

THE BLOODLINE WITH LLS

A PODCAST FOR PATIENTS AND CAREGIVERS

Episode: 'Removing Mystery from Myeloma: Questions to ask, Bone Health and Clinical Trials'

Description:

Join Alicia and Lizette as they speak with Dr. Marc Braunstein, a Board-certified hematologist, medical oncologist at NYU Winthrop in New York, NY. This is the second episode of five that will be part of 'Removing Mystery from Myeloma' series. On this episode, Alicia and Lizette discuss the topics pertaining to myeloma patients and caregivers. Dr. Braunstein explains how a myeloma patient and caregiver should choose their hematologist, new treatment for myeloma and how it has evolved over the years, questions to ask one's healthcare team, the importance of medication adherence, and how myeloma patients can build or maintain healthy bones.

Transcript:

Alicia: Welcome to *The Bloodline with LLS*. I am Alicia.

Lizette: And I'm Lizette. Thank you so much for joining us on this episode.

Alicia: Today, we will be speaking with Dr. Marc Braunstein, a Board-certified hematologist, medical oncologist with a focus on the care of adults with hematological malignancies, particularly multiple myeloma. Dr. Braunstein completed his Fellowship at NYU Langone Medical Center and then joined the Division of Oncology/Hematology at NYU Winthrop in July 2017 working to enhance the autologous stem cell transplant program and further developed the innovative clinical trials program that provides their patients with unique and novel therapies. Thank you so much for joining us, Dr. Braunstein.

Dr. Braunstein: Thank you so much for having me. It's a pleasure to be here.

Alicia: Yes; so, before we jump in about the topic of myeloma, what brought you to the field of oncology or hematology?

Dr. Braunstein: Yeah; that's a great question because, we're currently interviewing medical students and residents for enrollment in our training programs and it's really fascinating to read their applications and their stories; and I think each one of us comes with a personal story. For me, much like many of my colleagues, my interest in medicine started with a true passion for science and also for working with people; and, while I was in college, I had a close family member that was also going through treatment for cancer and I have a brother who also was pursuing training in radiation oncology and although I don't come from a family of all doctors, these kind of different areas of my life kind of came together and really drew me towards medicine. And I felt that oncology, particularly, focused all of my interests and passions in one place where I could really interact with people at a critical point in their lives when they are very vulnerable and going through a lot of stress about a new diagnosis or a serious condition; and just merging the science, and the research, and the patient care really came together. I felt a career in oncology.

Alicia: Interesting. So, my great aunt, she was diagnosed with myeloma about 3 years ago and it was one of those diseases where it was confusing to her because it was a matter of it's in my bones, but it's really blood and it's hard to wrap your head around, as a patient, when you get that diagnosis and you try to understand exactly what's going on in your body. What is myeloma for the patient and caregiver listening?

Dr. Braunstein: Sure; and thank you, Alicia, for sharing your personal story. It can be confusing for patients. Multiple myeloma is a type of blood cancer, but it tends not to occur in the circulating blood, but more so in the bone marrow, where there are cells called plasma cells, and these cells are normally helpful cells in the body. They

help produce antibodies which are proteins that help us fight infections, but in multiple myeloma, these cells have become abnormal, and they hone back to the bone marrow where they grow in a supportive environment. So, everything that has to do with the consequences of the disease really stems from the fact that there are these abnormal plasma cells growing in the bone marrow and invading the bone that surrounds the bone marrow. So, it's not really a bone cancer per se, but really a cancer of cells that exist inside of the bone marrow, which is an organ in and of itself whose normal function is to produce all the blood cells that circulate in our blood.

Lizette: Yeah. We've had a lot of people call our Information Resource Center and speak to an Information Specialist and preface their conversation with, "I have bone cancer" and when we delved deeper, it's really that it's multiple myeloma so there is that confusion a lot of times, especially since there is so much bone pain associated with myeloma.

Dr. Braunstein: Yeah; absolutely. Even the name of the disease stems from the fact that it was identified by the finding of these bone, or what we call lytic lesions, scattered throughout the skeleton and each of those areas is a site where these abnormal plasma cells are growing into or invading into the bone. So, the name of the disease, itself, stems from the fact that it is a disease that invades the bone, but not a cancer of the cells that make up bone.

Alicia: For those listening, we definitely want you to check out our other episodes that we recorded with Dr. Racquel Shelton who speaks about the actual diagnosis of myeloma and we go into great depths about that as well, but for this episode, we really want to talk to Dr. Braunstein about the other topics that patients are discussing and the conversations and questions that they have. And one of those is, we all know that the relationship with your doctor is very important, especially when it comes to a hematologist or oncologist since this is the team that the patient needs to feel

comfortable and confident that they are diligently and intelligently working to save their life. So, for the myeloma patient or caregiver of that patient who is listening, how should they choose their hematologist?

Dr. Braunstein: Yeah; that is a great question, Alicia, and really a crucial one because there's so much information that is discussed with a new diagnosis of any cancer. And, as a patient, I think one has to be really comfortable that the person treating you at such an important juncture of your life, really has your best interest in mind, really takes the time to explain things to you, as the patient, and your family to make you feel like you are getting the best possible care anywhere in the world; and that they are coming up with a treatment plan that takes into account all the things involved in your life, in addition to the disease. You know, what your needs are. If you are working, do we have to work around your work schedule? And so, I think that's the first thing is taking into account all the patient needs and then, specifically for multiple myeloma, I think that, as a patient, you want to be treated by an oncologist that really lives and breathes myeloma, that really has a focus on this condition, and is comfortable dealing with the nuances of the treatment and the treatment side effects as well as has access to or performs, him or herself, autologous stem cell transplantation.

So, ultimately, the key thing is being comfortable with the individual that's treating you and their team since, oftentimes, we work in a team with many other clinicians who work behind the scenes to take care of our patients, but it is ultimately about having a relationship, and then going into more detail about how that person is going to treat you and what their level of expertise is.

Lizette: And isn't it more important nowadays, especially with the past. I would even say it's like 5 to 10 years where there is so many new treatments available now for

myeloma that patients and caregivers seek out somebody well-versed in myeloma just because the field has been changing so much.

Dr. Braunstein: Yes; Lizette. You make an excellent point. The field has changed tremendously since I started doing research almost 20 years ago. And at that time, we really didn't have as much targeted therapy as we do now and, in the past 2 decades, we have seen more than 10 new FDA-approved medications to treat these diseases and even more combinations of those agents. So, it's a challenge even to keep up with the latest literature because so many new studies are coming out in combination of these agents. And so, it really is necessary to work with an oncologist who has a firm grasp on the--all the data and all the steps involved in treating, ahh, myeloma in such a complex ecosystem of treatment paradigms now.

Alicia: And going back to when you were speaking about a patient needing to feel comfortable, I guess it's a challenging situation because I know for me and my family when my great aunt had myeloma, but my grandmother actually passed away from kidney cancer, and it was one of those things where you've never had to be in this type of setting before, so you are introduced to this new environment, and even though you might not feel comfortable, you hear "cancer", you want to start treatment and feel as if you are doing as much as you can, but I think you bring up a great point where you have the time to feel comfortable with your healthcare team so that you feel you are in the right hands.

Dr. Braunstein: I agree; and also, The Leukemia and Lymphoma Society offers a number of brochures to help educate patients. I often advise my patients to go and seek those out and do their homework. When they come back and read it, I give them an A+ because it really is valuable information written very carefully and very helpful to patients, in a way they can understand. And I feel that once they read that information at a reliable site like LLS, they can come back to me with much more

sophisticated questions and things that often take more time for them to understand. So, educating patients is really the first step before we talk about anything about treatment options or anything else. It's really making sure that we both have a firm understanding of each other and of the disease and that I convey that information in a way that the patient and their family members and relatives really, really understand.

Lizette: Definitely. Something that Alicia said was, a lot of times, you're not used to being part of a discussion with, you know, taking care of a family member that has cancer and once you hear the word "cancer", you do want to start treatment right away. You want to fight, and I think one of the things with myeloma is we do get a lot of inquiries about smoldering myeloma and people wanting to start treatment right away. And I know that the field might be changing a little bit, but I know that, "watch and wait" or "watch and worry" may be a treatment protocol for smoldering myeloma.

Dr. Braunstein: That's right and I try to explain to my patients that multiple myeloma, in general, is more of a marathon than a sprint; and that can be difficult for patients who have a lot of anxiety about treatment, and they want to move everything so quickly, and while we may be able to start treatment quickly, the overall pace of the disease is, oftentimes, long and punctuated by periods of relapse or remission. Now, the precursors to multiple myeloma, including something called MGUS and smoldering myeloma, which you mentioned, Lizette, have historically just been monitored and we haven't treated these patients. However, now, more and more, we are looking at the smoldering group as they have about a 10 times higher risk of progressing to multiple myeloma than patients with MGUS. We are looking at this group and thinking more and more about intervening earlier to even try to cure the disease before it advances to multiple myeloma. Now, that doesn't mean that the standard, currently, is to treat all patients with smoldering myeloma, but there are certain sub-groups of patients who have smoldering myeloma who can be categorized as having a higher risk of progression to symptomatic multiple myeloma. And those

patients could be considered for earlier intervention, ideally in the context of a clinical trial.

Lizette: Yeah; it keeps changing this field, which is great, because there's so many different treatment options now available for myeloma patients that weren't available before and, like you said, more targeted developments, more targeted medications, treatments that might have less side effects associated with them.

Dr. Braunstein: Exactly; and that's really the key thing. With targeted therapy, which basically means that it's specific for that particular cancer. So, drugs that are specific for multiple myeloma that really go out and seek out the pathophysiology of the myeloma and its weaknesses, not only are those drugs more effective, but they are also better tolerated and, as such, patients have fewer side effects than they would with more traditional cytotoxic chemotherapy that tends not to distinguish as well the healthy cells from the myeloma cells. And so, because these drugs are more well tolerated, we can begin to think about moving them into the smoldering myeloma setting where patients could still have a good quality of life, but also have the benefit, possibly, of prolonging the duration at which they would otherwise progress to symptomatic myeloma.

Alicia: Doctor, jumping back to the information that you shared regarding how important it is for patients to approach their doctors having done research and going through credible organizations to receive that information. And for those listening, you could actually visit www.lls.org/booklets where you can download, or you can order our publications free-of-charge. Something that happened for me is we would walk into appointments with my grandmother, and we would, you know, we would leave sometimes thinking, "did we ask that question" or "should we have asked that question"? And along with our publications at LLS, we also created a list of printable question guides so people can download and print these questions for them to just to

remember to ask these questions of their healthcare team. What questions should we ask upon diagnosis for a myeloma patient?

Dr. Braunstein: Sure, Alicia. You bring up a good point and I often encourage patients to keep sort of a diary or list of running questions that may pop into their head in the middle of the night. So, the questions you want to ask with a new diagnosis of myeloma are really questions that are unique to that particular patient. So first off, how was the diagnosis made? Are you sure that this is the correct diagnosis? So, you want to review with your doctor what the bone marrow biopsy showed, how and what criteria were used to document this patient as having symptomatic myeloma, as opposed to some of the precursor conditions we spoke about.

And then, you want to dive a little bit deeper into the results of the bone marrow. What were the genetic changes in those abnormal plasma cells because that information helps stage patients and also helps predict their response to treatment. And then, you want to talk about the staging. So, there are 3 stages, I, II and III. The higher the stage, the shorter the survival. And you want to speak about treatment options and what treatment options would best suit that particular individual and the biology of their myeloma; and what supportive measures they may need. For example, to support their bone health, exercise, nutrition, all those things that patients actually often ask me about because they want to feel like they have some control over the process as well and typically, they can do that with diet and exercise. So, it's a long visit and there's a lot to unpack in that first visit talking about the diagnosis and the treatment options, but I think having those question lists from LLS is really helpful. That way, you don't miss the really important questions.

Lizette: And Alicia also developed a myeloma calendar which is really especially important nowadays with a lot of the oral medications that are available for myeloma

and the adherence, issues that come along with taking an oral medication and just to remember. So, Doctor, as you were saying, journaling, just to help because a lot of times with these newer medications, it's—the onus is on you to take them if you are going to take them at home, which is great that you're able to take the medication at home, but at the same time, some people feel like "oh my gosh, I have to remember", so people do get a little bit taken back sometimes that they're the ones that have to remember to take this medication and to take it the way it's prescribed, to which sometimes can be difficult.

Dr. Braunstein: That is true. I mean, I think it's one of the advances in the treatment of multiple myeloma that many of the novel agents are oral. In fact, in the recent few years, we've seen entirely oral 3-drug regimens so I think, more and more, patients are going to have the availability of oral regimens that they can take, for the most part, at home. And so, when I see a new patient, I work with a navigator, who is a nurse that kind of helps make sure everything is going according to plan with our patients and nothing falls through the cracks. And that person will be with me on the first visit, where we talk about treatment options, and she'll have a calendar to really go through and reinforce what I spoke about. And then, our infusion nurses will also review that calendar with the patient, but you know, we treat patients who are typically more elderly. I mean the median age for diagnosis of myeloma is the late 60's, although it can affect people much younger than that, but in general, it's a disease of older individuals and, in some cases, patients who are at the extreme of aging. And so, we obviously tailor our therapy for individual patients, but patients who may have some baseline dementia or other compliance issues, making it difficult for them to adhere to the treatment schedule. Those patients we have to tailor the therapy as well and, oftentimes, reinforce the treatment, enlist their family members or other relatives, sometimes have a visiting nurse, and also call them at punctuated points throughout their treatment to make sure that they are taking their medications appropriately.

Lizette: That's good to provide that follow-up, right? Alicia, that's ...

Alicia: Yeah; yeah.

Lizette: ...important.

Alicia: We had one doctor, I think, tell us that—Lizette, I don't know if you remember this, but one doctor said a patient came in and said, you know, these drugs are expensive. She made her own schedule based on the fact that she wanted this medication to last. And it's one of those things where you have to educate the patient and let them know exactly how important this is for their survival.

Dr. Braunstein: Sure, Alicia. And this goes back to one of the first things we were talking about, about having that relationship with the patient that they feel comfortable coming to you with things like financial issues, or compliance issues, or any other adverse effect of the treatment schedule—the treatment regimen. Oftentimes, our patients may have financial concerns. You know, these are patients who may be in the retirement phase of their life and have a limited income or not have insurance that doesn't cover some of these oral regimens; and so, this is an important conversation that has to be had. And in a lot of times, I find patients are timid about bringing up issues, sometimes they just don't want to say they're having a side effect because they feel it might affect their treatment, or sometimes they feel awkward about talking about financial issues, but quite the contrary, we try to foster an open space where patients should not only feel comfortable, but really need to let us know about these things so we can help them rather than having these issues sort of go under the rug and not come out and adversely affecting their response to the treatment.

Alicia: Right. Although multiple myeloma is classified as a blood cancer, patients with this disease often experience bone-related symptoms, too, and this includes bone pain, frequent fractures, loss of low bone density or bone damage, that can show up through skeletal scans. How does multiple myeloma affect bone health and What can myeloma patients do to build or maintain healthy bones?

Dr. Braunstein: Good question. So, one of the diagnostic criteria for multiple myeloma involves having these lytic bone lesions, in which the myeloma kind of invades into the bone. And about 60 to 70 patients will have at least one area of lytic lesions upon diagnosis. So, the co-management of myeloma involves, treating the plasma cells that are abnormal, but also helping to support the bone function; and there's 2 ways that we generally go about that. One is prevention. So, if a patient has a large lytic lesion or one in the spine and that fractures, that could lead to a pathologic fracture and severe disability. So, we aim to prevent these events from happening by giving them supportive medications to help prevent any skeletal events. So that can include giving patients calcium and vitamin D, which seems a little bit counter-intuitive for myeloma since it can present with high calcium, but oftentimes, the body still needs vitamin D and calcium to support the healthy parts of the bone. The second part is that we'll typically give patients monthly injections of medications called "bisphosphonates" and these are medications that also help support bone strengthening cells and there's also literature to suggest that they work synergistically with the treatment directed at the myeloma, itself.

Now, if a patient presents with a fracture or a painful lytic lesion, then we move onto secondary prevention to prevent that lesion from getting worse or causing more disability. And that can involve things such as radiation, which can—which is a focal therapy that's generally well-tolerated and can help refurbish the bone or, if it's an area typically in the spine that's caused a compression fracture, we may work with an orthopedic surgeon or an interventional radiologist to do something called

“vertebroplasty” or “kyphoplasty” which is sort of like injecting cement into the bone and giving it more structural support. So, these are things that we have, conversations that we have, with every patient regardless of whether they have a lytic lesion at diagnosis; and it is really important because having bone disease in myeloma can be, sometimes, painful and really lead to decreased quality of life and we try to prevent skeletal-related events.

Alicia: Absolutely. And for most myeloma patients, they’ll receive maintenance therapy as part of their treatment plan. And I was reading data that show that maintenance therapy can extend progression-free survival in overall survival after initial treatment, which can include a variety of drug combinations or stem cell transplant. I guess my first question is what is maintenance?

Dr. Braunstein: That’s a good question because, as I said before, with targeting medications, they tend to be so well-tolerated that we can now even consider continuing them. So, maintenance therapy is essentially continuous therapy that typically at a lower dose from the initial treatment dose and the way I sometimes explain it to patients is that if you had high blood pressure and you were prescribed a blood pressure medication, you wouldn’t necessarily stop the blood pressure medication even if the blood pressure was suddenly controlled. So, specifically in multiple myeloma, though, this is a disease that’s considered to be incurable, but highly treatable like a chronic disease; and so, the idea behind maintenance therapy is to give a lower dose of targeted therapy to try to keep some surveillance of the disease and to try to keep it under control before it would otherwise progress. If there are any residual myeloma cells lurking around, the maintenance therapy would prevent those cells from growing the myeloma back. So, this has now essentially become a standard of care, particularly in patients who have undergone autologous stem cell transplant. We will give patients, typically, either an amino modulator, like lenalidomide, or a proteasome inhibitor, like bortezomib, as maintenance therapy and this

has been shown not only to prolong progression-free survival, but also overall survival when they grouped all the data together. So, it's essentially become standard of care.

Lizette: So, in the past when someone was in remission, they would stop treatment for a while and then when the myeloma returned, they would begin treatment again.

Dr. Braunstein: That's correct. So, it's worth noting upfront that not every patient may be a candidate for maintenance therapy if they didn't tolerate certain medications, and it is okay to sometimes monitor patients off therapy, because we have plenty of other agents in the arsenal that can suppress the disease should it relapse, but , typically all patients will go on some form of maintenance therapy because it has been shown to prolong the duration at which the disease is kept under control.

Alicia: And so, speaking about therapy to be, and you probably get this too, Dr. Braunstein, but I know that we get calls about CAR T-cell-

Dr. Braunstein: Sure.

Alicia: -therapy and, you know, you hear about clinical trials, you hear about CAR T, you hear about it being used, you know, for a myeloma patient, how and when should a patient explore a clinical trial when it comes to myeloma?

Dr. Braunstein: Yeah; that's a great question, Alicia, because clinical trials have many benefits. They not only do they advance the science that serves as the foundation for new treatment regimens, but specifically in multiple myeloma, many of the clinical trials testing new agents or new combinations of established agents have been highly successful; and often the experimental arm that contains the new agent or the new combination, outpaces the control arm, which may be the standard. So, there's always a good time to consider a clinical trial with the current armamentarium of event of myeloma drugs, it's typically not required up front for the treatment of

myeloma but can be considered. Many of the clinical trials for myeloma explore treatment in patients who have failed their initial therapy or have relapsed refractory disease.

CAR T-cells is one area that appears to be proving very successful in the treatment of highly refractory myeloma patients who would otherwise have had no additional options and a very low likelihood of remission with the available agents. So, CAR T-cells, it's a biological therapy that involves harvesting a patient's T-cells and then sort of reprogramming them so that when they are re-infused, they go back and use the immune system to kill the myeloma cells. So, that is not currently FDA-approved for myeloma, but it is for other blood cancers such as non-Hodgkin lymphoma. But I think this therapy is imminently going to be FDA-approved in the future, but right now, it's really conducted in the context of clinical trials; typically, at larger academic centers that have the infrastructure to support this technology and this therapy. But I think one of the questions on the list, like we were talking about in the beginning, to ask you oncologist is, you know, do you think I am a candidate for a clinical trial now, and how do I search for them? How do we work together to find a clinical trial for me because there is never a bad time to enroll in a clinical trial?

Lizette: Are there any other clinical trials going on right now for myeloma that you're excited about besides CAR T?

Dr. Braunstein: Sure; I am certainly excited about the CAR T-cells because there is a lot of creativity that can be had with that technology for targeting different elements of the myeloma cell. I am excited to see some of the oral agents that have been used as part of the initial treatment being used as maintenance therapy. I am also excited about some of the newer monoclonal antibodies which already have proven to be highly successful, and we are actually going to be opening up an arm of an international clinical trial using one of the monoclonal antibodies, daratumumab, in the upfront setting. So, I am excited to see how that plays out in terms of achieving

deeper remissions when using these monoclonal antibodies that are already approved in the relapse setting but bringing them into the initial treatment setting. So, there is a lot of activity going on now in monoclonal antibodies as well; different targets, conjugated antibodies where not only do you deliver the antibodies to target the myeloma, but you also now focally deliver chemotherapy to the myeloma cell, so I think we are going to continue to see many new FDA-approved medications for myeloma. And it's really a truly exciting time to be involved in the field.

Lizette: It is. That's great.

Dr. Braunstein: I do want to make a quick plug, though, for some research we are doing. It's a non-interventional study, but we're looking at the gut microbiome, which are sort of the passenger bacteria and organisms that live with us, which hasn't really previously been explored much in multiple myeloma, but we are trying to look at whether this is abnormal since multiple myeloma is a disease of the immune system and the immune system is intimately involved in our gut flora interactions. And we are looking to see if there is anything abnormal in multiple myeloma patients compared to healthy volunteers, and MGUS, and smoldering myeloma patients. And whether that has any relevance to the disease pathogenesis of progression.

Alicia: Wow! I would be very interested to see how that develops.

Dr. Braunstein: Yeah; so am I. It should be interesting.

Alicia: We might have to get you back on an episode, Dr. Braunstein.

Dr. Braunstein: Happy to help.

Lizette: It sounds very similar to the Dana Farber's new trial that's coming up and it's for healthy patients, that are either African American or the first generation of a myeloma patient and they are going to see what other things may be predictive of who is going to get-

Dr. Braunstein: Sure.

Lizette: -myeloma.

Dr. Braunstein: Right. So, there are a number of repository studies where they are banking samples from patients at various points along the disease because, one of the issues we have in the field is that we don't have very good predictive markers to tell when a patient may progress from MGUS to smoldering, or smoldering to myeloma, or MGUS to myeloma. We can sub-categorize those people into higher risk categories, but we still don't know when they are going to tip the scale towards symptomatic myeloma. So, there is a lot of research looking for markers and indicators of what really leads patients to progress along that spectrum to symptomatic myeloma.

Lizette: Yeah; it's interesting. We always get that question, you know, I have MGUS, I have smoldering. Why can't we stop it before it turns into multiple myeloma? We always get that.

Dr. Braunstein: Sure; and, also, I always get asked what caused this? What caused me to develop this? And sometimes there may be an association. For example, living in New York, we have patients who were 911 first responders and there is a documented association between that exposure and MGUS, but many times, we don't know the cause. And really, the etiology of multiple myeloma, for the large part, remains unknown so there's a lot of smart scientists and clinicians working together to try to figure that out.

Lizette: Yes; we thank you all.

Alicia: Yes.

Lizette: Thank you all very much.

Dr. Braunstein: I'm grateful, too, yeah.

Alicia: Okay. Doctor, so we know that multiple myeloma is the most common hematological malignancy in African Americans with twice the incidence of Caucasians. I am curious to know, with my great aunt living in Jamaica and being diagnosed with myeloma, is there any research or studies being done looking at those patients from the Caribbean diagnosed with myeloma?

Dr. Braunstein: Sure; sure. That's a great question, Alicia, and I was going to ask, because you mentioned that your African American background, but specifically, in the Caribbean population, these patients also seem to have a higher risk of myeloma. In graduate school and medical school, I worked in an area in Brooklyn that had a high prevalence of patients coming from the Caribbean and so we noted that these patients seem to have a rate of multiple myeloma that was out of proportion to what would be expected. So, there is research going on to try to categorize these patients based on their country of origin. There are other diseases that are known to have predilection for sort of equatorial countries; and so, although the reason is not clear, there are groups that are banking samples from patients specifically from the Caribbean, many of which live in Brooklyn in New York, in order to see why this particular population seems to be at higher risk for multiple myeloma.



Alicia: Right, well, like Lizette said, we are still thankful for yourself and for others in the field that are doing so much work to help to get answers to these questions and, of course, treatment to these patients. So, thank you so much for all you do.

Dr. Braunstein: My pleasure. Thank you; and thank you to the LLS for all the work they do to help our patients.