Automated Transcription – Episode 9 Season 2 – Professor Leonie Young

A diagnosis of breast cancer can cause a lifechanging ripple effect of impact, affecting those we love the most and those upon whom we lean, for comfort and strength in the most challenging of times. My name is Aisling Hurley and I'm the CEO of Breast Cancer Ireland and you're listening to More Than A Lump, a podcast that talks openly and honestly to a selection of guests about their very personal connections to breast cancer – be it through their career choice, their own first-hand experience of the disease, or through sharing the experience of close family members. My conversations will centre on how breast cancer has informed their perspective on life, love, family, health, their goals, and aspirations. Although each story is utterly unique, the one common thread that runs through each one, is that breast cancer is more than a lump.

Consistent and intensive breast cancer research is vital in changing the landscape of the disease. And last week we were proud to sponsor the Breast Cancer Ireland Cancer Conference at the Royal College of Surgeons in Ireland, which saw a gathering of world class specialist cancer researchers share and collaborate on latest developments. Given this is the penultimate episode of our second season of More than A Lump podcast, I've invited the co-chair of the conference, Scientific Director Beaumont RCSI Cancer Center, Professor Leonie Young, to come into our studio today to share an update from the conference with our listeners, as we have done with many of our other guests.

(01:47):

I also ask Leonie about our own journey into this area of specialization and reveal what inspires and motivates her and her team. Leonie you are very welcome to our More Than a Lump podcast. As you know, I've been keen to have you on for a while and can't believe we're nearly at the end of season two.

You and I have worked together now for so many years, and I know firsthand how passionate you are about your work, having seen you and your wonderful team of researchers working away in the labs we fund through the generosity of our donors. And so I'm really delighted to have you here to share progress with our listeners. We have a very strong and loyal, base and I know that there is a huge interest in last week's conference, but before we get into the details, can you take a little step back and ask you about your own career path and what brought you to this field of research?

Speaker 2 (02:31):

Thank you so much, Aisling. I suppose I started my undergraduate studies in Trinity College where I did natural sciences, which I enjoyed tremendously, particularly neuroscience. Um, and then I went off and did PhD in pharmacology, which was also really exciting. Um, and I did that in the Mater Hospital. Um, so in U C D, um, then I went abroad and did a postdoc and then came home to get a Newman Scholarship, which was an endocrinology. And this, I suppose, really started my lifelong obsession with steroids, how they work. And obviously that brought me on to steroids driven cancer, such as breast cancer.

So I took a job, uh, and started in the Conway Institute way back in 2001, further and further back than I, than I care to think. Um, and I started working with, with a lifelong colleague, Arnold Hill. Uh, so that's been both enjoyable, uh, fruitful, uh, and really meaningful.

(03:28):

We started working with you really early on, uh, Aisling. And I think the really nice thing about Breast Cancer Ireland was that it's very, um, very popular now to talk about patients involvement and their involvement in research. But you guys had ppartnered with your patients always. And from a very, very early time, we got to meet patients that we were really working for. They came into the lab and they told us their stories. And what we really gained from that experience and working with the patient ambassadors is where their real concerns were. And we found that it was really in the metastatic setting. So where, where the disease was more advanced, and that's where we focused our, our, our research. And then I suppose I brought my love of neuroscience mm-hmm. <affirmative>, um, and, and my love of working in metastatic cancer. And we really focused down on brain metastasis cause it's such an extraordinary disease with such a terrible, um, poor prognosis mm-hmm.

Speaker 1 (04:22):

<affirmative>. And I suppose for the listeners, um, tell me a little bit, I was really excited, you know, co couple of months back when you approached us and asked us to be involved and to help you with the conference that you were putting together. Because this is an opportunity where you're bringing together the best in class, the best people who are working on such high level research into metastatic disease primarily, but in the whole area of breast cancer in general. And I think that's what is fantastic. Tell us a little bit of the, the takeouts from that conference. What's, what's new and exciting?

Speaker 2 (04:51):

Okay. There were several hot topics this year. So as you mentioned, I think all roads nearly lead to advanced disease. Um, so obviously there's people who are, are passionate about, um, about early breast cancer, about prevention, but where the biology really becomes tremendously exciting and where we really feel a scientists that we can make an impact, um, in terms of new targeted therapy, really is in that advanced metastatic setting.

So that's really what you heard an awful lot about, talked about, um, over the end of last week. Um, so areas that really came up were really, again, in terms of brain metastasis and a good look at dormancy. So dormancy is that perio that we call from when the patient is first diagnosed and that they have their initial treatment, be it surgery, targeted therapy, and then it looks like the patient may have, you know, a good period of disease free time.

(05:46):

Now really good news is if you have triple negative breast cancer and you are disease free for five years, you're considered cured. Wow. So that's one phenomenal piece of fabulous mission. Hmm. However, if you have estrogen receptor (ER) positive breast cancer, which is often considered less aggressive, you may suffer a disease recurrence 10, 15 or 20 years out. So why does this occur? Who are these patients and how can we treat them better? And how can we predict which of those patients may indeed have a

recurrence so that women don't feel like they have this lifelong threat sitting on their shoulders? Um, so there's been really, really amazing work done on this area, um, of dormancy why the cells go to sleep, where they go to sleep, and what eventually wakes them up. Mm. And can we predict that region of dormancy, um, because it's gonna be a really, really good place to target mm-hmm. <affirmative>, um, to target to

Speaker 1 (06:41):

Kill those cells. And that's, that's, that's part of kind of, you know, all the clinical trials that we try to invest in, if we can come up with targeted therapy that can sort of block that progression. Mm,

Speaker 2 (06:52):

Absolutely. Absolutely. So we know that they're there, We know that they're hiding and it's a really good place to get them and kill them off for good.

Speaker 1 (06:59):

Yeah. I love that. Love that. Cause I suppose ultimately, and you know, you and I have had these conversations over the last number of years is breast cancer. Ireland's whole remit is to transform the disease through research like this, into a, you know, into, into a disease that can be maintained, long-term it's a chronic illness, but, you know, we will reduce fatalities completely. That's the ultimate end game. Absolutely.

Speaker 2 (07:20):

Absolutely. To turn this into, you know,

Speaker 1 (07:22):

Treatable illness,

Speaker 2 (07:23):

Absolutely and one, not just that we can treat, but that we can treat compassionately so that the drugs are kind, that you're not just living with cancer, you're living well. Exactly. You're beyond it and that you have a good life. Mm. Um, another really exciting drug, and I want to tell you about this in particular because this is pioneered by your old pal, Geoff Greene from Chicago. From Chicago. Mm. So, um, Aisling and all the guys at Breast Cancer Ireland, uh, support, uh, Geoff's work and, um, our shared work on brain metastasis. But I didn't know if you knew this but Geoff first cloned the estrogen receptor. Wow. Yeah. So he is really rockstar of, um,

Speaker 1 (08:04):

And just explain that to our listeners who may not understand that that terminology cloning the estrogen receptor

Speaker 2 (08:09):

So we always talk about targeted therapies and how, you know, good target makes a good therapy, makes a clean therapy and an effective therapy. While in breast cancer, all therapies lead back to the

estrogen receptor. It is the king of targets. Mm. And it works so well because it just, it stops the proliferation of the cells and it stops them going further and therefore being, being involved in a more advanced disease. So cloning the estrogen receptor is basically finding out all of the key components of the eastern receptor and then making the crystal structure so you can look at the different pockets of the receptor and design effective drugs that will block it. Wow. It's just, it's so intricate, but it's so elegant. Mm. Um, so he's been working on targeted therapies for the estrogen receptor for, oh my gosh, I dunno how many years?

(09:02):
20, 30 years. Um, and we know now that the estrogen receptor can change after a long exposure to treatment for it. So you, you know, yourself, the traditional treatments for, um, estrogen receptor positive disease would be tamoxifen. Yeah. And more later aromatase inhibitors. So some women, small percentage, most women do very well. Small percentage of women will have disease recurrence. And what frequently happens is that the estrogen receptor itself becomes mutated. Ah. So it changes cleverly and then doesn't need estrogen anymore to activate it. Okay. And doesn't really care about tamoxifen or Aromatize Okay. Therapy inhibitors and can co on and do, uh, its job just fine. Mm-hmm. Well, Jeff has been looking at the steroid rare receptors and the changes that occur in them and has introduced a new drug called Lasofoxifene with impressive results in the clinical trial Elaine 2.

Speaker 1 (09:56):
This love the name never

Speaker 2 (09:57):
Remember it. I know they never, they never have short names do

Speaker 1 (09:59):
They? Lazo? We'll just call it laser cause I'll never remember that name. Yeah, exactly. But

Speaker 2 (10:03):
Anyway. Wow. So this drug is so cute because it works not only on the, but it also works on these estrogen receptor that have become mutated. Okay. So it's going to be suitable for women with advanced cancer. Wow. Um, and that's really nice. It's gone through trial called Elaine, and now Elaine 2 is out. So it's gone through safety and efficacy, and now also it's, uh, it's shown really good results. So Elaine two was just presented there at ASCO recently, and, and the results were very exciting. Wow. That's really good. And that I think is such, I don't know, it's such a really lovely example of somebody who's given his life absolutely. To, to working, but had had fruitful progression and started with something so basic and has now bought it full circle.

Speaker 1 (10:50):
And it also for me, um, gives me great happiness to see that, you know, we do invest in great projects. We invest in clinical trials, and that's the key. I mean, we've done with your help, we have had huge successes in speeding up our scientific discovery output by all of the papers and the collaborations with our designated cancer hospitals, um, where we are churning out a lot of peer reviewed publications. Like

10 years ago, we were lucky if we saw one peer reviewed publication in about 18 or 24 months from each center of excellence. Now we are seeing like 10, 12 a year, which is fantastic. So tick box, we have speeded up the discovery part in the lab. However, the key now from breast cancer, Ireland's point of view is we have to translate that lovely discovery into clinical trial and get the investment into clinical trials, get them across the line. So we come up with better targeted therapies to treat more and more people.

Speaker 2 (11:41):

So I think that that is one of our hugest goals. Mm. So, you know, we just established Beaumont Cancer Center. Yep. And our stated goal, my personal stated goal is that we will increase our current output, which is approximately having 5% of our patient population on clinical trial. Now I know that that sounds super low, but if you think about it, so many patients aren't suitable for clinical trials. So many, uh, trials aren't suitable for the patients or they're not open in the area. But our goal is to have 10% of patients on clinical trial within the next five years. Great. Um, and I think that this is a realistic goal, but I think that the sweet spot that isn't really been focused on and what is going to enhance not just clinical trials, but new innovations in clinical trials to make like Jeff's observations, like, like, um, Jeff's clinical trial, a significant leap and not just small incremental changes, is that bridge from the translation into the clinic. And to do that, we need to fund observational and translational trials so that we can then promote investigator initiated trials and have those really truly unique, um, observations and targeted therapies that will make that difference.

Speaker 1 (13:00):

Mm-hmm. <affirmative> mm-hmm. <affirmative>. Yeah. And, and, and, and I agree. And you know, even in talking to, uh, Professor Adrian Lee and step from the lab in, in U P M C last week, like they are so passionate about, again, this whole area of metastatic disease. Um, and also the importance of having and being given the right to choose the best staff to come on board and, and work in their labs and, you know, instigate great trials and, you know, produce fantastic results, which is what it's all about. But that's where investment, oftentimes I think with donors, they don't realize that that's the really important piece. We need to get that funding. We need to invest, continue to invest. It's like, you know, we've been told in the past, you know, we had a global pandemic. We all the world rallied. We got a vaccine for covid, many of them. Um, but we could do the same really in this whole breast cancer world. And

Speaker 2 (13:50):

I, I think the world has taken up that challenge. Actually, I think we're all working towards it. If you look at the EU and their cancer mission, that is, that is now, that is continuing mm-hmm. <affirmative>, um, with you guys and your work in breast cancer Ireland, that there is, there is a feeling that we exactly what you said, that we achieved so much with covid under such a short, short time mm-hmm. <affirmative> that now if we just pick up the baton for cancer mm-hmm. <affirmative> that we can make it. And, um, you know, in America, the US president there has called cancer out as one of his key things that he needs to achieve. Um, I think that there is a feeling that this is now our time that we can do it, but it's going to take smart collaborations between scientists and clinicians.

(14:34):

It's going to take funding, but it's gonna take a mind shift in terms of clinical trials that patients need to ask their, their doctors, their GPS about clinical trials. It needs to be a ground movement, which I think is

really important. I think we need to provide the clinical trials that our patients are interested in and in areas where that, that, that they're worried about, particularly in advanced disease mm-hmm. <affirmative>. And we cannot ignore the worst of the advanced diseases, which is, uh, breast cancer brain metastasis, just because it's tricky. Yeah. And, and like most breast cancer brain metastasis patients are excluded from clinical trials. Did you know that Ash?

Speaker 1 (15:09):

That's, Well, it's interesting you say that because one of our fantastic ambassadors, lord of mercy on her, um, Adel Cannon, she was approved during covid to go to San Francisco Oh yeah. For that particular trial. Yeah. Um, but her brain mets, uh, interrupted that when, when the brain, when her, she metastasis to the brain and it was quite aggressive. So then she was ruled out as being, she was not suitable. She was excluded. Yeah. And she had got her pa her visa through the US embassy excepted to travel in covid times. So, I mean, that's devastating. That's a, that's a driver, you know, but I do, and that's the one area, you know, Laura, we lost or burn over a year ago from, again, brain metastasis. So this is something that I feel passionate about. Yeah. Because it is that, as you've always said, it's that last challenging piece that really is, it needs so much investment and we need to, we need to find how we can put targeted therapies in place to prevent Yeah.

Speaker 2 (15:58):

The, the survival times post diagnosis are only 12 months currently. Yeah. And that's, that's, it's, it's, it's, it's just staring us in the face. Yeah. There's difficulty with the drugs plotting the blood brain barrier. Mm. And also, I think it might a little bit too be the interaction between the cancer cells and the brain and the brain tissue, because the brain tissue is so alive and so energetic and there's all those neuro factors. Mm. So it's trying to, to kind of, to come to terms with all of these, uh, challenges Mm. To make effective, targeted treatment.

Speaker 1 (16:30):

But I do, you know, what I also believe, and I think, you know, you and I have had these conversations all of the time, is rather than working in a silo, you know, we are a typical Irish nation where we like to do our own little bit of research, and we think our research is the best research in the world. Um, but we are a small island. And when we look at Europe, but even when we look internationally at the States and Australia and others, if we can put the hand across the ocean and try and collaborate our impact is so much greater.

Speaker 2 (16:55):

Yeah. Yeah. So, so very true. So very true. I'm not sure we think we're the best in Ireland, <laugh>, but in saying in saying that, that's why last week was so special and, and you know, how much we collaborate particularly with our US co colleagues, but with Jeff Green and with Stephanie and Adrian in, in, in Pittsburgh, Um, and also with Fergus Couch, who, uh, you met last week as well. Mm-hmm. <affirmative>. So Fergus is out of Tramor in Waterford and is now the leading oncologist, um, in, uh, the Mayo Clinic. Wow. And his work particularly focuses on, um, family history Okay. Of breast cancer and risk factors. Um, and he's just phenomenal. But together, uh, we collaborated with Fergus and with Stephanie and Adrian, and were able to profile 45 patients with breast cancer brain metastasis Wow. To see what things had changed. Mm. And to come up with new, uh, targeted therapies. Mm. Um, and we did, and that was, thanks to a little bit of the old Irish boys network, a little bit of long star term

collaborations with Stephanie and Adrian. Um, but it made a huge difference mm-hmm. <affirmative>, and also, you know, you're right, it does, it raises the bar and it makes us think that we need to be international in our outlook, and we need to play at that level.

Speaker 1 (18:10):

Absolutely. Absolutely. And I know another area that you are very passionate about is patient profiling. Yes. And, you know, biobanks and having them, you know, over 5, 10, 15, 20 years and, and knowing the history of where people are along that journey. Yes. And that's a key thing, and I know in recent conversations it's one of your, I suppose, unique selling positions is that you really are passionate about, you know, developing that and extending that.

Speaker 2 (18:35):

I think for years, when we thought about breast cancer and when we thought about how to manage it, we looked at the primary tumor, and that is how the patient was treated. So no matter how long that the patient was on treatment or how far the extended, that is how we looked at the patient on that first snapshot. And we simply now know that that's not true. Mm-hmm. <affirmative>, that the tumor changes, it changes in relation to the types of targeted therapy it's on. It changes in relation to if it metastasizes to a different organ, it's new host mm-hmm. <affirmative> and the interactions there. So we need to be cognizant of those changes. We need to act on them, but they also present new opportunities. So these are new vulnerabilities that we may, may be able to treat mm-hmm. <affirmative>, so we could come up with new treatments or we could come up with just changing the management could be super effective.

(19:23):

Um, and another really interesting thing about that is, and, and we were chatting about it before, is this whole idea of liquid biopsies. Mm. So we can take small blood samples, maybe a saliva sample or another sample from a patient and that, that could tell us an awful lot about what's going on in their body. Oh. If they have cancer or burden in the body, um, and what it could be, uh, treatable with mm-hmm. <affirmative>. So that's a huge, big area, but it's, without these longitudinal trials, without looking at the patients throughout their journey, looking at how their tumor changes, we will never be able to do this work. Mm-hmm. <affirmative>. So with your, um, generous support over many years, we've opened up this trial in many of our cancer centers mm-hmm. <affirmative>, and we've now 4,000 patients. Yeah. Um, which we have had on our trial, and currently we've 1700 patients active on the trial at the moment that is, which we're current currently following. Mm. Um, and it's been, it's, it's been, you know, a game changer, I think, for us. Yeah. And even just to even show the clinicians look at how the patients are changing, look at their subtype switching mm-hmm. <affirmative> that we have to be aware of that and we have to go back in and biopsy if possible, and if, if not, to try to check

Speaker 1 (20:37):

Other ways. Okay. And I suppose, you know, it comes, it comes back down to it that it is so important, you know, if you have a diagnosis of breast cancer, that you talk to your team about clinical trials that you could get involved with, you know, because that's, that's, that's what, that's what's gonna make a difference for us,

Speaker 2 (20:52):

Uh, 110%. And there may be a trial out there that you're suitable for, may not be in your hospital, may be in another hospital, but every team chats to each other, and that they will hopefully be able to find, uh, a trial that's suitable for

Speaker 1 (21:08):

You. So Leon, one of the other, um, areas that, I know that during the conference you had a, a talk and lunch that was incorporated on Thursday in relation to lobular breast cancer. And I know some of the, uh, patient supporters that have contacted us that quite a, it's only a small handful of people and it is quite a rare diagnosis. Lobular. Can you explain a little bit about where that's going or what it is?

Speaker 2 (21:30):

Absolutely. I think, so lobular cancer is, is a rare cancer amongst the eastern receptor positive breast cancer super family. Um, it looks different. It is very much more aggressive. And though is eastern receptor positive, it doesn't always respond well to endocrine therapy. Okay. Now that, um, because it's rare, sometimes people find it difficult to work on because there isn't very many models. So there isn't very many ways of experimenting on it or, or looking for new targeted therapies within the lab. So to this end, um, Step Estrich and Adrian Lee, who we, we both know, uh, well, um, from Pittsburgh, have really devoted their lives to investigating lobular cancer. So we were really lucky that they gave a short specific symposium on lobular cancer, um, at the, uh, meeting on Thursday. And we followed this by, uh, patient fa uh, facing, um, event, a lunch, uh, where members of the public interested people, um, you guys, um, and Stephanie and Adrian came to chat about how that their re their research was going and some of the advances that they've made. So it was really nice and that there was loads of chat, chat about the importance, um, of consideration of H R t importance of, of the length of time the patients are endocrine therapy, should they be on endocrine therapy for longer if they've had a diagnosis of breast cancer and, and what kind of things could they can expect maybe coming down the road.

Speaker 1 (23:06):

Hmm. And on the r t aspect, um, I, I understand, you know, yes, there, there is certain, there was a certain hesitancy, I don't know is that there anymore, but I think there was in the past over a report that was produced saying, Oh, H R t, you know, can be a cause of breast cancer, which everybody's up in arms and, you know, women of my age, um, or kind of going, No, no, you can't go on HR T. But an actual fact HOR t has been a godsend for so many.

Speaker 2 (23:33):

I think H R T has been a godsend, um, for, for women who are hitting the menopause or, or then shortly in after, when you do the traditional risk factors for breast cancer or enhanced steroids in part to play an enhanced risk, it's very tight ashing. And I don't think that the numbers are there to support it anymore. And I also think that H R T has changed. Mm. Um, I think it's become much more sophisticated and that the way that it, it it's delivered is sophisticated. But I would like to put in the caveat that I am not an oncologist

Speaker 1 (24:05):

<laugh>. No, totally. I understand that. No, I understand. But as you say, so like the H R T that my mother, you know, 30 years ago might have gone on, is very different. It's very different to what's available today. Very,

Speaker 2 (24:17):

Very different. I think that and our understanding of how H R T works and, and how it should be delivered uhhuh. So I would encourage any woman who, uh, who is worried about it or thinking about it to have a good chat with their gynecologist. Sure. An oncologist and, and they would be able to

Speaker 1 (24:35):

Advise that. I'd say there's a massive sigh of relief being heard everywhere around who's listening to this podcast at the moment. And I suppose then shock, you know, finishing off though, um, when you look at advances that have been made and in the sh like whatever, I'm in breast cancer, Ireland, we set it up in 2011, but in that period of time, I have seen huge advances down to the point that now we realize that every patient's diagnosis is very personal to them. We have tailored, you know, treatment plans for each person that's diagnosed. No longer can, you know, you put 1,000 people, a hundred women in the room and with breast cancer and you give them all chemotherapy. The rule is that only, it'll only work on 10%. So the others don't have to go through the grueling, um, chemotherapy side of things because it necessarily won't work.

Speaker 2 (25:18):

Actually. You're so Right. I actually think that that's one of the major advances is knowing when not to treat. Yeah. Knowing when not to overtreat,

Speaker 1 (25:25):

Uhhuh, <affirmative>

Speaker 2 (25:25):

Being cognizant of the disease, knowing and understanding what the disease is. And there's so many really good genetic tests now that give an indication, uh, for women, particularly with early breast cancer, whether chemotherapy will be an advantage or not an advantage. Mm-hmm. <affirmative>. Now in saying that there are some subtypes that do super well on chemotherapy. Exactly. We chatted earlier about, uh, triple negative disease. Mm. That is a super drug for, uh, a portion of those patients mm-hmm. <affirmative>, but it's identifying those patients Yep. And, and knowing which ones, um, and who will be, were most benefit from, from chemotherapy. But I do think that the biggest advantage is in the sophistication of the drugs, the targeted therapy mm-hmm. <affirmative> and understanding the drugs not only have to work, but they also have to be kind.

Speaker 1 (26:08):

Absolutely. And I suppose you talk, you talk about triple negative and it's an area that you and I worked on when we did our national call out for, you know, research teams who are interested in working in the area of triple negative breast cancer and looking at alternative, um, but very effective drug therapies mm-hmm. <affirmative> for patients, because these tend to be much younger women and these tend to affect, obviously with chemotherapy, it affects fertility, et cetera. So not only have they got to go through a diagnosis of breast cancer before that they've got to consider, um, their, their families, you know, whether they need to freeze eggs, et cetera. Yeah. And because of the brutal nature of chemotherapy on their system, and it's something that a lot of our younger ambassadors who were triple negative diagnosed, it really struck me that this is horrible. Why do they have to go through this? Surely if we

invest in a fellowship and try and get some u understanding of alternative ways to help treat these women. Because again, it's a, it's that personalized treatment plan.

Speaker 2 (27:03):

And I know that PO Mullin has been doing great work in Queens in triple negative, um, breast cancer. I think there's the complexity of triple negative breast cancer is that it's nearly a whole series of cancers in itself. Yeah. And it itself is now, they were saying last week it was gonna be broken down to about 10 different diseases. So I think it's understanding that, and again, so which population there will do really, really well on chemotherapy. Mm. Also, a lot of these patients also express, uh, the antigen receptor. And there's a little very, another lovely new target that's been worked on, particularly by Wayne Tilly in Australia. And he explained his fabulous work to us. And they are now going to clinical trial with an AOR agonist. So it's something similar to testosterone. Okay. But not at the levels that will cause virilization. Okay. Like that just not frightening, but that's now going Wow. June to go to clinical trial hopefully in 2023. Yeah. And that's really another exciting targeted therapy for this group of previously very poorly served patients. Mm-hmm. <affirmative>. And so I think, again, it's breaking down the problem into bite sizes, really trying to understand the biology and really trying to understand what would make a good drug.

Speaker 1 (28:18):

Well, he only, as always, it's inspiring having the conversation with you. I don't think we talk enough about the amazing research that is being done in the country and what you're doing collaboratively, but also, you know, research in a general sense. There's lots and lots being done that's really, really positive. Um, I think everybody just looks for the cure. And unfortunately in a breast cancer world, because there are a lot of permutations of breast cancer, the one cure is not gonna fit all. But we are getting to a point where we are certainly changing positively the landscape going forward.

Speaker 2 (28:50):

Oh. I think without a doubt. And I think it's all about understanding, understanding the disease, understanding your patient, understanding your patient's needs and, and wishes to make better treatments, to make better management strategies. And, and a personal note, I would just like to say huge thanks to breast cancer Ireland, cuz I know that our lab wouldn't exist without you guys. And also we wouldn't understand the patients as well as we do without your lovely breast cancer ambassadors, without your understanding. Um, and I really, I think that we've had a great journey together Hmm. Over such a

Speaker 1 (29:23):

Long time, time and, and it's very true. I mean, the amount of people who initially I was a bit nervous to bring sort of, if I call them, lay people into a research environment like a lab and have somebody walk them through, you know, what you do on a daily basis. Because I kind of thought that might be just over my head, let alone their heads. But it actually proved to be the complete opposite. They were fascinated by how you showed them under microscope, et cetera. Various different, you know, uh, research that you're working on and your lab team are, were so accommodating. And I remember one guy saying to a family that we brought through, you know, it's amazing now I can put a face to the name, to the cell that I'm looking underneath the microscope, but that I know this is ultimately going to help your, you know, person in your family or whatever. And I think that's really powerful.

Speaker 2 (30:10):

Oh, 110%. The, the communication goes both ways. And I think the passion and the interest goes both ways. Mm-hmm. <affirmative>. Mm-hmm. <affirmative>. Um, so thank

Speaker 1 (30:16):

You. Well, thank you very much. Well only thank you so much for joining us today. I think it's been insightful. I hope our listeners, um, have, have taken on board the fa fantastic research advances that are being made and more to come in the future. So thanks million for being with us on More Than a Lump podcast.

Speaker 2 (30:31):

Thank you so much, Ling.

Speaker 1 (30:32):

The information in this podcast is based on the personal stories of those we have chatted to. If you are concerned in any way, please contact your GP immediately, or you can contact us@breastcancerireland.com.