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2025 Annual Report Emphasizes Northside's Dedication to Innovation and Quality Care

In 2025, Northside Hospital Cancer Institute continued to grow as an integrated cancer network. With expanded programs, new clinics, and enhanced research and clinical trial offerings, Northside continues to bring the latest advancements closer to the communities we serve. A few highlights from 2025 include the following:

Development and growth of several hospital-wide programs:

- The **High Risk Program**, launched in December 2022, has expanded its reach with the opening of new clinics across the health system, now serving five locations, Alpharetta, Atlanta, Canton, Cumming and Lawrenceville.
- Northside Hospital Cancer Institute continues to expand access to leading-edge lung cancer care with the addition of a new **Lung Nodule Clinic** on the Northside Hospital Atlanta campus – the fourth in a growing network dedicated to the early detection and treatment of lung disease. Northside's Lung Nodule Clinics are now located in Atlanta, Canton, Cumming and Lawrenceville.
- The **Hematologic Malignancy Program** now offers dedicated support for patients with myelodysplastic syndromes. The expansion includes access to a blood cancer coordinator, who guides patients from diagnosis through treatment with one-on-one support, education and assistance navigating the Northside Hospital system.

Enhanced quality of care through improved patient outcomes:

- For the **17th consecutive year**, the Northside Hospital Cancer Institute's Blood and Marrow Transplant (BMT) Program **exceeded predicted one-year survival outcomes** for U.S. transplant centers.
- Northside Hospital Cancer Institute has received a **"Better than Expected" rating** — the highest possible quality designation — from the Society of Thoracic Surgeons (STS) for excellence in patient care and outcomes following lung cancer surgery.
- Northside achieved or maintained several quality **accreditations, certifications, and designations**, including:



To read the full annual report, please visit northside.com/docs/default-source/cancer-institute/nhci-2025-annual-report.pdf

Clinical Trials and Research

New and Ongoing Cancer Clinical Trials

Disease Site	Sponsor, Protocol Number and Study Title	NCT Identifier		
Breast	STEMLINE STML-ELA-0422 ELEGANT ; Elacestrant Versus Standard Endocrine Therapy (ET) in Women and Men with Node positive, Estrogen Receptor-positive, HER2-negative, Early Breast Cancer with High Risk of Recurrence - A Global, Multicenter, Randomized, Open-label Phase 3 Study	NCT06492616		
<p>Study Design</p> <ul style="list-style-type: none"> This is a phase 3, global, multicenter, randomized, open-label, study in participants with node-positive, ER-positive/HER2-negative, early breast cancer who have received at least 2 years of adjuvant ET, including AI or tamoxifen with or without CDK4/6i and are currently receiving ET; and are considered at high risk of recurrence and are recurrence-free 2-6 years after curative surgical resection of the primary tumor. Eligible participants will be randomized in a 1:1 ratio to either switch to elacestrant monotherapy (experimental arm) or continue their current SoC endocrine monotherapy (control arm). 				
Bone Metastasis	SOCIETY OF INTERVENTIONAL ONCOLOGY SIO-2025-01 TRIBUTE ; A Multi-Center Observational Trial of Symptomatic, High-Risk Bone Metastases Treated with Percutaneous Ablation and Palliative Radiation Therapy	NCT06859801		
<p>Study Design</p> <p>This is a prospective, single-arm, non-randomized, multi-center, observational, open-label study to evaluate effectiveness of percutaneous ablation combined with palliative RT as part of SoC in patients with previously untreated symptomatic, high-risk skeletal metastases.</p>				
BMT	LYELL IMMUNOPHARMA LYL314-102 PINACLE-H2H ; A Phase 3 Randomized Controlled Trial of Rondecabtagene Autoleucel, an Autologous, Dual-Targeting CD19/CD20 CAR T-Cell Product Candidate, Versus Investigator's Choice of CD19 CAR T-Cell Therapy in Patients with Relapsed or Refractory Large B-Cell Lymphoma in the Second-Line Setting	NCT07188558		
<p>Study Design</p> <p>This is a Phase 3 multicenter, open-label, randomized, controlled trial evaluating the efficacy and safety of ronde-cel versus investigator's choice of commercially available autologous CD19 CAR T-cell therapies (axi-cel or liso-cel) in adult patients with relapsed or refractory LBCL in the second-line setting.</p> <p>Eligible patients will be randomized 1:1 into:</p> <table border="0"> <tr> <td style="vertical-align: top;"> <p>Arm A: Experimental Arm (ronde-cel)</p> <ul style="list-style-type: none"> Patients will undergo leukapheresis for autologous T-cell collection. Patients will receive lymphodepleting chemotherapy (LDC) with fludarabine (30 mg/m²) and cyclophosphamide (500 mg/m²) daily for three days before ronde-cel administration. Patients will receive a single IV administration of ronde-cel at a dose of 100 × 10⁶ CAR-positive cells. </td> <td style="vertical-align: top;"> <p>Arm B: Investigator's choice of CD19 CAR T-cell therapy (axi-cel or liso-cel)</p> <ul style="list-style-type: none"> Patients will undergo leukapheresis for autologous T-cell collection. Patients will receive LDC with fludarabine and cyclophosphamide daily for three days before administration per local product labeling specific to the selected CAR T-cell therapy. Patients will receive a single administration of commercially approved CD19 CAR T cells at the standard dose per local product label. </td> </tr> </table>			<p>Arm A: Experimental Arm (ronde-cel)</p> <ul style="list-style-type: none"> Patients will undergo leukapheresis for autologous T-cell collection. Patients will receive lymphodepleting chemotherapy (LDC) with fludarabine (30 mg/m²) and cyclophosphamide (500 mg/m²) daily for three days before ronde-cel administration. Patients will receive a single IV administration of ronde-cel at a dose of 100 × 10⁶ CAR-positive cells. 	<p>Arm B: Investigator's choice of CD19 CAR T-cell therapy (axi-cel or liso-cel)</p> <ul style="list-style-type: none"> Patients will undergo leukapheresis for autologous T-cell collection. Patients will receive LDC with fludarabine and cyclophosphamide daily for three days before administration per local product labeling specific to the selected CAR T-cell therapy. Patients will receive a single administration of commercially approved CD19 CAR T cells at the standard dose per local product label.
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AI = aromatase inhibitor; BMT = bone marrow transplant; CDK4/6i = cyclin dependent kinase 4/6 inhibitor; ER = estrogen receptor; GI = gastrointestinal; HER2 = human epidermal growth factor receptor; IV = intravenous; LBCL, large B cell lymphoma; LDC = lymphodepleting chemotherapy; NSCLC = non small cell lung cancer; PD-L1 = programmed cell death ligand 1; RT = radiation therapy; SoC = standard of care.

To learn more about Clinical Trials at Northside Hospital Cancer Institute, visit our [Cancer Research and Clinical Trials page](#) or call **404-303-3355**.


IN THE NEWS: Update for Clinicians

Updated ASCO–Ontario Health Guidelines Redefine the Management of Multiple Myeloma

Evidence-based recommendations on the treatment of multiple myeloma were first published jointly by American Society of Clinical Oncology (ASCO) and Ontario Health (Cancer Care Ontario) (OH CCO) in 2019.¹ Since the publication of that guideline, several practice-changing trials have been completed. The ASCO's Evidence-Based Medicine Committee (EBMC) and OH-CCO agreed to jointly update the guideline, which was recently published in the *Journal of Clinical Oncology*.² This systematic review-based guideline

was developed by a multidisciplinary expert panel, which included a patient representative and an ASCO guidelines staff member with health research methodology expertise.

The updated multiple myeloma guideline reflects an extensive systematic review and offers updated recommendations for newly diagnosed, smoldering, transplant-eligible and ineligible patients, and those with relapsed or refractory disease.



Expert Commentary

By Hong De Sa, MD

The treatment landscape for multiple myeloma has evolved substantially over the past 6–7 years, prompting major updates in the 2025 ASCO-CCO Living Guideline. The introduction of novel therapies has improved outcomes across all risk categories but has

(continued on page 3)

Updated ASCO–Ontario Health Guidelines Redefine the Management of Multiple Myeloma *(continued from page 2)***Expert Commentary** *(continued)*

also increased the complexity of treatment selection. To address this, the guideline synthesizes data from more than 150 clinical trials into a practical framework for clinicians.

Transplant eligibility should be based on overall patient assessment rather than age alone. Quadruplet therapy followed by autologous stem cell transplant is standard-of-care, with transplant planning initiated early. Post-transplant maintenance is generally recommended for at least 2–3 years. Transplant-ineligible patients with good functional status may also benefit from upfront quadruplet therapy.

For patients with relapsed/refractory myeloma, referral to a transplant/cellular therapy center for consideration

of CAR T-cell therapy is strongly recommended. CAR T is a cornerstone of R/R disease due to high response rates and durable remissions. Importantly, every effort should be made to avoid the use of bispecific antibodies prior to CAR T-cell therapy. In disease that has relapsed following CAR T or in patients who are not eligible for CAR T, options include bispecific antibodies, antibody–drug conjugates, and targeted small-molecule therapies, with preference given to combinations of previously unused agents and treatment strategies individualized to each patient.

Lastly, smoldering myeloma (SM) is a new focus in this guideline. Patients with low- or intermediate-risk SM should not receive therapy, while those with high-risk may be considered for careful observation versus treatment with daratumumab based on the AQUILA trial.³

References: 1. Mikhael J, et al. *J Clin Oncol.* 2019;37:1228-1263. 2. Kicks LK, et al. *J Clin Oncol.* 2026;JCO2502587. 3. Dimopoulos MA, et al. *N Engl J Med.* 2025;392(18):1777-1788.

Highlights from SABCS 2025**Giredestrant Improves Disease-free Survival Over Standard of Care for Patients with Early-stage Breast Cancer in Phase 3 lidERA Trial**

Dr. Aditya Bardia, from the University of California, Los Angeles Jonsson Comprehensive Cancer Center, and colleagues presented results from the phase 3 lidERA trial evaluating the efficacy and safety of giredestrant versus standard of care endocrine therapy (SoC ET) for hormone receptor positive (HR+) human epidermal growth factor receptor 2 negative (HER2-) early-stage breast cancer.¹ Eligible patients had anatomic stage I-III disease, were premenopausal or postmenopausal, had breast cancer surgery within 12 months and had received neoadjuvant chemotherapy if indicated. Patients were stratified by risk level (medium versus high-risk stage I-III breast cancer), geographic region (USA/Canada/Western Europe versus Asia-Pacific versus rest of world), previous chemotherapy (yes versus no), menopausal status (premenopausal versus postmenopausal). The primary endpoint was invasive disease-free survival (IDFS), excluding second primary non-breast cancer. Secondary endpoints included disease-free survival, distant recurrence-free interval (DRFI), IDFS (including second primary non-breast invasive cancer with the exception of non-melanoma skin cancers in situ

carcinomas of any site), locoregional recurrence-free interval, overall survival (OS) and safety. The median age was 54 years in both arms, most patients were postmenopausal (~59%) in both arms, and most patients (~69%) were defined as having high-risk disease at baseline.

The trial met its primary endpoint at a prespecified interim analysis. After a median follow-up of 32.3 months, patients who received giredestrant had significantly better IDFS than their counterparts who received SoC ET and were 30% less likely to develop invasive disease progression at the time of follow-up. The secondary endpoint of DRFI was also met. Patients who received giredestrant were 31% less likely than those in the SoC arm to experience distant recurrence at the time of follow-up. OS data were immature, with future analysis planned. The incidence of all-grade and grade ≥ 3 treatment-related adverse events (AEs) was similar between the two arms. The most common treatment-emergent AEs occurring in both arms were arthralgia, hot flush and headache. These findings suggest that giredestrant may serve as a new treatment option for patients with HR+/HER2- early breast cancer.

**Expert Commentary**

By I-Wen Chang, MD

The lidERA study represents a landmark moment in the adjuvant treatment of HR+ early breast cancer. For the first time, a phase 3 trial has demonstrated a clear advantage for an oral selective estrogen receptor degrader (SERD), giredestrant, over standard adjuvant ET. At the first interim analysis, giredestrant reduced the risk of invasive disease recurrence by 30% compared with conventional endocrine treatment, with a safety profile that was largely

comparable between arms. Notably, there appeared to be fewer treatment discontinuations due to arthralgias in the SERD arm, an observation that may have meaningful implications for long-term adherence.

The availability of a more potent antiestrogen option in the adjuvant setting is undeniably exciting, yet several clinically important questions remain unanswered. Chief

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Highlights from SABCS 2025 (continued)

Giredestrant Improves Disease-free Survival Over Standard of Care for Patients with Early-stage Breast Cancer in Phase 3 lidERA Trial (continued from page 3)

Expert Commentary (continued)

among them is durability: with longer follow-up, how will these early gains with giredestrant compare to the established outcomes seen in patients eligible for adjuvant CDK4/6 inhibitors combined with aromatase inhibitors? Additionally, it remains unclear whether SERDs will ultimately be best positioned as monotherapy or whether they may provide additive or synergistic benefit when layered onto CDK4/6 inhibition. Finally, careful patient selection will be essential, identifying who stands to benefit most from SERD monotherapy versus escalation strategies and will shape how this class is integrated into practice.

Despite these open questions, lidERA is arguably the most consequential advance to emerge from this 2025 SABCS. By introducing a more effective antiestrogen therapy into the early-stage setting, this study has the potential to meaningfully improve cure rates for the majority of patients diagnosed with breast cancer. As follow-up matures and combination strategies are explored, oral SERDs may fundamentally reshape the adjuvant treatment landscape for HR+ disease.

Reference: 1. Bardia A, et al. Presented at the 2025 San Antonio Breast Cancer Symposium; December 9-12, 2025; San Antonio, TX, USA; GS1-10.

Highlights from ESMO 2025

OptiTROP-Breast02 Trial Demonstrates Improvement in Progression-Free Survival With Sacituzumab-TMT in Patients with HR+/HER2- Metastatic Breast Cancer

Dr. Ying Fan, from the Chinese Academy of Medical Sciences and Peking Union Medical College, and colleagues presented results from the phase 3 OptiTROP-Breast02 trial evaluating the efficacy and safety of sacituzumab tirumotecan (sac-TMT) versus investigator's choice of chemotherapy for HR+/HER2- metastatic breast cancer (mBC).¹ Eligible patients had received 1-4 prior lines of chemotherapy and at least one endocrine therapy (ET), CDK4/6 inhibitor and taxane in any setting. Patients were stratified by previous lines of chemotherapy (1 versus >1), HER2 status (zero versus low) and ET \geq 6 months (yes versus no). The primary endpoint was progression-free survival (PFS) assessed by blinded independent central review (BICR) per RECIST v1.1. As of January 22, 2025, 399 patients were randomized. The median age was ~54 years in both arms, and most patients (~73%) in both arms received prior chemotherapy in the neoadjuvant setting.

Findings demonstrated a statistically significant improvement in median PFS by BICR of 8.3 months in the sac-TMT arm and 4.1 months in the control arm. A consistent PFS benefit of sac-TMT over chemotherapy was observed across all predefined subgroups. Sac-TMT also showed longer median duration of response versus chemotherapy: 6.7 months versus 4.2 months (HR 0.29, 95% CI 0.15, 0.55). The incidence of all-grade and grade \geq 3 treatment-related adverse events, which were predominantly hematological, was similar between the two groups. Grade \geq 3 diarrhea occurred in 1% of patients in the sac-TMT group. Low ocular surface toxicity (11.5% dry eyes, 4% corneal disease, all grade 1-2) was also observed in the sac-TMT group. These findings suggest that sac-TMT may serve as a new treatment option for patients with HR+/HER2- mBC following endocrine-based therapy and chemotherapy.



Expert Commentary

By Madhuri Chengappa, MD

The phase 3 OptiTROP-Breast02 trial provides important evidence supporting the role of sac-TMT in patients with HR+/HER2- mBC who have progressed on multiple prior lines of therapy. The study demonstrated a clinically meaningful improvement in PFS compared with investigator's choice chemotherapy with a notable hazard ratio of 0.35, reflecting substantial disease control in a heavily pretreated population. This benefit was observed consistently across predefined subgroups. The safety profile was favorable and manageable, with low rates of clinically significant gastrointestinal and ocular toxicity.

Several considerations warrant attention when interpreting these findings. The study was conducted

entirely within Chinese cancer centers, and validation in more diverse populations will be important to establish global applicability. The heterogeneous comparator arm of investigator's choice chemotherapy while reflective of real-world practice, complicates cross-trial comparisons. Additionally, optimal sequencing remains unclear, particularly with respect to positioning relative to trastuzumab deruxtecan in HER2-low disease and other emerging antibody drug conjugates (ADCs). Nonetheless, the magnitude and consistency of benefit underscore the promise of sac-TMT and reinforce the expanding role of ADCs as effective chemotherapy sparing options in advanced HR+ breast cancer.

Reference: 1. Fan Y, et al. Presented at the European Society of Medical Oncology 2025 Annual Meeting; October 17-21, 2025; Berlin, Germany; LBA23.


Highlights from ASH 2025

PARADIGM Trial Demonstrates Improvement in Event-Free Survival in Newly Diagnosed Fit Adults With Acute Myeloid Leukemia

Dr. Amir Fathi, from Massachusetts General Hospital, and colleagues presented results from the phase 2 PARADIGM trial, which prospectively tested whether azacitidine and venetoclax (aza-ven) was superior to induction chemotherapy in newly diagnosed fit adults with acute myeloid leukemia (AML). Adults eligible for induction chemotherapy were included. Patients with core binding factor fusions, FLT3 mutations or NPM1 mutations (unless aged ≥ 60) were excluded. The primary endpoint was event free survival (EFS). Key secondary endpoints included response rates, overall survival, toxicity, measurable residual disease, hospitalization metrics and quality of life. Patients were stratified by age (≥ 65 versus < 65) and pre-randomization selection in the induction chemotherapy arm to 7+3 or CPX-351. As of July 25, 2025, 172 patients at nine U.S. centers were randomized to aza-ven (n=86) or induction chemotherapy (n=86), and accrual is complete. Median age was 64 for patients who received aza-ven and 65 for patients who received induction chemotherapy. The majority of patients were male, 55% and 60% in the aza-ven

and induction chemotherapy arms, respectively, and 65% and 69% were White.

Findings demonstrate that aza-ven significantly improved outcomes compared with induction chemotherapy, with higher overall response (88% versus 62%) and composite emission rates (81% versus 55%). A higher proportion of patients who responded to protocol therapy proceeded to allogeneic hematopoietic cell transplant (HCT) in the aza-ven arm (61% compared with 40% in the induction chemotherapy arm). With a median follow-up of 16 months, EFS favored aza-ven (1-year EFS 53% versus 39%; HR 0.61), with benefit maintained after adjustment for age. Safety profiles were comparable, with similar rates of grade 3-4 hematologic toxicities in both arms. Patient-reported outcomes and healthcare utilization also favored aza-ven, including improved quality of life, reduced symptom burden and fewer inpatient days. These findings suggest that newly diagnosed fit adults with AML could benefit from treatment with aza-ven.



Expert Commentary
By Joseph Maakaron, MD

Venetoclax was approved for treatment of AML in 2018. Since then, it has revolutionized our treatment approaches to this aggressive leukemia. Venetoclax synergizes with standard chemotherapy and thus improves outcomes as is outlined here in the PARADIGM study. These data have long been awaited, whereas we always asked ourselves if a venetoclax-containing “low-intensity” regimen is non-inferior, or even better, than aggressive chemotherapy. In this trial, the age-old “7+3” regimen was compared to a “low-intensity” regimen. The difference in outcomes, favoring aza-ven, is striking, and it provides definitive proof that a novel targeted agent can replace an older cytotoxic chemotherapeutic drug. Though, it is worth noting that a significant proportion of patients with AML were excluded (those with favorable risk, NPM1, FLT3, etc). This significantly limits the generalizability of these findings to the entire population.

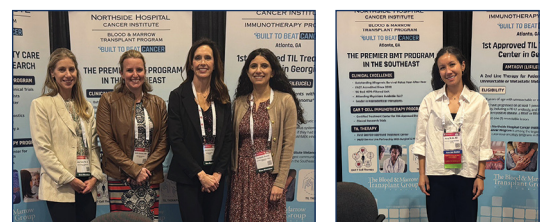
Furthermore, progress sometimes outpaces our ability to generate high-quality data. In Northside’s Blood & Marrow Transplant Program, we have already moved past 7+3 and aza-ven combinations into more effective, venetoclax-containing, multidrug regimens. Fit individuals at our center receive a combination of three chemotherapies combined with venetoclax called FLAG-Ilda + ven, and our low-intensity regimen also combines two chemotherapies with venetoclax (i.e., CLAV). These approaches have historically achieved complete remissions in the vast majority of patients, estimated around 80-90%, and have been very well tolerated given our robust supportive care program. These regimens compare even more favorably to the PARADIGM results. While PARADIGM might alter the paradigm at other centers, Northside continues to set the paradigm for future research!

Reference: 1. Fathi A, et al. Presented at the American Society of Hematology 2025 Annual Meeting; December 6-9, 2025; Orlando, FL, USA

American Society of Hematology 2025 Annual Meeting Presentations From Northside Hospital Blood and Marrow Transplant, Immunotherapy and Leukemia Programs

The Northside Hospital Blood and Marrow Transplant (NH-BMT), Immunotherapy and Leukemia Programs had a strong presence at the 67th American Society of Hematology (ASH) Annual Meeting held December 6-9, 2025, in Orlando.

The Program's physicians authored or co-authored and collaborated on twenty oral and poster presentations. Highlights of several presentations are shown below.



(continued on page 6)

American Society of Hematology 2025 Annual Meeting Presentations From Northside Hospital Blood and Marrow Transplant, Immunotherapy and Leukemia Programs *(continued from page 5)*

Collaborative Oral Presentations: Titles	Summary of Findings
Effect of FLT3 maintenance in older FLT3-ITD+ adults undergoing allogeneic HCT: A post hoc analysis of BMT CTN 1506	In a post-hoc analysis of patients aged >60 years enrolled in BMT CTN 1506, gilteritinib maintenance did not improve relapse-free survival or overall survival. Gilteritinib use was associated with reduced relapse regardless of peri-HCT MRD status, demonstrating a disease-modifying effect; however, higher non-relapse mortality limited the overall benefit.
Phase 2 registrational study of anitocabtagene autoleucl for the treatment of patients with relapsed and/or refractory multiple myeloma: Updated results from iMMagine-1	Ongoing results from the phase 2 iMMagine-1 trial demonstrate a 97% investigator-assessed ORR per IMWG criteria, with a CR/sCR rate of 68% and median time to first response of 1.0 month. Of those evaluable for MRD testing (n=75), 93% achieved MRD negativity at the level of 10 ⁻⁵ with a median time to MRD negativity of 1.0 month, and MRD negativity at the level of 10 ⁻⁶ was achieved in 78%. No delayed or non-ICANS neurotoxicities, including Parkinsonism, cranial nerve palsies, Guillain-Barré syndrome and IEC-associated enterocolitis have been observed across the phase 1 or phase 2 iMMagine-1 studies to date.
A Phase 1 study of KITE-753 or KITE-363 in patients with relapsed/refractory B-cell lymphoma: Initial safety and preliminary efficacy of KITE-753 and updated results of KITE-363	In the open-label, multicenter, umbrella phase 1 study of KITE-753 or KITE-363 in patients with relapsed/refractory B-cell lymphoma, KITE-363 showed high response rates, with encouraging durability in DL3 and a manageable safety profile. KITE-753's rapid manufacturing process and bicistronic CAR design with dual co-stimulation, was associated with low incidence of CRS and ICANS, mostly grade 1/2.
Azer-cel, an allogeneic (allo) CD19 CAR T, in combination with low-dose interleukin-2 (IL-2) demonstrates clinical activity in patients with large B-cell lymphoma (LBCL) who relapsed after autologous (auto) CAR T	Results of a phase 1/1b trial evaluating zer-cel followed by low-dose SC IL-2 in patients with r/r LBCL who relapsed after prior autologous CAR T therapy showed a 75% ORR, including a CR rate of 50%. ICANS occurred in 17% (one grade 2, one grade 3), and CRS in 67% (grade 1-2 only). Infections were reported in four patients (all grade 2), and no deaths occurred in the low-dose IL-2 cohort.
The MEASURE Genome Atlas: Acute Myeloid Leukemia at diagnosis and complete remission	In the largest reported cohort to date of paired diagnostic and remission WGS from 18 major U.S. cancer centers, deep WGS in AML identified numerous structural and copy number abnormalities missed by standard clinical testing, including potential therapeutic targets, and revealed a higher rate of tandem duplications than previously reported using other methodologies.
Pre- or post-CAR T allogeneic hematopoietic cell transplant provides relapse-free survival benefit for r/r Philadelphia negative B-cell acute lymphoblastic leukemia (B-ALL) successfully treated with brexucabtagene autoleucl in the real world	In this real-world analysis, a first consolidative HCT after achieving MRD neg CR with brexu-cel was associated with a significant decrease in relapse. Additionally, use of brexu-cel for post-HCT relapse was also associated with a significantly lower risk of relapse compared with those who never received an allogeneic HCT, suggesting there is a benefit for relapse-free survival in patients receiving an allogeneic HCT at some point in the course of treatment for r/r Ph neg B-ALL.
Time from AML diagnosis to HCT and pre-HCT FLT3 inhibition impact pre-transplant MRD and benefit from post-HCT gilteritinib	In a post hoc analysis, time from AML diagnosis to HCT and pre-HCT FLT3 inhibitor use influenced MRD levels before transplant. Findings help explain regional differences in post-HCT gilteritinib benefit in the BMT CTN 1506 trial and highlight a clinical tradeoff between deeper MRD reduction with additional FLT3-inhibitor-based therapy and the increased risk of relapse from delaying HCT.

AML = acute myeloid leukemia; BMT CTN=Blood & Marrow Transplant Clinical Trials Network; CR = complete response; CRS, cytokine release syndrome; DL3 = dose level 3; HCT = hematopoietic cell transplantation; ICANS = immune effector cell-associated neurotoxicity syndrome; IEC = immune effector cell; IL-2 = interleukin 2; IMWG = International Myeloma Working Group; LBCL = large B cell lymphoma; MRD = measurable residual disease; ORR = overall response rate; Ph neg B-ALL = Philadelphia negative B-cell acute lymphoblastic leukemia; r/r = relapsed/refractory; SC = subcutaneous; sCR = stringent complete response; U.S. = United States; WGS = whole genome sequencing.

Elevating the Patient Experience

Blood and Marrow Transplant Program: 2025 Survival Outcomes

The Northside Hospital Bone Marrow Transplant (BMT) Program continues to demonstrate exceptional clinical outcomes, achieving one-year survival rates that significantly exceeded expected benchmarks for 17 consecutive reporting cycles from 2009 to 2025. In the most recent reporting cycle, patients undergoing transplantation at Northside Hospital achieved a 78.9% one-year survival rate, placing the program in the 95th percentile nationally for risk-adjusted survival outcomes. Notably, Northside is the only transplant center in Georgia with outcomes statistically superior to predicted rates and is among just eight centers nationwide, representing fewer than 5% of U.S. transplant programs, to receive this distinction. Congratulations to the Northside BMT on this outstanding achievement.

OUR SURVIVORS ARE LIVING PROOF WE EXCEED EXPECTATIONS!

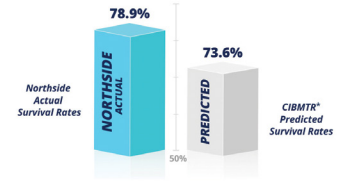
ONLY BMT CENTER IN US

TO EXCEED PREDICTED SURVIVAL RATES FOR THE LAST 17 CONSECUTIVE YEARS (2025*)



TRANSPLANT SURVIVAL RATES

2025 ONE-YEAR ALLOGENIC SURVIVAL RATES



Around Our Campuses

Northside Cardio-Oncology Program Re-Certified as IC-OS Gold Center of Excellence



The Cardio-Oncology Program at Northside Hospital has been recertified as a gold-certified Center of Excellence by the International Cardio-Oncology Society (IC-OS) for another three years. IC-OS defines a Center of

Excellence as “a program within a health care institution that is assembled to supply an exceptionally high concentration of expertise and related resources centered on a particular area of medicine, delivering associated care in a comprehensive, interdisciplinary fashion to afford the best patient outcomes possible.” Northside Hospital is one of 27 institutions in the U.S. to have the Gold rating. To learn more about the Cardio-Oncology Program at Northside, visit northside.com/services/cardiovascular/programs-treatments/cardio-oncology.

Lalitha Medepalli, MD, FACC, FASE, RPVI, Medical Director of the Northside Hospital Cardio-Oncology Program and a member of the IC-OS Education Committee, announced the recertification following official notification from IC-OS. “Our goal and vision are to ensure that patients can receive life-saving cancer therapies while proactively minimizing cardiotoxicity during treatment and reducing long-term cardiovascular risk in cancer survivors,” said Dr. Medepalli. “Through heightened awareness, rigorous cardiovascular surveillance, and the use of advanced imaging and evidence-based care pathways, we deliver comprehensive, patient-centered cardio-oncology care. Our program at Northside Hospital stands alongside the nation’s and world’s leading cardio-oncology programs, setting a benchmark for excellence in cancer survivorship and cardiovascular outcomes.”

Provider Features



Andrew Fuson, MD is an otolaryngologist–head and neck surgeon who recently joined [Atlanta Head & Neck Associates](http://AtlantaHead&NeckAssociates.com). To learn more, visit northside.com/andrew-r-fuson.



Piyush Patel, MD is a hematologist and oncologist who recently joined [Georgia Cancer Specialists – Canton](http://GeorgiaCancerSpecialists.com) and [Georgia Cancer Specialists – Jasper](http://GeorgiaCancerSpecialists.com). To learn more, visit gacancer.com/ourteam/piyush-patel-md.



Stephen Szabo, MD is a hematologist and oncologist who recently joined [Georgia Cancer Specialists – Johns Creek](http://GeorgiaCancerSpecialists.com) and [Georgia Cancer Specialists – Alpharetta](http://GeorgiaCancerSpecialists.com). To learn more, visit gacancer.com/ourteam/stephen-szabo-md.



Sarah Wood, MD is a hematologist and oncologist who recently joined [Georgia Cancer Specialists – Blue Ridge](http://GeorgiaCancerSpecialists.com) and [Georgia Cancer Specialists – Blairsville](http://GeorgiaCancerSpecialists.com). To learn more, visit gacancer.com/ourteam/sarah-wood-md.

Upcoming Education and Events

CONTINUING EDUCATION

Northside Hospital Cancer Institute Oncology Lecture Series

Third Thursday of each month from 12-1 p.m.
Upcoming dates are March 19 & April 16, 2026.
Please contact Northside Hospital Department of Medical Education at medical.education@northside.com for more details.



2026 NHCI Symposium - Precision & Progress: The Future of GI Cancer Therapy

February 21, 2026 from 8 a.m.-3 p.m. @ The Whitley
northside.com/nhcsymposium2026



Atlanta Myeloma & Lymphoma Symposium 2026

July 18, 2026 @ Loews Atlanta Hotel
Registration will open in the spring. Stay tuned for more information!



NHCI Oncology Nursing Symposium: Shaping Tomorrow's Healthcare Landscape

August 29, 2026 from 7 a.m.-2:30 p.m. @ The Hotel at Avalon in Alpharetta
Registration will open soon. Stay tuned for more information!



CANCER SCREENING & PREVENTION

Skin & Prostate Cancer Screenings

March 12, 2026 from 5:30-8 p.m. @ Northside Hospital Cancer Institute Radiation Oncology - Cherokee
April 16, 2026 from 5:30-8 p.m. @ The Cancer Support Center at Northside Hospital Gwinnett
northside.com/community-wellness/health-screenings

Built To Quit- Smoking and Tobacco Cessation Course

Next six-week session start date: March 17, 2026
Weekly classes include the American Lung Association Freedom from Smoking curriculum.
northside.com/community-wellness/built-to-quit



COMMUNITY EVENTS

National Dress in Blue Day for Colon Cancer Awareness

March 6, 2026

Lustgarten Pancreatic Cancer Research Walk

March 15, 2026 @ 8:30 a.m. @ the Porche Experience Center in Atlanta
hope.lustgarten.org/fundraiser/nhci



National Brain Tumor Society's Georgia Brain Tumor Walk & Race

April 25, 2026 from 8-10:45 a.m. @ The Battery in Atlanta
braintumor.org/event/georgia-brain-tumor-walk-race/



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