A Reconstructive Surgeon with Life-Changing Solutions
3 Telehealth Visits Channel Care Directly to Patients at Home

Recovering from a procedure or surgery takes time and often requires post-operative appointments. Yale Urology offers a new program that can save our patients time and discomfort: The opportunity to meet with a physician from the comfort of your own home or office using your smart phone, tablet, or computer.

4 A Reconstructive Surgeon with Life-Changing Solutions

As the only male genitourinary reconstructive surgeon in Connecticut, Jaime Cavallo, MD, MPH, considers it a privilege to help men regain their confidence and quality of life. Repairing debilitating genitourinary disorders, whether urinary or sexual, requires elite skill but also, open communication with the patient and often their partner.

7 The Discoveries are Big, but the Applications are Nuanced

A leader in drug development and a major player in identifying new chemotherapy agents that are getting better results for patients with prostate, bladder, and other cancers, Dr. Daniel Petrylak is often the person surgeons and other oncologists turn to discuss cases. His expertise in the field has helped countless patients, mentored trainees, and he is continually pushing to develop new treatments.

10 A New Solution for BPH

Typically, men with extremely enlarged prostates have limited, often morbid, options for treatment. Now, Yale New Haven Hospital is the first medical center in Connecticut to offer a minimally invasive procedure known as HoLEP, bringing men relief with faster recovery time.

12 Using AI to Make Prostate Biopsies More Accurate

John Onofrey, PhD, is on the vanguard of a new kind of precision medicine: Using machine learning to make up for the limitations of imaging technology and improve cancer detection. He says this kind of work gets to the heart of personalized, precision medicine.

14 Turning Ideas into Action: The Urology Advisory Group

A former patient and now chairman of the Urology Advisory Group, Michael Silverberg leads the efforts to support the Yale Urology’s strategic and philanthropic goals, as well as raising funds for unfunded urology missions.

17 Yale Urology Faculty and Clinicians
“While we continue to refine and expand our goals, our commitment to patient-centric, innovative care remains steadfast.”

— Peter S. Schulam, MD, PhD

2019 was filled with opportunity and growth across our clinical practices and throughout the Yale Department of Urology. We continued to expand our footprint into new communities across Connecticut and into Rhode Island; we welcomed six new faculty, adding to our already highly-respected member of the department who provided faculty with numerous opportunities and we are so grateful for their involvement now and for the future.

While we continue to refine and expand our goals, our commitment to patient-centric, innovative care remains steadfast. I hope you enjoy this issue of Urology at Yale and look forward to sharing our new advances and breakthroughs in the year to come.

Most sincerely,

Peter G. Schulam, MD, PhD
Chair, Department of Urology
Yale School of Medicine
Chief of Urology
Yale New Haven Hospital

Telehealth Visits Channel Care Directly to Patients at Home

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When Yale Urology launched its telehealth service early in 2019, it joined an institution-wide implementation across Yale Medicine to provide patients with easier, faster access to healthcare. “We felt it was very important for us to offer this service to our patients,” said Patrick Kenney, MD, Clinical Vice Chair, Department of Urology. Dr. Kenney spearheaded the launch with urologist Marianne Passarelli, MD, the physician lead. “Our goals were to not only address the patient experience, but to be able to provide truly outstanding care in an efficient way that decreases the barriers that can exist between patients and their providers.”

Telehealth offers multiple benefits for patients—starting with a tremendous time and cost savings. “We share our patients’ concerns about the total cost of care, including missed days from work and travel time,” Dr. Kenney said. “It’s incorporated within existing workflows. The patient has a defined visit time and we see them just as we would if they were coming to the office.”

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Jaime Cavallo, MD, MPH

“Genitourinary reconstructive surgery can offer hope to men when other treatments fail. Obstructive voiding, urinary incontinence, or sexual dysfunction can resist behavioral and pharmaceutical therapies, and yet, fellowship-trained surgeons who can manage these complex cases are uncommon. With the arrival of Dr. Jaime Cavallo to Yale Urology, a fellowship-trained surgeon from the Lahey Clinic and the only male genitourinary reconstructive surgeon in Connecticut, her skill promises to be life-changing for patients. “The ability to make a very dramatic improvement in a patient’s quality of life” is why Dr. Cavallo chose genitourinary reconstructive surgery. “There are many aspects of these genitourinary disorders, whether they be urinary or sexual or both, that can be debilitating and even embarrassing to the patient. And so, for me, it’s a privilege to discuss these very personal issues with patients, address their concerns, and offer them potentially life-changing solutions.”

Men, and sometimes their partners, usually have many questions and concerns when they inquire about reconstructive surgery. The types of urologic disorders

“It’s a privilege to discuss these very personal issues with patients, address their concerns, and offer them potentially life-changing solutions.”

Jaime Cavallo, MD, MPH

A Reconstructive Surgeon with Life-Changing Solutions
Dr. Cavallo treats include urethral strictures, urinary incontinence, Peyronie’s disease, erectile dysfunction, and buried penis. Ultimately, Dr. Cavallo knows that for her elite skills to make a difference, she has to help her patients navigate their options.

“Patients with severe erectile dysfunction often feel embarrassed and disconnected from their partner. Their self-esteem declines. Some may not respond to pharmaceutical therapy and this can exacerbate how they feel,” she said. “It’s really gratifying to know that you can offer a patient a procedure that, for even the most refractory cases, can allow them to have erections again. In doing so, they can reestablish connections with their partner and their quality of life improves dramatically and fairly immediately.”

Among the specialized procedures Dr. Cavallo provides to patients is urethroplasty, a definitive treatment for urethral strictures. Urethral strictures are narrowings of the urethra from scar tissue that can make it difficult and painful to urinate. This scar tissue can be the result of prior interventions, inflammation, infection, injury, or other causes. The most common treatments are endoscopic procedures, such as urethral dilation and direct vision internal urethrotomy (DVIU), endoscopic procedures, such as urethral dilation and direct vision internal urethrotomy (DVIU), and patient-reported outcomes.

All of the surgeries that Dr. Cavallo performs address quality of life, something she would like to see tracked using validated instruments and recorded in electronic health records—both to improve individual clinical care and to support research endeavors. Using the quality of life data, she aims to analyze the comparative effectiveness and comparative cost of available therapies. For example, some patients with Peyronie’s disease, an acquired curvature of the penis, qualify for treatment with either an injectable pharmaceutical or surgery. To best inform patients about their therapeutic options, Dr. Cavallo believes that the treatments should be compared with respect to cost as well as effectiveness using both objective measurements and patient-reported outcomes. Only then can treatment options be placed in the context of a patient’s personal goals of care.

When Dr. Daniel Petrylak graduated from medical school in 1985, there was little to offer in the way of chemotherapy to patients with genitourinary cancers. “For bladder cancer, there was no effective treatment,” he recalled. Likewise, oncologists struggled to find treatments that were effective against prostate cancer. Three years later, as a fellow at Memorial Sloan Kettering Cancer Center, it was Dr. Alan Yagoda, acclaimed oncolgist and researcher, who steered his mentor, Dr. Petrylak, towards research in prostate cancer. His influence made a career in medical oncology with a focus on genitourinary cancers particularly appealing.

“You work in areas where there’s a need, and that’s one of the reasons why I chose prostate cancer initially,” he said. “The population is aging, and there weren’t a lot of effective treatments. The need for research and advances was really apparent.”

Years later, in 2012, Dr. Petrylak brought his expertise in genitourinary (GU) cancers to Yale. He is a leader in drug development and has played a major role in identifying new chemotherapy agents that are getting better results for patients with prostate, bladder, and other cancers. His wide-ranging role at Yale as Professor of Urology and of Medicine and co-director of the Cancer Signaling Networks Research Program at Yale Cancer Center, allows for the opportunity to pursue research with the hope and excitement of new discoveries and new cures. One of the most important meetings of the week for Dr. Petrylak is when the Genitourinary Tumor Board convenes, a multiphysician group of physicians who work together to develop care plans for complex patient cases. He views a multidisciplinary approach to GU malignancies as critical to personalized patient care, but the consultations do not end then.

Dr. Petrylak’s patient schedule is frequently comprised of international patients from across Europe and the Middle East who fly to the U.S. for a consultation. His international role in

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We always start with the patients expressing what their concerns are and then I have the opportunity to educate them about what we’re capable of achieving together. — Dr. June Cavallo

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Daniel Petrylak, MD

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THE DISCOVERIES ARE BIG

but the applications are nuanced
cancer research has him traveling around the world to confer with colleagues and addressing symposia. As a result, the international exposure he has gained has also expanded his portfolio of patients, each of whom is seeking his experience and advice.

In addition to making big discoveries, Dr. Petrylak is especially adept at discerning small differences between patients’ diagnoses and then working with other physicians to chart optimal courses of treatment. “Even though there are clinical practice guidelines, interpreting them, especially in complex cases, involves a lot of thoughtfulness, a lot of expertise,” said Dr. Michael Leapman, a Yale Urology surgeon. He described a recent patient with bladder cancer. “Because this patient was not able to receive conventional chemotherapy after surgery, Dr. Petrylak was able to enroll him on a clinical trial of a promising drug that may reduce his risk of cancer recurrence,” he said. Surgeons throughout the department share similar stories of Dr. Petrylak making a decision that was not initially obvious, but was ultimately more beneficial for a patient. Those good outcomes are exactly what Dr. Petrylak was looking for when he began his career. “It’s rewarding to see people who had a poor prognosis just a few years ago live longer,” he said.

Dr. Petrylak has access to clinical trials, led by himself or by colleagues, that may be an appropriate option for patients when conventional therapies are failing. “They do offer hope,” said Dr. John Colberg, a surgeon who specializes in prostate and bladder cancers. Dr. Colberg sends his patients to Dr. Petrylak for a consultation. Even if there isn’t a current trial, new studies tend to emerge in a matter of months providing patients with more possibilities. “Dr. Petrylak is so well-connected in the research world that he will always know of relevant trials,” Dr. Colberg said.

“In the evenings, back in the office, the faculty are all talking to Dan,” said Dr. Peter Schulam, Chair of Urology. “Some colleagues are seeking mentorship on research projects; others, on clinical cases.”

Being a resource to his colleagues at Yale while conducting national and international research collaborations takes a great deal of flexibility. “Fortunately, his phone works everywhere,” said Dr. Schulam. He spoke about testing Dr. Petrylak on a Friday, when he was just arriving in Calgary for the Annual Global Summit on Genitourinary Malignancies. They spoke and emailed over the weekend about two cases and met the following Monday at the Tumor Board. “He didn’t miss a beat,” said Dr. Schulam. “Really what surgeons want is the same thing that patients want—accessibility.”

The collaboration between medical oncologists like Dr. Petrylak and surgeons is part of a larger story that shapes the care patients with genitourinary cancers at Smilow Cancer Hospital receive. “If you’re looking for great care, you’re looking for a team, not an individual,” Dr. Schulam explained. Urologists, radiologists, interventional radiologists, pathologists, medical oncologists, and surgeons must all be outstanding if patients are going to receive top-notch care. He noted that Dr. Peter Humphrey, Director of Genitourinary Pathology at Yale, is one of the foremost diagnosticians in the world. “We are all as good as the information that we have to work with,” Dr. Schulam said.

Dr. Petrylak agrees. He believes that advanced diagnostics are the key to better outcomes in genitourinary cancers. “I think that all patients will soon have their tumors profiled molecularly, and once that’s done we can select the appropriate treatment. I think that’s where the future’s going to be,” he said.

Though his colleagues valorize his mentorship and collaboration, his proudest moment as a researcher came from being extremely independent. He believed that doctoral had the potential to help men with metastatic prostate cancer. “That was a concept nobody wanted to touch,” he recalled. The manufacturer did not share his enthusiasm and declined to fund a study. So, Dr. Petrylak pieced together funding from other sources and went forward. “I was confident because of what I was seeing in the laboratory,” he said, adding with a laugh: “I know how to pick ’em.” The drug showed a survival benefit and now has FDA approval as a prostate cancer treatment.

A certain boldness pays off. “It’s important that ideas move forward, but there are also a lot of failures. It’s difficult to predict what’s going to happen,” he said. But he added that even when patients do not respond, there is still much to learn. “The important thing is to figure out why,” he said.

Dr. Roy Herbst, Chief of Medical Oncology at Yale Cancer Center and Smilow Cancer Hospital, along with Dr. Schulam, recruited Dr. Petrylak to Yale with a vision toward making it a center for world-class research and clinical care in genitourinary cancers. Dr. Petrylak’s skill and reputation as an international leader in his field is helping to bring even more clinical and research capacity to Yale, said Dr. Herbst. Junior medical oncologists are working closely with Dr. Petrylak and developing their own programs of research with his mentorship. “It raises their game. They are working with a luminary in the field, and he certainly is that,” said Dr. Herbst.

Dr. Petrylak is “a wise voice on clinical research even outside his area,” Dr. Herbst noted. He consults with colleagues about everything from regulatory issues to managing patients in large trials.

For Dr. Petrylak, discovering treatments is an ongoing passion. Targeted therapy and immunotherapy options for genitourinary cancers need to continue to increase so that patients who do not respond to current drugs have more options. “It gives people hope,” he said.
When it comes to treatment of the prostate, most patients typically want to avoid invasive procedures. But when Daniel Kellner, MD, Assistant Professor of Clinical Urology at Yale School of Medicine told Max Sabrin that he would undergo HoLEP (Holmium laser enucleation of the prostate), a promising newer technique for treating benign prostatic hyperplasia (BPH), Sabrin, 66, was more than game.

“For a decade, I’d been getting up to urinate two to three times a night, three times a night, then, as the years passed, five times a night. I was becoming a zombie,” Mr. Sabrin, who lives with his wife in Old Saybrook, Connecticut, said.

Though he tried alpha blockers, which are the standard medication for BPH, he didn’t like the side effects; they gave him headaches and made him feel congested and tired. “I even tried herbal supplements. Maybe they help some people, but for me, it was just wishful thinking.”

The fact that medication had not worked well for Mr. Sabrin doesn’t surprise Dr. Kellner. “Medical treatment for BPH fails a large proportion of patients,” he explained. “Yet getting treatment for BPH can be crucial, despite the fact that the condition is considered benign. Besides causing frequent urination, irregular or weak flow, and other disruptive symptoms over time, BPH can also result in bladder damage. That was the case for Mr. Sabrin. After looking at MRI scans of his prostate, Dr. Kellner told him that his bladder was being damaged—perhaps irreversibly—because it was not emptying fully. Mr. Sabrin said, ‘For me, that was the point of no return.’

Typically, a normal prostate is about the size of a walnut, weighing about 20 grams. But with BPH, the prostate can get so big as a grapefruit and weigh as much as 300 to 500 grams, choking off the urethra, “like a bagel stuffed with dough in the middle,” so the urine cannot flow normally, said Dr. Kellner. Despite its prevalence—BPH affects 50 percent of men between the ages of 51 and 60 and up to 90 percent of men older than 80—many of the current minimally invasive procedures available to treat the condition don’t work well for men with very large prostates, including the most common, so-called gold standard surgical treatment for the condition, known as TURP (for transurethral resection of the prostate). “With TURP and other procedures, you are limited as to how big a prostate you can operate on,” said Dr. Kellner. “For one thing, there can be a lot of bleeding during the TURP scraping procedure. Second, as the body absorbs all that fluid, the patient’s salt level can drop,” he explained. The bottom line: “It’s very difficult to cut away adequate tissue when you’re dealing with a very large prostate.”

There are other ways to surgically treat BPH, including open surgery, a prostatectomy. “But that’s also a very complicated procedure, and it often means spending five days or so in the hospital,” said Dr. Kellner. Instead, Dr. Kellner recommended that Mr. Sabrin choose a newer minimally invasive procedure known as HoLEP. How it works: A surgical laser is inserted through the urethra and used to remove the excess prostate tissue in a process Dr. Kellner likens to ‘peeling an orange from the inside,’ then working the tissue up and into the bladder. “This creates a generous opening, and during the process it’s easy for the surgeon to see the blood vessels and to coagulate the largest ones with the laser. That makes for a lot less bleeding—it’s a different level of control,” he explained. Next, a second instrument, known as a morcellator, cuts the tissue into smaller fragments and removes them from the bladder.

“The advantage with HoLEP is that you can treat any size prostate, with no incisions, less bleeding, a shorter hospital stay, and better results,” said Dr. Kellner. “The excess tissue is also removed more completely than with TURP, which means there is less need for follow up treatment.” Indeed, while the retreatment rate for TURP is over 7 percent, “with HoLEP, it approaches zero,” said Dr. Kellner.

Yet, despite these advantages, surgeons in the U.S. have been slow to adopt HoLEP. “It has a steep learning curve,” explained Dr. Kellner. “Besides needing special equipment, it is a different technique than most surgeons are accustomed to, and it can be disorienting.” With TURP, surgeons can see certain landmarks with a camera which helps them check their position. In contrast, HoLEP requires the surgeon to adjust to a new orientation. “You need to be able to read the texture of the tissue—like being able to tell the orange peel from the pulp,” Dr. Kellner explained. “It takes time and dedication to get used to it.”

It didn’t faze Mr. Sabrin that this was a newer procedure to Yale. “Dr. Kellner was very matter of fact and reassuring,” said Mr. Sabrin. Indeed, Dr. Kellner trained with experts across the country, then brought the procedure to Yale New Haven Hospital, the only medical center in the state of Connecticut to offer it. “Now we are able to treat large prostates in a minimally-invasive way. We’re filling a void in terms of treatment options for men with enlarged prostates.”

Dr. Kellner performed HoLEP on Mr. Sabrin, who was released from the hospital the next day. Within two weeks or so, he was mostly back to normal, with few side effects. Best of all, six months after his surgery, Mr. Sabrin says he now gets up only once a night to urinate. “It have a clean bill of health and I’m sleeping well now,” he said. “It’s a whole new world for me.”
Using AI to Make Prostate Biopsies More Accurate

John Onofrey, PhD, is on the vanguard of a new kind of precision medicine: Using machine learning to make up for the limitations of imaging technology and improve cancer detection.

Prostate cancer is the second leading cause of cancer death in men in the U.S.—which means that when a malignancy is suspected, getting an accurate biopsy is crucial. Yet the standard method for urologists to biopsy for the disease is not as accurate as it could be. Typically, a urologist will use trans-rectal ultrasound (TRUS) imaging technology to guide the needle as they do the biopsy. “But with ultrasound imaging, cancerous lesions in the prostate don’t tend to show up well,” said John Onofrey, PhD, Assistant Professor of Urology and of Radiology and Biomedical Imaging. To make up for the limitations of the ultrasound image, a urologist will generally take 12 small biopsy samples along the prostate in a 4 X 3 grid. That may seem all-encompassing, but it accounts for less than 0.5% of the volume of the prostate, explained Dr. Onofrey. “Some researchers have likened this process to a game of chance in terms of whether this technique is actually going to be able to detect cancer in a clinically significant way.”

Blame the nature of human anatomy—and of the prostate. “It’s a squishy gland,” said Dr. Onofrey. An ultrasound, it looks different depending on how a patient moves, breathes or whether their rectum is filled with air or with stool. “That means the same features you see in an MRI show up looking completely different on an ultrasound—there’s not a one-to-one correspondence there,” said Dr. Onofrey. “Think of the prostate as a rubber ball that you can flatten out—the urologist is often left trying to align one image from the MRI machine with a totally different ‘deformed’ image from the ultrasound. Even though the images come from the same person, they look nothing alike.”

That’s where Dr. Onofrey’s research comes in. With the right algorithms, he and his post-doctoral advisor, Xenophon Papademetris, PhD, Professor of Radiology and Biomedical Imaging and Biomedical Engineering at Yale’s School of Engineering and Applied Science, surmised that it might be possible to predict those differences—and ignore them, taking them out of the equation altogether so the two images align. To that end, Dr. Onofrey developed an algorithm based on ultrasound data from the biopsies of more than 100 patients. “Our aim was to come up with a model that could withstand the errors in the ultrasound—that would be robust in spite of those errors.”

The model they came up with, known as a non-rigid ‘deformation model,’ acts as a template prostate, one that serves as a kind of atlas “of how the prostate changes shape between the MRI image and the ultrasound without worrying about someone’s prostate actually changing shape,” he shared. In a 2017 NIH-funded study published in the journal Medical Image Analysis, Drs. Onofrey and Papademetris, along with their co-authors, found that this model was “significantly robust to increasing levels of noise”—meaning that it was able to set aside inaccuracies in the image due to the ever-changing shape of the prostate gland.

More recently, in a 2019 pilot study with 20 patients at Yale and 20 patients at Stanford University, Dr. Onofrey tested his model in the clinic, alongside men undergoing prostate biopsies. For this, Dr. Onofrey collaborated with Preston Sprenkle, MD, Associate Professor of Urology, who performs image-guided biopsies weekly at Yale. “To our knowledge, it’s the first time anyone has been able to test an algorithm right in the clinic,” he said. The advantage is that urologists can see, in real time, if what they come up with manually matches the model.

This model benefits patients by helping to ensure that urologists take their biopsy samples from the correct sections of the prostate gland, rather than a game-of-chance approach. During the pilot study, when Dr. Onofrey’s computer-generated model and the fusion model were in agreement as to the likely location of a lesion, “the urologist felt very comfortable sampling that area,” he said. And when the two methods yielded widely different results? “That’s when the urologist could conceivably sample a wider area.”

Dr. Onofrey eventually hopes to use the data from hundreds and even thousands of prostate images to improve the accuracy of his model—and to expand its use. “There’s real power in using machine learning and artificial intelligence not to replace human beings, but to help them make more accurate decisions.”

For the time being, however, his goal is narrower, though just as significant: “To marshal the resources of Yale and all its expertise in machine learning and image processing to improve our ability to diagnose prostate cancer.”
Turning Ideas into Action: The Urology Advisory Group

“The What ifs?” are one of the most exciting and powerful questions in medicine. It opens minds and open doors to new opportunities, new approaches, and new treatments to benefit patients.

Over the past six years, the Urology Advisory Group has been assisting Yale Urology in transforming the “What ifs?” questions into action plans by supporting its strategic and philanthropic goals and raising funds for unfunded urology missions. The group’s efforts—under the leadership of chairman Michael Silverberg—have enabled Yale urologists to share their expertise with underserved patients in the New Haven community and as far afield as Uganda.

“When we started the group in December 2013, we wanted to accomplish two goals,” said Mr. Silverberg, a patient of Yale Urology and an insurance advisor in West Hartford, Connecticut.

“We wanted to get the name of Yale Urology out into the community so that people know that Yale is a place to get care equal to or better than what they’d find in Boston or New York. And we wanted to raise money for situations where current Yale funding is not available. I think we’ve done a pretty good job at both.”

When Mr. Silverberg was diagnosed with an aggressive form of prostate cancer in spring 2013, there was no doubt in his mind where he would seek treatment. He has had a lifelong fondness for Yale. “I was born at Grace New Haven Hospital, where Smilow Cancer Hospital is today,” he said. “It was natural for me to go to Yale.”

Nostalgia aside, Mr. Silverberg knew he’d be in skilled hands at Yale. He and his wife, Gale, had contributed to the building fund for Smilow Cancer Hospital and knew of Yale’s vast resources for cancer care. Through his involvement with the Yale Cancer Center Director’s Advisory Board, he heard a presentation by Peter Schulam, MD, PhD, and was thoroughly impressed by Dr. Schulam’s expertise.

“When I told my daughter in Ohio that I was diagnosed with prostate cancer and getting treatment at Yale, a urologist acquaintance of hers said, ‘Wow, how did Mike connect with Dr. Schulam?’” he recalled. “I knew I was fortunate to be dealing with a nationally renowned prostate and urological surgeon.”

Under Dr. Schulam’s leadership, Yale Urology has expanded from eight to more than 30 physicians at the forefront of their field. Mr. Silverberg benefitted from the team’s advanced skills. Preston Spreenkle, MD, a pioneer in advanced imaging techniques, conducted his MRI-guided biopsy. Mr. Silverberg underwent surgery with Dr. Schulam, an expert in minimally invasive surgery. After a course of radiation, trace amounts of cancer remain in his blood. As a result, he continues on hormone treatment and closely monitors his PSA levels under the watchful eye of Daniel Petrylak, MD, a leader in the research and development of new drugs and treatments to fight urological cancers. “My care has been exceptional,” Mr. Silverberg said. “Every person I have encountered has been friendly, efficient, and caring.”

Mr. Silverberg’s gratitude for his care at Yale made it an easy “yes” when he was asked by Dick Capobianco to help launch the Urology Advisory Group in late 2013. “The group’s efforts—under the leadership of chairman Michael Silverberg—have enabled Yale urologists to share their expertise with underserved patients in the New Haven community and as far afield as Uganda. Twice per year, a Yale Urology faculty member and urology resident provide hands-on training in urological surgery to physicians in vastly under-resourced areas. The team also brings needed medical supplies. “The stories the urologists have brought back from Uganda have been unbelievable,” Mr. Silverberg said. “The types of tumors they see are staggering, but it’s what these people learn to live with because they don’t have urological care available to them.”

That outlook is now changing, thanks in large part to the support of the Urology Advisory Group. “It is a distinct pleasure working with Mike and everyone on the Urology Advisory Group,” said Dr. Schulam. “They are engaged and enthusiastic about our work and we are grateful for their support of the efforts of the physicians, researchers and staff of the Yale Urology.”

Mr. Silverberg always looks forward to hearing the next “What if?” question that Dr. Schulam might present at the upcoming Urology Advisory Group meeting. “Our members are a wonderful group of very generous, committed people who are very loyal to Yale Urology,” Mr. Silverberg said. “We want to help, not just by giving money but by giving our support in ways that will bring people to Yale Urology’s doors.”