New Hope for SFT Patients: Research, Trials and Breakthroughs with Dr. Gina D'Amato Transcript

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Podcast Introduction and Guest Preview

Welcome to the Doctors Making a Difference podcast, where we help physicians to be empowered with the tools they need to successful in medicine, in finance, and in life.

Join us as we highlight doctors and other professionals around the world who are making a difference. This episode connects with me on a very personal level.

I'm excited to present Dr. Gina DiMatto. She's been a guest on couple of other previous episodes when we've talked about solitary fibrous tumor oncology cancer research.

she's really kind of a superhero in this field. Dr. D'Amato is a professor of medicine at the University of Miami Sylvester Comprehensive Cancer Center and she oversees the Horowitz Solitary Fibrous Tumor Initiative Fund.

And today's episode is the big deal because she is talking about the results of some preliminary work they've done. with the patient registry. She's talking about a clinical trial that may involve people with solitary fibrous tumor, a rare type of sarcoma that I'm also unfortunately a patient of.

And I am excited to present this data. I think it'll be useful for the physicians who tune into doctors making a difference. and I'll think will be for patients and family members who enjoy learning about solitary fibers tumor.

It's not just an academic interest. This is a very personal interest for me and for my family. If you're a doctor listening, and you have a patient with a rare type of sarcoma, this episode's for you.

If you're a patients listening who's looking for hope and looking updates and answers, This episode is for You. I'm very excited to present Dr. Gina DiMatto.

So I am excited today to have Dr Gina Dimatto She's a repeat customer or a friend of the podcast. She has been so gracious to give of her time and share with us on the podcasts, some of this research that she's done before and give us a background.

I want to reference you back to a couple of podcasts that's she has on November 17th of 2025 and then November 19th, 2025, she was a guest and she had Mr.

Dr. Gina D'Amato Introduces the SFT Registry

Joel Horowitz as a guests on The November podcast, I'll reference your back those as the way to kind of get to know Dr. DeMotto and her story. But just briefly, Dr.

D'Amato, do you mind introducing yourself to people who've never met you or maybe have never heard a podcast episode before? Yes. Hi, I'm Gina D'Amato.

I am a sarcoma medical oncologist working as a professor of medicine and sarcoma lead at University of Miami Sylvester Comprehensive Cancer Center. Have been treating sarcooma patients for over 20 years now and the administrator of the Horowitz Solitary Fibros Tumor Initiative, which of course we're going to be speaking about today.

Thank you so much. Ed, you say it so humbly, but in the world of sarcoma and solitary fibrous tumor, You're like the superhero. Everybody's very excited about what you're doing and what the Horowitz Foundation is

accomplishing.

And so I'm excited to dive right in and kind of share some of the things that you've been up to and some updates for us. So maybe just briefly to give people a little bit of context.

Again, we had a podcast on this in November with Mr. Horowicz, But what is the horowitz foundation studying specifically? And again, solitary fibrous tumor is something that I have and a lot of Mr.

Horowitz, unfortunately, also has. Maybe just give us a little bit of a synopsis of what's the objective and the mission of the Horowitz Foundation as it studies sarcoma and specifically solitary fibers tumor.

A solitary fibrous tumor is a rare type of serofoma, 2% of all seropomas. And there's a lot unknown about the solitary fibers tumor. It could start out from connective tissue, because that's where serophomas start.

Usually, it can start in the brain and the meninges, which is different than brain cancer. Can start on the pleura. Could start at an extremity. And it can behave differently.

Different people could be very slow growing and not very aggressive, and then it could potentially pick up speed. So there's a lot of unknown. There aren't a lots of treatments available for this disease.

And so, you know, Mr. Horowitz approached me and said, listen, I want to find a cure for. This and what we're doing is we are casting a very wide net.

He donated money. We're trying to find a cure, but in order to fight the cure we need to figure out what caused it. And so we developed a patient registry and bio bank and we're try to capture information from patients all across the entire world to understand maybe causes.

Was it hereditary? Cancer is either herditary or environmental, right? Right. Or with a gene that was passed on from your parents that made you susceptible to the cancer or you were just exposed to some sort of environmental toxin.

and developed a mutation and had the cancer. So we need to better understand it. And so we've developed this registry. We're excited to announce that we have close to 100 patients registered in the registry, our goal, of course, is over 600 because we believe that probably the incidence, meaning the rate of diagnosis per year in the US is probably about 300 or 400 as patients being diagnosed.

Then of course we have worldwide. So we want to try to capture as many patients as possible. Initially it was only limited We had to get all the IRB approvals, all regulatory approables that initially was only open to University of Miami patients, but now globally, happy to announce any patient that has the diagnosis currently or ever was diagnosed with solitary fibrous tumor can join this registry.

And we actually have go to solitaryfibrustumor.org. That's our website. They can get registered, they fill out a form, quick form to say, okay, I'm available these days.

And then we have the people that are working for the SFT. It's a behavioral science program. There's wonderful people and they will walk you through exactly what you need to do.

There is a questionnaire where we're grasping at straws, you know, we are asking, where did you grow up? Were your parents in the military? Have you been exposed to 9-11?

Did you grew up in a golf course? What kind of diet did have? How many patients? how many people in family with cancer? And then what we're going to do is after that, every 50 patients that are enrolled, we are going analyze the data.

We've already analyzed some and it's interesting. And I can go over a little bit more in detail, some of the

preliminary results we have.

Registry Findings and Molecular Subtypes

Were also going be collecting the LUD and tumor specimens and medical records. Okay. That's all part of the registry patient. They'll help them. Our people will help the patients get their pertinent medical information.

And then we also will collect the blood and tumor specimens. Then we're going to try to correlate that with molecular findings on their tumor specimens and in their blood to see, can we find anything?

Maybe someone that grew up off a golf course developed this one kind of mutation and they had their SFT maybe starting out in there lung, right? Or somewhere else.

So we're going to try to figure out maybe some causes. Okay. Well, I just want to highlight two things you said. One, a hundred patients doesn't sound like that many.

600 patients. Doesn't seem like many, but yeah, for physicians who are listening or patients who were listening, realize that if you participate in this, it's a big deal.

Like it a really big because we're not looking for hundreds of thousands. We're looking four hundreds. You know, so we are at a 100 patients and hoping to get to 600. And then the second big thing you just said, this is now open to people worldwide.

Is there any restriction on it can be any country of the world or is there a restriction as far as that? Right now, there's not a restrictions. We have to get the interpreters, which we will have interpreter.

There may be some regulations with the blood and the tissue collection. As far is registering and filling out the questionnaire, that's no restriction.

Excellent. So we're still working on some of the paperwork to get, you know, blood samples, but we are still also waiting on the some paperwork from patients that are not within U. S.

But at least we have people registered and collecting that questionnaire, that survey data, because we've had some interesting findings on that. You know it's a little too soon because it is only 50 people.

Like for example, Women in the literature, the average age is 50 to 70 and equal gender distribution. Whereas the people that are registered, there's more women registered than men, but that's usually as a nature.

Women tend to get more involved in online groups for cancer. That's just the nature of women tend do that more. But as time goes on and maybe women's spouses or loved ones of male patients will encourage their male patient, their loved one to enroll.

Even though it's not a lot of patients, but if we could get over 600, if you can get a thousand, we can really learn a lots about the disease. This is more like the surface level.

Once we start collecting the blood and the tissue, then we can potentially correlate it with some of the results of how they tolerate treatment or how their tumor responds.

Solitary fibrous tumor in order to make the diagnosis of solitary fibrous tumor. Of course, we want the tumor specimen to be evaluated by a sarcoma expert, but what's patho-pneumonic, meaning that what makes the diagnoses of solitaire fibrous tumor is a specific gene mutation.

It's a fusion gene where NABB2 is fused with STAT6. Okay. And okay, that's easy. Well, we can just study that one fusion protein. But there's actually, of course, to make things complicated, 12 different variants.

of that mutation okay so we have to understand and so far the work that's been done we've been able to show that based on where the mutation is the specific mutation exon 4 and exons 2 or 6 and 16 that correlates with the primary location of the tumor.

So 617 or 616 usually is the meningeal or the brain area, whereas maybe the lung or intra-abdominal or extremity is 42, the 42 is most common. We need to understand that because when we're designing, when were trying to find drugs and treatments, we need understand because one treatment may not work for A certain very so we have to and we want to find out maybe there was a certain toxin that caused a very enduring.

So we wanted to correlate all that with medical record where the primary. what kind of treatments that these patients have and what were their outcomes.

Okay. And so some of the work that we're doing as right now, we have studied this in you have patients called what we call a retrospective review, meaning like going back and looking at charts that have already been treated.

of patients that we've already analyzed their tumors, and we already treated these patients and they've been diagnosed over 20 years, we looked at that.

But the registry is collecting the data prospectively, meaning like opening it up to more people and live what's happening right. So in our retrospective review, we actually have been able to collect patient information of over 50 patients.

We'll have it 100 patients where we're looking at the next generation sequencing, meaning we've sent the tumor specimen out for special molecular profiling to look at which gene variant it was.

Do they have any other mutations. The most common mutations that we found on SFT are p53 mutations, TERT mutations in CDK and B. So then we're correlating that if you have these mutations, does it respond more to treatment?

Are you at higher risk of recurrence if it was resected? The cure for all cancer for solid tumors are surgery, right? Right. Remove, but half will come back.

Who are those half? Okay. Right now it's there's an existing prognostic tool that's used called the D'Amico scoring. And that is a pathologic tool where they look at to see, okay, there are this many cells growing and dividing, different features under the microscope.

There's a D'mico classification based on the size, the pitotic index, et cetera, and you classify it. by the stomache and then it correlates with, okay, the tumor was removed, what are the chances it's going to come back?

And if it is going back, where is it going spread and how long is the patient going live? I mean, obviously we can never predict how long someone's going to live, but you know, the average rate.

Okay. And so what we're trying to do is improve upon that because that doesn't include the molecular findings, right? Part of that classification isn't the variant, and other potential mutations.

So we are analyzing all that and we've actually been accepted, which is a huge deal. Our work has been excepted as a rapid or abstract presentation at ASCO, clinical oncology, very hard to get an oral abstract.

Mostly it's clinical. This is preclinical work. We're really making huge breakthroughs. We were able to show prognostic factors based on the variant of the mutation and the primary location.

And then we're correlating that with responses and seeing if we can tweak or improve upon the demico classification. So there was a paper that was done in China.

They looked at a hundred patients and they were able to have some correlation between different molecular

findings. We're trying to prove upon that and really hone it in and obviously with more patient samples.

So yes, my medical student, she's a third year student. She's, a superstar. she has been leading all the data collection. coordinating, you know, making sure that Dr.

Rosenberg, our pathologist, is sending the slides for molecular profiling, collecting all the information, heading up other medical students to review these medical records for accuracy and making as we have to see.

We need to collect all of the data very accurately so we can correlate it with the molecular findings. So it's very difficult to even get an oral abstract presentation out of Granite.

It's a mini oral, but still. And then as a medical student, we're talking full professors usually are the ones presenting. So very excited for Kirthana Shreyas Kumar.

and it is going to be May 31st, 430 to 6 o'clock Central Time. The title is Association of NAPI-2-STAT6 Distal Fusion with Risk Level of Metastatic Disease and Thoracic Primary Site.

This is a big deal. I don't think SFT has ever had an oral abstract presentation at ASCO.

ASCO Abstract and Sarcoma Advocacy

We're lucky enough to get one at CTOS, which is Connective Tissue Oncology Society. So, you know, we're hoping we can learn more about this. So that's one aspect of what we are doing is retrospectively looking back and then we will be doing the same thing prospectively with getting the patient samples and we'll be able to analyze even more charts.

Right now, this is our finding based on analyzing 50 to 100 charts, but could you imagine if how much we can't discover if we had 600 charts. Oh, yeah.

Well, I think that's a big point for people listening who may be family members or patients of SFT or doctors that are seeing it. The more people we enroll, the more power the study gets.

One of the things I was going to ask you on ASCO, you know, it's an important scientific meeting of all sarcoma for throughout the entire world. So it is a Big deal to get this put on prime time.

Some people are talking about it and understanding it For folks who are very interested in that, is there a way that they can observe that even if they're not attendees at ASCO or is the document published?

So right now the abstract has been released, the title of the abstraction has then released. If you're a member of ASCO and you can't attend the meeting, you could always buy it virtually and see the presentation.

You can attend if you haven't paid for the registration, but eventually the Abstract will be printed online. course, will be publishing the data, we'll be having a full manuscript.

So once the full manuscripts is out, of course that anybody will pretty to that information. But I think there's probably ways that you can find it out.

Of course if you have the virtual option, you could listen to it or see it live or right after. Now, some patients and some people don't always attend ASCO.

It's a big meeting. And so before ASCo, the morning of where ASco begins on Friday morning, of every ASCCO, there's the SARC meeting, which is the Sarcoma Alliance for Research Collaboration.

That is where all the sarcomaexperts gather. SARCs are funded by the NIH with funding that has a score grant. And basically, the goal of SARC is to create clinical trials that are available for certain patients.

And so they present some nice pre-clinical data. update everybody on the sarcoma trials. We also use it as an opportunity to do some networking and meeting people.

I believe that I think Steve at BEE is going to be there. Yeah. He mentioned he's going go. So that's interesting because it's not just networking for researchers and physicians, but also patient advocates.

Am I correct on that? Cause Steve is someone who's been on this podcast and has been really involved in this. And he mentioned, he is gonna go, which is great.

Yes, and also you know, SART really welcomes patient advocates because in a rare cancer, so if you have a very common cancer breast cancer colon frosty, you don't necessarily need to I would say advertise if there's a better word, but directly to the patient because all the doctors know about what trials are available.

There's plenty of resources for the patients. But if you have a rare cancer, one of the best ways patients find out about potential clinical trials and potential treatments and a potential experts is through patient advocacy groups.

And so sarcoma experts welcome the groups because they help us, they helped us find patients. They help treat patients and get to the patients because otherwise patients kind of get lost in the shuffle.

Studies have shown that patients with sarcooma, which means SFT, that are treated by sarcoma experts live longer, have better outcomes. Especially there's data behind that and there is data that they have a better outcome because they're going to a doctor that only treats that kind of cancer.

So we welcome the patient advocacy groups. They have many patient advocates groups that attend the CERC meeting at before ASCO. And then of course, at CTOS, which is the Connective Tissue Oncology Society.

That's only a CERT meeting that's in November. So yeah, one of the speakers is actually Brandy Benson is at Cercoma Alliance, patient advocacy group that includes all sarcoma patients to help them get second opinions so that if they can't afford to go to a saricoma expert, they could apply for a grant to get to the saracoma experts.

And so Brandy is a Sarcomasurvivor, so she's going to be talking at that meeting. at the Sark meeting before. At the Sarc meeting. Yeah. So that's exciting because the sarc meeting, like you said, that a huge opportunity for advocacy groups.

And so if you're a patient like me listening, you know, put it on your list, maybe not this year, but next year come and be a part of that because it's a really cool opportunity to network.

If you have a sarcoma, especially a rare sarcoma, You're one of a small group. Most of the studies, like we talked about on a previous podcast, a lot of studies are retrospective and they have way fewer than a hundred patients.

And so we're basing treatment protocols and whatnot based on that. Your objective is to get these much larger data sets and try to get it more and more people and get more of a worldwide population so we can figure it out and figure out which of the subtype you might have and then get a better predictive model.

So absolutely being involved as a patient, as the researcher, we're in this together. And so I think that brings a lot of hope to me and to other people who are listening to this because they listen and say, instead of just feeling lost and I don't know anybody that even has this, maybe there's a group of people that are going to win.

They're going find a solution, but it takes all of us to Yes. So again, that was one of our updates that we were very excited about. Another update that were we very, very exciting about is that.

We've been trying for three years to develop a sarcoma cell line, meaning a directly taking someone's tumor out of them and chopping it up and creating a cell like that is what we call immortal.

You can grow it and it won't die. Then, if you created this cell line, you can test so many things on it. You can tests

treatments, the molecular structure of it, look at the genes, and you know, really learn a lot from these cell lines.

Cell Lines, Organoids, and Research Collaborations

And it's very, very difficult to grow an SFT cell line. We've tried, I think we've had about 12 to 15 attempts over the years. And Mr. Horowitz, he had some tumors in his lungs and in June of last year, He had one of the lung lesions removed.

we'd been wanting him to get it, but he's had radiation. But anyway, so finally got one. Cause he has one removed years ago, But you know that you can't use it because And so in March, February, March cells finally started growing.

So awesome. Yes. And. We're doing these molecular tests. and we showed him under the microscope, you know, these are all joles and so we'll have to name it once we confirm.

I've been in contact with other researchers as well and a lot of times what happens is the cells grow, they wind up losing the gene fusion mutation. So we're testing that because we were having a difficulty finding it.

It doesn't mean it's not SFT, but if the tumor becomes very aggressive, it does lose that mutation, so we are in the process of testing In the meantime, we've made some progress in the lab as far as creating mouse models and a new technology called organoids.

In organoid, basically, instead of creating a whole cell line, you do a few cells and then they form into these little ringlets and that's almost like a cell-line and you can test things on these ringlet.

and so they're called organoids. And so we've had a PhD professor, Dr. Saragni from UCLA, who's now in Colorado. She came to the lab and she showed Dr Lombard and his group, she gave the technique on how to do this.

So we been using this organoid technology and we continue to have more collaborations with researchers around the world. And so we're very hopeful. One of the researchers, Dr.

Kubrow, Fred Hutchinson, just reached out to us. So we are going to work with him. We'll continue to working with people at Buffett and Dr Brodo. And we really very happy with the collaborations that we've made.

I want to make just one little recognition for a second. I know you've collaborated with our friend Heather Hayenga, a PhD researcher from Texas. And again, there's a previous podcast with Heather.

Heather, long-term warrior with this disease and had the interesting role of being both a patient of the disease, and one of leading researchers on it.

She had coordinated with you on some of her research and Heather died recently as a result of solitary fibrous tumor. So I just wanted to honor Heather and the work that she has done and recognize the tremendous contribution she's made to the field and that sacrifices that.

She made, to be there and honor her family has no doubt mourning her loss. And it's, you know, kind of a collective loss for all of us to have someone that is so influential in this field.

Yes, thank you for bringing her up because, you know, most of the work in solitary fibrous tumor and the preclinical work, she's been involved in. Anybody that you talk to, everyone knows her.

She's so supportive. They work so hard to advance the field and even anybody that I talk with, the doctor at Fred Hutchinson. He actually created a 3D confirmation from ourselves.

Anybody that's in the field knows her and knows how hard she tried and what she did. And she's a wonderful

woman. It's huge loss, but we're going to do this work for her, and for all the other patients that we've lost with this disease.

We're gonna use that as motivation to move forward because we don't want anything to be in vain. And that serves it. Totally agree with that. Yeah. One of the things everybody hopes for in this world is clinical trials, you know, opportunities to take this data, the raw data and the understanding and say, are there treatments, with all the different types of cancer treatment modalities that are out there?

Are there things that work on cell lines? Or is there actually a clinical trial that would allow us to test some of these things on living patients rather than just cell lines or mouse models.

Do you have any updates on that? We're very excited about potential clinical trials. We are continuing to work in the lab to develop some novel treatments, as well as novel combinations, trying to find already existing drugs.

So far, we're hopeful with HDAC inhibitors, which are working with the epigenetics, altering the cell as it's mutating. It's underlying mitosis. HDAC inhibitors that are approved for other cancers.

So we're working on that. But there was a trial that was done in Germany with a technology called therapeutics or radiothera gnostics. Yeah. and it was very promising and we were trying to get it over to the U. S.

and finally do so. There are a couple of companies that have these drugs, but what they found is that a lot of the majority of solitary fibrous tumors express this particular protein called FAP protein.

Now, when you hear F-A-P, you may think of familial adenomatous polyposis. That's colon cancer. This is a different F. A. P., just to confuse everybody.

Clinical Trial Update: FAP-Targeted Therapy

F A P stands for fibroblast activation protein, that's the protein that's on these stromal cells which are the connective tissue, the glue, right? So solitary fibrous tumor is basically the fibrous cells, so of course solitary fibrous tumors express a lot of this.

other cancers, the connective tissue, what we call the stromal tumor around those do express it. So it can potentially work, it could work in other cancer.

Of course, that's the motivation behind the company pursuing it, I don't think they're just pursuing for solitary fibrous tumor, but our solitary fibers tumor patients can reap the benefits, right?

Absolutely. They're fine to take other treatments if it works. Who cares if this was invented for another cancer or our cancer, we don't care. We just want to give it to the patients, right?

We want patients to receive it. So the majority of solitary fibrous tumors have this FAP. It's a fibroblast activation protein. Okay. And so how this Trial works.

We're gonna have it open any day now at University of Miami. It's open in a few centers already. This is Perspective Therapeutics. The drug name is PSV359.

When a drug is early in its development, it has just numbers and letters. As it moves forward from phase one to phase two and it looks promising, then it becomes a name.

And then if it's phase three and it shows that it is effective and goes to the FDA and gets FDA approved, then it has a generic name and a brand name.

So we're still in the early phases because it only has numbers and letters. What it is, it's called a radio ligand, image-guided alpha particle therapy.

So what they do is they take the lead, 203 PB, they create a radionucleotide, and there's two particles. One is the 202. And that, you can use it as a PET scan.

A patient undergoes the PET-scan, which basically they get radioactive dye tagged to 203PB, tagged the FAP, right? So it's binding specifically to those proteins, and you could see it on a scan, on the pet scan because it has that radionucleotide attached.

Correct. If the tumors light up, then you're a candidate for the treatment. Okay. After that, so first you get the PET scan to see, does your cancer light off?

Okay? If it doesn't light, why are you going to get a treatment that's not going work? But we think that the majority will light. So then it lights up.

Then they get four injections. eight weeks apart, that the injection is tagged to PB 212, okay, tagged, to the FAP, and then they get this alpha particle, which is basically radiation, right?

A little bit of radiation. Instead of radiating these big tumors and big amounts of the radiation now you're getting radiation specifically to Okay. And so we're very excited about that and that's going to be open any day.

It's gonna be opened, but it's to open for all solid tumors. So we want to stockpile, of course, we wanna get any solitary fibrous tumor or even sarcoma patient in so that we can prove that it is effective and then we could move forward.

And then we can show, if we could show even five patients, 10 patients with solitary fibrous tumor works in the majority, then this could potentially be fast-tracked to be approved, or at least another trial where it's only solitary fibros tumor patients or only sarcoma patients that add a lot with solitaire fibro tumor.

Because other sarcoomas also express FAP, so we don't wanna exclude our sarcoma friends, right? So that is promising. And then the thing is that this technology right now, it's tagged to a radial light.

It's tag to alpha particle, but you can tag it to chemo. You can target to another drug, right? So there's this new technology called Aden-C antibody drug conjugate.

So say in the lab, if we see that the HDAC inhibitor, for example, is effective, then we could create a drug. We tag the H-stack inhibitors to the FAP particle in their radionucleotide and then inject it.

And then instead of getting radiation, you get the chemo drug or the HPAC right into the Exactly, site-directed to those specific proteins which are in the cells that are compressing the genetic abnormality, which is amazing.

Which could also lead to, of course, better tolerability, right? And because right now all our medications go everywhere in our body. If we could target it specifically to just the SFT cells, just to the cell that express FAP, then you don't have all the side effects.

Same principle, we can create a vaccine with it. We tag the FAP, and we engineer T cells to recognize theFAP as well. So there's a lot that we could do.

And I think if we enroll a decent amount of SFT patients onto this trial, Then we can prove, look, number one, the tumors express FAP, right? Even just getting the PET scan itself showing this and then showing that this technology can work.

limitless as far as what we can do with this. That's super exciting. Yeah. So on clinicaltrials.gov, it will be listed as our site as soon as it's activated.

I think there's just, of course, always paperwork. And we've already had all of the procedures and they told me any day now. is released, you know, editing all my arms out.

They always make us sound better than we really do. So if someone says I'm listening to this and I want to see if I am a candidate for it, do they go through the registry or how do you go about finding out information to say this?

I wonder if i'm a So they can go to the registry. They can also go clinicaltrials.gov and put in 359. If they put it in just SFT, they're not going to get it because this is for all solid tumors.

You can put also put FAP, but when I tried to do that, it was hard to find. But then, of course, you can just go the the Registry and ask as well on our website.

Once we have it on clinical trials. We will be posting the trial availability on the website Which is SolitaryFibersTumor.org. When we publish this, I want to make sure we include SolitaryFiberStumour. Org.

I wanted to include any links you have, if you had a link to that trial with the Theragnostics study that came out of Europe. And just any information that you can pass on, because I wanna pass this on to Our patients and what I'm hoping Dr.

D'Amato's as time goes on will do another update here in a few months and see where it's at.

How Patients Can Get Involved and Closing Remarks

But if you're a patient listening, this is your call to action. Sign up for the registry. Check out the ASCO meeting and. See what you can do with joining with Sark or some other thing that can be involved as a Check out clinicaltrials.gov and look up PSV359 as that rolls out here over the next few weeks.

See if you're a candidate. And like Mr. Horowitz told me in the last one, we are going to win. He is such a dynamic, excited guy. I agree. We will. This has been a super fun episode to record.

Do you have any other thoughts as we wrap up our time here? No, I just really want to thank you for your time. You know, there's very encouraging data, but we've made a lot of progress and we're very hopeful we can make more.

But in order for us to make this progress, we need patients enrolled in the registry and need to get patients on these clinical trials so we So they can be treated, of course, to make them better, but also to help others so we can learn the best treatments.

Very hopeful. So thank you so much. Thank you. You know, thank to Heather Hayenga, and deepest thanks to Mr. Horowitz for making this all possible. It's just a dream come true.

Awesome. Keep in touch, Dr. Tomato. I really appreciate it. Okay. Thanks so Thanks for tuning in to the Doctors Making a Difference podcast. And thank you for what you do to help your patients and your community.

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