“Treatment Options Review for Advanced Prostate Cancer Patient Mike Yancey” (Mike Yancey) [#27]

Brad Power and Mike Yancey
September 28, 2022

“My cancer is very aggressive. I have PTEN loss and mutations in the RB1 and the TP53 genes. Those three together are known as tumor suppressor genes, and if you have any two out of three, that's considered an aggressive variant. And I got three out of three. Lucky me.” Mike Yancey

“RB1 is one thing to look at and study, but we have to include PTEN and TP53, and look at the signaling pathways, and what drugs are available that can begin to impact them. A lot of the drugs that we're going to look at today haven't been tested in prostate cancer; they've been tested in other cancers and shown some benefits for some of these pathways. And of course, when we start mixing multiple drugs, we get back into the bigger issue of no clinical trials and no dosing information.” Mike Yancey

Meeting Summary

In this meeting, advanced prostate cancer patient Mike Yancey discussed (1) his medical history, (2) the treatment opportunities and challenges he is facing now, and (3) his testing and treatment strategy. Mike has an aggressive prostate cancer driven by some key mutations that he believes needs to be treated with an equally aggressive drug combination.

1. Medical History

Mike Yancey had been diligent in getting an annual physical and having his PSA tested. In July 2021 his PSA rose to 2.4, and he was diagnosed with metastatic prostate cancer. He had metastases in his bones, which made it difficult to walk. Because at diagnosis he was already metastatic, the standard of care treatment skipped surgical removal (a prostatectomy). Instead, he immediately started taking a male hormone (androgen) deprivation drug (Lupron) and a chemotherapy agent (docetaxel). He finished this line of treatment four months later (in November 2021). It caused his PSA to reach its lowest point (0.07). He also received pelvic radiation – not focused on a cure, but for his bone pain.

In February 2022 Mike and a doctor he was seeing discussed a study he had seen that showed that another hormone therapy drug (abiraterone) was effective after the chemotherapy he had taken (docetaxel). The doctor suggested Mike take it since it would not hurt anything, and in April 2022 he started taking it. He has not seen a lot of impact from it, but his current oncologist confirmed that he should continue taking it because she felt that it might be doing some good. (Brian McCloskey challenged that advice since patients with one of Mike’s mutations – RB1 – are known to be resistant to abiraterone, and it is likely to have a low or no response. “This is the definition of a lack of precision medicine, and the flip side is that there are consequences of taking any drug.”)

“Treatment Options Review for Advanced Prostate Cancer Patient Mike Yancey” (Mike Yancey) [#27]

In March 2022 Mike’s PSA began to increase slowly. He was concerned, but his local oncologists told him not to worry since the PSA increase was small and under 1.0.

In May 2022, still concerned and feeling a recurrence of bone pain, this time in his shoulders, he consulted with a new oncologist in Houston who determined that his cancer was a very aggressive type. Testing revealed mutations in three key “tumor suppressor genes” (PTEN loss, and RB1 and TP53 mutations). If someone has mutations in any two of these three genes, then the cancer is designated as “Aggressive Variant Prostate Cancer”. In his case, he had mutations in all three, which only 1% of prostate cancer patients have. Patients with this profile do not respond as well to many of the standard prostate cancer drugs, such as the ones he had received. Usually the cancer is held back for up to two years, but in his case it was only four months. He also learned that his cancer does not express much PSA, another common trait of this aggressive form, which is why they didn’t catch his prostate cancer earlier.

Mike got a scan that looks for a protein (Prostate Specific Membrane Antigen - PSMA) found on the surface of prostate cancer cells. It lights up throughout the body where it finds the protein, which confirmed his cancer had spread from his pelvis, spine, and right femur into his shoulders. He had an unusually high expression of PSMA (30 to 40 standardized uptake value vs. a median of 8.8, ranging from 2.1 to 62.4), which indicated he would be a good candidate for a newly approved therapy that combines a radioisotope that binds to PSMA to deliver radiation directly to the cancer (Pluvicto). Due to production issues with this new therapy, initial treatment was delayed a month; during this time his bone pain got so bad that he was prescribed a steroid. When he finally got Pluvicto in early August, it eliminated all bone pain, and he was able to resume his daily regimen of walking. He completed his second treatment round in mid-September 2022. His PSA had crept up again between July and early September. He is scheduled to have a new PSMA-PET scan in late October to see what impact the Pluvicto is having.

Mike has had a liquid biopsy, which showed two additional minor mutations in addition to the six that his bone biopsy report showed and were part of the input provided to the companies offering treatment option information. His plan is to have a liquid biopsy every six months to see what, if any, new mutations appear. He has never had a tissue biopsy of his prostate. His oncologist does not feel that the infection risk and discomfort is worth the benefit. (The meeting participants pushed for a biopsy of his prostate, given the potential information benefit.)

2. Current Treatment Opportunities and Challenges

The primary purpose of our conversation was to figure out what Mike should do after he completes his current line of therapy with Pluvicto.

Since cancer is heterogeneous, Mike wonders how much of his cancer does not express PSMA, and therefore will not be impacted by Pluvicto. And since his aggressive type of cancer had a relatively brief response to his previous line of therapy, how long it will be before the cancer comes roaring back this time.

“Treatment Options Review for Advanced Prostate Cancer Patient Mike Yancey” (Mike Yancey) [#27]

Besides the recommendations from his medical team, Mike has received information on treatment options from Foundation Medicine, which did his gene sequencing; Massive Bio, which identified several clinical trials; and CureMatch, which provided several three- and two-drug combinations of FDA-approved drugs. He has a total of 17 treatment options to consider, of which he has ranked 8 on a short list. (Please see his spreadsheet and discussion for more on his treatment options.)

The only standard treatment option is the use of another chemotherapy (cabazitaxel and carboplatin), which would take about four months for the treatment cycle, and assuming the durability is equal to the four months experienced with his other chemotherapy (docetaxel), in eight months he will be out of options. He obviously needs other options.

3. Testing and Treatment Strategy

Mike plans to have PSMA-PET scans done in the next few weeks, prior to his third round of treatment with Pluvicto, and then do them again prior to the fifth round of treatment, and a final set of scans after he has completed the Pluvicto treatment course (the sixth round of treatment). If Mike is not having much success, which he doesn't expect, he may discuss whether to continue with Pluvicto. He knows that some people have taken Pluvicto and had very little response, and they've stopped.

Mike’s treatment strategy depends on understanding the signaling pathways associated with his key mutations, and what drugs are available that can impact them. A lot of the drugs that are on Mike’s list of treatment options have been tested with other cancers and shown some benefits, but haven’t been tested in prostate cancer. Some of these drugs are pretty toxic.

Mike’s research has convinced him that his unique aggressive combination of genomic mutations (PTEN loss, RB1, and TP53) calls for multiple therapies at the same time to attack multiple signaling pathways, rather than the traditional application of single agents, or serial application of single agents. Therefore, the drug combination treatment recommendations from CureMatch are at the top of his list. However, he is facing the challenge of convincing his treating physician, or finding a new one, to prescribe personalized, novel treatment combinations that are off-label, overcoming concerns about toxicity, reimbursement, and liability, when there are no randomized clinical trials that have tested these combinations.

“Treatment Options Review for Advanced Prostate Cancer Patient Mike Yancey” (Mike Yancey) [#27]

Treatment Options Walkthrough

Please see Mike’s treatment options spreadsheet to accompany this discussion.

Mike has identified 17 treatment options, 8 of which he has ranked on his short list because they stood out as having a higher probability of success. His ranking builds on what he found out about the treatments, such as the use of Everolimus, recommended by Foundations Medicine.

He has noted for each treatment the organization which recommended it. Most came from CureMatch, with a few from Massive Bio and from Foundations Medicine. He also added a couple of clinical trials for Ipatasertib that were of interest to him that he found in doing some other research.

Beginning at the top of his spreadsheet, the first two recommendations are from Foundation Medicine, which did somatic testing on his bone biopsy that was taken in July 2021. They recommended two possible monotherapy drugs, Everolimus and Temsirolimus. Further research that Mike did revealed that these drugs, when used alone, have not provided much of a response, therefore these two were not ranked as part of his preferred options. These two drugs also are very toxic so significant caution is needed in their use.

As we get further down his list to some treatment combinations recommended by CureMatch, you will again see the drug Everolimus, but with their recommendation it is used in conjunction with one or two other drugs.

The third treatment option on his list is a chemotherapy-based, “Standard of Care” option. This treatment is a combination of Cabazitaxel along with Carboplatin, where the platinum element has shown to have some better benefit with Aggressive Variant Prostate Cancer. However, the durability is going to be short, probably three to four months in his case after you have finished the 18 week series of treatments. So this is a decision of doing another chemotherapy with a relatively short durability along with the side effects, which he admits he is a little vain, but the hair loss for incremental benefit does not bring this high enough to rank.

Next are the recommendations from Massive Bio. There are 3 clinical trials they suggest. The first is Bipolar Androgen Therapy (BAT) coupled with another radioactive treatment called Radium 223. Radium 223 does nothing towards the primary cancer in the prostate, but impacts the bone mets. BAT holds interest to Mike, however the testosterone injections coupled with his very aggressive cancer and potentially having his cancer take off and grow very, very quickly, presents significant concerns, as it would take some time to minimize the testosterone in his body. As many have stated, it might be like “throwing gasoline on a fire”. So, even though he does not have it ranked in his preferred list of possible treatments, there is still a lot of interest in this option.

WIth respect to this treatment and Brian’s question as to whether Mike has AR copy number gain, Mike does not know. It definitely was not listed in his Foundations Medicine bone biopsy

somatic testing report, nor the report for his liquid biopsy. Brian understands that having the TP53 mutation along with AR copy number gain might point to potential benefit from BAT.

Two additional clinical trial recommendations were made by Massive Bio, but based on a review meeting where Mike provided more clarification on his situation, it was determined he is not a candidate for either of these two trials. One is a combination of Enzalutamide and Rucaparib, providing an AR inhibitor along with a PARP inhibitor, while the other is a combination of Cabozantinib and Atezolizumab which targets PD-L1 expression.

Now we are down to the CureMatch treatment recommendations beginning with numbers 7 thru 9. At this point he has provided his ranking assessments. He has ranked the first CureMatch treatment as number 1. When CureMatch provides possible treatment matches, they also give each treatment a match value or score. This first one has a match value of 67, which according to Ally Perlina of CureMatch is quite high. On average they find matches somewhere in a range around 33%. So this match is double the normal average, and based on their research and looking at Mike’s mutations, this drug combination may have a positive impact. This treatment option is planned to target the AKT2 pathway via mTOR as well as the PTEN loss using the drug Everolimus, which we looked at a few minutes ago as a monotherapy recommended by Foundation Medicine. Also the drug Ponatinib is expected to target both Mike’s SRC mutation as well as TP53, using the FLT1 gene and KDR gene. Last is the use of Pembrolizumab targeting PDL1 overexpression via the PD-1 pathway. This is his top ranked treatment, but there is significant potential toxicity possibilities individually which is increased with the use of multiple drugs. So most likely it would require some slow experimentation to see what level of dosages a person can use safely.

As Brad Power mentioned, this toxicity concern with drug combinations has been a recurring theme. However, he has been introduced to a doctor at UCSD, Mina Nikanjam, who is a specialist in dosing strategies, which may help address this concern.

The next CureMatch recommendation is number 8 on the list, and Mike’s ranking as the number 2 treatment of interest. This one also has a high CureMatch score of 65%, so once again a very high potential for benefit. This drug combination is very similar to number 7, which we just looked at, but makes a slight change by using Bosutinib in place of Ponatinib. Where Ponatinib targeted both his SRC mutation as well as TP53 using the FLT1 gene and KDR gene, Bosutinib is targets only his SRC mutation. Based on some further research Mike did, and may not be entirely correct, Bosutinib has less significant toxicity as compared to Ponatinib. So potentially an option to reduce some toxicity concerns but retain a high probability of benefit.

The next treatment option is number 9, which Mike has ranked as number 3. Similar to option 8, this treatment option is the same as Option 7, but substitutes Ponatinib with Nintedanib and also carries a relatively high CureMatch score of 63%. Much like Option 7, Nintedanib targets the SRC mutation as well as TP53 using the FLT1 gene and KDR gene. This treatment option also retains the use of Everoimus and Pembrolizumab.

“Treatment Options Review for Advanced Prostate Cancer Patient Mike Yancey” (Mike Yancey) [#27]

Mike has ranked these three drug treatment options (7, 8, and 9) as his top 1, 2, and 3 choices.

Now we move to two-drug combinations recommended by CureMatch. Number 10, which Mike has ranked as his number 4, still carries a CureMatch score of 59%. It retains the Everolimus and Pembrolizumab that were part of the three drug options 7, 8, and 9. This treatment option is planned to target the AKT2 pathway via mTOR as well as the PTEN loss using the drug Everolimus, and the use of Pembrolizumab targeting PDL1 overexpression via the PD-1 pathway.

Next is number 11, which Mike has ranked as number 5 with a CureMatch score of 58%. In comparison to number 10 which we just looked at, it retains Pembrolizumab while removing Everolimus and adding Ponatinib, which was part of option 7 for the three-drug combinations.

Number 12, which Mike has ranked number 6, is also a two-drug combination with a CureMatch score of 56%. This mirrors number 11, which we just looked at, retaining Pembrolizumab while substituting Bosutinib in place of Ponatinib.

Next we have 3 one-drug treatment recommendations from CureMatch, numbers 13, 14, and 15. Mike did not rank these because once again he feels confident that with his particular aggressive cancer, the one-drug options are going to do very little; he feels strongly that any benefits will only be achieved with multi-drug treatment options, so his preference is for the three-drug recommendations.

Numbers 16 and 17, the last two on the list, are two clinical trials he found online while doing some research. These trials are testing the drug Ipatserib with number 16, which he has ranked at number 7, coupled with Abiraterone, and number 17, which he has ranked as number 8, coupled with Atezolizumab.

Mike is currently taking Abiraterone, but some preliminary trial information, particularly in patients with PTEN loss, shows that median radiographic progression free survival is 19.1 months versus 14.2 months using Abiraterone alone. This potential treatment is targeting the PTEN and AKT pathway.

The last one, number 17, which Mike has ranked number 8, uses Atezolizumab with Ipatserib targeting the AKT pathway. He does not know a lot about this trial other than the prime target is the AKT pathway.

Mike is expecting, but has not yet received any recommendations from Cancer Commons because Emma Shtivelman is in agreement that Pluvicto is the best treatment option at this time, and as we have already discussed, seems to be providing positive results. She wants to wait until Mike has completed Pluvicto and another round of tests, then provide some treatment options to use going forward.

“Treatment Options Review for Advanced Prostate Cancer Patient Mike Yancey” (Mike Yancey) [#27]

Johnathan Starr asked whether stereotactic body radiotherapy (SBRT - precisely focused radiation beams) could address Mike’s bone metastases. Mike responded that he is completely covered with lesions, including his spine, pelvic region, right femur, and more recently left clavicle and right shoulder. When he was first going to have pelvic radiation to address his bone pain, the first words out of the radiation oncologist’s mouth when she looked at the body scan was, “Well, that is not normal.” So he knew he was in trouble.

Jonathan Starr also asked whether Mike is considering Provenge as a treatment option. Mike responded that he will most likely need to determine that he is interested in pursuing this, as his oncologist in Houston is definitely not interested. However, his local oncologist who has been administering the Pluvicto seems much more open to using that if he decides he wants to pursue it. Brian McCloskey added that his oncologist, Rana McKay, is considering the use of Provenge after he has had his surgery in November. Typically patients do not get a PSA response, but it can sometimes be helpful in keeping the tumors in check. Provenge shows some longevity benefits.

Johnathan Starr also recommended Mike consider a new oral chemotherapy drug, Sabizabulin, also known as VERU-111. It is an anti-tubulin with few or mild side effects compared to what we normally call chemotherapy. It is in Phase 3 clinical trials for prostate cancer, but it has also been found effective for Covid. It was rushed through approvals for Covid, so perhaps shortly it might be available and could be given consideration as an off-label treatment option.

“Treatment Options Review for Advanced Prostate Cancer Patient Mike Yancey” (Mike Yancey) [#27]

Meeting Notes

SUMMARY KEYWORDS

drugs, cancer, oncologist, treatment, mutations, scans, option, pathway, variant, point, rb1, months, psa, pretty, fact, liquid biopsy, ranked, pain, pdl, case

SPEAKERS

Mike (57%), Brad (16%), Rick (13%), Jonathan (7%), Brian (7%)

Mike Yancey
0:00
I just want to go through this spreadsheet of treatment options.

Brad Power
1:22
Could you please take a step back and introduce yourself and your medical history before we jump into the treatment options you are considering?

Mike Yancey
1:33
I'm Mike Yancey. I was diagnosed in July of 2021 with de novo metastatic prostate cancer and immediately started treatment. At that point in time, I didn't know anything. I've learned a lot since then. But I was immediately put on Lupron as well as docetaxel chemo. I finished up my docetaxel on November 29 last year. We did the blood test then, and my PSA was at its lowest at .07. However, by March, it already started to increase slowly. And that concerned me and I actually voiced my concern to a couple of oncologists. And they said, “Don't worry about it. It's so small and still way under one.” And that's when I ended up getting with a new oncologist down in Houston. She had me get some tests, which determined that I was much sicker and my cancer is very aggressive. I got the primary mutations, which is a lot of what has been focused on here with these treatment recommendations. I have PTEN loss. And then I've got mutations in the RB1 and the TP53 genes. And those three together are known as tumor suppressor genes, and if you have any two out of three, that's considered an aggressive variant because I got three out of three, lucky me. And so anyway, having finished docetaxel, I was put on abiraterone in April, and I really haven't seen a lot of impact from that even though I am still taking it. And then of course, the primary thing that up to this point in time that we're doing is I started to Pluvicto which, of course is a radioisotope radiation. I started that in August on August 8, I think it was, and I just finished my second treatment last Thursday, and so far from the

perspective of any pain, etc., it eliminated almost all of that. And with respect to my PSA, once again, it has creeped up a little bit more, since I had my test done in July. And so we're gonna have a scan on October 20. And we'll get a better picture PSA scan. And so hopefully we get a better picture as to what impact the Pluvicto was actually having on cancer from the original scans that were done back in July.

Brad Power
4:21
If I could just summarize back if I remember the highlights, when you were diagnosed, you were immediately metastatic. And so you skipped the prostatectomy, which is what for many other prostate cancer patients is step one. And the other thing is you metastasized into your bones. And so you had bone mets and you had a lot of bone pain. So one of the effects was you really had difficulty walking, mobility issues. And so the Pluvicto is the first therapy you've taken. I wanted to get a sense of how you felt through the different treatment regimens you've had. How many lines of therapy have you had?

Mike Yancey
5:11
I've had, of course, Lupron, ADT, and then I immediately had chemotherapy at the same time, and also had pelvic radiation whose initial purpose was not really focused on the cancer itself, but to relieve the pain issues I had. And so I had that when I started, I had the chemotherapy almost simultaneously, and that really did knock down the cancer and help a lot while I was taking chemotherapy, which ended like sitting at 29 and was doing pretty good starting to at least rebuild my strength. Then we found in March that my PSA was beginning to creep up even though it was still you know, sub one. And that's when I got with a new oncologist. She was able to determine that my cancer was characteristic of an aggressive variant oftentimes is that cancer does not put out much PSA, which gets back to a lot of the reasons why we were never able to catch it. Or even though I had an annual physical and an October before diagnosed in July, my PSA was only 2.4.

Brad Power
6:34
How has your bone pain been relative to those treatments? Did you know when your cancer was knocked down by the chemo? Did it also reduce your bone pain?

Mike Yancey
6:49
Yes, the combination of that and the radiation eliminated pretty much my bone pain for a period of months. I did start to get quite a bit more bone pain beginning in May. In fact, I had bone pain when I went to my new oncologist in Houston. It was in my shoulders at that point. And that's when we did the PSMA scan which confirmed it. Indeed, it had spread beyond my pelvis, my femur and my spine to my shoulders. And that's when we decided on Pluvicto and because of the Pluvicto issues with respect to production, etc. It was delayed. I'll say a month because we originally were looking at July, and it was delayed till August and my bone pain got so bad that I

ended up taking some steroids that helped to push the bone pain back while I was on a trip. Since I got back from my trips when I started Pluvicto and so far with Pluvicto has eliminated all pain. I've started my four miles every morning walking with no problems whatsoever. We're under the assumption that it is doing what it was intended to do, which is knocking back the cancer. And we will confirm that with the scans on October 20.

Brad Power
8:05
For those who don't know about Pluvicto, it targets the PSMA, the same PSMA that you get in the PET scan to find out where the cancer has metastasized. It's the fact that you had a PSMA-PET scan and it said you lit up in all these places that makes you a good candidate for Pluvicto because you know you're presenting a lot of PSMA. How did you arrive at the selection of the Pluvicto? Or was that something you picked up from this group? Or had you gotten it from another source? And when you recommended it to your physician, was there any immediate reaction?

Mike Yancey
8:49
The tests that were done in Houston, confirming that I have an aggressive variant. I'd already started abiraterone around a month and a half before I met her. She decided that Pluvicto was the next best option because this particular cancer is known not to respond to the variety of drugs there. So therefore, things like Abiraterone just don't seem to be responding to that. When most patients get chemotherapy with the so-called normal version, a lot of times you can take the chemo, the docetaxel, and it'll knock the cancer back for maybe up to two years where in my case, which about 1% of people have, I got four months. And so at this point in all honesty, with the standard of care after I finished the Pluvicto, and the fact that we're Pluvicto is currently not approved to do a second time, the only option we've currently got on my plate will be cabazitaxel with carboplatin. And once we do that – it'll take about four months to get through the treatment cycle with that, and then assuming that it works pretty much like the other chemo did, I’ll have about four months after that, and then we're out of options. So that's why these treatments that we're going to look at today are of interest.

Brad Power
10:18
It's interesting that one of the things that Michael Liebman pointed out was, it's important to segment the kind of cancer you have at the outset, which can often come from pathology. But it seems like you've almost got a situation like women who have triple negative breast cancer – it's like you've got triple positive on these three markers. And those came through gene sequencing. And so once you're in that category, it sounds like that really steers you to some treatments that are likely to work and those that aren't. But it's very important to have that first. Those three markers are critical for indicating what will and won’t work among treatments.

Brian McCloskey
11:09

“Treatment Options Review for Advanced Prostate Cancer Patient Mike Yancey” (Mike Yancey) [#27]

You have a pretty aggressive cancer as we just mentioned. RB1 is particularly tough, and it is known to be resistant to Abiraterone. Why did the doctors decide to give you Abiraterone? I'm assuming that they knew that the likelihood that it would respond would have been low?

Mike Yancey
11:38
Well, let me let me let me back up just a bit. I started Abiraterone, basically, when I actually saw a doctor in February, who are no longer in a patient of and I brought up the peace study the peace one study with with him and the fact that it had been sown. And that was actually before I got my somatic testing done on the DNA. But the piece one study has shown that it can be very beneficial, you know, following docetaxel, etc. So, he basically suggested that go ahead and start taking so it definitely would not not hurt anything. It did take me some time to find that particular drug because I wanted Medicare Part D and I wasn't clairvoyant. So therefore I didn't know Abiraterone may be one of the drugs that might need to take in the future. For I ended up with a drug plan that doesn't cover Abiraterone very well. And so it took me about a month to find find it where it was at a price that I was willing to pay. And so that's why there was a lag between February and April. And then of course when I saw my oncologist in the new one that I had in May. They basically were okay with me continuing Abiraterone and in fact, I just saw them two weeks ago, two and a half weeks ago and asked should I continue the Abiraterone and basically she was told she told me that I should go ahead and continue taking it even though initial indications are he was not doing much. But her response was that she felt like it might be doing some good just not enough that we can actually measure that.

Brian McCloskey
13:12
This is the definition of lack of precision and precision medicine. But I also think about the flip side of it is that there are consequences of taking Abiraterone. I'm on Abiraterone. And so, you know, this is a case of why take a drug, if it's not going to do anything? RB1 is resistant to abi. There's this proclivity to give drugs, just so that the doctor is doing something. But knowing that it may, in fact, not do a whole lot. You know, this is a bit of a conundrum.

Jonathan Starr
14:12
Regarding the RB1 mutation, does that also mean that the Enzalutamide and Darolutamide will also not work?

Mike Yancey
14:32
Most likely that would be correct. I think that's true, Jonathan.

Jonathan Starr
14:40
Really good points about the incentive to just offer something. If you are offering something then you're doing your job.

Brad Power
14:49
It’s very defensible to do something that's within the standard of care. The moment you start to get personalized, it starts to get more fringy and off label and potentially liability issues might be concerns.

Jonathan Starr
15:11
All right. All right, but you're not sure about whether or not the Enzalutamide or apalutamide would also not work.

Brian McCloskey
15:20
I'm pretty sure it doesn't work. I know that abi does not. And there's similarity across all those drugs.

Mike Yancey
15:36
The RB1 is going to pretty much prevent all the AR drugs from working.

Brian McCloskey
16:02
To cross the t's and dot the i’s on this one, because RB1 is a difficult target to treat, we should really be thinking about what the available options are to treat it. You're taking Pluvicto, and that probably shouldn't work, but to a certain extent, that's where we should be focusing a lot of our efforts.

Mike Yancey
16:28
That's part of the challenge with any of those three mutations without God pretended mutation, it's just a flat loss. The issues are, really, you really get into the signaling pathways, etc. And that's where it begins to get very murky. And, of course, I'm not enough of a cellular biologist to fully understand everything I've been studying. But for example, PTEN. Really it affects the Pi3K signaling pathway. And so far, a lot of the drug efforts towards coming up with a solution that addresses that PTEN pathway has come up very, very short. And what I have found is that it's better to start looking downstream, if you will, at some of the other pathways such as AKT and mTOR, which is a lot of what we're going to find the recommendations here. I have that we're trying to address those pathways further downstream.

Rick Stanton
17:35
I didn't know about this prior to this conversation. I just started Googling RB1. And this was the first article that came up and looks like something that I'll try to read. I am familiar with tumor

signaling to a degree. I'll be looking into LSD1 inhibition, and see if there's any hope there, or what the article has to say.

Mike Yancey
18:23
RB1 is one thing to look at and study on, but really we have to bring the PTEN as well as the TP53 into the conversation. There's some commonality in a lot of cases, but all it gets back to the signaling pathways, and what drugs are available that can begin to impact those and a lot of the drugs that we're going to look at today haven't been tested in prostate cancer, they've been tested in other cancers and shown some benefits for some of these pathways. But prostate cancer really hasn't had testing done with these particular drugs, and of course, then we start mixing multiple drugs, then you get back into the bigger issue, you know, without any clinical trials, etc., no dosing specific information, etc. So it's really up to the oncologist or whatever to make those decisions and determine how to go forward, as well as be able to monitor use so that when we do get significant adverse events when some of these drugs are pretty toxic, how do we respond to those so those are some of the challenges that we have?
I'm now at Houston Methodist in Houston.

Brad Power
I recall, and maybe Brian can speak to this, the PTEN and TP53 were variants that Bryce Olson had. And if I recall PTEN is very common, but they don't have a lot of drugs for it?

Mike Yancey
20:15
PTEN is in about 50% of the very aggressive variant cancers. You're right: there's not a lot of drugs that that really work on that because that gets back to that PTEN pathway. With PTEN loss you see this cancer migrate towards being neuroendocrine, which is even worse.

Brian McCloskey
20:44
That’s true for RB1. Bryce has those two mutations as well.

Brad Power
20:54
How has that influenced his treatment? It seems to me that it meant in his case that some things that he might have tried, you could have predicted wouldn't work. When he tried the radionuclide, like Pluvicto, it was predictable that he might not respond well, and he didn't. So that is, do you recall how those two mutations influenced Bryce's treatment choices?

Brian McCloskey
21:23
I believe he was taking a PARP inhibitor for PTEN. But don't quote me on that. I don't remember the correlation between all of his mutations in his treatment, so I wouldn't want to misspeak there.

“Treatment Options Review for Advanced Prostate Cancer Patient Mike Yancey” (Mike Yancey) [#27]

Brad Power
21:39
To make an underline, Mike, having a conversation with Bryce would be useful, because he's really smart about all this stuff, because he's been at it for so long. And he's very articulate. And he also has a couple of the same variants of significance.

Brian McCloskey
22:00
To add one more point to that, it would be interesting to know whether or not that is successful with patients who have RB1. It's a question to ask.

Mike Yancey
22:18
And one comment I'll make with respect to the public. Of course, in my case, based upon my PSMA-PET scans, my uptake was very, very high. I was in like, the 30 to 40 range. And so that is way up there, a lot of times you'll find uptake being in you know, 10 or less. So that that did indicate that we would have some success. Another question I've got and have asked is Okay, so we're potentially going to be successful and knocking back from this cancer, it's pressing psi, which is good. But how much cancer do I have that does not express PSMA, which Pluvicto is not going to impact the other thing. And expectation in my mind, and this is why when I asked a question that I have not had any medical folks argue back with me is my expectation is that I will finish Pluvicto treatment in March, and that by July, the cancer will be roaring back once again. And that's when the last standard of care option is cabazitaxel with carboplatin.

Brad Power
The purpose of the conversation we're having today is to figure out what you do after Pluvicto; trying to help you figure out what your next best treatment option is, knowing full well that as Brian has experienced, especially when we start talking about drugs that have not necessarily been clinically tested for prostate cancer and the fact that you're mixing multiple drugs and finding medical folks that will line up with you and assist you in in trying some of these new things is going to be a challenge. Rick and I had a conversation just this week with Dawn Lemanne, who is an integrative medical oncologist who is working closely with Bob Gatenby, whom we love and has the heterogeneity, adaptive therapy, evolutionary biology approach. She may be someone who could advise you. Rick is proceeding on becoming a patient of hers. I've encouraged Brian to have a conversation with her as well. So that might be a way for you to get to a treating physician who's willing to prescribe more off-label types of treatments.

Rick Stanton
25:21
She doesn't take insurance. She charges $10 a minute,for her time. So she's $600 an hour. Which is expensive, but I'm willing to step up for an hour or two and I think it's probably well spent. She's integrative. So she is an expert. Her credentials are super. And we talked for half an hour. She seems great. So I look like I'm very similar to you, Mike, because I'm starting, I'm

doing a PSMA scan Friday. And I'm starting Pluvicto on the 13th. And I'm on Abiraterone as a bridge right now. And this has to be something that Jonathan would say, I'm taking something probably that is not going to help. But I'm hoping I'm one of the 10% or 5%. What you're saying Mike is resonating with me, and probably all of us here.
Dr. Lemmane offers a complementary perspective and something that I can do through diet and exercise, and maybe some other, I won't say, alternative drugs, but drugs that would be complementary to what I would get from a comprehensive cancer center, running down the NCCN guidelines. So I'm going to sign up. Let's do everything we can do. I think we all understand that just taking a few drugs alone is not going to do it. It's not going to save us. And by doing everything we can we might extend our lives.

Brad Power
28:01
Maybe you should walk us through your spreadsheet here and talk about some of the options you've seen and what your priorities are and what your shortlist is. First of all, how many do you have in total?

Mike Yancey
28:24
It looks like I have 17. Much like Brian.

Brad Power
28:31
17. Most of those came from CureMatch. Others from Foundation Medicine, Massive Bio.

Mike Yancey
28:44
Correct. Those are the primary ones. And I found a couple towards the bottom, which is having to catch my eye based on research and study that I had, which is I've had pets, pets a rib, which has some clinical trials right now. But if you'll as we go down through here, you'll see the ones that are ranked, there's many not ranked at all, but the ones that are ranked include that Petzl rib, as well as the cure match option massive by Foundation Medicine. I didn't even didn't even bother to try to
MY
Mike Yancey
29:15
split hairs and rank those

Brad Power
29:18
And are these in rank order? Are they any kind of order?

Mike Yancey
29:23

Basically, it's just as far as the flow through the spreadsheet you got by the recommending agency. I started with Foundation Medicine, but then I ranked them in order further down based upon the ones that I specifically did rank.
We can take the first one everolimus I guess he does as well the second one which is Test, test roll Ms. Both those are foundational tests and based upon my DNA analysis, if you will, but once again, what's been found with the These particular two drugs by themselves in the monotherapy, they've not not provided a lot of response. And so therefore, I have not ranked these two. As we get on down here in a moment, we'll see CureMatch also has those drugs recommended, but in conjunction with some other drugs. So I think you know, once again, their perspective is that by themselves, it may not work well. But when you combine it with some other things, you might have a better response. And so we'll talk about that in a moment. So my number is number three. And number three, of course, is just, as I've already stated to you capacity taxes with carboplatin, which Foundation Medicine also was one of their recommendations, but that's basically a standard of care option. And at this point in time, the expectation and the knowledge that I've had is that that would work very much like docetaxel, even though I will admit with aggressive variant, the carboplatin, the platinum element of that has shown to be somewhat responsive, if you will, with respect to not in cancer back. But once again, the durability of it's gonna be very short, probably three or four months, in my case is all it's going to do. So it's a matter of, you know, are you even interested in doing another chemotherapy, I'm a little vain, maybe, but lose my hair again, and for no more than, you know, a few months. So that's why it's not ranked at all, it's something the standard of care world is my only option going forward. But hopefully I can think differently between now and then. The next option comes from Massive Bio. And that was a bipolar antigen therapy in conjunction with another radio nuclear nucleotide, which is radium 223. Now radium 2.3 really does nothing towards the primary cancer in the prostate, which, as you've already mentioned, Brad, I still have mine, I've never had a biopsy of it. My current lead oncologist does not want to do a biopsy due to a she puts at risk. So all my boxes to date and the DNA that Foundation's done did came from my bone biopsy that was done in the hospital a little over a year ago. But via bipolar engine therapy, this particular clinical trial recommendation but massive bio, it interests me, however, saying that, based on my studies and what my limited understanding can bring together, I'm not sure how successful it might be in I think there's a lot of risk with it being as some put it throwing gasoline on the fire, and especially with this aggressive variant that I've got. So even though it interests me very much, I'd love to try it. Getting shot up with with a high dose of testosterone and having a cancer take off very, very quickly and grow very, very quickly. In that being get the testosterone editing system quick enough good could end up with some results, but I'm not interested in seeing

Brian McCloskey
33:12
Do you have AR copy number gain?

Mike Yancey
33:15
Not that I know. Okay. We I think you

“Treatment Options Review for Advanced Prostate Cancer Patient Mike Yancey” (Mike Yancey) [#27]

Brian McCloskey
33:19
should probably try to try to get a handle on that. Because as far as I know, those are the two indicators for positive responses t 53. And AR copy number again.

Mike Yancey
33:31
How do you do that? Brian? Because I'm you're you're giving me information, I don't have a clue on how to find out.

Brian McCloskey
33:38
So it would come from a sequencing report. So we should probably go back to Foundation to see if they have that information or if it actually is in your report. I can't remember if it is Mike.

Rick Stanton
33:57
This is something that is not always included in the report. So, you know, from over expression, from RNA seq data to copy number gain, not always included, especially from Foundation, which is a very streamlined glimpse of sequencing. They're known to be very streamlined in their reporting. Meaning it would be easy that you have AR copy number gain, but there's been reported, it would be easy that you had other significant variants that just are not reported. So you may have to dig a little deeper. I think you should have RNA seek because the copy number gain is the precursor for over expression. of AR. So that's all that copy number gain. And, you know, you can infer that, well, if you have a bunch of AR copy number games, then you're probably making you know more AR, but you could also get that from RNA seek, which would be a more direct view. One step more towards the actual, am I making a lot more AR?

Mike Yancey
35:34
I'm trying to work onit. It's going slowly, I will admit, but I'm trying to get the Tempus XA right now.

Rick Stanton
35:40
I don't know why you wouldn't get a biopsy of your primary tumor. I have no idea why that's risky.

Brad Power
35:53
We are such gluttons for anything that gives you more data to guide your treatment, the notion that you wouldn't take advantage of a biopsy, which Brian just went through and essentially demanded needle biopsies. And he's also leaning into met surgery, which is going to harvest a

bunch of more tissue that he can do various tests on. Maybe your clinician is conservative, because they don't value the insights you can get from analyzing tissue biopsy.

Mike Yancey
36:33
I think we ought to take into account I'm not once again that the Pluvicto is significantly radiating the prostate. And so I'm not sure what will be left and we're done.

Brian McCloskey
36:53
Do you have a contact at Foundation? Because if you don't, I know somebody who does patient navigation work. I'll send an email to David Marchek. He’s the usual guy that helps us, but he's on paternity leave. I've got a backup. I will send them out after this call.

Mike Yancey
37:21
We'll get down to where I rank some things towards the next to Mr. Vieau did provide to me, and I just kept them on this list. Even when we did do kind of a review of what they offered in hand, I've clarified a few things, I am not eligible for these two clinical trials per the criteria they provided. So therefore, they're not ranked is and now we're down to number seven, which, of course is pure match. And that's where I've started to rank things. And the first one that I have ranked there, ended up with a cure match number, if you will, of 67 which is speaking with Ally, that's quite high, because you said in most cases, on average, the the matches in like the 33% range. So I'm like double the normal average that they see. So this you know, theoretically from their, their research and their biology looks like it might have some drawn possibilities of having some impact with the well. Once again, we get back to looking at at Target and molecular alterations. What they provide to me here, of course, is the aka to pathway via mTOR which of course is everolimus once again, but then also combining it with a PDL one with Kimbro lose Mab. And then of course hitting the R SRC mutation in TPP, three via the kinetic for Nilotinib, if you will. So this looks very interesting to me. But once again, based on my research as a non medical person who is oftentimes struggling there, if this would take an oncologist, it's really going to work very closely with you because you start mixing these and they all have some pretty significant toxicities. And so it's gonna be a matter of probably some, some slow experimentation to see what levels of dosages you can use and what mix of those dosages can be applied. To see

Brad Power
39:25
This has been a recurring theme with the drug combinations from CureMatch. At a target cancer meeting I was at last week Razelle Kurzrock, who's the founder of CureMatch recommended a doctor at UCSD, Mina Nikanjam, who's a specialist in dosing. We've been looking for this. So if you're taking three drugs, do you take 1/3 than a normal dose or do you titrate up? How do you do it? This doctor has thought that through. So if you proceed down a combination path, we have an expert now who can help you with that dosing strategy.

“Treatment Options Review for Advanced Prostate Cancer Patient Mike Yancey” (Mike Yancey) [#27]

Jonathan Starr
40:30
Do you have the PDL-1 or at dmmr mutations that favor using pembrolizumab?

Mike Yancey
40:42
I did have on the Foundation report, they have PDL-1, and it showed I forget what the numbers were on that but Ally Perlina saw that as she was putting this report together. And that's why they included pembrolizumab in this set of actions.

Rick Stanton
41:01
Just to mention, I keep folks as noggins don't seem to get that PDL one expression is not on a report is not typically a mutation, it's over expression or a high or an expression. It's not a mutation. So I just keep trying to chip in on this. So if Foundation flagged PDL-1 in any way one would have to expect that they looked at RNA seq. So they're quantifying the RNA expression and noted that PDL-1 was on the higher side relative to other patients, which would indicate that the target for pembrolizumab is in your tumor. And that's very encouraging because most of us, prostate cancer patients don't have that.

Mike Yancey
42:11
And I will admit and once again, my understanding in order to even talk intelligently is limited, but no on their report, they didn't mention did mention with respect to Pdl, one was via IHC.

Rick Stanton
42:25
Oh, they didn't IHC Okay, great. That's awesome.

Mike Yancey
42:29
Okay, well, at least at least at least I remembered something about you.

Rick Stanton
42:34
You are really revealing that you've been doing your homework.

Mike Yancey
42:41
It was way over my head when I first talked to you.

Rick Stanton
42:43

I see a huge Depth of Knowledge increase to be commended.

Mike Yancey
42:54
I appreciate that. Rick, thank you very much. I have learned a lot. I'm still far from what I need to learn.

Jonathan Starr
43:03
Rick does what you just said. Does that apply to this MSI high feature also?

Rick Stanton
43:16
No, no, MSI is microsatellite instability. Right. And that will be revealed by sequencing that expression.

Jonathan Starr
43:30
So that is a mutation. Or just a genetic feature, or?

Rick Stanton
43:39
I would have to say more of a genetic, I have to look that up. I think it's considered a rearrangement. I'm not an expert, because I've never really come across MSI high patients in all my work at Human Longevity. I believe it's a nucleotide repeating pattern that tends to allow the immune system to recognize better, and so that's why it's included in the criteria for pembrolizumab. But I need to look that up, but it's not an expression, it is from the genome.

Mike Yancey
44:49
Sorry, my direct. My number two of course, is basically the same thing from from pure math once again with a 65% matching score. So once again, very high in this case pretty much the same to drugs everolimus and pembrolizumab. But this time substituted, substituting the permitted one minute tip with Busselton nearby, if you will, and it's just a slightly different option we've got the positive, does have some pretty toxic, toxic elements with it. And so I think, based on what I understand and researching this snib is not quite as toxic. So maybe another option here to reduce slightly the toxic concerns that we have, but still have basically the same three drugs or same three types of shots that are impacting many of the same signaling pathways, etc, that are impacted by mutations. And, of course, the next one here, once again, also a cure match. Once again, you'll see the same thing, you know, everolimus pembrolizumab, and then the two minute nib, if you will. And of course, it's also once again, src, TPP, two, three. And so it's just another option that we've got once again, to a pretty high score of 63%. So 63657, with the top three, your match options are three drug combos, and that's where I pretty much rank them in one, two, and three. And then, of course, we get into your matches, to drug combos,

and of course, still 59%. And then of course, as you can see, the next one is 58%. And so here in this case, we're pretty much sticking with in number four option, if you will, everolimus and pembrolizumab. With everolimus, you know, really focus on aka to pathway with mTOR. And then for CBD one option also. And then of course, number five there is is you've still got the pembrolizumab. But this time instead of everolimus, looking at the negative, if you will, which is which is impacting or affecting one of the different pathways, if you will, then then everolimus did. And so basically I've got these 1011. And the poster next to drug option, I've got this to this is my number six options. So 123456. And of course, like I said, at the to drug option, we're here in six one we are substituting once again, that was Deneb for the everolimus, if you will, but still retaining the pembrolizumab. And then quickly that we get into your matches one drug options, which I didn't even rank because once again, I I feel confident that with my particular cancer, the one one drug options are going to do very little, I think it's really going to take a multi drug option. And really my preference is a three drug drug options, of course. Then we get into the last two that I've got here, which is some that I found online using a path to rehab if you will, the person who has a patch of red plus Abiraterone, we've already kind of talked about the fact that I've read around doesn't seem to be doing much for me at all. The data we have is currently in some clinical trials. And if you'll notice over here, some preliminary information they've got is particularly in patients with p 10. Loss tumors, they're finding that survival progression free survival is 90.1 months versus 14.2 months, we just have a rat around a loan. And so also, once again, it's focused or targeting if you will on that. Katie in this case they picked the one pathway and then of course the last one here was being a pet passer rabbits with another clinical trial scuze me is adventure salsa. But this time instead of ever right around there, there's the substituting a tease Elisa Mab with with in the combinations that packs her ribs. So like so these are two trials that don't know that much about don't know much about exactly how they're going to in particular, my molecular alterations of the fact that a KT pathway from my research is one of the things we're trying to get here. So that's pretty much what I can tell you with respect to these options.

Brad Power
49:26
I noticed that you didn't include any options from Cancer Commons, and I know Emma Shtivelman has been very, very helpful. Have you not had a chance to interact with her yet?

Mike Yancey
49:36
No. Emma told me that she knew I was getting ready to take Pluvicto. She felt like it was a very good course of action. And she was going to wait until we saw how that went, how that treatment process goes. And then she felt like at that point in time, she would look at some other options to go forward with so basically at this point, I've gotten away from them. And based on the fact that that they'd be like, Well, vecto is a good option for me right now.

Brad Power
50:05

You're going to get another round of scans coming up soon as you sort of get to the end of the Pluvicto treatment, and then you could go to her with that information as input.

Mike Yancey
50:18
Yeah, it's basically going to be after we've finished 1/3, I mean, finished, finished courses one and two of six, we're gonna do the scans before I do my third one, we most likely will do another scans after my fourth one. And then of course, another set of scans at the sixth one. So we'll be doing scans after one and two scans after three and four. And then of course, at the end five and six. However, if we see we're not having much success, which we don't expect, there may be some discussion as to whether we continue or not, because I know that some people have taken Pluvicto had very little response, and they've actually stopped.

Brad Power
50:56
In the chat, Rick threw out the idea that you should get a liquid biopsy. Are you you considering that?

Mike Yancey
51:05
I had one once again with Foundation Medicine. It came back with two additional mutations that didn't seem to be super significant. That was part of what was provided to all these providers, e.g., Massive Bio as well as CureMatch when they made these recommendations. So they had all that information.

Brad Power
51:27
I would recommend you get liquid biopsies because they are relatively painless, and you're getting blood draws anyway. Given the possibility that your cancer may be moving in response to the treatment you're giving it, it would be useful to repeat liquid biopsies. You're doing your scans every couple of months, it would seem useful to me.

Mike Yancey
51:56
Yeah, my intent, I had the head liquid biopsy done. I believe it was around July of this year. And of course, my intent I have not had specific discussion on that point. But my intent was to have a liquid biopsy done about every six months. Cool.

Jonathan Starr
52:32
Did you consider sbrt to spot tumors?

Mike Yancey
52:51

I really don't have spots. I've pretty much got complete coverage. My spine is in very bad shape. My pelvic region was pretty much covered. My right femur was pretty much covered. And now my left clavicle as well as my right shoulder have significant tumors if you will. So it's not a matter of spots. It's a matter of pretty much my entire skeleton. I've got metastasis on my ribs, down everywhere. I don't have metastases in my forearms, my hands and my head that I know. When I got my initial radiography, the radiology oncologist pulled up the scan. She she brought it up on the screen and first thing out of her mouth was, “Well, that's not normal.” You know you're in trouble at that point.

Jonathan Starr
53:55
Yeah. All right. Well, maybe it's still something to consider after the blue victo treatment. Like, let's hope, let's hope that the blue victo gets almost everything. And then maybe they're okay, a couple of nights.
MY
Mike Yancey
54:14
Exactly. At that point, I think there may be if we if we if we're, if we're significant, and knocking back to cancer enough, then there may may be some significant opportunities to do some hot spot work. In fact, my local oncologist is actually the one giving the double victo as mentioned that, for example, I have had a lot of back pain. I think it's more muscular, but that's one of the things we're going to look at October 20. And if indeed, it's cancer related, we may end up doing some some spot radiation just to give me some relief in my back. Like I said, right now, I think it's muscular more than cancer Orient.
JS
Jonathan Starr
54:50
Okay. Okay, well, I've got two other things to ask you about one is again, after your play victo and all that Mmm, maybe consider Provenge if it's worked well.
MY
Mike Yancey
55:05
Yeah, I've actually asked about Provenge now, once again, I'm gonna end up probably playing one oncologist against another my quarterback, my lead oncologist down in Houston. Definitely not interested in even looking at programs that feel like that's of any value. Never go on colleges given the victo.
MY
Mike Yancey
55:26
Didn't didn't give me
MY
Mike Yancey
55:28

I'll say, positive reviews, but also was was not dismissive. And so that's something that I will continue to keep in the back pocket as as something to look at. Okay.

Brian McCloskey
55:40
I mean, just chime in there real quick, Jonathan, I'm glad that you brought that up. I was gonna bring that up as well, Mike, I just had a conversation with random McKay. And after my surgery that I'll have, you know, next month or in November, she suggested that we look at doing Provenge, you don't typically get a PSA response. But sometimes it can be helpful in keeping the tumors at bay. So that's just another oncology voice. You know, in the mix, every patient is different, but I wanted to share that.
MY
Mike Yancey
56:11
No, and I appreciate that very much. And I'm in agreement with you, I do my PSA course in my case, I don't put that much PSA. So it's kind of a mystery. But it does show some some longevity benefits.
JS
Jonathan Starr
56:25
Okay, and one other thing I want to put out that I sent an email out about is us savvy, Zab eulen, which is also known as veru 111. It's a sort of an oral, well, it's an anti tubulin, chemo drugs or anti tubulin. Okay, and I won't go into detail unless you want me to. But anyway, it's sort of like an oral chemo, but with very few side effects, or very mild side effects relatively. And
JS
Jonathan Starr
56:59
so it's
JS
Jonathan Starr
57:02
now it's in phase three clinical trials for prostate cancer. But it's also been found to be effective against COVID. So of course, they rushed that through, they could do those on a shorter timescale. And then in a week or so it's going to go to the FDA for consideration for approval for COVID, at least for emergency use authorization. So I asked one of my oncologists about whether or not he might be able to get that on, off label, you know, if it is approved in that way, could he get it off label for prostate cancer? And he said, Maybe we will see how to quote him. Exactly. So I'm just tossing that out as a possibility of something else you might be able to use, especially if you're considering cabeza taxall. If you know, which will have side effects, you'll get a sort of a similar impact was hopeful it was sad. But without the side effects or with much less side effects. Including that okay, so also code veru Ve are, you want to let them a little easier to remember. All right, well, anyway, though, just wanted to throw those things out. Good luck. So you've already had your first approved victo treatment.
MY

“Treatment Options Review for Advanced Prostate Cancer Patient Mike Yancey” (Mike Yancey) [#27]

Mike Yancey
58:36
First two, verse two verse two already,
JS
Jonathan Starr
58:38
and how are you doing? I mean, especially like dry mouth and all that.
MY
Mike Yancey
58:45
Very, very, very minimal, hardly notice it at all. In fact, on another call on there's been quite a few folks that have done dunkel, victo. And
MY
Mike Yancey
58:55
the worst
MY
Mike Yancey
58:57
person that has responded says they had dry mouth in the morning. And after they finished the video, it lasted for about three months, and they were back pretty much normal. But this time, I'm having really dry mouth to speak up. And as far as the pain elimination is working wonderfully. So. Like I said, we're hoping that we do the scans will find that it has been very successful and knocking back a lot with the answer.
JS
Jonathan Starr
59:24
Yeah. Okay. Well, good luck. Thank you.
BP
Brad Power
59:29
So I think we've just about run out of time. This has been great conversation. Thank you, Mike, for sharing your situation. And your gracious, I thought it was pretty rich conversation around some of the considerations around it. And when we send out the notes, you know, we'll solicit feedback from those who weren't able to join us today.