So welcome everyone,
my name is Doctor Pamela Koons
and I am a GI medical oncologist.
I am the director of the Center for
Gastrointestinal Cancers at Yale Cancer
Center and Smilow Cancer Hospital.
We will have a CME on rectal cancer
starting tonight on neuroendocrine tumors
and I will be your host on Thursday,
April 21st. We will have a CME on rectal cancer
00:00:26.767 --> 00:00:28.937 hosted by Doctor Michael Cicchini,
NOTE Confidence: 0.83776292
00:00:28.940 --> 00:00:31.090 and on Thursday, May 19th.
NOTE Confidence: 0.83776292
00:00:31.090 --> 00:00:33.176 We will have a CME on gastric
NOTE Confidence: 0.83776292
cancers hosted by Doctor Jill Lacy.
NOTE Confidence: 0.92255316
00:00:37.530 --> 00:00:41.345 So this evening I have the pleasure
NOTE Confidence: 0.92255316
00:00:41.345 --> 00:00:43.858 of hosting and moderating this
NOTE Confidence: 0.92255316
talk on neuroendocrine tumors.
NOTE Confidence: 0.92255316
00:00:43.858 --> 00:00:45.826 I will be giving a brief overview of Nets
NOTE Confidence: 0.92255316
00:00:45.830 --> 00:00:49.304 and then we’ll help moderate the
Q&A.
NOTE Confidence: 0.92255316
00:00:49.310 --> 00:00:51.518 I’m joined by Doctor Miriam,
NOTE Confidence: 0.92255316
00:00:51.520 --> 00:00:53.430 a boy and an assistant professor
NOTE Confidence: 0.92255316
00:00:53.430 --> 00:00:55.560 of radiology and nuclear medicine,
NOTE Confidence: 0.92255316
00:00:55.560 --> 00:00:57.610 and she will be speaking about
NOTE Confidence: 0.92255316
00:00:57.610 --> 00:00:59.590 the role of molecular imaging and
NOTE Confidence: 0.92255316
00:00:59.590 --> 00:01:01.721 theranostics in care of patients with
NOTE Confidence: 0.92255316
Nets and doctor Saj Khan and associate professor of surgery and surgical.
Allergy and Section chief of Hepato Pancreato, biliary and mixed tumors will be joining us this evening and talking about the surgical management of pancreas and small foulness. So I will just go ahead and get started, so I’m just for our audience. Each of our talks will be about 20 minutes. Please feel free to put questions in the chat or Q&A throughout. We will try to respond with a typed response throughout, but we will also have time at the end.
NOTE Confidence: 0.92255316
00:01:38.759 --> 00:01:42.288 for a through Q&A and you can ask them.

NOTE Confidence: 0.92255316
00:01:42.290 --> 00:01:44.818 These are my disclosures, so I’m going to talk briefly about the

NOTE Confidence: 0.92255316
00:01:44.820 --> 00:01:48.990 epidemiology and nomenclature of Nets.

NOTE Confidence: 0.92255316
00:01:48.990 --> 00:01:51.355 Talk about characteristics that I think really impact treatment selection

NOTE Confidence: 0.92255316
00:01:51.355 --> 00:01:53.720 for patients and then talk about

NOTE Confidence: 0.92255316
00:01:53.792 --> 00:01:56.048 treatment for hormone and tumor control.

NOTE Confidence: 0.92255316
00:01:56.048 --> 00:02:00.805 I usually like starting with a little

NOTE Confidence: 0.92255316
00:02:00.805 --> 00:02:02.415 bit of history so neuroendocrine

NOTE Confidence: 0.92255316
00:02:02.415 --> 00:02:04.640 tumors and the description of

NOTE Confidence: 0.92255316
00:02:04.640 --> 00:02:07.570 Nets goes back to the late 1800s,

NOTE Confidence: 0.92255316
00:02:07.570 --> 00:02:10.900 and it was really in the early 1900s that.

NOTE Confidence: 0.92255316
00:02:10.900 --> 00:02:13.990 Doctor Urban door for a German

NOTE Confidence: 0.92255316
00:02:13.990 --> 00:02:16.718 pathologist coined the term carcinoid.
It meant cancer like and he described and felt that there were five key characteristics that they were. These tumors were small and multifocal had undifferentiated cellular formations, had well defined borders, no metastatic potential, and were slow growing and harmless, and though he contributed really important early knowledge about this disease, we now know that many of these characteristics are not true. And I think the term carcinoid and cancer like, unfortunately, really slowed the field in terms of our
recognition that these are in fact cancers.

The term carcinoid is really fallen out of favor and instead we are using the term neuroendocrine tumor and then by which primary site.

So we have seen an explosion of advances, both therapeutics and diagnostics really since 2011.

So in the 1980s we had strept Zosyn and Ivy alkylating agent, and octreotide that was initially approved for hormone control, and then since 2011 we have had therapeutic advances in the areas of biologics of everolimus and snib somatostatin analogs of lanreotide.
to look just at for carcinoid.
00:03:36.670 --> 00:03:39.316 We’ll talk about some of the.
00:03:39.320 --> 00:03:41.552 Other systemic agents and then also
00:03:41.552 --> 00:03:43.919 some of the imaging agents that
00:03:43.919 --> 00:03:45.944 are listed above the timeline.
00:03:45.950 --> 00:03:49.182 I like also sort of nailing down the
00:03:49.182 --> 00:03:52.665 point that Nets are really not that rare,
00:03:52.670 --> 00:03:54.428 so they are rare by incidents,
00:03:54.430 --> 00:03:57.196 so incidents being the number of
00:03:57.196 --> 00:03:59.793 patients diagnosed per year and for
00:03:59.793 --> 00:04:02.497 this is based on a large Sears study
00:04:02.575 --> 00:04:04.969 conducted in 2017 and the incidence
00:04:04.969 --> 00:04:07.646 rate for Nets is about 7 per 100,000
00:04:07.646 --> 00:04:10.214 and this is in the yellow line on the
figure compared to the blue line, which is the incidence of all malignant neoplasms which has remained relatively stable. However, the prevalence of neuroendocrine tumors is actually the second highest prevalent GI malignancy. It exceeds stomach and pancreatic adenocarcinoma combined, and that’s likely because this is a more indolent disease and patients live for many years more commonly with the low grade neuroendocrine tumors. Nets are epithelial neoplasms derived from neuroendocrine cells throughout the body,
most commonly found in the GI tract, but also in the lungs and other sites, and most grow slowly in comparison with their adenocarcinoma counterparts. The majority are sporadic and the minority are associated with familial syndromes such as von Hippel-Lindau and Neurofibromatosis. VON Hippel-Lindau and Neurofibromatosis pathognomonic for this disease is the fact that somatostatin receptors are present on the cell surface in about 80 to 90%. Of netson, this is typically with somatostatin.
receptor type 2.
NOTE Confidence: 0.905978501333333

The diagnostic work up and I will say if you take away one thing from
NOTE Confidence: 0.905978501333333

this is that the cross sectional
NOTE Confidence: 0.905978501333333

imaging is really the mainstay of how
NOTE Confidence: 0.905978501333333

we monitor the patients with Nets.
NOTE Confidence: 0.905978501333333

Either a multiphasic CT and that
NOTE Confidence: 0.905978501333333

arterial phase is critical if
NOTE Confidence: 0.905978501333333

you’re ordering a CT scan or an
NOTE Confidence: 0.905978501333333

MRI somatostatin receptor.
NOTE Confidence: 0.905978501333333

Imaging is important but is not
NOTE Confidence: 0.905978501333333

the primary modality with which
NOTE Confidence: 0.905978501333333

we image these patients.
NOTE Confidence: 0.905978501333333

These are done commonly at time of
NOTE Confidence: 0.905978501333333

diagnosis and for patients with
NOTE Confidence: 0.905978501333333

metastatic disease we may do them.
Annually or every two years, somatostatin receptor imaging is now used with gallium 68, dotatate pet or copper 64, and I’m going to actually. This will be a little bit of a teaser. I’m going to let doctor a boy and talk more about somatostatin receptor based imaging. The tissue diagnosis we like to know the primary site if we can identify it and four key data elements are important when you’re looking at a pathology report. The Who grade Ki 67 mitotic index.
Degree of differentiation.

We’ll talk about that in a moment.

And then tumor markers or hormones are important for this disease, but I will say that tumor markers such as chromogranin or neuron specific enolase or pancreas statin often fluctuate and may not actually track with what’s happening radiographically. The field has swung away from using these and I often don’t use chroma granite a now because really the gold standard is the imaging.

Hormones, however, such as serotonin or 24 hour urine 5 hiaa,
which is a byproduct or a metabolite of serotonin. Those can be useful and should be tracked overtime. So I find that there are really six key characteristics that impact treatment hormone status stage and burden of disease grade and differentiation. Pace of growth, primary site and somatostatin receptor status. I’ll spend just a moment on each of these just to really set the stage in terms of how we talk about and think about
treatments for nuts.

So a functional neuroendocrine tumor is defined as a patient who has symptoms from a measurable hormone that’s in either the urine or the blood. Carcinoid syndrome is a classic example of that. 10% of patients with small intestine Nets have carcinoid syndrome, and it’s due to production of peptides and am means such as serotonin or five hiaa, and it can cause Flushing Venus telangiectasis as shown in this picture on the left diarrhea. Bronchospasm, valvular fibrosis, and hypotension.
This is also a picture of a of
the pulmonary and tricuspid
valves that are very fibrotic.
Pancreatic neuroendocrine tumors can also
secrete hormones in about 40% of patients,
most commonly insulin,
followed by gastrin,
Glucagon and vaso intestinal polypeptide,
and the symptoms are really defined by
the hormones secreted and nonfunctional.
Nets are defined as patients who are
either asymptomatic or have symptoms
that are not from hormone access.
So stage and grade.
I think this is I really try to
describe this to patients 'cause I think for patients in particular this can be very confusing. So to this audience however, stage is very familiar term. What's interesting is that the AJC staging criteria have only included Nets since 2010. This is a really nice picture here of a localized pancreatic net, which will show in the video and a metastatic pancreatic net with high degree of liver burden. As you can see here, grade is really what the cells look like under the microscope.
Low grade is slower, growing higher grade is faster growing. We really base this on the Ki67 in mitotic index. The 2019 digestive WHO classification is the most recent. I’m next to the Red Arrow. New change that was made to this so we have well differentiated. Net grade 1/2 and three and poorly differentiated nurkin carcinoma grade 3 and that’s divided into small cell and large cell. When I didn’t put on this slide is kind of the breakdown of the
Ki 67 in mitotic index,

but really the take away from this is that clinically we treat

the grade one and two well differentiated Nets very similarly.

This well differentiated grade 3 net is a relatively new category.

I think that we have to treat based on the individual patients

biology bulk of disease.

The poorly differentiated neuroendocrine carcinomas are treated very differently.

That will not be the primary topic of.

Kind of the subsequent slides on treatment.

That’s typically those patients are

typically treated with platinum at openside.
So pace of growth, something I was getting to really does inform our treatment selection. We may need a patient with a metastatic low grade net who has very stable disease or slow progression, or may have more rapid progression. Some of those patients may not need treatment initially. Observation may be appropriate, whereas others may have high burden of disease or symptoms from tumor bulk and they may need treatment. I know this is a GI focused talk,
but Nets can happen in almost any organ in the small intestine. Most commonly that is one of the most common sites we see commonly in the ilium, but we will also see pancreatic Nets and other Nets in the GI tract, and many clinical trials and treatments are really tailored based on primary site. Therefore, FDA approvals are sometimes limited specifically to primary sites. One example of that. Is synonym for pancreatic Nets. We now know that somatostatin receptor status is critical both for diagnosis and therapy.
Again, I’m going to let Doctor boy and go into this. This is an interesting picture just to show an octreoscan which has now really completely been replaced by gallium dotate. This is the same patient image with an octreoscan and a gallium 68 dotate pet, and you can see that the resolution is far superior with the pet based imaging. So now we’re going to launch in the next sort of the final half of my presentation on general treatment categories for nuts. I will go into some of the specifics just so that you have access to this.
If you choose to watch this again, so we have 4 main categories, somatostatin analogs, peptide receptor, radionuclide therapy, biologics, and cytotoxic chemotherapy. I am going to really focus my conversation or presentation tonight on antitumor treatments. Just a brief comment that we know. So not a statin. Analogs were really initially developed for a hormone control and remain as the primary tool that we use for hormone control, but I'm not going to go into just for sake of time. Details on hormone control tonight, so somatostatin receptors.
and theranostics again, I'm going to just use this to talk about some of the therapies. Dr Abovyan will go into this as well, but in terms of my cartoon here, imagine you have a patient in population for whom you would like to select out. Do they have a receptor on the surface of their cells? We do in fact have that. So with the gallium 68 or copper 64 pets, we select out those patients using that imaging, and then we in fact have a targeted therapy that goes to that target.
So that’s theranostics Dr. Boy and will focus on that. When I described this to patients, I used the lock and key description or analogy. I think that helps them understand why we use somatostatin analogs, why we use the Dota Tate imaging. So think of the somatostatin receptor as the lock, the key is the peptide, and then there’s a reporting unit. So for somatostatin analogs, we actually have two trials that demonstrated antitumor effect.
00:13:31.564 --> 00:13:33.910 effect of octreotide versus placebo,
NOTE Confidence: 0.776700743043478
00:13:33.910 --> 00:13:36.826 and the clarinet study demonstrated the
NOTE Confidence: 0.776700743043478
NOTE Confidence: 0.776700743043478
00:13:39.370 --> 00:13:43.142 Both had a primary endpoint of of
NOTE Confidence: 0.776700743043478
00:13:43.142 --> 00:13:45.046 the permits that it was time to
NOTE Confidence: 0.776700743043478
00:13:45.046 --> 00:13:46.657 progression and that the clarinet
NOTE Confidence: 0.776700743043478
00:13:46.657 --> 00:13:48.342 study was progression free survival
NOTE Confidence: 0.776700743043478
00:13:48.342 --> 00:13:50.416 and they both should have benefit
NOTE Confidence: 0.776700743043478
00:13:50.416 --> 00:13:51.540 over placebo octreotide.
NOTE Confidence: 0.776700743043478
00:13:51.540 --> 00:13:54.690 Is not formally does not have a
NOTE Confidence: 0.776700743043478
00:13:54.690 --> 00:13:57.930 formal FDA label for antitumor effect.
NOTE Confidence: 0.776700743043478
00:13:57.930 --> 00:13:59.766 It is primarily in hormone control,
NOTE Confidence: 0.776700743043478
00:13:59.770 --> 00:14:00.793 but it is.
NOTE Confidence: 0.776700743043478
00:14:00.793 --> 00:14:02.498 These two agents are often
NOTE Confidence: 0.776700743043478
00:14:02.498 --> 00:14:03.180 used interchangeably.
Landry Tide was FDA approved in 2014 as an antitumor agent.

I’d like to put this up because I get asked this a lot. So how do we think about dosing for tumor control? Octreotide LARC is usually used at the 30 milligram I am monthly dose and lanreotide at 120 milligrams deep. Subq. There is no need to overlap with short acting unless it’s a functional tumor. I think there was data years ago that we needed to do a test dose to test for allergy. That’s not generally needed in practice and there is little data to support the routine use.

Above standard dose of somatostatin
analogues for tumor control.

The side effects include nausha, diarrhea, cholelithiasis, and hyperglycemia.

I'm going to go through these quickly. I have them just kind of as placeholders, but Doctor Brian will talk about these, and we've had incredible advances in the diagnostics for Nets as well and there is a very handy paper and I have this here just as a reference on the appropriate use criteria for somatostatin receptor PET imaging and new under consumers. That’s a great reference. And then in the therapy is something that also Doctor Boy and will discuss and
specifically around the Netter one phase, three clinical trial. So I’ll mention it just in passing that this was a study I had the opportunity to serve as a key. It’s a randomized study that really set the stage for using their Gnostics and specifically alluded it, and that’s it. Was a positive study. I will give that punchline away for Doctor O’Brien. But moving on to some of the other systemic therapies,
Everolimus is approved for pancreatic net and non functional GI and lung Nets.

This is an inventory inhibitor.

There were sister studies Radiant three and Radiant four and.

Both of them showed a progression free survival benefit in these patient populations, and they were both approved.


And tyrosine kinase inhibitors also have a role in neuroendocrine tumors.

Sonett nib was approved on the
basis of this randomized study in patients with well differentiated advanced pancreatic Nets.

So that’s the one that I said we don’t yet have a tyrosine kinase inhibitor approved for small bowel Nets. This was also approved on the basis of a PFS benefit. You’ll notice that most neuroendocrine tumor clinical trials have progression free survival as a primary endpoint, and that’s because OS is an impractical endpoint given that patients tend to receive many subsequent therapies after these clinical trials and it be given.
00:16:53.983 --> 00:16:56.010 the indolence of the disease,
00:16:56.010 --> 00:16:57.270 it would be too difficult,
00:16:57.270 --> 00:16:58.202 practically speaking,
00:16:58.202 --> 00:17:00.066 to use overall survival.
00:17:00.070 --> 00:17:03.790 So this was approved in 2011.
00:17:03.790 --> 00:17:06.198 Sir Afatinib is not yet FDA approved.
00:17:06.200 --> 00:17:08.540 It is under FDA review.
00:17:08.540 --> 00:17:09.090 At present,
00:17:09.090 --> 00:17:11.015 this was on the basis of two
00:17:11.015 --> 00:17:12.622 large studies conducted in China
00:17:12.622 --> 00:17:14.212 and then a phase one.
00:17:14.220 --> 00:17:15.900 Two study that has been
00:17:15.900 --> 00:17:17.580 conducted in the United States
00:17:17.651 --> 00:17:20.004 in a more traditionally Western population.
00:17:20.004 --> 00:17:23.160 But this was positive in both
pancreatic and extra pancreatic Nets.

And is, I suspect that at some point this spring or summer, we will have a decision from the FDA.

I’d like to mention a study on chemotherapy that I had the opportunity to lead for pancreatic Nets, so this was a study of temozolomide versus capecitabine intimas Olumide for grade one or two metastatic pancreatic Nets. This was a study that ultimately demonstrated that Caped M was superior to temozolomide alone and median progression.

Free survival was about 23 months for the combination versus 14 months. For Thomas Olumide at the time
00:18:06.392 --> 00:18:08.020 of the initial analysis,

00:18:08.020 --> 00:18:10.799 it appeared as if there was an

00:18:10.799 --> 00:18:12.650 overall survival benefit benefit.

00:18:12.650 --> 00:18:13.538 Stay tuned.

00:18:13.538 --> 00:18:16.202 We have the final analysis submitted

00:18:16.202 --> 00:18:19.918 to ASCO for an updated analysis.

00:18:19.920 --> 00:18:21.691 I think one of the key takeaways

00:18:21.691 --> 00:18:23.984 of this is that we see a higher

00:18:23.984 --> 00:18:25.840 response rate than we’ve seen really

00:18:25.840 --> 00:18:27.760 for any of the other therapies.

00:18:27.760 --> 00:18:29.158 I did not go into that,

00:18:29.160 --> 00:18:32.840 but somatostatin analogues, mtor inhibitors,

00:18:32.840 --> 00:18:35.582 tyrosine kinase inhibitors all have a

00:18:35.582 --> 00:18:39.250 you know 5% or less objective response rate.

00:18:39.250 --> 00:18:41.776 So for patients with pancreatic Nets
who need objective tumor shrinkage, these are actually very good therapies to think about. So let’s wrap this up. We’re actually in a fortunate place now of having a number of therapies, but it gets very difficult to know what order in which we should use them, so this is adapted from Nancy CN guidelines, so I would say commonly a first line treatment is either observation.
or octreotide or lanreotide, but where it gets very confusing as thinking about second line therapies. So I have a handy table to help you think about that, and I’ve put them in. Order of how I generally will think about using them. I often will consider using PR T or Ludo tape or lutathera as the as it’s also called in the second line setting. It has a modest response rate of about 18% along PFS and is well tolerated and we do have to take care if patients GFR is less than 30 but
we are developing more experience with them.

The chemotherapy tamela mining capecitabine has the highest response rate.

And should be considered for patients with pancreatic Nets who need an objective response.

It does have higher adverse events for older patients.

I will sometimes consider temozolomide alone.

Forever Elemenin soon if they both have very low response rates,

the PFS is about a year best for low volume disease,

but I find that the adverse event profile is tough for both of these.

Everyone ever really miss in
particular is good for insulinoma because it can cause hyperglycemia, but it’s tough and can cause pneumonitis and the hyperglycemia can be difficult for patients with uncontrolled diabetes. So takeaways I hope you’ve learned that Nets are not that rare. They are deserving of high quality basic research. We’ve had incredible advances in the last 10 years. PRT is really a game changer and I expect the next decade of
00:20:44.405 --> 00:20:46.050 clinical trials to be looking
NOTE Confidence: 0.859887359166667
00:20:46.050 --> 00:20:48.105 at better patient selection,
NOTE Confidence: 0.859887359166667
00:20:48.105 --> 00:20:50.405 minimizing toxicities and increasing
NOTE Confidence: 0.859887359166667
00:20:50.405 --> 00:20:52.219 efficacy and multidisciplinary care
NOTE Confidence: 0.859887359166667
00:20:52.219 --> 00:20:55.584 and team science is really key for this
NOTE Confidence: 0.859887359166667
00:20:55.584 --> 00:20:59.486 disease so I am going to stop share.
NOTE Confidence: 0.859887359166667
00:20:59.490 --> 00:21:01.674 I think I’m close to time.
NOTE Confidence: 0.859887359166667
00:21:01.674 --> 00:21:03.376 Doctor Abovyan and then Doctor Boyd
NOTE Confidence: 0.859887359166667
00:21:03.376 --> 00:21:05.368 if you can then pass that baton
NOTE Confidence: 0.859887359166667
00:21:05.368 --> 00:21:07.405 when you’re done to Doctor Khan and
NOTE Confidence: 0.859887359166667
00:21:07.405 --> 00:21:09.656 then we will do a Q and a great.
NOTE Confidence: 0.597898
00:21:15.590 --> 00:21:19.460 Thank you doctor Kuntz. This was fantastic.
NOTE Confidence: 0.334057785
00:21:19.460 --> 00:21:20.969 Sam my screen.
NOTE Confidence: 0.875899366363636
00:21:31.900 --> 00:21:34.161 So I’m going to talk about the
NOTE Confidence: 0.875899366363636
00:21:34.161 --> 00:21:35.740 role of molecular imaging,
and there are Gnostics in the care of patients with neural neoplasms I’m in. I’m at Yale Department of Radiology and I am in a nuclear medicine and new radiology sections.

For disclosures, I have a research collaboration with vistage imaging and I do clinical trials with Blue Earth diagnostics. We’re going to start a little bit with standard imaging, CT, and MRI, but we’re not going to focus on this imaging modalities because they’re pretty well understood in the community and just kind of going over the basics of it. For carcinoid tumors, we can do very
nice chest imaging with CT of the chest.

We can do contrast and noncontrast imaging,

and here is an example of a lung carcinoid lesion.

For pancreatic neuroendocrine tumors we can do CT imaging.

Enhance CT imaging,

but we can also do MRI and here you see actually a patient with pancreatic tail or entropy neoplasm that is heterogeneous solid and partially cystic and you can see that it’s actually sometimes difficult to evaluate.

We can also do MRI imaging with abdominal MRI.

You can do it with contrast.
and without contrast, you can evaluate in this particular patient static liver lesions within the. This MRI pretty well and this actually is same patient that progressed in development has to season the liver. But we want to also start imaging beyond standard anatomical imaging with molecular imaging and with standard and understandable imaging we can see a lot of the basics of actually delineate the borders of the tumor and where they’re located, it’s really hard to say what is
the characteristics of the tumor, so we're very good at defining the anatomy and the location and the extent of the disease and location of disease. But not so much in terms of is the same neuroendocrine tumor. If you just look at the lover? Or is this something else? What's really nice is that you can actually use targeted imaging to describe the receptors on the surface of tumors, without having to do a biopsy. And this is an example of a gallium dotatate PET.
which I'll describe this little alphabet. So soup in the next few slides, what it allows you to do is to visualize semantics. Some of some analog binding to a somatostatin receptor, and being able to see it light up on this Cam. I'm so glad Doctor Kunz mentioned that tree a scam that used to be the standard way of trying to see some exciting receptor receptor expression on tumors. And as you can see, these are not very good images.
and they’re very hard to see.

And it’s very difficult to tell where the tumor is, this is actually the same patient I showed you earlier.

With pancreatic tail tumor, and you can barely see where this illusion is, this is a planar imaging, and if we did SPECT, we could localize it to the left upper quadrant, but it would be very difficult to localize it to the pancreas very well.

Also, if there were smaller lesions, we wouldn’t be able to see it.
And here’s an example of a trio scan being lined up right next to door dotate scan gallium dotatate pet in the same patient, and you can see how many lesions are being missed. An actress can that can be clearly seen on the pet C team. But going to the dough depart a lot of folks ask me Doda what, lot of folks ask me Doda what, but there’s actually a very nice logic to it. So let’s go over that.
because then you will never question what these are. So first, let's talk about labeling in chemistry. When you're thinking about radionuclides such as gallium and copper, which are used for imaging and pet, you cannot just attack, give them to the patient, they're actually toxic, so you need to keep them in the cage, and this is a doda cage. So you would kill 8 the gallium 68 in this doda cage, and what's really nice about this cage. It has a couple of. Four different arms and to these arms you
can actually attach your targeting molecule, so in this case it’s actually a tight analog Tate, so you attach this peptide to the doda and you have your radionuclide chelated inside of the Doda. So there’s a very logical name to this. This value attach it through the ARM gallium Doda date. Very simple, right? So now that you understand. This kind of logic it it becomes very easy to understand how we mean these scans and with the labeling you can actually really be able to see this.
So this is a gallium dotate PET CT in a patient with multiple metastases. Some medicine receptor positive liver metastases and you can actually see that there is also a period where did metastasis in the lymph node that’s outside of the liver and here you have kidneys and bladder. So it really helps you evaluate the patients in terms of the appropriate use criteria. I’m so glad Doctor Kunz had a full slide on this in terms of evaluating. Not all patients need to be getting gallium daughter take pets and there’s there. We’re still truly evaluating exactly where
and when we should be doing these scans, but there's several indications that can. That are appropriate and some of the most indicative are the initial staging after histologic diagnosis of neuroendocrine tumor and localization of primary tumor. This skin is so sensitive form lesions, so you'll be able to see it and then the other very common. Very important point is selection of patients for some meta stat.
and receptive targeted therapy
Later now what’s really nice about this
Later now what’s really nice about this
Later now what’s really nice about this
Later now what’s really nice about this
Later now what’s really nice about this
Later now what’s really nice about this
Later now what’s really nice about this
Later now what’s really nice about this
Later now what’s really nice about this
Later now what’s really nice about this
Later now what’s really nice about this
Later now what’s really nice about this
Later now what’s really nice about this
Later now what’s really nice about this
therapeutic for neuroendocrine tumors.

So this would be called very logically.

I know you're thinking about this.

Lu teach to Doda tape.

Very simple.

So we imaged with gallium dotatate

and we treat it with lutetium

and we just have to do lutetium,

we can also use other radionuclides

such as alpha emitters and here

at Yale we're now are approved to
start doing this and it's very exciting new development to start doing these therapies in patients. So how do these alpha and beta emitters work? Well for lutetium and this is an image from a website where basically describes the mechanism of lutetium and you administer the drug intravenously. The drug gets taken up into the neuroendocrine tumor sides. The drug binds to the receptors through endocytosis and the radionuclide emits its particles beta particles, or if using that actinium type of therapy.
Luther, it’s really the beta particles because it’s lutetium and that can cause DNA damage. And once you have DNA damage you can that can lead to tumor cell death. And that’s and that’s the main mechanism. So to just kind of overview this again in terms of image guided therapy, you can select patients for whether they are eligible for this kind of therapy with your imaging agent, gallium dotatate. And you can see if the patient expresses this amount of statin receptors in the body, and in this particular patient.
there are multiple metastatic lesion that can take up the targeting.

Molecule, then you bring the patient in and provide intravenous therapy.

And that is basically the same as the imaging agent, except it has the radionuclide that causes DNA damage.

And what’s really interesting is that lutetium can also emit.

Image trace that you can see on gamma camera and you can basically see exactly where lutetium dotatate went.

Now it’s not as crisp and beautiful as PET CT,
00:32:11.090 --> 00:32:13.665 but you can actually see
where this therapy went.

00:32:13.665 --> 00:32:15.725 And you can actually start
doing those symmetry.

00:32:15.730 --> 00:32:20.026 These images so this kind of technology
allows selection of right patient
and providing the right drug for
the patient and in neuroendocrine
tumors that has really changed how
we change how we treat patients.

00:32:20.030 --> 00:32:23.720 These images so this kind of technology
allows selection of right patient
and providing the right drug for
the patient and in neuroendocrine
tumors that has really changed how
we change how we treat patients.

00:32:23.720 --> 00:32:25.975 These images so this kind of technology
allows selection of right patient
and providing the right drug for
the patient and in neuroendocrine
tumors that has really changed how
we change how we treat patients.

00:32:25.975 --> 00:32:28.742 The indications for lutetium dotatate.

00:32:28.742 --> 00:32:30.922 The indications for lutetium dotatate.

00:32:30.922 --> 00:32:33.547 We need to confirm some metastatic
GI neuroendocrine tumors
and they have to be well differentiated.

00:32:33.547 --> 00:32:35.947 We need to confirm some metastatic
GI neuroendocrine tumors
and they have to be well differentiated.

00:32:35.950 --> 00:32:38.938 So these are the GI neuroendocrine tumors
and they have to be well differentiated.

00:32:38.938 --> 00:32:41.070 So these are the GI neuroendocrine tumors
and they have to be well differentiated.

00:32:41.070 --> 00:32:43.898 G1 and G2 tumors.

00:32:43.898 --> 00:32:47.100 We need to confirm some metastatic
G1 and G2 tumors.

00:32:47.100 --> 00:32:51.170 We need to confirm some metastatic
G1 and G2 tumors.
receptor expression and that can be done with gallium dotatate PET CT.

We’re still allowed to use octreoscan and sometimes we will use it if insurance will deny that the pet city, but you really want to be doing this with a pet CT. We also evaluate bone marrow function, renal function, and liver function. Yes, and this is the point where nuclear medicine physicians are starting to become partners with oncologists and surgeons in treatment of these patients. Because we no longer just read the images were actually evaluated. Whether the patient is eligible
for the study and we evaluate, and we do those symmetry.

And this is of patient oriented, patient facing role for nuclear medicine physicians and radiologists.

Now.

Even though the letter one has established the parameters for treatment of patients with Sarah, but we are still, we’re still figuring out the exact guidelines for which patients will benefit most, and they’re still.

There’s a lot of active research going on in this field,
and it’s very exciting to be part of this field as we’re expanding beyond the netter one. Trial indications. But you’re probably thinking, well, what about FDG? GS News and pretty much every other oncological indication. How about your endocrine tumors? Well, a lot of the well differentiated G1 on your endocrine tumors are actually not hypermetabolic, so we there’s really no role for our DG in the well differentiated once, and there is the spectrum that the tumors will express.
A lot of this medicine receptor and will not have as much. Hypermetabolic activity, but the higher grade tumors. Then you’re in different parts. Sonoma is Angie 3 tumors. They will have hypermetabolic activity and there’s still a lot of Gray area in between them as well, because sometimes they look the lower grade tumors will also have hypermetabolic activity, but in nuclear medicine we have this idea that there’s dedifferentiation that happens.
So this is a patient with a well differentiated neuron, different tumor. With multiple somatostatin receptor avid lesions and this is a patient that had dedifferentiation that neural different from which the tumor is now hypermetabolic, or it can actually expect express sounds of medicine receptors, but not as many. So the exact point where we would treat these patients, particularly the ones that have FDG uptake.
Is still not fully evaluated, but hypermetabolic activity within these tumors is seen as a poor prognostic marker. So in terms of PRT treatment, the standard dose of 200 millicuries every eight weeks and we do 8 cycles. During the therapy we do an amino acid infusion for renal protection and we provide antiemetics for nausea and we provide antisomatostatin and lock therapy at this during PRT treatment now.
None of you are thinking well. What if?

How do we treat a patient?

Every single patient with the same dose?

And you’re thinking right, the whole field of theranostics right

Now and treatment PRT treatment is moving towards personalized

of symmetry and that is becoming

And the reason is there, nastix agents are becoming more and

more available for different cancers

and in prostate cancer will have a
new theranostic agent that's very likely to be FDA approved next month.
And with that targeted therapy,
you want to think about it in a couple different ways and just in terms of
global way with with their Gnostics, you can image the targets such as
location of the tumors and that way you can provide targeted therapy
in terms of location of the tumor, because you can see where the drug is and then you can just exchange the radionuclide and and target that therapy.
You can also think of targeted therapy in another way where you target as
particular step in the mechanism of.
Therapy, and that is targeting a specific pathway step.
So for FDA approved radiopharmaceuticals there’s really been an explosion in the recent years.
So it we really kind of started with a cold see lemon cooling for prostate cancer and gallium dotatate was approved when you’re entering tumors in 2016 and then was followed by Gallium Delta talk and the difference between Tate and talk is in the peptide portion of the targeting agent.
And in there they work pretty much the same in terms of ability to
detect some metastatic receptors.

We also now have a copper 64 labeled DOTATATE and.

The therapy for lutetium builder did was.

He has also been FDA approved for quite a while now and it was basically approved based on the meter one trial, which showed improved progression free survival in these patients and I really appreciate Doctor Koontz going over.

For this so for future directions we have to evaluate PRT efficacy and higher grade neuroendocrine neoplasms. We’re also working on personalized symmetry, so providing the right dose to the
patient and hopefully see better outcomes in patients, and we need to evaluate indications for re-treatment of patients. So after they completed the four cycles of therapy, what are the indications for repeat? Treatment another cycle of therapy and also of the alpha therapeutics. And another thing that we’re working on here at Yale is personalized tumor directed analysis with basically doing volumetric assessment of the different metastases and generating growth curves for each individual lesion in the volumetric form and following.
Physical growth parks and figuring out which lesions are growing and needs targeted therapy through different ways and which ones are not so, so. In conclusion, cross sectional imaging with CT and MRI can diagnose and follow in your Endocrine meal Plaza. And it’s they’re really excellent ways to do imaging for these patients, but. And molecular imaging of somatostatin receptor expression allows for better molecular characterization of new rendering. Gallium Dotatate pet is very sensitive.
for detection of metastatic lesions

and allows to evaluate whether patient

is eligible for PR T lutetium

dotatate therapy is established

and allows to treat some medicine

and receptor tumors expressing

Staten receptor expressing neuron doctrine,

neoplasms, and it allows us to visualize the location of the therapy

and many advances for personalized therapy are being evaluated right now,

so stay tuned to this field ’cause it’s really changing how we’re managing their endocrine schermers.

I really want to thank you for your time
and pass the Bhutan to doctor Sajid Khan.

You’re on mute. Doctor Khan.

OK, OK, I think I’m unmuted now. I’m that right?

OK, yes, OK, alright.

Thank you Doctor rebellion that was just an outstanding talk.

I learned a lot from that talk and I’m sure other people in the audience learned a lot.

And Doctor Kunz talk was also at standing.

So, uh, you know, so I’m going to spend the next 20 minutes talking to you from a slightly different perspective, and one that will include the surgical management of neuroendocrine tumors.
And since just the surgical management of neuroendocrine tumors is a large topic in and of itself, no, over the next 20 minutes, I’ll focus specifically on pancreas and small bowel, new render consumers and I’d love to ask answer any questions towards the end. First time I have no disclosures. So this is a a slide from a paper that Doctor Kuhn said side didn’t hurt talk for. Looking at it from the end where they looked at. Sear based study of the incidence of neuroendocrine tumors over the course of time and what’s striking about this talk,
and this is kind of the punch line.

One of the points that Romans made is neuroendocrine tumors are not necessarily a rare anymore because the incidence of these is rising and this includes the focus of this talk, which will include pancreas and as you can see, there's been a very steady and then more recently, a steeper rise in the incidence of pancreas. Under consumers and in green over here, a small bowel or under consumers. 2 and that’ll be the focus of this talk. I’m sure many people in
the audience know that.

Many of our patients are getting scans. A cross sectional imaging, and they’re often incidental findings. And oftentimes these are how neuroendocrine tumors are discovered as our other kinds of tumors as well, and I’m sure that’s driving the higher incidence that we’re seeing over time.

So the interesting thing about neuroendocrine tumors is that the survival for neuroendocrine tumors is, generally speaking, favorable when we and the focus again will be on pancreas.

Neuroendocrine tumors and small
bowel neuroendocrine tumors and the survival is dependent on grade, and we’re not going to talk too much about grade three grade 4 door under consumers and much of what we see are grade one and grade tuna under consumers and the survival. Is is usually favorable and that leads to. That the perspective of how these new entrants should be managed and you know, and you know I’m going to give you my perspective as a surgical oncologist. And I think we all have our own perspectives on things.
longer progression free survivals,
the longer survivals impact how?
What kind of surgical management
we offer to our patients.
So for the talk, we’ll break it up
into the remainder of the talk.
Will break it up into three different.
Sessions one will be the pink
richner endocrine tumors,
which I’ll talk about first.
I’ll follow that with the small
bowel and are under consumers.
And lastly, we talk about metastatic
neuroendocrine tumors as well.
These are common surgical scenarios
that maybe some of your patients
have experienced and hopefully this will provide some types.

So in regards to the pancreas

So you know,

I think in order to understand if someone needs an operation,

one needs to just understand the

basics of the neuroendocrine tumors.

And you know these are some of the points that are important to a surgical oncologist.

When we see patients who think christner under consumers.

I'm I'm very interested in tumor biology and I could tell that to
rebooting is also from her very elaborate talk and pink Krishna render from rumors arise from the endocrine cells of the pancreas, which are important to understand and they account for 3% of pancreas tumors altogether. So still pancreatic ductal adenocarcinomas and other kinds comprise majority but 3% of pink christner under consumers are comprised of by peanuts. The median age at diagnosis is 60 years and the survival is longer than that anchors adenocarcinoma, so that’s very important point.
to understand is as all of us in the audience have.
I'm sure I can understand, and they're obviously people. Some celebrities over the years that we have observed that have been diagnosed with these kinds of tumors. Both adenocarcinoma. The note status is very important, so patients with node negative peanuts tend to have them. Sorry to interrupt you.
So the survival is very important based on the nodal status.

So patients with no negative peanuts have a very favorable survival at 136 months.

The addition of noteworthy metastasis to lymph nodes decreases the survival to 77 months and one patient presents with distant metastases. This survival is 24 months and 60% of patients do present with distant metastases. And I think that plays into the decision making process.

So for how to treat the patient optimally and as doctor Kunz
had mentioned during her talk,

majority of cases are sporadic and some are familiar.

Pink Reisner under consumers are nonfunctioning tumors and and nonfunctioning tumors do not produce clinical symptoms, even though the tumors can’t still produce hormones, but they don’t produce enough hormones that cause clinical symptoms.

The nonfunctioning tumors, now in the updated literature, revealed account for about
75% of these tumors. I think some of this has to do with these smaller new render consumers, the child. Talk a little bit about that are diagnosed more and more frequently in that number has increased over overtime and then functioning tumors, so functioning tumors are tumors that have hormone hypersecretion that does lead to clinical manifestation. The six types are listed here, which are insulinomas most commonly that we see Glucagon, omas, gastrinomas VIP,
adenomas and others as well functioning tumors tend to have better survival than nonfunctioning tumors and part of this. Probably is patient present symptom with symptomatology earlier than non functioning tumors and that might lead to a better survival ultimately because it was diagnosed or earlier on in the process.

So when a surgical oncologist, if you come to Yale Surgical and I see one of the Yale surgical oncologists you know there are certain things that we think are
important to guide our principles

of sort of surgical management of patients for assessing a patient.

For that and our goals for surgery are the first is to maximize local control, so I think that’s a very important point for not just bankers neuroendocrine tumors, but in general for other types of neuroendocrine tumors as well. Another goal is to increase ones quality of life. Quality of Life OK, so sometimes that even non functioning tumors can have an adverse effect on the individuals quality of life. So surgery can improve, increase funds, quality of life progression.
Free survival is an important point as well given the behavior of these tumors a lot of times. Progression free survival is very important for this kind of tumor. Generally speaking we aim for R0 resection margins and that’s something we strive for. We’ll talk a little bit more about that’s.
not always the case,

but that's for some of the metastatic tumors.

But we are usually striving for

an artist or section and the other

final goal is we try to alleviate

clinical symptoms,

and this is very important for those

with the functioning or underprint tumors.

And and with the source of the hormone,

hypersecretion is removed.

It can substantially alleviate ones

clinical symptoms in the completely.

Address it altogether.

And we also, you know,

with our surgeries and a lot of

these pancreas cases can be major
00:50:39.922 --> 00:50:40.978 operations and us.

00:50:40.978 --> 00:50:44.070 But we do try to limit our short term morbidity and the long term morbidity as well too in the few.

00:50:44.070 --> 00:50:45.982 See one of the surgical oncologists at Yale.

00:50:49.780 --> 00:50:51.736 We our role is taking this into consideration.

00:50:51.736 --> 00:50:52.388 specific surgical scenarios here that may be of some use and you know one scenario includes a patient that presents the localized non metastatic pancreas neuroendocrine tumor.

00:50:54.800 --> 00:50:57.635 So, so I’m gonna give you some specific surgical scenarios here that may be of some use and you know one scenario includes a patient that presents the localized non metastatic pancreas neuroendocrine tumor.

00:50:57.635 --> 00:50:59.202 We our role is taking this into consideration.

00:50:59.202 --> 00:51:01.897 that may be of some use and you know one scenario includes a patient that presents the localized non metastatic pancreas neuroendocrine tumor.

00:51:01.897 --> 00:51:03.931 And generally speaking, we respect the for the resection is feasible.
The meeting survival in the literature is 7.1 years, but the important thing to understand, and is that about half the patients do recur at two almost three years. So recurrence free survival is important to consider here as well, so so many patients to recur. Another common scenario are these small pink trees that are under 15 years, so these are pink creature under consumers that when we say that there are small, we’re thinking 1.5 to 2 centimeters in the consumers that when we when we say that there are small, depends on which studies you’re looking at. There’s a good study out of
There’s another good study out of Massachusetts General and then that’s where this number of less than two centimeters or 1.5 to 2 centimeters comes up, because given the behavior of neuroendocrine pancreas, sometimes surgery is not necessary for these patients, but I would recommend careful observation and you know each patient is an individual and we need to evaluate individually and but oftentimes patients with
smaller tumors can be observed, you know, and I just want to make a quick comment about that.

And that being said, you know if there’s a young patient that’s diagnosed with a 1.8 centimeter neuroendocrine tumor that’s in her late 20s or so, you know one can make a reasonable argument that with a longer life term expectancy, maybe that might not be the person we tried.

Decide to observe with the small neuron consumer and we do survey these patients.
And if there are changes to their cross sectional imaging, which is an important point for neuroendocrine tumors, we will consider them per section. Another scenario that sometimes comes up is a locally advanced and metastatic on fund, resectable. Patient in that kind of a scenario, you know, sometimes we consider palliative surgery with some of the options listed here, and that’s sometimes a scenario and then limited liver metastases. We’re going to talk at the last
third of this talk a little bit more about metastatic disease and in some patients with limited liver metastases. Will will use a asynchronous approach where the primary tumors are addressed and the liver tumors is addressed, or we considered a surgery in a staged fashion. So for all of these for sections I'm just figured I'd share some patient examples for you to try to put it into some perspective and and the first patient I'd like to present is an 80 year old male who presented with hypoglycemic episodes and he had Whipple's triad,
which we’ve heard about, and for Pinkerton are under consumers, what we teach our residents is, you know, if you’re ones considering a functional. Increased our hundred tumor work up starts with the biochemical workup and this patient did have a biochemical work up, which indeed was consistent with insulinoma. After the biochemical work up, then we preceded with the localization studies to identify where this tumor is located and in this patient. Here, this is the frontal images and it shows.
I don’t think my arrow is projecting here, but there’s a hyper enhancing mass in the head of the pancreas which is seen. And that is sometimes the look of how a neuron tumor shows up on cross sectional imaging, and we performed a pancreaticoduodenectomy with an extended lymphadenectomy on this patient specimen seen on the right, and interestingly, immediately the patient’s hypoglycemic episodes were completely resolved and provided this gentleman with many years of custom free life.

Next, I’d like to transition to small bowel neuroendocrine tumors.
And these are tumors that are submucosal neoplasms which primarily arise from the jejunum and the ileum. And there they do have neuroendocrine differentiation, just like some of these other tumors that we’re talking about today. They have an ability to secrete functional hormones and a means they are the most common tumor of the small bowel with malignant potential. Which is interesting because this is shifted because when I was in intern almost 20 years ago now we used to not look at small bowel neuronal tumors as
00:55:44.780 --> 00:55:46.600 the most common small bowel tumors.
NOTE Confidence: 0.836767505
00:55:46.600 --> 00:55:48.510 We would think more of adenocarcinoma
NOTE Confidence: 0.836767505
00:55:48.510 --> 00:55:51.100 and then more often even benign tumors.
NOTE Confidence: 0.836767505
00:55:51.100 --> 00:55:51.970 But interestingly,
NOTE Confidence: 0.836767505
00:55:51.970 --> 00:55:53.710 now neuroendocrine small bowel
NOTE Confidence: 0.836767505
00:55:53.710 --> 00:55:55.960 tumors are the most common.
NOTE Confidence: 0.836767505
00:55:55.960 --> 00:55:59.890 Small bowel tumor with Fullington potential.
NOTE Confidence: 0.836767505
00:55:59.890 --> 00:56:02.445 Nearly a third of these tumors arise
NOTE Confidence: 0.836767505
00:56:02.450 --> 00:56:04.646 relatively close to the ileocecal valve,
NOTE Confidence: 0.836767505
00:56:04.650 --> 00:56:06.774 and that the reason that’s important
NOTE Confidence: 0.836767505
00:56:06.774 --> 00:56:08.590 is our operative decision making
NOTE Confidence: 0.836767505
00:56:08.590 --> 00:56:11.490 takes that into consideration.
NOTE Confidence: 0.836767505
00:56:11.490 --> 00:56:13.420 Many patients present with multifocal
NOTE Confidence: 0.836767505
00:56:13.420 --> 00:56:15.350 disease that’s also very important.
NOTE Confidence: 0.836767505
00:56:15.350 --> 00:56:17.990 When I talk about surgical approaches,
NOTE Confidence: 0.836767505
00:56:17.990 --> 00:56:20.665 and about 35% of patients
00:56:20.665 --> 00:56:22.805 present with distant metastases,
00:56:22.810 --> 00:56:24.820 so surgical resection is a preferred
00:56:24.820 --> 00:56:26.670 frontline treatment for these patients.
00:56:29.060 --> 00:56:30.956 And the reasons for that is number one.
00:56:30.960 --> 00:56:33.408 It can improve survival.
00:56:33.410 --> 00:56:36.134 Number two can reduce the risk
00:56:36.134 --> 00:56:37.950 for developing metastatic disease.
00:56:37.950 --> 00:56:40.831 #3 can alleviate symptoms and
00:56:40.831 --> 00:56:42.658 finally #4 it can prevent or delay
00:56:42.658 --> 00:56:44.489 the onset of symptom development,
00:56:44.490 --> 00:56:46.295 and that’s important as we
00:56:46.295 --> 00:56:48.550 talk a little bit more here.
00:56:48.550 --> 00:56:49.183 So you know.
00:56:49.183 --> 00:56:50.660 So like I thought it would be
00:56:50.712 --> 00:56:52.218 useful to go over some scenarios
that some of your patients may present with into the hospital. And 11 scenario is in east symptomatic prime patient that the patient presents with asymptomatic disease with the primary tumor without distant metastases. So even though these patients present with asymptomatic disease, in retrospect, many of them will have some symptomatology. And they won’t know about it until after they’ve had their surgery. But that symptomatology may have prompted their imaging in the 1st place and the cross sectional imaging Dr Booing can speak to this better than I can.
but oftentimes it shows something such as a mesenteric or small bowel mass, which is hyper enhancing. Speculated or calcified, and interestingly in the operating room, the speculation is something we really appreciate because these tumors in the OR or the mesenteric mass in the OR tend to be fixed, as opposed to something that some freely movable, which is the case with some of the benign small bowel tumors.
and even small biologists.

Another scenario is an asymptomatic primary tumor with distant metastasis.

I'm going to talk a little bit about that.

In the last scenario, because I think that’s going to be an important thing to go over.

And symptomatically.

You know, sometimes these neuroendocrine tumors present with the bowel obstruction.

Abdominal pain, bleeding, and the so-called carcinoid syndrome as well.

An approach that is important is expectations for our patients suffer.
00:58:29.010 --> 00:58:31.378 Patient knows what to expect in a non
00:58:31.378 --> 00:58:33.195 emergent setting prior to undergoing
00:58:33.195 --> 00:58:35.145 a surgical and conchological section.
00:58:35.150 --> 00:58:36.854 It goes along way for their
00:58:36.854 --> 00:58:37.990 satisfaction down the road.
00:58:37.990 --> 00:58:39.918 That’s something that our
00:58:39.918 --> 00:58:42.293 our group at Yale uses.
00:58:42.293 --> 00:58:45.837 So we talked to our patients ahead of
00:58:45.837 --> 00:58:47.978 surgery and one thing that we talked
00:58:47.978 --> 00:58:50.245 to our patients about is sometimes that
00:58:50.245 --> 00:58:52.744 because of the multifocality of these tumors,
00:58:52.750 --> 00:58:54.180 larger areas of small bowel
00:58:54.180 --> 00:58:55.324 need to be respected.
00:58:55.330 --> 00:58:57.685 Lead to increased frequency of
00:58:57.685 --> 00:59:00.040 their bowels of bowel movements.
We also consider perceptibility.

A lot of it comes down to the mesenteric artery and the vein superior mesenteric,

That’s something we strongly consider for respectability for these guys into tumors,

Sometimes it involves resection of a mesenteric mass,

which is how a patient may present,

and indirectly or small bowel resection with a lymphadenectomy.

Sometimes it involves resection of a mesenteric mass,

which is how a patient may present,

and indirectly or small bowel resection with a lymphadenectomy.

It’s very important to palpate for synchronous tumors,
and I just want to spend just a minute talking about that as well too. So we do a lot of laparoscopic and minimally invasive surgery at Yale. A lot of our operations are done in that manner, and the way I look at laparoscopy and minimally invasive surgeries that it should be a tool to provide a good oncologic operation. It shouldn’t not be the other way around, meaning someone should not get. A minimally invasive surgery just for the sake of getting minimally invasive surgery,
but so so for the way we approach these are we usually will do them. Laparoscopic Lee roulette, metastases and sometimes we could make a very small incision and eviscerate the tumor and palpate the entire small bowel to make sure that they’re synchronous. Tumors are are not missed, which sometimes is the case with true laparoscopic operations. For these small bell, any tease we value for distant metastases and sometimes consider a cholecystectomy and a lot of that. Ends up being a conversation with the
01:00:29.559 --> 01:00:31.750 surgical oncologist and medical oncologist,
01:00:31.750 --> 01:00:34.137 and about this patient may be a
01:00:34.137 --> 01:00:35.911 candidate for lanreotide in the
01:00:35.911 --> 01:00:37.957 future which can predispose to the
01:00:37.957 --> 01:00:41.080 development of gallstones. Uhm?
01:00:41.080 --> 01:00:43.270 So so a few scenarios.
01:00:43.270 --> 01:00:46.276 So patient presents with an incidental
01:00:46.280 --> 01:00:48.330 finding on cross sectional imaging.
01:00:48.330 --> 01:00:50.244 You know our suggestions are the
01:00:50.244 --> 01:00:52.213 patient should be evaluated by a
01:00:52.213 --> 01:00:54.899 surgical oncologist per section
01:00:54.900 --> 01:00:56.918 the patient presents,
01:00:54.918 --> 01:00:56.822 with an isolated mesenteric
01:00:56.822 --> 01:00:58.672 mass or small bowel mass,
01:00:58.672 --> 01:01:00.730 and the reasons we consider surgery
01:00:31.750 --> 01:00:34.137 and about this patient may be a
01:00:34.137 --> 01:00:35.911 candidate for lanreotide in the
01:00:35.911 --> 01:00:37.957 future which can predispose to the
01:00:37.957 --> 01:00:41.080 development of gallstones. Uhm?
01:00:41.080 --> 01:00:43.270 So so a few scenarios.
01:00:43.270 --> 01:00:46.276 So patient presents with an incidental
01:00:46.280 --> 01:00:48.330 finding on cross sectional imaging.
01:00:48.330 --> 01:00:50.244 You know our suggestions are the
01:00:50.244 --> 01:00:52.213 patient should be evaluated by a
01:00:52.213 --> 01:00:54.899 surgical oncologist per section
01:00:54.900 --> 01:00:56.918 the patient presents,
are again, it could be diagnostic.

Sometimes these tumors are not always new render consumers,

but they usually are when we look at it with our radiologists,

so it’s something to consider. In, the operation is potentially curative and this is very important.

It can avoid future symptoms of bowel obstruction, bleeding or ischaemia, which sometimes happens in these small bells are under primary. Tumors are left alone,
so that’s an important point to mention and we do see that sometime and again with the patient that had an arrangement in which was being observed and so the patient can present with some symptoms down the road. And of course it can avoid reduced risk. Another scenario is an asymptomatic primary with distant metastasis, and again this can be. This would suggest to be evaluated by a surgical oncologist and the reasons for surgery in order.
to avoid future complications and metastasis and discomfort.

This kind of an approach can still provide a profession free survival advantage.

And then, if patients sometimes present symptomatically and impatient that’s presenting should probably just get to the operating room and be seen by a general surgeon in the local hospital. Because sometimes these patients you know don’t have room to be transferred, and they and acute ballot traction should just usually be managed locally and the reasons for this.
Of course the obvious it alleviates her symptoms. That it can be diagnosed and be potentially cured. And a patient example here is an asymptomatic patient with an asymptomatic small bell NET. This is a 59 year old male who presented with a 4.2 centimeter hyper enhancing mesenteric mass on CT for abdominal pain, which resolved by the time we evaluated him and then this picture shows a CAT scan with a hyper In Sync 4.2 centimeter mass, which we ended up taking to the OR and resecting which is
01:03:03.502 --> 01:03:05.699 showing all the way in the right.
NOTE Confidence: 0.876315255
01:03:05.700 --> 01:03:09.060 And we did an en bloc small bowel
NOTE Confidence: 0.876315255
01:03:09.060 --> 01:03:11.204 resection with the mesenteric mass
NOTE Confidence: 0.876315255
01:03:11.204 --> 01:03:13.700 and the surgical pathology
NOTE Confidence: 0.876315255
01:03:13.774 --> 01:03:15.679 revealed multifocal tumors.
NOTE Confidence: 0.876315255
01:03:15.680 --> 01:03:18.910 Node positive disease without metastasis,
NOTE Confidence: 0.876315255
01:03:18.910 --> 01:03:22.109 and it was a grade one tear.
NOTE Confidence: 0.876315255
01:03:22.110 --> 01:03:22.956 And finally,
NOTE Confidence: 0.876315255
01:03:22.956 --> 01:03:25.494 I'll end this session by submitting
NOTE Confidence: 0.876315255
01:03:25.494 --> 01:03:27.469 metastatic here under consumers.
NOTE Confidence: 0.876315255
01:03:27.470 --> 01:03:28.136 So again,
NOTE Confidence: 0.876315255
01:03:28.136 --> 01:03:29.801 some perspective on things from
NOTE Confidence: 0.876315255
01:03:29.801 --> 01:03:31.384 a surgeon's perspective that so
NOTE Confidence: 0.876315255
01:03:31.384 --> 01:03:32.980 the reason we find this important
NOTE Confidence: 0.876315255
01:03:32.980 --> 01:03:34.489 is because the third patient,
NOTE Confidence: 0.876315255
01:03:34.490 --> 01:03:36.010 present with cysteine metastasis
in the liver, happens to be the most common site of metastasis. Metastasis is important because it negatively affects revival as, and that’s the case with all cancers, and there’s a increased risk of death compared to an individual that has localized disease. Clinical presentation can include hormonal symptoms, and that’s more often the case for small bowel and any tease. This could be diarrhea,
wheezing and flushing, and sometimes the patients could have valves are right sided valvular disease which can lead to heart failure.

Increase your under. Consumers are important. They’re at their often nonfunctional in cases of metastasis.

The goal for the arguments supporting surgery for metastatic any teas are the first in the important thing is to control the tumor burden and by respecting ones metastatic neuroendocrine tumors.

The progression free survival improves the patients as a whole and you know
the literature can show five year overall five year survival up to 74%. That’s overall survival, but the important thing to understand is there’s a high risk of recurrence. Despite that kind of an approach, so even though I’m talking about 5 year old roll survival, if 74% the recurrence rate is nearly is over 80%. But there is benefit to doing this because it can provide effective symptom control, particularly for functioning tumors. It could prevent or delay the
01:05:03.667 --> 01:05:05.399 sequelae of carcinoid syndromes.
NOTE Confidence: 0.876315255
01:05:05.400 --> 01:05:07.435 It can improve one’s performance
NOTE Confidence: 0.876315255
01:05:07.435 --> 01:05:08.656 status and pain,
NOTE Confidence: 0.876315255
01:05:08.660 --> 01:05:11.516 and this is the case more for
NOTE Confidence: 0.876315255
01:05:11.516 --> 01:05:12.994 nonfunctioning tumors and the number
NOTE Confidence: 0.876315255
01:05:12.994 --> 01:05:14.808 has shifted us to the number of the
NOTE Confidence: 0.876315255
01:05:14.808 --> 01:05:16.664 percent of tumor that we’d like to site,
NOTE Confidence: 0.862897105555556
01:05:16.670 --> 01:05:17.465 or reducing individual.
NOTE Confidence: 0.862897105555556
01:05:17.465 --> 01:05:19.055 And there was a time where.
NOTE Confidence: 0.862897105555556
01:05:19.060 --> 01:05:20.670 We used to think more along the
NOTE Confidence: 0.862897105555556
01:05:20.670 --> 01:05:22.665 lines of 90% but more recent
NOTE Confidence: 0.862897105555556
01:05:22.665 --> 01:05:24.840 literature has suggested that that
NOTE Confidence: 0.862897105555556
01:05:24.840 --> 01:05:26.957 number might be closer to 70%.
NOTE Confidence: 0.862897105555556
01:05:26.960 --> 01:05:28.800 Reduction of the tumor burden,
NOTE Confidence: 0.862897105555556
01:05:28.800 --> 01:05:30.228 and it’s important if one can
NOTE Confidence: 0.862897105555556
01:05:30.228 --> 01:05:31.940 have this kind of cytoreduction,
01:05:31.940 --> 01:05:33.935 and we usually try to remove the primary tumor in the regional disease.

01:05:33.935 --> 01:05:35.785 In this 70% number that I mentioned.

01:05:35.785 --> 01:05:37.872 But even if one does not have their primary tumor that's identified.

01:05:40.503 --> 01:05:42.187 One can still consider a cytoreductive surgery if greater than 70% of the disease burden that's clinically present can be addressed.

01:05:53.543 --> 01:05:54.419 And extrahepatic disease is not a contraindication to the surgical site or reduction.

01:05:57.110 --> 01:05:59.672 The tools that we use in surgical oncology for Cytoreduction, and I'm focusing a little bit more.
on the liver because I'm very biased towards the liver and, uh, I like operating the liver and then this ends up being the most one of the most common sites for the most common cited medicine disease. For any tease, we often will try to do what's called prank while sparing resections, because, as I mentioned before, many of these patients were occur and they can have a longer survival, and they can recur in the liver, so we try to do prank whispering resections. Impossible understanding that. Well, if there's another recurrence down the road,
it can allow the patient for a second liver operation or liver directed therapy down the road. But sometimes we do need to perform major head protect me as given the distribution of the testis is sometimes we consider a microwave ablation where we put a probe into the center of the tumor or sometimes our interventional radiology colleagues who are very adept at doing that can do that as well too. And if they can do it in the last invasive fashion, that’s always. Investing for the patient and surgical
site or rejection should be attempted
when it’s anatomically feasible and it can be performed with a low morbidity.
So I’ll end with a patient example, and this is a 62 year old male who, when I had seen him,
was five years after the status posted, dissipated protect me for nonfunctioning tankers or under consumer one of his smile.
Medical oncologists was surveying and and identified enlarge.
And this doesn’t show everything, but this is a patient that had three tumors when we had seen him,
one in the left lateral liver,
one in the left medial liver,
and then one in the right liver.
And then we went ahead and we actually needed to do a major liver section for the left side, and apparently sparing resection on the right side to clear all of the disease.
And we did a cholecystectomy in this case as well too, and the pathology revealed for neuroendocrine tumors, which were identified in the liver, which were well differentiated.
So the surgical manager of papers at
small bowel neuroendocrine tumors, the incidence is rising. Section of primary neuroendocrine tumors. This clinical benefit and we’ve shown that, and I’ve shown that the pancreas for under consumers those non functioning, functioning and for small V al any teas and finally surgical site of reduction for metastatic. Any tease has clinical benefit at greater than 70% of the tumor burden. Which percentage. OK, thank you for your time. Thank you to doctors appointment and con. Those were both great presentations, so I think what we’ll try to do is
01:08:48.810 --> 01:08:50.544 tackle some of the questions that have come through the chat and I also have some questions for the two of you and we can have a conversation.

01:08:56.290 --> 01:09:00.586 So one of the first questions that came through is I think this was in reference and Doctor Boy and maybe I'll direct this to you.

01:09:00.586 --> 01:09:03.061 Is can the Ludo dictate treatment? PR T if it started early I'm can we achieve cure from this? And particularly if the cancer load is low, that's I think aspirational, but I will allow you to maybe comment some on that.

01:09:04.363 --> 01:09:05.987

01:09:05.990 --> 01:09:11.640

01:09:11.640 --> 01:09:16.440

01:09:16.440 --> 01:09:23.288

01:09:23.288 --> 01:09:27.180

01:09:27.180 --> 01:09:28.616

01:09:28.616 --> 01:09:30.088
What are the goals of treatment and in what setting do we typically use it? Yeah, this is a really great question now. The indications for which PRT is being used for right now is for well differentiated tumors, and when we do the therapy majority of the tumors actually do not decrease in size, but it does slow their growth, so there's significant improvement in progression. Free survival. So no, this is not a cure, but it does improve symptoms and improve survival. In patients. So that's for the lutetium. We still have a lot of other therapies in in...
the pipeline that we’re still evaluating,

but the goal is not cure. The goal is extension of life and improvement of symptoms.

Thank you, there was another question that I think perhaps Doctor Khan can answer.

So and I think you addressed this a little bit in the course of your surgical indications, but maybe you can address that some. Yes, yeah, so that’s not an uncommon scenario.
Back spoons, and that’s very good question.

And you know it is all worth it to look for the primary tumor and do a thorough exhaustive look for the primary tumor. However, the primary tumor cannot be found.

There is benefit towards some. If a patient has a resectable metastatic disease, which could be said or reduced to over 70%, and the morbidity is is not very high.

Uh, I would still recommend consideration for surgical cytoreduction because of the improvement in professional free survival.

And I’ll just comment this. You know, entity of unknown primaries is
certainly something that we come across, although I will say I think that’s less in the era of gallium 68 PET scans. I think we are often identifying the primary a little bit more easily with better imaging so, but we do still see that I have a couple of questions actually there. I think there is one more in the Q&A from the audience, so this is something. Maybe I’ll tackle first, but would welcome comments from my partners.

Here, so some cancers, even lung adenocarcinomas,
had endocrine secretion.

How can we treat that?

I didn’t personally spend a lot of time talking about how we treat hormone control, but I think for certainly for many patients with neuroendocrine related hormones secretion we the mainstay is really using somatostatin analogs. First they were approved on the basis of controlling hormones, specifically carcinoid syndrome, which is diarrhea and flushing. They are also indicated in some other forms of hormones secretion, including gastrinomas and others. But we also try to PSI to reduce or
01:12:41.069 --> 01:12:44.040 kind of reduce the bulk of the tumor,
01:12:44.040 --> 01:12:46.932 either through surgery as Doctor Khan
01:12:46.932 --> 01:12:48.816 indicated or other systemic treatments
01:12:48.816 --> 01:12:51.559 that have the ability to shrink the tumor.
01:12:51.560 --> 01:12:54.710 So cytotoxic chemotherapy can do that.
01:12:54.710 --> 01:12:56.492 Doctor Khan, I think, spoke about
01:12:56.492 --> 01:12:58.880 some of the like oblalated procedures.
01:12:58.880 --> 01:13:00.903 We often we didn’t talk tonight a
01:13:00.903 --> 01:13:03.019 lot about liver directed treatments,
01:13:03.020 --> 01:13:05.642 but I think that when patients
01:13:05.642 --> 01:13:07.136 have secretion of hormones,
01:13:07.136 --> 01:13:08.544 we really it’s tricky.
01:13:08.550 --> 01:13:10.632 Because we need to think about
01:13:10.632 --> 01:13:12.448 both managing the hormones and
NOTE Confidence: 0.93715871
01:13:14.372 --> 01:13:16.220 can you have any other comments on that?
NOTE Confidence: 0.891338747777778
01:13:17.380 --> 01:13:20.098 Yeah, I know, I think those are why you
NOTE Confidence: 0.891338747777778
01:13:20.098 --> 01:13:23.019 know if if if an individual has a patient.
NOTE Confidence: 0.891338747777778
01:13:23.020 --> 01:13:25.252 If a if a provider has a patient with,
NOTE Confidence: 0.891338747777778
01:13:25.260 --> 01:13:27.410 you know neuroendocrine tumor general,
NOTE Confidence: 0.891338747777778
01:13:27.410 --> 01:13:28.815 but in this specific scenario
NOTE Confidence: 0.891338747777778
01:13:28.815 --> 01:13:30.709 it’s good to have them evaluate
NOTE Confidence: 0.891338747777778
NOTE Confidence: 0.891338747777778
NOTE Confidence: 0.891338747777778
01:13:33.354 --> 01:13:36.096 I’m not saying everyone needs surgery
NOTE Confidence: 0.891338747777778
01:13:36.100 --> 01:13:38.530 and sometimes systemic options are
NOTE Confidence: 0.891338747777778
01:13:38.530 --> 01:13:40.960 much more effective at controlling
NOTE Confidence: 0.891338747777778
01:13:41.033 --> 01:13:43.638 these symptoms than surgical options.
NOTE Confidence: 0.891338747777778
01:13:43.640 --> 01:13:45.481 And and I think that’s why you
NOTE Confidence: 0.891338747777778
01:13:45.481 --> 01:13:47.674 know an active discussion by a
multidisciplinary tumor board.

Is it very beneficial for the patient, but you know if one is able to control you, know a high burden of disease like I threw the number of 70% out there. That’s for surgical literature. But I don’t know if this is true or not, but perhaps that would be true for non-surgical approaches as well. And I think if we’re able to address the source of where the hormones are being separated from, we could probably really provide some good clinical abilities to our patients.
Right, right now I agree.

Good doctor Brian.

I have a question that comes up almost in many of my patient interactions and also when I’m teaching trainees. This actually just came up yesterday. How do we interpret SUV on Gallium 68 PET? Should we pay attention to it? Is it different than how we think about FDG PET? Oh yeah, that’s a great question. It’s a we can give a whole lecture tracer uptake, so I would think too. I do recommend, so it’s a. It’s a general unit of Tracer.
01:14:54.762 --> 01:14:56.387 update that’s generalized


01:14:58.700 --> 01:15:00.430 But the the big issue?

01:15:04.760 --> 01:15:07.704 Hope we lost Doctor Abovan there for a

01:15:07.704 --> 01:15:09.480 moment. So hopefully she will be back.

01:15:09.480 --> 01:15:11.650 I can text her, we technical issues.

01:15:13.120 --> 01:15:14.400 Related to the tax, there will be a

01:15:15.140 --> 01:15:16.540 doctor boy and we lost you for

01:15:16.540 --> 01:15:18.955 just a minute. Maybe you can

01:15:18.955 --> 01:15:20.730 repeat the last portion of that.

01:15:21.500 --> 01:15:24.076 Oh sorry, I was having Internet connectivity

01:15:24.076 --> 01:15:26.556 issues so so in terms of that SUV is

01:15:26.556 --> 01:15:29.230 it’s a it’s a way to measure tracer


01:15:31.620 --> 01:15:35.420 And it is a semi quantitative that measure.
Now there’s a whole field of quantitative PET that requires very complex mathematical modeling. And here at EO, under the guidance of Doctor Rich Carson, their leaders, they go pet center in quantitative PET imaging and we’re still trying to figure out how to apply to clinical practice because it’s not used in clinical practice. But as UV is kind of a poor man’s approach to try to quantitate so it’s a semi quantitative measure, but I would really focus on looking at the CVS within a specific tracer.
01:16:10.582 --> 01:16:11.857 SUV values only,


01:16:14.780 --> 01:16:16.530 Don’t compare them between gallium dotate and don’t talk or gallium dotate,

01:16:16.530 --> 01:16:19.304 and if you’re so,

01:16:19.304 --> 01:16:21.136 if you have a patient that’s being imaged with MTG pad,

01:16:21.140 --> 01:16:22.958 then you can compare the SUV values.

01:16:22.958 --> 01:16:24.480 if you have a patient that’s significantly so supposedly lost a lot of weight in between the scans,

01:16:24.480 --> 01:16:27.980 then you have to be really careful

01:16:27.980 --> 01:16:30.330 But if you’re patient change

01:16:30.330 --> 01:16:32.200 significantly so supposedly lost a lot of weight in between the scans,

01:16:32.200 --> 01:16:34.800 then you have to be really careful

01:16:37.490 --> 01:16:39.795 and usually in nuclear medicine

01:16:39.795 --> 01:16:42.100 when we do the reports,

01:16:42.100 --> 01:16:43.655 we do mention the numbers
’cause everybody wants some.

Connotation, but we do try to use language as well because it’s it’s a semi quantitative analysis.

Thank you, yeah that’s helpful.

Doctor Khan I have a question that comes up a lot in tumor board. You know, I think I’d love to hear from you of. Are there situations or notable situations where you’re like? Gosh, I really wish I saw this patient earlier, like when?

When should medical oncologists or surgeons in the community be thinking about surgery?
When should it be on their radar? I’d say specifically for metastatic disease. OK, you know the first. Maybe I can also answer one about non metastatic disease. Some you know. I think if one identifies a hypervascular mesenteric mass, I would consider sending it to one of the surgical oncology, or at least one of the general surgeon to evaluate for it, because you know, every so often we do see a patient that
01:17:47.942 --> 01:17:50.557 has had this followed a cross sectional
NOTE Confidence: 0.842575879166667
01:17:50.557 --> 01:17:52.651 imaging and then presents with you
NOTE Confidence: 0.842575879166667
01:17:52.651 --> 01:17:55.014 know some sort of a problem with the.
NOTE Confidence: 0.842575879166667
01:17:55.020 --> 01:17:56.680 Primary small bowel related issue.
NOTE Confidence: 0.842575879166667
01:17:56.680 --> 01:17:59.040 Whether it’s this kimia infarct
NOTE Confidence: 0.842575879166667
01:17:59.040 --> 01:18:00.714 or balance truction and then it
NOTE Confidence: 0.842575879166667
01:18:00.714 --> 01:18:02.840 becomes more of an emerging problem.
NOTE Confidence: 0.842575879166667
01:18:02.840 --> 01:18:04.478 And it’s something that I probably
NOTE Confidence: 0.842575879166667
01:18:04.478 --> 01:18:06.644 could be less of a bigger operation
NOTE Confidence: 0.842575879166667
01:18:06.644 --> 01:18:08.660 for metastatic disease as well too.
NOTE Confidence: 0.842575879166667
01:18:08.660 --> 01:18:09.718 So actually,
NOTE Confidence: 0.842575879166667
01:18:09.718 --> 01:18:13.421 the last patient I presented was being
NOTE Confidence: 0.842575879166667
01:18:13.421 --> 01:18:16.536 followed for awhile because the the
NOTE Confidence: 0.842575879166667
01:18:16.536 --> 01:18:19.605 tumors were were visible and I had
NOTE Confidence: 0.842575879166667
01:18:19.605 --> 01:18:22.090 given a talk on liver metastasis about.
NOTE Confidence: 0.842575879166667
01:18:22.090 --> 01:18:24.136 You know around that time and
then the individual who. Caring for that patient was didn’t realize that surgical options and options for that patient, so I think if a patient is known to have a neuroendocrine tumor and perhaps present was the liver metastases, I think it’s worth it for that patient to be seen by GI medical oncologist or surgical oncologist. Because I do think that we can provide a good progression free survival benefit for most patients in that kind of a scenario. If with a good multidisciplinary approach.
Great thank you and doctor Brian.

Maybe I’ll ask you one one more and sort of.

I’d say a really exciting direction

and something you and I are partnering on is really thinking

Can you speak to how you think the field is changing and how we are likely to see

is changing and how we are likely to see

the development of theranostics programs?

Sort of in multiple locations,

but maybe the value of that.

What that means and and sort of how

nuclear medicine docs are going to be.

Providing direct patient care.

Oh, thank you. Yes,

this is a very exciting field and
I just came back from Society of Nuclear Medicine and Molecular Imaging Therapeutics conference where we met for several days and talked about how different sites across USA are starting the theranostics centers and their layout plans and how they’re going to be treating the patients. And this is really changing. We are now going back to senior patients. We’re now we’re now becoming. Parts of teams with oncologists and surgeons and really practicing together and with radiation oncology as well.
we're really practicing together as a team in terms of taking care of patients. There's sites where patient is being seen by their GI oncologist and followed up by a visit with nuclear medicine Doc to discuss PRRT and the specifics of radiation based therapy radionuclide. Therapy and that really helps patients in terms of understanding what they're going to be undergoing and their side effects and the risks. The nuclear medicine physicians are following up on the patients and are involved in in the care. So another thing that's really helpful is that we're starting to combine
chemotherapy with radionuclide therapy and trials and trying to see how we can improve the efficacy of these therapies. And the only way to do it is to work together. So it’s a really exciting team based approach that’s happening across the country and it’s really gonna change radiology and how we care for our patients. Not very exciting, I think. Lots of opportunities for asking for really good patient care and I think you know one thing we can speak to is really
the importance of multidisciplinary care for the care of these patients. I think the intent was to have three different disciplines represented on this panel tonight and I think we all certainly work together and caring for our patients with Nets. So I think what we can do is I don’t see other. I don’t know if Doctor Boyd or Doctor Khan you had any other burning questions for each other. Doctor Khan you had any other. If not, I really want to thank the two of you. Certainly for your time and excellent presentations,
I want to thank our audience for their time and listing tonight.

This will be recorded, so we will make this available to the Community and stay tuned for our future GCM E series in April and May.

We will promote those and hope that some of you will listen again.

So thank you and have a wonderful evening.