# Living with Metastatic Cancer #49: Dr. Gina D'Amato on Rare Sarcoma and the SFT Patient Registry Transcript

(Transcripts are generated by AI and may contain errors)

## Introduction and Guest Welcome

This is the doctors making a difference podcast, living with metastatic cancer, highlighting patients, doctors, and researchers who are fighting to win against cancer.

We are privileged today to welcome Dr. Gina D'Amato. Dr D'mato works at Sylvester in Florida. I'm so pleased that she's willing to take the time to come.

and talk about her interesting cancer research. She's not only a physician, but a cancer researcher. And as listeners of this podcast, know this is very interesting and near and dear to my heart because I'm a Cancer patient and a Physician, and I just really appreciate what Dr.

DiMatto is doing. Anyway, would you mind? Gina, do you mean if I call you Gina? Do you might introducing yourself to our audience? Sure. You're welcome to call me, Gina.

I'm very excited here and thank you so much for having me on your show. My name is Gina D'Amato. I'm a sarcoma medical oncologist, professor of medicine, clinical lead for sarcoma medical oncology at Sylvester Comprehensive Cancer Center at University of Miami Miller School of Medicine.

Oh, that's wonderful. Well, and how long have you been there at Sylvestre? Six and a half years now. Seems like yesterday. Well, it goes by fast when you're doing important work.

Would you mind kind of sharing a little bit of your journey? I want to know how did Gina DiMatto choose to become a doctor and then become sarcoma specialist in Florida?

We all arrive in these interesting places as physicians and it's interesting to hear your journeys. Do you mine sharing briefly your story of how you ended up doing this?

Yes. So if you're a good student and you know this and most doctors know, you are a student, and then your parents will say, oh, should be a doctor because you like science and math.

That was a little bit of the background, but really I was very interested in cancer from very early on when my grandmother passed, when I in third grade of GYN cancer.

And then when was in high school, my sister was her senior year and she was diagnosed with Hodgkin's lymphoma. And I actually had around the same time had a benign condition called lymphomatoid papulosis.

And they are related. They're both CD 30 positive lympho-peripherative disorders. Of course, she had the cancer and had to go through chemotherapy and everything, and I didn't have to do any treatments.

And so of course I became fascinated in cancer at that time. So then that's where I went to university in Miami, was an undergrad and then got into a medical scholars program and went into medical school, did residency at university Miami.

Actually I was here for 10 years, 18 years ago, well more than 18, years then came back 18 year later. I went on to do my fellowship at Moffitt Cancer Center and I was really interested in lymphomas.

I really was interested cutaneous T-cell lymphoma because of my background with the lymphocytes and papulosis.

## Dr. D'Amato's Path to Sarcoma Oncology

And I had an NIH grant, I have the K-12 grant to study this, but my mentor left to become the cancer center director of Penn State. So then I kind of was without a project and at the time, The Moffitt did not have a sarcoma medical oncologist.

So this is early 2000s and there were only, there was a limited number of sarcoma medical on colleges. There were, you know, fair number, but still rare orthopedic oncologists.

The orthopaedic on college is there. Dr. Lettson had been trying to recruit somebody. He had actually been. Trying to. Recruit Dr Trent, who was at MD Anderson.

And he had been trying to recruit all the experts and they said, no, they're not moving their institution. So Dr. Trent said why don't you, instead of trying recruit a sarcoma expert, why not you take a fellow and train that person.

We can train them remotely this back before we had remote learning and how it started. I had, when I was in high school, I'm with close friends with someone that played University of Miami.

So my sister went to University Miami, and then I joined her two years later and Brad was in, in her class. But I hung out with them and he was playing football for University in Miami and broke his femur.

And then when they took him off the wait list, that's when he found the sarcoma. He was actually treated at University Of Miami by Dr. Benedetto. When I was at medical school, and residency, I would follow Dr.

Benedetto around and he did sarcoma. But again, in lymphoma. So then when I was at Moffitt and they were saying, oh, we need someone for sarcoma. I said, well, I do know a little bit about sarcoma and then they said that there's an international meeting called CITAS and it's in Barcelona.

And then it said international travel and I say, okay, a bit of sarcoa, international traveling. But I liked that it was rare and that was a huge unmet need.

And so I did, I didn't like that. And I actually had all the world's experts train me. I had George Dimitri who was at Dana-Farber, Bob Benjamin at MD Anderson, Dr.

Trent at M. D. Anderson. Bob Mackey at Sloan Kettering, Larry Baker at Michigan. These were the top medical oncologists. and I would see patients with a preceptor, lung cancer, Doctor Williams, who's really very nice and very intelligent.

And we built the program there at Moffitt and I was there for about four years, three and a half years. Four years and then I moved on to Emory to build a sarcoma program.

There and after that I went to was actually stayed in Atlanta and was working in a Uh, private practice, but it was a kind of this hybrid private where I was able to still see sarcoma patients.

Now, while I going there, Dr. Trent from MD Anderson was recruited to University of Miami Sylvester to build a sarcooma program. And so. I said, I would love to work with him.

And he built this big program and then eventually recruited me back. So I'm happy to be full circle, kind of similar to your story, a little bit different, but full circled back in.

18 years later came back here and really thriving and loving the opportunities. Because when I was in private practice, it was very good. I could see patients and I did have some clinical trials.

But the research opportunities here far exceeds any place that I've been. And Celestro has been extremely supportive in our research efforts and to build a sarcoma program because Not every cancer center really puts the

support behind building a program because it's rare and there are not a lot of experts.

Just to be frank, you get more money and more research funds from breast cancer, colon cancer and prostate cancer. That's where a lots of the cancer centers kind of focus and they don't want to give special attention to sarcoma.

But at University of Miami, Sylvester, they're really very, very supportive. Well, it's interesting. Like I say, most of the people listening to this podcast are physicians.

I think everybody can relate to. the reasons why you choose the job you chose. It's who you know. You know, and it's the opportunities that come up. And it is your personal experience.

That's your family member that had a cancer and the type of cancer in your grandma. I think everybody can go back and say, hey, why do I do what I did?

Because somebody along the way may have this powerful impact on me and changed my life and I'll do whatever it takes to make that difference. So you've kind of followed that same path.

Now you're back studying a the type of cancer that's more rare. And for those of us that unfortunately have a type a sarcoma, we're just so thankful. So thankful for that research that is being done.

Because as a physician, you get to take care of patients in vivo, but you also get do bench top and clinical research, that makes a big difference. The world of cancers is expanding tremendously, and you got to be right at the cutting edge of that.

How is that? I mean, it's really great because sarcomas, again, just in comparison, 300,000 Americans get diagnosed with breast cancer every year and only 17,00 with sarcooma.

And unlike breast or colon cancer where, yeah, there may be a few different types of those cancers, sarcommas there's over 100 different type of sarcomas, so each individual Sarcoma is even more rare, right?

So if you have, for example, the solitary fibrous tumor, which is 2% of sarcomas. So maybe if I did, we don't even have the numbers, but maybe 300 to 400 Americans get diagnosed every year.

Each time you work with a sarcoma patient, each individual sarcombas are rare as well. So you're rare and then even rare. And I do like it. It becomes frustrating because there's a lot of unknown.

But then that unknown is actually very good because you know, you just have endless amounts of questions that you can be answering. And, and you, know that, that your really making an impact in people's lives.

## Why Sarcoma Research Matters

Any little thing, any needle that move you're really, making huge advances because of the unchartered territory that we're, it's just all un-charter territory.

Every time you try to do a research project, It's never been done before. And simple things that when, if you go to a breast cancer conference or a colon cancer or just ASCO, which is American Society of Clinical Oncology, and you peek in on their presentations and then you to the sarcoma conferences, you're very humbled because they're doing science that's probably 30 years more advanced than what we're.

But we're getting there and we are getting with the support of institutions and the private donors. That's how we getting funding and that's we able to advance the needle.

Well, it makes a big difference. My wife and I were talking this morning, we went on a bike ride and talking about, hey, I have metastatic solitary fibrous tumor, which I hate.

I don't want to have this disease. They didn't do anything to get it. It just showed up. And the thing we've decided to do is just live life like normal and just pray and hope that science stays one step ahead of it and we are at the kind of at stage of understanding on most things and the more we understand about it the More treatment modalities present themselves and it is kind of an exciting time to be a researcher It's never a good time to be a cancer patient.

I don't think of anybody that wants to have that. But that's what you kind of hang your hopes and your prayers on to say, okay, please stay one step ahead of this, because we've gone from systemic therapies to really targeted therapies.

And the more that we understand, it asks 10 more questions, but the we more understand the treatments can be devised and then hopefully you get more funding from both our government funding, private donor funding because the chance of making a huge change on this is huge.

It's just really a really kind of a cool time to be in the middle of that sort of research that you're doing. Yeah, I mean, you know, an oncologist, finished my fellowship in 2004. So, over 20 years now of being an oncologist and the changes and improvements that we've made is is really phenomenal.

And I tell patients, listen, we're so close and we've made major advances and the advances that we have made, maybe it was in this direction, but now that have all the technology and gene mutation profiling and all of the advancements that with computers and technology, now we're going like this.

So that trajectory has become much steeper. The trajectory is going to be so much higher. And I tell patients, look, at this cell phone. Look at the smartphone.

We didn't have this 20 years ago. This is a computer. this is, a calculator, this, is this a camera. I call it my second brain. Siri, tell me what to do, where to go, everything.

And it's in this little box that I can put in my hand. So if we can do this, we are going to have way better treatments. We're going have cures and it is going be in our lifetime.

And that's what we, and I think the research that we're doing now is gonna prove that. I I think we're more, we are analyzing it. You know, in the past we just did chemotherapy, right?

Chemotherapy just kills cells that are growing and dividing because we didn't really understand what's driving these cells to grow and divide. But now we have to understand at the molecular and the genetic and epigenetic level, what is driving the cells grow in divide and how do we stop them?

How do stop? Why are the genes mutating? Why does it happen? Can we prevent it from happening? And if they are, what's the result of that genetic mutation and then how do we stop it?

So, you know, it's, and that's what we're doing with this solitary fibrous tumor initiative, the Horowitz Solitary Fibrose Tumor Initiative that we have, I mean, a patient of mine, Joel Horowicz, The best guy in the whole world, besides my family, what can I say about him?

Maybe he's better, don't say that, but hopefully. Anyways, Mr. Horwitz was committed, he says, Listen, I want to find a cure for a solitary fibrous tumor.

I'm like, okay, well, we know how to do it. We just need the money and the resources to. And I said, what we need to is we to number one, try to figure out what causes it, right?

But at the same time, trying to better treatments once it's spread. and then understand the genes and the systems that are in place of causing it to spread and being sensitive to treatments.

So it's a real wide spread research project. One we've started in the lab, we're growing cell lines. We're trying to

create cell-lines from the human tumors, which is very hard, sarcomas.

If you can buy, I can, I can get a cell line from breast cancer on the phone in 30 minutes. You know, there's so many breast cell lines, colon cancer celllines.

Carcinomas are easy to grow and there are so much and of course it's more common. Sarcoma cell-lines are very hard to growth. We have a lot of tissue, but they're very to hard grow.

And so we're working on building cell Lines directly from cancer, from the tumors itself. While we're doing that, we are actually engineering the mice to develop the solitary fibrous tumor by injecting them which is very complex.

And I let Dr. Lombard, what I did was I said, I know how to do it. I knew how get the smart people to it, okay. Uh, we'll get all the laboratory researchers.

MD I'm not an MD PhD. Dr Trent's an MDP HD, Dr Ornicek, our orthopedic oncologist MD, PhD, and we have MD-PhDs in the lab. Did do a little dabbling of lab work when I was at Moffitt again, dr.

Trent would give me his cell lines and. I worked on them, but I was always called to the patients. So I don't work directly in the lab, I've got the smart people to do the actual lab.

## Solitary Fibrous Tumor Research Initiative

We recruited Dr. Lombard from University of Michigan and he works in his epigenetics lab so he's been able to engineer these mice. Solitary fibrous tumor, just a little background, it's a rare Sarcoma, sarcomas are cancers of connective tissue.

Again, 17,000 cases every year of saroma and about maybe 340 roughly US solitary fibrous tumor. Usually occurs between ages 50 and 70, but we've seen younger, we have seen older.

And it could start out anywhere in your body. extremities, retroperitoneal area. It could start out actually in the brain, and if it starts out in brain then it's called hemangiopericitoma.

And they realized that solitary fibrous tumor and hemangiopericitoma is actually the same thing because it has a specific gene mutation that's a chromosomal translocation between the NABB2 and the STAT6.

So basically STAT6 drives the cancer cell to grow and divide, and it's supposed to be stopped. But instead of being stopped, NAB2 gets attached to it and drives it further.

And so if you inject mice with the NB2-STAT-6, now you have a model of a solitary fibrous tumor model. Maybe not as good as growing cell lines and injecting them to mice.

pretty good. And so, while we're trying to get the cell lines, we've developed these mouse models and we are testing. We also have, and can derive cell-lines from those, also worked with researchers from around the world.

Dr. Martin Brodo in Spain and then there's another patient, Heather Hwanga, that's in Dallas that and they have cell lines. So we've used their cell line as well while we're building our own.

And they've been very, very helpful and collaborative. We're growing these celllines and then we are testing them on thousands of different drugs to see the sensitivities of the drugs.

And then we do have a couple of hits, and then once we have shown that these drugs are effective in the cell lines and in mouse, then were going to take it to the clinic and part of a grant initiative is to have clinical trial.

We're hoping, we're thinking that it's likely going be with an HDAC inhibitor, that's so far, but we initially built the thought that we would develop a drug against a STAT6 inhibitor.

That was the original plan. But then as we're studying it more and more, we are realizing that that's going to be too difficult to the way the molecular driver is, it's not really STat6.

So that is why we wanted to do some laboratory work before we take it directly to a clinic. We are still working on that. We have some other potential leads.

So while that is going on, we have developed a patient registry, which I'm very excited about. We just enrolled our first patient on it, and we're really wanting to spread the word about this patient register.

Basically, the goal is to have every patient that's ever been diagnosed with solitary fibrous tumor part of this registry. They will go on to the website and there'll be someone that can help them fill out the information.

There'll will be a survey where they'll all be asked questions and trying to figure out what causes it. What are the causes? Is it hereditary? So we want every patient to go to their genetic counselor and get germline testing to see was this heruditary and then If it's not hereditary, then it is environmental.

Mr. Horowitz was exposed to 9-11, the air quality there. So, and we know that burn pits are associated with sarcomas. We know Agent Orange, which is an herbicide is associated, with Sarcoma.

so we want to get all that information, anything. Could it be a virus? Could be our patients with that are, that have autoimmune disorders? Are they more likely?

It has to be something. And I think the more data we collect, the information. Did you grow up in a certain area? Was something in the water? So we, we have questions like that.

You know, where did you grew up? What are your ancestors from? Right. So not just what's your nationality or what your race, right? Because you're white, I'm white.

But we look very different. I am Italian descent. I don't know what your descent is, but you don' look Italian to me. All Northern European. We sunburn too much.

I mean, you just don''t look at Italian. You're in Idaho, okay? Right. So we're different even though we''re, if you fill out the race, we' Caucasian.

In Miami, w have such a diverse population and we have a lot of Blacks. But black is not African American because they're Caribbean American. They're from Haiti, they are from Dominican Republic.

So it's a different environment and what was their environment? And so we have, right now we're starting within University of Miami, the registry, and of course we are going to be opening it up globally.

We really want to spread the word about this solitary fibrous tumor registry. And so I think if we try to get to the basics, like maybe we can find some causes.

Then we have the germline testing, you know, how hereditary is this? We don't even know. And we working with the cell lines, growing them, understanding the molecular processes.

So we had genetics and then we epigenetics. Genetics is looking at the genes, right? And then the epi genetics, well, what's driving these genes? It's not just the genes.

Genes turn into, you know, DNA makes RNA, makes proteins. What's driving these proteins? How are they working? So we have the epigenetics and hopefully we'll be able to, and then also we sent out, we had 150 samples, which is a lot for solitary fibrous tumor of patients that have been seen at UM for about 20 years.

And we've got the blocks, their tumor blocks And we are sending it up for molecular profiling to CARIS. We have a contract with them and we'll have full molecular profile.

And it'll probably have the data maybe two or three weeks. Then we have some medical students that have gone through the charts and have all the clinical data on those patients.

When they were diagnosed, where their primary tumor was. what kind of, what treatments, how do they respond to the treatments? And we can potentially build like a gene library, so to speak.

So that if we had that data, we could see, okay, and so in the NABB B2, STAT6 chromosomal translocation, which is patho-pneumonic for the disease, you don't have solitary virus tumor if you do not have that gene mutation.

You might've been diagnosed with it. We send it for molecular profiling. You don't have it, sorry, you're in another category. It may be good news for you, maybe bad news, I don' know.

But there are 13 variants of this. And we know the most common variants are this exon 2, 4, whatever. I dunno if you wanna get that much into the weeds of these, but the data that we have done before, just on other samples, international samples.

We have, there have been two studies, one a smaller study, we did another study where we could see the variant will correlate with where the primary tumor was.

So if it's in the brain, it is going to be more like 16, 17. I may be stating this wrong, but, and then if its more in extremity, its whatever, four, two and things like that.

So we know that it correlates, it can correlate with the primary, but what else does it correlate? Does it correlated with responsive treatment? You're on a Timidara-Vastin Regimen, which is a regimen that Dr.

Trent, who is my longtime mentor, actually developed when he was at MD Anderson, you know, based on brain, primary brain. And so. Are you, if you have a certain variant, are you more likely to respond or less likely you respond?

Or if have certain gene pattern, Are more you likely respond to it or not? So we also have other treatments. We have Votri, Pizopinib and some others.

So, we could potentially gear your treatment based on your gene signature. And so, collecting this information is vital. So that's all part of the project.

So very, very exciting. And this is what we hope for, because I have patients come to me and I say, OK, well, we'll try this. If this doesn't work, will try.

Unfortunately, I don't have a blood test to tell you, oh, you have this enzyme in your liver and you had this gene pattern. I'm going to give you X drug.

But if we collect the information and we study it, that will happen. And then I'll be like, okay, you know, Dr. Grain, Okay, let me analyze the whole thing.

Okay. This is your molecular signature. You have this liver enzyme B that means that you're going to metabolize this drug better and then you are going be on this medicine and whatnot.

So that's like the near future. Then of course, the ultimate future is can we do gene therapy? I think the ultimate, ultimate goal would be to do gene therapy against the NABV2 STAT6, or if we can find out why someone developed that mutation, how someone develop that and can we prevent it.

Well, I hear the excitement and passion in your voice as you talk about it, which excites me as a patient. I'm like, oh, good. She's looking into this.

But, you know, thinking back, like you obviously were very interested in tuning into cancer. from way back. But I

remember like going over all the different subtypes of sarcoma in a class in medical school and thinking like, well, that one's rare and that was rare.

I got to pass the test. And I knew about them. It's just not the same level of engagement as when you're like okay, now I have this disease or I've a family member that has this and I talked to another oncologist and somebody else told me that It's not if you get cancer, it's when you have cancer.

Cancer is so common. If you live long enough, you're probably going to get some type of a cancer and so the more we understand about this, rather than having this catch-all like, oh, cure cancer which is sometimes put out to the lay public, It is more like okay, of these, however many thousand diseases of cancer that are all unique but share some features, what can we do and how can change it?

And I think just like you said, going from systemic therapy where we're just using chemotherapy drugs that stop rapidly dividing cells to gene therapy and understanding the genetics of specifically behind those tumors.

I mean, it's life changing and not just for the patients who have it now, but for future patients. And then that research can be extrapolated all across the world.

People get this disease and now we have an understanding at the molecular level.

## Registry, Molecular Profiling, and Treatment Matching

So anyway, thank you so much. Love the passion and the drive and excitement for what you're doing. What do you find are your biggest barriers to this research?

I mean, obviously you have this really brilliant team of people collected from all over the place to study this rare cancer. What are the biggest barrier you found?

I mean, I think the biggest barrier, if you're working in a lab, you have to do 100 experiments to get one to work, right? So that's why I kind of stay out of the lab.

And everything is always slower than you think. To grow a cell line, for example, we It's an effort. Whenever there's a surgery that's going on that we know that it's gonna be a solitary fibrous tumor, we get in the troops and then we collect it and we have it in lab, but it takes a long time because solitary fibers tumors are not very aggressive and they grow very slowly.

Some can be aggressive, The majority grows slowly, so it takes so long. So even if you collected a sample from July, you don't have anything until December.

And you, you that's grown enough and then you still have to test it. Cause it could just be regular fibroblasts and you have. To have the mutation and if it doesn't, so it just takes a long time.

And so there's a lot of effort and your yield could be low in that. So that, that a little bit on the frustrating start, but then again, of course we've pivoted from the, we pivot it and done other research in the lab.

kind of counteract that we, that it just takes so long to grow these cell lines. Also, the registry part of it was I wasn't putting as full of effort because I was seeing so many patients.

So I really had to, I, wasn' getting paid per se, you know, for the research. And then finally I had say, okay, really need to actually put more effort in and see less patients so I can really put the time into write the protocol.

You have to get it approved by the IRB and you have You have to get the flyers out and the fliers are approved by the IRB. And then you notice a mistake on the fire.

Like we had the original flyer and then it was like the wrong website. So I'm like, we can't have these flyars. Then

every time you change it, you have go back to the IIRB and so it's just been time consuming all the paperwork that goes in at least into the registry.

It just takes longer than you think and you just want it right away, but in medicine and You just know you can't get, you know, there's no quick fix, right?

Everyone wants a quick-fix. But I think the progress is slowly being made, but just a lot of, still, even if, granted, it's not a, when you apply for a grant, an NIH grant that's extremely rigorous in the amount of paperwork that you have to do and the red tape and then this.

I don't have that red take, which is very nice, but it's still, and I was like, Oh, I didn't do as much paperwork because it was not a grant, you still have the paperwork.

You still make sure that it is a protocol and that people are guiding by the protocol because we're still doing research. It's just, we still need to make that is solid and that patients are worried they don't want their data being spread everywhere.

So we have to make sure that everything is secure and safe for the patients to be able to share their date. That takes a while. Developing the website, we finally have a website up that took some time.

Everything kind of takes time, but I think the barriers are much less than if you have federally funded grant because You have to spend so much time writing the grant and then you only have maybe 9% chance of getting the grand.

Whereas this, we wrote the proposal and we were able to start right away. So what do you, what would you say on the registry? Are you at this stage where you want that to be shared and do want me to show notes?

Go ahead and tell me what it is and then share with me the specific website, tell it to me and let's put it in the show note and make sure because while this is a rare cancer, people like me have it, but this gonna go out to lots of doctors and somebody out there is gonna find another patient with solitary fibrous tumor and we need to get them connected with a sarcoma center and a registry and a research team so that we make sure that the next generation of these treatments aren't just systemic, but that are a little bit more focused.

So yeah, what would you direct to her and then just go ahead and tell me like the what it is that Sylvester flyer and that will put in the show notes.

Okay, that will be good. Yes. So right now the, the survey is open for, and the registry is opened for UM patients. University of Miami, Sylvester. And we, because it was easier to open up through the IRB that way and then make it global, but we can register you as a Sylvestre patient and then we can get you in that way.

Or, you know, obviously if you're a solitary fibrous tumor patient, and you want to get an opinion from our team, You could do that and get in the registry that.

And so we're trying to work out some of the kinks as far as getting patients that aren't at UM. onto the registry until we have full approval. But, you know, while we're getting the approval, I think we can go in through other means.

So if somebody has, again, if they have solitary fibrous tumor, or if you're a physician listening to this and you say, hey, I think I've got a patient that has that, search up solitary fibers tumor Sylvester, and I will put a link when we're done with this.

I'll put link in the show notes so that we can get directly to that registry. And if I'm understanding correct, Gina, patients who are part of University of Miami can easily register, And then folks who were outside of that system would need to either do a consultation with somebody at Sylvester or somehow kind of get tied into that system, but they can, they could access that sort of information on the website.

Is that correct? Correct, correct. Okay. So yes, I can put solitary fibrous tumor Sylvester and it should pop right up.

Yeah, it'll pop up. So if you just Google or other search engine, solitary fibrous tumor Sylvester, you would find the registry.

Well, or you could put Horowitz solitary fibers tumor initiative as well. Okay. Well, that's useful information for everybody. You know, as far as it pertains to, you know most people listening to this aren't going to have solitary fibers, fibrous tumor.

And they may not even have a patient with solitary fibers tumor because it's a rare, rare disease. But sarcomas in general, these rare diseases, I think this is a strategy for coming up with answers.

We make a registry. We have to get funding, we do research, and then once we understand things at the molecular level, so much more can be done. And when you're a patient like me, suddenly you go from like, okay, it's fun to understand this to like I just am anxious for every little piece of information that comes out about it because it It's so impactful to my life and it's really kind of an interesting life to live where you spend part of the time as a patient doing all these things and then part the of time of a physician diagnosing and treating it and so it is interesting to kind walk that path between both worlds.

Another question for you. You know, you've talked about funding, and what would you say to somebody else who is, another person who's interested in research and says, I have all these ideas, but I'm not sure how to get funding?

Because that's been a big challenge, in cancer research in general, But you were able to do it outside of an NIH grant. Do you have any tips or tricks or anything else that you would suggest for folks who are in that same situation?

Yeah, so, you know, at Sylvester, they're very accommodating and they are really pro-research. A lot of the cancer centers do have internal funding. So, for example, when I came on, I have a startup fund that I put into my contract, right?

That I had startup funds to write clinical trials. And then we also have the dolphins cancer challenge where the Miami dolphins have pledged to donate money to Sylvester and they have right now I think raised over 100 million for us over the years.

And so we can use some of that funding for some preliminary results. So you always want to have preliminary result before you apply for the grant, right?

## Funding Research and Building Collaborations

So for example, this grant that we have this initiative is the preliminary results for us to be able to actually apply to maybe for a sport grant and get federal funding.

But a federal fund they're not going to want, they want you to already have these cell lines and these mouse models. They're are not paying for you develop the cell-lines and the mouse-models.

You have to get that from other funding once you have the mouth models and you had the sell lines created then you could potentially apply for the grant.

So you have to have money to make it. So this is kind of like seed money, right? So, but most institutions will get emails all the time about these grants coming in and little ones.

You can get even little one. That, you know, just have keep applying and, 50,000, a hundred thousand, something like that to, they can, get you to the bigger money down the road.

And then also collaborating, You want to be, if you're at it in, you know, usually obviously a researcher is going to in an academic institution, right?

So you want always be attending the conferences and seeing who's doing what. And you may be able to lob on or, not lob, but you can maybe join someone else's already existing research projects.

If you are academic, physician scientist and you're you want to work with the PhD or the lab researcher you wanted to be doing translational even though you may not have a lot of knowledge about the molecular processes and what their experiments are doing you have the patience and that's key so you can contribute a a to their research by just having patience And so if you collaborate and you with others, then they may be able to get some funding and then you can get onto their funding or you could contribute to that.

And then eventually you get enough experience and have enough preliminary data to actually apply for the grants. Other ways to do research, so I also am a clinical researcher.

In the clinical research you write your own clinical trials, but you need funding for those because you have to but you can get pharmaceutical-sponsored trials as well.

So if you know a drug that looks very promising in sarcoma, for example, and you write the clinical trial, there are LOIs, which are letters of intent that you, then you go to the drug company and say, listen, this drug is very promise, I can test this in Sarcomas, can you fund this clinical trail?

So you get it through private ways aswell. Other ways you can get it through CTEP, which you you. Can write the clinical trial, but you don't have to do the whole thing.

You just do. The letter and then they will list certain drugs that they have that there that. They will that that, they. Will give you so to speak to be able to.

Do the trial. So there's a lot of resources. You just have to find them. You can apply for grants through ASCO. These are all cancer, but every specialty has their groups.

And you just to keep being persistent and use your resources to your maximum. As we wrap up here, I just want to tell you thank you, Gina. I love the, like I said, the passion and the drive.

love what you do and you're passionate about it. And I think whoever listens to this is going to recognize that. Again, there's lots of people that listen to his podcast and they may find ideas and and, you may, find other patients with the same disease.

Anyway, I just want to express my gratitude and appreciation for what your doing and applaud you and keep up the great work. Thank you so much for, what do you?

Thank, thank you. I, just, think the passion comes from just wanting to help. Right. So if you love your patients, but I tell, you know, I told meds, med students, You love Your patients.

## Closing Remarks and Podcast Outro

And then you're going to do the best thing for them. You're gonna be the Best doctor you can be. If you Love your Patients and you care for Them. you don't have to think you just do.

Well, again, thank you so much. Hope you keep in touch and look forward to putting this podcast out. Again, everybody check out the show notes for that registry, because I think that's an important piece of this.

And again, Dr. Gina D'Amato, appreciate it. Talk to you later. Thank you. We'll have to have you sign up for the registry for sure. Sounds perfect. Thanks for tuning into the Doctors Making a Difference podcast.

And thank you for what you do to help your patients and your community. Your work truly helps so many people. We produce this content to have the tools you need to stay in medicine and to highlight the amazing work being done by physicians around the world.

Please note that while I am a physician and many of the guests on this program are also physicians or other professionals, the discussions on the podcast do not represent my employer or any professional organizations to which I belong.

This podcast is for your information and entertainment only, and should not be taken as professional advice. You should seek appropriate professional advise pertaining to your own situation.

Please check out more of our content on our website, doctorsmakingadifference.com. Also, please follow, like, or subscribe on your podcast player or YouTube channel and give us a five-star rating.

It really helps to spread the message. Finally, if you'd like to be a guest on the podcast or if he'd to nominate someone else to the guest, Please visit the website or email admin at doctors making a difference.

See you next time. No.