32 Cancer Center grand rounds.

I’m making a guest appearance today and I can’t say that it’s wonderful to be a guest in introducing a very special speaker who is Doctor Kathy Yang and many of us know Doctor Ang who is very well known in the field of Colt GI Malignancies and Doctor Lang. Is the David Johnson chair and surgical Leader of the GI Cancers research program. At Vanderbilt, she’s also, I think Co. Director of the OR Director of the Young
Adults Cancer Initiative and started at Vanderbilt about a couple years ago, so really has done phenomenally.

Kathy received her MD from Hahnemann and then her residency in internal medicine at Russia and then did her fellowship in hematology oncology at the University of Chicago and then spent majority of her life at MD.

Anderson focused on what is close to, I think several of our hearts in colorectal cancers, GI cancers and translational research and what impact can we do in in those fields.

She also played important roles in faculty governance. I was excited to see.
Kathy ticker roll in as in the faculty Senate, which often is an important piece and then move to Vanderbilt in 2019. Her interest has been in clinical trials and how can we define novel drugs for treatment of these cancers. And as I mentioned, is also beyond focus on the young adult colorectal cancer patients has also focused on role of immunotherapy in HP. Associated Cancers has published many, many papers on these fields and has led many trials. I’m not going to enumerate.
All of her leadership roles in the various national societies, most recently that rang was chosen as the Vice chair of the swag GI Committee and NCI GI Steering Committee, and has focused on workforce shortages. So overall, what I would describe as not only a talented clinician, but also thinking about our field and oncology and the broader things that guide us. Really looking forward to her presentation today. Welcome, Kathy.
Well, thank you so much and let me go ahead and share my screen. And. Sorry.

OK, did it come across OK?

Perfect so today is March 1st,

so it’s colorectal Cancer Awareness Month,

so I am delighted to participate in this session with all of you today.

With so many familiar faces and thank you so much for inviting me.

So we’ll just be touching up on kind of the general field regarding colorectal cancer,

since it seems appropriate for March colorectal Cancer Awareness Month.

And these are the topics we’ll be discussing.

And these are my disclosures.
So friendly reminder for those that are don’t treat colorectal cancer in a regular basis. It is expected in 2022 that 151,000 individuals will be diagnosed with this disease and about 45 thousand of those will be rectal carcinoma. It still remains the second leading cause of cancer death for men and women combined and the meeting age. As many of you are aware is usually in the late 60s, but I’m going to be touching upon that because of my own interest in early onset colorectal cancer and for as long as I’ve been in practice.
Unfortunately, the five year survival for our stage four patient population has basically only changed from about 13 to 14%, and it looks closer now to 15%. Based upon these numbers.

Friendly reminder as well for the majority of our patients. Unfortunately they do not have an inherited form of colorectal cancer such as Lynch syndrome or FAP. In the majority of cases are going to be sporadic and that’s why this is very difficult.
believe it’s largely multifactorial.

I’m not going to be touching upon the very basic information regarding chemotherapy because most of the literature nowadays is about molecular subsets, and I’ll touch upon the more recent data on some of those subsets. But for us for any stage 4 surgically unresectable, patient or patient that is going to receive neoadjuvant therapy with metastatic disease prior we often consider the use of systemic chemotherapy and the most common regimens,
as many of you are familiar with. May include folfox or folfiri with the consideration of a targeted agents such as berbasis, ma’am or anti EGFR therapy such as PM AB or C tax map. If the patient is rest wild type. If the patients treatment naive if they don’t have a right sided tumor, we may want to consider anti EGFR therapy, although that is not my personal preference. I tend to reserve it for further down the line and then full Fox. Erie for a patient that is well with good performance status.
00:05:23.870 --> 00:05:25.892 Fair reasonable file with the high
NOTE Confidence: 0.882954597
00:05:25.892 --> 00:05:28.300 response rate of 65 to 78% and then
NOTE Confidence: 0.882954597
00:05:28.300 --> 00:05:30.330 of course we have our oral agents
NOTE Confidence: 0.882954597
00:05:30.396 --> 00:05:32.446 regorafenib and lonsurf that are
NOTE Confidence: 0.882954597
00:05:32.446 --> 00:05:34.496 currently FDA approved as single
NOTE Confidence: 0.882954597
00:05:34.562 --> 00:05:36.262 agents in the refractory setting
NOTE Confidence: 0.882954597
00:05:36.262 --> 00:05:38.426 and then last but not least,
NOTE Confidence: 0.882954597
00:05:38.426 --> 00:05:40.250 the rare subtypes currently.
NOTE Confidence: 0.882954597
00:05:40.250 --> 00:05:42.735 Our median survival for all stage four
NOTE Confidence: 0.882954597
00:05:42.735 --> 00:05:45.253 patients is roughly 32 to 34 months
NOTE Confidence: 0.882954597
00:05:45.253 --> 00:05:46.988 for the general patient population,
NOTE Confidence: 0.882954597
00:05:46.990 --> 00:05:49.987 but once again,
NOTE Confidence: 0.882954597
00:05:47.989 --> 00:05:49.987 right sided tumors do not appear
NOTE Confidence: 0.882954597
00:05:49.987 --> 00:05:52.158 to fear as well in regards
NOTE Confidence: 0.882954597
00:05:52.158 --> 00:05:54.272 to overall survival for our.
NOTE Confidence: 0.882954597
00:05:54.272 --> 00:05:56.236 Either Rasputin patients and

10
then our right side of patients. And these are the molecular subsets that we've largely been focused on recently. Queiroz is the most common mutations. Majority of our patients, but we do like to take into account other rare RASK mutations such as N Rasen d'etre, and then we do have some other rare mutations, including MSI high, which will be discussing the BRAF mutation, which is less than 10% of our patient population with V600E. PIK 3 CA is being investigated, as in clinical trials and then.
And then there’s the end track fusion, which I will not be touching upon, because that’s extremely rare and have yet to see a patient with the interact fusion. But I’m always curious when people tell me they’ve had one occasional patient, and that’s less than 1% of all patients. So for all of our patients with metastatic disease, I’m going to be focusing on that in large part for this talk and then touching upon a little bit on early stage, colon and rectal if brief time. But next generation sequencing is extremely important for our patient population.
and identifying once again those mutations that I mentioned. And these are some of the aspects will be touching upon. Once again, MSI Grass B RAF and her two amplification. For MSI high colorectal carcinoma patients, which represent less than 10% of our patient population. This is one of the most important studies to date for MSI high patients, and I'm sure many of you are familiar with the role of pembrolizumab in treatment. Naive MSI high colorectal carcinoma patients. This was basically a one to one
randomization that has since been updated in regards to overall survival compared to standard chemotherapy, and in this case was two primary endpoints, PFS and OS, and the results were extremely impressive when they were originally. Presented and eventually published. And this is looking at the progression free survival for our MSI high treatment naive patients when receiving Pember Lizum app. This is single agent pembrolizumab. Now you may say that there’s a crossover in about 1/3 of patients in those that did receive Pember Lizum app at 1st and did not appear to benefit from this drug. And unfortunately we don’t have the exact
etiology to account for this right now.

But as you can see here, the PFS was twice as high for that versus standard chemotherapy for the majority of patients.

And the OS has also been determined to be of significance in the sense that there was crossover loud. Once again, this is a Co primary endpoint, so 60% of patients were allowed to crossover to receive IO therapy, and so that is obviously an issue when I’m looking at your statistical significance. The prespecified P value was supposed to be 0.0246,
so they did not meet its pre
specified value for OS,
however.
Obviously I would say we can clearly see
that there was crossover 60% of patients,
and that’s likely accounted for
this and also keeping in mind this
is really considered the standard
of care for these patients.
Now what is the other 1/3 of patients that
do not appear to benefit from IO therapy?
Once again, we still have yet to understand why that is,
and obviously it does bring to mind
that is there a potential benefit for
the consideration of chemotherapy,
00:09:25.360 --> 00:09:26.683 plus IO therapy?

00:09:26.683 --> 00:09:30.599 And that is an ongoing trial by the way.

00:09:30.600 --> 00:09:31.788 Looking at response rate,

00:09:31.788 --> 00:09:35.952 you can see here 44% versus 33% for

00:09:35.952 --> 00:09:38.924 pembrolizumab versus standard chemotherapy.

00:09:38.930 --> 00:09:40.748 But what is of great interest?

00:09:40.750 --> 00:09:43.180 I think for many of us is the fact

00:09:43.180 --> 00:09:45.215 that there may be some potential

00:09:45.215 --> 00:09:46.627 benefit for combination therapy.

00:09:48.490 --> 00:09:48.789 that we’re not comparative arms,

00:09:53.130 --> 00:09:55.923 It was part of a large study

00:09:55.923 --> 00:09:58.789 looking at various cohorts,

00:10:00.490 --> 00:10:02.182 and this was in the treatment
naive setting here, primary endpoint was response and this was published by Heinz Josef Lenz last fall, and I told you the response rate was 44% for single agent pembrolizumab. Keeping in mind this is once again a small study, 45 patients. This is not a phase three, but the response rate was 69% and once you can see across the board. Quite impressive response rates and they reported that the 24 month of OS was 79%, so it’s actually quite impressive and obviously I think many of us look forward to learning more about the benefit of combination therapy.
and see if it is truly superior.

But once again, Pember Lizum app has demonstrated this in a phase three trial.

What are the ongoing trials?

So there is a stage three trials called Atomic, which is folfox plus or minus 8 SO.

And then, as I mentioned before, there is a combo study that was very slow to enrollment.

Hopefully will it will finish enrollment at some point called commit.

Looking at Folfox plus Bev.

And then it has, oh there is a Merc platform study that is also new and ongoing as well.
And in rectal cancer there’s actually some very intriguing data regarding MSI high and that was just reported. So we’ll touch upon that.

Obviously the results from Pember Lism AB are quite impressive and there was another pilot trial called the Niche trial looking at a very very small number of MSI high patients and looking at the role new Advent IO therapy in that setting and they noticed there was some significant benefit. So why not consider that in an MSI high rectal patient population
and this trial was actually just presented by Doctor Loomis who is a fellow at Memorial Sloan Kettering under the guidance of my friend Andrea Sirsak. They’re looking at the star lamat, so here locally advanced MSI high rectal cancer stage two stage three. Now be results from this trial were so impressive that they decided to go ahead and provide the presentation on
00:12:19.441 --> 00:12:21.913 the 1st 11 out of 16 patients enrolled.
NOTE Confidence: 0.900595142222222
00:12:21.920 --> 00:12:24.506 The total number of patients expect.
NOTE Confidence: 0.900595142222222
00:12:24.510 --> 00:12:28.290 Roll and roll in. This trial is 30 patients.
NOTE Confidence: 0.900595142222222
00:12:28.290 --> 00:12:29.991 And here is what they call clinical
NOTE Confidence: 0.900595142222222
00:12:29.991 --> 00:12:30.477 complete response.
NOTE Confidence: 0.900595142222222
00:12:30.480 --> 00:12:33.030 Once again is the endoscopic CR
NOTE Confidence: 0.900595142222222
00:12:33.030 --> 00:12:35.589 plus the radiographic CR and they
NOTE Confidence: 0.900595142222222
00:12:35.589 --> 00:12:38.305 required all patients to have an MRI.
NOTE Confidence: 0.900595142222222
00:12:38.310 --> 00:12:40.008 And this was the patient population.
NOTE Confidence: 0.900595142222222
00:12:40.010 --> 00:12:43.420 Just to give you an idea real quick,
NOTE Confidence: 0.900595142222222
00:12:43.420 --> 00:12:45.946 A lot of patients were T3T4 a lot
NOTE Confidence: 0.900595142222222
00:12:45.946 --> 00:12:47.406 of patients were node positive.
NOTE Confidence: 0.900595142222222
00:12:47.410 --> 00:12:49.554 These were MSI high,
NOTE Confidence: 0.900595142222222
00:12:49.554 --> 00:12:52.770 but all were BRAF wild type.
NOTE Confidence: 0.900595142222222
00:12:52.770 --> 00:12:54.828 And this is the very early results.
We do not have long term results, just early results of the 1st 11 patients out of the 16 enrolled this far and they reported a complete CR. And in this study in fact they omitted the consideration of radiation and surgery. So do keep that in mind in this patient population. Obviously single institution study we need more follow up and I’d like to see this data validated.

Kristen See Amber who I’m helping to mentor and I worked with her extensively on this.

Protocol we had actually created this.
national trial supported by Ekaki,
NOTE Confidence: 0.8154273212

a 2201 looking at New Advent Niveau
NOTE Confidence: 0.8154273212

EP also in the MSI high patient
NOTE Confidence: 0.8154273212

population with the consideration of
NOTE Confidence: 0.8154273212

five by five radiation therapy and then
NOTE Confidence: 0.8154273212

also the consideration of sphincter
NOTE Confidence: 0.8154273212

preservation here primary endpoint was
NOTE Confidence: 0.8154273212

Patsy R because the findings from Asco
NOTE Confidence: 0.8154273212

GI from Doctor Loomis this trial is
NOTE Confidence: 0.8154273212

going to undergo some rapid amendment
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to maybe allow the consideration.
NOTE Confidence: 0.8154273212

Of not necessarily requiring 5 by 5
NOTE Confidence: 0.8154273212

radiation therapy unless there's bulky
NOTE Confidence: 0.8154273212

tumor and adenopathy and obviously
NOTE Confidence: 0.8154273212

once again it's very interesting
NOTE Confidence: 0.8154273212

'cause we actually recommended the
consideration of making sphincter preservation as a primary endpoint.

But when we originally wrote this trial, we were told that that was being too progressive and here we are today trying to amend this trial to keep up. But once again, this is a national trial and we will remain open and we hope to enroll these patients once again. Pilot study of roughly 31 patients as well.

What about our Brafman patients? Well, for our MSI stable be wrapping in patients,
it's very poor prognostic factor for these patients. It's less than 9% of our patient population. Unlike Melanoma, single agent Byref inhibitors have not been impressive with response rate of less than 5%, and we noted that there were basically escape mechanisms in colorectal cancer in comparison to the success that was seen in Melanoma with standard chemotherapy, the median overall survival is only 12 to 14 months. And So what can we do? How can we basically not only utilize our B RAF inhibitors?
But how can we also consider other downstream impacts? And so here we have the combination. Basically with Ralph, Egypt are and then there was an attempt in combination with Mac. This was the B control, so the B control had a triplet versus the doublet versus standard chemotherapy. For patients that have received at least one prior line of therapy for B RAF meeting V.

Mutation and the doublet was determined to be just as successful as the triplet,
and this was FDA approved.

This is the regimen called B raft OD,

and it resulted in OS of nine point 3

months versus standard chemotherapy.

Now what’s really interesting is

they decided to examine that regimen

because it seemed to be the most

successful and try to move it up

front to the treatment naive setting.

And this is the anchor trial which was

reported at ESMO and I show it here.

’cause this has since been updated as well.

At ESMO last year.

And they reported a response rate

of about 50%.

However, the PFS was only about four months,
and so that was clearly not a home run for a treatment naive patient. So at this year’s Oscar GI just a couple weeks ago, Dan Morris, from MD Anderson has completed this pilot trial at MD Anderson looking at end crafted and so text amount so the beer F to V but in combination with immune checkpoint inhibition with nivolumab in this setting and this is in previously treated patients and the reason for that is because there appears to be a higher immune activation and higher team be in this patient population.
And as you know some of the B RAF subtypes actually are very similar to this one. So more likely to respond to IO therapy, single institution study, small numbers, important to keep in mind. And here’s the primary endpoint response, and these were the doses that were provided to these patients. Keeping in mind these patients need a better option as they just showed you, they don’t do well with standard chemotherapy therapy, and even with RAF target therapy, they still need a better response. So once again,
single institution very thought provoking.

They report a response rate 50% so not much higher than what was already reported in the prior study.

However, the PFS was a little bit higher at 7.4 months, and the OS was 15.1 months. This is after a medium fault time of 16 months.

Now these results were impressive enough that now this is going to be a national trial swab 2107 with a 2 to one randomization of the addition of BIOTHERAPY.

At a study less than 75 patients,
00:17:45.750 --> 00:17:47.350 this should be opening up.
NOTE Confidence: 0.684076439
00:17:47.350 --> 00:17:48.058 This is March,
NOTE Confidence: 0.684076439
00:17:48.058 --> 00:17:49.710 so it should be opening up at
NOTE Confidence: 0.684076439
00:17:49.770 --> 00:17:51.680 the latter part of April and we
NOTE Confidence: 0.684076439
00:17:51.680 --> 00:17:53.230 are excited about this trial.
NOTE Confidence: 0.684076439
00:17:53.230 --> 00:17:56.245 It allows one to two prior lines of therapy,
NOTE Confidence: 0.684076439
00:17:56.250 --> 00:17:57.910 so that’s in your previously
NOTE Confidence: 0.684076439
00:17:57.910 --> 00:18:00.550 treated brip patients.
NOTE Confidence: 0.684076439
00:18:00.550 --> 00:18:02.170 If you have any patient
NOTE Confidence: 0.684076439
00:18:02.170 --> 00:18:03.670 starting in the next two months,
NOTE Confidence: 0.684076439
00:18:03.670 --> 00:18:05.936 please consider this trial when
NOTE Confidence: 0.684076439
00:18:05.936 --> 00:18:07.336 it is open at time to activate
NOTE Confidence: 0.684076439
00:18:07.340 --> 00:18:10.147 Now there is a phase three trial
NOTE Confidence: 0.684076439
00:18:10.147 --> 00:18:12.352 that is ongoing for these patients
NOTE Confidence: 0.684076439
00:18:12.352 --> 00:18:14.690 and I also want to highlight this
because it is the only phase three trial in treatment naive patients.

So this is a one to one to one randomization of basically beer after V.

So end carafe, and if the BRAF inhibitor plus the text map or that same combination be wrapped heavy plus folfox,

they've actually decided not to proceed with full fury.

That was part of the run in phase and so does now with Folfox.

This phase three arm just opened about two weeks ago and then the control arm is standard chemotherapy,
so this trial is largely being run in Europe and they're about 9 sites.

The last time I checked in the United States, we are one of the sites that are participating in this trial.

Once again, we really need to find an option for these patients with very poor prognosis otherwise, so please consider enrollment to this trial.

I wanted to just briefly touch upon her too, 'cause there's a lot of interest and direct. Can I know that many of you are familiar with direct can because it is proved in gastric and breast cancer, but her two positivity is extremely
rare in colorectal cancer,

unlike a gastric and breast cancer,

it's about 4% of our patients,

and once again it is required to be 3 plus

by IHC or fish amplified and IHC 2 plus.

So ongoing studies that I will

not be touching upon 'cause they.

Finished enrollment,

but have not yet been reported yet.

There’s swag 1613,

which is treasure map plus produce

which is treasure map plus produce

a map versus standard chemotherapy

in the previously treated setting,

and then the Mountaineer study was

to catnip plus restitution amount.
Now I'll just be touching on destiny because this was a recently updated as well. Destiny is looking at an antibody drug conjugate, which is direct can and this trial was extremely interesting for many of us in colorectal cancer because it's number one. It's a different type of drug and #2 they allowed patients that have had prior anti her two therapy.

You'll see here they provided the 6.4 milligram per kilogram dose and I mention that because there's a second study that is also testing the dose. Currently that is open and this is
at Q three weeks you’ll see cohort. Today is your IHC 3 plus patient population or your fish positive cohort B is I see two plus and the cohort C is IHC one plus primary endpoint was response. 'cause keeping in mind these are small patient population.

And here focusing on Cohort 8, that’s really where your focus should be. 53 patients of those 53 patients, had a response, and these were heavily pretreated patients. If I recall correctly, the median line of therapies was free and
and basically the response rate was 45%.
So once again it can be provided to a patient.
That’s her two positive that is naive to trust its map,
or it can be provided to a patient that has.
Had progression of disease which has treasuries map and this could be an option now very similar to the studies in breast and gastric.
There is a known toxicity as many of you are aware,
with interstitial lung disease, which is in less than 10% of the patient population,
but something important to keep in mind.
And then it wanted to touch upon Cara.

So Karas mutation for us in colorectal cancer has been one of the most common mutations. Especially when you take into account your standard crass. But then you also have your address and then rest. Which means all these patients do not benefit. So that’s about 30 to 60% of patients do not benefit from anti EGFR therapy. And then recently there’s been some interest looking at drugs that are specific to the Cross G 12. The mutation now keeping in mind this is very, very rare.
In colorectal cancer it’s less than 5% of our patients, but it is a potential option now this has been reported, you probably seen the data already with long, much more impressive with lung and colon. Not so impressive as a single agent. Basically the response rate was about a little less than 10% and this was just published recently. So Teresa is the drug. Progression free survival was four months. The medium fall was after this. After meeting followed 11 months, the 12 month PFS was only 11% and now there are obviously looking
at this drug in combination.

So I look forward to seeing some of that data.

Although not specific to colorectal cancer.

Once again, this is at aggressive from another competing company and I wanted to show this because it was very impressive in regards to pancreatic cancer.

Once again, the very small numbers, so I always.

I’m always very hesitant when I see very early data.
GI patient population and they reported that there was basically a response attend in 10 patients. Five out of those ten had a response with pancreatic cancer, which is unheard of as many can guess because once again, pancreatic cancer is still remains a challenge, and we don’t have a lot of novel agents. This is once again G12C, which is not the most common RASC mutation in pancreatic cancer, but once again could be. Potentially beneficial, and then they are looking at it.
Other malignancies very similar so that to the Soeder as they are looking at it in combination as well. So just intriguing data from this year’s Oscar GI. I did want to focus on the role of circulating tumor DNA, just very briefly, because there are two ongoing trials and early stage disease, and then there was this trial that was just presented at ASCO. Doctor Katata called Circulate Japan and I thought that this was a very very important study that should...
receive attention because it

00:24:26.470 --> 00:24:29.420 looked at basically all stages.

00:24:29.420 --> 00:24:32.510 Colon rectal cancer resectable stage

00:24:32.510 --> 00:24:34.786 four they basically obtained pre-op

00:24:34.786 --> 00:24:36.856 circulating tumor DNA using the

00:24:36.856 --> 00:24:38.683 signature platform and then they

00:24:38.683 --> 00:24:40.717 followed the patients at four weeks,

00:24:40.720 --> 00:24:43.198 12 weeks, 24 and 36 weeks,

00:24:43.200 --> 00:24:45.510 and so they provided their data

00:24:45.510 --> 00:24:47.436 regarding the 1st 1000 plus patients

00:24:47.436 --> 00:24:49.511 that have been enrolled this far in

00:24:49.511 --> 00:24:51.215 this trial and they’ve compiled it

00:24:51.215 --> 00:24:53.280 based upon these three ongoing studies.

00:24:53.280 --> 00:24:54.430 As you can see here.

00:24:56.440 --> 00:24:58.890 Like Vega Galaxy and Altair.

00:25:01.010 --> 00:25:03.649 And what it really shows basically where
we think the field is obviously going. Here we have some information for stage one through stage four and as you can see here at the disease free survival if you’re circulating dramatically different from if you remained positive and this is at post-op when compared to baseline at 4 weeks. And then they continued to look at their sequential circulating at tumor DNA at 4 weeks and 12 weeks. And as you can see here, obviously if it remain negative, that’s a very positive benefit in
regards to disease free survival.

But if you went from negative to positive that changed your disease free survival from 98% to 63%.

If you went from positive to negative, let’s say with attachment chemotherapy that improved your disease free survival but positive to positive obviously was not a good prognostic indicator.

And this is looking at the role of adjuvant chemotherapy here. If you have a positive circulating tumor DNA, so very intriguing data, and probably the largest data to date. So it’s just important to note. And once again the purpose of this
lecture today is kind of give you an idea of the existing interest on many of the studies that are currently and as many of you that know me, I’m heavily involved in the NC cooperative groups with swag and ACOG, and especially with my role now on the GI Steering Committee and very supportive of cooperative group trials. So this is the COBRA trial looking
specifically at stage 2 colon cancer.

As many of you know, for stage 2 colon cancer, as long as I was in fellowship till now, it’s always been a discussion with the patient about the role of Management chemotherapy ’cause it’s never been really well defined and has not been statistically significant thus far in any prospective trials.

So here can you utilize the role of circulating tumor DNA and take some of this new science so they’re using the Guardian platform and apply it?

And so this is being led by Van Morris, who I mentioned to you earlier.
NOTE Confidence: 0.9349497
00:27:22.116 --> 00:27:23.880 is running the be raft trial,
NOTE Confidence: 0.9349497
00:27:23.880 --> 00:27:25.728 looking at patients that are either
NOTE Confidence: 0.9349497
00:27:25.728 --> 00:27:27.970 just going to receive standard
NOTE Confidence: 0.9349497
00:27:27.970 --> 00:27:29.490 care with active surveillance.
NOTE Confidence: 0.9349497
00:27:29.490 --> 00:27:32.458 Or they have their circulating tumor DNA if
NOTE Confidence: 0.9349497
00:27:32.458 --> 00:27:35.408 there’s no circulating tumor DNA detected,
NOTE Confidence: 0.9349497
00:27:35.410 --> 00:27:37.528 they just go on standard surveillance.
NOTE Confidence: 0.9349497
00:27:37.530 --> 00:27:38.830 If it is positive,
NOTE Confidence: 0.9349497
00:27:38.830 --> 00:27:41.145 then they will receive full Fox Orc
NOTE Confidence: 0.9349497
00:27:41.145 --> 00:27:43.245 pox and so this trial is ongoing.
NOTE Confidence: 0.9349497
00:27:43.250 --> 00:27:45.728 So if you have stage two,
NOTE Confidence: 0.9349497
00:27:45.730 --> 00:27:47.910 play patients with colon carcinoma,
NOTE Confidence: 0.9349497
00:27:47.910 --> 00:27:51.558 please consider enrolling to this trial.
NOTE Confidence: 0.9349497
00:27:51.560 --> 00:27:53.606 There’s also the circulate US study,
NOTE Confidence: 0.9349497
00:27:53.610 --> 00:27:55.136 which will be led by Chris Lu
NOTE Confidence: 0.9349497
and Arvind Dasari.

Once again, my very close colleagues and I've had the pleasure of working with them and mentoring them over the years. And now they have their own trial as well. If you're circulating tumor DNA is detected, you would be randomized to folfox Erí versus standard capox or folfox. So this trial should open up any day. It’s had an amendment even before it was opened, and that’s resulted in a delay in. About a year.
And other ongoing trial.

So in full disclosure I am the one of the national pies here in the United States. For fresco.

I just wanted to make sure to keep this on your radar because this trial has completed enrollment and well, hopefully we’ll get some information regarding the results at some point soon, so we can determine if there is a benefit from this agent.

This is an anti veg F agent as well and it was compared to placebo in patients that have been previously treated with.

All standard chemotherapy,
and they may have received regorafenib or lawn service, or the combination. Sorry, but exposed to both of them in the past, so it allowed all patients to participate in the reason I also wanted to demonstrate this. Show this to you is because in enrolled very quickly earlier than the expected time frame, and that’s because it was such an unmet need for our pretreated metastatic colorectal carcinoma patients. There is only one phase, three ongoing trial at this time, which is an international trial. It’s leap.
It's based upon this very small study of originally 30 patients. They have this small phase two study of 30 patients and they've now expanded it. Based upon these results, basically 22% with a short PFS of 2.3 months and they've created this phase three trial that is ongoing looking at live at net plus pembrolizumab. So I'm trying to identify another potential option for patients and then patients will be considered compared to the standard of care of regorafenib or lawn service.
00:30:04.310 --> 00:30:06.194 so this is the only ongoing phase three trial.
NOTE Confidence: 0.881475446363636
00:30:06.194 --> 00:30:07.136 Currently enrolling and I’m sure it will also finish enrolling quickly.
NOTE Confidence: 0.881475446363636
00:30:09.228 --> 00:30:11.433 Hope I believe there’s and hopefully another couple of other trials that are going to be open soon,
NOTE Confidence: 0.881475446363636
00:30:14.298 --> 00:30:18.740 but currently when I last checked, these were the only activated trials.
NOTE Confidence: 0.881475446363636
00:30:16.088 --> 00:30:18.740 And I wanted to touch on rectal cancer, ’cause I think it’s really important for people to see where the field is going.
NOTE Confidence: 0.881475446363636
00:30:28.820 --> 00:30:30.959 we had always provided neoadjuvant chemotherapy with five, we had always provided neoadjuvant chemotherapy with five,
NOTE Confidence: 0.881475446363636
00:30:34.900 --> 00:30:37.110 a few based treatment,
and then proceeded to surgical resection with the Tammy and then followed by Advent chemotherapy. Whether it’s five, a few based or oxaliplatin based, but the reality was that a fair number of patients were never receiving. Our Advent chemotherapy, either due to delays from surgical resection due to toxicities or wound healing issues or just lack of compliance in regards to their actual treatment. So what can we do to change this aspect and in Europe they just started looking at the sequence.
and then in the United States.

We have followed suit and now it’s called total neoadjuvant therapy.

If you could potentially provide all your treatment, chemotherapy and your chemo radiation therapy. Up front before consideration of surgical resection or the reverse sequence where it chemo radiation therapy followed by chemotherapy, but I wanted to touch upon this trial because it’s important that I do want to mention this and the other reason is that obviously, radiation therapy has known...
toxicities and for our patients. This is obviously an issue that we do want to take into account, so is there a way to reduce our toxicities and is there a way potentially to even avoid surgical resection? So this is Angelita Habr Gama, who at leave is in her late 80s at this point, and when she originally published on the consideration of just observing by close surveillance, those patients that had had a significant response to their treatment instead of proceeding with TMA,
00:32:19.440 --> 00:32:21.440 can you watch and wait?
NOTE Confidence: 0.898623703636364
00:32:21.440 --> 00:32:23.155 Basically do a watch and wait approach
NOTE Confidence: 0.898623703636364
00:32:23.155 --> 00:32:24.914 and watch them conservatively and when
NOTE Confidence: 0.898623703636364
00:32:24.914 --> 00:32:26.858 she originally brought up this concept?
NOTE Confidence: 0.898623703636364
00:32:26.860 --> 00:32:28.380 She herself as a surgeon.
NOTE Confidence: 0.898623703636364
00:32:28.380 --> 00:32:30.020 People thought there was this
NOTE Confidence: 0.898623703636364
00:32:30.020 --> 00:32:32.310 was this could not be possible.
NOTE Confidence: 0.898623703636364
00:32:32.310 --> 00:32:34.770 This data was not real.
NOTE Confidence: 0.898623703636364
00:32:34.770 --> 00:32:37.946 Why would a surgeon not offer a patient
NOTE Confidence: 0.898623703636364
00:32:37.946 --> 00:32:40.119 surgical resection with rectal cancer?
NOTE Confidence: 0.898623703636364
00:32:40.120 --> 00:32:42.604 And in fact, she appears to have caught up.
NOTE Confidence: 0.898623703636364
00:32:42.610 --> 00:32:44.584 Obviously she was way ahead of her
NOTE Confidence: 0.898623703636364
00:32:44.584 --> 00:32:47.418 time once again for this amazing idea.
NOTE Confidence: 0.898623703636364
00:32:47.418 --> 00:32:51.022 So now we have some very interesting data
NOTE Confidence: 0.898623703636364
00:32:51.022 --> 00:32:53.440 from the Memorial Sloan Kettering Group.
NOTE Confidence: 0.898623703636364
00:32:53.440 --> 00:32:55.660 They created the Oprah trial,
The Oprah trial was a Phase two study. I don’t want to emphasize. This needs to be validated. This is a phase two study done that was completed at select sites. I think about 15 to 18 sites in low lying rectal tumors. Providing the patients either chemo radiation therapy followed by chemotherapy or induction chemotherapy followed by chemoradiation therapy and the patients were evaluated by endoscopy and MRI. If they had no complete response. Then they went on to total misso rectal excision.
00:33:32.020 --> 00:33:34.645 or they had clinical response.
NOTE Confidence: 0.898623703636364
00:33:34.650 --> 00:33:38.500 You could undergo watch and wait approach.
NOTE Confidence: 0.898623703636364
00:33:38.500 --> 00:33:40.789 And here you can see regardless of
NOTE Confidence: 0.898623703636364
00:33:40.789 --> 00:33:42.659 the sequence that you received,
NOTE Confidence: 0.898623703636364
00:33:42.660 --> 00:33:46.290 there was equivalent disease free survival.
NOTE Confidence: 0.898623703636364
00:33:46.290 --> 00:33:49.349 But he also noted, was those patients
NOTE Confidence: 0.898623703636364
00:33:49.349 --> 00:33:51.839 once again low lying tumors.
NOTE Confidence: 0.898623703636364
00:33:51.840 --> 00:33:53.856 Stage tumors stage three.
NOTE Confidence: 0.898623703636364
00:33:53.856 --> 00:33:56.376 If you received chemo radiation
NOTE Confidence: 0.898623703636364
00:33:56.376 --> 00:33:59.167 therapy first then followed by
NOTE Confidence: 0.898623703636364
00:33:59.167 --> 00:34:01.375 chemotherapy for systemic therapy,
NOTE Confidence: 0.898623703636364
00:34:01.380 --> 00:34:03.336 these patients appear to be more
NOTE Confidence: 0.898623703636364
00:34:03.336 --> 00:34:05.026 likely to have sphincter preservation
NOTE Confidence: 0.898623703636364
00:34:05.026 --> 00:34:07.273 and were more likely to undergo a
NOTE Confidence: 0.898623703636364
00:34:07.273 --> 00:34:09.047 watch and wait approach because
NOTE Confidence: 0.898623703636364
00:34:09.047 --> 00:34:10.837 of their degree of response.
00:34:10.840 --> 00:34:12.770 Now this is phase two.

00:34:12.770 --> 00:34:13.688 It is being.

00:34:16.290 --> 00:34:19.517 Expanded more, not the exact same way,

00:34:19.520 --> 00:34:21.704 but it is going to be a phase

00:34:21.704 --> 00:34:23.520 three trial led by Josh Smith.

00:34:23.520 --> 00:34:25.340 Also for Morris Sloan Kettering.

00:34:25.340 --> 00:34:28.000 For consideration of this watch

00:34:28.000 --> 00:34:30.971 and wait approach and once again

00:34:30.971 --> 00:34:33.713 we need to validate the data.

00:34:33.720 --> 00:34:35.380 Now they did update their

00:34:35.380 --> 00:34:37.550 data just so you are aware.

00:34:37.550 --> 00:34:39.920 At last year’s ASCO and here’s

00:34:39.920 --> 00:34:41.500 pictures of clinical complete

00:34:41.566 --> 00:34:44.196 response near complete response and

00:34:44.196 --> 00:34:46.270 incomplete complete response and the

00:34:46.270 --> 00:34:48.710 we need to validate them again.

00:34:48.710 --> 00:34:51.607 Now this is phase two.
time frame of which they assessed.

When the response.

Sorry of the degree of response,

was roughly 7 to 8 weeks.

And here you can see when looking at organ preservation,

obviously those that had a political complete response at three years that was 78% versus a near complete response at three years was 45%.

So obviously there was possible there’s possibility of a watch and wait approach for some of your patients.

Whenever we have this opportunity, we review it with both our radiation oncologists,
00:35:18.930 --> 00:35:20.430 our surgical oncologists and our
00:35:20.430 --> 00:35:21.930 medical oncologists and really make
00:35:21.978 --> 00:35:23.478 this a multidisciplinary approach.
00:35:23.480 --> 00:35:25.255 Then discuss it at our
00:35:25.255 --> 00:35:26.320 multidisciplinary tumor board,
00:35:26.320 --> 00:35:27.440 and I obviously encourage
00:35:27.440 --> 00:35:29.120 everyone else to do the same.
00:35:29.120 --> 00:35:30.008 So very intriguing.
00:35:30.008 --> 00:35:31.192 Obviously we look forward
00:35:31.192 --> 00:35:32.750 to the phase three trial.
00:35:34.850 --> 00:35:36.500 And last but not least,
00:35:36.500 --> 00:35:38.572 I do want to touch pad on something
00:35:38.572 --> 00:35:40.872 very dear to me or early onset
00:35:40.872 --> 00:35:41.907 colorectal cancer patients,
00:35:41.910 --> 00:35:44.409 so this data is not new data.
This is looking at the senior database from 1975 to 2010. It was originally published by Christina Bailey, who is actually now my colleague here at Vanderbilt. She wrote this when she was a fellow at MD Anderson, and as you can see here, there is an expected increase over the next decade for our young patients in Blues, and as you can see here, there is an expected increase over the next decade for our young patients in Blues, 20 to 34 years of age and red is 35 to 49 years of age. I'm sorry somebody has the wrong number. I apologize and rectal cancer also is supposed to be increased by the
year 2030 by 124% in the very young.

The 20 to 34 year age group.

This obviously was recognized by patient advocates, patients and their providers as well, and this resulted in a change and I think as many of you are aware by the US preventive taskforce to reduce our screening age from 50 years old to 45 years old, and so this is a new recommendation. Obviously if the patient is having symptoms and it’s younger than 45 years of age, we would encourage screening immediately.

But this is an issue you can see here.
Trends in the United States looking at 2001 through 2005 versus a decade later on. And you can see there’s an increased incidence of young onset colorectal cancer, and especially in those states with higher incidence of obesity. This actually has been demonstrated as well in the nurses health study. Looking at your current BMI and your risk of colorectal cancer. And there’s also been some interesting data looking at the role of antibiotic use and exposure and how it may impact the microbiome. This is one of roughly about three to four studies that have been published as of late.
So intriguing data.

Once again, we don’t know the exact reason why our young adults, who the majority of them, have spontaneous colorectal cancer. They do not have Lynch syndrome or developing colorectal cancer at such an early age. So we had the honor of publishing a picture paper recently in Lansing Oncology looking at how to create a framework for these patients. As many of you know, I’ve created this Young Adult Cancer Center here at our institution,
which is not just for colorectal cancer patients. It’s for all young adult cancer patients between the ages of 20 and 45, and these are some of the aspects you really need to think about when you’re seeing these patients. Fertility financial guidance, physical wealth beating being.

But other concerns obviously regarding job security, body image and just the fear of not knowing exactly how best to address this, because these individuals are very young and they’re going through
a very different aspect of their life versus our older median age patient of 67 years old.

In addition, we you know, as you can guess, these patients face other concerns, especially regarding financial toxicities and the pressure that they feel because some of them obviously are still working and don’t have financial independency. They’re not financially independent, but they don’t have to worry about the cost of care, and so these are important things
to take into account for our young adult patient population. So here are my Co directors. I just wanted to highlight that Michael Byrne and Libby Davis. Michael Byrne is BMT, and Libby Davis in sarcoma. And this is just the information on our program and we’re very grateful to have many involved in our group and provide resources for our patients. And this was actually one of my patients. She was 32. And you know, I love it when people say, well, you look too healthy.
00:39:34.370 --> 00:39:35.870 You can’t have colorectal cancer.

00:39:35.870 --> 00:39:38.114 Well, she was training for a marathon and she was in great health but had bowel issues,

00:39:38.114 --> 00:39:40.190 probably for about 8 months.

00:39:40.190 --> 00:39:41.890 They kept in telling her that she had irritable bowel disease or it was hemorrhoids, or it’s from her marathon training.

00:39:41.890 --> 00:39:43.760 And when I saw her she had about 50 to 60% of her liver involved with tumor.

00:39:43.760 --> 00:39:45.795 They kept in telling her that she had irritable bowel disease or it was hemorrhoids,

00:39:45.795 --> 00:39:47.864 that she had irritable bowel disease or it was hemorrhoids,

00:39:47.864 --> 00:39:49.974 or it’s from her marathon training.

00:39:49.980 --> 00:39:53.136 And when I saw her she had about 50 to 60% of her liver involved with tumor.

00:39:53.140 --> 00:39:56.440 Unfortunately, she as you can see here.

00:39:56.529 --> 00:39:58.608 She fought for with her basically amazing individual thought her colorectal cancer.
Lived with it for about five years and unfortunately passed away the latter part of last year, but during her time she made a huge effort to serve an advocacy groups and became a national patient advocate for the fight colorectal cancer program and that was actually a picture of her in Times Square and she used to run regularly these 5K events with her friends walk run. So in closing points, Please remember screening starts at the age of 45. Please continue to educate others about the signs and symptoms of
00:40:44.155 --> 00:40:45.375 colorectal cancer and recognize
00:40:45.375 --> 00:40:47.422 that these patients may need to be
00:40:47.422 --> 00:40:49.081 screened earlier than 45 if they have
00:40:49.081 --> 00:40:51.100 these symptoms that do not resolve,
00:40:51.100 --> 00:40:53.512 recognize the unmet needs are so
00:40:53.512 --> 00:40:55.820 psychosocial needs of our patients.
00:40:55.820 --> 00:40:56.200 Currently,
00:40:56.200 --> 00:40:58.480 most of the advances in colorectal
00:40:58.480 --> 00:41:00.689 cancer have largely been made in
00:41:00.689 --> 00:41:02.267 the rare molecular subtypes and
00:41:02.267 --> 00:41:03.689 for the majority of our patients.
00:41:03.690 --> 00:41:05.000 We still need novel agents
00:41:05.000 --> 00:41:06.048 and unfortunately for us.
00:41:06.050 --> 00:41:08.360 Colorectal cancer IO therapy has
00:41:08.360 --> 00:41:10.208 had limited efficacy excluding
00:41:10.208 --> 00:41:11.772 the unmet needs are so
Next generation sequencing is always the standard of care for our patients, and I always try to enroll to a clinical trial whenever possible so we can obviously make greater treatment advances.

So thank you so much for your attention and I would be happy to take any questions.
I think Nita may have the first question.

Thank you Kathy, and thanks Eric.

I ask Doctor Wyner,

mentioned really informative and and

taking us through where the field is.

Perhaps my first question to you is

Perhaps my first question to you is

more around rectal cancer management.

And as you mentioned,

at the end of the hammer,

gamedata and watchful waiting and I

think the early trial on neoadjuvant.

I think part of the worry there is are you?

How are you all accounting in this

you know is around this field where

there’s not only a biological?
Implications, but. Quality of life implications. That is, do you miss the window on a curative approach without an ostomy and and I wonder if that was considered, especially in that first trial, which I thought was. Interesting that people at Memorial agree to do that to put in Check Point early on. And because you may lose a window and I wonder where you think the field is on that. And then I have a bigger question. Perhaps around colon cancer, I think because number one in rectal cancer, you know as as I showed you,
the incidence is expected to be quite higher over the next decade, especially for our young patients.

So from my own personal experience, when I’m seeing these patients a lot of them are willing to take that risk because especially if they have a low lying tumor, they don’t want to consider an APR, and so they’re willing to consider that risk as long as they’re being followed closely, and many of them are extremely compliant, then in that setting. So I think that in that case, as long as they have a good relationship with their surgical oncologist and
medical oncologist, I think it’s very reasonable to consider it in. In that setting, you know. Obviously what I didn’t show you is that. No one really looked at the role of circulating tumor DNA in this setting, right? But in the phase three trial, that’s I. I don’t know, I presume won’t be open for another 8 to 10 months. I hope they will also take that into account, and I think other trials are also trying to take that into account. And obviously ’cause that could impact our surveillance period as well. But I agree with you, you know,
recurrent rectal cancer is one of the most challenging cancers because of the quality of life on patients because. Lost largely the involvement of the sacrum, when they have recurrent disease in the pain that means do. But I I it's very interesting when you talk to the national patient advocacy groups, once you get a large number of them are younger patients, they are more than willing to take that risk to avoid the potential issues with bowel issues to avoid even radiation therapy in the setting
of the MSI high patient population
NOTE Confidence: 0.842676015

because of toxicities as well.
NOTE Confidence: 0.842676015

So they’re really looking at quality of life.
NOTE Confidence: 0.842676015

The majority of them,
NOTE Confidence: 0.842676015

no,
NOTE Confidence: 0.842676015

I think
NOTE Confidence: 0.828638490833333

they’re the ones that are low and you
NOTE Confidence: 0.828638490833333

can avoid a stoma. They’ll do it.
NOTE Confidence: 0.828638490833333

I think the ones where the worry
NOTE Confidence: 0.828638490833333

is it’s perhaps an LAR.
NOTE Confidence: 0.828638490833333

And now you’re dooming them
NOTE Confidence: 0.828638490833333

to a recurrence and Eric will
NOTE Confidence: 0.828638490833333

remember this in the late 90s.
NOTE Confidence: 0.828638490833333

We were doing local excisions for T2T3,
NOTE Confidence: 0.828638490833333

and then they were coming back with a APR.
NOTE Confidence: 0.828638490833333

So I think that that perhaps is the part.
That, I think would be a concern, and I think Brazilian data they follow their patients really closely, whereas we’re not as a coordinated system in America.

And and you have a very valid point, but but patients are really motivated. Can I ask just a little question before you get to your big question needed? And my little question is. How do you you know? So I understand you follow people closely, but. How do you follow people closely? I mean you can’t. You can’t be biasing multiple
little areas all the time, so you’re following people closely with just, you know, some sort of scoping. We kind of followed at our institution. We kind of followed the memorial data and have also done the regular intervals with endoscopy. Testing as well as diagnostic imaging with MRI. Yes Nita yeah no. I think Eric you hit the knee. I think who is examining and do they pay attention? I think that’s the set.
The second question perhaps is similar now that you know if you’re looking at breast and standardization, I’d still sense that even though colorectal cancer is one of our most common cancers, there remains a gap in standardized testing and you just showed U.S. data of the 1% rule, right? The one person you know, the 3% hurt to the MSI. And how do we sort of work in national agencies in your role in? I still think it’s a Wild West out there.
00:46:39.880 --> 00:46:41.553 If we ignore some of the top
NOTE Confidence: 0.691858658
00:46:41.553 --> 00:46:42.736 institutions you know when you
NOTE Confidence: 0.691858658
00:46:42.736 --> 00:46:44.185 get to the rest of the country
NOTE Confidence: 0.917322238
00:46:44.480 --> 00:46:46.260 I I would say that.
NOTE Confidence: 0.917322238
00:46:46.260 --> 00:46:48.290 From my experience thus far,
NOTE Confidence: 0.917322238
00:46:48.290 --> 00:46:49.970 I would say the majority of people
NOTE Confidence: 0.917322238
00:46:49.970 --> 00:46:51.698 do get tested for obviously rash.
NOTE Confidence: 0.917322238
00:46:51.700 --> 00:46:53.356 That has been the most common thing which,
NOTE Confidence: 0.917322238
00:46:53.360 --> 00:46:54.940 which obviously is extremely important.
NOTE Confidence: 0.917322238
00:46:54.940 --> 00:46:56.565 So then they can avoid
NOTE Confidence: 0.917322238
00:46:56.565 --> 00:46:57.924 anti EGFR therapy there.
NOTE Confidence: 0.917322238
00:46:57.924 --> 00:47:00.612 I fully agree with you though there
NOTE Confidence: 0.917322238
00:47:00.612 --> 00:47:02.542 are patients that still come to me
NOTE Confidence: 0.917322238
00:47:02.542 --> 00:47:04.498 that have never had the raft testing,
NOTE Confidence: 0.917322238
00:47:04.500 --> 00:47:06.420 which obviously is extremely important.
NOTE Confidence: 0.917322238
00:47:06.420 --> 00:47:09.282 They’ve never had MSI testing and
you know I fully agree with you.

I would just say that in every single lecture we give every single bit of publications that we can provide to individuals to educate others. We have to encourage that all patients need to be tested for molecular marker analysis. I mean, that is critical to their overall treatment and and you know it’s so interesting when bearoff. So when Scott Kopetz originally talked about testing for BRAF, everybody thought he was crazy because it was such a rare patient population. And how we’re going to get people to do that,
but it’s really as you know, it’s a matter of education. And now it’s it’s. It’s for the majority people. It is considered a standard of care. I would say a large number of people test for it now, but her two is still. It’s still, you know, we’re trying to get there, but her two is not commonly tested for, Kathy does that affect treatment for stage one and stage two disease no? So, I mean, you’re really talking about more advanced disease. We’re testing is really.
Critical, correct?

Although obviously for MSI high we would encourage it in all stages.

Yes, for largely metastatic disease ‘cause we have not found benefit of these other targeted agents in early stage disease.

We’ve tried.

With anti EGFR therapy, we’ve tried with anti VEGF.

We’ve tried with anti VEGF.

Therapy and stage three, which was they were not successful studies.

OK, so I’m going to ask a question.

That you know, sort of a like big
question about the future or the present.

But if you had could do anything.

And the goal is to reduce colon cancer deaths in the United States and beyond.

And you have two interventions

What would you do?

Two interventions or two interventions or two? You know?

What are the unmet needs so the two biggest unmet needs

for colorectal cancer in 2022?

I would say, well, the the number

one needs still remains screening.

I mean, in all fairness, we are still

under screening in the United States.
It’s still I think it’s like 78 percent is the best so so many people are being missed.

And just because they don’t want to be screened. Number 20.

If I could do something and make it effective,

I wish we could find some way to make IO therapy helpful in the majority of her MSI.

Stable colorectal cancer patients.

We appear to be at a standstill in regards to any potential combination thus far.

It you know it has.

It’s worked well in other malignancies.

Obviously, Upper GI, HTC Cholangio,

and here we are still nowhere with it,
In colorectal cancer, except the less than 5% with MSI HIGH. But screening I would rather prevent the colorectal cancer and not have to treat it. That would be my number one thing which I know sounds odd coming as a medical oncologist. Well look look, we all want to put ourselves out of work eventually and to what extent do health care disparities lay in tech excess and to what extent do health care disparities lay in colorectal cancer? So obviously this isn’t. This is an issue as you know in our clinical trials.
As like many other clinical trials, especially though in colorectal cancer, the majority of patients that enroll in clinical trials are not our average patients, 95% are of their Caucasian or white, and the majority of patients do not participate in clinical trials. I wish I could. So if the number if I could ask, have a number three, I would get more people to appreciate the importance of clinical trials and to help with enrollment, and allow us to be able to provide. The standard treatment arm in the
00:51:21.372 --> 00:51:23.546 community you know and and that
NOTE Confidence: 0.85571975375
00:51:23.546 --> 00:51:25.296 way will help with enrollment,
NOTE Confidence: 0.85571975375
00:51:25.300 --> 00:51:27.100 so that would be my number three thing,
NOTE Confidence: 0.85571975375
00:51:27.100 --> 00:51:30.926 but in regards to diversity we are
NOTE Confidence: 0.85571975375
00:51:30.926 --> 00:51:33.636 lacking in clinical trials completely,
NOTE Confidence: 0.85571975375
00:51:33.640 --> 00:51:35.600 and a large number of the obviously
NOTE Confidence: 0.85571975375
00:51:35.600 --> 00:51:36.820 the datasets that exist.
NOTE Confidence: 0.85571975375
00:51:36.820 --> 00:51:38.910 So I love Andrea sirsak.
NOTE Confidence: 0.85571975375
00:51:38.910 --> 00:51:40.098 She’s a friend of mine memorial,
NOTE Confidence: 0.85571975375
00:51:40.100 --> 00:51:42.473 but she just published a big publication
NOTE Confidence: 0.85571975375
00:51:42.473 --> 00:51:44.220 looking at mutations at Memorial.
NOTE Confidence: 0.85571975375
00:51:44.220 --> 00:51:46.474 It’s one of the largest data sets,
NOTE Confidence: 0.85571975375
00:51:46.480 --> 00:51:49.570 but yet 95% of her patients.
NOTE Confidence: 0.85571975375
00:51:49.570 --> 00:51:50.300 Or white,
NOTE Confidence: 0.85571975375
00:51:50.300 --> 00:51:51.940 and so it’s not representative
NOTE Confidence: 0.85571975375
00:51:51.940 --> 00:51:53.252 of the actual community.
Nothing against her.

It’s the data she has, but that’s the patient population they have at Memorial.

The problem, so we have a kitten question from Mary Kate Kelly, and that question is, there’s a low fat diet or a vegetarian diet help decrease the chance of colorectal cancer. I would say definitely does not hurt. There’s a lot of literature going back and forth. We’re going in the diet. I think the majority of studies have shown.
Obviously your tendency to obesity is more of a concern. There was also a very nice publication just recently from my colleague here, Martha Shrubsall and epidemiology looking at polyphenols, I believe. And the increased risk actually in the black patient population which was published just recently. And a related question just came in, which is in patients who have had colorectal cancer, and they say to you, what can I do to prevent a recurrence? Are there any data that would support lifestyle interventions?
such as exercise, diet, any nutritional supplements, and finally, aspirin.

Right, so there is data regarding aspirin that appears to be more beneficial in the PIK 3 CA mutation patient which is about 15 to 20% of our patients. Better baby aspirin seems to be fairly benign and potentially helpful. And then Jeff Meyer Heart has published before on the role of exercise as well. I would say all good healthy eating patterns and exercise obviously can’t harm you and I would highly recommend them.
And then there’s been some. I would say those the majority of the data.

Alright, well, and any data on vitamin D that is an ongoing trial being led by Kim Eing I think it is called. I apologize, it is being run through the alliance and so they are looking at that.

Alright, well I think that everyone got a tremendous amount out of this. Thank you so much for joining us all, everyone.

be it from a distance we look forward to having you here in person at some time. And please please give our best to all our friends at Vanderbilt and we really...
enjoyed having you thank you so much.

Thank you so much. It’s been my pleasure.

It’s been great thanks. Have a great day.