00:00:00.000 --> 00:00:02.080 Young presentation that I have
00:00:02.080 --> 00:00:04.604 lined up here right back to
00:00:04.604 --> 00:00:06.806 the share screen and let’s see.
00:00:06.810 --> 00:00:11.430 I guess this is the one share.
00:00:11.430 --> 00:00:13.621 Let’s see here we go and
00:00:13.621 --> 00:00:15.289 then we connected this.
00:00:18.090 --> 00:00:19.332 Doctor Chris Korea.
00:00:19.332 --> 00:00:23.997 So nice to see you so we I did I did
00:00:23.997 --> 00:00:26.750 your lovely intro before but and we
00:00:26.750 --> 00:00:29.060 have actually I will just say verbally
00:00:29.060 --> 00:00:31.410 but we have a plaque to give you.
00:00:31.410 --> 00:00:34.275 You are actually officially our
00:00:34.275 --> 00:00:36.110 inaugural annual speaker for
our new Center for GI cancers, so we’re happy to invite you and. Really excited to hear you today so. And we appreciate everyone who waited and I think Doctor Cruz will probably need to end. Maybe like 5 minutes before the hour or 10:10. We’d love to have time for questions, but if not, we understand. Alright. Yeah, wonderful and well, I’ll do. You know, the last part I can skip.
I see that the time it’s there.

So we have about 2025 minutes.

OK, well, so good afternoon to everyone and thank you very much for dealing with the right?

I mean we plan many things in our lives and there are things that you learned.

That there are things that you cannot control so later and I’ll tell you what happened.

But you know, the good news is that we’re here and I’m delighted and honored to be part of this presentation.

So briefly, address some of the concepts that our group have been working on.
for the last years over a decade.

At this point, and we have been focusing on Latinos and.

Family communities, and specifically in GI cancers,

and I’m going to, you know, narrowed the topic to colorectal

the disparities that we have seen across

the different ethnic and racial groups.

So the talk has three main areas and

I will briefly discuss some of the

epidemiological data that we have.

Then I’m going to talk about some of
the environmental factors and then
the molecular aspects and then putting
that together trying to understand,
you know.
How much do we know of the reasons
behind these academic that we’re
seeing across different groups,
including the Hispanics?
So this chart comes from the
national databases where you can
see that by the year 2050, right?
You can see where the places where you’re
going to have larger groups of Hispanics,
and you know colorectal cancer.
It’s one of those answers that
continue to increase this.
Find the available at screening methods that we have. And when you look at, you know the world right in the in the US we see that many Hispanic U.S. citizens have this high burden of this. So is the second most common cause of cancer among US Latinos. You can see the number there, the third most common cause of cancer worldwide. And then the fourth most common cause of cancer related death. So clearly this is a disease that continues to.
You know to take the life of so many people every single year. And here I described right where we go from the public to the cancer and this takes close to 10 to 15 years for people without having to re cancer. And when you put this into perspective right? And this is, I’m thinking about Latinos in America. You see that depending where you are, the burden of colorectal cancer changes dramatically. So if you look at, you know I put some arrows in order why at him? Tina and Puerto Rico. You can see the differences in
incidence and mortality both for male and female, and you know places like autowire, jentina, and Puerto Rico. We have things in common. Not only do we speak the same language, but with different accents, right? For those of people that know the different Hispanic communities. But we also eat a lot of meat, right? So that’s one of those factors that might come into play or might be contributing at this point and then looking at the data from the US. This is actually age adjusted.
Incidence rates are in colorectal cancer in the US. Looking at the different races and Hispanic communities so you can see that the bias burden for both male and female, it’s in the black community. However, when you look at what American Hispanics, it’s very closed to when you combine all the races and is. I’m close to. I Landers, or are Native Americans, right? So you can see how.
so it’s not the same thing as when you look at Hispanics that are from Mexico versus those that are from the Caribbean and you can hypothesize many of the reasons why we’re seeing those differences.

So this article was, or over 10 years old. But I still look at this because it was mesmerized actually met Doctor Pinheiro in a presentation. And basically you know when they were looking at, he was evaluating the incidents. Rate for cancer and he looked at
different groups and he looked at the incidence rate of cancer in their native community and then when they move to the US and this is data from Florida. So you can see that you know Mexicans and Mexico had a lower incidence rate as compared to Mexicans that move to the US. The same thing happened for Puerto Ricans. You can see how they you know when they are native Puerto Ricans living in Puerto Rico. The incidence is slower but when they move to the US this. Number goes up the same thing for Givens and look at how very close to their incidents for incidence rate for
those that are native from Florida, so you know it’s impossible to have this huge change based on the genetic changes, right? So of course, environment is what really comes over and over into place. So I started working with several groups from the US including an Anne Marie Anna published this article. A few years ago where she look at the disparities in colorectal cancer incidence among Latinos. cancer incidence among Latinos.
But California is a melting pot. Don’t know, right?
So we have Latinas from South America, Central America and of course also from the Caribbean.
So she was able to identify that 17% of all Latinas from California presented with colorectal cancer before the age of 50. So early on set colorectal cancer and this was published before the recent guidelines,
Now we start performing colorectal cancer screening at the age of 45 according to the US Preventive Services Task Force. So this is before,
you know, five years before that happened and you know she had a good representation from Puerto Rican’s and also Mexican Americans. And then of course the other you know worrisome factor was at 49% of Latinos presented with colorectal cancer and advanced age. So not only younger, but also an advanced age. And this is data from our group. When they presented with early onset colorectal cancer, this survival is is less.
So now let’s chip gears and talk a little bit about some of the environmental factors that we and others have been evaluating. Things like tobacco are fabulous diet right which sometimes can not be as good as it could. It could be obesity, which is, you know, dietary risk factor for many diseases, including cancer and of course is sedentary lifestyle. And you know. Looking at the different aspects right a few years ago in 2015 The World Health Organization classified red and processed meat as part of the carcinogenic risk factor.
So specifically, processed red meat was classified as a carcinogenic class one, and to put everyone into context, this is the same category where you have H. Pylori where you have asbestos where we have other other factors like tobacco, so they’re all carcinogens. Nonetheless, but the risk associated to exposure of this particular environmental factor. It’s much less that that you know that observed in other risk factors such as asbestos, for instance.
you know this started as supported on the role between the exposure of these carcinogens because they, we know now that there are changes that occur at the level of the DNA where you get a heterocyclic amines and you know changes that increase carcinogenesis at the level of the colon and in the colony sites. So a few years later there were also articles that started to put together the role of the diet with the role of the microbiome, right? And we’ve seen. This on our group have also evaluated the potential link between the
NOTE Confidence: 0.84841123333333
00:09:15.963 --> 00:09:18.450 MICROBIUM and the cancer risk,
NOTE Confidence: 0.84841123333333
00:09:18.450 --> 00:09:21.816 so this article was one of the few first
NOTE Confidence: 0.84841123333333
00:09:21.816 --> 00:09:24.566 rather articles that started to look at
NOTE Confidence: 0.84841123333333
00:09:24.566 --> 00:09:27.929 the role of the microbiome and cancer,
NOTE Confidence: 0.84841123333333
00:09:27.930 --> 00:09:31.220 and this beautiful paper by the group
NOTE Confidence: 0.84841123333333
00:09:31.220 --> 00:09:33.642 at Pittsburgh presented data looking
NOTE Confidence: 0.84841123333333
00:09:33.642 --> 00:09:36.112 at the different they phylogenic
NOTE Confidence: 0.84841123333333
00:09:36.112 --> 00:09:38.624 differences in the gut microbiome
NOTE Confidence: 0.84841123333333
00:09:38.624 --> 00:09:40.560 between Africans from Africa.
NOTE Confidence: 0.84841123333333
00:09:40.560 --> 00:09:42.684 That’s on the left panel and
NOTE Confidence: 0.84841123333333
00:09:42.684 --> 00:09:44.100 Africans from North America.
NOTE Confidence: 0.84841123333333
00:09:44.100 --> 00:09:47.702 So you know the classic African U.S.
NOTE Confidence: 0.84841123333333
00:09:47.702 --> 00:09:50.672 citizens so you can see that even
NOTE Confidence: 0.84841123333333
00:09:50.672 --> 00:09:53.297 if we don’t know that much about,
NOTE Confidence: 0.84841123333333
00:09:53.300 --> 00:09:55.380 you know these statistics, right?
NOTE Confidence: 0.84841123333333
You can see that the colors right of these beautiful figures were different, right? So the Africans from Africa have it?

How distinct microbiota as compared to the North American Africans? Right there African Americans rather. So and then you know when you look further down and he did and you look at you know what type of metabolomics was present in the God from people that were in Africa and those North American African Americans. Not only was where the bacteria different but also the mandible. You know the type of metabolomics.
that were present.

So for instance he looked.

He looked at short chain fatty acids and he looked also in bile.

Africans had a higher good short chain fatty acids versus the African Americans had more carcinogenic bile.

You can see how the different compounds that he look at where higher Lee were present at a higher prevalence among individuals that had the microbiome was a distinct microbium.

So we started looking.

You know,
of course, motivated by this group of investigators at Pittsburgh and some others. We started to evaluate not only the bacteria nor the microbiome composition, but also the jeans that are present because depending on the Organism that it’s in the bowel, the jeans that are produced and the answer the proteins that are produced by the jeans and the specific genes that we can find that are bacterial genes may also modify the risk of having inflammation and the risk of cancer. So we started looking at this particular group of genes which are bacterial.
00:11:47.038 --> 00:11:49.936 CTD and jealous,
NOTE Confidence: 0.851543954
00:11:49.940 --> 00:11:53.566 and eyes Ian such toxic necrosis factor
NOTE Confidence: 0.851543954
00:11:53.566 --> 00:11:55.760 necrotizing factor rather an USB,
NOTE Confidence: 0.851543954
00:11:55.760 --> 00:11:58.760 and you can see here is summary of what is
NOTE Confidence: 0.851543954
00:11:58.839 --> 00:12:01.989 the role of this particular bacterial genes,
NOTE Confidence: 0.851543954
00:12:01.990 --> 00:12:04.734 and our hypothesis was that in patients
NOTE Confidence: 0.851543954
00:12:04.734 --> 00:12:07.160 that have colorectal cancer had had
NOTE Confidence: 0.851543954
00:12:07.160 --> 00:12:09.512 colorectal cancer or those with polyps.
NOTE Confidence: 0.851543954
00:12:09.520 --> 00:12:11.431 We may see a difference not only
NOTE Confidence: 0.851543954
00:12:11.431 --> 00:12:12.980 in the bacterial composition,
NOTE Confidence: 0.851543954
00:12:12.980 --> 00:12:15.506 but also in the bacterial genes.
NOTE Confidence: 0.851543954
00:12:15.510 --> 00:12:17.730 And we set ourselves to do
NOTE Confidence: 0.851543954
00:12:17.730 --> 00:12:19.210 a series of experiments,
NOTE Confidence: 0.851543954
00:12:19.210 --> 00:12:21.634 and we published recently an you
NOTE Confidence: 0.851543954
00:12:21.634 --> 00:12:24.091 know from this group of of bacterial
NOTE Confidence: 0.851543954
genes we were able to start to see some differences right? So I can show you here the USP was we saw, you know a small signal. We are repeating this sample and adding additional bacterial genes to try to understand whether or not you know is it bacterial. You know the the microbiome per say. Or it is are those bacterial genes, the ones that are really increasing the risk? So there’s a lot more that is happening in this arena. But you know, I’m a physician scientist and you know you always have to think about you.
NOTE Confidence: 0.851543954
00:13:00.640 --> 00:13:03.146 Know if we can modify certain things
NOTE Confidence: 0.851543954
00:13:03.146 --> 00:13:06.107 like you know what we eat and if we're
NOTE Confidence: 0.851543954
00:13:06.107 --> 00:13:08.635 able to show that a particular dysbiosis
NOTE Confidence: 0.851543954
00:13:08.635 --> 00:13:11.547 in your God is associated with you.
NOTE Confidence: 0.851543954
00:13:11.550 --> 00:13:13.338 Know with the inflammation
NOTE Confidence: 0.851543954
00:13:13.338 --> 00:13:15.573 and changes in the genome,
NOTE Confidence: 0.851543954
00:13:15.580 --> 00:13:17.148 then you know we'll work on that.
NOTE Confidence: 0.851543954
00:13:17.150 --> 00:13:19.286 But there are things that are like low,
NOTE Confidence: 0.851543954
00:13:19.290 --> 00:13:19.804 you know,
NOTE Confidence: 0.851543954
00:13:19.804 --> 00:13:21.860 low hanging fruits and you know access to
NOTE Confidence: 0.851543954
00:13:21.918 --> 00:13:23.990 healthcare which we all know that it has.
NOTE Confidence: 0.851543954
00:13:23.990 --> 00:13:25.698 If it's you know,
NOTE Confidence: 0.851543954
00:13:25.698 --> 00:13:28.132 huge impact in this part is that
NOTE Confidence: 0.851543954
00:13:28.132 --> 00:13:29.284 we have been observing,
NOTE Confidence: 0.851543954
00:13:29.290 --> 00:13:30.210 including disparities,
that we see in colorectal cancer.

I said it help collaborating with them several investigators at the University of Puerto Rico that were focusing on delays in access to healthcare.

So basically there are three main delays that could occur that could interfere with the outcome of a patient, so you have what’s called primary delay. Secondary delay is from the first contact with that primary care physician. Secondary delay is from the first contact with the primary care physician.
NOTE: Physician to a confirmed diagnosis.
NOTE: The third chair is.
NOTE: Delay is the time from their confirmation to the start of treatment.
NOTE: Disparities in any of these areas right between one group of patients and another group of patients, or across segments of the population like rural versus urban or people with Medicaid versus those on commercial insurance. Will result in differences in outcomes. We examined our patients with colorectal cancer and this was published.
A few years ago where we saw in this graph we were looking at relative survival and five years of colorectal cancer among Hispanics from Puerto Rico. An in orange you can see in the top line you can see the relative survival among individuals that were on private insurance. On the gray or the second line you can see their relative survival for individuals that diagnosed with colorectal cancer at different time points and you can see that at 1/3 and also five years, this survival associated, you know, seen and observed among people that
had the public insurance was lower as compared to the private insurance, and this was adjusted for buy as many factors as we could possibly adjust for. But of course lifetime exposure. Right to die it to the place that you were raised to the community that you leave. We cannot account for that, so you know there might be things that occur much before we’re able to classify patients according to the health insurance that we can actually not measure. That is beyond their the. Environmental variables we couldn’t.
We can’t control for, so I want to finalize.

You know, I now focus on an area that is extremely important, which is. Can we modify the genes? Can we blame the genes right? And when you think about Hispanics, Hispanics, we are a group of individuals that are a mix race. Hispanics have a mixture on depending where you find the Latinos in the US or in Latin America. The composition of our genes berries dramatically. So if you go to places like in the Caribbean, 20% of our genes are from African ancestry.
and in fact I did genomic ancestry and I have 14 and you know if you go to South America there places that most of the genes are Europeans, but there are places where there is a significant percentage of the genes that come from Amerindian, so places like in Central America and some areas in South America as well. So when the TSJ it started, you know years back now this was published years ago. Yeah, as part of the Cancer Genome Atlas, one of the questions that we had and we had hoped for,
was that when this samples
the tumor samples were.
We’re going to be analyzed that there
would be good representation from
different racial and ethnic groups,
and we all know now that that’s not the case.
So this is basically for colorectal cancer.
There was no data on Hispanics from
you know that were included when
you know, overall we learned that
16% of the tumors were hyper mutated and
and there was no molecular difference
when we look at rectal cancer rectal.
You know cancer in direct
numbers is cancer in the colon.
And of course you know later on papers were published where you know we saw the differences in the percentage of tumors that came from individuals from minorities. Both racial and Hispanic minority. So of course, you know we need to continue to collect my data. There's a lot of great efforts that I applaud many of the institutions and including the NIH, NCI, and some other, you know, large populations like the. Breaking Cancer Society a CRM, others that have now started.
funding like that, you know as part of the effort to try to understand tumors from minorities, some including the Genie project that I'm sure that you guys are also information are involved with. So this was a publication we've had a few years ago doing a whole genome sequencing for patients with colorectal cancer data from the Puerto Rican Hispanic was included in this server. A fifth of all. Hispanics were from Puerto Rico and you can see that we were able to replicate some of the GI. You know the slaves that were
NOTE Confidence: 0.84933018875
00:18:46.880 --> 00:18:48.790 seen in non Hispanic groups,
NOTE Confidence: 0.84933018875
00:18:48.790 --> 00:18:50.477 but there were some that were only
NOTE Confidence: 0.84933018875
00:18:50.477 --> 00:18:52.290 pressing in or his family community.
NOTE Confidence: 0.84933018875
00:18:52.290 --> 00:18:54.468 So again there are some differences
NOTE Confidence: 0.84933018875
00:18:54.468 --> 00:18:57.289 that may might be drivers of this is,
NOTE Confidence: 0.84933018875
00:18:57.290 --> 00:18:59.838 but there’s still a lot to do.
NOTE Confidence: 0.84933018875
00:19:01.880 --> 00:19:04.430 We started evaluating this
NOTE Confidence: 0.84933018875
00:19:04.430 --> 00:19:06.570 We also started violating this
NOTE Confidence: 0.84933018875
00:19:06.570 --> 00:19:08.282 melodic profile of Latinos
NOTE Confidence: 0.84933018875
00:19:08.282 --> 00:19:10.299 with colorectal cancer and.
NOTE Confidence: 0.84933018875
00:19:10.300 --> 00:19:12.094 This is the first publication we
NOTE Confidence: 0.84933018875
00:19:12.094 --> 00:19:13.999 had years back and now I have.
NOTE Confidence: 0.84933018875
00:19:14.000 --> 00:19:15.792 We have more recent data and I’m
NOTE Confidence: 0.84933018875
00:19:15.792 --> 00:19:17.901 going to share with you and the first
NOTE Confidence: 0.84933018875
thing we notice was that Puerto Rican Hispanic with colorectal cancer. Those tumors were not. No, we’re not. You know, we’re not similar in several. Key biomolecular markers, like you know, microsatellite instability. Right now it is. We know that MSI is so important because it really defines a phenotype that responds beautifully to certain agents, like immunotherapy. Like immunotherapy. So in our regulation, we started seeing that our patients, you know,
had very little microsatellite instability.

And when you look at the CPG Island Middle Asian phenotype was also, you know, lower as compared to non Hispanic whites and also are African American. So are tumors were little bit different so we decided in the last three years we decided to replicate this effort and now with the availability of commercial testing an analysis that was just probably not published.
Was just presented at the ACR annual meeting. Trying to have better understanding of those actionable somatic mutations that are key now of what we all call precision oncology. When you think about large institutions, not minorities serving institutions, but those that serve other. You know non minority communities access to precision oncology within the framework of patient care. However, when you look at smaller centers, hospitals or even you know...
minorities every institution.

If this is something that it's starting to occur,

and thanks to the technology that now has become more financially accessible,

we're now being able to incorporate this,

you know. River care for patients?

Then why is this important?

Because there are molecularly targeted therapies that we have seen that not only in GI cancer,

but you know in non squamous cell lung cancer.

And I'm just showing you some of the key articles that actually change the
way that we practice medicine nowadays.

So like just zoom up for her two positive and you can see right?

Of course for the BRAF mutated Melanoma, which now we’ve seen some other tumors.

So it’s key because the.

Pharmacol from the pharmacogenomics are being studied,

but are almost like a secondary.

It doesn’t start with the pharmacogenomics,

it starts with the farmac

pharmacodynamics of one group,

so this is key.

Because if we don’t know how prevalent

are those biomarkers where we have?

Therapies that we can use.
Then you know our patients will never benefit. So the first thing that we have to do is to try to understand and we actually were able to do this. This analysis which I just alluded to and that was burned there is here and we evaluated close to 1929 hundred thirty one individuals and you can see here the distribution of the tumors, you know, thirty one individuals and you can see here the distribution of the tumors, you know, the how many most of you know 60% male, I mean female and you can see the. Age distribution for the
people that we evaluated.

We used commercially available testing and we did it in collaboration with the Precision Oncology Alliance and we look at actionable mutations specifically for colorectal cancer, and you can see you know if you look at your patient population. We saw, you know, find different prevalence of some of the key oncogenes and some of the key markers. So for instance, video one was only present in 1% of our patients MSI, in 2%, which is much less than other groups,
you can see how Keras, which entered be rough, was also highly prevalent.

So what we did was that we compare our data from patients data that was available for non Hispanic colorectal cancer tumors that were reported as part of the PGA.

Queiroz be rough interests or her to Intrax Ann.

And here you can see the actionable genes.

You can see in green we have the Puerto Rican Hispanics and in blue we have the non Hispanic tumors from the TSJ and for some
of the key oncogenes like Keras, you can see that Hispanics from Puerto Rico who are more likely to present with mutations in this particular oncogenes. And that’s terrible because then we have less access to some of the you know antibodies against EGFR for instance. This same thing, you know lack of certain biomarkers like PDL one or or Ms one. Among you know, this Hispanic community really also affects right? The availability of therapies to finalize. I want to very briefly show you some of the data that we have been working again with a group of collaborators, actions,
collaborators from different places, including them rikidozan. Garner from inside and now he’s in New York, so we actually look at African ancestry. Why? Because we know that African Americans have a higher risk of having colorectal cancer. They’re having higher mortality as compared to other non African American groups, so we look at on the association between having African ancestry in Puerto Rican Hispanics and certain phenotypes and also molecular markers. In our patients with rectal cancer,
so we were able to identify that individuals with African ancestry were more likely to have tumors located in that.is.com. So two times more likely than those Puerto Ricans without African ancestry. We also saw that the differentiation, they weren't the tumor from Puerto Rican's with higher African ancestry had a higher likelihood of having a low to moderate tumor difference differentiation. And you know, this might also contribute to the increased mortality that we observe in our population. So to finalize and there's many more data than we could discuss that may be asking
the QA I want to keep everyone in mind. Keep everyone in mind that still the number one tool that we have available for you know the Christmas parties is doing colorectal cancer screening. Having access to die early diagnosis and you know still to this day there still. Differences in the optic of colorectal cancer screening. When you look at the different minorities and racial groups and the same thing we see in Puerto Rican Hispanics and also you can see it in the US Hispanics and because of the burden of disease where we had 10% of our patients with colorectal cancer.
colorectal cancer in Puerto Rico, were part of being diagnosed with colorectal cancer before the age of 50. We move with the Department of Health, and in 2015 we. Put together an administrative order to start screening for colorectal cancer with feet. So we have a national feed program for people without family history to start performing fit testing at age 40, which was the highest and that was just before the Big Hurricane and then copied came to Puerto Rico. So now we have where’s have started again, you know,
to continue to promote screening.

So in summary, we've been able to briefly discuss some of the Asian associated disparities, writing incidents and survival for correct cancer among US Hispanics. We have shown differences not only between non Hispanics and Hispanics, but also across the different Hispanic subpopulations. Among Hispanics compared to non Hispanic

We discuss some of the differences are at the molecular level that include key, actionable biomarkers that are not present or present depending on the biomarker.

Among Hispanics compared to non Hispanic
and you know how non European ancestry, at least in the Caribbean, Hispanics from Puerto Rico was associated with worse colorectal cancer outcomes and nutrition, which you know when you think about the disease, is front and center might mediate the microbiome dysbiosis and it. You know we might be able to modify some of those risk factors. This is the team that I work with and this was this past March. For the correct awareness dressed in blue and I would like to finalize by thinking about the National Cancer
Institute and the NIGMS as well as local fan from Puerto Rico government.

For some of the work that you have seen, ankle appears from multiple places including the friend of mine, Doctor, Shabbir Yard and hopefully maybe he’s in the call and some other great friends across different centers in the US.

For what we do, thank you very much. I think I was trying to make the time 10 minutes. Let’s see. This is part of our campaign that we have for.

We call it the other cleavage so our people to stop,
00:29:04.180 --> 00:29:04.744 you know,
NOTE Confidence: 0.859347231538462
00:29:04.744 --> 00:29:06.718 to think about the colon and do
NOTE Confidence: 0.859347231538462
00:29:06.718 --> 00:29:07.979 colorectal cancer screening.
NOTE Confidence: 0.839141456
00:29:11.040 --> 00:29:13.220 Can you hear me again?
NOTE Confidence: 0.839141456
00:29:13.220 --> 00:29:16.888 OK, good good good thank you so much.
NOTE Confidence: 0.839141456
00:29:16.888 --> 00:29:20.400 You are efficient and I was trying to.
NOTE Confidence: 0.839141456
00:29:20.400 --> 00:29:23.460 I’m sorry no that’s so great.
NOTE Confidence: 0.839141456
00:29:23.460 --> 00:29:26.268 So I am going to Roy.
NOTE Confidence: 0.839141456
00:29:26.270 --> 00:29:28.326 I might let you ask a question first
NOTE Confidence: 0.839141456
00:29:28.326 --> 00:29:30.238 if you’re willing while I pull up.
NOTE Confidence: 0.839141456
00:29:30.240 --> 00:29:32.106 Your Cam has a massive thanks.
NOTE Confidence: 0.839141456
00:29:32.110 --> 00:29:33.180 So much for being here.
NOTE Confidence: 0.5952122625
00:29:33.340 --> 00:29:34.560 How are you Roy?
NOTE Confidence: 0.866032571666667
00:29:35.500 --> 00:29:36.508 Let me ask you a question.
NOTE Confidence: 0.866032571666667
00:29:36.510 --> 00:29:38.022 It’s something related so you know
NOTE Confidence: 0.866032571666667
00:29:38.022 --> 00:29:39.305 I’m working very closely with
the Clinical Trials Office here and I notice that our accrual of Latin Hispanic patients is really poor, and that’s something throughout the United States. Any any tips on how we can improve that? I know it’s a general problem. Yeah, it’s a general problem there. There’s a lot of distrust, right? There’s a huge Guinea pig concept, so you know one of the things that we have done, locally, you know. And remember, I’m a Puerto Rican working with Puerto Rican’s, right?
So people shouldn’t be discriminated or feel discriminated because of the you know, rate, racial and ethnic concordance. But one of the concepts that we have started to use is that I don’t like to use the word investigation, which means research, because when you put the word investigation or research, or you know people immediately, they stop so. So the word that we’re using now. We used protocols, you know, National Cancer Institute protocol and industry treatment protocols. And then we explained to them what it means.
00:30:40.118 --> 00:30:42.590 this is before the FDA approves the drug,
00:30:42.590 --> 00:30:43.820 so I tell them that.
00:30:43.820 --> 00:30:45.982 But it’s almost like it’s at
00:30:45.982 --> 00:30:47.254 least this is what I see.
00:30:47.260 --> 00:30:49.948 You know, when you use the word research,
00:30:49.950 --> 00:30:52.080 most people simply become scared,
00:30:52.080 --> 00:30:54.504 so you need to have cultural competency
00:30:54.504 --> 00:30:58.230 and you know as much as we can have,
00:30:58.230 --> 00:31:01.110 and if you can do that concordance,
00:31:01.110 --> 00:31:03.126 During navigators now, and we’re
00:31:03.130 --> 00:31:04.830 translating all the consent forms.
00:31:04.830 --> 00:31:06.105 translating all the consent forms.
00:31:11.120 --> 00:31:12.780 Salute Lee, you know Roy.
NOTE Confidence: 0.724583196
00:31:12.780 --> 00:31:14.730 Even there be a you know.
NOTE Confidence: 0.724583196
00:31:14.730 --> 00:31:15.958 I wish everyone would
NOTE Confidence: 0.724583196
00:31:15.958 --> 00:31:17.493 imagine that they will have.
NOTE Confidence: 0.724583196
00:31:17.500 --> 00:31:19.344 You know, multiple language
NOTE Confidence: 0.724583196
00:31:19.344 --> 00:31:22.110 consent forms they do not sovyet
NOTE Confidence: 0.724583196
00:31:22.192 --> 00:31:24.160 trials which I have, you know,
NOTE Confidence: 0.724583196
00:31:24.160 --> 00:31:25.880 and I I was adamant about the fact
NOTE Confidence: 0.724583196
00:31:25.933 --> 00:31:27.653 that you know they had to have any
NOTE Confidence: 0.724583196
00:31:27.653 --> 00:31:29.172 more than one language because you
NOTE Confidence: 0.724583196
00:31:29.172 --> 00:31:31.053 know we have people that are U.S.
NOTE Confidence: 0.724583196
00:31:31.053 --> 00:31:32.668 citizens that speak another language.
NOTE Confidence: 0.724583196
00:31:32.670 --> 00:31:34.930 So I said we better than you
NOTE Confidence: 0.724583196
00:31:34.930 --> 00:31:36.005 know and it’s it’s working.
NOTE Confidence: 0.724583196
00:31:36.010 --> 00:31:37.384 So yeah black,
NOTE Confidence: 0.724583196
00:31:37.384 --> 00:31:38.758 I congratulate you.
For doing that where we’re trying now, listen before we go on.
Cam has a little presentation for you. I mentioned in the beginning that Russia is our inaugural recipient of this annual Lectureship, so we will be sending this to you. We wish it were interested, but we’re really grateful for your presentation and presence today, so thank you so much for joining us. Thank you very much.
It’s an honor, and you know.
I’m trying to pull all these things together.
It’s it’s, you know, he’s really a Humira Chal sometimes. And you know and we need to work as teams, so I’m glad that you are. You know, doing this for thank you. Thank you. Yes, now we would. We would love to do that, you know. And I think that one thing just to highlight for you. And I think for potential future conversations and collaborations are are greater. New Haven community is very diverse and I think we have a lot of you know Hispanic patients and. My patients and I think,
as I’m sure you know,
this three year work with doctor
were eager to make sure that
we’re meeting the needs of these
patients in our catchment area.
And I think I was really,
I think I really liked your work on
the microbiome versus bacterial genes,
and I think really trying
do a deeper dive,
both in terms of that but also
precision medicine to really meet the
needs of a more diverse population.
That’s correct, that’s correct,
and you know, it’s almost like impossible.
00:33:17.770 --> 00:33:20.560 You know to try to answer every question,
NOTE Confidence: 0.838421344285714
00:33:20.560 --> 00:33:23.116 so the way that we have you know our
NOTE Confidence: 0.838421344285714
00:33:23.116 --> 00:33:25.175 approach has been to really collaborate
NOTE Confidence: 0.838421344285714
00:33:25.175 --> 00:33:27.732 with teams and you know from basic
NOTE Confidence: 0.838421344285714
00:33:27.732 --> 00:33:30.084 scientists and you know to physician
NOTE Confidence: 0.838421344285714
00:33:30.084 --> 00:33:31.718 scientists and even the Community, you
NOTE Confidence: 0.838421344285714
00:33:31.718 --> 00:33:33.670 know that that work that I show you about.
NOTE Confidence: 0.838421344285714
00:33:33.670 --> 00:33:35.170 You know access to care.
NOTE Confidence: 0.838421344285714
00:33:35.170 --> 00:33:37.818 I mean, I, I, I was really amazing.
NOTE Confidence: 0.838421344285714
00:33:37.820 --> 00:33:39.554 I love the molecules and you
NOTE Confidence: 0.838421344285714
00:33:39.554 --> 00:33:40.684 know when you talk about jeans,
NOTE Confidence: 0.838421344285714
00:33:40.684 --> 00:33:42.226 I get very excited but but
NOTE Confidence: 0.838421344285714
00:33:42.226 --> 00:33:44.184 then I realize that, you know,
NOTE Confidence: 0.838421344285714
00:33:44.184 --> 00:33:46.473 we have to also tackle the community.
NOTE Confidence: 0.838421344285714
00:33:46.480 --> 00:33:48.660 The access to health care.
NOTE Confidence: 0.838421344285714
00:33:48.660 --> 00:33:50.236 It doesn’t explain all.

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OK, because you know Sweasy populations have been published many times over that with the same access to care you see differences. But you know some of the key factors may be mediated to you, knowing those genes that we inherit and there was a an article published maybe three months ago by the group that blanket and it was published in Nature. He was about. Lung cancer an ancestry and you know it was beautifully presented but that depending on your ancestry,
particular genes that were driver for
lung cancer were present, so you know.
Of course, if you are exposed to more carcinogens right,
you will have a higher risk for developing cancer,
but it was not explained by the environment was explained by the genes.
And now you know, you know what are those other you know.
Genes that might be related to inflammation,
you know, stress related and not really.
You know, you know Uncles genes,
but maybe just stress related right?
And you get more of you know like for instance we’ve been looking into interleukins and whether or not having a particular Geno type in key interleukins that are inflammatory mediated my increase the risk of developing cancer once you know expose that to two whatever carcinogen and we’re doing that. My work is part of the team, it’s not my. My work is part of the team, so you know there are many more questions that we could try to attend by really dissecting all the different areas.
That’s great, I don’t see any other questions in the chat, but please post them if you have any, and I’ll maybe ask.

Ask another one or just a comment

You know I did not know that the TGA had really like such little diversity and zero Hispanics, you know I did not know that the TGA had really like such little diversity and zero Hispanics,

and I think that I’m wondering as you can in your sort of leadership roles in the survey,

To conduct more diverse research,
00:36:01.700 --> 00:36:03.160 yeah and and you know,
00:36:03.160 --> 00:36:05.575 thank God that this has started already,
00:36:05.580 --> 00:36:07.010 so you know they said,
00:36:07.010 --> 00:36:09.450 you know when when we were all like you know,
00:36:09.450 --> 00:36:12.130 looking at the data and you know seeing
00:36:12.130 --> 00:36:15.420 the the lack of diversity right at the
00:36:15.420 --> 00:36:19.570 same time a huge effort started on the ACR.
00:36:19.570 --> 00:36:21.946 Really, you know, promoted the genie,
00:36:21.950 --> 00:36:23.470 the project Genie right?
00:36:23.470 --> 00:36:26.305 Which now when you look at the
00:36:26.305 --> 00:36:28.665 centers that contribute to tumors.
00:36:28.670 --> 00:36:30.246 Much more diverse centers,
00:36:30.246 --> 00:36:32.610 and now we have close to
00:36:32.688 --> 00:36:34.258 10% in certain cancers.
00:36:34.258 --> 00:36:36.026 We have 1015% representation and
then the same thing is happening with the prostate cancer right there.

Large cohort of prostate cancer.

Men that had our 2000 and it’s it’s halfway there in the collection and it’s really focus on African Americans with prostate cancer. Because I mean, how can we understand and better serve our communities like the ACR and you know and even inside NCI because you.
00:37:11.858 --> 00:37:13.655 would say why didn’t we think about
00:37:13.655 --> 00:37:15.399 this right when we put it together?
00:37:15.400 --> 00:37:17.510 Well, there’s something called subliminal.
00:37:17.510 --> 00:37:18.822 You know bias right?
00:37:18.822 --> 00:37:20.462 I mean some sometimes subconsciously
00:37:20.462 --> 00:37:21.509 messed up conscious.
00:37:21.510 --> 00:37:23.180 Sometimes you don’t even think
00:37:23.180 --> 00:37:25.155 about it because there’s nobody on
00:37:25.155 --> 00:37:26.668 the table to remind you, right?
00:37:26.668 --> 00:37:28.754 So you know when you look at
00:37:28.754 --> 00:37:30.138 institutions like you know the.
00:37:30.140 --> 00:37:31.706 NCI that represents,
00:37:31.706 --> 00:37:34.713 you know the whole USA America
00:37:34.713 --> 00:37:35.892 right 350 million,
00:37:35.892 --> 00:37:37.857 whichever number we are right,
we need to have representation and you know when you look at the NCI. For instance, there are two important bodies like they NCIB right in the baby. I forgot the whole nomenclature is one of the groups that advisory boards with the National Cancer Institute Advisory Board. And then we also have the Board of scientific advisors. So you know, those are the group of individuals that are scientists that represented different segments of our community of sign. That it’s important that we start
having representation from the top, because if we are not at the table right, you know what they idiom says. So I think that that’s one of the things that has started to happen, and you know the same thing applies for women. And you know, I always have to, you know, remind people that you know 50% of us are they look like me, but sometimes when you look at the leadership, you only see 10% of us, so you know it’s important to promote diversity.
Across religion ethnicity, you know gender and you know race and I'm starting with leadership positions and when we are there you know then we make, you know we make our point. We make sure that we're not oblivious to that. So I think you know the short answer is that we're doing better. We're going to have good data in the next few years and that data that I just showed you. We mean, that was commercial data, so we basically took RSR group of patients and you know, in 10 years before that would have been.
Impossible for anyone to afford. You know, over $1000 that that cost about $3000 per patient. And you know that we’re required a large or one to do it right? But now we can use those commercially available databases, which you know allows an investigator you know to start comparing and pulling data. You know DJ is only one of the databases. We have multiple lines. I mean, there are multiple lines that. Smart people can I get? You know people that you know have good questions,
can pull an evaluate,
so hopefully soon will have much more.
Great, well we are just
about at the hour or so.
Thank you Doctor Cruz Correa
for joining us today.
Thank you for tonight.
We’re excited to continue the
conversation with you and other forums.
It’s wonderful to have you here
and hopefully someday in person and
looking forward to working with you,
you’ve given us many things to think
about that are really important
for our community and for patients.
And thank you so much for your time. We are really privileged to be able to do something that we love, and I think that’s for me. That’s the key. I see you guys are also doing the same. We will be sending you that plaxo. We will be sending you that plaxo. OK, you’re gonna love your office about. I’m right here so thank you. Thank everyone and
goodbye. My friends are there as well. So happy to see you all bye bye thank you.