

Yale Cancer Center

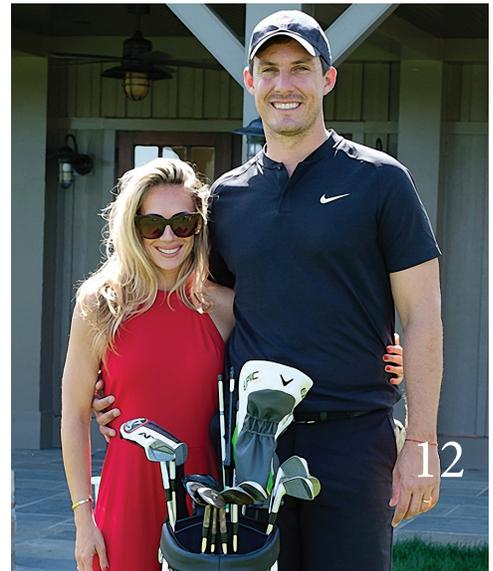
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MAGAZINE

A man with grey hair and glasses, wearing a dark suit, light blue shirt, and maroon tie, is smiling. He is standing in front of a stone wall with large, white, serif letters that read "SMITHOW HOSPITAL".

Bold Plans for
Cancer Care at Yale

spring | summer 2022



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On the Cover

Eric P. Winer, MD
Director, Yale Cancer Center
Physician-in-Chief,
Smilow Cancer Network
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Yale Cancer Center

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I'm just four short months into my tenure at Yale Cancer Center and the Smilow Cancer Network and it feels as though I've been welcomed home. The days have passed quickly, and I continue to be truly amazed by the dedication and talent that exists within Yale Cancer Center and our Smilow Cancer Network.

In the coming months, we will articulate the scientific priorities and clinical imperatives for Yale Cancer Center and the Smilow Cancer Network, as well as the steps we will take to achieve the greatest possible impact over the next five years. We want to provide the best possible care that can be delivered today, and we want to make sure that today's standards are replaced by far better approaches—more effective, less toxic, more convenient, less disruptive—as soon as possible. To ready ourselves to achieve these goals, we are planning bold new initiatives at Yale Cancer Center.

One of our major initiatives will focus on improving the cancer care available to underserved residents of our state. Connecticut is a study of contrasts in income and in healthcare. We will use the Smilow Cancer Network to provide the highest quality subspecialty oncology care, inclusive of clinical trials, to an ever-growing population of patients with cancer who are impacted by healthcare disparities. Harnessing the expertise in our Network is not enough. We must link that expertise with the growing strength of our Center for Community Engagement and Health Equity. With careful thought, effort, and teamwork, I believe we can transform cancer care in Connecticut.

As our research and clinical missions continue to evolve and expand at Yale Cancer Center and the Smilow Cancer Network, our goal remains the same: To be a world leader in cancer care, research, and education. I look forward to working closely with our leadership team to push the boundaries in cancer research and care delivery at Yale and throughout the Smilow Cancer Network in the years ahead.

Sincerely,



Eric P. Winer, MD
Director, Yale Cancer Center
Physician-in-Chief, Smilow Cancer Network
Alfred Gilman Professor of Medicine and Pharmacology





BOLD PLAN

for Cancer Care at Yale

Steve Kemper writer **Peter Baker** photographer

Forty-eight years ago, a high school senior from Boston submitted a college essay that got the attention of the Yale Admissions Office. He wrote that he had hemophilia and considered himself lucky because it had broadened his experiences, and that he thought of his diagnosis “as nothing but a positive.” It spurred instead of deterred him.

That determined, irrepressible young man, Eric Winer, was admitted to the Yale College Class of 1978. He went on to Yale School of Medicine and then did his internship and residency at Yale New Haven Hospital. His wife, Nancy Borstelmann, earned an MPH at Yale

School of Public Health, and two of their three children were born in New Haven.

After leaving Yale, Dr. Winer spent thirty-four years building a distinguished career at Duke and at Dana-Farber Cancer Institute as a breast cancer clinician and researcher. In February of 2022, he returned to his medical school roots, becoming director of Yale Cancer Center and physician-in-chief of Smilow Cancer Network. “I never thought I would move back to New Haven,” he said, “but I’m as happy as I can be here.” His plans, like him, are bold.

He returns to Yale after earning many laurels. His research has altered clinical

practice and improved treatments and outcomes for patients with breast cancer. He has won awards, collected honors, and served in significant national leadership positions, most recently as co-leader of the National Cancer Institute’s Breast Cancer Steering Committee, and as the newly-elected president of the American Society of Clinical Oncology (ASCO). Along the way, he published more than 350 papers and mentored dozens of young oncologists.

The steady focus of Dr. Winer’s research has been to use general discoveries from clinical trials to more finely calibrate treatment for individual patients at each



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Eric Winer, MD

stage of breast cancer—the best drug or combination of drugs, the most effective dosages, the duration of treatment that balances benefits against disagreeable side effects.

“I am data-driven and believe we need to respect the results of large clinical trials,” he explained, “but we also have to recognize that different patients and different tumors require different types of therapy.” In addition, he has studied how lifestyle factors such as diet and exercise can influence tumorigenesis and cancer outcomes. “It’s really impossible to have a full understanding of cancer in an individual without understanding more about that individual,” he continued. “Every time we start a course of therapy, we have to be willing to adjust it based on each patient’s reaction.”

Knowledge about breast cancer and its treatment have grown phenomenally over the last two decades, partly because of Dr. Winer’s contributions. Most forms of the disease are now curable, and even individuals with metastatic breast cancer can do well for many, many years. Dr. Winer predicts that in a decade or so, no one who receives appropriate care will die of breast cancer. “I think our biggest challenge will be making sure we can deliver care to everyone who needs it,” he said.

Meeting that challenge is on his long to-do list for Yale Cancer Center and Smilow Cancer Hospital, where most of his time is devoted to overseeing both clinical care and research. He does not expect to have much time to conduct independent research or see large numbers of patients, but he will be maintaining a presence in the clinical world seeing patients with breast cancer every Thursday morning. “At this point in my career, I don’t need to be up on a podium presenting a paper,” he said. “Making other people successful and helping other people’s research is what matters to me now.” That’s what appealed to him about the chance to run Yale Cancer Center—the opportunity to

We can strive to provide the best care today and learn how to make it ever so much better in the future—that’s what drives me to build an even stronger cancer center and programs at Smilow that focus on patient experience.

build something on a bigger scale. “The Cancer Center will look very different in five years,” he said. “We’re going to become far more nationally and internationally prominent. I am pushing change, and at the same time, we want to tackle cancer care disparities here in Connecticut.”

For starters, Dr. Winer says the cancer program must get much bigger and serve more patients. That means recruiting many more physicians and researchers. He praises many aspects of the program, starting with the “phenomenal” basic science, and he has been impressed by the collaborative and supportive environment within the Cancer Center and Hospital.

“But we have work to do,” he added. “The reason I was recruited is that people recognize Yale isn’t where it needs to be in terms of national prominence. We’re going to build an efficient and highly productive clinical research enterprise that will be able to rapidly complete cutting edge clinical trials. We’re also going to use our broad network across the state to tackle the problem of healthcare inequities in Connecticut. I feel passionate about making progress in this area.”

Dr. Winer says that everything he does, including administrative decisions, is influenced by his experiences taking

care of patients who have taught him what does and does not work. “If we pay attention to our patients, we learn so much about what to pursue in our research and how to provide the care in clinic. We can strive to provide the best care today and learn how to make it ever so much better in the future—that’s what drives me to build an even stronger cancer center and programs at Smilow that focus on patient experience,” he said.

This philosophy may stem from his own medical history. The medical innovation called Factor VIII allowed him to live a full life despite hemophilia. He has had to deal with a number of medical complications stemming from his hemophilia, but dramatic medical advances have allowed him to lead a very full life. Nonetheless, he understands firsthand the benefits and the risks of medical therapy. “I don’t remotely define myself by my health challenges. That said, we are all an accumulation of our life experiences, and for me, personal experiences with the health system have likely affected my approach to patient care and research. I think the single biggest lesson I’ve learned over the years is that if you scratch below the surface, most people have had to deal with some difficulties or even tragedies in their lives. There are very few people who live in perfect houses surrounded by a neat white picket fence. On so many levels, the adversities we face bring us all together.”

In Boston, Dr. Winer was an avid participant in the Pan-Mass Challenge bike ride to support cancer research at Dana-Farber. He has been training on a Peloton all winter and plans to participate in this September’s Closer to Free Ride, riding with his oldest son who scored a bike in exchange for his promise to participate. As most know, Closer to Free is the annual fundraising bike ride held for Smilow Cancer Hospital and Yale Cancer Center. He is recruiting others to ride as well to raise money for research and cancer care at Yale. “I’m all in,” he pledged. 🚴

DEFINING THE LANDSCAPE OF PROSTATE CANCER TREATMENT

Steve Kemper writer

Peter Baker photographer

Smilow Cancer Hospital is now offering a new surgical option for prostate cancer treatment unavailable elsewhere in Connecticut, and still rare throughout the United States. The beneficiaries are men in need of a prostatectomy, a procedure in which the prostate is partially or completely removed to eradicate localized cancer.

More than 95 percent of prostatectomies in the United States are performed by surgeons using robotic instruments. In the vast majority of these procedures, the robot has four arms that hold surgical instruments and a high-resolution camera. The surgeon manipulates the arms from a console and each arm enters the body through its own small abdominal incision, or 'port.' The surgeon also makes two additional incisions as 'assistance ports,' for a total of six.

Isaac Kim, MD, PhD, MBA



The new technology and expertise at Smilow Cancer Hospital reduces those incisions to two—one for the robot, the other for assistance. This is possible because the da Vinci SP (Single Port) merges all the instruments into one robotic arm.

“That allows us to work in a much tighter space,” said Isaac Kim, MD, PhD, MBA, Professor and Chair of Urology at Yale School of Medicine, and Chief of Urology at Yale New Haven Hospital. “The multiport robot has arms coming through four incisions, and you can’t have them too close together or they’ll start colliding with each other, so you don’t have the range of motion that you get with the single port.”

Operating through a single incision offers several other benefits. The prostate, normally about the size of a golf ball, envelops the urethra and sits between the bladder and the rectum. It is surrounded by muscles, nerves, and blood vessels necessary for erections and bladder function. The multiport typically goes through the peritoneal space, the abdominal cavity that contains the intestines, stomach, and liver.

“That’s important because that’s where the bowel sits,” explained Dr. Kim. “In single port surgery, the incision is made right under the navel, and we don’t have to violate the peritoneal space. That means the potential for complications are a lot less.”

Fewer incisions also mean less pain, and hence less need for pain medications. Instead of opiates, Dr. Kim typically prescribes a couple of days of acetaminophen with codeine. Another major advantage is faster recovery. “With this new technology,” he said, “we’ve basically made prostatectomies an outpatient procedure.” Patients come in in the morning, have their surgery, spend a few hours in recovery, and “are sleeping in their own bed that night.” One report found that hospital stays after the single port procedure averaged 4.3 hours compared to 26 hours for multiport surgery.

Despite these advantages, single port technology is still uncommon. One reason is price. The new instrument costs about \$2 million and doesn’t improve patient outcomes over conventional multiport surgery. That makes budget-conscious administrators leery, though the higher technology costs are likely offset by shorter hospital stays.

Single port robots also remain rare, said Dr. Kim, because of the steep learning curve for surgeons. He has done more than 2,000 multiport prostatectomies, but the new technology requires different skills.

“Not everyone is going to be good at using it,” he said. For instance, he continued, his son constantly crushes him at video games. “Does that mean the technology is worse for me? Of course not. It’s a matter of what the operator can achieve with it. This new technology allows us to push the boundaries of what’s possible, but whether we’re able to take advantage of that new capability is really up to the skills of the individual surgeon.”

Dr. Kim began using the single port instrument two years ago and has completed more than 100 prostatectomies with it. He came to Yale from Rutgers last year partly because Yale offered the state-of-the-art technology. He is also training residents to use the new instrument.

Patients referred to him for prostatectomies expect the multiport procedure and are pleasantly surprised by the single port option.

In his clinical research, Dr. Kim focuses on patients with prostate cancer that has metastasized to the bone, lung, liver, and lymph nodes. The current standard of care is hormonal therapy and chemotherapy, but the prognosis is difficult. “I’m interested in determining whether surgery has any role for these patients,” he said. He hopes to answer that question as co-principal investigator of a study that will eventually enroll 870 patients across 25 institutions worldwide. The study is analyzing whether cytoreductive

radical prostatectomy—complete removal of the prostate—impacts outcomes for patients with metastatic prostate cancer. The results from the Phase I data will soon be published and were more than encouraging.

Our early data show that, in a minority of patients, combining surgery with hormonal therapy and chemotherapy may produce a long-term durable response where there’s no evidence of cancer off hormonal therapy after more than four years of follow-up,” said Dr. Kim. “That is a significant finding. Men with metastatic prostate cancer must continue hormonal therapy for the rest of their lives. But now, by adding surgery, some men may discontinue hormonal therapy after a few years. Yale Cancer Center is now the leading center exploring this potential paradigm-changing concept.” He and his colleagues are currently enrolling 190 patients for the Phase II study.

Why does removing the primary tumor seem to affect metastatic prostate cancer? Dr. Kim answers by describing the movie *Independence Day*, in which alien spaceships invade Earth, and the world’s best pilots can’t touch them because they’re shielded by a force field. The lead character figures out that the shield is being projected by a mother ship hiding behind the moon.

“He destroys that mother ship, and the force field goes down, and then the alien ships are vulnerable,” explained Dr. Kim. “That is precisely the scientific premise of this. There is some sort of communication from the primary tumor, the mother ship, to these metastatic sites. By removing the primary tumor, you’re taking away the shield, which allows the hormonal therapy and chemotherapy to be much more effective against the metastatic cancer in the bone and lymph nodes.”

Dr. Kim was able to tell some of his patients on the Phase I trial that they have no evidence of disease after a metastatic prostate cancer diagnosis more than four years ago and hormonal therapy was stopped for more than two years.

“We’re talking about something that was considered absolutely incurable even just five years ago,” he said. “I’m really excited because the potential is huge, and what we’re doing will put Yale Cancer Center and Smilow Cancer Hospital in front of this changing landscape in how we treat prostate cancer.”



“ With this new technology, we’ve basically made prostatectomies an outpatient procedure. ”

—Dr. Isaac Kim



David Sturges

Wajih Kidwai, MD, FACP

WORKING TOGETHER:

A PATIENT-AS-PARTNER AP

When David Sturges was diagnosed with chronic myelogenous leukemia (CML) in 2011, only a few months after he lost his partner Ellen to ovarian cancer, he wasted little time grieving or wondering where to go for treatment. “Ellen had gotten excellent care at Yale, so I went to see Wajih [Zaheer Kidwai, MD, FACP] at the Smilow Cancer Hospital Care Center in Guilford, CT. It’s convenient and it’s still part of Yale, so you get the best doctors,” said Mr. Sturges.

At 81, Mr. Sturges still has the commanding air of the former naval officer he is. “I was on the personal staff of the Chief of Naval Operations as his flag journalist,” he said. Because of that training, he took what he describes as a “military approach” to dealing with his diagnosis. “It’s the only way to get things done,” he explained. “A military approach requires good communication and follow through and discipline.”

Mr. Sturges ended up needing that discipline, because his case turned out to be surprisingly complex, calling for stamina on his part and creative thinking on the part of his oncologist. “Usually, when patients have CML, in which the bone marrow produces too many white blood cells, the standard treatment is to give them imatinib, a drug that targets the molecule responsible for the chromosomal abnormality that causes the disease. With imatinib, also known as Gleevec, most patients go into remission,” said Dr. Kidwai, an Associate Professor of Clinical Medicine (Medical Oncology) and Medical Director of the Smilow Cancer Hospital Care Center in Guilford.

That wasn’t always the case. Before imatinib was approved by the FDA in 2001, the life expectancy for CML was only about three years. “Now, patients take a pill a day for the rest of their life, and you’d never know they had cancer,” marveled Dr. Kidwai. “It’s a true game changer.”

But imatinib didn’t work for Mr. Sturges. In fact, soon after he started the regimen, he developed a rare type of allergic skin reaction that nearly killed him. “I could hardly move,” recalled Mr. Sturges. “My hands swelled, my knees swelled, everything swelled. I ended up in the hospital for three weeks at Smilow, and I couldn’t get out of bed or do anything until every trace of the medication was out of my body. It was a very scary experience. But Dr. Kidwai helped me get going again and administered the discipline to get me on my feet and moving.”

After spending more than a month in a rehabilitation facility learning to walk, eat, and function again, Dr. Kidwai prescribed another medication known as SPRYCEL (dasatinib). “It has the same molecular target as Gleevec but a different side effect profile,” he explained. Because of Mr. Sturges’ history, Dr. Kidwai monitored him very closely, something his patient appreciated. “Initially, we met every two weeks, and Dr. Kidwai was extremely solicitous and careful,” he said. “Along the way, we kept discussing what was going on with research in the field, because treatment of CML is improving all the time, with more and more medications available.”

True to military form, it was often Mr. Sturges who drove those discussions. “Mr. Sturges is very detail oriented and very much involved in his own care, which is a good thing,” said Dr. Kidwai. “I feel a strong connection with all of my patients, but he is unique in that right from the start, he did the research on his condition, took responsibility, and became very knowledgeable about it. At every appointment, he asks, ‘What’s new in the field today?’ and we have a different discussion every time.”

Indeed, Mr. Sturges decided to go further than mere talk and research: He started an endowment fund at Yale Cancer Center focused on CML and other myeloproliferative disorders focused on keeping patients and the public up to date about what is going on in the fast-changing field. “I’d started an endowment for ovarian cancer after Ellen died, and I figured I would do the same thing here, for CML. I told Dr. Kidwai that my intent was to fund a series of lectures, using me and other patients as case studies.” Characteristically, Mr. Sturges has a crystal-clear vision for the project, right down to how to publicize it.

That teamwork is paying off. Mr. Sturges is now in complete remission. And recently, after 10 years on SPRYCEL, he has gone off the drug due to a side effect which in Mr. Sturges’ case led to a build-up of fluid in one of his lungs. But even without the medication, his numbers have been excellent. Other than the aches and pains of age—“At 81, you face all kinds of things,” he mused, for Mr. Sturges, CML is “off the worry plate,” as he puts it. “Medications like Gleevec and SPRYCEL have created a cancer victory for this type of leukemia,” Mr. Sturges said. “That’s due to everyone’s contributions in the field. Dr. Kidwai is at the top of my team, and he deserves credit for that.”

PROACH TO CANCER CARE



New Research on Colorectal Cancer

Innovative therapies are expanding treatment options for patients with cancer and changing the way many cancers are managed. Unfortunately, some types of cancer have benefitted less than others. The standard treatment for colorectal cancer (CRC), for example, remains cytotoxic chemotherapy, even though CRC is the third most common cancer and the third most common cause of cancer death among both men and women.

Michael Cecchini, MD, Assistant Professor of Medicine (Medical Oncology), Co-Director of the Colorectal Program in the Center for Gastrointestinal Cancers at Smilow Cancer Hospital and Yale Cancer Center, and a member of Yale Cancer Center's Developmental Therapeutics Research Program, has been working to change that. His research got a boost and a large vote of confidence last fall when the National Cancer Institute awarded him a K08 grant, more formally called a Mentored Clinical Scientist Research Career Development Award.

Michael Cecchini, MD

“What it really does is ‘protect’ my time,” said Dr. Cecchini, “so I can devote more time to research that advances the field of colorectal cancer.”

The research grant aims to investigate multiple clinical trials for patients with colorectal cancer, initiated by Dr. Cecchini under the mentorship of Patricia LoRusso, DO, Professor of Medicine (Medical Oncology) and Associate Cancer Center Director for Experimental Therapeutics. The first trial is a Phase II study in which patients will be treated with a combination not normally used against colorectal cancer: temozolomide (TMZ), a well-known drug, and olaparib, from the relatively new class of drugs of PARP inhibitors.

TMZ has been used for some time against gliomas and glioblastomas (GBMs). The drug damages a tumor cell’s DNA, which can slow or stop the tumor’s growth. It is well established in the literature that gliomas and GBMs became more sensitive to TMZ when a protein called O6-methylguanine-DNA methyltransferase (MGMT) was hypermethylated in the tumor—that is, absent or silenced. MGMT is crucial to the repair of damaged DNA caused by TMZ, so when MGMT is absent, the tumor’s DNA cannot repair itself.

“Reviewing the literature, I realized that the same defect—the loss of MGMT—is present in colorectal cancer in up to 40 percent of cases,” said Dr. Cecchini. “That has been historically underappreciated. MGMT is a potential biomarker we can identify in these colorectal tumors. So, I thought, ‘Ah ha! Maybe we can think about this subtype of colorectal cancer the way we think about GBM and use similar drugs on colorectal cancer, which we normally would never think to use.’ I’m also trying to take it a step further by adding on drugs to synergize with TMZ for more efficient killing of colorectal cancer.”

The synergy comes from adding the PARP inhibitor, olaparib. PARP inhibitors

This is also an opportunity to develop biomarker-driven therapies so that we can give the right patients the right treatment at the right time. That’s really what I’m interested in developing.”

—Dr. Michael Cecchini

kill cancer cells by hindering DNA repair. “So, you impair DNA repair with one approach,” said Dr. Cecchini, “and then add to that a PARP inhibitor.” The trial is identifying patients that have MGMT promoter hypermethylated colorectal cancer and offering enrollment in the trial of temozolomide plus olaparib.

“This is also an opportunity to develop biomarker-driven therapies so that we can give the right patients the right treatment at the right time. That’s really what I’m interested in developing,” said Dr. Cecchini, “because after chemotherapy we have few options to offer to our patients with colorectal cancer.” The trial is enrolling patients now.

Dr. Cecchini’s other clinical trial, which he hopes to open by the end of 2022, will combine TMZ with an inhibitor of ATR, another protein involved in DNA repair. “This is a true Phase I study,” said Dr. Cecchini. “It will be the first clinical experience anyone has had with this combination of drugs, and it’s potentially a more potent combination than TMZ and olaparib.” The trial’s goals are to

determine toxicity and safe dosage in anticipation of a Phase II trial.

The most urgent need for patients with colorectal cancer, says Dr. Cecchini, is immunotherapy. He is intensely curious to see whether the drug combinations he is studying will stimulate the immune system to the point where it begins attacking and killing cancer cells on its own.

“We think that certain therapies increase the tumor’s mutational load,” said Dr. Cecchini. “The more mutations the tumor has, the more likely that one of the mutations will lead to a neoantigen that can be highly recognized by the immune system.”

In some lab experiments, TMZ has been shown to have that effect. If TMZ can do that on its own, Dr. Cecchini reasoned, maybe adding other agents that damage DNA will further increase the mutational burden and let the immune system lock on to the cancer better. “If we can do that,” he said, “more T-cells will enter the tumor microenvironment to fight the colorectal cancer.”



Giving from the Heart

Lovemark happens to be their last name, but it's also the perfect name for the nonprofit foundation that Tiva and Jamie Lovemark have established to financially and emotionally support patients diagnosed with brain tumors at Smilow Cancer Hospital. Through their generous donations—nearly \$500,000 over the past five years—the couple is making their mark and showing their devotion to patients whose journey they understand so well.

In 2002, when Tiva was a high school freshman in nearby Stamford, CT, severe headaches prompted her to have an MRI. The diagnosis: a benign cerebellar brain tumor. She consulted with doctors elsewhere who pressured her to have brain surgery immediately. She and her parents weren't comfortable with that recommendation. Tiva was so young, an active cheerleader and gymnast, and she had no other symptoms.

Then they met with Charles Duncan, MD, FAANS, a now retired Yale neurosurgeon, who established the first dedicated pediatric neurosurgery program in Connecticut. "You feel like you're with a family member when you're with him," Tiva said. "His

Tiva and Jamie Lovemark

bedside manner stood out; it didn't feel so sterile. And my mom had done her research; he was the best neurosurgeon we could have seen in our area." Dr. Duncan recommended a different course for Tiva: They would instead monitor the tumor, with regular scans, rather than surgery.

However, MRIs are expensive. While in nursing school, Tiva didn't have health insurance to cover the scans. And even though she worked two jobs, she didn't have the money to cover the significant out-of-pocket expense. "I wrote to Yale to ask for a grant," Tiva said. "When I received it, I was very grateful. I felt, 'I'm going to give back some day.'"

Tiva's desire to pay it forward intensified with each stable scan and as she worked with oncology patients in her nursing career. When she met her husband Jamie, a pro golfer on the PGA tour, she shared her intentions with him. In 2017, the couple decided the time was right to make Tiva's wish come true. They established the Lovemark Foundation and put their plan into action.

They were introduced to Jennifer Moliterno, MD, FAANS, Associate Professor of Neurosurgery, Chief of Neurosurgical Oncology, and Clinical Director of the Chênevert Family Brain Tumor Center at Smilow Cancer Hospital and Yale Cancer Center. Dr. Moliterno has established herself as the busiest brain tumor neurosurgeon in Connect

icut and is renowned for taking on complex brain tumor cases that other neurosurgeons have referred to her for her expertise "The stars aligned when we met with Jen," Tiva said. "Our vision was symbiotic with what she was already doing on a personal level."

They all understood how a brain tumor diagnosis can put an enormous financial strain on families, even those who are normally able to cover their bills. The Lovemark Foundation would help alleviate that strain by covering expenses that patients sorely needed, by providing funds to be put towards mortgage or utility payments, wheelchairs and, particularly, transportation to seek the exceptional care at Smilow Cancer Hospital.

"As a neurosurgical oncologist, I strive to give my patients the best clinical outcome with the safest and most aggressive surgery possible," Dr. Moliterno said. "The generosity of the Lovemark Foundation perfectly aligns with the overarching clinical mission of our Brain Tumor Center and that is to provide the most exceptional care with compassion and support. The Lovemark monies also allow people who may not otherwise have the resources to travel here from afar to now do so and receive the high quality of care that we provide."

Those costs are covered by the Lovemark Foundation's annual Charity Golf Pro-Am tournament. Every penny

raised goes directly to patients. Given his longevity on the PGA Tour, Jamie has been able to recruit many of his friends and fellow pros—including Luke Donald, Keegan Bradley, and Camilo Villegas—to participate in the tournament. "We usually get between 15 to 18 pros, which stands out in the PGA Tour community," Tiva said. "The fact that our friends come back year after year says a lot about the tournament."

As the pandemic unfolded in 2020 and forced the cancellation of the golf tournament, the Lovemarks still made a sizeable donation at year's end to help brighten the holidays for patients and families with young children. "I know firsthand that you can work so hard, but sometimes it's just not enough," Tiva said. "Sometimes you need a bump—maybe just \$1,000—especially at the holidays to get you over the next hump and get you where you need to be."

The tournament resumed in 2021. Jamie and friends will be back on the links at the Hudson National Golf Club on June 27 for another round of golf and another infusion of support for patients cared for through the Chênevert Family Brain Tumor Center. "Tiva and Jamie are such kind and generous individuals," Dr. Moliterno said. "Their work comes from the heart. I'm so thankful on behalf of our patients for the ongoing support they provide our patients." 🔄

The generosity of the Lovemark Foundation perfectly aligns with the overarching clinical mission of our Brain Tumor Center and that is to provide the most exceptional care with compassion and support.

—Dr. Jennifer Moliterno



Treating the Whole Patient

It's exhilarating to build something from scratch—to design and mold it exactly as you want it to be. Smilow Cancer Hospital's new Psycho-Oncology Program draws on best practices from across the country and within Smilow to provide psychotherapy counseling and support for patients experiencing challenges such as depression, anxiety, insomnia, and fatigue while undergoing cancer treatment.

“There is a high incidence of psychological distress that comes with a cancer diagnosis,” said Shannon Mazur, DO, MA, Assistant Professor of Psychiatry in the Section of Psychological Medicine and one of two care providers leading the new Psycho-Oncology Program. “There are also patients who already had pre-existing psychological conditions that may or may not have been treated. We target the acute symptoms they're facing related to their cancer treatments with the hope of improving their quality of life and ability to fully access what they need for their care.”

When she was recruited to launch the program, Jennifer Kilkus, PhD, Assistant

**Shannon Mazur, DO, MA, and
Jennifer Kilkus, PhD**

“I’ve always had this connection to the importance of treating the whole person, not just the symptoms, and making sure we’re providing patients with the best quality of life they can have.”

—Dr. Shannon Mazur

Professor of Psychiatry, knew immediately what her top priority would be for the new initiative. “It had to be collaborative,” she said. “This is not just a referral service. We want to be as integrated as possible, where we’re communicating with a patient’s oncologist and other members of the treatment team to share feedback about the patient.”

Drs. Kilkus and Mazur receive patient referrals from Smilow’s fellow care team members and assess how to best meet the needs of each patient. Some patients may be better suited for group therapy rather than individual therapy. Others may be struggling with challenges not related to their treatment—such as relationship or family issues—that are better addressed by a therapist outside the hospital. “It’s normal to need support,” Dr. Kilkus said. “We can help them figure out what type will be the most helpful.”

Both women felt a strong calling to this line of work. Dr. Mazur had worked in hospice care prior to joining Yale. “I’ve always had this connection to the importance of treating the whole person, not just the symptoms, and making sure we’re providing patients with the best quality of life they can have,” she said.

Dr. Mazur balances her outpatient clinic with inpatient consultation services. She helps patients manage

their medications for such conditions as depression and anxiety. When patients with psychiatric needs are admitted to Smilow, she reviews their chart with other care team members to see which medications and conditions to be aware of and if the patient would benefit from the Psycho-Oncology Program. “Because we take a collaborative care approach, we are proactive in trying to get in front of any issues before there is any distress,” Dr. Mazur said.

Dr. Kilkus describes her role in the Psycho-Oncology Program this way: “I’m not a psychologist who just happens to work in a cancer center. I’m a psychologist who works specifically with cancer-related issues.” She helps patients adjust to their diagnosis, handle changes in mood, address their fear of recurrence, manage physical symptoms, side effects, and stress, and transition to life after treatment.

To guide patients through these challenging phases, Dr. Kilkus draws on cognitive behavioral therapy in her individual psychotherapy sessions. This approach identifies thought patterns and behaviors that can adversely affect a patient’s well-being and provides solution-focused interventions that patients can use in their daily routines to break the negative cycle and improve their quality of life.

For example, if a patient’s fatigue from treatment leads them to stay in bed all day, perhaps they can progress to sitting up in bed, or rising to shower and change clothes. If a patient is withdrawing from loved ones, maybe they could start by talking to one person a day. “If we can pick one small, simple task to do to address an issue, it gives the patient a sense of accomplishment,” Dr. Kilkus said.

Fellows from the clinical psychology internship program have assisted Dr. Kilkus in leading group psychotherapy sessions, which have addressed such topics as mindfulness and cognitive behavioral therapy skills for cancer survivors.

Dr. Kilkus reassures patients that what they’re feeling and experiencing in this extremely challenging period of their lives is normal. “There’s a strong narrative in our culture that if you’re struggling, that you’re doing something wrong or need to be stronger or more positive,” she said. “Really, it’s just part of being human. We all struggle when we encounter difficulties. I have the opportunity to really hear them and help them make changes that may serve them better with what’s happening right now in their lives.” 



Smilow Cancer Hospital Care Centers at Trumbull and Fairfield

CENTER AT A GLANCE

- A patient-centered focus on exceptional cancer care with 50+ staff members and oncology board certified clinicians
- Medical Oncology: 2,100+ patient visits & 1,800+ infusion visits per month
- Radiation Oncology: 1,000+ radiation patient visits monthly
- Multispecialty care teams, including breast, lung, head & neck, gynecologic, gastrointestinal, and melanoma surgery expertise
- On site diagnostic imaging, pharmacy, and clinical trials
- Access to supportive care clinicians, including an oncology nurse coordinator, social workers, a dietician, clinical research staff, palliative care, and survivorship planning
- Access to Integrative Medicine services, including massage, Reiki, acupuncture, music therapy, and psychology

SMILOW CANCER HOSPITAL CARE CENTERS AT TRUMBULL & FAIRFIELD

TRUMBULL:

5520 Park Avenue
Park Avenue Medical Center
Trumbull, CT 06611
(203) 502-8400

FAIRFIELD:

111 Beach Road
Fairfield, CT 06824
(203) 255-2766

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meet the physician

Sarah Schellhorn Mougalian, MD

Associate Professor of Medicine (Medical Oncology)
Chief Ambulatory Officer

You have led an initiative to bring Next Day Access to patients at Smilow Cancer Hospital. How has Next Day Access impacted the delivery of patient care? How have patients responded?

One of the most anxiety-provoking times in a patient's cancer journey is the time between diagnosis and the formulation of a treatment plan. We are committed to minimizing that anxiety by seeing patients as quickly as possible. Although all of the necessary information may not yet be available at the time of that first appointment, patients have appreciated the opportunity to meet the team, ask questions, and get a sense of what their treatment may be. Our feedback has been overwhelmingly positive.

Your clinical practice is focused on the care of women with breast cancer. What recent advances are making the biggest impact for your patients?

It's an exciting time in breast cancer drug development. Some of the most exciting advances in breast cancer relate to both immunotherapy, which harnesses a patient's own immune system to help fight the cancer, and more cancer-targeting therapy, where specific abnormalities in a cancer cell can be addressed by treatments that are less toxic than traditional chemotherapy. We are also using several antibody-drug conjugates, which serve to deliver potent chemotherapy directly to cancer cells and their surroundings, with less effects on normal tissue and therefore fewer side effects.

Breast cancer treatment and care is a multidisciplinary effort; how do you collaborate with your colleagues at Smilow Cancer Hospital to create a plan for your patients?

I rely on my colleagues in radiology and pathology to provide me with the information I need to present treatment options to my patients. I work closely with the breast surgeons and the breast radiation oncologists, as well as the reconstructive surgeons at Smilow Cancer Hospital, and many times we see patients on the same day or even at the same time during one appointment. Ultimately, we all work together to make sure that we not only treat the cancer, but also address every patient's individual goals and values.

Read their stories:
<https://www.ynhh.org/smilow/news-media/survivor-stories>

