THE LACNETS PODCAST

With Daneng Li, MD
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Transcription:

Lisa Yen
Welcome to The LACNETS Podcast. I'm your host Lisa Yen. I'm the LACNETS Program and Outreach Director, as well as a caregiver and advocate for my husband who is living with NET. In each podcast episode, we talk to a NET expert who answers your top 10 questions. This podcast is for educational purposes only and does not constitute medical advice. Please discuss your questions and concerns with your physician.

Welcome, everyone, to another episode of The LACNETS Podcast. Today's special guest is Dr. Daneng Li from City of Hope. He's a medical oncologist and Co-director of the Neuroendocrine Tumor Program at City of Hope. Dr. Li has been dedicated to NET cancer research, advocacy and care of the NET community. He's been a close colleague and a friend to LACNETS and to myself. He helped co-develop NET Vitals along with Giovanna Imbesi and myself and we've collaborated on several NET Cancer Day symposiums which we typically host at City of Hope, as well as the LACNETS annual conference. Welcome, Dr. Li! It's so great to have you! We'd love to hear from you how you got involved in the NET cancer community and what led you to learn about NET cancer.

Dr. Daneng Li
Thanks so much, Lisa, for having me. It's an honor to be with everyone again today. As Lisa mentioned, I'm a GI medical oncologist. So I had a particular interest in terms of helping patients with GI cancers during my fellowship at Memorial Sloan Kettering in New York City. And it was really during that time where I was actually studying predominantly pancreatic cancer that I had a lot of experience encountering patients with pancreatic neuroendocrine tumors. And why I found it particularly fascinating was that the pancreatic neuroendocrine tumor patients were completely different. Compared to many of the other GI malignancies that I was learning to treat at that time. So that really sparked my interest. Potentially help patients with neuroendocrine tumors because I really saw unmet need for this population, given the rarity of the tumor type, as well as limited research that was going on at the time. So that really led me to look at this as potentially something that I certainly wanted to incorporate in terms of my career. Then I had a great opportunity to build my own program here at City of Hope, coming out of fellowship. I really took that and came here. It was during that time that I got introduced LACNETS with Giovanna. I remember that I met her at one of the symposium meetings and we just really felt that there was, again, a really unmet need in terms of the care of patients with neuroendocrine tumors, and really find a balance in terms of how potentially patients and physicians could really team up together and communicate better so that we can ultimately have better outcomes for our patients, as well as to instill better understanding and knowledge for our physicians about this disease.

Lisa Yen
Wow, thanks for sharing that story. What I really love about the story of your journey is how much of an impact patients had. Patients sparked your interest. Giovanna also helped lead that interest into working with LACNETS and continuing to helped fuel your desire to meet that unmet need. Thank you for just that heart to meet unmet need, particularly with our population.

Dr. Daneng Li
Yeah, absolutely.

Lisa Yen
Let's dive into the questions. We have ten interesting questions for you today. As you know, these are common questions that are asked in the NET cancer community. And the first one is, how important is it to find the primary tumor site? And in other words, how much effort should go into pursuing this? And a follow up question would be, how common is it to have a NET cancer with an unknown primary site?

Dr. Daneng Li
Sure, I think that's a very important question. I think it is fairly important to try to find the primary tumor if it is able to be found. And the reason why that is, is that there are differences between the different primary neuroendocrine tumors in terms of overall prognosis, outcomes, as well as potential treatment options. So what do I mean by that? So for patients that have small intestine neuroendocrine tumors, often times these are patients have potentially a more indolent neuroendocrine tumor diagnosis. And many of these patients can actually do really well for a prolonged period of time on just somatostatin anolog therapy. And this is very important. And if someone has a small intestinal tumor, oftentimes, we can actually be fairly aggressive with the disease in terms of surgical debulking procedures, resections, and whatnot. And these patients, we might potentially sequence, are different systemic treatment options in a certain way, compared to other types of neuroendocrine tumors just based off of clinical trial data that we already have in the past, despite the fact that we don't have pure sequencing, direct comparison, clinical trials for this population reset. Now, compare that to someone who has pancreatic neuroendocrine tumors, I would say someone who has pancreatic neuroendocrine tumors, we might be a little bit more cautious in terms of surgical debulking procedures. As you can imagine, if you remove the pancreas, from someone who has advanced pancreatic neuroendocrine tumors, they might be really impacted in terms of their overall daily quality of life in terms of, are they going to have development of diabetes, pancreas insufficiency that leads to malabsorption diarrhea? All these things have to be thought out for that type of patient. In addition, there are more active agents potentially for pancreatic neuroendocrine tumors, from systemic therapy perspectives. Whether it's VEGF tyrosine kinase inhibitors, such as sunitinib as well as capecitabine and temozolomide chemotherapy, that traditionally would not necessarily work as well for our small intestinal neuroendocrine tumors. And then finally, for the lung neuroendocrine tumors, this is also very important just because we really have less guidance and less data for the lung neuroendocrine tumors, but we can potentially borrow agents that potentially have activity for lung cancer in general and use those in addition to our neuroendocrine tumor treatments for our patients with lung neuroendocrine tumors. So this is really where finding the primary is really important. And I would also say that it's important because different clinical trials might have criteria that's specific for the different types of neuroendocrine tumors. So to meet eligibility, it's really important to potentially find the primary. For the second question in terms of how far should we go to find the primary? Sometimes, unfortunately, we're not able to identify the primary despite all our extensive workup, including multiple scans, endoscopic ultrasound procedures. So then here, it's really to assess the overall risk and benefit of how far to do, let's say, a preemptive laparoscopic procedure to look for a small intestine neuroendocrine tumor, versus whether or not you already have clues of possibly where the tumor might be coming from based off of

genomic profiling of the tissue that you have from a distant site. So that's an individual overall risk benefit assessment that needs to be determined with your physician. This is still relatively common, I would say, particularly for our practice. We probably only see 3-4% of patients really having neuroendocrine tumor of unknown primary in our practice.

Lisa Yen
This is really helpful. As you and I know, that's why we put that language in NET Vitals and in our NET Intro, so that we from the patient and caregiver community will identify that primary tumor site in our communications with providers. So I guess a point of clarification, sometimes I hear patients wonder, after that primary tumor site is cut out, how do they identify their disease?

Dr. Daneng Li
So once it's cut out, that's still the primary tumor. So meaning that if you had a primary tumor, let's say in the intestine, or in the colon, or in the stomach, wherever they removed that from the original time of diagnosis, for example, or at the time of a debulking surgical procedure, that still remains your primary. And that will be something to always kind of keep in mind moving forward. Now, let's say you have an instance where you only have a mass or tumors within the liver and there's no other sites of disease, then I would say most likely that's a case of a neuroendocrine tumor of unknown primary, and it should be classified as that. It would be very rare for you to have an actual primary neuroendocrine tumor of the liver. The incidence of that is essentially probably less than 1%.

Lisa Yen
That's really helpful. And how common is it to have a NET with an unknown primary site?

Dr. Daneng Li
So as I mentioned, in our practice, I would say we probably see it probably anywhere between 3-4%. And I think this is fairly consistent with other institutions as well.

Lisa Yen
Right, thank you so much. This is all really helpful. So our second question is, what do you do when someone has been diagnosed with NET, and they have elevated tumor markers and symptoms, but the scans show no evidence of disease?

Dr. Daneng Li
I think this is another great question. And this is a question that we have encountered on numerous instances. My general approach, in that case, is to essentially just continue to monitor over time. And I know that for many patients, this is certainly very frustrating because they might have symptoms. And as a result of their symptoms, they want something to potentially make them feel better. But if there is no evidence of disease, I think it's also very important to figure out whether or not a patient's presumed diagnosis of neuroendocrine tumor is actually true or not. Because there are other illnesses that can potentially lead to a rise of certain types of tumor markers that we use for neuroendocrine tumors, because unfortunately, the markers that we have for neuroendocrine tumors are somewhat nonspecific, meaning that it doesn't just necessarily happen in neuroendocrine tumors. And it could be a result of other things, such as other illnesses, other medications, other medical problems. So it's really first to establish whether or not someone truly has a diagnosis of neuroendocrine tumor. And if they even have a high suspicion, that it's a diagnosis of neuroendocrine tumor, if there is no evidence of disease, my perspective is actually to potentially first hold off on any treatment targeting, let's say, a treatment for neuroendocrine tumor, and just potentially help with symptomatic management initially, until a definitive diagnosis is actually established moving forward. If someone already had a diagnosis of neuroendocrine tumor, and the question is

about whether or not there is recurrence of disease, or there's disease that's still present. If a scan is not showing any evidence of disease, that's considered what's known as non-measurable disease, meaning that we can't measure the disease. And again, in this setting, I would most likely approach this by holding off on a treatment that's specifically targeting the neuroendocrine tumor, rather focus on potentially symptomatic management initially.

Lisa Yen
Thank you so much, Dr. Li, for that really thorough answer of a complex question. Sounds like you're treating the patient and not the numbers.

Dr. Daneng Li
Yeah, absolutely.

Lisa Yen
That's a nice segue to the next question, which is what's the difference between a functional and non-functional NET?

Dr. Daneng Li
So a functional neuroendocrine tumor is essentially a neuroendocrine tumor that potentially secretes excess hormones or additional proteins that may cause additional symptoms for a patient with a diagnosis of neuroendocrine tumor. Now, historically, what has been reported is that, I would say 80% of neuroendocrine tumors are classified as what is known as nonfunctional neuroendocrine tumors, meaning that they don't produce necessarily excess hormones, and about 20% of patients will have these functional neuroendocrine tumors that do produce excess hormones, of which the most common hormone that you may encounter is for patients to have a functional neuroendocrine tumor that releases excess serotonin. And this excess serotonin hormone can lead to a constellation of symptoms that we classify as carcinoid syndrome, which really encompasses symptoms that are related to flushing, diarrhea, as well as ultimately an impact on the valves of the heart as well as the lungs.

Lisa Yen
That's helpful. And sometimes we have new people come to our groups, and they hear other people talk about symptoms, especially diarrhea, but also issues with their heart valves or flushing, perhaps other symptoms. And the new people often ask us, is this what I have to look forward to? Will I also be experiencing these symptoms?

Dr. Daneng Li
Yeah, so again, a majority of patients will not necessarily experience these symptoms as a result of a functional neuroendocrine tumor, just because functional neuroendocrine tumors are much less common compared to nonfunctional neuroendocrine tumors. This is really where it's important to figure out what your symptoms are due to. One of the most common symptoms that patients with a diagnosis of neuroendocrine tumor, in terms of what they might encounter, is diarrhea. But diarrhea can actually be due to different things. In one patient can certainly be a result of excess serotonin secretion if they have a functional neuroendocrine tumor with carcinoid syndrome diarrhea. But in another patient, it could be due to just having a shortened small intestinal tract if they had their small intestine surgically removed at the time of initial diagnosis. And in another patient, it could just be malabsorption diarrhea, if their pancreas is not functioning as well, or if they're on treatment that suppresses the release of regular hormones that our pancreas will release if we're eating high fatty or high protein meals. So I think it's really important to figure out what your symptoms are due to, as not all symptoms may be just due to excess hormone secretion from a functional neuroendocrine tumor.

Lisa Yen
Thanks for that. And just for emphasizing that each person's unique, just like the stripes in the zebra. And it's really important to figure out the causes behind the symptom, if people are experiencing symptoms. And for our listeners out there, if you want to learn more about diarrhea, our first episode was all about diarrhea with Dr. David Metz. So you can go back and listen to that episode. So our fourth question is, how are bone mets treated?

Dr. Daneng Li
So bone metastasis for patients with neuroendocrine tumors is a little bit of a conundrum. Traditionally, before we had really good technology, such as the Gallium 68 DOTATATE PET scan, in terms of identifying patients with neuroendocrine tumors and the degree of disease burden that's involved in individual patients, oftentimes, many patients bone metastasis, I would say, we're actually missed on our conventional imaging modalities. So for the most part, I think now, if someone has very minimal and isolated bone metastasis, we would say that it wouldn't necessarily change our management. We know that it's there. And if someone was recommended for, let's say, debulking surgery, then that patient would still probably proceed with debulking surgery. And if someone was recommended systemic therapy, then it's really not a problem because the systemic therapy will circulate throughout the entire body, and would also be able to target the bone metastasis as well. The time where we would consider a specific treatment for the bone metastasis itself is if it's causing, let's say, significant symptoms of pain. Or there is an area where the bone metastasis is growing, that it can potentially encroach on a vital structure, such as the spinal cord, or whatnot. And in those cases, we might also consider potentially a targeted treatment approach, such as radiation to that specific area.

Lisa Yen
That's really helpful. It's reassuring to hear that surgery is still an option for people who have bone mets because this concern comes up. And the second thing is, again, you're treating the patient and not necessarily a scan. You really are concerned about how the patient feels overall and how it might affect them, instead of just worried about a spot or a few spots on scans. So the next question is related to bone metastasis, how concerned would you be with a patient's bone marrow during PRRT treatment especially if they have bone metastases or bone lesions?

Dr. Daneng Li
So this is a very interesting question. And I would say, we really don't have much data to ultimately guide us on this. My thoughts on this is that, for the most part, neuroendocrine tumors tend to be more indolent compared to, let's say, many of our other aggressive GI cancers or even lung cancer. And what I mean by that is that even for a patient that has significant bone metastasis, they might not be symptomatic from their bone metastasis if they have a diagnosis of neuroendocrine tumor. Whereas for those more aggressive malignancies, oftentimes, a patient's bone metastasis will be certainly more symptomatic. So this tells me that most likely, the biology of the bone metastasis itself for a patient with neuroendocrine tumor is different compared to other cancers. And why is that important? Because I think when we think about bone metastasis, and how it can potentially impact a person's bone marrow, you're really then thinking about, well, what is the number of cells that's potentially required from a bone metastasis in terms of it having ultimately infiltration into someone's bone marrow, and then essentially pushing out the regular cells within the bone marrow to cause this myelosuppressive syndrome that you would be concerned about if you're treating with something like PRRT, cecause PRRT can potentially lower the blood counts in the bone marrow. And I just think that for most indolent neuroendocrine tumors, you don't necessarily see significant tumor cells pushing out the regular cells in the bone marrow. And as a result of that, I don't think you would have to be very concerned about treating a patient with PRRT in that setting. Now, that is very different for a patient that, let's say has a neuroendocrine

carcinoma or potentially a more higher grade neuroendocrine cancer that is dividing very quickly, and in those cases, a neuroendocrine carcinoma, there can be instances, especially for a poorly-differentiated neuroendocrine carcinoma, where a patient can have diffuse bone disease, and in that instance, potentially, the neuroendocrine cancer cells can infiltrate the bone marrow much more quickly, and potentially be pushing out the cells that are normally living in the bone marrow itself.

Lisa Yen
Wow, thank you for that very thoughtful response. Our next question is do tumor grades ever change?

Dr. Daneng Li
This is a great question, as well. And this is, again, something that we see fairly often in our practice, I would say tumor grade definitely can change over time. And the reason why this is, is that while were able to control the neuroendocrine tumor cells and oftentimes are able to control them in a very successful manner, there is essentially a push and pull between our treatments and asserting pressure on the neuroendocrine tumor cells, as well as the neuroendocrine tumor cells themselves trying to circumvent that pressure and try to outsmart the treatments that we are using to control the disease. So for a patient that is undergoing treatment for their neuroendocrine tumor with, let's say, systemic therapy, oftentimes they can get good control of their disease for prolonged number of years. But as that goes on, in some cases, a patient's neuroendocrine tumor can essentially try to go rogue and try to develop certain types of mutations or resistance mechanisms to circumvent the treatment that was controlling the disease. And when that happens, that's usually a time that we will see that a grade of the tumor can change. So a patient that potentially started, let's say, with a grade one, or very slow growing neuroendocrine tumor can potentially evolve into a grade two neuroendocrine tumor, and sometimes it can potentially also evolve into a grade three neuroendocrine tumor as well. So, this is really something to keep in mind. And if you do see that the biology and the overall, essentially, tumor growth over time is changing, then that could be a discussion that you might have with your treating physician to potentially consider assessment to see whether or not the tumor grade of the tumor has now changed over time.

Lisa Yen
And the follow up question to that is, how much time would it take for those tumor grades to change, if they do?

Dr. Daneng Li
I would say everyone is different. And it is very individualized. For some patients, it could be after they have gone through multiple treatments, which would encompass several years before there might be a change in tumor grade. But then, in some other patients, for whatever reason that we don't know, even right now, it could change very quickly. So certainly, we have very rarely seen patients who have only been on treatment for a year, and their tumor has changed very quickly, and they have transitioned, let's say for from a low grade neuroendocrine tumor to now a high grade neuroendocrine tumor. Again, this is a more rare instance. But this really just speaks to the fact that overall approach, as well as management, should really be individualized for the specific patient.

Lisa Yen
Yeah, thanks for that. And along those lines of individualizing care and treatment, when would you recommend doing another biopsy?

Dr. Daneng Li
I usually would recommend doing a biopsy around the time that there's a change in the overall control of the disease. So what do I mean by that is that a time to really potentially consider a repeat biopsy, could be at the time of progression of the disease on imaging. So that's usually a good time, because then what you're potentially saying is that you're really kind of possibly biopsying a patient only once every few years to really get a sense of whether or not the biology as well as the tumor grade of the neuroendocrine tumor has really changed. Now, if someone has an acute change very quickly, on imaging as well as symptomatically, then you might potentially consider a biopsy a little bit earlier. The other time to also consider a biopsy a little bit earlier is, let's say you have already established a diagnosis of neuroendocrine tumor, and you have the biology, and you get a gallium-68 DOTATATE scan to see whether or not all the neuroendocrine tumors express somatostatin receptors or not. But on that scan, you actually see that there are some tumors that don't express somatostatin receptors. I would say in those cases, you can potentially consider a biopsy of those lesions that are not expressing somatostatin receptors, because they might have slightly different grading or slightly different biology compared to the tumors that do express somatostatin receptors. And you might want to have that information to help you potentially consider possibly a combination treatment approach compared to just a single agent treatment approach that we traditionally do for our patients with neuroendocrine tumors.

Lisa Yen
Very interesting. I'm so glad that we have you on this episode so that you can answer these nuanced questions and really addressing how important it is to individualize the care. Another question is, what is the role of adjuvant therapy for NET, and if you might also explain what adjuvant therapy means?

Dr. Daneng Li
Sure. So adjuvant therapy really refers to what's known as post-operative therapy. So traditionally, adjuvant therapy is really meant for patients that have, let's say, a localized neuroendocrine tumor that has undergone surgical resection. And the overall intent of treatment was for curative intent, to essentially cure you of the neuroendocrine tumor. In that setting, just like other diseases, the question is whether or not giving, let's say, additional post-operative treatment in the form of systemic therapies will decrease the risk of recurrence, or the cancer, in this instance, the neuroendocrine tumor from ever coming back. So that's really what adjuvant therapy is meant to do. For neuroendocrine tumors, unfortunately, we don't really have data on the role of adjuvant treatment. Meaning that we don't have data to say that if you get any postoperative treatment, after curative surgical resection of your neuroendocrine tumor, that that adjuvant treatment can actually lead to a decreased risk of the cancer from ever coming back. Now, there are currently ongoing clinical trials that are trying to address this question. One specifically is trying to address this question in pancreatic neuroendocrine tumors. There's a national cooperative group trial that's looking at patients that have pancreatic neuroendocrine tumors, and that have potentially some high risk features defined by the study protocol. And for those patients, they're going to get surgery, and after surgery, they are going to be randomized to receive either capecitabine plus temozolomide oral chemotherapy versus placebo. And the idea is to see whether or not those patients that are getting capecitabine plus temozolomide would actually have a less chance of recurrence compared to patients that are not getting any postoperative treatment. I think this is an important question. I think this is a question that's going to take us a long time to answer. So outside of enrolling in that clinical trial, I would say, as of right now, we do not have any data to necessarily support the role of adjuvant treatment for patients that have undergone curative resection for neuroendocrine tumors.

Lisa Yen
Wow, that's really, really helpful. And just another kind of follow up question is, sometimes people ask, is there a difference in this decision making if the margins were shown as clean on the pathology report, or on the operative report versus margins that were not clean?

Dr. Daneng Li
Yeah, so I think that's also another very complex question. And again, this is where I think our individualized approach comes in. I think the concern for a margin-positive neuroendocrine tumor is that is there, essentially leftover cells that were left behind. And ideally, the hope is that at the time of the surgical resection, that the surgeon would have checked already intraoperatively, to make sure that the margins were clear. Now, sometimes because of the location of the tumor to surrounding vital structures, they might not be able to obtain a clear margin. And if that's the case, then I think it is a discussion within the multidisciplinary tumor group of the institution where you're being treated, to have a discussion of, is there any additional role in terms of follow up systemic treatment options or radiation approaches to the localized region to try to hopefully target any residual cells that were left in place because a clean margin was not able to be obtained. But I think that's a slightly different question, compared to the prior question, because the prior question about adjuvant treatment is really meant for a patient that has a clear surgical resection for curative intent, where you're having that discussion of postoperative treatment.

Lisa Yen
Right. Thank you for clarifying. And you already brought up clinical trials and the importance of research. And we know that you're invested in clinical trials and doing research on behalf of the NET cancer community. And you have ongoing trials. So the next question is, when do you consider clinical trials for your NET patients?

Dr. Daneng Li
So I think this is going to be a recurring theme from this podcast that we mentioned. Consideration of clinical trials, just like any other management or treatment for patients with neuroendocrine tumors, really should be individualized. What do I mean by this? Every single patient that I encounter can have very different thoughts about clinical trials and as a result of that, their approach for clinical trials will be very different. So some patients are potentially willing to try a novel experimental treatment, even with limited data, because the potential benefit of that is that they might get an additional treatment in their arsenal that they might not have otherwise, because it takes a long time for approval of different treatments for neuroendocrine tumors. So for that patient, let's say, if they have only three FDA-approved treatments, they might want to go on clinical trials relatively early, because they want to have a chance to see an agent that they might not have otherwise. And for that patient, we strategize from the very beginning to make sure that when clinical trials are available, that those patients have an opportunity to get on those trials, because a lot of our clinical trials for neuroendocrine tumors sometimes, especially earlier phase trials, might be very competitive, and they might only have limited slots are available in the United States. Other patients might approach clinical trials a little bit differently. So other patients might say that, hey, you know, this sounds good. This potentially is innovative, you have some preclinical data in cell lines or in animal studies. But, I'm the type of person that unless you tell me that there's really already some proven efficacy, I don't necessarily want to go on an experimental or novel clinical agents, until there's a lot of proven activity. And then for those patients, we would strategize a little bit differently. And we would say, we certainly understand your perspective, and therefore, we will treat you with the standard FDA approved treatments, and only go to clinical trials once you have developed disease progression through those standard treatment options. So that's really what we get to in terms of helping patients establish a timeline of when to introduce clinical trials, and how often to introduce clinical trials. And I would say, certainly my patients are very

different in terms of what they want from these two very different approaches, and this really allows us to strategize for them from day one, so that we get them the opportunities that they would want.

Lisa Yen
That's really interesting. So you start the conversation early about clinical trials. And so the last question is, how do patients or advocates find out about clinical trials and decide if that's the best option for them?

Dr. Daneng Li
I think the best way to find out about clinical trials is to just ask your physician. Do they know of any clinical trials? Or ask your local NET expert. Do they know of any clinical trials? You can also look at websites such as www.clinicaltrials.gov for a list of clinical trials, although sometimes that list can be somewhat exhausting, as well as not necessarily fully updated. Sometimes, on that website, there will be a list of institutions where the clinical trial is going on. I think my information on some of those trials are listed on those websites where if there's a particular trial that you're interested in, you can email us or call us to say, hey, are there available spots that's available for this clinical trial? Can I get a consultation to discuss the clinical trial? And we can certainly arrange that usually. You will have to have a visit to see whether or not there are availability of those clinical trials, or whether or not you're eligible for clinical trials. But those are the different ways to figure out. At the end of the day, I would say for clinical trials, it's all about timing, because there's oftentimes a lot of movement between these clinical trials, especially the earlier phase trials. So it's just really important to check fairly frequently with your either local experts or go on www.clinicaltrials.gov and email different sites that have the clinical trials to say, hey, where are you on this clinical trial? Are there spots left? Because sometimes for these earlier phase trials that can change relatively quickly.

Lisa Yen
Thank you for that. Thank you for answering all these questions. As you said, there's been this theme of the importance of individualized care. The importance of treating the patient, not numbers of scans. Considering clinical trials and the timing is important. And of course, patient preference is important. And the importance of talking to your physician. There needs to be open conversation and discussion that's customized to patient preference. Thank you so much for all your time, for all your service to the NET cancer community, and for all that you do for LACNETS and the whole community as a whole. It's great to have you here with us today.

Dr. Daneng Li
The honors all mine, Lisa. Thank you for having me, as well as LACNETS, for supporting our community, not only in Los Angeles, but also broadly, globally these days. I think it's a lot of important work that you guys are doing, advocating for patients and raising awareness, as well as knowledge, so that patients are empowered in their treatment decisions for their treatment for their neuroendocrine tumors.

Lisa Yen
We couldn't do it without you. We definitely make a great team together. So thank you for all you do. We're really grateful for you.

Dr. Daneng Li
Sure, happy to be playing a little part in this role.

Lisa Yen
Thanks again for joining us today.

Dr. Daneng Li
Thank you so much.

Lisa Yen
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