BUILT TO BEAT CANCER

NORTHSIDE HOSPITAL CANCER INSTITUTE

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Northside Hospital Cancer Institute Hosts 14th Annual Oncology Nursing Symposium

On Saturday, Aug. 29, 2026, the Northside Hospital Cancer Institute hosted its 14th Annual Oncology Nursing Symposium at The Hotel at Avalon in Alpharetta. The continuing education event drew 238 oncology nurses and industry representatives from across the Southeast, providing valuable opportunities for professional development, collaboration and knowledge sharing.

Centered on preparing for the future of oncology care, the symposium featured didactic presentations and interactive sessions on a range of clinical and professional topics. Sessions explored cellular therapy in solid tumors, high-dose-rate brachytherapy, multidisciplinary cancer care, the evolving role of oncology nurses, and the growing influence of emerging technologies and artificial intelligence. Presenters also addressed broader issues affecting patient care, including global and cultural considerations in palliative care and disparities in access to cancer care across Georgia.

The symposium also honored exceptional nursing professionals through the 2026 Distinguished Service Awards. Recipients included **Tamara Anderson** of Atlanta Cancer Care-Conyers, who received the Leadership Excellence Award; **Veronica Brann** of Georgia Cancer Specialists-Canton, who received the LPN Excellence Award; and **Janie Elizabeth Griffin** of Georgia Cancer Specialists-Marietta and **Kayla Parrof** of Acute Care Inpatient Oncology, who each received Clinical Nursing Excellence Awards.

Additionally, the event recognized 261 nurses who earned professional certifications in specialties including oncology nursing, advanced oncology nursing practice, blood and marrow transplantation, and pediatric hematology/oncology.

Through educational programming, peer engagement and recognition of clinical excellence, the symposium reinforced Northside Hospital Cancer Institute's commitment to advancing oncology nursing practice and supporting high-quality, patient-centered cancer care.











Clinical Trials and Research

New and Ongoing Cancer Clinical Trials

Disease Site	Sponsor, Protocol Number and Study Title	NCT Identifier
Breast	**Olema Pharmaceuticals, Inc. || OP-1250-302 || OPERA-02:** A Phase 3 Randomized, Double-Blind, Active-Controlled Study of Palazestrant With Ribociclib Versus Letrozole With Ribociclib for the First-Line Treatment of ER+, HER2- Advanced Breast Cancer	NCT07085767
	Study Design International, multicenter, randomized, double-blind, active-controlled phase 3 trial **comparing efficacy and safety of** (Arm A: investigational arm) **palazestrant in combination with ribociclib + letrozole-matching placebo to** (Arm B: control arm) **letrozole in combination with ribociclib + palazestrant-matching placebo** in participants with **ER+, HER2– locally advanced or metastatic breast cancer** who have not received any prior systemic therapy for advanced disease.	
Breast	**Relay Therapeutics, Inc. || RLY-2608-102 ||**A Phase 3 Open-label Randomized Study Assessing the Efficacy and Safety of **RLY-2608 + Fulvestrant Versus Capivasertib + Fulvestrant** as Treatment for PIK3CA-mutant Hormone Receptor Positive, Human Epidermal Growth Factor Receptor 2 Negative (HR+/HER2-) Locally Advanced or Metastatic Breast Cancer Following Recurrence or Progression On or After Treatment with a CDK4/6 Inhibitor	NCT06982521
	Study Design Global, multicenter, open-label, randomized phase 3 study comparing the efficacy and safety of zovegalisib + fulvestrant to capivasertib + fulvestrant for the treatment of participants with HR+/HER2- ABC with PIK3CA mutation following recurrence or progression on or after treatment with a CDK4/6 inhibitor. Eligible participants will be enrolled and randomized in a 1:1 ratio to receive either zovegalisib + standard dose fulvestrant or capivasertib + standard dose fulvestrant	
Colorectal	**Bristol-Myers Squibb || CA266-0003 || ROSETTA CRC-203:** A Blinded, Randomized Phase 2/3 Study of Pumitamig in Combination with Chemotherapy Versus Bevacizumab in Combination with Chemotherapy in Participants with Previously Untreated, Unresectable or Metastatic Colorectal Cancer	NCT07221357
	Study Design Phase 2/3, randomized, global study of **pumitamig** in combination with chemotherapy versus **bevacizumab** in combination with chemotherapy as 1L treatment for advanced or metastatic CRC The **phase 3** part of the study will be randomized, **blinded** to investigators, participants and the sponsor, and will compare the efficacy and safety of the selected dose of **pumitamig combined with chemotherapy** (FOLFOX, FOLFIRI or CAPOX) versus **bevacizumab combined with chemotherapy** (FOLFOX, FOLFIRI or CAPOX). CAPOX is included in the phase 3 study to provide additional chemotherapy options aligned with local SOC preferences across global sites. In the phase 3 part, eligible participants will be randomized 1:1 to the following arms: • **Arm C:** pumitamig RP3D, Day 1 + FOLFOX or FOLFIRI, Q2W or pumitamig RP3D + CAPOX, Q3W • **Arm D:** bevacizumab, Day 1 + FOLFOX or FOLFIRI, Q2W or bevacizumab + CAPOX, Q3W Blinded study intervention in combination with FOLFIRI will be limited to approximately 15% of the participants per arm.	
Prostate	**Alliance for Clinical Trials (NCI) || A032302 || ASPIRE:** Docetaxel Addition in Metastatic Castrate-Sensitive Prostate Cancer	NCT06931340
	Study Design Randomized, open-label, phase 3 study comparing **ADT plus apalutamide** with **ADT plus apalutamide plus docetaxel**. All patients will receive apalutamide (240 mg PO once daily) and ADT until progression or withdrawal. Patients will be randomized to Arm 1 or Arm 2: **Arm 1: ADT + Apalutamide** • Patients will receive only apalutamide and ADT. **Arm 2: ADT + Apalutamide + Docetaxel** • Patients will receive 6 doses of docetaxel administered every 21 days with a backbone of ADT and apalutamide.	
Lung	**BioNTech SE || BNT327-03 || ROSETTA Lung-01:** A Phase III, multisite, double-blinded randomized trial of BNT327 in combination with chemotherapy (etoposide/carboplatin) compared to atezolizumab in combination with chemotherapy (etoposide/carboplatin) in participants with first-line extensive-stage small-cell lung cancer	NCT06712355
	Study Design Phase 3, multisite, randomized, double-blinded trial in participants with first-line ES-SCLC. There are two stages in this trial: **Stage 1** will have three arms, and **Stage 2** will start when the final dose is selected and will have two arms. **Stage 1:** • **Control Arm:** Participants will initially receive four cycles of combination therapy: 1) Atezolizumab, 2) Carboplatin, 3) Etoposide, 4) Atezolizumab maintenance period • **Treatment Arm 1:** Participants will initially receive four cycles of combination therapy: 1) BNT327 2,000 mg, 2) Carboplatin, 3) Etoposide, 4) BNT327 2,000 mg maintenance period • **Treatment Arm 2:** Participants will initially receive four cycles of combination therapy: 1) BNT327 IV 1,400 mg, 2) Carboplatin, 3) Etoposide, 4) BNT327 1,400 mg maintenance period **Stage 2:** • **Control Arm:** Participants will initially receive four cycles of combination therapy: 1) Atezolizumab, 2) Carboplatin, 3) Etoposide, 4) Atezolizumab maintenance period • **Treatment Arm:** Participants will initially receive four cycles of combination therapy: 1) BNT327 1,500 mg, 2) Carboplatin, 3) Etoposide, 4) BNT327 1,500 mg maintenance period	

1L=first line; ABC=advanced breast cancer; ADT=androgen deprivation therapy; CAPOX=capecitabine + oxaliplatin; CDK4/6=cyclin-dependent kinases 4 and 6; CRC=colorectal cancer; ER+=estrogen receptor-positive; ES-SCLC=extensive-stage small-cell lung cancer; FOLFIRI=folinic acid (leucovorin), fluorouracil, irinotecan; FOLFOX=folinic acid (leucovorin), fluorouracil, oxaliplatin; HER2–=human epidermal growth factor receptor 2-negative; HR+=hormone receptor-positive; IV=intravenous; mg=milligram; NCI=National Cancer Institute; NCT=National Clinical Trial; PIK3CA=phosphatidylinositol-4,5-bisphosphate 3-kinase catalytic subunit alpha; PO=by mouth (per os); Q2W=every 2 weeks; Q3W=every 3 weeks; RP3D=recommended phase 3 dose; SOC=standard of care.

IN THE NEWS: Update for Clinicians

2025 Cancer Nation Survivorship Survey Highlights Gaps in Cancer Care and Support

The 2025 Cancer Nation Survivorship Survey, which included responses from more than 2,000 cancer survivors across the United States, highlights ongoing challenges in cancer care, including declining patient satisfaction, financial hardship, mental health concerns and gaps in survivorship care planning.

Although most survivors continue to trust their healthcare providers, satisfaction with care has declined, largely driven by increasing financial burdens and mental health challenges. While the majority of respondents felt their providers coordinated care effectively, nearly 60% reported still having to share medical information between providers themselves.

Survivorship care planning also remains an important area for improvement, with only 36% of respondents reporting receipt of a survivorship care plan, down from 43% in 2024. Those who received a plan reported greater confidence in managing their health, treatment-related side effects and emotional well-being after treatment.

Financial and psychosocial burdens are also significant. Half of respondents reported at least one financial hardship related to their cancer diagnosis, up 12% from 2024. One-third experienced depression or anxiety during treatment, but only one-third of those affected felt adequately supported in managing their mental health. Additionally, more than 90% reported treatment-related side effects, with fatigue, fear of recurrence and pain among the most common concerns.

Insurance-related barriers also affected care, with one-quarter of respondents reporting that insurance coverage influenced their treatment decisions and approximately one-third experiencing insurance-related challenges during treatment.

These findings emphasize the importance of a comprehensive, patient-centered approach to cancer care that prioritizes survivorship care planning, symptom management, psychosocial support and improved care coordination to enhance quality of life during and after treatment.

Reference: Cancer Nation. 2025 Cancer Nation Survivorship Survey: Executive Summary.



Expert Commentary

By Christina Austin-Valere, PhD, LCSW

At Northside Hospital Cancer Institute we recognize the importance of addressing patients' emotional and psychological needs throughout their cancer journey. Our Behavioral Health/Psych-Oncology Program provides short-term therapy, distress management, support groups and referrals for additional behavioral health services when needed. Through a team of licensed clinical social workers, professional counselors and psychologists, we help patients navigate challenges such as anxiety, depression and emotional distress during treatment and survivorship.

Recognizing the importance of survivorship care planning, Northside is also working to expand the delivery of survivorship care plans across our system. These plans provide patients with a summary of their treatment, recommended follow-up care and available support resources, helping them navigate life after cancer treatment with greater confidence.



CAR T-Cell Therapy KITE-753 Shows High Response Rates and Low-Grade Toxicity in Relapsed/Refractory Large B-Cell Lymphoma

By Lizamarie Bachier Rodriguez, MD

Updated results from the phase 1 PALISADES-1 trial (NCT04989803), presented as an encore presentation at the 2026 Society of Hematologic Oncology (SOHO) Annual Meeting, evaluated KITE-753, an investigational CD19/CD20 CAR T-cell therapy for relapsed/refractory (R/R) B-cell lymphoma. Although CD19 CAR T-cell therapy has improved outcomes in R/R large B-cell lymphoma (LBCL), some patients do not respond and others relapse. KITE-753 uses a bicistronic construct with dual CD28/4-1BB co-stimulation and a rapid manufacturing process designed to preserve naive and memory T cells. Northside Hospital was among the participating sites.

Eligible patients had B-cell lymphoma that was R/R after ≥2 lines of therapy or primary refractory in the second line. Phase 1a was dose escalation and phase 1b was LBCL dose expansion. Patients received one of three dose levels (DL): 0.3, 1 or 2×10^5 CAR T cells/kg (DL3). As of March 13, 2026, 34 patients had been treated, 23 of them at DL3. Median follow-up was 10.7 months. Overall, 74% had received ≥2 prior lines of therapy and 29% had prior anti-CD19 CAR T-cell therapy. The median time from leukapheresis to product delivery was 14 days.

Among CAR-naive patients at DL3 (n=18), the overall response rate (ORR) was 89% and the complete response (CR) rate was 78%. The 6-month CR rate was 71%, an endpoint validated as a surrogate for long-term outcomes. In patients with prior CAR T-cell exposure (n=10), the ORR was 50%, and the CR rate was 30%.

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CAR T-Cell Therapy KITE-753 Shows High Response Rates and Low-Grade Toxicity in Relapsed/Refractory Large B-Cell Lymphoma *(continued from page 3)*

No dose-limiting toxicities occurred. At DL3, cytokine release syndrome (CRS) was mild (61% grade 1-2), as was immune effector cell-associated neurotoxicity syndrome (ICANS; 22% grade 1-2). No grade ≥3 ICANS occurred at any dose level. In DL3 patients, grade ≥3 treatment-emergent adverse events occurred in 91%, and all grade 4 events were hematologic. Peak CAR T-cell expansion came later with KITE-753 than that reported with axi-cel (median 15 versus 8 days).

These results support continued development of KITE-753. The phase 2 portion of the trial, evaluating the recommended dose of 2×10^5 CAR T cells/kg in R/R LBCL after ≥2 lines of therapy, is enrolling globally, and expansion cohorts in first-line LBCL and R/R mantle cell lymphoma are open.

Reference: Dahiya S, et al. Presented at: 2026 Society of Hematologic Oncology Annual Meeting; Poster ABCL-629.



Liso-cel Shows High Response Rates in First Real-World Analysis in Relapsed/Refractory Mantle Cell Lymphoma

By Lizamarie Bachier Rodriguez, MD

Real-world data from the Center for International Blood and Marrow Transplant Research (CIBMTR), presented as an encore presentation at the 2026 SOHO Annual Meeting, evaluated lisocabtagene maraleucel (liso-cel) in relapsed/refractory (R/R) mantle cell lymphoma (MCL).[1] Liso-cel is an FDA-approved autologous CD19-directed CAR T-cell therapy for R/R MCL after ≥2 prior lines of systemic therapy, including a BTK inhibitor (BTKi). In the MCL cohort of the pivotal TRANSCEND NHL 001 trial (TRANSCEND MCL), liso-cel produced an overall response rate (ORR) of 83% and a complete response (CR) rate of 72%.[2] This analysis provides the first report of liso-cel's real-world effectiveness and safety in R/R MCL. Northside Hospital Cancer Institute was among the contributing centers.

This retrospective, observational study included U.S. patients with R/R MCL who received commercial liso-cel between May 2024 and December 2025 and had ≥1 post-infusion follow-up report to CIBMTR. Of 160 infused patients, 121 had post-infusion data. The population was older (median age 71 years; 72% aged ≥65 years) and heavily pretreated (median of 4 prior lines of therapy received; range, 2-12). Prior treatment included a BTKi in 98% of patients (noncovalent BTKi in 57%), a BCL2 inhibitor in 26% and hematopoietic stem cell transplant in 22%. Disease was refractory at infusion in 68% of patients, and 72.5% received bridging therapy. Median time from leukapheresis to infusion was 36 days, and 39% of patients were infused in the outpatient setting.

At a median follow-up of 6 months, the ORR was 89%, and the CR rate was 79%. Responses were similar in the 53% of patients who would have been ineligible for TRANSCEND MCL (ORR 86%; CR rate 75%). Median duration of response, progression-free survival (PFS) and overall survival (OS) were not reached. The 6-month duration of response rate was 81%, the 6-month PFS rate was 79%, and the 6-month OS rate was 92%.

The safety profile was consistent with TRANSCEND MCL. Cytokine release syndrome (CRS) occurred in 65% of patients and was mostly grade 1-2. Two patients (2%) had grade 4 CRS, with no grade 3 or 5 CRS events. Immune effector cell-associated neurotoxicity syndrome (ICANS) occurred in 36% of patients, including grade ≥3 events in 14%. One patient had grade 5 ICANS, which was a contributing cause of death; disease progression was the primary cause. Median time to CRS onset was 4 days and ICANS onset 7 days.

Among the 47 patients infused as outpatients, safety was similar to the overall population. Of these, 60% were later hospitalized, at a median of 5.5 days after infusion.

These early real-world results show high response rates and encouraging 6-month outcomes with liso-cel in a broad R/R MCL population that included older patients, heavily pretreated patients and patients who would not have met trial eligibility criteria. Outcomes were consistent with those of the pivotal trial. Longer follow-up will be needed to confirm the durability of benefit.

References: 1. Huang JJ, et al. Presented at: 2026 Society of Hematologic Oncology Annual Meeting; Presentation CT-230. 2. Wang M, et al. *J Clin Oncol.* 2024;42:1146-1157.

Continuous Lenalidomide Maintenance Does Not Improve Overall Survival Versus 2-Year Fixed-Duration Therapy in Standard-Risk Multiple Myeloma: Results From the Phase 3 ENDURANCE Trial

Dr. Shaji Kumar and colleagues reported results from the second randomization of the phase 3 ENDURANCE trial, which evaluated whether indefinite-duration lenalidomide maintenance improves outcomes compared with fixed-duration maintenance in patients with standard-risk, newly diagnosed multiple myeloma who were not undergoing up-front autologous stem-cell transplantation (ASCT). Although lenalidomide maintenance is generally continued until disease progression, the optimal duration of therapy remains unclear, particularly given the cumulative toxicity and cost associated with prolonged treatment.

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Continuous Lenalidomide Maintenance Does Not Improve Overall Survival Versus 2-Year Fixed-Duration Therapy in Standard-Risk Multiple Myeloma: Results From the Phase 3 ENDURANCE Trial *(continued from page 4)*

Following induction with carfilzomib, lenalidomide and dexamethasone (KRd) or bortezomib, lenalidomide and dexamethasone (VRd), 516 patients without disease progression were randomized to lenalidomide maintenance given indefinitely until disease progression (n=260) or to a fixed duration of lenalidomide for 2 years (n=256). Lenalidomide 15 mg was administered once daily on days 1-21 of each 28-day cycle. The primary endpoint was overall survival (OS), with progression-free survival (PFS) as a key secondary endpoint.

At a median follow-up of 86 months, indefinite-duration maintenance did not significantly improve OS. Seven-year OS was 68.6% with indefinite-duration lenalidomide versus 69.0% with fixed-duration therapy. Median PFS was 42.5 versus 38.9 months, respectively, and 7-year PFS was 36.1% versus 29.7%.

Grade ≥3 adverse events were more frequent with indefinite-duration versus fixed-duration maintenance (62.4% versus 46.9%), as were grade ≥3 treatment-related adverse events (44.7% versus 33.5%; p=0.009). Adverse events led to treatment discontinuation in 15.3% and 9.8% of patients, respectively. The 5-year cumulative incidence of second primary cancers, excluding nonmelanoma skin cancer, was 11.2% with indefinite-duration therapy and 8.3% with fixed-duration therapy.

The authors concluded that indefinite-duration lenalidomide maintenance was associated with greater toxicity and did not have an OS benefit compared with 2 years of maintenance in standard-risk patients. **These findings suggest that the benefit of lenalidomide maintenance may be achievable with a 2-year treatment duration in patients with standard-risk disease who do not undergo up-front ASCT.**

Reference: Kumar S, et al. *N Engl J Med*. 2026;395:221-232.



Expert Commentary

By Rodrigo Maegawa, MD

As hematologists, we are often inclined to think that longer duration of therapy could be advantageous in providing best treatment outcomes. The ENDURANCE trial challenges this paradigm and its findings suggest that for many standard-risk multiple myeloma patients who are not undergoing up-front autologous stem cell transplant, the benefits of maintenance therapy may be achieved within a defined duration of 2 years rather than indefinite therapy. Overall survival at 7 years was nearly identical (69.0% in the 2-year fixed-duration group versus 68.6% in the indefinite-duration group) while more frequent toxicity was observed with indefinite duration of therapy (grade ≥3 nonhematologic adverse events 48% versus 32%; 5-year cumulative incidence of second primary cancers 11.2% versus 8.3%).

This practice-changing trial has significant implications for 1) patients: as it moves them one step closer to normalcy following lenalidomide maintenance treatment. Fewer years on treatment means fewer adverse events such as fatigue, anemia and risk of secondary malignancies; 2) hematologists: goals of care in the age of novel agents have evolved. Simply extending life is not enough: Helping patients live healthier and more normal lives with less treatment burden is a key consideration for clinical development of emerging therapies in multiple myeloma.





Neoadjuvant Immunotherapy for Stage III Melanoma: Outcomes From Northside Hospital Cancer Institute

By Carly McCain, BSN, RN (left), and Nicole Kounalakis, MD (right)

Clinical stage III cutaneous melanoma with resectable nodal disease represents approximately 10% of all melanoma cases. Before checkpoint inhibition immunotherapy, clinical stage III melanoma would be a high-risk and/or terminal condition. In response to the advances of checkpoint inhibition immunotherapy, two large trials tested immunotherapy in the neoadjuvant versus adjuvant setting for this high-risk cohort: "Neoadjuvant Nivolumab and Ipilimumab in Resectable Stage III Melanoma" (NADINA) and "Neoadjuvant-Adjuvant or Adjuvant-Only Pembrolizumab in Advanced Melanoma" (SWOG 1801). Both trials clearly demonstrated that immunotherapy administered in the neoadjuvant setting provided an improved recurrence-free survival (RFS). Based on the significant results of these published trials, we evaluated and published the oncologic outcomes of patients with clinical stage III cutaneous melanoma who received neoadjuvant immunotherapy at Northside Hospital Cancer Institute. **Northside is the first community cancer center to publish its neoadjuvant immunotherapy experience for this patient population.**

Using Northside's hospital-based cancer registry, 47 patients met inclusion criteria of at least one pathologically proven lymph node with or without up to 3 in-transit lesions presenting as either de novo or recurrent disease. The disease must have been deemed resectable and the treatment plan involved neoadjuvant immunotherapy with ipilimumab and nivolumab. Northside's event-free survival (EFS) of all patients was 85% with a median follow-up of 22 months, while NADINA reported an 83.7% EFS at 12 months. Northside's major pathological response (mPR ≤ 10% viable tumor) to neoadjuvant immunotherapy was seen in 65% of patients (NADINA 59%), pathological partial response (pPR > 10 to < 50% viable tumor) in 4% of patients (NADINA

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Neoadjuvant Immunotherapy for Stage III Melanoma: Outcomes From Northside Hospital Cancer Institute

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8%), and pathological nonresponse (pNR > 50% viable tumor) in 30% of patients (NADINA 26.4%). Our RFS was 97% for the patients with a mPR (NADINA 95.1%), 100% with a pPR (NADINA 76.1%), and 71% with a pNR (NADINA 57%). Both Northside and NADINA demonstrated the safety of neoadjuvant dual-agent immunotherapy with comparable grade 3-4 adverse event rates: 15% versus 22%.

These findings demonstrated that neoadjuvant immunotherapy can be administered safely and effectively in a community cancer center in the United States with the use of a multidisciplinary team. To read the full article that outlines the Northside experience with neoadjuvant immunotherapy in a high-risk cohort, please visit surgoncinsight.org/article/S2950-2470(26)00070-8/fulltext.

Elevating the Patient Experience

Northside Rehabilitation Introduces Use of Bioimpedance Technology

The Northside Hospital Rehabilitation Department recently added bioimpedance spectroscopy (BIS) technology through the implementation of SOZO® Digital Health Platform devices to assess lymphedema and sarcopenia risk in patients with cancer. The technology is being made available at locations in Atlanta, Alpharetta and Cherokee.

Bioimpedance spectroscopy measures impedance across 256 frequencies in a rapid, noninvasive scan, enabling differentiation between intracellular and extracellular fluid. This technology provides an accurate whole-body composition profile and delivers actionable clinical data at the point of care to support treatment planning, recovery monitoring and evidence-based clinical decision-making.

Advancing Early Detection of Lymphedema

Up to 58% of patients with breast cancer are at risk for developing limb lymphedema, with risk exceeding 80% among some breast cancer populations depending on treatment modalities[1]. SOZO® with L-Dex® is currently the only FDA-cleared BIS solution for the clinical assessment of lymphedema.

By identifying lymphedema at a subclinical stage, clinicians have the opportunity to intervene earlier, limit progression and improve patient outcomes. The use of BIS technology also supports compliance with National Accreditation Program for Breast Centers (NAPBC) standards related to lymphedema risk assessment, surveillance and rehabilitation referrals. In addition, National Comprehensive Cancer Network (NCCN) guidelines emphasize the importance of early lymphedema detection and the use of objective assessment tools such as BIS.

The rehabilitation department has begun partnering with the Northside Hospital Cancer Institute's Quality Team and Breast Steering Committee on a performance improvement initiative evaluating the feasibility of lymphedema screening throughout the cancer care continuum. This project is focused on risk stratification, physician practice integration, rehabilitation workflow optimization and patient satisfaction. Findings and recommendations will be presented to the Breast Steering Committee to guide potential implementation throughout the cancer institute.

Addressing Sarcopenia Risk in Oncology Care

Sarcopenia is one of the most significant yet frequently underrecognized risks affecting patients with cancer. It may be present before diagnosis, develop as a consequence of the disease process, or result from treatment-related inflammation, metabolic stress, reduced physical activity and nutritional challenges.

Low skeletal muscle mass has been associated with decreased survival in patients with breast cancer, reduced tolerance to chemotherapy and increased rates of postoperative complications[2]. Importantly, sarcopenia is a modifiable condition. Early identification allows clinicians to implement targeted interventions, including resistance exercise and nutritional optimization, before muscle loss becomes increasingly difficult to reverse. Exercise advocacy is supported by the American College of Surgeons through newly revised Commission on Cancer standards effective in 2027. The new standard advocates for assessment and referral processes during the first course of cancer treatment that improve patients' awareness of exercise benefits and their access to expertise and programs that mitigate symptoms related to the disease or its treatment.

SOZO recently received FDA clearance for sarcopenia risk assessment using body composition measurements. The platform uses BIS technology to estimate lean body mass and skeletal muscle mass. Compared with traditional single-frequency bioelectrical impedance analysis (BIA), BIS provides a more detailed assessment of body composition through improved differentiation of body fluid compartments and tissue composition.

Moving forward, the rehabilitation department will continue collaborating with the cancer institute steering committees to evaluate the optimal integration of this technology into oncology care pathways and identify opportunities for sarcopenia screening and intervention across the health system.

To learn more about Northside's oncology rehabilitation services, visit northsiderehabilitation.com/services/oncology-rehab. A physician referral is required for outpatient rehabilitation services.

References: 1. American Cancer Society, *Cancer Facts & Figures 2022*, Atlanta: American Cancer Society; 2022. 2. Aleixo GFP, et al. *Breast Cancer.* 2023;30(1):101-109.



Expanded Breast Care Coordination Aims to Cut Time to Treatment

By Erica Nigro, RT(R)(M)(ARRT), BHCN

Northside Hospital Cancer Institute is expanding its Breast Care Coordination Program, building on a two-year pilot that demonstrated measurable reductions in time to treatment for patients with breast cancer. The expanded program is designed to help patients move quickly and seamlessly from diagnosis through the start of treatment.

Under the new process, any patient who receives a breast cancer diagnosis through the hospital's legacy locations will automatically be enrolled in this specialized program, with no separate referral or enrollment step required. A dedicated Breast Care Coordinator will guide the patient from diagnosis through the next phase of care, while keeping the referring provider informed along the way. For patients, this means fast-tracked surgical consultations scheduled according to the referring provider's preferences, coordination of any additional testing needed as well as support during a critical time, including identification and resolution of barriers to care through Oncology Navigation. Care is aligned across specialties from diagnosis into treatment, with the goal of a faster overall time to treatment. For referring practices, the program is intended to streamline coordination, reduce workload on office staff and provide proactive communication.

The process is designed to simplify referrals by having providers submit a comprehensive breast imaging order up front, with Northside's team coordinating the remaining steps. After gathering each provider's referral and communication preferences, the Breast Care Coordination team manages the patient's progress through the breast care continuum.

This approach allows Northside's Breast Imaging Team to coordinate any additional diagnostic workup without delays for additional orders, if clinically appropriate. By creating a more efficient workup and diagnosis process, Northside aims to reduce administrative burdens on referring practices, accelerate time to treatment and improve the overall patient experience.

For more information, contact Erica Nigro, Breast Care Coordinator, at 470-639-4802 or breastreferral@northside.com.

Around Our Campuses and Community

Fifth Annual Patient and Care Partner Education Conference Hosted by Northside Hospital Cancer Institute

On Saturday, Sept. 12, 2026, the Northside Hospital Cancer Institute hosted the fifth annual Patient and Care Partner Education Conference at The Hotel at Avalon. This year's conference, themed "The Power of Your Story," brought together patients, survivors, care partners and community partners to provide education, support and connection throughout the cancer journey.

Attendees participated in educational presentations and interactive discussions addressing a variety of topics, including the roles of the cancer care team, nutrition, communicating about difficult topics, finding strength through connection, and finding meaning and hope throughout the cancer journey. The program also included an interactive patient and care partner discussion, providing attendees with an opportunity to share their experiences and connect with others.

We look forward to hosting our sixth annual Patient and Care Partner Education Conference in 2027.







The Northside Hospital Cancer Institute was recently awarded accreditation from the American College of Surgeons Commission on Cancer (CoC) as an Integrated Network Cancer Program.

Provider Features

New Providers and Recognitions



Joon B. Kim, MD, is a colorectal surgeon who recently joined Georgia Colon & Rectal Surgical Associates. To learn more, please visit northside.com/joon-b-kim.



David Swift, MD, is a colorectal surgeon who recently joined Georgia Colon & Rectal Surgical Associates. To learn more, please visit northside.com/david-swift.

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New Providers and Recognitions *(continued from page 7)*



Justin Yeh, MD, is a hematologist/oncologist practicing at Suburban Hematology-Oncology Associates — Lawrenceville. To learn more, please visit northside.com/justin-yeh.



Chieko Hirano of ACC Tower was recognized as the outpatient oncology group's second DAISY Award recipient. The DAISY Award honors nurses for the compassionate care and kindness they provide, based on nominations from patients, families and colleagues. Congratulations, Chieko!

Upcoming Education and Events

CONTINUING EDUCATION

Northside Hospital Cancer Institute Symposium — Precision Oncology
March 13, 2027 from 7 a.m.-3 p.m. at The Westin Buckhead Atlanta
northside.com/nhcisymposium2027



CANCER SCREENING & PREVENTION

Built To Quit — Smoking and Tobacco Cessation Course
Next six-week session start date: Jan. 26, 2027
Weekly classes are led by a trained smoking and tobacco cessation facilitator.
Classes are available during afternoon and evening hours and remotely.
northside.com/community-wellness/built-to-quit

BUILT TO QUIT
Resources to help you stop smoking and using tobacco

Skin & Prostate Cancer Screening
March 11, 2027 at Northside Hospital Cancer Institute Radiation Oncology — Cherokee from 6 to 8 p.m.
For more information, please call 404-531-4444.

COMMUNITY EVENTS

NORTHSIDE EVENTS

Great American Smokeout
Nov. 19, 2026
Activities occurring at each Northside Hospital campus. More information to come.



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