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00:00:00.076 --> 00:00:21.730 Announcer Funding for Yale Cancer Answers is provided by Smilow Cancer Hospital. Welcome to Yale Cancer Answers with the director of the Yale Cancer Center, Doctor Eric Winer. Yale Cancer Answers features conversations with oncologists and specialists who are on the forefront of the battle to fight cancer. Here's Doctor Winer.

00:00:21.807 --> 00:01:05.115 Eric Winer My guest tonight is Doctor Michael Cecchini, who is an associate professor at Yale School of Medicine and co-director of the Colorectal Program in the center for Gastrointestinal Cancers. He's also an investigator in our phase one program, phase one, meaning drug development, and director of the GI clinical research team here at the cancer center. Mike, you have a lot of titles, primarily, though, he is a doctor who takes care of patients with largely colorectal cancer and does research related to colorectal cancer and some other GI cancers.

00:01:05.153 --> 00:01:08.846 Eric Winer So, Mike, welcome to Yale Cancer Answers.

00:01:09.153 --> 00:01:10.653 Michael Cecchini Thanks for having me today, Eric.

00:01:10.692 --> 00:01:22.769 Eric Winer First, you know you are in the GI cancer world about how much of your time do you spend taking care of patients who have specifically colorectal cancer?

00:01:22.846 --> 00:01:51.153 Michael Cecchini Yeah, so I see patients in the clinic two days a week. I do a one day of our phase one clinic where I do only see primarily patients with gastrointestinal cancers there. But in that clinic, I do see patients that have pancreas cancer, biotech, cancer or gastric cancer as well. But still, I would say the proportion, maybe two thirds of the patients I see there have colorectal cancer, and then probably 80 to 90% of my colorectal, my gastrointestinal practice the other day is colorectal cancer.

00:01:51.230 --> 00:01:56.192 Eric Winer All right. And what got you interested in cancer?

00:01:56.269 --> 00:02:22.000 Michael Cecchini Well, I think first my interest started in gastrointestinal cancers and that started in fellowship. Like many things in life. Great mentorship can lead you to focus on areas of need and in specific areas of medicine. So I had two great mentors when I was a fellow here at our our at our cancer center here, Doctor Russo mentoring me in the phase one arena, and Doctor Joe Lacey mentoring me in the GI arena.

00:02:22.038 --> 00:02:39.115 Michael Cecchini So that got me kind of focused on GI cancers, where I saw just this huge need. And then specifically with colorectal cancer, this disease that has a very high incidence, seeing this huge need, very, very.

00:02:39.192 --> 00:02:57.000 Michael Cecchini A huge need in terms of new therapies. We're using full fox. You're using full theory repeated really. And not a lot of the new therapies that were coming through were making an impact in the patients that I was seeing. So that drew me to try and try and improve upon that, make new therapies available for these patients.

00:02:57.115 --> 00:03:03.192 Eric Winer Educate us a little bit about colorectal cancer. How many cases are there in the US each year?

00:03:03.269 --> 00:03:34.576 Michael Cecchini There's about 156,000 patients that are diagnosed annually with colorectal cancer in the United States. Overall, if you look at the incidence, it's actually gone down over time because of effective screening. However, it's not going down remarkably fast. And there are certain age groups this actually rising, which is of course been highlighted quite a bit, both in the news as well as our literature, that there's this rising early onset rectal cancer, largely defined as in each group less than 50.

00:03:34.615 --> 00:03:42.769 Eric Winer And of the 150,000 plus cases, what proportion in men versus women?

00:03:42.846 --> 00:03:48.500 Michael Cecchini It's largely it's largely split 5050 between men and women.

00:03:48.576 --> 00:03:58.384 Eric Winer This decline in incidence because of screening, that's because the screening can actually eliminate premolar lesions.

00:03:58.461 --> 00:04:24.076 Michael Cecchini Yeah. Screening is a very powerful tool for this disease. Largely. It used to be when I started my training, I just starting on the faculty that colonoscopy was recommended. And adults above the age of 50. The screening guidelines have changed to screen 45 and above. And while colonoscopy I think is a powerful tool, at the end of the day, I think the right screening test is the one that a patient is willing to do.

00:04:24.153 --> 00:04:42.230 Michael Cecchini And so there are fecal testing. There's even blood based testing now. But but colonoscopy, as you alluded to, has the potential to not just diagnose and early lesion or a polyp, but really to remove pre malignant lesions. And so it's an incredibly powerful screening tool.

00:04:42.269 --> 00:04:46.307 Eric Winer So can actually prevent colon cancer from developing.

00:04:46.384 --> 00:04:51.423 Michael Cecchini Absolutely diagnose cancer at an earlier stage or hopefully prevent it from becoming cancer.

00:04:51.615 --> 00:05:05.000 Eric Winer And in that way it's very different from mammography for example, which can't eliminate a woman's risk of developing cancer. It can only pick up cancers at a very early stage.

00:05:05.076 --> 00:05:06.423 Michael Cecchini That's great.

00:05:06.500 --> 00:05:25.807 Eric Winer Let's now turn to this topic of early onset cancers that you just started touching upon. The the incidence of colon

cancer in younger patients has risen, and it's pretty alarming how much of a change has there really been?

00:05:25.884 --> 00:06:01.807 Michael Cecchini Yeah, it's been rising for several decades now at a rate of about 2% per year. Overwhelmingly. Still, the median age is in the in the 60s, but but still, again, at about 2% per year. Since the 90s, the incidence has been rising in early onset disease still again represents a smaller fraction of the cancers we see. We don't, frankly understand why this rise is happening, but it's not it's not we're certainly not screening patients typically with average risk less than age of 45.

00:06:01.846 --> 00:06:36.384 Michael Cecchini But that doesn't explain why an incidence would arise. So there's some lifestyle there's some environmental factors that are playing a role in this. Not specifically what they are. We don't have enough to, I think, come down on a specific singular cause, like for example, smoking in lung cancer. But there's tremendous area of work going on in this regard at major cancer centers, including our cancer center, developing programs around early onset, both about how we maybe care for these patients clinically slightly differently, but certainly as well as developing research strategies to go to the heart of the matter of why this has happened in the first.

00:06:36.384 --> 00:06:42.038 Eric Winer Place, other hypotheses about why we're seeing more colon cancer and younger people.

00:06:42.115 --> 00:07:07.115 Michael Cecchini I mean, I think diet certainly has something to do with some of the lifestyle factors that are being investigated. There's certain, I think, pesticides that are being investigated. The microbiome is a big factor here. But that's such a complicated, you know, complicated piece to this. Every time I go to a microbiome, not sure. I think I walk out with more questions and that I walked in with.

00:07:07.192 --> 00:07:10.884 Michael Cecchini But but these things are regulating the microbiome and that is having some impact.

00:07:11.000 --> 00:07:17.384 Eric Winer And what do we know about the mortality rate of colon cancer in younger people?

00:07:17.500 --> 00:07:43.576 Michael Cecchini Yeah. Well, unfortunately younger people tend to be diagnosed at a more advanced stage than, than the average age of onset. And that's probably because it's ultimately misdiagnosed for a period of time. I unfortunately have a number of people in my practice that thought they had hemorrhoids, or were even told by clinicians that that was the most likely diagnosis.

00:07:43.576 --> 00:08:10.500 Michael Cecchini And I think, understandably, sadly, that's where many of our differential diagnosis would lead us to. I mean, hemorrhoids are certainly higher in incidence and these different age populations, but it's always important that GI bleeding is worked up properly. So higher incidence of stage four disease, which means higher incidence of scenarios where we ultimately can't cure the cancer. So mortality is worse.

00:08:10.692 --> 00:08:37.269 Eric Winer There has been no real screening in younger people, certainly under the age of 45. Now it goes down to 45 the recommendations. And then as you say, you know, when a doctor sees somebody who's 33 and has some GI bleeding, unfortunately some of the time they're all too willing to write it off as being a benign problem, something that doesn't have to be investigated.

00:08:37.269 --> 00:08:52.038 Eric Winer And, and, you know, there's there's probably a patient element to that too. But I think the message is if there's a problem, it really does need to be fully evaluated and not just chalked up to something that isn't going to be a problem.

00:08:52.115 --> 00:09:18.000 Michael Cecchini Yeah, that's that's completely right. The screening, you know, the screening guidelines are 45 is above and above. As you point out, the typical scenario when we think about adenoma condition to carcinoma invasive cancer. Is that a ten year process. So if we're really trying to reduce cancer in an age group that happens to be in the 40 to 45 range, we have to account for that when we recommend these concepts.

00:09:18.038 --> 00:09:49.346 Michael Cecchini Now, screening and guidelines around screening and and efforts to not over treat overdiagnosis are very important as well. But I do think we need to give careful thought to our guidelines. Now that 45 and above is for our average risk patients. And of course, we see patients that maybe have a first degree family member. And we need to be even more vigilant in those scenarios so that if you have a first degree family member that colonoscopy recommendations at age 40 or 10 years before the age the family member was diagnosed.

00:09:49.346 --> 00:09:57.307 Michael Cecchini So if a family member was diagnosed at age 42, my brother or something like that, then my guidelines would be 32 and above. I should start my screen.

00:09:57.346 --> 00:10:21.230 Eric Winer In terms of colon cancer, when you think about how advanced the diseases, what are the categories you look at? I mean, there is staging and there's stage one, stage two, stage three, stage four. Stage four is when the cancer has already spread outside of the colon and the regional lymph nodes. But what about stage one and stage two disease?

00:10:21.307 --> 00:10:27.076 Eric Winer What's the prognosis for those conditions. And and how do you define stage one. Stage two.

00:10:27.230 --> 00:10:49.615 Michael Cecchini Yeah. So stage one, two and three are all localized disease into the colon the rectum or and for sage three the surrounding lymph nodes. But stage one is a small tumor that starts within the lumen, the inside of the colon and has not invaded much through the walls of the colon. The difference between stage one and stage two is that depth of invasion into the walls of the colon.

00:10:49.615 --> 00:11:19.846 Michael Cecchini If you think about the the the walls of the second onion with layers, cancer starts to invade through those

layers. And that's it. It becomes more band stage. The prognosis with stage one colorectal cancer is exceptionally good. The vast majority of patients are cured with surgical, operational low, and then there is no recommendation for additional chemotherapy. We sometimes give chemotherapy after surgery for colorectal cancer to mop up any particles that might be left behind in stage one, the likelihood that is so low, we don't recommend that.

00:11:19.846 --> 00:11:25.576 Michael Cecchini And again, surgery is considered to be cured in the vast majority, least 90% of people.

00:11:25.730 --> 00:11:27.000 Eric Winer In stage two.

00:11:27.038 --> 00:11:44.076 Michael Cecchini Yeah. So stage two is when it's invaded a little bit more, yet has not spread to the leaf node. And we make the staging. We're confident that the staging is stage one or stage two after that surgery has occurred and they've removed the tumor and we can really look under the microscope and say, This is invaded through enough walls to be categories.

00:11:44.230 --> 00:12:07.615 Michael Cecchini Stage two or it has into the stage one. But stage one, excuse me, in stage two is a very heterogeneous prime because we subtype the cancer staging even more. We say stage two A, stage two B, stage two C, and stage two A has an exceptionally good prognosis. And if there's no additional risk factors, we typically also will not recommend additional chemotherapy.

00:12:07.615 --> 00:12:32.423 Michael Cecchini But as the cancer becomes stage to see a meaning, going through more and more of those walls, colon to see actually has a worse than some of stage three. So for for many patients with stage two disease, we're still recommending chemotherapy. Curates again can range for from somewhere around 50 to 60% to more than 8,085% with that lower risk stage two.

00:12:32.461 --> 00:12:42.461 Michael Cecchini So it's a it's a wide range. And fortunately and that's where risk stratification and in-depth discussions with an oncologist for shared decision making are really key in that initial visit.

00:12:42.461 --> 00:12:54.615 Eric Winer And before we take our break, let me just ask you, for patients with stage three and some patients with stage two disease, when you give chemotherapy, how long a course of chemotherapy is that.

00:12:54.692 --> 00:13:13.307 Michael Cecchini Yeah. So for stage three, as you point out we recommend chemotherapy to just about everybody because that risk of recurrence has gotten up. And that risk of those particles exist is high. And we want to destroy them as we can. The chemotherapy. We again we risk stratify lower risk diseases. We disease states. We give three months of chemotherapy and higher risk.

00:13:13.307 --> 00:13:16.807 Michael Cecchini We typically give six. And that's

the and that's the full duration.

00:13:16.846 --> 00:13:23.615 Eric Winer And it's chemotherapy that's hard to get through easy. You know chemotherapy varies a great deal.

00:13:23.653 --> 00:13:48.269 Michael Cecchini Yeah I don't think I would ever describe chemotherapy as easy because of course there are completely different experiences that all of our patients encounter. But it is it is therapy that with the proper dose modifications, we can get nearly every patient through it to complete the course that we set out to do. Now, I think one of the arts of what we do as oncologists is really not just treating the patient so that they are in bed for two weeks and miserable, right?

00:13:48.269 --> 00:14:02.153 Michael Cecchini It's finding what that balance is and tweaking the doses. So there's actually manageable for the patient that we're treating. And I would say in the vast majority of patients, we can get through some form of that six months or three months of chemotherapy in a manner to them.

00:14:02.230 --> 00:14:20.153 Eric Winer All right. So we're going to have to take a break. When we come back, we'll talk about some newer treatments for colorectal cancer. We'll talk about some of the research that you're doing and what excites you the most and what you you see coming down the pike in the future. And we'll be back in just a minute.

00:14:20.230 --> 00:14:40.538 Announcer Funding for Yale Cancer Answers comes from Smilow Cancer Hospital, where experts on the forefront of cancer research and clinical trials, advanced research, prevention and patient care. Smilow's Cancer Research provides some patients with access to unique cancer clinical trials. SmilowCancerHospital.org.

00:14:40.615 --> 00:15:11.192 Announcer The American Cancer Society estimates that more than 65,000 Americans will be diagnosed with head and neck cancer this year, making up about 4% of all cancers diagnosed when detected early, however, had a neck. Cancers are easily treated and highly curable. Clinical trials are currently underway at federally designated comprehensive cancer centers, such as Yale Cancer Center and Smilow Cancer Hospital, to test innovative new treatments for head and neck cancers.

00:15:11.423 --> 00:15:39.423 Announcer Yale Cancer Center was recently awarded grants from the National Institutes of Health to fund the Yale Head and Neck Cancer Specialized Program of Research Excellence, or Spore, to address critical barriers to treatment of head and neck squamous cell carcinoma due to resistance to immune DNA damaging and targeted therapy. More information is available at YaleCancerCenter.org. You're listening to Connecticut Public Radio.

00:15:39.461 --> 00:16:15.846 Eric Winer Welcome back to Yale Cancer Answers. I'm Eric Winer and I'm speaking tonight with Doctor Michael Cecchini, who is an expert in colon cancer. Let's talk about some new research, if not brand

new research treatments that have become available over the course of the past 5 to 10 years that weren't previously available. So before we get to treatments that are part of clinical trials and aren't yet available commercially, what's new in colon cancer over the past decade?

00:16:16.000 --> 00:16:50.730 Michael Cecchini Certainly. So one thing that we kind of briefly touched on in the first segment is the drug. Five, four years, I'll certainly not new was developed in 1957 by Charlie Heidelberger at the University of Wisconsin. Yet we still use it every day in our GI clinic. This forms a backbone that we add on to. We've added on certain biologics things like bevacizumab, drugs, the target Jeff, things like AB or cetuximab things which target ETF R and our antibodies are targeted that we these drugs aren't brand new.

00:16:50.730 --> 00:17:17.384 Michael Cecchini But we have figured out how to augment who should get them and who should get the other medications as well. So we really refined like what the first treatment we should start with in this disease is. And when you look back over the last 20 years, the median survival for metastatic colorectal cancer has increased dramatically. When we all we had a single age of five few 25 years ago, it was about a year.

00:17:17.384 --> 00:17:42.192 Michael Cecchini And now for left sided wild type where we know we can use the R inhibitors, the median survivals over a three over three years at this point, but still not good enough. A lot of work that needs to be done. And what we've also done now is subtype the disease say okay for Kras mutated colorectal cancer tumors. This is going to be the treatment or for Braf, V6 hundred mutated colorectal cancers.

00:17:42.192 --> 00:18:07.692 Michael Cecchini This is what we're going to do. One big breakthrough in the last couple of years has been Braf targeted therapy, which Braf v 600 is in very aggressive mutation. We've seen about 10% of the cancer and first was developed was Braf inhibitors in combination with EGFR inhibitors for second line or third line colorectal cancer. Now these have been moved up to the first line.

00:18:07.730 --> 00:18:36.538 Michael Cecchini And we're seeing results that are remarkably promising and consistent with non Braf v 600 mutated disease. So now the first line treatment for Braf v 600 mutated colorectal cancer would be full Fox again that five drug but plus a b a rat inhibitor and toxin map and that that used to be the the worst prognostic marker to have was a Brac mutation.

00:18:36.538 --> 00:19:05.000 Michael Cecchini And now with that combination the media survival is is on par with with wild type B rhapsody society mutations. So that was a big breakthrough. Another big breakthrough has been in a rare subtype of the disease called mismatch repair deficient colorectal cancer, where immune therapies have really been able to be effective. Now, unfortunately for the more traditional common colorectal cancer, which we call mismatch repair proficient or microsatellite stable immunotherapy doesn't work.

00:19:05.000 --> 00:19:31.500 Michael Cecchini But for this rarer subtype for 5% of metastatic disease drugs like it, a map and novel map or even map by itself have made remarkable progress. With ipilimumab and novel map. We see at two years about 72% of patients despite widespread metastatic disease progression free. And so I think that durability is quite remarkable with the immune combination for those patients.

00:19:31.500 --> 00:19:47.153 Eric Winer And for patients who don't have stage four disease but are diagnosed with earlier stage disease where there's mismatch repair. Haven't there been studies recently that have used immunotherapy alone as the only treatment?

00:19:47.192 --> 00:20:24.730 Michael Cecchini That's right, that's right. So for rectal cancer we saw about five years ago. Now pembrolizumab with an extraordinarily high complete pathologic response and complete clinical response to just pembrolizumab alone, diseases localized. So in many patients not even needing to go to surgery anymore. There's also been emerging data within the last two years, trials called niche, where they gave IP Mab in nivolumab before surgical operation for colon cancer, rectal cancer for colon cancer, and show that about two thirds of the time when we do the operation, which is only less than two months after that, the tumors were completely gone.

00:20:24.730 --> 00:20:45.576 Michael Cecchini So there may be even opportunities to deescalate the surgical approach for some of those patients as well. This is only for the mismatch repair division colorectal cancer. But well, while in the metastatic setting, I'm saying it's only 4 to 5%. In the localized setting it's about 20%. So it's a non metastatic phenotype for and more common than non metastatic disease.

00:20:45.576 --> 00:20:49.038 Eric Winer So is this something you test for in all new patients.

00:20:49.115 --> 00:21:04.000 Michael Cecchini That's right. So the initial biopsy it's something that's tested by immunohistochemistry. So by staining. And the pathologist looking at the tissue under the microscope and giving a report for the oncologists I might see the patient first or the surgeon that this is a tumor that has mismatch repair division or provision.

00:21:04.076 --> 00:21:21.846 Eric Winer When you were speaking before about Braf mutations, is it now standard that any patient with newly diagnosed metastatic colorectal cancer who might be a candidate for these regiments, do they all undergo testing for for these mutations.

00:21:22.076 --> 00:21:43.846 Michael Cecchini 100%, that molecular testing is absolutely necessary to make sure we're giving the most effective therapy for our patients. So I always educate my fellows and I'm teaching, but also my patients to be empowered with this information that that we need to know a handful of things about the tumor, about the anatomy, to make sure we're giving the right treatment.

00:21:43.846 --> 00:22:07.846 Michael Cecchini And one of them is the what we call next generation C, C, and C, or molecular testing, where we're seeing what mutations are present in the tumor. I need to know whether or not there's a mutation, a brief mutation or lack thereof, and also look for other rare mutations that may may be relevant to the care. But I also need to know about this Mr. match repair status that we just talked about, so that I can know his therapy going to be my recommendation over chemotherapy.

00:22:07.846 --> 00:22:24.384 Michael Cecchini I even need to know, did this tumor start on the left side of the colon or the right side of the column? Because that provides me information about which drugs to add on to in terms of biologics. Should I be using that as a map? If it's a left sided tumor where there's no mutation and no Braf mutation, should I use padded tumor matter?

00:22:24.461 --> 00:22:29.730 Eric Winer And the left right distinction is because biologically those cancers are different.

00:22:29.884 --> 00:22:54.423 Michael Cecchini That's correct. Yeah. So this was from post-doc analysis from some studies about a decade, 15 years ago now with those agents. And really it began to be looked at because these are different. These the left and the right colon come from different embryological tissue. And basically at the splenic lecture and distal would be hindgut versus midgut.

00:22:54.500 --> 00:23:21.269 Eric Winer Wow. Something I never knew when when you talk about median survivals of three years that's better than a year. But it's still not a long time. Now, of course, that's a median. So there are people who don't do quite as well. And then there are occasional people who do exceptionally well. But what are you doing to try to push that out further?

00:23:21.269 --> 00:23:27.692 Eric Winer What are what are the most promising different types of research going on these days?

00:23:27.807 --> 00:23:46.384 Michael Cecchini Sure. And I think also one thing to highlight is one thing that I asked myself, and we always ask ourselves that our group meetings are tumor boards is when we see a patient with with metastatic colorectal cancer and that cancer has spread to the lungs or the liver or perhaps even both. Does this patient still have a pathway to cure with limited disease?

00:23:46.384 --> 00:24:08.653 Michael Cecchini We can still incorporate surgery along with things like chemotherapy or other therapies. And there's still about 15 to 20% of people that can be cured with that approach. That is not high enough. We're trying to do better, but that is an important distinction that needs to be made. Is are we giving the chemotherapy with just pure palliative expectation, prolonged life, improved survival, improve symptom burden?

00:24:08.692 --> 00:24:27.500 Michael Cecchini Or are we doing because we actually think we can eradicate the cancer completely in about 15 to 20% of that disease? There's still that opportunity. But that also means the vast

majority of people, the cancer is not cured of it. And or we try that approach and it comes back. So so we're developing a number of novel therapies.

00:24:27.500 --> 00:24:51.000 Michael Cecchini There are Kras inhibitors there about G12, C inhibitor that's FDA approved. But there are a number of Cars inhibitors that are in development now. They're lagging behind what we see with pancreatic cancer, because it's a bit more complicated than colorectal cancer in terms of some of the resistance pathways that develops. So you actually need to develop combinations rather than by itself, which is always more complicated.

00:24:51.076 --> 00:25:14.038 Michael Cecchini I think two of the two of the big types of therapies, though, that are in phase three clinical trials for colorectal cancer are antibody drug conjugates. And there are two that are in phase three clinical trials right now. One is with a drug that targets CEA, one of the main tumor markers, and something that is expressed on the colon cancer cells, and one that it gets.

00:25:14.076 --> 00:25:38.076 Michael Cecchini CML was a drug called solicitous TXN, a trial that we have open at the cancer center. These are being compared as third line treatment compared to the standard of care which is which is into Bristol and bevacizumab. And we're where, you know, awaiting the results. The earlier studies that led up to these phase three studies were quite promising for both of these drugs.

00:25:38.153 --> 00:25:59.192 Michael Cecchini The other class of drugs that are being evaluated are something called bispecific antibodies. And these are being evaluated broadly, I would say across across cancer and by specific antibodies do two things. And sometimes trying to do two things in one drug is better than the sum of the parts. And that's that's the science that the science tells us.

00:25:59.269 --> 00:26:13.115 Michael Cecchini And so there's several drugs that bind to PD one and veg up as simultaneously. And that the man has the, the activity of a drug that's trying to take the brakes off of the immune system.

00:26:13.153 --> 00:26:28.346 Eric Winer So these are these are drugs that simultaneously target both the immune system trying to help a patient's own immune system fight the cancer, and also targets engine or blood vessel growth.

00:26:28.500 --> 00:26:55.076 Michael Cecchini That's right. Yeah. And and in theory they do cooperative binding meaning when they do both of those things together they do it better. And so that's that's why one drug is theoretically better than two. And we'll see how the results of those play out. And there's, there's three of these trials being evaluated in a phase three trial. So the last step potentially for approval of trials as initial therapy for colorectal cancer on top of the chemo.

00:26:55.115 --> 00:27:05.192 Michael Cecchini Again, these are being used as adjuncts. We hope someday we'll be having trials that are trying to get rid of

the chemo altogether, but we're not quite there, at least with the initial therapy yet.

00:27:05.269 --> 00:27:23.884 Eric Winer And so as we wrap up, I just want to ask you a couple of questions. So for patients with early stage disease. So stage 123 where the goal is cure, what are you most optimistic about in terms of pushing those cure rates in the years ahead?

00:27:24.038 --> 00:27:54.269 Michael Cecchini Well, I think one thing that we've discovered is that when colorectal cancer is localized or even maybe just not metastatic to the liver, there's more of an opportunity to use immune therapy and immune therapies. Real potential is this durability of response and potential complete eradication with a systemic therapy. And we've we've realized that this this dogma that colorectal cancer doesn't respond to immunotherapy has been true.

00:27:54.269 --> 00:28:15.076 Michael Cecchini Where in many of the therapy settings we've investigated it. But in the localized disease, it seems to be a bit of a different story. So even the microsatellite stable or mismatch repair partition, again, those are synonyms. Using immunotherapy before surgery, there's been some early data that shows that those those tumors actually can respond quite robustly to certain immune agents.

00:28:15.076 --> 00:28:21.115 Michael Cecchini So I'm optimistic we're going to incorporate immunotherapy earlier. And we're actually going to get to start to see it work.

00:28:21.115 --> 00:28:38.384 Eric Winer So Mike, thanks so much for our listeners. Again I've been talking to Doctor Michael Cecchini, associate professor of medicine at Yale School of Medicine and a leading expert in colorectal cancer. Thanks so much, Mike, and to our listeners. I'll see you again next week.

00:28:38.576 --> 00:28:57.692 Announcer If you have questions. The address is CancerAnswers@Yale.edu and past editions of the program are available in audio and written form at YaleCancerCenter.org. We hope you'll join us next time to learn more about the fight against cancer. Funding for Yale Cancer Answers is provided by Smilow Cancer Hospital.