Episode 5 Transcript: Managing hair loss in a metastatic setting: investigating scalp cooling with Enhertu

SPEAKERS
Elahe Salehi, DNP, ANP-BC, Richard Paxman

Richard Paxman 00:02
Hi, my name is Rich Paxman, and welcome to Changing the Face of Cancer podcast. In this episode, I'll be chatting with Elahe Salehi, who is involved in the groundbreaking clinical trial currently being carried out at the Dana Farber Cancer Institute, comparing hair retention rates with scalp cooling in the metastatic setting. The chemotherapy drug regimens in question are Sacituzumab govitecan, Eribulin, and the highly anticipated Trastuzumab deruxtecan, also known as Enhertu. We discuss the motivations behind the trial and its design, and the outcome measures decided upon which look closely at the impact on patient quality of life. And we also ask, why is it that previously little has been done in the metastatic setting with scalp cooling, and that just because the majority of scalp cooling research has been carried out with early stage solid tumors, this is not a valid reason to not offer to metastatic patients.

Richard Paxman 00:57
So hi Elahe, lovely to have you on today. I want to start by first asking you a little bit about yourself. So tell us where you're from and the work that you do. But also, I think more importantly, what got you into oncology? What got you to the place you are today?

Elahe Salehi 01:18
Hello, and thanks for having me. So good to be here. You know, my life story is long, but I try to make it very brief and short. I travelled around and nursing was my second career. And I really did not think about oncology. It was not something that I was thinking about it, until I got my first interview at Yale Hospital in an oncology floor, and I totally fell in love. And that's when I said yes, I want to be an oncology nurse. And that was back in 2002. And since then, I have been in oncology, I can't believe it's almost two decades.

Richard Paxman 01:57
Wow, that sounds a long time when you put it like that two decades. Seems two minutes ago, doesn't it? 2002.

Elahe Salehi 02:03
Exactly. So it has been a long time. I really loved education, and I thought that knowledge is power, always. So after a year, in nursing, I went back and I got my Master's in nursing in oncology concentration at Yale School of

Nursing. And I started to work as a Nurse Practitioner there. Then I moved to Boston, and of course, I wanted to go back to school and I got my doctorate degree at Institute of Health Profession, and I continue to learn every single day.

Richard Paxman 02:35
So tell us a little bit about why you got interested in scalp cooling, then of course, your role is incredibly broad, and you cover lots of areas of oncology, what really is interested you in scalp cooling?

Elahe Salehi 02:46
So you know, I've been doing breast since 2008. And I've seen a lot of patients who really felt uncomfortable with not having their hair. And I also work with a physician oncologist at Dana Farber, Erica Mayer, who sees tonnes of young women. If you think about it, breast cancer, and the surgeries that you have to have already is disturbing a lot of patients for their body image, and add that hair loss, continues to be a really dramatic aspect of their treatment. So when you think about it, for decades, we have worked on adverse events for any chemotherapy agents. And we have done a fantastic job. A decade ago or two decades ago, when I used to push Adriamycin people used to vomit. And now people do fantastically well. So if we see nausea and vomiting as an adverse event of chemotherapy, why not alopecia as an adverse event of chemotherapy? And that's what brought me to do a lot of my work on this because I really think that we should look into chemotherapy induced alopecia as an adverse event, and we need to look at it and try to build the way that we can manage this adverse event like the others that we have.

Richard Paxman 04:14
Yeah, wholeheartedly agree there, I think. And of course, you know, there are more safety concerns with regards to nausea and vomiting, but it still is an adverse event of the chemotherapy and it's something that really affects our patients psychologically. So hopefully, I think I'm sure you'll agree that we're starting to see it taken a lot more seriously. And you know, you've just mentioned about being at a conference and talking about scalp cooling, and that was something of real interest to a large number of the attendees which is music to my ears of course after doing this for so long.

Elahe Salehi 04:44
Absolutely. I have to say a lot of places now we are offering scalp cooling to our early stage breast cancer patients. This is kind of like a checklist that okay, we are offering chemo and this is it. You know you have the choice to go on scalp cooling and use the scalp cooling to prevent alopecia. So we have gone a long way since me and you met few years back.

Richard Paxman 05:09

Indeed. So interesting point you just mentioned there, and I think you said early stage breast cancer patients. So there seems to be a lack of data surrounding scalp cooling with metastatic breast cancer patients. So why do you think that's the case? Why do you think it's all in the early stage setting?

Elahe Salehi 05:28
So we both know that Europe has been using scalp cooling for quite a while, but not really in USA until 2015, when it got FDA approved. And we have a lot of work to do in that regard. So because it's a new concept, and it's been approved for early stage breast cancer, the NCCN guideline changes. And those are factors that will contribute to not really looking further into metastatic setting, right, because for us 2015, until now, it's kind of a new concept. And that's why a lot of people are not presenting scalp cooling to metastatic patients. Although that doesn't mean that we should not do this because I think that specially with the trajectory of our breast cancer treatment, having changed all the new agents that targeted agents that we have there showing a great success for our breast cancer patients in metastatic setting, we need to look in that as well, because to me, patient is a patient, whether they're early stage or metastatic setting. So here is a concept that is difficult for patients even in a metastatic setting as well. The more we look into seeing breast cancer as a chronic disease, the more we understand better, that we need more data in our metastatic setting as well.

Richard Paxman 06:56
Yeah, absolutely agree. And I think there has been a sort of shift as well, even from where we started in terms of where we've been using the technology, especially in Europe. Just thinking about, and there may not be a real answer to this question. But is it more important for a patient who has metastatic cancer to be thinking about hair loss? Or is it equal? Or what are the different rationales behind that perhaps?

Elahe Salehi 07:22
I think if you want to compare in an adjuvant setting to metastatic disease, patients who have told me, the concept of hair loss, obviously will work more towards the adjuvant setting, because this is something they will do it once and they hope that the cancer is never going to come back again. In metastatic setting you have a disease that might constantly change its figure, and have to continue getting treatment with all of these agents. Being able to accommodate that might become more difficult for metastatic patients. But that doesn't mean that we should not try. That doesn't mean that the patient who is in metastatic setting would not want to have scalp cooling. Although I have to say that obviously when your disease progression, and one gives you an option to get a treatment that might cause alopecia versus a treatment that is might not help you, but it's not going to cause alopecia, I guarantee you most of the metastatic patients will choose one that will actually make their disease better. So that's, I think, a difference between metastatic population versus adjuvant setting. But it brings me to the few first questions that you ask that the trajectory of cancer treatment has changed. So when we think about our metastatic patients living longer and longer, with antibody drug conjugates, specifically for our patients, that one consider, hey, if I'm going to live for the next 24 months, I better want to have my hair as well. And that is something that we are seeing lately. Now, I have to say I have a patient who was on Taxol

treatment for nine months, metastatic patient, and she wanted to keep her hair that was one of the things that she really wanted to do. And she had this beautiful grey hair. And she kept her entire hair for the nine month duration that she was on Taxol. And that really kept her quality of life quite high.

Richard Paxman 09:31
Yeah, absolutely. I had a similar story with a patient actually she was being treated here. I think she was on a second line treatment and she had beautiful results with scalp cooling. She was doing really well in herself. But obviously it's had to still continue treatment and that had stopped working for her. She was actually flying to Australia to continue with the treatment but they had no scalp cooling access. So we got a scalp cooler all the way to Australia for her, and then she continued for another 12 months, and unfortunately she passed away in the end, but you know she kept her hair and her husband, I met her husband when I was out in Australia soon after. And he said that for his wife made such an incredible difference throughout all her treatment, and for her young children as well, which still remember that very, very dearly.

Richard Paxman 10:14
So, we have started to look at some work in this area together looking at scalp cooling in a metastatic setting, but with three relatively new and novel drugs with really limited data on scalp cooling, and hair loss. So tell us a little bit about these three new drugs if you could do, if there's any interesting information that you could share with the audience.

Elahe Salehi 10:37
We started thinking beyond what we did before. So we said okay, now let's move to shift the whole scalp cooling to metastatic setting and look into the drugs. And we really didn't have any data. So we wanted to find a base foundation for our trial with only few agents and then go on and add. And thank you absolutely Paxman for the support, so we decided to have three agents. Now we have mostly seen that being used and no data. One of them is Sacituzumab govitecan, which is an FDA approved drug for triple negative breast cancer patients in a metastatic setting. We have tonnes of patients on this drug, and that's one of the things that we did not have data about. The second we looked into was an antibody drug conjugate Enhertu, or Trastuzumab deruxtecan, that we use and is FDA approved for HER2-positive metastatic breast cancer patients who have done fantastic in keeping overall survival and disease free progression for metastatic patients. And then the third agent we looked into is not a new agent. It's actually a very old agent, Eribulin, that we use in our metastatic patients - we have been using for many years. But we don't have any data, even the Dutch registry that I was looking at, there is no data of Eribulin and so we said okay, so that's a drug that we tend to use a lot for our patients as well. Let's start with these three agents. And that's what we are looking at. Our primary objective is hair preservation and our secondary objective is our quality of life and body image.

Richard Paxman 12:19

And just on the Eribulin, and agree yes we have limited data and wanted to collect some data for some time. So I was delighted although this drug has been around that you were of interest here. What setting is that in? So it looks like Sacituzumab - and I'm so pleased that you've presented and pronounced all the drug names for me - are both in different settings, where does Eribulin sit then?

Elahe Salehi 12:40
It is a metastatic setting as well. You're positive, triple negative, in actually all parts of a metastatic setting.

Richard Paxman 12:48
Okay, perfect. And does it look like the data as well for the other drugs are going to be in all metastatic patients as well, not just either triple negative or HER2-positive.

Elahe Salehi 12:57
Yeah, so the trial is only for metastatic setting, so that's one of the eligibility criteria is they need to have metastatic setting. And what happened in the schema of the trial is that the provider and the patient decides according to their disease what type of treatment to use, so let's say if second line treatment metastatic setting in triple negative breast cancer they're going to go on Sacituzumab govitecan. So if they choose that arm, this is a patient centered trial. So the patient then decides whether they want to go on scalp cooling or not. And that arm divided to scalp cooling and non-scalp cooling. So it depends on what the provider and patient decides on the treatment based on the characteristics of the tumor.

Richard Paxman 13:50
So just on the clinical trial design, then give us a little bit more of a flavor for that. How is the study designed? You said its patient centered, which I love this approach. I think we're going more and more that way of course, but tell us about the sort of patient numbers, number of arms etc. would be helpful.

Elahe Salehi 14:06
Yes, it is patient centered because you know, we went back and forth about making it a randomized trial but it just did not feel comfortable, because I wanted everybody who wanted to have scalp cooling to have a say in this. So it is a prospective pivotal trial. We are hoping for 120 patients each arm, which is only three arms, Sacituzumab govitecan arm, Trastuzumab deruxtecan arm and Eribulin arm. Each arm is actually 40 patients. Each of that 40 patient arm divides into 20 patients of scalp cooling and 20 patients without scalp cooling. There are criteria for eligibility and of course they have to have a full set of hair, that's very important, then they also have to have metastatic disease and start one of these agents at a full dose. So once they get registered, we have pictures taken in all four angles. And we do two questionnaires, body image questionnaire and CADS questionnaire. And they go on the trial and cycle three day one, I believe cycle five day one, we'll repeat this, all the pictures and the questionnaires until they have progression of disease or a grade 2 toxicity that they have to come off of the trial. And we do obviously questionnaires at the end of the trial. So we started this over I think

our first patient was October of last year, it is going a little bit slower than what we had hoped for, because of the pandemic. It really put us behind schedule. But we are hopeful we just opened it up actually on our satellite and Milford, which is going to improve patients coming from the satellites as well. And so they don't have to drive all the way to Boston, they actually can get the scalp cooling trial at satellite and we're hoping to open up further satellites such as Foxborough, which is opening up in August, and then south shore as well. So I'm hopeful that we're going to have more patients going on to trial.

Richard Paxman 16:15
And are you finding it more difficult to recruit patients to the scalp cooling arm just based on proximity of scalp cooling and opting to be chosen at their local site rather than the main campus? Is that one of the barriers at present?

Elahe Salehi 16:28
That is one of the barriers for sure. The second barrier is that our patients in a metastatic setting have gone through chemotherapy treatments. So sometimes when they have progression of disease, and they're coming to go on a different trial for a different chemotherapy agent or ADC agent, and what happens they don't have a full set of hair. So they won't be part of the trial. And that is part that we are having difficulty with recruitment.

Richard Paxman 16:57
Yeah, that's obviously a big factor, of course, depending on if they've had scalp cooling before or not, and being successful or not being successful. And I guess there's also a lot of information to take on board, it's a difficult time more decisions to take on board to join a clinical studies.

Elahe Salehi 17:13
That's absolutely right. Although you brought a very, very great point that we are going to look into it during the study, is when a patient comes in for metastatic setting and being part of the trial, did they use scalp cooling before in an adjuvant setting or metastatic setting? And was it successful or not? And how those people are going to be? So sometimes actually, we have patients in our adjuvant setting who use scalp cooling with fantastic results. And unfortunately, now they have metastatic disease. So they starting the trial with another scalp cooling, and it's good to actually see what their results and outcome is going to be as well.

Richard Paxman 17:55
Yeah, and I guess not only from a visible hair loss, but actually as well from a psychosocial perspective as well looking at the CADs, etc. Which scales are you using then for hair loss, but also quality of life?

Elahe Salehi 18:08
So CTCAE criteria five, we are using it. So anything grade 2, that means more than 50% of hair loss, and they will come off. Body image and CADs we are using it.

Richard Paxman 18:22
Okay. And tell us a little bit about CADs. Is that a relatively new scale being used, and is it widely used as yet?

Elahe Salehi 18:29
Yeah, it's a new scale. I like this because it has four domains. So it's kind of separate the domains on this questionnaire. And it makes it easier for patients to respond to the four domains. You have your psychological aspect of it, you have what the hair loss means to, you what the body image. So all in one questionnaire, which I think that is going to be very helpful.

Richard Paxman 18:57
Yeah and I'm looking forward to not only seeing the results of CADs in this particular study, but also others because I think we've talked about this a few times. And we have definitely Elahe just around the existing scales that we've tried to use historically not always been fit for purpose, looking at specifically chemotherapy induced hair loss. So we're hopeful this is a little bit fit for purpose. You focus quite a lot of course on quality of life as a secondary end point. What's your gut feeling about this based on the results? Is it hard to tell at this moment in time?

Elahe Salehi 19:32
It is hard to tell at this moment, unfortunately, because of the I think we have recruited not even close to 20% yet, so it's hard to really say, but I'm hopeful that with the CADs questionnaire adding to the body image questionnaire, we will have more data in regards to quality of life, we'll have a better picture of what really, patients will think. And because it's metastatic setting, I think that we're going to get a true feeling of how they feel. It's not about so in the adjuvant setting sometimes we think that okay, we hand in this question or the first time they come in and most of the trials that, you know, they do this questionnaires are right upfront patient just got diagnosed with breast cancer, they are digesting what breast cancer is. Now we're telling them, they need chemo that they're going to lose a lot of their self-esteem with all of these chemotherapy agents and side effects. And then on top of that we saying, let's start using scalp cooling and tell us how you feel. I think that all of these data are so tough for patients to swallow in one visit. But in metastatic setting, they have gone through this process, they know what to expect. And now we're asking them, 'hey, having hair would really benefit you and your quality of life? Would it matter to you or not?' And I think we can get a better answer, we're going to get a true answer because they've gone through this before.

Richard Paxman 20:59
That's a really interesting perspective and not one that I've heard or even thought about before. So yeah, looking forward to delving into that a little bit deeper when, when we can do. So can you talk about any results yet? Can you give us any inkling? Or is it all hush hush until the publication.

Elahe Salehi 21:19
So to be honest with you, I'm so new in this too. So I'm not sure! But I have to say I can give you a very general idea. This way, I'm not going to step on anybody's toes, but for some agents is working quite nicely. And for some agents it's not.

Richard Paxman 21:40
Just on that piece, then and I'm not saying you can say which agent etc. But you're a provider, you speak to your patients on a regular basis, you see metastatic patients day in day out, if you are working at another site now, and you have a patient that's come in and you know, hair loss is a concern to them. What should the messaging be today, even without clinical data? Should they be considering trying it? Or at least it'd be an option for them based on the sort of risks etc., and costs? Or is it something we should sit back and wait to see the results? What's your view on that at the moment?

Elahe Salehi 22:17
That's a great point. So I am lucky, I work in an institution that really focus on patient centered. So what we do, we do actually offer patients scalp cooling, even in metastatic setting. But we want to make sure that we are upfront with our patients because we don't want to see disappointment on their faces. So what we tell our patients or what I always tell my patients is that we don't have enough data in metastatic setting, we don't have enough data in these agents you're going to receive, whichever one they are. But I'm happy to offer you and you can give this a try. And I have to say eight out of 10 patients will say yes, I want to try it. And they go for it despite of no data or limited data. I think one of the other aspect of it is that we have seen lately is the education piece about scalp cooling, that is one of the most important aspects for the outcome. Whether in adjuvant setting, or metastatic setting, I had couple of patients who ripped their scalp cooling off within two minutes of it because it was so cold. But they were not educated. They did not watch the videos, so they didn't know what to expect. So I think that we need to make sure that we educate our patients about, I always say, the first 15 minutes is going to be very, very cold and uncomfortable. Take this Ativan so you can stay through it. And everybody does well. And that's what we came up with as needed medications template for our patients who go on scalp cooling. So I think that is a key factor. Because sometimes we say Oh, it didn't work. It's not that it didn't work the scalp cooling, is just that the patient just ripped it off. So that's why it's not working.

Richard Paxman 24:12
Absolutely. And I think we can always get better at our education as well. And we try it's just can be education overload for patients can't it early on in their diagnosis or even, you know, later on in their diagnosis, there's so much information to take. So it's how we deliver that in the best possible way I guess. Is there any patients that really stand out so far in the clinical trial for you, any stories that you want to share?

Elahe Salehi 24:35

I have patients who are on cycle six of their agents on this trial and they are doing great. They're doing great as from a metastatic breast cancer perspective, and they're doing great from their hair perspective as well.

Richard Paxman 24:49
I was really pleased to see the news that came out of ASCO for both of the drugs in terms of the great data for the newer drugs anyway, the Sacituzumab and the Enhertu, a really good hope for the patients and pleased, that hopefully, you know whether it's one agent or both agents, scalp cooling can also add a bit more benefit to that patient from a psychosocial stage as well.

Elahe Salehi 25:10
It is very important to be able to tell a patient that we have this antibody drug conjugate that is going to help not only HER2-positive disease, but now low Her2-positive, which is a new phenomenon for breast cancer patients. And then on top of that, I can actually give you medication to help with your nausea. But I also can help you with not losing your hair by providing scalp cooling. So I think that we have come a long way.

Richard Paxman 25:43
So just on, and it's similar to the sort of where I was talking earlier, but with regards to this trial, and of course, we've got to wait till the data is published. But do you think it's going to help motivate clinicians to perhaps think a little bit wider in who they offer scalp cooling to, whether it's an adjuvant versus metastatic patient, or even a different side tumor, because you know, we're still always talking about breast but there's so much more we can do in other areas. Do you think this will help motivate and also kick start other clinical trials?

Elahe Salehi 26:16
Absolutely, absolutely. I think this is a great foundation for these type of agents. And I hope that we will add more agents to this trial or a new trial. As you know, most of these agents that come out, they get FDA approved for other solid tumors as well. And this will help them as well to realize that yes, this drug that helps, let's say with thoracic patients, it's actually helping with breast and we have data now that supports it. So there are so many positive outcome from this trial that is going to go, and it definitely going to change a provider's perspective of whether they are going to introduce scalp cooling to their patients or not.

Richard Paxman 27:00
Very exciting to get some more patient recruitment in and ultimately see the results and get it published. So just moving on to talking about scalp cooling at Dana Farber. So, you know, I think we've been scalp cooling as it since 2018?

Elahe Salehi 27:15
November of 2017.

Richard Paxman 27:18
So you know better than I do, and you're one of our early adopters. And I recall that process and it felt like a long process to me to start with. But it was really well implemented from day one, a really strong multidisciplinary team that worked on it. I think it was Suzanne Connelly I think I worked with closely who I dearly miss - are you now offering scalp cooling pretty much standard of care in adjuvant and metastatic and other solid tumor cancers at Dana Farber?

Elahe Salehi 27:48
So we have a program now as you know that we started this whole process in November of 2017 after Paxman got approved. And Eric Weiner at the time was the chief director for the breast. And we started with our breast group very, very small amount of docs and very small amount of agents. And then once it got approved for entire solid tumors, we actually built a program for solid tumors and scalp cooling for Dana Farber. I have to say it depends on really the disease center. So GYN does use it, GI at times use it, GU sometimes use it. So it really depends on the agents that they give and also the patient population as well. You know, one of the things in GYN which I think should be looked at, so I'm hoping that will be my next four studies that I want to do is in GYN patients, so we know that taxanes really help, but what about when you give those settings higher dosage, short or longer interval, so what will happen - so we don't have that much of a data in that regards. And GYN uses a lot of those high doses, taxol and high dose of carbo, so I think that is something that we need to look further into. But standardly offered it just the patient if they want to take it or not. That's a different story, but it is offered to most of the patients.

Richard Paxman 29:15
And I think that's the most important thing, isn't it? It's that it's offered, that it's a patient choice. So I'm incredibly proud of the work that we've all done together I guess at Dana Farber, for cheerleaders like yourself, who have really driven it which is a massive benefit to patients.

Elahe Salehi 29:30
It's a true team effort both from our side and your side to be honest with you because otherwise we could have not made this happen.

Richard Paxman 29:36
If you were to measure how successful scalp cooling implementations been at Dana Farber or a few words to that. Are you pleased with its rollout? Are you pleased with its success? And how many locations are currently now offering scalp cooling at Dana Farber?

Elahe Salehi 29:49
I am very pleased. I am very pleased with the success of scalp cooling. Park and Dana Farber main campus, we are offering a Chestnut Hill, we are offering it at Milford, we offering it at South Shore, I just did a presentation

for Merrimack Valley, and they are going to offer it now. And then Foxborough is opening in August, and then we're going to immediately offer to them. So I think we have come along a long way with the scalp cooling. I mean, you know, when we first started, it was so small. But now getting a satellite up and running is so much faster for us, because we already have all the data, we already know how to build this program.

Richard Paxman 30:30
And what do you think has allowed that pace to change? Is it just from your learnings, is it the locations and processes you've put in place? What's the driver behind the success there? And the speed?

Elahe Salehi 30:41
Yeah, I think the process that we put in place. So when we first started the scalp cooling, as a pilot, we saw a lot of things that could have gone better, smoother, a lot of things that we did well, a lot of things that we didn't do well, that's where my study came in, when I was doing my doctorate degree. I saw that concept. My study was basically a qualitative approach looking at redesigning the best practice guidelines and procedures and policies for scalp cooling. And I think by doing that, we change a lot of what was working, what was not working. And we built a good solid program - when you have a solid foundation it is easy to build on.

Richard Paxman 31:28
And do you think the work you've done in the main Dana Farber location is still adaptable? Or adoptable? Should I say in more of your community settings? Or have you had to slightly amend how you work with your sort of outreach sites?

Elahe Salehi 31:42
The sites will work very much similar, I think the only thing will be the chair time. So you know, for a bigger main campus, of course, arranging the timeframe for the scalp cooling is going to be a little bit more complicated than our smaller satellites. But otherwise, I think it's going to be the same.

Richard Paxman 32:00
Remind me, do you have post cooling rooms at Dana Farber main campus? I think you might do.

Elahe Salehi 32:04
So we did actually come up with a nice post cooling spot. But that unfortunately, did not last so long because of the pandemic. We had to switch a lot of our rooms and especially with all of our providers coming back to places that they need to eat and be alone. So we had to change everything. But now we have a great system, we just use our own chair time. And it works quite well.

Richard Paxman 32:34

Which actually to me is preferable if we can keep a patient and manage that chair time in that way, rather than move them then I think it's great. And if my belief is if Dana Farber can manage it, then I think there are many of the sites in in not only America, but the rest of the world that could look to manage their chair time appropriately for scalp cooling.

Elahe Salehi 32:55
Yeah, by switching a few things around, for example, on THP. We used to give the HP components first and then taxol later. And then we switched it back, we're giving you the taxol and then HP so they are having the cooling time while they're receiving the treatment. So really, nothing has changed for the chair time. By opening up Chestnut Hill I think that really helped us a lot too, because we moved more than 35% of our patients to Chestnut Hill location. And that really helped us well.

Richard Paxman 33:23
Of course, that makes a lot of sense. So if a site listening to this, and they want to understand a little bit more about your workflows and the processes you get in place, is there an ability to get that information? Do you share your processes with other sites?

Elahe Salehi 33:37
Absolutely. I'm happy to share it, they can just email me directly. I'm happy to share it. It's so interesting, you asked this question, because over the weekend, when I was giving the talk, I had people from Kentucky and New York actually approaching me after and try to talk about what our processes was to get the scalp cooling going. And I'm happy to share it. Absolutely.

Richard Paxman 34:02
Well, we very much appreciate that. And I think that peer to peer learning is obviously incredibly important. So we very much talk about changing the face of cancer. And we feel that scalp cooling does that in a number of different ways. But what does changing the face of cancer mean to you?

Elahe Salehi 34:18
Changing the face of cancer - I would say to me means moving from an impossible to a promising future in oncology cancer care.

Richard Paxman 34:30
I like that. Yeah, that's got a lot of hope there.

Elahe Salehi 34:33
We need hope.

Richard Paxman 34:34
We do absolutely, without a doubt. Well, I want to thank you for today. You've been a wonderful guest as always, and I look forward to speaking soon.

Elahe Salehi 34:43
Happy to be here. And thank you. Hopefully we'll see each other soon.

Richard Paxman 34:50
Thank you for listening to this episode of Changing the Face of Cancer. And that's it for this series. Thank you to all of our inspiring guests who have made our debut series a success. Make sure to subscribe to the channel and follow our socials, because in the coming weeks we will be releasing our Scalp Cooling Summit Series episodes and have some exciting series in the pipeline.