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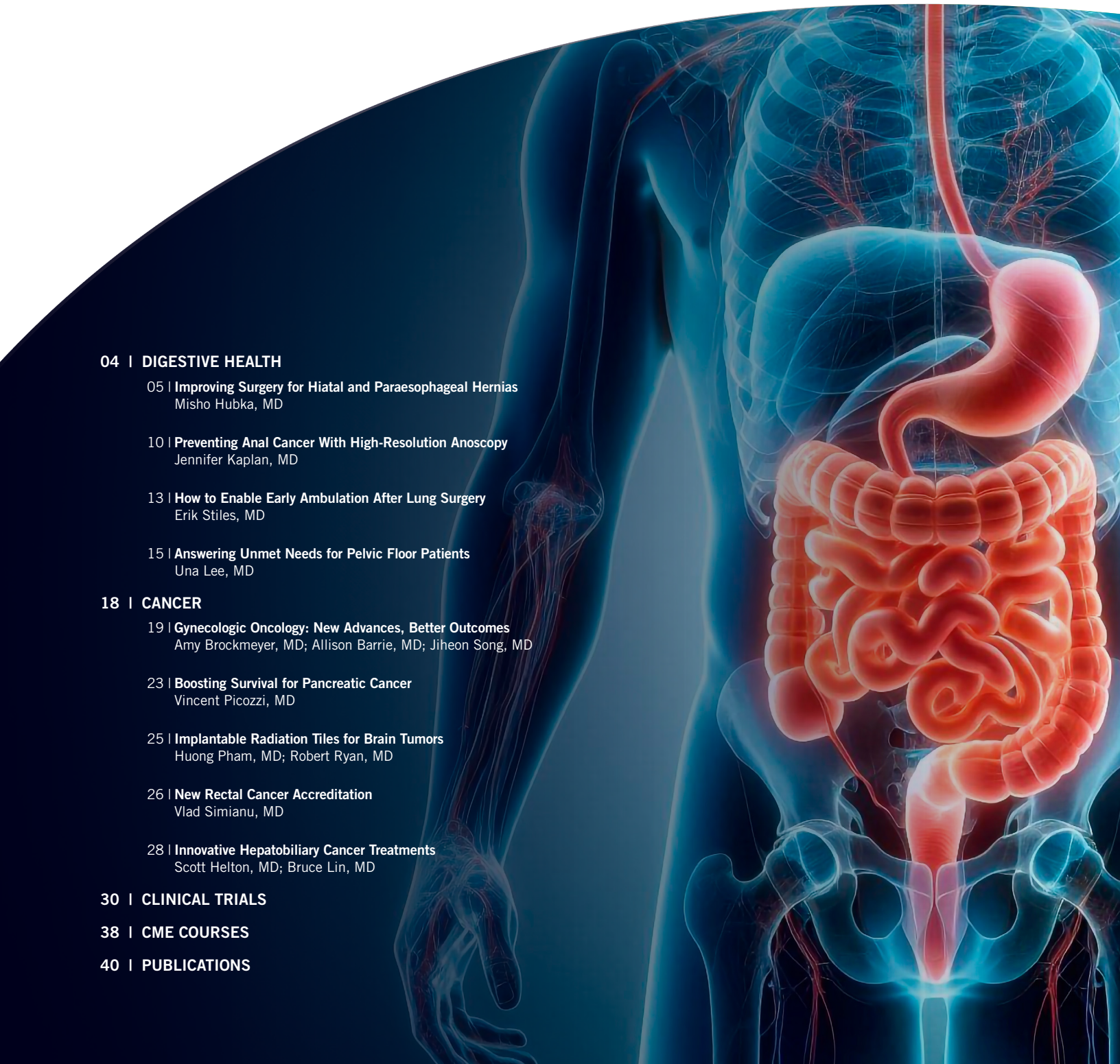

Message from the CEO

Dear Colleagues,

I am proud to introduce the latest issue of the Virginia Mason Franciscan Health Bulletin. This publication has been showcasing the expertise of our team members, highlighting scientific advancements, and breaking down walls between research and practice since 1922. I am grateful to Don Low, MD, who was the past editor of this publication and retired last year, and the many team members who have contributed over the years.

In the spirit of continuous improvement, you will notice a fresh new look and feel as well as some new content direction in this issue. After evaluating how to make the Bulletin as useful as possible to you, the reader, we're presenting not only research and clinical advances, but also highlighting specific programs and services at Virginia Mason Franciscan Health in shorter, more accessible articles. Our aim is to provide information you can use to help your patients today while keeping you abreast of research that holds promise to transform healthcare tomorrow.

I am excited to share this new format with you and build on the legacy of working with all providers, both inside and outside of Virginia Mason Franciscan Health, as partners in care. We will publish two issues of the Bulletin each year. This issue focuses on two of our key service lines, Digestive Health and Cancer Care, while our next issue will focus on Cardiovascular Health and Neurosciences and Spine Health.

As always, our commitment to clinical excellence and relentless pursuit of improvement in patient care is reflected in this edition's collection of articles. You'll learn about novel approaches to anal cancer detection; strategies to enable early ambulation for surgery patients; multidisciplinary specialty care for pelvic floor conditions; promising new therapies for gynecologic, rectal and pancreatic cancers as well as hiatal and paraesophageal hernias; innovative protocols for esophagectomy; and cutting-edge clinical trials for brain tumors and hepatobiliary cancers.

Our patients are fortunate to be the beneficiaries of the passionate, dedicated healthcare professionals and researchers who contributed to this issue of the Bulletin. I hope you enjoy learning about the medical advances, new technologies, and innovative treatments and procedures that are shaping the future of healthcare.

Sincerely,

Ketul J. Patel

CEO, Virginia Mason Franciscan Health

Northwest Region President, CommonSpirit Health

Section 1

Digestive Health

Providing the Most Appropriate and Effective Surgical Care for Hiatal and Paraesophageal Hernias

Michal (Misho) Hubka, MD

Hiatal and paraesophageal hernias (HH/PEH) are defined as gastric herniation into the posterior mediastinum through the esophageal hiatus. In HH, this results in loss of function of the antireflux mechanism. PEHs can cause postprandial chest discomfort, dysphagia and food regurgitation. It also carries a life-threatening risk of strangulation of the stomach.

At Virginia Mason Medical Center, we see some of the highest volumes of HH and PEH patients in the country, with over 2,000 operations performed in the last 23 years.

We follow a number of surgical and nonsurgical strategies that contribute to exemplary success rates, including a recurrence rate that is 2 to 7 times lower than that of other centers.

"Hiatal hernias are common and paraesophageal hernias are dangerous. Centers wishing to improve patient outcomes should understand key aspects and differences of these conditions and consider adopting the strategies that make our team successful," says Michal (Misho) Hubka, MD, thoracic surgeon at Virginia Mason Franciscan Health.

HH and PEH may both cause GERD but have important differences

Gastric acid reflux into the esophagus commonly causes heartburn and can result in reflux esophagitis. This condition is seen primarily in adults and often occurs with age.[1]

In the United States, approximately 20% of people experience gastroesophageal reflux disease (GERD) symptoms at least once a week.1 It has also been reported that approximately 110,000 people are hospitalized for GERD annually in the United States.[2]

We see some of the highest volumes of HH and PEH patients in the country, with over 2,000 operations performed in the last 23 years.

GERD occurs when the antireflux mechanism between the esophagus and stomach is compromised by disruption of the anatomy, making HH and PEH a common cause.[3]

Patients with GERD should undergo an endoscopy to look for herniation of the stomach into the chest and, when hernia is present, identify the type.

- Type I (HH) occurs when the stomach and the esophagogastric junction herniate into the chest.
- Type II (PEH) occurs when the stomach herniates through the hiatus adjacent to the esophagus.
- Type III (PEH) occurs when both Type I and Type II hernias are present together.
- Type IV occurs when the stomach herniates (PEH) along with another organ.

The vast majority of hernias affecting the esophagus are Type I/HH, which may cause painful symptoms but pose no serious risks. That is not the case for all hernias.

"With paraesophageal hernia — types II, III and IV — the stomach can become strangulated and lose blood supply, which can be life-threatening," Dr. Hubka says.

As a result, surgery is the first course of action for PEH, whereas some HH patients can be treated nonsurgically.

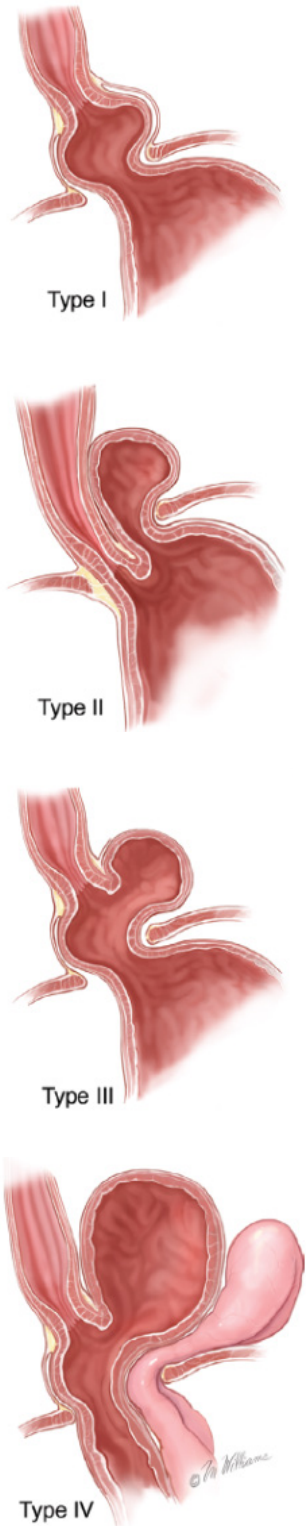

Image courtesy of Adult Chest Surgery 2nd Ed.

Surgery required for some HHs, all PEHs

Treatment for these hernias depends on the presence of symptoms and the type of hernia. In mild cases, lifestyle changes (e.g., not lying down immediately after eating, avoiding heavy lifting, weight control) and medication – including protein pump inhibitors (PPIs) – are recommended. In severe and recalcitrant cases, surgery may be necessary.

Pros and cons of laparoscopic and robotic surgeries

Minimally invasive surgery (MIS) techniques have advanced to the point that MIS is now the treatment of choice for many abdominal surgeries, including HH/PEH repair, yielding less postoperative pain, improved patient mobility and shorter hospital length of stay (LOS). The first laparoscopic HH/PEH repair was performed by Cuschieri, et al., in 1992, and since then laparoscopic HH/PEH repair has become the gold standard option for surgical treatment of HH/PEH.[4,5,6]

However, laparoscopic HH/PEH repair is a time-consuming and technically demanding procedure. Among other difficulties, surgeons contend with limited maneuverability and a lack of depth perception, due to two-dimensional (2D) imaging.

Robotic surgery has remedied these shortcomings. Since the Food and Drug Administration (FDA) approved the DaVinci robotic surgery system (Intuitive Surgical, Sunnyvale, CA) for clinical use in 2000, robotic surgery has grown in popularity.[7] Robot-assisted approaches offer better ergonomic conditions, a three-dimensional (3D) view, improved access to the mediastinum, and a wider range of motion — namely, the wrist-like movement of instruments that is very useful for suture closure of the diaphragmatic hiatus.[8] Our team at Virginia Mason Medical Center transitioned to robotic-assisted HH/PEH in 2018.

However, robotic surgery has also demonstrated drawbacks, including longer operative times and increased cost and complexity.[9] As such, the debate regarding optimal surgical approach is ongoing.

Surgery success: By the numbers

Our team has pursued excellence in surgical care for HH and PEH for more than 20 years, continually testing and implementing new practices to improve outcomes.

From 2000 to 2023, we surgically treated 1834 patients for HH and PEH. Patients ranged from younger than 30 to older than 90 and come from Washington, Oregon, Alaska, Idaho and beyond. Surgeries included open, laparoscopic and robotic-assisted procedures, with a growing emphasis on robotics as we have observed its effectiveness for a wide range of patients.

Extremely low recurrence and reoperation rates

Our recurrence and reoperation rates are now less than half what is common at other centers.

We evaluate for recurrence via follow-up esophagrams for all patients 3 and 12 months after surgery. Of those whose esophgrams demonstrate recurrence, those without symptoms are monitored; those with symptoms receive a second operation.

When is surgery recommended?

Sliding hiatal hernia (type I)	• When GERD symptoms persist after treatment with PPIs and eating modification. OR • When hernia is larger than 5 cm.
Paraesophageal hernia (type II, III, IV)	• When symptoms are present. OR • When hernia is larger than 5 cm.

	Recurrence Rate	Reoperation Rate
Virginia Mason Medical Center	8.6%	2.4%
Other Centers	15 to 60% [10,11]	10-16%[12]

Many other centers don't do follow-up scopes or imaging as a matter of course, so their recurrence data is based on patient responses to questionnaires.

"This means our recurrence numbers are not only lower but also more carefully monitored than the norm," says Dr. Hubka.

Sending patients home sooner

Our team has explored and adopted numerous practices to shorten patient length of stay, with the goals of improving patient value and experience and increasing capacity for our team.

Currently, our median length of stay for HH repair is 1.5 days — meaning a patient typically has surgery in the morning and goes home the following afternoon or evening.

In light of our low recurrence and readmission rates, this proves that it is possible for centers to reduce the duration of care without undermining outcomes.

"In fact, you can send people home sooner and reduce their odds of readmission at the same time," Dr. Hubka adds.

Robotics support success

To achieve these outcomes, we have adopted and developed numerous best practices during and after surgery.

On the surgical side, the most notable innovation is our use of robotics. Robotic-assisted surgery is now our dominant method for HH and PEH repair, accounting for nearly 4 out of 5 surgeries since 2020. While robotics carry some downsides in cost and complexity, as mentioned above, the upside in patient outcomes is substantial.

"Our data show patients are significantly more likely to have their symptoms resolved after robotic surgery compared to open surgery," Dr. Hubka says.

However, not every center has or can acquire the necessary equipment and experience for robotic-assisted HH and PEH repair.

"Luckily, there are other, more accessible ways to improve care as well," Dr. Hubka adds.

Nonsurgical factors contribute to improved outcomes

Our experience shows that many interventions affecting recurrence and length of stay occur after surgery. Centers that wish to improve patient outcomes and experience, therefore, should consider focusing on the following aspects of inpatient and outpatient care.

Aggressively respond to nausea

Managing patients' nausea is common practice after any surgery, but it is especially important after upper GI surgery. Retching puts exceptional strain on the diaphragm and surrounding tissue, which may not hold up mere hours after operation.

Median Length of Stay		
Other Centers	Virginia Mason Medical Center (2016)	Virginia Mason Medical Center (2024)
~3 days[13]	3.5 days	1.5 days

"Aggressive nausea management begins in the operating room with aggressive anesthetic techniques to minimize postoperative nausea and vomiting and continues immediately after the operation. This is one of the key factors to prevent early inpatient recurrence. I am happy to say that our stellar nursing staff helps us avoid this problem completely, by vigilantly monitoring patients and giving anti-nausea medication as soon as signs of nausea emerge," says Dr. Hubka.

Repeat esophagrams after surgery

If there is any sign of complication the day after surgery, we perform an esophagram. Then we can identify and treat any problems with anatomy and function before they worsen and jeopardize the repair or cause the hernia to return.

As noted above, we also see patients for follow-up esophagrams at 3 and 12 months after surgery. Standardizing these checkups enables teams to identify patients with recurrent but asymptomatic hernias, monitor those patients, and intervene sooner should their condition worsen. It also provides hard data to help teams target and measure improvements.

Ensure careful dietary advancement

Patients recovering from HH repair must follow a strict diet, advancing from clear liquids to pureed solids to soft foods over a span of several weeks. Breaking from this diet risks overtaxing the repaired tissue while it heals, which can require follow-up care.

To help patients adhere to the diet, a dietitian meets with each one after surgery and explains the dietary plan and offers advice for how to follow it.

"Talking to an expert gives patients tips and perspective that others can't provide. It makes the diet more achievable," Dr. Hubka explains.

Tips for enabling improvement

Identifying levers of change is one thing, but activating them is quite another. For centers that wish to implement some or all of the practices described above, Dr. Hubka has the following advice:

- **Focus on the patient's best interest.** Sometimes this means intensifying care, such as responding to nausea. Some aspects call for pulling back, such as monitoring patients with asymptomatic hernias rather than rushing to surgery. "Think of all the factors that matter to patients, and weigh them from their point of view," explains Dr. Hubka.

- **Strike a new balance for inpatient and outpatient resources.** Shorter lengths of stay require less of your inpatient care team. But that only works when you compensate with increased outpatient care and expert outpatient teams, including esophagrams after discharge to verify short- and long-term success.

- **Track your data and consult it regularly.** You can only improve what you measure. Track recurrence rates, complication rates and other outcome metrics and test how different practices affect them. Data not only provide you with a foundation on which to make improvements but also enable you to give patients highly personalized expectations about upcoming surgeries. "If you're a male patient in his 50s with a large paraesophageal hernia, you don't care about our success with someone older than you who has a different type of hernia. You want the data relevant to you. We document all that, so I can share the results most relevant to each respective patient," says Dr. Hubka.

HH and PEH may always be common, but high rates of recurrence and long hospital stays don't have to be. With attention to the details of different hernias, investment in beneficial practices, and a steady commitment to improvement, we can give patients a symptom-free future — and swiftly get them home to their own beds.

For more information or to discuss a patient, please contact Dr. Hubka at misho.hubka@vmfh.org.

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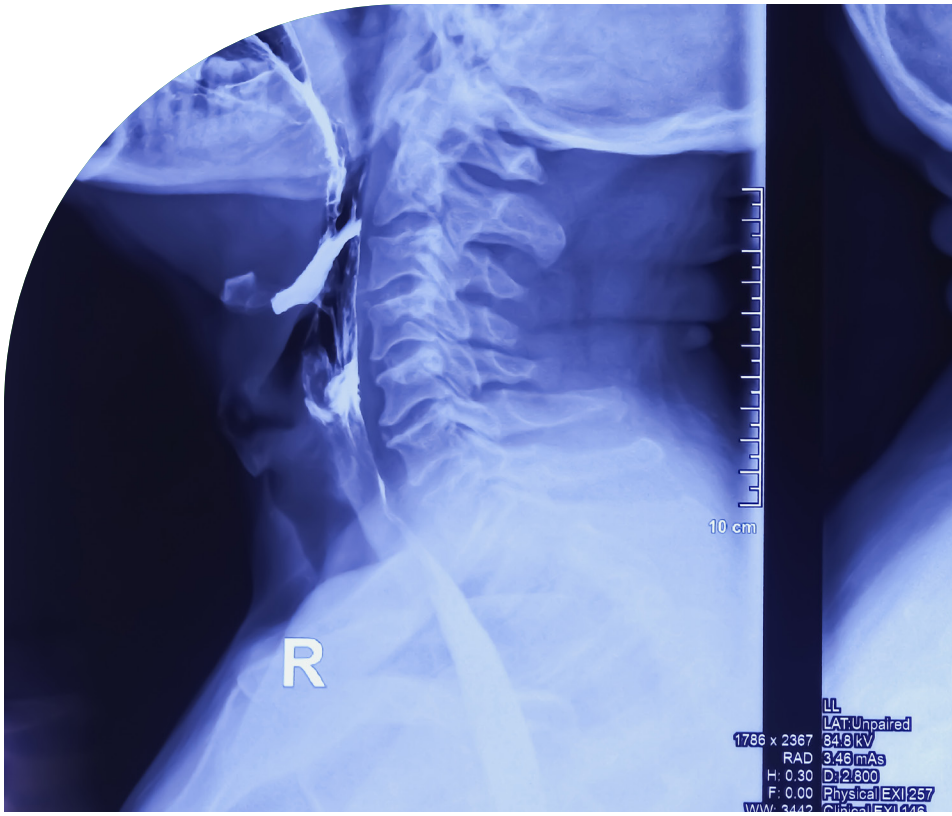

Preventing Anal Cancer With High-Resolution Anoscopy

Jennifer Kaplan, MD

Currently, no official screening protocol exists for detecting early signs of anal cancer and preventing it from developing. As a result, many patients aren't diagnosed until they experience symptoms and require intense treatment that typically results in a permanent colostomy.

High-resolution anoscopy (HRA) may change that. HRA enables surgeons to see and remove abnormal tissue within a patient's anal canal — similar to colposcopy for precancerous gynecologic conditions and colonoscopy for removal of precancerous colon polyps.

A recent study in adults with HIV proved HRA can be very effective at preventing the progression to anal cancer. Surgeons at Virginia Mason Franciscan Health took part in that study and are currently using HRA to screen and remove precancerous tissue from a variety of high-risk patients, including women with complications related to human papillomavirus (HPV).

While HRA is not new, it is also not widely used, and many providers are unaware of the procedure and its potential.

"Understanding who's at risk for anal cancer and how they can get screened is critical for reducing the impact of this difficult disease," says Jennifer Kaplan, MD, colorectal surgeon at Virginia Mason Medical Center.

Making precancerous lesions visible and treatable

HRA is similar to standard anoscopy but uses staining agents and a digital microscope to make precancerous lesions more visible. The staining agents are the same ones used for colposcopies and have the same effect: Acetic acid turns areas of dysplasia bright white, while iodine fails to turn those areas green.

"Lesions that appear acetowhite and iodine-negative are removed and sent to pathology," Dr. Kaplan explains.

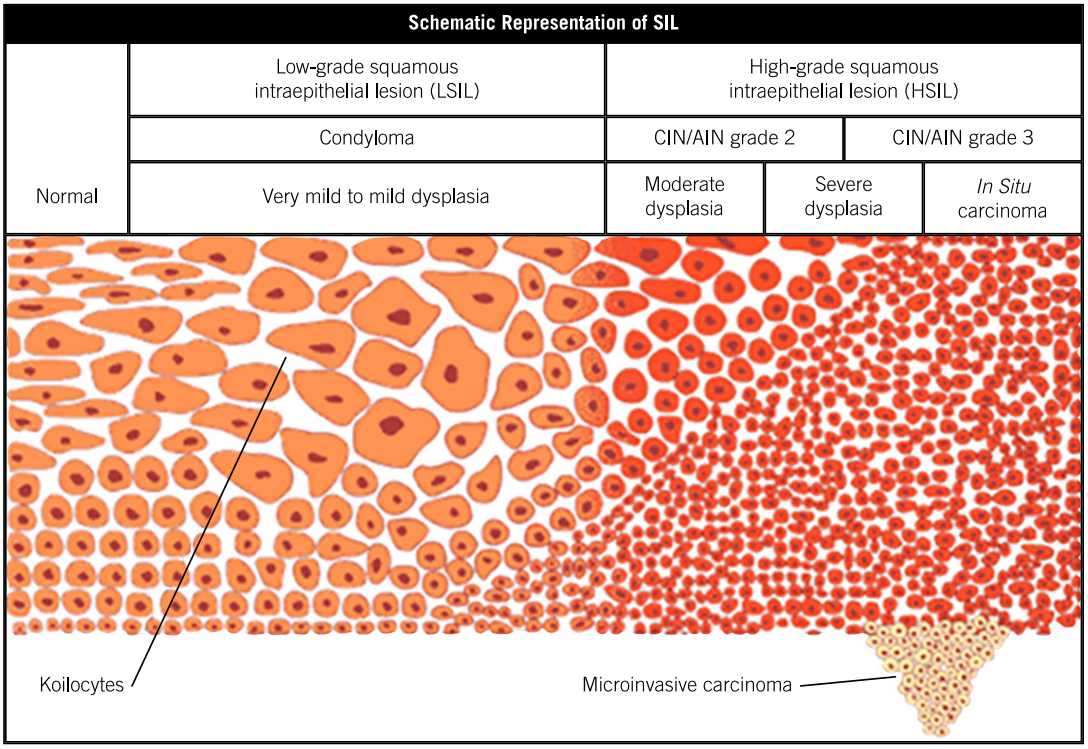

Image from Palefsky J. (2001). Screening for anal and cervical dysplasia in HIV-infected patients. The PRN Notebook, 6(3), 25.

Proof that HRA can reduce risk for anal cancer

The value of HRA was underscored dramatically in the Anal Cancer/ High-Grade Squamous Intraepithelial Lesion Outcomes Research (ANCHOR) study. Virginia Mason Medical Center was one of 21 sites participating in the study, which evaluated whether screening adults with HIV and removing precancerous lesions using HRA would reduce their risk of developing anal cancer. The study included more than 4,000 patients, split into two groups: one that had lesions removed, one that did not.

The treatment group fared significantly better, developing anal cancer at a rate nearly 60% lower than the monitor group.[1]

"The evidence was so clear that investigators closed the study early," says Vlad Simianu, MD, MPH, a colorectal cancer surgeon who directs the colorectal cancer service line and is medical director of the clinical research programs at Virginia Mason Medical Center. [h2] Which patients should be screened?

While the ANCHOR study was limited to HIV+ patients, many other populations face increased risk.

Primary care physicians are instrumental in identifying these patients and referring them for advanced testing and treatment. In fact, they should perform initial screening themselves, via digital rectal exam, in all patients over age 50.

"Patients in medium- and high-risk groups should be referred to a multidisciplinary care center for advanced testing and treatment," says Dr. Kaplan.

These include:

High-risk patients

- People who are HIV positive
- Men who have sex with men
- Women with vulvar or vaginal dysplasia

Medium-risk patients

- Women with cervical or vaginal cancer or cervical complications from HPV
- People who are immunosuppressed for other reasons such as solid organ transplantation

Providers should pay particular attention to symptoms in older women, who were not exposed to the HPV vaccinations we have today and who have the highest prevalence of anal cancer.[2]

"I see countless women with bleeding and other pelvic symptoms: They've been told it's hemorrhoids, but it's the beginning of anal cancer," Dr. Kaplan says.

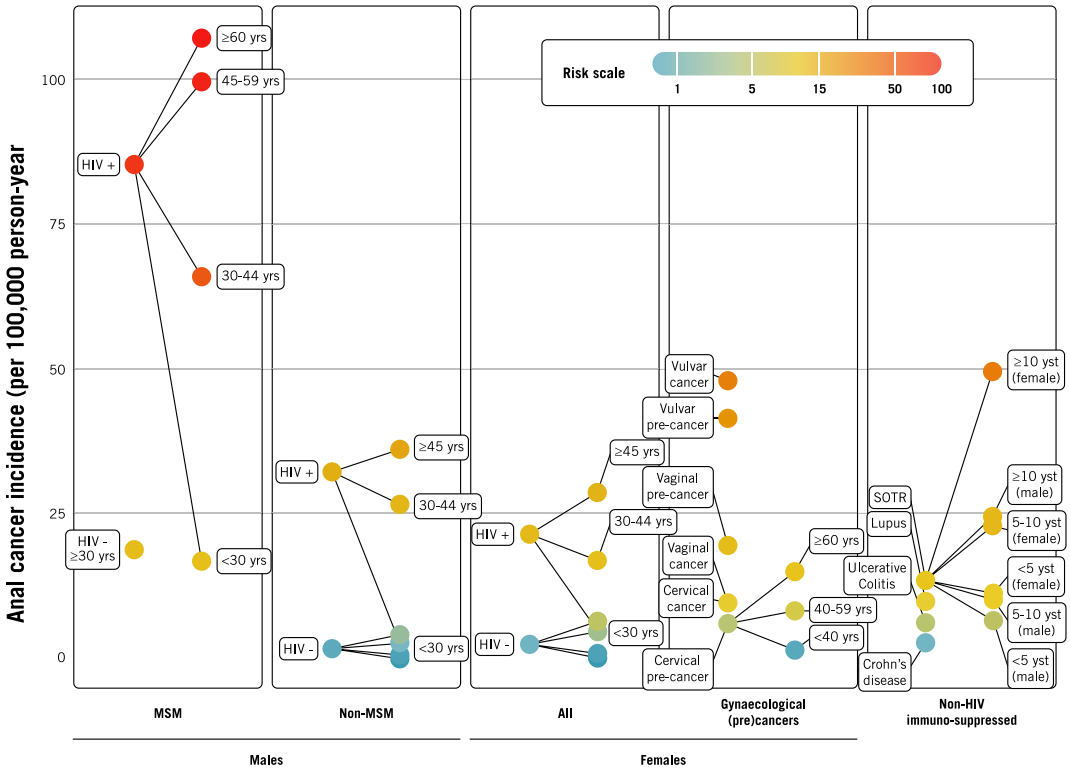

Image from Clifford, et al. (2021). A meta-analysis of anal cancer incidence by risk group: Toward a unified anal cancer risk scale. International Journal of Cancer, 148(1), 38–47.

MSM stands for: Men who have sex with men.

Training available for providers

To become as common and effective as colposcopy and other screening procedures, HRA needs to be much more widely available. Only a few centers in Washington state offer it currently.

"Developing expertise with HRA enables providers to expand their careers and lead a new wave of anal cancer prevention," says Dr. Simianu.

The multidisciplinary anal cancer team at Virginia Mason Medical Center have performed HRA for over a decade and offer training to colorectal surgeons and other providers who wish to offer it in their practices. Interested providers should contact the General Surgery department at (206) 341-0060.

For questions or to discuss a patient, please contact Dr. Kaplan at jennifer.kaplan@vmfh.org.

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How to Enable Early Ambulation and Shorter Inpatient Stays After Lung Surgery

Early ambulation is widely recognized for helping patients recover more quickly after surgery. But teams often struggle to prioritize ambulation amid the many protocols that factor into postoperative care.

Surgical and nursing teams at Virginia Mason Medical Center have developed highly effective strategies for getting patients on their feet and avoiding the consequences of immobility.

How effective? In a retrospective study of 145 patients recovering from robotic lobectomy, 56 percent went home the day after surgery thanks to early ambulation and other nested Enhanced Recovery After Surgery (ERAS) interventions. By comparison, the national average for postoperative day 1 (POD1) discharge after lung resection — including open and thoracoscopic procedures — falls just below 4 percent.[1,2]

"Early ambulation is one of the most modifiable components of an ERAS framework. With a few simple adjustments to their approach, other centers can get patients walking sooner to help spark a healthy recovery and minimize length of stay," says Erik Stiles, MD, general surgery resident at Virginia Mason Medical Center.

Early ambulation reduces postoperative harm

Immobility has serious consequences. Postoperative patients have been shown to become insulin resistant, with slowed gastrointestinal motility and deconditioning of their musculoskeletal and pulmonary systems.[3] Other research shows patients lose 2-5 percent of their muscle mass each day they don't walk.[4]

Early ambulation, by contrast, signals the body to maintain muscle mass. It also helps reduce the perception of pain and restore healthy respiration — important after any surgery, but especially after lung surgery.

"Early ambulation gets your breath, your blood, your whole body back to normal faster," Dr. Stiles says.

All of this contributes to earlier discharge — without introducing extra risk. In the retrospective study at our center, patients discharged on POD1 not only walked earlier but also had lower complication and readmission rates than patients in the POD2-3 and POD4 discharge groups.

Erik Stiles, MD

"Early ambulation is one of the most modifiable components of an ERAS framework. With a few simple adjustments to their approach, other centers can get patients walking sooner to help spark a healthy recovery and minimize length of stay." - Erik Stiles, MD

ERAS Pathway for Robotic Assisted VATS Lobectomy

Preoperative	Perioperative	Postoperative
Preadmission Education	VTE Prophylaxis	Scheduled Acetaminophen
Smoking cessation	Surgical Antibiosis and Chlorohexidine prep	Stop IV fluids
Alcohol cessation	Convective active warming	Reinstitute oral diet in PACU
Avoid pre-anesthetics	Foley catheter if anticipated greater than 4 hours	Continue beta blockade if already established
	Realtime decision support system	Medela Topaz Digital Drainage System to -8 cm H2O
	Target euvolemia with Lactated Ringers	Moblize as soon as possible
	28F chest tube placed through VATS port site	Remove chest tube without air leak on POD1
	Avoid epidural anesthesia	If air leak, consider discharge with portable chest tube device
	Paravertebral block versus cryoneurolysis	

ERAS pathway implemented at Virginia Mason Medical Center. "Mobilize as soon as possible" is one of many complementary interventions that enhance recovery.

Prioritizing ambulation: 3 tactics

To succeed in getting patients ambulating early, centers can focus on three simple aspects of postoperative care.

Postoperative care orders

The first step to ensuring early ambulation is for surgeons to make it a standardized part of their postoperative care orders.

Nurses at Virginia Mason Medical Center are trained on the importance of early ambulation and are adamant about following through. The nurse manager posts a daily dashboard that shows the unit's performance over time.

Our surgeons draft orders for patients to walk 3 times a day, starting as soon as feasible after robotic lobectomy.

"The median time to first ambulation for POD1 patients in our retrospective study was 8.9 hours," says Dr. Stiles.

Patients discharged on POD2 or later, meanwhile, waited an additional 7 hours before taking their first steps.

Get buy-in from the nursing team

"Ambulation orders shouldn't be treated as any less important than orders for medication or testing," says Dr. Stiles.

Nurses at Virginia Mason Medical Center are trained on the importance of early ambulation and are adamant about following through. The nurse manager posts a daily dashboard that shows the unit's performance over time. The dashboard not only helps nurses keep patients on track but also helps them alert the rest of the care team to possible complications.

"Any patient who falls behind in ambulation deserves a closer look, to see what's holding them back," Dr. Stiles explains.

Get creative about incentivizing ambulation

In addition to having patients walk up and down the hallway for exercise, the team also creates situations that require patients to move their feet.

The surgical team avoids the use of Foley catheters during lobectomy, which not only staves off bladder infections but also encourages mobility.

"For many of our patients, their first ambulation is walking to the bathroom," says Dr. Stiles.

Another "micro intervention" involves simple steps in the process of obtaining postoperative X-rays. Patients require a stretcher for the long trip to radiology, and our nurses place it in the hallway so that the patient has to walk to reach it.

"There are many opportunities to get patients walking. Every little step counts toward getting them home and making a strong recovery," Dr. Stiles says.

For more information or to discuss a patient, please contact Dr. Misho Hubka at misho.hubka@vmfh.org.

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Answering Unmet Needs for Pelvic Floor Patients

Bladder, bowel problems and other issues stemming from pelvic floor conditions are quite common. But many patients struggle to find the care they need or are unaware that solutions even exist.

The Pelvic Floor Center at Virginia Mason Medical Center provides critical answers, comprehensive treatment and compassionate care for these patients. It features a multidisciplinary team and a variety of treatment options for the many conditions affecting this area of the body, from stress urinary incontinence to rectal and vaginal prolapse.

"Primary care physicians play a vital role in connecting pelvic floor patients to appropriate care. It's important for them to understand who is affected by these issues, how to discuss them with patients, and what treatment options may be available," says Una Lee, MD, urologist/urogynecologist at Virginia Mason Medical Center.

Women are especially affected

Pelvic floor issues can affect anyone, but they are more prevalent among women:

- Urinary incontinence is twice as common among women than men.[1] In a national survey of more than 15,000 women who were at least 20 years old, 56 percent reported having the condition.[2]
- Women are 6 times more likely as men to experience rectal prolapse.[3]
- Fecal incontinence affects as many as 1 in 4 women over age 40.[4]

While childbirth is a common cause for pelvic floor conditions, it's not the only one. For example, one-third of women who experience rectal prolapse have never given birth.[5] For these patients, prolapse results from causes like chronic constipation or the simple weakening of muscles that comes with age.

Many barriers prevent appropriate care

Despite their prevalence, pelvic floor conditions often go undiagnosed and untreated.

"Problems like a leaky bladder can be embarrassing, and that makes it hard for people to ask for help," says Dr. Lee.

Symptoms and conditions also frequently coexist, and patients don't know which provider to turn to — their PCP, a urologist or someone else. Lastly, many patients simply don't know that their conditions are treatable.

"These barriers are why pelvic floor centers like ours exist. Patients can find all the expertise and understanding they need in one place," says Jenny Kaplan, MD, a colorectal surgeon on our team.

Conditions call for multidisciplinary treatment

Pelvic floor care encompasses multiple specialties — urology, colorectal surgery, urogynecology, gastroenterology, gynecology, physical therapy, and others. Providers from different specialties often work together to diagnose the extent of a patient's condition and provide appropriate treatment.

For example, rectal and vaginal prolapse are common comorbidities that may require:

- Pelvic floor testing with a colorectal surgeon or urologist
- Referral to a gastroenterologist to investigate underlying constipation
- Robotic surgery by a colorectal surgeon and urogynecological surgeon working in tandem
- Pelvic floor physical therapy both before and after surgery, to ensure repairs are successful and function is maximized

Una Lee, MD

Jennifer Kaplan, MD

Vlad Simianu, MD, MPH

The breadth and depth of surgical expertise at Virginia Mason Medical Center prepares the team for the most challenging repairs and reconstructions.

"But many patients don't need or want surgery, and we have options for them too," says Vlad Simianu, MD, MPH, a colorectal cancer surgeon who directs the colorectal cancer service line and is medical director of the clinical research programs at Virginia Mason Medical Center.

Nonsurgical options include injections, medication and devices like a sacral nerve stimulator. The stimulator acts as a pacemaker for the pelvic floor, coordinating electrical signals to help resolve urinary incontinence and accidental bowel leakage. It works extraordinarily well, improving symptoms for more than 90 percent of patients.

"More than half of patients with the sacral nerve stimulator live symptom-free for 10 or more years," Dr. Simianu adds.

Patient-centered conversations

With so many barriers to treatment, it's important for providers to enable open, caring conversations with patients.

"PCPs can start off by asking patients about their urination and bowel patterns and letting them know that issues are both common and treatable," says Dr. Lee.

From there, pelvic floor specialists dig deeper to learn exactly how patients are affected by their conditions and what they want out of therapy. For example, some patients are focused on resolving incontinence. Others are most concerned about pelvic prolapse, pain or sexual dysfunction.

"These conversations guide us to the right treatment and help us avoid jumping to wrong conclusions and unnecessary interventions," Dr. Simianu says.

During these conversations, providers may navigate the potential role played by trauma. Conditions like fecal obstruction can result from past sexual assault or abuse. Discussing patient history and potential causes with these patients is exceptionally delicate, and providers connect patients with mental health counseling when appropriate.

"Caring for pelvic floor patients is so much more than treating their condition. It's listening to their stories and partnering with them on the changes they want to see in their lives," says Dr. Kaplan.

> "More than half of pelvic floor patients with a sacral nerve stimulator live symptom-free for 10 or more years." - Vlad Simianu, MD, MPH

Find the right expert for your patients

Patients with common pelvic floor conditions can be referred to the following teams at Virginia Mason Medical Center:

- **Colorectal surgery** for rectal prolapse and fecal incontinence
- **Urogynecology** for urinary incontinence or other pelvic prolapse
- **Motility gastroenterology** for constipation or diarrhea

Patients with urgent needs or well-documented conditions may go straight to consultation. In other cases, the team may recommend a series of tests and consultations to get a complete picture of symptoms and causes and develop a care plan.

"Every patient is unique, and we're here to provide what is best for each individual," Dr. Lee says.

For more information or to discuss a patient, please contact Dr. Lee at una.lee@vmfh.org.

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Section 2

Cancer

Gynecologic Oncology: How New Advances and Specialized Care Are Improving Outcomes

Nearly 95,000 women are diagnosed with gynecologic cancer every year in the U.S., but many of those patients — and, in some cases, their providers — may not be aware of how their outcomes can be influenced by the type of physician they see.

Studies have shown that seeing a gynecologic oncologist — an oncologist who specializes in both medical oncology and surgery for gynecologic cancers — improves outcomes and survival rates for many patients.

Consider ovarian cancer, where the five-year survival rate is around 50 percent.[1] Studies have found that ovarian cancer patients undergoing surgery performed by a gynecologic oncologist survive 10 months longer, on average, than those whose surgery was performed by a general surgeon or general gynecologist.[2]

Seeing a specialist can also matter for patients affected by gynecologic cancers that have higher survival rates, including endometrial and cervical cancer.

For patients with advanced endometrial cancer, seeing a gynecologic oncologist for surgery resulted in 30 percent increased survival in one study.[3] Similarly, patients with advanced cervical cancer who needed radical hysterectomies experienced significantly better survival outcomes if that surgery was performed by a gynecologic oncologist.[4]

A major reason for these outcomes differences: Gynecologic cancers are complex, and research and treatments are evolving rapidly. Because gynecologic oncologists are focused on a single area, they can constantly reevaluate and refine their practices based on new advances and information.

"Cancers of the gynecologic tract are unique. There's a lot of important, detailed information that is solely studied in gynecologic cancer patients," says Amy Brockmeyer, MD, a gynecologic oncologist at Virginia Mason Franciscan Health. "Someone who isn't up to date on all that emerging information, be it surgical or medical, and doesn't have expertise on the disease trajectory can't optimally manage these patients — and it's borne out in patients' survival."

At Virginia Mason Franciscan Health, any patient diagnosed with a gynecologic cancer is automatically referred to our two gynecologic oncologists: Drs. Brockmeyer and Allison Barrie. This team is intricately linked to many other subspecialists, including a recently-hired radiation oncologist, Jiheon Song, MD, who specializes in brachytherapy — a type of radiation therapy that has been shown to significantly improve survival for patients with advanced cervical cancer.[5]

New therapies target biomarkers

Drs. Barrie and Brockmeyer do their best to bring the most promising advances to their patients. For example, ovarian cancer has the lowest survival rates of any gynecologic cancer, but therapies are evolving especially quickly. In the last few years, more targeted therapies have become available for patients whose ovarian cancer has stopped responding to standard treatment.

"It's an exciting time – I don't think things have ever changed this quickly before in gynecologic cancer treatments," Dr. Barrie says.

Ovarian cancer symptoms are often so minor that they go unnoticed. In turn, many patients are not diagnosed until the cancer has reached late stages, making it very difficult to cure. But new drugs can improve survival for some patients whose cancer has progressed despite standard chemotherapy.

Many of these new therapies are targeted at biomarkers. For example, PARP inhibitors target tumors with BRCA mutations or other defects in the homologous recombination pathway. Another class of

Amy Brockmeyer, MD

Allison Barrie, MD

Jiheon Song, MD

Studies have shown that seeing a gynecologic oncologist improves outcomes and survival rates for many patients.

drugs known as antibody-drug conjugates (ADCs) link a potent cancer-killing drug to an antibody that homes to a specific molecule on a cancer cell's surface.

Earlier this year, the ADC mirvetuximab soravtansine was approved by the Food and Drug Administration for ovarian cancer patients who have developed platinum-resistance. Most ovarian cancer patients eventually develop this resistance. Mirvetuximab targets folate receptor alpha, a protein often present in high levels on ovarian cancer cells.

"For ovarian cancer, just in the past few years we've gone from having only one antibody-based drug available to having multiple immunotherapy agents and multiple kinds of targeted therapies that we think are actually improving the cure rate," Dr. Brockmeyer says.

Along with new drugs, advances in gynecologic surgery practices have enabled more patients to benefit from minimally invasive surgeries. For example, Drs. Barrie and Brockmeyer recently changed their practice for patients with cervical or endometrial cancer who require surgery. They used to remove 10 to 20 lymph nodes to check for cancer spread, a more invasive surgery that could sometimes leave patients with long-term complications like lymphedema. Now they remove only two lymph nodes.

Hope against platinum-resistant ovarian cancer

Drs. Brockmeyer and Barrie are also involved in research to accelerate new treatments. Within ADCs, they're participating in an upcoming national trial, REFRαME-O1, run by Sutro Biopharma. This study will include a site at Virginia Mason Medical Center to test an experimental ADC — called luveltamab tazevibulin, or Luvelta — for patients with platinum-resistant ovarian cancer. This drug targets folate receptor alpha. But unlike mirvetuximab soravtansine, where patients must have 75 percent receptor-positive cancer cells to be eligible for the drug, patients only need a 25 percent expression level or higher to be eligible for the Luvelta trial.

"If this trial has positive results, which we're really hopeful it will, we will have obtained a new drug for a cancer that's very challenging to treat, and given a larger population of people access to these promising treatments," Dr. Barrie says.

Drs. Barrie and Brockmeyer also work closely with other Seattle-area research centers to give their patients access to many other ongoing clinical trials.

"For ovarian cancer, just in the past few years we've gone from having only one antibody-based drug available to having multiple immunotherapy agents and multiple kinds of targeted therapies that we think are actually improving the cure rate."
- Amy Brockmeyer, MD

Innovative radiation therapy

Other specialists at Virginia Mason Franciscan Health also bring leading-edge techniques to patients with gynecologic cancers. For example, Dr. Song joined our radiation oncology team in 2023 and is one of only a handful of radiation oncologists in Washington state who specialize in brachytherapy for gynecologic cancers.

This form of radiation therapy is commonly used in uterine cancer and cervical cancer. In contrast to external beam radiation, brachytherapy uses small coated wires or beads to bring cancer-killing radiation directly into the tumor. Although brachytherapy is more than 100 years old, it has seen a renaissance with the advent of real-time imaging techniques that allow practitioners to follow the radiation's exact course as it's administered and ensure it's precisely delivered to the tumor. Practices have also shifted to deliver higher doses of radiation in shorter amounts of time, further reducing the risk of exposing healthy tissue to radiation.

These recent improvements have specifically made a difference for patients with locally-advanced cervical cancer. One large study found that cervical cancer patients who received brachytherapy had 25 percent longer overall survival than those who received external beam therapy alone.[6]

"We have come a long way in terms of advancing radiation oncology techniques and skill sets, but we're at a point where there's

only so much we can improve on in the field — with the exception of brachytherapy," Dr. Song says. "This is a subspeciality where I see the potential to advance patient care much further than in any other area of radiation oncology."

Expanding access to specialty care

Despite the potential for better outcomes, many patients with gynecologic cancer don't receive care from gynecologic oncologists. One study looking at patients with advanced gynecologic cancers found that two-thirds received chemotherapy treatment from medical oncologists, compared with one-third who received the treatment from gynecologic oncologists.[7]

This is partly due to lack of access. A study found that over 90 percent of U.S. counties had no local gynecologic oncologist and more than 60 percent of counties had no specialist locally or in their neighboring counties.[8]

Drs. Barrie and Brockmeyer are improving access in the Seattle area by offering care at both Virginia Mason Medical Center in downtown Seattle and at the Virginia Mason Franciscan Health Medical Pavilion – Federal Way. They also plan to expand their practice to St. Anne Hospital in Burien.

For patients farther afield, they streamline care to improve access to treatments and procedures only available in Seattle. The team sees patients from across Washington state and understands how difficult it can be to travel long distances for treatment. They often work with patients' local providers to deliver some aspects of their care close to home, and will connect with patients and their providers virtually, limiting long-distance travel to the "big" events like surgery, chemotherapy infusions or brachytherapy. That makes care more convenient and reduces patients' travel costs.

"In cancer care, we think a lot about toxicity of treatment. But we can forget that financial toxicity is also a huge challenge for many patients," Dr. Barrie says. "If there's any way we can ease that burden for folks, we try to do so."

To make access as easy as possible, Drs. Brockmeyer and Barrie see new patients quickly, typically within three to four days of referral. That fast access continues throughout treatment — the physicians take pride in coordinating with other departments and specialists throughout Virginia Mason Franciscan Health to ensure patients can get specialized imaging, radiation therapy, or other necessary tests and procedures within days.

We are improving access to gynecologic oncologists in the Seattle area by offering care at both Virginia Mason Medical Center in downtown Seattle and at the Virginia Mason Franciscan Health Medical Pavilion – Federal Way. We also plan to bring gynecologic oncology to St. Anne Hospital in Burien.

A patient-first approach

Patients with gynecologic cancers fare better when treated by a centralized, multidisciplinary team, studies have found.[9] For example, one study looking at patient outcomes in a region of England before and after it centralized gynecologic cancer care found that survival increased 40 percent after centralization.[10]

Our gynecologic oncologists do their best to deliver the benefits of centralization, by providing timely care and coordinating across departments to give patients access to the specialties they need. Drs. Barrie and Brockmeyer also stay in communication with a patient's referring physician to make sure all providers are on the same page, even if they're not in the same health system.

"One reason I joined Virginia Mason Franciscan Health is because we not only focus on the delivery of treatment – we also look at patients' view of their experience," Dr. Song says. "Treatment is not just one-way here."

Drs. Brockmeyer and Barrie echoed that sentiment.

"Something I hear frequently from our patients, especially those who come to us for a second opinion, is that it is the first time someone went into detail with them about their diagnosis, or that they really understood the choices available to them," Dr. Brockmeyer says. "We're committed to making sure patients are informed enough to be full partners in decisions."

For questions about gynecologic oncology or to discuss a patient, please contact Dr. Brockmeyer at amy.brockmeyer@vmfh.org.

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Innovative Pancreatic Cancer Trials Could Further Boost Survival

Vincent Picozzi, MD

Vincent Picozzi, MD, and his colleagues have made significant progress in their work to improve pancreatic cancer outcomes, as evidenced by the fact that overall pancreatic cancer survival rates at Virginia Mason Franciscan Health are more than double those seen in the National Cancer Institute's Surveillance, Epidemiology, and End Results national database for cancer outcomes. But Dr. Picozzi still struggles against the perception that pancreatic cancer cases are hopeless.

"The pessimism that pervades pancreatic cancer is a huge challenge, even today," says Dr. Picozzi, a medical oncologist and head of our Pancreatic and Biliary Cancer Program. "People really take a dim view of their prospects. And it's not just the patients and family members, but doctors as well."

Dr. Picozzi points out that average five-year survival rates have doubled in the past decade.[1] Our team sees the highest volume of pancreatic cancer patients in the Pacific Northwest and is working to keep improving outcomes via the region's largest portfolio of pancreatic cancer clinical trials. These trials investigate a wide variety of innovative therapies and approaches and include:

- PANOVA-3, a Phase 3 trial testing a device that pulses electrical fields at tumor sites, in combination with chemotherapy. These electrical fields disrupt cancer cell division by interfering with a cellular complex important for the cell cycle.

- Two trials testing pamrevlumab, an antibody that targets a protein in human connective tissue, in combination with chemotherapy. Pancreatic cancer is unusual in that tumors surround themselves with a thick wall of connective tissue. Using pamrevlumab to disrupt this tissue may render pancreatic tumors more susceptible to chemotherapy and other cancer-killing agents. We currently offer access to this approach via a Phase 2/3 trial through the Precision Promise Initiative, which is open to patients with metastatic pancreatic cancer, and the the Phase 3 Lapis trial, which is open to patients with locally-advanced pancreatic cancer.

- A study of the KISIMA™ cancer vaccine in patients with pancreatic cancer. This vaccine is a therapeutic chimeric recombinant protein vaccine based on the KISIMA platform, which is engineered to induce an efficient immune response by activating helper and cytotoxic T cells. The platform also aims to promote immunologic memory. The study utilizes the vaccine (ATP150/ATP152) as a heterologous prime boost in combination with VSV-GP154 (a recombinant vesicular stomatitis virus) and exabenlimab (a PD-1 inhibitor). The study offers potential clinical benefit against pancreatic cancer and is a step toward extending KISIMA to treat other gastrointestinal cancers, regardless of tumor type.

"We're hopeful these trials will help us further improve survival, and they're part of our commitment to offering access to clinical trials that address all aspects of the disease, from new medical treatments to innovative devices

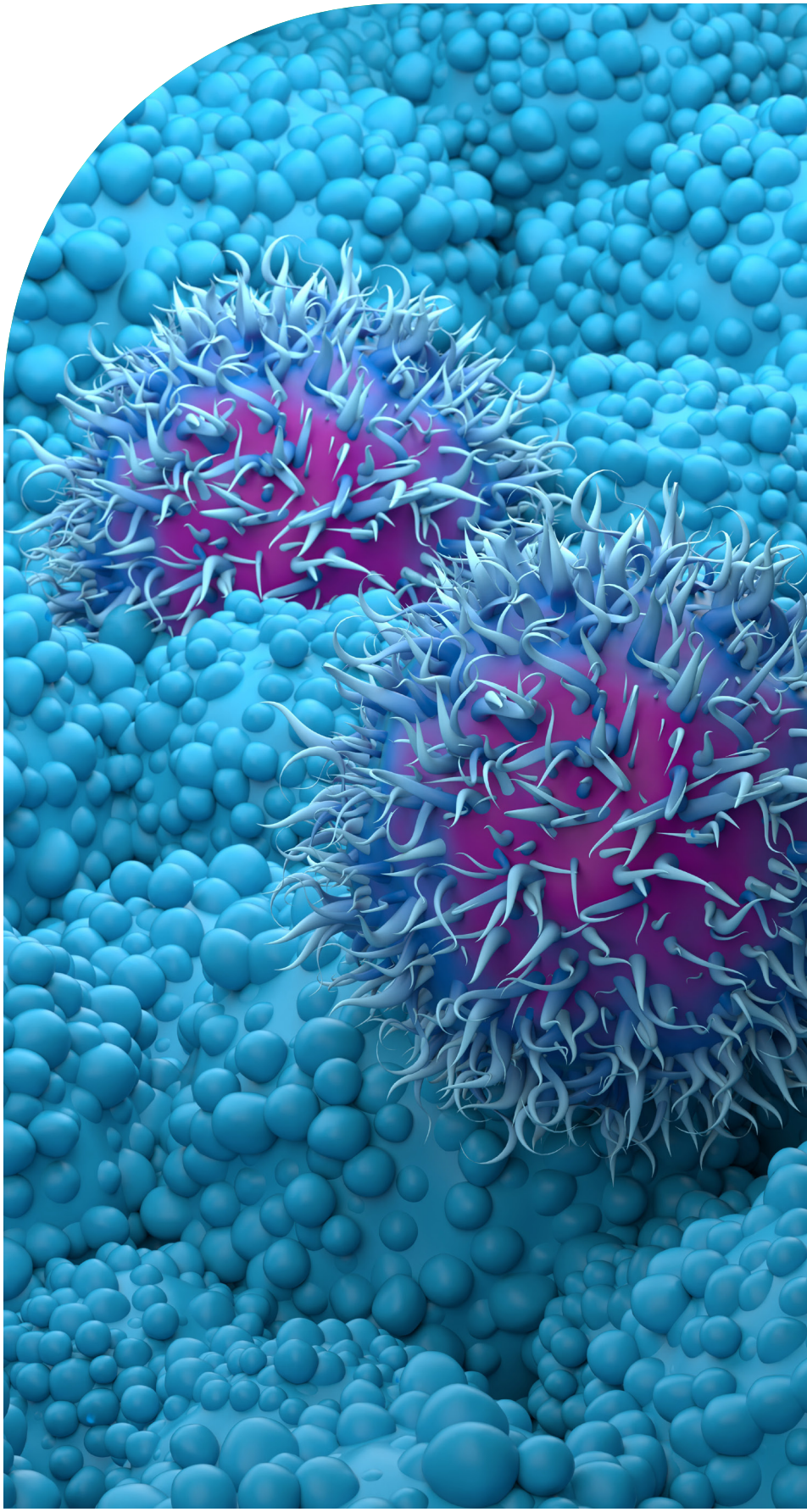
Average five-year survival rates for pancreatic cancer have doubled in the past decade.

to supportive care," Dr. Picozzi says.

This commitment is also reflected in Dr. Picozzi's role as co-principal investigator and Clinical Trials Consortium chair for the Precision Promise Initiative, which aims to become the largest-ever clinical trial for advanced pancreatic cancer. This trial, which initially enrolled patients at 28 sites around the country including Virginia Mason Medical Center, uses adaptive randomization to allocate patients with metastatic pancreatic ductal adenocarcinoma to different experimental therapies based on the probability of that treatment's success for individual patients. The trial has completed enrollment to test their first three experimental treatments, with more therapies to be tested in the future.

"Precision Promise brings all the major U.S. institutions working on pancreatic cancer together to form what we believe is a better model for clinical investigation and a better bridge between translational science and clinical science," Dr. Picozzi says. "We hope this approach will transform drug development for pancreatic cancer and it could ultimately be used as a model for clinical research in solid tumor cancer in general."

For more information or to discuss a patient, please contact Dr. Picozzi at vincent.picozzi@vmfh.org.



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Clinical Trial Spotlight: Implantable, Resorbable Radiation Tiles for Brain Tumors

Huong Pham, MD

Robert Ryan, MD

Virginia Mason Franciscan Health is participating in a landmark clinical trial that aims to make progress against recurrent brain tumors. This trial, called the ROADS study, offers patients access to GammaTile, an implantable, resorbable tile that emits targeted radiation at the tumor site.

Virginia Mason Medical Center was the first center in the region offering GammaTile, a surgically-targeted radiation therapy (StaRT) that's about the size of a postage stamp and is embedded with four small radiation sources. GammaTile is implanted at the end of surgery to remove a brain tumor. The tile immediately starts delivering targeted radiation to the tumor bed, with the goal of stopping or delaying tumor regrowth, while minimizing radiation impact on healthy tissue. And GammaTile doesn't need to be removed — the body naturally resorbs it after the radiation dose is delivered.

Under site principal investigators Huong Pham, MD, and Robert Ryan, MD, the study compares GammaTile with another FDA-approved radiation treatment: stereotactic radiotherapy.

It's just one example of how our clinical research team is working to improve cancer survival and reduce the side effects of treatment. The team is composed of clinical research coordinators and research assistants who carry out dozens of clinical trial protocols across many cancer types. All treatments are provided at Virginia Mason Medical Center's downtown location.

To learn more about clinical research at Virginia Mason Medical Center, please call 206- 342-6915 or visit https://www.benaroyaresearch.org/clinical-research-vmmc.

How Our Colorectal Team Achieved a New Rectal Cancer Accreditation

Vlad Simianu, MD, MPH

Five years ago, the colorectal cancer care team at Virginia Mason Medical Center launched an overhaul to ensure every patient receives optimal care. This led to a series of improvements that, last year, resulted in Virginia Mason Medical Center becoming the first Seattle hospital to receive accreditation by the National Accreditation Program for Rectal Cancer (NAPRC), a program of the American College of Surgeons and Commission on Cancer.

Colorectal-specific tumor board ensures comprehensive treatment

The NAPRC launched in 2017 to address widespread disparities among rectal cancer care and outcomes in the U.S. To receive accreditation, centers must meet 20 performance and process measures. The requirements include using a multidisciplinary approach and following best practices for staging, surgery and pathology. Rectal cancer patients treated at centers that meet these measures have survival rates that are roughly 14 percent better than patients who are treated elsewhere.[1]

To meet these standards, our colorectal team made a series of improvements, including creating a tumor board that focuses only on colorectal cancer cases. Before 2019, colon, rectal and anal cancer cases were presented to a general gastrointestinal tumor board. The board's multidisciplinary team provided important oversight, but was spread thin because they had to review so many different cases.

"We believe every patient deserves the highest level of care and we realized we needed to back that up with the best processes by creating a separate board," says Vlad Simianu, MD, MPH, a colorectal cancer surgeon and director of the colorectal cancer service line.

Today, 96 percent of colorectal cancer cases are presented to the colorectal tumor board. Because so many different specialists sit on the board, they see each patient from all angles, ensuring nothing is missed in their treatment and follow-up plans. For example, patients whose cases are presented to this board are more likely to be referred to a geneticist or offered enrollment in a clinical trial.

Helping patients avoid surgery

The accreditation also reflects how the colorectal team constantly develops and embraces new best practices for care, from screening to treatment to survivorship.

For example, the team helped lead a recent shift that is enabling many rectal cancer patients to avoid surgery. Less than 15 years ago, nearly 50 percent of these patients in the U.S. needed such radical surgery that they would need colostomy bags for the rest of their lives. By embracing the latest non-surgical therapies — including immunotherapies and chemotherapies — we have significantly reduced the number of patients who need surgery. Now, nearly half of our patients can avoid surgery. Of the patients who do need surgery, less than 25 percent need permanent colostomy bags.

"That only happens by making sure every case is evaluated by all our experts and that treatment is individualized to the patient," Dr. Simianu says.

Another component of our comprehensive care: providing access to cutting-edge clinical trials. Virginia Mason Medical Center is part of two ongoing multi-site trials, the JANUS trial and the NEO-RT trial, that focus on strategies to preserve the rectum and avoid radical surgery for rectal cancer patients. We also offer a trial that investigates whether a cancer vaccine could prevent colon cancer recurrence after surgery.

To qualify for the new accreditation, our colorectal team made a series of improvements, including creating a tumor board that focuses only on colorectal cancer cases. Today, 96 percent of colorectal cancer cases are presented to the colorectal tumor board.

Leading care for colon, anal and rare GI tract cancers

No similar accreditation exists for colon or anal cancers, but the NAPRC accreditation reflects quality care for all cancers the colorectal team treats. That's because the team's processes apply to every patient they see.

"Even though the accreditation is focused on rectal cancer, the same team and the same standards apply to the colon cancer, anal cancer, and rare GI tract cancer cases that we treat," Dr. Simianu says.

For more information or to discuss a patient, please contact Dr. Simianu at val.simianu@vmfh.org.

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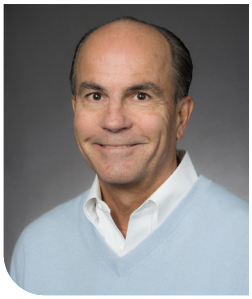
Hepatobiliary Cancers: Innovative Treatments For Patients Throughout Puget Sound



Scott Helton, MD

Bruce Lin, MD

The hepatobiliary cancer team at Virginia Mason Medical Center is extending its ability to bring top outcomes to patients across our region, by adding two new specialized surgeons to serve patients throughout Virginia Mason Franciscan Health's 10 hospitals. The surgeons will join a team that includes experts in medical oncology, interventional endoscopy, radiology and supportive care.

"The more complex the disease, the more important it is to have a close working relationship among all our experts," says Scott Helton, MD, Director of the Liver, Pancreas and Biliary Surgical Center of Excellence at Virginia Mason Franciscan Health. "We've been treating these cancers for 40 years and have really honed what we can offer."

The team sees a high volume of patients and uses a comprehensive approach to pursue optimal outcomes.

For example, studies have found that patients who undergo liver or pancreas surgery at facilities that perform 15 or more major hepatobiliary surgeries a year have lower 30-day, 90-day and overall mortality than patients treated at lower-volume facilities.[1,2] Our surgeons together perform more than 150 hepatobiliary surgeries every year.

The hepatobiliary cancer team also offers the latest nonsurgical treatments. These include targeted drug therapies and immunotherapies, and we will soon offer histotripsy — a non-invasive treatment modality that uses ultrasound waves to destroy liver tumors.

If a patient needs a liver transplant, we quickly refer patients to a local transplant team and work closely with them to ensure timely and effective care.

We also go out of our way to see new patients as quickly as possible — typically within days.

"When patients have a new cancer diagnosis, they're often very anxious, so it means a lot to them to be able to get in so quickly — and to know they have access to all of our different experts," says Bruce Lin, MD.

A broad clinical trials portfolio

Through Dr. Lin – who is an expert in liver cancer and bile duct cancer – and Vincent Picozzi, MD, the team's lead pancreatic cancer specialist, patients can access a wide variety of clinical trials for hepatobiliary cancers.

Dr. Lin runs multiple clinical trials in liver cancer and bile duct cancer, and is a member of the International Cholangiocarcinoma Research Network. Dr. Picozzi and his colleagues are national leaders in promising pancreatic cancer trials that could extend recent gains in survival. (See article on page 23.)

Many of the hepatobiliary cancer trials include molecularly targeted therapies and immunotherapies, bringing new treatment options to patients who used to have very few.

"We're in an era of molecular analysis; we're getting so much more information from tumors than we did even 10 years ago," Dr. Lin said. "For example, that allows us to match our patients with Stage 4 liver cancer with the right targeted therapies, which often extends their lives by several years."

Our hepatobiliary cancer team also offers the latest nonsurgical treatments, including targeted drug therapies and immunotherapies. We will soon offer histotripsy, which uses ultrasound waves to destroy liver tumors.

For more information or to discuss a patient, please contact Dr. Helton at scott.helton@vmfh.org.

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A Phase 1b/2a, Dose Escalation Trial of Safety, Pharmacokinetic/Pharmacodynamic and Preliminary Clinical Activity of Briquilimab in Adult Patients with Chronic Spontaneous Urticaria (CSU) Who Remain Symptomatic Despite Treatment with, or Who Cannot Tolerate Omalizumab

NCT06162728

Principal Investigator:
Rahool Dave, MD

Site: Virginia Mason Medical Center, Seattle

Protocol Title: A Phase 3, Double-blind, Placebo-controlled, Randomized Study to Assess the Efficacy and Safety of Epicutaneous Immunotherapy with DBV712 250 µg in 4-7-year-old Children with Peanut Allergy (VITESSE)

NCT05741476

Principal Investigator:
Rahool Dave, MD

Site: Virginia Mason Medical Center, Seattle

Cancer Research

Please email cancerresearch@virginiamason.org or call (206) 287-6270 for more information.

Bladder Cancer

A Randomized Phase III Trial of Intravesical BCG versus Intravesical Docetaxel and GEmcitabine Treatment in BCG Naïve High Grade Non-Muscle Invasive Bladder Cancer (BRIDGE)

NCT05538663

Principal Investigator:
Huong Pham, MD

Site: Virginia Mason Medical Center, Seattle

Blood Cancer

A Phase 3, Multicenter, Randomized, Open-Label Trial to Evaluate the Safety and Efficacy of Epcoritamab + Rituximab and Lenalidomide (R2) Compared to Chemoimmunotherapy in Previously Untreated Follicular Lymphoma (EPCORE™FL-2)

NCT06191744

Principal Investigator:
David Aboulafia, MD

Site: Virginia Mason Medical Center, Seattle

Brain Cancer

A Multicenter Observational Study of GammaTile™ Surgically Targeted Radiation

Therapy (STaRT) in Intracranial Brain Neoplasms Short Title: STaRT

NCT04427384

Principal Investigator:
Huong Pham, MD

Site: Virginia Mason Medical Center, Seattle

A Phase 3 Randomized Controlled Trial of Post-Surgical Stereotactic Radiotherapy (SRT) versus Surgically Targeted Radiation Therapy (STaRT) with Gamma Tile for Treatment of Newly Diagnosed Metastatic Brain Tumors

NCT04365374

Principal Investigator:
Huong Pham, MD

Site: Virginia Mason Medical Center, Seattle

Lomustine-Temozolomide Combination Therapy Versus Standard Temozolomide in MGMT+ GBM

NCT05095376

Principal Investigator:
John Paul Flores, MD

Site: Virginia Mason Medical Center, Seattle

Cancer: Non-Specific

A prospective observational cohort study to assess miRNA 371 for outcome prediction in patients with newly diagnosed germ cell tumors

NCT04435756

Principal Investigator:
John Paul Flores, MD

Site: Virginia Mason Medical Center, Seattle

EA2197: Optimal Perioperative Therapy For Incidental Gallbladder Cancer (OPT-IN): A Randomized Phase II/III TrialEA2197: Optimal Perioperative Therapy For Incidental Gallbladder Cancer (OPT-IN): A Randomized Phase II/III Trial

NCT04559139

Principal Investigator:
Bruce Lin, MD

Site: Virginia Mason Medical Center, Seattle

Virginia Mason Medical Center and Benaroya Research Institute Tumor Tissue Repository (VM-BRITE) Sample Collection Protocol

Principal Investigator:
Christopher Gault, MD

Site: Virginia Mason Medical Center, Seattle

Colorectal Cancer

A multi-site, open-label, Phase II, randomized, controlled trial to compare the efficacy of RO7198457 versus watchful waiting in resected, Stage II (high risk) and Stage III colorectal cancer patients who are ctDNA positive following resection

NCT04486378

Principal Investigator:
Bruce Lin, MD

Site: Virginia Mason Medical Center, Seattle

A Phase 2, Randomized, Open-label Study of Onvansertib in Combination with FOLFIRI and Bevacizumab or FOLFOX and Bevacizumab Versus FOLFIRI and Bevacizumab or FOLFOX and Bevacizumab or First-line Treatment of Metastatic Colorectal Cancer in Patients with a KRAS or NRAS Mutation

NCT06106308

Principal Investigator:
Bruce Lin, MD

Site: Virginia Mason Medical Center, Seattle

The Janus Rectal Cancer Trial: A Randomized Phase II/III Trial Testing the Efficacy of Triplet Versus Doublet Chemotherapy Regarding Clinical Complete Response and Disease-free Survival in Patients with Locally Advanced Rectal Cancer

NCT05610163

Principal Investigator:
Val Simianu, MD

Site: Virginia Mason Medical Center, Seattle

The NEO-RT Trial: A Phase 3 Randomized Trial Of Neoadjuvant Chemotherarpy, Excision And Observation Versus Chemoradiotherapy For Early Rectal Cancer

NCT06205485

Principal Investigator:
Huong Pham, MD

Site: Virginia Mason Medical Center, Seattle

Gastroesophageal Cancer

A Phase 2 Study of Futibatinib in Combination with PD-1 Antibody-based Standard of Care Therapy in Patients with Solid Tumors

NCT05945823

Principal Investigator:
Bruce Lin, MD

Site: Virginia Mason Medical Center, Seattle

Gynecologic Cancer

REFRaME-O1: A Phase 2/3 Open-label Study Evaluating the Efficacy and Safety of Luveltamab Tazevibulin (STRO-002) versus Investigator's Choice (IC) Chemotherapy in Women with Relapsed Platinum-resistant Epithelial Ovarian Cancer (Including Fallopian Tube or Primary Peritoneal Cancers) Expressing Folate Receptor Alpha (FOLR1)

NCT05870748

Principal Investigator:
Allison Barrie, MD

Site: Virginia Mason Medical Center, Seattle

Hepatobiliary Cancer (Liver and Biliary Tract)

A Phase 1b/2 Multicenter, Open-label Study to Evaluate the Safety and Efficacy of TTI-101 as Monotherapy and in Combination in Participants with Locally Advanced or Metastatic, and Unresectable Hepatocellular Carcinoma

NCT05440708

Principal Investigator:
Bruce Lin, MD

Site: Virginia Mason Medical Center, Seattle

A Phase 2/3 Randomized, Controlled Study of CTX-009 in Combination with Paclitaxel versus Paclitaxel Alone in Adult Patients with Unresectable Advanced, Metastatic or Recurrent Biliary Tract Cancers who have received One Prior Systemic Chemotherapy Regimen

NCT05506943

Principal Investigator:
Bruce Lin, MD

Site: Virginia Mason Medical Center, Seattle

A Phase II, Open-Label, Multi-Cohort, Multicenter Study In Patients With Unresectable Hepatocellular Carcinoma and Child-Pugh B7 and B8 Cirrhosis

NCT06096779

Principal Investigator:
Bruce Lin, MD

Site: Virginia Mason Medical Center, Seattle

HIV/AIDS Associated Malignancies

AMC-101, A Pilot Study of Ibrutinib and R-da-EPOCH for Front Line Treatment of AIDS-Related Lymphomas

NCT03220022

Principal Investigator:
David Aboulafia, MD

Site: Virginia Mason Medical Center, Seattle

Use of a Screening Tool to Describe HIV-Related Cancer Burden and Patient Characteristics in the AIDS Malignancy Consortium

NCT05510908

Principal Investigator:
David Aboulafia, MD

Site: Virginia Mason Medical Center, Seattle

Kaposi Sarcoma

A Phase 2 Trial of Ixazomib for Kaposi Sarcoma

NCT04305691

Principal Investigator:
David Aboulafia, MD

Site: Virginia Mason Medical Center, Seattle

Multicenter Phase II Study of Pomalidomide Monotherapy in Kaposi Sarcoma

NCT04577755

Principal Investigator:
David Aboulafia, MD

Site: Virginia Mason Medical Center, Seattle

Lung Cancer

Impact of Behavior Modification Interventions and Lung Cancer Screening on Smoking Cessation in People Living with HIV: A Feasibility Study

NCT04949464

Principal Investigator:
David Aboulafia, MD

Site: Virginia Mason Medical Center, Seattle

Pancreatic Cancer

A Phase 1/1b Study of ASP2138 in Participants with Metastatic or Locally Advanced Unresectable Gastric or Gastroesophageal Junction (GEJ) Adenocarcinoma or Metastatic Pancreatic Adenocarcinoma Whose Tumors Have Claudin (CLDN) 18.2 Expression

NCT05365581

Principal Investigator:
Vincent Picozzi, MD

Site: Virginia Mason Medical Center, Seattle

A Phase 1b Study to Evaluate the Safety, Tolerability and Preliminary Efficacy of ATP150/ATP152, VSV-GP154 and Ezabenlimab (BI 754091) in Patients with KRAS G12D/G12V Mutated Pancreatic Ductal Adenocarcinoma

NCT05846516

Principal Investigator:
Vincent Picozzi, MD

Site: Virginia Mason Medical Center, Seattle

A Phase 1b/2a Study of Gemcitabine and Nab-paclitaxel in Combination with Avutometinib (VS-6766) and Defactinib in Patients with Previously Untreated Metastatic Adenocarcinoma of the Pancreas

NCT05669482

Principal Investigator:
Vincent Picozzi, MD

Site: Virginia Mason Medical Center, Seattle

A Phase 2, Randomized, Open-Label, Controlled Study to Evaluate the Efficacy and Safety of Ampligen® Compared to Control Group / No Treatment Following FOLFIRINOX in Subjects with Locally Advanced Pancreatic Adenocarcinoma

NCT05494697

Principal Investigator:
Vincent Picozzi, MD

Site: Virginia Mason Medical Center, Seattle

A Phase I/II Study of MCLA-128, a full length IgG1 Bispecific Antibody Targeting HER2 and HER3, in Patients with Solid Tumors

NCT02912949

Principal Investigator:
Vincent Picozzi, MD

Site: Virginia Mason Medical Center, Seattle

Alternating neoadjuvant Gemcitabine-Nab-Paclitaxel and nal-IRI with 5-Fluorouracil and folinic acid (Leucovorin) regimens in resectable and borderline resectable pancreatic cancer, A Pilot Study

NCT03703063

Principal Investigator:
Vincent Picozzi, MD

Site: Virginia Mason Medical Center, Seattle

Prostate Cancer

A Phase 2 Open-label Extension Study for Subjects with Prostate Cancer Who Previously Participated in an Enzalutamide Clinical Study

NCT02960022

Principal Investigator:
John Paul Flores, MD

Site: Virginia Mason Medical Center, Seattle

NRG-GU009: Parallel Phase III Randomized Trials For High Risk Prostate Cancer Evaluating De-Intensification For Lower Genomic Risk and Intensification of Concurrent Therapy for Higher Genomic Risk with Radiation (PREDICT-RT*)

NCT04513717

Principal Investigator:
Huong Pham, MD

Site: Virginia Mason Medical Center, Seattle

NRG-GU010: Parallel Phase III Randomized Trials Of Genomic-Risk Stratified Unfavorable Intermediate Risk Prostate Cancer: De-Intensification and Intensification Clinical Trial Evaluation (Guidance)

NCT05050084

Principal Investigator:
Huong Pham, MD

Site: Virginia Mason Medical Center, Seattle

Cardiology Research

Please email mainctu@benaroyaresearch.org or call (206) 287-6260 for more information.

Irrigated Radio Frequency Ablation to Terminate Non-Paroxysmal Atrial Fibrillation (Terminate AF Study)

NCT03546374

Principal Investigator:
Robert Moraca, MD

Site: Virginia Mason Medical Center, Seattle

Percutaneous or Surgical Mitral Valve REpair in PAtients with Primary Mitral Regurgitation whose mitral valve has been determined to be suitable for correction by MV repair surgery

NCT04198870

Principal Investigator:
Ming Zhang, MD

Site: Virginia Mason Medical Center, Seattle

Post-Approval Study Protocol for Hybrid Convergent of Epicardial RF Ablation and Endocardial Ablation for the Treatment of Symptomatic Long Standing Persistent AF

NCT05393180

Principal Investigator:
Robert Moraca, MD

Site: Virginia Mason Medical Center, Seattle

Deliver Insights in Hypertrophic Cardiomyopathy and Observational Outcomes in Real World (DISCOVER-HCM): United States Prospective Registry Study

NCT05489705

Principal Investigator:
Mariko Harper, MD

Site: Virginia Mason Medical Center, Seattle

HERMES: Effects of ziltivekimab versus placebo on morbidity and mortality in patients with heart failure with mildly reduced or preserved ejection fraction and systemic inflammation

NCT05636176

Principal Investigator:
Sara Weiss, MD

Site: Virginia Mason Medical Center, Seattle

A Randomized, Sham-Controlled, Clinical Trial for Evaluation of the Edwards APTURE Transcatheter Shunt System (ALT-FLOW II)

NCT05686317

Principal Investigator:
Bhanu Gupta, MD

Site: Virginia Mason Medical Center, Seattle

An Open-label Study to Evaluate the Safety, Tolerability, Pharmacokinetic, and Pharmacodynamic Effects of EDG-7500 in Adults with Obstructive Hypertrophic Cardiomyopathy

NCT06347159

Principal Investigator:
Mariko Harper, MD

Site: Virginia Mason Medical Center, Seattle

A Phase 3, Multi-Center, Randomized, Double-Blind Trial to Evaluate the Efficacy and Safety of Aficamten Compared to Placebo in Adults with Symptomatic Non-Obstructive Hypertrophic Cardiomyopathy

NCT06081894

Principal Investigator:
Mariko Harper, MD

Site: Virginia Mason Medical Center, Seattle

For information about the following studies at St. Joseph Medical Center, please contact Boyoung Moore at (253) 426-6495 or Jacquelyn Lusk at (253) 426-6377.

A Phase 3, Randomized, Double-blind, Placebo-controlled, Event-driven Study to Demonstrate the Efficacy and Safety of Milvexian, an Oral Factor XIa

NCT05754957

Principal Investigator:
John Luber, MD

Site: St. Joseph Medical Center, Tacoma

ARTEMIS: RAvulizumab to PRotect PaTients With Chronic Kidney DisEase (CKD) froM Cardiac Surgery Associated Acute Kidney Injury (CSA-AKI) and Subsequent Major Adverse Kidney Events (MAKE): A Phase 3, Randomized, Double-blind, Placebo-controlled, Multicenter Study

NCT05746559

Principal Investigator:
John Luber, MD

Site: St. Joseph Medical Center, Tacoma

Real-world Experience of Catheter Ablation for the Treatment of Symptomatic ParoxysmaL and Persistent Atrial Fibrillation Using Novel CARTO Technologies: REAL AF Registry

NCT04088071

Principal Investigator:
Nasir Shariff, MD

Site: St. Joseph Medical Center, Tacoma

The Long-term Safety and Effectiveness Evaluation of the QDOT MICRO™ System Use in Conjunction with VISITAG SURPOINT™ Module for the treatment of symptomatic drug refractory paroxysmal atrial fibrillation (A nested sub-study of REAL AF registry)

NCT06324201

Principal Investigator:
Nasir Shariff, MD

Site: St. Joseph Medical Center, Tacoma

Algorithm Using LINQ Sensors for Evaluation And Treatment of Heart Failure (ALLEVIATE-HF)

NCT04452149

Principal Investigator:
David Zhang, MD

Site: St. Joseph Medical Center, Tacoma

Gastroenterology Research

Please email crp@benaroyaresearch.org or call (206) 341-1021 for more information.

Paclitaxel Coated balloon for the Treatment of chronic bEnigN sTricture- Bowel

NCT05561127

Principal Investigator:
Sam Rosenfeld, MD

Site: Virginia Mason Medical Center, Seattle

Protocol for the Comparison of Surgery and Medicine on the Impact of Diverticulitis (COSMID) Trial

NCT04095663

Principal Investigator:
Val Simianu, MD

Site: Virginia Mason Medical Center, Seattle

REC-4881-201 A Phase 2, Multicenter, Trial to Evaluate the Efficacy, Safety, Pharmacokinetics, and Pharmacodynamics of REC-4881 in Patients with Familial Adenomatous Polyposis (FAP)

NCT05552755

Principal Investigator:
Gautam Mankaney, MD

Site: Virginia Mason Medical Center, Seattle

Examination of Programming with the Enterra® Therapy System in a Double-Blinded, randomized, Prospective Study In the Treatment of Nausea and Vomiting Symptoms using Gastric Electrical Stimulation

NCT06560307

Principal Investigator:
Pierre Blais, MD

Site: Virginia Mason Medical Center, Seattle

ALTUS: Performance of a Multi-Target Hepatocellular Carcinoma (HCC) Test in Subjects with Increased Risk

NCT05064553

Principal Investigator:
Asma Siddique, MD

Site: Virginia Mason Medical Center, Seattle

Casting Light on Urgency and Effectiveness of Advanced Therapies in Ulcerative Colitis (CLUES-UC): A Non-interventional, Observational Cohort Study of Mirikizumab and Other Biologics in Adult Participants with Moderately to Severely Active Ulcerative Colitis

NCT05767021

Principal Investigator:
Tim Zisman, MD

Site: Virginia Mason Medical Center, Seattle

Neurosciences & Spine Research

Please email mainctu@benaroyaresearch.org or call (206) 287-6260 for more information.

A randomized, double-blind, double-dummy, parallel-group study, comparing the efficacy and safety of remibrutinib versus teriflunomide in participants with relapsing multiple sclerosis, followed by extended treatment with open-label remibrutinib

NCT05156281

Principal Investigator:
Mariko Kita, MD

Site: Virginia Mason Medical Center, Seattle

The VISTA Study: A Phase 2, Randomized, Double-Blind, Placebo-Controlled, Dose-Ranging Multicenter Study to Evaluate the Safety and Efficacy of Oral PIPE-307 as an Adjunctive Treatment in Subjects with Relapsing-Remitting Multiple Sclerosis

NCT06083753

Principal Investigator:
Lucas McCarthy, MD

Site: Virginia Mason Medical Center, Seattle

Advanced Techniques in Intraoperative Monitoring for the Lateral Lumbar Interbody Fusion Procedure: A Utility Study

NCT05648474

Principal Investigator:
Philip Louie, MD

Site: Virginia Mason Medical Center, Seattle

Sleep SMART: Sleep for Stroke Management And Recovery Trial

NCT03812653

Principal Investigator:
Fatima Milfred, MD

Site: Virginia Mason Medical Center, Seattle

Radiology Research

Please email mainctu@benaroyaresearch.org or call (206) 287-6260 for more information.

A Randomized, Double-Blind, Placebo-Controlled, Phase 3 Study of the Safety and Efficacy of OMS721 in Patients with Immunoglobulin A (IgA) Nephropathy

NCT03608033

Principal Investigator:
Mehran Fotoohi, MD

Site: Virginia Mason Medical Center, Seattle

Rheumatology Research

Please email mainctu@benaroyaresearch.org or call (206) 287-6260 for more information.

A Randomized, Double-Blind, Placebo Controlled Phase 4 Clinical Trial to Evaluate the Long Term Safety and Efficacy of Avacopan in Subjects with ANCA associated Vasculitis

NCT06072482

Principal Investigator:
Vivian Stone, MD

Site: Virginia Mason Medical Center, Seattle

Please call 800.888.4187 for more information.

Determining how dietary fiber alters immune cells in ankylosing spondylitis

Site: Benaroya Research Institute, Seattle

Adults with and without Rheumatoid Arthritis before and during Acute Respiratory Viral Illness (HIPC-RV)

Site: Benaroya Research Institute, Seattle

Urology Research

Please email crp@benaroyaresearch.org or call (206) 342-6915 for more information.

CELLEBRATE: An Adaptive, Two-Stage, Double-Blind, Stratified, Randomized, Controlled Trial Comparing the Safety and Efficacy of AMDC-USR with Placebo in Female Subjects with Stress Urinary Incontinence

NCT03104517

Principal Investigator:
Una Lee, MD

Site: Virginia Mason Medical Center, Seattle

Type 1 Diabetes Research

Please email Diabetes@BenaroyaResearch.org or call 800.888.4187 for more information.

The TrialNet Natural History Study of the Development of T1DM (Pathway to Prevention Study)

NCT00097292

Site: Benaroya Research Institute, Seattle

Long-Term Investigative Follow-Up in TrialNet (LIFT)

Site: Benaroya Research Institute, Seattle

Effects of Rituximab on the Progression of Type 1 Diabetes in New Onset Subjects (TN25).

NCT00279305

Site: Benaroya Research Institute, Seattle

A Phase 2 Multi-Center, Randomized, Double-Blind, Placebo-Controlled Study to Evaluate the Safety and Efficacy of Subtype-Selective JAK Inhibitors for Preservation of Pancreatic B Cell Function in Newly Diagnosed Type 1 Diabetes Mellitus (TN31)

NCT05743244

Site: Benaroya Research Institute, Seattle

Low Dose Antithymocyte Globulin (ATG) to Delay or Prevent Progression to Stage 3 T1D

NCT04291703

Site: Benaroya Research Institute, Seattle

Type 1 Diabetes Extension Study (T1DES)

NCT02734277

Site: Benaroya Research Institute, Seattle

AT Cell Phenotype Signature Driven Dose Finding Study with Siplizumab in Type 1 Diabetes Mellitus (ITN095AI-DESIGNATE)

NCT05574335

Site: Benaroya Research Institute, Seattle

Diabetes RElated to Acute Pancreatitis and Its Mechanisms (DREAM) An Observational Cohort Study from the Type 1 Diabetes in Acute Pancreatitis Consortium (T1DAPC)

NCT05197920

Site: Benaroya Research Institute, Seattle

A 52-week Randomized, Double-blind, Placebo-controlled, Multi-center Phase 2b Study With a 52-week Blinded Extension Assessing Safety and Efficacy of Frexalimab, a CD40L-antagonist Monoclonal Antibody, for Preservation of Pancreatic β-cell Function in Adults and Adolescents With Newly Diagnosed Type 1 Diabetes on Insulin Therapy

NCT06111586

Site: Benaroya Research Institute, Seattle

Benaroya Research Institute (BRI) Registries

Please email biorepository@BenaroyaResearch.org for more information.

BRI Immune-Mediated Diseases Registry and Repository: Allergy and Asthma

Diabetes Translational Research Project

Immune-Mediated Diseases Registry and Repository: Control Group Protocol

Immune-Mediated Diseases Registry & Repository: Down Syndrome & Human Immunity Translational Research Study Protocol

Immune-Mediated Diseases Registry and Repository: Gastrointestinal Diseases Group Translational Research Study Protocol

Immune-Mediated Diseases Registry and Repository: Infectious Diseases and Vaccine Studies

Immune-Mediated and Neurologic Diseases Translational Research Study Protocol

Immune-Mediated Diseases Registry and Repository: Pulmonary Diseases amd Human Immunity

Immune-Mediated Diseases Registry and Repository: Rheumatic Diseases Translational Research Study Protocol

2024 - 2025

CME Courses

CME Courses at Virginia Mason Medical Center

For more information, please go to VirginiaMasonCME.org

Date	Course Title
Friday, February 28, 2025	**Preoperative Evaluation and Surgical Readiness in the Modern Era**
Friday, March 21, 2025	**Colorectal Cancer Update**
Friday, April 25, 2025	**16th Annual Topics in Primary Care**
Friday, May 16, 2025	**Updates in Neurology**
Friday, June 13, 2025	**Topics in Nephrology for Primary Care Providers**
Friday, June 27, 2025	**Palliative Care is Everyone's Job - Take 2**
Friday, September 19, 2025	**Gastroenterology & Hepatology Update 2025**
Friday, October 3, 2025	**Integrated Patient Empowerment of the Pelvic Floor**
Friday, October 17, 2025	**It Takes a Village –Diversity, Equity, and Social Determinants of Health**
Friday, November 21, 2025	**Advocacy and Activism and Social Media: How to Improve Medicine for Clinicians and Patients**

Upcoming CME Courses in Tacoma/Other Sites

For more information, please contact Diann.Winkcompleck@VMFH.org

Connections: Relationship-Centered Communication and Meaning in Medicine

A live, in-person all-day course offered to hospital and ambulatory physicians, advanced practice nurses and physician assistants (open only to virginia mason franciscan health providers)

Offered monthly. 2024 classes are full. **2025 dates below.**

For more information, contact: Jessica.Dunn900@commonspirit.org

Wednesday, January 15, 2025 |	**Tacoma**
Tuesday, February 12, 2025 |	**Tacoma**
Tuesday, March 18, 2025 |	**Tacoma**
Wednesday, April 23, 2025 |	**Seattle**
Tuesday, May 20, 2025 |	**Tacoma**
Tuesday, June 17, 2025 |	**Tacoma**
Wednesday, July 16, 2025 |	**Tacoma**
Tuesday, September 16, 2025 |	**Seattle**
Wednesday, October 16, 2025 |	**Tacoma**
Wednesday, November 12, 2025 |	**Tacoma**
Tuesday, December 16, 2025 |	**Seattle**

Best practices to Reduce your Worker Compensation Headaches

Date: 3/8/2025

Location: WA State History Museum

Contact: wwcohe@vmfh.org

Time: 8:00 – 4:00

Advanced Communication Academy: Builds communication skills for clinicians in the setting of advanced serious illness and end of life.

This live 9.5 hour course is offered monthly in Tacoma. Seats limited.

Dates TBA.

For more information contact: ACA@VMFH.org

Featured

Publications

Virginia Mason Franciscan Health Publications

1. **Chung C, Stovall S,** Biehl SR, Rocha F, **Wancata L, Helton S, Biehl T.** Pancreas preserving duodenectomy (PPrD). Am J Surg. 2024 Nov;237:115746. doi:10.1016/j.amjsurg.2024.04.017. Epub 2024 Apr 16. PMID: 38641448.

2. Brown TA, Alterio M, **Stiles EC,** Vu M, Washington BB, Chauvin TR, Kumar AS. Surgical journal clubs: Navigating the post-pandemic landscape. Am J Surg. 2024 Nov;237:115706. doi: 10.1016/j.amjsurg.2024.03.002. Epub 2024 Mar 11. PMID: 38519404.

3. **Nicholls M,** Guo K, Chen YH, Shen Y, Chang Y, Guo A. A retrospective claims data analysis of health care utilization and cost among patients receiving multi-injection intraarticular hyaluronic acid. J Manag Care Spec Pharm. 2024 Oct;30(10):1117-1127. doi: 10.18553/jmcp.2024.30.10.1117. PMID: 39321119; PMCID: PMC11424917.

4. **Kozarek R.** Editorial: Does ESWL-ERCP for pancreatic duct stone removal change the natural course of symptomatic chronic calcific pancreatitis? Aliment Pharmacol Ther. 2024 Oct;60(8):1130-1131. doi: 10.1111/apt.18253. Epub 2024 Sep 17. PMID: 39287617.

5. Markar SR, Sgromo B, Evans R, Griffiths EA, Alfieri R, Castoro C, Gronnier C, Gutschow CA, Piessen G, Capovilla G, Grimminger PP, **Low DE,** Gossage J, Gisbertz SS, Ruurda J, van Hillegersberg R, D'journo XB, Phillips AW, Rosati R, Hanna GB, Maynard N, Hofstetter W, Ferri L, Berge Henegouwen MI, Owen R. The Prognostic Impact of Minimally Invasive Esophagectomy on Survival After Esophagectomy Following a Delayed Interval After Chemoradiotherapy: A Secondary Analysis of the DICE Study. Ann Surg. 2024 Oct 1;280(4):650-658. doi: 10.1097/SLA.0000000000006411. Epub 2024 Jun 21. PMID: 38904105.

6. Rana Z, Kamran SC, Shetty AC, Sutera P, Song Y, Bazyar S, Solanki AA, Simko JP, Pollack A, McConkey D, Kates M, Siddiqui MM, Hiken J, Earls J, Messina D, Mouw KW, Miyamoto D, Shipley WU, Michaelson MD, Zietman A, Coen JJ, Dahl DM, Jani AB, Souhami L, Chang BK, Lee RJ, **Pham H,** Marshall DT, Shen X, Pugh SL, Feng FY, Efstathiou JA, Tran PT, Deek MP. Prognostic Significance of Immune Cell Infiltration in Muscle-invasive Bladder Cancer Treated with Definitive Chemoradiation: A Secondary Analysis of RTOG 0524 and RTOG 0712. Eur Urol Oncol. 2024 Oct;7(5):986-989. doi: 10.1016/j.euo.2024.03.015. Epub 2024 Apr 18. PMID: 38641541; PMCID: PMC11427165.

7. Jin JL, Baylor C, Teixeira J, Yorkston K, **Nuara M.** Reframing transgender communication in gender-affirming communication care: Comfort and confidence are the main goals. Int J Speech Lang Pathol. 2024 Oct;26(5):750-764. doi:10.1080/17549507.2023.2259124. Epub 2023 Oct 31. PMID: 37907084.

8. Kuemmerli C, Sijberden JP, Cipriani F, Osei-Bordom D, Aghayan D, Lanari J, de Meyere C, Cacciaguerra AB, Rotellar F, Fuks D, Liu R, Besselink MG, Zimmitti G, Ruzzenente A, di Benedetto F, Succandy I, Efanov M, Memeo R, Jovine E, Vrochides D, Dagher I, Croner R, Lopez-Ben S, Geller D, Ahmad J, Gallagher T, **White S,** Alseidi A, Goh BKP, Sparrelid E, Ratti F, Marudanayagam R, Fretland ÅA, Vivarelli M, D'Hondt M, Cillo U, Edwin B, Sutcliffe RP, Aldrighetti LA, Hilal MA; International Consortium on Minimally Invasive Liver Surgery (I-MILS). Is prolonged operative time associated with postoperative complications in liver surgery? An international multicentre cohort study of 5424 patients. Surg Endosc. 2024 Sep 30. doi: 10.1007/s00464-024-11276-x. Epub ahead of print. PMID: 39347957.

9. **Bansal A, Kumar R,** Lipson P, **Alostaz M, Nemani V, Leveque JC, Louie PK.** Comparison of Oswestry Disability Index Scores Between Surgical Candidates and General Population: Insights into Evaluation Criteria for Spine Surgery. Spine (Phila Pa 1976). 2024 Sep 30. doi: 10.1097/BRS.0000000000005165. Epub ahead of print. PMID: 39344073.

10. **Bouche R, Fotoohi M.** Percutaneous Puncture from a Pancreatic Duct Leak into the Stomach to Treat a Pancreaticocutaneous Fistula. J Vasc Interv Radiol. 2024 Sep 28:S1051-0443(24)00606-7. doi: 10.1016/j.jvir.2024.09.012. Epub ahead of print. PMID: 39349241.

11. Elmunzer BJ, Zhang J, Coté GA, Edmundowicz SA, Wani S, Shah R, Bang JY, Varadarajulu S, Singh VK, Khashab M, Kwon RS, Scheiman JM, Willingham FF, Keilin SA, Papachristou GI, Chak A, Slivka A, Mullady D, Kushnir V, Buxbaum J, Keswani R, Gardner TB, Forbes N, Rastogi A, **Ross A, Law J,** Yachimski P, Chen YI, Barkun A, Smith ZL, Serrano J, Petersen B, **Wang AY,** Saltzman JR, Spitzer RL, Ordiah C, Spino C, Foster LD, Durkalski-Mauldin V; SVI Study Group*. Technical Factors Associated With the Benefit of Prophylactic Pancreatic Stent Placement During High-Risk Endoscopic Retrograde Cholangiopancreatography: A Secondary Analysis of the SVI Trial Data Set. Am J Gastroenterol. 2024 Sep 27. doi: 10.14309/ajg.0000000000003052. Epub ahead of print. PMID: 39207308.

12. Simpson CL, Tiwaa A, **Zaver SA,** Johnson CJ, Chu EY, Harms PW, Gudjonsson JE. ERK hyperactivation in epidermal keratinocytes impairs intercellular adhesion and drives Grover disease pathology. JCI Insight. 2024 Sep 26:e182983. doi: 10.1172/jci.insight.182983. Epub ahead of print. PMID: 39325541.

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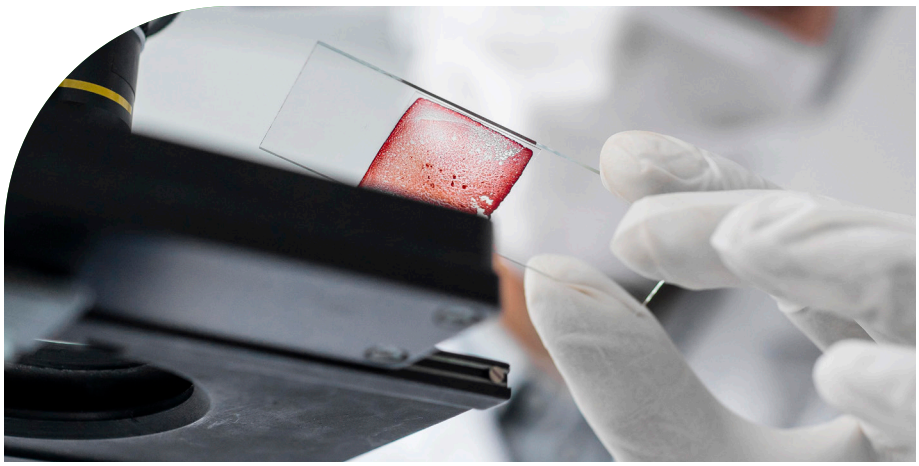

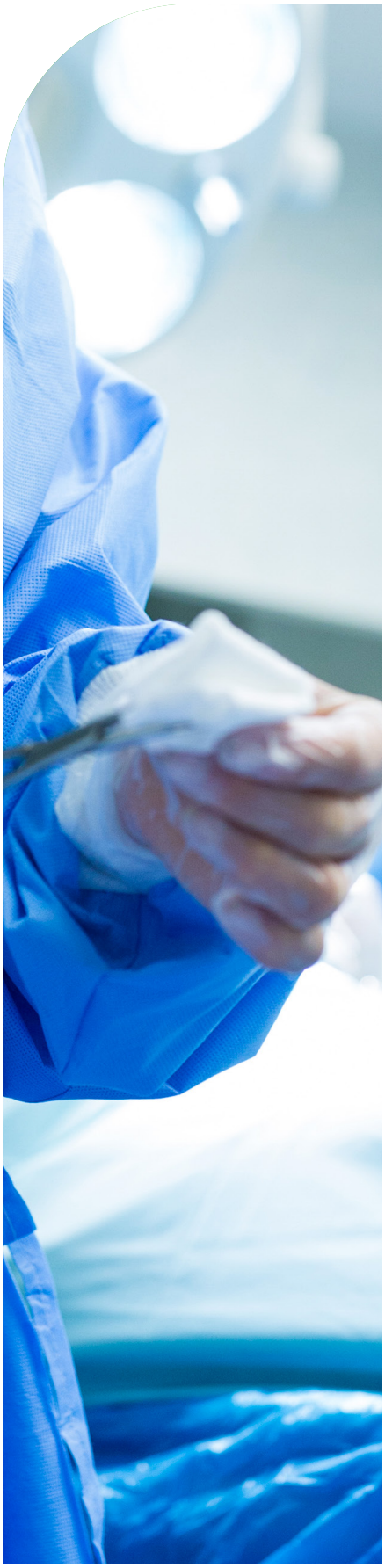

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PUBLICATIONS

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