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
00:00:36.690 --> 00:00:38.185 a relatively large panel where
00:00:38.185 --> 00:00:39.739 we’re going to hear from some
00:00:39.739 --> 00:00:41.430 of the members of the thoracic
00:00:41.430 --> 00:00:43.152 center and and get their thoughts.
00:00:43.160 --> 00:00:44.735 And there’s also some exciting
00:00:44.735 --> 00:00:46.310 breaking news on lung cancer
00:00:46.365 --> 00:00:47.697 for anyone who has a nap,
00:00:47.700 --> 00:00:49.856 they’ve probably seen the articles in the
00:00:49.856 --> 00:00:52.246 Times and other CNN just in the last hour,
00:00:52.250 --> 00:00:53.948 so we we knew about that.
00:00:53.950 --> 00:00:56.708 So we’re going to talk about that.
00:00:56.710 --> 00:00:57.403 So welcome everyone,
00:00:57.403 --> 00:00:59.399 I’m going to introduce the panel at the end,
00:00:59.400 --> 00:01:00.933 but I’m going to show a few
00:01:00.933 --> 00:01:02.527 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, and 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% The weather or twality for this disease is really improving and you can.
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,

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
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 Frank Susan main. Frank Susan main. Now one of the ranking members of the FDA with Susan was here working with Bonnie Gould, David rhyming.
00:05:04.377 --> 00:05:06.680 Kurt Shopper if any of the scientists
NOTE Confidence: 0.8338785
00:05:06.734 --> 00:05:09.423 in the audience need tissue, we have it.
NOTE Confidence: 0.8338785
00:05:09.423 --> 00:05:11.428 Then I came around 2011,
NOTE Confidence: 0.8338785
00:05:11.430 --> 00:05:12.670 about 10 years ago.
NOTE Confidence: 0.8338785
00:05:12.670 --> 00:05:14.540 Actually, exactly 10 years ago today,
NOTE Confidence: 0.8338785
00:05:14.540 --> 00:05:15.395 and you know,
NOTE Confidence: 0.8338785
00:05:15.395 --> 00:05:17.960 we work very hard to even build further,
NOTE Confidence: 0.8338785
00:05:17.960 --> 00:05:20.759 and we develop the yell spore in lung cancer.
NOTE Confidence: 0.8338785
00:05:20.760 --> 00:05:22.315 P50 the lung nodule screening
NOTE Confidence: 0.8338785
00:05:22.315 --> 00:05:24.257 program is a robust and going
NOTE Confidence: 0.8338785
00:05:26.225 --> 00:05:28.397 about two years ago that Dan Buffa
NOTE Confidence: 0.8338785
00:05:28.397 --> 00:05:30.083 organized and you can see the
NOTE Confidence: 0.8338785
00:05:30.090 --> 00:05:31.950 numbers of people that are involved.
NOTE Confidence: 0.8338785
00:05:31.950 --> 00:05:35.556 This is truly a team effort.
NOTE Confidence: 0.8338785
And here you can see a bit of the evolution and you know people have aged quite gracefully. I think you know. So here is 2004. Now at the very origin Scott I just come 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 Helmand, 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 with with 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. And we're just going to do more of that with this new iteration of the thoracic center.
NOTE Confidence: 0.84947467
00:07:14.630 --> 00:07:15.995 Now thoracic research and I've
NOTE Confidence: 0.84947467
00:07:15.995 --> 00:07:17.670 given grand rounds that my my
NOTE Confidence: 0.84947467
00:07:17.670 --> 00:07:18.950 team have given grand rounds.
NOTE Confidence: 0.84947467
00:07:18.950 --> 00:07:20.300 I just want to introduce
NOTE Confidence: 0.84947467
00:07:20.300 --> 00:07:21.650 that research can be basic.
NOTE Confidence: 0.84947467
00:07:21.650 --> 00:07:23.810 In the lab we have tons of that.
NOTE Confidence: 0.84947467
00:07:23.810 --> 00:07:25.735 Yeah, it’s the best in the world
NOTE Confidence: 0.84947467
00:07:25.735 --> 00:07:27.590 translation or the lab to the clinic.
NOTE Confidence: 0.84947467
00:07:27.590 --> 00:07:29.210 I think that’s the special sauce.
NOTE Confidence: 0.84947467
00:07:29.210 --> 00:07:31.370 Being able to take that back and forth.
NOTE Confidence: 0.84947467
00:07:31.370 --> 00:07:33.386 Of course to the clinic and clinical studies
NOTE Confidence: 0.84947467
00:07:33.386 --> 00:07:35.689 and not to forget outcomes in the community.
NOTE Confidence: 0.84947467
00:07:35.690 --> 00:07:37.040 You know we have proteomics.
NOTE Confidence: 0.84947467
00:07:37.040 --> 00:07:38.390 We have genomics right now.
NOTE Confidence: 0.84947467
00:07:38.390 --> 00:07:39.740 The key is community omics.
NOTE Confidence: 0.84947467
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 --> 00:07:57.648 Again, just a few.
NOTE Confidence: 0.84947467
00:07:57.650 --> 00:07:59.054 Immunotherapy Scotts get out.
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 before I even knew Scott or a new bout.
NOTE Confidence: 0.84947467
00:08:06.070 --> 00:08:08.502 Yeah I.
NOTE Confidence: 0.84947467
00:08:08.502 --> 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. And papers again not meant to be in detail. One of the things we’re going to do as part of this new disease center is keep a full lot. 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.
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.
00:12:43.562 --> 00:12:44.378 align research team.
NOTE Confidence: 0.8792891
00:12:44.380 --> 00:12:45.740 This is a picture from
NOTE Confidence: 0.8792891
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.

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.
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.

with leadership in the in the swag.

Several of the group have

leadership committees.
NOTE Confidence: 0.8792891
00:14:08.230 --> 00:14:09.830 Leadership position in the lung
NOTE Confidence: 0.8792891
00:14:09.830 --> 00:14:11.430 Committee that Decker has leadership
NOTE Confidence: 0.8792891
00:14:11.483 --> 00:14:12.848 myself and several others that
NOTE Confidence: 0.8792891
00:14:12.848 --> 00:14:14.213 Cappelletti and you can see
NOTE Confidence: 0.8792891
00:14:14.265 --> 00:14:15.678 investigator initiated trials.
NOTE Confidence: 0.8792891
00:14:15.680 --> 00:14:18.669 About 10% we’re going to do even
NOTE Confidence: 0.8792891
00:14:18.669 --> 00:14:21.438 more of those for the future.
NOTE Confidence: 0.8792891
00:14:21.440 --> 00:14:22.721 This just opened,
NOTE Confidence: 0.8792891
00:14:22.721 --> 00:14:24.856 I think Scott’s probably downstairs
NOTE Confidence: 0.8792891
00:14:24.856 --> 00:14:27.116 putting someone on so this is
NOTE Confidence: 0.8792891
00:14:27.116 --> 00:14:28.452 an investigator initiated trial
NOTE Confidence: 0.8792891
00:14:28.452 --> 00:14:30.120 with the drug cyclic 15.
NOTE Confidence: 0.8792891
00:14:30.120 --> 00:14:31.488 What does it mean?
NOTE Confidence: 0.8792891
00:14:31.488 --> 00:14:33.540 Investigator initiated Yell holds the Ind
NOTE Confidence: 0.80150825
00:14:33.607 --> 00:14:35.945 Yell is fully responsible for this trial.
NOTE Confidence: 0.80150825
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, Kevin, 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
00:17:12.606 --> 00:17:14.410 you're not listed on the cabinet,
00:17:14.410 --> 00:17:15.196 you're not critical.
00:17:15.196 --> 00:17:16.244 They’re going to work.
00:17:16.250 --> 00:17:17.840 Streams are going to be subgroups,
00:17:17.840 --> 00:17:19.418 but this is just the start.
00:17:19.420 --> 00:17:21.010 As we launch this, I’ve agreed.
00:17:21.010 --> 00:17:22.588 I have plenty else to do,
00:17:22.590 --> 00:17:23.910 but I’m passionate about this.
00:17:23.910 --> 00:17:25.488 I think as you all know,
00:17:25.490 --> 00:17:27.610 and I can work all the different areas.
00:17:27.610 --> 00:17:29.714 I’m going to be the coordinator for now,
00:17:29.720 --> 00:17:31.568 and I’m starting out as a coordinator,
00:17:31.570 --> 00:17:33.404 but Dan Boffa remains the clinical director.
00:17:33.410 --> 00:17:35.258 He’s doing amazing job with this Scott.
00:17:35.260 --> 00:17:35.786 Get challengers,
00:17:35.786 --> 00:17:37.364 our Chief of Thoracic Medical oncology.

NOTE Confidence: 0.8006987

00:17:37.370 --> 00:17:39.554 Sarah Goldberg will be the research director.

NOTE Confidence: 0.8006987

00:17:39.560 --> 00:17:40.718 And Katie Poletti,

NOTE Confidence: 0.8006987

00:17:40.718 --> 00:17:41.876 the scientific director.

NOTE Confidence: 0.8006987

00:17:41.880 --> 00:17:44.211 They only speak working very closely with

NOTE Confidence: 0.8006987

00:17:44.211 --> 00:17:46.530 Kevin and with administrative staff,

NOTE Confidence: 0.8006987

00:17:46.530 --> 00:17:48.846 and this cabinet is meant to

NOTE Confidence: 0.8006987

00:17:48.846 --> 00:17:50.004 represent different disciplines,

NOTE Confidence: 0.8006987

00:17:50.010 --> 00:17:51.558 but also different centers.

NOTE Confidence: 0.8006987

00:17:51.558 --> 00:17:52.719 Suggestions at Greenwich,

NOTE Confidence: 0.8006987

00:17:52.720 --> 00:17:56.656 Vinny is at Bridgeport and I'm going to

NOTE Confidence: 0.8006987

00:17:56.656 --> 00:17:59.828 introduce them all in just one moment.

NOTE Confidence: 0.8006987

00:17:59.830 --> 00:18:00.950 So here's our panel.

NOTE Confidence: 0.8006987

00:18:00.950 --> 00:18:02.890 I did what I wanted to do.

NOTE Confidence: 0.8006987

00:18:02.890 --> 00:18:03.426 20 minutes.

NOTE Confidence: 0.8006987

00:18:03.426 --> 00:18:05.950 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 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.
throughout Connecticut.

So with that, I think I'll stop.

I just went over knowledge.

We have so much support from the team, but also philanthropy.

This is all philanthropy that comes to lung cancer.

More on the way I hope.

And we have peer reviewed funding as well.

So I don't let me see if Lynn is on the line.

Lynn's not here yet, so.

After sort of do a Bayesian approach here.

Lynn's not here yet, so.

So let me stop sharing.

And I'm going to put the screen up.

and let me ask the panel members

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,

Dan Lynn’s about to be here, and I want to save the screening discussion for her.

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. The things that I so I've,
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, 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 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. You know there’s experts in clinical trials. There’s experts in complex surgery. Need to be experts.
not just the tough parts,
but the general well being.
And so we're trying to refine what it feels like to be a patient in the thoracic oncology program. Throughout the entire journey. So what are some of the innovations we hear about robotic surgery, vats, surgery, different techniques or are we using that throughout our system? Yeah, they actually. So all of the surgeons do minimally invasive surgery. The right now three of the six,
we’re going to 7 in July.
Three of the six do robotics,
but 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 robotics
platform is an important part of that.
But I also think that maintaining the principles of oncology and in doing complete resections safely. You know that’s where the and matching people with the most appropriate treatment to their goals of care. I mean, that’s really where the art and science. Come together. Thanks Dan and will get back to you in a bit Lynn. I thanks for joining so I hope your ears were burning so I showed some of those slides you you loan me about the origins of
00:23:21.629 --> 00:23:23.126 top and actually was fortunate.
NOTE Confidence: 0.795016
00:23:23.126 --> 00:23:25.470 I met Lynn about 20 years ago when
NOTE Confidence: 0.795016
00:23:25.530 --> 00:23:27.665 when I first came through and visited
NOTE Confidence: 0.795016
00:23:27.665 --> 00:23:29.763 Yale and then actually one key hiding
NOTE Confidence: 0.795016
00:23:29.763 --> 00:23:31.996 my mentor who is a very strong advocate,
NOTE Confidence: 0.795016
00:23:31.996 --> 00:23:33.088 unfortunately passed away a
NOTE Confidence: 0.795016
00:23:33.088 --> 00:23:34.720 few years ago of prevention.
NOTE Confidence: 0.795016
00:23:34.720 --> 00:23:35.752 We know we talked,
NOTE Confidence: 0.795016
00:23:35.752 --> 00:23:39.178 so then I thought you could
NOTE Confidence: 0.795016
NOTE Confidence: 0.795016
00:23:41.148 --> 00:23:43.466 Say a few words about what you do,
NOTE Confidence: 0.795016
00:23:43.470 --> 00:23:44.730 but there was some news within the
NOTE Confidence: 0.795016
00:23:44.730 --> 00:23:46.158 last hour on lung cancer screening,
NOTE Confidence: 0.795016
00:23:46.160 --> 00:23:47.808 so I did show your first slide show.
00:23:47.810 --> 00:23:48.404 The second slide.
00:23:48.404 --> 00:23:50.090 I can put it up if you want,
00:23:50.090 --> 00:23:51.326 but tell us what’s so exciting.
00:23:51.330 --> 00:23:53.122 It’s in the New York Times right
00:23:53.122 --> 00:23:54.320 now as we speak.
00:23:54.320 --> 00:23:57.251 so as of 11:00 o’clock this morning,
00:23:57.251 --> 00:24:00.795 the United States Preventive Services
00:24:00.795 --> 00:24:02.459 Task Force revised its recommendations
00:24:02.460 --> 00:24:05.790 So Roy, if you could put up the slide,
00:24:05.790 --> 00:24:08.747 OK, Paul is going to help me here.
00:24:08.747 --> 00:24:10.582 And so if you already
00:24:10.582 --> 00:24:12.450 showed this slide I had,
00:24:12.450 --> 00:24:14.627 you know that we’ve been screening on
NOTE Confidence: 0.795016
NOTE Confidence: 0.86453956
NOTE Confidence: 0.86453956
NOTE Confidence: 0.86453956
NOTE Confidence: 0.86453956
NOTE Confidence: 0.86453956
NOTE Confidence: 0.86453956
NOTE Confidence: 0.86453956
NOTE Confidence: 0.86453956
NOTE Confidence: 0.86453956
NOTE Confidence: 0.86453956
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 on 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 that was done in Europe and this much more aligns with the eligibility that was done in Europe and this much more aligns with the eligibility that was done in Europe and this much more aligns with the eligibility that was done in Europe and this much more aligns with the eligibility.

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 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 Anne, certain minority groups,
00:26:10.758 --> 00:26:12.096 including African Americans,
00:26:12.100 --> 00:26:14.900 are more susceptible to lung.
00:26:14.900 --> 00:26:16.760 Carcinogenesis from cigarette smoke,
00:26:16.760 --> 00:26:20.056 but it is clear that those groups
00:26:20.056 --> 00:26:22.196 benefit more than other groups
00:26:22.196 --> 00:26:25.093 when you screen them and the whole
00:26:25.093 --> 00:26:27.307 point of lung cancer screening is
00:26:27.307 --> 00:26:29.820 to find people early because early
00:26:29.820 --> 00:26:32.370 detection means better chance of cure.
00:26:32.370 --> 00:26:34.922 It also lets us have a chance to
00:26:34.922 --> 00:26:37.433 talk to those people about smoking
00:26:37.433 --> 00:26:40.115 cessation which is a big part
00:26:40.198 --> 00:26:42.858 of the decision support visit
00:26:42.858 --> 00:26:44.986 that’s mandatory before every.
00:26:44.990 --> 00:26:47.048 Before the 1st initial Screening Study,
00:26:47.050 --> 00:26:50.137 an having had the chance to cover for Poly.
NOTE Confidence: 0.8483535
00:26:50.140 --> 00:26:52.534 Recently, Anne and talk to 8 people.
NOTE Confidence: 0.8483535
00:26:52.540 --> 00:26:54.250 One day about tobacco cessation,
NOTE Confidence: 0.8483535
00:26:54.250 --> 00:26:57.680 an one of them quit on the basis of that,
NOTE Confidence: 0.8483535
00:26:57.680 --> 00:26:59.726 I think that that’s a huge
NOTE Confidence: 0.8483535
00:26:59.726 --> 00:27:01.442 opportunity that actually will be
NOTE Confidence: 0.8483535
00:27:01.442 --> 00:27:03.164 expanded as well because of the
NOTE Confidence: 0.8483535
00:27:03.164 --> 00:27:05.230 change in the screening criteria.
NOTE Confidence: 0.8483535
00:27:05.230 --> 00:27:07.288 So we’re pretty excited about that.
NOTE Confidence: 0.8483535
00:27:07.290 --> 00:27:10.368 That’s going to be a huge amount of work.
NOTE Confidence: 0.8483535
00:27:10.370 --> 00:27:13.114 We have some time before CNS approves that,
NOTE Confidence: 0.8483535
00:27:13.120 --> 00:27:14.830 but CNS will approve it.
NOTE Confidence: 0.8483535
00:27:14.830 --> 00:27:16.012 If USPS TF.
NOTE Confidence: 0.8483535
00:27:16.012 --> 00:27:16.800 Recommended it,
NOTE Confidence: 0.8483535
00:27:16.800 --> 00:27:19.016 so we’re going to be gearing up right?
NOTE Confidence: 0.80038095
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, and 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
early will help so many more people.

And actually maze surgery or surgery and then chemo radiation.

But first with surgery,

tell us a little bit what you do.

You’re at Bridgeport and actually so you have an amazing screening talk.

A few months ago so you obviously doing a lot of it there. Yeah no thanks allot you asked to talk about the Four WS, what, where and why. I’m Vinny, you know, I’m one of the thoracic surgeons, one of 6/2.

Soon to be 7 like Dan talked about and I’m the site director for thoracic surgery at 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 understanding the regional differences that Doctor Tamui 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, 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 in lung cancer screening, so it’s going to grow quite quickly. And what is the importance of working together in this way?
00:31:01.270 --> 00:31:03.080 Thanks for having me Justin
NOTE Confidence: 0.81839705
00:31:03.080 --> 00:31:04.166 Blasberg thoracic surgery.
NOTE Confidence: 0.81839705
00:31:04.170 --> 00:31:06.954 I work for Vinny and Dan with Vinny
NOTE Confidence: 0.81839705
00:31:06.954 --> 00:31:09.596 and Dan and Fort Vinny and Dan.
NOTE Confidence: 0.81839705
00:31:09.600 --> 00:31:11.766 I. I’ve been at Greenwich since
NOTE Confidence: 0.81839705
00:31:11.770 --> 00:31:13.576 the beginning of the year,
NOTE Confidence: 0.81839705
00:31:13.576 --> 00:31:15.028 and like Vinny said,
NOTE Confidence: 0.81839705
00:31:15.030 --> 00:31:16.945 we’ve been working towards bringing
NOTE Confidence: 0.81839705
00:31:16.945 --> 00:31:19.672 our standard of the New Haven campus
NOTE Confidence: 0.81839705
00:31:19.672 --> 00:31:22.262 across the network and Vinny’s done a
NOTE Confidence: 0.81839705
00:31:22.262 --> 00:31:24.612 really good job doing that over the
NOTE Confidence: 0.81839705
00:31:24.612 --> 00:31:27.614 past couple of years and my goal at
NOTE Confidence: 0.81839705
00:31:27.614 --> 00:31:30.200 Greenwich is to mirror that success.
NOTE Confidence: 0.81839705
00:31:30.200 --> 00:31:31.385 On all fronts,
NOTE Confidence: 0.81839705
00:31:31.385 --> 00:31:33.365 including an ear *** protocol.
NOTE Confidence: 0.81839705
00:31:33.365 --> 00:31:35.340 Developing lung cancer screening program,
bringing robust robotic surgery to Greenwich, which granted already has that capability but will be able to sort of bring our expertise to that campus, which is great for patients and then also our multi-disciplinary clinics similar to what we have in this sort of the New Haven campus. There's a critical mass there of thoracic support, both a sunley for medical oncology. And others from radiation oncology and an opportunity for us to see patients in a common space and talk.
about multi modal approaches to

treating patients with either early

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 radiation

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
00:33:14.876 --> 00:33:17.160 were the thoracic radiation oncologist.
NOTE Confidence: 0.818339

00:33:17.160 --> 00:33:19.472 When Top was born and we now
NOTE Confidence: 0.818339

00:33:19.472 --> 00:33:22.178 have a large network of fantastic
NOTE Confidence: 0.818339

00:33:22.178 --> 00:33:24.234 thoracic providers that serve.
NOTE Confidence: 0.818339

00:33:24.240 --> 00:33:25.532 All of our sites,
NOTE Confidence: 0.818339

00:33:25.532 --> 00:33:27.470 and I’ve recently turned over the
NOTE Confidence: 0.818339

00:33:27.540 --> 00:33:29.264 clinical leadership of thoracic
NOTE Confidence: 0.818339

00:33:29.264 --> 00:33:31.419 radiation oncology to Henry Park
NOTE Confidence: 0.818339

00:33:31.419 --> 00:33:33.570 was not able to be here today,
NOTE Confidence: 0.818339

00:33:33.570 --> 00:33:35.894 but Henry is done really an amazing
NOTE Confidence: 0.818339

00:33:35.894 --> 00:33:38.059 job in creating a cohesive thoracic
NOTE Confidence: 0.818339

00:33:38.059 --> 00:33:40.249 radiation unit that can offer all
NOTE Confidence: 0.818339

00:33:40.249 --> 00:33:43.240 of our new technology and all of our
NOTE Confidence: 0.818339

00:33:43.240 --> 00:33:45.417 exciting treatments at all of our
NOTE Confidence: 0.818339

00:33:45.417 --> 00:33:47.930 sites in in a very uniform fashion.
NOTE Confidence: 0.818339

00:33:47.930 --> 00:33:53.280 And so I give him a lot of credit for that.
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.

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.

Right, one of these protons I hear about it carbon and everyone wants the newest techniques.

Are we moving towards any of those and are they better or do they need studies?
Yeah, so so we are moving forward with a couple of new technologies so we are hoping to build a 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 and this is, you know, 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
00:35:34.579 --> 00:35:36.592 why I think were so strong on this
NOTE Confidence: 0.80467445
00:35:36.592 --> 00:35:38.314 long program with spores and stand
NOTE Confidence: 0.80467445
00:35:38.314 --> 00:35:40.256 up for cancer grants and more are
NOTE Confidence: 0.80467445
00:35:40.256 --> 00:35:42.459 ones that I can even count to press.
NOTE Confidence: 0.80467445
00:35:42.460 --> 00:35:44.301 Katie, you’ve been here over 10 years
NOTE Confidence: 0.80467445
00:35:44.301 --> 00:35:45.998 and really has formed the basis.
NOTE Confidence: 0.80467445
00:35:46.000 --> 00:35:47.687 You know with many other scientists but
NOTE Confidence: 0.80467445
00:35:47.687 --> 00:35:50.100 but is now our scientific Director and Katie,
NOTE Confidence: 0.80467445
00:35:50.100 --> 00:35:51.465 we’ve really seen the science
NOTE Confidence: 0.80467445
00:35:51.465 --> 00:35:52.557 of lung cancer grow.
NOTE Confidence: 0.80467445
00:35:52.560 --> 00:35:54.387 I know when when I went into
NOTE Confidence: 0.80467445
00:35:54.387 --> 00:35:55.829 this field 2025 years ago,
NOTE Confidence: 0.80467445
00:35:55.830 --> 00:35:58.295 no one wanted to work in this field, but.
NOTE Confidence: 0.80467445
00:35:58.295 --> 00:35:59.395 Anything, breakthroughs and only
NOTE Confidence: 0.80467445
00:35:59.395 --> 00:36:01.220 we only have a few minutes,
NOTE Confidence: 0.80467445
00:36:01.220 --> 00:36:02.708 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? I’m Katie Polit. I’m a cancer biologist. I’ve 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, 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, like EGF receptor for example,
another oncogenic drivers or

carass for example in the cell,

but also that are tumor cell extrinsic.

So targets in the micro

environment and we have.

You heard about this new next cure trial,

for example, from Roy.

That is an example of that.

We also have a lot of groundbreaking

studies in modeling lung cancer,

so developing new and better models to

study the biology of lung cancer and to

study sensitivity and resistance to therapy.

And again,

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
happening in those human tumors. And understand the biology of the disease in those contexts, and so with these different models, we can leverage them then to study mechanisms of sensitivity and of resistance to therapy and really get to some of these very difficult issues that are being faced by patients in the clinic. And so I think that those are just some examples of areas and things of work that is ongoing here at Yale, and I think this is a great place to really bring together
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 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.
00:40:00.320 --> 00:40:02.180 You’re here and how long
NOTE Confidence: 0.8319545
00:40:02.180 --> 00:40:04.040 are you at your now?
NOTE Confidence: 0.8319545
00:40:04.040 --> 00:40:06.760 You’re on the screen. I’ve
NOTE Confidence: 0.8420241
00:40:06.760 --> 00:40:09.119 been here longer than most of you,
NOTE Confidence: 0.8420241
00:40:09.120 --> 00:40:10.477 Lynn’s been here longer,
NOTE Confidence: 0.8420241
00:40:10.477 --> 00:40:12.162 but over over 15 years,
NOTE Confidence: 0.8420241
00:40:12.162 --> 00:40:13.860 and I’ve certainly seen dramatic
NOTE Confidence: 0.8420241
00:40:13.860 --> 00:40:16.950 change in our loan program.
NOTE Confidence: 0.8420241
00:40:16.950 --> 00:40:18.528 Great, now is that everyone
NOTE Confidence: 0.82667166
00:40:18.530 --> 00:40:20.105 sort of come together and
NOTE Confidence: 0.82667166
00:40:20.105 --> 00:40:21.363 then it’s raster program.
NOTE Confidence: 0.82667166
00:40:21.363 --> 00:40:23.565 I think we’re great model for other
NOTE Confidence: 0.82667166
00:40:23.565 --> 00:40:25.460 cancer groups because we have basic
NOTE Confidence: 0.82667166
00:40:25.460 --> 00:40:27.030 scientists are working with us.
NOTE Confidence: 0.82667166
00:40:27.030 --> 00:40:28.922 We have clinicians. We have things.
NOTE Confidence: 0.82667166
00:40:28.922 --> 00:40:31.125 We have all sorts of people working
on the same projects for me. My problem, my primary responsibility is treating my patients and we certainly have a good amount of patience and my second responsibility is to learn from my patients and to try to understand who responds and who doesn’t respond so we can extend responses to all of our patients. And for me, I do this with all of you and primarily with Katie Palladian. I we have a protocol where we aggressively biopsy patients their tumors, their blood sites of toxicity, and stand. Who’s responding? Who’s responding?
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 10-20 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,
00:41:33.060 --> 00:41:36.000 we’re trying to get to that let me ask you,
00:41:36.000 --> 00:41:37.470 you’ve been here. You recruited,
00:41:37.470 --> 00:41:38.662 probably Wilson was director.
00:41:38.662 --> 00:41:39.556 Eddie Chu yeah.
00:41:39.560 --> 00:41:42.071 So tell me how did you get that first
00:41:42.071 --> 00:41:44.475 trial with Nivo Map was a trial that was
00:41:44.475 --> 00:41:46.376 being run with Mario tells the story.
00:41:46.380 --> 00:41:47.512 It’s pretty exciting, no.
00:41:47.512 --> 00:41:50.209 So so I have my office is no Hall with
00:41:50.209 --> 00:41:52.390 Mario Show who’s really a giant when it
00:41:52.390 --> 00:41:54.022 comes to immuno therapies for cancer
00:41:54.022 --> 00:41:56.468 and he one day just knocked on my door.
00:41:56.468 --> 00:41:58.330 Since I got this trial of this
00:41:58.396 --> 00:42:00.546 drug MDX 1106 and I said what is
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. Frank 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 --> 00:44:05.718 the surgeons with Frank on their screening.
NOTE Confidence: 0.82436866
00:44:00.848 --> 00:44:02.583 We provide the reports in a
NOTE Confidence: 0.82436866
00:44:02.590 --> 00:44:04.680 way that can help declination
NOTE Confidence: 0.82436866
00:44:04.680 --> 00:44:05.718 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
00:44:07.808 --> 00:44:09.200 you first start scanning.
NOTE Confidence: 0.82436866
00:44:09.200 --> 00:44:12.430 A lot of people you see all the other
NOTE Confidence: 0.82436866
00:44:12.430 --> 00:44:14.405 things thyroid nodule adrenal nodule.
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.
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.
Always about, you know.
Expertise in radiology across the
whole network is 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.
You do you review all the
NOTE Confidence: 0.79031104
00:46:20.445 --> 00:46:21.899 pathology before we treat before
NOTE Confidence: 0.79031104
00:46:21.899 --> 00:46:23.399 we make a diagnosis here?
NOTE Confidence: 0.79031104
00:46:23.400 --> 00:46:25.098 Even if it’s from the outside.
NOTE Confidence: 0.79031104
00:46:25.100 --> 00:46:26.228 First of all, I
NOTE Confidence: 0.79031104
00:46:26.230 --> 00:46:28.494 wanna thank you for letting me talk today.
NOTE Confidence: 0.79031104
00:46:28.500 --> 00:46:29.826 That’s really great.
NOTE Confidence: 0.79031104
00:46:29.826 --> 00:46:32.370 Lynn Tanui, I have the old folks.
NOTE Confidence: 0.79031104
00:46:32.370 --> 00:46:35.367 I’ve only been in jail since for 42 years,
NOTE Confidence: 0.79031104
00:46:35.370 --> 00:46:37.368 so not here my whole life.
NOTE Confidence: 0.79031104
00:46:37.370 --> 00:46:39.866 But so far so the role pathology really
NOTE Confidence: 0.79031104
00:46:39.866 --> 00:46:42.686 is sort of central to the whole process.
NOTE Confidence: 0.79031104
00:46:42.690 --> 00:46:44.022 Everything sort of narrows
NOTE Confidence: 0.79031104
00:46:44.022 --> 00:46:45.687 down through the you know,
NOTE Confidence: 0.79031104
00:46:45.690 --> 00:46:47.688 the eyes of some histopathologist somewhere.
NOTE Confidence: 0.79031104
00:46:47.690 --> 00:46:49.350 It’s actually make a diagnosis.
NOTE Confidence: 0.79031104
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 something that 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 of small cells sort of shown up. 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, you know, 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.
doing the same thing for pathology images, which we hope to get to at some point as well.

Yep, thanks Robin for everything you do and it’s good to know.

Every Monday morning we might not be there, but you’re there and and you know really, keeping the tumor board running and no will do more of that.

So you know when I came here to build us for, it’s really based on tissue. Yeah, strong statistician.

You of course need a science. So I was fortunate to meet 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 this guy in my lab is great. We’ve got to keep him here. I 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
Kurt tell us a little bit about
yourself and what you do.
And thanks for being here today.

Thanks Roy. So I’m Kurt chopper.
I’m a pathologist,
an immuno oncology researcher.
I joined us an assistant professor
and was appointed in 2015 and
we have had a very active.
we have had a very active.
I got any program actually look up today
and we have 64 publications since 2015.
More than 20 trainees and a lot of grants
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 now we’re trying with Dave Rim. Actually, we have implemented a lot of technology and we have been trying to be ahead of the game, and now we’re trying with Dave Rim. Actually, we have implemented a lot of technology and we have been trying to be ahead of the game, and now we’re trying with Dave Rim. Actually, we have implemented a lot of technology and we have been trying to be ahead of the game, and now we’re trying with Dave Rim. Actually, we have implemented a lot of technology and we have been trying to be ahead of the game, and now we’re trying with Dave Rim.
The other aspects of my function within the top program has been to oversee the biospecimen repository that was, 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 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

nurse practitioners

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, thanks right?

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. 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.
practice providers are new patient.
NOTE Confidence: 0.7789418
00:53:22.297 --> 00:53:23.560 coordinators practice nurses.
NOTE Confidence: 0.7789418
00:53:23.560 --> 00:53:25.216 Our clinical trial team,
NOTE Confidence: 0.7789418
00:53:25.216 --> 00:53:26.458 which is outstanding.
NOTE Confidence: 0.7789418
00:53:26.460 --> 00:53:29.068 Our medical assistants and
NOTE Confidence: 0.7789418
00:53:29.068 --> 00:53:30.800 the other partners of our team,
NOTE Confidence: 0.7789418
00:53:30.800 --> 00:53:32.350 which are the infusion nurses.
NOTE Confidence: 0.7789418
00:53:32.350 --> 00:53:33.100 I mean,
NOTE Confidence: 0.7789418
00:53:33.100 --> 00:53:34.975 they’re really with our patients
NOTE Confidence: 0.7789418
00:53:34.975 --> 00:53:37.913 side by side when it comes to
NOTE Confidence: 0.7789418
00:53:37.913 --> 00:53:39.649 other medical oncology patients.
NOTE Confidence: 0.7789418
00:53:39.650 --> 00:53:40.634 Pharmacy social work.
NOTE Confidence: 0.7789418
00:53:40.634 --> 00:53:41.290 Palliative care.
NOTE Confidence: 0.7789418
00:53:41.290 --> 00:53:42.844 The checkout people that people that
NOTE Confidence: 0.7789418
00:53:42.844 --> 00:53:44.324 are doing the financials radiology
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 --> 00:54:01.234 what we have at smilow to all the
00:54:01.234 --> 00:54:03.523 other delivery networks and to make
00:54:03.523 --> 00:54:05.480 sure that we have that one signature
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 you know 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 some some thoughts and then

Well then we’ll open for questions.

Well thanks right?

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 research. Clinical trials and translational research help 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 they do. OK, very good. 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 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
00:58:11.046 --> 00:58:12.900 up your camera, but I just want.
NOTE Confidence: 0.78598315
00:58:12.900 --> 00:58:15.388 I just thank you for all you do for
NOTE Confidence: 0.78598315
00:58:15.388 --> 00:58:16.973 for multiple teams with certainly
NOTE Confidence: 0.78598315
00:58:16.973 --> 00:58:19.287 the lung Groupon and the lung Spore.
NOTE Confidence: 0.78598315
00:58:19.290 --> 00:58:21.298 And if you are able to say a
NOTE Confidence: 0.78598315
00:58:21.298 --> 00:58:23.483 little bit about big data and how
NOTE Confidence: 0.78598315
00:58:23.483 --> 00:58:25.490 we’re using the database at Yale.
NOTE Confidence: 0.843073
00:58:27.770 --> 00:58:28.654 Hi Roy, I wasn’t expecting
NOTE Confidence: 0.843073
00:58:28.654 --> 00:58:29.534 to be on camera here.
NOTE Confidence: 0.843073
00:58:29.540 --> 00:58:30.779 I have the sun in my eyes
NOTE Confidence: 0.843073
00:58:30.779 --> 00:58:31.838 and I gotta get you in
NOTE Confidence: 0.843073
00:58:31.840 --> 00:58:32.368 front of me.
NOTE Confidence: 0.8308418
00:58:34.110 --> 00:58:35.916 Yeah, so Wade Schultz with the
NOTE Confidence: 0.8308418
00:58:35.916 --> 00:58:37.422 hospital has been working very
NOTE Confidence: 0.8308418
00:58:37.422 --> 00:58:38.930 hard to get his computational
NOTE Confidence: 0.8308418
00:58:38.930 --> 00:58:40.430 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 science 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. We have a few questions where we’re at time, but you know this is like having our first Cabinet meeting.
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 are we going to have 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. In terms of clinical trials, 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 you know give input on to 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,
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?

01:00:52.540 --> 01:00:53.708 Vinny, you're in Bridgeport.

01:00:53.708 --> 01:00:55.460 That's an area that certainly I would hope you'd want to reach out to the community and help 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. I think you were at a church or you were out there.

01:01:00.230 --> 01:01:03.386 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. You know we’ve had you know, lunch meals that you know the, get out there pre covid to meet people, 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 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 and 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 we’re achieving and expanding, and that will certainly
contribute to better care.

Well, listen, it’s been a great panel and we’ve had our first Cabinet meeting in public and will do more of these. The goal is to raise the bar for patients. Uh, and do it. We have all the pieces in place at the center. We’re going to do this in other disease areas too. Thank you Kevin. Best for all your help and inspiration to all the team. And really there are so many other people that aren’t on the panel that are part of this and we’re really thankful.
Thank you all and see you next week at grand rounds.
Thank you.