ASTRO DAILY NEWS

TUESDAY AND WEDNESDAY | ISSUE 2

63RD ANNUAL MEETING | OCTOBER 24–27, 2021

2021 Survivor Circle Grant awarded Sunday

Sue Armato,
Cancer Support Center

Angela McCrum,
LivingWell Cancer Resource Center

See page 23 for more!

On-site COVID-19 Testing Available

Do you need to get a COVID-19 test to travel or return to work? On-site COVID testing is available.

Hyatt Regency McCormick Place; Room: Adler C

Tuesday and Wednesday
10:00 a.m. – 4:00 p.m.

Schedule an appointment at astro.org/covidtesting

Walk-ins welcome.

Visit www.astro.org/COVIDtesting for additional information and for off-site COVID testing locations.

‘The time for change is now’

ASTRO President Laura A. Dawson, MD, FASTRO, addresses attendees on why the time for change is now in radiation oncology

BY DIANE KEAN, ASTRO COMMUNICATIONS

MONDAY AFTERNOON, ASTRO President Laura A. Dawson presented her Presidential Address to Annual Meeting attendees. Setting the stage for change, Dr. Dawson began by discussing the need for increasing workforce diversity, noting that radiation oncology ranks near the bottom of all specialties with respect to racial and ethnic diversity. She then discussed burnout in medicine and the factors that lead to its prevalence. Dr. Dawson also touched on prior authorization in the U.S. leading to delays for patients and how the model could lead to loss of revenue with a negative impact on access to treatment, disproportionally affecting vulnerable patients and those living in rural areas.

“It is said that crises are the driving force behind any substantial change,” said Dr. Dawson. “I would say that now is the time to disrupt the status quo in radiation oncology.”

Reflecting on the change that was forced upon the world over the past year and learning how to practice in different ways that were never thought possible, Dr. Dawson said, “Moving forward, let’s keep the momentum, but shape the change of the future together to improve meaningful outcomes for our patients and better experiences for ourselves, all while raising the profile of radiation oncology.”

Dr. Dawson identified several areas of change to strive toward, beginning with equity and a call to continue to improve the diversity of the field with regard to race and gender, as well as the LGBTQ+ community, diversity in academic versus private practice, urban versus rural and early career versus late.

Touching on the theme of this meeting, Dr. Dawson addressed the need to shift toward a more person-centered care approach, citing different examples of how “a patients’ perspectives is different from ours” and the strong rationale to include patient input in every aspect of education, research priorities, clinical trials, survivorship and new models of care.

Dr. Dawson encouraged members to reach beyond their comfort zone, share their ideas, take some risks and aim high, with a reminder that some initiatives will not always be successful, and that is OK. She referenced trailblazers that initially faced criticisms and reminded the audience to “aim high.”

In this same vein, Dr. Dawson spoke of potential new uses of radiation therapy, radiopharmaceuticals and the need to lead beyond radiation oncology. “We’re a data-driven specialty,” said Dr. Dawson. She went on to say the field can share lessons learned with our technologies to raise the profile of radiation oncology.

Shifting to a discussion on culture of change, Dr. Dawson remarked on the need for change and to have more empathy for one another and remove the “taboo” of needing to take a break, whether for maternity or paternity leave or other reasons.

She then shared lessons learned related to liver cancer radiation therapy, specifically hepatocellular carcinoma, a topic she is passionate about. Referencing a patient and the importance of continuing to follow your patients and the need to know what happens to our patients, Dr. Dawson reflected on continuing her practice and research on patients with primary and metastatic liver cancer, building an SBRT program and scaling up phase I, II and III trials.

Dr. Dawson concluded her address with thanks to her many colleagues from the University of Michigan and University of Toronto, her students and mentees, friends and family, and a thanks to all attendees. “Without you, there would be no meeting. Moving forward, let’s share our ideas on how to change together to improve equitable, high quality person-centered care in radiation oncology. The time for change is now.”

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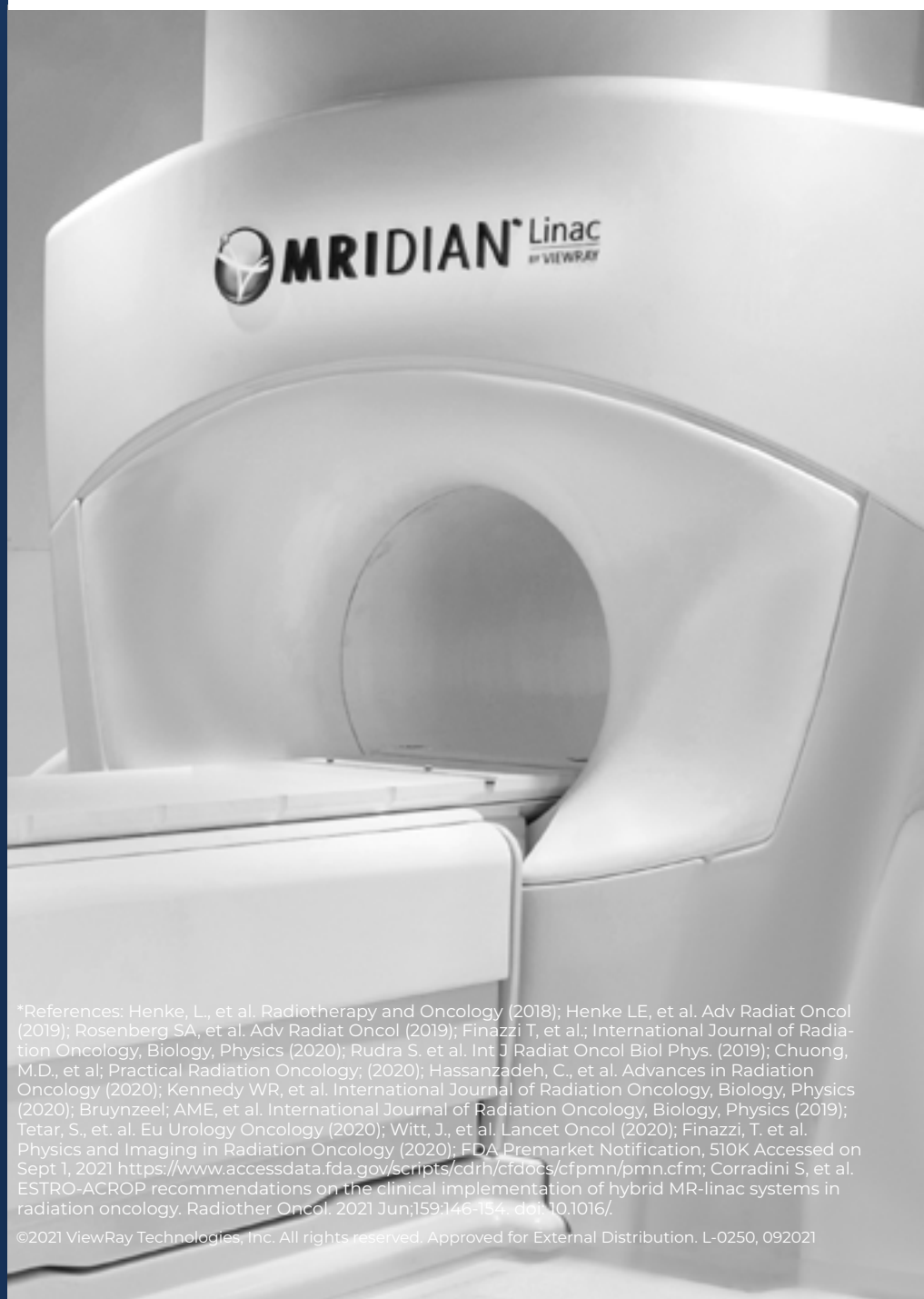

*References: Henke, L., et al. Radiotherapy and Oncology (2018); Henke LE, et al. Adv Radiat Oncol (2019); Rosenberg SA, et al. Adv Radiat Oncol (2019); Finazzi T, et al.; International Journal of Radiation Oncology, Biology, Physics (2020); Rudra S. et al. Int J Radiat Oncol Biol Phys. (2019); Chuong, M.D., et al; Practical Radiation Oncology; (2020); Hassanzadeh, C., et al. Advances in Radiation Oncology (2020); Kennedy WR, et al. International Journal of Radiation Oncology, Biology, Physics (2020); Bruynzeel; AME, et al. International Journal of Radiation Oncology, Biology, Physics (2019); Tetar, S., et. al. Eu Urology Oncology (2020); Witt, J., et al. Lancet Oncol (2020); Finazzi, T. et al. Physics and Imaging in Radiation Oncology (2020); FDA Premarket Notification, 510K Accessed on Sept 1, 2021 https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfpmn/pmn.cfm; Corradini S, et al. ESTRO-ACROP recommendations on the clinical implementation of hybrid MR-linac systems in radiation oncology. Radiother Oncol. 2021 Jun;159:146-154. doi: 10.1016/.

SCHEDULE AT A GLANCE

Tuesday, October 26, 2021

8:00 a.m. – 9:00 a.m.
EDU 13 – *Radiotherapy Options for Early–stage Breast Cancer: How to Select the "Best" Regimen Among an Increasing Array of Options and the Implications for Patients and Practices*
Room W196 a/b/c 1.0 CME

8:00 a.m. – 9:00 a.m.
SS 14 – Phys 5 – *Image Guidance and Motion Management*
Room W185 a/b/c/d 1.0 CME

8:15 a.m. – 9:15 a.m.
EDU 14 – *Challenging Cases in GI Malignancies* LIVE SA–CME
Room W375 e 1.0 CME

8:15 a.m. – 9:15 a.m.
QP 13 – Hem 3 – *Pulling the Chestnut Out of the Fire: Treating Relapsed Lymphoma*
Room W178 a/b 1.0 CME

8:15 a.m. – 8:45 a.m.
Science Highlights 3 – *Head and Neck Cancer*
Room W175 a/b/c 0.50 CME

8:15 a.m. – 9:15 a.m.
SS 15 – GU 1 – *Biomarkers and Salvage RT*
Room W181 a/b/c 1.0 CME

8:30 a.m. – 9:30 a.m.
EDU 15 – *Hypoxia: Back in the Spotlight*
Room W179 a/b 1.0 CME

8:30 a.m. – 9:30 a.m.
Joint Session 03 – *Challenging Cases in Palliative Care*
Room W186 a/b/c 1.0 CME

8:30 a.m. – 9:30 a.m.
Poster Q&A 06 – *Diversity, Equity and Inclusion in Health Care and Health Services Research/Global Oncology*
Outside Room W375 e 0 CME

9:00 a.m. – 9:30 a.m.
Science Highlights 4 – *Gynecologic Cancer*
Room W175 a/b/c 0.50 CME

9:00 a.m. – 9:30 a.m.
Zen Den 01 – *Conversation Starters by Energy Types*
Room W180, 0 CME

9:45 a.m. – 10:45 a.m.
Keynote Address – The Choices that Matter
Speaker: Barry Schwartz, PhD
Room W375 a/b/c/d 1.0 CME

10:00 a.m. – 5:00 p.m.
Exhibit Hall Open
Halls F1–F2

10:45 a.m. – 12:00 p.m.
Awards Ceremony
Room W375 a/b/c/d 0 CME

11:00 a.m. – 11:30 a.m.
Zen Den 07 – *Tips and Apps for Productivity & Time Management*
Room W180 0 CME

11:30 a.m. – 12:30 p.m.
Keynote Address – Illuminating the Dark Space of Health Care with Ambient Intelligence
Speaker: Fei–Fei Li, PhD
Room 375e and Digital XP 1.0 CME

12:00 p.m. – 1:15 p.m.
ASTRO Business Meeting and Luncheon
Voting Members Only
Room W183 a/b/c 0 CME

12:00 p.m. – 12:30 p.m.
Zen Den 08 – *Meditation Techniques to Increase Focus*
Room W180 0 CME

12:15 p.m. – 1:15 p.m.
Innovation Hub 04 – *HyTEC: NTCP Overview and Representative Site–specific Examples*
ASTRO Innovation Hub 0 CME

12:45 p.m. – 1:15 p.m.
Zen Den 06 – *Top Ways to Overcome Burnout*
Room W180 0 CME

1:15 p.m. – 2:30 p.m.
EDU 16 – *Novel Radiotherapy Approaches in Stage IV NSCLC: Consolidation, Oligometastases and Oligorecurrences*
Room W181 a/b/c 1.25 CME

1:15 p.m. – 2:30 p.m.
Panel 11 – *Warning: The COVID–19 Pandemic May Be — IS Hazardous to Your Mental Health*
Room W375 e 1.25 CME

1:15 p.m. – 2:30 p.m.
Poster Q&A 07 – *Head & Neck Cancer*
Outside Room W375 e 0 CME

1:15 p.m. – 2:15 p.m.
QP 14 – GU 3 – *GU Smorgasbord*
Room W178 a/b 1.0 CME

1:15 p.m. – 1:45 p.m.
Zen Den 09 – *Top Ways to Evaluate Your Posture and Ensure Great Health*
Room W180 0 CME

1:30 p.m. – 2:45 p.m.
EDU 17 – *Leveraging the Power of Radiation Therapy to Modulate Anti–tumor Immunity*
Room W192 a/b/c 1.25 CME

1:30 p.m. – 2:45 p.m.
Panel 12 – *Recent Developments in the Prediction of Clinical Outcomes Data in Radiation Oncology* LIVE SA–CME
Room W184 a/b/c/d 1.25 CME

1:30 p.m. – 2:45 p.m.
SS 17 – Phys 3 – *Novel Planning and Treatment Techniques*
Room W185 a/b/c/d 1.25 CME

1:30 p.m. – 2:45 p.m.
SS 18 – Bio 2 – *Experimental Therapeutics*
Room W179 a/b 1.25 CME

1:45 p.m. – 3:00 p.m.
Panel 13 – *Real–world Data and Real–world Evidence in Radiation Oncology: An ASTRO–ASCO Jointly Sponsored Session*
Room W187 a/b/c 1.25 CME

1:45 p.m. – 3:00 p.m.
Panel 27 – *Judicious Use of SRS and HSRT in the Management of Limited Large Brain Metastases*
Room W194 a/b 1.25 CME

1:45 p.m. – 3:00 p.m.
Special Session 04 – *ASTRO/SNMMI Joint Session*
Prostate Cancer Molecular Imaging and Radiotheranostics
Room W196 a/b/c 1.25 CME

1:45 p.m. – 3:00 p.m.
SS 19 – Palliative 1 – *Improving Outcomes and Selection of Patients for SBRT in the Oligometastatic Setting and Beyond*
Room W186 a/b/c 1.25 CME

2:30 p.m. – 3:30 p.m.
Innovation Hub 05 – *Future of FLASH*
ASTRO Innovation Hub 0 CME

3:00 p.m. – 3:30 p.m.
Break
Exhibit Hall, Halls F1–F2

3:30 p.m. – 4:45 p.m.
Panel 14 – *Clinical Translation of FLASH Radiotherapy*
Room W196 a/b/c 1.25 CME

3:30 p.m. – 4:45 p.m.
Panel 15 – *Challenging Cases in GU Malignancies*
Room W183 a/b/c 1.25 CME

3:30 p.m. – 4:45 p.m.
Poster Q&A 08 – *Lung Cancer/ Thoracic Malignancies and Palliative Care*
Outside Room W375 e 0 CME

3:30 p.m. – 4:30 p.m.
QP 15 – GYN 2 – *Clinical Innovation in Gynecologic Cancers*
Room W178 a/b 1.0 CME

3:45 p.m. – 5:00 p.m.
EDU 18 – *Priming the Immune System Prior to CAR T Cell Therapy: An Emerging Role of Radiation*
Room W184 a/b/c/d 1.25 CME

3:45 p.m. – 5:00 p.m.
Panel 16 – *ASTRO's First Evidence–based Clinical Practice Guidelines on Radiation Therapy for Primary Liver Cancers* LIVE SA–CME
Room W375 e 1.25 CME

3:45 p.m. – 5:00 p.m.
SS 20 – DHI 1 – *Clinical Applications of Big Data Informatics and Machine Learning*
Room W176 a/b/c 1.25 CME

3:45 p.m. – 5:00 p.m.
SS 21 – Breast 2 – *Biology and Outcomes*
Room W185 a/b/c/d 1.25 CME

4:00 p.m. – 5:15 p.m.
Panel 17 – *Challenging Cases in Patient Safety: Leveraging RO–ILS Events to Improve Patient Treatment and Experience*
Room W181 a/b/c 1.25 CME

4:00 p.m. – 5:15 p.m.
SS 22 – Bio 3 – *Immunotherapy, Immune Response and Inflammation*
Room W179 a/b 1.25 CME

See Wednesday's schedule on next page

PRESS HIGHLIGHTS

Genetic biomarker test predicts recurrence and survival outcomes for men with high-risk prostate cancer

PAUL L. NGUYEN MD, DANA-FARBER/BRIGHAM AND WOMEN'S CANCER CENTER IN BOSTON, ET AL.

A new meta-analysis finds that a genetic biomarker test accurately predicts how men with high-risk prostate cancer will respond to treatment with radiation and hormone therapy. The study, by Paul L. Nguyen, MD, et al., examined biopsy samples collected from three large, randomized clinical trials. Results indicate that physicians potentially can use genetic test scores to personalize treatment for men with the most aggressive form of prostate cancer. Two-thirds of prostate cancer deaths occur in patients with high-risk prostate cancer, for whom standard treatment involves radiation therapy and two years of hormone therapy. Researchers believe that biomarkers could potentially be used to develop more precise treatment guidelines and designate who might benefit from less therapy or from additional treatment with newer hormonal agents.

External-beam radiation therapy underused for people with liver cancer awaiting transplant

NIMA NABAVIZADEH, MD, OREGON HEALTH & SCIENCE UNIVERSITY, PORTLAND, ET AL.

People with liver cancer awaiting transplantation could benefit from non-invasive radiation treatments but are rarely given this therapy, according to a new analysis of U.S. national data. Many patients receive liver-directed bridging therapy, which is treatment to prevent the growth or spread of tumors during the waiting period. External-beam radiation therapy is a proven, established, safe and effective treatment option for patients with unresectable liver cancer, yet it is under utilized within this population. Dr. Nabavizadeh and his team analyzed data to see which bridging therapies were prescribed most often. Of the 18,477 patients with HCC awaiting transplant since 2013, 85.4% received some type of bridging therapy. However, just 3.6% of those patients were treated with EBRT, either alone or in combination with another type of therapy.

Press Highlights continued on page 19

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STREET TALK

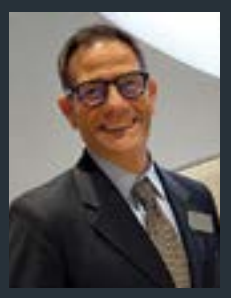
How has it felt to be back at an in-person meeting?

Anthony Zietman, MD, FASTRO
Massachusetts General Hospital

"Call me old-fashioned but I love a live meeting. Every presentation is a shared experience, every pause or break a chance for community and friendship. Zoom has carried us through this pandemic, but only real human contact will bring us out. I couldn't be happier that we are back."

C. Jillian Tsai, MD, PhD
Memorial Sloan Kettering Cancer Center

"I truly appreciated the human connection in an in-person meeting. The ability to share real-time scientific exchange cannot always be achieved virtually."



Michael Saracen
VP Clinical Marketing, ViewRay

"It's great to be back — it's so important to get back to engaging in person. Even on day one, we're pleasantly surprised with the quantity and quality of engagement. The ASTRO community seems very excited to be back together again. We're excited to hear the compelling MRIdian clinical results being presented later in the conference."

SCHEDULE AT A GLANCE

Wednesday, October 27, 2021

8:00 a.m. – 9:00 a.m.
EDU 19 – *Practical Management of Vulvar and Vaginal Cancers: Standard and Challenging Scenarios*
Room W183 a/b/c 1.0 CME

8:00 a.m. – 9:00 a.m.
SS 23 – HSR 1 – *Best of Health Services Research*
Room W187 a/b/c 1.0 CME

8:15 a.m. – 9:15 a.m.
QP 16 – Phys 7 – *Dose Response Analysis and Novel Treatment Technology*
Room W178 a/b 1.0 CME

8:15 a.m. – 8:45 a.m.
Science Highlights 5 – *Lung Cancer*
Room W175 a/b/c 0.50 CME

8:30 a.m. – 9:30 a.m.
EDU 21 – *Biological Intelligence in Oligometastases: Are We There Yet?*
Room W179 a/b 1.0 CME

8:30 a.m. – 9:30 a.m.
EDU 22 – *How to Manage the Complex Needs of Pelvic Radiotherapy Survivors*
Room W184 a/b/c/d 1.0 CME

8:30 a.m. – 9:30 a.m.
SS 24 – Patient Reported Outcomes 1 – *The Heart of Person–Centered Care*
Room W185 a/b/c/d 1.0 CME

9:00 a.m. – 9:30 a.m.
Science Highlights 6 – *Gastrointestinal Cancer*
Room W176 a/b/c 0.50 CME

9:30 a.m. – 10:30 a.m.
Cancer Breakthroughs
AACR, AAPM, ASCO
Room W375 a/b/c/d 1.0 CME

10:30 a.m. – 11:45 a.m.
Poster Q&A 09 – *Physics: Treatment Techniques and Patient Safety*
Outside Room W375 e 0 CME

10:30 a.m. – 11:30 a.m.
QP 17 – GI 3 – *Where Are We Going with Pancreatic Cancer Radiotherapy? Novel Biomarkers and Dosing Strategies*
Room W178 a/b 1.0 CME

10:45 a.m. – 12:00 p.m.
Panel 19 – Difficult Cases in Small Cell Lung Cancer LIVE SA–CME
Room W375 e 1.25 CME

10:45 a.m. – 12:00 p.m.
Panel 20 – *Molecular Biomarkers and Tumor–free DNA in HPV–associated Oropharyngeal Cancer and Implications for Future Clinical Trials*
Room W179 a/b 1.25 CME

10:45 a.m. – 12:00 p.m.
SS 25 – GU 2 – Intermediate– and High–risk Disease
Room W183 a/b/c 1.25 CME

10:45 a.m. – 12:00 p.m.
SS 26 – Hem 1 – *Enhancing Efficacy and Reducing Toxicity for Patients with Hematologic Malignancies*
Room W181 a/b/c 1.25 CME

10:45 a.m. – 11:15 a.m.
Zen Den 07 – *Tips and Apps for Productivity & Time Management*
Room W180 0 CME

11:00 a.m. – 12:15 p.m.
Joint Session 04 – ASTRO/SNO – *Glioma Controversies: Patient–focused Case–based Discussion*
Room W184 a/b/c/d 1.25 CME

11:00 a.m. – 12:15 p.m.
Panel 21 – *Advances in Image–guided Adaptive Radiotherapy*
Room W185 a/b/c/d 1.25 CME

11:00 a.m. – 12:15 p.m.
SS 27 – Peds 1 – *Improving the Therapeutic Ratio in Pediatric Malignancies*
Room W186 a/b/c 1.25 CME

12:15 p.m. – 12:45 p.m.
Zen Den 09 – *Top Ways to Evaluate Your Posture and Ensure Great Health*
Room W180 0 CME

1:00 p.m. – 2:15 p.m.
EDU 23 – *Optimizing the Use of Patient–reported Outcomes in Research and Practice*
Room W186 a/b/c 1.25 CME

1:00 p.m. – 2:15 p.m.
Panel 22 – *From Art to Science: The Rise of Automation in Treatment Planning*
Room W185 a/b/c/d 1.25 CME

1:00 p.m. – 2:15 p.m.
Poster Q&A 10 – *Central Nervous System and Gynecological Cancer*
Outside Room W375 e 0 CME

1:00 p.m. – 2:00 p.m.
QP 18 – H&N 2 – *Head and Neck Cancer in 2021: Updates and New Directions*
Room W178 a/b 1.0 CME

1:00 p.m. – 1:30 p.m.
Zen Den 03 – *Relaxation Techniques: Simple Steps to Unwind*
Room W180 0 CME

1:15 p.m. – 2:30 p.m.
EDU 24 – *Transforming Radiation Therapy for Lymphomas in 2021: Embracing Change to Achieve More Comfort, More Safety and Better Outcomes*
Room W181 a/b/c 1.25 CME

1:15 p.m. – 2:30 p.m.
SS 28 – Bio 4 – *Cancer Biology*
Room W179 a/b 1.25 CME

1:15 p.m. – 2:15 p.m.
Storytelling 02 – *Promoting Women and Underrepresented Minorities as Essential Leaders of Research*
Room W192 a/b/c 1.0 CME

1:30 p.m. – 2:45 p.m.
Panel 24 – *Exploring mHealth and Wearables in Oncology: Opportunities and Challenges*
Room W187 a/b/c 1.25 CME

1:30 p.m. – 2:45 p.m.
SS 29 – Patient Safety 1 – *How to Stay Calm and Carry On in a Pandemic*
Room W184 a/b/c/d 1.25 CME

3:00 p.m. – 4:15 p.m.
EDU 25 – *Updates in Locoregional Skin Cancer Management*
Room W178 a/b 1.25 CME

3:00 p.m. – 4:15 p.m.
Panel 25 – *Why We Disagree: Clinical Trial Interpretation and Philosophies from Frequentist, Bayesian and AI Perspectives*
Room W187 a/b/c 1.25 CME

3:00 p.m. – 3:30 p.m.
Zen Den 08 – *Meditation Techniques to Increase Focus*
Room W180 0 CME

3:15 p.m. – 4:30 p.m.
EDU 26 – *Radiation, Autophagy and Senescence in Tumor Response: Mechanisms and Clinical Implications*
Room W179 a/b 1.25 CME

3:15 p.m. – 4:30 p.m.
Panel 26 – *Financial Toxicity in Radiation Oncology: Impact for Our Patients and for Practicing Radiation Oncologists*
Room W186 a/b/c 1.25 CME

3:15 p.m. – 4:30 p.m.
SS 30 – Lung 2 – *Individualized Radiotherapy Approaches for Lung Cancer*
Room W183 a/b/c 1.25 CME

3:30 p.m. – 4:45 p.m.
Panel 28 – *Adaptive Radiation Therapy with Artificial Intelligence: The Emerging Technologies and Clinical Translation*
Room W185 a/b/c/d 1.25 CME

Cancer Breakthroughs Session

Don't miss Cancer Breakthroughs, back for another exciting session of groundbreaking research from ASCO, AAPM and AACR.

Wednesday, October 27
9:30 a.m. – 10:30 a.m.

Keynote speaker Wendy Dean, MD, addresses systemic issues that lead to physician challenges

BY LISA BRAVERMAN, ASTRO JOURNALS MANAGING EDITOR

Monday morning, Keynote speaker Wendy Dean, MD, gave a timely and thought-provoking talk about the challenges physicians face, the importance of naming such challenges appropriately and solutions for addressing the crises that face medicine today. Dr. Dean, a trained physician, got into this work because she missed her friends who had left the medical profession due to stress. "What I want is good medicine where good people can do good work together," she said.

The COVID-19 pandemic did not begin the epidemic of physician distress, Dr. Dean explained. Forty-three percent of doctors were burnt out before the pandemic, and the human and financial costs of physicians leaving the profession is tremendous. In addition to the heartbreaking statistics surrounding doctor and nurse suicide, Dr. Dean noted that patients feel physician distress and report lower levels of satisfaction with their care.

Daily annoyances became catastrophic during COVID, as evidenced by the mass PPE shortage early in the pandemic. As of this writing, 115,000 health care workers have died of COVID; Dr. Dean estimated those deaths amount to a million years of experience we have lost.

"We've laid this crisis at the feet of burnout," Dr. Dean said. But the term "burnout" implies individual frailty rather than systemic issues that need to be addressed. Instead of burnout, Dr. Dean focused on the concept of moral injury — the invisible wounds that are inflicted on individuals through traumatic events (historically applied to soldiers in battle). Moral injuries may make physicians feel like changed or worse people. Research has shown that physicians are significantly more resilient than the general population, but with so many stressors on physician time, doctors are certainly not protected from symptoms of burnout.

> "What I want is good medicine where good people can do good work together"

"But why does it matter what we call it?" Dr. Dean asked, speaking about the distinctions between burnout and moral injury. There is an epidemic of not listening to people in distress, she said. The best way to show individuals you are listening is to use their language, and we should use different language if the words we are saying do not speak to colleagues' and patients' experiences. While burnout is about the individual, moral injury is about larger systems and situates problems outside oneself.

As health care systems get bigger and bigger, there is more of a focus on administration and the business side of medicine. This shift has led to greater stresses on physicians, and Dr. Dean offered suggestions about how to mitigate these burdens. She argued for more porous communicative boundaries in health care, with clinicians and administrators discussing the roadblocks they face with greater frankness. Administrators should be asked what they are doing, and what they are going to do, to support clinicians in providing better patient care. We should also support clinician leadership so physicians will consistently be at the tables where decisions are being made.

We get ourselves out of extraordinarily difficult situations by cultivating ample curiosity and empathy, Dr. Dean said. She encouraged the audience to begin making small, positive changes in the world around them, then scale up those changes. Changes of all sizes should be celebrated. One small change everyone can make immediately is to commit to their colleagues, to promise them you will be there for them in the future.

After Dr. Dean's prepared remarks, she had a lively conversation with Suzanne Evans, MD, MPH, and ASTRO President Laura Dawson, MD, FASTRO. The three discussed clinician vulnerability, compartmentalization, connection and more. Dr. Dean emphasized the need to establish more clinician safety in medicine; once doctors know others are profoundly supporting them, they have space to be vulnerable and begin to heal the symptoms of moral injury.

Real world data prevails over randomized clinical trials in Presidential Symposium debate

BY LISA BRAVERMAN, ASTRO JOURNALS MANAGING EDITOR

THIS YEAR'S PRESIDENTIAL DEBATE featured five passionate and engaging speakers who presented on what they argued were the best modes for gathering research data. Soren M. Bentzen, DSc, PhD, FASTRO, and Reshma Jagsi, MD, PhD, FASTRO, presented on the side of randomized clinical trials (RCTs), Corinne Faivre-Finn, MD, PhD, and C. David Fuller, MD, PhD, spoke about the superiority of real world data (RWD), and Jill Feldman provided a patient's perspective on the nature of data collection and how care must be more patient-centered. The debate was moderated by Gita Suneja, MD, MS, and Jeffrey D. Bradley, MD, FASTRO.

Dr. Bentzen began the debate by giving a brief history of clinical trials. He cited several trials that delivered unexpected results, such as RTOG 0617, in which the lower dose arm for the treatment of NSCLC outperformed the higher dose arm. RCTs are unbiased, and that is why we should stick to them, Dr. Bentzen argued, and he claimed RWD could not control bias. While he did not deny that RCTs are expensive, he noted that practitioners can routinely incorporate them into daily practice. Importantly, Dr. Bentzen argued, real world data comes from clinical trials.

Speaking in favor of real world data, Dr. Faivre-Finn argued that the most significant limitation of RCTs is the limited ability to generalize their results. In contrast to Dr. Bentzen, Dr. Faivre-Finn said RCTs are indeed biased; most of the patients who participate in them are over the age of 65 and are white. She argued that clinical trial entry criteria are too rigid, and we are not getting enough data from RCTs. Citing real world evidence (RWE) rather than simply "real world data," Dr. Faivre-Finn claimed RWE helps amass and integrate more data with existing clinical trials information. RWE can lead investigations in new directions easier than RCTs.

Returning to the side most supportive of RCTs, Dr. Jagsi argued that RCTs are necessary for establishing efficacy. She was quick to note that she and Dr. Bentzen were not arguing that RCTs are cheap, or that observational studies are not worthwhile. RWD is subject to confounding, she said. In observing a relationship between variables A and B, for example, a hidden variable is often responsible for what is being witnessed. Observational data are important to determine which treatments might have promise, but they cannot replace RCTs for causal inference. Importantly, there has been poor agreement between observational studies and RCTs in oncology. In closing, Dr. Jagsi said we can certainly find more efficient ways to do trials, but we cannot abandon trials to rely on real world evidence alone.

The real winner in this debate, Dr. Fuller argued, is data. The size of a dataset is incredibly important, and RCTs generally do not provide large enough sample sizes to make airtight recommendations. Randomization, he said, is no panacea for confounders. With RWD, what you see is what you get. One thousand patients per trial is not sufficient for generalizability. And finally, the fundamental restriction of RCTs is that they isolate one therapeutic effect at a time. "Reality isn't perfect, but at least it's true," Dr. Fuller said.

Jill Feldman, a patient advocate and lung cancer survivor, provided the final perspective on the debate. After losing five close relatives to lung cancer, she was diagnosed with the disease at age 39. Ms. Feldman highlighted the difficulty that patients and their families face when making decisions about their treatments and potential side effects. Data do not always provide enough nuance, she said, and longer lives do not always equate to better lives. The close monitoring of patients in clinical trials often does not mirror the levels of monitoring and care patients receive in other settings. Ms. Feldman pointedly stated, however, "I'm alive because of research."

After an animated Q&A session covering the lack of diversity in RCTs, disparities in care and the ways in which dosing is determined, the audience voted on whose argument was the most convincing. It was close, but real world data prevailed with 56% of the vote compared with randomized clinical trials' 44%. Attendees were encouraged to bear in mind one of Ms. Feldman's main points: "The true value of research to patients is hope."

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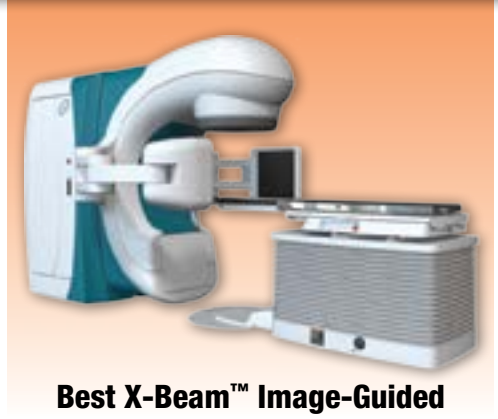

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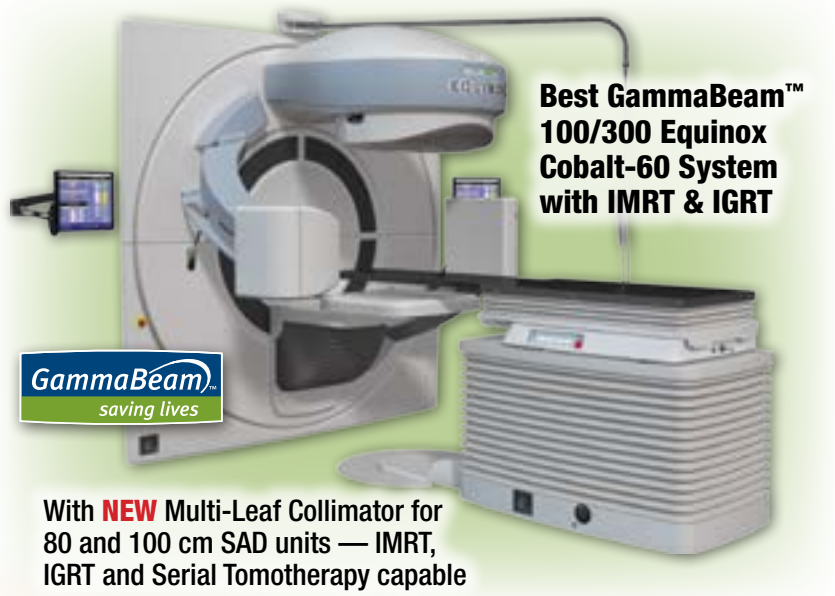

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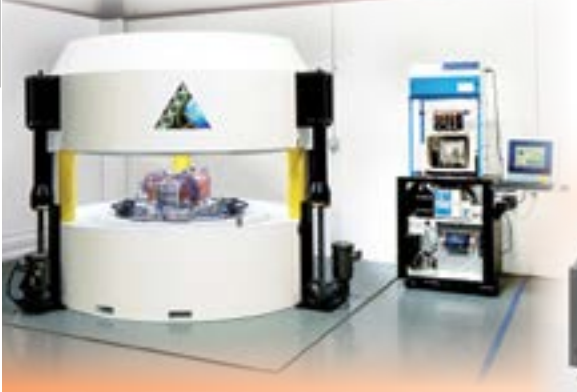

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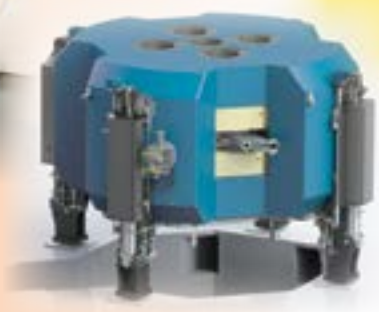

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Plenary Highlights

BY SABRINA JOSEPH, PHD, ASTRO SCIENTIFIC AFFAIRS

THE PLENARY WAS HELD ON MONDAY AFTERNOON and continued to be a main attraction for attendees. Moderated by Andrea Ng, MD, MPH, FASTRO and Felix Feng, MD, chair and co-chair of the Annual Meeting Scientific Committee, respectively, the session reviewed recent results from pivotal studies of scientific significance

Following each presentation, discussants highlighted the implications of the results for clinical practice asking "How do you approach evidence-based clinical practice?". The discussants included Bridget Koontz MD, GenesisCare; Jennifer Bellon, MD, FASTRO, Dana-Farber/Brigham and Women's Cancer Center; Brandon Mahal, MD, University of Miami Sylvester Cancer Center; and Farzan Siddiqui, MD, PhD, Henry Ford Hospital/ Wayne State University.

Read expert commentary on the four abstracts presented during the Plenary Session below and online at www.astro.org/dailynews.

Elective internal mammary node irradiation in women with node-positive breast cancer: Results of a randomized, phase III trial

Presenting author: Yong Bae Kim, MD

Breast cancer is the most common cancer in women. For patients with high risk of recurrence and metastasis, guidelines have recommended postoperative adjuvant radiotherapy for the chest wall and regional lymph nodes for improved local control and survival rates. However, treatments specifically involving internal mammary node irradiation (IMNI) have historically been debated, due to limited data on clinical efficacy and the risks of side effects to key organs such as the heart and lungs. Yong Bae Kim, MD, reviewed results from the Korean Radiation Oncology Group (KROG) prospective randomized phase III trial (KROG 08-06) that was designed to investigate the effect of internal mammary node irradiation (IMNI) on disease-free survival (DFS) and toxicity in women with node-positive breast cancer.

Thirteen hospitals in South Korea enrolled 747 patients who were pathologically confirmed to have axillary node-positive breast cancer after surgery (either modified radical mastectomy (MRM) or breast conservation surgery (BCS). All patients underwent axillary dissection, in which eight or more lymph nodes were identified. Patients were stratified according to N stage (N1 vs. N2 or N3) and type of surgery (breast conservation versus mastectomy) and were randomized to receive radiotherapy (1.8-2 Gy fractions once per day, up to a total dose of 45-54 Gy) either with or without IMNI. The primary endpoint was seven-year DFS. At the median follow-up of 8.4 years, 127 patients had breast cancer-related events and 89 patients had died. At seven years, DFS rates between patients treated in the IMNI arm compared to the non-IMNI arm were similar. However, further subgroup analyses demonstrated significant DFS improvement and reduced breast cancer mortality for patients with medio-centrally located tumors treated in the IMNI arm compared to the non-IMNI arm. Analyses of adverse events related to cardiac toxicity and radiation pneumonitis revealed no differences between treatment arms.

The study investigators concluded that the results support consideration for the selective use of IMNI for patients with medially or centrally located tumors.

MC1675, a phase III evaluation of de-escalated adjuvant radiation therapy (DART) versus standard adjuvant treatment for human papillomavirus-associated oropharyngeal squamous cell carcinoma

Presenting author: Daniel Ma, MD

While human papillomavirus-associated oropharyngeal squamous cell carcinoma (HPV+ OPSCC) incidence is on the rise, treatment is associated with more favorable prognoses and survival outcomes compared to HPV-negative head and neck cancers. However, standard treatments that include adjuvant radiation therapy is often associated with long-term side effects. As patients are typically younger with good prognoses, there's been a surge of de-escalation studies in attempts to reduce standard of care (SOC) treatment morbidities while maintaining disease control. Among the more aggressive deintensification approaches, are the clinical studies by Daniel Ma, MD, of the Mayo Clinic, Rochester, and colleagues. Dr. Ma, one of the recipients of the Steven A. Leibel Memorial Award, presented the recent results from the MC1675 randomized phase III trial. The trial included 194 HPV+ OPSCC patients with negative surgical margins; 72% of whom were non-smokers. Patients were prospectively stratified according to presence of extranodal extension (ENE) or without ENE (intermediate risk). The median age was 59.4 years; 89% were male, 11% female. For the de-escalated adjuvant radiation therapy (DART) experimental arms, the intermediate risk cohort (Cohort A) received 30 Gy in 1.5 Gy fractions twice daily over two weeks with docetaxel at 15 mg/m2 on days one and eight. Patients with ENE (Cohort B; high risk) simultaneously received 36 Gy in

1.8-Gy fractions twice daily to ENE+ nodal level plus docetaxel. Patients were randomized 2:1 in these DART arms (N=130) compared to the SOC treatment arms (N=64); 60 Gy in 2 Gy fractions once a day over 40 days. The high risk SOC treated patients also received weekly cisplatin. The primary endpoint compared the rate of late grade 3-5 toxicities between the DART and standard adjuvant therapy arms.

At a median follow up of 25.3 months, 27.4% of the SOC treated patients required a feeding tube compared to 1.6% of patients treated with the DART regimen. At three months there was also a significant difference (p=0.058) in detected grade ≥3 adverse events between the DART (1.6%) versus SOC (7.1%) treatment groups. Swallowing function assessed at baseline, and one month post RT was superior among the DART treated patients compared to SOC. Additionally, quality of life assessments from baseline to three months by the Functional Assessment of Cancer Therapy-Head and Neck (FACT-HN), the European Organization for Research and Treatment of Cancer (EORTC-HN35) and University of Michigan Xerostomia QOL Scale (XeQOLS) showed significantly superior reported outcomes for patients treated with DART compared to SOC.

Two-year overall survival, progression free survival (PFS) and locoregional control showed no significant differences between the DART and SOC arms with one exception: PFS among the high-risk DART treated patients. This was reported to have been driven mostly by patients with pN2 disease (i.e., cancer had spread to more than four lymph nodes). It was therefore advised to exhibit caution for de-escalating adjuvant radiotherapy for such patients.

Dr. Ma concluded "Our randomized trial demonstrated that for selected patients with HPV-associated oropharynx cancer who received a transoral surgery, a de-escalated adjuvant course of radiation therapy consisting of 30-36 Gy had less toxicity, improved QOL and similar disease control when compared to the standard dose of 60 Gy."

Read expert commentary on the results of the NRG/RTOG 0815 trial and NRG Oncology GU003 trial at www.astro.org/dailynews.

ROI
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PARTICIPANTS IN THE 5K RUN FOR CANCER RESEARCH to benefit the Radiation Oncology Institute were disappointed that the race was cancelled on Monday morning due to the weather. The wind and the resulting waves were covering the race course and running the race would have been dangerous.

All registered participants will be transferred to the virtual race, and the deadline to submit running times has been extended one week to 10:00 a.m. CST on November 1.

The ROI thanks the participants, the corporate sponsors and most importantly Radiation Business Solutions (RBS) for hosting the events for over a decade.

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CASTLE BIOSCIENCES

Showcase on technology advancing person–centered care

Four studies highlight technological innovations in person–centered care

BY DORIANN GELLER, ASTRO COMMUNICATIONS

THIS YEAR'S ANNUAL MEETING THEME, Embracing Change, Advancing Person-Centered Care, focuses on the myriad ways that treatment involving patients in care-giving decisions, supporting caregiver roles and assessing impact — on the clinic, the bottom line and most of all, patient satisfaction, for example — is born from the idea that person-centered care makes a measurable difference.

Among the many studies that focused on the theme, four studies uniquely exemplify how treatment performed with the hardest of science is improved by the softest of touch...making the treatment environment better for patients. What makes these four studies, presented at today's press briefing, so special is not how they improved patient outcomes — although they did — but how they improved the patient experience.

Impact of Pediatric Radiation Oncology with Movie Induced Sedation Effect (PROMISE) on patient movement and general anesthesia use in pediatric radiation therapy

Presenting author: Jeffrey T. Chapman, BS, University of Texas Southwestern Medical Center

Medical student Jeff Chapman, working with co-principal investigator Kiran Kumar, sought to answer the question, "Is there a better way to help children stay still during their treatments?" Anesthesia is often required to ensure immobilization for safe and accurate treatment, but repeated anesthesia can compromise health and quality of life while incurring logistical and financial burdens. PROMISE (Pediatric Radiation Oncology with Movie Induced Sedation Effect) is an interactive incentive-based movie system that also allows for real-time monitoring of patient motion and automatic shut-off of the beam and video if the patient moves outside of defined parameters. They worked with Steve Jiang, PhD, who dreamed up the idea 10 years ago at the University of California San Diego. Researchers found that PROMISE resulted in a 30% absolute reduction in general anesthesia use for children ages 3-7. Further, patient movement during RT with PROMISE was minimal and providers anecdotally noted significant improvement in patient and family quality of life, as well as reducing the number of hours required by using anesthesia for each treatment session.

Site-specific education using digital media to improve patients' understanding of the radiotherapy trajectory: An interventional study

Presenting author: Hussain Almerdhemah, B.App.Sc-RT, King Faisal Specialist Hospital and Research Centre

Radiation therapist Hussain Almerdhemah explained that patients in Saudi Arabia receive education at the time of diagnosis, but that providers have observed that the information is not always fully internalized or retained. In a novel study, he and his team used digital media for site-specific information to increase patients' and families' knowledge about radiation treatments to assess the effectiveness of a site-specific video educational material in improving patients' understanding and confidence regarding radiation therapy. They created one generic and six site-specific animated cartoon videos to provide a concise overview of the overall patient's treatment trajectory, with full visual descriptions of the procedures and specific preparation measures. A 14-item questionnaire was designed to assess pre- and post-intervention levels of understanding and confidence of patients. Patients' understanding and confidence increased, especially for understanding what to expect with RT. Their study found that the use of digital educational material in radiation oncology meets an urgent need for concise and site-specific patient education, while sparing extra hospital visits to meet with education coordinators during the COVID-19 public health emergency.

Development and impact of a virtual PSA monitoring clinic for follow-up of prostate cancer patients: An efficient model with unique benefits relevant to COVID-19

Presenting author: Richard Boyajian, MSN, RN, NP, Dana-Farber/Brigham and Women's Cancer Center

Lead author Richard Boyajian, a nurse practitioner and himself a cancer survivor, described the development, clinical impact, financial impact and patient satisfaction of using a Virtual Prostate Cancer Clinic (VPCC) for follow-up with patients treated for prostate cancer in this 2015 study. The VPCC is a novel method of delivering follow-up care virtually with a [digital health platform (DHP)] infrastructure that led to high patient satisfaction and significant patient time-savings. Remote monitoring improved prostate cancer care by allowing patients to stay at home more often. The impact of missed work, commuting, wait times and expense can be quantified. Mr. Boyajian shared, "This approach allows a small number of providers to manage a larger patient population, while still ensuring the entire population receives the care they need." Access and convenience were improved, according to a survey completed by 636 patients. Ninety percent said that this platform improved their health care experience, making it easier and more convenient while still meeting their medical needs, reducing travel-related stress and getting test results in a timely manner.

3-D virtual reality imaging review in cancer patients' understanding and education of their disease and treatment

Presenting author: Douglas E. Holt, MD, Eastern Idaho Cancer Center

It is widely accepted that current educational strategies for people with cancer need improvement. In this prospective study by Douglas Holt and colleagues at the University of Colorado, 3-D virtual reality (VR) imaging review was shown to be more effective in conveying and contextualizing complex information regarding tumor anatomy and spatial relationships by substantially improving understanding over currently utilized methods. VR was patients' most preferred and top rated educational tool. "One of the big struggles for people with cancer is just trying to understand what's happening to them," said Douglas Holt, MD, and people with cancer often struggle to understand their own disease with current educational methods. Virtual reality (VR) has the potential to intuitively convey abstract, complex information. This study aimed to assess the impact of using VR with people with cancer and their caregivers. VR was rated the top educational tool by 83% of participants over all other educational strategies with 97% preferring VR over verbal discussion alone, self-research, drawings, handouts or a standard computer screen in imaging review.

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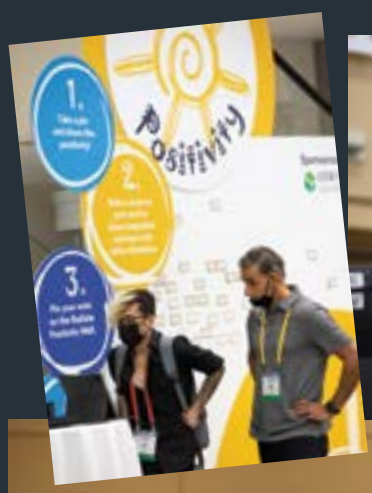



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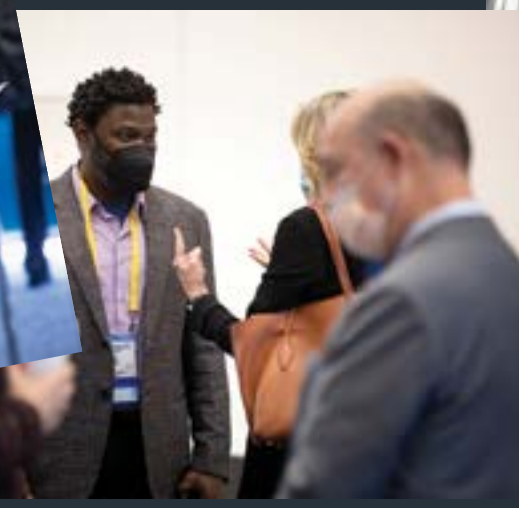

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Room W180, Level 1

All presented by: DAHLIA+Agency

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Tuesday, October 26, 2021
9:00 a.m. – 9:30 a.m. Conversation Starters by Energy Types REPEAT
11:00 a.m. – 11:30 a.m. Tips and Apps for Productivity and Time Management REPEAT
12:00 p.m. – 12:30 p.m. Meditation Techniques to Increase Focus
12:45 p.m. – 1:15 p.m. Top Ways to Overcome Burnout REPEAT
1:15 p.m. – 1:45 p.m. Top Ways to Evaluate Your Posture and Ensure Great Health
3:00 p.m. – 3:30 p.m. Essential Oils for Busy Professionals REPEAT

ABSTRACT SUMMARIES

Preoperative Stereotactic Radiosurgery Followed by Resection for Brain Metastasis is Associated with Excellent Short-term Local Control

BY SIMON S. LO, MB, CHB, FASTRO, UNIVERSITY OF WASHINGTON MEDICAL CENTER

Presenting author:
Uzoma Kevin Iheagwara, MD, PhD

Iheagwara et al., from University of Pittsburgh Medical Center, reported the results of a phase II trial on preoperative stereotactic radiosurgery (SRS) followed by resection for brain metastases from solid tumors excluding lymphoma, leukemia, myeloma and germ cell tumors. The patient had to be 18 years old or older with a KPS of at least 50 and a life expectancy of at least 12 months. In addition, the patient had to have four or fewer lesions measuring 1.5-4.0 cm in size, and patients with tumors <3 cm in size were required to be symptomatic to be eligible. The SRS dose was 15 Gy, 18 Gy or 24 Gy, all in one fraction, based on size. Surgical resection was to occur within seven days of SRS.

Twenty-four patients were enrolled with one deemed to be ineligible for resection. The median number of lesions was one (range 1-3). Nine patients had non-small cell lung carcinoma. The median days from consultation to SRS was 3.9 days, and the median SRS dose was 16.5 Gy (range 15-24) in one fraction. The median number of surveillance MRIs was six (range 1-17). The 6-, 12-, and 24-month local brain control was 90%, 90% and 74%, respectively. The corresponding distant brain control was 66%, 60% and 54%, respectively. The 6-, 12- and 24- month progression-free survival was 46%, 38% and 29%, respectively. The corresponding overall survival was 66%, 58% and 50%, respectively. The authors stated that preoperative SRS was associated with excellent short-term local control but suggested further exploration of this approach.

Abstract 48 – A Phase II Study to Determine the Efficacy of Pre-operative Stereotactic Radiosurgery Followed by Resection for Brain Metastasis was presented on October 25, 2021, during the SS 07 session: Clinical Trials and Novel Approaches to Malignant Brain Tumors.

Separation Surgery Followed by Stereotactic Body Radiotherapy for Metastatic Epidural Spinal Cord Compression

BY SIMON S. LO, MB, CHB, FASTRO, UNIVERSITY OF WASHINGTON MEDICAL CENTER

Presenting author: Kei Ito, MD, PhD

Ito et al. reported the results of their phase II trial of separation surgery followed by stereotactic body radiotherapy (SBRT) for symptomatic metastatic epidural spinal cord compression from solid tumors. A posterior approach was used for surgery. The Sunnybrook regimen of 24 Gy in 2 fractions was used for SBRT. A total of 33 patients were enrolled with 32 completing treatment. The primary endpoint was 12-month local failure, and the secondary endpoints were ambulatory function and adverse effects.

Twenty-three patients had radioresistant histologies. Four, eight and 21 patients had Bilsky grades 1C, 2 and 3 disease, respectively. With a median follow-up of 15 (range three to 35) months, 90% (26/29) of patients had Bilsky grade 1 or less disease at three months. The 12-month local failure was 13%, and 20 patients were able to walk normally or with a cane after 12 months. There was no observed radiation myelopathy and one patient developed radiation radiculopathy and six patients developed a vertebral compression fracture. The authors suggested that a large, randomized phase 3 trial comparing SBRT and conventional radiotherapy should be performed to better define the role of SBRT in this setting.

Abstract 114 – Phase II Clinical Trial of Separation Surgery Followed by Stereotactic Body Radiotherapy for Metastatic Epidural Spinal Cord Compression was presented on October 26, 2021, during the SS 19 session: Improving Outcomes and Selection of Patients for SBRT in the Oligometastatic Setting and Beyond.

A case-based discussion on the ASTRO clinical practice guideline on radiation therapy for liver cancer

LATER TODAY, HIGINIA ROSA CARDENES, MD, PHD, WILL MODERATE a panel discussion based on the recently published, evidence-based guideline on external beam radiation therapy (EBRT) of primary liver cancers. This session qualifies for live SA-CME credit.

Primary liver cancers, comprised primarily of hepatocellular carcinoma (HCC) and intrahepatic cholangiocarcinoma (IHC), are one of the most commonly diagnosed cancers and the fourth leading cause of cancer mortality worldwide.[1] In the United States, incidence rates have more than tripled since 1980 and increased by approximately 2% per year in the last two decades, with an estimated 41,810 new cases in 2020.[2] Despite the availability of screening for HCC and improvements in the prevention and treatment of risk factors (hepatitis B and C virus infection and non-alcoholic fatty liver disease), mortality rates continue to rise. Interest in the treatment of HCC and IHC, therefore, remains high.

In light of these complexities and rapid growth of EBRT data, ASTRO commissioned a task force to review the published literature and develop evidence-based recommendations on the role and use of EBRT for HCC and IHC. The task force addressed five clinical key questions (KQs) that centered on the indications, techniques and outcomes of EBRT in HCC and IHC. The task force consisted of radiation, medical and surgical oncologists, medical physicists, a hepatologist, a transplant surgeon and a radiation oncology resident.

The guideline is intended to cover multiple settings for which EBRT may be used, including definitive, preoperative, salvage, consolidative, adjuvant and as a bridge to orthotopic liver transplantation (OLT). Palliative management as it relates to EBRT for symptomatic primary liver cancers is also addressed.

Key Questions:

- KQ 1. What is the role of EBRT in the definitive/non-transplant and palliative settings in HCC?
- KQ 2. What is the role of EBRT in the neoadjuvant setting prior to surgical resection or OLT for HCC?
- KQ 3. In patients receiving EBRT for HCC, what are the preferred techniques, fractionation regimens and recommended OAR dose constraints?
- KQ 4. What is the role of EBRT in the definitive and adjuvant setting in IHC?
- KQ 5. In patients receiving EBRT for IHC, what are the preferred techniques, fractionation regimens and recommended OAR dose constraints?

ATTEND PANEL 16

ASTRO's First Evidence-Based Clinical Practice Guideline on Radiation Therapy for Primary Liver Cancer

Tuesday, 3:45 p.m. - 5:00 p.m.

The clinical practice guideline, External Beam Radiation Therapy for Primary Liver Cancers: An ASTRO Clinical Practice Guideline, is published In Press in Practical Radiation Oncology. DOI: https://doi.org/10.1016/j.prro.2021.09.004

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2. American Cancer Society. Cancer Facts & Figures 2020. Accessed November 22, 2020. https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-facts-and-figures/2020/cancer-facts-and-figures-2020.pdf

It's not just lunch — the Annual Business Meeting and Luncheon keeps members up to date on the important happenings in the field and in the Society

THE ANNUAL BUSINESS MEETING AND LUNCHEON will be held today from 12:00 p.m. to 1:30 p.m., in room W 183 a/b/c in McCormick Place West. ASTRO voting members — Active, Affiliate and International members — are encouraged to attend. Important topics including updates on the RO Model, steps ASTRO is taking with regard to match and workforce concerns, ASTRO recommendations to ACGME proposed revisions, as well as proposed changes to the ASTRO bylaws.

ASTRO Chair Thomas J. Eichler, MD, FASTRO, will open the meeting by recognizing the volunteers who are rotating off their respective councils and committees. Of special note, the following members will be rotating off the ASTRO Board of Directors: Immediate Past Chair Theodore DeWeese, MD, FASTRO, Health Policy Council Chair William Hartsell, MD, and Science Council Chair Catherine Park, MD, FASTRO. Next, Dr. Eichler will introduce and welcome the new ASTRO Board members including President-elect Jeff M. Michalski, MD, MBA, FASTRO, incoming Health Policy Council Vice-chair Catheryn Yashar, MD, FASTRO, and incoming Science Council Vice-chair John Buatti, MD, FASTRO.

ASTRO Chief Executive Officer Laura Thevenot will follow with important updates on ASTRO's advocacy strategy against Medicare Physician Fee Schedule cuts and the RO Model. Ms. Thevenot will also share proposed bylaws changes. The bylaws were last updated in the fall of 2019, and since that time, several Board decisions require modifications to the bylaws:

- Adding a new Health Equity, Diversity and Inclusion (HEDI) Council to the Board of Directors
- Including criteria for candidates for ASTRO elected Board positions
- Minor technical updates/corrections to reflect updated practices

As per the bylaws, these changes require ratification by ASTRO members. An electronic ballot will be sent out to all voting members in November.

Dr. Eichler will return to the podium to provide a recap of a very busy year. During his year as ASTRO Chair, he faced challenges and enjoyed successes. Dr. Eichler lead ASTRO's initiatives in the face of the pandemic, including a total re-imagining of last year's ASTRO Annual Meeting, advocacy for access to patient care and against the radiation oncology physician payment cuts, increased outreach to raise awareness of radiation oncology among students and formed a taskforce to address workforce concerns. Dr. Eichler will also report on the success of APEx — the fastest growing radiation oncology practice accreditation program and the exclusive provider for VA facilities — new guideline publications and ASTRO's industry fellowships and research funding. Following his remarks, the gavel will pass to Laura A. Dawson, MD, FASTRO, who will assume her new role as ASTRO Chair.

Dr. Dawson will share her priorities for the year ahead, which include working on the implementation of the HEDI Council priorities; understanding the changes caused by the pandemic with respect to education, and then developing educational content for the future; and working with the Communications Committee to continue to build patient education and awareness in the field. Additional priorities include building resources in respect to radiopharmaceuticals; continuing the Board's work on program evaluations and assessments; working on a new Strategic Plan for the Society; and implementing the Workforce Study recommendations.

The Business Meeting will end with the newly installed ASTRO President Geraldine Jacobson, MD, MBA, MPH, FASTRO, who will preview next year's Annual Meeting in San Antonio, Texas. Dr. Jacobson will provide a sneak peek of the focus of the meeting, which is themed AI and EI: Caring for the Patient in a Wireless World. The Annual Business Meeting and Luncheon is a prime opportunity for you to stay in touch with your Society and leadership. We invite you to attend the meeting, enjoy lunch and the camaraderie of your fellow members and participate in the conversation.

Call for papers for two Advances special collections closes October 31

ASTRO's open-access journal, Advances in Radiation Oncology, is calling for papers for two special collections: Use of Radiopharmaceuticals, which will look at the emerging role of radiopharmaceuticals in the treatment of cancer, and Evolving Threats in Cybersecurity and Radiation Oncology, which will focus on the threat of cybersecurity and its potential impact on patient care in radiation oncology.

Submit your papers by October 31 through the journal's submission system and select "Radiopharmaceuticals" or "Cybersecurity" as the article type. Reach out to the editorial office with any questions at advances@astro.org.

ASTRO research funding opportunities available

Call for applications for ASTRO-Industry Fellowship Program

ASTRO is currently accepting applications for the 2022 ASTRO-Industry Radiation Oncology Research Training Fellowship Program. These fellowships provide unique research training for residents and other trainees in the industry setting for up to one year. ASTRO is offering research training fellowships with the following:

- **ASTRO-AstraZeneca Radiation Oncology Research Training Fellowships**
- **ASTRO-Nanobiotix Radiation Oncology (New for 2022)**
- **ASTRO-Novocure Radiation Oncology Research Training Fellowship (New for 2022)**
- **ASTRO-Varian Radiation Oncology Research Training Fellowship**

Fellowship application deadline: January 7, 2022

Research Grants

ASTRO funds research for junior faculty, residents, fellows and postdoctoral fellows in support of radiation oncology researchers' careers. Resident/Fellows seed grants provide up to $25,000 over one year. Applicants must be enrolled in a U.S. residency or fellowship at the time of application. View available grants and details at www.astro.org/fundingopps.

Grant Application Deadline: February 11, 2022; 11:59 p.m. ET (GMT-5)

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Join Us in 2022 for ASTRO's 64th Annual Meeting in San Antonio

BY GERALDINE JACOBSON, MD, MPH, MBA, FASTRO, ASTRO PRESIDENT-ELECT

HELLO FELLOW HUMANS. We are looking forward to seeing you in person at the 2022 Annual Meeting in San Antonio!

The theme of the 2022 Annual Meeting will be Artificial Intelligence and Emotional Intelligence: Caring for the Patient in a Wireless World. The Annual Meeting will highlight both the opportunities of AI in radiation oncology and the central role of human interaction in caring for and curing our patients. AI has the potential to improve treatment precision and reproducibility and to change our current treatment paradigms by incorporating molecular and genetic information to inform our treatment plans. But it also has the possibility of distancing us from interpersonal relationship with our peers and patients. We will be exploring the possibilities and challenges of AI in oncology care and new technology that expands our treatment capabilities. We will also emphasize the power of our human interactions and our unique role as physicians and health care providers to improve our patients' lives. We will listen to our patients' stories and highlight patient reported outcomes. In our Survive and Flourish session, we will explore strategies to reduce or reverse treatment-related morbidity. We will bring diverse voices to discuss solutions to improve treatment access for marginalized populations. Our Keynote speakers will be selected to expand our concept of the possible.

> ""The future ain't what it used to be."
> – Yogi Berra

During the last two years, we have experienced unprecedented change, affecting every aspect of our personal and professional lives. We plan to highlight some of the unique challenges and solutions to providing oncology care during the global pandemic and climate-related crises. These include delays in treatment and the unequal impact on diverse populations as well as the rapid expansion of telemedicine and the adoption of ultra-short treatment schedules. We look forward to learning about your personal experiences during these challenging times as well as suggested topics.

The Presidential Address will highlight the state of radiation oncology in 2022. This will include scientific and treatment advances and global trends and challenges for our specialty. We will continue ASTRO's tradition of providing cutting edge scientific presentations and high-quality professional education with new methods of interactive content delivery.

Come to the 2022 Annual Meeting. Connect, reconnect and learn. Be amazed and inspired. San Antonio is a vibrant, walkable city with great restaurants and tons of culture. We look forward to seeing you there.

Innovative session explores the nature of hope in cancer treatment

BY LISA BRAVERMAN, ASTRO JOURNALS MANAGING EDITOR

Hope is a complicated phenomenon, undergirding so many aspects of cancer treatment. Four presenters interrogated hope's many facets in Monday's session, "The Science of Hope: Why and How to Approach the Most Difficult Situations in Oncology." Kate Bowler, PhD, provided a patient's perspective on hope, Anna Ferguson, OCN, BSN, RN, offered a working definition of the concept, Susan Lutgendorf, PhD, delved into hope's psychoneuroimmunologic basis and Ben Corn, MD, FASTRO, discussed the concept of "hope math," — while some versions of hope are congenital, most can be cultivated and augmented. The session was moderated by Suzanne Evans, MD, MPH.

Dr. Bowler began the presentations by describing how, in the midst of a busy life at the age of 35, she was diagnosed with stage 4 colon cancer. Unfortunately, Dr. Bowler's own diagnosis and subsequent experiences intersected with her research interests of self-help and the religious/secular stories we tell ourselves. People kept telling her to stay positive in the midst of her life-threatening diagnosis; the relentless positivity suggested to her that if she was a hopeful person, perhaps she would have better odds at survival. "Hope was a way to game the system," she said.

Optimism, so often equated with hope, can certainly help patients get through difficult times. But, Dr. Bowler argued, it can also be an exhausting form of lying — of framing a uniquely challenging experience as less challenging. "It was like I was auditioning to be the person worth saving. It may have made me a fun patient, but it did not make me a good patient," she said. Perpetual optimism can quietly encourage patients not to report all their symptoms or the extent of their side effects, or make patients feel like they must withstand treatment doses that are too high for them. Dr. Bowler explained she no longer confuses hope with cheerfulness, that for her, hope is a story about what our lives mean and that good things may still be possible.

Ms. Ferguson compellingly argued that hope is a vital coping mechanism, and patients have always known that hope matters for the quality of their lives. When asked to define hope, patients described the emotion as a sustaining force, strength, an alternative to despair, a lifeline, something that helps them get out of bed in the morning and an emotion that helps them recover from a bad day. She cited Snyder's theory of hope, which emphasizes having goal-oriented thoughts, developing strategies to achieve those goals and being motivated to achieve success. To conclude her talk, she discussed the many metaphors that punctuate cancer care, specifically referring to patients using the language of fighting and war. The sunflower is a particularly apt metaphor for her, however. Sunflowers, emblematic flowers of hope, bend toward the light. Sunflower pins are available at the Radiate Positivity wall while supplies last!

Discussing the complex relationship between stress and cancer progression, Dr. Lutgendorf explored the psychoneuroimmunology not just of hope, but of one of hope's key components: social support. Depression predicts faster progression in many cancers, as well as shorter overall survival. The research speaks volumes — trauma leads to faster progression in breast cancer, and phenomena such as isolation and depression are felt in the body and change the brain. Behavioral risk factors affect immune cells, creating an environment that may be more favorable for tumor progression. Conversely, social support has been shown to lead to slower disease progression and better overall survival. She provided a "hope composite," showing that overall patients are very hopeful, and higher levels of hope are associated with lower levels of stress hormones and better sleep.

In the final presentation of the session, Dr. Corn introduced the concept of "hope math." When conceptualizing hope, he argued, most people see the "glass half empty/half full" metaphor. He prefers a model that considers pathological versus congenital optimism. Hope and optimism can certainly be cultivated; they are not cures for difficult circumstances, but they can serve as antidotes to despair. Dr. Corn, along with the other speakers, considered doctors who are faced with the situation of needing to deliver bad news to patients. While this interaction is one doctors often dread, the conversation can be mitigated by a more concerted development of hope. As a concrete suggestion, he presented the notion of "hope mapping," where individuals chart a path to a particular goal, note the obstacles that may stand in their way and develop strategies with others to address those obstacles.

The audience was appreciative of each panelist's perspective and engaged the speakers directly in a lively Q&A session. Attendees discussed the various factors that may cause increased stress and that may help foster hope, the language of hope and stress as it relates to the development of cancer. Dr. Corn reminded everyone to "respect and hold the fight of the patient."

PRESS HIGHLIGHTS

Intervention eliminates Black-white gaps in survival from early-stage breast and lung cancer

MATTHEW MANNING, MD, CONE HEALTH, GREENSBORO, NORTH CAROLINA, ET AL.

A new study that focused on structural, institutional change rather than individual change shows that system-level changes to the way cancer care is delivered can also eliminate Black-white disparities in survival from early-stage lung and breast cancer. The Accountability for Cancer Care through Undoing Racism and Equity (ACCURE) clinical trial is the first prospective study designed to erase gaps in cancer treatment completion and survival among Black and white patient populations. Led by Matthew A. Manning, MD, the ACCURE approach involved multiple changes to the way patients were supported while receiving cancer treatment. By identifying and addressing the specific obstacles facing their patient populations and intentionally examining how obstacles varied by race, the ACCURE team was able to curb the negative impact of these barriers.

Prior authorization costs radiation oncology clinics more than $40 million each year, study estimates

BRIAN S. BINGHAM, MD, VANDERBILT UNIVERSITY MEDICAL CENTER, NASHVILLE, ET AL.

Prior authorization is a cost-control process used by health insurance companies to determine whether they will cover prescribed medical procedures or medications. The time required to secure prior authorization approvals for radiation therapy treatments equates to a financial impact of more than $40 million annually for academic medical centers, according to a new study. While surveys from ASTRO and other groups estimated time spent by medical practices on prior authorization, the study from Dr. Bingham's team is the first to analyze the financial impact of this time within radiation oncology. To do so, they combined compensation data with work-hour estimates to calculate the cost of physician and staff time spent on the process. They found that compensation costs for treatment-related prior authorization totaled an estimated $40,125,848 for academic radiation oncology practices nationally.

High-dose radiation thwarts tumor growth in patients with advanced lung cancer

C. JILLIAN TSAI, MD, PHD, MEMORIAL SLOAN KETTERING CANCER CENTER, NEW YORK, ET AL.

High-dose radiation therapy can be used to lengthen progression-free survival for people with advanced lung cancer when systemic therapy has not fully halted the growth or spread of metastases, according to a new study. This study is the first randomized trial to test the use of stereotactic body radiation therapy to treat oligoprogressive, metastatic lung and breast cancer. Cancer may be considered oligoprogressive when there is a mixed response to systemic therapy, where some metastatic sites become drug-resistant and others are suppressed by the systemic therapy and remain stable. The current standard of care typically is to switch to a different targeted therapy or chemotherapy, but this can cause additional side effects, and an alternate drug is not always available. Adding local therapy like SBRT allows patients to stay on their current therapy by targeting only the drug-resistant lesions.

Join your colleagues in honoring leaders of the field at today's Awards Ceremony in room W375 a/b/c/d at 10:45 a.m. to 12:00 p.m.

Gold Medalists

2021 GOLD MEDALISTS

Colleen A. F. Lawton, MD, FASTRO
Medical College of Wisconsin
Milwaukee

Lori J. Pierce, MD, FASTRO
University of Michigan
Ann Arbor, Michigan

2020 GOLD MEDALISTS

Bruce Haffty, MD, FASTRO
Rutgers Cancer Institute of New Jersey
New Brunswick, New Jersey

Brian O'Sullivan, MD, FASTRO
Princess Margaret Hospital, University of Toronto, Toronto

2021 ASTRO Fellows

ASTRO is pleased to present the 2021 Class of ASTRO Fellows (FASTRO). This distinguished honor is conferred on the following ASTRO members in recognition of their outstanding leadership and significant service to ASTRO and contributions to the field of radiation oncology.

Gopal K. Bajaj, MD, MBA
Inova Schar Cancer Institute

James Michael Balter, PhD
University of Michigan

John Breneman, MD
University of Cincinnati

Jay Burmeister, PhD
Karmanos Cancer Center, Wayne State University

Yuhchyau Chen, MD, PhD
University of Rochester

Bouthaina Shbib Dabaja, MD
The University of Texas MD Anderson Cancer Center

Jun Deng, PhD
Yale University

Charles A. Enke, MD
University of Nebraska Medical Center

Eric Ford, PhD
University of Washington

Karyn A. Goodman, MD, MS
Icahn School of Medicine at Mount Sinai

B. Ashleigh Guadagnolo, MD, MPH
The University of Texas MD Anderson Cancer Center

Daniel A. Hamstra, MD, PhD
Baylor College of Medicine

David Hodgson, MD, MPH
Princess Margaret Cancer Centre

Salma K. Jabbour, MD
Rutgers Cancer Institute of New Jersey

Christopher Ryan Kelsey, MD
Duke University Medical Center

John P. Kirkpatrick, MD, PhD
Duke Cancer Institute

Billy W. Loo, Jr., MD, PhD
Stanford University School of Medicine

Amit Maity, MD, PhD
Perelman School of Medicine at the University of Pennsylvania

Constantine Mantz, MD
Fort Myers, Florida

Andrea K. Ng, MD, MPH
Dana–Farber Cancer Institute/ Brigham and Women's Hospital, Harvard Medical School

Zoubir Ouhib, MS
Boca Raton Regional Hospital

Adela Poitevin, MD
Medica Sur

Dirk Rades, MD
University of Lübeck

Andrew L. Salner, MD
Hartford HealthCare

Michael Seider, MD, PhD
Wooster Cancer Treatment Center, Salem Regional Medical Center

Charles R. Thomas, Jr., MD
Geisel School of Medicine at Dartmouth, Norris Cotton Cancer Center

Neha Vapiwala, MD
University of Pennsylvania

Wendy Woodward, MD, PhD
The University of Texas MD Anderson Cancer Center

2020 ASTRO Fellows

ASTRO is pleased to present the 2020 Class of ASTRO Fellows (FASTRO).

Elizabeth H. Baldini, MD, MPH, FASTRO
Brigham & Women's Hospital/ Dana–Farber Cancer Institute

Sushil Beriwal, MD, MBA, FASTRO
Allegheny Health Network

Ronald C. Chen, MD, MPH, FASTRO
University of Kansas Cancer Center

Prajnan Das, MD, MS, MPH, FASTRO
The University of Texas MD Anderson Cancer Center

William F. Demas, MD, FASTRO
Seidman Cancer Center at Salem Regional Medical Center

Jason A. Efstathiou, MD, DPhil, FASTRO
Massachusetts General Hospital, Harvard Medical School

Ronald D. Ennis, MD, FASTRO
Cancer Institute of New Jersey, Rutgers University

Michael Hagan, MD, PhD, FASTRO
Virginia Commonwealth University

Anuja Jhingran, MD, FASTRO
The University of Texas MD Anderson Cancer Center

Stanley Liauw, MD, FASTRO
University of Chicago

Anita Mahajan, MD, FASTRO
Mayo Clinic

Mark J. Rivard, PhD, FASTRO
Brown University, Rhode Island Hospital

Joseph K. Salama, MD, FASTRO
Duke University

Felicia E. Snead, MD, FASTRO
University of Pittsburgh, Hillman Cancer Center

Dian Wang, MD, PhD, FASTRO
Rush University Medical Center

Julia S. Wong, MD, FASTRO
Brigham & Women's Hospital/ Dana–Farber Cancer Institute

Sue Sun Yom, MD, FASTRO
University of California, San Francisco

Ning Jeff Yue, PhD, FASTRO
Rutgers Cancer Institute of New Jersey

Michael J. Zelefsky, MD, FASTRO
Memorial Sloan Kettering Cancer Center

2022 MPFS: A new year nightmare?

2021 Coding and Coverage Seminar Takes a Closer Look

BY ADAM GREATHOUSE, SENIOR MANAGER, HEALTH POLICY, ASTRO

THE 2022 MEDICARE PHYSICIAN FEE SCHEDULE (MPFS) proposed rule was released by the Centers for Medicare and Medicaid Services (CMS) on July 23 and contained some very concerning proposals for radiation oncology: the combined impact means an overall reduction in payment for radiation oncology of almost 9%, and some payments for RO services will be cut by as much as 23%!

ASTRO will be covering issues with the 2022 MPFS proposal in the upcoming 2021 Coding and Coverage Seminar, but suffice it to say, the biggest contributing factor to the cuts is the proposed update to clinical labor pricing. For radiation oncology, clinical labor pricing includes the cost of medical physicists, medical dosimetrists, radiation therapists and nurses. While the update is long overdue (the last one was in 2002), the price tag of the update is about $3.5 billion, and that money has to come from somewhere. Because of budget neutrality requirements, by increasing the clinical labor pricing, physician services with high-cost supplies and equipment — like radiation oncology — are disproportionately impacted.

Why? Clinical labor is a part of the practice expense component of the MPFS (the other component being supplies and equipment). Practice expense is about 45% of the total physician payment, and that percentage is fixed. So, when clinical labor rates go up, it results in a shift of relative value units (RVUs) that previously went to supplies and equipment (imagine balancing weights on a scale). Medicare was reimbursing 59 cents on the dollar for supply and equipment costs, but under the proposed rule, it will be 44 cents on the dollar — a 24% cut.

Radiation oncology equipment is some of the most expensive equipment used in medicine and continues to improve in precision, efficacy and efficiency. Unlike other fields where operating costs are flexible due to low fixed costs, RO operating costs are inflexible due to high fixed costs for equipment and facilities used to deliver radiation therapy. If payments change drastically in the final rule, which we expect to be released just after Halloween, there will be no way to accommodate those shifts through operating expenses without cuts elsewhere, such as in staff and services offered. These steep cuts to payment rates are likely to hinder technological progress in radiation oncology and will prevent Medicare beneficiaries from receiving modern, less invasive cancer treatments close to their homes.

In light of these cuts, it is hard to understand how radiation oncology is expected to contribute to President Biden's important goal of "ending cancer as we know it," especially in the middle of an ongoing global pandemic. ASTRO has been advocating against these cuts to radiation oncology. However, we won't know the final outcome until the 2022 MPFS final rule is released. We hope the 2022 MPFS final rule will include a "trick" or two to fix the significant payment cut that will result from the clinical labor pricing update. Otherwise, radiation oncology will be facing a nightmare scenario heading into the new year unless Congress intervenes.

The 2022 MPFS and clinical labor pricing update topic will be covered during ASTRO's December 11 Coding and Coverage Seminar "Hot Topics" session. More information about the seminar, including registration, can be found on the ASTRO website.

INDUSTRY–EXPERT THEATERS

TUESDAY, OCTOBER 26

Theater 1, Innovation Hub
Naveris Inc.
10:15 a.m. – 11:15 a.m.
Clinical Evidence of Novel Blood Test for HPV-Driven Cancer Detection and Monitoring

Theater 1, Innovation Hub
Accuray
12:15 p.m. – 1:15 p.m.
Go ITV-free and Gating-free with Accuray

Jackson Park Room, Hyatt Regency McCormick Place
Merck & Co. Inc.
12:15 p.m. – 1:15 p.m.
Personalizing Your Approach with First-Line Treatment Options in R/M HNSCC

MAIN STAGE PRESENTATIONS

TUESDAY, OCTOBER 26

12:15 p.m. - 1:15 p.m.	*HyTEC: NTCP Overview and Representative Site-specific Examples*
2:30 p.m. - 3:30 p.m.	*Future of FLASH*

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2021 Survivor Circle Grants awarded Sunday

BY DORIANN GELLER, ASTRO COMMUNICATIONS

Angela McCrum, LivingWell Cancer Resource Center: intends to use the Grant to assist with providing transportation to treatment for the clients they serve.

SURVIVOR CIRCLE WAS CREATED IN 2003 to honor cancer survivors by recognizing organizations that further the fight for survivorship. Each year, ASTRO awards two grants of $10,000 to support organizations located in the state that hosts the Annual Meeting.

ASTRO, almost wholly from the generous support of our exhibitors, has raised approximately $425,000 since the inception of the program, 100% of which has gone to the grant recipients.

The 2021 Survivor Circle Grant recipients are LivingWell Cancer Resource Center and The Cancer Support Center.

LivingWell Cancer Resource Center

Founded in 2005, LivingWell Cancer Resource Center (LWCRC) is a free oncology support center that provides services to empower people facing cancer with knowledge, strengthened by action and sustained by the supportive LivingWell community. Now part of Northwestern Medicine, a not-for-profit, integrated academic health care system, LWCRC specializes in supporting individuals, families and children impacted by cancer. Their counselors and social workers focus on helping cancer patients and their caregivers learn vital coping skills that enable them to regain control, reduce isolation and enhance their quality of life.

Utilizing a distress screening process, where the oncology social workers are able to anticipate patients' needs prior to meeting with them, LivingWell social workers often are able to have suggestions for support by the first meeting. Solutions include nutrition, counseling, and substantive resources for improved quality of life.

"LivingWell Cancer Resource Center provides education and support so those on this journey learn how to cope with the disease through classes on, among other, how to eat differently to combat the side effects of treatment," according to LWCRC Director Angela McCrum. Individual counseling session help patients and caregivers talk about their thoughts, feelings and reactions to a diagnosis.

In addition, Ms. McCrum said, "Licensed oncology social workers connect patients to resources and provide education to help reduce stress and remove barriers to care, and support groups connect with others to process the physical and emotional impact of a diagnosis."

One of those barriers to care is transportation. LivingWell established a relationship with Uber Health in 2019 after piloting a transportation program and presenting the value of the program to Northwestern Medicine's Process Improvement Committee. Since implementation, LWCRC has continued to seek grants and donations to support this need, which has been exacerbated by decreases in other social services' transportation support programs.

According to Ms. McCrum, they intend to use the Survivor Circle Grant money to assist with providing transportation to treatment for the clients they serve. "There has been a 110% increase in the number of Uber Health rides provided to patients, resulting in a 76% increased cost to transportation funds," said Ms. McCrum. "This grant will ensure patients have one less barrier to care and allow LivingWell to continue to be a resource for patients when this is a challenge, supporting transportation for two years, with providing 200 rides annually."

Most cancer patients require multiple treatment appointments, sometimes scheduled daily. "For some cancer patients, securing transportation to these appointments is difficult and creates a barrier to receiving cancer care," said Ms. McCrum.

She continues: "Uber Health provides timely, cost-effective, reliable and HIPAA-compliant transportation for oncology patients with transportation barriers receiving treatment as an outpatient. Uber Health has decreased patients' distress related to this practical concern and increased staff efficiency when arranging transportation. By having access to Uber Health to assist with transportation; the oncology social workers are able to assist patients who would not be able to get to treatment due to the lack of a vehicle or finances. This ensures all patients receive quality oncology care."

In addition to their counseling and support services, they also tap into the arts and yoga to help reduce stress, regain strength and promote healing. While in-person classes are not advisable, LivingWell offers virtual fitness and yoga classes available to their registered clients through dedicated links, and they offer a list of on-demand recordings of fitness and yoga classes on their YouTube channel.

Sue Armato, Cancer Support Center: plans to create a new series of introductory videos focusing on how supportive care can improve the lives of the patients they serve.

LivingWell also addresses needs for survivorship. Currently they are offering a weekly survivorship series to address what happens after cancer treatment ends. This free, seven-week "Back-on-Track: Surviving Survivorship" online series is designed to help patients and caregivers navigate the challenges people experience as they transition into survivorship.

"Whether you are a patient or a caregiver, no one is prepared for a cancer diagnosis," said Ms. McCrum. LivingWell Cancer Resource Center provides education and support to those on this journey to learn how to cope with the disease."

The Cancer Support Center

The Cancer Support Center (CSC), located in Chicago, is a community-based non-profit organization with two facilities in Chicago's Southland neighborhoods of Homewood and Mokena. The CSC serves anyone seeking oncology care and focuses on a health equity initiative providing services to communities of color with high cancer morbidity rates.

The programs and services created by therapists, counselors, nutritionists, and health care experts are evidence-based and delivered personally, either virtually or in-person settings, making them accessible to everyone. They include comprehensive emotional and wellness support to cancer survivors and their caregivers.

According to Executive Director Sue Armato, CSC uses the Five Point Model of Cancer Care, which comprises Counseling/ Stress Management, Education, Nutrition, Fitness and Body Image. "Navigators," as they call their providers, address these points at the first meeting, the first time "participants," as they call their clients, come in the door. Addressing these five points will, ideally, improve people's quality of life, Ms. Armato said. "We find that if we involve them in two or three [of these points], their quality of life is significantly improved. In fact, our research shows that 95% of people who are involved with two or more points report that they have a substantial improvement in their day-to-day quality of life."

Pre-COVID, when a cancer patient came to CSC, they immediately met with a program navigator who began the patient support process. "We thought in person was best," Ms. Armato said. But since COVID, they are finding that "We actually can achieve the same level of care through well-made and intentional videos." With their grant funding, they plan to create a brand new series of introductory videos focusing on how supportive care can improve their participants' lives.

"We are super excited now that we can create those videos, which provide such a great, gentle way for people to get to know us a little before they come in," stated Ms. Armato. The videos will provide basic, yet critical, information including who they are and how they can support their participants, so that no matter how a cancer patient accesses their services — in person or virtual — "they are fully apprised of who we are and how we can help them," she added.

CSC serves Chicago's southern neighborhoods and the south suburbs. These communities are predominantly communities of color and have lower economic status. Though hospitals are available, there are barriers to accessing medical care. CSC works closely with community partners to address and eliminate these barriers and provide assistance to accessing care. CSC brings services directly to cancer patients. "We exist to provide strength, guidance and support to anyone impacted by cancer — whoever and wherever they are," according to their website.

What substantially differentiates the CSC's approach to health care equity is that they are embracing community organizing to bring health care to underserved communities. Their newest initiative, Kick It Cancer, connects community leaders and residents to promote early detection and prevention through access to care and ongoing support.

Knowing that they have to build trust, CSC engages community leaders, even tapping into the networks of the Divine Nine (the nine African American sororities and fraternities) to lend credibility to their efforts. Through PSAs, health fairs, pledge cards and onsite screening, they are reaching these underserved comminutes and building trust.

"In partnership with one of the hospitals in Chicago we are now doing community organizing through community centers and schools and churches to let them know about the importance of screening," Ms. Armato explained. Through health fairs, they are breaking down barriers to care, asking attendees to sign a pledge card to get a screening. "What makes us so different is our community organizing efforts around this effort. We figure out the barriers and break them down. We bring everything we have to the community," she said.

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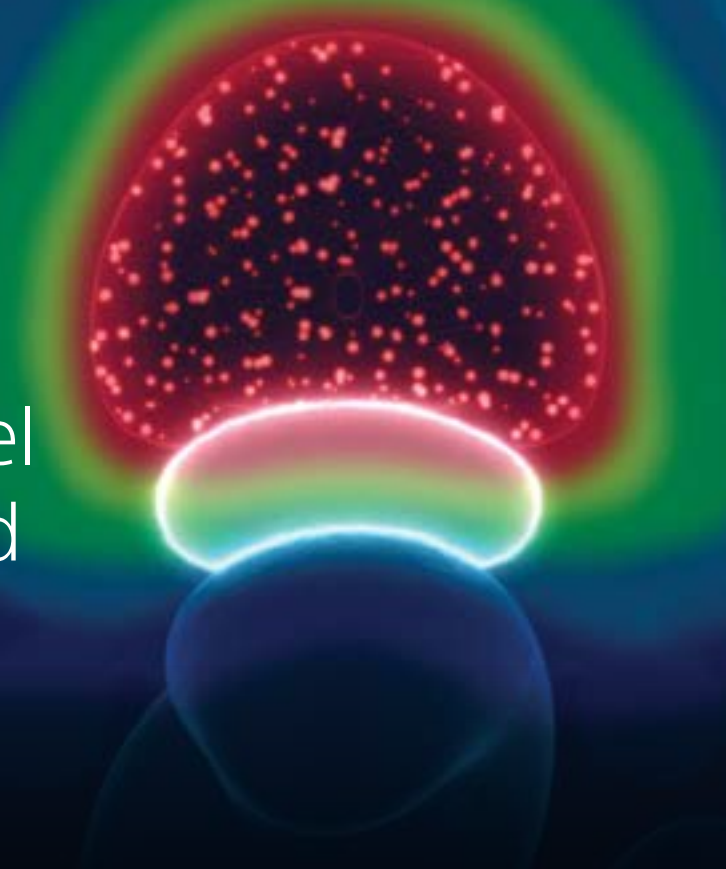

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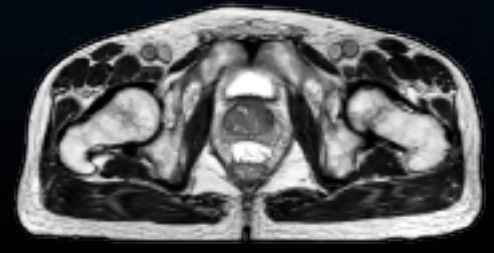
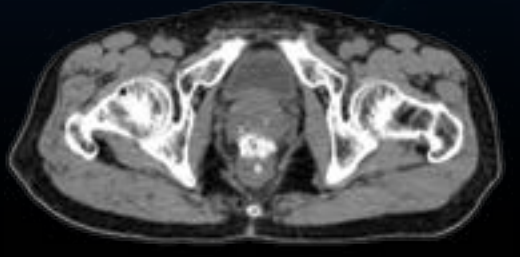
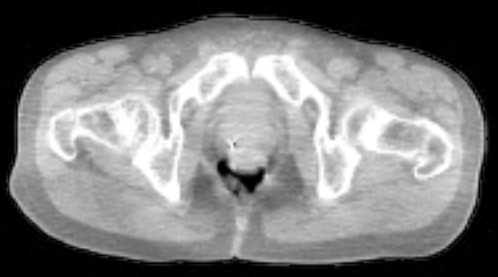


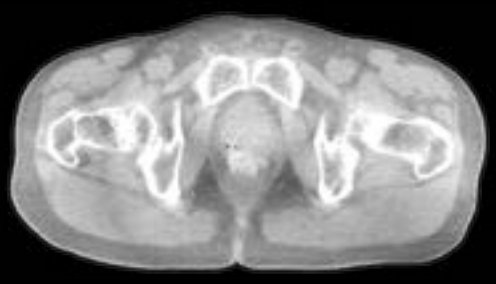
T2-weighted Magnetic Resonance image.*



Computed Tomography image.*



kV Cone-beam Computed Tomography image.*
First Fraction



kV Cone-beam Computed Tomography image.*
Last Fraction

Visit Booth #1529

* Jeff Michalski, MD (2020). Permission granted by Washington University Ima ging.

1. Data on file at Boston Scientific.

CAUTION: US Federal law restricts this device to sale by or on the order of a physician. SpaceOAR Vue Hydrogel is intended to temporarily position the anterior rectal wall away from the prostate during radiotherapy for prostate cancer and in creating this space it is the intent of SpaceOAR Vue Hydrogel to reduce the radiation dose delivered to the anterior rectum.

Prior to using these devices, please review the Instructions for Use for a complete listing of indications, contraindications, warnings, precautions and potential adverse events. As with any medical treatment, there are some risks involved with the use of SpaceOAR Vue Hydrogel. Potential complications associated with SpaceOAR Vue Hydrogel include, but are not limited to: pain associated with SpaceOAR Vue Hydrogel injection; pain or discomfort associated with SpaceOAR Vue Hydrogel; needle penetration of the bladder, prostate, rectal wall, rectum or urethra; injection of SpaceOAR Vue Hydrogel into the bladder, prostate, rectal wall, rectum or urethra; local inflammatory reactions; infection; injection of air, fluid or SpaceOAR Vue Hydrogel intravascularly; urinary retention; rectal mucosal damage, ulcers, necrosis; bleeding; and rectal urgency. URO-989810-AA