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COLLABORATING TO CONQUER CANCER

FALL 2025

A LUNG CANCER JOURNEY: FROM DOCTOR TO PATIENT

D. ROSS CAMIDGE, MD, PHD, HAS SPENT HIS CAREER FIGHTING LUNG CANCER. THAT FIGHT TURNED PERSONAL WHEN HE RECEIVED A LUNG CANCER DIAGNOSIS OF HIS OWN.

Cancer Center

NCI-DESIGNATED COMPREHENSIVE CANCER CENTER

CU CANCER CENTER RESEARCHERS HELP TO VALIDATE BLOOD TEST FOR OVARIAN CANCER

Working with Denver-based company AOA Dx, University of Colorado Cancer Center members **Kian Behbakht,** MD, MBA, the Emily McClintock Addlesperger Endowed Chair in Ovarian Cancer, and **Benjamin Bitler,** PhD, the D. Thomas and Kay L. Dunton Endowed Chair in Ovarian Cancer Research, were co-authors on research published in August showing the validity of a new blood test for ovarian cancer.

Created by AOA, the blood test uses lipids as biomarkers to detect early-stage ovarian cancer. At the CU Cancer Center and other sites nationwide, women experiencing vague abdominal symptoms—such as bloating, abdominal pain, early satiety (feeling full quickly), and urinary issues—enrolled in a clinical trial where their blood samples were tested with AOA's diagnostic technology.

Behbakht separately published research showing the effectiveness of using the electronic medical record to ask women if they have experienced any of the listed symptoms as a way to pre-select women who should receive a blood test such as AOA's. He says the focus on symptoms, combined with the success of the blood test in the clinical trial, offers new hope for detecting ovarian cancer early.

"If there can be an alert screen in the electronic health record that says, 'Your patient has these symptoms. Have you considered this test that will rule out an ovarian cancer?,' my guess is that most providers would order that test," he says. "If they do so, then maybe we will diagnose ovarian cancer early and prevent women from dying."

KIAN BEHBAKHT, MD, MBA

BENJAMIN BITLER, PHD

From left, CCSP leaders Andrea Dwyer, PhD; Elsa Staples, MPH; and Jo Henning, MPH.

AMERICAN CANCER SOCIETY NAMES COLORADO CANCER SCREENING PROGRAM ITS STATE PARTNER OF THE YEAR

For its success in advancing cancer prevention and early detection efforts across the state, the University of Colorado Cancer Center's Colorado Cancer Screening Program (CCSP) has been named the American Cancer Society (ACS) 2024 Colorado State Partner of the Year.

"Your leadership in promoting equitable access to colorectal cancer screening has made a measurable difference in the lives of Coloradans—particularly in rural and underserved communities where barriers to care are often most pronounced," Allie Bain, associate director of state partnerships for the ACS, said in her notification letter to the CCSP.

Founded in 2006, the CCSP partners with local, state, and national clinical and community organizations to navigate Coloradans—particularly rural and medically underserved populations—to screening for colorectal cancer, lung cancer, and more recently, gastric cancer.

"Our partnerships with organizations such as the ACS are pivotal to ensuring all available resources to support colorectal cancer prevention and early detection are distributed to the clinic systems and eligible individuals most in need," says **Elsa Staples,** senior program manager for the CCSP.

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news.cuanschutz.edu/cancer-center

LEADERSHIP TRANSITION

RICHARD SCHULICK, MD, MBA, MOVING ON AFTER SEVEN YEARS

RICHARD SCHULICK, MD, MBA

Richard Schulick, MD, MBA, director of the University of Colorado Cancer Center, announced in October that he will join the University of Rochester Medical Center in spring 2026 as chief clinical officer, senior vice president for health system strategy, and vice dean for clinical affairs.

Schulick's time at the University of Colorado started in 2012 as chair of surgery; he was named director of the CU Cancer Center in 2018. He spearheaded numerous initiatives and achieved many notable successes during his tenure, including boosting participation in clinical trials; recruiting nationally renowned program leaders; increasing funding for basic and population science research; and instituting multidisciplinary cancer clinics that allow patients to be evaluated by multiple specialists in one day.

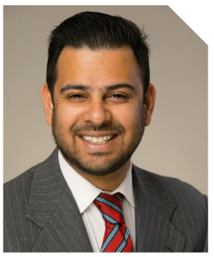
In 2022, Schulick led the CU Cancer Center—the only National Cancer Institute-designated comprehensive cancer center in Colorado—to its latest renewal with the center's best rating ever.

"Rich completely transformed the CU Cancer Center, putting us on a path for greater scientific discoveries, superb clinical care, and translational work that set us apart from our peers. We are deeply grateful for all that he has done," says Deputy Director Cathy Bradley, PhD.

The cancer center remains committed to advancing cancer care and discovery, building on the strong foundation established during Schulick's tenure.

"Rich provided amazing leadership, building a highly effective cancer center through recruitment of fantastic researchers, support for new technologies, boosting clinical trials, promoting outreach and implementation of discoveries into the community, and supporting the education of the next generation of researchers," says Deputy Director James DeGregori, PhD. "And somehow, he makes effectively orchestrating all of these moving parts appear natural."

PATIL RECEIVES PAUL CALABRESI CLINICAL SCHOLARS AWARD



TEJAS PATIL, MD

University of Colorado Cancer Center member **Tejas Patil,** MD, has been selected for the Paul Calabresi Clinical Scholars Award, part of a National Cancer Institute-funded career development program that aims to increase the number of cancer clinicians trained in research.

Patil, a thoracic oncologist, says the award funds will help him pursue answers to "a very important question in lung cancer" involving a subset of cancer cells that survive therapy and contribute to cancer relapse.

"One of the challenges in an academic physician's life is balancing multiple competing responsibilities between clinic education, administrative time, and research time," Patil says. "This award allows me to protect my research time and take some of the ideas and concepts I have to a more advanced level, so I can be on track for a higher grant, like an R01."

$15 MILLION GIFT WILL MOVE PANCREATIC CANCER RESEARCH FORWARD

WELLS MESSERSMITH, MD

MARCO DEL CHIARO, MD, PHD

A $15 million philanthropic investment from Tom and Cydney Marsico will harness the power of artificial intelligence and next-generation data science to uncover the biological drivers of pancreatic cancer and accelerate the development of personalized therapies.

Overseen by **Wells Messersmith,** MD, associate director for clinical services at the University of Colorado Cancer Center and the Emily Coe Atherton Endowed Chair in Pancreatic Cancer Research, and CU Cancer Center member **Marco Del Chiaro,** MD, PhD, professor and division chief of surgical oncology and the Morton and Sandra Saffer Cancer Center Endowed Chair, the initiative will employ technological tools such as spatial transcriptomics, single-cell multiomics, and advanced machine learning to build a comprehensive picture of pancreatic cancer at the cellular level, leading to more precise and effective treatments.

A Lung Cancer Journey: From Doctor to Patient

D. Ross Camidge, MD, PhD, has spent his career fighting lung cancer. In 2022, that fight turned personal when he received a lung cancer diagnosis of his own.

BY JESSICA CORDOVA

> There's the potential for some good to come out of this dual role, expert and patient, and I thought this might be the time to share.

In his 20-year research career in Colorado, University of Colorado Cancer Center member D. Ross Camidge, MD, PhD, has published nearly 400 academic papers. But perhaps none has been so personal to him as a May 2025 analysis, published in the Journal of Thoracic Oncology, on how clinical researchers describe the side effects caused by new anti-cancer treatments.

"If a treatment is so horrible that a patient can't handle it, then it is not an advancement in care," Camidge says. "We don't treat laboratory models or even patients. We treat people with lives that the cancer is in the way of."

In the article, Camidge notes that "using terms such as 'tolerable' or 'acceptable' places the investigators running clinical trials in the untenable position of determining whether a patient's experiences with toxicity are 'tolerable' or 'acceptable' to the patient. Similarly, words such as 'encouraging' or 'favorable' used in efficacy reporting may reflect the enthusiasm of the investigators to continue development of a treatment but may be interpreted very differently by the people considering receiving the treatment."

It's research he hopes will help other lung cancer doctors and all oncologists to better treat their patients, but it's also research that reflects his own personal experience.

What few of his colleagues knew at the time the paper was published was that Camidge—one of the world's leading lung cancer researchers—had himself been diagnosed with aggressive lung cancer in 2022. Earlier this year, he had a progression that led to treatment that was harder the second time around.

"The chemotherapy was a little different this time around, and it was really tough on me," he says. "It was the closest thing to being completely incapacitated I've ever been. Sometimes I was just lying there, and the only function of each day was for it to finish so that the next day I might feel a little bit better."

For the past three years, Camidge has only revealed his diagnosis to a small group. But after the recent progression, he feels it is time to reveal that he is also a patient.

"I didn't want to end my life like that and have people say, 'And oh, by the way, he had lung cancer.' There's the potential for some good to come out of this dual role, expert and patient, and I thought this might be the time to share."

Could it be?

It started with a wheeze and a little pain in his back, which Camidge originally thought could have been due to a pulled muscle. But after a few weeks, he decided it was time to see his doctor.

"As a good paranoid oncologist, I thought, 'Let me just go to my primary care physician,'" says Camidge, the Joyce Zeff Chair in Lung Cancer Research in the CU Anschutz School of Medicine. "During that appointment on June 10, 2022, I said to them, 'Oh, by the way, I am a lung cancer oncologist, so could we get a chest x-ray?' They rolled their eyes, but they ordered one.

"I went and got the chest x-ray on the way back to my office. Then I pulled it up on my computer a short time later. As soon as I saw my chest x-ray, I knew. I've seen thousands of people with lung cancer, and you see the chest x-ray, and you go, 'That's lung cancer.'"

His doctor scheduled him for a CT scan the same day. His wife, Windy, and young daughters were boating up in the mountains at the time. "I told Windy what was going on and that I was worried, but that they should finish their day on the lake.

"Later the same day, I was looking at the CT scan myself, and I could see that there were deposits in both lungs, in bones, and it turns out they were in my brain as well. So, I knew on the same day I had gone in with just a wheeze and a pulled muscle that I had cancer and that it was advanced and incurable," Camidge says. "I moved into professional mode."

A bronchoscopy to get a biopsy from his lungs provided the last piece of the puzzle to confirm Camidge had advanced non-small cell lung cancer driven by a specific acquired genetic change in the tumor cells—one of the types of lung cancer he has spent his career researching and treating.

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He went from visiting his primary care physician to receiving a full diagnosis, complete with body and brain scans, a biopsy, and molecular testing, and starting targeted therapy all within four days. The process normally takes about two weeks, Camidge explains, “I didn’t call in any favors. I think my colleagues just stepped up to the plate for one of their own. However, to me it also shows this timeline is possible, and we should try to do that for everyone.”

Once Camidge was through all of the necessary diagnostic procedures and the treatment had started, the professionalism faded, and the reality hit him.

“Two things would make me cry repeatedly for multiple days,” he says, “One was anyone being nice to me. The other was any thought about my children, in terms of what their future is and whether I’d have a role in that.”

Camidge has two daughters. At the time of his diagnosis, Sophie was 12 and Alex was 10. “They were still so vulnerable. I didn’t want to go away. I didn’t want to not be there to help them through all the challenges of life.”

Starting treatment

It was clear that the tumor was not something that could be cut out, so Camidge went to one of his former trainees and colleague, CU Cancer Center member Tejas Patil, MD, to ask if he would be his oncologist.

“One of the things that I thought about when I was taking care of Ross was that this is not going to be a traditional doctor-patient relationship,” Patil explains. “This is really going to be like a coach relationship. Thinking of the way former Swiss tennis player Roger Federer had a coach, I was always wondering what the coach could possibly teach Roger Federer, who's the best in the world at what he does. But I think coaches act as a mirror and can help point out things that sometimes get missed. I viewed my relationship with him like that.”

Camidge, who was 55 at the time of his diagnosis, was able to start treatment right away with a daily pill of targeted therapy directed toward the genetic change driving his cancer. Then he started chemotherapy for 12 weeks, followed by weeks of on-and-off radiation therapy to everything his colleagues could still see on the scans.

“It was the most aggressive thing we could have done,” says Patil, adding that three years later, this combination is now almost the standard of care, though it was not at the time.

After finishing his chemo and radiation around the holidays of 2022, Camidge entered a phase where he would continue his daily pill and get scans of his body and brain, as well as blood work, every 90 days.

“When you start with those scans, you enter this period of time for about a week before the scan where you go a little crazy, and you get very angry with people if they talk about anything in the future,” says Camidge. “You can’t even plan for next week.”

Every time his blood work and scans were completed, Camidge would head to his office and look at the reports and the images himself. His experience let him know the outcome of his treatment right away. The medication, the chemotherapy, and the radiation shrank everything down, and for years, there was no further cancer growth.

“With each good scan, then this weight that has been building up just comes off your shoulders. And I know this sounds like ‘The Wizard of Oz,’ but the colors are a little brighter, and the birdsong is a little louder, and you just feel very happy.”

90-Day Challenge

“It became clear that I didn't want the time between scans to just be me waiting until the next bit of bad news,” Camidge says. “I wanted to be able to look back on each of those 90-day periods and say, ‘I did X.’ So, we created the idea of the 90-day challenge, which we spilled over into the patients, the staff, and everyone else.”

The goal was not to climb Mount Everest, he says, though it could be if you wanted. The idea behind the challenge was to do something you have been putting off or always wanted to do, to help the time between scans become more than just waiting.

“It initially started with me wanting to get my fitness back, so I was going to do a couch to 5K, which actually took me two sets of 90 days to get to the 5K.

“But then I would do other things,” he adds. “I went to yoga classes for the first time.” He also learned how to draw and do watercolor, went to a restaurant he always wanted to try, bought a 20-year-old convertible, rejuvenated his garden, tried archery, and many other new things.

“It doesn't have to be monumental. Just have an answer when asked, ‘What did you do in those 90 days?’ It could be, ‘I went to see great Auntie Gertie,’ but you did something.”

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D. Ross Camidge By the Years

1992
PhD, University of Cambridge, United Kingdom

1995
MD, University of Oxford, UK

2005
Joined CU as a visiting professor

2007
Recruited as full-time faculty

Progression

In February 2025, nearly three years after his diagnosis, Camidge had his first progression. His quarterly CT scan showed that everything was fine, but his blood-based markers had gone up.

“Then we did a PET scan,” says Camidge. “And there was a little strip lighting up at the back of my right thorax, in what's called the pleura, the outer lining of the lung.”

Although some lung cancers are caused by smoking, Camidge was never a smoker, and this type of acquired mutation in his cancer is not caused by cigarettes.

“So somewhere along the 50-odd years of my life, I breathed something in, and it landed on one of my lung cells. That caused a change in the DNA and the genetic material in that cell, and it became a cancer,” he says.

The progression of his cancer this year meant that Camidge had to start chemotherapy and radiotherapy again, this time adding an additional antibody-based treatment to the chemo.

Coming out of this progression, Camidge’s appearance has changed. “I have more freckles on my face, and I have scabs on my head and have lost some hair too.”

Camidge is also in a different mental place going into his next set of scans. He says he has less anxiety about what the scans will show.

“There's an element of the first progression event being something that you're most terrified of, that’s the worst pre-scan anxiety, because it's potentially the first bell ring of mortality,” he says. “You're not immortal, that scan could announce. You're not going to be the exception. You're not going to be the one who never progresses. That's what you're afraid of.”

He says he is going into the next set of scans after having heard that ring already, “not with as much fear, almost with an acceptance.”

Sharing the news

When a patient is diagnosed with lung cancer and comes to Camidge for care, he tells them it is important to “figure out who you're going to tell, what you're going to tell, get your finances in order, and figure out what's important to you in terms of, ‘If you only had a certain amount of time left and you had the flexibility to do it, what do you want to do with that time?’”

Camidge took his own advice. When he was first diagnosed, Camidge decided he was not going to go public with the diagnosis. For treatment, he went to a satellite clinic in Cherry Creek to avoid running into his own patients. He shared with his team but kept the diagnosis within a small group.

“One way to protect yourself was not telling people, then they don't have to be nice to you or treat you differently,” Camidge says. “They could just be as ornery and unpleasant as they normally are, and that's totally fine.”

He also did not want to take the focus away from his patients and wanted to continue to make progress in the thoracic oncology space. “I debated whether I should still see patients or take on new patients. I got my clinic team to promise to tell me if they thought I was acting differently, and so far, the years of professionalism are still winning through. Although I try and build the clinics of my colleagues with most of the new patients that enter the program, as I should, I have continued to see my patients, because I believe, I am still adding value.

“We had just bought a new house, which we'd been doing up, and financially I didn't want to suddenly not be invited to this, that, and the other thing where I am paid for my expertise.”

Now, multiple necessities are set in place. His finances are stabilized, and there are new faculty members to take his patients if he gets to a place where he needs to stop practicing. He feels if “other opportunities go away, or people don’t want to see me, simply because some people now know something they didn’t know for the last three years but I’m still performing at the same level, then so be it. If people embrace an expert with a lived experience of what they are an expert in, maybe some good could come of that too.”

His daughters growing up over the past three years has also played a role in how much he has begun to feel comfortable about publicly sharing his condition.

> “You’re not immortal, that scan could announce. You’re not going to be the exception. You’re not going to be the one who never progresses. That’s what you’re afraid of.”

“By the end of the year, our children will turn 16 and 14, they’re full-on teenagers, but when I was diagnosed, I felt they were just little girls,” says Camidge. “Over time, they can process things differently. Windy had looked up the best way to break this sort of news to children, and we told them about the diagnosis within about a week. Pretty much once I'd started on treatment. We didn't sugarcoat things. We didn't say this is curable or is going to go away. But we highlighted that I was on a treatment and also how well Daddy's patients usually do. Over the years, they’ve met some of my patients at various functions, and they often look pretty good.”

Becoming an expert

At age 19, long before he became an internationally recognized lung cancer researcher, Camidge, who was born in 1966, started his medical career as a student at the University of Oxford. Going into his third year of medical school, when you normally start clinical work, Camidge decided he was not done with his scientific training and so went to Cambridge to get his PhD in molecular biology.

He then returned to Oxford Medical School with a few more years of maturity under his belt and began his clinical training. He ended up choosing to pursue oncology because it combined molecular biology and patient care.

During the time he was working at cancer centers in England and Scotland, Camidge elected to pursue a training attachment with AstraZeneca to learn about drug development directly as an industry physician. Following completion of his training in the UK, he then decided to follow his career in academic oncology to the United States.

“While I was at AstraZeneca, that was when the first targeted therapies were being developed, and some of the best responses were being seen in patients with lung cancer. I felt this was an area that was about to explode. I also really liked the patients with lung cancer that I had met. They were often a little beaten down and humble, and their lack of demands made me want to step toward them even more,” explains Camidge on why he decided to focus his career on lung cancer.

He goes on to explain, “Lung cancer kills more men and women than breast cancer, bowel cancer, pancreas cancer, prostate cancer–combined. And yet people only think it affects heavy smokers, which is not the case.”

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In October 2005, Camidge decided CU was the place for him after learning more about the growing amount of drug development taking place there.

Eventually, he became director of CU's Thoracic Oncology Program, helping to grow it into a nationally and internationally recognized center that accrues about 40% of lung cancer patients into clinical trials–more than double the rate of the next best academic lung cancer program in the country and more than 10 times the national average.

"The research I am most proud of is when we saw something first and reported it first, even though it was under everyone's nose," says Camidge.

When looking at his own diagnosis and treatment plan, he could see developments that he had helped put in place.

"There was an element of, 'Oh, I'm benefiting from some of the research that I've done myself. That's cool.'"

Fellow lung cancer oncologists have recognized Camidge's work, which has led to multiple awards over his career. One of the honors Camidge received was the Bonnie Addario Lectureship Award from the Addario Lung Cancer Foundation in California.

"I was lucky enough to get the Addario award pretty early in my career. I had to set up a lot of things in Colorado without much senior input or feedback. So, when I looked at past winners of this big award, who were all very distinguished, I felt that maybe I wasn't terrible at my job, and that keeps you going," Camidge says. "It included having your photo up in Times Square for a microsecond—long enough to get a photograph of it, which I still have."

But his favorite award he received was in 2014, from Claremont University, for being "an exemplary mentor in the positive development of junior colleagues in the profession."

Training the next generation

Even after diagnosis, Camidge continues to prioritize being a mentor.

"You get to a point in your career where another presentation, publication, or award doesn't have the tingle it used to. But seeing people you have helped find their version of success still does that for me," says Camidge.

One of the trainees who has worked closely with Camidge for the past two years is thoracic oncology fellow Alec Watson, MD. Camidge told him about his diagnosis within a few days of his arrival. If anything, it has deepened Watson's experience learning about treating patients and research techniques from one of the world's experts in thoracic oncology.

> "He has an ability to connect and to care for his patients that goes beyond the medical side. I think that is what a lot of people are looking for in their physicians, especially caring for something as impactful as a cancer diagnosis."

"Ross has an ability to turn a problem around and to ask questions that haven't occurred to other people, or if they occur, we don't think that's something feasible to answer," Watson says. "But he has such a curious mind and is able to parse a problem and look at it from a different angle that leads to these very insightful questions that are important for practice."

Watson says that in the clinic, Camidge also has much to share.

"The way that he approaches and builds relationships with his patients is something I plan to emulate as best I can and incorporate into my practice," Watson says. "He has an ability to connect and to care for his patients that goes beyond the medical side. I think that is what a lot of people are looking for in their physicians, especially caring for something as impactful as a cancer diagnosis."

After his diagnosis, Camidge started a podcast with OncLive, "How This is Building Me," interviewing many different people around the world who have experience of, or who work with, cancer across the full spectrum of life experiences. Again, he did not tell the organizers of the podcast, or any of his guests, about his diagnosis.

"I remember one episode where I interviewed a hospice chaplain," Camidge says. "Some of the questions I am asking are clearly coming from a different place of knowledge than the audience really appreciates."

It's all part of Camidge's new reality—the irony of being the lung cancer expert who is now facing a terminal diagnosis of his own. The patient he wrote about in his article about unendurable side effects is no longer hypothetical.

"Early on, when I told a close friend of mine that I had lung cancer, I said, 'Maybe the cancer gods are just sick and tired of me making progress, and they're getting their own back,'" he says. "And she replied, 'No, you were diagnosed now because it was the right time to be diagnosed. And the cancer gods were saying, look, you've made this progress, now you are ready to take on this burden.'" ⌖

Ross Camidge: Select honors

- Clarivate (analytics company) – Highly Cited Researcher in Clinical Medicine (top 1% of all authors in clinical medicine), each year 2017–24.
- International Association for the Study of Lung Cancer – Daniel C. Ihde Lectureship Award for Medical Oncology, 2023.
- CU Division of Medical Oncology – Inaugural Division Award for Exceptional Clinical Care, 2023.
- Bonnie J. Addario Lung Cancer Foundation – Breath Away From The Cure Award (for outstanding contributions in lung cancer oncology), 2016.
- Quality of Life Center at Claremont University – Physician Mentorship Recognition (as an "exemplary mentor in the positive development of junior colleagues"), 2014.

Photo courtesy of the Denver Broncos

Denver Broncos Coach Finds the Perfect Treatment Team at the CU Cancer Center

Diagnosed with a yolk sac tumor in 2024, Zack Grossi was treated by Laura Graham, MD, after a chance meeting in the ER.

BY GREG GLASGOW

As pass game specialist for the Denver Broncos, Zack Grossi knows how important it is for a team to work together, executing a plan as they move the ball down the field.

“I work specifically with the wide receivers, coming up with plays,” says Grossi, who has been part of the Broncos coaching staff since 2022. “It's a great group of guys, and we’re looking forward to having a good year.”

In 2024, when he was undergoing treatment for a yolk sac tumor with providers at the University of Colorado Cancer Center, Grossi was inspired to see that same sense of teamwork among the doctors, nurses, and others who took care of him.

“Once I got the treatment plan, it became a very clear opponent,” he says. “It was fourth-and-1 every day.”

Symptoms he could no longer ignore

When the whole ordeal started in January 2024, Grossi chalked it up to the stress of a long season and so much time spent on the road. He had put on a few pounds, so he started working out, but he found he got winded easily. No matter how tired he was, he couldn’t fall asleep.

If he put his hand to the left side of his rib cage, he could feel his heart beating. Soon after the 2024–25 football season started, he developed a deep, body-racking cough. By the time the Broncos played the New York Jets on September 29, 2024, he knew he was in bad shape.

“We came back from the Jets game, and I had a horrible week. I just felt terrible,” he says. “I was talking to one of our trainers, and he said, ‘Let's get you in to see the doc.’”

Unusual blood work prompted the team physician to order an MRI, which revealed the problem that had been causing Grossi’s symptoms–a massive tumor in his chest.

“I had called my dad a week or two before my scans, and I said, ‘I think something's wrong. I've never felt this bad,’” Grossi remembers. “Then, when you hear those words, ‘You have cancer,’ you start thinking about everything. Your mind starts racing. You call your family, call your loved ones. I remember I called my wife, and I said, ‘Look, I have a tumor in my chest. I have cancer.’ And she didn't even blink. She said, ‘Well, we have to kill it.’”

Fateful moment in the ER

Plans were made to send Grossi to a cancer center in Texas, where the Broncos had connections, but days before he was scheduled to fly out, he started coughing up blood. He ended up in the emergency room at UCHealth University of Colorado Hospital at CU Anschutz, where the on-call oncologist just happened to be CU Cancer Center member Laura Graham, MD, a specialist in the exact type of cancer with which Grossi had been diagnosed.

“I went in and met him in the emergency room that night, and he was really nervous,” Graham says. “He had this plan to go somewhere else. And I said, ‘Why? You don't need to go anywhere else. This is what I do, and I promise I'm going to take great care of you.’”

Yolk sac tumors explained

Graham explains that a yolk sac tumor–a type of germ cell tumor–is a rare cancer that forms in the cells that line the yolk sac of the embryo.

“They’re cells that at some point are going to turn into either sperm or eggs, the sex cells for men or women,” Graham says. “Generally, we think of germ cell tumors as being testicular cancers, but about 1% to 2% of germ cell tumors actually start in the chest, which is probably from some abnormal migration during development.”

The standard treatment for yolk sac tumors is chemotherapy, followed by surgery, so Graham got Grossi started right away on a chemo regimen that required him to stay in the hospital for the duration of the treatment.

“I told him, ‘We need to start tomorrow.’ These tumors grow really quickly, but they're incredibly sensitive to chemotherapy,” Graham says.

Support system

Grossi responded to the treatment almost immediately, his symptoms subsiding and his blood markers for the cancer coming down. He developed complications, including blood clots, but he stayed the course through four rounds of chemo with the support of his family and his team.

“The day I got my diagnosis, I heard from (Broncos owners) Greg Penner and Carrie Walton Penner, his wife,” Grossi says. “I had their full support, and they never wavered. It wasn't just a little bit of support here, a little bit of support here–it was all the way, and they wrapped their arms around me and my family like we never thought was possible. They couldn't have supported me and my family more, and I think it made a big difference in my recovery.”

Grossi has similar praise for Graham, whose direct communication style was just what he needed as he was going through the chemo.

“She gave me the facts. She told me when things were good and when they were bad, and I really appreciated that,” he says. “She was always there to answer questions–I could message her on the UCHealth app at any time, and she would get back to me right away. It was obvious to me that she's not just working a job and going home. She’s invested in her craft, and she’s invested in the science.”

Surgery and everything after

Not only did Graham see Grossi through his chemo treatment, but she also served as a liaison to the cancer center in Texas where Grossi chose to get his surgery.

“We share patients with other cancer centers all the time,” Graham says. “This little community that treats germ cells is pretty small. We all communicate and share patients and share expertise.”

After a five-hour surgery that involved the removal of 15% of his right lung, Grossi is now cancer-free and back on the field working with the Broncos’ wide receivers. He goes to see Graham every few months to make sure the cancer hasn’t returned, but for now he is living life with a new sense of perspective.

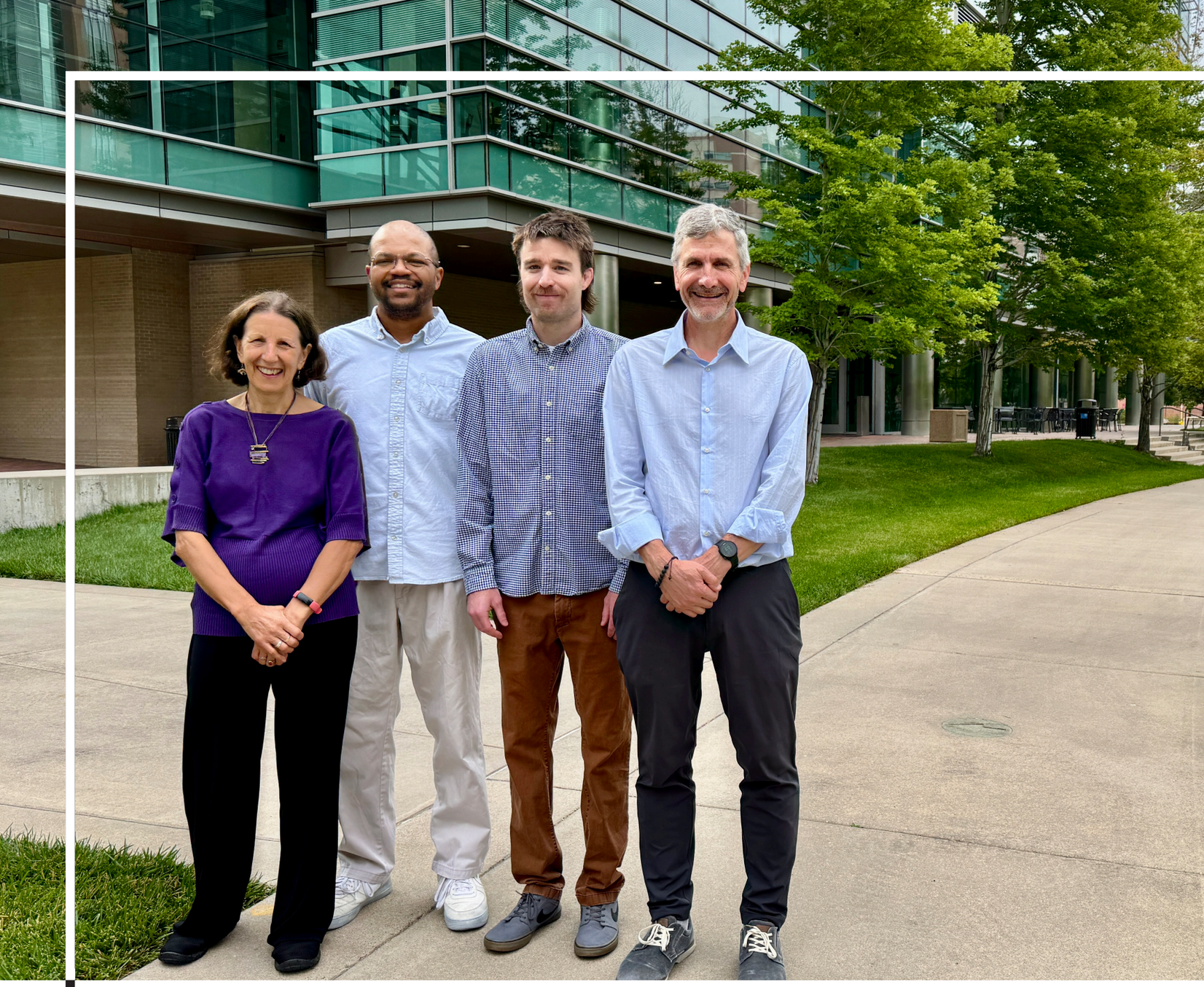
“You appreciate the little moments so much more now, and they’re moments that everybody around you is taking for granted,” he says. “It can be the smallest thing, like picking your daughter up from school or traveling with the team and having a good laugh on the airplane. It can hit you at any time. I talk less and listen more now, and I try to be where my feet are every day. You don't look ahead quite as much, because you have an appreciation for that day, and you try to live that day to the fullest.”

A CLOSER LOOK: Yolk Sac Tumors

A yolk sac tumor is a type of germ cell tumor — a rare cancer that forms in the cells that line the yolk sac of the embryo.

- Among men between the ages of 15 and 40, germ cell cancer is the most common solid tumor.
- The worldwide incidence of germ cell cancer is 70,000 cases.
- Compared to all solid tumors in men, germ cell cancer accounts for 1% of all male tumors.
- Ovarian germ cell tumors are rare, accounting for approximately 5% of all ovarian malignancies.
- The mortality of germ cell tumors is about 13%.

—Source: ScienceDirect



From left, CU Cancer Center researchers Mercedes Rincon, PhD, Felipe Pereira, PhD, Bryan Johnson, and James DeGregori, PhD.

Can COVID-19 Bring Cancer Back?

CU Cancer Center-led research shows that respiratory viral infections such as COVID can awaken dormant cancer cells.

BY GREG GLASGOW

The effects of the SARS-CoV2 virus on the elderly and people with compromised immune systems is by now well-documented, but new research led by University of Colorado Cancer Center Deputy Director James DeGregori, PhD, reveals another group that could be affected by COVID infection—cancer patients, in particular, cancer patients whose disease has gone into remission.

In research published in July in the journal Nature, DeGregori and an international research team from the U.S. and Europe show that respiratory viral infections such as COVID trigger inflammation that can awaken dormant cancer cells in the lungs, raising the risk of lung metastasis and cancer-related death.

Key collaborators include CU Cancer Center members Mercedes Rincon, PhD; Dexiang Gao, PhD; Junxiao Hu, PhD; Andrew Goodspeed, PhD; James Costello, PhD; and Thomas Morrison, PhD, as well as investigators in New York and Europe. The project was spearheaded by Shi Biao Chia, PhD, a former postdoctoral fellow at the CU Cancer Center, and graduate student Bryan Johnson.

“This complex and multidisciplinary study truly took a village,” DeGregori says.

Fuel on the fire

It is known that people who are treated for their cancers can remain disease-free for many years, only to relapse years or even decades later from metastatic disease originating from their original cancer. Extensive research has shown how cancer cells, often as solitary cells or small clumps, can remain dormant at metastatic sites for years or decades, but researchers lack a good understanding of the conditions that favor their reawakening.

Previous studies have revealed that inflammation can promote dormant cancer cell awakening. Together with Rincon and other collaborators, Chia and Johnson initiated experiments during the COVID-19 pandemic, using animal models of breast cancer, to ask whether respiratory viral infections, such as the flu virus or SARS-CoV2, known to cause massive inflammation in the lungs, could trigger metastatic progression in the lungs.

The results were striking, DeGregori says: Infection of the animal models with either flu virus or SARS-CoV2 led to massive expansion—more than 100-fold—of the previously dormant breast cancer cells in the lungs. Though only breast cancer was modeled, DeGregori says that the findings are likely applicable to other types of cancer. These results prompted the team to reach out to collaborators who could analyze human data to see if there were similar connections.

“Dormant cancer cells are like the embers left in an abandoned campfire, and respiratory viruses are like a strong wind that reignites the flames,” DeGregori says.

Increasing the risk of death from cancer

Using patient data from UK and U.S. health databases, another part of the study looked at the effects of a COVID infection on previously diagnosed cancer patients.

The team of epidemiological collaborators looked at people in the UK biobank whose cancer was diagnosed either five or 10 years ago.

“This means they were almost certainly in remission,” says DeGregori, the the Courtenay C. and Lucy Patten Davis Endowed Chair in Lung Cancer Research. “We studied those individuals who either got a positive or negative test for COVID-19 in 2020, the period before vaccination had started, and we asked, ‘Did they die from their cancer, and when?’ These analyses showed that the chance of dying from cancer was higher among the people who had contracted the virus. This risk seemed to be strongest in the year after contracting the virus.

“The odds ratio for death from cancer was substantial for the first year (2020), which means they were much more likely to die of their cancer if they got COVID,” DeGregori continues. “The extent of this increased risk is almost unheard of in epidemiology for cancer. It’s a significant effect.”

Additional analyses of Flatiron Health data of women with a diagnosis of breast cancer, led by Hu and Gao, provided more specificity, showing that contracting COVID-19 significantly increased the risk of development of metastatic disease in the lungs.

“Breast cancer cells stay in the lung, but they stay in very small numbers, in essentially a quiescent state,” DeGregori says. “What our data suggest is that if you are a cancer patient who has these dormant cells, you may end up living a normal life and dying with these dormant cells, instead of dying because those dormant cells awakened. But if you get a respiratory virus like influenza or COVID, your chance of dying from those dormant cells awakening is much greater.”

DeGregori says it is important to note that the study examined the effect prior to the availability of COVID-19 vaccines.

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“At this time, it is not yet known whether vaccination has reduced this risk,” he says. “However, since vaccination results in a much milder dysregulation of the immune system, we speculate that the observed risk would be lower in vaccinated individuals. That said, further research is needed to determine whether any residual risk remains after vaccination."

The IL6 factor

Driving the reawakening of dormant cancer cells, the researchers found, is interleukin 6 (IL6), a cytokine known to be involved in inflammatory responses. Here, the decades-long experience of Rincon in understanding this cytokine was key.

“It's interesting, because IL6 is actually targeted in some people who get COVID,” DeGregori says. “If you have severe COVID, they might give you an antibody that blocks signaling through the IL6 receptor to lessen the inflammatory response and increase survival. So it could be a win-win. While any changes to recommendations or clinical practice will require further research and trials, our studies reveal pathways that can be modulated by FDA-approved drugs that hold the promise of reducing the risks of metastatic progression in cancer survivors who experience viral lung infections like flu or COVID.”

Further investigation needed

Given the dramatic results of their initial research, DeGregori and Rincon, along with the Aguirre-Ghiso lab at the Einstein College of Medicine in New York, now plan to look more closely at how the reawakening process works, how it can be prevented, and how the immune system might be engaged to eliminate awakened cancer cells.

The researchers recently were awarded a five-year grant from the National Cancer Institute to pursue these studies, although most of the results presented in the Nature publication relied on philanthropic support—including from the Cancer League of Colorado and the Kay Sutherland and Monika Weber Research Fund, together with additional funding from the Veterans Administration and other sources—that was not originally designated for this project.

DeGregori and his colleagues are also extending their work to study important follow-up questions that arise from the current research: Does it matter which cancer you had before infection, or are all ex-cancer patients at risk? Does virus-induced cancer awakening only occur in the lung, or also in other sites like the brain and bone? Does vaccination for respiratory viruses like the flu or COVID reduce the risks of cancer reawakening?

“By understanding underlying mechanisms, we will work hard to develop interventions that can limit the risk of metastatic progression in cancer survivors who experience respiratory viral infections. We also plan to extend our analyses, both in animal models and through mining of clinical data, to other cancer types and other sites of metastatic disease,” DeGregori says. “Respiratory viral infections are forever a part of our lives, so we need to understand the longer-term consequences of these infections.”

> “Respiratory viral infections are forever a part of our lives, so we need to understand the longer-term consequences of these infections.”

RESEARCH THAT TOOK A VILLAGE

In addition to investigators at the University of Colorado Cancer Center, other researchers around the world contributed to James DeGregori's paper on how respiratory viral infections trigger inflammation that can awaken dormant cancer cells. Participating institutions include:

Albert Einstein College of Medicine, Bronx, New York

COVID-19 International Research Team, Medford, Massachusetts

Imperial College London, London, United Kingdom

Johns Hopkins University School of Medicine, Baltimore, Maryland

University College London, London, United Kingdom

University of Connecticut School of Medicine, Farmington, Connecticut

University of Pennsylvania, Philadelphia, Pennsylvania

University of Pittsburgh, Pittsburgh, Pennsylvania

Utrecht University, Utrecht, The Netherlands

Coach Deion Sanders, with left, Janet Kukreja, MD, and right, Lauren Askevold, Sanders' trainer. Photo by Derek Marckel, CU Athletics.

'Prime' Directive

Robotic surgery expert Janet Kukreja, MD, successfully treated coach Deion Sanders for bladder cancer.

BY GREG GLASGOW

When University of Colorado football coach Deion "Coach Prime" Sanders held a press conference on July 28 to talk about his recent experience with bladder cancer, he had a CU Cancer Center member by his side.

University of Colorado Cancer Center member Janet Kukreja, MD, director of urologic oncology and associate professor of urology in the CU Anschutz Department of Surgery, was the surgeon who successfully treated Sanders for the disease.

"I trusted and believed in you 100%," Coach Prime told Kukreja during the press conference.

Robotic expert

Kukreja is one of the foremost practitioners of robotic cystectomy, a surgery to remove all or part of the bladder. Using a surgical robot for the procedure is now common, though questions around its ability to completely remove a tumor and surrounding cancerous cells dogged it in its early days in the mid-2000s.

"People were very skeptical of robotic surgery at first—of negative margins and recurrence rates vs. doing an open surgery," Kukreja says.

"Multiple clinical trials were performed, and eventually it was demonstrated that robotic has the same cancer outcomes, the same yield of removal for lymph nodes, and actually decreases the need for transfusions. It also leads to decreased hospital stay and decreased complications."

The smaller incisions used for robotic surgery take a shorter time to heal, Kukreja says, which means that, on average, patients receiving the surgery spend just three to four days in the hospital, instead of the seven to 10 days required for a traditional open surgery.

Technological advances

Kukreja, who has been performing robotic cystectomies for the past seven years, says she has only seen the technology get better.

"The newer generations of the surgical robot are even more surgeon-friendly," she says. "It's easier for us to attach the robot to the patient and it's easier for us to take it off, and the vision is getting better and better, too. The robotic technology continues to improve and continues to make our jobs easier."

Urinary alternatives

One of the most important parts of her job as a bladder surgeon, Kukreja says, is counseling patients like Sanders on what sort of urinary diversion—or way to collect and dispose of urine—to use once their bladder is gone.

“They have a few choices,” she says. “One is called an ileal conduit, which is a small piece of intestine that sits on their abdomen and collects urine, which then collects in an external bag. There's something called a neobladder, which we re-create in the same spot where the old bladder was, and the patient uses their pelvic muscles to empty. Then there's something called an Indiana pouch, where the patient has a stoma on their abdomen that they have to periodically connect to a catheter to empty. All these methods have advantages and disadvantages, and not one is right for every single patient.”

It can be a daunting change for patients, but Kukreja says most adjust to their new arrangement within four to six weeks and get back to their normal quality of life.

“It’s all done at the same time, and it’s all done robotically,” she says. “That's something that we offer here that no other place in Colorado offers. We are unique in that most do the neobladders with an open incision. We're one of the only places that does everything robotically, no incision, just little laparoscopic ports.”

Road to cystectomy

For most people, bladder cancer is first detected when they see blood in their urine; some people also experience unusual frequency or urgency of urination. The presence of cancer is confirmed through a special biopsy called a transurethral resection of bladder tumor, which is done through the urethra. This can be done with white light and a special technology called blue light to detect even more cancer. Kukreja can perform the procedures, but by the time she sees a patient, they typically have had the biopsy elsewhere and are now ready to discuss treatment.

“Depending on what the cell type of their bladder cancer is, a lot of patients will get four cycles of chemotherapy first, so it ends up being a couple of months until they have surgery,” she says. “Some people will get surgery and then have chemo afterward. And some people will have had a different type of bladder cancer, where they got treatments in their bladder and didn't respond, and they get no chemo. They're ready for surgery when they first come in.”

Patient-first approach

In addition to surgery, there are recently FDA-approved treatments for bladder cancer that Kukreja makes it a point to keep up on, so she can tailor a personal treatment plan for each patient.

“It really depends on where patients are in their life,” she says. “I see a very broad spectrum of patients–from people in their 30s all the way up to people in their 90s. And a 90-year-old’s values are different than a 30-year-old's values.”

No matter their age, patients can trust the CU Cancer Center to give them the best treatment for their situation, Kukreja says.

“The University of Colorado is a leader in this area, and we do a lot of these surgeries,” she says. “We have a great program around the surgery too—our inpatient nurses, our after-care nurses, our nurses in clinic—we have a comprehensive multidisciplinary program.”

AT A GLANCE: Janet Kukreja, MD

Medical School

MD, University of Missouri-Kansas City School of Medicine

Graduate School

MPH, University of Rochester School of Medicine, New York

Residency

Chief Resident, Urology, University of Rochester/Strong Memorial Hospital

Fellowship

Urologic Oncology Fellow, University of Texas at Houston/MD Anderson Cancer Center

Certifications

American Board of Urology
American Board of Medical Quality

Making a Mentee

CU Cancer Center education programs helped Fahiima Abdullahi prepare for a career as a physician-scientist.

BY GREG GLASGOW

> Fahiima was an exceptional case, because she came to me after that first year and asked if she could join the lab. That's when I realized that she has passion. I don't have many students, but I like the students who are really driven. And Fahiima has shown that from the beginning.

As she began her time in the University of Colorado Cancer Center's PIKE-PREP research training program for post-baccalaureate students over the summer, Fahiima Abdullahi took another step in a mentoring journey that goes back to her days as an undergraduate at CU Denver.

"I've always been interested in science and medicine, but I didn't really solidify that interest until early in undergrad, when I did a summer internship program at CU Anschutz," says Abdullahi, who grew up in Englewood, Colorado. "That's where I first got paired with Dr. Mercedes Rincon, who introduced me to the MD-PhD program, which is something I didn't even know existed. She also educated me about other programs and opportunities available to me, and she even paired me with some doctors to shadow. That really solidified my interest in medicine."

Starting early

Rincon, a CU Cancer Center member and professor of immunology and microbiology in the CU Anschutz School of Medicine, connected Abdullahi with opportunities through the cancer center's Cancer Research Training and Education Coordination (CRTEC) program, which supports multidisciplinary education and training of mentees across a broad spectrum of educational stages including middle and high school students, undergraduates, post-baccalaureates, graduate students, medical students, residents, and fellows.

"I've always believed that if you want to grow and develop yourself in research, you have to start early," Rincon says. "Fahiima was an exceptional case, because she came to me after that first year and asked if she could join the lab. That's when I realized that she has passion. I don't have many students, but I like the students who are really driven. And Fahiima has shown that from the beginning."

Creating a physician-scientist

Working in Rincon's lab throughout her CRTEC experience, on a project studying the role of CD8 T cells in cancer therapy, has helped Abdullahi develop her research skills, while shadowing other physician-scientists has inspired her to pursue a career at both the bench and the bedside.

"It's been really great to see how that project has evolved and how we've been able to answer our research questions over time," says Abdullahi, 22, who received a degree in biology from CU Denver. "I'd like to be a clinician and a researcher, and that ability to apply what you're doing in research to the patients you're seeing in the clinic is really inspiring."

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Carrying it forward

In addition to the mentoring and training she has received at the CU Cancer Center through CRTEC, Abdullahi also spent the summer of 2024 doing a medical research internship at Dartmouth College in New Hampshire. She participated in PIKE-PREP with the plan of applying for medical school in spring 2026. She hopes to stay involved in cancer research, inspired by her CRTEC experiences.

"These programs have been very helpful, especially since each one is unique in its own way and allowed me to learn about something different," she says. "The first program I did was more immunology-focused, and I learned about PhD programs and research and what that career looks like. Getting into the cancer biology side of things and learning how you can incorporate medicine into that was really helpful as well. The CRTEC programs allowed me to learn about those types of things."

LEARNING OPPORTUNITIES

The CU Cancer Center's Office of Cancer Research Training and Education Coordination (CRTEC) offers many cancer-focused education opportunities for students at the K-12 level and beyond, including:

The **BEST (Bioscience Educator Support and Training) Program** builds partnerships between the CU Cancer Center and local high school science teachers to transform bioscience education.

Offered twice a year, **Learn About Cancer Day** is a daylong seminar for high school students that includes tours of cancer-related research laboratories at CU Anschutz combined with a cancer-focused activity and a career panel.

The **Cancer Center Research Rangers** program brings local middle school students to the CU Cancer Center to learn more about cancer research and the biomedical sciences through interactive programming and laboratory investigations.

Every summer, through the **Cancer Research Experience for Undergraduates** (CREU) program, selected college undergraduate fellows spend 10 weeks in cancer research laboratories at CU Anschutz.

The **PIKE-PREP** program offers a yearlong, multi-dimensional mentoring and research training experience to prepare post-baccalaureate students who have experienced a lack of access in education and training activities to enroll and succeed in a top-tier, research-focused doctoral program and commit to a career in biomedical research.

For more information, visit ***medschool.cuanschutz.edu/colorado-cancer-center/education.***

WHAT TO KNOW ABOUT: CANCER CLINICAL TRIALS

For people with cancer, participation in a clinical trial can mean access to promising treatments, and it can also help advance scientific discoveries that benefit others.

It's estimated that 7.1% of people under treatment for cancer in the United States participate in a clinical trial, and more than one in five of those enroll in a trial at a National Cancer Institute-designated comprehensive cancer center like the University of Colorado Cancer Center.

To answer questions about clinical trials and why you might want to consider participating in one, we turned to Wells Messersmith, MD, associate director for clinical services at the CU Cancer Center.

What is a clinical trial?

A clinical trial is a highly regulated research study in which we look to develop a new treatment, a diagnostic tool, or a prevention tool for cancer. The goal is to advance the field and develop better techniques to prevent, diagnose, and treat cancer across the country and the world.

A clinical trial can give you access to treatments–whether that is a drug, radiation, or novel surgical technique–before they're available to the general public. Granted, not every trial shows an improvement over the current standard, but all of the incredible breakthroughs that we've had in cancer over the last few decades have started in clinical trials.

Why is the CU Cancer Center a good choice for clinical trials?

We are a very large center, and we're the only academic center in the state of Colorado, so we're one of the few available avenues for patients here to access the most promising treatments in the world.

Through clinical trials, our doctors, nurses, pharmacists, and other staff gain experience with new drugs and technologies years before they are FDA approved, so we know how to handle side effects and dose adjustments out of the gate when they become widely available.

Are cancer clinical trials only for people diagnosed with cancer?

No, there are numerous trials that look at novel screening techniques for cancer, such as CT scans or blood-based testing. Also, there are trials looking at things that can be done to prevent cancer in the first place, like whether taking aspirin could reduce the risk of colorectal cancer, or the benefits of exercise and diet in reducing cancer risk. Screening and prevention studies can be very important to decrease the overall burden of cancer.

When someone is diagnosed with cancer, at what point should they and their doctor talk about participating in a clinical trial?

That's a conversation to have every step of the way. Even if it's a very early stage of an easily curable cancer, there are clinical trials on potential treatment options to decrease the chance of recurrence of that kind of cancer, for instance. If someone is diagnosed with advanced incurable cancer, there are clinical trials for patients who've never been treated before. If someone has been under treatment for a while, there are trials for patients who've received all the standard therapies. And there are often clinical trials for various situations in between.

What are some common misunderstandings about clinical trials?

A lot of patients assume there's going to be a placebo given to some people. Actually, most of the studies we do at the CU Cancer Center are not placebo trials. We have over 600,000 square feet of lab space on campus, hundreds of investigators, and enough infrastructure to do more complex, earlier phase trials where everyone gets the drug.

And even in studies where not everyone is in the experimental group, if someone is supposed to be getting an active treatment, they get the FDA-approved, safe, and effective standard of care for their cancer. The experimental group gets the standard of care plus something else, or perhaps a new standard.

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and access in all aspects of employment and patient care.

THE MESSAGE

FROM THE DIRECTOR
RICHARD SCHULICK, MD, MBA

DIRECTOR,
UNIVERSITY OF COLORADO
CANCER CENTER

ARAGÓN/GONZALEZ-GUÍSTÍ
ENDOWED CHAIR OF SURGERY,
UNIVERSITY OF COLORADO ANSCHUTZ
SCHOOL OF MEDICINE

NCI Comprehensive Cancer Center
A Cancer Center Designated by the National Cancer Institute

GETTING TO KNOW ROSS CAMIDGE, THE PATIENT

I have known Ross Camidge for many years, and it's been a pleasure to watch as he has become one of the most respected lung cancer experts in the country, if not the world. At the University of Colorado Cancer Center, Dr. Camidge is director of our Thoracic Oncology Program, helping to grow it into a nationally and internationally recognized center that accrues about 40% of lung cancer patients into clinical trials—more than double the rate of the next best academic lung cancer program in the country and more than 10 times the national average.

But reading the cover story in this issue of the C3, I got to fully understand a different side of Dr. Camidge—as a cancer patient, with the same questions and fears that all cancer patients have. I can only imagine how he felt in 2022, when he was first diagnosed after suffering from a wheeze and a twinge of pain in his back. How well he must have known those symptoms, and how terrifying it must have been for him to look at that first set of scans that showed cancer in his lungs, bones, and brain.

I see it as an act of bravery to share his story in the way Dr. Camidge has done. It shows how much he cares for his lung cancer patients that he's willing to be vulnerable. Doctors don't always make the best patients, but it seems that Dr. Camidge has learned to accept his diagnosis with grace and humility, at the same time fighting it with everything we have.

By showing himself as a patient, he's also hoping to move the ball faster in our fight against lung cancer. The article describes how he went from visiting his primary care physician to receiving a full diagnosis, complete with body and brain scans, a biopsy, and molecular testing, then starting targeted therapy—all within four days.

I have such deep respect for Dr. Camidge—not only for his great scientific and clinical contributions, but also for how he is dealing with this major illness. He has helped turn the lung cancer program at the University of Colorado Cancer Center into one of the best in the world, and I am strongly rooting for him as his cancer journey continues.

I will, however, be following Dr. Camidge's progress from afar—in October, I accepted a position at the University of Rochester, and I will be leaving the University of Colorado Cancer Center early next year. This was not an easy decision to make, but I'm excited for a new challenge, and I believe this will benefit the cancer center and offer it new opportunities to continue its amazing trajectory of scientific discovery, premier clinical care, education, and community impact.

I am so grateful for the opportunity I've had to serve as director of the CU Cancer Center for the past seven years. It has been a true privilege to follow all the amazing research that goes on at our center and to witness the dedication of the cancer center's staff.

I thank the entire CU Cancer Community—our researchers, clinicians, trainees, staff members, patients, and donors—for their dedication to discovering the root causes of cancer and working so diligently to transform basic discovery to interventions that reduce incidence, offer better treatment options, and lead to better outcomes for those whose lives are impacted. I am also grateful for all of the trainees taking this work forward into the next generations. Your work improves lives.