NEUROENDOCRINE
CANCER FOUNDATION
Podcast
Top 10 Questions With
Neuroendocrine Cancer Experts

EPISODE 45: ‘Spotlight on Medical Oncology’ with Dr. Sandy Kotiah

Lisa Yen 00:00

Welcome to the Neuroendocrine Cancer Foundation podcast. I’m your host Lisa Yen. I’m the Director of Programs & Outreach, as well as a caregiver and advocate for my husband who is living with neuroendocrine cancer. In each podcast episode, we talk to an expert who answers your top 10 questions. This podcast is for educational purposes only and does not constitute medical advice. Please discuss your questions and concerns with your physician.

Lisa Yen 00:30

Welcome to the Neuroendocrine Cancer Foundation Podcast. I'm excited to introduce our guest for today, Dr Sandy Kotiah. Dr Kotiah is a board-certified medical oncologist and serves as the Director of the Neuroendocrine Tumor Center at Mercy. She is a member of Medical Oncology and Hematology at Mercy in Baltimore, Maryland. Dr Kotiah leads a multidisciplinary team of specialty doctors focused on providing some of the best treatment options for rare neuroendocrine diseases. Dr Kotiah's compassionate and caring nature, as well as her exceptional clinical knowledge and dedication to searching for answers to complicated cancer diagnosis makes her a sought after Medical Oncologist and Hematologist in the Baltimore region.

Dr Kotiah has been a friend of LACNETS and has spoken at our 2021 Virtual NET Cancer Day Symposium and the 2022 Virtual Annual Conference, as well as our in person Patient Education Conference in September 2023 at the National Cancer Institute, at the National Institute of Health in Bethesda, Maryland. We appreciate her commitment to the neuroendocrine cancer community and her clear, straightforward communication and the way that she cares so much about her patients and the community. Welcome Dr Kotiah.

One fun fact I'd like to share about Dr Kotiah is that she survived a 24-hour trip to Mauritius with her almost four year old son a couple months ago where naps were not an option. And she says that some people climb Kilimanjaro, and she survived this trip. So welcome, Dr Kotiah, and I'd love to also hear from you how you got involved in the neuroendocrine cancer field.

Dr Sandy Kotiah 02:04
Well, first of all, thank you very much for inviting me to this podcast. I always enjoy talking about myself, of course, and my second favorite thing is talking about neuroendocrine tumors. But you know, I really enjoy our interactions over the years and the opportunity to come and talk to people about what I do for a living and what my interests are. So, you know, I got involved with neuroendocrine tumors not on purpose, but I finished fellowship 15 years ago, and I was looking to start my career and just established myself. And I came to Mercy, and the head of the surgery department as the cancer surgeon, Dr Sardi, said to me, “Listen, I see that there's a lot more neuroendocrine patients, and they keep coming back, and they're living a long time. And it's a rare disease, but they need a center. They need a place that's going to anchor them, because they can be complicated, and it can require a lot of different levels of care. So, I think we should start a program.” Because he had already had a program for appendix cancers, which was quite rare also. And of course, being a typical new grad, I ignored him for a year, and I tried to avoid him in the hallways because I wasn't ready, because I was thinking, "I've only seen two neuroendocrine tumors in my entire fellowship. So how am I going to do that? I'm just trying to figure out how to take care of patients." But one day a year later, he cornered me, and he said to me, “Here are all the people who want to be involved in this program, and you need to make this work.” So, I started going to conferences to learn about neuroendocrine tumors, and I've never looked back. And it's been probably the most enjoyable thing about my career is taking care of neuroendocrine tumor because I feel I can make a difference. And it really fulfills that part of me that wants to try to help people who have rare diseases and get them the right type of help. So, I actually thank him now when I didn't before. I thank him all the time, and he's very happy that this program happened.

Lisa Yen 03:42
Yeah, it's a great fit for you, and we're so grateful that you're willing to help the neuroendocrine cancer community.

Dr Sandy Kotiah 03:49
Oh, thank you.

Lisa Yen 03:50
We invited you today because in this next series, I'd really like to focus on the role of each discipline in the neuroendocrine cancer field and the different specialties that might make up someone's medical team, so that people can understand who plays what role and how to understand each provider's role in their medical team. And for you, if it's okay, I'd love to explore a little bit more of what you do, and for you to give us some clarity around that.

Dr Sandy Kotiah 04:18
Yeah, of course. So, you know, my role changes depending on what stage the patient is in. So, if somebody has been diagnosed at a place where they're able to have surgery and they have not had spread to another organ, then my role is mainly a surveillance role. I'm watching with the surgeon to make sure that there's not a recurrence of the tumor. And I'm not giving any sort of medication to manage anything actively. Sometimes I'll have the patient just follow the surgeon. Sometimes we'll both follow the patients, especially if we're concerned that there's a high risk that something will come back in the liver or someplace else. But my role is very different when somebody has known spread of their cancer. So, if something has started in their small bowel that's going to their liver. Or something that started in the pancreas and spread to the liver, then I take an active role as the quarterback for the team. So just like your primary care is supposed to be the person that gets all information and manages what happens to you in the big picture kind of thing. That is how the medical oncologist works.

We are the big picture people. And we're supposed to know all the types of treatment that can be given to you for the type of cancer that you have. We're supposed to know that there's surgery options available for you. We're supposed to know that there's liver directed therapy, where the interventional radiologist is going to be able to feed some sort of treatment directly to your liver. We're supposed to know that the nuclear medicine physician can deliver some type of targeted radiation to your tumor like PRRT. We're supposed to understand that the radiation oncologist can sometimes help deliver radiation to the tumor. And we send you to those different specialists when we need their help, when we think that that's the best option for you. And we talk, "Okay, we're at a fork in the road, and your cancer is growing, and these are your options. We could do option A, which is medication, we could do option B, which is surgery, we could do option C." And we'll always give you our two cents, like we think this is the one that's going to be the most effective one and the least toxic one, because we're always looking to preserve quality of life and give you something that hopefully will keep your cancer in remission for quite a while. So, we're always thinking about risk-benefit and how you are going to do and where you are in your journey. So, we're supposed to be the big picture people. And then we borrow the services of all the other specialties to try to help keep you in shape and keep you healthy.

Lisa Yen 06:23

That's helpful. So, the big picture people. Let's dive in a little bit deeper with that in terms of who the oncologist is. What is a medical oncologist? And what kind of training is involved? And is that the same thing is a medical oncologist? The same thing as a "hematologist-oncologist" or a "cancer doctor"?

Dr Sandy Kotiah 06:41
It depends. So, what happens is, when you decide to become a physician and you finish medical school, and then some of us do **internal medicine**. Some of us do surgery, some of us do orthopedics, some people go into dermatology. So, people who go into the cancer field usually have to have three years of training in internal medicine first. And then after that, they get to go into the specialization. And most programs required to specialize in blood and cancer. So, there's pure blood problems, like low red cells, low platelets, blood clotting, things like that. Then there's the **blood cancers**, the leukemias and lymphomas. And then there's the **solid tumors**: the neuroendocrine tumors, the lung cancers, pancreatic cancers. So, you're supposed to train for three years to be able to treat all those conditions. And then when you finish your fellowship, you can decide that you're going to go to Johns Hopkins or one of the academic centers and just focus on solid tumors and just focus on the GI tract. Or you can go into a community practice, a community hospital, and you have to treat a variety of conditions, the blood conditions, some of the blood cancers, as well as the solid tumors. And if you feel like there's something that you don't see enough of, or that you're not treating as much, then you refer those patients to the academic guys, who see a lot of them. Actually, that's what I do. And the private practice physicians also treat everything that comes into their door, and they try to refer out if they feel like they're out of their depth.

But by definition, **medical oncologists use medications to control your cancer, so our job is to try to control growth in your body**. But if something is localized, it can be cut out or burnt out, then we leave it to the physicians who can do surgery or can do radiation. But when it comes to something that's advanced, and it's in several different places, and we're trying to get it to stop growing wherever it is, and we need to use medication that can get to it wherever it is, then that's where we get involved. The sole exception is the treatment called PRRT, which we have to give in conjunction with the nuclear medicine physicians. But in terms of drugs like lanreotide, octreotide, everolimus, cabozantinib, chemotherapy, these are all things that are within our purview to give, to try to control growth of the tumor.

Lisa Yen 08:47
Yeah, that's helpful. So, the medical oncologist prescribes or oversees medications and treatments, except for PRRT. And I think one thing that's confusing to a lot of people in the community is, what's the difference between a medical oncologist and surgical oncologist, because they both have oncologists in it, right?

Dr Sandy Kotiah 09:05
So, there's three types of oncologists. There's a medical oncologist, there's a surgical oncologist, and then there's a radiation oncologist. So, the **radiation oncologists** like to say that they give healing beams of light so that they can control cancer, but really what they do is they try to deliver radiation to the cancer cells to damage the DNA of the cancer cells as they're trying to grow. And they have lots of different technology, and they can give either a large area of radiation, or a very focused area of radiation, using their technology. So, they have their role to play in cancer treatment. And depending on the cancer, some of the treatments are radiation sensitive. Some of them are not.

And then the **surgical oncologists** operate on cancer wherever it is in the body. They usually do a lot of abdominal surgeries, because there's a lot of abdominal cancers. They can do very complicated abdominal surgeries where they do debulking and stripping of the lining, of the peritoneum. And they can also remove lung masses if they want to, but we have thoracic surgeons who prefer to do that also. So, everybody has their role to play. Most of the time, the surgical oncologists here at Mercy are doing abdominal operations – a pancreas operations, small bowel operations, stripping, liver debulking, things like that. They sometimes do melanoma removal as well. So, there's thyroid cancers that they can remove. So, it always amuses me when my patients are like, "Are you going to be in the operating room?" I'm like, "No, and you don't want me there because I haven't scrubbed and god knows how long, and I'm probably going to make something dirty, and then I'm going to have to go back out there and wash for another 15 minutes by hand. So no, I'm not going to be there. But I'll be outside when you're finished, and I'll see you in the hospital, but I'm definitely not going to be in the operating room with you."

Lisa Yen 10:34
That's really helpful to hear that there's the three different types and how they play the different roles. Another question that comes up often is, what is a NET expert? And how does someone become a NET expert?

Dr Sandy Kotiah 10:46
Yeah, that's a good question. I felt like a fraud for the first few years, because I felt like I had to build up knowledge and I had to build up patient experience to become a NET expert. I think that anybody who shows an interest in learning more about neuroendocrine tumors by going to conferences where the topic is discussed, by learning about the latest treatments and keeping up with the latest technologies and options that are available for treatment, and who can network with other physicians who treat neuroendocrine tumors, because there's sometimes complicated cases, and you want to run it by somebody who also sees a lot of patients that have neuroendocrine tumor, and you can network to try to give the patients the best care. Or if you don't have the right treatment, but somebody else has a

trial for them, then you can discuss that with that person, and you know who they are because you're part of that community.

I think that's what constitutes a NET expert, is somebody who's willing to dedicate time only for those patients to learn about their condition, to stay ahead of what's happening and to try to take care of as many patients with neuroendocrine tumor as possible. So, my practice has grown from about 30 patients when I first started, the first year to over 1,000 fifteen years later. So now I feel very comfortable calling myself a NET expert. But if you had asked me when I first started, the first three to four years, I really felt uncomfortable calling myself a NET expert, because I was still building my practice, building my program, and I didn't think that I had seen enough volume and enough variation. Because the thing that's amazing about neuroendocrine tumors is you think you might have seen it all, but then somebody walks in the door and shows you a different side of a neuroendocrine tumor. Even after 15 years, I feel like I'm still constantly learning about presentations and how people present and how things can happen and how I really need to individualize care, because you can't always cookie cutter neuroendocrine tumors. In fact, it's wrong to try to cookie cutter neuroendocrine tumors, because even it might look the same under the microscope, but how it behaves in that person is different. So that's something that I've learned, and I find kind of challenging, but also rewarding when I can figure it out with the patients.

Lisa Yen 12:42
That's a really good point, that volume matters, and there's a difference between someone who sees a handful of neuroendocrine cancer patients and someone who sees even 30, but now you're saying 1000. That's a lot. It also highlights the fact that perhaps it's not as rare as it was once thought.

Dr Sandy Kotiah 12:57
Yeah, I definitely think that. I typically see in a month, 10 new neuroendocrine tumor referrals on top of the other patients that I have who have had over the years, who continue to come back for management and care. And I used to see maybe five NET patient referrals per month. So, it's definitely growing. I think there's more patients presenting, there's more patients being referred in. And that's, I think, why it's over 1000 because some of my patients have been with me for 15 years. Some of my patients are new, and maybe it just keeps accumulating.

Lisa Yen 13:27
Yeah, it's encouraging that people are living longer, so that there are more and more people alive with it. I think one thing that comes up often is, if someone's newly diagnosed and they're looking for a neuroendocrine cancer expert, what type of doctor are they looking for? You mentioned three different types of oncologists if they're looking for someone, who should they be seeking?

Dr Sandy Kotiah 13:45
Well, I think it's always a good idea to have a surgery consultation, a surgical oncologists, because even if you have spread sometimes, they will still offer you surgery. And I think it's always a good idea to have a medical oncologist who can treat you. So those are the two people that should be involved in your care. And if you need additional people involved your care, that's what your medical oncologist is for. They can pull those people into your care to try to treat whatever they think is best.

Lisa Yen 14:07
Like the quarterback. Big picture person, as you said.

Dr Sandy Kotiah 14:12
Yes, exactly.

Lisa Yen 14:13
Another question that comes up often as people are trying to navigate the systems is how they find someone so for example, if they call a medical institution, whether they call Mercy or somewhere else, will they automatically get assigned to a NET expert or neuroendocrine cancer expert?

Dr Sandy Kotiah 14:28
Well, you know, I'm the only person who treats neuroendocrine tumors at Mercy. And I know at Hopkins there's only one physician who really concentrates on neuroendocrine tumors. If she's unavailable, people go to one of her partners, but they don't necessarily see the same volume of neuroendocrine tumors as she does. So ideally, speaking, if you're calling in with that disease state, you should be seeing the person that treats the most of that disease state, and not somebody who's only covering or casually covering. And sometimes I've gone on vacation and somebody has come, my partner has done the initial intake but then sends them to me when I come back from vacation. But you should always end up with the person who treats your condition if you're calling a center that treats neuroendocrine tumors.

Lisa Yen 15:03
So, asking for the person that sees the highest volume. So, if someone tells me that they are a NET expert, does that mean that they are a neuroendocrine cancer expert?

Dr Sandy Kotiah 15:13
Hopefully they're not lying. Hopefully they're saying what they feel to be the truth. But I think it's important to say, "How many cases have you treated? And do you work with a team of people or are you just taking care of the patients by yourself?" Because neuroendocrine experts cannot operate by themselves. You need the help of other specialists. And not just physicians, but other people, like

nutritionists, social workers. It's a team effort to take care of people with neuroendocrine tumors, especially the nutritionist, because of all the diarrhea that happens and all the malabsorption that happens. So, if somebody tells you, "Well, I'm the only person here who treats neuroendocrine tumor, there's really nobody else that is on my team," then I'm not really sure that they're technically a neuroendocrine expert. But if somebody's treated a lot and has managed a lot of neuroendocrine, but again, you need to be able to have access to PRRT. You need to be able to have to access to a surgeon. You need to be able to have access to a nutritionist. These people need to be on hand because you want to give the best care. So, I think it behooves the patient to ask, "How long have you been treating NET? How many cases have you seen? Have you seen my type of condition before? And are you part of a team, or are you working solo?"

Lisa Yen 16:16
These are some really key questions that you're sharing with us for people to ask. Thank you so much for these. So now going to your very first appointment with someone, likely a newly diagnosed patient. What can I expect if I'm someone who's newly diagnosed on my very first appointment?

Dr Sandy Kotiah 16:31
I'll tell you that I saw a patient yesterday with a neuroendocrine tumor newly diagnosed, and when I walked in, I said to her, "How are you feeling?" My favorite open-ended question, and usually they're like, "I'm fine." Okay, so you're eating, okay. Breathing is fine. No new pain anywhere. So, I'll start going through a list of basic things that make us feel good every day, which is not being in pain, being able to eat, being able to move your bowels, normally. And usually, I'll try to pinpoint how sick the person is, just based on what they're saying to me and what I'm going to explain to them. Are there symptoms that I'm going to have to address to make them feel better when they leave the appointment? So then, after I get a sense of who they are, and we go through their history, we go through, “What did you do for a living? What kind of medical conditions do you have? What kind of support system do you have? When did your symptoms start? How long have you been ill?” All these things.

Then we sit down and say, and I usually write down on the piece of paper. I know I'm old school. I don't have the iPad that I pull out and start drawing. I'm not that fancy, but I have a pad and I have a pen, and I start writing things down. So, I'll start explaining what is a neuroendocrine tumor and how is it different for the other types of cancers that we find in that organ. I'll explain to them about what the pathology report looked like. Well-differentiated tumor. Poorly-differentiated tumor. What the growth rate looks like. What does that mean to you? Is your tumor producing hormones or not. What stage are you? What are the goals of treatment? Am I trying to control syndrome? Am I trying to control tumor growth? How much of a liver burden do you have? What are the things that you need to do to keep yourself healthy-- exercise, diet, things like that. What are we going to do to treat your symptoms? And I'll try to give them a sense of, you might not be curable, but I can help you stay alive longer. And these are the all the treatment options and also do a big picture like these are all the types of treatments that you have available, but I think we should start with this one, and this is why. And I'll explain the side effects to them.

So, most visits will take at least 45 minutes to an hour, to try to get things going. And I'll try to show them their scans, if I can and show them their imaging, and if I need more imaging, I'll get that as well. But most of the time, my team is great at getting records, and we already review the pathology here, and we have all the films downloaded so I can pull them up. I think it's important to get an idea of what your diagnosis is, and what kind of neuroendocrine tumor presentation. Do you have a fast growing or slow growing one? Is yours producing hormones or not? What stage are you? And what are the treatment options and what is the best one to start with? So, I think all the oncologists need to have that in place when they first meet you.

Lisa Yen 18:59
I think this is really helpful. You're really explaining how important it is to understand the actual disease and certain factors with the disease, the differentiation and growth rate and whether it's functional or not, some of the key factors before you can even move into that discussion about what treatments you might offer or suggest.

Dr Sandy Kotiah 19:17
Yeah, I have patients who are presenting with very low liver burden, and I have patients who are presenting with 80% of their liver involved. So, discussions are going to be different about what the goals are, what the treatment options are, depending on how they're presenting. But I think it's important for you to know where did we catch your cancer? Did we catch it at a place where you have a low burden of disease. Or did we catch it at a place where you have a higher burden of disease? And now we have to try to play catch up a little bit, and how can we shrink things? Is it possible to shrink things? And what are the options available?

So, it's always important to be able to follow the logic when your oncologist is talking to you. And if you're overwhelmed, it's okay, because it can be overwhelming to hear that you have something that is eventually going to be life threatening and how you're going to get ahead of it. And if there needs to be more discussion, it's okay. Sometimes it takes a good two to three visits for people to start feeling comfortable. Like I get where you're going with this. I understand what the goals are. I understand what you're seeing now, because not everything will sink in the first appointment.

Lisa Yen 20:13
It takes time, and it takes processing. So that's a really good point that people often come in feeling overwhelmed, scared. They often wonder, I'm sure you hear this all the time, "How long do I have?"

And they worry, how fast the cancer is growing. They're unsure what to tell their families and friends. How do you address these concerns?

Dr Sandy Kotiah 20:33
Well, if I'm lucky, they've brought their family and friends with them, and that spares them from telling their family and friends and spares me from repeating myself. But sometimes people want to hear it first before they synthesize it to their families, and that's okay. It's kind of, "I want to protect my family too from the news," but I try to be very honest that I am not a crystal ball holder. And last I know, I don't have the certificate in fortune telling. But I tell most patients that they have years, and some people might have several years, some people might not have as many years. But I never try to be specific, because I really don't know, because everything hinges on how you respond to treatment. Some people respond to treatment very well. Some people don't respond to treatment as well, and that will determine how the course of things go. And also, where are you starting? Are you starting from a place where you have a lot of cancer in your body or less cancer in your body?

So, these are tough decisions. I mean, I have a young guy who has 90% of his liver involved. He's in his 40s, and he has a really high tumor burden, and he really doesn't have a lot of symptoms. He had some vague abdominal pain. That's how he came to attention, and I just gave him treatment with a somatostatin injection and chemo. And in two or three months, his cancer has grown. So, am I worried about him? Yes, very much so. And I was very upfront with him, and I said to him, "I am worried that your liver is going to fail sooner than later, and I'm trying very hard to prevent that, and we're going to have to switch your treatment again and hope that we can find something that will pull the growth back."

And if I'm not so worried, I tell the patients, "I'm not so worried," because my patients are very anxious, and they might not have the amount of disease that would make me lose sleep at night. So, I tell them, "I don't lose sleep over you. I think you're doing fine. I think you're on the right track. Your disease is behaving well. You're responding very well to treatment. If it ever got bad, I will let you know. I will make sure that you're prepared, and I'll make sure that you have enough time to figure things out. But right now, I'm very happy with how you're doing, and I think we've been doing well." And sometimes I'll remind them, "You know, we've been doing this for 10 years. Oh, you know, we've been doing this for 15 years." I remind them of that.

So, I think, you know, it's always time that makes things clearer and that helps us with planning. Because, like I say to all the patients, you have the same pathology report as did nine other people that I saw this year. But that doesn't mean that I know how your cancer is going to behave. I'm hoping it's going to be very slow growing, but until time goes by, I'm not really sure how slow growing it's going to be, because one of you guys will grow half a centimeter in a year, one person will grow half a centimeter in 10 years, and that person will grow half a time of year in six months. So, I have to see how things go to really understand how the cancer behaves in you, and really how much I have to do or not do to try to keep you healthy.

Lisa Yen 22:58
This is one of the things that it's really hard to wrap our heads around, especially because with other cancers, sometimes there's a very clear cut 5-year survival, 10-year survival. You can be told these things and to hear that, it takes time, and you don't know, and can't know for certain, that uncertainty can be really hard.

Dr Sandy Kotiah 23:16
You can always give people statistics, like, the 5-year survival is 85% for small bowel NET, the 10-year survival was 50% but what does that mean to that person in front of you? Like, okay, there's 50% chance of being alive in 10 years. That's fine. I always say to the patient, "You're not supposed to know, and you're not supposed to anticipate, you're supposed to just live your life. And if I feel like you're getting in trouble, I will warn you ahead of time so that you can prepare yourself." But I try to have conversations from the get-go, like, "Listen, this is not something I'm going to be able to fix. Eventually it will get you, I just don't know when, but my job is to try to hold off that outcome as much as possible, and so we're going to work together and figure this out. And your job is to stay fit and healthy as much as you can, and work with me in getting the treatment. And that's all we can do, right?"

Lisa Yen 24:00
Yeah, we do our part. You do your part, and together, live as long and as well as well as possible.

Dr Sandy Kotiah 24:06
Exactly.

Lisa Yen 24:07
So, if I'm someone who's going into that first appointment with a NET expert, what questions should I be asking or thinking about in preparation for that appointment?

Dr Sandy Kotiah 24:16
You know, the best thing about the first visit with me is when somebody comes in with like, five pages of questions, and they're like, ready to tackle me as soon as I'm done blabbing. And then they say to me, "Oh, you answered all my questions." And I'm like, "Wait, let me look again. Oh, you answered them. Oh, wait, I do have this one question about supplements." Go for it.

So, I think that it's always good to be prepared and to have a list of questions. And you know, your group is very good at providing that kind of information to the patients about these are the things you should be asking. And we know what you guys want to know. You want to know your stage. You want to know how bad it is. You want to know what the treatment plan is. You want to know whether the treatment is going to be tolerated by you. You want to know how much of a burden it's going to be on you financially, how much of a burden it's going to be on your family, how much traveling is going to be involved. All these things. So, we try to address them in a global level of a way as possible, without overwhelming.

I had a new cancer patient today, it was a neuroendocrine tumor, and it was a very complicated discussion, and I sketched out a skeleton plan about this is what treatment is going to look like, but I didn't go in depth because it's too much today. She can't handle that today until the next visit, we'll go more in depth about side effects and drugs, because you're not going to remember anything I see right now, because you're still trying to process the fact that I just told you you had cancer. So sometimes.

Sometimes things can happen in layers, and that's okay. But your basic questions of, what do I have, and how aggressive is it, and how much time are we talking about? Do I have more time or less time? And are you going to give me treatment, and how sick is it going to make me, and how effective is it? Those are the core things that you should have addressed at your first visit. And then you can always sweat the details later, and if it's not too overwhelming of a visit, like if I just had surgery and my cancer is in remission, and I just want to know, what should I be eating, what should I be drinking, and how often you're going to do scans on me, and then you can address all of that the first visit and not be overwhelmed. But the patients who have more advanced disease, or who have disease that's in their liver, they might need more time or a couple of visits to get all their questions answered properly.

Lisa Yen 26:10
That's really helpful, a layered or a tiered approach to go through the questions. And thanks for identifying those core things to address. So, after that first appointment, how often, and I guess, when should I be seeing the medical oncologist?

Dr Sandy Kotiah 26:24
We should tell you that, right? So, it depends. If I'm starting on a new treatment, I'm not going to wait months to see you, ideally. I'm going to try to see you a month or two after you start a new treatment, just to see how you're tolerating it. Even something that is fairly well tolerated, like lanreotide and octreotide, I want to know, are you having headaches on it? Are you having bad fatigue? Are you getting horrible cramps in your abdomen? Is your diarrhea better or not? So, I have to get some sort of sense of how it's doing and how it's working, and whether you're tolerating if you're somebody who's

under observation, I'm going to say to you, "I'll see you in six months with a lab and some scans." Or "I'll see you in a year with labs and scans."

So, we should set the plan with you, so that when you leave the office, you know that this is the next time I'm going to be seeing you. And sometimes I will not lie. I don't have a plan yet, because I want to look at the films. I want to see everything in a tumor board, and I want to make a plan. So then I will tell a patient, you do not have a follow up with me, and that's okay, because I'm planning to present your case at tumor board, and I'm planning to look at everything together with everybody. And then I will let you know what the next step will be, and then we will arrange follow up. But it's up to your medical oncologist to talk to you and say, "This is how often I want to you, and this is why."

Lisa Yen 27:29
That's helpful. And you mentioned scans or films. Who goes over my scan results with me, and how soon after those scans should I expect some results?

Dr Sandy Kotiah 27:38
In the ideal world, it should always be the person who ordered the scan, who goes over the scan with you, and who explains it to you. And sometimes I do my terrible drawings. I'm not an artist, but I'll pretend this is the lung, pretend this is the liver. This is what we're seeing. And sometimes I'll try to pull up the scan in the office so that can show the patients the scan. But it should always be somebody from your team who explains the scans to you, ideally in person, but sometimes it's a surveillance scan and things are looking good, and we have things like MyChart where we can release results to you. So, if a scan looks good, I'll just tell the patient, "Your scan looks good. I'll see you next week." But if it's a complicated scan, then I'll say, "You know what your scan is showing some progression. I need to look at it with the radiologist. I don't know if it's enough for me to change treatment or what the treatment is right now, I want to look at things myself, and I'll get back to you." But always your oncologist, if they're ordering scans should explain the scans to you in detail and what the next step is in terms of follow up or in terms of change of treatment. And if it's your surgeon, then your surgeon should explain it to you.

Lisa Yen 28:35
Okay, so whoever orders the scan, and hopefully that can be communicated. You also mentioned the tumor board. Who communicates the results of the tumor board discussions?

Dr Sandy Kotiah 28:46
It depends. If it's complicated, I call the patients myself. If it's not complicated, or if my nurse navigator has a very good relationship with the patients, then I rely on her to communicate the results. For example, I'll tell the patient at the visit, "I'm probably going to end up sending you to the surgeon

because I think your tumor is resectable. But let's present your case at tumor board, and then we'll let you know." So if we present the case and the surgeons are like, "Yes, we want to see this patient," then I'll say to my nurse navigator, "Can you please call the patient back to them I discuss their case of tumor board, and the surgeon does want to see them, and I want you to help them set up the appointment."

However, I don't know if I'm going to give you treatment A versus treatment B, til I look at the films. And I look at the films, I decide that treatment B is better, then I have to call the patient and say, "I looked at your films, I'm going to give you treatment B. This is why I want to give you treatment B. And these are the things you should be expecting. I'm going to set you up an appointment with this, and these are the side effects, and I want you to come in, so we can go over everything in person." So, it depends on how complicated the discussion is after Tumor Board who calls the patient. Sometimes the surgeon will call the patient, because the surgeon has to be the one who does the next step. And then they'll say, "You need to come in and so we can talk to you about the surgery."

Lisa Yen 29:47
So, it depends. We talked about the scan results. Who orders the scans?

Dr Sandy Kotiah 29:51
Myself or my nurse practitioners. It depends who's seeing the patient. Sometimes my nurse practitioners and I will flip flop seeing patients. But if it's time for your scan, one of us will order the scan. If the scans look good, my nurse practitioners will tell the patients their scans look good. The scan doesn't look good. They always punt it to me to review. And then I have to decide what I'm going to do after that, whether I'm going to bring the patient in for an appointment or just to call them on the phone.

Lisa Yen 30:12
So, it can depend as well. So, looking at the bigger picture of the care team, how's the care coordinated with other doctors in the team within one institution? How do you coordinate care within the team?

Dr Sandy Kotiah 30:22
Within the institution, that's what my navigator is for. If the patient needs to come in and they need to see myself and the surgeon on a regular basis, we try to take a day of clinic where we're both in clinic. Because the surgeons and I share the same office space. They're at one end of the hallway. We're on the other end. And the radiation oncologists are in the basement. So, for us, all the cancer docs are in one building and so it's easy enough. If my patient's coming from Delaware, they're coming from Virginia, we try to coordinate for them so that they don't have to take long trips and see people on different days.

I think across institutions, it requires communication between the physicians, but we try not to do across institutions unless we have no option, because it's much harder to coordinate care across institutions versus within the same institution. Some places are huge, and they have different buildings, like Hopkins has different buildings. So, you might meet your medical oncologist in one building and your radiation oncologist in a different building, and that will require some coordination also. Maybe a golf cart. I don't know. But certainly, there should always be a coordinator to try to help facilitate appointments and try to make things easier for the patients. Like, where do you come in? What time is your appointment with Dr X? What time is your point with Dr. Y, you know, that kind of thing.

Lisa Yen 31:22
So hopefully a navigator or some coordinator can help. What about the communication in terms of the treatment planning? How do you communicate with the rest of the team in terms of the treatment planning for your patients?

Dr Sandy Kotiah 31:34
So, I have a central location at the hospital, and I have two different offices in the suburbs. So usually, after I talk to the patient, I say to them, "This is the treatment I want to give you, and this is why," I'll write the orders in the computer, and then I will email my nurse practitioner, and I will email my nurse navigator, and I'll say to them, "This is a treatment. This is when I want to start, and this is the location the patient wants to start it in." And then the order goes to the finance people to get approved. And then when it gets approved, the patient gets called and they get an appointment, and then they get a follow up appointment with the provider after the treatment is scheduled. So, all that happens in like a coordinated fashion, with the help of everybody on the team to make sure the patient's aware of the drug, what the side effects are, where they're supposed to get that injection, when they're supposed to see me?

Lisa Yen 32:16
So, there's some internal coordination within your team. What about with providers outside the team? Say the patient goes to you and also someone closer to them, or maybe they get a second opinion. How do you communicate with other NET experts or providers in the community?

Dr Sandy Kotiah 32:33
Actually, it's the other way, like there's a local oncologist who's asking me for a second opinion, and the patient usually lives kind of far away, and I want them to get their treatment where they live. So, what I'll say to them is, "This is a treatment that I would like for you to have, and let's send our notes to your local oncologist, and we'll send our information and our number to them if they want to talk to

us. But this is the treatment I want you to start, and this is when I want to get your next scan. And when you get your next scan, then I want to have the results, and if your scans look good, fine. If they don't look good, then you're going to need to come back so we can discuss a change of treatment plan." So, I try to coordinate in that sense that you're going to have all your monthly appointments there, your bloodwork there, all that stuff. And when time comes with a scan, then we can even do have telemedicine. I don't really care, because if they're in Maryland, they can do telemedicine. If they're out of state, they have to come in. But then when the change, the decision treatment comes, then I need to see them again and talk to them and see what kind of shape they're in.

Lisa Yen 33:21
So that's helpful. So, patients can see their local provider for maybe their shots and some local things that they can do but then come in and see you for bigger picture things and follow up after scans.

Dr Sandy Kotiah 33:33
Yeah, so that will be months between appointments versus you have to come in every month to get a shot from my office and drive three hours. That I try to discourage as much as possible.

Lisa Yen 33:41
So, I guess patients wonder, do you talk to the local providers? Is this communicated somehow, in email fashion, or in the chart somewhere. How's it done?

Dr Sandy Kotiah 33:52
It depends. Some of the local oncologists, we have each other's cell phones. They will text me when they're worried about the patient, or they'll call me, and then I'll get their patients scheduled. And then I will text them back or call them back if there's something that I'm recommending that I want them to do. There are some providers that I've never spoken to, amazingly, where the patients are getting their injections there, and I'm sending my notes. And they're always just following my guidelines, but they never actually discuss the patient with me. Not ideal, but if the patient's not sick, that's not a big deal.

If the patient's sick, and I'm really worried, I will call the local provider and talk to them. And then they can always access me. So my nurse navigator is really good about saying so and so wants to talk to you. Can you please give them a call? This is their office number. I will say, Can you please get a hold of the office? I want to talk to that physician and find out the best way that we can get a hold of them so that we could talk about the patient.

But if things are kosher and everything's great and everything's going well, there doesn't need to be discussion amongst the two physicians. But if there's some problem or there's a complication, there needs to be discussion. So there are times when I've called the cardiologist at a different hospital because I've seen a patient with carcinoid syndrome and they are having a murmur, and I'm ordered an echo and their heart valve is leaking, and I have to get a hold of that cardiologist to talk to them. And I'm not just going to rely on a note that gets faxed, because I want to make sure that they have the information. So it depends on how important the information is to relay and how much effort you're going to put in. If it's something minor, you can send a note. If it's something major, you have to call.

Lisa Yen 35:15
Okay, so it depends as well, and it's helpful to know that you get on the phone and talk to local providers. So, second opinions come up often, and this is not necessarily someone who's already seeing you, but in general, many people get seen in the community, and they wonder about getting second opinions, and the value of getting second opinions, and how to get second opinions, and how providers feel when patients ask for second opinions. So, what happens if someone wants a second opinion and say they're seen by a local provider, or say they've seen someone else? What are your thoughts about second opinions?

Dr Sandy Kotiah 35:45
I saw a patient that I've been following for 13 years for a blood clotting disorder, and she's on the blood thinner, and she keeps having blood in her urine. She gets very frustrated by it. It's been eight years, and she's had kidney stones, and she said other things happen, and the urologist has been managing her, and she was so frustrated. I said to her, "You know, there's probably not a bad idea for you to get a second opinion, because you're clearly frustrated by this problem. It's been going on forever, and I'm not saying that the urologist is doing anything wrong. I don't necessarily think that he's doing anything wrong, but you need to know that he's not doing anything wrong and that he's doing everything he can for you, because then you're going to be less frustrated." So I encouraged her, and I gave her a name of a urologist somewhere else.

And in the same sense, there's nothing wrong with telling a patient, and I have sent my patients several times, even though I'm very comfortable with the treatment plan, not just neuroendocrine tumor, for other cancers, I'm very comfortable with the treatment plan that I came up with them, the treatment plan that I formulated for them. I'm very comfortable with that plan, but I also want to make sure that they are comfortable with that plan, because they're meeting me for the first time. They don't know me from Sam. So I'll say to them, go see Dr-so-and-so at this hospital who treats primarily what you have and make sure that they're saying to you the same thing that I'm saying to you. And if you decide to get your care with them, I'm fine. If you decide you want to come back here to get your care, and I'm fine with that. You don't want somebody to be your patient who doesn't quite trust what you say, and you don't have a good therapeutic relationship, because it makes you uncomfortable and it makes the patient uncomfortable.

What gets crazy for me with neuroendocrine patients is when they get the third opinion, the fourth opinion, the fifth opinion. That gets a little bit crazy, because then you can get confused if three different doctors say three different things. I think it's reasonable to get two maybe three opinions, but after that, you should just make up your mind. But this is how you're going to move forward, and this is who you're going to put your trust in, because it does involve you putting your trust in a physician and that you're going to see how it goes, and you're going to keep an open mind, and you feel comfortable with that person. You feel comfortable communicating with them and with the way that they explain things to you, because that's what really matters. Because sometimes it's not about, "This is the correct answer. This is the correct treatment." Sometimes there are different ways to do the something, different ways to approach a disease, and what really should matter is you feel that you're comfortable with your relationship with that physician, that if things are going well, right. If things aren't going well, that you're going to be able to reach out to them and they're going to be able to take care of you.

Lisa Yen 37:55
So at some point, after getting to a NET expert, there's some trust involved, and moving forward with that trusting relationship to work together. So really good point that you brought up. Sometimes people seek a couple opinions and there are differing recommendations. What advice do you have if there are differing recommendations between different doctors?

Dr Sandy Kotiah 38:17
That's even happened to me as a patient, where people have given different opinions, and I have to decide what's best for me, what makes sense for me. And did that person explain, in a way to me that I feel comfortable this is the way I'm gonna proceed. Because when you make decisions in life, whether you're buying a car or whether you're making a health decision, there's pros and cons, and sometimes it behooves you to make a list pros and cons. And you know yourself. Well, this is probably what's gonna work better for me, because this is how I am. And if there's two ways about it, this way makes me feel more comfortable than that way. And this person makes me feel more comfortable than the other person. Sometimes that's how you make a decision. It's sometimes some logic and some emotion that goes into it, but there's not always a right or wrong answer. You just have to trust your gut. The thing that's frustrating about cancer is nobody guarantees you anything. Nobody says to you, "Well, if you do this, for sure, 100%, you're going to end up where you need to be.” No. Everything you do in life, even if you decide to go to Harvard to get a PhD, for sure, you're going to have the job of your dreams, and you're going to live the life of your dreams. No, that's not how life works. You put your best effort in, and you try your best to get to where you need to be based on the information that you have, and you hope that it's going to work out for you. And that's the thing that frustrates people. I don't know. Am I doing the right thing? Because where am I going to end up in six months? Where am I going to end up in a year? We don't know. We're hoping that we know, and we can give you there's a

60% chance that your cancer will stop growing, but are you going to be that 60% or not? That's the thing that's scary, the unknown, and that's not something you can always take away from people, which is frustrating. But understandable.

Lisa Yen 39:49
Yeah, really, good point, and really acknowledging that there's a lot of uncertainty, and there's not a perfect certainty around it, because, as you said, you don't have a crystal ball. We don't have those powers yet, those superpowers that we wish we had but we don't yet have. And to lean into it and to move forward with knowing that we're making the best informed decision possible.

Dr Sandy Kotiah 40:09
Just to give you an example, not to get too personal, but I had gone on a fertility journey myself. And I put my heart and soul into it because I really love children, and I didn't find the partner of my dreams, if that's a thing. And I just was getting older, and I'm like, I really need to work on this. And I went through a long seven-year process, and it almost came to nothing, and it was a lot of expense later. And by some miracle, I was able to have my son, and I thank the powers that be for that. But I was thinking to myself, "Gosh, after all this effort that I've put in it, all this stuff that I put my body through, all these hormones and all these collections and all these years and all this money that I spent, it could end up that I end up with nothing." In that moment before I knew whether my last embryo was going to actually do anything out of the nine that I produced, I said to myself, "If it doesn't work out, then so be it. I'm going to enjoy my freedom. I'm going to hang out with my friends. I'm going to travel. I can adopt. I'm not going to wallow in it. I can't wallow in it." Because we never, never supposed to know how long we live and how much we get. Some people never have children. Some people have children. It's not for you to decide, for you to know. You can only do your best and hope for the best, and if things don't work out, then you'd make the best of that situation. Because otherwise, you can live till you're 95 and be miserable the entire time. Or you can live till you're 30 and pack a huge amount of life into that. It's all how you look at things, how you perceive things, and whether you choose to be happy or not. I've learned that from my patients and from doing what I do in life, and I'm grateful for it.

Lisa Yen 41:39
Thanks for sharing that personal example of also how you've been inspired by your patients, and how those lessons learned have applied to you. I think that journey and that example is relatable to a lot of people, the uncertainty related to fertility, and many people have been on that road as well, in that journey as well.

Dr Sandy Kotiah 41:58
And I'm not trying to equate the two, right? Please don't misunderstand me. I'm not trying to equate cancer to fertility, but just the concept of putting your heart and soul into something and thinking that

it's got to work out. And then you're like, "Wait, it might not work out. What am I going to do if it doesn't work out?" I'm going to try differently. I'm going to look at it differently. I'm going to look at myself differently. And I'm not going to say that somehow it was my fault, or somehow I didn't do everything I could, because people do put everything into it. And sometimes it works out, and we rejoice. Sometimes it doesn't work out, then we have to rework things and look at it from a different angle.

Lisa Yen 42:29
So, it's really, of course, different from cancer, but the lessons learned and that processing that you're talking about and the perspective can be similar in terms of how you approach it. Thank you for sharing that. That's really profound and really encouraging.

Going back to communication, if someone has a question, concern or symptom, who do they communicate with? And what's the best way would you advise to communicate with their provider?

Dr Sandy Kotiah 42:54
We have Epic, and Epic allows patients to send emails. And I have, thankfully, two nurse practitioners, usually, who work with me, and one of them is constantly monitoring the messages. So most people will say, call if you're having an emergency. It goes to a call center and these people are not always in my office, so it's not always getting directly to me. So sometimes I'll say to my patients, "Email me if you're having a problem and let me know, and we'll try to call you as soon as we get the email, because there's usually somebody who's checking it every hour." But sometimes people can just call the office line and try to get a hold of the nurse or try to get a hold of the nurse practitioner on the phone. And if it's really an emergency, if it's really, really bad, you can't get a hold of anybody and you don't feel well, you have to go to the emergency room, unfortunately.

Lisa Yen 43:36
That's helpful to know that perhaps the MyChart or Epic or email might work the best. What if after my appointment I remember something I'm like, "Oh, I forgot to tell Dr Kotiah that." Or if we run out of time during the appointment, how do I communicate something that I feel like, "Oh, maybe I should have told you this or asked you this."

Dr Sandy Kotiah 43:52
Patients always MyChart me, or they call me and leave you a message and say, "Can you call me back?" And you have to ask your provider, "What is the best way for me to contact you? Do you prefer me to email you on the MyChart? Do you prefer to call you? Do you prefer that I call your nurse practitioner. What number is the best way to get a hold of you?" Because everybody's different. Some people are not great at MyChart. Some people are better at MyChart.

Lisa Yen 44:10
That's really helpful. Just really again, an important question to ask your provider: "How do you prefer that I communicate with you?" What do you say to people who are kind of shy about communicating? If there's some question or concern, I'm like, "Oh, I wish I could talk about that, but I'm not sure. I don't feel comfortable." What do you say to them?

Dr Sandy Kotiah 44:29
I would be very upset if my patient thought that about me. I've been mad at some of my patients who have had side effects and don't tell me, because they don't want to, quote, unquote, bother me. And then they come to my office, and they've been sick for months, or they've been not feeling well for months because they've had side effects. I'm like, "Do you really think that any part of me wants you to be suffering for three months versus you just picking up the phone or just sending me an email? I'd rather know, because your quality of life matters to me." And I think the most awkward thing that comes up is sexual dysfunction. And I don't really know why, but I have breast cancer patients who have sexual dysfunction because of drugs that they're on. Some people have that because of surgeries that they've had or pain and scar tissue. So, it comes up and I'll bring it up and I won't make it awkward, because to me, it shouldn't be anything to be awkward about. Your doctor is not there to judge you and not there to make you feel weird about things. You should be able to bring things up comfortably. And if you're not able to do that, then do it with a different team. But if you have a closer relationship with your nurse navigator, then ask your nurse navigator. If you like the nurse practitioner better, whoever makes you feel like, "I can say this to them, and I know they're not going to be judging me or make me feel weird about it." Then so be it. It doesn't have to be your doctor, you know. And they can always communicate to your doctor or you and come back to you with whatever the answer should be. I would think the patient should feel like, "Hey, this person's on my team, and they really got my back. And I really shouldn't feel bad about asking about anything." I've heard all kinds of weird stories. It's fine. It's part of the job. I'm not judging.

Lisa Yen 45:52
Thank you for normalizing it and normalizing that there's some of these challenges that are difficult to talk about. As you've seen, people have issues sometimes with trust, and maybe because there's been symptoms for many years, and they've talked to providers who have dismissed those symptoms. So, what advice do you have to help build trust with my doctor? And what would you say is my responsibility as a patient or caregiver and your responsibility as an oncologist?

Dr Sandy Kotiah 46:16
So that's tough. I think when patients have symptoms that are chronic, there comes a point in time when you've tried everything that medical science has been able to provide, and still the person's not

having complete relief of that symptom. And I think that the job of the physician is to say to them, "This is a symptom. These are the things that we've tried, and these are the things that have failed, and these are the limitations of science." So the question is, "How can we get you to feel less bothered by this? And whether it's just giving pain medication or whether it's just trying to get it just controllable enough for you to go out and enjoy your show sometimes we have to compromise about this is never going to be perfect, but it's hopefully good enough to get you some quality of life."

If you feel like you're not being heard at all, and you've had a symptom for a long time and it's not being addressed, then you need to find a provider who's going to listen to you and who's going to say, "I hear you. These are my thoughts, and we might have to pull in so-and-so to help. But let's try this and that and see how things work out." And if you feel like somebody's actually listening and trying things, even if they don't work out, at least you know that we're trying to do something about it. So, it just depends on where you are on your journey. And sometimes things change, and you've had the symptom for a while, and that symptom has now become more intense, and it might not be clear to your provider that the intensity has changed, or the frequency has changed. Then you say, “Wait, hold on. Time out. I was having this symptom for a long time, but for the last six months, this is what I've noticed. And I just want to be very clear, I get it, I've had this, but now I feel like this is more intense, or this is happening more frequently.” To try to really pause. Versus “Oh, you've had this pain. So now, let's talk about your scans.” I mean, that's not that we want to be dismissive. But if we feel like there's a symptom that you've had that we've never been able to get to go away, then sometimes people are like, “Okay, I've done what I can for that symptom. Let me move on to the next thing.” But if it's really frustrating, sometimes people live with chronic symptoms and it's really, really depressing sometimes, or it's really, really frustrating, it's really anxiety producing, and it always makes sense to see a mental health therapist, not because they're going to fix your symptoms, but to help give you some sort of coping mechanism to deal with the frustration of that and the sadness of that.

Lisa Yen 48:25
Yeah, so underscoring the importance of a multidisciplinary team and multiple providers in the care for a whole person approach. So, we'll end with this last question. If there's one thing you would like all people living with neuroendocrine cancer to know, what would that be?

Dr Sandy Kotiah 48:41
That's a very good question. I would say to the patients who live with neuroendocrine tumor that most of you, not always, all of you, are going to be living with neuroendocrine tumor, and it's not so much about the end of your journey. It's more about the journey itself and making sure that the journey is what you want it to be. And don't put the cancer at the forefront of your life. It should never be that way. You should stay well educated. You should stay informed. You should have a good relationship with your team. You should make sure that you're doing what you need to do to keep the cancer at

bay so you can keep living your life. But living your life on your terms and making sure that you're maximizing your enjoyment of your life should be the priority always if you're living with a chronic illness. I don't care if it's Crohn's. I don't care if it's ulcerative colitis. I don't care if it's neuroendocrine tumor. Because we don't always get to know when our end is going to be.

Sometimes when we get closer, we get to know. But until that day comes, you live your life fully. And I live by that principle very much so because of what I do for a living. Just because I don't have neuroendocrine tumor doesn't mean that I'm not going to get hit by a car. You never know what's going to happen in life. You're not always supposed to know these things. But you're supposed to live your life as fully as you can. And try to minimize your stress as much as you can. And the relationships you have with the people who love you are going to be the things that bring you the most amount of happiness. And they might not always be family, might be just friends, but it doesn't matter. Might be your pet. It doesn't matter. It brings you joy. That's what matters.

Lisa Yen 50:08
Yeah. What really matters most is to not allow the cancer to steal that joy from you, but to really live as richly and fully as possible, despite living with cancer.

Dr Sandy Kotiah 50:20
Yes.

Lisa Yen 50:21
This has been really helpful. I hope that you've gotten a lot out of it as well.

Dr Sandy Kotiah 50:26
Always.

Lisa Yen 50:27
I really appreciate your time, your insights, the straightforward nature in which you talk, and just really normalizing some of the things and naming some of the things that people wonder about. They don't necessarily have answers to, and we don't always have answers to it but just talking about it. Talking about how to talk about things. Thank you so much for all you do. Thank you for how much you care for your patients. Because it's really clear that you care.

Dr Sandy Kotiah 50:50
Yeah, I do. They're like my family.

Lisa Yen 50:51

You're not just focusing on helping people live longer, but to live well, and that's so key. That's ultimately what people want. To live really well.

Dr Sandy Kotiah 50:58
That's what I would want. So that's why I want for them, even when that social stressors come into place, "I'm like, what what is your husband doing again? Let me talk to him." Or, like, "What is your wife saying again? Bring her in here. Let me talk to her." You know, like, sometimes I feel like a marriage counselor, but I have to, like, reset people a little bit. Like, remember, this stuff is not important. Big picture, this is what's important, and I think it's helpful. We're like family.

Lisa Yen 51:19
Like family, yeah. You're the big picture person. So, thank you so much for that. Thank you for all this time, for all you do for the neuroendocrine cancer community. We really appreciate you, and we look forward to talking to you again in the future.

Dr Sandy Kotiah 51:19
Oh, thank you. I appreciate you guys, too.

Lisa Yen 51:34

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