Good afternoon, everybody.

Thank you all for coming.

It’s my really true pleasure to introduce Sherry Dimas today.

Sherry is a world’s expert on treatment of gynecologic malignancies and you know.

We I’m not just throwing that those words around.

She really is a leader,

and we’re so lucky to have her here at Yale University.

Sherry trained at Cornell and then did her residency at Memorial Sloan

1
Kettering and joined us 11 years ago.

She's now professor of therapeutic radiology, and she. It built our HDR brachytherapy service here at Yale, which is really an incredible accomplishment.

So today she's going to be speaking to us about advances in treatment of cervical cancer and welcome Sherry.

Thank you so much, Joe, for that very kind introduction and for that very kind introduction and it's really an honor to be here. So as you heard, I direct the gynecologic radiotherapy program here at Yale and today I'm going to be talking about brachytherapy and
the treatment of cervical cancer, how we approach these patients and specifically the supportive and innovative programs that we have here at Yale for this unique patient population. And they have no financial disclosures. So cervical cancer is a global health problem. Worldwide, there’s more than 600,000 new cases per year and more than 340,000 deaths in 2020. And it’s particularly a problem in resource limited countries where it’s a very common type of cancer and a very common cause of cancer mortality.
And in certain regions of Africa and Central America, it’s actually the leading cause of cancer related mortality. And unfortunately this is a cancer that disproportionately effects women in low socioeconomic groups and there are complex challenges for these women at every step in the cervical cancer continuum. In the United States, there’s more than 14,000 new cases per year and more than 4000 deaths expected in 2022. The highest incidence is among US Hispanic, black and Native American populations.
This is a cancer of young women. It is most frequently diagnosed in women ages 35 to 44. And as we all know, HPV is central to the development of cervical cancer. It causes more than 95% of cases. Risk factors include various sexual behaviors, including young age at first coitus, multiple sexual partners, history of STI's. It’s also more common among those with a compromised immune system. So fortunately, screening cervical cytology and...
HPV testing has led to reductions in cervical cancer mortality, particularly in resource rich settings.

And the incidence of cervical cancer is affected both by epidemiologic risk factors as well as by having access to screening programs.

So for those who are screened, cervical cancer may be discovered asymptomatically and very early stages, for example because of an abnormal pap smear or if you know a visible lesion is discovered incidentally on a pelvic examination. But these are not the patients that I see in my practice.
So the types of patients that I might see in my practice are typically, let’s say, a young woman in her 30s or 40s who has a very advanced cancer that’s highly symptomatic. And she’s probably had bleeding and pain going on for some time. She’s perhaps bounced around between different emergency departments and different hospitals, misdiagnosed with fibroids or infection, and she’s often from an underserved community. She is often suspicious of the medical student of the medical system.
and has not had routine screening.

She may even be suspicious of a GYN exam, perhaps a history of abuse or trauma in her past and often life hasn’t treated her well, and now she’s hit with this. What do I mean by this? So this is locally advanced cervical cancer. That’s when the tumor has grown to be clinically visible more than 4 centimeters. It invades beyond the cervix into the parametrial tissues. It can extend out to the pelvic sidewall, down into the vagina, can also extend into the surrounding structures of the pelvis,
Including the bladder or the ****.

And for these patients, the primary treatment is not surgery, but rather these patients are treated with chemo, radiation and brachytherapy.

The paradigm for treatment is shown here and what I’m showing on the horizontal line is the time frame of treatment. So we try to get all of the treatments done within eight weeks. So for the first five to six weeks of treatment, the treatment consists of external beam radiation, which is what I’m going to show you.
These arrows can note weekly cisplatinum chemotherapy, which has been shown in randomized trials to improve the overall survival in this population. So the first five to six weeks are chemo radiation. That is followed by brachytherapy, which I’m going to talk about today. And again, all these treatments we tried to complete within eight weeks, studies have shown that. Sending treatment beyond eight weeks is associated with a reduction in tumor control and worse outcomes.
I think many of you here are familiar with external beam radiation, also called evart. The patient comes every day to our department for five days a week. For five weeks she lies on a table that looks like this. This is called a linear accelerator that delivers high energy X-rays from the outside into a very carefully designed target like what you see here. And this is a target that’s designed to incorporate the pelvic tissues that are involved, any lymph nodes that are...
involved in the pelvis, as well as the periaortic region, which is a common area that’s involved with cervical cancer. And specifically with MRT, we’re able to deliver a very carefully designed field to the areas that are at risk and give much lower dose to any of the surrounding structures in the pelvis through a very carefully modulated beam. Again, we’re avoiding the bowel, the spine, the kidneys, the bone and the muscle. So we’re able to deliver this.
type of treatment with much less toxicity than in the olden days.

Another advantage of IRT using the modulated beams is we’re able to deliver a high dose to the pelvic lymph node regions and deliver a dose of approximately 60 Gray while giving simultaneously a much lower dose to any of the surrounding tissues in the pelvis.

But for cervical cancer, what’s unique is that external beam radiation alone is not enough.

The second-half of their treatment is delivered with brachytherapy,
also called internal radiation,
where we have to deliver a much higher dose to the central tumor,
really a dose of about 90 Gray.
really the only way to do this is from inside the tumor,
not from outside.
So brachytherapy involves placing radioactive source and direct contact with the tumor to kill the rapidly dividing cancer cells that are surrounding it and cervical cancer.
This is done by placing a rod inside the uterus and a ring type structure in the vagina.
And through these applicators,
Whether they’re plastic or metal, we’re going to deliver a radioactive source that’s going to do well in these applicators. And therefore deliver a much higher dose to the tumor and in doing so with a very steep dose gradient going to give a much lower dose to any of these surrounding tissues. So unlike other types of cancers where brachytherapy is seen as an option, but there are other similar efficacious options like asperity and protons and cervical cancer, that’s not the case.
There is no substitute for brachytherapy because these other modalities don’t allow us to achieve that very high steep dose gradient that I mentioned.

But the thing about brachytherapy, it’s different than external beam, it’s interventional and it requires technical skill, but also specialized resources, different equipment, special applicators, and so not everywhere has it.

Is this a study from 2013 from a 2013 database which looked at cervical cancer patients with locally advanced disease who were treated...
00:07:42.145 --> 00:07:43.540 with brachytherapy compared to those that did not receive brachytherapy.

00:07:44.808 --> 00:07:46.783 And you can see that the cause specific survival as well as the overall survival is significantly improved among those that had brachytherapy?

00:07:53.140 --> 00:07:55.460 This is a similar study from the NCDB in 2014, again more than 7000 locally advanced cervical cancer patients.

00:07:55.460 --> 00:07:57.670 And specifically asked the question is there how do patients who receive a different form of treatment to escalate those to the cervix such as SPRT, IRT compared to those who have brachytherapy.

00:08:00.960 --> 00:08:03.307 And again you can see that the
Women that have brachytherapy have a significantly improved overall survival.

So here at Yale, I'm very proud to work with the dedicated team who assure highly coordinated and interdisciplinary care for these women.

These pictures are just an illustration of some of the people who might help with any of these cases on a given day.

We work very closely with nurses in the, in the OR in the pacu.

We work with the technologists in the MRI suite within our own department.

We have dedicated dosimetrist,

we have radiation therapists who are intimately involved in our cases,
dedicated nursing staff, physics, and we have faculty. Within our own department, as well as faculty within the Joanne Oncology department that we work very closely with, for all of these cases, we work with coordinators, administrative assistance, nurses, residents, fellows from all these different departments listed here. These folks are not only committed to delivering high quality brachytherapy with safety and excellence, but what stands out to me is the
compassion that they show and caring for the whole patient and understanding that this is a unique population. A treatment that can be painful, upsetting or even traumatic for patients and requires a recognition of that as well as an interpersonal touch. The good news that I'm going to share with you today is that there has been tremendous technological advances in the field of brachytherapy over the past 10 to 15 years, and I am grateful for the support of my department, the hospital and the Cancer Center for recognizing the
benefits that these provide.

Today what I'll be talking about is how brachytherapy evolved to modern MRI guided adaptive technique.

I'm going to discuss the role of 3D printing and innovation and directions for future.

I'm going to discuss training the next generation of brachytherapy providers with simulation based education.

And finally, I'll discuss the resources that we have here at Yale to help assure that these women go on to live normal lives after cancer treatment, given the challenges and potential morbidities, sexual and otherwise.
that can be associated with such treatments.

So how did we get here?

So one of the things that drew me to the field of radiotherapy was the technological advancements.

And while that’s for sure true and well known within our external beam treatments and MRT, it hasn’t always been the case with brachytherapy.

So there was a period of about four or five decades, I would say between the 1960s and early 2000s were brachytherapy really looked like this.

It was kind of the same.
This is called an intrauterine tandem that was placed inside the uterus, inside the operating room and this is called a vaginal ovoid. And two of these would be placed on either side of the cervix. We would do this under anesthesia while the patient was in the operating room to surround. These are metal applicators that would surround the cervix. They would get packed into place and we would take an image of these applicators through these.
Replicators.

We would then load cesium sources to give off a cloud of radiation.

So cesium sources came in different strengths and our physicists would figure out how much cesium and where inside these applicators to place them to create a symmetrical pear shaped distribution that looks like this.

So we had mathematical formulas and lots of decades of data to know what type of dose we needed to get to these different points in relation to the applicators to achieve good outcomes local control of about 75%.

In the mid 2000s things began
improving in the planning,

optimization and treatment delivery.

We had newer applicators that were compatible with an HDR source.

So basically the applicators, they were kind of the same idea tandem.

This is called a ring which sits in the vagina,

but after placing it, packing it,

designing radiation plan rather than having a patient have to stay in the hospital.

So with cesium the patients would be admitted.

In order to give off the dose cloud that was necessary,
the patient would have to be admitted to the hospital for 48 to 72 hours. With a decaying radioactive source inside of them. The benefit of an HDR source which is Iridium, is that the same treatment can be delivered in a course of about 10 minutes and it can be done in an outpatient setting in a brachytherapy suite. So we could place the applicators, design the radiation plan and treat them in a breakey therapy suite over a period of about 10 minutes. Once the treatment was done they could go home.
Another benefit of the applicators is that rather than just imaging them with a plain film, they were CT compatible. So that allowed us to not only see the applicators but actually see the nearby organs, the sigmoid bladder, the bowel, and we were still aiming for that symmetrical pear shaped distribution, but we were able to optimize the dwell times and sort of shrink the dose, and therefore give much lower...
dose to the surrounding organs.
And it turns out that had a big benefit.
This was shown in the stick trial
which was a prospective but not
randomized trial of about 800 women
with locally advanced cervical cancer.
And basically compared those that had
the film based treatments to those
with CAT scan based treatments,
SO3 dimensional seeing the organs.
And you can see that local control
in both groups was very good,
in both groups was very good,
about 75% like I mentioned.
But the main advantage of switching
to 3/3 dimensional imaging was
there was a significant decrease
NOTE Confidence: 0.825945304
00:13:06.257 --> 00:13:07.840 in grade three to four toxicity.
NOTE Confidence: 0.825945304
00:13:07.840 --> 00:13:09.322 So in the film based era
NOTE Confidence: 0.825945304
00:13:09.322 --> 00:13:10.310 the likelihood of having.
NOTE Confidence: 0.825945304
00:13:10.310 --> 00:13:11.010 You know,
NOTE Confidence: 0.825945304
00:13:11.010 --> 00:13:12.410 bowel obstruction and perforation
NOTE Confidence: 0.825945304
00:13:12.410 --> 00:13:14.412 bleeding fistula was about 20 to 25%
NOTE Confidence: 0.825945304
00:13:14.412 --> 00:13:16.828 whereas once you see your organs and you,
NOTE Confidence: 0.825945304
00:13:16.830 --> 00:13:17.646 you know,
NOTE Confidence: 0.825945304
00:13:17.646 --> 00:13:19.686 optimize your your beam accordingly.
NOTE Confidence: 0.825945304
00:13:19.690 --> 00:13:21.184 Now the likelihood of grade 3
NOTE Confidence: 0.825945304
00:13:21.184 --> 00:13:22.730 or 4 toxicities only two to 3%.
NOTE Confidence: 0.825945304
00:13:22.730 --> 00:13:23.810 So that was a big advantage.
NOTE Confidence: 0.768999615555556
00:13:26.130 --> 00:13:27.672 The next advancement came in the
NOTE Confidence: 0.768999615555556
00:13:27.672 --> 00:13:29.230 mid 2000 tens, really pioneered in
NOTE Confidence: 0.768999615555556
00:13:29.230 --> 00:13:30.790 Europe by a group of researchers
NOTE Confidence: 0.768999615555556

29
known as the embraced trialists. And what they sought to do is to incorporate MRI to improve the way we do brachytherapy and to improve local control. And really this group created a renaissance in the cervical brachytherapy community by incorporating MRI into treatment planning. So MRI has always been an important diagnostic imaging modality for cervical cancer. We always get an MRI up front at the time of staging to help determine the local extent of the tumor, if there’s any involvement of the vagina.
the uterus, the parametrium, the surrounding structures. And even in the LDR era, we would often get a pre brachytherapy MRI after about five weeks of radiation. This is a rapidly growing tumor, so it responds rapidly to radiation. It can shrink by about a centimeter per week. So getting an MRI before brachytherapy would give us information about how much of the tumor is left and also the dimensions of the uterus prior to going to the operating room. But the embrace trial took it one step further and said we could design
applicators that are MRI compatible. We can do the procedure like we’ve done place the applicators but now instead of going to CAT scan we can go to MRI and that now we can actually see the cervix in relation to the applicator and see the tumor in relation to the applicator and change the way that we prescribe radiation different from how we’ve done it for decades. So I mentioned for decades we were looking for this type of pear shaped distribution aiming to get radiation to a certain point from the applicators but with this. Anyway,
they through they designed very carefully thought out and develop principles to allow us to deliver dose to the residual cervix and the remaining tumor as seen on MRI. So lots of institutions began adopting this approach and they presented their retrospective outcomes. And you can see here that there was significant improvement in local control when you look at these individual institutional studies looking like local control was now about 90% or higher. So this looked really good and still very low toxicity.
The embrace trialists went on to develop a series of prospective studies following over 1000 women and collecting patient reported outcomes and validated toxicity information, looking not only how to optimize the way that we prescribe the dose to the tumor, but also seeking to reduce any treatment related morbidity and how to optimally constrain the dose to the normal tissues. And they put out very high impact papers showing us how we could monitor the dose to the rectal morbidity. How to decrease dose of the bladder.
and keep the bladder morbidity low. And they even put out data for how to limit dose to the vagina to produce less vaginal toxicity for these patients.

So with all of this mounting evidence here at Yale, we were able to establish an MRI based program at around 2016 or 2017. And in order to have an MRI based program you need to have access to an MRI. So some radiation departments have an MRI simulator in their department. We do not. So like others we partner with the MRI that’s available in our diagnostic imaging suite.

You need to invest in MRI safe applicators,
you need to meet with our radiology colleagues to develop proper sequences and protocols for imaging and you have to study the concepts, these new concepts. From the get Castro and embrace how to do these target volume delineation, you have to invest in an MRI safe transport system because you're placing applicators in the operating room and now you're taking them to the MRI. You have to have trained staff and you have to have integrated MRI safety procedures, patient questionnaires and procedural checklists.
So all of this, this has been our standard way for treating cervical cancer patients for the past six or seven years. And this is what in modern MRI intracavitary tandem and ring plan might look like. You can see that the dose is very concentrated on the cervical tissue due to the physical proximity of the source to the tumor. There’s a very steep dose gradient. So none of this high dose is going to any of these surrounding organs. This looks a little bit different.
than the old fashioned film and point based plans that I showed you. But I will mention here that because of the sort of simplicity of the applicators tandem and ring, you still have a symmetric dose distribution. But the more you start visualizing your tumors on MRI, the more you realize that not every tumor is symmetric and also not every tumor is going to be perfectly covered by one of these symmetric dose distributions. So depicted here in blue is a tumor and in red is the 100% dose that I'm trying to give.
And you can see that they’re aspects of this tumor in blue that are extending outside of the red. So that is with sort of pushing our dose the best that we can with our intracavitary applicator, whereas an ideal coverage depiction might look like this where the entire tumor is covered in the red. So it turns out that if you take your standard intracavitary applicator and you add what are called interstitial needles that look like this thin plastic needles. tandem and ring and you add what are called interstitial needles that look like this thin plastic needles.
00:18:15.708 --> 00:18:17.347 needles into the tumor to the parts
NOTE Confidence: 0.832564517
00:18:17.347 --> 00:18:18.769 of the tumor that are extending
NOTE Confidence: 0.832564517
00:18:18.826 --> 00:18:20.308 beyond the boundaries of what you
NOTE Confidence: 0.832564517
00:18:20.308 --> 00:18:22.022 would expect to be covered with
NOTE Confidence: 0.832564517
00:18:22.022 --> 00:18:23.466 a standard intracavitary plan,
NOTE Confidence: 0.832564517
00:18:23.470 --> 00:18:24.570 then you could significantly
NOTE Confidence: 0.832564517
00:18:24.570 --> 00:18:25.670 improve the dose coverage.
NOTE Confidence: 0.909349757
00:18:27.900 --> 00:18:30.182 And this is the birth of the
NOTE Confidence: 0.909349757
00:18:30.182 --> 00:18:31.160 so-called hybrid approach,
NOTE Confidence: 0.909349757
00:18:31.160 --> 00:18:32.936 which is basically that it’s saying,
NOTE Confidence: 0.909349757
00:18:32.940 --> 00:18:34.571 it’s saying that for tumors which you
NOTE Confidence: 0.909349757
00:18:34.571 --> 00:18:36.564 know are larger and might not be well
NOTE Confidence: 0.909349757
00:18:36.564 --> 00:18:37.814 covered with an intracavitary plan,
NOTE Confidence: 0.909349757
00:18:37.820 --> 00:18:39.980 you can add a couple of needles and
NOTE Confidence: 0.909349757
00:18:39.980 --> 00:18:41.759 thereby improve the dose coverage and
NOTE Confidence: 0.909349757
00:18:41.759 --> 00:18:43.860 more and more places started doing this.
In fact vendors came up with hybrid applicators that look like this. So again like a tandem and ring, but within the ring applicator there are holes that allow you to thread interstitial needles. So an example of the benefit of this approach is illustrated here. This was a young woman with a very large cervical tumor, stage 3B invading into the left pelvic sidewall. She had a very large tumor that responded well to external beam radiation, but she still had a significant
00:19:09.700 --> 00:19:11.184 amount of tumor that was present
NOTE Confidence: 0.909349757
00:19:11.184 --> 00:19:12.479 at the time of brachytherapy.
NOTE Confidence: 0.909349757
00:19:12.480 --> 00:19:14.040 If she were to be treated
NOTE Confidence: 0.909349757
00:19:14.040 --> 00:19:14.820 with Intracavitary alone,
NOTE Confidence: 0.909349757
00:19:14.820 --> 00:19:16.800 you would have this circular symmetric
NOTE Confidence: 0.909349757
00:19:16.800 --> 00:19:18.520 dose distribution around the tandem.
NOTE Confidence: 0.909349757
00:19:18.520 --> 00:19:20.428 What you can see here is this is covering
NOTE Confidence: 0.909349757
00:19:20.428 --> 00:19:22.056 the anterior aspect of her tumor,
NOTE Confidence: 0.909349757
00:19:22.060 --> 00:19:23.920 but she still has tumor which
NOTE Confidence: 0.909349757
00:19:23.920 --> 00:19:25.160 is sitting laterally and.
NOTE Confidence: 0.909349757
00:19:25.160 --> 00:19:27.750 Posterior to this dose distribution.
NOTE Confidence: 0.909349757
00:19:27.750 --> 00:19:29.451 So what you could do and probably
NOTE Confidence: 0.909349757
00:19:29.451 --> 00:19:31.113 what you should do would be
NOTE Confidence: 0.909349757
00:19:31.113 --> 00:19:32.578 increase the amount of radiation
NOTE Confidence: 0.909349757
00:19:32.578 --> 00:19:34.251 you’re putting in the tantum to
NOTE Confidence: 0.909349757
00:19:34.251 --> 00:19:35.546 better cover the tumor target.
Here you can see now we’re covering that lateral and posterior aspect of the tumor. But because of the nature of these intracavitary applicators are simultaneously increasing dose anteriorly to the bladder and that’s going to result in an increased risk of bladder morbidity. So the benefit of these hybrid applicators is that rather in a case like this, you could thread needles into the lateral and posterior aspect of her tumor, which is what we did. And then you can shape the dose distribution more like this.
00:20:03.680 --> 00:20:05.365 pull that dose posteriorly to
NOTE Confidence: 0.909349757
00:20:05.365 --> 00:20:07.050 cover the target and actually
NOTE Confidence: 0.909349757
00:20:07.112 --> 00:20:08.827 simultaneously reduce the dose going
NOTE Confidence: 0.909349757
00:20:08.827 --> 00:20:11.609 to the bladder and pull the dose back
NOTE Confidence: 0.909349757
00:20:11.609 --> 00:20:13.289 to create this asymmetric target.
NOTE Confidence: 0.815388461875
00:20:15.440 --> 00:20:17.784 So what this graph shows is something that
NOTE Confidence: 0.815388461875
00:20:17.784 --> 00:20:20.256 I think a lot of departments have seen,
NOTE Confidence: 0.815388461875
00:20:20.260 --> 00:20:22.320 but once you introduce MRI,
NOTE Confidence: 0.815388461875
00:20:22.320 --> 00:20:25.896 you suddenly go from IT department where
NOTE Confidence: 0.815388461875
00:20:25.896 --> 00:20:27.466 you’re doing almost no interstitial
NOTE Confidence: 0.815388461875
00:20:27.466 --> 00:20:30.078 procedures to very quickly finding
NOTE Confidence: 0.815388461875
00:20:30.078 --> 00:20:32.163 that about 50% of your cases are
NOTE Confidence: 0.815388461875
00:20:32.163 --> 00:20:36.150 being done with interstitial needles.
NOTE Confidence: 0.891907318
00:20:36.150 --> 00:20:37.970 So I think these days,
NOTE Confidence: 0.891907318
00:20:37.970 --> 00:20:39.086 customizing dose distributions
NOTE Confidence: 0.891907318
00:20:39.086 --> 00:20:40.946 on a per patient basis,
we are doing this more and more.

We’re no longer aiming for that perfect pear shape,

just dosimetry that I showed you earlier and that we did for so many decades.

And maybe this seems simple for those of you in the audience, right, we’re adding needles,

more degrees of freedom.

And yet the truth is there’s a very steep learning curve within the breakthrough therapy community and it does take time for these new concepts to catch on.

And that might be because
by training and by nature, many of us in radiation oncology. Not interventionalists, but also sometimes there's inertia and changing the way that you've done things for decades, and also there's training and resources that are required to invest in these types of new procedures.

So how common are MRI and interstitial? So this is a American breakey therapy practice survey from 2014. So it's a little bit older, but it showed that between 2007 and 2014, MRI use increased to about 34% of practices. So probably nowadays that would be more.
And a 2020 Canadian Practice Survey found that between 2015 and 2020, interstitial use increased. That’s the use of needles increased to about 70% of practices. So more and more places are doing this. But not everywhere and currently we are the only place in Connecticut that does MRI guided interstitial brachytherapy. So we do see a lot of referrals from around the state. This is an example of a 73 year old who had a stage 3A cervical cancer with vaginal involvement. So she was treated with pelvic
radiation and an outside hospital.

But because of the extent of her vaginal involvement, she was not going to be properly treated with intracavitary radiation and so she was sent here for her needle placement, which you can see here in order to better cover this vaginal extent of her disease.

This is a 41 year old from an outside hospital who had a very large stage 4A cervical cancer. It was invading into local organs in the pelvis, but it was also extending very laterally.
So you can see here what her dose distribution looked like. If she were treated with just tandem and ovoids, her dose distribution would be more narrow. So we added needles to extend her dose out laterally to the side walls of the pelvis. This was a woman who had a very bulky cervical tumor that had a lot of bulk and also intrauterine extent at the time of brachytherapy. So she benefited from this Vienna applicator for dose escalation to her tumor. And this is a young woman that had...
had a prior early stage cervical cancer treated with a hysterectomy and developed a vaginal recurrence mainly on the left side of her vagina. She would not have benefited from asymmetric dose distribution, but rather she needed needles preferentially in the left necks of her vagina.

In order to give the proper dose, we realize that with MRI, it’s helpful not just to sort of place everything in the operating room and then go to MRI post facto and what you get is what you get,
but rather to use the MRI, especially for complicated cases to actually help guide the needles. So we do that with iterative T2 sequences. So we’ll bring the patient while they’re under anesthesia to the MRI, place our needles the best we can. And if we need to make adjustments, we’ll advance further deeper into the pelvis. Take another T2 sequence until we’re happy with the needle adjustments. So this is kind of more of an MRI guided approach and in addition to everything that I told you you needed for an MRI based program here.
you also need to have access to an MRI,

excuse me to an anesthesia team available at the MRI which we are lucky to have here.

We need to request extra time in the MRI suite because we’re going to be taking multiple scans.

We need time to make adjustments and this also requires another level of care coordination between the OR anesthesia imaging, pacu, GYN, oncology etcetera.

We reserve these for our most complex cases.

So that is our current state of MRI at this time. And I’ll just mention here
in terms of some research, there's research ongoing at Johns Hopkins led by Doctor Akila Viswanathan, to try to improve the efficiency of the MRI procedure by developing kind of MRI tracking devices that allow you to see the needles as you're placing them in real time. So who knows, maybe this will be the state of the field soon. So all of this time and effort and attention to detail is it worth it. So the data shown here would say that it is especially for the larger tumor targets.
the more importance getting that proper dose is in order to achieve local control. So basically giving covering your tumor better is directly correlated with controlling your tumor better. And another advantage by doing these asymmetric dose distributions and, you know, pulling the dose off of the surrounding tissues as you’re giving a lower dose to the surrounding organs and causing less morbidity. And now all of this has been shown prospectively in the embrace one trial which was published last year in Lancet Oncology which was the first large scale prospective study testing all these.
00:25:33.240 --> 00:25:35.040 concepts of MRI guided brachytherapy.

00:25:36.168 --> 00:25:37.296 It accrued patients from

24 centers in Europe,

00:25:37.300 --> 00:25:39.628 Asia and North America more than

1400 patients between 2008 and

2015 and results were reported at

a median follow-up of 51 months.

00:25:43.008 --> 00:25:44.859 The main finding was that five year

local control was excellent 92%.

Even in the stage three and four tumors,

00:25:50.590 --> 00:25:52.340 What was especially impressive about

these results is that this 92%

local control was not just in the

stage one and two smaller tumors,

00:25:57.570 --> 00:25:59.190 but was true across the board.

00:25:59.190 --> 00:26:00.950 Even in the stage three and four tumors,
these very large and infiltrative tumors
still had excellent local control.
Especially when we think back to the 75%
that we sort of assumed in the olden days.
They looked at overall survival
at five years which was 74%.
There’s no direct comparison,
but by looking back at it
traditional cohorts,
that’s an improvement by almost 7 to 10%.
There was significant reduction
in dose to the surrounding organs,
50% decrease in major morbidities
and five year incidence of a Grade
3 or higher toxicity on a per organ
basis was about 3 to 9%.
So these are all very positive outcomes for our patients. So what comes next? So I mentioned that for decades it seemed like the field of break therapy was a little bit sleepy and there wasn’t much room for change. And yet here we are now in 2023, and I feel like the way we do brachytherapy is ever improving. It’s getting more customized. And part of that is because of 3D printing. As I’ve shown you, every patient and every tumor is a
little bit different and breakey therapy

lets us get up close and personal.

So the better that you do

this on a per patient basis,

the better her outcomes will be.

But unfortunately,

the regulatory system and industry are

not always catching up fast enough.

And although I showed you some of the

modern equipment that we have available,

it can take almost a decade for

a new device to come to market

and to be FDA approved.

And it’s not particularly

profitable for the device companies

because at the end of the day,
it’s just a small group of US specialized users who are doing these treatments. So a lot of the technological advancements nowadays is grassroots and ground up and led by the doctors. And maybe this is fortunate because it’s forcing the people who know the field the best to innovate. So we’re seeing a rising interest in 3D printing for brachytherapy because it allows customization, low cost and convenience. So this was one of the first published examples of a 3D printed customized ring applicator to guide flexible.
00:27:53.973 --> 00:27:55.499 needles into a complex target.
NOTE Confidence: 0.919944976
00:27:55.500 --> 00:27:57.324 So you can see this is a cervical
NOTE Confidence: 0.919944976
00:27:57.324 --> 00:27:58.868 cancer which is extending to the
NOTE Confidence: 0.919944976
00:27:58.868 --> 00:28:00.416 sidewall and also to the vagina.
NOTE Confidence: 0.919944976
00:28:00.420 --> 00:28:02.076 Looking at this case up front,
NOTE Confidence: 0.919944976
00:28:02.080 --> 00:28:03.361 you kind of know this case is
NOTE Confidence: 0.919944976
00:28:03.361 --> 00:28:04.729 going to need at least you know,
NOTE Confidence: 0.919944976
00:28:04.730 --> 00:28:06.898 10 needles or so to properly cover it.
NOTE Confidence: 0.919944976
00:28:06.900 --> 00:28:08.745 So one way is to go to the operating
NOTE Confidence: 0.919944976
00:28:08.745 --> 00:28:10.438 room and freely place these needles
NOTE Confidence: 0.919944976
00:28:10.438 --> 00:28:12.195 and hope that your needles don’t
NOTE Confidence: 0.919944976
00:28:12.195 --> 00:28:14.127 deflect and that they are going to
NOTE Confidence: 0.919944976
00:28:14.127 --> 00:28:15.664 penetrate deep enough into your tissue
NOTE Confidence: 0.919944976
00:28:15.664 --> 00:28:17.440 and land in the exact right spot.
NOTE Confidence: 0.919944976
00:28:17.440 --> 00:28:18.440 But what this group?
NOTE Confidence: 0.919944976
00:28:18.440 --> 00:28:20.576 Did is they said well based on her
pre brachytherapy MRI we could design this custom ring cap that’s going to go over the existing ring and they drilled holes at pre specified distance and at angles to help guide the needles into the right place. So that going into the procedure of the breakey therapist was able to place these needles at the sort of predetermined spots and better shape the needles and guide them to the tumor. I think that there’s now been a couple more of these types of
published examples in the literature, and it seems like brachytherapy might be a perfect match for 3D printing, given the individualization needed for every application. We’re no longer in A1 size fits all era. This is another example of a 3D printed cylinder, similarly to guide needles. And I will say that when you’re in the OR in this very tight space and a very narrow vagina and you’re trying to properly deflect and guide needles at a specific angle, it can be very challenging to do so. Having an applicator which is
kind of doing that for you, it's bending and also stabilizing the needle in the right spot makes a lot of sense. This is work from a colleague of mine at Stanford University who worked together with her physicist and engineers at Stanford that they came up with these templates and they basically said rather than 3D customized printing on a per patient basis, rather they developed a repertoire of templates to have in their department to use for all of their cervical cancer cases. So basically they designed a couple of 3D printed templates and they choose
one of these prior to a procedure.

The hitch is on to the tandem.

So they’ll place a tandem and their ovoids, and then through one of these templates, guide the needles.

It’s a place and they’ll figure out ahead of time which template would be best suited for a given patient.

They found this to be a low cost solution and cost about $5 to print this in house and $100 if they.

It removes some of the variability and randomness of the freehand approach and helps standardize the procedure more, and that way it can make it more
NOTE Confidence: 0.880266404333333
00:30:23.326 --> 00:30:24.602 accessible to trainees or other practitioners who are looking to get started with a hybrid application process.
NOTE Confidence: 0.880266404333333
00:30:26.240 --> 00:30:28.056 This was a 3D printed applicator from two of our own brachytherapy, physicist Doctor Christian and Doctor Jay Chen.
NOTE Confidence: 0.880266404333333
00:30:30.130 --> 00:30:32.098 So this was printed for a patient who had a very narrow vaginal anatomy that wouldn’t fit one of our standard applicators and required needles.
NOTE Confidence: 0.880266404333333
00:30:34.710 --> 00:30:35.925 made of biocompatible material and 3D printing can be used to rapidly manufacture and implement customized vaginal applicators that could be sterilized, made of biocompatible material and
NOTE Confidence: 0.880266404333333
00:30:37.550 --> 00:30:39.615 So this was printed for a patient who had a very narrow vaginal anatomy that wouldn’t fit one of our standard applicators and required needles.
NOTE Confidence: 0.880266404333333
00:30:39.615 --> 00:30:42.449 who had a very narrow vaginal anatomy that wouldn’t fit one of our standard applicators and required needles.
NOTE Confidence: 0.880266404333333
00:30:42.449 --> 00:30:45.065 So 3D printing can be used to rapidly manufacture and implement customized vaginal applicators that could be sterilized, made of biocompatible material and
NOTE Confidence: 0.880266404333333
00:30:45.065 --> 00:30:46.405 applicators and required needles.
NOTE Confidence: 0.880266404333333
00:30:46.410 --> 00:30:48.546 So 3D printing can be used to rapidly manufacture and implement customized vaginal applicators that could be sterilized, made of biocompatible material and
NOTE Confidence: 0.880266404333333
00:30:48.546 --> 00:30:50.385 manufacture and implement customized vaginal applicators that could be sterilized, made of biocompatible material and
NOTE Confidence: 0.880266404333333
00:30:50.385 --> 00:30:52.465 So 3D printing can be used to rapidly manufacture and implement customized vaginal applicators that could be sterilized, made of biocompatible material and
NOTE Confidence: 0.880266404333333
00:30:52.470 --> 00:30:54.095
potentially result in high quality brachytherapy for patients whose anatomy is not ideally suited for commercially available applicators. And sometimes we need smaller ones or different shaped ones. This is a different 3D printed vaginal applicator that we're currently testing in a clinical trial here at Yale. It's not for cervical cancer, but for endometrial cancer where vaginal brachytherapy is typically done after hysterectomy. So just to Orient you, this is looking at a patient sideways, this is the bladder, this is the *****.
And a typical applicator is this straight vaginal applicator. And through that we aim to give her a dose of radiation to the vaginal apex. So with this trial is looking at is asking whether if we designed the applicator to look the same at the top where we’re giving the radiation, but to taper and narrow as it exits the patient through the lower portion of the vagina and the introitus if that would be more comfortable. For patients and more well tolerated. So I mentioned the applicator here because of the story which led to
its development as a clinician.

I had been walking around with this idea in the back of my head for several years.

And then one day, completely by chance, I received an e-mail from one of my colleagues who was working with the medical students who had a background in interest in 3D printing and engineering and he just needed a clinical application. So the two of us met and we put our heads together and we designed and printed this one which I mentioned we’re currently testing in a trial. So.
I think we’re still very early on in this journey of 3D printing, but I do know that 3D printing is used in some of the other surgical fields and perhaps there are others here at the Cancer Center or the medical school who have similar programs and developments and would like to collaborate with us. As it stands now, I think potential applications of 3D printing for cervical cancer include manufacturing personalized guidance templates to optimize needle positions and...
target dose distributions,

also designing individualized applicators to fit patient anatomy.

And I do see this as an area of future. Growth and promise.

So now I’m going to talk about efforts to improve the way that we teach brachytherapy to our trainees.

So I mentioned in the beginning of my talk that without breakey therapies, survival outcomes in cervical cancer are not as good. And yet the same research has shown a disturbing high recent decline in the utilization of brachytherapy. Specifically between 1998 and 2009,
it was estimated there was a decreased utilization rate of brachytherapy from 83% to 58%. And also data, the research has shown that patients are less likely to receive standard of care treatments at low volume centers. There has been a lot of thought and writing about this particular problem and the potential causes for underutilization of radiotherapy. It could be because of a lack of equipment, because of the intensive workflow. If you’re at a smaller practice, you’re treating all types of cancers.
Maybe you don’t have the time and resources for this type of cervical cancer program. There’s also patient access issues. Not everyone can travel for these treatments. Something that’s also come out of numerous surveys is perhaps we aren’t properly training our residents. There was a survey of recent grads and trainees who felt that not seeing a lot of cases during their residency training was a very big barrier to learning these therapies. So perhaps people were coming out of training and not feeling comfortable or
Confident that they could do breakey therapy.

So as a field, we’ve realized that we need to improve the way that we teach it, to make it more accessible and to change its perception from being an advanced, technically challenging technique to one that’s a component of routine practice.

So it’s hard to teach breakey therapy in real time cases.

The stakes are high, the patients under anesthesia, things are moving pretty quickly.

So to supplement training, there’s been a growing interest in doing simulation based education,
which basically means using a pelvic mannequin in a setting outside of the OR where you can conduct workshops with residents and they can have the opportunity to place the applicators in a low risk setting. And this has been shown to help trainees remember the steps of the procedure and feel confident in doing the procedure. So that they’re more likely to do it when they go out in their own practice. And I’ve been able to participate in these workshops at an institutional level, also at national and international meetings, and this picture is taken from work that I
00:35:10.048 --> 00:35:14.620 did during my sabbatical and in Israel so.

NOTE Confidence: 0.873604502105263

00:35:14.620 --> 00:35:16.498 I also mentioned earlier in my talk the movement towards more

NOTE Confidence: 0.873604502105263

00:35:16.498 --> 00:35:18.234 customized applications using needles

NOTE Confidence: 0.873604502105263

00:35:18.234 --> 00:35:22.059 into the residual cervical tumor.

NOTE Confidence: 0.873604502105263

00:35:22.060 --> 00:35:22.948 For a long time,

NOTE Confidence: 0.873604502105263

00:35:22.948 --> 00:35:24.058 the mannequins that were available to us were very kind of hard,

NOTE Confidence: 0.873604502105263

00:35:24.058 --> 00:35:25.396 durable plastic material that wasn’t very stretchy and didn’t permit needle placements.

NOTE Confidence: 0.873604502105263

00:35:25.400 --> 00:35:28.352 But in 2021, a new prototype Phantom was released.

NOTE Confidence: 0.873604502105263

00:35:29.940 --> 00:35:31.149 This model was made of this colloidal material that

NOTE Confidence: 0.873604502105263

00:35:31.149 --> 00:35:36.960 colloidal material that it

NOTE Confidence: 0.817171624166667
00:35:37.024 --> 00:35:39.328 was stretchy, it had a vagina,  
NOTE Confidence: 0.817171624166667
00:35:39.328 --> 00:35:41.196 cervix, uterus, ***** and bladder,  
NOTE Confidence: 0.817171624166667
00:35:41.196 --> 00:35:43.440 and it also permitted our applicators  
NOTE Confidence: 0.817171624166667
00:35:43.503 --> 00:35:44.825 as well as needle. Placements.  
NOTE Confidence: 0.817171624166667
00:35:44.825 --> 00:35:46.535 So we designed an inaugural workshop  
NOTE Confidence: 0.817171624166667
00:35:46.535 --> 00:35:48.690 here at Yale to validate the model  
NOTE Confidence: 0.817171624166667
00:35:48.690 --> 00:35:50.250 for teaching hybrid needle placements.  
NOTE Confidence: 0.817171624166667
00:35:50.250 --> 00:35:52.050 We presented this work at ABS,  
NOTE Confidence: 0.817171624166667
00:35:52.050 --> 00:35:53.686 the American Brachytherapy Society,  
NOTE Confidence: 0.817171624166667
00:35:53.686 --> 00:35:56.660 last year and recently published our results.  
NOTE Confidence: 0.817171624166667
00:35:56.660 --> 00:35:58.172 This was from the 14 residents  
NOTE Confidence: 0.817171624166667
00:35:58.172 --> 00:35:59.846 in our program who were surveyed  
NOTE Confidence: 0.817171624166667
00:35:59.846 --> 00:36:01.670 and this was their responses to  
NOTE Confidence: 0.817171624166667
00:36:01.670 --> 00:36:03.259 questions pre and post workshop.  
NOTE Confidence: 0.817171624166667
00:36:03.260 --> 00:36:04.870 We asked them questions about  
NOTE Confidence: 0.817171624166667
00:36:04.870 --> 00:36:06.002 their knowledge, preparedness,
00:36:06.002 --> 00:36:07.930 confidence in performing hybrid
brachytherapy procedures.

00:36:08.900 --> 00:36:10.286 Red meant that they were not
at all confident,
blue meant that they were very confident.

So you can see the shift in responses
from pre workshop to post workshop.

Obviously we know you can’t do this workshop
one time and expect everyone to be experts,
but there are lots of.

Uh, there’s lots of programs and
development at a national level
to improve brachytherapy training,
but at least at an institutional level,
we hope to continue conducting similar
hands-on workshops yearly in our program.

So in the last few minutes I’m going to shift gears and talk about quality of life and survivorship and cervical cancer. This is another area at Yale that we have a lot of support with help from our behavioral health and gynecologic colleagues, to make sure that our patients are on board with this information. As I think I’ve shown, breakey therapy is a very personal treatment, and while going through it can be intense and emotional, for some women it could even be traumatic that we do our best to offer compassion and support every step of the way.
Post treatment, even if the cancer is cured and the patient wants to forget about it, put it behind them. The problem is that there can be significant long-term sequelae which take time to develop. These can be sexual or other effects that can negatively and permanently impact the lives of our patients if they’re not properly addressed. But many of these issues can be addressed, treated or even prevented. So we have to follow our patients very closely.
So in my opinion, post treatment care of women who’ve been through breaking therapy is a critical aspect of caring for the whole patient because we don’t want to save one part of their lives and then accidentally ruin another part.

So this is just an example of what happens to vaginal tissue after radiation. Now we all know that whatever your treatment modality is, whether it’s surgery, chemotherapy or radiation, the name of the game is to minimize side effects.

So here’s what happens after radiation. This is a biopsy from a healthy, normal vagina.
This is looking in the basil layer and you can see this is elastin, which is imaged with autofluorescence and it looks nice and linear. This is biopsy.

From the vagina of a cervical cancer patient three to five years after radiation. So again it takes time, but what you can see is proliferation and elastosis and this can lead to progressive thickening and stiffening of the vagina. This can take months to years to develop after radiation and its effects can be permanent, results in difficulty with.
exam or pain with intercourse.

So vaginal morbidity to some extent, whether it’s mucosal adhesions or bleeding after radiation is pretty common. And you know, even if it’s mild that can have a significant impact. Studies have shown that one to four, one to five cervical cancer patients have vaginal issues causing dyspareunia, and a significant proportion of these women stay sexually active despite pain to maintain their partner satisfaction and avoid marital problems.
So this is a pretty complex problem. Physical symptoms can lead to all of these issues here, whether it’s distress, fear of pain, cancer, loss of femininity, decreased body image, difficulty with partner. A very simplified example of this would be a young cervical cancer patient is treated with radiation. She has pelvic issues that result in problems with dyspareunia. She doesn’t bring it up with her doctors. She remains sexually active.
albeit with tremendous pain and suffering.

She has relationship issues that result.

Her partner leaves her,

she has low self esteem and she

thinks something’s wrong with her.

I’m not saying that we as radiation

can help with all

but we could do a lot simply by

raising and normalizing sexual

concerns with our patients,

asking them about what they’re

experiencing and making appropriate.

Girls when needed.

So one simple thing that we can

do is really just ask our patients
00:39:43.936 --> 00:39:44.875 about their symptoms.

00:39:44.880 --> 00:39:47.455 So this is guidelines that

00:39:47.455 --> 00:39:49.515 were written by ASCO,

00:39:49.520 --> 00:39:50.745 so I’d encourage you all to take

00:39:50.745 --> 00:39:52.191 a look at this if you haven’t seen

00:39:52.191 --> 00:39:53.938 it was put out in 2018 looking at

00:39:53.938 --> 00:39:55.038 interventions to address sexual

00:39:55.038 --> 00:39:56.506 problems in people with cancer.

00:39:56.506 --> 00:39:58.414 The number one recommendation is that

00:39:58.414 --> 00:39:59.922 it’s the provider’s responsibility

00:39:59.922 --> 00:40:02.376 to initiate this conversation and to

00:40:02.376 --> 00:40:05.558 ask patients. About their symptoms.

00:40:05.560 --> 00:40:07.898 So how are we doing radiation oncology?

00:40:07.900 --> 00:40:10.280 This is a abstract that was presented

00:40:10.280 --> 00:40:12.389 at Astro in 2022 looking at

NOTE Confidence: 0.881755205714286

85
disparities in physician assessment

of sexual dysfunction in women

versus men receiving brachytherapy.

Men population was prostate cancer,

women population with cervical cancer.

Among the prostate cancer patients

90% had sexual function assessed.

Among cervical cancer patients about 10%.

So I think that unwittingly a lot

of providers are in addressing

sexual health with their patients,

especially with their female patients.

It’s probably not on the.

Providers, radar,

it’s not really part of our culture.

I remember seeing this first hand
as a resident understanding that patients are having these issues, but not really knowing how to address it, not being trained how to address it. So there's a lot of barriers to discussion and you can see here there's physician barriers, here there's barriers on the patient side as well. And when you add these up, it's very, you know, becomes very difficult to talk about these issues in the clinic. And I think it's especially amplified in the female cancer population. But I think that one of the main
reasons why doctors might not ask is because they might not know how to address the problems they might uncover. But the tragedy of that really is that there’s a lot of very, very simple low tech tools that can really be available to everyone. So these are strategies to improve vaginal and sexual health and I would say they could be effective for probably about 80% of the types of symptoms that we see after radiation. So just some examples would be educating patients and giving them dilators to improve elasticity and present prevent adhesions.
A lot of our patients have atrophy after radiating the pelvis, that hypo, estrogen and. Also fragility of the mucosa as a result of the radiation, the brachytherapy vaginal estrogen is very helpful, improving soreness and friction. Lots of education about lubricants and moisturizers or improving, you know, genito urinary symptoms of menopause or climacteric symptoms. A lot of our patients benefit from hormones. So in our practice,
we recommend a comprehensive approach where the conversation starts before any treatments been given up front. We counsel patients about potential vaginal and sexual morbidity, quote incidence rates, discussed mitigation strategies and normalize the concern. During the radiation planning, we try to limit the vaginal dose as much as we can. Now we have guidelines from the embrace and others as to how to do this effectively. And then in terms of secondary prevention, a lot of the strategies that I showed you earlier recommending dilators,
lubricants, moisturizers,

screening patients for sexual concerns.

Assessing vaginal and vulvar tissue quality,

screening patients for menopausal symptoms,

and referring our patients for

further counseling and intervention,

if warranted.

So I’ll mention here that education

on this topic is an interest of mine,

and I am a board member for an

organization called the Scientific Network

on female sexual health and cancer.

So for those of you who are interested,

the website is shown here.

It has a lot of links to valuable resources,
both for patients as well as for providers, so I’d encourage you all to take a look. And back in November, I hosted here at Yale the 8th annual scientific meeting, which drew almost 100 researchers from around the country. We are very lucky at Yale to have The Sims Clinic. So we realize that physical symptoms aren’t the full picture and that sexual dysfunction can be a complex problem that has psychological, relational and cultural components. And the symptoms caused by radiation can compound already existing...
emotional and interpersonal issues.

So one of this resource is The Sims Clinic, developed by Doctor Ratner and Doctor Minkin and has representation from Julianne, oncology, gynecology with specialization and menopause, as well as psychiatry and psychology, and they do a comprehensive evaluation.

For our patients, we refer many of our patients there for their sexuality, menopausal and intimacy needs after brachytherapy. So I’m making a major plug
00:43:43.392 --> 00:43:44.260 for this wonderful program.
NOTE Confidence: 0.864862045
00:43:44.260 --> 00:43:45.235 And actually at the meeting
NOTE Confidence: 0.864862045
00:43:45.235 --> 00:43:46.610 that we hosted here in November,
NOTE Confidence: 0.864862045
00:43:46.610 --> 00:43:48.087 it was a pleasure to have a
NOTE Confidence: 0.864862045
00:43:48.087 --> 00:43:49.289 presentation from The Sims Clinic.
NOTE Confidence: 0.864862045
00:43:49.290 --> 00:43:52.328 I should mention that’s also run by
NOTE Confidence: 0.864862045
00:43:52.328 --> 00:43:54.578 Johanna Diario and it’s really one
NOTE Confidence: 0.864862045
00:43:54.578 --> 00:43:56.790 of the oldest programs in the world
NOTE Confidence: 0.864862045
00:43:56.857 --> 00:43:59.041 like this and has served as a model
NOTE Confidence: 0.864862045
00:43:59.041 --> 00:44:01.199 for many of the others to emulate.
NOTE Confidence: 0.864862045
00:44:01.200 --> 00:44:04.220 So with that, I’ll end.
NOTE Confidence: 0.864862045
00:44:04.220 --> 00:44:05.940 We should be proud at Yale to have
NOTE Confidence: 0.864862045
00:44:05.940 --> 00:44:07.620 the resources that we need to treat
NOTE Confidence: 0.864862045
00:44:07.620 --> 00:44:08.825 our cervical cancer patients the
NOTE Confidence: 0.864862045
00:44:08.879 --> 00:44:10.383 best way that we can and to also
NOTE Confidence: 0.864862045
00:44:10.383 --> 00:44:11.835 help them live their lives the best
00:44:11.835 --> 00:44:13.279 way they can when treatment is done.

00:44:13.280 --> 00:44:14.680 So thank you for your attention and

00:44:14.680 --> 00:44:16.250 I’d be happy to take any questions.

00:44:25.460 --> 00:44:32.630 OK. Joe. So great, fantastic structure.

00:44:32.630 --> 00:44:35.290 So the the amount of

00:44:35.290 --> 00:44:37.230 personalization of therapy is.

00:44:39.430 --> 00:44:41.775 Unlike any other site for the treatment.

00:44:46.184 --> 00:44:49.340 just to hear a little bit more about.

00:44:49.340 --> 00:44:51.800 How you work with the community?

00:44:51.800 --> 00:44:52.816 Because obviously we have

00:44:52.816 --> 00:44:54.086 all of these resources here,

00:44:54.090 --> 00:44:56.594 we have you here, you know, and you’re

00:44:56.594 --> 00:44:58.179 instrumenting some of your patients,

00:44:58.180 --> 00:45:00.784 get treated a little bit in the

NOTE Confidence: 0.9788471
Community and then come here.

How do you negotiate that and how do you work with the outside referring Dr.

Yeah, I think that’s a great question.

So, I don’t see myself as like a technician like philosophically I care for the whole patient.

So many patients are treated outside Connecticut and they do a wonderful job.
00:45:30.444 --> 00:45:32.320 hospitals, but they also know these.

00:45:32.320 --> 00:45:33.892 Are referring doctors know that for patients that need a lot of needles,

00:45:33.892 --> 00:45:35.698 if it’s a particularly big tumor

00:45:35.700 --> 00:45:37.218 or you know a vaginal that has a lot of vaginal involvement,

00:45:37.218 --> 00:45:39.244 they will send them up front to see me and I’ll partner with them because.

00:45:39.244 --> 00:45:40.829 So I don’t think I need to be treating all of the cases in Connecticut.

00:45:40.830 --> 00:45:42.382 But there are some cases that will really clearly benefit from needles

00:45:42.382 --> 00:45:44.247 and in general we don’t want to split care between teams.

00:45:44.250 --> 00:45:45.879 So I think you know if there’s one doctor

00:45:45.879 --> 00:45:47.319 In general we don’t want to split care between teams.

00:45:47.320 --> 00:45:49.203 So I think you know if there’s one doctor

00:45:49.203 --> 00:45:50.533 really clearly benefit from needles

00:45:50.533 --> 00:45:52.185 and in general we don’t want to split care between teams.

00:45:52.185 --> 00:45:53.369 So I think you know if there’s one doctor

00:45:53.370 --> 00:45:55.260 So I think you know if there’s one doctor
that can do the whole thing start to finish, that's going to be better. There will be less delays and you'll get through that treatment time a lot quicker. And Umm, you know, so I think that when there's really no other effective way, I'm always happy to see the patient. I meet them up front and this is kind of our policy here. We always review their pathology here. We are part of the decision making up front. We do our own baseline exam and you know, because of resources and whatnot, I have to set up the OR times in advance. So I guess I see myself as a referral.
for the most complicated cases, but not for all the cases. Does that answer your question?

Yes. Especially.

You mentioned about it, you just, you know, place much under the R, so you place the Middle Ages or transcript.

Oh, that's a great question. So, right. So the question is about real time image guidance of needles. So you're right. There are several, not a lot, but there are some institutions that have an expertise doing transrectal
ultrasound and that is a very good modality to see where you’re placing your needles in real time. And others do MRI's kind of like how we’ve been doing it. I think there’s a learning curve with the transrectal ultrasound. So I tried it a couple of times, but I found that sort of placing the needles and going to MRI. Is effective for me, but there are practices that do the transrectal ultrasound with excellent results.
Yeah, it’s a good question.

Yes.

Yeah, they can do it pretty quickly.

I don’t recall in that particular case, but I think it’s faster.

So I would like to grow our 3D printing program.

I think that’s really an area for future development and a lot of promise.

They have an in House 3D printer within their own department.

So they can do that very rapidly.

I don’t think it takes too much time to do but we needed a couple of weeks.
00:48:10.840 --> 00:48:11.650 Just do it for sure.
NOTE Confidence: 0.9269076
00:48:15.070 --> 00:48:15.420 Yes.
NOTE Confidence: 0.6382878
00:48:17.980 --> 00:48:18.110 Yeah.
NOTE Confidence: 0.83442530375
00:48:35.410 --> 00:48:37.386 So I don’t see Chris in the audience.
NOTE Confidence: 0.83442530375
00:48:37.390 --> 00:48:39.442 I think he he’s done some
NOTE Confidence: 0.83442530375
00:48:39.442 --> 00:48:40.810 research into that question.
NOTE Confidence: 0.83442530375
00:48:40.810 --> 00:48:41.846 So the Mr. Lennox,
NOTE Confidence: 0.83442530375
00:48:41.846 --> 00:48:44.169 I think you can use to image your,
NOTE Confidence: 0.83442530375
00:48:44.170 --> 00:48:46.468 it is the right amount of magnetism
NOTE Confidence: 0.83442530375
00:48:46.470 --> 00:48:49.879 that you can image your implants well,
NOTE Confidence: 0.83442530375
00:48:49.879 --> 00:48:52.448 but I don’t and I know one of our
NOTE Confidence: 0.83442530375
00:48:52.448 --> 00:48:55.035 physicists has sort of looked into that
NOTE Confidence: 0.83442530375
00:48:55.035 --> 00:48:57.051 but because we don’t have an MRI linac,
NOTE Confidence: 0.83442530375
00:48:57.117 --> 00:48:59.365 so I haven’t examined that too
NOTE Confidence: 0.83442530375
00:49:01.128 --> 00:49:02.995 extensively but I I think that
it would be compatible with the majority of the MRI. Safe applicators.

Yes, look, look. Move forward to new innovations and new therapies as you know proton therapy. Do you think that that’s another modality that you’ll be able to? Used to produce side effects. Are there? Other sites that are using. So it’s not not that common. I know that Doctor Lily Lynn at MD Anderson has the most experience using protons for gynecologic malignancies. But apart from that,
I don’t think it’s been used that often.

I don’t think it’ll replace brachytherapy, but in terms of whether it would be useful for pelvic radiation, there’s really not a lot of data about that at this point. I feel like when we start our program, we’re going to be focused more on some of the more CNS type of and pediatric type of cases, but maybe. With more research, we’ll see if that’s helpful. So to be determined. But probably for reradiation cases I can imagine that would be very helpful. OK.