



# An Introduction to: GYROSCOPIC RADIOSURGERY PLATFORM

ITAPA HEALTH & CARE March 2023

Hotel IMPOZANT, Valčianska dolina

David Miles,

*EIMEA*

# ZAP MOTIVATION

- Dr. Adler's Vision
  - Treat more patients in more places
    - 2 million a year!
  - Redefine the future of radiosurgery: a less challenging prospect, every day use intuitive and patient friendly
  - State-of-the-art machine
  - Aesthetically pleasing
  - Streamlined workflows

➤ <https://firstinmanfilm.com>



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## **SURGICAL and RADIOSURGICAL**

- Clinical outcomes are equitable in numerous disease type categories, suitable for RS.
- Reduction of negative side effects of treatment often favor RS.
- Social effect on patients' wellbeing immediately after procedure considerably favors RS
- Cost of clinical procedure's significantly lower for RS.
- Selection of RS reduces surgical waiting times for treatments not suitable for RS.
- Social economic impact to patient and state vastly superior for RS.



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# RADIOSURGICAL Procedures

- Selected malignant cancers
- Selected benign cancers
- Selected metastatic cancers
- Vascular disorders
- Functional disorders
  - Trigeminal Neuralgia
  - Essential Tremor



## Clinical Conditions for which Functional Radiosurgery Has Been Used (mainly GK)

Essentially any indication for which precision lesioning of the brain can produce the desired physiological effect

- Trigeminal neuralgia (70-90Gy TGN)
- Parkinsonian tremor (130Gy Gpi)
- Essential tremor (130Gy VIM)
- Dystonia (120Gy STN)
- Cancer pain (130Gy CMN or 160Gy Pituitary)
- Thalamic pain (130Gy VPN)
- Obsessive compulsive disorder (180Gy anterior capsule)
- Epilepsy
- hypothalamic hamartomas (~15Gy to hamartoma)
- mesial temporal sclerosis (40-48Gy amygdala)
- Sphenopalatine neuralgia (80Gy to SPG)
- Chronic cluster headaches (80Gy to SPG or TGN)

# Incidence of brain metastasis is increasing

Incidence of brain metastasis is increasing<sup>1</sup>:

- Improvements in imaging (e.g. MRI)
- Clinical trial screening
- Improvements in systemic cancer control (brain is a sanctuary site)
- Rates of brain metastasis may be influenced by changing treatments
  - 25% of lung cancer patients have brain metastasis at initial presentation
  - 80% of lung cancer patients surviving >2 years will develop brain metastases

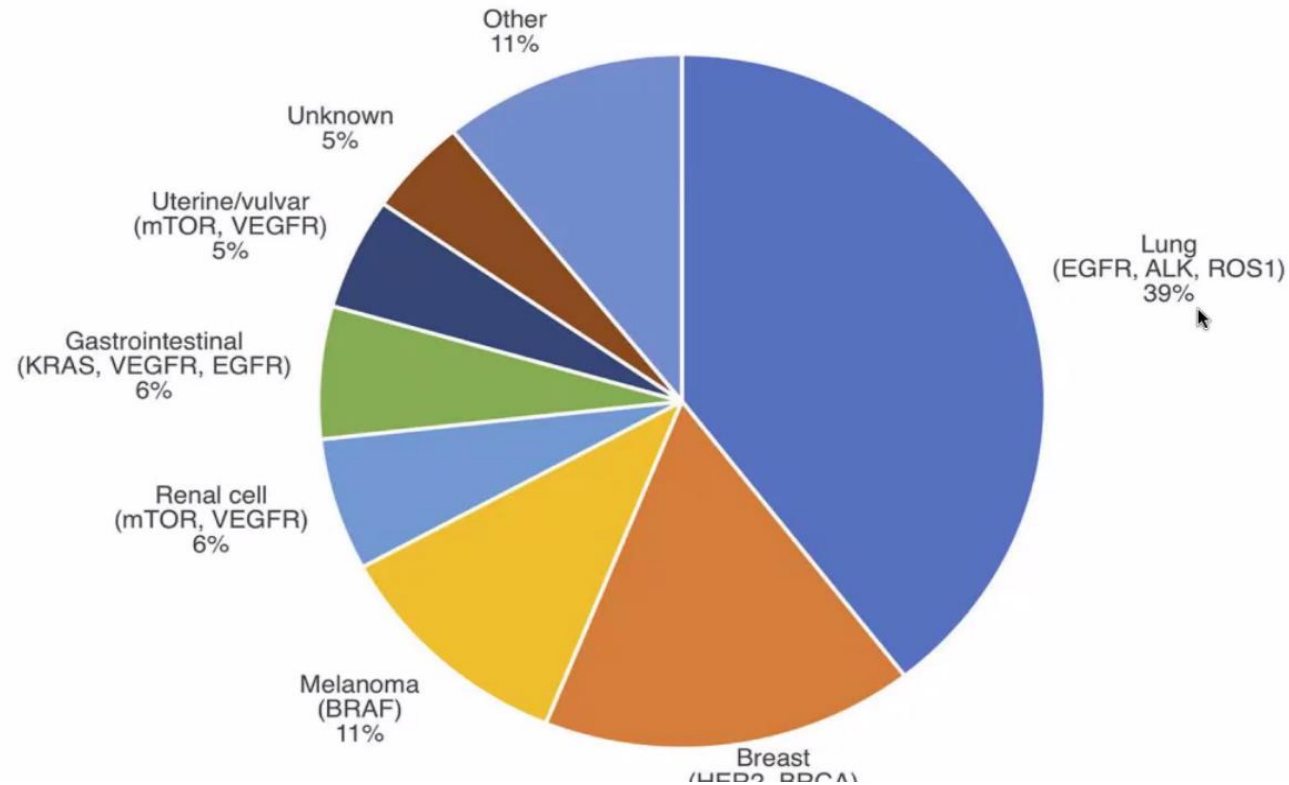
Brain metastases may be underdiagnosed

- Autopsy results reveal brain metastases that were not diagnosed clinically<sup>2</sup>
- Clinical trial screening reveals patients with asymptomatic brain metastases<sup>1</sup>

# The Impact of Targeted Therapy on Intracranial Metastatic Disease Incidence and Survival

Anders W. Erickson<sup>1</sup> and Sunit Das<sup>2,3\*</sup>

<sup>1</sup> Institute of Medical Science, Faculty of Medicine, University of Toronto, Toronto, ON, Canada, <sup>2</sup> Division of Neurosurgery, University of Toronto, Toronto, ON, Canada, <sup>3</sup> Li Ka Shing Knowledge Institute, St. Michael's Hospital, Toronto, ON, Canada



Frontiers in Oncology

Disease group	N (% of all cancers)	N (%) with IMD	Median (IQR) time until brain met (months)	1-yr all cause mortality	Median (IQR) time until death since brain met
Lung and bronchus	77,613 (12.9%)	15,193 (19.6%)	2.1 (0.2, 7.5)	55%	1.7 (0.5, 3.9)
Breast	87,233 (14.5%)	2,686 (3.1%)*	22.8 (10.9, 40.5)	4.3%	4.6 (1.6, 12.5)
Colorectal	66048 (11.0%)	919 (1.4%)	16.6 (3.9, 34.8)	20.2@	2.5 (1.2, 6.2)
Melanoma	24,650 (4.1%)	1,581 (6.4%)*	11.7 (2.1, 26.6)	8.2%	3.4 (1.3, 8.7)
Kidney	18,237 (3%)	765 (4.2%)*	7.2 (1.0, 22.0)	16.5%	4.1 (1.6, 11.8)



# Postoperative stereotactic radiosurgery compared with whole brain radiotherapy for resected metastatic brain disease (NCCTG N107C/CEC-3): a multicentre, randomised, controlled, phase 3 trial

Paul D Brown, Karla V Ballman, Jane H Cerhan, S Keith Anderson, Xiomara W Carrero, Anthony C Whitton, Jeffrey Greenspoon, Ian F Parney, Nadia N I Laack, Jonathan B Ashman, Jean-Paul Bahary, Costas G Hadjipanayis, James J Urbanic, Fred G Barker II, Elana Farace, Deepak Khuntia, Caterina Giannini, Jan C Buckner, Evanthia Galanis, David Roberge

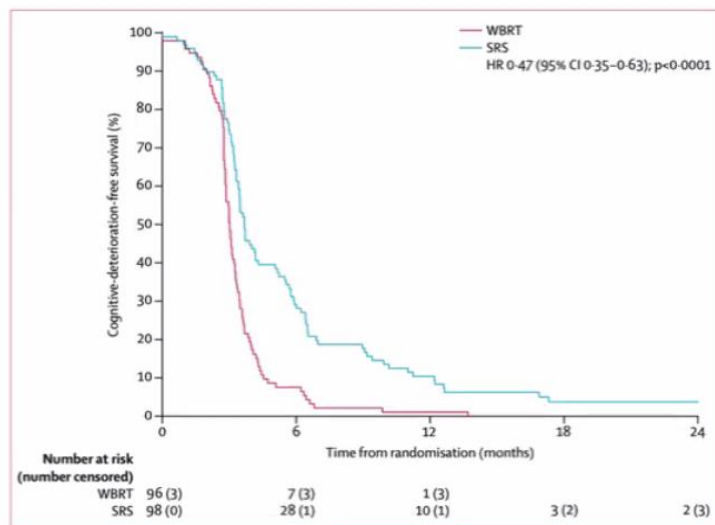


Figure 2: Cognitive-deterioration-free survival  
WBRT=whole brain radiotherapy. SRS=stereotactic radiosurgery.

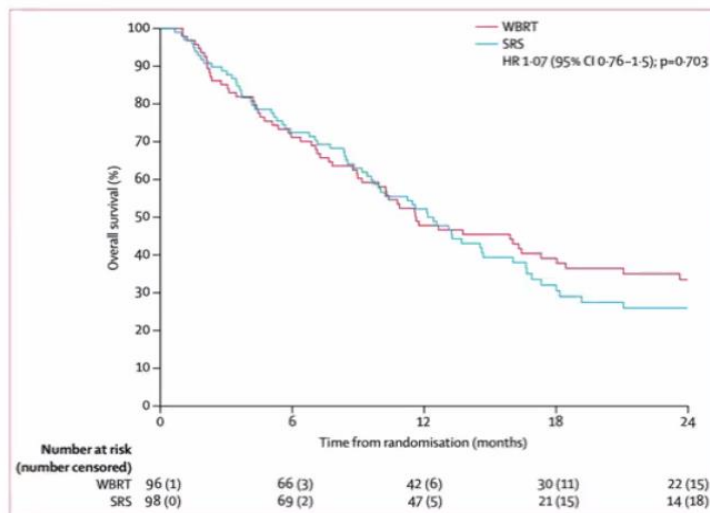


Figure 3: Overall survival  
WBRT=whole brain radiotherapy. SRS=stereotactic radiosurgery.

	SRS (n=54)	WBRT (n=48)	Mean difference (95% CI)	p value
<b>HVLT-R Immediate Recall</b>				
Deterioration	9 (17%)	23 (49%)	..	..
Non-deterioration	45 (83%)	24 (51%)	32.3 (20 to 44.5)	0.00062
Test not attempted	0	1	..	..
<b>HVLT-R Delayed Recall</b>				
Deterioration	14 (26%)	29 (62%)	..	..
Non-deterioration	39 (74%)	18 (38%)	35.3 (22.5 to 48.1)	0.00054
Test not attempted	1	1	..	..
<b>HVLT-R Recognition</b>				
Deterioration	10 (19%)	16 (36%)	..	..
Non-deterioration	43 (81%)	29 (64%)	16.7 (4.6 to 28.8)	0.0707
Test not attempted	1	3	..	..
<b>TMT-A time to complete</b>				
Deterioration	9 (17%)	18 (38%)	..	..
Non-deterioration	45 (83%)	29 (62%)	21.6 (9.6 to 33.6)	0.0233
Test not attempted	0	1	..	..
<b>TMT-B time to complete</b>				
Deterioration	10 (19%)	19 (42%)	..	..
Non-deterioration	43 (81%)	26 (58%)	23.4 (11 to 35.7)	0.0149
Test not attempted	1	3	..	..
<b>COWAT total</b>				
Deterioration	4 (7%)	7 (15%)	..	..
Non-deterioration	50 (93%)	39 (85%)	7.8 (-0.9 to 16.5)	0.3368
Test not attempted	0	2	..	..
<b>Overall outcome for cognitive deterioration</b>				
Deterioration	28 (52%)	41 (85%)	-33.6 (-45.3 to -21.8)	..
Non-deterioration	26 (48%)	7 (15%)	..	0.00031

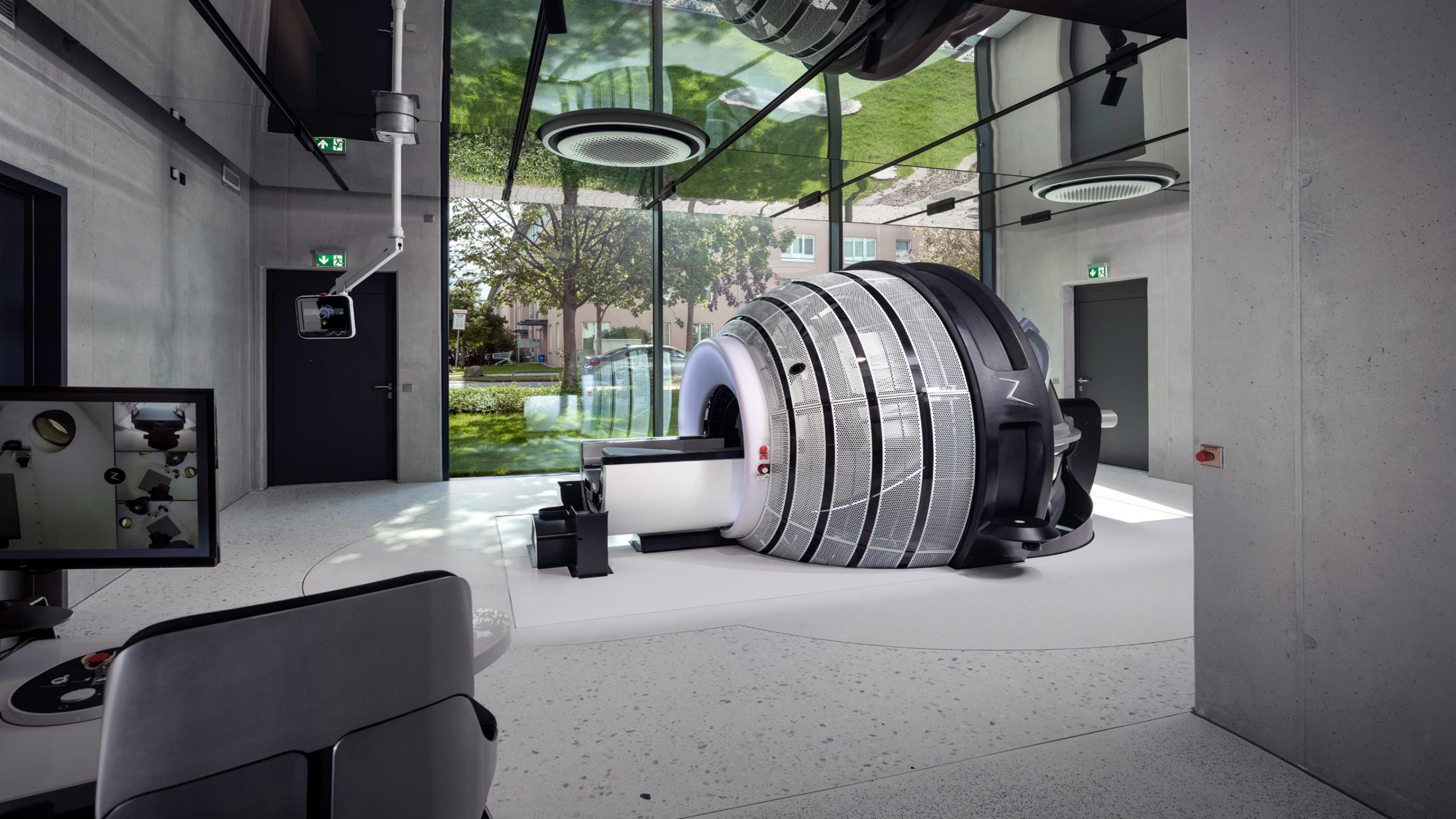
We defined cognitive deterioration as a drop of 1 SD in score from baseline. There are missing values for some cognitive tests, as reflected by total number of a particular test being less than the total number of patients. p values were calculated with Fisher's exact test. WBRT=whole brain radiotherapy. SRS=stereotactic radiosurgery. HVLT-R=Hopkins Verbal Learning Test-Revised. TMT-A=Trail Making Test part A. TMT-B=Trail Making Test part B. COWAT=Controlled Oral Word Association Test.

Table 2: Cognitive deterioration at 6 months

Lancet Oncol 2017; 18: 1010-20



**THIS IS NEXT THE GENERATION.**  
ZAP-X GYROSCOPIC RADIOSURGERY.

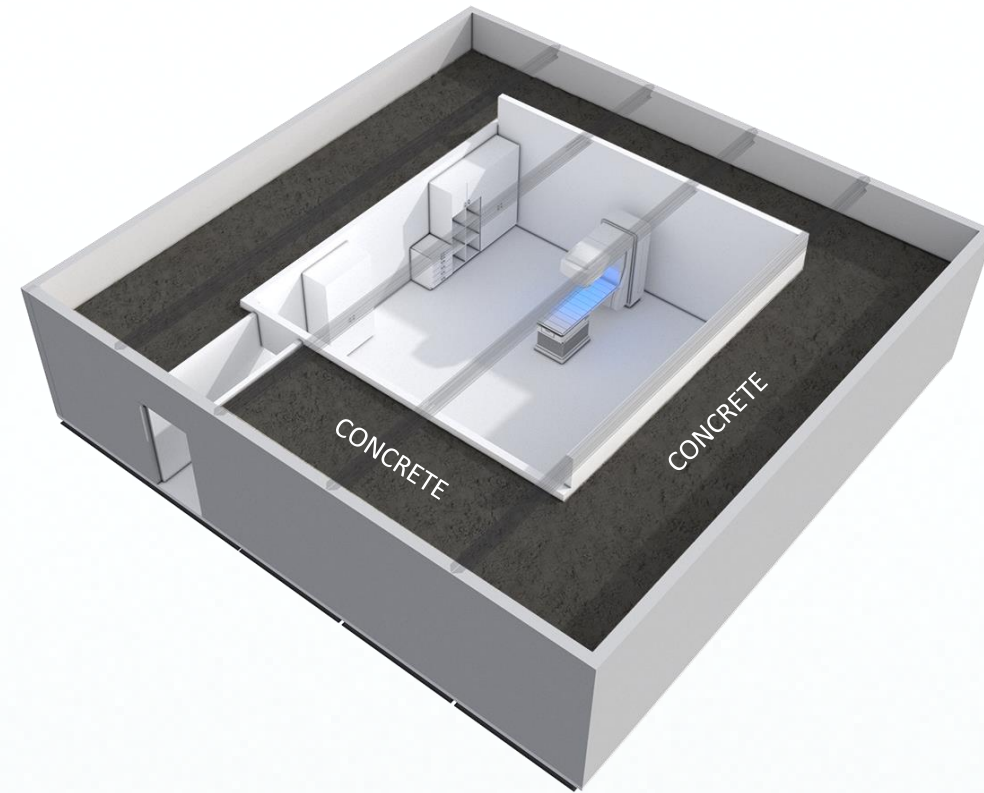


— Radiation Shielding



**ZAP-X**

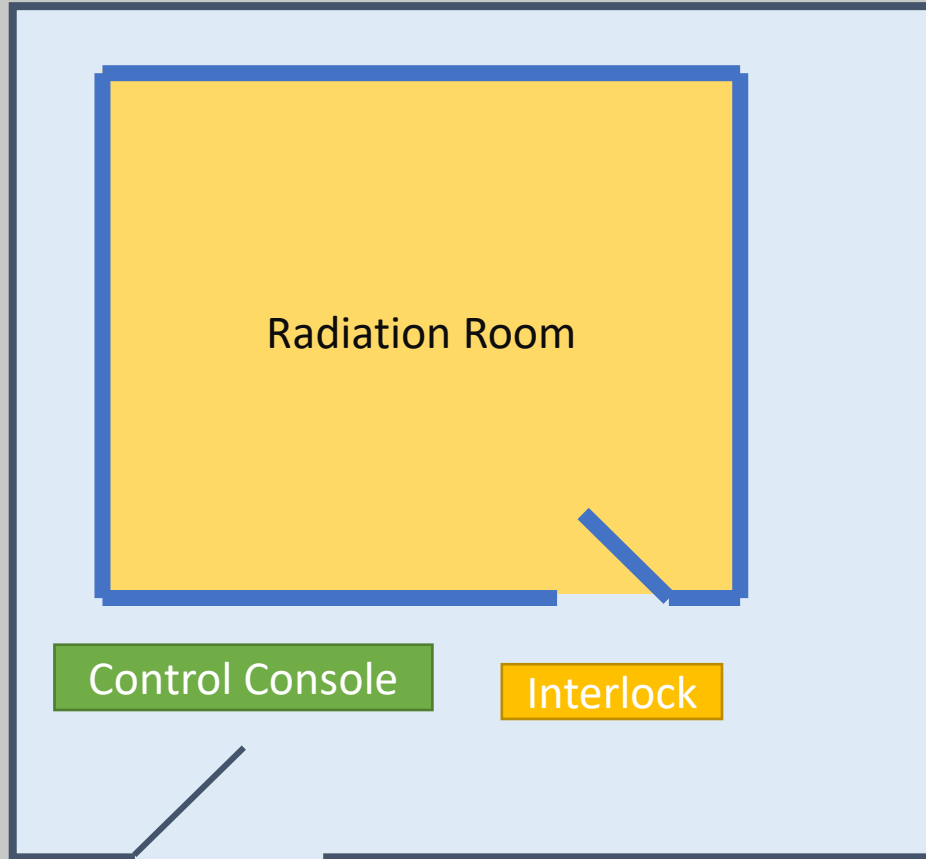
The first and only vault-free SRS delivery system, eliminating £££+ in infrastructure. In addition to allowing for simple department expansions, makes access to new satellite and outpatient settings feasible, while reaching new and underserved patient populations.



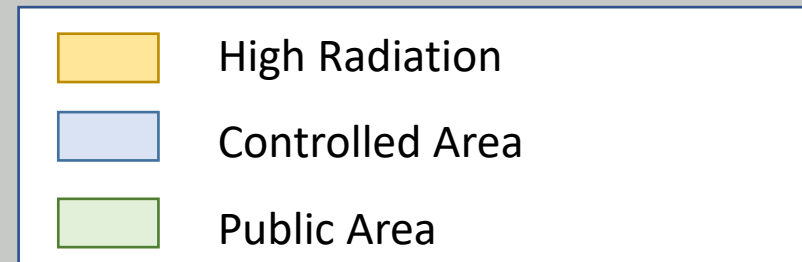
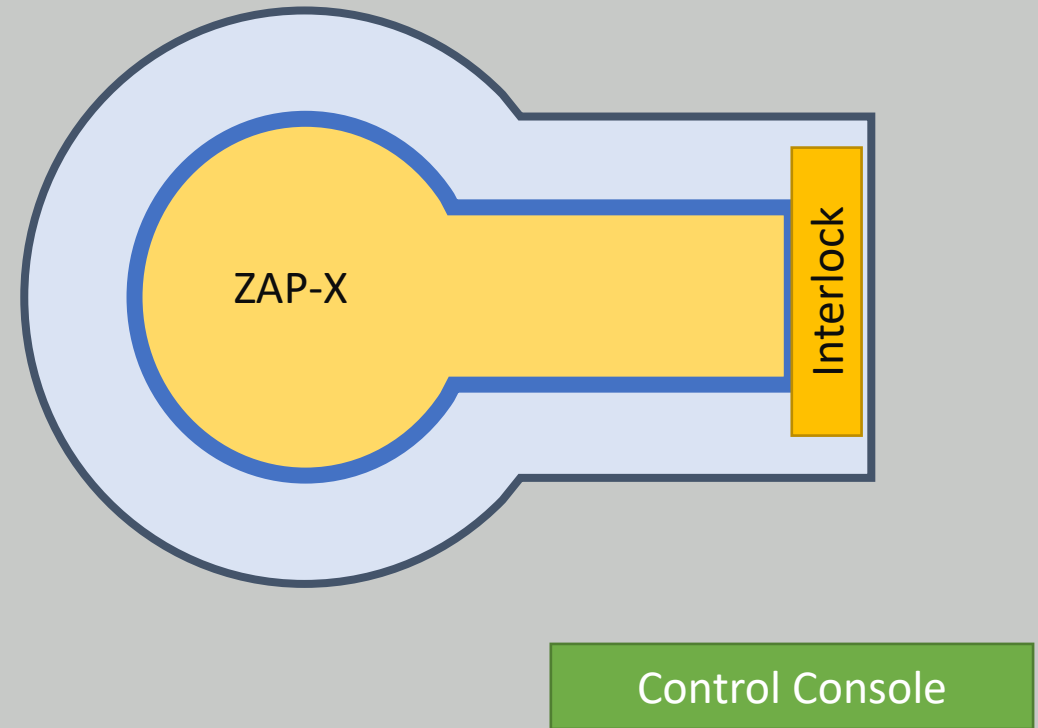
**Multi-Purpose Gantry LINAC**

Requires costly shielded radiation vaults in all instances. Comprised of >3M lbs. of high-density concrete and steel with a carbon footprint equivalent to the lifetime of ~300 automobiles.

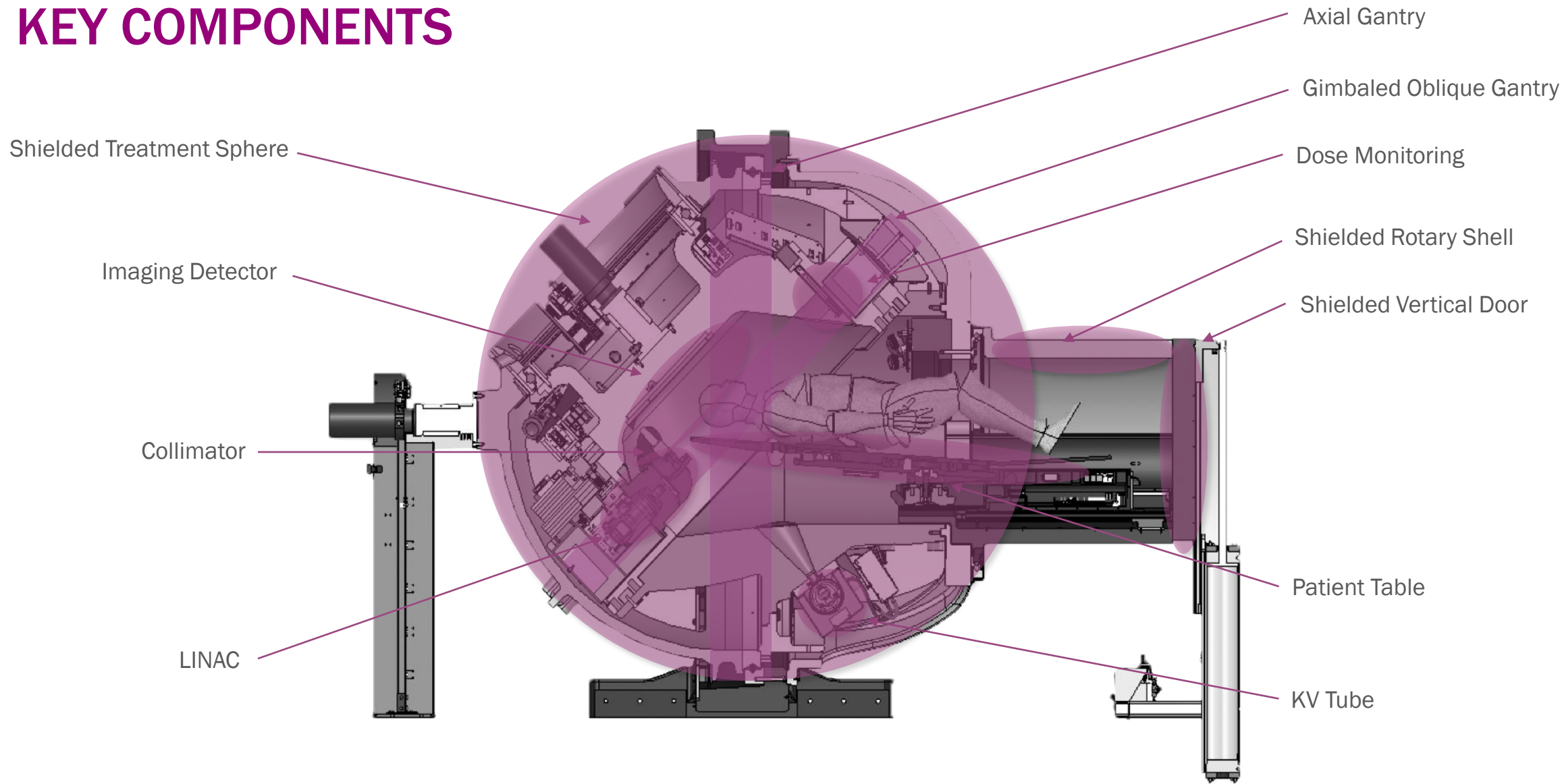
# Typical Treatment Vault



# Integrated System Shielding



# KEY COMPONENTS



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# NHS RTTQA PROGRAM

- Report commissioned by the UK's NHS
- Objective:
  - Understand significant variations in outcomes across 21 hospitals
- Methodology:
  - Based on 6 benchmark cases, each site evaluated for contouring, planning and treatment delivery quality
- The largest device comparison study ever



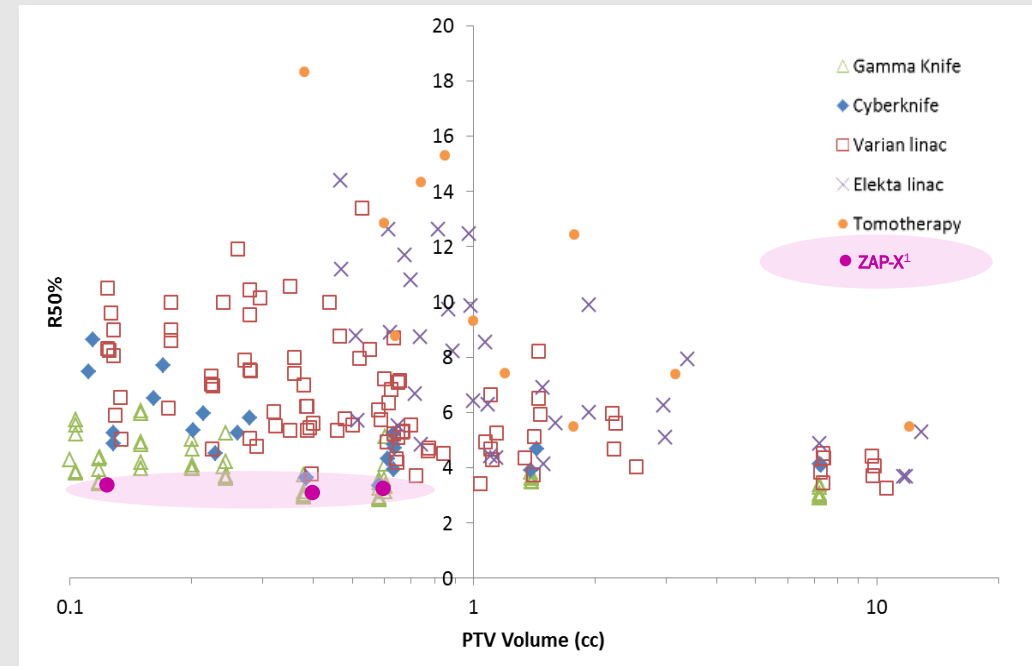




## CASE #2

### – The $R_{50\%}$

- Combines selectivity (absence of dose spillage) with gradient
- $\frac{\text{Volume of 50\% of prescription dose}}{\text{Volume of target}}$



ZAP-X Gyroscopic Radiosurgery

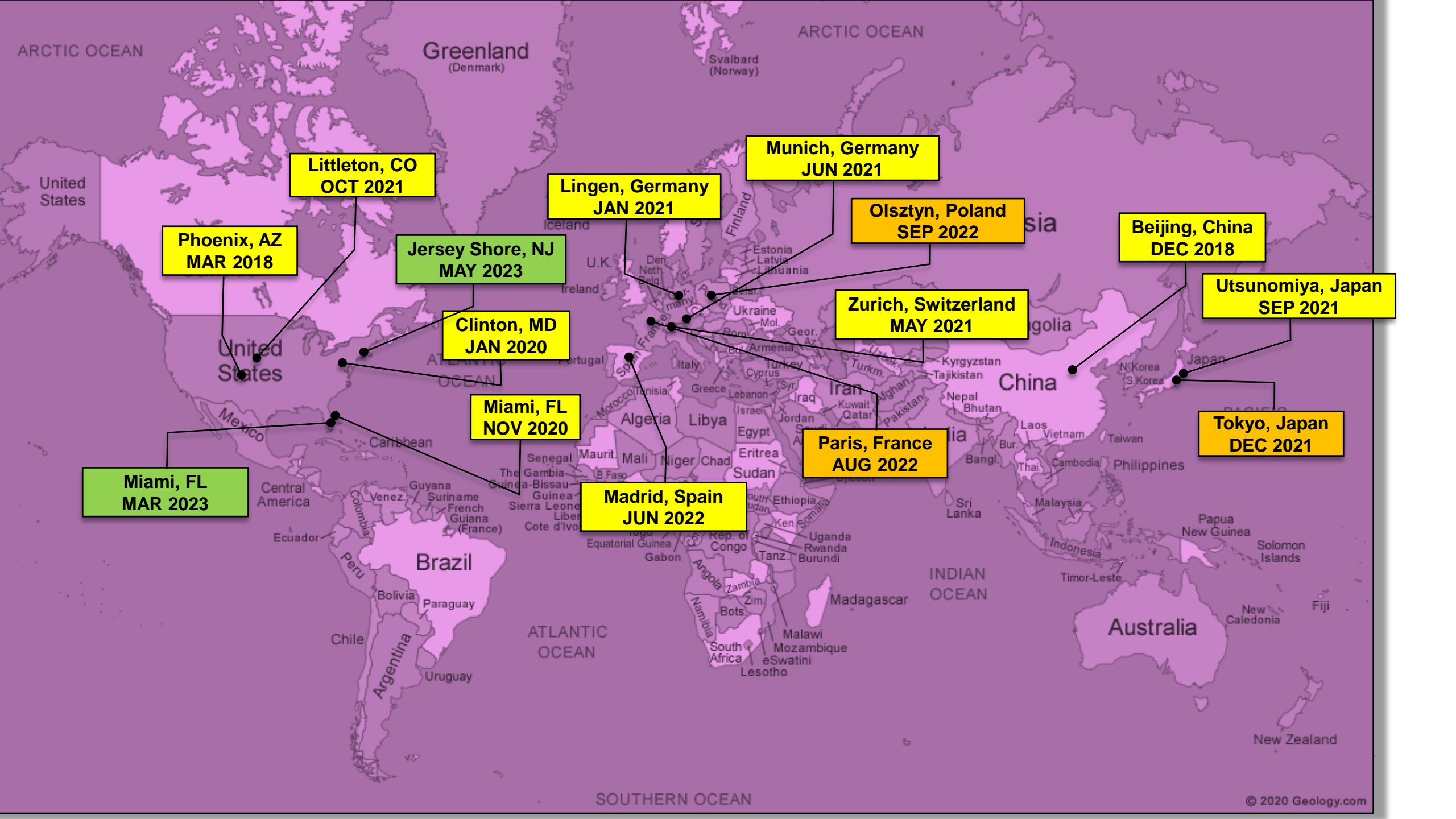
Who are we and where are first users around the world.

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# ZAP SURGICAL SYSTEMS, INC.

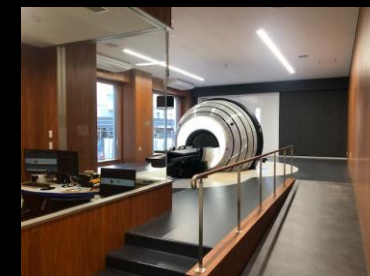
- **Founded in 2014 by John Adler, MD**
  - Professor of Neurosurgery, Stanford University
  - Inventor of the CyberKnife®
  - Former CMO of Varian
- **Funded by Varian, Foxconn, and others**
- **Headquartered in Silicon Valley, CA**





**12 sites treating  
(15 soon)**

**+1420 fractions  
treated**



ZAP-X designed from concept to bridge the gap between today's shortfall of patients and tomorrow increasing need.

THANK YOU and Questions