



Tile-Based Radiation Therapy: A New Approach to Tumor Control

Reconsidering timing and delivery in operable brain tumors

Indication

GammaTile® is authorized for commercial distribution in the United States as a treatment for patients with newly diagnosed malignant intracranial neoplasms and patients with recurrent intracranial neoplasms.



Brain metastases: A multidisciplinary challenge

The Clinical Challenge

30%

Up to 30% of patients with cancer develop brain metastases¹



Brain metastases negatively impact function, survival, and systemic therapy



Treatment requires coordinated care: neurosurgery, radiation oncology, and medical oncology

Current SOC (Operable)



Surgical resection + SRT: the established, evidence-based standard of care



Published 12-month local control: 61–85%²⁻⁷



Supported by RCT: post-op SRT vs. resection + WBRT and post-op SRT vs. resection only^{3,4}

1. Aizer AA, et al. *Neuro Oncol.* 24:1613-1646 (2022). 2. Patchell RA, et al. *N Engl J Med.* 322:494-500 (1990). 3. Brown PD, et al. *Lancet Oncol.* 18:1049-1060 (2017). 4. Mahajan A, et al. *Lancet Oncol.* 18:1040-1048 (2017). 5. Kocher M, et al. *J Clin Oncol.* 29:134-141 (2011). 6. Eitz KA, et al. *JAMA Oncol.* 6:1901-1909 (2020). 7. Lehrer EJ, et al. *Int J Radiat Oncol Biol Phys.* 103:618-630 (2019).

Expanding options for care

Opportunities for Optimization

- Time between resection and SRT initiation is a recognized clinical challenge due to recovery, planning and access to care, leading to worse outcomes^{1,2}
- Target delineation and cavity dynamics add complexity to post-operative planning³⁻⁵
- 12-month local control for tumors >3 cm: ~44%⁶

Introducing ROADS Phase 3 RCT⁸



Multi-site RCT with independent central radiology review



Prior to ROADS, no randomized trial had improved local control of resected brain metastases since 2017⁶⁻⁸

Cs-131 tile-based radiation therapy offers a new immediate option designed to address these challenges at the time of surgery

1. O'Brien DAR, et al. *J Neurosurg.* 135:1695-1705 (2021). 2. Brennan C, et al. *Int J Radiat Oncol Biol Phys.* 88:130-136 (2014). 3. Shi S, et al. *Pract Radiat Oncol.* 10:e363-371 (2020). 4. Soliman H, et al. *Int J Radiat Oncol Biol Phys.* 100:436-442 (2018). 5. Jarvis LA, et al. *Int J Radiat Oncol Biol Phys.* 84:943-948 (2012). 6. Mahajan A, et al. *Lancet Oncol.* 18:1040-1048 (2017). 7. Brown PD, et al. *Lancet Oncol.* 18:1049-1060 (2017). 8. Weinberg JS, Imber BS, DiNapoli V, et al. *J Clin Oncol.* (2026). DOI: 10.1200/JCO-26-01894.

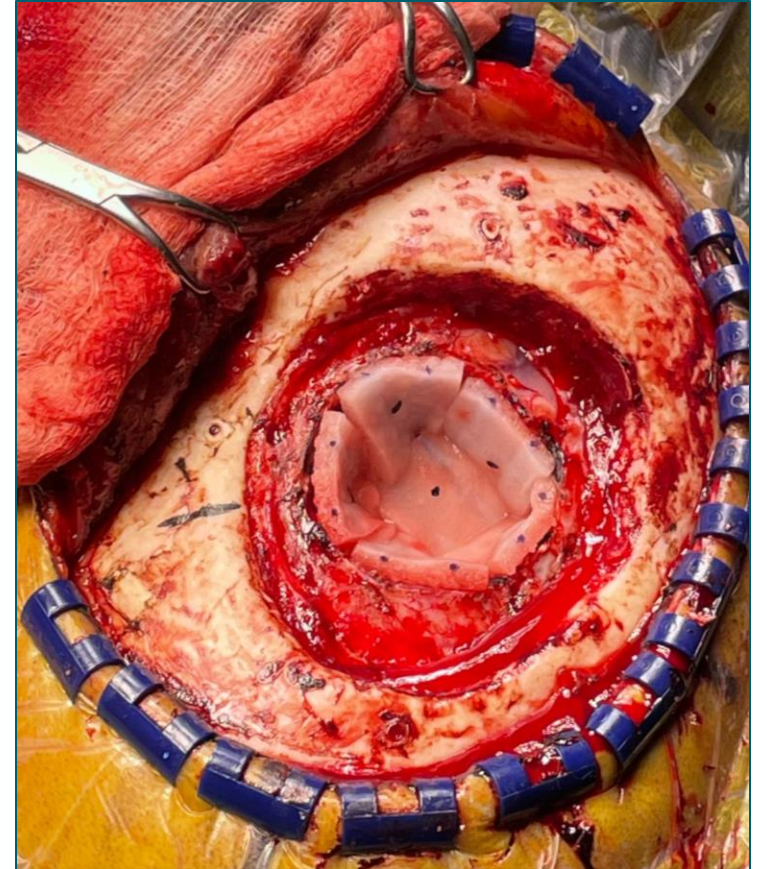
How GammaTile works

Mechanism of delivery

- Implantable radiation sources placed directly in the resection cavity
- Guaranteed immediate initiation of the prescribed dose at the time of surgery
- Localized, dose-escalated radiation delivered to the surgical margin with controlled dose distribution¹

Treatment implication

- Eliminates the interval between surgery and radiation initiation
- Reduces dependence on post-op recovery and adherence

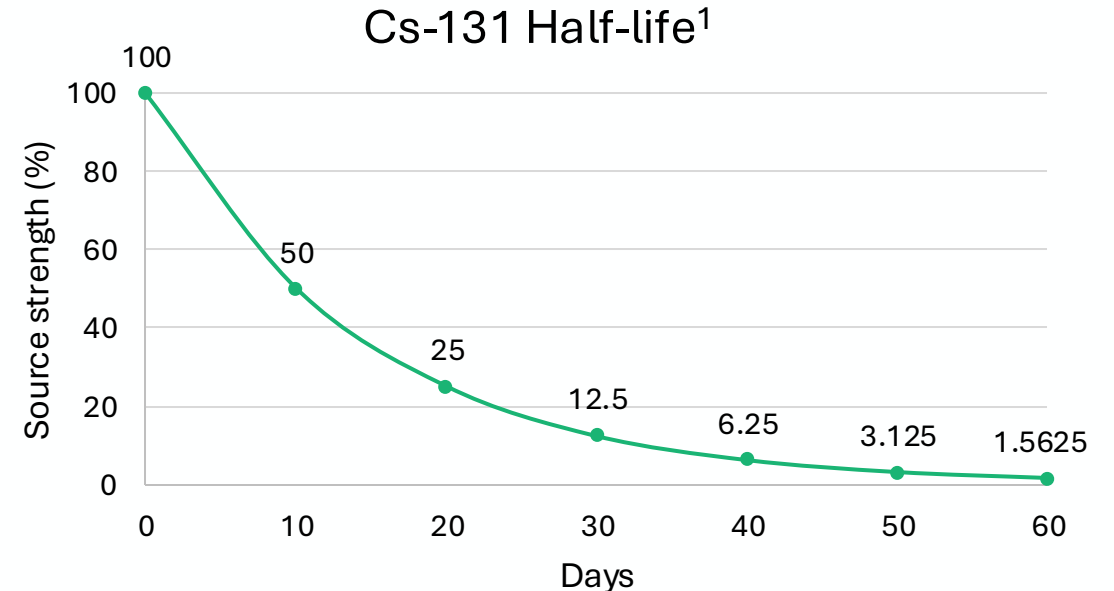
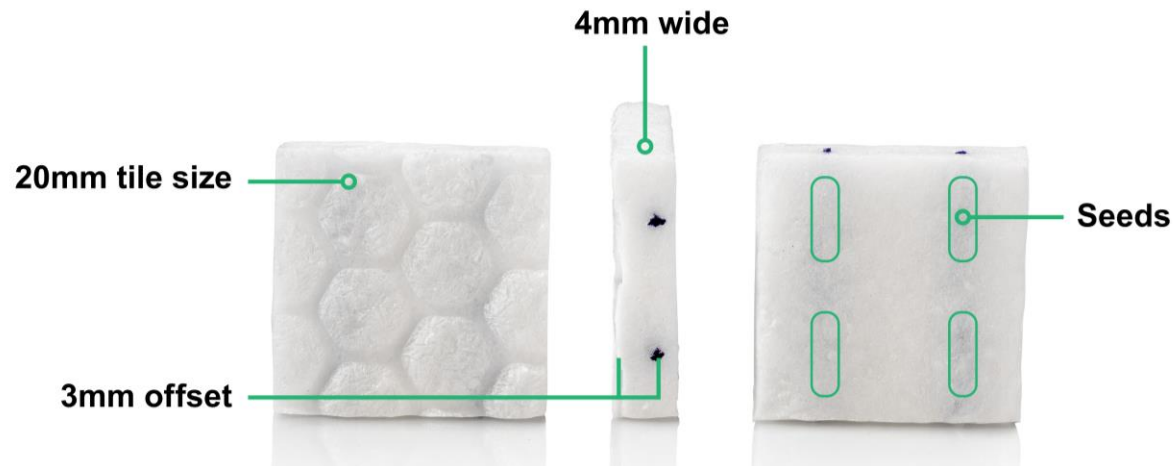


1. Kutuk T, et al. *Brachytherapy*. 23(6):751-760 (2024).

Design features enabling safe tile-based radiation delivery

Tile-based radiation therapy delivery^{1,2}

- Delivered in a standard operating room, no dedicated radiation treatment room required
- Cesium-131 radiation sources (half-life of 9.7 days) embedded in a bioresorbable collagen matrix
- Conforms to the resection cavity for margin-focused dose delivery
- Fixed source strength (3.5 U/seed) and predictable source spacing enable consistent dose distribution
- 0% reported reoperation for radionecrosis across peer-reviewed publications



1. Kutuk T, et al. *Brachytherapy and Radiation Principles in Clinical Practice*. 48:795-820 (2024). 2. Brachman DG, et al. *J Neurosurg*. 131(6):1819-1828 (2018).

ROADS Full 230-Patient Analysis

Surgery and tile-based radiation therapy versus surgery and stereotactic radiation for newly diagnosed brain metastases (ROADS): a randomized, open-label, phase 3 trial

Now Published in the *Journal of Clinical Oncology*

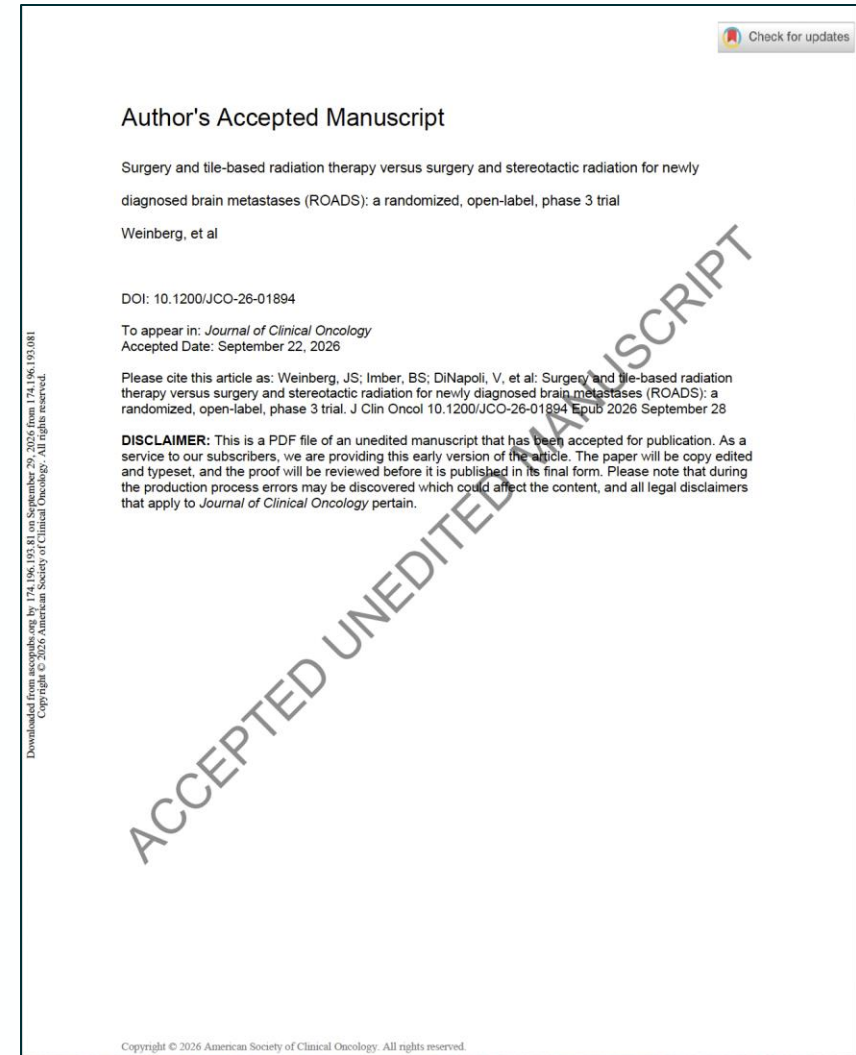


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Published as a Rapid Communication in JCO

- Published as a Rapid Communication in the *Journal of Clinical Oncology*, the official journal of ASCO
- Rapid Communication is a discretionary designation JCO's editors may grant to manuscripts, reserved for findings of exceptional significance¹
- Rapid Communication manuscripts post online within days of acceptance and are openly accessible upon publication, well ahead of standard timelines¹
- "Cesium 131 tiles are a novel therapy that reduces local recurrences after surgical resection and may be the preferred therapy." - *Relevance statement written by JCO Editor-in-Chief Designate.*



ROADS: A multi-site phase 3 RCT against the current SOC

Study Type

- Phase 3, randomized (1:1), multicenter (32)

Objective

- Compare resection + SRT versus resection + TBRT for treatment of a single, newly diagnosed, surgical brain metastasis (index metastasis)

R+SRT Arm (standard of care)

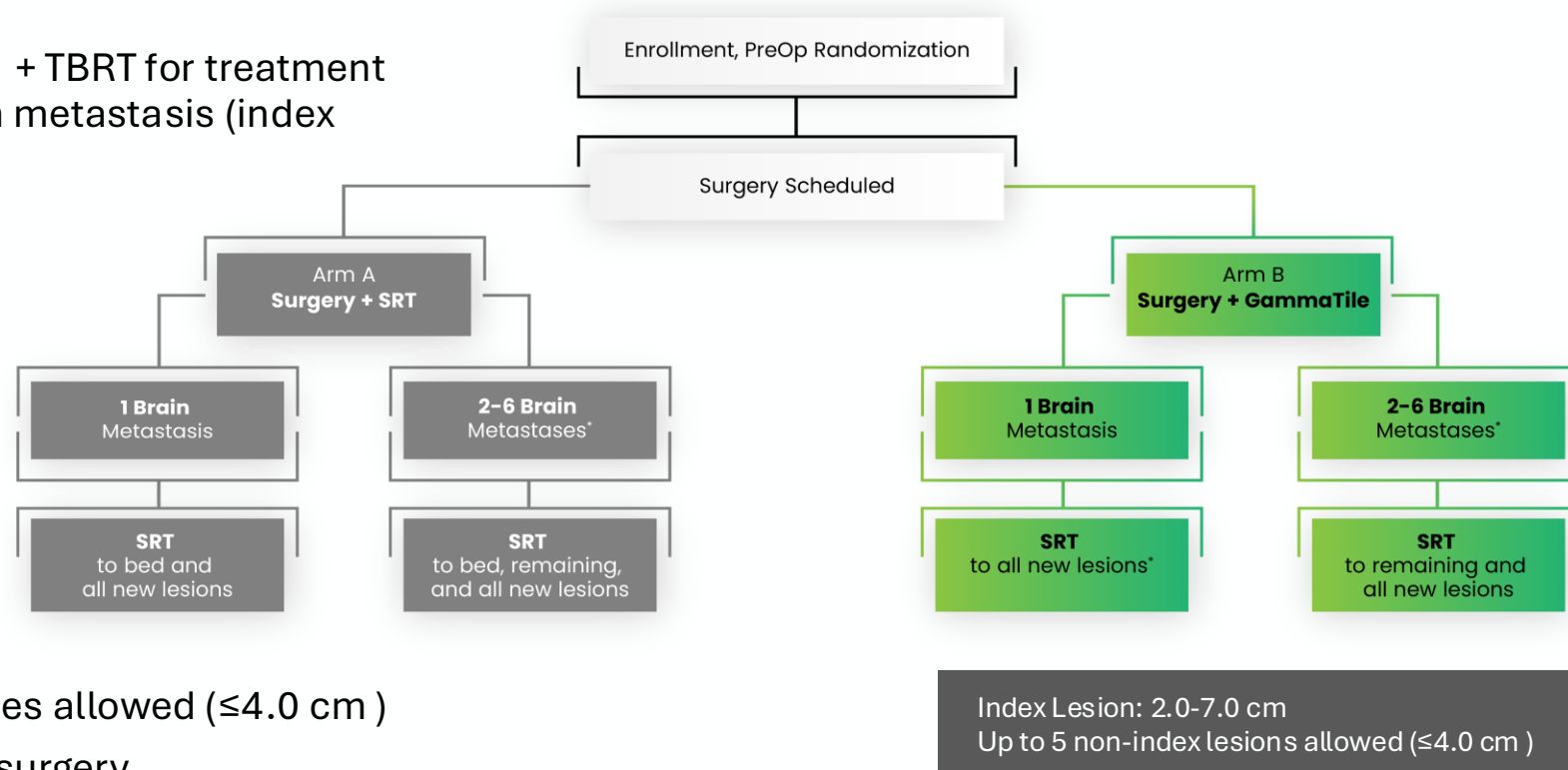
- Maximal safe resection
- SRT starting 21±7 days from surgery

R+TBRT Arm

- Maximal safe resection
- TBRT devices implanted at time of surgery

Non-index brain metastases (both arms)

- 0-5 additional non-surgical brain metastases allowed (≤ 4.0 cm)
- Treated using SRT starting 21±7 days from surgery



Co-primary endpoints confirmed by independent central radiology review

Co-primary endpoints*†

- Time-to-surgical bed recurrence (time-to-SBR)
- Surgical bed recurrence-free survival (SB-RFS)

Pre-specified modified intent-to-treat (mITT) population was used for efficacy analyses

- mITT = patients who had surgery, pathologically confirmed metastasis, any follow-up information
 - Excludes non-metastatic histologies (e.g., glioblastoma)

Secondary endpoints

- Overall survival (OS)
- Quality of life (FACT-Br)
- Functional status (KPS, Barthel-ADL)
- Neurocognitive function
- Leptomeningeal disease (LMD)‡
- Radiation necrosis (RN)
- Factors delaying SRT
- Seizure frequency, craniotomy hospitalization, CSF leak, wound infection

* SBR = radiographic evidence of new or progressive contrast-enhancing metastasis within the surgical bed

† Site-reported SBRs were centrally reviewed by two independent, board-certified neuroradiologists overseen by the American College of Radiology, with complete concordance on SBR determinations

‡ Confirmed and categorized by central review

Rigorous hierarchical statistical testing used to control for multiplicity¹

Co-primary outcomes: time-to-SBR and SB-RFS

- Non-inferiority design based on hypothesis that R+TBRT confers convenience/access-to-care advantages
- **If R+TBRT was statistically non-inferior, superiority testing was performed using hierarchical testing to control type I error in the following order:**



- Non-inferiority and superiority tests used Cox proportional hazards models with stratification variables as covariates
- Survival estimates were made using the Kaplan-Meier method

Key secondary outcome: overall survival

- If co-primary outcomes established superiority of R+TBRT, OS was compared using the same methodology

1. Weinberg JS, Imber BS, DiNapoli V, et al. *J Clin Oncol*. (2026). DOI: 10.1200/JCO-26-01894.

Baseline characteristics: Well-balanced arms across a representative population

Median follow-up: 12.9 months

Parameter	R+TBRT	R+SRT
Randomized Patients (Total 230)	115	115
Modified Intent-to-Treat Population (Total 204)	103	101
Median age in years	64	63
Sex, M:F	40:63	52:49
Race, %: White, Black, Asian, other/unknown	85.4 8.7 0.0 5.9	80.2 13.9 2.0 4.0
Duration of extracranial disease ≤ 3 months, %	52.4	54.5
Median resected tumor diameter, cm (range)	3.20 (2.0–6.1)	3.25 (2.1–5.8)
Mean number of brain metastases (SD)	1.8 (1.13)	1.8 (1.23)
Number of brain metastases, %: 1 2-4 5-6	60.2 36.9 2.9	58.4 36.6 5.0

Histology	R+TBRT (%)	R+SRT (%)
Lung	43.7	45.5
Melanoma	14.6	10.9
Breast	12.6	8.9
Renal	4.9	5.0
Colon	2.9	5.9
Other	21.4	23.8
R+SRT Arm		
Fractions: 1 3-5		7.8% 92.2%
Median days from resection to SRT		27 (6–47)
Reasons for SRT delay		rehabilitation, weather events, scheduling

1. Weinberg JS, Imber BS, DiNapoli V, et al. *J Clin Oncol.* (2026). DOI: 10.1200/JCO-26-01894.

Co-primary endpoints

ROADS Phase 3 RCT

Journal of Clinical Oncology 2026

- Time-to-surgical bed recurrence (time-to-SBR)*
- Surgical bed recurrence-free survival (SB-RFS)*

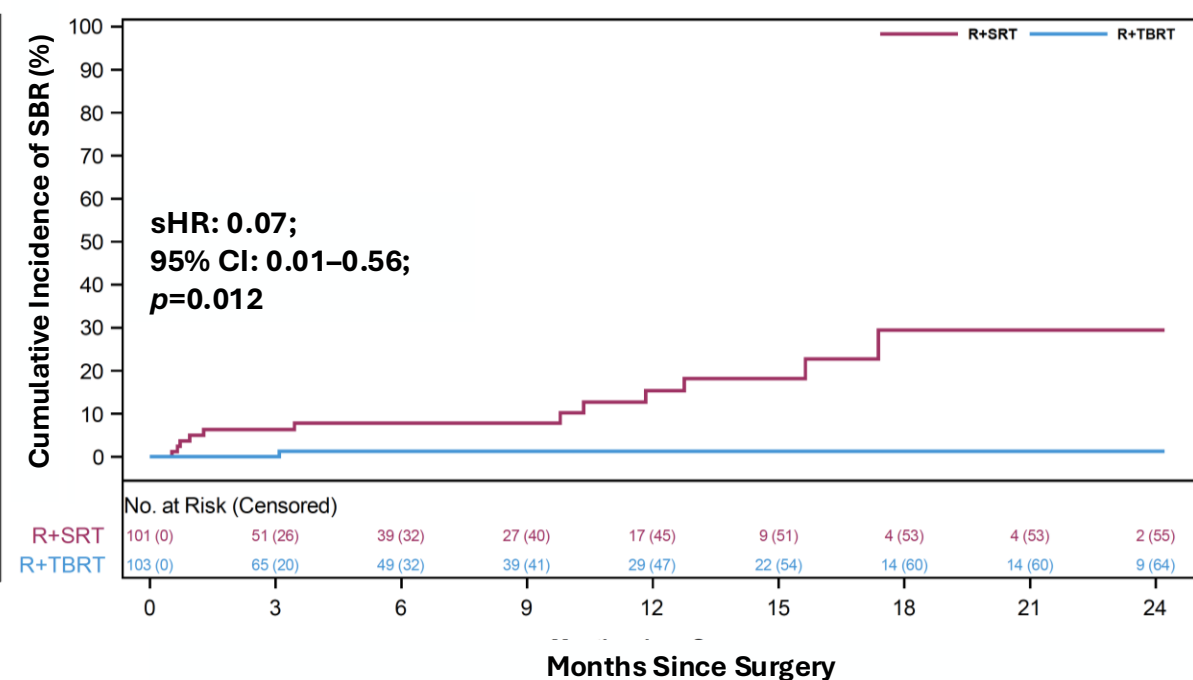
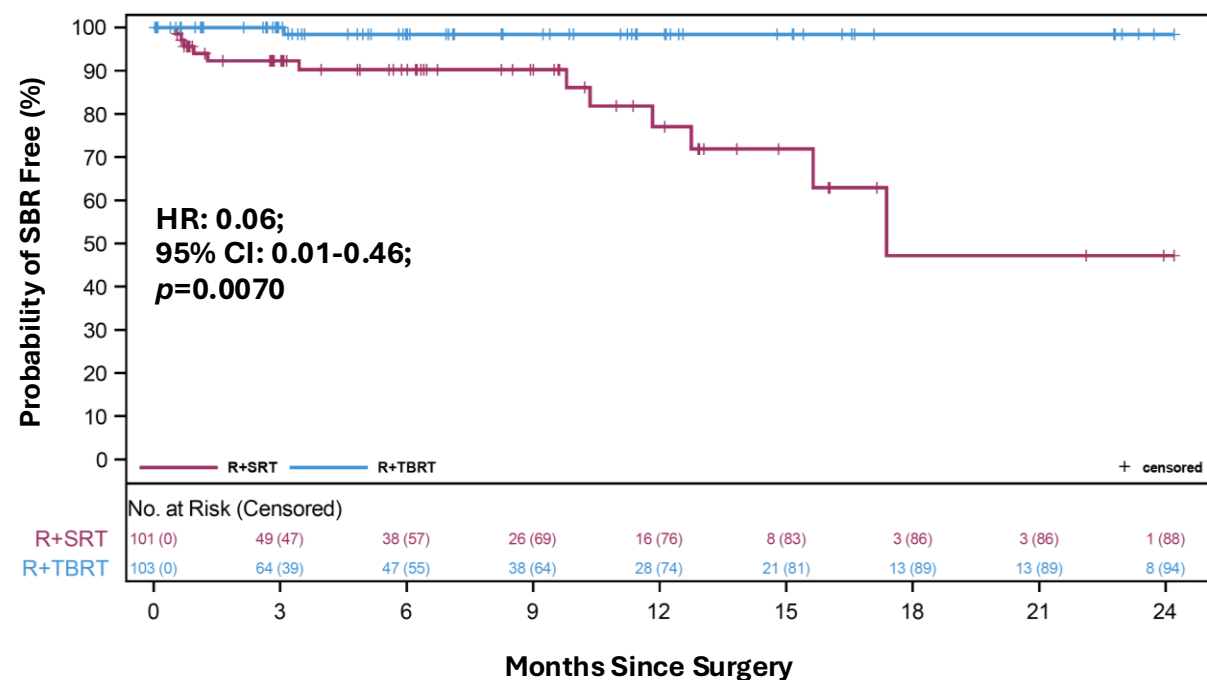
* SBR = radiographic evidence of new or progressive contrast-enhancing metastasis within the surgical bed
1. Weinberg JS, Imber BS, DiNapoli V, et al. *J Clin Oncol*. (2026). DOI: 10.1200/JCO-26-01894.



GammaTile demonstrated *superior* time to surgical bed recurrence (SBR)¹

Time-to-SBR = time from surgery to SBR

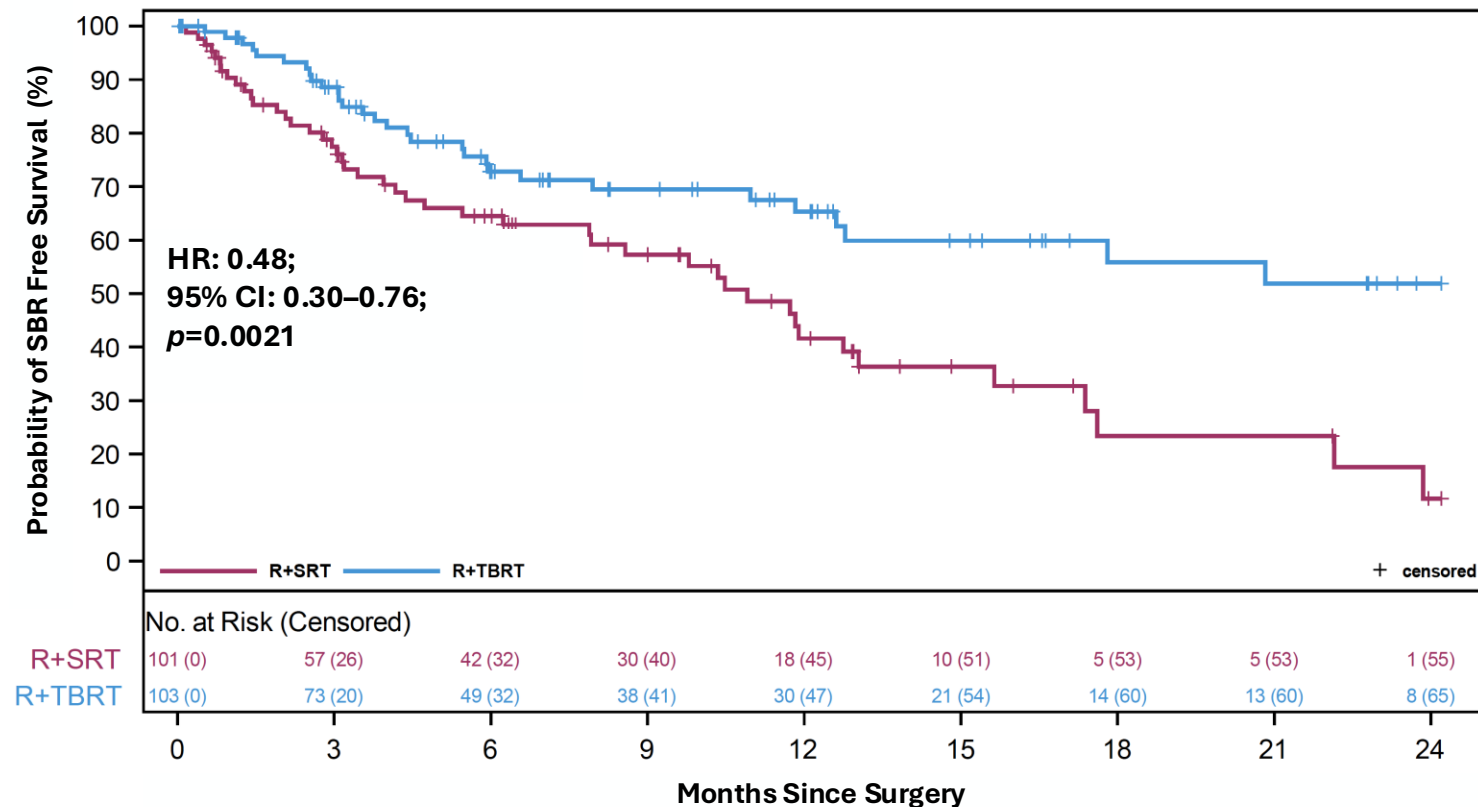
- Median time-to-SBR was not reached in R+TBRT vs. 17.4 months in R+SRT ($p=0.0070$, HR: 0.06)
- 12-month cumulative incidence of SBR was 1.3% in R+TBRT vs. 15.4% in R+SRT ($p=0.012$, sHR: 0.07)



GammaTile demonstrated superior surgical bed recurrence-free survival (SB-RFS)¹

SB-RFS = time from surgery to either SBR or death from any cause, whichever occurred first

- Median SB-RFS was not reached in R+TBRT vs. 10.9 months in R+SRT ($p=0.0021$, HR: 0.48)



1. Weinberg JS, Imber BS, DiNapoli V, et al. *J Clin Oncol*. (2026). DOI: 10.1200/JCO-26-01894.

Post-operative SRT non-completion: a documented and reproducible clinical reality¹

Patient Post-Operative Treatment Non-Adherence	
ROADS RCT Data	Post-Op Prospective Trial Data
17.8% of R+SRT patients did not complete their intended SRT ²	20-27% of patients on prospective trials did not complete their intended SRT ^{3,4}

- An inherent challenge with postoperative SRT is that it is not guaranteed
- In previous trials, 20-27% of trial patients did not complete their intended postoperative SRT^{3,4}

Median Days from Surgery to Beginning Radiation (Brain Mets)		
ROADS RCT Data		Post-Op Meta-analysis
No delay GammaTile ²	27 days Median post-op SRT gap ²	27.8 days Median post-op SRT gap ⁵ Meta-analysis; n=1,338

1. O'Brien DAR, et al. *J Neurosurg.* 135:1695-1705 (2021). 2. Weinberg JS, Imber BS, DiNapoli V, et al. *J Clin Oncol.* (2026). DOI: 10.1200/JCO-26-01894. 3. Yeboa DN, et al. *JAMA Oncol.* 11(8):890–899 (2025). 4. Brennan C, et al. *Int J Radiat Oncol Biol Phys.* 88:130–136 (2014). 5. Nwankwo A, et al. *Precis Radiat Oncol.* 7:278-285 (2023).

Three analysis populations tested the robustness of the co-primary mITT results¹

Population	Intent-to-treat (ITT) <i>All randomized patients</i>	Modified intent-to-treat (mITT) <i>Prespecified analysis, patients who had surgery and pathologic confirmation of metastases</i>	Per-protocol (PP) <i>Patients who completed assigned treatment</i>
Total patients, N	230	204	186
Total patients per arm, N	R+TBRT: 115 R+SRT: 115	R+TBRT: 103 R+SRT: 101	R+TBRT: 103 R+SRT: 83
Definition	All randomized patients	Patients who: • Had surgery • A pathologically confirmed brain metastasis • Any follow-up information (incl. documented death or hospice admission)	mITT patients who: • Received assigned radiation
Excluded	None	• 26 randomized patients: • 14 did not undergo surgery • 11 had ineligible pathology • 1 had no follow-up	• 18 R+SRT patients from the mITT who did not receive SRT
Role in analysis	Supportive analysis • Gold standard analysis; includes every randomized patient, regardless of surgery or pathology	Prespecified population for all efficacy analyses • Comparison of two treatment strategies; resection + GammaTile vs. SOC	Sensitivity analysis addressing R+SRT patients who did not receive their intended SRT • Comparison of radiation; tests whether results hold when the 18 R+SRT patients who did not receive SRT are removed

1. Weinberg JS, Imber BS, DiNapoli V, et al. *J Clin Oncol.* (2026). DOI: 10.1200/JCO-26-01894.

Co-primary endpoints remain superior across all analyses¹

	ITT		mITT (Prespecified Protocol Analysis)		Per Protocol*	
	R+TBRT	R+SRT	R+TBRT	R+SRT	R+TBRT	R+SRT
Patients, N	115	115	103	101	103	83
Surgical Bed Recurrence (SBR)						
Median time-to-SBR, months	Not reached	17.4	Not reached	17.4	Not reached	17.4
Hazard ratio (95% CI)	0.06 (0.01,0.46)		0.06 (0.01,0.46)		0.06 (0.01,0.46)	
p-value	0.0070		0.0070		0.0069	
Surgical Bed Recurrence-Free Survival (SB-RFS)						
Median SB-RFS, months	Not reached	10.9	Not reached	10.9	Not reached	11.8
Hazard ratio (95% CI)	0.48 (0.30,0.76)		0.48 (0.30,0.76)		0.57 (0.35,0.93)	
p-value	0.0021		0.0021		0.025	

*Even when removing patients who did not receive SRT on the SRT arm (per protocol analysis), co-primary endpoints remained significant¹

Secondary and exploratory endpoints

ROADS Phase 3 RCT

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Overall survival (OS)

Quality of life (FACT-Br)

Functional status (KPS, Barthel-ADL)

Neurocognitive function

Leptomeningeal disease (LMD)*

Radiation necrosis (RN)

Factors delaying SRT

Seizure frequency, craniotomy hospitalization, CSF leak, wound infection

Exploratory: time to SBR or RN

*Confirmed and categorized by central review

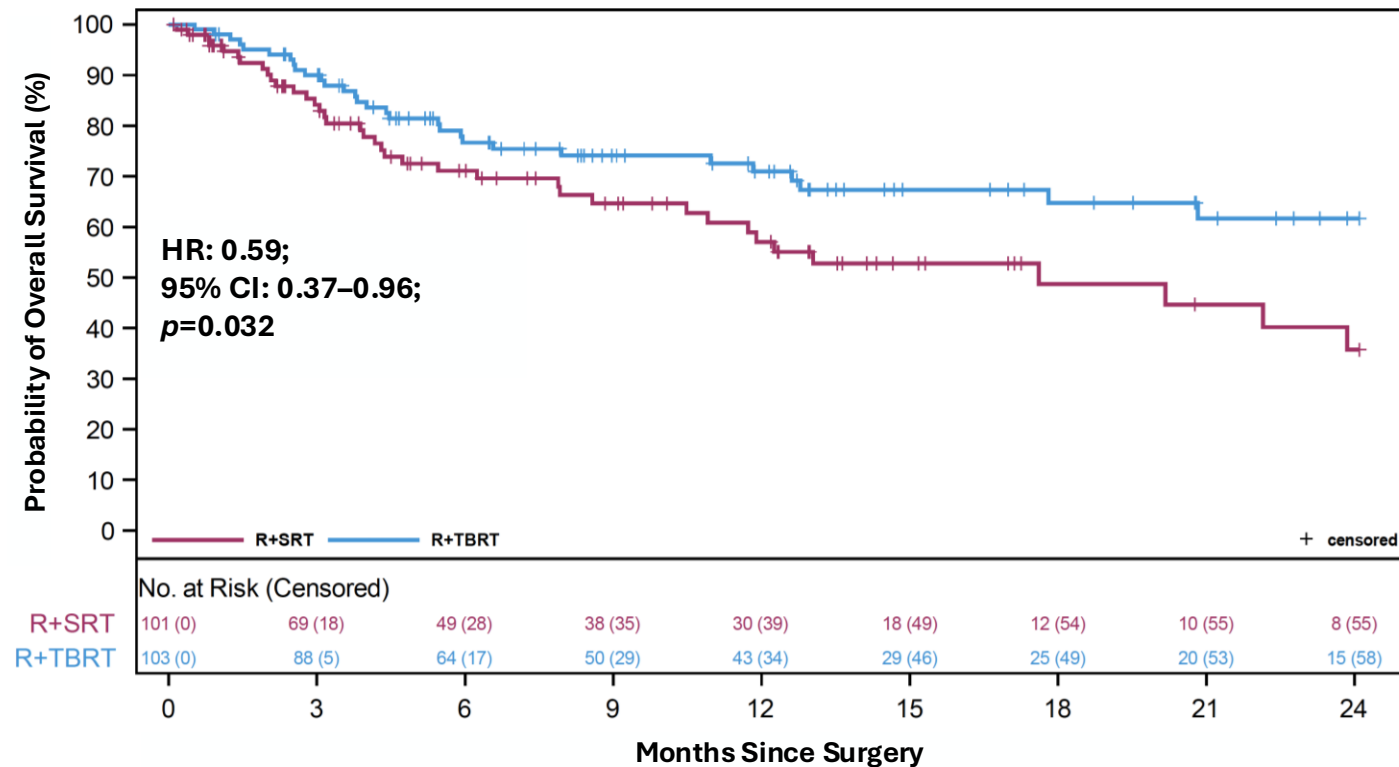
1. Weinberg JS, Imber BS, DiNapoli V, et al. *J Clin Oncol*. (2026). DOI: 10.1200/JCO-26-01894.



GammaTile demonstrated significantly improved overall survival¹

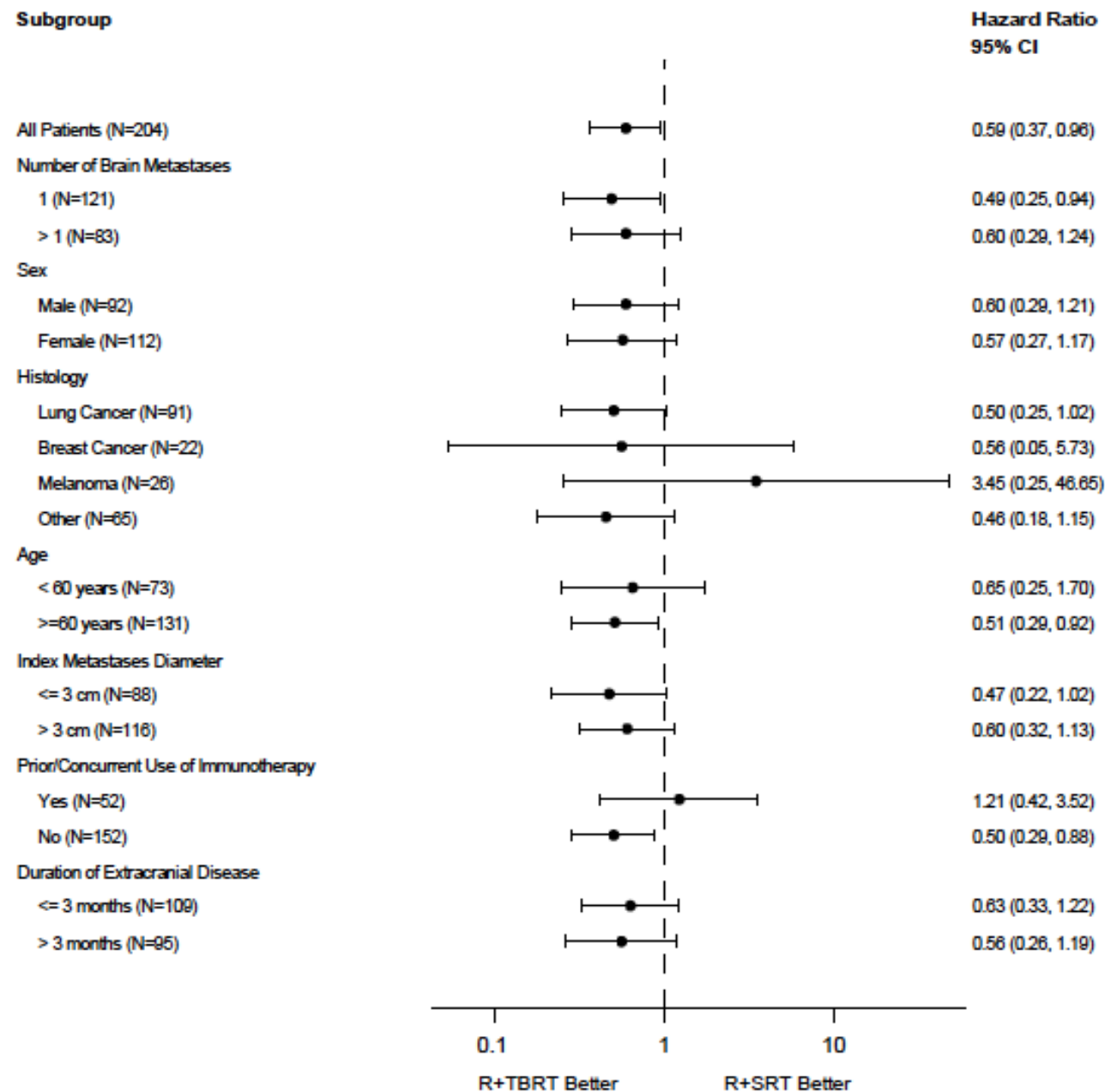
OS = time from surgery to death from any cause

- Median OS was 42.5 months in R+TBRT vs. 17.6 months in R+SRT ($p=0.032$, HR: 0.59)



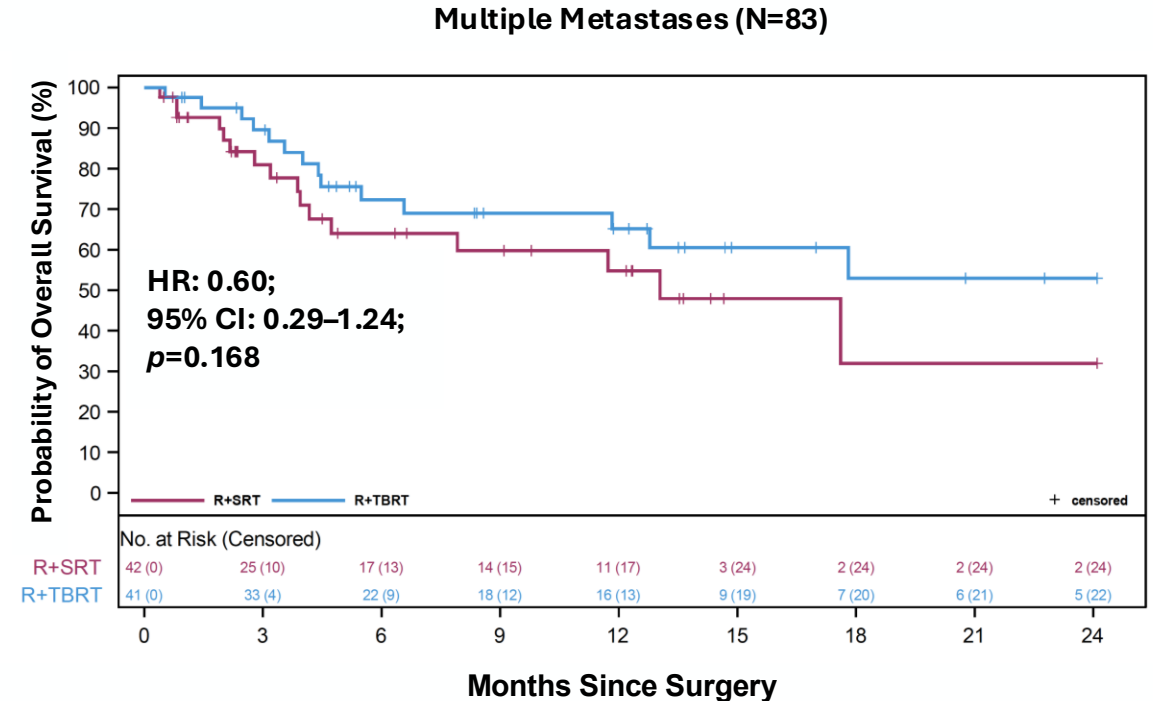
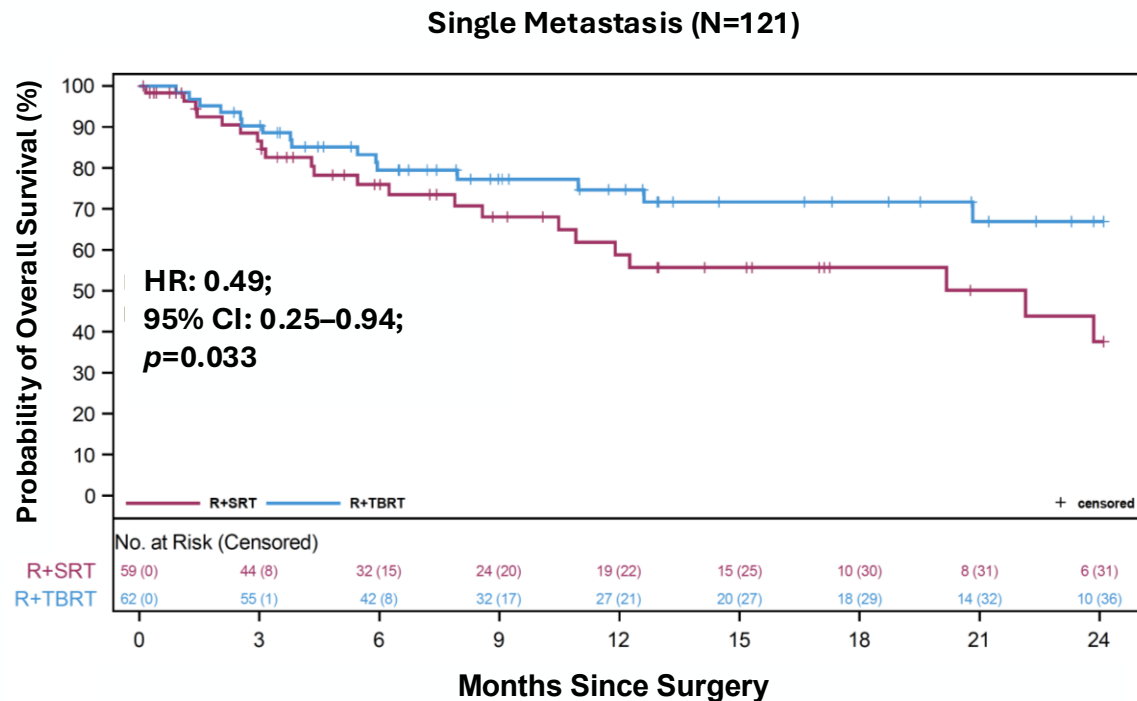
1. Weinberg JS, Imber BS, DiNapoli V, et al. *J Clin Oncol.* (2026). DOI: 10.1200/JCO-26-01894.

OS benefit was directionally consistent across most subgroups in the mITT population¹



Overall survival analysis by number of brain metastases

- Single metastasis (N=121): median OS not reached (R+TBRT) vs. 22.1 months (R+SRT); HR 0.49 (95% CI 0.25–0.94); $p=0.033$
 - Consistent with prior literature linking effective local management of single brain metastases to longer survival^{2,3}



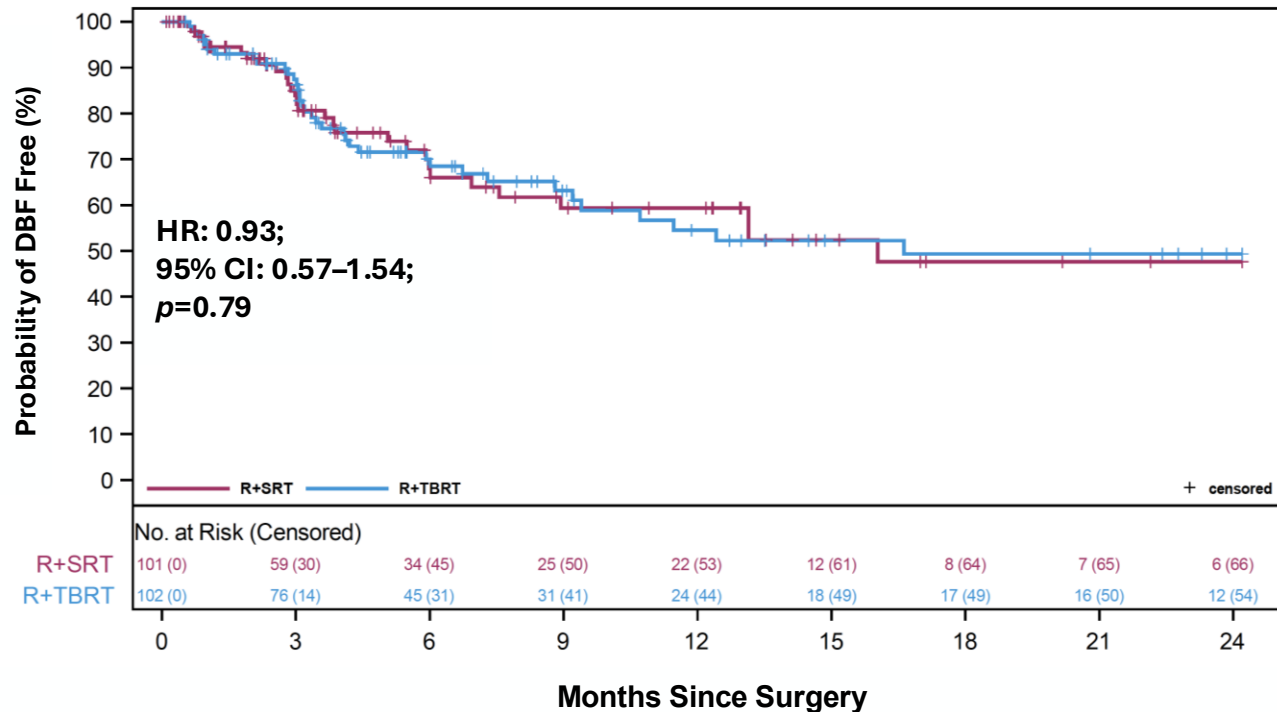
1. Weinberg JS, Imber BS, DiNapoli V, et al. *J Clin Oncol.* (2026). DOI: 10.1200/JCO-26-01894.

2. Patchell RA, et al. *N Engl J Med.* 322(8):494–500 (1990). 3. Andrews DW, et al. *Lancet.* 363(9422):1665–1672 (2004).

Distant brain failure was similar in each arm¹

Distant brain failure (DBF) = development of any new brain metastases during the study

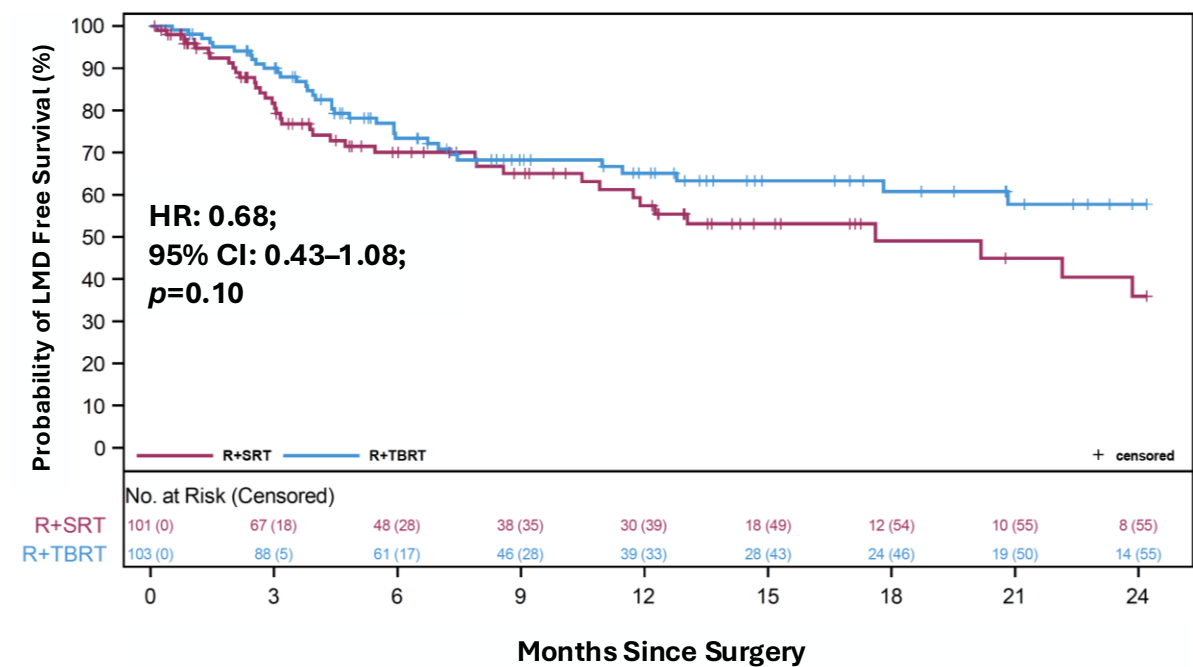
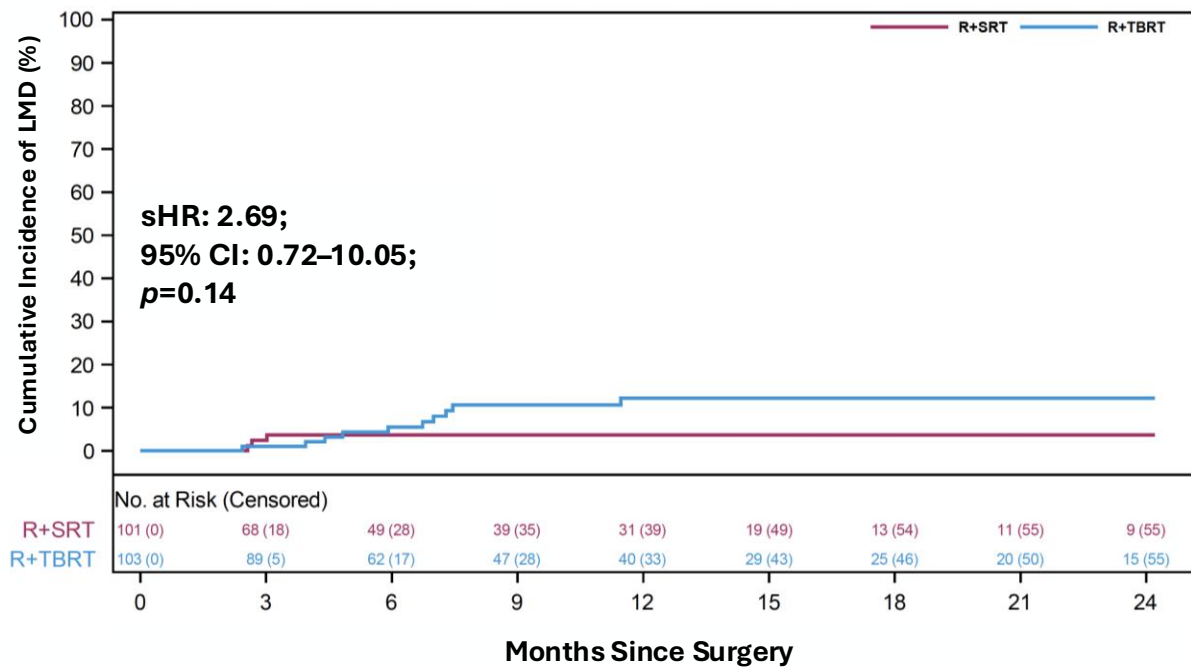
- Time-to-DBF = time from surgery to DBF
- No difference in time-to-DBF between arms ($p=0.79$)



1. Weinberg JS, Imber BS, DiNapoli V, et al. *J Clin Oncol.* (2026). DOI: 10.1200/JCO-26-01894.

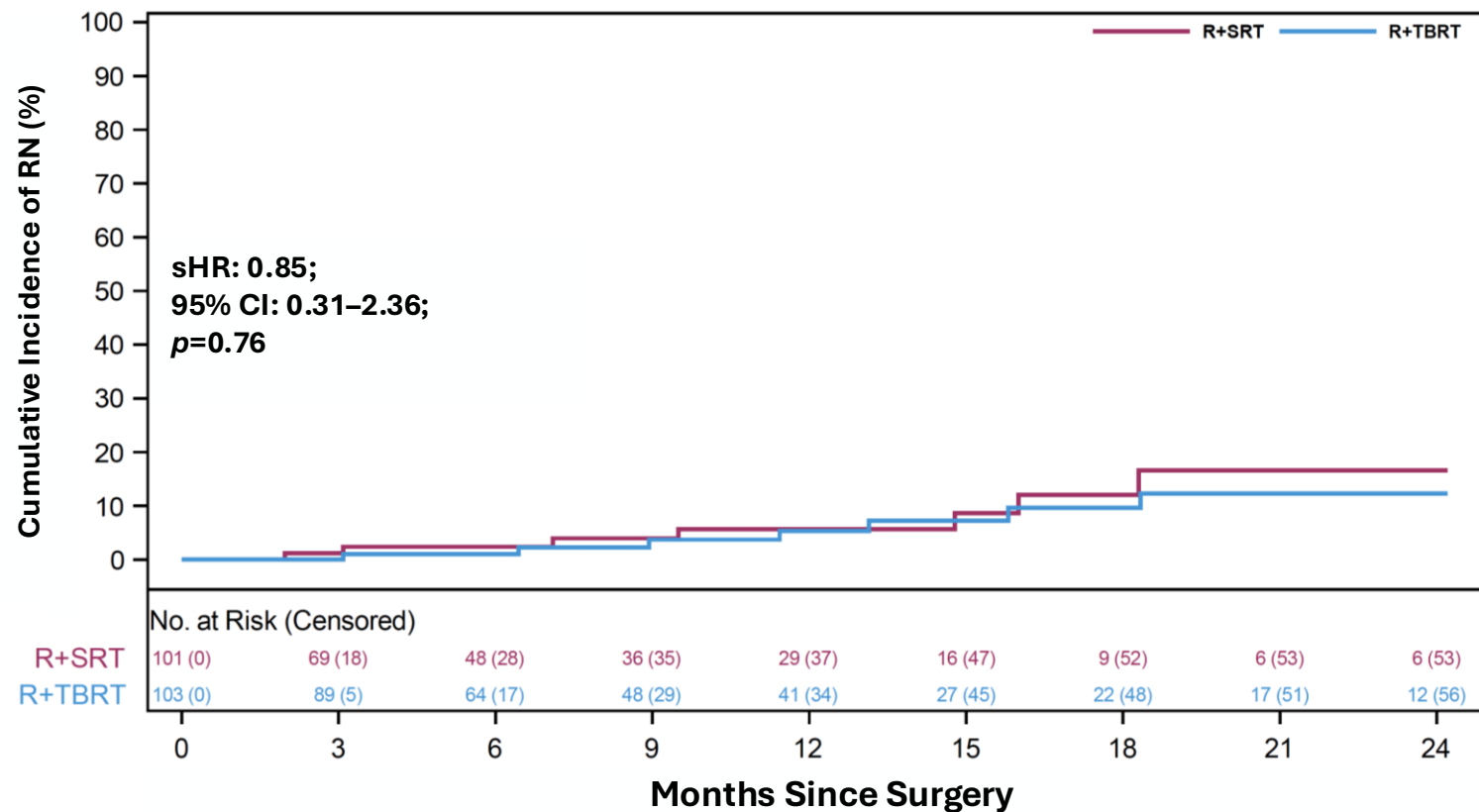
There was no statistically significant difference in LMD¹

- No significant difference in LMD-free survival (LMD or death, whichever occurs first) ($p=0.10$)
- No significant difference in cumulative incidence of LMD ($p=0.14$)



Radiation necrosis was similar in each arm¹

- 12-month cumulative incidence of RN was 5.3% (95% CI: 1.7-12.2) in R+TBRT vs. 5.7% (95% CI: 1.8-13.0) in R+SRT
- No difference in cumulative incidence of RN between arms ($p=0.76$)



The percent of patients who experienced AEs was balanced between arms¹

	R + TBRT	R + SRT
General*	(N=105)	(N=83)
Any adverse event (AE)	79.0%	80.7%
Serious AE	43.8%	54.2%
All ≥grade 3 treatment-related adverse events (TRAEs)	20.0%	21.7%
Grade ≥3 radiation necrosis	1.9%	1.2%
Pre-specified expected AEs[†]	(N=103)	(N=101)
Seizure	4 (3.9%)	7 (6.9%)
Wound complication	9 (8.7%)	10 (9.9%)
Wound infection	1 (1.0%)	0 (0.0%)
CSF leak	1 (1.0%)	1 (1.0%)

*Safety population: patients who underwent surgery and received study radiation (R+TBRT: tiles implanted, R+SRT: SRT delivered).

[†]mITT population; events reported up to 3 months after surgery.

Secondary endpoints showed no significant differences in quality of life, functional status, or neurocognitive function¹

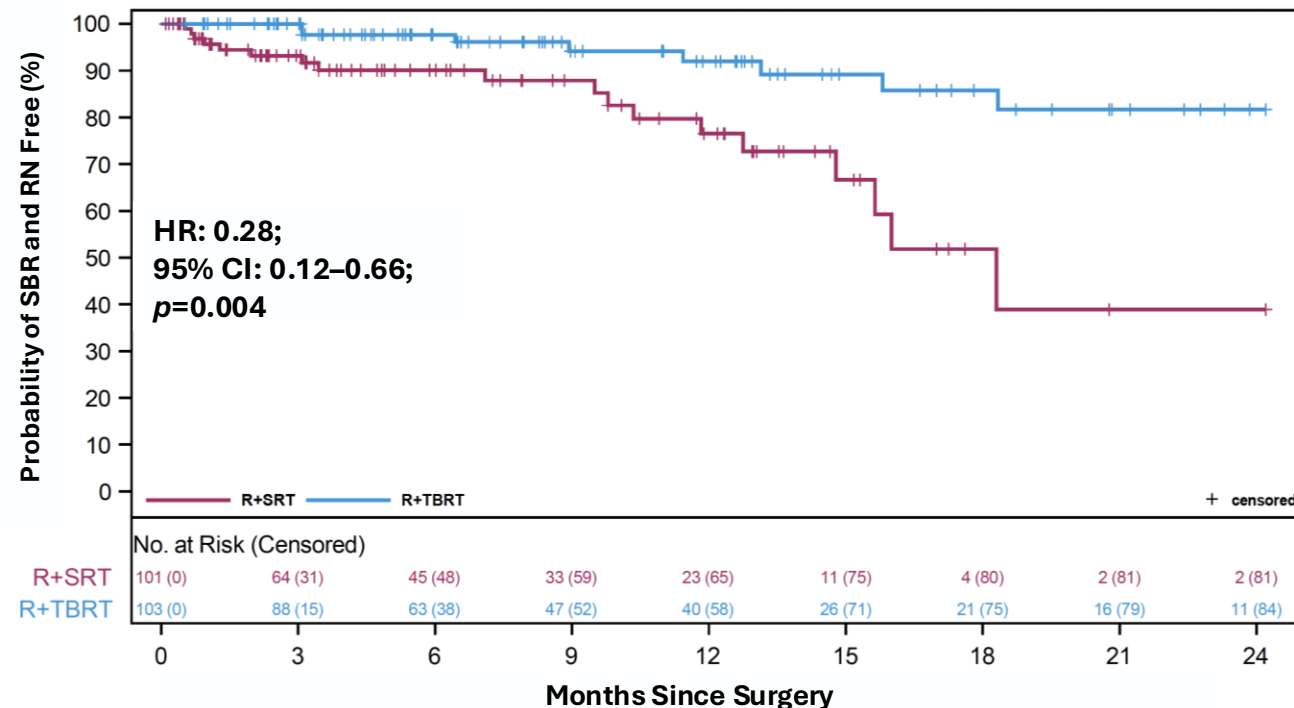
Outcome	R + TBRT	R + SRT	Result
Quality of life (FACT-Br)			No difference between arms
Functional status (KPS, Barthel-ADL)	Baseline median KPS 80 (60–100)	Baseline median KPS 80 (60–100)	No difference between arms
Neurocognitive function			No difference between arms
Median craniotomy hospitalization	3.0 days	4.0 days	HR 1.09 (0.82–1.45); p=0.56

1. Weinberg JS, Imber BS, DiNapoli V, et al. *J Clin Oncol*. (2026). DOI: 10.1200/JCO-26-01894.

GammaTile led to significantly longer time to SBR or RN¹

Time-to-SBR or RN = time to either surgical bed recurrence or radiation necrosis, whichever occurred first

- This composite endpoint helps alleviate concern that SBR and RN could be mistaken for one another, a common diagnostic dilemma
- TBRT showed significantly longer protection from worrisome radiographic brain changes (both SBR and RN)



1. Weinberg JS, Imber BS, DiNapoli V, et al. *J Clin Oncol.* (2026). DOI: 10.1200/JCO-26-01894.

Improved outcomes did not come at the expense of increased toxicity¹

	R+TBRT	R+SRT	
Co-Primary Endpoints (SBR and SB-RFS)			
Median time-to-SBR	Not reached	17.4 months	HR: 0.06; 95% CI: 0.01-0.46; $p=0.0070$
12-mo cumulative incidence of SBR	1.3%	15.4%	sHR: 0.07; 95% CI: 0.01-0.56; $p=0.012$
Median SB-RFS	Not reached	10.9 months	HR: 0.48; 95% CI: 0.30-0.76; $p=0.0021$
Secondary Endpoints			
Median OS	42.5 months	17.6 months	HR: 0.59; 95% CI: 0.37-0.96; $p=0.032$
12-mo cumulative incidence of RN	5.3%	5.7%	sHR: 0.85; 95% CI: 0.31-2.36; $p=0.76$
Patients with LMD	10 (9.7%)	3 (3.0%)	$p=0.15$
≥grade 3 TRAE	20.0%	21.7%	-

LMD = leptomeningeal disease; OS = overall survival; RN = radiation necrosis; SBR = surgical bed recurrence; SB-RFS = surgical bed recurrence-free survival; TRAE = treatment-related adverse event

Authors conclude R+TBRT should be considered a standard-of-care option

- This conclusion is based on:¹
 - ROADS is a multicenter randomized phase 3 trial with longer median follow-up than the studies that established post-operative SRT as standard-of-care
 - GammaTile was superior on both co-primary endpoints
 - The reduction in surgical bed recurrence was substantial
 - The efficacy gain came without an increase in radiation necrosis, neurocognitive decline, or quality-of-life deterioration



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How to discuss ROADS with patients and caregivers (lay summary)

- For patients who had surgery to remove a new brain metastasis, tile-based radiation therapy, compared with standard treatment, showed:¹
 - The cancer was less likely to grow back in the treated area
 - Patients were less likely to have worrisome changes on their follow-up brain MRIs
 - Patients lived longer
 - Treatment with tile-based radiation did not increase the chance of side effects

GammaTile clinical evidence: proven tumor control, low rates of toxicity

STUDY	STUDY DESIGN	# PTS	# TREATED TUMORS	EFFICACY OUTCOME	SAFETY
Newly Dx Brain Mets (BM)					
Weinberg 2026	Phase 3 RCT	230	103 (GT)	1.3% cumulative incidence of SBR at 12 mos. Median SB-RFS: Not reached Median OS: 42.5 mos.	5.3% RN at 12 mos.
Chuck 2026	Retrospective, multi-center	36	39	100% LC at 12 mos. 98% LC at 24 mos.	2.6% RN
Kite 2026	Prospective Phase 4 (Registry)	51	55	92.3% LC at 12 mos. 7.8% LMD	Total AE: 9.8% No RN Reported 88.5% LMD-free survival at 12 mos.
Recurrent Brain Mets (BM)					
Shrivastava 2026	Retrospective	16	19	89.5% LC at 12 mos. (all) 100% LC at 12 mos. with GTR.	6.3% Symptomatic RN
Beckham 2025	Retrospective	31	38	87% LC at 12 mos.[†] (all) 94% LC at 12 mos. with GTR[†]	8% Symptomatic RN 3.2% Infection (<i>Unrelated to GammaTile</i>)
Zeller 2024	Prospective Phase 4 (Registry)	28	30	NR (Perioperative safety analysis)	Serious AE: 3.6% / Total AE: 21.4% <i>No AEs were definitively related to GammaTile</i>
Kutuk 2023	Retrospective	10	12	100% LC at 6, 12, and 18 mos.	8% Symptomatic RN
Imber 2022	Prospective	20	25	92% LC at 12 mos.[†]	16% Symptomatic RN
Newly Dx & Recurrent Brain Mets					
Dharnipragada 2023	Retrospective	10	10	100% LC at 6.2 mos. median follow-up	No RN No Surgical Complications
Nakaji 2020 [‡]	Prospective	11	16	All 83% LC at 12 mos. [†] Newly Dx (n=4): 100% LC Recurrent (n=12): 83% LC[†]	12.5% Radiation Brain Changes Newly Dx (N=4) = 0% Recurrent (N=12) = 12.5%

[‡]Evidence drawn from a prototype device in pre-commercial product evaluation.

LC = Local Control; LF = Local Failure; NR=Not Reported; OS = Overall Survival; RN = Radiation Necrosis; SB-RFS: Surgical bed recurrence-free survival

GammaTile clinical evidence: proven tumor control, low rates of toxicity

STUDY	STUDY DESIGN	# PTS	# TREATED TUMORS	TUMOR TYPE	EFFICACY OUTCOME	SAFETY
Recurrent Glioblastoma (GBM)						
Chuck 2026	Retrospective	60	60	GBM (Recurrent)	88% / 79% LC at 12 mos. (MGMTm/MGMTu) Median OS: 11.1 mos.	2% RN 3% Pts with Surgical Complications
Haisraely 2026	Retrospective	15	15	IDH Wild-type GBM (Recurrent)	Median OS: Not Reached Median PFS: 9 mos.	6.7% Symptomatic RN
Smith 2022	Prospective	28	28	GBM (Recurrent)	Median time to LF: 12.1 mos. Median OS: 25.0 mos. Median PFS: 11.7 mos.	7% Symptomatic RN
Gessler 2022	Prospective	22	22	IDH Wild-type GBM (Recurrent)	86% LC at 6 mos. / 81% LC at 12 mos. Median OS: 24.4 mos. Median PFS: 8.2 mos.	No RN 9% Pts with Surgical Complications
Newly Dx & Recurrent Glioblastoma (GBM)						
Yekula 2024	Prospective	7	7	Rapidly Growing GBM (Newly Dx & Recurrent)	Median OS (Newly Dx): 11.5 mos. Median OS (Recurrent): 10 mos. Median PFS (All): 10.6 mos.	No RN No Surgical Complications
Recurrent Meningioma						
Lee 2026	Prospective	27	29	Meningioma (Recurrent)	79% LC at 36 mos. 73% LC at 48 mos. 48% LC at 60 mos.	Surgically related complications: 14% (4) Symptomatic radiation injury: 14% (4), all medically resolved
Brachman 2018 [‡]	Prospective	19	20	Meningioma (Recurrent)	Median OS: 26 mos. 89% PFS at 18 mos.	10% RN 10% Pts with Surgical Complications

[‡]Evidence drawn from a prototype device in pre-commercial product evaluation.

LC = Local Control; LF= Local Failure; NR=Not Reported PFS=Progression Free Survival; RN = Radiation Necrosis

Advancing care through ongoing clinical studies

	GT MEDICAL TECHNOLOGIES SPONSORED STUDIES				INVESTIGATOR INITIATED STUDIES
	GTM 101 STaRT Registry	GTM 102 ROADS – PUBLISHED IN JCO	GTM 103 GESTALT – FULLY ACCRUED	GTM 105 BRIDGES	MEMORIAL SLOAN KETTERING IIT – FULLY ACCRUED
	Multi-Tumor Types	Newly Dx Mets	Newly Dx GBM	Newly Dx GBM	Recurrent Mets
Design	Basket, observational real-world use	RCT comparing S + GT vs. SOC (S + SRT)	Single arm feasibility, combining GammaTile and Stupp Protocol	RCT comparing inclusion of GT with Stupp vs. SOC	RCT comparing S + GT vs. S alone
N	Minimum 600	230	67	766	76
Outcomes	LC, OS, Functional Status, AEs, QoL (at select sites)	LC, OS, AEs, Functional Status, Neurocognitive Status, QoL	Starting Stupp protocol ≤35 days post-surgery, AEs Secondary: OS, LC	OS, PFS, time to next unplanned treatment, KPS, AEs, QoL	LC, AEs, Neurocognitive Status
Sites	Up to 50 sites	32 sites Lead site: MDACC	Up to 20	Up to 80	Lead site: MSKCC Sub site: MCI

Thank you

For product information or assistance, or to be connected with your GammaTile representative, contact:

GammaTile Customer Service Department

(833) 662-0044 | customerservice@gammatile.com

For adverse event reports and product complaint reports, contact:

GammaTile Medical Information Department

(833) 662-0044 | feedback@gammatile.com

GammaTile® is indicated as a treatment for patients with newly diagnosed malignant intracranial neoplasms and patients with recurrent intracranial neoplasms. The potential for, and symptoms of, adverse events related to radiation exposure vary depending on the radiosensitivity of the exposed tissue, the amount of radiation delivered, and the placement of GammaTile(s). GammaTile should not be used for patients with a known history of hypersensitivity to bovine-derived materials. More information on indications, contraindications, warnings, and instructions for use can be found in the GammaTile Instructions for Use.

CAUTION: The law restricts these devices to sale by or on the order of a physician.

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