

# TCL

THE CANCER LETTER

Inside information on cancer  
research and drug development

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– Richard L. Schilsky, MD, FSCT, FACP, FASCO  
ASCO Chief Medical Officer and Executive Vice President

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STOP  
KILLING  
US



GUEST EDITORIAL

# I COULD HAVE BEEN GEORGE FLOYD—MANY TIMES

## REFLECTING ON THE CANCER OF RACISM

I am almost certain that no other director of an NCI-designated cancer center can claim the distinction of having had a gun pulled on them by police.



**By Robert A. Winn, MD**

*Director, Virginia Commonwealth University Massey Cancer Center*

I've had that experience not once, but twice.

I struggled a great deal in deciding whether to put something together this week in response to the senseless killing of Mr. George Floyd. His untimely death has stirred up a number of complex issues, which I thought I had wrestled under control.

If there is anything we've learned from the COVID-19 crisis, it's that the boundaries between cancer and non-cancer can be porous. And health disparities come in bunches, bouquets of injustice.

And, as a pulmonologist, I hear Floyd's last words—"I can't breathe." Don't tell me that chokeholds, literal and figurative, are anything other than a public health issue.

And let's not forget that George Floyd, before being killed by rogue cops, had survived COVID-19.

I am proud of being a director of an outstanding NCI-designated cancer center. I am also proud to have the distinction of being the only African American currently in that position. But as a black male I cannot forget that when

I step out from behind my desk, hang up my white coat and get out into the street, I am just a black male—just like George Floyd.

To this day, I have considerable difficulty understanding my first experience with inappropriate policing.

I was walking back to my car with a couple of friends—who by the way, have been very successful, one is a physician, the other, a high-level MBA.

We were in Chicago, and after a late dinner, we were on our way back home. As

I approached my car, I was asked if the car I was walking towards was mine. For the record, the car in question was a 1972 Coupé de Ville, a beautiful boat.

“Yes,” I said, and within seconds, I was up against a wall, frisked, then dropped to the ground by what felt like an army of police officers.

When that happens to you, you try to remember all the information your Dad has passed on to you, that his Dad had passed on to him, about the lethal dos and don'ts. (By the way, post-Floyd, I have passed on “The Talk” to both my son and daughter. It's a macabre rite of passage for us black folks.)

But let me get back to Chicago, with me on the ground, face-down, Cadillac-side, cops on my back.

For what felt like eternity, I answered a series of questions that I can't remember. Nor can I remember anything the officers were saying. I know there was a lot of yelling, intensity, and nervousness.

What I remember most, was a click, and a gun being placed to the back of my head. Why? Because, disregarding the Talk, I asked the officer, who had me pinned down, to give me his badge number. He didn't.

Luckily, after the cops were satisfied that I was not a threat to society, I was freed; no bullet wounds, no chokehold injuries—just a few bruises, a few abrasions, and the feeling of deep sadness, with confusion mixed in.

I wish, I could say that this was my only experience. Being cuffed, and sitting in the back of a police car, became a familiar routine. Sitting there gives you an opportunity to think.

As I sat there, I wondered, how was it possible that even with obeying the law, the speed limit, not rolling through a

stop sign, not having a cracked head- or tail light, getting through college, medical school, and residency, how was it possible that I was sitting in the back of this damned police car?

More disturbing were the thoughts that I could end up like Emmet Till, Fred Hampton, or Rodney King, the forerunners, of George Floyd, Eric Garner, or Michael Brown. One miscommunication, one misinterpretation of a look, or a movement can cost you your life—as it has cost many others.

Please note, I was never arrested or charged with anything. It's probably also important to point out that there was nothing particularly exciting leading up to these events—no drugs, guns, alcohol, hanging out with the “wrong” crowd. No unruly behavior whatsoever. I can't even claim that the events were associated with something important, like participating in public protests or acts of public defiance. (I have participated in a few protests in my time, but, in my experience, perversely, carrying a protest sign is less perilous than simply driving while black—DWB).

I am not anti-law enforcement. I am very proud of my brother, who has served his time well, and with both distinction and honor, as an investigator with the New York State Police, Major Crimes Bureau. He is an example of good policing.

And I am not so much pointing a finger at our law enforcement system, as much as I am simply trying to reduce unnecessary use of force and stop chokeholds. It's becoming increasingly clear that a contributing factor to the increase in police violence, may be due to the fact that most police officers don't live in the area they work. As a result, it sets up a mindset that they are more like an “army” of occupiers, as opposed to a police force serving a neighborhood. It is in this spirit that I share with you my experience.

I say all this, as a director of an NCI-designated cancer center director, as a pulmonologist, as a disparities researcher, as an American, as a proud father: I hope that all of these deaths will end.

In my experience, our endemic institutional racism is, and has always been, a public health issue. In fact—as a result of the COVID-19 disaster—we are all now finally recognizing that racism is a contributing factor to chronic diseases, including cancer.

One way we can battle the chronic disease of racism is to recognize it, and rebuke it in all its forms. Another strategy is to continue to double down on building real pipeline programs to diversify our cancer center, and our cancer work force.

But at this moment, urgently, let's all make our voices heard, from every cancer center in the land, that the practice of chokeholds must cease. It is a public health issue of great importance.

I would like to be remembered as being a part of a group of cancer center leaders who were not only known for discovering new miracle cures to fight cancer, but also for the strength of moral character to stand against all things that threaten our humanity.

Like many others, I hope we can put the current COVID-19 crisis behind us so that we might get back to the primary job of curing cancer. I have faith in all of us. We will find the strength to cure all types of cancer: those that originate from solid tumors, those that originate from liquid tumors—as well as those that stem from racism.





GUEST EDITORIAL

# I could have been George Floyd, too

The past ten days have seen an outpouring of emotions as American society, devastated by the tragic murder of George Floyd by four Minneapolis police officers, plunges into a crisis of conscience.



**By Otis W. Brawley, MD, MACP, FASCO, FACE**

*Bloomberg Distinguished Professor of Oncology and Epidemiology,  
Johns Hopkins University*

Floyd's death may be a pivotal point in America, similar to the televised beating of peaceful civil rights marchers by police on the Edmund Pettus Bridge in 1965. It has led to a number of protests and, unfortunately, some violence, including an attack by federal law enforcement as they beat and pepper-sprayed peaceful protesters in front of the White House.

The use of force against demonstrators in front of the White House is particularly ironic, considering that this entire series of events stems from an act of police brutality.

The police brutality is the tip of the iceberg. The fact is, it is the most obvious and dangerous aspect of systemic racism. There are a number of social injus-

tics that collectively make blacks feel that their lives are not valued, and these issues are not being addressed by American society as a whole. Many Americans simply do not care, or aren't aware.

If they are not aware, they are not listening.

Suspicious deaths of blacks at the hands of police have been in the news for years. Floyd's death wasn't even the first to be seen on video. Rarely is a policeman held accountable for one of these deaths. Colin Kaepernick conducted a peaceful protest to bring light to this problem. It led to this talented professional football player losing his career and being viciously criticized and called a "son of a bitch" by the President of the United States.

Still, many well-meaning Americans are now shocked and surprised learning of the pervasiveness of mistreatment of blacks by police.

Police mistreatment of blacks—especially black men—is widespread. It is especially bad for young blacks, but no black is exempt.

Even a 40-plus-year-old military officer and physician can get thrown to the ground, handcuffed and questioned at gunpoint for looking suspicious in a nice part of Montgomery County. That would be yours truly a few years ago.

My real offense: standing in the garage of my own home.

By the way, the cops didn't apologize, even after realizing that the address on my driver's license was the address of the house they just invaded. Indeed, some of the excuses for police harassment and intimidation would be comical, if the situations weren't so dangerous. The result is many black Americans do not trust police and, worse, live in constant fear of police.

Police harassment and mistreatment is a form of oppression. It exists to remind blacks of their social position. Other things exist to remind us of our social position, such as Confederate Civil War monuments and flags. Police harassment is just a part of the social injustice that black people live with on a daily basis.

We call it, "our burden." It's also called systemic racism or white privilege. It is an American form of apartheid. It is the evolution of the old segregation. It is a mindset on the part of many whites and blacks. It is so ingrained in society, both whites and blacks have come to accept it, not question it, and live by the rules.

Through redlining and other societal forces, blacks are forced to live in segregated areas where everything is inferior. The governmental services, the environment, the schools, the availability of nutritious food, even the health care is inferior. The forces holding blacks back are tremendous. Perhaps the greatest tragedy is when a talented black accepts their destiny is to stay in the circle of deprivation. They start believing they are inferior.

American society has great praise for those of us who break out of the entanglements of the ghetto, but even then, there are barriers. No matter what your accomplishments, you are still questioned. You are still less legitimate. Your views, opinion, and work product are still never quite as valid as those of white colleagues. You still have some of the fears. The oppressors can still get you. Colin Kaepernick found out what happens if you get too mouthy.

Disparities in health are a big part of the social injustice. Blacks get health care in clinics and public hospitals. Whites have a doctor; blacks have a clinic. The healthcare system in American is segregated by socioeconomic factors, but because of the socioeconomic factors of America, that means segregated race. The whites have ongoing care that includes prevention of disease. The blacks have a safety net for when they get sick.

We in medicine propagate racism by using race as a biological categorization. We forget that the concept was created as sociopolitical justification of slavery and white superiority. Scientific fact, there are small genetic differences among people by area of geographic origin, but as Ancestry.Com and 23andMe have taught us, everybody is all mixed up. To categorize the population by race is like trying to slice soup.

Another example of systemic racism in medicine: When blacks have worse outcomes than whites, we so often look to "the disease is more aggressive in blacks compared to whites."

Dr. Kim Rhoads, at the University of California, San Francisco, has noted that the colorectal cancer of blacks is often not staged as rigorously as that of whites, because blacks are more commonly treated in overcrowded hospitals, where pathologists typically have four to six cases per day, and whites are more often treated in hospitals where the pathologist commonly has one or two cases per day.

We then conclude that blacks have more aggressive disease, when a bunch of blacks with stage II disease (have 0 out of 6 nodes assessed) relapse, and a bunch of whites with stage III disease (1 out of 24 nodes positive) do not relapse.

We need to change the attitudes of many people.

Those who simply say, "I am not a racist" are complicit in perpetrating the inequi-

ty. It is time for reflection, it is time for awareness, it is time for listening, it is time for empathy and caring. We need a South African-style Truth and Reconciliation process. Blacks also have to be open change as well.

There is a lot of fear, pent-up anger, and frustration.

There is also a reason for hope. There is awareness; people may be listening. The recent deaths have led to statements of concern from companies and institutions. This never happened during the height of the civil rights movement in the 1960s. The protests after George Floyd's death have been attended by a tremendously diverse group of people. For some of us who have borne the burden, the diversity of support is most gratifying.

The fact that people of all races are coming together to call for justice is a move to Make America Great—Finally.

Why are white folks so into superiority?

“

If you can convince the lowest white man he's better than the best colored man, he won't notice you're picking his pocket. Hell, give him somebody to look down on, and he'll empty his pockets for you.

”

—Lyndon B. Johnson

# Here's what cancer groups say about police brutality and health disparities

## National Institutes of Health



National Institutes  
of Health

### Francis S. Collins, NIH director:

I am writing on this troubling day to share with you my personal sense of heartbreak and devastation at the events surrounding the death of George Floyd in Minneapolis. And this tragic event has too many echoes of what has come before. As we witness repeated episodes of violence perpetrated against our African American brothers and sisters, it is impossible not to experience a deep sense of outrage, disbelief, and grief.

Though by birth and life course I am undeniably a privileged white male, I cannot let these horrific acts go by without denouncing the underlying and ongoing bias and prejudice that fuels them. Such actions are a crime against humanity. They are utterly antithetical to NIH's commitment to find ways to reduce suffering and promote health—for everyone.

I am reaching out to you today to share the grief and anger that I know you also feel, but also to reaffirm our common resolve. It will not be helpful to sanitize the facts or underestimate the challenges before us as a society. Four hundred years after the introduction of the sin of slavery in this country, there is still a tremendous amount of difficult work to do. It is hard not to feel helpless in the face of circumstances like this. But both as private citizens and as members of this great institution, I call on myself and everyone at NIH to do what we can—to ensure that we foster a culture of inclusion, equity, and respect for one another, and that justice will endure.

As leaders in health research, it is our duty to continually uncover new ways

to improve people's lives and keep them free from harm and disease. One of our most important callings is to address the health disparities that prevent many from experiencing the full and complete life they hope for and deserve. The COVID-19 pandemic has shone a bright and deeply distressing light on just how much health inequity persists in our society. We need to look at this unflinchingly, and embrace that challenge, enlisting the vision of the talent all around us. We are surrounded by deeply committed colleagues who have not only studied health disparities and racial violence, they have lived them. We're reliable, capable, and resilient because of our many races, ethnicities, cultures, faiths, gender identities, sexual orientations, ages, abilities, and backgrounds. Our diversification fuels our creativity and drives innovation. I embrace that—now, more than ever.

COVID-19 has regrettably kept us apart from one another. I long to be with all of you now. We could have an amazing face to face town meeting right now. I could learn a lot from you. We might even sing together. But despite physical distancing, we are still a community that

cares about each other. I encourage you to reach out, lend an ear, and provide a virtual shoulder to those in need. Let's show our collective strength by remaining allies and advocates for one another. Although the recent headlines make us want to look away in disgust and disappointment, let us look to each other for strength and hope, and recommit ourselves to our shared goals of making the world a better place—for everyone.

Though I am heartbroken by the injustice of this dark moment, and deeply troubled about the increasing threat of violent responses, now is the time for us to come together as we serve together—across the NIH community. Our work has never been more critical. Our concern for each other has never been more important.

In the words of the great Dr. Martin Luther King, Jr.: "Injustice anywhere is a threat to justice everywhere. We are caught in an inescapable network of mutuality, tied in a single garment of destiny. Whatever affects one directly, affects all indirectly."

Dear friends, I wish you peace, health, vision, and safety.

## National Cancer Institute



### Norman E. Sharpless, NCI director:

When I was 13, I remember watching a televised assault on a group of black and hispanic protesters by members of the KKK and neo-Nazis in my hometown of Greensboro, NC. Five people were killed in this massacre that occurred

in broad daylight, on TV, and with the foreknowledge of local police, and not a single person ever went to jail for these indisputably racist murders. The year was 1979. Since then, I have told myself that things are getting better; and in truth, they have been getting better, but as recent events have proven, not quickly enough.

Forty-two years later, I am sickened by the disregard for the lives—including those of George Floyd, Ahmaud Arbery and Breonna Taylor—of African Americans, a group that continues to be marginalized in this country. I am outraged by the manner in which laudable, non-violent protests against these acts have been disrupted by those with a very different agenda, resulting in rioting and further injury and death. For me, and perhaps for you, these events make it hard to concentrate on our task at hand: fulfilling the mission of the NCI.

During these unprecedented times, I do take comfort in knowing that our mission includes and benefits everyone, regardless of race, socio-economic status, education, geographic location or access to care. The events taking place today only strengthen our resolve to help eliminate these injustices. I truly hope that each and every one of you understands the value and importance of your work in achieving our mission during this time of unrest and pandemic. Work on our mission not only helps patients with cancer, but over the long run, it makes America a healthier country for everyone.

Thank you so much for your efforts and the remarkable work you're doing.

## FDA Oncology Center of Excellence



### Richard Pazdur, director of the FDA's Oncology Center of Excellence and acting director of the Office of Oncologic Diseases in the FDA's Center for Drug Evaluation and Research:

Earlier this week, a small group of staff met with me (virtually) to discuss our response to recent events. We felt it was important not to remain silent at this time, given the disturbing, painful, and distressing events of the past 2 weeks, and to decry the life-threatening impact of racism on the health and wellbeing of our country.

Collectively, we decided to issue a [tweet](#), signed by me, affirming our commitment to diversity and disavowal of discrimination in any form. You received by email a copy of the tweet yesterday.

I also want to address all of you here at FDA, who work with us to advance products to diagnose and treat patients with cancer, and reiterate our commitment to a culture of inclusion:

The Oncology Center of Excellence stands in solidarity with patients with cancer and all communities experiencing the distress and pain borne out of the events of the past few weeks. We uniformly disavow all forms of discrimination and injustice. We are proud of—and better for—our diverse backgrounds, and reaffirm our commitment to executing our mission by supporting equity and inclusion in our workplace, in healthcare, and in drug development.

To quote Dr. Martin Luther King Jr., "Whatever affects one directly, affects all indirectly. I can never be what I ought to be until you are what you ought to be, and you can never be what you ought to be until I am what I ought to be.... This is the interrelated structure of reality." As we look ahead, I implore you not to be discouraged by these events but to instead have a renewed belief that we can individually and collectively do our parts to build a better society.





**#FDAOncology** stands in solidarity with patients with cancer and all communities experiencing distress and pain from events of the past week. Our diverse staff is committed to supporting **#equity** and **#inclusion** in healthcare and disavows all forms of discrimination. - Richard Pazdur



8:36 AM · Jun 4, 2020 · Hootsuite Inc.

39 Retweets 70 Likes

In addition to promoting equity and inclusiveness in our work with each other at the FDA, the OCE has many opportunities to promote these values in our local and professional communities. We have listed a sampling of these activities and initiatives below. While these initiatives may not be directly related to the painful and sometimes deadly experiences that Blacks and other marginalized members of our society face much too often, they reflect our resolve and efforts to proactively address inequities in our unique professional setting. But, we can and should do more. If you wish to join these efforts or have any ideas of your own, I encourage you to please contact me, your supervisors, or any of the OCE Associate Directors.

With the COVID-19 pandemic and the incidents of racism, this has been a very trying several months for all of us. I encourage you to lean on each other for support during this time. I am also available to you. If you are experiencing mental distress, or just need someone to talk to, please take advantage of resources for counseling and other referrals available through the federal Employee Assistance Program or phone 1-800-222-0364, which is available 24 hours a day, 365 days a year.

Please be sure to take good care of yourself and your family.

## American Society of Clinical Oncology



### Lori J. Pierce, ASCO president:

I hope this message finds you safe and well. Months ago when I defined a theme for my year as ASCO President, "Equity: Every Patient. Every Day. Everywhere," I never imagined we would experience a healthcare pandemic that would disproportionately impact people of color. Nor could I know this would be the moment when yet another brutal crime against an African American would so capture the nation's attention and bring long-simmering pain to the surface.

This has been a difficult week, on top of a difficult past few months. But even after the protests conclude and the pandemic is contained, we will still be left with deep-seated issues of racial, social, and economic inequity in America and other parts of the world.

We know that racism undermines public health, and we know it deeply affects patients with cancer. Racial and ethnic minorities face poorer outcomes, are less frequently enrolled in clinical trials, and are less likely to be offered palliative care, genetic testing, and other critical care. Specifically, African Americans have the highest death rate and shortest length of survival of any racial ethnic group for most cancers.

We cannot tolerate these inequities any longer. We must commit the same energy and focus we pour into conquer-



ing cancer to addressing systemic issues that affect the health of people of color in our country.

Since its founding in 1964, ASCO has been dedicated to equal access to the highest quality cancer care for everyone, no matter who they are, where they live, or the color of their skin. But this moment calls on us to do more, and we must work together to enact meaningful change.

The oncology community must confront and address complex forces and systems that have created disparities in cancer prevention, diagnosis, treatment, and research. At ASCO, we are embedding a health equity lens into all of our programs. More than ever, we are committed to using our collective voices to advocate for policies that improve access to insurance coverage and affordable care for all patients.

We are also committed to building on our work that aims to cultivate a diverse oncology workforce and support people of color as they advance in their careers. Later this summer, ASCO's Health Equity Committee will issue concrete recommendations to achieve health equity in the near and long term. To be clear, this is just a start, and there is a lot of hard work ahead of us. We know that meaningful change requires confronting our own prejudices and biases – and we must begin the difficult work of addressing them for the benefit of our colleagues, our patients, and our communities.

I am so proud of the hope and promise that ASCO represents and I am committed to leading our Society forward at this particular moment in our history. We are stronger when we work together, united in purpose to conquer cancer—for every patient, every day, everywhere. As always, ASCO is here to support you as you go about your important work caring for patients with

cancer. In the days and weeks ahead, we welcome your ideas and participation in advancing this dialogue through-out ASCO and promoting long overdue equity in all aspects of cancer care and research.

## American Association for Cancer Research



**Elaine R. Mardis, AACR president; Antoni Ribas, AACR president-elect; David A. Tuveson, AACR president-elect designate; Elizabeth M. Jaffee, immediate past president; William N. Hait, treasurer and past president; Margaret Foti, chief executive officer; and on behalf of the AACR Board of Directors, John D. Carpten, chair, Minorities in Cancer Research Council:**

AACR is outraged and saddened about the pervasive racism and social injustices toward African Americans in our country and all people of color around the world. As a scientific organization focused on the conquest of cancer whose core values include equality, diversity, and inclusion, we stand in solidarity in denouncing the recent tragic deaths of George Floyd, Tony McDade, Breonna Taylor, Sean Reed, Ahmaud Arbery, and countless others before them whose lives have been taken because of racism. Along with our AACR members, patient advocates, patients with cancer and cancer survivors, staff members, and all others around the world, we wish to voice our anguish and deep frustration with the systemic injustices that have led to significant social and health inequities among racial and ethnic minorities. We deplore discrimination, racism, and racial injustice in any form,

including the long-standing disenfranchisement of Black communities.

Racial and ethnic minorities in the United States and around the world continue to experience health care inequities, including a disproportionate burden of cancer. As a glaring example, African Americans have the highest overall cancer mortality rates compared to all other racial or ethnic groups in the U.S. These stark health inequities have drawn renewed attention and concern in the face of the ongoing COVID-19 pandemic, which has also disproportionately impacted communities of color. For example, African Americans account for 13% of the U.S. population, but about 23% of the deaths from the novel coronavirus.

Research is driving tremendous progress against cancer and other human diseases, but the grim reality is that these advances have not benefited everyone equally. Progress has come too slowly for people of color, and the monumental cost of health disparities in terms of health care inequities, premature deaths, and the impact on communities must be immediately addressed.

The AACR will continue to actively promote high-quality, impactful science and policies that are focused on eliminating cancer disparities in racial and ethnic minorities. To accomplish this vitally important goal, we will continue to foster advances against cancer and COVID-19 disparities through our state-of-the-art conferences and scientific journals and publications. Further, we will champion the work of minority and other researchers, physicians, and advocates who are working tirelessly to eradicate health disparities and to prevent and cure cancer in all populations.

The AACR is deeply committed to realizing the vision of social justice and equality for all Black and other racial and

ethnic minorities, both nationally and globally. We stand in solidarity against racial discrimination and inequality, and will work with our diverse membership to help create a world that achieves equity, unity, and justice for all.

## American Society for Radiation Oncology



### Theodore L. DeWeese, chair of the ASTRO Board of Directors:

Since March, we have all faced the enormous challenge of managing patients during the SARS-CoV2 pandemic. The resulting health effects of this virus have disproportionately affected African American, Latino and low income communities. The pandemic has resulted in not only the loss of life and health, but has also ravaged global economies, leaving our poorest citizens most vulnerable. Finally, we have seen attempts by some to blame Asian American citizens and immigrants for this virus because of its link to Asia.

As challenging as the viral pandemic has been, the unnecessary death of Mr. George Floyd in Minnesota illuminates another formidable crisis that links our social and health care systems. Specifically, racial injustice remains pervasive in the United States and around the world. We must confront the reality that people of color, particularly African Americans, are at a higher risk of death because of endemic poverty, poor access to high quality education and healthy nutrition and inequities in the health

care system, including the lack of optimal support systems and safety nets.

ASTRO is dedicated to diversity and inclusion as a core value of our Strategic Plan. This essential principle transcends the notion of solely being applicable to our members. It is our duty as physicians to oppose racial injustice of any kind and to work peacefully and purposefully to address those wrongs within our power. This is an inviolable part of our social contract as physicians.

As a community of physicians and educators, ASTRO is committed to embracing the ethics of equal treatment for all. As the largest professional medical society for radiation oncologists, we have a voice and an obligation to impact society through our work and our decisions. Our collective voice can help drive the change we seek when we speak out loudly against any form of racial injustice, including the most virulent form, health disparities based on race. As Dr. King once said, "Of all the forms of inequality, injustice in health care is the most shocking and inhumane."

We are challenged today by events that may seem out of our control. Yet, I am confident that history is on our side. ASTRO members have and will continue to respond at the highest level of our professional oath and the ASTRO Board and I have the greatest admiration for the dedication you demonstrate every day caring for those in need. ASTRO stands in unity with the Council of Medical Specialty Societies and the 800,000 physicians across 45 medical specialties that deplore the negative impact of racism in our nation and of racial inequities in our health care system. Let us reaffirm that ASTRO members stand with all those who seek justice and equality and that we will work to reduce the inequities in our health care system that have been so dramatically highlighted during recent events.

## American Cancer Society



### Chief Executive Officer Gary Reedy and Chief Operations Officer Kris Kim:

It is almost indescribable to see the deeply felt emotional response across the nation in the aftermath of the death of George Floyd and other recent incidents. We are sure we can speak for all of us in saying that we are saddened and distressed, both by the circumstances themselves and the underlying issues that led to them.

We first want to ensure that all of you are safe and doing what you need to do for your physical and emotional well-being. To our black volunteers and staff, we want to say that we are here for you. We recognize the depths of emotions you may be feeling, from sad to fearful to angry. Please take care of yourself and do what you need to do for yourself and your families.

It bears underscoring that the external climate and the issues of systemic injustice have a direct impact on our organization and our work. Diversity is a core value for the American Cancer Society and the American Cancer Society Cancer Action Network; inclusion and equity are critical to our mission. As organizations deeply committed to addressing health disparities, we recognize that health equity cannot be fully achieved without equity in all aspects of American life.

During times like these, we often ask ourselves what we can do to help. As you are considering what you personally can do, remember the important role you play at the American Cancer Society and ACS CAN to ensure we are living – not just talking about, but truly living – our commitment to diversity and inclusion. This is why we have been implementing comprehensive diversity and inclusion plans throughout the Society. It is why we are engaged with CEO Action, the largest CEO-driven organization designed to advance diversity and inclusion in the workplace. It is also why we have embraced CEO Action's Day of Understanding initiative to help us listen, learn, check our biases, and build the understanding necessary to ensure the American Cancer Society is an environment rooted in dignity and mutual respect. We are planning a virtual Day of Understanding for all staff in the coming weeks to ensure we are providing space to continue the dialogue.

We are proud to work for an organization and with volunteers and staff who are deeply committed to diversity, inclusion, and equity. It has never been more important, and we thank you for living that commitment every day."

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## Association of American Cancer Institutes



AACI condemns racism and discrimination. We firmly believe that these intertwined issues must be confronted with a sense of urgency — just as we

address cancer and other crises that impact public health.

The senseless and violent deaths of George Floyd and countless other African Americans saddens and angers AACI's Board of Directors, staff, and cancer center leaders.

As an association comprised of 100 academic and freestanding cancer centers across the United States and in Canada, AACI is dedicated to reducing the burden of cancer through research, treatment, and advocacy — and diversity and inclusion are key to fulfilling our mission. In our role as advocates, it is our duty to seek ways to improve health outcomes for all people.

Recognizing that the burden of cancer falls disproportionately on communities of color—particularly Black communities—AACI is committed to promoting health equity.

Earlier this year, AACI called upon U.S. presidential candidates to build on decades of progress against cancer by increasing access to comprehensive health care and addressing health disparities among racial and ethnic minorities. At our annual conferences, AACI continues to highlight the work of minority researchers and provide sessions on community outreach and engagement and recruiting diverse populations to clinical trials. Moving forward, AACI aims to foster mentor relationships within and across cancer centers to ensure that individuals in leadership roles represent the diverse makeup of our country. But there is still work to do.

We can do better. We must do better. We stand in solidarity with others in the cancer community—as well as citizens across the U.S. and throughout the world—who are working to confront health disparities caused by systemic racial discrimination and all forms of injustice.

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## National Coalition for Cancer Survivorship



NCCS is saddened and dismayed by the murder of George Floyd and many others who have suffered as a result of racial injustice. We condemn this and support our Black colleagues – survivors, advocates, caregivers, providers, and researchers. We pledge to do our part to fight inequities in the health care system that are systemic and centuries old.

NCCS represents the millions of Americans who live with, through and beyond a cancer diagnosis. But the cancer experience is not the same for everyone. Black Americans with cancer, as well as other people of color, experience greater obstacles to cancer prevention, screening, treatment, and clinical trial participation, as well as a host of other challenges. As a result of these systemic barriers, Black cancer survivors die of cancer at higher rates than other groups. That is unacceptable.

Change starts with each one of us. We're ready to listen, learn, and take action.

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## National Breast Cancer Coalition



As an organization of diverse individuals and groups across the country, the



National Breast Cancer Coalition knows the power of an informed and activist grassroots movement to effect needed change. We have seen the disparities in the healthcare system and throughout our nation that stem from ignorance and hatred and lead to discrimination, unwarranted fear and unnecessary death and suffering. NBCC's activism is focused on ending breast cancer for everyone. We will not get there until institutional racism is eliminated. We stand with all activists who are working to achieve that goal.

## Flatiron Health



**Nat Turner, co-founder and chief executive officer, and Zach Weinberg, co-founder and chief operations officer, Flatiron:**

It is more important than ever to step up and to speak out.

We stand with the black community and our black colleagues.

At Flatiron Health, our daily work is to improve lives by learning from the experiences of every cancer patient. We showed how disparities between Black and White cancer patients all but disappeared in states that expanded Medicaid under the Affordable Care Act. We understand how comorbidities, frontline health-worker risks, and limited healthcare access combine to make COVID-19 disproportionately worse among Black Americans.

But recent days bring more harsh, real-time illustrations of how much we all have to learn, and how much more

we all have to do, to end the pernicious racism, violence and inequality that are cancers in our society.

We don't know personally what it's like to live with the pain that Black Americans experience every day, and we should never pretend that we have the answers. But as leaders of a mission-driven company of 2,500-plus dedicated people, we are committed to actions that drive progress within our company and in our communities.

We promise that we will keep listening and learning. We will do the work to educate ourselves and help each other to be more informed and active advocates and allies to our Black colleagues. And we promise to leverage our platforms and our privileges where they can have the greatest impact.

Flatiron is making corporate and employee-match donations to organizations that address systemic racism and social injustice. Internally, we are opening more dialogues and extending more support and resources to our colleagues.

And today we are standing up to say publicly that recognizing and decrying racism as a moral wrong is not enough. Individually and together, we must all be a force against racism.

## Cancer Council Australia



Cancer Council Australia stands with our Aboriginal and Torres Strait Island-

er brothers and sisters in calling out racial inequalities. The evidence is clear: racism leads to poor health outcomes, with Aboriginal and Torres Strait Islander people experiencing 43% worse cancer outcomes. We are committed to closing the gap on health and will continue to make it our mission to stamp out inequalities and create a future that is healthier for all Australians.



As a scientific organization focused on the conquest of cancer whose core values include equality, diversity, and inclusion, we stand in solidarity in denouncing the recent tragic deaths of George Floyd, Tony McDade, Breonna Taylor, Sean Reed, Ahmaud Arbery, and countless others before them whose lives have been taken because of racism.



- AACR

# What We Believe

The Cancer Letter staff: Alexandria Carolan, Katie Goldberg, Matthew Ong, Paul Goldberg



It is not a matter of editorial opinion to say these words: **Black Lives Matter.**

The existence of systemic racism, social inequality, and health disparities is indisputable, and not a matter of bias or opinion. This is grounded in science and data.

Cancer does not discriminate. Our social infrastructure does.

*The Cancer Letter* strives to give you unbiased, balanced coverage grounded in standards of evidence-based medicine, the principles of peer review, disclosures, health equity, and social justice.

Our coverage since 1973 has adhered to this mission. But all of us must do more.

Diversity is fundamental to fair and balanced coverage, and to achieving health equity. As a news publication, we must amplify the voices of those who have been historically marginalized. This requires an ongoing, concerted effort in a world where the people who hold the keys to power are disproportionately white and male.

NCI should be commended for emphasizing Community Outreach and

Engagement as a key criterion for the designation of cancer centers. However, as a logical next step, we must also examine diversity at the cancer centers.

Of the 71 directors of NCI-Designated Cancer Centers, the vast majority are white and male. One is African American. Nine are women.

What does the leadership pipeline look like? We don't know. No robust data exist on the diversity among directors and deputy directors of NCI-designated cancer centers. These data should be generated, and made publicly available.

All of us—scientists, physicians, and journalists—have a role to play in bringing forward diverse viewpoints. It's fair, it's equitable, and it's essential to good science.

"In my experience, our endemic institutional racism is, and has always been, a public health issue," Robert Winn writes. "In fact—as a result of the COVID-19 disaster—we are all now finally recognizing that racism is a contributing factor to chronic diseases, including cancer."



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Lee & Chino spoke with  
Matthew Ong, associate editor of  
The Cancer Letter.

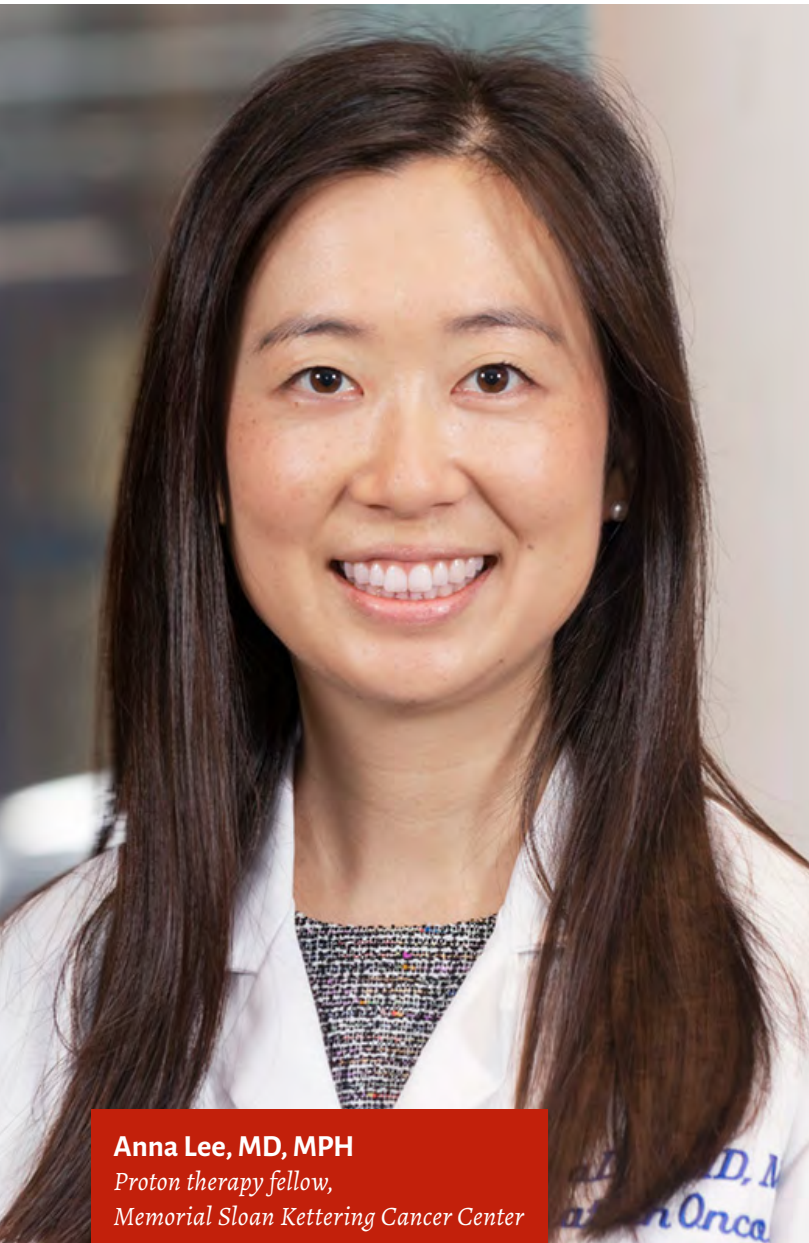
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CONVERSATION WITH  
THE CANCER LETTER

# States with Medicaid expansion have lower overall cancer mortality, study finds

**No additional decrease observed in black populations because of worse baseline**



**Anna Lee, MD, MPH**  
Proton therapy fellow,  
Memorial Sloan Kettering Cancer Center



**Fumiko L. Chino, MD**  
Radiation oncologist,  
Memorial Sloan Kettering Cancer Center

In a first nationwide study of its kind, two researchers at Memorial Sloan Kettering Cancer Center, Anna Lee and Fumiko Chino, set out to answer two questions:

- Did Medicaid expansion, as part of the Affordable Care Act, translate into a greater decrease in cancer mortality rates in states that adopted the expansion?
- How did the expansion affect the underserved communities—black, Hispanic, rural, etc.—that Medicaid is designed to help?

What Lee and Chino found was staggering: a 29% decline in age-adjusted overall cancer mortality rates in states with expanded Medicaid, falling from 65.1 to 46.3 per 100,000 individuals, from 1999 to 2017.

By comparison, in states that did not expand Medicaid, rates dropped by 25%, from 69.5 to 52.3 per 100,000 individuals.

“Health insurance matters. The simple action of facilitating people to get health care has really made a difference,” Chino, senior author of the study and a radiation oncologist at Memorial Sloan Kettering Cancer Center, said to *The Cancer Letter*. “Previous work has shown that gains in insurance have led to earlier stages of diagnosis, timelier treatment, improved access to treatment. All of those things matter and ultimately lead to survival benefit.”

The data show persistent health disparities in communities that have historically seen the worst outcomes. While Hispanic populations experienced the greatest decline in cancer mortality, no additional reduction was seen for black patients in states with Medicaid expansion—despite large mortality

gains over the study period (*The Cancer Letter*, [Feb. 7, 2020](#)).

“Black populations were continuing to have large improvements in mortality over time, this may have washed out any benefit from the ACA, but it’s still not enough to eliminate disparities,” Lee, lead author of the study and a proton therapy fellow at MSK, said to *The Cancer Letter*. “Black patients had such worse baseline cancer outcomes that the peri-ACA years were catch-up years. It’s clear we still have a ways to go to improve healthcare disparities in this population.”

Cancer is a “health care amendable” condition, where access to health care is expected to improve outcomes, the researchers said. About 20 million people gained insurance under the Affordable Care Act.

The study was conducted using data from the National Center for Health Statistics, which includes all U.S. residents. After assessing for baseline trends from 1999 to 2017, the researchers compared age-adjusted cancer-related mortality rates between 2011 to 2013 (prior to full state expansion) and 2015 to 2017 (the period following expansion) for states that adopted Medicaid expansion and states that did not.

Deaths due to cancer in patients under the age of 65 were included in the analysis, as patients 65 and older are eligible for Medicare. During the time period of this analysis, 27 states plus the District of Columbia had adopted Medicaid expansion, while 23 states had not.

The Lee *et al.* study was placed at the top of this year’s scientific program highlights at the American Society of Clinical Oncology’s virtual annual meeting.

“The overall age-adjusted cancer mortality was consistently worse in NonEXP states, cancer mortality fell from 64.7 to 46.0 per 100,000 in EXP states and

from 69.0 to 51.9 per 100,000 in NonEXP states from 1999-2017 (both trends  $p < 0.001$ , comparison  $p < 0.001$ ),” the [abstract](#) states.

In 2019, a study by Adamson *et al.*, which received similar attention, found that Medicaid expansion is associated with a 4% reduction in post-diagnosis time to treatment for black patients with metastatic cancer—effectively a near-elimination of racial disparities in timely treatment in states with Medicaid expansion (*The Cancer Letter*, [June 21, 2019](#)).

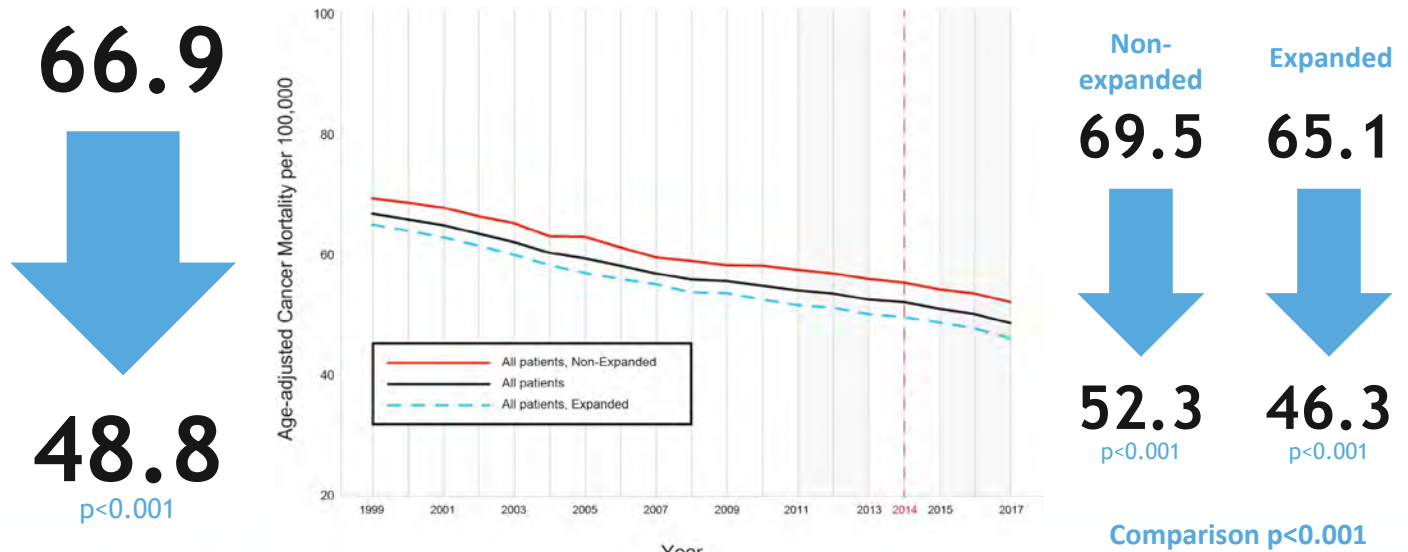
“I don’t think that Medicaid insurance is a magical insurance, and there are certainly many flaws within the ACA,” Chino said. “However, when we think about how to improve the overall healthcare status of the United States, a lot of the provisions that were put in place in the Affordable Care Act can be seen paying fruit now.”

The COVID-19 pandemic has once again put a spotlight on racial disparities and the dearth of public health care in the U.S. In Washington, D.C., for example, 80% of those who died from COVID-19 and whose deaths are listed on the D.C. Department of Health website are identified as African American. A similar pattern has been observed throughout the D.C.-Maryland-Virginia region, as well as across the country (*The Cancer Letter*, [May 8, 2020](#)).

“We’re seeing, in this COVID-19 pandemic, that there are large healthcare disparities in the U.S., and that the pandemic is disproportionately impacting and killing people of color and of lower socioeconomic status,” Lee said. “So, it is vital that we improve access to health care so that everyone has an equitable chance of surviving.”

Lee received her MD from Mercer University in Macon, GA, where she attended to patients with cancer, whose lives, she said, may have been saved if they were covered by Medicaid or some form

## Age-Adjusted Cancer Mortality per 100,000: 1999-2017 All Patients



PRESENTED AT: **2020 ASCO ANNUAL MEETING** #ASCO20

PRESENTED BY: @AnnaLeeMDMPH



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of health insurance. Georgia is a non-expansion state.

“I saw first-hand during my time on the wards as a medical student, patients who came in who had no insurance for very preventable cancers, like breast cancer,” Lee said. “So, they didn’t have a screening mammogram, presented with stage IV metastatic breast cancer, and died within a couple of months. And I think that that could have been preventable if they had health insurance.”

Chino’s academic research is informed by her lived experiences: her husband died from neuroendocrine carcinoma in 2007. He was a PhD candidate at Rice university, and his student insurance didn’t cover much—she was left with debt that is estimated to be in the hundreds of thousands of dollars.

“I’m very passionate about this, because the level of financial toxicity that my family went through with my husband’s treatment was extreme, and it would

not have happened under the Affordable Care Act,” Chino said.

“The next steps in terms of additional evaluation of the benefit of the Affordable Care Act, I am interested in looking to see how, for example, health insurance patterns have changed after the Trump administration came in. There was, at least based on national trends, unfortunately, a reversal of health insurance patterns with more and more people actually becoming uninsured again.”

Other authors on this study are: Kanan Shah at NYU Grossman School of Medicine, and Junzo P. Chino at Duke University Medical Center.

Lee and Chino spoke with Matthew Ong, associate editor of *The Cancer Letter*.

**Matthew Ong: What are the major takeaways from your study?**

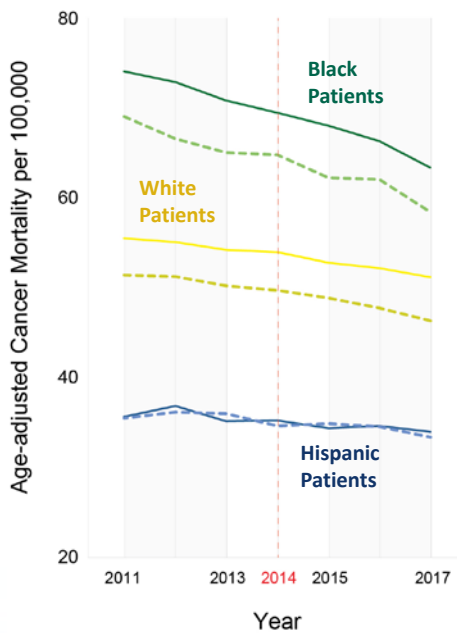
**Anna Lee:** The major takeaway was that we found an additional cancer mortality decrease in states that adopted Medicaid expansion in 2014. We also found that baseline cancer mortality rates are better in ACA expansion states and in all subpopulations within expansion states.

Some other findings observed support prior research, namely, that cancer mortality is falling for everyone and that disparities exist between groups—such as higher cancer mortality noted in the black population.

**Fumiko Chino:** Health insurance matters. The simple action of facilitating people to get health care has really made a difference. Previous work has shown that gains in insurance have led to earlier stages of diagnosis, timelier treatment, improved access to treatment. All of those things matter and ultimately lead to survival benefit.



## Difference-in-Differences in Cancer Mortality in the Peri-ACA Years



	Expanded States				Non-Expanded States			
	preΔ	postΔ	ΔΔ	p	preΔ	postΔ	ΔΔ	p
Overall	-1.4	-2.5	-1.1	0.006	-1.5	-2.1	-0.6	0.134
	<b>ΔΔΔ overall</b>						<b>-0.5</b>	<b>0.38</b>
Black	-4.0	-3.8	0.2	0.87	-3.3	-4.7	-1.4	0.23
	<b>ΔΔΔ black</b>						<b>1.6</b>	<b>0.33</b>
White	-1.2	-2.5	-1.3	0.001	-1.3	-1.6	-0.3	0.46
	<b>ΔΔΔ white</b>						<b>-1.0</b>	<b>0.08</b>
Hispanic	0.5	-1.5	-2.0	0.008	-0.5	-0.4	0.1	0.92
	<b>ΔΔΔ Hispanic</b>						<b>-2.1</b>	<b>0.07</b>

(per 100,000)

It's not something that's realized in a year or two years. I think it's something that will continue to develop, and we may be able to show potentially even larger benefits with even longer followup data.

**Dr. Lee, while baseline cancer mortality rates are better in Medicaid expansion states, black patients appear not to be experiencing the benefits. What's happening here, and what can you infer from the data?**

**AL:** Black populations were continuing to have large improvements in mortality over time, this may have washed out any benefit from the ACA, but it's still not enough to eliminate disparities.

Black patients had such worse baseline cancer outcomes that the peri-ACA

years were catch-up years. It's clear we still have a ways to go to improve health-care disparities in this population.

**Your study is described as the first nationwide study of its kind. What have you done that is different from what others have done?**

**AL:** Prior studies have assessed the changes the ACA has made on insurance status, cancer stage, or timely and appropriate access to cancer treatments—those are the first measurable changes after a large national health policy initiative like the ACA.

The translation of those benefits into an actual cancer mortality decrease can take years. This is likely why no prior study has been able to show this benefit from Medicaid expansion. Our study

team has been following cancer mortality changes for many years, we saw some early changes, but were not able to show the definitive benefit until now.

**FC:** I'm very passionate about access, delivery of care, and affordability. So, this has been something that I've been researching for a couple of years now. I think one of the benefits of our study is that its data source is truly comprehensive and includes all cancer deaths nationwide—it really allows us to show, in real cancer lives, how insurance matters.

Our groups' previous work showed decreases in uninsurance for patients receiving radiation treatment for newly diagnosed cancers. The current study is the culmination of prior work—basically, if you make all of these incremental improvements, it ultimately leads to saving lives.



**In the data, did you observe greater decreases in cancer mortality for specific cancers?**

**AL:** We looked at overall age-adjusted cancer specific mortality, but what you are asking about is correct in that we think the ACA may have had more of an impact for certain cancers over others. So, this is something that we are looking at now.

The hypothesis, obviously, is that patients with certain types of cancers that divide quicker may be the ones to benefit the most for gaining insurance. I think when you're trying to document a survival benefit, though, sadly it really is large numbers which allow you to show that.

And so, we may not be able to show that survival benefit for certain types of cancers yet. That may require even more years of follow up just based on, again, the volume. There's 600,000 people who die of cancer every year in the United States, but there's a much lower percentage of certain types of cancers.

**Could you describe why your study is especially important in our current social and political climate? And are there any aspects of your personal life or upbringing that give you a unique perspective that you bring to conversations on healthcare disparities?**

**AL:** Yes, I think we're seeing, in this COVID-19 pandemic, that there are large healthcare disparities in the U.S., and

that the pandemic is disproportionately impacting and killing people of color and of lower socioeconomic status. So, it is vital that we improve access to health care so that everyone has an equitable chance of surviving.

There are shifting environments with regard to the ACA. Many of the provisions that were put in place have eroded in the past couple of years, so this could erode the benefit of what our study shows.

And personally, I am from a non-expansion state of Georgia, and I went to medical school there. I saw first-hand during my time on the wards as a medical student, patients who came in who had no insurance for very preventable cancers, like breast cancer. So, they didn't have a screening mammogram, presented with stage IV metastatic breast cancer, and died within a couple of months. And I think that that could have been preventable if they had health insurance.

**FC:** Unfortunately, I was personally affected by one of the health care plans that were available before the Affordable Care Act—without all of the protections that were put in place with Obamacare in terms of, for example, caps or restrictions on services provided.

And so, I'm very familiar with the idea that when the Affordable Care Act passed, that it not just gave people insurance through Medicaid, but it also actually improved the standard for all health insurance plans, even for non-Medicaid plans.

I'm very passionate about this, because the level of financial toxicity that my family went through with my husband's treatment was extreme, and it would not have happened under the Affordable Care Act. So, honestly, I'm personally very vested in this.

**You've talked about this, but what would you say are some of the specific implications of your study, not only for health policy broadly, but also for underserved communities in an era of pandemics?**

**AL:** Poor access to health care continues to be a problem. There was a recent study that showed that patients living in certain areas had less access to testing for COVID-19. Likewise, we know that patients who have poor access are more likely to present at advanced stages of cancer. They're less likely to receive curative treatments like surgery, radiation, less supportive care. So, this work highlights the importance of health care, and that inadequate access can be a life or death matter.

**FC:** I will just add to that to say that some of the places in the United States that are really struggling, for example, rural communities. I think the data has really shown that they could be benefited by Medicaid expansion, because it may actually help some of those rural hospitals stay open; and then help actually provide enhanced or better access to those patients.

I don't think that Medicaid insurance is a magical insurance, and there are certainly many flaws within the ACA. However, when we think about how to improve the overall healthcare status of the United States, a lot of the provisions that were put in place in the Affordable Care Act can be seen paying fruit now.

**It's noteworthy, also, that Hispanics in expansion states experienced higher differential cancer mortality benefit. Do you have any thoughts as to why this was the case?**

## Conclusions

- First study to show **directly measured cancer survival benefit** from Medicaid expansion under the ACA
- Cancer mortality decreased over time across all populations
- **Additional mortality benefit** in states that expanded Medicaid after 2014
  - Estimated 785 less cancer deaths in 2017 in expanded states
  - Estimated 589 deaths could have been prevented if all states had expanded
- **Hispanic patients saw the greatest mortality benefit**
  - There was **significant baseline variability** in survival in Hispanic patients which may reflect known poor access to health care in this population
  - Similar benefit was not seen in the Black population perhaps due to continued large mortality gains over time

**AL:** There were more Hispanic patients that were living in the expanded states, compared to non-expanded states. And this group does have a highest baseline uninsurance rate. So, perhaps they did have the most to gain from Medicaid expansion. But also, we want to be very clear that in our data, there was a lot more variation year-to-year in the Hispanic population.

And so, this variability may be a reason why we detected a cancer mortality benefit, but we need better long-term data to be sure, to show a definitive benefit.

Is there anything else that you would like to highlight?

**FC:** I was just encouraged by all of the fantastic conversation that happened during the ASCO virtual meeting about

our study and about a lot of the other projects that were presented. There were many studies that were designed to try to level the playing field, to try to improve access for patients, designed to meet patients where they are.

There's been a real movement to design interventions that can provide the best care for patients, wherever they're coming from. And that was just really exciting for me.

What are your next steps for this study?

**AL:** So, right now, we're looking at, like we mentioned before, cancer-specific mortality from specific subtypes. We think certain cancers that divide quicker—like head and neck cancer, which is the area of my interest, and cervical cancer, which is Dr. Chino's interest—

patients who have these types of cancers may benefit more from Medicaid expansion, having timely access to health care through health insurance.

I think the fact that from the time a woman finds a lump in her breast, or even from the time that she had a screening mammogram that detects a mass to getting treatment, for us to see a benefit in just a few years since Medicaid expanded was really remarkable. So, we're excited to see, specifically, which types of cancers may be benefiting the most from Medicaid expansion.

What are some of the other projects that the both of you are currently working on, or other research questions that you'd like to pursue in the future?



Health insurance matters. The simple action of facilitating people to get health care has really made a difference. Previous work has shown that gains in insurance have led to earlier stages of diagnosis, timelier treatment, improved access to treatment.

— Fumiko L. Chino



**FC:** My major focus, in addition to access to care and healthcare disparities is cancer care affordability, which I think you can understand, they are all interrelated.

I'm at Memorial Sloan Kettering, we're currently working on designing interventions that are both patient-facing and provider-facing, to truly try to tackle the idea of cancer treatment affordability from many different angles. Because, I think we can all agree that—for some patients, not everyone—cancer treatment is honestly just unaffordable and that there are many steps along the way at which you could intervene to really make a meaningful difference in terms of the costs of care.

And then, honestly, the next steps in terms of additional evaluation of the benefit of the Affordable Care Act, I am interested in looking to see how, for example, health insurance patterns have changed after the Trump administration came in. There was, at least based on national trends, unfortunately, a reversal of health insurance patterns with more and more people actually becoming uninsured again.

For our study, of course, that's concerning because that could potentially erode the benefit of what we've seen in terms of overall survival. It's important to show that patients with newly diagnosed cancers either do or do not have health insurance, because the insurance that you had at diagnosis is often instrumental to you actually getting that diagnosis, and then starting timely treatment. And so, not having insurance really can delay a lot of steps along that way.

Even though emergency Medicaid is available in certain states for certain cancers, that's potentially an additional

delay. And so, in terms of going back to see, well, we showed that people gained health insurance, and now we've shown that there's been a mortality benefit. Are we going to see the reverse happening? That people are now not having health insurance and, ultimately, have negative downstream cancer outcomes?

**AL:** Well, I am completing a proton therapy fellowship right now, and we know that certain types of treatments are more expensive. And so, one that Dr. Chino and I hope to look at in the future is patients trying to garner funds on public fundraising platforms for specific types of treatment, like proton therapy.

I've seen and helped treat a lot of patients with proton therapy and this is one type of treatment modality that I'm interested in as I see the potential benefit. But also, I also want to make sure that it's affordable and accessible for patients and trying to ascertain, what are patients doing to try to get this sort of treatment?

Thank you for making the time to talk to me.

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## SESSION TOPICS

PROOF OF CONCEPT

HIGH- VALUE OPPORTUNITIES

CLINICAL TRIAL DESIGN: STATISTICAL OPTIONS/CHALLENGES

BIOSIMILARS AND PATENT ISSUES

CREATING THE INFRASTRUCTURE FOR INTERVENTIONAL PHARMACOECONOMIC TRIALS

OPPORTUNITIES TO OPTIMIZE CANCER DRUG POLICIES

THE INTERVENTIONAL PHARMACOECONOMIC TOOLBOX

FOCUS ON OPTIMAL DOSING OF IBRUTINIB

## WELCOME ADDRESS

**Allen Lichter**

Value in Cancer Care Consortium

## KEYNOTE SPEAKER

**Cliff Hudis**

American Society of Clinical Oncology

## **Web Conference Organizers**

Daniel Goldstein, MD – Davidoff Center, Rabin Medical Center, Israel

Mark J Ratain, MD – The University of Chicago

## **Hosted by:**

The University of Chicago, Value in Cancer Care Consortium (Vi3C), Clalit Health Services

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Hudis spoke with  
Alexandria Carolan, a reporter  
at The Cancer Letter, and Paul  
Goldberg, editor and publisher of  
The Cancer Letter.

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CONVERSATION WITH  
THE CANCER LETTER

## Clifford Hudis: What a virtual meeting can accomplish—and what a virtual meeting cannot accomplish

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What makes it useful to the world is you bump into people, you sit down, and over a cup of coffee, you talk about some ideas you have. Out of those happenstance and planned meetings, new collaborations are born.

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**Clifford A. Hudis, MD, FACP, FASCO**

*Chief executive officer,  
American Society of Clinical Oncology*

If you look at attendance, COVID-19 didn't derail ASCO20.

Registrations at the virtual annual meeting of the American Society of Clinical Oncology were a bit above the usual:

Total attendees—42,700; professional attendees—40,000.

"The final numbers are coming in, but it looks like we will end up with registered attendance that exceeds our typical attendance for the face-to-face meeting," Clifford Hudis, chief executive officer of the American Society of Clinical Oncology, said to *The Cancer Letter*.

"Even more importantly, the makeup of that attendees appears to have shifted in ways that are consistent with our mission," Hudis said. "For example, the number of professional attendees, as a proportion and raw number, went up. The number of international attendees went up. And even beyond that, the number of non-member attendees—all those three categories went up."

If you look at the academic medical record years from now, you will not find any appreciable difference between this ASCO and all the other ASCOs.

"The scientific program that you saw over the weekend contained 100% of the normal expected scientific program of any annual meeting. We did not drop any sessions. We recorded everything and put it all up," Hudis said. "Our goal, when we went into this, was that in the future when somebody looks back at ASCO20, they should not be able to tell that it was a different year from any other in terms of the science. There should not need to be any asterisk on the citations or discussions of it."

If you look at receipts, well, they aren't all in. There is still an educational meeting coming in August.

"Economically, we're not yet ready to talk about. It's no secret, of course, that like for many professional societies, along with publishing and membership dues, an annual meeting is an important source of revenue—and ours was profoundly compromised this year," Hudis said.

"Going virtual, compared to in-person, represented a huge financial hit. We have insurance, for the loss, but the size of our claim will have to be determined by how big a loss we end up with. So, to answer your question, in isolation, the meeting may be able to break even, or even better this year. But it will not offer the positive margin that a traditional meeting would have offered, at least not this year."

And then there is another flavor of loss—an intangible loss.

"If we were robots, and our job was to vacuum up all of the information in the most efficient way possible, the virtual meeting gets us in that direction pretty successfully. But that is not, really, what makes the ASCO meeting useful to the world," Hudis said. "What makes it useful to the world is you bump into people, you sit down, and over a cup of coffee, you talk about some ideas you have. Out of those happenstance and planned meetings, new collaborations are born.

"They lead to grants and research projects, and, ultimately, they lead to the generation of the very content that brings somebody to ASCO anyway. Most importantly, they lead to breakthroughs for patients of ASCO. How do you recapture all of that in a virtual format?"

"We even offered online networking, but sometimes it helps to just bump into somebody that you just hadn't thought about for two years, and have a discussion.

"Maybe this is ultimately why, like in the prior pandemics that have racked the world over the eons, humans still come back to the same behaviors they enjoy. And this is why I would expect that we will get back to face-to-face meetings when it is safe."

Hudis spoke with Alexandria Carolan, a reporter at *The Cancer Letter*, and Paul Goldberg, editor and publisher of *The Cancer Letter*.

**Paul Goldberg: How did it go? The first virtual ASCO...**

**Clifford Hudis:** It was our first virtual ASCO meeting, but we had to plan it just as we were converting ASCO to remote working. Both of these efforts were eased because of our foundation of a results-oriented work environment. But regardless, converting the meeting to virtual represented lots of strain and stress—so we can talk about that.

On the other hand, we started with a very good foundation on which we could build the virtual format. We've had the Meeting Library for years. We've been recording all of our lectures for years. This is a good bit of the infrastructure that you would need to put on a virtual meeting. Said more simply, we weren't starting from scratch, but we were for sure changing the way we prepared.

**PG: That must have been extraordinarily difficult.**

**CH:** We had six weeks, when you really think about it. It was tight.

**Alex Carolan:** How did attendance compare with your expectations for what usually happens at the annual meeting?

**CH:** First of all, I had no idea what to expect for a variety of reasons. But when we talk about numbers, it's important for me to point out that, of course, the reason we have the annual meeting is to make a difference in the lives of patients with cancer.

We do that by disseminating knowledge and information, and that dissemination means reaching as many of the right audience members as we can.

The final numbers are coming in, but it looks like we will end up with registered attendance that exceeds our typical attendance for the face-to-face meeting.

Even more importantly, the makeup of that attendees appears to have shifted in ways that are consistent with our mission. For example, the number of professional attendees, as a proportion and raw number, went up. The number of international attendees went up. And even beyond that, the number of non-member attendees—all those three categories went up.

So, while the total number of attendees was similar to what we would expect face-to-face, we reached, in a sense, deeper into our core and high-impact audience—the professional cancer care providers and researchers.

**PG:** Attendance is usually about 40,000, if I'm correct.

**CH:** It's been around for 42,000. I'm only being careful about the numbers,

because they're still counting. But I believe that our final tally will show that we actually registered more people for this meeting than for any in our history. Total attendees—42,700; professional attendees—40,000.

**PG:** There's a kind of a culture around an ASCO meeting, because it has its own personality. Can you capture and create that virtually? How does that culture split differently between the scientific and education programs?

**CH:** There are a couple of things to try to expand on. And I don't want to skip answering the question, but forgive me if I lose my way.

If we start with the scientific content and we, of course, solicit those abstracts—they come in during the wintertime. They are viewed by the scientific program committee in the springtime. They are assembled into the program by peer review, and then they're presented to the world, on this weekend every year. We felt that there was no real choice: the scientific content had to be shared on our usual schedule.

Most importantly, we have a moral and ethical responsibility to our patients to share this data on time, as promised. If the data and the results we've collected are truly important to the world, then, of course, we shouldn't sit on them. We need to get them out, again, when they're expected and in a timely, responsible manner.

In practical terms, this meant that you saw the abstracts posted on about the same day they would have been any other year. You saw the press program unfold the way it would have any other year. And you saw the availability of the

abstracts in total, with the posters and the oral sessions, and all of that, pretty much right on schedule.

If anything, you got them a day or two earlier, because we released all of that on Friday morning, as opposed to releasing it Friday, Saturday, Sunday, Monday, Tuesday, as the speakers got up to speak.

In order to make sure we could do that in a way that would be technically feasible, that wouldn't overstrain our resources, we made the decision to separate the science program and the education program. In fact, the education program is a separate committee from the scientific program.

The education committee meets earlier in the year, in the fall. They select the speakers and build the program, and so forth. During the annual meeting, we then present the education tracks and the scientific tracks over one long weekend.

But this year, we chose to separate them so that we could limit the technical burden of putting this all on at once. The education meeting is the weekend of Aug. 8, whereas all of the science program was presented this weekend.

In that regard, I hasten to add that the scientific program that you saw over the weekend contained 100% of the normal expected scientific program of any annual meeting. We did not drop any sessions. We recorded everything and put it all up.

Our goal, when we went into this, was that in the future when somebody looks back at ASCO20, they should not be able to tell that it was a different year from any other in terms of the science. There should not need to be any asterisk on the citations or discussions of it.

So, 100% of the science was put out just the way it should have been. While we



bundled it into the usual oral sessions, clinical science symposia and posted discussions and posters, the only difference is that we made it all available Friday morning all at once.

Now, on the education side, we couldn't aim for a hundred percent fidelity to the in-person program, because there are some educational sessions that are very high-touch, very hands-on and require a lot of engagement, that we're not able yet to duplicate online.

The education meeting will contain about 75% of what would have been in the in-person meeting. And the approach we've taken looks high-tech, but if you think about it, it actually was a low-tech approach.

We decided that we really couldn't count on successfully managing live presentations and transitions, both from live to tape or live-to-live. All of that required production capacity that would be extensive and risky under any circumstance. So, everything was pre-recorded.

In addition, we created a shared viewing experience with the opening ceremony on Saturday morning, and then the plenary session on Sunday afternoon.

**PG:** The saddest part was not being able to just wander around McCormick Center.

**CH:** You asked about the culture, and I'm looking at what people are saying on social media, and I'm thinking about it myself.

If we were robots, and our job was to vacuum up all of the information in the most efficient way possible, the virtual meeting gets us in that direction pretty successfully. But that is not, really,

what makes the ASCO meeting useful to the world.

What makes it useful to the world is you bump into people, you sit down, and over a cup of coffee, you talk about some ideas you have. Out of those happenstance and planned meetings, new collaborations are born.

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We even offered online networking, but sometimes it helps to just bump into somebody that you just hadn't thought about for two years, and have a discussion.

Maybe this is ultimately why, like in the prior pandemics that have racked the world over the eons, humans still come back to the same behaviors they enjoy. And this is why I would expect that we will get back to face-to-face meetings when it is safe.

**AC:** Definitely. Can we talk about the economics of the meeting for a minute? Does ASCO make more money throughout all of this, or less money? What happens to the exhibit hall, for instance?

**CH:** The exhibit hall was duplicated to a degree online—you could click on the exhibit hall, go into it, and wander in and out of booths.

The exhibitors varied in technical sophistication, including some with a virtual 3D experience, and many offered

the opportunity to make appointments and talk one to one. We know that they got a good bit of use, plus they're going to stay up for several months now.

I think that the ultimate impact and success of it is still to be determined, but it certainly got used, and it did help.

Economically, we're not yet ready to talk about. It's no secret, of course, that like for many professional societies, along with publishing and membership dues, an annual meeting is an important source of revenue—and ours was profoundly compromised this year.

Going virtual, compared to in-person, represented a huge financial hit. We have insurance, for the loss, but the size of our claim will have to be determined by how big a loss we end up with.

So, to answer your question, in isolation, the meeting may be able to break even, or even better this year. But it will not offer the positive margin that a traditional meeting would have offered, at least not this year.

**PG:** Even with insurance potential?

**CH:** Well, the insurance can't turn us to the profitable side; right?

It'll mitigate the loss. And we have to, for lots of reasons, take every step we can to mitigate the loss, because our responsibility in this context is to minimize the financial damage in every way we can. So, how big an insurance claim we might end up with will, in part, depend upon what our ultimate losses are, and what steps we took to make sure that we minimize those losses.

The other point is that the meeting isn't done until August, because we have to still do the education part of it.



**AC:** ASCO has done quite a bit with COVID, obviously. Could you summarize this for us?

**CH:** Well, actually I think you've covered a bit of it as well. For COVID-19, there really are several threads to the ASCO response.

In the face of the emerging pandemic and crisis in March, our members turned to us for support. What do we do about this disease, medically and scientifically, as well as practically? What do we do about our practices, and how do we stay viable?

And, of course, patients turn to us, a need we try to meet through Cancer.Net. They ask, what does this mean for me and my care, and so forth? And then, ASCO asks what can we learn from this, and how do we get ourselves organized to do that?

So, to go back through all this, we immediately started to get questions from our members, which we assembled into 30 to 40 pages of FAQs that we posted online. We sourced the highest quality answers we could find.

In many cases, there were no answers. But at least knowing that they weren't missing anything can be reassurance to clinicians that they are not missing something. We posted all that and updated it regularly. More recently we then upgraded that content and released it as a guide for practices now managing during the pandemic itself.

We also put on webinars with up to a thousand participants, in collaboration with the Oncology Nursing Society. It is important to note that and with support from the Infectious Disease Society of America helped us tremendously with the resources for all of this.

We put on these webinars to learn what front line docs were using as solutions and to share resources we had assembled. They are archived, so people can go back and view them now. We had participants globally and speakers from the front lines in Milan and elsewhere.

For patients, with the National Coalition for Cancer Survivorship, we created online resources at Cancer.Net. And we had a version of our Q&A for them and an [ongoing updated blog](#) from Merry-Jennifer Markham.

And then, we took a breath and asked what can we do to actually learn from this and help the community be prepared for whatever comes next? The result was the ASCO registry, that you have covered already with Rich Schilsky ([The Cancer Letter, April 17, 2020](#))

Through this, we're going to try to learn not just what happens individually to patients who have COVID-19 and cancer, but we also want to document, quantify the impact on practices as a whole. That registry is now open and running, and there are practices submitting data right now.

Finally, we stood up two task forces. They just are starting work right now.

We announced this at a press conference in April—they're operating under the perhaps uncreative name Road to Recovery, which everybody's using, but the truth is, they're not about a road to recovery—they're about a road to a better new normal.

And what I mean by that is in the research domain and in the clinical care domain, there are all manners of rapidly implemented compromises, changes, upgrades made in order to make it safer and easier for patients to get care and to participate in research as COVID-19 emerged. A simple example would be allowing a laboratory to do a blood test on a study patient, even though the

lab wasn't a previously certified one, things like that.

So, the question I think we have to ask ourselves is how many of those urgent compromises are better for patients all the time, and should be maintained?

I'm asking, not how do we turn back the clock to where we were, but, in fact—how do we not turn back the clock to the burdensome and unproductive things we did before? How do we preserve the upgrades? Telemedicine is another great example. If it was good enough in March and April, why isn't it good enough forever?

These two task forces will generate two reports to the ASCO Board. And they're going to do it on a short timeline—we're talking weeks to months now.

Our goal is to provoke, a little bit, introspection and make sure that we don't allow some of our inefficiencies that are not patient friendly and patient-centric to creep back into our work. There are economic implications of all this, but that just means we have to rethink some of our models—what we pay for and so forth.

**PG:** What do you think needs to happen on the economic side?

**CH:** I'll pick some simple examples. It's obvious that a telemedicine visit for 20 minutes should be reimbursed at the same level as any other 20-minute time block that a doc spends.

**PG:** Oh, that is an easy one.

**CH:** But it's an example, there are a many others.

I'll give you another simple one: If in the end, you could suspend enforcement of some of the HIPAA rules to allow people to use FaceTime or other audio, visual communication tools—why isn't that good enough forever? Why only in the midst of a pandemic?

**PG:** Can you project the impact of COVID on the practice of cancer medicine? Who's hit hardest? Is it geographic, is it by type of healthcare delivery? How does it work?

**CH:** I think it's the same story we hear all the time, which is that the part of practice that's under the most constant pressure, historically, over the past years, is probably the group that's going to have the greatest change from this as well.

So, the small rural practices and the under-resourced urban practices, for example. Ultimately, the consolidation trends that we've been seeing will only be accelerated by this. And that has a lot of implications obviously.

We are getting some data, and I think we've shared this with you. If not, I think Rich (Dr. Schilsky) will in a week or so. But both from our PracticeNET resources and from CancerLinQ, we are generating and sharing observations about trends in the care delivery that I think are noteworthy.

**PG:** Wouldn't the science of COVID-19 be applicable to cancer? It feels like it would be.

**CH:** It's so great that you asked that, because one of the things that I could never have predicted, was that the overlap would be seen in Dr. David Faj-

genbaum's talk as he gave our opening speech. Did you watch his talk or have you read his book [Chasing My Cure](#)? When you get a chance, you should watch the opening ceremony. You can also listen to his interview on NPR Fresh Air from about two weeks ago.

Here's the issue: He describes his personal quest to understand and impact Castleman disease, which is what he had as a young physician. He describes the cytokine storm that can be part of a Castleman Disease crisis, is similar to that seen with COVID-19.

Then, in recent weeks, he converted part of his lab efforts to address this part of COVID-19 and has published already on that.

So, it's a remarkable question you ask, because it turns out that our opening ceremony speaker used his own disease and his own scientific quest in exactly that way. He pivoted from his disease to COVID-19, because of the commonalities they shared.

**AC:** You mentioned this briefly earlier, but where do you think these meetings are headed in the future? Do you think it'll be more of a blend between virtual and in person?

**CH:** It's interesting. I think quietly we've already had that plan, and I alluded to this when we first started to speak.

We were able to launch our virtual meeting, in part, because so much of the technology infrastructure was already there. In the past, we hold the meeting and then we would make the resources from the meeting available on the back end. And you could go back and watch the lecture with slides and so forth.

When you think about it, the virtual meeting just changes the order of all that. There are a few other small changes, like having everybody record at home in advance, but the concept isn't that different from a technology perspective.

When I look at what we saw and are still seeing on social media—the fact that people really, I think, appreciate the opportunity to start and then stop, and to take notes and think, to sit at home in their pajamas and watch—getting the content out virtually clearly is useful and increases its reach and impact as well as even the engagement.

But what everybody else also laments is the loss of the serendipity, the happenstance of the meetings that take place at ASCO—and, also the planned meetings, with the opportunity to go to arranged events and brainstorm or participate in collaborative discussions and so forth.

Your question really hinges on how we upgrade what we've done in the past to maintain the great strength of the virtual meeting, and also how we facilitate the great strengths of the in-person meeting.

I know that is where the ASCO staff will be focusing in the weeks ahead. I think we're going to need a system that is flexible for the next couple of years while we get through the pandemic. And we are really dependent on either herd immunity, which seems to be far off, or an effective broadly distributed vaccine, which is also somewhat far off at the moment, before we could really count on a big in-person meeting, without risk, I think.

Our vision is that we will for sure end up with a more flexible approach to meetings that allows us to fine-tune them, depending on conditions. I think people want to get together, but I don't think

we're going to give up some of the clear benefits of the virtual format either.

**PG:** You also conduct a whole lot of meetings. Are they also going virtual now?

**CH:** The way we're approaching the general question of business travel, headquarters, operations, and meetings altogether is on a quarter-by-quarter basis right now.

At the moment, we've already announced that we're remaining on in our current remote working mode with no business travel and no face-to-face meetings through September 30th—so through the second and third quarters. We will make a decision on the fourth quarter in the coming weeks, the summer. And then after that, we have to decide on the first quarter of 2021.

There are a lot of variables that go into these decisions, but the number one thing first and foremost is the safety of our membership and the attendees and the patients, they go on to care for, and our staff. And as long as that's in jeopardy, we're going to be choosing this conservative course, I think.

**PG:** You couldn't possibly predict whether there will be an ASCO annual meeting in Chicago next year.

**CH:** There will be an annual meeting next year. In order to answer that question specifically—virtual or in-person—I would have to be making a bet on vaccination, public health and public policy.

For example, if you go back to March, when we made the decision to cancel the meeting, it turned out that just a week later, the Army Corps of Engineers took over McCormick Place. They were going to put a field hospital in there, and they did. I submit to you humbly that we are downstream of those big variables and forces, and what we need is to have an organization and approach that's flexible enough to cope.

When you ask—are we going to have a face-to-face meeting in Chicago in a very concrete way—I hear the question as, will the vaccine be available at the CVS on your corner?

**AC:** Is there anything else we forgot to mention?

**CH:** I don't think so. The one thing I would say about all this for us is that all of this underscores the urgency of our ongoing digital transformation. This is where a tremendous amount of ASCO operational attention is focused now.

We've got to serve our members where they are. And that requires us to go, even more rapidly, deeper into the digital transformation already underway at ASCO.

**PG:** Thank you very much.

**AC:** Thank you.

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## GUEST EDITORIAL

# Fostering a culture of gender-based respect and inclusion in oncology



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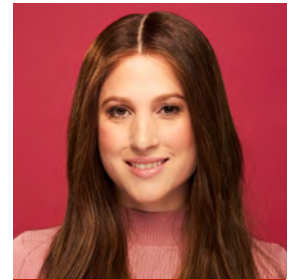
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**Miriam  
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“Please welcome Claudia to the stage; she will be discussing resistance mechanisms to immune checkpoint inhibitors.”

This type of introduction is frequently heard at national and international professional medical meetings. However, it embraces one of the oldest challenges

faced by women in medicine—unconscious bias.

## Gender bias in speaker introductions

This issue was first published by [Dr. Files et al.](#), who evaluated speaker introductions at The Mayo Clinic Internal Medicine Grand Rounds. The authors

observed that female speakers were less likely to be introduced by their professional title (Dr. Last Name or Dr. Full Name) than their male colleagues, and more-so when women were introduced by men.<sup>1</sup> When Dr. Files reported the results to the medical community, many identified with the challenge and noted similar experiences in their own professional lives.



How prevalent was this familiar anecdote within our oncology community?

## Gender bias in speaker introductions also occurs in oncology

During the 2018 ASCO annual meeting, Dr. Duma created a Twitter poll asking meeting attendees if they noticed a difference in introductions for women and men during the meeting's scientific and educational program.

The poll was small and limited to fewer than 100 responses, but launched a robust research effort to answer the question. Dr. Miriam Knoll saw the poll on Twitter and contacted Dr. Duma. Together, they assembled a diverse team of men and women to evaluate archived videos of speaker introductions at the 2017 and 2018 American Society of Clinical Oncology annual meetings.

Results from the study were presented at the 2019 ASCO annual meeting. Duma et al. observed that at the world's largest oncology conference, i.e., ASCO's annual meeting, female speakers were addressed less often by their professional title compared with male speakers (62% vs. 81%;  $p < .001$ ) and were more likely to be introduced by their first name only compared to their male colleagues (17% vs. 3%;  $p < .001$ ).<sup>2</sup> These findings brought awareness to the issue of unconscious bias within the global oncology community, perpetuating gender inequality in medicine. This research was subsequently published by Duma et al. in the *Journal of Clinical Oncology* in 2019.<sup>2</sup>

## Why titles matter

Unequal introductions have repercussions beyond the lack of equal recognition for professional status. These inequalities also maintain an outdated

hierarchy in which women are positioned lower than their male colleagues.

When a woman is introduced as “Claudia” instead of “Dr. Fuentes,” it diminishes her credibility in front of an audience that may be less likely to be familiar with her work.<sup>3,4,5</sup> Previous linguistic studies have demonstrated that speakers' introductions affect the probability of the audience paying attention to the presentation and subsequent trust in the findings presented.<sup>6,7</sup> This is particularly important in the era of social media in which our attention is divided between what is happening in the meeting and the discussion taking place across diverse social media platforms.

The impact of cumulative unprofessional address on the careers or psyche of women in medicine has not been fully characterized, but data on gender-based discrimination more broadly suggest how damaging this might be. Resume studies have long shown that women with equivalent credentials are discriminated against.<sup>8</sup> Enacting bias in gender introductions is analogous to erasing an entire degree or years of work experience from a resume.

Women, therefore, face a double hit—they are discriminated against, when equal to men, and are made to appear inferior when they are not. This systematic bias means that for each degree, accolade, or work experience that women possess, they only reap a fraction of the credit. In addition to unjustly delaying their career progression, this results in inefficient use of human capital for society. If a woman is the most impactful cancer researcher in the room, and we don't choose her, that impact is lost. That unnecessary loss translates to worse patient quality of life and fewer cancers being cured.

Additionally, women who observe this public display of gender bias may decide to exist in spaces that better value their worth. Junior faculty may be particularly susceptible. If men expect appropri-

ate compensation for their work, why should women accept anything less?

Compensation includes more than salary here—promotion, inclusion, and respect should all be given where deserved. If women leave, we all lose.<sup>9,10</sup>

## Language of respect

The ASCO “[Language of Respect](#)” guideline was developed to address the inequalities observed and foster a more inclusive environment at ASCO meetings. The guidelines were created under the direction of Dr. Tatiana Prowell, chair of the 2020 ASCO annual meeting Education Committee, in collaboration with 2019-2020 ASCO President, Dr. Howard “Skip” Burris, other annual meeting leadership, and ASCO staff.<sup>6</sup> The document serves as a call to action for the oncology community and addresses respectful communication in reference to both patients and colleagues. The document, which was made available to all ASCO members and the public via social media platforms, provides several examples of commonly used problematic language followed by alternative language that demonstrates appropriate respect for patients, families, advocates, and health care professionals.

The Language of Respect guideline calls for the use of patient-first language that emphasizes the person over his or her disease. For example, “Patients with lung cancer” not “lung cancer patients.” The guidelines also point out that language like “the patient was a screen failure” or “the patient failed treatment” places blame on patients. Instead, the authors propose the use of more patient-centered language such as “eligibility criteria excluded the patient” or “cancer did not respond to treatment.”

Cancer does not define our patients, and we should avoid language that implies the patient is first and foremost a disease. Finally, the guideline encourag-

es the use of more precise terms such as “risk reduction” rather than “cancer prevention” in response to concerns expressed by advocates that many patients following best practices such as eating a healthy diet, engaging in regular exercise, and avoiding smoking nonetheless are diagnosed with cancer. To these patients, the phrase “cancer prevention” suggests that if only they had tried harder to follow these practices, they would not have developed cancer, which is seldom true. As a result, the phrase risk reduction is favored.

## 2020 ASCO annual meeting

As a team, we waited for the 2020 ASCO Annual Meeting to continue encouraging the use of the Language of Respect Guidelines. Due to the COVID-19 pandemic, the meeting was converted to a virtual format to promote social distancing and infection control practices.

Introductions by session chairs have been removed for 2020 as the presentations were pre-recorded everywhere from living rooms and laundry rooms to home offices, eliminating the need for a chair to moderate a question and answer period.

The setting may have changed, but our pledge to promote respectful language remains intact. Our unconscious biases may be more likely to emerge during stressful times; therefore, we need to be more vigilant, not less, of the language we use during this time when referring to our patients and colleagues even at a distance. Though the 2020 ASCO annual meeting is not occurring in person, unconscious bias can manifest via social media as well. Therefore, we created a list of practical actions for attendees to use to foster gender equity at virtual meetings.

The language we use when speaking to or about our patients and colleagues should reflect our respect for them and their contributions to our oncology community.



For more information visit [The Language of Respect](#)

Created by @NarjustDumaMD, @MKnollMD, @tmprowell and @DrSGraff

## References

1. Files JA, Mayer AP, Ko MG, Friedrich P, Jenkins M, Bryan MJ, Vegunta S, Wittich CM, Lyle MA, Melikian R, Duston T. Speaker introductions at internal medicine grand rounds: forms of address reveal gender bias. *Journal of Women's Health*. 2017 May 1;26(5):413-9.
2. Duma N, Durani U, Woods CB, Kankeu Fonkoua LA, Cook JM, Wee C, Fuentes HE, Gonzalez-Velez M, Murphy MC, Jain S, Marshall AL. Evaluating Unconscious Bias: Speaker Introductions at an International Oncology Conference. *Journal of Clinical Oncology*. 2019 Dec 20;37(36):3538-45.
3. Boiko J, Anderson A, Gordon R. Representation of Women Among Academic Grand Rounds Speakers. *JAMA Internal Medicine*. 2017 May 1;177(5):722-724. doi: 10.1001/jamainternmed.2016.9646.
4. Albert M. #Me\_Who Anatomy of Scholastic, Leadership, and Social Isolation of Underrepresented Minority Women in Academic Medicine. *Circulation*. 2018;138:451-454. DOI: 0.1161/CIRCULATIONAHA.118.035057
5. Yu P, Parsa P, Hassanein O, Rogers S, Chang D. Minorities Struggle to Advance in Academic Medicine: A 12-y Review of Diversity at the Highest Levels of America's Teaching Institutions. *J Surg Res* 2013 Jun 15;182(2):212-8. doi: 10.1016/j.jss.2012.06.049. Epub 2012 Jul 17.
6. Pololi LH, Civian JT, Brennan RT, Dottolo AL, Krupat E. Experiencing the culture of academic medicine: gender matters, a national study. *Journal of General Internal Medicine*. 2013 Feb 1;28(2):201-7.
7. Morand DA. What's in a name? An exploration of the social dynamics of forms of address in organizations. *Management Communication Quarterly*. 1996 May;9(4):422-51.
8. Handley IM, Brown ER, Moss-Racusin CA, Smith JL. Quality of evidence revealing subtle gender biases in science is in the eye of the beholder. *Proceedings of the National Academy of Sciences*. 2015 Oct 27;112(43):13201-6.
9. Prowell T. What's in a Name: An Introductory Guide [podcast]. *J Clin Oncol*, 2019. <http://jcopodcast.jcopodcast.libsynpro.com/whats-in-a-name-an-introductory-guide-with-tatiana-m-prowell-md>.
10. Blackstock U. Why Black doctors like me are leaving faculty positions in academic medical centers. *Stat News*, 2020. <https://www.statnews.com/2020/01/16/black-doctors-leaving-faculty-positions-academic-medical-centers/>



## GUEST EDITORIAL

# ASCO data will provide actionable insights from the COVID-19 pandemic—for every patient



## Richard L. Schilsky, MD, FACP, FSCT, FASCO

*Executive vice president, chief medical officer,  
American Society of Clinical Oncology*

The year 2020 will no doubt be recorded as one of the most tumultuous in our nation's, if not the world's, history.

Even as we gathered virtually last weekend for ASCO's annual scientific program, events unfolding across the United States shifted our attention from the impact of COVID-19 on global health and well-being to the impact of systemic racism and social inequity on the lives of people of color across America.

If we learn anything from the COVID-19 pandemic and the current crisis of civil unrest, it's the importance of leveraging our collective experience to conquer cancer and ensuring that every person with cancer has access to high-quality care—no matter who they are, where they live, what they earn, or the color of their skin.

That vision drives ASCO's work and is why we have dedicated significant resources to disseminating evidenced-based information to support the cancer care community and to deriving insights about the impact of the coronavirus on the people in our care.

In the early days of the pandemic, ASCO quickly assembled resources across the entire organization to help cancer care delivery teams pivot under the unparalleled demands placed on them by a rampaging and previously unknown virus. Most recently, we released the [Guide to Cancer Care Delivery During the COVID-19 Pandemic](#), which describes immediate and short-term steps oncology practices can take to protect the safety of patients and healthcare staff as the pandemic response evolves.

As states and municipalities implement gradual easing of pandemic-related restrictions, we hope this guide will give cancer practices the information they need to restore operations, safely resume routine care and ensure uninterrupted patient access to necessary treatments and diagnostic services.

We also set out to collect data and, currently, have three lines of sight into the COVID-19 impact.

The first I've written about previously on these pages: the [ASCO Survey on COVID-19 in Oncology Registry](#), is collecting both baseline and longitudinal data on how the virus is impacting patients with cancer, their cancer treatment, and outcomes to inform current cancer care and decision-making for fu-



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ture disease outbreaks. Still in its early stages, the ASCO Registry continues to recruit oncology practices across the United States, all eager to contribute knowledge about their patients' experience during this challenging period. More than 100 practices have expressed interest in contributing to the Registry and more than 20 have already begun to enter data.

On another front, CancerLinQ, ASCO's big-data initiative, is monitoring

Third, to complement the clinical data gathered by CancerLinQ, ASCO's PracticeNET program has compiled [data on practice activity](#) from its benchmarking collaborative. Starting in March 2020, a group of 16 practices have shared weekly data in order to analyze the impact of COVID-19 on practice operations.

These observations have shown, among other findings, a decrease in total visit activity, including new patient visits, established patient visits, and hospital



If we learn anything from the COVID-19 pandemic and the current crisis of civil unrest, it's the importance of leveraging our collective experience to conquer cancer and ensuring that every person with cancer has access to high-quality care.



COVID-19 diagnoses among active cancer patients in its database of 1.5 million cancer patients from participating organizations. COVID-19 disease is being detected by searching for positive tests for the SARS-CoV-2 virus and/or a diagnosis code for COVID-19 disease and/or a diagnosis code for viral pneumonia not attributed to known agents.

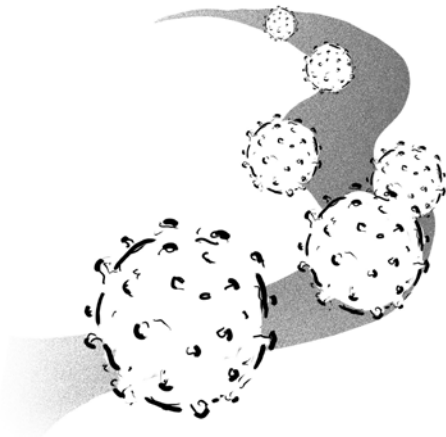
These cases have been characterized by age, gender, race, ethnicity, and cancer diagnosis. In addition, we have provided similar distributions for all active cancer patients from the sites that are reporting COVID disease ("Baseline Cases") for purposes of comparing the COVID-19 infected cancer population with the non-infected patient population at the same sites. We are sharing this data with the cancer community in a [series of regularly updated reports](#).

visits; a growth in telehealth, including telephone-only visits, e-visits, and virtual check-ins; a decrease in overall physician work relative value units, a measure which reflects the volume, nature and complexity of physician services; a sustained decrease in non-chemotherapy drug infusions; and a fall in new patient and consult activity, primarily for patients with blood cancers and benign hematology disorders.

Collecting data from multiple sources will allow ASCO, and the larger cancer community, to confirm, deepen, and extend our insight into the pandemic's impact on individuals with cancer and the cancer care delivery system. This investment will provide actionable, accurate, and reliable insights that can be used to improve cancer care today, shape the future of care delivery and leverage our collective experiences even during times of grief and uncertainty.



## COVID-19 UPDATES



## FDA publicly shares antibody test performance data from kits as part of validation study

FDA publicly posted test performance data from four more antibody, or serology, test kits on [open.fda.gov](https://open.fda.gov) from its independent performance validation study effort with NCI (*The Cancer Letter*, [May 15, 2020](#)).

These results are among the first to come from a collaborative effort by the FDA, NIH, Centers for Disease Control and Prevention and Biomedical Advanced Research and Development Authority. Additional performance data will be made available as the FDA reviews and determines if any further actions are appropriate for those test kits prior to publication.

An intergovernmental team is leveraging NCI's capability for the U.S. government to independently evaluate certain antibody tests, including antibody tests that were not the subject of an EUA or

pre-EUA, as well as those that were under FDA review. Data from an antibody test kit were first posted on May 4. Today, the FDA has shared data from four additional tests.

"These data are the result of an important cross-government effort," FDA Commissioner Stephen M. Hahn said in a statement. "There's been incredible teamwork across scientists at the FDA, NCI, CDC and BARDA and I'm glad to be sharing the data with the wider research community. By posting these data publicly, we're advancing not only Americans' access to trustworthy tests, but also the wider field of research into serology testing."

"We're pleased to step up and provide NCI's laboratory capacity and expertise to support this crucial partnership to further our understanding of antibody test performances," NCI Director Ned Sharpless said in a statement. "This speaks to the terrific convening power of the federal government and highlights the strength of cross-agency collaboration within the Department of Health and Human Services. NCI will continue to play its part by examining these kits and generating important data that supports FDA's decision-making."

The testing was performed at the Frederick National Laboratory for Cancer Research, a Federally Funded Research and Development Center sponsored by NCI and through a collaborative effort with the FDA, NIH, CDC and BARDA to evaluate certain serological tests. Essential reference samples and materials used in the evaluation were provided by the NIH National Institute of Allergy and Infectious Diseases, the Mount Sinai Health System, the Icahn School of Medicine at Mount Sinai, including members of the Departments of Microbiology and Pathology, and the Vitalant Research Institute.

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## IN BRIEF



## Richard L. Schilsky, chief medical officer of ASCO, to retire in February



Richard L. Schilsky, chief medical officer of the American Society of Clinical Oncology, plans to retire Feb. 28, 2021.

Schilsky is ASCO's first CMO. He also served as senior vice president and executive vice president over the past eight years.

"As is true in everything Rich does, his careful planning, foresight, and thoughtfulness means that ASCO will have his continued expertise and guidance over the next 9 months as we recruit the best possible candidate to serve as our second CMO," ASCO CEO Clifford A. Hudis wrote in an [ASCO Connection](#) blog.

"In the past six months, Rich has led ASCO's efforts to provide much-needed, high-quality clinical guidance to members desperate to provide excellent care to patients with cancer during COVID-19. Our rapid success here was only possible because of the foundation he helped put in place across ASCO.

"In recent years, Rich led the transformation of ASCO from an organization that not only responsibly disseminates the latest scientific discoveries (through our world-class meetings and highly regarded journals) into one that also actively contributes new knowledge to the field," Hudis wrote.

## CancerLinQ Discovery platform offers access to real-world cancer data

ASCO's CancerLinQ has launched a platform for [CancerLinQ Discovery](#), its de-identified real-world cancer data product.

The platform includes real-world cancer care data available for analysis, along with a streamlined data request process and a personalized Amazon Web Services Workspace analytics environment.

Through CancerLinQ Discovery, researchers can examine curated sets of aggregated, de-identified data on a variety of cancer type. The CancerLinQ Discovery data set, which has more than

1.5 million cancer patient records, can be studied to uncover unseen patterns in patient characteristics and outcomes, with the goal of revealing opportunities to improve the quality of care.

The new CancerLinQ Discovery Research Platform enables researchers to:

- Access a user-friendly view of available CancerLinQ Discovery data sets. At launch, CancerLinQ is offering data for five disease areas: breast, lung, ovarian, and prostate cancers, as well as chronic lymphocytic leukemia/small lymphocytic lymphoma, with plans to launch several more data sets over the course of the year.
- Review key summary statistics about each data set prior to requesting access.
- Complete streamlined data requests, approvals, and access processes.
- Access a secure AWS workspace for completing analytic work, leveraging scalable cloud computing resources and tools like Apache Spark, RStudio, and Jupyter Notebooks, with additional tools and upgraded computing resources available upon request.
- CancerLinQ Discovery is already being used by major cancer centers, government agencies, and other institutions to inform patient care and generate new hypotheses for clinical research.

This year, 11 abstracts completed using CancerLinQ Discovery data were accepted to the 2020 ASCO virtual annual meeting.

CancerLinQ is capturing data on COVID-19 infection directly from CancerLinQ-participating practices and, through CancerLinQ Discovery, will be providing de-identified data and analyses to help inform the cancer community's ongoing response to the pandemic.

## David Rivadeneira named director of Northwell Health Cancer Institute at Huntington



David Rivadeneira was named director of the Northwell Health Cancer Institute at Huntington. For the past seven years, Rivadeneira has led surgical services and colorectal surgery at Huntington Hospital.

Rivadeneira specializes in laparoscopic, and other minimally invasive procedures including advanced robotic procedures for the treatment of colon and rectal diseases, including cancer. He is a professor of surgery at the Donald and Barbara Zucker School of Medicine at Hofstra/Northwell.

## MD Anderson, Rakuten Medical collaborate to advance Illuminox platform for cancer treatments

MD Anderson Cancer Center and Rakuten Medical Inc. formed a collaboration to develop cancer therapies based on Rakuten Medical's Illuminox technology platform.

"The Illuminox technology represents a new form of therapy with the potential to selectively target cancer cells while sparing surrounding normal tissues through light-activatable antibody-dye conjugates," Jeffrey Myers, chair of head and neck surgery at MD Anderson, said in a statement.

The Illuminox technology platform is based on a cancer therapy called photo-immunotherapy, developed by Hisataka Kobayashi and colleagues from NCI. Illuminox is a technology combining drugs and laser device systems being evaluated for the treatment of different cancers.

Under the agreement, Rakuten Medical and MD Anderson will collaborate to conduct studies based on the Illuminox technology platform and to determine study designs, combination therapies, and target patient populations for future clinical trials. The alliance is designed to expand development of the technology and bring a novel therapeutic approach to patients with cancer, with an initial focus on those with head and neck cancers. This agreement expands upon an existing sponsored research agreement between Rakuten Medical and MD Anderson.

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# THE CLINICAL CANCER LETTER

## CLINICAL ROUNDUP



## ACS study defines lost earnings for black cancer patients

A new American Cancer Society study puts a price tag on racial disparities in cancer mortality, finding that \$3.2 billion in lost earnings would have been avoided in 2015 if non-Hispanic blacks had equal years of life lost from cancer deaths and earning rates as NH whites.

The study appears in [\*JNCI Cancer Spectrum\*](#).

Investigators, led by Jingxuan Zhao, compared person-years of life lost and lost earnings due to premature cancer deaths by race/ethnicity. PYLL was calculated using national cancer death and life expectancy data. That was combined with annual median earnings to generate lost earnings. PYLL and lost earnings were then compared among individuals who died at age 16-84 years due to cancer by racial/ethnic groups:

NH white, NH black, NH Asian or Pacific Islander, and Hispanic.

They found that in 2015, age-standardized lost earning rates (per 100,000 person-years) were \$34.9 million for NH whites, \$43.5 million for NH blacks, \$22.2 million for APIs, and \$24.5 million for Hispanics. NH blacks had higher age-standardized PYLL and lost earning rates than NH whites for 13 out of 19 cancer sites studied.

“If age-specific PYLL and lost earning rates for NH blacks were the same as those of NH whites, 241,334 PYLLs and \$3.2 billion lost earnings (22.6% of the total lost earnings among NH blacks) would have been avoided,” the authors write. “Improving equal access to effective cancer prevention, screening, and treatment will be important in reducing the disproportional economic burden associated with racial/ethnic disparities,” they conclude.

## Keytruda monotherapy significantly reduces risk of disease progression, death in colorectal cancer

A phase III trial evaluating Keytruda monotherapy demonstrated a significant reduction in risk of disease progression in death in microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) unresectable or metastatic colorectal cancer.

Results from KEYNOTE-177, a phase III trial evaluating KEYTRUDA, Merck’s an-

ti-PD-1 therapy, showed that Keytruda monotherapy reduced risk of disease progression or death by 40% (HR=0.60 [95% CI, 0.45-0.80; p=0.0002]) and showed a median progression-free survival of 16.5 months compared with 8.2 months for patients treated with chemotherapy (investigator’s choice of mFOLFOX6 or FOLFIRI, with or without bevacizumab or cetuximab), a current standard of care in this patient population.

As previously announced, the study will continue without changes to evaluate overall survival, the other dual primary endpoint. These results were selected for presentation on Sunday, May 31, 2020 in the plenary session of the virtual scientific program of the 2020 American Society of Clinical Oncology annual meeting (Abstract #LBA4).

“For many years, the standard of care for the first-line treatment of patients with MSI-H colorectal cancer has been the combination of mFOLFOX6 plus bevacizumab. This is the first time a single-agent, anti-PD-1 therapy demonstrated a superior, statistically significant and clinically meaningful improvement in progression-free survival, compared to chemotherapy for these patients,” Roy Baynes, senior vice president and head of global clinical development, chief medical officer, Merck Research Laboratories, said in a statement.

“Keytruda monotherapy significantly reduced the risk of disease progression or death by 40% versus standard of care chemotherapy, with fewer treatment-related adverse events observed, in patients with MSI-H metastatic colorectal cancer. Keytruda also demon-



strated a long-term, durable response that lasted over two years for those who responded to treatment,” Thierry Andre, professor of medical oncology at Sorbonne University, and head of the Medical Oncology Department in St. Antoine Hospital, Assistance Publique Hôpitaux de Paris, said in a statement.

In May 2017, Keytruda was the first cancer therapy approved by FDA for use based on a biomarker, regardless of tumor type, in previously treated patients with MSI-H or dMMR solid tumors.

## Alecensa increases OS rate in ALK-positive NSCLC

The phase III ALEX study demonstrated an increased five-year survival rate with Alecensa (alectinib), compared with crizotinib, in people living with anaplastic lymphoma kinase-positive non-small cell lung cancer.

These data confirm the longer-term efficacy of Alecensa already demonstrated across three phase III clinical trials. Full findings were presented at the ASCO annual meeting on May 29.

“Importantly, these data show clinically meaningful benefit in people with or without central nervous system metastases,” Levi Garraway, chief medical officer and head of global product development at Roche, said in a statement.

The updated results from the ALEX study show a five-year survival rate of 62.5% (95% CI: 54.3-70.8) in the Alecensa treatment group, versus 45.5% (95% CI: 33.6-57.4) with crizotinib. Despite longer median treatment duration, the safety profile of Alecensa remains favourable and consistent with previous data, with no new safety signals identified. The overall survival data, which are not yet mature, show a benefit in patients with

CNS metastases at baseline (42% reduction in the risk of death versus crizotinib (95% CI: 0.34-1.00)), as well as in those without CNS metastases at baseline (24% reduction in the risk of death versus crizotinib (95% CI: 0.45-1.26)).

These data follow on from the final, mature progression-free survival data from the ALEX study, presented at the European Society for Medical Oncology congress in September 2019, which demonstrated a reduced risk of disease worsening or death by 57% (hazard ratio=0.43, 95% CI: 0.32–0.58) with Alecensa, versus crizotinib, in ALK-positive NSCLC.<sup>2</sup> The updated data confirm the superior efficacy and tolerability of Alecensa in comparison to crizotinib.

## Xtandi significantly extends OS in men with non-metastatic CRPC

Xtandi plus androgen deprivation therapy reduced the risk of death in the phase III PROSPER trial evaluating Xtandi (enzalutamide) plus ADT versus placebo plus ADT in men with non-metastatic castration-resistant prostate cancer.

Xtandi and ADT reduced risk of death by 27% (n=1,401; hazard ratio [HR]=0.73; [95% confidence interval [CI]: 0.61-0.89]; p=0.001) compared to placebo plus ADT. The median OS was 67.0 months (95% CI: 64.0 to not reached) for men who received Xtandi plus ADT compared to 56.3 months (95% CI: 54.4 to 63.0) with placebo plus ADT. OS was a key secondary endpoint of the trial.

Xtandi is sponsored by Pfizer Inc. and Astellas Pharma Inc.

These data were simultaneously published online in the *New England Journal of Medicine* and presented during the

virtual scientific program of the 2020 ASCO annual meeting (Abstract #5515).

In findings published in the *New England Journal of Medicine* in 2018, the PROSPER trial met its primary endpoint of metastasis-free survival, demonstrating a significant reduction in the risk of developing metastasis or death with Xtandi plus ADT compared to ADT alone in men with nmCRPC (HR=0.29 [95% CI: 0.24-0.35]; p<0.001). MFS was measured as the time from patients entering the trial until their cancer was radiographically detected as having metastasized, or until death, within 112 days of treatment discontinuation.

### DRUGS & TARGETS



## Atezolizumab + bevacizumab approved by FDA for unresectable HCC

Atezolizumab in combination with bevacizumab was approved by FDA for patients with unresectable or metastatic hepatocellular carcinoma who have not received prior systemic therapy.

Tecentriq and Avastin are sponsored by Genentech, a unit of Roche.

Efficacy was investigated in IMbrave150 (NCT03434379), a multicenter, international, open-label, randomized trial in patients with locally advanced unresectable or metastatic hepatocellular carcinoma who had not received prior systemic therapy. A total of 501 patients were randomized (2:1) to receive either atezolizumab 1200 mg as an intravenous infusion followed by bevacizumab 15 mg/kg IV on the same day, every 3 weeks, or sorafenib orally twice daily.

The main efficacy outcome measures were overall survival (OS) and independent review facility -assessed progression-free survival per RECIST 1.1. Additional efficacy outcome measures were IRF-assessed overall response rate per RECIST 1.1 and mRECIST.

Median OS was not reached in the patients who received atezolizumab plus bevacizumab and was 13.2 months (95% CI: 10.4, NE) in the patients who received sorafenib (HR 0.58; 95% CI: 0.42, 0.79;  $p=0.0006$ ). Estimated median PFS was 6.8 months (95% CI: 5.8, 8.3) vs. 4.3 months (95% CI: 4.0, 5.6), respectively (HR 0.59; 95% CI: 0.47, 0.76;  $p<0.0001$ ). The ORR per RECIST 1.1 was 28% (95% CI: 23, 33) in the atezolizumab plus bevacizumab group compared with 12% (95% CI: 7,17) in the sorafenib group ( $p<0.0001$ ). The ORR per mRECIST was 33% (95% CI: 28, 39) vs. 13% (95% CI: 8, 19), respectively ( $p<0.0001$ ).

## Ramucirumab + erlotinib approved by FDA for first-line metastatic NSCLC

Cyramza (Ramucirumab) was approved by FDA in combination with erlotinib for first-line treatment of metastatic non-small cell lung cancer with epidermal growth factor receptor exon 19 deletions or exon 21 (L858R) mutations.

Cyramza is sponsored by Eli Lilly and Company.

Efficacy was evaluated in RELAY (NCT02411448), a multinational, randomized, double-blind, placebo-controlled, multicenter study in patients with previously untreated metastatic NSCLC whose tumors have EGFR exon 19 deletion or exon 21 (L858R) substitution mutations. A total of 449 patients were randomized (1:1) to receive either ramucirumab 10 mg/kg or placebo every 2 weeks as an intravenous infusion, in combination with erlotinib 150 mg orally once daily, until disease progression or unacceptable toxicity.

The major efficacy outcome measure was progression-free survival as assessed by the investigator (RECIST 1.1). Additional efficacy outcome measures included overall survival, overall response rate, and duration of response. Median PFS was 19.4 months in the ramucirumab plus erlotinib arm compared with 12.4 months in the placebo plus erlotinib arm (HR 0.59; 95% CI: 0.46, 0.76;  $p<0.0001$ ).

ORR was 76% in the ramucirumab plus erlotinib arm and 75% in the placebo plus erlotinib arm, with median DoR of 18.0 months and 11.1 months, respectively. At the time of the final analysis of PFS, OS data were not mature as only 26% of the deaths required for the final analysis had occurred (HR 0.83; 95% CI: 0.53, 1.30).

## Piqray receives positive CHMP opinion to treat HR+/HER2- advanced breast cancer with a PIK3CA mutation

Piqray received a positive opinion from the Committee for Medicinal Products for Human Use of the European Medicines Agency.

CHMP recommended approval of Piqray (alpelisib) in combination with fulvestrant for the treatment of postmenopausal women, and men, with hormone receptor positive, human epidermal growth factor receptor-2 negative locally advanced or metastatic breast cancer with a PIK3CA mutation after disease progression following endocrine therapy as monotherapy.

Piqray is sponsored by Novartis.

The CHMP opinion is based on results of the Phase III SOLAR-1 trial that showed Piqray plus fulvestrant nearly doubled median progression-free survival compared to fulvestrant alone in HR+/HER2- advanced breast cancer patients with tumors harboring a PIK3CA mutation (median PFS 11.0 months vs. 5.7 months; HR=0.65, 95% CI: 0.50-0.85;  $p<0.001$ ), the study's primary endpoint. PFS subgroup analyses demonstrated consistent efficacy in favor of Piqray, irrespective of presence or absence of lung/liver metastases.

In SOLAR-1, most adverse events were mild to moderate in severity and generally manageable through dose modifications and medical management.

The European Commission will review the CHMP recommendation and usually delivers a final decision within approximately two months. The decision will be applicable to all 27 European Union member states plus the United Kingdom, Iceland, Norway and Liechtenstein. Additional regulatory filings are underway with other health authorities worldwide.

Patients with HR+/HER2- advanced breast cancer should be selected for treatment with Piqray based on the presence of a PIK3CA mutation in tumor or plasma specimens, using a validated test. If a mutation is not detected in a plasma specimen, tumor tissue should be tested if available.

## Sarclisa approved by European Commission for adults with relapsed and refractory multiple myeloma

Sarclisa (isatuximab) was approved by the European Commission in combination with pomalidomide and dexamethasone for the treatment of adult patients with relapsed and refractory multiple myeloma who have received at least two prior therapies including lenalidomide and a proteasome inhibitor and have demonstrated disease progression on the last therapy.

Sarclisa is a monoclonal antibody that binds to a specific epitope on the CD38 receptor of MM cells.

“Sarclisa in combination with pom-dex demonstrated median progression-free survival of nearly one year, a five-month improvement over pom-dex alone, in patients who had already failed at least two prior therapies,” John Reed, global head of research and development at Sanofi, said in a statement.

In the Phase 3 ICARIA-MM study, Sarclisa added to pom-dex (Sarclisa combination therapy, n=154) demonstrated a statistically significant improvement of progression-free survival, with a median PFS of 11.53 months compared to 6.47 months with pom-dex alone (n=153) (HR 0.596, 95% CI: 0.44-0.81, p=0.001). Sarclisa combination therapy also demonstrated a significantly greater overall response rate compared to pom-dex alone (60.4% vs. 35.3%, p<0.0001). In additional analyses, Sarclisa combination therapy compared to pom-dex alone showed a treatment benefit consistent across select subgroups reflective of real-world practice, including patients with high risk cytogenetics, those aged

75 years and older, patients with renal insufficiency and patients who were refractory to lenalidomide.

## Subcutaneous formulation of Darzalex approved by EC for multiple myeloma

The subcutaneous formulation of Darzalex (daratumumab) was granted marketing approval by the European Commission for the treatment of adult patients with multiple myeloma in all currently approved daratumumab intravenous formulation indications in frontline and relapsed / refractory settings.

Darzalex is sponsored by Genmab. In August 2012, Genmab granted Janssen Biotech Inc. an exclusive worldwide license to develop, manufacture and commercialize daratumumab.

The approval follows a Positive Opinion by the CHMP of the European Medicines Agency in April 2020. The SC formulation is administered as a fixed-dose over approximately three to five minutes, significantly less time than IV daratumumab, which is given over several hours.

Patients currently on daratumumab IV will have the choice to switch to the SC formulation.

The approval was based on data from two studies: the phase III non-inferiority COLUMBA (MMY3012) study, which compared the SC formulation of daratumumab to the IV formulation in patients with relapsed or refractory multiple myeloma, and data from the Phase II PLEIADES (MMY2040) study, which is evaluating SC daratumumab in combination with certain standard multiple myeloma regimens.

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## NCI TRIALS



## NCI Trials for June 2020

The National Cancer Institute Cancer Therapy Evaluation Program approved the following clinical research studies last month.

For further information, contact the principal investigator listed.

### Phase I - NRG-G1007

Phase I Trial with Expansion Cohort of OBP-301 (Telomelysin) and Definitive Chemoradiation for Patients with Locally Advanced Esophageal and Gastroesophageal Adenocarcinoma Who Are Not Candidates for Surgery

*NRG Oncology*  
Ku, Geoffrey Yuyat  
(646) 888-4588

### Phase I/II - 10313

A Phase IB and Randomized Open-Label Phase II Study of M6620 in Combination with Carboplatin/Gemcitabine/Avelumab in Patients with Chemotherapy-Native Advanced Non-Small Cell Lung Cancer of Squamous Cell Histology

*University of Pittsburgh Cancer Institute LAO*

Villaruz, Liza C.  
(412) 648-6577

### Phase II - 10300

Blockade of PD-1 Added to Standard Therapy to Target Measurable Residual Disease in Acute Myeloid Leukemia 1 (BLAST MRD AML-1): A Randomized Phase 2 Study of the Anti-PD-1 Antibody Pembrolizumab in Combination with Conventional Intensive Chemotherapy as Frontline Therapy in Patients with Acute Myeloid Leukemia

*Yale University Cancer Center LAO*  
Zeidan, Amer M.  
(203) 737-2572

### Phase II - APEC1621M

NCI-COG Pediatric MATCH (Molecular Analysis for Therapy Choice)- Phase 2 Subprotocol of Tipifarnib in Patients with Tumors Harboring HRAS Genomic Alterations

*Children's Oncology Group*  
Pratilas, Christine Anne  
(443) 287-8623

### Phase II - EA5191

A Randomized Phase II Trial of Cabozantinib and Cabozantinib Plus Nivolumab Versus Standard Chemotherapy in Patients with Previously Treated Non-Squamous NSCLC

*ECOG-ACRIN Cancer Research Group*  
Neal, Joel William  
(650) 725-3081

### Phase II - TRC-10446

Tocilizumab in Hospitalized Cancer Patients with Coronavirus 2019 (SARS-CoV-2) and Severe Complications of Coronavirus Disease 19 (COVID-19)

*National Cancer Institute*  
Little, Richard Fowler  
(240) 276-6560

### Phase III - Ao81801

Integration of Immunotherapy Into Adjuvant Therapy for Resected NSCLC: ALCHEMIST Chemo-IO

*Alliance for Clinical Trials in Oncology*  
Sands, Jacob M.  
(671) 632-6049

### Phase III - NRG-CC005

FORTE (Five or Ten Year Colonoscopy for 1-2 Non-Advanced Adenomatous Polyps)

*NRG Oncology*  
Schoen, Robert E.  
(412) 648-9825

### Phase III - S1925

Randomized, Phase III Study of Early Intervention with Venetoclax and Obinutuzumab Versus Delayed Therapy with Venetoclax and Obinutuzumab in Newly Diagnosed Asymptomatic High-Risk Patients with Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma (CLL/SLL): EVOLVE CLL/SLL Study

*SWOG*  
Stephens, Deborah Marie  
(801) 587-4354

### Phase III - WF-1901

Internet-delivered Management of Pain Among Cancer Treatment Survivors (IMPACTS)

*Wake Forest NCORP Research Base*  
Penzien, Donald B.  
(336) 716-4382

### Phase Other - NCICOVID

NCI COVID-19 in Cancer Patients Study (NCCAPS): A Longitudinal Natural History Study

*National Cancer Institute*  
Korde, Larissa A.  
(240) 276-6077