OK, why don’t we? Oh, get started. We have a good number of people on the line now. Welcome to grand rounds. Today May 18th, 2021. We’re focusing on GI cancers today, challenges and opportunities and we’ll hear from two members of that newly formed center. It was actually the first official disease center that we formed, and it’s fitting that we have these two speakers. And what we’ll do is we’ll have each
00:00:35.778 --> 00:00:38.290 speak for 2025 minutes and then
00:00:38.290 --> 00:00:40.906 we’ll do some questions right after.
00:00:40.910 --> 00:00:43.675 So the first is Doctor Pan Kunz,
00:00:43.680 --> 00:00:46.050 who is associate professor of internal
00:00:46.050 --> 00:00:47.630 medicine and medical oncology,
00:00:47.630 --> 00:00:50.367 and the director of the Center for
00:00:50.367 --> 00:00:53.184 GI Cancers and the and the and
00:00:53.184 --> 00:00:55.530 the Chief of GI Medical Oncology.
00:00:55.530 --> 00:00:58.690 And we’re really fortunate to have Pam here.
00:00:58.690 --> 00:01:01.448 She’s been here less than a year.
00:01:01.450 --> 00:01:03.804 She moved from Palo Alto, Atherton.
00:01:03.804 --> 00:01:06.422 And two New Haven during a very
00:01:06.422 --> 00:01:07.969 tough year to travel.
00:01:07.970 --> 00:01:10.574 So we’re so happy you came Pam.
00:01:10.580 --> 00:01:12.340 She received her medical degree
00:01:12.340 --> 00:01:14.274
from Dartmouth Medical School and Residency and Fellowship at Stanford.

She then was at Stanford until she joined us in 2020 at Stanford. She was the director of the Stanford Neuroendocrine Tumor Program, the leader of Endocrine Oncology Research Group and the Director of the Neuroendocrine Tumor Fellowship.

As you all probably know, she’s an international leader in the clinical care of patients with neuroendocrine tumors. We call those Nets and ETS and is advancing the field through clinical trials and translational research.
She’s got a broad investigation or program and you’re going to hear today about her, her plans, and what she’s already initiated to really build her own program. But more importantly, the entire Geo program here at the Yale Cancer Center Smile Cancer Hospital, so Pam, thanks for being here today and I’m looking forward to your talk.
00:02:11.664 --> 00:02:13.890 Well thank you everybody and where I
NOTE Confidence: 0.82296735
00:02:13.948 --> 00:02:16.048 thank you for that kind introduction.
NOTE Confidence: 0.82296735
00:02:16.050 --> 00:02:17.904 I’m very excited to share with
NOTE Confidence: 0.82296735
00:02:17.904 --> 00:02:19.730 you our GI cancer program.
NOTE Confidence: 0.82296735
00:02:19.730 --> 00:02:22.058 But before we jump in I just want
NOTE Confidence: 0.82296735
00:02:22.058 --> 00:02:24.850 you to save the date for a very
NOTE Confidence: 0.82296735
00:02:24.850 --> 00:02:27.080 exciting grand rounds in two weeks.
NOTE Confidence: 0.82296735
00:02:27.080 --> 00:02:28.958 See we’re having our first annual
NOTE Confidence: 0.82296735
00:02:28.958 --> 00:02:30.750 yield Center for GI cancers.
NOTE Confidence: 0.82296735
00:02:30.750 --> 00:02:31.752 Visiting lectureship with
NOTE Confidence: 0.82296735
00:02:31.752 --> 00:02:33.088 Doctor Marcia Cruz Korea.
NOTE Confidence: 0.82296735
00:02:33.090 --> 00:02:35.142 She is a professor of medicine
NOTE Confidence: 0.82296735
00:02:35.142 --> 00:02:36.923 and biochemistry and the director
NOTE Confidence: 0.82296735
00:02:36.923 --> 00:02:39.011 of the GI Oncology Program at
NOTE Confidence: 0.82296735
00:02:39.011 --> 00:02:40.869 the University of Puerto Rico.
NOTE Confidence: 0.82296735
00:02:40.870 --> 00:02:43.236 She has held leadership roles in ACR,
most recently the women in Cancer Research Committee and she was the chairperson for that. The focus of her research is understanding genetic and AP genetic pathways for colorectal cancer among Hispanic patients. So we’re very excited to host her in a couple of weeks. So I will be sharing the virtual podium today with Doctor, Mandar, Mazumdar and we are excited to share with you an overview of the program and some of the goals Mandar will take on the scientific vision.
So I’d like to start off just by recognizing that this is a an incredible team effort and what I will be talking about today really is the work of the entire team. It’s been a pleasure to get to meet everybody will be at mostly by zoom over the last year, and we have really tremendous team members and have started also doing some recruiting. These are my disclosures, so I will take on providing you a background on GI cancers talking about this newly launched center and then I’ll speak about our patient care.
education and clinical research

initiatives and then I will pass

the baton to Doctor Mazumdar.

So first just a brief background

on GI cancers and aspects that

make up make our center unique.

So if you try to count up all of the

different primary sites in the GI system,

there are at least 12.

Depending on how you count them,

and I think that poses both some

challenges and some opportunities as

we think about developing a center

and really trying to address all of

these different primary sites via all
00:04:24.815 --> 00:04:27.160 of the main pillars of patient education,
NOTE Confidence: 0.89496815

00:04:27.160 --> 00:04:29.026 patient care, education,
NOTE Confidence: 0.89496815

00:04:29.026 --> 00:04:30.270 and research.
NOTE Confidence: 0.89496815

00:04:30.270 --> 00:04:32.979 In terms of estimated new cancer cases,
NOTE Confidence: 0.89496815

00:04:32.980 --> 00:04:35.896 colon, rectal and pancreas are in
NOTE Confidence: 0.89496815

00:04:35.896 --> 00:04:39.869 the top 10 for both men and women.
NOTE Confidence: 0.89496815

00:04:39.870 --> 00:04:40.313 However,
NOTE Confidence: 0.89496815

00:04:40.313 --> 00:04:42.971 there is a larger proportion attributed
NOTE Confidence: 0.89496815

00:04:42.971 --> 00:04:45.810 to GI cancers or estimated deaths.
NOTE Confidence: 0.89496815

00:04:45.810 --> 00:04:46.650 In fact,
NOTE Confidence: 0.89496815

00:04:46.650 --> 00:04:50.010 27% of estimated deaths in men or due
NOTE Confidence: 0.89496815

00:04:50.106 --> 00:04:53.578 to GI cancers that school in pancreas,
NOTE Confidence: 0.89496815

00:04:53.580 --> 00:04:54.036 liver,
NOTE Confidence: 0.89496815

00:04:54.036 --> 00:04:57.684 and oesophageal and for women it’s about 21%.
NOTE Confidence: 0.89496815

00:04:57.690 --> 00:04:58.147 Colon,
NOTE Confidence: 0.89496815

00:04:58.147 --> 00:04:59.518 pancreas and liver.
We’ve also had a number of FDA approvals over the last 12 months. This is since May of 2020 in fact, just in the last six weeks we’ve had three new FDA approvals in the immunotherapy space for advanced Asafa Geo, Pembroke Plus for permitting nivo plus floor permitting and Pembroke Plus tries to the map in floor permitting. So it’s been very exciting for us. GI cancers have also been in the news quite a bit in the last year, which I think has done a lot to raise awareness.
awareness, which is quite important.

So Chadwick Boseman sadly died at a very young age of colorectal cancer.

Ruth Bader Ginsburg died of metastatic pancreas cancer.

We’ve also seen recommendations for the colon cancer screening age to drop to age 45, and this is on the basis of a draft recommendation from the United States President. Preventive Services task force.

For average risk, adults age 45 to 49 that they should start screening. This is not been put into practice just yet.

So in terms of our center, I think Kevin best for this slide.
Many of you have seen this, but Roy and I are in a bit of a competition, so both of our centers have launched. We went. We just edged out the thoracic center, but it’s very exciting and there are 13 more centers yet to launch. These centers, I think, as many of you know, have a shared organizational structure with a leadership cabinet. There are common rules in all the disease centers. These include the director, and I will be serving that position.
for our center patient care Services

Director Maureen Major Campos and Operations and planning director.

I also have a scientific director, doctor Mandel, Razum Dar,

which I’m very excited about it. I’m currently serving an interim role as the clinical director.

We also have the flexibility of adding a number of ad hoc rules specific to GI cancers.

We wanted all of the relevant stakeholders to have a place in this leadership cabinet.

So these include Sir junk education, cancer imaging, RAD ONC pathology,
and Network Director, biorepository advanced endoscopy and importantly, 
You’ll see that that GI service line dotted line is really indicated to represent a bridge with our 
Bosco has done a wonderful job building a liver cancer program over 
many years and we still plan to work very closely with he and his team. 
In addition, we have started and launched for disease specific programs,
including pancreas,

neuroendocrine advanced hepatic

bilary and colorectal ING.

Alone.

I'll speak about those in just

a moment and we have some tumor

boards that match up with these,

which we will also talk about.

So we have implemented some

new meetings on the yellow.

The yellow Star indicates things

that have been implemented newly

in the last year, so we have had an

existing trimmer but actually just

yesterday we launched a split, so this

is now a single hour and a half meeting,
but we have an upper GI pancreas net tumor board and a colorectal **** tumor board.
The Liver Tumor Board is still on Thursdays. We have our existing DART clinical trial review, but we started a Center for GI Cancer Seminar series on Thursday afternoons that consists of Journal club being led by Doctor Christie Gomez. Scientifiche talks clinical talks and industry pipeline talks. In addition, we’ve started a number of working groups and committees. This includes a GI tumor board revamp working group.
This initial phase has concluded, but we will continue to meet quarterly a GI multi D Clinic working group. We started this in March and or having monthly meetings to pilot some multi D clinic switch, I will speak about on a later slide. We have leadership cabinet meetings and program leader meetings. So we’ve been quite busy. So I’ll speak next about our disease programs. I want to mention some shared themes that I won’t repeat on some of the specific slides, but we all envision in the pancreas,
colorectal advanced hepatic bilary, and net programs to focus on these pillars. So multi disciplinary clinics, tumor boards, care coordination really important to GI cancers, integration of palliative care and we actually just have newly recruited Doctor Laura Baum who is palliative care and he Monk trained. She will join us this summer. In terms of education, we plan on expanding physician education and CME events, patient education events,
mentoring with shovel ready, projects for trainees, and plan an advanced fellowship in GI Oncology for research. We hope to expand on clinical trials, specifically IIts. That's something that we need to increase in our portfolio and I will let Doctor Mazumdar speak later about some of our basic and translational research efforts. And then Lastly, I'd like to think of this as the fourth pillar, and particularly in my role as the Vice
Chief for DTI and getting more involved

with community engagement and HealthEquity.

I’d like for us to think about these aspects as we do all of our patient care,
education,

and research.

So the pancreas program is being Co led by doctors Jill Lacy and Mandar Mazumdar.

And in terms of patient care

would I have done on these sides?

Is underlying some of the key aspects

that are unique to this program

so they have planned a pilot,

pancreatic cancer multi D clinic with

a focus on non metastatic disease.
We have just recently started point of care.

Germline testing with collaboration with Shabbier your and his cancer genetics team.

Advanced endoscopy expertise.

As I’d mentioned, we are embedding palliative care in our program and we had a pink pancreatic cancer early detection clinic in terms of education.

We are hoping to launch a pancreatic cancer interest group for trainees and then in terms of Community wide efforts, we had a very successful Yale Pack seminar series this past year under Research Summit led by Mandor.

In terms of research,
50% of our new pancreas patients are consented into clinical trials and we have been the leading in roller for clinical trials in the US between 2016 and 2019, we treated over 400 patients, 38% at care centers from on clinical trials, and we plan to grow the IIT. Samples and this represents 61% of all of our biorepository samples, so that’s a problem for the other diseases which we will speak to as an opportunity. And then we also plan on leveraging innovative multi omics profiling on the right are some of our recent publications.
The colorectal program is Co led by doctors Michael Cicchini Shabbier your and ready in terms of patient care, we plan on developing a Nurse Navigator program, fully integrating genomics with patient care and developing an early age of onset colorectal clinic in terms of education, we hope to work with stakeholders such as this Milo screening program on public campaigns. This is especially pertinent as the USPS TF guidelines. Roll out for the lower colorectal cancer screening age. And then, in terms of research
00:12:55.498 --> 00:12:57.270 for the colorectal program,
NOTE Confidence: 0.86282706
00:12:57.270 --> 00:12:59.944 we aim to enhance collection of colorectal specimen in aryel GI BIOREPOSITORY and
NOTE Confidence: 0.86282706
00:13:02.720 --> 00:13:04.796 increased clinical trial enrollment,
NOTE Confidence: 0.86282706
00:13:04.800 --> 00:13:05.892 again with IIT's,
NOTE Confidence: 0.86282706
00:13:05.892 --> 00:13:08.440 and then expand the early age of onset colorectal cancer thinktank.
NOTE Confidence: 0.86282706
00:13:11.000 --> 00:13:13.598 This is a committee that was started by Shawbury Orangel Mamma.
NOTE Confidence: 0.86282706
00:13:13.598 --> 00:13:15.880 And then Lastly, our community outreach plans for colorectal with
NOTE Confidence: 0.88139915
00:13:17.910 --> 00:13:20.664 And then Lastly, our community outreach
NOTE Confidence: 0.88139915
00:13:20.664 --> 00:13:23.750 and engagement plans for colorectal with
NOTE Confidence: 0.88139915
00:13:23.750 --> 00:13:26.690 developing targeted strategies and special
NOTE Confidence: 0.88139915
00:13:26.690 --> 00:13:29.390 emphasis on underserved populations.
NOTE Confidence: 0.88139915
00:13:29.390 --> 00:13:31.425 The advanced hepatic Bilary program
NOTE Confidence: 0.88139915
00:13:31.425 --> 00:13:34.229 built will link very closely with Mario,
This is being Co led by doctors, David Madoff, Stacy Stein and Saj Khan and the Patient Care Education. We routinely perform tumor profiling for biliary cancers, which has proven critical in terms of therapy selection. In terms of education, mostly within the liver cancer program and some of the research plans are very much in line with the other shared programmatical’s. The neuroendocrine tumor program.
I will be co-leading with Doctor Darko Pukaar from nuclear medicine and from a patient care perspective.

We plan on launching a pre-PRT clinic. For those of you who don’t know, PRT is peptide receptor radionuclide therapy. The agent is 177 Letitia Ndoda Tate and we plan on doing this to really streamline and provide some consistency for heart patients getting here.

In terms of education, we also plan on having more patient events such as Milo, carers and hopefully in person and collaborating with some.
00:14:47.669 --> 00:14:50.008 of our nonprofit foundations.
NOTE Confidence: 0.88139915

00:14:50.010 --> 00:14:51.450 In terms of research,
NOTE Confidence: 0.88139915

00:14:51.450 --> 00:14:52.890 the BIOREPOSITORY is also
NOTE Confidence: 0.88139915

00:14:52.890 --> 00:14:54.279 enriched for nut cases,
NOTE Confidence: 0.88139915

00:14:54.280 --> 00:14:57.484 and we hope to build on this and then,
NOTE Confidence: 0.88139915

00:14:57.490 --> 00:14:59.270 in terms of clinical trials,
NOTE Confidence: 0.88139915

00:14:59.270 --> 00:15:01.686 we have a real opportunity that should be
NOTE Confidence: 0.88139915

00:15:01.686 --> 00:15:04.608 a key site for impactful clinical trials.
NOTE Confidence: 0.88139915

00:15:04.610 --> 00:15:05.190 In fact,
NOTE Confidence: 0.88139915

00:15:05.190 --> 00:15:07.510 we are one of five Centers for a
NOTE Confidence: 0.88139915

00:15:07.581 --> 00:15:09.105 international clinical trial Meter
NOTE Confidence: 0.88139915

00:15:09.105 --> 00:15:12.233 2 on which I sit on the steering
NOTE Confidence: 0.88139915

00:15:12.233 --> 00:15:14.519 committee and there are a number
NOTE Confidence: 0.88139915

00:15:14.519 --> 00:15:16.436 of other novel peptide receptor
NOTE Confidence: 0.88139915

00:15:16.436 --> 00:15:18.346 radionuclide agents that we hope
NOTE Confidence: 0.88139915

00:15:18.346 --> 00:15:20.268 to examine in clinical trials.
And we have a number of grants in the works that will hopefully start bringing together both Yale Science and outside science.

Moving on to patient care. This data represents new patient visits from both in the tank and Sir junk. This does not include radiation oncology and in our leadership cabinet meetings we have started reviewing data and key performance indicators with the goal to develop a dashboard of GI cancer specific metrics. So as you can see here, this is trends overtime.
We certainly dipped and have really plateaued since the covid pandemic, but we have bounced back.

Another interesting set of data that we looked at then courtesy of Kevin Best was our Connecticut population and distribution of GI services across our service area, and I think this is helpful for us as we think about developing and placing services in specific locations.

So as an example here in red or a GI medical oncology.

Providers in yellow GI radiation oncology.

And in green GI surgical oncology.
NOTE Confidence: 0.87521565
00:16:43.630 -- 00:16:45.405 at areas of denser population.
NOTE Confidence: 0.87521565
00:16:45.410 -- 00:16:47.540 Those are in the dark blue,
NOTE Confidence: 0.87521565
00:16:47.540 -- 00:16:50.498 but I think there are still
NOTE Confidence: 0.87521565
00:16:50.498 -- 00:16:51.977 certainly some opportunities.
NOTE Confidence: 0.87521565
00:16:51.980 -- 00:16:55.158 Another data slide that I found also
NOTE Confidence: 0.87521565
00:16:55.158 -- 00:16:57.480 especially interesting as we think
NOTE Confidence: 0.87521565
00:16:57.480 -- 00:16:59.680 about sort of strategic planning,
NOTE Confidence: 0.87521565
00:16:59.680 -- 00:17:02.398 is the incidence of new GI
NOTE Confidence: 0.87521565
00:17:02.398 -- 00:17:04.210 cancers across the state.
NOTE Confidence: 0.87521565
00:17:04.210 -- 00:17:06.928 We here look at colon stomach,
NOTE Confidence: 0.87521565
00:17:06.930 -- 00:17:08.478 Asafa, Geo liver,
NOTE Confidence: 0.87521565
00:17:08.478 -- 00:17:12.090 and pancreas the the higher rates for
NOTE Confidence: 0.87521565
00:17:12.184 -- 00:17:15.834 the state are in red and I have kind of
NOTE Confidence: 0.87521565
00:17:15.936 -- 00:17:19.968 squares around the two disease sites where.
NOTE Confidence: 0.87521565
00:17:19.970 -- 00:17:22.826 Our rates are higher than the US rates,
NOTE Confidence: 0.87521565
30
and that’s true for both stomach and pancreas, and I think that’s perhaps why we actually accrue so successfully to pancreatic cancer clinical trials and have a very robust clinical and research program in pancreas cancer. Would like to also mention you know, like almost everybody, covid has disrupted our outpatient practice. GI Medical Oncology main campus is still on the 1st floor of the North Haven Care Center. I’d like to use this as an opportunity to really thank my nursing partners, Ali and seller Ooley Hazare PSM,
Kathleen Moseman and Vanna Dest. We have worked hard to try to make this space work for our team. There are still some challenges for sure, but we're appreciative. Of some of the small wins that we've had, such as a new counter space and putting in a for new workstations. I’ll mention just briefly, our GI tumor burden multi D efforts, so as I had mentioned yesterday, we launched our split of the GI Tumor Board. This was initiated due to really incredible growth in our tumor board.
and this is really with credit due to Stacy

sign and more in the lead and others,

and in addition the colorectal team would

like to launch the National Accreditation

Program for Rectal Cancer and in.

We are required to have a separate

tumor board so the upper GI pancreas

and net tumor board will be led by

Stacy Stein in the colorectal **

This is our actually tumor board

from yesterday via zoom.

I’d like to also re late take this

as an opportunity to thank Lauren
Mallette who does an incredible job with tumor board and the support from other leaders to make this happen. It was a little bit more complicated than I imagined, but to Kevin Billingsley, hell Terra David. Fisher, Sonya, Bricelyn tide Wilcox. Are multi D clinics or a work in progress and we are building on some lessons learned from the earlier colorectal cancer pilot that was done in North Haven and delayed by Covid. We have plans for 2 pilots of colorectal cancer, multi Dion Trumbull and a pancreas.
multi D at main campus and we have already started some smaller working groups and are meeting regularly to try to think about some strategic planning that includes some of the elements listed here such as enhancing signature of care. Aligning with our existing disease programs. Aligning with local expertise and specialties. Selecting an optimal location and then later on we will work on operational topics, workflow being creative with Tele health, etc. Lastly, in the round with patient care,
I’d like to mention that our team members make important contributions to the NCC and panels are institutional, representative issues, and Higgins who sits on the NCC and guidelines steering Committee, and she’s been very helpful, helpful with guidance around this. So Stacy Stein serves on the hepatic biliary piano. John Kunsman on the pancreas, panel, and Sajc on on the neuroendocrine tumor panel, Jill Lacey on the Asafa Geo. and Gastric panel in Kim Jong on the small bowel, colon, rectal,
Channel so let’s move on and talk about education.

I’d like to give two of our fellows a big shout.

Out papers just gave presentations last week at our fellow research retreat and Doctor Timmel Patel gave a presentation on clinical outcomes or first line, full fear and ox versus Gen Plusnet, paclitaxel in metastatic pancreas. Cancer Timmel is a senior fellow who will be graduating this year and has taken a job with the FDA where he will serve as a medical officer.
Timol and his mentors Gelasia Michael Cicchini wanted to compare overall survival and time to treatment. Discontinuation for two main chemotherapy regiments from metastatic pancreas. Cancer folfirinox in gym mat paclitaxel. They reviewed over 300 patients and found These patients were younger and less likely to be admitted while on treatment and rates of treatment discontinuation. Due to toxicity actually similar
between the two regiments.

Secondly, Doctor James Zang is currently on RT32 training grants. She has one more year left on that she presented on her project at MGM. Her mentors are Doctor Kurt Shelper, Michael Cicchini and Jill Lacey, and her specific aims and I will not go into all of the details on her project, which are were beautifully presented by her. At the specific aims are to quantify MGMT expression in colorectal cancer cohorts and assess Association of MGMT.
NOTE Confidence: 0.78860774
00:22:38.455 --> 00:22:40.760 expression with DNA damage repair,
NOTE Confidence: 0.78860774
00:22:40.760 --> 00:22:42.520 adaptive tumor, immune response,
NOTE Confidence: 0.78860774
00:22:42.520 --> 00:22:46.647 and overall survival,
NOTE Confidence: 0.78860774
00:22:46.647 --> 00:22:48.853 and then Secondly review some of these
NOTE Confidence: 0.78860774
00:22:48.853 --> 00:22:50.717 same characteristics in an investigator
NOTE Confidence: 0.78860774
00:22:50.717 --> 00:22:53.525 initiated clinical trial launched
NOTE Confidence: 0.78860774
00:22:53.525 --> 00:22:57.260 by Doctor Cicchini and Tamil Patel
NOTE Confidence: 0.78860774
00:22:57.260 --> 00:22:59.405 using tamazula, my dental lab rib.
NOTE Confidence: 0.78860774
00:22:59.410 --> 00:23:01.636 So very exciting.
NOTE Confidence: 0.78860774
00:23:01.640 --> 00:23:04.244 In the realm of patient education,
NOTE Confidence: 0.78860774
00:23:04.250 --> 00:23:05.805 we tested out the Smilow shares platform,
NOTE Confidence: 0.78860774
00:23:05.805 --> 00:23:07.903 which was actually very user
NOTE Confidence: 0.78860774
00:23:07.903 --> 00:23:09.827 friendly and lots of fun during
NOTE Confidence: 0.78860774
00:23:09.830 --> 00:23:12.427 colorectal Cancer Awareness Month.
NOTE Confidence: 0.78860774
00:23:12.427 --> 00:23:12.427 In March we gave two separate presentations,
one to the New Haven community and the other to the Greenwich Community, and we took advantage of again local expertise, particularly in Greenwich. We collaborated with one of the colorectal surgeons at Greenwich Hospital and two of our Care center, medical oncologists, Doctor Lee and Doctor. So moving on to clinical research. So how does the GI DART clinical trial portfolio compare internally and again? These are metrics that we are looking at in the course of our leadership cabinet discussions. A thank you. Great thank you to Christina Weishar CTM.
So the GI DART clinical trial portfolio is 8% of YCS overall clinical trial portfolio, yet it represents actually 11% of all the clinical trial accruals. We have proved quite well. And 14% of analytic cases indicating that we could potentially do better. 5% of the GI cancer analytic case volume accrues to clinical trials, so we are higher than the national benchmark. However, the NCI expectation is as much as 20%, so for sure it opportunity to do better, or GI DART sponsor mix is as follows. The ideal is thought to be a third,
a third a third, so we certainly would like to increase our IIT. 
Our accrual trends follow the overall YCC accrual trends with a dip during covid and we are now starting to recover and our accrual over the last 12 months has been heavily reliant on cooperative group studies and industry studies. And note that the numbers on this slide represent trials managed by the GI Dark, but we have a number of patients that go on to other other darts, such as phase one. We are grateful and very reliant on our care center colleagues for
accrual to our clinical trials.

In fact, 38% of our clinical trial accruals came from our care centers between 2016 and 2019.

I’d like to highlight two of our investigator initiated clinical trials that first here is pid by Doctor Jill Lacey.

It’s a phase two study of PERI operative modified folfirinox and localized pancreas cancer.

It’s a single arm study in which patients receive 6 cycles of modified folfirinox followed by surgery followed by 6 more cycles of modified folfirinox. This is actually one patient.
00:25:53.385 --> 00:25:54.933 away from completing enrollment,
NOTE Confidence: 0.8227002
00:25:54.940 --> 00:25:56.920 so we’re very excited about
NOTE Confidence: 0.8227002
00:25:56.920 --> 00:25:58.900 that and I think that.
NOTE Confidence: 0.8227002
00:25:58.900 --> 00:26:01.912 There will be some very interesting
NOTE Confidence: 0.8227002
00:26:01.912 --> 00:26:04.770 correlative’s that come along with this.
NOTE Confidence: 0.8227002
00:26:04.770 --> 00:26:07.794 Doctor Kim Jong is leading another
NOTE Confidence: 0.8227002
00:26:07.794 --> 00:26:09.306 investigator initiated trial,
NOTE Confidence: 0.8227002
00:26:09.310 --> 00:26:12.796 a phase two study to evaluate modified
NOTE Confidence: 0.8227002
00:26:12.796 --> 00:26:15.578 folfirinox and stereotactic body radiation
NOTE Confidence: 0.8227002
00:26:15.578 --> 00:26:18.598 and nonmetastatic unrespectable key back.
NOTE Confidence: 0.8227002
00:26:18.600 --> 00:26:21.198 In this study, patients received up
NOTE Confidence: 0.8227002
00:26:21.198 --> 00:26:23.998 front fulfi Rannoch 6 to 12 cycles,
NOTE Confidence: 0.8227002
00:26:24.000 --> 00:26:28.290 followed by SPRT, followed by surgery.
NOTE Confidence: 0.8227002
00:26:28.290 --> 00:26:31.506 There are a number of really.
NOTE Confidence: 0.8227002
00:26:31.510 --> 00:26:34.340 It’s a very interesting correlative’s
NOTE Confidence: 0.8227002
00:26:34.340 --> 00:26:37.170 that are multi disciplinary including
US elastography with doctors Farallones

leniency T DNA with Doctor Patel,

molecular and immune future

assessment with doctors.

Cikini Joshi Farallon Sklar

and development of pancreatic

organoids instructor Joshi.

I also would like to really give

some kudos to Doctor Michael Cicchini

who has just received his KO 8,

so this is really a beautiful combination

of the clinical and translational research.

So the title of his Kaylie does DNA

damage as a tool to enhance the

immunogenicity of cold GI tumors.
His mentorship committee is listed here. His aims in his K-8. I'll just read them and won't go into the details. But it is to perform clinical trials with novel combinations of DNA damaging agents for patients with MGMT promoter hypomethylated colorectal cancer to identify predictive biomarkers for novel alculator combinations in CRC and Tour desk, assess DNA damage is a tool to enhance the immunogenicity of cold colorectal tumors. I'd like to end with a couple of new projects that we're working on. This one is actually very exciting and
I'll give a little bit of a teaser and I think Roy and add Captain and I are talking about finding another forum, but we are working on a clinical trial matching project in GI oncology with Guangdong and Wade Schultz and a team to really determine if we can match patients to the clinical trial at the right time, accurately efficiently with high volume in a project that’s scalable. Other team members included Kathy and Christina Weiss, myself in your fish back. We are using this clinical trial on its Michael Cicchini is tamazula.
My dental lab rib study.

As a pilot we’ve selected for inclusion criteria in which Gwen and Wade and their team use natural language processing and structuring data from the EMR.

This is the workflow focus on the orange box and we are using the entry event in the pre screening event as pilots right now.

Just to give you a sense of the numbers, we that blue top line looks at the number of visits to GI Oncology Department by week followed by the number of patients unique patients to GI oncology by week, then down in Gray.

The number of patients with colorectal cancer than those with metastatic stage four,
and then ultimately that bottom line where you see the numbers in red range from 10 to 15 patients per week that could potentially be eligible for this clinical trial. How great would it be if you got in your inbox? A list of eligible patients every week for your individual trials. So this pilot was incredibly effective and efficient. It had about a 98% accuracy rate and it really cut down on the amount of time. So before we estimated 3.11 minutes per chart for 10 week full time.
working hours and afterwards 1.82
NOTE Confidence: 0.8166703
00:29:48.557 --> 00:29:50.987 minutes per chart which just equals
NOTE Confidence: 0.8166703
00:29:50.987 --> 00:29:53.825 three days of full time working hours.
NOTE Confidence: 0.8166703
00:29:53.825 --> 00:29:57.095 So I’m really excited to see
NOTE Confidence: 0.8166703
00:29:57.095 --> 00:29:59.360 where where this goes.
NOTE Confidence: 0.8166703
00:29:59.360 --> 00:30:02.125 Lastly,
NOTE Confidence: 0.8166703
00:30:02.125 --> 00:30:04.160 Aryel GI tumor biorepository is a
NOTE Confidence: 0.8166703
00:30:04.160 --> 00:30:07.360 real foundation for our program.
NOTE Confidence: 0.8166703
00:30:07.360 --> 00:30:09.360 This is being PII by by Doctor John,
NOTE Confidence: 0.8166703
00:30:09.360 --> 00:30:11.574 Councilman and the technician Joanna,
NOTE Confidence: 0.8166703
00:30:11.574 --> 00:30:14.559 who it’s been in existence since
NOTE Confidence: 0.8166703
00:30:14.560 --> 00:30:17.360 2012 and we have over 1100 patients,
NOTE Confidence: 0.8166703
00:30:17.360 --> 00:30:20.560 but it certainly has, like many things,
NOTE Confidence: 0.8166703
00:30:20.560 --> 00:30:23.185 taken a bit of a hit during covid.
NOTE Confidence: 0.8166703
00:30:23.185 --> 00:30:25.360 John has really taken this as an
NOTE Confidence: 0.8166703
00:30:25.360 opportunity to revamp and modernize,
so our accrual numbers have certainly increased overtime or biorepository. Is over represented with colon, rectal and pancreas tumors. We certainly hope to expand on this. And as I’d mentioned, John really has revamped the infrastructure, so we have an existing steering committee, but we now actually have a new location and BML. We have a brand new freezer and John has completely overhauled the consent and intake process to reduce the survey link for patients and to add explicit language for modern.
research activities such as multi-omics cell lines and organoids and deposition of anonymized data in the public repository's. And we have a number of examples of active Projects including a study in pydoc with UCLA and then Elappara Bram study on this multi institution study. So we have a number of future needs, including more, broader and more diverse tumor collection, resumption of specimen collection in our care centers and updating our database. I'm going to just end with a mention of some really exciting work that Wade Schultz and his team are doing to use
a computational health platform to build an integrated clinical database.

So imagine. That you have all of your structured EHR data, imaging, pathology, genetics, all of these data sources. You put it into a funnel and this is essentially a workflow you can create curated data by the use of red cap and then Wade and his team create aid and integrated user interface so that it really minimizes redundancy of manual data entry. The CHP news cases include COVID-19, in which they were.
The teams were quite prolific.

Hematology is just starting to launch this and integrating a number of key structured databases including C, Bioportal, Redcap, omaf genomic data in registry data.

So to end, you know, I think that we have a number of strengths. We have a high patient volume within our network. We have a large clinical trial and financially healthy portfolio. Still that we’re hoping to maintain. We have an existing and expanding biorepository and strong basic and translational science.
I think we have a lot of opportunities in the next one to five years, including expanding our clinical trial portfolio with IIT’s. I think really investing and expanding and the Biorepository, I think that will help us help lead us to better team science and then in the long term or medium term goals of obtaining multipy and program project funding. So I will stop there. And pass the baton to Amanda, and then we’ll take questions after right?
Thanks, Pam. I think we should move on to Amanda and then we’ll do questions at the end. Please put your questions in the chat. I know I have a few for you, but now we’re very fortunate to have Mandar who is assistant professor of genetics and Medicine. He’s part of the Yale Cancer Biology Institute, threes at West Campus, and my Dream is one day will hold one of our grand rounds in person on West Campus. I promised that tomorrow I’m We will hold to that scientific director.
00:33:46.359 --> 00:33:48.260 of the Center for Gastrointestinal
Cancers here at the hospital
00:33:48.260 --> 00:33:50.320 and just quickly his background.
00:33:52.560 --> 00:33:54.894 He’s also has a Stanford background
00:33:54.894 --> 00:33:56.450 medical degree from Stanford
00:33:56.511 --> 00:33:58.421 and then internship residency at
some small Hospital in Boston,
00:34:00.340 --> 00:34:01.892 Brigham and Women’s Hospital,
00:34:01.892 --> 00:34:03.444 Dana Farber Cancer Institute.
00:34:03.450 --> 00:34:05.616 And then he completed his postdoctoral
research at the Koch Institute of
00:34:05.616 --> 00:34:10.055 Integrative Cancer Research at MIT,
00:34:10.060 --> 00:34:13.552 so a lot more I can say about manager,
00:34:13.560 --> 00:34:14.520 but I will.
00:34:14.520 --> 00:34:17.256 Let you hear about his work, and I’m Amanda.
The floor is yours.

Great thank you Roy for the kind introduction.

I just want to build on what Doctor Kunz is described and talk a little bit more about up challenges and opportunities in translational research, specifically in GI cancers at Yale.

So I’ll briefly discuss some more detailed metrics on the current state of GI Cancer Research at Yale and then talk about some of our goals in building translational Sciences within the center.

Describing four specific overarching initiatives.
Distance shown here and then, talk a few. A bit about some of the more specific initiatives that we have planned using pancreatic cancer and the Yale Pancreatic Cancer Collaborative is an example of the types of things that we’re hoping for. So I’d like to start by saying that GI Cancer Research at Yale within the Cancer Center is prolific, high impact and inclusive. Shown here are data from the Cancer Center GI cancer related publications over an 18 month types time span.
From July 2019 to December 2020, and as you can see, there were more than 130 publications within this 18 month time span, amounting to about 7.5 publications per month, which I personally thought was quite impressive given that many of our investigators were dealing with the pandemic during this time. Importantly, more than 1/4 of these publications, four published in high impact journals, and they represented the full spectrum of diseases within.
The GI space, including pancreatic cancers, colorectal and gastrointestinal cancers, stomach and liver cancers. Furthermore, these publications included 47 individual investigators within the Cancer Center. Again, quite a diverse crew including basic scientists, clinical and translational scientists, and epidemiologists. Now the story is very similar for active research funding where the GI cancer portfolio includes nearly $5 million.
00:36:16.871 --> 00:36:20.789 million in direct costs of research funding. 
NOTE Confidence: 0.83620965

00:36:20.790 --> 00:36:23.695 This is about 2/3 in peer reviewed. 
NOTE Confidence: 0.83620965

00:36:23.700 --> 00:36:27.276 Either NIH or competitive foundation grants. 
NOTE Confidence: 0.83620965

00:36:27.280 --> 00:36:29.548 And the remaining from industry or 
NOTE Confidence: 0.83620965

00:36:29.548 --> 00:36:31.540 non peer reviewed foundation grants. 
NOTE Confidence: 0.83620965

00:36:31.540 --> 00:36:34.284 You can see there is a heavy influx 
NOTE Confidence: 0.83620965

00:36:34.284 --> 00:36:37.319 of money focused on pancreatic cancer, 
NOTE Confidence: 0.83620965

00:36:37.320 --> 00:36:40.015 but there is a good spread across 
NOTE Confidence: 0.83620965

00:36:40.015 --> 00:36:41.870 the different disease programs. 
NOTE Confidence: 0.83620965

00:36:41.870 --> 00:36:44.950 this funding has been accumulated by 
NOTE Confidence: 0.83620965

00:36:44.950 --> 00:36:46.671 24 independent investigators with 
NOTE Confidence: 0.83620965

00:36:46.671 --> 00:36:49.086 a very similar spread in the basic 
NOTE Confidence: 0.83620965

00:36:49.086 --> 00:36:50.950 clinical translational epidemiologic space. 
NOTE Confidence: 0.83620965

00:36:50.950 --> 00:36:53.428 Importantly, most of these funding sources, 
NOTE Confidence: 0.83620965

00:36:53.430 --> 00:36:55.490 in fact, the vast majority,
are really independent grants,

single investigators,

and so the hope is to really love

leverage this great breath.

Of scientific expertise,

clinical care,

and clinical research expertise

and try and build and synergize

t heir efforts into teams,

and that’s sort of the major goal

of where we’re going to go with

the GI Cancer Center.

So again,

one of our major goals is to build

across display research teams
that bring together clinical, translational, basic and population health scientists.

With the plan to allow these teams to enable team based research grants including multi P IR ones, PO1. Since for grants to try and grow investigator initiated trials based on yell science Doctor Kunz, allude to the fact that less than 20% of our current grants are investigator initiated would like to bump that up to at least a third if not a half really showing. Sort of the importance of science within Yale and what can result
in terms of translational care.

And finally, we’d like to use these teams to inspire trainees towards the Korean translational.

She, like Cancer Research Doctor Kunz highlighted several of our trainings doing really exciting science within this space. We like to recruit even more to really further the mission.

And Jack answers. Ultimately, the goal is to make Yale’s destination Center for GI cancers such that Yale is synonymous for outstanding,
not only clinical care, but also homegrown science. That translates to the clinic. Now there are number of challenges that get in the way of boosting translational science in GI cancers. Indeed, these are challenges that Roy could speak to for thoracic or even other cancers, and also challenges that exist across the academic spectrum, and these include a lack of time and these include a lack of time or lack of institutional resources, or lack of knowledge or expertise, or even awareness of potential collaborators within the institution.
And as team based science is increasing.

Ensuring adequate recognition or opportunities for career advancement.

So in terms of overarching initiatives to combat these particular challenges,

we’ve come up with four.

One is to really emphasize community building,

which is hopefully to bring awareness of potential collaborators,

enhance the community knowledge and expertise,

and that can be leveraged towards team based grants.

Additionally,
try to enhance research education
across spectrum to try and get
basic scientists to communicate
with clinical scientists and vice
to enhance knowledge and
bring together teams.
The third pillar is to develop resources
that’s both financial in terms of
grants and funding pilot funding,
but also institutional resources for
tissue resources such as bio banks
that are hard to come by and hard
to leverage within individual labs.
And finally,
we like to take advantage of these
great developments and disseminate
it to the Community using web based or social media platforms as an opportunity not only to tell everyone what a great place Yale is for GI Cancer Research and clinical care. But also potentially to recruit outside funding to support some of these others. So to start to chip away and sort of build some of these pillars, a group of us started the yellow Pancreatic cancer collaborative. Shown here is the steering committee that includes Mary leaders in pancreatic Cancer Research and
clinical care across different divisions and departments. Including medical oncology, radiation oncology surgical oncology, gastroenterology, pathology and the basic Sciences. We formed the Yale Pack, which is an inclusive team of physicians, scientists and trainings that seeks to synergise the strengths of the science and clinical expertise to accelerate transformative research and pancreatic cancer. We held a summit for Community building last August.
This was a entirely virtual summit that included more than 130 participants. Importantly, more than a third of whom were trainees in participation included 16 different departments and three institutes. We had 16 different speakers who either were actively pursuing pancreatic Cancer Research initiatives or those shown in red had not prior previously been involved in pancreatic Cancer Research to highlight existing research, as well as to engage. Scientists with innovative technologies that could be applied to this research.
space and through these efforts, we've been able to actually generate some teams. I'll describe a few here of examples of multidisciplinary teams in GI cancers, one of which is involves our own lab in collaboration with the key being endocrinology and submit the Krishnaswamy endocrine exocrine hormonal signaling axis that is a driver. Pancreatic ductal and questionable progression in obesity. Luisa Escobar hires in radiation therapy,
NOTE Confidence: 0.8392697
00:42:03.270 --> 00:42:05.634 has partnered with Jeff Townsend by
NOTE Confidence: 0.8392697
00:42:05.634 --> 00:42:07.686 Statistics John Chrisman and Surgery
NOTE Confidence: 0.8392697
00:42:07.686 --> 00:42:10.128 and Nick Joe Sheehan immunology to
NOTE Confidence: 0.8392697
00:42:10.128 --> 00:42:12.090 understand RNA splicing and tumors,
NOTE Confidence: 0.8392697
00:42:12.090 --> 00:42:14.868 adaptation and a tumor immunity building
NOTE Confidence: 0.8392697
00:42:14.868 --> 00:42:17.566 off really seminal science from the
NOTE Confidence: 0.8392697
00:42:17.566 --> 00:42:19.888 Escobar Hoyos slab that identified a
NOTE Confidence: 0.8392697
00:42:19.888 --> 00:42:23.301 novel role for Mutant P 53 and splicing
NOTE Confidence: 0.8392697
00:42:23.301 --> 00:42:25.013 regulation and pancreatic cancer.
NOTE Confidence: 0.8392697
00:42:25.020 --> 00:42:27.512 Both of these teams based grants have
NOTE Confidence: 0.8392697
00:42:27.512 --> 00:42:29.862 been recently funded by the Damon
NOTE Confidence: 0.8392697
00:42:29.862 --> 00:42:31.478 Runyon Rachleff Innovation Award,
NOTE Confidence: 0.8392697
00:42:31.480 --> 00:42:34.045 highlighting that these team based
NOTE Confidence: 0.8392697
00:42:34.045 --> 00:42:37.129 approaches are really well received by
NOTE Confidence: 0.8392697
00:42:37.129 --> 00:42:39.769 funding organizations in the NCI alike.
NOTE Confidence: 0.8392697

74
The Teen Challenge awards that have been pioneered by the Cancer Center have also funded several GI cancer related teams. I'll highlight two of them here. This one, led by heres on in chemistry that tries to examine the molecular cancer microbiology and the underpinnings of microbiome associated carcinogenesis. Building on work from South Arizona and collaborator Jason Crawford and synthesizing the Genotoxin. Cali Bactine, which is thought to be an inducer of colorectal cancer. And leveraging this kind of seminal...
pre clinical work to understand pathogenesis by which microbiomes promote cancer in particular colorectal cancer. And another grant funded by the Teen Challenge Award is includes Auto Group in collaboration with John Wessel, Mirsky, Anne Rd, Hoffer and Comparative Medicine which seeks to define the effects of dietary fatty acids on breast cancer and pancreatic cancer progression, leveraging innovative high fat diets than Metro diapers group has developed that represented the diversity of bias.
found in human cancers and trying to identify effects on host Physiology as well as on tumor progression and you can see there’s a diversity of effects. On pancreatic cancer progression using these diets. Beyond building teams, we’ve also been interested in educating these teams on the latest and greatest advances and basic science and clinical and translational science by forming the Yale Pancreatic Cancer Collaborative Seminars series. This included an outstanding cadre of investigators, principally outside of Yale,
who encompass that Breath of basic clinical science, as shown here, and was an opportunity for our community to learn about. The advances in pancreatic Cancer Research and care, and to try and build upon some of what has already come before us and really understand the unmet needs in this space and how Yale could position itself to meet these particular needs. Another core initiative for our group is to really build resource development.
Biobank, which is actually quite prolific, includes a large number of samples in the pancreatic cancer and codirector cancer, and specifically and beyond. Expanding this to other cancers in the GI space. We've also been working closely with their collaborators in surgery, Pathology, and Lab Medicine to develop new living cancer models. Based on these perspective collection of samples. These include patient drives into graphs and patient derived organoids with the hope of developing and
molecularly characterizing some of these very precious tissues. Now importantly, many of these tissues are quite limited, particularly in diseases like pancreatic cancer, where the tumor fraction is quite low, and so we need to be able to leverage emerging technologies that are able to garner a large quantity of information from small and scarce samples. Answer To that end, our collaborative has tried to bring together innovative scientists such as Stephen weighing in genetics.
and wrong thing and biomedical engineering who developed interesting multi omics technologies that allow spatial analysis of gene expression, protein expression and even 3D genome organization in very scarce tissue based samples. And so we’re excited of the possibility of taking advantage of the Bio Bank to do deep molecular characterization to build resources that could be leveraged. Or to address particular questions that our investigators might have. And finally, I think it’s important for us to be able to expand and let the community know.
about our translational science efforts.

Shown here are the breakthroughs magazine this year that highlighted the team building that we’ve done in the pancreatic cancer space.

And shown here also is the ability to use Twitter to really expand our reach of our center and in hopes of not only educating the community but also potentially as a fund raising mechanism in the future.

So what are some of the future specific plans we have in mind to meet these initiatives?

One is we like to expand the
activities we’ve done in pancreatic cancer to the other centers to focus on community building through a similar types of summits or seminar series across our core programs. We’d also like to develop some cross program initiatives within the center. Importantly, we want to focus on physician scientist recruitment in GI cancers. And in the center from Michael Instagram Cology, which is actively pursuing junior physician scientists, recruiting and we hope to be able to bring in more who have a real focus in GI cancers.
We also want to try and bridge the gap between basic and clinical scientists, and to do that, we’re going to try and launch the doctors in series. This is a series to allow clinicians to educate basic researchers on the diagnosis, treatment, and importantly, the unmet needs. For specific answers only. This will these be important but also an opportunity to educate our basic science community on the challenges faced in the clinic. We want to include basic and translational research talks into the CME events within
our community that Doctor Kunz described
again as an education initiative,
but also an opportunity for outreach.
We want to facilitate team
based grant funding,
in particular trying to take advantage
of internal support such as TCA.
The team challenge awarded the
teacher grants and ultimately to
direct these teams and support these
teams administratively towards
developing or program project grants.
Just peel ones and spores we want
to increase Accessibility in Electro
characterization of biobank samples.
Doctor Kunz describe some events,
some initiatives in the computational side.

We also want to leverage some of the multi-omics technologies.

And finally we want to fundraise towards the center and disease programs to support this translation.

Research clearly to be able to build these teams and provide private pilot funding. Some amount of philanthropy is going to be required.

And to do that we want to create a unified Twitter and website presence to really unify the center, but also to make key announcements of advances in translational...
science within our center.

And so with that, we’re happy to take any questions.

Thank you both.

That was absolutely wonderful. Well,

we’ll put some questions in the chat,

so maybe I’ll start, you know,

for you, Pam can you speak a little bit about what the current guidelines are and how we’re addressing that here?

At? Yes, my own.

Also, the whole HealthEquity issue around this.
How are you making sure that all patients are getting in for a screening?

So, at present the recommended screening age is still 50 on the USPS TF guidelines. The draft has not been accepted into practice just yet.

I have an in since my husband is a gastroenterologist in the community, but he has said that I think this is appropriate that we recommend if patients who are between the ages of 45 and 40 interested that they check with.
their insurance company first.

I mean, I anticipate that this will in fact be adopted and then we will. Have a considerable education to do and I think that partnering with shabbier your and this the colorectal cancer program Shabbir died and his team. We talked a lot about outreach and how we can improve our efforts in that space.

Right, you mentioned you’re using Wades database. Are you able to look through that database by the patients that you’re screening, representing the Community in general,
or their areas to enhance?

So we are just starting working with Wade, but that’s an excellent idea and I think ways that we can leverage that and also with Marcelonis Smith.

Amanda, why is pancreatic cancer so difficult to treat?

You know, you have these new new approaches, but immunotherapy. It doesn’t seem to work as well there as in many of the other cancers.

What’s the reason for that?

Yeah, I think there’s a number of kind unique features of pancreatic cancer, in particular that make it
particularly challenging for therapeutics and even therapy space. It’s well known that pancreatic cancer has a quite a bit of a different stromal microenvironment. In particular, it’s thought that this micro environment made up of fibroblast immune cells, like macrophages in particular, as well as exercising matrix proteins, can be quite immunosuppressive, and even in mismatch repair deficient. Pancreatic cancer is the response. Rates are quite a bit lower than, for example, what we’d see in colorectal cancer,
suggesting that there's something unique about the intrinsic biology of pancreatic cancer, and I think the stroma quite plays quite a bit of a role. Importantly, pancreatic cancer is genetically fairly bland. It gets 4 hallmark recurrent genetic alterations, in particular in the proto oncogene carass, and three other tumor suppressor genes. So in terms of targetable genetic alterations, there are few. And even within care as mutations
there currently targetable 1G12C mutations are quite rare, only found by two to 3% in our own data suggested that even if you had a perfect chaos inhibitor, resistance is likely to emerge at least half of the cases, and so I think there are a number of factors that lead to the poor outcomes of pancreatic cancer, and I think one aspect that deserves more attention is prevention in the disease. One of the key factors to poor outcomes is often late stage of diagnosis, where more than 80% of patients
are found at a time when they're not surgically resectable, which really is the mainstay curative option in this disease, and So what can we do to understand when this disease emerges? Can we intervene earlier? Can we identify earlier disease, and can we even develop strategies for prevention by understanding risk factors? For example, how they play a role, and that's sort of driven some of our own efforts in the obesity. Pancreatic cancer space. Other genetic risks as well and I
00:53:08.749 --> 00:53:11.397 have to use big data AI approaches.
NOTE Confidence: 0.8314319
00:53:11.400 --> 00:53:14.272 Do you think we'd find some some genomic
NOTE Confidence: 0.8314319
00:53:14.272 --> 00:53:16.970 factors that might tell us who might need
NOTE Confidence: 0.8314319
00:53:16.970 --> 00:53:18.710 need to be screened earlier?
NOTE Confidence: 0.8314319
00:53:18.710 --> 00:53:21.013 Yeah, there are a number of genetic
NOTE Confidence: 0.8314319
00:53:21.013 --> 00:53:22.810 factors that have been identified
NOTE Confidence: 0.8314319
00:53:22.810 --> 00:53:24.974 only about 10% of pancreatic cancers
NOTE Confidence: 0.8314319
00:53:24.974 --> 00:53:27.410 are thought to be familial in nature,
NOTE Confidence: 0.8314319
00:53:27.410 --> 00:53:29.580 and a subset of those patients will
NOTE Confidence: 0.8314319
00:53:29.580 --> 00:53:30.970 have known genetic alterations
NOTE Confidence: 0.8314319
00:53:30.970 --> 00:53:32.980 and our screening clinic here.
NOTE Confidence: 0.8314319
00:53:32.980 --> 00:53:34.428 Led by James Farrell,
NOTE Confidence: 0.8314319
00:53:34.428 --> 00:53:36.890 is focused on that in trying to.
NOTE Confidence: 0.8314319
00:53:36.890 --> 00:53:38.282 Follow these familial cases
NOTE Confidence: 0.8314319
00:53:38.282 --> 00:53:40.370 not only in terms of genetics,
NOTE Confidence: 0.8314319
00:53:40.370 --> 00:53:42.296 but also to understand other risk
factors such as new onset diabetes. And it turns out about 1% of pancreatic cancer cases can be identified when you want to diabetes. Could we use that as a biomarker of sort of early detection? And so there are a number of avenues that people are exploring, and certainly big data type approaches that mirror that match. Clinical prior clinical history again may be taking advantage of. EMR mining, like Wade Schultz is doing, could help identify some of those
patients and identify other risk factors and their number of groups, including the Dana Farber Group that is trying to build risk scores. That combined with genetics as well as non genetic factors to truly determine who are perhaps the most highest risk. And finally, we still need to further optimize. What are the best screening protocols? Is it a combination of endoscopic ultrasound imaging, blood based biomarkers? All of those are active areas investigation. We have a few questions,
00:54:41.830 --> 00:54:43.250 so Pam, you’re very modest.

00:54:43.250 --> 00:54:45.077 I actually, I’m waiting to see how

00:54:45.077 --> 00:54:47.321 you do the GI program and I’m at

00:54:47.321 --> 00:54:49.380 all the long program after you you

00:54:49.380 --> 00:54:51.494 just fantastic and I have to just

00:54:51.494 --> 00:54:52.980 compliment you coming here during

00:54:52.980 --> 00:54:54.750 this very difficult year and telling

00:54:54.800 --> 00:54:56.275 this amazing group together between

00:54:56.275 --> 00:54:58.310 the campuses and I just think it’s

00:54:58.310 --> 00:55:00.095 remarkable and I guess zoom has helped

00:55:00.095 --> 00:55:02.030 a little bit but hopefully at some

00:55:02.030 --> 00:55:04.058 point we’ll see each other in person.

00:55:04.060 --> 00:55:05.831 But how do you clinically with care

00:55:05.831 --> 00:55:08.048 on going at 15 different care centers?

00:55:08.050 --> 00:55:09.802 And I was impressed by that

NOTE Confidence: 0.8396771
picture where you actually.

All the different people,

how are you putting practice plans in

place and knowing that someone who

goes to North Haven versus someone that

goes to Greenwich or Main campus is

getting the same sort of approach and

care for one of these diseases?

That that’s a great question.

You know, I’d say that the first step

has been creating forums where our

team members will get together and

I have to say that we’ve had just

has been creating forums where our

team members will get together and

I have to say that we’ve had just

really tremendous virtual attendance,

and I think that’s one silver lining

of the zoom format is that we have no
30 to 40 people attending tumor board, averaging 40 patients attending our seminar series, and those’s really community building. I think Mandar spoke to that as well, and I think as soon as we have that as a foundation, it creates other opportunities for collaboration.

I’m Julie, she is our Director of Education in our leadership cabinet and I know that. She’s told me this, but I think I can say this, but I think she’s she and I and the team are really eager to work on
00:56:15.373 --> 00:56:17.550 that signature of Karen and talking.
NOTE Confidence: 0.8391838
00:56:17.550 --> 00:56:19.416 That’s why we have Journal clubs.
NOTE Confidence: 0.8391838
00:56:19.420 --> 00:56:21.250 We talk about standard practices very
NOTE Confidence: 0.8391838
00:56:21.250 --> 00:56:23.459 openly with all of our team members,
NOTE Confidence: 0.8391838
00:56:23.460 --> 00:56:26.330 and we have really tremendous.
NOTE Confidence: 0.8391838
00:56:26.330 --> 00:56:27.820 Dissipation from our care center
NOTE Confidence: 0.8391838
00:56:27.820 --> 00:56:29.012 members and you know,
NOTE Confidence: 0.8391838
00:56:29.020 --> 00:56:31.106 I think that’s helped by Jeremy Corbyn’s.
NOTE Confidence: 0.8391838
00:56:31.110 --> 00:56:32.610 Key really being an integral
NOTE Confidence: 0.8391838
00:56:32.610 --> 00:56:33.810 part of our team.
NOTE Confidence: 0.8391838
00:56:33.810 --> 00:56:36.250 He has been for a long time and I think
NOTE Confidence: 0.8391838
00:56:36.319 --> 00:56:38.888 infusing his role that’s helping as well.
NOTE Confidence: 0.79950714
00:56:40.580 --> 00:56:40.853 Absolutely,
NOTE Confidence: 0.79950714
00:56:40.853 --> 00:56:43.310 I would just at the end of the hour.
NOTE Confidence: 0.79950714
00:56:43.310 --> 00:56:44.680 Any other questions or comments?
NOTE Confidence: 0.79950714
00:56:44.680 --> 00:56:46.584 One thing I’ll ask you mentioned it.
You make sure Lacey ask both of you.

I see a lot of fellows on the line.

One of the groups is fellows room, so I guess there hopefully had getting a solution there.

If not, let me know for next week.

But the question is, do you have projects you know our fellows and we have great fellows? Medical students might even be some undergraduates listening.

I don’t any one of their projects.

How it’s one find a project in GI cancer Mandar.

If they wanted to work in the lab.
00:57:12.050 --> 00:57:13.438 or between a lab in the clinic,
NOTE Confidence: 0.79950714
00:57:13.440 --> 00:57:14.450 or Pam in the clinic,
NOTE Confidence: 0.79950714
00:57:14.450 --> 00:57:15.460 can you let us know?
NOTE Confidence: 0.8436312
00:57:16.530 --> 00:57:18.175 Yeah, I think one of our goals
NOTE Confidence: 0.8436312
00:57:18.175 --> 00:57:20.080 is to make very accessible shovel
NOTE Confidence: 0.8436312
00:57:20.080 --> 00:57:21.975 ready projects for people with
NOTE Confidence: 0.8436312
00:57:21.975 --> 00:57:23.769 limited time medical students,
NOTE Confidence: 0.8436312
00:57:23.770 --> 00:57:25.240 residents, fellows and I think
NOTE Confidence: 0.8436312
00:57:25.240 --> 00:57:27.390 there are a couple of advantages.
NOTE Confidence: 0.8436312
00:57:27.390 --> 00:57:30.342 The one is the biobank
NOTE Confidence: 0.8436312
00:57:30.350 --> 00:57:31.734 particularly in again pancreatic
NOTE Confidence: 0.8436312
00:57:31.734 --> 00:57:33.464 cancer and colorectal cancer that
NOTE Confidence: 0.8436312
00:57:33.464 --> 00:57:35.076 might allow tissue based analysis
NOTE Confidence: 0.8436312
00:57:35.076 --> 00:57:36.596 that might be more efficient.
NOTE Confidence: 0.8436312
00:57:36.600 --> 00:57:38.574 The second is we have a
large number of patients, particularly the pancreatic cancer space, that we followed for many years, and so some of these studies, Doctor Patel has done is based on those types of retrospective analysis and this clinical database that we have in GI cancers. And so again those types of projects are probably much more numerous and we need to make those clearer and make them more shovel ready so that we can get our trainees involved quickly.
In any further I'll just yeah, I'll if I can just add right, we had our one of our programs director’s meetings last week and we as a those four programs, all the code leaders identified as our next top priority doing just that of really developing this list as we have new trainees coming in July and having that available. Right, and you guys are great. Actually one big part of the shovel is the handle, which is the mentor ship and on these projects you don’t want to have a good idea, but you know it’s I can tell you
from my own career it’s having mentors and people that help you so I can see you have that.
And plenty of that in the GI Group will look forward to having you back in six months or so to hear more progress, maybe bring some other members of the group, but this is been a fantastic grand rounds today.
Will look forward to your first grand rounds for the GI program with an invited guest from Puerto Rico in two weeks and. Thank you all.
Thanks everyone for coming today and we’ll see you back next week.
00:59:03.671 --> 00:59:05.096 for Cancer Center grand rounds.
NOTE Confidence: 0.8201183
00:59:05.100 --> 00:59:05.690 Thank you.
NOTE Confidence: 0.8201183
00:59:05.690 --> 00:59:06.280 Pam, Amanda.
NOTE Confidence: 0.9220947
00:59:07.490 --> 00:59:09.482 Thank you, thanks.