence: 0.8006987
00:18:59.010 --> 00:19:02.010 So let me stop sharing.
NOTE Confidence: 0.8006987
00:19:02.010 --> 00:19:04.770 And I’m going to put the screen up
NOTE Confidence: 0.8006987
00:19:04.770 --> 00:19:07.602 and let me ask the panel members
NOTE Confidence: 0.8006987
00:19:07.602 --> 00:19:10.070 to unmute and welcome you all,
and thanks for being here. I guess maybe that the first word I’d like to introduce is Dan Boffa, who’s the clinical director and Dan Lynn’s about to be here, and I want to save the screening discussion for her. Can you just introduce yourself? Tell us a little bit about some of the innovations in surgery and why multimodality care is so important. Sure, thanks Roy. So for those of you who don’t know,
I'm one of the thoracic surgeons and there have been a number of innovations in surgery that really tie to care delivery in general that one of our research interests in the division of Thoracic Surgery has been networks and how networks can function better to provide care. We've really identified a number of opportunities where satellites are not performing at the same levels as the main campus, and we believe we've discovered several ways to improve that.
I’ve served as the clinical director of top, and I think that moving into the next chapter is how do we bring? Our multidisciplinary care model to other centers across the network and and I really tried to image what does care, feel like across the network. You know it and really just comes down to care. Really needs to feel like it’s connected so that all of our centers are connected and all of our clinicians are connected. Care has to feel navigated and we’ve totally revamped our entire nursing model so that we now have practice nurses.
We’ve essentially doubled the number of practice nurses across the threats, and so that really, there’s going to be somebody holding your hand that’s identifiable throughout your entire cancer journey. And when there’s a handoff across modalities, it’ll be to somebody who’s on that team. And finally, it’s gotta be expert care.
00:21:41.760 --> 00:21:43.720 not just the tough parts,
NOTE Confidence: 0.8407886
00:21:43.720 --> 00:21:45.680 but the general well being.
NOTE Confidence: 0.8407886
00:21:45.680 --> 00:21:48.312 And so we’re trying to refine what
NOTE Confidence: 0.8407886
00:21:48.312 --> 00:21:51.517 it feels like to be a patient
NOTE Confidence: 0.8407886
00:21:51.517 --> 00:21:53.512 in the thoracic oncology program.
NOTE Confidence: 0.8407886
00:21:53.520 --> 00:21:55.404 Throughout the entire journey.
NOTE Confidence: 0.8407886
00:21:55.404 --> 00:21:56.346 So what
NOTE Confidence: 0.8122789
00:21:56.350 --> 00:21:58.210 are some of the innovations we
NOTE Confidence: 0.8122789
00:21:58.210 --> 00:21:59.765 hear about robotic surgery, vats,
NOTE Confidence: 0.8122789
00:21:59.765 --> 00:22:01.340 surgery, different techniques or are
NOTE Confidence: 0.8122789
00:22:01.340 --> 00:22:03.170 we using that throughout our system?
NOTE Confidence: 0.867156
00:22:03.830 --> 00:22:05.108 Yeah, they actually.
NOTE Confidence: 0.867156
00:22:05.108 --> 00:22:07.664 So all of the surgeons do
NOTE Confidence: 0.867156
00:22:07.664 --> 00:22:09.470 minimally invasive surgery.
NOTE Confidence: 0.867156
00:22:09.470 --> 00:22:12.760 The right now three of the six,
NOTE Confidence: 0.867156
we’re going to 7 in July.

Three of the six do robotics,

but by by hopefully by

December or January next year.

Five of the six will be doing robotics,

but everything is done.

You know, we do.

The vast majority of things

minimally invasive Lee.

Um? You know,

we’re trying to grow bigger,

but we’re also trying to grow

safer and try to grow stronger.

And so we believe the the robotics

platform is an important part of that.

It’s.
But I also think that maintaining the principles of oncology and in doing complete resections safely, you know that’s where the art and science come together.
top and actually was fortunate.

I met Lynn about 20 years ago when I first came through and visited Yale and then actually one key hiding my mentor who is a very strong advocate, unfortunately passed away a few years ago of prevention. We know we talked, we actually met for a summer to talk about prevention efforts. So then I thought you could introduce yourself. Say a few words about what you do, but there was some news within the last hour on lung cancer screening, so I did show your first slide show.
The second slide.
I can put it up if you want,
but tell us what’s so exciting.
It’s in the New York Times right
now as we speak.
So Roy, if you could put up the slide,
Paul is going to help me here.
And so if you already
showed this slide I had,
the basis of the eligibility criteria
of the national lung screening trial,
which occurred back in 2011.
Unfortunately CMS dinner.
Really, with the help of policy there,
who is the nurse coordinator
for cancer screening program?
We've really taken off an this new
recommendation had been out for public
comment last summer and there was
a great deal of controversy about
expanding the eligibility criteria.
But the bottom line is after
that period of open comment,
the new recommendations are to
screen people who are ages 50 to 80,
so they’ve decreased the entry age from 55 to 50 and with at least 20 pack years of smoking, and so that was decreased from 30 to 20. And that recommendation really was based on the Nelson screening trial which was broader than the national screening trial. You still have to be currently smoking or have quit within the past 15 years which is came out of the NOST. And what that means is that the
number of people eligible for lung cancer screening in the US is going to double from about 8 to 9 million to 16 to 18 million people, and one of the big push is behind the expansion of the eligibility criteria. Was that both and LST and the Nelson study showed that there was actually benefit for everyone but more benefit for women and certain minority groups sent for us, that's you know. People who are African American and there's a lot of debate. Still as to whether women and certain minority groups,
including African Americans, are more susceptible to lung. Carcinogenesis from cigarette smoke, but it is clear that those groups benefit more than other groups when you screen them and the whole point of lung cancer screening is to find people early because early detection means better chance of cure. It also lets us have a chance to talk to those people about smoking cessation which is a big part of the decision support visit. That’s mandatory before every.
an having had the chance to cover for Poly.
00:26:50.140 --> 00:26:52.534 Recently, Anne and talk to 8 people.
00:26:54.250 --> 00:26:57.680 One day about tobacco cessation,
00:26:57.680 --> 00:27:01.442 I think that that’s a huge
00:27:01.442 --> 00:27:03.164 opportunity that actually will be
00:27:03.164 --> 00:27:05.230 expanded as well because of the
00:27:05.230 --> 00:27:07.288 So we’re pretty excited about that.
00:27:07.290 --> 00:27:10.368 That’s going to be a huge amount of work.
00:27:10.370 --> 00:27:13.114 We have some time before CNS approves that,
00:27:13.120 --> 00:27:14.830 but CNS will approve it.
00:27:14.830 --> 00:27:16.012 If USPS TF.
00:27:16.012 --> 00:27:16.800 Recommended it,
00:27:16.800 --> 00:27:19.016 so we’re going to be gearing up right?
00:27:19.020 --> 00:27:20.688 Well, listen it all about access
then people need to have access to get this done and they have to have insurance or CNS coverage, so hopefully this will help with that. How have we done this past year with Covid we continue to screen a lot of patience. So everything shut down outpatient for a few months, but after that Poly we open screening at Young Haven, doing it, doing the decision support visits remotely, and so we’ve been meeting across the system with the screening program at Lawrence, which is very well established. Run by Lou Massarelli.
Vinny Mazes has got the program at Bridgeport up and running, and there's they're starting to accrue screening population, Greenwich is still in the planning process, but has a nurse coordinator. And so I think we can standardize something. Some of this is regional specific because of the way that the community practices, but it's been great to actually all get together and talk about what we can standardize, what our goals are, you know, to have the nurse coordinators working together.
I think this is really going to accelerate things we’ve been screening at Yale, New Haven between 4 and 600 people a year. Um and we are working really hard to try to acquire or develop an epic tracking system that will allow us to actually keep track of all these hundreds of people. Actually a couple thousand at this point that we’ve accumulated and we want to be sure that we follow properly. That’s great, you know, as much as we have these new targeted therapies and immunotherapy’s preventing lung cancer or catching it.
00:28:56.202 --> 00:28:57.980 early will help so many more people.
NOTE Confidence: 0.81494343
00:28:57.980 --> 00:28:59.525 And actually maze surgery or
NOTE Confidence: 0.81494343
00:28:59.525 --> 00:29:01.070 surgery and then chemo radiation.
NOTE Confidence: 0.81494343
00:29:01.070 --> 00:29:02.342 But first with surgery,
NOTE Confidence: 0.81494343
00:29:02.342 --> 00:29:04.780 tell us a little bit what you do.
NOTE Confidence: 0.81494343
00:29:04.780 --> 00:29:06.508 You’re at Bridgeport and actually so
NOTE Confidence: 0.81494343
00:29:06.508 --> 00:29:08.489 you have an amazing screening talk.
NOTE Confidence: 0.81494343
00:29:08.490 --> 00:29:10.398 A few months ago so you
NOTE Confidence: 0.81494343
00:29:10.398 --> 00:29:11.890 obviously doing a lot of
NOTE Confidence: 0.81494343
00:29:11.890 --> 00:29:14.046 it there. Yeah no thanks allot you
NOTE Confidence: 0.81494343
00:29:14.046 --> 00:29:16.524 asked to talk about the Four WS, what,
NOTE Confidence: 0.81494343
00:29:16.524 --> 00:29:18.686 where and why. I’m Vinny, you know,
NOTE Confidence: 0.81494343
00:29:18.686 --> 00:29:21.386 I’m one of the thoracic surgeons, one of 6/2.
NOTE Confidence: 0.81494343
00:29:21.386 --> 00:29:24.592 Soon to be 7 like Dan talked about and I’m
NOTE Confidence: 0.81494343
00:29:24.592 --> 00:29:27.301 the site director for thoracic surgery at
NOTE Confidence: 0.81494343
00:29:27.380 --> 00:29:30.054 the You know Bridgeport Park Ave area.
Been on the staff now for three years and really appreciate the opportunity to expand. I think you know one of the exciting things that you talked about. Roy was. You know it’s about, you know, being present and that it takes a village and I think that’s one of the things that is exciting. As we expand. You know at Bridgeport it’s understanding the regional differences that Doctor Tanui talked about. But also how do we continue to deliver the same stand? So that the standard of care at
Bridgeport Park Ave is exactly the same like it is with in New Haven, New Haven County or at York Street. And that’s been a source of many discussions and we, you know, we work to achieve that, and that’s one of the exciting things that as we continue to expand at Bridgeport, we’re starting to roll out the enhanced recovery after surgery, which was started at York Street. We started off with a small lung cancer steering committee.
Um, about three years ago, and you know, there was about 10 people that were screened, and now we’re up to about 100, and there’s 160 orders that are currently in place for lung cancer screening, so it’s going to grow quite quickly. Well, thanks, Vinny, and you know the multi modality care is so important. Justin white. Tell us where you are and why is multi modality care so important and what is the importance of tumor board and and and all working together in this way?
Thanks for having me Justin

Blasberg thoracic surgery.

I work for Vinny and Dan with Vinny and Dan and Fort Vinny and Dan.

I’ve been at Greenwich since the beginning of the year,

and like Vinny said, we’ve been working towards bringing our standard of the New Haven campus across the network and Vinny’s done a really good job doing that over the past couple of years and my goal at Greenwich is to mirror that success. On all fronts,

including an ear protocol.

Developing lung cancer screening program,
NOTE Confidence: 0.81839705
00:31:35.340 --> 00:31:37.710 bringing robust robotic surgery to Greenwich,
NOTE Confidence: 0.81839705
00:31:37.710 --> 00:31:39.780 which granted already has that
NOTE Confidence: 0.81839705
00:31:39.780 --> 00:31:42.654 capability but will be able to sort
NOTE Confidence: 0.81839705
00:31:42.654 --> 00:31:45.209 of bring our expertise to that campus,
NOTE Confidence: 0.81839705
00:31:45.210 --> 00:31:47.466 which is great for patients and
NOTE Confidence: 0.81839705
00:31:47.466 --> 00:31:49.464 then also our multi disciplinary
NOTE Confidence: 0.81839705
00:31:49.464 --> 00:31:52.404 clinics similar to what we have in
NOTE Confidence: 0.81839705
00:31:52.404 --> 00:31:55.090 this sort of the New Haven campus.
NOTE Confidence: 0.81839705
00:31:55.090 --> 00:31:57.065 There's a critical mass there
NOTE Confidence: 0.81839705
00:31:57.065 --> 00:31:58.250 of thoracic support,
NOTE Confidence: 0.81839705
00:31:58.250 --> 00:32:00.620 both a sunley for medical oncology.
NOTE Confidence: 0.81839705
00:32:00.620 --> 00:32:01.468 Bruce mcgibbon.
NOTE Confidence: 0.81839705
00:32:01.468 --> 00:32:03.588 And others from radiation oncology
NOTE Confidence: 0.81839705
00:32:03.588 --> 00:32:05.717 and an opportunity for us to see
NOTE Confidence: 0.81839705
00:32:05.720 --> 00:32:08.010 patients in a common space and talk
NOTE Confidence: 0.81839705
about multi modal approaches to treating patients with either early stage or local regional disease. And so all of those tools are in place at Greenwich. And it's an exciting opportunity for us to treat patients there as if they were on the New Haven campus or the Bridgeport campus. But it's amazing. We have surgeons, medical oncologists across all the campuses and of course radiation oncology. And when I call in all oncologist Roy Decker and when I first got here I used to fall asleep at tumor board and they really were you thinking.
Oh boy but Fortunately was Leroy Decker.

They were asking opinion of so Roy tell us a little bit about radiation oncology.

What’s exciting new techniques and I know you also have another role in clinical trials. We’ll get to that later.

So I have to say first Thanks, Roy. And when Roy and I see each other in the hallway we say hi Roy Roy and it has not stopped being funny yet so I just keeps on going.

So I’m right Decker. I’ve been here many many years now there were two of us Lynn Wilson and I
were the thoracic radiation oncologist.

When top was born and we now have a large network of fantastic thoracic providers that serve.

All of our sites, and I’ve recently turned over the clinical leadership of thoracic radiation oncology to Henry Park was not able to be here today, but Henry is done really an amazing job in creating a cohesive thoracic radiation unit that can offer all of our new technology and all of our exciting treatments at all of our sites in in a very uniform fashion.

And so I give him a lot of credit for that.
00:33:53.280 --> 00:33:55.656 I am very excited to work with this group and I always have been and it has grown so amazingly over the last decade or more that it quite honestly it’s difficult to keep up with.

00:34:00.193 --> 00:34:02.765 I remember we used to have discussions about what day the rest that clinic was, and I believe we are now a five day week operation so it’s pretty exciting.

00:34:02.765 --> 00:34:05.205 Right, one of these protons I hear about it carbon and everyone wants the newest techniques.

00:34:07.359 --> 00:34:09.797 Are we moving towards any of those and are they better or do they need studies?
Yeah, so we are moving forward with a couple of new technologies so we are hoping to build or planning to build a proton center that will serve our network. It will be a smaller proton unit, but it may benefit some of our lung cancer patients. So far, trials have not shown a huge benefit to protons in lung cancer, at least not for all patients. But we think there may be a subset of patients that could benefit, and this is an enormous investment on the part of the hospital and several of our partners.
and we're excited to watch it grow.

It's probably going to be 2 years before we treat a patient.

You know,

we're also exploring other new technologies like biologically guided radiation therapy that will be very useful in the treatment of patients with Metastatic disease so you know.

Honestly, there's still exciting things coming from us.

An excellent well let's take a little bit of a different tack.

I'm going to get everyone but Katie Poletti know one of the reasons
why I think were so strong on this long program with spores and stand up for cancer grants and more are ones that I can even count to press. Katie, you’ve been here over 10 years and really has formed the basis.

You know with many other scientists but is now our scientific Director and Katie, we’ve really seen the science of lung cancer grow. I know when when I went into this field 20 years ago, no one wanted to work in this field, but.

Anything, breakthroughs and only we only have a few minutes, but what’s exciting about the science
and how are you working to bring the science from the lab to the clinic and in your role as the basic science leader?

Yes, thank you very much Roy. So I’m Katie politi. I’m a cancer biologist and have been at Yale for almost 11 years now in the Department of Pathology and a medical oncology, and my laboratory focuses on understanding mechanisms of tumor initiation, progression, and the biology of lung cancer, as well as understanding sensitivity and resistance to different therapies in the disease.
And I think that there are a lot of amazing things that we have seen developed. Over the years in lung cancer, an really here at Yale, we have amazing science that is happening in these different areas that are really making a difference in taking our findings in the lab and moving them to the clinic and then taking them into the community as well. And that goes from the identification of new targets for lung cancer therapy, whether they be targets that are inside the cell. The cancer cell, like EGF receptor for example,
NOTE Confidence: 0.84002584
00:37:15.300 --> 00:37:16.848 another oncogenic drivers or
NOTE Confidence: 0.84002584
00:37:16.848 --> 00:37:19.170 carass for example in the cell,
NOTE Confidence: 0.84002584
00:37:19.170 --> 00:37:21.879 but also that are tumor cell extrinsic.
NOTE Confidence: 0.84002584
00:37:21.880 --> 00:37:24.185 So targets in the micro
NOTE Confidence: 0.84002584
00:37:24.185 --> 00:37:26.029 environment and we have.
NOTE Confidence: 0.84002584
00:37:26.030 --> 00:37:29.438 You heard about this new next cure trial,
NOTE Confidence: 0.84002584
00:37:29.440 --> 00:37:31.144 for example, from Roy.
NOTE Confidence: 0.84002584
00:37:31.144 --> 00:37:33.660 That is an example of that.
NOTE Confidence: 0.84002584
00:37:33.660 --> 00:37:36.495 We also have a lot of groundbreaking
NOTE Confidence: 0.84002584
00:37:36.495 --> 00:37:38.808 studies in modeling lung cancer,
NOTE Confidence: 0.84002584
00:37:38.810 --> 00:37:41.650 so developing new and better models to
NOTE Confidence: 0.84002584
00:37:41.650 --> 00:37:44.490 study the biology of lung cancer and to
NOTE Confidence: 0.84002584
00:37:44.568 --> 00:37:47.760 study sensitivity and resistance to therapy.
NOTE Confidence: 0.84002584
00:37:47.760 --> 00:37:48.610 And again,
NOTE Confidence: 0.84002584
00:37:48.610 --> 00:37:51.160 this goes from really developing refined,
genetically engineered mouse models, for example, that can be used to study. For example, the immune interactions between cancer cells and immune cells, with some of the pioneering work from various different groups here, like Nick Joshi like Leaping Chan like Richard Flavelle and others and also then to the development of models that can be used to really study the disease in patients. So patients arrived models where we can really study what is
00:38:24.186 --> 00:38:26.679 happening in those human tumors.
00:38:26.680 --> 00:38:28.460 And understand the biology of
00:38:28.460 --> 00:38:30.240 the disease in those contexts,
00:38:30.240 --> 00:38:32.372 and so with these different models,
00:38:32.372 --> 00:38:34.610 we can leverage them then to
00:38:34.610 --> 00:38:36.114 study mechanisms of sensitivity
00:38:36.114 --> 00:38:38.098 and of resistance to therapy and
00:38:38.098 --> 00:38:40.446 really get to some of these very
00:38:40.446 --> 00:38:42.296 difficult issues that are being
00:38:42.296 --> 00:38:44.481 faced by patients in the clinic.
00:38:44.481 --> 00:38:47.392 And so I think that those are just
00:38:47.392 --> 00:38:50.029 some examples of areas and things of
00:38:50.029 --> 00:38:52.304 work that is ongoing here at Yale,
00:38:52.310 --> 00:38:54.242 and I think this is a great
00:38:54.242 --> 00:38:56.353 place to really bring together
00:38:56.353 --> 00:38:58.239
this multidisciplinary research.

Because of the really good size that we have of Yale.

So at Yale where we have.

The big clinical enterprise,

but it’s very,

very connected also to the scientific enterprise,

and so this is a really remarkable opportunity to bring everybody together and leverage the the infrastructure that is being developed through resources like this for example,

other projects that are happening here at Yale.

Like the Generations Project,
which is focused on germline sequencing in people individuals.

For example the development of models and bringing these altogether.

We're going to really work hard to leverage that and bring the science to the clinic.

Thanks Katie, it's great to have worked with you and all of us.

But now we're going to really transform things even more.

Scott Scott’s just up from clinic I talked about.
You’re here and how long are you at your now? You’re on the screen. I’ve been here longer than most of you, Lynn’s been here longer, but over over 15 years and I’ve certainly seen dramatic change in our loan program. Great, now is that everyone sort of come together and then it’s raster program. I think we’re great model for other cancer groups because we have basic scientists are working with us. We have clinicians. We have things. We have all sorts of people working
00:40:31.125 --> 00:40:33.550 on the same same projects for me.

00:40:33.550 --> 00:40:35.675 My problem, my primary responsibility

00:40:35.680 --> 00:40:37.736 is treating my patients and we

00:40:37.736 --> 00:40:39.788 certainly have a good amount of

00:40:39.788 --> 00:40:41.492 patience and my second responsibility

00:40:41.492 --> 00:40:44.230 is to learn from my patients and to

00:40:44.230 --> 00:40:46.275 try to understand who responds and

00:40:46.275 --> 00:40:48.679 who doesn’t respond so we can extend

00:40:48.680 --> 00:40:50.729 responses to all of our patients

00:40:50.730 --> 00:40:54.144 and for me, I do this with all of you

00:40:54.144 --> 00:40:55.854 and primarily with Katie Palladian.

00:40:55.854 --> 00:40:58.593 I we have a protocol where we we

00:40:58.593 --> 00:41:00.306 aggressively biopsy patients their tumors,

00:41:00.306 --> 00:41:02.010 their blood sites of toxicity,

00:41:02.010 --> 00:41:03.462 surrender stand. Who’s responding?

00:41:03.462 --> 00:41:05.360 and
Why someone gets the toxicity to improve upon.

What we have now and.

I can tell you that from we have patients from early trials who are doing incredibly well now with immunotherapy’s 10 years and plus how some people have never heard of. So my focus right now is to understand those patients. Why does a patient who has a prognosis of three months live 10 years without any evidence of disease, years without any evidence of disease, and hopefully another 1020 years? Why can’t we do that for all of our patients and with the help
00:41:31.590 --> 00:41:33.060 of Katie and everyone else,
NOTE Confidence: 0.809984

00:41:33.060 --> 00:41:36.000 we’re trying to get to that let me ask you,
NOTE Confidence: 0.809984

00:41:36.000 --> 00:41:37.470 you’ve been here. You recruited,
NOTE Confidence: 0.809984

00:41:37.470 --> 00:41:38.662 probably Wilson was director.
NOTE Confidence: 0.809984

00:41:38.662 --> 00:41:39.556 Eddie Chu yeah.
NOTE Confidence: 0.809984

00:41:39.560 --> 00:41:42.071 So tell me how did you get that first
NOTE Confidence: 0.809984

00:41:42.071 --> 00:41:44.475 trial with Nivo Map was a trial that was
NOTE Confidence: 0.809984

00:41:44.475 --> 00:41:46.376 being run with Mario tells the story.
NOTE Confidence: 0.809984

00:41:46.380 --> 00:41:47.512 It’s pretty exciting, no.
NOTE Confidence: 0.809984

00:41:47.512 --> 00:41:50.209 So so I have my office is no Hall with
NOTE Confidence: 0.809984

00:41:50.209 --> 00:41:52.390 Mario Show who’s really a giant when it
NOTE Confidence: 0.809984

00:41:52.390 --> 00:41:54.022 comes to immuno therapies for cancer
NOTE Confidence: 0.76924354

00:41:54.022 --> 00:41:56.468 and he one day just knocked on my door.
NOTE Confidence: 0.76924354

00:41:56.468 --> 00:41:58.330 Since I got this trial of this
NOTE Confidence: 0.76924354

00:41:58.396 --> 00:42:00.546 drug MDX 1106 and I said what is
NOTE Confidence: 0.76924354
it Mario 'cause we certainly need things for our patients, he said. It’s an immunotherapy and I said Mario, don’t you know? Immunotherapy doesn’t work for lung cancer? We’ve been doing it for decades. All the trials are negative and Mary said just just believe me, just try this. A different type of immunotherapy. So we put a few patients on trial and the first thing I noticed was that these patients were tolerating therapies incredibly well. Most of patients back then were
going on phase one trials, which were very harsh. You know combinations of chemotherapy and targeted therapies. The first thing these patients really where we’re having detriment in their quality of life. And then we started seeing the responses. That was about 10 years ago and we still a patient from that first trial who are doing well after finishing their course of therapy over a year or two now. 8-9 years later, without any evidence of cancer,
so I attribute that to Mario, who introduced me. And then from there it was easy with what we needed to do. I still remember going to Scott’s office when I was interviewing here. Can you show me some of those films and? Again, they were not doing this at MD Anderson. They were not doing this at memorial back. We have a tumor board. We probably need more of them as we expand. We look at radio radiology. Isabel so you have a hard job. In fact, we hit you with like 20
cases on a Friday and you have to look at all the films on the weekend. You and your team tell us a little bit who you are, what you do and tell us about radiology in lung cancer. Thank you for having me here. I miss about quarter past. See, I’ve the section chief of Thoracic Imaging here at Yale. First started here in 2010 when working with Lee and Anne back then with Amanda and.
00:43:42.410 --> 00:43:43.798 of lung cancer screening,
NOTE Confidence: 0.82436866
00:43:43.798 --> 00:43:45.538 there was challenging, so I
NOTE Confidence: 0.82436866
00:43:45.540 --> 00:43:47.976 think we have been involved in all
NOTE Confidence: 0.82436866
00:43:47.976 --> 00:43:50.061 aspects in terms of thoracic malignancies,
NOTE Confidence: 0.82436866
00:43:50.061 --> 00:43:52.148 from screening to assessment of treatment.
NOTE Confidence: 0.82436866
00:43:52.148 --> 00:43:54.584 We work closely together with laying with
NOTE Confidence: 0.82436866
00:43:54.584 --> 00:43:57.022 the surgeons with Frank on their screening.
NOTE Confidence: 0.82436866
00:43:57.022 --> 00:44:00.848 We provide the reports in a
NOTE Confidence: 0.82436866
00:44:00.848 --> 00:44:02.583 way that can help declination
NOTE Confidence: 0.82436866
00:44:02.590 --> 00:44:04.680 with the lung RADS evaluation.
NOTE Confidence: 0.82436866
00:44:04.680 --> 00:44:05.718 We also have worked a lot
NOTE Confidence: 0.82436866
00:44:05.720 --> 00:44:07.808 on incidental findings
NOTE Confidence: 0.82436866
00:44:07.808 --> 00:44:09.200 which was a big problem when
NOTE Confidence: 0.82436866
00:44:09.200 --> 00:44:12.430 you first start scanning.
NOTE Confidence: 0.82436866
00:44:12.430 --> 00:44:14.405 A lot of people you see all the other
NOTE Confidence: 0.82436866
Coronary calcium and what to do with those?

So we try to implement that on our report to guide their referring physicians who may not know what the next step would be.

We have been expanding the lung cancer screening as well, together with that special clinical to trying to reach more and more sites. We started here. I think we evolved a lot when in Mar imaging of thoracic malignancies as well.

Since 2010 we have been applying more MRI for mediastinal tumors in
characterizing anterior mediastinal, particularly thymoma, and versus dynamic hyperplasia, before surgical excision.

Before treatments.

We had recently start looking at MRI, the ability to assess post radiation changes in lung cancer, in combination with pets, so there is a lot of research going on that as well. If you can be better or complementary to pet City, which is hard with. All the information for radiation and
the other area that mean radiology is always quickly evolving. We have a lot of machine learning artificial intelligence. One of the fields that we think could be applied is that. As Scott, without some patients get document the immunotherapy or the therapy and they get progression on imaging. But later on you go back and was actually pseudo progression. So we’re trying to see if we can come up with machine learning model. They can analyze additional texture analysis of
these cancers on that city that our eyes cannot do an if we can try to differentiate pseudo progression versus true progression early on in therapy.

Expertise in radiology across the whole network is critical and we have a tumor board every week. As I said, Rob Homer is a constant there. Looking at that issue you've been doing this since I've been here. Robin and will have Kurt Chopard speak a little bit about more research pathology, but tell us, Rob, you know what is your role. So you do you review all the...
00:46:20.445 --> 00:46:21.899 pathology before we treat before
00:46:21.899 --> 00:46:23.399 we make a diagnosis here?
00:46:23.400 --> 00:46:25.098 Even if it’s from the outside.
00:46:25.100 --> 00:46:26.228 First of all, I
00:46:26.230 --> 00:46:28.494 wanna thank you for letting me talk today.
00:46:28.500 --> 00:46:29.826 That’s really great.
00:46:29.826 --> 00:46:32.370 Lynn Tanui, I have the old folks.
00:46:32.370 --> 00:46:35.368 so not here my whole life.
00:46:35.370 --> 00:46:37.368 I’ve only been in jail since for 42 years,
00:46:37.370 --> 00:46:40.022 Everything sort of narrows
00:46:42.690 --> 00:46:44.022 Everything sort of narrows
00:46:44.022 --> 00:46:45.687 down through the you know,
00:46:45.690 --> 00:46:47.688 the eyes of some histopathologist somewhere.
00:46:47.690 --> 00:46:49.350 It’s actually make a diagnosis.
So clearly I represent a lot of people behind me. It’s like.

There’s a lot of people in not just at Yale, but at other places.

Cytology, other his pathologists.

And so you know the case of the wind up in tumor board course.

Do most of those go through some pathologist?

I might May may not review all of them.

Certainly any cases that are little unusual or exceptional.

I’ve tried to put my eyes on and I know that pathology language is not English, right?

It’s sort of funny language,
and so there's a certain amount of interpretation that needs to go in. And a little bit of spin to help explain, because some things are very straightforward, somethings not so much. So of course, the other things we're looking forward to in terms of what's new, what we're excited about. Small cell is really kind of been sort of. Not much going on with it for forever, Not much going on with it for forever, and we're kind of excited that subsets and we're kind of excited that subsets. I've been involved in a little bit of that. I expect that we're going to be
giving that up into something more, hopefully more approachable, and in terms of the Department. You know, we’ve moved. We had used a relatively small panel from most lung cancers. Now we’ve sort of moved to a much larger panel for a. Of genetic abnormalities that we can do on a routine basis, which is great, and with the assistance of the new chair of the Chen and the hospital. We’re hoping to move digital pathology into the features so we
can actually do a better job of sharing images across the network. You know, moving physical pieces of glass around seems very antiquated and hopefully we’re going to sort of move forward in that. And that’s really going to open up, that’s really going to open up, in the same way that Isabel talked about digital image analysis, in a computer assisted work for radiology, that’s really the first step to start.
00:48:35.132 --> 00:48:37.289 doing the same thing for pathology images,
NOTE Confidence: 0.79031104
00:48:37.290 --> 00:48:38.904 which we hope to get to
NOTE Confidence: 0.79031104
00:48:38.904 --> 00:48:40.390 at some point as well.
NOTE Confidence: 0.79029346
00:48:41.160 --> 00:48:42.630 Yep, thanks Robin for everything
NOTE Confidence: 0.79029346
00:48:42.630 --> 00:48:44.600 you do and it’s good to know.
NOTE Confidence: 0.79029346
00:48:44.600 --> 00:48:46.896 Every Monday morning we might not be there,
NOTE Confidence: 0.79029346
00:48:46.900 --> 00:48:49.196 but you’re there and and you know really,
NOTE Confidence: 0.79029346
00:48:49.200 --> 00:48:52.639 keeping the tumor board running
NOTE Confidence: 0.79029346
00:48:52.640 --> 00:48:54.544 So you know when I when I
NOTE Confidence: 0.79029346
00:48:54.544 --> 00:48:56.370 came here to build us for,
NOTE Confidence: 0.79029346
00:48:56.370 --> 00:48:57.810 it’s really based on tissue.
NOTE Confidence: 0.79029346
00:48:57.810 --> 00:48:58.668 Yeah, strong statistician.
NOTE Confidence: 0.79029346
00:48:58.668 --> 00:49:00.384 You of course need a science.
NOTE Confidence: 0.79029346
00:49:00.390 --> 00:49:02.094 So I was fortunate to meet
NOTE Confidence: 0.79029346
00:49:02.094 --> 00:49:03.550 David Rim in David Rim.
As you all know, is involved in all the sports here at Yellow Three. Now they all rely on David and David. Still very involved with us but. Um, what is it? Current 4-5 years ago, he said, I’ve got this guy in my lab is great. We’ve got to keep him here. We don’t want to go back to Chile and he did it, and that skirt shopper in Kurt’s just been a wonderful collaborator or scientifically and therapeutically in his lab and the Corps ’cause you gotta, you gotta collect that issue and
00:49:29.140 --> 00:49:30.947 get it in the right place and
NOTE Confidence: 0.79029346
00:49:30.947 --> 00:49:32.739 get it from all these centers so
NOTE Confidence: 0.79029346
00:49:32.794 --> 00:49:34.621 Kurt tell us a little bit about
NOTE Confidence: 0.79029346
00:49:34.621 --> 00:49:36.156 yourself and what you do.
NOTE Confidence: 0.79029346
00:49:36.156 --> 00:49:38.394 And thanks for being here today.
NOTE Confidence: 0.79029346
00:49:38.400 --> 00:49:38.720 Thanks
NOTE Confidence: 0.78116035
00:49:38.720 --> 00:49:40.310 Roy. So I’m Kurt chopper.
NOTE Confidence: 0.78116035
00:49:40.310 --> 00:49:41.270 I’m a pathologist,
NOTE Confidence: 0.78116035
00:49:41.270 --> 00:49:42.550 an immuno oncology researcher.
NOTE Confidence: 0.78116035
00:49:42.550 --> 00:49:44.626 I joined us an assistant professor
NOTE Confidence: 0.78116035
00:49:44.626 --> 00:49:46.634 and was appointed in 2015 and
NOTE Confidence: 0.78116035
00:49:46.634 --> 00:49:48.290 we have had a very active.
NOTE Confidence: 0.78116035
00:49:48.290 --> 00:49:50.530 I got any program actually look up today
NOTE Confidence: 0.78116035
00:49:50.530 --> 00:49:53.068 and we have 64 publications since 2015.
NOTE Confidence: 0.78116035
00:49:53.070 --> 00:49:56.067 More than 20 trainees and a lot of grants
NOTE Confidence: 0.78116035
00:49:56.067 --> 00:49:58.495 including a number of NIH and DoD grants.
So we have been VC. But it’s a great environment to be able to achieve this. The other thing we have been focusing on is trying to enhance our capacity to do sort of further molecular analysis of samples, and we have implemented a lot of technology and we have implemented a lot of technology to be able to be ahead of the game, and now we’re trying with Dave Rim. Actually, to move some of these technologies into the clinic with the goal of having diagnostics that no one else has in that we’re focusing on.
The other aspects of my function within the top program has been to oversee the biospecimen repository that was, as you mentioned, initiated by link to New Years ago, and we have been able to grow it at infrastructure and also be able to disseminate the samples and we have a very rich repository that I would love everyone to use at some point. And finally the other aspect of what I’ve been doing is after a lot of effort from Euro in Mario at Gaston Dave Ramon. Also, they’d have to.
We have created a platform that we can use to be able to use some of these molecular methods in the context of clinical trials and really learn from them. And over the years since 2015 we have actually been able to work with seven clinical trials, three of which are IIT’s and we have been collecting, processing and analyzing samples in ways that very few people can in the world. I’m hoping to have a, you know, learn from it and be able to go to the next stage.
so again, it has been busy. 

It has been very happy, very productive, and I’m very proud of being part of this team. Thank you.

Thanks for all you’ve done and all the men tease know that I hope this is coming out all the students and medical students and fellows that are working with these labs and the basic labs. The clinical labs working between the different areas of a few more minutes. Vanna Dest, so operations and the clinic and the nurse practitioners I’m sitting up here because someone is finishing up the clinic for me.
We were a team.

We work together and that has been a glue.

Tell us a little bit about your thoughts about expanding thoracic cancer unit to all the different areas.

With a multi modality flare. Avana Sir,

So I’m the senior program manager of this Milo Aips and I’ve been here.

It’s Milo and working as a thoracic oncology ATP since 2013.

I do represent the patient care services on this thoracic oncology cabinet and the goal of patient care services,
which is directed by Kim Slusser.

Is really to advocate and to support for the growth of the Thoracic Oncology Center.

In? With that, we're trying to improve the system issues workflow issues, providing the infrastructure that we need to expand and succeed, as well as continued recruitment in education.

It really takes a dedicated and experienced team to deliver this expert, compassionate care to our patients, and I have to echo what everyone else has been saying.

We have a very gifted team that is formed a multidisciplinary partnership.
Our services include surgical oncology, radiation oncology, medical oncology, pulmonary intervention, pulmonary screening, smoking cessation and our team is huge. I mean, as everyone has been saying, it really does take a village to make this work. It’s not just one particular Department or one particular specialty that makes it all happen. So our team is made up of physician and nursing leadership. Our providers, both physicians and the advanced
practice providers are new patient
00:53:20.323 --> 00:53:22.297

coordinators practice nurses.
00:53:22.297 --> 00:53:23.560

Our clinical trial team,
00:53:23.560 --> 00:53:25.216

which is outstanding.
00:53:25.216 --> 00:53:26.458

Our medical assistants and
00:53:26.460 --> 00:53:29.068

ambulatory care associates and
00:53:27.764 --> 00:53:29.068

the other partners of our team,
00:53:29.068 --> 00:53:30.800

which are the infusion nurses.
00:53:30.800 --> 00:53:32.350

I mean,
00:53:32.350 --> 00:53:33.100

they're really with our patients
00:53:33.100 --> 00:53:34.975

side by side when it comes to
00:53:34.975 --> 00:53:37.913

other medical oncology patients.
00:53:37.913 --> 00:53:39.649

Pharmacy social work.
00:53:39.650 --> 00:53:40.634

Palliative care.
00:53:40.634 --> 00:53:41.290

The checkout people that people that
00:53:41.290 --> 00:53:42.844

are doing the financials radiology
00:53:42.844 --> 00:53:44.324
00:53:44.324 --> 00:53:45.515 interventional radiology pathology
00:53:45.515 --> 00:53:47.500 laboratory in our clinical secretaries.
00:53:47.500 --> 00:53:48.160 I mean,
00:53:48.160 --> 00:53:50.800 we truly have a world class team and
00:53:50.875 --> 00:53:53.384 I'm really happy to be apart of it.
00:53:53.384 --> 00:53:54.040 I mean,
00:53:54.040 --> 00:53:56.336 I think our goal is really to bring
00:53:56.336 --> 00:53:59.094 what we have at smilow to all the
00:53:59.094 --> 00:54:01.234 other delivery networks and to make
00:54:01.234 --> 00:54:03.523 sure that we have that one signature
00:54:03.523 --> 00:54:05.480 care for all of our patients.
00:54:06.540 --> 00:54:08.130 Absolutely a fully integrated team
00:54:08.130 --> 00:54:10.045 and with the best innovation of
00:54:10.045 --> 00:54:11.689 science and technology and and now,
00:54:11.690 --> 00:54:13.508 I'm sorry I didn’t forget you.
I was saving you for last.

So Sarah Goldberg is our research director and I still remember you’re here about eight years now, right? I still remember I was on a trip spending hours trying to recruit Sarah to get her to calm down Lincoln. I really desperately wanted her to come from mass general and get a farmer.

So Sarah tell us a little bit about the lung research team and I’d like to introduce Kuraan Jennifer too. About the the lung research team and how we meet in and how we’re staying on the cutting edge and
some thoughts and then well then we’ll open for questions. 

Well 

This is an amazing forum to bring everybody together and talk about our program.

I’m Sarah Goldberg, a medical oncologist.

I’ve been here for almost 9 years now, right. And so I think you’ve heard from so many people in the group. We have this amazing team and I think so much of what many of us have. Not really all of us focus on is is advancing the care of patients with lung cancer and so much of that is
through clinical trials and basic and translational research that helps inform our clinical trials and so. We've done so much over the last few years to improve the care of patients with lung cancer or targeted therapies have come so far. We have, you know, so many more therapies that we can offer. Patient Scott mention immune therapy were starting to understand resistance and how to overcome it and so now it’s really bringing that to the next level and advancing things even further. And so, as I mentioned, we have this amazing research team we meet.
We used to have one meeting a week and now we have so much to discuss. I think we’re up to like 2-3 meetings a week where we all get together and discuss various aspects of our clinical research program. So huge driving forces behind that are key Republican Jennifer Pope from the clinical Trials Office. And they’ve done so much to help us make our clinical trials of reality open up. You know, the best trials, I think for our patients and keep things running smoothly.
So I’m turning it over to them to introduce themselves and. And tell us about what OK, very good once you go 1st Gen. Hi everybody, I’m Jennifer Pope. I am the clinical trials team manager for the Thoracic group and I’m relatively new to this team but not new to the clinical trials Office. And I am looking forward to continue to work with Doctor Gettinger and work more closely with Doctor Goldberg and hoping to bring some more trials open quicker and to try to find the best trials for the patients
that we have across the network.

So looking forward to that.

Yeah, thanks for all you’ve done and will continue to do KERA.

Hi everyone, thank you for having me and your public.

I’ve been at Yale now for 12 years. This year, eight of which had been in the Clinical Trials Office and I’ve had the pleasure of working with many of those on the panel over the last several years. I’m currently one of the assistant Directors of clinical trials operations in the Clinical Trials Office,
under Director Joyce Tool.

So I’m responsible for the lung Melanoma, therapeutic radiology and head and neck clinical trials disease teams from an operational compliance standpoint. I work closely with the research team, the team leaders, managers, regulatory. Our hospital partners. It really does take a village is so many of you have already said and I want to say to that the investment of the research team is really inspirational on this team. The Link team is fortunate to have some really incredible and veteran team members. They have two research nurses who
are as dedicated as they come. They’ve been here for years series who are dedicated to doing the right thing for the patients. Gen Pope, who’s new and who’s been an excellent addition to the team and I just want to really take time to recognize all of their efforts as well as our regulatory partners in our regulatory manager, Christine Lee. It really does take the hard work of everyone to make what we do possible. Thanks Kera Ed captain, I don’t know if you want to light
up your camera, but I just want.

I just thank you for all you do for multiple teams with certainly

And if you are able to say a little bit about big data and how we're using the database at Yale.

Hi Roy, I wasn’t expecting to be on camera here.

I have the sun in my eyes and I gotta get you in front of me.

Yeah, so Wade Schultz with the hospital has been working very hard to get his computational health platform up and running,
and I think we finally have. Have it to a point where we can start to use it with our patients, so it should be exciting.

He just gave a presentation last week on the new C bio portal implementation that he has there. So a lot of our data will be going into that system that we can, you know, sort of democratize our data for research purposes. So that should be good.
It’s great, so I’m going to say there are three great issues that we have to attack: tackle access, community, and impact. Now these are three things I’d love to see. This team really, really tackle. I’m noticing the last three or four minutes anyone from the panel want to give me some ideas, something that how we get it. How we do that, how we get more patients treated here on protocol? How are we going to have even a bigger impact in our work? And how are we going to do seoi? Which is just so important?
Treat the people that live in our community and want to comment on that.

I'll say in terms of clinical trials. You know, we’ve done a lot of this over the last few years already, and I think it’s worked incredibly well where you showed our clinical trials numbers. I think we don’t feel like we could do better, but we I think we’ve been doing very well in trying to bring our trials to the community as much as possible and a huge part of that is, there’s. People in all of our care centers. Or maybe I’ll say most of our care
centers who really join in our weekly meetings and their part of the team. They give input on what trials we should open and what would be good to have in the Community. And I think we all make every effort to open trials and bring the protocols to the care centers whenever we can, and when that’s not possible, I think having all the clinicians informed about what’s available at the main campus is also really important and we try to do that as well. So I think that brings.

And best carrot, I think most of us agree is on a
01:00:43.442 --> 01:00:45.103 trial it to to the places where the patients are being treated and an if not bringing the patients to the trials.

01:00:50.110 --> 01:00:52.540 Any other comments or thoughts?

01:00:53.708 -- 01:00:55.460 That’s an area that certainly I would hope you’d want to reach.

01:00:57.006 --> 01:01:00.230 people to navigate and get in. How are you guys doing that? Yeah, I think you know you in your introductory you showed a picture.

01:01:08.180 -- 01:01:10.028 You know getting to know the community,
and I think that’s you know, that’s one of the key things
in order to improve access,
you have to get out their boots on the ground to understand
what some of the obstacles are, what some of the knowledge deficits are.
So you know, we’ve had. You know we’ve been fortunate enough to
meet different primary care doctors.
I’ve given a couple talks.
One was at the home for the Brave, a place in Bridgeport that actually
houses homeless veterans to talk about lung cancer screening to kind of learn, not just give a talk, but to learn about, you know what the access issues are to get those folks plugged into our system, ’cause sometimes they. They just don’t know. There are still people in the community that think that the Yale is just down in New Haven and it’s just down in New Haven and it’s getting out there to educate them that you know we’re right next door. You don’t have to go far, so that’s that’s one of the methods boots on the ground.
Hey, any other accounts, if they have one final question, I see Vince DVD on the line so we had a grand rounds three or four years ago when we talked about actions, disease and curing that can we cure lung cancer. What do people think, Scott? Depends on how you define cure, but yes. Radeker yes, I think so. In what way with chemo radiation or with the targeted therapies, the immunotherapy? I mean, I think ultimately we’re going to turn this into a chronic disease, right? So you will see that over
the course of your careers, what do you think Katie from the lab? What’s the most exciting thing coming out of the lab? Well, I think we’re releasing some drugs that are now showing efficacy on some targets that have for a long time been thought to be undruggable targets, for example, like drugs that are targeting carass, which accounts for quite a large subset of lung cancers. And so when we start to see things like that. So our understanding and having drugs that can target these undruggable
targets an you add on to that then.

Other modalities of treating this disease and then bringing it into earlier stages and screening and detection.

I think we’re going to see even more improvements in survival than we have seen in the past few years.

I agree we have to end, but Vince just run in the chat. You already are in a few cases which coming from him means a lot.

I think that we’re making a difference, but it only matters if we get access.

If we screen people and we find these mutations, we figure out how to treat resistance.
and then of course immunotherapy. And we need to personalize that Kurt. I think some of the work you’re doing, you know with all your quantitative unit chemistry with David and others that that perhaps could have our role there, correct? Yeah, you know, I think Roy, I think that it’s critical to understand the patients better, not only have new drugs have being able to use the drugs in the right patient, and that I think is what
01:04:10.888 --> 01:04:12.056 contribute to better care.
NOTE Confidence: 0.8731073
01:04:12.950 --> 01:04:14.980 Well, listen, it’s been a great panel
NOTE Confidence: 0.8731073
01:04:14.980 --> 01:04:17.094 and we’ve had our first Cabinet meeting
NOTE Confidence: 0.8731073
01:04:17.094 --> 01:04:19.440 in public and will do more of these.
NOTE Confidence: 0.8731073
01:04:19.440 --> 01:04:20.720 And we’re going to.
NOTE Confidence: 0.8731073
01:04:20.720 --> 01:04:23.949 The goal is to raise the bar for patients.
NOTE Confidence: 0.8731073
01:04:23.950 --> 01:04:25.931 Uh, and and do it. We have all
NOTE Confidence: 0.8731073
01:04:25.931 --> 01:04:27.660 the pieces in place at the center.
NOTE Confidence: 0.8731073
01:04:27.660 --> 01:04:29.142 We’re going to do this in
NOTE Confidence: 0.8731073
01:04:29.142 --> 01:04:30.130 other disease areas too.
NOTE Confidence: 0.8731073
01:04:30.130 --> 01:04:30.919 Thank you Kevin.
NOTE Confidence: 0.8731073
01:04:30.919 --> 01:04:32.497 Best for all your help and
NOTE Confidence: 0.8731073
01:04:32.497 --> 01:04:33.577 inspiration to all the team.
NOTE Confidence: 0.8731073
01:04:33.580 --> 01:04:35.330 And really there are so many other
NOTE Confidence: 0.8731073
01:04:35.330 --> 01:04:37.144 people that aren’t on the panel that are
NOTE Confidence: 0.8731073
01:04:37.147 --> 01:04:39.019 part of this and we’re really thankful.
Thank you all and see you next week at grand rounds.

Thank you.