Clinical Updates

BAPTIST MD Anderson Cancer Center
Making Cancer History®

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Hematologic malignancies: Rare cancers need doctors who treat rare stuff

Division of Cancer Medicine
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Lymphomas, multiple myeloma and leukemias are rare forms of blood cancers. The estimated number of new cases of non-Hodgkin's lymphoma and leukemia are five percent and four percent for men, and four percent and three percent for women, respectively. Multiple myeloma and Hodgkin's lymphoma account for less than one percent of all newly diagnosed cancer cases. In contrast, prostate cancer, lung cancer and colon cancer comprise roughly 40 percent of all new cancer cases for men, while breast cancer, lung cancer and colon cancer make up approximately 50 percent of all new cancer diagnoses for women.

The sequencing of the human genome (The Human Genome Project) led to rapid development of our understanding of the molecular basis of cancer. The identification of molecular cancer targets used for molecular testing, genetic screening, cancer prevention, oncogenomics and pharmacogenomics ushered in the new era of personalized cancer medicine. Subsequently, the FDA continues to approve new or expanded indications for all cancer subtypes. For example, there are more than 30 drugs approved for patients with multiple myeloma. While it is exciting to have many therapeutic options for patients, it is difficult to know how to sequence such therapy and manage any subsequent toxicity without an astute understanding of the underlying disease.

Intuitively, we as clinicians know that clinical experience matters when complex treatment is required. In light of the ever-growing mass of information that is available to the oncology community, it only makes sense that a disease-specific clinician is most capable of managing a specific cancer, especially a rare cancer. For example, patients with chronic lymphocytic leukemia are more likely to live an extra two years if they are treated by a disease-specific expert rather than a generalist. Patients with multiple myeloma have inferior outcomes if they are not evaluated by a myeloma specialist within a year of diagnosis. Furthermore, there exist significant barriers to adherence with evidenced-based guidelines among community-based oncologists.

At Baptist MD Anderson Cancer Center, we are passionate about taking care of patients with lymphoma, leukemias, multiple myeloma and other blood malignancies and disorders. Our model represents a unique multidisciplinary and comprehensive approach to the care of the blood cancer patient. Our outpatient team encompasses providers who are hematologic malignancy-specific and includes physicians, nurse practitioners, pharmacists, nurse navigators, clinic nurses and medical assistants. Our inpatient team is comprised of a dedicated Baptist MD Anderson blood cancer physician consultant and an oncology-specific hospitalist. All of our patients are discussed at our multidisciplinary care conference, and a team-based approach to care is instilled in our culture.

Our relationship with our Houston colleagues at MD Anderson Cancer Center enables us ongoing opportunities to bring the latest developments to our blood cancer patients and our clinical trials portfolio continues to grow. In addition, our hematology physicians are on the cutting edge of blood cancer research development as active members of several National Cancer Institute steering committees and advisors for biotechnology advances.

1 Freeman AT, Zhou L, Trogdon J et al., Impact of NCI Comprehensive Cancer Center Designation, Provider Specialization and Patient Sharing with Community Providers on Outcomes for Patients with Multiple Myeloma. Blood. 2017;130:529.
2 Goldberg SL, Akard LP, Dugan MJ, et al., Barriers to physician adherence to evidence-based monitoring guidelines in chronic myeloid leukemia. J Oncol Pract. 2015;11(3): e398-404.
3 Shanafelt TD, Kay NE, Rabe KG et al., Hematologist/oncologist disease-specific expertise and survival: lessons from chronic lymphocytic leukemia (CLL)/small lymphocytic leukemia (SLL). Cancer. 2012;118(7): 1827-37.
4 Siegel RL, Miller, KD, Jemal A., Cancer Statistics, 2017. CA: Cancer J Clin 2017;67:7-30.

Baptist MD Anderson Cancer Center Takes Part in Ground-breaking Phase 2 Clinical Trial Investigating Polio Virus in Glioblastoma

Led by neuro-oncologist, Dr. Robert Cavaliere, the neuro-oncology department at Baptist MD Anderson Cancer Center will participate in a groundbreaking Phase II clinical trial investigating the use of the recombinant nonpathogenic polio-rhinovirus chimera (PVSRIPO) in patients with recurrent glioblastoma. PVSRIPO recognizes the poliovirus receptor CD155, which is widely expressed in neoplastic cells of solid tumors and in major components of the tumor microenvironment. The Sabin type 1 polio vaccine is genetically modified so it cannot harm or kill normal cells. The target accrual for the study is 102 patients. Enrollment will start in the summer of 2019.

Objectives: The primary objective of this phase 2 study is to assess the efficacy of a single dose of PVSRIPO among adults with WHO grade JV malignant glioma at first or second recurrence relative to the survival observed in a historical control group. The secondary objective is to determine the safety of PVSRIPO treatment in recurrent VI/HO grade JV malignant glioma patients. All patients who are randomized and receive PVSRIPO treatment will be included in efficacy and safety analyses.

Treatment: PVSRIPO is a Sabin polio vaccine specifically modified to attenuate the inherent neurovirulence of the polio virus. It can safely be injected into the brain at the time of tumor resection or biopsy. It subsequently infects tumor cells by binding to CD155 receptors broadly expressed in gliomas. Tumor cell infection by PVSRIPO culminates in pro-inflammatory activation and facilitates antigen presentation/ immune effector functions.

Methodology: Subjects will receive PVSRIPO alone to evaluate the impact of the treatment regimens on 24-month survival relative to historical controls. PVSRIPO will be delivered intratumorally by convection-enhanced delivery (CED) using an intracerebral catheter placed within the enhancing portion of the tumor. Patients will be infused at a rate of 0.5 mL/hr. Once complete, the catheter is removed and the patient discharged. Patients will be monitored for tumor progression and toxicity. A well-documented consequence of immune based therapies is cerebral edema which represents an exuberant response to treatment which may have adverse effects. To minimize this complication (and the use of corticosteroids) bevacizumab, a non-steroidal agent that effectively controls edema is used.

Phase 1 results show promise

A phase 1 clinical trial enrolled patients with recurrent WHO grade JV malignant glioma (glioblastoma) from May 2012 through May 2017. A total of 61 patients underwent successful infusion of PVSRIPO. The overall survival rate was 21% at 24 months and 36 months (95% CI, 11 to 33) vs 14% and 4%, respectively, for historical controls. Three patients receiving PVSRIPO have survived beyond 5 years. There was no evidence of viral neuropathogenicity or virus shedding.

Background – why a virus in glioblastoma?

The neuro-oncology team at Baptist MD Anderson understands that novel approaches-such as oncolytic viral therapy-are needed to address the significant challenges presented by glioblastoma and other aggressive forms of cancer.

The glioblastoma microenvironment is "cold" or naturally immunosuppressive. This has been demonstrated by the exhausted phenotype of T-cells infiltrating the tumor. The tumor itself lacks neoantigens, the natural target of immune-based therapies. The immune suppressive properties of corticosteroids and chemotherapy further degrade potential immune responses. Consequently, immune therapy has failed to make a significant impact in the outcome of patients with glioblastoma. As such, the challenge remains making the "cold" CNS environment "hot." One way to modify the environment is to introduce an immune stimulus into the brain, such as a virus.

Oncolytic viro-therapy utilizes viruses, usually injected directly into the tumor bed at the time of resection or biopsy, which selectively kills infected cancer cells. Viral mediated tumor cell death is the first step in a complex process culminating in a brisk and potent immune response. As the cell dies, tumor specific antigens are released from the disrupted cancer cell which acts as a potent stimulus for the immune system. In addition, the virus-induced antiviral innate immune response acts as a potent adjuvant to further boost antigen presentation and consequent adaptive immune responses. As such, oncolytic viruses not only kill tumor cells but ultimately create an active cancer vaccine. Furthermore, the natural immuno-stimulatory effects of the virus convert a "cold "environment into a "hot" one.

A renewal in prostate cancer screening: new guidelines may change your practice

Division of Surgery
Jonathan Melquist, MD
Urologic Oncologist

It's an exciting time in men's health. Much progress has been made in the diagnosis and treatment of prostate cancer.

Prostate cancer is a common disease. Just over one in 10 men will be diagnosed in his lifetime. Despite the prevalence, only 2.5% of patients die from prostate cancer.[1] If undiagnosed, many patients would never have prostate cancer symptoms and, therefore, die of other causes. Hence, a dilemma remains over how to screen appropriately.

Prostate cancer screening guidelines:

- **Men aged 55 to 69 years:** For men aged 55 to 69 years, the decision to undergo periodic PSA-based screening for prostate cancer should be an individual one. Before deciding whether to be screened, men should have an opportunity to discuss the potential benefits and harms of screening with their clinician and to incorporate their values and preferences in the decision (Grade C recommendation).
- **Men 70 years and older:** The USPSTF recommends against PSA-based screening for prostate cancer in men 70 years and older (Grade D recommendation).[5]

The American Urological Association also has guidelines that are congruent with those of the USPSTF. They offer additional recommendations to account for various risk factors. They suggest that screening can be pursued from ages 40 to 55 if the patient:

- **Has a family history of aggressive or deadly adenocarcinoma** (e.g. prostate, breast, ovarian, and pancreatic cancer) over multiple generations, in 1st-degree relatives, or presenting at a young age.
- **Is of African-American race:** African-Americans have greater propensity to develop clinically significant prostate cancer.[6]

Prostate-specific antigen (PSA) screening has been scrutinized over the years. Whereas it has identified cancers that would have otherwise caused premature death, it has also led to overtreatment of clinically insignificant cancer. Such overtreatment led the US Preventative Services Task Force (USPSTF) to recommend against PSA-based screening in 2012.[2] The level of evidence for this recommendation at the time was Grade D, which advised practitioners to "discourage the use of this service."

The 2012 USPSTF recommendations were controversial among primary care providers, advocacy groups and urologists. The impact of the recommendations has been studied at several institutions. They led to a 28% decrease in the diagnosis of prostate cancer overall. There were fewer diagnoses in all risk categories (low, intermediate and high-risk prostate cancer).[3] Some studies identified stage and grade migration of prostate cancer at the time of diagnosis when comparing cohorts before 2012 to those after 2012. For example, Blair et al identified a statistically significant rise in bony involvement when metastatic disease was identified.[4]

In 2018, the USPSTF changed the guideline recommendations to reemphasize PSA screening. The impetus was multifold. First, urology practices widely incorporated active surveillance of low-risk prostate cancer. Resultantly, overtreatment concerns were mitigated. Second, long-term follow-up of studies previously cited in the USPSTF recommendations demonstrated greater benefit from screening than previously thought. Over time, the number needed to screen to prevent one death from prostate cancer went from 1,410 to 781. In other words, screening prevents 1.28 deaths for every 1,000 screened, instead of 0.7 to 1.0 for every 1,000, as previously thought.[5]

1. https://seer.cancer.gov/statfacts/html/prost.html.
2. Moyer VA, Force USPST. Screening for prostate cancer: U.S. Preventive Services Task Force recommendation statement. Annals of internal medicine. 2012;157(2):120-134.
3. Barocas DA, Mallin K, Graves AJ, et al. Effect of the USPSTF Grade D Recommendation against Screening for Prostate Cancer on Incident Prostate Cancer Diagnoses in the United States. The Journal of urology. 2015;194(6):1587-1593.
4. Blair BM, Robyak H, Clark JY, Kaag MG, Lehman EB, Raman JD. Impact of United States Preventive Services Task Force recommendations on prostate biopsy characteristics and disease presentation at a tertiary-care medical center. Prostate Int. 2018;6(3):110-114.
5. Force USPST, Grossman DC, Curry SJ, et al. Screening for Prostate Cancer: US Preventive Services Task Force Recommendation Statement. JAMA. 2018;319(18):1901-1913.
6. https://www.auanet.org/guidelines/prostate-cancer-early-detection-(2013-reviewed-for-currency-2018).

Open Baptist MD Anderson Clinical Trials

Sponsor Name	Study #	Principal Investigator	Study Title	Type of Study
BRAIN AND SPINE				
Alliance	N0577	Robert Cavaliere, MD	N0577 (CODEL): Phase III Intergroup Study of Radiotherapy with Concomitant and Adjuvant Temozolomide vs. Radiotherapy with Adjuvant PCV Chemotherapy in Patients with 1p/19q Co-deleted Anaplastic Glioma or Low Grade Glioma	Treatment
Penn State	BMDA 1703	Robert Cavaliere, MD	NeMeRe, a Multi-Institutional Retrospective and Prospective Registry of Neoplastic Meningitis in Adults	Registry
ECOG/ ACRIN	EAF151	Robert Cavaliere, MD	Change in Relative Cerebral Blood Volume as a Biomarker for Early Response to Bevacizumab in Patients with Recurrent Glioblastoma	Treatment
BREAST				
Alliance	A011104	Beth-Ann Lesnikoski, MD	Effect of Preoperative Breast MRI on Surgical Outcomes, Costs and Quality of Life of Women with Breast Cancer	Treatment
Alliance	A011106	Jennifer Crozier, MD	Alternate Approaches for Clinical Stage II or III Estrogen Receptor Positive Breast Cancer NeoAdjuvant Treatment (ALTERNATE) in Postmenopausal Women: A Phase III Study	Treatment
Alliance	A011202	Beth-Ann Lesnikoski, MD	A Randomized Phase III Trial Comparing Axillary Lymph Node Dissection to Axillary Radiation in Breast Cancer Patients (CT1-3 N1) Who Have Positive Sentinel Lymph Node Disease After Neoadjuvant Chemotherapy	Treatment
Alliance	A011401	Jennifer Crozier, MD	Randomized Phase III Trial Evaluating The Role of Weight Loss in Adjuvant Treatment of Overweight and Obese Women with Early Breast Cancer	Treatment
Alliance	A011502	Jennifer Crozier, MD	A Randomized Phase III Double Blinded Placebo Controlled Trial of Aspirin as Adjuvant Therapy for HER2 Negative Breast Cancer: The ABC Trial	Treatment
MD Anderson	BMDA 1705	Beth-Ann Lesnikoski, MD	Prospective Registry of Breast Cancer Patients with Axillary Nodal Metastases Identified During Ultrasound Staging at MD Anderson Cancer Center – PA11-1087	Registry
BMDA	BMDA 1707	Cynthia Anderson, MD	A Clinical Trial to Gather Prospective and Retrospective Data on the Recurrence Rates for Female Breast Patients Receiving Radiation Therapy at Baptist MD Anderson Cancer Center	Registry
Agendia, Inc	BMDA 1801	Jennifer Crozier, MD	MammaPrint, BluePrint, and Full-genome Data Linked with Clinical Data to Evaluate New Gene Expression Profiles: An Adaptable Registry (FLEX Registry)	Registry
MD Anderson	BMDA 1803	Beth-Ann Lesnikoski, MD	Eliminating Breast Cancer Surgery in Exceptional Responders to Neoadjuvant Systemic Therapy	Treatment
F. Hoffman LaRoche	BMDA 1805	Jennifer Crozier, MD	A Phase III, Multicenter, Randomized, Open-Label Study Comparing ATEZOLIZUMAB (Anti-PD-L1 Antibody) in Combination with Adjuvant ANTHRACYCLINE/TAXANE-Based Chemotherapy Versus Chemotherapy Alone in Patients with Operable Triple-Negative Breast Cancer	Treatment
Lumicell, Inc	BMDA 1809	Beth-Ann Lesnikoski, MD	Feasibility Study Phase C: Expansion Into Multiple Institutions For Training In The Use of The LUM Imaging System For Intraoperative Detection of Residual Cancer In The Tumor Bed of Female Subjects with Breast Cancer	Treatment

Sponsor Name	Study #	Principal Investigator	Study Title	Type of Study
Dune Medical Devices, Inc.	BMDA 1810	Beth-Ann Lesnikoski, MD	MarginProbe® System U.S. Post-Approval Study	Treatment
SWOG	S1416	Jennifer Crozier, MD	Phase II Randomized Placebo-Controlled Trial of Cisplatin With or Without ABT-888 (Veliparib) in Metastatic Triple-Negative Breast Cancer and/or BRCA Mutation-Associated Breast Cancer, With or Without Brain Metastases	Treatment
SWOG	S1418	Jennifer Crozier, MD	S1418/BR006, A Randomized, Phase III Trial to Evaluate The Efficacy and Safety of MK-3475 (PEMBROLIZUMAB) as Adjuvant Therapy for Triple Receptor-Negative Breast Cancer with 1 cm Residual Invasive Cancer or Positive Lymph Nodes (ypN+) After Neoadjuvant Chemotherapy	Treatment
GASTROENTEROLOGY				
ARMO BioSciences	BMDA 1701	Robert Zaiden, MD	A Randomized Phase 3 Study of AMO010 in Combination with FOLFOX Compared with FOLFOX Alone as Second-line Therapy in Patients with Metastatic Pancreatic Cancer that has Progressed During or Following a First-Line Gemcitabine Containing Regimen	Treatment
Intuitive Surgical, Inc.	BMDA 1807	Ron Landmann, MD	A Multi-Center Prospective Comparison of Intracorporeal and Extracorporeal Anastomoses for Minimally Invasive Right Colectomy	Treatment
NRG Oncology	NRG GI004	Robert Zaiden, MD	Colorectal Cancer Metastatic dMMR Immuno-Therapy (COMMIT) Study: A Randomized Phase III Study of mFOLFOX6/Bevacizumab Combination Chemotherapy with or without Atezolizumab or Atezolizumab Monotherapy in the First-Line Treatment of Patients with Deficient DNA Mismatch Repair (dMMR) Metastatic Colorectal Cancer	Treatment
NSABP	MPR1	Robert Zaiden, MD	NSABP Patient Registry and Biospecimen Profiling Repository	Registry
GENERAL				
MD Anderson	BMDA 1813	Michael Olson, MD	External Beam Radiation to Eliminate Nominal Metastatic Disease (EXTEND): A Randomized Phase II Basket Trial Assessing the Efficacy of Upfront Local Consolidative Therapy (LCT) for Oligometastatic Disease (2018-0349)	Treatment
GYNECOLOGY				
Xenetic BioSciences	BMDA 1704	Paul Nowicki, MD	A Phase 2, Single Arm, Two Period Study of Sodium Cridanimod in Conjunction with Progestin Therapy in Patients with Endometrial Carcinoma	Treatment
Clovis Oncology, Inc.	BMDA 1817	Jenny Whitworth, MD	A Multicenter, Randomized, Double-Blind, Placebo-Controlled Phase 3 Study in Ovarian Cancer Patients Evaluating Rucaparib and Nivolumab as Maintenance Treatment Following Response to Front-Line Platinum-Based Chemotherapy	Treatment
HEAD AND NECK				
NRG Oncology	HN004	Anterpreet Neki, MD	Randomized Phase II/III Trial of Radiotherapy with Concurrent MEDI4736 (Durvalumab) vs. Radiotherapy with Concurrent Cetuximab in Patients with Stage III-IVB Head and Neck Cancer with a Contraindication to Cisplatin	Treatment

Open Baptist MD Anderson Clinical Trials *(continued)*

Sponsor Name	Study #	Principal Investigator	Study Title	Type of Study
HEMATOLOGY				
BMS	BMDA 1812	Edward Gorak, DO	Randomized, Open-Label, Phase 3 Trial of Nivolumab plus Brentuximab Vedotin vs. Brentuximab Vedotin Alone in Participants with Relapsed Refractory or Ineligible for Autologous Stem Cell Transplant (ASCT) Advanced Stage Classical Hodgkin Lymphoma (CheckMate 812: CHECKpoint Pathway and NivoluMAb Clinical Trial Evaluation 812)	Treatment
ECOG/ ACRIN	E1910	William Hammond, MD	A Phase III Randomized Trial of Blinatumomab for Newly Diagnosed BCR-ABL-negative B Lineage Acute Lymphoblastic Leukemia in Adults	Treatment
ECOG/ ACRIN	EA4151	William Hammond, MD	A Randomized Phase III Trial of Consolidation with Autologous Hematopoietic Cell Transplantation Followed by Maintenance Rituximab vs. Maintenance Rituximab Alone for Patients with Mantle Cell Lymphoma in Minimal Residual Disease-Negative First Complete Remission	Treatment
SWOG	S1608	William Hammond, MD	Randomized Phase II Trial In Early Relapsing or Refractory Follicular Lymphoma	Treatment
Alliance	091401	William Hammond, MD	Randomized Phase II Study of Nivolumab With or Without Ipilimumab in Patients with Metastic or Unresectable Sarcoma	Treatment
ECOG-ACRIN	NHLBI MDS	Edward Gorak, DO	The National Myelodysplastic Syndromes (MDS) Study	Registry
LUNG AND CHEST				
Alliance	A081105	John Vu, MD	Randomized Study of ERLOTINIB vs. Observation in Patients With Completely Resected Epidermal Growth Factor Receptor (EGFR) Mutant Non-Small Cell Lung Cancer (NSCLC)	Treatment
Alliance	A151216	John Vu, MD	Adjuvant Lung Cancer Enrichment Marker Identification and Sequencing Trial (ALCHEMIST)	Treatment
MD Anderson	BMDA 1702	Bill Putnam, MD	Biospecimen Banking and Biomarker Validation for Lung Cancer Early Detection in Cohort Receiving Low Dose Helical Computed Tomography Screening	Treatment
BMS	BMDA 1710	John Vu, MD	A Phase 3, Randomized Study of Nivolumab plus Ipilimumab in Combination With Chemotherapy vs. Chemotherapy Alone as First Line Therapy in Stage IV Non-Small Cell Lung Cancer (NSCLC) (CheckMate 9LA, CHECKpoint Pathway and NivoluMAb Clinical Trial Evaluation 9LA)	Treatment
ECOG/ ACRIN	E4512	John Vu, MD	A Randomized Phase III Trial for Surgically Resected Early Stage Non-Small Cell Lung Cancer: Crizotinib vs. Observation for Patients with Tumors Harboring the Anaplastic Lymphoma Kinase (ALK) Fusion Proteinin	Treatment
ECOG/ ACRIN	EA5142	John Vu, MD	Adjuvant Nivolumab in Resected Lung Cancers (ANVIL) A Randomized Phase III Study of Nivolumab After Surgical Resection and Adjuvant Chemotherapy in Non-Small Cell Lung Cancers	Treatment
SWOG	S1619	John Vu, MD	A Feasibility Trial of Neoadjuvant Cisplatin-Pemetrexed With Atezolizumab in Combination and in Maintenance for Resectable Malignant Pleural Mesothelioma	Treatment

Baptist MD Anderson Cancer Center has active treatment and registry studies that may be a good fit for one of your patients. For a full list, please contact our clinical trials office at **904.202.7468.**

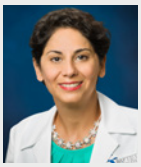
Eliminating surgery in breast cancer patients who are exceptional responders

In partnership with MD Anderson, we are offering a groundbreaking breast cancer clinical trial, "Eliminating Breast Cancer Surgery in Exceptional Responders with Neoadjuvant Systemic Therapy," (MDA 2016-0046, Principal Investigator, Beth-Ann Lesnikoski, MD) to investigate whether breast cancer surgery can be eliminated in selective patients who have been identified as "exceptional responders" after achieving pathologic complete response (pCR) following chemotherapy treatments.

In the study, radiation therapy is delivered to women who are at low risk for local recurrence after chemotherapy, making them strong candidates for less invasive treatment options. The goal of this study is to learn how often breast cancer returns in patients who have been treated with chemotherapy and radiation therapy, but not surgery, and are in complete remission. Ultimately, researchers will be able to determine whether surgery can be avoided in breast cancer patients identified as "exceptional responders."

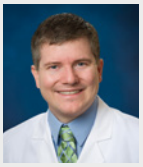
For additional information, please contact our clinical trials office at **904.202.7468**.

New Baptist MD Anderson Providers



Laila Samiian, MD, FACS

Laila Samiian, MD, joins Baptist MD Anderson in the Division of Surgery with a focus on benign and malignant breast disease. She is an experienced and fellowship-trained breast surgeon who provides comprehensive and individualized care to her patients. Dr. Samiian has more than 12 years of experience, including extensive work in the management of breast cancer, targeted sentinel node biopsies, oncoplastic breast preservation surgery, and skin and nipple sparing procedures.



Jonathan Melquist, MD

Jonathan Melquist, MD, has extensive training in surgical and clinical management of a wide spectrum of urologic problems. He applies his education and research from MD Anderson Cancer Center in Houston to provide advanced care for bladder, kidney, prostate, testicular and adrenal cancers, and has broad experience in treating general urologic conditions.

Sridhar Srinivasan, MD

Sridhar "Sri" Srinivasan, MD, joins Baptist MD Anderson in their Division of Cancer Medicine at Baptist Medical Center South. He is board certified in medical and hematology oncology and has extensive experience in management of solid tumors and hematologic conditions. Dr. Srinivasan specializes in the treatment of GI malignancies, lymphoma, myeloma, lung cancer and benign hematologic conditions.

Baptist MD Anderson Cancer Center is the only program in Florida and the Southeastern U.S. chosen to replicate MD Anderson Cancer Center's multidisciplinary model of care. This means world-renowned cancer care is now available to your patients, close to home. We look forward to partnering with you in caring for your patient — whether cancer is suspected, diagnosed or needs a second opinion. We're here to be an extension of your care team.

For additional information, consultation, or second-opinion, please call **1.800.MDA.BAPTIST** or fax to **904.202.2754**.

7.5 AMA PRA CATEGORY 1 CREDITS™

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Gender-Specific Clinical Strategies for Cancer Care: Screening, Diagnosis, and Treatment

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To register and view the full agenda, visit
baptistmdanderson.com/symposium

Seating is limited, please register by August 10. Baptist Health CME – ***7.5 AMA PRA Category 1 Credits™***

For questions or more information, call or email Lauren Maynard at **904.202.5053** or **Lauren.Maynard@bmcjax.com**

Morning Sessions
Female-specific strategies for:

- Gynecologic cancer
- Benign hematology
- Breast cancer
- Head and neck cancer
- Lung cancer

Afternoon Sessions
Male-specific strategies for:

- Prostate cancer
- Malignant hematology
- Immune therapies
- Colorectal cancer

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